

Derby City & Derbyshire County Pharmaceutical Needs Assessment 2015



Version History			
Version	Date	Review by	Authors
1.0	January 2015	March 2015	Chris McManus

CONTENTS

1. Executive summary
2. Introduction
 - 2.1 Wider Context.
 - 2.2 PNA development in Derby City and Derbyshire County Councils
3. Overview of Current Pharmaceutical Services Provision in Derby and Derbyshire
 - 3.1 Essential services
 - 3.2 Advanced services
 - 3.3 Locally commissioned services
 - 3.4 Out of hours provision
 - 3.5 Dispensing practices
 - 3.6 Dispensing Appliance Contractors
 - 3.7 Out of area providers of pharmaceutical services
 - 3.8 The effectiveness of pharmacy services
 - 3.9 Determination of localities for the PNA
 - 3.10 Current provision of community pharmacy services by district
4. Overview of findings from the public consultation on needs
5. Derby City Profile
 - 4.1 Introduction
 - 4.2 Population and other characteristics
 - 4.3 Key findings
 - 4.4 Future housing developments
 - 4.6 Current provision
6. Derbyshire County Profile
 - 5.1 Introduction
 - 5.2 Key challenges
 - 5.3 Population and other characteristics
 - 5.4 Key findings
 - 5.5 Future housing developments
7. Locality profiles and pharmaceutical provision
 - 6.1 Amber Valley
 - 6.2 Bolsover
 - 6.3 Chesterfield
 - 6.4 Derbyshire Dales
 - 6.5 Erewash
 - 6.6 High Peak
 - 6.7 North East
 - 6.8 South
8. Summary

9. APPENDICES

1. Steering Group Terms of Reference
2. List of pharmacies by District and services provided
3. Public consultation questionnaire
4. Summary of response to public consultation
5. Formal Consultation
6. Pharmacy opening hours
7. List of Dispensing GP practices
8. Locally Commissioned Services - further analysis (Derby City)

Derby City & Derbyshire County Pharmaceutical Needs Assessment 2015

1. EXECUTIVE SUMMARY

The local Pharmaceutical Needs Assessment (PNA) is a document that outlines services and ensures that pharmaceutical services across Derby and Derbyshire both meet the needs of the population and are in the correct locations to support residents.

The PNA became the responsibility of the local authorities following the Health and Social Care Act 2012 and replaces the previous PNA published by Primary Care Trusts in 2010. NHS England will use the PNA as the basis for informing decisions when applications for new pharmacies are received and for commissioning of new services within community pharmacies.

This report includes an overview of the pharmacy regulations relating to pharmacy needs assessment in addition to a review of the range of pharmaceutical services that are currently provided or may be commissioned in the future. The geographical area of the County has been divided into districts for the purpose of reviewing health needs and service provision at local level. Derby City is treated as a single entity.

Pharmaceutical services are provided by Community Pharmacies, Dispensing GP Practices and Dispensing Appliance Contractors.

The County has 161 community pharmacies, 21 Dispensing GP practices and 2 Dispensing Appliance Contractors (DACs); Derby has 63 community pharmacies.

In addition to their traditional role of providing prescription medicines, community pharmacies are important providers of additional health services to their communities such as medicines reviews and smoking cessation.

A comprehensive range of sources have been used to describe the health and social conditions of the district populations. This document provides details of:

- Population demographics: age, deprivation and health needs
- Public survey of pharmacy needs
- Number and location of community pharmacies, dispensing GP practices, DACs and the services provided
- Analysis of any gaps in necessary services
- Analysis of any gaps in locally commissioned services or access to services
- Impact of population changes and house building
- A description of any NHS service (or similar) which may affect pharmaceutical need
- Formal consultation on final draft PNA

Conclusion

The current mix of community pharmacies, dispensing GPs and Dispensing Appliance Contractors provides a comprehensive range of services to their local populations. Analysis of health needs and a public consultation did not provide any evidence of a lack of capacity in existing pharmacies. Housing projections in the short to medium term (3-5 years) are not expected to exceed current capacity. Access and levels of service in rural areas will need to be closely monitored: although currently adequate the loss of a single pharmacy could have significant effects.

The PNA will be reviewed 2018 unless there are significant changes to local need or provision.

2. INTRODUCTION

Background to Pharmaceutical Needs Assessment

The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWB) with defined statutory duties in every council. The Board includes leaders from the local health and social care system who work together to improve the health and wellbeing of their local population and reduce health inequalities. Each upper tier and unitary authority has its own Health and Wellbeing Board and one of their responsibilities, transferred from PCTs, is the development and updating of Pharmaceutical Needs Assessments (PNAs).

This PNA replaces the Derby City PCT and Derbyshire County PCT Pharmaceutical Needs Assessments published in 2010. The PNA is used by NHS England to identify the pharmaceutical needs of the local population and to support the decision making process for pharmacy applications. It will also be used to inform the planning of other services that can be delivered by community pharmacies to meet the health needs of the population.

Legislative Background

Pharmaceutical Needs Assessment is covered by regulations issued by the Department of Health¹, which set out the legislative basis for developing and updating PNAs.

Under the 2013 regulations, a person who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a relevant list.

Each Health and Wellbeing Board must:-

- assess the need for pharmaceutical services in its area;
- publish a statement of its first assessment and of any revised assessment.

The regulations contain the following requirements for PNAs:-

- It outlines the information that must be provided.
- The extent to which the PNA must take account of likely future needs.
- The date by which a HWB must publish their first PNA.
- The circumstances in which a HWB must make a new PNA.

In particular, the regulations determine:-

- the pharmaceutical services to which a PNA must relate;
- which specific persons and bodies must be consulted about specific matters when making an assessment;
- the manner in which an assessment is made;
- which matters a HWB must have regard to when making an assessment.

¹Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013

2.1 Wider Context

The Health and Social Care Act 2012 also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for HWBs in relation to Joint Strategic Health Assessments (JSNAs). The aim of the JSNA is to describe the health and wellbeing of the local community and support the reduction of inequalities. They are not an end in themselves, but a continuous process of strategic assessment for the health and wellbeing needs of the local population. They will be used to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to improve health outcomes and address health inequalities.

The preparation and consultation on the PNA should take account of the JSNA and other relevant strategies, such as the children and young people's and families plan, the local housing plans and the crime and disorder strategy in order to prevent duplication of work and multiple consultations with health groups, patients and the public. The development of PNAs is a separate duty to that of developing JSNAs as PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and by NHS England and clinical commissioning groups (CCGs). As such they cannot be subsumed as part of these other documents but can be annexed to them.

2.2 PNA development in Derby and Derbyshire

The Directors of Public Health are the HWB members accountable for the development of the Pharmaceutical Needs Assessment. County and City Public Health teams worked closely on the development of this PNA to ensure consistency of approach and to make effective use of scarce resources.

A task and finish group was established to direct the work programme to produce the PNA and met every 2 months. The group was chaired by the public health strategic lead for the JSNA in the County and had representation from:-

- Derbyshire Local Pharmaceutical Committee
- NHS England (Derbyshire & Nottinghamshire Area Team)
- NHS England (South Yorkshire and Bassetlaw Area Team)
- NHS Erewash CCG
- NHS Hardwick CCG
- NHS North Derbyshire CCG
- NHS Southern Derbyshire CCG
- NHS Tameside & Glossop CCG
- Public Health, Derby City Council

Terms of Reference for the group are available in *Appendix 1*.

The work programme consisted of 4 stages:-

- Collation of current and future health needs of the population and pharmacy data
- Compilation of up-to-date pharmacy locations and services commissioned by NHS England, Clinical Commissioning Groups (CCGs) and Local Authorities (Appendix 2)
- Public consultation on current service provision to understand public perception of pharmaceutical provision/services (Appendices 3 & 4). This was conducted both utilising

and on-line and paper questionnaires and promotion was conducted both by individual providers and social marketing techniques by commissioning organisations and Healthwatch in the City and County.

- Formal consultation with wider stakeholders.

The regulations stipulate that HWBs must consult formally for a minimum period of 60 days on a draft of their PNA at least once during its development and lists the persons and organisations that must be consulted.

In accordance with the regulations, HWBs, as a minimum, must publish a statement of revised assessment within 3 years of the publication of this document in April 2015. In addition, HWBs will make a new assessment of pharmaceutical need as soon as is reasonably practicable, should it identify any significant changes to the availability of pharmaceutical services that have occurred since the publication of the 2015 PNA. This will be undertaken only where, in the board's view, the changes are so substantial that the publication of a new assessment is a proportionate response.

In accordance with the regulations, a supplementary statement explaining any significant changes to the availability of pharmaceutical services since the publication of this PNA will be issued where the change does not warrant a complete review of the PNA.

All supplementary statements will be published with the PNA on [Derbyshire Observatory](#)

3. OVERVIEW OF CURRENT PHARMACEUTICAL SERVICES PROVISION IN DERBY AND DERBYSHIRE

There are 247 pharmaceutical providers including 224 community pharmacies, 21 dispensing practices and 3 Dispensing Appliance Contractors in Derby and Derbyshire.

3.1 Essential services

Under the community pharmacy contractual framework essential services are defined as those services or core activities that must be provided by all community pharmacy contractors. These are nationally agreed services and are not open to local negotiation. These include:-

- dispensing of medicines
- repeat dispensing
- disposal of waste / unwanted medication
- promotion of healthy lifestyles (Public health)
- signposting of patients
- support for self-care
- clinical governance

All of the 224 of the community pharmacies in Derby and Derbyshire provide these services in accordance with the requirements of the national community pharmacy contractual framework.

Dispensing appliance contractors provide dispensing, repeat dispensing and meet contractual clinical governance requirements.

3.2 Advanced services

Advanced services are nationally specified. Community Pharmacies can choose whether or not to undertake advanced services. Advanced services require the premises to be accredited by NHS England. There are currently 4 advanced services specified.

- The Medicines Use Review (MUR) and Prescription Intervention Service consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions.
- The New Medicines Service provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence.

Appliance contractors (and pharmacies providing an appliance dispensing service) may also offer to provide the following advanced services:-

- Stoma Appliance Customisation aims to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste;
- Appliance Use Reviews aim to improve the patient's knowledge and use of any specified pharmaceutical appliance in their own home.

200 of the 224 of the community pharmacies in Derby and Derbyshire offer the MURs service in accordance with the requirements of the national community pharmacy contractual framework (Table 3.2). 161 offer the New Medicines Service.

3.3 Locally commissioned services

Locally commissioned services can be commissioned by a number of routes - by NHS England, Clinical Commissioning Groups or Local Authorities. These services are optional and the pharmacies taking part in the locally commissioned services are shown in Appendix 2. See Table 3.2 for a summary of services offered in each district.

As of 31st March 2015 the Derbyshire & Nottinghamshire NHS England Area team commissions:

- Palliative Care Drug Stockist Scheme
- Out of Hours roster
- Emergency supply of prescription medicines service

Derbyshire County Council commissions the following services from community pharmacies (see appendix 2):

- Oral Emergency Contraception (OEC)
- Supervised Consumption (Substance Misuse Services)
- Needle Exchange (Substance Misuse Services)

Smoking cessation services formerly commissioned directly from pharmacies are now commissioned via Derbyshire Community Health Services NHS (DCHS). DCHS are currently recruiting pharmacies to provide smoking cessation advice and nicotine replacement therapy (see http://www.dchs.nhs.uk/home/healthy-you/livelifebetterderbyshire/stop_smoking1 for progress. From 1st April 2015, OEC provision is part of the Derbyshire Integrated Sexual Health Service. The Primary Contractor (DCHS) will sub-contract OEC provision from Community Pharmacies, as well as being responsible for managing and reviewing delivery of the OEC service (coverage, training of practitioners, patient group directions, quality, governance, performance and payments). Current community pharmacy OEC providers can opt to continue to deliver under these new arrangements, in line with the specified standards and key performance indicators.

Derby City Council commissions the following services from community pharmacies (see appendix 2):

- Oral Emergency Contraception (currently restricted to under 18 year olds)
- Supervised Consumption (Substance Misuse Services)
- Needle Exchange (Substance Misuse Services)

Support for lifestyle change around issues such as smoking, obesity, physical activity and alcohol consumption is now provided in the city through an integrated behaviour change programme delivered by Livewell. It provides support to individuals and their family over a sustained 12 months health coaching period to ensure change is embedded. Often people have more than one issue they want to change, this approach allows individuals to do this through one service.

To support the aim of reducing teenage pregnancy in the city, access to emergency contraception provided through community pharmacies was changed from being available to all women to those aged under 18 years from April 1 2014. For all women, including those aged 18 and above, provision continues to be available through GP services and Contraception and Sexual Health Service and can also be paid for through pharmacies.

Derbyshire CCGs directly commission local services from community pharmacies (see appendix 2) as follows:-

Erewash CCG:-

- Medication Administration Record Sheets
- Anticoagulants – INR testing

Hardwick CCG:-

- Medication Administration Record Sheets
- Anticoagulants – INR testing

North Derbyshire CCG:-

- Medication Administration Record Sheets

South Derbyshire CCG:-

- Medication Administration Record Sheets
- Gluten-free food service (Amber Valley only)
- Anticoagulants – INR testing

3.4 Out of Hours provision

There are 22 pharmacies open for 100 hours or more per week and 3 which offer a service until midnight Monday to Saturday (a fourth opens until 23:00). Out of hours prescribing is undertaken by Derbyshire Healthcare United (DHU) in most of the area except for the area around Glossop, which is covered by GTD Healthcare.

100 hours pharmacies provide a valued service which is useful to patients requiring pharmaceutical services in the out-of-hours period. The opening hours (current as of August 2014 and subject to change) of all 224 pharmacies in Derby and Derbyshire are shown in Appendix 6.

3.5 Dispensing practices

Dispensing practices provide dispensing services in rural areas where patients may have difficulty accessing a community pharmacy and where it is not viable for a community pharmacy to operate.

There are 21 dispensing practices in Derby and Derbyshire and these are listed in Appendix 7.

3.6 Dispensing Appliance Contractors

Dispensing appliance contractors (DAC) are unable to supply medicines. Most specialise in supplying stoma appliances.

NHS England currently has three dispensing appliance contractors in Derby and Derbyshire included on its own pharmaceutical list.

- Daylong, 10 Cossall Industrial Estate, Ilkeston, Derbyshire, DE7 5UG
- Fittleworth Medical Ltd, Unit 8, Tomlinson Industrial Estate, Alfreton, Derbyshire, DE21 4ED
- Salts Healthcare Ltd, Holywell House Annexe, Holywell House, Chesterfield, S41 7SH

A new contract for appliance contractors was published in April 2010, which allows appliance contractors to provide Appliance Use Reviews (AUR) and stoma customisation services (SCS). Community Pharmacies who dispense appliances can also choose to provide these advanced services. NHS England will ensure that, whilst the requirement for such services is low, people who need to access these services can do so within the City and County boundaries.

3.7 Out of area providers of pharmaceutical services

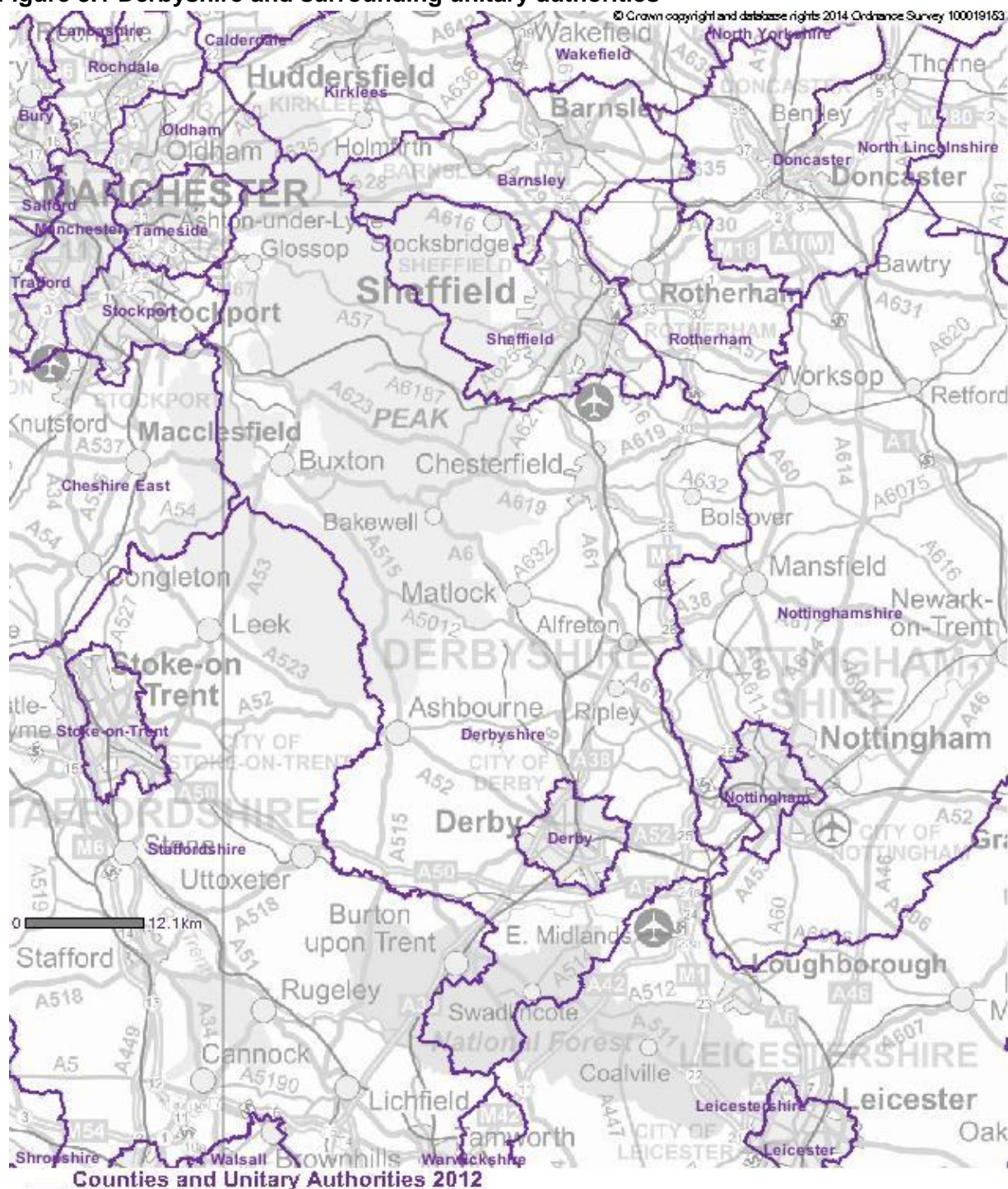
The Pharmacy Regulations require Local Authorities (LA) to identify any pharmaceutical services that are provided outside the area of the LA, and do not contribute towards meeting the need for pharmaceutical services in the LAs area, but which have secured improvements, or better access, to pharmaceutical services within its area.

To meet this requirement, consideration has also been given in this assessment to pharmaceutical services provided by community pharmacy contractors on neighbouring pharmaceutical lists.

In terms of neighbouring Councils, Derby City has direct borders with only Derbyshire County. Derbyshire has boundaries with Kirklees, Barnsley, Sheffield, Rotherham, Nottinghamshire, Leicestershire, Staffordshire, East Cheshire, Stockport, Tameside and Oldham (Figure 3.1).

Further analysis of prescribing data indicates that the number of prescriptions dispensed by pharmacies outside the County or City is small (less than 5%) and consistent with known commuter and shopping activity. It was therefore decided that there was no significant impact on the provision of pharmaceutical services across the County.

Figure 3.1 Derbyshire and surrounding unitary authorities



This material is Crown Copyright. You may re-use this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence. Information Policy Team, The National Archives, Kew. When reproducing this material, the source should be acknowledged.

3.8 The effectiveness of pharmacy services

Public Health England have reviewed the effectiveness of delivering public health services in a pharmacy setting (Consolidating and developing the evidence base and research for community pharmacy's contribution to public health: a progress report from Task Group 3 of the Pharmacy and Public Health Forum, John Newton, Chief Knowledge Officer, on behalf of Task Group 3 of the Pharmacy and Public Health Forum, December 2013).

A systematic search was carried out of electronic databases in the period from August 2002 and August 2012, restricted to the English language. The search focused on reviews rather than individual or primary studies and included the grey literature including websites such as Department of Health, Royal Pharmaceutical Society, Pharmaceutical Services Negotiating Committee, General Pharmaceutical Council and contributions from the Pharmacy and Public Health Forum.

Good evidence of effective in a pharmacy setting was found for:-

- Stop smoking services
- Oral Emergency Contraception in terms of timely access, though less evidence on outcomes, i.e. reducing teenage pregnancy rates
- Chronic disease management - community pharmacists can make an important contribution to the management of people with diabetes for screening, improved adherence with medicines and reduced blood glucose levels or HbA1c

Moderate quality evidence of effectiveness in a pharmacy setting was found for:-

- Methadone supervision
- Needle exchange schemes

More evidence of effectiveness in a pharmacy setting is required for:-

- Weight Management programmes
- Drug and alcohol misuse
- Minor ailments schemes

No reviews were available for:-

- Immunisations, but recent evidence on this suggests inclusion of trained community pharmacists in the care of intravenous drug users attending to obtain methadone substitution treatment, improved testing and subsequent uptake of hepatitis vaccination.

3.9 Determination of Localities for the PNA

In accordance with the regulations, the PNA group considered how to assess the differing needs of the localities in the area. It concluded that the best approach was to divide Derbyshire into 8 District and Borough Councils, with Derby City as a separate entity.

A summary of demographic information for the County was produced. A locality profile for each of the 8 district councils was extracted from JSNA geo-profiles and prepared for Derby City (Figure 3.2).

A public survey to seek views on pharmaceutical need was carried out between November and December 2014. The survey was provided on line and on paper accessible in pharmacies. Survey results were considered in the overall assessment of need.

Pharmaceutical need was assessed for each district. The level of need in necessary pharmaceutical provision was assessed. Other areas where community pharmacy could contribute to improving health needs in line with Local Authority priorities were also identified.

Figure 3.2 Map of Derbyshire Councils

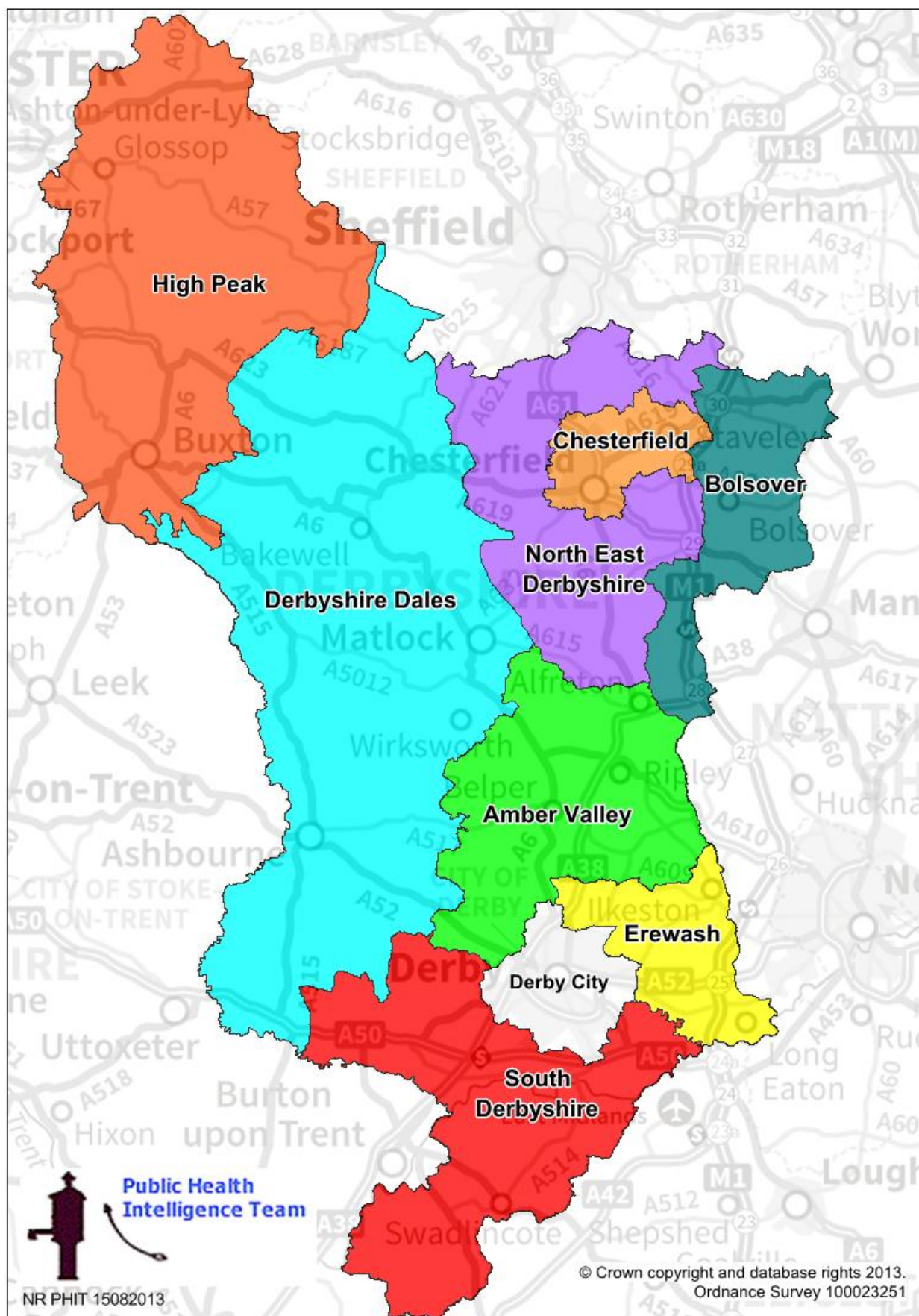
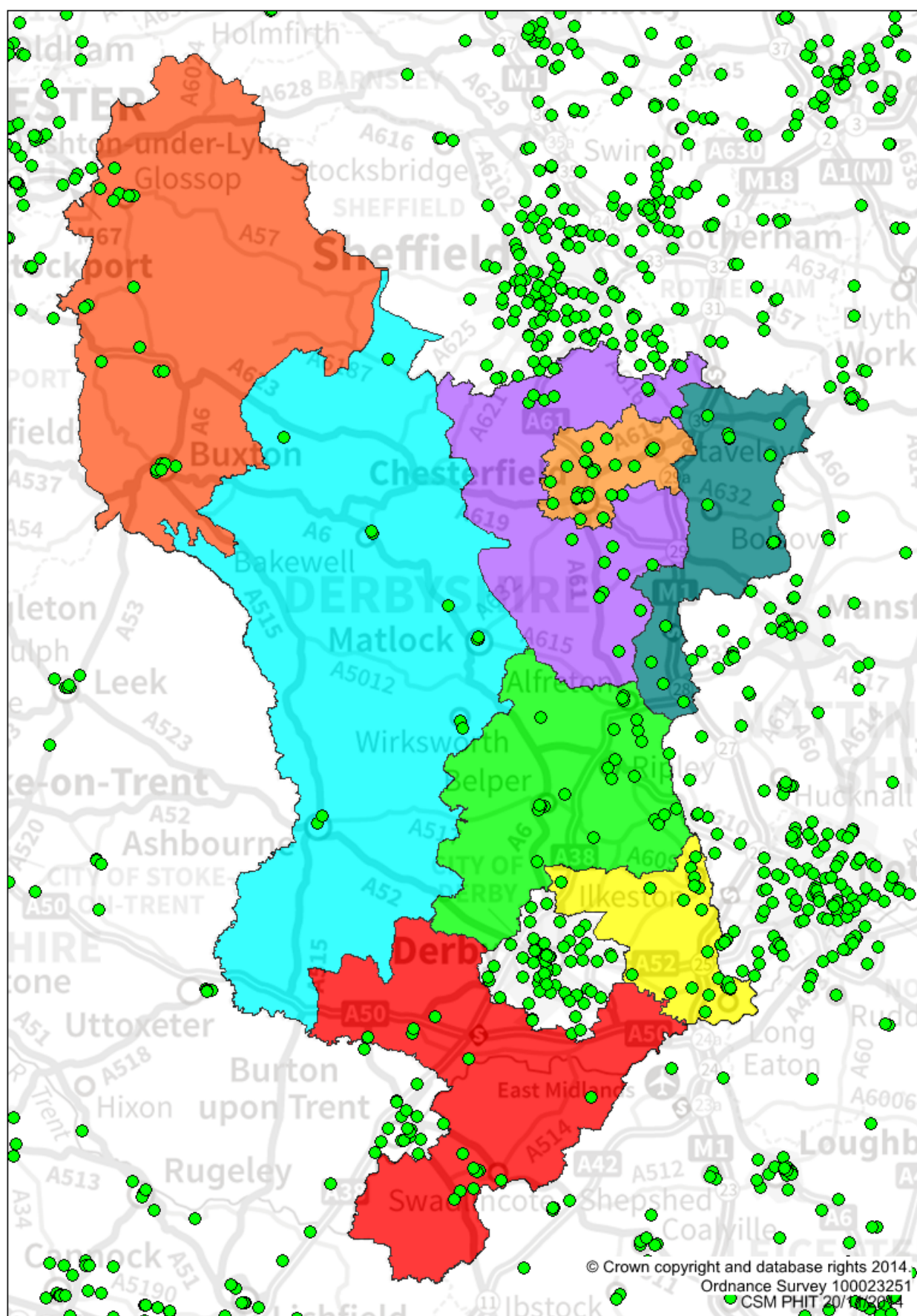


Figure 3.3: Derby City, Derbyshire County and border pharmacies



3.10 Current provision of community pharmacy services

There are currently 224 community pharmacies (December 2014) across Derby and Derbyshire. Table 3.1 below shows the distribution of community pharmacies by District. In addition, there are 21 dispensing GPs and 3 Dispensing Appliance Contractors.

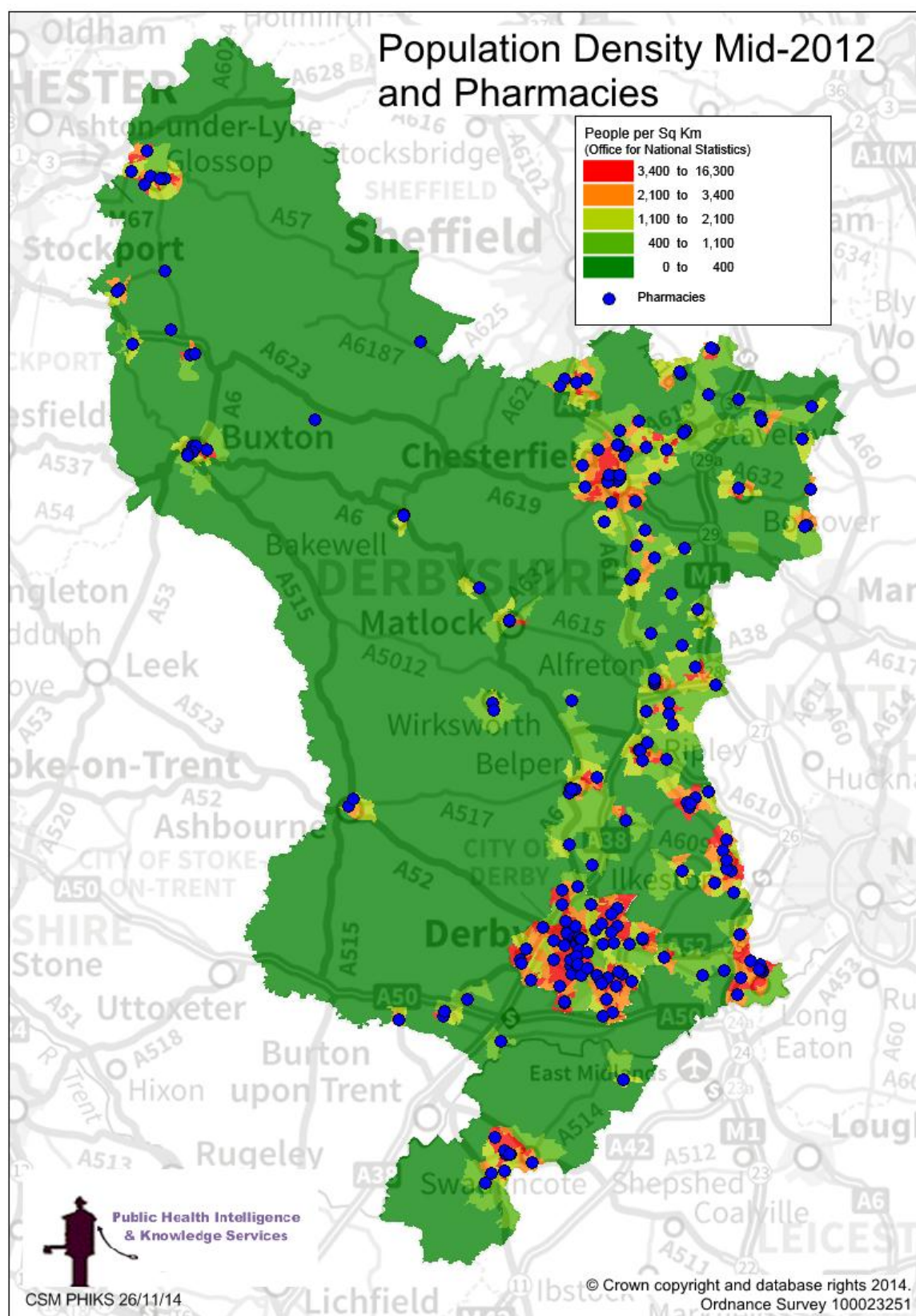
Table 3.1 Community Pharmacy Providers by District

Districts	No. Pharmacies	District Population	Pharmacies per 100,000 population
Amber Valley	27	122746	22
Bolsover	17	76447	22
Chesterfield	23	103782	22
Derbyshire Dales	12	71336	17
Erewash	26	112809	23
High Peak	21	91118	23
North East Derbyshire	20	99325	20
South Derbyshire	15	95959	16
County	162	773522	21
City	63	250568	25
England			22

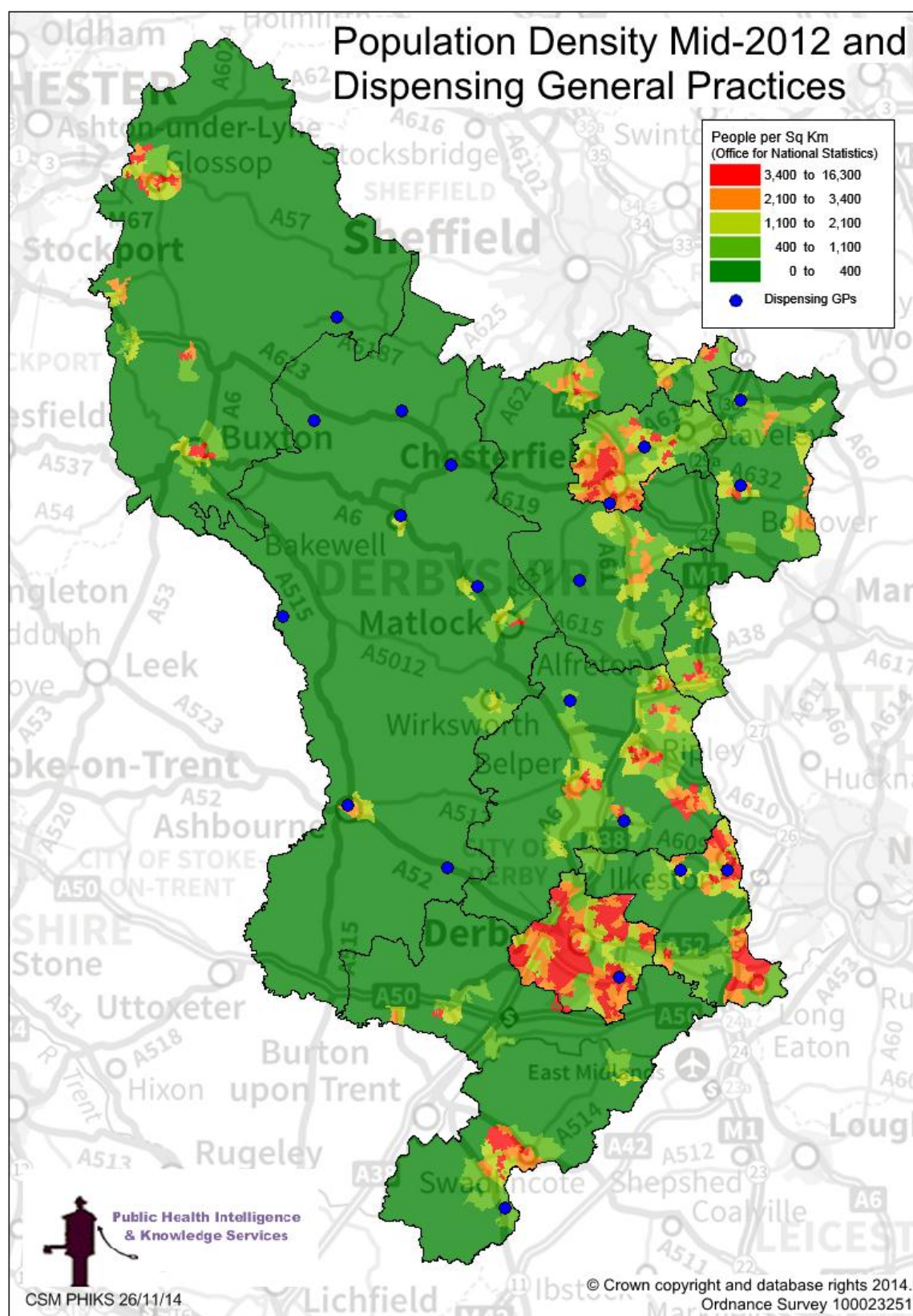
Table 3.1 shows the number of pharmacies in each district and the number of pharmacies per 100,000 population. Overall the number of pharmacies per head of population is similar to that for England as a whole (22). The lower concentration in South Derbyshire is likely to reflect the relatively high availability in the City and in neighbouring Burton-on-Trent. On the face of it, there does appear to be an underprovision of pharmacy services in Derbyshire Dales, however reference to the population density map shows that the population centres of this largely rural area are well covered. Derbyshire Dales also contains almost half of the dispensing General Practices in the area (9).

A wide range of services are provided by pharmacies across the City and County. Some services have been targeted at specific populations depending on health needs and so may not be available in every District. Pharmaceutical need will be considered at District level. Services provided by community pharmacies in each district are shown in table 3.2.

Figure 3.4: Population density and pharmacy location

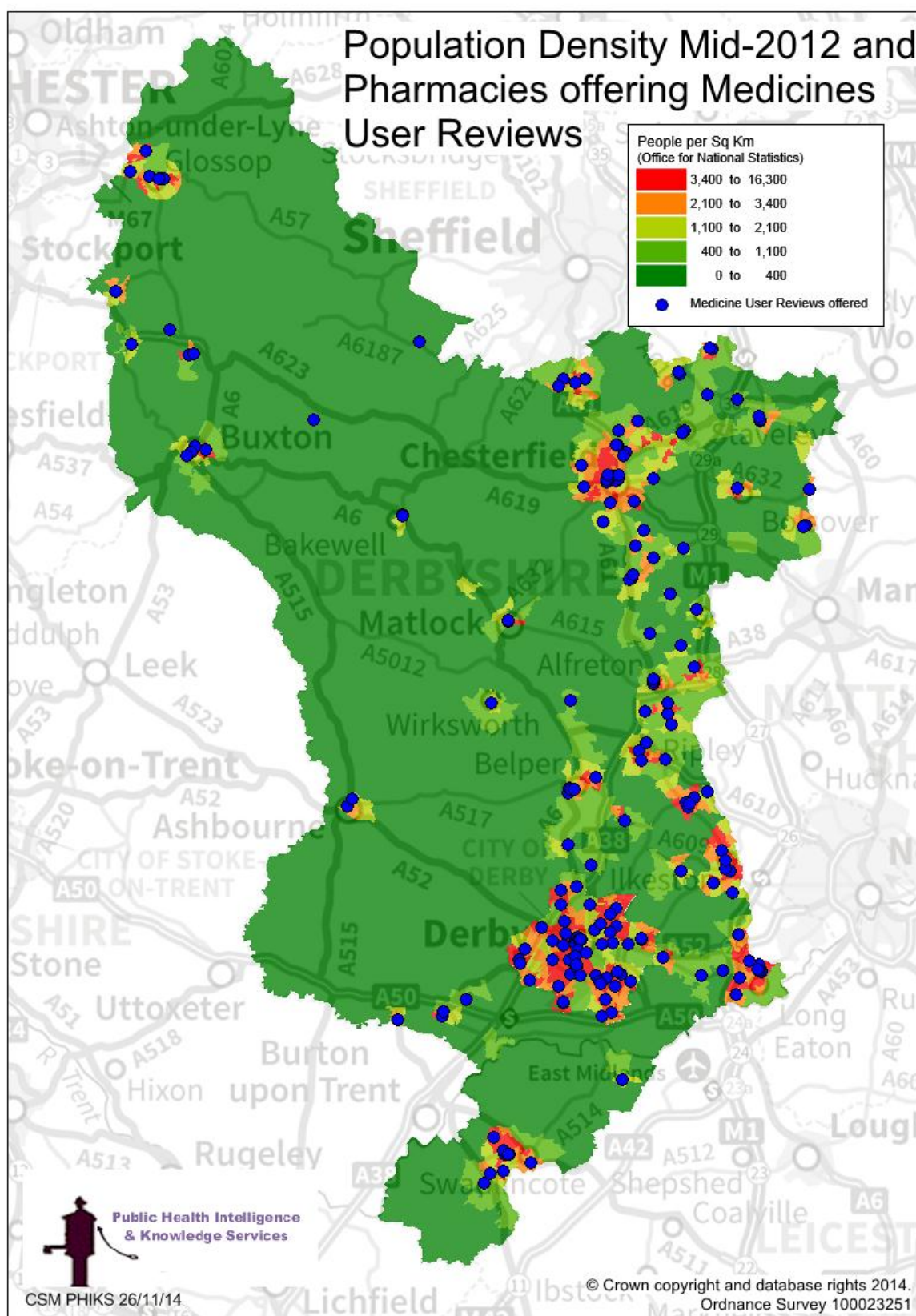


The map above shows the distribution of pharmacies compared with the distribution of the population. All areas of high population density have one or more pharmacies within them or nearby.

Figure 3.5: Population density and location of dispensing GPs

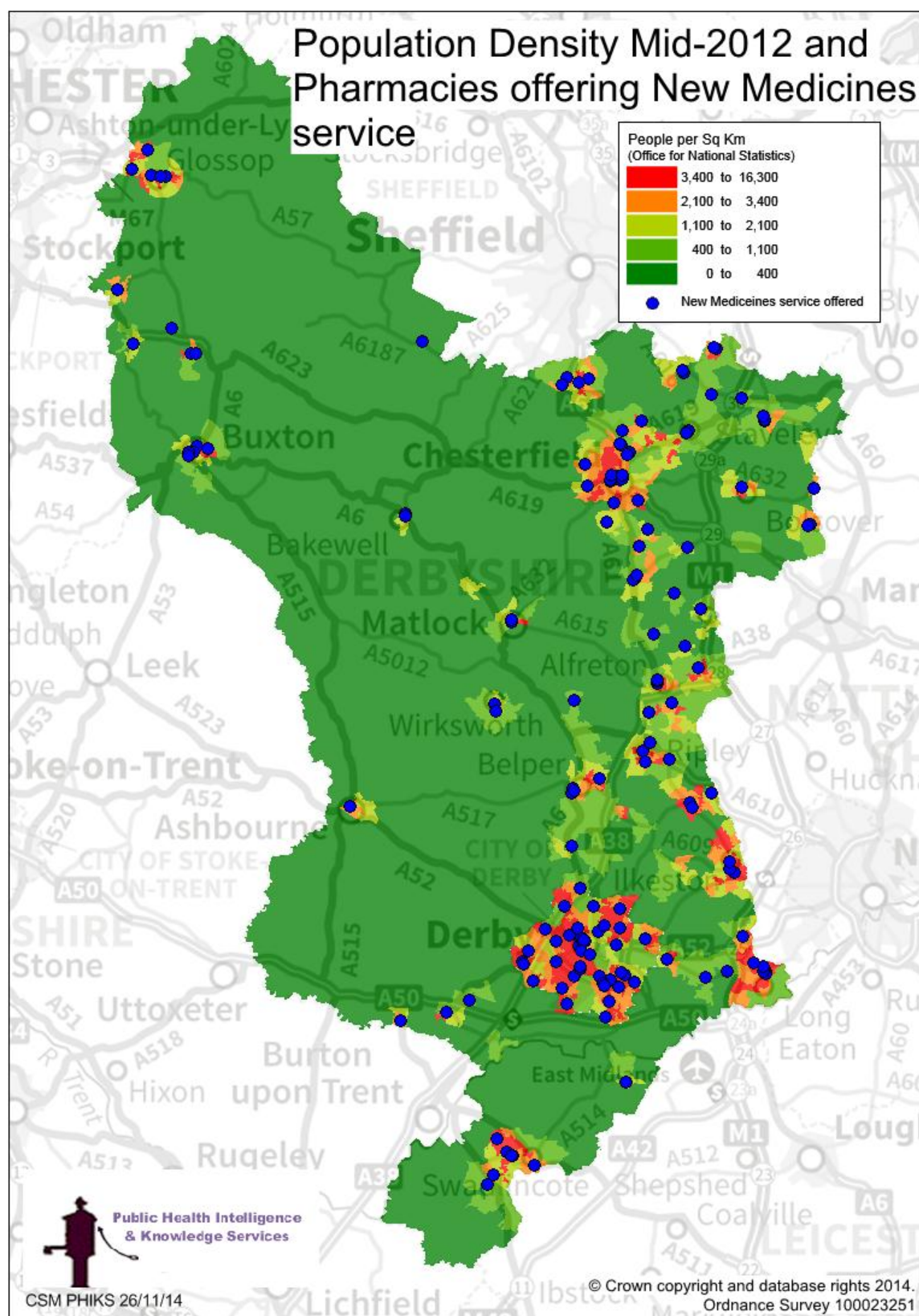
The map above shows the distribution of dispensing GP practices compared with the distribution of the population. Dispensing GPs tend to be located in less sparsely populated areas to make up for the lack of community pharmacies. Taken this in conjunction with preceding map it can be seen that the area is well-provided for in terms of dispensing services.

Figure 3.6: Population density and location of services: medicines use review



The above map shows the distribution of pharmacies offering Medicines User Reviews compared with the distribution of the population. Given that nine out of ten pharmacies within the area offer this it is unsurprising that there is widespread availability of the service.

Figure 3.7: Population density and location of services: new medicines service



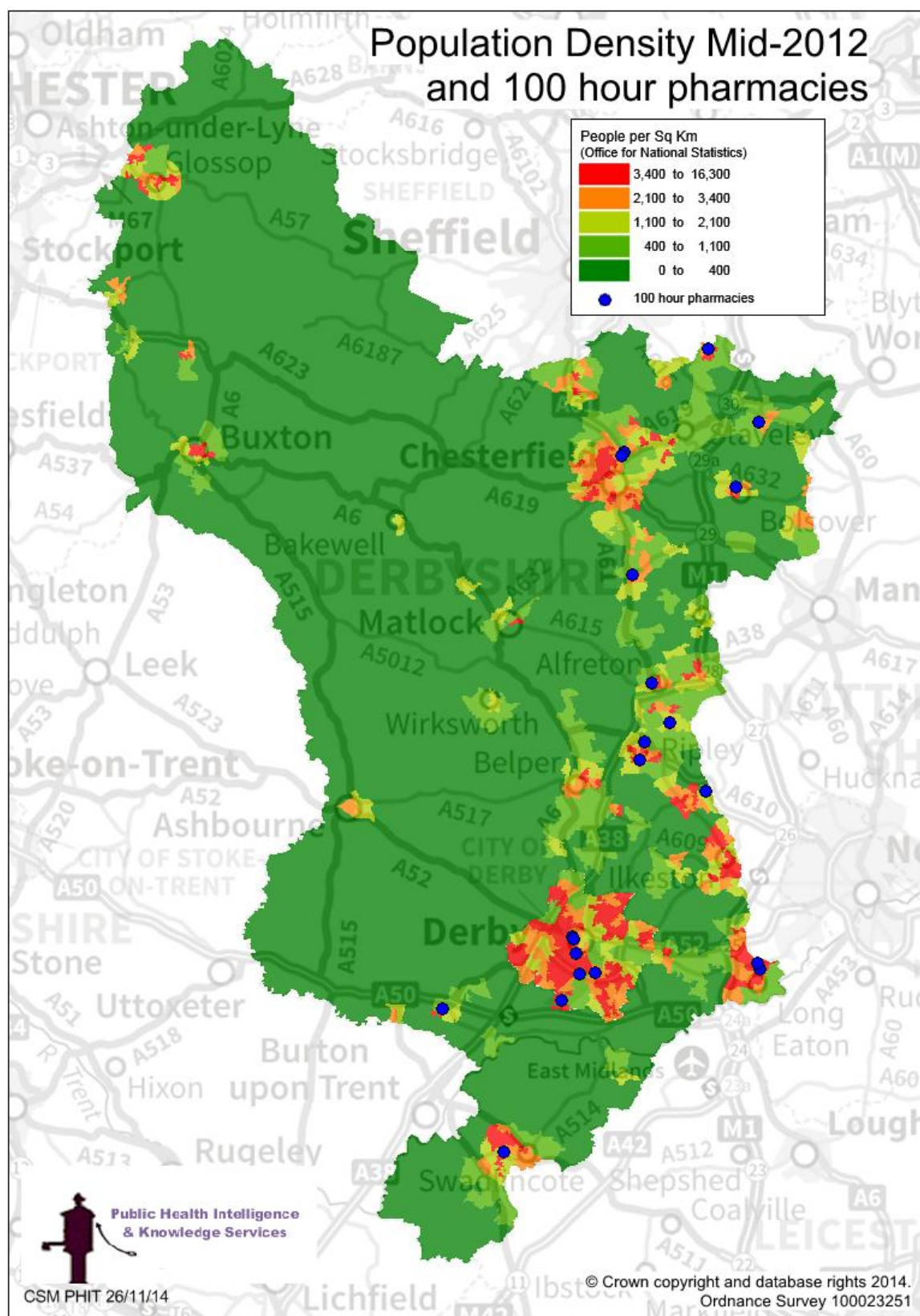
The above map shows the distribution of pharmacies offering the New Medicines service compared with the distribution of the population. Given that almost three quarters of pharmacies within the area offer this it is unsurprising that the most populated areas are well covered and that there is good access from other areas.

Table 3.2 Community Pharmacy Services in Derby and Derbyshire

Community Pharmacy Services	No. pharmacies	County	Amber Valley	Bolsover	Chesterfield	Dales	Erewash	High Peak	North East	South	City
MURs	200	144	26	14	19	10	25	16	20	14	56
New Medicines Service	161	118	19	12	19	9	14	16	18	11	43
100 hour pharmacy	22	16	5	2	2	0	3	0	2	2	6
Out of Hours	35	26	2	2	3	7	7	4*	1	4	5
Palliative Care	134	86	25	6	10	7	19	5*	7	12	42
Emergency Supply Service	182	119	25	14	20	9	22	12*	17	12	51
Public Health commissioned services:-											
Oral Emergency Contraception	147	101	17	5	15	10	14	11	15	14	46
Substance Misuse Service: Supervised Consumption	163	118	21	10	18	9	18	11	17	14	45
Substance Misuse Service: Needle exchange	56	40	6	4	6	3	5	6	6	4	16
CCG commissioned services:-											
MAR Sheets	154	109	23	6	15	8	21	7	15	14	45
Anticoagulants (INR testing)	8	8	2	1	0	0	2	0	0	3	0
Gluten-free food	24	24	23	0	0	0	1	0	0	0	0
Total	224	161	27	17	23	12	26	21	20	15	63
Dispensing GPs	21	20	2	2	2	9	2	1	1	1	1

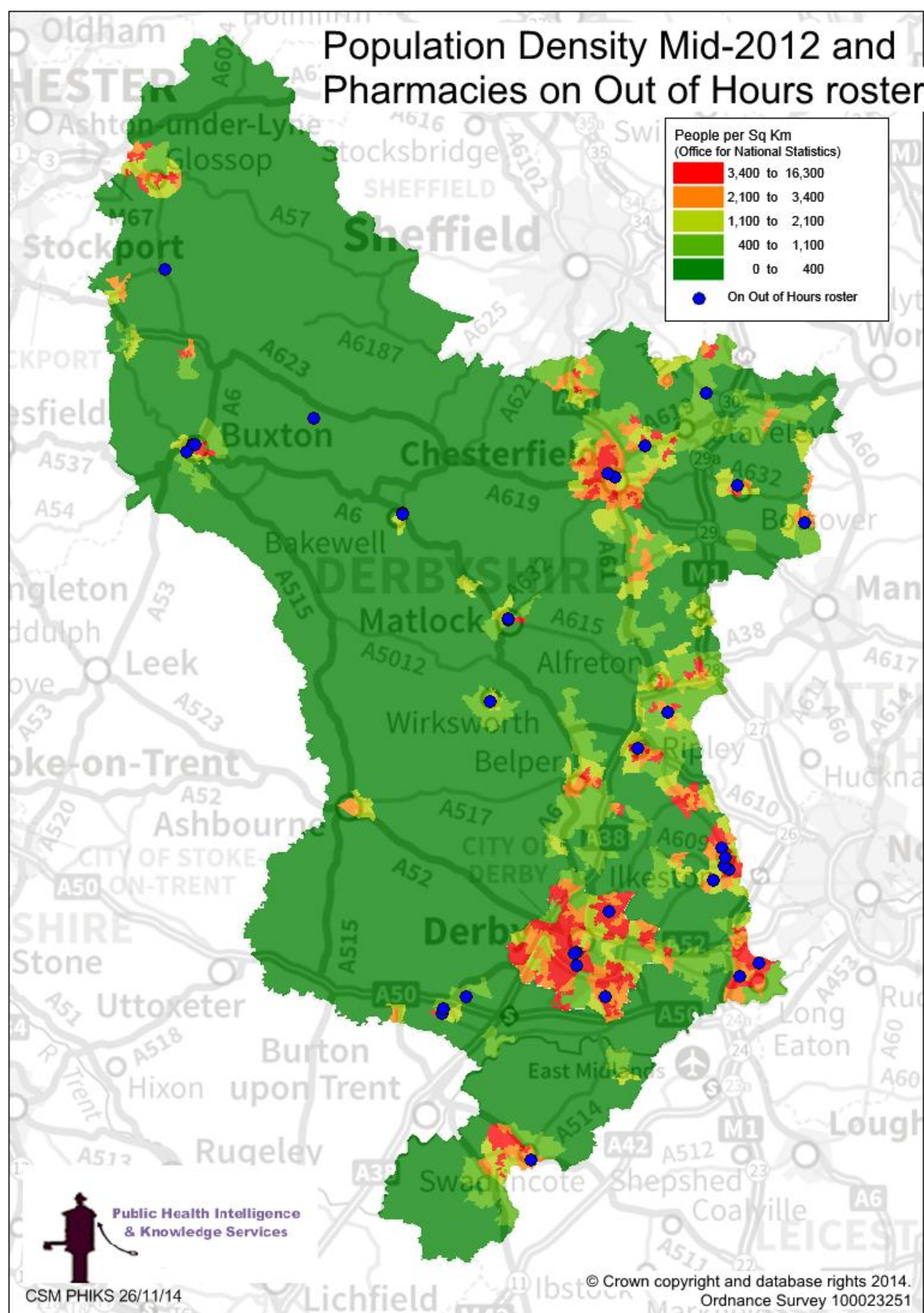
*Services commissioned by Greater Manchester LAT, from Glossopdale pharmacies, are as yet unknown.

Figure 3.8: Population density and location of 100 hour pharmacies



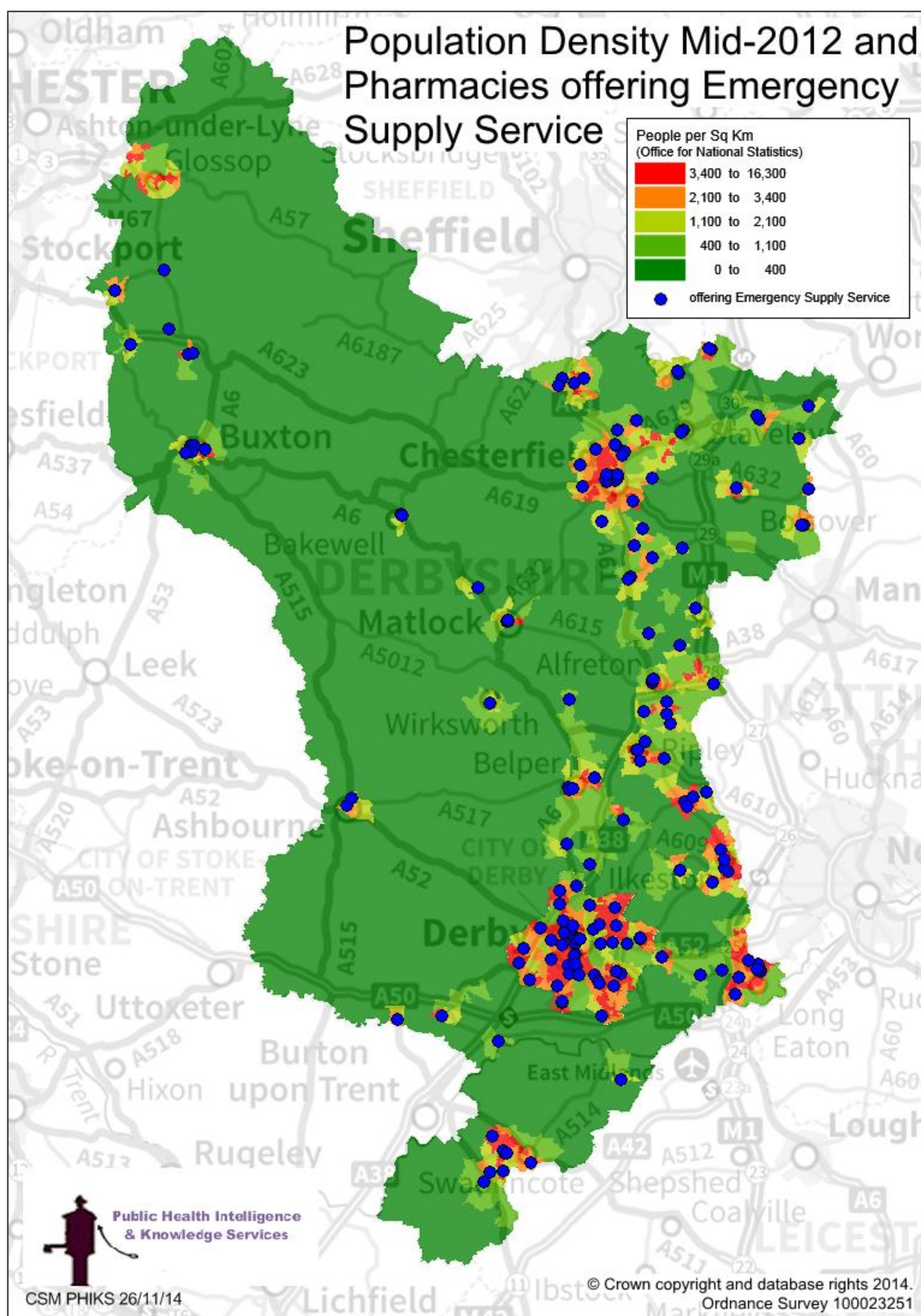
The above map shows the distribution of pharmacies open for 100 hours per week compared with the distribution of the population. This clearly shows there is adequate availability in the east of the area. Population centres in the west of the county may look to services outside the area.

Figure 3.9: Population density and location of services: out-of-hours roster



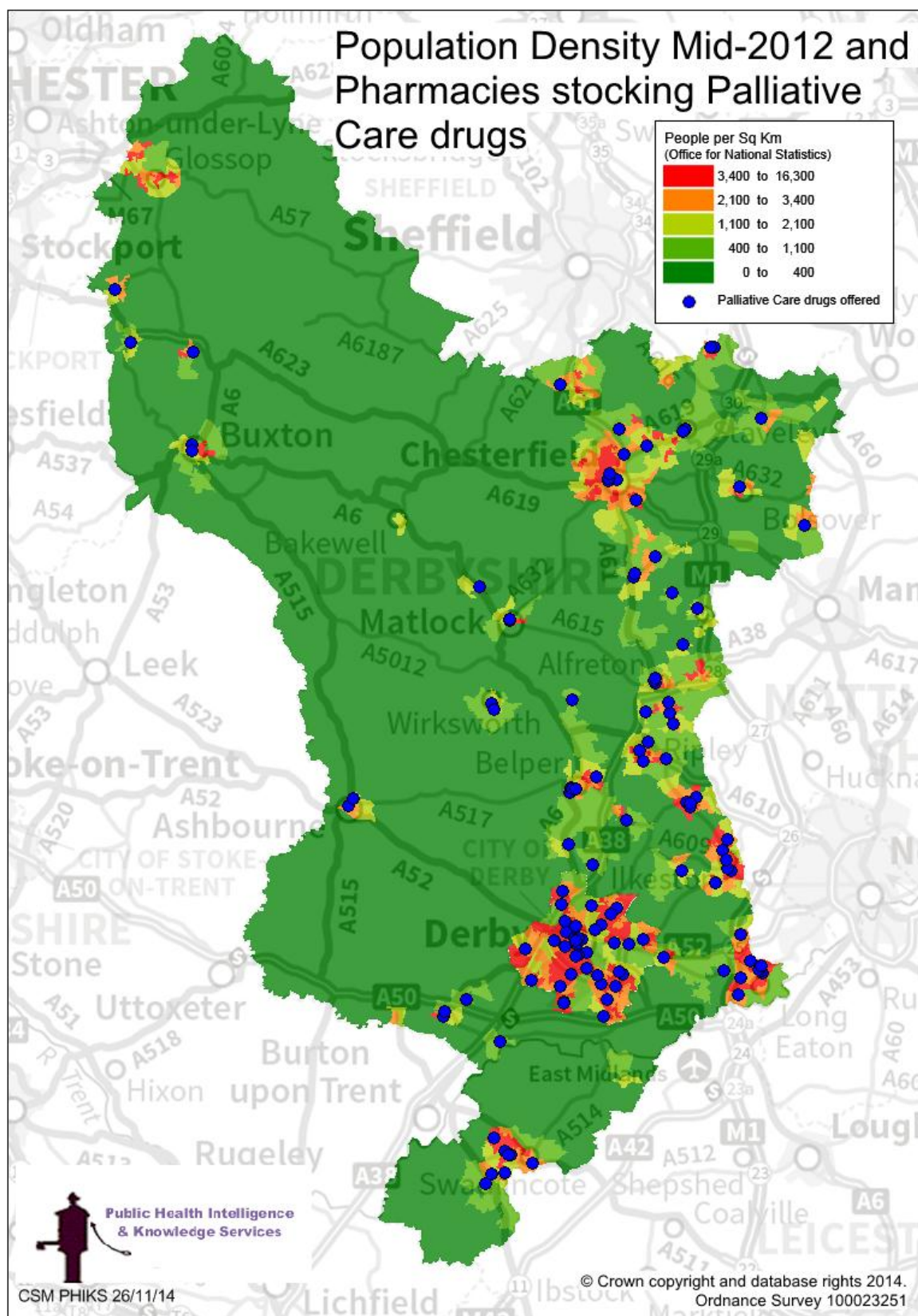
The map above shows the distribution of community pharmacies on the Out of Hours roster compared to the distribution of the population. This demonstrates an adequate availability of services to most of the population outside normal opening hours.

Figure 3.10: Population density and location of services: emergency supply service



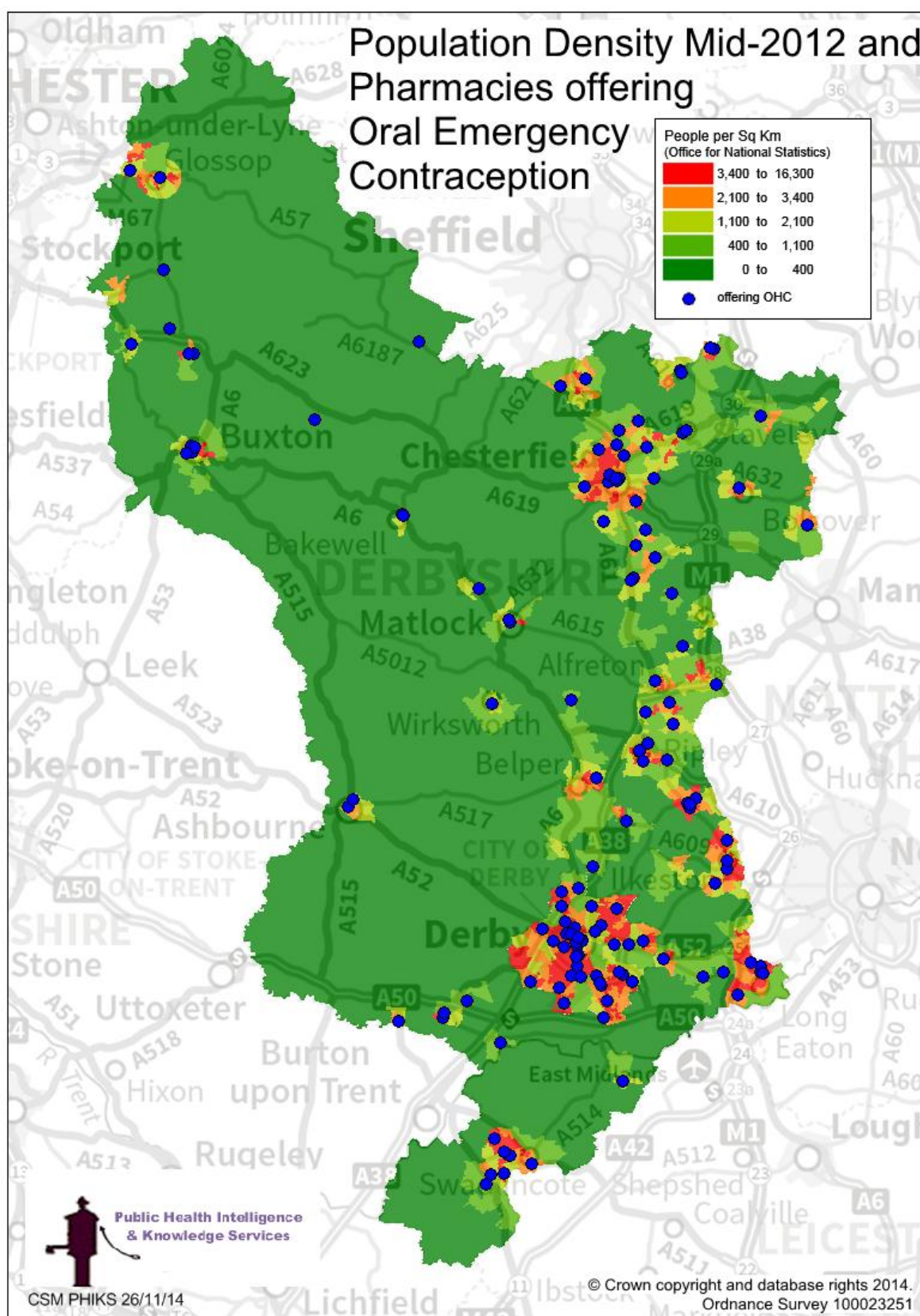
The map above shows the availability of community pharmacies who can offer an emergency supply of a patient's prescription drugs without them having to obtain a new prescription. The map demonstrates a good availability of this service across the area.

Figure 3.11: Population density and location of services: palliative care drugs stockist



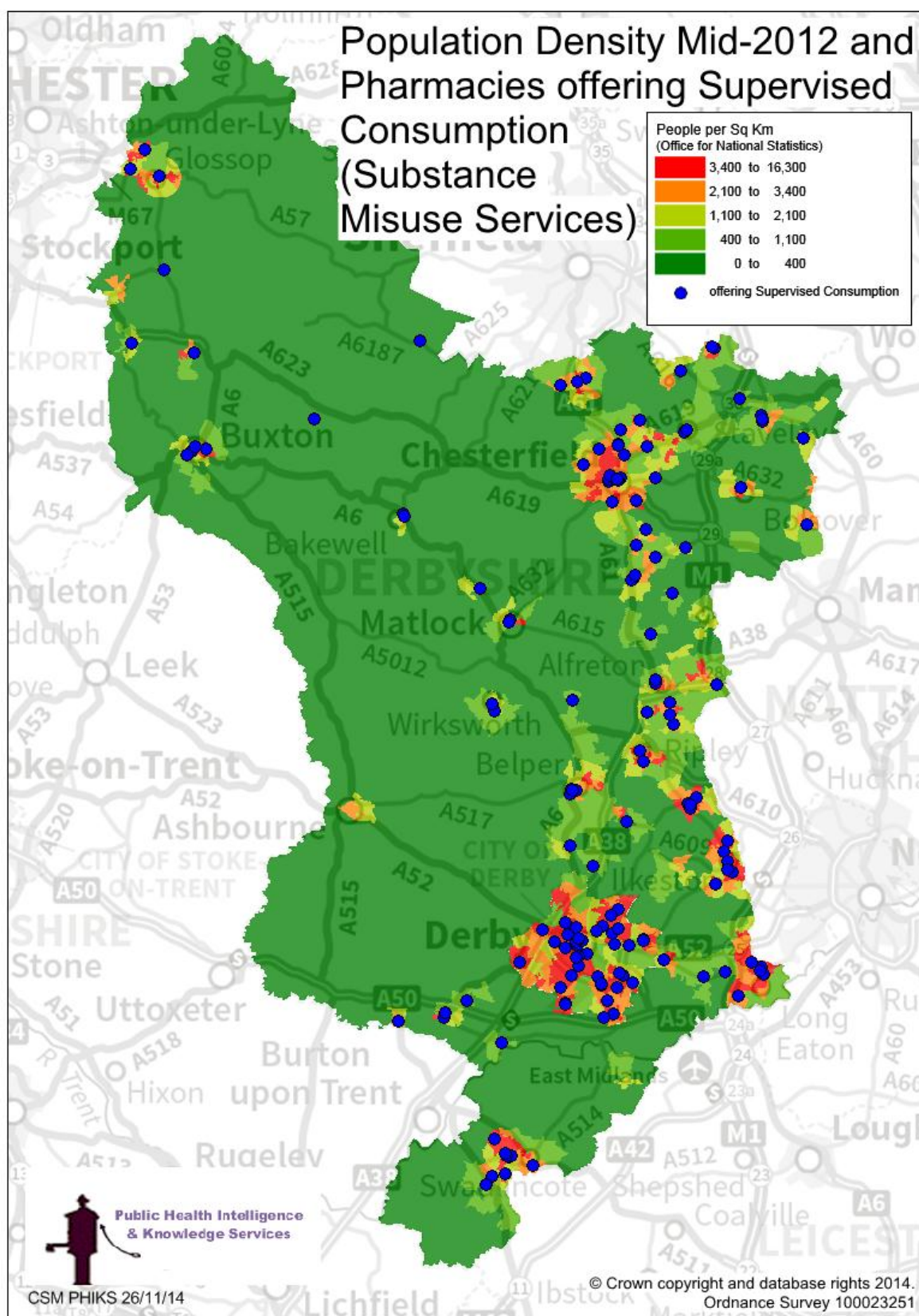
The map above shows the distribution of pharmacies stocking medicines for palliative care. It clearly demonstrates that the service is readily available throughout the area.

Figure 3.12: Population density and location of services: oral emergency contraception

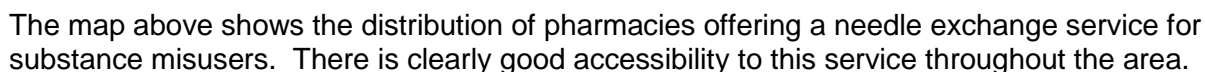


The above map shows the current distribution of pharmacies offering Oral Emergency Contraception. This shows a good availability of the service throughout the area. Please see section 3.3 for further information regarding the future of this service.

Figure 3.13: Population density and location of services: supervised consumption



The map above shows the distribution of pharmacies offering supervised consumption of methadone for substance misusers. There is clearly good accessibility to this service throughout the area.



4. RESPONSE TO PUBLIC SURVEY

The questionnaire used in the public survey into pharmaceutical need and satisfaction is in Appendix 3 with a full analysis of the responses in appendix 4. The survey was carried out as part of the needs assessment and was made available on line and in pharmacies and general practices across the City and County. The survey asked for people's views on their use of pharmacies, satisfaction with services and opening hours and the services they used. In view of the limited response it was decided that it would not be appropriate to make an analysis at locality level.

There were, altogether, 217 responses, of which 59% came from females and 41% from males. The mean age of respondents was 57, a reflection of the age at which people become both more frequent users of pharmacies and disposed to completing questionnaires. (Around half the responses were made via paper questionnaires). The biggest proportion, 15%, was in the 65-69 year age group. Only 18% of respondents considered themselves to be limited in their daily activities due to health or disability, considerably lower than expected. 42% of respondents were retired, 4% were not working because of illness. The vast majority of respondents (95%) described themselves as white.

The responses were generally positive with high levels of satisfaction with customer service, services available and opening hours. 93% were very or fairly satisfied with the service they received overall. Most people described themselves as users of community pharmacies, although there was some confusion as to what is a community pharmacy, resulting in some ticking the 'other' box. Most people used the same pharmacy all or most of the time, mostly because it was near to their home or GP, but with a majority also stating that this was because of friendly and knowledgeable staff. Most people said that they could get to the pharmacy of their choice. A majority of people visited their pharmacy once a month or more frequently. The majority of people said they went by car and 38% said they walked. Two-thirds travelled less than one mile to their pharmacy, but less than half said they would be prepared to travel no further than that.

The majority of people felt that they were able to access all the services at their pharmacy in the way they would choose. However 17% stated that they did not know what services were available. 58% said that their pharmacy offered a delivery service, but 35% did not know. Less than half of respondents had been offered or had a medicines use review in the last 12 months.

Asked which features and services of community pharmacy were important to them, a majority saw as very important to them: location, knowledgeable staff, friendly staff, staff who took time to listen to their needs, prescription dispensing, advice on medicines, and having medicines and products in stock. Also seen to be very or fairly important to a majority where: Saturday opening; a private consultation area, ordering repeat prescriptions, collecting prescriptions from GPs, over the counter medicines, disposal of waste medicines, medicines use reviews, advice on minor ailments and

illnesses, advice on long term conditions, signposting to other health and social care services.

Least valued seem to be smoking cessation, substance misuse, anti-malarial medication, oral emergency contraception, late, early and Sunday opening. This is likely to be heavily biased by the profile of responders to the survey, who might be considered unlikely to make use of these services themselves.

Table 4.1 Response to public consultation

District	Number of responses
Amber Valley	26
Bolsover	24
Chesterfield	18
Derbyshire Dales	27
Erewash	23
High Peak	15
North East Derbyshire	24
South Derbyshire	7
Derby City	25
Unknown	28

5. DERBY CITY PROFILE

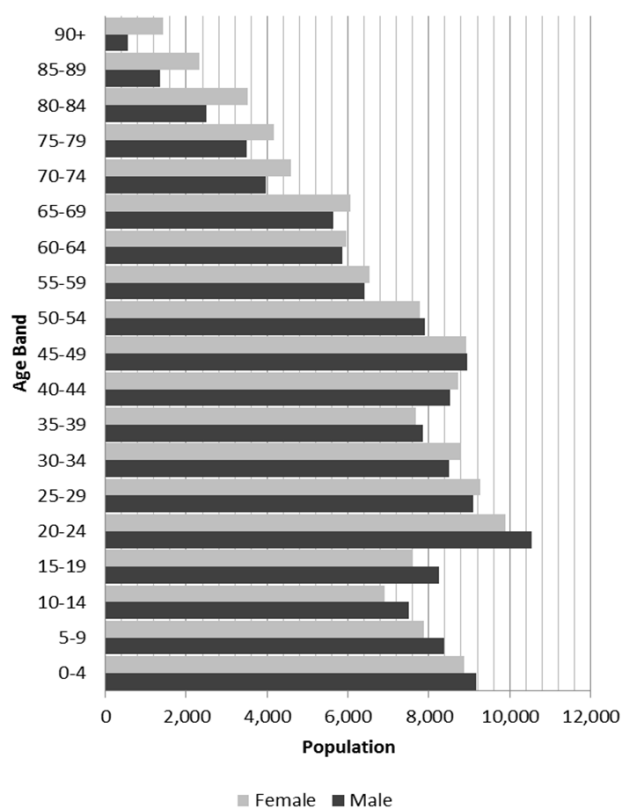
5.1 Introduction

Derby is a small, culturally diverse city with a population of 251,423 representing 182 nationalities, speaking 71 languages and 83 distinct dialects. It lies upon the banks of the River Derwent and is located in the south of the county of Derbyshire. It is an internationally renowned centre for advanced transport manufacturing, encompassing Rolls-Royce, Bombardier Transportation and Toyota Manufacturing. Approximately 25% of Derby's population are from BME communities, with its largest ethnic group comprised of the Asian/Asian British community. Derby's ethnic diversity is mirrored by its great variations in levels of deprivation. Overall, the city is within the 25% most deprived areas in the country. Pockets of deprivation are mainly concentrated within Arboretum, Normanton, Sinfen and Alvaston, all within the top 10% most deprived areas in England. These wards are characterised by high rates of unemployment and households with a lower than average annual income. Conversely, Allestree and Mickleover are amongst the least deprived 10% of wards in the country. This translates into vast health inequalities between Derby's wards. For example, a child born in Allestree could expect to live up to 12 years longer than a child born in Arboretum.

Derby is served by one upper-tier local authority, Derby City Council and one clinical commissioning group – Southern Derbyshire CCG (which also covers the south of the county). The city has 17 electoral wards. NHS Southern Derbyshire CCG is organised into four localities, two of which are within Derby City. The CCG localities are formed of groups of interested practices rather than being based on specific geographies.

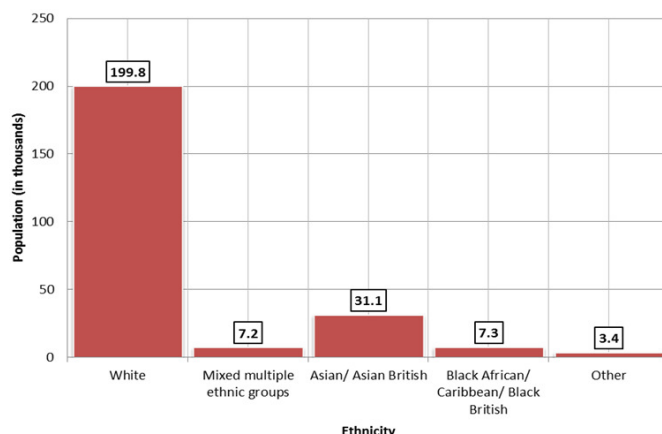
5.2 Population and other characteristics

Figure 5.1 Population structure



Derby's population has changed significantly since the last Census in 2001 when it was recorded at 221,716. The population has increased by approximately 18,000 people (7.8%), comprising 3,300 more children aged 0-4 years; an additional 5,500 people aged 20-29; 2,900 more people aged 60 plus, including 1,200 more people aged 75 plus and 1,000 more people aged 85 plus. Our BME community has increased from 15.7% to almost 25%.

Immigration is a key consideration for the city. In total, 34,600 individuals (14%) were born outside of the UK.

Figure 5.2 Ethnicity

Derby is home to more than 250,500 residents living in 103,000 households, 8,000 single parents, 357 couples in a same-sex relationship, 335 British Sign Language (BSL) users, 3,500 people without central heating, 20% of the population with a long-term illness, over 180 nationalities, 29% of households without a motor vehicle, 30% of households being home to a sole person and a population that will increase to 275,000 by 2021.

5.3 Key Findings

Maternity and Infancy

What happens in a baby's first years has a big effect on how healthy he or she will be in the future. This section explores some of the key outcomes for our mothers and infants that will help us to ensure that we give them the best start in life.

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn. Almost 6 in every 1,000 babies born in Derby die before their 1st birthday.

In the UK children receive 2 doses of the combined measles mumps rubella (MMR) vaccine as part of the routine childhood immunisation schedule. The MMR vaccine remains the most effective and safest way of protecting children against these dangerous diseases. In Derby 92.6% of 2 year olds are vaccinated for MMR.

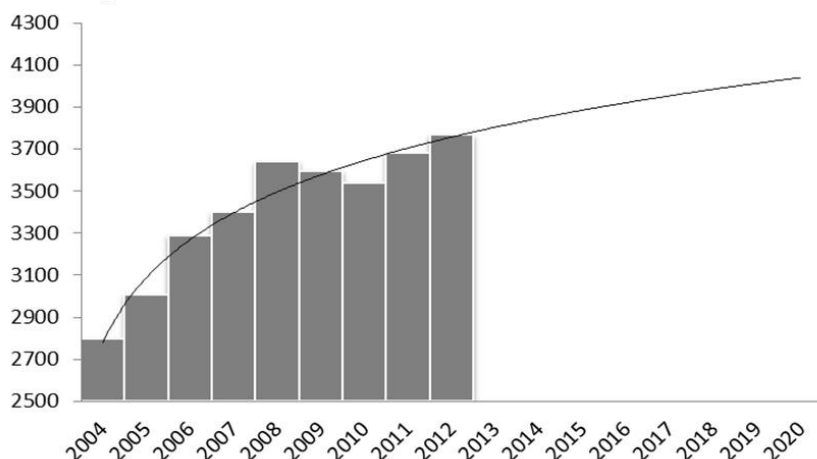
Low birth weight increases the risk of childhood mortality and of developmental problems for the child, and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with maternity services. 8.8% of new-borns in Derby are of a low birth weight.

There is a clear case for investing in services to support breastfeeding as part of local child health strategies. This is particularly important for mothers from low income groups. Breastfeeding protects the health of baby and mother, and reduces the risk of illness. Infants who are not breastfed are more likely to have infections in the short-term; such as gastroenteritis, respiratory and ear infections. In the longer term they will be at higher risk of developing Type 2 Diabetes as well as high levels of blood pressure and cholesterol. For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. It is the best form of nutrition, and exclusive breastfeeding is recommended for the first six months of an infant's life. In Derby only 4 in 10 mothers continue to breastfeed at 8 weeks

Smoking during pregnancy harms both the mother and the unborn child, and is closely related to health inequalities between those in need and the most advantaged. Some of the more notable consequences include an increased risk of miscarriage, reduced birth weight and perinatal death. In Derby 15.2% of mothers smoke while pregnant.

Local Authorities have a duty to protect and promote the welfare of children in need in the area. Abuse or neglect continue to be the most common primary needs for children in Derby, followed by family dysfunction. Child disability or illnesses ranks highly as a primary need code. 2,350 children living in Derby are classed as being "in need".

Figure 5.3 Birth Projection (numbers each year)



Children

This section explores their needs, including take-up of vital immunisation programmes, the lifestyle choices adopted by them and their parents, as well as their learning potential.

Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she: is provided with accommodation for a continuous period for more than 24 hours; is subject to a care order; or is subject to a placement order. Educational attainment of the looked after population is generally lower at all ages of assessment, and proportionally more receive a conviction or a final warning or reprimand for offending behaviour. In Derby 465 children are in care.

Children qualify for free school meals if their parents are in receipt of an income support payment. A lot of people do not claim free school meals even though they are entitled. 1 in 5 living in Derby claim free school meals

The National Child Measurement Programme (NCMP) weighs and measures children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years). Amongst other things, the programme helps to increase public and professional understanding of weight issues in children and is a useful vehicle for engaging with children and families about healthy lifestyles and weight issues. 1 in 5 Year 6 children in Derby are obese.

In Derby, children and their families can receive 12 months' free, friendly support to manage their weight by improving fitness, nutrition and self-esteem. 60% of Derby's children are physically active, and 61.7% involved in positive activities outside school.

Children with long-term disability are a diverse group. Some will have highly complex needs requiring multi-agency support across health, social services and education - the most extreme example perhaps being those who are technology-dependent. Other children will require

substantially less support, although having a long-term disability. There are 10,000 young people living with a disability in Derby.

The HPV vaccine protects against the two high-risk HPV types - 16 and 18 - that cause over 70% of cervical cancers. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. In England, girls in school Year 8 (12-13 years old) are offered the HPV vaccination through the national HPV immunisation programme. In Derby 93.5% of young girls are immunised for HPV.

Young Adults

To ensure that children develop well through their schooling and into adulthood, we need to first understand their behaviours and external influences on them at that age. This section looks at some of these influences on their lives.

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. Incidents can be avoided through improved education, awareness, road infrastructure and vehicle safety. There were 40.5 per 100,000 population reported road deaths and serious injuries in Derby.

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the woman, abortions represent an avoidable cost to the NHS. For some young women having a child when young can represent a positive turning point in their lives, but for many more bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child. There are 41.4 per 1,000 young women aged 15-17 years in Derby.

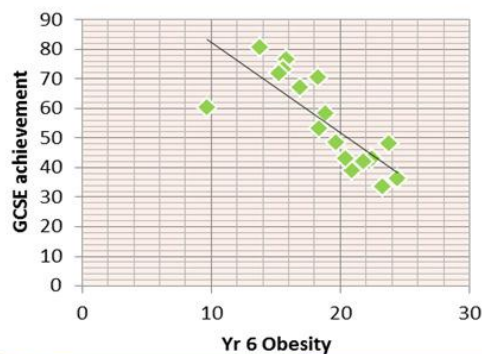
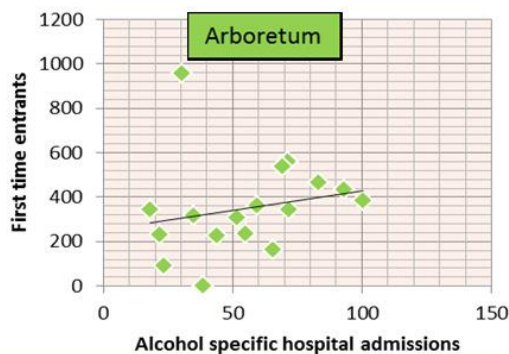
Hospital admissions for self-harm in children have increased in recent years, with admissions for young women being much higher than admissions for young men. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment. 1 in 20 young people aged 10 to 24 years are hospitalised for self-harm in Derby.

STIs, including chlamydia, continue to be an important public health problem in England. As well as highlighting the level of infection in the local population, it may be used as a measure of risky sexual behaviour in young people. 1,500 in every 100,000 people aged 15-24 years in Derby have a sexually transmitted infection.

When a child protection case conference decides a child or young person is at risk of abuse they are known as a 'child subject of a child protection plan'. This plan is an enabler of child safety, promotion of welfare, and support for the child's wider family to care for them if it can be done safely. 307 children and young people living in Derby are the subject of a child protection plan

The Priority Families programme is trailblazing a new way of targeting help and support to those families who need it most. Priority families have complex needs including: problems with crime and antisocial behaviour; children not in school, an adult on out-of-work benefits. The supportive approach focuses on the whole family and unites the skills and expertise of frontline partners to tackle all of their problems in unison. 425 families in Derby have been identified as 'Priority Families'.

In Derby 1,038 per 100,000 children and young adults become first time entrants to the youth justice system. These children and young people often have more unmet health needs than their peers. A lack of focus in this area could result in increased inequalities as well as an increase in re-offending.

Figure 5.4 Associations by Ward**Obesity and GCSE achievement****Alcohol and Youth Justice****Working age adults**

A person's physical and mental health is profoundly shaped by their experiences in the areas of education, employment, the living environment and income, and multiple disadvantages compound to produce significantly worse physical and mental health and wellbeing. There is much that can be done to improve the lives and health of people who have already reached working age and beyond. Services that promote the health, wellbeing and independence of older people make a significant contribution to ameliorating health inequalities.

The health of the nation is in the main gauged by health outcomes in adulthood. This section explores the physical and mental health of Derby's working age residents, the relationship between work, health and geography.

Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths worldwide. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/ breast cancer, as well as with improved mental health. 1 in 3 people in Derby are not physically active.

A healthy diet can help reduce the risk of developing coronary heart disease as well as prevent weight gain - reducing the risk of diabetes and high blood pressure. A balanced diet will also help lower cholesterol levels and mitigate the risk of some cancers. 3 in 4 people in Derby are not eating healthily.

Increasing and higher risk drinkers generally represent older drinkers, aged 15 and over drinking at increasing or higher risk levels for a sustained period of time, who will suffer longer-term alcohol-related illness or death. People can move in and out of this state throughout their lives depending on their circumstances but in many instances, the consequences of drinking to excess result in otherwise preventable attendances to A&E departments and admissions to hospital. There are an estimated 14,000 higher risk drinkers in Derby, and 6,618 admissions to hospital due to alcohol.

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of cardiovascular disease. A high take up is important to identify early signs of poor health leading to opportunities for early interventions. Only 36% of those eligible in Derby take up the offer of a free NHS Health Check.

Smoking is the single most important cause of preventable ill health and premature mortality in the UK. It is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. 1 in 5 People in Derby smoke.

Problematic drug use refers to drug use which could either be dependent or recreational, and not necessarily the frequency of drug use which is the primary 'problem'. The effects however, can be varied: socially, financially, psychologically, physically and legally. There are 2,500 problem drug users in Derby.

The adult population with a common mental health problem would fill the iPro Stadium to capacity.

Older People

Older people are our primary users of health and social care services. This section explores some of their needs that guide us in supporting them to maintain their independence.

Dementia is common after the age of 65. People with the condition can become apathetic or uninterested in their usual activities and have problems controlling their emotions. Eating a healthy diet, maintaining a healthy weight, exercising regularly, not drinking too much alcohol and stopping smoking, all help to reduce the risk of onset. There are believed to be 3,000 people living with dementia in Derby.

Derby City is home to the Royal School for the Deaf. For older people, being deaf and/ or blind can be particularly challenging. For instance, many will be faced with the dilemma of moving into residential care services who cannot communicate properly with them, which increases feelings of loneliness, isolation and depression. It is important that their needs are understood by decision makers and commissioners. In Derby 16.9 per 1,000 over 65 year olds are registered blind, while 7.1 per 1,000 are registered deaf.

Self-directed support is about people being in control of the support they need to live the life they choose. In local government settings, this is being more commonly referred to as 'personalisation' or 'personal budgets'. However it is described, it is all about giving people real power and control over their lives. 26.1% of social services clients in Derby receive self-directed support.

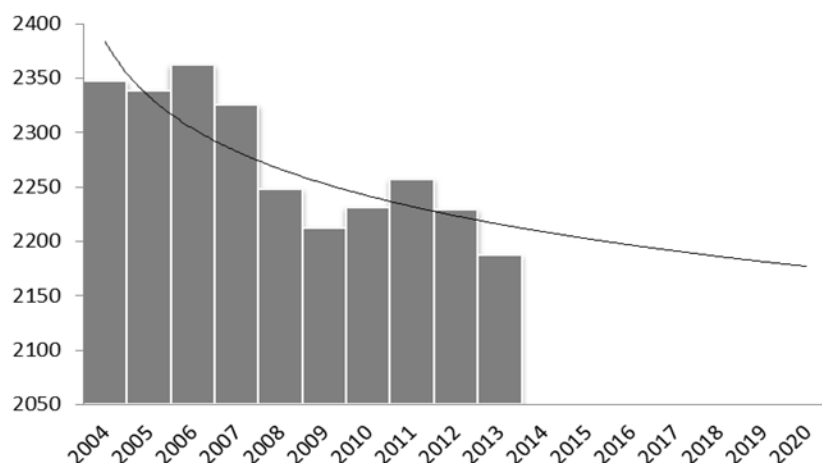
1,654 older people in Derby are hospitalised for hip fractures each year. This is a debilitating condition from which only one in three sufferers return to their former levels of independence, and one in three end up having to leave their own home and move to long-term care - resulting in social care costs. Hip fractures are almost as common and costly as stroked and the incidence is rising.

There is compelling evidence that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures (Wilkinson et al, 2001) and the recent Marmot Review Team report showed that low temperatures are strongly linked to a range of negative health outcomes; including excess winter deaths (which is generally larger in number than those who die on the roads each year). 15% of households in Derby are in fuel poverty.

Derby's HHS partnership recognises that people have the potential to enjoy a better home environment, improved health and well-being when they feel comfortable, confident, safe and secure at home. The aim of the service is to help those most vulnerable to poor health outcomes as a consequence of poor housing and fuel poverty through carrying out home improvements/ modifications that could reduce the risk of poor health and home accidents. By

way of newly established referral routes, many individuals who might ordinarily miss out on or fail to engage with initiatives offered by Derby City Council and its partners are now in receipt of support. 1,800 people are supported by the Healthy Housing Service.

Figure 5.5 Mortality Projection (numbers each year)



5.4 Future Housing Developments

The City Council considers that around 11,000 dwellings can be built in its administrative boundary by 2028 with an additional 7,000 dwellings built as urban extensions in Amber Valley and South Derbyshire. In all cases, the provision of health facilities will be determined through discussions with the relevant commissioning organisations.

5.5 Current Provision

Residents of Derby City have access to a range of services that reflect the health needs of the district. The density of pharmacies is similar to the County average. The numbers of pharmacies per head providing various advanced and locally commissioned services are also higher than County averages.

Rationale:

The map (figure 5.6) below shows that there are currently 68 pharmacies within Derby, giving 25 pharmacies per 100,000 population, rather higher than the County average. No patient need travel further than 1 mile to find a pharmacy and the vast majority will be much closer than that.

The locally commissioned services currently provided by these pharmacies are shown in Table 5.1. The 'spread' of these services is considered to be adequate across the area and population.

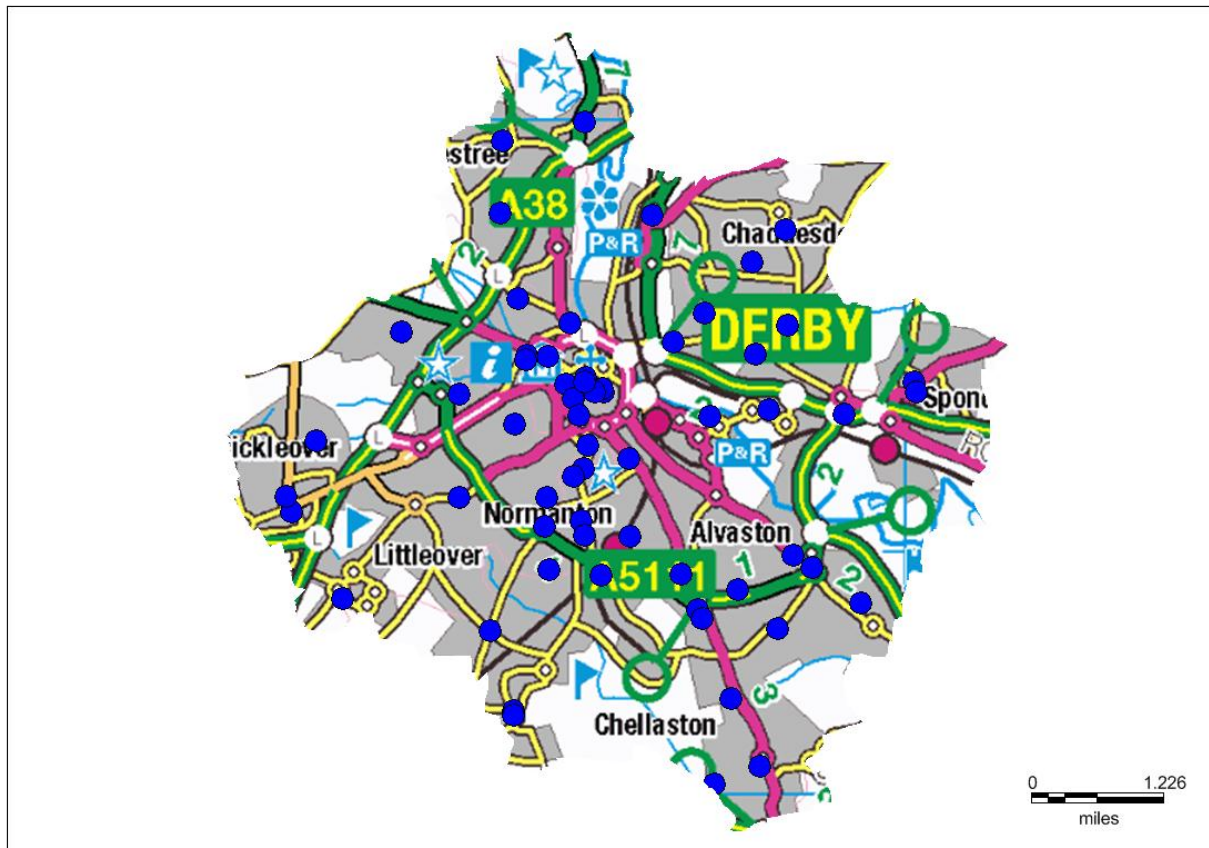
The opening hours of these pharmacies are shown in Appendix 6.

The projected housing plans are not expected to add appreciably to the population in the next 3 years and the largest developments are already supplied with pharmacies.

Table 5.1 Pharmaceutical services: number of providers and providers per head

Community Pharmacy Services	City		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	56	22	144	19
New Medicines Service	43	17	118	15
100 hour pharmacy	6	2	16	2
Out of Hours	5	2	26	3
Palliative Care	42	17	86	11
Emergency Supply Service	51	20	119	15
Public Health commissioned services:-				
Oral Emergency Contraception	46	18	101	13
Substance Misuse: Supervised Consumption	45	18	118	15
Substance Misuse: Needle exchange	16	6	40	5
CCG commissioned services				
MAR Sheets	45	18	109	14
Total	63	25	161	21
Dispensing GPs	1	1	20	3

Figure 5.6 Map of pharmacy locations



Statement of pharmaceutical need subject to consultation:-

The PNA found that that pharmaceutical need in Derby City is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

6. DERBYSHIRE COUNTY PROFILE

(Taken from the Derbyshire County Joint Strategic Needs Assessment 2014; [Derbyshire Observatory](#))

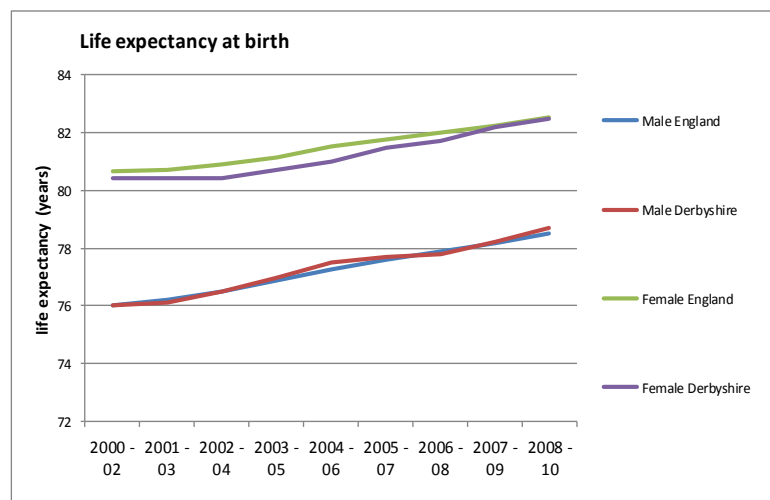
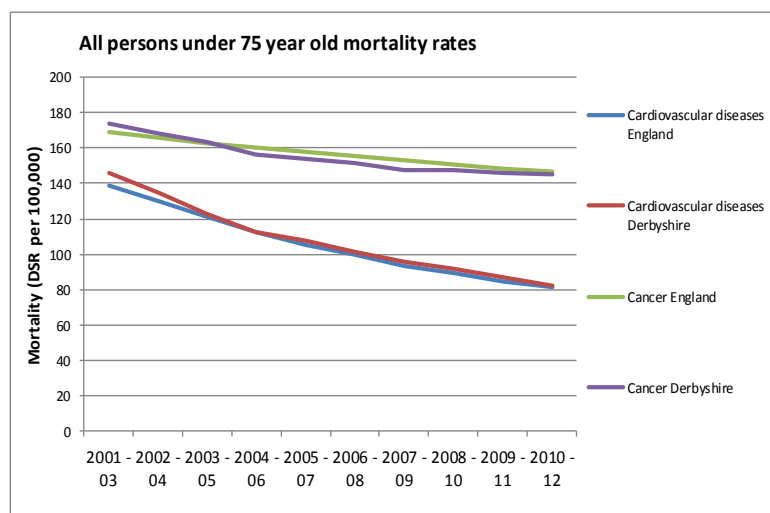
6.1 Introduction

The county of Derbyshire lies in the centre of England with an estimated population of three-quarters of a million people. Derbyshire is a largely rural county with no major urban centre. Of the eight local authority districts within Derbyshire, Amber Valley has the largest population followed by Erewash.

The Peak District National Park, an area of outstanding natural beauty, accounts for more than a third of the county's total land area and stretches beyond Derbyshire.

Health in Derbyshire is generally better than the England average and levels of deprivation are lower.

Figure 6.1 Mortality and Life Expectancy



Over the last 10 years, the rates of death from all causes and the rates of early death from cancer and heart disease and stroke have all improved and are close to the average for England.

Life expectancy at birth for both men and women is similar to that for England overall, but men's life expectancy is still considerably lower than women's. Life expectancy for men at age 65 is similar to that in England, while for women it is slightly lower, but still higher than for men in the county. Men can expect to spend between roughly one third to one half of this time disability free, whereas women can expect to be free of disability for between a third and three quarters. For men the highest district life expectancy at age 65 is slightly less than twice that for the lowest, for women it is roughly two and a half times.

The overall similarity to regional and national levels of health and deprivation at county level can

disguise large variations at electoral ward and even district level, in addition even smaller pockets of ill-health and deprivation exist which can easily go unnoticed.

The top local priorities in Derbyshire are maintaining the focus on reducing inequalities in avoidable mortality, early years health, wellbeing and literacy, lifestyle issues including alcohol, obesity and inactivity, increased community management of long term conditions, improving mental wellbeing through access to psychological therapies and maximising health and independence in old age.

Derbyshire County is associated with five NHS Clinical Commissioning groups: North Derbyshire, Hardwick, Erewash, South Derbyshire and Tameside & Glossop. The first three lie wholly within the county boundary, South Derbyshire also has localities within Derby City and Tameside & Glossop lies mostly outside the county boundary.

6.2 Key challenges

Children

Increase breastfeeding initiation and continuation rates
Improve the emotional and behavioural health of looked after children
Reduce the number of women smoking during pregnancy

Tackle the variation within Derbyshire in:-

Teenage conception rates
Smoking in pregnancy
Breastfeeding initiation and continuation rates
Vaccination rates for MMR at age five
DTaP/IPV immunisations at age two
Vaccination rates for HPV
A&E attendance rates
Hospital admission rates for asthma
Hospital admission rates for gastroenteritis in under 1 year olds
Alcohol specific admission rates
Rates of emergency admission of under 18s following injury, accident, assault and self-harm
Rates of perinatal, infant and child mortality
The percentage of children in workless households
Percentage of children eligible for free school meals
Children in Need
Children in care
Children with a Child Protection Plan
Educational attainment between schools
Fixed term exclusions from school
NEETs
First time entrants to the Youth Justice System

Adults

Reduce the rate of killed and seriously injured casualties on the roads

Tackle the variation within Derbyshire in:-

Alcohol admission rates
Prevalence of smoking
Rates of violent crime
Rates of killed and seriously injured casualties on the roads, in particular by reducing the disparity between Derbyshire Dales and other districts
Percentages of over 65s with moderate to very high needs for social care and receiving care
Rates of unplanned hospitalisation for chronic ambulatory care sensitive conditions
Adults in contact with secondary mental health services in employment
Patient experience of GP Out of Hours services
Hospital admission rates for acute conditions that should not usually require it

Hospital readmission rates

Rates of admissions as a result of falls or falls injuries in the over 65s

Rates of mortality in under 75s from cardiovascular diseases, cancer and respiratory diseases

Rates of mortality from causes amenable to healthcare

Excess winter mortality

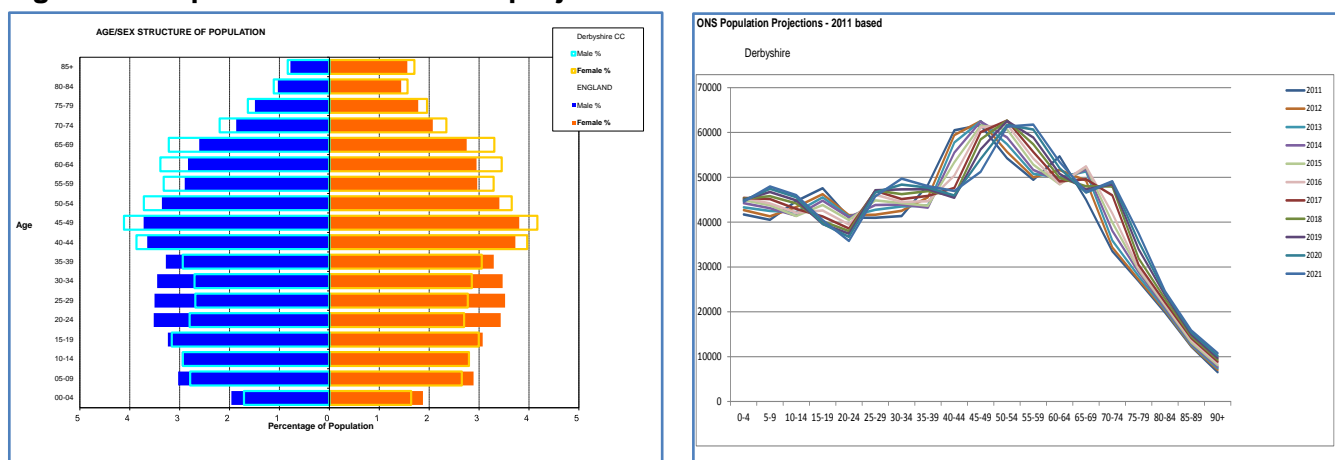
The percentage of people dying in their usual home

6.3 Population and other characteristics

Structure

The population of Derbyshire is overall older than that of England as a whole; the proportion aged over 40 being 55% compared to 49%.

Figure 6.2 Population structure and projections



Projection

Population projections show an ageing population, such that by 2021, 22.6% of the population will be aged over 65, 10.9% over 75 and 3.3% over 86. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before.

Density

The population is at its most dense along the eastern side of the county and this where most of the healthcare services are located. There are other population centres scattered across the rest of the county and this is where healthcare services are located. This may lead to access problems for people in more rural communities.

Deprivation

Deprivation is by far the greatest in the more densely populated eastern side of the county. There are however, smaller pockets of deprivation across the whole of the county and it must be noted that very localised areas of high deprivation may be masked by aggregation. Research by Durham University has shown that, in contrast to other health services, access to community pharmacies is better in less prosperous areas.

6.4 Key Findings

Birth & pregnancy

In 2012 Derbyshire's birth rate was significantly lower than England's, ranging from 53 per 1,000 women aged 15-44 in Derbyshire Dales - significantly lower than the Derbyshire average – to 66.6 in Bolsover – significantly higher.

Low birth weight babies are more prone to perinatal infant mortality and more likely to experience ill-health in later life.

In 2012 Derbyshire had a significantly lower rate of low birthweight births than England. At district level this ranged from 6.6% in South Derbyshire to 7.9% in Amber Valley, but only these two were significantly different from each other. The rate of very low birthweight births was also lower than for England, though not significantly so. There were not significant differences between the districts.

Teenage parents are at greater risk of postnatal depression and poor mental health in the three years following birth. They are also likely to have low educational attainment, experience unemployment and be living in poverty at age 30. Their children experience higher rates of infant mortality and low birthweight, A&E admissions for accidents and have a higher risk of being born into poverty.

The rate of under18 teenage conceptions in Derbyshire was significantly lower than for England in 2009-2011. Rates ranged at district level from 17.0 per 1,000 in Derbyshire Dales to 36.3 in High Peak, the only significant difference being between the two.

The under 16 pregnancy rate was lower than for England, but not significantly so. District rates ranged from 3.2 per 1,000 in Derbyshire Dales to 7.7 per 1,000 in Amber Valley; again the only significant difference was between these two.

Increases in breastfeeding initiation and prevalence are expected to reduce illness in young children. In the longer term, infants who are not breastfed are more likely to become obese in later childhood, develop type 2 diabetes and tend to have higher blood pressure and blood cholesterol in adulthood.

In 2012/13, new Derbyshire mothers initiated breastfeeding at a significantly lower rate than in England overall, ranging from 61.8% in Bolsover (significantly lower than for 6 of the other 7 districts) to 83.3% in High Peak (which, with Derbyshire Dales, had a significantly higher rate than the rest.).

After 10 days the fall off was almost a quarter across the board, the highest being in Amber Valley at 32.0% and the lowest in North East Derbyshire at 22.7%.

The percentage of mothers breastfeeding at 6-8 weeks was significantly lower than for England, all districts but Derbyshire Dales and High Peak having a significantly lower rate. Bolsover remained the worst performer with only 33.1% and Derbyshire Dales the best at 50.5%.

Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birthweight and sudden unexpected death in infancy.

In 2012/13 the percentage of mothers of all ages in Derbyshire who continued to smoke during pregnancy was significantly higher than for England, ranging from 13.3% in Derbyshire Dales – significantly lower than all the other districts - to a troubling 22.6% in Bolsover – significantly higher than all but one.

Lifestyle (child)

Excess weight in childhood often leads to excess weight in adults, and this is recognised as a major determinant of premature mortality and avoidable ill-health.

The prevalence of obesity among children aged 4-5 years (reception year) in 2012/13 in Derbyshire was significantly lower than that of England, ranging from 7.0% in Derbyshire Dales to 9.6% in Bolsover, neither in themselves significantly different to either Derbyshire or England. Child obesity among 10-11 year olds (year 6) in Derbyshire is also significantly lower than for England as a whole, ranging from 16.2% in High Peak to 20.2% in Erewash.

Being underweight can be a sign of malnutrition or illness. A smaller proportion of children in Derbyshire are underweight- significantly in reception though not in Year 6 - than in England overall.

In 2011/12 Derbyshire 5 year olds experienced on average significantly fewer decayed, missing and filled teeth than in England as a whole, with district rates ranging from 0.49 in Derbyshire Dales to 0.84 in High Peak: all lower than the England rate.

This was also true of 12 year olds in 2008/09, with district rates ranging from 0.39 in North East Derbyshire to 0.83 in Amber Valley.

Vaccination

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

All vaccination rates for children in Derbyshire as whole were above the national average (where known) in 2011/12; in some cases substantially so. In most cases, every district had a rate above the national average and, with the exception of Erewash, significantly so. In the case of HPV vaccination, both Erewash and High Peak had a lower rate. Chesterfield had the highest rates for DTaP/ IPV/Hib at age 1 and MMR 1st Dose; High Peak had the highest rate for Pneumococcal Booster; Amber Valley had the highest rate for Hib/Men C Booster; North East Derbyshire had the highest rates for DTaP/ IPV at age 2, MMR 2nd dose and HPV.

Hospital Activity

In 2012/13 the district rates of Accident and Emergency (A&E) attendances in the under 5s, ranged from 416.7 attendances per 1,000 in Chesterfield to 562.5 in Erewash attendances per 1,000, by district. Rates for 5-18 year old ranged from 251.0 in North East Derbyshire to 349.2 in High Peak.

In 2010/11-2012/13, rates of hospital admission per 100,000 population, for under 5 year olds with asthma ranged from 176.9 in Amber Valley to 352.0 in Chesterfield and for 5-18 year olds, from 96.3 in Derbyshire Dales to 246.7 in High Peak.

The admission rate with gastroenteritis for under 1 year olds ranged from 118.3 per 10,000 population in Amber Valley to 407.3 in Chesterfield.

The rate of emergency admission per 100,000 population of under 18s, for alcohol specific conditions, ranged from 23.9 in Erewash to 86.5 in High Peak.

The rate of emergency admissions with injuries in 0 to 14 year olds ranged from 62.8 in Derbyshire Dales to 100.3 in High Peak; for 15 to 24 year olds the rates ranged from 113.0 in Erewash to 168.3 in Chesterfield.

The rate of emergency admissions in under 18s following an accident ranged from 51.3 in Erewash to 86.5 in High Peak.

The rate of emergency admissions, in the same age group, following an assault ranged from 11.9 in Derbyshire Dales to 33.6 in Chesterfield.

The rate of emergency admissions following self-harm ranged from 83.1 in Derbyshire Dales to 86.5 in High Peak.

Mortality (child)

In 2010-2012, perinatal mortality in Derbyshire was significantly lower than for England as a whole; district rates per 1,000 live and still births were all lower, except for North East Derbyshire at 7.7, the lowest being for Bolsover at 6.0.

In the same period infant mortality was also significantly lower in Derbyshire than in England, with the lowest district rate – Erewash at 1.5 per 1,000 live births – significantly lower. The highest rate was in Amber Valley – at 6.3 the same as England.

Child mortality (under 20) per 100,000 population ranged between 20.2 in Erewash and 46.5 in Amber Valley.

Deprivation

On the basis of the Index of Multiple Deprivation 2010, the most deprived of Derbyshire's districts (Bolsover) ranked 58th most deprived in England, the least deprived 241st (DD), out of 326. Derbyshire itself was the 7th most deprived out of 27 counties.

In 2011, a significantly lower percentage of children and dependent young people aged under 20 lived in poverty in Derbyshire compared to England. Six of the eight districts had proportions significantly lower than England, including Derbyshire Dales – the lowest at 10.1%. Bolsover and Chesterfield had significantly higher proportions at 22.5% and 20.6% respectively.

The proportion of children under 16 living in poverty was also significantly lower than for England. Similarly all the districts but two had significantly lower proportions – Derbyshire Dales again the lowest at 10.7%. Again Bolsover and Chesterfield were significantly higher, at 23.2% and 21.4% respectively.

As at January 2013 the percentage of children eligible for free school meals was significantly lower than for England as a whole. All but 3 districts had a significantly lower rate, Derbyshire Dales having the lowest at 8.4%. Two districts had significantly higher rates – once again Bolsover and Chesterfield at 22.8% and 19% respectively.

Education

In 2012/13 the percentage of Key Stage 4 pupils achieving 5 or more A* - C GCSEs including English and mathematics A* - C GCSEs was significantly lower in Derbyshire than England as a whole, and ranged from 48.2% in Bolsover (significantly lower) to 69.3% in Derbyshire Dales (significantly higher).

The percentage of children with a Special Educational Needs as at the January 2013 school census was significantly lower than for England. Five districts, including North East Derbyshire (the lowest), had a significantly lower rate. At 21.6%, Bolsover had the highest rate, which was also significantly higher than England's.

The percentage of children with a Special Educational Needs status of Action Plus was also significantly lower than for England. Six districts had a significantly lower rate than England, including North East Derbyshire at 6.1%. Only Bolsover, at 8.4%, had a significantly higher rate.

The proportion of children with a statement of SEN was lower than for England. District rates ranged from 2.0% in North East to 3.2% in Chesterfield.

The percentage of school absence due to illness during 2009/10 for primary schools ranged from 2.3% in Derbyshire Dales to 2.9% in Chesterfield.

The percentage of school absence due to illness for secondary schools ranged from 3.2% in Erewash to 3.5% in Chesterfield.

The percentage of persistent school absence from primary school was significantly lower than for England, ranging from 1.3% in Derbyshire Dales to 3.6% in Bolsover for primary.

However, the percentage of persistent school absence from secondary school was only slightly lower than for England and ranged from 6.4% in Derbyshire Dales to 9.3% in Erewash.

The percentage of fixed term school exclusions from primary school was significantly higher than for England, but ranged from 0.8% in Derbyshire Dales to 1.6% in Amber Valley.

The percentage of fixed term school exclusions from secondary school was, however, significantly lower than for England, ranging from 1.4% in Derbyshire Dales to 16.9% in Erewash.

The incidence of permanent school exclusions was significantly higher although still very low, ranging from 0.02% in High Peak to 0.22% in Bolsover.

The percentage of 16-18 year olds not in education, employment or training (NEETS) was lower in Derbyshire than in England as a whole and ranged from 3.5% in Derbyshire Dales to 6.8% in Erewash.

Children in Need

The percentage of children (aged under 18 years) in need as at March 2013 was significantly lower in Derbyshire than in England as a whole and ranged from 1.7% in Derbyshire Dales to 3.6% in Chesterfield, which was the only district with a higher percentage than England.

The percentage of children in care was also significantly lower than for England and ranged from 1.2% in Derbyshire Dales to 6.4% in Chesterfield, the only district with a higher percentage than England.

The average score for emotional health of Children in Care (SDQ) was higher for Derbyshire than for England and ranged from 11.6 in Derbyshire Dales to 19.8 in North East Derbyshire. Two districts have an average score of 17 or over, which would be a basis for concern in an individual case.

The percentage of children with a Child Protection Plan was slightly higher than for England and ranged from 0.3% in Erewash to 0.7% in Chesterfield.

Crime

In 2012/13 the rate of first time entry to the youth justice system per 1,000 persons aged under 16 was significantly lower than for England, ranging from 276.5 per 100,000 in Derbyshire Dales to 777.0 in Erewash.

In 2013 the rate of first time entry to court ranged from 0.6 per 1,000 in Derbyshire Dales to 2.6 in Erewash.

Life Expectancy

Life expectancy is the average number of additional years a person can be expected to live for, if he or she experiences the age-specific mortality rates of the given time period for the rest of his or her life. It can be improved by extending life through better investigation, diagnosis and treatment of disease, early identification and management of risk factors, encouraging healthy lifestyles, better social care and social inclusion.

For 2009-2011 life expectancy at 65 for men stood at 18.2 years for the county overall, significantly lower than for England at 18.6. However this ranged from 17.2 years in Bolsover to 19.3 years in Derbyshire Dales. Life expectancy at 65 for women was 20.8 years, significantly higher than for men and but significantly lower than for England. It ranged from 19.8 years in Bolsover to 21.7 years in Derbyshire Dales.

Disability free life expectancy (DFLE) at age 65 ranged from 6.8 years to 10.4 years within Derbyshire in 2006-08 for males, and from 6.3 years to 15 years for females. Overall males tend to spend a higher proportion of their life disability free.

Lifestyle (adult)

These are measures of how people are adopting healthy lifestyles and making healthy choices. Generally speaking, Derbyshire fares slightly worse than England as a whole in terms of healthy living.

Lack of sufficient physical activity costs the NHS over £1bn per year and is one of the top risk factors for premature mortality.

According to the Active People Survey 2012/13 56.7% of Derbyshire people were physically active. This was similar to the England average, but districts ranged from 50.4% in Bolsover to 58.8% in South Derbyshire.

Alcohol misuse is the third greatest overall contributor to ill-health. Alcohol consumption is a contributing factor to hospital admissions and mortality from a wide range of conditions. Although the Derbyshire rate per 100,000 population in 2011/12 was significantly lower than that for England, there was considerable variation between districts within Derbyshire, with rates ranging from 1496.8 in the Dales to 1956.3 in Bolsover.

Smoking is the primary cause of preventable illness and premature death. Smokers are defined as those answering yes to the question “Do you smoke at all these days?”

Almost 18.5% of adults in Derbyshire said they were smokers in 2011/12, slightly lower than in England as a whole, but this ranged from 16.8% in South Derbyshire to 26.2% in Bolsover.

Diabetic complications (including cardiovascular, kidney, foot and eye diseases) result in considerable morbidity and have a detrimental impact on quality of life. The level of diabetes recorded in general practice was significantly higher in Derbyshire in 2013 than in England as a whole but ranged from 6.4% in High Peak to 6.2% in Bolsover.

Obesity is a major determinant of premature mortality and avoidable ill-health. Adults are defined as obese if they have a BMI greater than or equal to 30kg/m². A smaller proportion of adults in Derbyshire were recorded in general practice in 2013 as being obese compared to England as a whole, ranging from 8.7% in High Peak to 10.9% in Chesterfield.

Environment (adult)

These indicators include some of the wider issues which can impact on health and wellbeing.

A household is classified as fuel poor when it would need to spend more than 10% of its income on energy in order to maintain an adequate level of warmth. Living at low temperatures is strongly linked to poor health outcomes and excess mortality, and living at low temperatures is at least partially driven by fuel poverty.

In 2011 in Derbyshire over 5% of households were thought to be living in fuel poverty, ranging from 11.4% in North East Derbyshire to 16.6% in Amber Valley.

Tackling domestic abuse is vital for ensuring that some of the most vulnerable people in society receive the support, understanding and treatment they deserve.

The definition used here is: victims of crimes with a Domestic Violence marker, all crime types included, by victim home address, per 1000 population. There were some 3.6 cases of domestic abuse per 1,000 head of population in Derbyshire in 2011. The highest district rate was 6.2 in Chesterfield and the lowest 2.5 in North East Derbyshire.

Rates of violent crime by place of commission are available for Derbyshire. There were 9.4 violent crimes per 1000 people in 2011/12, significantly fewer than for England. Ward rates ranged from 1.0 in the Barlow and Holmesfield ward of North East Derbyshire to 57.2 in the St Leonards ward of Chesterfield. There is good reason to believe that much of this violence is alcohol-related.

Road safety has implications for the safety of communities, on the long-term costs to the health and social care systems, and to the wider community. For 2009-2011 Derbyshire had a significantly higher rate than England, but district rates ranged from 31.6 in Chesterfield to 86.8 in Derbyshire Dales.

Households in temporary accommodation often have greater health and social care needs than the general population. Derbyshire had a significantly much lower rate per 1,000 households than England as at 31st March 2012 – less than a tenth, but district rates ranged between 0.03 in Bolsover to 0.37 in Derbyshire Dales.

Social Care (adult)

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008 it was estimated that about 30% of the population aged over 65 in Derbyshire had moderate to very high needs. However, the rate ranged from 12.9% in the Stanton ward of Derbyshire Dales to 56.3% in Ridgeway and Marsh Lane of North East Derbyshire. In 2009 a higher percentage of over 65s received one or more services from Adult Social Care than nationwide, ranging at ward level from 3.9% in the Norbury ward of Derbyshire Dales to 32.0% in the Shirebrook North West of North East Derbyshire.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term condition.

In a survey in 2012/13 64% of people in England said they felt supported to manage their condition. However in Derbyshire 66% said they felt supported, ranging from 61.5% in South Derbyshire to 68.9% in Derbyshire Dales.

There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing, and financial benefits. In Derbyshire in 2010/11 only 1.1% of adults with learning disabilities were in employment. This compares unfavourably with 6.6% across England as a whole.

The nature of accommodation for people with learning disabilities has a strong impact on their safety and overall quality of life and reducing social exclusion. In Derbyshire in 2010/11 59.5% lived in settled accommodation as compared to 59.1% in England.

Supporting someone with their employment aspirations is a key part of the recovery process. Employment is a wider determinant of health and social inequalities. In Derbyshire in 2010/11 20.9% of adults in contact with secondary mental health services were in employment; ranging from 13.0% in North East Derbyshire to 36.9% in High Peak. This and five of the eight district rates were significantly higher than that for England (9.5%)

Accommodation is closely linked to improving safety and reducing the risk of social exclusion of adults in contact with secondary mental health services. In Derbyshire in 2010/11 83.8% live in settled accommodation; ranging from 77.3% in Bolsover to 90% in North East Derbyshire.

In 2012/13, Derbyshire had an overall rate of 216.2 for unplanned hospitalisation for chronic ambulatory care sensitive conditions, with ward rates ranging from 33.1 in the Norbury ward of Derbyshire Dales to 498.2 in the Shirebrook East ward of Bolsover.

The prevalence of dementia recorded in general practice in Derbyshire in 2013 was higher than in England. The districts had rates ranging between 0.48% South Derbyshire to 0.81% in North East Derbyshire.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

In 2012/13, a greater proportion of survey respondents had a favourable experience of GP Services in Derbyshire than in England as a whole, although this did vary between 81.2% in Erewash and 93.1% in Derbyshire Dales.

A smaller proportion, but still more than for England, also had a favourable experience of Out of Hours services, but this ranged from 68.2% in Derbyshire Dales to 86.0% in Erewash.

Take up of diabetic retinopathy screening in 2010/11, ranged at a district level from 69.8% in North East Derbyshire to 77.1% in Amber Valley.

Screening for cancer supports early detection which saves lives. The coverage rate in Derbyshire for cervical screening was significantly higher than the national rate. District rates ranged from 77.7% in High Peak to 80.8% in North East Derbyshire, all of which were higher than the national rate.

The coverage rate in Derbyshire for breast screening was also significantly higher than the national rate, with district rates ranging from 78.2% in Bolsover to 83.9% in Amber Valley, again all higher than England.

Take up of the NHS Health Check programme is important to identify early signs of poor health leading to opportunities for early interventions. In the last quarter of 2011 1.4% of the eligible population received a health check, district rates ranged from 0.8% in South Derbyshire to 1.9% in North East Derbyshire.

Vaccination coverage is closely correlated with levels of disease. The percentage of over 65 year olds who received a flu vaccination in the winter of 2010/11 was higher than the national average.

The rates for districts ranged from 71.0% in Derbyshire Dales to 77.3% North East Derbyshire, all equal to or higher than the national average.

In 2012/13 the rate of emergency admissions per 1,000 population for acute conditions that should not usually require hospital ranged from 157.0 in the Ashbourne North ward of Derbyshire Dales to 1020.9 in the Brimington North ward of Chesterfield 17% of hospital discharges in Derbyshire resulted in a readmissions, with ward rates ranging from 6.9% in the Lathkill and Bradford ward of Derbyshire Dales to 32.8% in the Belper Central ward of Amber Valley.

Self-harm is one of the top five causes of acute medical admission and those who self-harm have a one in six chance of repeat attendance at A&E within the year. 2010/11-2012/13 rates of admission per thousand population in Derbyshire districts ranged from 1.0 in High Peak to 3.7 in Chesterfield.

Falls are the largest cause of emergency hospital admissions in older people, and significantly impact on long term outcomes, e.g. moving from own home. In 2012/13, electoral ward falls admission rates ranged from 6.1 in the Belper East ward of Amber Valley to 42.1 in the Lowgates and Woodthorpe ward of Chesterfield.

Only one in three falls sufferers returns to their former levels of independence and one in three ends up leaving their own home and moving to long term care. Hip fractures are almost as common and costly as strokes and the incidence is rising. In Derbyshire the rate of hip fractures recorded per 1,000 people aged over 65 at district level, ranged from 12.2 in High Peak to 17.5 in Bolsover.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

Cancer is the biggest killer of the under 75s. In Derbyshire in 2009-2011 the rate of deaths per 100,000 population aged under 75 was significantly lower than the rate for England. The lowest ward rate was 36.9 in the Stanton in Derbyshire Dales and 216.6 in the Bolsover North West.

Cardiovascular disease remains one of the major killers of under 75 year olds. In Derbyshire the rate was also significantly lower than in England as a whole, ranging at ward level from 12.9 in the Ashover ward of North East Derbyshire to 106.9 in Langley Mill ward of Amber Valley.

Liver disease is one of the top causes of death. It is mostly preventable and high influenced by alcohol consumption and obesity. The mortality rate in 2007-2011 was significantly higher in Derbyshire than in England as a whole, ranging at district level from 12.8 in Derbyshire Dales to 26.2 in Chesterfield.

Respiratory disease is one other top causes of death in under 75s and smoking is the major cause of Chronic Obstructive Pulmonary Disease. The Derbyshire rate in 2007-2011 was significantly lower than the England rate, but ward rates ranged from only 7.4 in the Belper North ward of Amber Valley to 86.7 in the Clowne South ward of Bolsover.

Some premature deaths should not occur in the presence of timely and effective health care. The Derbyshire rate for mortality from causes considered amenable to healthcare in 2009-2011 was significantly lower than for England, ranging from 28.5 in the Ridgeway and Marsh Lane ward to 257.2 in the Holmewood and Heath ward, both of North East Derbyshire.

The suicide rate in Derbyshire was significantly lower than for England, with district rates ranging between 6.1 in Derbyshire Dales and 8.5 in South Derbyshire.

Cold weather is a major killer amongst the elderly and those on low incomes. There were slightly more excess deaths in Derbyshire in 2009-11 than in England as a whole. The extra winter deaths as a percentage of summer deaths ranged from 16.2% in North East Derbyshire to 28.3% in Bolsover.

Survey data suggests that many people would, given the choice, prefer to die at home and few wish to die in hospital. The indicator includes nursing and residential homes, if they are the patient's usual place of residence. Over 39% of people who died in Derbyshire, died in their usual home, but this ranged from 21.8% in the Whitfield ward to 69.8% in the Sett ward, both of High Peak.

6.5 Housing Plans 2014-2019

The East Midlands Regional Plan outlines plans for new housing across the County. By 2026 (from 2006) it is expected that 77,000 new homes will be built with 14,400 in Derby and 62,600 in the rest of the county. In the next 3-5 years, it is expected that around 14,000 new homes will be built in accordance with the plan.

Projected housing plans are published at District level in their Strategic Housing Land Availability Assessments (SHLAAs) which contain short and longer term housing projections to meet the needs of their populations. These will be considered within each District Health Profile. SHLAAs provide information on potential developments and even those with planning permission may not proceed to new builds. For the purposes of the PNA, it has been assumed that developments with planning permission and that are expected to be built within the next 3-5 years can be taken as a potential source of population expansion. Longer term plans can be considered in future PNAs. Short statements on local developments can be found within the locality profiles for districts in section 7.

7. LOCALITY PROFILES AND PHARMACEUTICAL PROVISION.

7.1 Amber Valley

7.1.1 Introduction

The borough of Amber Valley contains the four market towns of Alfreton, Belper, Heanor and Ripley as well as many villages and smaller settlements. Most of the borough's residents live in the four market towns, all of which have experienced economic and social difficulties as a result of the decline of their traditional industries. The population of around 121,000 is expected to rise to 141,000 by 2033 and includes just under 4% of people who are not White British.

There are marked health inequalities by gender and level of deprivation. Although the borough ranks 158th out of 326 English local authority areas in the 2010 English Index of Multiple Deprivation (1 is the most deprived), 7 of the 78 Lower Super Output Areas fall within the top 20% of most deprived areas in England. There is also a hidden element of deprivation which exists in the western parishes amongst the farming community.

However, the proportion of children living in poverty is lower than the England average and over the last 10 years, the rates of death from all causes and rates of early death from cancer have improved.

Much of the important work to address these health and wellbeing needs is achieved through the work of the Amber Valley Partnership as documented in the 2009-2014 Amber Valley Sustainable Community Strategy.

7.1.2 Key Challenges

Clinical Health

To reduce attendances at A&E by children and young people

To increase the number of adults in contact with secondary mental health services in settled accommodation

To increase the take up of the NHS Health Check programme by those eligible

To reduce the rate of emergency readmission within 30 days of discharge from hospital

To reduce inequalities in mortality rates

To reduce the number of excess winter deaths

Wider Determinants of Health

To address the requirements of children with Special Educational Needs.

To reduce school absence due to illness

To reduce fixed exclusions from school

To address inequalities in alcohol related admissions

To increase numbers of volunteers (community development / sustainable services)

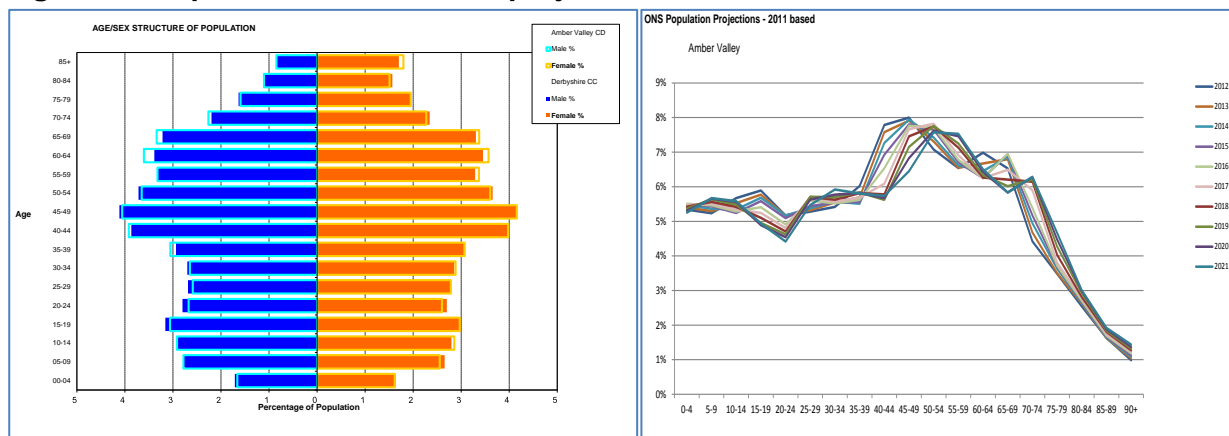
To provide sufficient numbers of suitable homes in the right location to meet future needs and support appropriate independent living into later life

To fund rising demand for housing adaptations to support independent living and those that are living with a long-term condition.

7.1.3 Population and other characteristics

Population Structure

Overall the population of Amber Valley is quite similar to that of Derbyshire as a whole.

Figure 7.1 Population structure and projections

Population Projection

Population projections show an ageing population, such that by 2021, 23% of the population will be aged over 65, 11% over 75 and 3% over 85, equating to 184500, 88700 and 26600 people respectively. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before.

Population Density

The population is at its most dense in the centre and along the eastern side of the borough and this is where most of the healthcare services are located.

Deprivation

Deprivation is greatest in the more densely populated eastern side of the borough, and to a lesser extent in the centre around Belper.

7.1.4 Health Profile

Education

The percentage of pupils with a statement of Special Educational Needs as at January 2013 was significantly higher than for Derbyshire. This was the third highest rate of any of the districts.

School absence due to illness at primary schools in 2012/13 was significantly higher than for Derbyshire. This was the third highest district rate.

The rate of fixed term exclusions from primary schools was the highest in Derbyshire and significantly higher than the Derbyshire and England rates.

Social Care (children)

The rate of Children in Need, as at 31st March 2013, was 229.1 per 10,000 – significantly lower than for Derbyshire and England. This was the second lowest district rate.

Life Expectancy

For 2009-2011 life expectancy at 65 for men stood at 18.1 years for Amber Valley, slightly lower than for the County, which in turn is slightly lower than for England. At 20.4 years, life expectancy at 65 for women is lower than the 20.8 for Derbyshire and 21.1 for England. Disability free life expectancy (DFLE) at age 65 ranged from 7.8 years to 10.4 years within

Derbyshire in 2006-08 for males and from 7.3 years to 15 years for females. Overall males tend to spend a higher proportion of their life disability free.

Lifestyle

These are measures of how people are adopting healthy lifestyles and making healthy choices. Generally speaking Amber Valley differs little from Derbyshire as a whole in terms of healthy living.

The rate of obesity recorded in general practice is significantly lower in Amber Valley than for England and the county as a whole.

Environment

These indicators include some of the wider issues which can impact on health and wellbeing.

Amber Valley has the highest percentage of households living in fuel poverty of the eight districts; however this is not significantly different from the county average.

There were 9.1 violent crimes per 1000 people in 2011 in Amber Valley, slightly lower than for the county as a whole and significantly lower than for England. However, at ward level this ranged from 1.2 to 18.1. There is good reason to believe that much of this violence is alcohol-related.

The rate of people killed or seriously injured on the roads is significantly lower than the Derbyshire average and lower than for England.

Social Care (adults)

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008 it was estimated that about the same proportion, 30.6%, of the population aged over 65 had moderate to very high needs in Amber Valley as in the county as a whole. However, the rate ranged from 19.3% to 33.8% at ward level. In 2009 a significantly lower percentage of over 65s were in receipt of one or more services from Adult Social Care than county-wide, ranging at ward level from 7.8% to 21.0%.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term condition.

In 2010/11 a higher proportion of adults in contact with secondary mental health services were in employment than in the county as a whole but a significantly lower proportion lived in settled accommodation.

In 2012/13 Amber Valley had a significantly lower rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions than Derbyshire, but at ward level this ranged from 77.7 per 1,000 to 277.8.

The prevalence of dementia reported in general practice in 2011 was lower than in Derbyshire overall and was the third lowest of the districts. Within the district practice rates ranged from 0.3% to 1.1% - tenth highest.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

In 2012/13 the great majority of survey respondents had a favourable experience of GP Services in Amber Valley, but this ranged from 81% to 96% according to practice.

Most, but by no means as many, also had a favourable experience of Out of Hours services, but again this ranged from 34% to 90%.

A significantly higher proportion of those eligible had taken up diabetic retinopathy screening in 2010/11, with practice rates ranging from 72% to 83% - the highest in the county.

The coverage rate in Amber Valley for cervical screening in 2010/11 was significantly higher than in Derbyshire as a whole. The coverage rate for breast screening was also significantly higher than across the county and was the highest for the eight districts.

In the last three months of 2011 significantly fewer of the eligible population in Amber Valley received an NHS Health Check than across Derbyshire. Ward rates ranged from 0.2% to 3.9%. Take up of flu vaccination by the over 65s was significantly higher in Amber Valley than in Derbyshire as a whole.

A&E attendance rates in 2012/13, for both under 5s and 5 to 18 year olds, were significantly higher than for Derbyshire as a whole. The under 5 rate was the highest and the 5 to 18 rate was the second highest in the county.

The 2012/13 rate of admission in under 1 year olds for gastroenteritis was significantly lower than for Derbyshire and was the lowest district rate.

The rate of emergency admissions for acute conditions that should not usually require hospital admission in 2012/13 was significantly lower than for Derbyshire, but ward rates ranged from 207.7 to 527.0 per 1,000 population.

A significantly higher proportion of discharges resulted in an emergency readmission in Amber Valley in 2010/11. This is the highest percentage of any district by some way. At ward level the proportions range from 17.4 to 32.8 – the highest in the county.

Although the rate of acute hospital admissions as a result of falls or falls injuries for over 65s in 2010/11 was slightly lower than for Derbyshire as a whole, ward rates ranged from 7.1 per 1,000 to 30.7.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

Although premature mortality from cancer in Amber Valley in 2009-2011 differed little from that for Derbyshire, it was significantly lower than for England. The ward rates ranged from 48.2 to 190.7 per 100,000.

Again, although premature mortality from cardiovascular disease in Amber Valley did not differ significantly from Derbyshire it was significantly lower than for England, and the ward rates ranged from 20.0 to 107.9.

Premature mortality from liver disease, although similar to the county was much higher than for England, though not quite significantly so.

For premature mortality from respiratory diseases, the Amber Valley rate was lower than the Derbyshire rate and significantly lower than for England. The ward rates ranged from 7.4 to 37.5 – the highest in the county.

Mortality from causes considered amenable to healthcare was slightly lower than the Derbyshire, with ward rates ranging from 37.1 to 167.3.

Survey data suggests that many people would, given the choice, prefer to die at home. Although broadly similar to the county as a whole the percentage of Amber Valley residents who died in their usual home ranged from 27.4 to 52.0.

7.1.5 Future Housing Developments

The emerging Local Plan for Amber Valley estimates that around 9,000 dwellings will be built by 2028. The 7 largest sites (of over 300 units) will be in Alfreton, Heanor, Ripley, North of Denby and on the edge of Derby.

7.1.6 Current Provision

Residents of Amber Valley have access to a range of services that reflect the health needs of the district. The density of pharmacies is similar to the County average. The numbers of pharmacies per head providing various locally commissioned services are also similar to County averages.

Rationale:

The map (figure 7.2) shows that there are currently 27 pharmacies within Amber Valley, giving 22 pharmacies per 100,000 population, about the same as the County average. Larger settlements are all within 1 mile of a pharmacy or dispensing practice.

The advanced and locally commissioned services currently provided by these pharmacies are shown in Table 7.1. The 'spread' of advanced and locally commissioned services is considered to be adequate across the area and population.

The opening hours of these pharmacies are shown in Appendix 7.

Amber Valley is partly rural and some patients may have to travel up to 5 miles to a pharmacy or for other goods and services. Car availability is higher than the national average and there is good provision of pharmacies across the district and on the borders of neighbouring counties.

The projected housing plans are not expected to add appreciably to the population in the next 3 years and the largest developments are already supplied with pharmacies.

Statement of pharmaceutical need subject to consultation:-

The PNA found that that pharmaceutical need in Amber Valley is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

Figure 7.2 Map showing location of pharmacies and concentric rings about each at one mile intervals

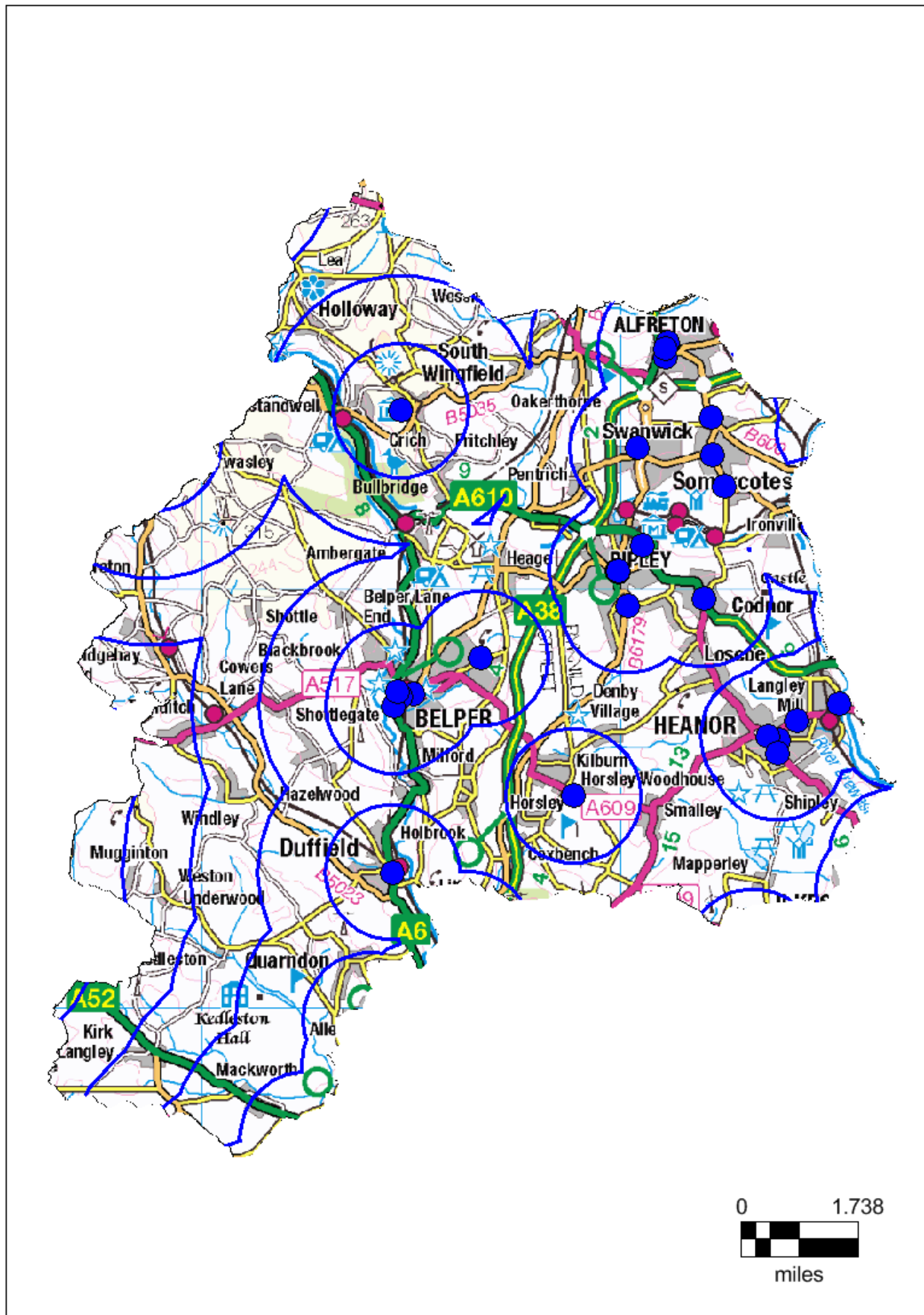


Table 7.1 Pharmacy Services provided in Amber Valley

Community Pharmacy Services	Amber Valley		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	26	21	144	19
New Medicines Service	19	15	118	15
100 hour pharmacy	5	4	16	2
Out of Hours	2	2	26	3
Palliative Care	25	20	86	11
Emergency Supply Service	25	20	119	15
Public Health commissioned services:-				
Smoking Cessation	13	11	71	9
Nicotine Replacement Therapy (NRT)	26	21	131	17
Oral Emergency Contraception	17	14	101	13
Substance Misuse/ Supervised Consumption	21	17	118	15
Needle exchange	6	5	40	5
CCG commissioned services				
MAR Sheets	23	19	109	14
Anticoagulants (INR testing)	2	-	8	-
Gluten-free food	23	-	24	-
Total	27	22	161	21
Dispensing GPs	2	2	20	3

7.2 Bolsover

7.2.1 Introduction

Bolsover is a largely rural district in the north eastern part of Derbyshire, which used to have a strong local economy based on coal mining. Bolsover is now the most disadvantaged area of Derbyshire with high levels of unemployment and relatively low skills base, both of which contribute to health inequalities affecting the district.

Bolsover's population of around 75,000 is approximately a tenth of the population of Derbyshire, and is expected to rise to about 84,000 by 2033. The age structure of the population is similar to the county as a whole, but by 2033, it is expected that the proportion of children and young people will be higher than average. Around 96% of the population are White British.

The health of people in Bolsover is generally worse than the national average with higher all cause mortality and lower life expectancy. Rates of hospital stays for alcohol related harm, people diagnosed with diabetes, deaths from smoking and excess winter deaths are all worse than the England average. Over the last 10 years, the rates of death from all causes and rates of early deaths from heart disease and stroke and from cancer have all improved, but they remain higher than the England average. The district is relatively deprived, ranking 58th out of 326 English local authority areas in the 2010 English Index of Multiple Deprivation (1 is the most deprived). Some 13 of the 48 Lower Super Output Areas in Bolsover fall within the top 20% of most deprived areas in England.

7.2.2 Key Challenges

Children

To reduce smoking in pregnancy

To increase the number of women initiating breastfeeding and continuing at both 10 days and 6-8 weeks

To reduce admissions for asthma

To reduce the number of children requiring free school meals

To reduce the numbers of children and dependent young people living in poverty.

To improve the GCSE pass rate

To address the issues of the large number of children with Special Educational Needs

To reduce the number of children requiring School Action Plus

To reduce the number of primary school absences due to illness

To reduce persistent absenteeism in primary schools

To reduce the number of school exclusions

Adults

To increase life expectancy at age 65

To increase the number of physically active adults

To reduce alcohol related admissions to hospital

To reduce the prevalence of smoking

To reduce the prevalence of diabetes

To reduce the prevalence of obesity

To reduce the prevalence of violent crime

To increase the proportion of adults in contact with secondary mental health services in settled accommodation

To reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions

To improve access to diabetic retinopathy screening

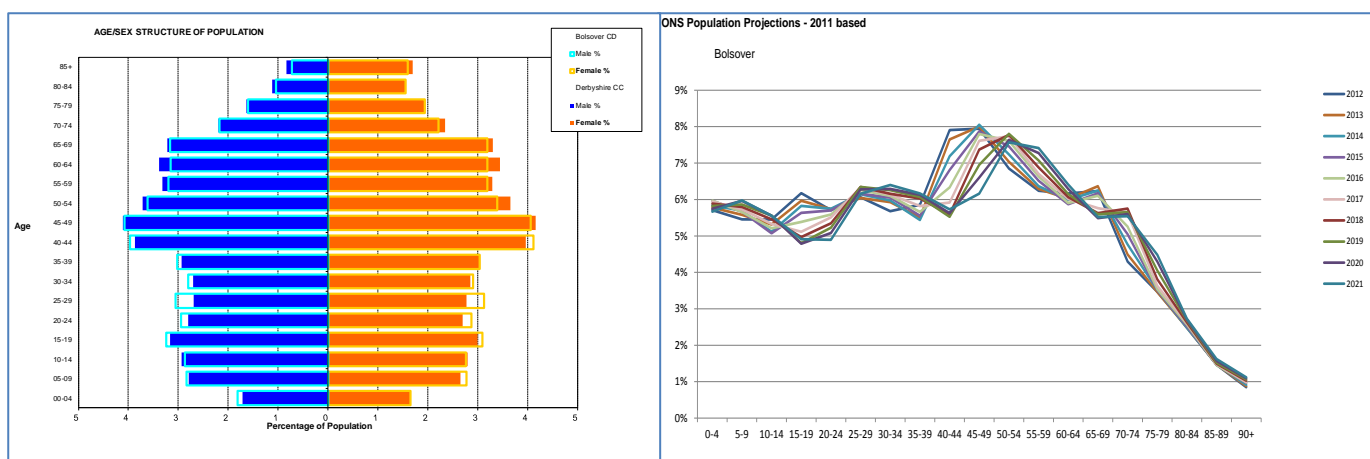
- To extend breast cancer screening coverage
- To extend cervical cancer screening coverage
- To increase flu vaccination uptake in the over 65s
- To reduce emergency admissions for acute conditions that should not usually require hospital admission
- To reduce hospital admissions as a result of self-harm
- To reduce under 75 mortality from respiratory disease
- To reduce excess winter deaths

7.2.3 Population and other characteristics

Structure

Overall the population of Bolsover is quite similar to that of Derbyshire as a whole. There is a greater proportion of people in their twenties and of children under 5, suggesting a larger number of young families.

Figure 7.3 Population structure and projections



Projection

Population projections show an ageing population, such that by 2033 21% of the population – 16,900 people - will be aged over 65, 10% (8,000) over 75 and 3% (2,200) over 87. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before. However the projected proportions of older people are lower than for the county as a whole, reflecting Bolsover's much worse rates of premature mortality.

Density

Bolsover's population is distributed fairly evenly across the district with a number of main population centres.

Deprivation

It is clear that with the exception of the far north, some of the south and very few other small areas, Bolsover is a particularly deprived district.

7.2.4 Health Profile

Pregnancy & birth

In 2012/13, Bolsover had the lowest rates of breastfeeding in Derbyshire and they were significantly lower than for Derbyshire and for England.

Smoking in Pregnancy was also significantly higher in Bolsover (compared to Derbyshire and England).

Deprivation

As at January 2013, the percentage of children entitled to free school meals was significantly higher than for both Derbyshire and England and was the highest for all of the districts.

The percentages of dependent under 20 year olds and under 16 year olds living in poverty in 2011 were both significantly higher than for Derbyshire and England. These were both the highest rates amongst the districts.

Education

In 2012/13, Bolsover had the lowest GCSE pass rate of all the Derbyshire districts, significantly lower than Derbyshire and England.

As at January 2013 Bolsover had the highest proportion of children with Special Educational Needs, significantly higher than Derbyshire, and England.

Bolsover also had a significantly higher proportion of children with a School Action Plan. This was also the highest district rate.

A significantly higher proportion also had a statement of SEN. This was the second highest district rate.

In 2011/12, Bolsover had a significantly higher absence rate due to illness from primary schools.

The rate of persistent absence from primary schools was also significantly higher than for Derbyshire and England, and the highest amongst the districts.

Bolsover also had a significantly higher rate of fixed term exclusions from secondary schools than Derbyshire and England. This was the second highest district rate.

There was also a significantly higher rate of permanent exclusions, also the highest amongst the districts, compared to Derbyshire and England.

Bolsover did, however, have a significantly lower rate for absence due to illness from secondary schools than both Derbyshire and England.

Social Care (children)

The rate of Children in Need, as at 31st March 2013, was significantly lower than for Derbyshire and England.

Life Expectancy at age 65

Life expectancy at 65 for men stands at 17.2 years for Bolsover, significantly lower than for the County at 18.2 and England at 18.7. Bolsover has the lowest male life expectancy of all the districts.

At 19.8, life expectancy at 65 for women is significantly lower than the 20.8 for Derbyshire and 21.1 for England, and is the lowest in the eight districts.

The gap in life expectancy from Bolsover to Derbyshire has narrowed in recent years.

Disability free life expectancy (DFLE) at age 65 ranged from 7.8 years to 10.4 years within Derbyshire in 2006-08 for males, and from 7.3 years to 15 years for females. Overall males tend to spend a higher proportion of their life disability free.

Lifestyle (adult)

These are measures of how people are adopting healthy lifestyles and making healthy choices. According to the Active People Survey just over 50% of people in Bolsover are physically active. This is significantly lower than the county and England averages and is the worst rate of the 8 districts.

The district rate of alcohol related admissions to hospital per 100,000 population in 2011/12 was significantly higher than that for the county and is the second highest in the eight districts.

The percentage of adults in Bolsover who smoke was higher than in Derbyshire overall and was the highest rate in the eight districts.

The level of diabetes recorded in general practice is significantly higher in Bolsover than in Derbyshire at 7.2%. This is the highest rate in any of the eight districts. Within the district practice rates range between 7.5% and 7.4% - the highest in the county.

A significantly higher proportion of adults in Bolsover have been recorded in general practice as being obese compared Derbyshire as a whole, However, the district has only the second highest rate in the eight districts. Practice rates range from 7.0% to 13.3% – fifth highest in the county.

Environment

These indicators include some of the wider issues which can impact on health and wellbeing.

The proportion of households in fuel poverty, while not so different from the county average is considerably higher than for England.

There were 10.2 violent crimes per 1000 people in 2012 in Bolsover, significantly more than for Derbyshire at 9.4, but still only the third highest of the districts. At ward level this ranges from 3.6 in to 27.2 – sixth highest in the county. There is good reason to believe that much of this violence is alcohol-related.

Social Care (adults)

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008 it was estimated that over 42% of the population aged over 65 in Bolsover have moderate to very high needs. This is significantly higher than the county as a whole and is by far the highest rate amongst the districts. The ward rates range from 33.0% to 57.3% and include the six highest in the county.

In 2009 17.4% of over 65s in Bolsover received one or more services from Adult social Care, significantly higher than the percentage receiving services county-wide. Again, this is the highest rate amongst the districts. The ward rates range from 9.0% to 32.0% and include the three highest in the county.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term conditions.

In 2010/11 13.5% of adults in contact with secondary mental health services were in employment, lower than across Derbyshire. This was the second lowest proportion of all the districts.

However, only 77.3% lived in settled accommodation, significantly lower than the 83.8% in the county overall. This was also the lowest rate amongst the eight districts.

Bolsover had a significantly higher rate than Derbyshire for unplanned hospitalisation for chronic ambulatory care sensitive conditions in 2012/13. Ward rates ranged from 111.4 to 498.2 per 1,000 population, the latter being the highest in the county.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

A significantly lower proportion of those eligible had taken up diabetic retinopathy screening in 2010/11 – the second lowest rate of the districts by a very small margin - with practice rates ranging from 64% to 76%.

The coverage rate in Bolsover for cervical screening was significantly lower than in Derbyshire and was also the third lowest amongst the districts.

The coverage rate for breast screening was also significantly lower than across the county. This was also the lowest rate amongst the districts.

Take up of flu vaccination by the over 65s was significantly lower in Bolsover than in Derbyshire as a whole.

The A&E attendance rate in 2012/13, for 5 to 18 year olds, was significantly lower than for Derbyshire as a whole. This was also the third lowest in the county.

Asthma admissions in 5-18 year olds were significantly higher than for Derbyshire in 2010/11-12/13.

The rate of emergency admissions for acute conditions that should not usually require hospital admission for Bolsover was significantly higher than for Derbyshire, and was the second highest amongst the eight districts. Ward rates ranged from 247.7 to 848.6 – the second highest in the county.

A significantly lower proportion of hospital discharges in 2010/11 resulted in an emergency readmission within 30 days in Bolsover. This is the second lowest percentage for any of the eight districts. The ward proportions range from 9.8 to 19.7.

The rate of hospital admission following self-harm was significantly higher than for the county, at 2.7 admissions per 1,000 population compared to 2.2.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

For the most part mortality rates 2009-2011 in Bolsover did not differ significantly from those for the county as a whole.

The premature mortality rate from respiratory diseases was significantly higher than for Derbyshire: 27.8 per 100,000 compared to 18.1. The ward rates ranged from 17.7 to 87.1 – the highest in the county.

The ward rates for premature deaths from cancer ranged from 51.6 to 217.6 – fifth lowest to highest in the county.

Ward rates for under75 mortality from all cardiovascular disease ranged from 51.2 to 141.6 – fourth lowest to eighth highest in the county.

Ward rates for mortality from causes considered amenable to healthcare ranged from 47.8 to 157.7.

There are significantly more excess winter deaths than in Derbyshire as a whole, with an Excess Winter Mortality Index of 28.3 compared to 19.7. Bolsover has the highest index by some way. The indices range from -17.3 (fewer deaths in winter) to 107.9 – ninth lowest to second highest in the county.

Survey data suggests that many people would, given the choice, prefer to die at home. 41.0% of people who died in Bolsover did so in their usual home, compared to 39.1% across Derbyshire. This was the second highest proportion amongst the districts. The ward rates ranged from 27.4 to 57.6 – ninth lowest to fifth highest in the county.

7.2.6 Future Housing Developments

Bolsover District has an assessed housing need for between 235 and 240 new homes per annum. This need will be met through delivery of key strategic housing sites including Brookvale in Shirebrook and Bolsover North, which together will see the delivery of around 1500 new homes, as well as smaller sites across the district.

7.2.5 Current Provision

Residents of Bolsover have access to a range of services that reflect the health needs of the district. The density of pharmacies is similar to the County average. The numbers of pharmacies per head providing various locally commissioned services are also similar to County averages, with the exception that there are fewer than half the pharmacies per population offering oral emergency contraception.

Rationale:

The map (figure 7.4) shows that there are currently 27 pharmacies within Bolsover, giving 17 pharmacies per 100,000 population, slightly lower than the County average. Larger settlements are all within 1 mile of a pharmacy or dispensing practice.

The advanced and locally commissioned services currently provided by these pharmacies are shown in Table 7.2. The 'spread' of advanced and locally commissioned services is considered to be adequate across the area and population.

The opening hours of these pharmacies are shown in Appendix 7.

Bolsover is largely rural and some patients may have to travel up to 4 miles to a pharmacy or for other goods and services. Car availability is higher than the national average and there is good provision of pharmacies across the district and on the borders of neighbouring counties.

The projected housing plans are not expected to add appreciably to the population in the next 3 years and the largest developments are already supplied with pharmacies.

Statement of pharmaceutical need subject to consultation:-

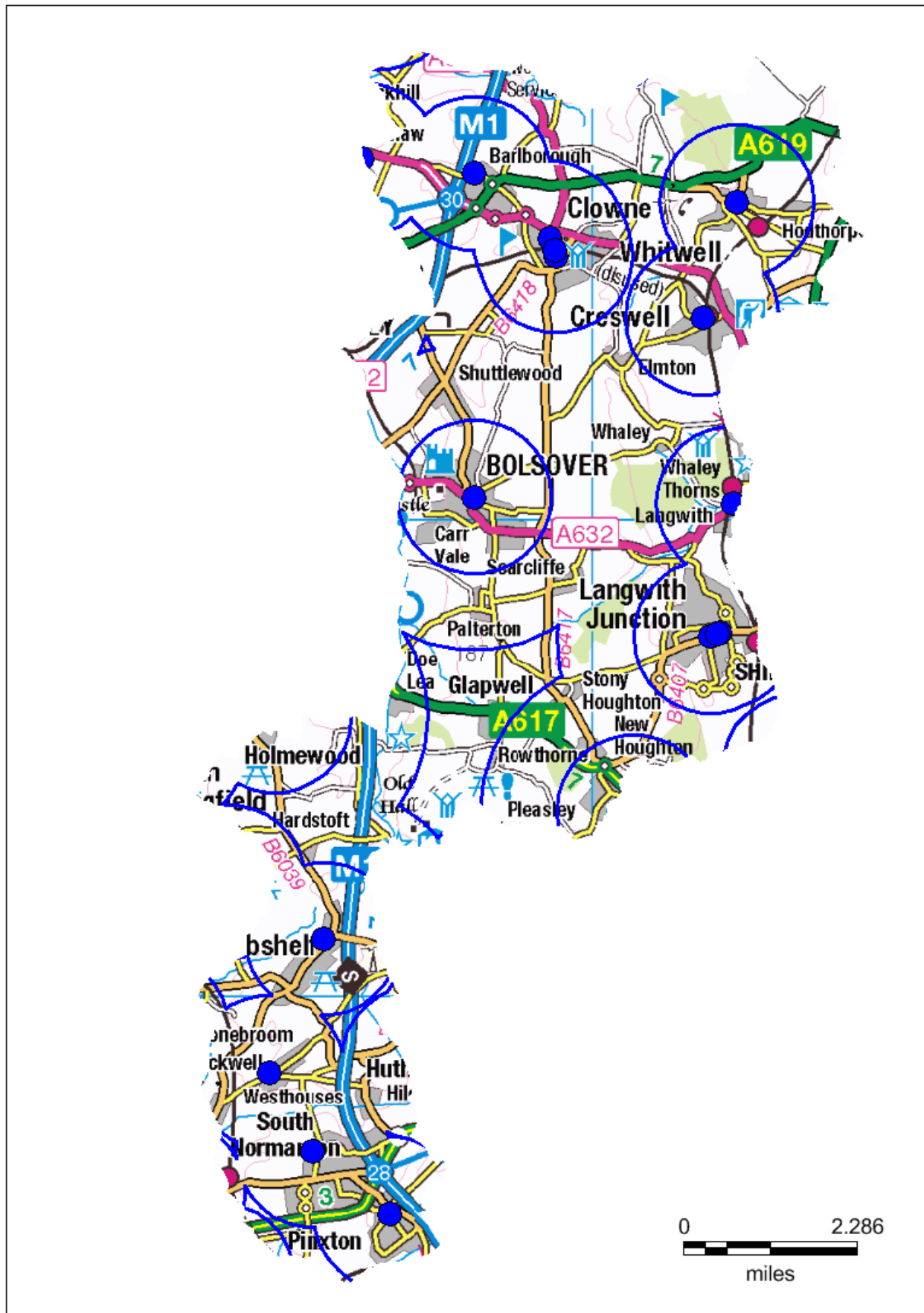
The PNA found that that pharmaceutical need in Bolsover is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

Table 7.2 Pharmacy Services provided in Bolsover

Community Pharmacy Services	Bolsover		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	14	18	144	19
New Medicines Service	12	16	118	15
100 hour pharmacy	2	3	16	2
Out of Hours	2	3	26	3
Palliative Care	6	8	86	11
Emergency Supply Service	14	18	119	15
Public Health commissioned services:-				
Smoking Cessation	8	10	71	9
Nicotine Replacement Therapy (NRT)	11	14	131	17
Oral Emergency Contraception	5	7	101	13
Substance Misuse/ Supervised Consumption	10	13	118	15
Needle exchange	4	5	40	5
CCG commissioned services				
MAR Sheets	6	8	109	14
Anticoagulants (INR testing)	1	-	8	-
Total	27	17	161	21
Dispensing GPs	2	2	20	3

Figure 7.4 Map showing location of pharmacies and concentric rings about each at one mile intervals



7.3 Chesterfield

7.3.1 Introduction

Chesterfield is the largest settlement in the county of Derbyshire. It is a relatively compact and mainly urban area. Chesterfield is a major centre of employment (over 48,000 people work in the Borough) and attracts almost 20,000 in-bound commuters on a daily basis. The Borough of Chesterfield has an estimated population of over 100,000; just under 95% of whom are White British and just over 5% are from other ethnic groups. The population of the Borough will have risen to over 112,000 by 2033. The Borough is relatively deprived, ranking 91st out of 326 English local authority areas in the 2010 English Index of Multiple Deprivation (1 is the most deprived). Some 17 of the 68 Lower Super Output Areas in Chesterfield fall within the top 20% of most deprived areas in England.

7.3.2 Key challenges

Children

- To reduce asthma admissions
- To reduce gastroenteritis admission in the very young
- To reduce injury admissions
- To reduce the number of children who need free school meals
- To reduce the numbers of children and young people living in poverty
- To address the high rate of children with a statement of Special Educational Needs
- To reduce school absences due to illness
- To reduce the number of children in need
- To reduce the number of children in care
- To reduce the number of children requiring a child protection plan

Adults

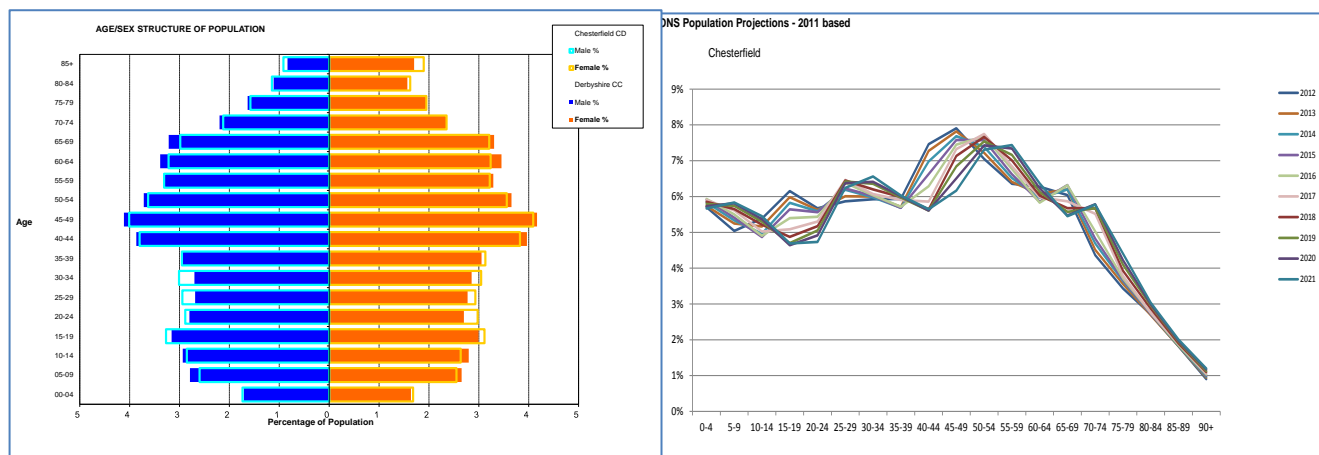
- To increase life expectancy at 65 for men
- To reduce alcohol related admissions to hospital
- To reduce the prevalence of diabetes
- To reduce the prevalence of obesity
- To reduce the prevalence of domestic abuse
- To reduce the prevalence of violent crime
- To reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions
- To address dementia and its impacts
- To extend breast cancer screening coverage
- To extend cervical cancer screening coverage
- To improve the patient experience of GP services
- To improve access to diabetic retinopathy
- To increase take up of the NHS Health Check programme by those eligible
- To reduce emergency admissions for acute conditions that should not usually require hospital admission
- To reduce hospital admissions as a result of self-harm
- To reduce hospital admissions in the over 65s as a result of falls
- To reduce mortality from cause considered amenable to healthcare
- To reduce the variation in excess winter mortality
- To increase the proportion of people able to die at home

7.3.3 Population and other characteristics

Structure

Overall the population of Chesterfield is quite similar to that of Derbyshire as a whole. There is a greater proportion of people aged under 40 but over 15 and of people aged over 80.

Figure 7.5 Population structure and projections



Projection

Population projections show an ageing population, such that by 2021 22% (23,400) of the population will be aged over 65, 11% (11,400) over 75 and 3% (3,400) over 87. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before.

Density

As might be expected Chesterfield's population is fairly evenly dense across the district with a number of healthcare centres.

Deprivation

The main areas of worst deprivation are to the east around Staveley and to the west around Chesterfield itself. There are areas of lower deprivation in between and on the western edge of the borough.

7.3.4 Health Profile

Childhood Vaccinations

A significantly higher proportion of two year olds received a first MMR dose in 2011/12 than in England and Derbyshire as a whole.

Deprivation

As at January 2013, the percentage of children entitled to free school meals – at 19.0% - was significantly higher than for both Derbyshire (17.3%) and England (18.0%) and was the second highest for all of the districts.

The percentages of dependent under 20 year olds (20.6%) and under 16 year olds (21.4%) living in poverty in 2011, were both significantly higher than for Derbyshire (17.4% and 17.1%) and England (20.1% and 20.6%). These were both the second highest rates amongst the districts.

Education

As at January 2013 a significantly higher proportion of children than in Derbyshire and England as a whole had a statement of Special Educational Need: 3.2% compared to 2.7% and 2.8% respectively. This was the highest district rate.

School absence due to illness at both primary schools (2.9%) and secondary schools (3.5%) in 2012/13 was significantly higher than for Derbyshire (2.61%). These were both the lowest district rates.

Social Care (children)

The rate of Children in Need, as at 31st March 2013, was significantly higher than for Derbyshire and England. This was the lowest rate in the county.

The rate of Children in Care, as at 31st March 2013, was also significantly higher than for Derbyshire and England. This was also the lowest rate of the districts.

The rate of children with a Child Protection Plan, as at 31st March 2013, was also significantly higher than for Derbyshire and England. This too was the highest rate of the districts.

Life Expectancy at age 65

Life expectancy at 65 for men stands at 17.4 years for Chesterfield, significantly lower than for the County at 18.2. Chesterfield has the second lowest male life expectancy of all the districts. At 20.5, life expectancy at 65 for women is about the same as for Derbyshire and is the fourth highest in the eight districts.

Disability free life expectancy (DFLE) at age 65 ranged from 7.8 years to 10.4 years within Derbyshire in 2006-08 for males, and from 7.3 years to 15 years for females. Overall males tend to spend a higher proportion of their life disability free.

Lifestyle

These are measures of how people are adopting live healthy lifestyles and making healthy choices.

Generally speaking the people of Chesterfield live more unhealthily than in the county as a whole, although according to survey there are more physically active people and fewer smokers than on average.

In 2012/13 the district rate per 100,000 populations of alcohol related admissions to hospital was significantly higher than that for the county and was the highest in the eight districts. There is however considerable variation between electoral wards within Chesterfield. The best rate was 1497.8 and the worst 2207.3.

In 2013 the level of diabetes recorded in general practice was significantly higher in Chesterfield than in Derbyshire. This is the second highest rate in any of the eight districts, with practice rates ranging from 7.0% to 7.2%: the 8th lowest and sixth highest.

In 2013 a significantly higher proportion of adults in Chesterfield were recorded in general practice as being obese compared with Derbyshire as a whole. At 10.9%, the borough has the highest rate in the eight districts, with practice rates ranging between 8.0% and 12.2%.

Environment

These indicators include some of the wider issues which can impact on health and wellbeing.

The proportion of households in fuel poverty, while not so different from the county average is considerably higher than for England.

There were significantly more cases of domestic violence per 1,000 head of population in Chesterfield in 2012, than in Derbyshire as a whole and this is the highest rate for the eight districts.

There were also significantly more violent crimes per 1000 people in 2012 in Chesterfield- 13.3 against 9.4 for the county - and this was the highest of the district rates. At ward level this ranges from 1.9 to 57.2 – half as much again the rate in any other ward in Derbyshire. There is good reason to believe that much of this violence is alcohol-related.

Chesterfield had a significantly lower rate of killed and seriously injured casualties on the road than the county as a whole. It also had the lowest rate amongst the eight districts by some margin.

Social Care (adults)

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008 it was estimated that significantly more of the population aged over 65 in Chesterfield had moderate to very high needs than in the county as a whole. The ward rates range from 27.1% to 47.2%. Overall, in 2009, a significantly higher percentage of over 65s in Chesterfield receive one or more services from Adult Social Services than is the case in the county as a whole. This is the highest rate amongst the districts and the ward rate ranges from 9.8% to 21.8%.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term condition.

In Chesterfield in 2010/11 a lower proportion (14%) of adults in contact with secondary mental health services was in employment. This is the third lowest proportion of all the districts.

The proportion living in settled accommodation was significantly higher at 87.9%.

In 2012/13, Chesterfield had a significantly higher rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions than Derbyshire, 27506 per 1,000 population compared with 217.2. This was by far the highest amongst the districts. Ward rates ranged from 107.0 to 478.1 – the second highest ward rate in the county.

The prevalence of dementia recorded in general practice in 2013, was significantly higher than that for Derbyshire. Within the district, practice rates ranged from 0.5% to 1.3%, including the sixth, seventh and eighth highest rates.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

In 2012/13 the proportion of survey respondents with a favourable experience of GP Services in Chesterfield was significantly lower than for the county as a whole, but this ranged from 79% to 95% according to GP practice.

The take up of diabetic retinopathy screening in Chesterfield in 2010/11 was significantly lower than in the county as a whole, ranging at practice level from 62% - the lowest in the county – to 78%.

The coverage rate in Chesterfield for cervical screening was slightly lower than in Derbyshire as a whole: 78.5 % compared with 79.5%. Breast screening coverage was significantly lower than in the whole county, 78.5% compared with 79.4%, and the second lowest rate of the districts. In the last three months of 2011 significantly fewer of the eligible population in Chesterfield received an NHS Health Check than across Derbyshire. Ward rates ranged from 0.6% to 2.4%.

The A&E attendance rate in 2012/13, for under 5 year olds, was significantly lower than for Derbyshire as a whole. This was also the lowest in the county.

The hospital admission rate for under 5 year olds with asthma was significantly higher than for Derbyshire in 2010/11-12 and this was the highest district rate.

The admission rate for under 1 year olds with gastroenteritis was also significantly higher than for Derbyshire; again the highest district rate.

The admission rate for 15-24 year olds with an injury was also significantly higher than for Derbyshire. Again, this was the highest rate amongst the eight districts.

The rate of admission for acute conditions that should not usually require hospital admission for Chesterfield in 2012/13 was significantly higher at 622.4 than for Derbyshire at 411.6 and by some way the highest amongst the eight districts. Ward rates ranged from 353.7 to 1020.9 – the highest ward rate in the county.

In 2010/11 a significantly lower proportion of discharges from hospital were followed by an emergency readmission within 30 days in Chesterfield. The proportions ranged from 9.7 to 19.2.

The admission rate as a result of self-harm in Chesterfield was significantly higher than for Derbyshire – 3.7 per 1,000 population and 2.2 - and was the highest amongst the districts. Chesterfield also had the highest ward rate at 7.7.

The rate for acute hospital admissions as a result of falls or falls injuries for over 65s, was significantly higher than for Derbyshire as a whole – 27.3 and 21.0 - with ward rates ranging from 11.8 to 42.1 – the highest ward rate.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

In 2009-11 the rates of premature death in Chesterfield were not significantly different from those in Derbyshire as a whole. Chesterfield had the worst rate for liver disease, the fifth highest ward rate for cancer, the third highest ward rate for cardiovascular diseases and the eighth highest ward rate for respiratory diseases.

The Chesterfield rate for mortality from causes considered amenable to healthcare was higher than Derbyshire rate – 102.6 per 100,000 population and 83.0 - with ward rates ranging from 32.4 to 171.3 – third highest in the county.

There were significantly fewer excess winter deaths in Chesterfield than in Derbyshire as a whole in 2007-10, with an Excess Winter Mortality Index of 18.6 compared to 19.7. The ward indices range from 0 (no excess winter deaths) to 68.0; eighth highest in county.

Survey data suggests that many people would, given the choice, prefer to die at home.

37.7% of people who died in Chesterfield did so in their usual home, significantly lower than the 37.4% across Derbyshire as a whole. This was the lowest proportion amongst the districts.

The ward rates ranged from 23.7 to 49.7.

7.3.5 Future Housing Developments

Chesterfield's Local Plan states that there is a requirement for 7,600 additional properties between 20011 and 2031. The two largest developments of over 1,500 dwellings will be at Chesterfield Waterside and the Staveley Corridor.

7.3.6 Current Provision

Residents of Chesterfield have access to a range of services that reflect the health needs of the district. The density of pharmacies is similar to the County average. The numbers of

pharmacies per head providing various locally commissioned services are also similar to County averages.

Table 7.3 Pharmacy Services provided in Chesterfield

Community Pharmacy Services	Chesterfield		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	19	18	144	19
New Medicines Service	19	18	118	15
100 hour pharmacy	2	2	16	2
Out of Hours	3	3	26	3
Palliative Care	10	10	86	11
Emergency Supply Service	20	19	119	15
Public Health commissioned services:-				
Smoking Cessation	11	11	71	9
Nicotine Replacement Therapy (NRT)	18	17	131	17
Oral Emergency Contraception	15	14	101	13
Substance Misuse/ Supervised Consumption	18	17	118	15
Needle exchange	6	6	40	5
CCG commissioned services:-				
MAR sheets	15	14	109	14
Total	23	22	161	21
Dispensing GPs	2	2	20	3

Rationale:

The map (figure 7.6) shows that there are currently 12 pharmacies within Chesterfield, giving 12 pharmacies per 100,000 population, similar to the County average.

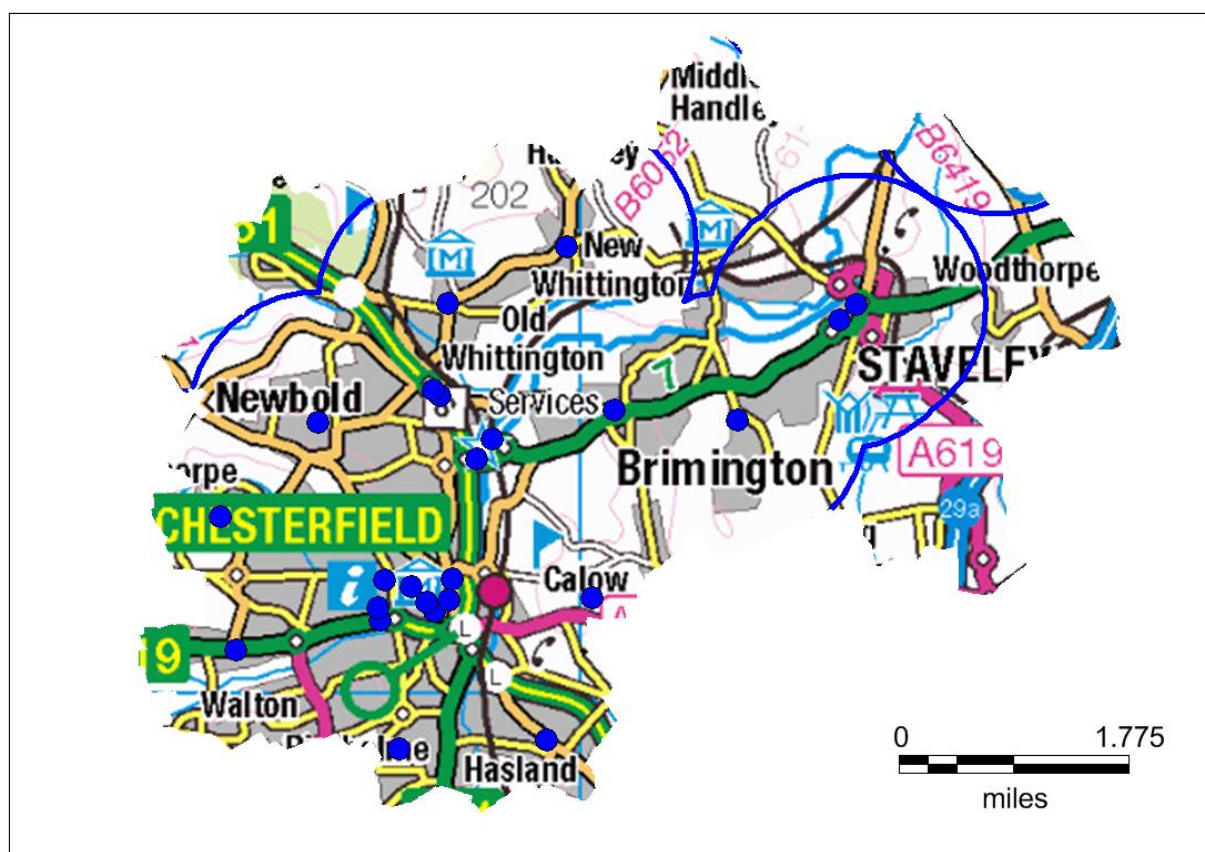
The advanced and locally commissioned services currently provided by these pharmacies are shown in Table 7.3. The 'spread' of advanced and locally commissioned services is considered to be adequate across the area and population.

The opening hours of these pharmacies are shown in Appendix 7.

Chesterfield is mostly urban and most points within it are no more than 1 mile from a pharmacy; none are more than 2 miles away.

The projected housing plans are not expected to add appreciably to the population in the next 3 years and the largest developments are already supplied with pharmacies.

Figure 7.6 Map showing location of pharmacies and concentric rings about each at one mile intervals

**Statement of pharmaceutical need subject to consultation:-**

The PNA found that that pharmaceutical need in Chesterfield is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

7.4 Derbyshire Dales

7.4.1 Introduction

Derbyshire Dales is a large geographical area covering 307 square miles that encompasses much of the Peak District National Park. The area is renowned for its outstanding beauty and is punctuated by over 100 small villages and three main market towns. The district has a population of over 70,000 of which over 80% live in rural settlements or market towns. Just over 6% are not White British.

The major industries are farming, mineral extraction and tourism, but public sector organisations such as the county council are also a major employer.

The health of the people in Derbyshire Dales is on average better than England average and the rest of Derbyshire County. However, the relatively prosperous appearance of the area masks small pockets of rural deprivation and health inequalities which cannot be easily detected in ward-based or other small area statistics.

7.4.2 Key challenges

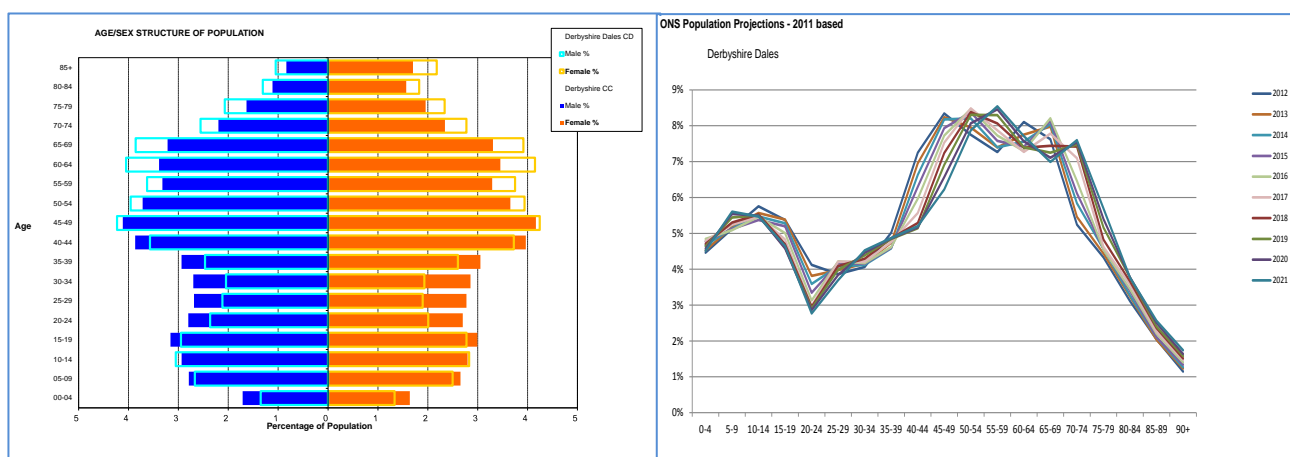
- To reduce A&E attendances by children
- To reduce killed and seriously injured casualties on the roads
- To increase take up of the NHS Health Check programme by those eligible
- To increase flu vaccination uptake in the over 65s
- To address inequalities in the rate of alcohol related admissions
- To address inequalities in emergency admissions

7.4.3 Population and other characteristics

Structure

The population of Derbyshire Dales is rather older than that of Derbyshire as a whole. There is a greater proportion of people aged and over (56% compared to 49%) and fewer in the under 45 age groups.

Figure 7.7 Population structure and projections



Projections

Population projections show an ageing population, such that, by 2021, 28% of the population (20,900 people) will be aged over 65, 14% (10,100) over 75 and 4% (3,200) over 85, with a large deficit in numbers entering working age. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before.

Density

Overall Derbyshire Dales is one of least densely populated parts of the county, although there are widely spread centres of high population. This leads to concentration of healthcare services and access issues for those living in more rural areas.

Deprivation

Relatively speaking Derbyshire Dales is not deprived, aside from an area in Matlock. However it must be noted that pockets of deprivation may still exist which are masked by the aggregation to Lower Super Output Area.

7.4.4 Health Profile

Pregnancy & Birth

In 2009-11, Derbyshire Dales had the lowest rates of teenage conception in the county, having significantly lower rates than Derbyshire as a whole for under 18s, and for under 16s.

In 2012/13, Derbyshire Dales also had significantly higher rates of breastfeeding than Derbyshire as a whole. Breastfeeding at birth and at 10 days were also the second highest rates amongst the districts whilst breastfeeding at 6-8 weeks was the highest.

Deprivation

The proportion of children eligible for free school meals, as at January 2013, was significantly lower than for Derbyshire or England and was the lowest for any of the districts.

In 2011, the proportions of both under 16 year olds and dependent under 20 year olds were significantly lower than for Derbyshire or England and were both the lowest rates in the county.

Education

The GCSE pass rate for 2012/13 in Derbyshire Dales was significantly higher than for Derbyshire and England and was the highest for the districts.

As at January 2013, the proportions of children with Special Educational Needs, with a statement of SEN and with a School Action Plus were all significantly lower than for Derbyshire and for England and were the second lowest rates for any of the districts.

In 2011/12, the rates of school absence due illness and persistent school absence, in both primary and secondary school, were all significantly lower than for Derbyshire and England and were the lowest rates in the county.

The rate of fixed term exclusions from secondary school was also significantly lower than for Derbyshire and England and was the lowest district rate.

In 2012/13, the proportion of 16-18 year olds not in education, employment or training was significantly lower than for Derbyshire and England and was the lowest rate for any of the eight districts of Derbyshire.

Social Care (children)

The rates of Children in Need and of Children in Care, as at 31st March 2013, were both significantly lower than for Derbyshire or England as a whole; they were also the lowest district rates in the county.

The rate of children with a Child Protection Plan was also significantly lower and was the second lowest in the county.

Life Expectancy at age 75

Life expectancy at 65 for men stands at 19.3 years for Derbyshire Dales, significantly higher than for the County at 18.2. Derbyshire Dales has the highest male life expectancy of all the districts.

At 21.7 years, life expectancy at 65 for women is significantly higher than for Derbyshire, at 20.8, and is also the highest in the eight districts.

Disability free life expectancy (DFLE) at age 65 ranged from 7.8 years to 10.4 years within Derbyshire in 2006-08 for males, and from 7.3 years to 15 years for females. Overall males tend to spend a higher proportion of their life disability free.

Lifestyle

These are measures of how people are adopting healthy lifestyles and making healthy choices. According to the Active People Survey almost 60% of people in Derbyshire Dales are physically active. This is the highest rate of the eight districts; although higher than the county average it is not significantly so.

The district rate of alcohol related admissions to hospital per 100,000 population is significantly lower than that for the county and is the lowest in the eight districts.

The level of diabetes recorded in general practice in 2011 is significantly lower in Derbyshire Dales than in Derbyshire. This is the third lowest rate in any of the eight districts. Within the district practice rates range from 3.8% - second lowest in the county – to 7.4%.

A significantly lower proportion of adults in Derbyshire Dales have been recorded in general practice as being obese compared to Derbyshire as a whole. The district has the second lowest rate in the eight districts. However, practice rates range from 7.3% to 10.4% - the highest in the county.

Environment

These indicators include some of the wider issues which can impact on health and wellbeing.

In 2011 Derbyshire Dales had a higher proportion of households thought to be living in fuel poverty than Derbyshire overall; the third highest percentage amongst the eight districts.

Derbyshire Dales had the lowest rate of domestic abuse in the eight districts; significantly lower than the rate for Derbyshire as a whole.

The rate of violent crimes was also significantly lower than for Derbyshire and was the second lowest of the district rates. At ward level rates ranged from 1.3 to 17.9.

Derbyshire Dales has a significantly higher rate of killed and seriously injured casualties on the roads than the county as a whole. It is also highest rate amongst the eight districts by some margin – almost half as high again as the next highest rate.

Social Care (adults)

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008, over 22.5% of the population aged over 65 in Derbyshire Dales were estimated to have moderate to very high needs. This was significantly lower than the county as a whole and was the lowest rate amongst the districts. The ward rate ranges from 12.9% to 27.5%; the four lowest ward rates are in Derbyshire Dales.

In 2009, 11.9% of over 65s in Derbyshire Dales receive one or more services from Adult Social Care, significantly lower than were receiving services county-wide. Again, this was the lowest rate amongst the districts. The ward rates range from 3.9% - the lowest in the county - to 17.3%.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term condition.

Derbyshire Dales had a higher proportion of people with a long-term condition who felt supported to manage their condition. At 68.9% this was the highest rate in the county. Practice rates ranged from 50.1% to 81.0% - the lowest and the highest in the county.

In 2010/11, in Derbyshire Dales 88.1% of adults in contact with secondary mental health services lived in settled accommodation, significantly higher than in the county overall. This is also the second highest rate amongst the eight districts.

In 2010/11 Derbyshire Dales had a lower rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions than Derbyshire. This was also the second lowest amongst the districts. Ward rates ranged from 33.1 - lowest in the county - to 273.2.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

In 2012/1, 93.15% of survey respondents had a favourable experience of GP Services in Derbyshire Dales – significantly higher than across Derbyshire – and the highest in the eight districts. Within the district, practice rates ranged from 90.0% to 98.4% - the fourth highest in the county.

However, only 72.5% had a favourable experience of Out of Hours services; the second lowest amongst the eight districts. Practice rates ranged from 53.6% - the lowest in the county – to 87.8%.

A slightly lower proportion of those eligible had taken up diabetic retinopathy screening in 2010/11, than across the county, with practice rates ranging from 66% to 79%.

The coverage rate in Derbyshire Dales in 2010/11 for cervical screening was significantly higher than in Derbyshire as a whole and was the second highest amongst the districts.

The coverage rate for breast screening was also significantly higher than across the county and was the third highest amongst the districts.

Take up of flu vaccination by the over 65s was significantly lower in Derbyshire Dales than in Derbyshire as a whole and was lower than any of the other districts.

The A&E attendance rate in 2012/13, for 5 to 18 year olds, was significantly higher than for Derbyshire as a whole.

The rate of emergency admissions for acute conditions that should not usually require hospital, in 2012/13, was lower than for Derbyshire. However, ward rates ranged from 157.0 – the lowest ward rate - to 653.0.

Asthma admissions in 5-18 year olds were significantly lower than for Derbyshire in 2010/11-12/13.

In 2010/11, there was a significantly lower proportion of hospital discharges resulting in an emergency readmission within 30 days for Derbyshire Dales than for the county as a whole. The proportions ranged by ward from 7.9 – the lowest in the county - to 28.0.

The hospital admission rate as a result of self-harm per thousand population was significantly lower than for Derbyshire and was the second lowest amongst the districts.

The rate for under 18s specifically was also significantly lower and was the lowest in the county.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

Premature mortality rates were all significantly lower than for Derbyshire as a whole, except for liver disease which was still the lowest of the district rates.

Ward rates for cancer ranged between 37.9 - the lowest ward rate - and 141.9.

For circulatory diseases they ranged between 22.7 and 87.9 – the fourth highest.

For respiratory diseases they ranged between 8.4 – the third lowest - and 32.8.

The Derbyshire Dales rate for mortality from causes considered amenable to healthcare was also significantly lower than the Derbyshire rate and was the lowest district rate, with ward rates ranging from 37.4 - the fourth lowest in the county - to 118.7.

There was little difference in excess winter deaths between Derbyshire Dales and Derbyshire as a whole. The ward indices ranged from -41.5 (fewer deaths in winter) to 100.0 - the lowest and the third highest ward indices.

Survey data suggests that many people would, given the choice, prefer to die at home. 41.6 of people who died in Derbyshire Dales died so in their usual home, compared to 39.1% across Derbyshire. This was the highest proportion amongst the districts. The ward rates ranged from 22.5 to 68.0 – the second lowest and the second highest in the county.

7.4.5 Future Housing Developments

At the current time the housing requirement for Derbyshire Dales is at least 6,500 dwellings over the period 2006-2028 – of this requirement approx. 4,800 are yet to be built -- the majority of the requirement will come forward in the market towns and larger villages in the area for which the District Council is the local planning authority.

7.4.6 Current Provision

Derbyshire Dales is a very rural district and the location of pharmacies within the highest density population clusters reflects this. There are relatively fewer pharmacies than the County average and no 100 hour pharmacy. However, there is much greater number of dispensing GPs than average and a larger number per population of pharmacies on the Out of Hours rota.

Rationale:

The map (figure 7.8) shows that there are currently 12 pharmacies within Derbyshire Dales, giving 22 pharmacies per 100,000 population, similar to the County average.

The advanced and locally commissioned services currently provided by these pharmacies are shown in Table 7.4. The 'spread' of advanced and locally commissioned services is considered to be adequate across the area and population.

The opening hours of these pharmacies are shown in Appendix 7.

Derbyshire Dales is very rural, but most points within it are less than 5 miles away from a pharmacy. Those that are not are served by a dispensing GP. No point is more than 8 miles away from a community pharmacy. Car availability is considerably higher than the national average and the major population areas are well covered.

The projected housing plans are not expected to add appreciably to the population in the next 3 years and the largest developments are already supplied with pharmacies.

Figure 7.8 Map showing location of pharmacies and concentric rings about each at one mile intervals

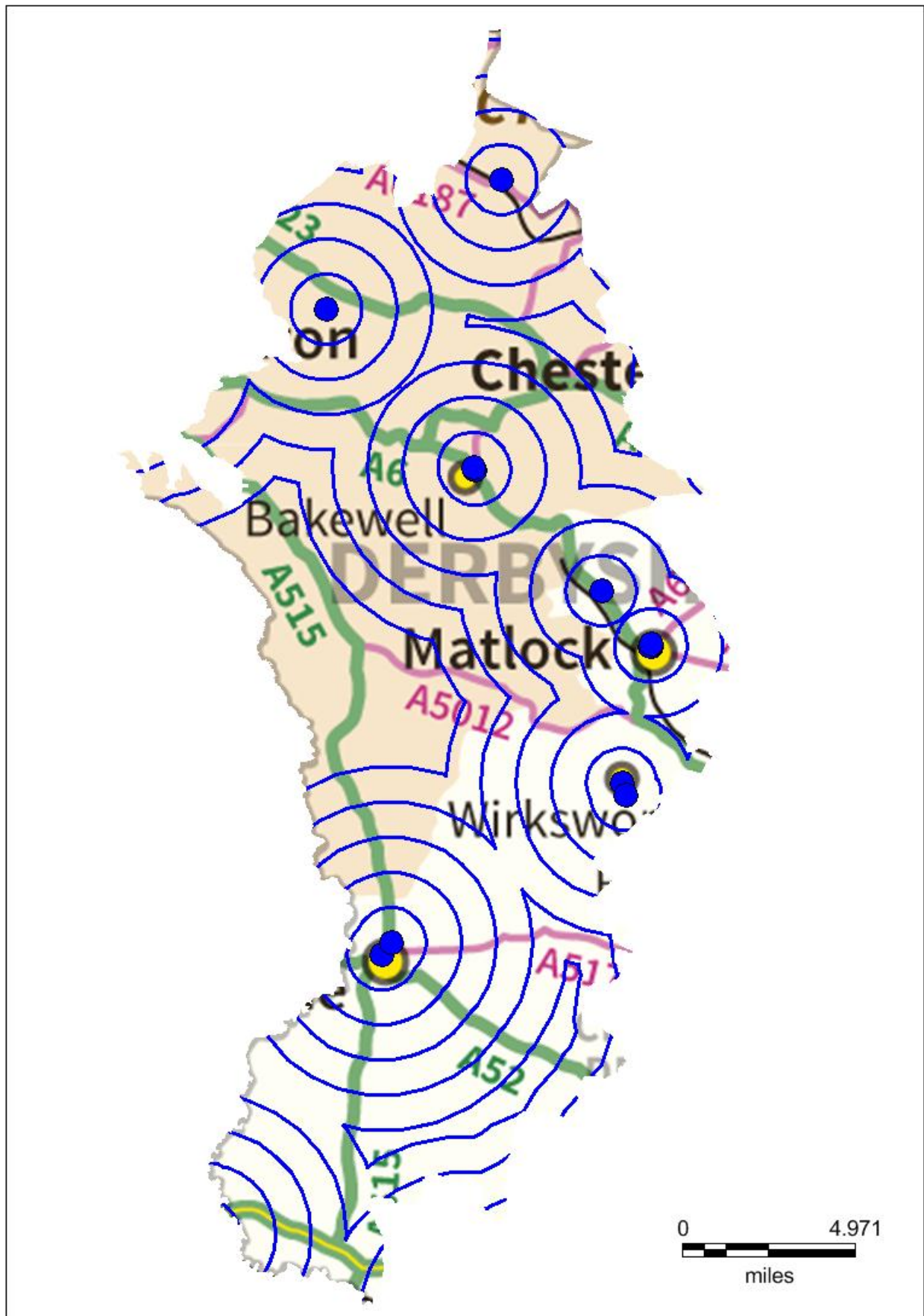


Table 7.4 Pharmacy Services provided in Derbyshire Dales

Community Pharmacy Services	Derbyshire Dales		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	10	14	144	19
New Medicines Service	9	13	118	15
100 hour pharmacy	0	0	16	2
Out of Hours	7	10	26	3
Palliative Care	7	10	86	11
Emergency Supply Service	9	13	119	15
Public Health commissioned services:-				
Smoking Cessation	5	7	71	9
Nicotine Replacement Therapy (NRT)	10	14	131	17
Oral Emergency Contraception	10	14	101	13
Substance Misuse/ Supervised Consumption	9	13	118	15
Needle exchange	3	4	40	5
CCG commissioned services:-				
MAR sheets	8	11	109	14
Total	12	17	161	21
Dispensing GPs	9	13	20	3

Statement of pharmaceutical need subject to consultation:-

The PNA found that that pharmaceutical need in Derbyshire Dales is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

7.5 Erewash

7.5.1 Introduction

Erewash has a population of around 111,000, expected to grow to 123,000 by 2033, just under 5% of which are not White British.

The health of people in Erewash is generally better than the England average. Although overall levels of deprivation are low, 12 out of 73 Lower Super Output Areas in Erewash are within the top 20% of most deprived areas in the 2010 English Index of Multiple Deprivation. Ilkeston remains one of the most deprived areas in England.

Over the last ten years the rates of death from all causes, and rates of early deaths from heart disease and stroke and from cancer, have all improved and are close to the England average.

However health inequalities are apparent within the district by gender and deprivation level. Men living in the least deprived area of the district can expect to live more than 5 years longer than men living in the most deprived area.

7.5.2 Key Findings

Children

To increase childhood vaccination coverage

To reduce A&E attendance rates

To reduce the number of children requiring free school meals

To reduce the number of children and dependent young people living in poverty

To address the numbers of children with a statement of Special Educational Needs

To reduce absence due to illness from schools

To reduce persistent absence from secondary schools

To reduce the number of permanent and fixed term exclusions from schools

To reduce the number of 16-18 year olds not in education, employment or training

To reduce the number of children in care

To reduce the number of first time entrants to the Youth Justice System

Adults

To reduce violent crime, including sexual violence

To increase the proportion of adults in contact with secondary mental health services in employment

To address dementia and its impacts, especially in primary care

To improve the patient experience of primary care, especially GP services

To reduce emergency readmissions within 30 days of discharge from hospital

To reduce the differences in emergency admission rates for chronic and acute diseases between wards

7.5.3 Population and other characteristics

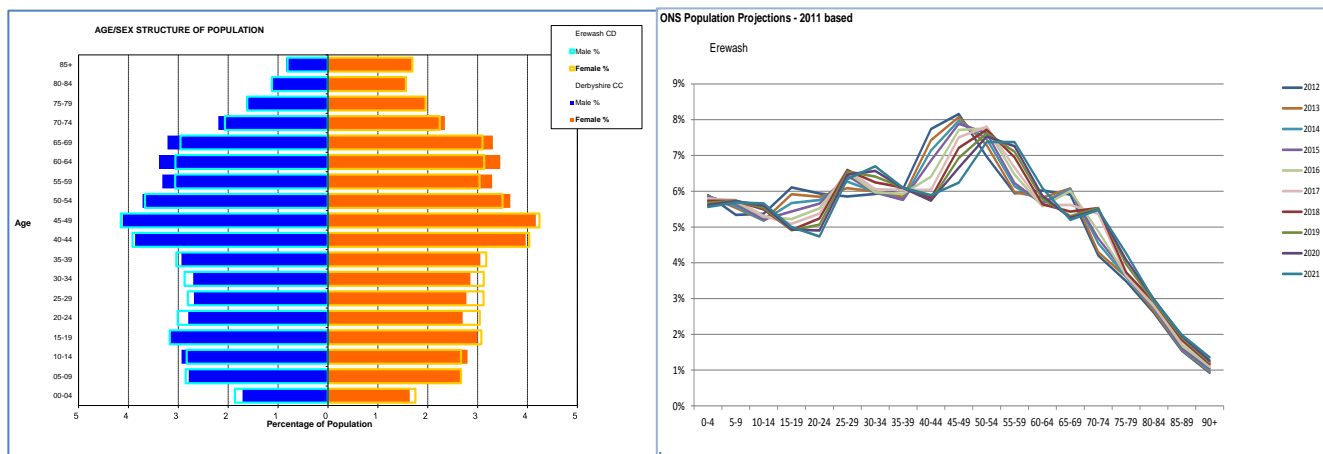
Structure

The population of Erewash is rather younger than that of Derbyshire as a whole. There is a greater proportion of people in the 20-40 age groups and fewer in the over 50 age groups.

Projections

Population projections show an ageing population, such that, by 2021, 23% of the population, 24,900 people, will be aged over 65, 11% over 75 (12,400) and 3% (3,900) over 85, with a large deficit in numbers entering working age. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before.

Figure 7.9 Population structure and projections



Density

Erewash's population lies mostly along the eastern and northern edges of the borough. This leads to a concentration of healthcare services and access issues for those living in more rural areas.

Deprivation

Overall Erewash is not one of the more deprived districts, although there are areas of high deprivation in the population centres of the east. However, it must be noted that pockets of deprivation may still exist which are masked by the aggregation to Lower Super Output Area.

7.5.4 Health Profile

Childhood Vaccinations

Erewash was the worst performing district in all of the indicators except for HPV, where it was the second worst. In 2011/12, the proportions of 2 year olds receiving the pneumococcal booster, the Hib/Men C booster, the DTaP/ IPV immunisations and the first MMR dose were all significantly lower than for Derbyshire, as was the proportion of 5 year olds receiving the second MMR dose.

Deprivation

The proportion of children eligible for free school meals, as at January 2013, was significantly higher than for Derbyshire or England and was the third highest for any of the districts. In 2011, the proportions of both under 16 year olds and dependent under 20 year olds in poverty were significantly higher than for Derbyshire or England and were both the third highest rates in the county.

Education

As at January 2013, Erewash had a significantly higher proportion of children with a statement of Special Educational Needs than Derbyshire and England.

In 2011/12, there were significantly higher rates of absence due to illness from both primary and secondary schools and of persistent absence from secondary schools.

Erewash also had the highest rates of fixed term exclusions from secondary school and the second highest rate of permanent exclusions, both significantly higher than for Derbyshire and England.

In 2012/13, the proportion of 16-18 year olds not in education, employment or training was significantly higher than for Derbyshire and England and the highest in the county.

Social Care (children)

As at 31st March 2013, Erewash had the second highest rate of Children in Care of the eight districts, significantly higher than for Derbyshire.

Life Expectancy at age 65

In 2007-2009 life expectancy at 65 for men stood at 18.6 years for Erewash, slightly higher than for the County or for England. At 21.3 years, life expectancy at 65 for women was also higher than for Derbyshire or England. Disability free life expectancy (DFLE) at age 65 ranged from 7.8 years to 10.4 years within Derbyshire in 2006-08 for males, and from 7.3 years to 15 years for females. Overall males tend to spend a higher proportion of their life disability free.

Lifestyle

These are measures of how people are adopting healthy lifestyles and making healthy choices. Generally speaking Erewash differs little from Derbyshire as a whole in terms of healthy living, and is better than England except in the percentage of people engaging in physical activity.

Environment (inc. crime)

These indicators include some of the wider issues which can impact on health and wellbeing. Again Erewash is similar to the county as a whole.

There were 12.9 violent crimes per 1000 people in 2012 in Erewash, significantly more than the Derbyshire rate, and the second highest of the district rates. At ward level this ranges from 3.7 to 37.0 - the second highest ward rate in the county.

In 2012/13, Erewash had the highest rate of first time entrants to Youth Justice System in the eight districts, significantly higher than Derbyshire and England.

Social Care (adult)

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008, it was estimated that over 27.7% of the population aged over 65 in Erewash have moderate to very high needs; significantly lower than the county as a whole. The ward rates ranged from 21.9% to 37.7%.

Overall, in 2009, 12.6% of over 65s in Erewash received one or more services from Adult Social Care, significantly lower than the percentage receiving services county-wide. The ward rates ranged from 7.7% to 20.4%.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term condition.

The proportion of adults in contact with secondary mental health services in employment was significantly lower than the county average at 17.3%.

Although Erewash had a similar rate to Derbyshire for unplanned hospitalisation for chronic ambulatory care sensitive conditions in 2012/13, the ward rates ranged from 67.0 to 369.8 – ninth highest in the county.

Erewash also had a significantly higher rate for the prevalence of dementia reported in general practice in 2013. Within the district practice rates ranged from 0.4% to 1.6% - the second highest in the county.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

Erewash patients had the lowest opinion of their GP services amongst the eight districts. In 2012/13, only 81.2% of survey respondents found them good or satisfactory - significantly lower than for Derbyshire. At practice level this ranged between 57.2% - by far the lowest rating of any practice in Derbyshire - and 93.7%.

However, they had higher regard for Out of Hours services than those in other districts: 87.0% finding them good or satisfactory – significantly higher than Derbyshire and the highest of the districts.

A significantly higher proportion of those eligible had taken up diabetic retinopathy screening in 2010/11, with practice rates ranging from 72% to 83% - the highest in the county.

The coverage rate for breast screening was 82.5%, significantly higher than across the county.

In the last quarter of 2011, 1.7% of the eligible population in Erewash received a NHS health check, significantly higher than the rate across Derbyshire. Ward rates ranged from 0.5% to 7.6%.

A&E attendance rates in 2012/13, for both under 5s and 5 to 18 year olds, were significantly higher than for Derbyshire as a whole. The under 5 rate was the second highest and the 5 to 18 rate was the third highest in the county.

The rate of emergency admissions for acute conditions that should not usually require hospital admission for Erewash was significantly lower than that for Derbyshire in 2012/13 but ward rates ranged from 207.7 – second lowest in the county - to 421.7.

The 2012/13 rate of admission in under 1 year olds for gastroenteritis was significantly lower than for Derbyshire and was the second lowest district rate.

Asthma admissions in 5-18 year olds were significantly lower than for Derbyshire in 2010/11-12/13, and were the second lowest in the county.

The alcohol specific admission rate for under 18s was also significantly lower than for Derbyshire and also the lowest district rate.

A significantly higher proportion of discharges resulted in an emergency hospital admission within 30 days and Erewash had the second highest percentage for any of the eight districts. The proportions for the wards ranged from 13.0 to 23.8.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

In 2009-2011, Erewash had similar rates of premature mortality to Derbyshire as a whole and for the most part lower than England. The ward rates for cancer ranged from 57.2 – eighth lowest in the county - to 141.8 per 100,000.

For circulatory diseases the ward rates ranged from 21.0 to 79.9 – 9th lowest to tenth highest.

The ward rates for respiratory diseases ranged from 8.4 to 47.8 – third lowest to fifth highest.

The rate for mortality from causes considered amenable to healthcare was similar to the Derbyshire rate with ward rates ranging from 37.7 – seventh lowest - in to 117.3.

There were significantly fewer excess deaths in Erewash than in Derbyshire as a whole, in 2006-2009, with an Excess Winter Mortality Index of 17.7 compared to 19.7. Erewash had the third lowest index. Mortality from liver disease was higher in Erewash than for the county and both rates were significantly higher than for England.

Survey data suggests that many people would, given the choice, prefer to die at home. 39.4% of people who died in Erewash did so in their usual home, compared to 39.1% across Derbyshire. The ward rates ranged from 27.2 to 50.7.

7.5.5 Future Housing Developments

Erewash adopted Core Strategy has a target for 6,250 new residential dwellings to be built for the plan period 2011 to 2028, with large developments at Stanton and Ilkeston. Of these new dwellings, a target of 1,200 *affordable* homes over the plan period is considered appropriate

7.5.6 Current Provision

Residents of Erewash have access to a range of services that reflect the health needs of the district. The density of pharmacies is slightly higher than the County average. The numbers of pharmacies per head providing various locally commissioned services are also similar to County averages.

Rationale:

The map (figure 7.10) shows that there are currently 26 pharmacies within Erewash, giving 23 pharmacies per 100,000 population, about the same as the County average. Larger settlements are all within 1 mile of a pharmacy or dispensing practice. Nowhere is more than 3 miles from a pharmacy.

The advanced and locally commissioned services currently provided by these pharmacies are shown in Table 7.5. The 'spread' of advanced and locally commissioned services is considered to be adequate across the area and population.

The opening hours of these pharmacies are shown in Appendix 7.

Amber Valley is partly rural and some patients may have to travel up to 5 miles to a pharmacy or for other goods and services. Car availability is higher than the national average and there is good provision of pharmacies across the district and on the borders of neighbouring counties.

The projected housing plans are not expected to add appreciably to the population in the next 3 years and the largest developments are already supplied with pharmacies.

Statement of pharmaceutical need subject to consultation:-

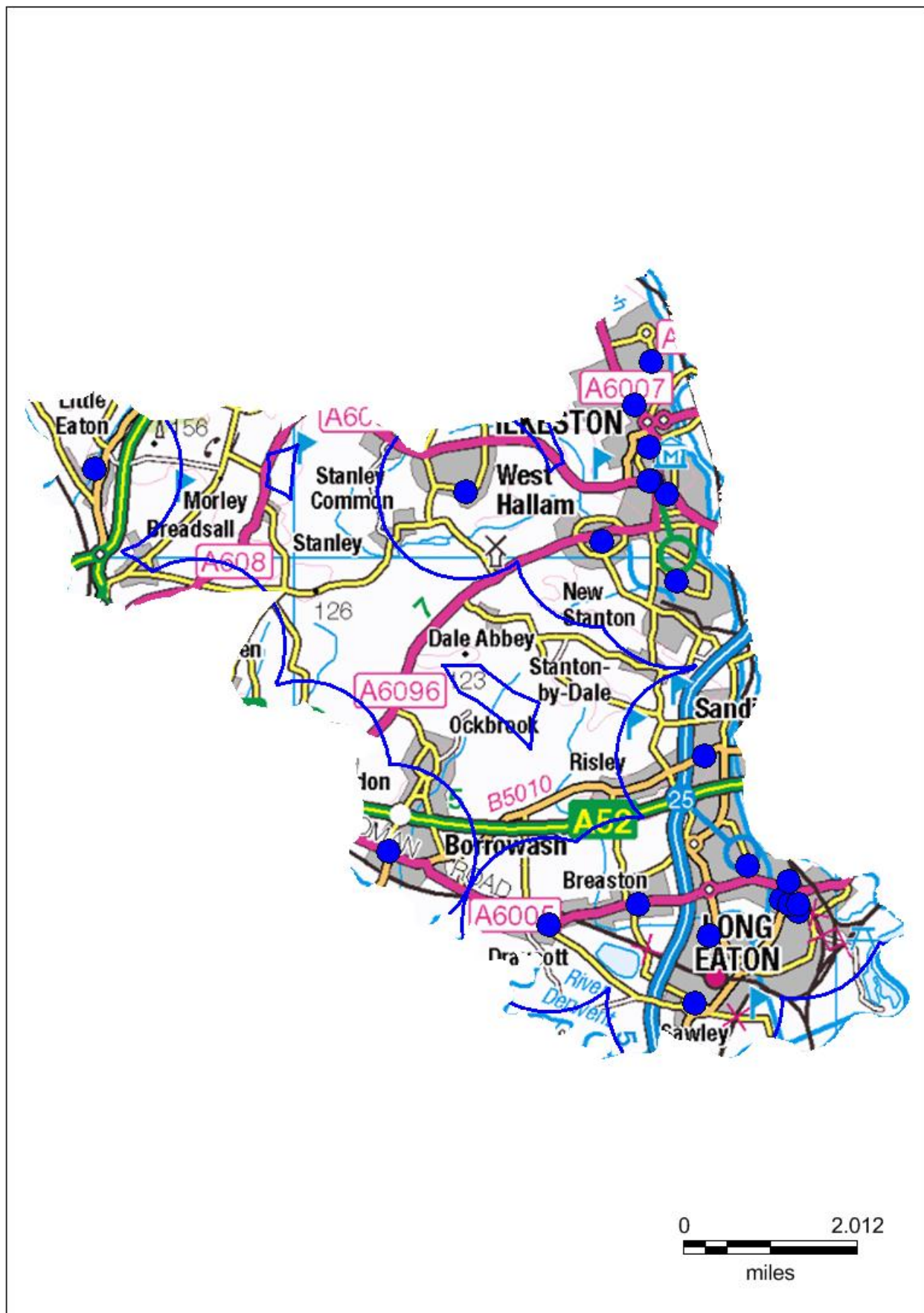
The PNA found that that pharmaceutical need in Erewash is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

Table 7.5 Pharmacy Services provided in Erewash

Community Pharmacy Services	Erewash		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	25	22	144	19
New Medicines Service	14	12	118	15
100 hour pharmacy	3	3	16	2
Out of Hours	7	6	26	3
Palliative Care	19	17	86	11
Emergency Supply Service	22	20	119	15
Public Health commissioned services:-				
Smoking Cessation	6	5	71	9
Nicotine Replacement Therapy (NRT)	23	20	131	17
Oral Emergency Contraception	14	12	101	13
Substance Misuse/ Supervised Consumption	18	16	118	15
Needle exchange	5	4	40	5
CCG commissioned services:-				
MAR sheets	23	20	109	14
Anticoagulants (INR testing)	2	-	8	-
Gluten-free food	23	-	24	-
Total	26	23	161	21
Dispensing GPs	2	2	20	3

Figure 7.10 Map showing location of pharmacies and concentric rings about each at one mile intervals



7.6 High Peak

7.6.1 Introduction

The borough of High Peak lies at the north-western tip of Derbyshire within the East Midlands Region and is the second largest district (53,915 hectares) in the County. Whilst two-thirds of the Borough falls within the Peak District National Park, around 93% of High Peak's 92,400 residents live outside the Park, with the major population centres being around Glossop to the north, and Buxton to the south. Over 4% of the population are not White British. The district's central position, linking the National Park to five counties (Cheshire, Greater Manchester, South Yorkshire, Staffordshire and West Yorkshire), is a popular tourist destination requiring diligent attention to sustain a good quality of life in High Peak.

The health of people in High Peak is generally better than the England average. Deprivation levels are low and life expectancy for men is higher than the average for England. However rural deprivation is often hidden by traditional indicators.

7.6.2 Key challenges

To extend HPV vaccination coverage

To reduce A&E attendances in children and young people

To reduce hospital admissions of children and young people, especially for asthma, alcohol specific conditions and accidents

To extend cervical cancer screening coverage

To extend breast cancer screening coverage

To extend take up of the NHS Health Check programme by those eligible

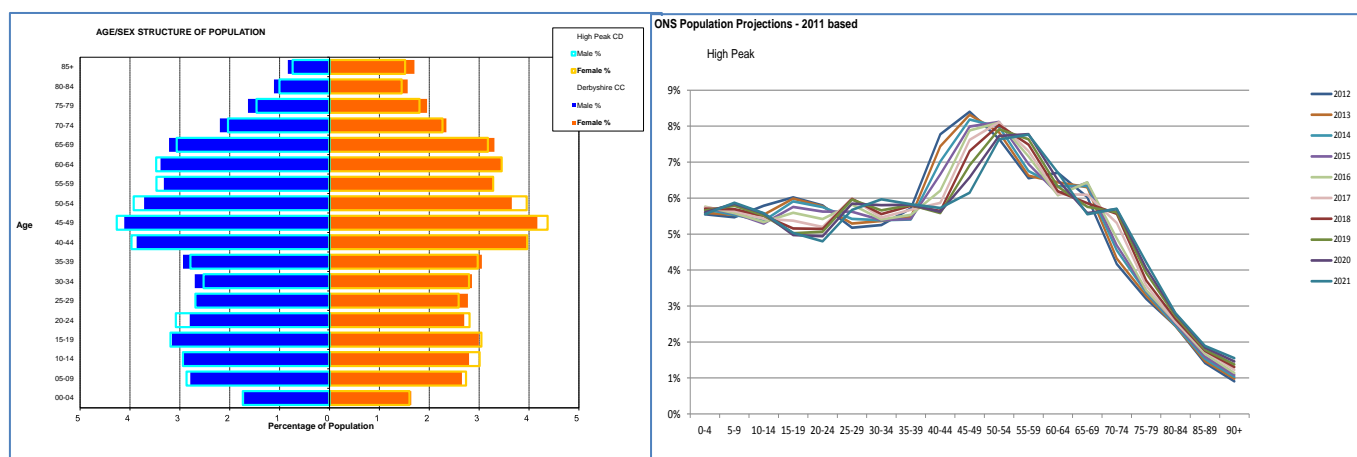
To reduce inequalities in mortality rates

To reduce excess winter deaths

To reduce the differences in the proportion of people able to die in their usual home

7.6.3 Population and other characteristics

Figure 7.11 Population structure and projections



Structure

The population of High Peak is rather younger than that of Derbyshire as a whole. There is a greater proportion of people aged under 65 and over 40, and of people aged under 27.

Projections

Population projections show an ageing population, such that, by 2021, 22% (21,200 people) of the population will be aged over 65, 10% (10,200) over 75 and 3% (3,400) over 85, with a large deficit in numbers entering working age. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before.

Density

On the whole High Peak is not particularly densely populated. There are a number of smaller population centres where healthcare services are also located. This may cause problems of access for more rural communities.

Deprivation

Overall High Peak is clearly not particularly deprived, although there are areas of high deprivation in both Glossop and Buxton. However, it must be noted that pockets of deprivation may still exist which are masked by the aggregation to Lower Super Output Area.

7.6.4 Health Profile

Pregnancy and Birth

High Peak had the highest breastfeeding rates in Derbyshire in 2012/13. Breastfeeding at birth, 10 days and after 6-8 weeks were all significantly higher than for Derbyshire.

Vaccinations

The HPV vaccination rate in 2010/11 was significantly lower than for both Derbyshire and England, and was also the lowest rate of all the eight districts.

Deprivation

As at January 2013, the proportion of children eligible for free school meals was significantly lower than for Derbyshire and England.

The proportions of under 16 year olds and of dependent under 20 year olds were both significantly lower than for Derbyshire and England and both were third highest for the districts.

Education

The proportion of children with Special Educational Needs, as at January 2013, was significantly lower than for Derbyshire and England, and was the second lowest of any of the districts.

The rates of absence due to illness from both primary and secondary schools in 2011/12 were significantly lower than for Derbyshire.

The rates of fixed term and permanent exclusion were all significantly lower than for Derbyshire.

Life Expectancy at age 65

Life expectancy at 65 for men stands at 18.4 years for High Peak, higher than for the County at 18.2. The District has the second highest life expectancy of the eight districts.

At 20.9 years, life expectancy at 65 for women is higher than for Derbyshire, at 20.8. Disability free life expectancy (DFLE) at age 65 ranged from 7.8 years to 10.4 years within Derbyshire in 2006-08 for males,

Lifestyle

These are measures of how people are adopting healthy lifestyles and making healthy choices. Residents of High Peak tend to live more healthily than the county average.

The proportion of physically active adults is higher, the third highest of the districts.

The district rate for alcohol related admissions to hospital for per 100,000 population was significantly lower than that for the county in 2011/12 and was the second lowest in the eight districts.

The percentage of adults in High Peak who smoke is lower than in Derbyshire overall. This is the second lowest rate in the eight districts.

In 2013 the level of diabetes recorded in general practice was significantly lower in High Peak than in Derbyshire was the lowest rate in any of the eight districts.

A significantly lower proportion of adults in High Peak have been recorded in general practice as being obese compared Derbyshire as a whole. High Peak has the second lowest rate in the eight districts.

Environment

These indicators include some of the wider issues which can impact on health and wellbeing.

High Peak has a higher proportion of households thought to be living in fuel poverty, but not significantly higher. This is also the second highest amongst the eight districts.

There was less domestic abuse in High Peak than on average.

There were fewer violent crimes per 1000 people in 2011 in High Peak than in Derbyshire, though ward rates varied from 1.4 per 1,000 to 27.8 – the sixth lowest to the fifth highest in the county.

High Peak has a slightly higher rate of killed and seriously injured casualties on the roads than the county as a whole.

The proportion of households in temporary accommodation was a little lower than the average.

Social Care

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008 it was estimated that over 27.3% of the population aged over 65 in High Peak have moderate to very high needs. This is significantly lower than the county as a whole and was the second lowest rate amongst the districts. The ward rates range from 18.4% - fourth lowest in the county - to 31.3%.

In 2009, 12.1% of over 65s in High Peak received one or more services from Adult social Care, significantly lower than county-wide. Again, this is the second lowest rate amongst the districts. The rate ranges from 7.9% - second lowest - to 18.2%.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term condition.

In High Peak in 2010/11 a significantly higher proportion of adults in contact with secondary mental health services were in employment, than across Derbyshire. This was the highest proportion of all the districts.

A similar proportion lived in settled accommodation as in the county overall.

High Peak had a significantly lower rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions than Derbyshire. This is the lowest rate amongst the districts. Ward rates ranged from 127.9 to 347.1.

The prevalence of dementia reported in general practice in 2013 was significantly lower in High Peak than in Derbyshire and this was the second lowest of the districts. Within the district practice rates range from 0.2% to 1.5% - the second lowest to the third highest in the county.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

In 2012/13 92.0% of survey respondents had a favourable experience of GP Services in High Peak – significantly higher than across Derbyshire – and the second highest in the eight districts. Practice rates ranged from 87.4% to 97.6% - the fifth best in the county.

Only 68.2% had a favourable experience of Out of Hours services, which was lower than for Derbyshire (77.2%) and lowest amongst the eight districts. Within the district practice rates ranged from 47.6% - second lowest in the county - to 89.4%.

A slightly higher proportion of those eligible had taken up diabetic retinopathy screening in 2010/11, than across the county, with practice rates ranging from 65% to 81%.

The coverage rate in High Peak for cervical screening was significantly lower than in Derbyshire as a whole and was the lowest for any of the districts.

The coverage rate in High Peak for breast screening was significantly lower than across the county. This was also the second lowest rate amongst the districts.

In the last quarter of 2011 1.2% of the eligible population in High Peak received a NHS health check, significantly lower than the rate across Derbyshire. This was the second lowest rate amongst the districts. Ward rates ranged from 0.6% to 2.1%.

A&E admissions in under 5 year olds were significantly lower than for Derbyshire and were the third lowest in the county.

A&E admissions in 5 to 18 year olds were significantly higher than for Derbyshire and were the highest in the county.

Admissions with asthma in 5 to 18 year olds were significantly higher than for Derbyshire and were the highest in the county.

The rate of emergency admissions for acute conditions that should not usually require hospital admission for High Peak was significantly lower in 2012/13 compared to Derbyshire, and was the lowest amongst the eight districts. Ward rates ranged from 247.0 to 607.0.

The rate of emergency admissions following an accident in under 18s was significantly higher than for the rest of the county and was the highest amongst the districts.

Alcohol specific admissions in 5 to 18 year olds were significantly higher than for Derbyshire as a whole and are the highest in the county.

A significantly lower proportion of hospital discharges resulted in an emergency readmission within 30 days. At ward level the proportions ranged from 11.3 to 22.0.

The hospital admissions rate as a result of self-harm per thousand population in High Peak was significantly lower than for Derbyshire and was the lowest amongst the districts.

The rate for acute hospital admissions as a result of falls or falls injuries for over 65s, was significantly lower than for Derbyshire as a whole. It was also the lowest rate amongst the districts. Ward rates ranged from 10.7 to 37.2.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

Mortality in High Peak was not significantly different from the county as a whole. However there were some large variations between wards.

For premature deaths from cancer per 100,000 population the ward rates ranged from 58.7 to 200.5 – the second highest in the county.

For under 75 mortality from all cardiovascular disease the ward rates ranged from 27.8 to 117.1 – the highest rate in the county.

The ward rates for premature mortality from respiratory diseases ranged from 11.8 to 62.5 – the second highest in the county.

The ward rates for mortality from causes considered amenable to healthcare ranged from 37.1 to 187.9 – sixth lowest to second highest.

There are significantly more excess winter deaths in High Peak than in Derbyshire as a whole. High Peak has the second highest index. The ward indices range from -40.0 (fewer deaths in winter) to 113.8 – the second lowest to the highest in the county.

Survey data suggests that many people would, given the choice, prefer to die at home. 38.8% of people who died in High Peak did so in their usual home, compared to 39.1% across Derbyshire. However, the ward rates ranged from 21.8 to 69.8 – the lowest and the highest rates in the county.

7.6.5 Future Housing Developments

High Peak Borough Councils has recently submitted our draft Local Plan to an independent planning inspector for approval. The requirement for housing across the borough identified in the plan is 360 per annum, equating to 7,200 units across the plan period 2011-2031. As part of the evidence base for the new Local Plan the Strategic Housing Market Assessment identified a high level of need for affordable housing and would need 526 dwelling per year to meet demand.

7.6.6 Current Provision

Residents of High Peak have access to a range of services that reflect the health needs of the district. The density of pharmacies is slightly higher than the County average. However there is no 100 hour pharmacy within the district.

Rationale:

The map (figure 7.12) shows that there are currently 21 pharmacies within Bolsover, giving 23 pharmacies per 100,000 population, slightly higher than the County average. Larger settlements are all within 1 mile of a pharmacy or dispensing practice. The population in the more sparsely populated east is also served by pharmacies in Derbyshire Dales.

The advanced and locally commissioned services currently provided by these pharmacies are shown in Table 7.6. The 'spread' of advanced and locally commissioned services is considered to be adequate across the area and population.

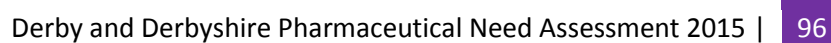
The opening hours of these pharmacies are shown in Appendix 7.

Bolsover is largely rural and some patients may have to travel more than 4 miles to a pharmacy or for other goods and services. Car availability is higher than the national average and there is good provision of pharmacies across the district and on the borders of neighbouring counties.

The projected housing plans are not expected to add appreciably to the population in the next 3 years and the largest developments are already supplied with pharmacies.

Table 7.6 Pharmacy Services provided in High Peak

Community Pharmacy Services	High Peak		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	16	18	144	19
New Medicines Service	16	18	118	15
100 hour pharmacy	0	0	16	2
Out of Hours	4	4	26	3
Palliative Care	5	5	86	11
Emergency Supply Service	12	13	119	15
Public Health commissioned services:-				
Smoking Cessation	6	7	71	9
Nicotine Replacement Therapy (NRT)	9	10	131	17
Oral Emergency Contraception	11	12	101	13
Substance Misuse/ Supervised Consumption	11	12	118	15
Needle exchange	6	7	40	5
CCG commissioned services:-				
MAR sheets	7	8	109	14
Total	21	23	161	21
Dispensing GPs	1	1	20	3



Statement of pharmaceutical need subject to consultation:-

The PNA found that that pharmaceutical need in High Peak is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

7.7 North East Derbyshire

7.7.1 Introduction

The district of North East Derbyshire is a mixture of rural and urban areas, with centres of population in and around a number of small towns and villages. It covers about 100 square miles and surrounds the neighbouring borough of Chesterfield to the north, west and south. The majority of the population live within the four main towns of Dronfield, Eckington and Killamarsh, in the north of the District, and Clay Cross in the south. There is a long history of industrial activity having taken place, mainly involving mining, engineering and iron and steel production.

The resident population of NEDDC is around at 98,000, but is expected to rise to 109,000 by 2033. Just over 4% of the population is not White British.

The picture of North East Derbyshire as a largely rural and prosperous district, disguises considerable inequality across the district. Six of the district's 63 Lower Super Output Areas (LSOAs) are within the 20% *most* deprived in England.

7.7.2 Key challenges

- To reduce admissions of the very young with gastroenteritis
- To reduce absence due to illness from secondary schools
- To reduce fixed term exclusions from secondary schools
- To improve the emotional health of children in care
- To address the variation in diabetes prevalence
- To address the variation in obesity prevalence
- To reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions
- To address the high prevalence of dementia and its impacts
- To improve access to diabetic retinopathy screening
- To reduce the rate of emergency admissions for acute conditions that should not usually require hospital admission and to address the variation in ward rates
- To address the variation in ward mortality rates
- To address the variation in ward excess winter mortality
- To address the variation in the proportion of people able to die in their own home

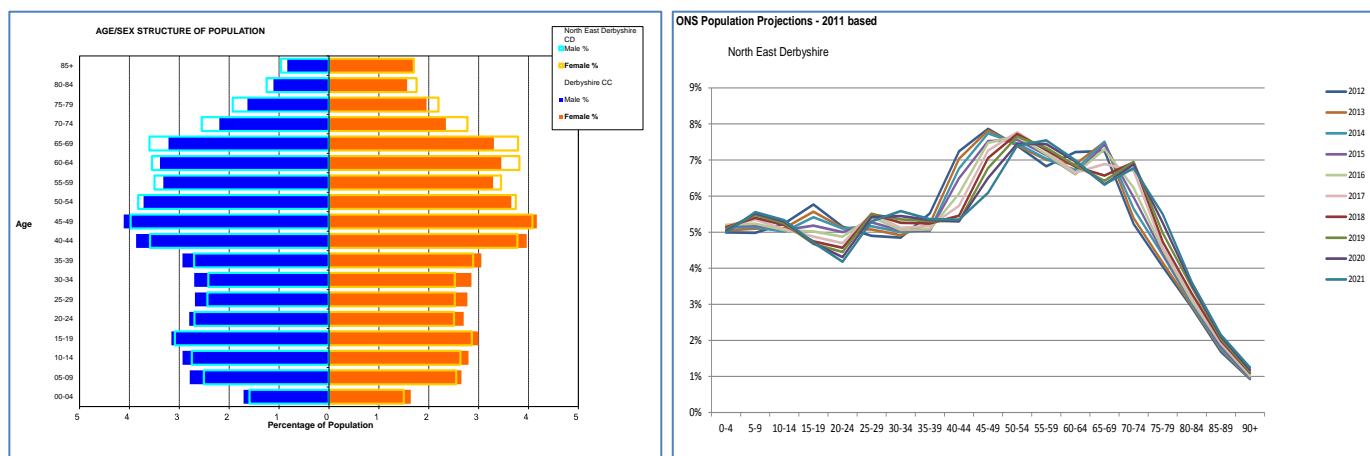
7.7.3 Population and other characteristics

Structure

The population of North East Derbyshire is rather older than that of Derbyshire as a whole. There is a greater proportion of people aged over 50: 44% compared to 41%.

Projections

Population projections show an ageing population, such that, by 2021, 26% of the population (26,500 people) will be aged over 65, 13% (12,900) over 75 and 3% (3,500) over 85, with a large deficit in numbers entering working age. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before.

Figure 7.13 Population structure and projections

Density

North East Derbyshire can be divided in two parts: the west which is sparsely populated and the East which is quite densely populated. And where, correspondingly most of the healthcare services are to be found. This may cause problems of access for more rural communities.

Deprivation

The less densely populated areas to the west are not deprived, but there are areas of severe deprivation in the southeast of the district. However it must be noted that pockets of deprivation may still exist which are masked by the aggregation to Lower Super Output Area.

7.7.4 Health Profile

Deprivation

As at 31st January 2013, the percentage of children eligible for free school meals was significantly lower than for Derbyshire and England.

In 2011, the proportions of children aged under 16 year olds and dependent under 20 year olds living in poverty were both significantly lower than for Derbyshire and England.

Education

As at January 2013, the rates of children with Special Educational Needs, a statement of SEN or a School Action Plus were all significantly higher than Derbyshire and England. They were each the lowest rate for the districts.

In 2011/12, the rate of absence due to illness from primary schools was significantly lower than for Derbyshire, whereas the rate for secondary schools was significantly higher and the second highest amongst the districts.

Fixed term exclusions from primary schools were also lower than for Derbyshire, and the lowest amongst the districts. In contrast, for secondary schools they were significantly higher and the highest amongst the districts.

Social Care (children)

As at 31st March 2013, the proportions of children in need and in care were both significantly lower than for Derbyshire and England.

The average emotional health score for children in care (where a low score is good) was significantly higher than for Derbyshire and was the highest amongst the eight districts.

Life Expectancy at age 75

Life expectancy at 65 for men stood at 18.6 years for North East Derbyshire in 2009-11, a little higher than for the County at 18.2. The District has the second highest life expectancy of the eight districts. At 21.0 years, life expectancy at 65 for women is a little lower than for Derbyshire, at 20.8. Disability free life expectancy (DFLE) at age 65 ranged from 7.8 years to 10.4 years within Derbyshire in 2006-08 for males, and from 7.3 years to 15 years for females. Overall males tend to spend a higher proportion of their life disability free.

Lifestyle

These are measures of how people are adopting healthy lifestyles and making healthy choices. Generally speaking North East Derbyshire differs little from Derbyshire as a whole in terms of healthy living.

In 2008/09, the mean number of decayed missing or filled teeth in 12 year olds was significantly lower than for Derbyshire and England, and is the lowest in the county.

At 7.0% the level of diabetes recorded in general practice in 2011 is significantly higher in North East Derbyshire than in Derbyshire as a whole. Within this practice rates ranged from 3.8% to 7.3% - the second and third highest in the county.

The level of recorded obesity in North East is significantly lower than in Derbyshire as a whole. However, practice rates ranged from the lowest in the county (3.4%) to the second highest (17.2%).

Environment

These indicators include some of the wider issues which can impact on health and wellbeing.

North East Derbyshire has the lowest proportion of households thought to be living in fuel poverty in Derbyshire.

The rate of domestic abuse per 1,000 head of population in North East Derbyshire was significantly lower than the rate for Derbyshire as a whole and is the lowest for the eight districts.

The violent crime rate was also significantly lower than for Derbyshire and was the second lowest of the district rates.

Social Care (adults)

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008 it was estimated that over 31% of the population aged over 65 in North East Derbyshire have moderate to very high needs. This is a little higher than the county as a whole and is the third highest rate amongst the districts. The ward rates ranged from 20.5% in Coal Aston to 47.6% in Ridgeway & Marsh Lane.

Overall 13.0% of over 65s in North East Derbyshire received one or more services from Adult Social Care in 2009. The ward rates ranged from 7.5% to 19.3%.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term condition.

In a survey in 2012/13, 67.7% of people in Derbyshire said they felt supported to manage their condition. In North East Derbyshire 69.7% said they felt supported, the second highest percentage in the eight districts.

In 2010/11 13.0% of adults in contact with secondary mental health services were in employment, lower than the 20.9% across Derbyshire, and the lowest of the districts.

A significantly higher proportion (90%) than for Derbyshire were living in settled accommodation. This is the highest rate amongst the eight districts.

North East Derbyshire had a significantly higher rate than Derbyshire for unplanned hospitalisation for chronic ambulatory care sensitive conditions, the ward rates ranged from 137.0 to 447.8 - the third highest in the county.

In 2013 the prevalence of dementia reported in general practice was 0.82% in North East Derbyshire, which is the highest of the districts. Within the district practice rates ranged from 0.4% - the lowest in the county - to 1.9% - the highest in the county.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

From a survey in 2012/13 significantly slightly more respondents had a favourable experience of GP Services in North East Derbyshire than across Derbyshire as a whole.

Fewer had a favourable experience of Out of Hours services but this was also higher than for Derbyshire as a whole.

A significantly lower proportion of those eligible had taken up diabetic retinopathy screening in 2010/11 - the lowest of the district rates - with practice rates ranging from 63% to 75%.

The coverage rate in North East Derbyshire for cervical screening was significantly higher than in Derbyshire and was also the highest amongst the districts.

The breast screening coverage rate was only slightly lower than across the county.

In the last quarter of 2011, 1.9% of the eligible population in North East Derbyshire received a NHS health check, significantly higher than the rate across Derbyshire. This was also the highest amongst the districts. Ward rates ranged from 0.8% to 3.1%.

The take up 'flu vaccination in the over 65s was also significantly higher than for the county as a whole.

In 2012/13 the A&E attendance rates for both under 5 year olds and 5 to 18 year olds were significantly lower than for Derbyshire. The rate for under 5's was the second lowest amongst the districts and the 5 to 18 rate was the lowest.

The rate of emergency admissions for acute conditions that should not usually require hospital admission was significantly higher than for Derbyshire. However, ward rates ranged from 277.1 – the lowest - to 841.8 - the third highest in the county.

A significantly lower proportion of discharges from hospital resulted in emergency readmissions within 30 days than for Derbyshire as a whole. This was also the lowest percentage for any of the eight districts. The ward rates ranged from 7.1 – second lowest in the county - to 19.7.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

Mortality rates in North East Derbyshire are not significantly different from those for the county as a whole. However, there is some variation in ward rates. For premature deaths from cancer these range from 57.8 to 173.5 – sixth highest - per 100,000 population.

For premature mortality rate from circulatory diseases ward rates ranged from 17.0 to 87.2 – the lowest to the fifth highest.

For mortality from causes considered amenable to healthcare ward rates ranged from 28.5 to 257.2 – the lowest to the highest in the county.

There was a significantly lower rate of excess winter deaths in North East Derbyshire than in Derbyshire as a whole. The ward indices ranged from -10.3 (fewer in winter) to 73.7.

Survey data suggests that many people would, given the choice, prefer to die at home. 39.1% of people who died in North East Derbyshire did so in their usual home, the same as for Derbyshire. The ward rate ranged from 23.1 to 67.7 – the third lowest to the third highest in the county.

7.7.5 Future Housing Developments

In North East Derbyshire District the target is to build 6,000 homes by 2031. This equates to around 300 per year. The largest sites are expected to be The Avenue, Wingerworth (up to 1,100 homes) Biwater, Clay Cross (up to 1,000 homes) and Coalite near Bolsover.

7.7.6 Current Provision

Residents of North East Derbyshire have access to a range of services that reflect the health needs of the district. The density of pharmacies is similar to the County average.

Rationale:

The map (figure 7.14) shows that there are currently 20 pharmacies within North East Derbyshire, giving 20 pharmacies per 100,000 population, similar to the County average. Larger settlements are all within 1 mile of a pharmacy or dispensing practice.

The advanced and locally commissioned services currently provided by these pharmacies are shown in Table 7.7. The 'spread' of advanced and locally commissioned services is considered to be adequate across the area and population.

The opening hours of these pharmacies are shown in Appendix 7.

North East Derbyshire is partly rural and some patients in the west may have to travel up to 4 miles to a pharmacy or for other goods and services. Car availability is higher than the national average and there is good provision of pharmacies across the district and close to the borders, particularly in Chesterfield.

The projected housing plans are not expected to add appreciably to the population in the next 3 years and the largest developments are already supplied with pharmacies.

Statement of pharmaceutical need subject to consultation:-

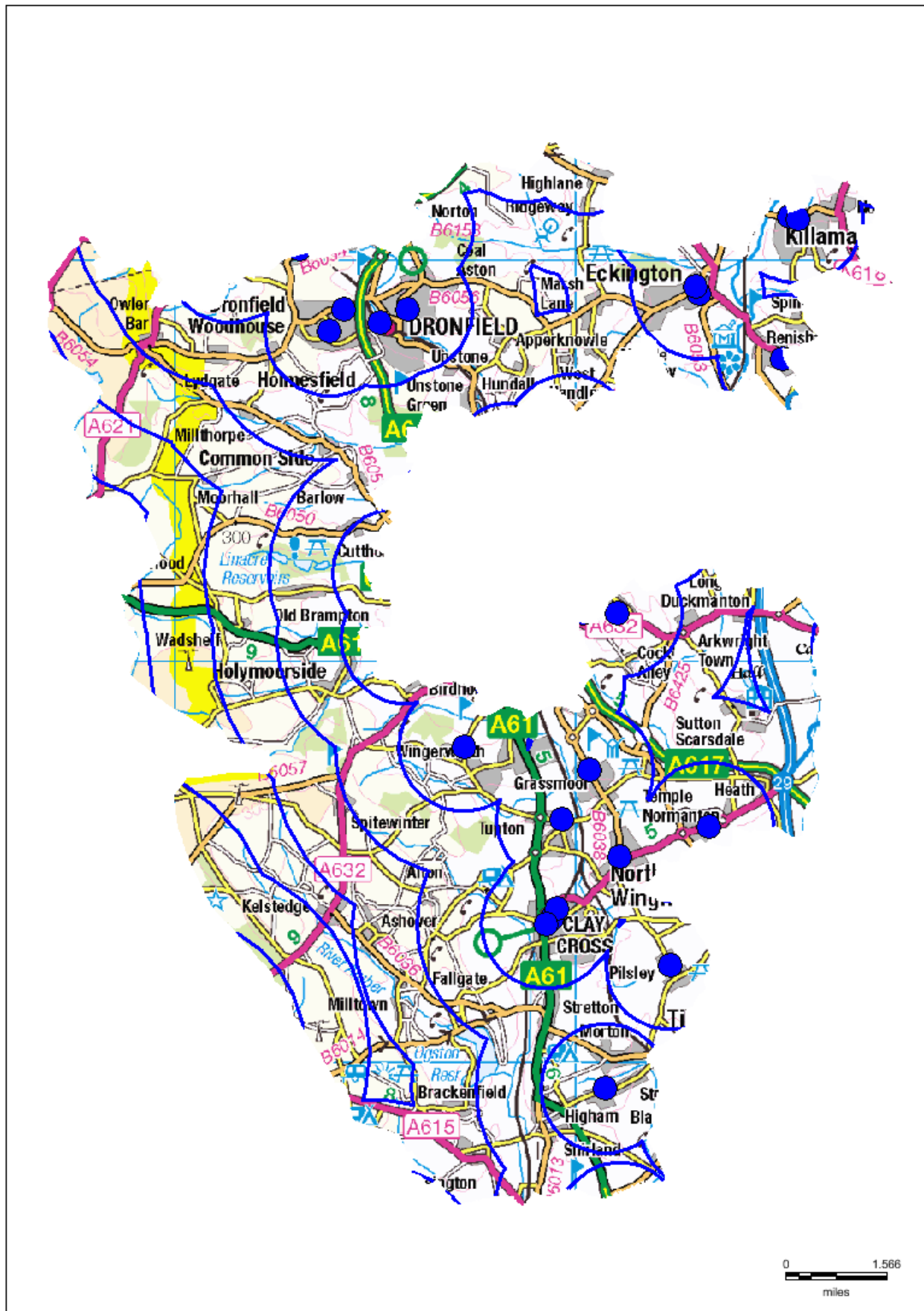
The PNA found that that pharmaceutical need in North East Derbyshire is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

Table 7.7 Pharmacy Services provided in North East Derbyshire

Community Pharmacy Services	North East Derbyshire		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	20	20	144	19
New Medicines Service	18	18	118	15
100 hour pharmacy	2	2	16	2
Out of Hours	1	1	26	3
Palliative Care	7	7	86	11
Emergency Supply Service	17	17	119	15
Public Health commissioned services:-				
Smoking Cessation	15	15	71	9
Nicotine Replacement Therapy (NRT)	19	19	131	17
Oral Emergency Contraception	15	15	101	13
Substance Misuse/ Supervised Consumption	17	17	118	15
Needle exchange	6	6	40	5
CCG commissioned services:-				
MAR sheets	15	15	109	14
Total	20	20	161	21
Dispensing GPs	1	1	20	3

Figure 7.14 Map showing location of pharmacies and concentric rings about each at one mile intervals



7.8 South Derbyshire

7.8.1 Introduction

South Derbyshire is the fastest growing district in the county and has a population of almost 93,000. In addition to an ageing population South Derbyshire will have a higher than average proportion of young people and a substantial rural population in coming years. Such growth energises the district but also puts pressure on all services including health, schools, transport and community facilities. Over 8% of the population are not White British.

The health of people in South Derbyshire is generally better than the England average. Deprivation levels are low and the proportion of children living in poverty is lower than the average for England. Rates of incapacity benefits for mental illness, new cases of tuberculosis and hospital stays for alcohol related harm are all better than the England average. Over the last ten years the rates of death from all causes and rates of early deaths from heart disease and stroke and from cancer have all improved and are close to the England average.

7.8.2 Key challenges

Children

To improve breastfeeding rates at birth

To reduce hospital admissions in the very young – especially for gastroenteritis

To improve GCSE pass rates

Adults

To address the variation in alcohol related admissions across the district

To extend cervical cancer screening coverage

To extend the take up of the NHS Health Check programme by those eligible

To improve take-up of diabetic retinopathy screening

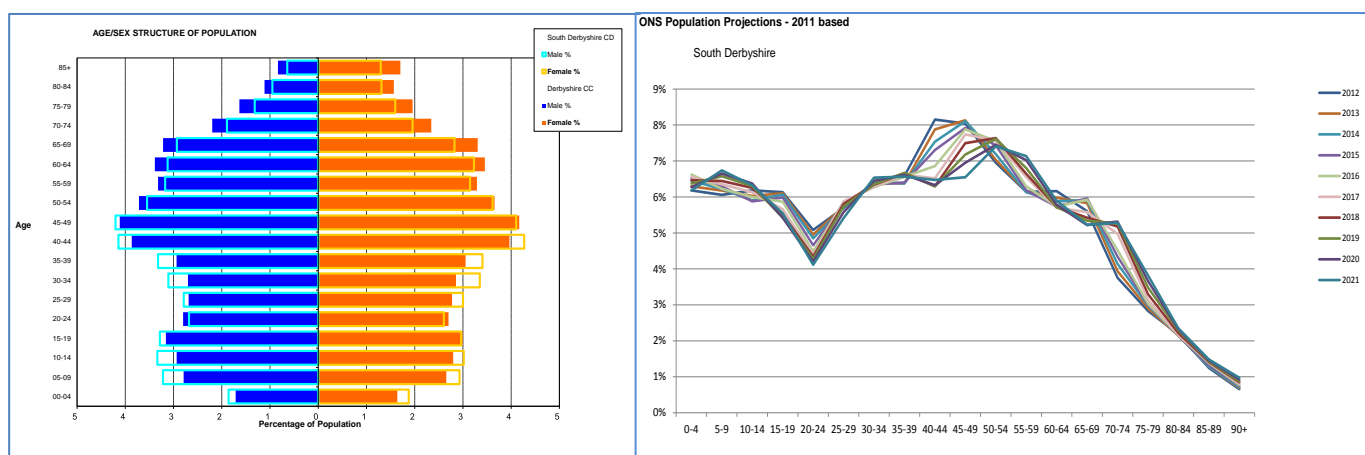
To increase flu vaccination uptake in the over 65s

To improve the patient experience of general practice

To reduce emergency readmissions within 30 days of discharge from hospital

7.8.3 Population and other characteristics

Figure 7.15 Population structure and projections



Structure

The population of South Derbyshire is rather younger than that of Derbyshire as a whole. There is a greater proportion of people aged under 45: 55% compared to 51%

Projections

Population projections show an ageing population, such that, by 2021, 19% of the population (20,600 people) will be aged over 65, 9% (9,300) over 75 and 2% (2,600) over 85, with a large deficit in numbers entering working age. Even if it can become healthier this ageing population will require more in terms of health and social care than ever before.

Density

South Derbyshire is not particularly densely populated, except in areas around Swadlincote, Willington and Hilton - where, correspondingly most of the healthcare services are to be found. This may cause problems of access for more rural communities.

Deprivation

Overall South Derbyshire is clearly not particularly deprived, except for small areas around Swadlincote. However, it must be noted that pockets of deprivation may still exist which are masked by the aggregation to Lower Super Output Area.

7.8.4 Health Profile

Pregnancy and Birth

The percentage of mothers breastfeeding at birth in 2012/13 was significantly lower in South Derbyshire, at 67.2% than in Derbyshire or England. This is the second lowest district rate.

Deprivation

As at January 2013, the percentage of children entitled to free school meals was significantly lower than for Derbyshire and England, and was the second lowest for all of the districts.

The percentages of dependent under 20 year olds and under 16 year olds living in poverty in 2011 were both significantly lower than for Derbyshire and England. These were both the second lowest rates amongst the districts.

Education

The GCSE pass rate in 2012/13 was significantly lower than for Derbyshire and England, and significantly lower than all but one of the other district rates.

School absence due to illness from both primary schools and secondary schools in 2012/12 was significantly lower than for Derbyshire. These were the second lowest and lowest district rates, respectively.

Persistent absence from secondary schools was significantly lower than for Derbyshire and England. This was also the second lowest rate amongst the districts.

The percentage of pupils with a statement of Special Educational Needs as at January 2013 was significantly lower than for Derbyshire and England. This was the second lowest rate of any of the districts.

Social Care (children)

The rate of Children in Need, as at 31st March 2013, was significantly lower than for Derbyshire or England. The rate of Children in Care, as at 31st March 2013, was also significantly lower. This was the second lowest rate of the districts.

Life Expectancy at age 75

Life expectancy at 65 for men in South Derbyshire is the same as for the County as a whole, at 18.2. At 20.6 years, life expectancy at 65 for women is a little lower than for Derbyshire (20.8). Disability free life expectancy (DFLE) at age 65 ranged from 7.8 years to 10.4 years within Derbyshire in 2006-08 for males, and from 7.3 years to 15 years for females. Overall males tend to spend a higher proportion of their life disability free.

Lifestyle

These are measures of how people are adopting healthy lifestyles and making healthy choices. Overall people in South Derbyshire live more healthily than people in the county as a whole. There is a higher proportion of physically active people, smoking prevalence is lower, the alcohol admission rate is significantly lower, diabetes prevalence is significantly lower and the prevalence of obesity is the same.

Environment

These indicators include some of the wider issues which can impact on health and wellbeing. Residents of South Derbyshire have a better environment than the county average. The proportion of households in fuel poverty is lower, the rate of domestic abuse is lower and the proportion of households in temporary accommodation is lower.

The rate of violent crimes is significantly lower than for Derbyshire as a whole.

The rate of death and serious injury on the roads is higher than for the county as a whole, though not significantly so, and is the third highest of the district rates.

Social Care (adults)

These indicators are about the need for and availability of help for people to continue to live independently in their own homes.

In 2008 it was estimated that over 28% of the population aged over 65 in South Derbyshire have moderate to very high needs. This was significantly lower than the county as a whole, which has a rate of 30.4%. The ward rates range from 18.5% to 37.6%.

In 2009, 12.8% of over 65s in South Derbyshire were in receipt of one or more services from Adult Social Care - significantly lower than the percentage receiving services county-wide. The ward rates range from 7.9% to 20.4%.

Living with a long-term condition

These indicators measure what is being done to help people manage and live with their long-term conditions.

In a survey in 2010/11 a smaller proportion in South Derbyshire said they felt supported than in Derbyshire as a whole. This was the lowest percentage in the eight districts.

The proportion of adults with mental illness who were in employment or who were living in settled accommodation were both higher than average.

In 2012/13, although the rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions was only slightly higher than that for Derbyshire, the ward rates ranged from 109.2 to 352.8.

The prevalence of dementia reported in general practice in 2013 was significantly lower than in Derbyshire overall and was the lowest of the districts.

Healthcare

These indicators are about access to services, early detection and appropriate treatment.

In 2012/13 a significantly smaller proportion of survey respondents had a favourable experience of GP Services in South Derbyshire than in Derbyshire as a whole. Within the district practice rates ranged from 78.7% to 92.7%.

A slightly lower proportion than for Derbyshire had a favourable experience of Out of Hours services. Practice rates ranged from 60.5% to 92.6%.

Take up of diabetic retinopathy screening in 2010/11 was significantly higher than for Derbyshire and was the second highest district rate, with practice rates ranging from 72% to 80%.

The coverage rate in 2012/13 for cervical screening was only slightly lower than in Derbyshire.

The coverage rate for breast screening was significantly higher than across the county. This was also the second highest rate amongst the districts.

A&E attendance rates in 2012/13, for both under 5s and 5 to 18 year olds, were significantly lower than for Derbyshire as a whole. The 5 to 18 rate was the second lowest in the county.

The 2012/13 rate of admission in under 1 year olds for gastroenteritis was significantly higher than for Derbyshire and was the second highest district rate.

A significantly higher proportion of hospital discharges resulted in an emergency readmission with 30 days. This was the third highest percentage for any of the eight districts

The rate of hospital admissions as a result of self-harm was significantly lower than for Derbyshire as a whole.

Mortality

These indicators reflect premature deaths, some of which could be avoided through treatment, and the process of dying with dignity.

In 2009-11 the rates per 100,000 of premature mortality were slightly lower than in Derbyshire overall.

The rate of mortality from causes considered amenable to healthcare was also lower than the Derbyshire rate.

The suicide rate in South Derbyshire was the highest of the Derbyshire districts.

In 2009-11, there were significantly fewer excess winter deaths in South Derbyshire than in Derbyshire as a whole. South Derbyshire has the second lowest index of all the districts. The indices range from -38.2(fewer deaths in winter) – the third lowest ward index in the county -in to 53.2.

Survey data suggests that many people would, given the choice, prefer to die at home. 37.6% of people who died in South Derbyshire did so in their usual home, compared to 39.1% across Derbyshire. The ward rates ranged from 27.1 to 57.2 – fifth highest in the county.

7.8.6 Future Housing Developments

To be confirmed

7.8.5 Current Provision

Residents of South Derbyshire have access to a range of services that reflect the health needs of the district. However the density of pharmacies is lower than the County average.

Table 7.8 Pharmacy Services provided in South Derbyshire

Community Pharmacy Services	South Derbyshire		County	
	No. pharmacies	Per 100,000	No. pharmacies	Per 100,000
MURs	14	15	144	19
New Medicines Service	11	11	118	15
100 hour pharmacy	2	2	16	2
Out of Hours	4	4	26	3
Palliative Care	12	13	86	11
Emergency Supply Service	12	13	119	15
Public Health commissioned services:-				
Smoking Cessation	7	7	71	9
Nicotine Replacement Therapy (NRT)	15	16	131	17
Oral Emergency Contraception	14	15	101	13
Substance Misuse/ Supervised Consumption	14	15	118	15
Needle exchange	4	4	40	5
CCG commissioned services:-				
MAR sheets	14	15	109	14
Total	15	16	161	21
Dispensing GPs	1	1	20	3

Rationale:

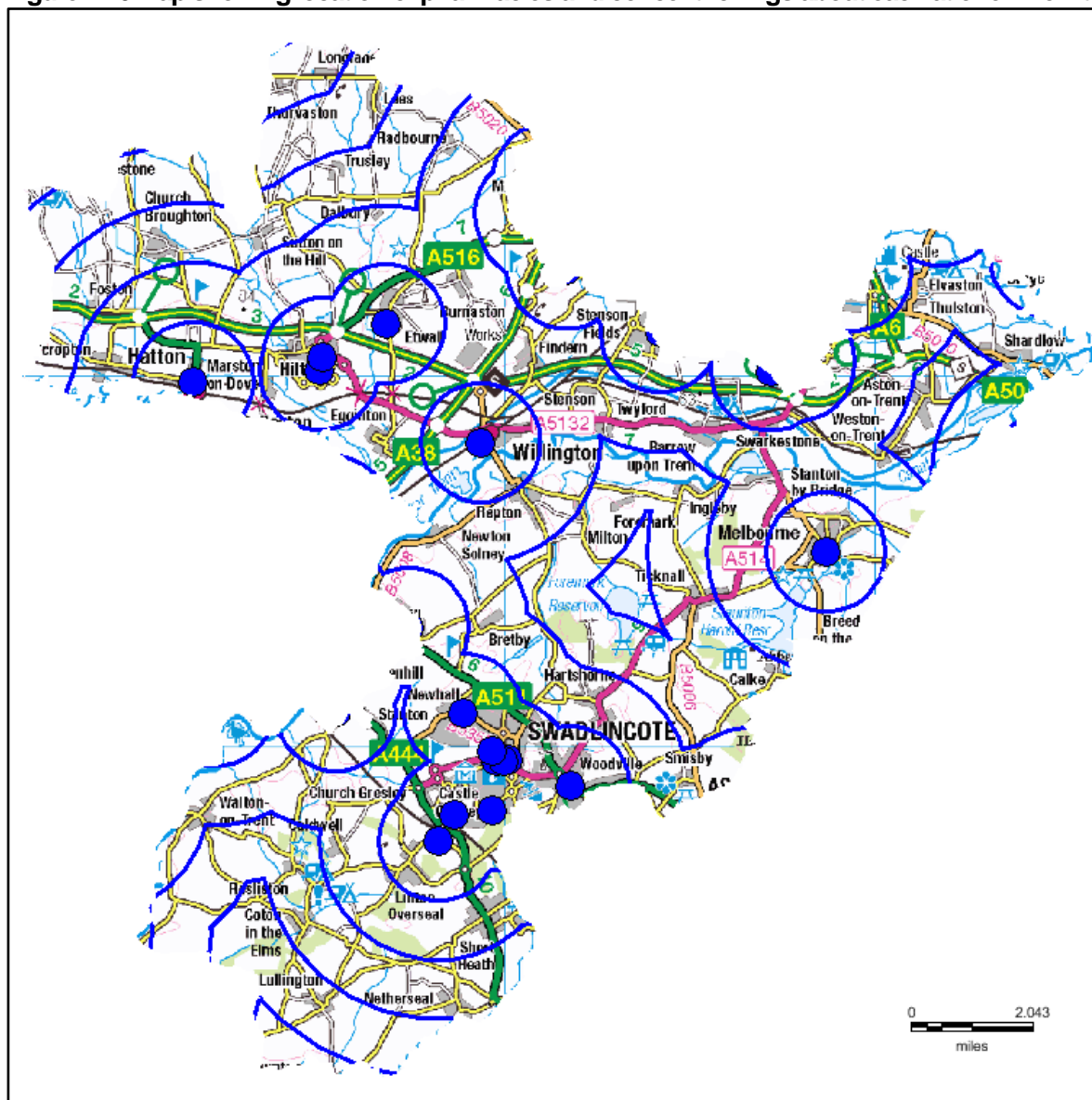
The map (figure 7.16) shows that there are currently 15 pharmacies within North East Derbyshire, giving 16 pharmacies per 100,000 population, rather lower than the County average. However, the services offered per head of population are similar. Larger settlements are all within 1 mile of a pharmacy or dispensing practice.

The advanced and locally commissioned services currently provided by these pharmacies are shown in Table 7.8. The 'spread' of advanced and locally commissioned services is considered to be adequate across the area and population.

The opening hours of these pharmacies are shown in Appendix 7.

South Derbyshire is largely rural and but no patient need travel much over 4 miles to a pharmacy or for other goods and services. Car availability is considerably higher than the national average and there is good provision of pharmacies across the district and close to the borders, particularly in Derby and Burton-on-Trent.

Figure 7.16 Map showing location of pharmacies and concentric rings about each at one mile intervals



Statement of pharmaceutical need subject to consultation:-

The PNA found that that pharmaceutical need in South Derbyshire is adequately met by the current pharmacy providers.

Pharmaceutical need will be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.

8. Summary

The PNA has not identified any significant gaps in pharmaceutical services for the Derby and Derbyshire population. The area is well served by community pharmacies providing a range of services sensitive to local health needs. Access is good and there is a good spread of pharmacies with longer opening hours and open at weekends. There are some rural areas within the County which are dependent on a small number of pharmacies and/or dispensing GPs and which would be especially vulnerable to closures or withdrawals of service. The public consultation revealed no significant gaps in services.

Recommendations

No action is required at the current time.

However special attention should be paid to the continued availability of pharmacies and services in rural areas, especially Derbyshire Dales.

Consideration should be given as to how the public can be better informed about the services available to them.

Pharmaceutical need should be reviewed in 2018 when the PNA is revisited or in the event of significant changes affecting need.