DERBY CITY COUNCIL

NHS Derby City

Joint Strategic Needs Assessment (JSNA)

September 2011

Update to JSNA 2009/10

Business Intelligence Unit
Knowledge for better decisions

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ACKNOWLEDGEMENTS

This JSNA refresh has been achieved through significant contributions from across the NHS, Derby City Council and partner organisations. Particular thanks go to the members of the JSNA steering group who shaped this refresh of the 2009/10 JSNA in response to national guidance and local requirements.

FORWARD

The Joint Strategic Needs Assessment (JSNA) has been a statutory requirement for upper-tier Local Authorities and Primary Care Trusts since 2008. Significant change is underway within the NHS through the Health and Social Care Bill with the expectation that responsibility for producing the JSNA will rest with the newly establishing Health and Wellbeing Boards. Significant contributions will be required from Clinical Commissioning Groups, Local Authorities and other partners.

As the JSNA was fully updated last year and given the significant changes underway we felt that it was appropriate for 2011 to produce a 'refresh' of the 2009/10 JSNA. This document updates a number of existing priorities but also includes some new areas, such as; housing and homelessness and child health and wellbeing.

Whilst we acknowledge that this document does not cover every issue, for example, mental health, it provides sufficient detail in conjunction with the previous JSNA and other key needs assessments to provide a good picture of the current health needs of the population of Derby. It is expected that the JSNA will play a central role in providing the evidence base for commissioners of health and social care services as they develop their commissioning intentions over the coming years.

Looking to 2012/13, we will be producing a "new-look" JSNA. This will include consideration of the needs of the newly formed Clinical Commissioning Groups as well as the local authority and support the identification of areas of potential integration. The aim of the JSNA will however, remain the same: to support effective strategic planning, priority-setting and commissioning decisions to improve the health and wellbeing of the people of Derby, and reduce health inequalities.

Andrew Bunyan, Strategic Director of Children and Young People

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4 EXECUTIVE SUMMARY

In 2009/10, a full update of the Joint Strategic Needs Assessment (JSNA) was completed. Given this and the significant changes underway, most notably within the NHS, but across the public sector as a whole, we felt that a 'light touch refresh' would be most appropriate to meet current organisational, commissioning and statutory requirements with a view to producing a new-look JSNA for 2012/13.

KEY POINTS:

- Derby has: more young people participating in sport per week and gaining a GCSE pass (5A*-C) than the national average; excellent smoking quit rates and decreasing mortality rates from cardiovascular disease.
- Derby's population is growing in terms of size and diversity and has a changing age profile. Service provision needs to reflect this.
- Derby remains comparatively deprived – ranked 88th (of 326) most deprived local authority. Levels of deprivation vary substantially across the city.
- Around a third of private sector dwellings are classed as 'non-decent' and there were over 7,000 applicants for social housing in March 2011.
- Derby has a higher than average: proportion of people smoking; alcohol-related harm; number of problematic drug users.
- The numbers of people in the city who are blind, partially-sighted or have a visual impairment are predicted to increase year-on-year, as are the number of people with physical disabilities.
- Mortality rates from cardiovascular disease have reduced substantially but remain higher than the national average.
- Premature mortality from cancer had been reducing since 1999, but increased in 2007 and 2008 and is now significantly higher than the national rate.
- There are increasing numbers of: children on child protection plans; referrals relating to safeguarding and family support; looked after children.
- Wide variation in deprivation, need and outcomes across the city's wards.

NEXT STEPS

- Tackling deprivation and the wider determinants of health, delivering prevention activities in early years, early detection of and intervention in diseases such as cancer and support for lifestyle and behaviour change would have significant impact on the health and wellbeing of the population of Derby.
- Detailed needs assessment work will be carried out on identified gaps, particularly mental health and workplace health.
- Future JSNA's will develop to meet the needs of changing local structures, for example, Health and Wellbeing Board and clinical commissioning groups.

4.1 Purpose

The purpose of the JSNA is to identify the current and future health and wellbeing needs of the local population. This is to support effective strategic planning, priority-setting and commissioning decisions to improve the health and wellbeing of the people of Derby, and reduce health inequalities.

4.2 Development

4.2.1 Process

Information from a wide range of sources have been collated, analysed and incorporated into the JSNA. This has been done jointly between NHSDerbyCity and Derby City Council. The relevant chapters were reviewed by leads and experts in those areas to identify gaps and potential implications.

4.2.2 Governance

The JSNA has been produced within the following governance and support arrangements:

- **Shadow Health & Wellbeing Board:** overall responsibility for the production of the JSNA. As part of delivering this responsibility it provided strategic direction and final approval of the JSNA. The Board has multi-agency membership including: the Director of Public Health; City Council Cabinet members and Strategic Directors; Southern Derbyshire Clinical Commissioning Group (SDCCG) and voluntary/ third sector representation.

- **Health & Wellbeing Coordination Group:** a sub-group to the Shadow Health and Wellbeing Board. This group acted as the steering group for the production of the JSNA. Again this has multi-agency membership.

- **JSNA Working Group:** this group reported to the Health and Wellbeing Coordination Group and had responsibility for the operational delivery of the JSNA. Its membership incorporated key information and area leads particularly from both PCT Cluster and Local Authority. This group led on obtaining relevant data and information from across agencies within the city and on the production of a draft JSNA.

To ensure strategic ownership of the JSNA it will be presented prior to publication to the following groups:

- City Council Chief Officer Group
- Council Cabinet
- NHS PCT Cluster Board
- Health and Wellbeing Board (final approval and sign-off).

4.3 Content

The 2009/10 JSNA was reviewed to identify those areas where there have been notable changes, for example, in terms of new data or service delivery transformations. In addition, a number of gaps were identified which are incorporated into the new document:

Areas being updated/ refreshed	New areas being added
• Demographics • Alcohol • Smoking • Substance misuse • Teenage pregnancy • Cardiovascular disease • Cancer	Including: • Housing & homelessness • Child health and wellbeing • Deaf and hearing impaired • Blind and partially sighted • Physical disability • Mental health

The JSNA is structured around the following chapters:

- ***Derby population profile*** – outlining the size and structure of the population of Derby in terms of factors such as age, sex and ethnicity.
- ***Social and environmental***– includes information on issues such as deprivation and housing.
- ***Lifestyle*** – including lifestyle behaviours such as smoking, alcohol and drug misuse.
- ***Burden of ill-health*** – considers the prevalence of diseases such as cancer, cardiovascular disease and stroke.
- ***Child health and wellbeing*** – looks at a range of measures of child health and wellbeing such as education, lifestyle, immunisation and hospital admissions.
- ***Ward-level analysis*** – provides summaries of health and wellbeing issues of the population by geographical area.

Given that the JSNA 2011 is a refresh only and not a full update, it is recommended that it is read in conjunction with the JSNA 2009/10. It should also be noted that other key needs assessments and documents have been published that should also be considered in relation to health and wellbeing needs in the city, for example: Homelessness Needs Assessment; Child and Family Poverty Needs Assessment; Drugs and Alcohol Needs Assessments.

Whilst the JSNA covers a broad breadth of information, some gaps remain, including mental health and workforce health. Work is underway to address this which will form either part of the next JSNA or as stand-alone topic-specific needs assessments.

4.4 Key findings

The JSNA presents a wide range of information in some detail. The following tables, however, summarise the key findings:

Table 1 Derby population profile: findings and implications

Key findings	Implications
• Derby has a resident population of 244,100 • The registered population figure is over 296,000 • Derby is an ethnically diverse city with an estimated 182 nationalities speaking 72 different languages • Asian residents form the largest minority ethnic grouping accounting for 10.5% of the population • Around 13,000 new international migrants arrived in Derby between 2002 and 2007 • Up to 20% of the population of some wards (e.g. Arboretum) are new migrants • Derby has a relatively young population with 48% of residents estimated to be under 35 • The 85+ age band is projected to be 40% larger than 2020 than it was in 2008.	➢ Different groups of people have very different needs, differing access to services and varying outcomes. Consideration needs to be given to delivering services appropriate to meeting varying need ➢ Asian and black ethnic groups are at higher risk of developing certain conditions such as diabetes.

Table 2 Social and environmental: findings and implications

Key findings	Implications
• Derby is 'relatively' deprived – 88th (of 326) most deprived local authorities • Derby has a greater proportion of people living in the most deprived groups/categories than both East Midlands and England • There is a big variation in the level of deprivation across the city • Almost one-quarter of households are 'pensioner-only' • It is estimated that 15% of Derby households suffer 'fuel poverty' • Half (4,691) of privately rented accommodation is 'non-decent' • Over 7,000 applicants for social housing • Over 4,000 empty properties in Derby.	➢ Deprivation increases the risk of early death and is associated with higher rates of illness and disease ➢ Deprivation is linked to 'risky' behaviour e.g. smoking ➢ Poor housing conditions contribute to preventable deaths, ill-health, and accidents particularly in vulnerable and older people ➢ Private-rented accommodation is more likely to be occupied by vulnerable people ➢ Homeless people are more likely to have drug and alcohol misuse, physical health and mental health problems.

Table 3 Lifestyle: findings and implications

Key findings	Implications
• One-quarter of 'all adults' in Derby smoke - significantly higher than the England average and has the third (of 11) highest smoking prevalence in its ONS family cluster • Derby has worse rates than the national and family average for: - Smoking attributable hospital admissions - Oral cancer registrations • Over one-fifth (22.4%) of Derby's population binge-drink • Derby has comparatively high rates of alcohol-related hospital admissions and alcohol-attributable crime • There are around 2,000 problematic drug users in Derby – around 70% of which are in treatment • Around one-quarter (24.2%) of adults in Derby are obese – similar to the national average • Almost three-quarters (72.9%) of adults do not eat healthy diets and just 13.6% of adults take part in three sessions of moderate exercise per week • Derby is not on course to achieve the 2011 target rate for teenage conceptions, however, the rate of teenage pregnancy is reducing in the city.	➢ Smoking is one of the main causes of avoidable ill-health and preventable deaths ➢ Heavy alcohol consumption can lead to a range of conditions (and increased risk of mortality) including cancer, heart and liver disease and stroke ➢ Drug misuse is associated with poor physical and mental health along with wider community consequences such as crime ➢ Obesity is associated with conditions such as diabetes ➢ Treating obesity and associated consequences in Derby was estimated to cost around £5.5 in 2009/10 ➢ Babies born to teenage mothers have a 60% higher mortality rate and 63% increased risk of being born into poverty and tend to do less well in school.

Table 4 Burden of ill-health: implications and findings

Key findings	Implications
• It is estimated that 11,344 people in Derby have a moderate physical disability, and 3,243 have a serious physical disability • Derby is a significant centre for the deaf community in the UK – with a deaf population estimated to be three-times higher than the national average • 1,585 are registered blind or partially-sighted • 7,281 people aged 65 or over are unable to manage at least one activity on their own and this is expected to rise by 48% by 2030 • Mortality rates from cardiovascular disease are significantly higher than the national rate, but have decreased by 44.7% since 1995-7	➢ The burden of ill health is not equally felt across the city – it is felt greatest by those living in the most socially and economically deprived areas – with higher incidence of disease and mortality rates ➢ The prevalence of various conditions vary dependant on factors such as age, sex and ethnicity ➢ High prevalence of conditions such as cancer and heart disease not only impact significantly on the health and

Key findings	Implications
• The two largest underlying causes of death in the city are ischaemic heart disease and cerebrovascular disease – where cause of death is 'heart attack', 'heart disease' and 'stroke' • Derby now has a higher incidence of malignancies than the East Midlands and England, and this is significantly higher in men • Premature mortality from cancer has reduced since 1999 but increased in 2007 and 2008 – against family, regional and national trends and is now significantly higher than the regional and national rate • Mortality rates for cardiovascular disease are significantly higher than the national rate but are decreasing • Emergency admission rates for stroke are higher than the national rate, and significantly higher in men than women • Those living in the most deprived areas of Derby are 1.7 times more likely to have an emergency admission for stroke than individuals living in the least deprived areas.	wellbeing of individuals and lead to reduced life expectancy, but also have a high financial cost ➢ Early diagnosis of cancers can improve treatment outcomes and life expectancy e.g. regular screening can reduce the risk of dying from bowel cancer by 16% ➢ Uptake of screening varies greatly between men and women, ethnic groups and socio-economic status with affluent areas tending to have higher uptake ➢ Many people with health conditions such as coronary heart disease remain undiagnosed (42.3% of the population of the city with coronary heart disease are estimated to be undiagnosed).

Table 5 Child health and wellbeing: findings and implications

Key findings	Implications
• Significantly more children in Derby participate in at least three hours of sport per week • The GCSE pass rate (5A*-C) in Derby is significantly higher than the comparable family group and national average • Derby performs significantly worse than its comparable family group and England in the following measures: - infant mortality rate - MMR immunisation by age two - hospital admissions due to substance misuse age 15-24 - first time entrants to the Youth Justice System - rate of family homelessness • The number of children in the city on child protection plans is increasing – 265 children required a new plan in 2009/10 an increase of 100 on previous year • Derby has a higher than average rate of	➢ A child's early years (including pregnancy) has long-term effects on their physical and mental health ➢ Early intervention (universal and targeted prevention) can improve the outcomes for children and young people ➢ Children in the care of local authorities are amongst the most vulnerable ➢ There are inequalities in the outcomes of children and young people across the city.

Key findings	Implications
referrals relating to safeguarding and family support, and a re-referral rate of 21% • As at 31st March 2010, there were 420 looked after children in Derby which had risen to 457 by the beginning of 2011 • 3,630 children in Derby are estimated to have 'some type of mental disorder' – the majority of who are diagnosed with conduct or emotional disorders.	

5 INTRODUCTION

Key findings:

- Joint Strategic Needs Assessment (JSNA) is a statutory requirement
- Significant changes underway within the NHS including:
  - commissioning function responsibility to move from Primary Care Trusts to 'clinical commissioning groups'
  - ability to purchase services from 'any qualified provider'
  - transfer of public health responsibility from the NHS to local authorities
- Development of aligned outcomes frameworks for NHS; public health and adult social care and associated reward funding
- Locally, a PCT Cluster has been established across Derbyshire along with five GP-led clinical commissioning groups operating in shadow form
- A shadow Health and Wellbeing Board is now operational in the city
- This JSNA is a 'light touch' refresh of the JSNA 2009/10.

Implications

- This JSNA (in conjunction with the previous JSNA) provides information and detail to support strategic priority-setting and planning.
- The JSNA will need to continue to provide integrated health, wellbeing and social care information to enable joined-up strategy and operational delivery across NHS, public health and adult social care.

Gaps and next steps

- Whilst this document covers a broad range of topics, there are a number of key gaps, most notably mental health and workforce health. Work is underway to develop these areas in future needs assessments.
- Future JSNAs will incorporate much more engagement with the public, service users, voluntary sector and other key stakeholders.
- The structure and content of future JSNAs will develop to meet the differing requirements of Health and Wellbeing Boards, local authority and clinical commissioning groups to ensure that their commissioning decisions adequately reflect the needs of the local population.

The Joint Strategic Needs Assessment (JSNA) has been a statutory requirement for upper-tier Local Authorities and Primary Care Trusts since 2008 throughthe Local Government and Public Involvement in Health Act 2007. The purpose of the JSNA is to identify the current and future health and wellbeing needs of the local population and enable commissioning decision-making.

Whilst the JSNA remains a statutory responsibility with the same purpose, the policy context and structural framework in which it is delivered is changing significantly.

5.1 The current context/ national picture

The coalition government came into power in May 2010 and have introduced significant policy changes in relation to both health and social care. These include:

- White Paper – 'Equity and Excellence: Liberating the NHS' (2010)[1]
- White Paper – 'Healthy Lives, Healthy People: Our strategy for public health in England' (2010)[2]
- Department of Health consultation document- Transparency in Outcomes: a Framework for Adult Social Care[3]
- Department of Health consultation document - The NHS Outcomes Framework 2011/12 [4]
- Department of Health (December 2010) Healthy Lives, Healthy People: Transparency in Outcomes[5].

5.1.1 NHS Structure

The structure of the NHS is changing significantly. The NHS White Paper, Equity and excellence: Liberating the NHS published in July 2010, set out the Government's plans for the future of the NHS. It proposed to:

- put patients at the heart of everything the NHS does;
- focus on continuously improving those things that really matter to patients - the outcome of their healthcare; and
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services[1].

To deliver this, the NHS White Paper proposed a number of significant structural and ideological changes that will influence the health and wellbeing agenda. Changes include the establishment of a NHS Commissioning Board; strengthened role of Care Quality Commission; devolvement of commissioning responsibilities to GP-led clinical commissioning groups; enablement of commissioners to buy services from 'any willing provider' and the abolishment of Strategic Health Authorities and Primary Care Trusts (PCTs). Whilst some of the original plans within the White Paper have changed, e.g. the shift towards wider professional involvement in commissioning groups and establishment of 'clinical commissioning groups' rather than GP consortia and 'any qualified provider' rather than 'any willing provider' [6], the broad direction remains the same.

The Public Health White Paper 'Healthy Lives, Healthy People: Our strategy for Public Health in England' outlines the Governments proposed approach to tackling public health. It suggests that there are still significant opportunities to be achieved through health improvements and tackling health inequalities. It also sets out the key principles, structures, accountabilities and funding arrangements to deliver this 'radical new approach'[(2)]. The new proposed arrangements include:

- A ring-fenced public health budget – currently estimated at £4 billion nationally
- A shift towards localism – with the devolvement of responsibilities and funding
- The transfer of health improvement functions to local government – with responsibility and allocated budgets from April 2013
- Establishment of Public Health England from April 2013
- The population protection function will remain the responsibility of central government
- Develop a shared/ partnership responsibility for delivery of public health – including individuals, government, business, employers and voluntary and community groups. This will be supported by the establishment of the 'Public Health Responsibility Deal'
- Focus on a coherent approach across different stages of life including: children and young people, working age population and 'active ageing' and the integration of physical and mental health
- Replacement of 'top-down targets' with the development of a public health outcomes framework and associated incentive scheme
- Promotion of an evidence-based approach to public health with an increased focus on 'information-led, knowledge-driven public health interventions'.

The Department of Health have consulted on the development of local statutory health and wellbeing boards. The purpose of the boards is to, "…bring together the key NHS, public health and social care leaders in each local authority area to work in partnership. The health and wellbeing board would be able to establish a shared local view about the needs of the community and support joint commissioning of NHS, social care and public health services in order to meet the needs of the whole local population effectively" [(2)]. The health and wellbeing boards will be required to make arrangements for the preparation of the JSNA. However, whilst the health and wellbeing board will hold the responsibility to 'make arrangements', it should be noted that, "GP consortia and local authorities, including DsPH, will each have an equal and explicit obligation to prepare the Joint Strategic Needs Assessment (JSNA)"[(2 p. 54)]. The role of the health and wellbeing boards will be to then identify local priorities against the available evidence base in order to develop an integrated local strategy for commissioning in relation to health and wellbeing.

The publication of the NHS Future Forum report proposed the strengthening of the role of health and wellbeing boards, "The legislation should strengthen the role and influence

of health and wellbeing boards…giving them stronger powers to require commissioners of both local NHS and social care services to account if their commissioning plans are not in line with the joint health and wellbeing strategy"[7]. Further, health and wellbeing boards '…will be given a formal role in authorising clinical commissioning groups' (6).

5.1.2 Accountability

The publication of the White Papers, 'Equity and Excellence: Liberating the NHS and 'Healthy Lives, Healthy People: Our strategy for public health in England' clearly stated the Government's intention to move away from 'top-down targets' and from a focus on process to outcome measures.

Steps to implement these intentions are now underway as demonstrated by shifts within NHS performance regimes, the ending of Local Area Agreements and the replacement of the National Indicator Set with a single list of central Government data requirements of local government[8].

The publication of the NHS Outcomes Framework 2011/12 and the consultation documents 'Transparency in outcomes: a framework for adult social care' and 'Healthy Lives, Healthy People: Transparency in Outcomes' marked a further step in this proposed shift from top-down targets and to an outcome focus.

There are a number of shared themes that cut across the three Outcomes Frameworks:

- Move away from top-down targets to local accountability
- Focus on outcomes rather than process
- Drive to improve quality
- Mechanism to support improved transparency and accountability
- Reduction in inequalities (particularly NHS and Public Health frameworks)
- Mechanism to support incentives/rewards (particularly Public Health and Adult Social Care frameworks).

All of the frameworks require the development of a core set of indicators and all outline the central provision and reporting of these datasets i.e. through Public Health England and NHS Information Centre for Health and Social Care. The plan is for the National Institute for Health and Clinical Excellence (NICE) to extend its remit into adult social care from 2012/13 and to develop a programme of Quality Standards which will underpin and provide an evidence base to the NHS and adult social care outcomes. The three frameworks are aligned and overlap to reinforce the need for joint strategic and operational delivery:

Table 6Over-arching framework of 'impact indicators'[9]

Domain	Proposed indicator
Improving population health and tackling health inequalities	• Differences in how long the best and worst off people can expect to live/to live without major health problems • Babies born at a healthy birth weight
Preventing people from dying prematurely	• Deaths that might have been avoided by better treatment • Deaths from avoidable diseases
Enhancing quality of life for people with care needs	• Quality of life for people with long-term conditions • Quality of life for people in social care
Preventing deterioration and helping people to recover from episodes of ill-health or following injury	• Hospital admissions for things that should usually be treatable outside hospital • The proportion of people leaving hospital who end up back in hospital within 28 days
Ensuring people have a positive experience of care	• Peoples experience of GP services • Peoples experience of being in hospital • Satisfaction with social care services
Treating and caring for people in a safe environment and protecting them from harm	• The number of safety incidents reported by hospitals and the number of incidents that lead to serious harm

The alignment of the three outcomes frameworks and associated indicators will need to be referenced within future JSNAs, potentially broadening its scope and nature of content.

5.1.3 Key publications

A number of other reports and documents have been recently published of relevance the Joint Strategic Needs Assessment:

- A Vision for Adult Social Care: Capable Communities and Active Citizens (2010)
- Think Local Act Personal (2011)
- Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care - guidance on eligibility criteria for adult social care, England (2010) web link
- The Importance of Teaching - The Schools White Paper 2010
- The Localism Bill 2010-11
- The Monro Review of Child Protection 2011

5.2 The local picture

5.2.1 Local government structure

Derby City Council is a Conservative/ Liberal Democrat coalition leadership. There are fifty-one councillors on the full council representing seventeen wards. Eight councillors make up the Council Cabinet with the following portfolios:

- Leader of the Council
- Planning and Environment
- Neighbourhoods
- Adult Social Care and Health
- Resources
- Children and Young People
- Housing and Advice
- Leisure and Culture.

5.2.2 Local NHS structure

NHS Derby City has joined with NHS Derbyshire County to form a 'PCT Cluster' as per national requirements. Whilst now largely operating as a single organisation, each PCT retains its statutory requirements and Directors of Public Health. In response to the NHS White Paper and Health and Social Care Bill, five clinical commissioning groups (CCGs)have been established in shadow form across Derbyshire covering:

- Erewash
- North Derbyshire
- Southern Derbyshire
- Hardwick Health
- High Peak.

The Southern Derbyshire group covers the city and the majority of southern Derbyshire. Within this consortia are four 'localities' – two of which cover the city and broadly match the geography represented in this JSNA.

5.2.3 Local priorities

The key priorities of the local authority for 2011/12 are included in the Derby Plan. The Derby Plan is a high-level plan that brings together the priorities of key partners from the public, private and voluntary sector. It covers the period April 2011 to March 2026.

Over the next fifteen years we aim to work together to improve the quality of life so all people in Derby will enjoy…

- A thriving sustainable economy
- Achieving their learning potential
- Good health and well-being
- Being safe and feeling safe
- A strong community
- An active cultural life

For more information download The Derby Plan 2011-2026.

5.2.4 Governance

In Derby, a shadow Health and Wellbeing Board has been established and is taking strategic leadership of the health and wellbeing agenda. The Board is chaired by the Leader of the Council and its membership includes: the Director of Public Health; Cabinet members and Strategic Directors for Adults, Health and Housingand Children and Young People; CCG representative and voluntary/ third sector representation amongst others. The Government expectation of Health and Wellbeing Boards is that they will bring the "…whole system together at the local level' and '…maximise opportunities for integration between the NHS, public health and social care, promoting joint commissioning, and driving improvements in the health and wellbeing of the population"[10 p. 15].

The shadow Health and Wellbeing Board has delegated responsibility (decision-making and finance) from the PCT Cluster Board and Derby City Partnership (local strategic partnership) and is seeking delegated responsibility from Derby City Council.

5.3 Process of development

5.3.1 Content

In 2009/10, a full update of the JSNA was completed. Given this and the significant changes underway most notably within the NHS, but across the public sector as a whole, we felt that a 'light touch refresh' would be most appropriate to meet current organisational, commissioning and statutory requirements with a view to producing a new-look JSNA for 2011.

The areas that have been refreshed are those where there has been significant new data published or there have been changes in the way that services are delivered. In addition, new sections have been added where notable gaps were identified in the 2009/10 JSNA.

Table 7 Areas updated/ added to the JSNA for 2011

Areas being updated/ refreshed	New areas being added
• Demographics • Alcohol • Smoking • Substance misuse • Teenage pregnancy • Cardiovascular disease • Cancer	Including: • Housing & homelessness • Child health and wellbeing • Deaf and hearing impaired • Blind and partially sighted • Physical disability • Mental health

A wide range of data and information has been collated and analysed for this JSNA. This includes nationally published datasets and reports, but also regional and local data. Whilst much of this is provided through NHS Derby City and Derby City Council, data has also been provided from a range of partners, for example, Derby City and Neighbourhoods Partnerships. The datasets used are listed in Appendix 1.

5.3.2 Engagement

Whilst public, patient and service user experience was incorporated to an extent in the 2009/10 JSNA, this was minimal and will be further developed within this and future JSNA's, particularly in response to the White Paper 'Equity and Excellence: Liberating the NHS' where the Government stated that, "…shared decision-making will become the norm: *no decision about me without me*"[1 p. 3].

A significant amount of engagement activity has been carried out through the development of publications such as the Derby Plan. There are a range of existing engagement structures and processes that can be used to inform the JSNA, for example:

- Neighbourhood Forum
- Social Inclusion Network
- LINK
- 'Three Wishes' consultation
- PALS reports
- NHS Surveys/Patient Surveys.

Engagement information is relevant within the JSNA for two purposes:

1. To inform the development of the JSNA
2. Consult on the JSNA to seek views and commentary on final document.

5.3.3 Governance

The production of the JSNA has been supported by the following governance and support arrangements:

- **Shadow Health & Wellbeing Board:** hadoverall responsibility for the production of the JSNA. As part of delivering this responsibility it provided strategic direction and final approval of JSNA. The Board has multi-agency membership including: the Director of Public Health; City Council Cabinet members and Strategic Directors; CCG and voluntary/ third sector representation.

- **Health & Wellbeing Coordination Group:** a sub-group to the Shadow Health and Wellbeing Board. This group acted as the steering group for the production of the JSNA. Again this has multi-agency membership.

- **JSNA Working Group:** this group reported to the Health and Wellbeing Coordination Group and had responsibility for the operational delivery of the JSNA. Its membership incorporated key information and area leads particularly from both PCT Cluster and Local Authority. This group led on obtaining relevant data and information from across agencies within the city and on the production of a draft JSNA.

Membership of these respective groups can be found in Appendix 2.

5.4 Relevant Documentation

Whilst this JSNA can be read as a stand-alone document, it should ideally be read in conjunction with the JSNA 2009/10. This is because the current document consists of refreshed and additional information only and there is considerable information within the 2009/10 document that is not referred to in this document.

Although the scope of the JSNA is relatively broad, it does not cover all areas and it reports information at a relatively high level. There is a range of other relevant documents published (or due to be published) within the city that can be read in conjunction with this report (a brief summary of each of the listed documents and link can be found in Appendix 3):

- JSNA 2009/10
- NHS Derby City Pharmaceutical Needs Assessment 2010/11
- NHS Derby City Sexual Health Needs Assessment 2010
- NHS Derby City Homelessness Needs Assessment
- NHS Derby City Obesity Report
- Derby City Council State of the City Report 2010
- Community Safety Partnership (CSP) Drugs and Alcohol Needs Assessments
- Derby Family Poverty Needs Assessment
- The Derby Plan
- Derby Strategic Intelligence Assessment
- NHS Derby City IMD2010 Briefing
- NHS Derby City Health Profiles 2011 Briefing
- NHS Derby City Cancer Briefing
- NHS Derby City Child Health Profiles Briefing
- CSPs Population, Migration and Community Profile of Derby (2008)
- Derby City Council's 'Your Neighbourhood Consultation'
- The Derby Sustainable Community Strategy.

Whilst there are significant changes in the structure and governance arrangements within the NHS and substantial financial challenges locally for NHS Derby City and Derby City Council, the purpose and importance of the JSNA remains undiminished. The following chapters identify the population profile of the city; socio-economic factors; lifestyle and risk; the burden of ill health; child health and wellbeing; and ward level summaries. For ease, each chapter will begin with a summary of key findings; implications and gaps and next steps.

6 DERBY PROFILE

Key findings:

- The resident population of Derby is 244,100
- The registered population figure is over 296,000
- Derby has a greater proportion of people living in the most deprived groups than both East Midlands and England
- Derby is an ethnically diverse city with an estimated 182 nationalities and speaking 72 different languages
- Asian residents form the largest ethnic grouping accounting for 10.5% of the population
- Around 13,000 new international migrants arrived in Derby between 2002 and 2007
- Up to 20% of the population of some wards (e.g. Arboretum) are new migrants
- Derby has a relatively young population with 48% of residents estimated to be under 35.

Implications:

- Different groups of people have very different needs, differing access to services and varying outcomes. Derby's ethnic diversity and varying deprivation levels demonstrates the need for the city to reduce inequalities and deliver services appropriate to need
- Asian and black ethnic groups are at higher risk of developing diabetes and tend to develop the condition at a younger age
- Deprivation increases the risk of early death and is associated with higher rates of illness from diseases such as Diabetes and Heart Disease.

Gaps and next steps:

- ➢ Future JSNAs will include further detail about the different groups of people who are living in the city and their experiences to improve understanding of their specific needs to enable commissioning of appropriate services
- ➢ Results of the recent Census will be incorporated into the next JSNA along with information sourced from engagement with local communities and providers of services to give a more up-to-date and robust picture of the population of Derby.

6.1 Introduction

Derby is an urban area, covering approximately 30 square miles. It is the UK's most central city and is located in the East Midlands, along with the cities of Nottingham and Leicester. Derby is a relatively young, vibrant, multicultural and contemporary city, which continues to undergo substantial regeneration with schemes such as Derby Riverlights.

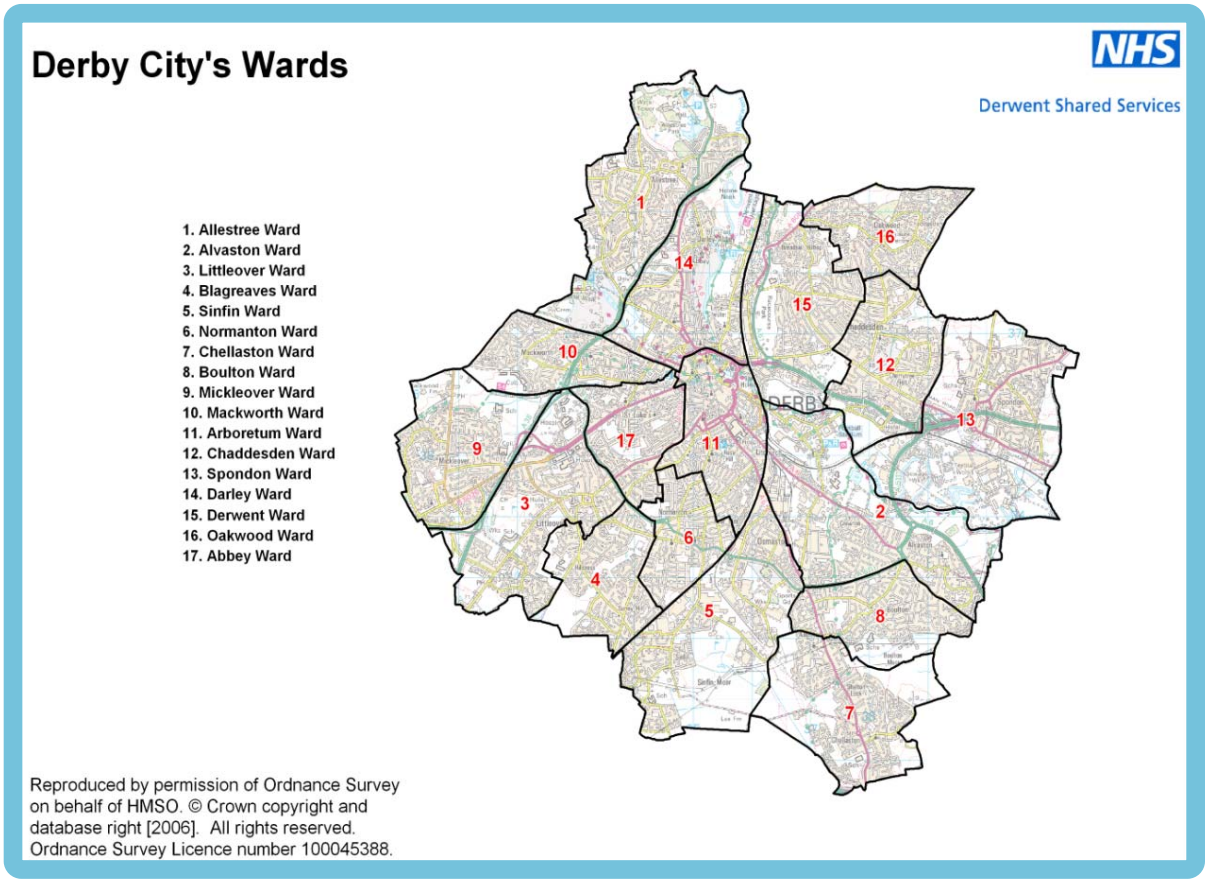
Derby has a long industrial history as shown by the recognition of the Derwent Valley Mills as a World Heritage Site. Derby is still recognised as a regional centre of engineering and manufacturing excellence with famous names such as Rolls-Royce, Bombardier, Royal Crown Derby, Acordis and, more recently Toyota.

Derby's city centre is compact coveringjust 1.4% of the city's geographical area but including almost a quarter of Derby'sbusinesses, 31% of the city's licensed premises and 38% of the city's restaurants[11].

6.2 Demographic overview

The Office for National Statistics (ONS) divides the city of Derby into census wards, which we use when considering the health profile of the local population. Figure 1 shows Derby split into its seventeen wards (see Derby City Council's State of the City Report[12] for further detail).Characteristics of the wards are described in Chapter 12.

Figure 1: Derby by census/ electoral wards



6.3 Population size

There are two ways of measuring population size relevant to this document: as 'resident' population, where a person is classed as living inside the city's boundary; or 'registered' population, where a person is recorded as registered with a GP Practice of NHS Derby City.

6.3.1 Resident population

The ONS 2009 Mid-Year Estimates (MYE) show the Derby resident population was approximately 244,100 which is a rise of approximately 900 people in the last year.

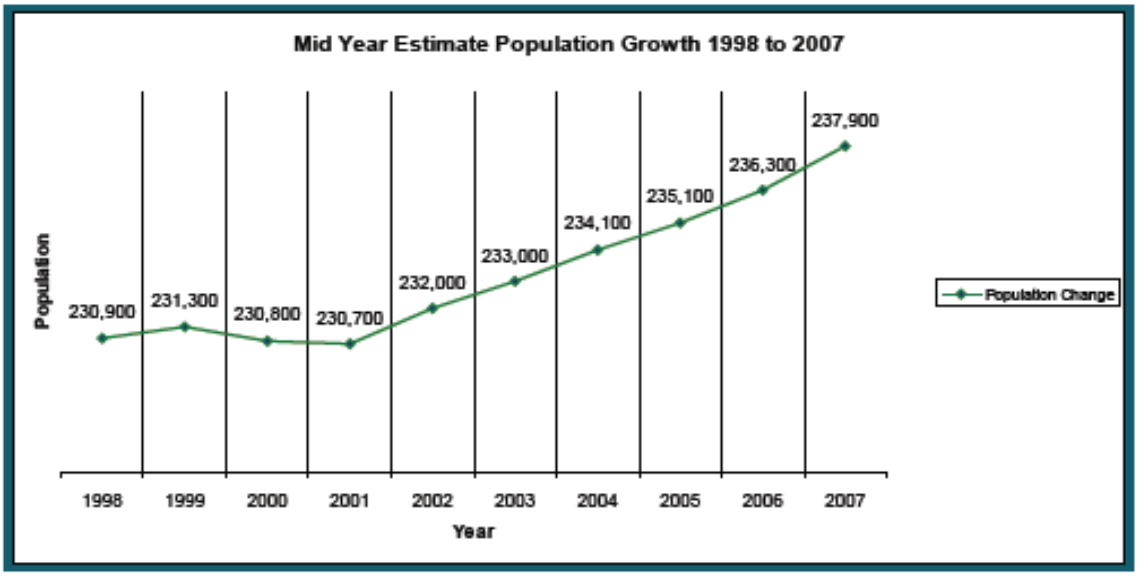
Table 8 shows the resident population, live births, and deaths for Derby, the East Midlands and for Leicester and Nottingham. It shows an estimated 0.4% resident population growth between 2008 and 2009, this compares to a growth of 0.5% in the East Midlands as a whole.

Table 8: Resident Population of Derby and the East Midlands

Area	Change between 2008-2009 (thousands)						
	Mid-2008 population	Live births	Deaths	Natural change	Net migration & other changes	Total change	Mid-2009 population
East Midlands	4,429.4	53.5	41.8	11.8	10.1	21.8	4,451.2
Derby	**243.2**	**3.5**	**2.3**	**1.3**	**-0.3**	**1.0**	**244.1**
Leicester	303.8	5.2	2.5	2.7	-1.7	1.0	304.7
Nottingham	296.6	4.2	2.5	1.8	2.4	4.2	300.8
Source: ONS 2009 MYE							

Figure 2 shows the estimated size of the population of Derby between 1998 and 2007:

Figure 2: Population growth 1998 – 2007 (estimated)



S ource: ONS 2007 mid-year estimate

The population of Derby is estimated to have grown year-on-year between 2001 and 2007. Population increases are estimated to have occurred in all age groups since 2001 - most notably 20 to 29 year group is estimated to have increased by 22% and 40 to 49 year group is estimated to have increased by 26% and those aged 80 or over by 10%.

6.3.2 Derby Births

The number of births to Derby's resident population increased from 3027 in 2005 to 3544 in 2008; however, this had declined slightly to 3430 in 2010(Public Health Births File). Interestingly, the number of births in the PCT registered population (including those mothers living in Derbyshire County), has shown a continued increase over the same period; 5,604 in 2008, 5,808 in 2009, 5,934 in 2010. Many wards within Derby experienced a comparatively stable number of births but increases were seen in some wards; the most notable of which occurred in Arboretum, Normanton, Chellaston and Alvaston wards.

6.4 Registered Population

The latest registered population figure for NHS Derby City is more than 296,000 with 150,000 males and 146,000 females (National Exeter System, 2011). Whilst the majority of NHS Derby City's registered population lives within the boundaries of the Local Authority (LA) in Derby, approximately 17% of its population live in the surrounding Local Authority Districts (LAD)[1] two-tier district authorities of Derbyshire County. Two of NHSDerbyCity's main GP practice surgeries are situated in southern DerbyshireCounty; these are Melbourne Health Care Centre in Melbourne, South Derbyshire LA, and Overdale Medical Practice in Borrowash, Erewash LA. There are also a number of branch surgeries of NHS Derby City located in the county.

6.5 Age profile of Derby

Table 9 shows the resident population figures split into three age groups: children aged between 0 and 15; those of a working age of 16 to 64 for males and 16 to 59 for females; and older people aged 65 plus for males and 60 plus for females.

Table 9: Population figures split between three age groups

Area	Mid-2009 Population Estimates: Selected age groups for Primary Care Organisations in England; estimated (thousands)						
	All ages Mid-2009	Children 0-15		Working age 16-64M/59F		Older people 65M/60F and over	
		No.	%	No.	%	No.	%
East Midlands	4,451.2	815.8	18.3	2,741.7	61.6	893.8	20.1
Derby City	**244.1**	**46.9**	**19.2**	**152.9**	**62.6**	**44.4**	**18.2**
Nottingham City	300.8	49.4	16.4	211.1	70.2	40.3	13.4
Leicester City	304.7	62.7	20.6	200.3	65.7	41.8	13.7
Source: ONS 2009 MYE							

[1] LAD (Local Authority District) 2 tier authorities are those that sit within the larger LAD 1 top tier counties i.e. Amber Valley Local Authority District in Derbyshire County

Derby has a slightly higher proportion of children and working age adults than the East Midlands as a whole and a lower proportion of older people. Figure 3shows the census ward populations of Derby by age band using the 2001 census data.

Figure 3: Derby population by age, sorted by ward

Ward Name	All Ages	Age Bands											
		0-04	05-09	10-14	15-19	20-24	25-29	30-44	45-59	60-64	65-74	75-84	85+
Abbey	13,100	5.5	4.6	5.0	6.5	12.7	10.9	23.0	14.4	4.3	6.1	4.8	2.1
Allestree	13,535	4.5	4.7	6.4	6.0	4.0	3.1	18.4	19.8	7.0	12.6	9.9	3.5
Alvaston	14,638	6.9	5.3	6.0	6.9	8.3	7.9	21.7	17.2	5.1	6.9	5.7	2.0
Arboretum	17,615	8.3	6.7	5.8	6.7	12.1	11.3	23.5	12.9	2.7	5.0	3.6	1.4
Blagreaves	12,864	5.1	6.0	6.5	6.2	6.3	5.9	20.1	18.5	5.7	10.0	7.3	2.2
Boulton	14,000	6.3	5.9	6.7	7.4	7.2	5.3	20.2	17.3	6.2	9.1	6.0	2.3
Chaddesden	13,362	6.2	5.7	6.5	7.0	6.7	5.2	20.4	18.4	6.8	9.0	6.1	2.1
Chellaston	14,363	6.9	6.6	7.0	6.1	5.2	5.3	23.8	17.7	5.2	7.5	5.9	2.7
Darley	12,812	4.5	3.4	3.8	7.6	14.5	8.6	20.9	16.2	5.1	6.8	5.7	3.0
Derwent	14,193	7.7	6.9	6.7	7.5	8.2	7.0	20.8	16.1	4.6	7.4	5.3	1.8
Littleover	13,949	6.1	6.7	7.2	6.6	5.8	5.7	23.3	19.9	4.9	6.7	5.2	1.9
Mackworth	13,265	5.3	4.8	5.5	6.9	12.6	8.4	19.9	15.4	4.4	6.5	8.0	2.4
Mickleover	13,496	4.1	4.5	5.4	6.2	5.4	4.5	18.8	22.3	7.2	10.6	8.1	2.9
Normanton	16,193	8.9	7.6	6.9	7.2	9.3	8.9	23.2	13.3	3.0	5.4	4.3	2.0
Oakwood	13,696	5.7	6.0	6.0	6.8	7.0	7.1	24.8	20.5	4.4	7.1	3.4	1.2
Sinfin	14,561	8.2	7.5	7.3	7.6	8.6	8.1	22.1	16.4	4.4	5.7	2.8	1.3
Spondon	12,250	4.2	4.9	5.6	6.8	5.8	4.9	19.6	19.2	7.9	11.7	6.6	2.8
Derby	237,892	6.3	5.8	6.2	6.8	8.3	7.0	22	17	5.1	7.8	5.7	2.2
East Midlands	4,172,174	5.7	6.3	6.7	6.2	5.9	6.1	22	20	5.0	8.5	5.7	1.8
England	49,138,831	6.0	6.4	6.6	6.2	6.0	6.7	23	19	4.9	8.3	5.6	1.9
KEY		Denotes highest % ward population in an age band											
		Denotes lowest % ward population in an age band											

Source: ONS, Census 2001 (KS02)

Note: Census 2001 data will be updated in future JSNAs with Census 2011 data once published.

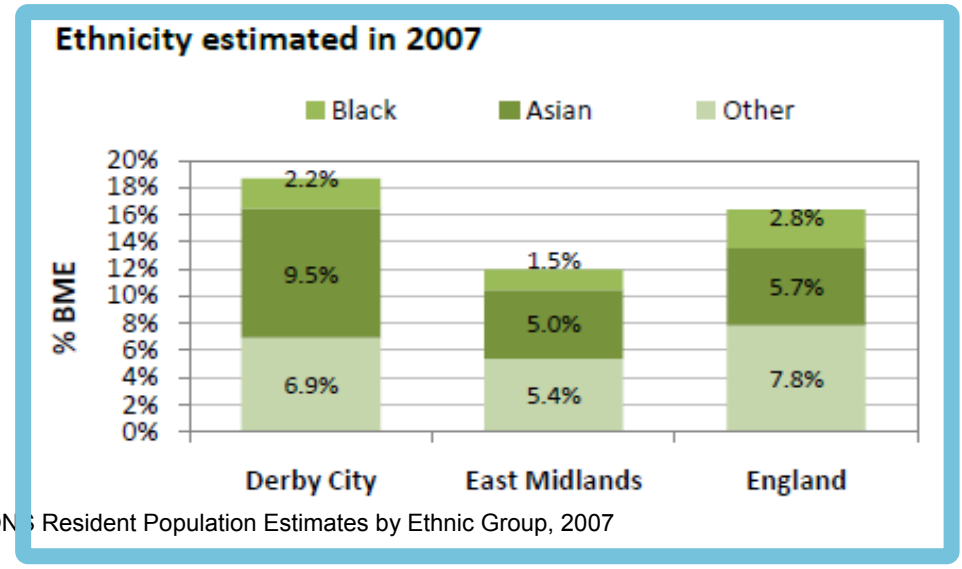
By identifying the age structure of each ward, it enables us to help understand some of the population needs at a local level. For example, Allestree ward has a high number of older people whilst other wards such as Darley have a higher number of teenagers and young adults. It is therefore likely that the health and wellbeing needs of the populations of these wards will be very different.

6.6 Ethnic profile of Derby

Britain has the largest mixed-race population within the European Union (EU) and it is the fastest growing demographic group in the UK. Derby is an ethnically diverse city with a particularly large Asian population. An understanding of the ethnic diversity of the city is important given the variation in health risks, e.g. increased risk of diabetes within South Asians and potential inequalities in health outcomes and access to services.

As part of the Cardiovascular Disease Profile 2011, an estimated ethnicity profile was produced which is shown inFigure 4. This shows that proportionally Derby has a much higher ethnic population for Black, Asian, and Other compared to East Midlands, and a higher proportion of Asian population to England.

Figure 4: Derby ethnicity in 2007 (estimated)



Source: ON S Resident Population Estimates by Ethnic Group, 2007

Although there has been no official update since 2001, Figure 5shows a modelled ethnic profile using Mosaic Origins based on a patient register snapshot taken in 2009.

Figure 5: Map showing modelled ethnic profile of Derby

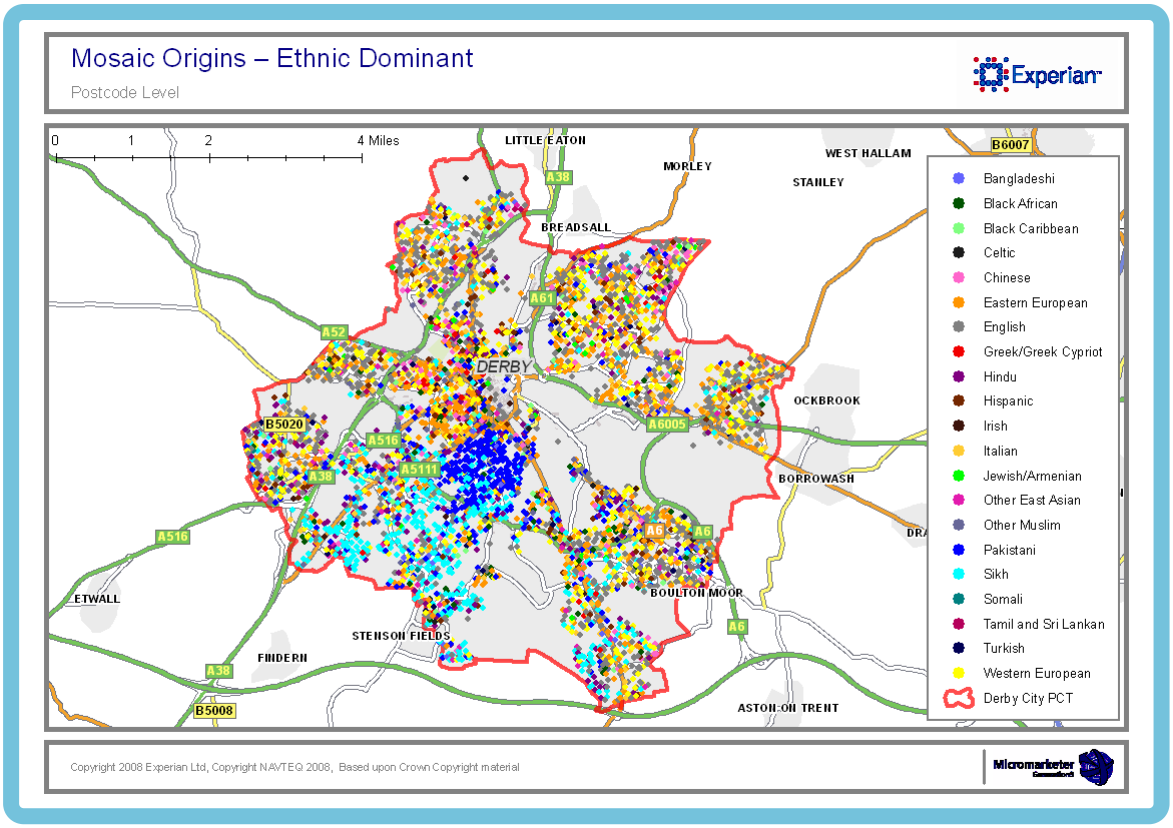
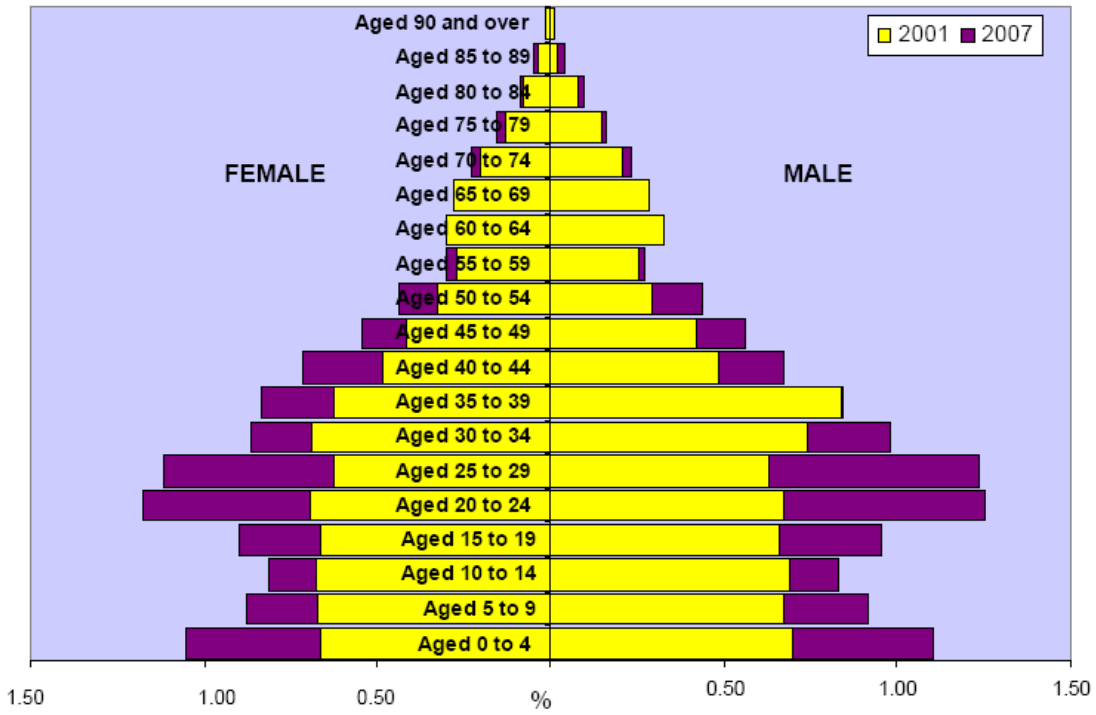


Figure 5 shows the larger proportion of Pakistani and Sikh communities living in Arboretum and Normanton wards.

There are approximately 182 nationalities represented within the city. Approximately seven percent of the city's population do not speak English as their first language. Seventy-two different languages have been identified as being spoken in the city. Punjabi, Urdu and Polish are the most commonly spoken languages after English.

There is significant variation in the population profiles in the seventeen city wards. Arboretum, Abbey, Darley, and Normanton have the widest variation of individuals from different backgrounds, each with around 130 distinct nationalities. Figure 6shows the estimated growth in Derby's non-White British population by age group, it shows notable increases in the 0-4 and 20-29 year age groups:

Figure 6: Estimated growth in the non-White British population between 2001–2007



Source: Derby Community Safety Partnership[13]

Some of the most notable increases since the 2001 Census are estimated to be in the ethnic group 'Other Asian', particularly Iraqi and Afghan populations; African residents, particularly Zimbabwean and Somali; and 'Other White'; particularly Polish, Slovak and Latvian populations.

Accurate and robust population data is limited in its availability and largely based on estimates. Future projections are also difficult given the unpredictable nature of migration etc. The 2011 Census has recently been undertaken and once published will provide an updated official data source.

6.7 Migrant population

It is important to understand the city's migrant population as different groups will have different health and wellbeing needs and potentially suffer inequalities in both outcomes and access to services. We need to understand the language and cultural needs of the range of migrant populations and how they impact on health and wellbeing need and services requirements.

Derby's international migration turnover has shown a steady decline from 2006 (19.608 per 1,000 population in 2006 to 10.242 per 1,000 population in 2009), however overall for England, the numbers remain more stable.

6.7.1 Characteristics of migrants:

Around 13,000 new international migrants are known to have moved to Derby between 2002 and 2007. There is no one single source of information that measures the extent of migration and estimates have been reached through the analysis and interpretation of a wide range of local data sets. All have their limitations but used together they provide useful estimates from which the following observations can be made:

- The majority of new migrants are of working age, with 59% being aged between 20 and 39
- Males are slightly over-represented amongst the new migrant population (54%), however this proportion is not as large as national reports have suggested
- Between 2002 and 2007, Eastern European migrants are estimated to have accounted for around 31% of all new migrants in Derby. 'Other Asian' and Western European migrants accounted for a further 14% and 13% of new migrants respectively
- People born in Poland accounted for the largest proportion of new migrants to Derby (12.8%) between 2002 and 2007
- Arboretum and Normanton wards experienced the largest rates of migration between 2002 and 2007, with new migrant populations accounting for at least 19.4% and 15.7% of the resident population respectively. Abbey and Darley wards also have a new migrant population of around 8.6% and 8.3% respectively.

6.8 Religion

With such a diverse mix of nationalities, an equally as diverse mix of religions is inevitable. Religion is taken from the 2001 Census which is the most robust source of these statistics. There are four dominant groups in Derby; these are those people who state their religion to be Christian (67.4%), those stating 'No Religion' (15.9%), those stating religion as Muslim (4.4%) and those stating their religion as Sikh (3.2%). There are in fact significantly higher numbers of people stating that their religion is Muslim or Sikh, than in the East Midlands or England.

Note: much ofthe information in this section summarises that found in the reports: Community Safety Partnership (April 2008) Derby Population, Migration and Community Profile[13] and Derby City Council (June 2010) State of the City Report 2010[12].

7 SOCIAL AND ENVIRONMENTAL

Key points:

- Derby is 'relatively' deprived – 88th (of 326) most deprived local authorities
- Derby has a greater proportion of people living in the most deprived groups/categories than both East Midlands and England
- There is a big variation in the level of deprivation across the city
- Almost one-quarter of households are 'pensioner-only'
- It is estimated that 15% of Derby households suffer 'fuel poverty'
- Half (4,691) of privately rented accommodation is 'non-decent'
- Over 7,000 applicants for social housing as at March 2011
- Over 4,000 empty properties in Derby.

Implications:

- Deprivation increases the risk of early death and is associated with higher rates of illness and disease
- Deprivation is linked to 'risky' behaviour e.g. smoking
- Poor housing conditions contribute to preventable deaths, ill-health, and accidents particularly in vulnerable and older people
- Private-rented accommodation is more likely to be occupied by vulnerable people
- Homeless people are more likely to have drug and alcohol misuse, physical and mental health problems.

Gaps and next steps:

➢ Tackling the wider determinants of health continue to be a priority to tackle poor health, premature mortality and health inequalities.

7.1 Introduction

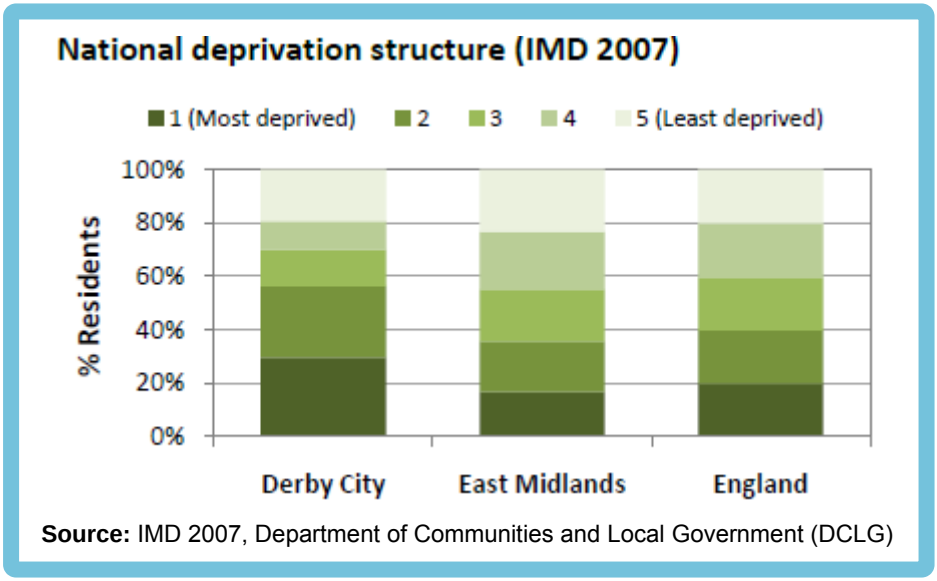
Even in the most affluent of countries, people who are less well-off have substantially shorter life expectancies and are more likely to suffer poorer health than the wealthy. Poor social and economic circumstances affect health throughout life. Disadvantage has many forms and may be absolute or relative. Having few family assets, a poor education, living in poor quality housing, or living on an inadequate pension are examples of just a few. These disadvantages tend to concentrate among the same people, and their effects on health accumulate during life[14].

7.2 Deprivation

Derby is a relatively deprived city but also has some geographical wards that are very affluent. Using the Indices of Multiple Deprivation (IMD) 2010, Derby City Council has seen an improvement in its ranking across all Las in England (326), from 69th to 88th most deprived. Nottingham City and Leicester City have equally seen improvements from their 2007 position; moving from 13th to 20th and 20th to 25th respectively.

The Cardiovascular Disease Profile 2011 published a national deprivation structure for Derby. This is shown in Figure 7.

Figure 7: National deprivation structure from SEPHO



Source: IMD 2007, Department of Communities and Local Government (DCLG)

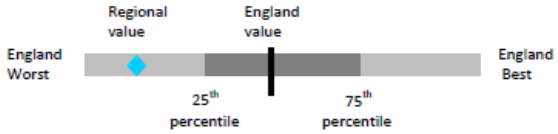
This shows that proportionally, Derby has a greater number of people living in the two most deprived groups than both the East Midlands and England. The impact of deprivation in Derby is illustrated in the following chart which shows the key Marmot indicators (which correspond as far as possible to the indicators proposed inFair Society, Healthy Lives)[15]. (See Appendix 4 and Figure 8)

Figure 8: Marmot indicators for Local Authorities in England - Derby

Marmot Indicators for Local Authorities in England

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value for this local authority is shown as a circle, against the range of results for England, shown as a bar.

- Significantly better than England value
- Not significantly different from England value
- Significantly worse than England value



Derby

	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	77.5	78.1	78.3	73.7		84.4
2	Inequality in male life expectancy (years)	12.6	9.0	8.8	16.6		2.7
3	Inequality in male disability-free life expectancy (years)	16.6	11.2	10.9	20.0		1.8
	Females						
4	Female life expectancy at birth (years)	81.5	82.1	82.3	79.1		89.0
5	Inequality in female life expectancy (years)	9.5	5.5	5.9	11.5		1.8
6	Inequality in female disability-free life expectancy (years)	13.9	9.7	9.2	17.1		1.3
	Social determinants						
7	Children achieving a good level of development at age 5 (%)	49.3	55.9	55.7	41.9		69.3
8	Young people not in employment, education or training (NEET) (%)	7.7	6.1	7.0	13.8		2.6
9	People in households in receipt of means-tested benefits (%)	18.7	13.9	15.5	41.1		5.1
10	Inequality in people in receipt of means-tested benefits (% points)	44.9	26.2	30.6	61.3		2.9

Figure 8 shows that Derby is significantly worse than England for all the key indicators for health outcomes and social determinants and most notably in:

- Inequality in life expectancy (male and female)
- Inequality in disability- free life expectancy (male and female)
- Children achieving a good level of development at age five
- Inequality in people in receipt of means-tested benefits.

The following sections review housing and homelessness.

7.3 Housing

7.3.1 National Context and impact on health

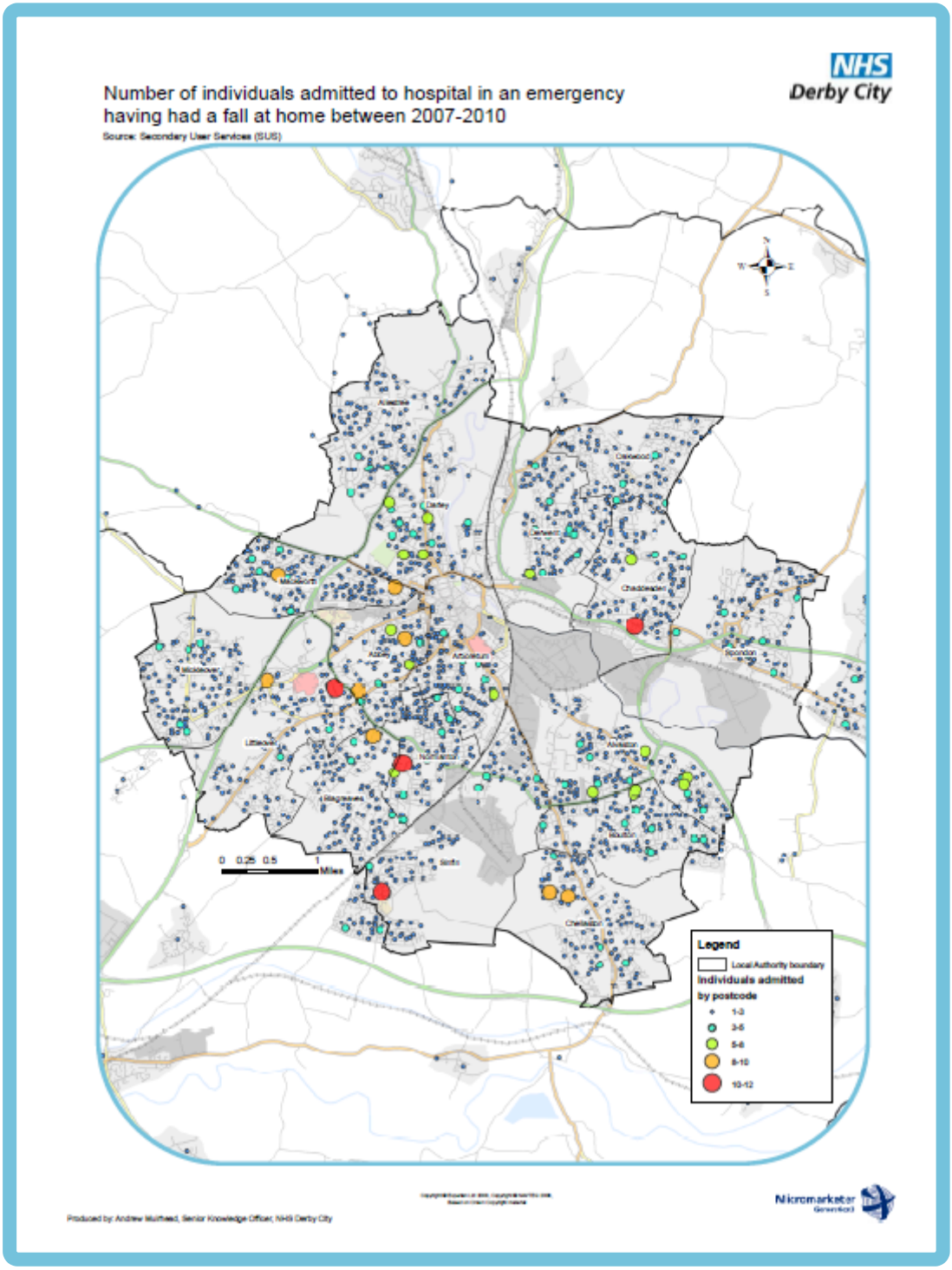
Housing is a key determinant of health, with poor quality housing being intrinsically linked with poor health. Poor housing conditions continue to cause preventable deaths, illness and accidents; they contribute to health inequalities, impact on peoples' life expectancy and on their overall quality of life.

People are able to enjoy a better home environment, enhanced quality of life, improved health and general well-being when they are warm, safe and secure in their own home – and where that can be achieved, they are at significantly reduced risk of accident and housing-related poor health. More than 500,000 people are living in overcrowded conditions and 70,000 people in temporary accommodation. Almost two million people are on council waiting lists for social housing[16][17].

There are a range of ways that poor housing impacts on health and wellbeing. Falls in the home are a particular risk for older and vulnerable occupants. The Department of Health report 'Falls and Fractures: Effective interventions in Health and Social Care'states, "Each year 35% of over-65s experience one or more falls and about 45% of people aged over

80 who live in the community fall each year. Between ten and 25% of such fallers will sustain a serious injury"[18 p. 6].

Figure 9: Map of emergency hospital admission hotspots in Derby, as a result of falls



Recurrence is also identified as a key concern in relation to falls, with the DTI estimating in 1993 that, "…one third of over 65 year olds living in the community will fall each year…predicting that 60-70% of those people falling are likely to fall again in the following 12 months."

Falls and other accidents in the home not only have a high impact on individuals in terms of health etc., but they also have a high cost financially, particularly in relation to health and social care. For example, "…the total annual cost of home accident casualties who are treated for their injuries at hospital – around 2.7 million people each year – is estimated to be £45.63 billion, based on an average cost of £16,900 per victim. That figure does not include the cost of home accident deaths, which number in excess of 4,000 every year...Also omitted are the costs associated with people seeking GP treatment after a home accident. The true cost to society of accidents at home is therefore likely to be far higher"[19].

There is some evidence to suggest that the implementation of 'handyperson'-type interventions such as: home repairs, minor home adaptations, home security improvements and installation of smoke alarms can improve wellbeing and can be cost-effective:

- "postponing entry into residential care by a year saves on average £28,080 per person
- preventing a fall leading to a hip fracture saves the state £28,665 on average
- housing adaptations reduce the costs of home care (saving £1,200 to £29,000 a year)
- hospital discharge services speed up patient release, saving at least £120 a day"[20 p. 2].

At the other end of the age spectrum, evidence suggests that children in bad housing conditions are more likely to have mental health problems, such as anxiety and depression, to contract meningitis, have respiratory problems, experience long-term ill health and disability, experience slow physical growth and have delayed cognitive development. These adverse outcomes reflect both the direct impact of housing and associated material deprivation.

Fewer accidents and better health result in significant benefits for the client, NHS, local authority and their partner agencies. The Organisation for Economic Co-operation and Development (OECD) estimate that 10% of people in member countries will be more than 80 years old by 2050 – representing a huge increase over the 4% in 2010 and 1% in 1950[21]. Based on this, Britain's projected bill for long-term care and support services – such as home help, adaptations to property, and residential accommodation (primarily local authority associated costs) – will almost double from 2.2% of GDP to 4.3% by 2050.

Cold housing is the main explanation for extra 'winter deaths' occurring each year between December and March. In 2008/9 there were 36,700 additional deaths in the December to March period in England and Wales. The estimated annual cost to the NHS of treating winter related disease due to cold private housing is £859 million. This does not include additional spending by social services, or economic losses through missed work[22].

7.4 Localcontext

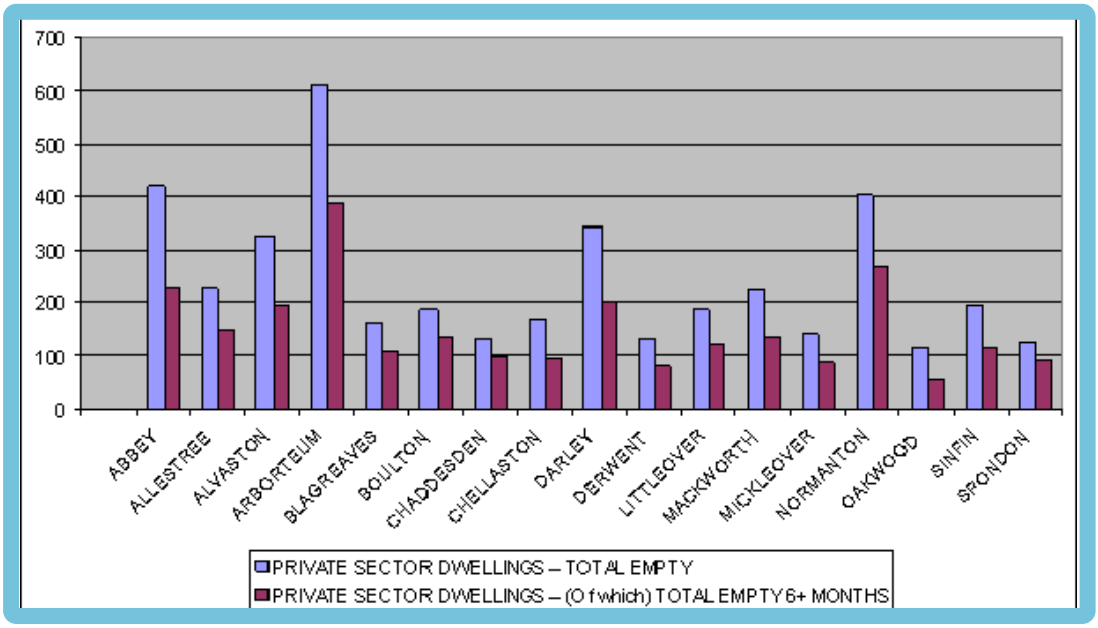
Derby has 104,458 households[23]. Of these households:

- almost one-third (29.8%) have dependent children
- 7.3% are lone-parent households with dependent children
- 24.3% are pensioner-only households
- 14.7% contain one pensioner living alone.

As already highlighted, poor housing can be a particular risk to vulnerable and older residents especially in relation to excess winter deaths and falls. The proportion of older people in Derby continues to increase and is projected to be nearly 25% by 2027. The 'Warm and Well in Derby' project estimates that 15% of households (15,000 households) in Derby suffer fuel poverty, with over 50% of those households containing people aged over 60[24]. There is now potential for this to be higher this year due to recent increases in fuel costs.

The number of disability related benefit claimants in Derby was 21,200 in 2009, of which 12,660 were aged over 60[23]. Latest figures (March 2011) show there were 7,139 applicants on Derby's waiting list for social housing; 2,040 of which had a 'need for at least one extra bedroom'. Given this, it is frustrating that in January 2011 there were 4,247 empty properties in Derby, of which 1,959 had been empty for six months or longer.

Figure 10: Number of private Sector dwellings in January 2011, by ward



Thirty-one per cent of private sector dwellings in Derby are non-decent and 22% are lacking thermal comfort[23]. In addition, the 2006 House Condition Survey identified 9,400 private sector dwellings in Derby as being privately rented and found 49.9% (4,691) of these to be non-decent. The number of private sector dwellings that are both

non-decent and occupied by vulnerable people in Derby, was estimated to be at least 8,367.

In Derby the number of emergency falls admissions between 2005 and 2010 has increased by 34.6%.The total population in Derby age 65 years and over that are predicted to fall are:

Figure 11: Derby population aged 65 years and over predicted to have a fall/ be admitted due to a fall

	2010	2015	2020
Predicted to fall	10,437	11,315	12,133
Predicted to be admitted to hospital due to a fall	843	905	986

Derby City Council's in-house calculations across a range of health issues indicate that the cost to Derby City Council Social Services of those people discharged from hospital equated to an average unit cost of £12,201 per year across each of the 202 such clients in 2010.

Table 10: Local Authority services delivered to those clients following discharge

Service	Clients
Adaptations and Equipment	92
Community based services (Meals, Home Care, Direct Payments, etc)	147
Long Term Residential	55
Short Term Residential	68
Total	**362**

Note: Clients may be counted more than once if they are in receipt of more than one service.

Table 11: Cost of total packages following discharge per annum

Age group	Clients	Full year cost	Average Cost
Under 65	31	£204,827	£6,607
65 to 74	22	£229,987	£10,454
75 to 84	58	£684,541	£11,802
85 to 94	82	£1,229,258	£14,991
95 and over	9	£115,991	£12,888
Total	**202**	**£2,464,604**	**£12,201**

The correlation between poor housing and ill health is evident. Enabling vulnerable, older, or disabled people, for example, to live in safe, warm homes should be seen as an integral part of promoting public health and wellbeing.

7.5 Homelessness

Homeless people are a vulnerable group in society with specific needs and are prone to drug and alcohol misuse and mental health problems. In order to gain further understanding around this population a Homelessness Needs Assessment was completed by the NHS Derby City Public Health team in 2008. Some of the findings included:

7.5.1 Demographics and recent living conditions

- Nearly four-fifths of those interviewed were male. The proportion of men in each group increased through the age groups, with women making up the majority of the 16-18 age groups, while almost all those aged 45 or over were men.
- Four-fifths of respondents were single.
- Almost 90% identified themselves as White.
- 25% of women and 14% of men had dependent children.
- Only one-tenth of respondents were in education, employment or training, while many reported being unemployed or redundant (49%) or unable to work due to illness or disability or the 'benefits trap' (38%).
- More than a fifth had been homeless for over four years, although 30% reported last having permanent accommodation in the past six months.

7.5.2 GP and dental registration

- Over four-fifths of respondents were registered with a local GP. Those who were not registered were significantly more likely to attend hospital with a physical health problem (43%, compared to 7% of those registered).
- Respondents were much less likely to see a GP about a mental health problem than a physical health problem (29% of all, compared to 65%) and much more likely to do nothing or deal with the problem by themselves.
- Only 29% were registered with a dentist. 14% reported being refused a dentist in the past year due to lack of spaces. Fewer than half said that they would attempt to see a dentist in the event of a dental problem. Many respondents highlighted a perceived need for more NHS dentists.

7.5.3 Suicide and general health

- Forty-five percent said that they had felt like taking or tried to take their own lives in the past year. Over a tenth of all respondents had attempted suicide more than once in the past year. There were significant correlations between those in this group and those reporting alcohol misuse, drug misuse, depression/nerves/anxiety, mental health issues and deliberate self-harm.
- Depression/nerves/anxiety were the most commonly reported health problems with nearly 40% reporting problems in this area. Thirty percent of respondents reported a problem with 'mental health issues' and 18% reported self-harm.

7.5.4 Substance misuse

- Thirty-seven percent reported taking illegal substances. Twenty-nine percent reported having one or more addiction problems (including addictions to alcohol and other legal substances).
- Reported alcohol consumption suggested that almost half of respondents were drinking 'high risk' or 'increased risk' quantities of alcohol.
- Those who were drinking almost every day were more likely to want to reduce their drinking, have sought help with their drinking and want help with their drinking than those drinking less regularly.
- Those registered with a GP were significantly more likely to have seen someone where they admitted a problem with drug or alcohol misuse.

7.5.5 Use of A&E and other services

- Over half of respondents had visited the Accident and Emergency department in the past year and those who attended at A&E had averaged more than two visits each.
- GP registered participants were significantly more likely to have accessed outpatient services and pharmacist/chemist services than unregistered participants.
- The majority of those reporting drug and alcohol misuse had accessed appropriate services. The majority of those who had used Bradshaw Clinic, alcohol services or other drug services said they were 'very satisfied' with their treatment, and few were dissatisfied.

7.5.6 Social circumstances

- Reasons given for becoming homeless: 30% cited family circumstances, with smaller numbers citing relationship breakdown, non-family eviction, drug and alcohol problems and issues around imprisonment.
- Over half had been questioned by police in the past year. Over 10% had been questioned multiple times for different types of crime. A minority reported being questioned as a witness or a victim.

Note: the information presented in this section on homelessness is a summary of information reported in the *Homelessness Needs Assessment: 2008* produced by NHS Derby City. As part of this needs assessment specific recommendations were identified around mental health workers, family support workers, education, employment and housing support workers, funding for hostels, training and NHS dental capacity. Further detail can be found by accessing the full report.

8 LIFESTYLE

Key findings:

- One-quarter of 'all adults' in Derby smoke - significantly higher than the England average and the third (of 11) highest smoking prevalence in its ONS family cluster
- Derby has worse rates than the national and family average for:
  - Smoking attributable hospital admissions
  - Oral cancer registrations
- Over one-fifth (22.4%) of Derby's population binge-drink
- Derby has comparatively high rates of alcohol-related hospital admission and alcohol-attributable crime
- There are around 2,000 problematic drug users in Derby – around 70% of which are in treatment
- Around one-quarter (24.2%) of adults in Derby are obese – similar to the national average
- Almost three-quarters (72.9%) of adults do not eat healthy diets and just 13.6% of adults take part in moderate exercise per week
- Derby is not on course to achieve the 2011 target rate for teenage conceptions, however, the rate of teenage pregnancy is reducing.

Implications

- Smoking is one of the main causes of avoidable ill-health and preventable deaths
- Heavy alcohol consumption can lead to a range of conditions (and increased risk of mortality) including cancer, heart and liver disease
- Drug misuse is associated with poor health and mental health along with wider community consequences such as crime
- Obesity is associated with conditions such as diabetes
- Treating obesity and associated consequences in Derby was estimated to cost around £5.5 in 2009/10
- Babies born to teenage mothers have a 60% higher mortality rate and 63% increased risk of being born into poverty.

Gaps and next steps

- ➢ Tackling lifestyle behaviours such as smoking continue to offer significant opportunity to improve health and wellbeing
- ➢ Inequalities in lifestyle should remain a priority for the city.

8.1 Introduction

The lifestyle choices people make can have significant impact on their health and wellbeing. Most notable of these are behaviours such as smoking, alcohol consumption, unprotected sex, poor diet and inactivity. In this chapter, the latest profiles and/or released data are presented.

8.2 Smoking

8.2.1 National picture

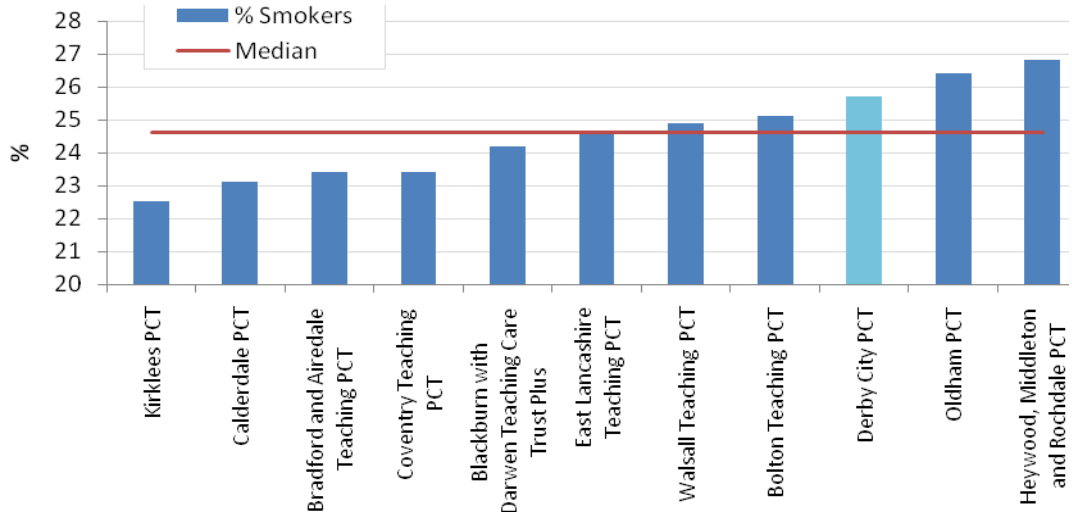
Just over one-fifth (22.2%) of the adult population of England are estimated to be 'current' (2006-08) cigarette smokers [25]. The East Midlands has a relatively high (24.0%) smoking prevalence – fourth highest of the nine regions, with the North East (27.9%) having the highest rate and the South West with the lowest rate at 21.4% [25].

8.2.2 Local picture

"Smoking is the single greatest cause of avoidable illness and preventable death both in the UK and in the East Midlands", according to the East Midlands Public Health Observatory (EMPHO).Every year, more than 7,000 people die from smoking-related illness in the East Midlands. It is the main risk factor for developing heart disease and stroke, as well as respiratory diseases and lung cancer.

Around one-quarter (25.7%) of Derby's adult (16+) population are estimated to smoke. This is the 43rd highest rate of the 152 PCTs and fourth highest of the ten PCTs (as per modelled estimates released in 2010) in the East Midlands – Nottingham has the highest (33.5%) prevalence of adult smokers in the country[25]. When compared to its 'most similar' (ONS cluster) PCTs, Derby has the third highest prevalence of the eleven PCTs (average 24.6%).

Figure 12: Showing the estimated percentage of the population aged 16+ who are current smokers – ONS cluster comparison



Source: Smoking prevalence Percentage of the adult population who are current smokers – Updated March 2011 (APHO)[25])

Quality Outcomes Framework (QOF) data shows that the percentage of patients with long-term conditions who smoke in Derby was 17.6% in 2009/10; similar to the rate in England (17.7%) and higher than the rate in East Midlands (17.5%).

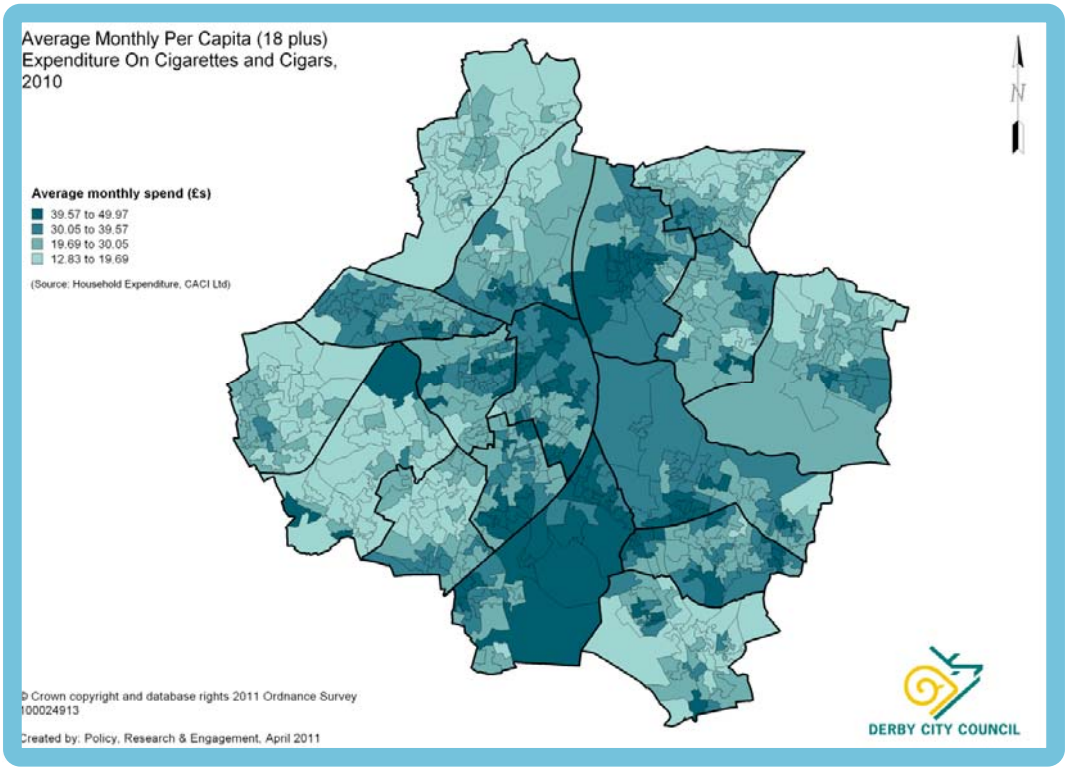
The SEPHO Cardiovascular Disease Profiles show the number of people in Derby that are registered with a GP with any combination of registered long-term conditions who smoke. The percentage of patients with long-term conditions who smoke in Derby is 17.6% (QOF data: 2009/10). This is similar to the England rate (17.7%) and East Midlands (17.5%)[26].

EMPHO released regional (East Midlands) and Local Authority (Derby) data for smoking in January 2011[27]. The data was taken from *'The Integrated Household Survey (I)'*[28]. Regional data for 'all adults' shows that smoking prevalence in the East Midlands (21.6%) is similar to that of England (21.4%). Smoking prevalence in Derby, however, is significantly higher than the England average at 25.9%. In some groups, for example, those in 'routine and manual' occupations i.e. call centre worker, electrician, train driver, HGV driver, postal worker, shop assistant[2],almost one-third (31%) smoke.

The 2011 'Health Profile' for Derby – published by the Association of Public Health Observatories in collaboration with the Department of Health – highlighted an increased proportion of adults smoking in the city in 2009/10 from what had been a decline over the previous four years (further detail on Derby Health Profile can be found in Appendix 5). This was also against a reducing trend in all of the city's comparator groups (England average, East Midlands average and 'Family' group of Local Authorities). A consideration would be to monitor whether this is a blip or start of an increasing trend and if the latter, gain an understanding of why the rate is increasing. It may be that more attention needs to be focussed on promoting reasons why not to start smoking as well as continue to help individuals stop smoking – which Derby has historically always performed well on. With regards focus of attention, the inner city, more deprived communities of Derby, spend far more on cigarettes and cigars than the more affluent communities found in the city's suburbs.

[2] Office for National Statistics (ONS) Socio-Economic Classification (NS-SEC)

Figure 13:Average monthly per capita (18 plus) expenditure on cigarettes and cigars, 2010



The East Midlands regional tobacco profiles summary is presented in Figure 14.

Figure 14: Regional Summaries for Tobacco Profiles

EAST MIDLANDS REGION

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- Significance not calculated
- Indicator not available at local authority level

	Smoking attributable deaths 2006-08	Smoking attributable deaths from heart disease 2006-08	Smoking attributable deaths from stroke 2006-08	Deaths from lung cancer 2006-08	Deaths from chronic obstructive pulmonary disease 2006-08	Smoking attributable hospital admissions 2008/09	Cost of smoking attributable hospital admissions 2008/09	Lung cancer registrations 2005-07	Oral cancer registrations 2005-07	Estimated adult smoking prevalence 2006-08	GP recorded smoking prevalence 2009/10	Smoking in pregnancy 2008/09	Successful quitters at 4 weeks 2009/10	Successful quitters at 4 weeks (CO validated) 2009/10	Completeness of NS-SEC recording by Stop Smoking Services 2008/09	Prescribed NRT 2009/10
East Midlands - All PCTs																
Bassetlaw PCT																
Derby City PCT																
Derbyshire County PCT																
Leicester City PCT																
Leicestershire County & Rutland PCT																
Lincolnshire PCT																
Northampton PCT																
Nottingham City PCT																
Nottinghamshire County PCT																

Source: Local Tobacco Control Profiles for England, London Health Observatory (LHO)[15]

Figure 14 shows the relative performance (against national comparison) of the East Midlands PCTs against a range of smoking-related indicators. Whilst Derby is the third poorest performer against these indicators in comparison to England, it is the best performing of the three East Midlands cities of Derby, Leicester and Nottingham.

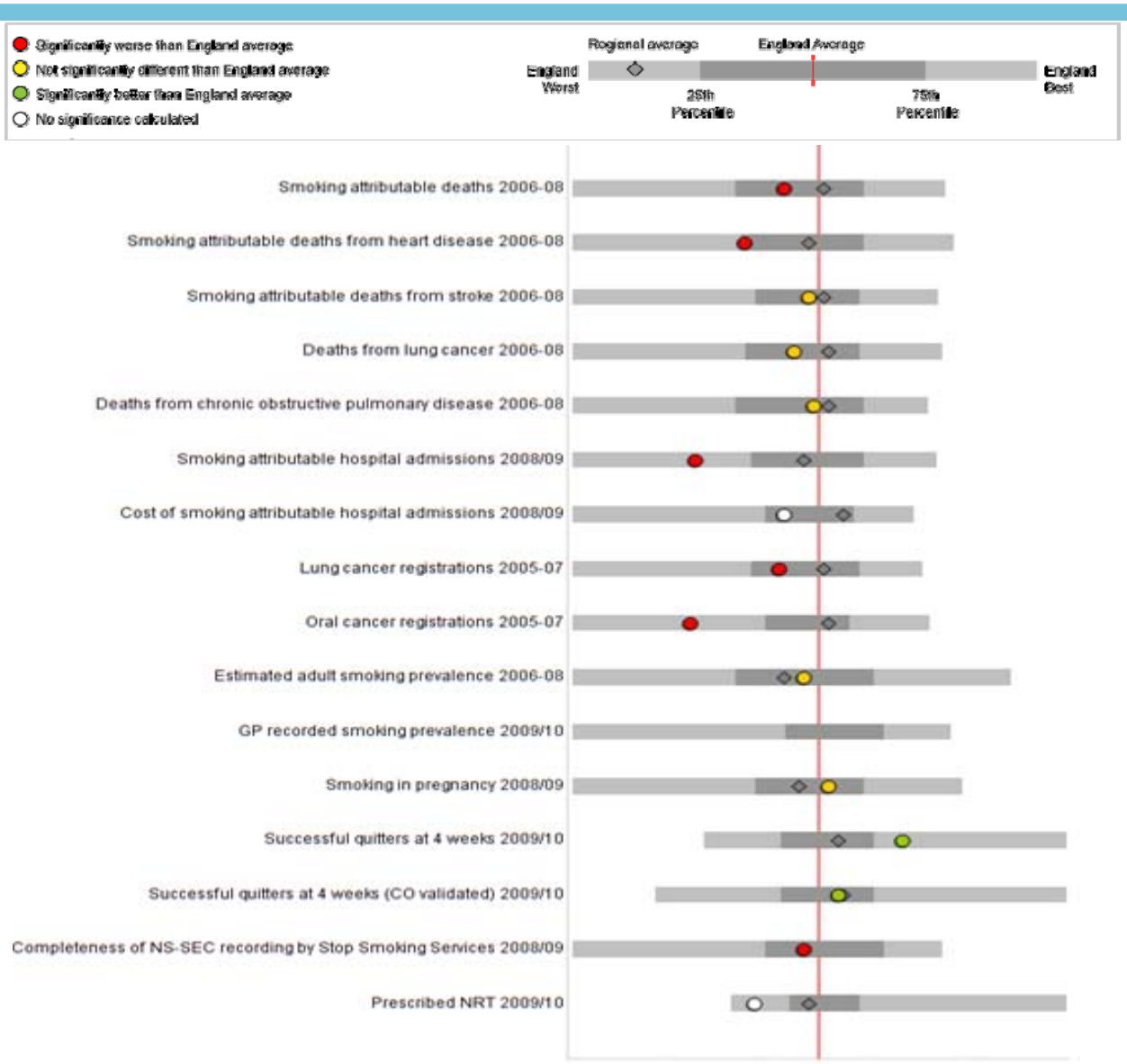
Figure 15 shows how NHS Derby City (PCT) compares with the rest of England[(15)]against these same indicators. The data for the NHS Derby City profile is in Appendix 6.Compared to England, Derby performance is significantly worse in the following areas:

- Smoking attributable deaths
- Smoking attributable deaths from heart disease
- Smoking attributable hospital admission
- Lung cancer registrations
- Oral cancer registrations
- Completeness of NS-SEC recording by Stop Smoking Services

Derby performs significantly better than the national average in terms of:

- Successful quitters at 4 weeks
- Successful quitters at 4 weeks (CO validated).

Figure 15: Local Tobacco Control Profiles for NHS Derby City & England[15]

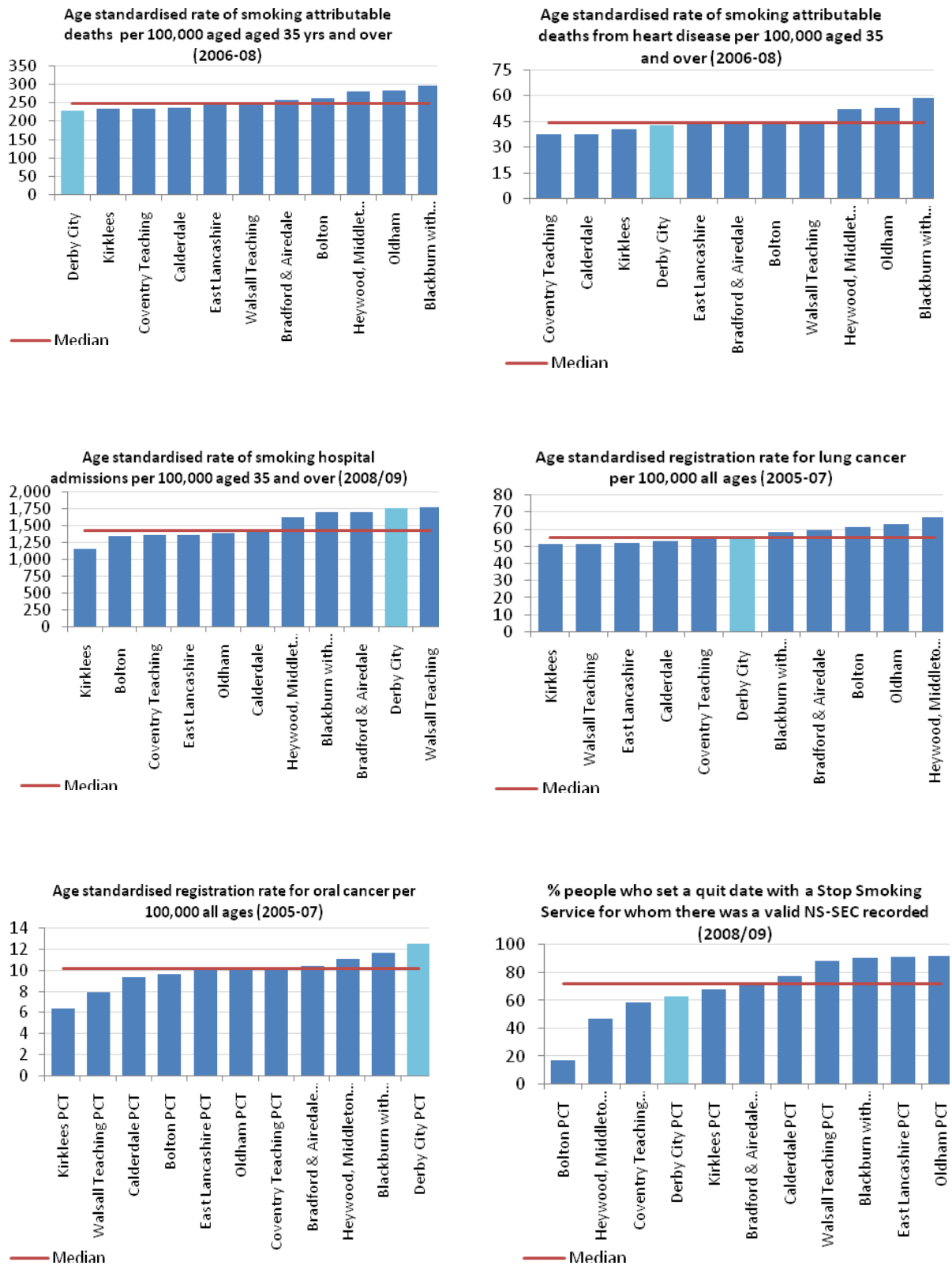


Source: Local Tobacco Control Profiles. Produced by the Association of Public Health Observatories
Note: Where there are no values shown, this is because the data are not available or suppressed

Note: The area's value for each indicator is shown as a circle. The average rate for England is shown by the vertical red line. The range of values for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator. Although a green circle shows this area is significantly better than the England average, it may still indicate an important issue in this locality.

Those indicators where Derby was performing significantly worse than the national average were looked at compared to its PCT comparative cluster (for definition see Appendix 6):

Figure 16: Local Tobacco Control Profiles: NHS Derby City compared to ONS cluster[15]



Source: Local Tobacco Control Profiles for England released October 2010

When compared to its closest comparators (ONS cluster) Derby has –

Worse rates of:

- Smoking attributable hospital admission
- Oral cancer registrations

Similar rates of:

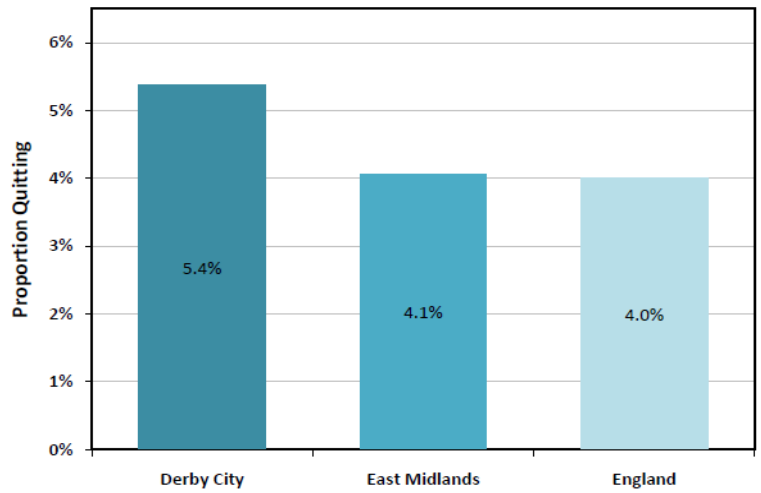
- Lung cancer registrations

Better rates of:

- Smoking attributable deaths
- Smoking attributable deaths from heart disease
- Completeness of NS-SEC recording by Stop Smoking Services.

Although smoking prevalence is relatively high along with some alcohol-related indicators (e.g. smoking attributable hospital admissions), Derby has been comparatively successful in the proportion of smokers quitting. In 2009/10 5.4% (2,432) of smokers in Derby City quit using the NHS Stop Smoking Services, a higher per cent than in England (4%) and higher per cent than in East Midlands (4.1%)[3]. However, it should be recognised that this is still just a small proportion of the estimated numbers of smokers. The South East Public Health Observatory (SEPHO) Cardiovascular Disease Profiles show the 4-week smoking quitters rate for Derby, the East Midlands and England. This is shown in Figure 17.

Figure 17: Four week quitters as a proportion of the synthetic estimate of smokers (2009/10)



Source: Smoking cessation 2009/10 ONS Mid-year population estimates 2008, Health Survey for England 2006-08 in Derby City Cardiovascular Disease PCT Health Profile[26]

[3] *This figure differs from the Tobacco Control Profiles, which use the no. of people who quit smoking as a proportion of the total population aged over 16. This profile uses the estimated no. of smokers in the population as the denominator.*

8.2.3 Current provision

We have made great strides in recent years to reduce smoking; particularly with the introduction of Smoke Free England and NHS Stop Smoking Services. Since 1998 adult smoking rates in England have fallen from 28 percent in 1998 to 21 percent in 2008 – a fall of nearly 2.5 million. These are the lowest smoking rates in England on record.

NHS Derby City established the 'Fresh Start' Stop Smoking Service over 10 years ago. Fresh Start is a free service for people living in Derby who want to quit smoking. The smoking cessation service offers either one to one or group support, and is also available at most GP practices and about half of all pharmacies in the city. Health visitors, district nurses and midwives are also trained to offer patients/users support to stop smoking. This could be broadened out to include council staff, staff from partner organisations and local workplaces.

NHS Derby City invested more into Fresh Start this year than in 2009/10. Assuming they meet the target number of clients, the expected cost of the service per personwill be a fraction of the cost of hospital treatment if an individual continued to smoke and developed a serious health condition as a result. The cost of treating lung cancer is not clear cut as few patients will undergo precisely the same treatment path, however, research carried out by the University of Nottingham suggested the average cost could be £12,000 per case.

In recent years, access to Fresh Start by Derby City residents has increased by over 200% to more than 4000 clients (2004/05 to 2007/08). However, four week quit rates have steadily fallen from 78% in 2004/05 to 57% in 2007/08. In 2008/09, the 4 week quit rate for NHS Derby City stood at 57% for a second year in a row with the 4 week quit rate standing at 59% in May 2010. Fresh Start actively support quitters to remain quit at 52 weeks however it has proved difficult to track the individuals. The target for 52 week quits for 2009/10 year is 15%. National research shows that approximately 75% of 4 week quitters relapse.

Despite progress; action to tackle tobacco needs to continue. The new tobacco control strategy for England establishes a vision of eradicating tobacco harms and creating a smoke-free future, so that we can support people to live healthier and longer lives. In Derby, we are continuing to support Fresh Start and explore options to further develop tobacco control measures.

8.2.4 Smoking Summary

Smoking - key findings:

- 25.9% of 'all adults' in Derby smoke - significantly higher than the England average of 21%
- Derby has the third (of 11) highest smoking prevalence in its ONS family cluster
- Derby has worse rates than the national and family average for:
  - Smoking attributable hospital admission
  - Oral cancer registrations
- Derby has better rates than the family average for:
  - Smoking attributable deaths
  - Smoking attributable deaths from heart disease
  - Completeness of NS-SEC recording by Stop Smoking Services.
- Derby performs significantly better than the national average for:
  - Successful quitters at 4 weeks
  - Successful quitters at 4 weeks (CO validated).

Implications

- Prevalence of smoking in Derby remains high and will therefore continue to have a high cost both in terms of population health and in the cost of service provision.

Gaps and next steps

- Smoking prevalence varies substantially between different local populations in terms of age, sex and ethnicity etc. Further work is required to understand the needs of different populations.
- Aim to continue achieving the comparatively high rates of smoking quitters.

8.3 Alcohol

8.3.1 National picture

In the past 60 years, the average intake of alcohol per person in the UK has risen steadily, from five litres a year in the 1950s, to over 11 litres a year in 2007. More than 10m adults in England now drink in excess of the recommended daily limit with 2.6m drinking more than twice that. There has also been a dramatic rise in drinking among women, with heavy drinking increasing by almost a third in the decade prior to 2008[29].

Evidence suggests that heavy alcohol consumption can lead to over forty medical conditions, including cancer, stroke, hypertension, liver disease and heart disease and can increase the risk of mortality from these conditions. Reducing harm and encouraging sensible drinking of alcohol was cited as one of the six key priorities of the White Paper *Choosing Health*. The topic features not only in a wide range of policy on health, education and skills, transport, employment, and crime, but also in the Public Service Agreement (PSA) targets of many government departments, requiring action to reduce harm from alcohol[28]. "The problem is not limited purely to healthcare. The damage that drinking causes echoes throughout society, contributing to 1.2 million incidents of violent crime a year, 40% of domestic violence cases and 6% of all road casualties"[29 p. 4].

Alcohol misuse is estimated to cost the NHS £2.7 billion a year, almost twice that of 2001 and is expected to continue rising to £3.7 billion[30]. The cost of alcohol to society as a whole is even greater, estimated to stand somewhere between £17 and 22 billion, and by some estimates is as high as £55 billion[29].

Increasing alcohol misuse has led to a range of consequences:

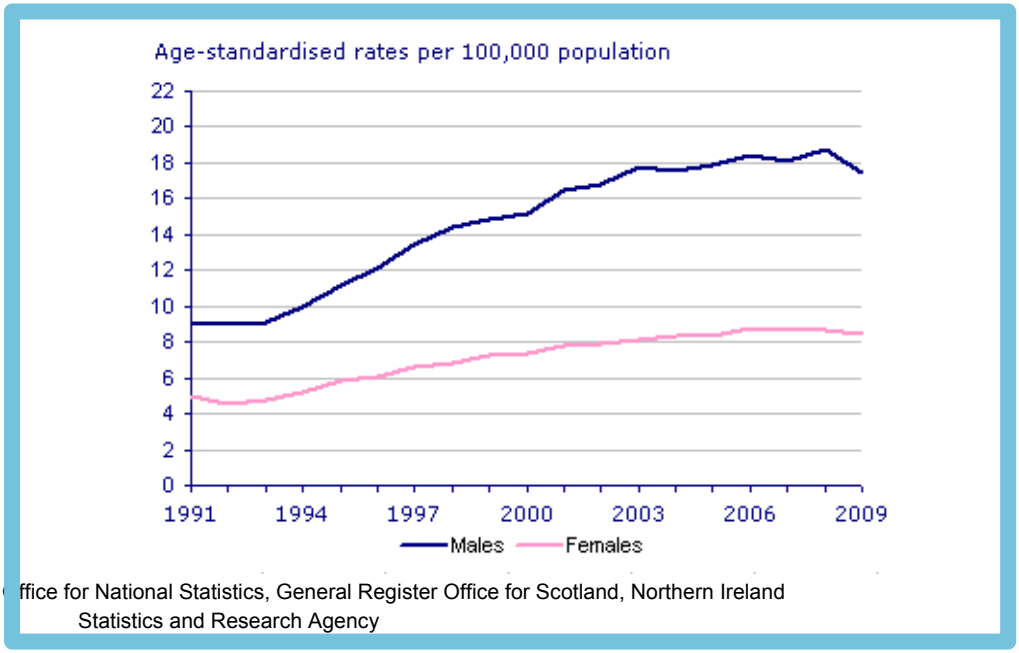
8.3.1.1 Alcohol related admissions

Around seven per cent of all hospital admissions are alcohol-related. In 2009/10, there were 1.1 million hospital admissions due to alcohol misuse The number that went into hospital for alcohol-related reasons rose by 52% between 1996 and 2006[31].

8.3.1.2 Alcohol related deaths

The number of alcohol-related deaths in the UK has increased since the early 1990s, rising from the lowest figure of 4,023 (6.7 per 100,000 population) in 1992 to the highest of 9,031 (13.6 per 100,000) in 2008. However, in 2009 the number of deaths fell to 8,664 (12.8 per 100,000) – 367 fewer than the number recorded in 2008[32]. This is shown in Figure 18.

Figure 18:Alcohol-related death rates, United Kingdom, 2000–2009[32]



Source: ffice for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency

There are more alcohol-related deaths in males than in females. Male rates more than doubled over the period from 9.0 per 100,000 in 1992 to 18.7 per 100,000 in 2008, although the rate was lower in 2009 at 17.4 per 100,000. There were steadier increases in female rates, rising from 4.6 per 100,000 in 1992 to 8.7 per 100,000 in 2007 and 2008. The rate decreased slightly in 2009 to 8.4 per 100,000.

Trends differ according to age. The highest alcohol-related death rate across the period was in men aged 55–74. In 2009 the rate for this group was 41.8 per 100,000. The lowest male rate was in those aged 15–34; the rate for this group in 2009 was 2.6 per 100,000. Female rates have been consistently lower than male rates, but the figures demonstrate a largely similar pattern between age groups. Like men, women aged 55–74 had the highest alcohol-related death rates over the period. In 2009 the rate for this group was 20.1 per 100,000. Rates were lowest in women aged 15–34. The rate for this age group in 2009 was 1.5 per 100,000[32].

The National Audit Office found that the average PCT expenditure on alcohol services was £600,000 (0.1% of annual budgets) in 2008. This compares with an average £2.7 million spent by each PCT on drug treatment, providing 58% of problem drug users with access to treatment services. Those with an illicit drug dependency are ten times more likely to have access to treatment than alcohol dependents[30].

Table 12: Comparison of drug & alcohol treatment expenditure and percentage in treatment[30]

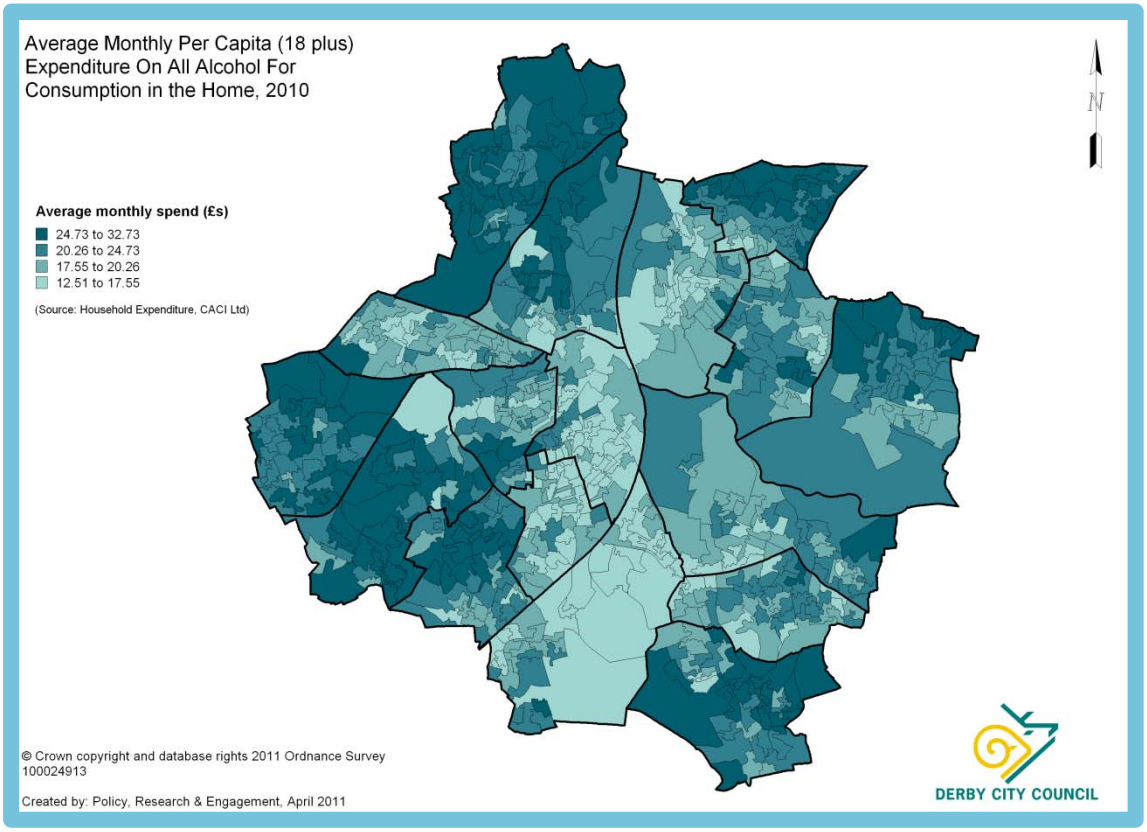
Substance	Prevalence of dependence	Numbers in treatment	Percentage in treatment	Expenditure on treatment
Drugs	332,000[33]	191,695[34]	58%	£436 million[35]
Alcohol	1.6 million[36]	100,098[36]	6%	£217 million[37]

8.3.2 Local picture

In Derby, it is estimated that 22.4% of the population in Derby binge drink – slightly higher than both England at 20.1% and the East Midlands at 20.1%[26]. The opportunity to drink in Derby is high –Derby has the fifth highest pub density in a single output area in England with 35 pubs situated in the city centre – the four cities with a higher concentration are London, Nottingham, Newcastle and Leeds[38].

Whilst binge drinking has health implications and an association with certain crimes, it should also be noted that regular drinking to relatively high levels also have significant impacts on health and life expectancy.

Figure 19: Average monthly per capita (18 plus) expenditure on all alcohol for consumption in the home (2010)



The latest alcohol profiles for NHS Derby City (Figure 20) were released in 2010 by the North West Public Health Observatory (NWPHO). They highlight indicators in relation to alcohol and illustrate how Derby performed during 2008/09 compared to England[39]. The chart shows Derby's measure for each indicator, as well as the regional and England averages and range of all PCT values (can also be viewed by Local Authority) for comparison purposes. The statistical data for this profile is in Appendix 6Table 62.

According to this profile, when compared to England, Derby performs significantly better in terms of:

- Mortality from land transport accidents
- Alcohol treatment – prevalence per 1,000 population

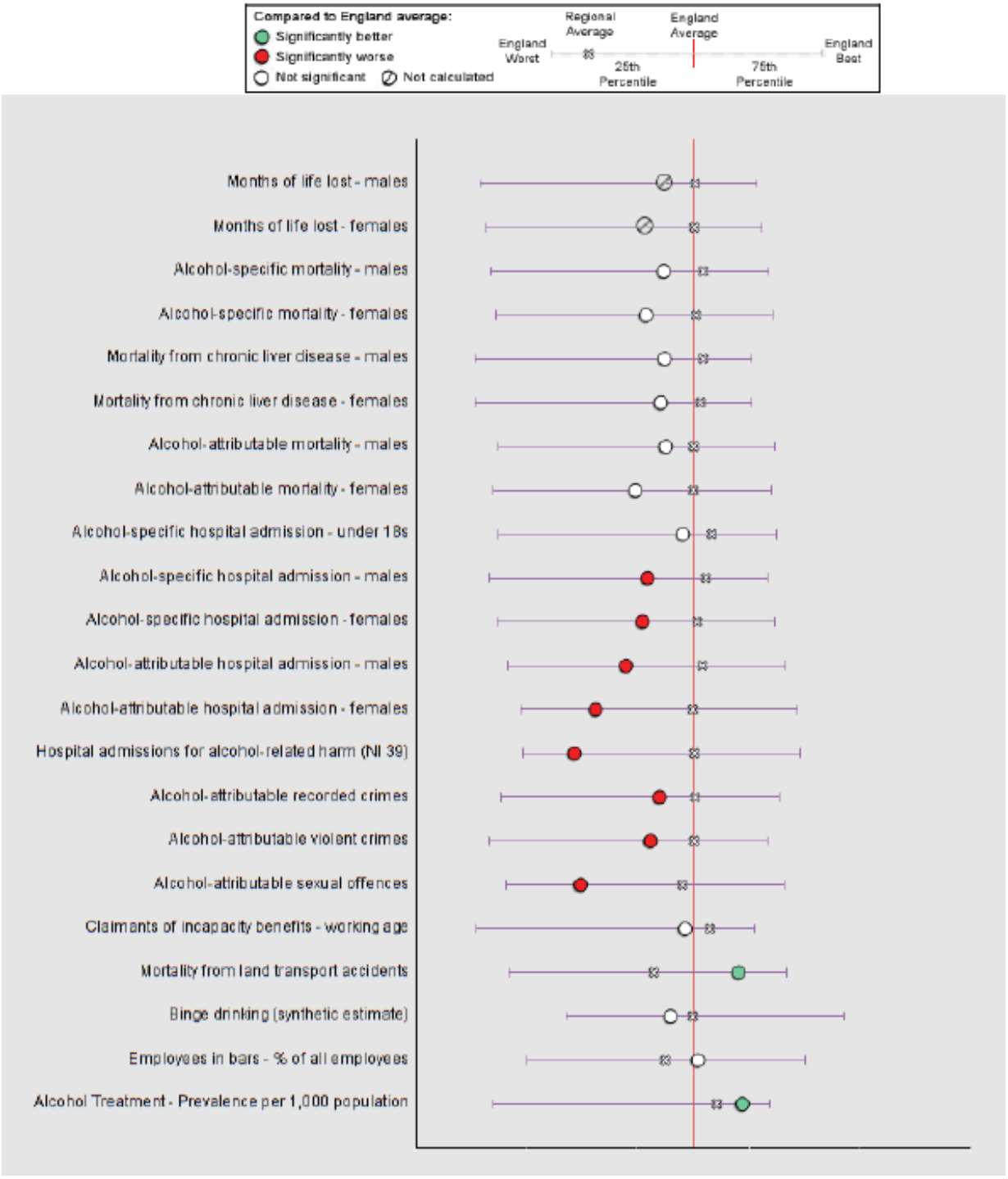
Similar to the national average in terms of:

- Alcohol-specific mortality (males and females)
- Mortality from chronic liver disease (males and females)
- Alcohol-attributable mortality (males and females)
- Alcohol-specific admissions – under 18s
- Claimants of incapacity benefits – working age
- Increasing risk drinking (synthetic estimate)
- Higher risk drinking (synthetic estimate)
- Binge drinking (synthetic estimate)
- Employees in bars - % of all employees

Worse than the national average in terms of:

- Alcohol-specific hospital admissions (males and females)
- Alcohol-attributable hospital admissions (males and females)
- Hospital admissions for alcohol-related harm (NI39)
- Alcohol-attributable recorded crimes
- Alcohol-attributable violent crimes
- Alcohol-attributable sexual offences.

Figure 20: Profile of alcohol-related harm – Derby City PCT[39]

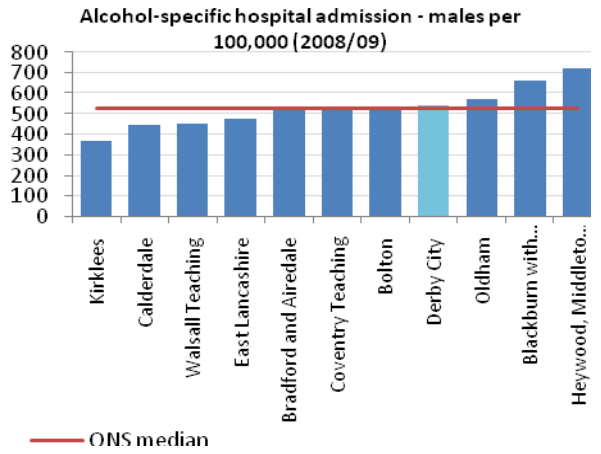


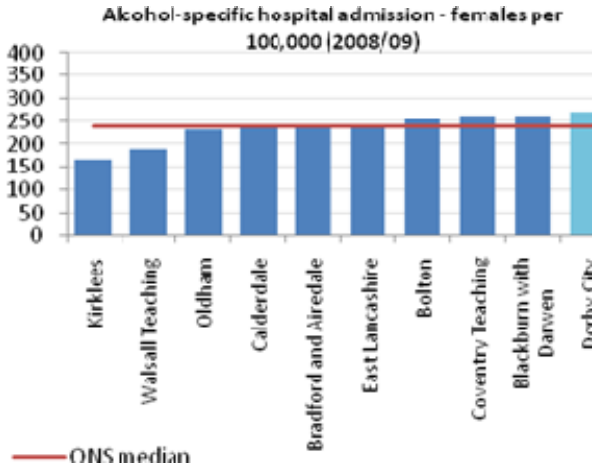
Source: Local Alcohol Profiles for England

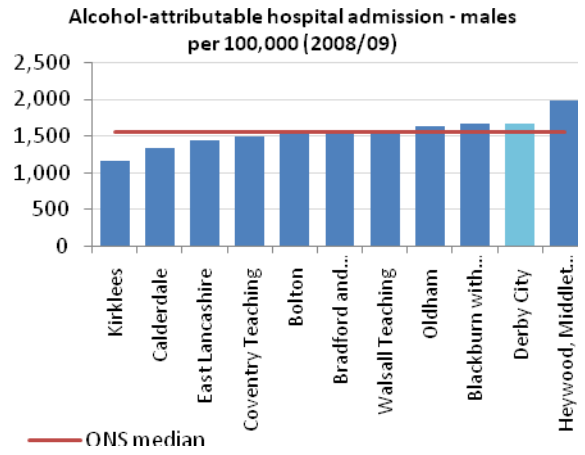
Note: The area's value for each indicator is shown as a circle. The average rate for England is shown by the vertical red line. The range of values for all local areas in England is shown as a grey/purple horizontal line. A red circle means that this area is significantly worse than England for that indicator. Although a green circle shows this area is significantly better than the England average, it may still indicate an important issue in this locality.

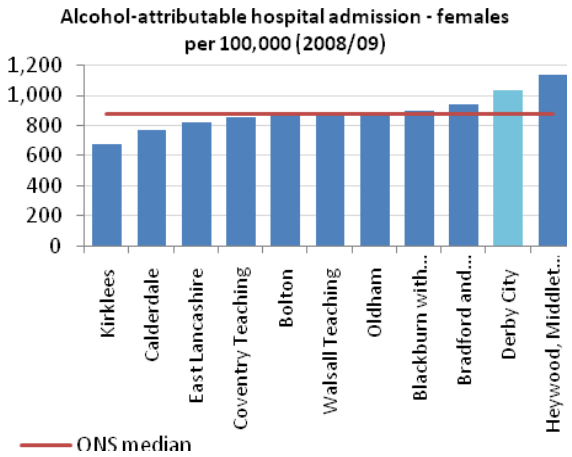
Those indicators where Derby was performing significantly worse than the national average were looked at compared to its PCT comparative cluster:

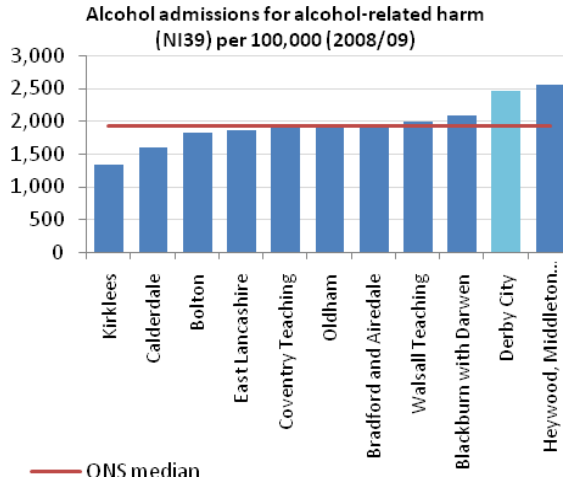
Figure 21: Derby City compared to ONS cluster – alcohol-related hospital admissions[39]











As well as being significantly worse than the national average for all alcohol-related hospital admission indicators, Derby also has higher rates than the ONS cluster median (although not significantly so).

Whilst the volume of alcohol-related admissions is higher for men than women, in Derby the rate of admissions for women particularly is comparatively high.

For these five measures, Derby ranks between 113th and 143rd out of the 152 PCTs.

Source: Local Alcohol Profiles for England

8.3.2.1 Alcohol related admissions

Table 13 shows a summary of the number of admissions attributable to alcohol for each PCT in the East Midlands compared to the England average by sex. Derby has the highest rate of alcohol-attributable hospital admissions in the region for both male and females.

Table 13: East Midlands – hospital admissions by sex (2009-10)[40]

PCT name	Female Admission*	Female PCT pop.**	Female admission rate***	Male Admission*	Male PCT pop.**	Male admission rate***
Bassetlaw	1055	56,100	1515	1669	55,800	2449
Derby City	2475	122,500	1710	4306	121,700	3306
Derbyshire County	6508	368,949	1361	10089	358,345	2259
Leicester City	2441	154,200	1526	4542	150,600	3176
Leicestershire County & Rutland	4675	344,200	1057	7414	339,200	1788
Lincolnshire	5083	357,184	1061	8683	343,373	1923
Northamptonshire	4817	344,800	1176	7780	339,000	2021
Nottingham City	2185	149,800	1441	3946	151,000	2925
Nottinghamshire County	5295	338,500	1215	8606	326,800	2146
National average:			**1297**			**2440**

***Source:** Alcohol Concern[40](Dr Foster Intelligence & SUS APC, April 2009 to March 2010 – directly age-standardised rate of alcohol attributable admissions per 100,000 populations).

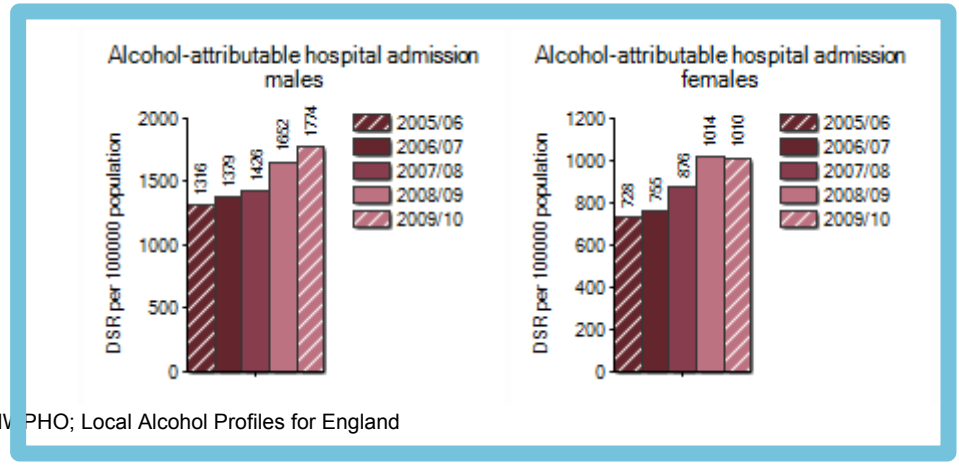
**PCT/LA Population: total population within each PCT/LA

***Standardised Rate: Directly age-standardised rate per 100,000 population

As well as a high rate of alcohol-attributable admissions regionally, Derby has a comparatively high rate nationally – with the 23rd highest admission rate of all the 152 PCTs.

While female alcohol-attributable admissions to hospital reduced in Derby in 2009/10, male hospital admissions have continued to rise as they have done since 2004/05.

Figure 22: Alcohol-attributable hospital admissions in Derby by gender[39]

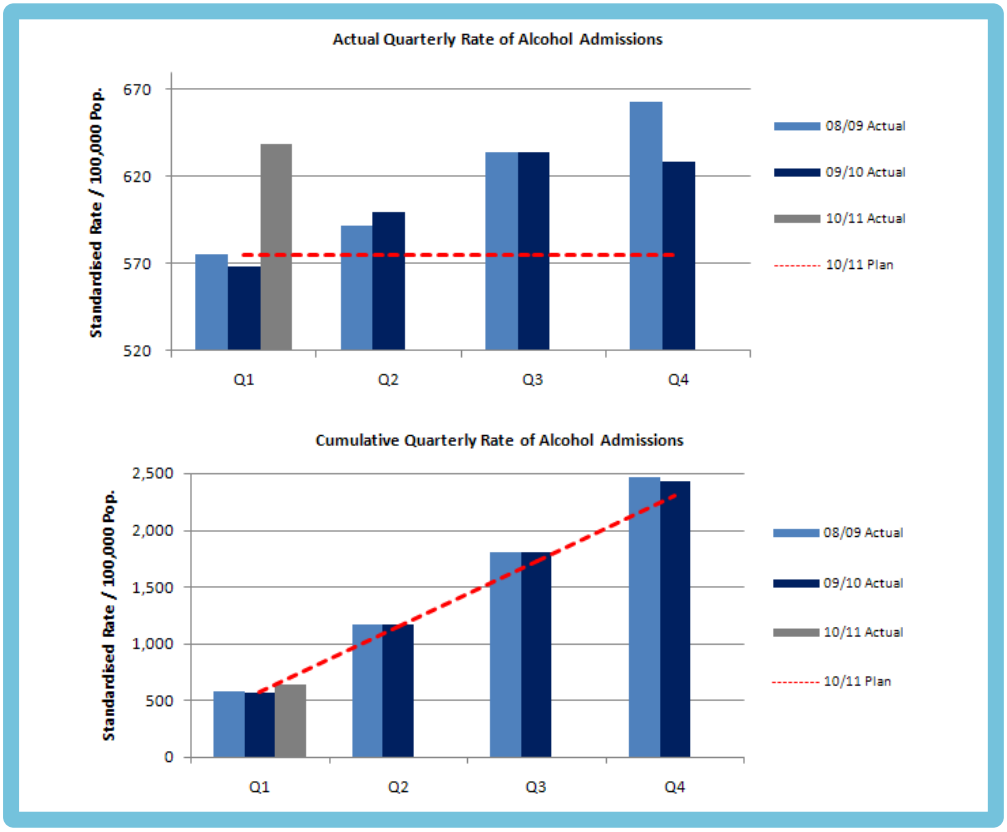


Source: NWPHO; Local Alcohol Profiles for England

End of year figures for 09/10, from the *NHS Derby City Health & Commissioning Outcomes Report*, showed a small reduction in the rate of admissions against 08/09, and Q4 was significantly lower than the previous year, however the data for Q1 10/11 showed a considerable increase of 12% (639 admissions) against the previous Q1 position.

Early examinations of the 10/11 Q1 data showed that there had been a large increase in the prevalence of long-term condition elements (hospital admissions for alcoholic liver disease rose by 100%).

Figure 23: Quarterly Alcohol Admissions



8.3.2.2 Alcohol related deaths

Table 14 shows that the rate of alcohol-related deaths increased significantly to 16.2 per 100,000 population in 2008 from 13.3 per 100,000 in 2007 for the male population but did reduce again in 2009 to 14.8 per 100,000 populations.

Table 14: Male alcohol-related death rates: by country and region (2000–2009)[32]

Rate per 100,000 population

Country/Government Office Region	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
United Kingdom	15.2	16.5	16.8	17.8	17.6	17.9	18.4	18.1	18.7	17.4
England	13.0	14.2	14.3	15.5	15.2	15.7	16.2	15.9	16.7	15.8
North East	15.2	15.6	17.6	17.5	20.9	20.1	21.7	21.4	22.6	20.6
North West	17.4	19.3	19.4	20.8	21.1	21.3	21.4	23.7	23.0	22.5
Yorkshire and The Humber	10.5	12.7	12.2	14.9	15.9	16.9	17.0	16.4	16.7	16.1
East Midlands	12.2	12.1	11.8	13.7	12.3	13.9	14.2	13.3	16.2	14.8
West Midlands	14.9	16.0	16.7	19.0	17.6	18.7	19.0	18.7	21.4	18.6
East of England	8.9	9.8	10.0	10.7	9.9	10.0	11.2	11.7	12.5	11.4
London	17.6	17.4	18.1	18.2	17.0	16.3	18.3	14.4	15.5	14.8
South East	10.6	13.3	12.4	13.6	12.3	13.0	13.3	13.1	12.6	12.9
South West	10.1	11.6	11.7	12.5	12.7	14.4	12.9	14.1	14.6	14.0
Wales	14.0	16.0	15.4	17.2	17.0	15.9	17.2	20.4	21.4	20.3

1 The causes of death included in the National Statistics definition of alcohol-related deaths are given below in Box 1.
2 Rates per 100,000 population standardised to the European Standard Population.
3 Deaths of non-residents are included in figures for the UK, but excluded in figures for England, Wales and Government Office Regions.
4 Figures are for deaths registered in each calendar year.

For females in the East Midlands, the rate has stayed relatively stable for the past three years, with 2009 having the highest rate at 7.9 per 100,000 populations.

Table 15: Female alcohol-related death rates: by country and region (2000–2009)[32]

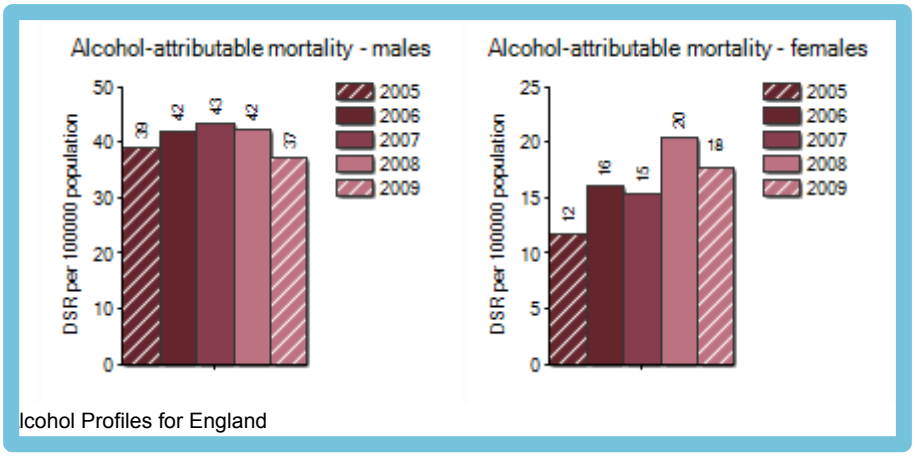
Rate per 100,000 population

Country/Government Office Region	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
United Kingdom	7.4	7.8	7.9	8.1	8.3	8.3	8.8	8.7	8.7	8.4
England	6.6	6.9	7.0	7.2	7.5	7.3	7.8	8.0	7.9	7.7
North East	8.9	9.1	7.4	10.8	10.5	9.3	9.7	11.4	11.7	10.6
North West	9.3	10.2	10.4	10.4	11.3	11.1	12.0	12.3	12.6	11.7
Yorkshire and The Humber	5.7	6.1	5.8	6.8	7.2	6.8	8.4	8.2	7.1	7.8
East Midlands	6.1	5.9	6.9	6.9	8.2	7.2	6.8	7.8	7.7	7.9
West Midlands	6.3	7.8	8.2	7.4	8.7	9.0	9.0	9.4	10.2	9.1
East of England	5.6	5.0	5.3	5.1	5.5	5.9	6.3	6.2	5.3	5.2
London	6.9	7.0	7.2	7.5	6.1	6.3	6.1	6.3	5.8	5.9
South East	5.8	5.8	6.0	6.1	6.2	6.1	6.7	6.2	6.2	6.5
South West	6.0	6.0	5.8	5.5	5.4	5.5	6.4	6.5	6.8	6.7
Wales	8.0	8.6	7.3	8.1	8.8	8.9	9.2	8.6	11.0	8.8

1 The causes of death included in the National Statistics definition of alcohol-related deaths are given below in Box 1.
2 Rates per 100,000 population standardised to the European Standard Population.
3 Deaths of non-residents are included in figures for the UK, but excluded in figures for England, Wales and Government Office Regions.
4 Figures are for deaths registered in each calendar year.

Figure 24 illustrates the alcohol-attributable mortality for both males and females for the years 2005 to 2009. Alcohol-attributable mortality broadly increased in Derby over the earlier years, though male mortality reduced in 2008 and again in 2009, and female mortality also reduced in 2009.

Figure 24: Male and female alcohol-attributable mortality for Derby[39]

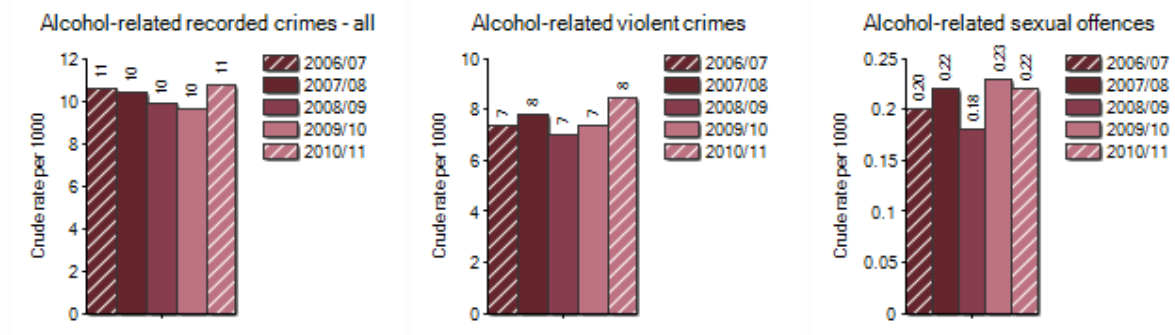


Source: Local Alcohol Profiles for England

8.3.2.3 Alcohol-related crime

Alcohol is known to have an association with crime, particularly violent crime and sexual offences. Overall, alcohol-related crimes have shown year-on-year reductions; alcohol-related violent crime has shown a broadly downward trend whilst sexual offences have been more variable and showed an increase in 2008/09. Of concern is that alcohol-related recorded and violent crimes both increased in 2010/11.The number of sexual offences that take place is relatively small and a change in the number of cases by just two or three can appear as a high percentage increase.

Figure 25: Alcohol related crime/offences for Derby



Source: Local Alcohol Profiles for England

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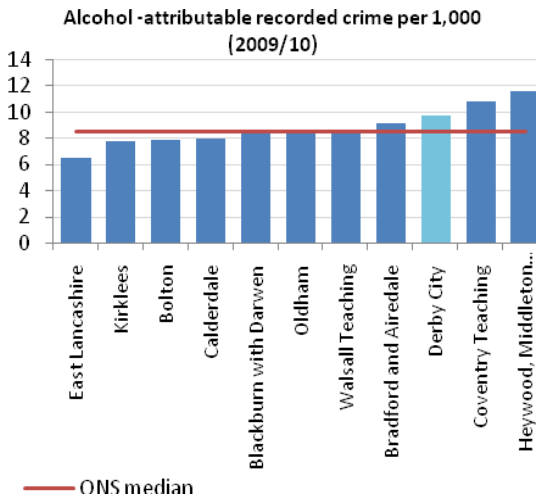
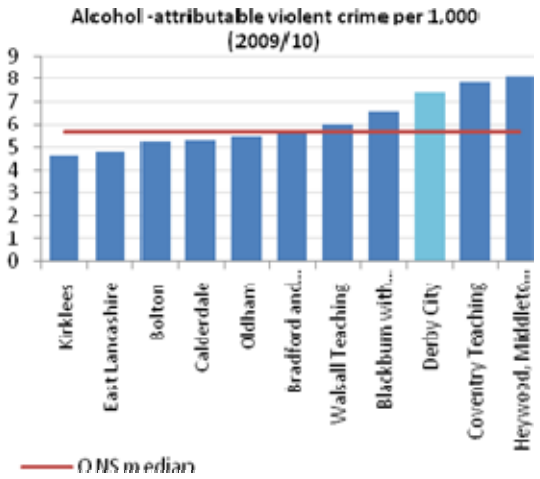
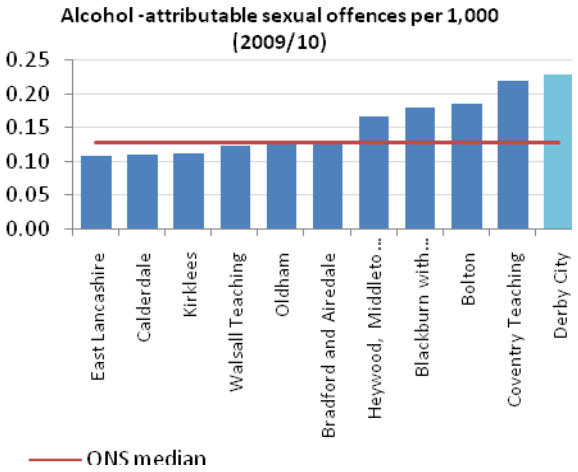
Figure 26:Derby City compared to ONS cluster – alcohol-attributable crime[39]







As well as being significantly worse than the national average for all alcohol-attributable crime indicators, Derby also has higher rates than the ONS cluster median (although not significantly so).

Whilst Derby has the highest rate of alcohol-attributable sexual offences within its ONS cluster, it should be noted that these are relatively small figures: 56 alcohol-attributable sexual offences in 2009/10. Derby is ranked nationally between 107th and 141st out of 152 PCTs on these crime measures.

Source: Local Health Profiles for England

8.3.3 What's currently being delivered?

- Cross-cutting Alcohol Strategy in place in Derby
- New model of Alcohol Treatment in operation from June 2010
- 'HALT' team operating in A&E.

Referrals into alcohol treatment come predominantly from the Criminal Justice System. There remains an under-representation of Black and Minority Ethnic communities within treatment services. A third of those in Alcohol Treatment are aged under 18 years[41]. More detailed information relating to alcohol can be found in the Alcohol Needs Assessment 2010 produced by the Community Safety Partnership.

8.3.4 Guidance and best practice

There is national guidance and best practice published in relation to alcohol:

- National Institute for Health and Clinical Excellence (2010) *Alcohol-use disorders: preventing the development of hazardous and harmful drinking*[42].

8.3.5 Alcohol Summary

Alcohol - key findings:

- Increasing average alcohol intake
- Whilst more men drink to excess than women, the rate for women is increasing at a faster rate
- Estimated that over one-fifth (22.4%) of the population binge drink
- Derby is comparatively worse than the national and ONS cluster group on the following measures:

  - Alcohol-specific hospital admissions (males and females)
  - Alcohol-attributable hospital admissions (males and females)
  - Hospital admissions for alcohol-related harm (NI39)
  - Alcohol-attributable recorded crimes
  - Alcohol-attributable violent crimes
  - Alcohol-attributable sexual offences

- The rate of alcohol-attributable hospital admissions increased year-on-year
- The rate of alcohol-attributable mortality broadly increasing
- Alcohol-related recorded crimes and violent crime has been declining
- Alcohol-related sexual offences variable trend and increased in 2008/09
- Expenditure on alcohol treatment remains comparatively lower than on drug treatment.

Implications

- Alcohol consumption and its consequences remain problematic in Derby and continue to have a high cost both in terms of population health and wider consequences such as crime and cost.

Gaps and next steps

- ➢ Further explore the reasons why Derby remains comparatively high across a range of alcohol measures and understand whether the gap is diminishing.
- ➢ Explore the success and impact of the Alcohol Strategy and range of interventions implemented.

8.3.6

8.4 Substance misuse

8.4.1 National picture

It is estimated that there were 306,150 opiate and/or crack users in England in 2009/10 – 8.93 per thousand population (aged 15-64). This was a significant reduction on the previous year. In the East Midlands, it is estimated that 8.76 per thousand population use opiate and/or crack. Whilst this was a reduction on the previous year, it is not statistically significant. The majority (85%) of opiate and/or crack users are aged 25 and over, with 45% aged between 35 and 64 years. Over three-quarters (77%) are male[43].

8.4.2 Local picture

Derby's problematic drug user (PDU) population is estimated to be between 1,931 and 2,001[44]. The demographic profile of adults in treatment during 2009/10 shows that most (75%) service users were male – this is similar to 2008/09 where males accounted for 74% (988) and females for 26% (345)[45]. The gender of adults in treatment in 2009/10 is similar to the regional figure for the East Midlands[46]and similar to the national findings from National Drug Treatment Monitoring Service (NDTMS).

8.4.3 Drug use in the adult drug treatment system

Previous years Needs Assessments have demonstrated that primary drug use within the treatment population has shown little change since 2005/06 and this has remained the case for 2009/10.

- Opiate[4]users remain the largest group (87%) in drug treatment in Derby. This is a higher level than the East Midlands (83%) [45] andEngland (76%)[46]
- The percentage of primary Crack users is far lower – 2%. The level of Crack use is similar to the East Midlands(2%) but lower than the national figures (5%)[47]
- Cocaine use in Derby (1%) is lower than the levels seen across the East Midlands (3%) and nationally (6%)
- There is the same number of users accessing treatment for both Crack and Cocaine use in 2009/10 as there were in 2008/09
- The number of adults in treatment with Cannabis as their main drug has increased from 56 in 2008/09 to 75 during 2009/10 – an increase of 34% (however, this is a lower rate of increase than previous years).

Table 16 displays the primary drug used by adults in treatment.

[4] Opiates is a broad category including Heroin, Methadone and Other Opiate derivatives

Table 16: Adults in treatment by main drug during 2008/09 and 2009/10[44]

Primary drug	2008/09	2009/10
Opiates	88.4% (1,179)	87.4% (1,214)
Cannabis	4.2% (56)	5.4% (75)
Crack	2.6% (35)	2.3% (32)
Amphetamines	1.8% (24)	1.9% (26)
Cocaine	1.3% (17)	1.3% (18)
Hallucinogens & Ecstasy	0.8% (10)	0.5% (7)
Other	0.5% (6)	1.3% (18)
Source: Drug Adult Needs Assessment 2010)		

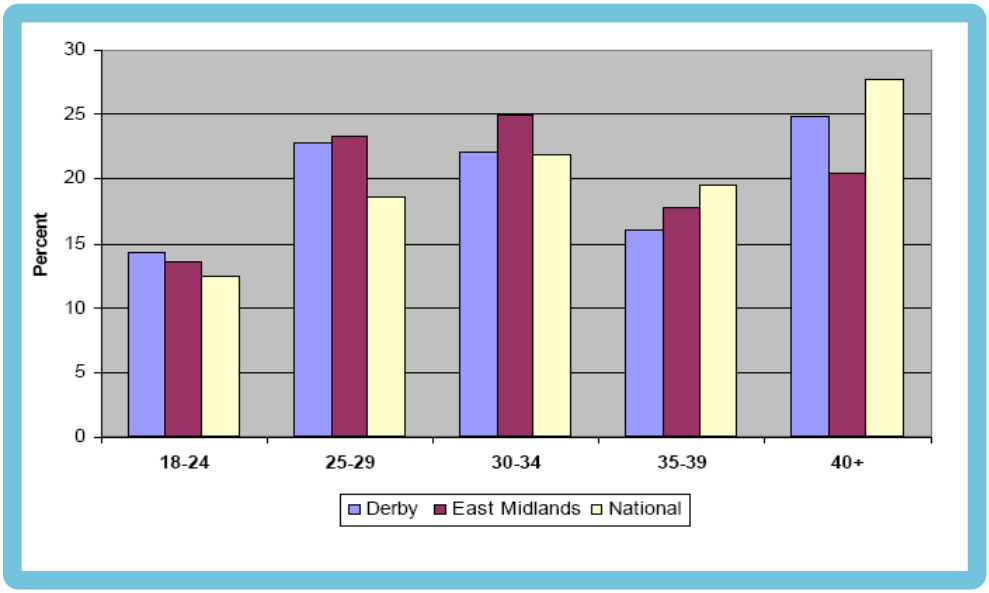
Secondary drug use has increased in 2009/10 with 51.4% of users reporting a secondary drug use at presentation compared to only 28.9% in 2008/09. Crack use is the most prevalent secondary drug and there was an increase in its secondary use from 12% in 2008/09 to 20% in 2009/10. There has also been an increase in Opiate use as a secondary drug rising from four per cent in 2008/09 to 11% in 2009/10. The number of individuals in treatment who are using Cannabis as a secondary drug has also risen from five per cent in 2008/09 to eight per cent in 2009/10.

8.4.3.1 Profile of the adult treatment population

The ethnic profile of the adult treatment population is similar to the national picture. However, black and minority ethnic (BME) groups are underrepresented in the treatment population particularly the Asian population where seven per cent are in treatment yet represent 11% of the population in Derby – this could be due to lower need within this population group or be due to unequal access to drug treatment services.

The age of adults in treatment in Derby is different to that found amongst those in effective treatment both regionally and the treatment population nationally[47]. As nationally, the largest group in Derby's treatment population are aged 40 and over. Within Derby, however, the next largest groups were the 25-29 year olds followed by the 30-34 year olds. Nationally, the 30-34 year olds and 35-39 year olds made up the next largest groups respectively. The age profile of those in drug treatment in Derby compared regionally and nationally is shown in Figure 27:

Figure 27: Comparison of Derby, regional and national age groups in treatment during 2009/10 as a percentage of total treatment populations



8.4.3.2 Treatment mapping

There has been a five per cent increase in the number of referrals into treatment (490 in 2009/10 compared to 466 in 2008/09). GP referrals account for three per cent of the referrals to treatment in 2009/10 compared to none in 2008/09.

During 2009/10 a total of seventeen different drug treatment agencies were accessed compared to just three in 2008/09 though seven of these agencies only had a single referral throughout the year. The number of interagency transfers increased from 90 to 125 in 2009/10 and involving 21 different agencies making this much more complex than 2008/09. The number of referrals into treatment that were treatment naïve (not previously been in treatment) at presentation continued to drop: 39% in 2009/10 compared with 41% in 2008/09 and 45% in 2007/08. Almost two-thirds (64%) of Cannabis users referred to treatment in 2009/10 were defined as treatment naïve.

Between the 2008/09 and 2009/10 treatment years there has been a:

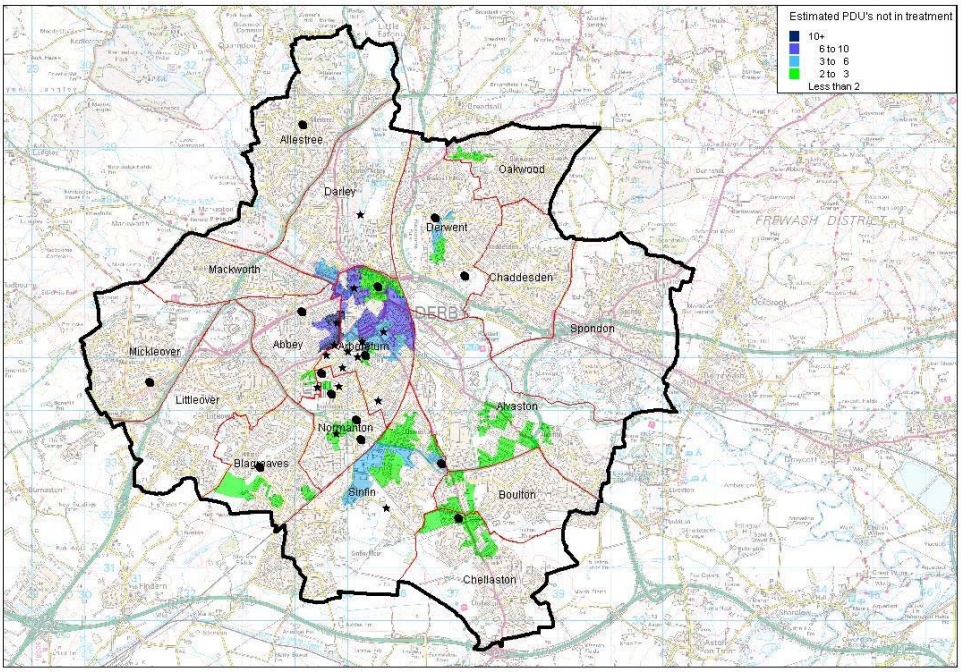
- Three per cent increase in the numbers in treatment (1,689 compared to 1,635)
- One per cent increase in treatment exits (from 363 to 368)
- The number of planned exits has increased by 48% from 73 to 108
- The proportion of unplanned exits has dropped to from 57% down to 38% in 2008/09.

Approximately 19% of the estimated numbers of PDUs in Derby are unknown to treatment. This is an improvement on last year's figure (23%). There has been a four per cent increase in the total number of PDUs in treatment as at March 31st 2010 this stood at 57% (with around 70% in treatment during 2009/10 – 99% of which were in effective treatment).

8.4.3.3 Estimated PDUs not in treatment by Output Area

Using the estimates of where the PDU populations may be located, it is possible to provide an estimation of where there are populations who are not accessing treatment. There are apparent concentrations of unmet need in Arboretum and Abbey, with smaller areas in Sinfin, Alvaston, Derwent, Normanton, Blagreaves and Chellaston.

Figure 28: Estimated PDUs not in treatment by output area[44]



Source: Derby Adult Drug Needs Assessment 2010

8.4.4 Drug Summary

Note: this section summarises some of the findings reported in the document *Full Adult Drugs Needs Assessment: November 2010* produced by Derby Community Safety Partnership. Further detail can be found in the full report.

Drug misuse - key findings:

- There was no significant change in the number of problematic drug users (PDUs) in treatment between 2008/09 and 2009/10
- Approximately 2,000 PDUs in Derby
  - about 70% of which in treatment during 2009/10
  - 99% of those in treatment are in 'effective' treatment
  - in 2009/10 19% of PDUs are treatment naïve
- In 2009/10 there was a four per cent increase in the number of drug users in treatment
- The majority of drug users – 87.4% are opiate users
- The proportion of adults using Cannabis as their primary drug (5.4%) increased by 34% and those using it as a secondary drug increased from five per cent to eight per cent
- Secondary drug use has increased from 28.9% of users in treatment in 2008/09 using a second drug to over half (51.4%) in 2009/10
- Derby has a different age profile of people in treatment to that of the wider region and England.

Implications

- Problematic drug use can impact significantly in the health and well-being of individuals and their families. It can also have wider community implications such as discarded needles and crime
- Problematic drug use is not increasing (although those with a secondary drug use are increasing) and more are in effective drug treatment.

Gaps and next steps

- To understand whether unrepresentative BME numbers in treatment is due to different levels of drug use or unequal access to drug treatment
- Continue to increase the numbers of PDUs in effective treatment
- Maintain awareness of changing drug use and potential need to change services in response.

8.5 Obesity

Worldwide, one billion adults and 42 million children are classed as overweight (Body Mass Index (BMI) of 25 and above) and more than 300 million are categorised as obese (BMI of 30 plus). Severely obese individuals are likely to die on average eleven years earlier than those with a healthy weight. This risk is comparable to, and in some cases worse than, the reduction in life expectancy from smoking[48].

8.5.1 National picture

In 1980 six per cent of men and eight per cent of women were classed as obese in the UK. This has since increased to 23% of men and 25% of women[49] and up to 65% of men and 56% (in 2007) of women when including overweight as well as obese[50]. In 2002, it was estimated that the economic cost of obesity, in the NHS, was between £3.3 and £3.7 billion, rising to £4.2 billion in 2007[51].

The Department of Health estimated in 2007 that obesity is responsible for more than 9,000 deaths a year in England[52][53]. Being obese is a risk factor for developing other diseases including heart disease and cancer. It is estimated that one million fewer obese people in England could mean:

- 15,000 fewer people with coronary heart disease
- 34,000 fewer people developing type 2 diabetes
- 99,000 fewer people with high blood pressure[51][53].

Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world, representing 60% of all deaths. Out of the 35 million people who died from chronic disease in 2005, half of these were under the age of 70[54]. Further, obesity in pregnancy is linked to increased likelihood of congenital abnormalities; foetal loss and caesarean section[55]. The Health Survey for England 2006 highlighted that rates of obesity in children are rising. In October 2007 the government pledged the following:

> *"to be the first major country to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to maintain a healthy weight. Our initial focus will be on children; by 2020, we aim to reduce the proportion of overweight and obese children to 2000 levels.*[48]

8.5.2 Local picture

It is estimated that around one-quarter (24.2%) of the adult population in Derby are obese – similar to England (24.2%) and the East Midlands (24.3%). In Derby figures from 2008/09 show the prevalence of obesity at 9.5% for 4-5 year olds and 17.2% for 10-11 year olds.

According to the Quality Outcomes Framework Obesity register, 11% of the adult population (aged 16 years and over) of NHS Derby City were registered as being obese in 2009/10. This prevalence is higher than that seen in the East Midlands (see Figure29)[56]. Around 10% of patients on general practice registers are obese, however,

this figure is based on the whole practice population aged 16 plus. In practice only 37% (88,067) of the practice population have been measured and of these, 25,232 (28%) have a BMI of over 30 and therefore classed as obese.

Figure29: Obesity prevalence rates quoted by Quality Outcomes Framework for each Strategic Health Authority (SHA) in 2009/10

Strategic Health Authority	Obesity prevalence (%)
North East	13.4%
North West	11.5%
Yorkshire and The Humber	11.4%
East Midlands	10.8%
West Midlands	11.6%
East of England	10.0%
London	9.5%
South East Coast	9.0%
South Central	9.6%
South West	9.9%

Figure 30 shows the prevalence of obesity in children, by ward, in Derby for 2008/09.

Figure 30: Prevalence of obesity by ward 2008/09

Ward	Number of Obese Pupils			Proportion of Obese Pupils		
	Reception Year	Year 6	Total	Reception Year	Year 6	Total
Abbey	11	25	36	10.0%	25.3%	17.2%
Allestree	8	18	26	5.6%	14.6%	9.7%
Alvaston	18	23	41	9.8%	16.1%	12.6%
Arboretum	29	36	65	13.3%	17.8%	15.5%
Blagreaves	8	20	28	7.0%	15.9%	11.6%
Boulton	15	31	46	8.8%	18.9%	13.8%
Chaddesden	5	28	33	5.0%	20.0%	13.8%
Chellaston	21	18	39	12.6%	12.6%	12.6%
Darley	<5	10	12	2.2%	11.2%	6.6%
Derwent	16	25	41	10.1%	15.7%	12.9%
Littleover	8	36	44	5.0%	17.0%	11.9%
Mackworth	18	28	46	12.9%	24.3%	18.1%
Mickleover	9	14	23	9.4%	15.6%	12.4%
Normanton	27	45	72	11.5%	20.9%	16.0%
Oakwood	7	19	26	9.6%	14.4%	12.7%
Sinfin	26	31	57	12.3%	17.1%	14.5%
Spondon	6	10	16	5.8%	11.9%	8.5%
Outside Derby	6	12	18	12.2%	16.0%	14.5%
Unknown	<5	5	7	6.7%	13.2%	10.3%
Grand Total	**242**	**434**	**676**	**9.5%**	**17.2%**	**13.3%**

Source: The Information Centre

It is estimated that 72.9% of people in Derby do not eat healthily (calculated as the proportion of the population not consuming five or more portions of fruit/ vegetables per day). This is slightly higher than both England at 71.3% and the East Midlands at 71.4%[(26)]. It is apparent from the figures below, that spend on fruit and vegetables is linked to affluence in the city. Individuals living in Mickleover, Littleover and Allestree wards particularly, are likely to spend more on fruit and vegetables per household.

Figure 31: Average monthly household expenditure on fruit 2010

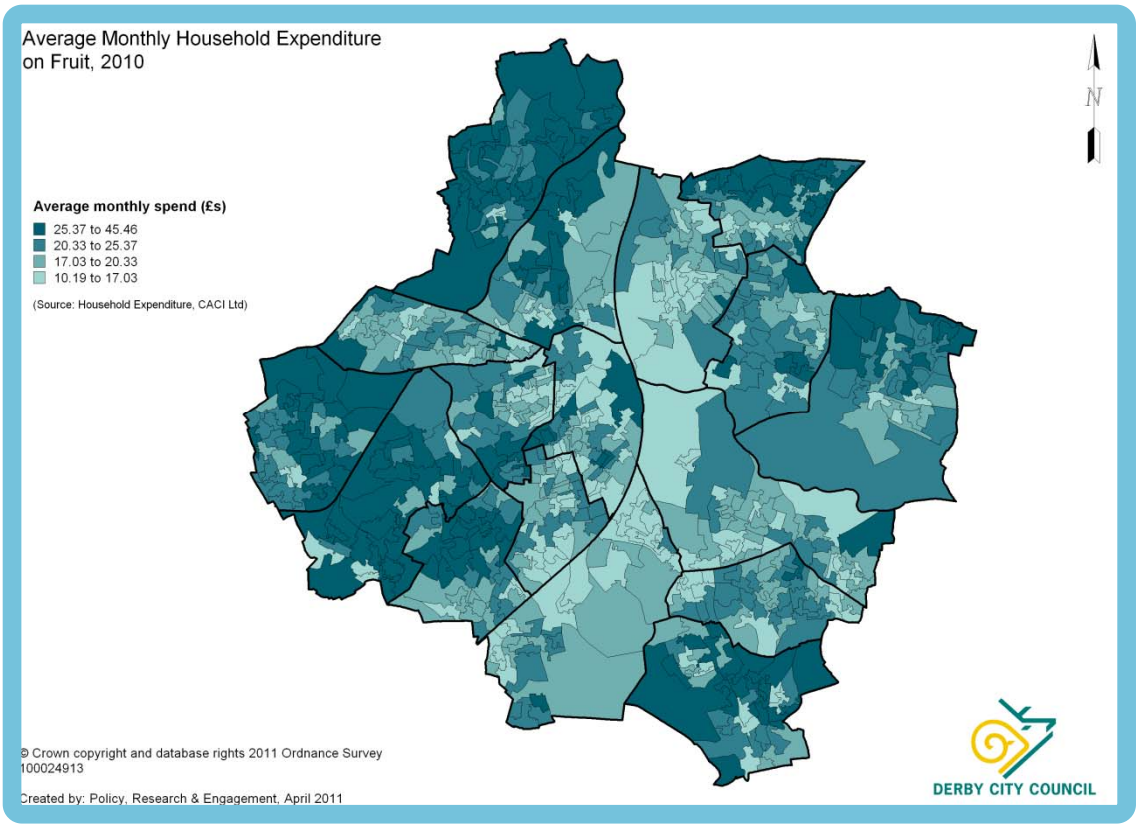
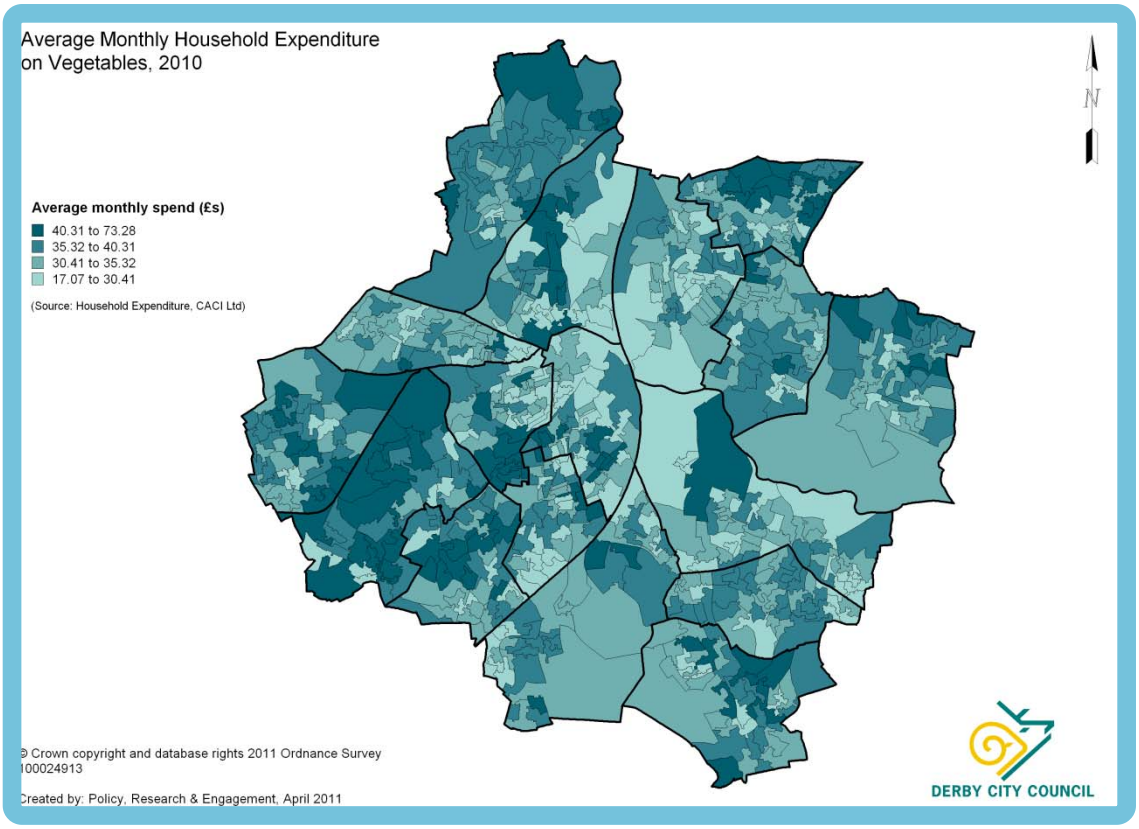
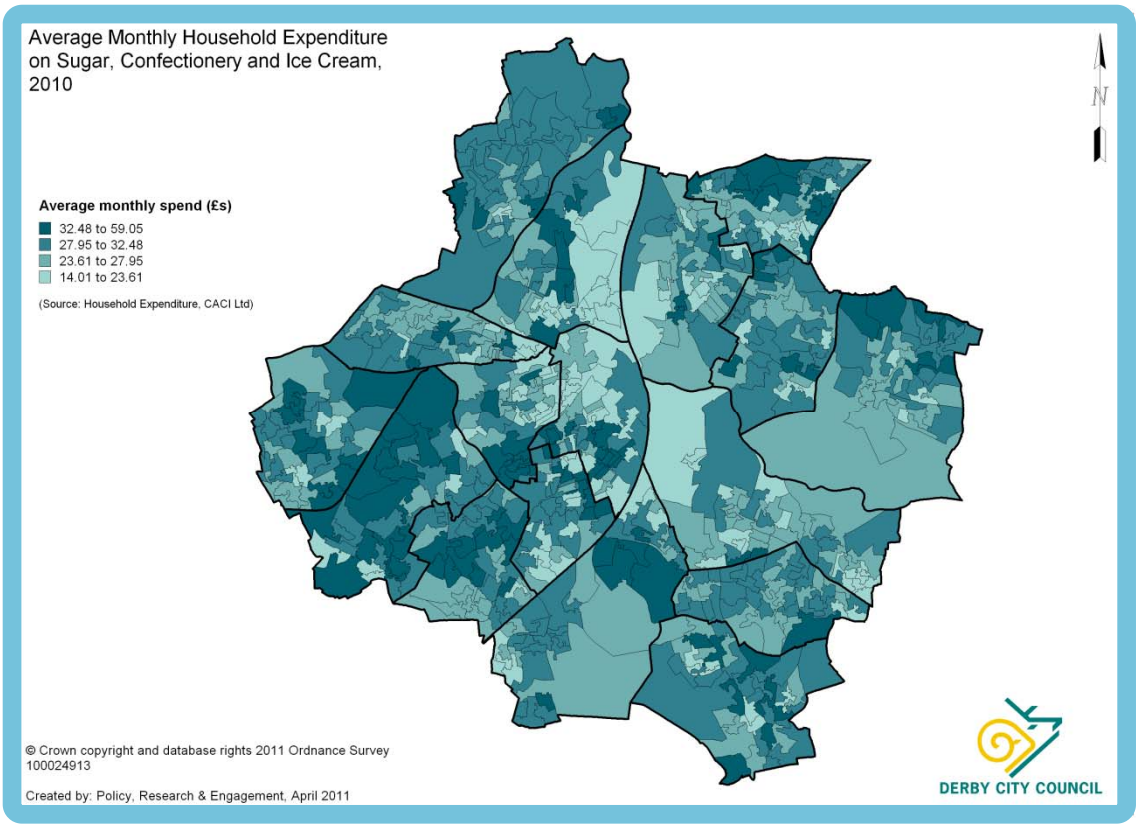


Figure 32: Average monthly household expenditure on vegetables 2010



Interestingly, whilst these maps of expenditure hint at Derby's affluent population consuming their '5-a-day', pockets of some of the city's more affluent wards also see high household expenditure on sugar, confectionary and ice cream and in some instances, double that seen in some of the most deprived areas of the city.

Figure 33: Average monthly household expenditure on sugar, confectionary and ice cream 2010



The estimated costs of treating obesity and its consequences in Derby for 2009/2010 was £5,544,567[57]. This figure includes inpatient admissions, prescription costs, GP consultations and outpatients. This has risen by approximately £227,847 since 2006/2007.

Table 17 shows the regional results relating to adult participation in three thirty minute moderate intensity sessions of sport and physical activity each week as found in the Active People Survey. The East Midlands was one of only two regions (also South East) recording a statistically significant reduction in activity between the rolling 2010/11 figures compared to both the Active People Survey 2 and 3.

Table 17: Adult participation in three thirty-minute moderate intensity sport and physical activity sessions each week by regional[56]

Region	Adult participation in 3 x 30 minutes (week), moderate intensity sport: Regional			
	APS2 2007-2008 (%)	APS3 2008-2009 (%)	APS4 2009-2010 (%)	Rolling 12 months (Jan 2010 – Jan 2011) (%)
East	16.2	15.8	15.7	15.9
East Midlands	**16.8**	**16.6**	**16.0**	**14.9**
London	16.5	17.2	16.6	16.3
North East	16.3	16.2	16.4	16.7
North West	17.0	17.1	17.7	17.4
South East	17.1	17.1	16.8	16.1
South West	16.0	16.4	16.5	16.4
West Midlands	14.5	15.2	15.5	15.1
Yorkshire	17.2	16.8	16.4	16.8

Source: Sport England – Active People Survey 1-4

Table 18 shows the level of adult participation in three thirty-minute sessions of moderate intensity sport and physical activity each week. Since 2008-2009 this level appears to be reducing – showing a statistically significantly reduction between April 2010 – April 2011 and the result in Active People Survey 3.

Table 18: Adult participation in three thirty-minute moderate intensity sport and physical activity sessions each week: Derby[56]

	Adult participation in 3 x 30 minutes (week), moderate intensity sport			
	APS2 2007-2008 (%)	APS3 2008-2009 (%)	APS4 2009-2010 (%)	Rolling 12 months (Apr 2010 – Apr 2011) (%)
Derby	17.5	19.2	15.7	13.6

Source: Sport England – Active People Survey 1-4

8.5.3 What's currently being delivered

Annually the National Child Measurement Programme (NCMP) is undertaken locally where all 4-5 year olds and 10-11 year olds (reception and year 6 children respectively) heights and weights are recorded in that academic year for conversion to Body Mass Indexes and high-level analysis of weight.

8.5.4 Guidance and best practice

National guidance and best practice published in relation to obesity:

- National Institute for Health and Clinical Excellence (2008) Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children[58]

- Scottish Intercollegiate Guidelines Network (2010) Management of Obesity: A National Clinical Guideline[59]
- Centre for Maternal and Child Enquiries &Royal College of Gynaecologists and Obstetricians (2010) *Management of women with obesity in pregnancy*[60].

Obesity - key findings:

- Around one-quarter (24.2%) of adults in Derby are obese – similar to the regional and national average
- Costs of treating obesity and associated consequences in Derby estimated to be in the region of £5.5 million in 2009/10
- Almost three-quarters (72.9%) of the population of Derby do not eat healthy diets
- Just 13.6% of adults take part in three sessions of moderate exercise in 2010/11 – statistically significantly reduction on 2008/09 (19.2%)
- There is variation in the prevalence of obesity by ward
- Physical activity levels in children are significantly higher in Derby than compared to England, the East Midlands and it's comparator group of local authorities, while in adults they are comparable to the national average.

Implications

- Obesity is linked to reduced life expectancy
- Obesity increases the risk of developing conditions such as:
  - heart disease
  - cancer
  - stroke
  - diabetes
- Obesity in pregnancy increases the risk of congenital abnormalities; foetal loss and caesarean section.

Gaps and next steps

➢ Whilst obesity levels in Derby are not significantly different to comparable areas, it should potentially be considered a priority given the volume of people it affects and its impact on health and wellbeing and costs to health and social care.

8.6 Teenage Pregnancy

In 1999 the Social Exclusion Unit launched the UK's ten-year Teenage Pregnancy Strategy. The Teenage Pregnancy Independent Advisory Group (TPIAG) was set up in 2000 to advise the Government on the Teenage Pregnancy Strategy and monitor its implementation. The strategy aimed to:

- Halve the rate of conceptions to the under 18's by 2010
- Increase the participation of teenage parents in education, training and employment[61].

8.6.1 National picture

The rates of teenage pregnancy in the UK are the highest in Western Europe with more than 25% of young people in Britain having sex before the age of 16[62]. In 2004, there were 39,545 under 18 conceptions in England of which 41% ended in abortion, and 7,179 under 16 conceptions with 57.6% of these ending in abortion[63].

8.6.1.1 Risk factors

Factors contributing to the likelihood of becoming young parents include:

- early onset of sexual activity
- poor contraception use
- mental health issues
- alcohol and substance abuse
- low education attainment
- disengagement from school
- living in care
- daughter of a teenage mum and daughter of a mum with low educational aspirations for them[63].

8.6.1.2 Consequences

Whilst early parenthood is a positive decision for some, for many, however, teenage pregnancy and early parenthood is problematic with a range of consequences:

- babies born to teenage mothers have a 60% higher infant mortality rate and a 63% increased risk of being born into poverty compared to babies born to older mothers
- children born to teenage mothers are more likely to do less well at school and disengage early from learning

and are at increased risk of:

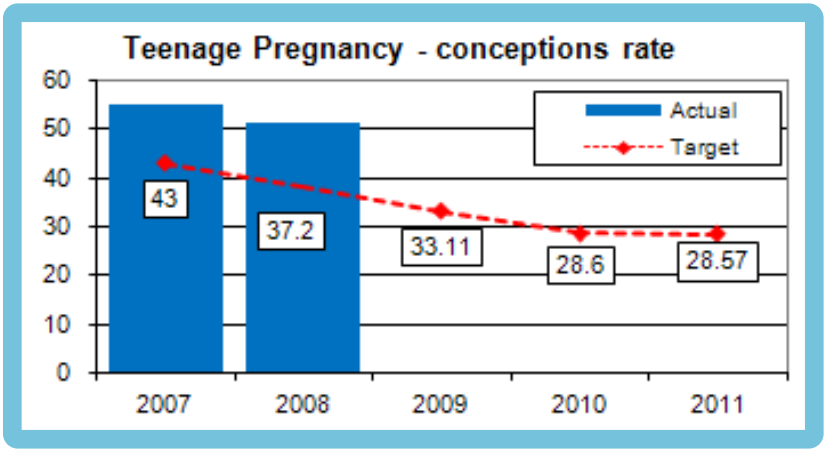
- poor parental supervision
- deprivation
- city living
- low educational expectations
- poor access to services[62].

Research suggests that timely access to appropriate care and support may help avoid poor outcomes and maximise the young people's chances of a positive transition to parenthood[64].

8.6.2 Local picture

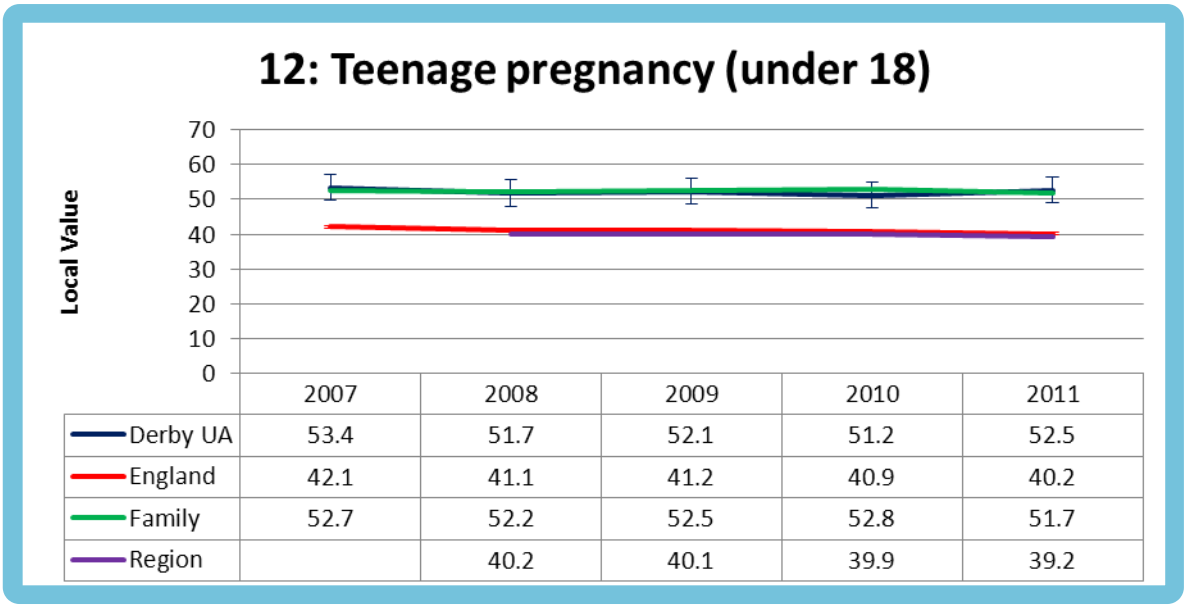
The target and actual teenage pregnancy rate is shown in Figure 34:

Figure 34: NHS Derby City teenage pregnancy rate



Provisional results for 2009 indicated the number of conceptions reached 235 against an annual plan of 149.

Figure 35: NHS Derby City teenage pregnancy trend and comparison



	2007	2008	2009	2010	2011
Derby UA	53.4	51.7	52.1	51.2	52.5
England	42.1	41.1	41.2	40.9	40.2
Family	52.7	52.2	52.5	52.8	51.7
Region		40.2	40.1	39.9	39.2

Source: Derby City local briefing paper; Health Profiles 2011 (August 2011)

The rate of teenage pregnancy in Derby, whilst significantly higher than England and the region, is comparable to our closest comparator family group. The rate is just higher than Leicester but notably lower than Nottingham. The rate of teenage pregnancy has remained relatively constant in the city since 2007 as it has across the comparator groups. Whilst we have achieved a 20% reduction from the 1998 baseline period, we need to review previous interventions and understand why they have not had the desired impact of halving the rate of teenage pregnancy in the city.

8.6.3 What's currently being delivered

- Derby RSE guidance completed March 2011 –for all those working with young people
- Work on-going with schools to sign up to enhanced school health services (tiers of service 1-4 from information to provision)
- To include teenage pregnancy in an overall sexual health strategy (currently awaiting national strategy) due Spring 2012
- City/ County developing vision for future commissioning of sexual health services via the public health function of the Local Authority

  Increased long acting reversible contraception (LARC) training in primary care has been undertaken to increase instigation and continued usage of LARC methods.

8.6.4 Guidance and best practice

National guidance and best practice published in relation to teenage pregnancy:

- Department of Health (2009) Getting maternity services right for pregnant teenagers and young fathers[(64)]
- Department of Health/ Department for Children, Schools & Families (2009) Teenage pregnancy prevention and support: A self-assessment toolkit for local performance management[(62)]
- Teenage Pregnancy Independent Advisory Group (2009) *Annual Report*[(61)].

8.6.5 Teenage Pregnancy Summary

Note: this section summarises some of the findings and recommendations of the Sexual Health Needs Assessment (2010) produced by NHS Derby City.

Teenage pregnancy - key findings:

- Teenage pregnancy in the UK is the highest in Western Europe
- The rate of teenage pregnancy in Derby, whilst significantly higher than England and the region, is comparable to our closest comparator family group of Local Authorities.
- Derby is not on course to achieve the 2011 target for teenage conception rate, however, the rate of teenage pregnancy has reduced by 20% since 1998.

Implications

- Teenage parents and their children have an increased risk of multiple poor outcomes compared with children of older parents
- Babies born to teenage mothers are at higher risk of:
  - higher infant mortality rates
  - being born into poverty
  - doing less well educationally and having lower educational expectations
  - poorer parental supervision
  - living in deprivation
  - poorer access to services.

Gaps and next steps

- Continue to implement the recommendations of the National Support Team visit.
- A new local sexual health strategy will be developed following the publication of the national strategy.

9 BURDEN OF ILL-HEALTH

Key Findings:

- It is estimated that 11,344 people in Derby have a moderate physical disability, and 3,243 have a serious physical disability
- Derby is a significant centre for the deaf community in the UK
- 1,585 are registered blind or partially-sighted
- 7,281 people aged 65 or over are unable to manage at least one activity on their own and this is expected to rise by 48% by 2030
- Mortality rates from cardiovascular disease are significantly higher than the national rate, but have decreased by 44.7% since 1995-7
- The two largest underlying causes of death in the city are ischaemic heart disease and cerebrovascular disease
- Derby now has a higher incidence of cancers than the East Midlands and England, and this is significantly higher in men
- Premature mortality from cancer has reduced since 1999 but increased in 2007 and 2008
- Emergency admission rates for stroke are higher than the national rate, and significantly higher in men than women
- Those living in the most deprived areas of Derby are more likely to have an emergency admission for stroke.

Implications

- The burden of ill health is felt greatest by those living in the most socially and economically deprived areas
- The prevalence of various conditions vary dependant on factors such as age, sex and ethnicity
- High prevalence of conditions such as cancer and heart disease not only impact significantly on the health and wellbeing of individuals and lead to reduced life expectancy, but also have a high financial cost
- Early diagnosis of cancers can improve treatment outcomes and life expectancy e.g. regular screening can reduce the risk of dying from bowel cancer by 16%
- Many people with health conditions such as coronary heart disease remain undiagnosed.

Gaps and next steps

- ➢ The burden of ill health and health inequality remains a challenge
- ➢ A wider range of health issues will be incorporated in the next JSNA.

9.1 Introduction

The areas that have been highlighted, from the JSNA, that specifically need updating are cancer, cardiovascular disease (CVD) and stroke. Disability has now been included in this chapter along with information on deaf and hearing impaired and blind and partially-sighted. Dementia and mental health will be updated in the 2012 JSNA.

9.2 Disability Profile

9.2.1 Deaf and hard of hearing

The Royal National Institute for Deaf People (RNID) estimates there are about nine million deaf or hard of hearing people in the UK – a term used to describe all levels of hearing loss. Hard of hearing is a generic term which includes those with any degree of hearing loss. It is often used by older people who have age related deafness, or those with a mild or moderate hearing loss. Deafened people are those who are born hearing and become severely or profoundly deaf later in life.

About seven per cent (688,000) of deaf people are severely or profoundly deaf. 41.7% of all over 50 year olds will have some kind of hearing loss and increases to 71.1% of over 70 years old.

Derby has become a significant cultural centrefor the deaf community in the UK. It is estimated that the deaf population in Derby is at least three times higher than the national average with only London having a larger deaf population. The Royal School for the Deaf in the city provides education in British Sign Languageand English.

Table 19shows people registered as deaf or hard of hearing by age, as at 31st March 2010 (this is an under-estimate as a lot of people do not fill in relevant forms to be included in this report)[65]

Table 19: Registered deaf or hard of hearing people in Derby

Derby	All ages	0-17	18-64	65-74	75 +
Deaf	865	20	530	80	230
Hard of hearing	705	-	80	45	575
Total	1,570	20	610	125	805

Information from PANSI – Projecting Adult Needs and Service Information – (Table 20) estimates the number of people with moderate or severe hearing impairment and therefore gives us some indication of what the need for services might be in the future:

Table 20: PANSI information on the number of people with severe or moderate hearing impairment in Derby

	2010	2015	2020	2025	2030
People aged 18-24	44	45	42	40	45
People aged 25-34	172	195	202	197	188
People aged 35-44	503	463	494	557	579
People aged 45-54	1,747	1,906	1,876	1,718	1,826
People aged 55-64	2,854	2,907	3,267	3,580	3,527
People aged 65-74	3,703	4,104	4,235	4,319	4,912
People aged 75-84	8,464	8,704	9,382	10,810	11,182
People aged 85+	4,669	5,518	6,198	7,302	8,746
Total 18 and over	22,156	23,841	25,695	28,523	31,005

Note: The information from PANSI for profound hearing impairment is low as registered figures show that there are more people than have been quantified.

9.2.2 Blind and partially sighted

9.2.2.1National context

One in twelve people over the age of 60 is registered as blind or partially-sighted in the UK. 90% of all people who are blind or partially-sighted are over 60 years old. One in twelve at age 60 have a degree of sight loss, one in eight by the age of 75 and one in four by the age of 80 (RNIB Good Practice in Sight). There are currently over two million people in the UK have an un-correctable sight problem; this is estimated to rise to 2.5 million within the next 30 years. (RNIB Blind survey 2003.)

9.2.2.2Local context

Table 21shows the people, in Derby, who are registered as blind or partially-sighted, as at 31st March 2008. Please note that these are usually an under estimation as people do not always wish to register(66).

Table 21: People in Derby registered as blind or partially sighted

Derby	All ages	0-4	5-17	18-49	50-64	65-74	75 +
Blind	995	-	25	175	165	170	460
Partially-sighted	590	-	25	100	85	100	275
Blind registered as new cases	65	-	-	-	5	-	50
Partially-sighted as new cases	80	-	-	10	10	-	50

Table 22shows the people in Derby, who are registered blind with an additional disability:

Table 22: People in Derby registered blind with an additional disability

Derby	Total	Mental Health	Learning Disabilities	Physical Disabilities	Deaf with speech	Deaf without speech	Hard of hearing
Blind	455	30	25	330	10	5	50
Partially-sighted	295	15	15	225	-	-	35

Table 23shows the people in Derby who are registered blind with an additional disability by age.

Table 23: Blind people registered who have an additional disability by age

Derby	All ages	0-4	5-17	18-64	65+
Blind	455	0	10	100	340
Partially-sighted	295	0	5	60	225

Table 24shows the Projecting Older People Population Information System (POPPI) data for Visual impairment for aged 65+.

Table 24: Other Blind data: POPPI data for Visual impairment for aged 65+

	2010	2015	2020	2025	2030
People aged 65-74 predicted to have a moderate or severe visual impairment	1,086	1,204	1,232	1,260	1,434
People aged 75 + predicted to have a moderate or severe visual impairment	2,381	2,542	2,790	3,212	3,509
People aged 75 and over predicted to have eye conditions that can be registered	1,299	1,312	1,440	1,658	1,811

9.2.3 Dual sensory

It is difficult to obtain relevant information as the majority of service user needs are linked to their primary condition and other information is not always completed. 138 adults were registered on Derby City Council's Swift database (used for recording Social Care related data) with dual sensory loss (Jan 2011). Fifty-one of these were receiving a service.

The deaf blind prevalence rate is 572 people per 100,000 (SENSE), with 16% aged 20-59, 16% aged 60-69 and 62% 70+ which equates to 1,268 people in Derby. It is estimated that by 2030 that this will increase to 806 per 100,000 people, equating to 2,261 people who are deaf blind.

The number of people who are deaf and/or blind increases with age. As we have an ageing population, these numbers will continue to increase. We therefore have to be clear of what these patients needs are and understand the increasing demand this will have on local services.

9.3 Physical Disabilities

It is difficult to estimate the number of people in Derby with physical disabilities. The recognised way is to look at national prevalence rates based on age bands for the city, these rates are for moderate and serious disability by age and sex, quoted on the PANSI website. The prevalence rates given in the survey for moderate physical disability are 4.1% for 18-24 year olds, 4.2% for 25-34 year olds, 5.6% for 35-44 year olds, 9.7% for 45-54 year olds and 14.9% for 55-64 year olds. The prevalence rates given in the survey for serious physical disability are 0.8% for 18-24 year olds, 0.4% for 25-34 year olds, 1.7% for 35-44 year olds, 2.7% for 45-54 year olds and 5.8% for 55-64 year olds. In 2010 it is estimated there are 11,344 with a moderate physical disability and 3,243 with a serious physical disability in Derby.

Table 25shows the predicted increase for 2010 to 2030 in Derby for those with a moderate physical disability. Table 26shows those predicted to have a serious physical disability.

Table 25: People predicted to have a moderate physical disability

People predicted to have a moderate physical disability	2010	2015	2020	2025	2030
People aged 18-24	1,148	1,136	1,054	1,062	1,173
People aged 25-34	1,533	1,747	1,810	1,756	1,680
People aged 35-44	1,966	1,809	1,926	2,190	2,268
People aged 45-54	2,988	3,279	3,211	2,958	3,133
People aged 55-64	3,710	3,755	4,246	4,664	4,574
Total	11,344	11,725	12,247	12,629	12,828

Table 26:People predicted to have a serious physical disability

People predicted to have a serious physical disability	2010	2015	2020	2025	2030
People aged 18-24	224	222	206	207	229
People aged 25-34	146	166	172	167	160
People aged 35-44	597	549	585	665	689
People aged 45-54	832	913	894	824	872
People aged 55-64	1444	1462	1653	1815	1781
Total	3,243	3,311	3,510	3,678	3,730

9.3.1 Mobility

Table 27shows people in Derby, aged 65 and over who are unable to manage at least one mobility activity on their own, by age and gender, projected to 2030. Examples of activities include going out of doors and walking down the road, and getting up and down stairs. (Information from POPPI).

Table 27: People unable to manage at least one activity on their own

People unable to manage at least one activity on their own	2010	2015	2020	2025	2030
People aged 65-69	884	1,004	944	1,037	1,208
People aged 70-74	1,166	1,254	1,442	1,348	1,488
People aged 75-79	1,290	1,326	1,437	1,677	1,569
People aged 80-84	1,476	1,483	1,566	1,772	2,065
People aged 85+	2,465	2,890	3,215	3,745	4,460
Total	7,281	7,957	8,604	9,579	10,790

9.3.2

9.3.3 Major Disabling Conditions

Table 28has the national estimated incidence rates of major disabling conditions in Derby[67].

Table 28: National incidence rates of major disabling conditions

	Type Prevalence per 10,000 population	Estimated incidence in Derby
Severe Head Injuries	15	359
Spinal Injuries	4	96
Multiple Sclerosis	8	191
Motor Neurone Disease	1	24
Muscular Dystrophy	1	24

9.4 Biggest causes of death in Derby

National performance-related targets on mortality have historically been measured by monitoring deaths in two main areas; cancers and circulatory diseases i.e. Coronary Heart Disease (CHD) and Stroke. Mortality from cancers and circulatory disease account for more than 40% of the top 50 causes of death in Derby, and are four of the top five causes.

The two largest underlying causes of death to individuals of any age and any gender in Derby are the circulatory diseases, ischaemic heart disease and cerebrovascular disease. The main cause of death (as stated on the death certificate) in individuals with these underlying conditions are: heart attack, heart disease and stroke.

In 0-14 year olds the top cause of death, albeit with numbers mostly less than five each year, are disorders related to length of gestation and foetal growth i.e. premature babies.

In the 15-44 year old age group, the biggest cause of mortality each year is intentional self-harm i.e. suicide, followed by diseases of the liver (predominantly as a result of alcohol) and mental and behavioural disorders due to psychoactive substance use, namely opioids. The number of deaths in each of these areas is far higher in males.

In the 45-74 year old age group, seven of the top ten causes of death are cancers and circulatory diseases; with the top three being cancers of the digestive and respiratory organs as well as ischaemic heart disease. With regard to those aged over 75 years; influenza and pneumonia, and dementia (highest in females) are the two leading causes of death. Fourteen of the top 50 underlying causes of death are cancers.

9.5 Cancer

9.5.1 Nationalcontext

Around 293,600 cases of cancer are newly diagnosed in the UK each year, with one in three people developing some form of cancer during their lifetime. Although cancer causes one in four of all deaths in the UK, due to more effective treatment and earlier diagnosis through education and screening, half of those diagnosed are surviving over five years.

The most common cancers are: breast, lung, bowel and prostate, together accounting for over half of all new cancers each year. Lung cancer is the most common cause of cancer death in both men and women, leading to around one-quarter of all deaths from cancer in men and one-fifth in women.

Although cancer can develop at any age it is most common in older people. Around three-quarters of cases occur in people aged 60 and over, whilst three-quarters of deaths from cancer are in people aged 65 and over. Lifestyle, socio-economic factors, ethnicity and genetic predisposition,however, also have an influence on cancer risk, with smoking being the single biggest cause of cancer. The relationship between deprivation and lung cancer incidence and mortality has been shown to be particularly strong, with incidence rates being two and a half times higher and mortality rates twice as high in the most deprived areas as the least[(68)].

9.5.2 Local context

9.5.2.1Incidence

The trend of registration of all cancers in Derby since 1993, and forecast to 2010, highlights that whilst the incidence rate in Derby was once lower than that seen in the East Midlands and England overall, latest figures show that Derby's rates are now higher than England and East Midlands.

Table 29compares the incidence of cancers in Derby to England, the East Midlands, Nottingham and Leicester. For men, Derby's incidence rate (Directly Age Standardised Rate - DASR) is 437.0 per 100,000. This is significantly higher than England and East Midlands. The female incidence rate (DASR) is 375.2 per 100,000. This is also higher than England and the East Midlands, but not significantly. Note: DASR allows for differences in age profiles of different populations.

Table 29: Incidence of all malignancies (excluding non-melanoma skin) in the East Midlands 2004-2008

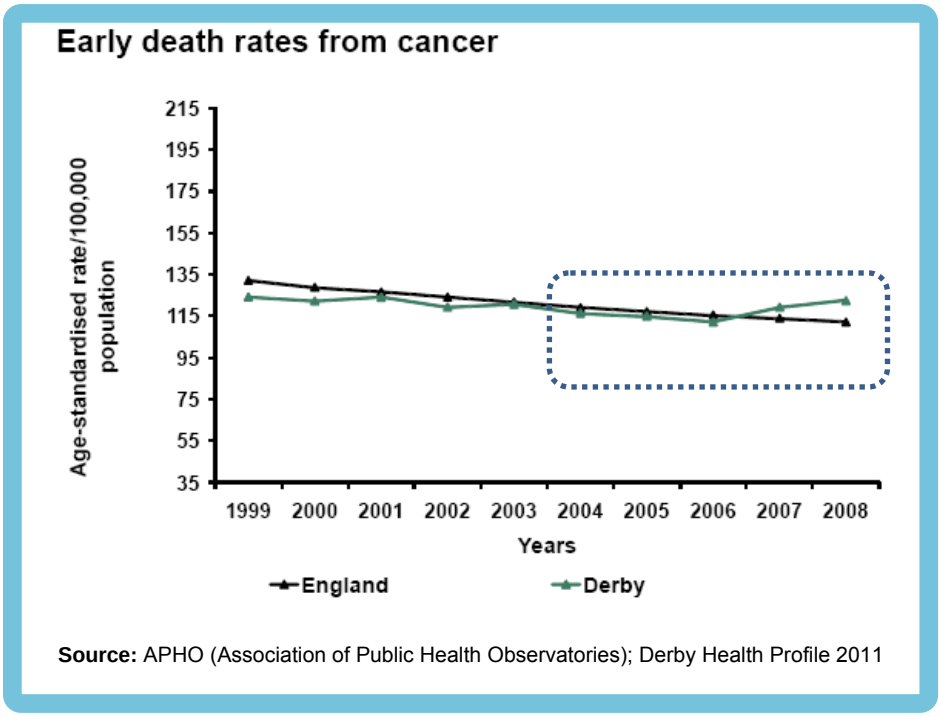
Incidence of all malignancies (excluding non-melanoma skin) in the East Midlands 2004-2008								
	Males				Female			
	OBS	DASR	95% CI		OBS	DASR	95% CI	
England	630,160	417.2	416.2	418.3	621,730	360.7	359.8	361.7
East Midlands GOR	56,375	416.3	412.8	419.7	55,195	370.1	366.8	373.3
Local Authorities (boundaries as of April 2004)								
Derby UA	3,050	437.0	421.2	452.7	2,845	375.2	360.4	390.0
Leicester UA	2,730	398.5	383.4	413.6	2,870	359.8	345.9	373.8
Nottingham UA	3,090	465.2	448.4	481.9	3,015	398.9	383.6	414.3
Indicator: Incidence of All Malignancies (ICD 10 C00-C97 exc C44)								
Statistic: *Directly age-standardised rates (DASR) per 100,000, using the European Standard population*								
Age Group: All ages								
Period: 2004-2008 Pooled								
OBS: *Total number of cases for 2004-2008 period*								
Source: *UK Cancer Information Service (UKCIS), December 2010*								
Note: *Care should be taken in interpreting trends over time or making comparisons between areas in cancer incidence and survival because of potential changes/differences in the way cases are registered. 95% CI = 95% certain that the incidence falls within the estimated range of values indicated.*								

9.5.2.2 Mortality

The government set out four specific mortality reduction targets in "Saving Lives: Our Healthier Nation", published in 1999. One of these related to cancer and was "to reduce the death rate from cancer in people under 75 by at least one-fifth (20%) by 2010".

In 2009 (using 2005/07 mortality data), Derby had achieved a 17% reduction towards this target but in 2011 (using 2007/09 mortality data), this reduction has lessened to 10% after a subsequent two-year rise in mortality. This is only half of the target set at the turn of the century. In England as a whole, the 20% reduction has been achieved.

Figure 36: Trend of premature mortality from cancer

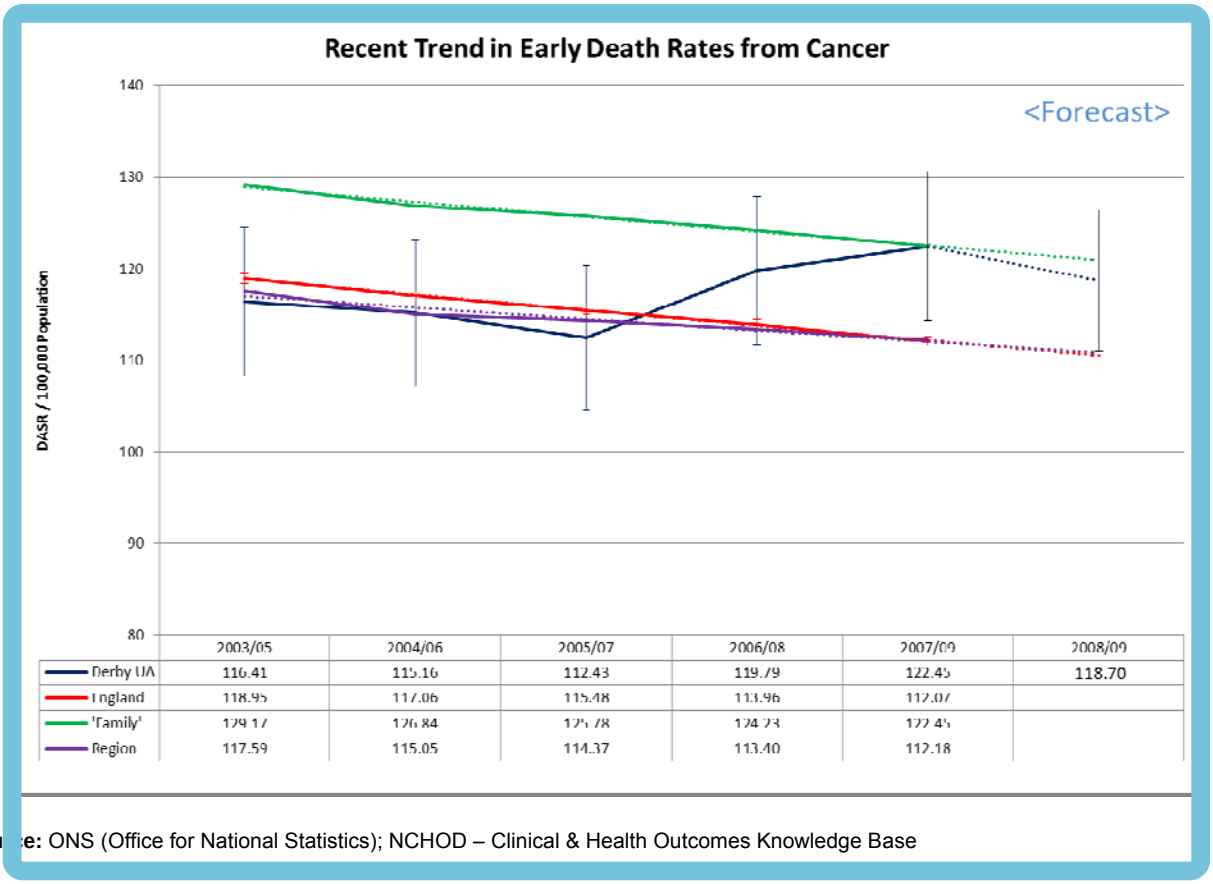


Source: APHO (Association of Public Health Observatories); Derby Health Profile 2011

Figure 36shows Derby's trajectory in early death rates from cancer since the 1999 baseline, where in 2007 and 2008 an increase in rate has been seen locally. Figure 37below, is a more detailed view of the area bordered by the dotted line in the previous figure, and shows as well as England, the East Midlands region and Derby's 'Family' group average rates; and a forecast of the 2008/09 mortality rate.

Whilst the family group of local authorities has seen rates of mortality far greater than in Derby, all three areas (national, regional and family) have demonstrated a similar downward trend. In 2011 (using 2007/09 years of mortality data), the rate in Derby has climbed to the same seen across its family group, and is also now significantly higher than seen nationally.

Figure 37: Recent comparison trend and forecast of premature mortality from cancer



	2003/05	2004/06	2005/07	2006/08	2007/09	2008/09
Derby UA	116.41	115.16	112.43	119.79	122.45	118.70
England	118.95	117.06	115.48	113.96	112.07	
'Family'	129.17	126.84	125.78	124.73	122.45	
Region	117.59	115.05	114.37	113.40	112.18	

Source: ONS (Office for National Statistics); NCHOD – Clinical & Health Outcomes Knowledge Base

Appendix 7gives details of the numbers of early deaths from cancer in Derby in the respective years of registration. Evidently, the numerator – the number of deaths [856] anticipated to be published in 2012 (2008/10 years of mortality data) is expected to return to a similar number [851] seen in the data published in 2010. The denominator – population aged under 75 will continue to grow and as such, the rate of early deaths from cancer is expected to fall to approximately 119 per 100,000 age standardised population.

Based on an exponential forecast trend of the other area's rates; while Derby's will still be high in 2012, the rate is likely to be marginally comparable to that seen nationally.

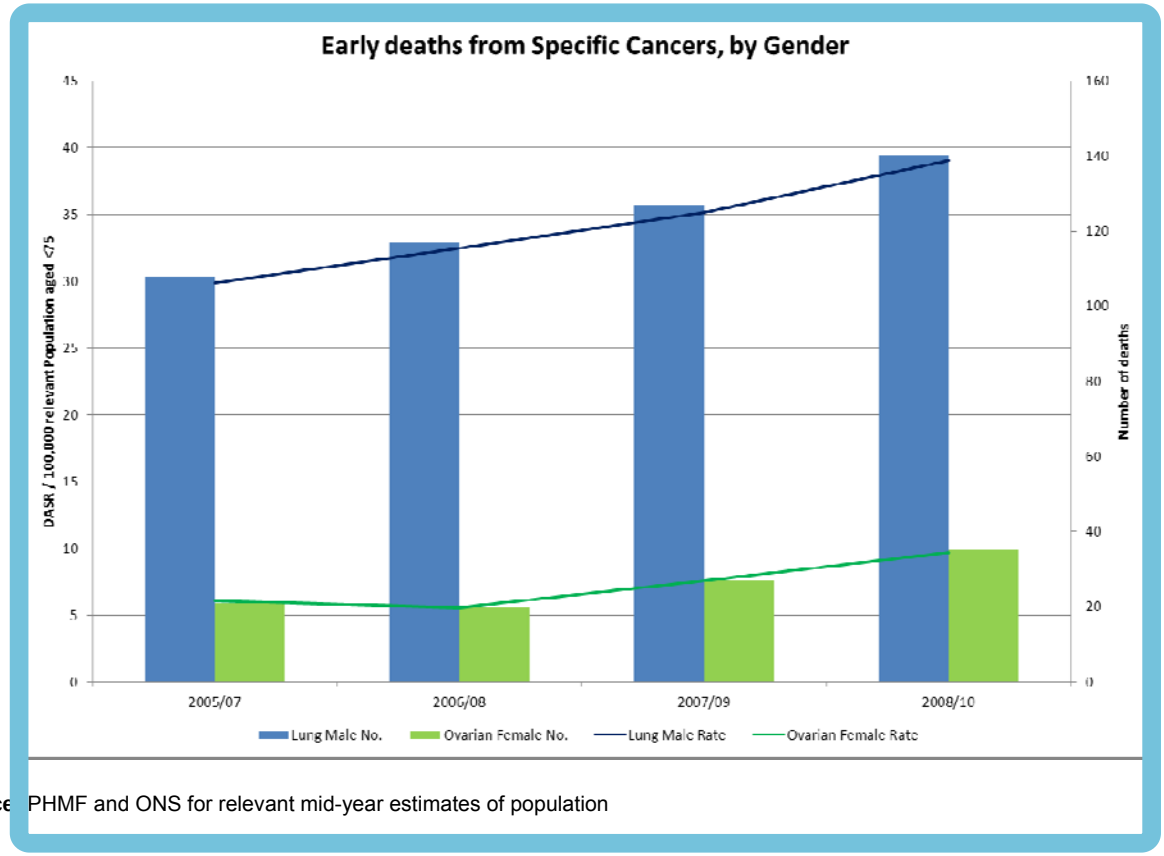
9.5.2.3Why the increase?

Studying the numbers of early deaths from cancer over the last four, 3-year periods; an increase in lung cancer deaths in males have had the biggest single impact in terms of volume

(part of the 'respiratory and intrathoracic organs' type of cancers seen in Appendix 7), as have sigmoid colon cancers [1, 3, 6, 8 deaths] and mesotheliomas [19, 19, 28, 28 deaths].

In females, early deaths from ovarian cancers (part of the 'female genital organs' type of cancers seen in Appendix 7) have increased, as have skin cancers [2, 6, 9, 14 deaths] and multiple myelomas [5, 8, 8, 10 deaths]. The number of early deaths from breast cancer in females has shown a decline in recent years.

Figure 38: Top causes of recent increase in premature mortality by gender



Source PHMF and ONS for relevant mid-year estimates of population

9.5.2.4 Cancer referrals and two week waits

- The referral rates in the East Midlands Cancer Network are highest in Derby City for Upper GI cancers, although there is no higher detection rate when compared to other East Midlands PCTS.
- Rates of routine and urgent referrals are notably high for a number of cancer sites in Derby City.
- The proportion of two week wait referrals (TWW) resulting in cancer diagnosis (conversion rate) is below 20% for all East Midlands PCTs for diagnoses of gynaecological, colorectal and upper GI cancers.
- For diagnoses of lung cancer, the proportion of TWW referrals is around 30% for most PCTs, however for Derby PCT over 40% of TWW are diagnosed with lung cancer.

(East Midlands Cancer Network Clinical information Analysis headlines June 2011, EMPHO/ Trent Cancer Registry)

9.5.2.5 Screening

9.5.2.5.1 Breast Screening

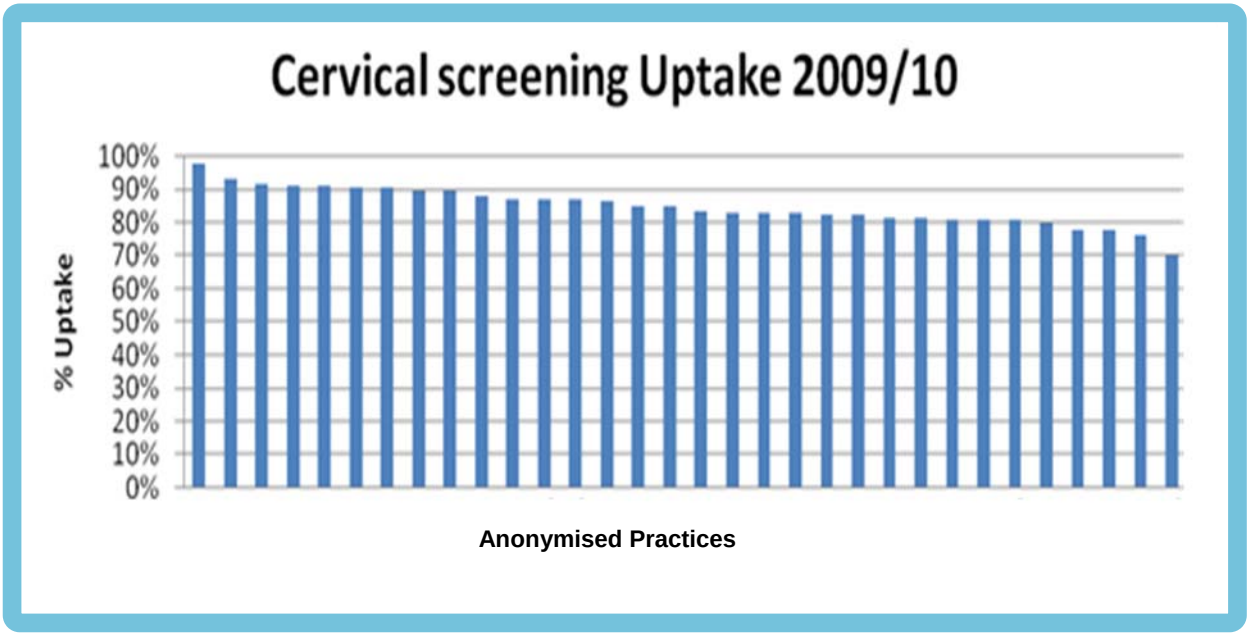
In 2008 there were 47,693 new registrations of breast cancer in women in the UK, and 341 in men (Cancer Research UK). The Breast Screening Programme in the UK has screened more than 19 million women and has detected around 117,000 cancers www.cancerscreening.nhs.uk)

9.5.2.5.2 Cervical Screening

Around 900 women die of cervical cancer in England each year. Not participating in cervical screening is one of the biggest risk factors for developing cervical cancer. It is estimated that 4,500 lives will be saved each year in England by cervical screening. There is strong evidence that both incidence and mortality are worse in patients living in the more deprived PCTs.

The latest cervical screening uptake rates (09/10) show that Derby PCT average is 76.1%. Uptake varies greatly between the practices in Derby from 70% to 97.5% as shown in Figure 39. Whilst variation is considered to be a reflection of the level of deprivation and ethnic makeup of the practice populations, a number of the city's practices tell a different story; with some practices for instance in the more ethnically diverse inner city area performing better than the practices in more affluent, less ethnically diverse areas of the city.

Figure 39: Cervical Screening Uptake in Derby 2009/10



9.5.2.5.3 Bowel Cancer Screening

About one in twenty people in the UK will develop bowel cancer during their life time. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with

over 16,000 people dying from it each year. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.

Bowel screening uptake rates vary greatly between GP practices and between men and women. Between the time period of March 2007 to December 2010, overall bowel screening uptake was as high as 67.5% and as low as 26.7%. In general, the affluent areas have higher uptake rates, and the most deprived areas with high ethnic minority groups have the lower uptake rates.

Figure 40: Bowel Screening Uptake in Derby 2007-10

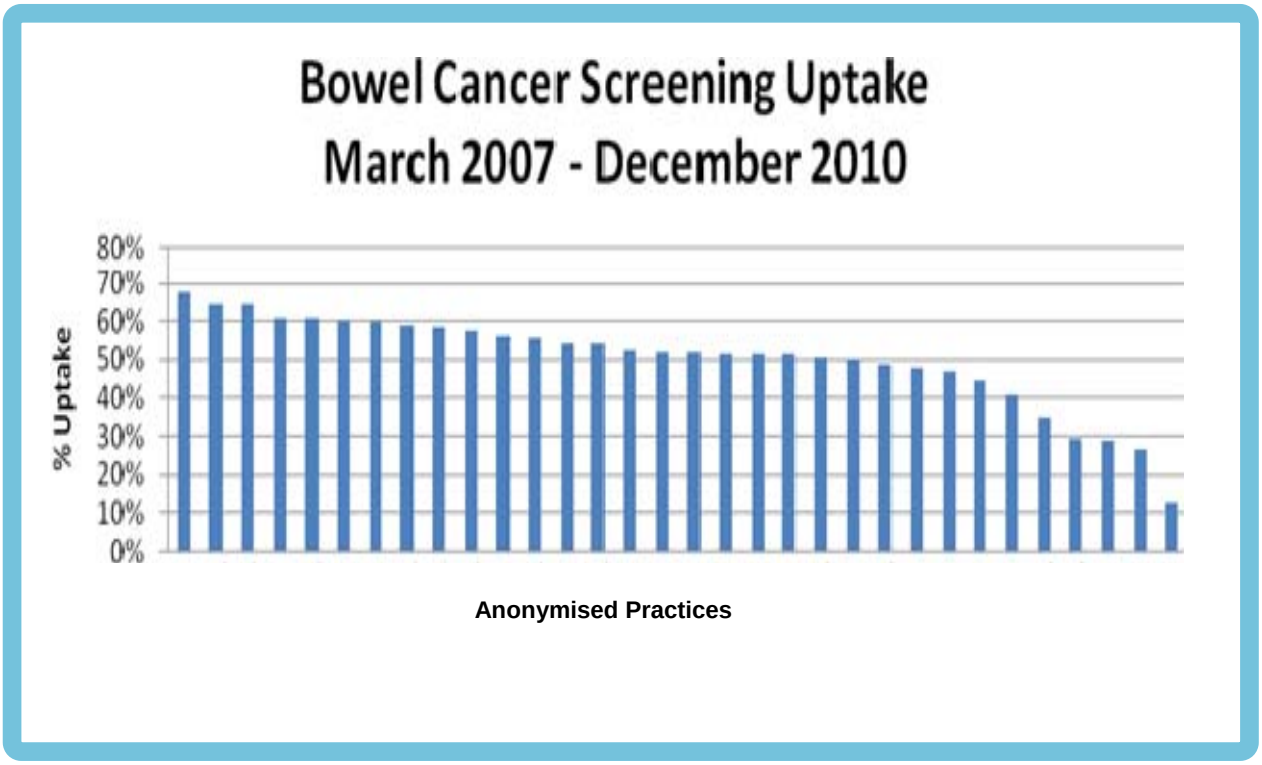
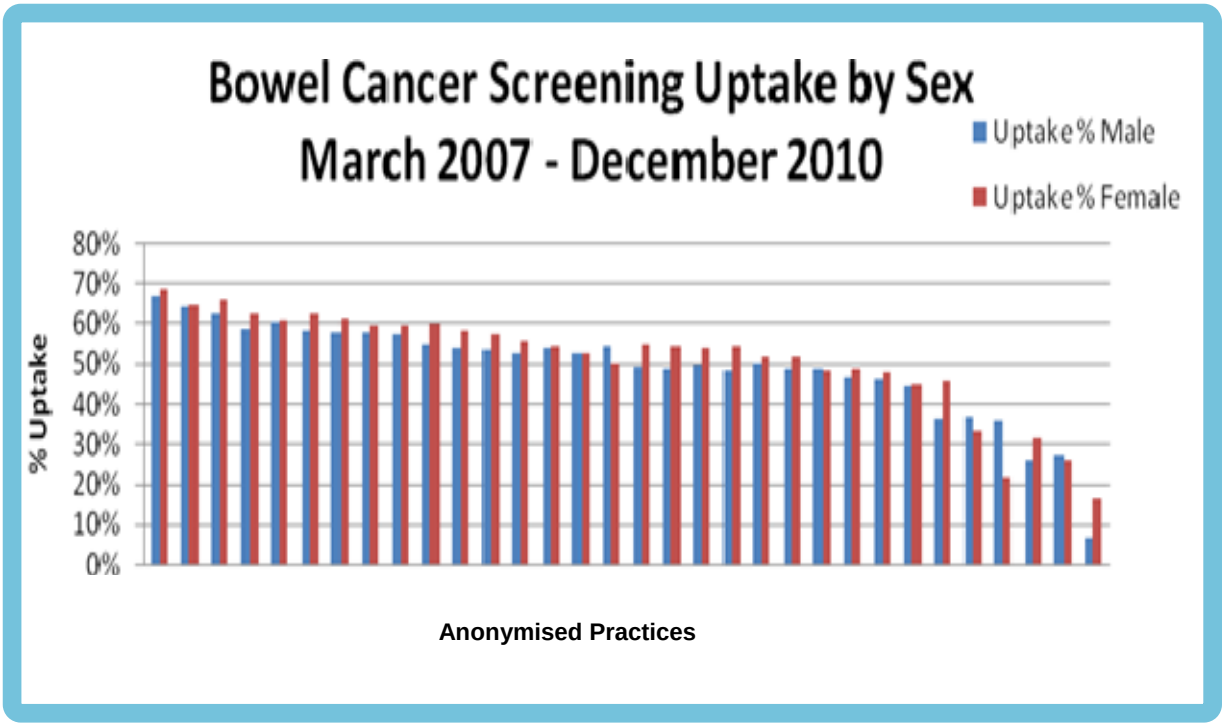


Figure 41shows that with the exception of four practices, women generally have a higher uptake rate than men. This is an area that potentially needs further investigation to understand the barriers to uptake in these practices and identify methods to improve this.

Figure 41: Bowel Screening Uptake in Derby 2007-10, by gender



9.5.3 Cancer Summary

- Male cancer incidence rate is significantly higher in Derby than in the East Midlands and England
- Rate of premature mortality from cancer in Derby is now significantly higher than seen nationally and across the East Midlands, though is comparable to its 'Family' group of local authorities
- Two of the biggest causes of this increase are; lung cancer in males and ovarian cancer in females. However, numbers by individual cancer can in some instances be very small
- Early indications from local (PHMF) data sources suggest the rate published in 2012 will fall again to 2010 levels of premature mortality from cancer
- Some practices have a very low bowel cancer screening uptake in women compared to male uptake.

9.5.4 What are we doing now?

- Working with Macmillan to target specific ethnic minority communities

- Continued delivery of the Health Checks programme
- Partnership working with the local authority and piloting of the 'B-you' programme
- A review is taking place of primary care audit outcomes involving education for GPs by secondary care clinicians. .

9.5.5 Gaps and next steps

- To understand why early deaths in lung and ovarian cancer have risen over the period (looking at quality of treatment offered, coding changes, time taken to diagnose, and changes in population demographics)
- Further investigation into low screening uptake rates
- Reporting of staging data is poor and needs to be improved.

9.6 Cardiovascular Disease

9.6.1 National Context

Cardiovascular diseases (CVD) are the main cause of death in the UK causing around 156,800 deaths in England in 2008 (around a third of all deaths). Around 45% of all deaths from CVD are from coronary heart disease (CHD) and more than a quarter from stroke (28%). CHD is the most common cause of death in England and Wales (15% of all deaths)[26].

9.6.2 Local Context

Cardiovascular profiles have been released by the South East Public Health Observatory (SEPHO) for each PCT[26]. These provide a snapshot of key issues relating to heart disease and stroke. Incidence, mortality, risk factors, treatments and costs are all included. The key messages are:

- Mortality rates in Derby from CVD are significantly higher than the national rate but have decreased by 44.7% since 1995-7
- The absolute gap in CVD mortality for persons under 75 years between the most deprived and least deprived local areas has increased by 16.5% between 2001 and 2009
- There are a slightly higher proportion of stroke patients under 75 years discharged back to their usual place of residence compared to the national picture
- The summary indicators for NHS Derby City are shown in Figure 42:

Figure 42: Summary indicators for NHS Derby City for cardiovascular disease[26]

	Indicator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
1	CVD mortality (under 75)	81.3	70.4	121.8		46.3
2	Change in CVD mortality (%)	44.7	50.1	33.8		59.9
3	AMI mortality (under 75)	17.6	16.3	36.0		6.6
4	Stroke mortality (under 75)	13.1	12.8	25.9		7.8
5	Abs gap (rate) in quintiles CVD mort	112.9	75.0	130.2		-3.5
6	Rel gap (%) in quintiles CVD mort	383.3	183.9	550.7		-7.5
7	Estimated % smokers (16+)	23.0	22.2	35.2		12.0
8	Estimated % obese (16+)	24.2	24.2	32.8		13.2
9	4 week quitters per smokers (%)	5.4	4.0	2.2		7.5
10	Obs/Exp CHD prevalence	0.58	0.61	0.31		0.84
11	Obs/Exp Hypertension prevalence	0.46	0.44	0.32		0.52
12	CHD emergency admissions	214.8	205.3	379.1		125.1
13	Stroke emergency admissions	110.5	104.2	199.6		67.1
14	Primary angioplasty call median time	100.0	112.0	652.0		0.0
15	Stroke patients discharged home (%)	84.4	78.5	56.7		97.5
16	CHD expenditure per pop	27.5	41.1	7.2		111.9
17	Cerebrovascular expenditure per pop	19.5	21.5	9.9		50.6
18	Statins cost in CHD population*	175	219	362		144

Key:

CVD – Cardiovascular Disease
AMI – Acute Myocardial Infarction
Abs – Absolute
Rel – Relative
Obs/Exp – Observed/Expected ratio
CHD – Coronary Heart Disease
Pop – Population

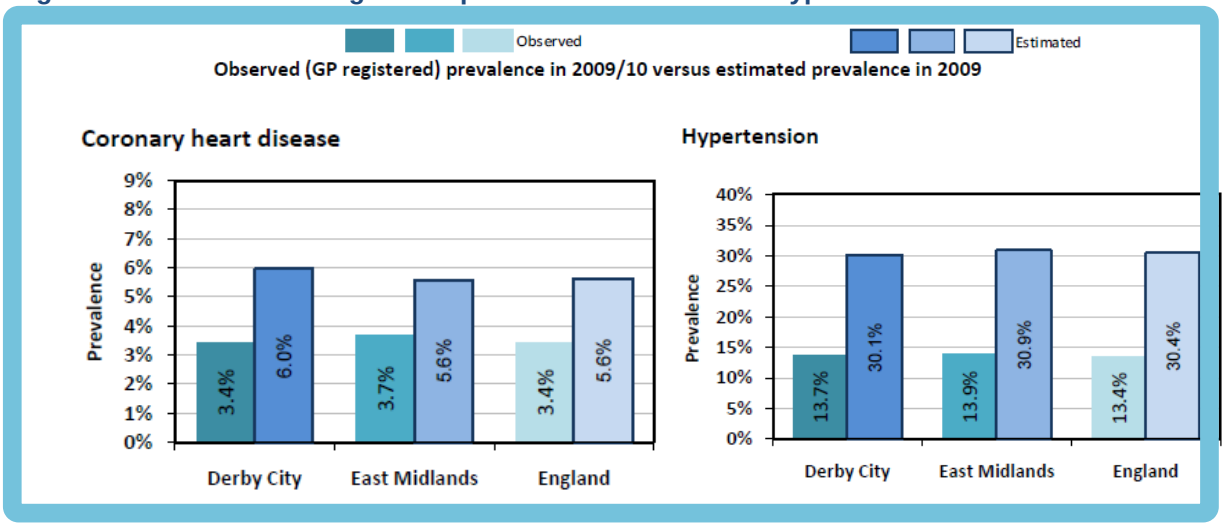
9.6.2.1 Prevalence

GP practices maintain registers of patients diagnosed with certain medical conditions including coronary heart disease or stroke. Estimated prevalence takes into account the population structure and the known incidence in various sub groups of the population. The observed prevalence for CHD in Derby is 57.7% of the estimated prevalence. This compares to 61.2% for England and 65.8% for East Midlands.

In this instance, the expected prevalence is the proportion of the population expected to have CHD based on the population demographics – predominantly the age/sex and ethnic structure (derived from national studies). The observed figure is the proportion of the population that has actually been diagnosed as having CHD. On this basis, 42.3% of Derby City's CHD population is still to be diagnosed.

The observed prevalence for hypertension in Derby is 45.6% of the estimated prevalence. This compares to 43.9% for England and 44.9% for East Midlands. The gap between recognised and treated hypertension and actual hypertension levels in the community has been long recognised – though as stated above, this relates only to patients diagnosed and placed on the practice register. See Figure 43.

Figure 43: Observed GP registered prevalence for CHD and Hypertension[26]



The Quality and Outcomes Framework (QOF) performance is for coronary heart disease and hypertension is shown in Figure 44.

Figure 44: Quality and Outcomes Framework performance for CHD and Hypertension[26]

2009/10 Significantly lower than England | The same as England | Significantly higher than England

Coronary heart disease

	Derby City	East Midlands	England
% newly diagnosed angina patients referred for exercise testing or assessment	93.5	94.3	94.7
% CHD patients with record of blood pressure in last 15 months	98.4	97.9	97.7
% CHD patients in whom last blood pressure reading was 150/90 or less	90.2	90.3	89.8
% CHD patients with a record of total cholesterol in last 15 months	93.5	94.0	93.7
% CHD patients in whom last cholesterol measurement was 5mmol/l or less	84.6	83.1	82.1
% CHD patients taking aspirin, an alternative anti-platelet therapy or an anti-coagulant in last 15 months	92.9	93.5	93.9
% CHD patients currently treated with beta blocker	75.1	75.0	73.7
% patients with history of myocardial infarction currently treated with ACE inhibitor or angiotensin II antagonist	87.0	88.7	89.1
% CHD patients immunised against influenza in Sept-March 05	92.6	92.0	91.9

Hypertension

% hypertension patients with record of blood pressure in last 9 months	92.2	91.8	91.5
% hypertension patients (with record in last 9 months) in whom last blood pressure was 150/90 or less	79.6	79.5	78.7

Source: Quality and Outcomes Framework 2009/10

The QOF indicators show that there are three areas where Derby is significantly worse than the England average. These are:

- % newly diagnosed angina patients referred to exercise testing or assessment
- % CHD patients taking aspirin, an alternative anti-platelet therapy or an anti-coagulant in the last 15 months
- % patients with a history of myocardial infarction currently treated with an ACE inhibitor or angiotensin II antagonist.

There are four indicators where Derby is significantly better than the England average. These are:

- % CHD patients with a record of BP in the last 15 months.
- % CHD patients in whom last cholesterol measurement was 5 mmol/l or less.
- % CHD patients currently treated with a Beta Blocker
- % CHD patients immunised against influenza in Sept – March 05.

Derby is significantly better than England for both hypertension indicators. These indicators reflect the Derby average and will vary between practices.

9.6.2.2 Admissions

In 2009/10 the emergency admission rate for CHD, all persons, in Derby was 214.8 per 100,000 (675 admissions). This is higher than England (205.3 per 100,000) and higher than East Midlands (201.9 per 100,000). Male CHD emergency admission rates are significantly higher than female CHD emergency admission rates. The emergency admission rate for CHD in Derby City has decreased by 33.6% between 2003/04 and 2009/10. In England it has decreased by 24.2% and in East Midlands it has decreased by 27.5%.

The emergency admission rate for CHD in 2009/10 for persons who live in the most deprived areas of Derby City was 307.6. This is more than two (2.2) times greater than the emergency admission rates for persons who live in the least deprived areas of the city (149.3). The absolute gap in CHD emergency admission rates between the most and least deprived areas in Derby City was 158.4 in 2009/10. This has decreased from 332.5 since 2003/04. In England the gap in the emergency admission rate has decreased by 22.2% and in East Midlands by 39.4%.

9.6.2.3 CHD Summary

- Emergency admissions for CHD have decreased by 33.6% between 2003/04 and 2009/10
- Mortality rates for CVD are significantly higher than England but are decreasing
- Deprivation has a significant impact on CVD mortality rates with the absolute and relative gaps between the most and least deprived areas showing an increase.

9.7 Stroke

9.7.1 National Context

Stroke is a major cause of death both nationally and in Derby City; it is and is the leading cause of severe disability. It is estimated that in the UK, 150,000 people will have a stroke each year.

Stroke has a major impact on people's lives. It starts as an acute medical emergency which has diagnostic implications, presents complex care needs (which may result in long-term disability) and can lead to admission for long-term care. The majority of people who have a stroke are aged over 65 but it can occur at any age, even in childhood. Stroke is recognised as a preventable and treatable condition.

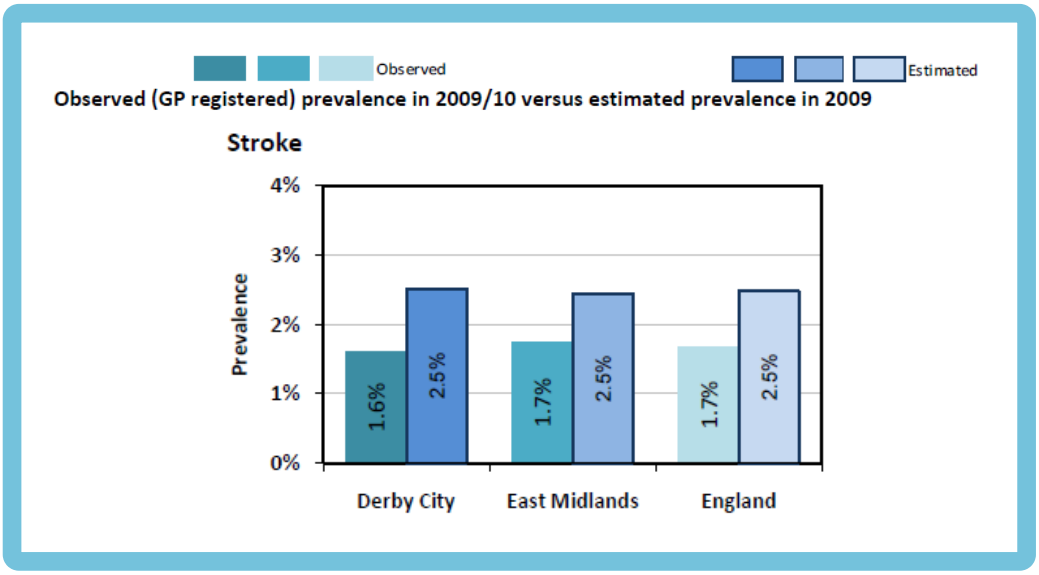
Transient Ischaemic Attacks (TIAs) sometimes described as mini-strokes, present with the same symptoms and signs as stroke. The symptoms last from a few minutes to a few hours and resolve within 24 hours. Having a TIA increases the subsequent chances of a stroke, and so requires urgent investigation and treatment.

9.7.2 Local Context

9.7.2.1 Prevalence

The observed prevalence for stroke in Derby City is 63.9% of the estimated prevalence. This compares to 67.9% for England and 71.0% for East Midlands, and means that in Derby, over 36% of individuals expected to have had a stroke in the population have not, or have not been registered with their GP as having had a stroke. See Figure 45.

Figure 45: Observed GP registered prevalence for stroke[26]



9.7.2.2 Quality and Outcomes Framework Indicators

In the SEPHO the Quality and Outcomes Framework performance is given for stroke. This is shown in Figure 46

Figure 46: Quality and Outcomes Framework performance for stroke[26]

2009/10 Significantly lower than England | The same as England | Significantly higher than England

Stroke

	Derby City	East Midlands	England
% stroke patients with a record of blood pressure in last 15 months	97.0	96.8	96.8
% stroke patients whose blood pressure was 150/90 or less	88.0	88.3	88.1
% stroke patients with record of cholesterol in last 15 months	89.7	91.5	91.4
% stroke patients whose cholesterol was 5mmol/l or less	80.0	78.6	77.3
% stroke patients immunised preceding Sept-March	89.2	89.0	89.0
% non-haemorrhagic/with history of TIA stroke patients taking anti-platelet agent/anti coagulant	93.9	94.0	94.1
% new patients with a stroke referred for further investigation	95.0	90.6	90.2

Source: Quality and Outcomes Framework 2009/10

These QOF indicators show that Derby is significantly worse than England for:

- % Stroke patients with record of cholesterol in last 15 months.

Derby was significantly better than England for:

- % Stroke patients whose cholesterol was 5 mmol/l or less
- % new patients with a stroke referred for further investigation.

In 2009/10 the emergency admission rate for stroke, all persons, in Derby was 110.5 per 100,000 (378 admissions). This is higher than England (104.2 per 100,000) and higher than East Midlands (101.2 per 100,000). Male stroke emergency admission rates are significantly higher than female stroke emergency admission rates[26].

The emergency admission rate for stroke in 2009/10 for persons who live in the most deprived areas of Derby City was 150.2. This is 1.7 times greater than the emergency admission rates for persons who live in the least deprived areas of Derby City (86.6). The emergency admission rate for stroke in the city has increased by 1.9% between 2003/04 and 2009/10. In England it has decreased by 4.8% and in East Midlands it has decreased by 10.4%.

The absolute gap in stroke emergency admission rates between the most and least deprived areas in Derby City was 63.6 in 2009/10. This has decreased from 77.5 since 2003/04. In

England the gap in the emergency admission rates has decreased by 23.2% and in East Midlands it has decreased by 11.3%.

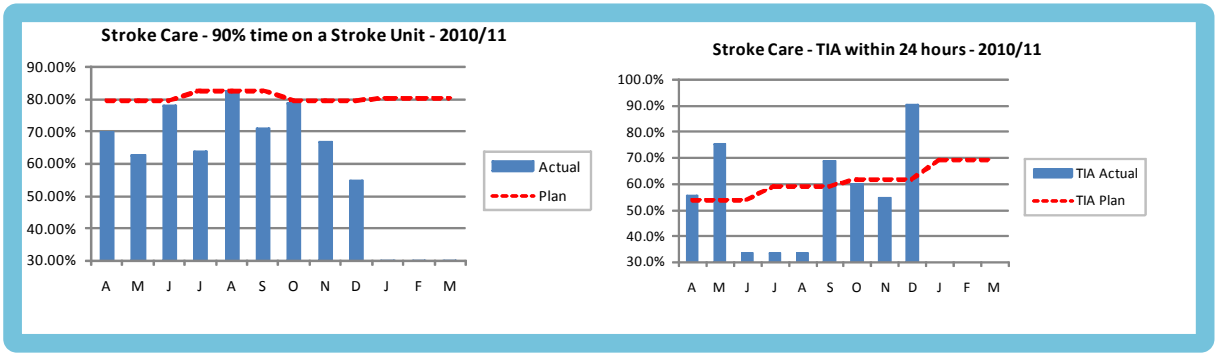
The proportion of patients under the age of 75 discharged from hospital following a stroketo their home or usual place of residence in Derby City is 84.4%, which is higher than East Midlands (74.6%) and England (78.5%). 67.6% of patients aged 75 or over are discharged to home, which is higher than East Midlands (66.5%) but lower than England (72.7%).

The 30 day stroke case fatality rate (the rate of mortality within thirty days of having a stroke) for Derby City is 199.6, which is lower than England (211.5).The rate of re-admissions within 30 days for Derby City is 4.3%, this is higher than England and East Midlands (4.2% and 3.7% respectively).

The Proportion of CT/MRI scans performed within 24 hours for stroke patients is 97.1% in Derby City; this is higher than East Midlands and England (89.3% and 87.8% respectively).

From the NHSDerby City Health & Commissioning Outcomes Report: VSA14Stroke Care: Percentage of stroke patients spending at least 90% of their time on a stroke unit / Percentage of higher risk TIA cases treated within 24 hours. See Figure 47.

Figure 47: NHS Derby City Health & Commissioning Outcomes Report



90% time on a stroke unit: December result was 55% and below trajectory with the cumulative position at 69.8%. Based on the latest benchmarking data (2009/10) made available from the Department of Health, Derby City PCT's performance is shown to be well above the national average.

9.7.3 What are we doing now?

- A local pathway of care for acute, rehabilitation and support services has been agreed and being developed
- The Stroke Commissioning Group has developed a service specification for a single stroke rehabilitation pathway
- The stroke co-ordination and support service is in place and the trial period of Early Supported Discharge began in February 2011. Joint discharge processes are being developed to ensure seamless transfer of care and closer working.

9.8 Communication Disorders

There is limited understanding of the needs of people with acquired communication disorders in Derby. The most frequent cause of communication disorders is stroke. Over 300 people survive strokes in Derby each year. The estimated prevalence of stroke in the city is 4393 of whom at least one-third will experience some degree of acquired communication disability with either language or speech impairment. A smaller number of other people also have impaired communication ability as a result of traumatic head injury, tumour or other, usually neurological, condition. Affected people may be unable to produce physical speech or understand or express spoken or written language.

Table 30: Description of Types of Communication Disorders

Condition	Description
Aphasia	People with aphasia (sometime known as dysphasia) have damage in the areas of the brain that are used to process language. They have difficulty either using and/or understanding spoken and written language. This may result in slow word finding skills; repetitive use of a single or small number of words; use of speech that does not make sense to the listener. The affected person may not be able to read, write or understand symbols. People who have aphasia may seem to have poor general understanding, but unless another problem is present that is not the case, it is the ability to use and understand language that is affected
Dysarthria	Dysarthria occurs when the muscles that are used to shape and produce words and sounds are affected. Verbal communication may be distorted, slow or slurred. The person may sound drunk.
Dysphonia	If the muscles that move the vocal chords or control air flow over them are affected by stroke or another condition this can affect the production of sound. The person may find it difficult to control and moderate the voice which can sound tight, broken, or whispery.
Dyspraxia	People who have this condition have difficulty co-ordinating the movements and actions that create speech. They may not be able to string syllables and sounds together to form coherent words. Speed, rhythm, cadence and inflection may also be affected.

Affected people may be isolated by their communication disorder because service operators and providers of information do not have the necessary skills or knowledge to provide the necessary information formats. It may be hard for them to understand information about health, educational, welfare, advisory, leisure and social services. Difficulties may be faced gaining information about their specific communication problem. It is very hard for people to be understood by strangers or even by their own family and friends. This can reduce access to services, benefits, culture leisure and activities.

9.8.1 What are we doing now?

The Derbyshire Speech and Language Therapy Service provides services to adults across Derbyshire with about twenty therapists working in the acute hospitals, in community hospitals, in mental health settings, in people's homes and in other community locations.

Following an initial assessment for people with acquired communication difficulties it may be appropriate to offer therapy, to provide advice only or to help carers support someone experiencing communication difficulties. If therapy is needed, the aim of the therapy will be discussed between the therapist and patient and will be to an agreed timescale.

The Stroke Association provides a communication support service in Derby that is funded by Derby City Primary Care Trust. The service aims to help people to cope with aphasia and difficulty using language after stroke. It offers communication related activities in a group or one-to-one setting. Trained volunteers work with affected people to help them build upon skills and develop confidence, supporting better recovery.

9.9 Health Check Programme

The NHS Health Check is a national programme that aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. Implementation of the programme will be phased and the full implementation is expected by 2012/13.

The Health Checks Plus programme links into a number of high-level priorities in primary care. In general practice, the registration and ongoing management of new patients with vascular disease will contribute to current Quality and Outcomes Framework (QOF) indicator. These indicators cover the clinical domains of Diabetes Mellitus (DM), CKD, Stroke and Transient Ischemic Attack (TIA), CHD, Hypertension, Obesity, Smoking and Cardio-Vascular Disease (CVD) – Primary Prevention. The identification of smokers will also generate activity for the practice's stop smoking Local Enhanced Service (LES).

This programme also links in with the Cancer Reform Strategy with specific reference to raising the public awareness of the signs and symptoms of breast and colorectal cancer.

10 CHILD HEALTH & WELLBEING IN DERBY

Key Findings:

ChiMat data shows there are two measures where Derby performs comparatively better than England and its comparable 'Family':

- Percentage participating in at least three hours of sport
- GCSE pass rate (5A*-C) – overall and males.

There are five measures where Derby performs comparatively poorer than England and its comparable 'Family':

- Infant mortality rate*
- MMR immunisation by age two
- Hospital admissions due to substance misuse age 15-24
- First time entrants to Youth Justice System
- Rate of family homelessness.

*Note: one of these, the infant mortality figure is considered to potentially be an anomaly as this has always previously been at similar level.

Child protection 09/10 shows an increase in the number of children on child protection plans when compared to 08/09. Derby is performing worse than the national average where children ceased to be a subject of a child plan that lasted two years or more. At the beginning of 2011, 457 children were in care with 70% in fostering placements.

Implications:

Early intervention including universal and targeted prevention is key to addressing many of the outcomes for children and young people[70][131], it is more cost effective and is more likely to achieve the best outcomes.

There are stark inequalities in the outcomes for children and young people across the city. Health inequalities are complex and often deep rooted and so can only be tackled through a multi-agency strategic response

Gaps and next steps:

There are some key information gaps in this current document which will be developed for the 2012 JSNA:

- Further demographic data on our most vulnerable children and young people – including disabled C&YP, young offenders, children in care, children not in full time education, home schooled/ educated and those not in full time education or training.
- Maternity data including smoking in pregnancy and breast feeding.
- Children's perception data
- Education data including key stage achievement.

10.1 Introduction

10.1.1 National Context

UNICEF produce a summary report card to assess wellbeing across the 24 OECD countries. In the last report, 2010, the UK ranked 19 lowest out of 24 for material wellbeing, 13th out of 24 for educational wellbeing and 11th out of 24 for health wellbeing[69]. Overall the UK has a comparatively high level of inequality for overall wellbeing amongst the developed countries.

National data demonstrates that 19% of 10-11 year olds are obese, teenage pregnancy rates are comparatively high although reducing, only half of children are working securely at foundation stage of education and although 75% achieve 5 A-C grades at GCSE, this is only 26% for children in care.

There is a growing evidence base that children need the best start in life to achieve their potential. Marmot describes how a child's early years, including during pregnancy, has long term effects on their physical and mental health, plus their ability to achieve in education and employment. Graham Allen in his review of early intervention[70] also emphasised the importance of investment in the early years, from pregnancy and through to school, to reduce inequalities in child development. The experience in our early years is strongly related to, and perpetuates, inequalities in the outcomes for children and young people in our society.

10.1.2 Local Context

Derby has a higher percentage of children and young people aged four years or less than the average for the East Midlands and England. This indicates a potential increase in need for services for this age group[53].

10.1.2.1 Latest Child Health Profiles/Data Release

The Child and Maternal Health Observatory (ChiMat) is a national public health observatory established to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health. ChiMat has published Child Health Profiles for each top tier local authority in England. These provide a snapshot of child health and wellbeing in February 2011[71] – although it should be noted that each measure does not necessarily cover the same time period and some data is several years old (See Appendix 7, for a full list of data sources used).

This metadata used includes the definitions and sources of the data presented in the Local Authority Child Health Profiles. The data for each indicator in the Child Health Profiles is available in the ChiMat Data Atlas. The Data Selector allows the data to be viewed as data as maps, charts or tables, or it can be downloaded as an Excel file. The following link accesses this data: http://www.chimat.org.uk/profiles/metadata.

The data for Derby Unitary Authorities has been compared against England, the East Midlands (Nottingham and Leicester), and Derby's 'Family' (see 'comparison of data' section for further explanation) to identify the areas of good performance and potential improvement. There are 32 indicators used for each Metropolitan District (MD) or Unitary Authority (UA). The majority of the indicators are the same for each MD and UA but some do vary.

10.1.2.1.1 Comparison of Data

The data, from the ChiMat outputs, for Derby UA has been taken and compared against England and Derby's 'Family' to identify the areas of good performance and potential improvement in Derby Each UA or MD has what are classed as 'nearest neighbours' or 'Family'. The Family groups are based on a wide range of socio-economic indicators [56]. The Family group, classed as the nearest to Derby UA is:

- Bolton MD
- Calderdale MD
- Coventry MD
- Darlington UA
- Doncaster MD
- Dudley MD
- Kirklees MD
- Peterborough UA
- Rotherham MD
- St. Helens MD
- Stockton-On-Tees UA
- Stoke-on-Trent UA
- Swindon UA
- Walsall MD
- Wolverhampton MD

The Derby data has been compared directly against the England average. Comparison to a 'Family' group is not reported in ChiMat; however, this has been collated for this report. It is provided for information and is not significance tested. The data for the two other main cities in the East Midlands, Leicester and Nottingham, have also been included for comparative purposes. These family group comparisons are useful as they provide a more accurate and realistic benchmark of what we could expect our performance in these key areas to be. We expect to see a variation in our performance when we compare across a number of indicators and this is particularly useful in helping us to prioritise which areas we need to focus upon over the coming months and years.

10.1.2.1.2 Child Health in Derby

Eleven areas have been identified by the ChiMat data as significantly worse than the England average. These areas have been compared to existing data for these indicators: the Derby Health profile that was released 2010 and the data in the Derby Health Schools Report 2009 (see Appendix 7) to validate the figures and to show whether Derby has improved/deteriorated over time. The data sources for each area may be different and therefore not be fully comparable but are indicative.

Three areas are considered significantly better than the England average. Thirteen areas are considered to be not significantly different to England. Four areas were not significance tested.Collated information can be seen in a single table in Appendix 7 but here they have been split in to the five sets of indicator data used in the ChiMat datasets for ease of analysis: Health; Safety; Achievement; Social Contribution and Economic Wellbeing.

Table 31: Colour key for the indicators

Derby vs. England	
Significantly worse than England (red indicator)	
Significantly better than England (green indicator)	
Not significantly different (amber indicator)	
Significantly not tested (white indicator).	

Derby vs. 'Family'	
Worse than Family (red indicator)	
Better than Family (green indicator)	
Data for both is very similar (amber indicator)	

The 'significantly worse' figures for Derby have also been compared to the previous published data as shown in Appendix 7.It should be noted that for all the following categories that even if a section is 'green' there may still be issues that require addressing.

10.1.2.1.3 Health

Table 32shows the comparison data for this area. This shows:

- Participation in at least 3 hours of sport in Derby is comparatively good against our family and against the England average
- Infant mortality rate appears comparatively poor (this is inconsistent with previous figures and may be an anomaly).

Table 32: Health ChiMat comparison data for Derby, Family and England

Measure: Health	Derby Performance against national	Derby Performance against 'family'	Derby	Leicester	Nottingham	'Family'	England
Infant mortality rate (Per 1,000)			7.4	7.3	6.2	5.8	4.7
Child mortality rate age 1-17 (Per 100,000)			16.2	19.9	23.7	18.4	16.9
Breastfeeding initiation (%)			72.3	75.2	73.8	65.8	74.6
Obese children age 4-5 (%)			10.3	11.4	11.3	10.2	9.83
Obese children age 10-11 (%)			19.4	21.9	21.9	20.3	18.7
Participation in at least 3 hours of sport (%)			56.6	38.3	47.9	48.6	49.6
Decayed, missing or filled teeth age 5 (Average per child)			1.5	2.2	1.7	1.4	1.1
Children who have someone to talk to (%)			63	65	56	61.3	64
Teenage conception rate age <18 (Per 1,000)			50.9	52.9	68.3	52.7	40.9
Under 18 conceptions ending in abortion (%)			36.5	40.1	37.1	45	49.7

Derby vs. England: Three indicators – infant mortality rate, decayed/missing teeth and teenage conception rate are significantly worse than England. Appendix 1, Table 7 shows that the infant mortality rate from 05/07 and 06/08 was on par with the rest of the East Midlands and England. The data from 05/06 for tooth decay in children shows Derby was lower than the England average, this is potentially worsening in Derby. The teenage conception rate (age <18 years) has gradually improved since 05/06.

Derby vs. Family: Derby is comparatively better in seven categories; comparable in two and comparatively worse in terms of infant mortality rate.

10.1.2.1.4 Safety

Table 33shows the comparison data for this area. This shows:

- MMR immunisation by age two appears comparatively poor in Derby
- For this category Derby does not perform notably better than the England or Family average on any of the measures.

Table 33: Safety ChiMat comparison data for Derby, Family and England

Measure: Safety	Derby Performance against national	Derby Performance against 'family'	Derby	Leicester	Nottingham	'Family'	England
Pupils who say that they have been bullied (%)			23	19	24	23.8	23
Hospital admission rate due to injury age<18 (Per 100,000)			1694	1844	1616	1613	1444
MMR Immunisation by age 2 (%)			86.3	90.1	82.2	90.2	88.2
Children in care immunisations (%)			87	91	85	87.3	83.9
Change in children killed/seriously injured in RTA (%)			11.5	-16.7	15.3	5.4	6.4

Derby vs. England: The hospital admission rate due to injury (age <18 years) has increasedsignificantly and is more than 200 per 100,000 populations higher than the England average. The yearly target for MMR immunisation is 95%; however, none of the PCT's in England has reached this target. Derby has increased from 81% to 86% in one year.

Derby vs. Family: The % of MMR immunisation by age two is comparatively worse than the family average. The RTA indicator was not measured in the Derby vs. England data; however, when it was compared against the family data it has a higher rate of change.

10.1.2.1.5 Achievement

Table 34shows the comparison data for this area. This shows:

- Derby performs comparatively better than both England and Family group in terms of GCSE pass rate (with the exception of 'females' where this is a comparable level)
- Derby's percentage of children working securely at foundation stage is lower than both England and Family comparison.

Table 34: Achievement ChiMat comparison data for Derby, Family and England

Measure: Achievement	Derby Performance against national	Derby Performance against 'family'	Derby	Leicester	Nottingham	'Family'	England
Primary school exclusions (%)			0.0	-	0.03	0.009	0.02
Secondary school exclusions (%)			0.23	-	0.27	0.17	0.17
Children working securely at foundation stage (%)			44	41	52	49.3	51
GCSE pass rate (5A*-C)(%)			76.5	71.5	71.4	76.8	74.8
GCSE pass rate (5A-C*) Male (%)			74.3	64.9	67	62.7	70.8
GCSE pass rate (5A-C*) Female (%)			78.8	78.4	75.7	69.5	79
GSCE pass rate (5A*-C) for children in care (%)			-	-	17	-	26.1
Derby vs. England: Derby is either better (notably GCSE pass rate) or not significantly different in any of these measures. **Derby vs. Family**: Children working securely at foundation stage is comparatively low compared to the Family average.							

10.1.2.1.6 Social Contribution

Table 35shows the comparison data for this area. This shows:

- Performance across 'social contribution' is mixed
- Derby has a comparatively high rate of hospital admissions due to substance misuse (age 15-24) in relation to both National and Family average
- Derby has a comparatively high rate of first time entrants to the Youth Justice System in relation to both National and Family average.

Table 35: Social contribution ChiMat comparison data for Derby, Family and England

Measure: Social Contribution	Derby Performance against national	Derby Performance against 'family'	Derby	Leicester	Nottingham	'Family'	England
Hospital admissions due to alcohol specific conditions < 18 (Per 100,000)			69.8	66.9	44.9	81.6	64.5
Hospital admissions due to substance misuse age 15-24 (Per 100,000)			85.9	87.1	40.2	84.6	62.75
Children and young people using drugs (%)			4	3	6	3.5	4
Children and young people using alcohol (%)			16	7	13	14	15
First time entrants to Youth Justice System (Per 100,000)			2100	1340	2010	1527	1472
Reoffending rates (%)			0.8	1.2	1	0.9	1.1
Participation in positive activities (%)			61.7	56.6	61.2	60.3	65.8
Not in education, employment or training age 16-18 years (%)			7.1	7.6	5.4	8	6.4

Derby vs. England: Derby rates are significantly worse than the national average in the measures: substance misuse hospital rate; first time entrants to the Youth Justice System and has seen a jump of more than 300 per 100,000 populations in one year. It is over 700 per 100,000 populations more than the England average; percentage participation in positive activities; 'Not in education etc.' ishigher than the England average but it has dropped since 2007 from 7.4.

Derby vs. Family: Derby performs better than the Family group in: hospital admissions due to alcohol specific conditions <18; participation in positive activities; proportion not in education, employment or training age 16-18 and worse in hospital admissions due to substance misuse; children and young people using alcohol and first time entrants to the Youth Justice System (over 500 per 100,000 populations higher than the 'Family').

10.1.2.1.7 Economic Wellbeing

Table 36shows the comparison data for this area. This shows:

- Derby performs comparatively poorly in relation to the rate of family homelessness in relation to the England and Family averages
- Derby has a significantly higher percentage of children living in poverty age <16 than the national average and slightly higher than the Family average.

Table 36: Economic Wellbeing ChiMat comparison data for Derby, Family and England

Measure: Economic Wellbeing	Derby Performance against national	Derby Performance against 'family'	Derby	Leicester	Nottingham	'Family'	England
Rate of family homelessness (Per 1,000)			3.7	1.6	5.2	2.1	1.91
Children living in poverty age < 16 (%)			25.1	34.1	37.3	24.3	21.6

Derby vs. England: The rate of family homelessness is significantly high in comparison to the England average. Even though 'children in poverty' is significantly higher than the England average, it has reduced since 2007 by over 2%.

Derby vs. Family: The rate of family homelessness is high in comparison to the Family average.

Note: eight out of the 17 (47%) Derby census wards are measured as being part of the most deprived areas in the country (JSNA 2009/PNA 2011). This clearly has implications for these measures.

10.2 Children and Mental Health Services (CAMHS)

A Mental Health and Psychological Wellbeing Needs Assessment for the City of Derby was completed in September 2009. From this, a number of conclusions can be drawn about the mental health needs of the children and young people in the city.

10.2.1 Expected Prevalence of mental disorders

The way expected prevalence has been estimated is to take the known rates of mental disorder for the whole population and apply them to Derby City, using the average prevalence rates for mental disorders in children and young people, first reported by Meltzer et al for the Department of Health and updated in 2004[(71)]. It is important to note that the prevalence rates estimated here are for mental disorders – that is diagnosable conditions. There are of course a much larger number of children and young people who have mental health or psychological problems, which may be less clearly defined.

The estimated number of children in Derby City 'with some type of mental disorder' is 3,630. Of these the majority are diagnosed with conduct or emotional disorders, plus smaller numbers with hyperactivity and other less common disorders.

We know that diagnosed mental disorders are more common in boys that girls (5:3) and that rates are higher for both sexes aged over 11 compared with the younger age group. Local data is required to increase our understanding of this area.

10.3 Child Protection

During 2010 there were around 3,450 referrals relating to safeguarding and family support made to the city's Children's and Young People Directorate. This equates to 649 children per 10,000 population which is above the national average. Derby's re-referral rate is 21% of referrals occurring within 12 months of a previous referral which is an increase from 17% in the previous year. The contacts made to children's social services last year were predominately from the Police (22%), Schools and other Educational Organisations (15%), Primary and Secondary Health settings (12%) and family or relatives (11%). Table 37shows the primary reason for the referrals:

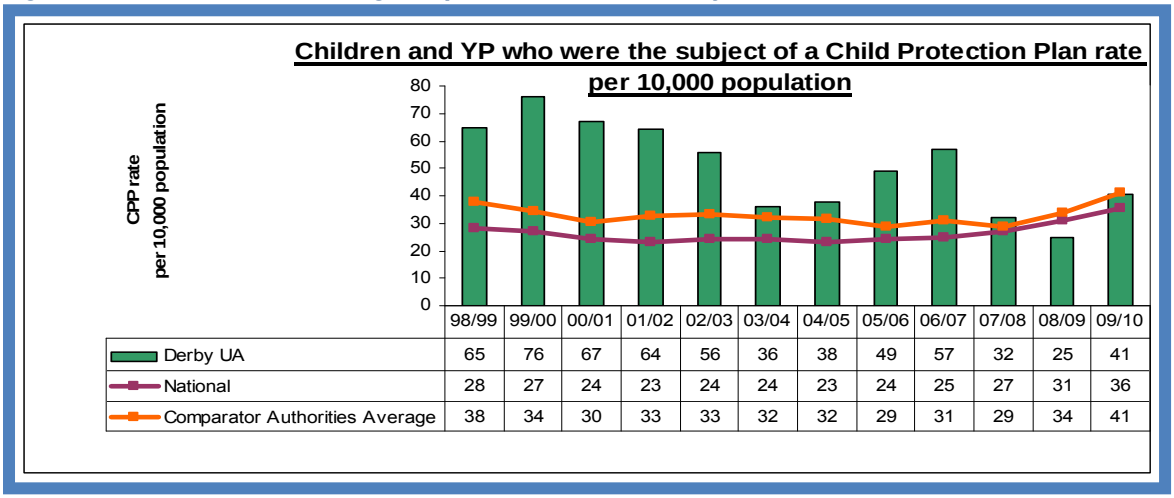
Table 37: Primary reason for referral in Derby during 2010

Referral Reason	%	Referral Reason	%
CN1 Physical Abuse	18.8%	CN3 Parenting Problems	2.3%
CN1 Domestic Violence	16.9%	CN4 Homelessness	2.1%
CN1 Neglect	16.1%	CN1 Children who abuse others	1.4%
CN1 Sexual Abuse	10.0%	CN2 Mental Health	1.0%
CN2 Emotional/Behavioural Difficulties	8.0%	CN5 Behavioural Management	0.9%
CN1 Emotional Abuse	4.4%	CN7 Low Income	0.7%
CN1 Schedule 1 Offender	4.2%	CN4 Financial / Sect 17	0.6%
CN3 Parents Abusing Alcohol/Drugs	2.9%	CN4 Welfare Rights	0.5%
CN3 Parent with Mental Ill Health	2.8%	Others	6.0%

Source Swift April 2011

The number of children in Derby subject to a child protection plan at 31 March 2010 was 217 which equates to 40 per 10,000 population. This is an increase from 2008/09 which was 25 per 10,000 population.There are a number of national indicators relating to child with protection plans and it is important that they are looked at collectively. NI 65 measures those children who become subject to a child protection plan for a second or subsequent time and Derby performs better than the national averages at 11.3%, Derby also performs well against the review timescales for child protection plans with 100% completed on time.

Figure 48: Children and Young People who were the subject of a Child Protection Plan



	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10
Derby UA	65	76	67	64	56	36	38	49	57	32	25	41
National	28	27	24	23	24	24	23	24	25	27	31	36
Comparator Authorities Average	38	34	30	33	33	32	32	29	31	29	34	41

Source: DfE First Statistical Release – Children Looked After in England Oct 10

An area where performance is slightly worse than the national average relates to NI 64 which measures the proportion of children who ceased to be subject of a CP plan that lasted two years or more. Derby's figure for 2009/10 was 7% with the national average being just 6%. The indicator is being monitored closely and improvements are being seen during 2010/11.

During 2009/10, 265 children required a new child protection plan which is an increase of approximately 100 extra children compared to the previous year. The primary reasons for children requiring child protection plans are shown inTable 38.

Table 38: Primary reason for referral in Derby during 2010

	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple
Derby	26%	16%	10%	48%	0%
Statistical neighbour average	45%	14%	5%	32%	4%
National average	44%	13%	6%	28%	9%

Source: DfE First Statistical Release – Children Looked After in England Oct 10

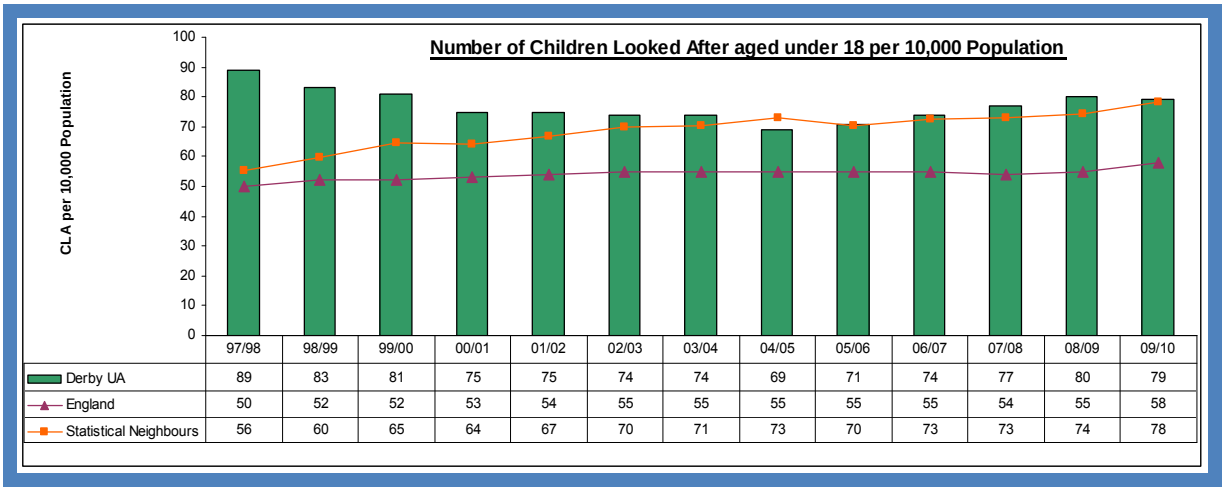
From the table we can see that the percentage of cases with a primary reason stated as neglect is proportionately lower than our statistical neighbours. This may be a real difference, relate to differences in how cases are coded or be due to an under detection of cases with this primary reason.

10.3.1 Children in Care

Children in the care of Local Authorities are one of the most vulnerable groups in society. The majority of children who remain in care are there because they have suffered abuse or neglect. At any one time around 60,000 children are looked after in England, although some 90,000 pass through the care system in any year.

The number of children looked after in Derby at 31st March 2010 was 420 which is a slight decrease from the previous year (Figure 49). However, during 2010/2011 there has been a sharp rise in the numbers with 457 children in care at the beginning of 2011. This is significantly higher than national averages.

Figure 49: Number of Children Looked After aged under 18



	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10
Derby UA	89	83	81	75	75	74	74	69	71	74	77	80	79
England	50	52	52	53	54	55	55	55	55	55	54	55	58
Statistical Neighbours	56	60	65	64	67	70	71	73	70	73	73	74	78

Of the 457 children in care at the beginning of 2011, most (70%) are cared for in foster placements, and of these around three quarters are living with local authority recruited cares.

297 of the children in care live with carers or homes that are situated within the local authority boundary. 160 live outside the boundary with a relatively high number living around north Staffordshire and west Nottinghamshire.

Almost a third of our children have been in care for less than a year, and around a similar proportion have been in care for five years or longer.

10.3.2 Children in Care: Health, Wellbeing and Attainment outcomes

Derby has a similar proportion of children in care offending than national averages. Last year seventeen children aged ten or over were cautioned or convicted which equates to eight percent. The national average was around nine percent.

The completion of Health Assessments is also monitored annually and the latest national figures show that Derby completion rates are 9% lower than national averages. The number of children receiving a dental check during the year is low with only 67% seeing a dentist.

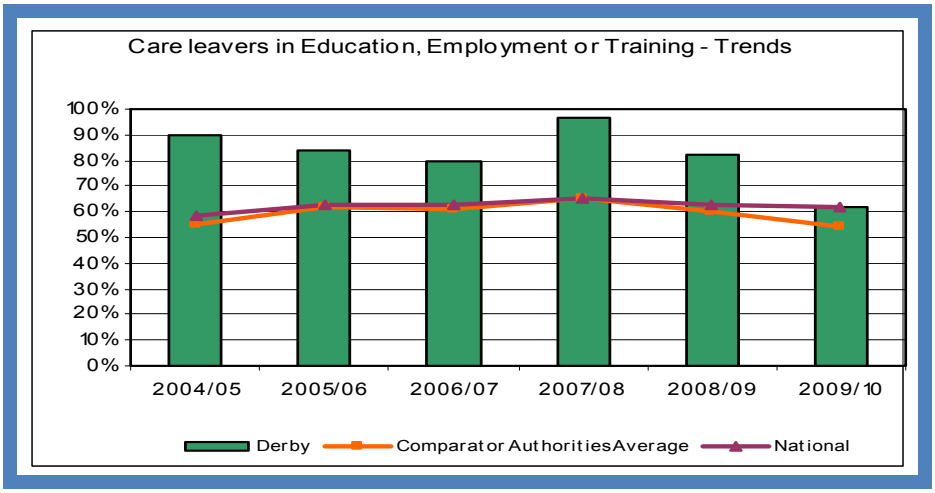
Education figures for children at Key Stage 2 showed that 69% of children were working to their expected level for English and 62% for Maths. However, due to the action taken by some schools not to participate in the KS2 tests last year, results for only thirteen children were returned. The Derby average for children who sat the tests last year was 74% for English and Maths.

Results for children who sat GCSEs last year showed that 30 children achieved 5 A* to C grades. Of these just two achieved the A* to C grade with Maths and English. This equates to 6.7% which compares to the Derby average of 55%.

Most recent figures show that 11% of children in care missed 25 days or more at school. This is an increase on previous years but below national averages. Three children were excluded from school during the same period.

Care leaver outcomes are measured nationally on their 19th birthday where Education, employment & training status is assessed along with the suitability of their accommodation. Derby has generally been able to show good performance against these measures over the last 5 years; however there was a significant fall in the 2009/10 cohort in the number of young people in Employment, Education and Training. (See Figure 50).

Figure 50: Trends of care leavers in Education, Employment or Training



10.3.3 Child Health Summary

10.3.3.1 Overall ChiMat summary

- Eleven areas have been highlighted by the ChiMat data where Derby is considered to be significantly worse than the England average
- Four of these areas have actually improved in Derby from the previous year although still classed as significantly worse (teenage conception rate, MMR immunisation, those not in education or work and children in poverty)
- Four areas have become worse (tooth decay, hospital admission rate due to injury, first time entrants to the Youth Justice System and rate of family homelessness)
- Three are considered significantly worse for the first time (infant mortality, hospital admission rate due to substance misuse and the participation in positive areas)
- Three areas are considered significantly better than the England average (participation in at least 3 hours of sport, GCSE pass rate overall and GCSE pass rate for males)
- Thirteen areas are considered to be not significantly different to England

- Four areas were not significance tested.

10.3.3.2 Comparison to family summary

- Five of the eleven areas, highlighted as significantly worse than the England average are also worse than the Family group (infant mortality; decayed/missing teeth; MMR immunisation; hospital admissions due to substance misuse; first time entrants to Youth Justice System and the rate of family homelessness)
- Three other areas; the percentage change of those killed/seriously injured in RTA; children working securely at foundation stage and children and young people using alcohol were shown to be worse than the family group
- Eleven are comparable
- Twelve areas appear to be better than the family group.

11 WARD-LEVEL ANALYSIS

The following tables provide summaries for each of the seventeen wards and reference population, pharmacy provision, lifestyle and behaviours, overall health, use of the existing services, the key local needs, what you have told us so far and what the local services are. Key health promotion opportunities have been identified for each ward and are stated here.

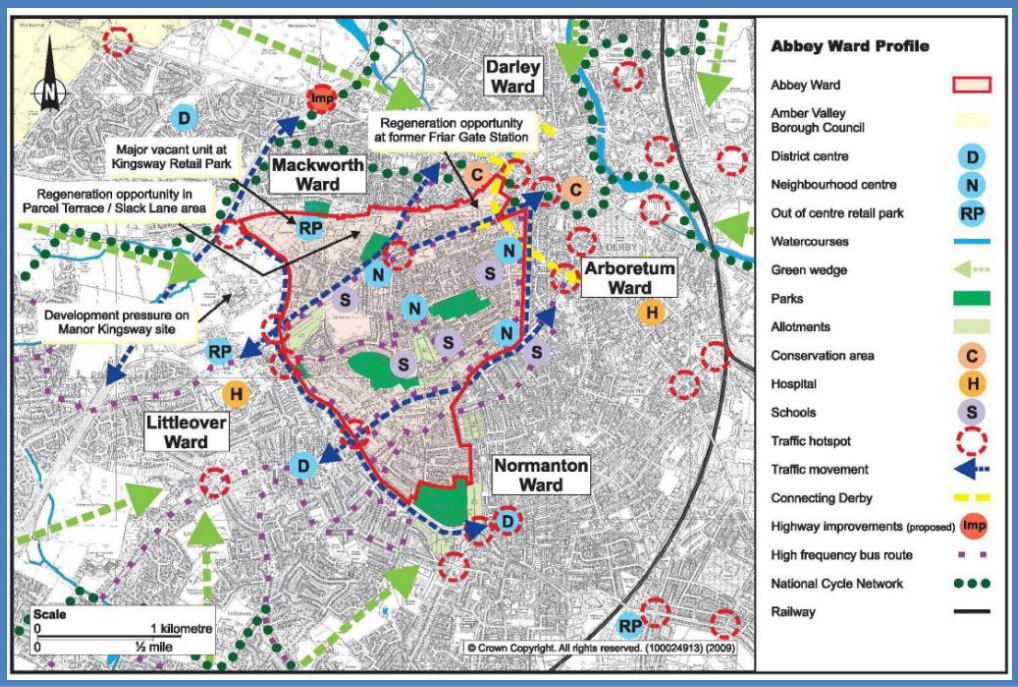
The following information has been obtained from these sources:

1. The JSNA 2009, NHS Derby City and Derby City Council.
2. Derby Population, Migration and Community Profile 2008, Derby Community Safety Partnership.
3. State of the City Report 2010, Derby City Council.
4. NHS Derby City Pharmaceutical Needs Assessment 2011
5. Derby City Council: Your Neighbourhood consultation[5(72)]

[5] The pictures shown in the following 17 tables have been taken directly from the website that has been referenced; click on each ward separately for each picture.

Table 39: Detail for the ward of Abbey

Abbey



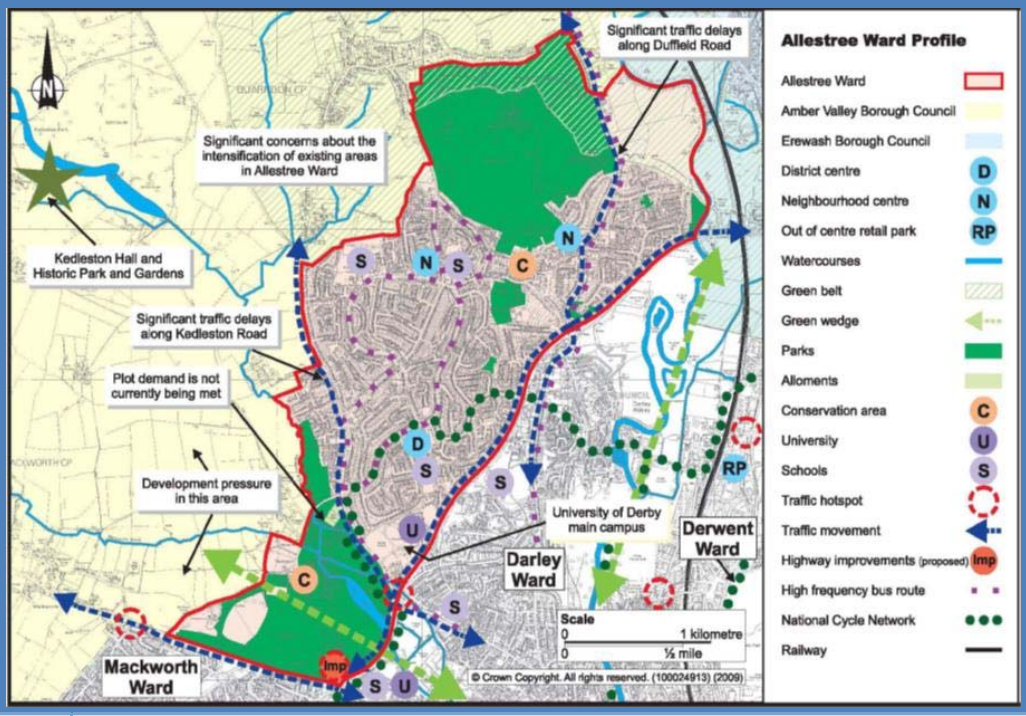
Population	There is an ethnically diverse population with over 10% of the population being Asian/ Asian British (35% non-'White British'). There are over 130 nationalities with new migrants accounting for 8.6% of the population in 2007. 9.5% of the population do not have English as a first language. The 20 to 34 year old group is comparatively large and there is a high student population. There is a high representation of the Christian religion.
Deprivation	Abbey is in the top four most deprived wards in the city. The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide smoking cessation, needle exchange, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	Over £30 per person per month is spent on tobacco. There are high levels of regular and excess drinkers, plus binge drinking. There is a high level of illicit drug use and dealing. There is a low monthly spend on fruit and vegetables. A low percentage of adults who state that their interests include exercise or sports. In 2007/8 the Child Measurement Programme identified a high percentage of obese children. There are also a high proportion of households without central heating or access to a car/van.
Health	There is an above average level of long term limiting illness and a significantly higher all age all-cause mortality than average for the City. The population profile indicates that we would expect to find a high prevalence of Coronary Heart Disease (CHD), Diabetes, Sexually Transmitted Infections (STIs), Tuberculosis (TB) and poor dental health. The occurrence of mental and behavioural disorders is above average.
Use of services	There is a low uptake of Bowel Cancer Screening.
Key local needs	Services appropriate to the diverse population, including access to information in languages other than English. Smoking cessation and substance misuse (including alcohol) services. Health promotion regarding diet and exercise, contraception and sexual health, dental health and the Bowel Cancer Screening programme. Identification, treatment and advice for patients with CHD, Diabetes, STIs and TB.
What you have told us?	Concerns have been raised about the long-term vacancy of Friar Gate Goods Yard and related anti-social behaviour. Disappointment expressed at the failure of plans for the regeneration of the Rowditch area. The significant numbers of vacant and derelict properties are of concern. Overcrowding of properties is noted. Concerns were raised that there were no plans for a library

Services	There are no GP surgeries or branch surgeries.
Education	GCSE achievement at Bemrose School is amongst the lowest in the city.
Economy	Unemployment is above average.

Key health promotion opportunities	
How to use NHS services/ register with a GP Warmfront Healthy Eating Safe drinking Smoking cessation Promotion of physical activity Promoting behaviour change through Christian festivals	Bowel screening promotion Cardiovascular disease, diabetes and TB awareness Dental health promotion Sexual health promotion Information about illegal drugs and how to access services

Table 40: Detail for the ward of Allestree

Allestree

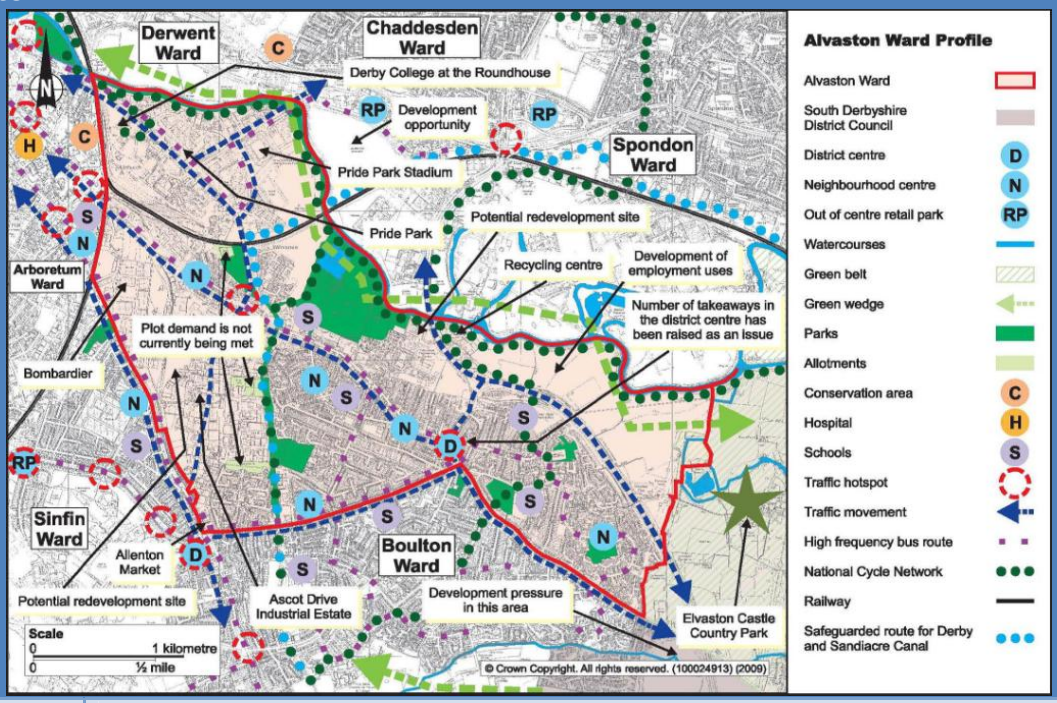


Population	A high percentage of the population are over 65 years of age and there are a high proportion of single person pensioner households. There is a high representation of the Christian religion.
Deprivation	The population are within the 20% least deprived nationally.
Pharmacy Provision	Enhanced services provide smoking cessation, needle exchange, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	Over £30 per person per month is spent on off licence alcohol
Health	There are over 25% excess winter deaths. The population account for the highest number of falls in those over 65 years of age due to the large numbers of older people. There is the highest estimated prevalence of dementia.
Use of services	The population are the highest users of home care and there is a high provision of unpaid care.
Key local needs	Falls prevention through the management of long term conditions, reviews of medication and the provision of information. Health promotion regarding staying warm in winter and safe drinking. Identification, treatment and advice for patients with dementia. Services to support the housebound and their carer's.
What have you told us	Greater emphasis needs to be given to the improvement of public transport. The more successful district centres for example Park farm, support a range of comparison shopping opportunities and by doing so reduce the number of trips required to the city centre. Parking around the University is an issue. The ward lacks some facilities namely a day centre for the elderly and those with dementia. Concerns were raised about potential developments in the area and their impact on flooding issues and the negative impact on schools, local shops and roads. The Neighbourhood Board meeting also supported the principle of re-using brownfield land and protecting greenfield sites. The adverse impact on the character of the area from inappropriate and intensive development in the area was highlighted as an issue.
Services	There are three GP surgeries or branch surgeries.
Education	All of the schools in the area have a surplus of places, most notably Portway Infant.

Employment	There is very little commercial activity within the ward.

Key health promotion opportunities	
Promoting behaviour change through Christian festivals Safe drinking Warmfront/ keeping warm in winter	Falls prevention Dementia awareness Social care information

Table 41: Detail for the ward of Alvaston

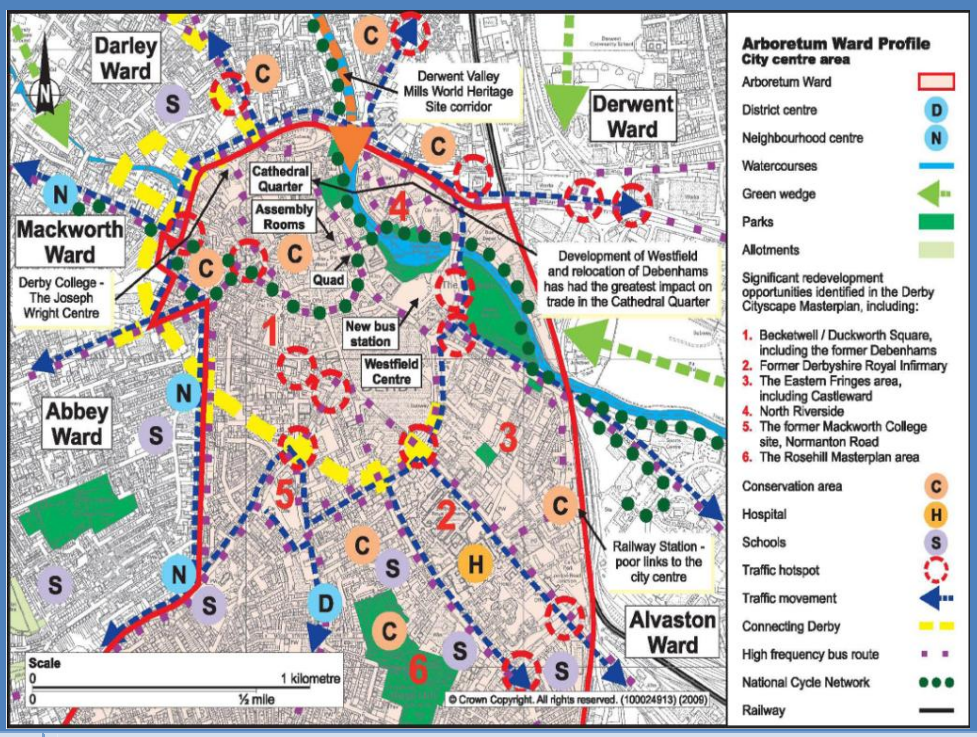
Alvaston	
	
Population	There is an ethnically diverse population with over 100 different nationalities. There is an increasing trend in the birth rate.
Deprivation	Alvaston is the fifth most deprived ward in the city. The population are within the 20% most deprived nationally
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	There are areas of the ward where more than 50% of the population smoke and over £30 per person per month is spent on tobacco. There are high levels of regular and excess drinkers, plus binge drinking. There is a low monthly spend on fruit and vegetables. A low percentage of adults who state that their interests include exercise or sports. In 2007/8 the Child Measurement Programme identified a high percentage of obese children. There are high rates of teenage pregnancy. There are also a high proportion of households without central heating.
Health	The population report an above average level of long term limiting illness. The population profile indicates that we would expect to find a high prevalence of CHD, STIs and poor dental health. There are a high percentage of low birth weight babies.
Use of services	The district centre has a vacancy rate of 15%. The proportion of takeaway units in the district centre has also been raised as an issue.
Key local needs	Services appropriate to the diverse population, including access to information in languages other than English. Smoking cessation and alcohol misuse services, including a focus upon pregnant women. Health promotion regarding diet and exercise, healthy pregnancy, contraception and sexual health, safe drinking and dental health. Identification, treatment and advice for patients who are pregnant, have CHD or an STI.
What have you told us?	Loss of Boulton Moor Green wedge would have negative impacts on the local community. A high proportion of affordable housing in the ward.
Services	There are three GP surgeries or branch surgeries. Contraception and sexual health services through the Coleman Youth clinic and at the Roundhouse for Derby College students. FreshStart smoking cessation at Colman Street. Falls Service at Coleman street.
Education	The proportion of residents with no qualifications is higher than average. The proportion

	achieving higher level qualifications is below average.
Economy	Average household incomes are below average by approximately £3600 and unemployment is above average.

Key health promotion opportunities	
Healthy pregnancy / Healthy start Warmfront Smoking cessation Healthy Eating Safe drinking	Sexual health promotion Cardiovascular disease awareness Dental health promotion Promotion of physical activity

Table 42: Detail for the ward of Arboretum

Arboretum



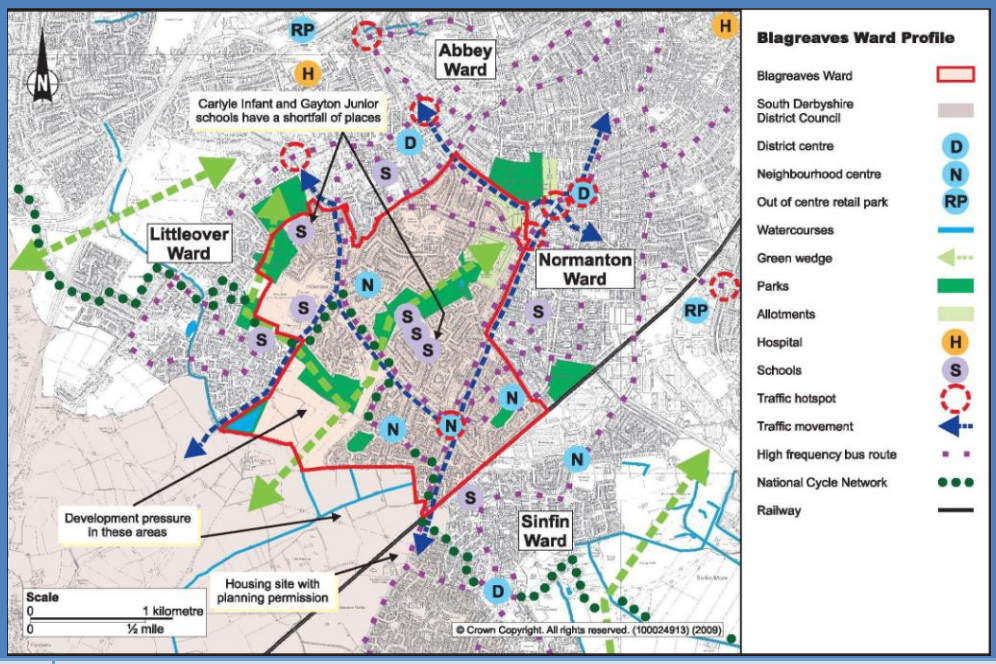
Population	There is an ethnically diverse population with over 40% of the population Asian/ Asian British (77% non 'White British'). There are around 130 nationalities with new migrants accounting for 19.4% of the population in 2007. 33.3% of the population do not have English as a first language. The 20 to 34 year old group is comparatively large, the 45 to 74 year old group is comparatively small and there is a high student population. There are a disproportionate percentage of young males, probably due to inward migration. The birth rate is significantly high for the City and increasing. There is a high representation of the Christian religion.
Deprivation	Arboretum is the most deprived ward in the city. The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, needle exchange, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	Over £30 per person per month is spent on tobacco. There are high levels of regular and excess drinkers, plus binge drinking. There is a high level of illicit drug use and dealing. There have also been complaints regarding prostitution in the area. There is a low monthly spend on fruit and vegetables. A low percentage of adults state that their interests include exercise or sports. In 2007/8 the Child Measurement Programme identified a high percentage of obese children. High rates of teenage pregnancy. There are also a high proportion of households without central heating or access to a car/van.
Health	There is a very high level of long term limiting illness and a significantly high all age all-cause mortality with high premature mortality from CHD and Cancer. The population profile indicates an expected higher prevalence of CHD, Diabetes, STIs, TB and poor dental health than average for the City. There are a high percentage of low birth weight babies and a significantly high infant mortality rate. There is a high rate of falls in the over 65's indicating a population at higher than average risk.
Use of services	There is a low uptake of Bowel Cancer Screening. There is high use of social care, including residential and nursing care.
Key local needs	Services appropriate to the diverse population, including information access in languages other than English. Services should be accessible to young men. Smoking cessation & substance misuse services, with focus on pregnant women. Health promotion regarding diet and exercise, healthy pregnancy, contraception and sexual

	health, SIDS prevention, safe drinking and dental health. Identification, treatment and advice for patients with CHD, Diabetes, STIs & TB. Falls prevention through the management of long term conditions, reviews of medication and the provision of information. Services to support residential and nursing homes.
What have you told us?	The Arboretum area is in need of regeneration and the redevelopment of the DRI site presents an opportunity to overcome some of the local problems experienced. There is overcrowding and too much social housing and related health and poverty issues. There is congestion on Osmaston Road and related pollution issues. Absentee landlords were raised as an issue. Other uses for Castleward instead of an urban village, major tourism and employment uses with significant footfall would be ideal. Castleward should be considered for the new Leisure complex
Services	There are six GP surgeries or branch surgeries. Contraception and sexual health services are provided through the Walk in Centre and for young people through The SPACE. Genitourinary Medicine Clinic & Chest Clinic at London Road Community Hospital. Other health services through the Walk in Centre, including FreshStart smoking cessation. Specialist needle and syringe programmes at the Bradshaw clinic and Phoenix Futures
Education	
Economy	The average household income in Arboretum is lower than the average and the proportion of households earning less than £15k is the highest in the city. Arboretum includes the commercial hub of the city; however unemployment amongst residents of the ward is the highest level in the city.

Key health promotion opportunities	
How to use NHS services/ register with a GP Promoting behaviour change through Christian festivals Healthy pregnancy/ Healthy start Warmfront Healthy Eating Safe drinking Smoking cessation Bowel screening promotion	Promotion of physical activity Sexual health promotion Information about illegal drugs and how to access services Baby safe sleeping/ SIDS prevention TB, diabetes, Cardiovascular disease and cancer awareness Dental health promotion Social care information Falls prevention

Table 43: Detail for the ward of Blagreaves

Blagreaves

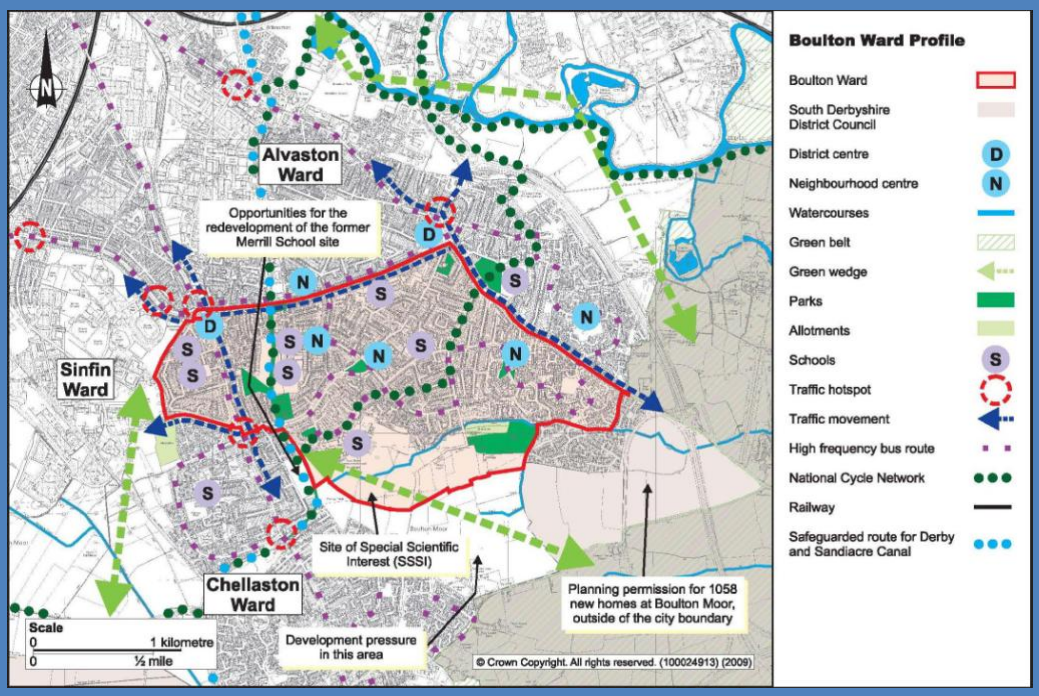


Population	There is an ethnically diverse population with over 10% of the population Asian/ Asian British (36% non 'White British'). There are a high percentage of new migrants. The 20 to 29 year old group is comparatively small. There is a high representation of the Sikh religion.
Deprivation	
Pharmacy Provision	Enhanced services provide smoking cessation, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	There is no identified district centre or major food store within the ward. Subsequently large amounts of convenience retail expenditure are spent outside of the ward, predominantly in Sinfin.
Health	The population report above average levels of long term limiting illness. The population profile indicates that we would expect to find a higher prevalence of CHD, Diabetes and TB. There are over 20% excess winter deaths.
Use of services	There is high use of social care.
Key local needs	Services appropriate to the diverse population, including access to information in languages other than English. Health promotion regarding keeping warm in winter. Identification, treatment and advice for patients with CHD, Diabetes, and TB. Services to support the housebound and carers.
What have you told us?	Need to make sure Green Wedges are protected and improved. Opposed to building on proposed City Park site. Need to identify local priorities on deficiencies in the area e.g. no community centre
Services	There is one GP surgery or branch surgery. FreshStart smoking cessation at Blagreaves Library.
Education	
Economy	

Key health promotion opportunities	
Promoting behaviour change through Sikh festivals How to use NHS services/ register with GP Warmfront- keeping warm in winter	Cardiovascular disease, diabetes, TB awareness Social care information

Table 44: Detail for the ward of Boulton

Boulton



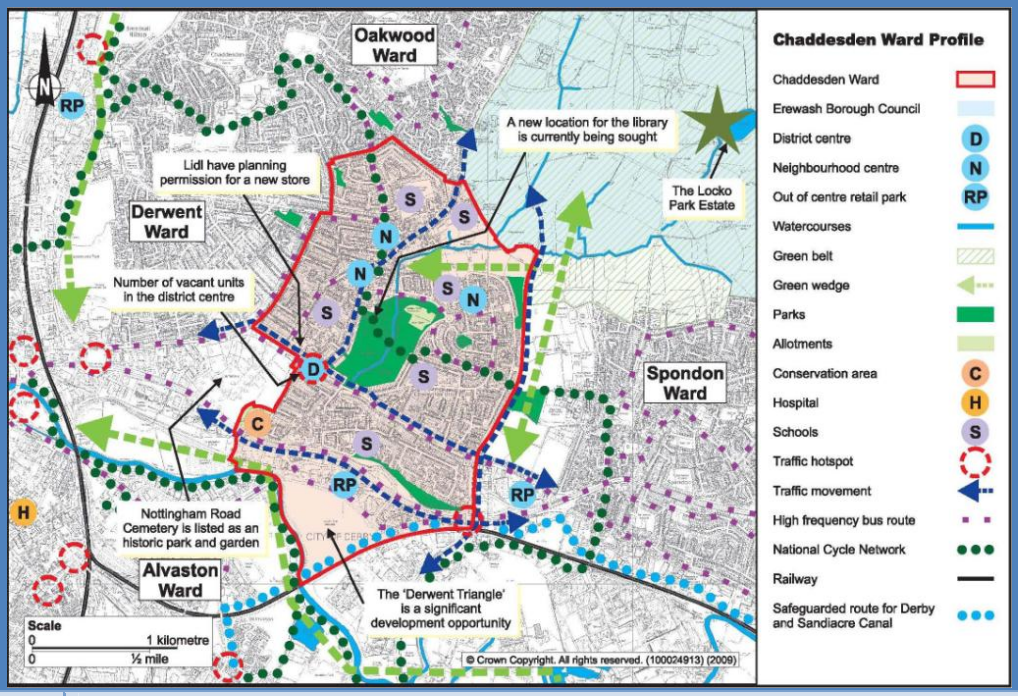
Population	There is a high representation of the Christian religion.
Deprivation	The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	Over £30 per person per month is spent on tobacco. A low percentage of adults who state that their interests include exercise or sports. High rates of teenage pregnancy.
Health	The population report an above average level of long term limiting illness. There is a significantly high mortality from respiratory disease. The population profile indicates that we would expect to find a higher prevalence of CHD, STIs and poor dental health. Hospital episodes related to mental / behavioural disorders is slightly above average;
Use of services	There is a low uptake of Bowel Cancer Screening. There is high use of day care.
Key local needs	Smoking cessation services. Health promotion regarding exercise, healthy pregnancy, contraception and sexual health, SIDS prevention, the Bowel Cancer Screening programme and dental health. Identification, treatment and advice for patients with CHD and STIs. Services to support carers.
What have you told us?	The controlled release of greenfield land could bring about benefit to Derby's communities in terms of physical and green infrastructure, these can be maximised by concentrating development in a few strategic locations e.g. Boulton Moor. Concern about the impact of additional housing development at Boulton Moor.
Services	There are two GP surgeries or branch surgeries. Contraceptive and Sexual Health Services through Spaceman, Boulton Lane

	Community Centre.
Education	The proportion of residents with no qualifications is higher than average. The proportion achieving higher level qualifications is below average.
Economy	Household income is below average compared to the city as a whole and there is very little commercial activity within the ward.

Key health promotion opportunities	
Promoting behaviour change through Christian festivals Smoking cessation Promotion of physical activity Sexual health promotion	CVD and Respiratory disease awareness Dental health promotion Bowel screening awareness Social care information

Table 45: Detail for the ward of Chaddesden

Chaddesden

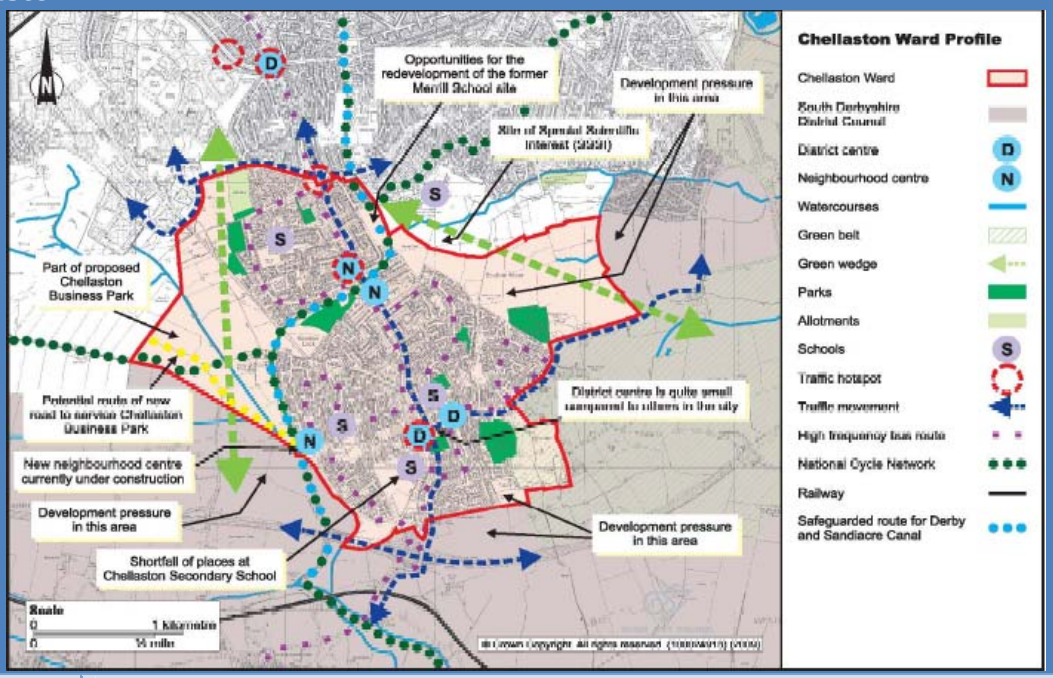


Population	The proportion of large homes is below average and the proportion of properties classed as being in disrepair or non-decent is higher than more peripheral areas of the city.
Deprivation	The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide smoking cessation, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	There is a low monthly spend on fruit and vegetables.
Health	The population report above average long term limiting illness. The population profile indicates that we would expect to find a high prevalence of CHD, STIs and poor dental health. There are 25% excess winter deaths.
Use of services	There is high use of social care, specifically day care. There is a high provision of unpaid care.
Key local needs	Health promotion regarding diet, contraception and sexual health, keeping warm in winter and dental health. Identification, treatment and advice for patients with CHD and STIs. Services to support the housebound and carers.
What have you told us?	There is very little land available for new development apart from in-fill plots. The proposed Derby and Sandiacre Canal proposals would make a positive contribution to any new development, particularly in respect to any potential development opportunities at the Derwent Triangle. Lafarge made the point that any new development should take account of, and not compromise, their aggregate recycling facility at Chaddesden Sidings.
Services	There is one GP surgery or branch surgery.
Education	The proportion of residents with no qualifications is higher than average. The proportion achieving higher level qualifications is below average;
Economy	Average household income is below average.

Key health promotion opportunities	
Healthy Eating Warmfront- keeping warm in winter Cardiovascular disease awareness	Dental health promotion Sexual health promotion Social care information

Table 46: Detail for the ward of Chellaston

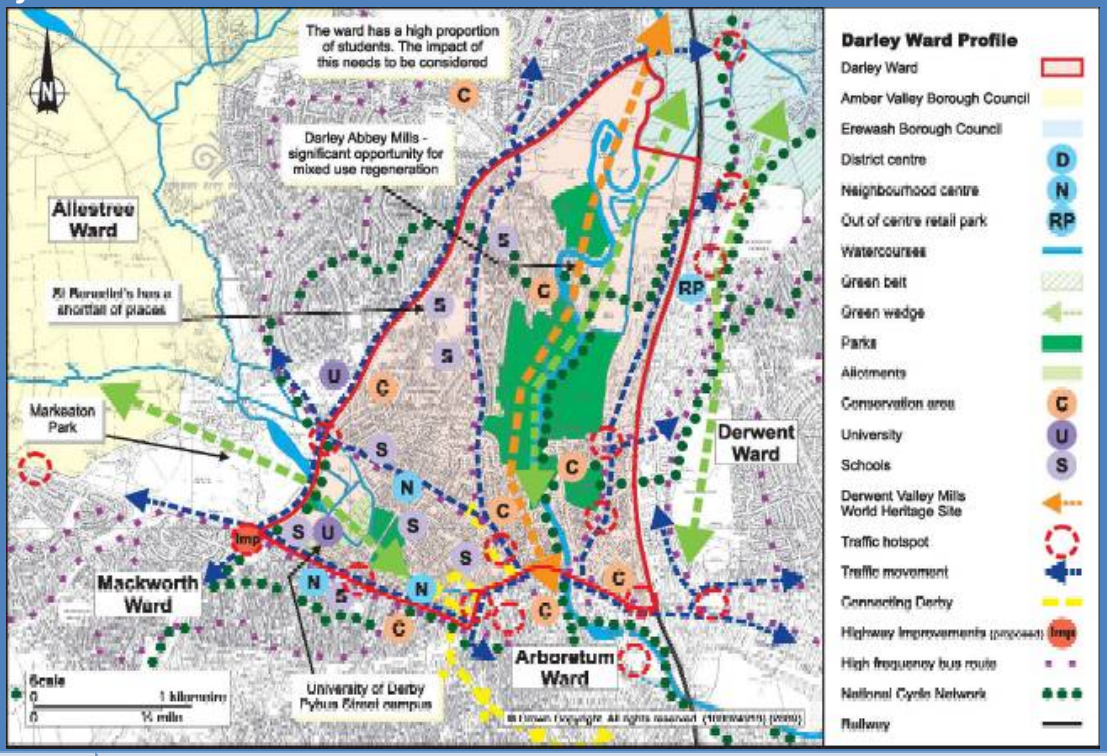
Chellaston



Population	The 20 to 29 year old group is comparatively small. The birth rate is increasing. There is a high representation of the Christian and Sikh religions.
Deprivation	
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, needle exchange, supervised methadone, Pharmacy First, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	Some households are up to 25 minutes public transport and walking travel time away from a GP surgery;
Health	The population report above average level of long term limiting illness. There is a high rate of falls in those over 65 years indicating a population at higher than average risk.
Use of services	There is high use of social care, specifically day care.
Key local needs	Health promotion regarding healthy pregnancy, contraception and sexual health. Falls prevention through the management of long term conditions, reviews of medication and the provision of information. Services to support carers.
What have you told us?	The large employment allocation is supported by development companies and value can be seen in extending the Chellaston Business Park allocation into South Derbyshire to include a new junction with the A50 and as part of a mixed use sustainable extension at Sinfin. Concerns about peripheral developments due to its impact on Chellaston. Roads and pavements are overused and in need of repair. Parkway, which is now the main route to the A514 for the new West Chellaston estate, is congested and any new development should not have access to the existing estate. Concerns were also raised on the ability of the district centre to meet the needs of any future proposed growth. If there were to be additional housing development then the infrastructure
Services	There are two GP surgeries or branch surgeries.
Education	
Economy	Some households are up to 30 minutes public transport and walking travel time away from employment uses because there is very little commercial activity within the ward.

Key health promotion opportunities	
Promoting behaviour change through Christian and Sikh festivals Healthy pregnancy/ Healthy start	Falls prevention Social care information

Table 47: Detail for the ward of Darley

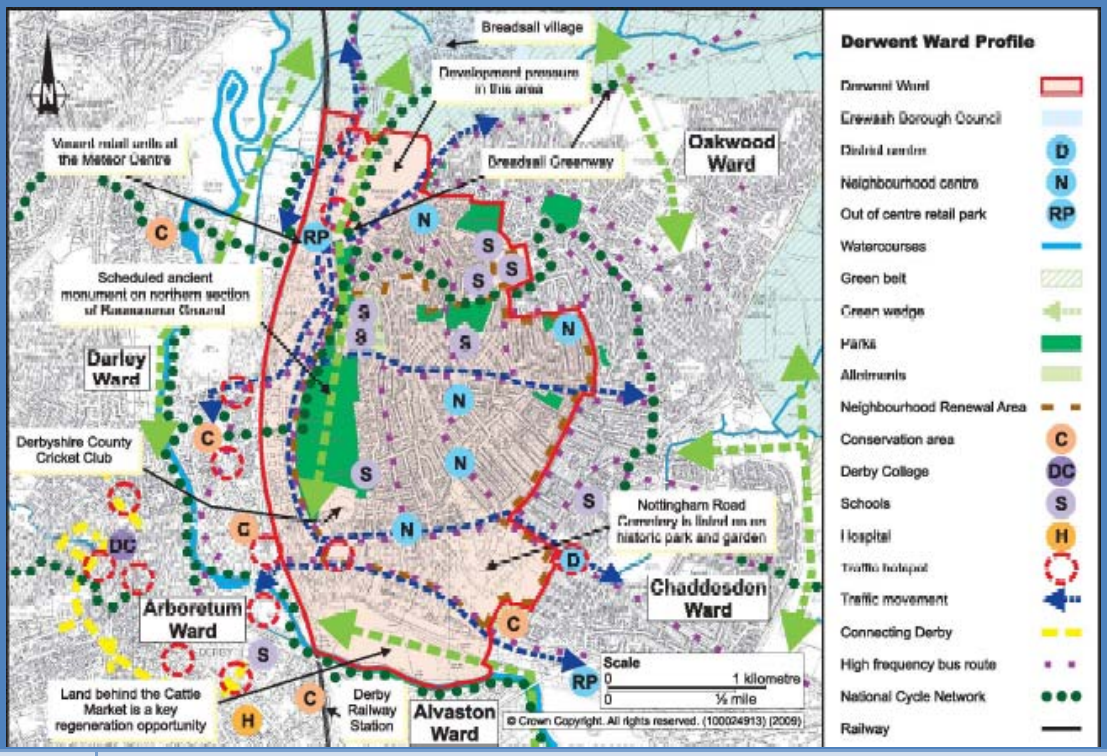
Darley	
	
Population	There are around 130 nationalities with new migrants accounting for 8.3% of the population in 2007. The 15 to 29 year old group is comparatively large and there is a high student population. The 5 to 14 year old group is comparatively small. There are a high proportion of single pensioner households. There is a high representation of the Christian religion.
Deprivation	The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, needle exchange, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	Over £30 per person per month is spent on tobacco. There are high levels of regular and excess drinkers, plus binge drinking. Over £30 per person per month is spent on off licence alcohol.
Health	The population report an above average level of long term limiting illness. There is a significantly high all age all-cause mortality and a higher mortality from respiratory disease. The population profile indicates the expectation that a higher prevalence of CHD, STIs and poor dental health than average for the city. The occurrence of hospital episodes related to mental / behavioural disorders is above the city average.
Use of services	There is the highest use of nursing care in the city.
Key local needs	Services appropriate to the diverse population, including access to information in languages other than English. Services appropriate for young adults and students Smoking cessation and substance misuse (including alcohol) services. Health promotion regarding diet and exercise, contraception and sexual health, safe drinking and dental health. Identification, treatment and advice for patients with Respiratory disease, CHD and STIs. Services to support nursing homes.
What have you told us?	At the Neighbourhood Board meeting comments were made that differing approaches on the location of future developments may impact less on transport congestion and school provision. It was noted that housing provision adjacent to Mackworth could have an influence on plans for an underpass at Markeaton Island.
Services	There are three GP surgeries or branch surgeries.

Education	
Economy	The proportion of working age residents working within the city is below average, whilst the proportion of residents working in Amber Valley and Nottingham is noticeably higher than average. Residents of Darley also tend to travel further to work than people living in other areas of the city.

Key health promotion opportunities	
How to use NHS services/ register with a GP Promoting behaviour change through Christian festivals Safe drinking Smoking cessation	Cardiovascular disease and respiratory disease awareness Sexual health promotion Social care information Dental health promotion

Table 48: Detail for the ward of Derwent

Derwent



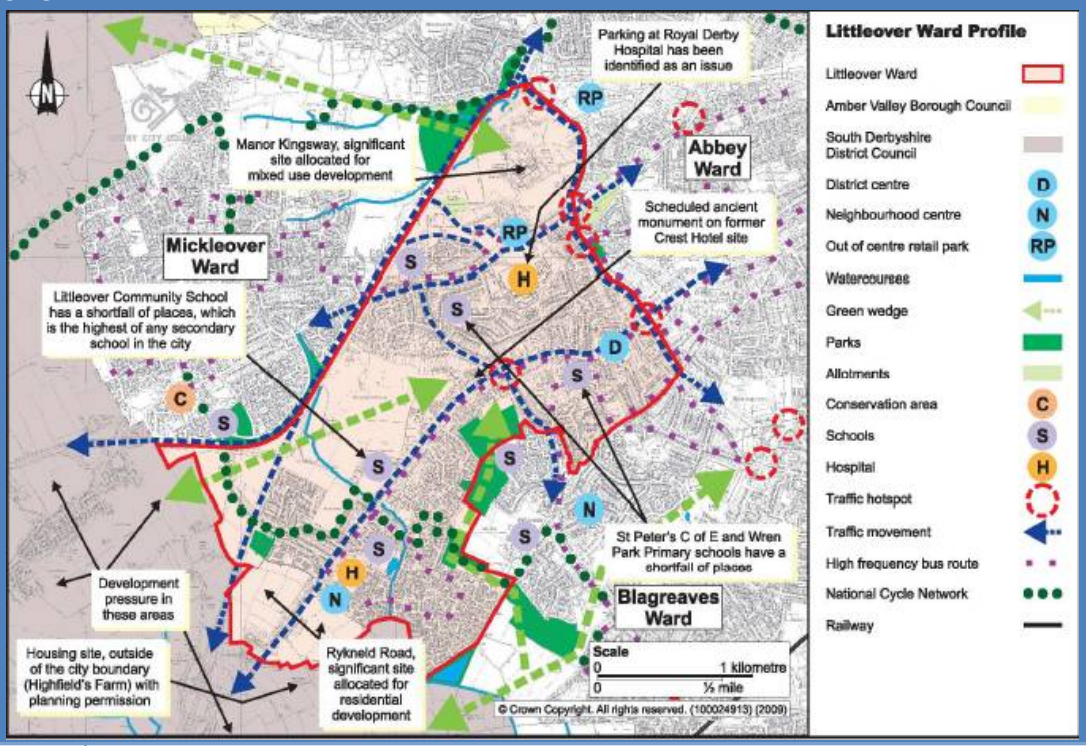
Population	The 0 to 9 year old group is comparatively large and there is a significantly high birth rate compared to the City. The predominant religion is Christianity..
Deprivation	Derwent is the fourth most deprived ward in the city. The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide smoking cessation, needle exchange, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	There are areas of the ward where over 50% of the population smoke. Over £30 per person per month is spent on tobacco. There are high levels of binge drinking. There is a low monthly spend on fruit and vegetables. In 2007/8 the Child Measurement Programme identified a high percentage of obese children. There are high rates of teenage pregnancy. There are also a high proportion of households without central heating
Health	The population report an above average level of long term limiting illness. There is a significantly high all age all-cause mortality, and specifically for Respiratory disease. There is also high premature mortality from CHD and Cancers. The population profile indicates that the expectation is to find a higher prevalence of CHD, STIs and poor dental health than average for the city.
Use of services	There is high use of residential care and home care.
Key local needs	Smoking cessation and alcohol services. Health promotion regarding healthy pregnancy, diet and exercise, sexual health and contraception, safe drinking and dental health. Identification, treatment and advice for patients with Respiratory disease, CHD and STIs. Services to support Residential homes. Services to support the housebound and carers.
What have you told us?	A master planning exercise is supported. The need for smaller properties to accommodate the growth in younger and older households was Noted. There are large numbers of properties with large gardens that cannot be maintained satisfactorily which could provide a source of development land.
Services	There are two GP surgeries or branch surgeries. Contraceptive and sexual health services for young people through Spaceman at Roefarm clinic and Time 4 Girls at

	Derwent Youth Centre. FreshStart smoking cessation at Rennie Health Living Centre and Derwent Stepping Stones.
Education	Attainment in the ward is below average.
Economy	Average household income is below average and unemployment is above average.

Key health promotion opportunities	
Childhood vaccination and immunisation Promoting behaviour change through Christian festivals Healthy pregnancy/ Healthy start Warmfront Smoking cessation Healthy Eating	Safe drinking Sexual health promotion Cardiovascular disease, cancer, respiratory disease awareness Dental health promotion Social care information

Table 49: Detail for the ward of Littleover

Littleover

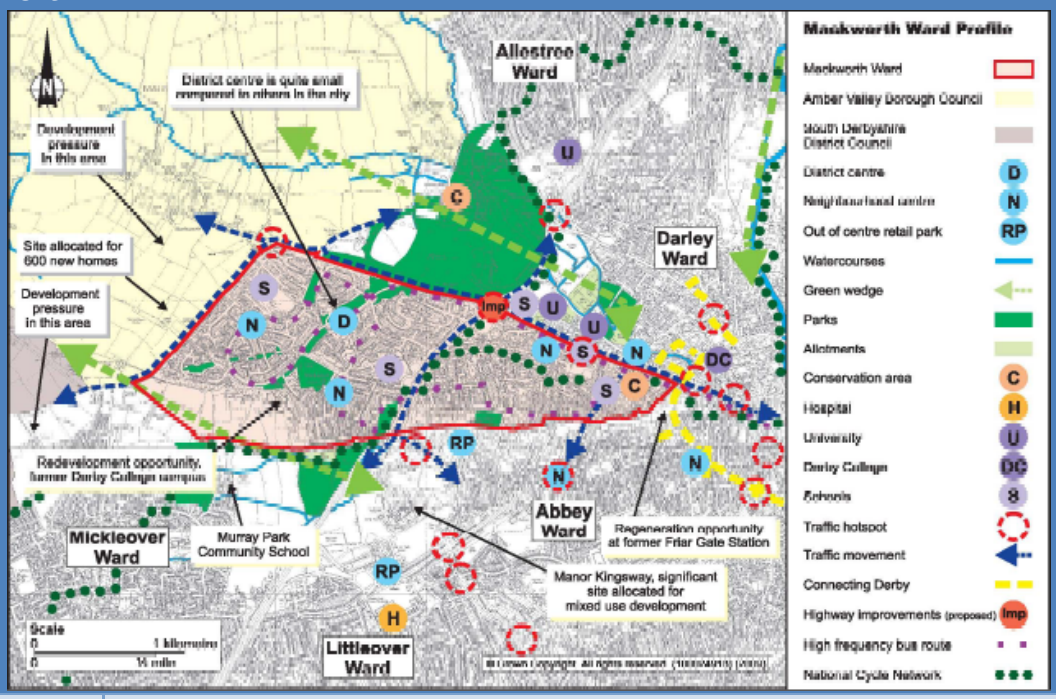


Population	There is an ethnically diverse population with nearly 10% of the population Asian/ Asian British. There are over 100 nationalities and a high proportion of new migrants. The 20 to 29 year old group is comparatively small. There is a high representation of the Sikh religion.
Deprivation	
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	Over £30 per person per month is spent on off licence alcohol. There are a higher proportion of children and young people living in the ward than in other areas of the city.
Health	The population profile indicates that we would expect to find a higher prevalence of CHD, Diabetes and TB. There are over 30% excess winter deaths. The occurrence of hospital episodes related to mental and behavioural disorders is slightly above average compared to other areas of the city.
Use of services	There is a high use of home care and a high provision of unpaid care.
Key local needs	Services appropriate to the diverse population, including access to information in languages other than English. Health promotion regarding staying warm in winter and safe drinking. Identification, treatment and advice for patients with CHD, Diabetes and TB. Services to support the housebound and their carer's.
What have you told us?	An individual respondent reflected that Littleover maintains some separate identity from inner city Derby by the barrier provided by the ring road. The neighbourhood's limited opportunities for expansion were emphasised, especially as open space is already in short supply. Concern was raised regarding the potential loss of a land between Moorway Lane and Boylestone Lane which residents are aware is currently proposed as an extension to the city park. Concern was raised regarding the impact of additional development on schools and infrastructure including medical, social and recreational facilities which would all need improving.
Services	There is one GP surgery or branch surgery. A&E at Derby Royal Hospital.
Education	

Economy	Derby Royal Hospital is located here and is one of the largest employers in the city.
Key health promotion opportunities	
Promoting behaviour change though Sikh festivals How to use NHS services- register with a GP Warmfront- keeping warm in winter	Safe drinking Cardiovascular disease, Diabetes, TB awareness Social care information

Table 50: Detail for the ward of Mackworth

Mackworth



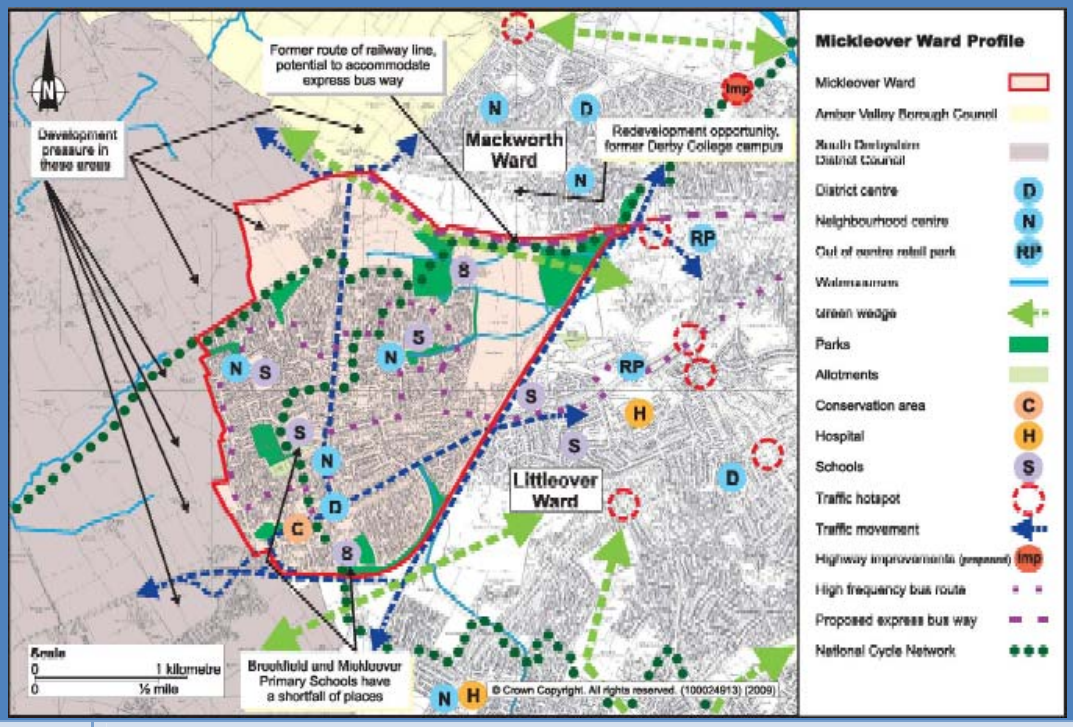
Population	There are over 100 different nationalities. The 20 to 34 year old group is comparatively large and there is a high student population. There are a high proportion of single pensioner households.
Deprivation	The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	Over £30 per person per month is spent on tobacco. There are high levels of regular and excess drinkers and a low monthly spend on fruit and vegetables. There are rates of teenage pregnancy. There are a high proportion of households without central heating.
Health	The population report a very high level of long term limiting illness. The population profile indicates that the expectation of a higher prevalence of CHD, STIs and poor dental health than average for the City. The occurrence of hospital episodes related heart disease is higher than average.
Use of services	High use of social care, particularly residential care.
Key local needs	Services appropriate to the diverse population, including access to information in languages other than English. Services appropriate for young people and students. Smoking cessation and alcohol services. Health promotion regarding diet and exercise, sexual health, safe drinking and dental health. Identification, treatment and advice for patients with CHD, Diabetes, STIs and TB. Services to support Residential homes.
What have you told us?	Congestion and rat running have been identified as problems. The main issue highlighted by residents is the poor transport links to other parts of Derby and pressure on transport infrastructure. There is little opportunity for employment and if the college site is redeveloped for housing opportunities will be further reduced. Development of land including and adjacent to the Derby College site could be undertaken in a sustainable way without affecting the function and effectiveness of the Mackworth/Mickleover Green wedge. Significant future housing development would generate the need for more infrastructures. The area lacks a secondary school, allotments, shops and healthcare facilities. Concerns about Mackworth Brook being a potential flood risk.

Services	There are four GP surgeries or branch surgeries. Contraceptive and sexual health services for young people through Mackworth Youth Centre. FreshStart smoking cessation at MackworthSureshift
Education	Attainment is generally lower than other areas of the city.

Key health promotion opportunities	
Warmfront	Sexual health promotion
Smoking cessation	Cardiovascular disease awareness
Healthy Eating	Dental health promotion
Safe drinking	Social care information

Table 51:Detail for the ward of Mickleover

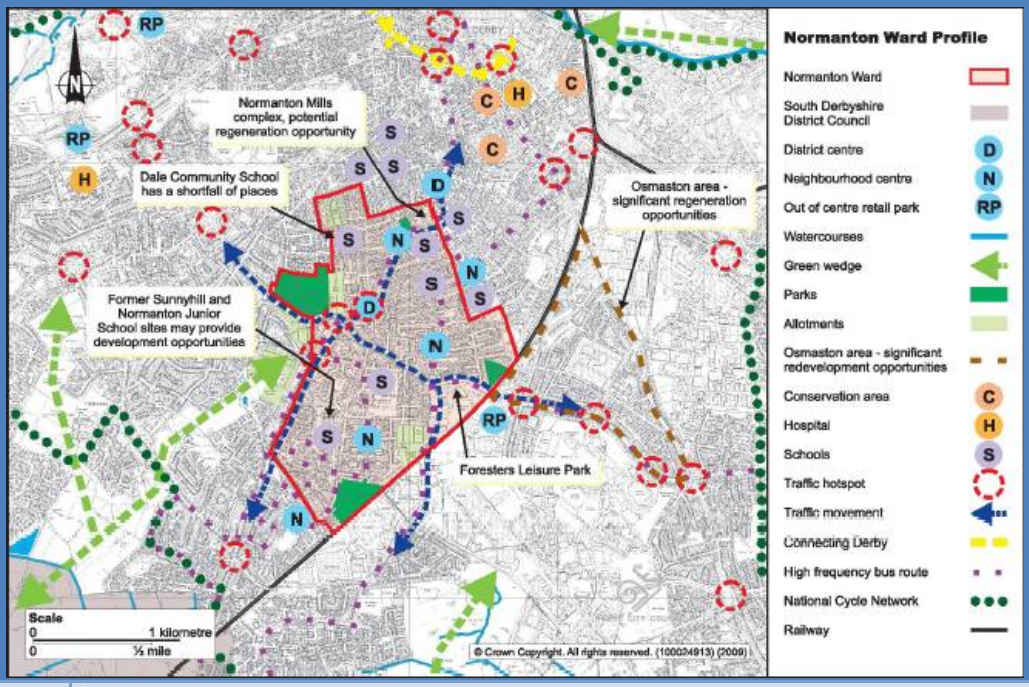
Mickleover



Population	The 55+ age group is comparatively large. There is a high representation of the Christian religion.
Deprivation	The population are within the 20% least deprived nationally.
Pharmacy Provision	Enhanced services provide support to care homes, needle exchange, supervised methadone, Pharmacy First, the Liverpool Care Pathway and MAR sheets.
Lifestyle & behaviours	Over £30 per person per month is spent on off licence alcohol. A low percentage of adults who state that their interests include exercise or sports.
Health	The population have the second highest number of falls in those aged 65 years, due to the large numbers of older people.
Use of services	There is a low overall use of social care. There is a high provision of unpaid care.
Key local needs	Health promotion regarding exercise and safe drinking. Falls prevention through the management of long term conditions, reviews of medication and the provision of information. Services to support the housebound and carers.
What have you told us?	Concerns raised about potential growth on the edge of Mickleover and its capacity impacts on local services and the highway network which is already congested. Brownfield locations should be considered in favour Greenfield land. Important to keep the neighbourhoods of Mackworth and Mickleover distinct and separated by green open spaces. Parking around shops in inadequate. The shops are all very poor in comparison to other areas. Drainage constraint issues exist. New development on the edge of Mickleover will be a tax burden on Derby as Derby won't receive the revenue. The countryside around Mickleover contributes towards its character as well as being an important resource for residents. The green wedge needs to be maintained. Extension of the hospital has increased journey times into the city from 30 minutes to 50 minutes Congestion areas were highlighted primarily around the District Centre and the Royal Derby Hospital. There are few employers in the area to provide jobs for new housing areas and bus service provision to major employers is poor.
Services	There are two GP surgeries or branch surgeries.
Education	
Economy	There is very little industrial and commercial activity located within the ward. The proportion of residents working within the city is below average whilst the proportion

	working in South Derbyshire and East Staffordshire is noticeably higher than the average. The proportion of residents travelling between 5 and 10 kilometres is over double the average.
Key health promotion opportunities	
Promoting behaviour change through Christian festivals Safe drinking	Falls prevention Social care information Promotion of physical activity

Table 52: Detail for the ward of Normanton

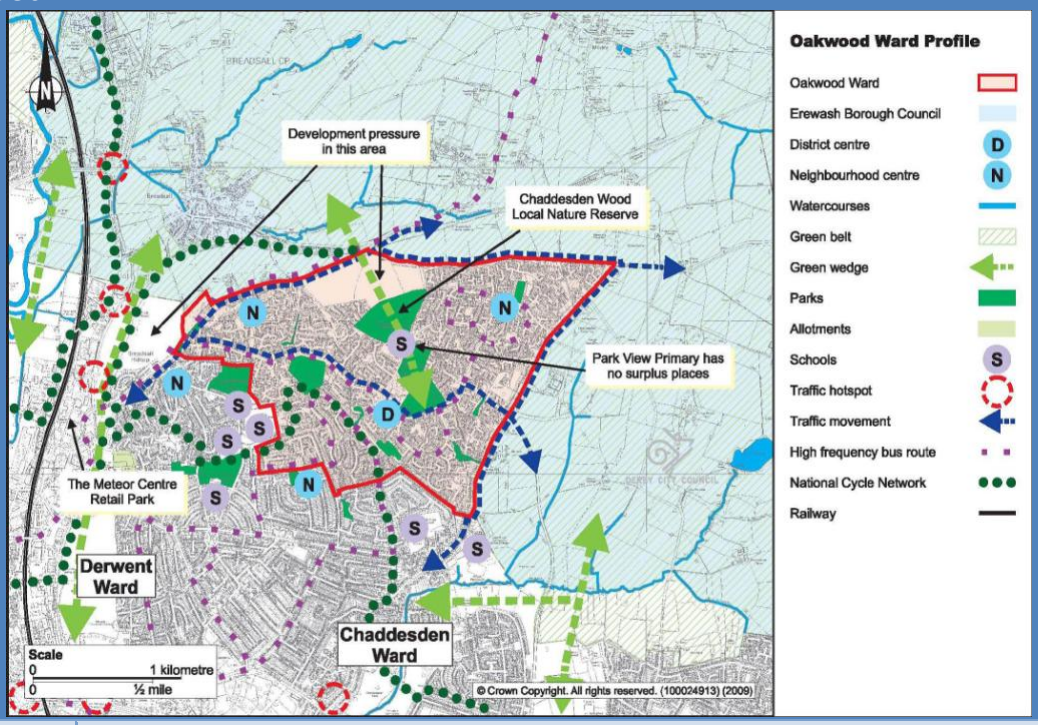
Normanton	
	
Population	There is an ethnically diverse population with almost 40% of the population Asian/ Asian British (67% non-'White British'). There are around 130 nationalities with new migrants accounting for 15.7% of the population in 2007. 19.8% of the population do not have English as a first language. The 0 to 9 year old group is comparatively large and there are a disproportionate percentage of males probably due to inward migration. The birth rate is significantly high and increasing. There is a high representation of the Muslim and Sikh religions.
Deprivation	Normanton is the second most deprived ward in the city. The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, needle exchange, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	The ward contains areas where over 50% of the population smoke. There are high levels of regular and excess drinkers. There is a high level of illicit drug use and dealing. There have also been complaints about prostitution in the area. There is a low monthly spend on fruit and vegetables. A low percentage of adults who state that their interests include exercise or sports. In 2007/8 the Child Measurement Programme identified a high percentage of obese children. There are high rates of teenage pregnancy. There are also a high proportion of households without central heating or access to a car/van.
Health	The population report a very high level of long term limiting illness. There is a significantly high all age all-cause mortality and also a high premature death rate from CHD and Cancers. The population profile indicates the expectation of finding a high prevalence of CHD, Diabetes, STIs, TB and poor dental health than average for the City. There are a high proportion of low birth weight babies. There are over 20% excess winter deaths.
Use of services	There is a low uptake of Bowel Cancer Screening.
Key local needs	Services appropriate to the diverse population, including access to information in languages other than English. Smoking cessation and substance misuse (including alcohol) services with a focus upon pregnant women. Health promotion regarding diet and exercise, healthy pregnancy, contraception and sexual health, dental health, keeping warm in winter and the Bowel Cancer Screening programme. Identification, treatment and advice for patients with CHD, Diabetes, STIs and TB.

What have you told us?	Infill in the area was previous employment uses; this reduction in the mix use of land has gone unchallenged and has resulted in increasing travel for access to jobs and services. New development has tended to be fairly high density; further development of this type needs to be done with care recognising pressure on open space. Concerns raised about potential loss of allotments. Concerns about significant numbers of vacant and derelict properties alongside overcrowding
Local services	There are five GP surgeries or branch surgeries, including the Derby Open Access Centre. Contraceptive and Sexual Health Services through Peartree Clinic and HadhariNari. FreshStart smoking cessation at Peartree Clinic.
Education	Attainment is generally lower than other parts of the city.
Economy	There is very little industrial and commercial activity located within the ward and household income is lower than the average. Unemployment is high and the proportion of residents claiming benefits is also higher than average.

Key health promotion opportunities	
Childhood vaccination and immunisation How to use NHS services- register with a GP Promoting behaviour change through Muslim and Sikh festivals Healthy pregnancy/ Healthy start Warmfront- keeping warm in winter Smoking cessation Healthy Eating	Safe drinking Promoting physical activity Sexual health promotion Information about illegal drugs and how to access services Cardiovascular disease, cancer, diabetes and TB awareness Dental health promotion Bowel cancer screening promotion

Table 53: Detail for the ward of Oakwood

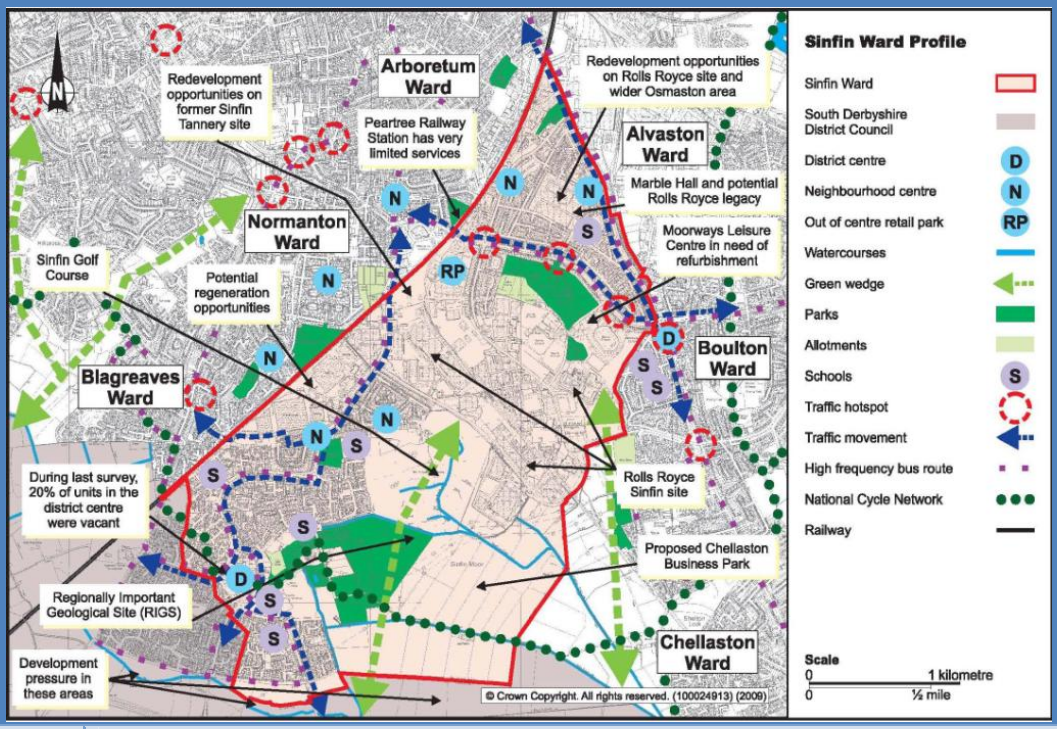
Oakwood



Population	The 30 to 59 year old group is comparatively large and the 60+ age group is comparatively small.
Deprivation	
Pharmacy Provision	Enhanced services provide smoking cessation, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	There is over £30 per person per month spent on off licence alcohol.
Health	
Use of services	A large number of households are up to 40 minutes walking and / or public transport travel time from a further education establishment;
Key local needs	Health promotion regarding safe drinking.
What have you told us?	Better bus services into the city centre are needed. It was felt that new houses should be built close to facilities to help create communities. It is felt the area is well provided in terms of public open space but that this needs protecting. Concerns raised about potential developments on the Green wedge.
Services	There are three GP surgeries or branch surgeries.
Education	
Economy	There are very few employment opportunities within the ward. The proportion of residents working within the city is the lowest of any ward. Residents generally travel further to work than residents of other areas of the city.
Key health promotion opportunities	
Safe drinking	

Table 54: Detail for the ward of Sinfin

Sinfin



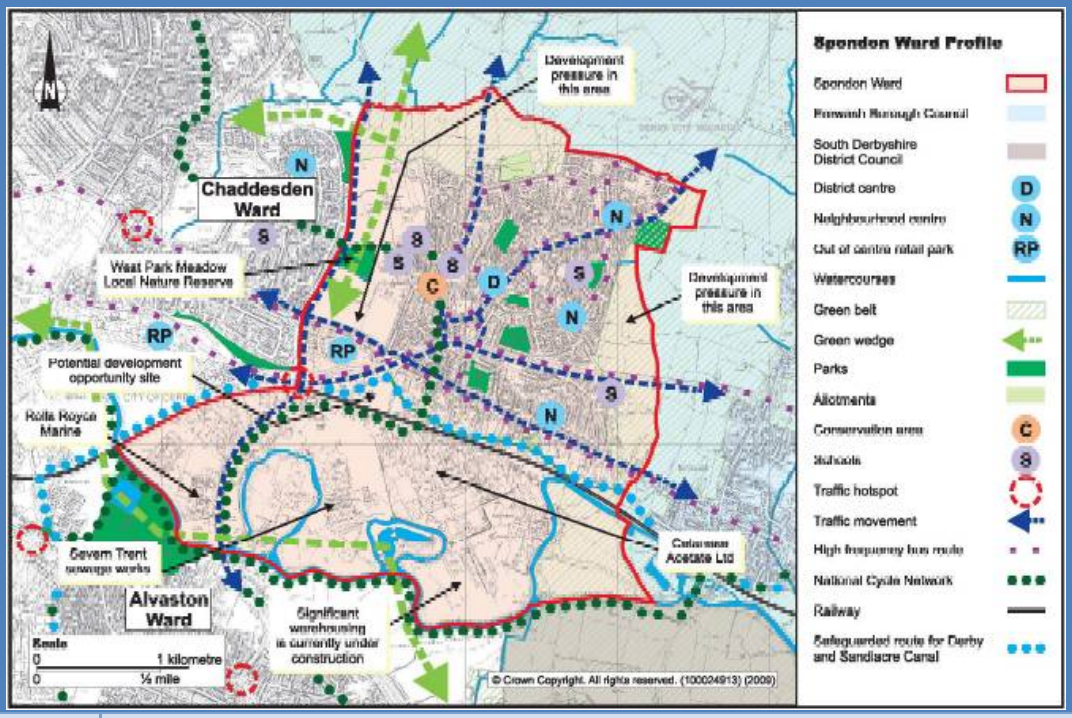
Population	There is an ethnically diverse population with nearly 10% of the population Asian/ Asian British. There are over 100 different nationalities. The 0 to 19 year old group is comparatively large and the over 60 age group is comparatively small. There is a significantly high birth rate for the City. There is a high representation of Christians in the North and Sikhs in the South.
Deprivation	This is the third most deprived ward in the city; however Osmaston contains the 3 most deprived sub areas in the city. The population are within the 20% most deprived nationally.
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, needle exchange, supervised methadone, Pharmacy First, the Liverpool Care Pathway, and oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	The ward contains areas where over 50% of the population smoke. Over £30 per person per month is spent on tobacco. There is a low monthly spend on fruit and vegetables. In 2007/8 the Child Measurement Programme identified a high percentage of obese children. There are high rates of teenage pregnancy. The proportion of lone parent households is above average. There are also a high proportion of households without access to a car/van.
Health	The population report an above average level of long term limiting illness. There is a significantly higher all age all-cause mortality, including specifically for Respiratory diseases. The population profile indicates that we would expect to find a higher prevalence of CHD, Diabetes, STIs, TB and poor dental health. There are a high proportion of low birth weight babies. There are over 30% excess winter deaths.
Use of services	Some areas of the ward are up to 30 minutes public transport or walking time from further education establishments and secondary schools.
Key local needs	Services appropriate to the diverse population, including access to information in languages other than English. Smoking cessation, with a focus upon pregnant women. Health promotion regarding diet and exercise, healthy pregnancy, sexual health and contraception, dental health and keeping warm in winter. Identification, treatment and advice for patients with Respiratory disease CHD, Diabetes, STIs and TB.

What have you told us?	There is a need for a new school at Osmaston. Concerns were raised about potential housing around Sinfin which already has too much pressure on existing services. Sinfin is in need of more cultural/leisure facilities. Concerns raised about planning for gypsies and travellers. Feeling of being a dumping ground for land uses not wanted anywhere else in the city
Services	There are 2 GP surgeries or branch surgeries. Contraceptive and Sexual Health Services for young people through Sinfin Health Centre.
Education	Attainment is generally lower than most other parts of the city and GCSE achievement at Sinfin Community School is the lowest in the city.
Economy	The average household income in Sinfin is lower than the average and the proportion of households earning less than £15k is amongst the highest in the city. Sinfin is home to one of Derby's largest employers (Rolls-Royce); however unemployment in Sinfin is the third highest in the city.

Key health promotion opportunities	
Childhood vaccination and immunisation Promoting behaviour change through Christian ad Sikh festivals Healthy pregnancy/ Healthy start Smoking cessation Healthy Eating	Sexual health promotion Warmfront- keeping warm in winter Cardiovascular, diabetes, TB and respiratory disease awareness Dental health promotion

Table 55: Detail for the ward of Spondon

Spondon



Population	The 45+ year old group is comparatively large. There is a high representation of the Christian religion.
Deprivation	
Pharmacy Provision	Enhanced services provide support to care homes, smoking cessation, supervised methadone, Pharmacy First, the Liverpool Care Pathway, Oral Emergency Contraception and MAR sheets.
Lifestyle & behaviours	A low percentage of adults who state that their interests include exercise or sports.
Health	The population report an above average level of long term limiting illness. There are over 30% excess winter deaths. The occurrence of hospital episodes related to ischaemic heart disease is above the city average.
Use of services	A high use of nursing care and a high provision of unpaid care.
Key local needs	Health promotion regarding diet and exercise and keeping warm in winter. Services to support Nursing Homes. Services and support for the housebound and their carer's.
What have you told us?	Congestion on the main road through the village raised as a concern, it is felt a relief road is needed. The Celanse site could be used to create a major housing development. There is no need for additional shopping floor space, the internet is reducing this need.
Services	There are two GP surgeries or branch surgeries.
Education	Attainment is generally slightly lower than the city average.
Economy	The proportion of working age residents working within the city is below average and residents tend to travel further to work than residents of other areas. The proportion of residents working in Erewash, Nottingham, Amber Valley and North West Leicestershire is also above average.

Key health promotion opportunities	
Promoting behaviour change through Christian festivals Promoting physical activity	Warmfront- keeping warm in winter Social care information

12 SUMMARY

Whilst there are positives: more young people in Derby participating in sport and more gaining a GCSE pass (5A*-C) than the national average; excellent smoking quit rates and mortality rates from cardiovascular disease that have decreased by 44.7% since 1995-7, there remain significant health and wellbeing issues in the city.

Derby's population is growing in terms of size and diversity, and its age profile is also changing. Different groups and populations have different needs, different access to services and different outcomes. Service provision needs to reflect this varying and changing need.

Whilst Derby as a whole has become slightly less deprived, it remains comparatively deprived – ranked 88th (of 326) most deprived local authority. Further, levels of deprivation vary substantially across the city with some areas being considerably deprived. Around a third of private sector dwellings are classed as 'non-decent' and there are over 7,000 applicants for social housing. Issues such as deprivation and poor housing have a significant negative impact on health and wellbeing.

The city has excellent smoking cessation services with better than average quit rates, however, Derby continues to have a higher than average proportion of people smoking. Levels of alcohol-related harm also remain high and the city has higher than average numbers of problematic drug users. Good treatment services for both, however, are now in place.

The numbers of people in the city who are blind, partially-sighted or have a visual impairment are predicted to increase year-on-year as are those with physical disabilities. Whilst the rate of mortality from cardiovascular disease has reduced substantially over the last fifteen years, it remains higher than the national average. Similarly, premature mortality from cancer had been reducing since 1999 but increased in 2007 and 2008 and is now significantly higher than the national rate.

There are increasing numbers of children in the city on child protection plans, and the number of referrals relating to safeguarding and family support are also increasing as are the number of looked after children.

Tackling deprivation and the wider determinants of health, universal and targeted prevention activities in childhood early years, early detection and intervention in diseases such as cancer and cardiovascular disease as well as support for lifestyle and behaviour change, could have significant impact on the health and wellbeing of the population of Derby and reduce inequalities.

The shape, content and development of future JSNA's will need to change to meet the changing structures and delivery mechanisms including clinical commissioning groups, and support the increasing integration of health and social care through the Health and Wellbeing Board.

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14 ABBREVIATIONS

Acronym/Word	Description
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
DASR	Directly Age Standardised Rate
DsPH	Directors of Public Health
EMPHO	East Midlands Public Health Observatory
IMD	Indices of Multiple Deprivation
LA	Local Authority
LAD	Local Authority District
LAPE	Local Alcohol Profiles for England
LARC	Long Acting Reversible Contraception
MYE	Mid-year estimate
NDTMS	National Drug Treatment Monitoring Service
ONS	Office for National Statistics
PANSI	Projecting Adult Need and Service Information
PCT	Primary Care Trust
PDUs	Problematic Drug Users (PDUs) are classified as any drug user presenting to treatment with Opiates and/or Crack Cocaine as their primary, secondary or third drug. This does not usually include users who have alcohol as a main drug.
POPPI	Projecting Older People Population Information System
QOF	Quality Outcomes Framework
SDCCG	Southern Derbyshire Clinical Commissioning Group
SEPHO	South East Public Health Observatory
SHA	Strategic Health Authority
TIA	Transient Ischaemic Attack

1 APPENDIX: DATASETS/ DATA SOURCES USED

Data Source	Description
ACORN	ACORN is a geo-demographic segmentation of the UK's population; which segments small neighbourhoods, postcodes, or consumer households into categories, groups and types. It is produced by the company, CACI, and is the council's classification of choice for Derby.
Alcohol Concern	Alcohol Concern is the national agency on alcohol misuse campaigning for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems. Data provided by the organisation is made up primarily of SUS and Dr Foster Intelligence – a privately funded organisation providing an additional source of healthcare information and benchmarking across England – sources.
Cancer Screening Centres	Data has been sourced from a variety of national guided and locally implemented screening centres; including breast, cervical and bowel.
Cardiovascular Disease (CVD) Profiles	South East Public Health Observatory (SEPHO) produced national CVD profiles earlier this year. They provide a snapshot of key issues relating to heart disease and stroke; including incidence, mortality, risk factors, treatments and cost.
Census 2001	Every 10 years, a nationwide census is conducted in the United Kingdom. Census 2001 was the 20th UK Census and recorded a resident population of 58,789,194. Early results of Census 2011 are not expected until 2012.
Child & Adolescent Mental Health Services (CAMHS)	CAMHS are a specialist NHS organisation in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties.
Child Health Profiles	The Child and Maternal Health Observatory (ChiMat) is a national public health observatory established to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health. ChiMat has published Child Health Profiles for each top tier local authority in England. These provide a snapshot of child health and wellbeing
Derby City Council's Townscape Character Assessment and Neighbourhood Overviews	Derby City Council's Neighbourhood Overviews have been produced as part of the city's wider evidence base. Each overview brings together information about factors such as population, education, health, economic prosperity, transport and the environment to give a deeper understanding of each Ward in the city, how it functions and the issues which need to be addressed. The Townscape Character Assessment of each ward present information about the built environment and what makes up the area's identity.
Disability Living Allowance (DLA)	DLA is a tax-free benefit for children and adults who need help with personal care of have walking difficulties because they are physically or mentally disabled.
East Midlands Public Health Observatory	EMPHO is one of 12 Public Health Observatories (PHOs) working across the UK. The nine PHOs in England work together through a single work programme which contains both national and local

Data Source	Description
(EMPHO)	elements. EMPHO is our regional source of information, data and intelligence on people's health and health care. They currently lead on teenage pregnancy, renal disease, food and nutrition and cancer, on behalf of APHO.
English House Condition Survey (EHCS)	The EHCS provides information on the condition and energy efficiency of housing in England.
Health Profiles	The Department of Health's 'Health Profiles' programme is a partnership endeavour between the DH and the Association of Public Health Observatories (APHO). The aim of the profiles are to improve availability and accessibility to national heath and health-related information by giving a snapshot overview of health for each Local Authority (LA) in England.
Indices of Deprivation	Department for Communities and Local Government (DCLG) produce the English Indices of Multiple Deprivation. The indices identify the most deprived areas across the country. They combine a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in the country.
Local Alcohol Profiles for England (LAPE)	The LAPE is produced by the North West Public Health Observatory (NWPHO). The profiles contain 25 alcohol-related indicators for every local authority and 22 indicators for every primary care trust in England. The indicators measure the impact of alcohol on local communities and include a national indicator generated by the DH – admission episodes for alcohol-attributable conditions (previously National Indicator 39 or NI39).
Local Tobacco Control Profiles	APHO produces the Local Tobacco Control Profiles on behalf of the London Health Observatory. They bring together a detailed picture of the burden of smoking-related disease, costs and action for every local authority and primary care trust in England.
Marmot Indicators	The London Health Observatory (LHO) and the Marmot Review Team have produced baseline figures for some key indicators of the social determinants of health, health outcomes and social inequality that correspond to the indicators proposed in The Marmot Review of Health Inequalities.
Mid-year estimates of Resident Population (MYE)	Each year, the Office for National Statistics (ONS) releases estimates of the resident population for all areas within England and Wales. The estimated resident population of an area includes all people who usually live there, whatever their nationality. It also takes into account migrant inflows and outflows.
Mosaic Origins	A detailed classification based on family name/personal name combinations and probabilities giving an understanding of the general make-up of a population. There are 227 origin 'types'. Based on a patient register snapshot taken in 2009. (Experian Ltd)
Mosaic Public Sector	Mosaic Public Sector has been developed by the company, Experian. It is the UK's only classification designed specifically for use by the public sector and focuses on the needs of citizens. It provides a detailed and accurate understanding of each citizen's location, their

Data Source	Description
	demographics, lifestyles and behaviours. Mosaic is the classification of choice by the NHS in Derby.
National Centre for Health Outcomes Development (NCHOD)	The Clinical and Health Outcomes Knowledge Base is a one-stop source of all information on health outcomes generated by NCHOD. Alongside advice on how to measure health and the impact of health care, it includes the Compendium of Clinical and Health Indicators.
National Exeter System (2011)	Also known as the National Health Application and Infrastructure Service (NHAIS). It underpins the primary care level of the NHS IT; managing services, patient registration and demographic details for England, Wales and Northern Ireland.
National Health Profiles	The Department of Health's 'Health Profiles' programme is a partnership endeavour between the DH and the Association of Public Health Observatories (APHO). The aim of the profiles is to improve availability and accessibility to national heath and health-related information by giving a snapshot overview of health for each Local Authority (LA) in England.
NHS Health Check	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of those diseases and will be given support and advice to help them reduce or manage that risk.
Projecting Adult Need and Service Information (PANSI)	PANSI was launched by Department of Health (DH) in October 2008 and has proved an important starting point for councils to plan for future demand. The tool projects local characteristics and prevalence data onto local population estimates.
Projecting Older People Population Information (POPPI)	POPPI was originally developed for the Care Services Efficiency Delivery Programme (CSED), part of the DH. The system provides population data by age band, gender, ethnic group, religion, tenure, transport, living with no central heating, household growth and by state pension for English local authorities.
Public Health Birth/Mortality Files (PHB/MF)	The PHBF and PHMF are electronic records provided by the Office for National Statistics (ONS) to local areas on a monthly basis. They list all registered births and deaths of individuals resident in your local authority area, and provide a wealth of data that i.e. causes of death and birth weights, that can be analysed locally.
Secondary User Services (SUS)	SUS is the single, comprehensive repository for healthcare data which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services. It is primarily a data warehouse, and is delivered by the NHS Information Centre (IC) and NHS Connecting for Health.
Sport England	Sport England is focused on the creation of a world-leading community sport system, through the investment of National Lottery and Exchequer funding in organisations and projects that will grow and sustain participation in "grassroots" sport. The Active People Survey is the largest every survey of sport and active recreation in Europe, and is undertaken by Sport England.

Data Source	Description
Swift	Derby City Council's Adult Social Care data warehouse.
Teenage Pregnancy Unit (TPU)	The TPU is a cross-Government Unit located within the Department for Education and Skills which was set up to implement the Social Exclusion Unit's report on Teenage Pregnancy.
The Department for Education	The Department for Education is responsible for education and children's services. They are also a source of various child specific data, including children looked after in England.
The Quality and Outcomes Framework (QOF)	The QOF is the annual reward and incentive programme detailing GP practice achievement results. It is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004. QOF awards surgeries achievement points for the likes of managing some of the most common chronic diseases, to how patients view their experience at the surgery. It is managed by the IC.
UK Cancer Information Service (UKCIS)	The National Cancer Intelligence Network's (NCIN) UKCIS is a web-based reporting tool that enables users to monitor cancer rates for local areas of responsibility.

2 APPENDIX: JSNA GOVERNANCE GROUP MEMBERSHIP

2.1 Health and Wellbeing Board

Job Title	Organisation
Cabinet Member for Adult Social Care and Health, Derby City Councillor for Blagreaves Ward (Liberal Democrats)	Derby City Council
Cabinet Member for Children and Young People, Derby City Councillor for Spondon Ward (Conservative)	Derby City Council
Chair	Derby City LINk
Chief Executive	Derbyshire Healthcare NHS Foundation Trust
Chief Executive Officer	Women's Work (Derbyshire) Ltd
Chief Operating Officer	Southern Derbyshire Clinical Commissioning Group
Cluster Chief Executive	NHS Derby City and Derbyshire County
Cluster Director of External Relations	NHS Derby City and Derbyshire County
Dean of Faculty of Education and Health Science	University of Derby
Deputy Chief Executive/Executive Director of Business Support	Derbyshire Healthcare NHS Foundation Trust
Derby City Councillor for Arboretum Ward (Labour)	Derby City Council
GP Chair	Southern Derbyshire Clinical Commissioning Group
Joint Interim Director of Public Health	NHS Derby City
Leader of the Council	Derby City Council
Medical Director	Derby Hospitals NHS Foundation Trust
Operations Director	Community Action Derby
Shadow Cabinet Member for Children and Young People, Derby City Councillor for Chaddesden Ward (Labour)	Derby City Council
Strategic Director Adults, Health and Housing	Derby City Council
Strategic Director Children and Young People	Derby City Council
Vice Chair Children and Young People, Derby City Councillor for Mickleover Ward (Liberal Democrats)	Derby City Council

2.2 Health and Wellbeing Coordination Group

Job Title	Organisation
Assistant Director of Children's Services	NHS Derby City
Assistant Director of Education	Derbyshire Healthcare NHS Foundation Trust
Assistant Director of Knowledge Management	NHS Derby City
Consultant in Public Health Medicine	NHS Derby City
Coordinator	Derby City and Neighbourhood Partnerships
Deputy Director of Strategy and Market Management	NHS Derby City
Head of Strategic Planning	NHS Derby City
Health Improvement Principle	NHS Derby City
Joint Interim Director of Public Health	NHS Derby City
Locum Consultant in Public Health Medicine	NHS Derby City
Officer	Derby LINk
Operations Director	Community Action Derby
Senior Knowledge Officer	NHS Derby City
Service Director for Strategy and Commissioning	Derby City Council
Strategic Director of Adults, Health and Housing	Derby City Council
Strategic Director of Neighbourhoods	Derby City Council

2.3 JSNA Working Group

Job Title	Organisation
Assistant Director of Children's Services	NHS Derby City
Assistant Director of Knowledge Management	NHS Derby City
Director of Business Intelligence and Sector Development; Adults, Health and Housing	Derby City Council
Head of Business Efficiency and Delivery; Adults, Health and Housing	Derby City Council
Head of Older People's Commissioning	Derby City Council
Head of Policy, Research and Engagement	Derby City Council
Housing Initiatives Manager	Derby City Council
Information Manager for Strategic Services and Transformation	Derby City Council
Intelligence Manager	Derby City Council
Knowledge Services Manager	NHS Derby City
Senior Knowledge Officer	NHS Derby City

3 APPENDIX: RELEVANT SUPPORTING DOCUMENTS

Document	Description
Derby City's Pharmaceutical Needs Assessment (PNA)	The Health Act, 2009 placed a duty on all Primary Care Trusts (PCTs) to develop and publish a PNA that identifies current service provision and reflects the local health needs of the Derby population. The PNA will be used as a basis for determining future pharmaceutical service provision and market entry to support local health needs, and is available on Derby City PCT's website.
Derby City's Sexual Health Needs Assessment	The Department of Health's Teenage Pregnancy National Support Team (NST) visit to Derby in November 2009 advised the urgent completion of a young people's sexual health needs assessment (SHNA) to inform commissioning decisions and the targeting of interventions. Good sexual health is an important part of the work on broader health and well-being undertaken in Derby, and looking to the future, it is important to take stock of progress. This needs assessment provides that comprehensive 'stock take'.
Derby City's Homelessness Needs Assessment	The main purpose of this assessment was to assess the current local homeless need in order to help the Council and its partners (such as housing associations, advice agencies, health organisations, voluntary groups and charities) work together effectively to tackle homelessness.
NHS Derby City Obesity Report	Obesity and the related chronic diseases are largely preventable. The Department of Health in 2007 estimated that obesity is responsible for more than 9,000 deaths each year in England, at a cost of approximately £3.5 billion in 2002, rising to £4.2 billion in 2007. This report examines the current prevalence of obesity in Derby, and the potential impact of introducing obesity programmes to improve the health of the local population, and save the local health service money.
Derby City Council State of the City Report	The State of the City Report will underpin the identification and selection of the themes for Derby's Sustainable Community Strategy, from a Local Authority perspective. It willalso assist in measuring the achievement of agreed socio-economic outcomes overtime. As the Council's objectives and priorities for change are now based on thethemes and priorities of the Sustainable Community Strategy, the State of the CityReport will support indirectly all corporate objectives and priorities for change.
Community Safety Partnership (CSP) Drugs and Alcohol Needs Assessment	Department of Health (DH) best practice indicates that all Primary Care Trusts (PCTs) should evidence the demand for drug and alcohol treatment through a local needs assessment, taking into account the diverse needs of the population. As lead on drug and alcohol treatment provision across the city, the CSP has led on the production of this annual document.
Derby Family Poverty Needs Assessment	The purpose of this needs assessment will be to understand the distribution, drivers and impact of economic deprivation for children and young people in Derby. This understanding will inform joint and single actions for public organisations to tackle family poverty and its effects locally.

Document	Description
The Derby Plan	The Derby City and Neighbourhood Partnership has recently published the 2011-2026 'Derby Plan'. It sets out the most important and challenging things that the Derby City Partnership will work towards to improve life in Derby by 2026. It has been based on statistics, residents' views (from the likes of the '3 Wishes' Campaign) and what the partnership believes will happen over the next 15 years. Everyone in Derby has a role to play in The Derby Plan.
Derby's Strategic Intelligence Assessment	In partnership with Derbyshire Constabulary and Safer Derbyshire, City and Neighbourhood Partnerships undertake an annual assessment of community safety, known as the Strategic Intelligence Assessment. This assessment identifies the main risks to community safety throughout the force area from a robust evidence and intelligence base, then by way of an annual partnership event, brings key individuals together to agree effective actions to reduce the risks that these areas pose.
NHS Derby City IMD2010 Briefing	The Department for Communities and Local Government (DCLG) has measured levels of deprivation across England since the 1970s. This process has become more comprehensive over the years and the broader concept of multiple deprivation – used to identify unmet need – is now published statistically in the English Indices of Deprivation (ID). This report gives a brief overview of the change in levels of deprivation in Derby between 2007 and 2010 indices.
NHS Derby City Health Profiles 2011 Briefing	The Department of Health's 'Health Profiles' programme is apartnership endeavour between the DH and the Association of Public Health Observatories (APHO). The aim of the profiles is to improve availability and accessibility to national heath and health-related information by giving a snapshot overview of health for each Local Authority (LA) in England. This local briefing combines all 5 previous years of health profile data and compares Derby not only to England, but to the region and 'Family' group of LAs; to help better prioritise areas of concern.
NHS Derby City Cancer Briefing	The government set out four specific mortality reduction targets in 'Saving Lives: Our Healthier Nation', published in 1999. One of these related to cancer and was "to reduce the death rate from cancer in people under 75 by at least one fifth [20%] by 2010".In recent years the mortality rate in Derby has increased after coming close to achieving the 20% required; and this report sets out to discover why.
NHS Derby City Child Health Profiles Briefing	The Child and Maternal Health Observatory (ChiMat) is a national public health observatory established to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health. ChiMat published Child Health Profiles for each top tier local authority in England in February 2011; providing a snapshot of child health and wellbeing. This local briefing compares the data for Derby against England, the East

Document	Description
	Midlands (Nottingham and Leicester), and Derby's 'Family' group of LAs; to identify the areas of good performance and potential improvement.
Derby Population, Migration & Community Profile (2008)	Derby's demographic profile has seen substantial changes since 2004 as a result of increased internal and international mobility, yet the Census 2001 remains the most widely used source for population estimates. This report builds upon a wide range of datasets in order to answer a number of research questions, including: what is Derby's demographic composition in terms of age, sex, ethnicity and nationality; and how is the picture changing, particularly in respect of migration and newly emerging communities.
Derby City Council's 'Your Neighbourhood Consultation'	This document reports the engagement process that took place as part of the Local Development Framework Core Strategy – a statutory document that will replace the City of Derby Local Plan Review. A key development of this new system is that the local development documents will become more 'spatial' and embrace the wider social, economic and environmental issues of the City rather than the previous land-use based Local Plan.
The Derby Sustainable Community Strategy	The City's Sustainable Community Strategy sets out to convey the strategic vision for Derby, establishing long-term objectives and short-term priorities. It is built on a strong evidence base and not only balances but integrates social, economic, spatial and environmental needs and goals, as well as tackles difficult issues e.g. social inclusion, climate change and narrowing the gap.
JSNA 2009/10	This was the second Joint Strategic Needs Assessment for Derby, and represented a significant development in an ongoing commitment to gain a better understanding of the local population, its health and social care needs. Building on the 2008/09 publication, it formed the central repository of intelligence and information on which local health partnership plans would be based, including the Sustainable Community Strategy, the Children & Young Persons Plan and the PCT's 5 year Strategic and Local Operational Plans. The JSNA has continued to evolve in response to national guidance and local needs, and strategic direction.

4 APPENDIX: FAIR SOCIETY, HEALTH LIVES

Marmot Indicators for Local Authorities in England

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value for this local authority is shown as a circle, against the range of results for England, shown as a bar.

- Significantly better than England value
- Not significantly different from England value
- Significantly worse than England value

Derby

	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	77.5	78.1	78.3	73.7		84.4
2	Inequality in male life expectancy (years)	12.6	9.0	8.8	16.6		2.7
3	Inequality in male disability-free life expectancy (years)	16.6	11.2	10.9	20.0		1.8
	Females						
4	Female life expectancy at birth (years)	81.5	82.1	82.3	78.1		89.0
5	Inequality in female life expectancy (years)	9.5	5.5	5.9	11.5		1.8
6	Inequality in female disability-free life expectancy (years)	13.9	9.7	9.2	17.1		1.3
	Social determinants						
7	Children achieving a good level of development at age 5 (%)	49.3	55.9	55.7	41.9		69.3
8	Young people not in employment, education or training (NEET) (%)	7.7	6.1	7.0	13.8		2.6
9	People in households in receipt of means-tested benefits (%)	18.7	13.9	15.5	41.1		5.1
10	Inequality in people in receipt of means-tested benefits (% points)	44.9	26.2	30.6	61.3		2.9

Indicator Notes

A copy of this report and a more detailed Indicator Guide is available from the London Health Observatory website:
http://www.lho.org.uk//LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

Life expectancy at birth (Indicators 1 and 3)
Estimate of the average number of years of life expectancy at birth, based on current mortality rates.
Figures for England and the English regions represent the actual life expectancies for these areas.
Time period: 2007-09 Source: Office for National Statistics (ONS)

Inequality in life expectancy (Indicators 2 and 4)
This indicator is the Slope Index of Inequality in life expectancy. It summarises the social inequality in life expectancy within each local authority. It was calculated by, firstly, grouping lower layer super output areas (LSOAs) within each local authority into deciles based on the Index of Multiple Deprivation score (IMD 2007) for each LSOA. Deciles each contain approximately a tenth of the LSOAs in the local authority. The life expectancy for each decile is calculated, based on mortality data for the five-year period 2005-09. The Slope Index of Inequality represents the gap in years of life expectancy between the least and most deprived areas within the local authority, based on a statistical analysis of the relationship between life expectancy and deprivation scores across the whole authority. The higher the value, the greater the inequality within the local authority.
The figure for England is the median value of the figures for all upper-tier local authorities. The figure for each English region is the median value of all upper-tier LAs within that region.
Time period: 2005-09 Source: Association of Public Health Observatories, based on analysis of ONS mortality data and population estimates

Inequality in disability-free life expectancy (Indicators 3 and 6)
Disability-free life expectancy (DFLE) is the average number of years a person could expect to live without an illness or health problem that limits their daily activities. This indicator is the Slope Index of Inequality in DFLE. It summarises the social inequality in DFLE within each local authority. It was calculated by, firstly, ranking the middle layer super output areas (MSOAs) in each local authority by their level of deprivation using IMD 2007 scores. The Slope Index of Inequality represents the gap in years of disability free life expectancy between the least and most deprived areas within the local authority, based on a statistical analysis of the relationship between DFLE and deprivation scores across the whole authority. As with life expectancy, the higher the value, the greater the inequality within the local authority.
The figure for England is the median value of the figures for all upper-tier local authorities. The figure for each English region is the median value of all upper-tier LAs within that region.
Time period 1999-2003 Source: Slope Index of Inequality - London Health Observatory based on analysis of DFLE figures from ONS

5 APPENDIX: DERBY HEALTH PROFILES

Table 56: Derby Health Profile 2011

Health Profile 2010

Derby

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

Health Profiles are produced every year by the Association of Public Health Observatories.

Visit the Health Profiles website to:

- see profiles for other areas
- use interactive maps
- find more detailed information

www.healthprofiles.info

Population 239,200

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

DH Department of Health

APHO

Derby at a glance

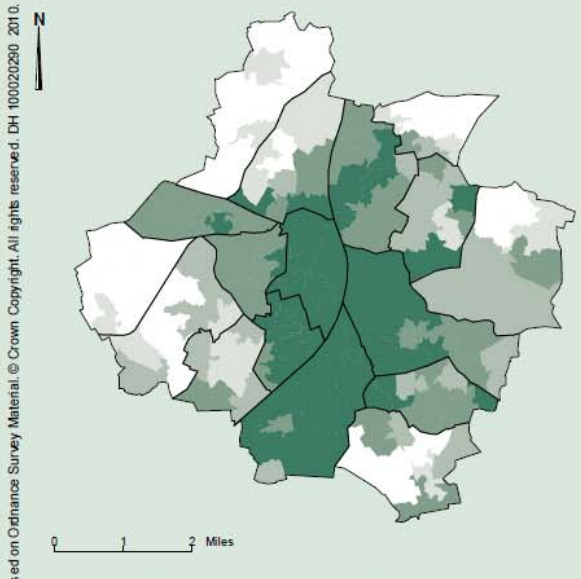
- The health of people in Derby is generally worse than the England average. Deprivation levels are high and life expectancy is lower than the average for England. Rates of hospital stays for alcohol related harm, new cases of tuberculosis, incapacity benefits for mental illness, deaths from smoking, and people diagnosed with diabetes are all worse than the England average.
- There are inequalities within Derby by gender and level of deprivation. For example, life expectancy for men living in the least deprived areas is about 9 years higher than for men living in the most deprived areas.
- Over the last 10 years, the rates of death from all causes and rates of early death from heart disease and stroke have improved, but they are still higher than the England average. There has been little change in the rates of early deaths from cancer in the past 10 years.
- Levels of tooth decay in children aged 5 and teenage pregnancy are worse than the average for England. Rates of physically active children are better than the England average.
- The Derby Local Area Agreement has prioritised tackling physical activity, alcohol misuse, teenage pregnancy, smoking, and early deaths from heart disease and stroke.
- There are more details about the health of this area in the Annual Report and the Joint Strategic Needs Assessment, available from www.derbycitypct.nhs.uk

NHS

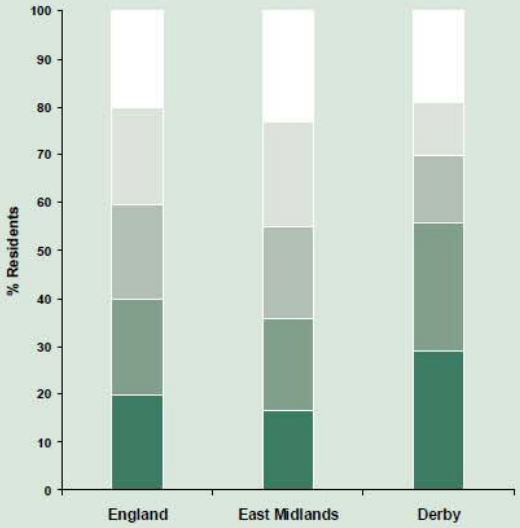
Derby – updated 28 July 2010

Deprivation: a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.



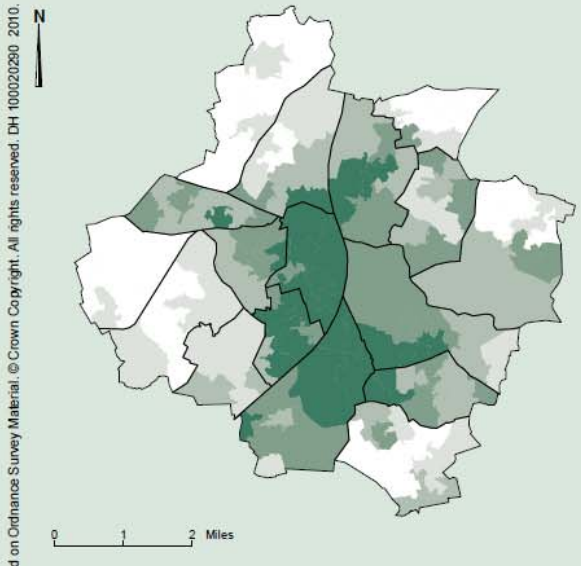
This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



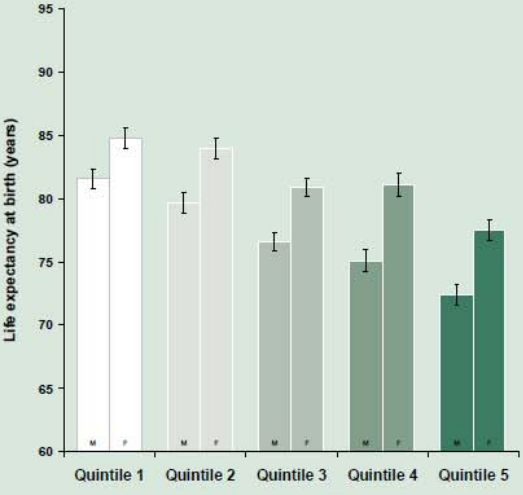
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.



95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

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Health inequalities: changes over time

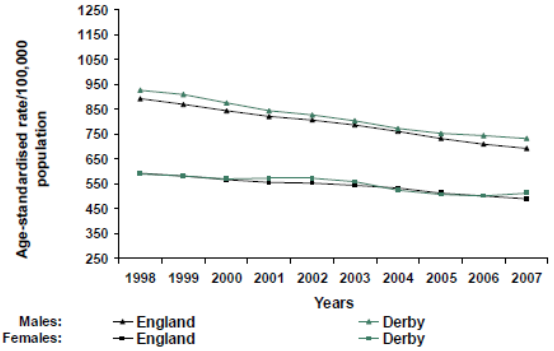
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

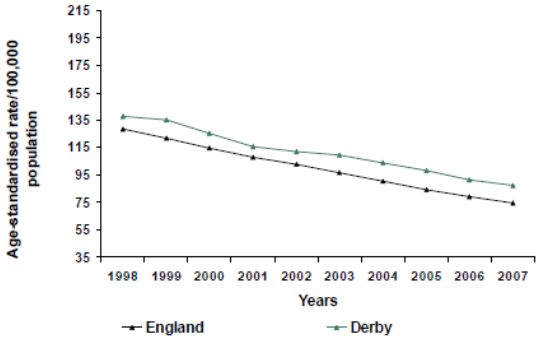
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

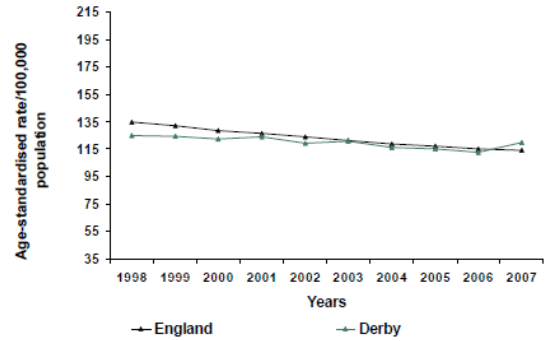
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

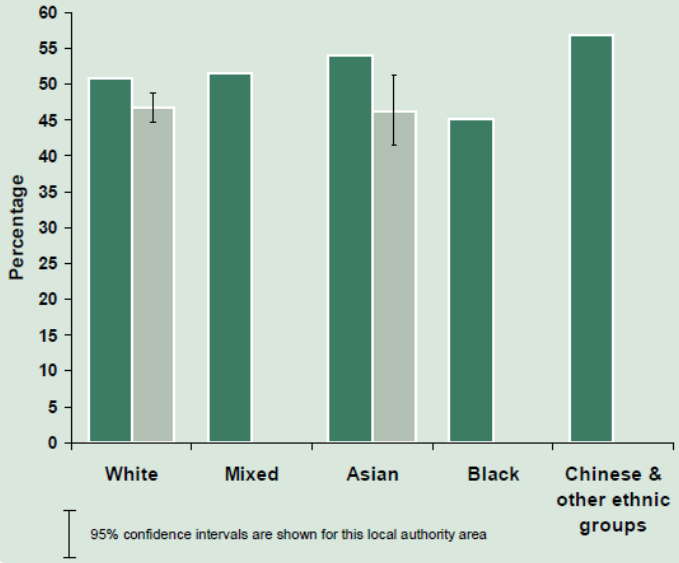


Trend 3:
Early death rates from cancer



Health inequalities: ethnicity

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	46.7	1,022
Mixed		
Asian	46.3	188
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Derby

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The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	68097	29.0	19.9	89.2		0.0
	2 Children in poverty	12848	27.3	22.4	66.5		6.0
	3 Statutory homelessness	298	2.97	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1306	45.6	50.9	32.1		76.1
	5 Violent crime	4627	19.5	16.4	36.6		4.8
	6 Carbon emissions	1576	6.6	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	517	13.9	14.6	33.5		3.8
	8 Breast feeding initiation			72.5	39.7		92.7
	9 Physically active children	19084	56.6	49.6	24.6		79.1
	10 Obese children	242	9.5	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.5	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	238	51.2	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	23.0	22.2	35.2		10.2
	14 Binge drinking adults	n/a	22.4	20.1	33.2		4.6
	15 Healthy eating adults	n/a	27.1	28.7	18.3		48.1
	16 Physically active adults	n/a	12.3	11.2	5.4		16.6
	17 Obese adults	n/a	24.2	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	23	10.2	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	4532	30.5	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	6580	2490	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	13495	5.64	4.30	6.72		2.69
	23 New cases of tuberculosis	48	20	15	110		0
	24 Hip fracture in over-65s	246	488.1	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	120	17.1	15.6	26.3		2.3
	26 Life expectancy - male	n/a	77.2	77.9	73.6		84.3
	27 Life expectancy - female	n/a	81.5	82.0	78.8		88.9
	28 Infant deaths	19	5.68	4.84	8.67		1.08
	29 Deaths from smoking	393	228.0	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	210	87.3	74.8	125.0		40.1
	31 Early deaths: cancer	283	119.8	114.0	164.3		70.5
	32 Road injuries and deaths	110	46.1	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

More indicator information is available in The Indicator Guide: www.healthprofiles.info For information on your area contact your regional PHO: www.apho.org.uk

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Table 57: Health Summary for Derby

Health Summary for Derby 2011

Source: APHO Health Profiles; www.healthprofiles.info. In partnership with Department of Health

Domain	Indicator	Derby performance against national	Derby performance against 'family'	Derby performance against region	Derby	Leicester	Nottingham	'Family'	Region	England	England Worst	England Range	England Best	Derby Trend data (where available) 2007	2008	2009	2010	2011	Sparkline Trend
Our communities	1 Deprivation				29.0	47.7	59.3	32.0	16.6	19.9	89.2		0.0						
	2 Proportion of children in poverty				24.5	33.7	36.3	23.7	18.4	24.5	57.0		5.7	27.5	27.3	27.3	27.3	24.5	
	3 Statutory homelessness				3.2	0.6	4.9	2.0	1.7	1.9	8.26		0.06	10.8	8.1	4.5	2.9	3.2	
	4 GCSE achieved (5A*-C inc. Eng & Maths)				55.1	48.9	44.9	51.8	53.7	55.3	38.0		78.6	55.6	54.6	49.4	45.6	55.1	
	5 Violent crime				19.9	31.4	26.1	16.2	15.6	15.8	35.9		4.6	22.7	20.5	21.5	19.5	19.9	
	6 Long term unemployed				7.5	14.1	12.5	9.2	6.6	6.2	19.6		1.0						
Children's and young people's health	7 Smoking in pregnancy				14.0	14.8	17.5	18.1	15.4	14.0	31.4		4.5		15.0	17.8	13.9	14.0	
	8 Breast feeding initiation				73.2	73.9	71.2	64.3	73.4	73.6	39.9		95.2		73.7	74.4		73.2	
	9 Physically active children				59.1	47.5	50.5	53.2	56.2	55.1	26.7		80.3						
	10 Obese children (Year 6)				19.4	21.9	21.9	20.3	18.4	18.7	28.6		10.7						
	11 Children's tooth decay (at age 12)				0.9	1.3	0.9	0.9	0.7	0.7	1.6		0.2						
	12 Teenage pregnancy (under 18)				52.5	48.2	64.2	51.7	39.2	40.2	69.4		14.6	53.4	51.7	52.1	51.2	52.5	
Adult's health and lifestyle	13 Adults smoking				24.6	21.5	26.4	23.1	21.4	21.2	34.7		11.1	26.3	25.0	25.0	23.0	24.6	
	14 Increasing and higher risk drinking				21.9	18.1	22.2	22.4	23.9	23.6	39.4		11.5						
	15 Healthy eating adults				28.6	25.8	26.6	23.9	28.6	28.7	19.3		47.8	21.6	26.9	26.9	27.1	28.6	
	16 Physically active adults				11.9	8.4	10.8	10.6	11.9	11.5	5.8		19.5	10.4	10.4	12.5	12.3	11.9	
	17 Obese adults				23.4	23.4	22.7	26.8	24.3	24.2	30.7		13.9	22.1	24.6	24.6	24.2	23.4	
Disease and poor health	18 Incidence of malignant melanoma				9.7	8.0	7.5	11.9	12.7	13.1	27.2		3.1						
	19 Hospital stays for self-harm				319.2	326.1	246.5	244.2	225.1	198.3	497.5		48.0						
	20 Hospital stays for alcohol related harm				2434.3	2286.0	2181.2	1995.2	1714.4	1742.8	3114		849			2016.7	2488.8	2434.3	
	21 Drug misuse				15.3	13.0	14.2	12.4	8.9	9.4	23.8		1.8						
	22 People diagnosed with diabetes				6.3	6.9	4.9	6.0	5.7	5.4	7.87		3.28		4.3	5.4	5.6	6.3	
	23 New cases of tuberculosis				20.7	70.0	25.3	15.2	12.3	15.5	120		0			16.2	20.0	20.7	
	24 Hip fracture in 65s and over				429.2	527.2	599.7	494.2	470.0	457.6	631.3		310.9			422.5	488.1	429.2	
Life expectancy and causes of death	25 Excess winter deaths				19.9	16.5	19.5	18.4	17.2	18.1	32.1		5.4			17.6	17.1	19.9	
	26 Life expectancy - males				77.5	75.4	75.2	76.7	78.1	78.3	73.7		84.4	76.6	76.8	77.0	77.2	77.5	
	27 Life expectancy - females				81.5	80.0	80.3	81.1	82.1	82.3	79.1		89.0	81.4	81.7	81.9	81.5	81.5	
	28 Infant deaths				7.4	7.3	6.2	5.6	5.1	4.7	10.63		0.68	5.3	4.2	5.0	5.7	7.4	
	29 Smoking related deaths				242.4	249.0	302.6	254.8	213.2	216.0	361.5		131.9	248.9	234.7	221.8	228.0	242.4	
	30 Early deaths: heart disease & stroke				81.1	111.3	97.9	83.3	70.5	70.5	122.1		37.9	103.9	98.2	91.4	87.3	81.1	
	31 Early deaths: cancer				122.5	116.0	138.8	122.4	112.2	112.1	159.1		76.1	116.4	115.2	112.4	119.8	122.5	
	32 Road injuries and deaths				45.8	29.8	54.2	40.4	54.6	48.1	155.2		13.7	45.5	46.9	45.1	46.1	45.8	

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Other map data © Collins Bartholomew.

Population 244,000

Mid-2009 population estimate

Source: National Statistics website: www.statistics.gov.uk

KEY POINTS:

- Derby performs significantly worse than England, the East Midlands and 'Family' group averages in the following indicators:
  - Statutory homelessness
  - Violent crime
  - Hospital stays for self-harm
  - Hospital stays for alcohol related harm
  - Drug misuse
- The health of people in Derby is generally worse than the England average. Deprivation is higher than average and 13,665 children live in poverty. Life expectancy for both men and women is lower than the England average.
- Life expectancy is 12.6 years lower for men and 9.5 years lower for women in the most deprived areas of Derby than in the least deprived areas (based on the Slope Index of Inequality published on 5th January 2011).
- Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen but remains worse than the England average.
- About 19.4% of Year 6 children are classified as obese. A higher percentage than average of pupils spend at least three hours each week on school sport. Levels of teenage pregnancy and tooth decay in children are worse than the England average.
- Estimated levels of adult smoking are worse than the England average. Rates of smoking related deaths and hospital stays for alcohol related harm are higher than average.
- Priorities in Derby include inequalities, physical activity in children and alcohol. For more information see www.derbycitypct.nhs.uk

Source: Derby Health Profile 2011; *Derby at a glance*

Performance

Significantly worse
No significant difference
Significantly better

Table 58: Listed Derby performance against comparators, grouped by significance

	National	Family	Region
Significantly worse	1 Deprivation 2 Proportion of children in poverty 3 Statutory homelessness 5 Violent crime 6 Long term unemployed 11 Children's tooth decay (at age 12) 12 Teenage pregnancy (under 18) 13 Adults smoking 19 Hospital stays for self-harm 20 Hospital stays for alcohol related harm 21 Drug misuse 22 People diagnosed with diabetes 23 New cases of tuberculosis 26 Life expectancy - males 27 Life expectancy - females 28 Infant deaths 29 Smoking related deaths 30 Early deaths: heart disease & stroke 31 Early deaths: cancer	3 Statutory homelessness 5 Violent crime 19 Hospital stays for self-harm 20 Hospital stays for alcohol related harm 21 Drug misuse	1 Deprivation 2 Proportion of children in poverty 3 Statutory homelessness 5 Violent crime 6 Long term unemployed 12 Teenage pregnancy (under 18) 19 Hospital stays for self-harm 20 Hospital stays for alcohol related harm 21 Drug misuse 22 People diagnosed with diabetes 23 New cases of tuberculosis 28 Infant deaths 29 Smoking related deaths 30 Early deaths: heart disease & stroke
Similar	4 GCSE achieved (5A*-C inc. Eng & Maths) 7 Smoking in pregnancy 8 Breast feeding initiation 10 Obese children (Year 6) 14 Increasing and higher risk drinking 15 Healthy eating adults 16 Physically active adults 17 Obese adults 24 Hip fracture in 65s and over 25 Excess winter deaths 32 Road injuries and deaths	2 Proportion of children in poverty 4 GCSE achieved (5A*-C inc. Eng & Maths) 10 Obese children (Year 6) 11 Children's tooth decay (at age 12) 12 Teenage pregnancy (under 18) 13 Adults smoking 14 Increasing and higher risk drinking 15 Healthy eating adults 16 Physically active adults 18 Incidence of malignant melanoma 22 People diagnosed with diabetes 23 New cases of tuberculosis 24 Hip fracture in 65s and over 25 Excess winter deaths 26 Life expectancy - males 27 Life expectancy - females 28 Infant deaths 29 Smoking related deaths 30 Early deaths: heart disease & stroke 31 Early deaths: cancer 32 Road injuries and deaths	4 GCSE achieved (5A*-C inc. Eng & Maths) 7 Smoking in pregnancy 8 Breast feeding initiation 10 Obese children (Year 6) 11 Children's tooth decay (at age 12) 13 Adults smoking 14 Increasing and higher risk drinking 15 Healthy eating adults 16 Physically active adults 17 Obese adults 18 Incidence of malignant melanoma 24 Hip fracture in 65s and over 25 Excess winter deaths 26 Life expectancy - males 27 Life expectancy - females 31 Early deaths: cancer
Better	9 Physically active children 18 Incidence of malignant melanoma	1 Deprivation 6 Long term unemployed 7 Smoking in pregnancy 8 Breast feeding initiation 9 Physically active children 17 Obese adults	9 Physically active children 32 Road injuries and deaths

Table 59: Health Profile Sources of Data

Domain	Indicator	Source	Year
Our communities	1 Deprivation	Department of Communities and Local Government website	2005
	2 Proportion of children in poverty	HM Revenue & Customs	Aug-08
	3 Statutory homelessness	Department for Communities and Local Government	1 April 2009 to 31 March 2010
	4 GCSE achieved (5A*-C inc. Eng & Maths)	Data received directly from the Department for Education	At the end of the academic year 2009/10
	5 Violent crime	Home Office	financial year 2009/10
	6 Long term unemployed	NOMIS – official labour market statistics	1 January 2010 to 31 December 2010
Children's and young people's health	7 Smoking in pregnancy	Department of Health (DH), NHS IC Omnibus	Financial year 2009/10
	8 Breast feeding initiation	Department of Health (DH), Vital Signs Monitoring Return	Financial year 2009/10
	9 Physically active children	TNS-BMRB PE and Sport Survey on behalf of the Department for Children, Schools and Families (now Department for Education).	2009/10 academic year
	10 Obese children (Year 6)	The Information Centre for health and social care (IC).	School year 2009/10 (September 2009 to August 2010)
	11 Children's tooth decay (at age 12)	2008/09 NHS Dental Epidemiology Programme for England survey of the dental caries of 12-year-old children in England.	2008/09
	12 Teenage pregnancy (under 18)	Produced by the Office for National Statistics and disseminated via the Teenage Pregnancy Unit in the Department for Education	2007-2009 (provisional) pooled data
Adult's health and lifestyle	13 Adults smoking	The Integrated Household Survey, Office for National Statistics.	April 2009 to March 2010
	14 Increasing and higher risk drinking	Hospital Episode Statistics (HES), 2008/09 and Public Health Mortality File 2006 to 2008, ONS.	2006-2008
	15 Healthy eating adults	Health Surveys for England, National Centre for Social Research (NatCen).	2006-2008
	16 Physically active adults	Survey data set provided by Sport England.	October 2009 – October 2010 and October 2008 – October 2010
	17 Obese adults	National Centre for Social Research (NatCen)	2006-2008
Disease and poor health	18 Incidence of malignant melanoma	NCHOD	2005-2007 (3 year average of annual rates)
	19 Hospital stays for self-harm	Hospital Episode Statistics (HES)	2009-2010 Financial year
	20 Hospital stays for alcohol related harm	NHS Information Centre for Health and Social Care (extracted from HES)	2009/10
	21 Drug misuse	PDU estimates for DATs, GORs and England are available from the National Treatment Agency.	2008/09.
	22 People diagnosed with diabetes	The Information Centre for health and social care (from QOF)	Fiscal year 2009/10
	23 New cases of tuberculosis	Health Protection Agency	2007-2009
	24 Hip fracture in 65s and over	Extracted through direct link from HES, NHS Health and Social Care Information Centre.	2009-2010 Financial year
Life expectancy and causes of death	25 Excess winter deaths	Annual Mortality File provided by ONS for PHOs	Deaths occurring in the period: 1 August 2006 to 31 July 2009
	26 Life expectancy - males	Office for National Statistics (ONS)	2007-2009
	27 Life expectancy - females	Office for National Statistics (ONS)	2007-2009
	28 Infant deaths	Data received directly from NHS Information Centre	2007 – 2009
	29 Smoking related deaths	ONS for mortality data 2007-2009	2007-09
	30 Early deaths: heart disease & stroke	Data received directly from NHS IC/ NCHOD.	2007-2009 (3-year moving average **) ** average of annual rates
	31 Early deaths: cancer	Data received directly from NHS IC/ NCHOD.	2007-2009 (3-year moving average **) ** average of annual rates
	32 Road injuries and deaths	Department for Transport	Numerator 2007-2009, denominator mid-2008.

6 APPENDIX: HEALTH PROFILE DATA TABLES

6.1 Smoking

Table 60 and Table 61 have the background data used to produce the smoking profiles. Table 60 has data for Derby UA and Table 61 has data for NHS Derby City.

Table 60:'Derby UA' smoking profile data

Indicator	RAG Rating*	Indicator Value	Regional Average	England Average	England Worst	England Best
Smoking attributable deaths 2006-08	🔴	228.0	204.1	206.8	360.3	118.7
Smoking attributable deaths from heart disease 2006-08	🔴	42.6	35.3	34.0	62.2	17.1
Smoking attributable deaths from stroke 2006-08	🟡	10.0	9.5	9.6	18.9	4.5
Deaths from lung cancer 2006-08	🟡	41.7	37.0	38.6	70.7	19.4
Deaths from chronic obstructive pulmonary disease 2006-08	🟡	27.0	25.7	26.6	52.3	12.2
Smoking attributable hospital admissions 2008/09	🔴	1595.5	1,328.7	1265.9	2451.1	654.1
Cost of smoking attributable hospital admissions 2008/09	⚪	33.1	31.5	33.4	56.0	20.3
Lung cancer registrations 2005-07	🔴	54.9	47.2	48.0	90.1	24.8
Oral cancer registrations 2005-07	🔴	12.5	8.1	8.5	16.2	3.6
Estimated adult smoking prevalence 2006-08	🟡	23.0	24.0	22.2	35.2	10.2
Smoking in pregnancy 2008/09	🟡	13.9	16.0	14.6	33.5	3.8

Note: Where there are no values shown, this is because the data are not available or suppressed.

*RAG rating refers to whether a local value is significantly better, worse, or similar to the England average. Red means that the indicator for the area is significantly worse than the England average, Amber means that the area's indicator value is similar to the England average, and Green means that the indicator for the area is significantly better than the England average. White indicates that statistical significance was not calculated.

Table 61: 'NHS Derby City' smoking profile data

Indicator	RAG Rating*	Indicator Value	Regional Average	England Average	England Worst	England Best
Smoking attributable deaths 2006-08	🔴	227.8	204.1	206.8	360.9	128.3
Smoking attributable deaths from heart disease 2006-08	🔴	42.6	35.3	34.0	62.4	18.6
Smoking attributable deaths from stroke 2006-08	🟡	10.0	9.5	9.6	18.9	5.2
Deaths from lung cancer 2006-08	🟡	41.7	37.0	38.6	70.7	22.7
Deaths from chronic obstructive pulmonary disease 2006-08	🟡	27.0	25.7	26.6	52.3	15.4
Smoking attributable hospital admissions 2008/09	🔴	1758.8	1,316.9	1265.3	2260.6	794.4
Cost of smoking attributable hospital admissions 2008/09	⚪	36.7	31.2	33.3	56.3	24.6
Lung cancer registrations 2005-07	🔴	54.9	47.2	48.0	90.1	30.5
Oral cancer registrations 2005-07	🔴	12.5	8.1	8.5	16.2	5.0
Estimated adult smoking prevalence 2006-08	🟡	23.0	24.0	22.2	35.2	12.1
GP recorded smoking prevalence 2009/10				18.8	33.4	11.1
Smoking in pregnancy 2008/09	🟡	13.9	16.0	14.6	33.5	3.8
Successful quitters at 4 weeks 2009/10	🟢	1238.9	973.8	894.7	405.7	1933.9
Successful quitters at 4 weeks (CO validated) 2009/10	🟢	686.2	695.8	614.2	51.4	1455.3
Completeness of NS-SEC recording by Stop Smoking Services 2008/09	🔴	62.9	62.0	66.1	1.6	98.1
Prescribed NRT 2009/10	⚪	995.5	2,632.2	2997.0	143.5	10886.6

Note: Where there are no values shown, this is because the data are not available or suppressed.
*RAG rating refers to whether a local value is significantly better, worse, or similar to the England average. Red means that the indicator for the area is significantly worse than the England average, Amber means that the area's indicator value is similar to the England average, and Green means that the indicator for the area is significantly better than the England average. White indicates that statistical significance was not calculated.

6.2 Alcohol

Table 62 has all the background data used to produce the NHS Derby City alcohol profiles.

Table 62: NHS Derby City alcohol profiles Data table

Indicator	Measure(a)	National Rank (b)	Regional Average
Months of life lost - males	10.9	107	9.1
Months of life lost - females	5.5	128	4.3
Alcohol-specific mortality - males	16.5	104	11.9
Alcohol-specific mortality - females	8.8	126	5.9
Mortality from chronic liver disease - males	18.3	103	12.5
Mortality from chronic liver disease - females	9.6	116	6.7
Alcohol-attributable mortality - males	42.5	96	37.0
Alcohol-attributable mortality - females	20.6	134	15.2
Alcohol-specific hospital admission - under 18s	69.8	85	54.4
Alcohol-specific hospital admission - males	541.9	113	357.1
Alcohol-specific hospital admission - females	270.3	122	188.1
Alcohol-attributable hospital admission - males	1667.8	121	1246.1
Alcohol-attributable hospital admission - females	1027.7	137	732.5
Hospital admissions for alcohol-related harm (NI 39)	2463.9	143	1571.9
Alcohol-attributable recorded crimes	9.7	107	8.0
Alcohol-attributable violent crimes	7.4	113	5.8
Alcohol-attributable sexual offences	0.2	141	0.1
Claimants of incapacity benefits - working age	127.7	87	92.5
Mortality from land transport accidents	1.1	27	2.2
Increasing risk drinking (synthetic estimate)	17.7	24	18.9
Higher risk drinking (synthetic estimate)	4.9	67	4.6
Binge drinking (synthetic estimate)	22.4	107	20.1
Employees in bars - % of all employees	1.9	71	2.3
Alcohol Treatment - Prevalence per 1,000 population	1.1	12	1.9

(a)The actual indicator value for the primary care organisations as calculated in the definitions below. For some indicators PCT values were estimated as a population weighted average of component local authority values - indicators: 15, 16, 17 - Alcohol-attributable recorded crimes; 18 - Claimants of incapacity benefits; 20, 21 - Increasing and Higher risk drinking.
(b) The rank of the local indicator value among all 152 primary care organisations in England. A rank of 1 is the best local authority in England and a rank of 152 is the worst. For indicators 23 and 24, a rank of 1 is the highest and a rank of 152 is the lowest value, as the desirability of the value (what is better or worse) has not been determined.

7 APPENDIX: EARLY DEATHS FROM CANCER - ANALYSIS

Briefing Paper: *Early deaths; cancer*

July 2011

Context

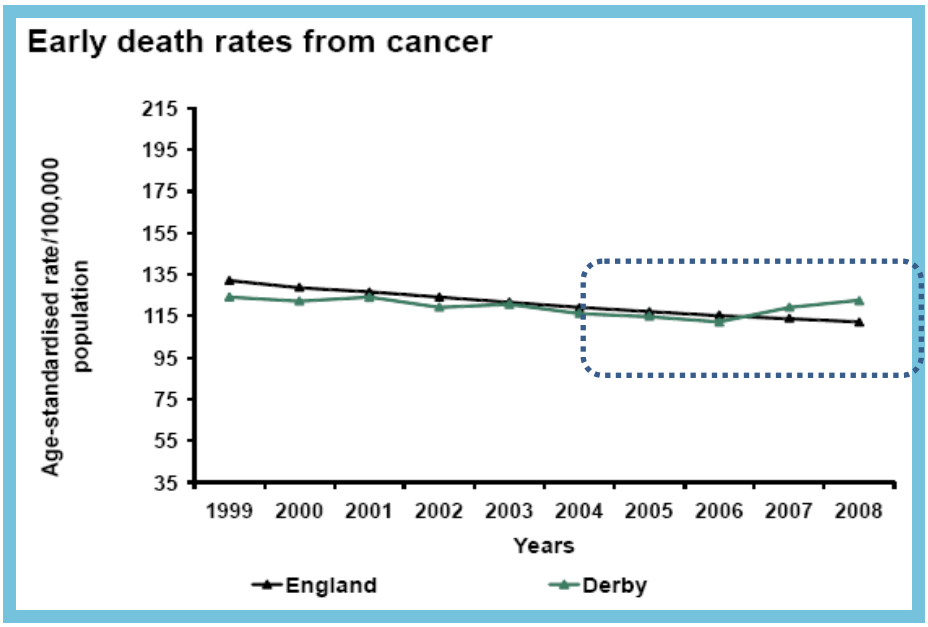
The government set out four specific mortality reduction targets in "Saving Lives: Our Healthier Nation", published in 1999. One of these related to cancer and was "to reduce the death rate from cancer in people under 75 by at least one fifth [20%]by 2010".

In 2009 (using 2005/07 mortality data), Derby had achieved a 17% reduction towards this target but in 2011 (using 2007/09 mortality data), this reduction has lessened to 10% after a subsequent two-year rise in mortality. This is only half of the target set at the turn of the century. In England as a whole, the 20% reduction has been achieved.

KEY POINTS:

- *Rate of premature mortality from cancer in Derby is now significantly higher than seen nationally and across the East Midlands, though is comparable to its 'Family' group of Local Authorities (LAs).*
- *Two of the biggest causes of this increase are; lung cancer in males and ovarian cancer in females. However, numbers by individual cancer can in some instances be very small.*
- *Early indications from local (PHMF) data sources suggest the rate published in 2012 will fall again to 2010 levels of premature mortality from cancer.*

Figure 51: Trend of premature mortality from cancer



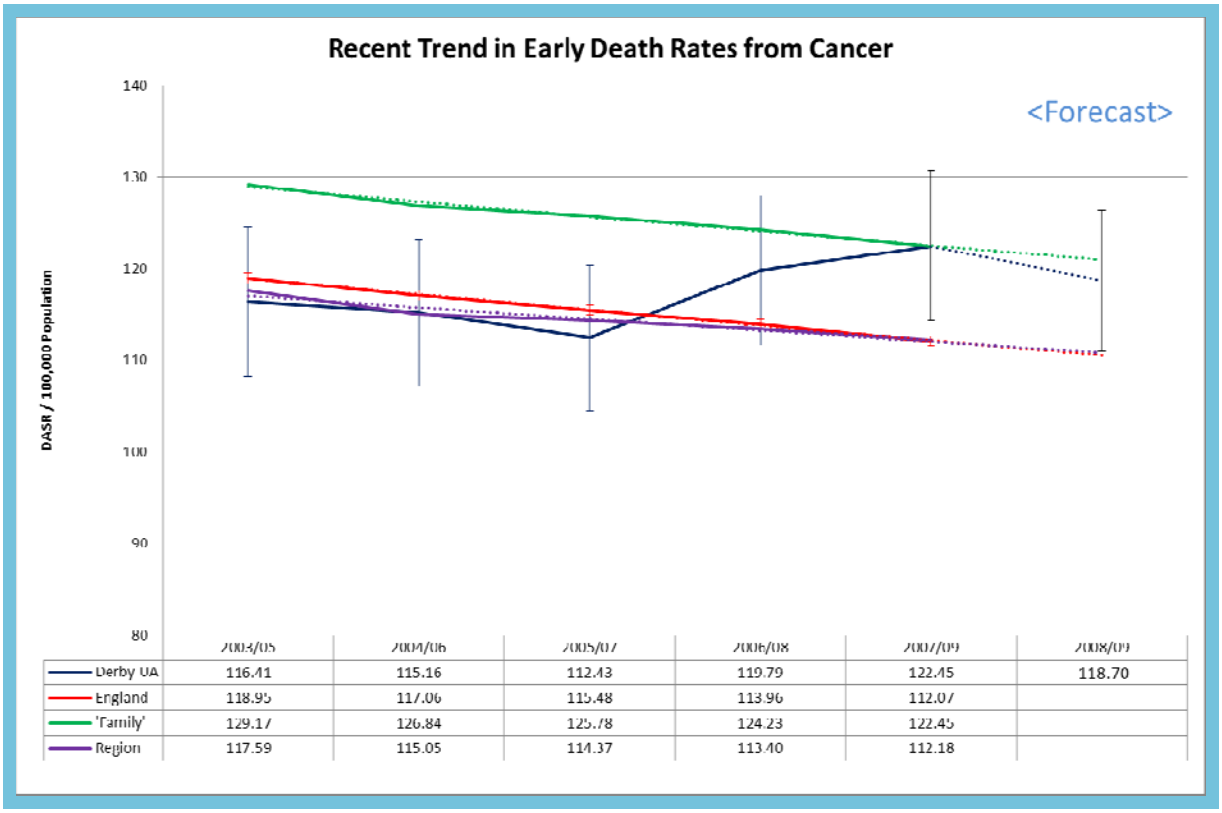
Source: APHO (Association of Public Health Observatories); Derby Health Profile 2011

Analysis

Figure 1 shows Derby's trajectory in early death rates from cancer since the 1999 baseline, where in 2007 and 2008 an increase in rate has been seen locally. Figure 2 below, is a more detailed view of the area bordered by the dotted line in the figure above, and shows as well as England, the East Midlands region and Derby's 'Family' group average rates; as well as a forecast of the 2008/09 mortality rate – due to be published in 2012.

Whilst the family group of LAs has seen rates of mortality far greater than in Derby, all three areas (national, regional and family) have demonstrated a similar downward trend. In 2011 (using 2007/09 years of mortality data), the rate in Derby has climbed to the same seen across its family group, and is also now significantly higher than seen nationally.

Figure 52: Recent comparison trend and forecast of premature mortality from cancer



	2003/05	2004/06	2005/07	2006/08	2007/09	2008/09
Derby UA	116.41	115.16	112.43	119.79	122.45	118.70
England	118.95	117.06	115.48	113.96	112.07	
'Family'	129.17	126.84	125.78	124.23	122.45	
Region	117.59	115.05	114.37	113.40	112.18	

Source: ONS (Office for National Statistics); NCHOD – Clinical & Health Outcomes Knowledge Base

Appendix 1 gives details of the numbers of early deaths from cancer in Derby in the respective years of registration. The figures are extracted from the Public Health Mortality File (PHMF) stored locally within the NHS, which also gives more timely data than that published nationally – hence why 2008/10 data is shown here when only 2007/09 has recently been published.

Evidently, the numerator – the number of deaths [856] anticipated to be published in 2012 (2008/10 years of mortality data) is expected to return to a similar number [851] seen in the data published in 2010. The denominator – population aged under 75 will

continue to grow and as such, the rate of early deaths from cancer is expected to fall to approximately 119 per 100,000 age standardised population.

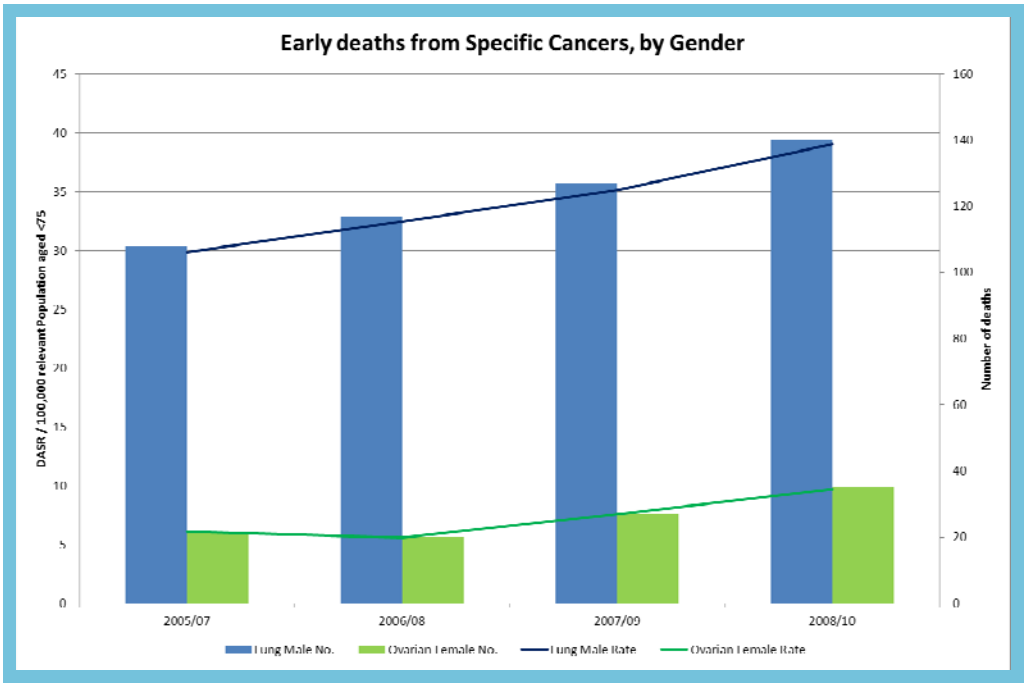
Why the increase?

Based on an exponential forecast trend of the other area's rates; while Derby's will still be high in 2012, the rate is likely to be marginally comparable to that seen nationally.

Studying the numbers of early deaths from cancer over the last four, 3-year periods; an increase in lung cancer deaths in males have had the biggest single impact in terms of volume (part of the 'respiratory and intrathoracic organs' type of cancers seen in Appendix 1), as have sigmoid colon cancers [1, 3, 6, 8 deaths] and mesotheliomas [19, 19, 28, 28 deaths].

In females, early deaths from ovarian cancers (part of the 'female genital organs' type of cancers seen in Appendix 1) have increased, as have skin cancers [2, 6, 9, 14 deaths] and multiple myelomas [5, 8, 8, 10 deaths]. The number of early deaths from breast cancer in females has shown a decline in recent years.

Figure 53: Top causes of recent increase in premature mortality by gender



Source: PHMF and ONS for relevant mid-year estimates of population

KEY CONSIDERATIONS:

- *Why have early deaths in these types of cancer risen over the period in question?*
  - *Is the quality of treatment offered different to elsewhere?*
  - *Is it simply a change in coding technique when registering the deaths?*
- *Why is the trend different in Derby:*
  - *Are there issues with time taken to diagnose?*
  - *Is it as a result of changes in population demographics?*
- *Could this potentially be the start of a fluctuating upward trend?*

Numbers of early deaths from cancer

Table 63: Numbers of Early Deaths from Cancer in Derby, by Type

Broad Type of Cancer	Gender	2005/07	2006/08	2007/09	2008/10
Respiratory and intrathoracic organs	Male	116	123	137	146
	Female	82	98	96	93
Digestive organs	Male	136	144	144	137
	Female	72	72	85	79
Malignant neoplasms of ill-defined, secondary and unspecified sites	Male	36	38	33	31
	Female	38	42	37	39
Breast	Male			<5	<5
	Female	62	64	61	60
Primary Malignant neoplasms of lymphoid, haematopoietic and related tissue	Male	35	31	27	29
	Female	25	26	28	33
Female genital organs	Male				
	Female	43	38	46	49
Urinary tract	Male	34	33	33	26
	Female	12	13	11	11
Male genital organs	Male	32	32	27	23
	Female				
Eye, brain and other parts of central nervous system	Male	20	22	18	16
	Female	10	10	10	7
Mesothelial and soft tissue	Male	19	19	28	28
	Female	<5	6	<5	<5
Lip, oral cavity and pharynx	Male	15	14	15	9
	Female	<5	<5	<5	<5
Skin	Male	9	7	6	5
	Female	<5	7	10	15
Thyroid and other endocrine glands	Male	<5	<5	6	6
	Female		<5	<5	<5
Malignant neoplasms of independent (primary) multiple sites	Male	<5	<5	5	<5
	Female	<5			
Bone and articular cartilage	Male	<5	<5	<5	<5
	Female	<5	<5	<5	
TOTALS	Male	**815**	**851**	**876**	**856**
	Female				

Source: PHMF (Public Health Mortality File)

8 APPENDIX: CHILD HEALTH DATA COMPARISONS

8.1 Areas highlighted as significantly worse than the England average

Table 64are the areas highlighted as significantly worse than the England average have been compared to existing data for these indicators: the Derby Health profile that was released 2010 [74] and the data in the Derby Health Schools Report 2009. This has been done to highlight the accuracy of the figures and to show whether Derby has improved over the last couple of years in these areas even if it is still showing that is significantly below the country average.

Table 64: Child health data comparison from the ChiMat data

Indicator	Data	Source	Derby	England average
Infant Mortality	ChiMat 2011	*ONS per 1,000 live births 07-09*	7.4	4.7
	Derby Health Profile 2010	*ONS per 1,000 live births 06-08*	5.68	4.84
	Derby Healthy Schools report 2009	*ONS per 1,000 live births 05-07*	5	4.9
Tooth decay in children (average per child)	ChiMat 2011	*APHO health profiles 07/08*	1.5	1.1
	Derby Health Profile 2010	*5yr old sampled rate 07/08*	1.5	1.1
	Derby Healthy Schools Report 2009	*05/06*	1.2	1.5
Teenage conception rate age <18	ChiMat 2011	*ONS/Teenage pregnancy unit per 1,000 age 15-17 06/08*	50.9	41.0
	Derby Health Profile 2010	*per 1,000 age 15-17 07/08*	51.2	40.9
	Derby Healthy Schools Report 2009	*per 1,000 04/06 & 05/06*	52.1	41.2
Hospital admission rate due to injury <18	ChiMat 2011	*HES per 100,000 06-07 -09/10*	1694.2	1443.2
	Derby Healthy Schools report 2009	*HES per 10,000 2008-09*	119	-
MMR immunisation-2 yrs.	ChiMat 2011	*NHS IC 2009/10* (%)	86.3	88.2
	NHS Derby City figures	*08/09* (%)	81.4	84.87
Hospital admission due to substance misuse age 15-24	ChiMat 2011	*HES per 100,000 05/07-08/09*	85.9	62.8
	Derby Healthy Schools Report 2009	*HES per 10,000 08/09**	9.3	10.9
First time entrants to the youth offenders system	ChiMat 2011	*Department of Education per 100.000 08/09*	2100.0	1472.0
	Derby Healthy Schools Report 2009	*per 100,000 population 07/09 – 07/08*	1811	1840
Participation in positive activities	ChiMat 2011	*Tellus4Survey NFER (Year 10)*	61.7	65.8
	Derby Healthy Schools Report 2009	*Tellus4Survey* (%)	68.6	69.5
Not in education, employment or training age 16-18	ChiMat 2011	*Connexions service 2009 DfE*	7.1	6.4
	Derby Healthy Schools Report 2009	*% of Derby ward population 2007*	7.4	10.3
Rate of family homelessness	ChiMat 2011	*Dept. for Communities & Local Government 2008 per 1,000*	3.7	1.9
	Derby Health Profile 2010	*rate per 1,000 household 08/09*	2.97	2.48
	Derby Healthy Schools report 2009	*rate per 1,000 household 07/08*	4.5	2.8
Children in poverty age <16	ChiMat 2011	*% of children under 16 in families in receipt of benefits/tax credits where income is less than 60% median income 2008 HMRC*	25.1	21.6
	Derby Health Profile 2010	*As above but 2007 data*	27.3	22.4

***substance misuse rate only - not hospital admissions. Please note than some of these sources are per 1,000 population, some are per 10,000 population and some are 100,000 population**

8.2 Tables 18-22 collated

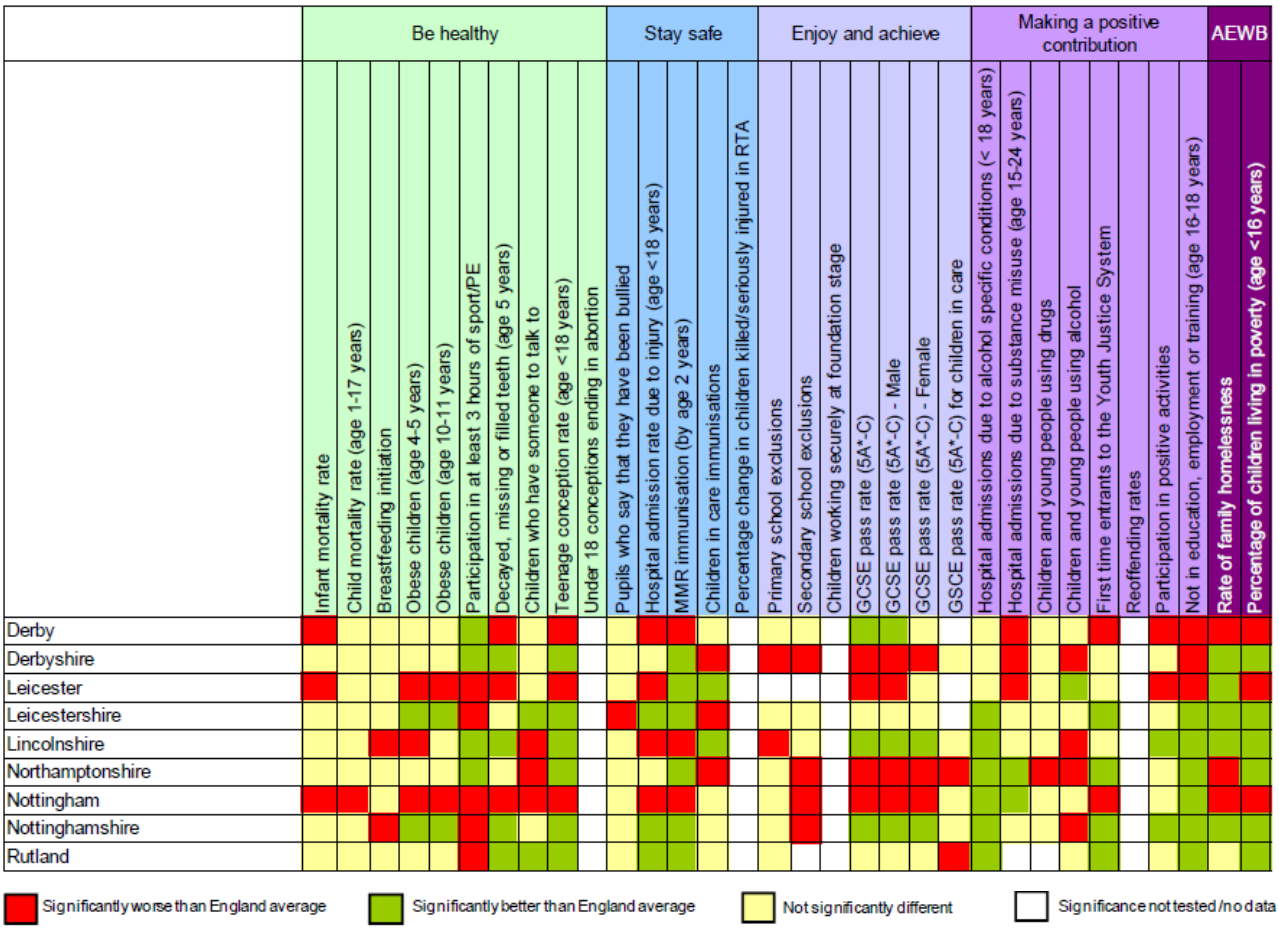
Table 65: Collated information for Tables 18 to 22

Measure/Indicator	Derby Performance against national average	Derby Performance against 'family' average	Derby	Leicester	Nottingham	'Family'	England
Infant mortality rate			7.4	7.3	6.2	5.8	4.7
Child mortality rate age 1-17			16.2	19.9	23.7	18.4	16.9
Breastfeeding initiation (%)			72.3	75.2	73.8	65.8	74.6
Obese children age 4-5 (%)			10.3	11.4	11.3	10.2	9.83
Obese children age 10-11 (%)			19.4	21.9	21.9	20.3	18.73
Participation in at least 3 hours of sport (%)			56.6	38.3	47.9	48.6	49.6
Decayed, missing or filled teeth age 5 (average per child)			1.5	2.2	1.7	1.4	1.1
Children who have someone to talk to (%)			63	65	56	61.3	64
Teenage conception rate age <18			50.9	52.9	68.3	52.7	40.9
Under 18 conceptions ending in abortion (%)			36.5	40.1	37.1	45	49.7
Pupils who say that they have been bullied (%)			23	19	24	23.8	23
Hospital admission rate due to injury < 18			169	1844	1616	1613	1444
MMR Immunisation by age 2 (%)			86.3	90.1	82.2	90.2	88.2
Children in care immunisations (%)			87	91	85	87.3	83.9
Percentage change in children killed/seriously injured in RTA			11.5	-16.7	15.3	5.4	6.4
Primary school exclusions (%)			0.0	-	0.03	0.009	0.02
Secondary school exclusions (%)			0.23	-	0.27	0.17	0.17
Children working securely at foundation stage (%)			44	41	52	49.3	51
GCSE pass rate (5A*-C)(%)			76.5	71.5	71.4	76.8	74.8
GCSE pass rate (5A-C*) Male (%)			74.3	64.9	67	62.7	70.8
GCSE pass rate (5A-C*) Female (%)			78.8	78.4	75.7	69.5	79
GSCE pass rate (5A*-C) for children in care (%)			-	-	17	-	26.1
Hospital admissions due to alcohol specific conditions < 18			69.8	66.9	44.9	81.6	64.5
Hospital admissions due to substance misuse age 15-24			85.9	87.1	40.2	84.6	62.8
Children & young people using drugs (%)			4	3	6	3.5	4
Children & young people using alcohol (%)			16	7	13	14	15
1st time entrants to Youth Justice System			2100	1340	2010	1527	1472
Reoffending rates			0.8	1.2	1	0.9	1.1
Participation in positive activities (%)			61.7	56.6	61.2	60.3	65.8
Not in education, employment or training age 16-18 years (%)			7.1	7.6	5.4	8	6.4
Rate of family homelessness			3.7	1.6	5.2	2.1	1.91
Percentage of children living in poverty age < 16			25.1	34.1	37.3	24.3	21.6

8.3 Comparison to East Midlands

Table 66shows a comparison for the Child Health data between Derby and the rest of the East Midlands.

Table 66: Summary of child health in Derby compared to East Midlands[70]



8.4 Data sources

These are the data sources used for the Child Health Section

Table 67: Data sources

	Indicator / measure	Source
Be Healthy	Infant mortality rate	*ONS per 1,000 live births 07/09*
	Child mortality rate age 1-17	*ONS per 100,000*
	Breastfeeding initiation (%)	*VSM return Q2 10/11*
	Obese children age 4-5 (%)	*NCMP 09/10*
	Obese children age 10-11 (%)	
	Participation in at least 3 hours of sport (%)	*APHO health profiles 08/09*
	Decayed, missing or filled teeth age 5 average per child (%)	*APHO health profiles07/8*
	Children who have someone to talk to (%)	*Tellus4Survey 2009*
	Teenage conception rate age <18	*ONS/Teenage pregnancy unit 06/08 per 1,000*
	Under 18 conceptions ending in abortion (%)	*ONS/Teenage pregnancy unit 06/08*
Stay Safe	Pupils who say that they have been bullied (%)	*Tellus4Survey 2009*
	Hospital admission rate due to injury < 18	*HES per 100,000 06/07-09/10*
	MMR Immunisation by age 2 (%)	*NHS IC 2009/10*
	Children in care immunisations	*DfE 2009* (%)
	Percentage change in children killed/seriously injured in RTA	*DfT 07/09*
Enjoy and Achieve	Primary school exclusions	*DfE 08/09* (%)
	Secondary school exclusions	
	Children working securely at foundation stage	*DfE 2010* (%)
	GCSE pass rate (5A*-C)	*DfE 09/10* (%)
	GCSE pass rate (5A-C*) Male	
	GCSE pass rate (5A-C*) Female	
	GSCE pass (5A*-C) children in care	*DfE 2010*(%)
Making a Positive Contribution	Hospital admissions due to alcohol specific conditions < 18	*LAPE per 100,000 06/07 – 08/09*
	Hospital admissions due to substance misuse age 15-24	*HES per 100,000 05/07-08/09*
	Young people using drugs	*Tellus4Survey 2009 Years 8 & 10*
	Young people using alcohol	*Tellus4Survey 2009 drunk 1+ times in last four weeks*
	1st time entrants to YJS	*DfE per 100,000 08/09*
	Reoffending rates	*Youth offending Team 08/09*
	Participation in pos. activities (%)	*Tellus4Survey NFER - Year 10*
	Not in education, employment or training age 16-18 years(%)	*DfE Connexions Service 2009*
AEWB	Rate of family homelessness	*Dept. for Communities & Local Government 2008 per 1,000*
	Percentage of children living in poverty age < 16	*in families claiming benefits/tax credits & income < 60% median income 2008 HMRC*
Some of the sources are per 1,000 populations, some are per 10,000 population and some are 100,000 populations.		

9 APPENDIX: NATIONAL GUIDANCE AND BEST PRACTICE

9.1 Alcohol

Source	Key recommendations
National Institute for Health and Clinical Excellence	
Alcohol-use disorders: preventing the development of hazardous and harmful drinking June 2010[45]	Recommendation include: **Price:** Making alcohol less affordable is the most effective way of reducing alcohol-related harm. ***Action:***Consider introducing a minimum price per unit and regularly review the minimum price per unit. **Availability**: Reducing the number of outlets selling it in a given area and the days and hours when it can be sold is an effective way of reducing alcohol-related harm. ***Action:*** Consider revising legislation on licensing to ensure: health bodies are responsible authorities; licensing departments can take into account the links between the availability of alcohol and alcohol-related harm when considering a licence application. **Marketing:** There is evidence that alcohol advertising does affect children and young people. ***Action:*** Ensure children and young people's exposure to alcohol advertising is as low as possible by considering a review of the current advertising codes. **Licensing:** Use local crime and related trauma data to map the extent of alcohol-related problems before developing or reviewing a licensing policy. If an area is **'saturated'** with licensed premises and the evidence suggests that additional premises may affect the licensing objectives, adopt a 'cumulative impact' policy. If necessary, limit the number of new licensed premises in a given area. (An alcohol saturation review has been written – see 0) **Resources for screening and brief interventions:** Prioritisation of an alcohol-use disorder prevention as an 'invest to save' measure. A local joint alcohol needs assessment should be carried out and a locally defined integrated care pathway for alcohol should be implemented. Plans should include screening and brief interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers). **Supporting children and young people aged 10 to 15 years:** If there is a reason to believe that there is a significant risk of alcohol-related harm, consider referral to child and adolescent mental health services, social care or to young people's alcohol services for treatment, as appropriate and available. **Screening young people aged 16 and 17 years:** Complete a validated alcohol screening questionnaire. Focus on key groups that may be at an increased risk of alcohol-related harm. **Extended brief interventions with young people aged 16 and 17 years:** Give those who are actively seeking treatment for an alcohol problem a physical and mental assessment and offer, or refer them for, appropriate treatment and care. **Sceening Adults:** Routinely carry out alcohol screening as an integral part of practice during new patient registrations, when screening for other conditions and when managing chronic disease or carrying out a medicine review. **Brief advice for adults:** Offer a session of structured brief advice on alcohol and routinely monitor progress in reducing alcohol consumption to a low-risk level. **Extended brief interventions for adults:** Offer an extended brief intervention: this could take the form of motivational interviewing or motivational-enhancement therapy. **Referral:** For those who have failed to benefit from structured brief advice and an extended brief intervention.
Source	Key recommendations
National Institute for Health and Clinical Excellence	
'Alcohol-use disorders:	One of the recommendations was aimed at the **licensing** of alcohol premises with the intention that Local Authorities, the Police, Trading Standard Officers,

Source	Key recommendations
preventing harmful drinking' June 2010[75]	Magistrates and Revenue and Customs could action it [75]Pg.12. The recommendation is: *"Use local crime and related trauma data to map the extent of alcohol-related problems before developing or reviewing a licensing policy. If an area is '**saturated**' with licensed premises and the evidence suggests that additional premises may affect the licensing objectives, adopt a 'cumulative impact' policy. If necessary, limit the number of new licensed premises in a given area".* (Cumulative impact refers to the potential impact on the promotion of the licensing objectives of a significant number of licensed premises concentrated in one area.) Another recommendation was aimed at the **availability** of alcohol: *"International evidence suggests that making it less easy to buy alcohol, by reducing the number of outlets selling it in a given area and the days and hours when it can be sold, is an effective way of reducing alcohol-related harm. Changes to the current licensing provisions will enable members of licensing authorities to be an interested party. However, the Licensing Act does not, as it stands, cover public health considerations. Making this kind of change to the current licensing provisions may result in some initial implementation difficulties. However, the PDG believes that the long-term benefits would outweigh any immediate difficulties".* Pg.32 Since 2004, the detrimental effects of alcohol-use disorders have resulted in several government policy initiatives. In addition, the need to prevent and reduce alcohol-use disorders has been incorporated into several public service agreements (PSAs). For examples, see the NICE document Pg. 27.

9.2

9.3 Teenage pregnancy

Source / Title	Key recommendations
Department of Health	
Getting maternity services right for pregnant teenagers and young fathers **Revised edition 2009** [65]	Timely access to appropriate care and support can help avoid poor outcomes and maximise young people's chances of a positive transition to parenthood. This guidance suggests that maternity services can engage more effectively with young people by adopting the following: • An environment welcoming to young women and young men • Easily accessible services • Clarity about confidentiality and child protection • Young people are treated with respect • An empowering approach • Accessible information that meets both parents' needs • Young fathers' value is openly acknowledged • Strong referral links with relevant agencies • Effective support to both young parents to prevent second unplanned pregnancies • Staff are trained to work with young women and men.
Department of Health, Department for Children, Schools & Families	
"Teenage pregnancy prevention and support: A self-assessment toolkit for local performance management" May 2009[63]	The resource builds on guidance for LAs and PCTs. It is expected that there is already a performance management framework in place; this is a self-assessment toolkit for use as part of the annual planning and review cycle, contributing to work under the remit of the Children and Young People's Plan. The toolkit focuses on more tangible measures of inputs, process and, where possible, outcomes rather than a subjective assessment of local strategy implementation. To ensure the best practice activities identified in the toolkit are having the desired impact, sections include suggestions of relevant local data which can be used to monitor the impact of local action. It is recommended for use as part of the annual planning and review cycle by those responsible for achieving the teenage conception target and supporting teenage mothers and young fathers.
Teenage Pregnancy Independent Advisory Group (TPIAG)	
Annual Report **2008/09** [62]	Their reports finds: • There is still wide geographical variation in success over the past nine years. If all local areas had done as well as the top 25%, then the national target would be closer to being achieved. • The extra funding for contraception from the DH, for example, has not been accessed and used consistently by all local areas. • The teenage pregnancy rate has resumed its downward trend and many areas have achieved significant reductions. • TPIAG's biggest achievement for 2008/9 was its part in persuading the Government to make PSHE education a statutory subject.

Source / Title	Key recommendations
	These have to be addressed for local strategies to work effectively: • Strong executive and strategic leadership in the LA and PCT and an up-to-date vision for teenage pregnancy embedded within the Children's Trust • A senior level group must define the long-term vision for teenage pregnancy and ensure the work is integrated into all services and agendas • All stakeholders, including specific groups such as elected council members and school governors, are empowered to become confident teenage pregnancy champions • The Teenage Pregnancy Co-ordinator must have senior status so that s/he can work with colleagues at a strategic level and undertake commissioning • Local data must be used effectively to ensure performance monitoring indicators cover all aspects of the Strategy • A communications strategy must be in place to promote clear and consistent messages to internal and external audiences • There must be effective identification and targeting of young people most at risk through a consistent, co-ordinated approach • A co-ordinated children's workforce development strategy must ensure members are confident and competent to address sexual health issues • Parents and carers must be supported to discuss sex and relationships confidently. **Recommendations:** 1. Mechanisms should be put in place to identify those at risk of teenage pregnancy. 2. TPIAG urges Government to ensure that the legislation to make PSHE/SRE statutory goes through Parliament swiftly. 3. TPIAG calls for CASH services, to be available to all young people through on site health services in school, further education colleges and community services and recommends the Government tries new, innovative approaches, such as offering personalised advice and support to all young people. 4. TPIAG recommends that Government ensures the new 14-19 reform agenda meets the specific needs of young parents. 5. TPIAG urges Government to keep to its commitment of investing £30 million over three years in supported housing for 16-17 year olds, including teenage parents. Further funding will need to be identified. 6. TPIAG calls for Government to commit adequate resources to ensure that LAs, PCTs and the voluntary sector support young mothers and fathers in developing parenting and life skills and ensuring long-term inclusion. The Teenage Pregnancy Strategy needs to be extended beyond 2010 and developed further for the next decade.

9.4 Obesity

Title	Key recommendations
National Institute for Health and Clinical Excellence (NICE)	
Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children **December 2006**[59]	This guidance makes a series of recommendations. There are three aims: • To stem the rising prevalence of obesity and associated diseases • To increase the effectiveness of interventions to prevent overweight and obesity • To improve the care provided to adults and children, particularly within primary care. It recommends that diet changes and exercise, supported by behaviour change should be the first line of treatment for adults who are overweight or obese, followed by drug treatments if lifestyle interventions are unsuccessful. Surgery can also be considered. The document states that: Healthcare professionals should advise people on maintaining a healthy weight through being physically active, eating five portions of fruit and vegetables a day and avoiding foods that are high in fat and sugar. Drug treatment should only be considered after dietary, exercise and behavioural approaches have been started and evaluated or in patients who have not reached their target weight loss or have reached a plateau using dietary, activity and behavioural changes alone. Surgical treatments are currently only recommended for people with a BMI of 40kg/m² and above or 35kg/m² and above if they have additional health complications such as type 2 diabetes or high blood pressure and if all appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least 6 months; the person has been receiving or will receive intensive management in a specialist obesity service and the person is generally fit for anaesthesia and surgery; the person commits to the need for long-term follow-up. Surgery is only recommended as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m2. There are many factors that could be affecting a person's ability to stay at a healthy weight or succeed in losing weight. Staff working directly with the public need to be aware of these: People choose whether or not to change their lifestyle or agree to treatment. Assessing their readiness to make changes affects decisions on when or how to offer any intervention. Barriers to lifestyle change should be explored. Possible barriers include: • Lack of knowledge about buying and cooking food, and how diet and exercise affect health • The cost and availability of healthy foods and opportunities for exercise • Safety concerns, for example about cycling • Lack of time • Personal tastes • The views of family and community members • Low levels of fitness, or disabilities • Low self-esteem and lack of assertiveness. Advice needs to be tailored for different groups. Treating children for being overweight/obesity may stigmatise them and put them at risk of bullying, which in turn can aggravate problem eating. Interventions to help children eat a healthy diet and be physically active should develop a positive body image and build self-esteem. **Priorities for implementation:** NHS Managers and health professionals in all primary care settings should ensure that preventing and managing obesity is a priority, at both strategic and delivery levels. Dedicated resources should be allocated for action.

Title	Key recommendations
Scottish Intercollegiate Guidlines Network (SIGN)	
Management of Obesity: A National Clinical Guideline. February 2010[60].	This guidance provides evidence based recommendations on the prevention and treatment of obesity within the clinical setting, in children, young people and adults. In particular the guideline addresses: • Primary prevention of obesity in children, young people and adults • Treatment of overweight/obesity by diet and lifestyle interventions • Treatment of obesity by pharmacological therapy and bariatric surgery • Prevention of weight regain following treatment. Key recommendations: **Prevention**: Individuals should be advised to reduce the intake of energy dense foods, 'fast foods' and alcohol and be encouraged to be physically active and reduce sedentary behaviour. **Physical**: overweight and obese individuals should be prescribed a volume of physical activity equal to approximately 1800-2500 kcal/week (225-300 minutes/week) **Pharmacological**: Orlistat should be considered as an adjunct to lifestyle interventions in the management of weight loss for patients who have a BMI of ≥28kg/m^2 with co-morbidities or who have a BMI of ≥30kg/m^2. **Bariatric surgery**: This should be considered on an individual case with patients who have a BMI of ≥35kg/m^2 and a presence of one or more sever co-morbidities and have evidence of the completion of a structured weight management programme. **Health CareServices**: Explicit care pathways should be implemented offering a range of weight management interventions targeted at various subgroups of the population.
Centre for Maternal and Child Enquiries (CMACE) &Royal College of Gynaecologists and Obstetricians (RCOG) joint guideline	
Management of women with obesity in pregnancy March 2010[61]	The CMACE, together with the RCOG has developed these guidelines for the management of women with obesity during pregnancy. Maternal obesity has become one of the most commonly occurring risk factors in obstetric practice. These are a summary of the guidelines: • Primary care services should ensure that all women of childbearing age have the opportunity to optimise their weight before pregnancy. Advice on weight and lifestyle should be given during family planning consultations, and weight, BMI and waist circumference should be regularly monitored. • Women with BMI≥30 wishing to become pregnant should be advised to take 5mg folic acid supplementation daily and to take 10mcg Vitamin D supplementation daily during pregnancy and while breastfeeding. • Management of obesity in pregnancy should be integrated into all antenatal clinics, with clear policies and guidelines for care available, their weight and height measured and their BMI calculated. • Women with BMI≥40 should have consultation with an obstetric anaesthetist, to identify difficulties with venous access, regional or general anaesthesia. • Women with BMI≥40 should have a documented assessment to determinemanual handling requirements for childbirth and consider tissue viability issues. • Women with BMI≥30 should be assessed at their first antenatal visit and throughout pregnancy for the risk of thromboembolism and should be encouraged to mobilise as early as practicable following childbirth. • Those with BMI≥30 requiring pharmacological thromboprophylaxis should be prescribed doses appropriate for maternal weight.

Title	Key recommendations
Management of women with obesity in pregnancy March 2010[61] (cont.)	• Women with a booking BMI≥35 have an increased risk of pre-eclampsia and should have surveillance during pregnancy. • All those with BMI≥30 should be screened for gestational diabetes. Those who are diagnosed with it should have a test of glucose tolerance approximately 6 weeks after giving birth. • Women with BMI ≥30 should have an informed discussion antenatally about possible intrapartum complications associated with a high BMI. • Women with BMI≥30 should have an individualised decision for vaginal birth after caesarean following informed discussion and consideration of all relevant clinical factors. • Women with BMI≥35 should give birth in a consultant-led obstetric unit with appropriate neonatal services, • The duty anaesthetist covering labour ward should be informed when a woman with BMI ≥40 is admitted to the labour ward if delivery or operative intervention is anticipated. • Operating staff should be alerted regarding anyone whose weight exceeds 120kg and is due to have an operative intervention in theatre. • Women with BMI≥40 should have venous access established early in labour. • Women with BMI≥30 having a c-section have an increased risk of wound infection and should receive prophylactic antibiotics at the time of surgery. • Obesity is associated with low breastfeeding initiation and maintenance rates. Women with BMI ≥30 should receive appropriate specialist advice and support antenatally and postnatal. • Women with BMI≥30 should continue to receive nutritional advice following childbirth, with a view to weight reduction.
National Obesity Observatory	
Obesity and Ethnicity(76) January 2011	Obesity prevalence varies substantially between ethnic groups for bothadults and children in the UK. Estimates of adult obesity prevalence by ethnic group seem to differ according to the measurement used (for example, BMI, waist-to-hip ratio and waist circumference): • Black African women have the highest obesity prevalence when using waist circumference as a measure, and • Bangladeshi women when using waist-to-hip ratio; and • Chinese men and women appear to have the lowest obesity prevalence whichever measure is used There is continuing debate about the applicability of definitions of obesity across ethnic groups for adults and children. • Different ethnic groups have different physiological responses to fat storage • Data from the National Child Measurement Programme (NCMP) show that obesity appears to be increasing for Bangladeshi boys • Revised BMI thresholds have been recommended for the South Asian population who are at risk of chronic diseases and mortality at lower BMI levels than the European population

Title	Key recommendations
	Following International Diabetes Federation (IDF) guidelines, lower waist circumference thresholds of 90cm (men) and 80cm (women) for the South Asian population compared to the general population are in common use Similarly, a recommendation has been made to reduce the healthy waist circumference threshold for men from Chinese ethnic groups from 94cm to 90cm, to indicate increased risk. In terms of public health action it is particularly important for South Asian populations in the UK to be aware of the health risks of increased BMI and waist circumference