BORDERS DIRECTOR OF PUBLIC HEALTH REPORT 2015

NHS Borders

Scottish Borders COUNCIL

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FOREWORD

I am pleased to present the 2015 Borders Director of Public Health Report. There is much to talk about and some major successes and improvements to celebrate, some of which I've included in this Report.

There have been many changes in the Borders since Dr Baijal, who has now retired as Director of Public Health, produced his report for 2013/4 report 'Working towards Well Being in the Scottish Borders'. This drew together the consultation responses to his 2011-2012 report "Fact or Fantasy? Your Health 2020" and produced an action plan based on responses received. Many of these actions are currently being taken forward by NHS Borders and the Scottish Borders Council in partnership with local communities through the Community Planning Partnership (CPP). The establishment of a new Health and Social Care Integrated Joint Board (IJB) for the strategic planning of health and social care community services is also a significant step in improving the health of the population of the Borders.

Traditionally, the Director of Public Health's Annual Report covered a lot of information that is now covered in the CPP and IJB strategic plans and the NHS Borders Clinical Strategy[1,2,3,4]. As Interim Joint Director I have decided to present a Public Health Report on the health and wellbeing of the people of the Borders in a different way. The rationale is to provide timely and easily accessible information about health trends that:

- identify key areas on which to focus preventative measures and develop health policies and strategies, and
- increase public and stakeholder understanding of the health of the population and the factors that affect it.

I wanted to make the information accessible and understandable to as many people as possible and so this report summarises the key health data at different stages of the life course – starting with local health outcomes for children and moving through adulthood to old age. Specific population topics and health inequalities are also highlighted. I have attempted to highlight challenges for the Borders community at the end of each chapter and these are also summarised at the beginning of the Report.

The production of this Report has very much been a team effort and 'distils' the experience and expertise of all members of the very talented, often "virtual", Public Health Team both within Scottish Borders Council and NHS Borders. I am extremely grateful for support of the Team and of many others within NHS Borders and Scottish Borders Council who are passionate about improving the health of Borders people. As editor, I personally take responsibility for any errors, whether of omission or commission.

I hope you enjoy reading this report as well as finding it of interest and value. Please try and play your individual part in taking responsibility for your own health, addressing the issues raised as well as trying to interest others in them.

Dr Tim Patterson
Interim Joint Director of Public Health

FURTHER INFORMATION

If you have any questions or comments about any aspect of the report or should you require further copies of this report please contact:

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A copy of this report is also available at www.nhsborders.org.uk and www.scotborders.gov.uk.

SUMMARY OF KEY CHALLENGES FOR 2016

There is a lot to celebrate in this report but there are also areas of concern. The following are key challenges to be considered by local organisations, planning groups, communities and individuals involved in improving health and well-being in the Borders. They are referenced to the relevant Report Chapter.

CHAPTER 3: WHO LIVES IN THE BORDERS?

The numbers of people aged 65-74 may increase by almost one third (32%), whilst the numbers aged 75 and over may increase by 75%. As our population ages it is vital that maintaining and improving physical, mental, social and economic wellbeing of older adults is a priority.

Census data may not capture the seasonal economic migration that occurs in the Borders to support the farming and fishing industry. Significant migration to the UK has also occurred since the 2011 census and the 2011 data may under report white non British and other ethnic minorities. Local services need to be sensitive to migrant health issues.

CHAPTER 4: HOW LONG MIGHT WE LIVE?

There are areas within the Scottish Borders where the male and female life expectancy is lower than for Scotland. Differences in average life expectancy between people living in the least and most deprived areas are mainly due to deaths from coronary heart disease, stroke, cancer and respiratory disease. These inequality issues are covered in more detail in Chapter 11: Health Inequalities in the Borders.

CHAPTER 5: ARE WE HAPPY WITH OUR LIVES?

The mental health of children and young people (C&YP) under 17 years in Scotland has improved or stayed broadly constant over the past decade or so. However the data suggest that there is considerable scope for action. Life satisfaction and happiness decreased with age between P7, S2 and S4 pupils. Inequalities by area deprivation (SIMD) are common across both mental wellbeing and mental health problems.

More than 80,000 people aged 65 plus in Scotland describe themselves as often or always feel lonely. Loneliness can be seriously damaging and recent studies have shown it has double the impact of obesity and that feeling extreme loneliness can increase an older person's chances of premature death by 14%. The Scottish Government Equal Opportunities Committee is currently examining the issue of loneliness in Scotland.

CHAPTER 6: STARTING WELL: MATERNITY AND INFANCY

The rate of smoking in pregnancy appears higher in Scottish Borders than the Scottish average and is particularly high in the most deprived areas. The reduction of smoking in pregnancy remains a very high priority.

Although breastfeeding rates locally compare reasonably well with those from other parts of the country, far higher rates have been achieved elsewhere and therefore it is possible to do even better. This should be a priority for the future for the benefit of children and mothers.

Nutrition is an important foundation for good health and there continue to be challenges in ensuring access to affordable healthy food for all families with young children.

We need to ensure that children have the best possible opportunity for health and wellbeing and recognise the difference that family circumstances can make.

CHAPTER 7: DEVELOPING WELL: CHILDREN AND YOUNG PEOPLE

In Scotland as a whole, around 14.8% of girls and 17.2% of boys, aged 2-15 years, are estimated to be at risk of obesity. The rate of increase over the past 15 years has been greater for boys. If the Scottish trends also apply to Borders young people there may be an increasing problem with teenage boys gaining excess weight and all the physical and mental health issues that may bring.

It is disappointing that nationally there has been no overall increase or decrease in physical activity for Borders boys between 2008 and 2013. Public Health, Education and wider partners need to work closely to promote nutrition and healthy weight through the curriculum and activities and opportunities in local communities and by promoting a good food culture in Borders.

The emotional health of our young people affects all other aspects of their lives and we need to be sure that we are doing all we can to support young people to develop resilience to face the challenges of life.

CHAPTER 8: LIVING WELL: WORKING AGE ADULTS

A HEALTHY LIFESTYLE = DRINKING RESPONSIBLY

At least 43% of adults in the Scottish Borders may be exceeding recommended alcohol drinking limits. Alcohol related mortality is linked to long term drinking behaviours and so the impact of recent drinking is yet to appear. Reduction of excess drinking in men and women remains a priority.

A HEALTHY LIFESTYLE = REDUCING HARM FROM DRUGS

The trend for Scottish Borders drug related hospitals stays is increasing particularly in deprived areas. As drug users grow older i.e. 35 years, they are more likely to experience concurrent physical and mental health problems and service providers need to be aware of these needs.

A HEALTHY LIFESTYLE = EATING WELL AND BEING ACTIVE

The estimated prevalence of obesity tends to rise with increasing age, from around 1 in 9 people aged 16-24 to more than 1 in 3 people aged 55-74.

The majority of the population in the Scottish Borders do not meet the recommended level of physical activity. 29% of the population have low levels of physical activity.

CHAPTER 9: AGEING WELL

FUEL POVERTY

The lower income groups have the highest rates of fuel poverty, but fuel poor households are found in all income bands.

CARING AND CARERS

The percentages of carers rating their own health as bad or very bad increases with the amount of unpaid care provided. 3% of people providing less than 20 hours of care per week rated their health as bad/very bad, compared with 13% of people providing more than 50 hours of unpaid care. Service providers need to be aware of the needs of this group.

LONG TERM CONDITIONS

By the age of 65, nearly two-thirds of people will have developed a Long Term Condition: 75% of people aged 75-84 have two or more such conditions. Management of elderly persons with multiple conditions is one of the most challenging problems faced by service providers particularly in primary care. Organisations need to recognize that providing appropriate support to such patients will not only help maintain patients in good health but ultimately reduce demands on services in the future. The evaluation report from the local LTC project, expected in early 2016, should be carefully considered so we learn from it and use it to improve the management of LTCs across the region.

FALLS

The rate of hospital admissions following a fall in the Borders for the over 65s in the period 2012-12 was similar to that for Scotland. However this means there is still nearly 500 emergency admissions each year in Borders persons over 65 years due to falls.

EMERGENCY ADMISSIONS

The Scottish Borders has a higher rate of emergency hospitalisations compared to Scotland with more deprived communities having higher rates. By far the highest rates of emergency admissions to hospital are amongst people aged 75 and over. The most common cause of admission in this age group is chest infection. There may be opportunities to improve care for these patients in the community and thus prevent hospital admissions.

DEMENTIA

The cases of dementia are expected to significantly increase in the Borders over the next 5 years. This will have significant implications for families, communities and care providers.

CHAPTER 10: COMMON ILLNESSES SPANNING AGE GROUPS

CANCER

The actual numbers of cases of cancer have risen over the last decade, largely due to an ageing population, as the incidence of new cancer cases rises quickly after 65 years. Sustained prevention measures are important to bring about a reduction in the lifestyle risk factors amongst higher risk groups, although positive impact on the incidence of new cancers and prevalence will be gradual. Prevention should also include implementation of health promoting actions in acute care settings for those who already have health problems – inherent in the Health Promoting Health Services (HPHS) initiative. All these activities should aim to promote healthy weight, increase physical activity, promote smoking cessation and reduce alcohol consumption with effective pathways into community services and resources.

Bowel screening is one of the most effective screening programmes available and is estimated to save 7 lives per year in the Borders. Borders men have a lower uptake of bowel screening than women: 57.8% v 64.5% and the uptake is even lower in the most deprived groups. Every effort needs to be made to increase uptake in these groups.

DIABETES

The prevalence of diabetes across Borders is increasing year on year. The excess healthcare costs attributable to diabetes are substantial and pose a significant clinical and public health challenge. This burden is an important consideration for decision-makers, particularly given increasing concern over the sustainability of the healthcare system, aging population structure and increasing prevalence of diabetic risk factors, such as obesity.

A recent National Institute of Clinical Effective review suggests that the role of bariatric surgery for patients with a BMI of 30 or over who have recent-onset type 2 diabetes and who have failed to lose weight by other means, is likely to significantly increase in the future.

MENTAL ILL HEALTH

Lifestyle factors and barriers in accessing services adversely affect the physical health of people with mental health problems: poorer diets, low rates of exercise and higher prevalence of smoking than among the general population. All care providers need to be aware of these risks.

Men of working age, particularly in deprived communities, are a key risk group for suicide in the Scottish Borders. Suicide prevention strategies need to include explicit aims to reduce socio-economic inequalities and gender inequalities in suicide.

LEARNING DISABILITIES

Research tells us that people with learning disabilities have some of the poorest health of any group in Scotland. They are considerably more likely to die at an early age than the general population - on average 20 years before. Some of the causes of death are potentially preventable, and the main causes of death differ from those of the general population.

INFLUENZA

Even though we have nearly reached the Scottish Government target of 60% uptake for under 65 years at risk residents, we still have as many as 5437 eligible under 65 years at risk Borders residents at higher risk of complications from influenza due to underlying medical conditions who did not receive the vaccine during 2014/15. Continued sustained efforts are needed to reduce this figure.

Even though our NHS staff vaccination programme has achieved its highest uptake rate ever, continued sustained efforts are needed to increase this uptake performance in order to protect patients from infection.

CHAPTER 11: HEALTH INEQUALITIES IN THE BORDERS

There are significant inequalities in health in Scotland between people who are socially and economically well off, and those who are socially disadvantaged. Health inequalities are not only apparent between people of different socio-economic groups. Inequalities are also related to gender, ethnicity, age, mental health and learning disabilities. Whilst recognising that national government policies have a very important impact on health inequalities there is still a lot we can do in the Borders. We therefore need to enhance, develop and maintain partnership working across the Borders to address the many factors leading to health inequalities.

We need to ensure that all staff in statutory or non-statutory organisations understand their public health role in reducing health inequalities.

For example:

- Staff should understand what health inequalities exist and how these may be tackled
- Senior managers should provide leadership in supporting their staff to identify and address health inequalities.

We need to recognise people who are disadvantaged have higher health needs and the level and intensity of service provision should reflect that. Service development plans could contain a Health Inequalities assessment in addition to the current Equalities and Diversity assessment.

The built environment affects every aspect of our lives and has an influence on health inequalities e.g. availability of healthy food, location on health services, facilities for walking and cycling. We need to ensure that health is an important consideration in planning decisions. Health Inequalities Impact Assessment (HIIA) is a way for organisations to think about how their plans or decisions might affect people and population groups in different ways. The findings can inform the development and implementation of plans and policies, helping organisations to ensure that no-one is disadvantaged by what they do.

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CHAPTER 1

A PUBLIC HEALTH APPROACH TO IMPROVING HEALTH AND WELL-BEING

The public health approach to improving health and well-being in the Borders is for local organisations, planning groups, communities and individuals to work together to:

1. IMPROVE ACCESS TO, AND QUALITY OF, SERVICES AND FACILITIES

For example: healthy living centres; youth facilities; sports facilities; location of primary (and some secondary) care services in neighbourhoods; targeted outreach; workforce development.

2. PROACTIVELY SUPPORT HEALTHY LIFESTYLES, MENTAL AND PHYSICAL HEALTH AND WELLBEING

For example: smoking cessation programmes; exercise programmes and access to leisure facilities; diet, cookery and healthy food projects; sexual health projects; alcohol and drug misuse projects; promotion of screening and vaccination programmes.

3. TARGET VULNERABLE GROUPS

For example: early years and children; older people; people with alcohol and/or drugs problems; minority populations; teenage parents; those affected by long term health problems and disabilities.

4. TACKLE 'UPSTREAM' INFLUENCES ON HEALTH OUTCOMES

For example: welfare rights projects to improve income levels; improve access to employment related opportunities; improvements to neighbourhoods and green space; improvements to heating and security in homes; address social isolation.

5. INCREASE PARTNERSHIP WORKING

For example: notably with health service, social services and third sector organisations.

6. PROMOTE COMMUNITY INVOLVEMENT

For example: in planning and delivery of health interventions that increase involvement, choice and control.

LOCAL PARTNERS

A wide range of organisations are involved:

SCOTTISH BORDERS COMMUNITY PLANNING PARTNERSHIP

Community Planning is a process which helps public agencies to work together with the community to plan and deliver better services which make a real difference to people's lives.

The aims of the Scottish Borders Community Planning Partnership are:

- making sure people and communities are genuinely engaged in the decisions made on public services which affect them;
- allied to a commitment from organisations to work together, not apart, in providing better public services.

Scottish Borders has a simple structure comprising a Community Planning Board, a Chief Officers Group and 5 locally based Area Forums. Board members include representation from the Scottish Borders Council, NHS Borders and a range of other public and third sector partner representatives. The Partnership has set its three priorities as follows: Growing our economy; reducing inequalities; maximising the impact of the low carbon economy.

HEALTH & SOCIAL CARE PARTNERSHIP INTEGRATED JOINT BOARD

NHS Borders and Scottish Borders Council are working together to put in place formal joint working arrangements with the aim of providing better, more integrated adult health and social care services in the Borders. Planning of services for Scottish Borders Council and NHS Borders will be brought together by the Joint Integrated Board but a much wider range of services will be involved in the partnership.

PUBLIC HEALTH DIRECTORATE

Public Health focuses on promoting the health and well-being of people living in the Scottish Borders and protecting people from becoming ill. The Public Health Directorate consists of the following:

- The Joint Health Improvement Team leads and supports work across the Scottish Borders to improve health and reduce health inequalities.
- The Health Protection Team focus on protecting the public from infectious diseases and environmental hazards and coordinate screening services. Regulatory Services carry out work under a wide-range of legislation relating to the health, safety and welfare of our Borders community.

- The Alcohol and Drugs Partnership Support Team commission drug and alcohol services and interventions to reduce the impact of problem drug and alcohol use in the Scottish Borders.

- The Service Improvement Team assesses population needs and evidence to shape the design of local services.

- The Scottish Borders Public Health Inequalities Action Plan, currently in development, will underpin the Community Planning Partnership Reducing Inequalities Strategy Plan and identify the key priorities for the Scottish Borders and its partners.

HEALTH PROMOTING ORGANISATIONS

The 'Small Changes, Big Difference' campaign from NHS Borders aims to engage our staff, the public and businesses across the Borders to make small changes in their life and work practice to make a big difference to their own and other's health and wellbeing.

The NHS Borders Health Promoting Health Service (HPHS) programme focuses on the health and wellbeing of staff, patients and visitors in hospital and community settings. It has an underpinning theme that "every healthcare contact is a health improvement opportunity."

A project group has been set within the Scottish Borders Council to develop an implementation plan for promoting relevant aspects of the 'Small Changes, Big Difference' campaign to SBC staff.

ALCOHOL AND DRUGS PARTNERSHIP

The Scottish Borders Alcohol & Drugs Partnership (ADP) is tasked with delivering a reduction in the level of drug and alcohol problems amongst young people and adults in the Borders, and reducing the harmful impact on families and communities. ADP are committed to working with the Scottish Government, colleagues, people in recovery and local communities to tackle the problems arising from substance misuse.

ADP members, including Scottish Borders Council, NHS Borders, Police Scotland, and voluntary sector drug and alcohol services, adopt a joint strategic approach to reducing drug and alcohol problems amongst young people, adults and the harmful impact on communities.

HEALTHY LIVING NETWORK

Borders Healthy Living Network (HLN) was established in 2003 and operates in the most deprived areas in the Borders (Eyemouth, Langlee and Burnfoot) and aims to reduce inequalities in health by empowering communities to identify and address health issues that are relevant to them.

THIRD SECTOR ORGANISATIONS

The Third Sector makes a direct impact on the wellbeing of citizens in our local communities and contributes to the improvement of its public services which support people with particular health issues e.g. diabetes, mental health, sensory impairment, etc. Third Sector organisations can be very effective in addressing the wider factors underlying health inequalities. However a recent national report highlighted challenges faced by the sector including funding pressures; increasing service demand and a lack of understanding of the nature and role of Third Sector organisations[5].

KEY DELIVERY PLANS

The following highlights the key local delivery plans which local partners are already working with to promote health and wellbeing:

- Adult Services Business Plan (2015-16 – 2017/18)
- Joint Health Improvement Business Plan (2015/16 – 2017/18)
- Scottish Borders Health & Social Care Partnership Draft Strategic Plan (2015 – 2018)
- Alcohol & Drug Partnership Strategy 2015-2020
- Borders Alcohol and Drugs Partnership (ADP) Delivery Plan 2015-2018
- Children and Young People's Health Strategy for the Scottish Borders 2013 – 2018

The data in this Report should prove helpful in the development of these plans by highlighting priorities for action; measuring progress towards health targets; and assisting with the planning and monitoring of local programmes and services that impact on health over time.

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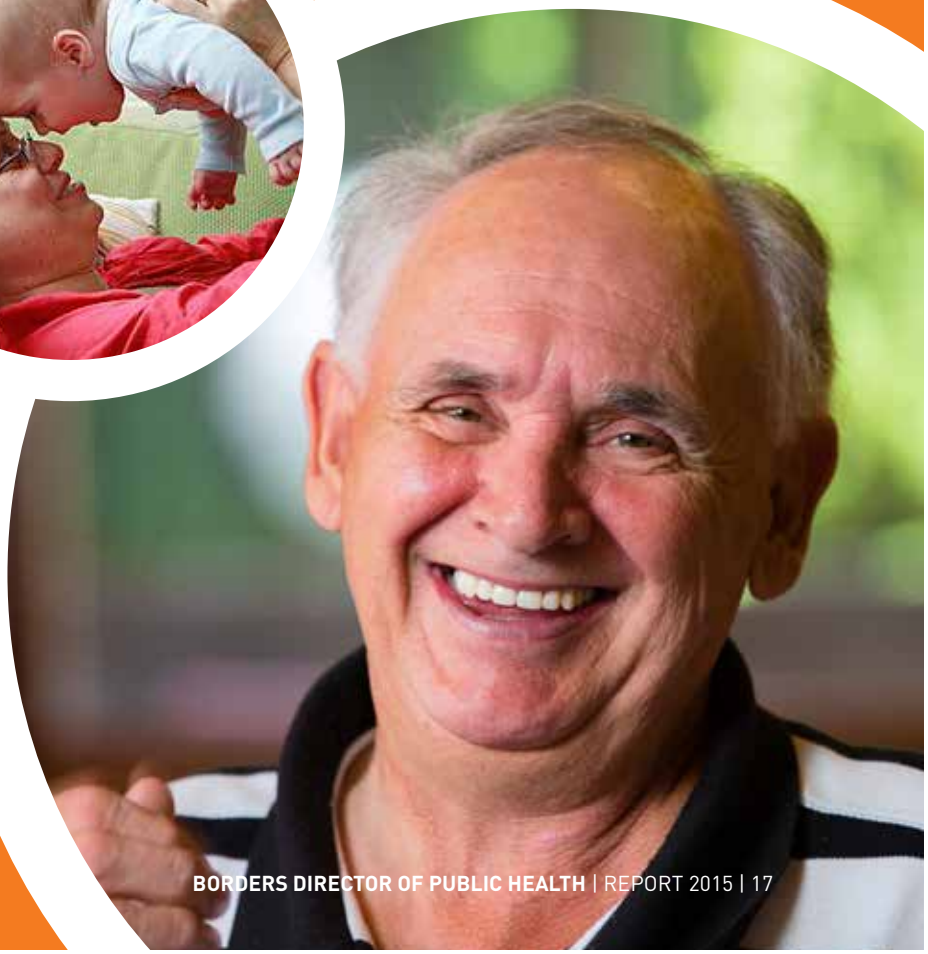
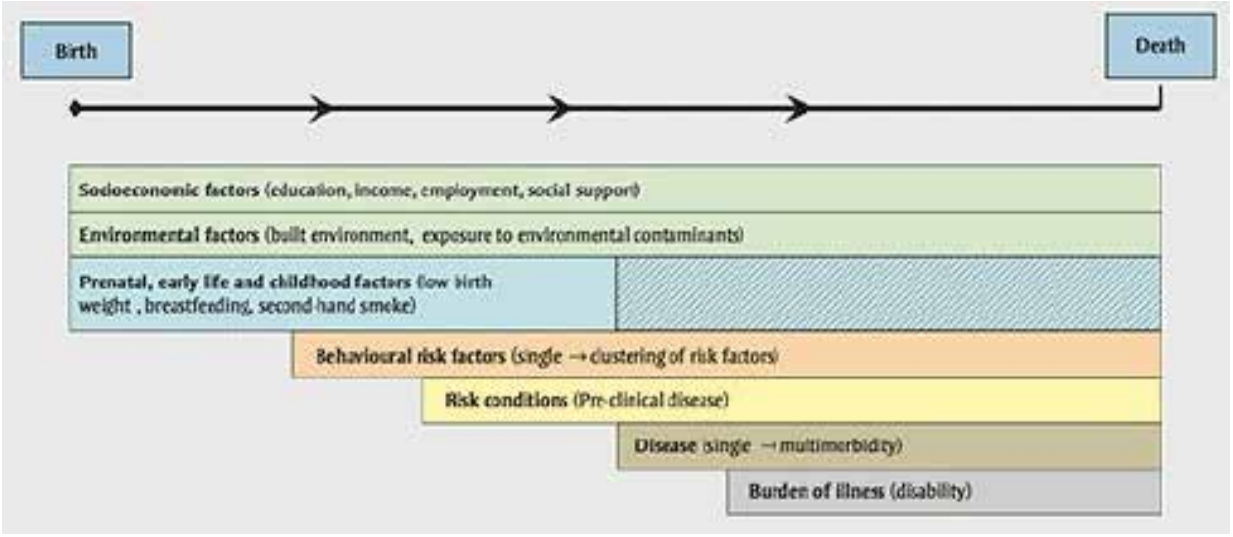
CHAPTER 2

LIFE COURSE STAGES



The World Health Organisation defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Therefore, the focus is not only on reducing mortality and morbidity, but on the impact of health determinants, the economic, environmental and social conditions, on health and well-being at various stages in life. Disadvantage (or advantage) starts before birth and accumulates throughout life, as shown in Figure 1 below. Opportunities for action to influence health determinants start before birth and continue throughout the life course.

FIGURE 1
OPPORTUNITIES FOR INFLUENCING HEALTH DETERMINANTS ACROSS THE LIFE COURSE STAGES[6]



Key stages in people's lives have particular relevance for their health. The life-course approach is about recognizing the importance of these stages, and this Report addresses them in four life periods: Early years; Children and young people; Working age adults; and Aging Well. It also highlights some important population diseases that affect all age groups.

The health indicators used in the Report have been chosen if they meet the following criteria:

LIFE COURSE STAGES INDICATOR CRITERIA	
Relevant	The information is clearly relevant to public health and/or is a plausible proxy.
Accurate	Scientific soundness: The scientific evidence supporting a link between the performance of an indicator and public health is strong.
Validity	The indicator appears reasonable as a measure of what it is intended to measure.
Reliability	The same results can be obtained if measurements are repeated under identical conditions.
Meaningful and useful	The information must be easy to understand, relevant for local plans and priorities and useful for public health action (e.g. targets population groups that are likely more affected).
Amenable to change	Provides information that can lead to action for change: inform and influence policy or funding, alter behaviour of health services providers, or increase general understanding in the community (e.g. improve behaviours, outcomes and health services use).
Ongoing	Data can be regularly collected and compared over time.

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CHAPTER 3

WHO LIVES IN THE BORDERS?

The Scottish Borders is a rural local authority with 5 towns with a population of between 5,000 and 15,000 (Hawick, Galashiels, Peebles, Kelso and Selkirk) and a further 5 towns with a population of 2,000 to 5,000 (Jedburgh, Eyemouth, Innerleithen, Duns and Melrose). According to the Scottish Government's 6-fold urban-rural classification, 47% of the population of the Scottish Borders live in rural areas compared to 18% for all of Scotland[7]. The rural nature of the Scottish Borders can lead to additional challenges for those experiencing inequalities.

In 2014 it was estimated that there are 114,030 people living in the Scottish Borders. Compared to Scotland the Scottish Borders has a similar proportion of children (16%), fewer people of working age (61% vs. 66%), but more people aged 65 and older (23% vs. 18%)[8]. There may be very little change in the overall number of people resident in Scottish Borders between 2012 (113,710) and 2032 (114,881), however, the numbers of people aged 65-74 may increase by almost one third (32%), whilst the numbers aged 75 and over may increase by 75%[9].

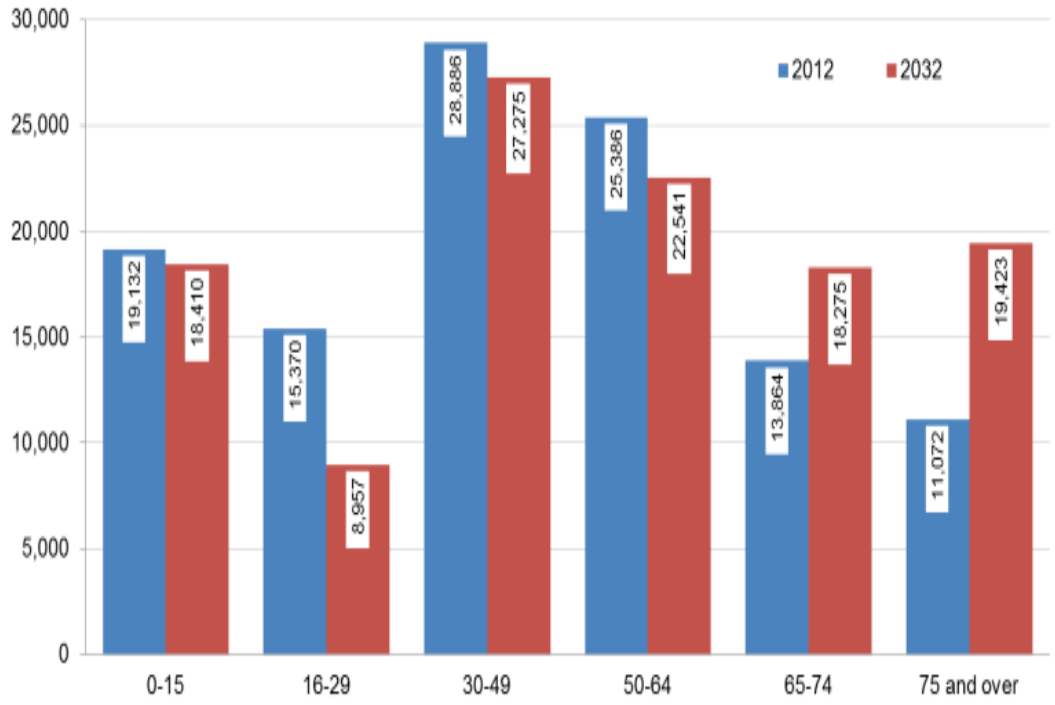
> *"The numbers of people aged 65-74 may increase by almost one third (32%)"*

Meanwhile, the numbers of children and people of working age are predicted to decrease. The estimated increase in the percentage of older people and accompanying dependency ratio reinforces the importance of prevention and early intervention to reduce care needs in the growing older population.

According to the 2011 Scotland Census, 98.7% of the Scottish Borders population self-report their ethnic group as white, higher than the 96.0% overall for Scotland. A large majority are White Scottish, although White British is relatively more common in Scottish Borders than in Scotland as a whole, reflecting our geographical position close to the Scotland-England border. Around 1 in 100 people in Scottish Borders (similarly to Scotland) are White Polish. Amongst the other ethnic groups, people who identify themselves as Asian, Asian Scottish or Asian British are the most numerous in Scottish Borders, albeit accounting for 0.6% of the Scottish Borders population, noticeably lower than the 2.7% average for Scotland.

However census data many not capture the seasonal economic migration that occurs in the Borders to support the farming and fishing industry. Significant migration to the UK has also occurred since the 2011 census and the 2011 data may under report white non British and other ethnic minorities. This may affect the ability of health services to address the health needs of migrant communities or other minority groups.

FIGURE 2
PROJECTED POPULATION OF BORDERS (2012 BASED) FOR 2012 AND 2032 BY AGE



Source: National Records for Scotland 2012-based population projections

Many parts of Scottish Borders suffer from geographic access deprivation, particularly communities in the Ettrick and Yarrow valleys, communities towards the Southern Upland hills and the Scotland-England border and isolated parts of Berwickshire, but these areas are not particularly associated with Multiple Deprivation. Access deprivation is more of an issue for people who lack resilience to geographical isolation or who do not live there by choice. Combinations of circumstances such as low income, disability, poor quality accommodation and no private transport can exacerbate access deprivation for vulnerable people, making it more difficult for them to access services[1].

KEY CHALLENGES

The numbers of people aged 65-74 may increase by almost one third (32%), whilst the numbers aged 75 and over may increase by 75%. As our population ages it is vital that maintaining and improving physical, mental, social and economic wellbeing of older adults is a priority.

Census data may not capture the seasonal economic migration that occurs in the Borders to support the farming and fishing industry. Significant migration to the UK has also occurred since the 2011 census and the 2011 data may under report white non British and other ethnic minorities. Local services need to be sensitive to migrant health issues.

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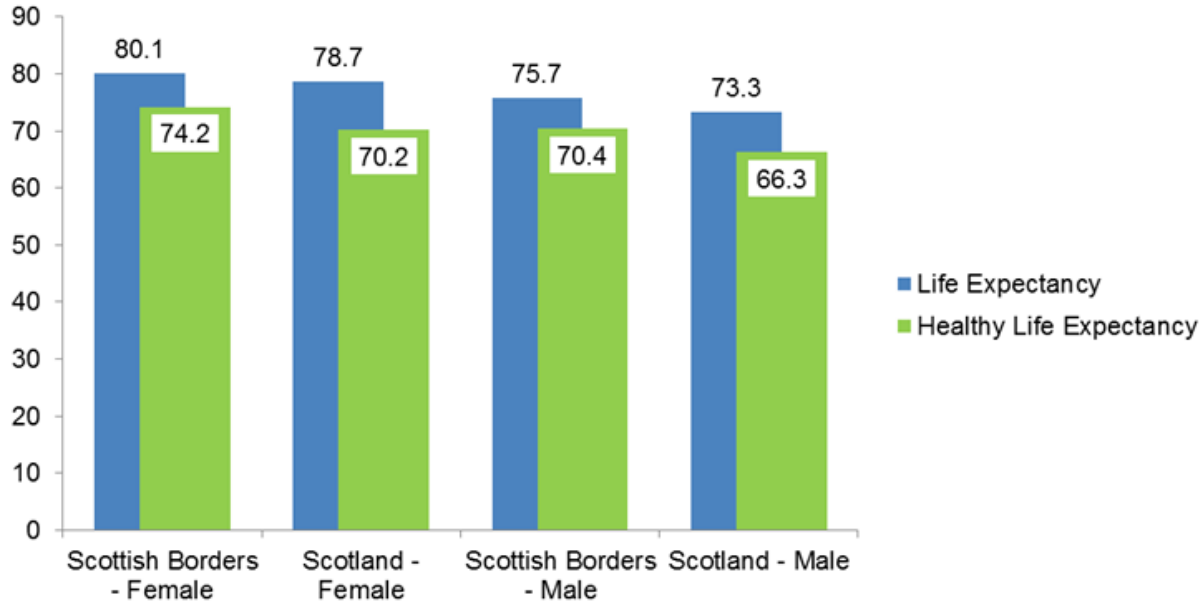
CHAPTER 4

HOW LONG MIGHT WE LIVE?

Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. In the Scottish Borders both men and women are expected to have higher life and healthy life expectancy compared to Scotland. Figure 3 below shows the "gaps" between healthy life expectancy and overall life expectancy are also narrower in Scottish Borders, at around 5-6 years, compared with Scottish averages of 7-8 years. At age 65, men and women in the UK are expected to live over half of their remaining lives free from disability (53.2% and 58.5% for women and men, respectively)[1].

FIGURE 3
LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY (YEARS) AT BIRTH, 5-YEAR PERIOD 1999-2003



Source: ScotPHO Profiles www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/nhs-boards

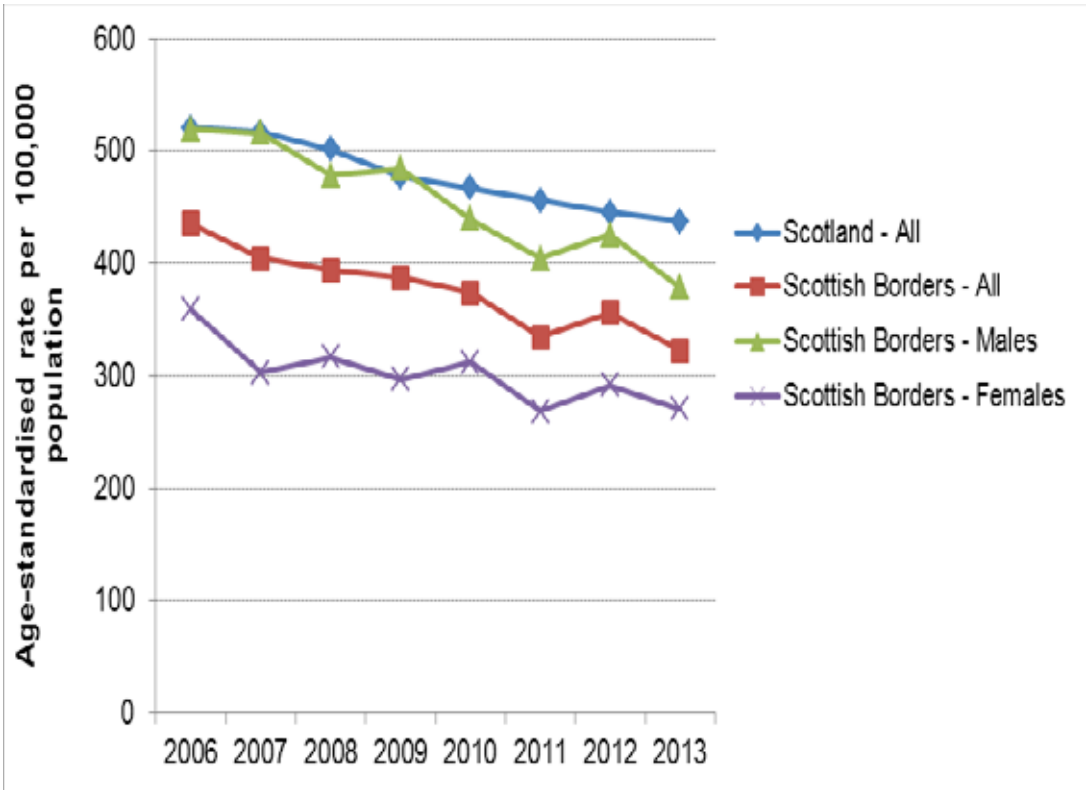
However, there are areas within the Scottish Borders where the male and female life expectancy at birth (using 5 year average 2009-2013) is lower than for Scotland. There are four Intermediate Zones (IZ) in the Scottish Borders where the male life expectancy is below the level for Scotland, these are Galashiels West, Langlee, Galashiels South and Galashiels North. There is 8.9 years difference in life expectancy for boys from Galashiels West years 74.7 years, compared to Berwickshire Central 83.6 years. For girls the life expectancy range is between 79.1 years in Galashiels North and 89.1 years in Ettrick, Yarrow and Yair, a difference of 10.5 years. Differences in average life expectancy between people living in the least and most deprived areas are mainly due to deaths from coronary heart disease, stroke, cancer and respiratory disease[2].

> *"There are areas within the Scottish Borders where the male and female life expectancy is lower than for Scotland"*

As in Scotland as a whole, in the Scottish Borders the top five causes of death are cancer (31.%), diseases of the circulatory system (29.8%), respiratory diseases, mental and behavioural disorders and digestive diseases. Compared to Scotland overall, cancer related deaths and deaths due to diseases of the circulatory system are a slightly larger proportion of total deaths than other causes and there are fewer deaths due to respiratory diseases[4].

Figure 4 below shows that within the Scottish Borders there has been a significant improvement in premature mortality between 2006-2013 and currently the region has the lowest rate of any mainland Board. Areas in the Scottish Borders which have higher rates of 'early deaths' compared to Scotland include Selkirk, Langlee, Jedburgh, Duns and Coldstream[2].

FIGURE 4
AGE-STANDARDISED DEATH RATES AMONGST PEOPLE AGED UNDER 75 YEARS 2006 TO 2013



Source: National Records of Scotland.

KEY CHALLENGES

There are areas within the Scottish Borders where the male and female life expectancy is lower than for Scotland. Differences in average life expectancy between people living in the least and most deprived areas are mainly due to deaths from coronary heart disease, stroke, cancer and respiratory disease. These inequality issues are covered in more detail in Chapter 11: Health Inequalities in the Borders.

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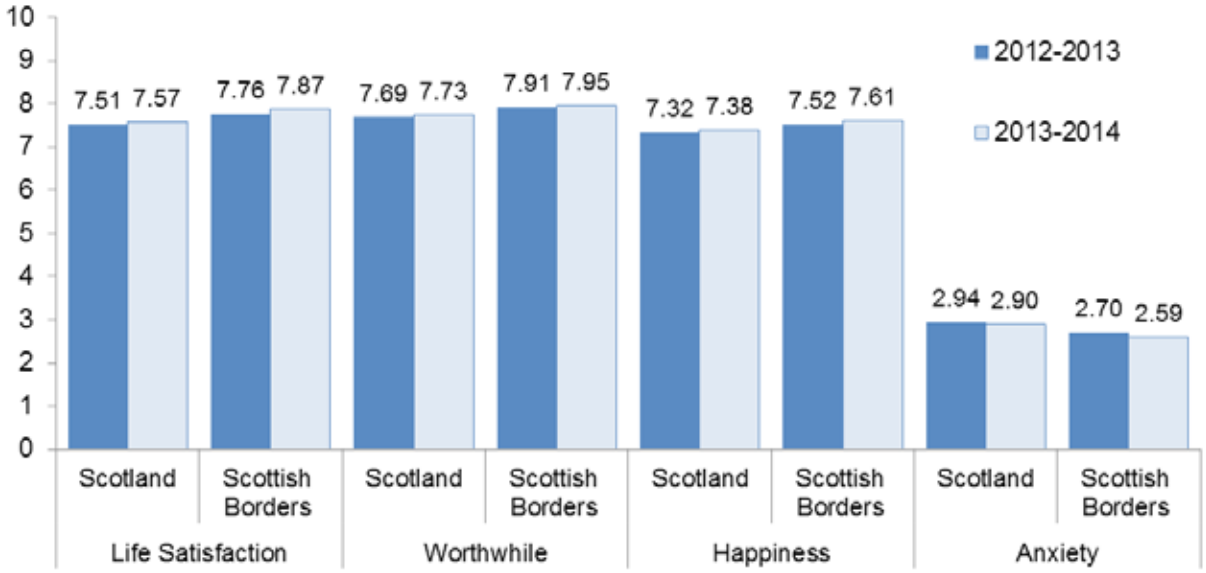
CHAPTER 5

ARE WE HAPPY WITH OUR LIVES?

Estimates of Life Satisfaction from the Annual Population Survey (APS) Personal Well-being in Figure 5 below show that personal well-being in the Scottish Borders appears to be improving with estimated average figures showing increases from 2012/13 to 2013/14 in life satisfaction, worthwhile and happiness measures, whereas average estimates of anxiety have reduced[1].

> *"Personal well-being in the Scottish Borders appears to be improving"*

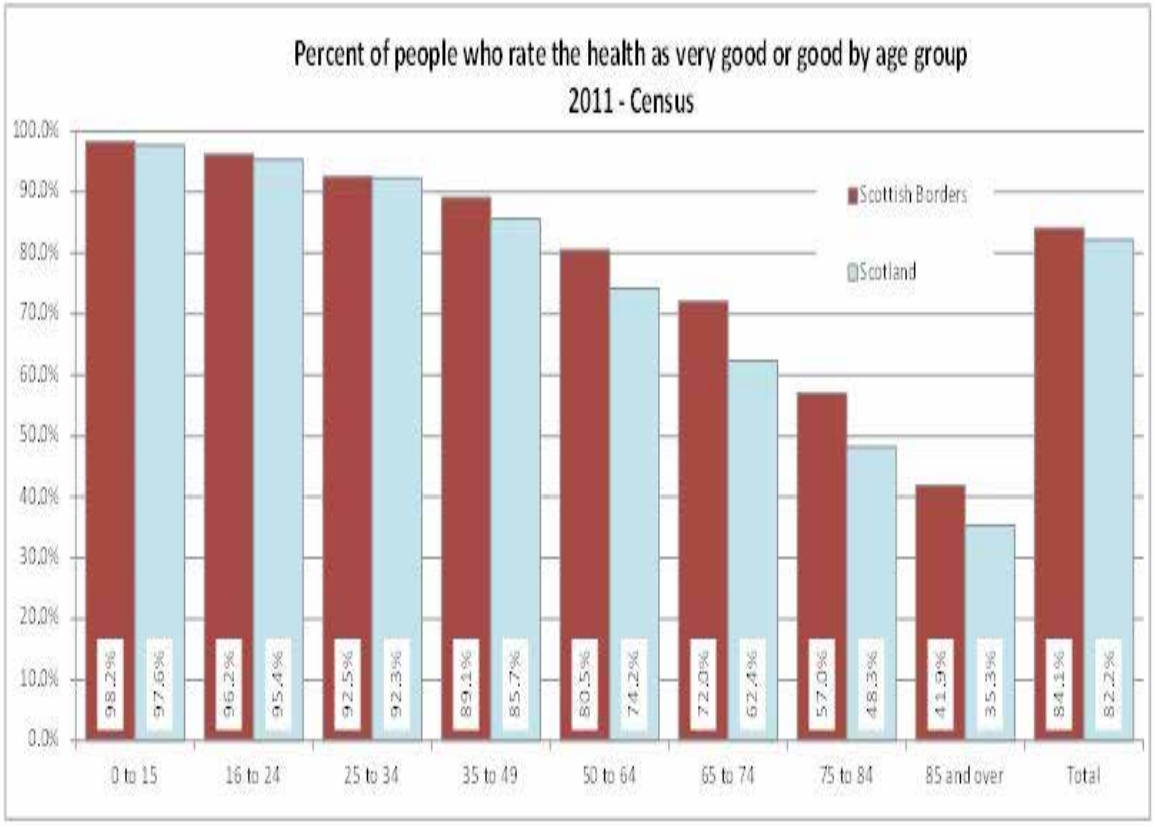
FIGURE 5
ESTIMATES OF PERSONAL WELLBEING, ON A SCALE OF 1-10, IN SCOTTISH BORDERS AND SCOTLAND, 2012-13 AND 2013-14



Sources: ONS (2013 and 2014) publications on Measuring National Well-being, Personal Well-being in the UK 2012/13, and 2013/14.

Figure 6 opposite shows that in the 2011 Census 84% of the Scottish Borders population considered their general health to be very good or good. 12% considered themselves in fair health. 4% assessed their health as bad or very bad. The Scottish Borders average of 84% of the population reporting themselves as in good/very good health is slightly higher than the Scottish average of 82%. Rates of good self-assessed health are lower in the 15% most-deprived datazones than in the 15% least-deprived. These are Hawick West End, Eyemouth, Coldstream and area, Hawick Central, Burnfoot and area, Kelso South and Langlee[2].

FIGURE 6
PERCENTAGE OF PEOPLE WHO ASSESS THEIR HEALTH AS VERY GOOD OR GOOD: 2011 CENSUS



Source: National Records of Scotland.

Whilst overall Borders has a high level of life satisfaction and self-rated good health, two particular groups have specific needs: children and young people and older people.

CHILDREN AND YOUNG PEOPLE

The NHS Health Scotland 2013 Report on the mental health of children and young people (C&YP) under 17 years found that mental well-being has improved or stayed broadly constant over the past decade or so[10] . Only one measure for an indicator of mental health problems (emotional symptoms for S4 pupils) deteriorated slightly. Although only one measure worsened over time, the data suggest that there is considerable scope for action among those measures which remained largely steady or improved over time, but which are still at a relatively high level. Being happy improved over time but was still only reported by around half of P7 pupils, less than half of S2 pupils and about a third of S4 pupils in 2010.

Mental wellbeing varied by gender with boys less likely to have common mental health problems, emotional symptoms or to report sadness. Girls were less likely to have conduct problems or to suffer from drug-related disorders or to complete suicide. The majority of measures deteriorated with age. Life satisfaction and happiness decreased with age between P7, S2 and S4 pupils. Inequalities by area deprivation (SIMD) were common across both mental wellbeing and mental health problems. C&YP living in more deprived areas had poorer mental health outcomes than

those living in less deprived areas. Only five out of 11 mental health outcome measures (45%) fluctuated by urban–rural classification but showed no obvious pattern.

Unfortunately we do not have data to be able to consider the mental health of young people in the Scottish Borders compared to data for Scotland as a whole.

OLDER PEOPLE

A 2014 Age Concern survey found that more than 80,000 people aged 65 plus in Scotland describe themselves as often or always feel lonely[11] . Across the UK the figure was more than a million. Loneliness is a huge issue which affects people all year round. The survey results reveal that around two in five (39% or about 350,000) older people in Scotland say their TV is now their main form of company. The research also shows that around one in six (16%) of those aged 65 plus in Scotland are feeling cut off from society, with a quarter (about 230,000). saying they would like to get out more. Loneliness can be seriously damaging and recent studies have shown it has double the impact of obesity and that feeling extreme loneliness can increase an older person's chances of premature death by 14%. The Scottish Government Equal Opportunities Committee is currently examining the issue of loneliness in Scotland.

KEY CHALLENGES

The mental health of children and young people (C&YP) under 17 years in Scotland has improved or stayed broadly constant over the past decade or so. However the data suggest that there is considerable scope for action. Life satisfaction and happiness decreased with age between P7, S2 and S4 pupils. Inequalities by area deprivation (SIMD) are common across both mental wellbeing and mental health problems.

More than 80,000 people aged 65 plus in Scotland describe themselves as often or always feel lonely.. Loneliness can be seriously damaging and recent studies have shown it has double the impact of obesity and that feeling extreme loneliness can increase an older person's chances of premature death by 14%. The Scottish Government Equal Opportunities Committee is currently examining the issue of loneliness in Scotland.

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CHAPTER 6

STARTING WELL: EARLY YEARS

WHY IS THIS IMPORTANT?

Starting well in life is vitally important for every child born today. The first three years of a child's life directly influences their health and wellbeing as a child, and later as an adult. What happens to a child during early years impacts on risks of long term ill health such as weight, substance misuse, risk of heart disease, and their mental health. The first few years of life can be critical for readiness to learn, educational achievement and ultimately wealth and economic status, a strong predictor of future health and wellbeing. Living in a healthy, caring family and community help most children achieve their potential. A nurturing environment builds a child's resilience and sets children up to succeed in all aspects of later life. Not all children have all these basic needs for good development met and there are differences in experience of good nurturing care and the right resources for growth. This means that a good universal child health system for every mother and child needs to also have additional more targeted support for children and families with greater need to achieve good outcomes for all children.

OUR VISION:

> *"That every child develops their unique potential in their early years"*

KEY FACTS:

ACCESSING MATERNITY SERVICES

88.8% of women in the Scottish Borders accessed maternity services before 12 weeks of pregnancy in 2013. The levels of access to maternity services before 12 weeks of pregnancy is not markedly different between the most deprived and least deprived areas within the Borders[2]. Pregnancy and Newborn Screening Tests are offered to help individuals make informed choices about their health and the health of the child. Pregnancy and Newborn Screening is considered to be an important component of good healthcare and should both underpin and inform child and family health and wellbeing and the provision and design of maternity care and child health services. The following conditions are covered by the current National Pregnancy and Newborn Screening Programme in Scotland.

PREGNANCY SCREENING	WHEN	NEWBORN SCREENING	WHEN
Communicable Diseases • HIV • Hepatitis B • Syphilis • Rubella • Varicella	Ideally between 8-12 weeks	Newborn Hearing	Birth to 4 weeks
Haemoglobinopathies • Sickle Cell Disease (SCD) • Thalassaemia	Ideally between 8-10 weeks	Newborn Bloodspot • Phenylketonuria (PKU) • Congenital Hypothryroidism (CHT) • Cystic Fibrosis (CF) • Sickle Cell Disorder (SCD) • Medium-Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)	Around day 5
Down's Syndrome	Between 11 & 14 weeks (Blood test)		
Fetal Anomaly	Between 18-21 weeks		

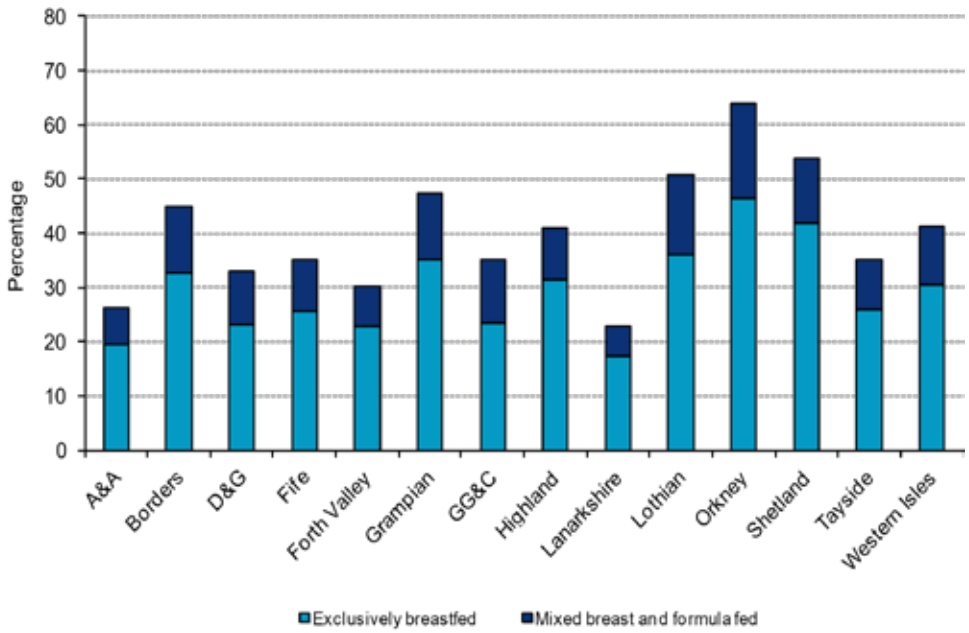
SMOKING IN PREGNANCY

The rate of women smoking in pregnancy appears higher in Scottish Borders than the Scottish average and is particularly high in the most deprived areas. NHS Scotland estimates that smoking during pregnancy is around two and a half times higher in the most deprived areas compared with the least deprived. However the proportion of women reported with 'unknown' smoking status has increased within the Borders in 2013 and is currently the highest (25%) compared to other areas in Scotland making the recent data difficult to interpret. A reduction of smoking in pregnancy remains a very high priority.

BREAST FEEDING

Figure 7 below shows that in 2013-2014, 45% of mothers in the Borders were found to be breast feeding their baby 6-8 weeks following birth with 33% of mothers reporting exclusively breast feeding. These rates are higher than Scotland overall but are significantly higher in the least deprived datazones (56%), compared to the most deprived datazones (31%) in the Scottish Borders[2].

FIGURE 7
BREAST FEEDING IN SCOTTISH HEALTH BOARDS 2013-2014



Source: ISD Scotland

LOW BIRTH WEIGHT

Low birth weight is defined as a birth weight of less than 2.5kg for a live single baby and can cause serious health problems for some babies. Low birth weight is associated with young ages, multiple pregnancies, previous low birth weight infants, poor nutrition, heart disease or hypertension, drug and/or alcohol misuse, and insufficient prenatal care. Overall there has not been a big change overtime in the Scottish borders. The current percentage of low weight live singleton births is 1.9%, close to the Scottish average of 2%[2].

CHILDHOOD IMMUNISATION

Primary and Booster immunisation uptake rates by 24 months of age for Diptheria, Polio and Haemophilus influenzae type B (Hib) for all data zones remain above the Scotland target of 95% and similar to the Scotland uptake each quarter. Measles, Mumps and Rubella (MMR) vaccination rates at 5 years have been consistently higher than the Scotland target of 95% for the last 4 quarters[12]. New vaccines (rotavirus, meningitis B) have recently been added to the childhood national programme. Meningitis ACWY has been added to the teenage booster programme.

KEY CHALLENGES

The rate of smoking in pregnancy appears higher in Scottish Borders than the Scottish average and is particularly high in the most deprived areas. The reduction of smoking in pregnancy remains a very high priority.

Although breastfeeding rates locally compare reasonably well with those from other parts of the country, far higher rates have been achieved elsewhere and therefore it is possible to do even better. This should be a priority for the future for the benefit of children and mothers.

Nutrition is an important foundation for good health and there continue to be challenges in ensuring access to affordable healthy food for all families with young children.

We need to ensure that children have the best possible opportunity for health and wellbeing and recognise the difference that family circumstances can make.

Examples of what we and partners are doing in Borders

Maternity services and Health Improvement are working together on maternal and infant health to reduce smoking in pregnancy, improve nutrition, promote mental health.

We work with the Early Years Centres and local Early Years Networks to offer families support e.g. development of peer support, events in local areas that give access to information and services.

Active promotion of entitlements for families with young children through a series of initiative such Healthy Start and financial help.

Developing knowledge and skills of the early years workforce through training programmes for example nutrition training for early years services

Joint work with ADP and Midwifery services to increase the number of conversations about alcohol with pregnant women.

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CHAPTER 7

DEVELOPING WELL: CHILDREN AND YOUNG PEOPLE

WHY IS THIS IMPORTANT?

Seeking good health and wellbeing for school age children and young people in the transition to adult life can have a hugely positive impact on their future. Five of the ten most common risk factors in adult disease are formed during adolescence, including mental health problems and obesity.

This period of young people's lives marks significant and unique changes, they become more independent and widen their awareness of the world around them. As children progress through school, they gradually assert greater autonomy, with family and friends remaining essential sources of support and advice. In the modern world external pressures, such as the media, social networks, advertising, also exert influences, and not always positive ones. Supporting children and young people at this stage therefore is important in the short term, as well as setting the stage for healthy, productive adults. Some children and young people have not had the good start in life that they needed and so may need additional services or more intensive or specialist support to enable them to reach their full potential ready for adulthood.

OUR VISION:

> *That every child and young person should be kept safe from harm,* ***able to develop their unique potential and feel ready for adult life***

KEY FACTS:

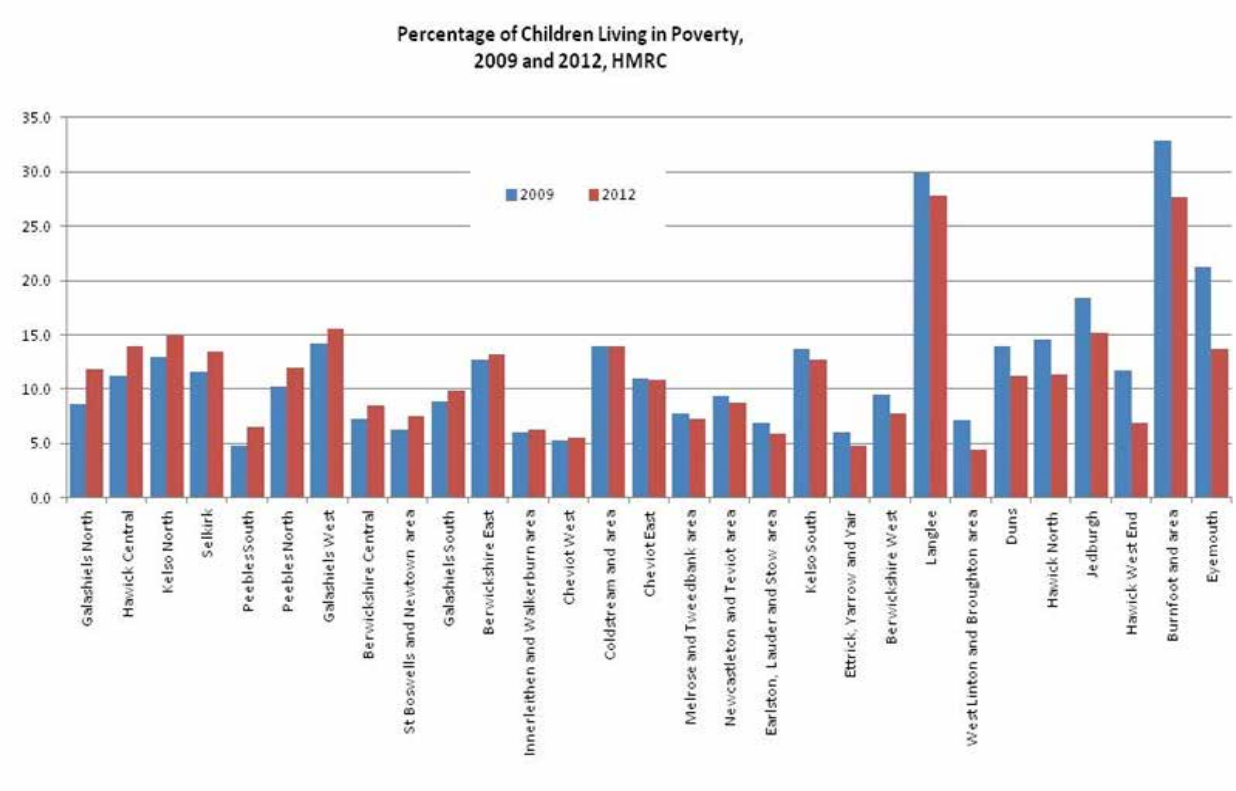
CHILDREN LIVING IN RELATIVE POVERTY

There are basically two current definitions of poverty in common usage: absolute poverty; and relative poverty. Absolute poverty is defined as the lack of sufficient resources with which to keep body and soul together. Relative poverty defines income or resources in relation to the average e.g. a household where the total income is less than 60% of the median income. It is concerned with the absence of the material needs to participate fully in accepted daily life. Figure 8 below shows the percentage of Borders children living in relative poverty using this definition.

In 2012 10.9% of children in the Scottish Borders were living in relative poverty, less than the 15.3% for Scotland. Between 2009 and 2012 the percentage of children living in relative poverty in the Scottish Borders has declined from 13.0% to 10.9%.

Within the Scottish Borders 15 areas have had a reduction in the percentage of children living in relative poverty including Langlee, Burnfoot and area, Duns, Jedburgh and Eyemouth. Other areas have experienced an increase in the percentage of children living in relative poverty including Galashiels North, Hawick Central, Kelso North and Selkirk. Within the Scottish Borders over 27% of the children in Langlee and Burnfoot and area were living in relative poverty[2].

FIGURE 8
PERCENTAGE OF BORDERS CHILDREN LIVING IN RELATIVE POVERTY.



Source: Her Majesty's Revenue and Customs

EDUCATIONAL ATTAINMENT

In March 2015 the percentage of leavers from Scottish Borders Council schools reported as still in a positive destination was 94%, 3.5% higher than the national average (91.5%), and higher than it was for the Borders in 2012/13 (92.1%).

Within Scottish Borders Council, the destination category that had the greatest percentage point increase between the initial and the follow up return was employment, with an increase of 3.4%. Conversely, the destination category that had the largest percentage point decrease between the initial and the follow up return was Further Education with a 1.5% decrease. This is in line with the trends nationally[13].

CHILDREN'S LIFESTYLES — HEALTHY WEIGHT

Interpretation of body mass index (BMI) values in children depends on comparison with age- and sex-specific growth reference data. Children within the top 5% centile are deemed at risk of being obese.

In Scotland in 2013, the Scottish Health Survey found that 14.8% of girls and 17.2% of boys, aged 2-15 years, were at risk of obesity[14]. The rate of increase over the past 15 years has been greater for boys.

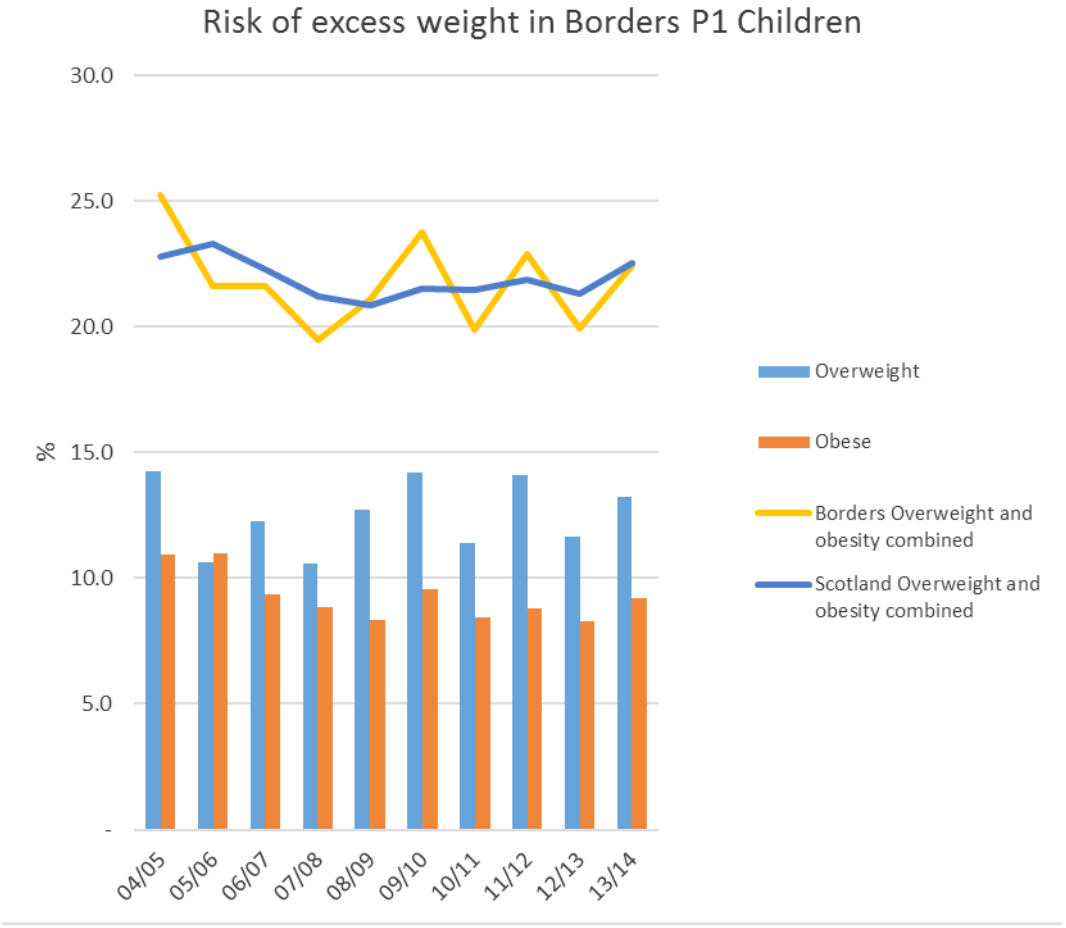
Between 1998 and 2013 in Scotland, at risk of obesity prevalence among girls aged 2-15 years remained steady, fluctuating around 14%, while in boys it increased from 14.5% in 1998 to 17.2% in 2013.

Figure 9 below indicates that Borders P1 children have a similar risk of being overweight and obese compared to Scotland as a whole. In 2013/14, 77% of children in Primary 1 were found to have a healthy weight. 9.1% of primary 1 age children in the Borders are at risk of obesity. This has been fairly constant in recent years.

The areas within the Scottish Borders where 15% of the P1 children are considered to be at risk of obesity are Cheviot West, Eyemouth, Berwickshire East, and Coldstream[2].

> ***9.1%*** *of primary 1 age children in the Borders are at risk of obesity*

FIGURE 9
BORDERS PRIMARY 1 CHILDREN AT RISK OF OBESITY 2004/05-2013/14



Source: ISD Scotland

In Scotland the prevalence of healthy weight is slightly higher amongst P1 girls than boys. In school year 2013/14, 77.2% of girls were classified as healthy weight compared to 75.7% of boys. In Scotland the prevalence of healthy weight amongst children in Primary 1 decreases as deprivation increases. In the least deprived areas (SIMD quintile 5), 81.1% of children were classified as healthy weight while in the most deprived areas (SIMD quintile 1) 73.2% were classified as healthy weight.

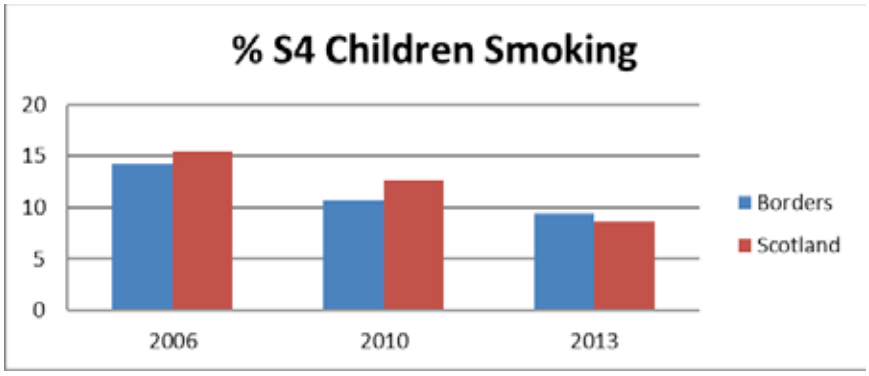
CHILDREN'S LIFESTYLES — SMOKING, ALCOHOL AND PHYSICAL ACTIVITY

SMOKING

Data about smoking is available from the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS). The Scottish Adolescent Lifestyle and Substance Use Study collects data every two years using a questionnaire sent to all S1 and S3 children.

Figure 10 below shows that there has been a large drop in the proportion of pupils reporting smoking in recent years. In 2013 the proportion or pupils reporting regular smoking is the lowest since the SALSUS survey began.

FIGURE 10
SMOKING BY BORDERS S4 PUPILS COMPARED TO SCOTLAND AS A WHOLE



Source: SALSUS http://www.isdscotland.org/Health-Topics/Public-Health/SALSUS/

ALCOHOL

The most recent SALSUS data set for alcohol consumption in children and young people suggests that, in line with Scottish experience, consumption has reduced significantly in recent years. There is no significant difference for these indicators between Borders and Scotland.

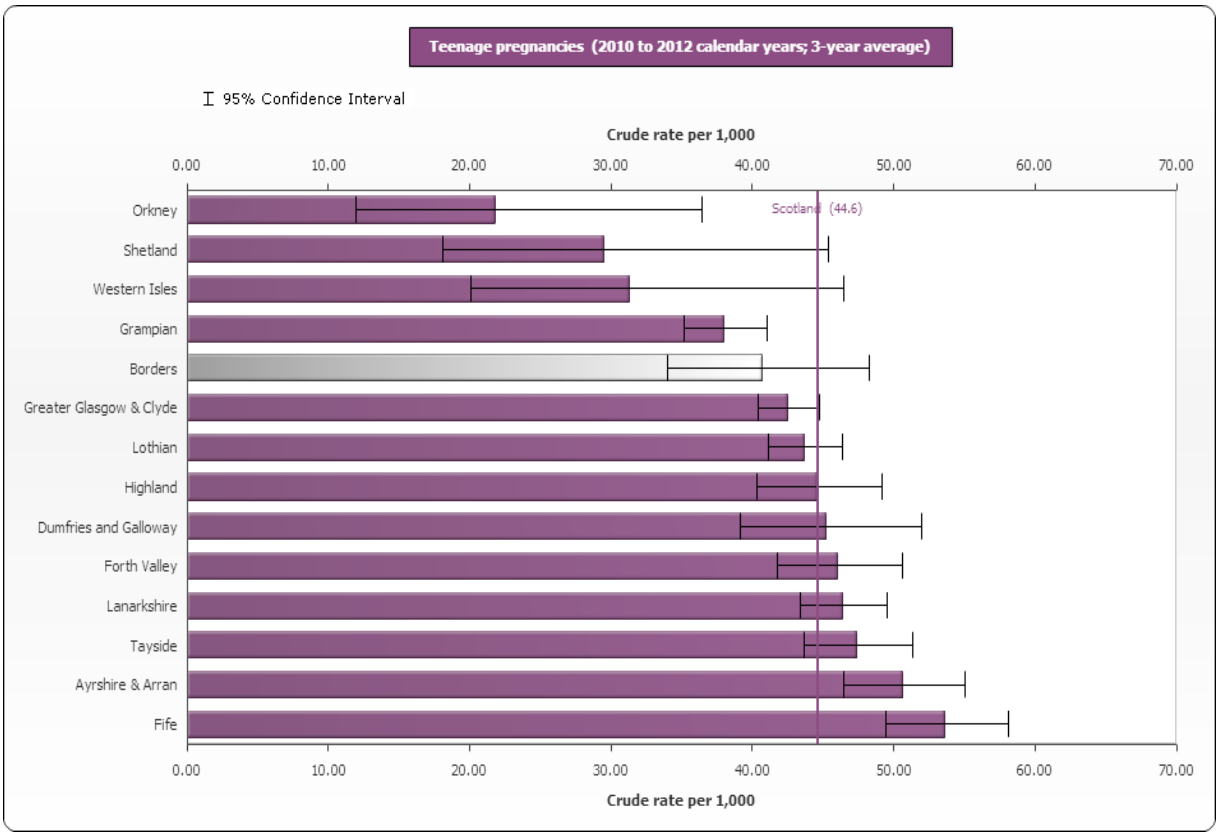
PHYSICAL ACTIVITY

The Scottish Health Survey 2013 indicates that in 2013 78% of boys met the National Guidelines for physical activity[9]. There has been no overall increase or decrease in physical activity between 2008 and 2013. There has been no change in the proportion of total activity that took place in school. 72% of girls met the National Guidelines, the trend has been towards increased activity between 2008 and 2013 but the activity levels remain lower than boys and there was no increased activity levels at school as a proportion of total activity.

TEENAGE PREGNANCY

Bringing up a child can be difficult for teenage mothers. Both young parents and their children are more likely to experience poorer health in future. Teenage mothers may not finish their education and can have poorer mental health; their children are more likely to live in poverty and have accidents and behavioural problems. Figure 11 below shows that Borders has a consistently low number of pregnancies in the 15-19 age group. The low numbers each year means large variations may be seen in the reported annual rate. This is illustrated by the wide 'confidence interval' i.e. is solid line, shown in the figure.

FIGURE 11
TEENAGE PREGNANCIES AS A THREE-YEAR ROLLING AVERAGE NUMBER AND THREE-YEAR AVERAGE CRUDE RATE PER 1,000 FEMALES AGED 15-19

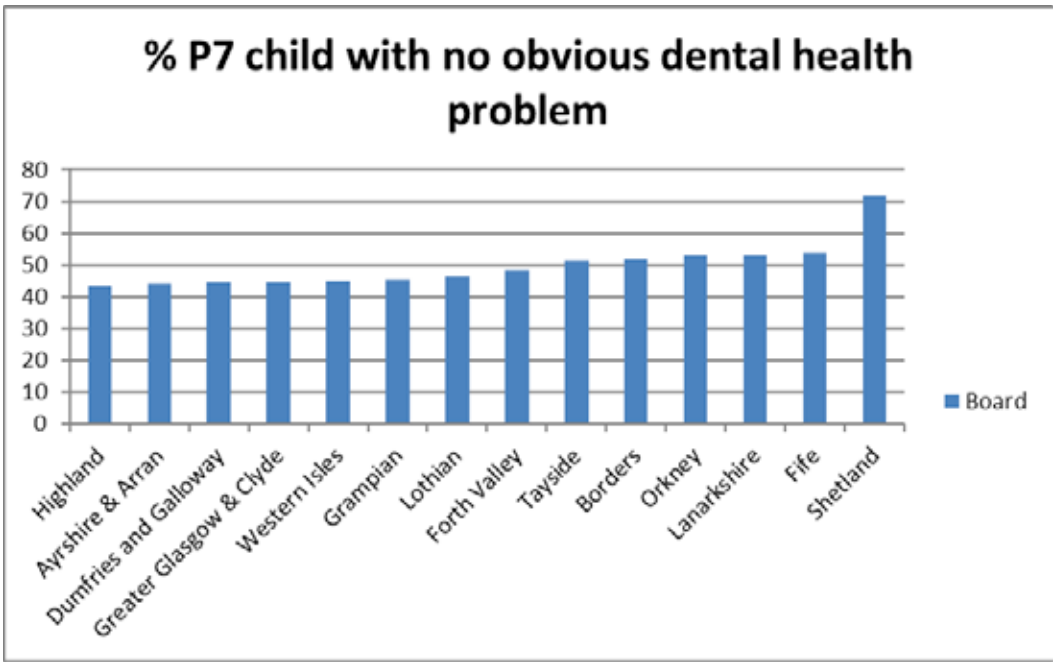


Source: ScotPHO Profiles http://www.scotpho.org.uk/

DENTAL HEALTH

In both P1 and P7 the Scottish Borders has a greater portion of children with no obvious dental decay compared to other areas in Scotland, as Figure 12 below shows. In 2013/14, there were four areas in the Scottish Borders where less than 60% of the P1 children had no obvious dental decay, these were Jedburgh, Eyemouth, Langlee and Burnfoot and area. For P7 children there are three areas where less than 40% have no obvious dental decay, these were Selkirk, Burnfoot and area and Peebles North[2].

FIGURE 12
DENTAL HEALTH IN SCOTTISH P7 CHILDREN



Source: ScotPHO Profiles http://www.scotpho.org.uk/

KEY CHALLENGES

In Scotland as a whole, around 14.8% of girls and 17.2% of boys, aged 2-15 years, are estimated to be at risk of obesity. The rate of increase over the past 15 years has been greater for boys. If the Scottish trends also apply to Borders young people there may be an increasing problem with teenage boys gaining excess weight and all the physical and mental health issues that may bring.

It is disappointing that nationally there has been no overall increase or decrease in physical activity for Borders boys between 2008 and 2013. Public Health, Education and wider partners need to work closely to promote nutrition and healthy weight through the curriculum and activities and opportunities in local communities and by promoting a good food culture in Borders.

The emotional health of our young people affects all other aspects of their lives and we need to be sure that we are doing all we can to support young people to develop resilience to face the challenges of life.

EXAMPLES OF WHAT WE AND PARTNERS ARE DOING IN BORDERS

Health Improvement specialists work increasingly closely with partners on a range of topics to take a holistic approach to young people's health and wellbeing. For example:

- With the youth sector and with schools and regulatory services on tobacco prevention with young people. The tobacco prevention worker has been working with Wheatlands Residential Home to provide tobacco policy development support and build the capacity of staff to work on tobacco issues with looked after children and young people.

- Delivering the Fit4Fun programme in partnership with schools to promote nutrition and activity.

- Continuing support for young people to make informed choices about relationships and sexual health and to provide access to information and services that are age appropriate and accessible.

- Access to information and support on emotional health in schools and youth settings. Work is underway to develop more joined up approaches.

- Targeted work with particular groups of young people such as those with a learning disability, young carers and those who are looked after, to support health and wellbeing.

- Action for Children is commissioned by the ADP to provide an alcohol and drugs service for Children and Families. This provides support to children affected by their own and others substance use as well as support for parents whose substance use is impacting on others

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CHAPTER 8

LIVING WELL: WORKING AGE ADULTS

WHY IS THIS IMPORTANT?

Living well in adult life is important not just to adults themselves, but to the children, young people and older people they support both financially and by caring for them. Working age adults support the welfare state and civic society through income generation and paying taxes and it is important that physical and mental health are protected and promoted with equal focus.

People continue to grow and develop from early adulthood where they start to live with financial independence through their first employment, into established adults forming families, long term relationships and making longer term life choices, and then into mature adulthood where attention starts to focus on planning for older age and a healthy retirement.

At every point in an adult's life there is potential to improve health and wellbeing, prevent diseases such as diabetes, musculoskeletal disease and cancer developing, as well as minimise the complications or progression of existing disease. However we know that often this group doesn't engage with services. To maximise opportunities for prevention there must be a focus on reducing risky behaviours, utilising opportunities to access support and advice.

OUR VISION:

> *"Every adult should be able to achieve a state of health and wellbeing that supports their social and economic independence, and help them provide a safe and stable environment for those they support."*

KEY FACTS:
EMPLOYMENT

Unemployment in the Scottish Borders, as measured by jobseeker's allowance, fell between August and September. Overall unemployment fell by 11.3% last month and has decreased by almost 36% since September 2014. There has been a 56.8% decrease since a year ago in claimants among 18-24 year olds. The number of jobseekers claiming for more than 12 months has decreased by 26.8% on a year ago.

FIGURE 13
NUMBER OF RESIDENTS CLAIMING JOBSEEKER'S ALLOWANCE BY MULTI-MEMBER WARD FOR SEPTEMBER 2015

	NUMBER	RATE %		NUMBER	RATE %
Galashiels and District	223	2.4	Tweeddale West	56	1.0
Hawick and Hermitage	97	1.8	Jedburgh and District	41	0.8
Hawick and Denholm	90	1.5	East Berwickshire	47	0.7
Selkirkshire	81	1.3	Leaderdale and Melrose	42	0.7
Scottish Borders	828	1.2	Mid Berwickshire	40	0.7
Kelso and District	69	1.1	Tweeddal East	42	0.6

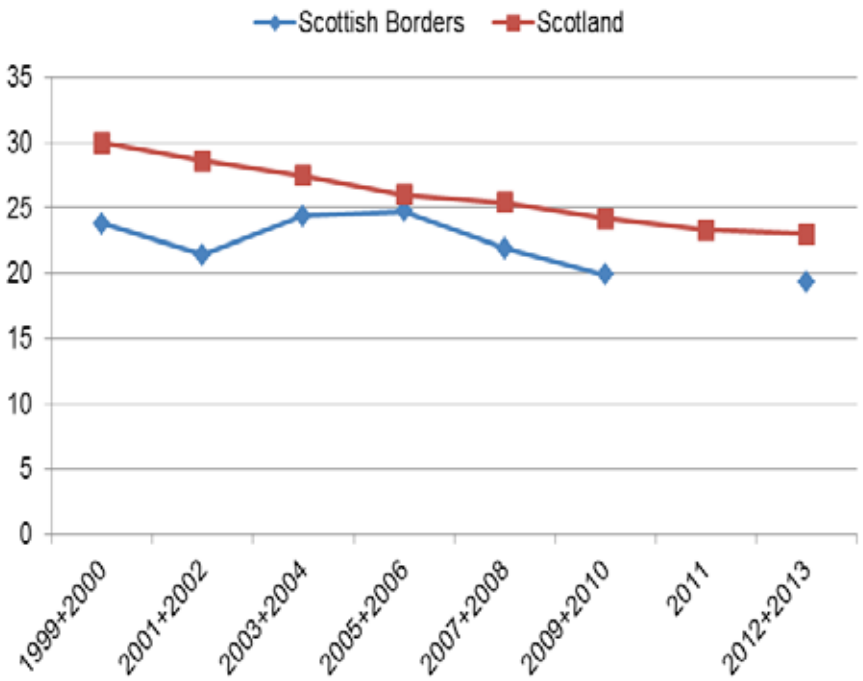
Source: Office for National Statistics

A HEALTHY LIFESTYLE = TOBACCO FREE

Smoking is still the most important cause of preventable ill health and early death in the UK. Smoking is a major risk factor for many diseases, such as lung cancer and many other cancers, chronic obstructive pulmonary disease and heart disease. About half of long-term smokers will die earlier as a result of smoking. High numbers of hospital admissions are caused by smoking related conditions. It is estimated that in Scotland almost half of adults who are permanently sick or disabled (48%) or unemployed and seeking work (46%) are current smokers smoking causes and exacerbates a number of chronic respiratory diseases and cardio-vascular disease, and can worsen the health of people with long-term conditions such as asthma. Smokers are less likely than non-smokers to describe their health as 'good' or 'very good' (64% and 77%, respectively) while 12% of smokers said their health is 'bad' or 'very bad' compared with 5% of non-smokers.

Figure 14 shows results from the annual Scottish Household Survey and these indicate a gradual decline over recent years in the prevalence of smoking in Scotland. The overall percentage of the Scottish Borders adult population who smoke appears to have been consistently lower than the average for Scotland.

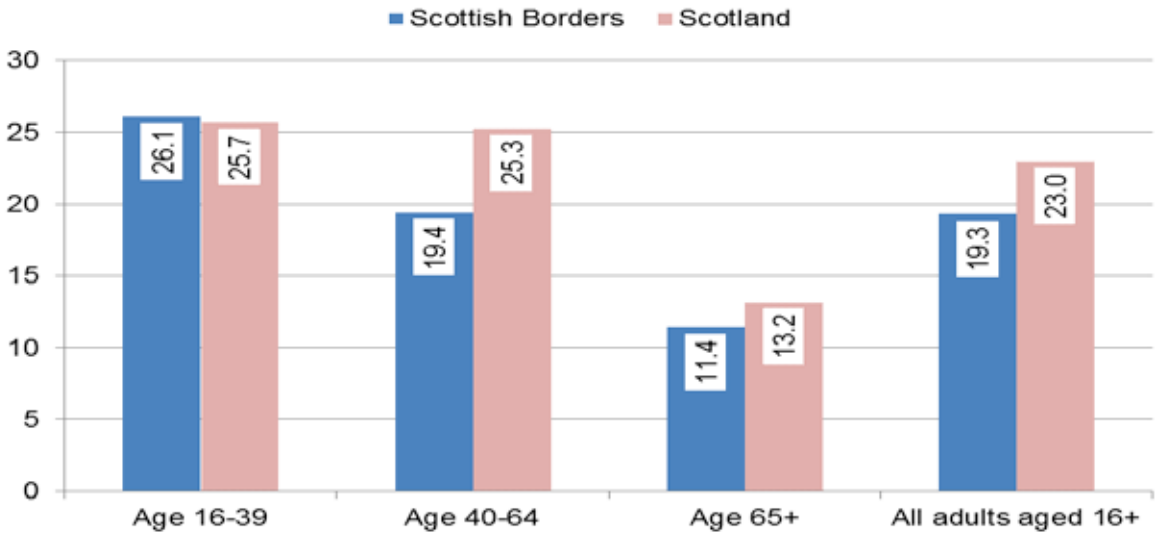
FIGURE 14
TRENDS IN PERCENTAGE OF ADULTS AGED 16+ WHO SMOKED; SCOTTISH HOUSEHOLD SURVEY RESULTS FROM 1999 TO 2013



Source: Scottish Household Survey

Figure 15 shows that whilst smoking prevalence amongst Borders residents aged 40-64 appears somewhat lower than the Scottish average (19.4% versus 25.3%, respectively), amongst people aged 16-39 the percentages are very similar (26.1% versus 25.7%, respectively). Overall rates of key smoking-related morbidity and mortality are significantly lower in Scottish Borders than across Scotland overall. It is estimated that around 275 smoking related deaths occur in the Borders each year[1].

FIGURE 15
PROPORTION OF SCOTTISH HOUSEHOLD SURVEY RESPONDENTS WHO SMOKED, BY AGE BAND, 2012+2013



Source: ScotPHO tobacco control profiles published January 2015.

Of concern is that most recent Scottish Household Survey found that 15 % most deprived areas of Scotland were considerably more likely than those in the rest of Scotland to be current smokers (34% and 18% respectively)[15]. Although the pattern is broadly similar to that in previous years, prevalence has reduced in all deprivation quintiles in the last year, most notably from 39 % in the 20% most deprived areas. This very welcome development may be related to the recent widespread adoption of electronic cigarettes.

> *"The highest rates of smoking are seen among routine and manual workers and in more deprived areas of the Borders"*

A HEALTHY LIFESTYLE = DRINKING RESPONSIBLY

The consumption of alcohol contributes to a range of health conditions and admissions to hospital. Alcohol-related conditions include liver disease, hypertension, oesophageal and other cancers and mental and behavioural disorders. Drinking alcohol is also linked to hospital admissions due to accidents and injuries and toxic effects of consumption, and causes considerable costs to the NHS.

In the Scottish Borders 43% of adults are estimated to drink outside of government guidelines i.e. men regularly exceeding 3-4 units of alcohol a day (equivalent to a pint and a half of 4% beer) and women regularly exceeding 2-3 units of alcohol a day (equivalent to a 175 ml glass of wine) during 2008-2011[16]. There is no significant difference between the rate of drinking outside guidelines or problem drinking between Borders and the Scottish average.

46% of Borders males are estimated to exceed limits compared to 40% of females. A recent national UK study also suggested there has been an increase in drinking amongst women and an increase in drinking among middle- and older-age groups. A further study found that people may significantly under report their drinking and true estimates of persons exceeding recommended limits may be 19% more men and 26% more women[17]. Applying this to the Borders may mean that 65% of men and 66% of women may be exceeding recommended limits.

There is no significant difference between the rate of binge drinking i.e. drinking more than double the lower risk guidelines for alcohol in one session, between Borders and the Scottish average. Binge drinking is higher for males (24%) than for females (14%) although both are lower than Scotland as a whole.

Despite a recent downward trend in alcohol-related harms, alcohol remains a major concern for public health in Scotland with consumption of alcohol and alcohol-related mortality considerably higher in Scotland than the rest of the UK. Figure 16 below shows that alcohol-related deaths have been variable for the Scottish Borders over the past ten years. Although nationally the trend for alcohol-related deaths is decreasing overtime, the rate of deaths for Borders is slightly higher in 2013 than 2003 but remains below the Scotland rate. When looking at alcohol related deaths the Langlee area has the highest rate in the Scottish Borders[2].

Alcohol related mortality is linked to long term drinking behaviours and so the impact of recent drinking may yet to appear.

FIGURE 16
ALCOHOL RELATED MORTALITY FOR SCOTTISH BORDERS COMPARED TO SCOTLAND AS A WHOLE

Source: National Records of Scotland

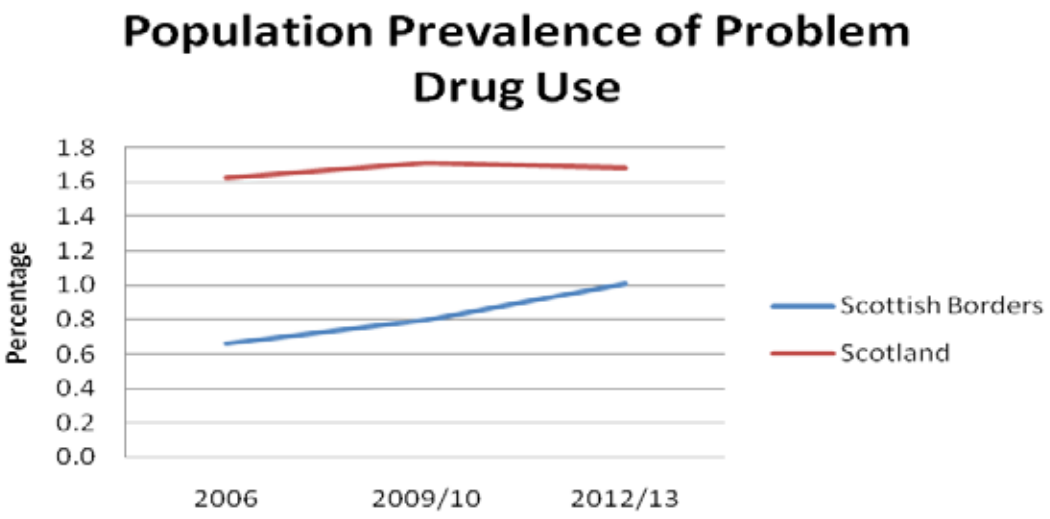
A HEALTHY LIFESTYLE = REDUCING HARM FROM DRUGS

The numbers of persons with a problem drug use is estimated from:

- clients registering with specialist drug treatment services
- drug-related hospital admissions
- police reports to the Procurator Fiscal under the Misuse of Drugs Act (opiates and/or benzodiazepines)
- Criminal Justice Social Work reports mentioning opiates and/or benzodiazepines

It is estimated that there are around 700 persons with problem drug use in the Borders: 550 males; 150 females[18]. Figure 17 below shows that local prevalence of problem drug use is significantly lower than the Scottish average but has shown a small increase in the most recent data set. There is no available national or local data set for other drugs commonly misused e.g. cannabis, cocaine or New Psychoactive Substances.

FIGURE 17
POPULATION PREVALENCE OF PROBLEM DRUG USER

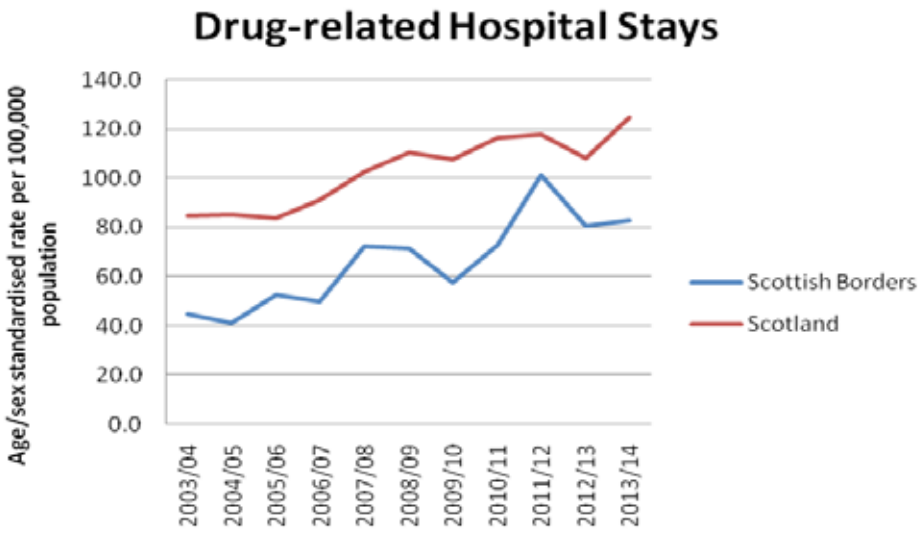


Source: ISD Scotland

Figure 18 below shows that the trend for Scottish Borders drug related hospitals stays is increasing, although it remains lower than the Scotland average. There are areas in the Scottish Borders where the rate is above Scotland, these are, Langlee, Kelso South, Selkirk, Hawick North, Galashiels West, Galashiels North and Peebles North.

As drug users grow older i.e. 35 years, they are more likely to experience concurrent physical and mental health problems. This, alongside the recent increased reported prevalence may account for some of the increase in hospital stays.

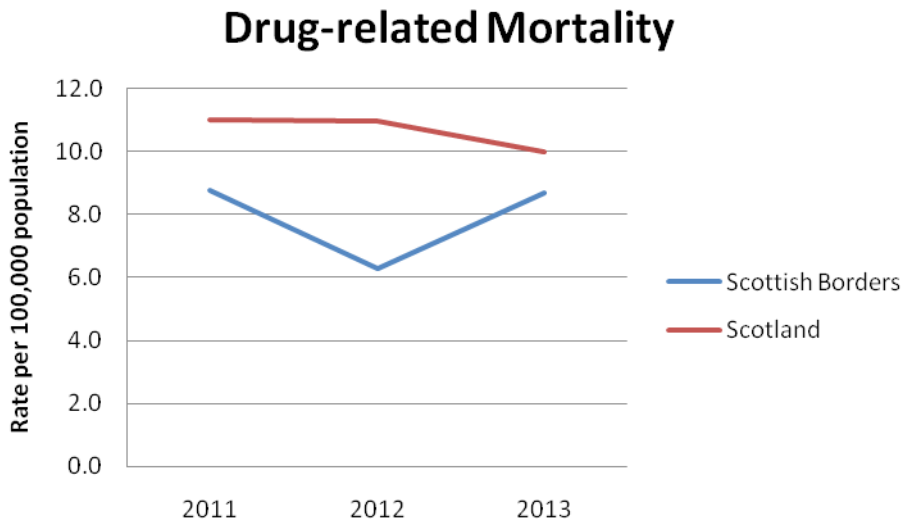
FIGURE 18
DRUG RELATED STAYS FOR BORDERS RESIDENTS



Source: ISD Scotland

Figure 19 below shows that Scottish Borders rate for drug related deaths has increased over the previous six years however remains below the Scotland average. The small numbers mean that large year-to-year variations are to be expected. The data which supports this indicator is from National Records of Scotland which records both accidental deaths from overdoses and intentional self-poisoning using controlled drugs.

FIGURE 19
DRUG RELATED MORTALITY FOR BORDERS RESIDENTS



Source: National Register Scotland

SEXUAL HEALTH

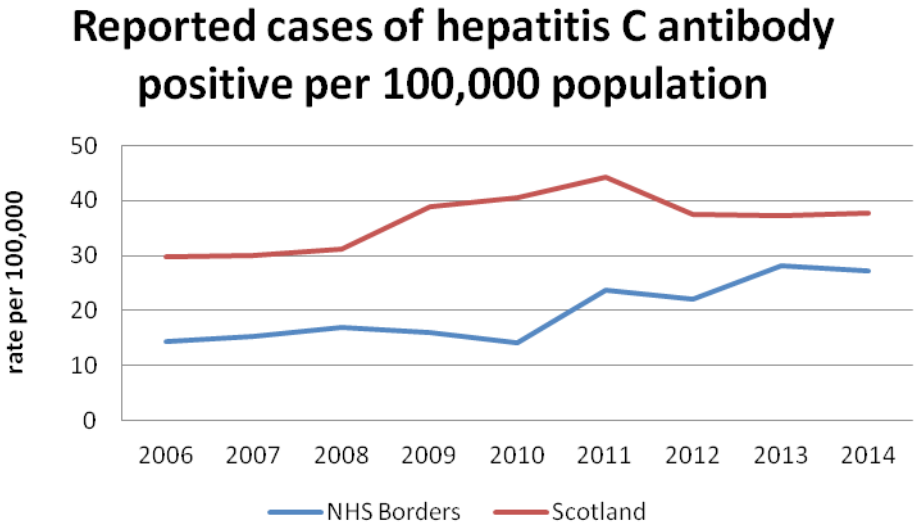
Borders has one of the lower rates of sexually transmitted diseases amongst Scottish health boards. In Scotland as a whole the number of reported cases of genital herpes and gonorrhea has increased in recent years, whereas the number of reported cases due to chlamydia infection in young women has declined probably due to more effective screening. In Scotland young people, particularly women, aged less than 25, are the group most at risk of being diagnosed with a sexually transmitted disease. In 2013, 77% and 72% of genital chlamydia and gonorrhoea diagnoses, respectively, in Scottish women were made in those aged under 25 years. The sexual health of Scottish men who have sex with men (MSM) continues to be of concern as there is evidence from both infection and behavioural survey data of continuing high risk behaviour – rectal gonorrhoea in men, a marker of unprotected anal intercourse remains high[19].

BLOODBORNE VIRUSES (BBVS)

HEPATITIS C

Figure 20 below shows that hepatitis C prevalence in the Borders is significantly lower than in Scotland overall however the prevalence appears to have increased at a higher rate than Scotland overall since 2001. There was a large increase in prevalence between 2010 and 2011 which does not reflect a national trend. This increase followed the introduction of dried blood-spot testing which was designed to increase the identification of undiagnosed individuals and support them into treatment (a key objective of national and local BBV strategies). The percentage of injecting drug users who test positive for Hepatitis C antibody in Scottish Borders remains significantly lower than the Scotland percentage. This indicator is based on data from the Needle Exchange Surveillance Initiative (NESI) in 2011 which aimed to measure and monitor the prevalence of the Hepatitis C virus (HCV) and injecting risk behaviours among people who inject drugs (PWID) in Scotland– a key 'at risk' group.

FIGURE 20
HEPATITIS C PREVALENCE IN BORDERS RESIDENTS



Source: Health Protection Scotland

HIV

There are around 3-4 new cases of HIV infection per year in the Borders. In total there are currently around 50 Borders residents with HIV infection and heterosexual sex (41%) is the most common form of transmission for HIV. This compares to heterosexual sex being responsible for only 32% of new HIV cases in Scotland as a whole. The majority (76%) of diagnoses each year in Scotland are made in those aged 25-49. Of note, however, while the numbers are still relatively small, there has been a steady increase in the number and proportion of HIV diagnoses in those aged over 50 since 2009 as a result of successful antiretroviral treatment and people living longer with HIV[20]. A high proportion of those eligible for HIV treatment and care in Scotland are receiving it and therapy continues to be successful: 96% of patients undergoing treatment for at least six months during 2013 had evidence of viral suppression.

A HEALTHY LIFESTYLE = EATING WELL AND BEING ACTIVE

Excess weight, diet and physical activity all have a significant impact on health. Obesity is a major determinant of premature mortality and avoidable ill health, increasing the risk of diabetes, heart disease, cancer, muscle and joint problems and depression. Physically active people have a 20-35% lower risk of cardiovascular disease, reduced risk of diabetes, obesity, osteoporosis and colon/ breast cancer, and better mental health.

EXCESS WEIGHT

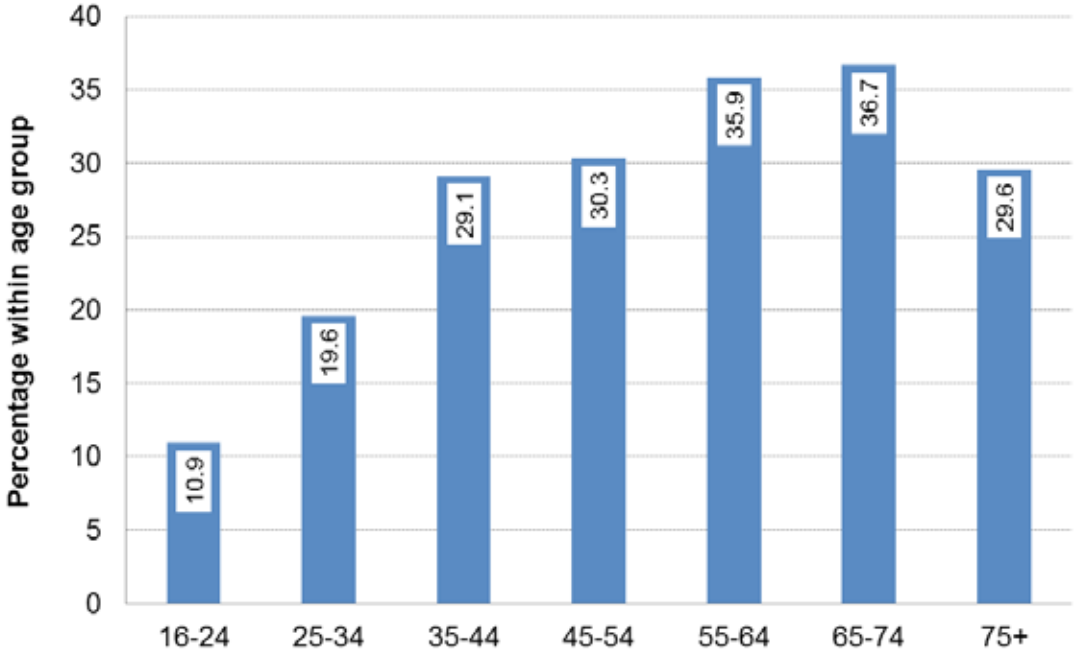
Excess weight for adults is usually estimated by calculation of a body mass index (BMI). A principal source of information on the prevalence of obesity in Scotland in working age people is the Scottish Health Survey. In 2013, it was estimated that, across Scotland:

- 27% of the population aged 16 and over were obese (had a Body Mass Index of 30 or more)
- 25% of males in this age group were obese
- 29% of females in this age group were obese

Whilst these estimates are based on relatively small numbers of survey respondents across Scotland (just over 4,100 for the 2013 survey), the estimated prevalence of obesity as generated from the survey have been very consistent across each successive year since 2008.

The estimated prevalence of obesity tends to rise with increasing age, from around 1 in 9 people aged 16-24 to more than 1 in 3 people aged 55-74, as shown in the Figure 21 below.

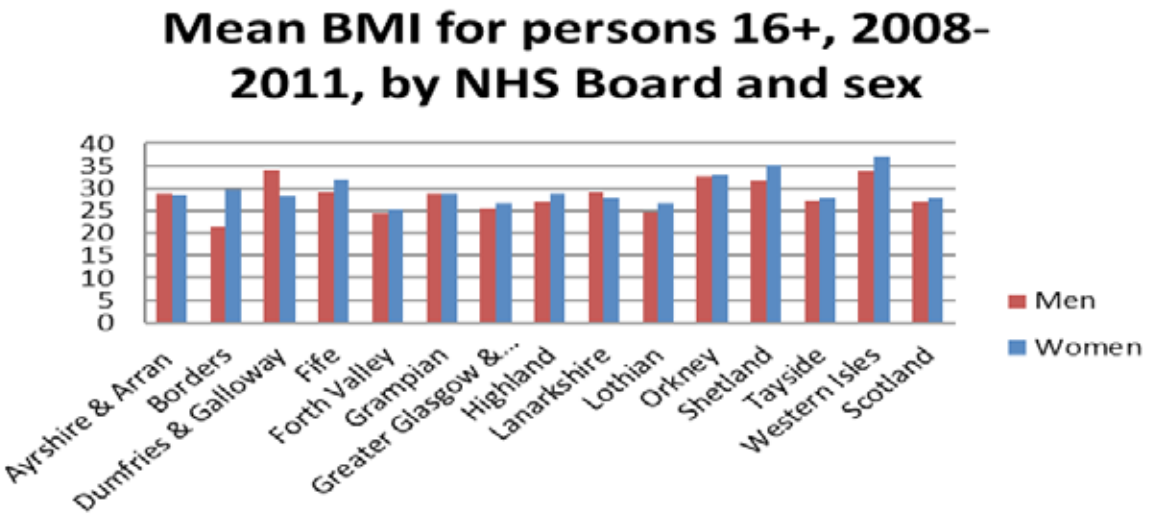
FIGURE 21
SURVEY-BASED ESTIMATES OF THE PROPORTIONS OF THE SCOTTISH POPULATION WHO ARE OBESE (BODY MASS INDEX OF 30 OR MORE), BY AGE BAND, 2013



Source: Scottish Health Survey Annual Report 2013

Due to the relatively small sample size of the survey, most of the results are published as national totals only. However, periodically the Scottish Government publishes figures at NHS Board level, based on aggregated results from a combined set of years. Figure 22 below illustrate some of the results for Scottish Borders compared with other parts of Scotland. For 2008-2011, the estimated prevalence of obesity amongst adult females in Scottish Borders was higher than for Scotland. However more men in Borders are within a healthy weight range.

FIGURE 22
MEAN BMI BY HEALTH BOARD FOR PERSONS 16 YEARS AND OVER 2008-2011 BY SEX

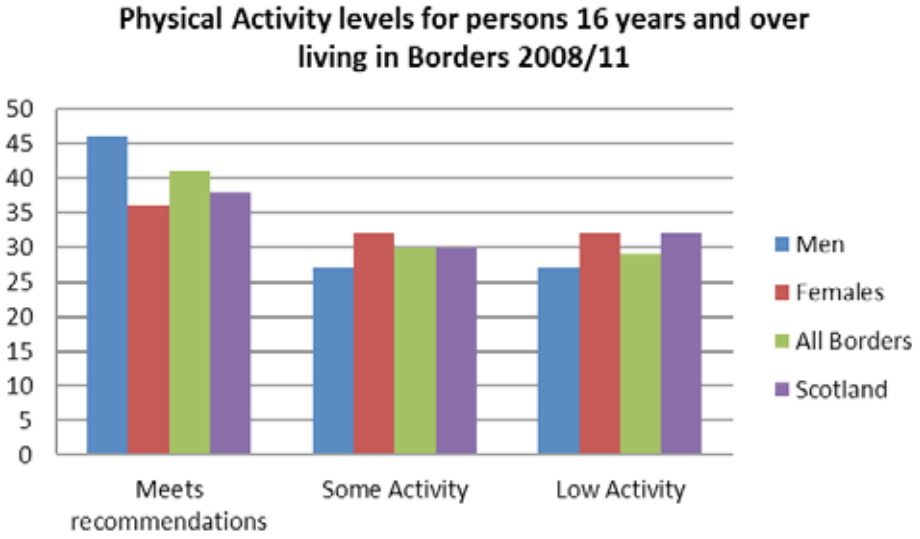


Source: Scottish Health Survey 2011

PHYSICAL EXERCISE

Figure 23 below shows that the majority of the population in the Scottish Borders do not meet the recommended level of physical activity with 29% of the population having low levels of physical activity.

FIGURE 23
PHYSICAL ACTIVITY LEVELS IN THE BORDERS 2008-2011 COMBINED



Source: Scottish Health Survey 2011

KEY CHALLENGES

A HEALTHY LIFESTYLE = DRINKING RESPONSIBLY

At least 43% of adults in the Scottish Borders may be exceeding recommended alcohol drinking limits. Alcohol related mortality is linked to long term drinking behaviours and so the impact of recent drinking is yet to appear. Reduction of excess drinking in men and women remains a priority.

A HEALTHY LIFESTYLE = REDUCING HARM FROM DRUGS

The trend for Scottish Borders drug related hospitals stays is increasing particularly in deprived areas. As drug users grow older i.e. 35 years, they are more likely to experience concurrent physical and mental health problems and service providers need to be aware of these needs.

A HEALTHY LIFESTYLE = EATING WELL AND BEING ACTIVE

The estimated prevalence of obesity tends to rise with increasing age, from around 1 in 9 people aged 16-24 to more than 1 in 3 people aged 55-74.

The majority of the population in the Scottish Borders do not meet the recommended level of physical activity. 29% of the population have low levels of physical activity.

EXAMPLES OF WHAT WE AND PARTNERS ARE DOING IN BORDERS

Providing intensive support to around 500 new people each year who want to adopt healthier lifestyles through the Lifestyle Advisor Support Service. Physical activity and/or diet are the commonest areas people want to focus upon, and evaluation shows increased activity after support and reductions in BMI and blood pressure.

Approximately 14% of our population have diagnosed hypertension and general practices are achieving good control of their blood pressure (BP). The Quality & Outcomes Framework data for 2014/15 show that local practices scored 100% for the indicator relating to BP control at 150/90 or less, the highest score of any mainland Health Board in Scotland. This will be preventing many heart attacks and strokes, now and in the future.

Under the local Tobacco Control Plan we are bringing together a range of actions that aim to reduce the impact of tobacco on the health and wellbeing of people in the Borders, that span promotion, protection and support for smoking cessation. This includes smoke free spaces and places, retail regulation, campaigns and awareness raising and targeted support for individuals to stop smoking. NHS Borders supports people across Borders who wish to stop smoking through the specialist Smoking Cessation Service, Quit4Good,and through community pharmacies. This support is also targeted at those living in the 40% most deprived areas.

Production of an annual Alcohol Profile which supports the Scottish Borders Alcohol Licensing Board with evidence of alcohol related harm in Borders. This is part of wider partnership work on access and availability of alcohol.

Provision of specialist treatment and support for people with alcohol and drug problems including access to injecting equipment provision (needle exchanges).

The Walk it project is funded by the Public Health Directorate who work closely with Scottish Borders Council to provide health walks across the Borders aimed at those with low activity levels. There are also a number of health walks for people with a range of health conditions.

Small Change Big Difference campaign aims to promote awareness of staff, patients, and the public at the actions we can all take to improve our own health and to support others to do so

Capacity building- the Joint Health Improvement Team works with a wide range of statutory and third sector organizations to develop skills and confidence of staff to support their clients make lifestyle changes for improved health and wellbeing. Training programmes are developed to respond to demand and to reflect local priority needs

The Blood Borne Viruses Managed Clinical Network and the Sexual Health Strategy Coordination Group have recently refreshed their Sexual Health and BBV Action Plan. Addition actions include:

- A programme of training for all staff working with those at risk of acquiring blood borne viruses. This is to ensure new staff and services are equipped with the knowledge and skills to help prevent the risk of infection, identify those already affected, and support engagement with treatment
- Commissioning of a Men who have Sex with Men Needs Assessment

BORDERS DIRECTOR OF PUBLIC HEALTH
REPORT 2015

CHAPTER 9

AGEING WELL

WHY IS THIS IMPORTANT?

As our population ages it is vital that maintaining and improving physical, mental, social and economic wellbeing of older adults is a priority. With significant improvements in healthcare and lifestyles, an increasingly large percentage of our population is made up of people aged over 65 years old. A larger population of older people means a larger population potentially affected by certain challenges to health in later life. Additional deaths occur during winter related to cold weather, and older people are at risk of falls and hip fracture. Older people are increasingly likely to require support from adult social care and social isolation becomes an important factor in older people's mental health. As well as simply living longer, we also want to live healthy for longer.

There is much that can be done to maximise the potential of older adults and enable them to live as independently as possible in their own community. Interventions such as seasonal flu vaccination, falls prevention, tackling fuel poverty, and community development projects to reduce social isolation all have the potential to support everyone to age well.

OUR VISION:

> *"That older adults should be a valued part of our society, able to live full and active lives for as long as possible and to be supported and cared for in the best possible way for them up to the end of their life"*

KEY FACTS:
FUEL POVERTY

Fuel poverty is the result of the interplay between income, fuel price and energy efficiency.

Results from the Scottish House Conditions Survey 2011-2013 include the following:

- The lower income groups have the highest rates of fuel poverty, but fuel poor households are found in all income bands.
- Around 12% of households in the Scottish Borders are in extreme fuel poverty, compared with a Scottish average of 10%
- Pensioners are most at risk of fuel poverty. Around 60% of pensioner households in Scottish Borders are fuel poor, higher than for other household types in Scottish Borders and for pensioner households across Scotland as a whole (54%)

CARING AND CARERS

Based on results of the Scottish Health Survey and the 2011 Scotland Census the number of people aged 16+ in Scottish Borders who provide unpaid care for someone else may be around 12,500. This estimate, used in the Scottish Borders Joint Carers Strategy 2011-2015, translates as around 13% of all residents aged 16+ having some sort of Carer responsibilities. This figure is higher than the 10,159 people aged 16+ who were counted via the 2011 Scotland Census (11% of people in this age group)[1].

The number of children aged 4-15 in Scottish Borders who act as a carer for someone may (if the situation in Borders is similar to that for Scotland) be roughly 760, translating as around 4% of all children in this age group. This is somewhat higher than the 187 carers aged under 16 who were counted via the 2011 Scotland Census.

The percentages of carers rating their own health as bad or very bad increases with the amount of unpaid care provided. 3% of people providing less than 20 hours of care per week rated their health as bad/very bad, compared with 13% of people providing more than 50 hours of unpaid care[1].

DISABILITY

At the time of the 2011 Scotland Census, 6,995 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a physical disability. This equates to 6.1% of all Scottish Borders residents at that time.

The age and gender profile of these 6,995 residents is shown below:

- 1,286 (55%) were aged 65 and over
- 1,868 (27%) were aged 50-64
- 1,127 (16%) were aged 16-49
- 143 (2%) were aged under 16

The prevalence of physical disabilities in the Scottish Borders population rises with increasing age. Just over 1% of young adults aged 16-24 are affected, compared with 10.8% of people aged 65-74 and 31.7% of people aged 85 and over[1].

HEARING LOSS

Around 21,500 people aged 16 and over living in Scottish Borders in 2012 may have some extent of hearing loss, of whom:

- Between 350-400 individuals may be Deaf/with profound hearing loss
- A further 1,400 people may have a severe hearing loss
- Around 8,500 people may have moderate hearing loss

Amongst people with moderate, severe or profound hearing loss, the estimated age breakdown is as follows:

- Around 1,200 people aged 16-60 (about 2%, or one in fifty of the population in this age group
- Around 4,900 people aged 61-80 (about 19%, or one in five people in this age group)
- Around 4,200 people aged 81 and over (about 74%, or three quarters of people in this age group)

The total numbers of Scottish Borders residents affected by hearing loss could rise to approximately 25,000 by 2022 and 29,500 by 2032[1].

SIGHT LOSS

Over 4,000 people aged 15 and over living in Scottish Borders in 2012 may have some degree of sight loss, of whom:

- Approximately 500 are blind or have severe sight loss
- A further 1,000 people may be living with moderate sight loss

Amongst people who are blind or have severe or moderate sight loss, the estimated age breakdown is as follows:

- Around 250 people aged 15-64
- Around 300 people aged 65-74
- Over 900 people aged 75 and over

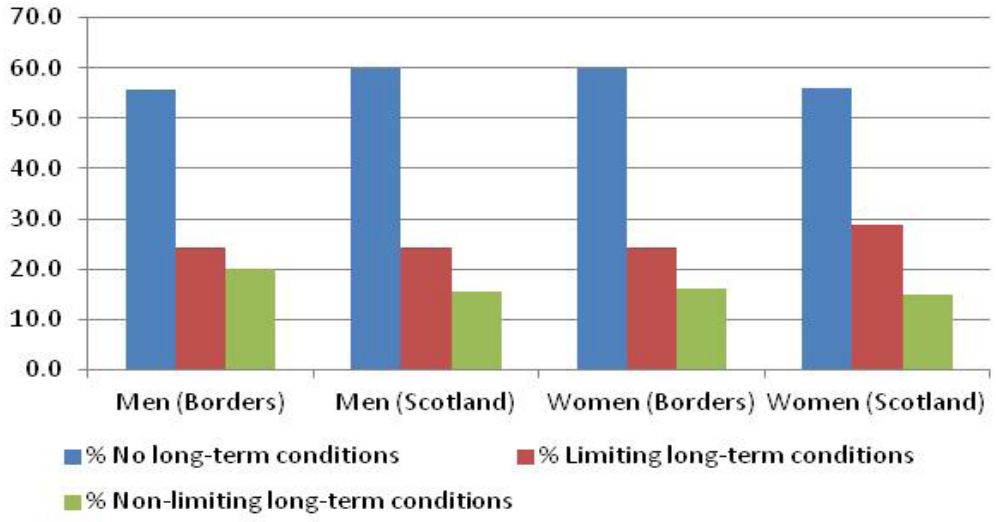
The total numbers of Scottish Borders residents aged 15 and over and affected by some extent of sight loss could rise to over 5,000 by 2022 and to around 6,500 by 2032[1].

LONG TERM CONDITIONS

Figure 24 below shows that 44% of people in the Borders are living with Long Term Conditions (LTC) of which 24% are reported as life limiting for both men and women. In Scotland overall, 27% of people are recorded as living with a life limiting condition with women reporting more life limiting conditions (29%).

Within the Scottish Borders the areas where more than 32% of people have one or more long-term condition are Kelso South, Coldstream and area, Hawick West End, Duns, Eyemouth, Galashiels South, and Hawick Central[2].

FIGURE 24
NUMBERS OF PERSONS LIVING IN THE BORDERS WITH LONG TERM CONDITIONS



Source: Scottish Health Survey 2013

Figure 25 below shows that by the age of 65, nearly two-thirds of people will have developed a LTC: 75% of people aged 75-84 have two or more such conditions. Studies have also found that socioeconomic deprivation is also associated with an increased prevalence of multi-morbidity (Including a mental health disorder).

11.0% of people in the most deprived areas have both a physical and mental disorder, compared with 5.9% of people in the least deprived areas (the authors of this study used deprivation deciles derived from Carstairs scores). Onset of multi-morbidity tended to occur at a younger age (10-15 years earlier) in people living in the most deprived areas compared with the most affluent.

FIGURE 25
ESTIMATED PERCENTAGE OF PERSONS HAVING ONE OR MORE CHRONIC DISORDERS BY AGE GROUP SCOTLAND 2007.

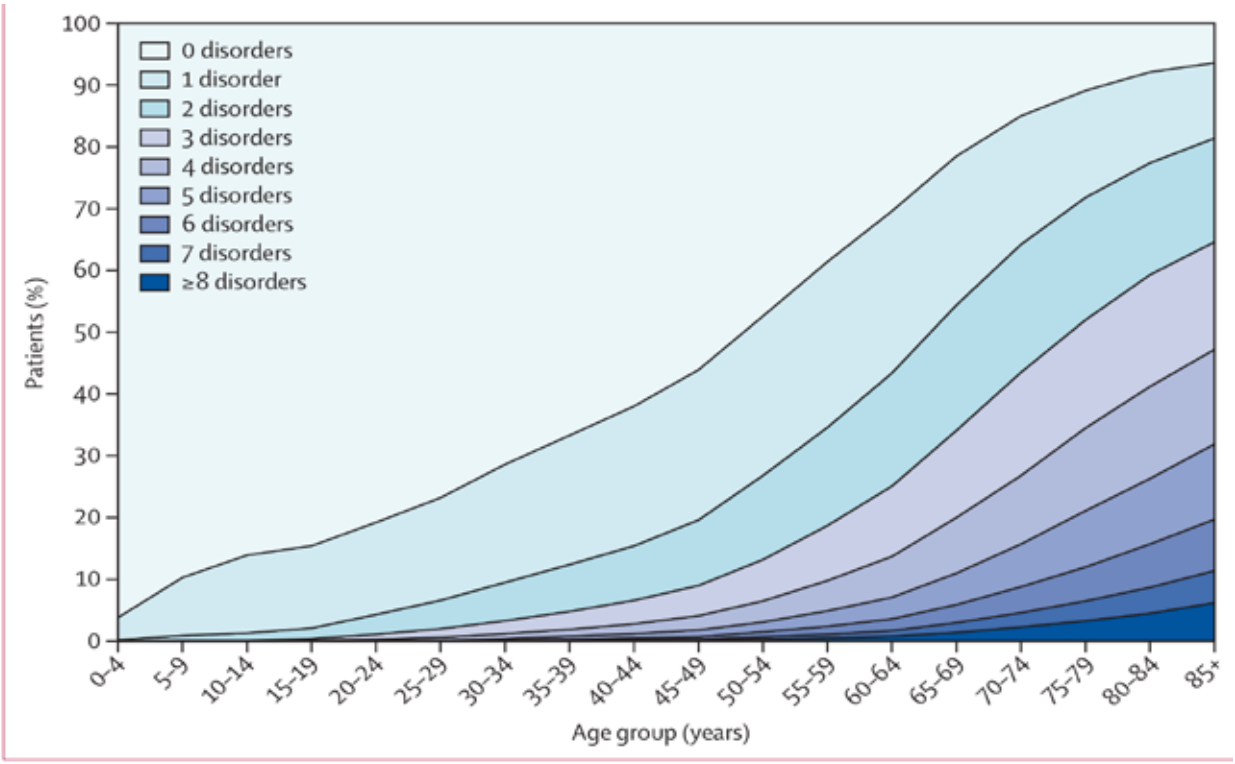


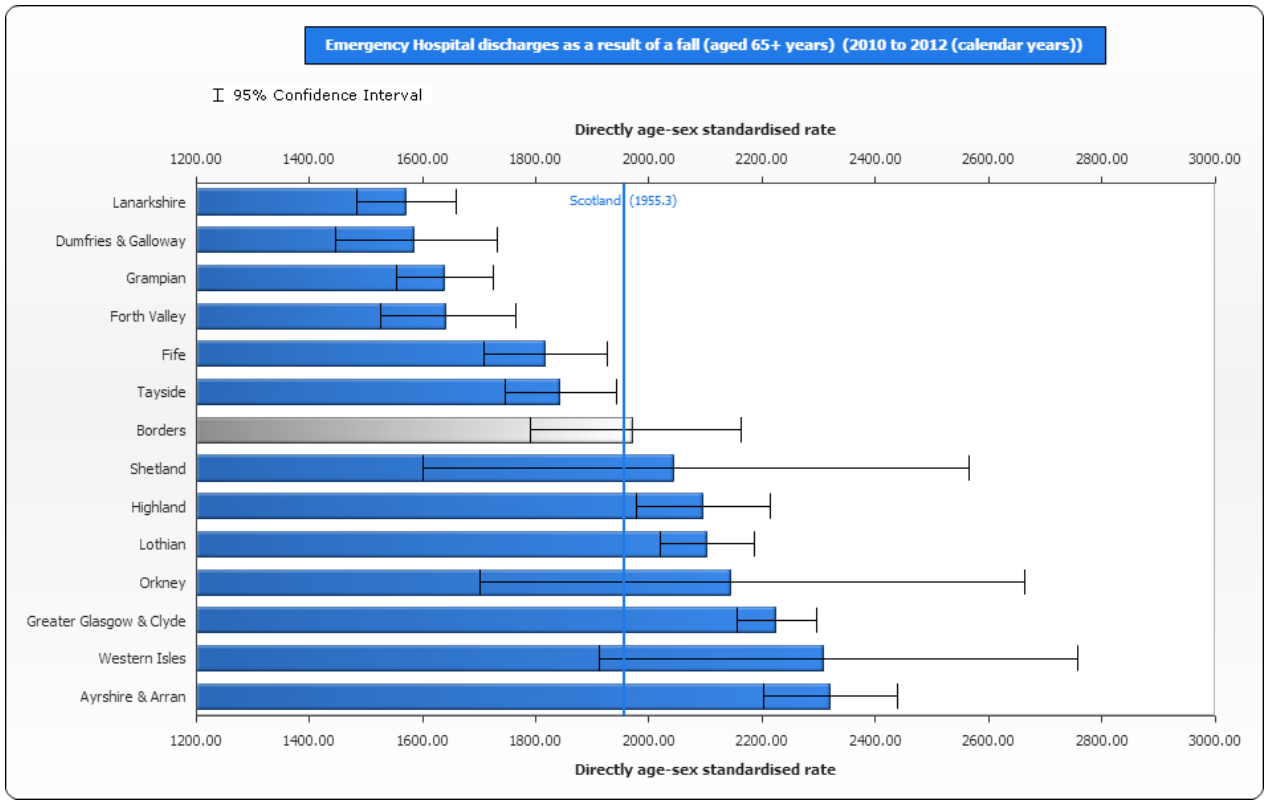
Figure 1: **Number of chronic disorders by age-group**

Source: :Barnett et al (2012)

FALLS

Figure 26 shows that the rate of hospital admissions following a fall in the Borders for the over 65s in the period 2012-12 was similar to that for Scotland. However this means there is still nearly 500 emergency admissions each year in Borders persons over 65 years due to falls.

FIGURE 26
DIRECTLY AGE-SEX STANDARDISED EMERGENCY HOSPITAL DISCHARGE RATE PER 100,000 POPULATION AS A RESULT OF A FALL (AGE 65+ YEARS) 2010-2012

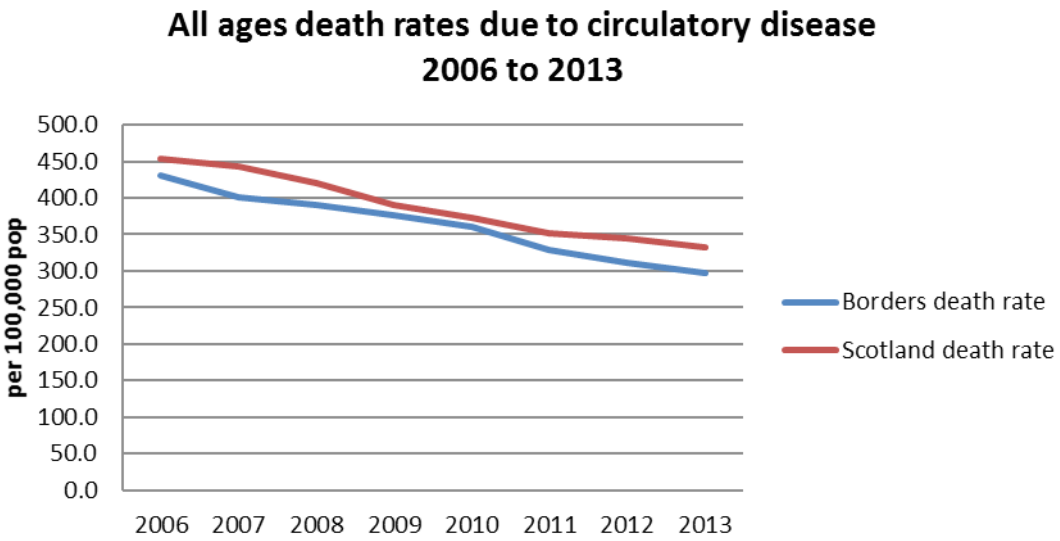


Source: ScotPHO Profiles http://www.scotpho.org.uk/

CORONARY HEART DISEASE (CHD)

Men continue to suffer more CHD than women. However Figure 27 below shows that the death rate from circulatory diseases, including CHD, in the Borders has fallen substantially in recent years. Because of population ageing, the total numbers of CHD admissions to hospital has remained fairly constant despite reductions in rates. Measures to reduce smoking, blood pressure and cholesterol levels could reduce incidence and mortality rates, and ensuring that the maximum number of eligible CHD patients receives appropriate medications could reduce admissions and deaths. The Langlee area stands out as the area with a high rate of hospital admissions and early deaths[2].

FIGURE 27
ALL AGES AGE-STANDARDISED DEATH RATES DUE TO CIRCULATORY DISEASE 2006 TO 2013

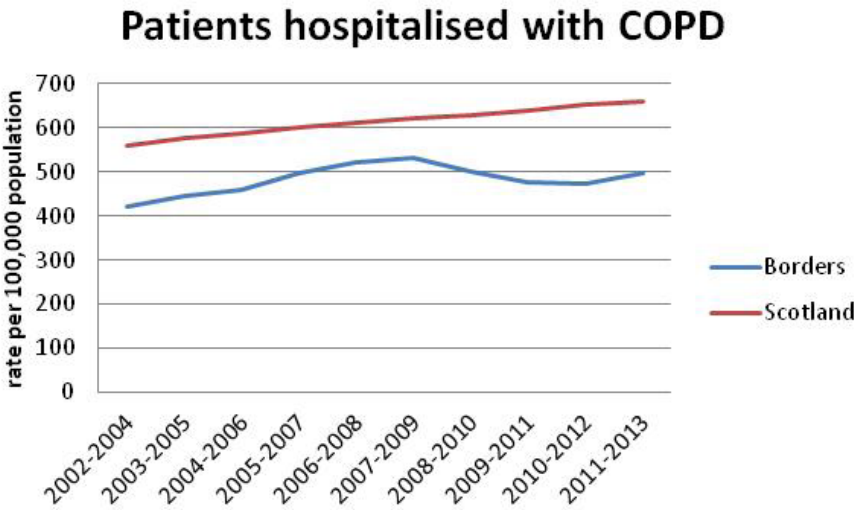


Source: National Records of Scotland

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Figure 28 shows that the Scottish Borders has a lower rate of patients hospitalised with chronic obstructive pulmonary disease (COPD) compared to Scotland. There are five areas in the Scottish Borders where the COPD hospitalisation rate is higher than Scotland are Galashiels West, Burnfoot and area, Langlee, Hawick North and Eyemouth[2].

FIGURE 28
AGE STANDARDISED INCIDENCE RATES OF PATIENTS HOSPITALISED WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)



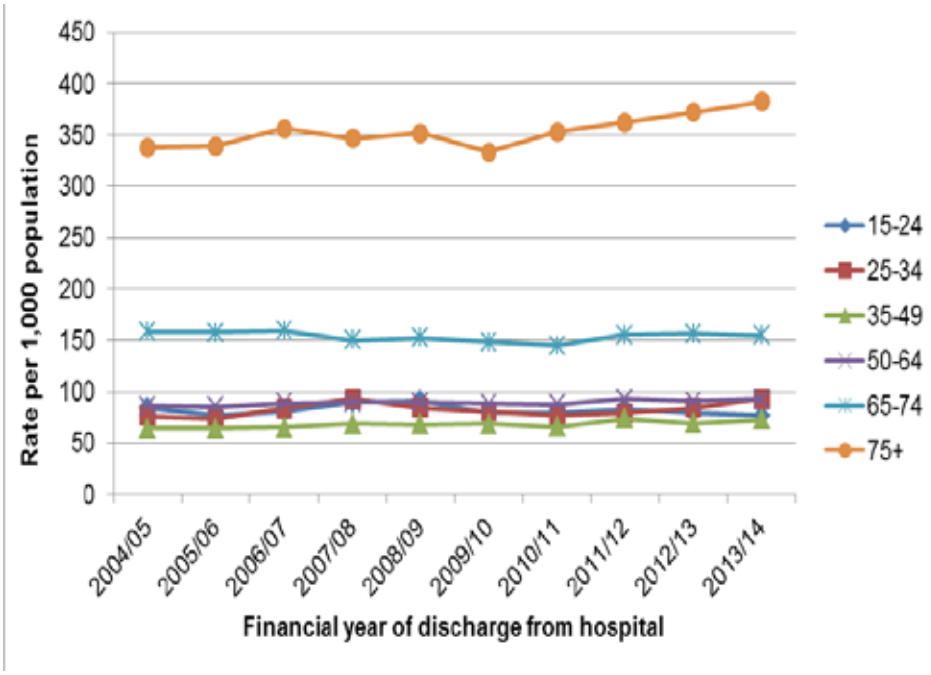
Source: ISD Scotland

EMERGENCY ADMISSIONS

An emergency admission to hospital may be the right course of action for someone who has a potentially serious or life threatening health problem that needs urgent specialist investigation or treatment in hospital. However, for some older people an emergency hospital admission can be followed by complications such as a loss of confidence and confusion that prolong their stay, compromising their independence and ability to return home quickly. The Scottish Borders has a higher rate of emergency hospitalisations compared to Scotland.

Figure 29 below shows that by far the highest rates of emergency admissions to hospital are amongst people aged 75 and over. In 2004/05, 3,285 hospital inpatient stays for Scottish Borders residents began with an emergency admission (a rate of 338 per 1,000 population in this age group). By 2013/14 the total had risen to 4,310 hospital stays (a rate of 382 per 1,000 population). The increase over the past ten years in emergency admissions amongst the over 75s accounts for approximately half of the overall increase in numbers of emergency admissions across all adult (age 15+) residents in Scottish Borders. The rates in younger age groups are constant although remain higher than Scotland as a whole. Recent data suggests that the overall increase in emergency admissions may be levelling off although the increase in the older age groups i.e. 65 years and over continues. The areas in the Scottish Borders with the highest level of emergency hospitalisations are Langlee, Burnfoot, Galashiels West, Selkirk and Galashiels South[2].

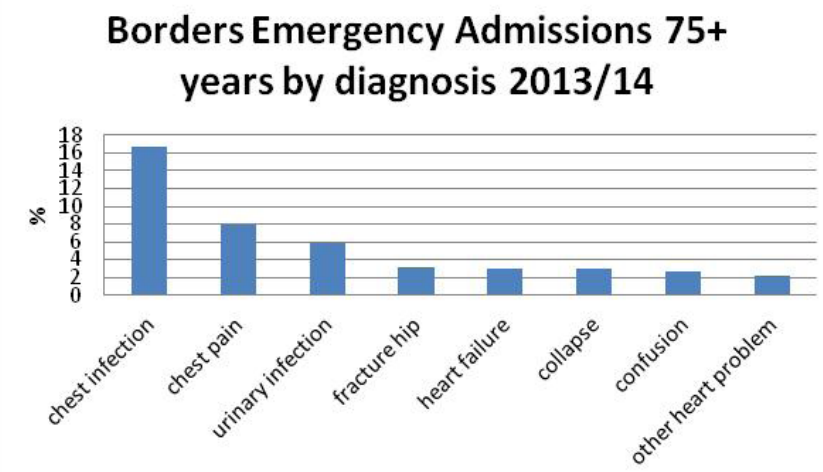
FIGURE 29
SCOTTISH BORDERS RESIDENTS ADMITTED TO HOSPITAL AS AN EMERGENCY; TRENDS IN RATES PER 1,000 POPULATION



Source: Hospital Care National Statistics, ISD, NHS National Services Scotland, published Dec 2014 www.isdscotland.org/Health-Topics/Hospital-Care/

Figure 30 shows that the most common causes of emergency admission for those aged 75 years and over are: respiratory infection (17%), chest pain (8%) and urinary tract infections (6%). There may be opportunities to improve care for these patients in the community and thus prevent hospital admissions.

FIGURE 30
BORDERS EMERGENCY ADMISSIONS 75 YEARS AND OVER BY DIAGNOSIS 2013/14



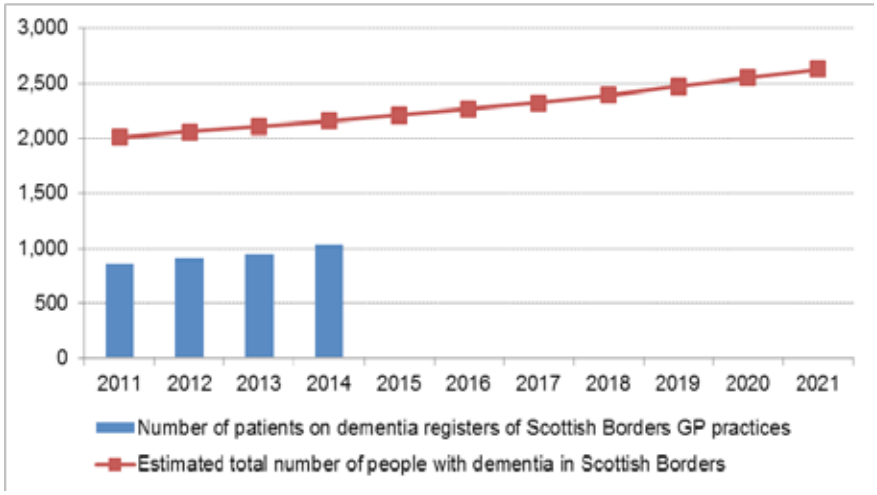
Source: NHS Borders

As the likelihood of emergency admission increases with age, so too does the likelihood of a patient having multiple emergency admissions. For patients aged 65 years and over who have had 2 or more emergency admission spells in hospital, in Scotland the rate per 100,000 population has increased over the last ten years from 4,380 in 2002/03 to 5,132 in 2011/12. The Scottish Borders has a similar level of multiple emergency hospitalisations for people age 65 and older compared to Scotland.

DEMENTIA

At March 2014, the 23 GP practices in Scottish Borders recorded a total of 1,027 patients known to them as having dementia1. Figure 31 below shows the diagnosed dementia cases in Borders versus projections of possible prevalence. Both show that cases of dementia are expected to significantly increase in the Borders over the next 5 years.

FIGURE 31
DIAGNOSED DEMENTIA CASES IN BORDERS VERSUS PROJECTIONS OF POSSIBLE PREVALENCE



Sources:
1. Diagnosed cases: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof
2. Estimated overall prevalence: Scottish Government projection, based on Eurocode prevalence model used by Alzheimer's Scotland, and 2010-based population projections.

KEY CHALLENGES

FUEL POVERTY

The lower income groups have the highest rates of fuel poverty, but fuel poor households are found in all income bands.

CARING AND CARERS

The percentages of carers rating their own health as bad or very bad increases with the amount of unpaid care provided. 3% of people providing less than 20 hours of care per week rated their health as bad/very bad, compared with 13% of people providing more than 50 hours of unpaid care. Service providers need to be aware of the needs of this group.

LONG TERM CONDITIONS

By the age of 65, nearly two-thirds of people will have developed a Long Term Condition: 75% of people aged 75-84 have two or more such conditions. Management of elderly persons with multiple conditions is one of the most challenging problems faced by service providers particularly in primary care. Organisations need to recognize that providing appropriate support to such patients will not only help maintain patients in good health but ultimately reduce demands on services in the future. The evaluation report from the local LTC project, expected in early 2016, should be carefully considered so we learn from it and use it to improve the management of LTCs across the region.

FALLS

The rate of hospital admissions following a fall in the Borders for the over 65s in the period 2012-12 was similar to that for Scotland. However this means there is still nearly 500 emergency admissions each year in Borders persons over 65 years due to falls.

EMERGENCY ADMISSIONS

The Scottish Borders has a higher rate of emergency hospitalisations compared to Scotland with more deprived communities having higher rates. By far the highest rates of emergency admissions to hospital are amongst people aged 75 and over. The most common cause of admission in this age group is chest infection. There may be opportunities to improve care for these patients in the community and thus prevent hospital admissions.

DEMENTIA

The number of people with dementia are expected to significantly increase in the Borders over the next 5 years. This will have significant implications for families, communities and care providers.

EXAMPLES OF WHAT WE AND PARTNERS ARE DOING IN BORDERS

NHS Borders and Scottish Borders Council are working together to put in place formal joint working arrangements with the aim of providing better, more integrated adult health and social care services. This new Health & Social Care Partnership Integrated Joint Board will be responsible for commissioning a wide range of health and social care services. The aim of Integration of health and social care is one of Scotland's major programmes of reform. At its heart, health and social care integration is about ensuring that those who use services get the right care and support whatever their needs, at any point in their care journey particularly for older people. The new Integrated Joint Board is currently consulting on a new Strategic Plan to guide its commissioning role.

Long-Term Conditions Project: This 2 year project supports improvements in the shared-management of Long Term Conditions (LTCs) amongst older people in the Borders. It is a partnership between Public Health, two GP practices (Galashiels and Coldstream), and the British Red Cross. Key aims of the project are:

- improved access to information, advice and local resources for patients and carers;
- improved health and well-being; and
- tailored support for those with two or more conditions who need help to manage.

An extension of 6 months has now been granted to ensure full evaluation and help to inform future developments in the shared-management of LTCs as part of the integration agenda. This project should not only improve patients' knowledge of their LTC and how to manage it better to improve their health and wellbeing, but should also help to reduce emergency medical admissions.

Falls and Osteoporosis – in response to the high level of falls locally a falls prevention project was set up and work continues within the Borders General Hospital and in the community to reduce them. There is also a local Osteoporosis service that identifies patients who fall and develop fractures caused in part by their osteoporosis and weaker bones. This service is recognized as one of the best in the country at identifying such patients and ensuring they are offered drug treatment to strengthen their bones and reduce fractures in the future. As a result of these local services hip fracture rates are now falling in Borders whilst they are increasing nationally.

Ecotherapy Dementia Project- Working in partnership with the Mental Health for Older Adults Team and the local environmental charity "Instinctively Wild" the Joint Health Improvement Team funded two ecotherapy projects for people with dementia. This project helps people with dementia regain a sense of connection and improve their well-being through gentle outdoor activities.

Working with Borders Carers Centre and alcohol and drugs services to better understand the needs of people affected by another's substance use.

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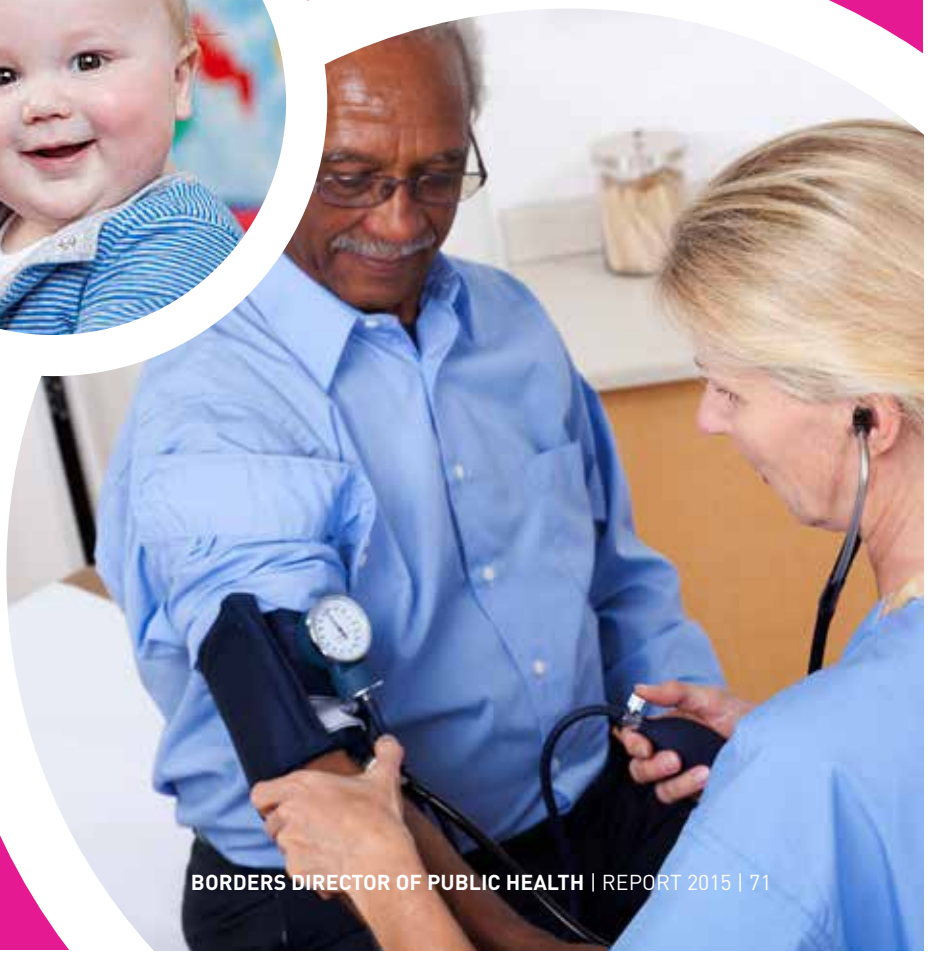
CHAPTER 10

COMMON ILLNESSES SPANNING AGE GROUPS



CANCER
WHY IS THIS IMPORTANT?

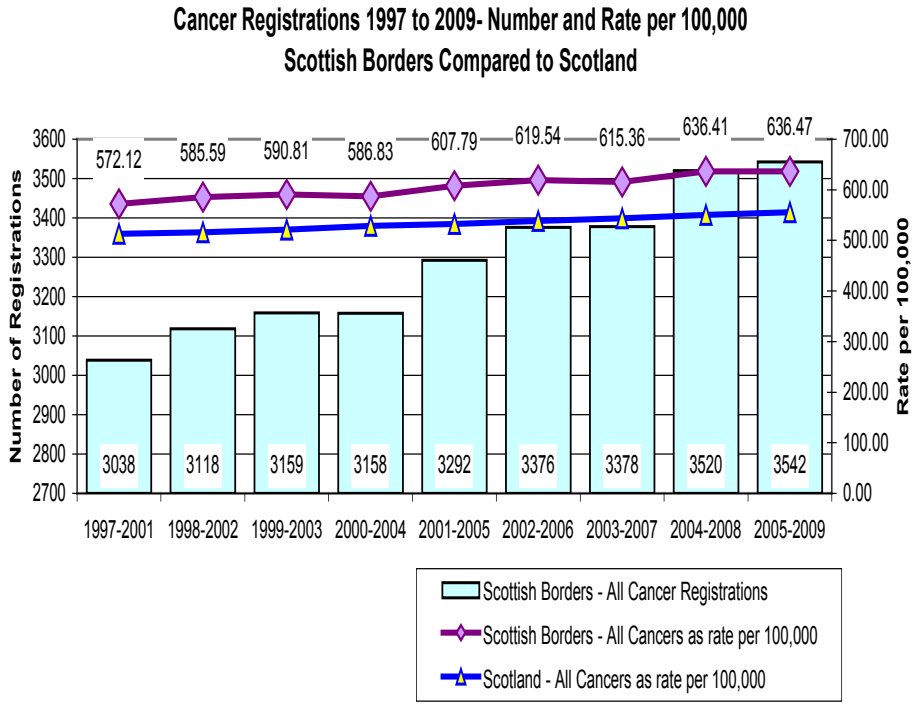
The population of Scotland experiences relatively high incidence of many common cancers, and deaths from cancer represent a significant fraction of total mortality. Within Scotland, there are significant variations in the risk and outcome of cancer, geographically and socially. There are also significant costs incurred: the cost of premature death, the cost of medical care to cancer patients, and the indirect cost of cancer on economic productivity through lost wages and hours worked. It also costs us the people we love. However, we have the tools at hand to do something about it in a rational way: reliable data on cancer incidence and outcome, and health professionals committed to improve services through evidence-based practice on prevention, diagnosis and treatment.

KEY FACTS:

Figure 32 below shows that the actual numbers of cases of cancer have risen over the last decade, largely due to an ageing population, as the incidence of new cancer cases rises quickly after 65 years.

Once the age profile of the Borders population is taken into account, overall age-standardised rates of cancer incidence in Scottish Borders are generally lower than that for Scotland. Reductions in risk factors such as smoking and obesity will contribute to a gradual decline in incidence rates, and improvements in detection and treatment will improve mortality rates.

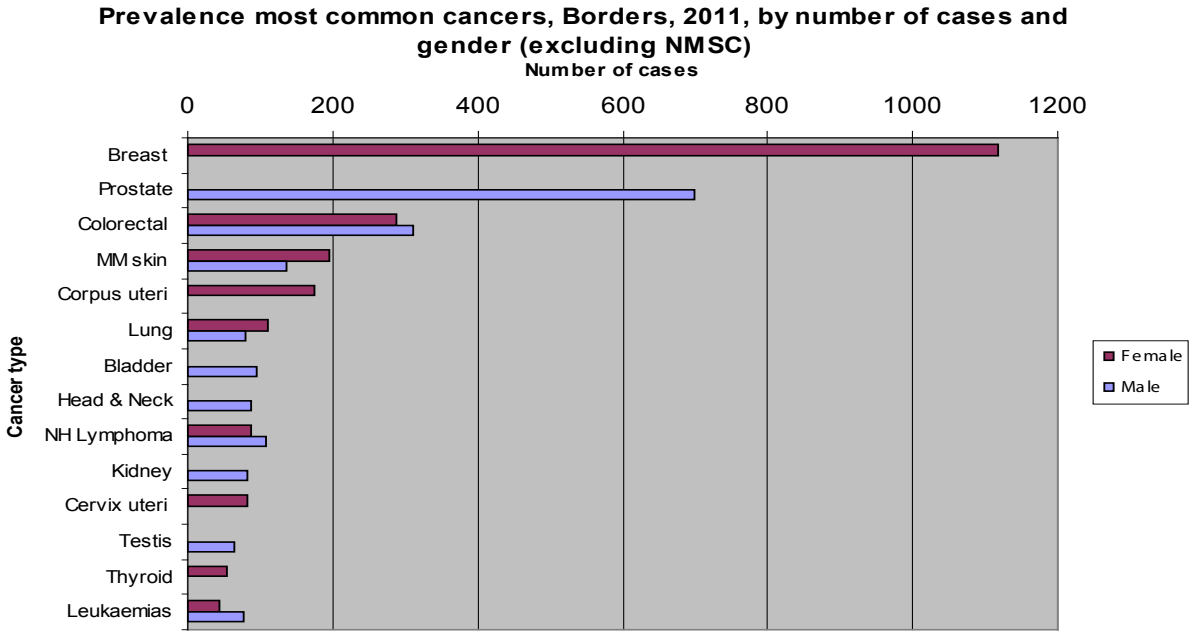
FIGURE 32
NUMBER AND RATE OF CANCER REGISTRATIONS FOR SCOTTISH BORDERS AND SCOTLAND (ALL AGES), 1997 – 2009



Source: SNS

Cancer incidence rates and trends show considerable variation between different types of cancer. Figure 33 below shows that for males, the most common cancers are prostate, lung and colorectal cancers, collectively accounting for 53% of cancers in men. For females, the most common cancers are breast, lung and colorectal cancers, accounting for 57% of cancer in women. New cancer cases are expected to increase by approximately 8% every five years up to 2020, reflecting projected increases in the number of older people[3]. The largest increase expected in the number of new cancers in the Borders is for prostate – a rise of 49%, followed by malignant melanomas of the skin (32%), colorectal cancer (20%), breast cancer (16%), and lung (3%).

FIGURE 33
PREVALENCE OF MOST COMMON CANCERS IN BORDERS RESIDENTS BY NUMBER OF CASES AND GENDER: 2011



Source: ISD Scotland

The prevalence of cancer in the Scottish population increases with age: overall, 65% of males and 56% of females who are living with a diagnosis of cancer are aged 65 and over. Cancer amongst young people is rare. There are around 170 cancers per year in persons aged between 15 and 24 years in Scotland (less than 1% of malignant neoplasms diagnosed in a given year). Lymphomas accounted for the highest proportion of cancers in this age group, at 22% of all diagnoses. The combination of leukaemias, lymphomas, melanoma and germ cell tumours accounted for 80% of all cancer diagnoses in this age group[3]. There is no clear long-term trend in the pattern of inequalities for premature cancer deaths. Patterns vary further when examining cancer incidence by type, although, of the four most common types, inequality levels are highest for cancer of the trachea, bronchus and lung[21].

Over the last twenty years, almost all cancers have shown improvement in survival five years after diagnosis and survival from cancer in Scotland is similar to that in England and Wales. Survival is often worst in patients with cancers that present at an advanced stage and which are less amenable to treatment (for example, cancers of the lung and pancreas). Early detection, for example through screening, and presentation for treatment increase the chances of survival (for example, breast cancer). Survival has also increased for those cancers which have seen major advances in treatment (for example, testicular cancer and leukaemias).

CANCER PREVENTION

The number of new cancer cases can be reduced and many cancer deaths can be prevented. Research shows that screening for cervical and colorectal cancers as recommended helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early stage, when treatment works best.

Vaccines also help lower cancer risk. The human papillomavirus (HPV) vaccine helps prevent most cervical cancers and several other kinds of cancer, and the hepatitis B vaccine can help lower liver cancer risk.

A person's cancer risk can be reduced with healthy choices like avoiding tobacco, limiting alcohol use, protecting your skin from the sun and avoiding indoor tanning, eating a diet rich in fruits and vegetables, keeping a healthy weight, and being physically active. It is estimated that 1 in 4 cancers could be prevented by these simple means and the proportionate effectiveness of each lifestyle factor is shown below[22].

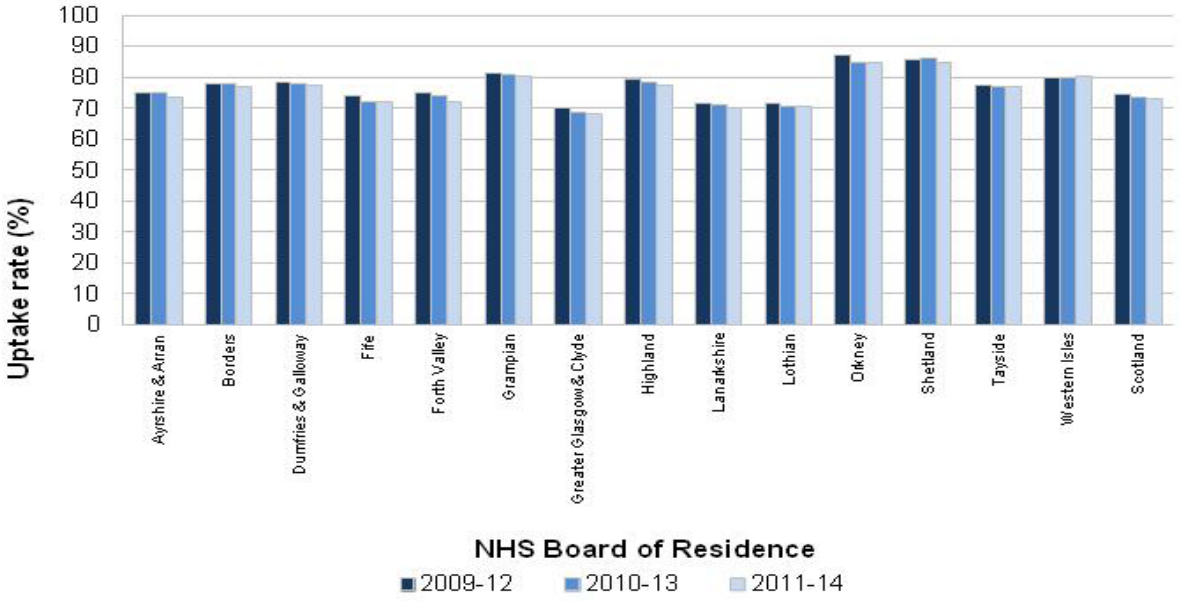
CANCER SCREENING PROGRAMMES

NHS Borders programmes for breast, cervical and bowel screening aim to detect cancers and signs of cancer at earlier, more treatable stages.

BREAST SCREENING

Women aged between 50 and 70 are invited to attend breast screening every three years. Figure 34 shows that NHS Borders uptake rates for breast screening for the three year rolling period 2005-8 to 2011-14 have fallen slightly in recent years. A similar trend is found nationally. The average attendance rate for the Borders during the ninth round of screening in 2011/14 was 77.0% which is slightly below the target of 80% but still higher than Scotland as a whole at 72.9%. Since the programme commenced in 2009, the uptake has been lowest in the most deprived groups.

FIGURE 34
BOARD UPTAKE RATES FOR BREAST SCREENING FOR THE THREE YEAR ROLLING PERIOD 2005-8 TO 2011-14

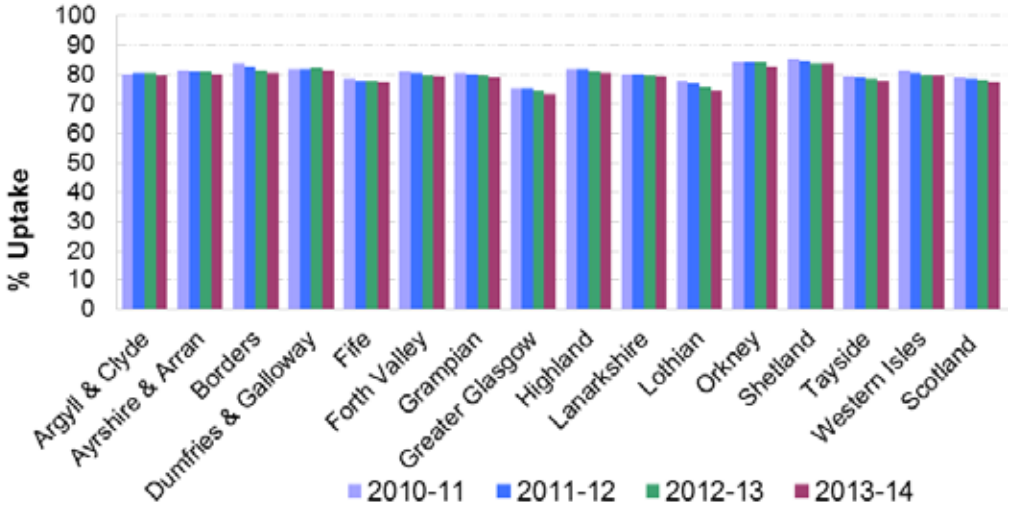


Source: ISD Scotland

CERVICAL SCREENING

Women are invited to attend cervical screening every three years between the ages of 20 and 60 years. Figure 35 shows that during 2013/14, 80.6% of Borders women in the target group had a smear during the last 5.5 years compared to a Scottish figure of 77.3%. The national target for coverage is at least 80%. Over the past 10 years there has been a long term gradual downward trend in the uptake of cervical screening, apart from an increase in 2009, which has been associated with the media attention around the diagnosis and death of Jade Goody[20].

FIGURE 35
CERVICAL SCREENING UPTAKE BY HEALTH BOARD

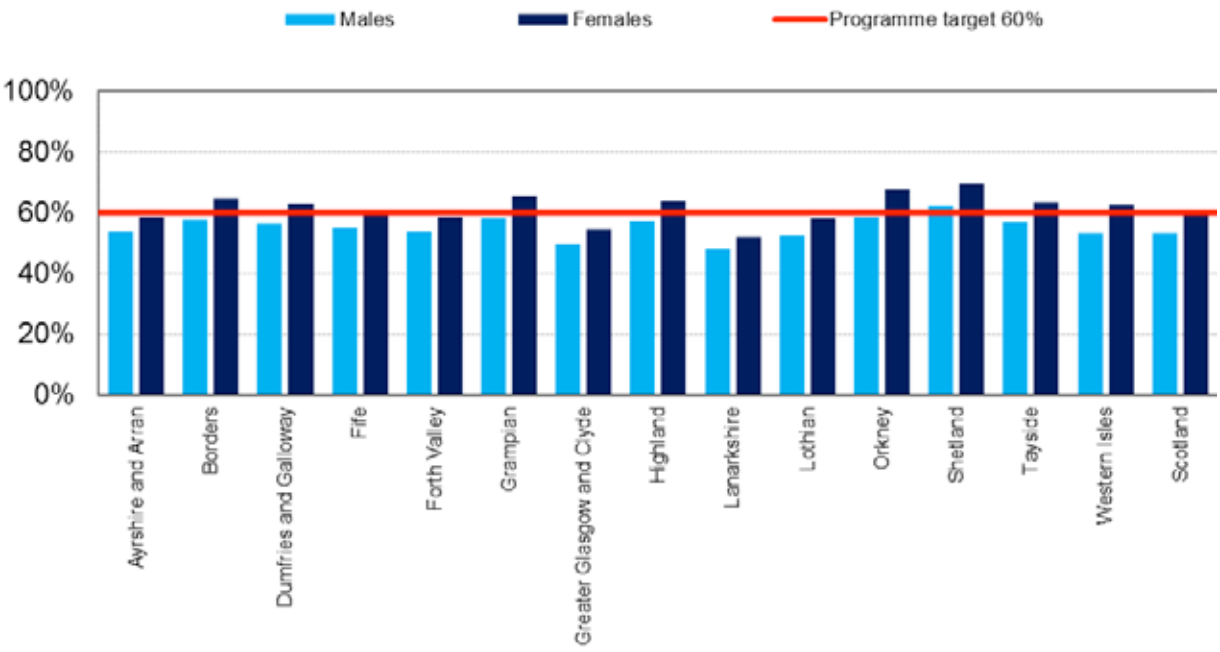


Source: ISD Scotland

BOWEL SCREENING

Bowel screening is one of the most effective screening programmes available and is estimated to save 7 lives per year in the Borders. All persons aged between 50 and 74 are invited to submit bowel screening tests every two years. Figure 36 below shows that Borders had an uptake of 61.2% compared to 56.1% for Scotland as a whole (target 60%). Borders men had a lower uptake than women: 57.8% v 64.5%. This figure contains data for NHS Boards in their prevalence and incidence rounds and at different points within the rounds so any direct comparison of figures between NHS Boards must be treated with caution. Since the programme commenced in 2009, the uptake has been lowest in the most deprived groups[20].

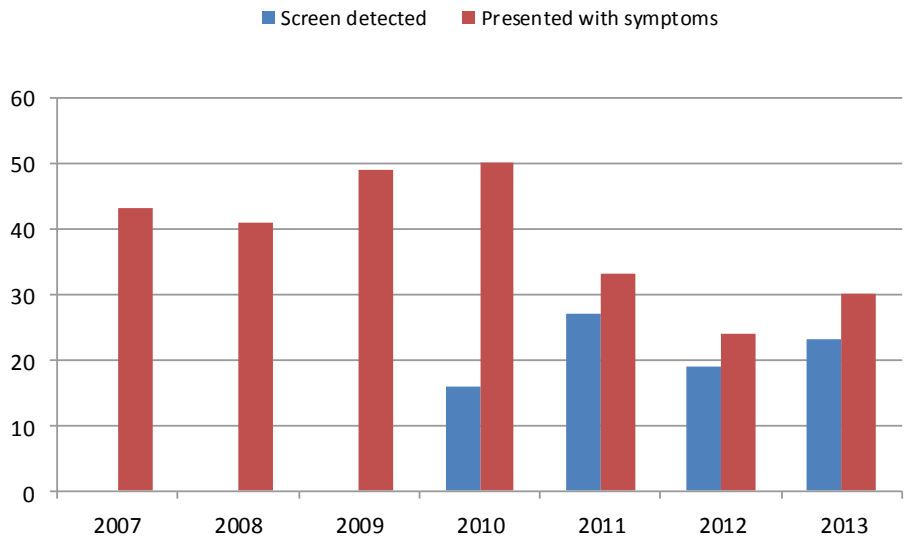
FIGURE 36
BOARD BOWEL SCREENING UPTAKE RATES (NOV 2011 – OCT 2013)



Source: ISD Scotland

Figure 37 below shows that the percentage of all cancers detected by screening has significantly increased during the first two years of the Borders programme.

FIGURE 37
PERCENTAGE OF ALL BOWEL CANCERS DETECTED BY SCREENING



Source: ISD Scotland

KEY CHALLENGES

The actual numbers of cases of cancer have risen over the last decade, largely due to an ageing population, as the incidence of new cancer cases rises quickly after 65 years. Sustained prevention measures are important to bring about a reduction in the lifestyle risk factors amongst higher risk groups, although positive impact on the incidence of new cancers and prevalence will be gradual. Prevention should also include implementation of health promoting actions in acute care settings for those who already have health problems – inherent in the Health Promoting Health Services (HPHS) initiative. All these activities should aim to promote healthy weight, increase physical activity, promote smoking cessation and reduce alcohol consumption with effective pathways into community services and resources.

Bowel screening is one of the most effective screening programmes available and is estimated to save 7 lives per year in the Borders. Borders men have a lower uptake of bowel screening than women: 57.8% v 64.5% and the uptake is even lower in the most deprived groups. Every effort needs to be made to increase uptake in these groups.

EXAMPLES OF WHAT WE AND PARTNERS ARE DOING IN BORDERS

Detecting Cancer Early: The national Detect Cancer Early (DCE) Programme was launched in February 2012. The programme focuses on the most common cancers (breast, bowel and lung) and aims to increase the proportion of Scots diagnosed in the first stage of cancer by 25% by 2015. For the Borders, this means an increase from 26.2% to 29% which we are on track to achieve. The main components of the programme locally have been:

- A communications programme to promote the uptake of screening, particularly in deprived areas and with vulnerable groups where uptake is lower;
- GP training session and information resources;
- A survey of NHS and Council staff of knowledge, attitudes and behaviour in relation to bowel cancer screening.

NHS Borders clinicians and managers work closely with other boards through the South East Cancer Network (SCAN) to plan for future developments in policy or clinical practice that may impact cancer services and patient care. Cancer services continually review guidelines, referral processes and service provision particularly for those cancers where a significant increase in demand is expected. Consideration is also given to impact on other services including primary care (ongoing monitoring and review; catheter care), Cancer Support Services (information and support), social care services, and carer services.

DIABETES
WHY IS THIS IMPORTANT?

The prevalence of diabetes across Borders is increasing year on year. It is a progressive disease that causes heart disease, stroke, blindness, kidney failure and limb amputations. The excess healthcare costs attributable to diabetes are substantial and pose a significant clinical and public health challenge. This burden is an important consideration for decision-makers, particularly given increasing concern over the sustainability of the healthcare system, aging population structure and increasing prevalence of diabetic risk factors, such as obesity. It is estimated that around 10% of all NHS expenditure is used to treat diabetes and its complications and this cost has increased by over 50% in the past 10 years[23].

KEY FACTS:

At the end of 2013, 6,031 people in Scottish Borders (5.3% of the population) were registered as having diabetes[24]. The crude prevalence rate for diabetes in the Borders population was higher than the overall Scotland rate of 5.05%, but this reflects the relatively older age profile of the Borders population in comparison with Scotland's overall.

Of the total 6,031 registered as having diabetes at the end of 2013:

- 3,528 (58.%) were aged 65 and over
- 2,503 (41.5%) were aged under 65 (this figures includes children).

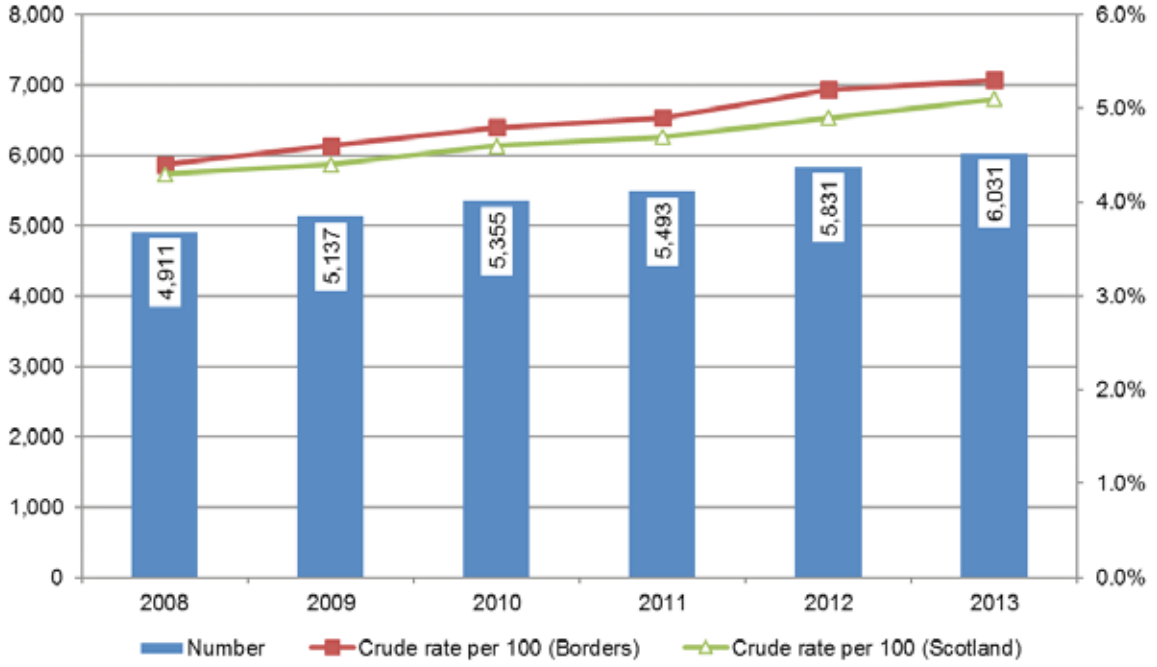
The breakdown of diabetes type was as follows:

- 5,349 (88.7%) had type 2 diabetes
- 633 (10.5%) had type 1 diabetes
- 49 (0.8%) had another type of diabetes

The prevalence of diabetes across Scotland is increasing year on year for several reasons, including:

- Diabetes is more prevalent in older people so the increasing number of older people each year increases the prevalence;
- The increasing levels of type 2 diabetes are associated with rising levels of overweight and obesity. For example, type 2 diabetes is estimated as being 13 times more likely to occur in obese women than in women of normal weight[25]. The estimated prevalence of obesity tends to rise with increasing age, from around 1 in 9 people aged 16-24 to more than 1 in 3 people aged 55-74 suggesting that many of the cases of diabetes in the Borders are preventable.
- Improved detection and management of diabetes has resulted in increased survival.

FIGURE 38
NUMBERS OF BORDERS RESIDENTS WITH DIABETES INCLUDING RATE PER 100,000 POPULATION FOR BORDERS COMPARED TO SCOTLAND AS A WHOLE



Source: Scottish Diabetes Survey

Diabetes retinopathy is a serious complication of diabetes and can be prevented by the Borders Diabetic Retinopathy Annual Screening Programme. The Borders is currently meeting the national target of screening at least 80% of the diabetic population each year[20]. National studies have shown that uptake of screening is lower in the younger age groups particularly those at university or at work.

KEY CHALLENGES

The prevalence of diabetes across Borders is increasing year on year. The excess healthcare costs attributable to diabetes are substantial and pose a significant clinical and public health challenge. This burden is an important consideration for decision-makers, particularly given increasing concern over the sustainability of the healthcare system, aging population structure and increasing prevalence of diabetic risk factors, such as obesity.

A recent National Institute of Clinical Effective review suggests that the role of bariatric surgery for patients with a BMI of 30 or over who have recent-onset type 2 diabetes and who have failed to lose weight by other means, is likely to significantly increase in the future[26].

EXAMPLES OF WHAT WE AND PARTNERS ARE DOING IN BORDERS

Local actions to prevent (type 2) diabetes involves firstly weight management to counteract the obesity trends, and secondly intensive support for those with impaired glucose tolerance or pre-diabetes to stop their progression to frank diabetes.

The former is being addressed by a local 4 tier weight management service:– from population wide work on physical activity and diet within health improvement; to a primary care based tier 2 service run by the Lifestyle Advisor Support Service (LASS); to a specialist weight management team at tier 3; and finally bariatric surgery at tier 4.

LASS also takes referrals of patients with pre-diabetes to work on intensive support to change diet and physical activity, which has been shown to reduce the incidence of diabetes by up to 50% for several years. Once patients have developed diabetes, treatment focuses on the control of glucose, but also importantly on reducing the risks of CVD and renal complications. Local guidelines on the prevention of CVD include patients with diabetes and are currently being reviewed and updated. New proteinuria screening and treatment guidelines in patients with chronic kidney disease (CKD), including those with diabetes, have recently been agreed and aim to ensure optimum treatment to reduce the risk of progression to renal failure.

MENTAL ILL-HEALTH
WHY IS THIS IMPORTANT?

When we are free of depression, anxiety, excessive stress and worry, addictions, and other psychological problems, we are more able to live our lives to the fullest. Mental health strengthens and supports our ability to:

- have healthy relationships
- make good life choices
- maintain physical health and well-being
- handle the natural ups and downs of life
- discover and grow toward our potential

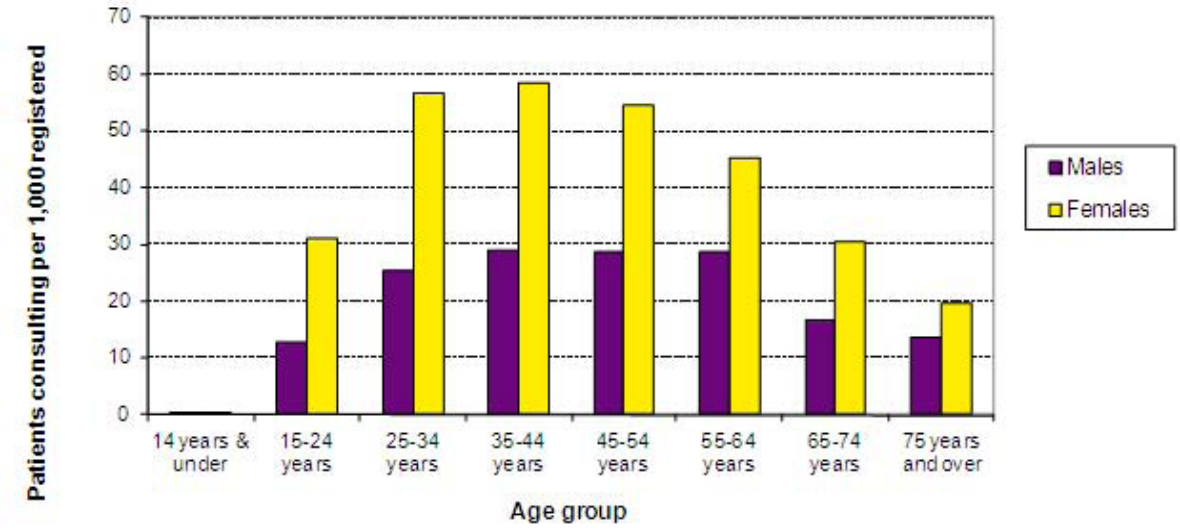
Many research studies have shown that when people receive appropriate mental health care, their use of medical services declines. Excessive anxiety and stress can contribute to physical problems such as heart disease, and can also reduce the strength of the immune system, making people more vulnerable to conditions ranging from the common cold to cancer. Psychological problems also increase the likelihood that people will make poor behavioral choices which can contribute to medical problems. Smoking, excessive alcohol or drug use, poor eating habits, and reckless behavior can all result in severe physical problems and the need for medical services.

KEY FACTS:
DEPRESSION AND ANXIETY

Figure 39 below shows that females in every age group have a higher number of consultations for depression. For both males and females the rates peak in the 35-44 years age group. A similar picture is seen in consultations for anxiety.

The estimated number of primary care consultations for depression in Scotland has reduced from 58 per 1000 population to 29 per 1000 population over the past 10 years. These reductions were seen for both men and women.

FIGURE 39
ESTIMATED NUMBER OF PATIENTS IN SCOTLAND CONSULTING A GP OR PRACTICE NURSE AT LEAST ONCE FOR DEPRESSION BY GENDER AND AGE: 2012/3



Source: Practice Team Information (PTI) – data from a representative sample of 60 GP practices across Scotland. www.isdscotland.org/pti.

ADMISSIONS DUE TO SERIOUS MENTAL ILLNESS

Within the Scottish Borders, there were 518 mental health admissions during 2012/13. This was a reduction from 2010/11 and 2011/12 figures. The Scottish Borders has a similar level of psychiatric hospitalisations to Scotland. Within the Scottish Borders, areas with more hospitalisations than Scotland are all of Galashiels, all of Hawick, Eyemouth, Jedburgh, Selkirk and parts of Kelso.

PHYSICAL HEALTH AND MENTAL ILLNESS

Lifestyle factors adversely affect the physical health of people with mental health problems: poorer diets, low rates of exercise and higher prevalence of smoking than among the general population[27].

People with mental health problems are:

- More likely to die sooner than the general population - people with schizophrenia and psychosis die on average 15-20 years younger than the general population
- Twice as likely as the general population to die from heart disease
- 61% of people with schizophrenia smoke, compared with 33% of the general population (it's now around 20%
- More susceptible to drug and alcohol addiction
- People with schizophrenia are 2-3 times more likely to develop type 2 diabetes than the general population
- Women with schizophrenia are 42% more likely to get breast cancer than other women
- People with schizophrenia who develop cancer are three times more likely to die than those in the general population with cancer.

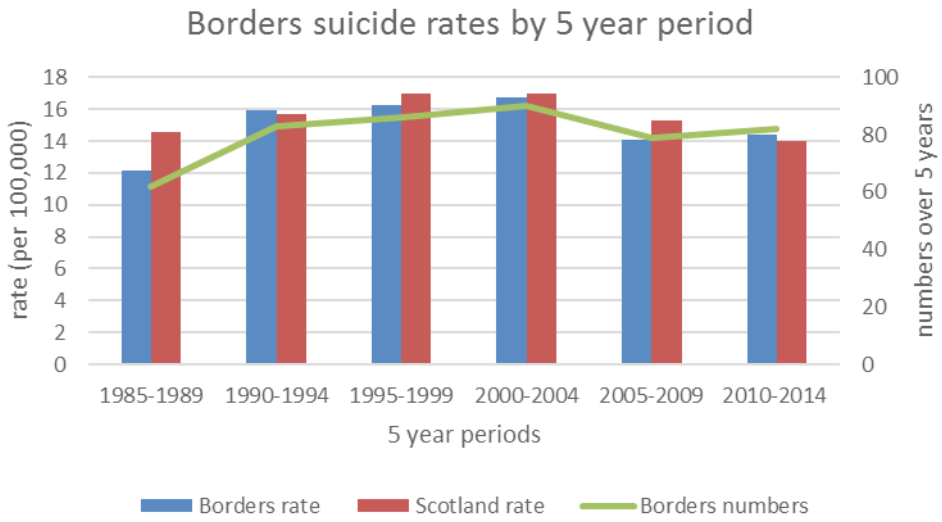
SUICIDE

For Scottish males and females, the trend in suicide rate since 2000-2004 (when the rate peaked at 18 per 100,000 in 2002) has been a decreasing one.

In 2014, the highest crude rate per 100,000 Scottish persons was observed for persons in the 35 - 44 and 45-54 age groups. The lowest suicide rate was observed in the 75-84 age group. This is the same for both males and females. Between January 2009 and December 2012 there were a total of 3,059 deaths from 'probable suicide' (intentional self-harm and undetermined intent) in Scotland. A total of 1,437 deaths (47%) involved people aged 35-54 years old, and 2,240 deaths (73%) were males which suggests that men are three times more likely to die from suicide than women.

Figure 40 below shows that there are around 15 probable suicides within the Scottish Borders each year which is a similar rate to Scotland as a whole. A breakdown of these figures indicates that men of working age are a key risk group in the Scottish Borders. A recent Samaritans report commented: "Suicide needs to be addressed as a health and gender inequality – an avoidable difference in health and length of life that results from being poor and disadvantaged; and an issue that affects men more because of the way society expects them to behave. It is time to extend suicide prevention beyond its focus on individual mental health problems, to understand the social and cultural context which contributes to people feeling they wish to die[28]." The Scottish Government have recently launched a suicide prevention strategy to tackle this problem[29].

FIGURE 40
SUICIDE CRUDE RATES PER 100,000 POPULATION AND SUICIDE NUMBERS 1985-2014



Source: ISD Scotland

KEY CHALLENGES

Lifestyle factors and barriers in accessing services adversely affect the physical health of people with mental health problems: poorer diets, low rates of exercise and higher prevalence of smoking than among the general population. All care providers need to be aware of these risks.

Men of working age, particularly in deprived communities, are a key risk group for suicide in the Scottish Borders. Suicide prevention strategies need to include explicit aims to reduce socio-economic inequalities and gender inequalities in suicide.

EXAMPLES OF WHAT WE AND PARTNERS ARE DOING IN BORDERS

Initial work has begun to focus on improving the physical health outcomes of people with mental health problems to improve health checks and to plan for mental health services to become smoke free.

Project work has begun to address the impact of social isolation on mental health, focusing initially on men of working age in one part of the Borders.

The multiagency training programme on suicide prevention and mental health improvement reaches a wide range of people and groups across Borders and raises awareness and skills levels.

Partners are also collaborating to improve access to information and support on mental health and wellbeing both for the public and for frontline services

LEARNING DISABILITIES
WHY IS THIS IMPORTANT?

People with learning disabilities and their families represent a diverse group and come from all backgrounds, cultures and walks of life. The need for people with learning disabilities to live independently, having the same choice, control and protection as all other citizens of Scotland in terms of the age-appropriate support they receive, is more relevant than ever.

KEY FACTS:

About 16,000 school aged children and young people, and 26,000 adults in Scotland have learning disabilities and require support[30]. Additionally, there are considerably more adults (almost three times as many) who have learning disabilities and had additional support needs when they were at school, but who do not now identify themselves, and are not identified by others, as being disabled, and who are not currently using statutory learning disabilities services. There are more boys and men with learning disabilities than girls and women, although at older ages the gender distribution is more equal, as women typically live longer. The proportion of people estimated to live in the population with learning disabilities is influenced by a wide range of factors such as the definitions of learning disabilities used, the age groups included, and the year the estimate was made.

At the time of the 2011 Scotland Census, 612 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Learning Disability. 485 people in this group (81%) were aged 16 or over in 2011. Figure 41 below shows the total number of adults with Learning Disabilities known to Scottish Borders services is higher than the figures captured through the Census. As at March 2014, 599 people aged 16+ with Learning Disabilities were known to Scottish Borders services, of whom 555 had confirmed addresses in the area.

FIGURE 41
NUMBERS OF ADULTS WITH LEARNING DISABILITIES RESIDENT IN SCOTTISH BORDERS AND KNOWN TO SCOTTISH BORDERS SERVICES IN 2014, BY AGE AND GENDER

AGE GROUP	NUMBER OF MALES	NUMBER OF FEMALES	BOTH GENDERS COMBINED	% WITHIN AGE GROUP
16 to 24*	70	44	114	21%
25 to 34	60	41	101	18%
35 to 49	88	64	152	27%
50 to 64	72	51	123	22%
65+	27	38	65	12%
Total	**317**	**238**	**555**	**100%**

Source: Scottish Borders Learning Disability Statistics return for March 2014

KEY CHALLENGES

Research tells us that people with learning disabilities have some of the poorest health of any group in Scotland. They are considerably more likely to die at an early age than the general population - on average 20 years before. Some of the causes of death are potentially preventable, and the main causes of death differ from those of the general population. Whilst the most common causes of death for the Scottish population are cancer, heart disease and strokes, the most common causes of death for people with learning disabilities are respiratory disease, cardiovascular disease (related to congenital heart disease) and different forms of cancer, principally related to gullet, stomach and gall bladder rather than lung, prostate and urinary tract.

Many of the causes of learning disabilities may also lead to physical or mental ill health. This means that people with learning disabilities may be more likely to be prescribed multiple drugs due to complex and multiple health needs which, in turn, can sometimes adversely affect health through side effects and drug interactions. In terms of prevention, people with learning disabilities are also less likely to exercise and eat healthily than the general public because they may not always have the knowledge or understanding to make healthy choices, and are reliant on others for support and communication. These issues are often added to by problems accessing the health services they need. What is clear is that some conditions go unrecognised or are recognised at a later stage than would be the case for the general population. Where there is a recognised condition, it may not be monitored as well unless individuals themselves, their carers and professionals proactively do this. Added to which, assumptions are sometimes made that a condition is part of the learning disability and it is not addressed because of this.

EXAMPLES OF WHAT WE AND PARTNERS ARE DOING IN BORDERS

Specialist Health and Social Care for adults with learning disabilities are provided by the Scottish Borders Learning Disability Service. This is a joint Scottish Borders Council and NHS Borders service and provides a range of services for adults with a learning disability across the whole of the Scottish Borders.

Health Improvement and Learning Disabilities services are collaborating on a healthy living programme to promote nutrition and activity with people with a learning disabilitiy and the carers and services that support them.

INFLUENZA
WHY IS THIS IMPORTANT?

Influenza is a viral infection that attacks your respiratory system — your nose, throat and lungs. Influenza, commonly called the flu, is not the same as stomach "flu" viruses that cause diarrhea and vomiting.

For most people, influenza resolves on its own, but sometimes, influenza and its complications such as pneumonia, can be deadly. People at higher risk of developing flu complications include:

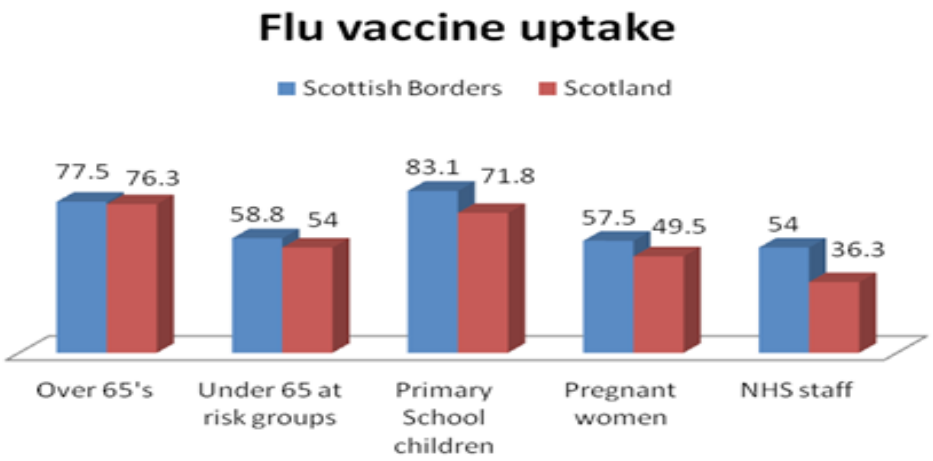
- Young children under 5, and especially those under 2 years
- Adults older than 65
- Residents of nursing homes and other long-term care facilities
- Pregnant women
- People with weakened immune systems
- People who have chronic illnesses, such as asthma, heart disease, kidney disease and diabetes
- People who are very obese, with a body mass index (BMI) of 40 or higher

The Scottish Government runs an annual flu immunization programme for those at high risk of the disease. Front line health and social care staff and carers are also recommended to have the vaccine.

KEY FACTS:

Figure 42 below shows that the flu vaccination uptake in the Borders was higher than for Scotland as a whole across all at risk groups. In fact Borders was the top performing board for primary school children, at risk groups and pregnant women which is a fantastic performance by Borders primary care teams and the school immunisation team.

FIGURE 42
FLU VACCINE UPTAKE BY TARGET GROUP 2014/15



Source: NHS Borders

KEY CHALLENGES

Even though we have nearly reached the Scottish Government target of 60% uptake for under 65 years at risk residents, we still have as many as 5437 eligible under 65 years at risk Borders residents at higher risk of complications from influenza due to underlying medical conditions who did not receive the vaccine during 2014/15. Continued sustained efforts are needed to reduce this figure.

Even though our NHS staff vaccination programme has achieved its highest uptake rate ever, continued sustained efforts are needed to increase this uptake performance in order to protect patients from infection.

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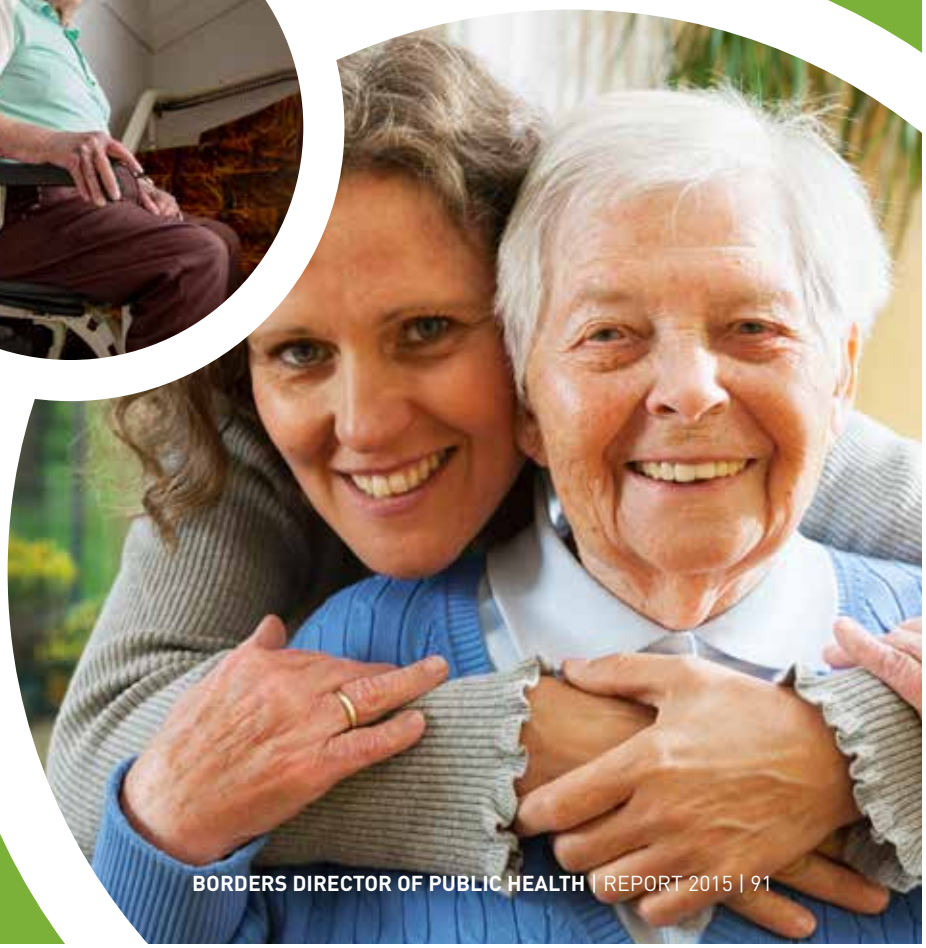
CHAPTER 11

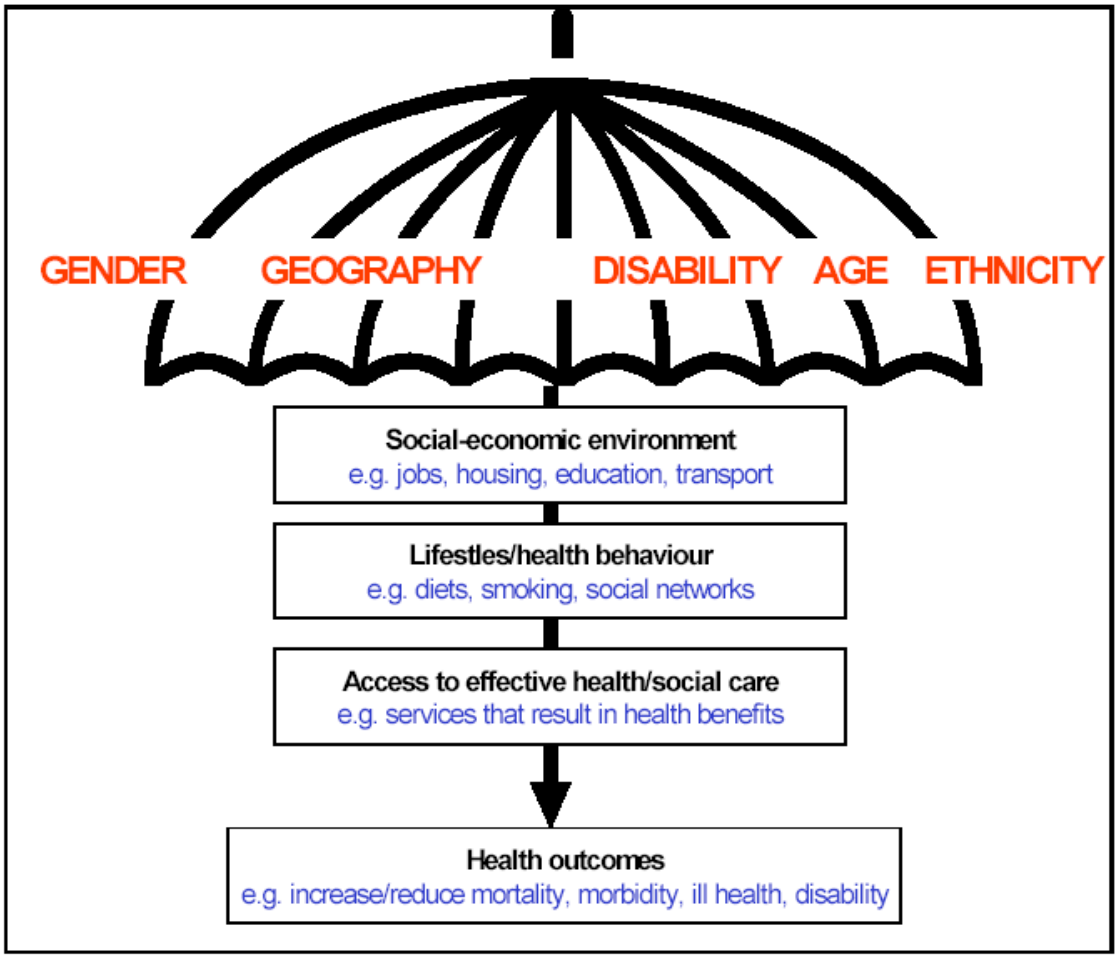
HEALTH INEQUALITIES IN THE BORDERS



WHY IS THIS IMPORTANT?

Health inequalities are 'systematic, unfair differences in the health of the population that occur across social classes or population groups'. These differences are not random or inevitable. There are significant inequalities in health in Scotland between people who are socially and economically well off, and those who are socially disadvantaged. Health inequalities are not only apparent between people of different socio-economic groups. Inequalities are also related to gender, ethnicity, age, mental health and learning disabilities. The causes of health inequalities are complex, and include lifestyle factors:smoking, nutrition, exercise to name only a few,and also wider determinants such as poverty, housing and education. Access to healthcare also plays a role,. Because the causes of health inequalities are complex no single approach is sufficient to reduce health inequalities - concerted efforts are required across many partners at local and national levels. This is illustrated in the Figure 43 below.

FIGURE 43
THE CAUSES OF HEALTH INEQUALITIES[31]



OUR VISION:

> *All residents in the Borders have the right to good health and enjoy equal opportunities to lead healthy, safe and fulfilling lives*

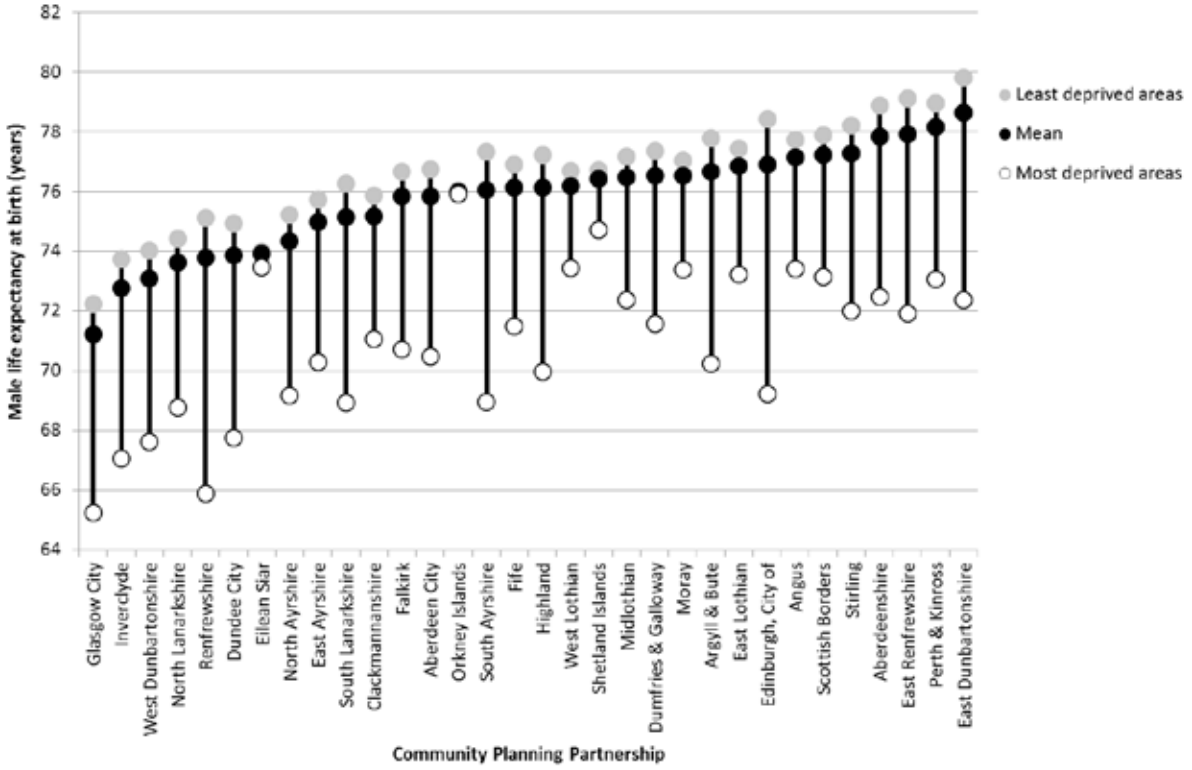
KEY FACTS:

The Scottish Government Long-term Monitoring of Health Inequalities October 2014 Report on Inequalities in Scotland found that[19]:

- The gap between the most and least deprived areas for premature deaths has continued to fall
- Admission rates for coronary heart disease have increased more in the most deprived areas compared to the least deprived
- There is no clear long-term trend in the pattern of inequalities for premature cancer deaths. Patterns vary further when examining cancer incidence by type, although, of the four most common types, inequality levels are highest for cancer of the trachea, bronchus and lung
- Alcohol-related hospital admissions are falling fastest in the most deprived areas, resulting in reduced inequality levels over the long term
- The difference between rates in the most and least deprived areas for alcohol-related mortality is reducing
- Inequalities in birthweight remain very low

Figure 44 shows that within all Scottish Community Planning Partnerships, more deprived areas have a lower male life expectancy than less deprived areas. It also shows male life expectancy for Borders residents to be higher and with less intra area inequalities compared to other Scottish Boards. However some of the more deprived areas in Borders have a lower life expectancy for men and women compared to the Scottish average[2].

FIGURE 44
INEQUALITY IN MALE LIFE EXPECTANCY BY LOCAL AUTHORITY, 2006-2010



Source: Health Scotland

Premature mortality in persons aged under 75 years can be viewed as an indicator of health inequalities. Each year there are around 1200 deaths in the Borders of which 30% occur in persons under 75 years old. However there has been a significant improvement in premature mortality in the Borders between 2006-2013 with currently the lowest rate of any main land Board. Areas with more 'early deaths' compared to Scotland in the Scottish Borders include Selkirk, Langlee, Jedburgh, Duns and Coldstream[2].

An analysis of inequalities in the Scottish Borders was carried out using the Scottish Index of Multiple Deprivation (SIMD) coupled with additional local data collection tools[2]. The ranking matrix shows the rank (1 to 29) for each of the small area geographies and for 46 inequality indicators. There are 9 Intermediate Geographies (small areas) in the Scottish Borders with 20% (9 of the 46) of indicators ranked between 1 and 5. These are shown in Figure 45 below.

FIGURE 45
INTERMEDIATE GEOGRAPHIES INEQUALITIES RANKS

INTERMEDIATE ZONE	NUMBER OF INDICATORS RANKING 1 TO 5 OF 29	% OF INDICATORS RANKED 1 TO 5 OUT OF 29
Langlee	31	67%
Burnfoot and area	28	61%
Eyemouth	22	48%
Galashiels West	22	48%
Hawick Central	15	33%
Galashiels North	14	30%
Hawick North	11	24%
Coldstream and area	10	22%
Hawick West End	10	22%

Source: Scottish Borders Council

However in the Scottish Borders, the Scottish Index of Multiple Deprivation alone does not provide a complete picture of deprivation. Although 5 datazones in the Borders were identified as being in the top 15% most deprived in Scotland, it could be argued that this does not take into account small pockets of deprivation in more rural areas.

Particular indicators of concern where deprived Borders areas do not fare well compared to more affluent areas include:

- Higher smoking rates particularly the percentage of pregnant women smoking at the time of booking for antenatal care
- Mental illness (hospital admissions and suicide) that may be due to unequal distribution of factors that promote and protect positive mental health and factors that are detrimental to mental health e.g. low income
- Hospital admissions related to alcohol
- Borders also has a significantly higher emergency admissions rate compared to Scotland as a whole although the reason for this is unclear. Admissions to hospital for coronary heart disease in the Borders are around a third higher in the most deprived areas compared to the most affluent areas and admissions due to respiratory disease almost twice as much. The reasons for this are also unclear but are likely to be related to higher rates of coronary heart and respiratory disease and associated lifestyle factors (smoking, diet, exercise) and possibly differing admission practices and community support
- Lower uptake of cancer screening (cervical, breast, colorectal)
- It is of interest that the most affluent areas in the Borders have a higher admission rate for cancer. This may be related to more affluent persons seeking early help for symptoms and to the lower uptake of cancer screening (cervical, breast, colorectal) seen in the most deprived communities.

Tackling these specific health inequalities will require concerted efforts across many partners at national and local levels. Suggested evidence based interventions are shown in Figure 46 below.

FIGURE 46
SUGGESTED EVIDENCE BASED INTERVENTIONS[31]

1. Programmes that ensure adequate incomes and reduce income inequalities
2. Programmes that reduce unemployment in vulnerable groups or areas
3. Programmes that improve physical environments, such as traffic calming schemes
4. Programmes that target vulnerable groups by investing in more intensive services and other forms of support for such groups, in the context of universal provision
5. Early year's programmes
6. Policies that use regulation and price (for example, minimum unit price or taxes) to reduce risky behaviours.

Health and social services also have a role in reducing health inequalities and suggested 'best practice' is shown in Figure 47 below.

FIGURE 47
SUGGESTED EVIDENCE BASED INTERVENTIONS[32]

- Services should fully engage local communities on service provision to target specific health inequalities
- Ensuring everyone is registered with a GP e.g. migrants, and that levels of provision and quality are high
- All staff are aware of needs of vulnerable groups: practice staff, health visitors, community nurses, social workers, care workers, pharmacists, third sector workers and have the skills and confidence to engage sensitively and effectively with people from a range of backgrounds.
- Staff act as patient advocates helping them to navigate complex health, social and benefit system
- Enhance role of frontline health practitioners to increase access to health care and freeing up GP time to focus on vulnerable groups (COPD , CHD, mental health, screening, vaccination)
- All staff have a local leadership role to engage with members of the community to seek solutions e.g. Fresh food, transport, exercise.

KEY CHALLENGES

There are significant inequalities in health in Scotland between people who are socially and economically well off, and those who are socially disadvantaged. Health inequalities are not only apparent between people of different socio-economic groups. Inequalities are also related to gender, ethnicity, age, mental health and learning disabilities. Whilst recognising that national government policies have a very important impact on health inequalities there is still a lot we can do in the Borders. We therefore need to enhance, develop and maintain partnership working across the Borders to address the many factors leading to health inequalities.

We need to ensure that all staff in statutory or non-statutory organisations understand their public health role in reducing health inequalities.

For example:

- Staff should understand what health inequalities exist and how these may be tackled
- Senior managers should provide leadership in supporting their staff to identify and address health inequalities.

We need to recognise people who are disadvantaged have higher health needs and the level and intensity of service provision should reflect that. Service development plans could contain a Health Inequalities assessment in addition to the current Equalities and Diversity assessment.

The social and built environment affects every aspect of our lives and has an influence on health inequalities e.g. availability of healthy food, location on health services, facilities for walking and cycling and opportunities for social interaction. We need to ensure that health is an important consideration in planning decisions. Health Inequalities Impact Assessment (HIIA) is a way for organisations to think about how their plans or decisions might affect people and population groups in different ways. The findings can inform the development and implementation of plans and policies, helping organisations to ensure that no-one is disadvantaged by what they do.

EXAMPLES OF WHAT WE AND PARTNERS ARE DOING IN BORDERS

Actions on inequalities can be categorised as:

- Actions that undo the underlying structural inequalities in power and resources
- Actions that mitigate the health and social consequences of social inequalities
- Actions that help individuals and communities resist the effects of inequality on health and wellbeing

Examples of Borders initiatives aiming to reduce tackle inequalities Borders by implementing such actions include:

SCOTTISH BORDERS COMMUNITY PLANNING PARTNERSHIP

The Scottish Borders Community Planning Partnership Inequalities Theme Group has developed a high level strategic plan to tackle and reduce five key strands of inequalities in the Scottish Borders. These are shown in Figure 48 below.

FIGURE 48
FIVE MAIN INEQUALITIES THEMES

This 'Reducing Inequalities Strategic Plan' sets out how Scottish Borders Council and its partners will fulfil our responsibilities, refreshing our commitment to tackling inequalities and strengthening the contributions made by all key partners and stakeholders. The Strategic Plan will focus activities which seek to reduce inequalities in the Borders on the groups who are identified at greatest risk of falling into the most disadvantaged circumstances and/or in those areas where there are the highest levels of deprivation.

- Single households
- Children in Poverty
- Single Parents
- Elderly
- Long term sick/disabled
- Homeless
- Women and Girls

The Plan aims to reduce the inequalities in health & wellbeing between the most and the least deprived people by addressing the following:

- People who are socially disadvantaged have poor health outcomes and the design, the level and intensity of local service provision should reflect that
- All staff in statutory or non-statutory organisations need to understand their public health role in reducing health inequalities and appreciate how health inequalities affect the population they serve
- Enhancing, developing and maintaining partnership working across the Borders to address the many factors leading to health inequalities
- Partnership working at a local and national level
- Through CPP and IJB established principles on reducing health inequalities from evidence-based work and apply these in a proportionate way across the Borders.

HEALTH & SOCIAL CARE PARTNERSHIP INTEGRATED JOINT BOARD

The Integrated Joint Board is currently consulting on a Strategic Plan and one of its key objectives is to reduce inequalities in the Borders. Once the Plan is agreed an implementation plan will support this important initiative.

PUBLIC HEALTH DIRECTORATE

The Joint Health Improvement Team leads and supports work across the Scottish Borders to improve health and reduce health inequalities. The Directorate is leading on the development of a Scottish Borders Public Health Inequalities Action Plan, which will underpin the Community Planning Reducing Inequalities Strategy Plan and identify the key priorities for the Scottish Borders and its partners.

HEALTH PROMOTING ORGANISATIONS

The award winning 'Small Changes, Big Difference' campaign from NHS Borders aims to engage our staff, the public and businesses across the Borders to make small changes in their life and work practice to make a big difference to their own and other's health and wellbeing. A project group has been set within the Scottish Borders Council to develop an implementation plan for promoting relevant aspects of the 'Small Changes, Big Difference' campaign to SBC staff.

ALCOHOL AND DRUGS PARTNERSHIP

The Scottish Borders Alcohol & Drugs Partnership (ADP) is tasked with delivering a reduction in the level of drug and alcohol problems amongst young people and adults in the Borders, and reducing the harmful impact on families and communities. ADP are committed to working with the Scottish Government, colleagues, people in recovery and local communities to tackle the problems arising from substance misuse.

HEALTHY LIVING NETWORK

Borders Healthy Living Network (HLN) was established in 2003 and operates in the most deprived areas in the Borders (Eyemouth, Langlee and Burnfoot) and aims to reduce inequalities in health by empowering communities to identify and address health issues that are relevant to them.

KEEP WELL

This service focuses of people from a more deprived background who are at higher risk of developing heart disease and strokes, and it assesses their risk and recommends lifestyle changes to reduce the risk and also refers to local GPs when appropriate for drug treatments. The service is run by the Lifestyle Advisor Support Service (LASS) and this means that the service can offer intensive support to help people change their lifestyle risk factor when required.

THIRD SECTOR ORGANISATIONS

The Third Sector makes a direct impact on the wellbeing of citizens in our local communities and contributes to the improvement of its public services which support people with particular health issues e.g. diabetes, mental health, sensory impairment, etc. Third Sector organisations can be very effective in addressing the wider factors underlying health inequalities.

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