Scottish Borders **Health & Social Care** Partnership

Joint Strategic Needs Assessment

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

Scottish Borders
Health and Social Care
PARTNERSHIP

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1 Introduction

1.1 Background

In order for the Borders Health and Social Care Partnership to commission and deliver services that best meet the needs of its local communities (and to intervene at an early stage to address health problems) we require a clear understanding of the health and care needs of the population, from both the perspective of the NHS and Local Authority, and other key stakeholders

The purpose of this Joint Strategic Needs Assessment (JSNA) is to provide this clear understanding. It brings together information (qualitative and quantitative) on the health and care needs of the adult population of the Scottish Borders together in one place; to create a picture of the service needs and enhance and strengthen the information intelligence available to the Partnership, in respect of integration.

This first draft of the JSNA provides a summary of the key findings to date from a wide range of data on; demographics, population projections, health and social care provision, long term conditions, etc. The JSNA is supported by a 'Statistics and Facts' document which contains detailed charts, tables, technical notes and references.

Localities are key to the success of the integration agenda. Their purpose is *to 'provide an organisational mechanism for local leadership of service planning, to be fed upwards into the Integration Authority' strategic commissioning plan.'*[1]

At the time of drafting this document it is being proposed that there are 5 localities within the Scottish Borders, these are

- Cheviot
- Eildon
- Teviot and Liddesdale
- Berwickshire
- Tweedale

It is likely that people's health and wellbeing and use of health and care services will vary across these localities; and there is a need to understand more about this in order to plan services and provides support. Some of the data within this JSNA will reference localities; however a more detailed localities document will sit alongside this population wide needs assessment

[1] Health and Social Care Integration – Localities Guidance, Scottish Government. March 2015

1.2 Existing Local Strategies and Plans and National Outcomes

This JSNA is an evidence based document, and there are a number of strategies and plans that underpin and inform it. Some of these strategies are based on existing partnership working, and it is important to note that the JSNA does not aim to replace or revise any of the current live plans. Where appropriate however this document references more up to date data and information that has become available since the strategies and plans were published, this is particularly relevant to the updated 2011 Census data.

The joint strategies and plans referenced are

- Older People Joint Commissioning Strategy
- Alcohol and Drugs Partnership Strategy
- Living Well with a Disability
- Review of Learning Disability Service Provision
- Mental Health Commission Strategy and Needs Assessment
- Caring Together in the Scottish Borders
- Strategy for Sensory Services in Scottish Borders
- Draft Needs Assessment for Palliative Care Services
- Borders Dementia Strategy
- Home Care/Reablement (does this exist)
- Health Improvement Strategy
- Long Term Conditions
- Single Outcome Agreement and Strategic Assessment
- NHS Borders Clinical Strategy

Each strategy was reviewed prior to the drafting of this JSNA and a number of key themes were identified, and which relate to the National Outcome Indicators for Health and Wellbeing. These are:-

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently at home or in a homely setting in their community
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- People who use health and social care services are safe from harm
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Resources are used effectively and efficiently in the provision of health and social care services.

1.3 Next Steps

To support the Strategic Commission Plan, the aim of this needs assessment has to be that it is sufficiently broad to reflect the entire system of adult health and social care, yet succinct enough such that the key messages are easily understood.

This document is a first draft, and subject to a consultation process. Any feedback and comments from the consultation exercise will be incorporated into the next draft. Along with any further work which is already planned to enhance the evidence base to support the commissioning process.

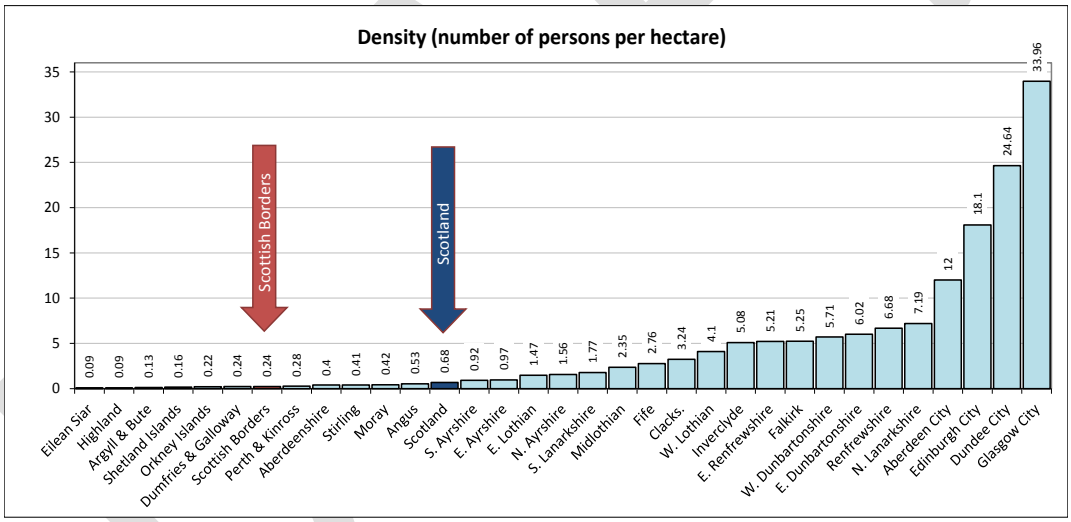
2 The Scottish Borders: Population

2.1 Current Population

The Scottish Borders geographic area is 473,614 hectares (1,827 square miles); located in the South East of Scotland, and is home to a population of 113,870. It has Edinburgh and the Lothian's to the North, Northumberland to the South and Dumfries and Galloway to the West.

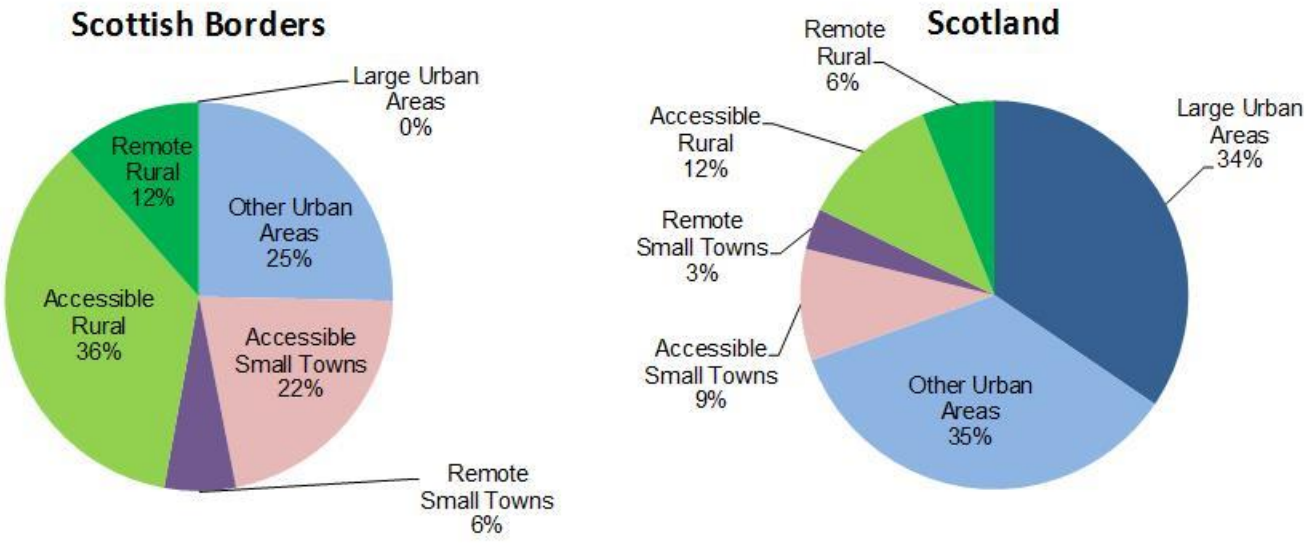
In terms of population density, the Scottish Borders is one of the most sparsely populated regions of Scotland, 0.24 persons per hectare, lower that the Scottish average of 0.68. This is important as it has an impact on how we plan and deliver services across the area.

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



Nearly half (48%) of the population in 2012 live in rural areas. Whilst 34% of the Scottish population live in 'Large Urban' areas (part of towns/cities with population of more than 125,000), there are no 'Large Urban' areas in the 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.

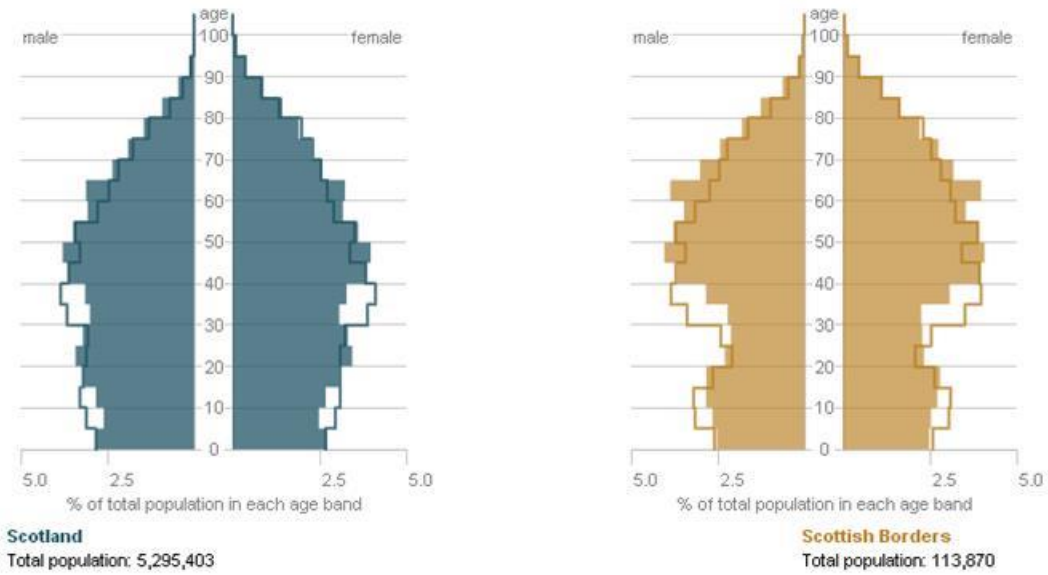
Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland. www.gov.scot/Publications/2014/11/2763/downloads

The relatively low population density, and the urban/rural profile of Scottish Borders, has 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 has a 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)

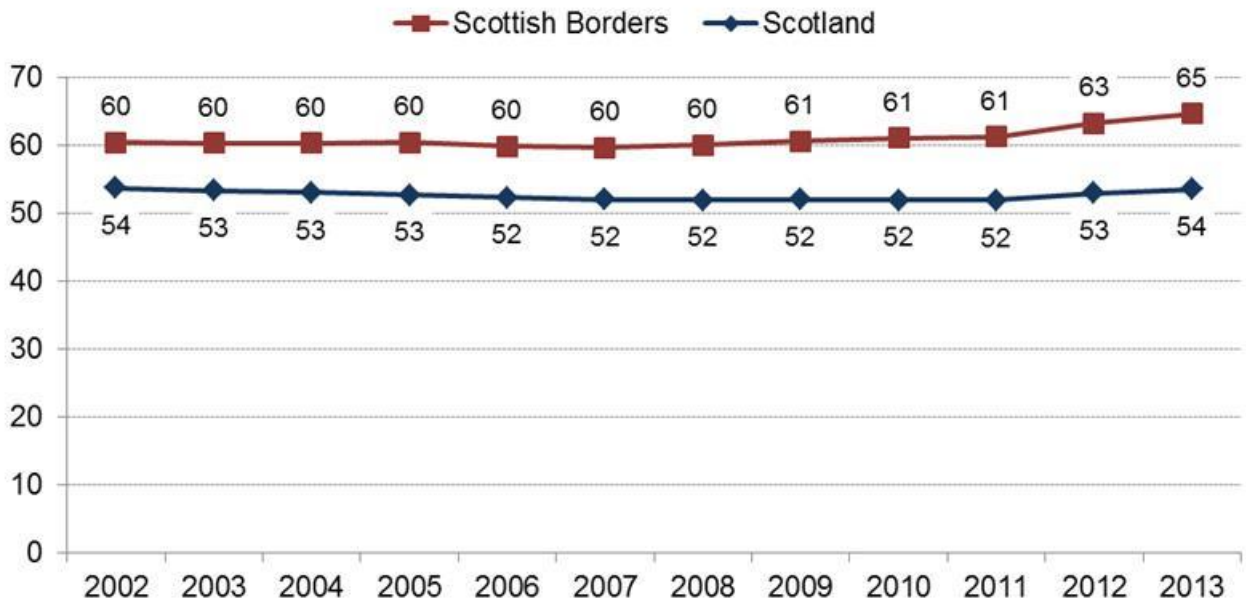


Source: Scotland Census 2011. Based on graphics by the Office for National Statistics (ONS)

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 that the ratio 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

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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.

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

2.2 Projections of future population

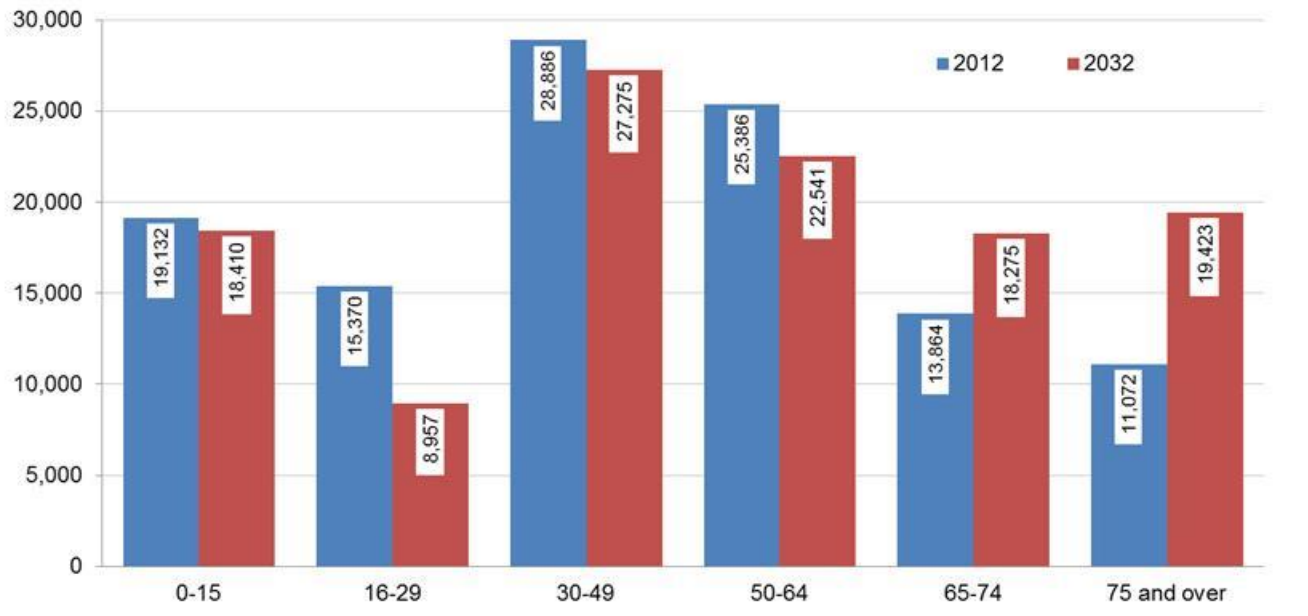
The National Records of Scotland population projections suggest that there may be very little or no change in the overall number of people resident in Scottish Borders between 2012 (113,710) and 2032 (114,881). These latest estimates differ from 2010-based projections, which suggested that the Scottish Borders population might grow by about 11% overall between 2012 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.

Figure 5: 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 6 Projected population of Scottish Borders (2012- based) for 2012 and 2032



Source: National Records for Scotland 2012-based population projections

Population: Key Findings

- Proportion of pensioners aged 65 and over is well above average (20.9% in Scottish Borders compared with 16.8% in Scotland)
- Dependency ratio (people aged under 15 or aged 65 and older) higher in the Scottish Borders compared to Scotland, and has been consistently higher over the last 10 years
- More people aged over 65 in single person households compared to Scotland
- Sparsely populated region with an uneven distribution of the population
- Overall population will remain unchanged over the next 25 year, however the relative number of older people are expected to increase significantly, 65-74 increase by one third whilst numbers aged 75 and over may double

What does the partnership need to consider?

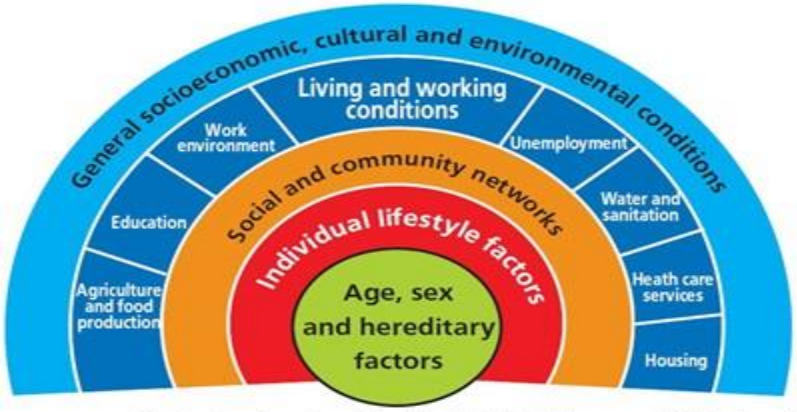
- The partnership needs to ensure that services take into consideration the increase in population of those aged 65 and over
- As the number of older people increase, demand for long term care is also likely to increase and likely to mean an increase in demand for informal care, as well as formal care.
- Older people are more likely to have more complex needs, and the partnership needs to ensure that service are designed to cope with these
- Our rural geography makes it difficult to provide specialist services across the area.
- The partnership should work with partners to develop community resilience – how can we make better use of local assets and resources to support the population to look after their own health, taking into consideration the demographics and rural geography

3 Life Circumstances

3.1 Health Inequalities

Health Inequalities caused by relative poverty can devastate communities, with more affluent people living longer and enjoying better health.

Research exploring the links between health inequalities and mortality shows that relative inequalities in mortality are increased where causes of death are more preventable (Scot et al 2013). This research asserts that a focus on individual behaviours alone (e.g. smoking) is unlikely to reduce health inequalities. Continued action to reduce exposure to the full range of determinants of health, such as housing, employment and education, is necessary to improve the health of the population. The diagram below by Dahlgren & Whitehead (1992) summaries this complex picture well.



The Determinants of Health (1992) Dahlgren and Whitehead

Recent analysis on inequalities in health by the British Academy for Humanities and Social Science (2014) has reinforced this view by claiming as little as 20% of the influences on health are to do with clinical care. Health behaviours account for 30% of influences and the physical environment for 10%, with socioeconomic factors having the largest impact on health at 40%

An important component of prevention therefore relates to wider strategies and interventions to address and reduce the impact of social economic inequalities on health.

3.2 Scottish Index of Multiple Deprivation

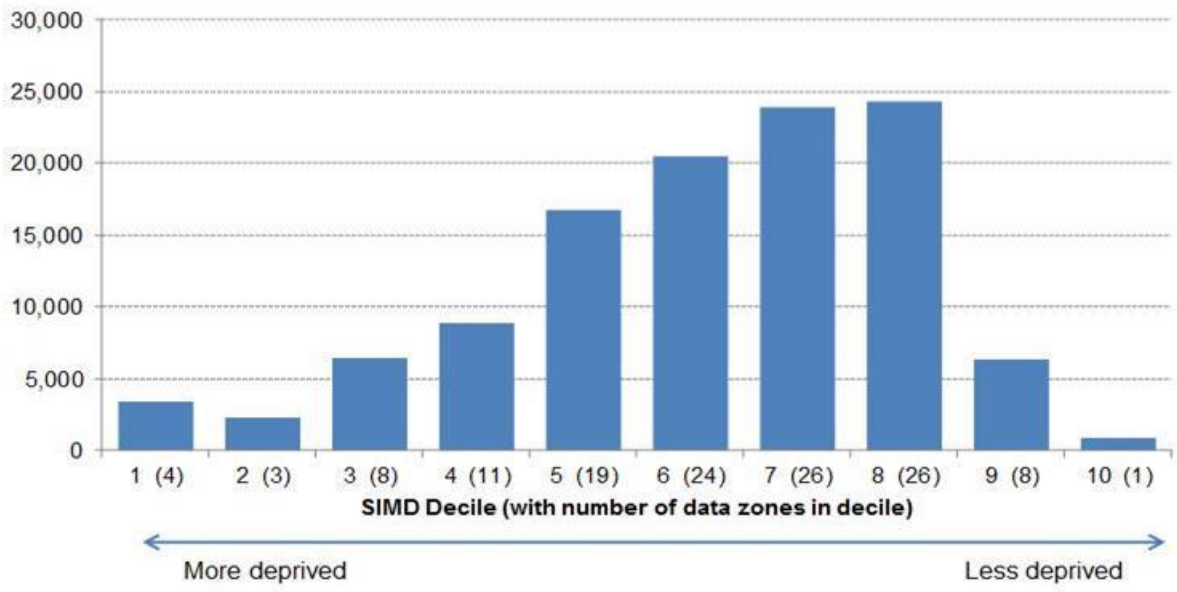
Scottish Index of Multiple Deprivation (SIMD) is a nationally used model that measures multiple domains of deprivation including income, employment, health, education, housing, crime and geographic access. The limitations of the SIMD are acknowledged in a rural area where deprivation can be hidden more easily; as data is averaged for an area, SIMD can hide what is happening in a rural community.

The latest SIMD analysis (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. 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.

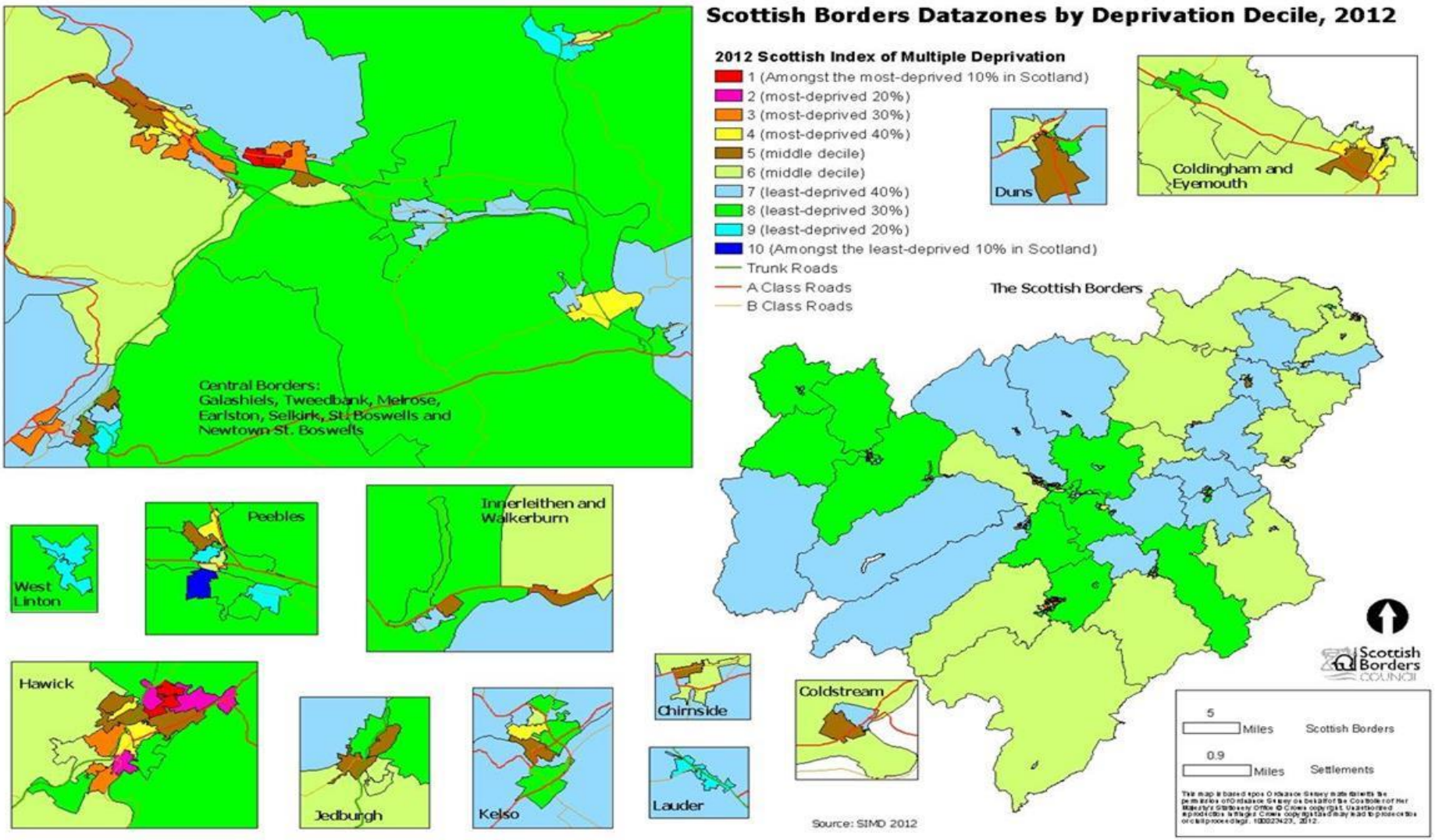
The most deprived data zone in Scottish Borders is still the Central Burnfoot area in, Hawick. The other 4 "15% most deprived in Scotland" data zones in Scottish Borders are also in Burnfoot (South and West), Hawick and in Langlee (Langlee Drive and Kenilworth Avenue), Galashiels.

Figure 6 below shows the number of data zones in Scottish Borders and 2011 Census population by each of the deciles (10 groups of equal size). The 20% most deprived data zones in the Scottish Borders are in the decile grouping of 1,2,3,4. These 26 data zones between them have 18.5% of the Borders population

Figure 7 Number of datazones in Scottish Borders, and 2011 Census populations, by SIMD decile



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


Scottish Borders Datazones by Deprivation Decile, 2012
2012 Scottish Index of Multiple Deprivation
1 (Amongst the most-deprived 10% in Scotland)
2 (most-deprived 20%)
3 (most-deprived 30%)
4 (most-deprived 40%)
5 (middle decile)
6 (middle decile)
7 (least-deprived 40%)
8 (least-deprived 30%)
9 (least-deprived 20%)
10 (Amongst the least-deprived 10% in Scotland)
Trunk Roads
A Class Roads
B Class Roads
Central Borders: Galashiels, Tweedbank, Melrose, Earlston, Selkirk, St. Boswells and Newtown St. Boswells
Duns
Coldingham and Eyemouth
The Scottish Borders
West Linton
Peebles
Innerleithen and Walkerburn
Hawick
Jedburgh
Kelso
Chirnside
Lauder
Coldstream
Source: SIMD 2012
Scottish Borders Council
5 Miles Scottish Borders
0.9 Miles Settlements

3.3 Geographical Deprivation

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

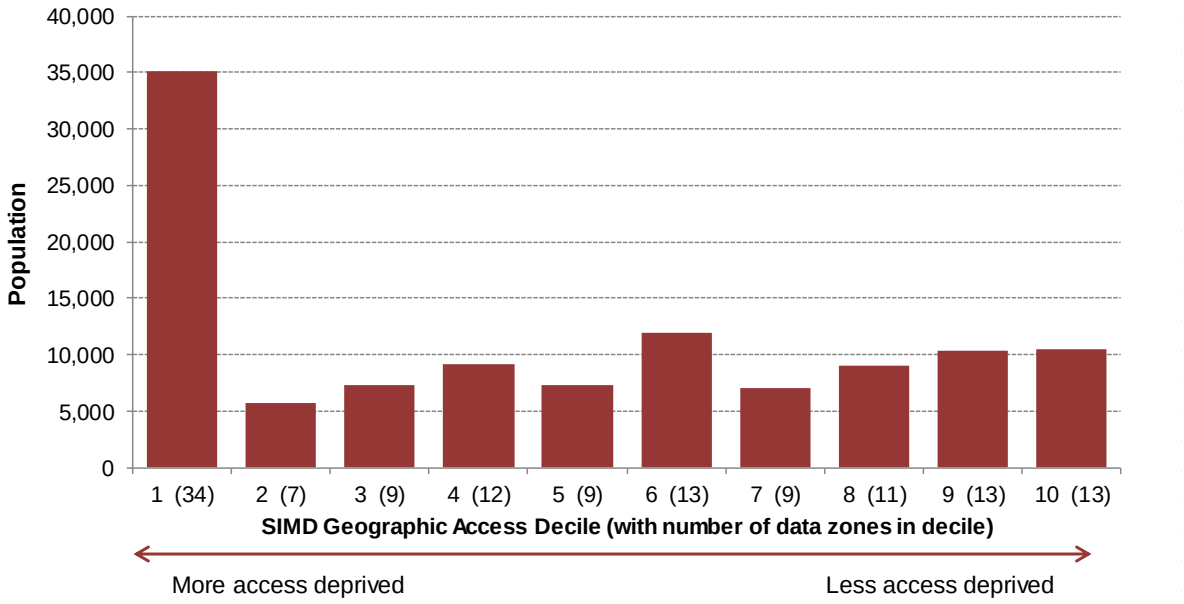
accommodation and no private transport can exacerbate access deprivation for vulnerable people, making it more difficult for them to access services.

Figure 8: 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 9: 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 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.
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Figure 10: 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).

Services, especially out with 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 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.

3.4 Housing

Background

Housing is important for many aspects of healthy living and well-being. A cold and damp home can exacerbate respiratory conditions; a property that is in poor condition may be detrimental to mental wellbeing, whilst a home in poor repair has the potential to increase falls and accidents. The wider local environment around the home is also important in terms of fear of crime, the accessibility of services, and the opportunity to be physically active. Increasingly in unstable economic conditions, the affordability of housing and the potential for individuals to lose their home because of debts they are unable to meet has become a problem for large numbers of people.

As outlined in the South East Scotland Plan -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.

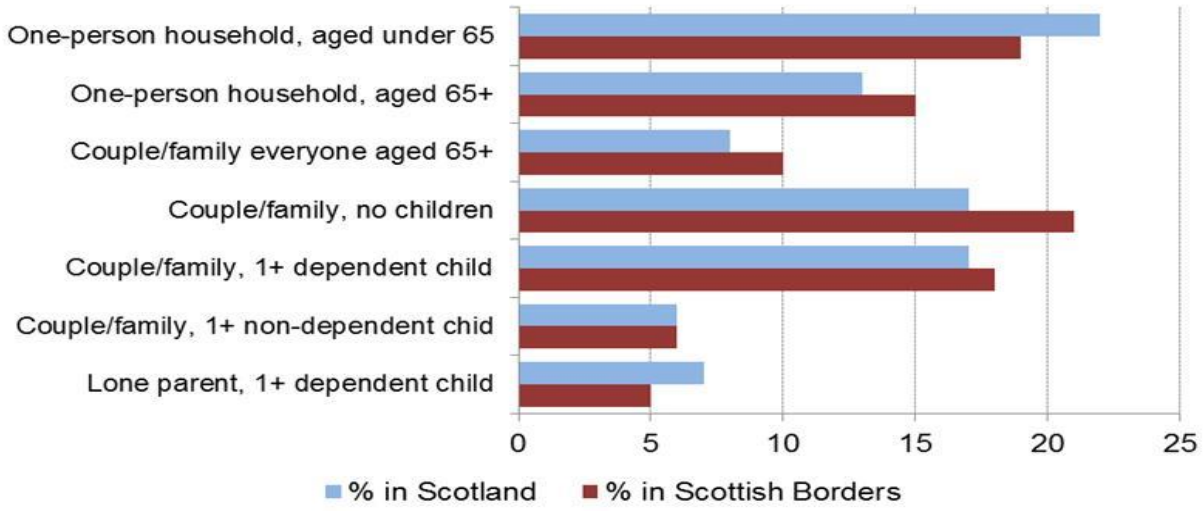
Household Structure

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 11 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.

Figure 12 Household Compositions 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

The SES Plan 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.

A recent report by Royal Voluntary Service (2012) revealed the fragmented nature of families today and the large number of over 75 years olds whose closest children live a substantial distance away from them. Nearly three quarters of over 75s that live alone feel lonely

Lack of social contact is a known risk factor for poor physical health outcomes and depression. Older people living alone are significantly less likely to have visited a

doctor as a result of a fall and that lack of social interaction means that those living alone are less likely to have people noticing deterioration in their condition.

A local workshop on mental health and wellbeing and older people (2010) also identified that social isolation impacted negatively on mental health. The diminishing opportunity for some older people to play a valued role in their community and to maintain/develop skills and interests were also felt to be key factors.

Feeling safe in your own home or neighbourhood is also important .Crime, particularly violent crime, such as assault, can obviously lead to direct effects on physical health. However crime and the fear of crime can also impact negatively on mental health, physical health (due to limited activity) and social well-being (due to isolation or limited social cohesion). The Scottish Borders has consistently been rated as a good place to live over the last few years, with low levels of crime and anti-social behaviour. Compared to Scotland there is a generally lower prevalence of neighbourhood problems.

3.5 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.

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.

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.

3.6. Employment, Benefits and Financial Issues (work in progress)

- Income and income inequality are strongly associated with health inequalities: those in the lower socio economic group have the poorest health outcomes and poor health occurs earlier in the life course
- The Scottish Borders has a smaller proportion of people of working age compared to Scotland and this is likely to continue. In 2012 the Scottish Borders had a dependency ratio of 60.18 compared to 50.35 for Scotland meaning that there are more people aged under 15 or aged 65 and older in the Scottish Borders compared to Scotland.

- Like Scotland and Great Britain the proportion of people claiming Jobseeker's Allowance (JSA) has increased over the past 10 years; particularly for people aged 18-24.

- Overall unemployment in the Scottish Borders is lower compared to Scotland.

Life Circumstances: Key Findings

- Influence on health include social and economic, as well as behavioural
- Areas of deprivation in the Scottish Borders have remained the same for a number of years
- Geographic access –access deprivation is the most widespread type of deprivation, and applies to a higher proportion of the Scottish Borders than for Scotland overall. 44% of household in the most deprived areas do not own a car
- For those who live in the most deprived areas in the Scottish Borders, it can take on average 12 minutes on public transport to get to a GP surgery
- Single person household aged over 65 are growing more rapidly in Scottish Borders, than in Scotland
- 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%
- Lack of social contact is a known risk factor for poor physical health outcomes and depression
- Scottish Borders has low levels of crime and is considered to be a good place to live
- 43% of all households in the Scottish Borders are fuel poor, higher than the Scottish average of 36%
- 60% of pensioner households in Scottish Borders are fuel poor, these rates are higher in rural areas than urban areas

What does the Partnership need to consider

- Create the conditions by 'putting inequalities' at the heart of what it does
- Work with partners to address the wider causes of health inequalities – such as housing, fuel poverty and geographic deprivation.
- Address the issue that not all communities are exposed to the underlying causes of health equally
- Be active participants in local actions to support planning around housing
- Make increased use of telecare and telehealth to reduce impact of rural geography and access deprivation.
- Work with partners to develop an integrated transport policy –so services are available to all

4 Behavioural Determinants of Health

Evidence shows that those from more disadvantaged backgrounds are more likely to adopt unhealthy behaviours such as smoking, poor nutrition, low levels of physical exercise and problematic drug or alcohol use, all of which give rise to poor health- particularly heart disease, stroke and cancer. This section examines some of these lifestyle /risk factors in more detail.

It is important to note future cohorts of older people may experience better or worse health than older people at present, depending on the lifestyle choice made earlier on in life. It is important therefore that for primary and secondary prevention that we address healthy ageing at an early enough life stage

4.1 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.

Figure 13 Trends in percentage of adults aged 16+ who smoked; Scottish Household Survey results from 1999 to 2013

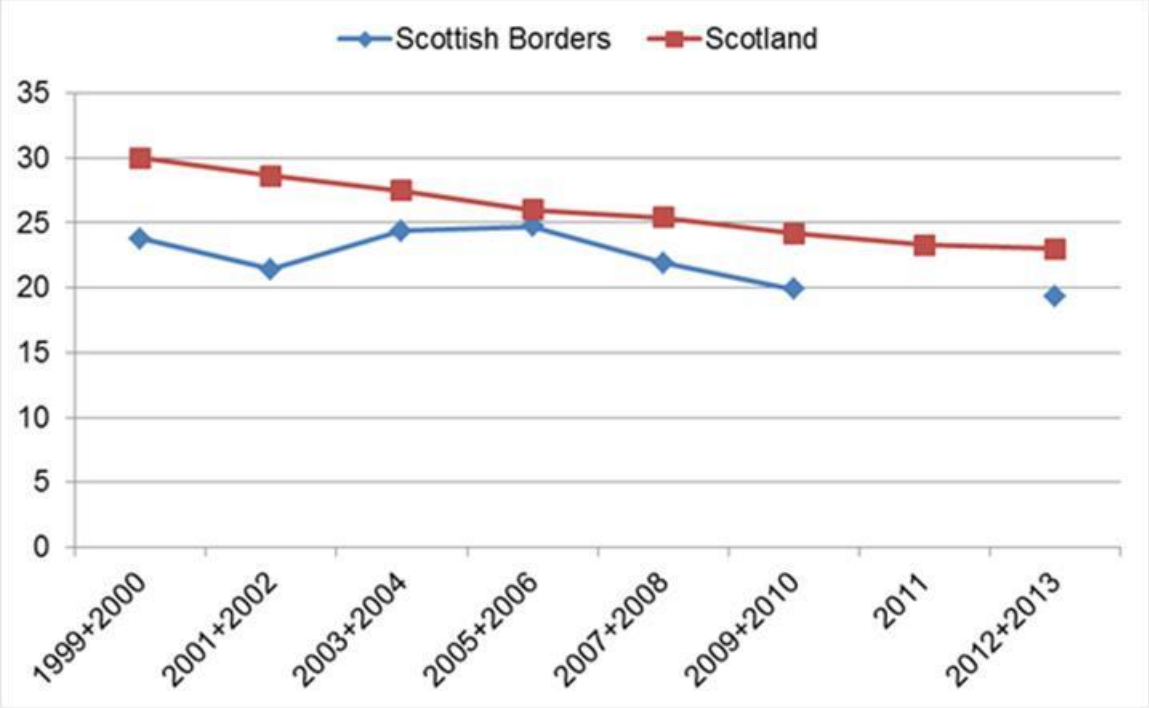


Figure 14 Proportion of Scottish Household Survey respondents who smoked, by age band, 2012+2013

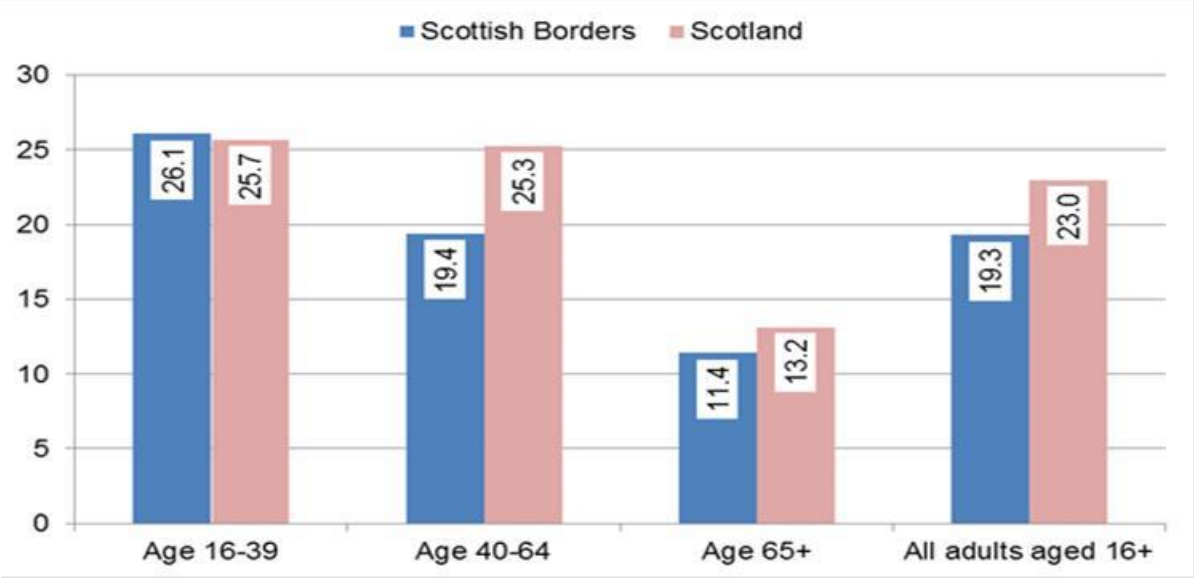


Figure 15 Age-standardised rates per 100,000 population of smoking-related illness and mortality, Scottish Borders versus Scotland

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	133.3
COPD "incidence" (first hospital admission for COPD within 5 years) (people aged 16+)	2011-2013	303.6	391.1

4.2 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 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 100,000.

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

4.3 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 100,000.

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

4.4 Healthy Weight

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

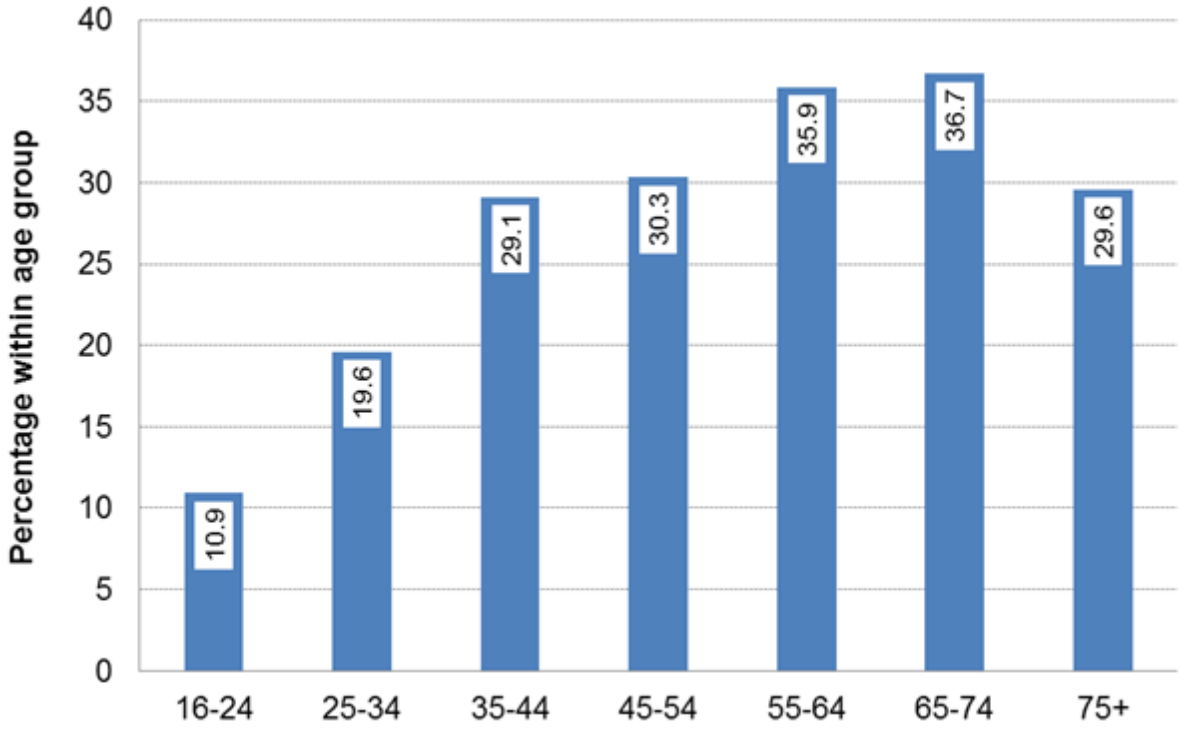
- 27% of the population aged 16 and over were obese (had a Body Mass Index of 30 or more)
- 25% of males in this age group were obese
- 29% of females in this age group were obese

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.

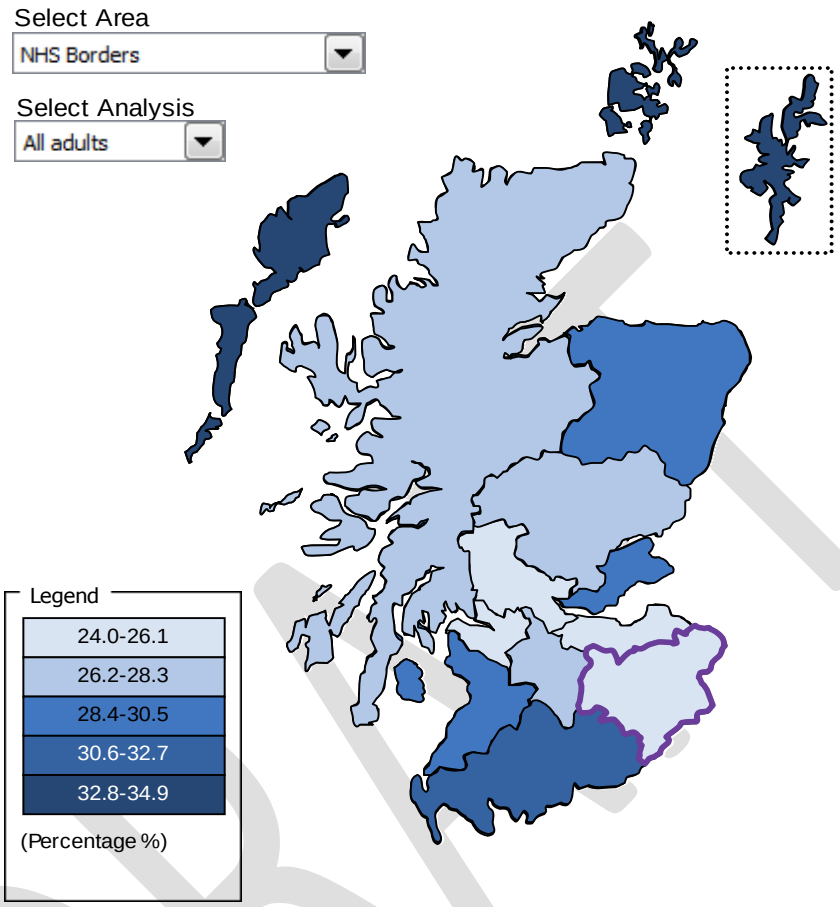
The estimated prevalence of obesity tends to rise with increasing age; from around 1 in 9 people aged 16-24 to more than 1 in 3 people aged 55-74, as shown in the graph below

Figure 16 Survey-based estimates of the proportions of the Scottish population who are obese (Body Mass Index of 30 or more), by age band, 2013



Due to the relatively small sample size of the survey, most of the results are published as national totals only. However, periodically the Scottish Government publishes figures at NHS Board level, based on aggregated results from a combined set of years. 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 17: 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



4.5 Diet and Nutrition (to be completed)

4.6 Physical Exercise (to be completed)

Lifestyle/Risk factors: Key Findings

- Alcohol problems is a major public health issue in Scotland
- Alcohol is recognised as a contributory factor in many other diseases including cancer, stroke and heart disease
- Survey figures on adults drinking on more than 5 days per week show Scottish Borders to have higher proportion than Scotland
- Adults smoking in Scottish Borders is consistently lower than the average for Scotland
- The estimated prevalence of obesity amongst adult females in the Scottish Borders was higher than for Scotland.
- The prevalence of obesity tends to rise with increasing aged
- Obesity is associated with an increased risk of a number of common causes of disease

What does the Partnership need to consider?

- To work in partnership with the Borders Alcohol and Drugs Partnership (BADP) to deliver its core aim which is to deliver a reduction in the level of drug and alcohol problems amongst young people and adults, and reduce the harmful impact on families and communities.
- Although smoking levels in adults are lower than average for Scotland, the figures from the younger adult age groups are consistent with the national average. The Smoking Cessation Service (part of the Joint Health Improvement Team) and the Lifestyle Advisor Support Service continue to provide local support to enable individuals to support lifestyle changes
- To actively support the Joint Health Improvement Plan for the Scottish Borders which has the key aim of supporting improvement in health and health inequalities across the Scottish

5. Health Status

5.1 General Health

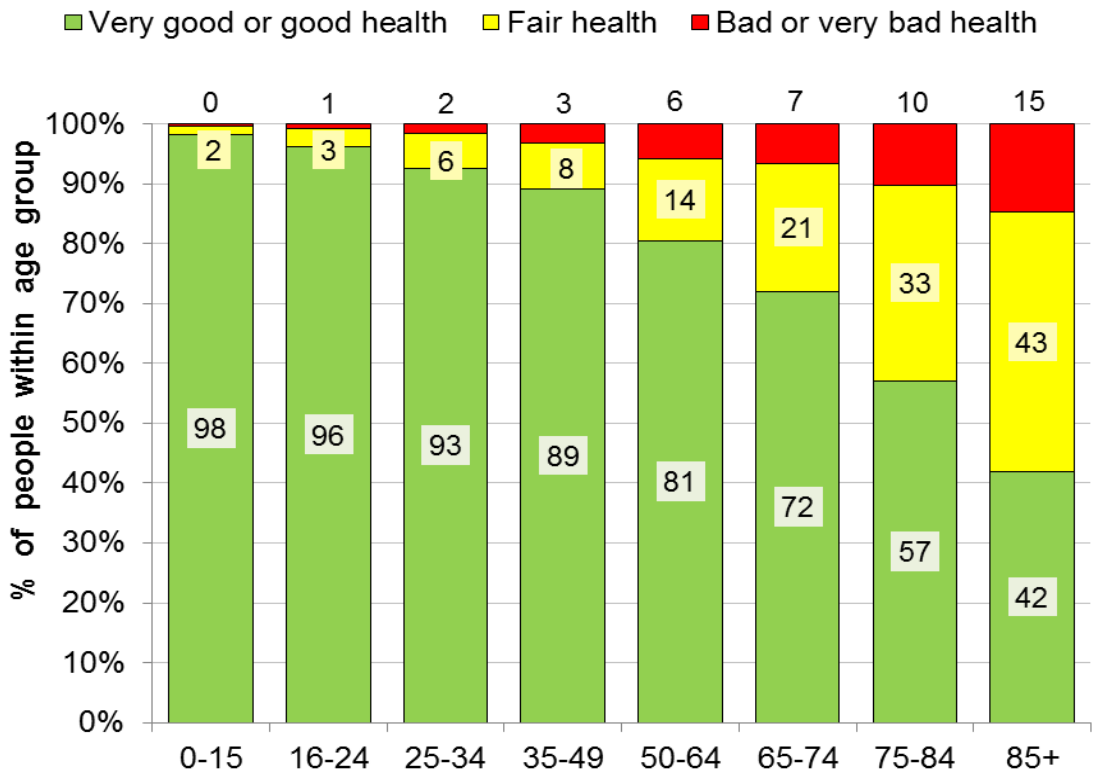
According to the 2011 Scotland Census:-

- 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 18 Self-reported general health amongst Scottish Borders residents, by age group



Source: Scotland Census 2011

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.

Figure 19: 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).

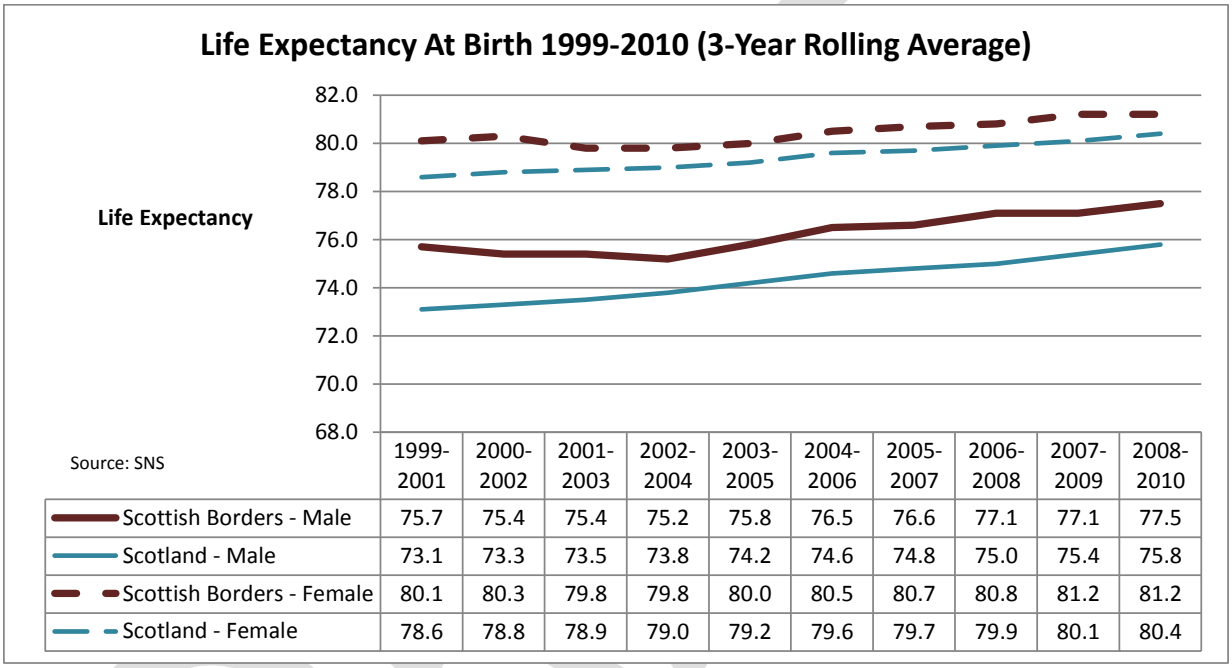
In the Scottish Borders there are 4 areas where less than 75% of the people living in the area consider their health to be "good/very good". These areas are: the Moat area and the East Burnfoot areas of Hawick, the Seafront/ harbour area of Eyemouth and the Old Town area of Galashiels. In the Scottish 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.

5.2 Life Expectancy and Healthy Life Expectancy

Life expectancy is an important measure of the health of the population, and is an estimate of the number of years a newborn child would live if it was to experience the current mortality rate for all of its life. It is one of the simplest ways we look at changes in population health over time. Life expectancy in Scotland has been slowly rising over time for both men and women. However Scotland still ranks lowest for UK life, and the

Scottish Public Health Observatory notes that Scotland has one of the lowest Life Expectancies in Western Europe. 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 below shows the 3-year rolling average of life expectancy at birth between 1999 and 2010; comparing Scottish Borders to Scotland

Figure 20



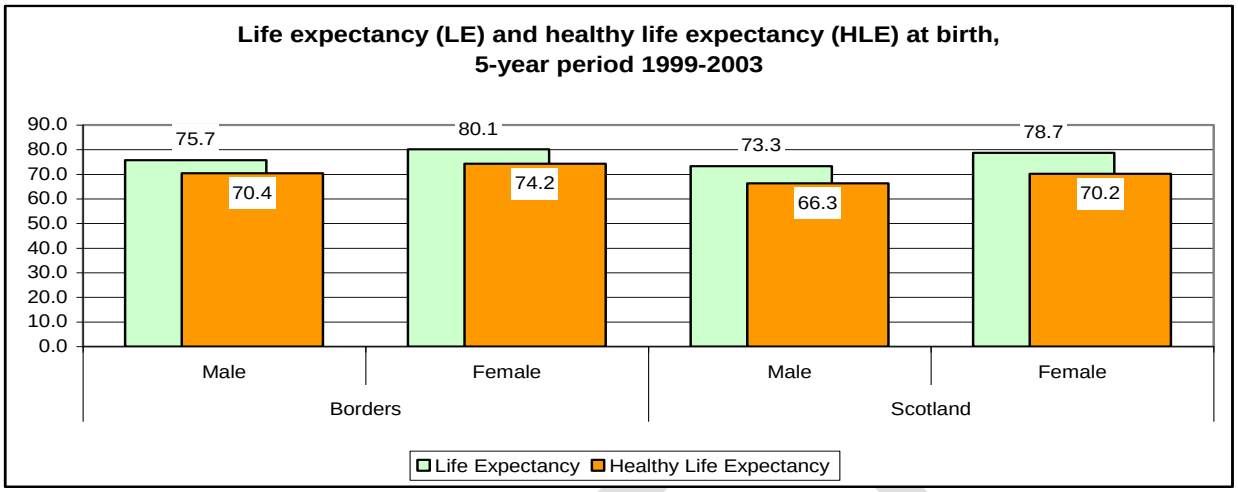
Source: SNS

	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Scottish Borders - Male	75.7	75.4	75.4	75.2	75.8	76.5	76.6	77.1	77.1	77.5
Scotland - Male	73.1	73.3	73.5	73.8	74.2	74.6	74.8	75.0	75.4	75.8
Scottish Borders - Female	80.1	80.3	79.8	79.8	80.0	80.5	80.7	80.8	81.2	81.2
Scotland - Female	78.6	78.8	78.9	79.0	79.2	79.6	79.7	79.9	80.1	80.4

However we know that life expectancy has not risen equally for all people. In Scotland, the average life expectancy of men living in the least deprived areas remains around 11 year higher than the most deprived. (Audit Scotland report)

Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. The graph below compared life expectancy to healthy life expectancy for the Scottish Borders and Scotland based on data from 1999 to 2003. In the Scottish Borders both men and women are expect to have higher life and healthy life expectancy compared to Scotland

Figure 21



Life expectancy and healthy life expectancy is important for planning health and social care services. As life expectancy has increased, Government have responded to the challenge of the ageing population by increasing the age at which people qualify for the state pension to 68 in future years. This has been done to maintain the ratio of working-age adults to pensioners. In addition this group of older workers may also be called upon to care for increasingly elderly dependants over longer periods of their own working lives, and that working carers themselves will be older on average.

People can only work and provide care if they remain in good health, hence the importance of healthy life expectancy. As life expectancy rises it is important that the gap between it and healthy life expectancy does not widen.

5.3 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 22: Age-standardised death rates amongst people aged under 75, years 2006 to 2013.

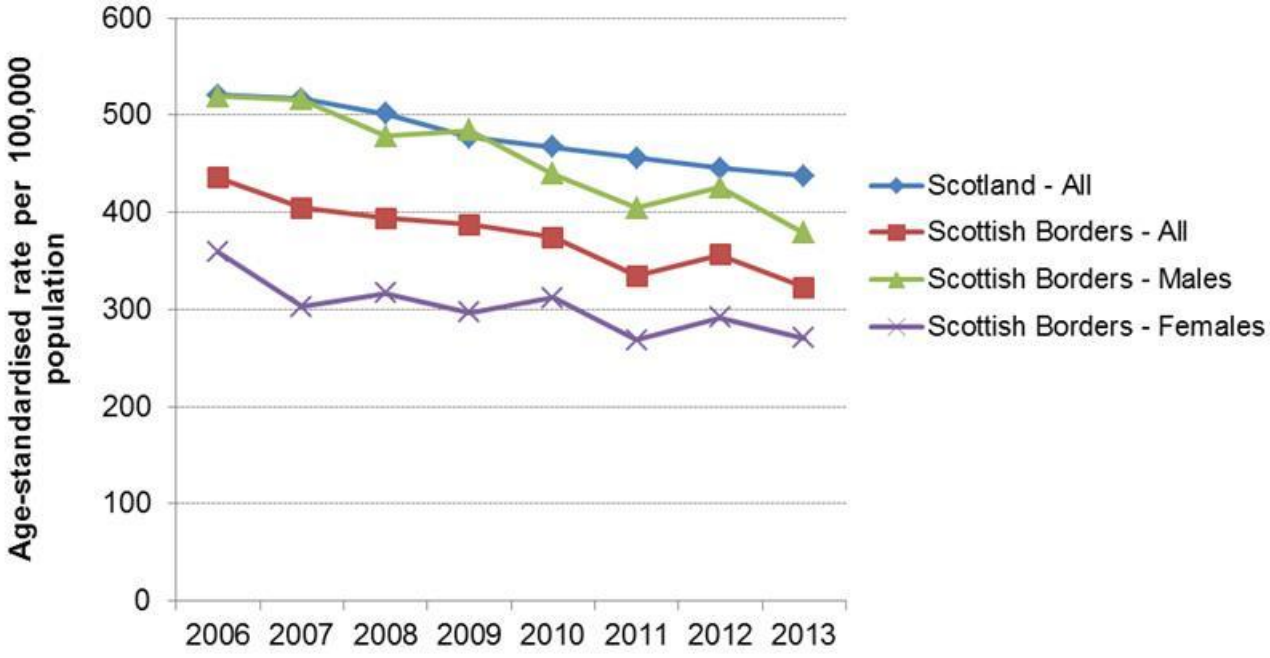


Figure 23: Age-standardised death rates (per 100,000 population) amongst people aged under 75, years 2006 and 2013.

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.

Figure 24: 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.

Note: To add in more on premature mortality by specific cause of death - CHD, Stroke and Cancer?

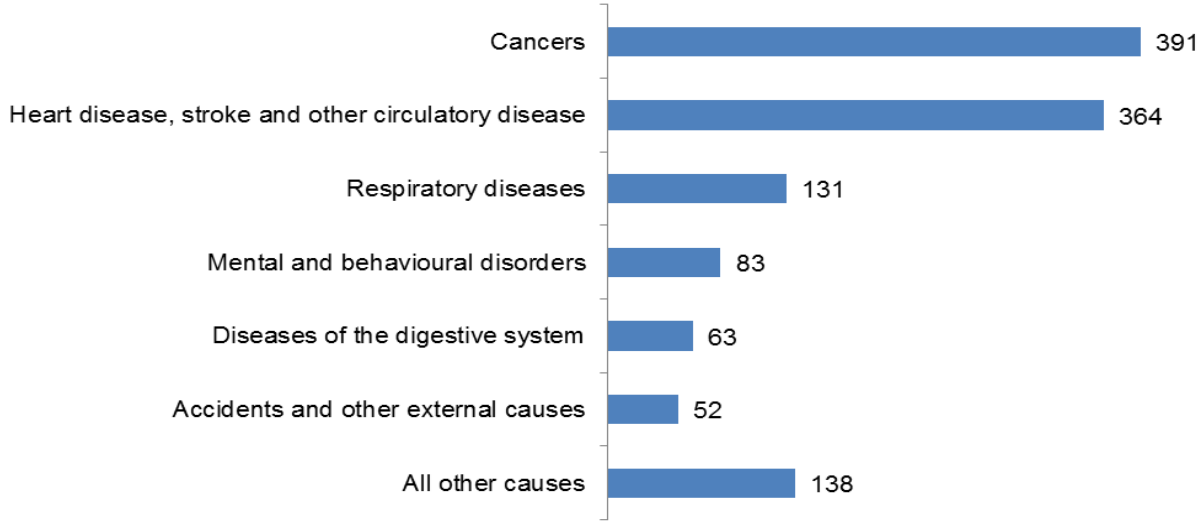
5.4 Mortality

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.

Note: To add in more on trends in mortality over time?

Note: Add in mortality by deprivation quintile – link between socioeconomic deprivation and levels of ill health.

Figure 25 Numbers of deaths in Scottish Borders (all ages) by cause, 2013



Source: National Records of Scotland.

Figure 26: 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.

5.5 Living with illness – Multi morbidity

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

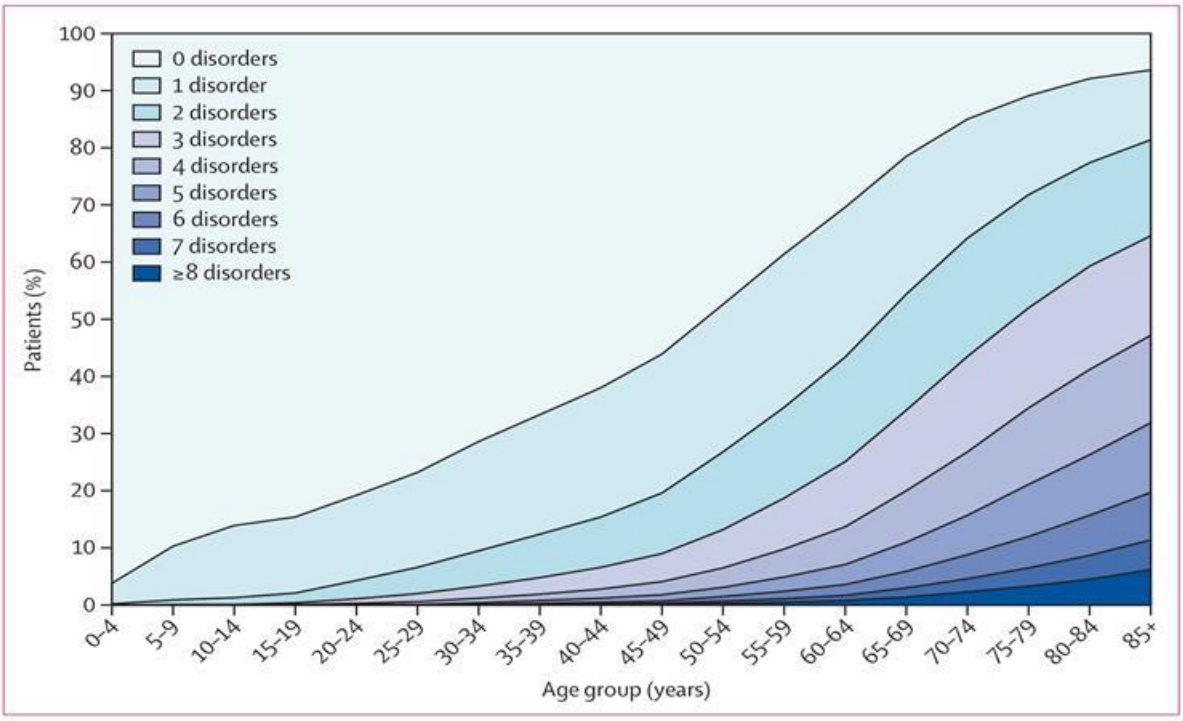
who suffer two or more long term conditions at the same time. Emergency admissions to hospital and attendances at A&E departments are rising in areas with a high level of multi-morbidity. Across Scotland, annual adult health and social care spend is over £10.9 billion and is projected to rise with this increasing demand. Most people with multi-morbidity in Scotland are under 65 years; and we know it occurs 10 to 15 years earlier in more deprived area compared to affluent areas. We also know that the most common co-morbidity in deprived area is a mental health problem

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

Figure 27 Percentages of patients having one or more chronic disorders, by age group, Scotland 2007



5.6 Living with illness- Long-Term Conditions

This section provides information on people who live with long term conditions. These are conditions that generally last a year or longer, and may impact upon a person's life. (E.g. cancer, stroke, diabetes). Although many people with a long term condition look after their day to day symptoms with support from health or social care services, others do need ongoing support. A small number of patients with very complex needs who needs support from multiple services for prolonged periods of times.

We know that the number of older people living with long term conditions is projected to increase and there are clear links between long term conditions, deprivation and lifestyle factors. It is widely acknowledged that the appropriate management of long term conditions is one of the biggest challenges facing health and social care systems

The current Long Term Condition project in the Scottish Borders identifies the importance of empowering patients to become actively involved in their own care,

alongside professionals committed to working in partnership with patients and carers; with improved links and access to community resources. The aim is to ensure good shared-management that promotes as healthy, active and independent living as possible, for as long as possible, and before they get to the stage of ending up in need of acute health and social care services

Currently we know that 60% of all deaths are attributable to long term conditions and they account for 80% of all GP consultations in Scotland. Furthermore people with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionally longer and account for over 60% of hospital bed days used. While within the social care sector most peoples who need long term residential care have complex needs usually arising from their multiple long term conditions.

5.6.1 Quality Outcomes Framework

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.

Figure 28: 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.

Note: Add in CHD

5.6.2 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 is 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).

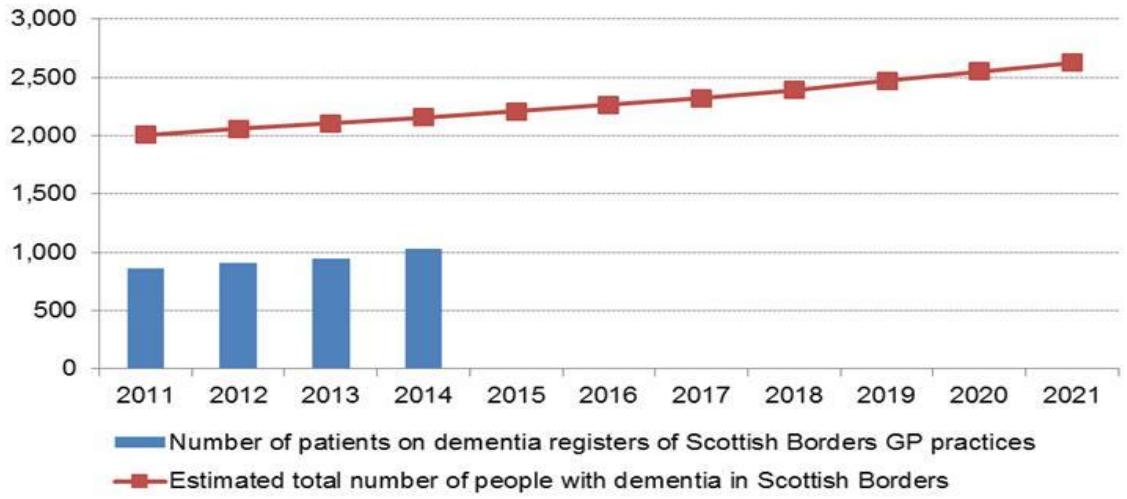
Significant patterns exist when examining incidence and mortality rates by deprivation in Scotland. For all cancers combined, the most deprived areas (those in the bottom quintile for multiple deprivation) have incidence rates that are 34% higher than the least deprived areas. Mortality rates are 71%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

5.6.3 Dementia

Dementia presents a significant challenge for health and care services, now and going forward into the future. The key aim of the *Borders Dementia Strategy (2009 -2014*) is to ensure that services providing care and support to people with dementia are appropriate to need and demand. It is recognised that services need to be varied, flexible, local and delivered by appropriately skilled and supported staff to ensure quality of life for people with dementia and their Carer.

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 29: 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 Euro code prevalence model used by Alzheimer's Scotland, and 2010-based population projections.

5.6.4 Diabetes

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:-

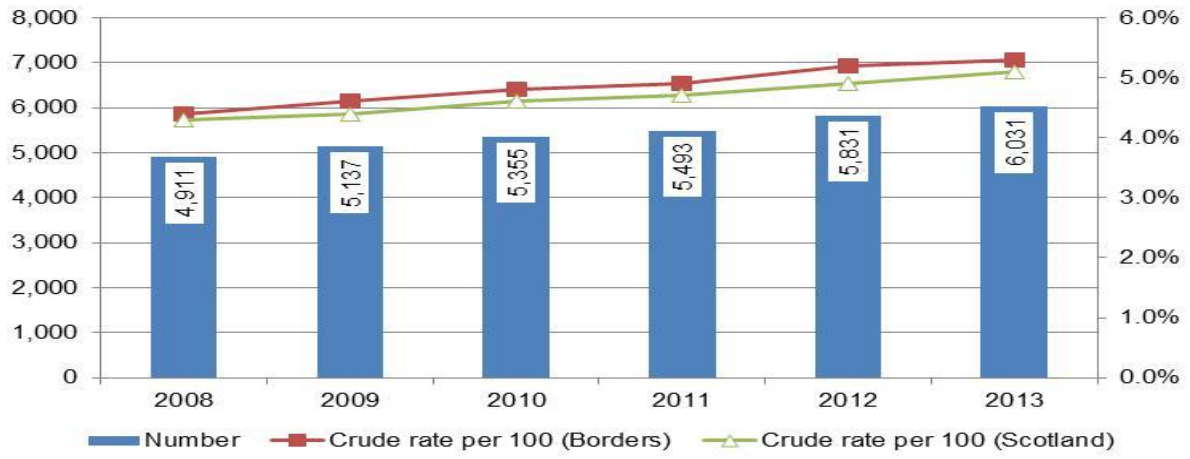
- 5,349 (88.7%) had type 2 diabetes
- 633 (10.5%) had type 1 diabetes
- 49 (0.8%) had another type of diabetes

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



5.7 Learning Disability

Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006, and published their joint strategy in September 2013. 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.

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. Figures from the 2013 eSAY ("electronic Same As You) report, published by the Scottish Consortium for Learning Disabilities, indicate that 601 adults with Learning Disabilities were known to Scottish Borders in that year. The age and gender profile of this group is shown in the table below

Figure 31: Numbers of adults with Learning Disabilities known to Scottish Borders services 2013, by age and gender*

Age group	Number of Males	Number of Females	Both genders combined	% within age group
16-17 and not in full-time education	7	0	7	1%
18-20	27	22	49	8%
21-34	106	70	176	29%
35-44	57	45	102	17%
45-54	66	39	105	18%
55-64	48	39	87	15%
65 and over	32	42	74	12%
Total	**343**	**257**	**600**	**100%**

*Age/gender not shown for one individual

Source: Learning Disability Statistics Scotland 2013 (the "eSAY" report) http://www.scld.org.uk/scld-projects/esay/publications-and-resources/statistics-releases

Note: Add in geographical breakdown, to illustrate the variation in numbers across each locality area?

5.8 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 Disorder: This is often used to cover a broad range of illnesses, learning disability, and 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.

5.8.1 Mental Wellbeing

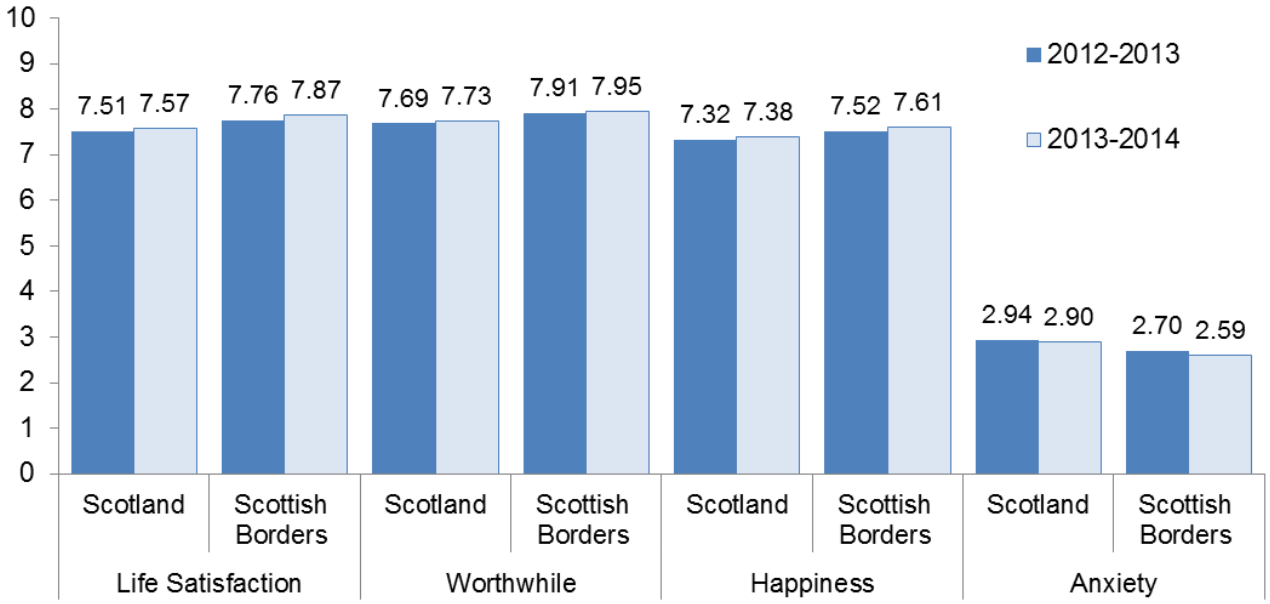
As outlined above, mental wellbeing is an essential part of person's capacity to lead a satisfying life, which includes the capacity to make informed choices, study, pursue leisure interests, as well the ability to form relationships with others. The concept of 'wellbeing' has gained a wider public airing 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 32: 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.

5.8.2 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 33 Scottish Borders residents identified through the 2011 Scotland Census as having Long Term Mental Health conditions; percent of population within gender and age group.

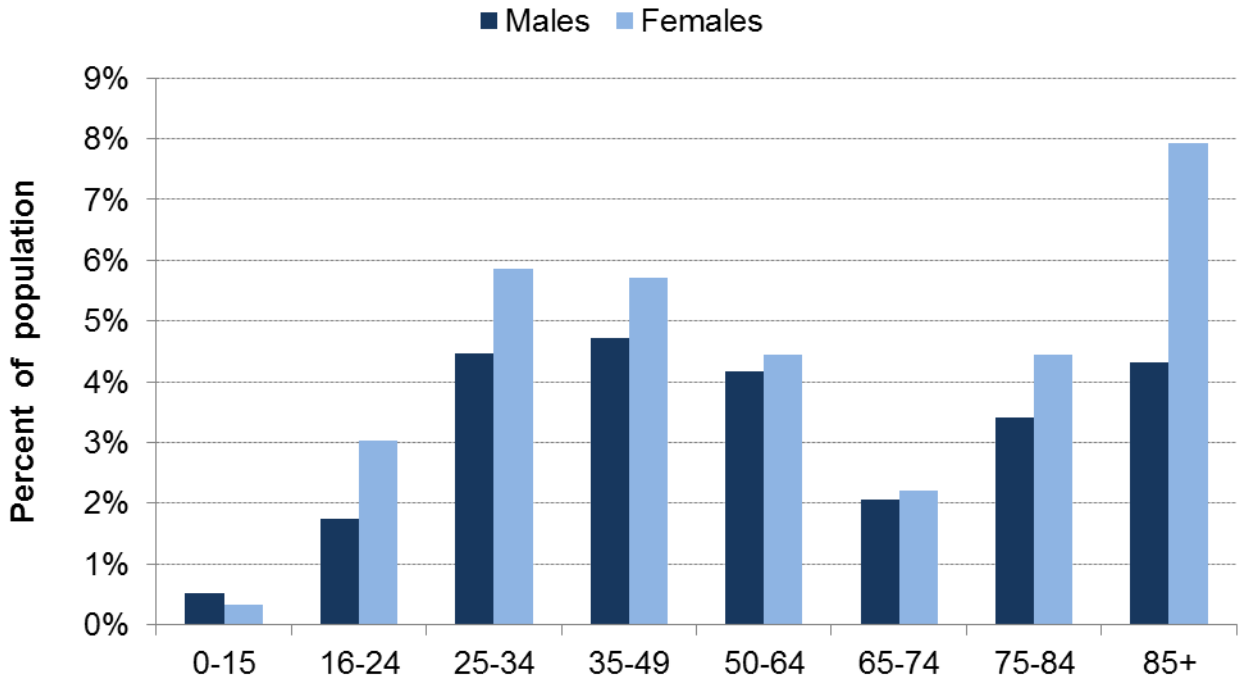
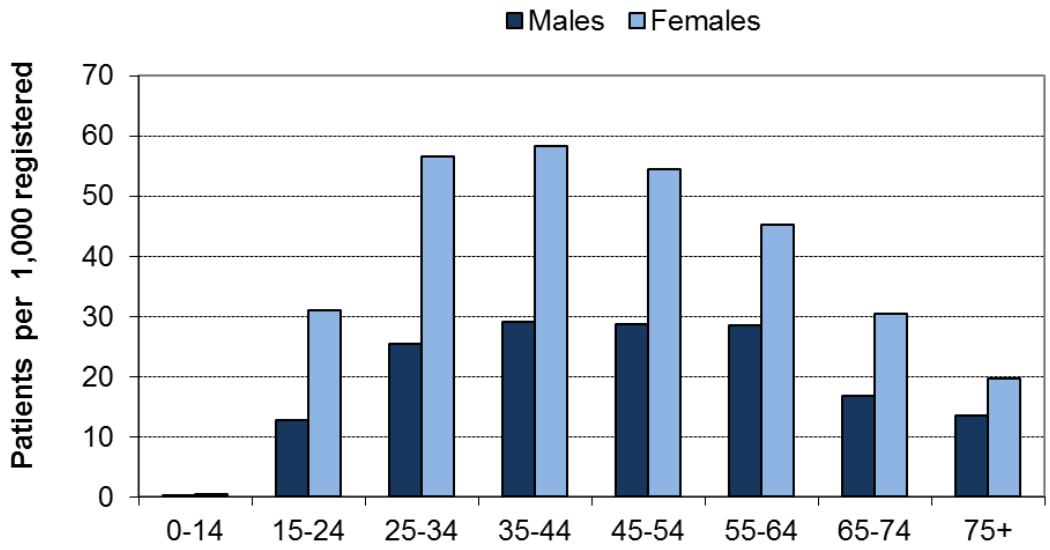


Figure 34: Depression – estimated number of patients in Scotland consulting a GP or practice nurse at least once in the financial year 2012/13, per 1,000 patients registered; by gender and age group



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.

Figure 35: 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.

5.9 Physical Disability

The Living Well with a Disability Joint Commissioning Strategy was published in March 2013, with the key aim '*to work in partnership to provide quality services that support the health and wellbeing of people with a physical disability and which enables them to live well with their 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.

Figure 36: 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%**

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)

5.10 Sensory Impairment (edit)

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 (Deaf blindness). 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

5.10.1 Hearing Loss

Approximately one in six adults is 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 Shield (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.

5.10.2 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.

5.10.3 Deaf blindness/dual sensory loss

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

Deaf blind Scotland estimate that there are approximately 5,000 people in Scotland with significant hearing and sight loss, most of who 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.

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

5.11 Frailty/Falls (work in progress)

30% of the 65+ population and 50% of those over 80 fall each year. This would equate to an estimated x falls across the Scottish Borders. Falls are the most common cause of accidental death in those aged 75+ and of accidental injury in older people in generally. Falls cause 85% of deaths due to home accidents in those over 65+ year and 1 million non-fatal accidents each year in the UK.

5.12 Oral Health (to be completed)

5.13 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:-

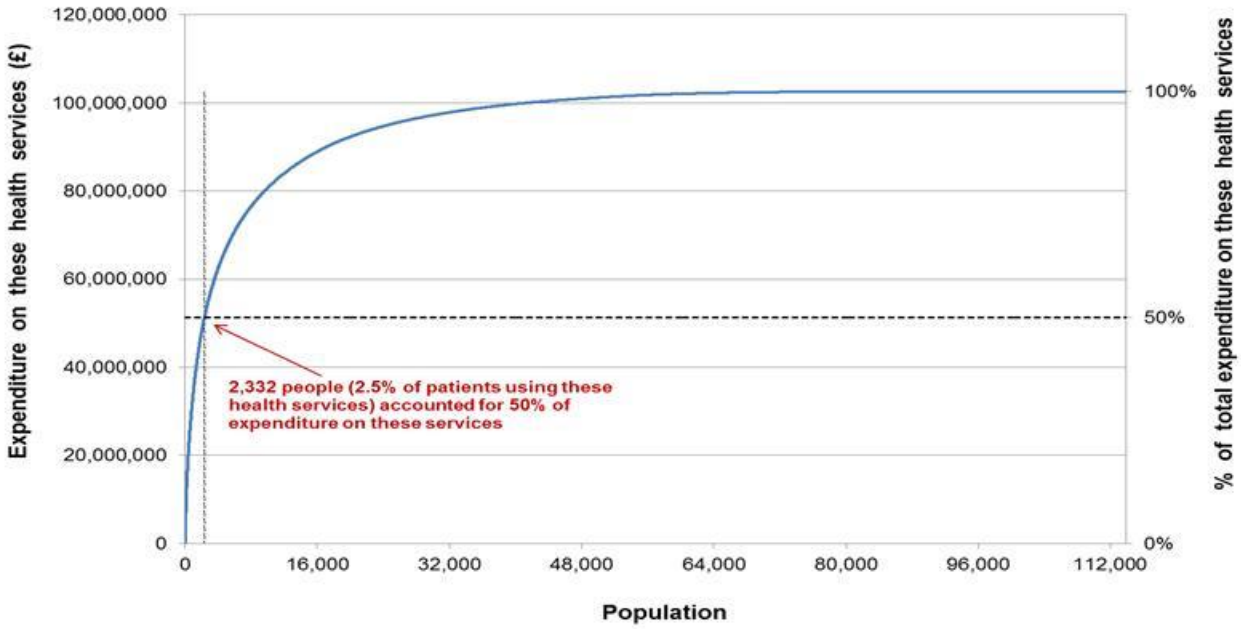
- Inpatient and day case hospital admissions (including all acute specialties, maternity, geriatric long stay inpatient care, and psychiatric inpatient care)
- A&E attendances
- New attendances at consultant-led outpatient clinics
- Community prescribing

"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 37 Cumulative expenditure for selected major health services*; for Scottish Borders residents; financial year 2012/13



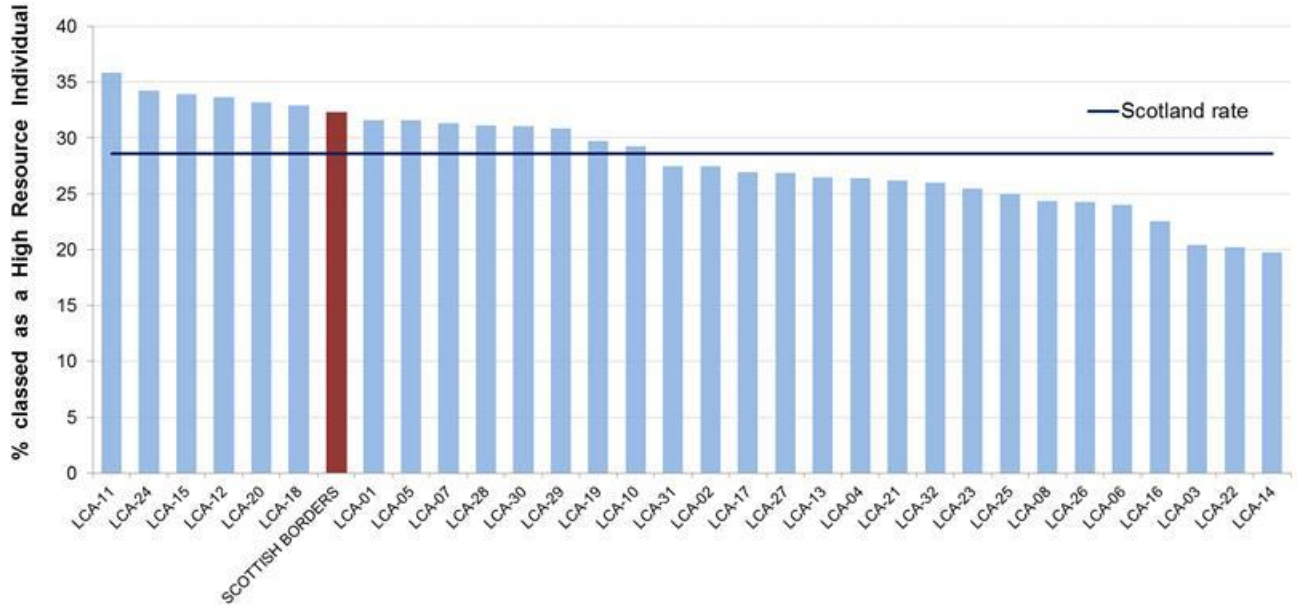
Analysis of the cost and activity data for these major health services illustrates something of the relationship between Long Term Conditions and the likelihood of being

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



Key Findings

- 84% of the Scottish Borders population consider their general health to be very good or good, rates are lower for residents who reside in the more deprived areas. Suggesting that poor health is more prevalent in those who are economically inactive
- In addition 1 in 10 of people aged +75 reported their health as being bad/ very bad, compared with 1 in 100 aged 16-64
- In the Scottish Borders both men and women have a higher life expectancy at birth compared to Scotland. For men the figure is 77.5 year and women 81.2 years.
- We also have a higher healthy life expectancy; this is important if people are having to work longer, and care for elderly dependants over longer periods.
- The Scottish Borders has lower rates of cancer incidence, once the age profile of the population is taken into account. However new cancer cases are expected to increase by 8% every 5 years up to 2020, reflecting the projected increase in the number of older people in the population.
- Rate of increase in dementia is faster than the national average, and may double over the next ten years given the increase in the proportion of older people. Presenting a significant challenge for health and care services for now and in the future. Nearly one third of patients aged 65+ who had a previous hospital admission for dementia, was classifies as High Resource Individual
- Mental health and wellbeing in the Scottish Borders appears to be improving with an increase in life satisfaction and levels of anxiety reducing. Overall personal wellbeing appears to be better than that for Scotland
- We have residents with a range of long term issues that impact on the ways they can access or use services – for example those with learning disabilities, physical disabilities and/or sensory (sight/hearing) loss.
- The prevalence of physical disability rises with increasing age
- The rate of multi-morbidity (two or more long term conditions) increase with age, with nearly two thirds of patients aged 65-84 and more than 85+ had multi-morbidity (Scotland wide data)
- 11% of people in the most deprived areas had both a physical and mental disorder, compared with 5.9% in the least deprived (Scotland wide data)

Key Findings (continued)

- 2.5% (2,332 people) of all Scottish Borders residents using any of the major health services, accounted for half of all expenditure.
- 7% (1,451 people) of all Scottish Borders residents aged 65+ using any of the major health services accounted for half of all expenditure
- Patients with two or more long term conditions are more likely to fall into the category of a High Resource Individual (HRI)
- Overall the age-standardised rates of premature mortality are lower than those for Scotland. However with the Scottish Borders, rates for men are higher than those for females
- Cancer, heart disease and stroke are the major causes of death in the Scottish Borders, 32% of all deaths are due to cancer.

What does the Partnership need to consider?

- We have a population which considers their general health to be good or very good; however this is not the case for those who live in the more deprived areas. The Partnership need to continue to work closely with other agencies to reduce social inequalities and promote social inclusion
- We have a population which has a higher healthy life expectancy compared to Scotland. The challenge going forward is to continue to promote good health amongst our aging population and to support older people to live independently in their own homes.
- The rapidly ageing population will result in significantly more people living with dementia. Providing services for people with dementia also accounts for a significant % of the total health and care expenditure. The Partnership should continue to work with partners to support the drive to increase the rate of early diagnosis and ensure that appropriate levels of post diagnostic support are in place, including support for carers.
- Managing long term conditions is one of the biggest challenges facing health care services across the globe. Current thinking is that people living with long term conditions should be more involved in decision-making and in control of their own care. The proposed model for delivering this patient-centred, integrated care is the 'House of Care' http://www.jitscotland.org.uk/wp-content/uploads/2014/11/Multiple-Conditions-20pp-new.pdf

6 Current Provision of Health and Social Care Services

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).

6.1 GP Services

Primary care, and in particular care delivered by general practice has been a cornerstone of the NHS since its inception. GPs and their practices will play an important part in influencing and shaping the priorities for the Partnership. Over the next few years, GPs will be faced with new challenges in terms of demand, capacity and access from an aging population.

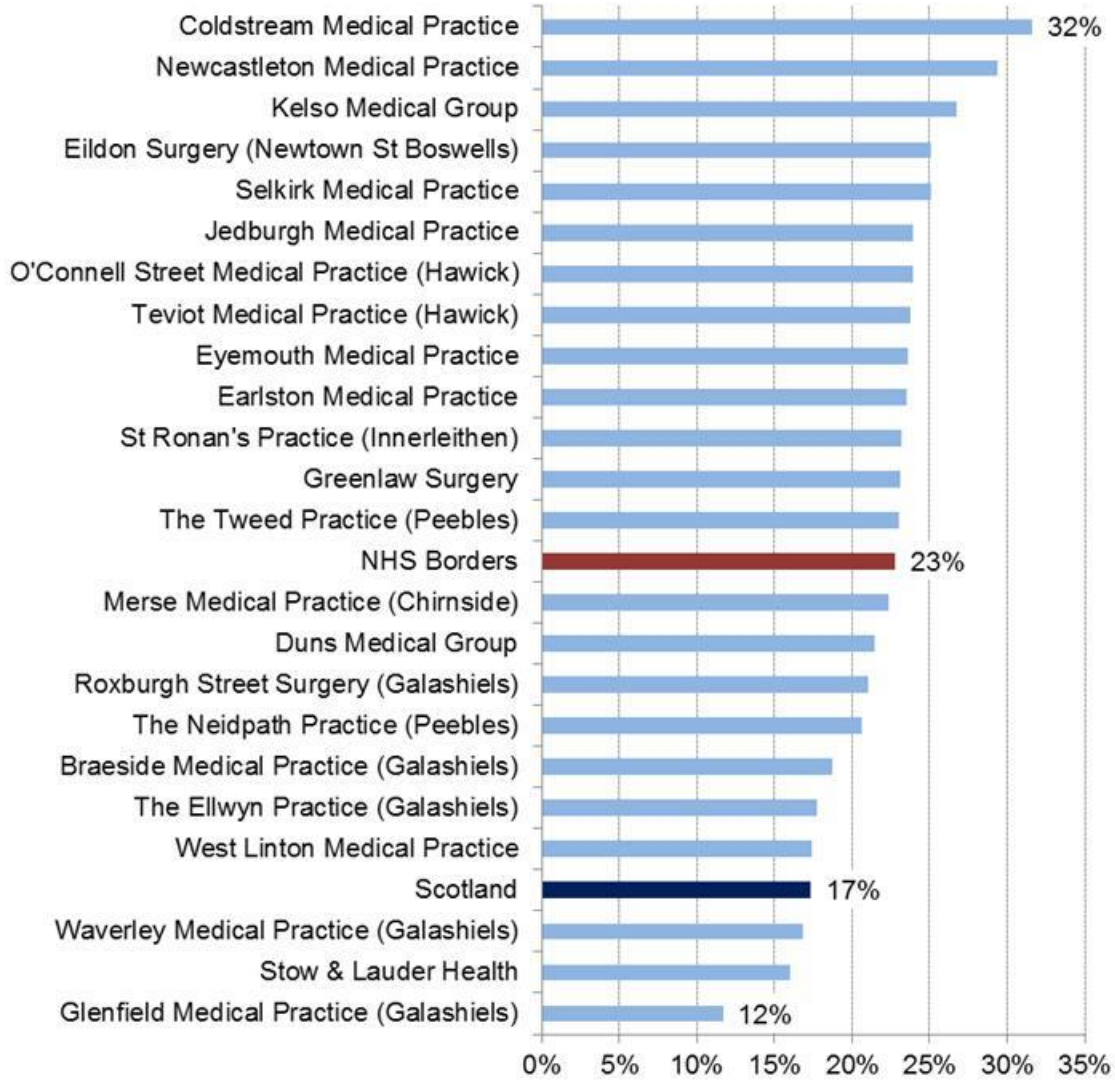
The recent 'Assessment of the Needs of Older People in the Scottish Borders 2012', commented that with the exception of babies and pre-school children, the older the person, the more like they are to visit their GP on a regular basis. The over 75s consult their GP an average of 5 times and a practice nurse 3 times during the year (compared to 3 times and once respectively for all ages).

There are 23 GP practices located across 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 percentage of over 65s registered with individual GP practices (see figure below) varies significantly across the region,

ranging from 12% in one of the Galashiels practices to 32% in Coldstream. The Scottish average is 17%.

It is known that GP practices are already struggling to meet existing demand, and the projected increase in the number of older people will have an impact on their ability to respond. The proportion of people with two or more long term conditions increases in the over 65s. There will be a particular impact where these services are delivered by the only practice present in a smaller town.

Figure 39: 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/

6.2 Unscheduled Care

Unscheduled care is a term used to describe any unplanned treatment, help or advice to people in an emergency or urgent situation. It can occur at any time and crosses the traditional boundaries between general practice, community and social care services and hospital services.

The Scottish Government has set partnerships targets for unscheduled care, including A&E attendances and unplanned hospital admissions. With an aging population in the Scottish Borders, pressure will continue to increase on acute hospital services and residential care placements unless we look to changing the way we deliver services.

The section below looks briefly at two key areas of unscheduled care – A&E attendances, and Emergency Admissions

6.2.1 A&E Attendances

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**.

6.2.2 Emergency Admission 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, reflecting the older population profile. .And since the 2009/10 financial year have been increasing more rapidly than those for Scotland overall.

Rates of emergency admission and multiple emergency admissions 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 40: Scottish Borders residents admitted to hospital as an emergency; trends in rates per 1,000 population by age group

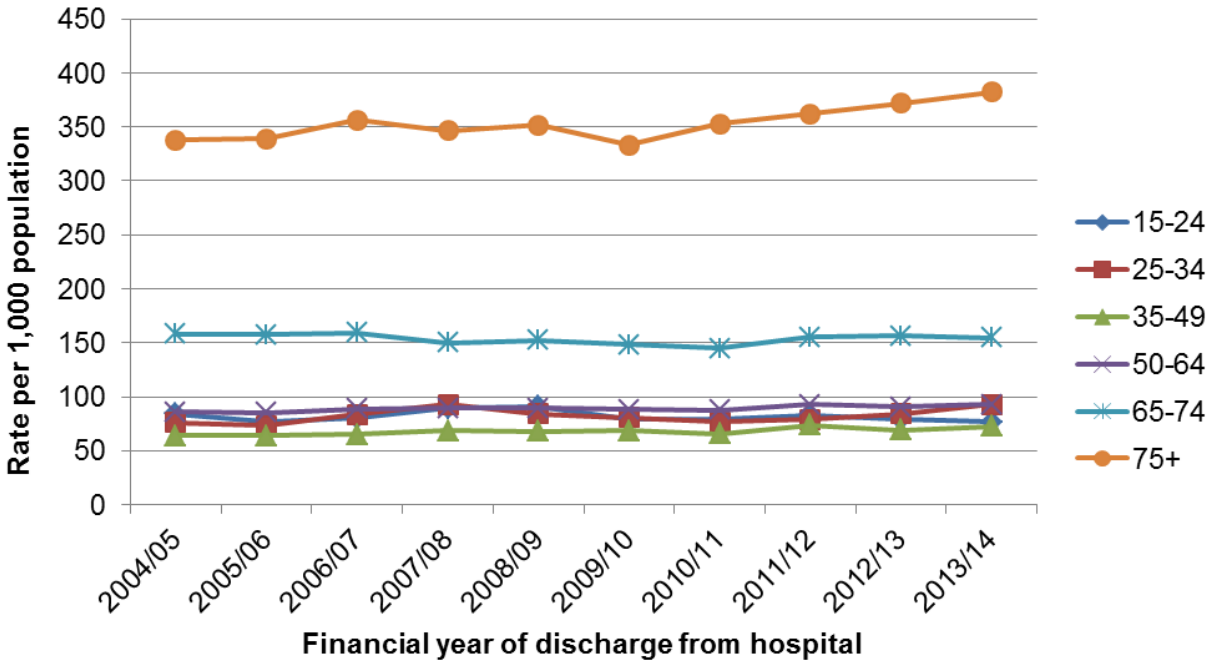
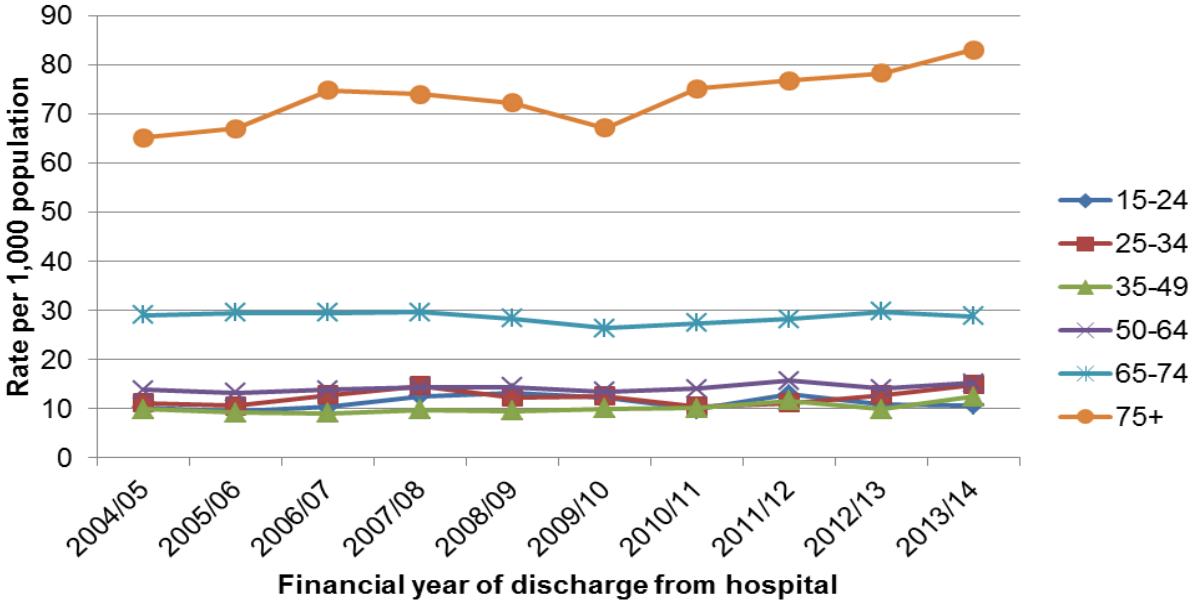


Figure 41: Scottish Borders residents with two or more emergency admissions to hospital within the same year; trends in rates per 1,000 population by age group



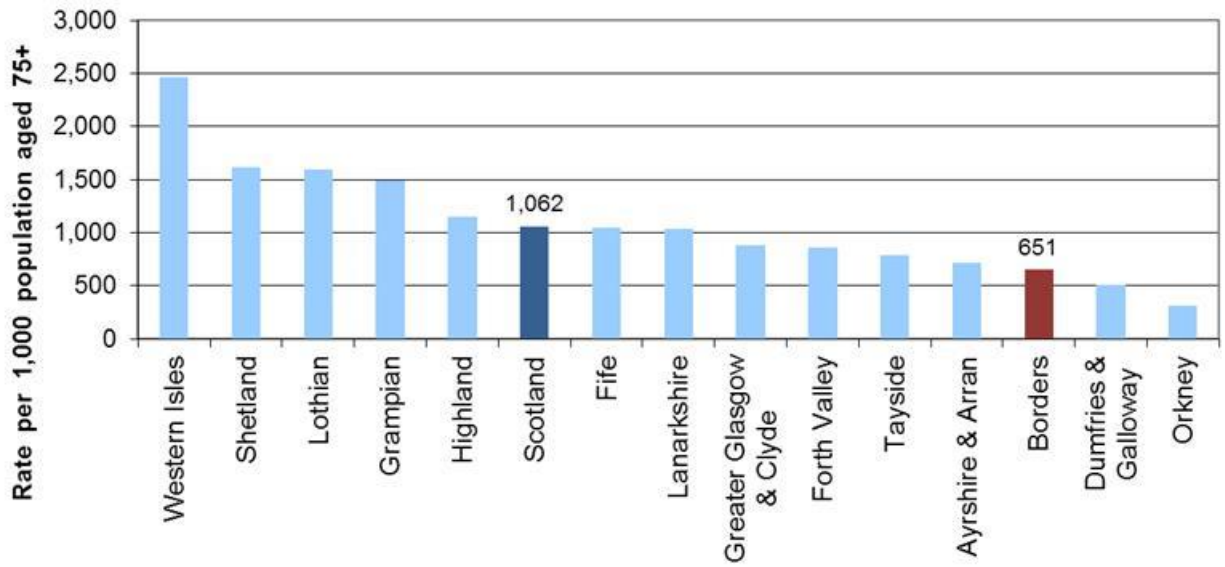
6.3 Reducing unnecessary admissions (work in progress)

As stated in the 'Assessment of the Needs of Older People', not all hospital admissions will be avoidable, some may be prevented through anticipatory care, and the provision of alternatives to admission.e.g. Intermediate care unit beds. Anticipatory care planning helps people, and their carers to make positive choices around the management of their condition, and promotes effective person-centred arrangements for the communication, planning and co-ordination of care, which is a cornerstone of the new national outcomes for health and wellbeing

6.4 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 42: 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.

6.5 Home Care

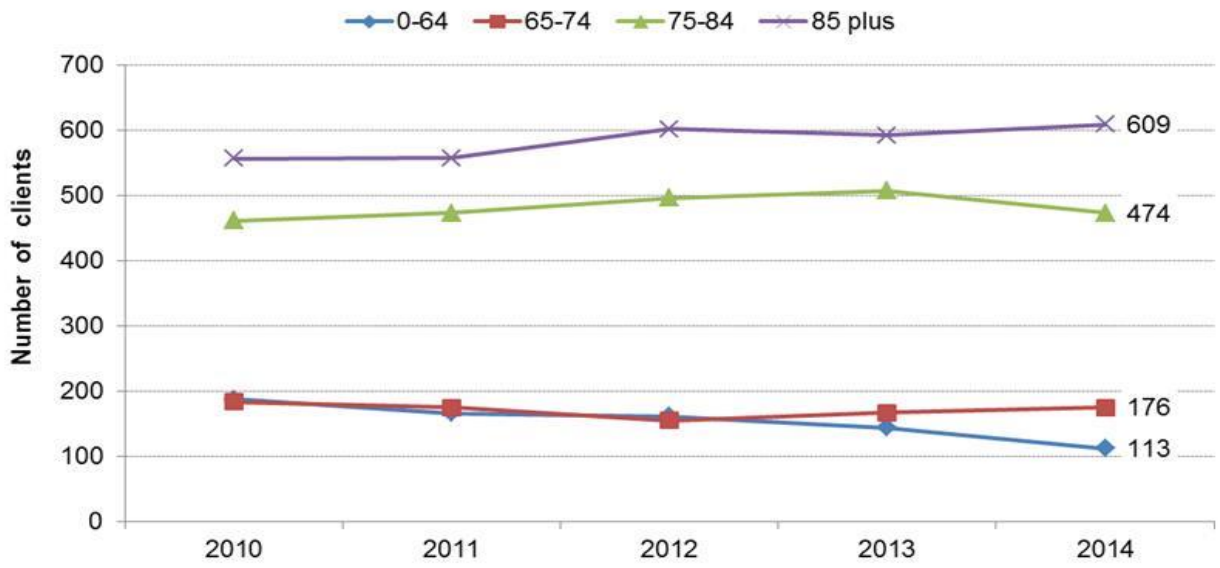
Help at home or "Home Care" describes a range of support available for daily living. Home care is care provided in an individual's own home to enable them to maintain independence and can include support with washing, dressing, eating and taking medication.

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.

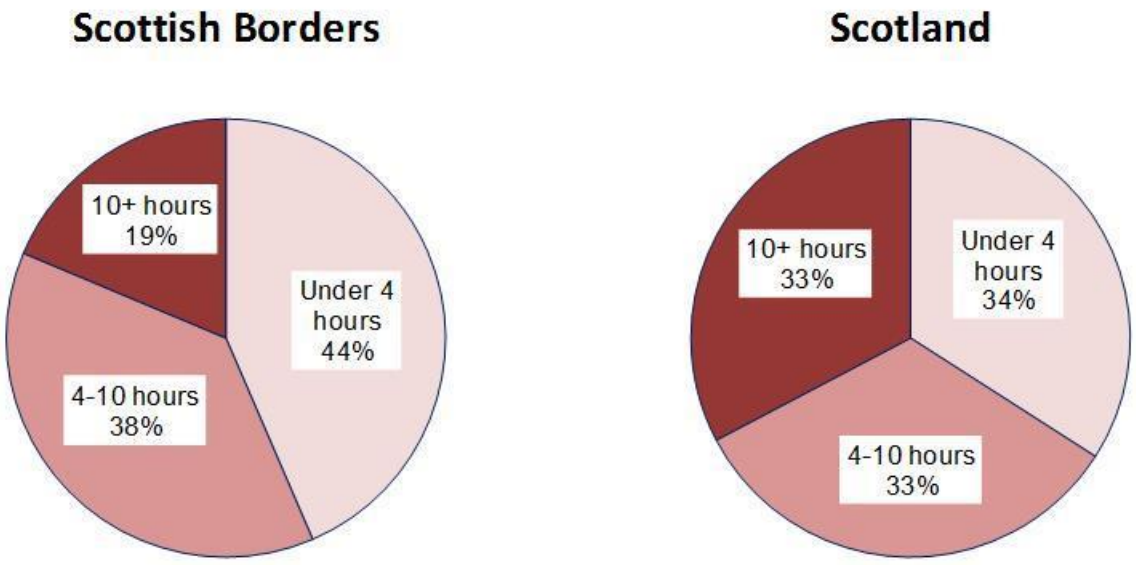
The majority of Scottish Borders home care recipients (92%) at the end of March 2014 were aged 65 and over. These 1,259 individuals represented just under 5% of the Scottish Borders population aged 65+.

Figure 43: Home Care Clients by age group, Scottish Borders, as at end March 2010 to 2014



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 44: 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

6.6 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:

1. Disabled people aged 16 or over (with short or long-term needs);
2. Disabled parents for children's services;
3. Carers aged 16 or over (including people with parental responsibility for a disabled child);
4. 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/

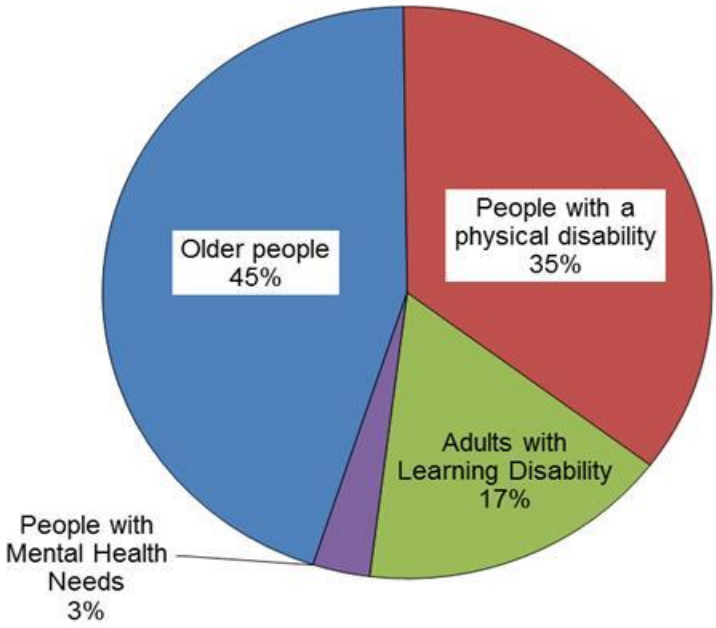
In Scottish Borders, there were 103 Self Directed Support clients at March 2014, and this number is expected to grow progressively over the next few years.

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 45: 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

6.7 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.

Figure 46: 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.

6.8 Housing with Care / Extra Care Housing

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 is 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.

6.9 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. Although the overall trend in numbers of residents in long stay care home is falling, (see Figure

14 below), the residents have increasingly complex and high level of care and support needs. Given the age, frailty and multiple morbidities of care home residents they can be views as one of the most complex and vulnerable group of people in our communities which have significant implications for the workforce providing their care and support.

Figure 47: Trend in numbers of Long stay care home residents March 2005 to March 2014, overall and as a percentage of numbers at March 2005

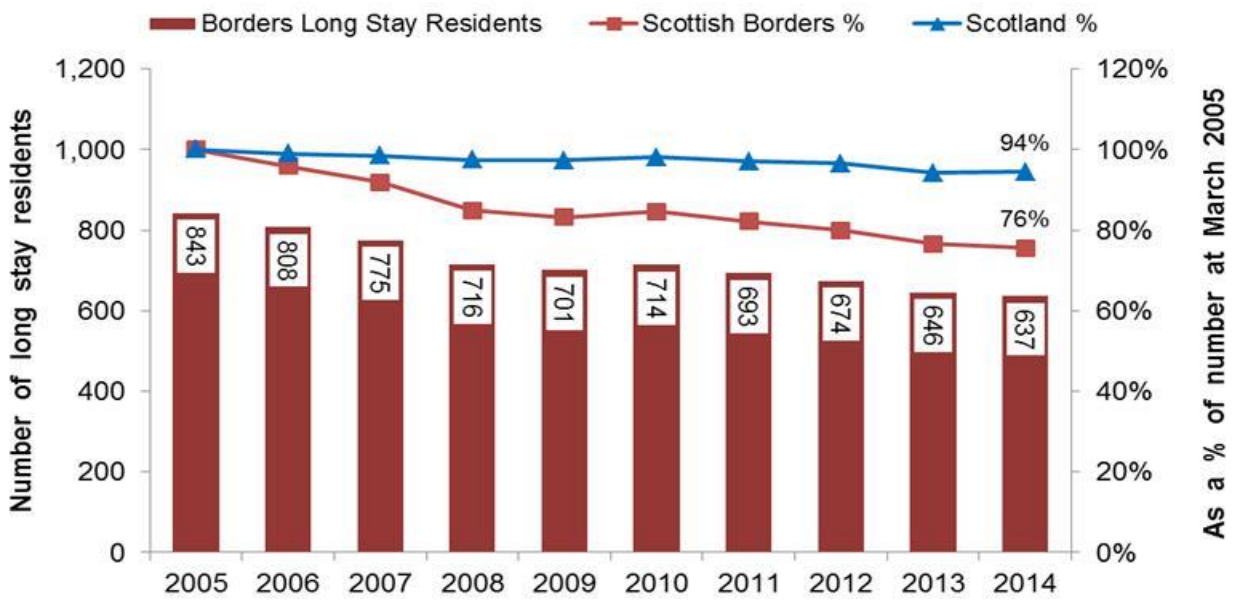


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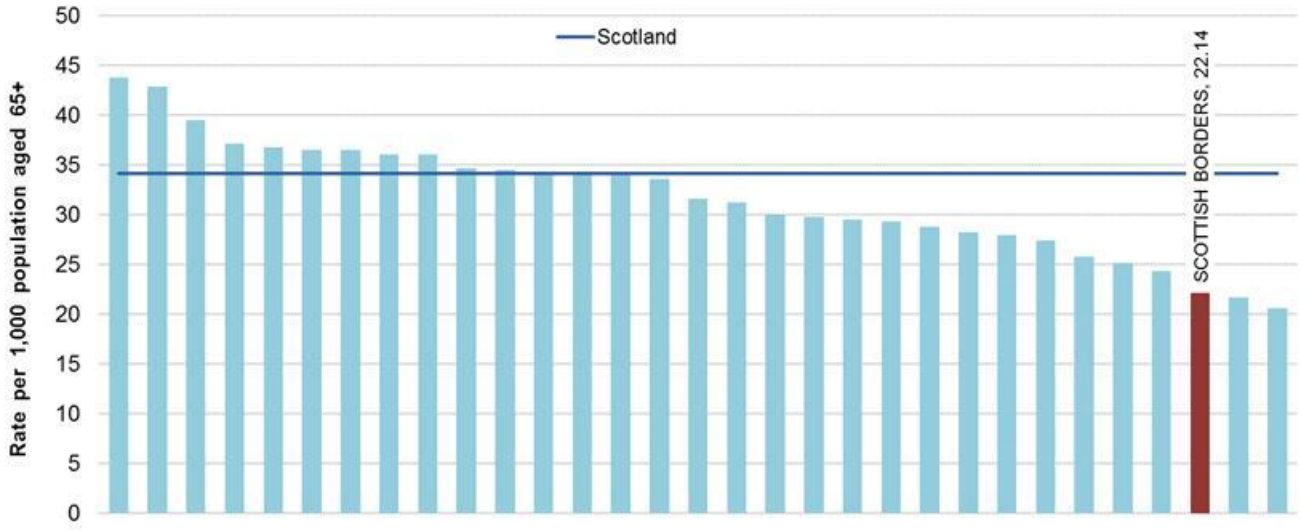
Figure 48: Percentage of population aged 65+ looked after as long stay residents in care homes, March 2014, by Local Authority



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

Figure 49: 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/

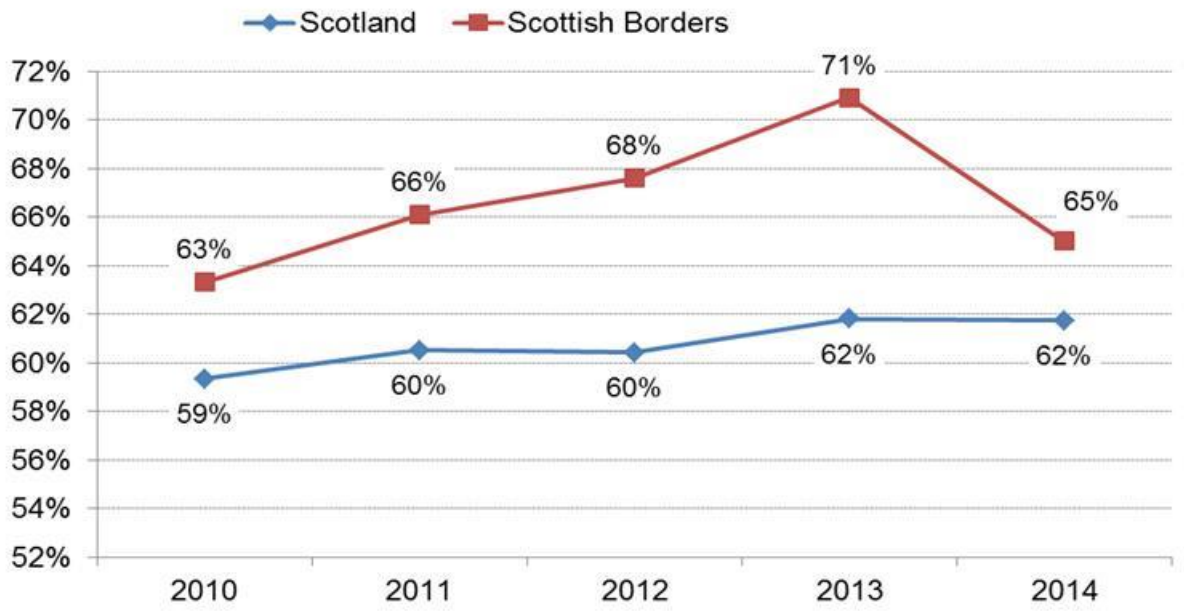
6.10 Balance of Care

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

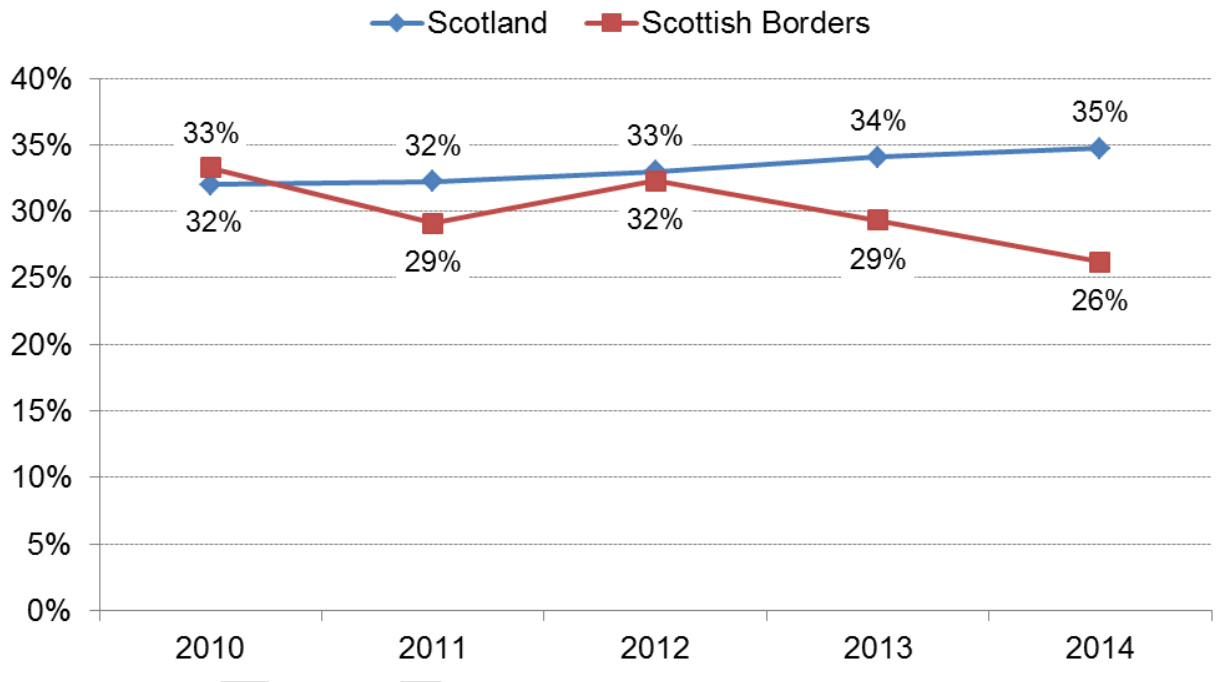


Source: Scottish Government – Health and Social Care National Performance Indicators www.gov.scot/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes

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 later 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 way that Social Care is delivered, that are not reflected in the way this indicator is measured. For example, 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

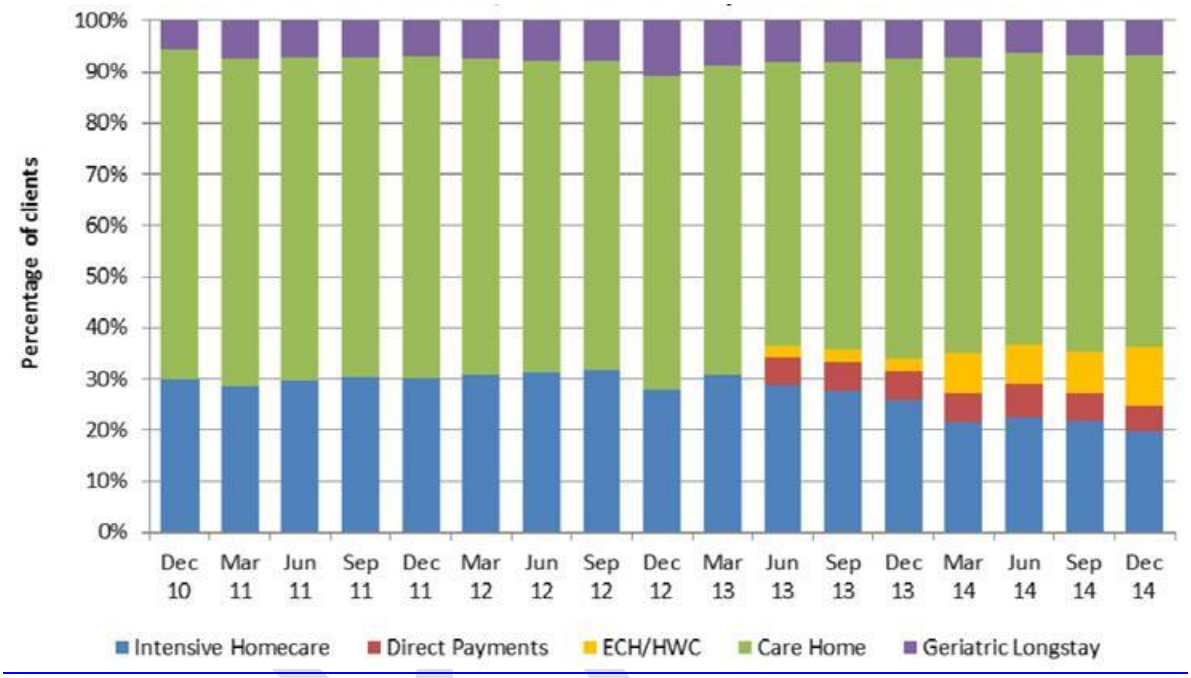
measure. A measure around SDS is expected to be introduced in the future. Additionally, as noted in Scottish Borders Council's April 2015 report "Improving the quality of Older People's Care Homes", provision of Housing with Care and Extra Care Housing (outlined below) has developed and the numbers of 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 51: 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 52: 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



Note: 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

6.11 Supported and Sheltered housing (to be added)

6.12 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:-

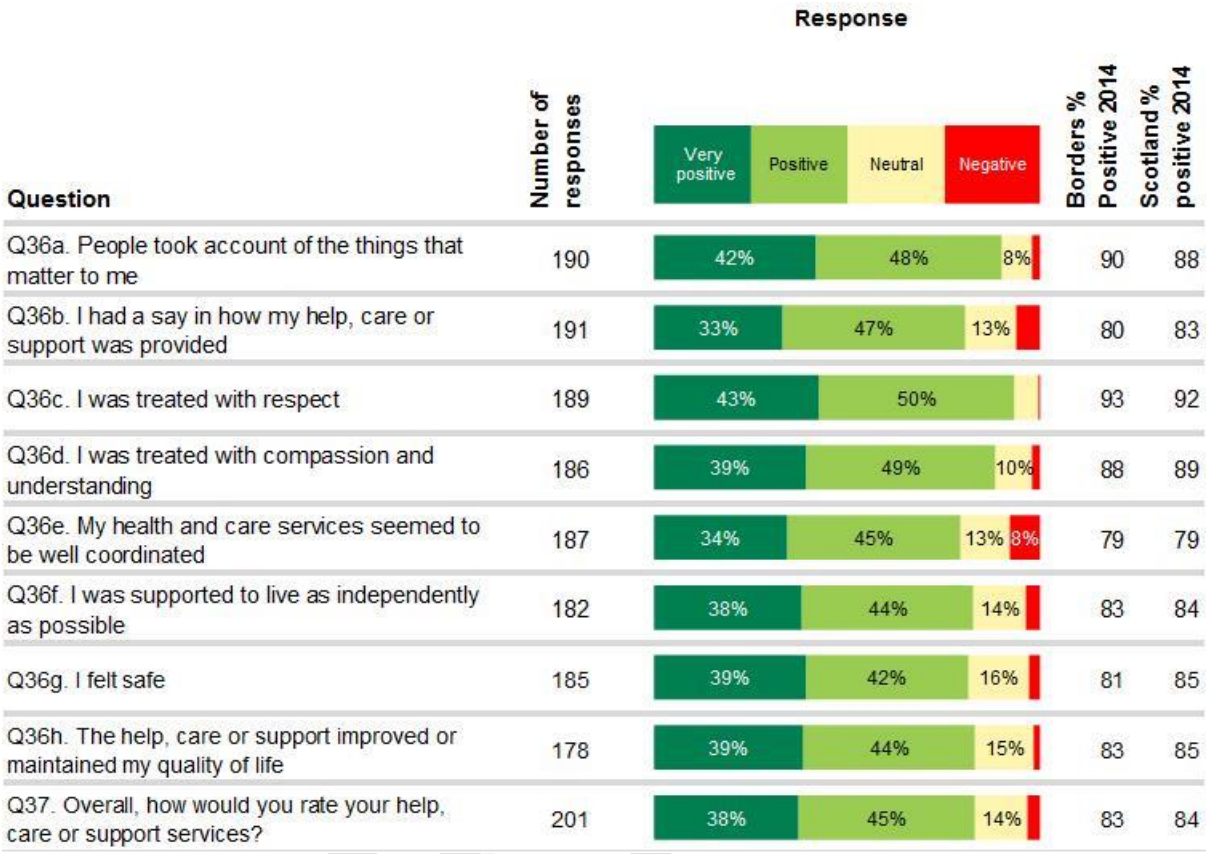
- Whilst 80% of the care recipients agreed or strongly agreed that they had a say in how their help, care or support was provided, 6% disagreed or strongly disagreed. A further 13% neither agreed nor disagreed. The 80% responding positively to this question in Scottish Borders was lower than the 83% 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 53. Experiences of a sample of care recipients in Scottish Borders, 2013/14



Question	Number of responses	Response: 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

6.13 End of Life Care

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".

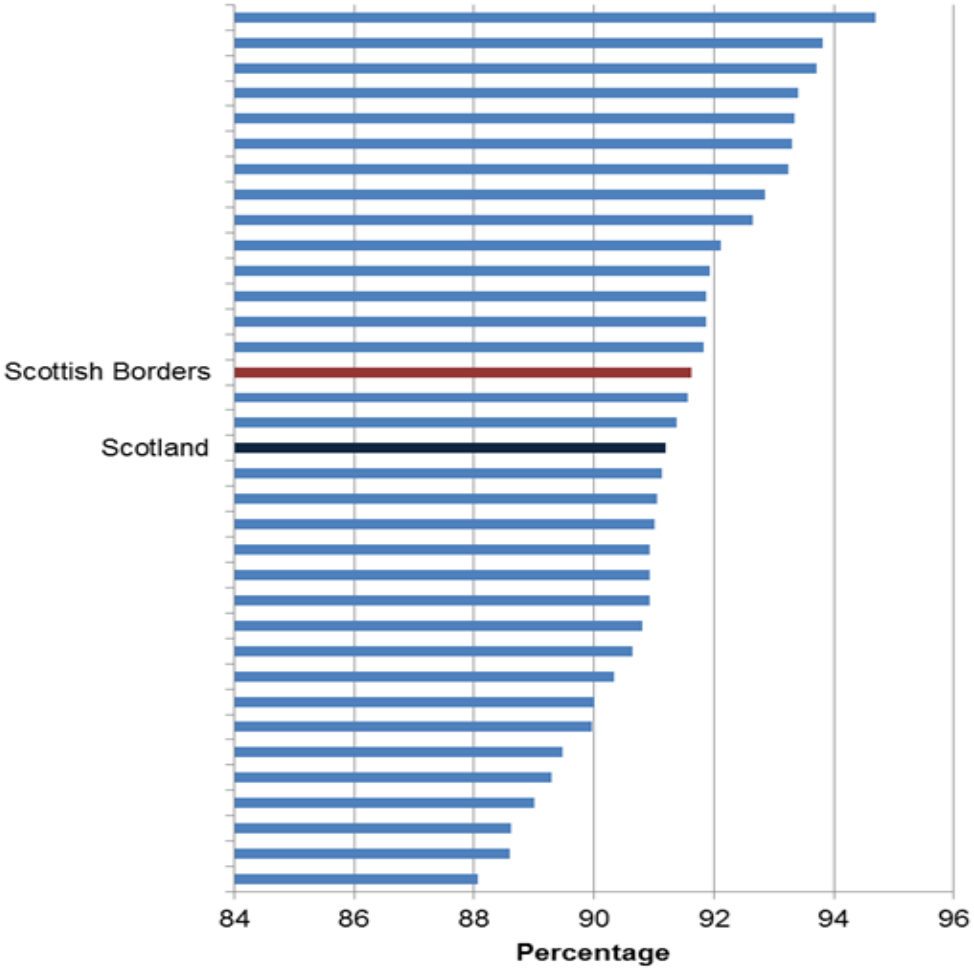
Ideally, this measure would relate directly to the preferred place of care at the end of life. However, this can change over time and is, therefore, difficult to track. National data is not currently available at this level of detail so it is not possible to focus the measure directly on preferred place 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 figure below shows that we perform well in supporting appropriate end of life care outside hospitals compared to other areas.

Figure 54:_ The percentage of last 6 months of life spent at home or in a community setting, by Community Health Partnership, financial year 2012/13



Key Findings

- GP services will be faced with new challenges in terms of demand, capacity and access from an aging population
- GP practices are already struggling to meet existing demand, and the projected increase in the number of older people in the area will have an impact of their ability to respond, particularly when it is the only practice in the town
- Emergency hospital stays and multiple emergency admissions for the Scottish Borders residents have been consistently higher than the Scottish average, reflecting the older population profile.
- The delayed discharge rate for patient aged 75+ is one of the lowest amongst the NHS Boards in Scotland. Patients can experience delays in discharge for a number of reason , such as waiting on social care arrangements or availability of a bed in a care home
- The number of people living in care homes on a long term bases has dropped over the last 10 years, as the emphasis has shifted to enabling people to stay at home or in extra care housing for longer.
- Although the over trend in numbers of residents in long stay care home is falling, the residents have increasingly complex and high level of care and support needs.
- The Scottish Borders has a consistently higher percentage of people aged 18+ receiving personal care at home, rather than in a care home or hospital, this is in line with Scottish Government strategy.
- The results of the national Health and Care Experience survey 2013/14 show that 80% of care recipients in the Scottish Borders agreed or strongly agreed that they had a say in how their, help, care or support was provided. This is slightly lower than the Scottish average of 83%
- The proportion of people whose last 6 month of life spent at home or in a community setting is above 90% for the Scottish Borders, and this compares favourably with other areas.

What does the Partnership need to consider?

- The pressures on GPs are increasing and the Partnership needs to look at how it can work with local Practices. The national 2020 vision for Scotland's Health Service highlights the need to strengthen the role of primary care to keep people healthy in the y for as long as possible
- Our rural geography is a particular challenge to the increasing demand on primary care
- We need to work with our partners to develop an understanding of our emergency hospital admissions and multiple emergency admissions to see what interventions and services could be put in place as safe and effective alternatives.
- Although the number of residents in long term care homes has dropped, those who require care in this setting have complex care needs. We need to examine how we can continue to provide the best possible medical and nursing care to enhance the patient's health and wellbeing.
- We have a high proportion of people who are supported to die at home or in a care home rather than in a hospital setting and the Partnership should continue to work with all relevant services to ensure the best quality care for patients and their families.

7. Carers

7.1 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.

7. 2 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.

- 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 50 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).

Figure 55: 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 56: Intensity of caring amongst Scottish Borders residents in each deprivation quintile

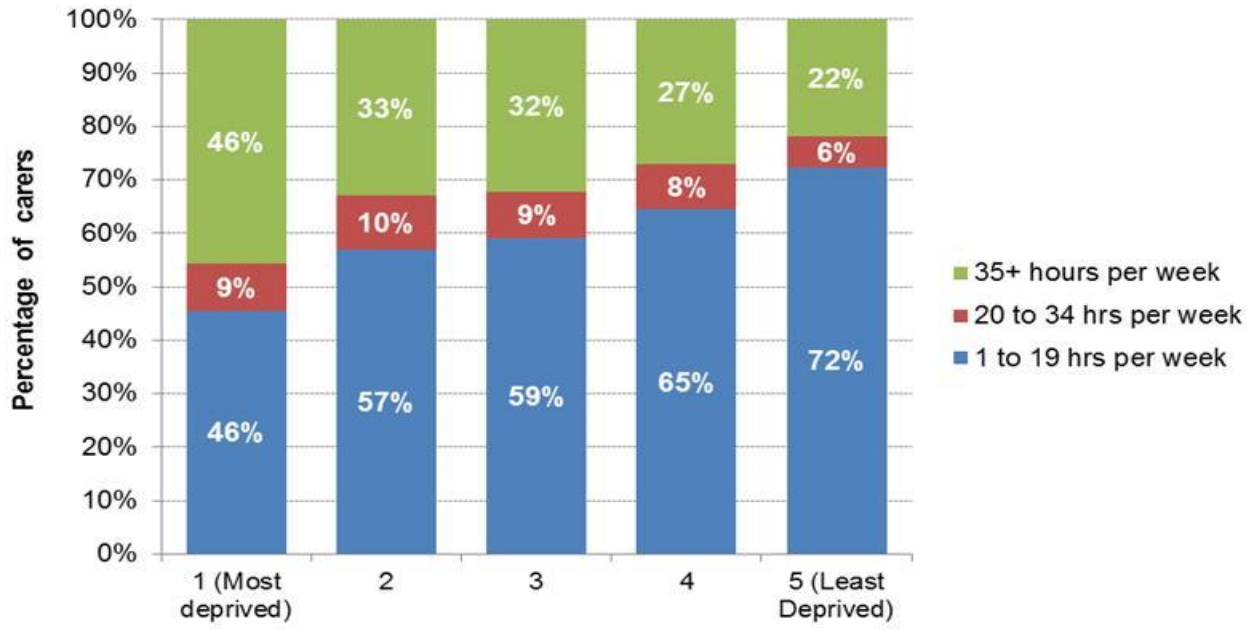


Figure 57: Self-reported general health amongst Scottish Borders residents, 2011, by weekly hours of unpaid care they provided

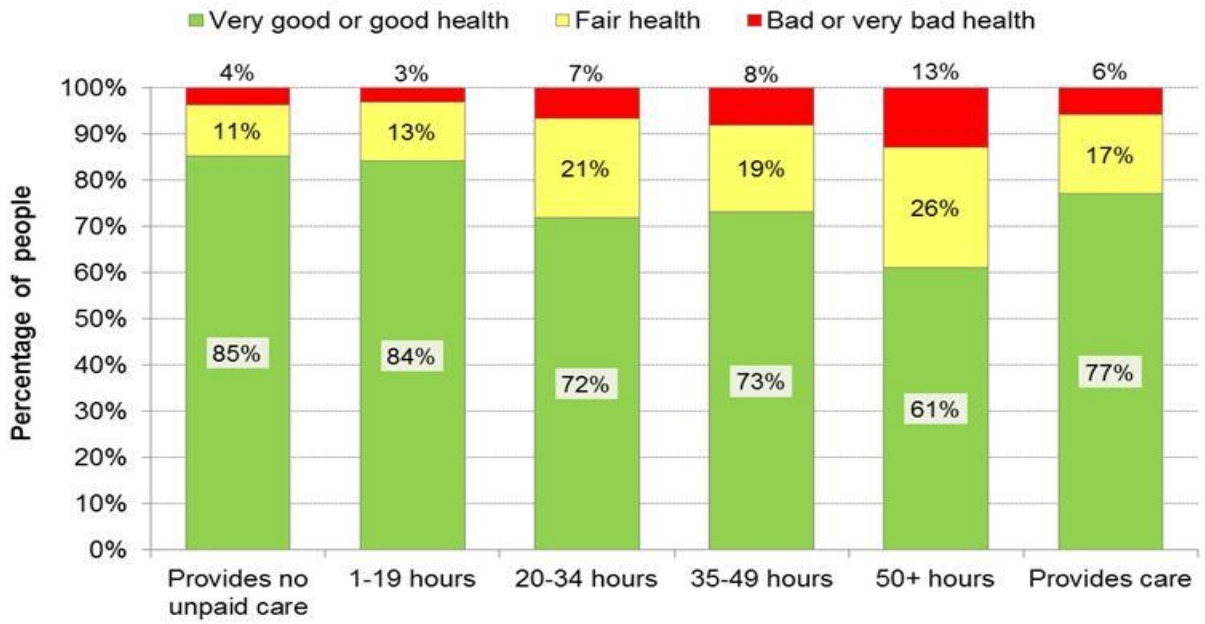
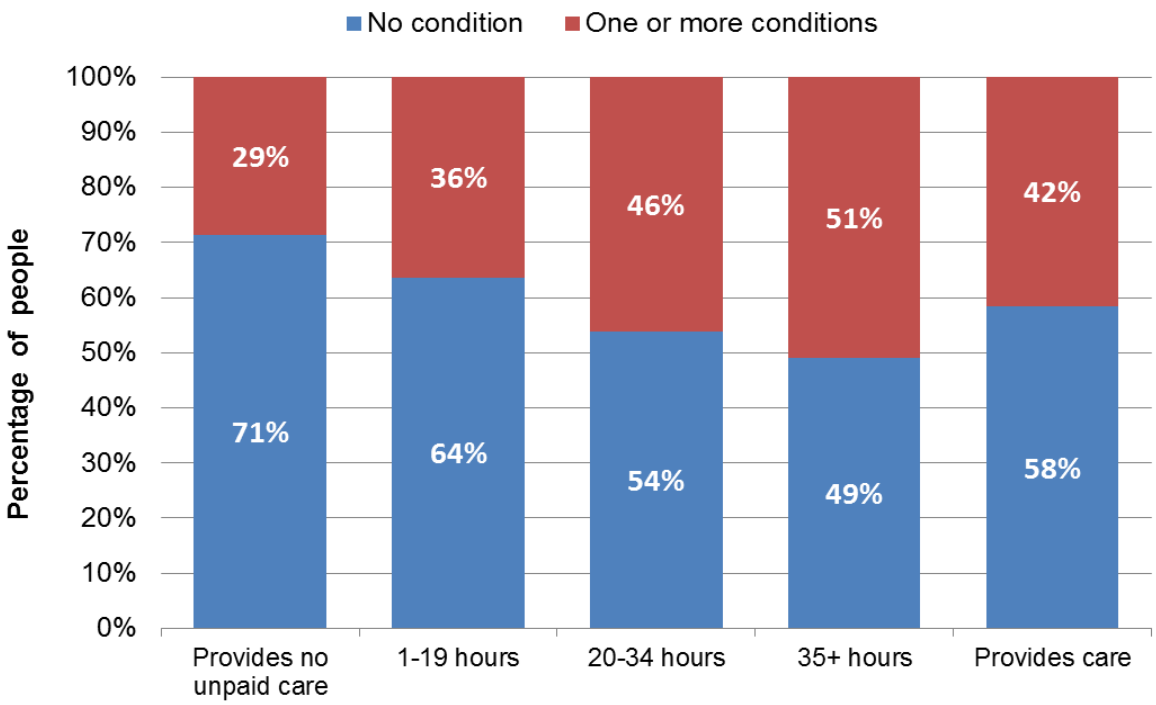


Figure 58: Percentage of carers with one or more long-term health conditions, 2011, by weekly hours of unpaid care they provided



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 59: 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%
Eldon	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).

7.3 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 it 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 60. 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

Key Findings

- The number of unpaid cares are difficult to identify, estimates by the Scottish Borders Joint Carers Strategy state that around 13% (12,500) of all residents aged 16+ have some sort of carer responsibility
- The Scottish Census provides some useful information on the characteristics of carers, with patterns for the Scottish Borders very similar to those seen across Scotland.
- Female are more likely than males to report that they have carer responsibilities
- 16% of the population aged 50-64 reported they had carer responsibilities, a higher proportion than any other group
- 42% of people identified as unpaid carers had one or more long term conditions or health problems themselves
- The prevalence of long term conditions rose with increasing intensity of unpaid care provision

What does the Partnership need to consider

- The contribution of unpaid carers is significant, the Partnership needs to help promote the positive aspects of caring - to support carers in their role, and to improve their health and wellbeing
- Partnership needs to work with partners to help identify carers – young and old, ensuring they have access to the appropriate support.
- Carers who provide in excess of 35 hours a week are of particular concern, especially as they are more likely to live in more deprived area. We need to ensure that support services are easy to access, this should also include access to appropriate respite care.