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PUBLIC

To: Members of Health and Wellbeing Board

Wednesday, 28 September 2022

Dear Councillor,

Please attend a meeting of the **Health and Wellbeing Board** to be held at **2.00 pm** on **Thursday, 6 October 2022** in Committee Room 1, County Hall, Matlock, DE4 3AG, the agenda for which is set out below.

Yours faithfully,

Helen E. Barrington

Helen Barrington
Director of Legal and Democratic Services

A G E N D A

PART I - NON-EXEMPT ITEMS

1. Agenda (Pages 1 - 2)

2. Apologies for Absence

   To receive apologies for absence (if any)

3. Declarations of interest

   To receive declarations of interest (if any)

4. Minutes (Pages 3 - 8)

To confirm the non-exempt minutes of the meeting of the Health and Wellbeing Board held on 07 July 2022.

5. Health and Wellbeing Board Terms of Reference and Membership (Pages 9 - 22)

6. Combatting Drugs (Pages 23 - 26)

7. Health Protection Board Update

8. Air Quality Strategy

9. Update Report on Work of the Shadow Derby and Derbyshire Integrated Care Partnership (Pages 27 - 44)

10. Cost of Living Update and Consideration of Health Impacts (Pages 45 - 50)

11. Health and Wellbeing Round Up (Pages 51 - 58)

12. Work Programme 2022/23 (Pages 59 - 62)

13. Pharmaceutical Needs Assessment - Formal Ratification of Final Version Following Virtual Approval (Pages 63 - 224)

14. AOB

DERBYSHIRE HEALTH AND WELLBEING BOARD

2pm-4pm, 6 October 2022

Committee Room 1, County Hall, Matlock, DE4 3AG

AGENDA

Time	Time allocated	Items	Presenter
14:00	15 minutes	Declarations of interest and Apologies for absence Introductions Minutes of the last meeting held on 7 July 2022	Cllr Hart
14:15	5 minutes	Health and Wellbeing Board Terms of Reference and membership (Report)	Ellie Houlston
14:20	20 minutes	Combatting Drugs (Presentation and discussion)	Helene Denness
14:40	5 minutes	Health Protection Board Update (Report)	Iain Little
14:45	20 minutes	Air Quality Strategy (Presentation and discussion)	Russell Sinclair and Matt Holford
15:05	15 minutes	Update report on work of the Shadow Derby and Derbyshire Integrated Care Partnership (Report and discussion)	Helen Jones
15:20	20 minutes	Cost of Living Update and consideration of health impacts (Presentation and Report)	Ellie Houlston
15:40	5 minutes	Health and Wellbeing Round Up (Report)	Helen Jones
15:45	5 minutes	Pharmaceutical Needs Assessment – formal ratification of final version following virtual approval (Report)	Ellie Houlston
15:50	5 minutes	AOB (Discussion)	Cllr Hart

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PUBLIC

MINUTES of a meeting of **HEALTH AND WELLBEING BOARD** held on Thursday, 7 July 2022 at County Hall, Matlock, DE4 3AG.

PRESENT

Councillor C Hart (in the Chair)

Councillors N Hoy and J Patten.

Officers present: Helen Jones (Executive Director - Adult Care), Dean Wallace (Director - Public Health) and Juliette Normington (Democratic Services Officer).

Also in attendance: Annette Appleton, Councillor Neil Atkin, Carol Camiss, Executive Director – Children's Services, Helen Denness, Ellen Langton, Iain Little and Lucy Wilson, Derbyshire County Council; Councillor Mary Dooley, Karen Hansan and Deborah Watson, Bolsover District Council; Bridgid Stacey, Derby and Derbyshire Integrated Care Board; Clive Stanbrook, Derbyshire Fire and Rescue; Harriet Nicole, Healthwatch Derbyshire; and Lee Pepper, North East Derbyshire District Council.

14/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

15/22 MINUTES

RESOLVED that the minutes of the meeting of the Board held on 31 March 2022 be confirmed as a correct record.

16/22 TERMS OF REFERENCE REVIEW

Helen Jones, Executive Director - Adult Care introduced the report, which had been circulated in advance of the meeting, asking the Board to note and agree changes to the Health and Wellbeing Board Terms of Reference and membership.

The changes updated the role and function of the Board so that it worked effectively within the new Integrated Care System structures which came into effect on 1 July 2022 and reflected Health and Wellbeing Board development sessions which had taken place since April 2022.

RESOLVED to:

1. Note the proposed changes to the Health and Wellbeing Board

Membership and Terms of Reference following development sessions in Spring 2022 where it had considered how the Board worked effectively and in partnership with the Integrated Care Partnership;

2. Agree the addition of the Derbyshire Integrated Care Board to its membership, as part of the statutory requirements of the Health and Care Bill which took effect from 1 July 2022; and

3. Note the revised draft Terms of Reference (attached at Appendix 2) and provide comment and feedback on them by 1 August 2022 so that a final version could be adopted at the Health and Wellbeing Board meeting on 6 October 2022.

17/22 JOINT STRATEGIC NEEDS ASSESSMENT TRANSFORMATION UPDATE

Dean Wallace, Director of Public Health introduced the report, which had been circulated in advance of the meeting, to update the Health and Wellbeing Board (HWB) on the on-going Joint Strategic Needs Assessment (JSNA) transformation programme in Derbyshire. The HWB oversaw the JSNA which was a statutory function and which had currently been identified as lacking in key information, containing out of date information, being difficult to access and not aligned to best practice.

A new process and platform were being created by the Public Health team to address the shortcomings of the current approach; no decision had yet been made on the process. The JSNA was currently led by one Council team and was not jointly owned and developed. The transformation programme would develop joint ownership.

RESOLVED to:

1. Note the upcoming changes to the JSNA process and platform; and

2. Support the engagement, testing and development of a shared approach with strategic leads and operational team members across the health and wellbeing system.

18/22 MENTAL HEALTH UPDATE

Helene Denness, Assistant Director of Public Health introduced the report, which had been circulated in advance of the meeting, requesting that the Health and Wellbeing Board adopt the population mental health statement for Derbyshire. The report was supported with a presentation.

The population mental health statement for Derbyshire, attached to the report, acknowledged that societal and structural factors were as important as individual factors in contributing to mental health problems. It recognised health inequalities played a significant role in increasing the risk of developing a mental health problem that could lead to poorer outcomes for those with existing mental health problems.

By adopting the population mental health statement for Derbyshire, the Board showed their commitment to system-wide work on population mental health aligning with the Health and Wellbeing Board strategy priorities.

RESOLVED to adopt the population mental health statement for Derbyshire and acknowledge that the statement will drive forward shared partnership action around this important health and wellbeing strategy priority.

19/22 HOMELESSNESS STRATEGY REPORT

Lee Pepper, North East Derbyshire District Council introduced the report, which had been circulated in advance of the meeting. It provided an update to the Health and Wellbeing Board and its members on the progress and support in the implementation of the county-wide Homelessness and Rough-sleeping Strategy. It also sought engagement in the four key priorities of the strategy and efforts in making homelessness everyone's responsibility.

The Strategy embodied a multi-agency collaborative approach to tackle homelessness and set out an ambitious plan to transform response to homelessness. Early intervention was embedded within it together with the offer of personalised solutions into homelessness services, especially where complex social issues were involved.

RESOLVED to:

1. Support the Derbyshire Homelessness and Rough Sleeping Strategy; and

2. Allow for the provision of regular updates on the progress of the strategy to be made to the Board as part of the Health and Wellbeing Strategy priority updates on 'Well planned and healthy homes'.

20/22 ANNUAL SECTION 75 UPDATE 0-19 COMMISSIONED SERVICES

Dean Wallace, Director of Public Health introduced the report, which had

been circulated in advance of the meeting, providing the Health and Wellbeing Board an update in relation to the delivery of the 0-19 Public Health Nursing Service over the 2020-21 academic year (September 2020 to August 2021).

The 2020-21 academic year continued to be a challenging one for the Service, in its continued response to the Covid-19 pandemic and restoring elements of the service delivery model that were either stood down or delivered via alternative means during the earlier stages of the pandemic. Despite these challenges, performance in relation to the KPIs had remained satisfactory and the service continued to make great efforts to help achieve the best outcomes for children, young people and their families.

There have been numerous priorities identified for the 2021-22 academic year to ensure the service continues to develop the delivery model and restore elements of the service in line with the current service specification. Both DCC and DCHS are committed to work in close partnership over the next academic year and beyond to deliver the best possible service for the families of Derbyshire residents.

RESOLVED to note the contents of the report.

21/22 HEALTH PROTECTION BOARD UPDATE

Iain Little, Deputy Director of Public Health introduced the report, which had been circulated in advance of the meeting, providing the Board with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda. The report was supported by a presentation, with focus on the following areas:

- COVID-19 - was still impacting on services, with statistics to the end of June suggesting an increase in infections across England and hospitalisations.
- Air Quality - no areas of Derbyshire had exceeded objectives.
- Immunisations - saw a focus on collaboration across the system with a national immunisation strategy due to be discussed at future Health Protection Boards. MMR catch-ups were being delivered and an increase in uptake for the influenza jab was expected. COVID-19 vaccinations continued.
- Screening – focus was aimed on inequalities (deprivation and population groups), PCN's were focussing on bowel and cervical screening uptake, breast screening was reducing backlogs and diabetic eye screening was out of recovery.
- Other current health protection issues included Monkeypox, the polio virus and the implications of the transfer of Glossop locality to

Derbyshire NHS.

RESOLVED to note the information contained in this round-up report.

22/22 BETTER CARE FUND OUTTURN REPORT

Helen Jones, Executive Director – Adult Care presented the report which had been circulated in advance of the meeting, giving an update on the outturn position of the Derbyshire Integration and Better Care Fund (BCF) through reporting of the required statutory return for 2021-22. The Department of Health and Social Care's Better Care Support Team published the National Return template on the 8 April 2022. Due to the meeting structures of the Board the report was presented retrospectively. The National Return Template was submitted on time.

An additional section reflected on successes and challenges over the course of the financial year and were reported in-line with the Logic Model for Integrated Care (developed by the Social Care Institute for Excellence, SCIE).

RESOLVED to:

1. Receive and sign off the report and note the responses provided in the Statutory Return; and

2. Continue to receive reports of the Integration and Better Care Fund throughout the 2022-23 financial year.

23/22 DRAFT PHARMACEUTICAL NEEDS ASSESSMENTS

Dean Wallace, Director of Public Health introduced the report which had been circulated in advance of the meeting and which provided an update of the Derby City and Derbyshire Pharmaceutical Needs Assessment (PNA).

The PNA was covered by regulations issued by the Department of Health and Social Care, which set out the legislative basis for developing and updating assessments. Under the 2013 Regulations, a person who wished to provide NHS pharmaceutical services needed to apply to NHS England to be included on a relevant list and needed to adhere to prescribed criteria. The revised assessment should be published every three years and, due to the Covid-19 pandemic, a delay was permitted until 1 October 2022.

RESOLVED to:

1. Note the update of the Derby City and Derbyshire Pharmaceutical Needs Assessment;

2. Note that the Pharmaceutical Needs Assessment would identify the needs of the population and support the decision-making process for pharmacy applications, as well as informing the planning of services that could be delivered by community pharmacies; and

3. Agree that following statutory consultation a final version of the draft, updated Pharmaceutical Needs Assessment be shared with Board members and, if approved by a majority of Board members, be published by 1 October 2022.

24/22 HEALTH AND WELLBEING ROUND UP

Helen Jones, Executive Director – Adult Care presented the report which had been circulated in advance of the meeting. The report gave a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda. It also provided a summary of the latest policy information to enable the development of the work plan for the Board.

RESOLVED - that the Health and Wellbeing Board note the information contained in the round-up report.

25/22 ANY OTHER BUSINESS

Carol Hart, Chair of the Board, thanked Dean Wallace for all the work he had done and wished him well in his new position of Chief Officer at Derbyshire Combined Health Services.

The meeting finished at 3.10 pm

FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE HEALTH AND WELLBEING BOARD

6 October 2022

Report of the Director of Public Health

Health and Wellbeing Board Terms of Reference and Membership

1. Purpose

1.1 The Health and Wellbeing Board is asked to:

a) Agree the Health and Wellbeing Board Membership and Terms of Reference following consultation, attached as appendix 2.

b) Note the revised draft terms of reference, which will be adopted by Derbyshire County Council.

2. Information and Analysis

2.1 Health and Wellbeing Boards were established under the Health and Social Care Act 2012 and have both set functions and a core membership. The statutory requirements of the Board are outlined in the terms of reference.

2.2 The statutory membership of the Board includes the following:

- At least one councillor of the upper tier local authority
- The director of adult social services for the upper tier local authority
- The director of children's services for the upper tier local authority
- The director of public health for the upper tier local authority
- A representative of the Local Healthwatch organisation for the area of the local authority
- A representative of each relevant clinical commissioning group (see 2.3 below)

2.3 The Health and Care Act (2022) amends the Health and Social Care Act (2012) replacing the representative of the Clinical Commissioning Group with a representative from the Integrated Care Board (amendments 183 and 184). There are also various other requirements relating to the presentation of Forward Plans and strategy documents which will require the Integrated Care Board to engage with the Health and Wellbeing Board formally. This relationship has been described in the revised terms of reference.

2.4 The Health and Wellbeing Board role is also described in the Terms of Reference to ensure that it adds value to the Derbyshire public sector system and effectively supports the work of the Integrated Care Board, the Integrated Care Partnership and other groups operating at district or borough level.

3. Alternative Options Considered

3.1 Not amend the Health and Wellbeing Board Terms of Reference to reflect recent development discussions and legislative changes. No changes would result in a risk to the Board and Derbyshire County Council as the body responsible for the Health and Wellbeing Board as it would not be compliant with legislation. If other changes were not adopted this may result in ineffective partnership arrangements and may reduce the effectiveness of all partner organisations to support health and wellbeing outcomes for the Derbyshire population.

4. Implications

4.1 Appendix 1 sets out the relevant implications considered in the preparation of the report.

5. Consultation

5.1 Members of the Health and Wellbeing Board have been consulted on the revised Terms of Reference and the Integrated Care Board have confirmed the officers and Non-Executive Directors who will be represented on both Derbyshire and Derby City Health and Wellbeing Boards.

5.2 The Derbyshire County Council Governance, Ethics and Standards Committee have been consulted as part of the process of amending the council constitution and fed back that Cabinet Members or Committee Chairpersons needed to act as district or borough council representatives, dependent on their governance arrangements. This is reflected in the Terms of Reference in Appendix 2.

5.3 Legal Services have provided some additional comments on the structure and format of the Terms of Reference.

6. Background Papers

6.1 Health and Social Care Bill (2022)

7. Appendices

7.1 Appendix 1 – Implications.
7.2 Appendix 2 – Draft Terms of Reference

8. Recommendation(s)

That the Health and Wellbeing Board:

a) Agree the Health and Wellbeing Board Membership and Terms of Reference following consultation, attached as appendix 2.
b) Note the revised draft Terms of Reference, which will be adopted by Derbyshire County Council.

9. Reasons for Recommendation(s)

9.1 The changes to the Health and Wellbeing Board Terms of Reference and membership update the role and function of the Board so that it works effectively within the new Integrated Care System structures which came into effect on 1 July 2022 and reflects Health and Wellbeing Board development sessions which took place earlier in 2022.

Report Author: Ellen Langton, Public Health Lead Strategic Intent
Contact details: ellen.langton@derbyshire.gov.uk

Appendix 1

Implications

Financial

1.1 There are no financial implications associated with the changes to the terms of reference

Legal

2.1 Health and Wellbeing Boards were established as statutory committees for upper tier local authorities within the Health and Social Care Act (2012). The 2012 Act prescribed core statutory functions and membership of the Board.

2.2 The Health and Social Care Act (2022) outlines a number of changes to NHS governance structures, including the requirement for Health and Wellbeing Boards to work alongside Integrated Care Boards and have representation from the Accountable Officer for the Derby and Derbyshire Integrated Care System, replacing the Chief Officer function from Clinical Commissioning Groups.

2.3 Member organisations and representatives should identify the process by which they are permitted to approve the Terms of Reference to ensure that any such governance process is followed. They may for example be required to seek approval from a governance group within their organisational structure and this should be completed prior to approval of the draft Terms of Reference.

2.4 The Terms of Reference of the Health and Wellbeing Board are contained in Article 14 of the Derbyshire County Council constitution. Revision of the Terms of Reference should therefore be considered and approved by full council once the Board and member organisations have approved these.

Human Resources

3.1 There are no human resource implications associated with the changes to the Terms of Reference.

Appendix 2 Revised Terms of Reference

Derbyshire Health and Wellbeing Board (HWB) - Terms of Reference and core strategic functions

Background

Under the Health and Social Care Act 2012 all local authorities are required to establish a Health and Wellbeing Board (HWB) for its area. The Health and Wellbeing Board is established as a committee of Derbyshire County Council.

The legislative framework for the wider health and social care system is within the Health and Social Care Act 2012.

Vision and objectives

Derbyshire Health and Wellbeing Board has a vision to:
Focus on prevention and the wider determinants of health so that the work of the Board will reduce health inequalities and improve health and wellbeing across all stages of life by working in partnership with our communities.

The objectives of the Board are to enable the residents of Derbyshire to:

- Start Well,
- Live Well and Stay Well,
- Age Well and Die Well.

Purpose and function

Derbyshire Health and Wellbeing Board must undertake the following statutory functions by:

- Preparing and publishing a Joint Strategic Needs Assessment (JSNA) of current and future health and social care needs and ensuring it informs the Health and Wellbeing Strategy and Integrated Care Strategy.
- Preparing and publishing a Joint Local Health and Wellbeing Strategy (JLHWS) for Derbyshire.
- Promoting integrated working in planning, commissioning and delivery of services to improve the health and wellbeing of the population of Derbyshire, including the use of Section 75 agreements.
- Receiving and responding to the plan of the Integrated Care Board
- Preparing and publishing a Pharmaceutical Needs Assessment to assess the need for pharmaceutical services in Derbyshire.
- Expressing an opinion when an application is received from pharmacies in Derbyshire where they wish to consolidate or merge.

These statutory functions will be supported by the following actions:

- Holding organisations and partners to account for delivering against the priorities outlined in the Health and Wellbeing Strategy.

- Ensuring the Health and Wellbeing Strategy has a clear focus on activity linked to primary and secondary prevention, which the Board, through the organisations represented on it, can lead on.
- Championing prevention and population health as important strategic issues and influencing organisations and partnerships both within and external to ICS to reflect this in their work.
- Working as part of the wider system to address strategic challenges for population health, with a particular focus, where appropriate, of working collaboratively with Derby City Health and Wellbeing Board.
- Representing Derbyshire in relation to health and wellbeing issues at a regional and national level where appropriate.
- Working closely with the Derbyshire Healthwatch to ensure appropriate engagement and involvement with patients and service users.
- Ensuring that, where appropriate, system wide delivery plans or shared spaces to collaborate are in place to support the HWBS strategic priorities and outcomes.
- Challenging performance against the outcomes outlined in the HWBS via the HWB dashboard indicators which make links to performance frameworks for the NHS, public health and local authorities.
- Developing mechanisms to measure, monitor and report improvements in health and wellbeing outcomes for Derbyshire.
- Ensuring there are effective and appropriate mechanisms to communicate, engage and co-produce health and wellbeing strategy priorities with local people and stakeholders.

Membership

The Health and Wellbeing Board will involve Integrated Care System and wider partners. The Cabinet member with Executive responsibility for Public Health will Chair the Board. The Vice Chair is indicated in the membership list below should the Chair be unable to attend a meeting.

Should neither the Chair nor vice-chair be able to attend a meeting of the Health and Wellbeing Board, the members present at the meeting will agree to appoint a Chair for that meeting from the members present.

The full Health and Wellbeing Board membership will comprise:

- Cabinet Member with Executive responsibility for Public Health (Chair) (Statutory)
- Chief Executive Officer for Derby and Derbyshire Integrated Care Board (Statutory)
- Non-Executive Director for Derby and Derbyshire Integrated Care Board (Vice chair) (Statutory)
- Senior officer with statutory responsibility for Adult Social Care, Derbyshire County Council (Statutory)

- Senior officer with statutory responsibility for Children's Services, Derbyshire County Council (Statutory)
- Director of Public Health, Derbyshire County Council (Statutory)
- One representative from Healthwatch Derbyshire (Statutory)

Statutory officer who fulfils role of

- Cabinet Member with responsibility for Adult Social Care
- Cabinet Member with responsibility for Children's Social Care
- Chair of 3D to represent the voluntary sector
- One elected member holding a relevant Cabinet portfolio or committee chairperson from each district or borough council in Derbyshire
- Police and Crime Commissioner for Derbyshire
- One senior officer representative from Derbyshire Constabulary
- One senior officer representative from Derbyshire Fire and Rescue Service

The Board can co-opt additional members as it considers appropriate in relation to Health and Wellbeing Strategy priorities.

Representatives from NHS England, Public Health England, the UK Health Security Agency, or Office of Health Improvement can attend the Board meetings as required, but in relation to specific issues or area of interest. These officers will not be able to vote on matters.

Senior officers from district and borough councils may attend the meeting to support district and borough elected members who are formal members of the committee. These officers will not be able to vote on matters.

Specific officers may be asked to attend one or a series of HWB meetings to provide detailed insight and input to particular topics or issues, such as one of the Health and Wellbeing Board priorities. These officers will not be able to vote on matters.

The Board membership will be reviewed annually in line with the municipal year.

Responsibilities of Board members

Members should be senior leaders and key decision makers who are able to actively contribute to, and be collectively accountable for, the development and delivery of the Health and Wellbeing Strategy and achievement of our shared ambition to improve population health and wellbeing outcomes and reduce health inequalities.

All members will:

- Endeavour to attend all meetings of the Health and Wellbeing Board as no substitutes will be permitted. If they are unable to attend any actions or issues will need to be raised via liaison with another Health and Wellbeing Board member.
- Fully engage in the Health and Wellbeing Board including active participation in discussions and decision-making relating to all relevant agenda items.
- Propose, as appropriate, agenda items, for information or discussion, to the Health and Wellbeing Board.
- Represent their respective organisations or networks they represent and must take responsibility for communicating all relevant information within their organisation or network.
- Actively progress any strategic decision or action agreed at the Health and Wellbeing Board through their own organisation and any relevant partners and networks.
- Ensure full support and implementation of the Health and Wellbeing Strategy through their own organisation and relevant networks.
- Ensure their organisations are fully represented and participate in relevant sub-groups and/ or Task and Finish groups as appropriate.
- In addition to the above expectations of all members, it is also the role of the Healthwatch representative to ensure the appropriate representation of the patient, public and carer population.

Term of office

The term of office of members shall end if:

a) Rescinded by the organisation by whom they are appointed
b) If a Councillor appointed by a Council cease to be a member of the appointing Council
c) If the individual change's role within an organisation and is no longer in the role that led to their appointment to the HWB

Governance

Agenda Planning

The Chair and Vice Chairs in conjunction with the Director of Public Health will set the agenda for future meetings. All Board members will be asked to put forward reports for consideration prior to agendas being finalised. The Board will be updated quarterly on the work of the Derby and Derbyshire Integrated Care Partnership.

Reporting
Reports considered by the Health and Wellbeing Board will need to make a clear recommendation and also demonstrate how they are delivering against Health and Wellbeing Strategy priorities. Reports for information and noting will be circulated electronically to the Board between meetings to ensure that information is shared in a timely manner.

All reports associated with agenda items must meet standard reporting requirements and be received by the secretariat by the date stated when agenda items are requested.

No late items will be accepted.

The agenda will be published at least five clear working days before the meeting, a copy of the agenda and associated papers will be sent to every member of the Board.

Minutes
The minutes of the proceedings will be approved at the next suitable meeting after they have been agreed as a correct record at that meeting. The minutes will be accompanied by a list of agreed action points which may be discussed in considering the minutes of the previous meeting should they not be specifically listed as items on the agenda for that meeting.

Minutes will be published on the Derbyshire County Council website.

Meetings of the Board

Frequency
The Health and Wellbeing Board will meet on a quarterly basis.

The date, time and venue of meetings will be fixed in advance by the Board and an annual schedule of meetings will be agreed.

Meetings will normally take place at County Hall, Matlock unless the Board is required to visit another venue or participate in a joint session with Derby City. The Board is a statutory committee of the council and therefore it is required to meet in person.

If there is insufficient business the Chair can agree to cancel the meeting up to 5 days in advance of the set meeting date

Additional meetings may be convened at the request of the Chair or Vice Chair.

Quorum
A quorum of five will apply for meetings of the HWB, with at least three statutory members present.

If any member of the Board has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

Attendance
Attendance of Health and Wellbeing Board meetings will be monitored and fed back to the Health and Wellbeing Board annually.

Development sessions
In addition to the formal public meetings, the Board will hold regular development sessions – both as a Derbyshire Health and Wellbeing Board and jointly with Derby Health and Wellbeing Board as appropriate. Development sessions will be held in private to support specific issues, focused discussion and learning, ongoing review of Board functioning and active development of the Board and its members.

Voting
At this stage of its development the HWB will operate on a consensus basis. If a vote is required, it will be amongst the statutory members of the Board only.

Declaration of Interests
Any interests held by members or co-opted members should be declared on any item of business at meetings in accordance with the Council's Code of Conduct for Members and the Localism Act 2011.

Public questions
Public questions must be tabled 3 working days in advance and in line with the procedures for Full Council and will be considered at the Chair's discretion to ensure they are relevant to the work of the Health and Wellbeing Board. Questions must be asked exactly as submitted, and no supplementary questions are allowed.

Scrutiny
Decisions of the Health and Wellbeing Board will be subject to scrutiny, but will not be subject to the "call-in powers" of the Improvement and Scrutiny Committee.

Renumeration
Members attendance at meeting will not result in additional payments. Mileage and expenses can be made by the respective authorities or organisations in line with organisational policy and procedures.

Secretariat
The Secretariat role will be provided by Council Democratic Services. This role will include minute-taking and distribution, administration of all agenda items and associated papers. Democratic Services will be supported with co-ordination and operational assistance by Public Health officers.

Support arrangements
Derbyshire County Council will also provide support via the Monitoring Officer and Section 151 officer.

Information Sharing Protocol
If necessary, the ICP and partners will develop an information sharing protocol to enable the effective sharing of information and ensure compliance with GDPR.

Access to Information/Freedom of information
The Board shall be regarded as a County Council committee for access to information purposes and meetings will normally be open to the press/public.

Operational Delivery
Work will be delivered by established system groups at a county wide level. The Health and Wellbeing Board will direct and commission specific pieces of work via Board members who will need to action, coordinate and feedback to the Board within agreed timescales.

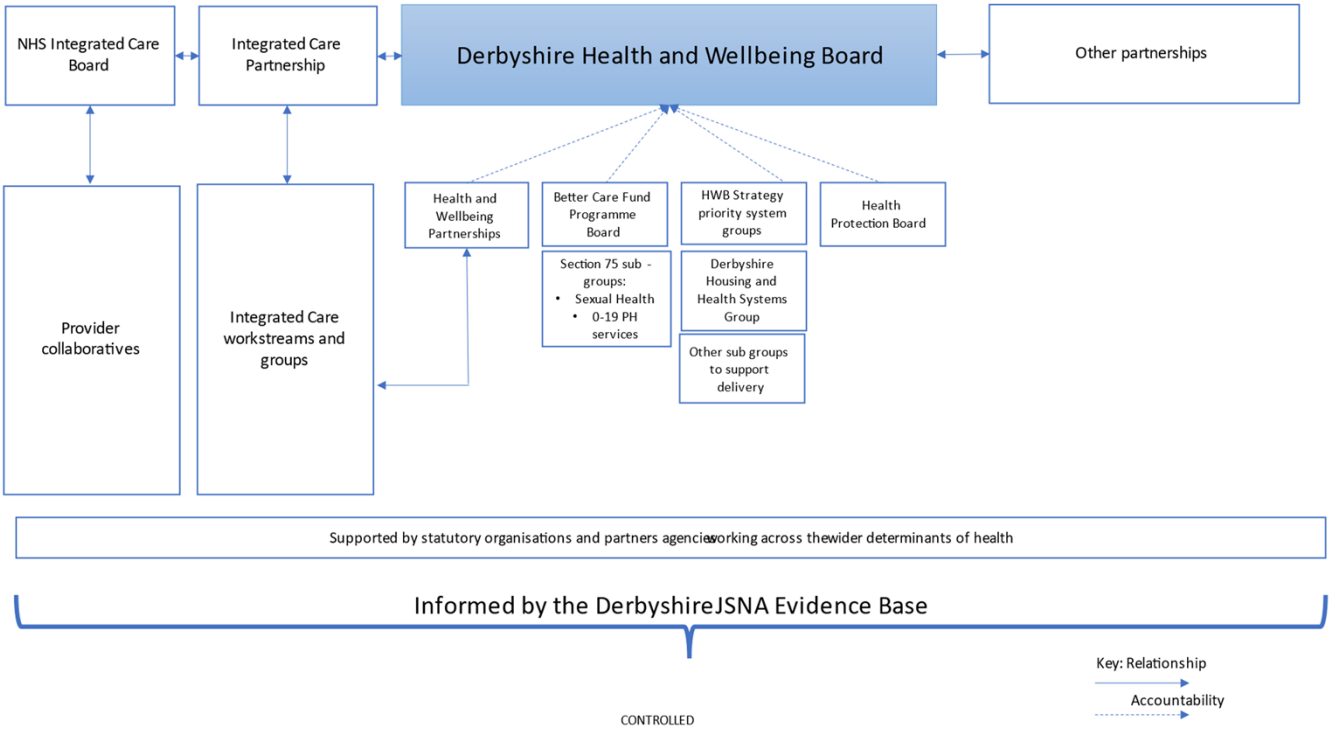
Task and finish groups will be established by exception to take forward key pieces of work for the Health and Wellbeing Board. Task and finish groups will include representatives from Health and Wellbeing Board member or partner organisations and wider stakeholders.

Derbyshire Locality Health Partnerships will act as a delivery structure, working alongside Integrated Care System Place Alliances, to coordinate delivery of agreed actions and pieces of work.

The governance diagram at the end of this document sets out the relationship between the HWB and other groups and programmes of work in Derbyshire. If required a protocol document between the Health and Wellbeing Board and other strategic groups will be established to facilitate discussions and delivery against priorities.

Review
These Terms of Reference will be reviewed annually or earlier if required.

Appendix 1: HWB Governance arrangements



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Last Review
May 2022

Next Review
May 2023

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FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

6 October 2022

Report of the Director of Public Health

Reducing harmful alcohol and drug consumption

1. Purpose

1.1 The purpose of this paper is to provide the Health and Wellbeing Board (HWB) with:

a. An overview of the current national context and local drivers in relation to substance misuse
b. An overview of local plans to reduce harmful alcohol and drug consumption.

2. Information and Analysis

2.1 Harmful alcohol and drug consumption is a significant contributor to poor health outcomes and inequalities. It also has an impact on the demand for health and care provision and is therefore of interest to HWB members. There is also a requirement to provide a local response to the national Drug Strategy (published 2021) and it is important that the HWB is fully aware of local plans including the development of a local city / county Combatting Drugs Partnership.

2.2 Dame Carol Black's Independent Review of drugs in July 2021 identified significant disinvestment in treatment in the previous eight years. In that time period there has been an increase in drug-related harm, alcohol-related harm and drug-related death, as well as a decrease in efficacy and quality of treatment.

2.3 ‘From Harm to Hope’, the Government’s recently published ten-year drugs strategy identifies that current and new investment includes improvement of drug and alcohol treatment. The national Joint Combatting Drugs Unit (JCDU) has asked local areas to develop local Combatting Drugs Partnerships to oversee and provide accountabilities for all three strands of the national drugs strategy, which are summarised below:

- Break drug supply chains
- Deliver a world-class treatment and recovery system
- Achieve a generational shift in the demand for drugs

2.4 Additional grant funding, the Supplemental Substance Misuse Treatment Recovery Grant, has been provided to all local authorities within a menu of interventions to deliver improvements to the quality and capacity of local treatment systems. This additional funding is intended to be a three-year programme of investment, although approval for years two and three of the funding has yet to be confirmed by HM Treasury.

2.5 Derbyshire’s primary focus in year one is to increase service capacity and quality through using the grant to deliver the following:

- Sustainment of the specialist criminal justice substance misuse team to increase community treatment access to offenders and improve continuity of care from prison to community
- Introduction and evaluation of prescribing of long-acting opiate substitute medication to specific cohorts
- Increased staffing for both adult and young people’s treatment services
- Enhanced hospital-based drug and alcohol care teams with community substance misuse in-reach to close gaps in care
- Enhanced support for increasing numbers of children and young people affected by the substance use of others

3 Alternative Options Considered

There is clear direction and governance from Government directing local response and use of grant monies, therefore no other options were considered.

4 Implications

4.1 Appendix 1 sets out the relevant implications considered in the preparation of the report.

5 Appendices

5.1 Appendix 1 – Implications.

6 Recommendation(s)

That the Health and Wellbeing Board:

a) Note the drivers and strategic direction of travel in planning to reduce drug and alcohol-related harm in Derbyshire.
b) Note the plans for using new grant investment to deliver improvements to treatment and recovery services in Derbyshire.
c) Agrees to receive an annual update on this shared partnership agenda.

7 Reasons for Recommendation(s)

That the Health and Wellbeing Board recognise the role that all partners play in jointly delivering these outcomes and respond positively to the call to action from national multi-departmental Joint Combatting Drugs Unit.

Report Author: Helene Denness, Assistant Director Public Health
Contact details: helene.denness@derbsyhire.gov.uk

Appendix 1

Implications

Financial

1.1 The Council has been allocated for 2022/23 a Section 31 grant of value £0.812m for drug and alcohol treatment and a further Section 31 grant of value £0.125m specifically for inpatient detoxification. There are specific conditions and expectations in relation to the use of the grant and outcomes expected to be achieved.

Legal

2.1 There are no legal implications.

Human Resources

3.1 There are no Human Resources implications.

Equalities Impact

5.1 It is accepted that alcohol and drug problems will differentially impact on some groups in the population including, but not limited to women, people with learning disabilities and mental health issues, and we are committed to action to reduce these differential impacts to work towards reducing stigma, and achieving equality, diversity, and inclusion across services.

FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

6 October 2022

Report of the Deputy Director of Public Health

Health Protection Board Update

1. Purpose

1.1 To provide an update of the key messages arising from the Derbyshire Health Protection Board from its meeting on 12 August 2022.

2. Information and Analysis

2.1 The Health Protection Board is a cross-Derbyshire Board that is a sub-group of the Derbyshire Health and Wellbeing Board.

2.2 The purpose of the Health Protection Board is to provide assurance to the Health and Wellbeing Boards of Derbyshire County and Derby City that adequate arrangements are in place for the prevention, surveillance, planning and response required to protect the health of the residents of Derby City and Derbyshire County.

2.3 The following updates were provided during the business of the meeting on 12 August 2022:

2.4 Screening and Immunisations Programmes:

- A national screening strategy is due, with implications for local delivery to be considered following publication

- Screening programmes have been prioritised as a response to the continuing impact of COVID-19, with a focus including managing patient backlog, and lab capacity and turnaround times. Nationally, the breast and cervical cancer screening programmes have been given the highest priority, followed by the bowel cancer and the ante-natal and new-born screening programmes, followed by the abdominal aortic aneurysm programme.
- The process for identification of a new site for placement of a mobile breast screening unit in Glossop continues
- A national immunisation strategy is due, with focus on local delivery. Implications of delivery of immunisations programmes across Derbyshire to be considered following publication
- A national Mumps, Measles and Rubella catch-up campaign will start in September, with support sought by NHS England from GPs

2.5 Air quality:

- The Derbyshire County and Derby City Air Quality Strategy 2020-2030 was approved by the Derbyshire Health and Wellbeing Board on 6 February 2020
- The annual air quality report for 2021 highlighted that there has been a general improvement in air quality across Derbyshire. 98.5% of monitoring sites met air quality objectives in 2021. Four Air Quality Management Areas and accompanying action plans are in place in the County.
- The importance of particulate matter (PM_{10} and $PM_{2.5}$) on health has become more apparent in recent years, and consultations have recently been undertaken by Department for Environment, Food and Rural Affairs on proposed target levels for $PM_{2.5}$ as required by the Environment Act 2021.
- Currently there are no known areas in Derbyshire where particulate levels exceed the nationally-set objectives, however the estimated local mortality burden attributed to particulate matter is 533 deaths. The local mortality burden attributed to nitrogen dioxide has not yet been calculated but is considered to be similar. The predicted proportion of mortality attributable to particular air pollution varies across Derbyshire, with Bolsover, Erewash and North East Derbyshire having a proportion higher than the national proportion (5.6%).
- Adaption of the national targets for particulate matter will inform future local policy and practice.
- A more detailed update on the air quality annual report will be provided in the accompanying presentation

2.6 Health protection role of Derby and Derbyshire Integrated Care Board:

- Ongoing discussions to ensure that health protection is appropriately reflected within the ICB governance arrangements and Integrated Care Strategy

3. Alternative Options Considered

3.1 None considered as report for information only.

4. Implications

4.1 Appendix 1 sets out the relevant implications considered in the preparation of the report.

5. Consultation

5.1 No consultation required

6. Background Papers

6.1 None

7. Appendices

7.1 Appendix 1 – Implications.

8. Recommendation(s)

8.1 That the Health and Wellbeing Board:

a) Note the update report from the Health Protection Board.

9. Reasons for Recommendation(s)

9.1 To meet the purpose of the Derbyshire Health Protection Board in providing assurance to the Derbyshire Health and Wellbeing Board that adequate arrangements are in place to protect the health of the residents of Derbyshire County

Report Author: Iain Little, Deputy Director of Public Health, Derbyshire County Council
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Appendix 1

Implications

Financial

1.1 None identified

Legal

2.1 None identified

Human Resources

3.1 None identified

Information Technology

4.1 None identified

Equalities Impact

5.1 None identified

Corporate objectives and priorities for change

6.1 None identified

Other (for example, Health and Safety, Environmental Sustainability, Property and Asset Management, Risk Management and Safeguarding)

7.1 None identified

FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

6 October 2022

Report of the Executive Director of Adult Social Care and Health

Update report on the work of the Shadow Derby and Derbyshire Integrated Care Partnership

1. Purpose

1.1 This report provides and update on activity in the last quarter from the Derby and Derbyshire Integrated Care Partnership that is relevant to the Derbyshire Health and Wellbeing Board, it's development and strategy implementation.

2. Information and Analysis

2.1 Within the revised terms of reference for both the Health and Wellbeing Board and the Integrated Care Partnership (ICP) there is the recognition of the importance of regular sharing of information between the Boards to enable effective coordination of issues across the health and wellbeing agenda and to ensure the development of a transparent partnership approach as the new governance arrangements are established.

2.2 The Health and Wellbeing Board will provide a summary update report on activity from the ICP each quarter with then a reciprocal report feeding back into the ICP on the work of the Health and Wellbeing Board. Several senior officers also sit on both partnership groups and can present the updates as well as providing further verbal updates as required.

2.3 The Integrated Care Partnership in Derbyshire is continuing to meet in shadow format, when it will become a formally constituted joint committee between the Integrated Care Board (ICB), Derbyshire County Council and the City Council.

2.4 In the last quarter there has been extensive development work reflecting on the proposals put forward by the Derbyshire and Derby City Health and Wellbeing Boards to agree a clear role and function for the ICP.

2.5 The ICP Terms of Reference are informed by and responds to the HWB development work that has taken place as agreed in the scoping discussions which took place between ICP members at the first meeting of the Partnership. A copy of the terms of reference are attached for information as Appendix 2 to this report.

2.6 It has been agreed that the ICP will be chaired by the Chair (or nominated representatives) of Derbyshire Health and Wellbeing Board and Derby City Health and Wellbeing Board on a rotating basis. The Chair of Derby and Derbyshire ICS will act as vice chair. This is a positive step and will ensure good read across on an ongoing basis and also an effective feedback mechanism.

2.7 In addition, Derbyshire County Council, Derby City Council and the Integrated Care Board have developed formal governance papers to establish the ICP as a joint committee. This paper will be considered by Derbyshire County Council's Cabinet on 13 October. It is proposed that the Integrated Care Partnership is hosted by Derby City Council on behalf of the three constituent bodies.

2.8 Initial planning and development work has also commenced on the Integrated Care Strategy (ICS Strategy), which is sponsored by the ICP, and scoping has made clear that this will not duplicate the priorities and work of the Health and Wellbeing Strategy in relation to primary prevention and tackling health inequalities.

2.9 The strategy development is being informed by the Derbyshire Joint Strategic Needs Assessment (JSNA) and wider insight which is being collated by the Joined Up Care Derbyshire Engagement Team.

2.10 The Government has requested that all ICP's complete an initial version of the ICS Strategy by December 2022. A final version of the strategy will be shared with the Health and Wellbeing Board, who will then need to consider whether the Derbyshire Health and Wellbeing Strategy needs to be updated to reflect the priorities and provide place level

leadership to ICS priorities. This works well as the HWBS is due for refresh in 2023 irrespective of these developments.

2.11 It has also been agreed that initially the ICP will not have a formal sub-committee structure, but work is taking place across the system to map how groups such as the Integrated Place Executive and County Place Partnership can evolve to support the delivery of the ICS Strategy. Work is also taking place at a county level to consider whether the County Place Partnership could act as an 'engine room' to deliver both the priorities of the ICS Strategy and the HWBS. Views on this proposal are welcomed from the Health and Wellbeing Board members alongside feedback as to whether any of the subgroups of the Health and Wellbeing Board would better sit linked to the County Place Partnership to act as thematic 'mini engine rooms' to drive forward priority-based work.

2.12 More broadly, Joined Up Care Derbyshire has introduced regular Team Derbyshire Briefings for all health and care colleagues working in Derby and Derbyshire. Sessions look at different aspects of the health and care system to help grow our understanding of what it means to be an Integrated Care System. Members of the Health and Wellbeing Board may find it useful to attend these virtual sessions. JUCD publishes bi-monthly newsletters which provide news and updates on the ICS. More information on Joined Up Care Derbyshire can be found by accessing: https://joinedupcarederbyshire.co.uk/

3. Alternative Options Considered

3.1 Not accept the update report from the Integrated Care Partnership.

4. Implications

4.1 Appendix 1 sets out the relevant implications considered in the preparation of the report.

5. Appendices

5.1 Appendix 1 – Implications.
5.2 Appendix 2 – Integrated Care Partnership Terms of Reference.

6. Recommendation(s)

That the Health and Wellbeing Board:

a) Note the development work of the Integrated Care Partnership and development of the Integrated Care Strategy.
b) Consider whether there is an opportunity to align the operational delivery work associated with the Health and Wellbeing Strategy priorities with the County Place Partnership so there is a combined 'engine room' working to deliver health, wellbeing and care priorities for the county.

7. Reasons for Recommendation(s)

9.1 To provide the Health and Wellbeing Board with the latest updates from the Derby and Derbyshire Integrated Care Partnership

9.2 To provide an opportunity for the Health and Wellbeing Board to consider how strategic priorities can be best delivered across the system maximising opportunities for joint working, preventing duplication and aligning the work of the Health and Wellbeing Board with the Integrated Care System.

Report Author: Ellen Langton, Public Health Lead Strategic Intent.
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Appendix 1

Implications

Financial

1.1 There are no financial implications of this report.

Legal

2.1 Health and Wellbeing Boards were established as statutory committees for upper tier local authorities within the Health and Social Care Act (2012). The 2012 Act prescribed core statutory functions and membership of the Board.

2.2 The Health and Social Care Act (2022) outlines a number of changes to NHS governance structures, including the requirement for Health and Wellbeing Boards to work alongside Integrated Care Boards and Integrated Care Partnerships.

Human Resources

3.1 There are no human resource implications of this report.

Appendix 2 – Terms of Reference for Integrated Care Partnership

Joined Up Care Derbyshire

Derby and Derbyshire Integrated Care System Partnership (ICP) Terms of Reference and core strategic functions

Background

The Derby and Derbyshire Integrated Care Partnership (ICP) is a statutory joint committee in accordance with Section 116ZA of Local Government and Public Involvement in Health Act 2007 and is part of the Derby and Derbyshire Integrated Care System (ICS).

Derby and Derbyshire Integrated Care System works across the local authority footprints of Derby City and Derbyshire County. The ICP is one of two statutory bodies within the ICS, the other being the Derby and Derbyshire Integrated Care Board (ICB), which has also been established by legislation.

The ICP is a broad alliance of organisations and representatives concerned with improving the care, health, and wellbeing of the population, jointly convened by local authorities and the NHS as equal partners to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care.

The ICP will work alongside other organisations and members of the voluntary sector, as well as the Health and Wellbeing Boards for Derby and Derbyshire, in relation to delivering population health and wellbeing outcomes.

Purpose and function

The ICP's primary purpose will be to act in the best interest of people, patients, and the system, rather than representing individual interests of any one constituent partner.

Under s1176ZB of the Local Government and Public Involvement in Health Act 2007 the Derby and Derbyshire ICP is required to prepare an Integrated Care Strategy that:

- Details how the needs of resident of its areas will be met either by the ICB, NHS England or local authorities.

- Considers how NHS bodies and local authorities could working together to meet these needs using section 75 of the National Health Service Act 2006.
- Must have regard to the NHS mandate and guidance published by the Secretary of State.
- Involves Local Healthwatch and people who live or work in the ICP's area.
- Is reviewed and revised as required when a new joint strategic needs assessment is received from a local authority within the ICP.
- Considers how health related services can be more closely integrated with arrangements for the provision of health services and social care in its area.
- Is published and provided to each local authority in its area and each partner Integrated Care Board of those local authorities.

Under s116B of the Local Government and Public Involvement in Health Act 2007 a local authority and each of its partner ICPs must have regard to:

- Any joint assessment of health and social care in relation to the area for which they are responsible.
- Any Integrated Care Strategy that applies to the area of the local authority.
- Any Joint Health and Wellbeing Strategy prepared by the local authorities and any of its partner ICBs.

These statutory functions will be supported by the following actions:

- Provide a forum to build on the joint positive working between the NHS ,local authorities and the voluntary sector.
- Sign off the strategic intent for the health and social care system including the development of the Integrated Care Strategy and refresh
- Oversee integration between NHS and social care, including conversations about shared budgets.
- Leads on preventative actions that are clearly linked to health and social care service provision.
- Drive the delivery of a shift of resources into prevention
- Provide the opportunity to unblock obstacles to success emerging in local Place Alliances and to hear the voices of those on the frontline to inform strategic thinking and planning within Derby and Derbyshire Integrated Care System.
- Develop a clear view on the contribution of the health and social care services into improving population health, the wider determinants of health and reducing health inequalities.
- Contribute to the "anchor" approach.

- Working with Health and Wellbeing Boards and with broader partnerships and partners to support action linked to primary prevention and the wider determinants of health.
- Collaborate with the activity of the Integrated Care Board to ensure an aligned approach to activity.
- Mobilises services linked to partner organisations to operationalise and support delivery in health and social care space

Chairing

Chair
The meeting will be chaired on a rotating basis by the Chair of Derby Health and Wellbeing Board and the Chair of the Derbyshire Health and Wellbeing Board.

The Health and Wellbeing Board representatives or ICB representative can name a suitable delegate to represent them on a regular basis at the meeting.

Vice-chair
The vice chair will be the ICB Board Chair, and this person will deputise should the scheduled Chair be unable to attend a meeting.
The chairs and vice chair will be equal functional roles in this partnership.

Chairing arrangements
The chair of the meeting will rotate after every three meetings. Development sessions will be jointly chaired, and appropriate arrangements will be put in place for any additional meetings convened at short notice.
Should neither the Chair nor vice-chair be able to attend a meeting of the Integrated Care Partnership, the ICP members present at meeting will agree to appoint a Chair for that meeting from the members present. It is assumed that in the first instance the Health and Wellbeing Board Chair not currently holding the chair on the rotation would be asked.

Membership

The full Integrated Care Partnership membership will comprise:
- Rotating Chairs: Derby City Council Health and Wellbeing Board Chair and Derbyshire County Council Health and Wellbeing Board Chair.

- Vice Chair: Integrated Care Board Chair

- NHS Derby and Derbyshire Integrated Care Board:
    - the ICB Chief Executive Officer
    - One Executive Director member

    - One Non-Executive member

At least one member of the ICB must be present at the meeting.

- Political leadership from Derby City Council and Derbyshire County Council comprising:
    - Executive member with responsibility for Public Health (if not covered by Health and Wellbeing Board Chair role)
    - Executive member with responsibility Adult Social Care
    - Executive member with responsibility Children's Social Care

- Local authority officers from Derby City Council and Derbyshire County Council comprising:
    - Statutory Officer who fulfils the role of Director of Adult Social Services
    - Statutory Officer who fulfils the role of Director of Children's Services
    - Statutory Officer who fulfils the role of Director of Public Health

At least one representative from each local authority must be present at the meeting. This can be a political or senior officer representative.

Other members of the Integrated Care Partnership include:

- Derbyshire Community Health Services NHS Foundation Trust, Chief Executive
- Derbyshire Healthcare NHS Foundation Trust, Chief Executive
- University Hospitals of Derbyshire and Burton NHS Foundation Trust, Chief Executive Officer
- Chesterfield Royal Hospital NHS Foundation Trust, Chief Executive Officer.
- East Midlands Ambulance Service NHS Foundation Trust representative.
- DHU Health Care, Chief Executive
- Primary Care Networks Clinical Director
- Place Partnerships Clinical Chair
- Provider GP Leadership Board Chair
- Clinical Professional Leadership Board Chair

- District and borough council political leadership comprising:
    - Two elected members who are representatives on Derbyshire Health and Wellbeing Board
- District and borough council chief officers comprising:
    - Two chief officers from the same organisations as the political district and borough council leadership reps

- Voluntary and Community Sector representatives:

    - One person representing Derbyshire based organisations
    - One person representing Derby City based organisations
- Healthwatch Chief Executive Officers
    - Healthwatch Derbyshire, Chief Executive Officer, Healthwatch Derbyshire.
    - Healthwatch Derby, Chief Executive Officer, Healthwatch Derby

Specific officers may be asked to attend meetings to provide detailed insight and input to topics or issues and these officers will not be able to vote on matters. NHS England shall be entitled to attend meeting as an observer and shall not be entitled to vote.

The ICP membership will be reviewed annually in line with the financial year commencing in April.

Public and patient experience, including those with lived experience, will feed into the Derby and Derbyshire ICP though its engagement activities and its Citizens Panel which will inform the work of the partnership.

Attendance

Attendance of ICP meetings will be monitored and fed back to the ICP annually. Members are expected to attend at least four meetings held each calendar year.

Term of office

The term of office of members shall end if:
a) Rescinded by the organisation by whom they are appointed
b) If a Councillor appointed by a Council cease to be a member of the appointing Council
c) If the individual change's role within an organisation and is no longer in the role that led to their appointment to the ICP.

Substitutes

It is expected that members will prioritise attendance at these meeting and make themselves available. Exceptionally where this is not possible a deputy of sufficient seniority may attend, if required who will be able to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this group. The Chair of the ICP must be informed in advance of the relevant meeting of the identify of a substitute.

Responsibilities of ICP members

Members should be senior leaders and key decision makers who are able to actively contribute to, and be collectively accountable for, the development and delivery of the Integrated Care Strategy and achievement of our shared ambition to health and care outcomes and reduce health inequalities.

All members will:

- Fully engage in the Integrated Care Partnership including active participation in discussions and decision-making relating to all relevant agenda items.
- Propose, as appropriate, agenda items, for information or discussion, to the Integrated Care Partnership.
- Represent their respective organisations or networks they represent and must take responsibility for communicating all relevant information within their organisation or network.
- Actively progress any strategic decision or action agreed at the Integrated Care Partnership through their own organisation and any relevant partners and networks.
- Ensure full support and implementation of the Integrated Care Strategy through their own organisation and relevant networks.
- Ensure their organisations are fully represented and participate in relevant sub-groups and/ or Task and Finish groups as appropriate.
- Members are expected to make good two-way connections between the Derby and Derbyshire ICP and the constituent partners, modelling a collaborative approach to working, and listening to the voices of people, patients, and the public utilising where possible the ‘Ten principles for how ICSs work with people and communities, attached as Appendix 2.
- District Council members are in attendance on behalf of the other district councils and therefore have an obligation to feed in and out from the broader group of district councils.
- For Local Authority representatives this will be in accordance with the due political process.
- The Integrated Care Partnership will direct and commission specific pieces of work
- ICP members will be expected to action, coordinate, and feedback on agreed actions within agreed timescales.

Frequency

The ICP will meet every eight weeks for a maximum of 3 hours unless the ICP agrees via a formal vote of members at the meeting to continue beyond this time limit.

If there is insufficient business the Chair can agree to cancel the meeting up to 5 days in advance of the set meeting date.

The date, time and venue of meetings will be fixed in advance and an annual schedule of meetings will be agreed.

Additional meetings may be convened at the request of the Chair or Vice Chair.

Reporting

Reports considered by the Integrated Care Partnership will need to make a clear recommendation and demonstrate how they are delivering against integrated Care Strategy priorities. Reports for information and noting will be circulated electronically between meetings to ensure that information is shared in a timely manner.

Agenda planning

All partnership members will be asked to put forward reports for consideration prior to agendas being finalised.

The Chair will set the agenda for the meeting.

Meeting Agenda

The agenda will be approved by the co-chairs and will follow the following format:

a) Apologies
b) Declarations of Interest
d) Minutes and action log of previous meeting
e) Items for discussion and decision
f) Items for information (where no decision is required).

All reports associated with agenda items must meet standard reporting requirements and be received by the secretariat by the date stated when agenda items are requested.

No late items will be accepted.

The agenda will be published at least five clear working days before the meeting, a copy of the agenda and associated papers will be sent to every member of the ICP.

Minutes

The minutes of the proceedings will be approved at the next suitable meeting after they have been agreed as a correct record at that meeting. The minutes will be accompanied by a list of agreed action points which may be discussed in considering the minutes of the previous meeting should they not be specifically listed as items on the agenda for that meeting.

Quorum

The meeting will be quorate when one ICB representative and one local authority member from both Derby and Derbyshire local authorities are present. The meeting will not proceed if Quorum is not met.

If any member of the Derby and Derbyshire ICP has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

Declaration of Interests

Any interests held by members should be declared on any item of business at the meeting in accordance with procedures of the host authority.
The code of conduct for the members organisation will apply e.g., Derbyshire County Council Councillor will utilise their code of conduct. If organisations do not have their own code of conduct, then the code of conduct for the organisation hosting the meetings will apply.

Voting

At this stage of its development the ICP will operate on a consensus basis.

Where items cannot be agreed on a consensus basis a small task and finish group involving necessary representatives will be established to consider matters outside of the ICP meeting, reporting back with an agreed way forward. If required, this will be facilitated by a third party.

Development sessions

In addition to the formal public meetings, the ICP will hold regular development sessions. Development sessions will be held in private to support specific issue focused discussion and learning and active development of ICP members.

Operational Delivery

Where possible delivery against priorities in the ICS Strategy and actions agreed by the ICP will be delivered by established system groups.

The ICP will be mindful of other system priorities and key groups, such as the Health and Wellbeing Board, Health and Wellbeing Partnerships and City Partnership when agreeing work programmes or actions.

The ICP will have a clear understanding of its relationships with other boards and seek to avoid duplication of effort and ensure alignment with other system activity. The governance diagram at Appendix 1 of this document sets out the relationship between the ICP and other groups and programmes of work in Derbyshire. If required a protocol document between the ICP and other strategic groups will be established to facilitate discussions and delivery against priorities.

The ICP will have two groups which can as appropriate report into the meeting, the Integrated Place Executive, and the Provider Collaboration Board. The Board will also receive regular updates from Derbyshire Health and Wellbeing Board and Derby Health and Wellbeing Board. The ICP will also update other Boards on its programme of work on a regular basis.

Place Alliances will be aligned to the Integrated Care Partnership and act as a delivery structure, working alongside Derbyshire Health and Wellbeing Partnerships and strategic groups in Derby City, to coordinate delivery of agreed actions and pieces of work.

Task and finish groups will be established by exception to take forward key pieces of work where this is no identified system group. Task and finish groups will include representatives from partner organisations and wider stakeholders.

Access to Information/Freedom of information

The ICP shall be regarded as a local authority committee for access to information purposes and meetings will normally be open to the press/public.

ICP papers

The agenda and supporting papers shall be circulated at least five clear working days in advance meetings and published on the Derby City Council website. Minutes will be published on the Derby City Council website.

Partners will be able to link to this online resource and share information about forthcoming meetings as appropriate.

Scrutiny

Decisions of the ICP will be subject to scrutiny and the “call-in” powers of the constituent councils’ scrutiny arrangements.

Secretariat

The Secretariat role will be provided by Derby City Council. This role will include minute-taking and distribution, administration of all agenda items and associated papers.

Renumeration

Members attendance at meeting will not result in additional payments. Mileage and expenses can be made by the respective authorities or organisations in line with organisational policy and procedures.

Support arrangements

The host authority will also provide support via the Monitoring Officer and Section 151 officer.

Information Sharing Protocol

If necessary, the ICP and partners will develop an information sharing protocol to enable the effective sharing of information and ensure compliance with General Data Protection Regulations.

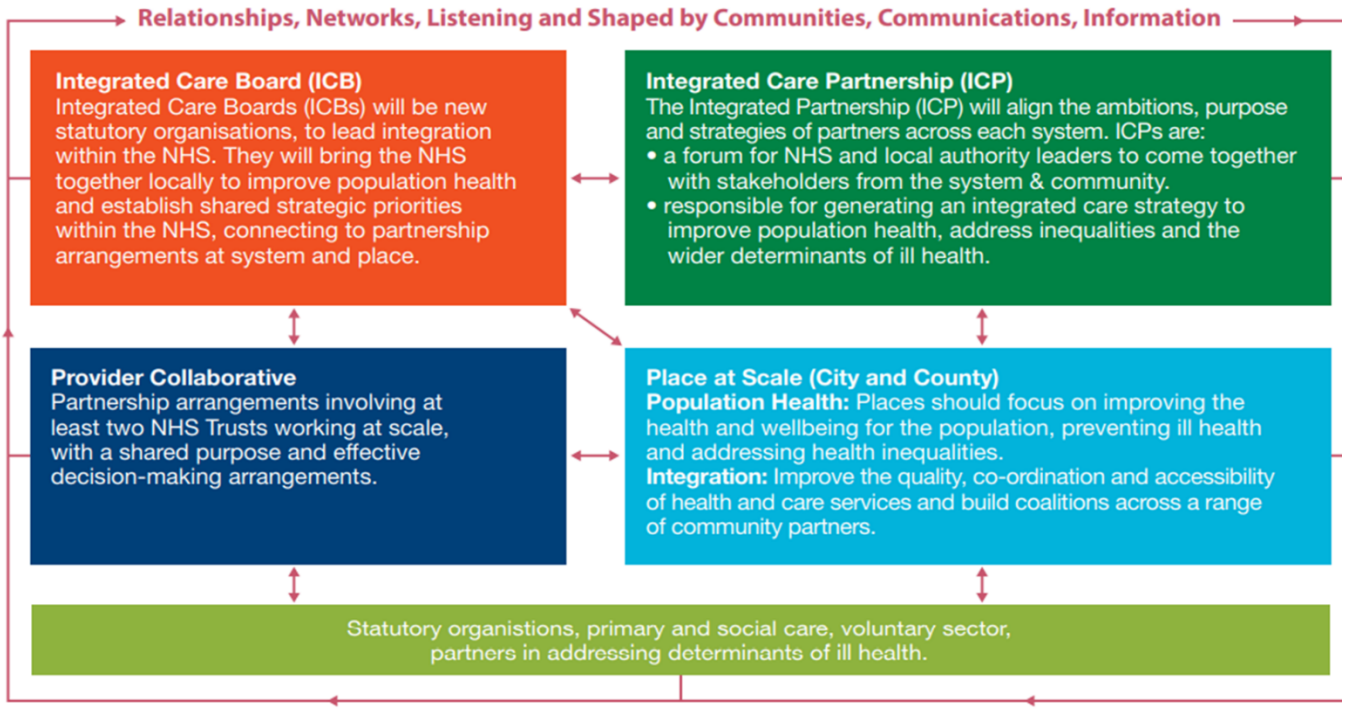
Review

These terms of reference will be reviewed annually or earlier if required.

Last Review
September 2022

Next Review
April 2023

Terms of Reference Appendix 1: ICP Relationship with other Boards



Terms of Reference Appendix 2: Ten principles for how ICSs work with people and communities

1.Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.

2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.

3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

4. Build relationships with excluded groups, especially those affected by inequalities.

5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.

6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.

7. Use community development approaches that empower people and communities, making connections to social action.

8. Use co-production, insight, and engagement to achieve accountable health and care services.

9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.

10.Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places

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FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

6 October 2022

Report of the Director of Public Health

Health impacts of the cost of living pressures in Derbyshire

1. Purpose

1.1 This report summarises the health impacts of the cost of living pressures caused by rising inflation and proposes that the Derbyshire Health and Wellbeing Board receives quarterly updates on this issue until summer 2023 when the position is reviewed.

1.2 Health and Wellbeing Board partner agencies are encouraged to actively share intelligence and information on this key issue. This will enable a broad partnership response to mitigate and reduce health impacts.

2. Information and Analysis

2.1 Across Derbyshire there is a wide partnership response taking place to help mitigate the adverse effects of the cost of living pressures. This report to the Health and Wellbeing Board and associated presentation highlight some of the health impacts of the cost of living pressures.

2.2 The direct health impacts include mental health issues such as anxiety and/or stress as a result of dropping household incomes, malnutrition, undernutrition or conversely obesity from food insecurity and cardiovascular disease from being in cold homes.

2.3 Increased cost of living will have far reaching impacts across the wider determinants of health. This will result in direct and indirect health harms. A summary of these include:

- Work – for example increased costs are resulting in local businesses having to pay more for their goods, heating, lighting and running costs
- Place – for example many people are reducing leisure opportunities, and some may not be able to afford improvements to their immediate environment.
- Money and resources – for example personal finances are stretched resulting in many people making difficult choices about how to spend limited income.
- Housing – for example, previously people who pay rent or have a mortgage tended to consider this their largest payment every month, but now these costs are being dwarfed by rising monthly energy costs for some households. This results in some people unable to heat their homes leading to them living in cold, damp environments or environments in a poor state of repair, increasing risk of injury, illness and material damage to homes.
- Food – for example the cost of key food items has increased within the last 12 months and alongside stretched monthly incomes people are deciding the type of food they buy, are unable to buy essential items or are relying on foodbanks and other forms of support. In some circumstances people are having to choose between eating, heating or housing costs.
- Education and skills - for example, some people who wish to undertake further education may no longer have this option due to the increased housing costs alongside tuition fees, others will need to gain part-time employment to provide further income whilst studying which may impact on educational outcomes, some families are struggling to buy uniforms and some young people may not be able to access technology to support their studies. For schools there are increased heating costs which may mean some headteachers considering what other activities are paused.
- Transport – increased travel costs are impacting on those who need to travel to specific work locations on a regular basis, and for others a larger proportion of their wage is covering fuel or transport costs.
- Friends, family and communities – due to the cost-of-living crisis having an impact in such a diverse and widespread way multiple people across networks of support may be grappling with the same choices and decisions. Whilst this may provide some peer support, it may also create mental health impacts, an inability for

family and friends to support each other through informal networks with budgeting and increase the risk of people falling into debt.

2.4 Recent estimates suggest that household energy bills are set to rise compared to last winter. Estimates suggest people will be paying double the average bill compared to October 2021 and people are already struggling with costs. Those with higher than average energy costs will pay more e.g. those who run medical equipment and those on pre-paid meters. Modelling suggests that despite the £400 cost-of-living rebate from the Government, this will push over two thirds of UK households into fuel poverty, exacerbating health inequalities that were already widened during the pandemic.

2.5 Leaders across the public sector are warning nationally that rising rates of fuel poverty will create a public health emergency, causing and exacerbating physical and mental illness and placing further strain on health and social care provision.

2.6 It is estimated that the NHS in England already spends £1.3 billion each year treating preventable conditions caused by cold, damp homes and this situation is set to get worse throughout winter 2022/23. Therefore, it is important that preventative action is prioritised wherever possible to help mitigate the risks created by a cold home environment, particularly in relation to mental and physical illnesses which are preventable.

2.7 For children and young people, growing up in poverty can create mental and physical health problems that can persist over the whole life course. Preventing child poverty, and therefore preventing avoidable lifelong illnesses acquired in childhood, is one of the most effective ways to manage demand on the healthcare system. For example, research by the Health Foundation suggests that children growing up in cold, damp homes are more than twice as likely to suffer from respiratory conditions than their classmates in warm homes. There are also wider impacts on mental health, with research from the Institute of Health Equity suggesting that adolescents living in cold housing are five times more likely to suffer from multiple mental health problems.

2.8 For adults and older people there are also increased health risks of living in a cold home such as increased risks of falls, increased risk of respiratory disease and increased demand on care and support provision. Whilst there is increased targeted support in place for

pensioners this winter pensioner poverty has now reached highs last seen in 2008.

2.8 People living with health conditions or in vulnerable situations are likely to be disproportionally impacted by the cost of living increase. National Voices has gathered insight and intelligence about the impact and have found that people living with kidney disease, who often choose to have dialysis at home will see energy costs of between £590 and £1,450 each year before recent energy price increases. Whilst some NHS trusts subsidise these energy costs, not all do. This support will be stretched further in coming months. Many people living with a long-term condition have found their limited incomes stretched and are choosing telephone rather than face to face appointments due to the increased travel costs.

2.9 The data and insight collated above and provided in the presentation to the Board forms part of an emerging picture of the potential wider health impacts of the cost of living pressures. Partner representatives on the Board are asked to provide feedback in advance of the next Health and Wellbeing Board in January 2023 regarding the impacts seen locally so that key themes can be collated and fed back at the next Health and Wellbeing Board meeting and specific actions via partnership action can be agreed to further mitigate and address local issues.

3. Alternative Options Considered

3.1 For the Health and Wellbeing Board not to have oversight of this issue. This is not favoured as the cost of living pressures are likely to have far reaching health impacts across the population of Derbyshire.

4. Implications

4.1 Appendix 1 sets out the relevant implications considered in the preparation of the report.

5. Appendices

7.1 Appendix 1 – Implications.

6. Recommendation(s)

That the Health and Wellbeing Board:

a) Highlights, monitors and responds to the health impacts of the cost of living pressures and proposes that the Derbyshire Health and Wellbeing

Board receives quarterly updates on this issue until summer 2023 when the position is reviewed.

b) Agrees that Health and Wellbeing Board members actively share intelligence and information on this key issue to enable a broad partnership response to mitigate and reduce associated health impacts.

7. Reasons for Recommendation(s)

9.1 To ensure that the Health and Wellbeing Board remains updated on this important matter on an ongoing basis.

9.2 To ensure that the partnership actively utilises and receives data, insight and learning to shape the local response to this matter.

Report Author: Ellen Langton, Public Health Lead Strategic Intent,
Contact details: ellen.langton@derbyshire.gov.uk

Appendix 1

Implications

Financial

1.1 There are no financial implications of this report.

Legal

2.1 There are no legal implications of this report

Human Resources

3.1 There are no human resource implications of this report.

FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

6 October 2022

Report of the Executive Director for Adult Social Care and Health Derbyshire County Council

Health and Wellbeing Round Up Report

1. Purpose

1.1 To provide the Board with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

2. Round-Up

2.1 **Stepping up to the challenge – Director of Public Health Annual Report 2022**
The Director of Public Health Annual Report details just some of the projects and pieces of work that have taken place across Derbyshire, demonstrating a huge team effort where everyone stepped forward together.

2.2 **Integrated care Strategy and HWB guidance**
NHS Confederation has published a useful summary of the documents: Integrated care strategy and health and wellbeing board (HWB) guidance: what you need to know. Its primary audience is NHS Confederation member organisations from the NHS, but senior officer and elected members of local authorities may also find it helpful

2.3 **Everyone has the right to a good later life**
The Centre for Ageing Better has published a strategy which aims to tackle everyday ageism. The strategy will seek to overturn the deeply entrenched negative attitudes within society towards older people through a collective and nationwide approach. The organisation will work with the public, age-friendly communities and employers, as well as other sector and industry partners, to change the way people think, feel and act about ageing. The new strategy also focuses on activities to reduce the inequalities people experience as they grow older.

2.4 **Mental health and loneliness: the relationship across life stages**
The Department for Digital, Culture, Media and Sport has published a report which presents the findings from a qualitative study exploring the experiences of loneliness among those who had experienced a mental health condition. Previous research has shown there is a link between experiences of loneliness and poor mental health.

2.5 **How can local authorities reduce obesity?**
The National Institute for Health and Care Research (NIHR) has published a themed review which considers 143 NIHR-funded studies on obesity that are relevant to local authorities.

2.6 **A community-powered NHS: making prevention a reality**
This report from New Local argues for a health care system that is focused as much on preventing illness as treating it. It discusses how working collaboratively with communities as equal partners in the design and delivery of health care could be a way of achieving this.

2.7 **Women's health strategy for England**
The Department for Health and Social Care has published Women's Health Strategy for England which aims to tackle the gender health gap. Measures include specific teaching and assessment on women's health for all new doctors, new research on female-specific health conditions, and £10 million for 25 new mobile breast screening units.

2.8 **Poverty, economic inequality and mental health**
The Centre for Mental Health has published a briefing which explores evidence about the links between poverty, economic inequality and mental health, showing that living in poverty increases people's risk of mental health difficulties, and that more unequal societies have higher overall levels of mental ill health. The briefing also demonstrates that poverty and economic inequality intersect with structural racism to undermine the mental health of racialised and marginalised groups in society.

2.9 **The National Disability Strategy 2021: Content and reaction**
The House of Commons Library has published a briefing which sets out what the National Disability Strategy is, how it has been received by disability groups and what the legal situation is.

2.10 **UK disability statistics: prevalence and life experiences**
The House of Commons Library has published a briefing which brings together disability data from a range of sources, providing information on the size and characteristics of the UK's disabled population, and highlighting disparities between the life experiences of disabled and non-disabled people.

2.11 **Care and support and homelessness: Top tips on the role of adult social care**
The LGA has published a report which focuses on the role of social care in supporting people experiencing and recovering from homelessness. The report provides 'top tips' under six themes which have been identified as enablers for achieving better outcomes for this cohort.

2.12 **Air quality: policies, proposals and concerns**
The House of Commons Library has published a briefing which considers air quality in the UK, including current law and policy, trends in air pollutants and information on the UK Government and devolved Governments' plans and ambitions to improve air quality.

2.13 **Future health challenges: public health projections - childhood obesity**
The LGA has published a report which sets out forecasts at local authority level for prevalence of obesity and overweight among children, at both reception and Year 6. It is hoped that these forecasts will allow local authorities to anticipate likely future levels of child obesity in their area, assuming that trends in child obesity continue in their current trajectories.

2.14 **Child Health Inequalities Case Study**
This case study publication by the LGA highlights how councils are targeting their services and community support in order to reduce child health inequalities. It covers areas such as oral health, physical activity, reducing teenage conception, providing early mental health support and school inclusion.

2.15 **Cost of Living Hub**
The LGA have developed a cost of living hub which is designed to share best practice and help councils to support their residents with the rise in the cost of living.

3. Notification of Pharmacy Applications

Under the requirements of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 the NHS Commissioning Board must notify the HWB of all relevant applications to provide pharmaceutical services, including the relocation of existing pharmacies.
Notification of the following application has been received.

3.1 Please note the change of supplementary hours for the Daleacre Healthcare Ltd, Evans Pharmacy, 84 College Street, Long Eaton, Nottingham, NG10 4NP. The supplementary hours have changed from Monday – Friday 09:00 – 12:30 & 13:30 – 18:00, Saturday 09:00 – 12:30 to Monday – Friday 09:00 – 12:20 & 13:30 – 18:00, Saturday and Sunday nil. Total opening hours with effect from 18 July (core and supplementary hours) Monday – Friday 09:00 – 12:30 & 13:30 – 18:00 and closed on Saturday and Sunday.

3.2 Please note the change of supplementary hours for the Daleacre Healthcare Ltd, Evans Pharmacy, 11 Wilsthorpe Road, Breaston, Derby, DE72 3EA. The supplementary hours have changed from Monday – Friday 09:00 – 13:00 & 13:30 – 18:00, Saturday 09:00 -13:00 to Monday – Friday 09:00 – 13:00 & 13:30 – 18:00, Saturday and Sunday nil. Total opening hours with effect from 18 July (core and supplementary hours) Monday – Friday 09:00 – 12:30 & 13:30 – 18:00 and closed on Saturday and Sunday.

3.3 Please note the change of supplementary hours for the Daleacre Healthcare Ltd, Evans Pharmacy, Cotmanhay Medical Centre, Skeavingtons Lane, Cotmanhay, Ilkeston, Derbyshire, DE7 8SX. The supplementary hours have changed from Monday – Friday 09:00 – 13:00 & 13:30 – 18:00, Saturday 09:00 -12:00 to Monday – Friday 09:00 – 13:00 & 13:30 – 18:00, Saturday and Sunday nil. Total opening hours with effect from 18 July (core and supplementary hours) Monday – Friday 09:00 – 13:00 & 13:30 – 18:00 and closed on Saturday and Sunday.

3.4 Please note the change of supplementary hours for the Daleacre Healthcare Ltd, Evans Pharmacy, 22 Queen Elizabeth Way, Kirk Hallam, Ilkeston, Derbyshire, DE7 4NU. The supplementary hours have changed from Monday – Friday 09:00 – 13:00 & 13:30 – 18:00, Saturday 09:00 -12:00 to Monday – Friday 09:00 – 13:00 & 13:30 – 18:00, Saturday and Sunday nil. Total opening hours with effect from 18 July (core and supplementary hours) Monday – Friday 09:00 – 13:00 & 13:30 – 18:00 and closed on Saturday and Sunday.

3.5 Consolidation onto the site at 2 Town End Point, Town End, Bolsover, Chesterfield, S44 6DT of Rowlands Pharmacy already at that site and Rowlands Pharmacy currently at 38, Town End, Bolsover, Chesterfield, S44 6DT.

3.6 Please note the change of supplementary hours for the Fairbrother & Marshall, Good Life Pharmacy, 60-62 Station Road, Hatton DE65 5EL. The supplementary hours have changes from Monday 24:00 – 14:00 & 17:30 – 18:00 to Monday – Friday 13:30 – 14:00 & 17:30 – 18:00. Total opening hours with effect from 28 August (core and supplementary hours) Monday – Friday 09:00 – 13:30 & 14:00 – 18:00 and Saturday 09:00 – 12:30 and closed on Sunday.

3.7 Please note that from 31 August 2022 Jhoots Healthcare Ltd t/a Jhoots Pharmacy, 5 Neighbourhood Centre, Hilton, Derby, DE65 5JR will cease to provide pharmaceutical services.

3.8 Please note the change of supplementary hours for the Shires Pharmacies Limited, Clowne Health Centre, Villa Park, Clowne, S43 4PL. The pharmacy will be closed on 24th and 31st December 2022.

3.9 Please note the change of supplementary hours for the PCT Healthcare Ltd, Gresleydale Health Centre, Glamorgan Way, Church Gresley, DE11 9JT. The pharmacy will be closed on 24th and 31st December 2022.

3.10 Please note the change of supplementary hours for the PCT Healthcare Ltd, Gorsey Brigg, Dronfield Woodhouse S18 8UE. The pharmacy will be closed on 24th and 31st December 2022.

3.11 Please note the change of supplementary hours for the PCT Healthcare Ltd, 190 North Wingfield Road, Grassmoor, Chesterfield, S42 5ED. The pharmacy will be closed on 24th and 31st December 2022.

2.12 Please note the change of supplementary hours for the PCT Healthcare Ltd, 67 Mansfield Road, Heanor, DE75 7AL. The pharmacy will be closed on 24th and 31st December 2022.

2.13 Please note the change of supplementary hours for the PCT Healthcare Ltd, 4-5 Thornbrook Road, Chapel-en-le-Frith, SK23 0LX. The pharmacy will be closed on 24th and 31st December 2022.

2.14 Please note the change of supplementary hours for the PCT Healthcare Ltd, 25 Market Place, Chesterfield, S40 1PJ. The pharmacy will be closed on 24th and 31st December 2022.

2.15 Please note the change of supplementary hours for the PCT Healthcare Ltd, 57 King Street, Belper, DE56 1QA. The pharmacy will be closed on 24th and 31st December 2022.

2.16 Please note the change of supplementary hours for the PCT Healthcare Ltd, 2a Bridge Street, Killamarsh, S21 1AH. The pharmacy will be closed on 24th and 31st December 2022.

4. Background Papers

5.1 Pharmaceutical notifications are held electronically on file in the Public Health Service.

5. Recommendation(s)

6.1 That the Health and Wellbeing Board:

a) Note the information contained in this round-up report.

6. Reasons for Recommendation(s)

7.1 To provide the Health and Wellbeing Board with a summary of the latest policy information to enable the development of the work plan for the Board.

Report Author: Ruth Shaw
Contact details: ruth.shaw@derbyshire.gov.uk

Appendix 1

Implications

Financial

1.1 No implications

Legal

2.1 No implications

Human Resources

3.1 No implications

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Anticipated Work Programme: 2022/23 - correct for October 2022 HWB meeting

Please see Derbyshire County Council's website for the meeting papers', Terms of Reference & Membership and Strategy of the Health and Wellbeing Board. You can also find information on The Joint Strategic Needs Assessment here.

Items on the work plan will be either: Statutory reports; Updates on HWB Strategy Priorities or a combination of both. Please note items on the work programme may be subject to amendment between meetings.

If there are any missing or incorrect items, or for further information, please contact director.publichealth@derbyshire.gov.uk

Report Title	Purpose	Link to Strategy Priority or Statutory report	Lead Officer	Report Author(s)
Meeting: Wednesday 25 January 2023 at 10am				
Making our Move – A plan for physical activity	To outline all aspects of the health and wellbeing offer to staff across the system	All people in Derbyshire are enabled to live healthy lives	Helen Jones / Ellie Houlston	Helene Denness / Linda Garnett (NHS/JUCD)
Overview of Population Health Management Work	To provide the board with an overview of the Population Health Management work throughout Derby and Derbyshire	All people in Derbyshire are enabled to live healthy lives	Ellie Houlston	Alison Wynn / Jonathan Ngai
Draft ICB 5-year plan / ICP Strategy	To provide the board with a draft ICB 5-year plan and request feedback from the board	Statutory	Chris Clayton	TBC
Localities Programme	To update the board on the work of the Localities Programme	Crosscuts all priorities	Ellie Houlston	Sara Bains (in conjunction with district and borough members)
Healthwatch update	To update the board on the work of Healthwatch Derbyshire	All people in Derbyshire are enabled to live healthy lives	Helen Henderson	Helen Henderson
Better Care Fund Outturn report	To provide an update on the outturn position of the	Statutory	Helen Jones	Parveen Sadiq

	Derbyshire Integration and Better Care Fund through reporting of the required statutory return for 2021-22.			
ICP Update	To provide the Board with feedback from ICP meetings	Statutory	Helen Jones	Helen Jones / Ellen Langton
Health and Wellbeing Board Round up	To provide the Board with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda	Statutory	Helen Jones	Ruth Shaw
Health Protection Board Update	To provide the board with an update from the Health Protection Board	Statutory	Ellie Houlston	Iain Little
Meeting: Wednesday 29 March 2023 at 10am				
ICB 5-year plan	To provide the board with an update on the ICB 5-year plan	Statutory	Chris Clayton	ICB (TBC)
Joint Capital Resource Use Plan and Performance Assessment	To provide the board with an update on the ICB Joint Capital Resource Use Plan and Performance Assessment	Statutory	Chris Clayton	ICB/ICP/DCC (TBC)
Disability Employment Strategy	TBC	All people in Derbyshire have opportunities to access good quality employment and lifelong learning	Ellie Houlston	TBC

Annual Section 75 update for commissioned sexual health services	To provide the board with an update on the section 75 commissioned sexual health services	Statutory All people in Derbyshire are enabled to live healthy lives	Ellie Houlston	TBC
Substance Misuse Strategy	To provide the board with an update on the Substance Misuse Strategy	All people in Derbyshire are enabled to live healthy lives	Ellie Houlston	TBC
JSNA Launch Event	TBC	Statutory	Ellie Houlston	Thom Dunn
Climate Change and health	To provide an update on climate change and the impacts on health	Crosscuts more than one priority	Ellie Houlston	TBC
Anchor Institutions	To provide the board with an update	All people in Derbyshire have opportunities to access good quality employment and lifelong learning	Ellie Houlston	Helene Denness
Housing and Planning	To provide the board with an update	All vulnerable populations are supported to live in well-planned and healthy homes.	Ellie Houlston	Helene Denness / Vicky Smyth
ICP Update	To provide the Board with feedback from ICP meetings	Statutory	Helen Jones	Helen Jones / Ellen Langton
Health and Wellbeing Board Round up	To provide the Board with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda	Statutory	Helen Jones	Ruth Shaw

Health Protection Board Update	To provide the board with an update from the Health Protection Board	Statutory	Ellie Houlston	Iain Little

FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

6 October 2022

Report of the Director of Public Health

Derby and Derbyshire Pharmaceutical Needs Assessment 2022-2025 – FOR RATIFICATION FOLLOWING VIRTUAL APPROVAL

1. Purpose

1.1 Members of the Health and Wellbeing Board are each asked to:

a) Note that on 7 July 2022 the Board agreed that following statutory consultation a final version of the draft, updated, Derby and Derbyshire Pharmaceutical Needs Assessment ("draft PNA") will be shared with Board members and, if approved by a majority of Board members, will be published by 1 October 2022

b) Note the summary of the responses to the consultation at Appendix 1

c) Note the draft PNA at Appendix 2, prepared in response to the consultation

d) Indicate whether they each approve the draft PNA by using the voting buttons on the covering email or emailing director.publichealth@derbyshire.gov.uk by 16 September 2022.

2. Information and Analysis

2.1 Health and Wellbeing Boards must publish a revised pharmaceutical needs assessment every three years. Revised assessments were due to be published by April 2021 but due to the Covid 19 pandemic this has been extended and publication must now be by 1 October 2022.

2.2 Board members are referred to Appendix 3, the report presented to them at the 7 July 2022 meeting, for further information and legislation background.

2.2 Since 7 July 2022 the statutory consultation has been completed. The responses received are summarised in Appendix 1.

3. Alternative Options Considered

3.1 Not approve the publication of a PNA, which would have reputational implications for the Health and Wellbeing Board as it is a statutory obligation to publish a revised assessment and as such is not legally possible.

3.2 Approve the publication of a PNA other than the draft PNA, for which a special meeting of the Board would need to be convened.

4. Implications

4.1 Appendix 4 sets out the relevant implications considered in the preparation of the report.

5. Consultation

5.1 Consultation with stakeholders on the content of the PNA took place between 23 June and 22 August 2022, following which minor amendments have been made.

6. Background Papers

N/A

7. Appendices

7.1 Appendix 1 – Summary of consultation responses

7.2 Appendix 2 – Draft Derby and Derbyshire Pharmaceutical Needs Assessment 2022-2025

7.3 Appendix 3 - Previous report to Derbyshire Health and Wellbeing Board – 7 July 2022

7.4 Appendix 4 - Implications

8. Recommendation(s)

That members of the Health and Wellbeing Board:

a) Note that on 7 July 2022 the Board agreed that following statutory consultation a final version of the draft, updated, Derby and Derbyshire Pharmaceutical Needs Assessment (“draft PNA”) will be shared with Board members and, if approved by a majority of Board members, will be published by 1 October 2022

b) Note the summary of the responses to the consultation at Appendix 1

c) Note the draft PNA at Appendix 2, prepared in response to the consultation

d) Indicate whether they each approve the draft PNA by using the voting buttons on the covering email or emailing director.publichealth@derbyshire.gov.uk by 16 September 2022.

Reasons for Recommendation(s)

9.1 The Pharmaceutical needs assessment is a statutory document which the Health and Wellbeing Board has oversight of the development of and therefore needs to be engaged throughout the process.

9.2 It is a legal obligation to publish a revised assessment by 1st October 2022.

Report Author: Chris McManus, Advanced Practitioner (Epidemiology)

Contact details: chris.mcmanus@derbyshire.gov.uk
01629 536053

Appendix 1: Summary of consultation responses

CONSULTATION

Consultation requirements

The NHS regulations set out that:

- HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA. Any neighbouring HWBs who are consulted should ensure any LRC in the area which is different from the LRC for the original HWB's area is consulted
- There is a minimum period of 60 days for consultation responses, and
- Those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

Consultation activities

Formal consultation with stakeholders took place between 23 June and 22 August 2022. The consultation was hosted on https://letstalk.derby.gov.uk/ along with the draft PNA. The consultation was also open to members of the public.

Consultation responses

- Response to the consultation was very limited, a total of five responses being received: one each from an NHS provider, a Derbyshire Pharmacist and a Derby City Pharmacy Contractor, as well as three from Derbyshire County Pharmacy Contractors.
- All agreed or strongly agreed that the purpose of the PNA was clearly explained.
- Three agreed or strongly agreed that the process for producing the PNA was clearly described, with the other two neither agreeing nor disagreeing.
- All agreed or strongly agreed that the locality profiles of the PNA effectively summarise the demographic characteristics, health need and pharmaceutical provision for each locality.
- Four of the five agreed that the PNA accurately reflects the current provision of pharmaceutical services in their area and clearly describes the services available in the Derby and Derbyshire areas. The fifth highlighted a typographical error which has been corrected.

- All felt that the PNA has provided information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises.
- Two found no inaccuracies in the document, one said there were inaccuracies and two didn't know.
- Four agreed or strongly agreed with the conclusions of the PNA; one neither agreed nor disagreed.
- One respondent, who strongly agreed with the above statements, commented that gaps in service provision for diabetes risk assessment and health education and asthma control assessment have not been identified in the PNA.
- One respondent wished to draw attention to changes in the opening hours of a number of Boots pharmacies in the Derby City and Derbyshire County area, most of which came into effect on the 28th February and were notified to NHS England.

Public survey

Healthwatch Derby ran a social media survey on pharmacy services during May 2022.

- 41% of respondents used their pharmacy more than once a month
- 89% said their pharmacy met their needs to a fair or great amount
- 86% said they would be likely or very likely to recommend their pharmacy

When asked what additional services they would like to see, one respondent asked for UTI home testing kits, one respondent wanted to bring back a larger range of lower priced and own brand products, and one respondent stated that they were not aware of the full range of services available.

Comments from other sources

The inclusion of statistics for Deaf people was welcome and should be used more widely.
The limit of 28 days supply of medications was a problem for some people, especially those with difficulties with access.
Sometimes labels were put on medicines packaging covering up key instructions.
Problems with accessibility at a number of (unnamed) pharmacies were mentioned, which do not seem to have been challenged by the NHS.
The length of time taken for a prescription to get from GP to pharmacy and then be dispensed to the customer was flagged as an issue.
Some pharmacies seem unaware of the problems faced by visually impaired people.

ADDENDUM

Since this report was completed and sent for consultation one pharmacy in Derby has ceased to provide pharmaceutical services. As there are several other pharmacies in close proximity to this one it is believed that this closure will not constitute a significant issue. It will be reflected in any subsequent updates or supplementary statements.

Appendix 2 – Draft Derby and Derbyshire Pharmaceutical Needs Assessment 2022-2025

(see separate Pdf attachment)

PNA 2022 HWB Draft.pdf

Appendix 3: Report to Derbyshire Health and Wellbeing Board 7 July 2022

FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

7 July 2022

Report of the Director of Public Health

Derby and Derbyshire Pharmaceutical Needs Assessment (PNA) 2022-2025

9. Purpose

9.1 The Health and Wellbeing Board are asked to:

e) Note the update of the 'Derby and Derbyshire Pharmaceutical Needs Assessment'.

f) Note that the Pharmaceutical Needs Assessment (PNA) will identify the needs of the population and support the decision-making process for pharmacy applications, as well as informing the planning of services that can be delivered by community pharmacies.

g) Agree that following statutory consultation, a final version of the draft, updated PNA will be shared with Board members remotely and if approved by a majority of Board members, will be published by 1 October 2022.

10. Information and Analysis

2.1 Legislative Background

The Pharmaceutical Needs Assessment is covered by regulations issued by the Department of Health and Social Care, 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 (HWB) 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 Health and Wellbeing Board (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

HWBs must publish a revised assessment every three years. Revised PNAs were due to be produced by April 2021, however due to the Covid-19 pandemic, a delay was permitted until 1 October 2022.

2.2 Developing the Derby and Derbyshire PNA

The Derby and Derbyshire PNA will:

- identify the pharmaceutical needs of the local population
- support the decision-making process for pharmacy applications
- inform the planning of other services that can be delivered by community pharmacies to meet the health needs of the population

A task and finish group was established to direct the work programme to produce the PNA. The group is chaired by the Assistant Director of Public Health (Corporate) from Derby City Council and has representation from:

- Derbyshire Local Pharmaceutical Committee
- NHS England (Midlands)
- NHS Derby and Derbyshire CCG (from 1 July 2022 NHS Derby and Derbyshire Integrated Care Board).
- Public Health, Derbyshire County Council

The work programme consists of four stages:

1. Collation of current and future health needs of the population and pharmacy data
2. Compilation of up-to-date pharmacy locations and services provided
3. Formal consultation with wider stakeholders
4. Production of the final report

The regulations stipulate that Health and Wellbeing Boards must consult formally for a minimum period of 60 days on a draft of their PNA before being finalised.

2.3 **Update on Progress**

Stages 1 and 2 above have now been completed and the formal consultation with stakeholders is taking place between 23 June and 22 August 2022.

The consultation is hosted on Pharmaceutical Needs Assessment Consultation | Let's Talk Derby along with the draft PNA.

The final PNA must be published by 1 October 2022. As the next HWB meeting is after this date, the final version will be sent virtually to all Board members in September 2022, and they will be asked to confirm if they agree to its publication.

11. Alternative Options Considered

3.1 Not agree a way to approve the development of a revised PNA by 1 October 2022, which would have reputational and legal implications for the Health and Wellbeing Board as it is a statutory document.

12. Implications

4.1 Appendix 1 sets out the relevant implications considered in the preparation of the report.

13. Consultation

5.1 Stages 1 and 2 above have now been completed and the formal consultation with stakeholders is taking place between 23 June and 22 August 2022.

The consultation will be hosted on Pharmaceutical Needs Assessment Consultation | Let's Talk Derby along with the draft PNA

14. Background Papers

https://observatory.derbyshire.gov.uk/pna/

15. Appendices

7.1 Appendix 1 - Implications

16. Recommendation(s)

That the Health and Wellbeing Board:

a) Note the update of the 'Derby and Derbyshire Pharmaceutical Needs Assessment'.
b) Note that the Pharmaceutical Needs Assessment (PNA) will identify the needs of the population and support the decision-making process for pharmacy applications, as well as informing the planning of services that can be delivered by community pharmacies.
c) Agree that following statutory consultation a final version of the draft, updated, PNA will be shared with Board members and, if approved by a majority of Board members, will be published by 1 October 2022.

17. Reasons for Recommendation(s)

9.1 The Pharmaceutical needs assessment is a statutory document which the Health and Wellbeing Board has oversight of the development of and therefore needs to be engaged throughout the process.

Report Author: Chris McManus, Advanced Practitioner (Epidemiology)

Contact details: chris.mcmanus@derbyshire.gov.uk

Appendix 1

Implications

Financial

1.1 Not applicable

Legal

2.1 Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings, particularly in light of the pharmacy contract changes

Human Resources

3.1 Not applicable

Appendix 4

Implications

Financial

1.1Not applicable

Legal

2.1 – Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings, particularly in light of the pharmacy contract changes

Human Resources

3.1 Not applicable

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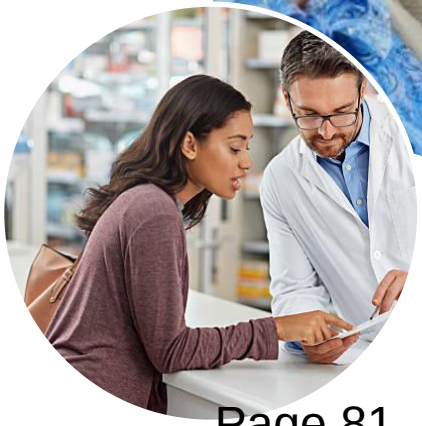
Derby City Council

DERBYSHIRE County Council

Derby and Derbyshire Pharmaceutical Needs Assessment 2022-2025



Public Health Knowledge & Intelligence Team

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This Pharmaceutical Needs Assessment has been produced for both Derby City Council and Derbyshire County Council Health & Wellbeing Boards.

Acknowledgements

The PNA Steering Group wishes to thank all the members of the public and wider stakeholders who participated in the consultation of this needs assessment. In addition, the Group would like to thank Michelle Butler, Shelley Harrod, Kelly Hitchcock and Becca Jones for their valued contribution to the content of this PNA. It also wishes to acknowledge Derby City, Derbyshire County and District Local Authority Planning Departments for contributing the detail on future housing plans, to support the assessment of future need for community pharmacy across the area.

COVID-19 pandemic

The PNA Steering Group wishes to acknowledge the efforts of all those continuing to provide pharmacy services throughout the pandemic and in its aftermath.

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EXECUTIVE SUMMARY

The Health and Social Care Act 2012 transferred responsibility for producing a Pharmaceutical Needs Assessment (PNA) from Primary Care Trusts to Health and Wellbeing Boards (HWB). The PNA is a statement of current pharmaceutical services provided in the local area. It assesses whether or not provision is satisfactory to meet the health, wellbeing and care needs of the local population, and makes recommendations where gaps are identified. PNAs must be used as the basis for determining market entry to a pharmaceutical list. Figure 1 highlights the numbers of community pharmacies in the Derby and Derbyshire area.

COVID-19 pandemic

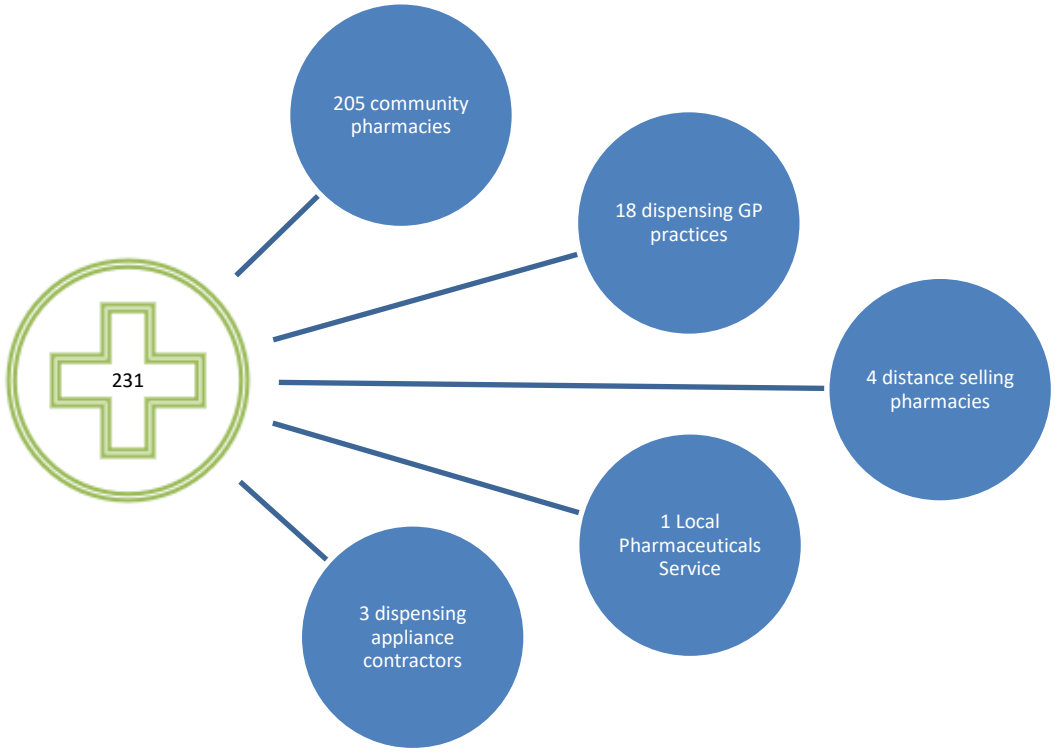
The COVID-19 pandemic has shown just how valuable the network of community pharmacies is. Pharmacy doors remained open for the duration of the pandemic when other areas of the NHS became harder to access. Pharmacies also contributed significantly to the vaccination efforts, delivering around 22 million COVID vaccinations so far. As well as this, pharmacies distributed a total of almost 15 million lateral flow devices in just 6 months, with 97% of pharmacies taking part in the service. Pharmacies were also commissioned to provide a prescription delivery service during the pandemic to ensure vulnerable or self-isolating patients could continue to receive the medicines they rely on.

As well as offering these COVID-specific services, pharmacies continued to offer other essential services to their communities including:-

- Dispensing over 1 billion prescriptions per year on behalf of the NHS
- Providing hundreds of thousands of NHS clinical services every year
- Administering record numbers of flu vaccinations, almost 5 million this autumn
- Relieving pressure on General Practice and hospitals by advising patients with minor ailments, through the NHS Community Pharmacist Consultation Service, as well as offering advice to walk-in patients

Key findings

Figure 1 Summary of community pharmacy numbers in Derby and Derbyshire



- There were an estimated 21 pharmacies to every 100,000 population in England.
- The 205 community pharmacies across Derby and Derbyshire represented a rate of 19 per 100,000.
- In Derby City there were 54 pharmacies, at 21 per 100,000, whilst in Derbyshire there are 151, at 19 per 100,000.
- At a District level, the rate varied from 23 (High Peak) to 13 pharmacies per 100,000 (South Derbyshire)
- Derbyshire Dales District had the greatest concentration of dispensing GP Practices (9, 50%)
- Of the distance selling pharmacies, two were in Derby, one in Erewash and one in North East Derbyshire
- Of the dispensing appliance contractors, two were based in Derby, one in Chesterfield
- There was one Local Pharmaceutical Service based in Chesterfield.

The Community Pharmacy Contractual Framework categorises pharmaceutical services as Essential, Advanced and Enhanced:-

- Essential services are those which all pharmacy contractors will provide and are commissioned by NHS England. These are currently:-
  - Dispensing Appliances
  - Dispensing Medicines
  - Disposal of unwanted medicines
  - Public Health (promotion of healthy lifestyles)
  - Repeat Dispensing/electronic Repeat Dispensing
  - Signposting
  - Support for Self Care
  - Discharge Medicines Service (from February 2021)

- Advanced services, also commissioned by NHS England, can be provided by contractors once accreditation requirements have been met. These are currently:-
  - New Medicines Service (NMS)
  - Appliance Use Reviews (AUR)
  - Population level flu vaccination
  - Community Pharmacist Consultation Service (CPCS)
  - Hypertension Case Finding (Blood Pressure Check) Service
  - Hepatitis C Testing
  - Smoking Cessation Service
  - Stoma Appliance Customisation
  - Between March 2021 and March 2022 pharmacies also provide LFD testing distribution and the Pandemic Delivery Service

- Locally commissioned, or enhanced services, are those that can be commissioned by NHS England, Local Authorities or Clinical Commissioning Groups, in response to the needs of the local population (The Secretary of State for Health, 2005). Pharmacy contractors can choose whether they wish to provide advanced or enhanced services. As of April 2022, these were in Derby City & Derbyshire:-
  - Emergency Supply of medicines Service (ESS)
  - Palliative Care Drug Stockist Scheme.
  - Needle Exchange.
  - Supervised Consumption
  - Emergency Hormonal Contraception (EHC)
  - Extended Care Services:-
    - Tier 1 services including the UTI and acute bacterial conjunctivitis (ABC) services.
    - Tier 2a skin services (pharmacy must deliver Tier 1 services)
    - Tier 3 Ear, Nose & Throat services – suspended during the Covid pandemic but re-introduction of a limited ear service expected soon.
  - Covid vaccination services are also provided under a LES from NHSE&I

Key pharmacy provision headlines:-

- 99% offered the New Medicines Service (NMS)
- 2 offered Appliance Use Reviews (AUR)
- 88% were registered to provide population level flu vaccination
- 89% offered the Community Pharmacist Consultation Service (CPCS)
- 77% provided the Hypertension Case Finding (Blood Pressure Check) Service[1]
- 16% signed up for Smoking Cessation[1]
- 8% offered Stoma Appliance Customisation
- 32% offered Needle Exchange.
- 70% offered Supervised Consumption
- 48% provided Emergency Hormonal Contraception (EHC)
- 47% offered Extended Care Services at Tier 1, 47% offering Tier 2 and 37% were signed up for Tier 3 (currently suspended)[1]
- 14% offered Covid vaccination services

Access to and availability of community pharmacy has been examined at different levels as part of this PNA. Twenty of the 205 pharmacies within the area (rate of two per 100,000 population) have 100-hour contracts. To ensure pharmacy provision on bank holidays/ substitute bank holidays, NHS England commissions a voluntary Out of Hours service in Derbyshire. Derby and Derbyshire have good public transport networks and most households, particularly in the more remote areas of the county, have access to a car. In rush hour/peak traffic conditions a pharmacy should still be accessible within a 5-minute drive for more than 90% of people. For the remaining 10%, most will be within a 10-minute drive with only a small volume of population having to travel for longer. In recent years community pharmacy has had to adapt to new technologies and digital services, both as adopted by the NHS and used by the general public. For the public, the need to be able to access provision remotely (through internet, postal and telephone channels), has grown gradually. Guidance published since the 2015-2018 PNA by the General Pharmaceutical Council in 2015[2] recognises two types of pharmacy: the 'traditional' service, where all aspects, including the sale and supply of medicines and advice, takes place in the registered premises; and 'at a distance', or Distance Selling Pharmacies, including on the internet.

It is an important part of the PNA process to consider future housing provision. Local authorities establish their housing needs and targets through their local plans. The city's housing needs were identified as over 16,000 new homes between 2011 and 2028, and a minimum target of 11,000 new homes are planned to be provided over this period in Derby itself. The remaining 5,000 of these will be built in Amber Valley and South Derbyshire as urban extensions to the city to ensure that Derby's needs are met in sustainable locations. There are expected to be in excess of 7,000 new homes built overall, on the edge of Derby but outside its administrative area, by 2028.

Across the Derbyshire County area, in excess of 50,000 new homes are planned over periods to the year 2033. Provision for health facilities, including pharmacy, will be determined through discussions with the relevant commissioning organisations. The annual delivery of new homes is expected to rise to over 1,000 a year in the coming years.

Key housing plan targets:

- Amber Valley: 9,000 by 2028 (contributing to 7,000 urban extension on edge of Derby)
- Bolsover: 3,600 by 2033
- Chesterfield: 4,269 by 2033, with the potential to increase to 8,863 new homes
- Derbyshire Dales: 6,440 by 2033
- Erewash: 6,250 by 2028
- High Peak: 1,681 by 2022
- North East Derbyshire: 6,600 by 2031
- South Derbyshire: 12,000 by 2028 (contributing to 7,000 urban extension on edge of Derby)

[1] Excluding Glossopdale pharmacies

[2] General Pharmaceutical Council, 2015

Health, wellbeing and care needs are varied and wide ranging across both HWB areas. Derby is a particularly young ethnically and culturally diverse city. One in five residents is aged under 18 . A recent population profiling exercise identified 182 nationalities resident across the 30 square mile area. Derby has a large Roma/Gypsy Traveller community. It also has significant Eastern European and South Asian communities. Generally, the health of the population of Derby is worse than the England average. Although it is no longer one of the most deprived local authorities in England about 21% of children live in poverty. Life expectancy for both men and women is lower than the national average, and significant inequalities exist. For men, life expectancy is currently 11.1 years lower in the most deprived areas of the city than in the least deprived. For women the difference is 19.2 years. The rate of smoking related deaths is worse than average for England in Derby, as are hospital admissions for alcohol-related conditions and self-harm. The risk of early death (before 75 years of age) from cardiovascular diseases is greater in Derby than the England average. Prevalence of certain long-term conditions, such as diabetes, are higher than average.

Top 3 causes of death (excluding COVID-19) where life expectancy could be gained[3]:

- Derby males:
  1 Coronary Heart Disease
  2 Other external causes (accidents, self-harm, assault)
  3 Dementia & Alzheimer's disease
- Derby females:
  1 Chronic lower respiratory diseases
  2 Dementia & Alzheimer's disease
  3 Lung cancer
- Derbyshire males:
  1 Coronary Heart Disease
  2 Other external causes (accidents, self-harm, assault)
  3 Chronic lower respiratory diseases
- Derbyshire females:
  1 Other cancers (excluding Lung cancer)
  2 Chronic lower respiratory diseases
  3 Other external causes (accidents, self-harm, assault)

Derbyshire is a diverse mix of expansive rural extents and village locations, as well as more bustling market towns, such as Chesterfield, and urban conurbations in close proximity to major transport links and other cities. The health of the population of Derbyshire is varied between areas as compared with the England average. Overall approximately 16.3% of children live in low-income families and life expectancy for both men and women is worse than for England, and the gap in life expectancy is 13.7 years for men and 13.5 years for women between the most and least deprived areas. The rates of admission for self-harm and alcohol-related conditions are significantly higher than the England average. The prevalence of both obesity and smoking in pregnancy is also higher than average.

Pharmacy teams play a pivotal role as a community and health asset within local areas. In Public Health England's paper, Pharmacy: A way forward for Public Health in 2017 (Public Health England, Opportunities for action through pharmacy for public health, 2017), a range of interventions are suggested for pharmacies to act and be a part of supporting the health of individuals, families and communities in the localities they service. High quality public health and clinical interventions drive delivery that is focused on prevention, health improvement and protection of local communities. The recent Community Pharmacy Clinical Services Review[4] made several

[3] Life expectancy years gained if most deprived quintile in the area had the same mortality rates as the least deprived quintile in the area (Public Health England, Segment Tool, 2022)
[4] Murray (2016)

recommendations to renew efforts to make the most of the existing clinical services that community pharmacies can provide.

Statement of pharmaceutical need: Derby City

Based on the information collated, the PNA found that the pharmaceutical need in the Derby City Health & Wellbeing Board area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

Statement of pharmaceutical need: Derbyshire County

Based on the information collated, the PNA found that the pharmaceutical need in the Derbyshire County Health & Wellbeing Board area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

1 INTRODUCTION

1.1 Background and purpose

The Health Act 2009 instructed National Health Service (NHS) Primary Care Trusts (PCTs) to publish an assessment of needs for pharmaceutical services in its area. This assessment formed the basis for determining market entry onto a 'Pharmaceutical List', i.e. reviewing pharmacy applications to ensure adequate pharmaceutical provision to meet needs within their area.

The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWB) with defined statutory duties in every upper tier Local Authority area in England. These Boards comprise elected members and system leaders, representing local health and social care organisations and other key partners. Underpinned by the Health and Wellbeing Strategy, the Board works in partnership to improve the health and wellbeing of their local population and reduce health inequalities and promote integration. With the abolition of PCTs, the Health and Social Care Act 2012 transferred the production of Pharmaceutical Needs Assessments (PNAs) to Health and Wellbeing Boards (HWBs) from 1st April 2013. At the same time the responsibility for using these PNAs as the basis to determine market entry transferred to NHS England under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

The PNA is a statement of current pharmaceutical services provided in the local area. It assesses whether or not provision is satisfactory for the local population given the health and care needs experienced which could be impacted on by appropriate pharmaceutical services. As part of this process, a consultation on the PNA is also undertaken to hear views directly from stakeholders. The preparation and consultation on the PNA should take account of the statutory Joint Strategic Needs Assessment and other relevant strategies, such as the children and young people's plan, the local housing plan and the crime and disorder strategy in order to prevent duplication of work and multiple consultations with health groups, patients and the public.

If a pharmacist or dispensing appliance contractor wants to provide pharmaceutical services, they are required to apply to the NHS to be included on the pharmaceutical list. The PNA informs the market entry process and provides NHS England with the information it will need to consider applications to amend or, where appropriate, to allow entry to the list of pharmaceutical service providers within the HWB area. This includes:-

- Determining market entry of new NHS pharmaceutical service providers
- Determining relocation or change of business premises of existing pharmaceutical service
- providers
- Determining changes of pharmaceutical services provided by any current individual
- pharmaceutical services provider.

1.1.1 Legislative and Policy Background

The PNA is fundamentally a commissioning tool, used primarily by NHS England to identify the pharmaceutical needs of the local population and to support the decision-making process for pharmacy applications. It is also be used to inform the planning of other services that can be delivered by community pharmacies to meet the health needs of the local population. This PNA replaces the previous joint Derby and Derbyshire PNA 2018-2021[5]. It represents the third publication of this assessment since 2010 when it was produced in a Primary Care Trust (PCT) setting. The Health and Social Care Act 2012 transferred duties and functions of PCTs, to NHS England and local Clinical Commissioning Groups (CCGs) from 1st April 2013.

The NHS Regulations 2013 set out the legislative basis for developing and updating PNAs. Under these regulations, each HWB must:-

- Assess the need for pharmaceutical services in its area
- Publish a statement of its assessment and of any revised assessment, relating to:
  1 All the pharmaceutical services that may be provided under arrangements made by NHS England

[5] Muirhead (2018).

2 the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list
3 the provision of local pharmaceutical services under an LPS scheme (but not LP services which are not local pharmaceutical services) or
4 the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by the NHSCB with a dispensing doctor)

A guidance document[6] setting out the requirements of the regulations, remains largely unchanged in terms of information to be included in the PNA.

Stipulations of Department of Health Regulations for PNA, under the Health and Social Care Act 2012

The regulations must make provision:-

- as to information which must be contained in a statement
- as to the extent to which an assessment must take account of likely future needs
- specifying the date by which a Health and Wellbeing Board must publish the statement of its first assessment
- as to the circumstances in which a Health and Wellbeing Board must make a new assessment

The regulations may in particular make provision:-

- as to the pharmaceutical services to which an assessment must relate
- requiring a Health and Wellbeing Board to consult specified persons about specified matters when making an assessment
- as to the manner in which an assessment is to be made
- as to matters to which a Health and Wellbeing Board must have regard when making an assessment

In accordance with the regulations, HWBs, as a minimum, must publish a statement of revised assessment within three years of the publication of the previous document. 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 this 2022 PNA. This will be undertaken only where, in the Boards' view, the changes are so substantial that the publication of a new assessment is a proportionate response.

On 5 December 2016, amendments to the NHS Regulations 2013[7] came into force to implement changes to the 2016/17 Community Pharmacy Contractual Framework (CPCF):-
Pharmacy consolidations (mergers)

- NHS pharmacy businesses may apply to consolidate the pharmaceutical services provided on two or more sites onto a single site (i.e. to merge multiple businesses into one). Such consolidations could require a change in the ownership of one of the businesses in question and a process will be in place to facilitate such consolidations.
- Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means in general terms they will not be assessed against the pharmaceutical needs assessment (PNA) produced by the Health and Wellbeing Board (HWB). Instead, they will follow a simpler procedure, the key to which is whether a gap in pharmaceutical service provision would be created by the consolidation.

Community pharmacy core funding was reduced by 8% from £2.8bn in 2015/16 to £2.6bn in 2017/18 and has remained at that level since. In practice this means real terms funding is reducing year on year, as inflationary pressures are not taken into account. This has led to the closure of some pharmacies and reductions in opening hours of others.

[6] Department of Health (2013)
[7] Pharmaceutical and Local Pharmaceutical Services (SI 2013/349)

In 2016, as part of the two-year final funding package imposed upon community pharmacies in England, the Department of Health and Social Care (DHSC) confirmed the introduction of a Pharmacy Access Scheme (PhAS), with the stated aim of ensuring that a baseline level of patient access to NHS community pharmacy services is protected. DHSC states that the PhAS will protect access in areas where there are fewer pharmacies with higher health needs, so that no area need be left without access to NHS community pharmaceutical services.
A revised scheme starting in January 2022 seeks to continue to support patient access to isolated, eligible pharmacies. It is funded to no more than £20 million from the Community Pharmacy Contractual Framework (CPCF). Eligibility for PhAS continues to be based on both the dispensing volume of the pharmacy, and distance from the next nearest pharmacy, although there are changes to the detailed eligibility criteria. PhAS Payments have changed from the 2016 scheme and are now based on a bell curve distribution, with larger and smaller volume eligible dispensing pharmacies receiving lower PhAS payments.

1.1.2 Murray Review

The Murray Review of Community Pharmacy Services (Murray, Community Pharmacy Clinical Services Review, 2016)[8] supported the view that Sustainability and Transformation Plans (STPs) could hold great opportunity for community pharmacy. Specifically, they could be the vehicle to providing a coherent strategy toward the commissioning of pharmacy services that in the current landscape, are split across multiple commissioners. Furthermore, that they offer the chance to develop coherent, system-wide services and pathways to deliver better care[9]. As part of the process towards a much more integrated community pharmacy, Public Health England, working alongside the Pharmacy and Public Health Forum have begun to publish a suite of quality-assured case studies intended to mobilise pharmacy in respect of public health delivery and ultimately, contributing to STP's in relation to prevention[10]. One such example is the development of healthy living pharmacies, the benefits of which are shown in Figure 2 below.

Figure 2 The impact of Healthy Living Pharmacies (Public Health England, Healthy living pharmacy: intro infographics for presentations, 2016)

1.1.3 Sustainability & Transformation Plans

In 2016 the NHS published its Shared Planning Guidance (NHS England, NHS Operational Planning and Contracting Guidance 2017-2019, 2016). This included a requirement for local areas to produce a Sustainability and Transformation Plan (STP) to cover the period October 2016 to March 2021. The purpose of the STP (now termed

[8] Murray (2016)
[9] Pharmaceutical Services Negotiating Committee (2016)
[10] Public Health England, Pharmacy and Public Health Forum (2017),

Sustainability and Transformation Partnership) was to show how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View (NHS England, NHS Five Year Forward View, 2014) vision for better health, better patient care and improved NHS efficiency. The STP sought to address three 'gaps' in health and wellbeing, care and quality, and finance and efficiency. Within the guidance, specific ambitions for pharmaceutical services were presented. These included the provision of clinical pharmacists in GP practices and care homes and integrating the role of pharmacists into pathways of care. For example, there was an expectation that CCGs would consider the value provided by a community pharmacy minor ailments service, and the contribution to better medicines use by patients with long term conditions.

1.1.4 Integrated Care System

In January 2019, the NHS Long Term Plan set out the aim that every part of England will be covered by an Integrated Care System (ICS), by April 2021, replacing STPs, but building on their good work to date. ICSs are population-based models of care that integrate primary, secondary, community and other health and care services and are a way of creating shared local responsibility for:-

- Managing NHS resources more efficiently/effectively to improve quality of care and access to care, improve health outcomes, and reduce inequalities in quality, access and outcomes. This means being able to focus both on delivering financial and performance standards, and addressing the population health challenges within each system
- Building wider partnerships with local government and other community partners to help address wider determinants of health and wellbeing and provide better, more independent lives for people with complex needs, and
- Creating the capacity to implement system-wide changes
- Most STPs have now evolved into ICSs, in which NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve

The belief is that local services can provide better and more joined-up care for patients when different organisations work together in this way. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations. And systems can better understand data about local people's health, allowing them to provide care that is tailored to individual needs.
By working alongside councils and drawing on the expertise of others such as local charities and community groups, the NHS can help people to live healthier lives for longer, and to stay out of hospital when they do not need to be there.
Specifically, in the context of implementation of the NHS Long Term Plan (LTP), ICSs should take forward the five major practical changes to the NHS service model described in Chapter 1, namely:

- Boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community services
- The NHS will re-design and reduce pressure on emergency hospital services
- People will get more control over their own health, and more personalised care when they need it
- Digitally enabled primary and outpatient care will go mainstream across the NHS, and
- Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new ICSs
- In return, ICS leaders gain greater freedoms to manage the operational and financial performance of services in their area. They will draw on the experience of the Vanguard sites, which led the development of new care models across the country

1.1.5 Primary Care Networks

The NHS LTP described the development of Primary Care Networks (PCNs), which were subsequently established in 2019 as an objective of the Network Contract Directed Enhanced Service (DES) for general practices. A PCN consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. They are the 'building block' of local healthcare systems and generally cover local populations of 30-50,000. PCNs are in their third year of existence and the continued ambitions for PCNs over the next three years include systematically delivering new services to implement the LTP and achieving clear, positive and quantified impacts for people, patients and the wider NHS. There are approximately 1,250 PCNs across England. The intention of PCNs is to be wider than general practice, incorporating a range of community providers, including community pharmacy. The Network Contract DES, from April 2020, required general practices, as part of their PCN, to collaborate with non-GP providers, such as community pharmacy. NHS England and NHS Improvement (NHSE&I) expect to see this collaboration reflected in the Network Agreement, which is agreed by all PCN member general practices, with community pharmacy being a key partner in PCNs. PCNs will be critically important to the development of primary care services over the next few years, and it is therefore essential that community pharmacy is fully engaged in PCNs.

1.1.6 Pharmacy Integration Fund

The Pharmacy Integration Fund (PhIF) was established in 2016 to accelerate the integration of:

- Pharmacy professionals across health and care systems to deliver medicines optimisation for patients as part of an integrated system
- Clinical pharmacy services into primary care networks building on the NHS Five Year Forward View and NHS Long Term Plan (LTP)

The NHS LTP (Jan 2019) is the driver for determining the PhIF priorities. The ambition to move to a new service model sets out five practical changes to be achieved by 2024:

- Boosting 'out of hospital care' to dissolve the historic divide between primary and community health services
- Redesign and reduce pressure on emergency hospital services
- Deliver more personalised care when it is needed to enable people to get more control over their own health
- Digitally enable primary and outpatient care to go mainstream across the NHS
- Local NHS organisations to focus on population health and local partnerships with local authority funded services and through new ICSs everywhere

The Community Pharmacy Contractual Framework (CPCF) agreement 2019-2024 sets ambition for developing new clinical services for community pharmacy. The PhIF pilots and evaluates these services
Nationally, the GP Long Term Plan sets out ambitions to explore a 'pharmacy connection scheme' to reduce in-hours and out-of-hours workload for GPs by redirecting minor ailments to pharmacists, rather than to GPs. This is the Community Pharmacist Consultation Service (CPCS) which is now live within community pharmacies.
Services that have been commissioned include:

- NHS Community Pharmacist Consultation Service (CPCS) – commissioned as an Advanced Service since November 2019 from NHS 111 providers and since November 2020 from General Practices
- NHS Community Pharmacy Blood Pressure Checks Service – commissioned as an Advanced Service since October 2021
- NHS Discharge Medicines Service (DMS) – commissioned as an Essential Service since February 2021. NHS Trusts are able to refer patients who would benefit from extra support with their medicines after they are discharged from hospital to their community pharmacy. This is a national priority and opportunity.[11] This will improve patient safety at transitions of care and reduce readmissions to hospital

[11] National Institute for Health and Care Excellence. (2017)

- Expansion of New Medicines Service – expansion of the Advanced Service from 4 medicines groups to 12 medicines groups since September 2021, including medicines for depression
- Smoking Cessation from secondary care – commissioned as an Advanced Service from March 2022: Inpatients who start a stop smoking attempt in hospital will be able to be referred to a community pharmacy to continue their stop smoking journey once they are discharged

Current PhIF pilot work includes:

- Routine monitoring and supply of contraception in community pharmacy (pilot)
- Pilot for additional routes into CPCS with referral pathways from Emergency Departments and Urgent Treatment Centres
- Pilot for an additional route into the Smoking Cessation Service from maternity units to include pregnant women and other members of their households
- Pilot for a further expansion of NMS to include antidepressants
- Exploring national scheme for pharmacists and technicians to gain access to information, working with SPS Medicines Information Services
- Workforce development

1.2 COVID-19 Pandemic

The COVID-19 pandemic has shown just how valuable the network of community pharmacies is. Pharmacy doors remained open for the duration of the pandemic when other areas of the NHS became harder to access. Pharmacies also contributed significantly to the vaccination efforts, delivering around 22 million COVID vaccinations so far. As well as this, pharmacies distributed a total of almost 15 million lateral flow devices in just 6 months, with 97% of pharmacies taking part in the service. Pharmacies were also commissioned to provide a prescription delivery service during the pandemic to ensure vulnerable or self-isolating patients could continue to receive the medicines they rely on.

As well as offering these COVID-specific services, pharmacies continued to offer other essential services to their communities including:-

- Dispensing over 1 billion prescriptions per year on behalf of the NHS
- Providing hundreds of thousands of NHS clinical services every year
- Administering record numbers of flu vaccinations, almost 5 million this autumn
- Relieving pressure on General Practice and hospitals by advising patients with minor ailments, through the NHS Community Pharmacist Consultation Service, as well as offering advice to walk-in patients

1.3 Process for producing the PNA

The PNA has been undertaken in line with the requirements of the NHS Regulations 2013 under the oversight of the Derby and Derbyshire PNA Steering Group. Organisational membership of the group is as follows:

- Derby City Council (Public Health)
- Derbyshire County Council (Public Health)
- Representation from the Derby City & Derbyshire CCG
- The Local Pharmaceutical Committee
- NHS England – Midlands Team

This Pharmaceutical Needs Assessment was originally due to be completed by April 2021, but owing to the ongoing COVID-19 pressures across all sectors, the Department of Health and Social Care (DHSC) suspended the requirement to publish renewed PNAs until October 2022.

The group had its first meeting in December 2021. At that time it was agreed that a full draft PNA should be developed and prepared for June 2022 when it would be consulted upon for 60 days.

The group has met regularly throughout the PNA process.

1.3.1 In scope

This Pharmaceutical Needs Assessment has been produced for both Derby City Council and Derbyshire County Council Health and Wellbeing Boards. It is therefore concerned with the needs of the resident population of Derby and Derbyshire. However, given the commissioning responsibilities of the NHS Clinical Commissioning Groups and going forward the Integrated Care Service (Joined up Care Derbyshire, JUCD), the needs of the registered populations of Derby City & Derbyshire CCG are also discussed. In these cases, the population will be resident not only in Derby and Derbyshire but also neighbouring Local Authority areas, travelling into Derbyshire for GP practice care. Overall responsibility for the health needs of these populations will rest with neighbouring Health and Wellbeing Boards.

It has been an important part of the PNA process to consult with these areas and ensure that population health needs are entirely accounted for, and that pharmaceutical services provision is considered in its widest geographical sense. This has been particularly relevant in the case of the High Peak District area of Derbyshire. NHS services, including community pharmacy, for the Glossopdale area of the High Peak, have been commissioned locally by NHS Tameside and Glossop CCG and nationally by NHS England – North Team. From July 2022 onwards these will be the responsibility of JUCD.

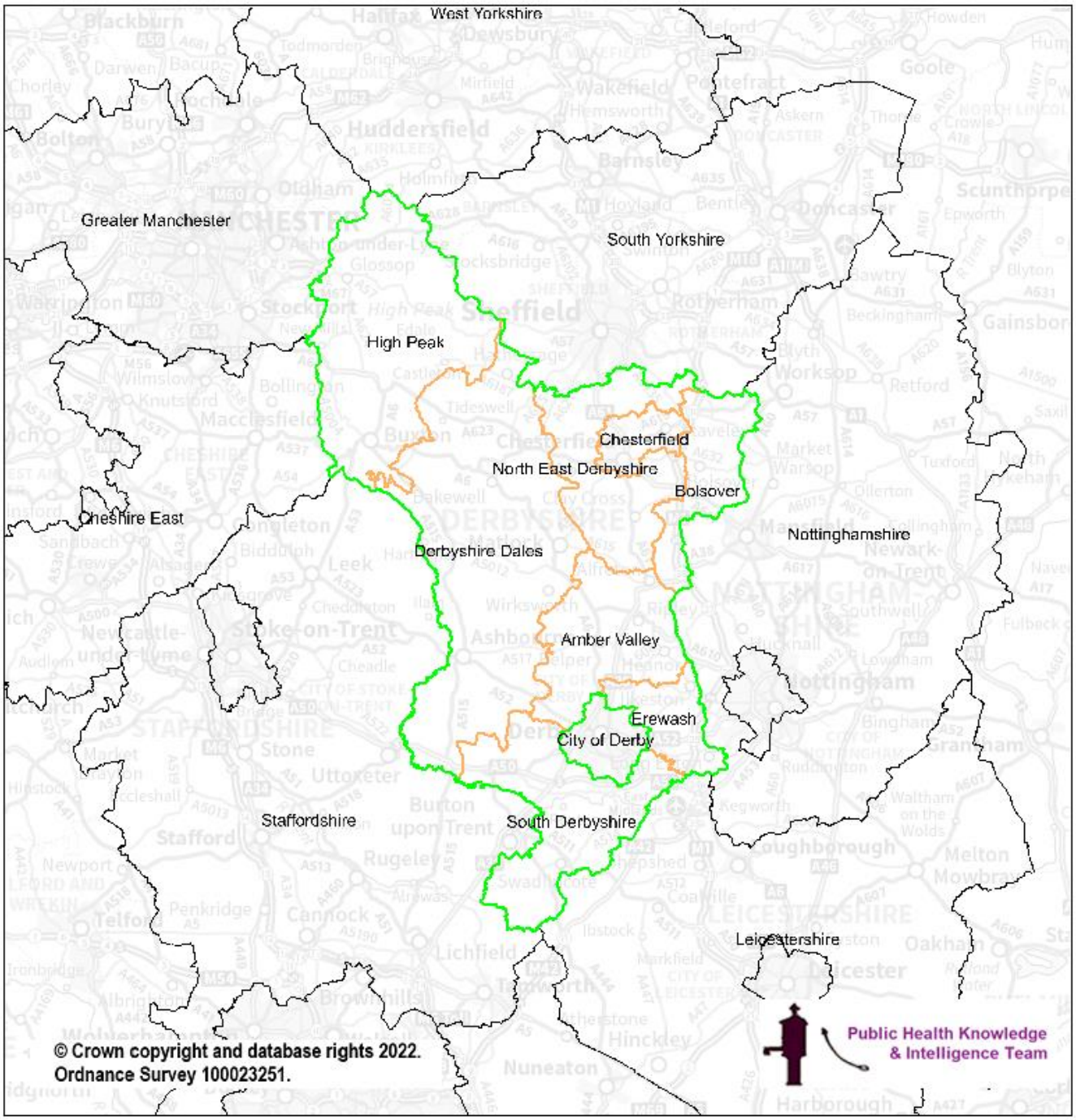
In accordance with the NHS Regulations 2013, the PNA steering group considered how to assess the differing needs of the localities in the area. It concluded that the best approach was to divide Derbyshire into its constituent eight District and Borough Councils, with Derby City as a separate entity, as was the approach with the previous PNA 2015. A summary narrative of geographic and demographic information for each area has been produced, as well as a more detailed review of wider population health, care and social needs across the JUCD area as a whole. Where available, these needs have been explored at a more granular level, including by Electoral Ward for Derby given the density of the population.

Community pharmacy provision is equally explored at a District and Derby City level. Where access is concerned, this has been determined on the basis of access to 'traditional' pharmacy – that is, where all parts of the service take place within the registered pharmacy premises. Whilst it is acknowledged that the role of distance selling pharmacy, including internet-based services, has grown considerably in recent years, there is limited access to information to inform our understanding of how these services are utilised by the local population.

1.3.2 Consultation

A public and professional stakeholder survey to seek views on pharmaceutical need was carried out in June, July & August of 2022. The survey was online and available as hard copy on request. Survey results were considered in the overall assessment of need. Other areas where community pharmacy could contribute to improving health needs are also identified.

Figure 3: Derby, Derbyshire and surrounding Local Authority areas



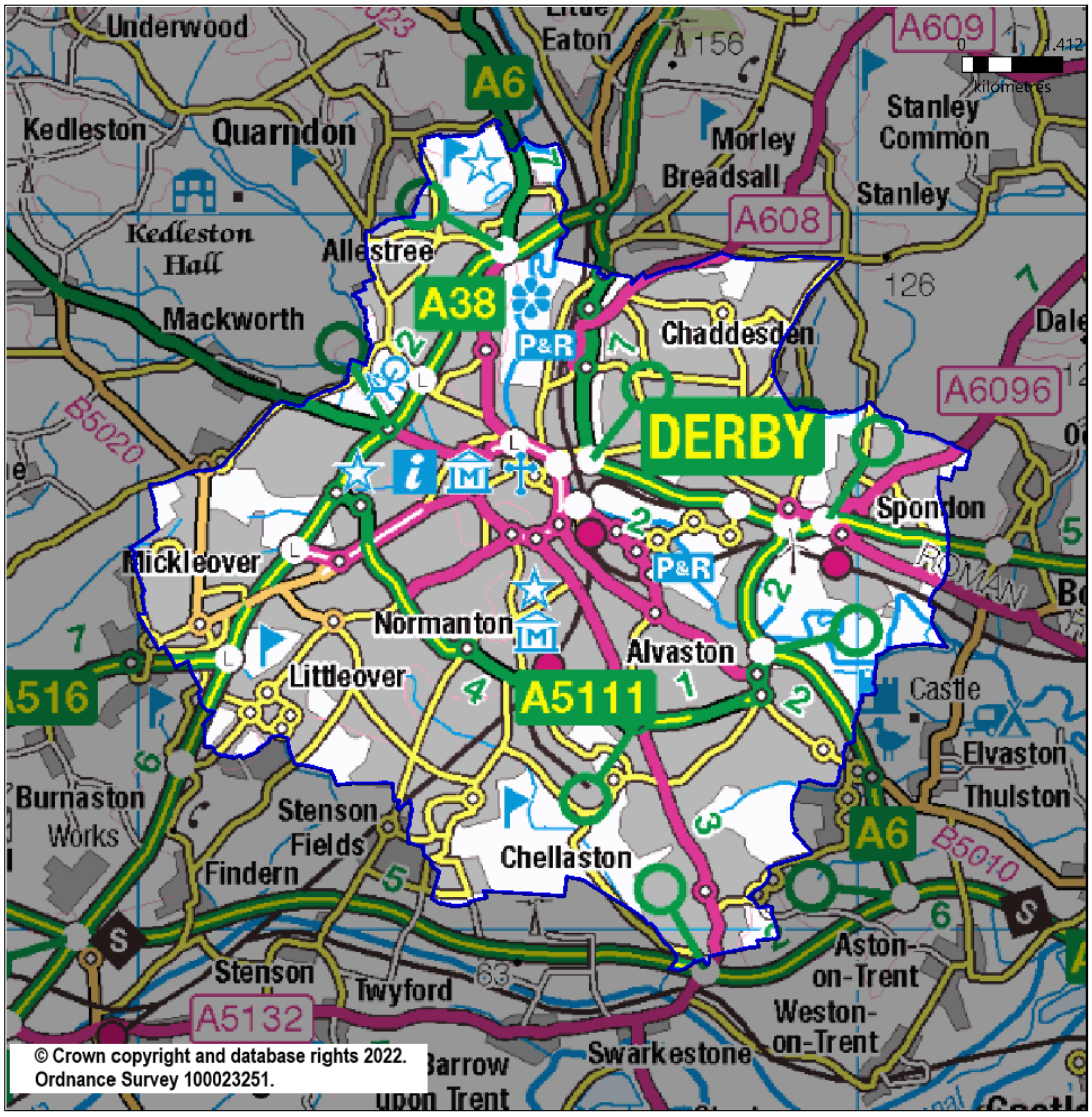
2 PNA LOCALITY PROFILES

The following section offers individual PNA summary profiles at a Derby City and Derbyshire District level, drawing insight from our understanding of the demographic characteristics, health needs and pharmaceutical provision, and whether it is felt that this provision is adequate on the basis of access and availability of services within each area. Each is discussed in greater detail in later sections of the document. Pharmaceutical services are accurate as of April 2022.

2.1 Derby City

Derby City lies upon the banks of the River Derwent and is located in the south of the county of Derbyshire. It is comprised of 17 wards that are characterised by varying levels of deprivation and ethnic diversity. These range from the lower levels within Allestree and Mickleover to higher levels across Arboretum and Normanton. The city's key points of interest include the Cathedral Quarter, Silk Mill Museum and Darley Abbey. Housing developments range from the modern, more affluent residential areas of Mickleover and Oakwood to the large council housing estates within Chaddesden. There are a number of assets to the area that include its parks and nature reserves, which are distributed across the wards. There are also a diversity of religious sites and community facilities.

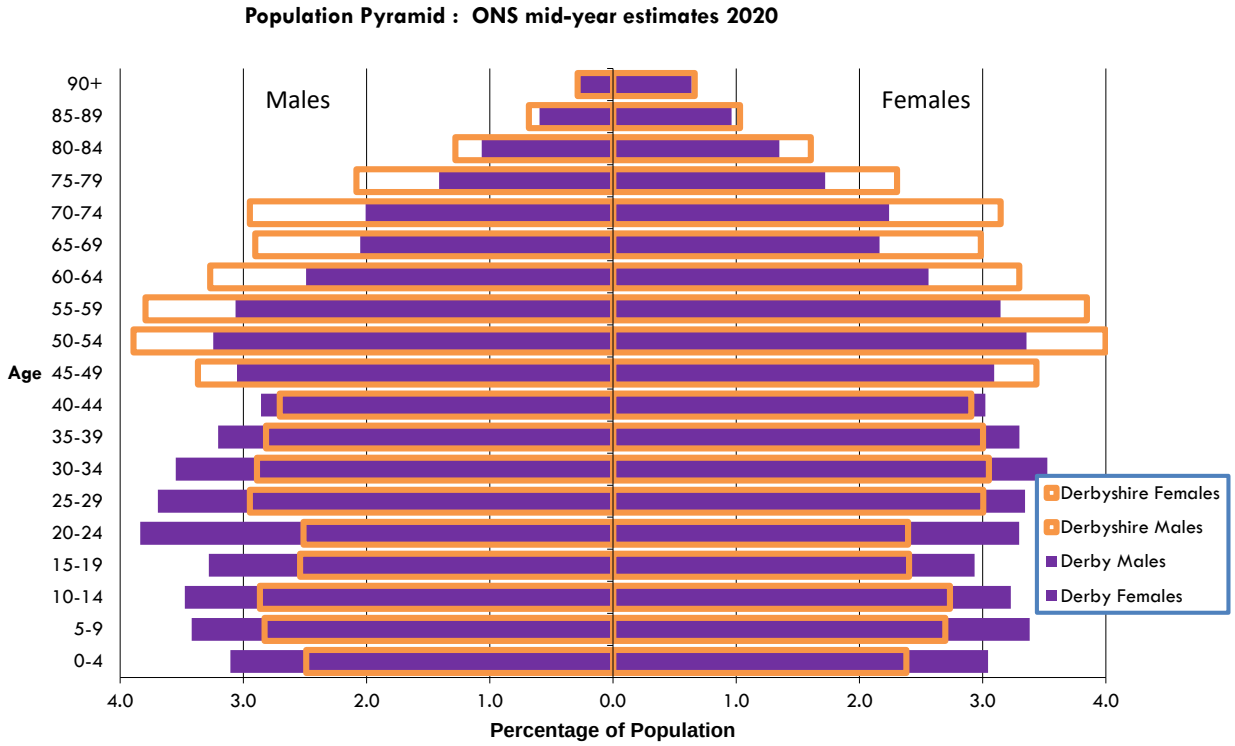
Figure 4: Map of Derby



Population

Derby has a population of 256,814 (Office for National Statistics, Population Estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2020). It is a relatively young city with a higher proportion of 20-34 year-olds (21.2%) than individuals over 65 years (16.5%). Derby has a higher proportion of younger people and a smaller proportion of older people than Derbyshire as a whole. However, the proportion of older people over 65 is expected to increase by 21.3% by 2043.

Figure 5: Derby City Population Pyramid



Employment

The city's largest employers specialise in manufacturing, extending across renowned businesses such as Rolls Royce, Toyota Motor Manufacturing and Bombardier. There are also several smaller creative companies that range from textiles to filmmaking.

NHS Services

There are 25 General Practices across the city, in addition to branch practices and walk-in centres, one of which is a dispensing practice. University Hospitals of Derby and Burton NHS Foundation Trust provide both acute hospital and community-based health services. Its hospitals consist of Royal Derby Hospital, Queen's Hospital Burton, Florence Nightingale Community Hospital, Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital. These provide a range of inpatient and outpatient medical and surgical specialities, intensive care, maternity services, community and children's services and accident and emergency care.

There are 54 pharmacies in the area that provide a range of services, including vaccinations, medicines use review, needle exchange supply and supervised consumption. Seven of these are '100' hour pharmacies that provide evening and weekend services, in addition to the core essential services (dispensing, repeat dispensing, disposal of waste medicines, self-care, signposting and promotion of health lifestyles). There are 2 Dispensing Appliance Contractors in Derby. Figure 6 shows the pharmacy services provided in Derby.

Poverty

Approximately 11,145 children (21.1%) live in poverty in the city. These children live in income-deprived families who experience deprivation relating to low income. At a ward level this ranges from 3.9% of the population of Allestree to 36.4% in Sinfin.

Quality of health

The city is affected by significantly higher rates of premature mortality from cardiovascular diseases, liver disease and respiratory disease than the national average.

Figure 6: Pharmaceutical services provided in Derby

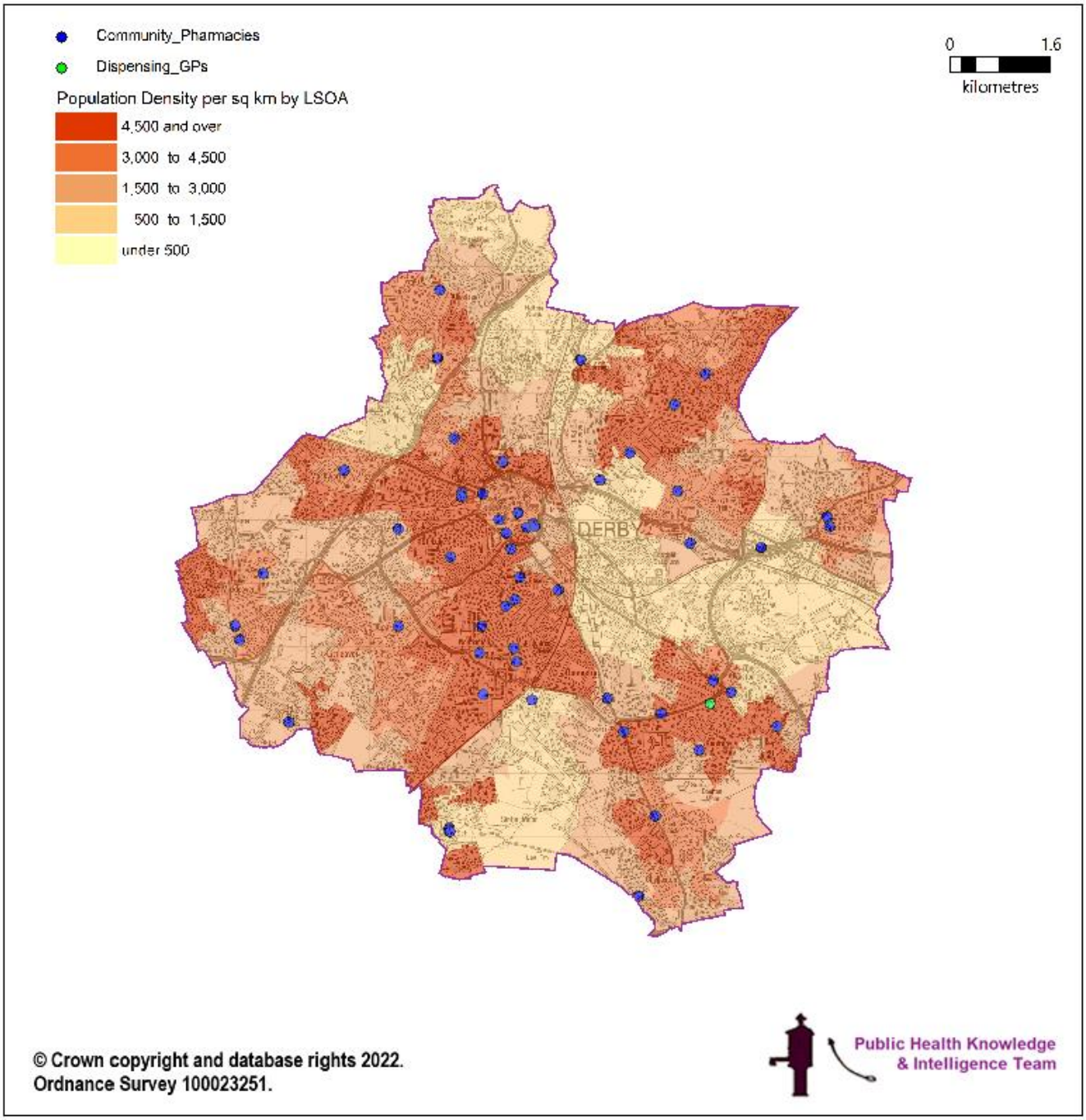
NHS England	Derby		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	51	20	199	25
100-hour pharmacy[12]	7	3	20	2
Flu vaccination (population)	48	19	181	22
Palliative care drugs stockist scheme	3	2	36[13]	3
Emergency Supply Service (ESS)	42	16	154[13]	14
Appliance Use Reviews (AUR)	1	0	2	0
Community Pharmacist Consultation Service (CPCS)	52	20	183	23
Hypertension Case Finding Service	-	-	157[13]	15
Hepatitis C Testing	0	0	0[13]	0
Smoking Cessation	-	-	32[13]	3
Stoma Appliance Customisation	4	2	16	2
Discharge Medicines Service	35	14	146	18
Covid vaccination services	5	2	28	3
Extended Care Services				
Tier 1 services	31	12	107[13]	10
Tier 2a skin services	27	11	90[13]	9
Tier 3 Ear, Nose & Throat services	-	-	75[13]	7

[12] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[13] Excluding Glossopdale

Local Authority (Public Health)				
Emergency Hormonal Contraception	32	12	98	9
Supervised Consumption	42	16	144	14
Needle Exchange	23	9	66	6

Figure 7: Map of pharmaceutical service coverage in Derby



Accessibility

There are 21 pharmacies to every 100,000 population in Derby, the same as the national average. There are seven 100-hour pharmacies in the city. There is also one Dispensing GP. Almost 100% of the population are within 1.6km (1 mile, representing an approximately 20-minute walk) of a pharmacy.

Strategic priorities and key health needs

Our ambition in the city is that the population start life well, live well and stay well and age well and die well. We are prioritising a number of areas that we know are contributing to reduced life expectancy and healthy life expectancy; morbidity; and health inequalities. These priorities are:-

- Reducing smoking prevalence
- Increasing the number of children and adults who are a healthy weight
- Reducing harmful alcohol consumption
- Increasing the number of adults and children, are participating in physical activity
- Increasing the number of people in Derby who have positive mental and emotional wellbeing
- Reducing the number of children living in low income households
- Increasing access to safe, suitable, and affordable housing.

Future housing plans

The Derby City Plan outlines a target to establish 11,000 new homes to 2028. Between 2011 and 2017, 3,000 have already been built. The annual delivery of new homes is expected to rise to over 1,000 a year in the coming years.

Statement of pharmaceutical need: Derby City

This PNA found that the pharmaceutical need in the Derby City Health & Wellbeing Board area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

2.2 Derbyshire County and Districts

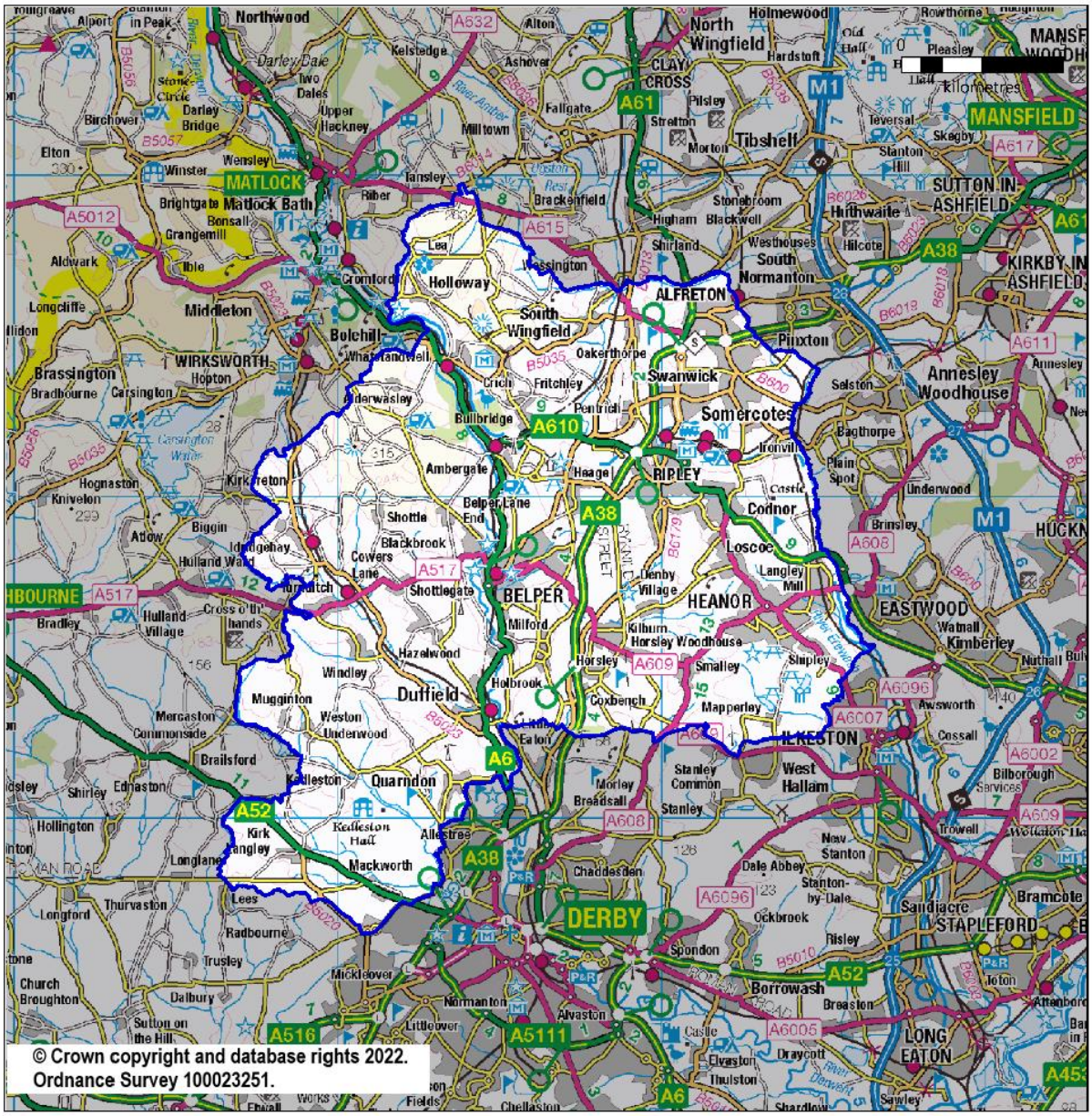
2.2.1 Amber Valley

The district of Amber Valley encompasses the four market towns of Alfreton, Belper, Heanor and Ripley, in addition to several villages and smaller settlements. Whilst the eastern area is primarily urban, the western part is more rural, with countryside surrounding the villages and town of Belper.

The borough ranks 167th out of 316 English local authority districts in the 2019 English Index of Multiple Deprivation, where 1 is the most deprived. However, there are pockets of deprivation in which 10% of its lower super output areas rank within the most deprived 20% nationally.

The latest census data highlights a markedly higher proportion of owner-occupied households than the national average (74.1% compared with 63.3%). Despite this, there are hidden elements of deprivation in which a minority of households are affected by overcrowding (3.2%) and a lack of central heating (2.2%). The area's nature reserves and award-winning parks, heritage features and architecture, make this an ideal location for being physically active as well as a high-quality environment for tourists.

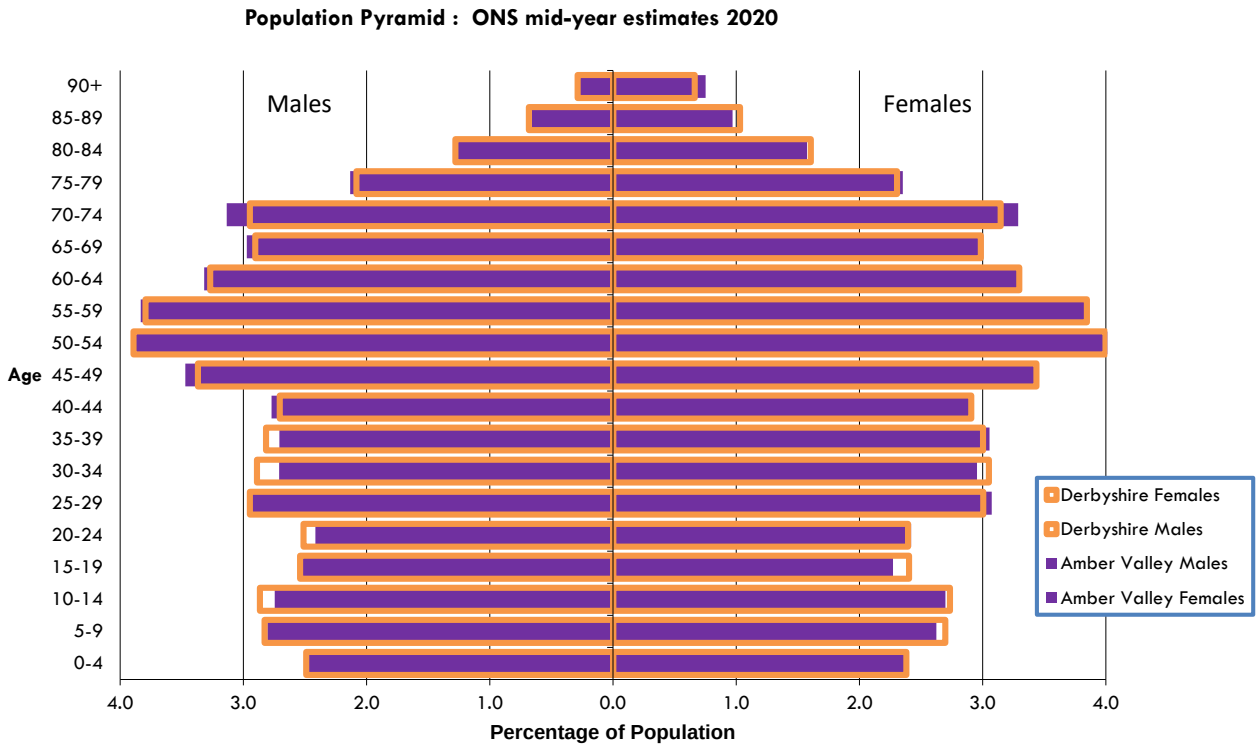
Figure 8: Map of Amber Valley



Population

Amber Valley has a population of 128,829 that is expected to increase to 145,446 by 2043. Black and minority ethnic individuals form a relatively low proportion, with less than 4% who are not White British. The age structure of Amber Valley is generally similar to Derbyshire as a whole. Older people over 65 years constitute 22% of the population, which is the same as the national average. By 2043, however, this is expected to increase to 28%.

Figure 9: Amber Valley Population Pyramid



Employment

Major businesses in the area specialise in retail, manufacturing, health, education and the provision of bespoke services such as tourism. The district is home to the head office of Thorntons (a leading confectionary brand), as well as a number of retail outlets across all four market towns. Leading manufacturing companies include HL Plastics – one of the district's largest employers and Alfreton Trading Estate, which comprises industrial/warehouse units.

NHS Services

There are 14 General Practices within the district – four of which are branch practices and one of which is a dispensing practice. Ripley Hospital is the main community hospital in the area. The majority of its services are provided by Derbyshire Community Health Services NHS Foundation Trust. These include cardiology, neurology and paediatrics services. Derby Teaching Hospitals NHS Foundation Trust provides diabetic medicine and diagnostic physiological measurement within the hospital. There are 25 pharmacies in the district all offering essential services in addition to those shown in Figure 10.

Poverty

It is estimated that 3,140 children (15%) live in poverty. These children live in income-deprived families who experience deprivation relating to low income. At a ward level this varies considerably from 3% in the Duffield to 28.6% in Aldercar and Langley Mill.

Quality of health

Within Amber Valley, there is a significantly higher rate of premature mortality from cardiovascular diseases considered preventable. The percentage of adults classified as overweight or obese is also significantly higher than the national average.

Accessibility

At time of publication of this document, there are 19 pharmacies to every 100,000 population in Amber Valley compared to the national average of 21. Figure 11 demonstrates that most of the population will be within 1.6km (a 1 mile walk of approximately 20 mins) of a pharmacy.

Strategic priorities and key health needs

Priorities in Amber Valley include mental health and wellbeing, maintaining healthy weight and reducing physical inactivity, and supporting older people. Key additional health needs include (but are not limited to):

- Child poverty
- Children with Special Education Need and/or Disability
- Violent crime and antisocial behaviour
- Recorded Diabetes
- Homelessness
- Smoking during pregnancy
- Breastfeeding

Future housing plans

The emerging Local Plan for Amber Valley estimates that around 9,000 dwellings will be built by 2028, some of which will contribute to the 7,000 homes being built as urban extensions to the edge of Derby. The other 6 largest sites (of over 300 units) will be in Alfreton, Heanor, Ripley, and North of Derby.

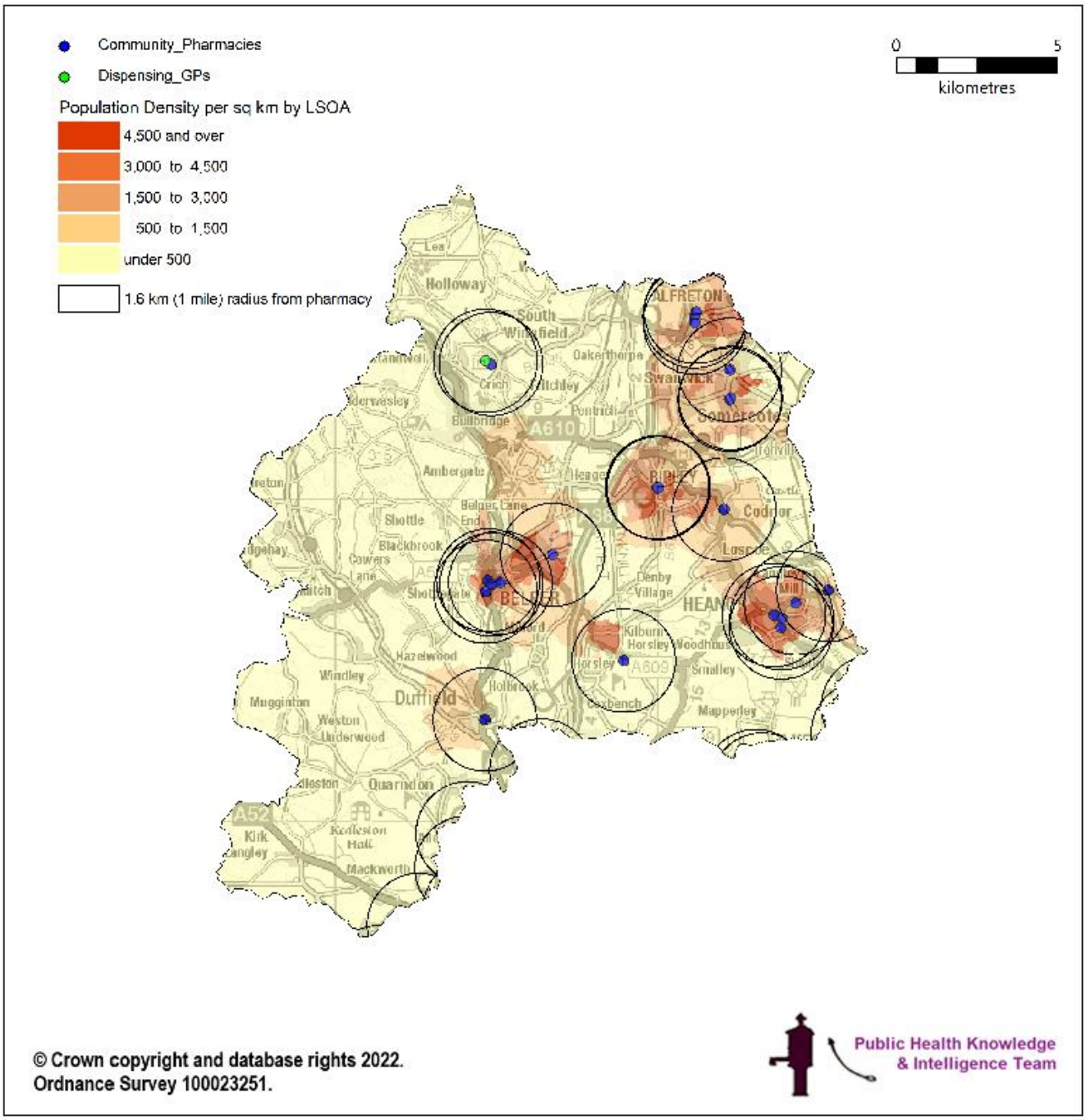
Figure 10: Pharmaceutical services provided in Amber Valley

NHS England	Amber Valley		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	24	19	202	25
100-hour pharmacy[14]	3	1	20	2
Flu vaccination (population)	23	19	181	22
Palliative care drugs stockist scheme	7	5	36[15]	3
Emergency Supply Service (ESS)	11	14	154[15]	15
Appliance Use Reviews (AUR)	0	0	2	0
Community Pharmacist Consultation Service (CPCS)	23	18	183	23
Hypertension Case Finding Service	-	-	157[15]	15
Hepatitis C Testing	0	0	0	0
Smoking Cessation	-	-	32[15]	3
Stoma Appliance Customisation	3	2	16	2
Discharge Medicines Service	14	11	146	18
Covid vaccination services	3	2	28	3
Extended Care Services				
Tier 1 services	15	12	107[15]	10
Tier 2a skin services	14	11	90[1515]	9
Tier 3 Ear, Nose & Throat services	-	-	75[15]	7
Local Authority (Public Health)				
Emergency Hormonal Contraception	9	7	98	9
Supervised Consumption	18	14	144	14
Needle Exchange	7	5	66	6

[14] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[15] Excluding Glossopdale

Figure 11: Map of pharmaceutical service coverage in Amber Valley



Statement of pharmaceutical need: Amber Valley

This PNA found that the pharmaceutical need in the Amber Valley area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

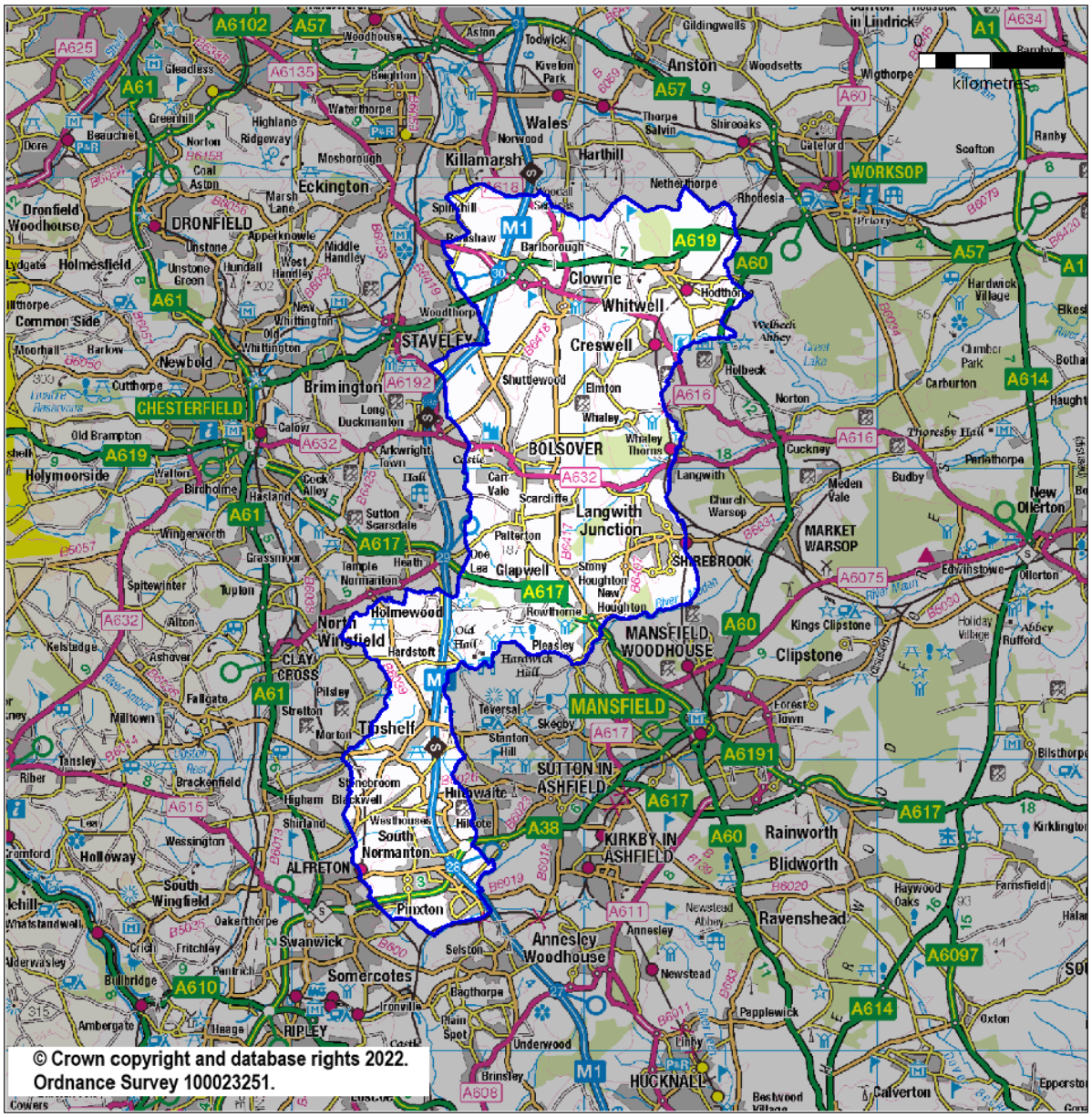
2.2.2 Bolsover

The Bolsover district is situated in the northeast of Derbyshire and has four towns and five main villages. Mainly rural in composition, it has a long history of coal mining and is the most deprived district of Derbyshire.

The area ranks 58th out of 316 English local authority districts in the 2019 English Index of Multiple Deprivation, where 1 is the most deprived. 23% of its lower super output areas rank within the most deprived 20% nationally.

Furthermore, the proportion of households that are deprived in two or more dimensions (33.2%) is higher than the Derbyshire (25.2%) and national average (24.8%). Despite this, there are a number of assets to the area such as its outdoor recreation facilities, including Pleasley Vale outdoor activity centre. There are also several retail outlets, including East Midlands Designer Outlet and markets that sell a wide range of goods.

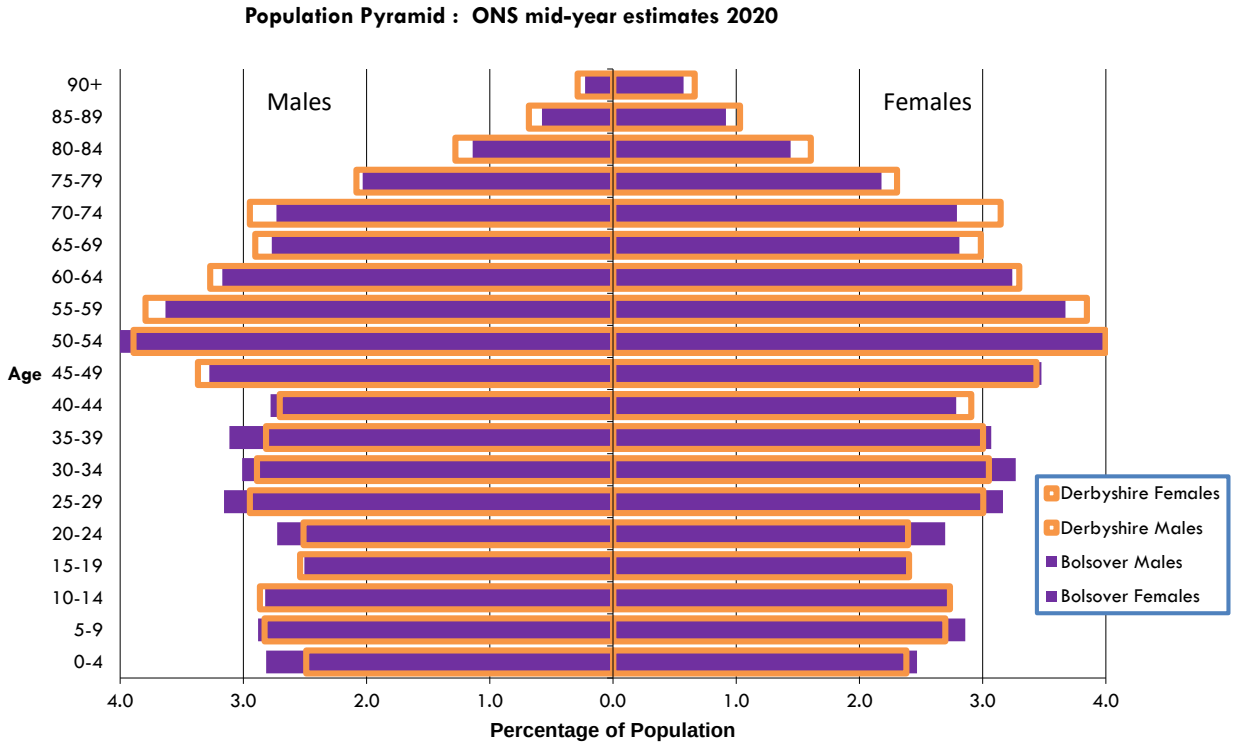
Figure 12: Map of Bolsover



Population

Bolsover has a population of 81,305 that is expected to increase to 92,436 by 2043. 20% of its population are aged 65 and over, which is less than the national average of 22%. The age structure of Bolsover is generally similar to Derbyshire as a whole. It is anticipated that by 2043, there will be a smaller proportion of younger and middle-aged people and a greater proportion of older people aged 70 and over. Black and minority ethnic individuals form 3.7% of the local population, which is lower than the Derbyshire (4.2%) and national (20.2%) average.

Figure 13: Population Pyramid for Bolsover



Employment

Business administration and manufacturing are key employment sectors within the area.

NHS Services

There are 12 General Practices across the district, as well as 17 pharmacies all offering essential services in addition to those shown in Figure 14. Three of the GP surgeries are branch practices and two provide dispensing services. Bolsover Hospital was the main community hospital in the area but was permanently closed in early 2019. It provided the following services which were transferred to the Castle Street Medical Centre:

- Community therapy services
- Intermediate care services
- Older people's mental health
- Falls prevention, and continence

Poverty

Approximately 2,835 children (20.5%) live in poverty, significantly higher than the national average of 17%. These children live in income-deprived families experiencing deprivation relating to low income. At a ward level this varies from 5.7% in Barlborough to 34.5% in Bolsover North and Shuttlewood.

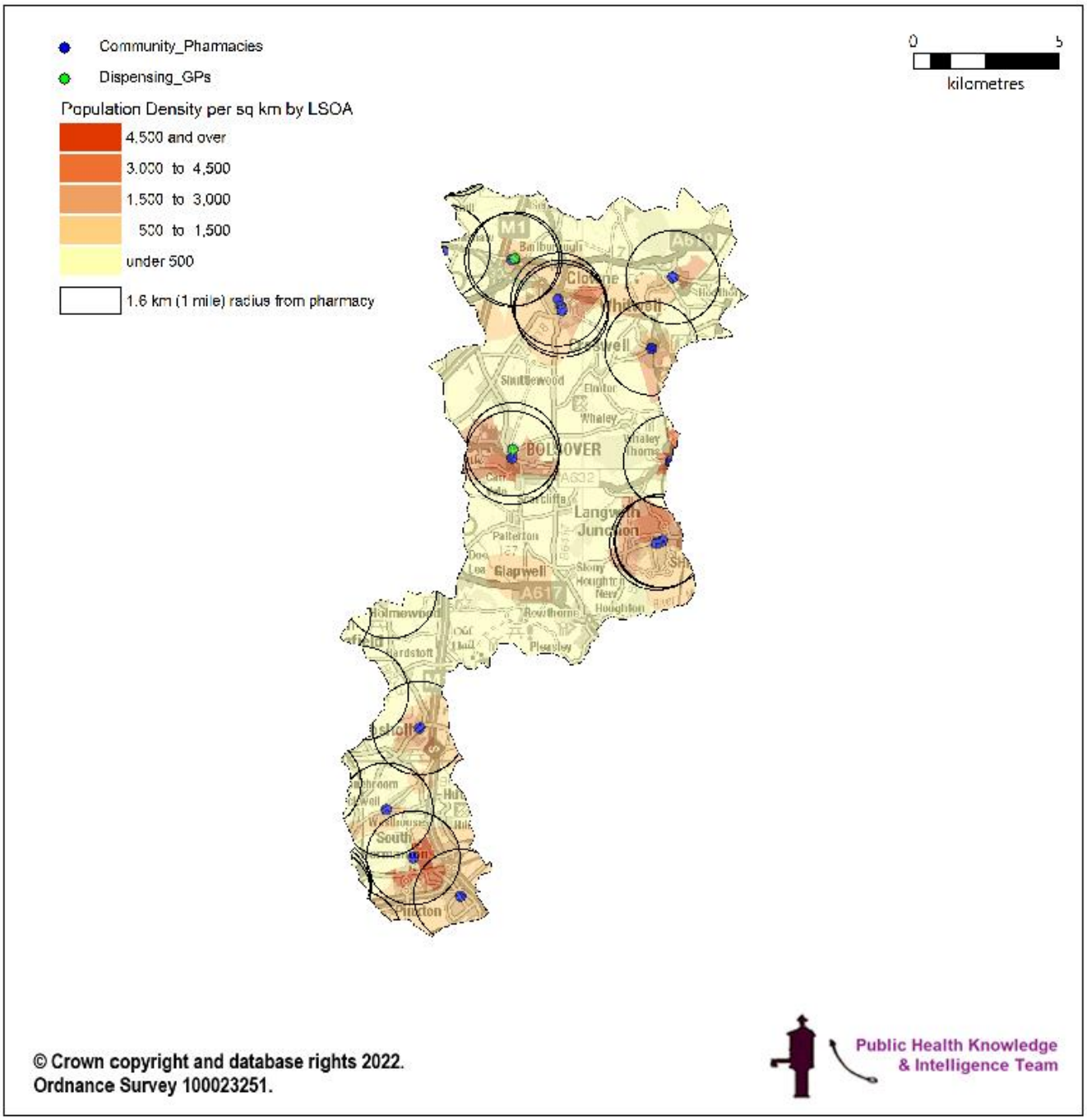
Figure 14: Pharmaceutical services provided in Bolsover

NHS England	Bolsover		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	17	21	202	25
100-hour pharmacy[16]	2	2	20	2
Flu vaccination (population)	14	17	181	22
Palliative care drugs stockist scheme	2	2	36[17]	3
Emergency Supply Service (ESS)	11	14	154[17]	15
Appliance Use Reviews (AUR)	-	-	2	0
Community Pharmacist Consultation Service (CPCS)	13	16	183	23
Hypertension Case Finding Service	-	-	157[17]	15
Hepatitis C Testing	0	0	0	0
Smoking Cessation	-	-	32[17]	3
Stoma Appliance Customisation	2	2	16	2
Discharge Medicines Service	13	16	146	18
Covid vaccination services	3	4	28	3
Extended Care Services				
Tier 1 services	7	9	107[17]	10
Tier 2a skin services	7	9	90[17]	9
Tier 3 Ear, Nose & Throat services	-	-	75[17]	7
Local Authority (Public Health)				
Emergency Hormonal Contraception	5	6	98	9
Supervised Consumption	13	16	144	14
Needle Exchange	7	9	66	6

[16] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[17] Excluding Glossopdale

Figure 15 : Map of pharmaceutical service coverage in Bolsover



Quality of health

Of particular note are the district's significantly higher rates of premature mortality from cancer and respiratory disease. The average health related quality of life for older people is significantly lower than national average.

Accessibility

There are 21 pharmacies to every 100,000 population in Bolsover, compared to the national average of 21. There are two 100-hour pharmacies (12% of the total). Figure 15 demonstrates that most of the population will be within 1.6km (a 1 mile walk of approximately 20 mins) of a pharmacy.

Strategic priorities and key health needs

Priorities in Bolsover include tackling smoking during pregnancy, reducing inequalities in healthy life expectancy, and mental health and wellbeing. Key additional health needs include (but are not limited to):

- Child poverty
- Children with Special Education Need and/or Disability
- Road traffic incidents and casualties
- Violent crime and antisocial behaviour
- Unemployment
- Educational attainment
- Early deaths from cancer
- Home care provision

Future housing plans

The Bolsover local Plan Consultation Draft (BLPCD) was published for consultation in October 2016, which included a housing target for the district of 3,600 dwellings during the period of 2018 to 2033. Four strategic growth sites are identified in the BLPCD at Bolsover North (900 dwellings), Clowne Garden Village (1,100 dwellings), the former Whitwell Colliery (200 dwellings) and former Coalite Chemical Works (600 dwellings).

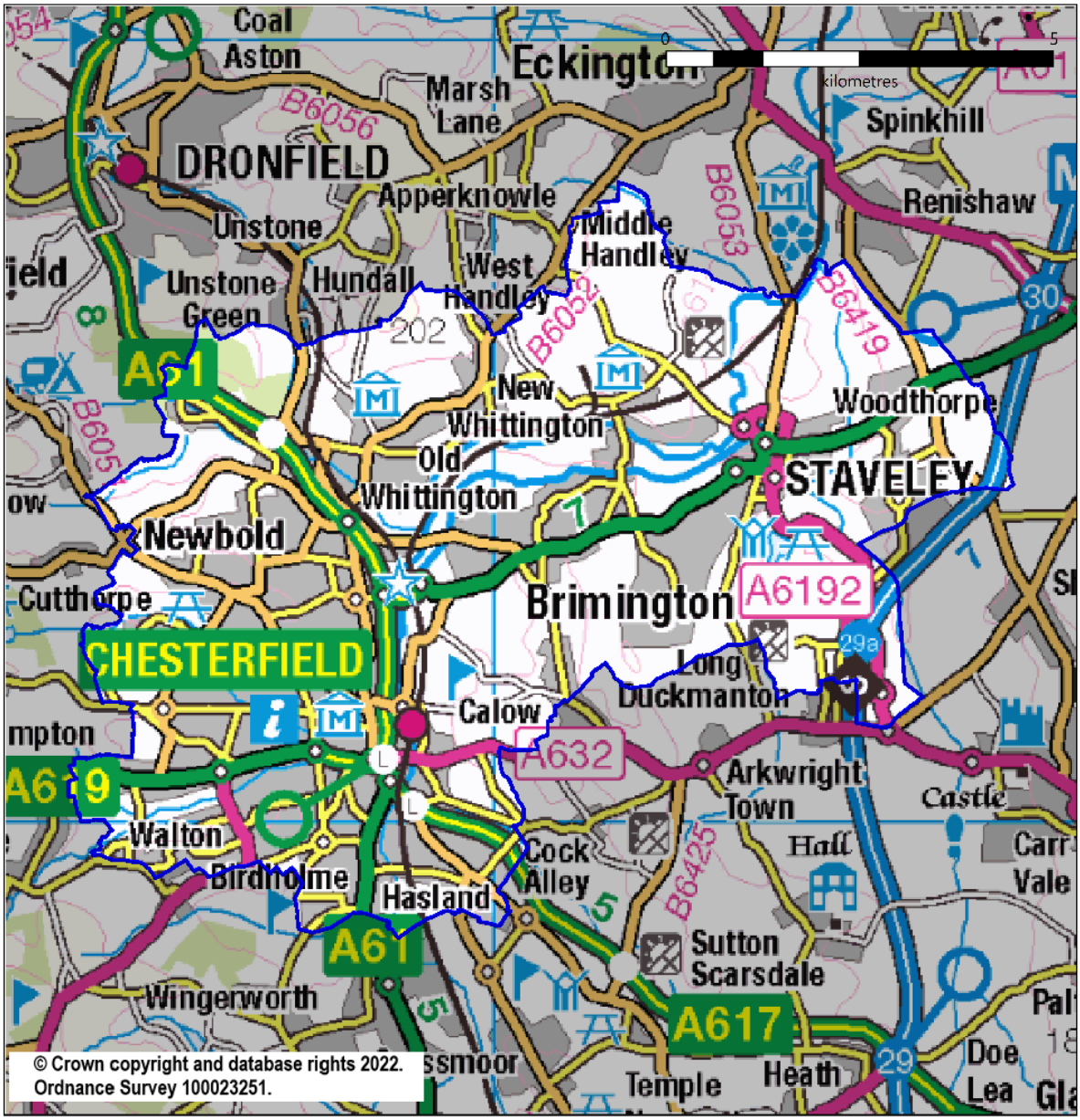
Statement of pharmaceutical need: Bolsover

This PNA found that the pharmaceutical need in the Bolsover area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

2.2.3 Chesterfield

Primarily urban, Chesterfield contains the two market towns of Staveley and Chesterfield and is known as the gateway to the Peak District. It is a major centre of employment that attracts almost 20,000 commuters every day. Despite this, the area is relatively deprived and ranks 86th out of 316 English local authority districts in the 2019 English Index of Multiple Deprivation, where 1 is the most deprived. 29% of its lower super output areas rank within the most deprived 20% nationally. Census data indicates that 28.8% of households are deprived in two or more dimensions. This is higher than the Derbyshire (25.2%) and national average (24.8%). Chesterfield is surrounded by unspoilt countryside, which serves as an enabler of physical activity. It also has a number of key attractions such as Creswell Crags – a world famous archaeological site, and Hardwick Hall – one of Britain's finest Elizabethan houses.

Figure 16: Map of Chesterfield



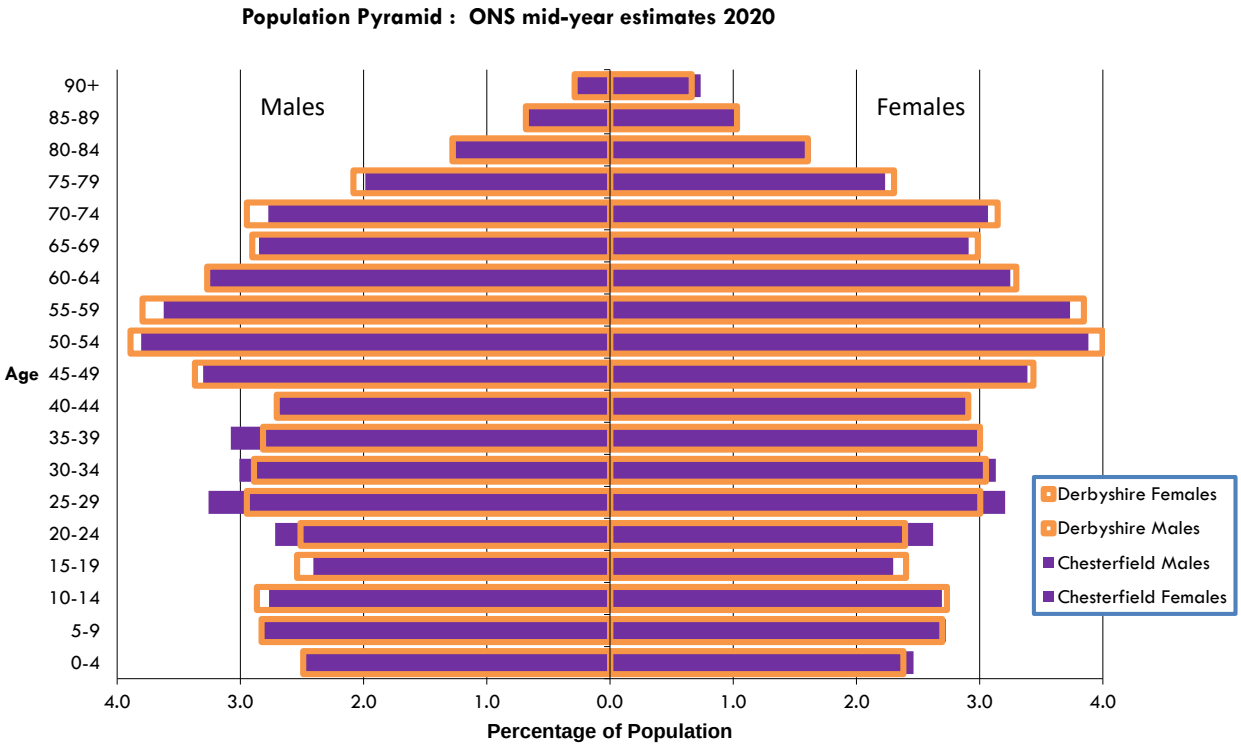
Population

Chesterfield has a population of 104,930 that is expected to increase to 110,052 by 2043. The district has a similar age structure to Derbyshire as a whole. 22% of residents are aged 65 and over, which is expected to increase to 26% by 2043. The proportion of black and ethnic minorities is relatively low (5.1%), although this is marginally higher than the Derbyshire average (4.2%).

Employment

Chesterfield's largest employer is the Post Office administration department, which is located on the edge of the town centre. Health, retail, manufacturing, and education form a significant proportion of employment openings in this town. Some of the borough's largest manufacturing employers include Robinsons and Franke Sissons Ltd.

Figure 17: Chesterfield Population Pyramid



NHS Services

There are 9 General Practices across the district. Three of these are branch practices and one provides dispensing services. Chesterfield Royal Hospital and Walton Hospital provide acute and community services within the area. The former provides a broad range of clinical services, including pathology, cardiology, palliative care and maternity services. The latter provides a psychiatry service and support for older people's mental health in addition to intermediate care services on behalf of Derbyshire Healthcare NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust.

There are 21 community pharmacies and one Dispensing Appliance Contactor in Chesterfield. Chesterfield Royal Hospital also provides a Local Pharmaceuticals Service.

Poverty

Approximately 3,568 children (20%) live in poverty. These children live in income-deprived families who experience deprivation relating to low income. At a ward level this varies considerably from 3% in Walton to 35.6% in Rother.

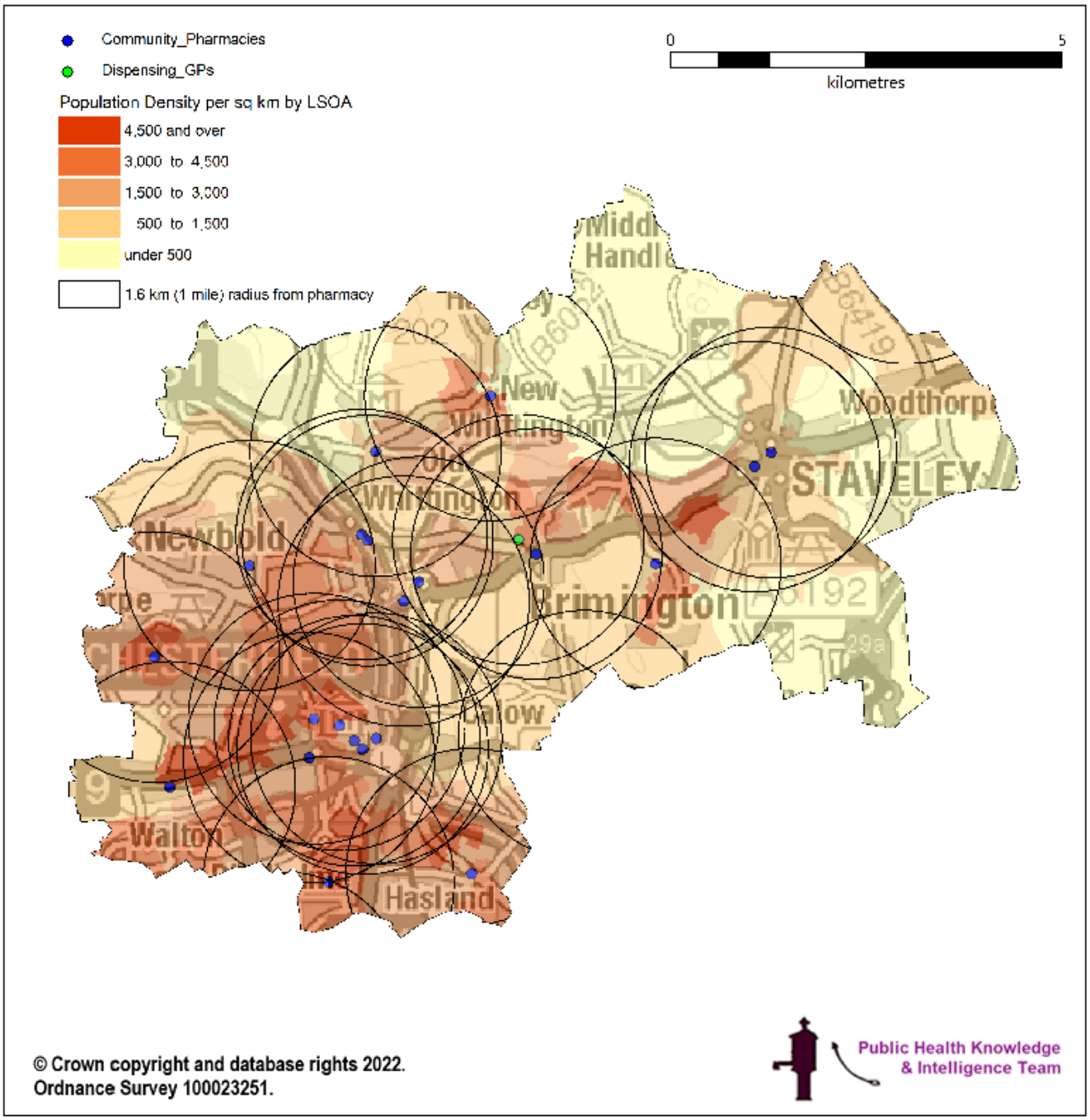
Figure 18: Pharmaceutical services provided in Chesterfield

NHS England	Chesterfield		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	20	19	202	25
100-hour pharmacy[18]	2	2	20	2
Flu vaccination (population)	18	17	181	22
Palliative care drugs stockist scheme	1	1	36[19]	3
Emergency Supply Service (ESS)	17	16	154[19]	15
Appliance Use Reviews (AUR)	1	1	2	0
Community Pharmacist Consultation Service (CPCS)	20	19	183	23
Hypertension Case Finding Service	-	-	157[19]	15
Hepatitis C Testing	0	0	0[19]	0
Smoking Cessation	0	0	32[19]	3
Stoma Appliance Customisation	3	3	16	2
Discharge Medicines Service	18	17	146	18
Covid vaccination services	4	4	28	3
Extended Care Services				
Tier 1 services	10	10	107[19]	10
Tier 2a skin services	8	8	90[19]	9
Tier 3 Ear, Nose & Throat services	-	-	75[19]	7
Local Authority (Public Health)				
Emergency Hormonal Contraception	11	10	98	9
Supervised Consumption	14	13	144	14
Needle Exchange	9	9	66	6

[18] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[19] Excluding Glossopdale

Figure 19: Map of pharmaceutical service coverage in Chesterfield



Quality of health

The area is affected by significantly higher rates of premature mortality from all cardiovascular diseases, cancer and respiratory disease.

Accessibility

There are 19 pharmacies to every 100,000 population in Chesterfield, compared to the national average of 21. There are two 100-hour pharmacies (10% of the total). Figure 19 demonstrates that most of the population will be within 1.6km (a 1 mile walk of approximately 20 mins) of a pharmacy.

Strategic priorities and key health needs

Strategic priorities and key health needs priorities in Chesterfield include encouraging healthier lifestyles, good mental health and wellbeing, and developing community resilience. Key additional health needs include (but are not limited to):

- Child poverty
- Violent crime and antisocial behaviour
- Unemployment
- Educational attainment
- Life expectancy in males and females
- Excess weight
- Hospital stays for alcohol-related harm

Future housing plans

Chesterfield Borough Council published the Chesterfield Borough Local Plan Consultation Draft in January 2017, with emphasis on concentrating new development within walking distance of the Borough's town, district and local centres and focusing on areas that are in need of regeneration. The Local Plan proposed a new housing requirement for the Borough of 4,269 dwellings (272 per annum) over the period 2016 to 2033. 69 potential housing allocation sites were identified with an overall capacity to accommodate 3,980 houses, together with 4 reserve sites at Dunston and Upper Newbold, which could accommodate 952 houses. Five Regeneration Priority Areas are identified which could accommodate 3,932 houses. In total, these three potential sources of housing land supply could accommodate 8,863 new homes.

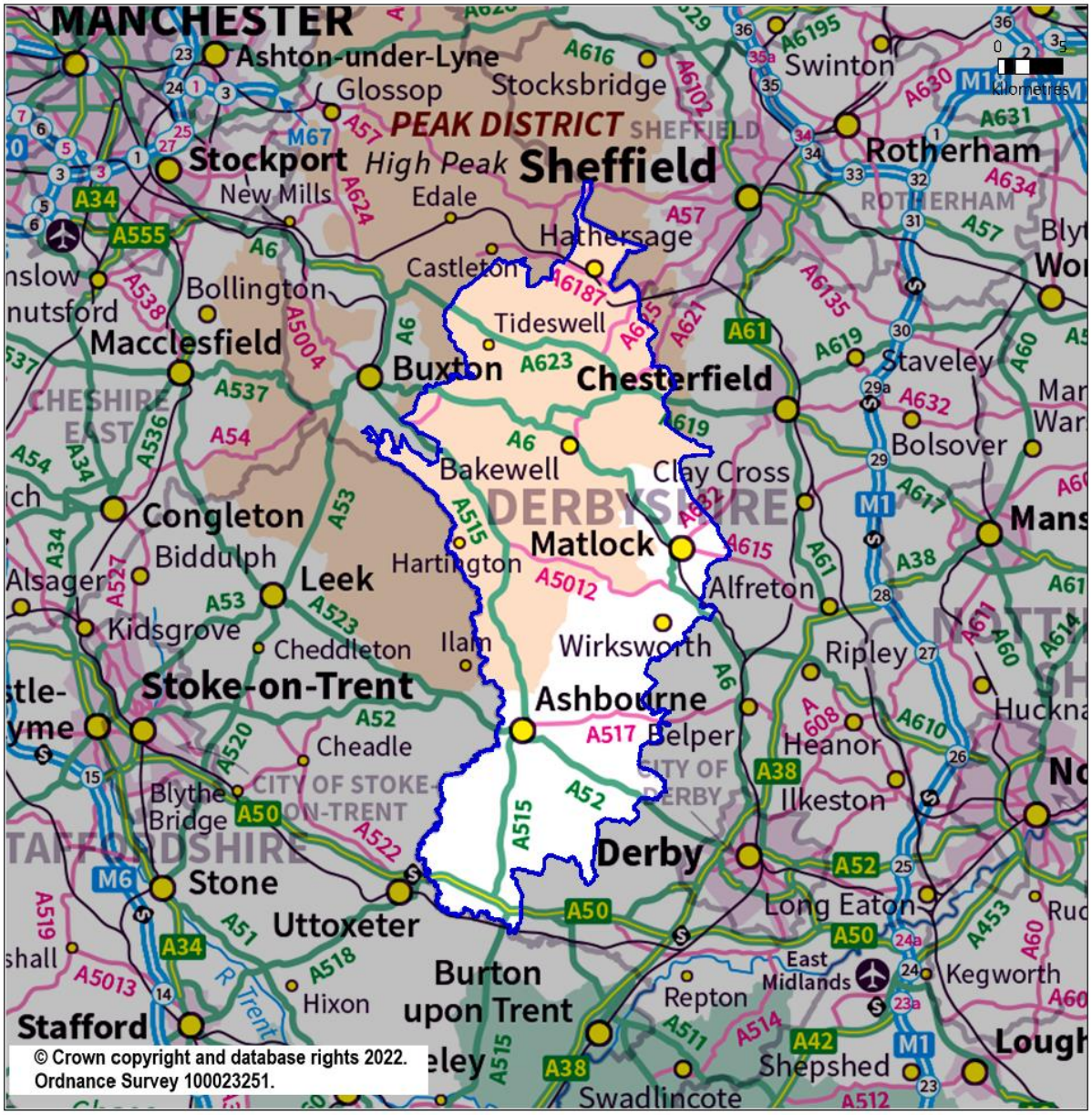
Statement of pharmaceutical need: Chesterfield

This PNA found that the pharmaceutical need in the Chesterfield area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

2.2.4 Derbyshire Dales

Derbyshire Dales is a large geographical area covering 307 square miles, which 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 is the least deprived in Derbyshire, ranking 265th out of 316 English local authority districts in the 2019 English Index of Multiple Deprivation (where 1 is the most deprived). However, there are small pockets of deprivation in which 2% of its lower super output areas are amongst the most deprived 10% nationally. The latest census profile highlights that 48.6% of households are not deprived in any dimension, which is greater than the Derbyshire (43.5%) and national (42.5%) average.

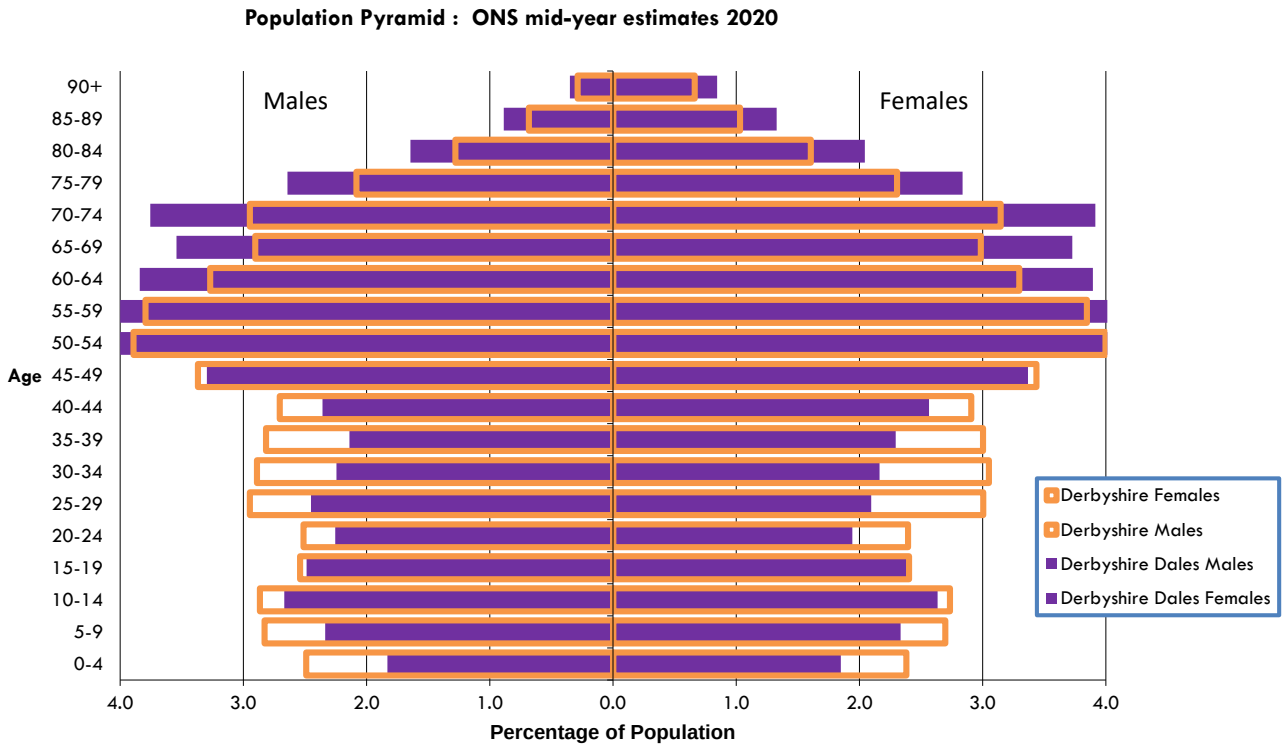
Figure 20: Map of Derbyshire Dales



Population

Derbyshire Dales has an estimated population of 72,422 that is projected to increase to 77,190 by 2043. With 27% of the population aged 65 and over, the borough is generally older than Derbyshire and England as a whole, which highlights a greater need for health and social care. The proportion of older people over 65 is expected to increase to 35% by 2043. The proportion of black and minority ethnic residents (3.2%) is lower than the Derbyshire (4.2%) and national average (20.2%).

Figure 21: Derbyshire Dales Population Pyramid



Employment

Derbyshire Dales has a thriving local economy that includes the traditional sectors of farming and quarrying in addition to innovative businesses that include design firms and small and medium sized manufacturers. Providing accommodation and food services, as well as retail and public administration form a significant proportion of employment openings in this town. Major employers include the public sector and DSF Refractories & Minerals Ltd – the largest shaped refractory producer in the UK.

NHS Services

There are 12 General Practices across the district. 7 of these are branch practices and 9 provide dispensing services to local residents. Whitworth Hospital is the main community hospital in the area, and provides a range of services, including musculoskeletal, community therapy and intermediate care services on behalf of Derbyshire Community Health Services NHS Foundation Trust. There are 10 pharmacies within the district all offering essential services in addition to those shown in Figure 22.

Poverty

Approximately 960 children (8.7%) live in poverty. These children live in income-deprived families who experience deprivation relating to low income. At a ward level this varies from 2.5% in Doveridge and Sudbury to 21.4% in Matlock St Giles.

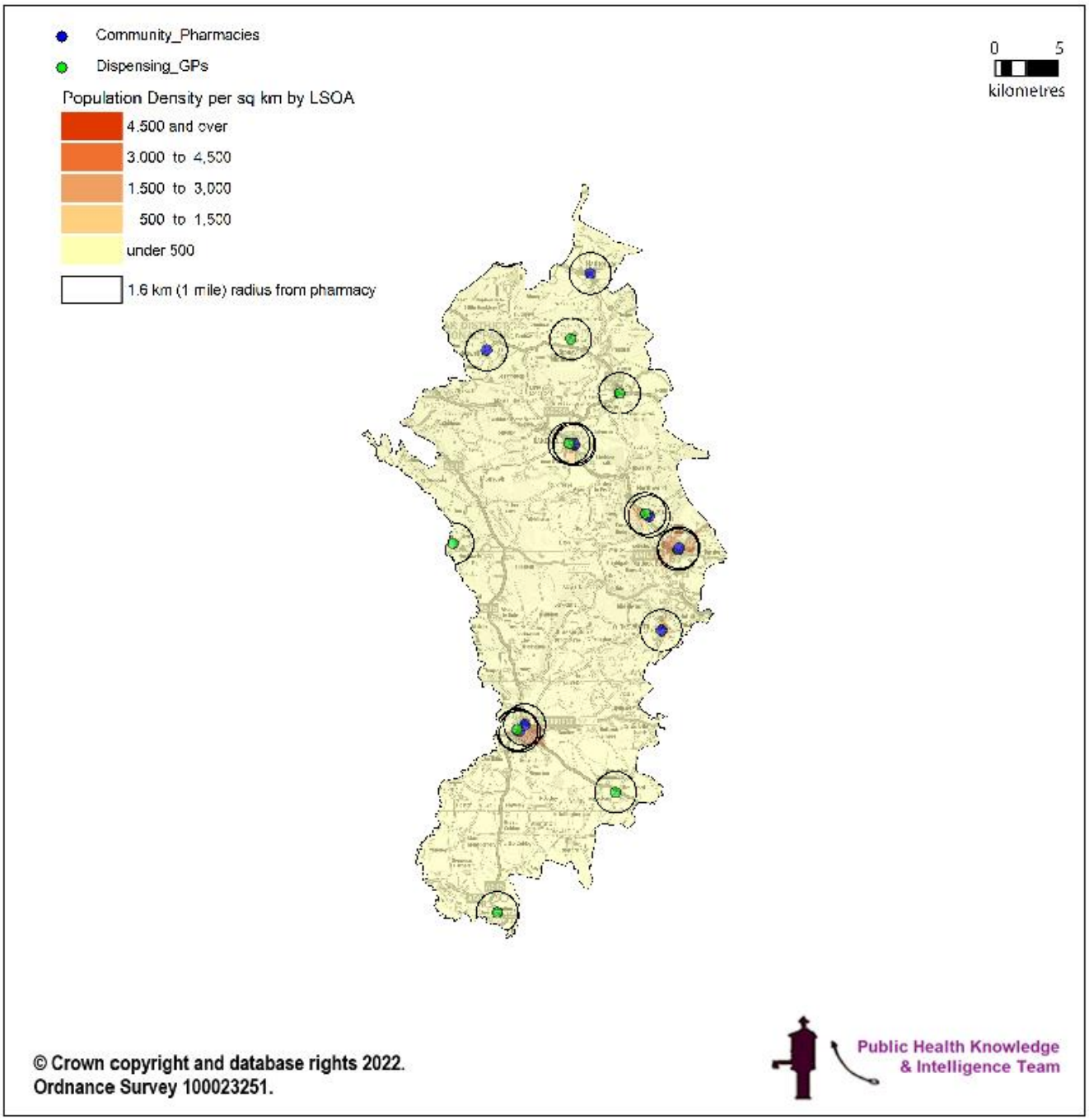
Figure 22: Pharmaceutical services provided in Derbyshire Dales

NHS England	Derbyshire Dales		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	10	10	202	25
100-hour pharmacy[20]	0	0	20	2
Flu vaccination (population)	9	9	181	22
Palliative care drugs stockist scheme	3	4	36[21]	3
Emergency Supply Service (ESS)	7	10	154[21]	15
Appliance Use Reviews (AUR)	0	0	2	0
Community Pharmacist Consultation Service (CPCS)	7	7	183	23
Hypertension Case Finding Service	-	-	157[21]	15
Hepatitis C Testing	0	0	0	0
Smoking Cessation	0	0	32[21]	3
Stoma Appliance Customisation	1	1	16	2
Discharge Medicines Service	6	8	146	18
Covid vaccination services	2	3	28	3
Extended Care Services				
Tier 1 services	3	4	107[21]	10
Tier 2a skin services	2	3	90[21]	9
Tier 3 Ear, Nose & Throat services	-	-	75[21]	7
Local Authority (Public Health)				
Emergency Hormonal Contraception	1	1	98	9
Supervised Consumption	6	8	144	14
Needle Exchange	1	1	66	6

[20] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[21] Excluding Glossopdale

Figure 23: Map of pharmaceutical service coverage in Derbyshire Dales



Quality of health

The area performs comparably or significantly better than the national average in relation to disease-related indicators. However, the chlamydia detection rate amongst 15–24-year-olds is significantly worse than the national average.

Accessibility

There are 14 pharmacies to every 100,000 population in Derbyshire Dales, lower than the national average of 21, but supported by the dispensing practices. There are no 100-hour pharmacies in the area. Figure 23 demonstrates that, considering the highly rural nature of the district, much of the population will be within 1.6km (a 1 mile walk of approximately 20 mins) of a pharmacy or dispensing practice.

Strategic priorities and key health needs

Priorities in Derbyshire Dales include reducing health inequalities, increasing healthy life expectancy, and improving mental health and wellbeing for residents. Key additional health needs include (but are not limited to):

- Fuel poverty
- Road traffic incidents and casualties
- Unpaid care provision
- Travel time to services (specifically GPs)
- Diagnosis of Dementia
- Living well with a long-term health condition or care need
- Financial inclusion
- Community resilience and networks
- Recovery from the pandemic

Future housing plans

The Derbyshire Dales Local Housing Plan was submitted to the Secretary of State in December 2016 and was subject to an Examination in Public between 9 May and 23 May 2017. The plan sets out an overall housing requirement for 6,440 dwellings over the period 2013 to 2033, with the main focus for housing growth being on the three main market towns of Ashbourne, Matlock and Wirksworth. The Plan identifies 28 housing site allocations, the main ones of which are at Ashbourne Airfield: 1,100 dwellings; Middle Peak Quarry, Wirksworth: 645 dwellings; Gritstone Road, Matlock: 430 dwellings; and Halldale Quarry: 220 dwellings.

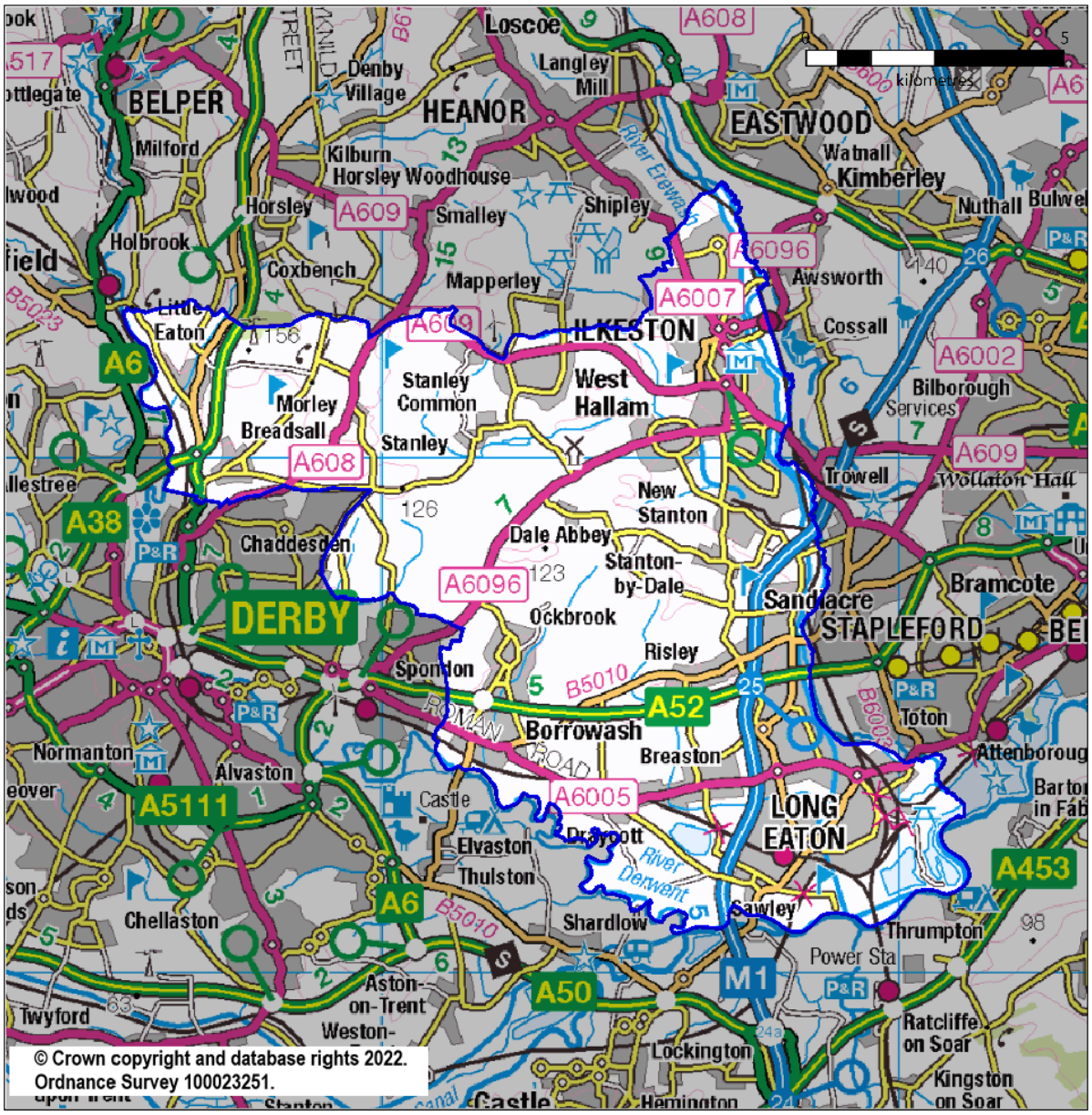
Statement of pharmaceutical need: Derbyshire Dales

This PNA found that the pharmaceutical need in the Derbyshire Dales area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

2.2.5 Erewash

The borough of Erewash lies to the east of Derby and the west of Nottingham. It is comprised of fourteen civil parishes and the towns of Ilkeston, Long Eaton and Sandiacre. Whilst the east is predominantly urban, the west is more rural with isolated villages. Erewash ranks 168th out of 316 English local authority districts in the 2019 English Index of Multiple Deprivation, where 1 is the most deprived. However, there are small pockets of deprivation in which 11 of 73 lower super output areas are amongst the most deprived 20% nationally. Furthermore, the proportion of households that are deprived in two or more dimensions (25.6%) is greater than the Derbyshire and national average (25.2% and 24.8% respectively).

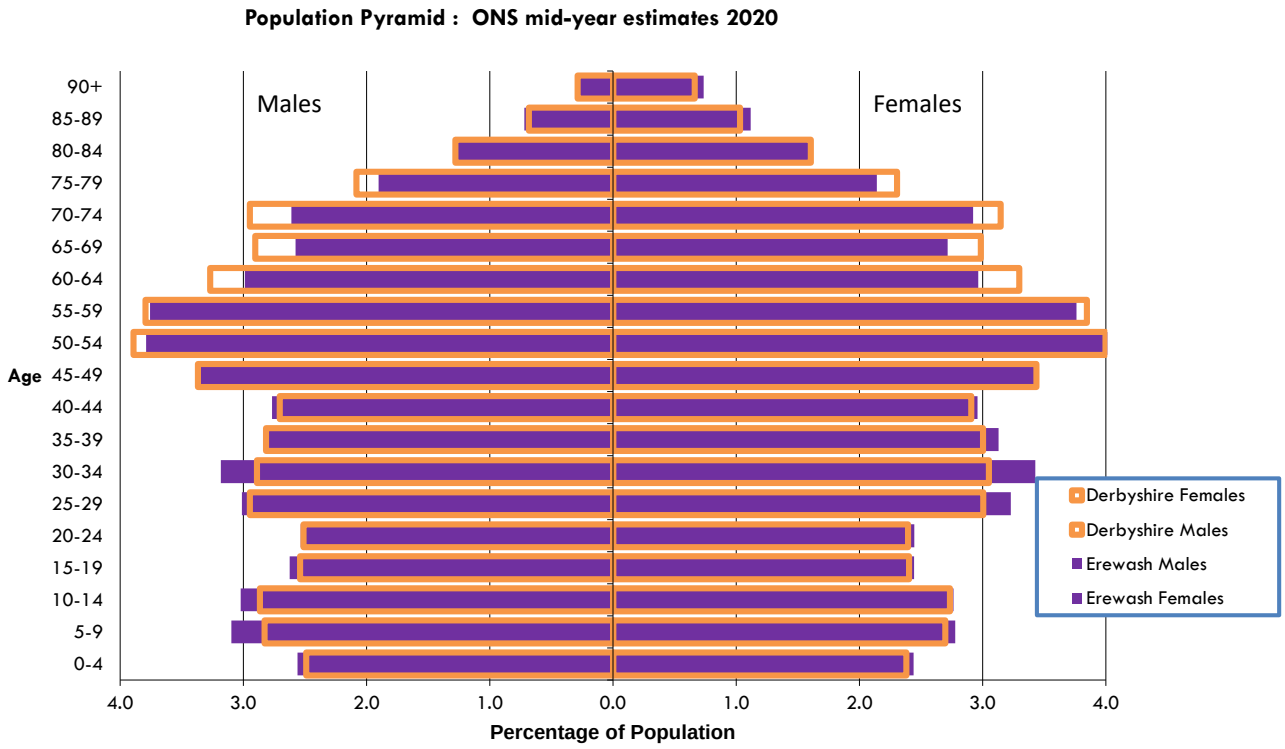
Figure 24: Map of Erewash



Population

Erewash has an estimated population of 115,332 that is projected to increase to 124,391 by 2043. The population of Erewash is generally young, with a relatively similar age composition to Derbyshire as a whole. In Erewash, there are a greater proportion of individuals aged 20-39 (24%) than that of those over 65 (21%). The proportion of black and minority ethnic residents is marginally higher than the Derbyshire average (4.8% compared with 4.2%).

Figure 25: Erewash Population Pyramid



Employment

Manufacturing and health are key employment sectors in the area and provide more than a quarter of jobs. Major manufacturing companies within this sector include Stanton Precast Concrete and Saint-Gobain PAM UK. In recent years, there has been employment growth in retail and accommodation and food services.

NHS Services

There are 14 General Practices within the borough. 8 of these are branch practices and 2 provide dispensing services to local residents. Ilkeston Community Hospital provides a range of services on behalf of Derbyshire Community Health Services NHS Foundation Trust. These include general surgery and therapy services, as well as dermatology and musculoskeletal services. There are 25 pharmacies across the district, and two 100-hour pharmacies located here. Each pharmacy offers a range of essential services in addition to those shown in Figure 26.

Poverty

Approximately 3,519 children (17.1%) live in poverty. These children live in income-deprived families who experience deprivation relating to low income. At a ward level this varies considerably from 5.4% in Breaston to 44.1% in Cotmanhay.

Quality of health

Of note in the area is the significantly higher rate of premature mortality from liver disease amongst females.

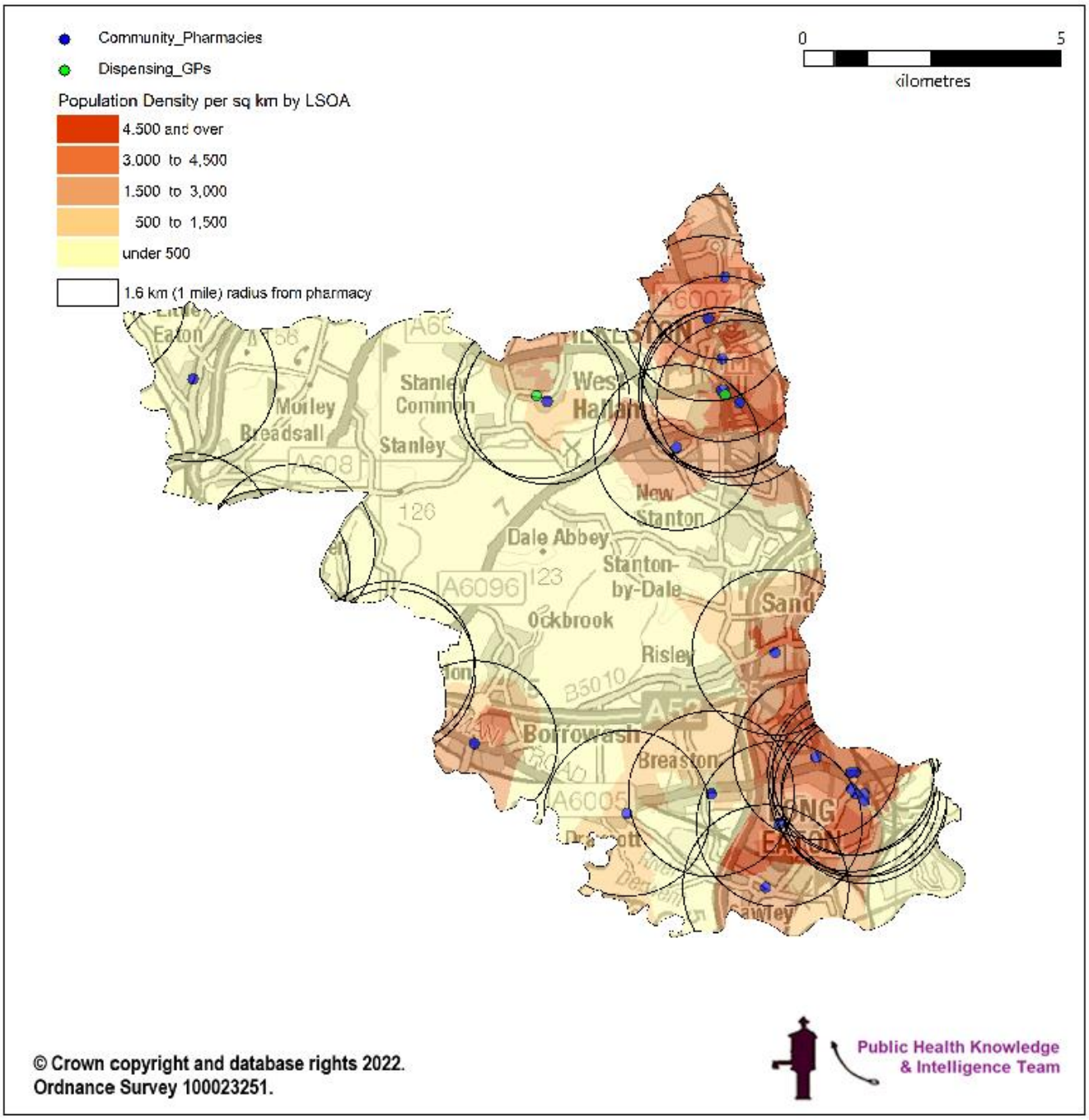
Figure 26: Pharmaceutical services provided in Erewash

NHS England	Erewash		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	23	20	202	25
100-hour pharmacy[22]	3	2	20	2
Flu vaccination (population)	23	20	181	22
Palliative care drugs stockist scheme	8	7	36[23]	3
Emergency Supply Service (ESS)	19	16	154[23]	15
Appliance Use Reviews (AUR)	0	0	2	0
Community Pharmacist Consultation Service (CPCS)	22	19	183	23
Hypertension Case Finding Service	-	-	157[23]	15
Hepatitis C Testing	0	0	0	0
Smoking Cessation	-	-	32[23]	3
Stoma Appliance Customisation	1	1	16	2
Discharge Medicines Service	19	16	146	18
Covid vaccination services	5	4	28	3
Extended Care Services				
Tier 1 services	15	13	107[23]	10
Tier 2a skin services	13	11	90[23]	9
Tier 3 Ear, Nose & Throat services	-	-	75[23]	7
Local Authority (Public Health)				
Emergency Hormonal Contraception	14	12	98	9
Supervised Consumption	15	13	144	14
Needle Exchange	4	3	66	6

[22] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[23] Excluding Glossopdale

Figure 27: Map of pharmaceutical service coverage in Erewash



Accessibility

There are 20 pharmacies to every 100,000 population in Erewash, compared to the national average of 21. There are two 100-hour pharmacies in the area (10% of the total). Figure 27 demonstrates that most of the population will be within 1.6km (a 1 mile walk of approximately 20 mins) of a pharmacy.

Strategic priorities and key health needs

Strategic priorities and key health needs Priorities in Erewash include encouraging healthy lifestyles, raising aspirations of young people, and reducing alcohol misuse. Key additional health needs include (but are not limited to):

- Child poverty
- Violent crime and antisocial behaviour
- Unemployment

- School absenteeism
- Home care provision
- Excess weight
- Recorded Diabetes

Future housing plans

The 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.

Future housing plans

The 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.

Statement of pharmaceutical need: Erewash

This PNA found that the pharmaceutical need in the Erewash area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

2.2.6 High Peak

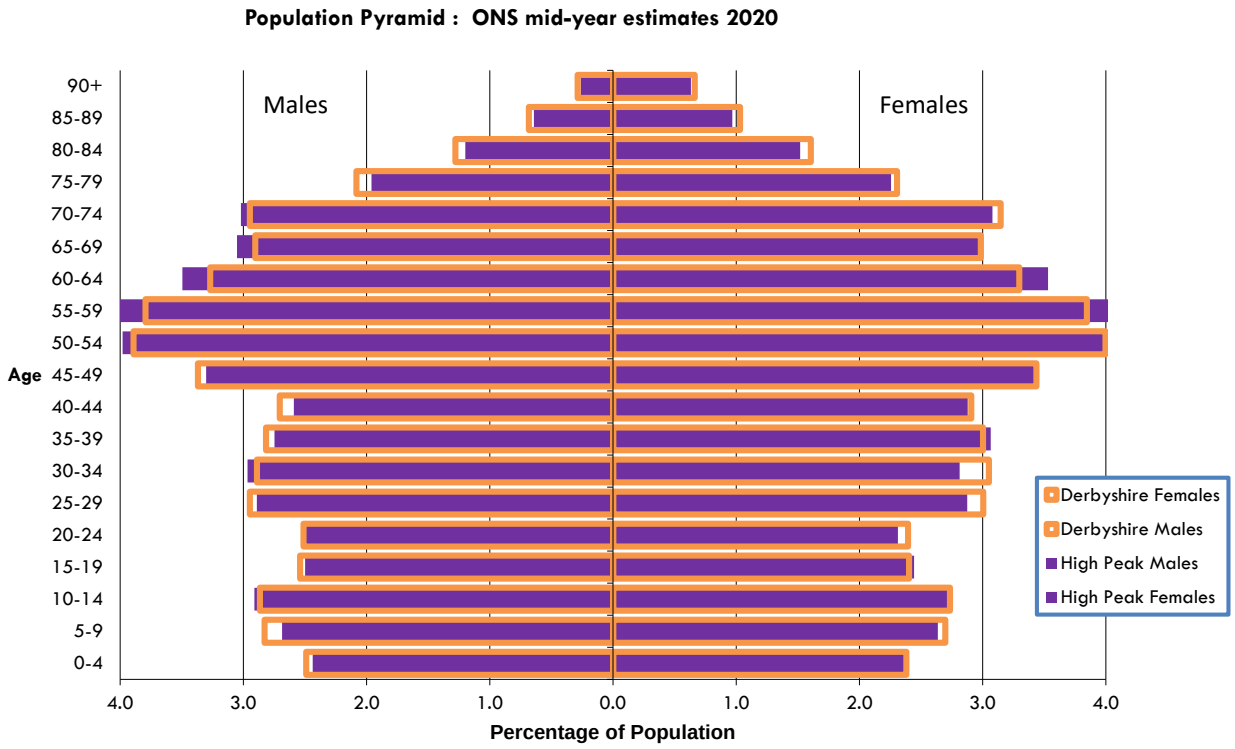
The borough of High Peak is located within the northwest of Derbyshire and contains the five market towns of Glossop, New Mills, Whaley Bridge, Chapel-en-le-Frith and Buxton. The area largely comprises the Peak District National Park; a popular tourist destination that also covers parts of Yorkshire, Staffordshire, and Cheshire. High Peak ranks 202nd out of 316 English local authority districts in the 2019 English Index of Multiple Deprivation, where 1 is the most deprived. However, there are small pockets of deprivation in the area. For instance, 21.7% of households are deprived in two or more dimensions, although this is lower than the Derbyshire (25.2%) and national average (24.8%).

Figure 28: Map of High Peak

Population

High Peak has an estimated population of 92,633 that is expected to increase to 100,066 by 2043. The population of the borough is generally similar to Derbyshire as a whole, although the former has a marginally higher proportion of middle-aged people aged 45-64. The proportion of black and minority ethnic residents is generally comparable with the Derbyshire average (4.1% and 4.2% respectively).

Figure 29: High Peak Population Pyramid



Employment

Manufacturing, health, education and retail form the largest employment sectors in High Peak. Major employers include Concept Life Sciences – a leading UK provider of drug research services, and Hope Construction Materials.

NHS Services

There are 14 General Practices within High Peak. Four of these are branch practices and one provides dispensing services to local residents. Cavendish Hospital provides a range of community hospital services within the district on behalf of Derbyshire Community Health Services NHS Foundation Trust and Stockport NHS Foundation Trust. Services from the latter include diabetic medicine, geriatric medicine, ophthalmology and pain management. There are 21 pharmacies across the district all offering essential services in addition to those shown in Figure 30

Poverty

Approximately 1,921 children (12.2%) live in poverty. These children live in income-deprived families who experience deprivation relating to low income. At a ward level this varies considerably from 4% in Sett to 38.3% in Gamesley.

Quality of health

Of particular note in the area is the emergency hospital admissions rate for hip fractures in people aged 65 and over, which is significantly higher than the national and regional average.

Figure 30: Pharmaceutical services provided in High Peak

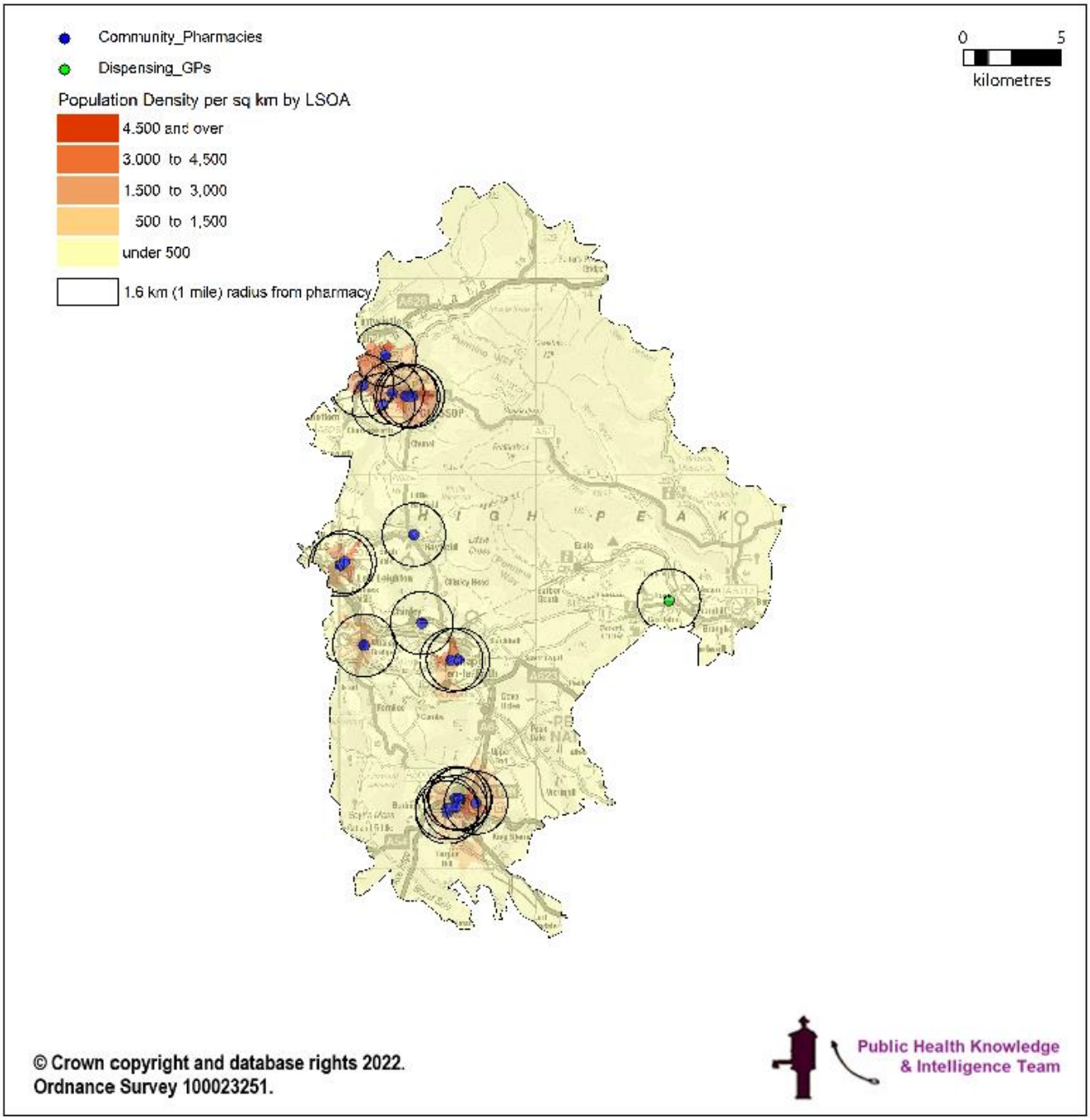
NHS England	High Peak		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	19	21	202	25
100-hour pharmacy[24]	0	0	20	2
Flu vaccination (population)	16	17	181	22
Palliative care drugs stockist scheme	2[25]	3	36[25]	3
Emergency Supply Service (ESS)	9[25]	15	154[25]	15
Appliance Use Reviews (AUR)	0	0	2	0
Community Pharmacist Consultation Service (CPCS)	16	17	183	23
Hypertension Case Finding Service	0[25]	0	157[25]	15
Hepatitis C Testing	0	0	0	0
Smoking Cessation	0[25]	0	32[25]	3
Stoma Appliance Customisation	1	1	16	2
Discharge Medicines Service	16	17	146	18
Covid vaccination services	1	1	28	3
Extended Care Services				
Tier 1 services	6[25]	10	107[25]	10
Tier 2a skin services	4[25]	7	90[25]	9
Tier 3 Ear, Nose & Throat services	-	-	75[25]	7
Local Authority (Public Health)				
Emergency Hormonal Contraception	6	6	98	9
Supervised Consumption	12	13	144	14
Needle Exchange	6	6	66	6

[24] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[25] Excluding Glossopdale

In addition, 7 pharmacies in Glossopdale, commissioned by Tameside & Glossop CCG, provide minor ailments and minor eye conditions services. After July 2022 JUCD will continue to commission these services until July 2023 when they will be reviewed.

Figure 31: Map of pharmaceutical service coverage in High Peak



Accessibility

There are 23 pharmacies to every 100,000 population in High Peak, compared to the national average of 21. There are no 100-hour pharmacies in the area. Figure 31 demonstrates that, considering the highly rural nature of the borough, much of the population will be within 1.6km (a 1 mile walk of approximately 20 mins) of a pharmacy or dispensing practice.

Future housing plans

The High Peak Local Housing Plan was adopted on 14 April 2016. The plan sets out a housing requirement for 7,000 new dwellings (350 per annum) over the period 2011 – 2031, with growth distributed across three Sub-Areas as follows: Glossop dale 958 – 1,242 dwellings; Central Area: 1,065 – 1,171 dwellings; and Buxton 1,136 – 1,526 dwellings.

Strategic priorities and key health needs

Priorities in the High Peak area include reducing smoking during pregnancy, inequalities in healthy life expectancy, and increasing rates of breastfeeding. Key additional health needs include (but are not limited to):

- Fuel Poverty
- Long-term unemployment
- School absenteeism
- Educational attainment
- Hospital stays for alcohol-specific conditions in young people
- Travel time to services (specifically GPs)
- Hip fractures

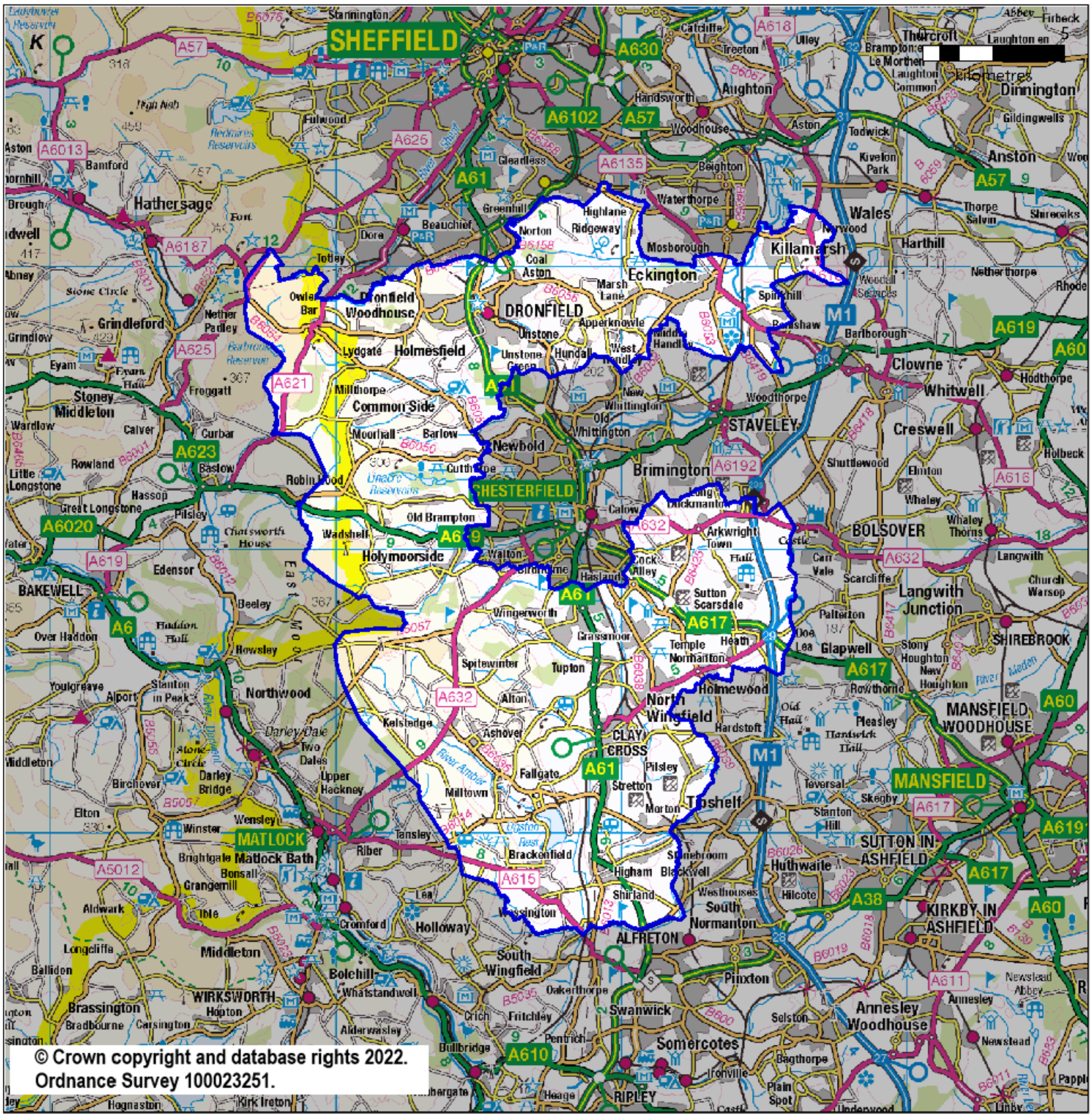
Statement of pharmaceutical need: High Peak

This PNA found that the pharmaceutical need in the High Peak area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

2.2.7 North East Derbyshire

The district of North East Derbyshire has a combination of rural and urban areas covering approximately 100 square miles. It contains the market towns of Dronfield, Clay Cross, Killamarsh and Eckington, and surrounds the neighbouring borough of Chesterfield to the north, west and south. The district ranks 177th out of 316 English local authority districts in the 2019 English Index of Multiple Deprivation, where 1 is the most deprived. However, there are significant levels of inequality in which 10% of its lower super output areas are amongst the 20% most deprived nationally. The latest census data indicates that 25.7% of households are deprived in two or more dimensions. This is greater than the Derbyshire (25.2%) and national average (24.8%).

Figure 32: Map of North East Derbyshire



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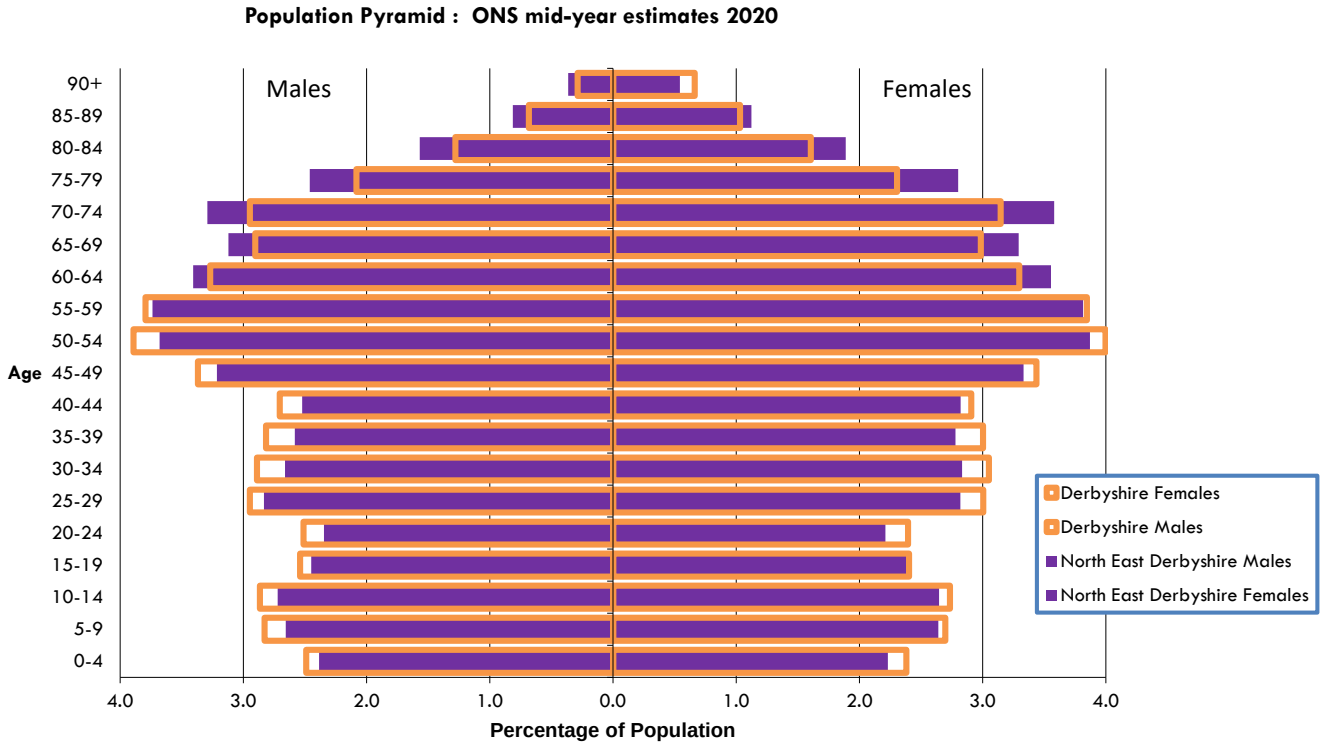
Population

North East Derbyshire has a population of 102,216 that is expected to increase to 110,583 by 2043. The population of North East Derbyshire is generally older than that of Derbyshire as a whole, with a greater proportion of individuals aged 65 and over (25% compared with 22%). There are a smaller proportion of black and minority ethnic residents than the Derbyshire and national average (3.1% compared with 4.2% and 20.2%).

Figure 33: North East Derbyshire Population Pyramid



Employment

Manufacturing is a major employment sector, accounting for 22% of employment within the district. Health, education, accommodation and food services, as well as retail comprise a significant proportion of employment in this area. Major retail centres are distributed across the town centres of Clay Cross, Dronfield, Eckington and Killamarsh.

NHS Services

There are 12 General Practices within North East Derbyshire. 9 of these are branch practices, and one provides dispensing services to local residents. There are 3 community hospitals within the area, namely Clay Cross Hospital, Scarsdale Hospital and Walton Hospital. These provide a range of services on behalf of Derbyshire Community Health Services NHS Foundation Trust. Walton Hospital also provides mental health and older people's services on behalf of Derbyshire Healthcare NHS Foundation Trust. There are 21 pharmacies within the district all offering essential services in addition to those shown in Figure 26.

Poverty

Approximately 2,332 of children (14.5%) live in poverty. These children live in income-deprived families who experience deprivation relating to low income. At a ward level this ranges from 2.8% in Wingerworth to 33.5% in Grassmoor.

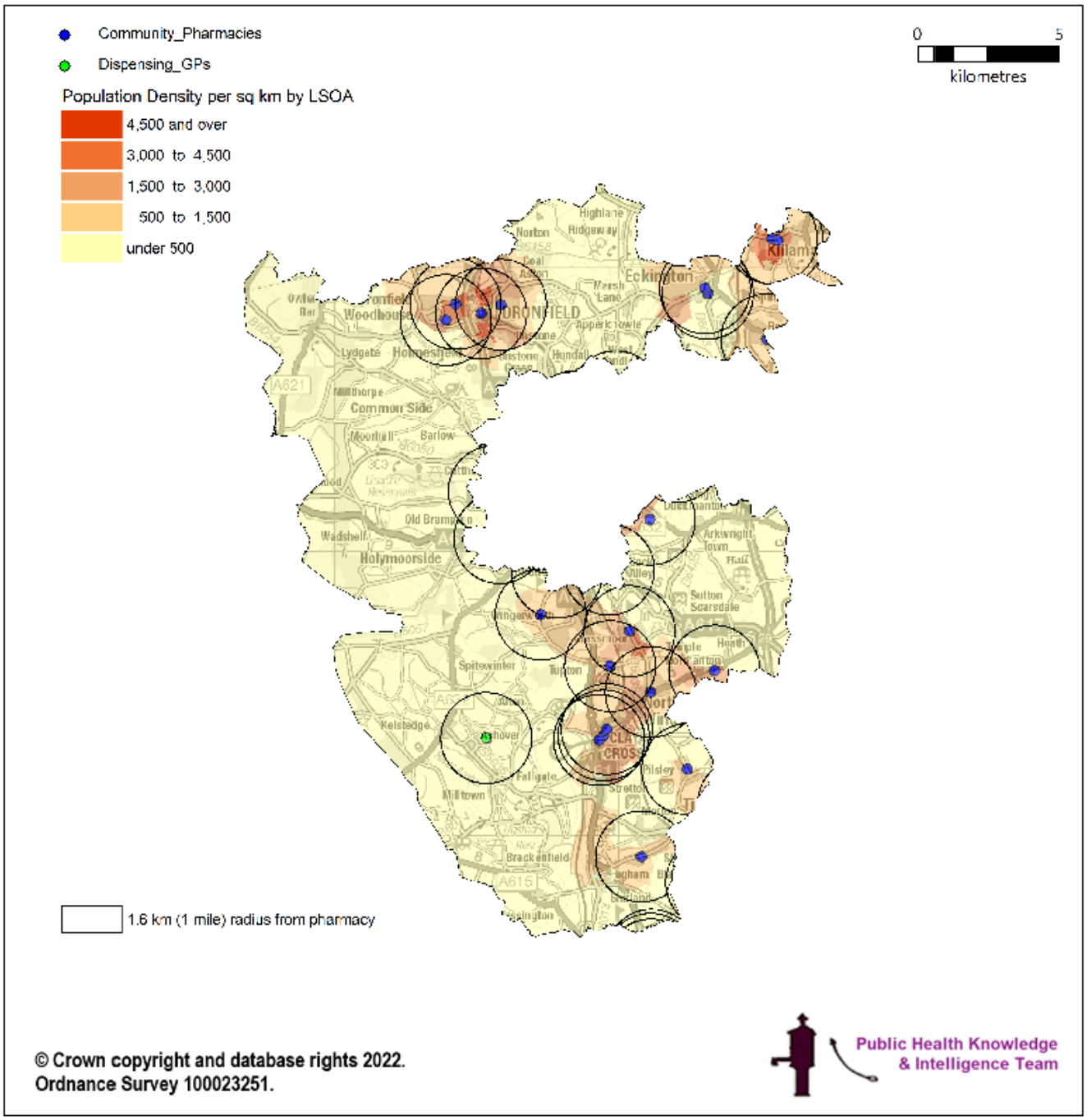
Figure 34: Pharmaceutical services provided in North East Derbyshire

NHS England	North East Derbyshire		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	20	20	202	25
100-hour pharmacy[26]	2	2	20	2
Flu vaccination (population)	18	18	181	22
Palliative care drugs stockist scheme	4	4	36[27]	3
Emergency Supply Service (ESS)	17	17	154[27]	15
Appliance Use Reviews (AUR)	0	0	2	0
Community Pharmacist Consultation Service (CPCS)	18	18	183	23
Hypertension Case Finding Service	-	-	157[27]	15
Hepatitis C Testing	0	0	0	0
Smoking Cessation	0	0	32[27]	3
Stoma Appliance Customisation	1	1	16	2
Discharge Medicines Service	17	17	146	18
Covid vaccination services	3	3	28	3
Extended Care Services				
Tier 1 services	10	10	107[27]	10
Tier 2a skin services	6	6	90[27]	9
Tier 3 Ear, Nose & Throat services	-	-	75[27]	7
Local Authority (Public Health)				
Emergency Hormonal Contraception	11	11	98	9
Supervised Consumption	15	15	144	14
Needle Exchange	5	5	66	6

[26] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[27] Excluding Glossopdale

Figure 35: Map of pharmaceutical service coverage in North East Derbyshire



Quality of health

Of particular note in the area is the significantly higher proportion of adults classed as overweight or obese and hospital admission episodes for alcohol-related conditions in females.

Accessibility

There are 20 pharmacies to every 100,000 population in North East Derbyshire, compared to the national average of 21. There are two 100-hour pharmacies in the area (10% of the total). Figure 35 demonstrates that, considering the highly rural nature of much of the borough, much of the population will be within 1.6km (a 1 mile walk of approximately 20 mins) of a pharmacy or dispensing practice.

Strategic priorities and key health needs

Priorities in North East Derbyshire include smoking during pregnancy, reducing inequalities in healthy life expectancy, and increasing rates of breastfeeding. Key additional health needs include (but are not limited to):

- Unemployment and economic activity
- Home care provision
- Excess weight
- Hospital stays for self-harm
- Hospital stays for alcohol-related harm
- Recorded Diabetes

Future housing plans

The North East Derbyshire Local Plan Consultation Draft (LPCD) was published in February 2017. In this district the target is to build 6,600 homes by 2031. The largest sites are expected to be The Avenue, Wingerworth (up to 1,100 homes) Biwater, Clay Cross (up to 1,000 homes), Dronfield, Eckington, Killamarsh and Coalite near Bolsover.

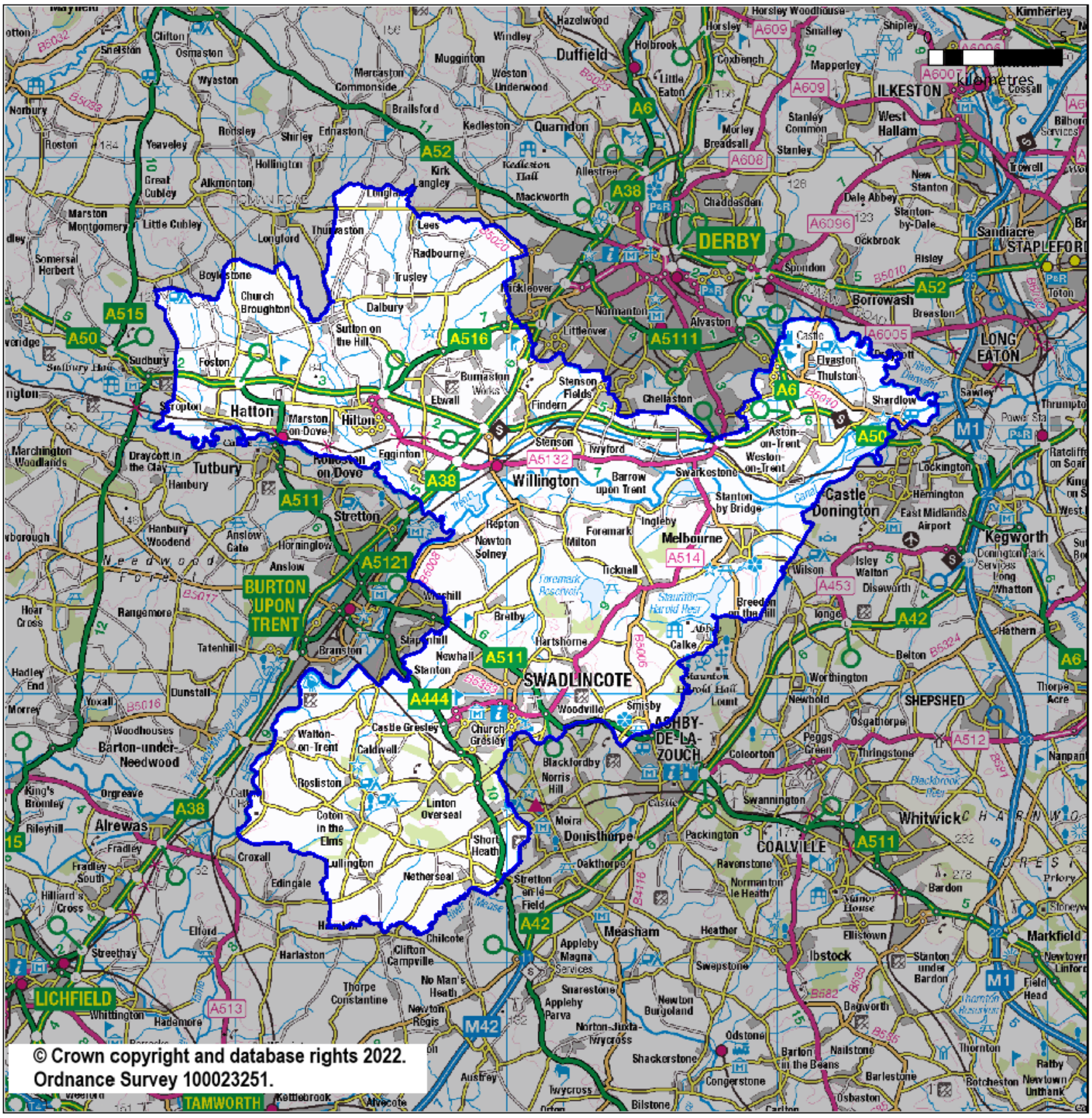
Statement of pharmaceutical need: North East Derbyshire

This PNA found that the pharmaceutical need in the North East Derbyshire area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

2.2.8 South Derbyshire

The South Derbyshire district is largely rural and covers a third of the National Forest; a varied landscape area that incorporates ancient woodlands and wildlife habitats. It also contains the market towns of Melbourne and Swadlincote and the town of Hilton. The area has a relatively low level of deprivation and ranks 218th out of 316 English local authority districts in the 2019 English Index of Multiple Deprivation, where 1 is the most deprived. A significant proportion of households are not deprived in any dimension (48.9%), which is higher than the Derbyshire (43.5%) and national (42.5%) average.

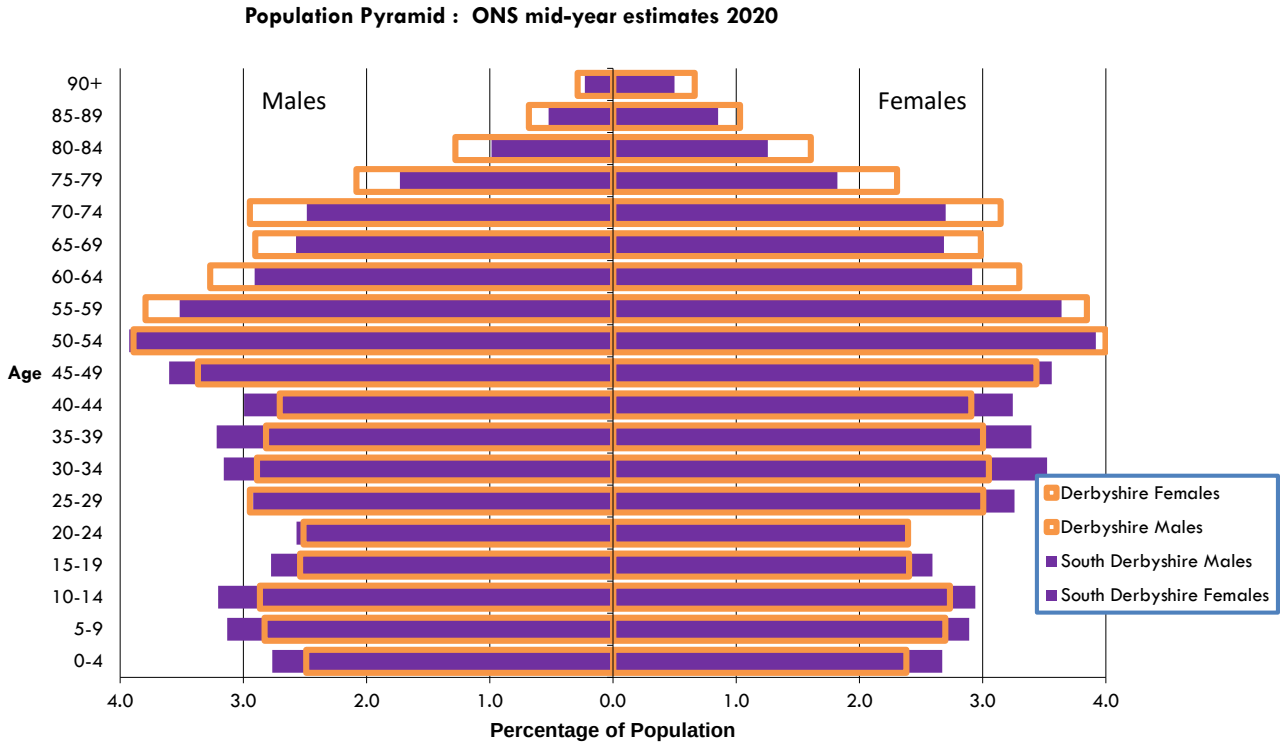
Figure 36: Map of South Derbyshire



Population

The district has a population of 109,516 that is expected to increase to 135,951 by 2043. The age structure of South Derbyshire is marginally younger than Derbyshire with a higher proportion of younger to middle-aged people aged 25-49 (33%). The proportion of black and minority ethnic residents (6.0%) is greater than the Derbyshire average but considerably lower than the national average (4.2% and 20.2% respectively).

Figure 37: South Derbyshire Population Pyramid



Employment

Manufacturing accounts for a large proportion of employment within the area. Key businesses include Toyota Motor Manufacturing and JCB, which is involved in the production of construction and agricultural equipment. Health and education also comprise a large proportion of employment within the district.

NHS Services

There are 8 General Practices within the district. Three of these are branch practices and there are no dispensing practices. There are also 15 pharmacies within the district all offering essential services in addition to those shown in Figure 38.

Poverty

Approximately 2,153 children (11.4%) live in poverty in South Derbyshire. These children live in income-deprived families who experience deprivation relating to low income. At a ward level this ranges from 3.6% in Aston to 18% in Newhall and Stanton.

Quality of health

Of particular note in the area is the high level of excess winter deaths within all ages but particularly in those aged 85+.

Figure 38: Pharmaceutical services provided in Southern Derbyshire

NHS England	South Derbyshire		Joined Up Care Derbyshire	
	No. pharmacies	Rate per 100,000	No. pharmacies	Rate per 100,000
New Medicine Service (NMS)	14	13	202	25
100-hour pharmacy[28]	2	2	20	2
Flu vaccination (population)	12	11	181	22
Palliative care drugs stockist scheme	6	5	36[29]	3
Emergency Supply Service (ESS)	12	11	154[29]	15
Appliance Use Reviews (AUR)	0	0	2	0
Community Pharmacist Consultation Service (CPCS)	12	11	183	23
Hypertension Case Finding Service	-	-	157[29]	15
Hepatitis C Testing	0	0	0	0
Smoking Cessation	0	0	32[29]	3
Stoma Appliance Customisation	0	0	16	2
Discharge Medicines Service	8	7	146	18
Covid vaccination services	2	2	28	3
Extended Care Services				
Tier 1 services	10	9	107[29]	10
Tier 2a skin services	9	8	90[29]	9
Tier 3 Ear, Nose & Throat services	-	-	75[29]	7
Local Authority (Public Health)				
Emergency Hormonal Contraception	9	8	98	9
Supervised Consumption	9	8	144	14
Needle Exchange	4	4	66	6

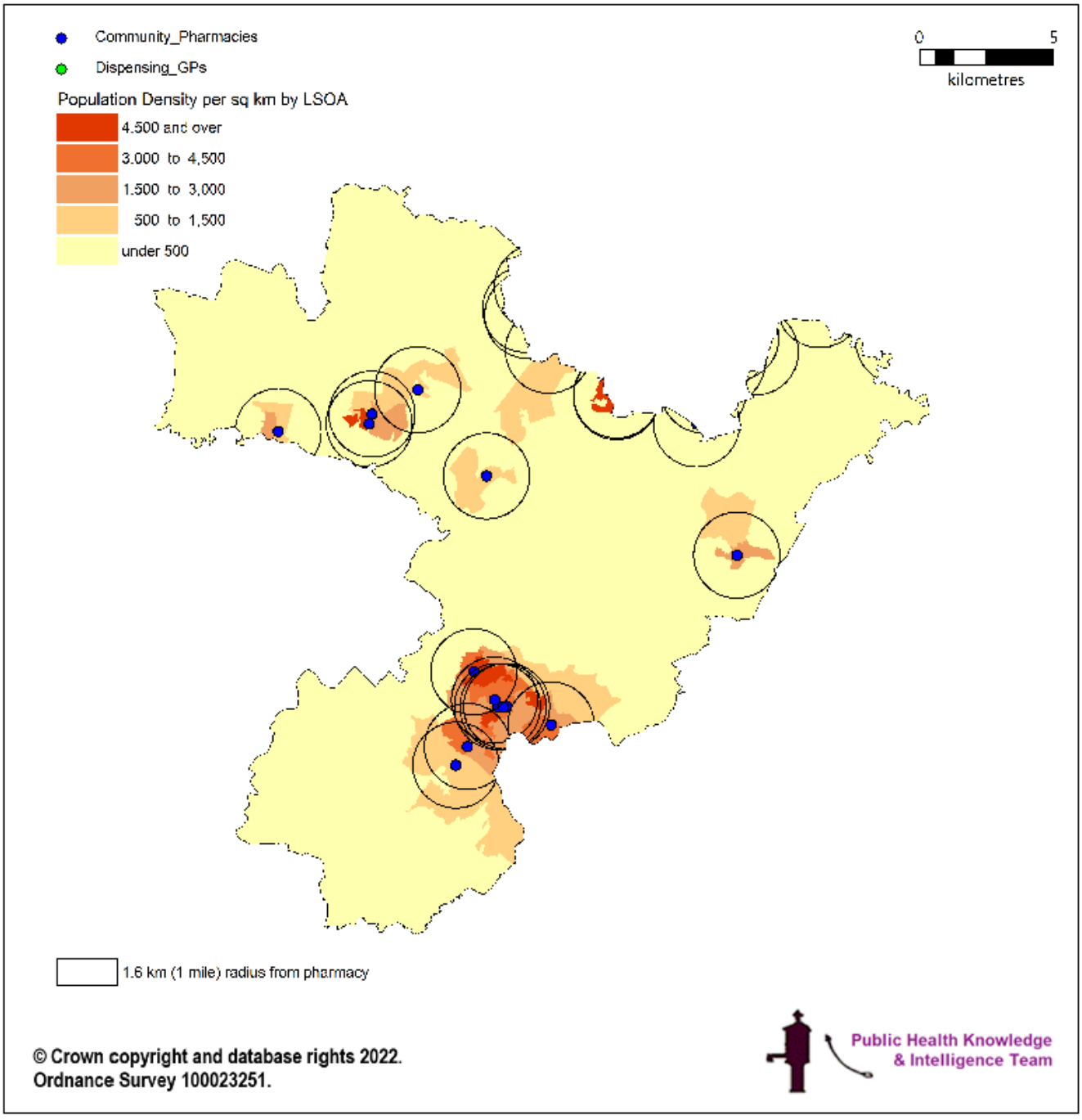
[28] 100-hour pharmacy provision has been included in individual Derby and District pharmaceutical services tables throughout this section. Whilst not a commissioned service, it was felt appropriate to reflect the number of pharmacies operating with 100-hour conditions as an indication of increased access and availability.

[29] Excluding Glossopdale

Accessibility

There are 13 pharmacies to every 100,000 population in South Derbyshire, compared to the national average of 21. There are two 100-hour pharmacies in the area (13% of the total). Figure 39 demonstrates that, considering the highly rural nature of much of the borough, much of the population will be within 1.6km (a 1 mile walk of approximately 20 mins) of a pharmacy or dispensing practice some of which may within the Derby City boundary.

Figure 39: Map of pharmaceutical service coverage in South Derbyshire



Strategic priorities and key health needs

Strategic priorities in South Derbyshire are:-

- Health inequalities between different communities are reduced
- People are supported to improve both their physical and mental wellbeing
- Older people, people with dementia and other long-term conditions and their carers have a good quality of life, retain their independence for as long as possible, and receive the support they need at the end of their lives
- Reducing social isolation and loneliness
- Supporting communities to respond to and recover from the impact of the Covid 19 pandemic

Key additional health needs include (but are not limited to), reducing excess weight in adults and children, reducing smoking during pregnancy, reducing inequalities in healthy life expectancy and increasing breastfeeding.

Future housing plans

South Derbyshire have an adopted local plan which sets a housing target of around 12,000 new homes between 2011 and 2028. Many of these will be on the edge of Derby so are included in the 7,000 urban extensions on the edge of Derby City, but they will also have several thousand new homes in South Derbyshire away from the city.

Statement of pharmaceutical need: South Derbyshire

This PNA found that the pharmaceutical need in the South Derbyshire area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

3 POPULATION HEALTH NEEDS

3.1 Population characteristics

The populations of Derby and Derbyshire were estimated as 256,814 and 807,183 people respectively in 2020 (Figure 40). Since 2012 the population has increased:

- Derby City population has grown by 6,232 people (2.5% increase over the decade)
- Derbyshire County population has grown by 33,457 people (4.3% increase over the decade)

Figure 40: ONS mid-2020 population estimates

	Derby	Derbyshire	East Midlands	UK
Males	127,639	396,425	2,407,678	33,145,709
Females	129,175	410,758	2,457,905	33,935,525
All people	256,814	807,183	4,865,583	67,081,234

3.1.1 Age

In Derby City, 160,852 (62.6%) of the population are aged 16-64 years, compared to Derbyshire where 493,210 (61.1%) of the population are in this age group.

- Derby City has a higher proportion of younger people (aged <40 years) than England
- One in every four residents of Derby is a child or young person (aged <18 years)
- Derbyshire County has a higher proportion of middle aged and older adults than national average.

Figure 41: Mid 2020 population pyramid for Derby with England comparison

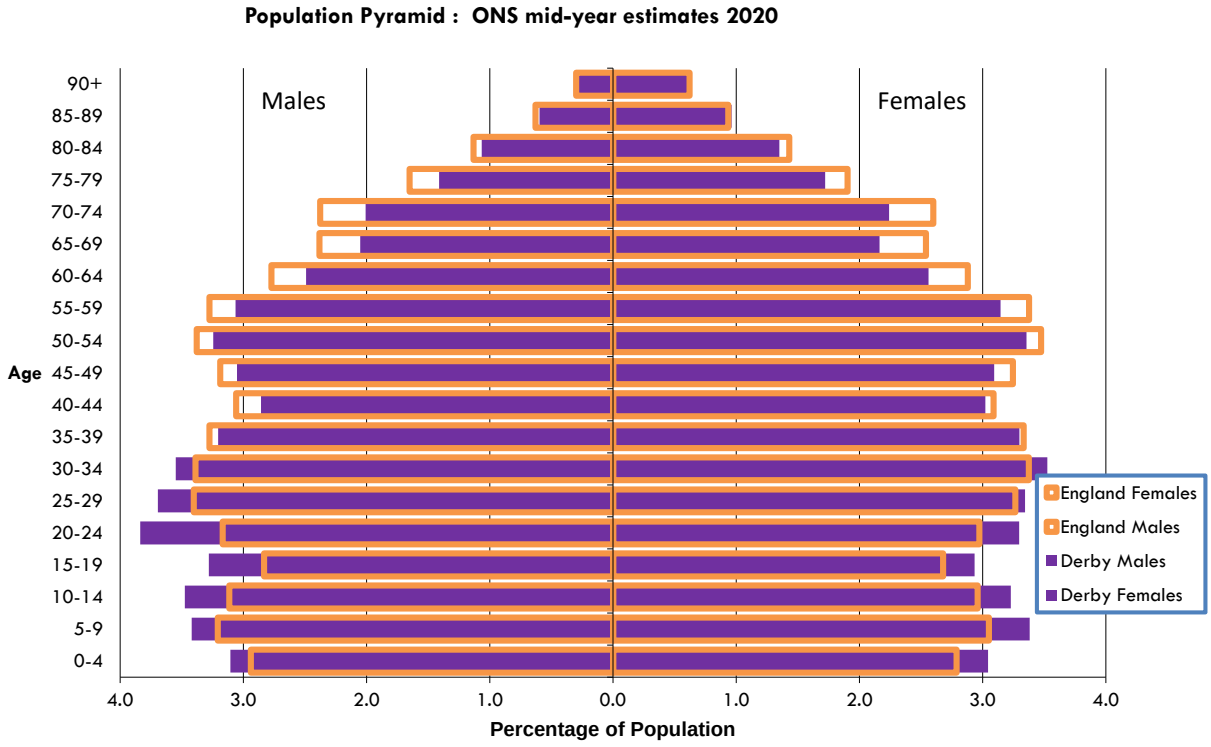
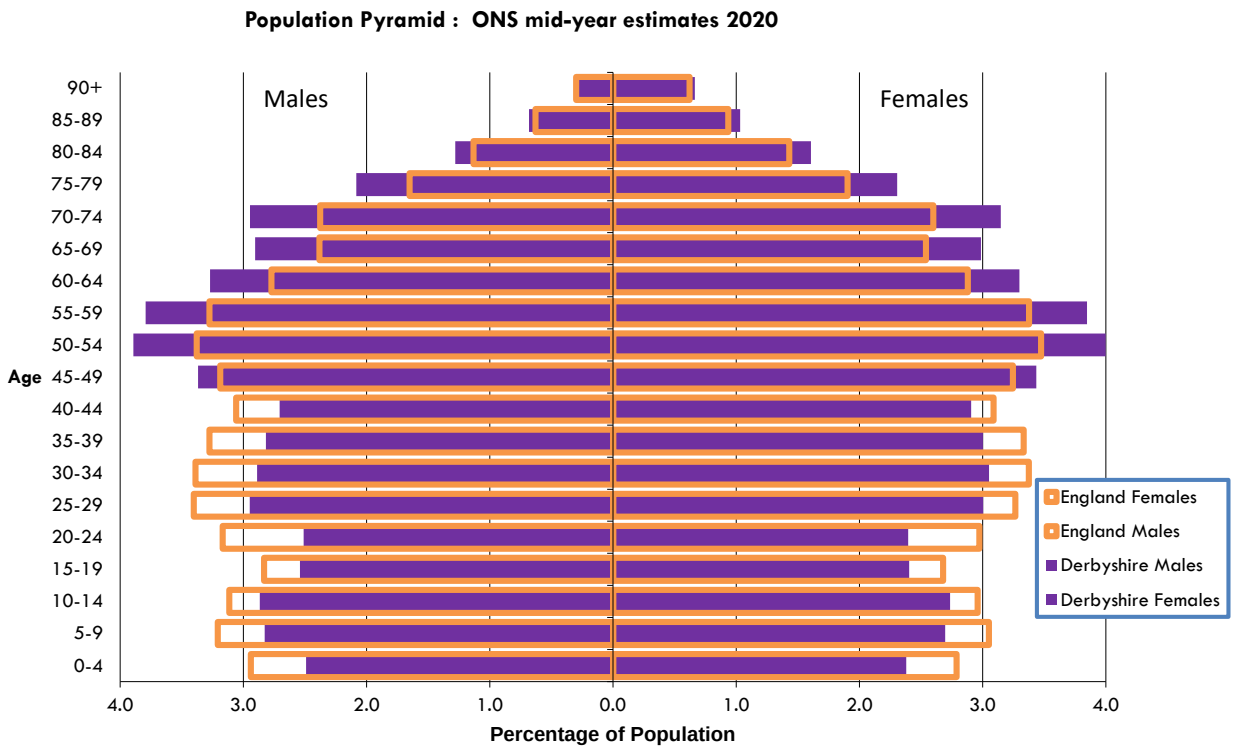


Figure 42: Mid 2020 population pyramid for Derbyshire with England comparison



Specifically, the population estimates by age groups (Figure 43) indicate high proportions of young people in Derby, Bolsover, Erewash and South Derbyshire and high proportions of older people living in Derbyshire Dales and North East Derbyshire.

Figure 43: ONS Mid-2020 population estimates for Derby City and Derbyshire districts

	Age Groups								
Local authority districts	**<18**		**18-39**		**40-64**		**65+**		**Total**
	N	%	N	%	N	%	N	%	N
Derby	59,691	23	78,013	30	76,749	30	42,361	16	256,814
Amber Valley	24,188	19	30,961	24	44,833	35	28,847	22	128,829
Bolsover	16,047	20	21,102	26	27,739	34	16,417	20	81,305
Chesterfield	19,874	19	27,010	26	35,535	34	22,511	21	104,930
Derbyshire Dales	12,261	17	13,909	19	26,326	36	19,926	28	72,422
Erewash	22,950	20	29,511	26	39,062	34	23,809	21	115,332
High Peak	17,596	19	22,146	24	32,918	36	19,973	22	92,633
North East Derbyshire	18,726	18	23,381	23	34,711	34	25,398	25	102,216
South Derbyshire	23,115	21	28,827	26	37,486	34	20,088	18	109,516

3.1.2 Census resident population

The census is taken every ten years and is an opportunity to capture a detailed snapshot of the population and various characteristics. The most recent census was conducted in 2021, however, the data is not yet available at the time of the PNA publication. The last available census data from 2011 provided a usual resident population by age groups for the Derby City wards (Figure 44 & Figure 45) and the Derbyshire Districts (Figure 46 & Figure 47), further demonstrating that a large number of people in younger age groups reside in Derby and a large number of middle-aged adults reside in Derbyshire.

Figure 44: The 2011 Census usual resident population by broad age band, Derby wards and England

	Age Bands					
Area Name	**0-4**	**5-15**	**16-24**	**25-64**	**65-84**	**85+**
Abbey	1,063	1,479	3,480	7,636	1,383	293
Allestree	624	1,664	1,120	6,520	3,201	493
Alvaston	1,332	1,936	2,160	8,651	1,852	324
Arboretum	1,761	2,535	3,150	9,536	1,394	214
Blagreaves	780	1,757	1,365	6,551	2,263	339
Boulton	917	2,009	1,672	6,902	2,083	293
Chaddesden	862	1,818	1,490	6,835	2,075	333
Chellaston	1,089	2,292	1,429	7,994	2,049	345
Darley	745	1,197	3,398	7,535	1,642	380
Derwent	1,271	2,110	1,768	7,020	1,717	216
Littleover	901	2,388	1,401	7,749	1,678	258
Mackworth	897	1,510	3,052	6,722	1,650	349
Mickleover	683	1,543	1,235	7,408	2,700	453
Normanton	1,798	2,888	2,332	8,224	1,520	309
Oakwood	907	1,774	1,448	7,517	1,459	154
Sinfin	1,443	2,618	1,971	7,592	1,326	178
Spondon	670	1,415	1,233	6,311	2,432	316
Derby	17,743	32,933	33,704	126,703	32,424	5,245
England	3,318,449	6,704,387	6,284,760	28,044,331	7,480,401	1,180,128

Figure 45: Percentage of 2011 Census resident population in broad age band, Derby wards and England

	Age Bands					
Area Name	**0-4 (%)**	**5-15 (%)**	**16-24 (%)**	**25-64 (%)**	**65-84 (%)**	**85+ (%)**
Abbey	6.9	9.6	22.7	49.8	9.0	1.9
Allestree	4.6	12.2	8.2	47.9	23.5	3.6
Alvaston	8.2	11.9	13.3	53.2	11.4	2.0
Arboretum	9.5	13.6	16.9	51.3	7.5	1.2
Blagreaves	6.0	13.5	10.5	50.2	17.3	2.6
Boulton	6.6	14.5	12.1	49.7	15.0	2.1
Chaddesden	6.4	13.6	11.1	51.0	15.5	2.5
Chellaston	7.2	15.1	9.4	52.6	13.5	2.3
Darley	5.0	8.0	22.8	50.6	11.0	2.6
Derwent	9.0	15.0	12.5	49.8	12.2	1.5
Littleover	6.3	16.6	9.7	53.9	11.7	1.8
Mackworth	6.3	10.6	21.5	47.4	11.6	2.5
Mickleover	4.9	11.0	8.8	52.8	19.3	3.2
Normanton	10.5	16.9	13.7	48.2	8.9	1.8
Oakwood	6.8	13.4	10.9	56.7	11.0	1.2
Sinfin	9.5	17.3	13.0	50.2	8.8	1.2
Spondon	5.4	11.4	10.0	51.0	19.6	2.6
Derby	7.1	13.2	13.5	50.9	13.0	2.1
England	6.3	12.6	11.9	52.9	14.1	2.2

- A comparatively large proportion of the population in the Derby wards of Normanton, Derwent, Arboretum and Sinfin are young children aged 0-4 years.
- The wards of Sinfin, Normanton and Littleover have a greater than national average proportion of children aged 5-15 years.
- One-in-five people in the wards Darley, Abbey and Mackworth are aged 16-24 years. These wards are located together and share the location of the University of Derby.
- The ward with the highest proportion of the population of working age (25-64 years) is Oakwood.
- Allestree, Spondon, and Mickleover have the greatest proportion of resident older adults (65+ years).

Figure 46: The 2011 Census usual resident population by broad age band, Derbyshire districts and England

	Age Bands					
Area Name	**0-4**	**5-15**	**16-24**	**25-64**	**65-84**	**85+**
Amber Valley	6,404	15,064	12,063	65,999	19,728	3,051
Bolsover	4,275	9,399	7,988	40,420	12,042	1,742
Chesterfield	5,778	12,415	10,958	55,346	16,513	2,778
Derbyshire Dales	3,077	8,740	6,152	37,320	13,640	2,187
Erewash	6,527	13,606	12,259	59,693	17,361	2,635
High Peak	4,961	11,515	9,677	49,070	13,701	1,968
North East Derbyshire	4,799	11,525	9,730	52,051	18,386	2,532
South Derbyshire	5,724	12,977	9,461	51,822	12,893	1,734
Derbyshire	41,545	95,241	78,288	411,721	124,264	18,627
England	3,318,449	6,704,387	6,284,760	28,044,331	7,480,401	1,180,128

Figure 47: Percentage of 2011 Census resident population in broad age band, Derbyshire districts and England

	Age Bands					
Area Name	**0-4 (%)**	**5-15 (%)**	**16-24 (%)**	**25-64 (%)**	**65-84 (%)**	**85+ (%)**
Amber Valley	5.2	12.3	9.9	54.0	16.1	2.5
Bolsover	5.6	12.4	10.5	53.3	15.9	2.3
Chesterfield	5.6	12.0	10.6	53.3	15.9	2.7
Derbyshire Dales	4.3	12.3	8.7	52.5	19.2	3.1
Erewash	5.8	12.1	10.9	53.3	15.5	2.4
High Peak	5.5	12.7	10.6	54.0	15.1	2.2
North East Derbyshire	4.8	11.6	9.8	52.6	18.6	2.6
South Derbyshire	6.1	13.7	10.0	54.8	13.6	1.8
Derbyshire	5.4	12.4	10.2	53.5	16.1	2.4
England	6.3	12.6	11.9	52.9	14.1	2.2

- There are fewer young children proportionally in all the Derbyshire districts (range: 4.3% to 6.1%) than the England average (6.3%).
- The percentage of school aged children in all the districts is similar to England.
- All districts have fewer young adults aged 16-24 years, than England (11.9%).
- The highest proportion of working aged adult population is found in the South Derbyshire district (54.8%).
- The majority of the districts have higher than national average proportions of older adult populations. In particular, the Derbyshire Dales and North East Derbyshire districts have 22.3% and 21.2% of adults aged 65+ comprising the resident population.

3.1.3 Predicted population growth

Continued growth in overall population across England is expected but increases will be unequal, with London, East of England and the South East regions experiencing rapid growth (4.9%, 5.0% and 4.4% respectively) and the North East the slowest (2.3%) over the ten year period of mid-2018 and mid-2028. The population projections are predicted to vary more widely across the local authorities, with Barrow-in-Furness in North West England preparing for a fall in population by 3.3% and Tower Hamlets within London region preparing for vast growth of 16%.

The population of Derby is projected to rise by:

- 6,244 between 2018 and 2028 (approximately 2.4% rise)
- 10,848 between 2018 and 2043 (approximately 4.1% rise)

The population of Derbyshire is projected to rise by:

- 45,646 between 2018 and 2028 (approximately 5.7% rise)
- 54,328.3 between 2018 and 2043 (approximately 6.5% rise)

The following population pyramids below show the population growth in Derby City and Derbyshire districts for the next 10 and 25 years.

Figure 48: Population projection pyramid for Derby 2028

Figure 49: Population projection pyramid for Derby 2043

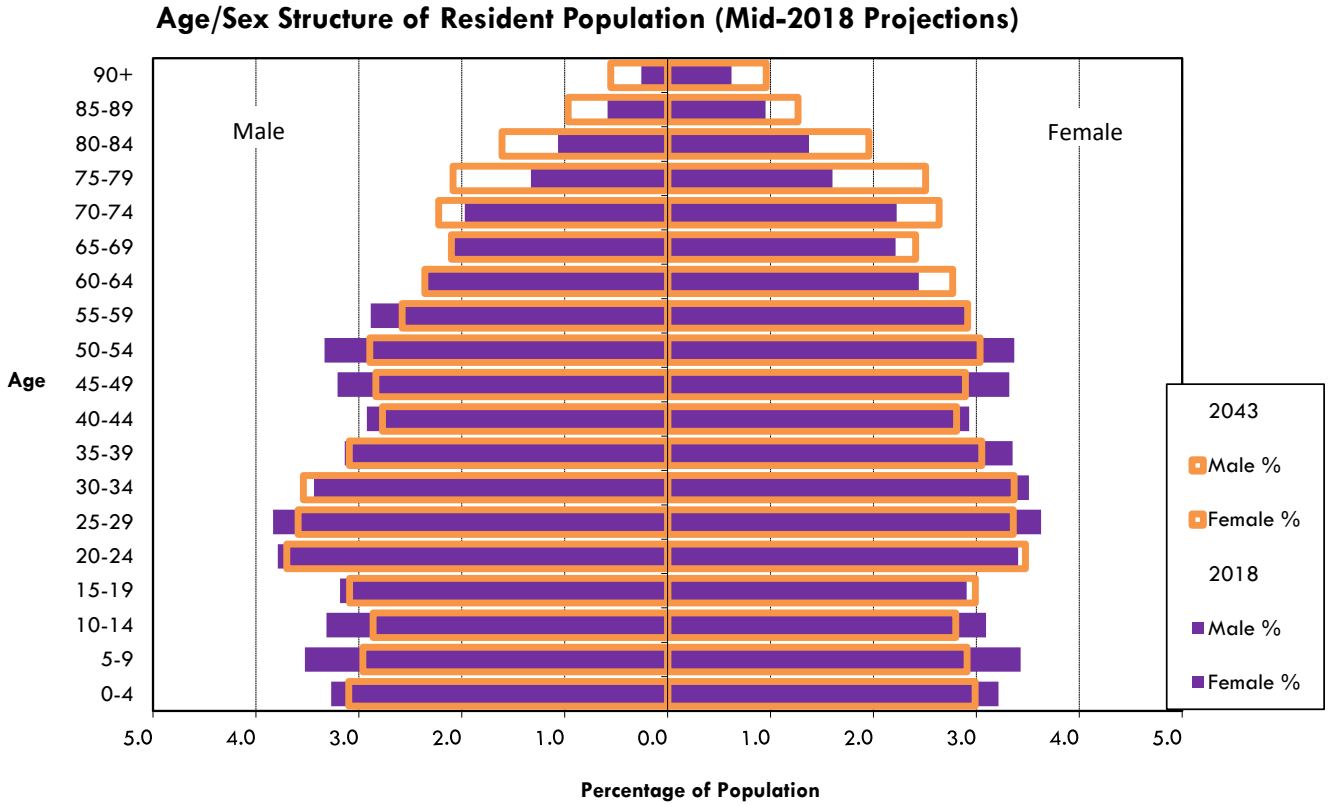


Figure 50: Population projection pyramid for Amber Valley 2028

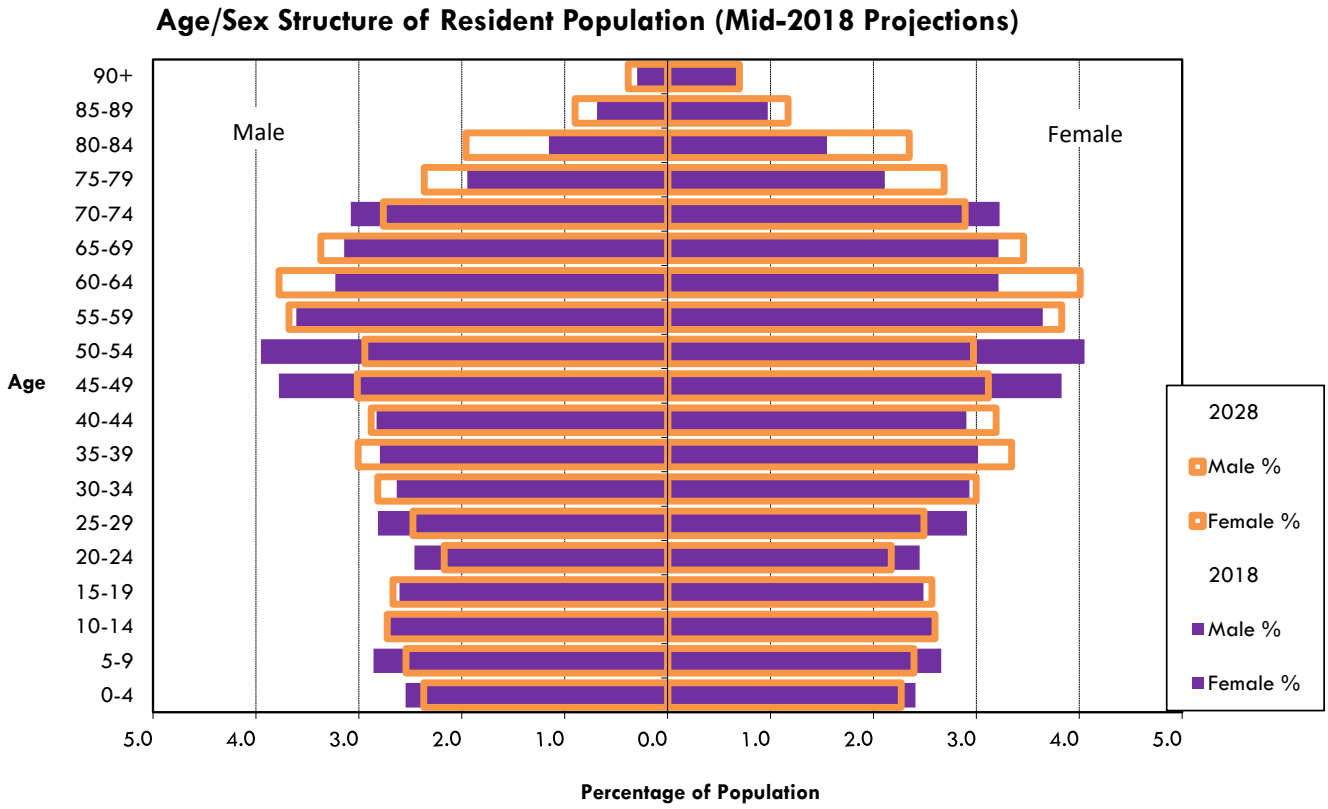


Figure 51: Population projection pyramid for Amber Valley 2043

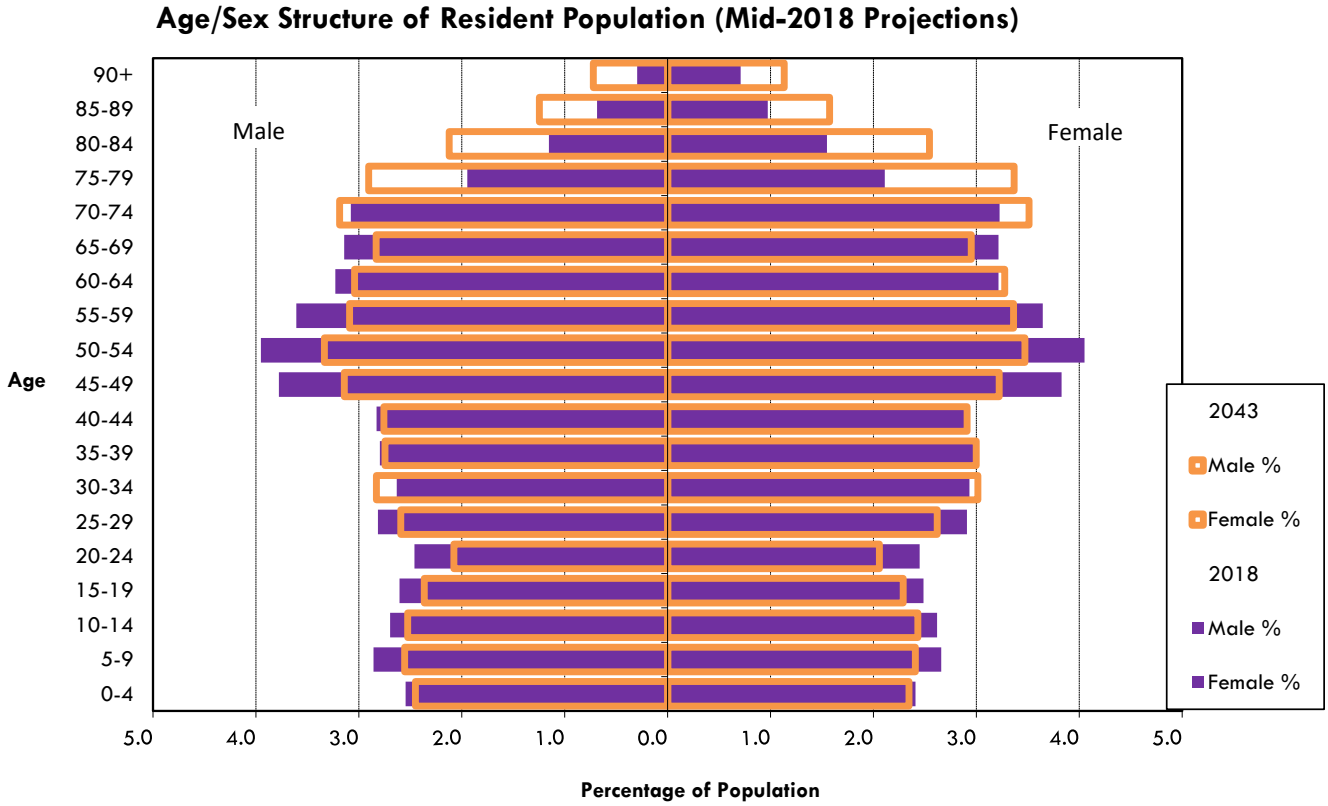


Figure 52: Population projection pyramid for Bolsover 2028

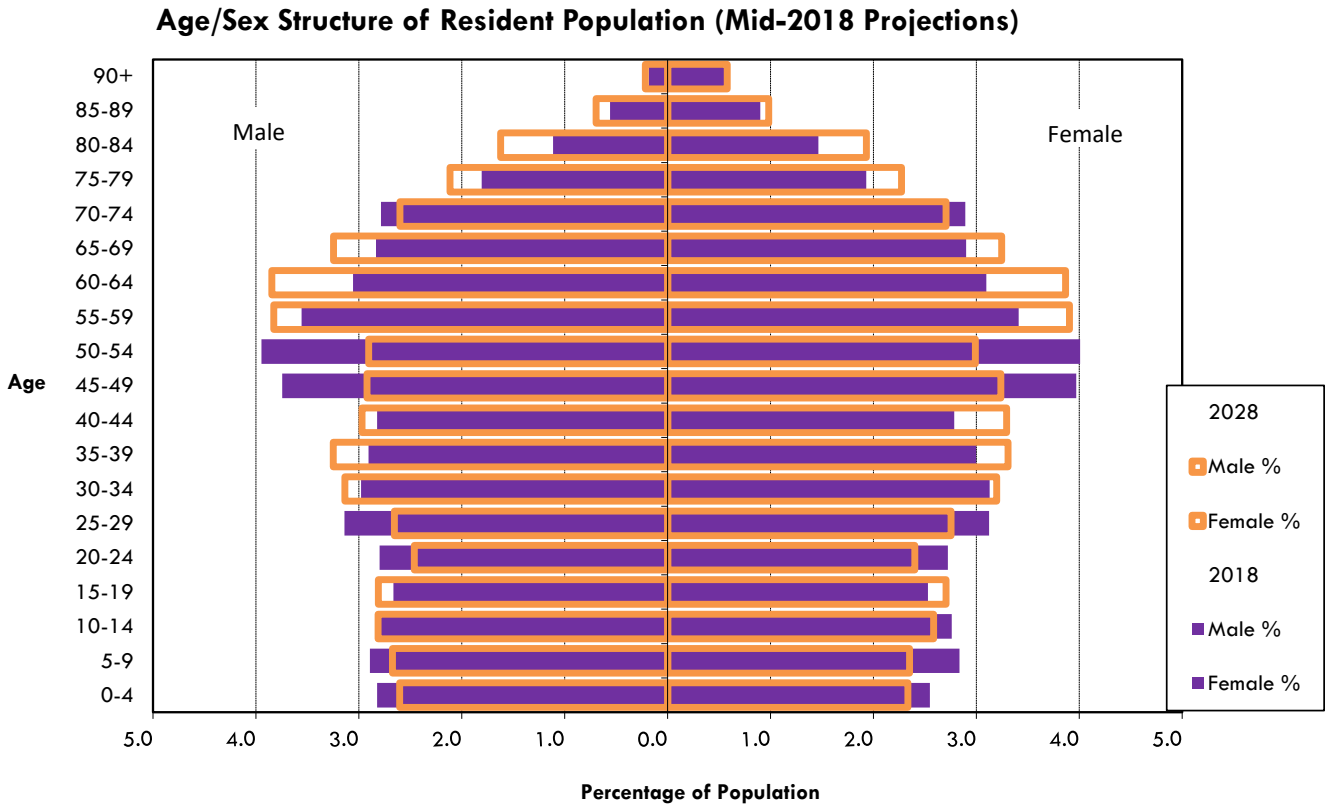


Figure 53: Population projection pyramid for Bolsover 2043

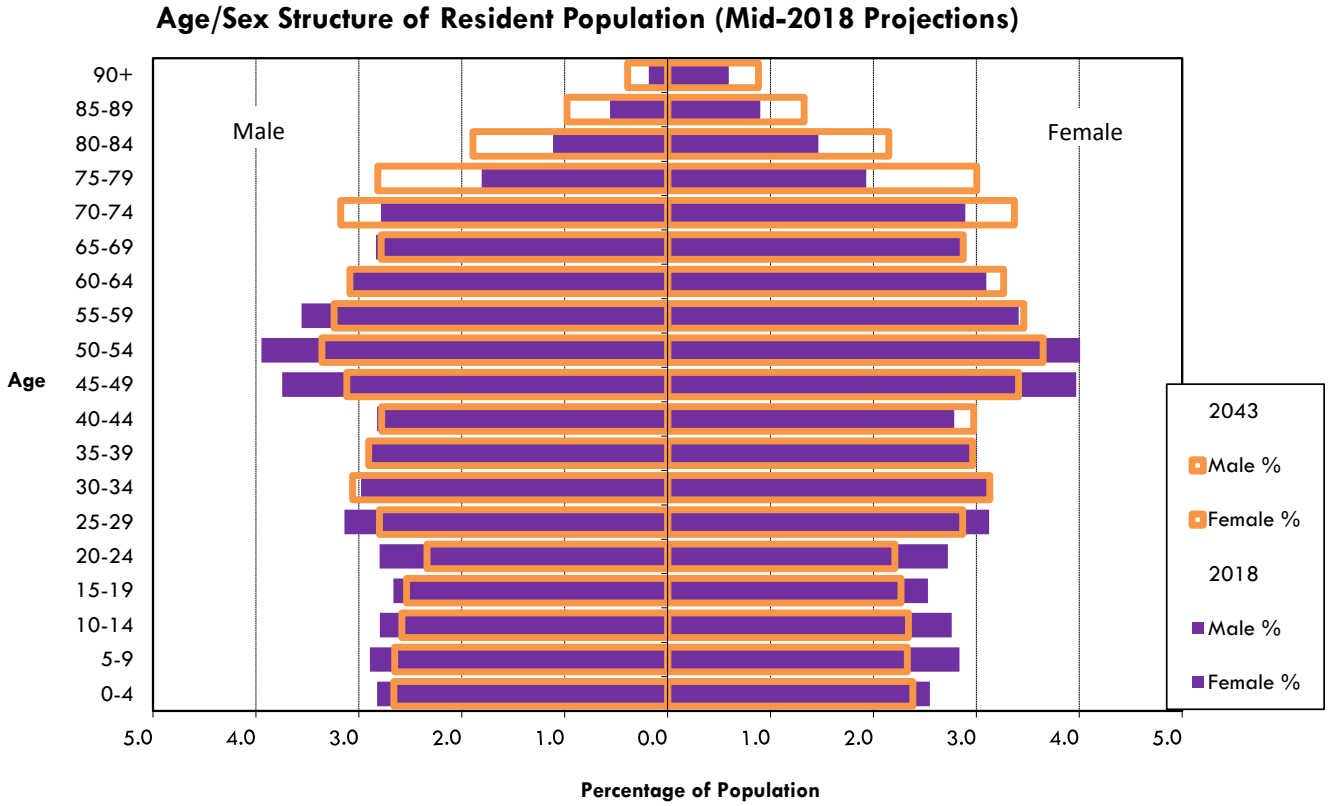


Figure 54: Population projection pyramid for Chesterfield 2028

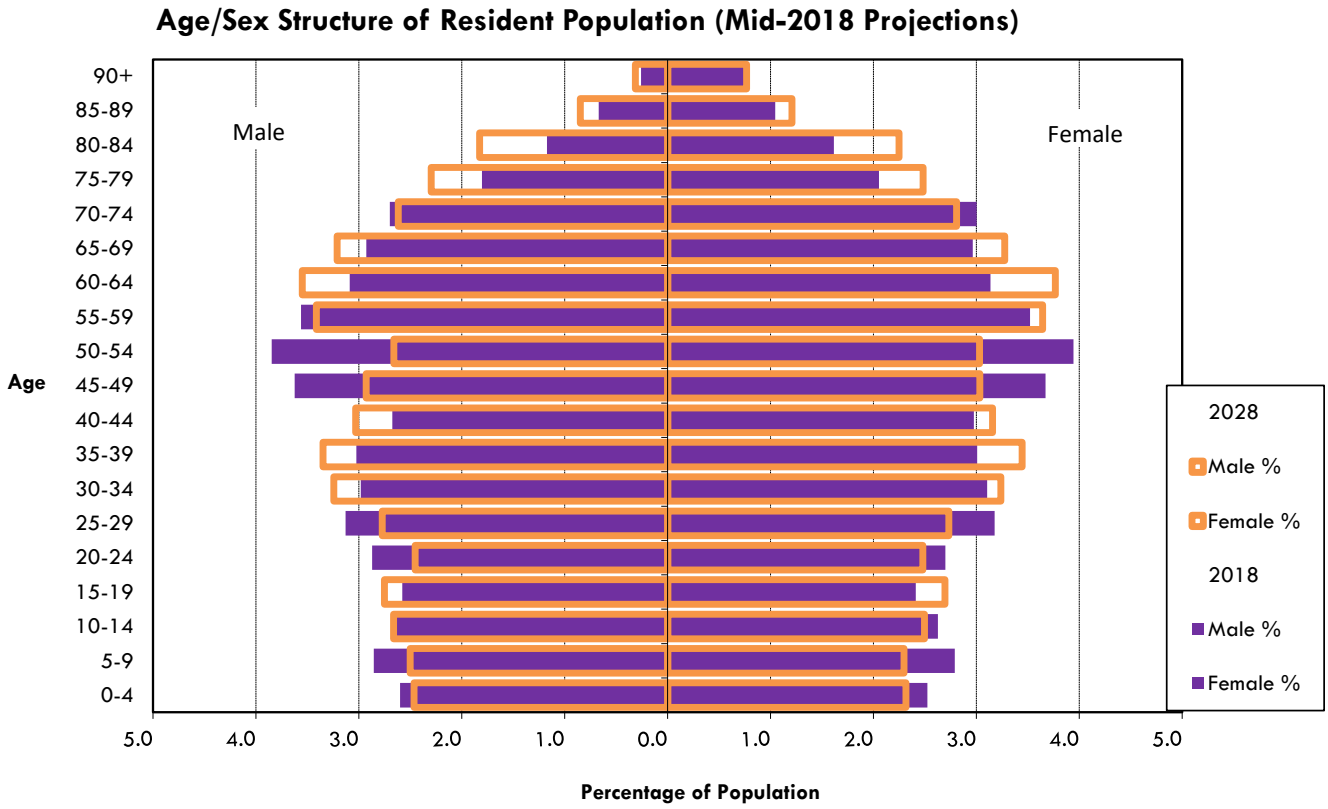


Figure 55: Population projection pyramid for Chesterfield 2043

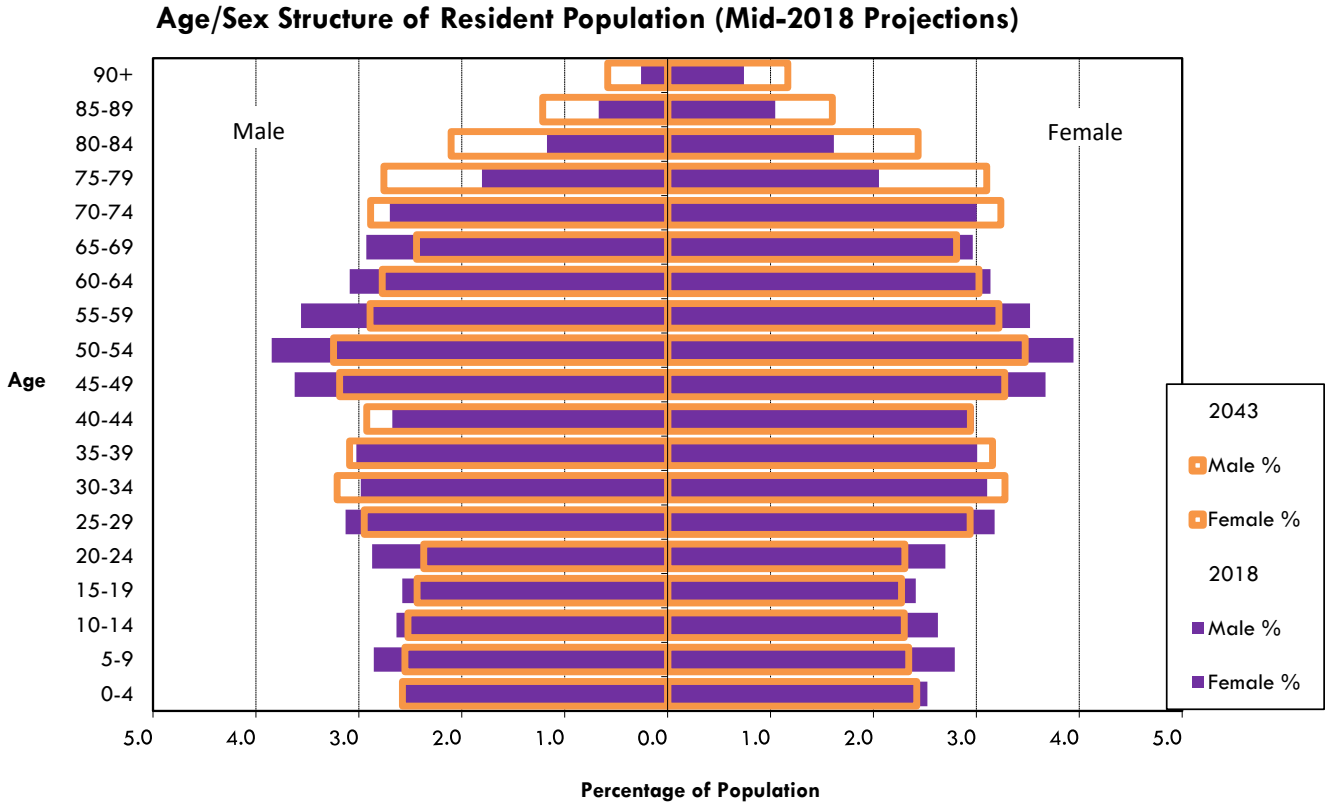


Figure 56: Population projection pyramid for Derbyshire Dales 2028

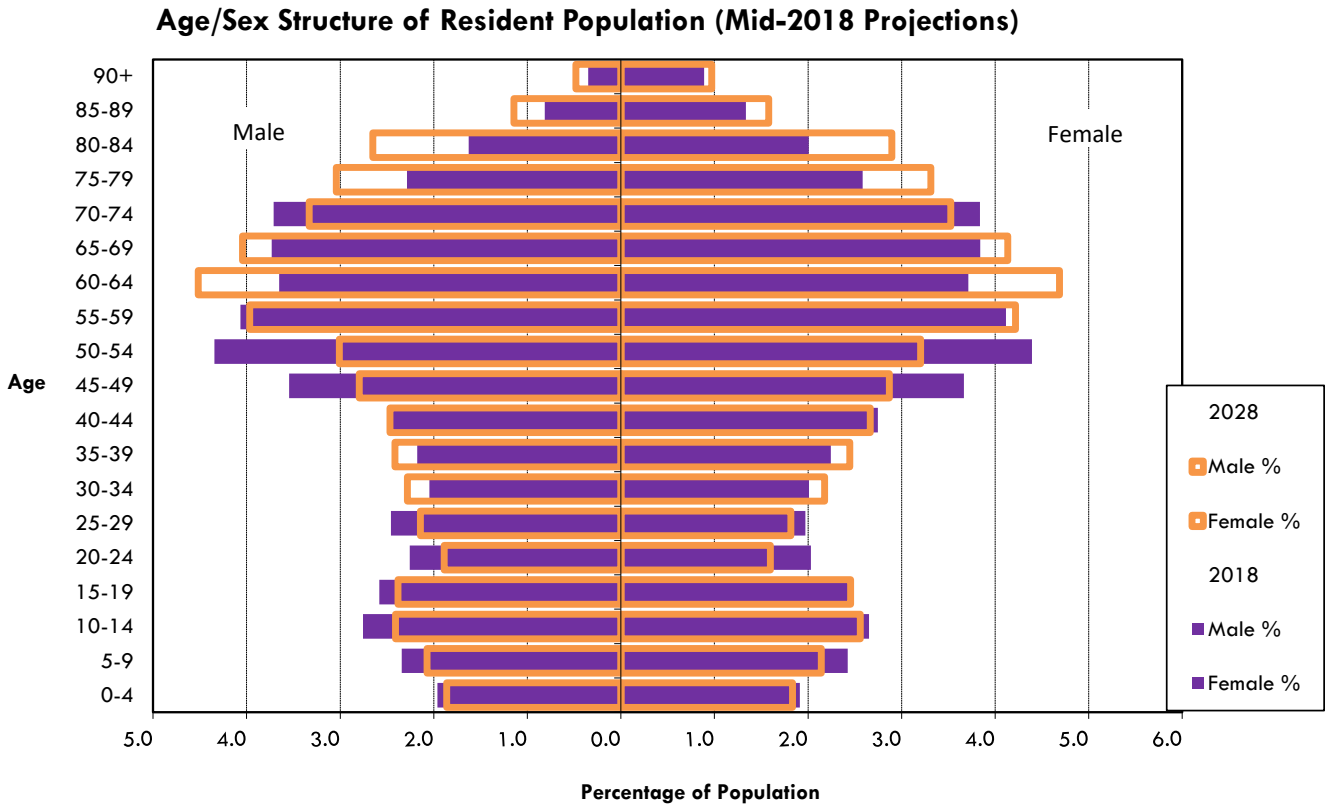


Figure 57: Population projection pyramid for Derbyshire Dales 2043

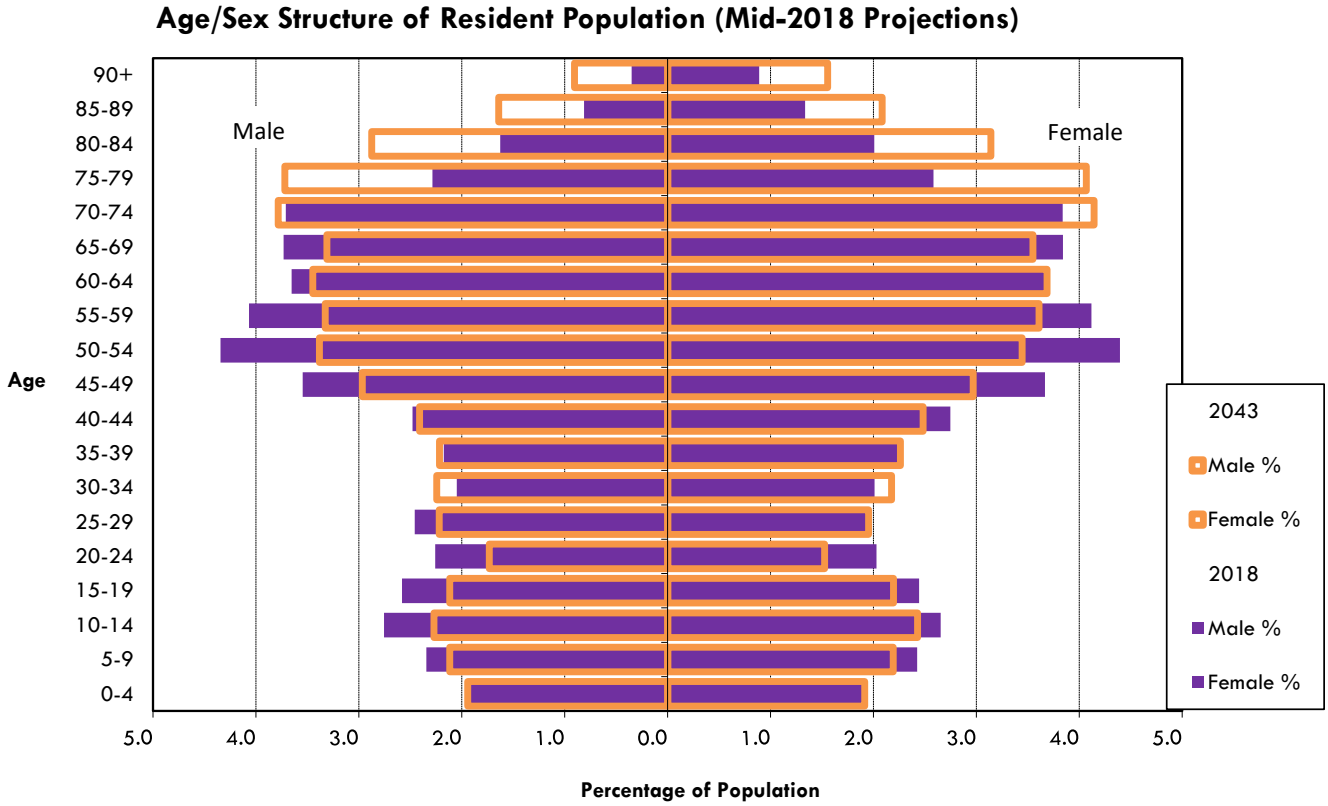


Figure 58: Population projection pyramid for Erewash 2028

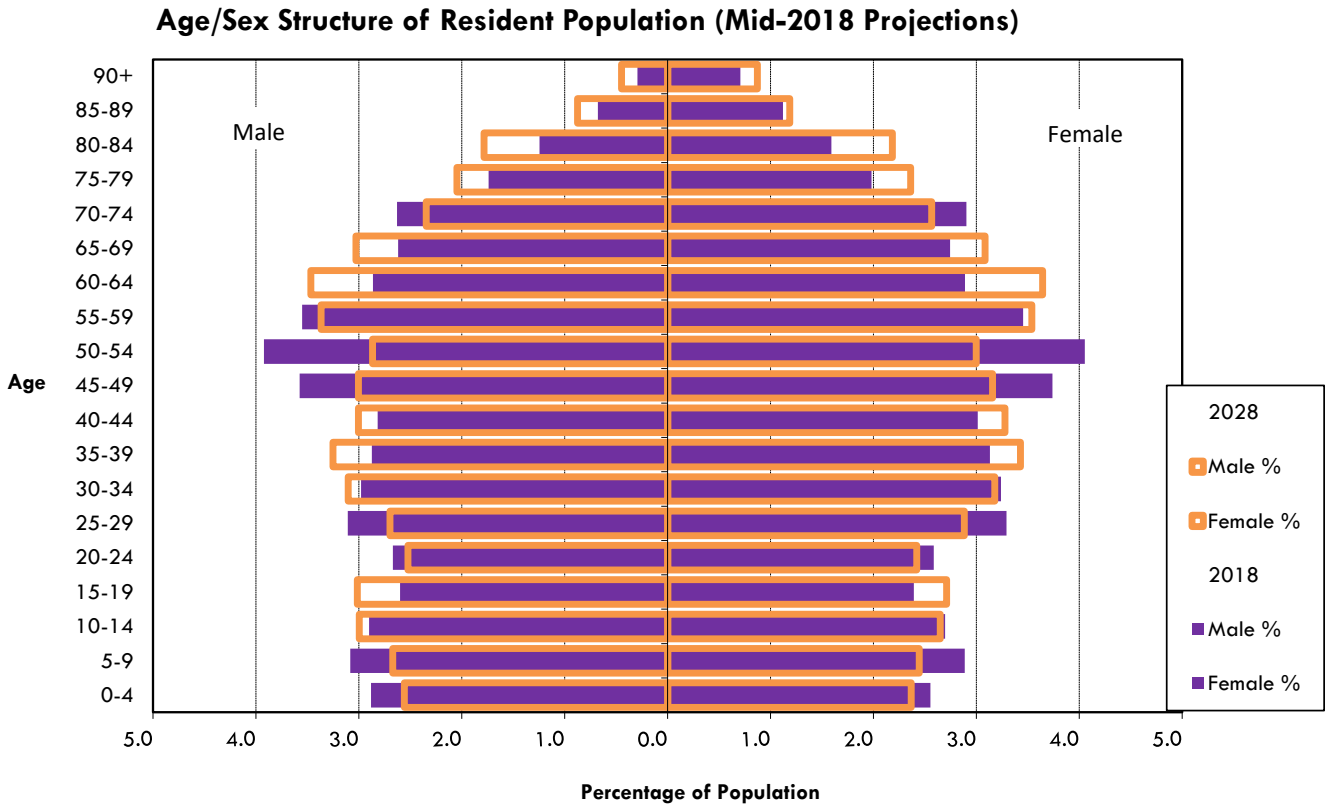


Figure 59: Population projection pyramid for Erewash 2043

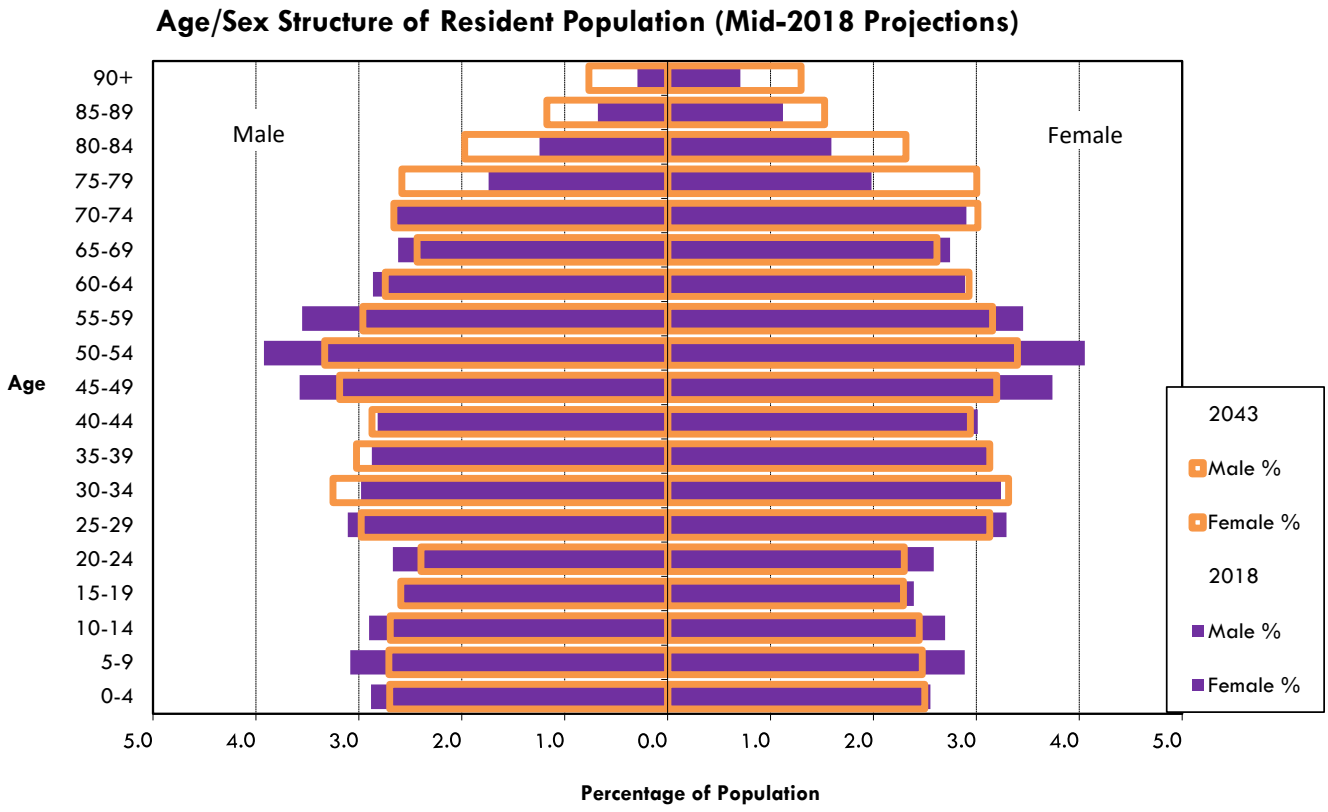


Figure 60: Population projection pyramid for High Peak 2028

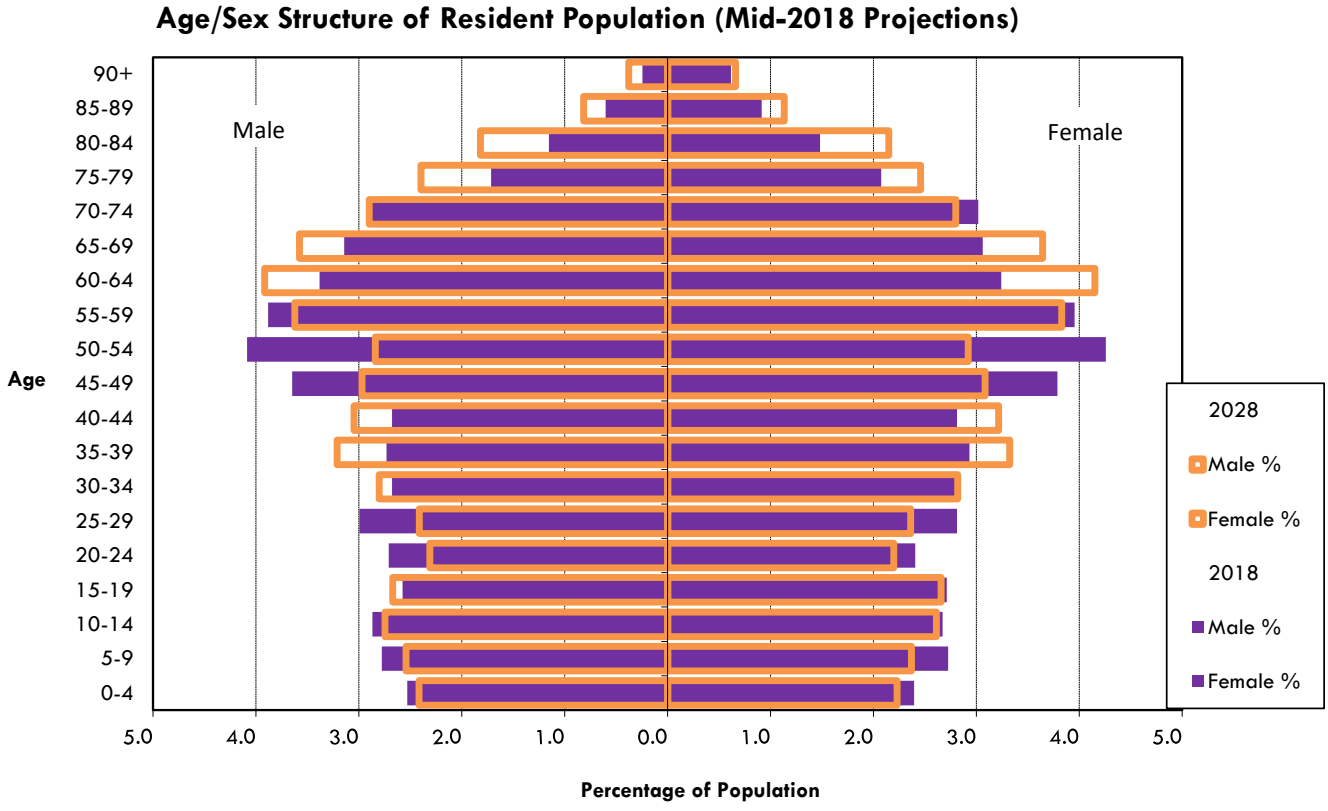


Figure 61: Population projection pyramid for High Peak 2043

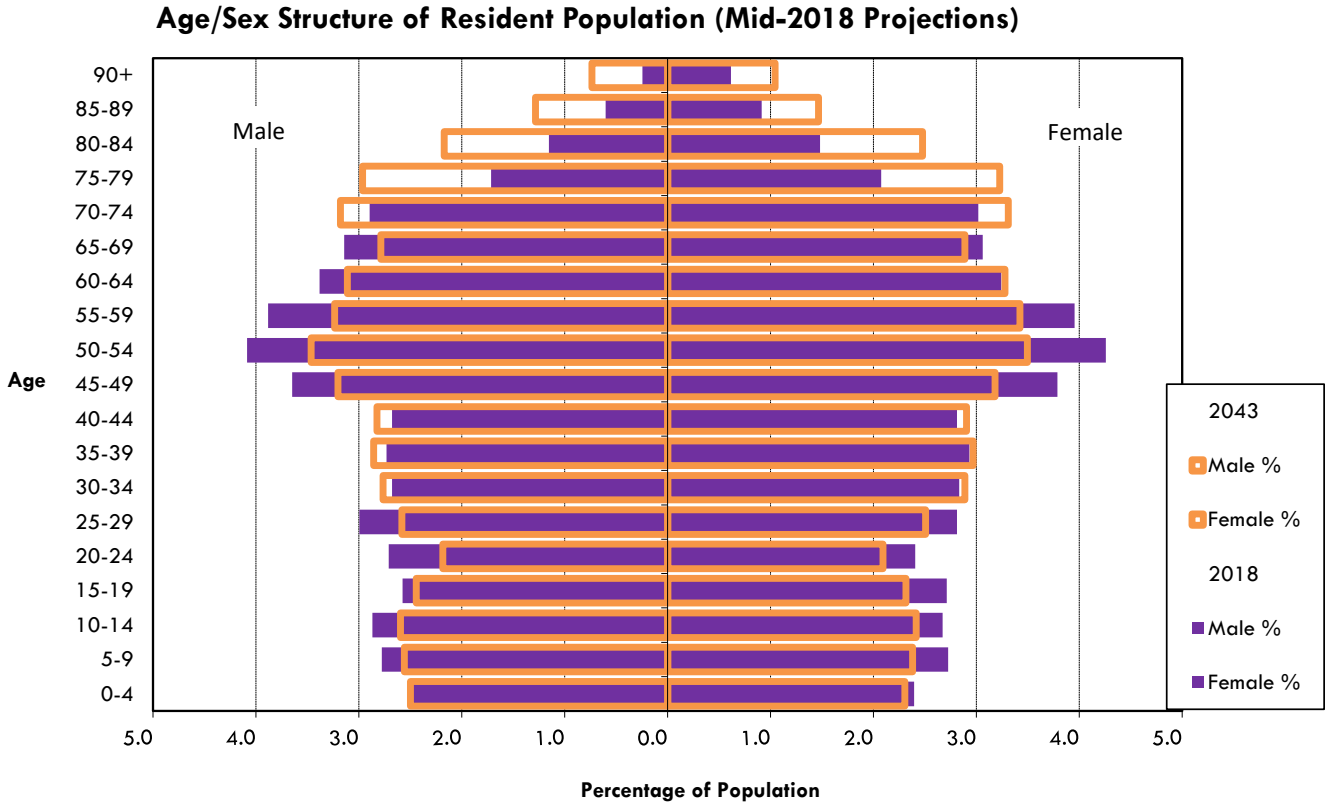


Figure 62: Population projection pyramid for North East Derbyshire 2028

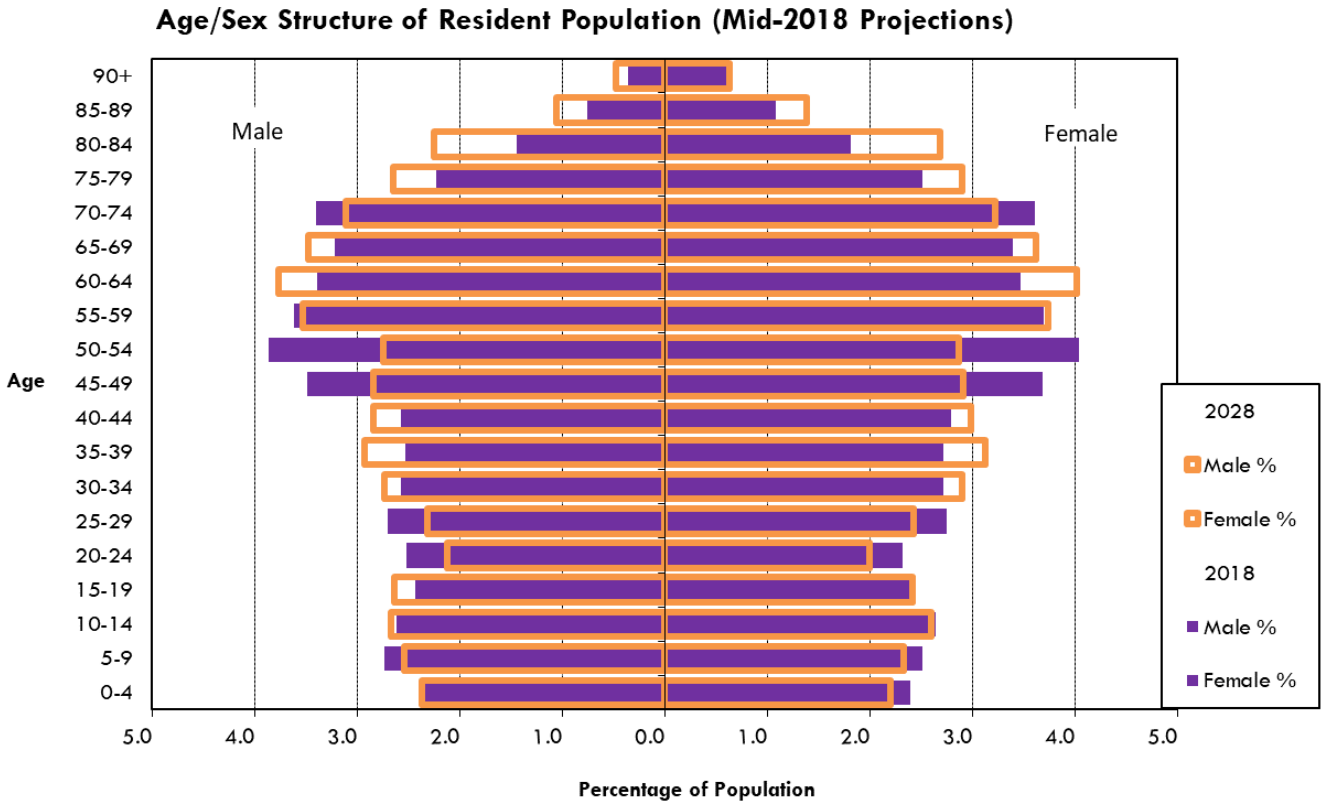


Figure 63: Population projection pyramid for North East Derbyshire 2043

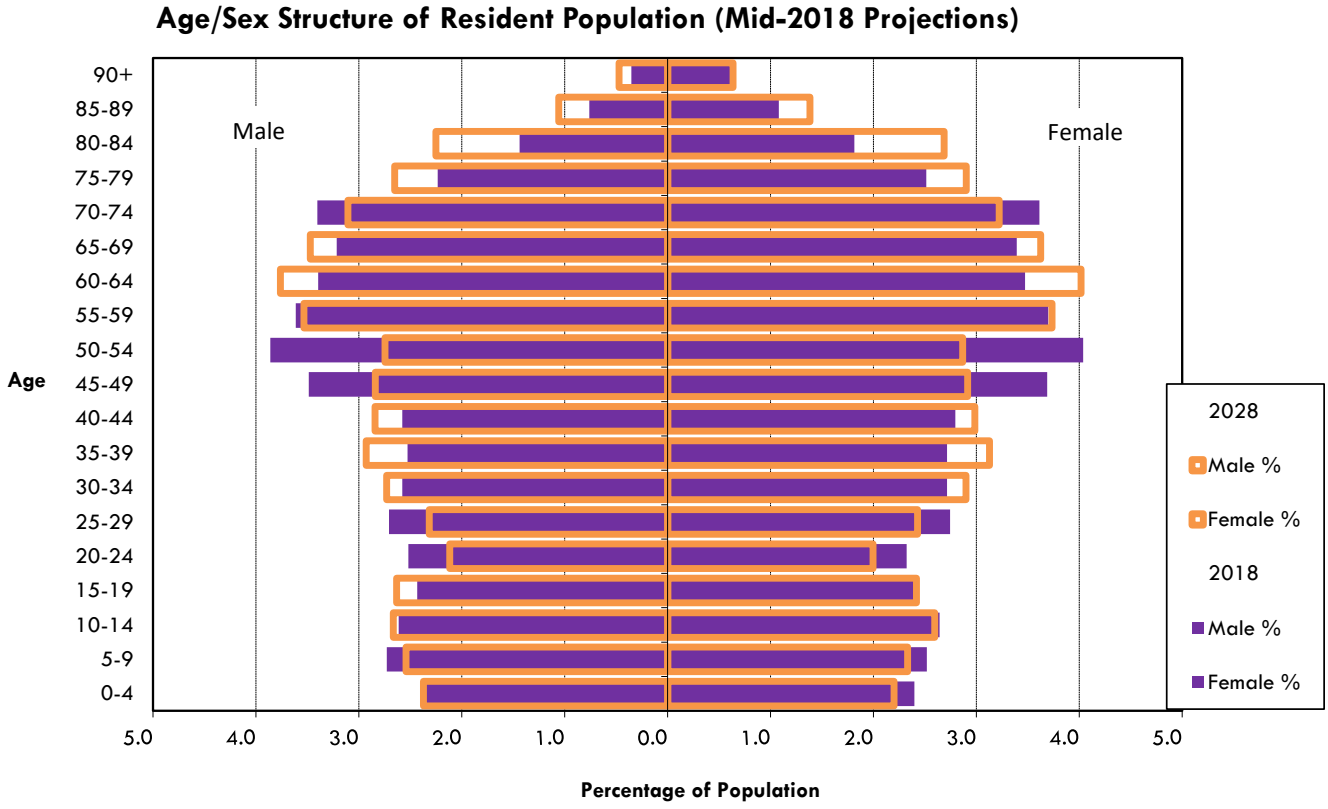


Figure 64: Population projection pyramid for South Derbyshire 2028

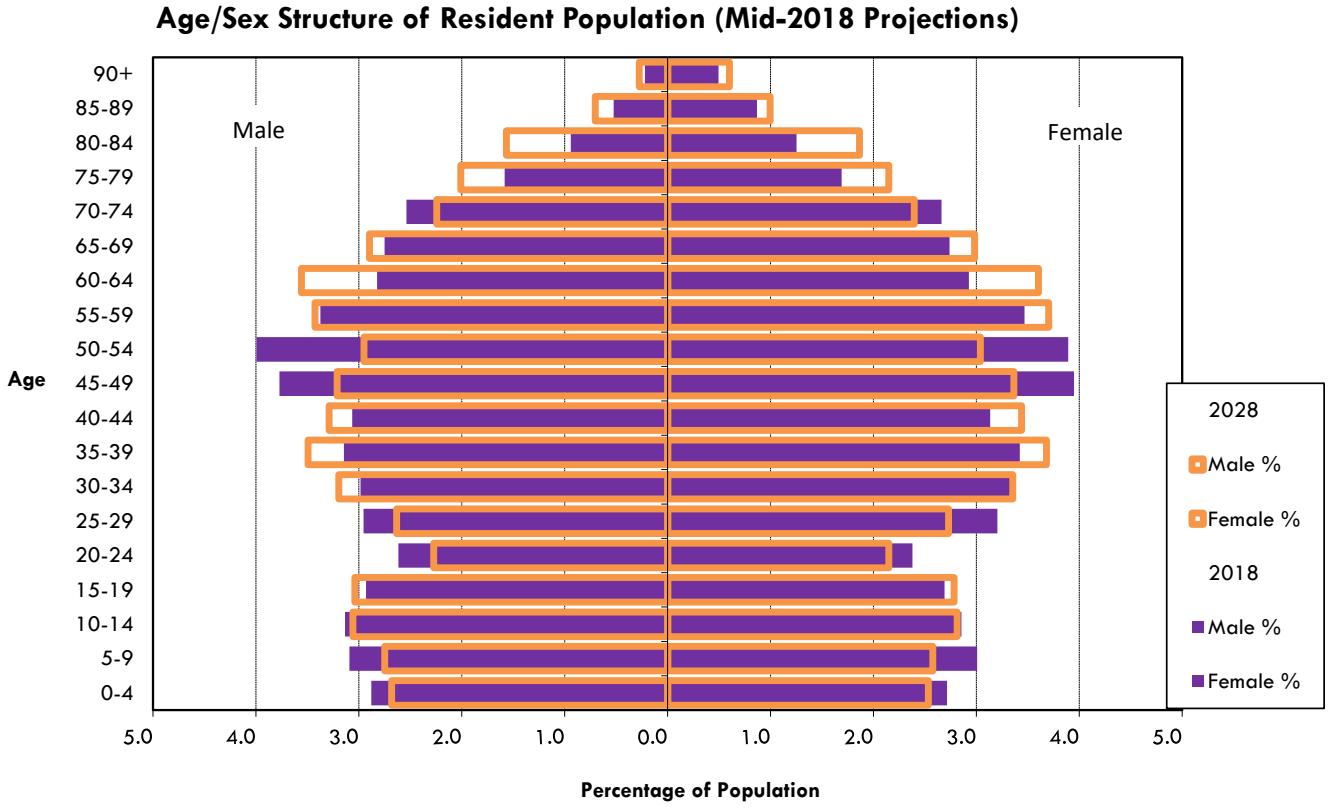
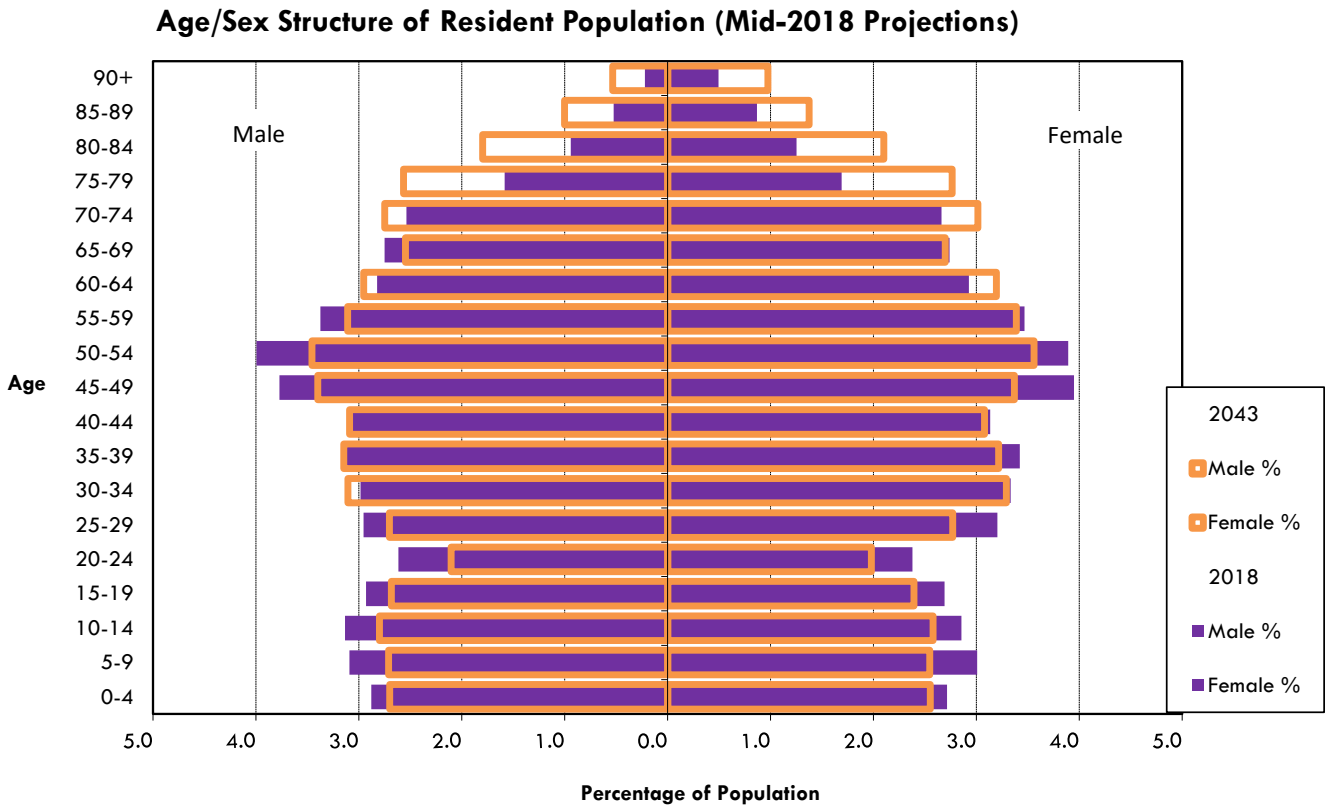


Figure 65: Population projection pyramid for South Derbyshire 2043



3.1.4 Housing developments

Derby

The City Council has set a target for a minimum of 11,000 new homes to be provided in the city between 2011 and 2028. The city's housing needs were identified as over 16,000 new homes between 2011 and 2028. About 5,000 however, of these will be built in Amber Valley and South Derbyshire mainly as urban extensions to the city to ensure that the city's needs are met in sustainable locations. There are expected to be in excess of 7,000 new homes built on the edge of Derby but outside its administrative area by 2028. Provision for health facilities will be determined through discussions with the relevant commissioning organisations. In Derby about 3,000 new homes have already been built between 2011 and 2017. This leaves about 8,000 more dwellings to be provided by 2028 to ensure that the minimum target of 11,000 is met. The housing trajectory indicates that over 3,500 new homes will have been built between 2014 and 2019 in the city. The annual delivery of new homes is expected to rise to over 1,000 a year in coming years. The Derby City 2017-2020 major housing trajectory detail is included in Appendix 1.

Derbyshire districts

The 2018-2020 housing development proposals in Derbyshire are outlined by each district in Appendix 2.

Amber Valley

The emerging Local Plan for Amber Valley estimates that around 9,000 dwellings will be built by 2028, some of which will contribute to the 7,000 homes being built as urban extensions to the edge of Derby. The other six largest sites (of over 300 units) will be in Alfreton, Heanor, Ripley, and North of Derby.

Bolsover

The Bolsover Local Plan Consultation Draft (BLPCD) was published for consultation in October 2016, which included a housing target for the district of 3,600 dwellings during the period of 2018 to 2033. Four strategic

growth sites are identified in the BLPCD at Bolsover North (900 dwellings), Clowne Garden Village (1,100 dwellings), the former Whitwell Colliery (200 dwellings) and former Coalite Chemical Works (600 dwellings).

Chesterfield
Chesterfield Borough Council published the Chesterfield Borough Local Plan Consultation Draft in January 2017, with emphasis on concentrating new development within walking distance of the Borough's town, district and local centres and focusing on areas that are in need of regeneration. The Local Plan proposed a new housing requirement for the Borough of 4,269 dwellings (272 per annum) over the period 2016 to 2033. 69 potential housing allocation sites were identified with an overall capacity to accommodate 3,980 houses, together with four reserve sites at Dunston and Upper Newbold, which could accommodate 952 houses. Five Regeneration Priority Areas are Pharmaceutical Needs Assessment 2018-2021 Derby City & Derbyshire County Page 76 identified which could accommodate 3,932 houses. In total, these three potential sources of housing land supply could accommodate 8,863 new homes.

Derbyshire Dales
The Derbyshire Dales Local Housing Plan was submitted to the Secretary of State in December 2016 and was subject to an Examination in Public between 9 May and 23 May 2017. The plan sets out an overall housing requirement for 6,440 dwellings over the period 2013 to 2033, with the main focus for housing growth being on the three main market towns of Ashbourne, Matlock and Wirksworth. The Plan identifies 28 housing site allocations, the main ones of which are at Ashbourne Airfield: 1,100 dwellings; Middle Peak Quarry, Wirksworth: 645 dwellings; Gritstone Road, Matlock: 430 dwellings; and Halldale Quarry: 220 dwellings.

Erewash
The 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.

High Peak
The High Peak Local Housing Plan was adopted on 14 April 2016. The plan sets out a housing requirement for 7,000 new dwellings (350 per annum) over the period 2011 – 2031, with growth distributed across three Sub-Areas as follows: Glossop dale 958 – 1,242 dwellings; Central Area: 1,065 – 1,171 dwellings; and Buxton 1,136 – 1,526 dwellings.

North East Derbyshire
The North East Derbyshire Local Plan Consultation Draft (LPCD) was published in February 2017. In this district the target is to build 6,600 homes by 2031. The largest sites are expected to be The Avenue, Wingerworth (up to 1,100 homes) Biwater, Clay Cross (up to 1,000 homes), Dronfield, Eckington, Killamarsh and Coalite near Bolsover.

South Derbyshire
South Derbyshire have an adopted Local Plan which sets a housing target of around 12,000 new homes between 2011 and 2028. Many of these will be on the edge of Derby so are included in the 7,000 urban extensions on the edge of Derby city, but they will also have several thousand new homes in South Derbyshire away from the city.

Residential care housing
A number of proposed residential care schemes in Derbyshire, that are either subject to planning applications or have gained planning approval in the last three years, are detailed in Appendix 3.

Student accommodation
Student accommodation has recently been built in Derby and additional student housing has either been granted planning permission for developments (Babington Lane; Cathedral Road) or is under construction for anticipated completion next year (Agard Street).

3.1.5 Locality Overview Charts

Spine charts provide the means to view several indicators at a glance on one page, and at a snapshot in time. Normally, spine charts demonstrate how one area compares with others across a range of measures. The England average is provided as a benchmark, along with the England range (best and worst) and the interquartile range (grey shading) for all Local Authorities. In this instance, both Derby and Derbyshire, and the eight District areas are presented to highlight inequalities within the Derbyshire STP area more clearly. The 'LA Value' is colour coded to indicate if the value for the area is significantly different from the England average. Some indicators are coloured to denote statistical significance (Red, Amber, Green) while others, where it was not appropriate to apply a scale of 'better' or 'worse', are colour coded by lower/higher values (Dark Blue, Amber, Light Blue).

Key points:

- Both Derby and Derbyshire have significantly higher rates of smoking during pregnancy than the England average
- Both Derby and Derbyshire have significantly lower rates of breastfeeding initiation.
- Derby has a significantly higher infant mortality rate than the England average
- Both Derby and Derbyshire have significantly higher premature birth rates
- Derby also has a significantly higher teenage conception rate
- Derby has a significantly higher rate of alcohol-specific hospital admissions for the population as a whole, whereas in Derbyshire the rate is significantly greater in young people
- Both Derby and Derbyshire have significantly lower rates of Chlamydia screening
- Derby has a significantly lower rate of MMR vaccination
- Both Derby and Derbyshire have a significantly lower rate of HPV vaccination
- Derbyshire has a significantly greater prevalence of excess weight in adults and in Reception age children, while in Derby it is significantly greater in Year 6 children
- Both Derby and Derbyshire have significantly higher rates of emergency hospital admissions for intentional self-harm than the England average
- Incidence of TB is significantly higher in Derby
- Derby has a significantly higher smoking attributable mortality rate than the England average
- Premature (U75) mortality rates from cancer, cardiovascular diseases and respiratory diseases are all significantly higher for Derby.
- Life expectancy at birth for both males and females is significantly lower in both Derby and Derbyshire

Figure 66: Derby and Derbyshire Health Profile 1

Key: Derby City; Derbyshire County

'Value' comparison with national average: Lower; Similar; Higher; Not compared

Better; Similar; Worse

Worse than 25th percentile | England Average | Better than 75th percentile

Domain		Indicator	LA Number Derby	LA Number Derbyshire	LA Value Derby	LA Value Derbyshire	England Ave.	Eng lowest/ worst	LA Variation England Range	Eng highest/ best
Our communities	1	Index of Multiple Deprivation (IMD) 2019 Score	-	-	26.3	18.4	21.7	5.8		45
	2	Homelessness - households owed a duty under the Homelessness Reduction Act (2020/21) (Rate per 1,000)	2195	2558	20.9	7.1	11.3	26.6		0.0
	3	Child Poverty, Income deprivation affecting children index (IDACI) (2019) %	11,145	20,428	21.1	15.2	17.1	32.7		3.2
	4	Average Attainment 8 score (2019/20)	132,607	384,706	46.3	49.9	50.2	42.9		60.0
	5	Violent crime – violence offences per 1,000 population (2020/21)	10,851	19,810	42.2	24.7	29.5	1.8		62.4
	6	Long-term unemployment rate (per 1,000 working age population)	579	966	3.6	2.0	3.2	12.5		0.0
	7	Low birth weight of term babies (2020) %	74	144	2.80	2.27	2.86	4.85		1.35
	8	Proficiency in English (% of people who cannot speak English well or at all) (2011)	6,893	2,192	2.9	0.3	1.7	0.1		8.7
	9	Black and Minority (BME) Population (2011) %	49,001	19,592	19.7	2.5	85.4	98.8		29.0
Children and Young People's Health	10	Smoking status at time of delivery (2020/21) %	332	800	11.9	11.8				
	11	Baby's first feed breastmilk (2018/19) %	1,940	4,225	63.4	64.3	67.4	43.6		98.7
	12	Prevalence of overweight (including obesity) in reception year (2017/18-19/20) %	1,970	4,855	23.0	23.3	22.6	30.0		15.3
	13	Prevalence of overweight (including obesity) in Year 6 (2017/18-19/20) %	3,625	6,950	37.6	32.6	34.6	44.7		22.1
	14	Admission episodes for alcohol-specific conditions – Under 18s rate per 100,000 (2018/19- 20/21)	25	165	13.9	35.7	29.3	83.8		7.7
	15	Pregnancy ending in abortion teenagers aged <18 (2019) %	30	89	34.8	50.3	54.7	32.5		91.3
	16	Teenage conceptions (age<18) rate per 1,000 (2019)	89	177	20.9	14.3	15.7	37.1		3.9
	17	Chlamydia proportion screened aged 15-24 years (2020) %	4,292	9,969	12.5	12.5	14.3	4.1		36.5
	18	Population vaccination coverage MMR for two doses in 5 years olds (2020/21) %	3,069	7,713	81.7	93.0	86.6	59.8		96.4
	19	HPV vaccination coverage for two doses (Females 13-14 years old) (2019/20) %	452	1,666	28.8	42.5	64.7	0.0		100.0
	20	Percentage of five-year-old children with experience of visually obvious dental decay (2018/19) %	No data		27.4	17.1	23.4	50.9		8.7
Adults health and lifestyle	21	Smoking prevalence in adults (18+) – current smokers (APS) (2020) %	No data		11.5	11.0	12.1	20.8		5.5
	22	Percentage of physically active adults (2019/20) %	No data		66.0	70.6	66.4	49.4		80.2
	23	Proportion of the adult population meeting the recommended '5-a-day' (2019/20) %	No data		55.0	56.4	55.4	41.4		66.9
	24	Percentage of adults classified as overweight or obese (2019/20) %	No data		62.5	66.8	62.8	78.3		41.6

Figure 67: Derby and Derbyshire Health Profile 2

Key: Derby City; Derbyshire County

'Value' comparison with national average: Lower; Similar; Higher; Not compared

Better; Similar; Worse

Worse than (25th percentile) England Average Better than (75th percentile)

Domain		Indicator	LA Number Derby	LA Number Derbyshire	LA Value Derby	LA Value Derbyshire	England Ave.	Eng lowest/ worst	LA Variation England Range	Eng highest/ best
Adults health and lifestyle	1	Emergency hospital admissions for intentional self-harm (2020/21) rate per 100,000	570	1,855	218.7	247.1	181.2	471.7		41.5
	2	Admission episodes for alcohol-specific conditions (2020/21) rate per 100,000	1,770	4,535	763	559	587	2,276		298
	3	Diabetes: QOF prevalence (ages 17+) (2020/21) %	17,207	52,322	7.3	7.8	7.1	2.8		10.1
	4	All new STI diagnosis rate (per 100,000) (2020)	1,652	2,902	643	360	562	225		3,060
	5	Hip fractures in people aged 65 and over, rate per 100,000 (2020/21	245	935	544	543	529	723		315
	6	Hypertension: QOF prevalence (all ages) (2020/21) %	38,283	135,092	12.8	16.6	13.9	7.1		18.1
	7	Adults with a learning disability who live in stable and appropriate accommodation (2020/21) %	610	1,628	84.1	85.6	78.3	28.4		100
Life expectancy and causes of death	8	Estimated dementia diagnosis rate (aged 65 and over) (2021) %	2,082	6,961	69.2	63.8	61.6	24.3		82.4
	9	Excess winter deaths index (age 85+) ratio (2019-20) %	70	270	25.2	28.3	20.8	61.5		-14.9
	10	Life expectancy at birth (male; years) (2018-20)	-	-	77.7	79.2	79.4	74.1		84.7
	11	Life expectancy at birth (female; years) (2018-20)	-	-	81.5	82.8	83.1	79.0		87.9
	12	Infant mortality (2018-20) per 1,000 live births	50	88	5.5	4.0	3.9	6.8		1.7
	13	Premature births <37 weeks gestation (2016-18) per 1,000	953	1,962	98.4	85.7	81.2	112.2		61.9
	14	Smoking attributable mortality (rate per 100,000) (2017-19)	982	3,079	243.5	199.5	202.2	419.7		75.9
	15	Suicide rate, DSR per 100,000 (2018-20)	61	237	9.2	11.2	10.4	18.8		5.0
	16	Under 75 mortality rate from cardiovascular disease, DSR per 100,000 (2017-19)	537	1,615	88.7	66.3	7034	121.6		43.6
	17	Under 75 mortality rate from cancer, DSR per 100,000 (2017-19)	867	3,085	147.0	126.8	129.2	182.4		87.4
	18	Under 75 mortality rate from respiratory disease, DSR per 100,000 (2017-19)	229	798	38.9	32.5	33.6	77.5		13.7
	19	Killed and seriously injured (KSI) casualties on England's roads, rate per billion vehicle miles (2020)	86	297	88.1	68.9	86.1	456.1		24.1
	20	Percentage of deaths that occur at home (85+ years) (2020) %	192	752	17.6	20.7	20.8	13.6		34.6
	21	Percentage of households that experience fuel poverty % (2018)	12,611	37,404	11.6	10.6	10.3	20.9		5.2

Figure 68: Derbyshire District Health Profile 1

'Value' comparison with national average: Lower, Similar, Higher, Not compared

Better, Similar, Worse

Key: Amber Valley, Bolsover, Chesterfield, Derbyshire Dales, Erewash, High Peak, North East Derbyshire, South Derbyshire

Worse/lower than England Average Better/higher than (25th percentile – 75th percentile)

Domain		Indicator	District Number: Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire	District Value: Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire	England Ave.	Eng lowest/ worst	District Variation: England Range	Eng highest/ best
Our communities	1	Index of Multiple Deprivation (IMD) 2019 Score	-	-	-	-	-	-	-	-	18.0	25.0	24.9	11.9	18.8	15.6	17.4	14.5	21.7	5.5		45.0
	2	Homelessness - households owed a duty under the Homelessness Reduction Act (2020/21) (Rate per 1,000)	397	98	568	241	293	447	235	279	7.0	2.7	11.7	7.4	5.7	10.7	5.1	6.0	11.3	31.0		0.0
	3	Child Poverty, Income deprivation affecting children index (IDACI) (2019) %	3,140	2,835	3,568	960	3,519	1,921	2,332	2,153	15.0	20.5	20.2	8.7	17.1	12.2	14.5	11.4	17.1	32.7		3.2
	4	Average Attainment 8 score (2019/20)	60,062	34,604	49,492	38,585	54,673	45,932	48,084	53,275	50.5	47.9	49.5	54.3	47.2	50.1	49.4	51.0	50.2	42.9		61.2
	5	Violent crime – violence offences per 1,000 population (2020/21)	3,259	2,145	3,416	1,153	3,022	2,157	2,348	2,313	25.4	26.6	32.5	15.9	26.2	23.3	23.1	21.6	29.5	1.8		62.4
	6	Proficiency in English (% of people who cannot speak English well or at all) (2011)	290	462	357	129	340	184	138	292	0.2	0.6	0.4	0.2	0.3	0.2	0.1	0.3	1.7	0.1		8.7
	7	Long-term unemployment rate (per 1,000 working age population)	185	112	189	56	50	165	138	72	2.4	2.2	2.9	1.3	0.7	2.9	2.3	1.1	3.2	12.5		0.0
Children and Young People's Health	8	Smoking status at time of delivery (2020/21) %	127	90	111	53	115	85	100	120	11.9	11.9	11.9	11.9	11.9	11.4	11.9	11.9				
	9	Low birth weight of term babies (2020) %	17	15	25	11	23	15	17	21	1.77	2.02	2.84	2.78	2.46	2.25	2.21	2.10	2.86	4.85		1.03
	10	Prevalence of overweight (including obesity) in reception year (2017/18-19/20) %	615	620	765	380	610	575	685	605	21.9	24.5	24.2	22.5	23.2	21.4	23.4	25.1	22.6	30.0		14.3
	11	Prevalence of overweight (including obesity) in Year 6 (2017/18-19/20) %	935	940	1,140	525	825	865	950	775	32.1	37.8	34.8	27.2	32.9	29.7	32.9	32.0	34.6	44.7		20.3
	12	Admission episodes for alcohol-specific conditions – Under 18s rate per 100,000 (2018/19- 20/21)	15	20	50	10	15	20	20	15	20.7	42.0	84.0	27.0	21.7	37.8	35.8	22.1	29.3	84.0		7.7
	13	Pregnancy ending in abortion teenagers aged <18 (2019) %	9	6	7	4	20	16	14	10	37.0	40.0	42.1	50.0	65.6	69.6	50.0	40.0	54.7	21.1		93.8
	13	Teenage conceptions (age<18) rate per 1,000 (2019)	27	15	19	8	32	23	28	25	14.1	12.1	12.8	7.0	18.0	15.9	18.4	13.7	15.7	37.1		3.9
	14	Chlamydia proportion screened aged 15-24 years (2020) %	1,429	971	1,613	757	1,577	1,216	1,178	1,228	11.5	11.6	15.3	11.5	13.6	13.4	12.3	10.8	14.3	4.1		36.5
	16	Percentage of five-year-old children with experience of visually obvious dental decay (2018/19) %	No data	-	-	-	-	-	-	-	14.9	17.2	23.3	15.6	15.2	16.9	14.1	17.3	23.4	50.9		1.1
	17	Hospital admission caused by unintentional and deliberate injuries in children (<15 years) (2020/21) rate per 10,000	110	100	170	50	80	140	140	120	54.3	74.2	101.5	50.6	41.6	95.8	89.6	62.2	75.7	173.4		26.5
Adults health and lifestyle	18	Smoking prevalence in adults (18+) – current smokers (APS) (2020) %	No data								10.2	12.7	17.7	7.4	7.6	10.6	7.7	12.8	12.1	25.0		2.3
	19	Percentage of physically active adults (2019/20) %	No data								70.4	62.8	77.7	78.4	63.8	76.1	70.0	67.6	66.4	49.4		80.2
	20	Proportion of the adult population meeting the recommended '5-a-day' (2019/20) %	No data								55.0	49.2	56.2	67.5	57.0	60.9	58.0	49.3	55.4	41.4		67.7
	21	Percentage of adults classified as overweight or obese (2019/20) %	No data								68.0	76.7	68.5	54.7	62.8	61.6	71.0	70.4	62.8	78.3		41.6

Figure 69: Derbyshire District Health Profile 2

'Value' comparison with national average:

Lower	Better
Similar	Similar
Higher	Worse
Not compared	

Key:

- Amber Valley
- Bolsover
- Chesterfield
- Derbyshire Dales
- Erewash
- High Peak
- North East Derbyshire
- South Derbyshire

Worse/lower than England Average Better/higher than

25th percentile | 75th percentile

	Domain	Indicator	District Number								District Value								England Ave.	Eng lowest/ worst	District Variation England Range	Eng highest/ best
			Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire				
Adults Health and Lifestyle	1	Emergency hospital admissions for intentional self-harm (2020/21) rate per 100,000	255	195	440	100	235	140	290	200	211.4	247.7	448.5	174.3	212.3	163.7	320.0	183.9	181.2	471.7		41.5
	2	Admission episodes for alcohol-specific conditions (2020/21) rate per 100,000	710	465	830	355	660	550	550	415	535	573	815	457	570	567	563	377	587	2,276		203
	3	All new STI diagnosis rate (per 100,000) (2020)	471	288	497	183	443	287	334	399	366	354	474	253	384	310	327	364	562	146		3,060
	4	Hip fractures in people aged 65 and over, rate per 100,000 (2020/21)	140	95	140	105	125	95	140	90	500	623	619	538	507	494	604	494	529	746		306
Life expectancy and causes of death	1	Hypertension: QOF prevalence (all ages) (2020/21) %	22,065	16,854	19,935	14,741	18,382	15,485	14,228	13,402	16.0	17.4	17.6	17.3	16.3	16.0	18.0	14.5	13.9	7.1		20.5
	2	Estimated dementia diagnosis rate (aged 65 and over) (2021) %	1,238	842	1,007	705	1,089	745	736	649	66.4	71.7	65.4	48.9	71.8	60.0	61.7	64.6	61.6	24.3		82.4
	3	Deaths from lung cancer (2017-19) DSR per 100,000	200	158	180	101	191	162	190	123	47.9	65.1	53.7	34.5	53.1	55.5	50.8	41.9	53.0	98.0		28.8
	4	Excess winter deaths index (age 85+) ratio (2019-20) %	50	30	40	30	40	20	20	50	31.6	41.3	25.7	26.1	26.6	18.8	11.2	57.1	20.8	61.5		-14.9
	5	Life expectancy at birth (male; years) (2018-20)	-	-	-	-	-	-	-	-	79.7	77.7	77.9	80.9	78.9	79.0	79.7	79.3	79.4	74.1		84.7
	6	Life expectancy at birth (female; years) (2018-20)	-	-	-	-	-	-	-	-	83.0	81.7	81.8	85.0	82.8	82.6	82.5	83.2	83.1	79.0		87.9
	7	Infant mortality (2018-20) per 1,000 live births	16	8	10	3	17	13	5	16	4.7	3.2	3.3	2.2	5.3	5.4	1.9	4.8	3.9	8.3		0.8
	8	Premature births <37 weeks gestation (2016-18) per 1,000	339	219	280	96	301	211	197	319	93.8	88.3	88.0	66.3	84.9	80.4	74.2	95.7	81.2	112.2		56.9
	9	Under 75 mortality rate from cardiovascular disease, DSR per 100,000 (2017-19)	264	189	255	136	228	151	212	180	66.2	81.0	82.9	52.7	70.0	52.7	63.5	62.1	70.4	121.6		39.8
	10	Under 75 mortality rate from cancer, DSR per 100,000 (2017-19)	463	348	443	287	407	348	435	354	116.3	149.9	142.9	113.1	125.4	122.3	130.3	122.3	129.2	182.4		87.4
	11	Under 75 mortality rate from respiratory disease, DSR per 100,000 (2017-19)	112	104	141	55	111	93	101	81	27.9	44.2	45.8	21.6	33.6	32.3	29.5	27.8	33.6	77.5		13.7
	12	Percentage of deaths that occur at home (85+ years) (2020) %	124	72	93	84	105	86	108	80	21.6	21.6	19.3	21.5	19.8	21.4	21.1	19.8	20.8	11.9		
	13	Percentage of households that experience fuel poverty % (2018)	5,867	3,754	5,140	4,130	5,340	4,346	4,760	4,067	10.5	10.8	10.4	12.6	10.3	10.5	10.4	9.8	10.3	20.9		5.2

3.1.6 Life expectancy

The life expectancy in both Derby City and Derbyshire is lower than the national average. Life expectancy is disproportionately lower for people living in deprived areas. For males, there is a difference of 10 years between the most and least deprived wards in Derby, and a difference of 10.6 years in Derbyshire. For females the difference is 11.7 years between the most and least deprived wards in Derby, and a difference of 7.1 years in Derbyshire.

Figure 70: Life expectancy at birth, in years, 2019-20 (Office for Health Improvement and Disparities, Fingertips, 2022)

	Derby	Derbyshire	England
Male	77.7	79.2	79.4
Female	81.5	82.8	83.1

3.1.7 Population segmentation

Mosaic Public Sector[30] offers the opportunity to segment the population into groups and types based on particular characteristics – spanning demographic, geographic, lifestyle, social and behavioural traits. In Derby the most frequent groups (of a total of 16) are 'I Family Basics', 'H Aspiring Homemakers' and 'J Transient Renters', signifying 41% of the city's total population. Whereas in Derbyshire the most frequent groups are 'H Aspiring Homemakers', 'G Domestic Success' and 'D Rural Reality', representing 35% of the county's population (Figure 49).

Figure 71: Mid-2020 population estimates for Derby City and Derbyshire across Mosaic Groups

Mosaic Public Sector Group Labels	Derbyshire Total	Derby Total
A City Prosperity	2	587
B Prestige Positions	44,553	14,711
C Country Living	69,419	0
D Rural Reality	76,017	0
E Senior Security	59,064	22,107
F Suburban Stability	68,888	15,276
G Domestic Success	81,184	20,359
H Aspiring Homemakers	126,961	35,341
I Family Basics	66,333	43,976
J Transient Renters	70,606	27,114
K Municipal Tenants	33,269	7,385
L Vintage Value	44,172	14,540
M Modest Traditions	63,111	13,802
N Urban Cohesion	829	22,794
O Rental Hubs	10,152	20,891
U Unclassified	0	0

The top three Mosaic Groups in Derby represent three very different groups of people: Families with limited resources who have to budget to make ends meet; younger householders settling down in housing priced within their means; single people privately renting low-cost homes for the short term. In Derbyshire, the top three Mosaic Groups characterise: thriving families who are busy bringing up children and following careers; young

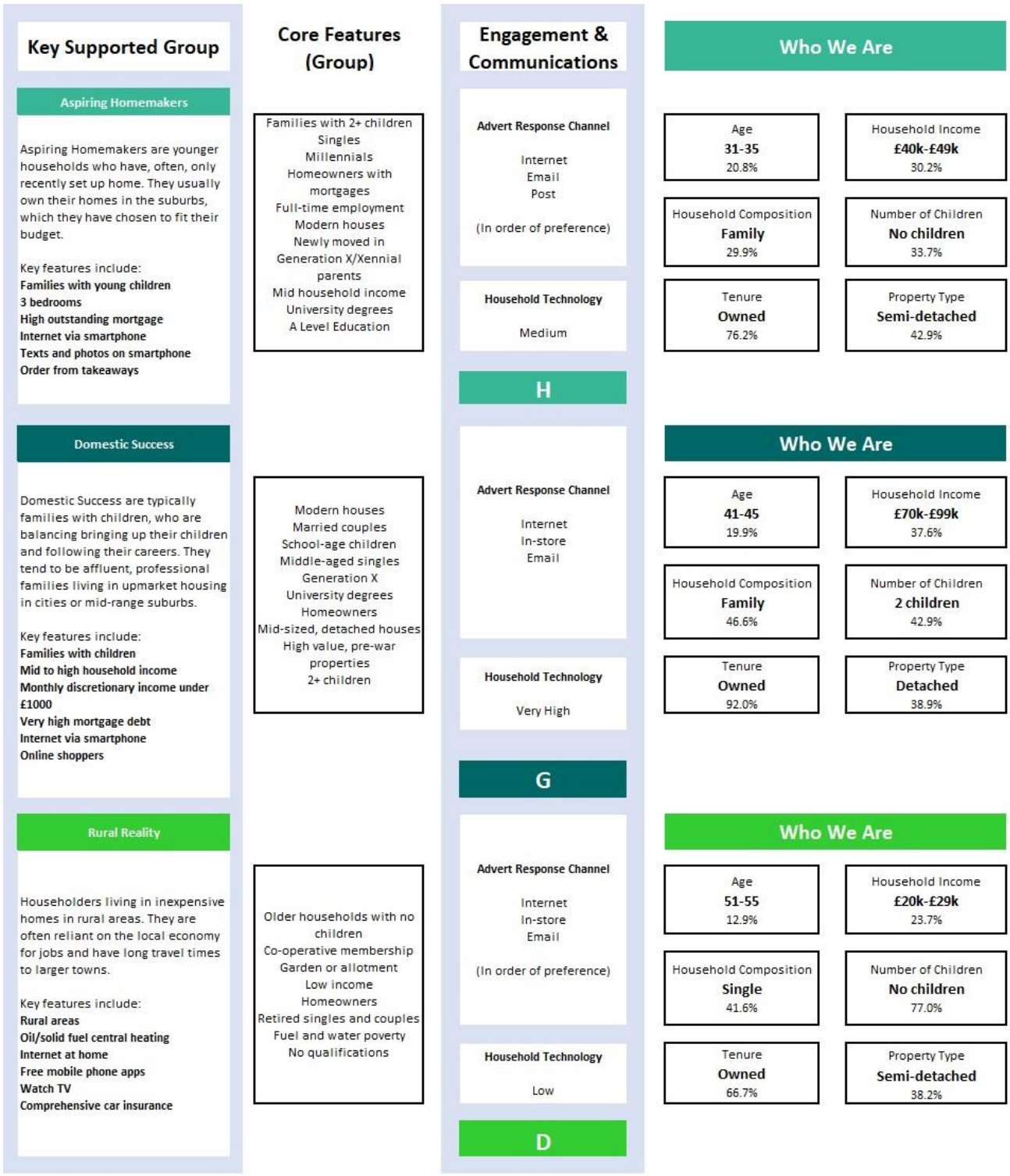
[30] Experian Ltd (2016)

families starting out in careers and homes; householders living in less expensive homes in village communities. Figure 72 and Figure 73 provide key features of the common Mosaic Groups in Derby and Derbyshire.

Figure 72: Most common Mosaic groups in Derby

Key Supported Group	Core Features (Group)	Engagement & Communications	Who We Are
Family Basics Family Basics are families with children who have limited budgets and can struggle to make ends meet. Their homes are low cost and are often found in areas with fewer employment options. Key features include: **Families with lots of children** **Council/HA tenants** **Low discretionary income** **Low affluence** **Internet via smartphone** **Games consoles**	School-age children 3 bedrooms Low value terraces No qualifications Low to mid household income Low outstanding mortgage Unemployed Solar panels Single trip travel insurance Water poverty	**Advert Response Channel** Internet In-store Telephone (In order of preference) **Household Technology** High **I**	Age **36-40** 16.0% Household Income **£40k-£49k** 30.2% Household Composition **Family + other adults** 26.6% Number of Children **1 child** 33.4% Tenure **Council/HA** 56.9% Property Type **Terraced** 49.4%
Aspiring Homemakers Aspiring Homemakers are younger households who have, often, only recently set up home. They usually own their homes in the suburbs, which they have chosen to fit their budget. Key features include: **Families with young children** **3 bedrooms** **High outstanding mortgage** **Internet via smartphone** **Texts and photos on smartphone** **Order from takeaways**	Families with 2+ children Singles Millennials Homeowners with mortgages Full-time employment Modern houses Newly moved in Generation X/Xennial parents Mid household income University degrees A Level Education	**Advert Response Channel** Internet Email Post (In order of preference) **Household Technology** Medium **G**	Age **31-35** 20.8% Household Income **£40k-£49k** 30.2% Household Composition **Family** 29.9% Number of Children **No children** 33.7% Tenure **Owned** 76.2% Property Type **Semi-detached** 42.9%
Transient Renters Transient Renters are single people who pay modest rents for low cost homes. Mainly younger people, they are highly transient, often living in a property for only a short length of time before moving on. Key features include: **Young singles and homesharers** **Millennials** **Rent low value terraces** **Internet via smartphone** **High social networking** **Don't use landlines**	Home built 1871-1919 Single Parents Singles and homesharers 2 bedrooms Low discretionary income Fuel and water poverty A-Level Education Vocational qualifications Living here for <1 year Coping on present income Whole/retail trade; repair of vehicles	**Advert Response Channel** Internet In-store Telephone (In order of preference) **Household Technology** High **J**	Age **18-25** 23.1% Household Income **£20k-£29k** 34.2% Household Composition **Single** 48.3% Number of Children **No children** 66.1% Tenure **Rented** 63.0% Property Type **Terraced** 57.2%

Figure 73: Most common Mosaic groups in Derbyshire



3.2 Vulnerable groups

3.2.1 Ethnicity

In England, 20.2% of the population are from Black or Minority Ethnic (BME) communities, and in the East Midlands, 14.6% (Office for National Statistics, 2011 Census data). Comparably, Derby has a higher proportion and Derbyshire a much lower percentage of BME communities than the national average with 24.7% and 2.5% respectively. In Derby this figure had risen from 15.7% in 2001. The Asian/Asian British community is the largest ethnic group in Derby comprising 12.6% of the total population. Within this group, the Pakistani community represented the largest BME group in Derby (5.9%), and the Indian community were the second largest BME group (4.4%).

Figure 74: Ethnicity breakdown by ward in Derby (NOMIS from Census 2011)

2011 ward	White		Mixed/ multiple ethnic groups		Asian/Asian British		Black/ African/ Caribbean/ Black British		Other ethnic group	
	Number	%	Number	%	Number	%	Number	%	Number	%
Abbey	11,260	73.4	591	3.9	2,620	17.1	662	4.3	201	1.3
Allestree	13,028	95.6	127	0.9	308	2.3	87	0.6	72	0.5
Alvaston	14,315	88.1	541	3.3	786	4.8	500	3.1	113	0.7
Arboretum	8,289	44.6	764	4.1	7,689	41.4	1,131	6.1	717	3.9
Blagreaves	8,787	67.3	439	3.4	2,951	22.6	577	4.4	301	2.3
Boulton	12,611	90.9	387	2.8	495	3.6	312	2.2	69	0.5
Chaddesden	12,867	95.9	234	1.7	181	1.3	91	0.7	40	0.3
Chellaston	13,467	88.6	385	2.5	1,054	6.9	240	1.6	52	0.3
Darley	13,555	91.0	368	2.5	501	3.4	291	2.0	182	1.2
Derwent	13,243	93.9	323	2.3	237	1.7	239	1.7	60	0.4
Littleover	9,972	69.4	404	2.8	3,294	22.9	356	2.5	349	2.4
Mackworth	13,099	92.4	328	2.3	374	2.6	298	2.1	81	0.6
Mickleover	12,945	92.3	214	1.5	616	4.4	165	1.2	82	0.6
Normanton	7,153	41.9	803	4.7	7,261	42.5	1,151	6.7	703	4.1
Oakwood	12,488	94.2	240	1.8	361	2.7	143	1.1	27	0.2
Sinfin	10,747	71.0	901	6.0	2,234	14.8	971	6.4	275	1.8
Spondon	11,925	96.3	183	1.5	133	1.1	106	0.9	30	0.2

In Derby, the highest proportions of BME communities reside in Normanton and Arboretum (Figure 74). In Derbyshire, South Derbyshire and Chesterfield have the highest rates of BME communities compared to the rest of Derbyshire (Figure 75).

Figure 75: Ethnicity breakdown by ward in Derby (NOMIS from Census 2011)

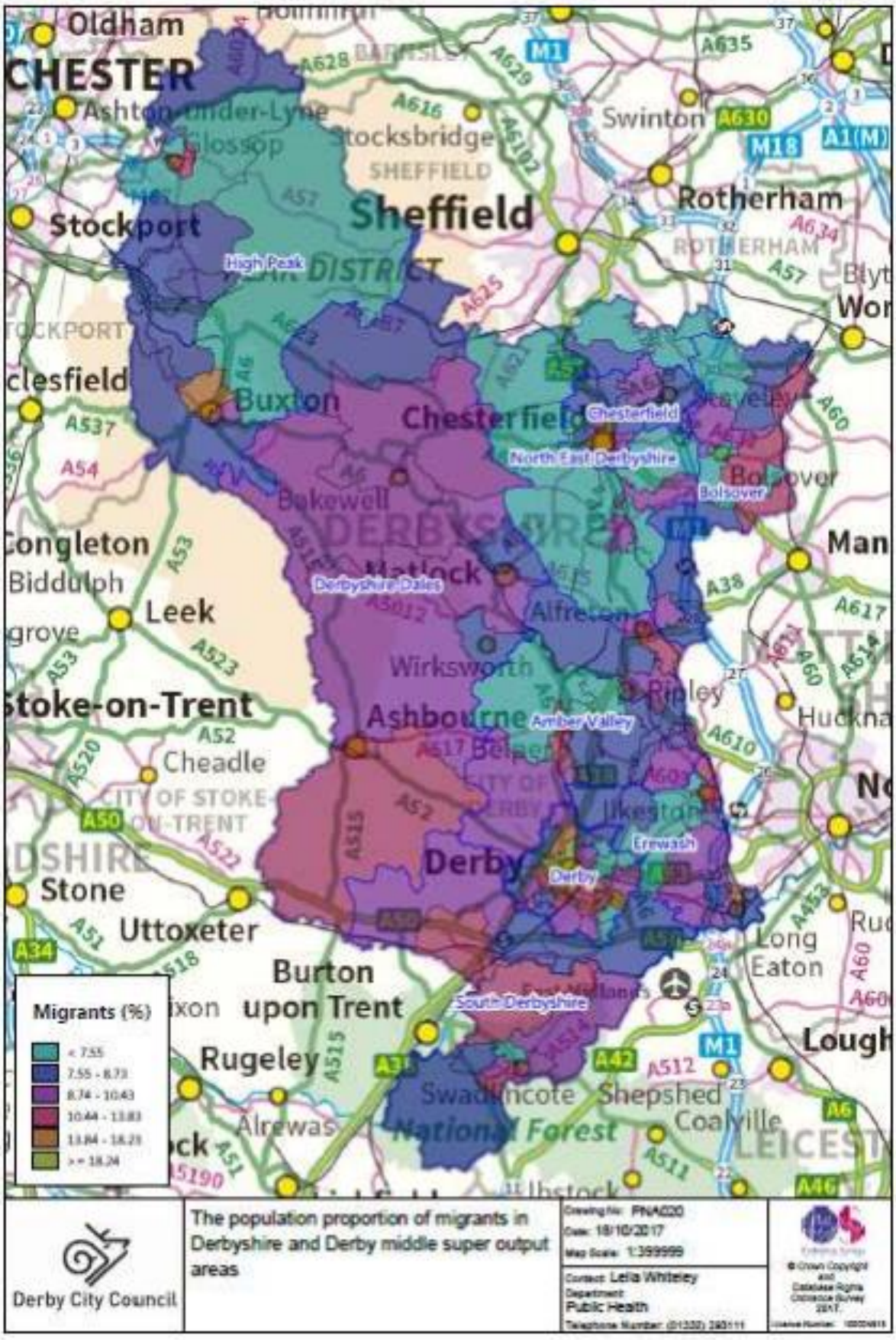
Local Authority	White		Mixed/ multiple ethnic groups		Asian/Asian British		Black/ African/ Caribbean/ Black British		Other ethnic group	
	Number	%	Number	%	Number	%	Number	%	Number	%
Amber Valley	120,023	98.1	980	0.8	929	0.8	253	0.2	124	0.1
Bolsover	74,452	98.1	514	0.7	612	0.8	267	0.4	17	0.0
Chesterfield	100,172	96.5	1,094	1.1	1,591	1.5	782	0.8	148	0.1
Derbyshire Dales	70,117	98.6	466	0.7	398	0.6	87	0.1	48	0.1

Erewash	108,765	97.0	1,269	1.1	1,383	1.2	536	0.5	128	0.1
High Peak	88,954	97.9	944	1.0	711	0.8	184	0.2	99	0.1
North East Derbyshire	97,084	98.0	786	0.8	795	0.8	236	0.2	122	0.1
South Derbyshire	90,527	95.7	1,062	1.1	2,375	2.5	425	0.4	222	0.2
Derbyshire County	**750,094**	**97.5**	**7,119**	**0.9**	**8,795**	**1.1**	**2,770**	**0.4**	**908**	**0.1**

3.2.2 Migrant population

The growing size and diversity of the proportion of the UK population who were born overseas has implications for meeting health needs. In England, 1.65% of the population stated that they cannot speak English well or at all. Derbyshire had a much lower rate of 0.29%, while in Derby 2.9% of the population had limited English language skills. In the county area, Bolsover followed by Chesterfield have the highest proportion of residents with limited English language skills. In Derby, 13.9% of its population were born outside of the UK, with residents from at least 180 different countries. The majority of those born outside of the UK are from the Middle East and Asia, and Europe. Similar to other cities across the Midlands, the majority of the non-UK born population in Derby have lived in the UK for 10 years or more (Census, 2011). In Derbyshire, 9% of the population were migrants (Census, 2011). Across Derbyshire the distribution of migrant registrations varies (Figure 76). Across the county the rate for migrant GP registrations is 1.7 per 1,000 population, while in Derby the rate is 11.5 per 1,000 population. Both of these figures fall lower than the national rate of 11.7 per 1,000 population.

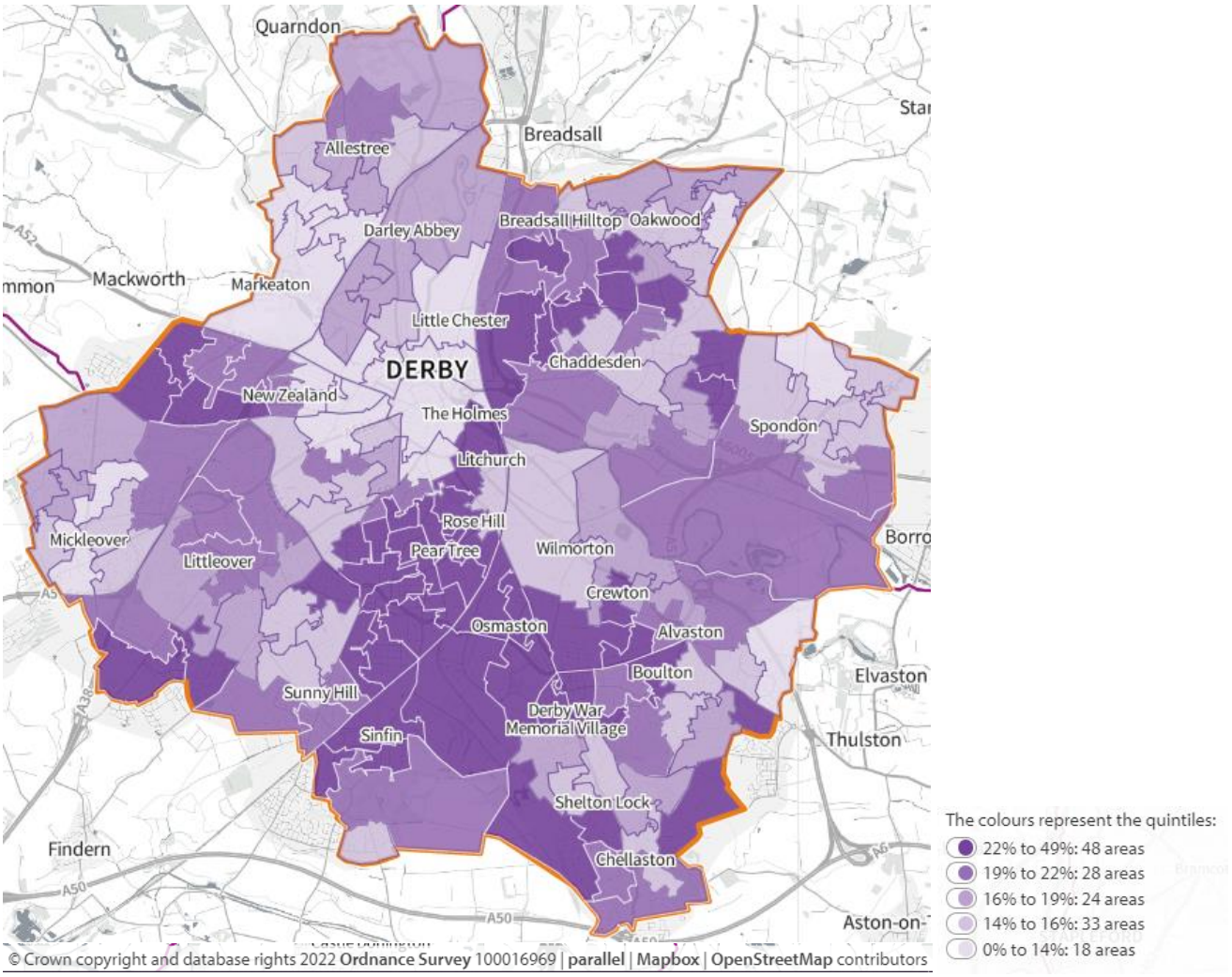
Figure 76: Migrant populations across MSOA areas of Derby city and Derbyshire



3.2.3 Children

Derby City has a young population: in 2020, 21.0% of the population were aged <16 years compared to 19.2% in England as a whole. It is apparent that a high proportion of children reside in the centre and the south of Derby city (Figure 77).

Figure 77: Population of children aged 0-15 years (%) in Derby city (Reproduced directly from the Office for Health Improvement and Disparities, 2022)



The population estimates indicate that 15.9% and 13.3% of the population, in Derby and Derbyshire respectively, are of primary and secondary school age (Figure 78). In comparison to England as a whole (14.6%), there is a slightly higher proportion of school age children in Derby city, and slightly lower proportion in Derbyshire. Around one-quarter (24.4%) of Derby's population is aged 0-18 years, in comparison to one-fifth (20.1%) in Derbyshire. Both of these proportions fall above and below the proportion of England as a whole (22.5%). The Office for Health Improvement and Disparities' Child Health Profile[31] enables a detailed examination of the health of children and young people in Derby and Derbyshire with England comparison. Generally, the health and wellbeing of children in Derbyshire is similar or better than the England average, but across a number. The child mortality rates in Derby and Derbyshire (10.5 per 100,000, and 11.7 per 100,000) are similar to England (10.3 per 100,000).

[31] Office for Health Improvement and Disparities (2022)

However, the infant mortality is significantly higher in Derby (5.5 per 1,000) than England (3.9 per 100,000), although Derbyshire (4.0 per 1,000) is similar to England.

Figure 78: ONS Mid-2020 population estimates for persons aged 0-18 years

	Derby		Derbyshire		England	
Age	**Number**	**Proportion of total population (%)**	**Number**	**Proportion of total population (%)**	**Number**	**Proportion of total population (%)**
0-4	15,795	6.4	39,320	4.9	3,239,447	5.7
5-16	40,908	15.9	107,110	13.3	8,240,816	14.6
17-18	6,061	2.4	16,173	2.0	1,219,636	2.2
Total 0-18	62,764	24.4	162,603	20.1	12,699,899	22.5
Total population	256,814	100.0	807,183	100.0	56,550,138	100.0

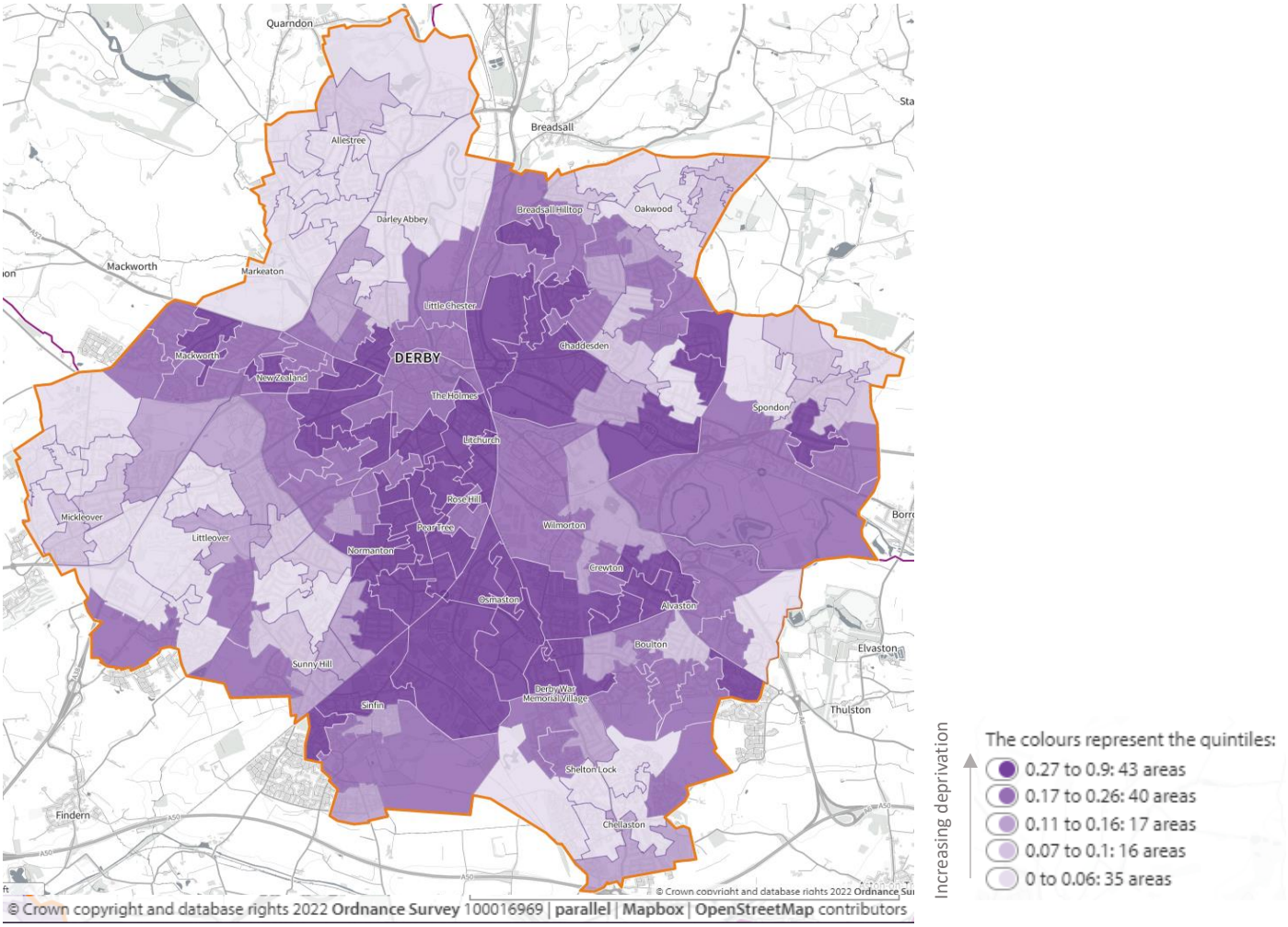
In 2017/18 - 2019/20, there were 35,755 A&E attendances in 0-4 year olds in Derby (714.0 per 1,000) which was significantly higher than the rate in England (642.5 per 1,000). Derbyshire had 73,445 A&E attendances for children under five years, and this was a significantly lower rate (607.8 per 1,000) than national average. Both Derby and Derbyshire perform better than England for hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years (54.2 per 10,000 in Derby; 86.6 per 10,000 in Derbyshire; 97.8 per 10,000 in England in 2019/20).

Derby and Derbyshire differ in terms of child poverty, with 21.0% of Derby children (all dependent children under 20 years) in low-income families compared with 15.0% of Derbyshire children. The England average falls in the middle of these proportions with 17.0% of children in poverty. The map showing child poverty across Derby city (Figure 79) illustrates that child poverty is unequally distributed across the city, with more children residing in poverty in the centre and south areas, and less child poverty on the fringes of the city.

Both Derby and Derbyshire had lower than average GCSE achievement for 16 year olds in 2015/16. Only 44.8% of children in Derby and 54.8% of children in Derbyshire achieved 5A*-C GCSEs (including England and Maths) compared to 57.8% achieved in England as a whole. In fact, Derby reported the lowest percentage in England in 2015/16.

Figure 79: Child poverty across Derby city (Reproduced directly from the Office for Health Improvement and Disparities, 2022)

% of all dependent children under 20 years living in income deprived households, English indices of deprivation



3.2.4 Children and adults in care

Derby City (108 per 10,000 <18 population) has significantly higher rates of children in care (aged under 18 years) compared to the national average (67 per 10,000 <18 population). Comparably, Derbyshire has significantly lower rates of children in care, with a rate of 58 per 10,000 <18 population. Figures for both Derby and Derbyshire have been increasing and getting worse since 2017.

Data for adults indicated that in Derby and Derbyshire 4.3 and 3.4 per 1,000 adults, respectively, with learning disabilities were receiving long-term support from local authorities. This is higher than the England rate (3.5 per 1,000 population).

84.2% of Derby's supported adult population with learning disabilities were living in settled accommodation; higher than the national average (77.3%). Whereas 77.4% of Derbyshire's supported adult population with learning disabilities were living in settled accommodation. Contrastingly, the national average for adults with learning disabilities living in unsettled accommodation (16.9%) was higher than for Derby (15.1%) but not for Derbyshire (22.1%). Of particular note, Derby had no supported adults with learning disabilities living in severely unsatisfactory accommodation.

3.2.5 People with disabilities

Long term disabilities

Figure 80 shows the number of people in the 2011 Census who reported long term health problems or disabilities which mean that day-to-day activities are limited a little or a lot. In Derbyshire, 20.4% of the resident population have reported that day-to-day activities are limited a little or lot. This is higher than the national average of 17.6% across the population. This difference may reflect the older population of residents in Derbyshire. In Derby, 18.7% of the population have a long-term health problem where activities are limited.

Figure 80: Number and proportion of population living with a limiting long term health problem or disability, 2011 (NOMIS, 2022).

Local authority/ country	Day-to-day activities limited a lot	Day-to-day activities limited a little	Total population in 2011 Census
Derby	21,984	24,472	248,752
(%)	8.8	9.8	100.0
Derbyshire	74,564	82,469	769,686
(%)	9.7	10.7	100.0
England	4,405,394	4,947,192	53,012,456
(%)	8.3	9.3	100.0

Hearing impaired people

The data below in Figure 81 indicates that 399 people per every 100,000 population aged 18-64 are registered Deaf or hard of hearing in Derby. This is significantly higher than rates in Derbyshire (126 per 100,000) and the national average (173 per 100,000).

Figure 81 : Rate of people (per 100,000) registered Deaf or hard of hearing, 2009/10 (Office for Health Improvement and Disparities Fingertips, 2017) (NOMIS, 2017)

	Derby	Derbyshire	England
People aged 18-64 registered Deaf or hard of hearing	399	126	173
People aged 65-74 registered Deaf or hard of hearing	658	620	620
People aged 75+ registered Deaf or hard of hearing	4238	2774	3089

Visual disabilities

The rate of people registered blind or partially sighted was higher in Derby than Derbyshire across both age groups. The national average rate of people aged 75+ registered as blind or partially sighted was higher than both Derby and Derbyshire's rate. Whereas the national average for people aged 65-74 was higher than Derbyshire but lower than Derby's rate (Figure 82).

Figure 82: Rate of people (per 100,000) registered blind or partially sighted, 2019/20 (Office for Health Improvement and Disparities Fingertips, 2022):

	Derby	Derbyshire	England
People aged 65-74 registered blind or partially sighted	800	170	536
People aged 75+ registered blind or partially sighted	3,049	1,171	3,429

3.2.6 Other distinct population groups

Prison populations are at high risk of poor health, social and emotional outcomes whilst within prison environments and upon release. HMP Foston Hall is a women's closed category prison, located to the west of Derby city in the South Derbyshire district. It has an operational capacity of 349 across eight wings. Nearby there is also the HMP Sudbury prison which is an open prison for adult males who fit the category D criteria. The operational capacity is 581 spread mostly across single or double rooms.

According to the 2011 Census, 1,259 people were recorded as serving in the Armed Forces in the city of Derby and districts of Derbyshire. The highest number, 250 people, live in Derby city.

Statutory homeless households are some of the most vulnerable in society and at risk of adverse outcomes. In 2020/21, the rate of statutory homelessness, where households are in temporary accommodation, was lower in Derby (0.9 per 1,000) than the England average (4.0 per 1,000). Derbyshire's rate (0.3 per 1,000) was lower than Derby's and England's.

Derbyshire is home to the Peak District National Park and as such attracts many visitors from day trippers to people staying for several weeks throughout the calendar year. It is estimated that there are 13.25 million visitors a year to the Peak District[32] (STEAM, 2018), and is one of the most popular national parks in the UK.

On average, Gypsy and Traveller population have poorer health, educational and social outcomes than the general population. In Derby, 1.98% of school children have a Gypsy/Roma ethnicity, which is the highest proportion in any local authority in the country. The national average of the proportion of school children who are Gypsy/Roma is 0.30% in England. In contrast, Derbyshire is 0.04% which is below England as a whole. There are Gypsy and Traveller pitch sites in both Derby and Derbyshire:

- In Derby there are 17 'permanent' pitches at the site Imari Park on Russell Street in Sinfin ward.
- In Derbyshire there are:
    - 26 long stay pitches (22 trailers, four transit) at Woodyard Lane in Foston, South Derbyshire district.
    - Eight short-stay pitches (eight trailers) at Lullington Crossroads, near Swadlincote, South Derbyshire district.
    - 20 long-stay pitches (16 trailers, four transit) at Corbriggs, Winsick, near Chesterfield, North East Derbyshire district.
    - 20 short-stay pitches (20 trailers) at Blackridge, Pleasley, Bolsover district.

[32] Global Tourism Solutions (UK) Ltd (2018)

3.2.7 Breastfeeding populations

The World Health Organization recommends exclusive breastfeeding in the first six months after birth for babies in all countries. Current breastfeeding rates fall short. Three in four mothers in England begin breastfeeding their babies after birth, and by the time the babies are 6-8 weeks old the women still breastfeeding has reduced by around 40%. In Derby the rate for breastfeeding initiation is slightly lower than the average in England. In Derbyshire, the rate for breastfeeding initiation is similar to the England average, but breastfeeding prevalence at 6-8 weeks after birth falls below the England average and Derby (Figure 83).

Figure 83: Mothers who breastfeed after birth and at 6-8 weeks later, %, 2019/20 (Office for Health Improvement and Disparities, 2016)

	Derby	Derbyshire	England
Breastfeeding initiation	66.7%	73.4%	74.5%
Breastfeeding prevalence at 6-8 weeks after birth	44.1%	41.6%	48.0%

3.2.8 Transportation

29% of the 102,271 households in Derby and 20% of the 332,637 households in Derbyshire, had no cars or vans availability compared to 80% which did in the 2011 census.

3.2.9 Deprivation

One of the most common used measures of inequality is the Index of Multiple Deprivation (IMD) which provides a weighted calculation of local measures of deprivation in England. The latest statistics of English Indices of Deprivation was released in 2019. The IMD provides an indication of the locations of the most deprived, as well as the least deprived, local populations. However, it is possible that there are deprived people living in less deprived areas and people who are not deprived living in highly deprived locations.

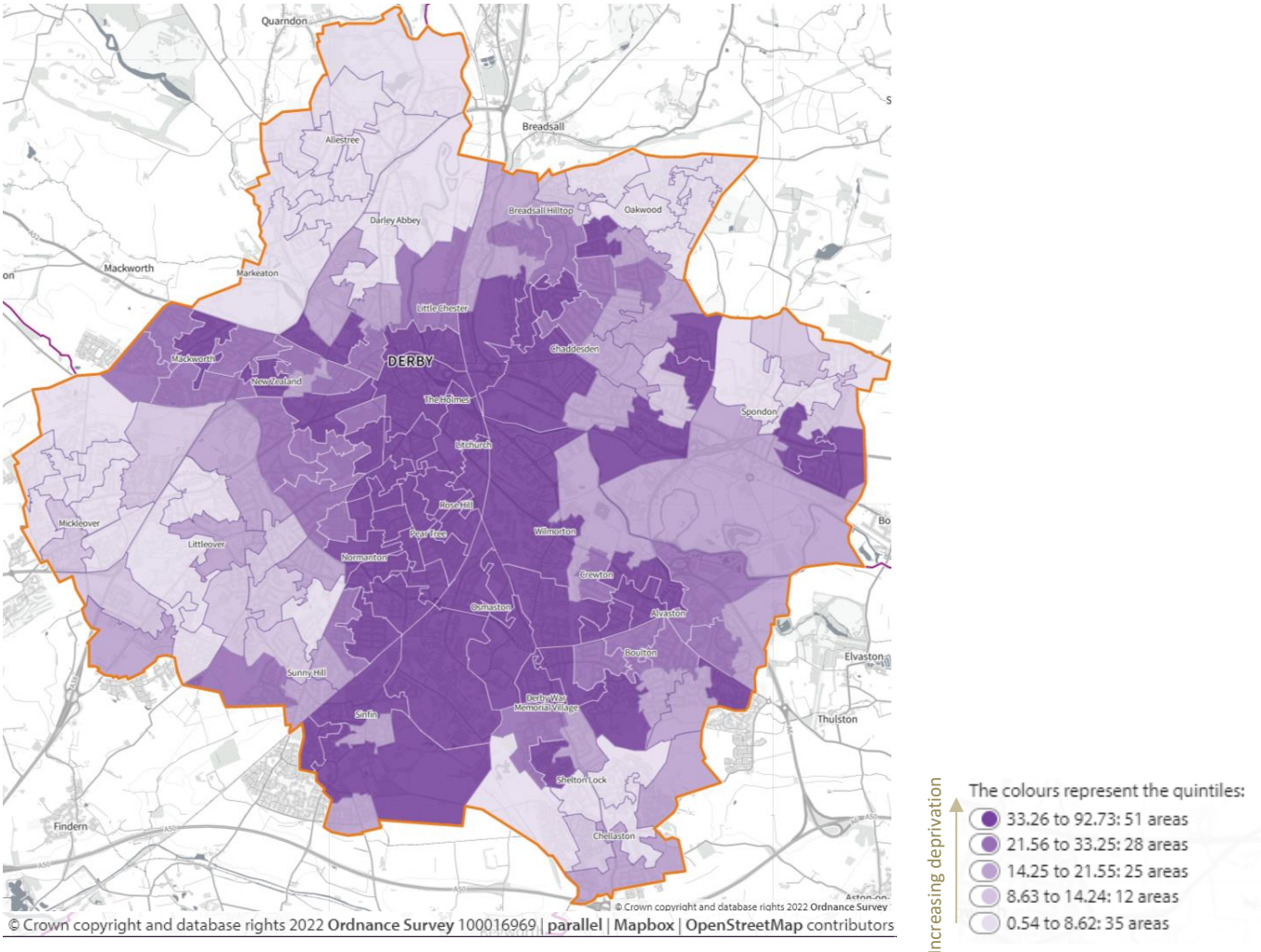
Of the 151 Upper tier Local Authorities in England that are ranked by an average rank, Derbyshire ranks 103rd, with 4% of the area falling within the 10% most deprived nationally. Bolsover is Derbyshire's most deprived district, ranked 58th of 316 local authority districts, followed by Chesterfield ranked 86th. Derbyshire Dales is Derbyshire's least deprived district, ranked 265th, followed by South Derbyshire ranked 218th. Derby is ranked at 90th, with 16% of Derby LSOAs in the most deprived 10% nationally. Derby has improved from rank 84th in 2015 to 90th in 2019. However, a large proportion of the population remain on the deprived end of the scale. The low rank position illustrates that many people in Derby are experiencing deprivation.

Figure 84: Local authority deprivation rank by average rank

Local Authority	LA rank 2015	LA rank 2019	Change
Amber Valley	162	167	5
Bolsover	61	58	3
Chesterfield	85	86	1
Derby	84	90	6
Derbyshire Dales	258	265	7
Erewash	149	168	19
High Peak	198	202	4
North East Derbyshire	190	177	13
South Derbyshire	230	218	12

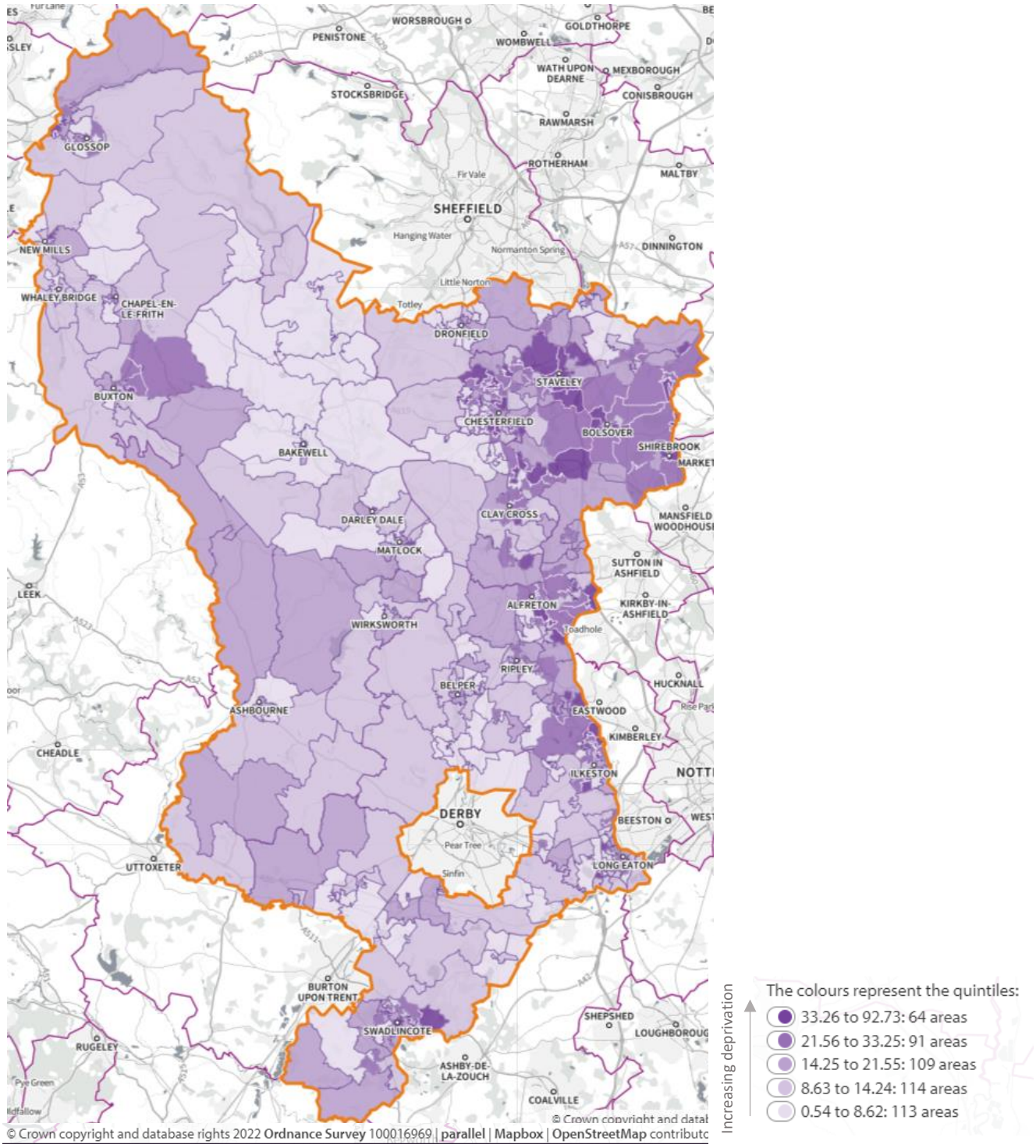
The seventeen wards within Derby City spread across the IMD 2019 Deciles. Derby is one of the 20% most deprived districts/unitary authorities in England and about 21% (11,145) of children live in low-income families. Pockets of deprivation are mainly concentrated within Arboretum, Normanton, Sinfin, and Derwent, 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. The map (Figure 85) shows the areas of Derby that are most deprived include Arboretum, Normanton, Sinfin, Derwent, Abbey and Boulton. In comparison to the least deprived areas of Allestree, Mickleover, Littleover, Oakwood and Chellaston. The map illustrates that the most deprived deciles are generally found in the city centre and along two lines laying north-to-south and east-to-west. The least deprived areas tend to be located on the city fringes in the suburbs.

Figure 85: Deprivation in Derby City (Reproduced directly from the Office for Health Improvement and Disparities, 2022)



The map of Derbyshire (Figure 86) covers a much larger area than Derby, but roughly, the more deprived areas are found on the east side. Bolsover and Chesterfield are particularly visible as having the most deprived areas. However, the county of Derbyshire is overall less deprived than England.

Figure 86: Deprivation in Derbyshire County (Reproduced directly from the Office for Health Improvement and Disparities, 2022)



3.3 Causes of ill health

This section describes the leading causes of ill health and mortality across Derby and Derbyshire. The highest mortality rates across Derbyshire, for all causes, for all individuals under 75 years, are in the Bolsover and Chesterfield districts. Lowest mortality rates were in the Derbyshire Dales. The contents in the summary table below will be explored in the following ill health subsections.

Figure 87: Deaths from all causes, under 75 years, standardised mortality ratio 2015-2019 (Office for Health Improvement and Disparities, 2022).

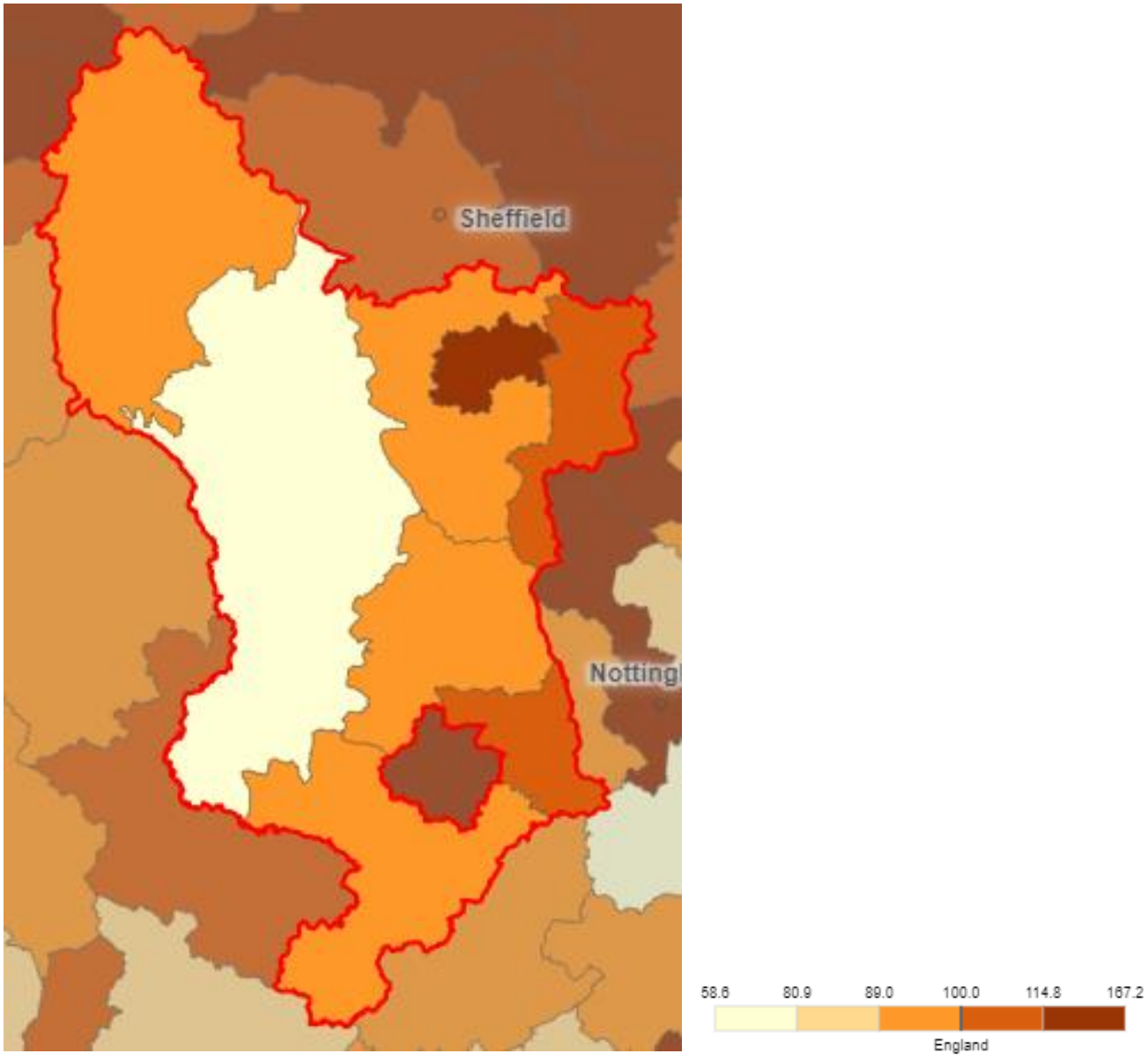


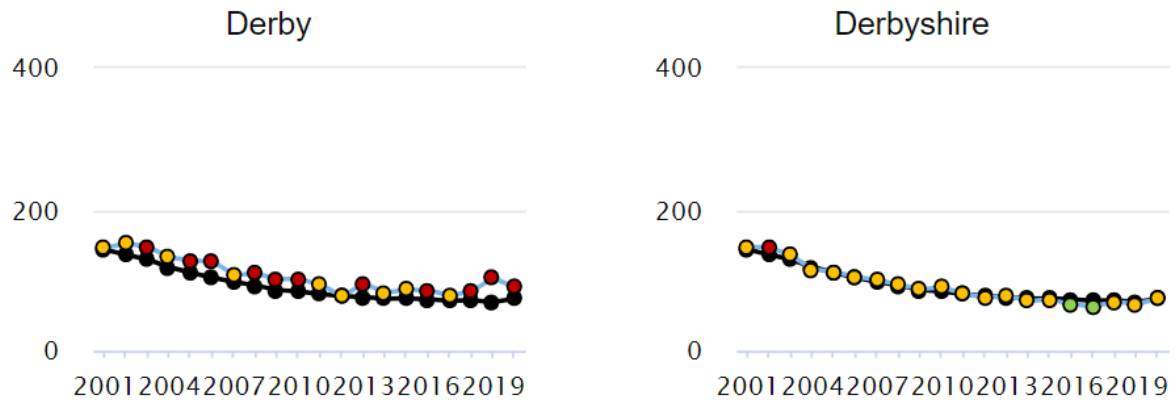
Figure 88: Directly standardised rates (per 100,000) mortality from selected conditions, under 75 years, 2020 (Office for Health Improvement and Disparities, 2022).

	Derby	Derbyshire	England
Mortality from CVD	88.7	73.3	73.8
Mortality from cancer	138.5	126.6	125.1
Mortality from respiratory disease	35.6	23.8	29.4
Mortality from injuries	19.4	14.9	14.4
Mortality from liver disease	20.1	10.9	10.8

3.3.1 Cardiovascular disease

Cardiovascular disease has a multifactorial aetiology with a number of potentially modifiable risk factors. Age, sex, cigarette smoking, blood pressure, total cholesterol and high-density lipoprotein (HDL) cholesterol, physical activity levels and sedentary behaviour are all factors. The rate of mortality from cardiovascular disease (CVD) in Derby and Derbyshire was 88.7 and 73.3, respectively, in persons less than 75 years of age per 100,000 population. This was higher in Derby, than the national and regional averages of 73.8 and 75.7 per 100,000, respectively. Overall, the trend data shows that under 75 mortalities from cardiovascular diseases has fallen since 2001 (Figure 89), with a rise in 2019 in Derby. Among people aged 65 and over, the rate of mortality from cardiovascular disease in Derbyshire (1,033.8 per 100,000 population) was slightly higher than the national average of 1,007.0 per 100,000 population.

Figure 89: Under 75 mortality rate (per 100,000) from all cardiovascular diseases 2001-2020, in Derby and Derbyshire (Office for Health Improvement and Disparities, 2022).



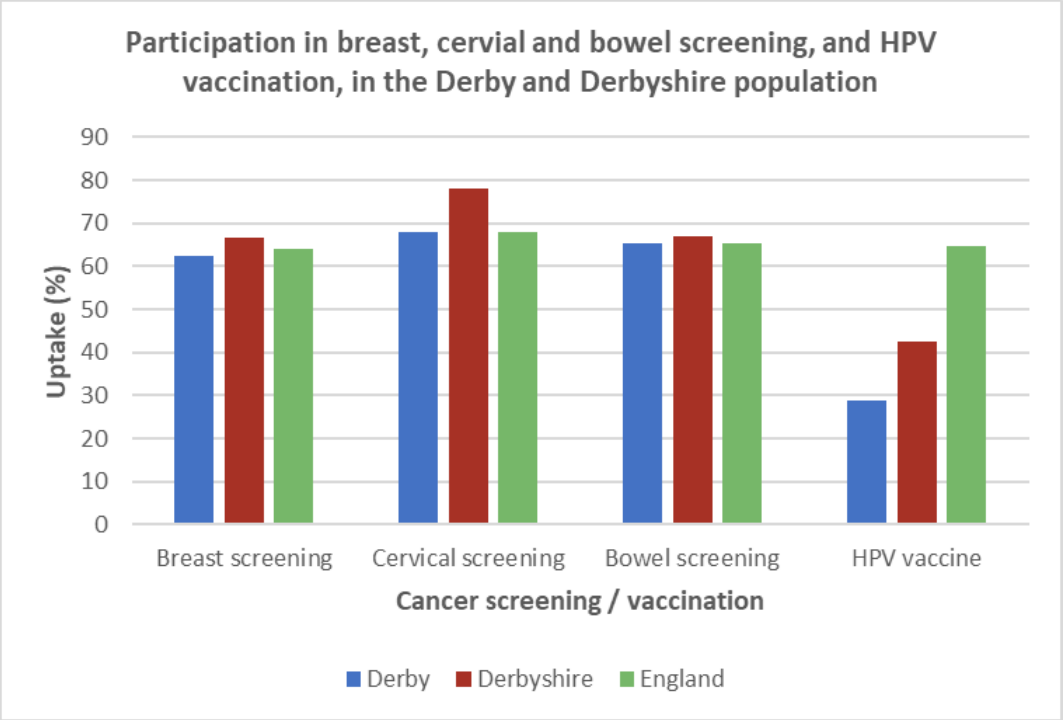
3.3.2 Cancers

Cancer is the second leading cause of death globally. Yet 30-50% of all cancer cases are preventable by healthy lifestyle choices such as avoidance of tobacco; accounting for approximately 25% of cancer deaths (World Health Organisation, 2022).

Screening / Vaccination Uptake

- 66.6% and 62.3% of individuals were screened for breast cancer in 2021 in Derbyshire and Derby, respectively, compared to the national average of 64.1%.
- In the last 3 years in Derby and Derbyshire, 62.4% of persons aged between 50-70 screened for breast cancer. The national average was 61.3%.
- 67% of people in 2021 screened for bowel cancer in Derbyshire, which was higher than Derby (65.5%) and the national average of 65.2%.
- 42.5% of 13–14-year-old girls in Derbyshire and 28.8% in Derby have had the 2-dose course of the HPV vaccine to protect against cervical cancer, which was significantly lower than the national average (64.7%).

Figure 90: Screening and vaccination uptake (%) in eligible Derby and Derbyshire populations



Cancer incidence

- In 2014-18 the incidence ratio of all cancers in Derby and Derbyshire were similar, with incidence ratios of 101.8 and 99.5, respectively.
- The incidence of prostate cancer was significantly lower than the national average in Derby (91.7) and similar in Derbyshire (97.3).
- In Derbyshire, the incidence ratio of lung cancer was 95.4 during 2014-18, which was lower than Derby's at 111.7.

Cancer mortality

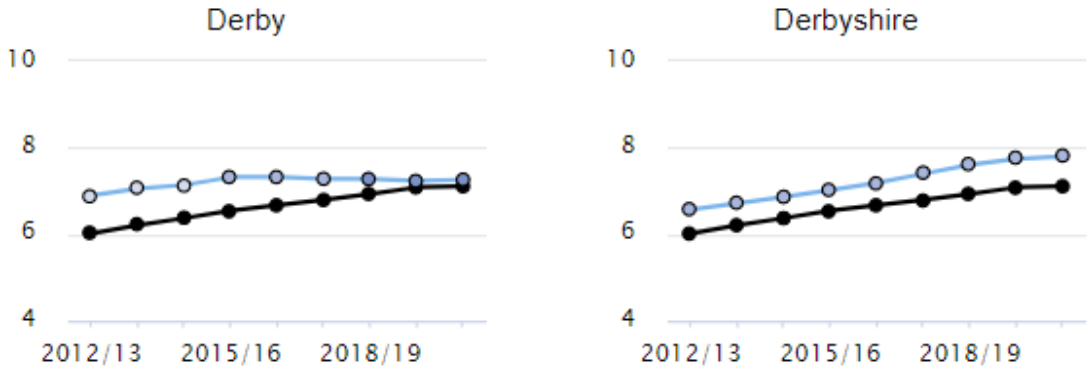
- In Derbyshire, mortality rate from lung cancer in 2020 was 52.0 per 100,000. While in Derby and England this value was 52.6 and 49.6, respectively

- The under-75 years of age mortality rate from cancer in 2017-19 was 126.8 per 100,000 population in Derbyshire and 147.0 per 100,000 population in Derby.
- The under 75 years of age mortality rate from cancers considered preventable in Derbyshire, was 50.4 per 100,000 population and 65.5 per 100,000 population in Derby in 2017-19.

3.3.3 Diabetes

There are an estimated 3.9 million people living with diabetes in the UK (Diabetes UK, 2022). For all adults and children, it is estimated that 10% of people with diabetes have Type 1, and 90% haveType 2. The risk of developing Type 2 diabetes can be reduced by changes in lifestyle (Diabetes UK, 2022). QOF prevalence data (2020/21) indicates that both Derby (7.3%) and Derbyshire (7.8%) have a higher prevalence of diabetes compared to England (7.1%) as a whole. The trend has increasingly risen over the past 5 years in Derbyshire (Figure 91).

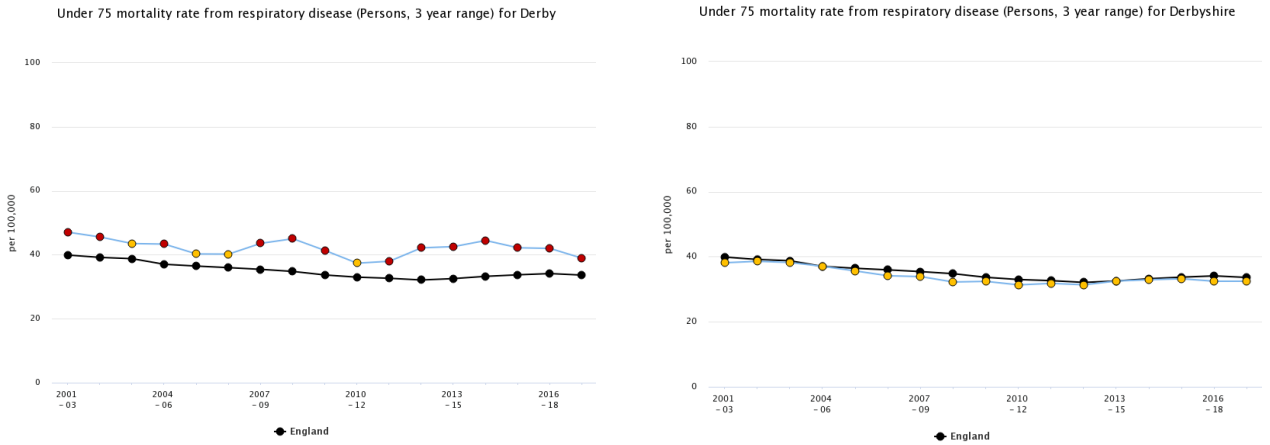
Figure 91: Diabetes: QOF prevalence (17+ %) 2012/13 – 2020/21, in Derby and Derbyshire (Office for Health Improvement and Disparities, Fingertips, 2022).



3.3.4 Respiratory Diseases

The UK has the highest mortality rates from respiratory disease in Europe, affecting 1 in 5 people (Public Health England, 2019). Between 2017 and 2019 the rate for under 75 mortality from respiratory disease was higher than the England average (33.6 per 100,000 population) in Derby City (38.9 per 100,000 population), while in Derbyshire it was slightly lower (32.5 per 100,000 population). Mortality from respiratory disease in under 75s considered preventable was also higher than national average (20.2 per 100,000 population) in Derby (23.8 per 100,000 population). Rates were slightly lower than the England average in Derbyshire (19.4 per 100,000 population).

Figure 92: Respiratory disease mortality in Derby and Derbyshire populations aged under 75 years, 2001-03 to 2017-19 (Office for Health Improvement and Disparities, Fingertips, 2022).



3.3.5 Chronic Obstructive Pulmonary Disease

The mortality rate from chronic obstructive pulmonary disease (COPD) in Derby (57.6 per 100,000) was higher than the national average (52.8 per 100,000), while the rate in Derbyshire (54.8 per 100,000) was similar in 2017-2019.

3.3.6 Asthma

The rate of asthma hospital admissions in children and teenagers in Derby and Derbyshire is belowthe national average (Figure 93).

Figure 93: Rate of asthma hospital admissions (per 100,000) in under 19 year-olds, 2020/21 (Office for Health Improvement and Disparities, Fingertips, 2022).

Hospital admissions for asthma (under 19 years) 2020/21 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	9,425	74.2	72.7	75.7
East Midlands region	↓	600	56.6	51.9	61.1
Leicester	→	75	84.6	67.6	107.3
Lincolnshire	↓	105	67.7	56.6	83.4
West Northamptonshire	–	60	61.7	48.0	80.6
Nottingham	–	45	60.6	46.5	84.2
Derbyshire	↓	95	58.4	47.8	72.1
Derby	↓	35	55.8	36.2	73.8
North Northamptonshire	–	40	47.6	33.0	63.4
Leicestershire	→	65	43.0	32.0	53.3
Nottinghamshire	–	75	42.4	32.4	51.9
Rutland	–	-	*	-	-

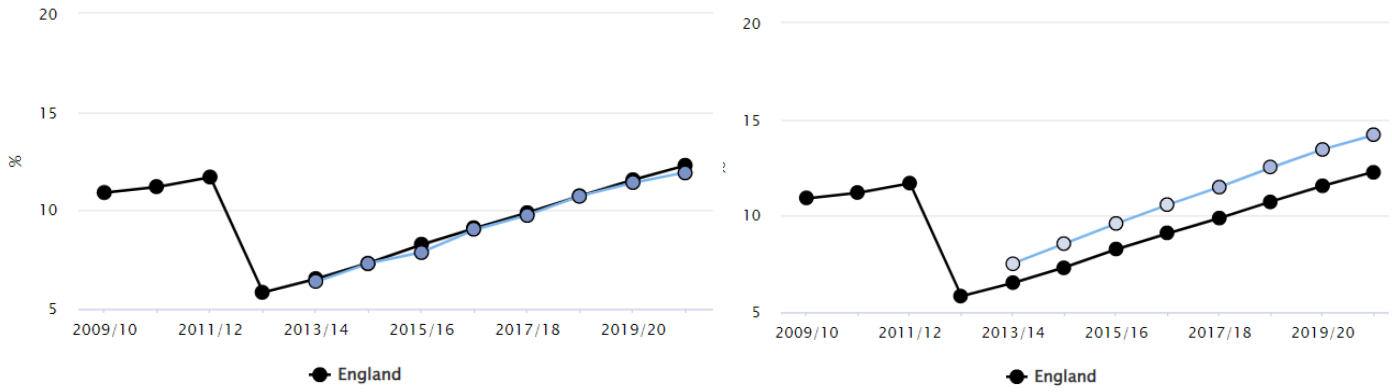
3.3.7 Depression and mental health

Mental health conditions are common across society and are a large contributor to premature death and frequently coexist with various physical ill health conditions. It is demonstrated that people with severe mental illnesses (SMI), on average, die prematurely: there is a 10-25 year life expectancy reduction in SMI patients (Mental Health Foundation, 2016).

In 2020/21, 11.0% of a Derby sample self-reported a low happiness score. This was higher than the England (9.2%) Derbyshire (6.8%) proportions. However, in contrast, the prevalence of adult depression was higher (14.2%) in Derbyshire than the national average (12.3%), while in Derby the prevalence was lower (11.9%) than in England. Notably, all indicators portray an upward trend of increasing prevalence of depression in adults. However, it is not clear whether this indicates an increasing prevalence of depression experienced in the population or an increase in the practice of recording depression on disease registers.

Throughout 2020/21, the proportion of adults in contact with secondary mental health services who lived in stable and appropriate accommodation in Derby (69%) and Derbyshire (81%), was higher than the national average (58%). However, Derby's rate has shown a slightly decreasing trend in recent years, whereas Derbyshire's rate has been relatively stable. Suicide rates in Derby (9.2 per 100,000) were slightly lower than the national average (10.4 per 100,000), but slightly higher in Derbyshire (11.2 per 100,000).

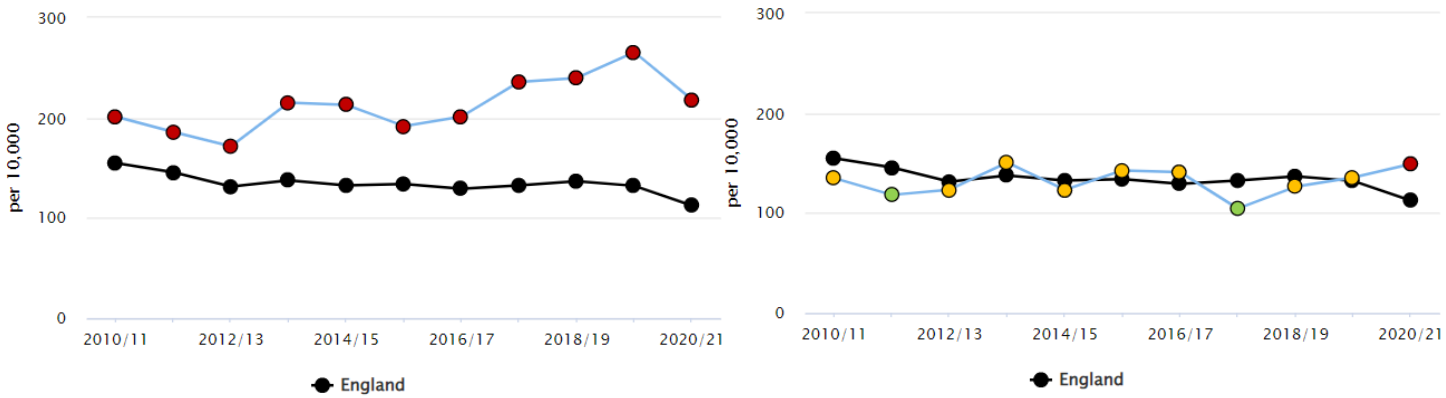
Figure 94: Prevalence (%) of depression recorded in the Derby and Derbyshire adult population, 2009/10 to 2019/20 (Office for Health Improvement & Disparities, 2022).



3.3.8 Injuries

Injuries are a major cause of hospital admission and premature mortality in children and young people. The hospital admissions rate due to injuries in children under 5 years old was 66.5 per 10,000 in Derby in 2020/21. This was significantly lower than the national rate of 108.7 per 10,000. Derbyshire was similar to the national average at 99.2 per 10,000 (Office for Health Improvement & Disparities, 2022). Further examination of the hospital admission injury data at district level illustrates diverging rates. The rate of hospital admissions for injuries in young people (15-24 years) is higher in the districts of Chesterfield and Amber Valley compared to neighbouring districts and the England average (Figure 95).

Figure 95: Rate per 10,000 of hospital admissions for injuries in young people (15-24 years) in districts Chesterfield and Amber Valley between 2010/11 and 2020/21 (Office for Health Improvement & Disparities, 2022).



3.3.9 Palliative care

Palliative care is the active holistic care of patients with advanced progressive illness, helping managing pain and other distressing symptoms. A palliative care package also involves psychological, social, and spiritual support for the patient and their families (NCPC, 2015). Care can take place in the patient's home, in care homes or hospices, or in hospitals, dependent on needs and preference.

For both Derby and Derbyshire, rates are comparable with the national average across the majority of indicators that come under end-of-life care. However, the percentage of hospital deaths amongst all age groups was

significantly higher in Derby compared to the national and Derbyshire averages: almost half of deaths in Derby occurred in hospital during 2020.

Comparably, deaths occurring at home were significantly lower in Derby (24.8%), while they were higher in Derbyshire (28.0%) and nationally (27.4%). National evidence indicates that people living in the most deprived quintile are significantly more likely to die in hospital than individuals living in other quintiles.

Figure 96: Place of death (%) for all ages, 2020 (Office for Health Improvement & Disparities, 2022).

	Derby	Derbyshire	England
Hospital deaths	44.2	41.5	41.9
Care home deaths	23.8	24.1	23.7
Hospice deaths	4.9	4.4	4.5
Home deaths	24.8	28.0	27.4
Deaths in other places	2.3	2.1	2.5

3.3.10 Lifestyle

Risk factors for disease

Figure 97 represents some of the key risk factors for disease across Derby and Derbyshire. Of particular note, smoking prevalence is significantly high in Derby (17.8%). In Derby, 30% of adults abstain from drinking alcohol, while in Derbyshire only 9.6% abstain, which falls significantly lower than the national average (15.5%). Alcohol consumption along with the percentage of adults carrying excess weight in Derbyshire (68.3%) could be contributing factors to the evidently higher prevalence of Hypertension (16.1%), compared to Derby (13.4%) and England (13.8%).

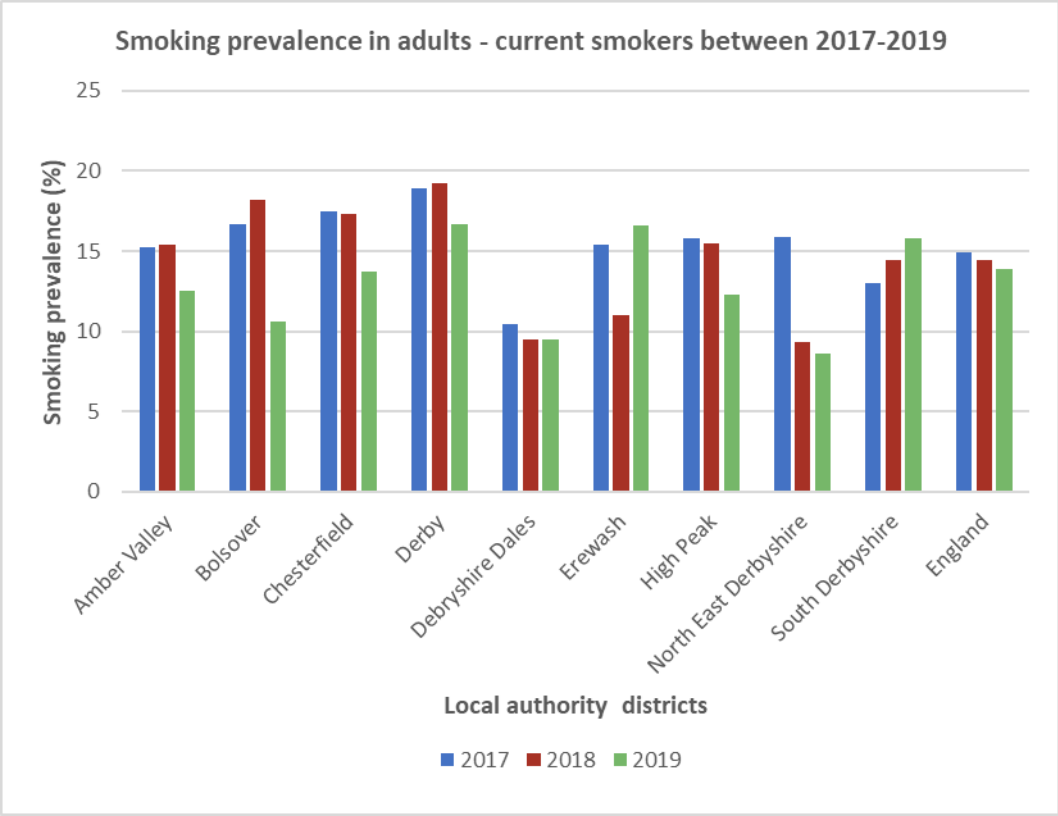
Figure 97: Prevalence (%) of key risk factors for ill health (Office for Health Improvement & Disparities, 2022).

	Derby	Derbyshire	England
Smoking prevalence in adults –current smokers (2020)	11.5	11.0	12.1
Hypertension: QOF prevalence (2020/21)	12.8	16.6	13.9
Physically active adults (2019/20)	66.0	70.6	66.4
Adults who abstain from drinking alcohol (2015-18)	24.4	10.6	16.2
Proportion of the population meeting the recommended '5-a-day' on a usual day, adults (2019/20)	55.0	56.4	55.4
Adults classified as overweight or obese (2019/20)	62.5	66.8	62.8

3.3.10.1 Smoking

In 2020 in Derby, the smoking prevalence in adults for current smokers is 11.5% which is similar to the national average of 12.1% and in Derbyshire of 11.0% (Annual Population Survey, 2020, cited within Office for Health Improvement and Disparities, 2022).

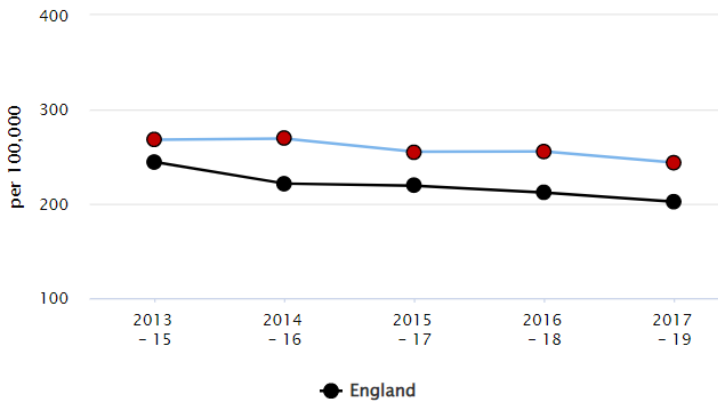
Figure 98: Smoking prevalence (%) in adults between 2017-2019 (Office for Health Improvement & Disparities, 2022).



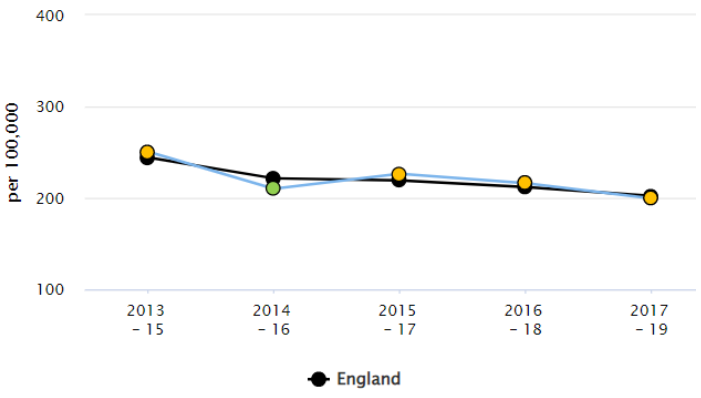
All local authority districts had a similar smoking prevalence to the national average in 2019. Smoking prevalence has dramatically reduced in Bolsover and North East Derbyshire in recent years but has increased in Erewash and South Derbyshire.

In 2017-19, the smoking attributable mortality in Derby was 243.5 per 100,000, which was significantly higher than the England rate of 202.2 per 100,000. Derbyshire's rate was similar to the England average (199.5 per 100,000) (Figure 99).

Figure 99: Smoking attributable mortality rate per 100,000, 2017-19 (Office for Health Improvement & Disparities, 2022)



Smoking attributable mortality - Derby



Smoking attributable mortality - Derbyshire

3.3.10.2 Drugs and alcohol misuse

Drug misuse

- The opiate treatment population was higher in Derby (5.5%) compared to the national rate (4.7%, but lower in Derbyshire (4.0%). 32.2% of non-opiate drug users successfully left treatment in Derby, which was similar to the national rate (33.0%) and slightly higher than in Derbyshire (29.7%).

- Nationally, the death rate from drugs misuse was 5.0 per 100,000 population in 2018-20. The rate was similar for Derbyshire (5.4 per 100,000), however, significantly higher in Derby (6.2 per 100,000 population). Of the deaths in Derby, 10.4 per 100,000 population were males, which is significantly higher than the national average (7.3 per 100,000) and Derbyshire (7.3 per 100,000).

- Derby and Derbyshire had similar proportions of people who had taken drugs (excluding cannabis) in the last month at age 15 in 2014/15 to the national average (Derby 0.9%, Derbyshire 0.8%, England 0.9%).

- Both Derby and Derbyshire had a higher number of deaths during drug treatment than would be expected in the population (Derby SMR 1.12, Derbyshire 1.09).

- The proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months in England was 82.0% in 2019. The proportions in Derby and Derbyshire were lower than the national average (Derby 79.2%, Derbyshire 66.7%).

Alcohol misuse

- In 2015-18 in Derby and Derbyshire, 12.1% and 18.2% respectively of the adult population binge drink, in comparison to the national average (15.4%).

- In 2020/21, Derby had a higher rate (2.4 per 1,000 population) of adults in treatment at specialist alcohol misuse services, compared to Derbyshire (1.7 per 1,000 population) and nationally (1.4 per 1,000).

- Derby and Derbyshire had slightly lower proportions of people who successfully completed alcohol treatment in 2020 than the national average (Derby 34.2%, Derbyshire 33.6%, England 35.3%).

- Derbyshire had a significantly higher proportion of those who had ever had an alcoholic drink by the age of 15 (71.9%) than the national average (62.4%). Whereas, Derby had a significantly lower proportion (58.3%).

Alcohol and related diseases

Alcohol misuse and alcohol related problems, especially binge drinking and alcohol-related liver disease, are major public health concerns which have the potential to result in death. The national average for alcohol specific mortality in 2020 was 13 per 100,000. The rate was similar in Derbyshire (13.1 per 100,000 population) but was significantly higher in Derby (22.3 per 100,000 population). Specific diseases can be related to the overuse of alcohol. Figure 100shows the rates of admissions for intentional self-poisoning were higher in both Derby and Derbyshire than the national average. The rates for admissions for alcoholic liver disease were higher in both Derby and Derbyshire than the national average. The admission rate for mental and behavioural disorders due to alcohol misuse were higher than the national average in Derby, rates however, were lower in Derbyshire.

Figure 100: Directly standardised rate per 100,000 of alcohol conditions and co-occurring disease (Office for Health Improvement and Disparities, 2022).

	Derby	Derbyshire	England
Admission episodes for mental and behavioural disorders due to use of alcohol condition (Broad) (2020/21)	409	318	379
Admission episodes for alcohol-related cardiovascular disease conditions (2020/21)	783	614	613
Admissions for intentional self-poisoning by and exposure to alcohol condition (Narrow) (2020/21)	61.7	70.9	43.1
Admission episodes for alcoholic liver disease condition (Broad) (2020/21)	255.6	136.1	128.3
Incidence rate of alcohol-related cancer (2016/18)	38.44	38.98	37.77

3.3.10.3 Obesity

Being overweight (BMI between 25 and 29) and obese (BMI 30 and over) is associated with diabetes type II, coronary heart disease, stroke, cancer, and hypertension, to list the most common conditions. 21.0% of primary school children in Year 6 and 62.8% of adults in England are categorised as obese (Office for Health Improvement & Disparities, 2019/20). The UK now has the highest level of obesity in Western Europe. In the last 30 years the obesity levels have trebled, and it is projected that if this trend continues, half of the UK population could be obese by 2050 (NHS Choices, 2015). Obesity rates increase throughout childhood.

The proportion of reception-aged children classified as obese is similar in Derby (9.2%), Derbyshire (8.9%) and England (9.9%). However, Derby has a higher proportion of obese Year 6 children (23.9%) than Derbyshire (19.7%) and the national average (21.0%). This increasing trend continues into adulthood; however, Derbyshire has a higher proportion of obese adults (66.8%) than Derby (62.5%) and England 62.8%).

Childhood obesity has rapidly increased for reception children in the district of South Derbyshire in from 2015/16 to 2018/19 (Figure 101). In Bolsover (Figure 102), obesity prevalence increased from 2015/16 to 2018/19 but has decreased in recent years. Increases in obesity have been seen in Derby City and Bolsover for children in the last year of primary school, Year 6 (Figure 103 & Figure 104).

Figure 101: Prevalence of obesity in reception-aged children in South Derbyshire

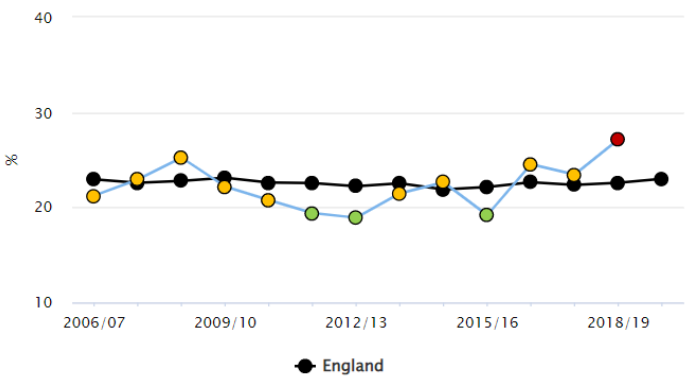


Figure 102: Prevalence of obesity in reception-aged children in Bolsover

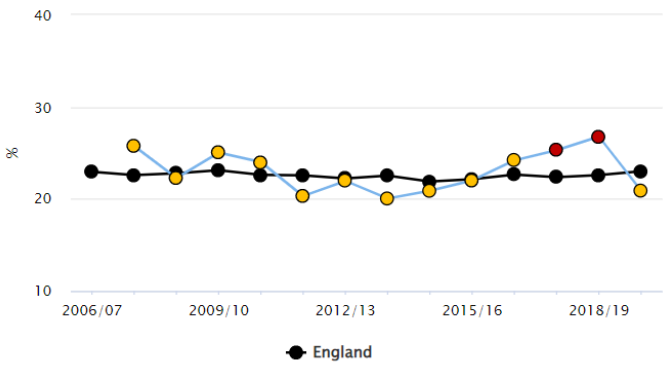


Figure 103: Prevalence of obesity in children in Year 6 in Derby

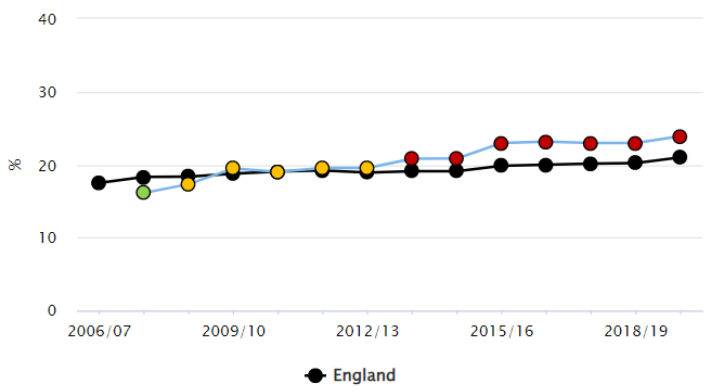
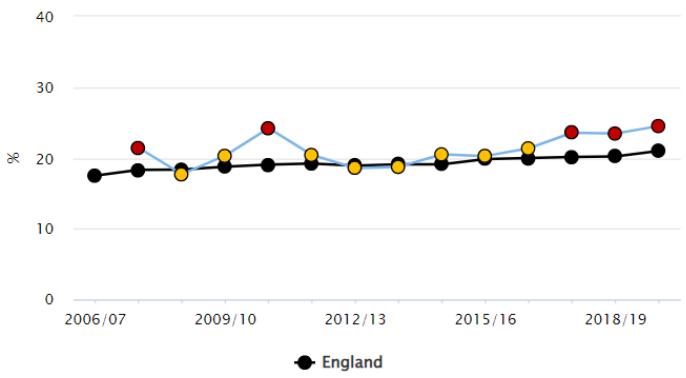


Figure 104: Prevalence of obesity in children in Year 6 in Bolsover



The percentage of adults classified as overweight or obese (BMI greater than or equal to 25kg/m^2) was 62.8% in England, 66.8% in Derbyshire and 62.5% in Derby (2019/20). There is variation in the proportion of obese adults across Derbyshire, with a greater proportion residing in Erewash, Amber Valley, Bolsover, and Chesterfield. In Derby City, a greater proportion reside in Spondon, Mickleover and Allestree.

Maternal obesity is measured as a BMI of 30kg/m² and above at the first antenatal consultation. In England 22.1% of women of childbearing age are overweight or obese. Maternal obesity poses health risks to both the pregnant women (e.g. gestational diabetes) and the baby in utero and after birth (e.g. macrosomia, still birth) (Office for Health Improvement and Disparities, 2018/19).

3.3.10.4 Sexual health and teenage pregnancy

The three areas of sexually transmitted infections (STI), reproductive health and teenage pregnancies provide an overview of sexual health across Derby and Derbyshire.

HIV & STI

Figure 105: Rate per 100,000 of infectious diseases (Office for Health Improvement & Disparities, 2022)

	Derby	Derbyshire	England
Chlamydia detection rate, 15-24 years old (2020)	1,505	1,246	1,408
Syphilis diagnostic rate (2020)	7.4	3.8	12.2
Gonorrhoea diagnostic rate (2020)	127	51	101
Genital warts diagnostic rate (2020)	40.1	34.4	48.6
Genital herpes diagnostic rate (2020)	37.8	28.0	36.3
HIV diagnosed prevalence rate aged 15+ (2020)	2.18	0.65	1.91

There is a lower detection rate of chlamydia in the Derbyshire population (1,246 per 100,000) compared to the national average (1,408 per 100,000), but higher detection rate in Derby's population (1,505 per 100,000).

Reproductive health

Derbyshire has the lowest over 25s abortion rate in England in comparison to all of the other counties (Figure 106). The over 25s abortion rate in Derbyshire is 8.6 per 1,000 and in England the rate is 14.5 per 1,000. A higher rate of pelvic inflammatory disease was evident in Derbyshire (259.1 per 100,000 population) in 2015/16 compared to the national average (237.0 per 100,000 population). Rates of cervical cancer registrations were

higher in both Derby (11.5 per 100,000 population) and Derbyshire (10.3 per 100,000 population) compared to England (9.6 per 100,000 population).

Figure 106: Reproductive health indicators (Office for Health Improvement & Disparities, 2022)

	Derby	Derbyshire	England
Under 18s conception rate, per 1,000 (2019)	20.9	14.3	15.7
Under 18s conceptions leading to abortion, % (2019)	34.8	50.3	54.7
Under 18s birth rate, per 1,000 (2015)	7.5	3.6	4.1
Under 18 births, % (2020/21)	0.9	0.6	1.8

Teenage pregnancy

There is a lower conception rate in teenagers aged under 18 in Derbyshire (14.3 per 1,000) compared to England (15.7 per 1,000). Comparably, there is a higher conception rate in teenagers aged under 18 in Derby (20.9 per 1,000). A greater proportion of under 18s conceptions lead to abortion in England (54.7%) compared to Derbyshire (50.3%) and Derby City (34.8%). Derby City has a significantly higher birth rate in under 18s (7.5 per 1,000), compared to Derbyshire (3.6 per 1,000) and England (4.1 per 1,000). Teenage pregnancies (mothers aged under 18) account for 0.9% of pregnancies in Derby, 0.6% in Derbyshire, compared to 1.8% in England.

Figure 107: Teenage pregnancy in Derby and Derbyshire (Office for Health Improvement & Disparities, 2022)

	Derby	Derbyshire	England
Total abortion rate, per 1,000 (2020)	18.2	14.5	18.9
Over 25s abortion rate, per 1,000 (2020)	16.2	13.0	17.6
Abortions under 10 weeks, % (2020)	85.5	86.2	88.1
Total prescribed LARC excluding injections rate, per 1,000 (2020)	43.2	42.2	34.6
Women choose injections at SRH Services, % (2020)	4.3	5.5	8.1
Women choose user-dependent methods at SRH Services, % (2020)	69.6	71.1	54.9
Women choose hormonal short-acting contraceptives at SRH Services, % (2020)	62.6	66.4	41.7
Pelvic inflammatory disease (PID) admissions rate, per 100,000 (2019/20)	208.9	238.6	254.7
Ectopic pregnancy admissions rate, per 100,000 (2019/20)	109.4	59.6	90.0
Cancer screening coverage - cervical cancer (aged 25 to 49 years old) (2021)	68.1	78.2	68.0

3.3.16 Oral Health

Derby performs similarly to the national average for children's oral health. 27.4% of Derby's 5-year-old children experienced visually obvious dental decay in 2018/19. This is slightly poorer but not statistically significant difference than the national average of 23.4%. In Derbyshire, less children experienced visually obvious dental decay (17.1%). Figure 108 shows the variation of this variable across the East Midlands region, with Derbyshire having the lowest proportion.

Figure 108: Proportion (%) of five-year-old children who experienced visually obvious dental decay.

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	23.4	23.1	23.7
East Midlands region	–	-	24.7	23.9	25.6
Leicester	–	-	38.6	35.7	41.6
Nottingham	–	-	35.8	29.6	42.5
Derby	–	-	27.4	20.3	35.8
Lincolnshire	–	-	25.5	23.7	27.4
Rutland	–	-	25.3	20.3	31.0
Nottinghamshire	–	-	19.9	17.9	22.0
Leicestershire	–	-	18.2	16.5	20.0
Derbyshire	–	-	17.1	15.2	19.3
North Northamptonshire	–	-	-	-	-
West Northamptonshire	–	-	-	-	-

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children (Biennial publication - latest report 2019) https://www.gov.uk/government/collections/oral-health#surveys-and-intelligence:-children

The average number of decayed, missing or filled teeth (dmft) is significantly higher in Derby with five-year-olds having 0.99 dmft on average compared to 0.80 dmft nationally. In contrast, oral health in five-year-old children is much better in Derbyshire with children having on average only 0.49 dmft (Figure 109).

Figure 109: Mean number of decayed, missing or filled teeth in five-year-olds, 2018/19 (Office for Health Improvement & Disparities, 2022).

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	0.80	0.78	0.81
East Midlands region	–	-	0.84	0.80	0.88
Leicester	–	-	1.59	1.42	1.76
Nottingham	–	-	1.52	1.11	1.93
Derby	–	-	0.99	0.55	1.43
Lincolnshire	–	-	0.87	0.78	0.96
Rutland	–	-	0.71	0.53	0.90
Nottinghamshire	–	-	0.57	0.49	0.65
Leicestershire	–	-	0.50	0.44	0.57
Derbyshire	–	-	0.49	0.41	0.57
North Northamptonshire	–	-	-	-	-
West Northamptonshire	–	-	-	-	-

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2019

3.4 Life expectancy gaps

3.4.1 PHE Segment Tool: segmenting life expectancy gaps by cause of death

Life expectancy at birth in England is 79.6 years for males and 83.1 for females. Life expectancy across the country varies by local authority. The table below (Figure 110) illustrates that life expectancy is lower than the national average in Derby, Bolsover, Chesterfield and South Derbyshire for males and females and in Amber Valley and North East Derbyshire for females. However, life expectancy is exceeding the national average in Derbyshire Dales and High Peak for males and females.

Figure 110: Life expectancy across Derby and Derbyshire districts, 2015-17 (Office for Health Improvement and Disparities Segmentation Tool)

	Life expectancy at birth (2015-17)		Absolute gap in life expectancy between LA and England in years	
	Male	Female	Male	Female
England	79.6	83.1		
Derby	78.5	82.7	-1.1	-0.5
Amber Valley	79.6	82.6	0.0	-0.5
Bolsover	77.9	81.5	-1.6	-1.6
Chesterfield	77.9	82.1	-1.7	-1.0
Derbyshire Dales	80.8	84.2	1.2	1.1
Erewash	79.5	83.4	0.0	0.3
High Peak	79.9	83.3	0.3	0.1
North East Derbyshire	79.7	82.9	0.2	-0.2
South Derbyshire	79.3	82.5	-0.3	-0.7

Figure 111 shows the life expectancies for the most and least deprived quintiles of each local authority area across Derbyshire and the absolute gap in life expectancy between these quintiles for males and females. There is a large life expectancy gap between the most deprived and least deprived quintiles for males and females across all local authorities. The greatest gap in life expectancy for males is in Erewash, followed by Derby and Amber Valley. For females, the largest gap in life expectancy is in Chesterfield, followed by Derby. The smallest gap for both males and females are in Derbyshire Dales, followed by Bolsover.

Figure 111: Life expectancy across Derby and Derbyshire districts by the least and most deprived areas, 2015-17 (Office for Health Improvement and Disparities Segmentation Tool)

	Life expectancy in most deprived quintile of LA (2015-17)	Life expectancy in most deprived quintile of LA (2015-17)	Life expectancy in least deprived quintile of LA (2015-17)	Life expectancy in least deprived quintile of LA (2015-17)	Absolute gap in life expectancy between most deprived and least deprived quintile of LA	
	Males	Females	Males	Females	Males	Females
Derby	74.8	78.5	82.4	85.5	-7.6	-7.0
Amber Valley	75.0	79.0	82.7	85.6	-7.6	-6.6
Bolsover	74.6	79.1	80.4	83.5	-5.8	-4.4
Chesterfield	74.4	79.1	81.7	86.5	-7.2	-7.4
Derbyshire Dales	79.1	83.1	81.6	85.8	-2.5	-2.7
Erewash	75.0	80.0	83.3	85.4	-8.3	-5.3
High Peak	76.5	80.3	83.0	85.6	-6.5	-5.2
North East Derbyshire	76.5	80.4	83.5	87.0	-7.0	-6.6
South Derbyshire	77.4	81.8	84.5	87.0	-7.1	-5.3

The table below (Figure 112) enables greater understanding of the gap in life expectancy between local authorities and the national average. In Derby, the largest proportion for lower than national life expectancy in males is caused by circulatory ill-health (23.9%), and early deaths are predominately caused by digestive diseases

in females (36%). Cancer is the main cause of early deaths in females in Amber Valley (27.9%), males in South Derbyshire (39.1%), as well as males and females in Bolsover (44.6% & 42.8%, respectively). In Chesterfield, the main causes are circulatory ill-heath in males (28.2%), and respiratory ill-health in females (40.33%). A number of district male and female rows are absent from the table, and this indicates that the LE is above the England average (Amber Valley male; Derbyshire Dales male and female; Erewash female; High Peak male and female; North East Derbyshire male).

Figure 112: Breakdown of the life expectancy gap between LA as a whole and England as a whole, by broad cause of death, 2015-17 (Office for Health Improvement and Disparities Segmentation Tool)

Percentage difference	Circulatory	Cancer	Respiratory	Digestive	External causes	Mental & behavioural	Other	Deaths <28 days
Derby (Males)	23.9	23.3	20.0	7.7	0	7.8	5.8	11.6
Derby (Females)	13.9	12.1	10.9	24.8	0	23.2	0.4	14.7
Amber Valley (Females)	14.7	27.9	4.4	5.9	0	7.8	24.7	14.6
Bolsover (Males)	11.9	44.6	23.3	0	4.7	14.2	1.4	0
Bolsover (Females)	8.9	42.8	16.9	7.9	0	15.1	8.4	0
Chesterfield (Males)	28.2	13.9	15.1	8.0	25.3	9.6		
Chesterfield (Females)	1.9	33.4	40.3	4.1	2.1	12.1	0	6.0
Erewash (Males)	0	0.1	19.6	47.2	0	33.1	0	0
North East Derbyshire (Females)	0	19.7	22.0	0	58.1	0	0.1	0
South Derbyshire (Males)	0	39.1	31.6	3.2	0	0	0	26.1
South Derbyshire (Females)	8.3	0.4	9.0	5.4	6.7	15.1	41.0	14.1

3.4.2 Health Inequalities

"Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives."[33]

Figure 113 below shows the distribution of income deprivation across electoral wards in Derbyshire. On the left, the wards Gamesley, Arboretum, Rother, Sinfin and Normanton feature due to a high number and percentage of income deprivation. The wards with the lowest income deprivation include Brailsford, Clifton and Bradley, Wingerworth and Allestree.

[33]NICE (2012)

Figure 113: Income deprivation by electoral ward across Derbyshire (Office for Health Improvement and Disparities – Local Health, 2019)

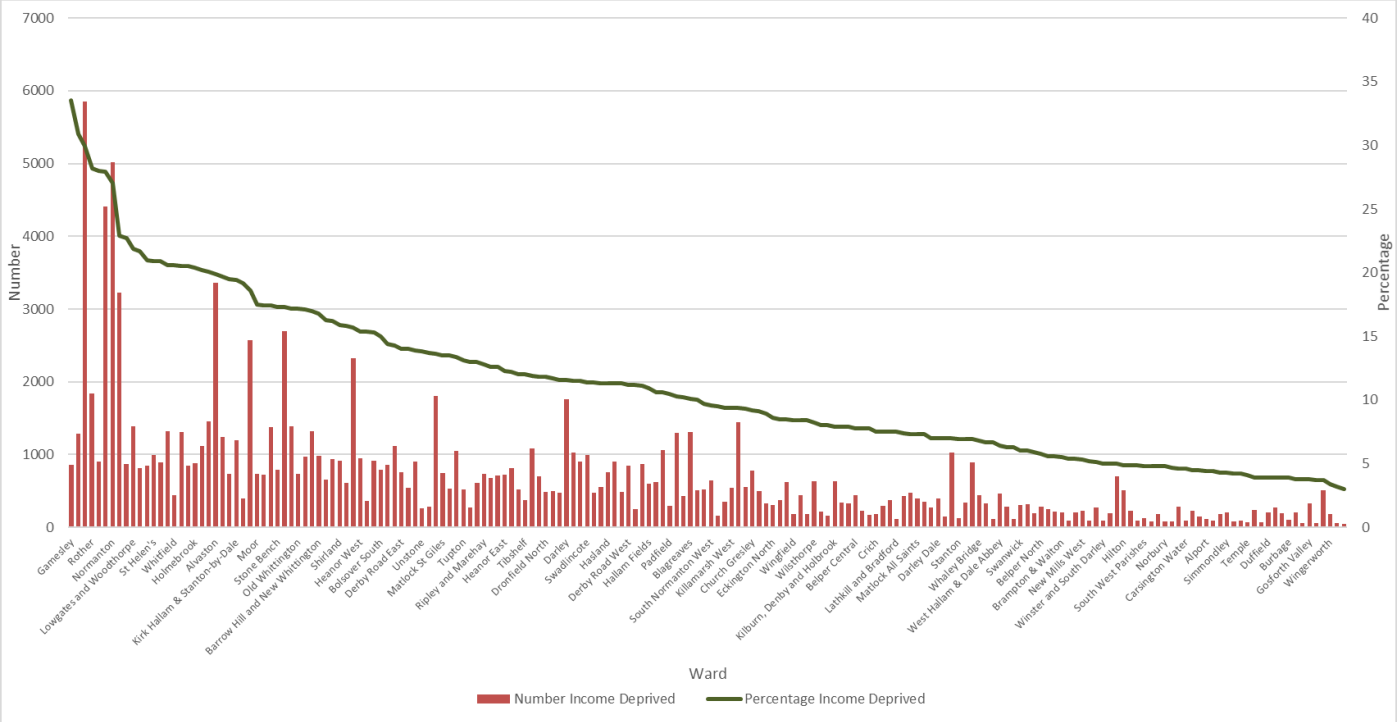


Figure 114 enables the visualisation of income deprivation at local authority level across Derbyshire. This shows higher proportions of income deprivation in Derby and along the east of Derbyshire in Bolsover and Chesterfield.

Figure 114: Income deprivation across local authority areas in Derbyshire, 2019 (%) (Ministry of Housing and Local Government, 2019)

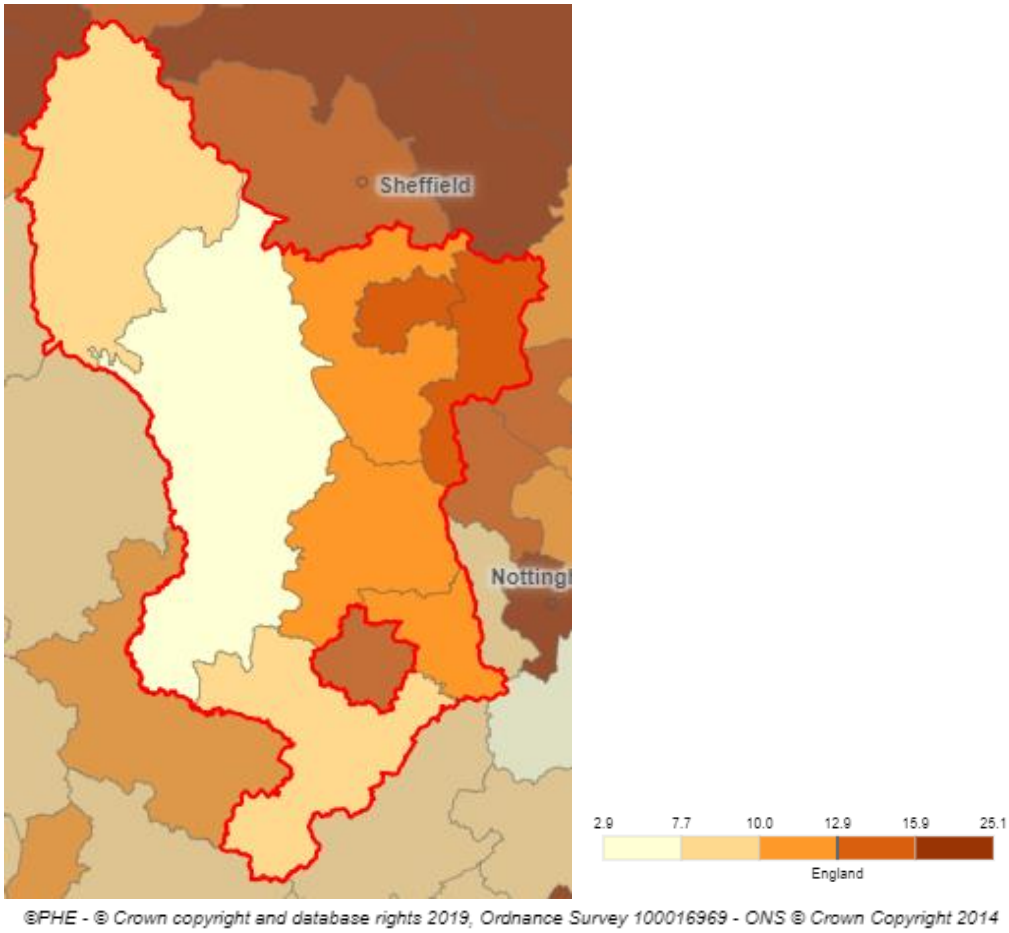


Figure 115 shows inequalities in important high-burden diseases. Shirebrook North, Clay Cross North, Ridgeway and Marsh Lane and Gamesley are wards in Derbyshire with the highest inequalities. In contrast, wards with the lowest include Hilton, Little Hallam, Doveridge and Sudbury, Alport and Hope Valley.

Figure 115: Highest and lowest wards in Derbyshire for the Global Burden of Disease conditions causing the largest burden.

GBD by cause	Indicator	Ward with lowest	Ward with highest
Low back and neck pain	Limiting long term illness or disability (%)	Hilton	Shirebrook North
Ischemic heart disease	Emergency hospital admissions for CHD (SAR)	Little Hallam	Clay Cross North
Cerebrovascular disease	Emergency hospital admissions for stroke (SAR)	Doveridge and Sudbury	Ridgeway & Marsh Lane
Chronic obstructive pulmonary disease	Emergency hospital admissions for COPD (SAR)	Alport	Ridgeway & Marsh Lane
Tracheal, bronchus, and lung cancer	Incidence of lung cancer (SAR)	Hope Valley	Gamesley

3.5 Health profiles and identified health needs

PHE/OHID produce annual Health Profiles for each local authority in England. These health profiles provide an overview of local health issues, priorities and needs and allow for comparisons to England and other local authorities. The health of people in Derby is generally poorer than the England average. Derby is one of the 20% most deprived local authorities in England and about 24% (12,800) of children live in relatively low income families. Life expectancy for both men and women is lower than the England average. The health of people in Derbyshire is varied compared with the England average. About 15% (20,200) of children live in relatively low income families. Life expectancy for both men and women is lower than the England average. In the tables below, the best outcomes are health outcomes where the rate in Derby and Derbyshire is better than national average. The health priorities section links to outcomes where the area is comparatively worse than the national average and therefore highlights a need. These tables provide a summary of much of the content discussed in the earlier sections of this health needs chapter.

Figure 116: Summary of PHE/OHID Local Authority Profile - Derby

Derby	
Best Outcomes	**Health priorities**
Killed and seriously injured (KSI) rate on England's roads	Under 75 mortality rate from all causes
Estimated dementia diagnosis rate	Mortality rate from all cardiovascular diseases
Hospital admission rate for alcohol-specific conditions	Mortality rate from cancer
New STI diagnoses rate (exc. chlamydia aged <25)	Emergency hospital admission rate for intentional self-harm
	Hospital admission rate for alcohol-related conditions
	Percentage of adults classified as overweight or obese
	Smoking prevalence in adults in routine and manual occupations
	Teenage conception rate
	Percentage of smoking during pregnancy
	Percentage of breastfeeding initiation
	Infant mortality rate
	Year 6: Prevalence of obesity (including severe obesity)
	Percentage of children in low income families
	Average GCSE attainment (average attainment 8 score)
	Statutory homelessness rate - eligible homeless people not in priority need

Figure 117: Summary of PHE/OHID Local Authority Profile - Derbyshire

Derbyshire	
Best Outcomes	**Health priorities**
Killed and seriously injured (KSI) rate on England's roads	Emergency hospital admission rate for intentional self-harm
Mortality rate from all cardiovascular diseases	Hospital admission rate for alcohol-specific conditions
Estimated diabetes diagnosis rate	Hospital admission rate for alcohol-related conditions
Teenage conception rate	Percentage of adults classified as overweight or obese
Year 6: Prevalence of obesity (including severe obesity)	Percentage of smoking during pregnancy
Percentage of children in low income families	Average GCSE attainment (average attainment 8 score)
Statutory homelessness rate - eligible homeless people not in priority need	
Violent crime - hospital admission rate for violence (including sexual violence)	
New STI diagnoses rate (exc. chlamydia aged <25)	
TB incidence rate	

4 NHS COMMUNITY PHARMACY

Community pharmacists are highly trained and accessible healthcare professionals. Pharmacies are a part of the wider NHS family, but unlike other services can often be found open and available to offer anything from medicines to advice, when other healthcare professionals are unavailable. They come in varying types, sizes and settings. Many of us will be familiar with the traditional and often convenient means of travelling to access a pharmacy, be that one of the large independent chains found in our towns and cities, pharmacies in supermarkets, hospitals, or attached to a local GP practice. They can also be found in much smaller, rural communities as individually owned premises. Community pharmacy is available to everyone and can often be found concentrated in more deprived neighbourhoods where need is greatest. In recent times community pharmacies have had to adapt to new technologies and an increasingly digital society, and a number are now operating 'at a distance' from the population through online, internet-based channels. In the future, the health and care system as a whole will need to ensure that community pharmacy is integrated and embedded within the transforming NHS and Social Care landscape.

4.1 Community pharmacy providers

There are currently 231 pharmaceutical providers across Derby and Derbyshire, including 205 community pharmacies, 4 distance selling pharmacies, 18 dispensing GP practices, 3 Dispensing Appliance Contractors and 1 Local Pharmaceuticals Service.

Figure 118: Registered Community Pharmacies by Derby and Derbyshire District

District	Pharmacies	Population	Pharmacies per 100,000
Derby	54	256814	21
Amber Valley	25	128829	19
Bolsover	17	81305	21
Chesterfield	21	104930	20
Derbyshire Dales	10	72422	14
Erewash	23	115332	20
High Peak	21	92633	23
North East Derbyshire	20	102216	20
South Derbyshire	14	109516	13

There are an estimated 21 registered pharmacies to every 100,000 people in England[34]. This figure has fallen from when the previous PNA was published and is at its lowest since 2015/16. Figure 118 demonstrates how the number and corresponding rates of community pharmacy providers by Derby and Derbyshire District compare to the national average. For the JUCD footprint as a whole, there are 19 pharmacies per 100,000 population. Derby City has a similar rate (21 per 100,000) while the Derbyshire County area has a lower than average rate (18 per 100,000), although this cannot be regarded as a thorough-going indicator of the adequacy of pharmacy services.

Much of the GP dispensing provision for Derbyshire is concentrated in the rural areas of the county which mitigates this lower concentration of premises.

[34] NHSBA (2021)

4.1.1 Distance Selling Pharmacies

Derby and Derbyshire have four distance selling pharmacies registered to premises in Erewash, North East Derbyshire and Derby City (2). These pharmacies receive prescriptions via the post or internet and dispense and deliver by courier, post or delivery driver. Data is unavailable as to the source of individual prescription requests to these four pharmacies, but it is important to note that there is no limit to the geographical area which they may cover. They are required to provide a national service. Distance Selling Pharmacies are not allowed to provide Essential Services face to face but may provide Advanced and Enhanced Services if they are unrelated to the provision of Essential Services.[35]

4.1.2 Dispensing GP practices

Dispensing GP practices provide dispensing services in rural areas where patients may otherwise have difficulty accessing a community pharmacy, or where it is not viable for a community pharmacy to operate. This facility is only available to patients who live at a distance of more than 1 mile, or 1.6km from traditional premises. Nationally, dispensing doctors provide primary healthcare to nearly nine million UK rural patients. Nearly 3.6 million of these patients live remotely from a community pharmacy and at the patient's request, have their GPs dispense the medicines that they prescribe for them. In total, approximately 7% of all prescription items are dispensed by doctors[36].
In England, any new pharmacy application in a controlled locality[37] will be considered against the current pharmaceutical services regulations. If successful, the pharmacy will gain the protection of the 1.6km radius for their dispensing rights. Patients who live within 1.6km of the new pharmacy will usually then lose their right to receive the GP dispensing service. If the total population living with a 1.6km radius of the new pharmacy is less than 2,750 people, then the patients who currently receive the GP dispensing service may choose to either remain with that service or use the new pharmacy. This is known as a reserved location.

Given the rural nature of much of Derbyshire, there are 18 dispensing GP practices offering this service to their registered and eligible populations, 9 of which are located in Derbyshire Dales. The rural area of the north Dales has the greatest concentration of dispensing practices covering the surroundings of towns and villages such as Ashover, Bakewell, Baslow, Darley Dale, Eyam and Tideswell. The south Dales has the second largest concentration, and covers the surrounding areas of Ashbourne, Brailsford and Hulland.

Figure 119: Dispensing GP Practice locations by District

District	Dispensing practices	Dispensing list size	Total list size
Derby	1	3004	300379
Amber Valley	1	2224	138377
Bolsover	2	4485	97079
Chesterfield	1	638	113414
Derbyshire Dales	9	31860	85495
Erewash	2	1344	112947
High Peak	1	3935	96958
North East Derbyshire	1	2116	79158
South Derbyshire	0	0	93233

[35] The Secretary of State for Health (2013)
[36] Dispensing Doctors' Association (2016)
[37] A controlled locality is a geographical area judged to be rural in nature by NHS England. NHSE may review the rural status of an area – a request that can also be made by a Local Medical Committee and a Local Pharmaceutical Committee, providing no determination has been made in the previous five years. The five year rule does not apply if there has been a significant change in the population or in the housing provision (Dispensing Doctors' Association, 2016)

4.1.3 Dispensing Appliance Contractors

Dispensing Appliance Contractors (DAC) are unable to supply medicines. They do, however, specialise in support for both Ostomy and Urology patients, including in the supply of stoma care products. In 2020/21 there were 112 appliance contractors actively dispensing in England[38]. NHS England currently commission three DACs in Derby and Derbyshire. These are:

- ATOS Care, Cardinal Business. Centre. 10. Nottingham. Road. Derby. DE1 3QT
- Fittleworth Medical Limited, Ground Floor, 61 Canal Street, Derby, DE1 2RJ
- Salts Healthcare Limited, Holywood House Annexe, Holywell Street, Chesterfield, S41 7SH

A contract for appliance contractors was published in April 2010, which allows appliance contractors to provide Appliance Use Reviews (AUR) and stoma customisation services (SCS) in addition to essential services. Community Pharmacies who dispense appliances can also choose to provide these advanced services. Dispensing appliance contractors provide services nationally. Pharmacies are also able to supply many of these specialised products on request.

4.1.4 Out-of-area providers

The Pharmacy Regulations require Local Authorities (LA) to identify any pharmaceutical services that are provided outside of their area 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.
Derby City has direct borders with only Derbyshire County. Derbyshire County, however, has boundaries with Kirklees, Barnsley, Sheffield, Rotherham, Nottinghamshire, Leicestershire, Staffordshire, East Cheshire, Stockport, Tameside and Oldham.
Analysis of prescribing data during the production of the PNA indicated that the number of prescriptions dispensed by community pharmacies outside the area was small (less than 4%) and consistent with known commuter and shopping activity. Given that there have been no major changes to the system or infrastructure surrounding access to traditional community pharmacy, it was agreed that out of area providers are likely to have had no discernible impact on the provision of specific pharmaceutical services across Derby and Derbyshire. It is however, acknowledged that access to 'at a distance' pharmacy through online channels will have grown considerably in recent years. Further, community pharmacy premises just over the border from Derbyshire have been considered to determine appropriate levels of access.

4.1.5 The effectiveness of pharmaceutical services

In a recent evidence review[39], described the evidence base underpinning the essential, advanced and locally commissioned services provided by community pharmacies. A summary of the services reviewed is provided below.

4.1.5.1 Essential and Advanced Services

Repeat Dispensing

The repeat dispensing scheme introduced in 2002 was received positively from General Practitioners (GPs) and patients alike. It allowed patients to collect repeat prescriptions without repeated visits to their GP, thus minimising workload and wastage. However, there are considerable variations in the uptake of this across clinical commissioning groups. This suggests that repeat prescribing should be incentivised for community pharmacies and GPs.

[38] NHSBA (2021)
[39] Wright D. (2016)

New Medicines Service

This was introduced in 2011 to improve medicines adherence in patients with newly prescribed asthma, hypertension, COPD, type II diabetes and antiplatelet/anticoagulant therapy. A randomised control trial[40] commissioned by the UK government showed a statistically significant improvement in composite adherence (measured by adherence and persistence) after ten weeks when intervention and control groups were compared. There was, however, a lack of data at 26 weeks. It is important to note that the participants were unblinded to the intervention, which means that social desirability bias may have influenced the results.

Influenza vaccinations

The influenza vaccination has been available through community pharmacies since 2015. The vaccine is targeted at high-risk groups, namely people over 65 years, individuals with long term conditions, pregnant women and those living in long-stay care facilities. Overall, the evidence suggests that this is a cost-effective service that has been linked with increased levels of uptake and choice for patients.

4.1.5.2 Clinical Enhanced Services

Chronic disease management

Community pharmacists have an integral role in chronic disease management, and it has recently been recommended that they assume responsibility for the management of patients with controlled hypertension[41]. International evidence suggests that community pharmacists can support patients with diabetes effectively through medication review, monitoring and adherence interventions to improve both control of HbA1C and blood pressure. Nationally, however, there is a need for high-quality economic evaluations. For instance, pharmacist led support for COPD was identified as cost-effective from a 2014 UK study[42]. However, there were significant dropouts after six months that were linked with errors in the design process such as the absence of a control group and the use of three different elements to the intervention. The latter makes it difficult to ascertain the contribution of each element to the final outcome.

Care homes services

There is evidence to suggest that there is an 8-10% chance of an error in the prescribing, dispensing or administration of a medicine in care homes[43]. Systematic reviews suggest that involving community pharmacists can improve the quality of prescribing. The cost-effectiveness however, of the intervention is unknown.

4.1.5.3 Public Health Services

Emergency hormonal contraception supply

There is currently no evidence available in relation to the cost-effectiveness of Emergency Hormonal Contraception (EHC) supply services provided by community pharmacies. The service is, however, linked with reduced waiting times in comparison with EHC provision through family planning clinics. Furthermore, the provision of EHC through community pharmacies is not linked with adverse effects such as a reduced use of other contraceptives or an increase in risky sexual behaviour[44].

Chlamydia screening and treatment services

Chlamydia screening was introduced in England in 2010 and is designed to identify the condition and treat it before it progresses to pelvic inflammatory disease (PID) and eventual infertility. This has been demonstrated as being a cost-effective service[45]. A systematic review of the provision of chlamydia screening through community

[40] Elliott et al. (2015)
[41] Dispensing Doctor's Association (2014).
[42] Wright, et al. (2015).
[43] Barber, et al. (2009).
[44] Raine, et al. (2005)
[45] Adams, Turner, & Edmunds (2007)

pharmacies showed that community pharmacists were competent in providing the test, and that patients found the location convenient and accessible[46].

Case finding

a. Type II diabetes screening

There is evidence that community pharmacists can effectively screen for Type II diabetes. Research in the UK suggests that screening with intervention for diabetes and impaired glucose tolerance for those between 45 and 75 is likely to be cost-effective. However, the cost-effectiveness of diabetes screening alone is uncertain. Potential strategies to improve this include targeting those at a greater risk and using more sensitive screening methods.

b. Chronic Obstructive Pulmonary Disease (COPD) case finding

A COPD case finding service delivered through community pharmacies has been shown to identify a significant proportion of patients with undiagnosed COPD. This can incentivise patients to access smoking cessation services, which has led to an improved quality of life and reductions in future costs to the NHS[47]. There is a need to prevent disease progression through the early identification of COPD. This can be achieved through monitoring patients who frequently request cough medicines or antibiotic prescriptions for chest infection.

c. Health checks

The NHS health check programme was introduced in 2009 for all eligible patients (i.e. those who are between 40 and 74 years of age, not pregnant, have not received another NHS health check within five years and have not been pre-diagnosed with medical conditions such as hypertension and diabetes). National evaluations have demonstrated improvements in behavioural and psychological risk factors after their introduction. The programme has been linked with significant benefits of early diagnosis of hypertension and type II diabetes[48]. Community pharmacists have the potential to support improvements in the uptake of NHS Health Checks. There is evidence that they can identify appropriate patients, and that they respond positively to receiving this service through community pharmacies.

Harm reduction services

Community pharmacists provide supervised consumption of opioid substitution medicines for patients who are dependent on opioids. A review of the effect of supervision on methadone-related deaths between 1993 and 2008 showed that the number of deaths reduced from 20 per 1 million defined daily doses of methadone to 2 in Scotland, and from 25 to 6 in England[49]. Needle and syringe programmes are also designed to minimise harm to users and have been shown to be a cost-effective use of resources.

Weight management

A systematic review[50] of public health interventions by community pharmacists revealed that community-based weight management services were as effective as other primary care strategies, although the cost-effectiveness of this service remains unclear.

Brief alcohol interventions

Two RCTs in the UK have not demonstrated long-term benefits of brief alcohol interventions delivered via community pharmacies[51], highlighting the need for more research and evidence before this service can be adopted in community pharmacies.

Smoking cessation

[46] Gudka, et al. (2013)
[47] Wright, Twigg, & Thornley (2015).
[48] Robson, et al. (2016)
[49] Strang, et al. (2010)
[50] Brown, et al. (2016)
[51] Watson (2011), Dhital, et al. (2015).

This includes the provision of smoking cessation services and nicotine replacement therapy (NRT). There is evidence that community pharmacy led smoking cessation services are both effective and cost-effective. A recent systematic review of 12 RCTs showed that patients in the intervention group were significantly more likely to quit compared with control groups and those receiving usual care[52].

In summary, there is a good evidence base underpinning most essential, advanced and locally commissioned services. However, there is a need for more robust economic evaluations of new services. It is also apparent that current funding models place more emphasis on payment by activity (i.e. quantity) than quality, which can be measured by outcomes or value. It has been proposed that "value-based contracts" should be introduced as part of an integrated quality outcomes framework between general practitioners and community pharmacists[53].
In an independent review undertaken by Richard Murray[54], community pharmacy services are described as having a significant potential to support the prevention element of Sustainability and Transformation Plans (STPs)[55]. However, there is currently a poor availability of information to inform decision making. Greater levels of interconnectivity are required to enable pharmacy staff to share clinical information about patient care. Murray also recommends a move from national towards the local commissioning of services. Community pharmacists have an integral role in ensuring that these services are more tailored to the needs of individual communities.

4.1.6 The role of digital and new technologies

Poor integration (with other parts of the NHS), lack of interoperability of digital clinical systems and wider system design issues were noted by the Community Pharmacy Clinical Services Review subgroup of the expert advisory group headed by Richard Murray, Director of Policy at the King's Fund, to be key thematic barriers to community pharmacies providing clinical services.[56]

Access to data was a further determinant, specifically the poor availability of information required to inform clinical decision making. To overcome it, the review of community pharmacy concluded that greater steps would need to be taken to reach digital maturity and interconnectivity to allow pharmacies to see, document and share clinical information about patient care with the clinical records held by other healthcare professionals.

For the public, the importance of digital and new technologies has grown exponentially in recent years. A review of the future pharmacist workforce undertaken by the Centre for Workforce Intelligence[57] that, "The future pharmacist workforce is particularly (and in many cases uniquely) affected by changes in technology, lifestyle behaviours and changes in the wider commercial environment. The essential broader role pharmacists may play in contributing to the delivery of community-based healthcare and public health, combined with the many complex factors shaping the profession, signify the importance of adopting a flexible approach, combined with careful monitoring and review."

Guidance published by the General Pharmaceutical in 2015[58] recognised two types of pharmacy: the 'traditional' service, where all aspects, including the sale and supply of medicines and advice, takes place in the registered premises; and 'at a distance', including on the internet. The guidance concludes that pharmacy must adapt and change to meet the needs of a society advancing in use of new technologies, and that different ways of providing pharmacy services are already becoming commonplace. Examples of alternate (to traditional) means of the population accessing community pharmacy include:

- Electronic prescription service (EPS)[59]
- Delivery services from the registered pharmacy to patients in their usual places of residence
- Mail order and 'Click and Collect' services

[52] Brown, et al. (2016)
[53] Wright D. (2016)
[54] Murray (2016)
[55] Superseded by Integrated Care Services e.g. Joined UP Care Derbyshire
[56] Pharmaceutical Services Negotiating Committee (2016)
[57] Centre for Workforce Intelligence, 2013
[58] General Pharmaceutical Council, 2015
[59] www.systems.hscic.gov.uk/eps

- Internet pharmacy service, owned and operated by either the registered pharmacy or by a third-party business.

4.2 Funding Community Pharmacy

Funding of community pharmacy comes from several sources:-

- NHS Community Pharmacy contractors are paid for services they provide under the community pharmacy contractual framework according to a set of fees and allowances agreed between the Department of Health and Pharmaceutical Services Negotiating Committee. These are published in the Drug Tariff each month. The whole framework is being reviewed nationally. The community pharmacy contractual framework is the mechanism the NHS uses to contract pharmaceutical service from community pharmacy contractors
- Local Commissioners: Additional income comes from providing services commissioned locally by CCGs, Local Authorities such as smoking cessation and needle exchange services
- Sale of goods and service over the counter

For most pharmacies, over 80% of their funding comes from their NHS contract, contracted under the Community Pharmacy Contractual Framework (CPCF). The Department of Health has announced cuts to the funding of pharmacies and there is concern that this could impact on the viability of some pharmacies. At this time the full impact of how many pharmacies might close is not known. In order to mitigate the risk of pharmacy closures, the Pharmacy Access Scheme (PhAS) has been introduced. Subject to fulfilling certain criteria, a pharmacy could qualify for payments to bridge the funding reduction.

4.2.1 Community Pharmacy Contractual Framework

NHS England is the national commissioner for NHS community pharmacy services. Its role is to ensure that the NHS provides safe, high quality patient care and services within community pharmacy, and to ensure that the NHS operates within its means. The NHS regulations categorise pharmaceutical services as Essential, Advanced, and Enhanced. Essential services are those which all pharmacy contractors will provide and are commissioned by NHS England. Advanced services, also commissioned by NHS England in the global sum from the national contractual framework, can be provided by contractors once accreditation requirements have been met. Locally commissioned, or enhanced services, are those that can be commissioned by NHS England on a regional basis, Local Authorities and Clinical Commissioning Groups in response to the needs of the local population. Pharmacy contractors can choose whether they wish to provide advanced or enhanced services. The Pharmaceutical Services Negotiating Committee (PSNC) leaflet, NHS Community Pharmacy Services – a summary[60] provides examples of services that the public can expect to be able to access under each of the three levels of services. It is important to note that locally commissioned, enhanced services will vary area by area nationwide.

Following the Five Year Forward View in October 2014 and the General Practice Forward View in April 2016, NHSE's Chief Pharmaceutical Officer commissioned The King's Fund to undertake an Independent Review of Community Pharmacy Clinical Services[61]. This was determined by:

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

[60] Pharmaceutical Services Negotiating Committee (2013)
[61] Murray (2016).

As discussed earlier, the review makes recommendations for commissioning models and clinical pharmacy services, aimed at ensuring community pharmacy is better integrated with primary care and making far better use of community pharmacy and pharmacists[62].

Figure 120: The NHS Community Pharmacy Contractual Framework (contract) example services

Essential Services	Advanced Services	Enhanced Services
Dispensing Appliances	New Medicines Service (NMS)	Emergency Supply of medicines Service (ESS)
Dispensing Medicines	Appliance Use Reviews (AUR)	Palliative Care Drug Stockist Scheme.
Disposal of unwanted medicines	Population level flu vaccination	Needle Exchange.
Public Health (promotion of healthy lifestyles)	Community Pharmacist Consultation Service (CPCS)	Supervised Consumption
Repeat Dispensing/electronic Repeat Dispensing	Hypertension Case Finding (Blood Pressure Check) Service	Emergency Hormonal Contraception (EHC)
Signposting	Hepatitis C Testing	Extended Care Services
Support for Self Care	Smoking Cessation Service	
Discharge Medicines Service	Stoma Appliance Customisation	

4.2.1.1 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/appliances
- Repeat dispensing
- Disposal of waste/unwanted medication
- Promotion of healthy lifestyles (Public Health)
- Signposting of patients
- Support for self-care
- Clinical governance
- Discharge Medicines Service

4.2.1.2 Dispensing NHS Prescriptions

A range of nationally and locally available data has been sourced to assess capacity of Derby and Derbyshire pharmacies to dispense prescriptions generated by GPs.
The EPS sends electronic prescriptions from GP surgeries to pharmacies, eventually removing the need for most paper prescriptions (NHS Digital, 2017). In 2020/21 all but one pharmacy in the JUCD footprint[63] were dispensing via EPS and almost 93% of prescriptions were dispensed using EPS[64].

[62] NHS England (2016).
[63] JUCD for 2020/21 excluded Glossopdale pharmacies which were included in the Greater Manchester STP
[64] NHSBA 2021, General Pharmaceutical Services in England 2015/16 to 2020/21

In 2020/21 a total of 15,897,810 items were prescribed within the Derby and Derbyshire area and dispensed across the country. Further analysis shows that:-

- 88% of these prescriptions were dispensed within Derbyshire community pharmacies
- 7% were dispensed by general practices
- 4% were through Distance Selling Pharmacies
- 1% were dispensed by appliance suppliers

Figure 121 below demonstrates that the dispensing workload of pharmacies in the JUCD footprint is somewhat lower than the national average, based on activity in 2020/21.

Figure 121: Prescription items dispensed 2020/21) - Pharmacy contractors only (NHS Business Services Authority, 2021)

	Number of community pharmacies	Total number of items dispensed	Average items per pharmacy
JUCD	205	13,938,079	67,991
England	10719	879,026,544	82,006

An additional 199,707 prescriptions were dispensed by the four Appliance Contractors in the same period.

Other key activity headlines for October 2017 across both pharmacy and appliance contractors, include:-

- 23,605 New Medicine Service interventions
- 128 Appliance Use Reviews
- 11,806 Stoma Customisation
- 7,149 Community Pharmacist Consultations.

4.2.1.3 Pharmacy Quality Scheme

The Department of Health introduced 'Quality Payments', into the community pharmacy contractual framework in 2017, to reward high quality in community pharmacies. This consists of gateway criteria i.e. those criteria a pharmacy must reach in order to gain payment for other quality related domains. Since the introduction of 'quality payments', the gateway criteria have changed over the years to ensure a continued quality improvement approach.

Currently the three gateway criteria are:-

1) Advanced service - Each contractor needs to have completed 20 New Medicine Service interventions between 1st April 2021 and 5th April 2022.
2) Safety report and demonstrable learnings from the Centre for Pharmacy Postgraduate Education (CPPE) Look-Alike, Sound-Alike (LASA) e-learning. This has two parts:
   a) CPPE LASA e-learning and assessment - All pharmacy professionals must have completed and passed this course, and
   b) New Safety Report - Each pharmacy must have a new safety report to replace one completed in 2020.
3) Risk Review. This has two parts:
   a) CPPE risk management e-learning and assessment, which must be completed by all pharmacy professionals, and
   b) Risk review of the whole pharmacy, specifically including management to minimise transmission of COVID-19

Once a community pharmacy contractor has achieved all of these, they are able to complete seven quality domains. A payment can be claimed for each of these providing the pharmacy meets the domain.

Figure 122: Seven quality criteria in the community pharmacy contract

Domain	Description
Medicines Safety and Optimisation	Audit of patients taking anti-coagulants
Respiratory	Personalised asthma plans, inhaler technique check, return of unwanted and unused inhalers Training for pharmacy professionals in conducting consultations remotely
Digital	Training for pharmacy professionals in conducting consultations remotely
Primary Care Networks	To work jointly with PCN GPs on the annual influenza vaccination programme
Prevention	Infection prevention control and antimicrobial stewardship*[65]
Addressing unwarranted variation in care	Training requirement for all pharmacy professionals on health inequalities
Health living support	Training around weight management for all pharmacy staff and all staff able to refer patients to local services.

4.2.1.4 Urgent and emergency medicine supply

154 of 205 (75%) community pharmacies in Derby and Derbyshire provide the locally commissioned Emergency Supply of Medicines Service (ESS) which allows patients who urgently require medicines to obtain them without the need for a prescription.

[65] Antimicrobial stewardship (AMS) refers to an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. Addressing antimicrobial resistance through improving stewardship is a national medicines optimisation priority, led by NHS England and supported by Public Health England. NICE (2013)

4.2.2 Locally Commissioned Services

The largest group of potential locally commissioned services fall under the heading of 'public health'. Examples of services which have been commissioned here and elsewhere include:

- Substance misuse services: including needle and syringe services; supervised consumption of medicines to treat addiction; Hepatitis testing and vaccination; provision of naloxone to drug users for use in emergency overdose situations
- Sexual health services: including emergency hormonal contraception services; condom distribution; Chlamydia screening and treatment; HIV testing; contraception advice and supply (including oral and long-acting reversible contraception)
- Stop smoking services: proactive promotion of smoking cessation through to provision of full NHS stop smoking programmes
- NHS Health Checks for people aged 40-74 years: carrying out a full vascular risk assessment and providing advice and support to help reduce the risk of heart disease, strokes, diabetes and obesity
- Weight management services: promoting healthy eating and physical activity through to provision of weight management services for adults who are overweight or obese
- Alcohol misuse services: providing proactive brief interventions and advice on alcohol with referral to specialist services for problem drinkers
- Pandemic and Seasonal 'Flu services: providing continuity of dispensing of essential medicines, provision of antiviral medicines; 'flu vaccination' services commissioned by Local Authority Public Health Teams for employees of the city and county councils.

Arrangements for monitoring locally commissioned services may be set out in local contracts or Service Level Agreements (SLA).

Derby City and Derbyshire County Councils Public Health Departments commission enhanced services for the local Derby and Derbyshire population. Enhanced services for the Glossopdale area of the High Peak District of Derbyshire were previously commissioned by NHS Tameside and Glossop CCG; from July 2022 these will fall under the remit of JUCD. NHSE also commission certain local services.

Figure 123: Summary of community pharmacy services and definitions in JUCD footprint, by commissioner

Commissioner	Service	Definition
NHS England	New Medicine Service (NMS)	An advanced service for people with long-term conditions newly prescribed a medicine, to help improve medicines adherence[66]
	Flu vaccination (population)	Refers to pharmacies that are registered to provide the flu vaccination service for 2017/18, for the at risk eligible population.[66]
NHS England (Midlands)	Palliative Care Drug Stockist scheme	Refers to pharmacies supplying palliative care and specialist medicines when in receipt of a prescription, the demand for which may be urgent and/or unpredictable. They are commissioned to have the drugs in stock ready when a prescription arrives[66]
	Emergency Supply Service (ESS)	Refers to pharmacies who offer a pharmacist assessment of whether there is urgent need for medicines, in circumstances where it is impracticable for the patient to obtain a prescription before the next dose is due[66]

[66]Pharmaceutical Services Negotiating Committee (2022).

	Extended Care Services	Refers to pharmacies where GP practices may redirect patients with urinary tract infections, impetigo, infected insect bites or infected eczema. Pharmacist may also independently supply and administer medicines to walk-in patients not directed from GPs[67]
Local Public Health	Supervised Consumption	Refers to pharmacies offering a supervised service of the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient[67]
	Needle Exchange	Refers to pharmacies providing access to sterile needles/syringes, and sharps containers for return of used equipment – to promote safe injecting practice and reduce transmission of infections amongst misusers[67]

Figure 124 highlights the number of pharmacies in Derby, Derbyshire and each District area, providing NHSE, Public Health and NHS CCG commissioned services. These are provided in more detail in district summary profiles that appear earlier in the document.

Other key points include:-

- 99% of pharmacies are signed up to the New Medicines Service
- 12% of pharmacies are not currently (in March 2022) registered to provide the advanced flu vaccination service. In Erewash, every pharmacy is registered.
- Over three-quarters of pharmacies are involved in hypertension case finding
- Almost half of pharmacies offer the locally commissioned Emergency Hormonal Contraception, with as many as two-thirds in South Derbyshire and as few as one-third in Bolsover
- Over three-quarters of pharmacies offer the supervised consumption service in Bolsover and North East Derbyshire
- Almost half of pharmacies are signed up to provide Tier1 and Tier 2 Extended Care Services

[67] Pharmaceutical Services Negotiating Committee (2022).

Figure 124: Pharmacies offering community services by District - number

District	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire	Derbyshire	Derby	JUCD
New Medicine Service (NMS)	25	17	20	10	23	19	20	14	148	51	199
100-hour pharmacy	3	2	2	0	2	0	2	2	13	7	20
Flu vaccination (population)	23	14	18	9	23	16	18	12	133	48	181
Palliative care drugs stockist scheme[68]	7	2	1	3	8	2	4	6	33	3	36
Emergency Supply Service (ESS)[68]	20	11	17	7	19	9	17	12	112	42	154
Appliance Use Reviews (AUR)	0	0	1	0	0	0	0	0	1	1	2
Community Pharmacist Consultation Service (CPCS)	23	13	20	7	22	16	18	12	131	52	183
Hypertension Case Finding Service[68]	-	-	-	-	-	-	-	-	-	-	157
Hepatitis C Testing	0	0	0	0	0	0	0	0	0	0	0
Smoking Cessation Service[68]	-	-	-	-	-	-	-	-	-	-	32
Stoma Appliance Customisation	3	2	3	1	1	1	1	0	12	4	16
Discharge Medicines Service	14	13	18	6	19	16	17	8	111	35	146
Covid vaccination services	3	3	4	2	5	1	3	2	23	5	28
Emergency Hormonal Contraception	9	5	11	1	14	6	11	9	66	32	98
Supervised Consumption	18	13	14	6	15	12	15	9	102	42	144
Needle Exchange	7	7	9	1	4	6	5	4	43	23	66
Extended Care Services[68]											
Tier 1 services	15	7	10	3	15	6	10	10	76	31	107
Tier 2a skin services	14	7	8	2	13	4	6	9	63	27	90
Tier 3 Ear, Nose & Throat services	-	-	-	-	-	-	-	-	-	-	75

[68] Excluding Glossopdale

Figure 125: Pharmacies offering community services by District – percentage

District	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire	Derbyshire	Derby	JUCD
New Medicine Service (NMS)	100	100	95	100	100	90	100	100	98	94	97
100-hour pharmacy	12	12	10	0	9	0	10	14	9	13	10
Flu vaccination (population)	92	82	86	90	100	76	90	86	88	89	88
Palliative care drugs stockist scheme[69]	28	12	5	30	35	10	20	43	22	6	18
Emergency Supply Service (ESS)[69]	80	65	81	70	83	43	85	86	74	78	75
Appliance Use Reviews (AUR)	0	0	5	0	0	0	0	0	1	2	1
Community Pharmacist Consultation Service (CPCS)	92	76	95	70	96	76	90	86	87	96	89
Hypertension Case Finding Service[69]	-	-	-	-	-	-	-	-	-	-	77
Hepatitis C Testing	0	0	0	0	0	0	0	0	0	0	0
Smoking Cessation Service[69]	-	-	-	-	-	-	-	-	-	-	16
Stoma Appliance Customisation	12	12	14	10	4	5	5	0	8	7	8
Discharge Medicines Service	56	76	86	60	83	76	85	57	74	65	71
Covid vaccination services	12	18	19	20	22	5	15	14	15	9	14
Emergency Hormonal Contraception	36	29	52	10	61	29	55	64	44	59	48
Supervised Consumption	72	76	67	60	65	57	75	64	68	78	70
Needle Exchange	28	41	43	10	17	29	25	29	28	43	32
Extended Care Services[69]											
Tier 1 services	60	41	48	30	65	29	50	71	50	57	52
Tier 2a skin services	56	41	38	20	57	19	30	64	42	50	44
Tier 3 Ear, Nose & Throat services	-	-	-	-	-	-	-	-	-	-	37

[69] Excluding Glossopdale

In addition, 7 pharmacies in Glossopdale, commissioned by Tameside & Glossop CCG, provide minor ailments and minor eye conditions services. After July 2022 JUCD will continue to commission these services until July 2023, when they will be reviewed.

4.3 Access and availability

For the purposes of this assessment, whilst the growing use of distance selling pharmacies is acknowledged, given the difficulty in measuring the activity, access will be determined on expected use of 'traditional' pharmacy. That is, physical location from registered premises so to consider ease of travel and physical attendance for services.
A searchable database of pharmacies, with opening times, is available here:-
https://www.nhs.uk/service-search/pharmacy/find-a-pharmacy

4.3.1 Opening hours

The opening hours used in this section are based on the total opening hours (both 'core' and 'supplementary' hours) recorded by NHS England - Midlands Team at the end of December 2021.

Figure 126: Contracted hours per week

Opening Hours	33.75		40 to <100		100+		Grand Total
District	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	
Amber Valley			22	17	3	2	19
Bolsover			15	18	2	2	21
Chesterfield			19	18	2	2	20
Derbyshire Dales			10	14		0	14
Erewash			21	18	2	2	20
High Peak	1	1	20	22		0	23
North East Derbyshire			18	18	2	2	20
South Derbyshire			12	11	2	2	13
Derbyshire	1	0	137	17	13	2	19
Derby			47	18	7	3	21
JUCD	1		184	17	20	2	19

Hayfield Pharmacy in the High Peak area of Derbyshire opens for a total of 33.75 hours per week following an appeal to provide less than the usual 40 hours minimum, in 2014. The regulations state in respect of pharmacy opening hours: -

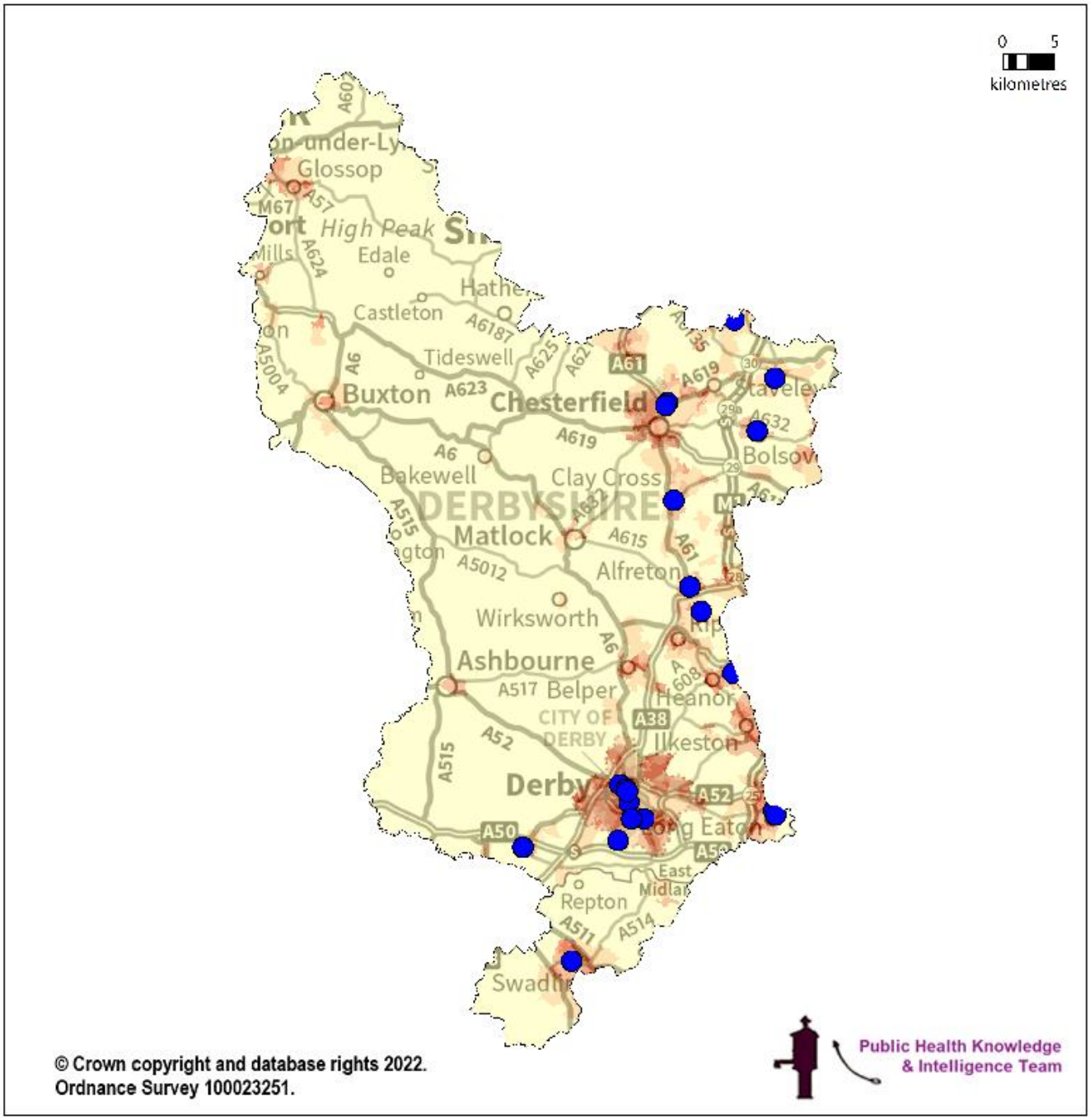
> *Pharmacy opening hours: general "23.—(1) An NHS pharmacist (P) must ensure that pharmaceutical services are provided at P's pharmacy premises— (a) for 40 hours each week; (b) for not less than 100 hours each week, in the case of premises in respect of which a 100 hours condition applies; (c) if the NHSCB or a Primary Care Trust, or on appeal the Secretary of State, has directed that pharmaceutical services are to be provided at the premises for fewer than 40 hours per week, provided that the person listed in relation to them provides those services at set times and on set days, at the times and on the days so set; (d) if a Primary Care Trust, or on appeal the Secretary of State, has (under previous Regulations) directed that pharmaceutical services are to be provided at the premises for more than 40 hours per week, and at set times and on set days, at the times and on the days so set; or (e) if the NHSCB or a Primary Care Trust, or on appeal the Secretary of State, has directed that pharmaceutical services are to be provided at the premises for more than 40 hours each week, but only on set times and on set days as regards the additional opening hours— (i) for the total number of hours each week required by virtue of that direction, and (ii) as regards the additional opening hours for which the person listed in relation to the premises is required to provide pharmaceutical services by virtue of that direction, at the days on which and times at which that person is required to provide pharmaceutical services during those additional opening hours, as set out in that direction, but the NHSCB may, in*

appropriate circumstances, agree a temporary suspension of services for a set period, where it has received 3 months' notice of the proposed suspension."

4.3.2 Out of Hours Enhanced Service

Community Pharmacies are allowed to close on a declared bank holiday or a substitute bank holiday under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. To ensure pharmacy provision on bank holidays/substitute bank holidays, NHS England commissions an out of hours enhanced service in Derbyshire. Participation by the pharmacies is usually on a voluntary basis, unless the needs of the people in an area are not met in which case NHS England have the power to issue a direction requiring a pharmacy to open. Pharmacies open on bank holidays/substitute bank holidays will provide the full range of services that the pharmacy usually provides.

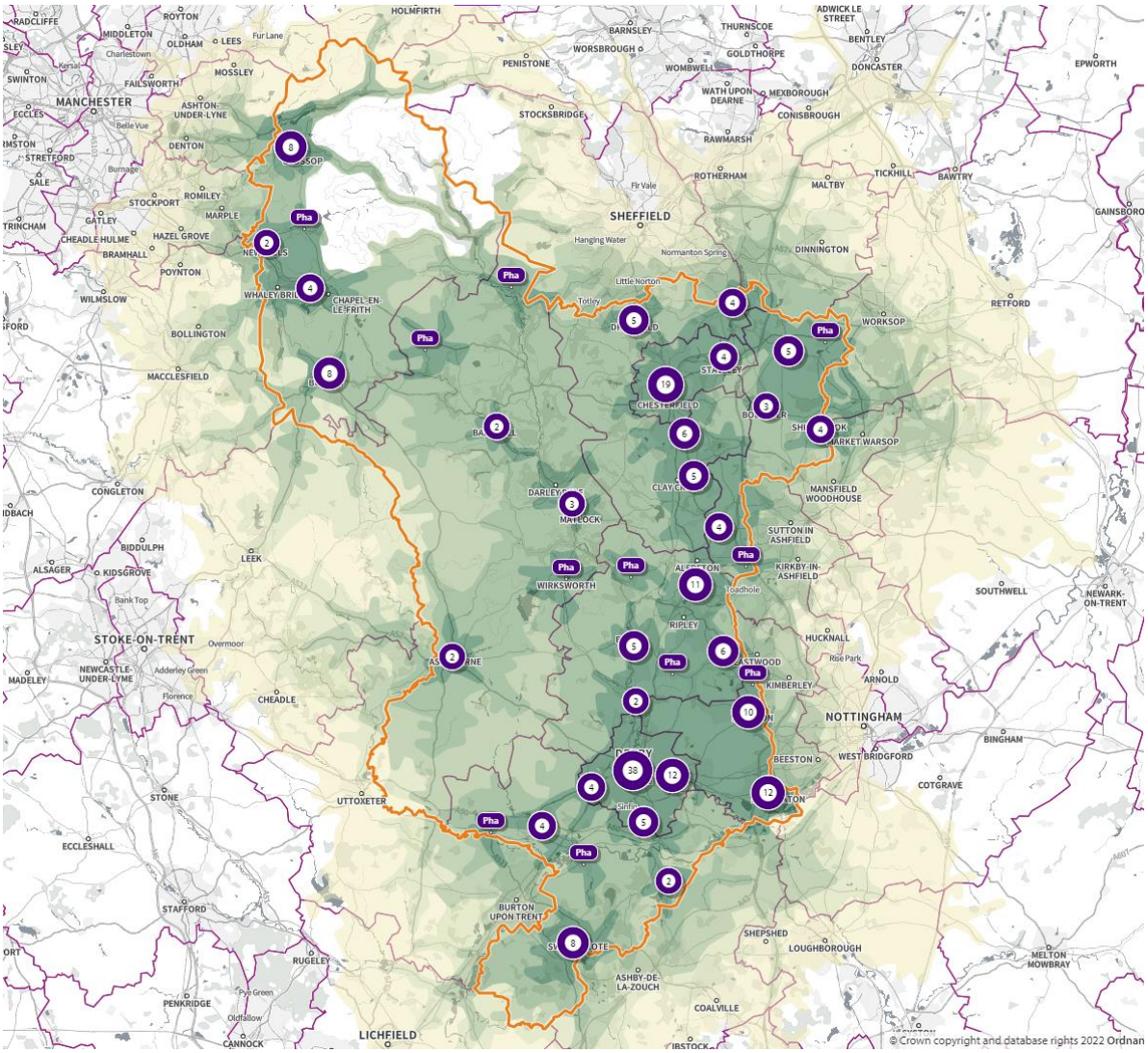
Figure 127: Map of 100-hour pharmacy locations in Derby and Derbyshire, with population density



4.3.3 Travel and transport

Derby and Derbyshire have good public transport networks and most households, particularly in the more remote areas of the county, have access to a car. In rush hour/peak traffic conditions a pharmacy should still be accessible within a 5-minute drive for more than 90% of people. For the remaining 10%, most will be within a 10-minute drive with only a small volume of population having to travel for longer.

Figure 128: Map of drive times in peak traffic conditions from pharmacies in Derby and Derbyshire; PHE SHAPE Atlas 18/05/22



The most up to date public transport route maps can be found here:-

Derby: https://derbysbus.info/images/derby_a.pdf
Derbyshire: https://derbysbus.info/maps/county.htm

4.4 Locally commissioned services under review

Significant changes to community pharmacy provision post consultation and publication of this document, will be reflected in future supplementary publications. At this time, the following items are noted:

4.4.1 Minor ailments

With an ever-increasing demand on NHS services, the NHS at a national and local level is constantly reviewing the products, services and treatments it provides to ensure that its resources are being used efficiently to provide the best health outcomes for the population. This enables the NHS to target its resources at frontline services and people with the most urgent clinical needs. Following review of the introduction of the Self-Care policy the minor ailments scheme was decommissioned in January 2019.
Minor ailments and minor eye conditions services commissioned by Tameside & Glossop CCG from Glossopdale pharmacies will continue to be commissioned by JUCD between July 2022 and July 2023, when they will be reviewed.

4.4.2 Change of hours

Community pharmacies constantly reflect upon and amend core and supplementary hours depending on demand for services from the local population. Alterations to the pharmaceutical list are collated centrally for the Derby and Derbyshire area, by NHS England - Midlands. The opening hours presented in this document are accurate as at January 2022.

5 CONSULTATION

5.1 Consultation requirements

The NHS regulations set out that:

- HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA. Any neighbouring HWBs who are consulted should ensure any LRC in the area which is different from the LRC for the original HWB's area is consulted
- There is a minimum period of 60 days for consultation responses, and
- Those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

5.2 Consultation activities

Formal consultation with stakeholders took place between 23 June and 22 August 2022. The consultation was hosted on https://letstalk.derby.gov.uk/ along with the draft PNA. The consultation was also open to members of the public.

5.3 Consultation responses

- Response to the consultation was very limited, a total of five responses being received. One each from an NHS provider, a Derbyshire Pharmacist and a Derby City Pharmacy Contractor, as well as three from Derbyshire County Pharmacy Contractors.
- All agreed or strongly agreed that the purpose of the PNA was clearly explained.
- Three agreed or strongly agreed that the process for producing the PNA was clearly described, with the other two neither agreeing nor disagreeing.
- All agreed or strongly agreed that the locality profiles of the PNA effectively summarise the demographic characteristics, health need and pharmaceutical provision for each locality.
- Four of the five agreed that the PNA accurately reflects the current provision of pharmaceutical services in their area and clearly describes the services available in the Derby and Derbyshire areas. The fifth highlighted a typographical error which has been corrected.
- All felt that the PNA has provided information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises.
- Two found no inaccuracies in the document, one said there were inaccuracies and two didn't know.
- Four agreed or strongly agreed with the conclusions of the PNA; one neither agreed nor disagreed.
- One respondent, who strongly agreed with the above statements, commented that gaps in service provision for diabetes risk assessment and health education and asthma control assessment have not been identified in the PNA.
- One respondent wished to draw attention to changes in the opening hours of a number of Boots pharmacies in the Derby City and Derbyshire County area, most of which came into effect on the 28th February and were notified to NHS England.

5.4 Public survey

Healthwatch Derby ran a social media survey on pharmacy services during May 2022.

- 41% of respondents used their pharmacy more than once a month
- 89% said their pharmacy met their needs to a fair or great amount
- 86% said they would be likely or very likely to recommend their pharmacy

When asked what additional services they would like to see, one respondent asked for UTI home testing kits, one respondent wanted to bring back a larger range of lower priced and own brand products, and one respondent stated that they were not aware of the full range of services available.

5.5 Comments from other sources

The inclusion of statistics for Deaf people was welcome and should be used more widely.
The limit of 28 days supply of medications was a problem for some people, especially those with difficulties with access.
Sometimes labels were put on medicines packaging covering up key instructions.
Problems with accessibility at a number of (unnamed) pharmacies were mentioned, which do not seem to have been challenged by the NHS.
The length of time taken for a prescription to get from GP to pharmacy and then be dispensed to the customer was flagged as an issue.
Some pharmacies seem unaware of the problems faced by visually impaired people.

6 FUTURE REQUIREMENTS/DEVELOPMENTS

6.1 Health & Wellbeing Strategy

Local health and wellbeing strategies and actions plans focus locally on materialising the potential of prevention at scale, to improve the health of the population[70] (Public Health England, 2017). Locally, the vision of both the Derby[71] and Derbyshire[72] Health and Wellbeing Strategies is to improve the health and wellbeing of people and reduce health inequalities, with an emphasis on integrating services and partnership working. Pharmacies are a key enabler in influencing the success of this strategy implementation through: promoting prevention and early intervention; promoting control, independence and responsibility; building strong and resilient individuals and communities; and making every contact count.

6.2 Delegation of NHSE commissioning to Integrated Care Boards

The intention is that responsibility for commissioning all pharmaceutical, general ophthalmic and dental services be delegated to Integrated Care Boards from 1 April 2023. This will mean that from that date Joined Up Care Derbyshire will be the commissioner for all advance and enhanced pharmaceutical services in the city and county area.

6.3 Pharmacist Independent Prescribers

The Royal Pharmaceutical Society[73] argues the case for pharmacist to be able to use their clinical skills:-

> As demand for health care increases and medication regimes become more specialised and complex, the role of the pharmacist independent prescriber has become increasingly important in the delivery of high-quality clinical care.
> The fusion of the unique in-depth understanding of medicines by pharmacists together with the competence to prescribe without the need to consult another prescriber is a significant asset to our health services. It offers patients and other health professionals' real opportunities in improved access to care and shifting capacity in the health care system.
> While non-medical prescribing was introduced in the United Kingdom some 30 years ago, the opportunities to harness the skills of pharmacist independent prescribers in clinical care have yet to be fully realised.
>
> Greater use of pharmacist independent prescribers, within the multi-professional team will increase patient access to care, improve capacity in the healthcare system and improve individual outcomes.

[70] https://www.gov.uk/government/groups/pharmacy-and-public-health-forum
[71] https://www.derby.gov.uk/media/derbycitycouncil/contentassets/documents/healthandsocialcare/publichealth/hwbs-plan-on-a-page-2021.pdf
[72] https://www.derbyshire.gov.uk/site-elements/documents/pdf/social-health/health-and-wellbeing/derbyshire-health-and-wellbeing-strategy-2022.pdf
[73] https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/pharmacist-independent-prescribers#r1

7 CONCLUSIONS

Health inequalities refer to the differences in health status or in the distribution of health determinants between different population groups. For example: by geography, demography or socio-economic status. Equity is the absence of avoidable or remedial differences among population groups. In health, it refers to the "fair" distribution of resources or opportunities according to population need. Evidence would suggest that in the current system, despite the founding principles of the National Health Service (NHS), the availability of good medical care tends to vary inversely with the need for the population served – the 'Inverse Care Law'. Proportionate universalism, that is the resourcing and delivering of services at a scale and intensity proportionate to the level of need across a given area, should be a key driver for commissioners.

Availability and access to community pharmacy has strengthened considerably over the years. In this respect, not only should the physical access to pharmaceutical premises be considered, but also the availability of GP dispensing, online access through the internet and out of the Derbyshire area provision that are likely to be supporting the local population. There has been some contraction in the number of physical premises since the last PNA, largely for economic reasons, including a number of consolidations of geographically adjacent pharmacies.

Following the analysis of health and care needs, geographical mapping of pharmaceutical services, consultation with both professionals and the public; the PNA Steering Group has determined that pharmaceutical need is adequately met by current pharmacy provision in both Derby and Derbyshire. Pharmaceutical need will next be reviewed in 2025 when the PNA is revisited, or in the interim in the event of significant changes affecting need.

7.1 Statements of Pharmaceutical Need

Statement of pharmaceutical need: Derby City

Based on the information collated, the PNA found that the pharmaceutical need in the Derby City Health & Wellbeing Board area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

Statement of pharmaceutical need: Derbyshire County

Based on the information collated, the PNA found that the pharmaceutical need in the Derbyshire County Health & Wellbeing Board area is adequately met by the current pharmacy providers. Pharmaceutical need will be reviewed again in 2025 when the PNA is revisited, or in the event of significant changes affecting need in the interim years.

7.2 Recommendations

Given the evidence available at time of publication, it is recommended that stakeholders proactively consider the role of community pharmacy in the context of an evolving local health and care system, and especially in the context of Primary Care Networks. Some consideration must be given to how the current economic crisis will affect the viability of pharmacies as business in the next few years.

Community pharmacies offer a range of services to promote the health and wellbeing of local populations, whilst also tackling health inequalities. Pharmacy staff are knowledgeable in areas of prevention, health promotion, behaviour change, as well as treatment of conditions, and the general public hold this in high regard.

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9 ADDENDUM

Since this report was completed and sent for consultation one pharmacy in Derby has ceased to provide pharmaceutical services. As there are several other pharmacies in close proximity to this one it is believed that this closure will not constitute a significant issue. It will be reflected in any subsequent updates or supplementary statements.

Appendix 1 Strategic Housing Land Availability Assessments

Derby
https://www.derby.gov.uk/environment-and-planning/planning/policy/strategic-housing-employment-land-availability-assessment/

Amber Valley
https://www.ambervalley.gov.uk/planning/planning-policy/housing-land-supply/

Bolsover
https://www.bolsover.gov.uk/index.php?option=com_content&view=article&id=95

Chesterfield
https://www.chesterfield.gov.uk/SHLAA/Final%202009%20SHLAA.pdf

Derbyshire Dales
https://www.derbyshiredales.gov.uk/images/documents/L/Local%20Plan%20evidence%20base%20docs%20July%202016/Full%20SHELAA%20Appendices%2016%20REDUCED.pdf

Erewash
https://www.erewash.gov.uk/planning-policy-section/shlaa-2019.html#:~:text=A%20SHLAA%20represents%20one%20of,(c)%20of%20the%20NPPF.

High Peak
https://www.highpeak.gov.uk/article/1392/Strategic-Housing-and-Employment-Land-Availability-Assessment-SHELAA

North East Derbyshire
https://www.ne-derbyshire.gov.uk/documents/local-plan-examination-library/03-supporting-documents-evidence-base/housing/eb-hou6a-housing-land-availabiltiy-assessment-laa-and-policy-assessment

South Derbyshire
https://www.southderbyshire.gov.uk/our-services/planning-and-building-control/planning/planning-policy/evidence-base-2/district-wide-evidence