Scottish Borders **Health & Social Care** Partnership

Scottish Borders
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Facts and Statistics

Working together for the best possible health and wellbeing in our communities

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Contents

Introduction

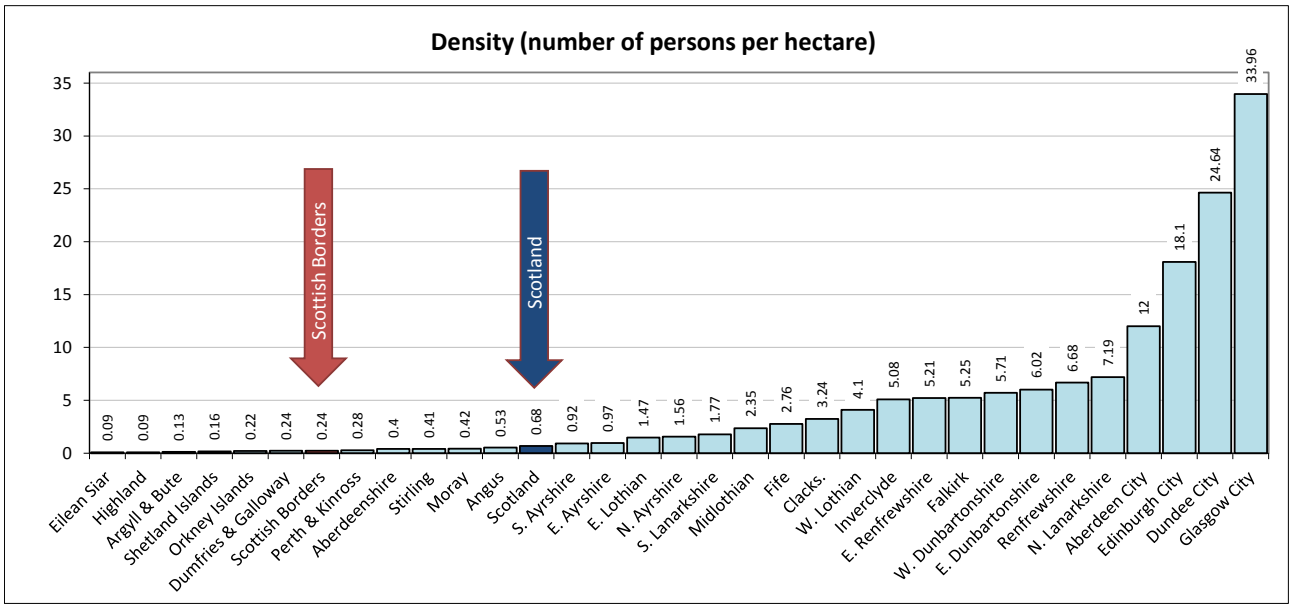
This “Facts and Statistics” document has been prepared by information analysts from NHS National Services Scotland and Scottish Borders Council to support the development of the Strategic Planning process within Scottish Borders Health and Social Care partnership. Some of the information in this document also appears in the Strategic Plan and/or the Needs Assessment that underpins it. However, this document provides additional detail on a range of themes that are relevant to the planning of Health and Social Care services in Scottish Borders. It is not an exhaustive overview of everything that may impact upon health or care needs, or all of the services that come under the responsibility of the Health and Social Care partnership. Rather, it is work in progress and part of gathering information and evidence to decision making. This work will be built on in the future.

Area and Population Profile

[This section is adapted from a similar profile in the Scottish Borders Strategic Assessment 2014 www.scotborders.gov.uk/downloads/file/7249/2014_strategic_assessment].

The Scottish Borders area is 473,614 hectares (1,827 square miles); located in the South East of Scotland. It has Edinburgh and the Lothians to the North, Northumberland to the South and Dumfries and Galloway to the West. Scottish Borders is one of the most sparsely-populated regions of Scotland. According to the 2011 Census, the population density for Scottish Borders is 0.24 persons per hectare, which is lower than the Scottish average of 0.68 persons per hectare and makes Scottish Borders the 6th-equal least-populated region in Scotland, alongside neighbouring South of Scotland region Dumfries & Galloway. The only mainland Local Authority areas with sparser populations than the South of Scotland regions are Highland and Argyll & Bute; the remainder are island regions.

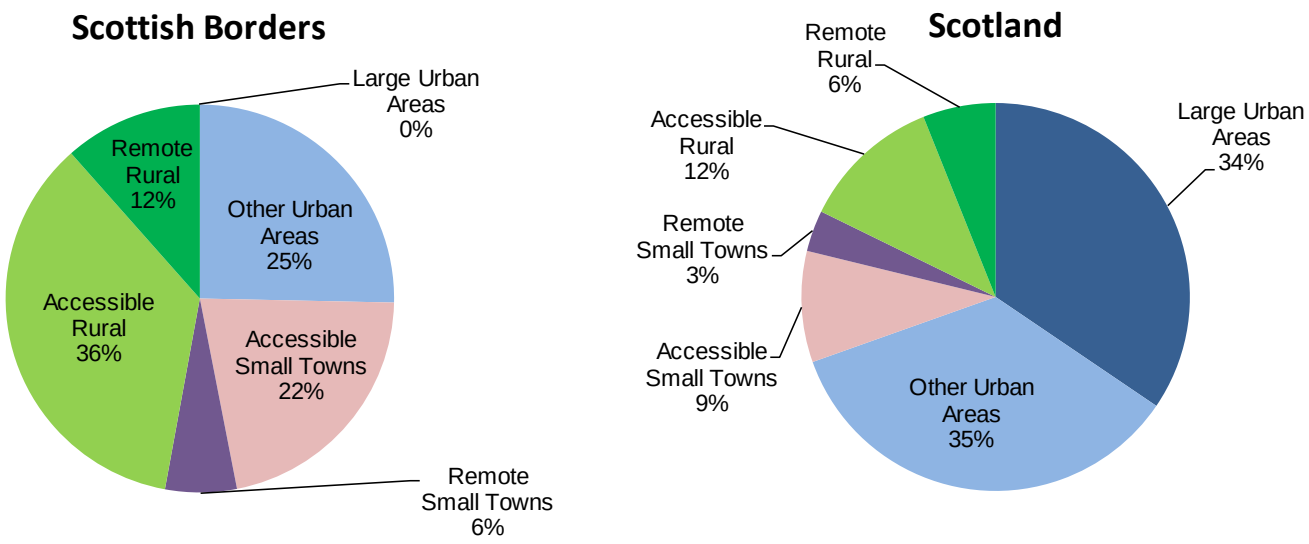
Figure 1: Average Population Density in each Scottish Local Authority area, 2011



Source: Scotland Census 2011

Scottish Borders is a rural local authority, with nearly half (48%) of the population in 2012 living in rural areas. Three out of every ten residents live in settlements of under 500 people or in isolated hamlets. Conversely, whilst 34% of the Scottish population live in "Large Urban" areas (part of towns/cities with populations of more than 125,000), there are no "Large Urban" areas in Scottish Borders. The largest town is Hawick, with a 2011 Census population of 14,029, followed by Galashiels with 12,604 – although, if neighbouring Tweedbank were included, Galashiels would be the largest town in Scottish Borders with a population of 14,705. The only other towns with a population of over 5,000 people are Peebles, Kelso and Selkirk.

Figure 2: Population shares (%) by Urban/Rural area, 2012



Category	Description
1 – Large Urban Areas	Settlements of 125,000 or more people.
2 – Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 – Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 – Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 – Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 – Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

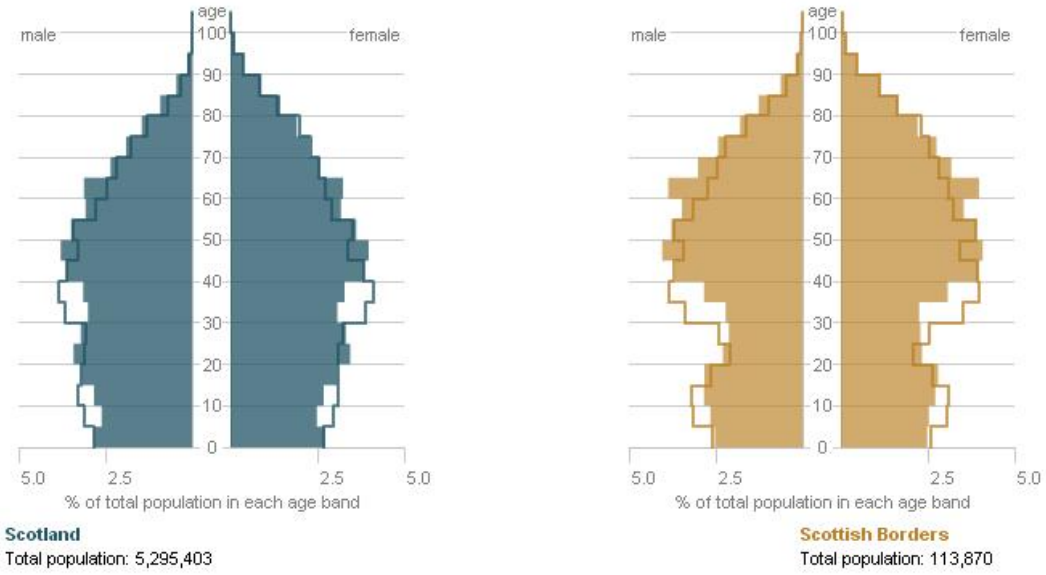
Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland. www.gov.scot/Publications/2014/11/2763/downloads

The relatively low population density, and the urban/rural profile of Scottish Borders, have implications on the costs of providing services in Scottish Borders, especially compared to densely populated city environments such as Glasgow, Edinburgh and Dundee. The uneven distribution of the population in Scottish Borders also makes it harder to plan services, with residents scattered in isolated hamlets in many parts of the region, yet with towns such as Hawick having a higher average population density than Glasgow.

The 2011 Census showed that there were 113,870 people in the Scottish Borders. The proportion of children aged under 16 is around the Scottish average at 17%. Working-age people aged 16-64 make up 62% of the Scottish Borders population, below the Scottish average of 66% and the proportion of pensioners aged 65 and over is well above average, at 20.9% in Scottish Borders compared with 16.8% in Scotland.

The diagram below show the population pyramids for Scotland and the Scottish Borders with a reference to the 2001 population structure. The pyramids show that the Scottish Borders greater proportion of people aged 40 and older compared to Scotland. The Scottish Borders pyramid also clearly shows the 'baby boomer' progression from 2001.

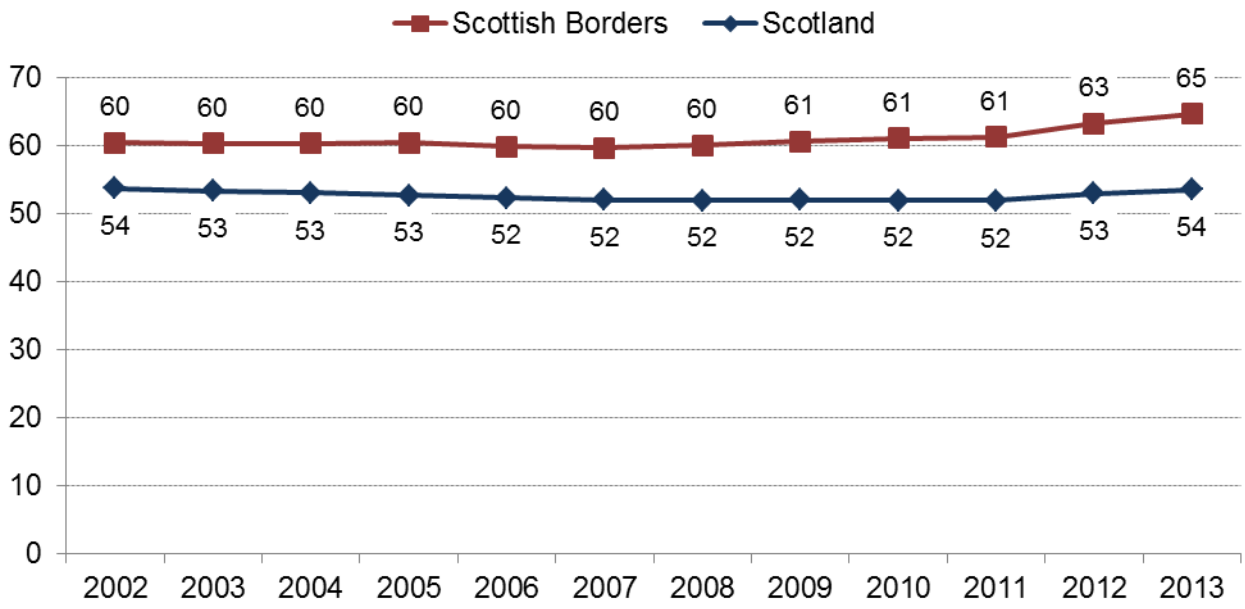
Figure 3: 2011 Census population pyramids for Scotland and Scottish Borders (outlines show 2001 populations)



Source: Scotland Census 2011. Based on graphics by the Office for National Statistics (ONS)

The Scottish Borders has a smaller proportion of people of working age compared to Scotland and this is likely to continue. This is illustrated by the dependency ratio (one of the Local Outcome Indicators used by Local Authorities). The dependency ratio is calculated by dividing the sum of the population of 0-15 and 65 plus year-olds by the population of 16-64 year-olds. The ratio is then converted to a percentage by multiplying by 100. Over the past ten years the dependency ratio in the Scottish Borders has risen from 60% to 65%, and has been consistently higher than the ratios of 52-54% for Scotland as a whole. This demographic profile has significant implications on the delivery of services into the future, especially in relation to the provision of care, on our future workforce and on economic development.

Figure 4: Dependency ratios for Scottish Borders versus Scotland, 2002 to 2013.



Source: Population Time Series data, National Records of Scotland

Scottish Borders has a healthy and industrious population with a higher than average rate of economic activity and a lower than average unemployment rate, despite the fact that 18.6% of adults aged under 74 are officially retired, which is again higher than the Scottish average. However, low wages, lack of employment opportunities and underemployment are ongoing issues in rural areas and the 2011 Census shows that Scottish Borders has a higher rate of part-time employees and a lower rate of full-time employees than average. Despite the popularity of traditional family household structures in the region, a lower-than-average percentage of adults consider themselves full-time home-makers and most adult family members aged under 75 are economically active in some capacity, either through preference or through necessity.

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.

Table 1: Scotland Census 2011; Ethnic group profile of the Scottish Borders versus Scotland.

	Scottish Borders Number	Scottish Borders Percent	Scotland percent
White (All)	112,400	98.7	96.0
White: Scottish	89,741	78.8	84.0
White: Other British	18,624	16.4	7.9
White: Irish	767	0.7	1.0
White: Gypsy/Traveller	64	0.1	0.1
White: Polish	1,302	1.1	1.2
White: Other White	1,902	1.7	1.9
Mixed or multiple ethnic groups	316	0.3	0.4
Asian, Asian Scottish or Asian British	733	0.6	2.7
African	207	0.2	0.6
Caribbean or Black	91	0.1	0.1
Other ethnic groups	123	0.1	0.3
Total: All people	113,870	100.0	100.0

According to the Scotland Census 2011, the main religion reported by Scottish Borders residents is Church of Scotland, with 39% of the population identifying with this Church, higher than the 32% on average in Scotland. This is offset by almost as many people (38%) who said they had no religion, which was the second most popular response in Scottish Borders and the single most popular response in Scotland as a whole. Less than half the Scottish average said they were Roman Catholic and a slightly higher proportion than average identified with another denomination of Christianity. Overall, the percentages of the Scottish Borders population identifying as Hindu, Muslim or Sikh were somewhat lower than across Scotland as a whole. However, we should also note that 8% of people in Scottish Borders (and 7% of people in Scotland) did not answer the question on religion, and we cannot necessarily assume that these people have a similar profile as to religious/non-religious beliefs as those who did respond to that part of the Scotland Census.

Table 2: Scotland Census 2011, population of Scottish Borders by religion, versus Scotland.

	Scottish Borders number	Scottish Borders percent	Scotland percent
Church of Scotland	44,819	39.4	32.4
Roman Catholic	7,219	6.3	15.9
Other Christian	8,599	7.6	5.5
Buddhist	279	0.3	0.2
Hindu	103	0.1	0.3
Jewish	55	0.1	0.1
Muslim	256	0.2	1.5
Sikh	18	0.0	0.2
Other religion	350	0.3	0.3
No religion	43,091	37.8	36.7
Religion not stated	9,081	8.0	7.0
All people	113,870	100.0	100.0

Projections of future population

Overview

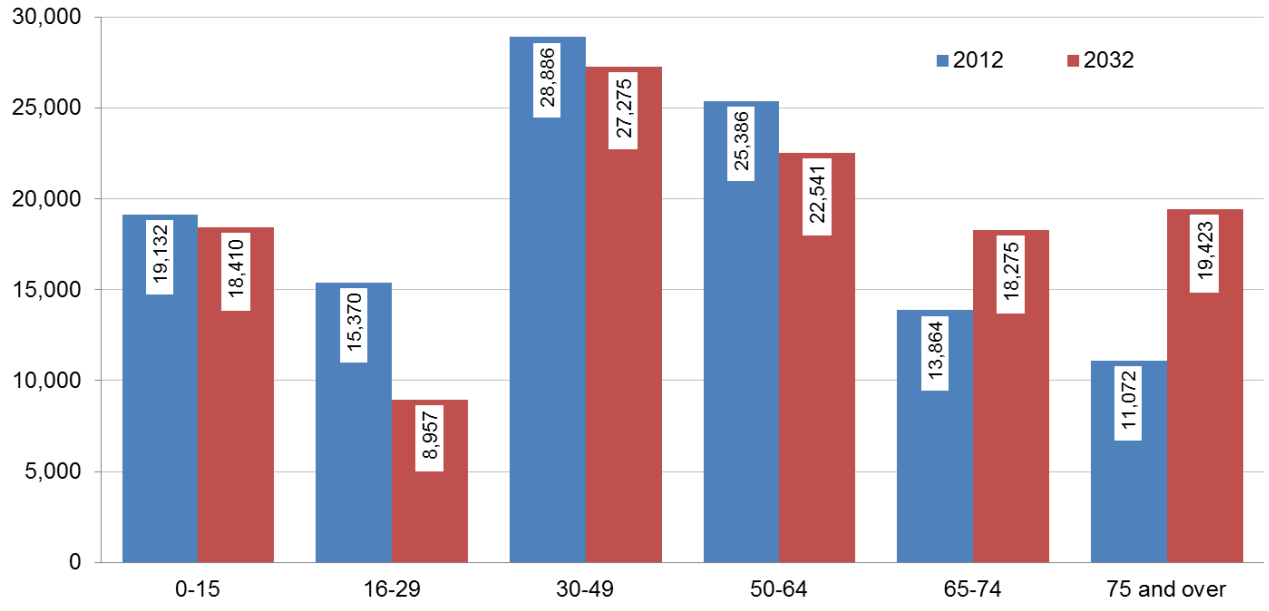
The National Records of Scotland population projections suggest that there may be very little change in the overall number of people resident in Scottish Borders between 2012 (113,710) and 2032 (114,881). These latest estimates differ from 2010-based projections, which suggested that the Scottish Borders population might grow by about 11% overall between 2010 and 2035. However, what is consistent between the two sets of projections is that the relative numbers of older people in Scottish Borders are expected to increase substantially. 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%. Meanwhile, the numbers of children and people of working age are predicted to decrease. This has substantial implications for potential levels of need for health and care support within Scottish Borders.

Table 3: Projected population of Scottish Borders (2012-based) for 2012, 2022 and 2032

	0 to 15	16 to 24	25 to 49	50 to 64	65 to 74	75+	All ages
2012 population	19,132	10,368	33,888	25,386	13,864	11,072	113,710
2022 population	19,024	8,900	28,724	27,517	16,021	14,876	115,062
2032 population	18,410	8,957	27,275	22,541	18,275	19,423	114,881
Projected change in population 2012-2022	-108	-1,468	-5,164	2,131	2,157	3,804	1,352
Projected % change in population 2012-2022	-1%	-14%	-15%	8%	16%	34%	1%
Projected change in population 2012-2032	-722	-1,411	-6,613	-2,845	4,411	8,351	1,171
Projected % change in population 2012-2032	-4%	-14%	-20%	-11%	32%	75%	1%

Source: National Records for Scotland 2012-based population projections

Figure 5: Projected population of Scottish Borders (2012-based) for 2012 and 2032



Source: National Records for Scotland 2012-based population projections

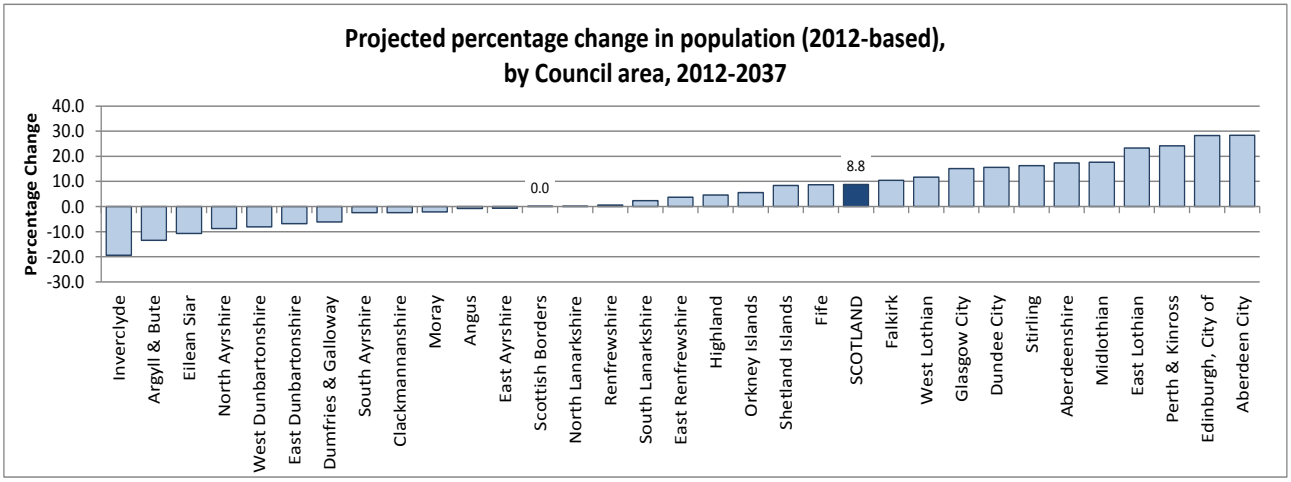
Commentary on differences between 2010-based and 2012-based projections

Staff at Scottish Borders Council examined the changes between the 2010-based and 2012-based population projections for Scottish Borders. The following comments are taken from their summary.

The NRS produces population projections every two years based on trend information over the most recent 5 year period related to natural change (births and deaths) and migration. The NRS states "*sub-national projections are trend-based, not policy-based. Many social and economic factors influence population change including policies adopted by both central and local government*." This means, for example, that the potential impact of the Borders Railway on the Scottish Borders population is not directly included in the projections.

The latest 2012-based NRS projections predict that, between 2012 and 2037, Scotland's population will increase by 8.8%. However, the NRS projects that there will be no net change in the Scottish Borders' population over the same period. Most of the projected growth is expected to happen in the large city authorities, with more rural areas such as Dumfries and Galloway, Argyll and Bute, and the Ayrshires expected to have a population decrease. The graph below shows the projected percentage change in population for the Scottish Council areas and Scotland.

Figure 6: Projected percentage change in population (2012-based) by Council area, 2012-2037



This is a marked change for the Scottish Borders from the 2010-based projections. The table below compares the 2010 and 2012 based population projections for both Scotland and the Scottish Borders, showing the components of the population change from natural change and net migration. Between 2012 and 2037 the NRS projects that the natural change for the Scottish Borders will decrease by 6.5% (compared to a smaller decrease of 3.4% in the 2010-based projections), and the net migration will increase by 6.5% (compared to a previous anticipated increase of 14.0% in the 2010 projections). These changes result in a reduction of the projected population from a 10.6% increase from 2010-35, to a flat projected population from 2012-37.

Table 4: 2010-based and 2012-based population projections for Scotland and Scottish Borders

Area	Time Frame	Natural Change (%)	Net Migration (%)	Percentage projected population change
SCOTLAND	2010-2035	1.3	8.9	10.2
	2012-2037	**1.6**	**7.2**	**8.8**
Scottish Borders	2010-2035	-3.4	14.0	10.6
	2012-2037	**-6.5**	**6.5**	**0.0**

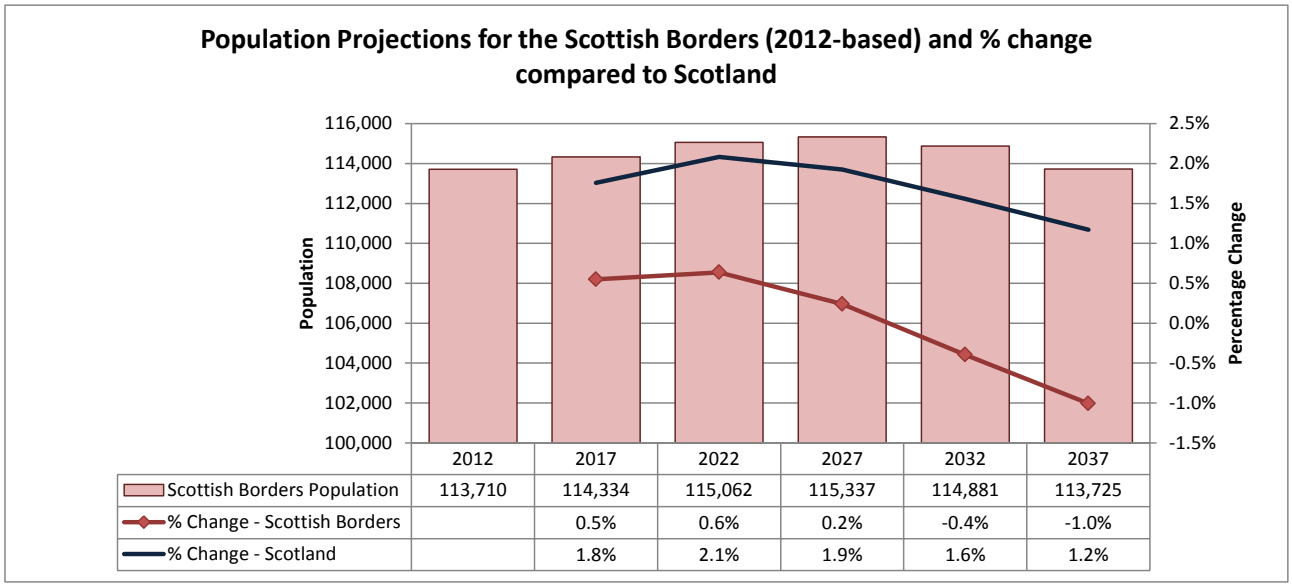
Source: National Records for Scotland.

The overall flat population projection for the Scottish Borders includes:

- an increase to 115,337 in 2027;
- a subsequent decrease to 113,725 in 2037.

The graph below shows the total population projection (2012-based) by 5 year interval between 2012 and 2037 and the percentage change between the 5 years for both Scottish Borders and Scotland.

Figure 7: Population Projections for the Scottish Borders (2012-based) and % change compared to Scotland



Source: National Records for Scotland.

The Scottish Index of Multiple Deprivation in Borders: Overview

[Material in this section is largely taken from the Scottish Borders Strategic Assessment 2014 www.scotborders.gov.uk/downloads/file/7249/2014_strategic_assessment].

Despite intervention work in Scottish Borders over the last 10 years, the same areas within the Scottish Borders continue to show as some of the most deprived in Scotland.

The Scottish Index of Multiple Deprivation (SIMD) 2012 identifies small area concentrations of multiple deprivation in Scotland. The 2012 SIMD combines 38 indicators across 7 domains. The overall index is a weighted sum of the seven domain scores: income (28%), employment (28%), health (14%), education (14%), geographic access (9%), crime (5%) and housing (2%). The SIMD uses data zones as the geographic areas. Based on 2001 Scotland Census geographies, there are 6,505 data zones in Scotland, 130 of which are in the Scottish Borders. Each data zone is ranked relative to each other where the most deprived data zone is ranked 1 and the least deprived data zone is ranked 6,505. It is important to note that the SIMD cannot be used to determine 'how much' more deprived one data zone is than another. For example it is not possible to say that data zone X, ranked 50, is twice as deprived as data zone Y, ranked 100. More information on the SIMD is available at www.gov.scot/Topics/Statistics/SIMD/BackgroundMethodology.

The Scottish Index of Multiple Deprivation is a relative measure and SIMD 2012 shows that the more deprived areas in Scottish Borders are still as deprived as they were in 2009, relative to the rest of Scotland. Furthermore, as other regions in Scotland succeed in decreasing inequality in their more deprived localities (this effect is particularly marked in Glasgow City), this has a displacement effect that can make localities in Scottish Borders appear relatively more deprived than before. As relative deprivation in other regions has decreased, relative deprivation in a number of Scottish Borders localities has shown a small increase since the SIMD was first produced. In 2012, Scottish Borders had 5 (or 0.5%) of Scotland's "most-deprived 15%" data zones, compared with 5 (0.5%) in 2009, 3 (0.3%) in 2006 and 2 (0.2%) in 2004. This concept of relative deprivation adds impetus for Scottish Borders to tackle deprivation and reduce inequalities with at least the same level of commitment as is being deployed in other regions.

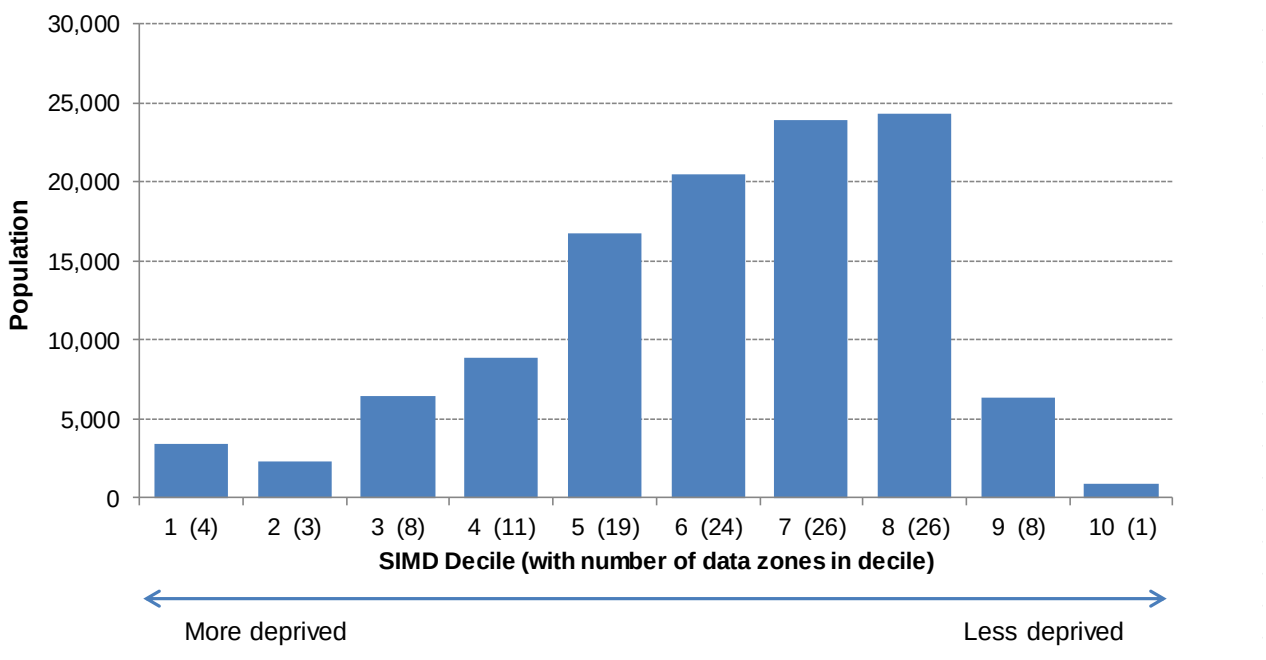
The table and figure below show the number of data zones in Scottish Borders and 2011 Census population by each of the deciles. The 20% most deprived data zones in the Scottish Borders are in the decile grouping of 1, 2, 3 or 4. These 26 data zones between them have 19.5% of the Borders population.

Table 5: Number of datazones* in Scottish Borders, and 2011 Census populations, by SIMD decile.

SIMD 2012 Decile	Number of datazones	% of datazones	2011 Census population	% of Census population
1 (most deprived)	4	3.1%	3,391	3.0%
2	3	2.3%	2,286	2.0%
3	8	6.2%	6,442	5.7%
4	11	8.5%	8,903	7.8%
5	19	14.6%	16,804	14.8%
6	24	18.5%	20,484	18.0%
7	26	20.0%	23,970	21.1%
8	26	20.0%	24,320	21.4%
9	8	6.2%	6,371	5.6%
10 (least deprived)	1	0.8%	899	0.8%
Scottish Borders total	130	100.0%	113,870	100.0%

*2001-based datazones. Source: Scottish Borders Strategic Assessment 2014.

Figure 8: Number of datazones* in Scottish Borders, and 2011 Census populations, by SIMD decile



*2001-based datazones. Source: Scottish Borders Strategic Assessment 2014.

The table below lists the 26 most deprived data zones in the Scottish Borders (those that are in SIMD deciles 1-4). Most notable are the 5 datazones in the Scottish Borders that are recognised by Scottish Government as being amongst the 15% most deprived in Scotland. These 5 data zones account for 3.2% of the Scottish Borders population. (A vigintile is a twentieth, or a measure of 5%, of all data zones in Scotland. Therefore, a data zone in vigintile 1 is recognised as being amongst the 5% most-deprived data zones in Scotland).

The most deprived data zone in Scottish Borders is still S01005382 (Central Burnfoot, Hawick). The other 4 "15% most deprived in Scotland" data zones in Scottish Borders are also in Burnfoot, Hawick and in Langlee, Galashiels. This is the same as SIMD 2009.

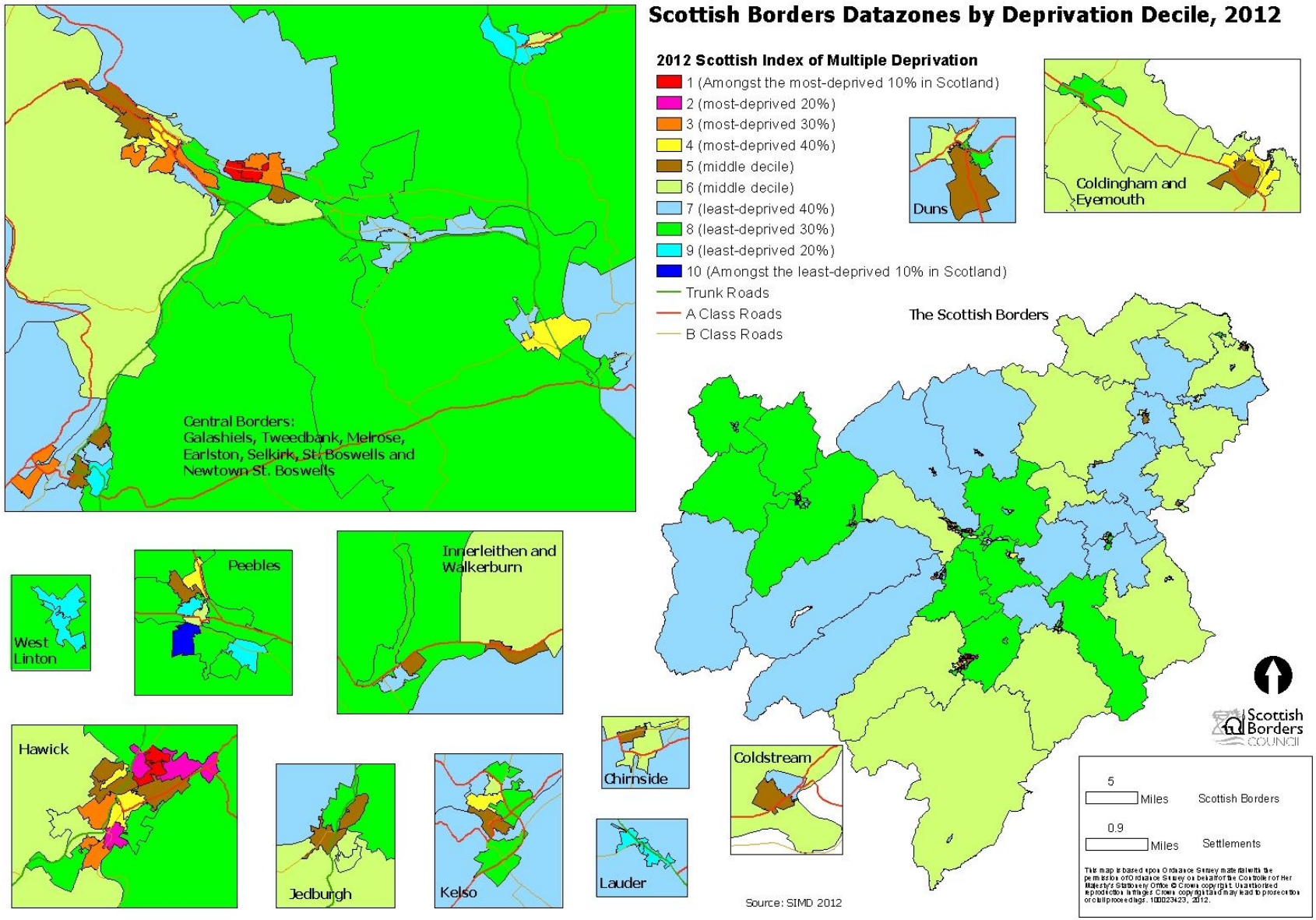
Table 6: The 26 most deprived datazones in Scottish Borders (those in SIMD deciles 1 to 4).

Data Zone (2001 based)	Data Zone Name	SIMD 2012 Rank	SIMD 2012 - Decile	SIMD 2012 - Vigintile	Total Census Population : 2011
S01005382	Hawick - Central Burnfoot*	279	1	1	834
S01005426	Galashiels - Langlee Drive*	481	1	2	769
S01005425	Galashiels - Kenilworth Ave Langlee*	487	1	2	980
S01005378	Hawick - South Burnfoot*	607	1	2	808
S01005381	Hawick - West Burnfoot*	694	2	3	641
S01005369	Hawick - Drumlanrig/ Wellogate	1,012	2	4	974
S01005380	Hawick - East Burnfoot	1,199	2	4	671
S01005400	Selkirk – Bannerfield	1,305	3	5	1,078
S01005427	Galashiels – Huddersfield	1,596	3	5	779
S01005373	Hawick - Princes St / Wilton	1,639	3	6	724
S01005367	Hawick - The Motte	1,653	3	6	751
S01005428	Galashiels - Hawthorn Rd	1,669	3	6	1,049
S01005431	Galashiels - Balmoral Rd	1,681	3	6	667
S01005429	Galashiels - Old Town	1,770	3	6	719
S01005368	Hawick – Crumhaugh	1,860	3	6	675
S01005377	Hawick - Silverbuthall Rd	1,970	4	7	863
S01005487	Eyemouth - Seafront/ harbour	2,097	4	7	733
S01005416	Kelso - Poynder Park	2,188	4	7	978
S01005434	Galashiels - Town Centre	2,229	4	7	807
S01005374	Hawick – Trinity	2,329	4	8	870
S01005488	Eyemouth - Haymons Cove	2,378	4	8	792
S01005485	Eyemouth – Gunsgreen	2,396	4	8	851
S01005372	Hawick - Bridge St/ Town Centre	2,464	4	8	864
S01005458	Peebles - Dalatho St	2,493	4	8	716
S01005408	Newtown St Boswells - East	2,575	4	8	579
S01005433	Galashiels - Thistle St	2,578	4	8	850
* One of the 15% most deprived data zones in Scotland					

*2001-based datazones. Source: Scottish Borders Strategic Assessment 2014.

The map on the following page shows the 130 data zones in the Scottish Borders by their SIMD decile ranking within the Scottish context.

Figure 9: Map showing Scottish Borders datazones by SIMD deprivation decile, 2012



Geographic Access to services

As outlined above, geographic access is one of the domains of the Scottish Index of Multiple Deprivation (SIMD). The access domain is intended to capture the financial cost, time and inconvenience of having to travel to access basic services (such as GP practices or shops). Access deprivation is the most widespread type of deprivation in Scottish Borders, and applies to a higher proportion of the population than for Scotland overall. This reflects the rural geography of Scottish Borders.

Within Scottish Borders:-

- 38 of the datazones (29%) are within the 15% most access deprived areas of Scotland. Scottish Borders ranks 9 out of 32 Local Authority areas currently when looking at the proportion of datazones that are classed as amongst the 15% most access deprived.

- 34 of the 130 datazones (26%) are within the 10% most access deprived areas of Scotland, in terms of drive times to services and accessibility of public transport. 31% of the Scottish Borders population live in these 34 datazones, all of which are rural areas.

Many parts of Scottish Borders do 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. To an extent, many residents in Scottish Borders are geographically disadvantaged by their distance from a major centre of population, except for the accessible northern parts of the region, as they do not have access to all the services that their counterparts in the city centre may take for granted. However, the most "access deprived" areas are also those of highest scenic amenity and can be an attractive choice for people seeking a certain quality of rural lifestyle. 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.

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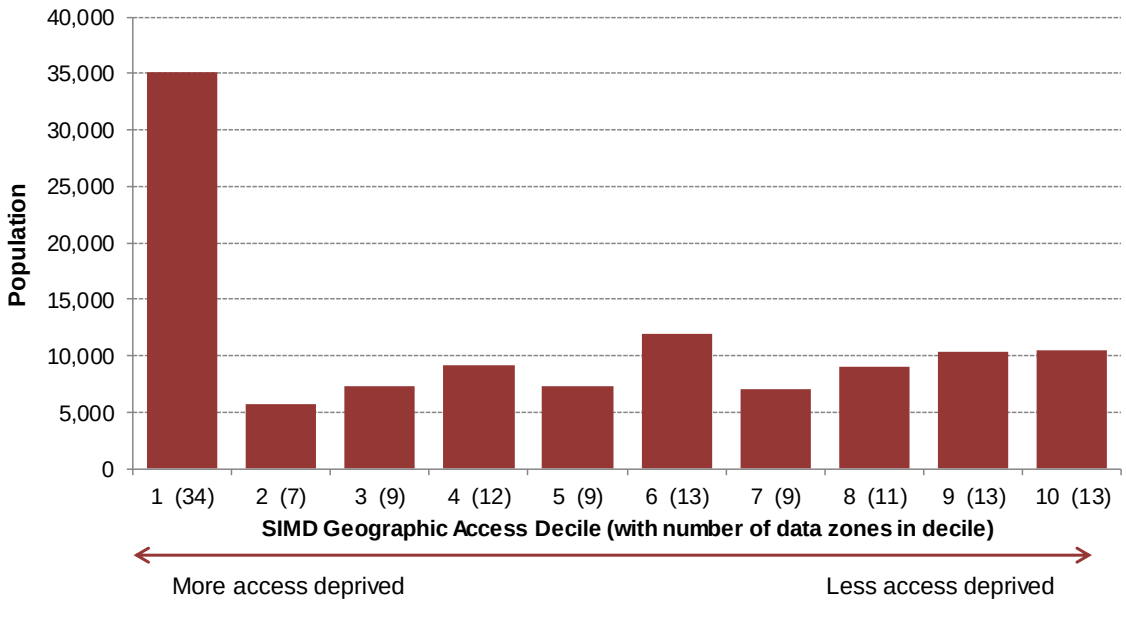
Table 7: Number of datazones* in Scottish Borders, and 2012 populations, by SIMD Geographic access deprivation decile.

Geographic Access Deprivation Decile	Number of datazones	% of datazones	2012 population	% of 2012 population
1 (most access deprived)	34	26.2%	35,171	30.9%
2	7	5.4%	5,755	5.1%
3	9	6.9%	7,364	6.5%
4	12	9.2%	9,223	8.1%
5	9	6.9%	7,276	6.4%
6	13	10.0%	11,947	10.5%
7	9	6.9%	7,071	6.2%
8	11	8.5%	9,006	7.9%
9	13	10.0%	10,383	9.1%
10 (least access deprived)	13	10.0%	10514	9.2%
Scottish Borders total	130	100.00%	113,710	100.0%

*2001-based datazones. Sources: Scottish Neighbourhood Statistics/SIMD2012 and National Records of Scotland 2012 Small Area Population Estimates.

Figure 10: Number of datazones* in Scottish Borders, and 2012 populations, by SIMD Geographic access deprivation decile



*2001-based datazones. Sources: Scottish Neighbourhood Statistics/SIMD2012 and National Records of Scotland 2012 Small Area Population Estimates.

The table below shows modelled estimates of drive times and public transport times to a GP in 2012, along with information on household access to private transport in the form of cars/vans. Overall, as can be expected, variations in estimated average journey time by public transport varies to much greater extent than estimated average drive time by private vehicle.

- The longest estimated drive times to a GP are 15-20 minutes for people living in the following four datazone areas:- Teviothead and the area around (but not including) Newcastleton; Ettrick, Ettrickbridge & around; Broughton & Upper Tweed; Cockburnspath/Cranshaws/Abbey St Bathans.

- Meanwhile, in six rural datazone areas, estimated average public transport journey times to a GP were an hour or more. These areas were:- Teviothead and the area around (but not including) Newcastleton; Broughton & Upper Tweed; Bonchester Bridge/ Chesters; Midlem/ Lilliesleaf/Ashkirk; Yarrowford/ Yarrow Feus & around; Longformacus/ Westruther/ Polwarth.

Table 8: Modelled travel times to a GP in 2012, and household access to cars/vans

Indicator/ Measure	Scotland	Scottish Borders	Average of the Scottish Borders Datazones in 15% Most Deprived in Scotland	Average of the Scottish Borders Datazones in 15% Least Deprived in Scotland	Max value out of all 130 Scottish Borders Datazones	Min value out of all 130 Scottish Borders Datazones
Drive time (minutes) to a GP in 2012	N/A	5.2	5.3	2.1	17.7	1.2
Public Transport time (minutes) to a GP in 2012	N/A	17.4	12.3	5.6	95.4	2.8
% of households with no car or van available	30.5%	20.5%	44.5%	16.1%	51.4%	1.5%
% with 1 car or van	42.2%	45.3%	42.8%	42.5%	56.0%	25.4%
% with 2 cars/ vans	21.6%	26.3%	10.8%	32.4%	55.3%	8.2%
% with 3+ cars/ vans	5.6%	7.9%	2.0%	9.0%	17.8%	1.1%
Average number of cars or vans per household	1.0	1.2	0.7	1.4	1.9	0.6

Source: Scottish Borders Council (2014). Reducing inequalities in the Scottish Borders; Geographic Access Profile (October 2014 V3).

The commentary in this section is drawn from the following document: Scottish Borders Council (2014). Reducing inequalities in the Scottish Borders; Geographic Access Profile (October 2014 V3).

Services, especially outwith the main towns, are substantially more difficult and inconvenient to get to when there is no choice but to travel by bus, and may be sufficiently inconvenient and expensive to reach for an individual on a low income that they may choose not to access the service, if they have the choice. Therefore, important lifestyle choices, for example choosing where to work or study, may be made around the practical difficulties and expense of getting there and back rather than being made on merit. Also, individuals may miss out on sporting, leisure and cultural services because of transport issues, leading to them making poorer use of their spare time than peers with no such issues and being excluded from fulfilling their potential.

Despite the similar accessibility/ geographic access deprivation issues facing the most and the least deprived communities in terms of their locations and local services, the above figures show that car ownership patterns between the communities are very different. Car ownership in Scottish Borders is higher than in Scotland on average, in recognition of the region's rurality and generally more difficult access to services than other regions in Scotland. The areas with 40% to 52% of the households with no access to a car are located in the main towns of Galashiels and Hawick. Conversely the areas with the highest number of cars are in the rural areas of the Scottish Borders.

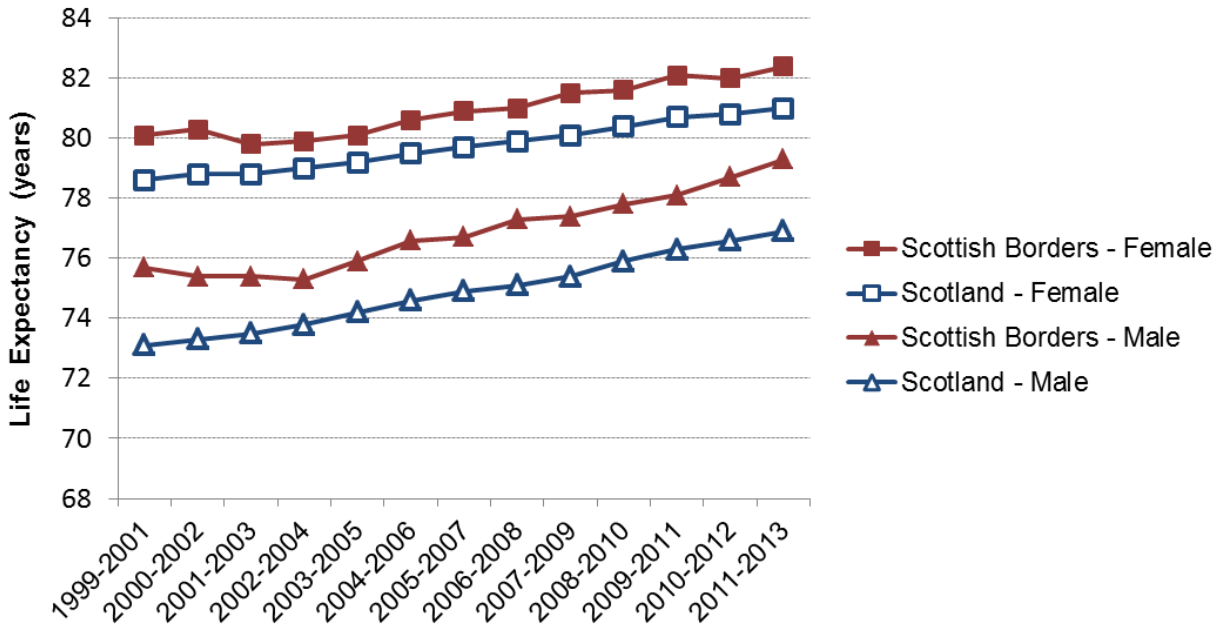
However, whilst 20% of households in Scottish Borders do not own a car, this figure is more than 44% in the most-deprived areas but only 16% in the least-deprived. Assuming that many communities in Scottish Borders must have similar transport needs and issues, it may be reasonable to assume that the difference is at least partly due to the cost of running a car.

Also, in a rural area like Scottish Borders, one car may not be enough. Of those who do own a car, substantially more own 2 or more cars in the least-deprived areas, meaning that, for 42% of households in the least-deprived areas, there is at least one car available to both parties in a traditional 2-adult household structure at all times of the day. In contrast, only 13% of households in the most-deprived areas have adequate private transport available to them all day. This impacts disproportionately on full-time parents and non-full time wage earners, usually women and children, who are left without private transport during the day. This means that whole sections of the population are reliant on public transport, which the evidence above suggests is more time-consuming and can be an inconvenient and expensive way to travel with children. Whilst getting to work and school is not necessarily an issue for the main wage-earner and the children, a lack of private transport means that women and children are more likely to be restricted in terms of non-essential activities such as after-school sports, clubs and hobbies, access to a full range of services and flexibility to get involved in the workplace or the community. This can put them at a disadvantage and exacerbate their social exclusion when compared with the activities taken for granted by their peers in the less-deprived areas. It can also make an already difficult task of finding a part-time job to support the family income even more difficult and many families may consider it not worthwhile seeking work if it means having to run a second car.

Life Expectancy and Healthy Life Expectancy

In general the life expectancy at birth for women is greater that for men. In the Scottish Borders both men and women have a higher life expectancy at birth compared to Scotland. Over time the life expectancy for men has increased at a greater rate than that for women. The graph and table below show the 3-year rolling average of life expectancy at birth between 1999 and 2013, comparing Scottish Borders to Scotland.

Figure 11: Life Expectancy at Birth 1999-2013 (3-Year Rolling Average)



Source: Scottish Neighbourhood Statistics, www.sns.gov.uk

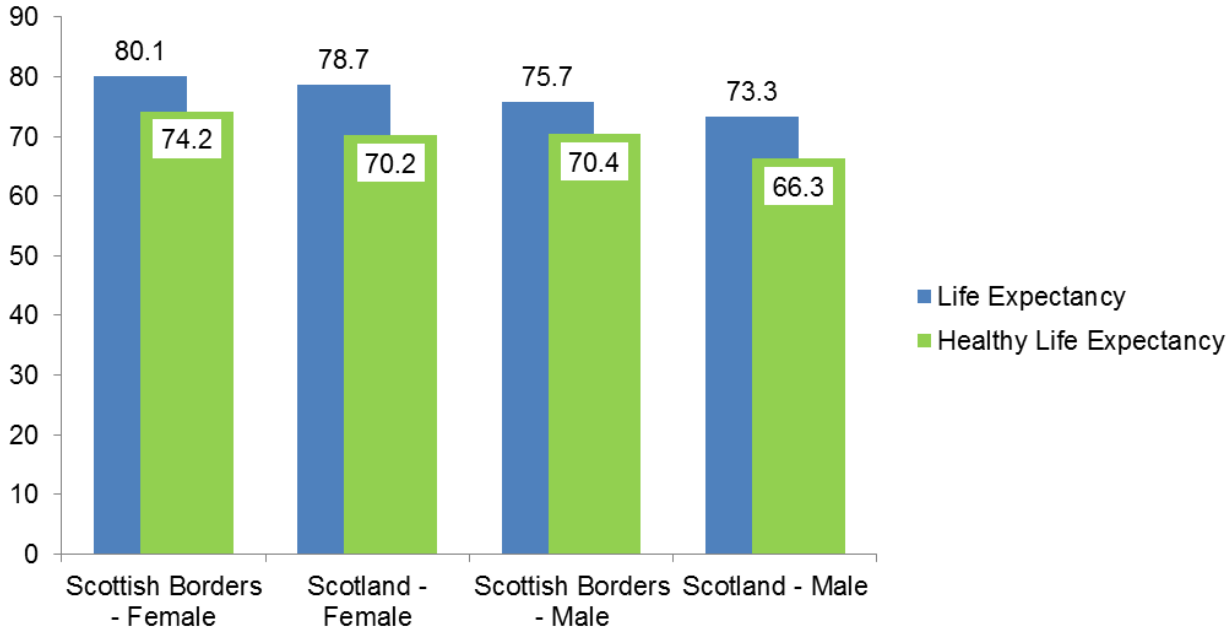
Table 9: Life Expectancy at Birth 1999-2013 (selected 3-Year Rolling Averages)

Area/Gender	1999-2001	2005-2007	2011-2013
Scottish Borders - Female	80.1	80.9	82.4
Scotland - Female	78.6	79.7	81.0
Scottish Borders - Male	75.7	76.7	79.3
Scotland - Male	73.1	74.9	76.9

Source: Scottish Neighbourhood Statistics, www.sns.gov.uk

Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. The graph below shows overall life expectancy and healthy life expectancy for people born in Scottish Borders and Scotland during the years 1999-2003. In the Scottish Borders both men and women are expected to have higher life and healthy life expectancy compared to Scotland. 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.

Figure 12: Life Expectancy and Healthy Life Expectancy (years) at birth, 5-year period 1999-2003



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

Households and Housing

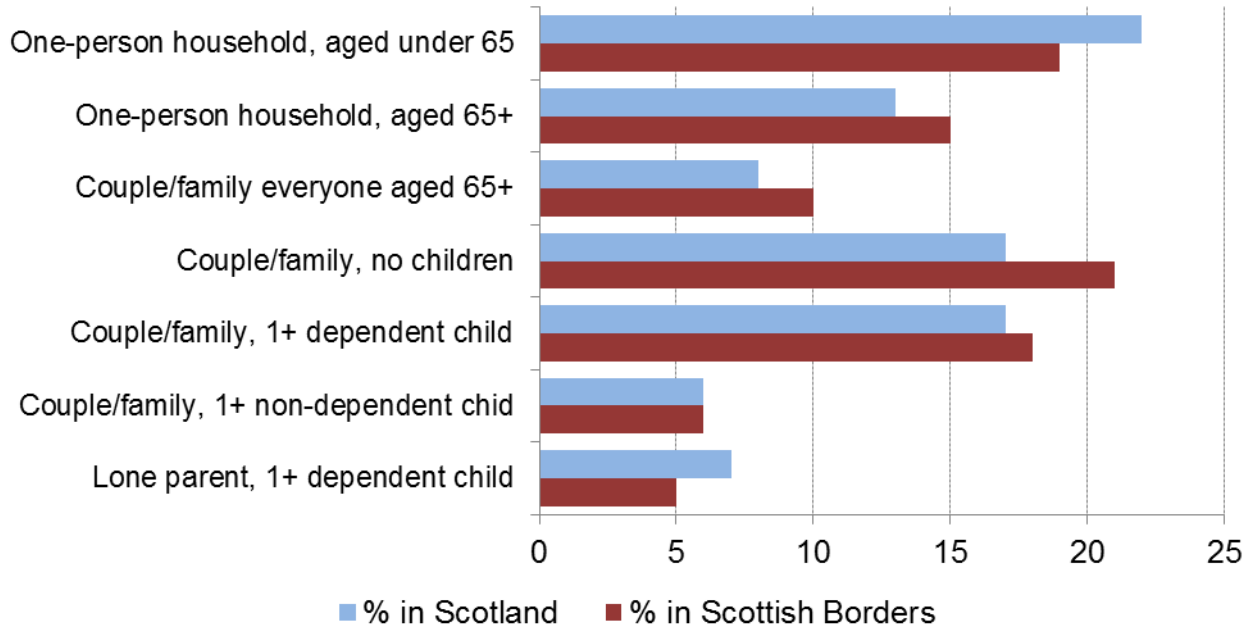
Household structure

A significant projected increase in the number of older-person households, increasing numbers of older people living alone and more older people having complex levels of need, will have major implications for housing and health and social care services.

In terms of household structure, results from the 2011 Scotland Census show that the most common household type in Scottish Borders is couples with/without children, but also that over a third of households overall are comprised of one adult. The proportion of households in Scottish Borders in which the sole or all occupants are aged 65+ is higher than for Scotland as a whole. Specific points include:

- One-person households where the resident is aged 65+ account for 15% of all households in Scottish Borders, compared with 13% in Scotland.
- Multi-person households where both/all of the residents are aged 65+ are more common in Scottish Borders (10%) than Scotland (8%).
- Conversely, one-person households where the resident is aged under 65 are a little less common in Scottish Borders (19%) than Scotland (22%).
- Lone parent households remain less common in Scottish Borders (5%) than Scotland (7%).

Figure 13: Household composition in Scottish Borders and Scotland, 2011



Source: Scotland Census 2011. Note that the graph represents the most common household types in Scottish Borders and not all households.

Table 10: Household composition in Scottish Borders and Scotland, 2011.

Household structure	% of households in Scottish Borders	% of households in Scotland
One-person household, aged under 65	19	22
One-person household, aged 65+	15	13
Couple/family everyone aged 65+	10	8
Couple/family, no children	21	17
Couple/family, 1+ dependent child	18	17
Couple/family, 1+ non-dependent chid	6	6
Lone parent, 1+ dependent child	5	7
Other Household types	6	9

Source: Scotland Census 2011. Note that the Scotland percentages do not add up to exactly 100, due to rounding.

The SESplan Housing Need and Demand Assessment, published in March 2015, summarises projected estimates of household numbers and composition in Scottish Borders:-

- The total number of households in Scottish Borders is projected to increase by 7% between 2012 (52,671 households) and 2037 (56,575 households).

- The number of single adult households is projected to increase by 24% over the same period. The number of larger households is projected to decline, for example with households consisting of 2 or more adults with children projected to decline by 23%.

- Households headed by people aged 60-74 are projected to increase by 9% and those headed by a person age 75 or over are projected to increase by 90%.

- Average household size in Scottish Borders is projected to decrease from 2.14 people in 2012 to 1.98 people in 2037. Average household size is expected to remain consistently smaller in Scottish Borders than across Scotland as a whole.

Housing

As outlined in the SESplan Housing Need and Demand Assessment (March 2015), housing is at the heart of independent living. Some of the ways in which the housing sector and work in relation to it can support effective health and social care for people, particularly vulnerable and older people, are:

- Ensuring an appropriate balance of housing provision, across all housing tenures, and a range of housing sizes and types, including extra care, sheltered and mainstream housing.

- Housing adaptations – making changes to people's homes to increase or maintain their independence and reduce the risk of an accident.

- Provision of low level support and preventative services – this includes community alarms; tele-care and tele-health; and care and repair/handyperson services to maintain and improve people's homes.

- Provision of specialist housing with care and support, which is suitable for people with greater health and care needs, particularly those with mobility problems and/or learning disabilities.

- Providing accommodation for respite and intermediate care, facilitating early discharge from hospital.

- Support to move home – helping vulnerable and older people with the emotional and physical demands of moving home, so they can move to a property which better suits their needs.

Fuel Poverty

The term “fuel poverty” is used to describe the inability of households to afford to heat the home to a satisfactory standard at a reasonable cost. The Scottish Fuel Poverty Statement (August 2002) sets out the Scottish definition:

> “A household is in fuel poverty if, in order to maintain a satisfactory heating regime, it would be required to spend more than 10% of its income (including Housing Benefit or Income Support for Mortgage Interest) on all household fuel use.”

Furthermore, 'Extreme Fuel Poverty' can be defined as a household having to spend more than 20% of its income on fuel.”

As the Scottish Poverty Statement notes, fuel poverty has a negative impact on individuals, households, and communities. For individuals and households, the main negative impact of fuel poverty is its damaging effects on quality of life and health. The effects are both direct and indirect. Illnesses such as influenza, heart disease and strokes are all exacerbated by cold, and cold homes can also promote the growth of fungi and number of dust mites – often linked to conditions such as asthma. Less directly, households that have to spend a high proportion of their income on fuel have to compensate in other parts of their family budgets. This can lead to poor diet, or reduced participation in social and leisure activities, both of which can also impact on health and quality of life. These negative effects of fuel poverty can be particularly significant for vulnerable groups.

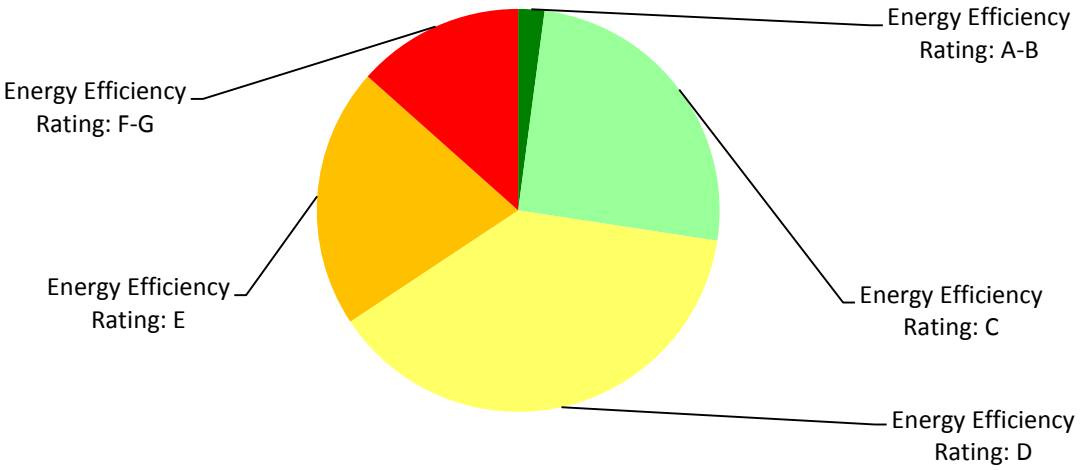
Fuel poverty is the result of the interplay between income, fuel price and energy efficiency.

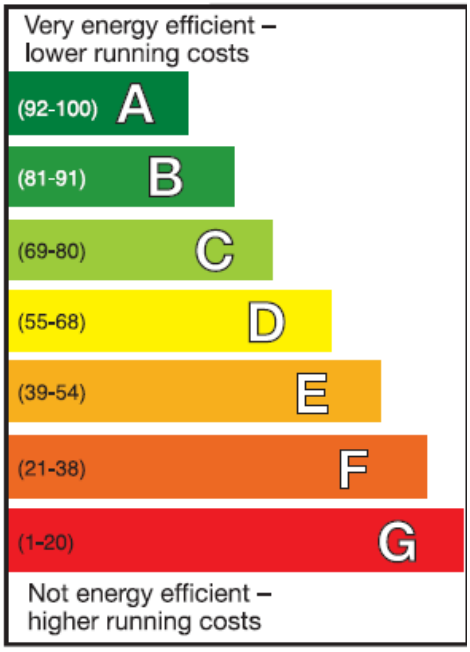
- The lower income groups have the highest rates of fuel poverty, but fuel poor households are found in all income bands.

- Fuel poverty also depends on the cost of energy for space and water heating, cooking, lighting and running appliances. Prices of different types of fuels can vary considerably, as can the availability of different fuels in different areas, and of different types of heating systems. This affects the ability of consumers to exercise choice.

- The thermal efficiency of the building and the efficiency of the heating source(s) determine the amount of energy that must be purchased to heat the home adequately. Better energy efficiency ratings are associated with lower fuel poverty rates. The Scottish House Conditions Survey 2013 estimates that 27% of houses with B or C ratings are fuel poor, compared with 87% of those rated F or G. In 2011-13 an estimated 9% of dwellings in Scottish Borders had an F or G energy efficiency rating, compared with 4% for Scotland overall. In contrast, information from the Energy Savings Trust (August 2014) suggests that roughly one quarter of all buildings in the Scottish Borders (domestic and commercial) would receive an energy efficient rating of A, B or C.

Figure 14: Estimated Energy Efficiency of buildings (domestic and commercial) in the Scottish Borders, 2014





Source: Energy Savings Trust (information provided directly to Scottish Borders Council, August 2014).

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

- Around 43% of all households in the Scottish Borders are fuel poor, higher than the Scottish average of 36%.

- 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%)

- More generally – referring to results across Scotland - while on average fuel poverty levels are higher in social housing, private sector housing is quite diverse and combines some of the highest and lowest rates of fuel poverty. Householders in Scotland who own their property with a mortgage are least likely to be assessed as fuel poor (19%) compared to all other tenures. On the other hand, over half (56%) of those whose homes are owned outright are fuel poor. Many households in this group consist of pensioners, who generally have lower earnings and whose required energy costs are assessed under an enhanced heating regime in accordance with the fuel poverty definition. The properties in which they live are often larger, requiring more energy to heat, and more likely to be detached which leads to greater heat loss.

- Fuel poverty rates are higher in rural areas than urban areas. This is likely due to factors such as limited access to mains gas, larger shares of detached dwellings and greater exposure to wind and weather.

Population Health

General Health

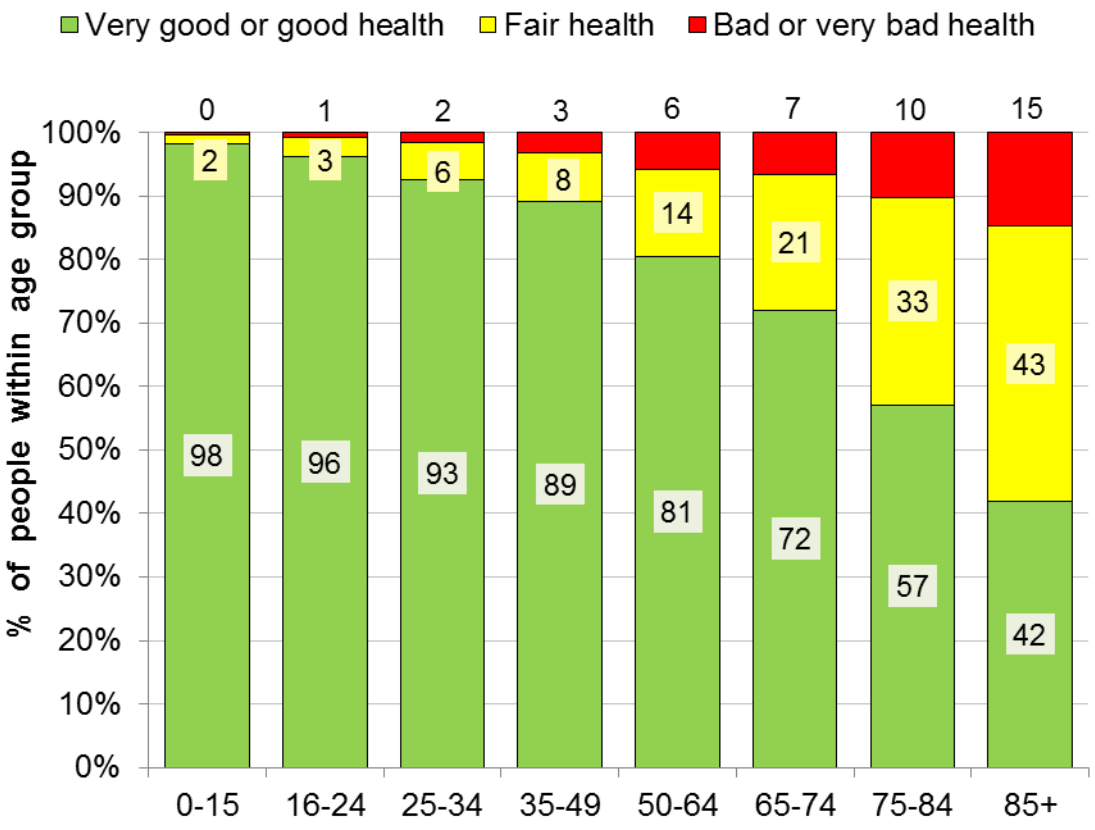
According to the 2011 Scotland Census:-

- 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 Census question on self-assessed health is a subjective, but nevertheless useful, measure as it gathers information on virtually the whole population across Scotland and can be reported in relation to a variety of characteristics of individuals and communities.

Across Scottish Borders, there is a clear increase in the percentage assessing their health as fair or bad/very bad, with increasing age. For example, more than 1 in 10 people aged 75+ reported their health as being bad/very bad, compared with only around 1 in 100 people aged 16-24.

Figure 15: Self-reported general health amongst Scottish Borders residents, by age group.



Source: Scotland Census 2011.

The percentage of Census respondents who assessed their general health as "good or very good" varied by ethnic group. Overall:-

- Around 84% of people in White, mixed or multiple ethnic groups reported being in good or very good health – the same as the Scottish Borders average, unsurprisingly as these ethnic groups comprise 99% of the Scottish Borders population.
- Around 92% of people in Asian, African, Caribbean or Black ethnic groups stated they were in good/very good health.
- Amongst other ethnic groups (comprising around 1 in 1,000 of the Scottish Borders population), 79% considered themselves to be in good/very good health.

The Scottish Borders average of 84% reporting themselves as in good/very good health is a little higher than the 82% average for Scotland. Rates of good self-assessed health are lower in the 15% most-deprived datazones than in the 15% least-deprived, although not by as much as might be expected, given that poor health is a key determinant of ability to work and therefore of household income. This suggests that poor health is more prevalent in economically inactive people, which is again what would be expected.

Table 11: Percentage of people who assessed their general health as very good or good, 2011.

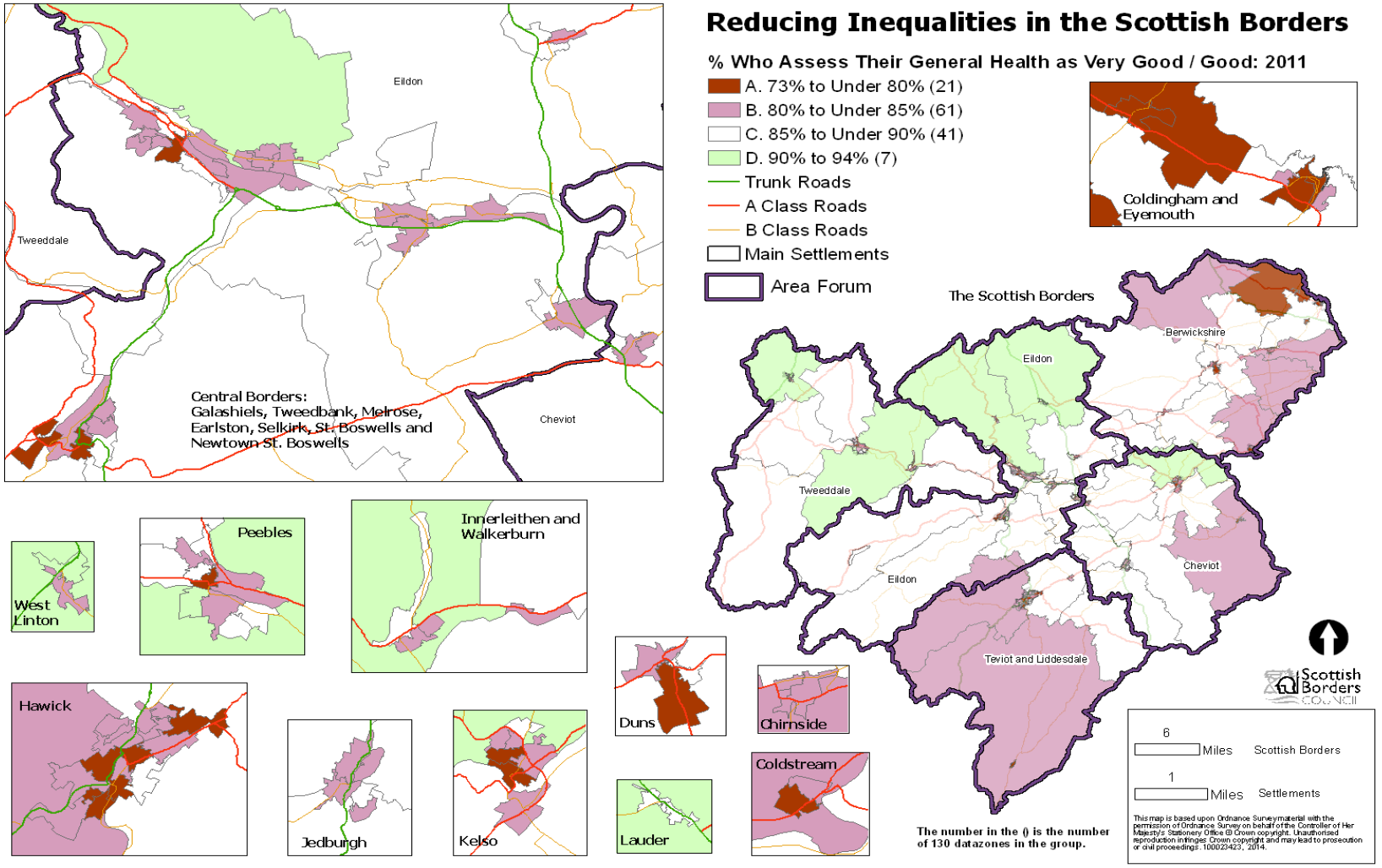
Scotland	82%
Scottish Borders	84%
Average of the Scottish Borders Datazones in 15% Most Deprived in Scotland	82%
Average of the Scottish Borders Datazones in 15% Least Deprived in Scotland	88%
Maximum value out of all 130 Scottish Borders Datazones*	94%
Minimum value out of all 130 Scottish Borders Datazones*	74%

*Datazones are small areas used for statistical reporting in Scotland. Each datazone has a population of between 500 and 1,000 residents. This table refers to 2001-based datazones.

Sources: Scotland Census 2011 and Scottish Index of Multiple Deprivation (SIMD).

In the Scottish Borders there are 4 areas where less than 75% of the people living in the area consider their health to be "good/very good". These areas are: the Motte area and the East Burnfoot areas of Hawick, the Seafront/ harbour area of Eyemouth and the Old Town area of Galashiels. In the Scottish Borders there is a strong correlation between increased Multiple Deprivation and fewer people considering their health to be "good/very good". This is unsurprising, as dependency on health-related welfare benefits is a key indicator of Multiple Deprivation.

Figure 16: Percentage of people who assessed their general health as very good or good, 2011, by Scottish Borders datazone



Cancer

Over the period 2008-2012, an annual average of 737 Scottish Borders residents were newly diagnosed with a malignant cancer (excluding non-melanoma skin cancer). This is an 18% increase from the average of 624 newly diagnosed cases per year over the period 1998-2002. Whilst the crude cancer incidence rate in Scottish Borders is higher than the crude rate for Scotland (649 per 100,000 in 2008-2012 compared with 577 per 100,000, respectively), this apparently higher rate overall is due to Borders having an older overall population profile compared to Scotland. Cancer incidence rates increase markedly with increasing age. 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.

Over the ten years from 2003 to 2012, age-standardised incidence rates of cancer in Scotland have fallen by 5% in males but increased by 8% in females. 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. Two in five people in Scotland will be diagnosed with some form of cancer during their lifetime, although this includes cancers that will have no detrimental impact on life expectancy.

Although expectations are that overall cancer incidence will continue to increase, overall mortality rates from cancer have fallen across Scotland. Although mortality rates have been falling, the numbers of deaths from cancer have not similarly fallen, largely reflecting an increase in the size of older age groups within the population. An average of approximately 350 deaths due to cancer are recorded amongst Scottish Borders residents annually. Although the crude cancer mortality rate for Borders is higher than for Scotland overall (311 per 100,000 compared with 293 per 100,000 over the period 2009-2013), once the relatively older age profile for Borders is taken into account, this difference reverses. The overall age-standardised (to the European Standard Population, 2013) cancer mortality rate for Borders residents was 295 per 100,000 in 2009-2013, compared with 339 per 100,000 for Scotland.

Increasing incidence of cancer and relatively stable numbers of cancer deaths/falling mortality rates combine to indicate increases in the numbers of people completely cured of their cancer and increases in the number of people living with cancer (that is, cancer prevalence). As part of the Quality and Outcomes Framework (QOF), GP practices across the UK keep cumulative registers of all of their patients that they know to have been diagnosed with cancer after 1st April 2003. At March 2014, the number of patients on the cancer registers of Scottish Borders GP practices was 3,282 (compared with a cumulative total of 3,057 at March 2013).

Significant patterns exist when examining incidence and mortality rates by deprivation in Scotland. For all cancers combined, the most deprived areas (those in the bottom quintile for multiple deprivation) have incidence rates that are 34% higher than the least deprived areas. Mortality rates are 71% higher in the most deprived areas compared with the least deprived.

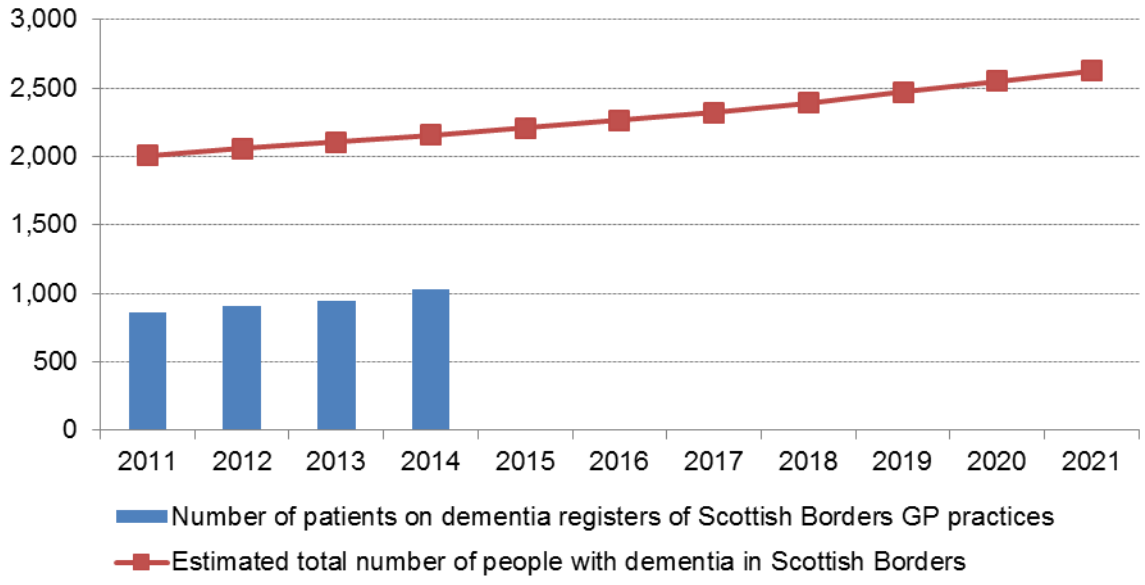
Sources of cancer information:-
www.isdscotland.org/Health-Topics/Cancer/Cancer-Statistics/
www.isdscotland.org/qof

Dementia

Dementia presents a significant challenge for health and care services, now and going forward into the future.

At March 2014, the 23 GP practices in Scottish Borders recorded a total of 1,027 patients known to them as having dementia. This equates to 0.9% of all patients registered to a GP practice in Scottish Borders at the time, or 4% of all patients aged 65 and over (the majority of dementia sufferers are aged 65+). However, the number already diagnosed with dementia is only part of the picture; over and above this there will be people living with signs and symptoms of the condition, but who have not been formally identified as having it. Since 2007, the NHS in Scotland has been working to increase the number of people formally diagnosed with dementia, further to Scottish Government estimates that less than half of people with dementia were recorded as having a formal diagnosis. Numbers of diagnosed cases have been increasing, but so too have projected estimates of the total prevalence of this condition in the population. These estimates suggest that the prevalence of dementia will continue to rise across Scotland, and that in Scottish Borders the rate of increase will be faster than the national average, given the relatively higher proportion of older people in our population. Overall, the number of people with dementia may double within the next ten years.

Figure 17: Diagnosed dementia cases in Scottish Borders versus Scottish Government projections of possible overall 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.

Diabetes

Source: Scottish Diabetes Survey: www.diabetesinscotland.org.uk/Publications.aspx

At the end of 2013, 6,031 people in Scottish Borders (5.3% of the population) were registered as having diabetes. 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:-

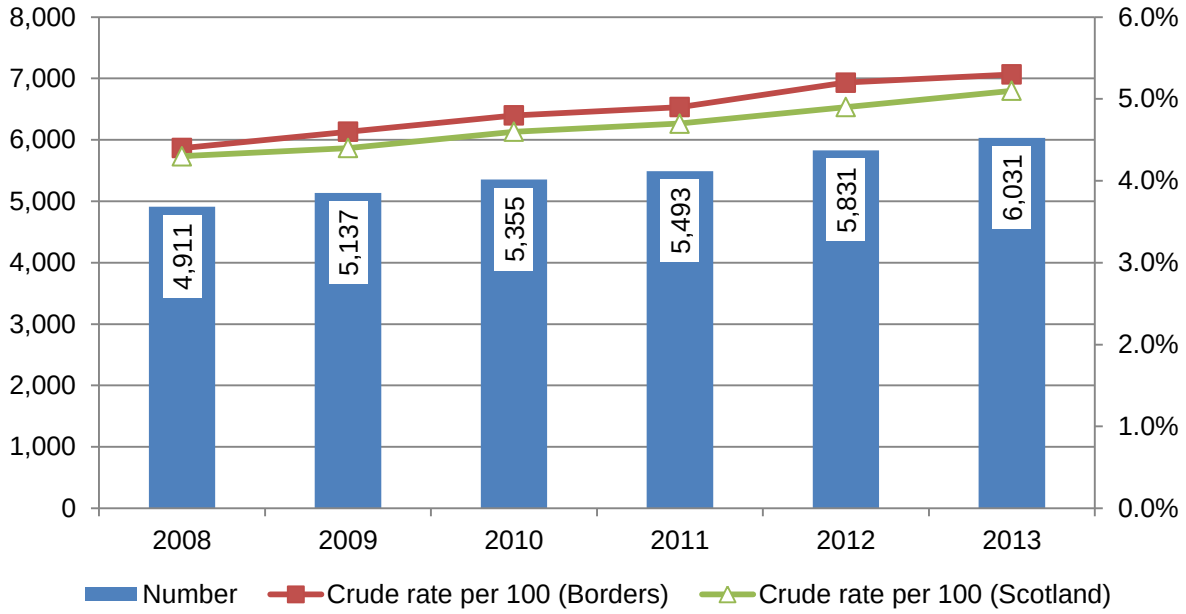
- 5,349 (88.7%) had type 2 diabetes
- 633 (10.5%) had type 1 diabetes
- 49 (0.8%) had another type of diabetes

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;
- Improved detection and management of diabetes has resulted in increased survival.

The chart below shows the rise in overall prevalence (all types, all ages) in Scottish Borders and Scotland.

Figure 18: Crude prevalence of diabetes (all types) in the Scottish Borders and Scotland 2008-2013 per 100 population (all ages)



Source: Scottish Diabetes Survey.

Learning Disability

As noted in "The Keys to Life", Scotland's learning disability strategy, people with learning disabilities have some of the poorest health of any group in Scotland. On average they die 20 years before others and some of these deaths are potentially preventable. Many of the causes of learning disabilities may also lead to physical or mental ill health. Some conditions can 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. 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.

Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require a more specialist intervention than that provided mainstream Health and Social Care services provided by the NHS and Scottish Borders Council, respectively.

As at April 2015, there are four care homes in Scottish Borders for people with learning disabilities, and nine supported living initiatives/organisations operating across Scottish Borders to support people with Learning Disabilities in their own homes.

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. Meanwhile, 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. The age and gender profile of this group is shown in the table below.

Table 12: 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%**

*For people aged 16 or 17, the count only includes those who are not in full time education.
Source: Scottish Borders Learning Disability Statistics return for March 2014

We can also use data from Scottish Borders services to illustrate the geographical distribution of our residents with Learning Disabilities. The table below shows that relatively more people with Learning Disabilities live in Eildon and Teviot & Liddesdale compared with other localities; conversely the numbers are smallest in Tweeddale. This information at locality level will be explored in more depth in later work.

Table 13: Numbers of adults* with Learning Disabilities resident in Scottish Borders and known to Scottish Borders services in 2014, by Area Forum Locality of residence

Locality (Area Forum)	Total population aged 16+ (2013)	Number of adults* with a Learning Disability	% of population aged 16+ with a Learning Disability
Berwickshire	17,556	101	0.58%
Cheviot	13,850	74	0.53%
Eildon	32,131	208	0.65%
Teviot & Liddesdale	15,697	107	0.68%
Tweeddale	15,607	65	0.42%
Scottish Borders Total	**94,841**	**555**	**0.59%**

*For people aged 16 or 17, the count only includes those who are not in full time education.
Sources: Scottish Borders Learning Disability Statistics return for March 2014, and NRS mid-year population estimates.

Mental Health

Defining "Mental Health" and "Wellbeing"

As discussed in the full 2014 Mental Health Needs Assessment prepared for Scottish Borders Council and NHS Borders, various terms around "mental health" and "wellbeing" are used and there is merit in providing definitions here:

- **Mental health problem**: This is an overarching term used to refer to a wide range of diagnosable mental illnesses and disorders, including common mental health problems of low severity and long lasting severe problems.

- **Mental illness**: This is generally used to describe more serious mental health problems which may require specialist services, ranging from depression and anxiety (often referred to as common mental problems) to less common problems such as schizophrenia and bipolar disorder (sometimes referred to as severe mental illness).

- **Mental Disorde**r: This is often used to cover a broad range of illnesses, learning disability, personality disorder and substance misuse problems. Under the 2003 Mental Health Act mental disorder was defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind' and was divided into a number of classifications. The 2007 Mental Health Act amended to a more general statement and removed specific classifications.

- **Wellbeing**: At a personal level wellbeing is "a positive physical, social and mental state". Research indicates that 'wellbeing' comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity, and engagement are characteristic of someone who has a positive experience of their life. Equally important for wellbeing is our functioning in the world. Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing.

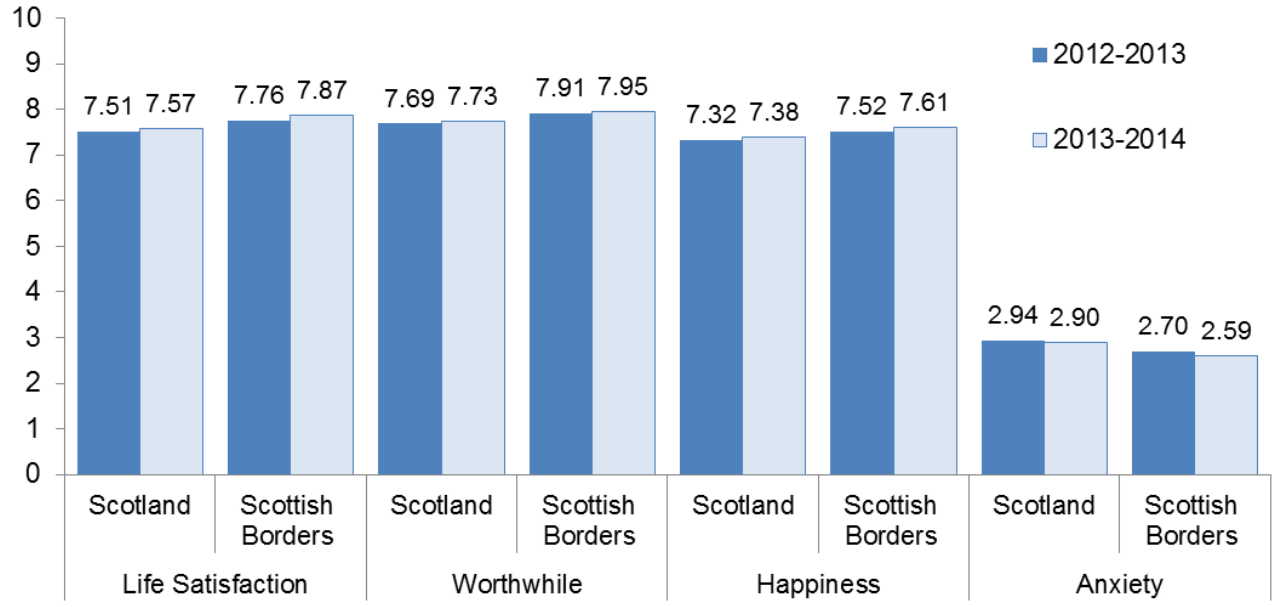
Wellbeing

As outlined above, mental wellbeing is an essential part of person's capacity to lead a satisfying life, which includes the capacity to make informed choices, study, pursue leisure interests, as well the ability to form relationships with others. The concept of 'wellbeing' has gained a wider public airing following the decision to embark on a national measurement programme developed by the Office for National Statistics (ONS), introduced in 2011. Information on levels of wellbeing is available for each Local Authority area from data in the UK Annual Population Survey, published by ONS. To assess personal well-being in the UK, the survey uses responses from approximately 165,000 people across the UK. It includes four key questions to measure well-being, which are answered on a scale from 0 (lowest) to 10 (highest). The questions are:-

- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

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 (2012/13=7.76; 2013/14=7.87), worthwhile (2012/13=7.91; 2013/14=7.95) and happiness measures (2012/13=7.52; 2013/14=7.61), whereas average levels of anxiety have seen a reduction (2012/13=2.70; 2013/14=2.59). Overall the personal well-being in the Scottish Borders appears to be better than that for Scotland.

Figure 19: Estimates of Personal Wellbeing 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.

Prevalence of Mental Health problems

At the time of the 2011 Scotland Census, 4,037 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Mental Health condition that had lasted, or would last, for at least 12 months. This equates to 3.5% of all Scottish Borders residents at that time.

Rates of self-reported long term Mental Health conditions varied by age and gender. In all adult age groups, reported rates were higher in females than males. Across both genders, however, there was a broadly shared pattern of prevalence increasing from childhood towards the 25-49 age range, then declining again to age 65-74, then increasing thereafter in the oldest age groups. This varying pattern reflects a likely mix of different types of mental health problems that people may suffer from at different ages. For example, the prevalence of dementia increases markedly with increasing age, particularly from the age of around 60 onwards. Meanwhile, there is evidence that rates of patients consulting a GP or practice nurse for depression are higher for females than males, and peak amongst females aged 25-54.

Figure 20: Scottish Borders residents identified through the 2011 Scotland Census as having Long Term Mental Health conditions; percent of population within gender and age group

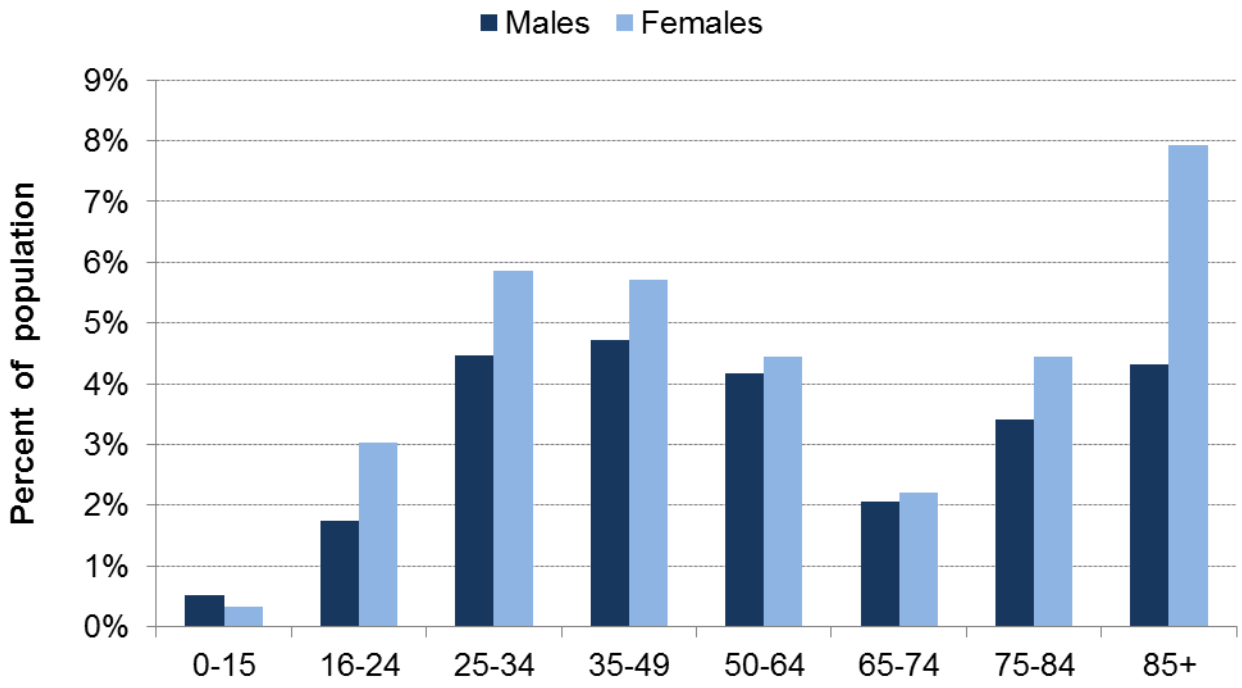
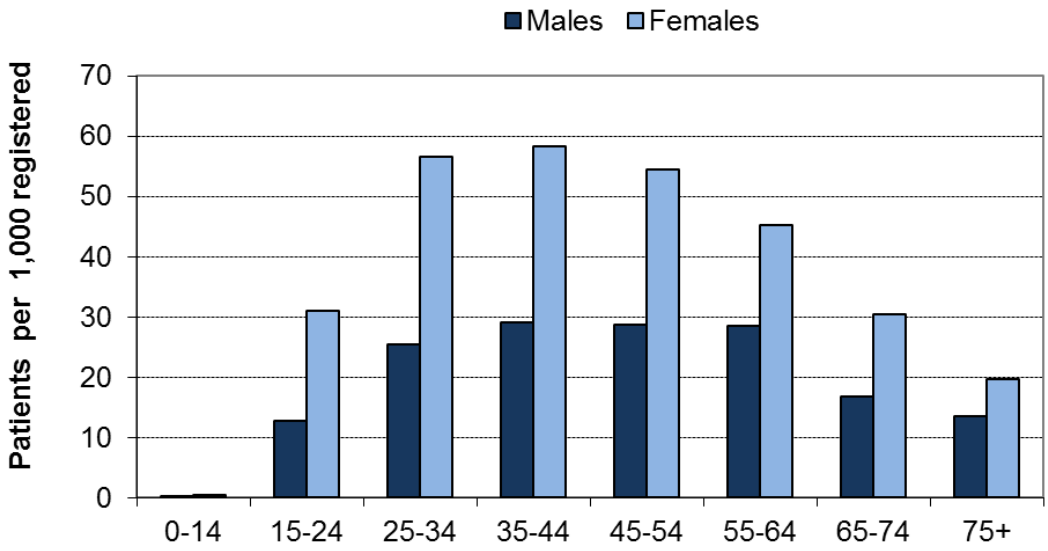


Figure 21: Depression – estimated number of patients in Scotland consulting a GP or practice nurse at least once in the financial year 2012/13, per 1,000 patients registered; by gender and age group



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

A principal source of information currently on the population prevalence of specific Mental Illnesses comes from GP practice registers, as part of the Quality and Outcomes Framework (QOF). At March 2014, the 23 GP practices in Scottish Borders recorded

- 881 patients with schizophrenia, bipolar affective disorder or other psychoses, equating to 0.8% of all patients registered to a GP practice in Scottish Borders at the time.
- 8,588 patients who had been newly diagnosed with depression since April 2010 (and with their depression not subsequently recorded by the practice as resolved). This equates to 7.4% of all patients registered to a Scottish Borders GP practice at the time.

Table 14: Numbers of patients on selected QOF registers of Scottish Borders GP practices

QOF register	Number at March 2014	Percentage of all practice patients at March 2014	Number at March 2013
Depression (cumulative register of patients newly diagnosed since April 2010 and with their depression not recorded as resolved)	8,588	7.4	7,859
Mental Health (Schizophrenia, Bipolar disorder and other psychoses)	881	0.8	873

Source: Quality and Outcomes Framework (QOF) statistics www.isdscotland.org/qof

In the year ending March 2013, an estimated 18,795 people in Scottish Borders (16.5% of the population) were prescribed drugs for anxiety, depression and/or psychoses. The Scottish Borders rate was a little higher than the Scottish average of 16.2%. (Source: ScotPHO Health and Wellbeing Profiles 2014). However, whilst prescribing data are sometimes used as a proxy for information on population prevalence of certain health conditions, there are challenges in interpreting them in the context of mental health problems. For example, the 2013 "Medicines for Mental Health" publication (ISD Scotland, 2013) notes that "Increased dispensing of drugs classified as antidepressants should be interpreted with caution; a notable proportion of these drugs are prescribed at low dose for conditions other than depression". More work is required as to whether prescribing data could be used in a more specific way in order to reasonably restrict the analysis to people who have received these drugs for a mental health problem in particular.

Obesity

Obesity occurs when a person puts on weight to the extent that it seriously endangers health. Obesity is associated with an increased risk of a number of common causes of disease and death, such as diabetes, cardiovascular disease, osteoarthritis and some types of cancer. For example, type 2 diabetes is estimated as being 13 times more likely to occur in obese women than in women of normal weight (Source: Scottish Public Health Observatory www.scotpho.org.uk/clinical-risk-factors/obesity/key-points). Being obese can impact on quality of life and/or health at any age in a person's life.

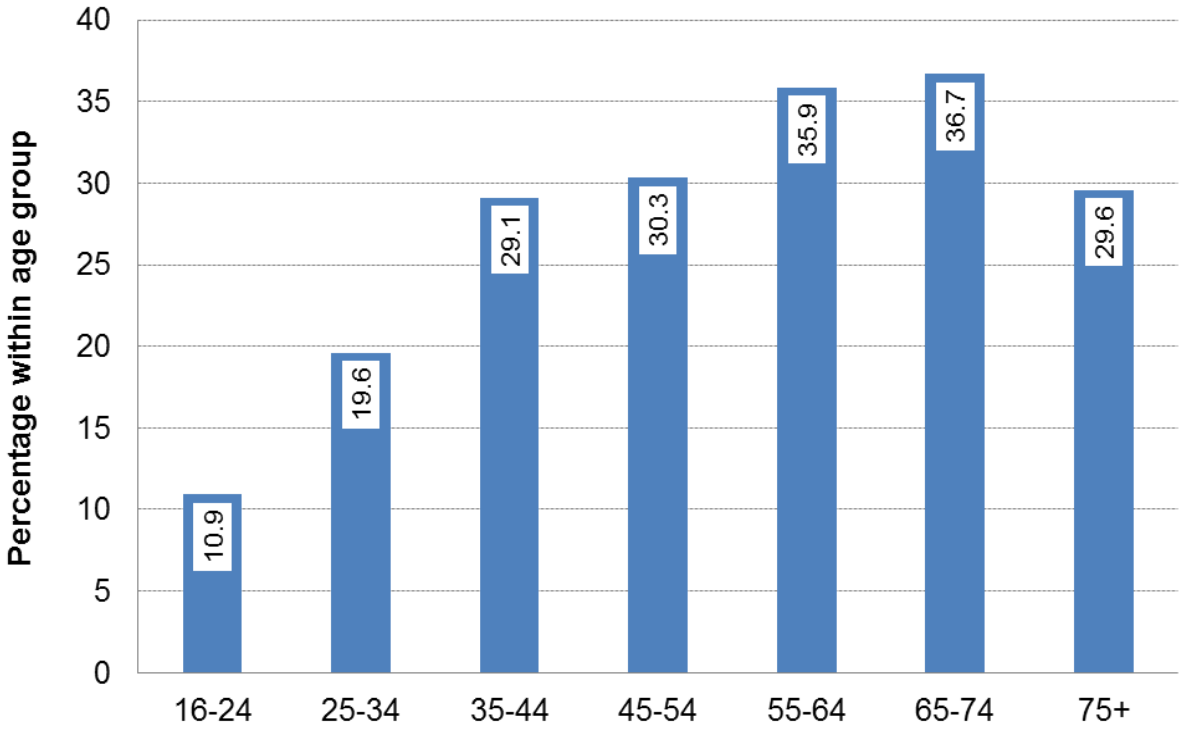
A principal source of information on the prevalence of obesity in Scotland is the Scottish Health Survey. In 2013, it was estimated that, across Scotland

- 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 graph below.

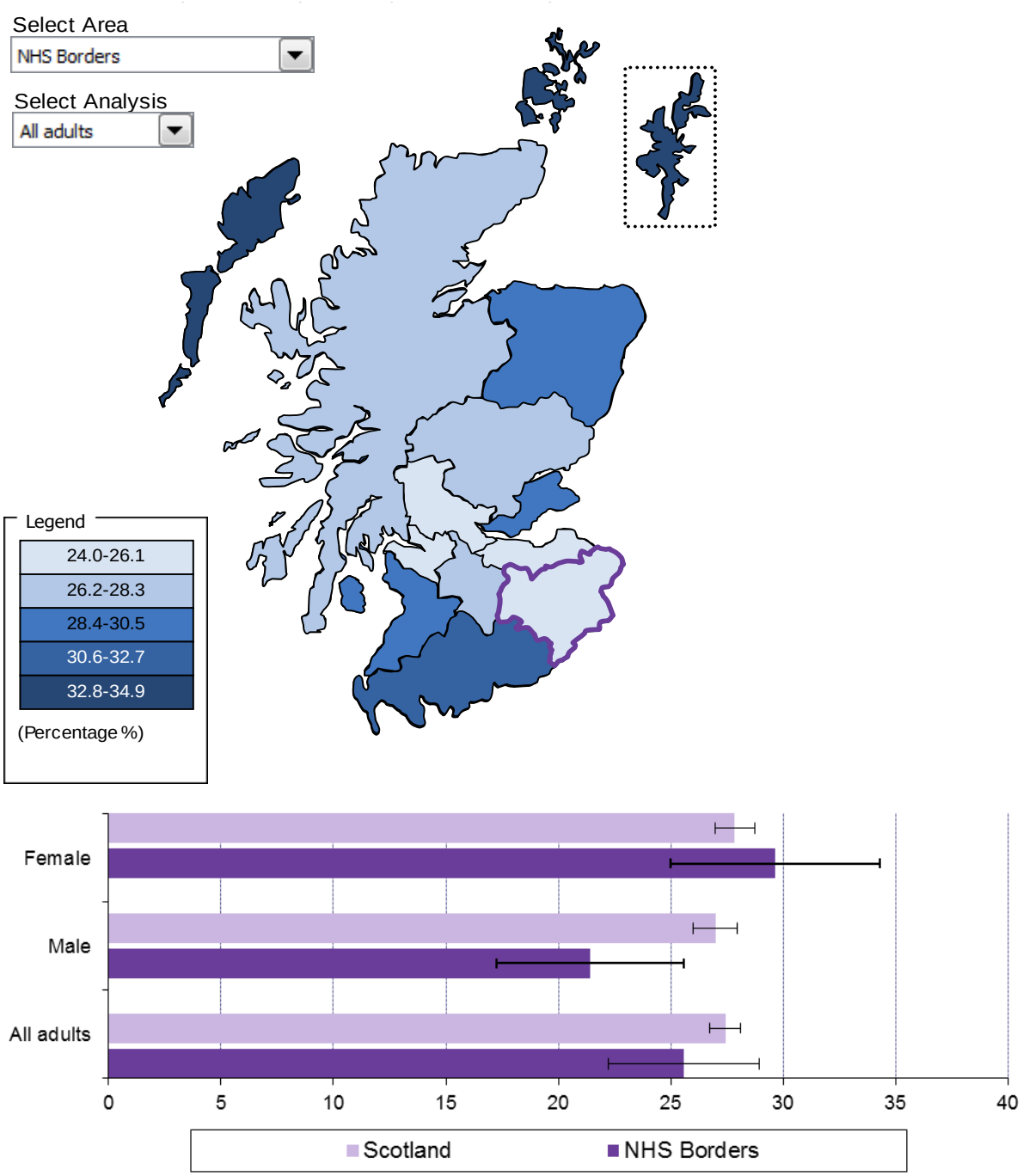
Figure 22: **Survey-based estimates of the proportions of the Scottish population who are obese (Body Mass Index of 30 or more), by age band, 2013**



Source: Scottish Health Survey Annual Report 2013
http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/scottish-health-survey

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. The map, graph and table 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. Conversely the estimates for males, and for both genders combined, were lower than for Scotland. However, none of these differences are statistically significant.

Figure 23: Survey-based estimates of the proportions of the population aged 16 and over who are obese (Body Mass Index of 30 or more), 2008-2011



Area	All people aged 16+	Males	Females
NHS Borders	25.6	21.4	29.6
Scotland	27.4	27.0	27.8

Source: Scottish Health Survey
http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/scottish-health-survey/Publications/healthboard2011

Physical 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 in the table below. Overall, of this group:-

- 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.

Table 15: Numbers of Scottish Borders residents identified through the 2011 Scotland Census as having a physical disability, by gender and age group.

Age group	Number of Males	Number of Females	Both genders combined	Number in this age group as a % of all ages	% of this age group who have a physical disability
0 to 15	87	56	143	2%	0.7%
16 to 24	62	47	109	2%	1.1%
25 to 34	102	69	171	2%	1.7%
35 to 49	404	443	847	12%	3.4%
50 to 64	948	920	1,868	27%	7.3%
65 to 74	673	729	1,402	20%	10.8%
75 to 84	629	886	1,515	22%	19.2%
85 and over	277	663	940	13%	31.7%
Scottish Borders Total	**3,182**	**3,813**	**6,995**	**100%**	**6.1%**

Source: Scotland Census 2011

These figures from the 2011 Scotland Census give us a more complete picture of potential need for services for people with physical disabilities than information on service use alone. For example, "Living Well with a Disability", published in March 2013 (before 2011 Scotland Census figures were available) noted that in 2012:-

- 5,700 people in Scottish Borders received Disability Living Allowance.
- 1,385 people aged under 65 and with a physical disability received a Social Work service (whereas the Scotland Census 2011 identified 3,138 Scottish Borders residents in this age group with a physical disability)

Table 16: Numbers of Scottish Borders residents identified through the 2011 Scotland Census as having a physical disability, by Locality of residence

Locality (Area Forum)	Total population 2011 (all ages)	Number of people with a Physical Disability (all ages)	% of population with a Physical Disability
Berwickshire	21,065	1,468	7.0%
Cheviot	18,445	1,135	6.2%
Eildon	35,284	2,048	5.8%
Teviot & Liddesdale	18,835	1,331	7.1%
Tweeddale	20,241	1,013	5.0%
Scottish Borders Total	**113,870**	**6,995**	**6.1%**

Source: Scotland Census 2011 (figures downloaded at data zone level and aggregated to "Best Fit" Localities as identified by Scottish Borders Council).

Sensory Impairment

The term 'sensory impairment' encompasses visual impairment (including people who are blind and partially sighted), hearing impairment (including those who are profoundly Deaf, deafened and hard of hearing) and dual sensory impairment (Deafblindness). Sensory impairments may be congenital (present from birth) or acquired at any age. Most sensory impairments develop gradually and are often secondary to other disabilities.

Hearing and/or sight loss can significantly impact on health and/or social care needs. For example, amongst older people, sensory impairment is a major contributory factor in falls and subsequent admission to hospital, and from there to a care home. Meanwhile, people with a learning disability are more likely than the general population to have a hearing loss, and ten times more likely to have some sight loss. This in turn can impact on how they are able to interact with other people. Hidden and/or untreated sensory loss leads to a withdrawal from social interaction and can result in consequent failure to respond appropriately to a person's needs.

Hearing Loss

Approximately one in six adults are affected by some degree of hearing loss. "See Hear", the Scottish Government's strategic framework for meeting the needs of people with a sensory impairment in Scotland (April 2014) acknowledged that this translates as around 850,000 people across the country.

The prevalence of hearing loss increases with increasing age, and the numbers of people with hearing loss is expected to rise as the projected numbers of older people in the population rises. By applying age-specific estimates of the prevalence of hearing loss in the UK to the current population profile of Scottish Borders and projected changes to the profile in future, we have calculated the following estimates:

- 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.

Sources: Prevalence rates from Sheild (2006) applied to NRS 2012-based population projections for Scottish Borders.

Many people may not notice that they are experiencing hearing loss until it becomes more pronounced, and/or they may consider it an inevitable part of growing older. This can partly explain why, for example, only around 8,500 Scottish Borders residents were identified through the 2011 Scotland census as having hearing loss, compared with the much higher estimates of likely prevalence, above.

Sight Loss

Significant sight loss is estimated to affect over 180,000 people in Scotland, equivalent to approximately one in 30 of the population. The majority are older people; it is estimated that one in five people over the age of 75 are living with sight loss, rising to one in two people aged over 90 (Success in Sight?, 2012). The "See Hear" strategic framework (Scottish Government 2014) notes that more than half of sight loss may be due to preventable or treatable causes, and over three quarters of people living with sight loss may have one or more other conditions for which they receive medical care.

As with hearing loss, the numbers of people with sight loss is expected to rise as the projected numbers of older people in the population rises. By applying age-specific estimates of the prevalence of sight loss in the UK to the current population profile of Scottish Borders and projected changes to the profile in future, we estimate that:

- 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.

Sources: Prevalence rates from Access Economics (2009) applied to NRS 2012-based population projections for Scottish Borders.

The Strategy for Sensory Services in Scottish Borders 2012-2017 notes that at the end of August 2012, there were 298 people in the Scottish Borders registered as blind and 366 as partially sighted. Of these 664 people, 149 were known to also have a hearing loss. However, registering is voluntary and people do not have to be registered to seek/receive help. The estimated figures given in the box above illustrate the likely tendency of the "registered" figures to undercount the total numbers of people in the population who may be affected by sight loss.

Deafblindness/dual sensory loss

The term Deafblind does not necessarily mean a person is totally deaf and totally blind, indeed many Deafblind people have some residual sight and/or hearing. A person is regarded as Deafblind if their combined sight and hearing loss causes difficulties with communication, access to information and mobility.

Deafblind Scotland estimate that there are approximately 5,000 people in Scotland with significant hearing and sight loss, most of whom are aged over 60 and having become dual sensory impaired as part of the ageing process. A significant cause of dual sensory loss in younger adults is Usher Syndrome, a genetic/inherited condition that affects hearing, vision and balance. http://www.deafblindscotland.org.uk/deafblindness/facts/

The Strategy for Sensory Services in Scottish Borders 2012-2017 notes that in 2012, Deafblind Scotland (the association for deafblind and dual sensory impaired adults) was aware of 26 dual sensory impaired adults living in Scottish Borders.

Other Long Term Conditions

As part of the Quality and Outcomes Framework (QOF), GP practices across the UK are funded to keep registers of all of their patients that they know to have certain health conditions. The table below shows, across all 23 GP practices in Scottish Borders, the numbers of patients included on 12 of these QOF registers.

Table 17: Numbers of patients on selected QOF registers of Scottish Borders GP practices

QOF register	Number at March 2014	Percentage of all practice patients at March 2014	Number at March 2013	Number at March 2012
Asthma	7,733	6.6	7,715	7,619
Atrial Fibrillation	2,324	2.0	2,202	2,177
CHD (Coronary Heart Disease)	5,774	5.0	5,798	5,811
CKD (Chronic Kidney Disease) (excluding people aged under 18)	4,206	3.6	4,235	4,310
COPD (Chronic Obstructive Pulmonary Disease)	2,621	2.2	2,579	2,551
Epilepsy (excluding people aged under 18)	798	0.7	799	798
Heart Failure	1,154	1.0	1,166	1,140
Hypertension	17,121	14.7	16,851	16,654
Hypothyroidism (under-active thyroid)	4,272	3.7	4,184	4,046
Peripheral Arterial Disease	1,013	0.9	N/A	N/A
Rheumatoid arthritis (excluding people aged under 16)	713	0.6	N/A	N/A
Stroke & Transient Ischaemic Attack (TIA)	3,000	2.6	2,917	2,911

Source: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof

Notes:-

- The total number of registered patients (all ages) across all 23 practices at 1st January 2014 was 116,597.
- Atrial fibrillation is a heart rhythm disorder. The QOF register definition applies to people with an initial event; paroxysmal (intermittent); persistent and permanent atrial fibrillation.
- CKD is from any cause. Inclusion in the register is based on estimated Glomerular Filtration Rate (eGFR), a measure of kidney function. Those whose kidney function is assessed at stage 3-5 based on this test are eligible for inclusion on the register.
- Peripheral Arterial Disease is a common condition where a build-up of fatty deposits in arteries restricts blood supply to leg muscles – a process called atherosclerosis. If someone has this condition, they have a much higher risk of developing other cardiovascular diseases including coronary heart disease and stroke.
- Rheumatoid arthritis is a long term condition which causes pain, swelling and stiffness in the joints. It is an autoimmune disease which means that the body's own immune system attacks the joints.

For most (nine) of the conditions listed above, a slightly higher percentage of patients in Borders practices are affected than for Scotland as a whole. However, the prevalence of many conditions is strongly related to age, and it is likely that the slightly higher apparent rates of prevalence in Scottish Borders reflects the older age profile in this area compared with Scotland as a whole. The numbers of people on each of these registers in Scottish Borders have remained relatively similar in each of the past three years, the most noticeable change being for hypertension (high blood pressure). In March 2012, there were 16,654 people on hypertension registers, but this had risen to 17,121 by March 2014. The risk of hypertension rises sharply with age and this increase over time will at least partly reflect the rising proportion of the population who are in older age groups. Unfortunately, information on the age profile of patients on QOF registers is not readily available so we cannot examine these differences in detail.

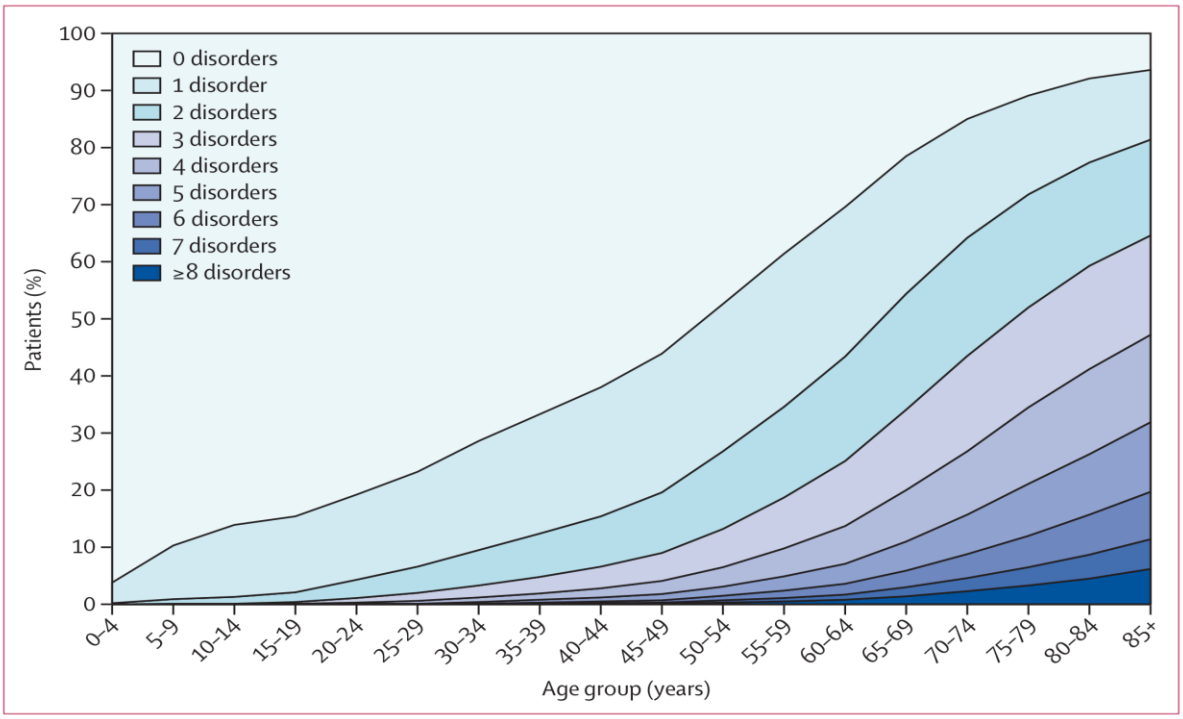
For epilepsy, hypothyroidism and peripheral arterial disease, slightly lower percentages of patients in Borders practices are affected than for Scotland as a whole. In the case of epilepsy and hypothyroidism, this is likely to reflect the age and gender profile of the Borders population. For example, hypothyroidism is more common in females than males, and rates of epilepsy, unlike those for many conditions, do not rise continuously with increasing age, but tend to decline in the oldest age groups. The small difference for peripheral arterial disease (which will be more common in older people) may be due at least in part to this being a new QOF register for 2013/14.

Multi-morbidity

Whilst long-term health problems are a significant challenge to the planning and delivery of health and social care services, even more so is "multi-morbidity", referring to people who suffer two or more long term conditions at the same time. An examination of anonymised records for over 1,750,000 GP practice patients across Scotland (Barnett et al, 2012) found that:-

- 42.2% of the patients had one or more out of a set of 40 morbidities (long term conditions rather than short-term /minor issues).
- 23.2% of the patients overall had two or more morbidities (that is, they had "multi-morbidity").
- Prevalence rates of multi-morbidity rose with age; nearly two thirds of patients aged 65-84 and more than 8 in 10 patients aged 85+ had multi-morbidity.
- Multi-morbidity can occur at any age, however, and the absolute number of people with multi-morbidity who were aged under 65 was higher than the absolute number aged 65 and over. This reflects that the total population aged under 65 is larger than the total population aged 65 and over.
- 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.
- Socioeconomic deprivation was associated with an increased prevalence of multi-morbidity that included a mental health disorder. 11.0% of people in the most deprived areas had 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).

Figure 24: Percentages of patients having one or more chronic disorders, by age group, Scotland 2007



Source: Barnett et al (2012).

High Resource Individuals

Health and Social Care resources are not utilised evenly across the population. As a Partnership, we need to develop a better understanding about the people who use very high levels of resource and use this knowledge to help plan our services. For example, where someone has had multiple hospital admissions and/or visits to A&E, it might have been more appropriate to deliver more of their care at home or in another community setting and reduce the risk of them having an avoidable admission to hospital. Changes in how care is provided to these people could produce better outcomes for them and allow us to treat more people more effectively.

To date, it has been possible to analyse money spent per patient across the following major health services:-

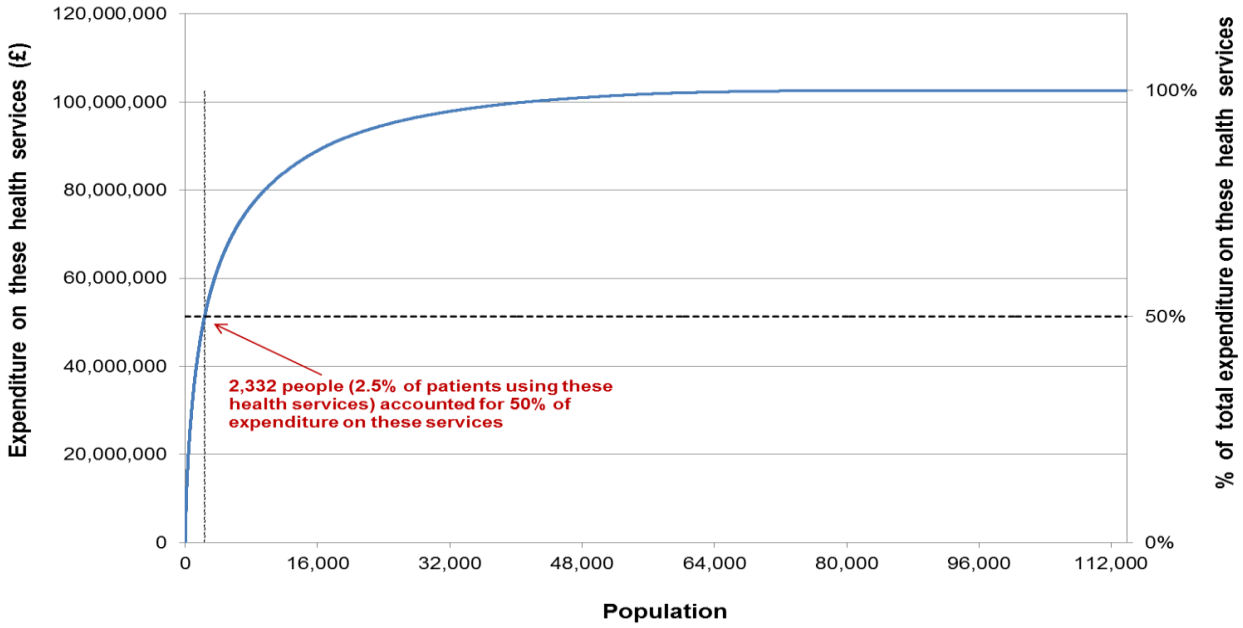
- Inpatient and day case hospital admissions (including all acute specialties, maternity, geriatric long stay inpatient care, and psychiatric inpatient care)
- A&E attendances
- New attendances at consultant-led outpatient clinics
- Community prescribing

"High Resource Individuals" (HRIs) are defined as the group of people who between them account for 50% of total expenditure. From analysis of expenditure in 2012/13, it has been identified that:-

- 2,332 people (2.5% of all Scottish Borders residents using any of these health services) accounted for half of all expenditure on this group of major health services.
- 1,451 people aged 65 and over (7% of Scottish Borders residents in this age group, who used any of these health services) accounted for half all expenditure on the over 65s across those services.

Future work is planned to include additional services in this analysis, as health and social care information is integrated and more becomes available at individual patient/service user level. This will allow us to look in more detail at the combinations of services that HRIs use and to examine where we could improve pathways of care. However, the information already available to us can give us some useful insights, as exampled below.

Figure 25: Cumulative expenditure for selected major health services*; for Scottish Borders residents; financial year 2012/13



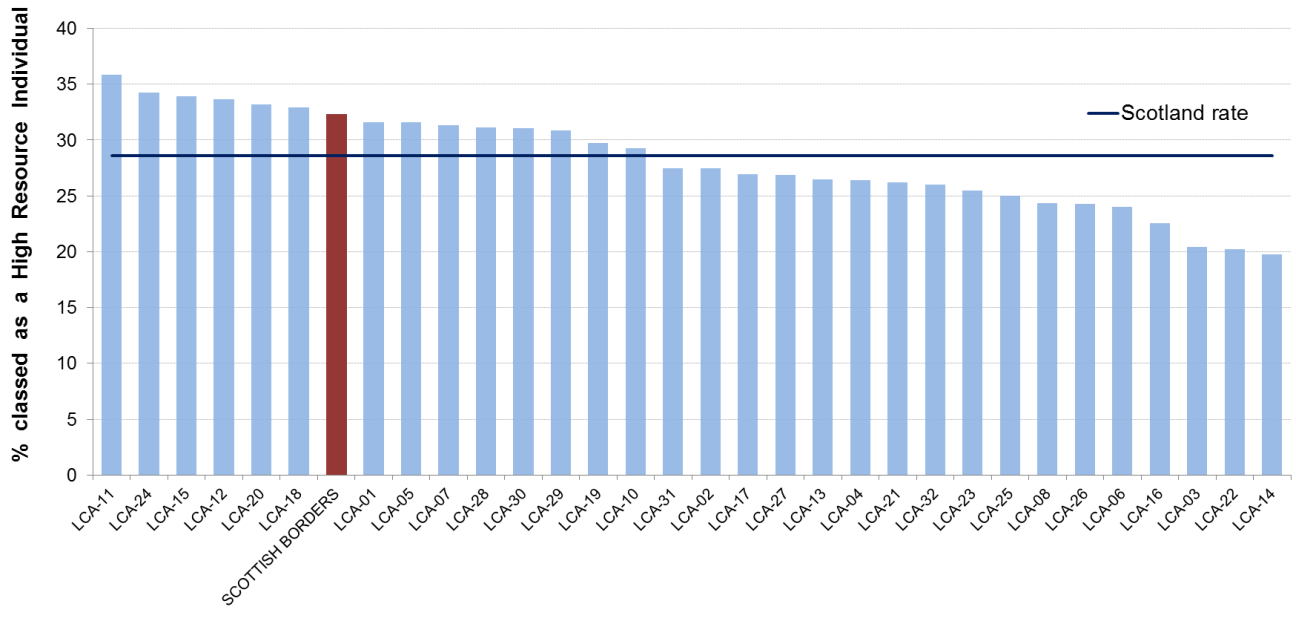
*Health Services included are: inpatient and day case hospital care, A&E attendances, new attendances at consultant-led outpatient clinics, and community prescribing.
Source: Integrated Resource Framework (IRF) developmental analysis, ISD, NHS National Services Scotland.

Analysis of the cost and activity data for these major health services illustrates something of the relationship between Long Term Conditions and the likelihood of being a High Resource Individual. Historical inpatient and day case data were analysed to find any previous record of any of the following long term conditions: CHD, COPD, Cerebrovascular disease, Dementia, Diabetes, Heart Failure, and Renal Failure. The results of this exploratory analysis indicated that, amongst Scottish Borders residents who had used one or more of these health services in 2012/13:-

- 19% of patients with two or more of the selected LTCs were classed as High Resource Individuals (HRIs).
- 8.5% of patients who had a single one of these LTCs were classed as HRIs.
- Amongst patients with none of these LTCs, only 1% were classed as HRIs.

We know that dementia presents a significant challenge for health and care services, now and for the future. In 2012/13, amongst patients aged 65+ who had a previous record of hospital admission for dementia, nearly one third (32%) of them were classed as High Resource Individuals. This is higher than the Scottish average (29%) and most other Scottish Local Authority areas, as shown in the graph below.

Figure 26: People aged 65+ with previous record of hospital admission for dementia; variations by Local Authority area in the percentage classed as High Resource Individuals*



*HRIs in relation to overall spend on the following major Health Services: inpatient and day case hospital care, A&E attendances, new attendances at consultant-led outpatient clinics, and community prescribing.

Source: Integrated Resource Framework (IRF) developmental analysis, ISD, NHS National Services Scotland.

Behaviours / Risk Factors

Alcohol

Alcohol problems are a major concern for public health in Scotland. Although drinking in moderation can have beneficial effects for some groups of people, such as protection against coronary heart disease in middle-aged men, excessive alcohol consumption can lead to a range of health and social problems. Short-term problems such as intoxication can lead to risk of injury and is associated with violence and social disorder. Over the longer term, excessive consumption can cause irreversible damage to parts of the body such as the liver and brain. Alcohol can also lead to mental health problems, for example, alcohol dependency and increased risk of suicide. In addition, alcohol is recognised as a contributory factor in many other diseases including cancer, stroke and heart disease. Wider social problems include family disruption, absenteeism from work and financial difficulties. In 2006/07, alcohol problems were estimated to cost Scotland over £2.25 billion.

The UK government have produced sensible drinking guidelines based on units of alcohol. Concern about certain patterns of drinking, such as drinking excessively on one occasion, led to a change from weekly limits to daily benchmarks. Current daily benchmarks are 3-4 units for men and 2-3 units for women, with two alcohol free days per week.

Source of the above paragraphs: Scottish Public Health Observatory (ScotPHO) website (accessed May 2015) www.scotpho.org.uk/behaviour/alcohol/introduction.

- In Scottish Borders, similarly to Scotland as a whole, results of the Scottish Health Survey 2008-2011 suggest that 43% of the adult population drink outwith recommended guidelines (meaning that they drink more in a day/week than the recommended limits).

- An estimated 9% of Scottish Borders residents aged 16+ may have a drinking problem, compared with 12% for Scotland as a whole.

- In the year ending March 2014, there were 632 alcohol-related hospital stays in Scottish Borders. This translates as an age-standardised rate of 566 stays per 100,000 population, lower than the Scottish average of 697 stays per 100,000 population.

- It has been calculated that 983 attendances at A&E in Scottish Borders (9% of all A&E attendances) in 2013/14 had alcohol as a contributing factor.

- In 2013, there were 16 alcohol-related deaths in Scottish Borders, translating as an age-standardised rate of 13 deaths per 100,000 population, lower than the Scottish average of 21 deaths per 100,0000.

Sources:

ScotPHO Alcohol Profile 2014 (accessed May 2015) www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

Scottish Borders Alcohol & Drugs Partnership Strategy 2015-2020; Draft for consultation http://www.badp.scot.nhs.uk/__data/assets/pdf_file/0010/19855/ADP-Strategy.pdf

Drugs

The illicit use of drugs and particularly opiates, benzodiazepines and psychostimulants, causes significant problems within Scotland as it does in other parts of the UK and Europe. Some of these problems are primarily social in nature, involving, for example, increases in acquisitive crime, prostitution, unemployment, family breakdown and homelessness. Others are more clearly associated with health problems, for example, the transmission of communicable diseases (HIV, hepatitis), injecting related injuries and increased demands upon health care services.

Source of the above paragraph: Scottish Public Health Observatory (ScotPHO) website (accessed May 2015) http://www.scotpho.org.uk/behaviour/drugs/introduction.

- An estimated 1% of the adult population in Scottish Borders have a problem with drug use, a little lower than the 1.7% across Scotland as a whole.

- In the year ending March 2014, there were 74 alcohol-related hospital stays in Scottish Borders. This translates as an age-standardised rate of 83 stays per 100,000 population, lower than the Scottish average of 125 stays per 100,000 population.

- In 2013, there were 8 drug-related deaths in Scottish Borders, translating as an age-standardised rate of 9 deaths per 100,000 population, slightly lower than the Scottish average of 10 deaths per 100,0000.

ScotPHO Drug Profile 2014 (accessed May 2015) www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

Smoking

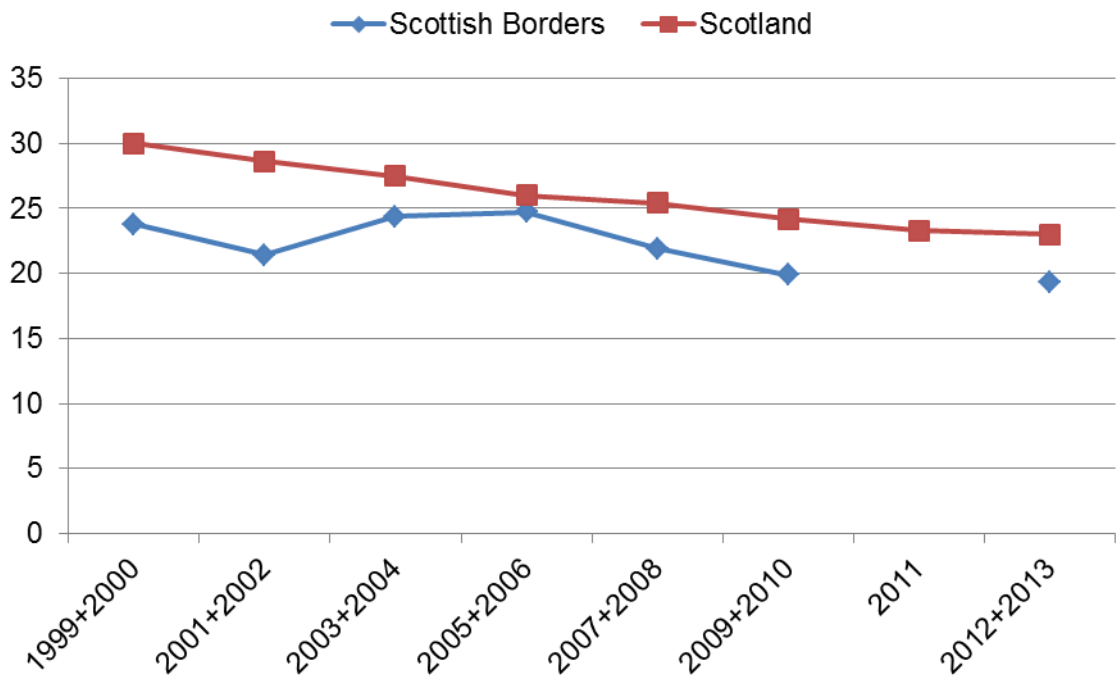
Results from the annual Scottish Household Survey indicate a gradual decline over recent years in the prevalence of smoking in Scotland. The overall percentage of the Scottish Borders adult population who smoke appears to have been consistently lower than the average for Scotland. For example, in the two years 2012-2013, an estimated 19.3% of Scottish Borders residents aged 16 and over smoked, compared with 23.0% for Scotland as a whole. The relationship is not consistent by age, however. 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. Taking account of the age profile of Scottish Borders, the area has, in comparison with Scotland:-

- A lower incidence (new cases) of lung cancer and COPD (Coronary Obstructive Pulmonary Disease);
- A lower rate of hospital admissions for illnesses that are attributable to smoking;
- A lower rate of deaths from lung cancer, COPD and smoking-attributable causes overall.

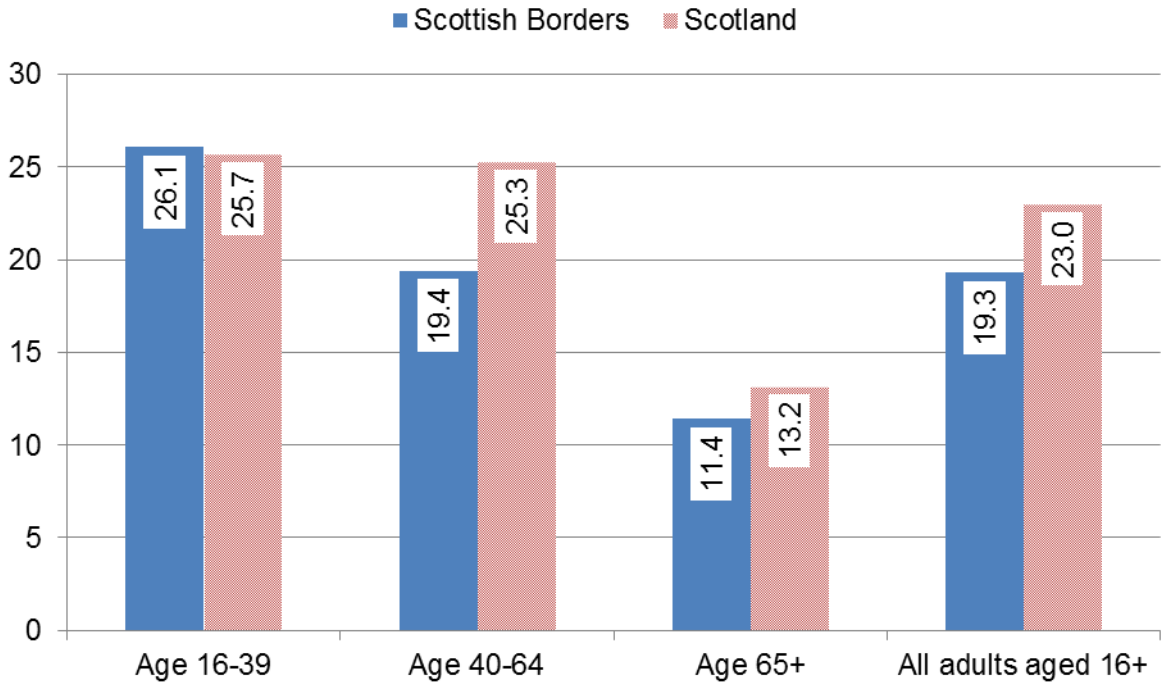
In contrast, the rate of smoking amongst pregnant women in Borders appears to be higher than for Scotland (source: ScotPHO Tobacco Control Profiles 2015). In the three years 2010-2012 combined, just under one in four (24.9%) of pregnant women in Borders were recorded as being smokers at the time of their first ante-natal appointment, compared with an average of around one in five (20.1%) across Scotland.

Figure 27: Trends in percentage of adults aged 16+ who smoked; Scottish Household Survey results from 1999 to 2013



Sources: ScotPHO Tobacco Control Profiles published January 2015, and Scottish Household Survey.

Figure 28: Proportion of Scottish Household Survey respondents who smoked, by age band, 2012+2013



Source: ScotPHO tobacco control profiles published January 2015.

Table 18: Age-standardised rates per 100,000 population of smoking-related illness and mortality, Scottish Borders versus Scotland

Measure	Calendar years	Scottish Borders	Scotland
Smoking attributable deaths (people aged 35+)	2012-2013	276.6	325.4
Lung cancer deaths (people aged 16+)	2011-2013	84.8	107.1
COPD deaths (aged 16+)	2011-2013	58.1	77.9
Smoking attributable admissions (people aged 16+)	2011-2013	2,531.4	3,149.4
Lung cancer registrations (people aged 16+)	2010-2012	106.0	133.3
COPD "incidence" (first hospital admission for COPD within 5 years) (people aged 16+)	2011-2013	303.6	391.1

Source: ScotPHO Tobacco Control Profiles published January 2015.

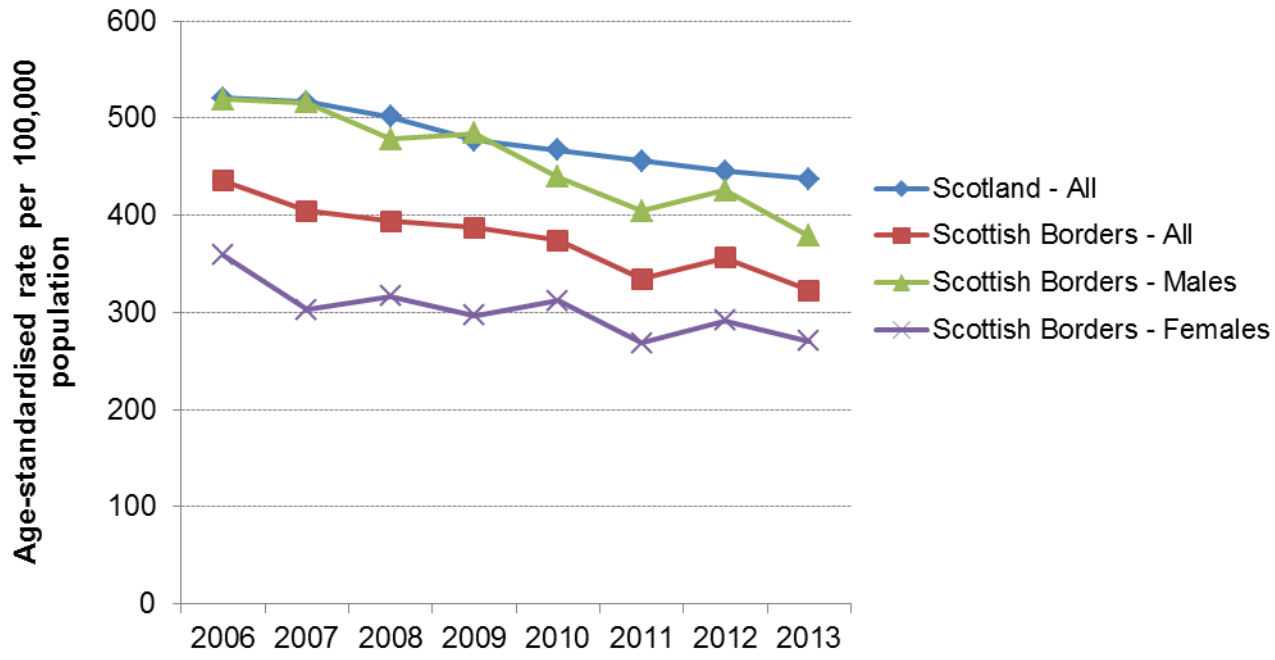
Mortality

Premature mortality

Premature mortality is an important indicator of the overall health of the population. Whilst death rates amongst people aged under 75 years have been decreasing in Scotland, more than 20,000 people aged under 75 still die each year. In Scottish Borders there were 377 deaths in 2013 amongst people in this age group.

In Scottish Borders, age-standardised mortality rates in the under 75s are also decreasing over time and have remained consistently lower overall than those for Scotland. This may at least in part be due to relatively lower levels of deprivation in Borders compared with Scotland as a whole, as premature mortality is more common in deprived areas.

Figure 29: Age-standardised death rates amongst people aged under 75, years 2006 to 2013.



Source: National Records of Scotland.

Table 19: Age-standardised death rates (per 100,000 population) amongst people aged under 75, years 2006 and 2013.

Area and Gender Group	2006	2013
Scotland - All	520	438
Scottish Borders - All	435	323
Scotland - Males	648	533
Scottish Borders - Males	520	379
Scotland - Females	405	349
Scottish Borders - Females	359	270

Source: National Records of Scotland.

In Scottish Borders, as in Scotland as a whole, premature mortality rates for males are noticeably higher than for females. In 2013:-

- 31% of deaths overall were amongst people aged under 75 (lower than the 37% average for Scotland);
- 35% of male deaths were for boys/men aged under 75;
- 26% of female deaths were for girls/women aged under 75.

Whilst age-standardised rates of premature mortality in Scottish Borders, overall and gender-specific, continue to be lower than those for Scotland overall, there may still be scope to deliver further improvements in the medium and long term.

Table 20: Deaths amongst people aged under 75 and 75+, 2013

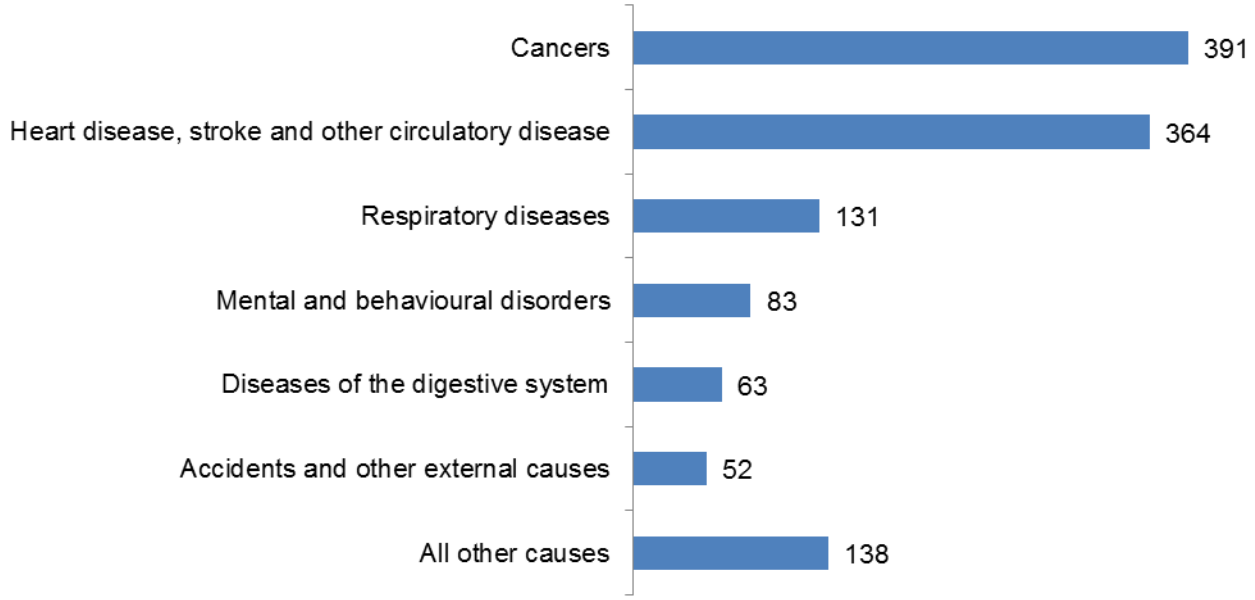
	Number of deaths (all ages)	Number of deaths - aged under 75	Percentage of deaths - aged under 75	Number of deaths - aged 75+	Percentage of deaths - aged 75+
Scottish Borders All	1,222	377	31%	845	69%
Scottish Borders Males	606	215	35%	391	65%
Scottish Borders Females	616	162	26%	454	74%
Scotland All	54,700	20,344	37%	34,356	63%
Scotland Males	26,325	11,906	45%	14,419	55%
Scotland Females	28,375	8,438	30%	19,937	70%

Source: National Records of Scotland.

Cause of death

In 2013, there were 1,222 registered deaths in Scottish Borders (across all age groups). Cancer, heart disease and stroke remain major causes of death: 32% of deaths were due to cancer, 30% to heart disease, stroke or other circulatory disease.

Figure 30: Numbers of deaths in Scottish Borders (all ages) by cause, 2013



Source: National Records of Scotland.

Table 21: Numbers and percentages of deaths in Scottish Borders (all ages) by cause, 2013

Cause of death	Number of deaths	Percentage of deaths
Cancers	391	32%
Heart disease, stroke and other circulatory disease	364	30%
Respiratory diseases	131	11%
Mental and behavioural disorders	83	7%
Diseases of the digestive system	63	5%
Accidents and other external causes	52	4%
All other causes	138	11%
Total	**1,222**	**100%**

Source: National Records of Scotland.

Carers

Overview

Unpaid carers are people who provide care and support to family members, other relatives, friends and neighbours. The people they care for may be affected by disability, physical or mental health issues (often long-term), frailty, substance misuse or some other condition. Anybody can become a carer at any time in their life and sometimes for more than one person at a time. Carers can be any age from young children to very elderly people. Some carers provide very intensive amounts of support for the person or people they look after, whilst for others it may be a case of helping someone for short periods of time. Some carers are life-long carers, while others may care for shorter periods of time. A carer does not need to be living with the person they care for to be considered a carer. Carers are not paid workers although some can receive payment for part of their time caring (for example through Carer's Allowance).

The numbers of unpaid carers in each Local Authority area are difficult to identify exactly. 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 (Source: Scottish Health Survey 2008-2011 results by NHS Board). 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).

- It is also possible that the total number of carers aged 16+ may be higher than this, perhaps even as high as 15,000-16,000. This is based on Scotland-level estimates from the Scottish Health Survey 2012/13 of 17% of all people aged 16+ having a Carer responsibility.

- 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 Census figures are acknowledged as under-counting the total numbers of carers in the population, particularly young carers and/or people who provide smaller amounts of care each week. They are, however, felt to provide good estimates of the numbers of people who provide substantial levels of care and support each week, particularly those providing 35 or more hours. Census data are also available for small geographies, whereas the Scottish Health Survey data, which are gathered from a sample of a few thousand people across Scotland, are mainly available at National level.

The report “Scotland’s Carers”, published by the Scottish Government in March 2015, summarises some of the main reasons why it can be difficult to identify people who are carers:-

- Often people providing care do not self-identify as a carer or with the term because they see their relationship is as a relative, maybe a child, or friend to which the caring activities are an integral dimension.
- Women are more likely than men to view tasks as integral to their existing role rather than as separate “caring”.
- Often caring commences at a low level and can include “invisible tasks” such as giving the cared for person; “emotional support, monitoring their situation and worrying about them” which are less recognised that the tangible caring tasks. More people come to identify as a carer when caring intensifies, which is common, and at key junctures such as giving up employment to care.
- Acceptance of the identity of care necessitates acknowledgement that the other person needs care, which can be difficult for one or both parties to do.

The “Scotland’s Carers” report also summarises some of the reasons why the estimated numbers of Carers as generated from the Scottish Health Survey are typically higher than the counts of Carers as gathered via the Scotland Census:-

- The question asked in both cases is the same -“Do you look after, or give any help or support to family members, friends, neighbours or others because of either long-term physical / mental ill-health / disability; or problems related to old age? (Do not count anything you do as part of your paid employment)” – but the Census returns are completed postally or online, whereas the Scottish Health Survey results are collected via interviews.

- In the Scottish Health Survey, each adult in the household is personally asked the carers’ question. Therefore each adult speaks directly to the interviewer and says whether they provide care and how many hours a week. They can ask for clarification if they don’t understand the question, but there is not this same opportunity with the Census.

- In Scotland’s 2011 Census, it may be the case that one person will answer the questionnaire for the whole household. This person may not be aware of caring activity going on elsewhere in the household or may feel uncomfortable explaining that someone else in the household provides care for them.

- The Scottish Health Survey question is asked as part of a detailed health survey and follows a block of questions about long-term conditions, which means that people will be thinking more about health and care issues when they answer the question.

- The Scottish Health Survey has an additional category asking if people provide care for up to 4 hours each week, whereas the first category in Scotland’s 2011 census is “up to 19 hours of care” a week. It may be that the large number of hours in the Census category deters people who only provide a small amount of care from answering.

Characteristics of Carers

Whilst the Scotland Census is acknowledged to under-count the number of people who provide unpaid care to others, nonetheless the results from it can still provide some useful information on the characteristics of carers. The patterns for Scottish Borders, outlined below, are very similar to those seen across Scotland.

- Females are more likely than males to report that they have carer responsibilities. 2011 Census results indicated that 59% of unpaid carers in Scottish Borders were female and 41% were male.

- 16% of the population aged 50-64 reported that they had carer responsibilities, a higher proportion than any other age group.

- 46% of carers living in the most deprived areas provide 35 or more hours of unpaid care per week, compared with 22% of carers living in the least deprived areas.

- The percentages of carers rating their own health as bad or very bad increased with increasing 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.

- 42% of people identified as unpaid carers had one or more long term conditions or health problems themselves, compared with 29% of people who did not provide any unpaid care. The prevalence of long-term conditions rose with increasing intensity of unpaid care provision. 36% of people providing less than 20 hours of unpaid care per week were also reported to have a long term condition themselves; this rose to 51% of people providing more than 35 hours of care per week.

- 12.4% of people reported as having a physical disability also provided unpaid care for somebody else.

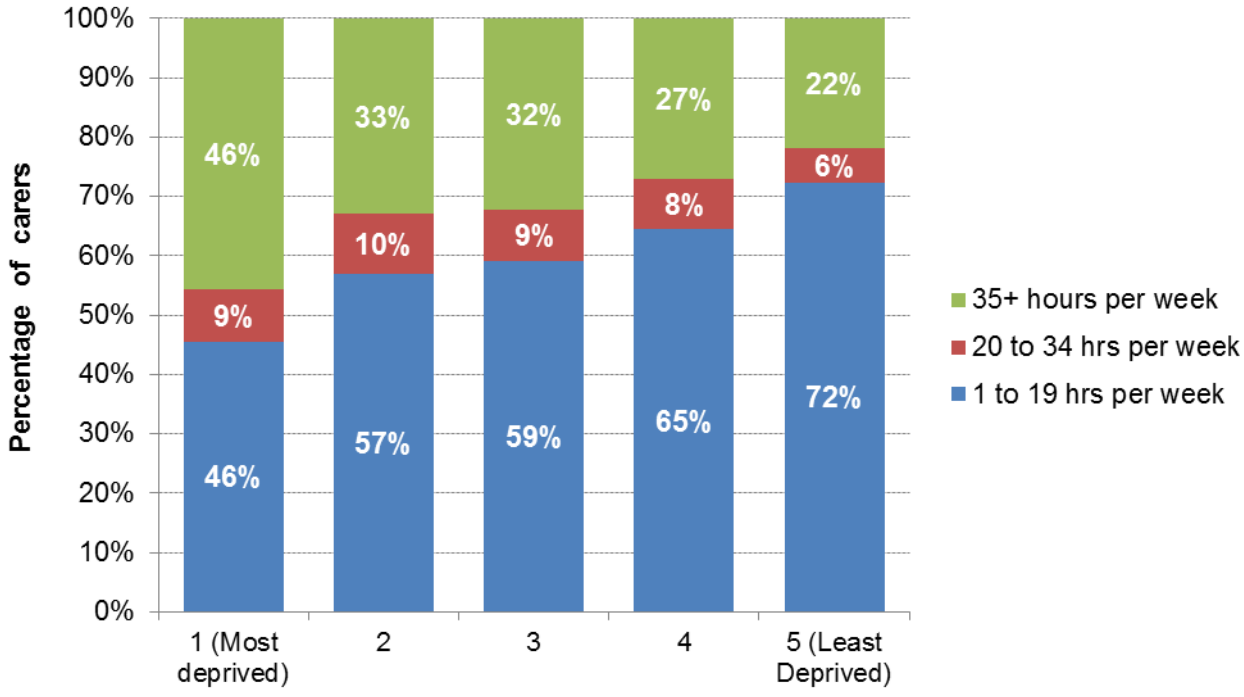
- 13.4% of people with a long term mental health problem also provided unpaid care for somebody else. Overall, a higher proportion of carers (5%) than non-carers (3%) reported that they had a long term mental health problem; differences were largely in the younger age groups (under 50).

Table 22: Numbers of Scottish Borders residents identified through the 2011 Scotland Census as providing unpaid care, by gender and age group.

Age group*	Number of Males	Number of Females	Both genders combined	Number of carers in this age group as a percentage of all ages	Percentage of population in this age group who provided unpaid care
0 to 15*	86	101	187	2%	1%
16 to 24	175	246	421	4%	4%
25 to 34	249	359	608	6%	6%
35 to 49	1,074	1,702	2,776	27%	11%
50 to 64	1,618	2,416	4,034	39%	16%
65 and over	1,039	1,281	2,320	22%	10%
Totals	**4,241**	**6,105**	**10,346**	**100%**	9%

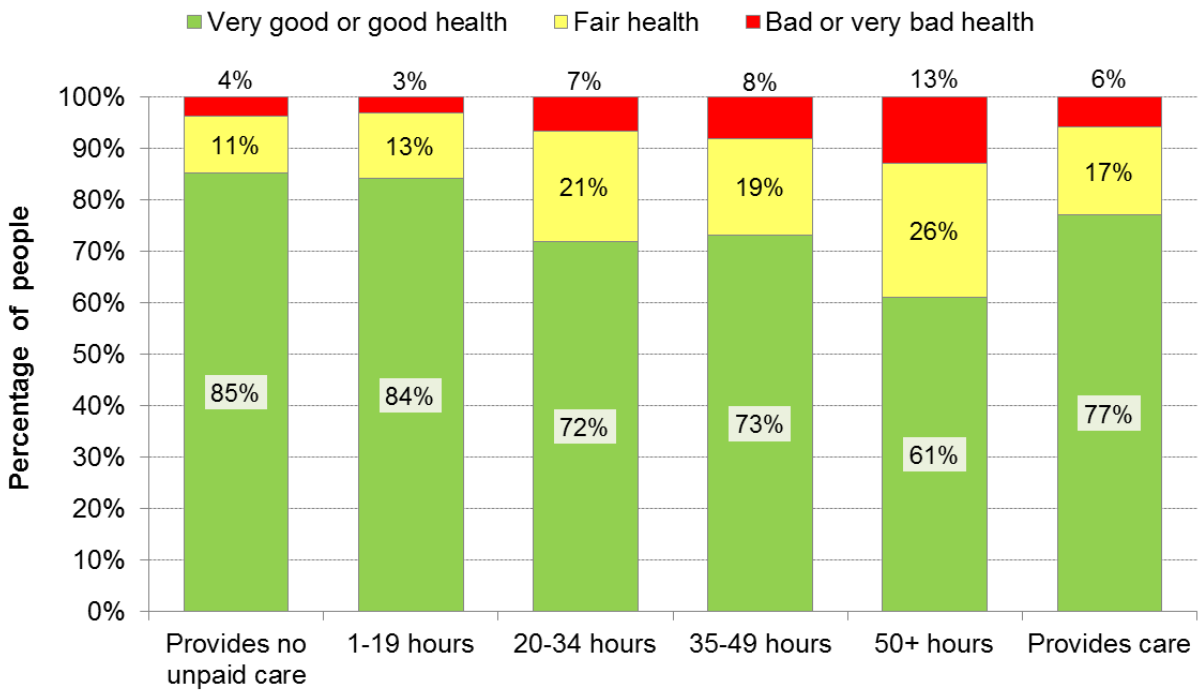
Source: Scotland Census 2011. *Figures are likely to be undercounts of the total numbers of carers in Scottish Borders, particularly children.

Figure 31: Intensity of caring amongst Scottish Borders residents in each deprivation quintile



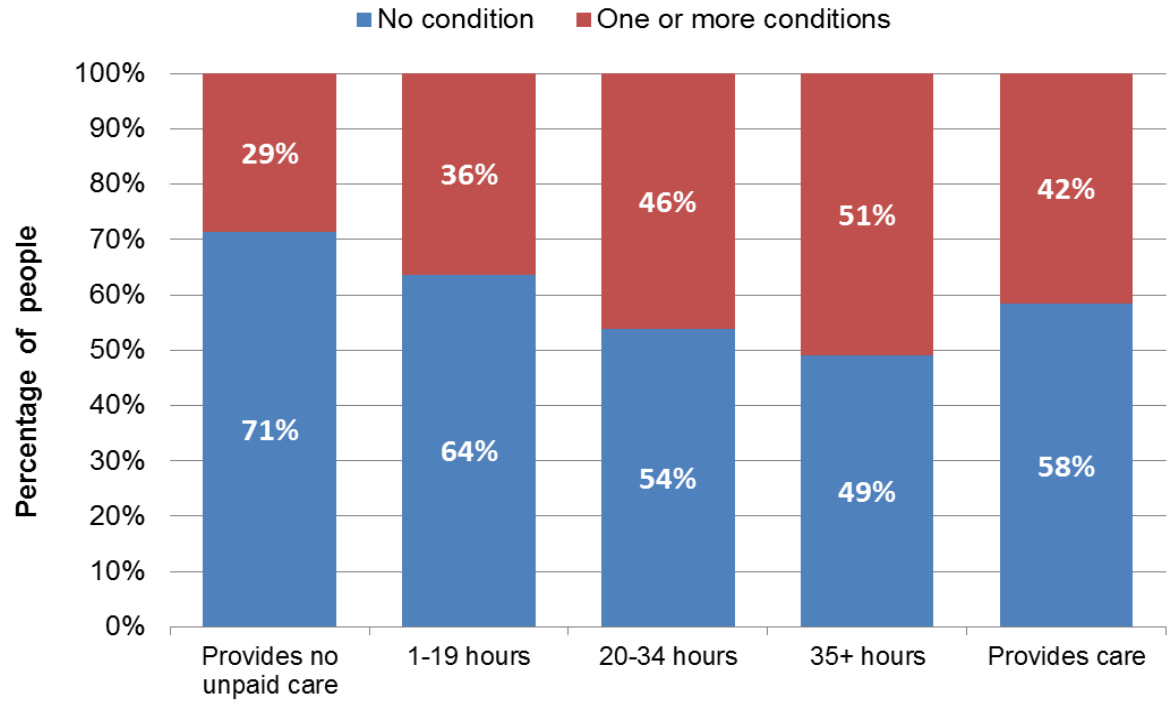
Sources: Scotland Census 2011 and Scottish Index of Multiple Deprivation (SIMD)

Figure 32: Self-reported general health amongst Scottish Borders residents, 2011, by weekly hours of unpaid care they provided



Source: Scotland Census 2011 / Scotland's Carers (Scottish Government, March 2015).

Figure 33: Percentage of carers with one or more long-term health conditions, 2011, by weekly hours of unpaid care they provided



Source: Scotland Census 2011 / Scotland's Carers (Scottish Government, March 2015).

We can also use data from the Scotland Census to indicate the minimum numbers of Carers resident in each of five Localities within Scottish Borders, and something of the geographical variation in the number and percent of residents who have carer responsibilities. This information at locality level will be explored in more depth in later work.

Table 23: Numbers of Scottish Borders residents identified through the 2011 Scotland Census as providing unpaid care, by Locality of residence

Locality (Area Forum)	Total population 2011 (all ages)	Number providing unpaid care	% Providing Unpaid Care	Minimum % for an individual data zone within this area	Maximum % for an individual data zone within this area
Berwickshire	21,065	2,104	10.0%	7.5%	12.3%
Cheviot	18,445	1,655	9.0%	7.5%	13.9%
Eildon	35,284	3,102	8.8%	6.7%	11.1%
Teviot & Liddesdale	18,835	1,644	8.7%	6.7%	10.7%
Tweeddale	20,241	1,841	9.1%	6.3%	11.5%
Scottish Borders Total	**113,870**	**10,346**	**9.1%**	**6.3%**	**13.9%**

Source: Scotland Census 2011 (figures downloaded at data zone level and aggregated to "Best Fit" Localities as identified by Scottish Borders Council).

Experience of Carers

The national Health and Care Experience Survey 2013/14 is a useful source of information on the experiences of people aged 16+ who provide unpaid care. Although the numbers of people included in the survey are relatively small, the survey design (it was sent to a random sample of people aged 16+ registered at each GP practice in Scotland) means that the results provide a good overview of the experiences of carers in each NHS Board and Local Authority area. In Scottish Borders, 2,467 survey respondents answered the question on carer responsibilities, and out of this group, 14% (342 people) indicated that they did provide unpaid care. This is a similar finding to the results of the Scotland Census and Scottish Health Survey.

The results of the Health and Care Experience Survey 2013/14 indicate clearly that there is scope for improving the situation for Carers in Scottish Borders. Findings included:-

- 30% of the Carers felt that caring had a negative impact on their own health and wellbeing; only 42% disagreed that there was any impact on them (the remaining 27% neither agreed nor disagreed).

- Only 41% agreed that they felt supported to continue in their caring role, lower again that the Scottish average of 44%.

- Whilst 54% felt they had a say in the services provided for the person(s) they looked after (better than the Scottish average of 49%), 20% disagreed (the remaining 27% neither agreed nor disagreed).

- Only 44% felt that the services for the person(s) they looked after were well co-ordinated, compared with 48% nationally.

Figure 34: Experiences of a sample of carers in Scottish Borders, 2013/14

Question	Number of responses	Response: Very positive	Positive	Neutral	Negative	Borders % Positive 2014	Scotland % positive 2014
Q45a. I have a good balance between caring and other things in my life.	337	24%	44%	20%	12%	68	70
Q45b. I am still able to spend enough time with people I want to spend time with.	332	22%	49%	16%	13%	71	72
Q45c. Caring has had a negative impact on my health and wellbeing.	324	14%	29%	27%	30%	42	42
Q45d. I have a say in services provided for the person I look after.	307	13%	41%	27%	20%	54	49
Q45e. Services are well coordinated for the person(s) I look after.	304	14%	30%	39%	17%	44	48
Q54f. I feel supported to continue caring.	306	11%	31%	41%	18%	41	44

Explanation of graph:-
Number of responses - the number of survey respondents in Scottish Borders who provided a valid response to this question. People who indicated that a question was not relevant to them, or who did not know the answer, are not included in the results.
Response - The percentage of positive, neutral and negative responses received for this question within Scottish Borders. For example, when asked if they felt supported to continue caring, the percentage positive refers to carers who strongly agreed or agreed. Where carers said they disagreed or strongly disagreed these responses have been counted as negative. Where they neither agreed nor disagreed their responses have been counted as neutral. Some questions in the survey are negatively phrased. For example, when asked if they felt that "Caring has had a negative impact on my health and wellbeing", the percentage positive refers to carers who DISAGREED or STRONGLY DISAGREED, that is they did not feel that their caring responsibilities had a negative impact.
Borders % Positive 2014 - the percent positive result; the total percentage of patients who responded positively (very positive + positive) to this question within Scottish Borders.

Source: Health and Care Experience Survey 2013/14, www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

Current Services

A snapshot of some of our care-providing premises

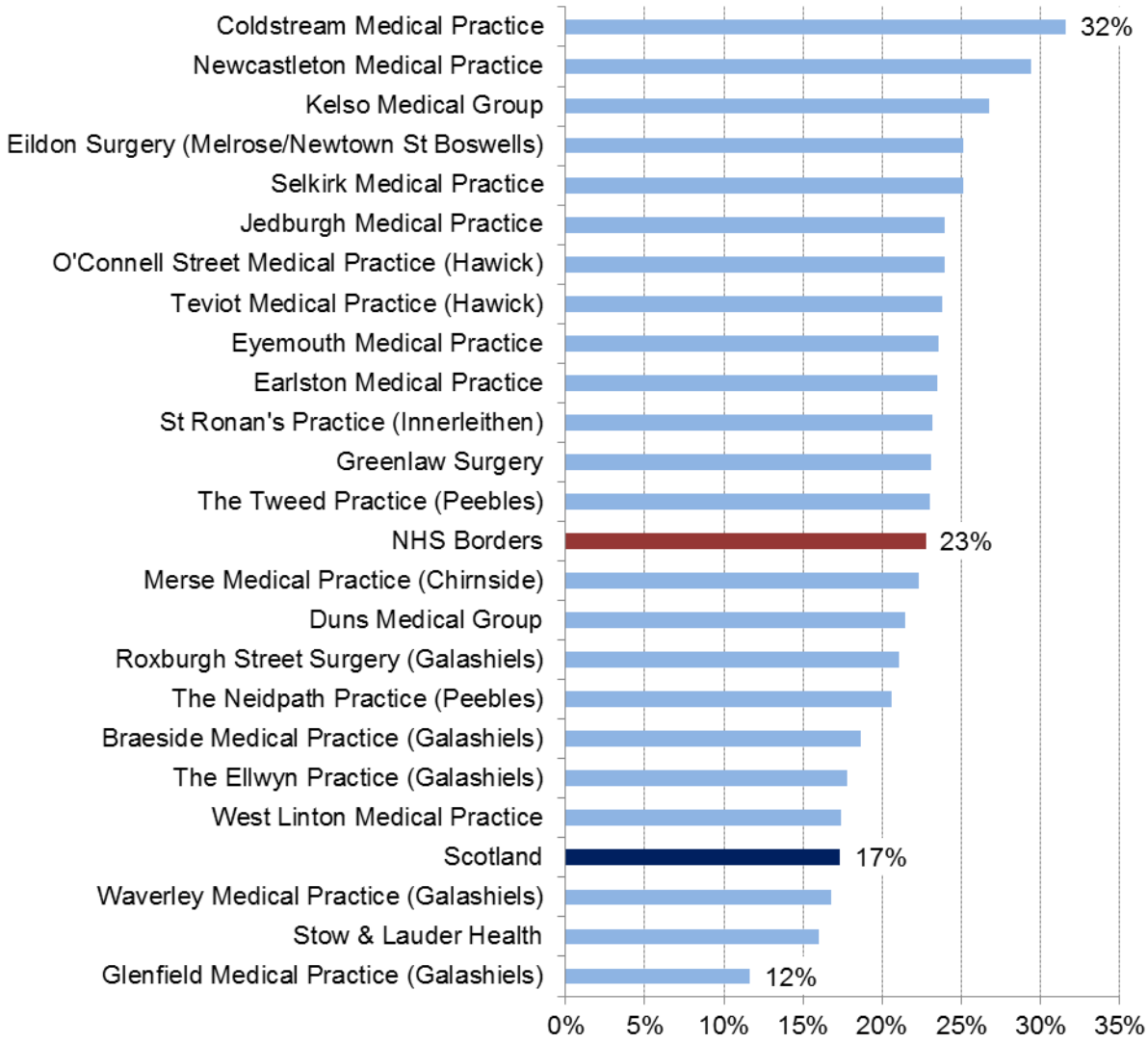
At April 2015, Scottish Borders has:-

- 23 GP practices
- 28 pharmacies
- 15 optician practices
- 18 dental practices
- 22 Care Homes providing care for older (age 65+) people.
    - 15 of these are privately run;
    - 5 are run by "SBCares" on behalf of Scottish Borders Council;
    - 2 are run by voluntary/not for profit organisations.
- 4 Care Homes providing care for adults with Learning Disabilities (run by voluntary/not for profit organisations).
- 1 district general hospital - Borders General Hospital (Melrose).
- 4 community hospitals, between them providing 87 beds for care and rehabilitation. These hospitals are
    - Hawick Community Hospital;
    - Kelso Community Hospital;
    - Knoll Community Hospital (Duns);
    - Hay Lodge Hospital (Peebles).

GP practices

There are 23 GP practices in the Scottish Borders. There are significant variations between the practices in the size and profiles of their registered patients, for example in the proportion of older people, which will influence the likely mix of conditions that patients present with. The graph below shows that the percentage of registered patients aged 65+ varies from 12% (Glenfield Medical Practice in Galashiels) to 32% (Coldstream Medical Practice). The absolute number of patients aged 65+ also varies considerably between individual practices. Glenfield Medical Practice is a comparatively small practice; 246 out of 2,107 patients registered to it at 1st January 2015 were aged 65+. At the opposite end of the spectrum, Kelso Medical Group is the largest GP practice in Scottish Borders and 3,149 of its 11,782 patients on 1st January 2015 were aged 65+.

Figure 35: Scottish Borders GP practices; variations in the percentages of registered patients aged 65+, January 2015



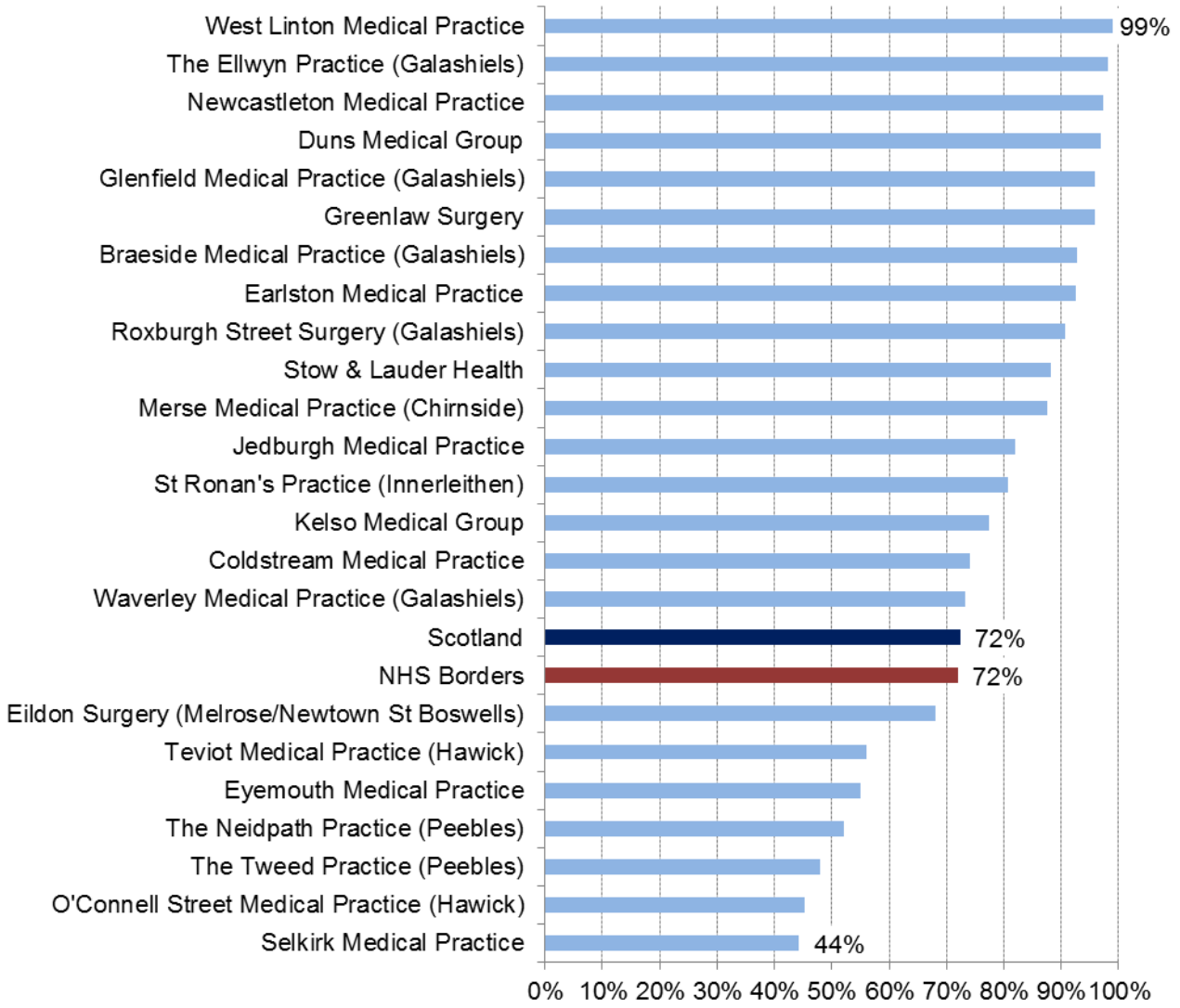
Source: General Practice Statistics, ISD, NHS National Services Scotland www.isdscotland.org/Health-Topics/General-Practice/

Table 24: Scottish Borders GP practices; variations in the numbers and percentages of registered patients aged 65+, January 2015

Practice name (and location)	Number of patients aged 65+	% of patients aged 65+
Coldstream Medical Practice	1,153	32%
Newcastleton Medical Practice	455	29%
Kelso Medical Group	3,149	27%
Eildon Surgery (Melrose/Newtown St Boswells)	1,658	25%
Selkirk Medical Practice	1,810	25%
Jedburgh Medical Practice	1,575	24%
O'Connell Street Medical Practice (Hawick)	1,598	24%
Teviot Medical Practice (Hawick)	2,541	24%
Eyemouth Medical Practice	1,476	24%
Earlston Medical Practice	722	24%
St Ronan's Practice (Innerleithen)	1,040	23%
Greenlaw Surgery	303	23%
The Tweed Practice (Peebles)	1,247	23%
Merse Medical Practice (Chirnside)	1,424	22%
Duns Medical Group	649	21%
Roxburgh Street Surgery (Galashiels)	688	21%
The Neidpath Practice (Peebles)	1,215	21%
Braeside Medical Practice (Galashiels)	878	19%
The Ellwyn Practice (Galashiels)	554	18%
West Linton Medical Practice	615	17%
Waverley Medical Practice (Galashiels)	839	17%
Stow & Lauder Health	688	16%
Glenfield Medical Practice (Galashiels)	246	12%
NHS Borders total	**26,523**	**23%**
Scotland total	**971,442**	**17%**

Source: General Practice Statistics, ISD, NHS National Services Scotland www.isdscotland.org/Health-Topics/General-Practice/

Figure 36: Percentage of survey respondents who rated arrangements to see a GP at their practice as Excellent/Good, 2013-14



Source: Health and Care Experience Survey 2013/14

www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/Survey1314

Current Use of Health and Social Care Services

Emergency Hospital Care

Accident & Emergency Activity and Waiting Times

Accident & Emergency (A&E) and other Emergency Departments are located at five hospitals within NHS Borders:

- Over 90% of A&E/Emergency Department attendances within NHS Borders are at Borders General Hospital, which has a full A&E Department open 24 hours a day, 7 days a week.

- Patients may also attend Minor Injuries Services in four community hospitals:
    - Knoll Community Hospital, Duns (24 hours a day)
    - Hawick Community Hospital (24 hours a day)
    - Hay Lodge Hospital, Peebles (24 hours a day)
    - Kelso Community Hospital (Minor Injuries Service available Out of Hours)

The number of attendances across all A&E and Minor Injuries services fluctuates from month to month, tending to dip in winter and peak between March and October each year. In addition to seasonal variations in pressures on A&E, an overall upward trend is apparent in the average monthly admissions from year to year:-

- In 2008, the average monthly number of attendances at A&E / other Emergency Departments in NHS Borders was 1,887.

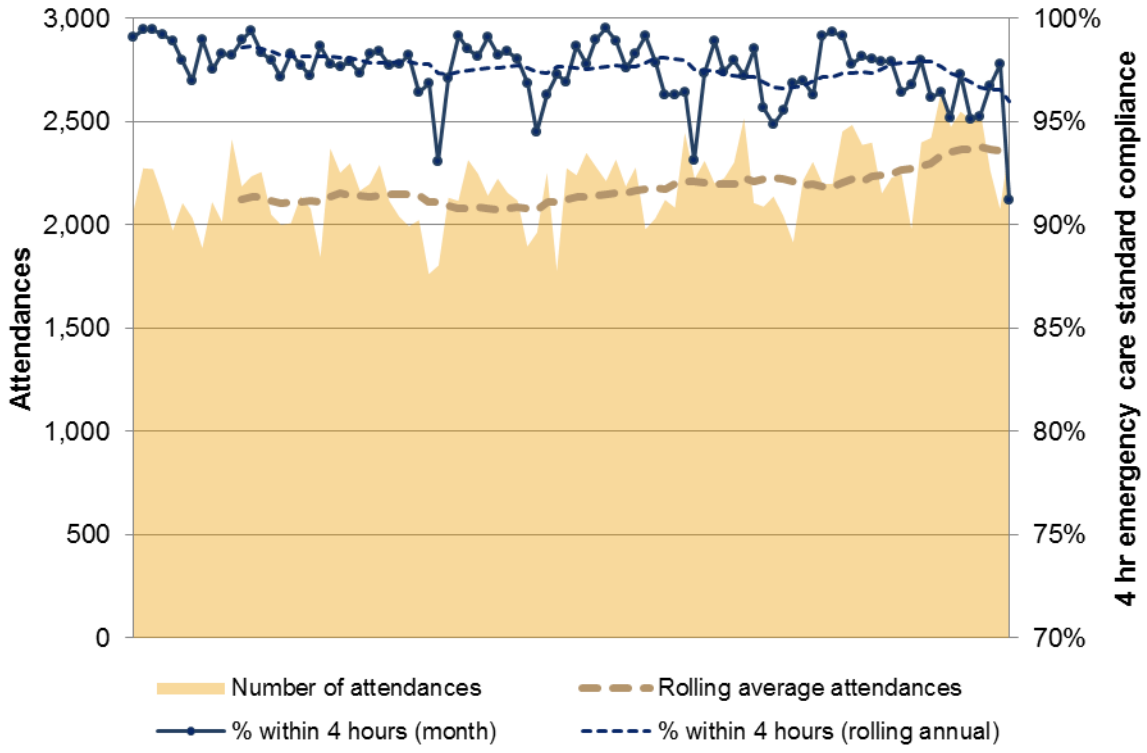
- By 2014, the monthly average had risen to 2,230.

Since 2007, the national standard for A&E waiting times is that new and unplanned return attendances at an A&E service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place. Across NHS Borders this standard has been met or exceeded in most individual months, however in some months (including December 2014) less than 95% of patients were seen within four hours.

When patients leave the A&E Department at Borders General Hospital:-

- Typically between 50-60% of them go back to their place of residence (including private and residential homes).
- Another 30-40% are admitted to hospital within NHS Borders.
- Approximately 10% are transferred to another NHS care provider or hospital.

Table 25: NHS Borders: Attendances at A&E and Minor Injuries Units, and compliance with the 4 hour waiting time standard, trends from July 2007 to December 2014



Source: Emergency Department Activity and Waiting Times National Statistics Publication, ISD, 3rd February 2015. www.isdscotland.org/Health-Topics/Emergency-Care/

Emergency Admissions to Hospital

Over the past ten years, overall rates of emergency hospital inpatient admissions across Scotland have increased gradually. Meanwhile, instances of individual patients having two or more emergency hospital stays within the same year are also increasing.

Overall rates of emergency hospital stays and multiple emergency admissions for Scottish Borders residents have been consistently higher than the Scottish averages, and since the 2009/10 financial year have been increasing more rapidly than those for Scotland overall.

Rates of emergency admission and multiple emergency admission vary by age, as does the situation for Scottish Borders relative to Scotland as a whole. For example:-

- 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 (provisional) 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.

- Similarly, by far the highest rates of multiple emergency admissions occur in people aged over 75, and it is in this age group that increases over time are the most pronounced. In 2004/05, 634 Scottish Borders residents aged 75 and over had two or more emergency hospital stays within one year (a rate of 65 per 1,000 population). By 2013/14 this had increased to 937 people (a rate of 83 per 1,000 population).

- Emergency and multiple emergency admission rates amongst Scottish Borders residents aged 50-64 and 65-74 have tended to be a little lower than average rates for these age groups for Scotland.

- In contrast, rates for younger adults (15 to 49) and the oldest members of the Scottish Borders population (75+) have tended to be higher than average rates for the same age groups across Scotland.

Note that the figures given above exclude patients admitted to Geriatric Long Stay beds and/or hospital stays that exceeded one year in duration.

Figure 37: Scottish Borders residents admitted to hospital as an emergency; trends in rates per 1,000 population, by age group

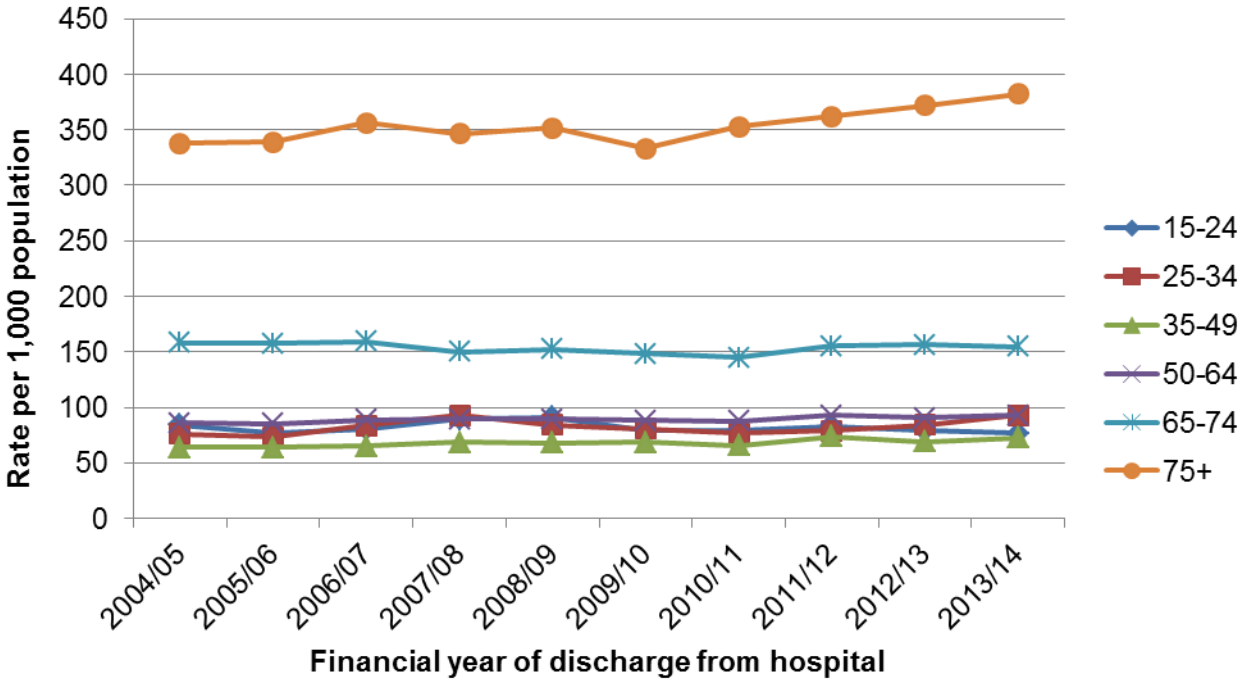
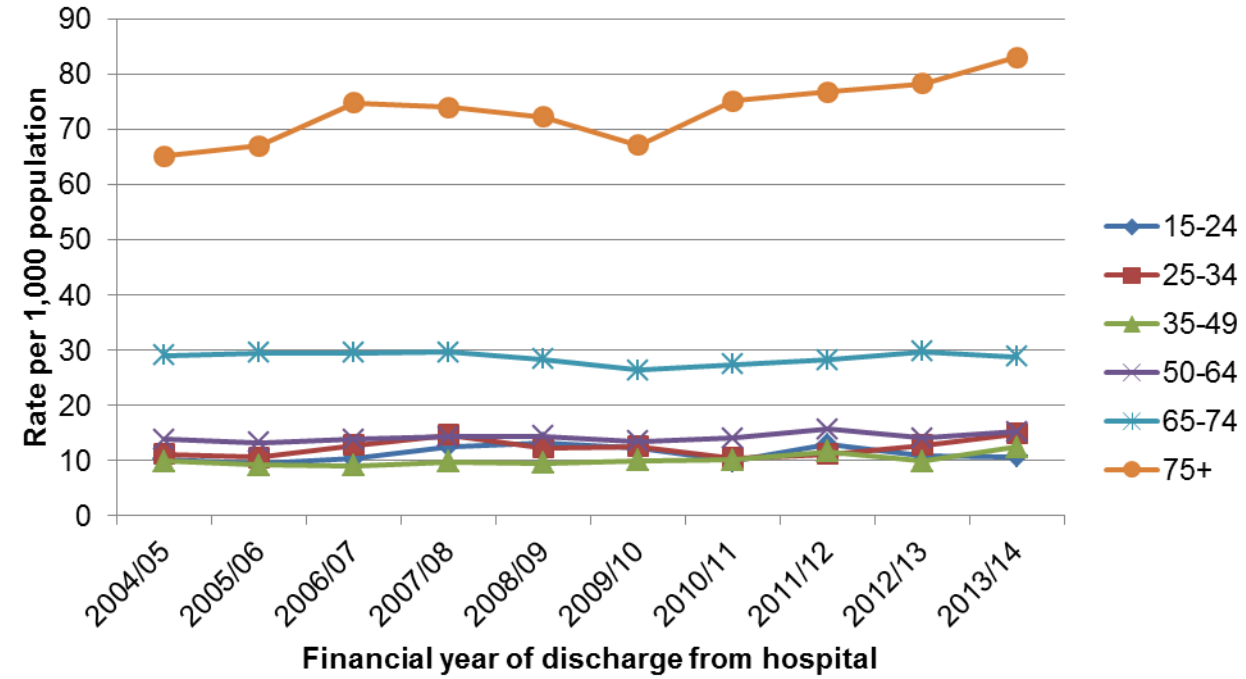


Figure 38: Scottish Borders residents with two or more emergency admissions to hospital within the same year; trends in rates per 1,000 population, by age group

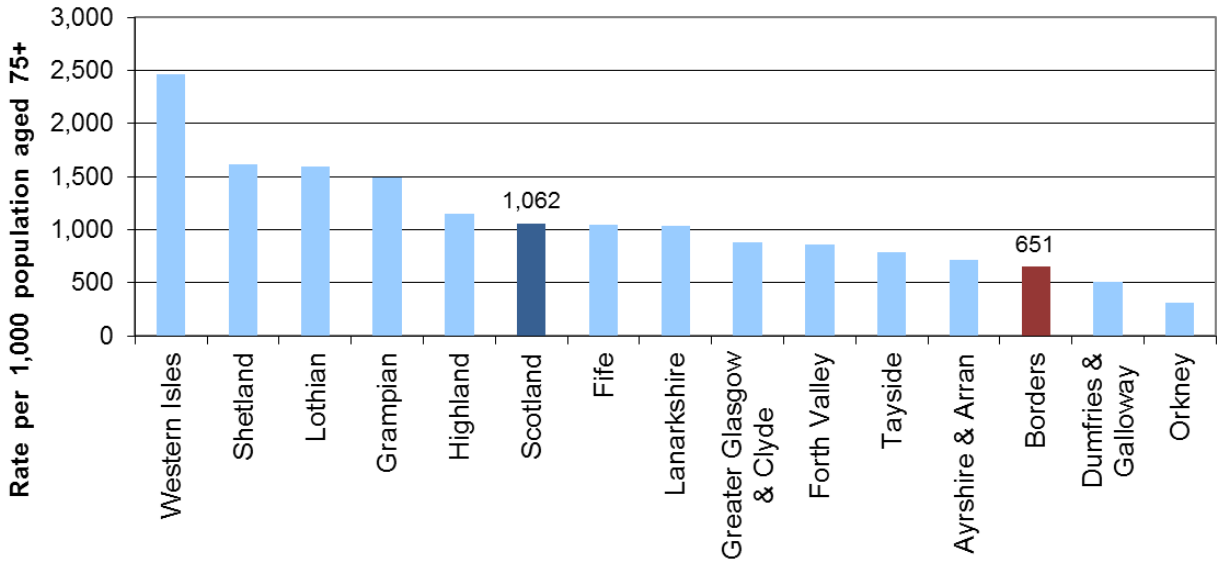


Source: Hospital Care National Statistics, ISD, NHS National Services Scotland, published Dec 2014
www.isdscotland.org/Health-Topics/Hospital-Care/

Delayed Discharges from Hospital

A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons. Over the period January to December 2014, 84% of bed-days occupied by adults in NHS Borders hospitals due to delayed discharge were for patients aged 75 and over, higher than the 73% average for Scotland. However, we already know that Borders has a higher proportion of older people than the Scottish average. Furthermore, for patients whose discharge from an NHS Borders hospital is delayed, the rate per 1,000 population of bed-days occupied patients aged 75+ is one of the lowest amongst the NHS Boards in Scotland, as shown in the graph below.

Figure 39: Delayed discharges from inpatient care, patients aged 75+: Bed days occupied per 1,000 population, January-December 2014, by NHS Board



Source: Delayed Discharge Census, ISD Scotland, www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/

The reasons why there are sometimes delays in discharging inpatients from hospital illustrate the need for Health and Social Care services to work together closely. Whilst some delays are due to a wait for healthcare arrangements (such as equipment provided by the NHS or an NHS bed in another hospital or facility), others can be due to patients waiting to go home on completion of social care arrangements, a wait for a place to become available in a care home, or a wait for a community care assessment to be completed.

Social Care Services

Home Care

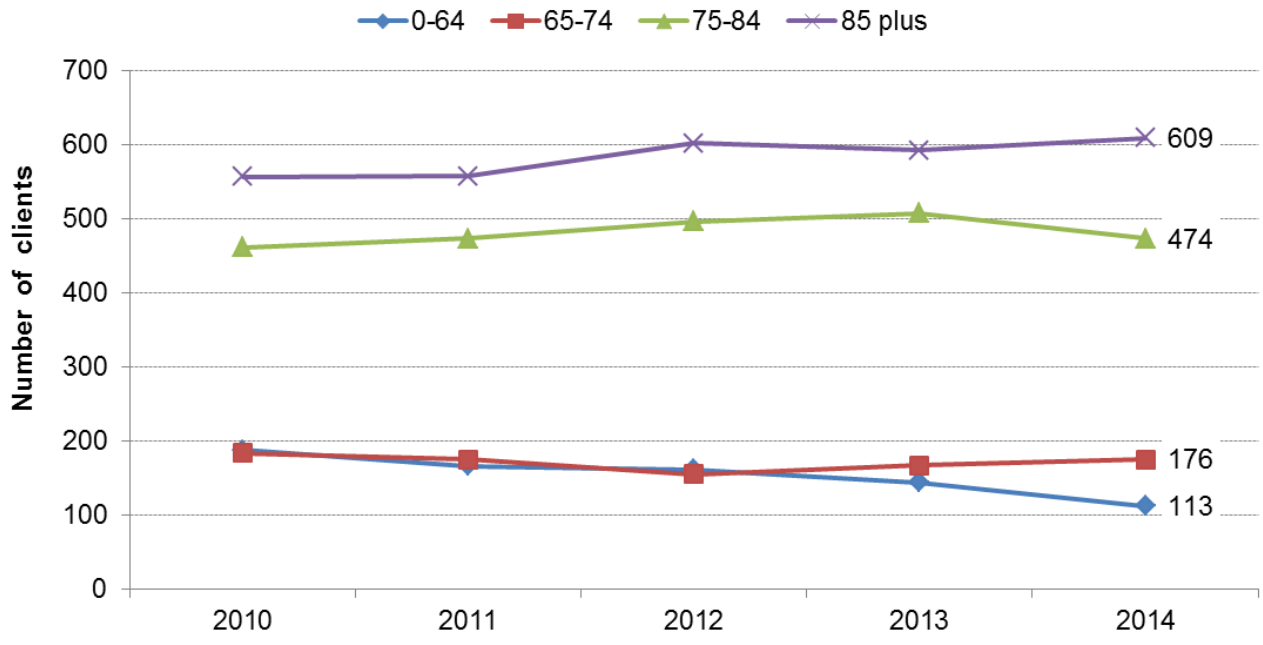
Help at home or "Home Care" describes a range of support available for daily living. Home care is care provided in an individual's own home to enable them to maintain independence and can include support with washing, dressing, eating and taking medication.

At the end of March 2014 there were 1,372 people in receipt of Scottish Borders home care services, similar to overall totals in each of the four years previously, which fluctuated around 1,400. Within this overall total, there has been an upward trend in the numbers of home care service users aged 85+, and a downward trend in the numbers aged under 65. At the end of March 2014:-

- 44% of home care recipients (609 people) were aged 85+;
- 35% (474 people) were aged 75-84;
- 13% (176 people) were aged 65-74;
- 8% (113 people) were aged under 65.

The majority of Scottish Borders home care recipients (92%) at the end of March 2014 were aged 65 and over. These 1,259 individuals represented just under 5% of the Scottish Borders population aged 65+.

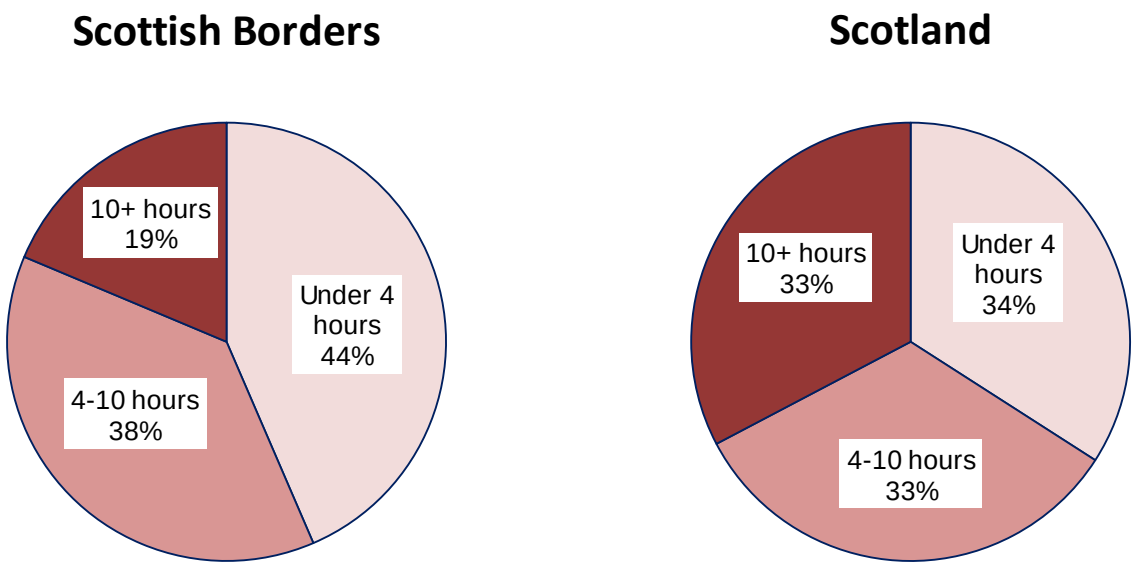
Figure 40: Number of Home Care Clients by age group, Scottish Borders, as at end March 2010 to 2014



Source: Health and Social Care data spreadsheets, Scottish Government, November 2014.
www.gov.scot/Topics/Statistics/Browse/Health/Data/CareData

Just under one in five (19%) of Scottish Borders home care clients aged 65+ received 10 or more hours of home care per week, lower than the average of one in three (33%) for Scotland as a whole. Conversely, 44% of Scottish Borders clients in this age group received under 4 hours of home care per week, compared with 34% in this age group across Scotland. These figures may not necessarily take account of all people assessed as having more intensive care needs and receiving their care at home. For example, increasing numbers of people have been moving since 2013 to Self-Directed Support (SDS – outlined below), which gives more flexibility on how people's support is provided and is typically not reflected in the numbers of people receiving home care packages from the Council.

Figure 41: Breakdown of weekly hours provided for Home Care Clients aged 65+, at end March 2014



Source: Health and Social Care data spreadsheets, Scottish Government, November 2014.
www.gov.scot/Topics/Statistics/Browse/Health/Data/CareData

Direct Payments / Self-Directed Support (SDS)

If an individual or carer has been assessed by social services as needing care or support services, they can apply to receive direct payments. These let the person choose and buy the services they need, instead of getting them as a care package from their council.

Direct payments can be made to:

- Disabled people aged 16 or over (with short or long-term needs);
- Disabled parents for children's services;
- Carers aged 16 or over (including people with parental responsibility for a disabled child);
- Elderly people who need community care services.

Source: https://www.gov.uk/apply-direct-payments

In Scottish Borders:-

- The number of people receiving direct payments increased from 103 in March 2005 to 359 in March 2014.
- In March 2014, half of direct payment recipients were aged under 65 and the other half were aged 65+.

Source: Scottish Government (2014): Social Care Services 2014
www.gov.scot/Publications/2014/11/1085/downloads

In 2013 The Scottish Parliament passed a new law on social care support, the Social Care (Self-directed Support) (Scotland) Act 2013. Self- directed support (SDS) allows people to choose how their support is provided, and gives them as much control as they want of their individual budget. SDS is the support a person purchases or arranges, to meet agreed health and social care outcomes. SDS offers a number of options for getting support. The person's individual (or personal) budget can be:

1. Taken as a direct payment. The person then arranges their own support by employing care staff or buying services from one or more organisations.
2. The council or an organisation of the individual's choice holds the money, but the person is in charge of how it is spent.
3. The individual asks their Local Authority to choose and arrange the support that they think is appropriate.
4. A mix of options 1, 2 and 3.

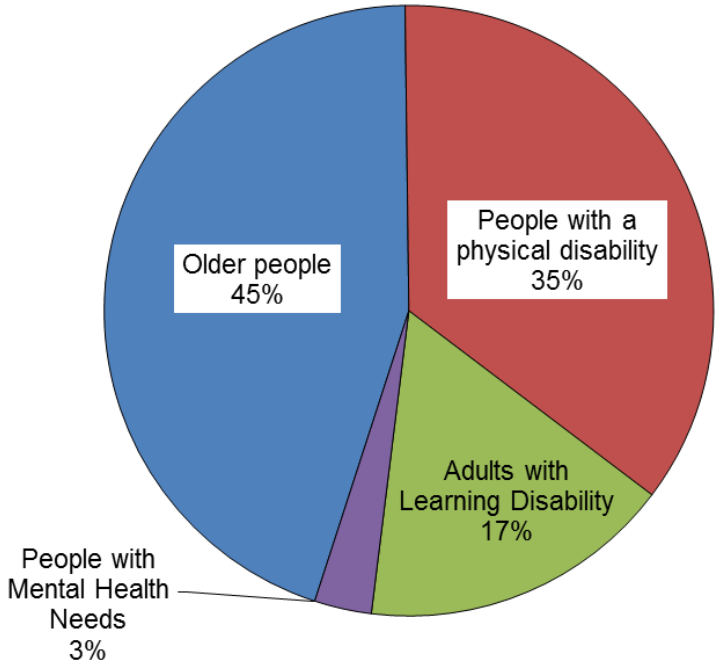
Source: www.selfdirectedsupportscotland.org.uk/

In Scottish Borders, there were 103 Self Directed Support clients at March 2014, and this number is expected to grow progressively over the next few years.

Source: Scottish Borders Council.

The chart below shows the breakdown of Direct Payment or Self Directed Support (SDS) clients in Scottish Borders at March 2014, by their (main) client grouping. Individuals can have more than one reason for needing help and support; for example someone in the "Older people" (age 65+) client group may also have a physical disability. However, in this summary each person is counted only once. 45% of Direct Payment/SDS clients at the time were older people; at least 35% had a physical disability; and at least 17% had a learning disability. A further 3% of these clients at the time had mental health needs as their "main" client grouping.

Figure 42: Scottish Borders Direct Payment / Self-Directed Support clients, by main group*, March 2014



*An individual client can have multiple needs but for this chart each person is counted only once.
Source: Scottish Borders Council Direct Payment/SDS Social Care return, March 2014.

Telecare / Community Alarms

Approaches such as 'Telecare', and 'Telehealth' are likely to have an increasing part to play in helping people to be looked after at home or in a homely setting. Telecare usually refers to electronic equipment which provides continuous, automatic and remote monitoring of care needs, emergencies and lifestyle changes. Telecare equipment can detect risks such as fires, floods, falls, or someone being out of their chair, bed or home for longer than expected. If a risk is detected, an alert is sent to a monitoring centre and/or the person's carer, so that help can be provided when it is needed. Community Alarms are one type of telecare. These are personal alarm systems that transfer alerts, alarms or other information to a monitoring centre or individual responder. Alarms can be triggered in a variety of ways such as buttons (e.g. on a phone, wristband or pendant) and/or pull chords.

The table below shows that, at March 2014:-

- 1,690 people aged 65+ were receiving Telecare services in Scottish Borders, of whom nearly all (97%) had a Community Alarm. 24% of the Telecare clients in this age group had a Community Alarm plus one or more other Telecare devices.

- 239 people aged 18-64 were receiving Telecare Services, of whom a majority (88%) had a Community Alarm. 32% of the Telecare clients in this age group had one or more other Telecare devices in addition to a Community Alarm.

Table 26: Number of clients receiving Community Alarm and/or other Telecare Services, Scottish Borders, 2014

Type of Telecare	Number of clients aged 18-64	% of clients aged 18-64	Number of clients aged 65+	% of clients aged 65+
Community Alarm Only	133	56%	1,233	73%
Other Telecare Only	29	12%	51	3%
Community Alarm + Other Telecare	77	32%	406	24%
All Telecare clients	239	100%	1,690	100%

Source: Social Care Services 2014 Statistical Release, Scottish Government, November 2014
www.gov.scot/Publications/2014/11/1085/downloads

We might reasonably expect to see these numbers increase over time in future. Figures for years prior to 2014, although available, are not shown in this document as they are not directly comparable due to differences in the way that Telecare was counted up to 2013 and from 2014 onwards.

Housing with Care / Extra Care Housing

[Most of the material in this section is taken from the Scottish Borders Council website at www.scotborders.gov.uk/info/917/housing_benefits_and_council_tax/760/supported_and_sheltered_housing. – content as live at 2nd June 2015. Numbers given below are from Scottish Borders Council Social Work department.]

There are a number of supported and sheltered housing options for people who have specific housing needs, such as some older people and/or those with physical or learning disabilities. In brief, the options are:-

- **Amenity housing**. This refers to flats or houses with special modifications for people with particular needs e.g. amenity housing for older people could provide bathroom handrails, non-slip flooring and repositioned electrical sockets. There is no warden service.

- **Cluster flats**. This allows individuals to hold their own tenancy for their respective bedrooms but share the use of common spaces. This arrangement is often used for special needs purposes, for example for people with learning disabilities with care and support being provided by a specialist agency.

- **Sheltered Housing / Housing with Care (HwC)**. This a type of housing that supports older people to live as independently as possible. Younger people with a disability may be accommodated in sheltered housing if they have a medical or physical disability. Sheltered Housing / HwC developments consist of self-contained flats, with a number of features to assist daily living, such as handrails and raised electrical sockets. Tenants have the independence of having their own home but can also enjoy the benefits of having staff on hand to provide flexible care and support should it be required. Support may be in the form of residential wardens and/or an emergency 24 hour call service connecting each house to a warden system. Currently (as at September 2015), Housing with Care accommodation is located in Galashiels, Innerleithen and Jedburgh.

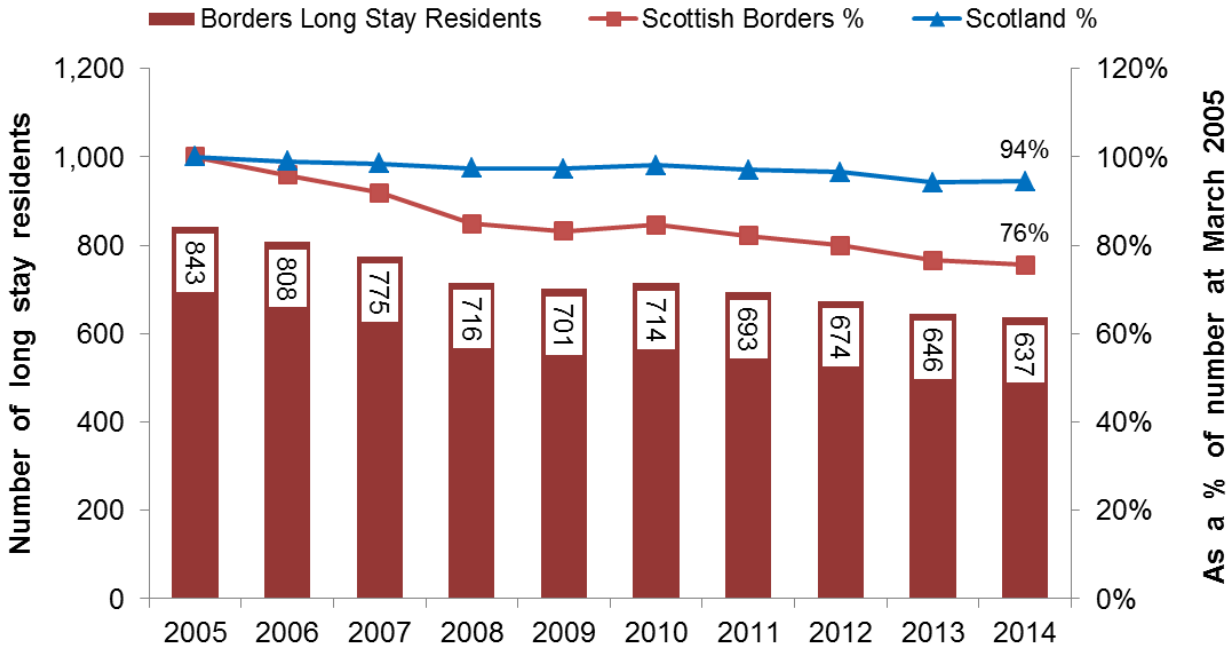
- **Very sheltered housing / Extra Care Housing**. This has the features of sheltered housing, but offers a greater level of care and support including extra wardens, domiciliary assistance and the provision of meals. Currently (as at September 2015) there is one Extra Care Housing development in Scottish Borders – Dovecot Court in Peebles. Dovecot Court has on-site care staff (available 24 hours a day, 7 days a week) and a community alarm service.

Care Homes

Over recent years, there has been a downward trend in the number of people living in care homes on a long term basis, as shown in the graph below. In March 2014, there were 637 long stay residents in Scottish Borders care homes, down by almost one quarter from 843 in March 2005. The relative reduction in numbers has been more pronounced in Scottish Borders than across Scotland as a whole. In March 2014, the proportion of people aged 65+ who were long stay residents in care homes was lower in Scottish Borders (22 per 1,000 population) than most other Local Authority areas in Scotland.

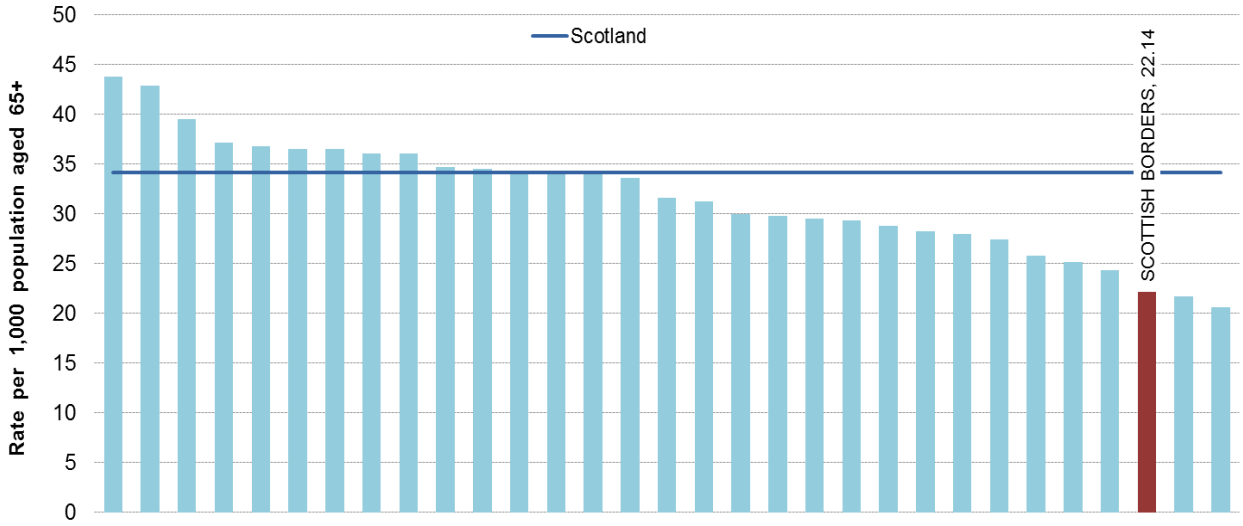
Of the 637 long stay residents in Scottish Borders care homes at March 2014, nearly two thirds (64%) had been looked after in a care home for at least one year. The majority of long stay care home residents are older people. In Scottish Borders in March 2014, 89% of the long stay residents were aged 65+ and 82% were aged 75+. The majority (78% across all age groups) were female. As shown in the table below, a high proportion of long stay residents have dementia, over a third require specific nursing care and over a third have a physical disability and/or chronic illness.

Figure 43: Trend in numbers of Long stay care home residents March 2005 to March 2014, overall and as a percentage of numbers at March 2005



Source: Scottish Care Home Census www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Census/

Figure 44: Percentage of population aged 65+ looked after as long stay residents in care homes, March 2014, by Local Authority



Source: Health and Social Care data spreadsheets, Scottish Government, November 2014.
www.gov.scot/Topics/Statistics/Browse/Health/Data/CareData

Table 27: Characteristics of Long Stay Residents in Scottish Borders Care Homes at March 2015

Characteristics of Long Stay Residents	% of Long Stay Residents
Requiring Nursing Care	38
Visual Impairment	16
Hearing Impairment	12
Acquired Brain Injury	6
Other Physical Disability or Chronic Illness	34
Dementia (Medically Diagnosed)	51
Dementia (Not Medically Diagnosed)	10
Mental Health Problems	8
Learning Disability	14

Note: an individual resident may have more than one of these characteristics, so the percentages do not add up to 100.

Source: Scottish Care Home Census www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Census/

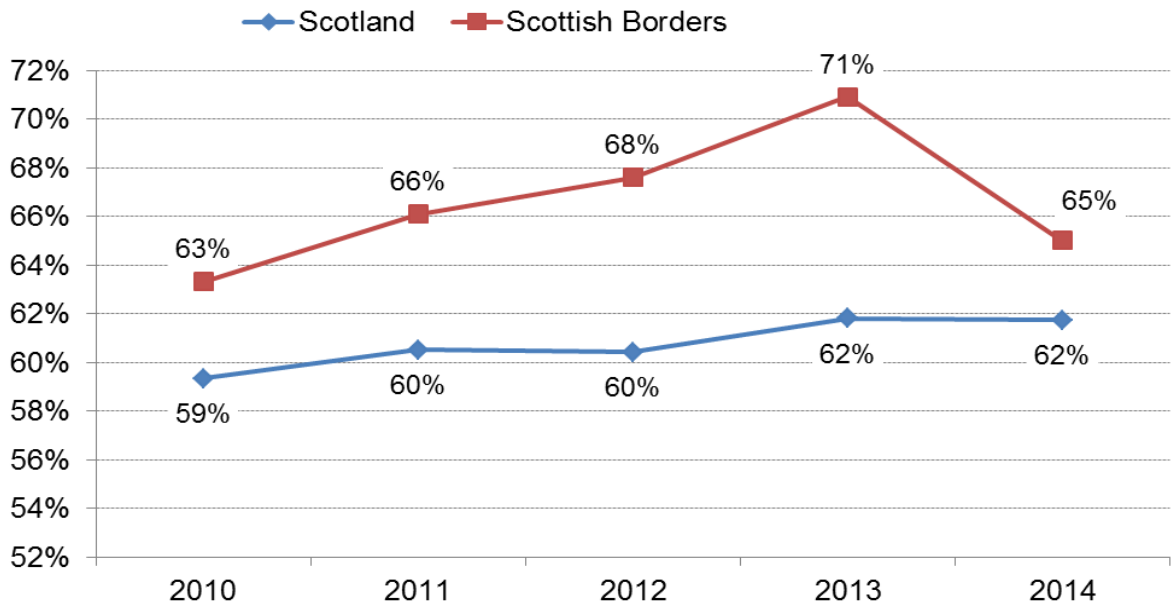
Balance of Care

Supporting people in their own homes helps them remain more independent for longer. This makes it a Scottish Government priority to increase the availability of home care and support for people, particularly those with high levels of care needs. As the population ages, and the number of people with complex care needs increases, the need to provide appropriate care and support becomes even more important.

The place where people are cared for is influenced by a number of factors, above all their needs and their level of dependency. Personal factors include: individuals' dependency levels, whether they live alone, and whether they have a carer. Local availability of affordable appropriate alternative care services and accommodation is also a factor. Access to personal income is becoming increasing important also, as public funding becomes more challenging as budgets are spread more thinly. The extent to which comprehensive, intensive home care packages are available to keep people at home safely and well supported is also a key factor.

One of the Scottish Government's National Indicators in relation to Balance of Care and the Integration of Health and Care measures the percentage of adults with intensive care needs who receive their care at home. Over the five years 2010 to 2014, the percentage of people aged 18+ receiving personal care at home, rather than in a care home or hospital, was consistently higher in Scottish Borders compared to Scotland. However, the upward trend in Scottish Borders from 2010 (63%) to 2013 (71%) was not continued in 2014; there was a drop at this point to 65%, albeit the figure was still higher than the Scottish average. This apparent drop may be influenced by changes in the way that Social Care is delivered, that are not reflected in the way this indicator is measured. This is discussed in more detail below.

Figure 45: Percentage of people aged 18+ receiving personal care at home, rather than in a care home or hospital, March 2010 to March 2014

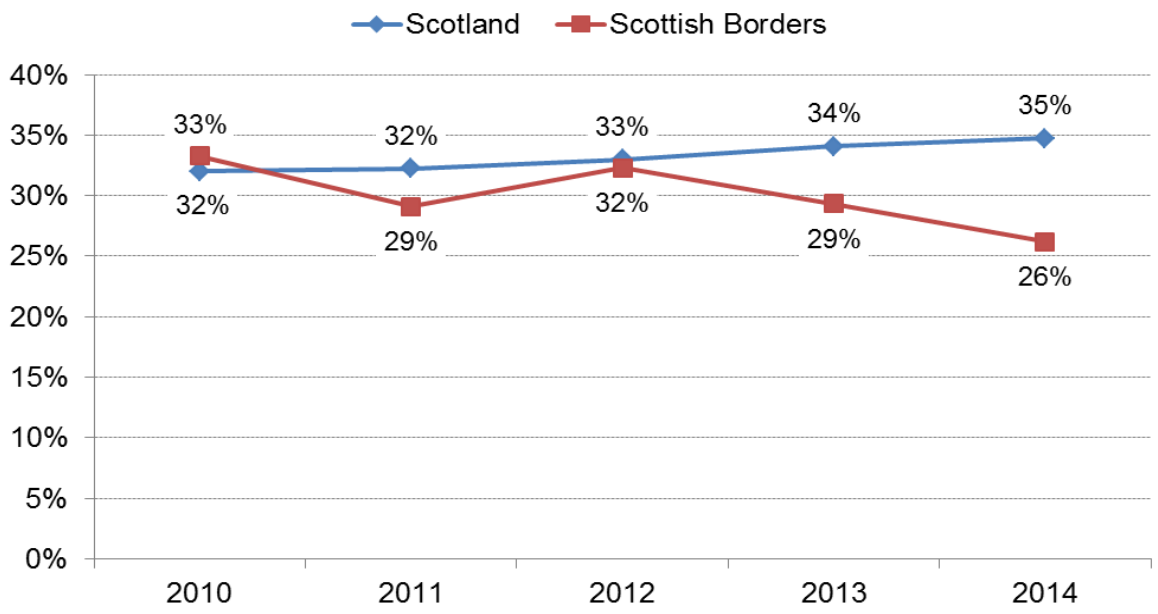


Source: Scottish Government – Health and Social Care National Performance Indicators
www.gov.scot/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes

A more specific indicator (previously a Scottish Government "HEAT" target) monitors the proportion of people aged 65 and over with high levels of care needs who are cared for at home. Across Scotland, the proportion has been increasing steadily since this indicator was introduced, for example from 32% in 2010 to 35% in 2014 (the way the indicator was measured prior to 2010 was different). However, the proportion for Scottish Borders has usually been lower than the Scottish average, has fluctuated and in latter years has dropped, from a high of 33% in 2010 to 26% in 2014, markedly lower than the overall figure for Scotland. This apparent reduction, which is expected to continue, is influenced by changes in the ways that Social Care is delivered, which are not currently reflected in the way the existing national indicator is measured. In brief, two key changes are:-

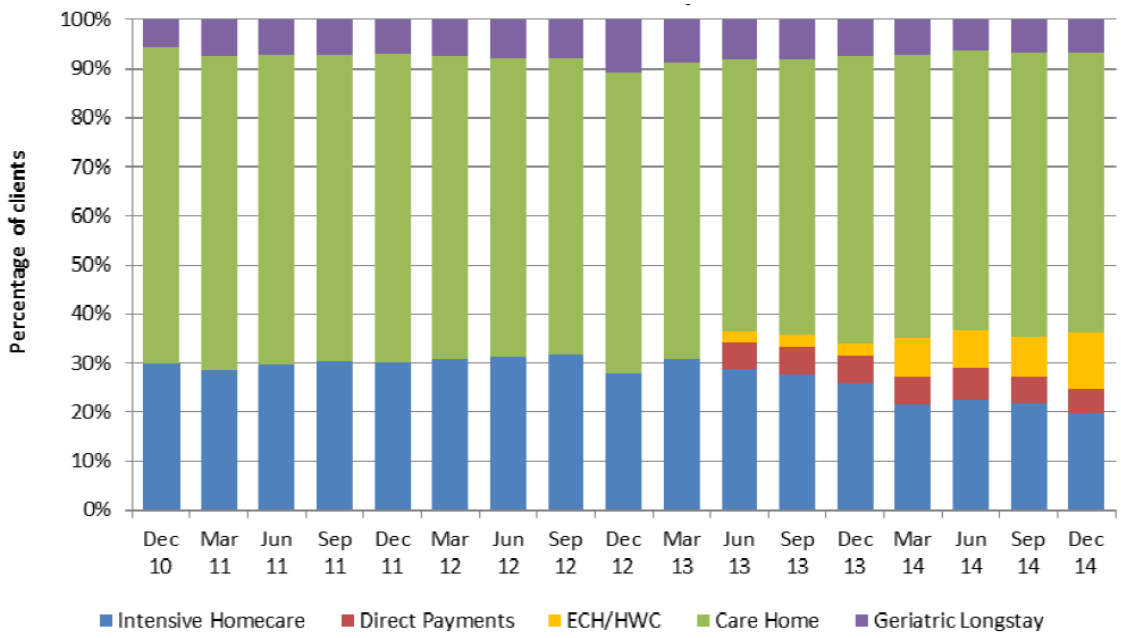
1. As noted on the Scottish Borders Performance Explorer web pages (www.covalentcpm.com/CovalentWebModule/Dashboard?c=119&i=4207189), there has been a reduction in the number of packages of care to maintain independence (people counted in the numerator for these percentages). However, many people assessed as needing higher levels of care have been moved since 2013 to Direct Payments or, more recently, Self-Directed Support (SDS), which is not counted in this indicator. A measure around SDS is expected to be introduced in the future.
2. Additionally, as noted in Scottish Borders Council's April 2015 report "Improving the quality of Older People's Care Homes", provision of Housing with Care and Extra Care Housing (outlined below) has developed and the numbers of people living in this type of accommodation have increased since mid 2013. People living in Housing with Care (HwC) or Extra Care Housing (ECH) are not included in the Scottish Government indicator currently, which is also a factor in explaining the corresponding decrease in the numbers of care home places and provision of care in people's own homes.

Figure 46: Percentage of people aged 65+ receiving 10+ hours per week of care at home, rather than in a care home or hospital, March 2010 to March 2014



Source: Scottish Government – Health and Social Care National Performance Indicators
www.gov.scot/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes

Figure 47: Percentage of people aged 65+ with high levels of care needs who are cared for at home, care home or hospital, living in housing with care/extra care housing, or receiving direct payments, quarters ending December 2010 to December 2014



ECH = Extra Care Housing and HWC = Housing with Care. Source: Improving the Quality of Older People's Care Homes - Report of Members/Officer Working Group
https://scottishbordersintranet.moderngov.co.uk/ieListDocuments.aspx?CId=161&MId=269&Ver=4

Experience of Care recipients

The national Health and Care Experience Survey 2013/14 is a useful source of information on the experiences of people aged 16+ who have received help and care services for everyday living. Although the numbers of people included in the survey are relatively small, the survey design (it was sent to a random sample of people aged 16+ registered at each GP practice in Scotland) means that the results provide a good overview of the experiences of people who have received care within each Local Authority area. In Scottish Borders, 197 survey respondents (out of 2,576 respondents overall) indicated that they had received help and support with everyday living from their Council, the NHS, voluntary organisations or private care agencies.

The results of the Health and Care Experience Survey 2013/14 suggest that the experiences of these randomly sampled care recipients tend to be fairly positive overall, but also that there is scope for improvement. Findings included:-

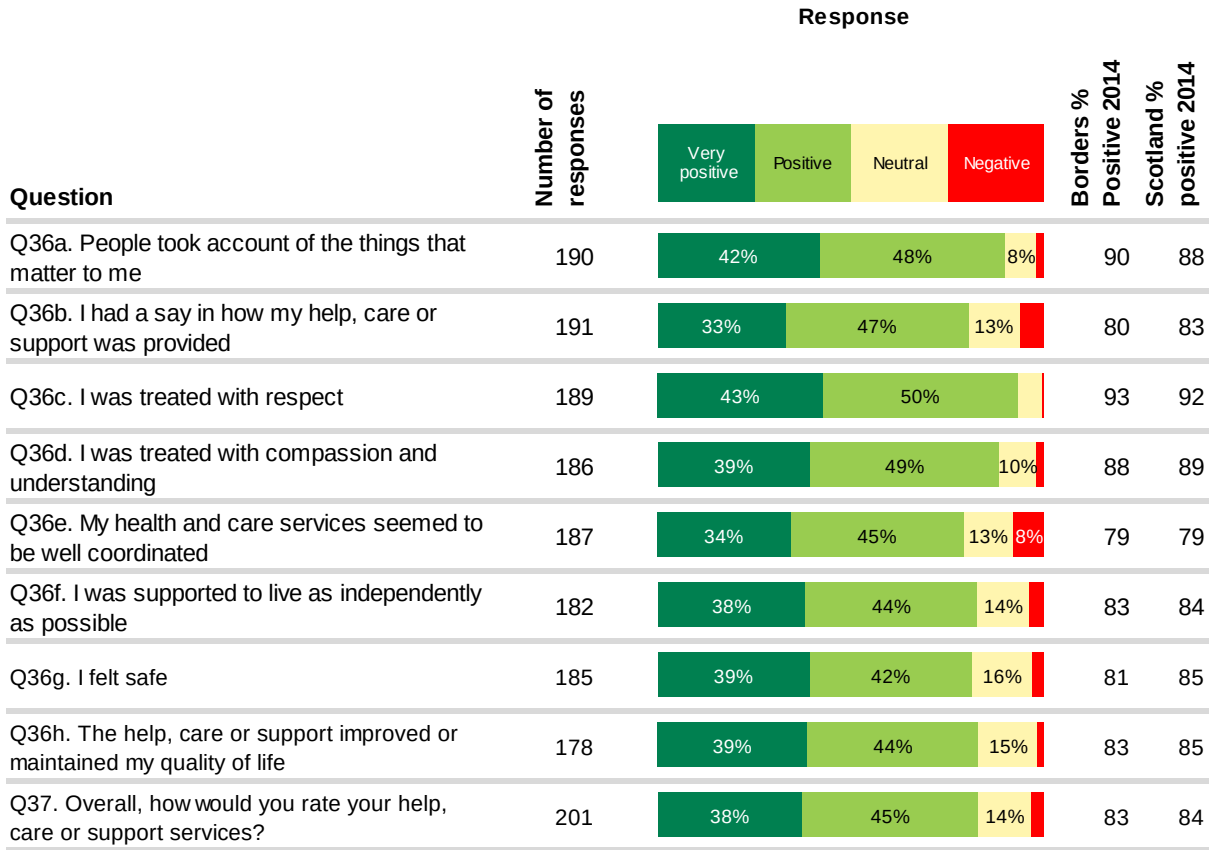
- Whilst 80% of the care recipients agreed or strongly agreed that they had a say in how their help, care or support was provided, 6% disagreed or strongly disagreed. A further 13% neither agreed nor disagreed. The 80% responding positively to this question in Scottish Borders was lower than the 83% overall for Scotland.

- Whilst 79% agreed or strongly agreed that their health and care services seemed to be well coordinated, 8% disagreed or strongly disagreed.

- Whilst 83% agreed or strongly agreed that they were supported to live as independently as possible, 4% disagreed or strongly disagreed with the statement. A further 14% neither agreed nor disagreed.

- 81% agreed or strongly agreed that they felt safe, lower than the 85% overall for Scotland.

Figure 48: Experiences of a sample of care recipients in Scottish Borders, 2013/14



Question	Number of responses	Very positive	Positive	Neutral	Negative	Borders % Positive 2014	Scotland % positive 2014
Q36a. People took account of the things that matter to me	190	42%	48%	8%		90	88
Q36b. I had a say in how my help, care or support was provided	191	33%	47%	13%		80	83
Q36c. I was treated with respect	189	43%	50%			93	92
Q36d. I was treated with compassion and understanding	186	39%	49%	10%		88	89
Q36e. My health and care services seemed to be well coordinated	187	34%	45%	13%	8%	79	79
Q36f. I was supported to live as independently as possible	182	38%	44%	14%		83	84
Q36g. I felt safe	185	39%	42%	16%		81	85
Q36h. The help, care or support improved or maintained my quality of life	178	39%	44%	15%		83	85
Q37. Overall, how would you rate your help, care or support services?	201	38%	45%	14%		83	84

Explanation of graph:-
Number of responses - the number of survey respondents in Scottish Borders who provided a valid response to this question. People who indicated that a question was not relevant to them, or who did not know the answer, are not included in the results.
Response - The percentage of positive, neutral and negative responses received for this question within Scottish Borders. For example, when asked if they were supported to live as independently as possible, the percentage positive refers to care recipients who strongly agreed or agreed. Where care recipients said they disagreed or strongly disagreed these responses have been counted as negative. Where they neither agreed nor disagreed their responses have been counted as neutral.
Borders % Positive 2014 - the percent positive result; the total percentage of patients who responded positively (very positive + positive) to this question within Scottish Borders.

Source: Health and Care Experience Survey 2013/14, www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

End of Life Care

This information has been largely sourced from the following web page: www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/ (accessed May 2015).

End of life care is an important, integral aspect of the health care provided to those living with and dying from any advanced or progressive and life-threatening condition. It is now possible to predict the progress of many of these conditions, enabling a planned approach to end of life care in ways which reflect, as far as possible, the needs and wishes of patients, carers and their families.

One of the Scottish Government's National Indicators in relation to Balance of Care and the Integration of Health and Care measures the proportion of people's last 6 months of life spent at home or in a community setting. The indicator was designed to help measure the impact of "Living and Dying Well: A National Action Plan for Palliative and End of Life Care in Scotland", which was published in 2008, and in particular on its objective to "produce achievable and measurable changes which will ensure quality improvement and enhance patient and carer experience".

Ideally, this measure would relate directly to the preferred place of care at the end of life. However, this can change over time and is, therefore, difficult to track. National data is not currently available at this level of detail so it is not possible to focus the measure directly on preferred place of death.

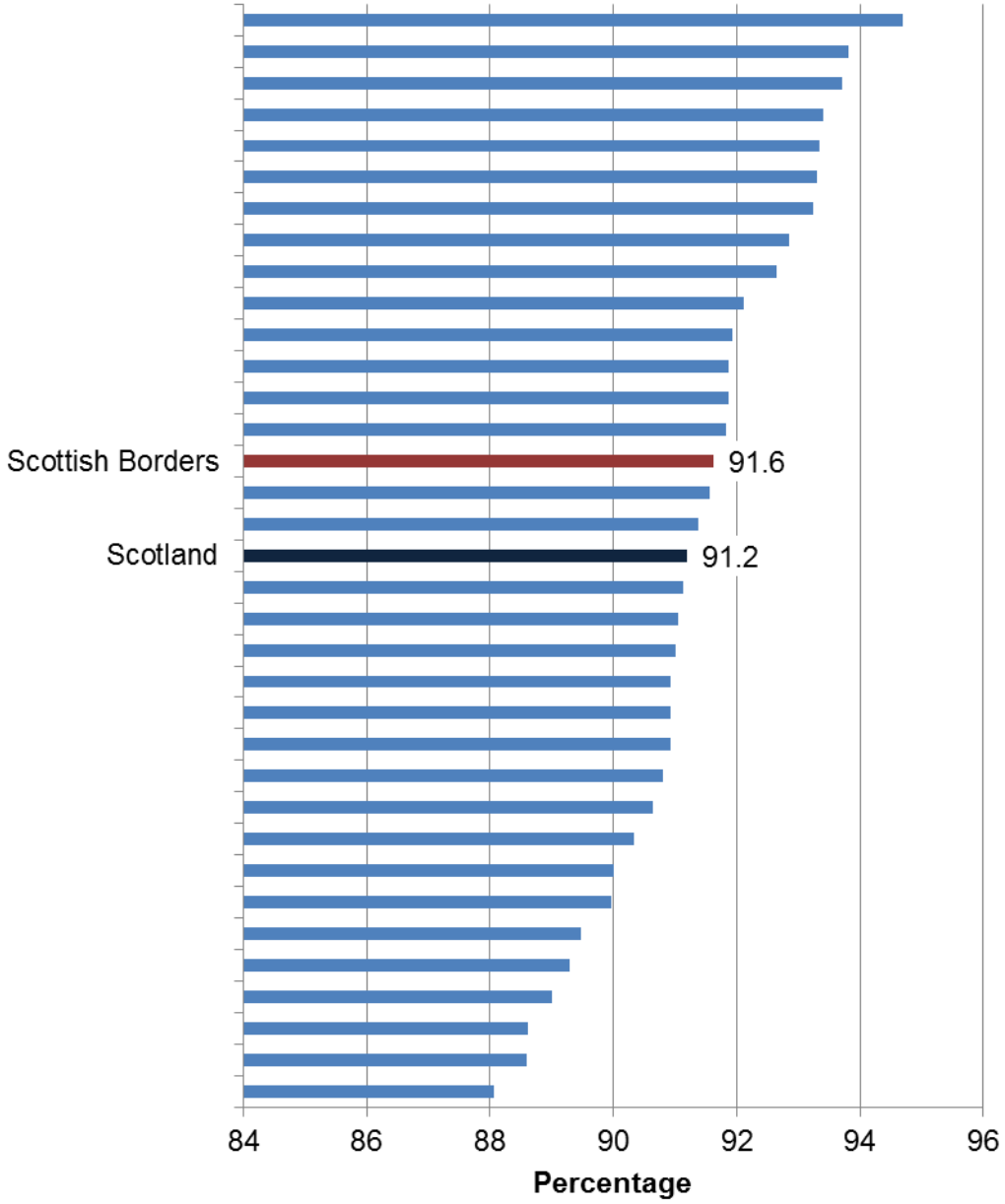
In the meantime, the proportion of time spent at home or in a community setting towards the end of life provides a high level indication of progress in implementation of the national action plan. These data can be inferred by measuring the amount of time spent in an acute setting during the last months of life (using hospital admissions data) and from this estimating the time spent at home or in a community setting.

It is envisaged that an increase in this measure will reflect both quality and value through more effective, person centred and efficient end of life care with people being better able to be cared for at home or closer to home with a planned approach to end of life care resulting in less time in an acute setting.

The most recent year for which this indicator is currently available, as it may be redefined in further work, is the year ending March 2013. Some of the key figures, shown on the graph below, include:-

- In 2012/13, the percentage of last 6 months spent at home was 91.6% for Scottish Borders, which was a little better than the Scottish average of 91.2%.
- The range of values for individual Community Health and Care Partnership areas was from 88.1% to 94.7%.

Figure 49: The percentage of last 6 months of life spent at home or in a community setting, by Community Health Partnership, financial year 2012/13



Source: Quality Outcome Measure 10: www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/

Costs of Health and Social Care in Scottish Borders

For the financial year 2012/13, the total expenditure on Health and Social Care (for children and adults) within Scottish Borders was just over £260 million. The majority of that expenditure (£239.4 million) has been analysed to show how the total breaks down by age as well as type of service.

- 72% (£171.3 million) was spent on NHS services and 28% (£68.1 million) was spent on Social Care. The equivalent proportions for Scotland were 74% and 26%, respectively.

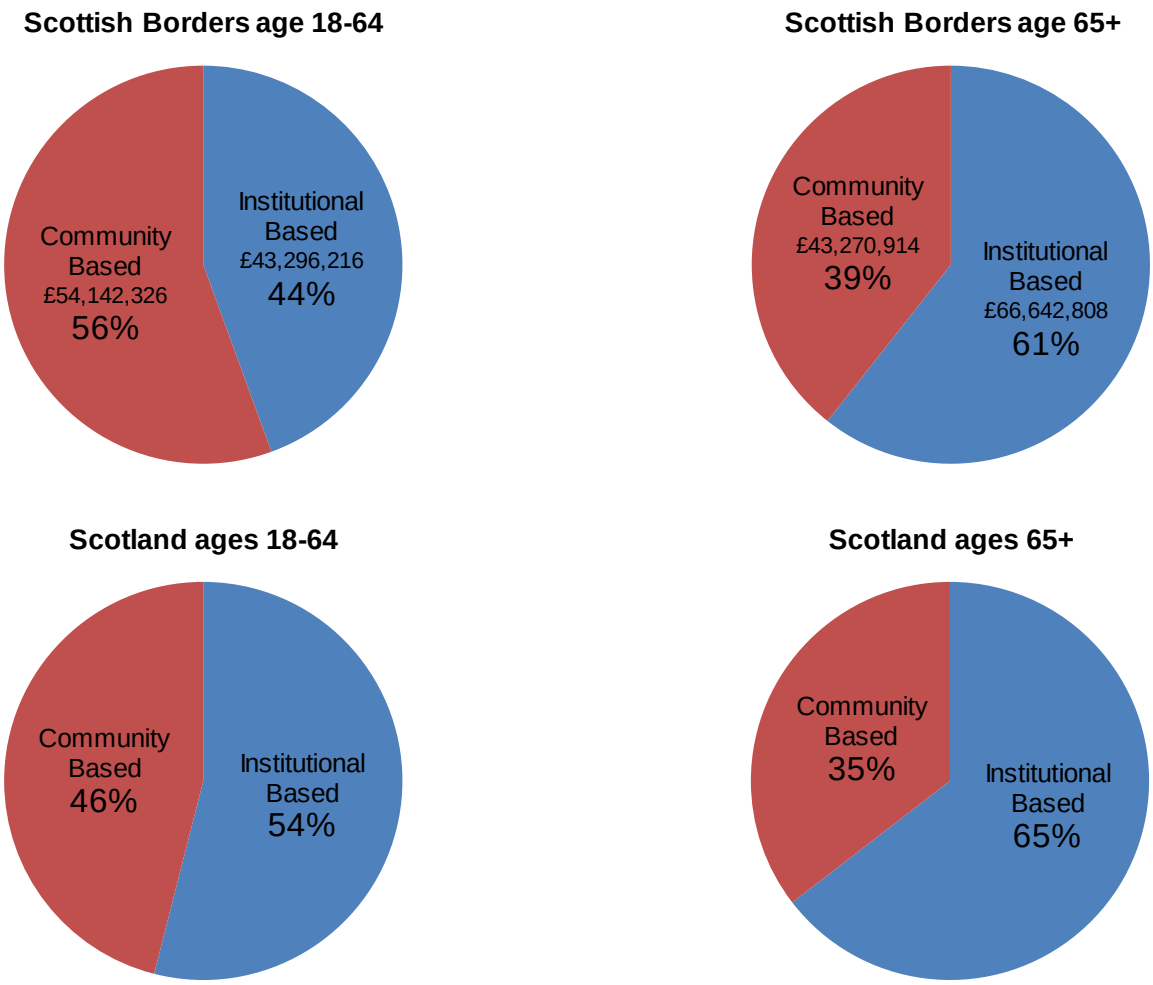
- 46% (£109.9 million) of the total expenditure was in relation to people aged 65 and over, higher than the 40% for Scotland overall. We know, however, that Scottish Borders has an older population profile than the national average.

- Across all age groups combined (including children) the spend in Scottish Borders split almost exactly 50:50 into Community-based care versus Institutional care. The overall split for Scotland was 44% on Community-based care versus 56% on Institutional-based care.

- The shares of overall spend that are accounted for by Institutional care increase with increasing age. For example, in Scottish Borders 44% of the costs for 18-64 year olds were in relation to Institutional care whereas this rose to 62% for people aged 75 and over.

- The pie charts below illustrate the variations by age, and between Scottish Borders and Scotland, in how expenditure was split between Community-based care and Institutional care.

Figure 50: Proportions of Health and Social Care Expenditure related to Community-Based care versus Institutional-Based care, ages 18-64 and 65+, financial year 2012/13



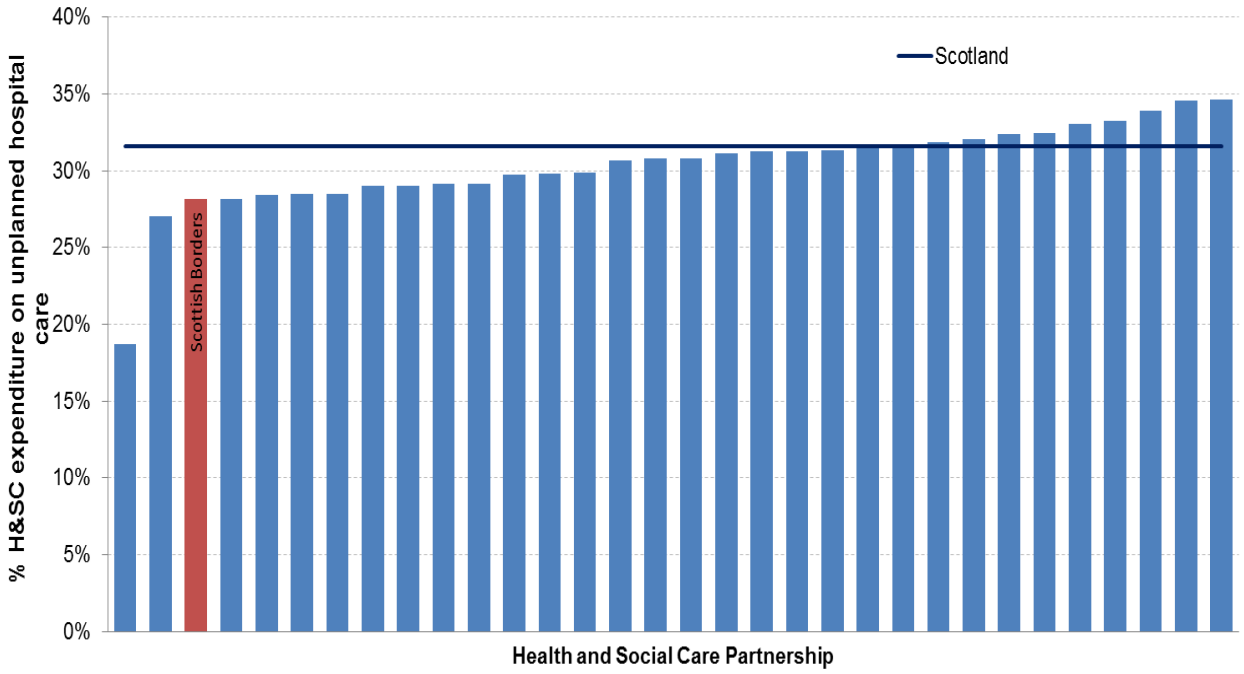
Notes:

1. Institutional-based care comprises all hospital based care including outpatients, day case and day patients, plus accommodation-based social care services.
2. Community-based care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation-based social care services.

Source: Integrated Resource Framework (IRF) developmental analysis, ISD, NHS National Services Scotland.

In Scottish Borders, the percentage of health and social care expenditure on people aged 65 and over that related to unplanned hospital inpatient care is one of the lowest in Scotland, as shown in the figure below. This might appear surprising as Scottish Borders has higher rates of emergency admissions to hospital than the national averages. However, it also has one of the highest proportions of overall spend on community-based care (as opposed to institutional based care) so this Partnership's ranking on the graph below will be influenced by overall balance of care within Scottish Borders.

Figure 51: Percentage of all health and social care expenditure for people aged 65+ that was due to unplanned inpatient hospital care, financial year 2012/13



Source: Integrated Resource Framework (IRF) developmental analysis, ISD, NHS National Services Scotland.

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