Leeds Pharmaceutical Needs Assessment 2018-2021

Leeds Health and Wellbeing Board

To be published 31st March 2018

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Executive summary

Statement and Purpose of PNA

A Pharmaceutical Needs Assessment (PNA) is a statement of the need for pharmaceutical services. Pharmaceutical services are provided by Pharmacies Dispensing Appliance Contractors, Distance selling pharmacies, Dispensing Doctors and Local Pharmaceutical Services.

The PNA has looked at the current provision of pharmaceutical services across Leeds, to assess whether it meets the needs of the population and to identify any potential gaps in service delivery.

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish a PNA and keep it up to date.
The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

If significant changes in the need for pharmaceutical services occur during the three years of the life of the PNA, then the Health and Wellbeing Board is required to publish a revised assessment as soon as is reasonably practicable. Supplementary statements to the PNA can be made if the provision of pharmaceutical services changes.

Process of producing PNA

The process of the PNA was broken down into four key stages:

- Scoping
- Analysis
- Formal consultation
- Final publication

During the development of the PNA, information was gathered about current service provision from a number of stakeholders, commissioners, community members and pharmacists themselves.

Summary of main findings

The PNA has found that Leeds has very good coverage of necessary pharmaceutical services with no gaps in provision. There are also no current gaps in the provision of other relevant services in the area of the Leeds Health and Wellbeing Board.

There is one less pharmacy since the 2015 PNA, but an increase in the number of distance selling pharmacies to seven. The Leeds Outer North East and Outer East areas have fewer community pharmacies within a one mile buffer zone of their

population, but in the Outer North East area there are seven dispensing GP practices to complement Community Pharmacy provision.

The majority of the Leeds population live within one mile of a pharmacy and 80% of the residents in the PNA public survey reported that availability of pharmacies in their area was very good (42%) or good (38%). 76% of residents said that the quality of pharmacies in their area was good or very good.

A very small minority of citizens reported some difficulty accessing out-of-hours pharmaceutical services.

Some newly-emerging communities may not be using available services as much as they might because of language and cultural barriers. By continuing to develop, exercise and extend where appropriate their expertise around Equality and Diversity, pharmacy teams can continue to respond fully to meeting the needs of a changing and increasingly diverse population.

The PNA having regard to likely changes to the number of people requiring pharmaceutical services, the demography of the Health and Wellbeing area, and the risks to the health and wellbeing of people in the area has not identified any future pharmaceutical needs within the next three years which cannot be met by providers currently on the pharmaceutical list.

If significant changes in the need for pharmaceutical services occur over the three year life of this PNA, then the Health and Wellbeing Board is required to publish a revised assessment as soon as is reasonably practicable. Supplementary statements to the PNA can be made, if the provision of pharmaceutical services changes.

Conclusions

The PNA concludes:

- There are no current gaps in the provision of necessary services in the area of the Leeds Health and Wellbeing Board

- There are no current gaps in the provision of other relevant services in the area of the Leeds Health and Wellbeing Board

- That as of 1st January 2018, all areas of Leeds have a reasonable choice of pharmaceutical services

- The PNA has not identified any future needs which could not be met by pharmacies already on the current pharmaceutical list which would form part of its related commissioning intentions

1. Introduction

The Public Health strategy for England “Healthy Lives, Healthy People” (2010) set out to put local communities at the heart of public health. It also stated that Health and Wellbeing boards would have a responsibility for producing pharmaceutical needs assessments (PNAs).

It recognised that:

“Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities.”

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish a PNA and keep it up to date.
The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

More recently, the NHS England Next Steps on the NHS Five Year Forward View report published March 2017 set out a detailed, costed package of investment and reform for primary care now through to 2020. It focuses on more convenient access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings, and better integrated with community and preventive services, hospital specialists and mental health care.

Most GP surgeries will increasingly work together in primary care networks or hubs, allowing them to share community nursing, mental health, and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access. It will also involve working more closely with community pharmacists, to make fuller use of the contribution they make.

Therefore community pharmacies are viewed as an important and integral part of the NHS and being at the very heart of local communities have an important part to play in supporting local people maintain their health.

This PNA has assessed the current provision of pharmaceutical services across Leeds, to ensure it can meet the needs of the population over the three years from 1st April 2018 to 31st March 2021.

2. Main Findings

2.1 Geographical coverage and access

The PNA has found that Leeds has very good coverage of necessary pharmaceutical services with no gaps in provision. There are also no current gaps in

the provision of other relevant services in the area of the Leeds Health and Wellbeing Board.

There is one fewer community pharmacy since the 2015 PNA, but there are now seven distance-selling pharmacies, which is up from two reported in 2015. Therefore general infrastructure to increase access to pharmaceutical services has improved over the last three years.

The majority of the Leeds population live within one mile of a pharmacy and 80% of the residents in the PNA public survey reported that availability of pharmacies in their area was very good (42%) or good (38%). 76% of residents said that the quality of pharmacies in their area was good or very good.

The Leeds Outer areas have fewer community pharmacies within a one mile buffer zone of their population and fewer open for extended hours but the Outer North East area has seven dispensing GP practices and there are seven distance selling pharmacies across Leeds to complement community pharmacy provision.

A very small minority of citizens reported some difficulty accessing out-of-hours pharmaceutical services.

Some newly-emerging communities may not be using available services as much as they might because of language and cultural barriers. By continuing to develop, exercise and extend where appropriate their expertise around Equality and Diversity, pharmacy teams can continue to respond fully to meeting the needs of a changing and increasingly diverse population.

2.2 Service Provision

The 2015 PNA reported 181 pharmacies working within the national contract. In October 2017, there were 180 pharmacies working within the national contract.

2.3 Opening times

Many of the community pharmacies have opening hours that accommodate access for citizens outside of the usual 9am -5pm Monday to Friday period and twenty seven community pharmacies are contracted by NHS England to open for a minimum of 100 hours a week, an increase from twenty one in 2015.

2.4 Access to pharmaceutical services in Outer Community Committee Areas

There are 31,424 people who live in Lower Super Output Areas (LSOAs) where the centre of the LSOA is outside the one-mile buffer zone (**Appendix 1**). This means that they live more than 1 mile away from their nearest pharmacy.

The Leeds Outer areas have fewer community pharmacies within a one mile buffer zone of their population and fewer open for extended hours but the Outer North East

area has seven dispensing GP practices and there are seven distance selling pharmacies across Leeds to complement community pharmacy provision.

The vast majority of the public responding to the PNA survey did not report any major access issues. Feedback from citizens in the community survey and focus group found that a small minority had on occasion needed to travel further to reach a community pharmacy, but this does not constitute a gap in pharmaceutical services for the area.

Significant improvement work in transport is being planned and within 10 years, the Leeds Public Transport Investment Programme, with additional investment from the bus operators, will result in over 90% of core bus services running every 10 minutes between 7am and 8 pm. These improved transport links will enhance the current good access to an already wide range of essential and advanced services, which will support them and the wider health and social care system.

2.5 Implications of GP extended hours

91% of pharmacies responding to the PNA survey replied that the extended opening hours of GP surgeries (to seven days a week) had had no impact on the services they provide.

Of the 8% who had noticed an impact, a number of pharmacies were taking the opportunity to match these hours. Increased footfall was reported in a positive way, suggesting increased public access. This model has not yet been fully implemented, but is being rolled out in Leeds to ensure 100% coverage by the March 2019 deadline. Given the extent and coverage of current opening, any additional GP hours will be adequately covered by the existing network.

2.6 Service use

The majority of people responding to the PNA survey use their pharmacies for traditional medicines-based services and just under half visit their pharmacy every month. The dispensing service is used most, with 35% of individuals regularly and 39% sometimes using this service. Buying over-the-counter medicines is also popular: 16% of respondents regularly buy over-the-counter medicines and 63% do so sometimes.

Fewer people use their pharmacy to dispose of old or unwanted medicines, with 5% of people regularly and 44% sometimes using this service. The electronic prescription service is well used, with 40% of people regularly and 10% sometimes using this service.

Relatively few people said they access pharmacies for lifestyle support such as stop smoking advice, with only 1.4% using lifestyle support services regularly or sometimes. Slightly more (3.1%) regularly, or sometimes use pharmacies for advice on chronic obstructive pulmonary disease (COPD), which is a long-term, mainly smoking-related condition.

Less than 1% of the sample population use chlamydia screening regularly or sometimes; 0.8% use the emergency contraception service regularly and 1.8% sometimes.

However, limitations of the data mean it may not fully reflect the views of the smoking sub-population, the needs of the sexually active or childbearing population or the needs of those living in deprived neighbourhoods, where smoking and unplanned pregnancy prevalence is generally higher.

A lack of awareness as to what a community pharmacy can or is commissioned to provide was evident from both the community survey and the BAME focus group, which was convened during the 60 day consultation period so more effective communication channels and more frequent awareness-raising activities might be helpful, if pharmacies are to fully reach their potential.

2.7 Perceived gaps in service

Despite the public response, the most frequent perceived gap in services that pharmacy staff identified, and would provide if commissioned to do so, was sexual health, pregnancy testing and/or emergency hormonal contraception, together with weight management, smoking cessation/nicotine replacement. One stakeholder suggested that long term condition management, BP monitoring across the city, weight management and smoking cessation across the city may become a gap over the next three years.

However, following a comprehensive service review in 2015, a health needs assessment and stakeholder consultation, the stand-alone stop-smoking support service ceased in primary care and pharmacies in October 2017. The value of this contract was £4,000. Clients are now receiving this service as part of a comprehensive integrated lifestyle package, with the expectation that pharmacies will signpost to it where appropriate.

There is therefore no anticipated gap in terms of reduction of positive outcomes for the population of Leeds.

2.8 Vulnerable groups and newly-emerging communities

2.8.1 Disabled groups

143 (93%) of the 154 pharmacies responding to the survey are part of the Leeds Dementia Friendly Scheme. This is an unfunded but important goodwill scheme to help protect vulnerable individuals who are living with dementia.

122 (79%) pharmacies have unaided disabled access and 146 (95%) have floors that are accessible by wheelchair. 120 (78%) pharmacies have blue badge parking within 10 metres of the pharmacy and a smaller number have facilities and adaptations to help people with physical, visual or hearing impairments, as well as older and less mobile people, access their service.

One stakeholder reported some difficulties with regards to the deaf community accessing information at the time of collecting prescriptions. This can be adequately addressed by current pharmacies in terms of their equality and diversity considerations and does not constitute a need for further provision.

2.8.2 Gypsy Travellers

A small Health Needs Assessment in the Leeds Gypsy Traveller community in 2013 found that pharmacies (described as chemists by this group) were well respected, frequently used and accessible to them. All but 12% (6 individuals) had used the 'chemist' in the previous month and 89% (41 individuals) of those who got medicine from the chemist said its use was explained to them in a way they could understand and remember and that they had received helpful advice.

53% visited the chemist monthly, or more often, with 93% saying it was easy to find a chemist and 87% saying it was open when they needed it. 86% rated their last experience at the chemist as good to excellent. It was at that time suggested that pharmacists could provide a useful mechanism to communicate health messages to the Gypsy and Traveller community. Current providers are successfully engaging this vulnerable group, and they may wish to consider if there is some transferable learning to apply to other vulnerable groups.

2.8.3 Newly-emerging communities

There are residents from over 140 ethnic groups, speaking 170 different languages, residing in Leeds neighbourhoods. It is therefore possible that individuals from some newly-emerging communities are experiencing some limitations in access. 22% of pharmacies reported they have all their staff trained and 19% have some staff trained around equality and diversity. 58% of responding pharmacies reported having no staff with equality and diversity training.

The suitability of using family members for interpretation purposes was raised during the consultation period so community pharmacies, along with other frontline services such as primary care, may not be realising their full potential for engaging with and ensuring full access to pharmaceutical services for these communities.

2.8.4 Cultural differences

Existing community pharmacies may be able to put in place simple measures to help improve accessibility for highly vulnerable groups to receive self-care advice. This is likely to become more important with the advent of the new NHS Charging Regulations, effective from August 2017.

A study by Stevenson and Rao (2014) supported other evidence that BAME populations in England have a greater prevalence of illnesses such as diabetes and cardiovascular disease in comparison with their White counterparts. Ethnic variations have also been observed in access to health care, with 'intrinsic' cultural differences

such as language and literacy, as well as organisational factors in health services, offered as possible explanatory factors.

In this paper, it was suggested that engaging with existing community structures and leaders to deliver information and support in a language, style and model that is best suited to individuals and communities, would be an appropriate method of adapting to meet their needs.

2.8.5 BAME Focus Group- perceptions of services

A focus group of mainly African Caribbean and South Asian individuals from the LS7 (Chapeltown) area of Leeds was convened during the 60 day consultation period to ascertain whether this group had the same, or different experiences to the main survey group when using community pharmacies. Some individuals with other protected characteristics were also present. However, as an English speaking group, their perspective was very useful, but possibly not fully representative of other non-English speaking BAME groups.

Availability of community pharmacies for this group, was also very good, or good and none had had difficulty finding a pharmacy when they needed one. Similarly all agreed that the quality of services pharmacies provided was very good, or good.

Everyone could reach a pharmacy within ten minutes and many could reach it in much less time. No one felt that they had difficulty in finding a pharmacy open in the evening if they needed one and in their area they had a choice of several. One person said she didn't expect the pharmacy to be open in the evening as they, **like everyone else, 'were entitled to a life.'**

As with the main survey, the relationship that the pharmacy team had built up with them over many years was highly valued and this meant that if things went wrong, such as medicines not being available, or people needed to re-order medication well before holiday periods, issues could be quickly ironed out.

Several people said they appreciated the home delivery service, as in the main survey. Occasional issues around breaks in the supply chain were raised and medicines were not always available when the customer needed them. This was not considered to be the pharmacists fault, but possibly the supplier to the pharmacist. However, it was felt to let down the quality aspect sometimes.

This was also raised in terms of individuals obtaining repeat medicine if their usual pharmacy runs out. It was inconvenient having travelled to another pharmacy, some way away, only to be told that the pharmacy does not dispense the items they need.

The group stated that the services that pharmacies provide could be better publicised so more people would use them. One person had found it much more convenient to go to the pharmacists to have her blood pressure checked as unlike her surgery, she could drop in and get it done very quickly.

One person said that whilst the staff in the local pharmacy were very good, she felt that they did not reflect the make-up of the community that they served, even though

her (African Caribbean) community had been a substantial proportion of the Leeds community for many years. She felt that this needed action by the training establishments and the pharmacies that employ staff.

Another participant added that although he spoke fluently in and understood English, he was aware that some people he knew needed to go to certain pharmacists, so they could speak and be spoken to in their own language.

In terms of community pharmacies reaching vulnerable communities in Leeds, continuing to develop, exercise and extend where appropriate their expertise around equality and diversity will ensure that pharmacy teams can continue to respond fully towards meeting the needs of a changing and increasingly diverse population. It should also help improve the understanding of more vulnerable individuals around self-care.

It may also be useful for community pharmacies to make informal connections with third-sector agencies such as the 'Better Together' providers. These, and projects such as Migrant Access Point, are locality-based and work closely with newly-emerging communities. This may lead to better awareness of the services that community pharmacies can deliver, greater uptake of services and work towards achieving more of the aspirations of the Community Pharmacy Forward View (2016).

2.8.6 Substance users

163 community pharmacies in Leeds are contracted to provide a supervised opiate substitute consumption service and 133 pharmacies who replied to the survey confirmed they are providing this. Although few people in this survey said they used this service, there is comprehensive coverage of this service to meet the needs of Leeds citizens. The Outer North East has fewer providers but commissioners regularly monitor usage to ensure provision is where user needs are greatest.

There is evidence of success in this intervention. Analysis of supervised consumption was undertaken by Price Waterhouse Cooper for the Pharmaceutical Services Negotiating Committee in 2016. The analysis reported that each patient supervised generated in excess of £4,000 in value in 2015 alone, and a further £7,500 in the long term. This included savings to the NHS and the Criminal Justice system.

2.9 Non-commissioned services

Some community pharmacists stated they are providing services on a private or unpaid basis.129 (84%) are providing free delivery of prescriptions to patients' homes and 137 (89%) are providing a prescription collection service, both of which were shown to be highly valued in the public survey responses.

112 (73%) offer blood pressure testing, which may detect untreated medical conditions but from the public survey, currently only 2.9% of people regularly and 9.6% sometimes use this service.

Blood pressure testing is being offered as a commissioned service from Leeds City Council from November 2017 in six community pharmacies located within deprived Leeds, such as Harehills, Bramley and Seacroft, with an aim to target 2,400 people over two years. This will increase access considerably in populations at risk, but awareness raising within the relevant communities will be essential.

Fewer, but fairly significant numbers of pharmacies provide diabetes checks/management (31%), inhaler reviews (32%) and palliative care medicines (24%).

One pharmacy was providing a falls prevention service. Although no other pharmacy highlighted it as a service they wished to provide if commissioned, it may highlight an opportunity for current pharmacy staff to incorporate 'making every contact count', particularly with middle-aged and elderly people, as part of a response to keeping the ageing population well.

2.10 Supporting primary care and public health 2015-2018

The 2015 PNA stated that Leeds was ambitious about growing the role of pharmacy teams in the delivery of integrated primary care and public health. There were opportunities to build on the services that pharmacies offer and to strengthen the links between pharmacies and other health and social care providers. Stakeholders also expressed the desire to work more closely and effectively with pharmacies to deliver improved health outcomes and closer integration of strategies.

NHS England is responsible for commissioning NHS primary care services in England, including community pharmacy services. The majority (90-95%) of total community pharmacy income comes from payment from NHS England, through the NHS pharmaceutical services contract and community pharmacies are a key part of the NHS. The NHS England funding settlement for 2015/16 was £2.8 billion, reducing to £2.687 billion in 2016/17.

Local Authorities and Clinical Commissioning Groups (CCGs) also commission services from community pharmacies, over and above those commissioned by NHS England. These services are described later in this assessment.

2.10.1 Changes to community pharmacy funding

Since the last PNA, there have been significant changes to the community pharmacy contractual framework. These changes are now being implemented and the impact of which is a reduction in the funding which community pharmacies receive. On 20th October 2016 the government announced that funding for NHS contractors providing services under the community pharmacy contractual framework was to be adjusted to £2.687 billion in 2016/17 and to £2.592 billion in 2017/18.

This represented a 4% reduction in funding in 2016/17 and a further 7.4% reduction in 2017/18.

Plans for change in the way funding was distributed were also announced:

- Establishment payments were to be phased out, and a range of dispensing fees to be amalgamated into a single activity fee.
- A Pharmacy Access Scheme (which was for 2017/18 only) was to be introduced to support services in isolated areas. The government published a list of 1,341 pharmacies that were to receive access payments.
- A £75 million Quality Payment Scheme was announced to award pharmacies extra funding based on how well they perform against criteria set out by the government.
- A Pharmacy Integration Fund to support closer working with other parts of the NHS.
- A further £42 million (which has subsequently been reduced to an unspecified amount), in addition to the 2016–2018 funding set out above was announced.

The changes took effect from 1 December 2016 so this needs assessment could be expected to identify/reflect any effects being felt as a result of those changes.

The pharmacy and community surveys did not show obvious evidence of these reductions in funding being a barrier to the day-to-day functioning of community pharmacies in Leeds, nor do they yet seem to be impacting significantly on customer experience. However, the impact may become more evident and continue to impact during and beyond the life of this PNA.

Some stakeholder feedback suggested that this may manifest in consolidation applications but it was felt that they can be managed through the current control of entry process and with very good current coverage, closure or consolidation of a pharmacy may not necessarily create a gap. During the preparation of the PNA, notice was received of three pharmacy closures in January 2018. This will reduce the number of community pharmacies in the relevant areas, but as they are positioned close to other sites, residents will still have a good choice of access.

2.11 Supporting primary care and public health 2018 – 2021

In Leeds, the full capacity of community pharmacy as described in the Community Pharmacy Forward View (2016) is developing, but has not yet been fully realised in Leeds. However, the PNA acknowledges that this untapped potential will allow community pharmacy teams to adapt and grow alongside the changing health landscape as capacity continues to build and be utilised.

At the time of responding to the PNA survey 52 (34%) of community pharmacies reported that they were a Healthy Living Pharmacy and a further 84 (55%) were working towards this. In January 2018 this had increased significantly to149 community pharmacies achieving HLP status.

The ongoing process of developing New Models of Care will also progressively change the local health landscape, including re-assessing the role and potential of the community pharmacy team. This can be done through their existing contracts to ensure they contribute fully towards supporting the health of local people.

The GP Forward View (2016) highlights an investment of a further £2.4 billion a year by 2020/21 into general practice services. Practices are encouraged to work together in 'hubs' or primary care networks. This is because a combined patient population of at least 30,000–50,000 allows practices to share community nursing, mental health and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access. It will also involve working more closely with community pharmacists, to make fuller use of the contribution they make.

The new Blood Pressure Wise initiative will also help to raise awareness of community pharmacy services, whilst further improving care for the public and patients. In time, it is possible that pressure on other parts of the NHS can be reduced through greater use of the skills of the community pharmacy team.

The demographic make-up of the Leeds population is changing, in terms of rapidly increasing numbers and a population that is becoming increasingly aged and increasingly diverse. As well as ensuring that the needs of the general public are met, it is therefore essential that the planning specifically considers the needs of particularly vulnerable groups, who may need additional support to engage fully with the current system.

This pharmaceutical needs assessment (PNA) has looked at the current provision of pharmaceutical services across Leeds, and found that it meets the needs of the majority of the survey population. With the changing health landscape in mind, it has identified a small number of areas where existing pharmacies could adjust practice to improve accessibility and reach, but there is currently no need for additional pharmacies. The geographical distribution is comprehensive and in terms of community pharmacy estate, the majority (92%) of premises were thought to be suitable for services planned in the future.

3 Background to PNA

People in England make 1.2 million visits to a pharmacy for health-related reasons every day. This presents a huge opportunity to support behaviour change through making every one of those contacts count (PHE, 2017). 'Utilising pharmacies to deliver commissioned services also has the potential to be hugely beneficial in the battle against high levels of avoidable illness and premature mortality' (RSPH, 2015).

A growing body of evidence shows that community pharmacies are successful when it comes to delivering health improvement initiatives. Community pharmacies are often embedded in some of the most deprived and challenging communities, providing daily contact for individuals seeking ad hoc and unplanned health advice, alongside picking up prescribed medicines, or purchasing over-the-counter health related products.

Pharmaceutical services are also important contributors to local communities through employment, supporting local people, improving health and wellbeing and playing an active role as a long-term partner in the local health care system. As New

Models of Care progress locally, the links between general practice, integrated teams and community pharmacies can be strengthened and become more formalised to provide a more 'joined up' and holistic response to Leeds communities' health needs.

The Independent Review of Community Pharmacy Clinical Services commissioned by the Chief Pharmaceutical Officer of NHS England in April 2016 helped inform the future provision of clinical pharmacy services. The recommendations from this report are being used by NHS England to inform its approach to the commissioning of NHS community pharmacy services.

The need for an in-depth pharmacy review was determined by the present context in which a pharmacy operates:

- the changing patient and population needs for healthcare, in particular the demands of an ageing population with multiple long-term conditions
- emerging models of pharmaceutical care provision from the UK and internationally
- the evidence of sub-optimal outcomes from medicines in primary care settings
- the need to improve value through integration of pharmacy and clinical pharmaceutical skills into patient pathways and the emerging new care models
- the need for service redesign in all aspects of care for a financially sustainable NHS.

3.1 Legislative requirements of the PNA

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep the PNA up to date. The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

PNAs are used by both the NHS and Local Authorities when considering which services can be, or need to be provided by community pharmacists.

NHS England commissions community pharmacy contractors to provide NHS pharmaceutical services through a Community Pharmacy Contractual Framework (CPCF). The CPCF consists of nationally commissioned essential services (services that all pharmacies must provide) and advanced services (national services that can be provided by all pharmacies once accreditation requirements are met) and locally commissioned Local Enhanced Services (commissioned by NHS England) to meet certain needs identified in the PNA.

Under the NHS regulations, a person who wants to provide NHS pharmaceutical services must apply to NHS England to be on a pharmaceutical list. NHS England will review the application and decide if there is a need for a new pharmacy in the proposed location, referring to the PNA to inform that decision. Exceptions to this

process include applications for needs not foreseen in the PNA or applications to provide pharmaceutical services online or via mail order only (known as distance selling).

3.2 Purpose of the PNA

The purpose of the PNA is to:

- Inform NHS England decisions on applications for new pharmacies and applications from current providers who would like to change their existing regulatory requirements. NHS England is required to refer to its local PNA.
- Help the HWB to work with providers to target services in areas of need and limit duplication of services where provision is adequate.
- Inform interested parties of the pharmaceutical needs in Leeds so that they can plan, develop and deliver pharmaceutical services that are appropriate for the local population.
- Inform commissioning decisions made by Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England.

4 Context of the PNA

4.1 National context of the PNA

The NHS Five-Year Forward View (2014) has recognised the key role of pharmacy, highlighting that there should be far greater use of pharmacists in prevention of ill health, support for healthy living, support for self-care for minor ailments and long-term conditions, medication review in care homes, and as part of more integrated local care models.

It states that a ‘radical upgrade in prevention’ is needed to improve people’s lives and achieve financial sustainability of the health and care system. This national plan sits alongside the local health and wellbeing strategies and action plans, which focus at a local level on maximising prevention at scale, to improve the health of the population.

The Community Pharmacy Forward View (2016) sets out a clear role for the sector in any future model of care, focusing on three core domains for community pharmacy as:

- the facilitator of personalised care for people with long-term conditions
- the trusted, convenient first port of call for episodic healthcare advice and treatment
- the neighbourhood health and wellbeing hub.

The vision is that, in future, all community pharmacies will operate as neighbourhood health and wellbeing centres, providing the ‘go-to’ location for support, advice and resources on staying well and independent. Building on the development of the Healthy Living Pharmacy model, the safe and efficient supply of medicines managed by pharmacist-led teams will remain at the core of this community pharmacy offer.

However, this will now be recognised as just one component of a broader set of resources and services available within these health and wellbeing centres.

To ensure that these services are responsive, effective and valued, pharmacy teams will work closely with community leaders to identify and understand local assets and needs, to develop interventions and services based on this intelligence, to collect data on impact and outcomes, and use this to continually improve their offer. Recent changes in the way that services in the community are organised in Leeds may pave the way to making this way of working more likely in the future.

4.2 Local context of the PNA

Leeds is ambitious to be the best city for health and wellbeing. The vision of the Leeds Health and Wellbeing Strategy 2016–2021 is that Leeds, a city with a population of 760,000 people, will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.
The Leeds Health and Wellbeing Board is responsible for overseeing the achievement of this vision.

The Leeds Health and Wellbeing Strategy 2016–21 focuses on five outcomes:

1 People will live longer and have healthier lives.
2 People will live full, active and independent lives.
3 People's quality of life will be improved by access to quality services.
4 People will be actively involved in their health and their care.
5 People will live in healthy, safe and sustainable communities.

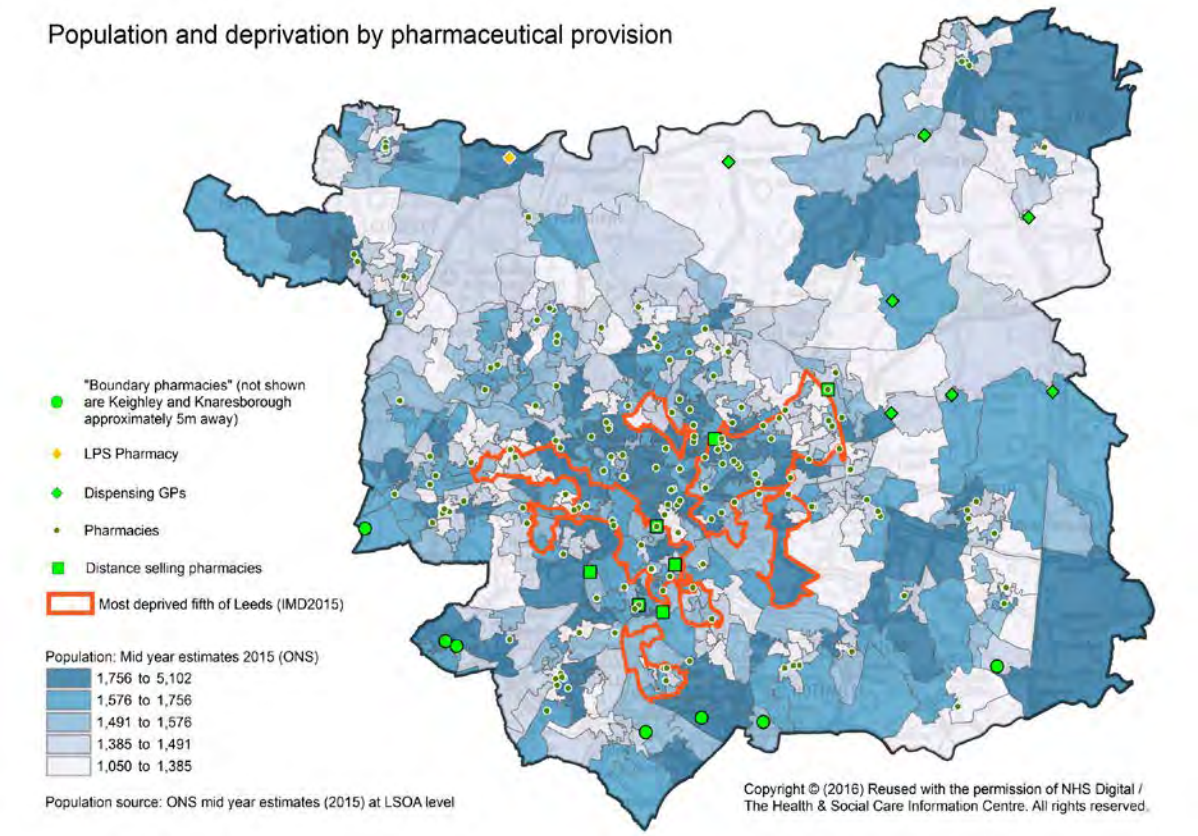
See: http://www.leeds.gov.uk/docs/Health%20and%20Wellbeing%202016-2021.pdf

The PNA supports the delivery of the five outcomes above, particularly outcomes 1-4.

However, differences in wealth status lead to differences in health status. There are significant health inequalities between different communities in Leeds. This is most notably demonstrated by the 10-year difference in life expectancy between people living in Hunslet, a very deprived inner-city community, and those living in Harewood, a very affluent rural outer community.

People living in deprived areas typically have more years of long-term ill health and higher levels of poor mental health and wellbeing and mental illness. Significantly, in 2015/16, 20% of the Leeds population – almost 155,000 people – were classified as being in 'absolute poverty' (Leeds Best Council Plan 2017–18).

Figure 1. Leeds pharmaceutical services by deprivation



The statistics around differences in health status of the Leeds population by Community Committee area are shown at **Appendix 2** to **Appendix 11**.

Access to services is only part of the reason for this health gap, but ensuring that all members of the population can access appropriate healthcare and advice at the earliest opportunity is essential. This means that, as well as considering any geographical gaps in community pharmacy provision, the PNA has considered whether the services available are fully accessible to the culturally and ethnically diverse population of Leeds. Those from protected equality groups can experience services differently when compared to those who are not protected under the Equality Act 2010.

This is important as certain groups are more likely to develop certain medical conditions, hence perhaps requiring more support to manage these. Diabetes, for example is much more prevalent in South Asian and African Caribbean populations and hence may more likely be of significance to pharmacies in Harehills in the Inner East Community Committee of Leeds and Chapeltown in the Inner North East Community Committee area.

The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document by Williams and Varney et al (undated) shows that LGB&T communities are more likely to be experiencing health inequalities in relation to public health areas and preventing premature mortality. The higher prevalence of smoking, alcohol use and drug use, and lower uptake of screening programmes, are likely to contribute to increased risk of preventable ill health.

It suggests that LGB&T people experience barriers to accessing mainstream health and social care services due to a lack of understanding of their specific needs and a lack of targeted service promotion. Furthermore, this document suggests that fewer LGB disabled people are out to their GP or healthcare professionals than non-disabled LGB people. This means that community pharmacy teams need to be highly skilled to provide their service in a way that is sensitively attuned in order to fully meet the diverse needs of their local community.

Community pharmacies also need to be sensitive to the population's diversity in terms of age-by providing a service to an increasingly ageing population as well as meeting the needs of the young people that reside in or travel to Leeds during a typical year. Leeds has five Universities, University of Leeds, Leeds Beckett, University of Law, Leeds Arts University and Leeds Trinity. Together with a number of other institutions, this means that Leeds has the fourth largest student population in the country.

The Leeds Health and Wellbeing Strategy 2016–2021 aims to put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high-quality services. The Leeds Health and Wellbeing Board is responsible for overseeing the achievement of this vision and, as a key part of the local health infrastructure, community pharmacies are ideally placed to help provide this.

4.3 New developments in GP and primary care services

Leeds has a history of success in supporting communities and neighbourhoods to be more self-supporting, leading to better wellbeing for older citizens and children, whilst using resources wisely to ensure that help will always be there for those who cannot be supported by their community. The Leeds Health and Care Plan (2017) highlights that the health and wellbeing of citizens in Leeds will be improved through more efficient services, investing more thought, time, money and effort into preventing illness, and helping people to manage ongoing conditions themselves. This will help prevent more serious illnesses that may result in expensive hospital treatment.

It starts with recognising how communities can keep people healthy through connecting them with activity, work, joining in with others and things that help give them a sense of wellbeing. GPs, community health and care services, and other community services such as voluntary groups, can focus better on keeping people healthy and helping them to manage their own health through working more closely together as one team. The city is therefore developing innovative GP services.

These approaches include new partnerships and ways of organising community and hospital skills to be delivered in partnership with local GPs and closer to home. This is happening at the same time as patients are being given access to extended opening hours, with areas of the city having GPs open 7 days per week.

It is also possible to make better use of health information to target those at risk of getting ill and so intervene earlier. Leeds is the first major UK city where every GP and healthcare and social worker can electronically access the information they need about patients through a joined-up health and social care record for every patient registered with a Leeds GP. This does not currently extend to community pharmacy staff, however.

The city is currently looking at how it can further enhance its integrated offer within the community and is enhancing the current Integrated Neighbourhood Team Model to include primary care. This new model is being referred to as 'Local Care Partnerships'.

Health and care services working in neighbourhoods will work in partnership as one team and look after all of an individual's needs. They will also support citizens to focus on the things that are most important to them in improving their wellbeing. This will mean that the whole experience of our local health service could change over time. There may be more joined-up help for housing, benefits and community activities. GPs may need to work more collaboratively to share resources, staff and premises to make sure they can work in this new way. Other health, care and community services – and, potentially, community pharmacies – will need to join in with the approach.

This change would mean training the existing and future workforces to work with citizens and with each other in new ways. The approach will bring some of the expertise of hospital doctors right into community services, which would mean less referral to specialists and ensure that as much as possible is done in the community. This should mean fewer visits to hospital for fewer procedures, but the hospital services will still be there when citizens and their family need them.

This development will help deliver the Leeds ambition to grow the role of pharmacy teams in the delivery of integrated primary care and public health as set out in the 2015 PNA. The opportunities to build on the services that pharmacies currently offer, and to strengthen the links between pharmacies and other health and social care providers, are beginning to create a more solid foundation for creating strong local health systems.

4.4 Healthy Living Pharmacies (HLPs)

In 2015, the Health and Wellbeing Board encouraged pharmacies to join the West Yorkshire Healthy Living Pharmacies programme (part of the National Healthy Living Pharmacies). HLPs aim to reduce health inequalities by adhering to quality criteria around workforce development, engaging with the local community and adhering to principles of a health promoting environment. The Healthy Living Pharmacy (HLP)

Level 1 helps to reduce health inequalities by evidencing adherence to the following quality criteria:

- Workforce development – develop the pharmacy staff so they are well-equipped to embrace the healthy living ethos and proactively promote health and wellbeing messages.
- Engagement – demonstrate that the pharmacy team is actively engaging with the local community, including the public, health and social care professionals, commissioners and other local organisations (e.g. the voluntary sector).
- Environment – have a health-promoting environment that embraces the ethos of a Healthy Living Pharmacy, including an atmosphere created by premises as well as staff attitudes and actions. The environment should also ensure confidentiality for service users.

4.4.1 Quality Payments Scheme

Achieving HLP level 1 (self-assessment) is now a Quality Payment criterion for the Quality Payments Scheme 2017/18.

In 2017, 52 (34%) of the 154 pharmacies replying to the PNA survey had achieved HLP Level 1 and 84 (55%) were working towards HLP status. Only 13 (8%) were currently not working towards achieving HLP status. In January 2018 this had increased significantly to 149 pharmacies achieving Healthy Living Pharmacy status. This provides an excellent base on which to build aspirations for the neighbourhood health and wellbeing hubs and reduce health inequalities.

4.5 Local Care Partnerships

The Local Care Partnerships and the Leeds Health and Care Plan continue to highlight the necessity for self-care in communities. The importance of all individuals having a good understanding of how to stay healthy when the GP is not available, or a condition does not require a GP's attention, means that community pharmacies are ideally placed to help increase that understanding.

4.6 Future planning

As described above, the Leeds picture is similar to that stated in the Independent Review of Community Pharmacy Clinical Services (2016). Whilst progress has been made towards implementing this vision, there is still untapped potential to improve care for patients, to reduce pressure on other parts of the NHS and to provide improved services to patients through making better use of the skills of the community pharmacy team.

The roll-out of extended services at weekends and evenings across the whole of the Leeds population – with an incremental programme from March 2018 (and some additional hub locations over the winter period) – may impact on community pharmacies by increasing footfall and demand from patients.

Future aspirations are against a background of reduced government funding for community pharmacies, so it may prove challenging to ensure that the New Models of Care fully realise their ambitions. However, the current proposals to increase access to GP services out of hours will be adequately met by the current pharmacy contractors, since many are already open beyond GP opening hours. By working more closely and effectively with pharmacies, improved health outcomes and closer integration of strategies is possible.

4.7 Definition of NHS pharmaceutical services

Pharmaceutical services as defined in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 include:

- **Essential services**. These are services which every community pharmacy offering NHS pharmaceutical services must provide (as described in Schedule 4, Part 2 of the Regulations). These include the dispensing of medicines, repeat dispensing, signposting, public health campaigns/promotion of healthy lifestyles, disposal of unwanted drugs and support for self-care. These services are negotiated and funded at a national level.

- **Advanced services**. These are services which community pharmacy contractors and dispensing appliance contractors can choose to provide, as long as they meet the requirements set out in the Secretary of State's Directions. Currently, these advanced services include medicines use reviews (MUR), prescription interventions, the new medicine service (NMS), flu vaccination, NHS urgent medicines supplies advanced service (NUMSAS), appliance use reviews (AUR) and the stoma customisation service provided by dispensing appliance contractors and community pharmacies.

- **Enhanced services**. These services can only be commissioned by NHS England. Services can include anti-coagulation monitoring, the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on-demand availability of specialist drugs, and out-of-hours services.

The regulations do not cover 'pharmaceutical services' commissioned by local authorities and CCGs. Although not a mandatory element of a PNA, where the need for a service is clear, it has been stated in this assessment to help guide local commissioning.

4.8 Types of pharmaceutical provider

Several types of providers can be added to the pharmaceutical list. These include:

- Pharmacy contractors – independent contractors working individually or as groups of pharmacies who provide NHS pharmacy services in community pharmacy settings.

- Dispensing appliance contractors – appliance suppliers are a subset of pharmacy contractors who supply appliances such as incontinence aids, dressings, bandages, etc. on prescription. They cannot supply medicines.
- Dispensing doctors – medical practitioners who are authorised to provide drugs and appliances in designated rural areas known as 'controlled areas'.
- Local pharmaceutical services (LPS) contractors – provide services specifically negotiated to meet local need; this must include an element of dispensing.
- Distance-selling pharmacies – although not covered by the same market entry system that relies on the PNA, distance-selling pharmacies are able to supply medicines to the population. They can only offer essential services remotely – not face-to-face.

4.9 Scope of assessment

The PNA will meet the requirements identified in Schedule 1 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and is summarised below:

- Current provision of necessary services – this includes services inside the Leeds Health and Wellbeing Board (HWB) geographical area as well as services that sit outside the Leeds HWB area, yet service its population.

This requirement also includes the need to map current provision of services by:

- Pharmacies.
- Distance-selling pharmacies.
- Dispensing appliance contractors.
- Dispensing doctors.
- Gaps in provision of necessary services – this includes current and future gaps in pharmaceutical health and also gaps by service type. For example, if a new housing development is planned in the Leeds Health and Wellbeing area then additional pharmaceutical services may need to be considered.
- Current provision of other relevant services – this includes services both inside and outside of the Leeds Health and Wellbeing area boundaries that are not meeting an identified need but do secure improvements or better access to services.
- Service provision that would secure improvements and better access if provided. This is a statement about identifying services that are not currently being provided but which will be needed to secure future improvements in pharmaceutical services.
- Other services – any NHS services provided or arranged by the HWB, NHS England, a CCG or NHS (Foundation) Trust which affect the need for pharmaceutical services, for example a large health centre providing a stop-smoking service.

4.10 Excluded from the PNA

The PNA's scope is defined by its regulatory purpose. Therefore, pharmaceutical services in prisons are excluded from this assessment as providers contract directly from the prison authorities.

4.11 Identification of health needs

The PNA used a number of documents to identify local health priorities. A health profile for each of the ten Community Committee areas has been produced and theses are shown at **Appendix 2** to **Appendix 11**. The tables below show that there is wide variation in health experience across Community Committee areas. There is also considerable variation within the Community Committee areas.

4.12 Inner Community Committee areas of Leeds

The Inner Community Committee areas of Leeds have the most concentrated deprivation and have health statistics that are the worst amongst the 10 Community Committees. However, when taken to smaller geographies (MSOA level) within individual Community Committee areas, there are sometimes also worst health outcomes than in Deprived Leeds.

Table 1. Life expectancy at birth 2014–16, ranked Inner Community Committees

Community Committee	All	Males	Females
Inner East	76.9	74.5	79.7
Inner South	77.4	76.0	78.9
Inner West	79.0	76.6	81.6
Inner North East	80.8	79.4	82.1
Inner North West	81.1	79.7	82.5
Leeds	80.9	79.1	82.7
Deprived Leeds	76.6	74.4	79.0

Source: Community Committee profile, August 2016

Life expectancy in the Inner East area of Leeds is comparable to that of Deprived Leeds but Inner East, Inner South and Inner West have life expectancy considerably lower than in Leeds as a whole and the Inner North areas (Table 1).

Whilst the all-cause premature (under 75 years) mortality rates are slightly lower than Deprived Leeds in all Inner Community Committee areas (Table 2), they are considerably higher than Leeds as a whole. The highest MSOAs in all three areas show premature mortality that is significantly higher than Deprived Leeds, especially Inner West.

Table 2. All-cause mortality (under 75 yrs) 2012–16, ranked Directly Age Standardised Rate (DSRs) per 100,000

Community Committee	All	Males	Females
Inner East	542	660	417
Highest MSOA	**617**	**738**	**528**
Inner South	523	617	422
Highest MSOA	**617**	**723**	**528**
Inner West	465	569	358
Highest MSOA	**692**	**763**	**603**
Leeds	356	427	286
Deprived Leeds	**573**	**683**	**459**

Source: Community Committee profile, August 2016

This is also the case for premature mortality from cancer (Table 3) where every category for each Inner area is higher than that of Leeds as a whole. The highest MSOAs in each area also exceed the rate found in Deprived Leeds.

Table 3. Cancer mortality (under 75yrs) 2012–16, ranked DSR per 100,000

Community Committee	All	Males	Females
Inner East	203	233	175
Highest MSOA	**254**	**315**	**221**
Inner South	194	205	183
Highest MSOA	**363**	**333**	**434**
Inner West	174	204	143
Highest MSOA	**232**	**277**	**204**
Leeds	147	164	133
Deprived Leeds	206	230	181

Source: Community Committee profile, August 2016

This situation is also true of the respiratory disease figures (Table 4), which are particularly high in the highest MSOA of Inner South. This is highly relevant to preventive work around smoking cessation and lifestyle support, as well as asthma and COPD management**.**

Table 4. Respiratory disease mortality (under 75 yrs) 2012–16, ranked DSR per 100,000

Community Committee	All	Males	Females
Inner East	61	70	52
Highest MSOA	**85**	**99**	**102**
Inner South	58	61	56
Highest MSOA	**142**	**150**	**129**
Inner West	53	58	48
Highest MSOA	**95**	**110**	**94**
Leeds	32	35	29
Deprived Leeds	**66**	**74**	**58**

Source: Community Committee profile, August 2016

4.13 Outer Community Committee areas of Leeds

Table 5. Life expectancy at birth 2014–16, ranked Outer Community Committees

Community Committee	All	Males	Females
Outer East	81.3	79.1	83.3
Outer North East	85.3	83.5	87.0
Outer West	80.7	79.0	82.2
Outer North West	83.8	82.0	85.5
Outer South	81.7	80.2	83.1
Leeds	80.9	79.1	82.7
Deprived Leeds	76.6	74.4	79.0

Source: Community Committee profile, August 2016

The life expectancy table (Table 5) shows that all Outer areas, with the exception of Outer West, have better life expectancy than Leeds as a whole and very much better than Deprived Leeds.

Table 6. All cause mortality (under 75 yrs) 2012–16, ranked Directly Age Standardised Rate (DSRs) per 100,000

Community Committee	All	Males	Females
Outer East	327	396	263
Highest MSOA	551	723	458
Outer North East	234	285	186
Highest MSOA	489	583	401
Outer West	346	418	278
Highest MSOA	617	701	528
Outer North West	270	324	220
Highest MSOA	379	454	310
Outer South	325	372	279
Highest MSOA	432	525	366
Leeds	356	427	286
Deprived Leeds	573	683	459

Source: Community Committee profile, August 2016

The all-cause mortality rates per 100,000 people in the Outer areas (Table 6) are also generally much lower than Deprived Leeds and lower than Leeds as a whole. There is however, some variation across each Community Committee area. Outer East's highest MSOA has a male rate considerably above that of Deprived Leeds and Outer West has an MSOA that is considerably higher than Deprived Leeds across all three measures.

Table 7. Cancer mortality (under 75 yrs) 2012–16 ranked DSR per 100,000

Community Committee	All	Males	Females
Outer East	138	159	120
Highest MSOA	216	282	192
Outer North East	111	124	100
Highest MSOA	205	234	179
Outer West	147	156	140
Highest MSOA	245	239	253
Outer North West	126	146	108
Highest MSOA	162	216	158
Outer South	145	154	137
Highest MSOA	161	191	193
Leeds	147	164	133
Deprived Leeds	206	230	181

Source: Community Committee profile, August 2016

The premature cancer mortality rates (Table 7) are more in line with those of Leeds as a whole but many of the highest MSOAs exceed the Deprived Leeds rates. They are, however, lower than those seen in the Inner Community Committee areas.

Table 8 Respiratory disease mortality (under 75 yrs) 2012–16 ranked DSR per 100,000

Community Committee	All	Males	Females
Outer East	24	29	20
Highest MSOA	52	85	38
Outer North East	14	15	13
Highest MSOA	50	61	40
Outer West	32	35	29
Highest MSOA	60	71	57
Outer North West	18	20	16
Highest MSOA	42	46	44
Outer South	29	29	28
Highest MSOA	49	54	62
Leeds	32	35	29
Deprived Leeds	66	74	58

Source: Community Committee profile, August 2016

In terms of respiratory disease, the Outer East, Outer North East and Outer North West have levels lower than those of Leeds as a whole and much lower than Deprived Leeds. However, Outer West has levels approaching those of Deprived Leeds and the Outer South's highest MSOA has higher female mortality than Leeds or Deprived Leeds. Outer North East has much lower levels than Leeds and Leeds Deprived.

There is a wealth of Leeds-related health and wellbeing information on the Leeds Observatory which is not replicated in the PNA. Go to: http://observatory.leeds.gov.uk/ The PNA should be read in conjunction both with the profiles placed there and also the Community Committee profiles at **Appendix 2** to **Appendix 11** to gather more detailed information on specific area and health needs.

4.14 Population growth

Leeds is a growing and increasingly diverse population with the population growing by 5.3% between 2005 and 2015. Section 2 of the Core Strategy Profile of Leeds District highlights an anticipated growth of the population of Leeds from 755,136 in 2010 to 860,618 by 2028.

This raises major challenges for Leeds in seeking to meet the housing needs of this growing and ageing population over this time period. We are also living longer in Leeds than ever before which is in agreement with the findings of the Independent Review of Community Pharmacy Clinical Services (2016). The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030. This is an incredible achievement, but also means that the city is going to need to provide more complex care for more people (Leeds Health and Care Plan 2017).

There are plans to build new housing developments to accommodate some of this anticipated population growth. The Leeds City Council draft Site Allocations Plan needs to identify land to accommodate 66,000 dwellings. A further 4,000 poor-quality homes will be replaced. The Core Strategy Policy SP7 further breaks down the total housing target for Leeds as follows:

Table 9. New housing developments planned by 2028

Area of Leeds	Number	%
Aireborough	2,300	3.0%
City Centre	10,200	15.5%
East Leeds	11,400	17.0%
Inner Area	10,000	15.0%
North Leeds	6,000	9.0%
Outer North East	5,000	8.0%
Outer North West	2,000	3.0%
Outer South	2,600	4.0%
Outer South East	4,600	7.0%
Outer South West	7,200	11.0%
Outer West	4,700	7.0%
Total	**66,000**	**100.0%**

The Leeds Core Strategy (adopted 2014) suggests that 70% of the new housing will be in existing settlements, which makes it likely that this housing expansion will increase pressure on GP service provision and increase visits to community pharmacies. However, with the current suggested ratio of one GP to a patient list size of 1,800 – 2,000 patients, it is unlikely that the pressure will be sufficient to create a gap in pharmaceutical provision over the life of this PNA.

There is very good coverage of community pharmacies in the Inner areas of Leeds, even though a substantial proportion of the proposed homes will be close to deprived communities, where need for health services is arguably much greater. GP audits (2015) showed that, in 2014, 166,765 out of 817,253 Leeds residents who were GP registered were recorded as living in deprived areas.

This is likely to include an increasing proportion of newly-emerging BME populations, as housing costs are lower in these areas. In 2016, 16.1 per 1,000 of new GP registrations were made by people who previously lived abroad compared to a Yorkshire and Humber average of 9.5 per 1,000 (Leeds Local Migration Profile 2016).

In accordance with the Core Strategy Policy P9, housing developers are encouraged to consult with NHS Leeds CCG Partnership in relation to proposed housing developments to establish whether there is any potential impact on local health care/primary care provision, which could include pharmaceutical services.

A map showing the future housing developments against pharmacies is shown at **Appendix 12**.

4.15 Localities for the PNA

The PNA has looked at community pharmacy provision across the whole HWB area, with Community Committee boundaries identified on maps to highlight local need. The 10 Community Committees have been selected as the localities for analysis and discussion for a number of reasons.

Firstly, the Community Committees hold meaning for the local authority and the elected members that represent the constituent wards in each area. Secondly, Community Committees are also used as convenient aggregate areas within other needs assessments and reports.

They provide useful geographies for comparing differences in health status between Community Committee areas but also by Ward which make up the Community Committee areas. Differences at the smaller Middle Super Output Areas (MSOA) level within each Community Committee can also be examined to compare statistics within and between Area Committee areas. Thirdly, the Community Committees coincide with the deprivation fault line that demonstrably separates the five deprived Inner areas and the five more affluent Outer areas.

The map which shows the deprived neighbourhoods across the Leeds area is shown earlier in this assessment at Figure 1.

5 PNA process and consultation

The process of developing the PNA was broken down into four key stages:

1. Scoping
2. Analysis and draft report writing
3. Formal consultation
4. Final publication

5.1 Stage one: scoping

This stage involved identifying all appropriate stakeholders and current commissioners and seeking their views and input, with a specific focus on current provision, perceived gaps in provision, and future developments within the health landscape and for pharmaceutical services**.**

This information was used to build a picture of need and future potential, but also to inform development of the pharmacist and public questionnaires so that perceived gaps and potential could be checked out and corroborated by pharmacists and public experience.

A project team was convened to ensure that the PNA covered all requirements, and to support it to completion. The project team consisted of:

- Liz Bailey (Head of Public Health)
- Rachael Oakley (Public Health Governance Manager)
- Richard Dixon (Public Health Intelligence Manager)
- Adam Taylor (Senior Information Analyst)
- Community Pharmacy West Yorkshire - Ruth Buchan FFRPS (Chief Executive Officer)
- NHS England - Samantha Cavanagh (Primary Care Manager)
- NHS Leeds Clinical Commissioning Groups Partnership - Sally Bower (Patient Safety and Medicines Optimisation Team)
- Healthwatch Leeds - Tatum Yip **(**Community Project Worker)

Other colleagues were consulted as and when required**.**

5.2 Community pharmacists consultation

A community pharmacy questionnaire was drawn up and distributed in paper format to 178 community pharmacies in Leeds and boundaries that appeared on the NHS England pharmaceutical list. Opening times were checked against the NHS Choices website and a request made for the receiving pharmacy to confirm or amend their current hours and address. This helped to ascertain out-of-hours services and ensure that the hours listed on the NHS Choices website are up to date and accurate so that members of the public are able to find the assistance they need quickly.

The questionnaires aimed to gain a current picture of the services that community pharmacists are providing. A public questionnaire was also developed and

distributed via the Leeds Citizens' Panel and a number of other routes to try to capture the public's views on availability, access and use of community pharmacies.

During the survey period 25 August to 22 September 2017**,** 154 responses were received (87% response rate) from the 178 community pharmacies on the NHS England pharmaceutical list – 94 paper responses and 60 online responses. A further two pharmacies were identified during later cross-checking of service provision but as this was outside the survey period and the survey link was no longer available, these have been included where services are known, but not in the self-reported aspects of the analysis.

The questionnaire asked pharmacy staff questions which aimed to identify their contractual status, provision of services and ease of access to those services.

Although there was considerable emphasis on physical access to community pharmacy services, such as disabled access, the questionnaire also aimed to identify any non-physical barriers that may deter some members of our increasingly diverse population from accessing the service. This included the availability of multi-lingual staff/resources and awareness of the needs of people according to their sexual orientation or religious beliefs.

The questionnaire also asked pharmacy staff to identify any gaps in provision. A summary of the pharmacy survey results is provided at **Appendix 13**.

5.3 Stakeholder input

A letter and reporting template was sent on behalf of the HWB to a number of stakeholders. The template sought to seek each organisation's view on:

- current pharmaceutical services provision within the Leeds HWB area
- perceived gaps in pharmaceutical services provision (either currently or which they foresee within the next three years)
- services operating outside the Leeds HWB area which they consider will impact on pharmaceutical services within the district
- any other factors they feel the HWB should consider when developing the PNA (e.g. any plans within their organisational strategy that may impact upon future pharmaceutical service provision)
- any future commissioning intentions that will impact upon pharmaceutical services.

The stakeholder letter was sent to a representative from each of the following organisations:

- Community Pharmacy West Yorkshire
- Leeds North, Leeds West and Leeds South and East Clinical Commissioning Groups (now NHS Leeds Clinical Commissioning Groups Partnership)
- Healthwatch Leeds
- Leeds Local Medical Committee (LMC)

- Leeds Teaching Hospital Trust
- Adult Social Care, Leeds City Council
- Children's Services, Leeds City Council
- the Third-sector representatives on the HWB
- Carers Leeds
- Leeds Involving People
- Tenfold
- MESMAC
- Local Professional Network (LPN) for Pharmacy.

Stakeholder responses were received from Community Pharmacy West Yorkshire, Healthwatch, NHS Leeds Clinical Commissioning Groups Partnership, Leeds Involving People and LCC Adult Social Care. A further individual response from a citizen was also received on this format from Age UK because the person was unable to access the community questionnaire.

The Local Medical Committee (LMC) sent a paper response to the address requested, but unfortunately this failed to arrive so could not be used. However, an LMC representative stated that the LMC agreed with a response sent in by Community Pharmacy West Yorkshire, so this was used.

Stakeholders were asked to rate the availability, quality and accessibility of community pharmacies in Leeds and this was on the whole rated as very good or good; there was one quality and accessibility rating as 'okay'.

Most stakeholders were not aware of any gaps in the service now and felt it unlikely that there would be any gaps in the next three years. However, one stakeholder felt that long-term conditions management, blood pressure monitoring across the city, and weight management and smoking cessation services across the city, would be a commissioning gap within the next three years. However, as this service has just been re-commissioned after a Health Needs Assessment and review process, it will be necessary to collect and analyse One You Leeds and Blood Pressure Wise data before a true assessment can be made.

There was awareness that the system integration that the CCGs are starting to work up within the Leeds HWB area will eventually include community pharmacy as part of a wider provider network. Therefore the PNA project group was asked to consider the changing health and social care landscape, the accountable care system and the Local Care Partnerships, which will be working closely with community pharmacy in the future.

Community pharmacies were considered to be well distributed across the whole of Leeds in high streets, supermarkets, community locations, next to and remote from GP surgeries – all embedded within the communities they serve. They were considered to be flexible and adaptable; they can (and do) change to meet new challenges and offer additional services where additional need is identified.

It was felt that community pharmacy is well placed to offer all of the services listed in question 5 of the consultation template, particularly people having good access to wrap around support in their own community. Although there will be changes to health and social care within the next three years, it was felt that the current community pharmacy network is likely to be able to meet these additional requirements.

It was pointed out that some pharmacy services are only commissioned from a set number of pharmacies and that this is limited by the commissioner. As some pharmacies are clearly providing some services outside the commissioning framework, for example prescription delivery (which is neither funded nor a contractual obligation), it is clear that this does not reflect on the will of community pharmacies to provide the service.

The funding changes imposed on community pharmacies by the Department of Health in 2016/17 and beyond, was not raised in the feedback from pharmacists. However, there was a perception from one stakeholder that it will have impact on community pharmacies. It was suggested that each situation should be individually assessed to determine whether a gap will be created or not.

On the service side, some issues were reported in terms of customer inconvenience, such as turning up to collect repeat prescriptions that had not been issued. It was unclear as to whether this is due to customers misunderstanding or internal/external systems failure.

A need to better communicate the services on offer to both patients and professionals was highlighted. There was a stakeholder perception that people are not aware of the full service that the pharmacy provides. This issue was raised a number of times during the PNA.

One stakeholder highlighted issues around dispensing and the deaf community, particularly if a British Sign Language interpreter is absent, the deaf patient is unable to ask questions about their medication.

There was an indication that some out-of-hours difficulties had been experienced. One stakeholder suggested that the HWB should consider making a 24-hour on-call pharmacy service available out of hours. However, the out-of-hours GP service has access to essential drugs that can be given to patients at times when a pharmacy is closed. This is a limited list, but it is nationally determined. It is considered that other drugs, not currently on the list, are not urgently needed and that clinically a patient can wait until a pharmacy opens.

5.4 Services provided across other local authority areas

The HWB and stakeholder feedback found no services operating within or outside the Leeds Health and Wellbeing area that are impacting, or will in the future impact, on the capacity of community pharmaceutical services for Leeds residents.

5.5 Public engagement

An electronic and paper questionnaire was developed and distributed through the Leeds City Council's Citizens' Panel. 3,350 residents were invited to respond online while 600 residents were sent a paper questionnaire. Additional measures were taken to capture the views of young people – via youth clubs and LCC Young People's Voice, Influence and Change Team – and those of BME groups – through Healthwatch, the LCC Communities Team and Leeds Gypsy Traveller Exchange (GATE). Tweets were also shared through various council twitter accounts, including @LeedsCC_News @HWBBoardLeeds @BetterLivesLds @OneYouLeeds. A range of others were tagged to get their involvement too.

An easy-read version of the questionnaire was considered, but the cost was felt to be disproportionate to the potential benefits so this was not pursued. Only one request for an easy-read version of the questionnaire was received and this person submitted their views as free text.

In the live survey period between 22nd August and 29th September 2017, 1059 online and 365 paper responses were received. Although not all returns were via Citizen Panel, the majority were and an approximate response rate of 36% was achieved.

A summary of the community survey results is shown at **Appendix 14**.

5.6 Stage two: analysis and draft report writing

The content of the PNA was produced as a result of collecting, analysing and compiling information from published national and local statistics and reports. Commissioners were asked about the services they commission and community pharmacists about the services they currently provide. This information was mapped to show the geographical spread of each commissioned service and also opening hours of the pharmacies to assess out of hours coverage and accessibility.

A community survey and a focus group added citizen's actual experience of availability, access to and satisfaction with community pharmacy services and a stakeholder consultation provided information around services within and outside the HWB, which could impact on community pharmacy provision and any perceived gaps now or in the next three years.

The draft document was shared with a number of stakeholders prior to draft publication.

5.7 Stage three: Formal consultation

The draft PNA was published on the Leeds Observatory website from 4 December 2017 to 2 February 2018: http://observatory.leeds.gov.uk.

This met the required formal consultation period of 60 days. The link to the draft was sent to all mandatory stakeholders on the first day of consultation, in line with Department of Health regulations and are shown below:

- All Elected Members
- All Leeds community pharmacists
- Neighbouring Health and Wellbeing Boards of Bradford District, Craven, Calderdale, Kirklees, Harrogate and Wakefield
- Third Sector representative of Leeds Health and Wellbeing Board
- Representatives of Leeds Clinical Commissioning Group Partnership
- Leeds Local Medical Committee (LMC)
- Leeds Community Healthcare
- Leeds Teaching Hospital Trust
- Community Pharmacy West Yorkshire
- Local Professional Network (LPN) for Pharmacy
- Community Pharmacy North Yorkshire
- Community Pharmacy Humber
- Healthwatch Leeds
- Leeds prescribing GPs

All pharmacies, other stakeholders, all Leeds City Council Elected Members and dispensing GP practices in the Leeds Health and Wellbeing area received a letter notifying them of the consultation.
Comments were received from Community Pharmacy West Yorkshire, Leeds Community Healthcare NHS Trust, NHS England, North Yorks County Council and two community pharmacies. These are tabled at **Appendix 27**.

5.8 Stage four: final publication

The HWB will publish the PNA prior to 1 April 2018 in line with the regulations. The PNA will then be placed on the Leeds Observatory website.

5.9 Lifespan and review of the PNA

The PNA will be valid for three years from 1 April 2018 to 31 March 2021 when an updated version will be published. A review statement may be published before then if significant change occurs.

6. Mapping of current pharmacy provision

The PNA has identified and mapped current provision of pharmaceutical services in order to assess the levels and appropriateness of the provision.

6.1 Community pharmacies

There are 180 pharmacies currently operating in Leeds. At the time of the 2015 PNA, there were also two Essential Small Pharmacy Local Services (ESPLPS). All ESPLPS contracts ceased on 31 March 2015 and the Leeds pharmacies operating

under these contracts were transferred to a Local Pharmaceutical Service (LPS) contract. ESPLPS no longer exist.

There is now only one such LPS pharmacy commissioned by NHS England operating in Leeds which is situated in Pool-in-Wharfedale

This pharmacy is shown at **Appendix 1** and other maps throughout the appendices**.**

The LPS contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

6.2 Dispensing GP practices (controlled areas)

Dispensing doctors are medical practitioners authorised to provide drugs and appliances in designated rural areas known as 'controlled areas'.

There are seven dispensing GP practices, all of which are situated in the Outer North East area:

- The Harewood site only, at the Wetherby and Harewood Surgery
- Church View Collingham and the Thorner branch surgery
- Bramham Medical Centre
- The Scholes site only at Manston Surgery
- The Barwick-in-Elmet and Aberford sites of Garforth Medical Centre

The main sites do not dispense because there is sufficient pharmacy provision available locally.

The Leeds West area does not have any dispensing practices.

These seven dispensing practices are mapped at **Appendix 15**.

6.3 Dispensing appliance contractors (DACs)

There are currently no NHS England contracted appliance contractors based in Leeds. There are four outside Leeds, which may be used by Leeds community pharmacies. However the use of DACs is unlikely to be geographically bound and patients may be using DACs from across the country.

6.4 Distance-selling pharmacies

A distance-selling pharmacy is a registered pharmacy that provides services over the internet. There are seven distance-selling pharmacies in Leeds, five more than in 2015.

Table 10 Distance-selling pharmacies in Leeds

Pharmacy	Trading name	Postcode
PHARMACY2U LTD		LS14 2AL
Pharma Corner Ltd	Pharmacy Corner	LS8 4JL
Nightingale Yorkshire Ltd	Nightingale Pharmacy	LS11 5NX
Mission Start Ltd	Living Care Pharmacy Deliveries	LS11 5JJ
HealthNet Homecare Ltd	HealthNet Homecare Limited	LS12 6LS
GreenPharma Ltd	Chemist 247	LS11 7HL
Future Practice Ltd	Advantage Pharmacy	LS11 5SS

Patients can access pharmaceutical services from any community pharmacy, including mail order/internet pharmacies of their choice. This option increases accessibility as patients can access locally or nationally based internet pharmacies. Distance-selling pharmacies do not offer face-to-face essential services, but may offer other face to face services.

Leeds Outer North East area has seven dispensing GP practices and taken together with the seven distance-selling pharmacies across Leeds and community pharmacies that can be accessed in neighbouring inner areas, this does not constitute a gap in pharmaceutical services in the area.

There are 31,424 people who live in Lower Super Output Areas (LSOAs) where the centre of the LSOA is outside the one-mile buffer zone. This means that they will not have access to a pharmacy within one mile of their home. Some of these residents live within the Outer Community Committee areas but most have proximity to good road networks so are likely to be able to access a pharmacy within 20 minutes by car or public transport.

There is therefore adequate provision and no geographical gaps for the needs of the population in the area of the Health and Wellbeing Board.

The location of all community pharmacies, dispensing GP practices and distance selling pharmacies in Leeds is included at **Appendix 1**.

6.5 Opening times

Table 11 Pharmacy opening times (October 2017)

Opening times	Number of pharmacies open
Before 8 am	22
After 6 pm	83
After 8 pm	31
After 10 pm	23
Saturday	126
Saturday afternoon	111
Sunday	41

In terms of out of hours access for Leeds citizens, 22 pharmacies are open before 8am, 83 after 6pm and 31 after 8pm. 23 are open after 10pm. A total of 126 of community pharmacies that responded to the PNA survey are open on Saturday. Of these, 111 are also open in the afternoon; 15 are open on a Saturday morning only and 41 community pharmacies are open on a Sunday. This means that overall, there is adequate provision for citizens to have a choice of pharmacies should they need to access out of hours.

The vast majority of heavily populated neighbourhoods in the Inner areas of Leeds have excellent access to a choice of local community pharmacies which are open for extended hours. The Outer Community Committee areas have fewer community pharmacies and fewer with extended opening hours.

Therefore, depending on where they live, some citizens may need to travel, either into one of the Leeds Inner areas, or to a pharmacy in an adjoining Health and Wellbeing area, should they require a service before 8am on a weekday, or on a Sunday. There is adequate provision within the Outer North East area on a Saturday and after 6pm, though none are open after 8pm.

This information is mapped at **Appendix 16 to 19**.

27 pharmacies are contracted by NHS England to open for a minimum 100 hours, an increase from 21 in 2015. This information is mapped at **Appendix 20**.

22 of the pharmacies which responded to the survey confirmed that they are working to a minimum of 100 hours. There are also now seven distance-selling pharmacies, an increase on the two reported in 2015. Infrastructure to aid access to pharmaceutical services has therefore improved over the last three years.

7 Commissioned services

Commissioners from Leeds City Council, NHS England and Leeds CCG Partnership were asked to provide details of all the services they commission in pharmacies. This information was mapped and analysed in stage two.

7.1 Local services commissioned by Leeds City Council

Community pharmacies can make a significant contribution to improving the public's health and are often a point of contact for people, including vulnerable people, who may not otherwise access health services.

Pharmacies can offer a number of services, commissioned or non-commissioned. This can range from signposting to offering more tailored services such as emergency contraception, blood pressure monitoring or diabetes support. Leeds City Council commissions community pharmacies to deliver a number of services which contribute towards the wellbeing of the Leeds population and delivery of the Leeds Health and Wellbeing Strategy.

7.1.1 Supervised consumption

Community pharmacists are commissioned to observe consumption of prescribed substitute medication for opiates to patients where supervision has been requested by the prescriber. The primary function of the service is to stabilise, reduce, and eventually replace, illicit opiate use and in so doing reduce harm and improve the health and psychological wellbeing of the patient. The aims of the service are to:

- offer a professional, user-friendly, non-judgemental, client-centred and confidential service
- ensure the safe and consistent consumption by patients of prescribed substitute medications for opiates
- minimise the misdirection of controlled drugs, thus contributing to a reduction in drug-related deaths in the community
- support patients in adhering to treatment programmes that will enable them to reduce the harm caused by illegal drug use
- monitor and offer advice to the patient on their general health and wellbeing
- promote access and make referrals to other primary care agencies where appropriate.

There are currently 163 community pharmacies in Leeds contracted to deliver this service and 133 of those returning questionnaires confirmed that they were providing this service. There is less provision in the Outer North East but depending on their postcode, it may be nearer for service users to travel to one of the pharmacies in an adjoining Community Committee area.

Appendix 21 shows the locations of the pharmacies that currently deliver the service.

The current contract for this service expires on 31 March 2018. A commissioning review was taking place during 2017, with new contracts to commence from 1 April 2018.

The review is looking at the whole process of opiate substitution treatment, from a service user first seeking support to address their drug use, through the period when

their medication is under supervision, to the point where they can take their medication unsupervised and ultimately become drug-free.

Leeds City Council is working closely with the commissioned drug and alcohol treatment provider in Leeds to monitor current need and estimate future levels of need for the service. Drug treatment services need to have city-wide coverage and be available in locations and at times which are convenient for service users.

All pharmacies within Leeds will be given the opportunity to demonstrate that they meet the requirements to deliver a supervised consumption service, as set out in the specification, and there will be no upper limit on the number of pharmacies that can be awarded a contract. Therefore there should be no gaps in this service over the life of the PNA.

7.1.2 Needle exchange

Community pharmacies are also commissioned to provide a convenient and flexible drop-in needle exchange service, offering free access to sterile needles, syringes and related materials. The aims of the service are to:

- Assist service users to remain healthy until they are ready, willing and able to address their injecting behaviour and ultimately achieve a drug-free life with appropriate support.
- Protect health and reduce the rate of blood-borne infections and drug-related deaths among service users by:
  - reducing the rate of sharing and other high-risk injecting behaviours
  - providing sterile injecting equipment and paraphernalia
  - promoting safer injecting practices
  - providing and reinforcing harm reduction messages including safe sex advice and advice on overdose prevention (e.g. risks of poly-drug use and alcohol use)
  - improving the health and safety of local communities by ensuring the safe disposal of used injecting equipment
  - encouraging and supporting service users to access local drug and alcohol services and other health and social care professionals where appropriate.7

The community pharmacy needle exchange service in Leeds was reviewed during 2015/16 in order to ensure that the service was being provided in the most appropriate geographical areas and that service users were receiving useful advice and support.

The review determined the areas in which the needle exchange provision is most needed. During January 2016, pharmacies which operate within the identified areas were invited to apply to provide the service. As a result, 15 pharmacies across Leeds were awarded contracts which are effective from 1 April 2016 until 31 March 2021.

Provision for this service is currently adequate, although regular monitoring is required to make sure that the locations and opening times of the pharmacies involved in the service continue to meet service user needs. **Appendix 22** shows the location of the pharmacies that deliver the service.

7.1.3 Lifestyle support

Data from the Health Survey for England (2016) highlight that

- two in 10 adults are smokers
- seven in 10 men and six in 10 women are overweight or obese
- one in three people have drinking habits that could be harmful
- half of women and one-third of men do not get enough exercise
- a quarter of the population engages in three or four unhealthy behaviours.

Forty per cent of the UK's disability adjusted life years lost are attributable to five risk factors: tobacco, hypertension, alcohol, being overweight or being physically inactive.

7.1.4 Smoking cessation

There has been significant progress made with respect to reducing smoking prevalence; this has been achieved through a comprehensive approach to tobacco control. However, despite significant reductions, smoking remains a high priority for Leeds and across the UK because it is still the major cause of premature morbidity and mortality, health inequalities and poor quality of life.

In Leeds, smoking prevalence is 17.8%, over 2% higher than the England average of 15.5%. This has improved from 22.7% in 2012 and is a reflection of the city's overall tobacco control activities and national policies. However smoking rates are significantly higher in several wards across Leeds, particularly in deprived areas, and amongst particular groups. These include routine and manual workers, with a smoking prevalence of 28.4%, members of some BME communities (particularly men), and people from lower socioeconomic groups.

In addition to the health impact that smoking has on our society, it is also a financial burden. It is estimated that in 2014/15, smokers in Leeds paid approximately £124m in duty on tobacco products; however, smoking costs the Leeds economy roughly twice the amount of duty raised at £224.8m.

7.1.5 Stop-smoking support

Stop-smoking services across the country are experiencing a decline in smokers accessing these services. The number of people setting a quit date through NHS Stop Smoking Services in 2016/17 fell for the fifth consecutive year to 307,507. This represents a decrease of 19.6% on 2015/16. However, the quality of interventions remains high, with a 51% success rate. There may be many reasons for the reduction in smokers accessing stop-smoking services, including the rise in smokers

switching to e-cigarettes and quitting. Stop-smoking services remain the most effective in helping smokers quit.

Following a comprehensive service review in 2015, a health needs assessment and stakeholder consultation, the stand-alone stop-smoking support service ceased in primary care and pharmacies in October 2017. The value of this contract was £4,000.

Despite this development, pharmacies remain an important setting in which to raise lifestyle issues and support customers to have a healthy lifestyle. Healthcare professionals can play an important role in supporting people to make small and sustainable changes that improve their health through making every contact count.

Brief and very brief interventions by healthcare professionals have also been shown to be effective ways of supporting sustainable behaviour change. Consumer research suggests that most people feel it is appropriate for healthcare professionals to ask about these behaviours and to offer help.

7.1.6 Maintaining a healthy weight

The latest Health Survey for England data (2016) shows that over a quarter of adults, and over 1 in 10 children aged 2 to 10 years, are obese, with the trend set to increase. Two Public Health Outcomes indicators are used to monitor the impact of overweight and obesity on the local population:

- the percentage of adults with excess weight
- the percentage of active and inactive adults.

In 2013/15, 62.3% of the Leeds population were overweight or obese; this is comparable with the England average. The Active People Survey is used to determine the percentage of active and inactive adults. In 2015, 28.9% of the adult Leeds population were inactive and 56.3% were active. These figures are also comparable with the England average.

Obesity can have a severe impact on people's health. Around 10% of all cancer deaths among non-smokers are related to obesity. The risk of coronary artery disease and type 2 diabetes directly increases with increasing levels of obesity and levels of type 2 diabetes are about 20 times greater for people who are very obese. These conditions shorten life expectancy.

Good eating and physical activity habits are key to maintaining a healthy body weight. These are impacted by significant external influences such as environmental and social factors. Changes in food production, the use and availability of motorised transport, and changing work/home lifestyle patterns, all contribute to the trend of increasing body weight.

There are currently no commissioned pharmacy weight management services in Leeds although pharmacists are encouraged to signpost to the One You Leeds service.

7.1.7 NHS Health Check

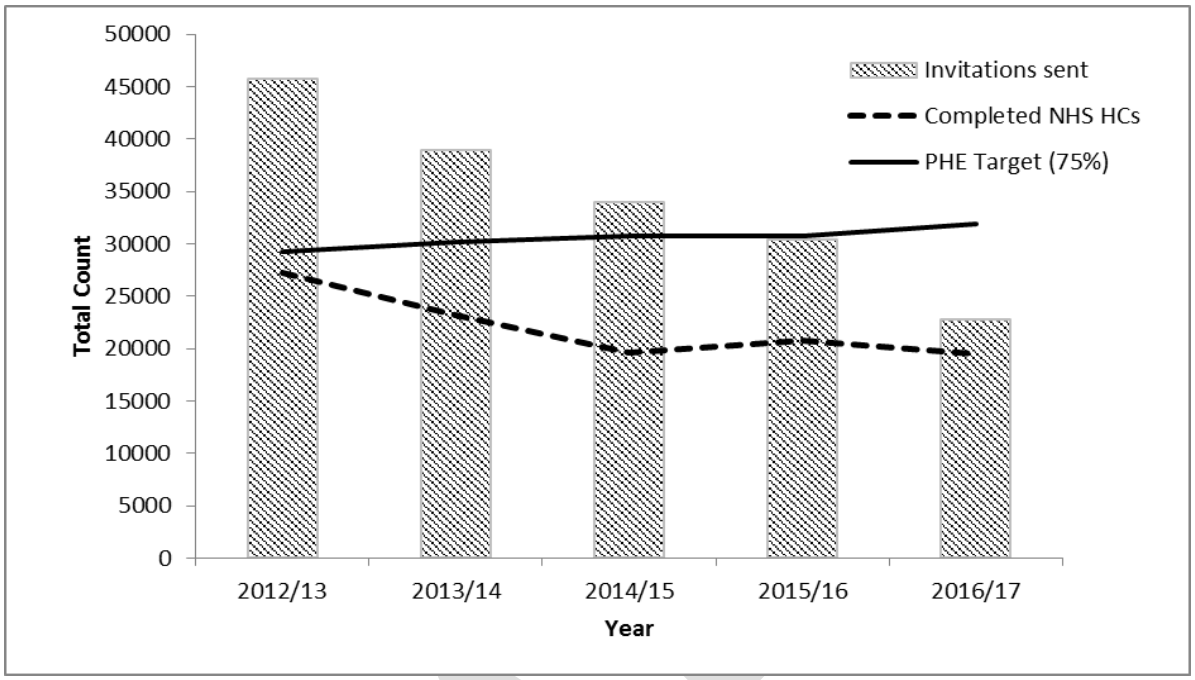
The NHS Health Check programme was introduced nationally by the Department of Health in 2009, following the publication of *Putting Prevention First: Vascular Checks and Risk Management* which set out plans for the NHS to introduce a systematic, integrated programme of vascular risk assessment and management. The aim of the NHS Health Check programme is to prevent cardiovascular disease (CVD), which includes heart disease, stroke, diabetes, kidney disease and certain types of dementia.

The programme is for people aged 40–74 who have not already been diagnosed with CVD. As part of a rolling programme, 20% of the eligible population are invited to have an NHS Health Check once every five years. Each NHS Health Check is delivered by a trained health professional who assesses the person for their risk of developing CVD in the future. Support and advice is then offered to help the person to reduce or manage their risk. The system allows referrals to treatment for those receiving abnormal results. Referrals to Healthy Living Services are also generated where appropriate.

The NHS Health Check programme has clear links to the outcomes set out in Section 4 of the Leeds Health and Wellbeing Strategy, in particular supporting people to live longer and healthier lives through behaviour change, early identification, prevention and management. The uptake of NHS Health Checks is one of the key indicators of the Best Council Plan (2015–2020).

According to data from Public Health England (2016/17), a total of 199,752 people in Leeds are eligible for an NHS Health Check. Leeds had an uptake of 73.2%; the average England uptake was 49.9%. However, data extracted locally via GP audit shows that the number of invitations sent to the eligible population has declined each year. As shown below, the number of completed NHS Health Checks has also plateaued in the last three years.

Figure 2 Leeds NHS Health Check performance (2012/13 – 2016/17)



Insight gained from Leeds residents in 2014 highlighted the need for a more flexible offer. As a result, a Health Check pilot project was commissioned to offer NHS Health Checks from four Asda pharmacies across the city. Over an 18-month period, a total of 78 people received an NHS Health Check through an Asda pharmacy. Despite low uptake, there were a number of positives including a strong working relationship between Public Health and Asda and staff willingness to deliver NHS Health Checks at a similar level of competence to primary care. Asda were able to refer into the Healthy Living Service and data could be extracted from the clinical system via Public Health to monitor outcomes.

A number of barriers were identified, including lack of participation from GPs, which impacted on the coverage of the programme. This then impacted on patient eligibility to take part in an NHS Health Check at the pharmacy and prevented wider marketing. The low number of completed NHS Health Checks meant staff skills were not maintained; further training was required, but proved difficult to arrange. Logistical issues were also experienced, such as lack of space and difficulty in tracking those people who were identified as high-risk back to primary care for follow up.

In 2015, a Citizens' Panel survey of 1,726 people was carried out to obtain views from the public on the NHS Health Checks in Leeds. Having appointments available at their GP surgery would encourage, or has encouraged, people to book an NHS Health Check. Having information on what happens during an NHS Health Check, and being sent reminders, were also important factors in their decision to book an NHS Health Check. The availability of appointments at a local pharmacy or other local community venues did not appear to be an incentive for booking an NHS Health Check, with just 153 out of 1,726 responses selecting this option.

Some people considered location to be an important factor in encouraging attendance and believed more flexibility is needed, particularly as a health check when feeling well is not always a priority, ahead of work and life commitments. However, there was a general lack of awareness of the NHS Health Check in terms of the intended target audience, who is responsible for the invitation and how often individuals can have a check.

The NHS Health Check service is currently being delivered citywide by 106 GP practices with the contract due to end in March 2018. A comprehensive review of the NHS Health Check programme has been completed to identify and assess reasons for the continued decline in invitation and uptake. A number of disengaged groups – particularly males, people from the 40–49 age category and people with learning difficulties or severe mental illness – were identified and Leeds City Council will use this insight to inform future activity.

Community pharmacies are not currently commissioned by Leeds City Council to provide NHS Health Checks, but coverage through GPs is adequate.

7.1.8 Leeds Blood Pressure Wise

Leeds Blood Pressure Wise was implemented in November 2017 following a collaborative funding application from Leeds City Council and the NHS Leeds Clinical Commissioning Group's Partnership to the British Heart Foundation.

The service will target 10,000 new blood pressure checks over a two-year period. The aim of the project is to increase the detection and management of hypertension and atrial fibrillation, whilst also acting as a gateway into NHS Health Checks and the One You Leeds service.

Of the 10,000 blood pressure checks, 2,400 will be delivered by trained pharmacy staff in six community pharmacies located within Deprived Leeds, such as Harehills, Bramley and Seacroft. The member of the pharmacy team nominated to become their trained blood pressure practitioner will receive training on how to measure blood pressure and lead better conversations around healthy living as well as receiving support with using the IT system.

The other 7,600 blood pressure checks will be targeted within the Leeds City Council workforce.

The service will target people aged 35 or above without pre-existing hypertension, atrial fibrillation or cardiovascular disease. Pregnant women and people who have had their blood pressure measured at their GP in the last 12 months are ineligible. Patients that enter the service will be required to consent to having their information shared with their GP via NHS spine. Patients that record an initial blood pressure of 140/90mmHg or higher will be offered the loan of a digital monitor to carry out a week's home blood pressure monitoring prior to a follow-up appointment with the practitioner in the commissioned pharmacy.

7.1.9 Sexual health and wellbeing

Sexual health is an important area of public health. A large proportion of the adult population of England is sexually active and access to good-quality sexual health services is known to improve the health and wellbeing of both individuals and populations. In Leeds there are strong links between deprivation and the incidence of sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest rates experienced by women, men who have sex with men (MSM), teenagers, young adults and BME groups.

The Public Health Sexual Health Team commission pharmacy-based services in Leeds which support the delivery of two main sexual health-related Public Health Outcomes Framework measures: under-18 conceptions and chlamydia diagnosis (15–24 year olds).

Across the city, 38 sites are commissioned to deliver the Enhanced Sexual Health Pharmacy Scheme (ESHPS). These sites have been selected based on their location within sexual health priority areas: areas where there are high levels of teenage conceptions and higher rates of multiple terminations and areas that are geographically more isolated from city centre services.

The ESHPS offers free access to emergency hormonal contraception (EHC), pregnancy testing and chlamydia screening. Participating sites which have a service level agreement with the local authority, have private consultation rooms and a toilet on site, operate core opening times for the scheme and have committed to declaring their competency and keeping training up to date. A Sexual Health Needs Assessment (SHNA) is currently underway with the aim of updating key sexual health data profiles and mapping the coverage of sexual health services around the city. This SHNA will be used to update sexual health priority areas and help assess whether services are located in areas of need.

The ESHPS is currently being reviewed in relation to the findings of the SHNA. This review will also provide sites currently not offering the scheme but based within areas of priority the opportunity to express their interest in running the scheme. The review also recognises the need to create better referral pathways between providers of EHC and contraceptive services in order to mitigate the risk of EHC being used as a primary form of contraception.

Although it is recognised that prices may change during the lifetime of this PNA, pharmacists are currently paid a £10 consultation fee when the ESHPS is accessed, an additional £3 when a pregnancy test is performed and £3 for a completed chlamydia screen (resources provided via the commissioner). Pharmacies are also reimbursed for the price of the drug provided (ulipristal acetate and levonorgestrel). From April 2018, Leeds Community Healthcare NHS Trust will take over the day-to-day management of the ESHPS as the contract provider of the Integrated Sexual Health Service in Leeds. This feature has been built into many Integrated Sexual Health services contracts nationally as it provides a closer relationship, clinical

governance overview and referral pathways between community pharmacy providers and clinical leads within the Sexual Health Service.

The current EHC pharmacies are mapped against population density of females aged 16+yrs at **Appendix 23** and against under-18 conceptions/unintended pregnancies at **Appendix 24**. They are sited in areas of highest teenage pregnancy and no gaps in services have been identified.

7.1.10 Medication Administration Record (MAR)

The Medication Administration Record (MAR) Chart scheme commissions community pharmacies to provide domiciliary patients (who receive assistance with their medicines from Leeds City Council Adult Social Care (ASC) or commissioned homecare providers) with an accurate Medication Administration Record (MAR) chart(s). This is a requirement at all times the pharmacy is open. The contract runs for 3 years from 1 April 2015 to 31 March 2018. This service does not cover anyone in care homes.

A map of the community pharmacists providing MAR is shown at **Appendix 25.**

7.2. NHS England-commissioned services

7.2.1 Health protection – national flu immunisation programme 2017/18

The aim of the national flu immunisation programme is to ensure high levels of flu immunisation, this being one of the most effective interventions we can make to reduce harm from flu and pressures on health and social care services during the winter. Those eligible should be encouraged to take up the offer of the free flu vaccination as early as possible between September and early November, before flu starts circulating in the community.

In 2017/18 the following people are eligible for flu vaccination:

- those aged 65 years and over
- those aged six months to under 65 in clinical risk groups (including morbidly obese people with a BMI of 40 or over)
- pregnant women (any trimester)
- all two and three-year-olds as part of the primary care programme
- four-year-olds and school-aged children in Years 1, 2, 3 and 4 as part of the schools-based programme (regardless of where educated or geography)
- those in long-stay residential and/or nursing care homes
- people in receipt of Carer's Allowance or who are the main carer of an elderly or disabled person (not paid/employed carers).

Health and social care workers who are in direct contact with patients or service users are shortly expected to be offered flu vaccination by their employer; this will include GP practice staff.

To improve access and choice with the aim of increasing uptake, NHS England commission the national community pharmacy advanced service, allowing them to offer and deliver flu vaccine to all eligible adult patients. In 2016/17 approximately 115 pharmacists in Leeds were signed up to deliver this service but this has increased to 134 in 2017/18.

Where pharmacies are not part of the national pharmacy flu service, NHS England suggest they should be actively promoting the flu vaccine through resources and advice and signposting the patient to their GP.

7.2 2 NHS Urgent Medicine Supply Advanced Service (NUMSAS)

In June 2017, NHS England commissioned the NHS Urgent Medicine Supply Advanced Service (NUMSAS) pilot. This replaced the West Yorkshire Urgent Repeat Medicine Service, which had previously been commissioned by all three CCGs in Leeds. The purpose of the service is to facilitate appropriate access to repeat medication out of hours and relieve pressure on urgent care and emergency care services by enabling access to repeat medicines in emergency situations. The service aims to reduce the pressures and demands on unscheduled care such as A&E, out-of-hours GPs and NHS111.

The community pharmacists commissioned by NHS England to provide NUMSAS are shown at **Appendix 26**. Although the Outer North East and Outer North West are less well served, main road links are nearby to facilitate reasonably speedy access to the nearest available site.

7.2.3 Palliative care

Palliative care services enable the prompt supply of specialist palliative care medicines, the demand for which may be urgent and/or unpredictable. Pharmacy contractors commissioned to provide this service are required to stock a locally agreed range of palliative care medicines and make a commitment to ensure that users of this service have prompt access to these medicines at all times in the event that they are required.

The pharmacy also provides information and advice to the user, carer and clinician. They may also refer to specialist centres, support groups or other health and social care professionals where appropriate.

At present the number of pharmacies commissioned, and the terms of the service commissioned, vary across CCG areas and Leeds community pharmacies are not currently commissioned to provide this service. However, some pharmacies returning survey questionnaires said they were providing this service.
NHS England are currently reviewing the palliative care service to ensure a consistent approach across West Yorkshire whereby all contractors commissioned to provide this service will receive the same remuneration and work to the same formulary. The new service is expected to be in place from 1 April 2018.

7.3 Local services commissioned by Leeds CCGs

The three previously separate CCGs in Leeds now work together as a NHS Leeds Clinical Commissioning Group's Partnership. The following services are currently commissioned.

7.3.1 Pharmacy First

The NHS Leeds Clinical Commissioning Group's Partnership commission Pharmacy First from the majority of community pharmacies. The only exceptions are pharmacies that have significantly higher usage of the NHS England-commissioned Minor Ailments Scheme.

The Pharmacy First scheme provides the local population with rapid access to a pharmacist who can give advice, and where necessary supply medication from an official list, for a range of minor ailments. This releases capacity in general practice and provides an appropriate alternative to the use of general practice or other healthcare environment (i.e. A&E, out-of-hours urgent care). The service is aimed at patients who use GP or out-of-hours services when they have a minor ailment, rather than self-care or purchasing medicines over the counter. The service aims to change patient behaviours and to educate and assist patients in how to access self-care and the appropriate use of healthcare services.

7.3.2 Head lice

The head lice scheme is now incorporated into the Pharmacy First service. Pharmacies providing this service offer evidence-based advice and support to people on the management of head lice and medication for the treatment of head lice. The service is intended to help reduce the number of inappropriate referrals made to the Head Start clinic, as well as helping GPs make efficient use of their time so they can focus on more complex patients. The service allows patients access to treatment on the NHS without a prescription but children less than six months must be referred to their GP. This is due to the product licences of the available treatments.

8. Maps of commissioned services

The appendices following this assessment show the full range of pharmacy provision that is currently available in the Leeds Health and Wellbeing area.

9. Conclusions

- The PNA has found that Leeds has very good coverage of necessary pharmaceutical services with no gaps in provision. There are also no current gaps in the provision of other relevant services in the area of the Leeds Health and Wellbeing Board.

- The PNA has assessed likely changes in the population that could change the requirement for pharmaceutical services, the demographics of the city and current health and wellbeing levels in the area. It has not identified any current or future needs which cannot be met by current providers on the pharmaceutical list.

- The 181 pharmacies which were working within the national contract in Leeds in 2015 has reduced by one to 180 but there are now seven distance selling pharmacists, an increase of five since the last PNA.

- Satisfaction with access to pharmaceutical services is high. The majority of the PNA survey respondents live within one mile of a pharmacy and 80% of the residents in the PNA public survey self-reported that availability of pharmacies in their area was very good (42%) or good (38%).

- A very small minority of residents reported some difficulty accessing out-of-hours services, but most areas have a choice of pharmacies that are open on Saturday, Saturday afternoon, after 6 pm, after 8 pm, after 10 pm and on a Sunday. 95% of residents self-reported that they have a choice as to which pharmacy they can use.

- The Outer North East Community Committee area is less well served, with no pharmacy open after 8 pm, after 10 pm, or before 8 am. However, there are seven dispensing GPs in this area and seven distance selling pharmacies across Leeds. 23% of the community survey sample reported that they use other pharmacies as well as their local pharmacy so this does not represent a gap for the area.

- There are fewer community pharmacists in all of the Outer areas but 73% of Leeds residents responding to the PNA survey said they can reach a pharmacy in up to 10 minutes; 87% of residents have access to public transport to within walking distance of the pharmacy and 71% of pharmacies report a bus or other public transport stop less than two minutes (walking at a moderate pace) from the pharmacy.

- A small minority of residents who responded to the survey (3.2%) take between 21–30 minutes, and 1% just over 30 minutes, to reach a pharmacy.

- Satisfaction with the quality of pharmacies is also high. Just over three-quarters (76%) of residents responding to the PNA survey said that the quality of pharmacies in their area was good or very good and 95% of residents reported that they are happy with the services that their local or usual pharmacy provides.

- Some of the newly-emerging communities may not be using the available services as much as they might because of potential language and cultural barriers, but this can be adequately addressed by current providers.

- The full capacity of community pharmacy as described in the Community Pharmacy Forward View (2016) does not yet seem to have been fully utilised in Leeds. However future capacity is building and there are now 149 Healthy Living Pharmacies in Leeds. This provides an excellent base on which community pharmacies can integrate into New Models of Care, build aspirations for the neighbourhood health and wellbeing hubs and reduce health inequalities

9.1 Recommendations

- That the Health and Wellbeing Board is satisfied that the population of Leeds currently has very good access to pharmaceutical services and there are no current gaps in the provision of necessary services to meet the needs of the Leeds Health and Wellbeing Board area population.

- That the Health and Wellbeing Board is satisfied that there are no current gaps in the provision of other relevant services to meet the needs of the Leeds Health and Wellbeing Board area population.

- That the PNA has not identified any future needs which could not be met by pharmacies already on the pharmaceutical list, which would form part of related commissioning intentions.

- That the Health and Wellbeing Board is satisfied that there is a reasonable and adequate choice of pharmacies and pharmaceutical services in all areas of Leeds.

- That the Health and Wellbeing Board is aware that New Models of Care will further change the local health landscape, including re-assessing the role and potential of the community pharmacy team. There is capacity for this enhanced role to be done through the existing contracts and will provide greater opportunities for them to fully support the public's health and wellbeing.

- That pharmacies continue to develop, exercise and extend where appropriate their expertise around equality and diversity to ensure they continue to respond fully to meeting the needs of a changing and increasingly diverse population.

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Appendix 13	Summary of the pharmacy survey results.
Appendix 14	Summary of the community survey results.
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Appendix 20	Map to show 100 hour pharmacies contracted by NHS England.
Appendix 21	Map to show pharmacies commissioned to provide supervised consumption and pharmacy reported provision of supervised consumption
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Appendix 25	Map to show pharmacists commissioned to provide Medication Administration Record (MAR).
Appendix 26	Map to show pharmacists commissioned by NHS England to provide NHS Urgent Medicine Supply Advanced Service (NUMSAS).
Appendix 27	60 day consultation feedback table

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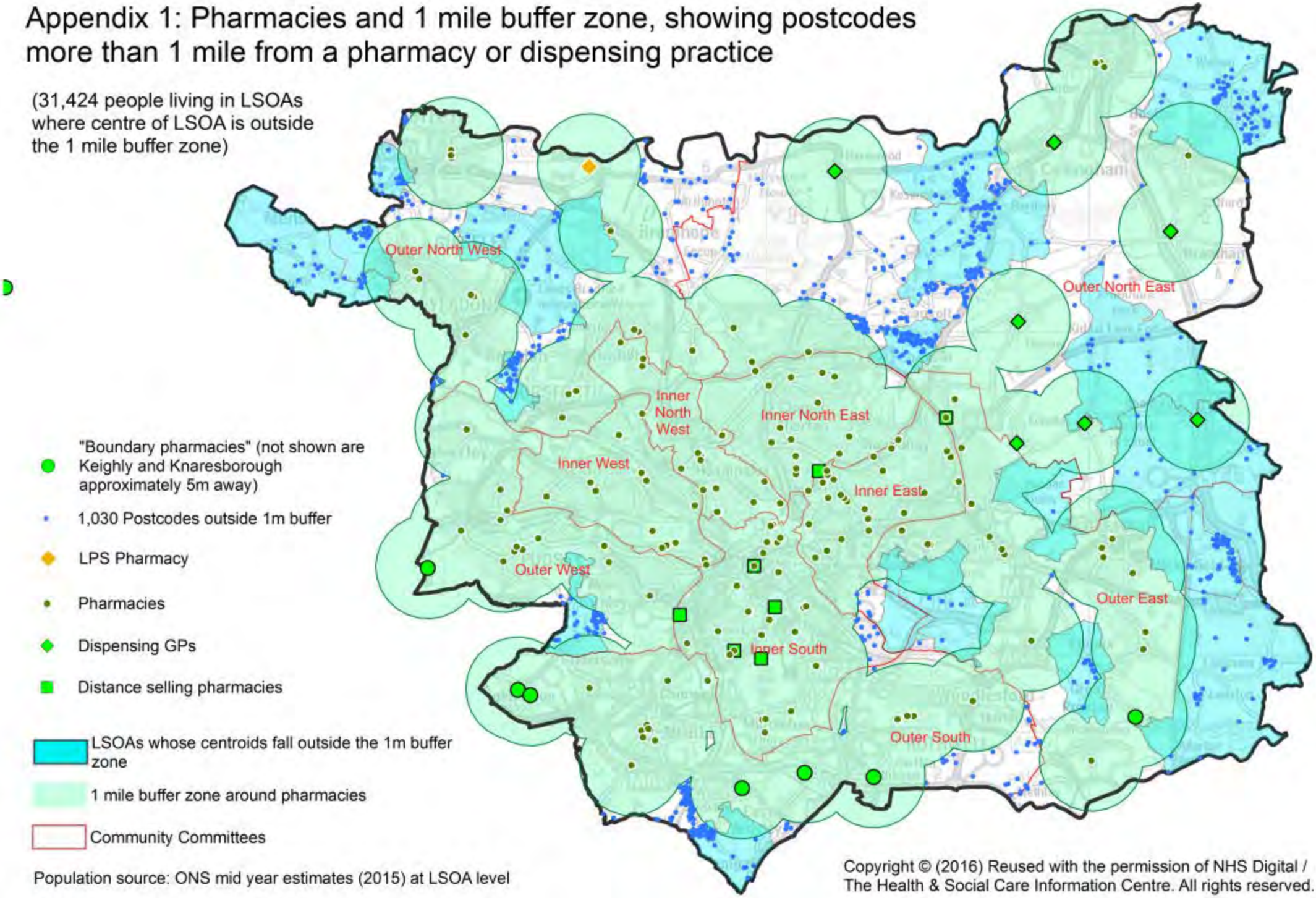
Appendix 1: Pharmacies and 1 mile buffer zone, showing postcodes more than 1 mile from a pharmacy or dispensing practice

(31,424 people living in LSOAs where centre of LSOA is outside the 1 mile buffer zone)



Population source: ONS mid year estimates (2015) at LSOA level

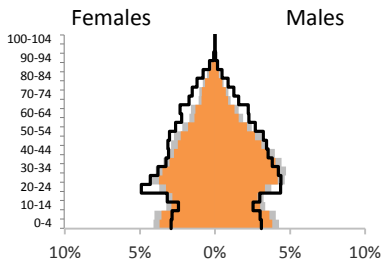
Appendix 2: Area overview profile for Inner East Community Committee

This profile presents a high level summary of data sets for the Inner East Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 89,506 43,035 46,471



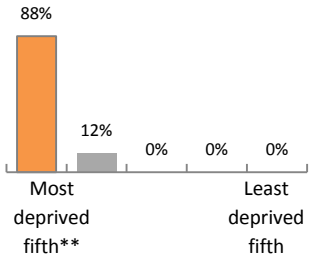
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	6,273	39%	67%
Pakistani	2,124	13%	6%
Black - African	1,832	11%	5%
Any other white background	1,153	7%	4%
Bangladeshi	691	4%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



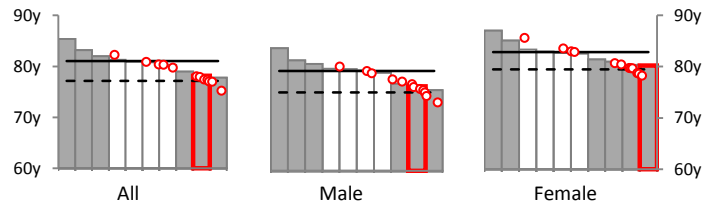
Pupil language, top 5	Area	% Area	% Leeds
English	9,382	60%	81%
Urdu	979	6%	3%
Bengali	491	3%	1%
Czech	428	3%	1%
Polish	337	2%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	% Area	% Leeds
White British	52%	71%
Other White Background	11%	10%
Pakistani or British Pakistani	9%	3%
Black African	8%	3%
Other Ethnic Background	4%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

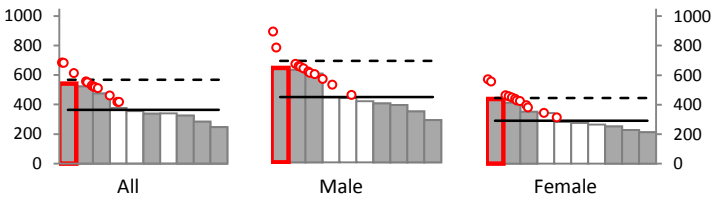
Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



(years)	All	Males	Females
Inner East CC	78.1	76.2	80.2
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

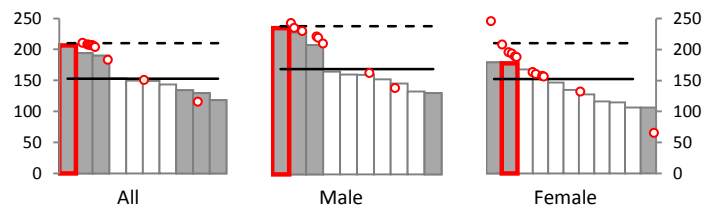
Slope index of inequality (see commentary) = 2.1

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner East CC	541	640	437
Highest MSOAs in area	683	884	569
Lowest MSOAs in area	415	454	311
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

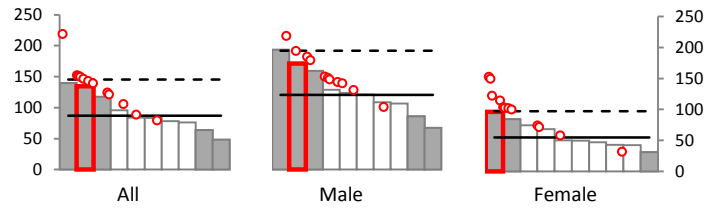


(DSR per 100,000)	All	Males	Females
Inner East CC	207	236	178
Highest MSOAs in area	270	307	245
Lowest MSOAs in area	116	139	65
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

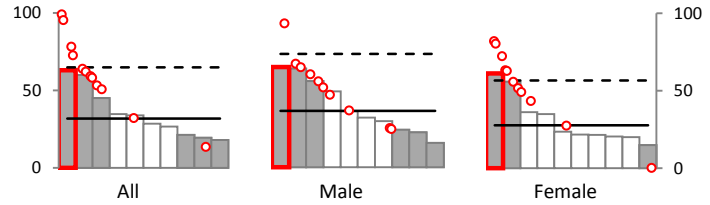
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Inner East CC	135	171	96
Highest MSOAs in area	219	306	152
Lowest MSOAs in area	79	101	31
Leeds resident	87	121	55
Deprived fifth**	145	192	97

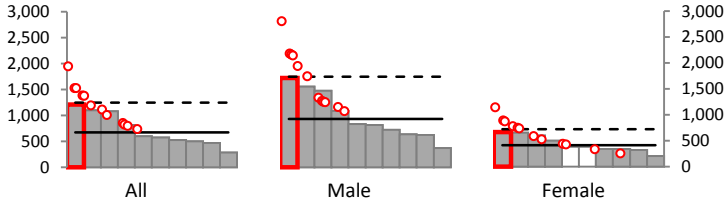
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Inner East CC	63	65	61
Highest MSOAs in area	99	116	138
Lowest MSOAs in area	13	25	0
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

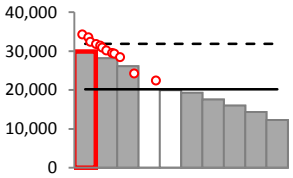
HES



(DSR per 100,000)	All	Males	Females
Inner East AC	1,211	1,724	663
Highest MSOAs in area	1,940	2,811	1,138
Lowest MSOAs in area	735	1,079	249
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

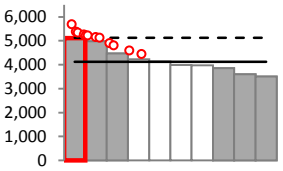
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



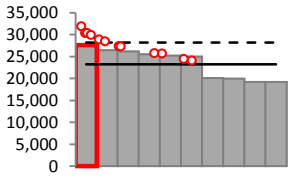
Smoking (16y+)

Inner E CC	29,919
Leeds	20,165
Deprived Leeds *	31,829



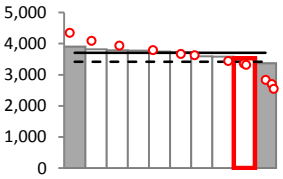
CHD

Inner E CC	5,113
Leeds	4,126
Deprived Leeds *	5,122



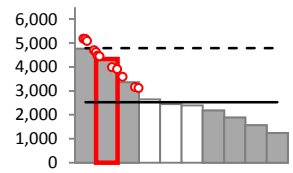
Obesity (16y+ and BMI>30)

Inner E CC	27,592
Leeds	23,226
Deprived Leeds *	28,196



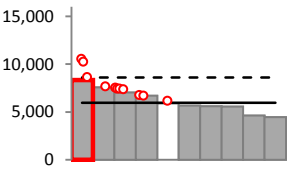
Cancer

Inner E CC	3,532
Leeds	3,703
Deprived Leeds *	3,419



COPD

Inner E CC	4,330
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Inner E CC	8,327
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map *shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area.* ****Deprived Leeds:*** *areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.* *****Most deprived fifth (quintile) of Leeds*** *- Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas.* ***Ordnance Survey*** *PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved.* ***GP data*** *courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.* ***Admissions data*** *Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Inner East Community Committee

The health and wellbeing of the Inner East Community Committee contains some variation across the range of Leeds, tending strongly towards ill health. Around 9 in 10 people live in the most deprived fifth of Leeds*. Life expectancy within the 12 MSOA** areas making up the Community Committee are generally among the shortest in Leeds and mostly significantly lower than Leeds (with some notable exceptions). However, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 2.1 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy for the Community Committee is significantly lower than Leeds for overall.

The age structure bears a close resemblance to that of Leeds overall but with larger proportions of children. GP recorded ethnicity shows the Community Committee to have smaller proportions of "White background" than Leeds and higher proportions of some BME groups. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture with BME groups more predominant than in Leeds.

All-cause mortality for under 75s is significantly above the Leeds average for men, women and overall – it is the highest for any Community Committee in Leeds. Most MSOAs are significantly above Leeds, and the *Cross Green, East End Park and Richmond Hill M*SOA has the second highest all-cause mortality rate overall in the city. The *Lincoln Green and Ebor Gardens* MSOA has the highest mortality rate in the city for men. For women, the MSOA with highest mortality rate is *Cross Green, East End Park and Richmond Hill* and this is the second highest in Leeds.

Cancer and circulatory disease mortality rates are quite widely spread at MSOA level but the overall Community Committee rates are significantly higher than Leeds. The Community Committee has the highest rates of respiratory disease mortality in the city, the *Cross Green, East End Park and Richmond Hill* MSOA has an overall respiratory disease mortality rate that is 3rd highest in the city overall, and also 2nd highest in the city for females.

Alcohol specific admissions for this Community Committee are the highest in Leeds, and almost all the MSOAs in the area have overall and male rates significantly above the Leeds rates. Smoking in the MSOAs is all significantly above the Leeds average, with the highest Community Committee rate in Leeds. Obesity rates in all the MSOAs are significantly above Leeds, the Community Committee again is the highest in the city. COPD and CHD show all MSOAs as being significantly above Leeds. Diabetes rates are also all significantly above Leeds average, with the Community Committee again coming top. Cancer at Community Committee level is nearly significantly below the city, and two MSOAs are within the lowest three in Leeds (*Harehills*| *Harehills Triangle*), this is expected as deprived areas often have low GP recorded cancer due to non/late presentation.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ******Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* ********Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

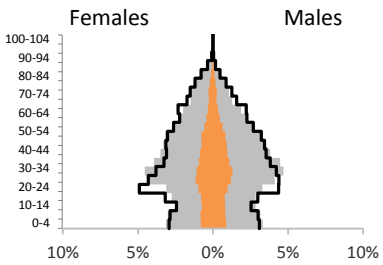
Appendix 3: Area overview profile for Inner North East Community Committee

This profile presents a high level summary of data sets for the Inner North East Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 80,349 40,180 40,169



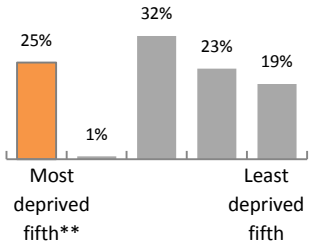
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	4,290	40%	67%
Pakistani	1,690	16%	6%
Indian	648	6%	2%
Black - African	537	5%	5%
Any other white background	508	5%	4%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



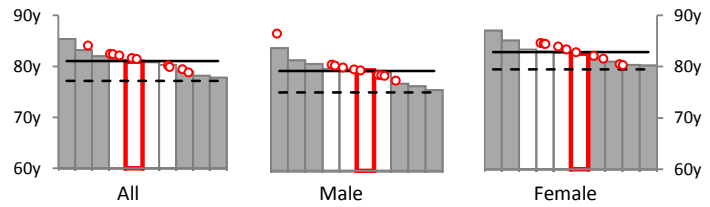
Pupil language, top 5	Area	% Area	% Leeds
English	7,580	73%	81%
Urdu	674	6%	3%
Panjabi	315	3%	1%
Bengali	172	2%	1%
Polish	135	1%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	% Area	% Leeds
White British	52%	71%
Other White Background	13%	10%
Pakistani or British Pakistani	8%	3%
Indian or British Indian	6%	3%
Black African	3%	3%

(October 2015, top 5 in Community committee, corresponding Leeds values)

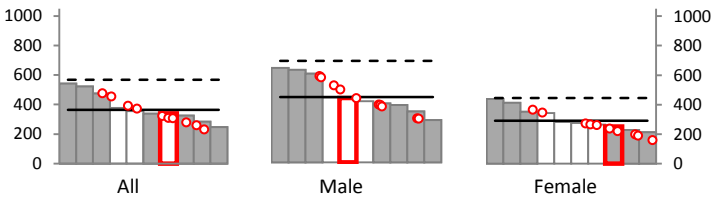
Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



(years)	All	Males	Females
Inner North East CC	80.9	79.3	82.5
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

Slope index of inequality (see commentary) = 4.2

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner North East CC	340	436	252
Highest MSOAs in area	474	582	364
Lowest MSOAs in area	227	294	157
Leeds resident	365	441	291
Deprived fifth**	567	687	444

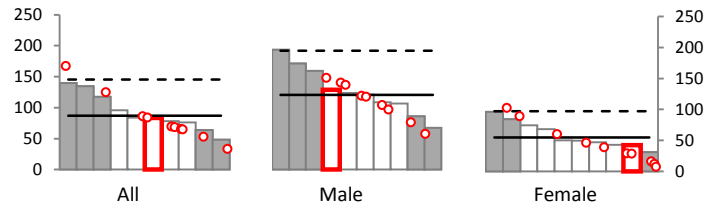
Cancer mortality - under 75s, 2010-14 ranked

(DSR per 100,000)	All	Males	Females
Inner North East CC	130	147	115
Highest MSOAs in area	179	216	160
Lowest MSOAs in area	71	92	54
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

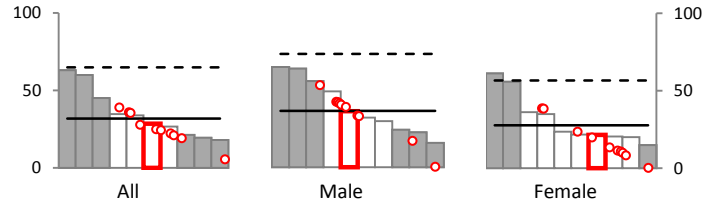
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Inner North East CC	84	129	42
Highest MSOAs in area	167	257	102
Lowest MSOAs in area	33	57	7
Leeds resident	87	121	55
Deprived fifth**	145	192	97

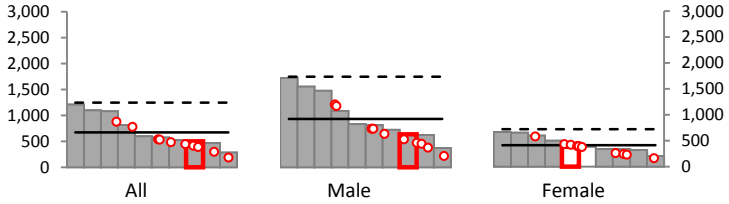
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Inner North East CC	28	36	22
Highest MSOAs in area	39	53	38
Lowest MSOAs in area	5	0	0
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

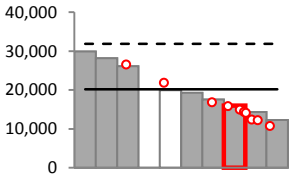
HES



(DSR per 100,000)	All	Males	Females
Inner North East AC	503	638	383
Highest MSOAs in area	878	1,211	575
Lowest MSOAs in area	181	216	154
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

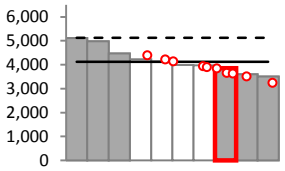
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



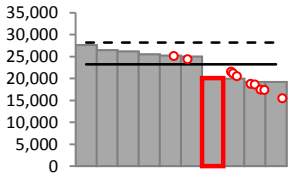
Smoking (16y+)

Inner NE CC	15,994
Leeds	20,165
Deprived Leeds *	31,829



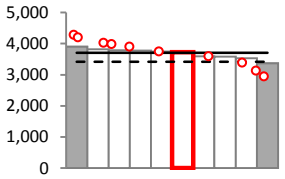
CHD

Inner NE CC	3,856
Leeds	4,126
Deprived Leeds *	5,122



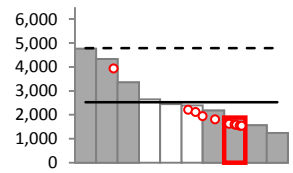
Obesity (16y+ and BMI>30)

Inner NE CC	20,065
Leeds	23,226
Deprived Leeds *	28,196



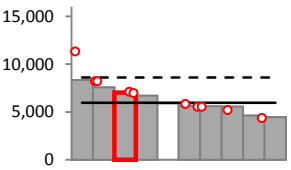
Cancer

Inner NE CC	3,724
Leeds	3,703
Deprived Leeds *	3,419



COPD

Inner NE CC	1,888
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Inner NE CC	7,033
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map *shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area.* ****Deprived Leeds:*** *areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.* *****Most deprived fifth (quintile) of Leeds*** *- Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas.* ***Ordnance Survey*** *PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved.* ***GP data*** *courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.* ***Admissions data*** *Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Inner North East Community Committee

The health and wellbeing of the Inner North East Community Committee contains some variation across the range of Leeds, overall in the midrange of Leeds. Around 25% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 10 MSOA** areas making up the Community Committee are generally average for Leeds. However, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 4.2 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy for the Community Committee is more or less the same as for Leeds overall.

The age structure bears a close resemblance to that of Leeds overall except for lower numbers of young adults. GP recorded ethnicity shows the Community Committee to have smaller proportions of "White background" than Leeds and higher proportions of some BME groups, especially "Pakistani or British Pakistani". However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is not significantly different to the Leeds average, none of the MSOAs have extremely high values. Cancer and circulatory disease mortality rates are widely spread over Leeds at MSOA level but the Community Committee rates are not significantly different to Leeds – except for cancer mortality overall which is. The *Chapeltown* MSOA male circulatory mortality is fifth highest in Leeds.

Alcohol specific admissions for this Community Committee are significantly below Leeds for men and overall. Almost all the MSOAs in the area have rates significantly below the Leeds rates. Smoking in the MSOAs is all below the Leeds average, except for *Chapeltown* and *Meanwood "6 Estates"* which are actually significantly above Leeds. GP recorded obesity shows the same situation, with *Chapeltown* and *Meanwood "6 Estates"* MSOAs again being above the Leeds average. All MSOAs have CHD rates around average or significantly below those of Leeds.

GP recorded cancer overall is not significantly different to the city, but the *Roundhay* MSOA has the 4th highest rate of recorded cancer in Leeds. Diabetes at MSOA level includes 5 areas above Leeds, the highest of which is *Chapeltown* in second place in the city.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ***Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* ****Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

Appendix 4: Area overview profile for Outer North East Community Committee

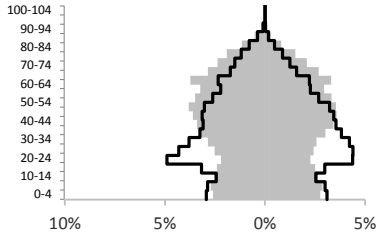
This profile presents a high level summary of data sets for the Outer North East Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 63,343 32,552 30,791

Females Males



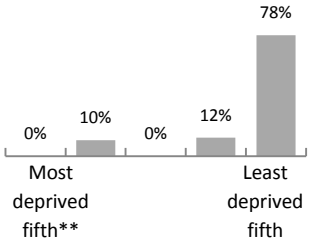
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	5,080	73%	67%
Indian	367	5%	2%
Pakistani	261	4%	6%
Any other white background	242	3%	4%
Any other Asian background	132	2%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



Pupil language, top 5	Area	% Area	% Leeds
English	6,047	90%	81%
Urdu	83	1%	3%
Panjabi	73	1%	1%
Arabic	49	1%	1%
Polish	43	1%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	% Area	% Leeds
White British	83%	71%
Other White Background	5%	10%
Indian or British Indian	4%	3%
Pakistani or British Pakistani	2%	3%
Other Ethnic Background	1%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*

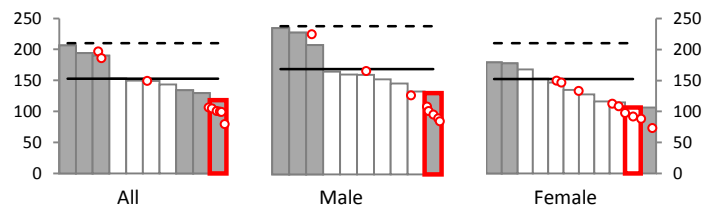
(years)	All	Males	Females
Outer North East CC	85.4	83.5	87.0
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

Slope index of inequality (see commentary) = 6.6

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)

(DSR per 100,000)	All	Males	Females
Outer North East CC	247	285	213
Highest MSOAs in area	472	556	397
Lowest MSOAs in area	176	178	164
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Outer North East CC	118	131	106
Highest MSOAs in area	196	253	149
Lowest MSOAs in area	79	85	72
Leeds resident	153	170	137
Deprived fifth	210	239	182

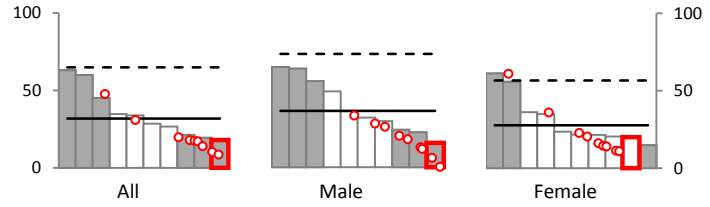
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations

(DSR per 100,000)	All	Males	Females
Outer North East CC	48	67	31
Highest MSOAs in area	91	144	42
Lowest MSOAs in area	30	34	14
Leeds resident	87	121	55
Deprived fifth**	145	192	97

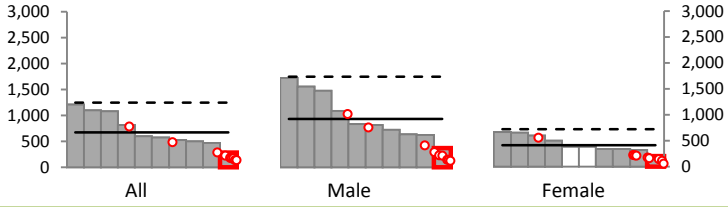
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Outer North East CC	18	16	20
Highest MSOAs in area	47	33	61
Lowest MSOAs in area	8	0	11
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

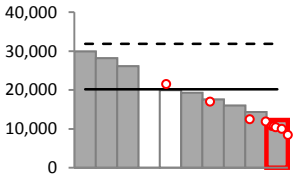
HES



(DSR per 100,000)	All	Males	Females
Outer North East AC	284	373	203
Highest MSOAs in area	783	1,022	551
Lowest MSOAs in area	131	120	49
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

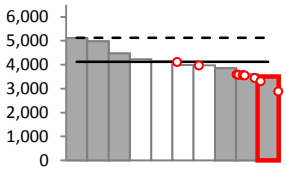
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



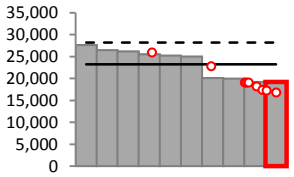
Smoking (16y+)

Outer NE CC	12,261
Leeds	20,165
Deprived Leeds *	31,829



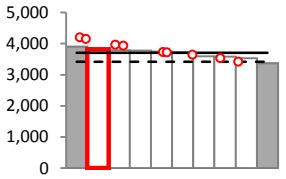
CHD

Outer NE CC	3,507
Leeds	4,126
Deprived Leeds *	5,122



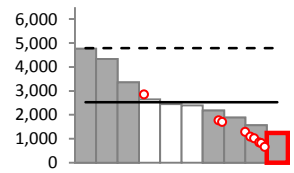
Obesity (16y+ and BMI>30)

Outer NE CC	19,180
Leeds	23,226
Deprived Leeds *	28,196



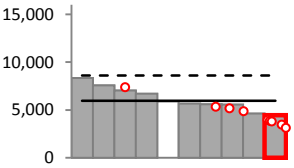
Cancer

Outer NE CC	3,821
Leeds	3,703
Deprived Leeds *	3,419



COPD

Outer NE CC	1,246
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Outer NE CC	4,441
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

*__Map__ shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. __*Deprived Leeds:__ areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. __**Most deprived fifth (quintile) of Leeds__ - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas. __Ordnance Survey__ PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. __GP data__ courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. __Admissions data__ Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Outer North East Community Committee

The health and wellbeing of the Outer North East Community Committee contains very wide variation across the full range of Leeds, overall looking very healthy within the city. None of the population live in the most deprived fifth of Leeds*. Life expectancy within the 9 MSOA** areas making up the Community Committee are mainly among the longest in Leeds but do include a reasonably wide variation, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 6.6 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and the highest in Leeds overall.

The age structure bears very little resemblance to that of Leeds overall with many fewer young adults and greater proportions of those aged over 40. GP recorded ethnicity shows the Community Committee to have larger proportions of "White background" than Leeds. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is well below the Leeds average for men and women, as well as overall for the Community Committee – the lowest rates in the city. Only two MSOAs are above Leeds the rate in every case - *Wetherby East, Thorp Arch and Moor Allerton*.

Cancer, circulatory, and respiratory disease mortality rates are widely spread but in the main are at the very low end, the Community Committee rates are therefore very low. The same two MSOAs feature as the highest two in the Community Committee in each case here.

Alcohol specific admissions are concentrated at the very low end except for the *Moor Allerton* MSOA which is higher than Leeds rates for males, females, and overall. GP recorded smoking, obesity, CHD, COPD and diabetes rates are the lowest of all Community Committees with the same *Moor Allerton* MSOA being the highest in each case.

GP recorded cancer for the Community Committee is almost the highest in Leeds reflecting the low numbers in more deprived areas who are thought to present with symptoms late.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ******Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* *******Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

Appendix 5: Area overview profile for Inner West Community Committee

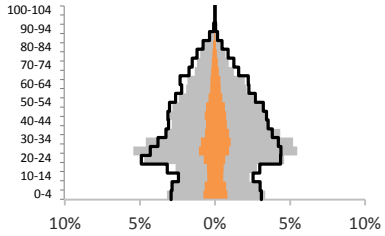
This profile presents a high level summary of data sets for the Inner West Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 75,838 36,996 38,842

Females Males



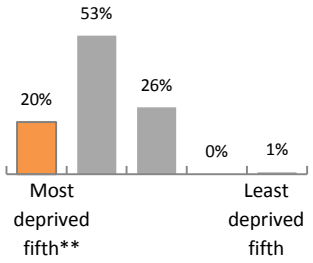
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	6,820	68%	67%
Any other white background	604	6%	4%
Pakistani	522	5%	6%
Black - African	424	4%	5%
Any other ethnic group	214	2%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



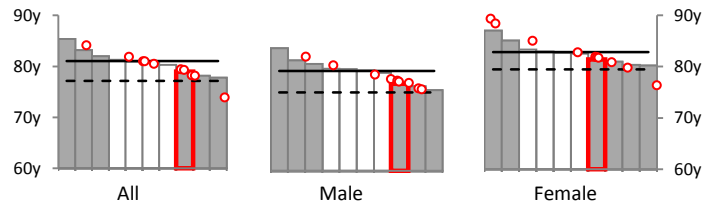
Pupil language, top 5	Area	% Area	% Leeds
English	7,833	80%	81%
Polish	265	3%	1%
Urdu	251	3%	3%
Other than English	220	2%	1%
Believed to be Other than English	161	2%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	% Area	% Leeds
White British	76%	71%
Other White Background	10%	10%
Black African	2%	3%
Pakistani or British Pakistani	2%	3%
Other Ethnic Background	2%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

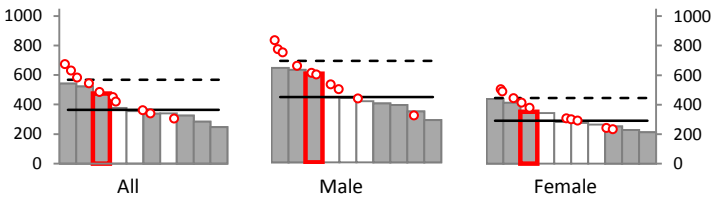
Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



(years)	All	Males	Females
Inner West CC	79.0	76.7	81.4
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

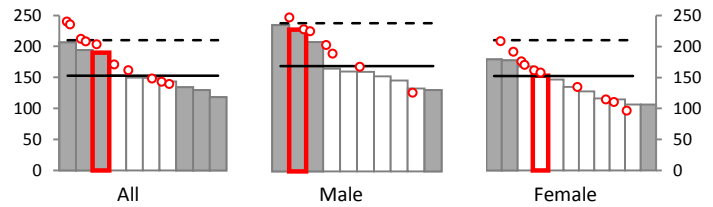
Slope index of inequality (see commentary) = 6.2

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner West CC	475	599	351
Highest MSOAs in area	671	825	503
Lowest MSOAs in area	302	314	232
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

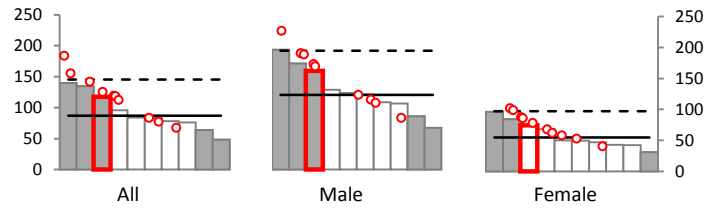


(DSR per 100,000)	All	Males	Females
Inner West CC	190	229	153
Highest MSOAs in area	240	292	208
Lowest MSOAs in area	139	127	96
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

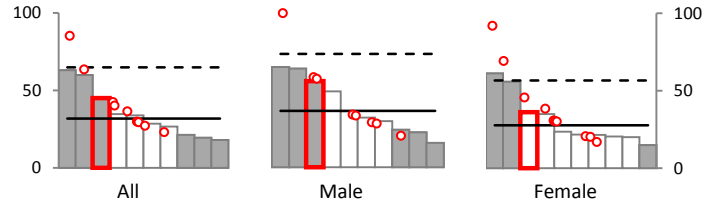
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Inner West CC	117	159	74
Highest MSOAs in area	184	261	101
Lowest MSOAs in area	67	83	40
Leeds resident	87	121	55
Deprived fifth**	145	192	97

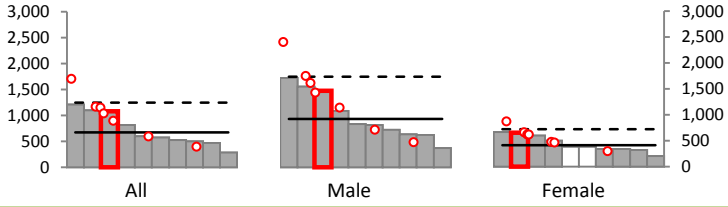
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Inner West CC	45	56	36
Highest MSOAs in area	105	119	92
Lowest MSOAs in area	23	20	17
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

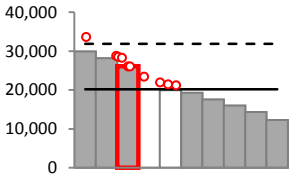
HES



(DSR per 100,000)	All	Males	Females
Inner West AC	1,080	1,480	655
Highest MSOAs in area	1,701	2,414	866
Lowest MSOAs in area	390	482	294
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

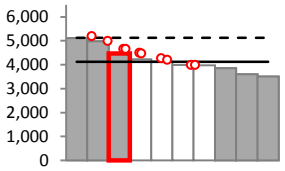
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



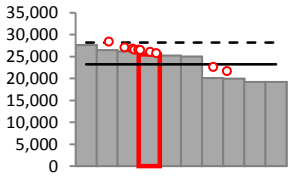
Smoking (16y+)

Inner W CC	26,129
Leeds	20,165
Deprived Leeds *	31,829



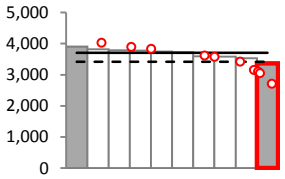
CHD

Inner W CC	4,470
Leeds	4,126
Deprived Leeds *	5,122



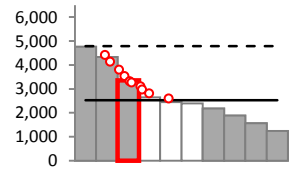
Obesity (16y+ and BMI>30)

Inner W CC	25,523
Leeds	23,226
Deprived Leeds *	28,196



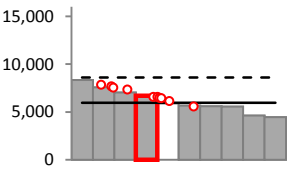
Cancer

Inner W CC	3,365
Leeds	3,703
Deprived Leeds *	3,419



COPD

Inner W CC	3,359
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Inner W CC	6,693
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map *shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area.* ****Deprived Leeds:*** *areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.* *****Most deprived fifth (quintile) of Leeds*** *- Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas.* ***Ordnance Survey*** *PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved.* ***GP data*** *courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.* ***Admissions data*** *Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Inner West Community Committee

The health and wellbeing of the Inner West Community Committee contains very wide variation across the full range of Leeds, and tends predominantly towards ill health. Around 20% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 10 MSOA** areas making up the Community Committee ranges vary widely from almost the shortest life expectancies in Leeds to almost the longest, however, comparing single MSOA level life expectancies is not always suitable***.

Instead, the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 6.2 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and it has significantly lower life expectancy than Leeds for men, women and overall.

The age structure bears a close resemblance to that of Leeds overall. GP recorded ethnicity shows the Community Committee to have slightly larger proportions of "White background" (76%) than Leeds (71%) and lower proportions of other groups. However around a sixth of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is significantly above the Leeds average for men and women, as well as overall for the Community Committee. The *Armley, New Wortley* MSOA in this area has the 3rd and 10th highest all-cause mortality rates for men and women respectively in the city, and the 4th highest rate overall.

Cancer mortality rates are widely spread and significantly higher than Leeds, for men, and overall. Circulatory disease mortality shows a similar widely spread MSOA pattern with the *Burley* area standing out as having the 4th highest male and overall rate in Leeds.

Alcohol specific admissions are significantly above Leeds rates for this Community Committee. The *Armley, New Wortley* area is 4th highest in Leeds overall, and 3rd highest in Leeds for men. Smoking in the MSOAs is all above or very close to the Leeds average, with an overall rate significantly higher than Leeds.

Obesity rates in this Community Committee and most of the MSOAs are significantly above Leeds. COPD and CHD show almost all areas to be significantly above Leeds, with *Armley, New Wortley* / *Bramley* as the highest in the Community Committee respectively. Diabetes rates are around Leeds average but cancer is the lowest Community Committee rate in Leeds – significantly below Leeds itself, three MSOAs are nearly the lowest in Leeds (*Armley, New Wortley* | *Bramley Hill Top, Raynville and Wyther Park* | *Upper Armley*), this is expected as deprived areas often have low GP recorded cancer due to non/late presentation.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ***Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* ****Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

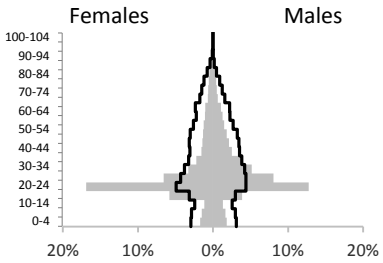
Appendix 6: Area overview profile for Inner North West Community Committee

This profile presents a high level summary of data sets for the Inner North West Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 82,907 41,024 41,883



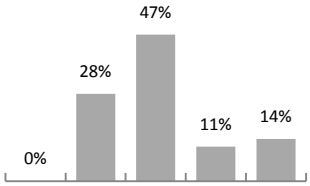
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	2,272	41%	67%
Pakistani	690	13%	6%
Black - African	492	9%	5%
Any other Asian background	425	8%	2%
Any other ethnic group	307	6%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



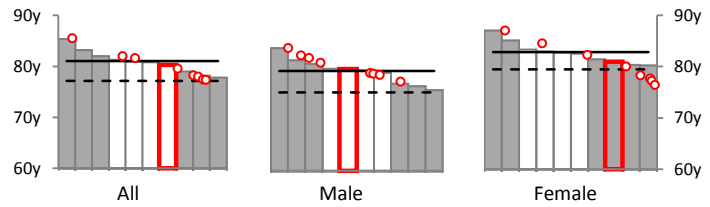
Pupil language, top 5	Area	% Area	% Leeds
English	3,310	62%	81%
Arabic	352	7%	1%
Urdu	314	6%	3%
Panjabi	216	4%	1%
Kurdish	138	3%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	% Area	% Leeds
White British	54%	71%
Other White Background	13%	10%
Other Asian Background	5%	2%
Chinese	5%	1%
Pakistani or British Pakistani	4%	3%

(October 2015, top 5 in Community committee, corresponding Leeds values)

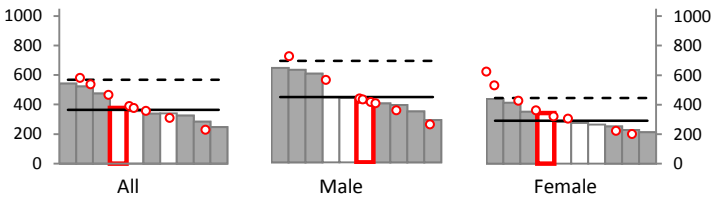
Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



(years)	All	Males	Females
Inner North West CC	80.3	79.5	80.9
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

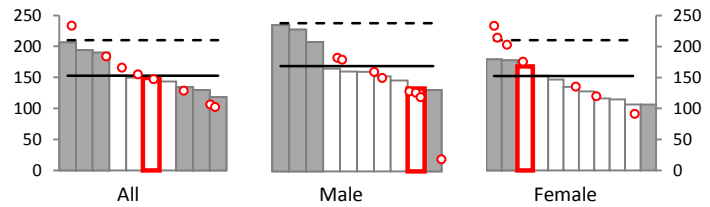
Slope index of inequality (see commentary) = 2.6

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner North West CC	378	413	342
Highest MSOAs in area	578	717	622
Lowest MSOAs in area	225	253	198
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

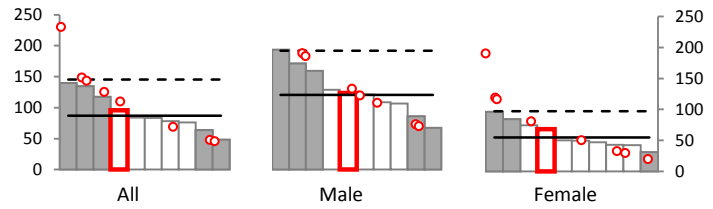


(DSR per 100,000)	All	Males	Females
Inner North West CC	149	134	168
Highest MSOAs in area	233	183	291
Lowest MSOAs in area	102	19	91
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

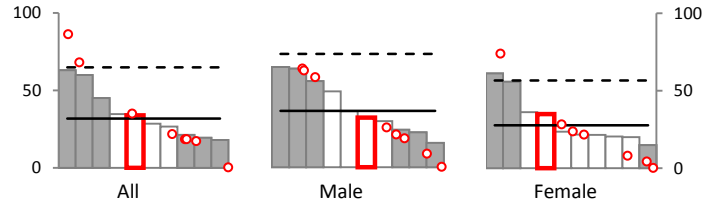
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Inner North West CC	96	124	68
Highest MSOAs in area	230	310	190
Lowest MSOAs in area	45	70	20
Leeds resident	87	121	55
Deprived fifth**	145	192	97

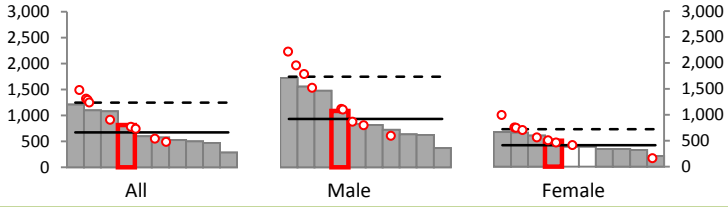
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Inner North West CC	34	32	35
Highest MSOAs in area	86	64	105
Lowest MSOAs in area	0	0	0
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

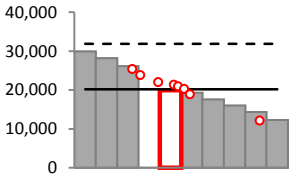
HES



(DSR per 100,000)	All	Males	Females
Inner North West AC	817	1,091	500
Highest MSOAs in area	1,487	2,225	992
Lowest MSOAs in area	488	603	157
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

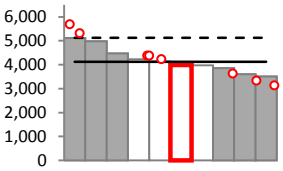
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



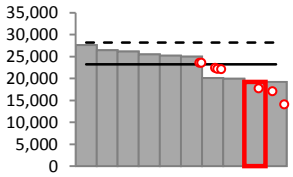
Smoking (16y+)

Inner NW CC	19,958
Leeds	20,165
Deprived Leeds *	31,829



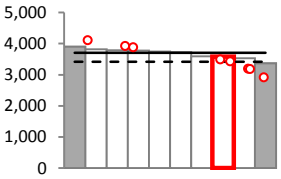
CHD

Inner NW CC	3,994
Leeds	4,126
Deprived Leeds *	5,122



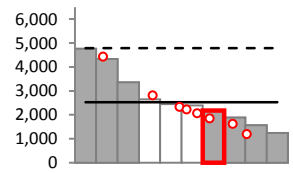
Obesity (16y+ and BMI>30)

Inner NW CC	19,227
Leeds	23,226
Deprived Leeds *	28,196



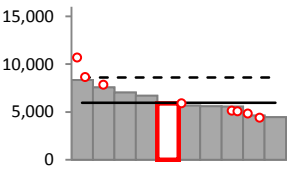
Cancer

Inner NW CC	3,579
Leeds	3,703
Deprived Leeds *	3,419



COPD

Inner NW CC	2,175
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Inner NW CC	5,902
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map *shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area.* ****Deprived Leeds:*** *areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.* *****Most deprived fifth (quintile) of Leeds*** *- Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas.* ***Ordnance Survey*** *PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved.* ***GP data*** *courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.* ***Admissions data*** *Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Inner North West Community Committee

The health and wellbeing of the Inner North West Community Committee contains very wide variation across the full range of Leeds, overall sitting somewhere in the middle of Leeds. Less than 1% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 8 MSOA** areas making up the Community Committee are widely spread, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 2.6 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and is very close to Leeds for men and overall, but with significantly lower life expectancy for women.

The age structure is very different to that of Leeds overall because of the student population. GP recorded ethnicity shows the Community Committee to have smaller proportions of "White background" than Leeds. However around a fifth of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a picture with smaller 'White British' proportions, and larger 'Pakistani', 'Black African' and 'other' groups than Leeds.

All-cause mortality for under 75s is not significantly different to the Community Committee. Cancer mortality rates are very widely spread at MSOA level but the Community Committee rates are mid-range. Circulatory disease mortality shows a wide MSOA pattern with *Little Woodhouse and Burley* and *Headingley Central* the highest in Leeds for men and women respectively. In terms of respiratory mortality, the Community Committee is not significantly different to Leeds, but the MSOAs are very widely spread.

Alcohol specific admissions are significantly above Leeds rates but overall still mid range for the city. Female admissions at MSOA level are almost all above Leeds rates.

GP recorded obesity in the MSOAs is mostly well below the Leeds average, with an overall rate significantly lower than Leeds. Smoking is recorded to be around the Leeds rate. COPD is significantly lower than Leeds but the MSOA *Little London, Sheepscar* stands out as much higher than other parts of the Community Committee. CHD is virtually the same as Leeds, but at MSOA level is extremely widely distributed - *HydePark, Burley*, and *West Park and Weetwood* are 3rd highest and 8th highest in Leeds overall.

Diabetes has some MSOA in higher ranks, including *Hyde Park, Burley* which is third highest in the city. Cancer recording in *West Park and Weetwood* is 12th highest in the city.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs. ****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ****Slope Index of Inequality: more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

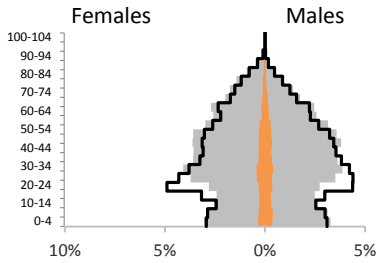
Appendix 7: Area overview profile for Outer West Community Committee

This profile presents a high level summary of data sets for the Outer West Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 64,368 32,693 31,675



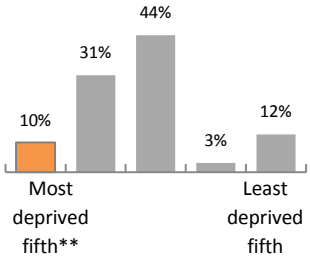
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	*% Area*	*% Leeds*
White - British	9,052	*80%*	*67%*
Pakistani	526	*5%*	*6%*
Indian	355	*3%*	*2%*
Any other white background	294	*3%*	*4%*
Any other mixed background	154	*1%*	*2%*

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



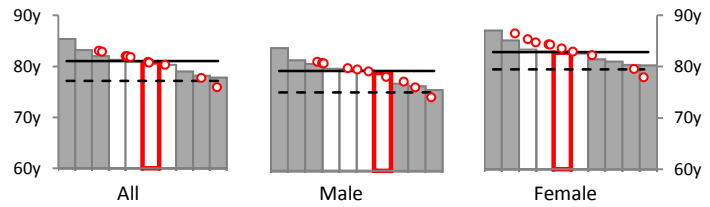
Pupil language, top 5	Area	*% Area*	*% Leeds*
English	9,958	*90%*	*81%*
Panjabi	197	*2%*	*1%*
Urdu	183	*2%*	*3%*
Other than English	144	*1%*	*1%*
Polish	115	*1%*	*1%*

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	*% Area*	*% Leeds*
White British	*89%*	*71%*
Other White Background	*5%*	*10%*
Indian or British Indian	*1%*	*3%*
Black African	*1%*	*3%*
Pakistani or British Pakistani	*1%*	*3%*

(October 2015, top 5 in Community committee, corresponding Leeds values)

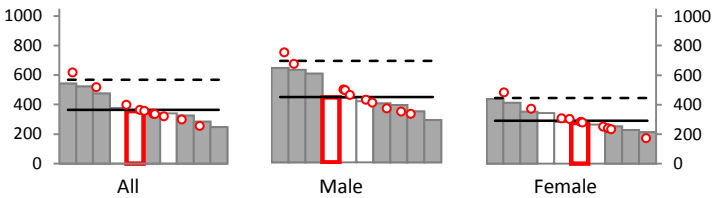
Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



(years)	All	Males	Females
Outer West CC	80.8	78.8	82.7
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

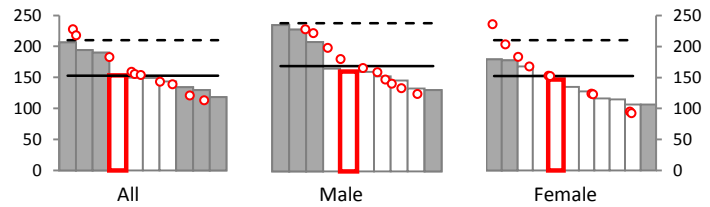
Slope index of inequality (see commentary) = 5.1

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer West CC	356	441	276
Highest MSOAs in area	616	741	481
Lowest MSOAs in area	252	327	171
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

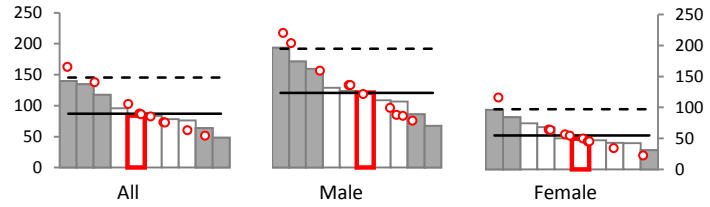


(DSR per 100,000)	All	Males	Females
Outer West CC	153	161	147
Highest MSOAs in area	228	229	236
Lowest MSOAs in area	113	125	92
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

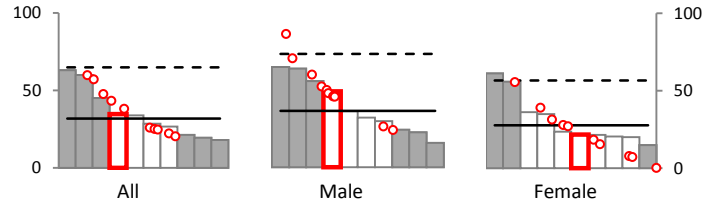
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Outer West CC	84	121	49
Highest MSOAs in area	162	217	116
Lowest MSOAs in area	51	75	22
Leeds resident	87	121	55
Deprived fifth**	145	192	97

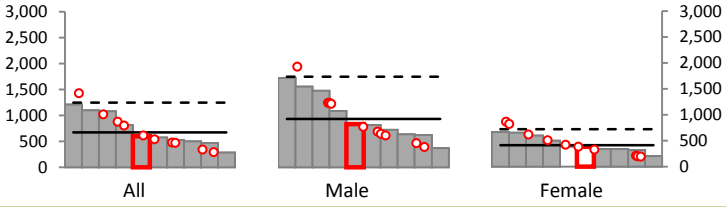
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Outer West CC	35	49	22
Highest MSOAs in area	60	86	55
Lowest MSOAs in area	20	24	0
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

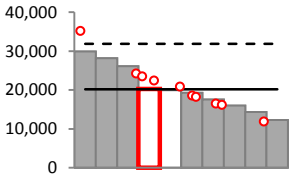
HES



(DSR per 100,000)	All	Males	Females
Outer West AC	602	836	381
Highest MSOAs in area	1,425	1,939	859
Lowest MSOAs in area	289	390	189
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

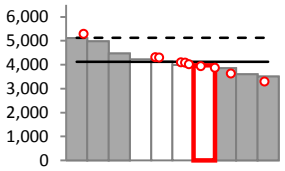
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



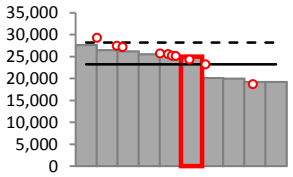
Smoking (16y+)

Outer W CC	20,234
Leeds	20,165
Deprived Leeds *	31,829



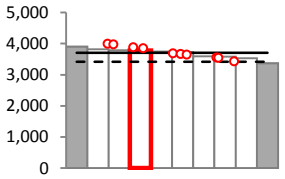
CHD

Outer W CC	3,979
Leeds	4,126
Deprived Leeds *	5,122



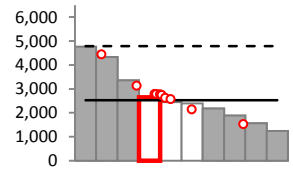
Obesity (16y+ and BMI>30)

Outer W CC	24,995
Leeds	23,226
Deprived Leeds *	28,196



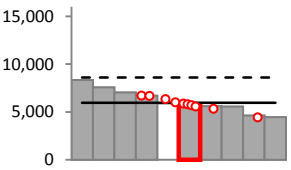
Cancer

Outer W CC	3,775
Leeds	3,703
Deprived Leeds *	3,419



COPD

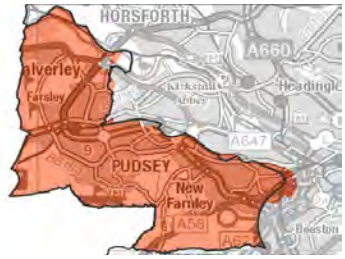
Outer W CC	2,644
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Outer W CC	5,671
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.



Map *shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area.* ****Deprived Leeds:*** *areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.* *****Most deprived fifth (quintile) of Leeds*** *- Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas.* ***Ordnance Survey*** *PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved.* ***GP data*** *courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.* ***Admissions data*** *Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Outer West Community Committee

The health and wellbeing of the Outer West Community Committee contains wide variation across the full range of Leeds, overall looking average for the city. Around 10% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 10 MSOA** areas making up the Community Committee are distributed across Leeds and include quite a wide variation, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 5.1 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and is very close to Leeds overall.

The age structure bears some resemblance to that of Leeds overall with fewer 15 to 30 year olds. GP recorded ethnicity shows the Community Committee to have slightly larger proportions of "White background" than Leeds. 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey which has a higher rate of recording shows a similar picture with a larger than Leeds proportion of 'White British'.

All-cause mortality for under 75s is very close to the Leeds average for men and women, as well as overall for the Community Committee.

Cancer mortality rates are in the mid range for the city, *Farnley* stands out as being highest above the Leeds rates. Circulatory disease mortality has an MSOA *Farnley,* which is higher than the deprived rate overall. Similarly, respiratory disease mortality rates at the Farnley MSOA are higher than deprived Leeds. Alcohol specific admissions are distributed widely, some below and some above Leeds rates, of note again is the *Farnley* MSOA which is very high within Leeds for men, women and overall.

GP recorded obesity is significantly above Leeds but mid range among other Community Committees. Diabetes is significantly below, but very close to Leeds. COPD, CHD, cancer and smoking rates are not really different to Leeds rates.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ***Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* ****Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

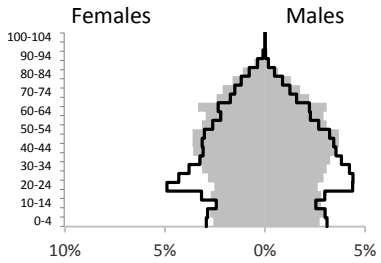
Appendix 8: Area overview profile for Outer North West Community Committee

This profile presents a high level summary of data sets for the Outer North West Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 90,773 45,940 44,833



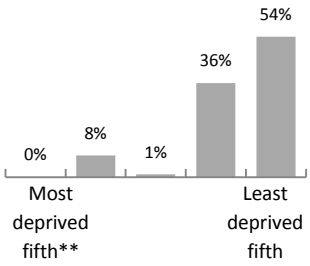
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	*% Area*	*% Leeds*
White - British	10,680	*87%*	*67%*
Any other white background	338	*3%*	*4%*
Any other mixed background	167	*1%*	*2%*
Indian	156	*1%*	*2%*
White and Asian	143	*1%*	*1%*

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



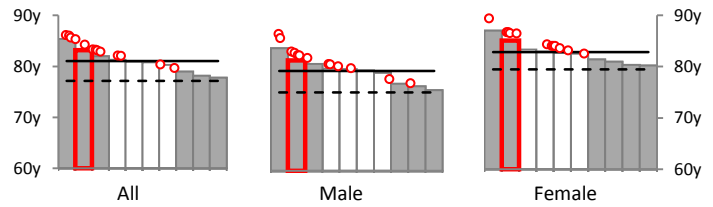
Pupil language, top 5	Area	*% Area*	*% Leeds*
English	11,543	*95%*	*81%*
Arabic	117	*1%*	*1%*
Polish	40	*0%*	*1%*
Farsi Persian (Any Other)	32	*0%*	*0%*
Urdu	29	*0%*	*3%*

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	*% Area*	*% Leeds*
White British	*90%*	*71%*
Other White Background	*5%*	*10%*
Indian or British Indian	*1%*	*3%*
Other Ethnic Background	*1%*	*2%*
Other Asian Background	*1%*	*2%*

(October 2015, top 5 in Community committee, corresponding Leeds values)

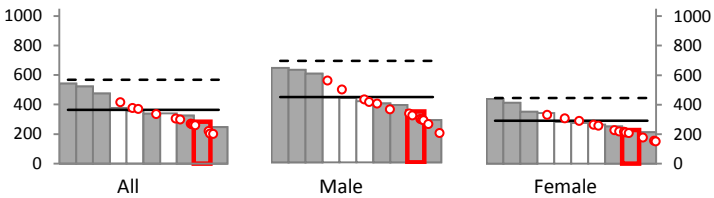
Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



(years)	All	Males	Females
Outer North West CC	83.2	81.2	85.1
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

Slope index of inequality (see commentary) = 3.7

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer North West CC	283	344	227
Highest MSOAs in area	414	550	328
Lowest MSOAs in area	199	195	148
Leeds resident	365	441	291
Deprived fifth**	567	687	444

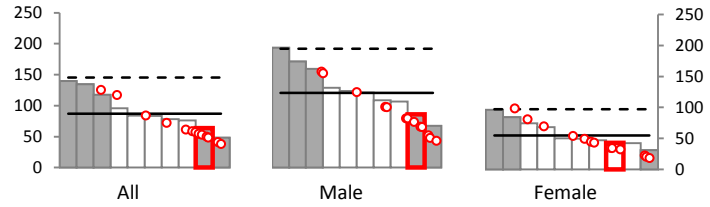
Cancer mortality - under 75s, 2010-14 ranked

(DSR per 100,000)	All	Males	Females
Outer North West CC	134	154	116
Highest MSOAs in area	170	233	157
Lowest MSOAs in area	100	113	83
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

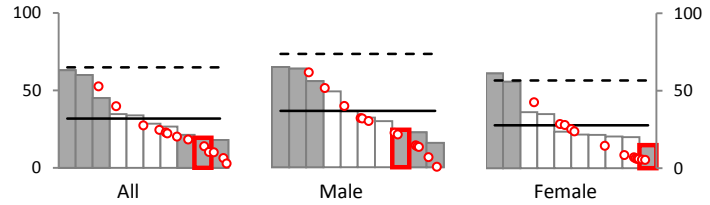
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Outer North West CC	64	86	43
Highest MSOAs in area	125	154	98
Lowest MSOAs in area	38	43	18
Leeds resident	87	121	55
Deprived fifth**	145	192	97

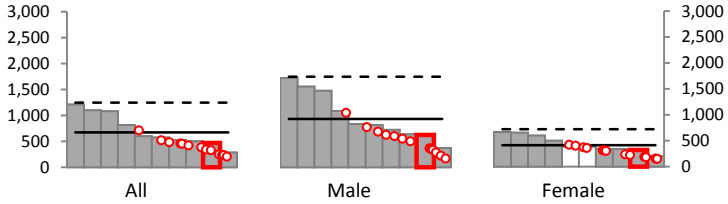
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Outer North West CC	19	24	15
Highest MSOAs in area	52	61	42
Lowest MSOAs in area	3	0	5
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

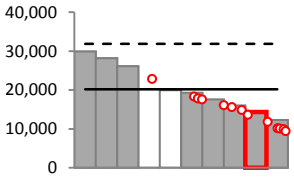
HES



(DSR per 100,000)	All	Males	Females
Outer North West AC	470	626	321
Highest MSOAs in area	708	1,047	416
Lowest MSOAs in area	201	166	147
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

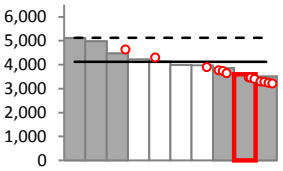
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



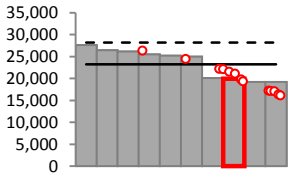
Smoking (16y+)

Outer NW CC	14,342
Leeds	20,165
Deprived Leeds *	31,829



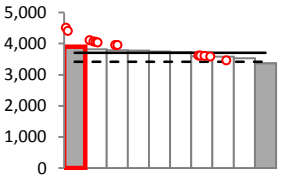
CHD

Outer NW CC	3,594
Leeds	4,126
Deprived Leeds *	5,122



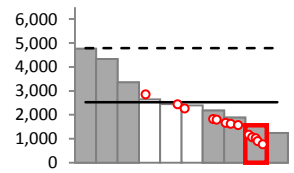
Obesity (16y+ and BMI>30)

Outer NW CC	19,939
Leeds	23,226
Deprived Leeds *	28,196



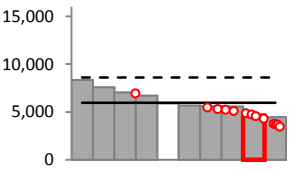
Cancer

Outer NW CC	3,896
Leeds	3,703
Deprived Leeds *	3,419



COPD

Outer NW CC	1,563
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Outer NW CC	4,626
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map *shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area.* ****Deprived Leeds:*** *areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.* *****Most deprived fifth (quintile) of Leeds*** *- Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas.* ***Ordnance Survey*** *PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved.* ***GP data*** *courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.* ***Admissions data*** *Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Outer North West Community Committee

The health and wellbeing of the Outer North West Community Committee contains wide variation across the full range of Leeds, including extremes, overall in the very healthy range for the city. None of the population live in the most deprived fifth of Leeds*. Life expectancy within the 13 MSOA** areas making up the Community Committee are mainly among the longest in Leeds but do include a reasonably wide variation, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 3.7 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and is significantly higher than Leeds overall.

The age structure bears little resemblance to that of Leeds overall with fewer young adults and greater proportions of those aged over 40. GP recorded ethnicity shows the Community Committee to have larger proportions of "White background" than Leeds. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is well below the Leeds average for men and women, as well as overall for the Community Committee. Cancer mortality rates are spread across the mid and low end of Leeds and the Community Committee rates are very low – significantly lower than Leeds for persons. Circulatory disease mortality is mostly gathered around the mid and low end in Leeds – the Community Committee is significantly below Leeds overall, and for men. Respiratory disease mortality rates are slightly more widely spread and very low.

Alcohol specific admissions are concentrated at the low end and mostly significantly lower than Leeds rates. Admissions at Community Committee level are among the very lowest in Leeds. Smoking, obesity, diabetes, CHD and COPD are very low except for the *Yeadon - Henshaws, Southway, Westfields* MSOA which is consistently the highest in the Community Committee.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ***Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* ****Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

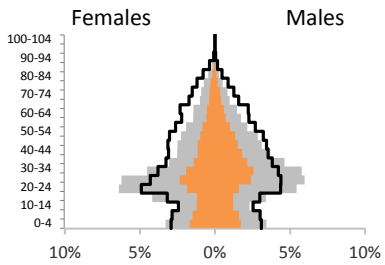
Appendix 9: Area overview profile for Inner South Community Committee

This profile presents a high level summary of data sets for the Inner South Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 95,747 46,370 49,377



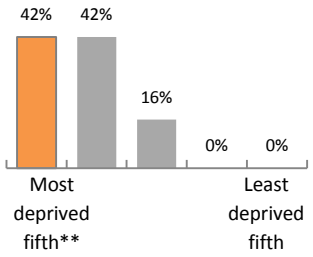
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	*% Area*	*% Leeds*
White - British	7,067	*55%*	*67%*
Black - African	1,369	*11%*	*5%*
Pakistani	1,162	*9%*	*6%*
Any other white background	903	*7%*	*4%*
Bangladeshi	463	*4%*	*1%*

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



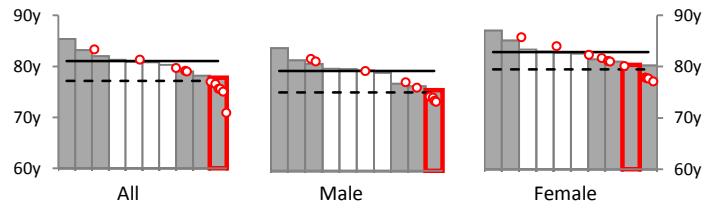
Pupil language, top 5	Area	*% Area*	*% Leeds*
English	8,763	*68%*	*81%*
Believed to be Other than English	468	*4%*	*1%*
Urdu	463	*4%*	*3%*
Other than English	424	*3%*	*1%*
Polish	401	*3%*	*1%*

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	*% Area*	*% Leeds*
White British	*59%*	*71%*
Other White Background	*15%*	*10%*
Black African	*6%*	*3%*
Pakistani or British Pakistani	*4%*	*3%*
Indian or British Indian	*3%*	*3%*

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



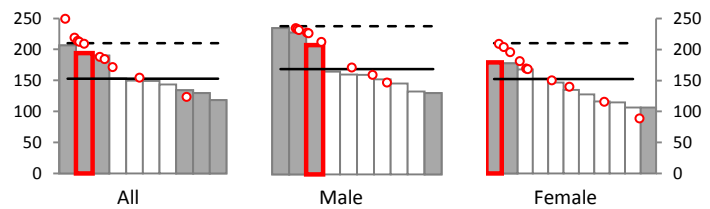
(years)	All	Males	Females
Inner South CC	77.8	75.5	80.3
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

Slope index of inequality (see commentary) = 4.3

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)

(DSR per 100,000)	All	Males	Females
Inner South CC	522	626	412
Highest MSOAs in area	914	1,118	555
Lowest MSOAs in area	378	452	308
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

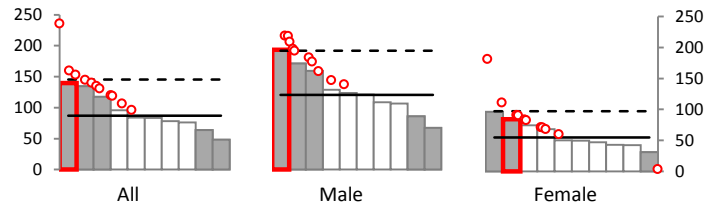


(DSR per 100,000)	All	Males	Females
Inner South CC	194	209	179
Highest MSOAs in area	299	340	267
Lowest MSOAs in area	123	148	88
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

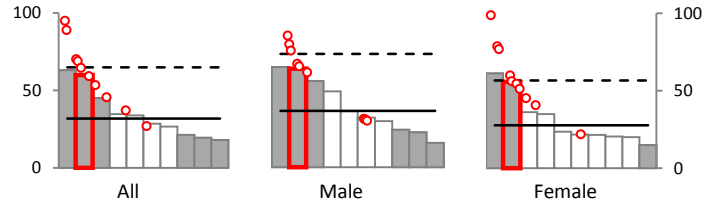
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Inner South CC	140	194	84
Highest MSOAs in area	236	270	181
Lowest MSOAs in area	96	137	3
Leeds resident	87	121	55
Deprived fifth**	145	192	97

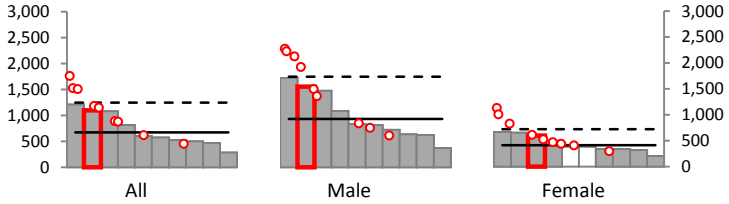
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Inner South CC	60	64	56
Highest MSOAs in area	277	310	163
Lowest MSOAs in area	27	30	22
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

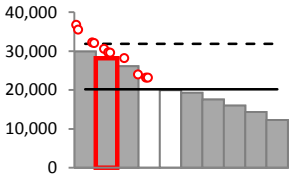
HES



(DSR per 100,000)	All	Males	Females
Inner South AC	1,101	1,561	599
Highest MSOAs in area	1,757	2,280	1,128
Lowest MSOAs in area	450	610	291
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

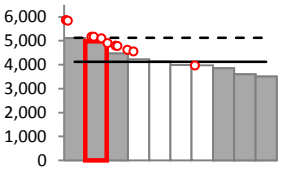
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



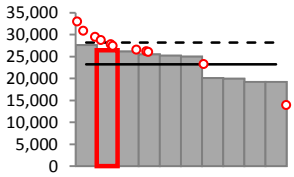
Smoking (16y+)

Inner S CC	28,170
Leeds	20,165
Deprived Leeds *	31,829



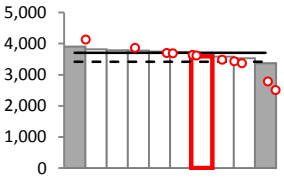
CHD

Inner S CC	4,976
Leeds	4,126
Deprived Leeds *	5,122



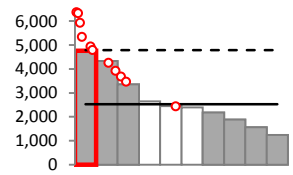
Obesity (16y+ and BMI>30)

Inner S CC	26,402
Leeds	23,226
Deprived Leeds *	28,196



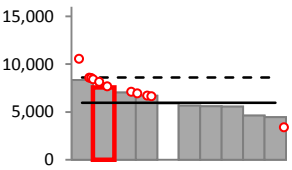
Cancer

Inner S CC	3,594
Leeds	3,703
Deprived Leeds *	3,419



COPD

Inner S CC	4,754
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Inner S CC	7,582
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map *shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area.* ****Deprived Leeds:*** *areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.* *****Most deprived fifth (quintile) of Leeds*** *- Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas.* ***Ordnance Survey*** *PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved.* ***GP data*** *courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.* ***Admissions data*** *Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Inner South Community Committee

The health and wellbeing of the Inner South Community Committee contains some variation across the range of Leeds, but tends overall towards ill health. Around 4 in 10 people live in the most deprived fifth of Leeds*. Life expectancy within the 11 MSOA** areas making up the Community Committee are generally among the shortest in Leeds and significantly lower than Leeds. However, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 4.3 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Overall life expectancy is the shortest of all Community Committees.

The age structure bears a little resemblance to that of Leeds overall with larger proportions of young adults and fewer aged above 40. GP recorded ethnicity shows the Community Committee to have lower proportions of "White background" to Leeds and higher proportions of some BME groups. However around a fith of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for the Community Committee is significantly above the Leeds average for all, and nearly the very highest in the city. The *city centre* MSOA in this area has the highest rate in the city.

Cancer mortality rates are widely spread at MSOA level and the Community Committee rates are significantly higher than Leeds (female cancer mortality is the highest in the city). Circulatory disease mortality shows an MSOA pattern high above the Leeds averages, with the *Beeston Hill M*SOA standing out as highest in Leeds overall. Respiratory disease mortality rates are very similar and at MSOA level the highest in the city.

Alcohol specific admissions for this Community Committee are very nearly the highest in Leeds, and many of the MSOAs in the area have rates significantly above those of Leeds. Smoking, Obesity, CHD and Diabetes in the MSOAs are almost all significantly above the Leeds average, with the Community Committee rates the 2nd highest in Leeds.

The Community Committee is highest in the city for GP recorded COPD with all but one MSOA being above Leeds. GP recorded cancer is not significantly lower than the city, this is expected as deprived areas often have low GP recorded cancer due to non/late presentation.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ***Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* ****Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

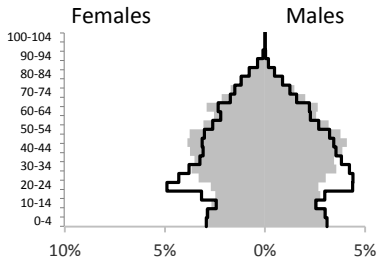
Appendix 10: Area overview profile for Outer South Community Committee

This profile presents a high level summary of data sets for the Outer South Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 89,594 45,367 44,227



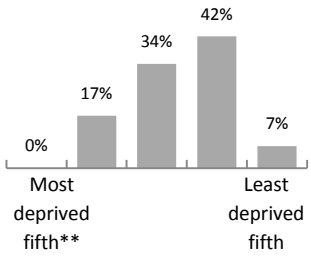
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	12,223	89%	67%
Any other white background	274	2%	4%
White and Black Caribbean	176	1%	2%
Any other mixed background	166	1%	2%
Indian	155	1%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



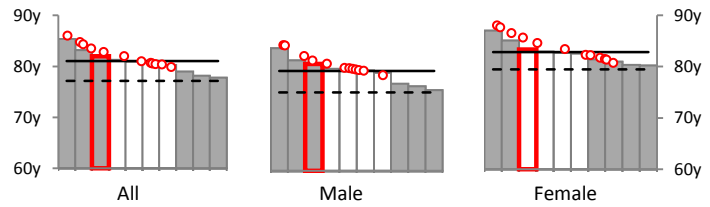
Pupil language, top 5	Area	% Area	% Leeds
English	12,959	96%	81%
Polish	93	1%	1%
Believed to be English	62	0%	0%
Other than English	52	0%	1%
Panjabi	37	0%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	% Area	% Leeds
White British	78%	71%
Other White Background	17%	10%
Indian or British Indian	1%	3%
Chinese	0%	1%
Other Ethnic Background	0%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

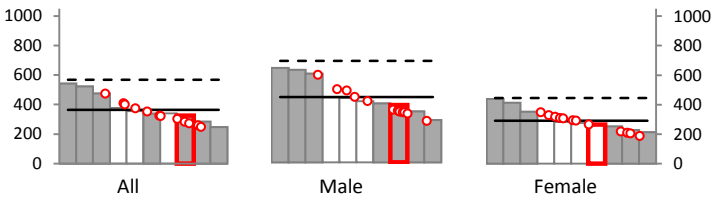
Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



(years)	All	Males	Females
Outer South CC	82.0	80.5	83.3
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

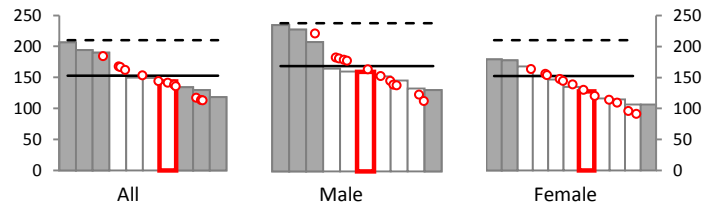
Slope index of inequality (see commentary) = 4.3

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer South CC	325	387	266
Highest MSOAs in area	472	590	347
Lowest MSOAs in area	246	278	185
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

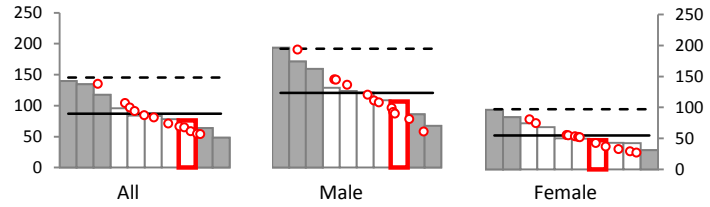


(DSR per 100,000)	All	Males	Females
Outer South CC	144	161	128
Highest MSOAs in area	184	223	163
Lowest MSOAs in area	113	113	90
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

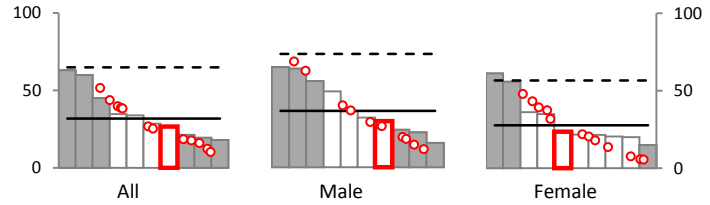
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Outer South CC	76	107	47
Highest MSOAs in area	135	190	80
Lowest MSOAs in area	53	58	27
Leeds resident	87	121	55
Deprived fifth**	145	192	97

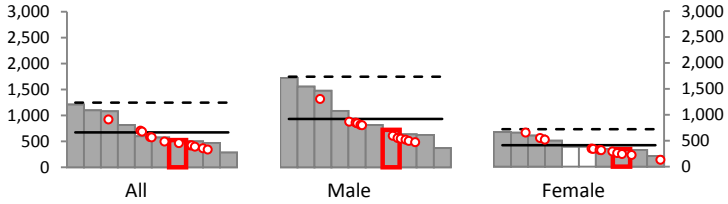
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Outer South CC	27	30	24
Highest MSOAs in area	51	68	48
Lowest MSOAs in area	10	11	5
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

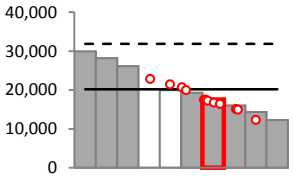
HES



(DSR per 100,000)	All	Males	Females
Outer South AC	524	723	338
Highest MSOAs in area	917	1,313	652
Lowest MSOAs in area	336	480	129
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

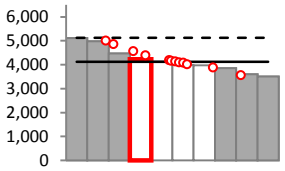
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



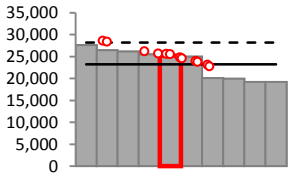
Smoking (16y+)

Outer S CC	17,529
Leeds	20,165
Deprived Leeds *	31,829



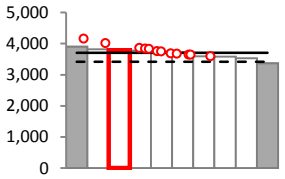
CHD

Outer S CC	4,234
Leeds	4,126
Deprived Leeds *	5,122



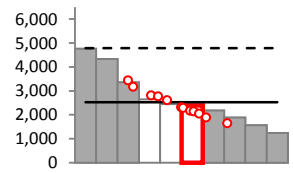
Obesity (16y+ and BMI>30)

Outer S CC	25,179
Leeds	23,226
Deprived Leeds *	28,196



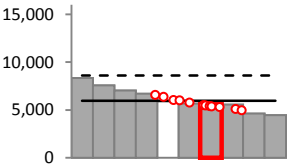
Cancer

Outer S CC	3,786
Leeds	3,703
Deprived Leeds *	3,419



COPD

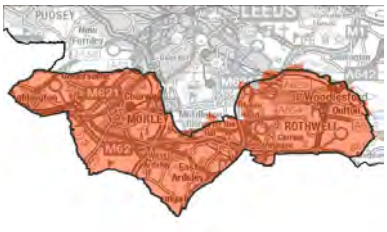
Outer S CC	2,397
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Outer S CC	5,579
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.



Map *shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area.* ****Deprived Leeds:*** *areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.* *****Most deprived fifth (quintile) of Leeds*** *- Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas.* ***Ordnance Survey*** *PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved.* ***GP data*** *courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.* ***Admissions data*** *Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Outer South Community Committee

The health and wellbeing of the Outer South Community Committee contains relatively wide variation across the range of Leeds, excluding the extremes, and is overall within the mid range for the city. None of the population live in the most deprived fifth of Leeds*. Life expectancy within the 12 MSOA** areas making up the Community Committee are mainly among the longest in Leeds but do include a wide variation, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 4.3 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and was significantly higher than Leeds overall and for men.

The age structure bears little resemblance to that of Leeds overall with fewer young adults and greater proportions of those aged between 40 and 74. GP recorded ethnicity shows the Community Committee to have larger proportions of "White background" than Leeds. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a clearer but similar picture.

All-cause mortality for under 75s for the Community Committee is significantly below the Leeds average for men and overall. The MSOA *Morley West* is significantly higher than Leeds overall and for men.

Cancer mortality rates are widely spread at MSOA level, the Community Committee rates are average. Circulatory disease mortality is mostly gathered around the mid range in Leeds. Respiratory disease mortality rates are slightly more widely spread but Committee level rates are very low.

Alcohol specific admissions are mostly concentrated around the mid range and almost all are significantly below Leeds rates. Much of the GP audit data for this Community Committee is mid range for the city. GP recorded smoking, and diabetes are significantly lower than Leeds, whereas obesity is significantly higher than Leeds.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* *****Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

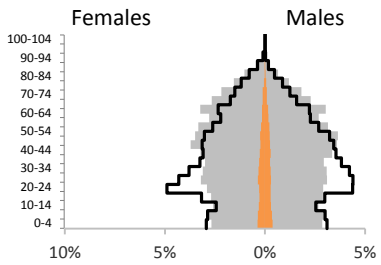
Appendix 11: Area overview profile for Outer East Community Committee

This profile presents a high level summary of data sets for the Outer East Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Population: 83,454 42,488 40,966



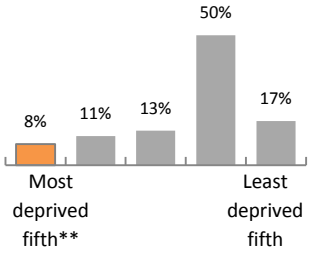
Comparison of Community Committee and Leeds age structures in October 2015. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

Pupil ethnicity, top 5	Area	*% Area*	*% Leeds*
White - British	11,896	*86%*	*67%*
Black - African	345	*3%*	*5%*
Any other white background	278	*2%*	*4%*
Unknown	187	*1%*	*1%*
White and Black Caribbean	173	*1%*	*2%*

(January 2016, top 5 in Community committee, corresponding Leeds value)

Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



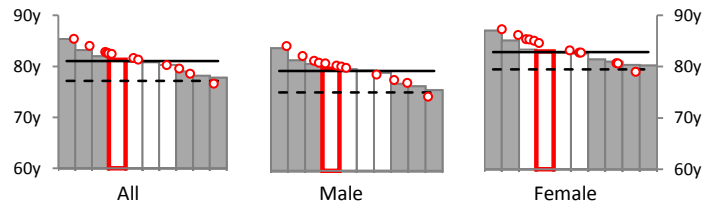
Pupil language, top 5	Area	*% Area*	*% Leeds*
English	12,688	*95%*	*81%*
Polish	109	*1%*	*1%*
Other than English	92	*1%*	*1%*
French	40	*0%*	*1%*
Believed to be English	37	*0%*	*0%*

(January 2016, top 5 in Community committee, corresponding Leeds value)

GP recorded ethnicity, top 5	*% Area*	*% Leeds*
White British	*91%*	*71%*
Other White Background	*4%*	*10%*
Black African	*1%*	*3%*
Indian or British Indian	*1%*	*3%*
White Irish	*0%*	*1%*

(October 2015, top 5 in Community committee, corresponding Leeds values)

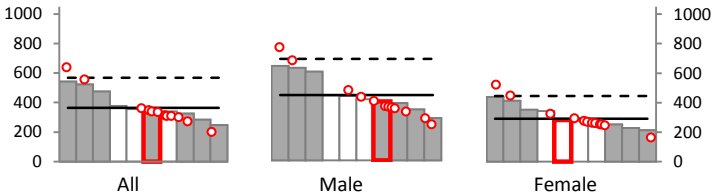
Life expectancy at birth, 2012-14 ranked Community Committees *ONS and GP registered populations*



(years)	All	Males	Females
Outer East CC	81.3	79.6	83.0
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

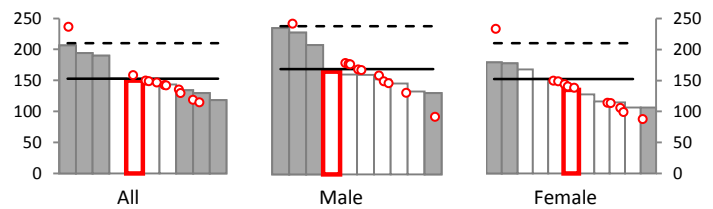
Slope index of inequality (see commentary) = 3.8

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer East CC	338	399	282
Highest MSOAs in area	636	765	520
Lowest MSOAs in area	199	240	162
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

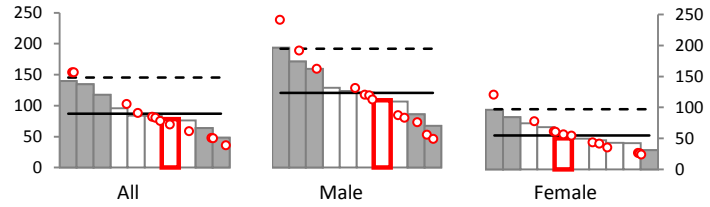


(DSR per 100,000)	All	Males	Females
Outer East CC	150	166	135
Highest MSOAs in area	266	260	276
Lowest MSOAs in area	114	93	87
Leeds resident	153	170	137
Deprived fifth	210	239	182

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

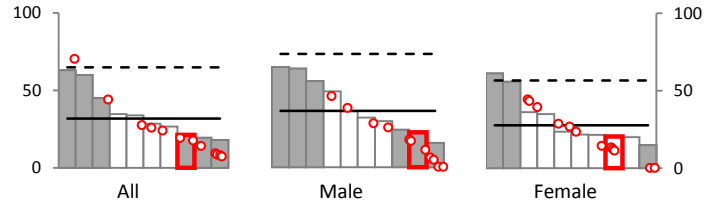
Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



(DSR per 100,000)	All	Males	Females
Outer East CC	78	109	50
Highest MSOAs in area	153	238	120
Lowest MSOAs in area	35	46	23
Leeds resident	87	121	55
Deprived fifth**	145	192	97

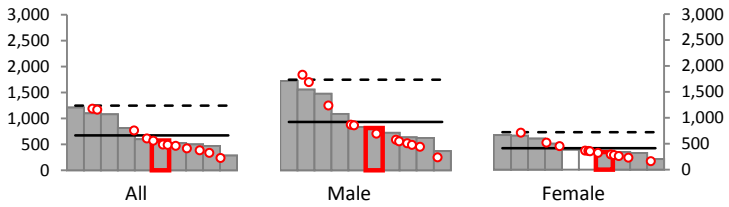
Respiratory disease mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Outer East CC	21	22	20
Highest MSOAs in area	70	105	44
Lowest MSOAs in area	7	0	0
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

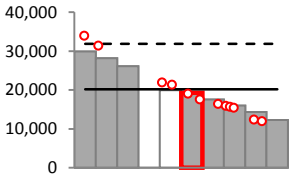
HES



(DSR per 100,000)	All	Males	Females
Outer East AC	574	818	340
Highest MSOAs in area	1,182	1,837	705
Lowest MSOAs in area	235	248	157
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

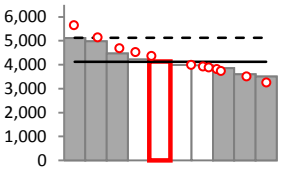
GP recorded conditions, persons, October 2015 (DSR per 100,000)

GP data



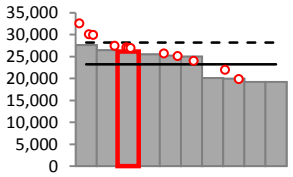
Smoking (16y+)

Outer E CC	19,277
Leeds	20,165
Deprived Leeds *	31,829



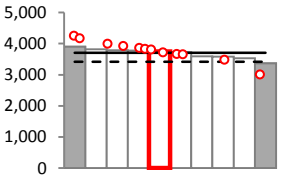
CHD

Outer E CC	4,129
Leeds	4,126
Deprived Leeds *	5,122



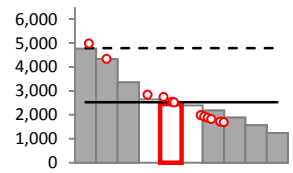
Obesity (16y+ and BMI>30)

Outer E CC	26,110
Leeds	23,226
Deprived Leeds *	28,196



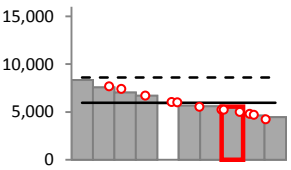
Cancer

Outer E CC	3,752
Leeds	3,703
Deprived Leeds *	3,419



COPD

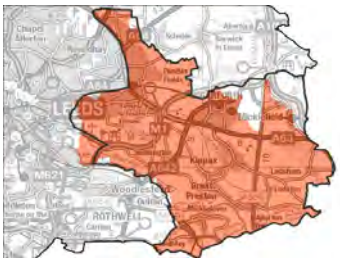
Outer E CC	2,450
Leeds	2,532
Deprived Leeds *	4,792



Diabetes

Outer E CC	5,570
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.



*__Map__ shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. __*Deprived Leeds:__ areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. __**Most deprived fifth (quintile) of Leeds__ - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas. __Ordnance Survey__ PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. __GP data__ courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. __Admissions data__ Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.*

Outer East Community Committee

The health and wellbeing of the Outer East Community Committee contains very wide variation across the full range of Leeds, overall in the mid range for the city. Only 8% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 12 MSOA** areas making up the Community Committee ranges vary widely including almost the shortest male life expectancy in Leeds, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 3.8 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and is not significantly different to Leeds overall.

The age structure bears little resemblance to that of Leeds overall with fewer young adults and greater proportions of those aged over 40. GP recorded ethnicity shows the Community Committee to have larger proportions of "White background" than Leeds. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is around the Leeds average for men and women, as well as overall for the Community Committee. The *Swarcliffe* MSOA in this area has highest rates in the Community Committee for men, women, and overall.

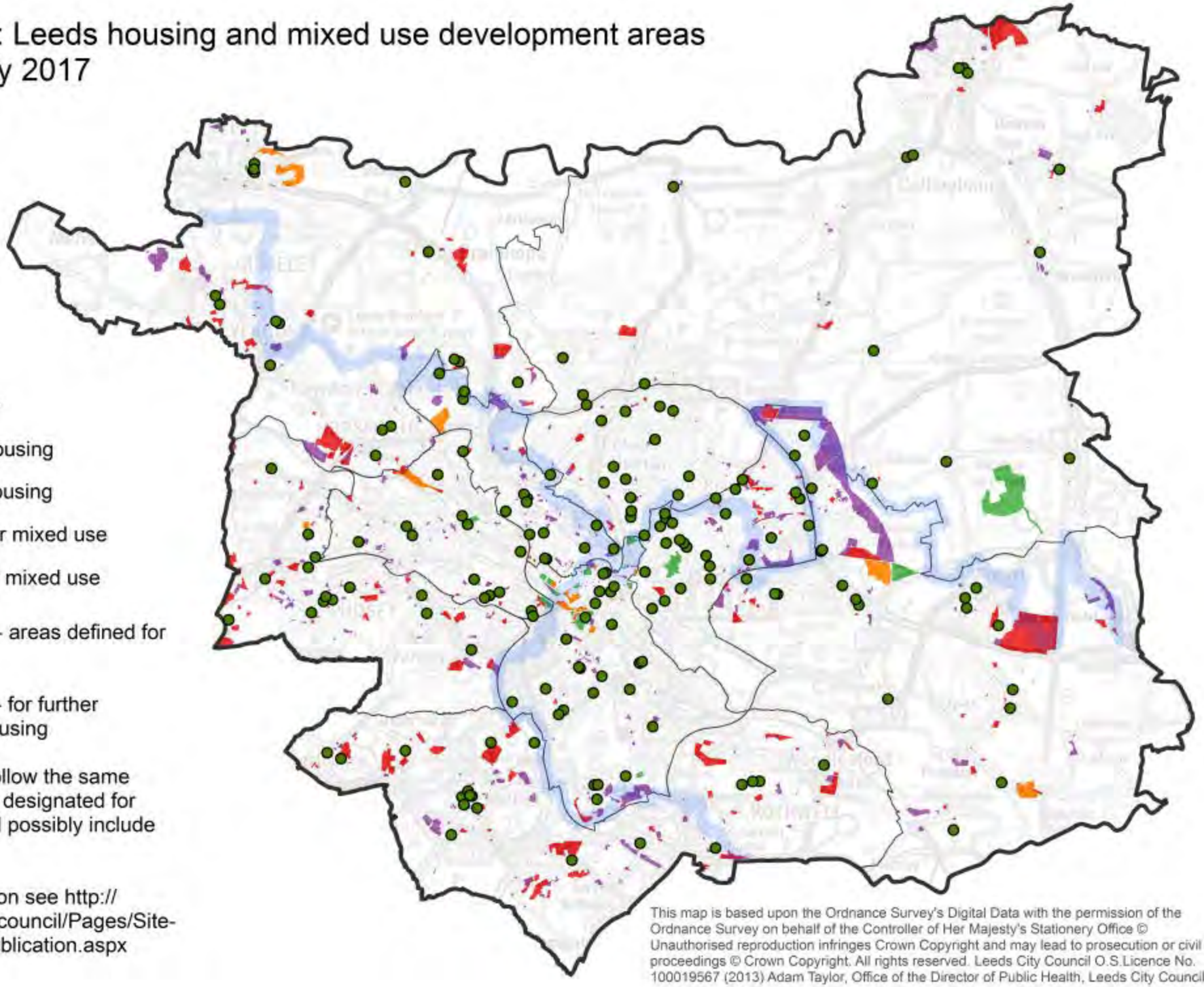
Cancer mortality rates are widely spread and the Community Committee rates are not significantly different to Leeds. One MSOA, *Swarcliffe* has the 3rd highest overall rate and 2nd highest female rates in the city. Circulatory disease mortality shows a similar widely spread MSOA pattern with the *Swarcliffe* area again standing out as having a very high rate. The *Halton moor, Wykebecks* MSOA has a male respiratory disease mortality rate that is 6th highest in the city (not charted as off the scale) but overall the Community Committee has low rates.

Alcohol specific admissions are significantly below Leeds rates for this Community Committee, and MSOA rates are well distributed around the Leeds rates but including some extremes such as *Halton Moor, Wykebecks*. Smoking rates in four of the twelve MSOAs are above Leeds, the *Halton Moor, Wykebecks* MSOA is actually fifth highest in Leeds, but overall the Community Committee rate is just significantly below Leeds.

Obesity rates in this Community Committee and almost all the MSOAs are significantly above Leeds, including *Swarcliffe* MOSA with the second highest obesity rate in the city. COPD and CHD are both around the Leeds value but again the *Halton Moor, Wykebecks* MSOA is the highest with rates near the largest in Leeds. GP recorded cancer is no different to Leeds overall, there are some high MSOAs with *Allerton Bywater, Methley and Mickletown* having the 5th highest rate in the city.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.*
***MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail. MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds.* ***Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality.* ****Slope Index of Inequality:** more details here http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.*

Appendix 12: Leeds housing and mixed use development areas as of mid July 2017



Allocated housing - areas defined for housing

Identified housing - for further investigation as housing

Mixed use areas follow the same convention but are designated for many uses and will possibly include housing.

For more information see http://www.leeds.gov.uk/council/Pages/Site-allocations-plan-publication.aspx

Appendix 13: Overview report
PNA 2017 Pharmacy Survey

Responses Received		
Online	*Paper - DE*	*Total*
60	94	154

		Total	%
Q1	**Please provide your ODS Code**		
	Responses received	154	100.0%
	NR	0	
		154	
Q2	**Is your pharmacy...**		
	A 100 hour pharmacy	22	14.3%
	A distance selling pharmacy	3	1.9%
	An LPS pharmacy	62	40.3%
	NR	67	43.5%
		154	
Q3	**What is your pharmacy's Healthy Living status?**		
	The pharmacy has achieved HLP Level 1 status	52	33.8%
	The pharmacy is working towards HLP Level 1 status	84	54.5%
	The pharmacy is not currently working towards HLP Level 1 status	13	8.4%
	NR	5	3.2%
		154	
Q3a	**If the pharmacy is working towards HLP Level 1 status, please state the date you expect to achieve this:**		
	Responses received	48	57.1%
	NR	36	42.9%
		84	
Q4	**Is the address to which this questionnaire was sent correct?**		
	Yes	125	81.2%
	No	27	17.5%
	NR	2	1.3%
		154	
Q4a	**If no, please provide the correct address below**		
	Responses received	27	100.0%
	NR	0	
		27	
Q5	**Do your opening hours match those that we enclose in the covering letter?**		
	Yes	106	68.8%
	No	47	30.5%
	NR	1	0.6%
		154	
Q6	**If no, please provide the correct opening hours below:**		
Q6a	**Monday - Friday**		
	Responses received	46	
Q6b	**Saturday**		
	Responses received	45	
Q6c	**Sunday**		
	Responses received	43	
Q6d	**If you know your Core Hours, please provide**		
	Responses received	27	

			% of responses	% of respondents
Q7	**Which of these advanced services do you currently provide? Please tick all that apply**			
	Medicines use review	148	32.7%	96.1%
	New medicines service	146	32.2%	94.8%
	NHS Urgent Medicine Supply Advanced Service (NUMSAS)	28	6.2%	18.2%
	Appliance use reviews	9	2.0%	5.8%
	Stoma appliance customisation	6	1.3%	3.9%
	NHS Flu vaccinations	114	25.2%	74.0%
	None of these	2	0.4%	1.3%
		453		

Q8	**Does the pharmacy dispense appliances?**		
	Yes – all types	124	80.5%
	Yes – excluding stoma appliances	3	1.9%
	Yes – excluding incontinence appliances	1	0.6%
	Yes – excluding stoma and incontinence appliances	1	0.6%
	Yes – just dressings	15	9.7%
	No	10	6.5%
		154	

			% of	% of
Q9	**Which of these locally commissioned services do you CURRENTLY provide? Please tick all that apply**		responses	respondents
	Stop Smoking Advice	28	5.9%	18.2%
	Nicotine Replacement Therapy	68	14.3%	44.2%
	Supervised consumption scheme	133	27.9%	86.4%
	Chlamydia Screening	11	2.3%	7.1%
	Emergency Hormonal Contraception	36	7.5%	23.4%
	Pregnancy Testing	20	4.2%	13.0%
	Needle exchange Service	11	2.3%	7.1%
	Pharmacy First Service	106	22.2%	68.8%
	NHS England Minor Ailment Service	64	13.4%	41.6%
		477		

			% of	% of
Q10	**Are you providing any of the following services on a private or unpaid basis? Please tick all that apply**		responses	respondents
	Diabetes checks/management	48	7.7%	31.2%
	Inhaler reviews	49	7.9%	31.8%
	Asthma	30	4.8%	19.5%
	COPD	19	3.1%	12.3%
	Palliative care medicines	37	5.9%	24.0%
	Alcohol Brief Advice	8	1.3%	5.2%
	Free delivery of medicine to patient's home	129	20.7%	83.8%
	Falls Prevention Service	1	0.2%	0.6%
	Prescription collection service	137	22.0%	89.0%
	Weight management	30	4.8%	19.5%
	Blood pressure testing	112	18.0%	72.7%
	Other	22	3.5%	14.3%
		622		

Q10a	**If other, please state**		
	Responses received	22	100.0%
	NR	0	
		22	

Q11	**Are there any gaps in services that you would want to provide if commissioned to do so?**		
	Responses received	64	41.6%
	NR	90	58.4%
		154	

Q12	**Has the extended opening hours of GP surgeries had an impact on the services you provide?**		
	Yes	13	8.4%
	No	140	90.9%
	NR	1	0.6%
		154	

Q12a	**If yes, please describe what the impact has been**		
	Responses received	12	92.3%
	NR	1	7.7%
		13	

Q13	**Are you a member of the following schemes?**		
Q13a	**Stay Safe Scheme**		
	Yes	9	5.8%
	No	119	77.3%
	NR	26	16.9%
		154	

Q13b	**Dementia Friendly Scheme**		
	Yes	143	92.9%
	No	9	5.8%
	NR	2	1.3%
		154	

Q14	**Please confirm if the following are applicable to your pharmacy…**		
Q14a	**The entrance to the pharmacy is suitable for unaided disabled access**		
	Yes	122	79.2%
	No	31	20.1%
	NR	1	0.6%
		154	
Q14b	**All areas of the pharmacy floor are accessible by wheelchair**		
	Yes	146	94.8%
	No	6	3.9%
	NR	2	1.3%
		154	
Q14c	**Customers can legally park within 50 metres of the pharmacy**		
	Yes	143	92.9%
	No	10	6.5%
	NR	1	0.6%
		154	
Q14d	**Disabled customers (who have a blue badge) can park within 10 metres of the pharmacy**		
	Yes	120	77.9%
	No	32	20.8%
	NR	2	1.3%
		154	

	What facilities do you have in the pharmacy aimed at helping disabled people access your services?		% of	% of
Q15	**Please tick all that apply**		responses	respondents
	Automatic door assistance	60	14.4%	39.0%
	Bell at front door	44	10.5%	28.6%
	Disabled toilet facility	21	5.0%	13.6%
	Hearing loop	89	21.3%	57.8%
	Large print labels/leaflets	75	17.9%	48.7%
	Non-stick tops	51	12.2%	33.1%
	Wheelchair ramp access	64	15.3%	41.6%
	Other	14	3.3%	9.1%
		418		

Q15a	**If other, please specify**		
	Responses received	13	92.9%
	NR	1	7.1%
		14	
Q16	**Is there a bus stop or other public transport stop within walking distance of the pharmacy?**		
	Yes	149	96.8%
	No	2	1.3%
	NR	3	1.9%
		154	
Q17	**If there is a bus stop or other public transport stop, how long (walking at a moderate pace) does the walk take?**		
	Less than 2 minutes	109	70.8%
	2 to 5 minutes	36	23.4%
	More than 5 minutes	3	1.9%
	NR	6	3.9%
		154	
Q17a	**If more than 5 minutes, please state how long approximately**		
	Responses received	3	100.0%
	NR	0	
		3	
Q18	**Do you feel that the pharmacy premises are suitable for services planned in the future?**		
	Yes	141	91.6%
	No	10	6.5%
	NR	3	1.9%
		154	
Q19	**Are there any restrictions on the changes you can make to your premises?**		
	Yes	35	22.7%
	No	117	76.0%
	NR	2	1.3%
		154	

Q19a	**If yes, please state briefly what these are**		
	Responses received	32	91.4%
	NR	3	8.6%
		35	
Q20	**Do you have a separate area/room suitable for private consultations with customers?**		
	Yes	147	95.5%
	No	7	4.5%
	NR	0	0.0%
		154	
Q21	**If you do have a separate area/room suitable for private consultations with customers, do any of the below apply:**		
Q21a	**It is accessible for someone who uses a wheelchair**		
	Yes	131	85.1%
	No	13	8.4%
	NR	10	6.5%
		154	
Q21b	**Seating is provided**		
	Yes	145	94.2%
	No	0	0.0%
	NR	9	5.8%
		154	
Q21c	**There is a computer terminal within the area to access patients' records / complete audit data**		
	Yes	119	77.3%
	No	26	16.9%
	NR	9	5.8%
		154	
Q21d	**There are handwashing facilities, or there is access to hand sanitiser gel nearby**		
	Yes	132	85.7%
	No	13	8.4%
	NR	9	5.8%
		154	
Q22	**Do any of your regular pharmacists or pharmacy staff speak a foreign language?**		
	Yes	93	60.4%
	No	61	39.6%
	NR	0	0.0%
		154	

			% of responses	% of respondents
Q23	**If yes, which languages are spoken? please tick all that apply**			
	Arabic	9	3.2%	5.8%
	Bengali	8	2.9%	5.2%
	Cantonese	2	0.7%	1.3%
	Czech	2	0.7%	1.3%
	Farsi	4	1.4%	2.6%
	French	8	2.9%	5.2%
	German	3	1.1%	1.9%
	Hakka	0	0.0%	0.0%
	Hindi	32	11.5%	20.8%
	Lithuanian	1	0.4%	0.6%
	Japanese	0	0.0%	0.0%
	Kurdish	1	0.4%	0.6%
	Mandarin	2	0.7%	1.3%
	Mirpuri	29	10.4%	18.8%
	Greek	6	2.2%	3.9%
	Gujrati	19	6.8%	12.3%
	Polish	8	2.9%	5.2%
	Punjabi	50	17.9%	32.5%
	Potwar	10	3.6%	6.5%
	Romanian	0	0.0%	0.0%
	Russian	0	0.0%	0.0%
	Serbian	1	0.4%	0.6%
	Somali	0	0.0%	0.0%
	Spanish	8	2.9%	5.2%
	Swahili	4	1.4%	2.6%
	Urdu	54	19.4%	35.1%
	Other	18	6.5%	11.7%
		279		

Q23a	**If other, please specify:**		
	Responses received	0	0.0%
	NR	18	100.0%
		18	
Q24	**Have any of your staff received Equality and Diversity awareness training?**		
	Yes - all of the staff	34	22.1%
	Yes - some of the staff	29	18.8%
	No - none of the staff	90	58.4%
	NR	1	0.6%
		154	
Q25	**Using the results from your most recent CPPQ, please identify the most frequent requests from patients as either improvements or additions to services:**		
	Responses received	136	88.3%
	NR	18	11.7%
		154	
Q26	**Details of person completing this form...**		
Q26a	**Name**		
	Responses received	154	
Q26b	**Signature**		
	Responses received	0	
Q26c	**Date completed**		
	Responses received	154	
Q26d	**Role**		
	Responses received	154	
Q26e	**Telephone number**		
	Responses received	152	

Appendix 14: Overview report - Public
Leeds Pharmacy Services Public Consultation 2017

Responses Received		
Online	*Paper*	*Total*
1059	365	1424

		Total	%
Q1	**Do you use your local (closest to where you live) pharmacy?**		
	Yes	1070	75.1%
	No	321	22.5%
	NR	33	2.3%
		1424	

			% of responses	% of respondents
Q2	**Thinking about the pharmacy you use the most, why do you use it? Please tick all that apply**			
Q2:1	It is the closest to where I live	866	22.1%	60.8%
Q2:2	It is the closest to where I work	57	1.5%	4.0%
Q2:3	It is the closest to my GP surgery	808	20.6%	56.7%
Q2:4	The pharmacy opening hours are convenient for me	531	13.6%	37.3%
Q2:5	I have a good relationship with the pharmacy and the staff there	532	13.6%	37.4%
Q2:6	Staff are able to speak to me in a language other than English	15	0.4%	1.1%
Q2:7	I can access general health and medicines advice	409	10.5%	28.7%
Q2:8	I can purchase other retail items (e.g. cosmetics or groceries) at the same time	313	8.0%	22.0%
Q2:9	I use it when convenient to do so, but also use others when out and about	324	8.3%	22.8%
Q2:10	Other	58	1.5%	4.1%
		3913		

Q2a	**If other, please briefly describe**		
	Response Received	57	98.3%
	NR	1	1.7%
		58	

Q3	**Is there anything stopping you from visiting your local pharmacy?**		
	Yes	184	12.9%
	No	1220	85.7%
	NR	20	1.4%
		1424	

Q3a	**If yes, please specify**		
	Response Received	175	95.1%
	NR	9	4.9%
		184	

Q4	**Do you have a choice about which pharmacy you use?**		
	Yes	1348	94.7%
	No	66	4.6%
	NR	10	0.7%
		1424	

Q4a	**If no, please provide further detail**		
	Response Received	47	71.2%
	NR	19	28.8%
		66	

Q5	**Can you find a pharmacy open in the evening if you need one?**		
	Yes	1117	78.4%
	No	254	17.8%
	NR	53	3.7%
		1424	

Q6	**Can you find a pharmacy open on a Sunday or a Bank Holiday if you need one?**		
	Yes	1051	73.8%
	No	298	20.9%
	NR	75	5.3%
		1424	

Q7 **Please rate the availability and quality of pharmacies in your area:**

Q7a **Overall, the availability of pharmacies in your area is...**

Very good	597	41.9%
Good	536	37.6%
Okay	238	16.7%
Bad	20	1.4%
Very bad	3	0.2%
NR	30	2.1%
	1424	

Q7b **Overall, the quality of pharmacies in your area is...**

Very good	514	36.1%
Good	572	40.2%
Okay	236	16.6%
Bad	17	1.2%
Very bad	8	0.6%
NR	77	5.4%
	1424	

	Which of the following are important to you when thinking about your use of pharmacies? Please tick all that apply		% of responses	% of respondents
Q8:1	Opening before 9am	375	4.4%	26.3%
Q8:2	Opening after 7pm	510	6.0%	35.8%
Q8:3	Saturday opening	783	9.3%	55.0%
Q8:4	Sunday opening	515	6.1%	36.2%
Q8:5	Convenient location	1130	13.4%	79.4%
Q8:6	Staff knowledge	861	10.2%	60.5%
Q8:7	Friendly staff	879	10.4%	61.7%
Q8:8	Shorter waiting times	449	5.3%	31.5%
Q8:9	Private areas to speak to the pharmacist/other pharmacy staff	566	6.7%	39.7%
Q8:10	Pharmacist/other pharmacy staff take time to listen	543	6.4%	38.1%
Q8:11	Pharmacy has the things you need	700	8.3%	49.2%
Q8:12	Pharmacy collects your prescription from your GP	788	9.3%	55.3%
Q8:13	Home delivery service	322	3.8%	22.6%
Q8:14	Other	32	0.4%	2.2%
		8453		

Q8a **If other, please specify**

Responses Received	32	100.0%
NR	0	0.0%
	32	

Q9 **How often do you use a pharmacy for medication, prescriptions or other purposes, e.g. self care advice or to buy medicines? Think about when you go to the pharmacy yourself, when someone goes for you, or when the pharmacy delivers your medications to you.**

Every week	97	6.8%
Every month	642	45.1%
Every couple of months	461	32.4%
Once or twice each year	151	10.6%
Less often	66	4.6%
NR	7	0.5%
	1424	

Q10 **What type of pharmacy do you usually use?**

One on a local high street	530	37.2%
One in a supermarket	140	9.8%
Pharmacy in or next to a doctor's surgery	657	46.1%
Pharmacy in a large retail park	37	2.6%
One on the internet	2	0.1%
Other	53	3.7%
NR	5	0.4%
	1424	

Q10a **If other, please specify**

Responses Received	50	94.3%
NR	3	5.7%
	53	

Q11	**How do you travel to your local (or usual) pharmacy?**		
	Car	717	50.4%
	Public transport	75	5.3%
	Walking	587	41.2%
	Other (e.g. bicycle)	38	2.7%
	NR	7	0.5%
		1424	
Q11a	**If other, please specify**		
	Responses Received	35	92.1%
	NR	3	7.9%
		38	
Q12	**If you travel by car, can you legally park within 50 metres of the pharmacy?**		
	Yes	977	68.6%
	No	60	4.2%
	Don't know	92	6.5%
	NR	295	20.7%
		1424	
Q13	**If you have a blue badge, can you park within 10 metres of the pharmacy?**		
	Yes	322	22.6%
	No	119	8.4%
	Don't know	357	25.1%
	NR	626	44.0%
		1424	
Q14	**How long does it take you to get to your pharmacy?**		
	Up to 10 minutes	1035	72.7%
	11 – 20 minutes	319	22.4%
	21 – 30 minutes	45	3.2%
	Over 30 minutes	13	0.9%
	NR	12	0.8%
		1424	
Q15	**Is there public transport within walking distance of the pharmacy?**		
	Yes	1237	86.9%
	No	83	5.8%
	Don't know	81	5.7%
	NR	23	1.6%
		1424	

Q16	**Do you have any difficulties travelling to pharmacies near you?**		
	Yes – I have problems parking	51	3.6%
	Yes – public transport does not run regularly	16	1.1%
	Yes – public transport is too expensive	8	0.6%
	No – I don't have any difficulties	1232	86.5%
	No – I use the delivery service	74	5.2%
	Other	31	2.2%
	NR	12	0.8%
		1424	
Q16a	**If other, please specify**		
	Responses Received	30	96.8%
	NR	1	3.2%
		31	
Q17	**If you walk to the pharmacy, how long (walking at a moderate pace) does the walk take?**		
	Less than 2 minutes	50	3.5%
	More than 2 minutes but less than 5 minutes	232	16.3%
	More than 5 minutes	903	63.4%
	NR	239	16.8%
		1424	
Q17a	**If more than 5 minutes, please state how many minutes (approximately):**		
	Responses Received	770	85.3%
	NR	133	14.7%
		903	
Q18a	**Alcohol support services**		
	Regularly	3	0.2%
	Sometimes	3	0.2%
	Never	1089	76.5%
	NR	329	23.1%
		1424	
Q18	**Which of the following services (if available) do you use at your local (or usual) pharmacy?**		
Q18b	**Asthma advice/care**		
	Regularly	39	2.7%
	Sometimes	86	6.0%
	Never	985	69.2%
	NR	314	22.1%
		1424	
Q18c	**Blood pressure checking service**		
	Regularly	41	2.9%
	Sometimes	136	9.6%
	Never	954	67.0%
	NR	293	20.6%
		1424	
Q18d	**Buying over the counter medicines**		
	Regularly	223	15.7%
	Sometimes	903	63.4%
	Never	167	11.7%
	NR	131	9.2%
		1424	
Q18e	**Cancer treatment support service**		
	Regularly	8	0.6%
	Sometimes	16	1.1%
	Never	1072	75.3%
	NR	328	23.0%
		1424	
Q18f	**Chlamydia screening**		
	Regularly	2	0.1%
	Sometimes	5	0.4%
	Never	1088	76.4%
	NR	329	23.1%
		1424	

Q18g	**COPD advice**		
	Regularly	13	0.9%
	Sometimes	31	2.2%
	Never	1052	73.9%
	NR	328	23.0%
		1424	
Q18h	**Diabetes screening service**		
	Regularly	17	1.2%
	Sometimes	44	3.1%
	Never	1039	73.0%
	NR	324	22.8%
		1424	
Q18i	**Disposal of old, or unwanted medicines**		
	Regularly	69	4.8%
	Sometimes	625	43.9%
	Never	530	37.2%
	NR	200	14.0%
		1424	
Q18j	**Electronic prescription service**		
	Regularly	563	39.5%
	Sometimes	145	10.2%
	Never	525	36.9%
	NR	191	13.4%
		1424	
Q18k	**Emergency contraception service**		
	Regularly	11	0.8%
	Sometimes	26	1.8%
	Never	1053	73.9%
	NR	334	23.5%
		1424	
Q18l	**Falls prevention**		
	Regularly	8	0.6%
	Sometimes	17	1.2%
	Never	1065	74.8%
	NR	334	23.5%
		1424	
Q18m	**Flu vaccination services**		
	Regularly	98	6.9%
	Sometimes	126	8.8%
	Never	907	63.7%
	NR	293	20.6%
		1424	
Q18n	**Handing in prescription for medication (dispensing)**		
	Regularly	495	34.8%
	Sometimes	548	38.5%
	Never	212	14.9%
	NR	169	11.9%
		1424	
Q18o	**Headlice Service**		
	Regularly	7	0.5%
	Sometimes	29	2.0%
	Never	1049	73.7%
	NR	339	23.8%
		1424	
Q18p	**Health and Medicines advice**		
	Regularly	87	6.1%
	Sometimes	571	40.1%
	Never	500	35.1%
	NR	266	18.7%
		1424	

Q18q	**Health checks services**		
	Regularly	40	2.8%
	Sometimes	120	8.4%
	Never	946	66.4%
	NR	318	22.3%
		1424	
Q18r	**Healthy weight advice**		
	Regularly	16	1.1%
	Sometimes	34	2.4%
	Never	1038	72.9%
	NR	336	23.6%
		1424	
Q18s	**Inhaler technique service**		
	Regularly	15	1.1%
	Sometimes	55	3.9%
	Never	1020	71.6%
	NR	334	23.5%
		1424	
Q18t	**Long term condition advice**		
	Regularly	38	2.7%
	Sometimes	93	6.5%
	Never	969	68.0%
	NR	324	22.8%
		1424	
Q18u	**Medicine use reviews**		
	Regularly	81	5.7%
	Sometimes	216	15.2%
	Never	837	58.8%
	NR	290	20.4%
		1424	
Q18v	**Minor ailment scheme**		
	Regularly	30	2.1%
	Sometimes	122	8.6%
	Never	950	66.7%
	NR	322	22.6%
		1424	
Q18w	**Needle exchange service**		
	Regularly	8	0.6%
	Sometimes	4	0.3%
	Never	1071	75.2%
	NR	341	23.9%
		1424	
Q18x	**Pregnancy testing**		
	Regularly	8	0.6%
	Sometimes	9	0.6%
	Never	1063	74.6%
	NR	344	24.2%
		1424	
Q18y	**Prescription collection service**		
	Regularly	570	40.0%
	Sometimes	218	15.3%
	Never	451	31.7%
	NR	185	13.0%
		1424	
Q18z	**Prescription delivery service**		
	Regularly	151	10.6%
	Sometimes	109	7.7%
	Never	866	60.8%
	NR	298	20.9%
		1424	

Q18aa	**Repeat prescriptions**		
	Regularly	815	57.2%
	Sometimes	174	12.2%
	Never	314	22.1%
	NR	121	8.5%
		1424	
Q18ab	**Supervised consumption service**		
	Regularly	4	0.3%
	Sometimes	9	0.6%
	Never	1064	74.7%
	NR	347	24.4%
		1424	
Q18ac	**Stop smoking advice**		
	Regularly	6	0.4%
	Sometimes	14	1.0%
	Never	1064	74.7%
	NR	340	23.9%
		1424	
Q19	**Overall, are you happy with the services that your local (or usual) pharmacy provides?**		
	Yes	1347	94.6%
	No	56	3.9%
	NR	21	1.5%
		1424	
Q19a	**If no, please provide details below**		
	Responses Received	54	96.4%
	NR	2	3.6%
		56	
Q20	**Are there any other services which are not available but you would like a pharmacy to provide?**		
	Yes	82	5.8%
	No	1272	89.3%
	NR	70	4.9%
		1424	
Q20a	**If yes, please specify**		
	Responses Received	76	92.7%
	NR	6	7.3%
		82	
Q21	**If there is anything else you would like to tell us about pharmacies in your area, please do so below:**		
	Responses Received	388	27.2%
	NR	1036	72.8%
		1424	

About You

Q22 Which of the Leeds electoral wards do you live in?

Adel and Wharfedale	215	15.1%
Alwoodley	55	3.9%
Ardsley and Robin Hood	15	1.1%
Armley	27	1.9%
Beeston and Holbeck	22	1.5%
Bramley and Stanningley	53	3.7%
Burmantofts and Richmond Hill	21	1.5%
Calverley and Farsley	25	1.8%
Chapel Allerton	60	4.2%
City and Hunslet	31	2.2%
Cross Gates and Whinmoor	43	3.0%
Farnley and Wortley	39	2.7%
Garforth and Swillington	54	3.8%
Gipton and Harehills	20	1.4%
Guiseley and Rawdon	30	2.1%
Harewood	20	1.4%
Headingley	24	1.7%
Horsforth	41	2.9%
Hyde Park and Woodhouse	11	0.8%
Killingbeck and Seacroft	22	1.5%
Kippax and Methley	19	1.3%
Kirkstall	24	1.7%
Middleton Park	23	1.6%
Moortown	46	3.2%
Morley North	28	2.0%
Morley South	47	3.3%
Otley and Yeadon	49	3.4%
Pudsey	67	4.7%
Rothwell	29	2.0%
Roundhay	64	4.5%
Temple Newsam	48	3.4%
Weetwood	28	2.0%
Wetherby	59	4.1%
Don't know	36	2.5%
NR	29	2.0%
	1424	

Q23 What is the postcode for your home?

Responses Received	1320	92.7%
NR	104	7.3%
	1424	

Q24 What is your gender?

Male	671	47.1%
Female	728	51.1%
Trans Male	2	0.1%
Trans Female	1	0.1%
Gender non-binary	0	0.0%
Other	2	0.1%
NR	20	1.4%
	1424	

Q24a If other, please specify

Responses Received	0	0.0%
NR	2	100.0%
	2	

Q25 Is your gender the same as that which was assigned at birth?

Yes	1381	97.0%
No	2	0.1%
NR	41	2.9%
	1424	

Q26 How old are you?

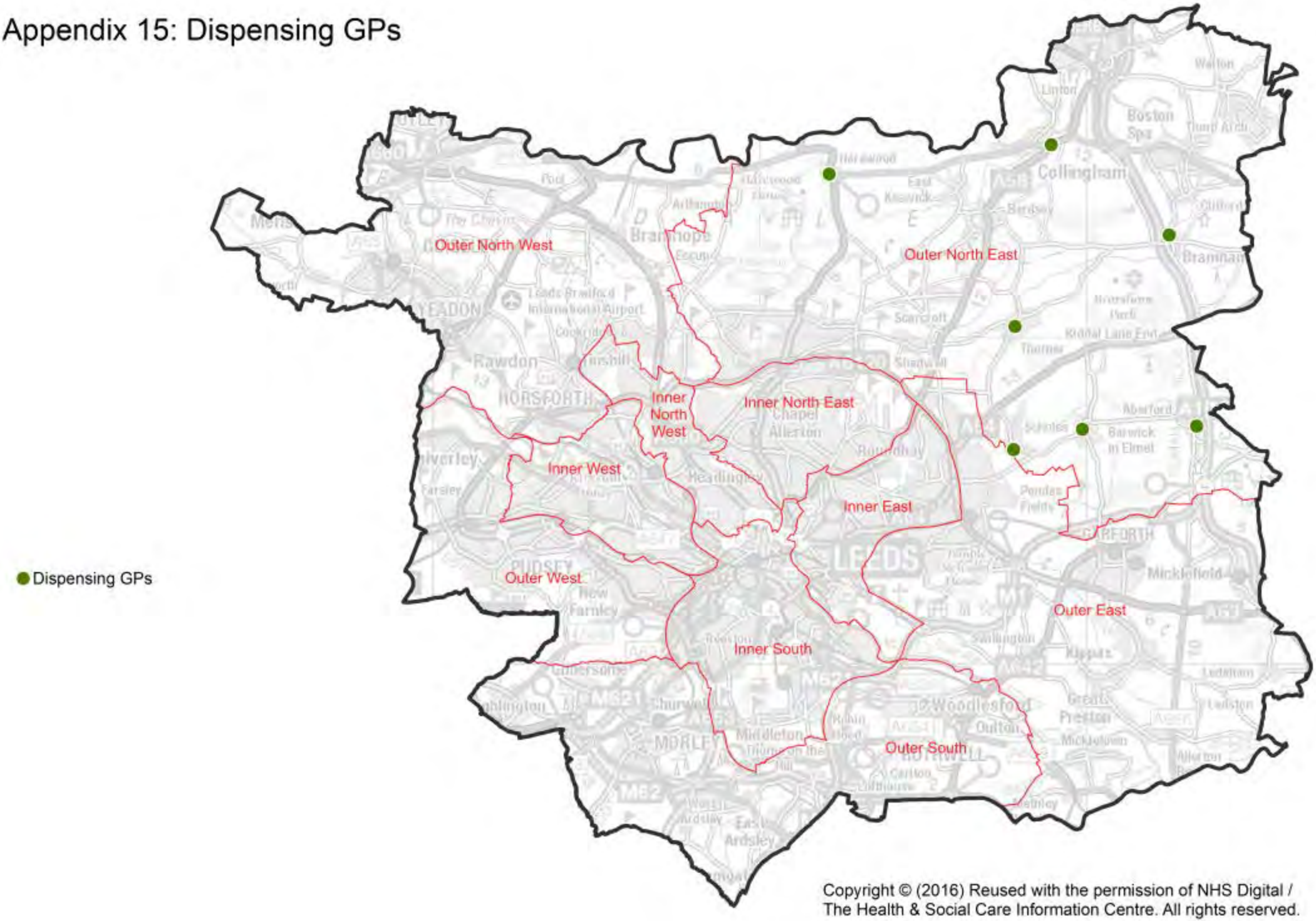
Under 18	18	1.3%
18 - 29	23	1.6%
30 - 44	162	11.4%
45 - 64	521	36.6%
65 +	676	47.5%
NR	24	1.7%
	1424	

Q27	**What is your sexual orientation?**		
	Heterosexual (straight)	1226	86.1%
	Lesbian (gay woman)	13	0.9%
	Gay man	33	2.3%
	Bisexual	13	0.9%
	Prefer not to say	75	5.3%
	NR	64	4.5%
		1424	
Q28	**What is your ethnic group? Tick the one option which best describes your ethnic group or background.**		
	White - English / Welsh / Scottish / Northern Irish / British	1260	88.5%
	White - Irish	14	1.0%
	White - Gypsy or Irish Traveller	1	0.1%
	White - Any other White background	24	1.7%
	Mixed - White and Black Caribbean	4	0.3%
	Mixed - White and Black African	3	0.2%
	Mixed - White and Asian	8	0.6%
	Mixed - Any other Mixed / multiple ethnic background	5	0.4%
	Asian - Indian	19	1.3%
	Asian - Pakistani	5	0.4%
	Asian - Bangladeshi	4	0.3%
	Asian - Kashmiri	3	0.2%
	Asian - Chinese	2	0.1%
	Asian - Any other Asian background	1	0.1%
	Black - African	11	0.8%
	Black - Caribbean	9	0.6%
	Black - Any other Black background	0	0.0%
	Other - Arab	0	0.0%
	Other - Any other background	9	0.6%
	NR	42	2.9%
		1424	
Q29	**What is your religion or belief?**		
	No religion	441	31.0%
	Christian	824	57.9%
	Buddhist	10	0.7%
	Hindu	8	0.6%
	Jewish	17	1.2%
	Muslim	17	1.2%
	Sikh	8	0.6%
	Other	34	2.4%
	NR	65	4.6%
		1424	
Q29a	**If other, please specify**		
	Responses Received	27	79.4%
	NR	7	20.6%
		34	
Q30	**Do you practice your religion or belief?**		
	Yes	526	36.9%
	No	751	52.7%
	NR	147	10.3%
		1424	
Q31	**Do you consider yourself to have a disability or long term illness / health problem?**		
	Yes	531	37.3%
	No	862	60.5%
	NR	31	2.2%
		1424	
Q32	**If yes, how would you describe your type of disability?**		
Q32:1	Physical disability (like needing a wheelchair to get around, difficulty using your arms)	153	23.6%
Q32:2	Sensory disability	20	3.1%
Q32:3	Sensory disability (like being blind or partially sighted or hearing loss)	64	9.9%
Q32:4	Mental health problem (like depression or schizophrenia)	76	11.7%
Q32:5	Learning disability (like Down's syndrome or autism)	4	0.6%
Q32:6	Long standing illness or health problem (like cancer, HIV, diabetes, epilepsy)	330	51.0%
		647	

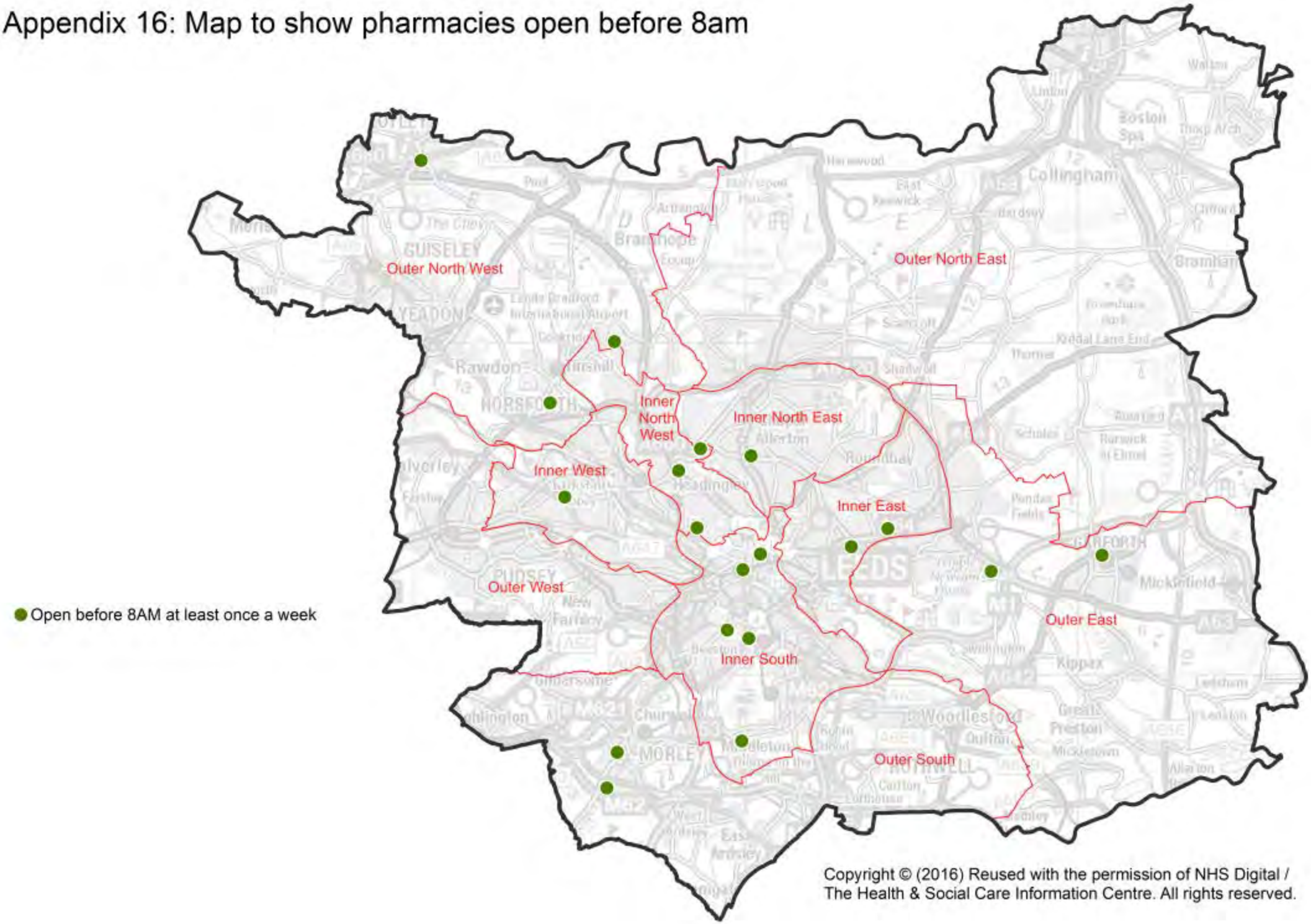
Q33	**Do you consider yourself to be a carer?**		
	Yes	229	16.1%
	No	1152	80.9%
	NR	43	3.0%
		1424	

Q34	**If you or someone you care for is disabled, have any adjustments been made to help with medicines (e.g. medication reminder charts, large print labels, non-stick tops)?**		
	Yes	90	6.3%
	No	288	20.2%
	Not applicable	955	67.1%
	NR	91	6.4%
		1424	

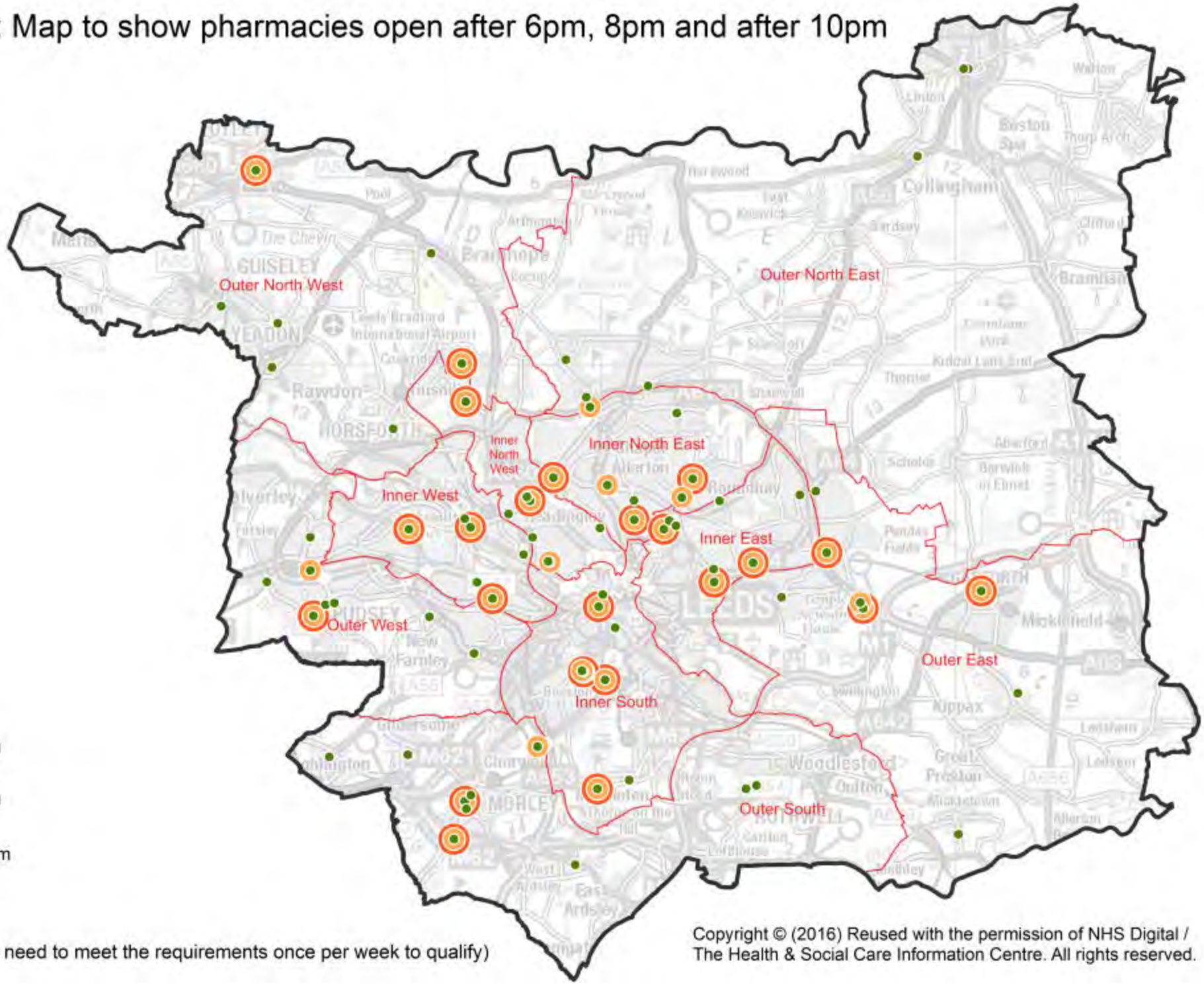
Appendix 15: Dispensing GPs



Appendix 16: Map to show pharmacies open before 8am

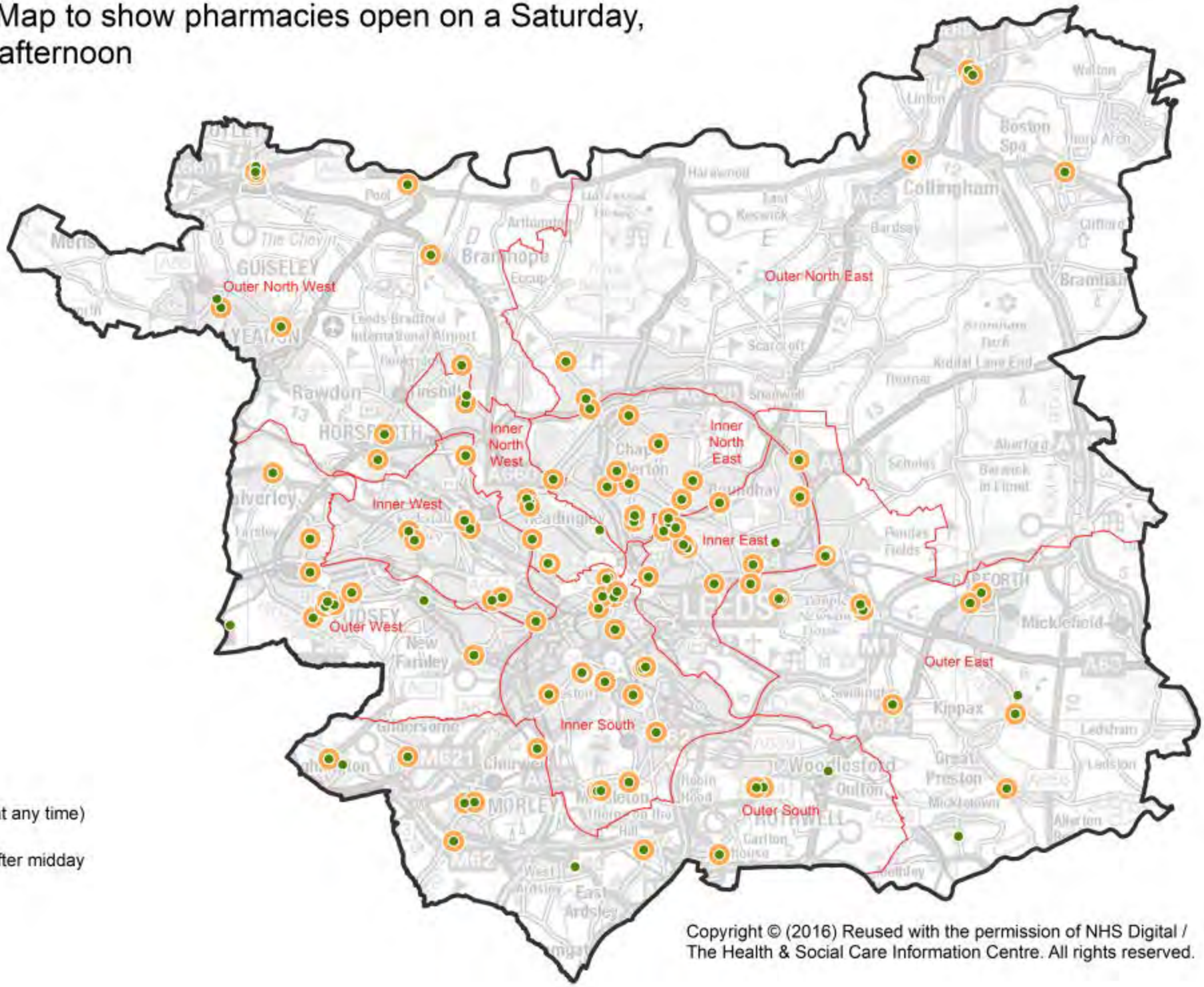


Appendix 17: Map to show pharmacies open after 6pm, 8pm and after 10pm

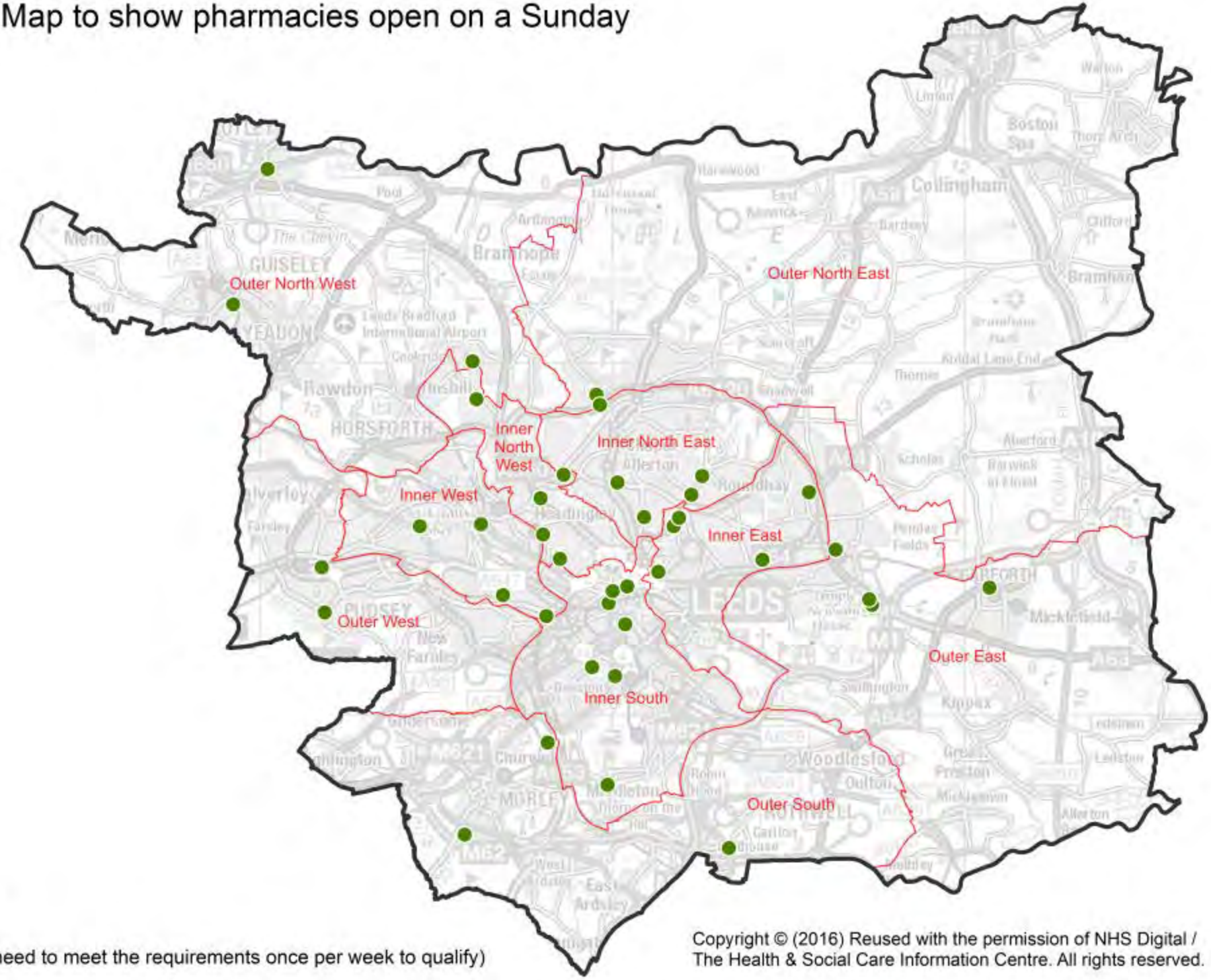


(Pharmacies only need to meet the requirements once per week to qualify)

Appendix 18: Map to show pharmacies open on a Saturday, and Saturday afternoon

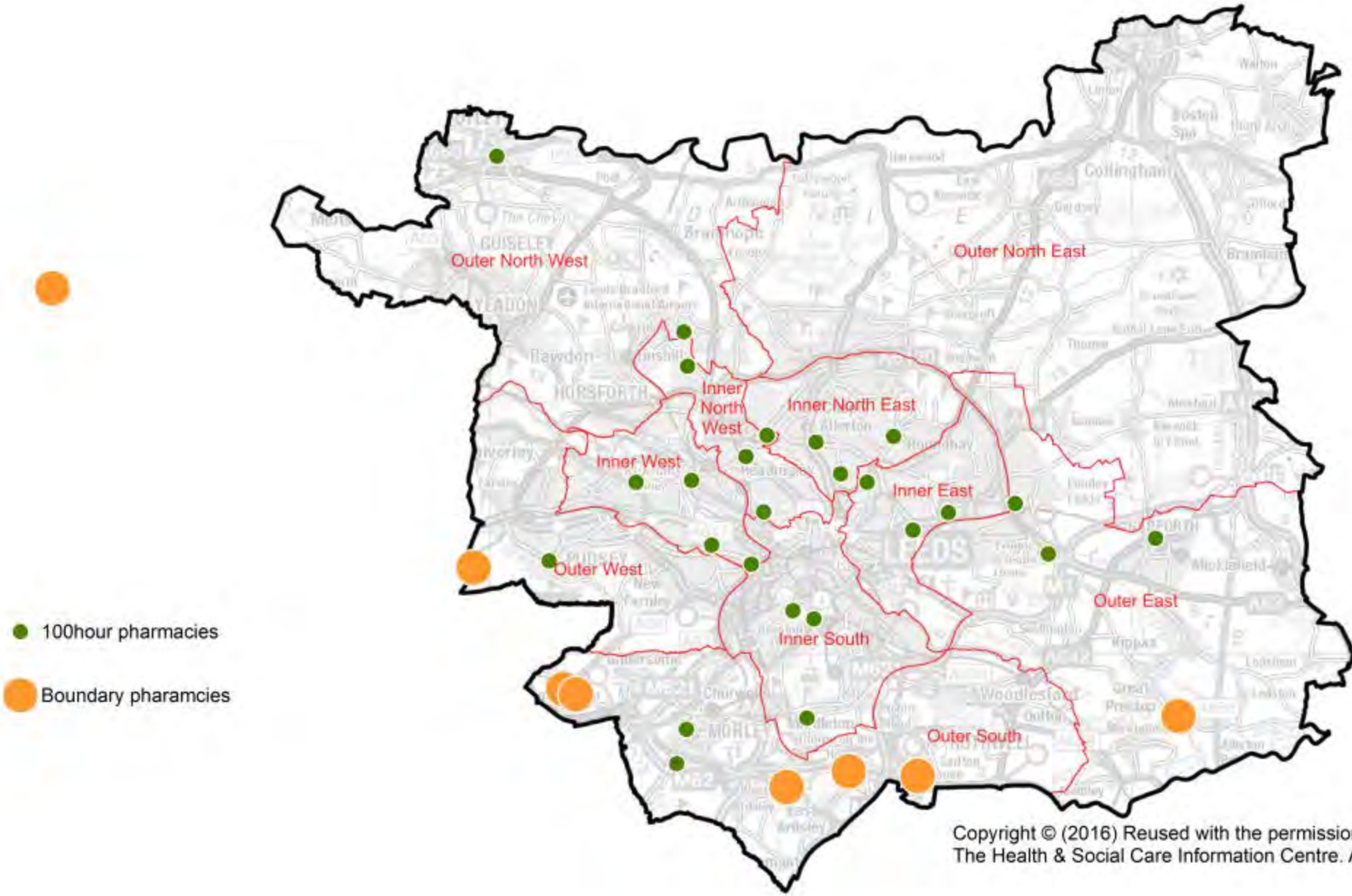


Appendix 19: Map to show pharmacies open on a Sunday

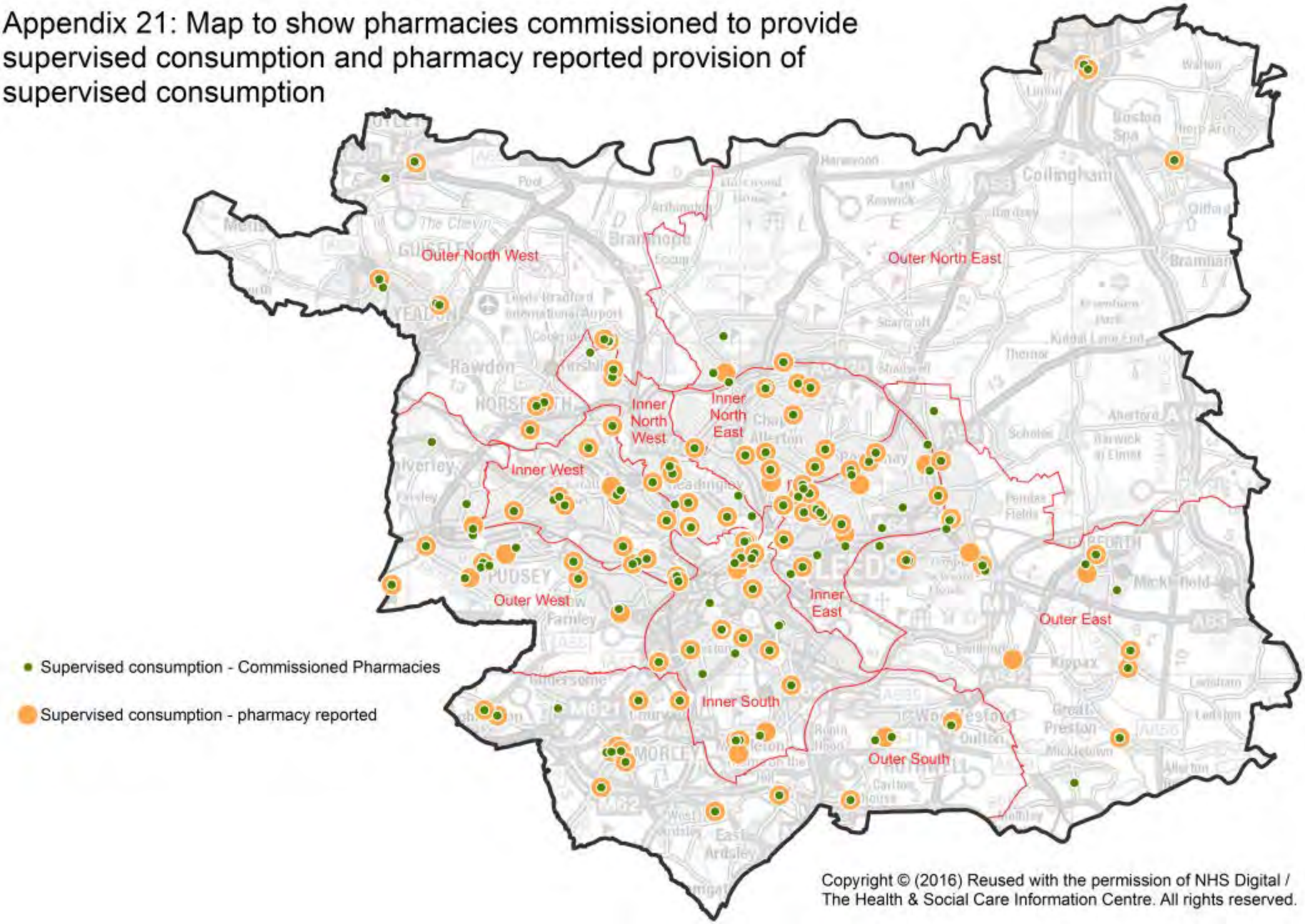


(Pharmacies only need to meet the requirements once per week to qualify)

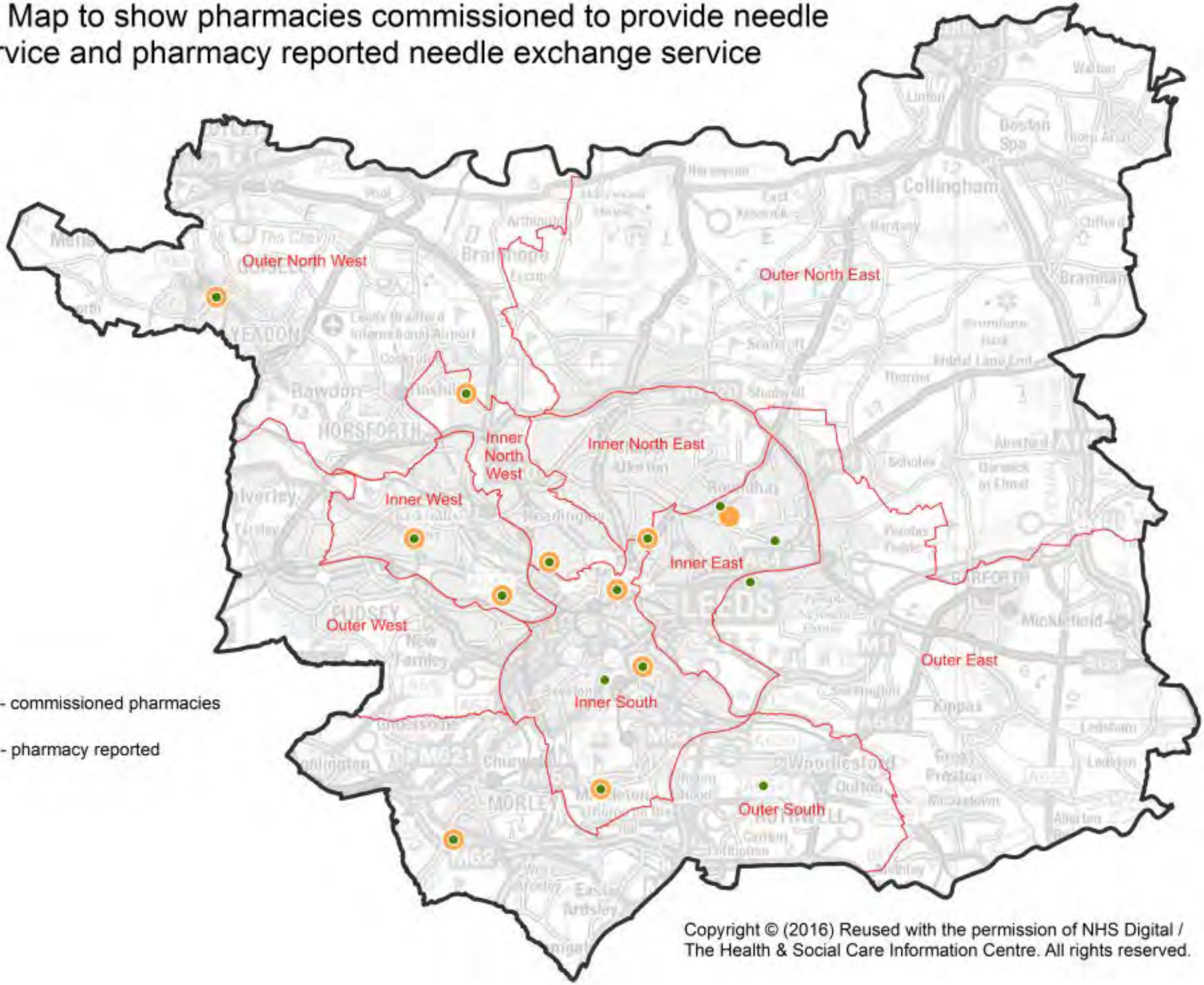
Appendix 20: 100 hour pharmacies commissioned by NHS England



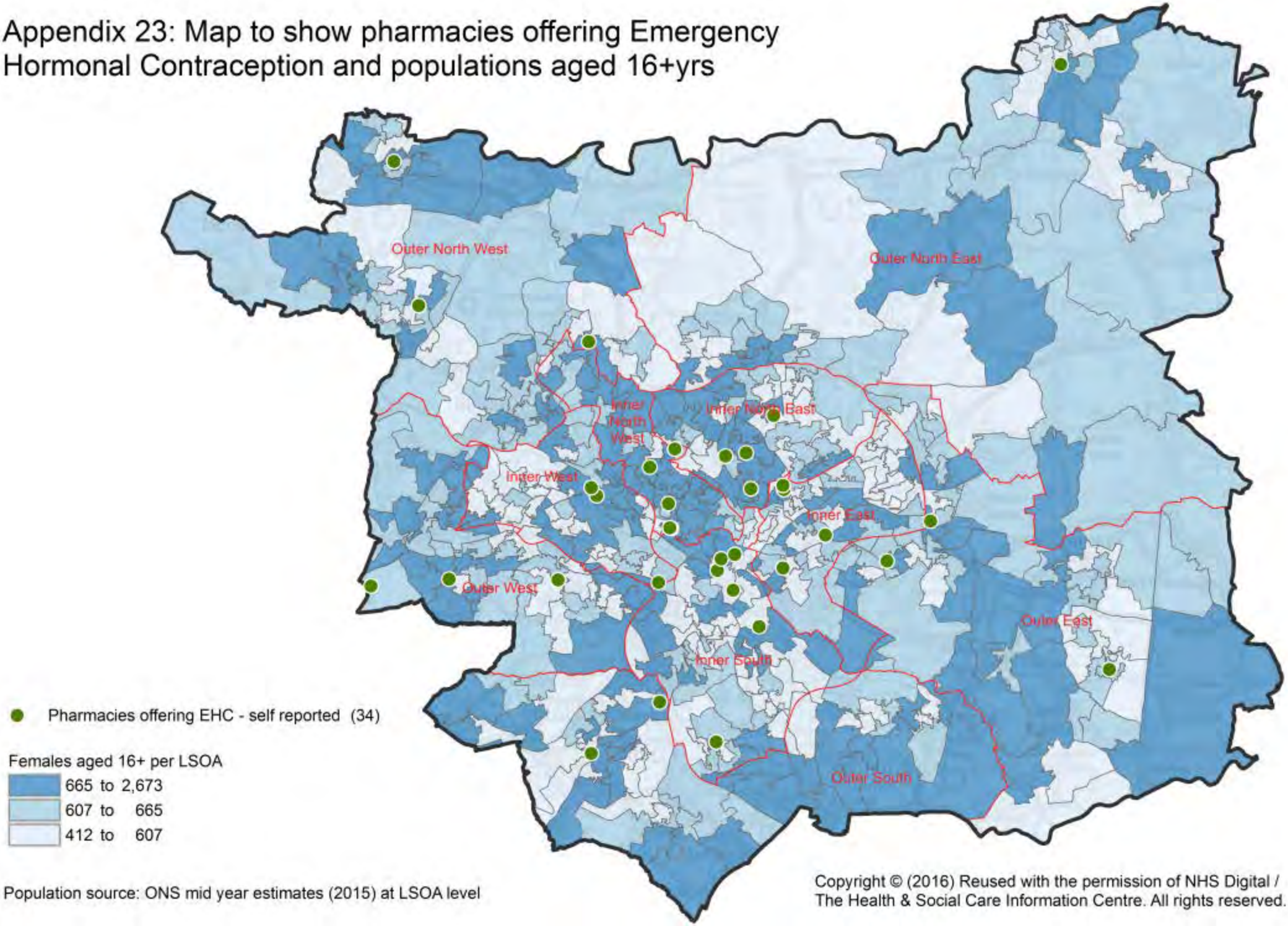
Appendix 21: Map to show pharmacies commissioned to provide supervised consumption and pharmacy reported provision of supervised consumption



Appendix 22: Map to show pharmacies commissioned to provide needle exchange service and pharmacy reported needle exchange service

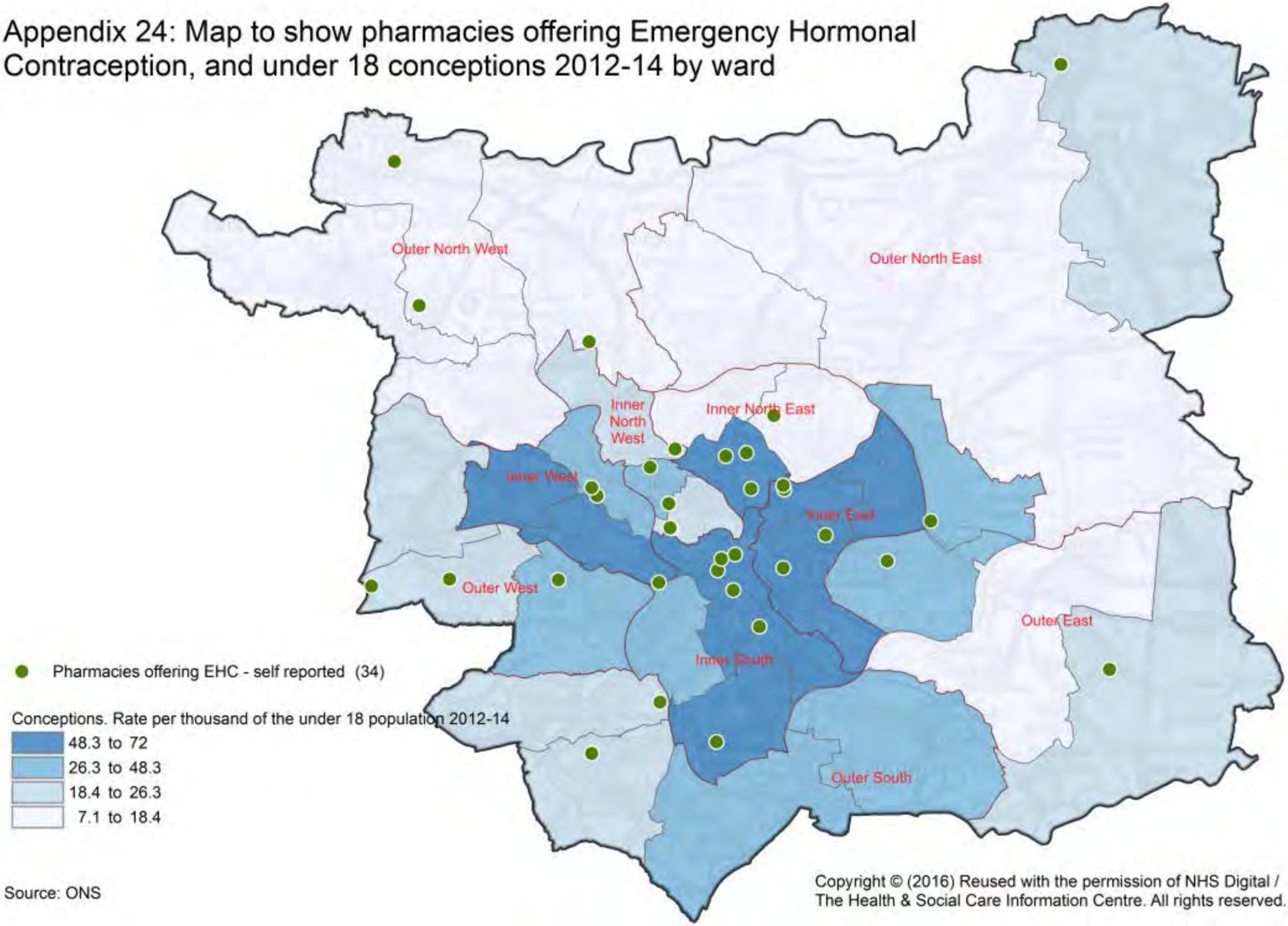


Appendix 23: Map to show pharmacies offering Emergency Hormonal Contraception and populations aged 16+yrs



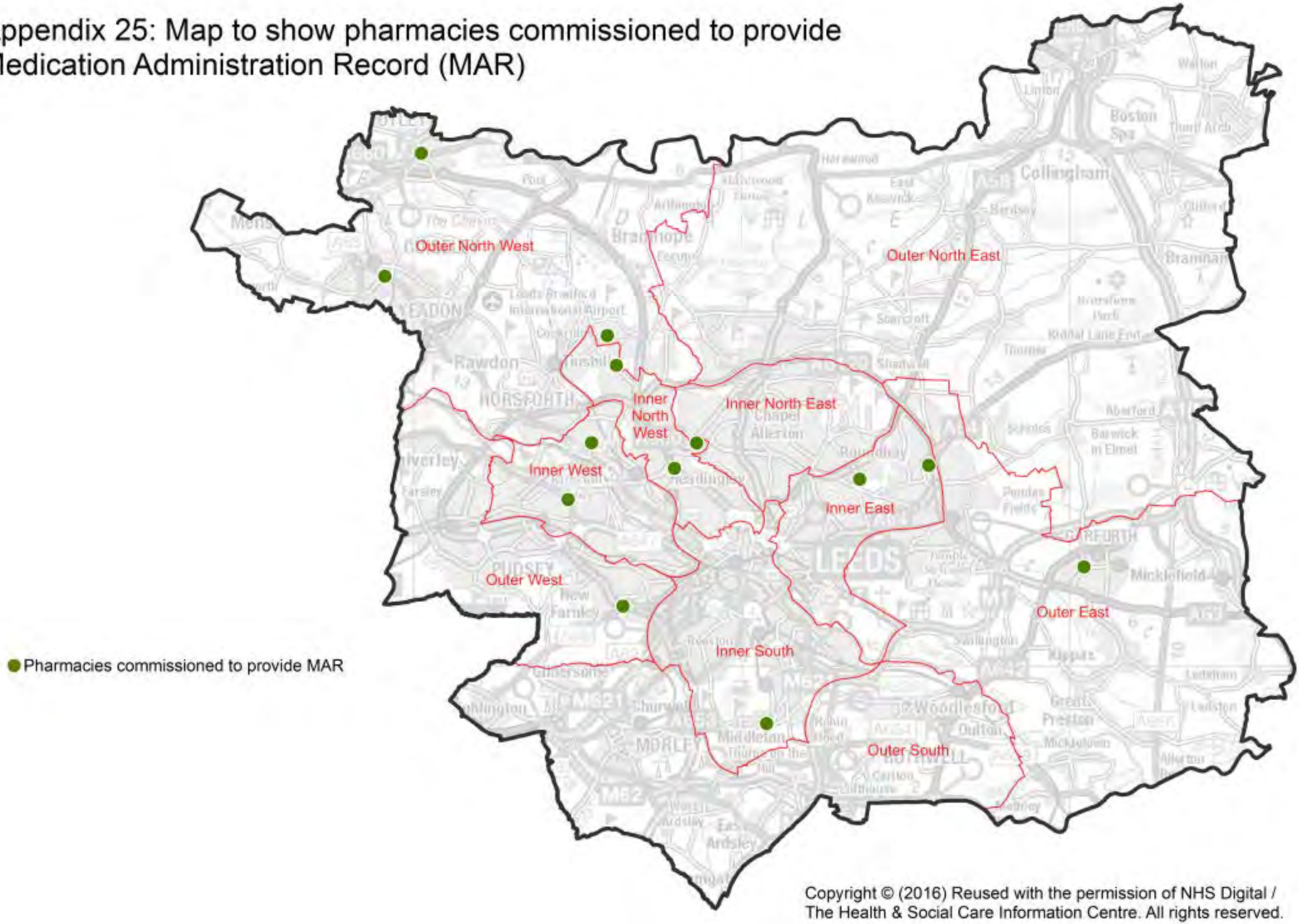
Population source: ONS mid year estimates (2015) at LSOA level

Appendix 24: Map to show pharmacies offering Emergency Hormonal Contraception, and under 18 conceptions 2012-14 by ward

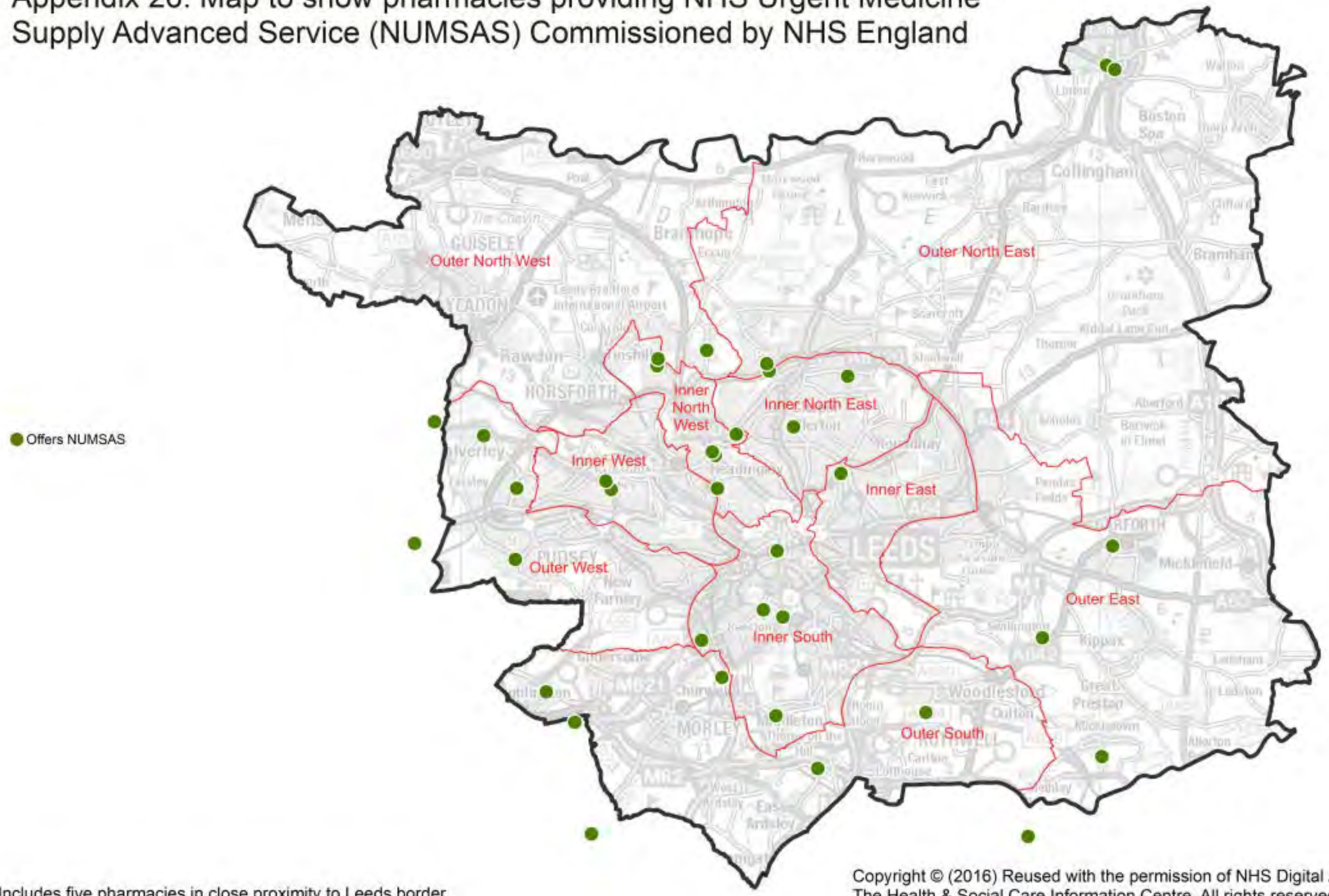


Source: ONS

Appendix 25: Map to show pharmacies commissioned to provide Medication Administration Record (MAR)



Appendix 26: Map to show pharmacies providing NHS Urgent Medicine Supply Advanced Service (NUMSAS) Commissioned by NHS England



Includes five pharmacies in close proximity to Leeds border

Leeds City Council PNA Stakeholder Feedback from 60 day consultation period

Appendix 27.

Who	What	Outcome	Date received
Pharm-Assist (Healthcare) Ltd	**Table 11** – seems to be an error. I can't imagine that 157 pharmacies are open after 8pm.	Agreed error-corrected	9-01-18
Leeds Community Healthcare NHS Trust (LCH):	**Question 1:** Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes. The draft PNA is very comprehensive. **Question 2:** Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? Yes. Significant detail is provided in the draft PNA. **Question 3**: Do you think that the service gaps that have been identified in the draft PNA are the right ones? Yes. Access to the minor ailment scheme and the development of an agreed palliative care scheme are of particular relevance to LCH.	Noted Noted Noted	17-01-18

Who	What	Outcome	Date received
LCH	**Question 4**: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? Nothing noted.	Noted	
Community Pharmacy West Yorkshire (CPWY)	**In general** Agree Leeds has excellent spread of pharmaceutical services and very good access to pharmaceutical services Encouraged that respondents expressed no concerns about current number, location and choice of pharmacies across city. Agree sufficient pharmacies and no gaps in necessary provision nor gaps where further services would result in better access to pharmaceutical services.	Noted	19-01-18
CPWY	**How assessment was carried out.** Confident points taken into account, but not explained clearly enough-how assessment was carried out, in particular how localities determined and different needs in localities, how it has taken into account different needs of people who share a protected characteristic.	Updated document	19-01-18
CPWY	**Gaps** Draft PNA not explicit enough when explaining position taken on gaps in provision- CPW suggested sentiment of PNA summarised by: "There are no current gaps in the provision of necessary services in the area of the Health and Wellbeing Board"	Wording amended as suggested to aid clarity. Added 'related' commissioning intentions as HWB does not commission services	19-01-18

Who	What	Outcome	Date received
CPWY	"There are no current gaps in the provision of other relevant services in the area of the Health and Wellbeing Board" The PNA has not identified any future needs which could not be met by pharmacies already currently on the pharmaceutical list, which would form part of its commissioning intentions.		
CPWY	**Regulation 9(1)** CPWY also believes all areas of Leeds have a reasonable choice of pharmaceutical services and we are not aware of a body of stakeholder views to the contrary. The intention of the PNA seems to be in agreement that this is the case and the sentiment of the draft PNA could be summarised with the following statement which we would suggest should be added to the final version to help meet Regulation 9(1)(b). **Regulation 9(2)** ☐We are not aware of any expected significant changes to demography, population size or changes to the health or wellbeing in the area which would mean, within the life of this PNA, that there would be a future need for additional pharmaceutical services for which there is a planned intention to commission. If this is supported by the PNA we would recommend including a statement to the following effect: ☐	Added "There is a reasonable and adequate choice of pharmacies and pharmaceutical services in all areas of Leeds" where appropriate	19-01-18

Who	What	Outcome	Date received
CPWY	"The PNA, having regard to likely changes to the number of people requiring pharmaceutical services, the demography of the area and the risks to the health and wellbeing of people in the area, has not identified any future needs which are not already met by providers currently on the pharmaceutical list"	Added where appropriate	
CPWY	**Question 1**: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes, The PNA contains relevant information about the health and pharmaceutical needs of the population. **Question 2**: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? Yes. The PNA has taken into account likely changes in numbers of the population requiring pharmaceutical services, the demographics of the city, and health and wellbeing in the Leeds City Council area which has enabled likely future needs over the next 3 years to be identified.	Noted Noted	19-01-18

Who	What	Outcome	Date received
CPWY	**Question 3**: Do you think that the service gaps that have been identified in the draft PNA are the right ones? The PNA does not identify any service gaps. It is recommended that the PNA clearly outlines this conclusion (see response above as to how the PNA 3 could be improved in line with the regulatory requirements.). Further clarity may be achieved by including a summary / conclusion at the beginning of the PNA. **Question 4:** Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? **Information on which the PNA is based** The PNA must clearly state that the date that on which the information included within it was correct. **Section 1.3 Opening times** The PNA would benefit from a description of pharmacies open in the weekday evening and Sundays.	Noted and amended to aid further clarity 1st January 2018 added Added	19-01-18

Who	What	Outcome	Date received
CPWY	It is noted that the draft PNA does describe Saturday opening in section 1.3 and overall opening in section 5.5. Merging of this information to make it clearer to the reader of the PNA should be considered.	Amended	19-01-18
CPWY	**The draft PNA section 1.3** includes information on access to pharmaceutical services. This information may benefit from a separate section. It should be made clear that being more than 1 mile away from a pharmacy does not create a gap in provision nor mean that a patient 'struggles' to access pharmaceutical services. There was no evidence to suggest that the current provision is not good and the future plans of Leeds Council to improve public transport will only improve the currently good access.	Noted-amended	19-01-18
CPWY	**University population** Leeds is a university city with 2 universities and several campus sites across the city. As such there will be an influx (both on a daily and term-time basis) of (mainly young) people. The requirements of this cohort of population should be noted within the PNA. This need is met by the current pharmaceutical provision but this should be captured within the PNA. Consideration may also be needed for college / post-16 education sites which draw in numbers of non-Leeds resident students on a daily-basis.	Added further information in protected characteristics section under age	19-01-18

Who	What	Outcome	Date received
CPWY	**Points of accuracy** 1.1 Access and geographical coverage This section states: The Outer North East area has fewer community pharmacists but there are now four dispensing GPs in this area and seven distance-selling pharmacies across Leeds. This means there are no geographical gaps in provision The word 'now' should be removed as the dispensing GPs were in place when the previous PNA was written	Amended. Also, all dispensing GPs fall into this Community Committee area	19-01-18
CPWY	**1.2 Services provided** The draft PNA includes Healthy Living Pharmacy (HLP) as the only service listed under section 1.2. HLP is not a service, but a quality mark of a pharmacies achievement against a defined framework. Information regarding HLPs should be moved to another section of the PNA Services.	Amended.	19-01-18
CPWY	**1.7 2 Newly-emerging communities** Equality and diversity training is not a requirement for community pharmacy and therefore not relevant to a pharmaceutical needs assessment. Pharmacy has demonstrated through is adapted offer to patients with a disability / patients whose first language is not English / Gypsy travellers that it can, and does adapt their services to make them more accessible for the populations that they service. It is therefore unfounded to state it is possible that some newly emerging communities experience limitations of access to pharmacy services where there is no evidence for this and other information suggests that	E & D training not a requirement but would be measure of good practice and would enhance offer to everyone, but especially diverse community of Leeds. Agree PNA shows community pharmacies adapt well, but views of non-English speaking individuals and LGBT individuals were not fully captured in the PNA. Alternative form of wording agreed which acknowledges the	19-01-18

Who	What	Outcome	Date received
	pharmacy adapts its offer to meet the needs of patients. Completion of specified training is not linked to accessibility of a service; non-completion of a specified training does not mean that a service cannot and does not adapt to improve accessibility. The inclusion of equality and diversity training must be removed.	skills of pharmacy staff, but encourages everyone to expand skills as appropriate.	19-01-18
CPWY	**Supporting primary care and public health 2015-2018** The draft PNA states that: the majority of NHS income for community pharmacies in England comes from payment from NHS England, through the NHS pharmaceutical services contract. This should be amended to state that the majority (90-95%) of total pharmacy income comes from payment from NHS England, through the NHS pharmaceutical services contract.	Amended	19-01-18
CPWY	**The Pharmacy Access Scheme** is currently for 2017/18 only. The draft PNA should be amended to reflect his.	Amended	19-01-18
	1.13 Changes to community pharmacy funding The 2017/18 funding cut was a 7.4% reduction not 3.4% as stated in the draft PNA.	Amended	19-01-18
CPWY	**Figure 1** appears to show 7 dispensing GP practices where earlier in the PNA it was stated that there were 4 dispensing GPs. Only the GP branches where dispensing occurs should be marked on the map.	Amended-all seven dispense in Outer North East Community Committee Area	19-01-18

Who	What	Outcome	Date received
	Figure 1. This should be amended to LPS pharmacy as an individual contractor should not be named.	Amended	19-01-18
CPWY	**Distance-selling pharmacies** (DSP) cannot provide face-to-face essential services. It therefore may be misleading to mark DSPs on the maps in the same way as a bricks and mortar pharmacy as patients cannot access their services from the DSP physical location. It is suggested that DSPs are marked using a different shape / colour to distinguish them from other community pharmacies	Amended	19-01-18
CPWY	**Distance-selling pharmacies** DSPs cannot provide face to face essential services (but some other services can be provided face to face). The draft PNA should be amended to reflect this	Noted and amended	19-01-18
CPWY	**3.4 Healthy Living Pharmacies (HLPs)** There has been a significant growth in the number of Healthy Living Pharmacies (HLP) over the past 12 months. The number of Healthy Living Pharmacies is set to rapidly increase by November 2017. The final published PNA should include updated figures of the number of HLP pharmacies. Currently there are 112 HLPs within the Leeds Health and Wellbeing Board area.	Number increased to 149 between survey taking place and update Jan 2018. Added to PNA	19 -01-18
CPWY	**3.8 Types of pharmaceutical provider** In Leeds, the Essential Small Pharmacies LPS contracts were all transferred to an LPS contract. Essential Small Pharmacy LPS no longer exist. The draft PNA should be amended to reflect this.	Was included in 5.1 of consultation draft but amended to make clearer	19 -01-18
CPWY	**5.3 Dispensing appliance contractors** The draft PNA states that there are four Dispensing Appliance Contractors (DAC) outside of Leeds. Whilst there are 3 DAC within West Yorkshire, patients are free to use	NHSE provided details of four DACS. Wording amended to show wider access	19 -01-18

Who	What	Outcome	Date received
CPWY	any DAC within England so are likely to be accessing DACs outside of West Yorkshire. Nationally there are numerous DACs which can be found: https://www.nhs.uk/service-search/Pharmacies/AppliancePharmacies/A The PNA should be amended to reflect that use of DACs is unlikely to be geographically bound		19-01-18
CPWY	**6.12 1 Health protection** – national flu immunisation programme 2017/18 NHS England should be asked for the numbers of pharmacies in Leeds providing the NHS Flu vaccination service in 2017/18. These figures are available and would provide a more up-to-date analysis of service provision. It is understood that significantly more pharmacies offer the NHS flu service in 2017/18 than in 16/17.	Updated figures (134) added	19-01-18
CPWY	**6.12 2 NHS Urgent Medicine Supply Advanced Service (NUMAS)** The service acronym is NUMSAS not NUMAS. This error is repeated in several areas of the draft PNA, including the appendixes and should be amended.	Amended	19-01-18
CPWY	NHS England should be asked for the numbers of pharmacies in Leeds providing the NUMSAS service. These figures are available and would provide a more up-to-date analysis of service provision. In December 2018 there were 29 pharmacies providing NUMSAS in Leeds.	Updated figures mapped	19-01-18
CPWY	NUMSAS cannot be provided as a non-commissioned service and reference to this should be removed from the PNA. Emergency supply is a non-commissioned service and can be provided by any pharmacy.	Removed. Some pharmacies had self- reported they were providing this service. Maps amended to show commissioned services	19-01-18

Who	What	Outcome	Date received
CPWY	**7.1 Recommendations** The recommendations include: That the Health and Wellbeing Board can be satisfied that the population of Leeds currently has very good access to community pharmaceutical services. It is recommended that the word community is removed to be in-line with the regulatory wording of pharmaceutical services.	Removed	19-01-18
CPWY	The draft PNA states: That the Health and Wellbeing Board will monitor and note any significant changes to population numbers, demographic composition and housing plans, making revisions to this PNA if deemed necessary, in accordance with regulations. A PNA cannot be amended other than producing a supplementary statement or conducting a complete PNA to revise the assessment.	Noted and amended	19-01-18
	Supplementary statements can only be made about the provision of pharmaceutical services. They cannot be used to describe changes in the need for pharmaceutical services. The Health and Wellbeing Board is only required to consider a revised assessment if there is a significant change to the need for pharmaceutical services. This should be clarified in the final version of the PNA.	Noted and amended	19-01-18

Who	What	Outcome	Date received
CPWY	The draft PNA states: That existing pharmacy teams review their equality and diversity training to ensure that staff who are not trained can build this into their training programme. This will help them to provide a more inclusive service for the diverse population of Leeds. Equality and diversity training is not a requirement for community pharmacy, nor a pharmaceutical service, and therefore not relevant to a pharmaceutical needs assessment. It is recommended that this recommendation is removed from the PNA. As per previous comments completion, or not, of specified training cannot be linked to the ability of a pharmacy contractor, or not, to adapt their services to improve access.	E & D training not a requirement but is indication of good practice and would enhance offer to everyone but especially diverse community of Leeds. Agree PNA shows community pharmacies adapt well, but views of non-English speaking individuals and LGBT individuals were not fully captured in the PNA. Alternative form of wording agreed which acknowledges skills of pharmacy staff, but encourages everyone to expand skills as appropriate	19 -01-18
Armley Pharmacy	**Question 1:** Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes **Question 2**: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? Yes	 Noted Noted	01-02-18

Who	What	Outcome	Date received
Armley Pharmacy	**Question 3:** Do you think that the service gaps that have been identified in the draft PNA are the right ones? Yes **Question 4**: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? N/A	 Noted Noted	01-02-18
NHS England	**Question 1**: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes **Question 2**: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? Yes	 Noted Noted	02-02-18

Who	What	Outcome	Date
NHS England	**Question 3**: Do you think that the service gaps that have been identified in the draft PNA are the right ones? No service gaps have been identified **Question 4:** Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? Shown below	 Noted Noted	
NHS England	We are supportive of the overall content of the draft PNA and are in agreement with the main findings of the PNA in that there are no current gaps in the provision of pharmaceutical services in the Leeds Health and Well Being Board area and that no future needs have been identified which could not be met by pharmacies on the already on the pharmaceutical list. It is felt that a robust process has been undertaken to review the PNA which has included strong engagement with a wide list of stakeholders as well as actively seeking the views of Leeds citizens.	Noted	02-02-18
NHS England	We would like to note the following points of accuracy and suggested revisions on the draft PNA; **Executive summary** The executive summary is rather lengthy and contains a lot of information. Our suggestion	Noted and amended	02-02-18

Who	What	Outcome	Date
NHS England	would be that the executive summary is reviewed to present the main findings of the information collected in a more concise way making it clearer to the reader. In particular in relation to 1.1 Access and geographical coverage, the findings described need to be more definitive in explaining what is being concluded.	Noted and amended	02—02-18
NHS England	**As a point of accuracy** a PNA cannot be amended once published other than producing a supplementary statement or where for any significant changes it is deemed that a revised assessment is required Suggestion for the wording in sections 1.1 Executive Summary and 7.1 Recommendations are revised to acknowledge this.	Noted and amended	02-02-18
NHS England	**1.13 Changes to community pharmacy funding** In this section the draft PNA describes that*:* 'Since the last PNA there have been significant funding cuts, which are now being implemented'. It is suggested is that the language used here is revised to replace the word *'cut'* with *'reduction'*. Please find suggested revision below: *'Since the last PNA there have been significant changes to the community pharmacy contractual framework. These changes are now being implemented and the impact of which is a reduction in the funding which community pharmacies receive'* Likewise on page 11, the draft PNA states that: "The community pharmacy survey did not show obvious evidence of these cuts being a barrier to the	Noted and amended	02-02-18

Who	What	Outcome	Date
NHS England	day-to-day functioning of community pharmacies in Leeds," Again it is suggested that this wording is revised to: *'The community pharmacy survey did not show obvious evidence of these reductions in funding being a barrier to the day-to-day functioning of community pharmacies in Leeds'*	Noted and amended	02-02-18
NHS England	**1.7 2 Newly-emerging communities** This section of the draft PNA reports that over half (58%) of responding pharmacies have no staff with Equality and Diversity training. NHS England would like to clarify that equality and diversity training is not a requirement for community pharmacy. In terms of the question asked it is felt that this could have been interpreted in a number of ways and that equality and diversity awareness can be raised via a number of routes and not only through formal training which was not captured in the survey questions. From the information collected there is not the evidence to suggest that there is a direct link between completion of equality and diversity training and access to pharmaceutical services. Equality and Diversity training is also included within the recommendations listed in Section 7.1, where the recommendation for existing	E & D training not a requirement but would be measure of good practice and would enhance offer to everyone but especially diverse community of Leeds. Agree PNA shows community pharmacies adapt well, but views of non-English speaking individuals and LGBT individuals were not fully captured in the PNA. Alternative form of wording agreed which acknowledges skills of pharmacy staff, but encourages everyone to expand skills as appropriate	02-02-18

Who	What	Outcome	Date
NHS England	pharmacy teams to review their equality and diversity training to ensure that staff who are not trained can build this into their training programme Whilst it is recognised that there is a need to understand the data and feedback collected during the process it is not felt to be relevant to include this recommendation within the PNA in terms of the purpose of the document		02-02-18
NHS England	**1.9 Gypsy Travellers** This section uses the term 'chemist' which is not used elsewhere in the document. Our suggestion would be review the use of word 'chemist' in terms of consistency of language throughout the document. It may be that there is a reason for the use of the term 'chemist' here but this isn't clear to the reader.	Chemist was the term used by Gypsy Travellers in the HNA referred to-amended to explain this in PNA	02-02-18
NHS England	**2.1 Legislative requirements of the PNA** This section in the draft PNA describes the primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list. Whilst this is accurate that the PNA supports NHS England to review applications, it is also worth reflecting that PNAs are used by both the NHS and Local Authorities when considering which services can be or need to be provided by community pharmacies. As a point of accuracy we ask that ' NHS England West Yorkshire team' is revised to NHS England. This is also consistent with the name used throughout the rest of the document.	Amended	02-02-18

Who	What	Outcome	Date
NHS England	**3.3 New developments in GP and primary care services** It is suggested that the following revisions be made to the wording within this section: Pg. 17 *GPs may need to ~~join some of their practices~~* ***work more collaboratively*** *to share resources, staff and premises to make sure they can work in this new way. Other health, care and community services – and, potentially, community pharmacies – will need to join in with the approach.* *This ~~big~~ change would mean training the existing and future workforces to work with citizens and with each other in new ways.* *Pg. 18* *The approach will bring some of the expertise of hospital doctors right into community services, which would mean less* ***referrals into hospitals with*** *~~to specialists and ensure that~~ as much as possible being done in the community. This should mean ~~fewer visits to hospital~~* ***patients being able to access their care closer to home*** *~~patients fewer procedures~~, but* ***still be able to access*** *~~the~~ hospital services ~~will still be there for~~ when ~~citizens~~* ***they*** *and their family need them.*	Amended where appropriate. Supplied by a colleague so reflected another perspective	02-02-18
NHS England	**5.5 Opening times** Table 11 Pharmacy opening times (October 2017) has one row labelled 'Saturday' and another 'Saturday afternoon'. It is not clear here to the reader what is meant by 'Saturday' and how this differs from 'Saturday afternoon'.	Amended to make clearer to reader	02-02-18

Who	What	Outcome	Date
NHS England	Section 1.3 Opening times (page 5) of the draft PNA states: *"A total of 126 pharmacies are open on Saturday. Of these, 111 are also open in the afternoon; 15 are open only on Saturday mornings."* Again it is suggested is that the wording is made clearer here. The use of the word 'only' open on Saturday morning may also want to be considered as could be interpreted in a negative tone rather than a factual statement.	Amended to make clearer to reader	02-02-18
NHS England	NHS England would like to highlight to Leeds City Council the need for a timely and robust process for acknowledging and reviewing changes in relation to the provision of pharmaceutical services following notification from NHS England and that these are considered through the appropriate governance structures. In particular there needs to be a clear process for the assessment of changes to pharmaceutical provision which are deemed to require a supplementary statement and the approval of these	To be addressed outside of PNA	02-02-18
North Yorkshire County Council	**Question 1:** Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes, we acknowledge that a thorough process has been followed in liaising with, and seeking feedback from, the public, relevant parties and organisations during the production of the PNA and we confirm that we believe it meets the requirements as set out in the regulations.	Noted	

Who	What	Outcome	Date
North Yorkshire County Council	**Question 2:** Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? Yes, although it might be worth noting that access to pharmacies by residents living to the North of Leeds may be enhanced by provision in North Yorkshire (the towns of Harrogate, Tadcaster in the main). The North Yorkshire draft PNA has concluded that no changes are required to provision in these areas. **Question 3:** Do you think that the service gaps that have been identified in the draft PNA are the right ones? No gaps in service identified so yes **Question 4:** Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? No	Noted Noted Noted Noted	01-02-18