better health in the borders

THE ANNUAL REPORT OF THE SCOTTISH BORDERS DIRECTOR OF PUBLIC HEALTH
for 2009/10

CONTENTS

CONTRIBUTORS

Nic Amos	Health Improvement Specialist – Sexual Health and Blood Borne Viruses
Helen Brand	Oral Health Improvement Manager
Irene Bonnar	Occupational Health Manager
David Cressey	Head of Housing and Community Justice
Fiona Doig	Health Improvement Lead – Healthy Living Network and Tobacco
Colin Easton	Policy, Planning and Performance Manager
Brian Emmerson	Team Leader, Better Government - Democracy
Christopher Faldon	Health Protection Nurse Specialist
Cathie Fancy	Group Manager – Housing Strategy and Services
Sarah Glendinning	New Ways Community Planning Co-ordinator
Ken Jones	Environmental Health Manager
Ian Lindley	Director of Planning and Economic Development
Allyson McCollam	Health Improvement Lead - Children and Young People and Mental Health
Alex McSorley	Emergency Planning Officer
Dr Alan Mordue	Consultant in Public Health Medicine
Julie Murray	Area Drug Partnership Strategic Lead
Dr Tim Patterson	Consultant in Public Health Medicine
Helen Ryall	Lifestyle Advisor Support Service – Service Manager
Kevan Sanderson	Health Improvement Specialist – Physical Activity
Douglas Scott	Team Leader – Working with Community
Fran Selkirk	Looked After and Accommodated Children Nurse
Meriel Smith	Planning and Performance Officer
David Stanger	Pharmacy Development Manager
Helen Summers	Health Improvement Lead – Food and Health
Tom Trotter	Health Improvement Officer
Elaine Torrance	Head of Social Care and Health

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As ever I must personally take responsibility for any errors, whether of omission or commission.

Should you require further copies of this report please contact:-

Sheila Patterson on (01896) 825560
or e-mail sheila.patterson@borders.scot.nhs.uk

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

INTRODUCTION

I write this independent report as Joint Director of Public Health, Scottish Borders Council, and NHS Borders. My aim is to describe the current state of health of the people of the Scottish Borders, to flag future challenges and to tackle these, particularly over the coming year.

The long-standing tradition of such reports goes back to the times of the previous Medical Officers of Health, the professional predecessors of the current Directors of Public Health, and I describe this in more detail further on in this introduction.

But what is Public Health? Sir Donald Acheson described it as "The science and art of preventing disease, prolonging life, and promoting health through organised efforts of society."[1]

The delivery of Public Health emphasises:

- The importance of the population as opposed to the individual
- Shared responsibility for health – improving it, protecting it and preventing disease
- The importance of working together (partnerships) of all those who contribute to the health of the population
- The key role of the state in influencing the wider determinants of health and disease

NHS Boards in Scotland have the statutory purposes of *"the securing of improved health for people in Scotland and the prevention, diagnosis and treatment of illness"*[2]. However, local authorities have a much longer tradition in promoting the public health agenda, now enshrined in legislation giving them both duties and powers.
The Public Health (Scotland) Act 1867 permitted local authorities to appoint Medical Officers (the term 'Medical Officers of Health' came in to use later) and to raise money by local rates for public health purposes. Only a few local authorities appointed full-time medical officers, however. The Local Government (Scotland) Act 1889 made it compulsory

[1]Public Health in England: The Report of the Committee of Inquiry into the Future Development to the Public Health Function. Chmn. Sir D. Acheson (1988)
[2]Part of the National Health Service (Scotland) Act 1978 confers a duty on the Cabinet Secretary for Health and Wellbeing, discharged through the NHS Boards in Scotland.

for County Councils to appoint County Medical Officers of Health to monitor and oversee the provision of measures to improve the health of the county.

This included isolation and treatment of people suffering from infectious diseases and identifying the source of such outbreaks. Shortly afterwards the requirement to appoint medical officers was extended to burghs by the Burgh Police (Scotland) Act 1892. The Public Health (Scotland) Act 1897 gave the Local Government Board for Scotland supervisory powers over local authorities with regard to the regulation of medical officers and sanitary inspectors. Duties of medical officers included the isolation and treatment of people suffering from infectious diseases and the identification of the source of such outbreaks. The duties of medical officers were widened after the First World War and also by the 1929 Local Government (Scotland) Act, under which poor law institutions and district mental hospitals transferred to county councils and district councils.

After the introduction of the National Health Service in 1948 some of the duties of Medical Officers of Health (relating to infectious disease hospitals, poor law hospitals, local authority maternity hospitals, and district mental hospitals) were removed from local government, but the provision of community and public health services remained their responsibility. The National Health Service (Scotland) Act 1972 transferred these roles to the new Health Boards and the post of Medical Officer of Health ceased to exist from 1 April 1974. A variety of miscellaneous environmental health services remained. In 1975 they became part of the functions of district or islands councils under the Local Government (Scotland) Act 1973.

The Annual Reports of County and Burgh Medical Officers of Health are frequently used for information on health, disease, and social conditions in Scotland from the late 19th century until the early 1970s. The last reports by most authorities were for 1972 (the health service changes at 1 April 1974 meant that there was not enough time to produce reports for 1973, the last full year of the Medical Officers of Health). The Annual Reports contain information about births, deaths, infant mortality, prevention and notification of infectious diseases, the distribution of population, industries, "offensive trades", working class housing, water supply, river pollution and the provision of some local hospitals and health services. All sorts of researchers use them.

From 1974 onwards the Directors of Public Health, the historical successors of the Medical Officers of Health, but usually NHS employees, have continued the tradition of an annual report with the same purpose as before. Over the past years as a Director of Public Health, I have continued to write about the same issues which remain serious challenges to our health.

The Local Government in Scotland Act 2003 gave local authorities the duty to initiate, maintain and facilitate a partnership process to provide public services in their area and ensure the planning of that provision, a process called "community planning"; their partner agencies have a duty to participate. The same Act gave local authorities the power to "advance well-being . . . the power to do anything which it considers is likely to promote or improve the well-being of its area and persons within that area".

The public health responsibilities of both local authorities and NHS boards have been clarified and enabled by the Public Health (Scotland) Act 2008. This Act enables these organisations to better protect public health in Scotland. It will also assist Scottish Ministers to meet their obligations under the International Health Regulations.'Protecting public health' for the purposes of the Act means 'the protection from infectious diseases, contamination or other such hazards which constitute a danger to human health; and includes the prevention of, the control of, and the provision of a public health response to such diseases, contamination or other hazards'. I describe these issues in more detail in Chapter 7.

Given this historical context, both NHS Borders and Scottish Borders Council have expressed their commitment to taking forward the public health agenda by creating the post of Joint Director of Public Health. I am delighted to have been appointed to this exciting post. I believe it offers me the opportunity to make a difference to the health of the people I seek to serve in a way I have never been able to do before. Given the fact that I have only been in post for nine months or so I am tempted to borrow the words of Dr Rob MacWatt, County Medical Officer of Health for Berwickshire who wrote in his Annual Report in 1892 "Having been appointed... so recently as May... it cannot be expected that I should be in a position to give a report for the whole year now ended". However there has been much positive progress over my first months in post, and so, much to bring to my readers' attention for action.

Scottish Borders Council have proved their commitment to tackling disadvantage and improving health. The "Social Atlas" is now in its third edition. It shows the latest Government information at a local community level and compares the health and well-being of Borders communities with Scottish Borders and Scotland as a whole. The Poverty Commission, which reported about a year ago, produced a financial inclusion strategy. The work to tackle fuel poverty has been a very positive step forward and I discuss this further later in my report (Chapter 5). The collaborative projects, "Transforming Children's Services" and "Transforming Older People Services", have been important in improving health and well-being as well as driving up the quality of services provided to these groups.

The work of the past year has taken forward the public health agenda. It positions both NHS Borders and Scottish Borders Council well to face the challenges of the coming year and the more distant future. In the report I have sought to use some of the available information to describe health in the Borders, assess progress, and point up priorities.

This report is not, and cannot be, either comprehensive or exhaustive. In reading it, I would caution the reader about the interpretation of statistics based on small numbers – the smaller the numbers the more vanishing the validity. I have sought to keep it simple enough for everyone and yet to be of interest to professionals. You, as reader, will be the judge of that, and as ever, I will be grateful for any feedback. I am, of course, responsible for any errors or inaccuracies.

TO THE

COUNTY COUNCIL OF BERWICKSHIRE

as Local Authority under the Public Health Acts.

DUNS, 10th February 1892.

THE County Council as Local Authority having, under Section 8 of the Public Health Act, adopted the Bye-Laws, No. I., recommended by the Board of Supervision for regulating the duties of County Medical Officers, I, in accordance with these regulations, have prepared the following report for the year ending 31st December 1891, which I have now the honour to submit to you.

Having been appointed County Medical Officer of Health so recently as May, and the District Medical Officers having held their appointments only for three months or thereabouts, it cannot be expected that I should be in a position to give a report for the whole year now ended.

During the months of May, June, July, and August, a mild form of Scarlet Fever and Hooping Cough was prevalent in the different Districts, but otherwise the county was fairly healthy. During September there were no new cases, but in October both diseases re-appeared, and mild cases were reported up to the end of the year. In the East District there were 33 cases reported with 1 death, and 3 cases ascertained without being notified. In the Middle District 46 cases were ascertained before the Notification Act came into operation, 2 proving fatal, and 41 notified with 2 fatal cases. In the West District there were 21 cases notified. These figures, however, cannot be relied upon as giving any useful statistical information, as Infectious Diseases Notification Act was adopted by the three districts at different periods…

ROB. C. MACWATT, M.D.,
County Medical Officer of Health for Berwickshire

CHAPTER 1

WHAT'S OUR HEALTH LIKE LIVING IN THE BORDERS?

Our Population

The social geography of the Scottish Borders is an important influence on the health of its residents. As Figure 1 shows the Scottish Borders is a largely rural Local Authority area. The population is sparse with a density of only 0.23 persons per *hectare*, which is the third-lowest in mainland Scotland. Two thirds of the population live outside the main towns of Galashiels, Hawick, Peebles, Selkirk, Kelso, Melrose, Eyemouth and Earlston, in a dispersed network of close-knit small settlements. This makes it difficult to measure and assess the needs of the people. The low population density means the communities struggle to register in the official statistics in terms of identifying indicators of socio-economic need. There are small areas where people's life chances are disproportionately poor, due, for example, to poverty, illness, poor housing, social environment or access to services, even when available information can show the region as a whole to have a relatively healthy socio-economic profile.

Figure 1: Map of the Scottish Borders

Despite this, life expectancy and healthy life expectancy in the Borders is amongst the best in Scotland. However, as with the rest of the western world the Scottish Borders faces the challenge of an ageing population. Compared with Scotland as a whole, the Scottish Borders has a slightly lower proportion of working age people and a higher proportion of those of pensionable age. The proportion of people of pensionable age is much higher in some settlements, for example 32.5% in Coldstream compared with 20.6% for Scotland as a whole (Appendix 1). This means that in Coldstream one in three people are of pensionable age compared with one in five for Scotland as a whole.

A key issue is how the size and structure of the population is likely to change over time.[3] The graph below (Figure 2) shows the Scottish Borders population by age group from 1981 to 2031. The overall increase in the population over this period is significant from around 100,000 to over 120,000. Since 1981 the Scottish Borders has had an average annual increase in population of 0.37%, this compares to a decrease of 0.03% for Scotland as a whole. The other striking thing about this graph is the increase in the 65 to 74 and 75+ age groups over the period.

Figure 2: Scottish Borders Population* 1981 to 2031 by Age Group

*GROS: 1981-2006 = Mid Year Estimates, 2011-2031 Population Projections

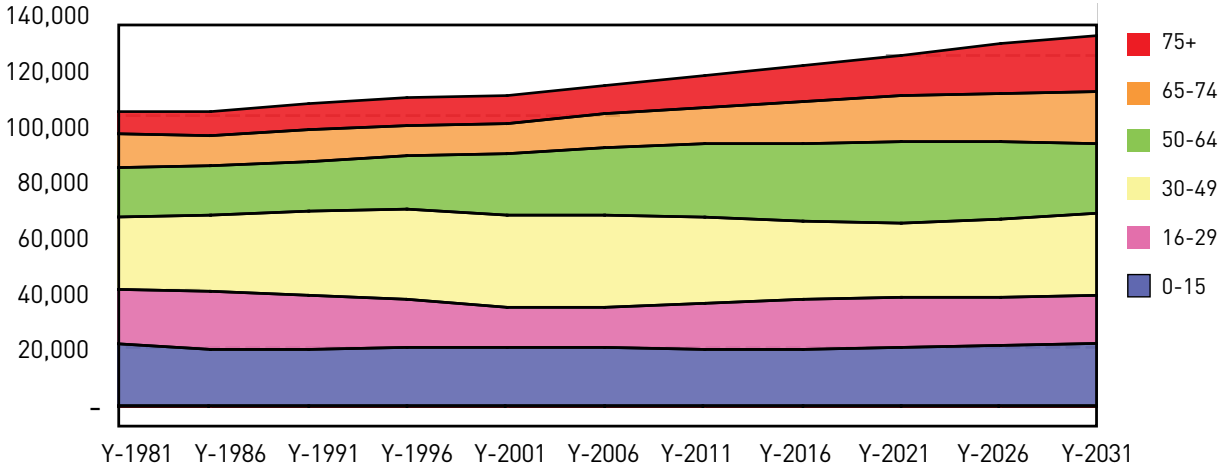
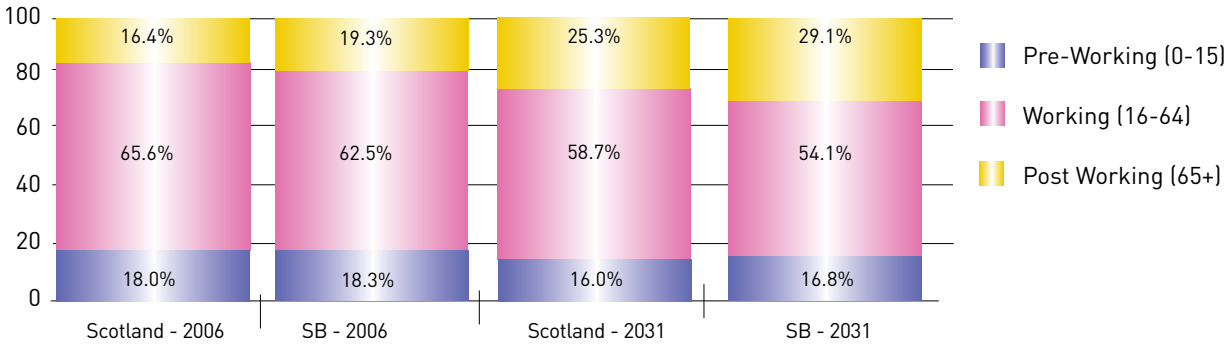


Figure 3 below compares the age distribution for Scotland and the Scottish Borders for 'Pre Working', 'Working', and 'Post Working' age between 2006 and 2031. Between these two years the proportion of people in the 'Working' group drops by 6.9% for Scotland, whereas the drop for the Scottish Borders is 8.4%. This contrasts with substantial increases for the "Post Working" group, which are again higher locally than nationally. This means that in the future there is likely to be proportionally fewer people economically active and more people potentially needing support:

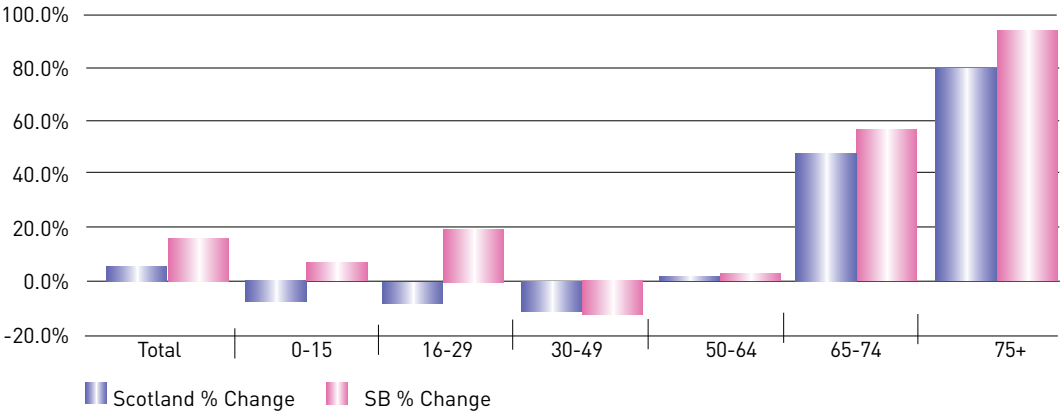
[3]"2009 Scrutiny Review: Changing Demographics of the Scottish Borders"

Figure 3: Age Group Distribution Scotland vs. Scottish Borders (SB) 2006 and 2031



Finally, the graph below (Figure 4) shows the percentage change across the age groups between 2006 and 2031 for the country and Scottish Borders. It shows clearly that all but one age group is likely to increase in the future locally, but nationally all groups below 50 will reduce. The result is significantly different total population changes from 2006 to 2031. The other remarkable feature of this graph is the percentage changes in the older age groups, with an increase of over 90% in the oldest and higher increases locally than nationally:

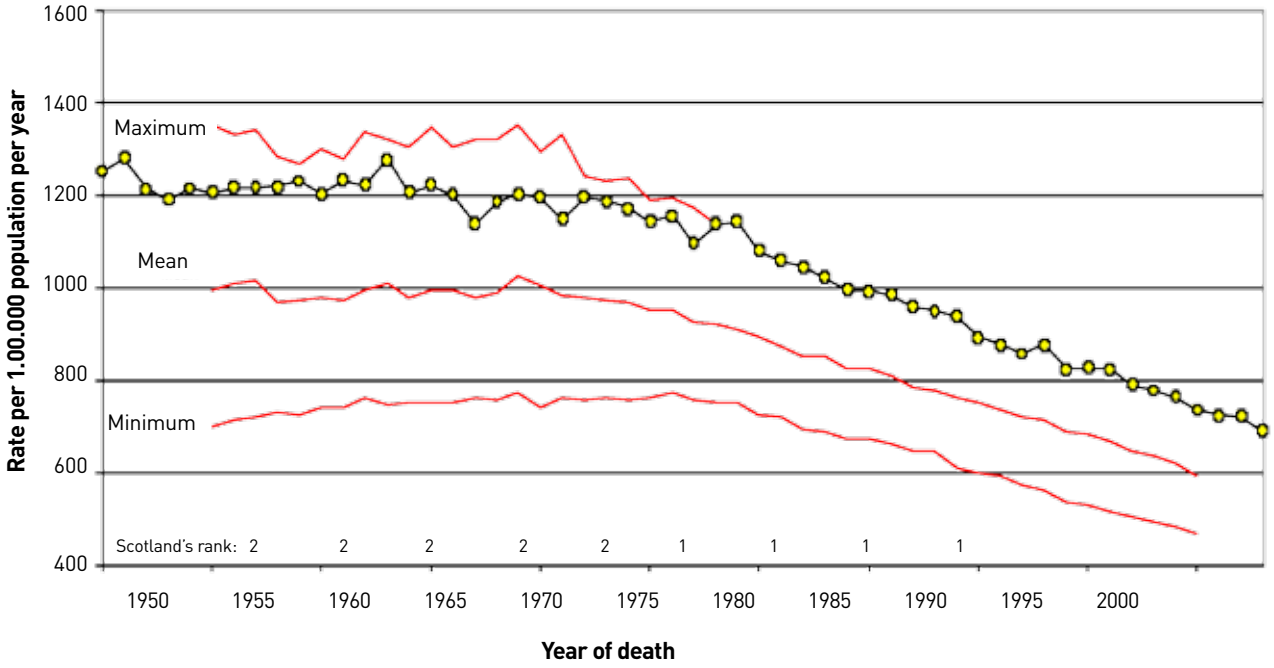
Figure 4: Percentage Change in Population 2006 to 2031: Scotland vs. Scottish Borders (SB)



The latest figures show that local men can expect to live two years longer than the average man in Scotland, whereas women can expect almost one and a half years extra. One of the ultimate aims of health services is to keep us all healthy for as long as possible, in other words to minimise the time when we are ill before we succumb, the so called "compression of morbidity". The charts in Appendix 2 show that for men in the Borders healthy life expectancy is 70.5 years on average with the remaining 5.5 years being with an illness. This compression is greater than for Scottish men generally who have around 7 years of illness before death. The difference is greater for women, 6 compared to 9 years. These data are consistent with many others and show that health in the Borders is very good compared to the country as a whole.

It is even worse for women; their mortality rate has been the highest in Europe since the late 50's.

Figure 5: All cause mortality age standardised rates among men aged 15-74 years
Scotland in context of maximum, minimum, and mean rates for
16 Western European countries
Compiled by ScotPHO. Source data: WHOSIS (Dec 2004) & GRO(S)

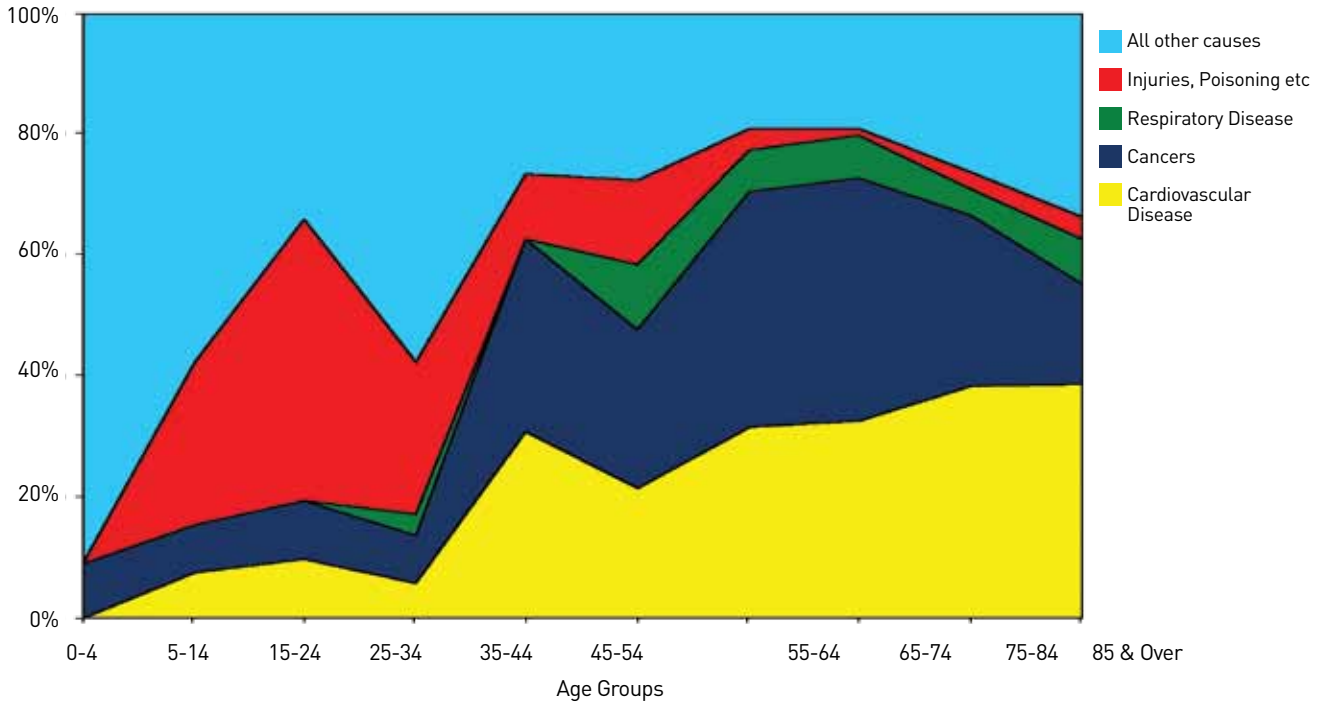


Compiled by ScotPHO. Source data: WHOSIS (Dec 2004) & GRO(S)

The Big Killers in the Borders

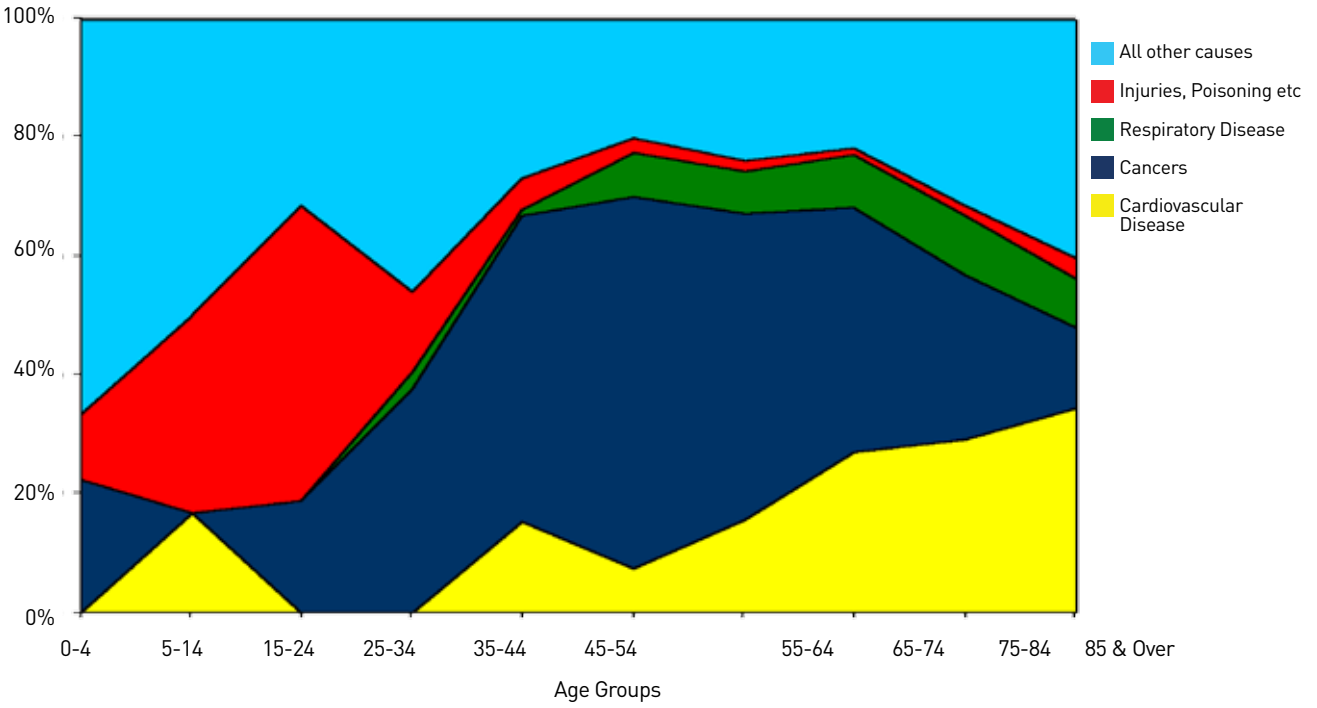
The causes of death change markedly with age. Figure 6 below shows that heart disease and strokes, together called cardiovascular diseases, account for a large percentage of deaths from middle age onwards in men. Cancers are responsible for deaths at all ages, even in the youngest age group, but rise to prominence from middle age too. "Injuries and poisoning etc" includes injuries caused by road accidents and injuries and poisoning which are self inflicted, in other words suicides. These two categories account for a significant percentage of deaths in young people.

Figure 6: Percentage of deaths by selected causes in Borders men by age group (2004-2008)



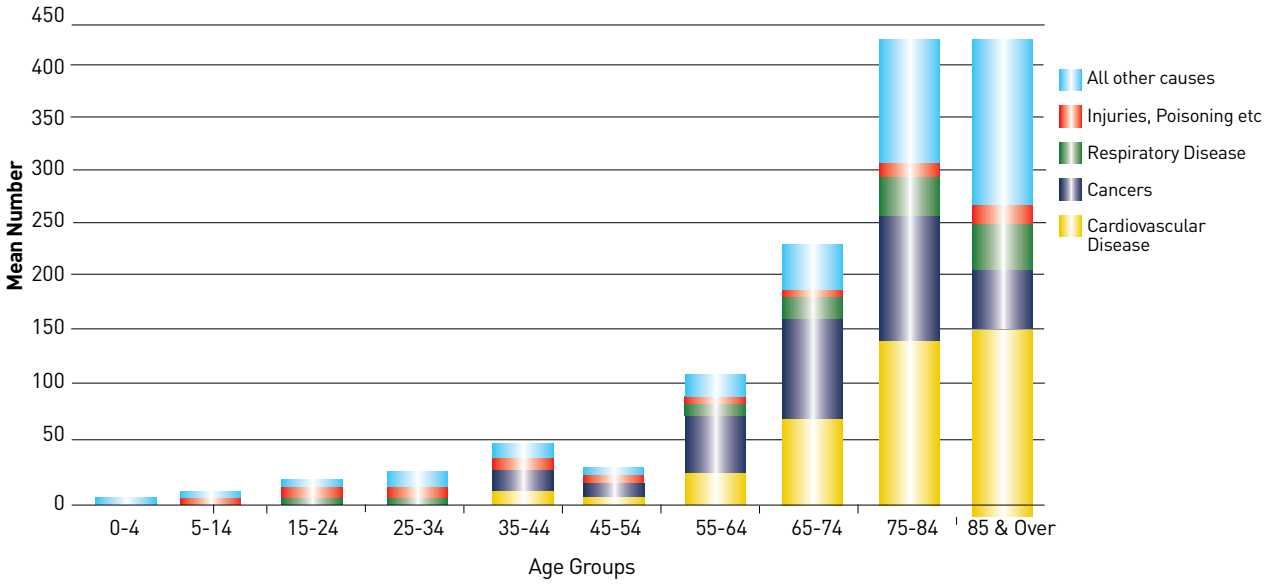
The picture is similar in women as shown below:

Figure 7: Percentage of deaths by selected causes in Borders women, by age group (2004-2008)



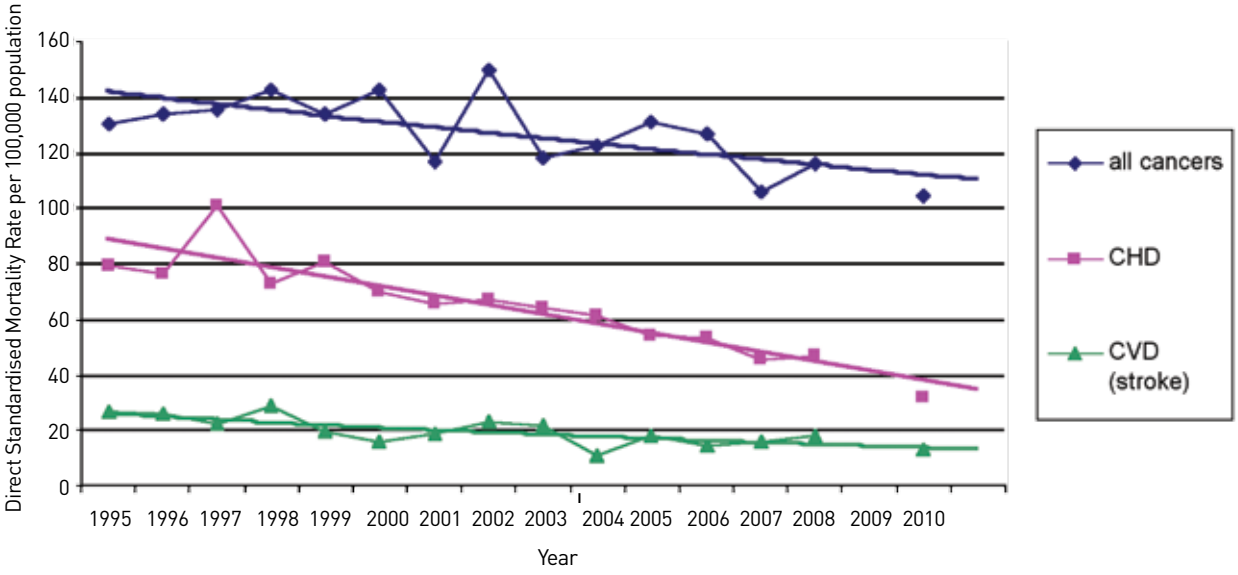
What the above charts do not show is the very different numbers of deaths occurring at different ages. Shown below, in the Borders these range from an average of four deaths each year in the 0-4 years age group to over 400 in the oldest.

Figure 8: Mean number of deaths per annum in Borders men and women, by selected causes, by age group (2004-2008)



Recognising the importance of coronary heart disease (CHD), cerebrovascular disease (CVD) or stroke, together called cardiovascular disease, and cancer the previous Scottish Executive set targets for reducing mortality for 2010. Although we are now in 2010 the latest data we have is for 2008 and this is presented in the graph below with the 2010 targets.

Figure 9: Mortality rates (directly standardised) from 1995-2008 for Borders men and women under 75 years of age and outcome targets for 2010



Progress has been steady for all three conditions with substantial reductions to 2008, particularly for heart disease, and the Borders should be at or close to the targets when 2010 data is available.

Serious Sickness in The Borders

Serious sickness is more difficult to describe than causes of death. The information we have is not comprehensive. We all suffer illnesses of varying duration and severity, from the common cold to arthritis or depression, and therefore we have to make judgements about which to prioritise. The illnesses that reduce healthy life expectancy towards the end of life tend to be those that also cause death or those that are long term and therefore affect people's quality of life by producing physical disability, or mental pain. They may need regular medication, review in clinics, and cause loss of work, limit social activities and hobbies or reduce independence, for example, by inability to drive. They can also increase the risk of other health problems, for example diabetes increases the risk of heart disease, and stroke, epilepsy increases the risk of injury. Other conditions can increase risk without necessarily resulting in symptoms – hypertension increases the risk of both heart disease and stroke and lifelong drugs therapy is usually required to control it.

Table 1 below shows the prevalence of some major illnesses and conditions from information collected in primary care in the Borders. This provides a useful insight into some long term conditions that have substantial impacts on health.

Table 1: Number and percentage of people with conditions recorded on primary care registers as at 31 March 2010 in the Borders

Condition	Number	% of population
CHD*	5741	5.1
Stroke	2837	2.5
Hypertension	16329	14.5
Diabetes	5082	4.5
COPD**	2384	2.1
Asthma	7336	6.5
Epilepsy	797	0.7
Mental Health (psychoses)	799	0.7
Depression (newly diagnosed with severity assessment)	10402	9.2
Dementia	717	0.6
Learning disability	633	0.6
Obesity	6637	5.9

* CHD = Coronary Heart Disease
** COPD = Chronic Obstructive Pulmonary Disease, formerly called chronic bronchitis +/- emphysema.

Some of these figures need to be interpreted with caution because the registers do not capture many people affected, for example those with dementia and obesity. However, for many conditions they accord with other estimates and population surveys, and therefore give an indication of the numbers of people affected locally.

While the primary care register data suggest that there are a little over 700 people with dementia in the Borders, using consensus estimates of prevalence indicates we have approaching 1700 people aged 60 and above with dementia. As the population ages, the number of people with dementia will increase and that number is likely to double over the next 25 years. Prevalence of dementia increases with age; while under 1 in 50 of the 65-69 year old population are affected, about one in three of the 90 plus age group is. Just over two thirds of people with dementia live at home in the community but two thirds of those in care homes suffer from it. Up to 70% of the care home population may have dementia. It is therefore a significant challenge.

Diagnosis and assessment can be difficult as can treatment and managing behaviour. In continuously improving the service response to dementia we need to be explicitly aware of rights, dignity, and personalisation. We need to change public attitudes and prevent stigmatisation. I think we have yet to make meaningful moves in health improvement for people with this condition, and I look forward to action based on Scotland's National Dementia Strategy.

As mentioned earlier, cancers cause many deaths, but they also account for considerable ill health in terms of pain, weakness, anxiety for the patient and their family, and side effects of surgery, chemotherapy, or radiotherapy. Of new cancers registered amongst Borders residents in 2007, 358 were in men and 306 in women. The pie charts (Figures 10 and 11) below present national data but the Borders percentages by cancer type will be similar.

Figure 10: Ten most commonly diagnosed cancers in men in Scotland, 2007

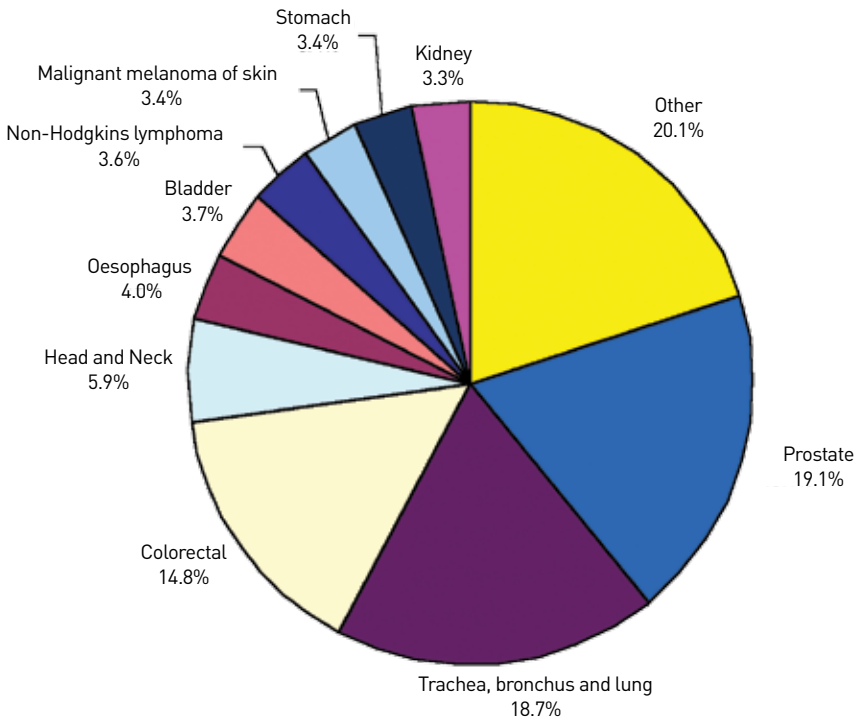
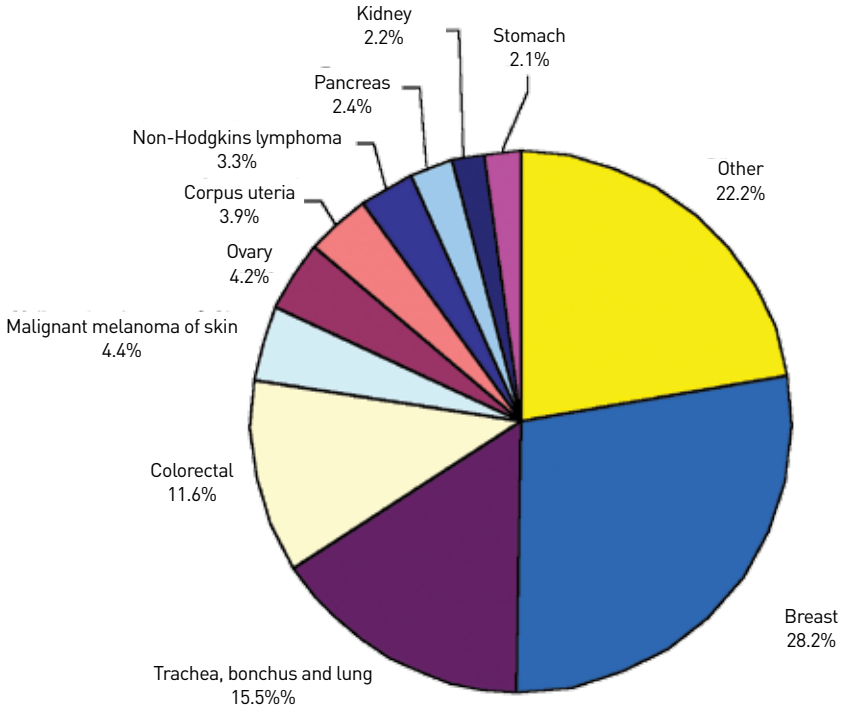


Figure 11: Ten most commonly diagnosed cancers in women in Scotland, 2007



Another way of gauging the impact of conditions is via the need for admission to hospital and the length of stay required. The table below shows the top six causes of inpatient stays.

Table 2: Top six Healthcare Resource Groups in Borders by occupied bed days, 2008/9

Healthcare Resource Group	Admissions	Length of Stay	Occupied bed days
Alzheimers Disease	89	75.6	7181
Senile dementia	129	52.4	7123
Schizophreniform Psychoses	183	29.8	5641
Depression	122	34.3	4215
Lower respiratory infection	314	12.5	3927
Kidney or urinary infection	256	15.2	3892

This analysis highlights the importance of dementia and mental illnesses, with their relatively long lengths of stay. However, the majority of people with dementia and mental illness do not need admission to hospital and therefore the number of admissions in Table 2 does not reflect the prevalence in the community. For example, the lifetime prevalence of depression is 25%, which means 1 in 4 of us will experience an episode at some point in our lives. Demographic changes increasingly result in greater number of older people who have dementia, so the impact of the top two HRGs is likely to increase further.

The Later Years

I must highlight the challenge of an ageing population. Although the figures in Table 1 suggest that few of the total population suffer from dementia, Table 2 shows that they make disproportionately high demand on health and social work services. This is a result of the three giants of the later years: immobility, intellectual impairment and inability - dependency. Consequently I am delighted to say that over the past 12 months there has been considerable work undertaken through the Transforming Older People's Review to ensure that the increasing older population in the Borders remains healthy, independent, and active in their own communities. This must be one of our key aims for the future. An underpinning outcome to the review is to promote health, wellbeing, and independence. As part of this work a handbook for over 50's "Ageing Well in the Scottish Borders" has been produced by a collaboration of NHS Borders, Scottish Borders Council, and the Voluntary Sector. The handbook provides information and contacts aimed at keeping people healthy and well into older age. It contains advice on continence care, sexual health, eating healthily and keeping healthy and mentally alert. I commend it as an exceptional publication and a worthwhile read for people of any age!

Delivering positive outcomes for service users and carers is important. This includes support for people to feel safe, having things to do, and being as well as a person can be so that people are enabled to lead a positive life in the way they want. A number of key actions have been agreed by NHS Borders and SBC to progress this agenda including the development of preventative services such as Neighbourhood Links, Falls Prevention and increased opportunities for older people to participate in their own communities.

Accidents, and in particular falls, are a significant issue for older people (see Chapter 2). People over the age of 75 have the greatest risk of suffering unintentional serious injury. This age group is most at risk of a serious injury and death from an accident within the home. In 2008/09 there were 266 emergency hospital admissions (over 50% of all serious home injuries and more than two and a half times all serious injuries on the road). With the proportion of over 65's expected to increase over the next 50 years the risk of serious injuries and possible deaths resulting from falls both in the home and outwith the home has to be considered a prevention priority.

One of the Scottish Borders Safer Communities Partnership Targets is a *10% reduction in the rate of emergency hospital admission for the over 65's as a result of a home accident to over 65's per 1000 population based on the 2002-2007 baseline.* The target for 2020 is a rate of no more than 12.71 hospital admissions per 1000 population.

Why Does it Happen?

The determinants of health and illness are complex and include the physical, social, emotional, and economic environment we grow up and live in. This is discussed in further chapters in the context of healthy communities. This range of determinants influence our health directly, and indirectly by influencing the choices we make to smoke or not, eat a healthy diet or not and drink to excess or not.

Although smoking prevalence has fallen rapidly over the last few decades, helped recently by the smoking ban introduced in 2006, a significant number of people still smoke in Borders. Drinking above recommended levels is also common and trends for obesity have already led to the situation where the majority of adults are overweight or obese. Poverty is also a significant problem locally and one that could get worse with the economic challenges we face. Table 3 below puts numbers on some of these influences on health in the Borders while the figures that follow in Chapter 4 show how lifestyles vary across the region.

Table 3: Quantifying some determinants of health in the Borders

Determinant	Percentage	Number
Alcohol (drinking above recommended limits)	34% (men) 23% (women)	18,150 13,080
Obesity (BMI >30, 2003)	25%	27,500
Smoking (adults, 2003/4)	24%	26,400
Poverty (estimated %/number of people in poverty)	16.4%	18,000

CHAPTER 2
LIFE IN THE BORDERS

The local economy, geography, housing, and travel, to name but a few all influence our health. In this chapter I highlight some important points about the social geography of the Borders.

The quality of the public and private sectors affects inward investment and so economic development. It also affects the levels of anti-social behaviour and can lead to a virtuous circle of community engagement and positive energy or to a cycle of reinforcing decay and despair which saps the health of individuals.

The Scottish Borders Council is one of two partner councils in the South of Scotland promoting Scotland's small towns – the centres of our respective populations, businesses and local services. The Scottish Small Towns Group (STG), convened by Scottish Borders Council, has actively promoted the role of communities, local government, agencies, and private interests in jointly addressing the needs and opportunities of small towns. The aim is to enable them to succeed as distinctive, attractive, valued, and sustainable entities.

The Council and its partners have a range of initiatives to fund social, cultural, economic and environmental or physical schemes in small towns; the STG promotes community engagement as a way of informing local decision-making and to support social cohesion. This is not only important to the economic future of communities but to the whole-health of individuals who live in and are served by towns of under 20,000 population – some 50% of Scotland's population.

Employment

Good work is good for you! Being in good employment protects health and conversely, unemployment contributes to poor health. Getting people into work, keeping them there and keeping them healthy is vital to reducing health inequalities. There has been an increase in activity in this area this year subsequent to Dame Carol Black's report "Working for a Healthier Tomorrow"[5] on the health of the working age population and the Scottish Government document "Health Works".[6]

[5] Black Dame C. Working for a Healthier Tomorrow: Review of the Health of Britain's Working Age Population (The Stationery Office, London 2008)
[6] Scottish Government, Health Works: A Review of the Scottish Government's Health Working Lives Strategy (RR Donnelly, December 2009)

Table 4 shows some interesting differences between the Borders and Scotland. The proportion of self-employed in the Borders compared to Scotland as a whole seems significantly larger.

Table 4: Employment Profile fo Workforce by Gender, 2007-08: Scottish Borders and Scotland

Source: Annual Population Survey

		% Males		% Females	
		Borders	Scotland	Borders	Scotland
Economically Active	Employed	67.8	67.9	71.5	68.1
	Self-Employed	17.3	11.0	6.5	4.2
	Unemployed	2.6	4.9	2.5	4.4
	Total in employment	85.1	78.9	78.0	72.3
Economically Inactive	Want a job	2.5	4.4	4.0	6.6
	Do not want a job	9.9	12.1	15.7	17.2
	Total economically inactive	12.4	16.5	19.7	23.8

Both the total percentages of males and females in employment in the Borders are higher than those for Scotland. More men in the Borders are self-employed; unemployment and demand for jobs is less. Interestingly fewer people in the Borders do not want a job. I would like to view this as positive, given the positive effect of good employment on health.

Workplace Health

Scottish Borders Council chairs the Borders Employability Group, of which NHS Borders is part in line with the requirements of "Health Works". This ensures that both health and employability are firmly on the agenda and every opportunity is taken to promote thinking and activity in this area. In addition, we are designing a local pathway to support those for whom health is a barrier to retaining or returning to work. NHS Borders is in partnership with Scottish Borders Council to update the Single Outcome Agreement to reflect progress made. We are also fully engaged with the Scottish Government's Health & Employability Delivery Group and wider network.

I am pleased to report that our strategy for the Borders on the "Health & Well-Being of the Working Age Population" will be launched in June 2010. This document and accompanying action plan will provide a framework for activity spanning the next three years promoting workability (a person's ability to operate effectively at work) and employability (a person's capability of gaining initial employment and/or returning to employment or other meaningful activity e.g. volunteering).

Occupational Health Services aim to ensure that people are in work that is compatible with their health and doesn't adversely affect it. As many individuals spend a large part of their adult life in the workplace, the service helps to support the overall objectives of any organisation by focusing on improving the health of staff at work.

NHS Borders 'one-stop shop' approach to occupational health service delivery with satellite clinics and on-site visits undertaken based on client need is part of the practical way forward.

As Specialist Public Health Practitioners, the NHS Occupational Health Team support the provision of safe and healthy working conditions by offering individual assessment and services including:

- Pre-employment health assessment
- Advice on the working environment and impact on health and well being
- Health Surveillance
- Advice on sickness absence, fitness for work, rehabilitation, redeployment and premature retirement on the grounds of ill health
- Confidential Counselling Service

Services have been provided to over 80 Small to Medium Enterprises this year covering a range of work environments such as textile manufacturers, bakeries, plastics, care providers, housing associations and construction.

Working Health Services

"Working Health Services" (WHS) is a Scottish Government funded pilot project which has been running for a year. It links directly to actions from the Adult Rehabilitation Framework. Providing job rehabilitation and occupational health advice, the service is designed to help employees of Small to Medium Sized Enterprises (SMEs), employing less than 250 people, stay at work or return to work sooner if they have health issues. To date, 255 people from 126 organisations have used the service with excellent feedback being received. Some interim outcomes of the two year pilot are noted below.

Table 5: Working Health Services outcomes April 2009 – March 2010

Measure	Pre Working Health Services	Post Working Health Services
At Work	79%	98%
GP visit in previous 3 months	1.8	0.6
General wellbeing scale	66 out of 100	83 out of 100

Quotes:
WHS Quote – from service user
"What a fantastic service. I can now go about my work duties with a lot more ease and have learned so much from my therapist about postures and managing my condition at work"

WHS Quote – from GP

"I saw one of my patients this afternoon who was absolutely delighted with the service she has received. She found the receptionist extremely helpful and sympathetic and received a very quick appointment for physiotherapy which has made a tremendous difference to her sciatica. Thanks for a first-rate service"

OHS Quote – service aim

"Our aim is to improve the health, safety and general well being of all employees and to ensure a healthier and safer working environment."

Workplace Lifestyle Assessment

The Workplace Lifestyle Assessment service has now been running for six years in its current format. Since December 2009 I am pleased to say it has linked into the 'Keep Well' project offering health checks in the work environment for individuals who meet the criteria of being 45-64 with a total household income under £30,000. This innovative approach has not been tried in other Health Board areas.

A total of 564 lifestyle assessments have been undertaken over the year with 15 meeting the original 'Keep Well' criteria. As part of this service a trained nurse has one-to-one discussion with the employee about their lifestyle with referral to other services as appropriate.

Healthy Working Lives

The Healthy Working Lives (HWL) Team provides a range of health related services for all businesses in the Scottish Borders, mostly SMEs. These include health and safety advice, health promotion advice, help with policy development, training, awareness raising, and a three tier award scheme. Training provided over the past year covered a range of topics such as Alcohol and Drugs, Physical Activity, Mental Health, Healthier Eating, Risk Assessment and Health and Safety. A variety of local networks such as Scottish Borders Licensing Board, Environmental Health, Childcare Partnership, and Business Gateway support have supported advisory visits at 34 SMEs over the past year. A variety of means have been used to raise awareness with 64 companies such as hosting awareness events with businesses and distributing information and resources linked to national campaigns. Awareness events cover everything from health and safety topics (eg noise, exposure to dusts, health surveillance), workplace health such as stress, mental well-being at work, musculo-skeletal health and lifestyle issues such as alcohol and exercise.

This is in addition to a monthly newsletter. Over the past year, a further 10 companies have registered for the HWL award bringing the total registered to 37.

Future Work

The 'Fit Note' to replace a doctor's 'Sick Note' was introduced by the Government for use nationwide on 6 April 2010. Formally called the 'Statement of Fitness for Work' it is designed to help people return to work sooner by providing more information about the effects of illness or injury on ability to work. This will provide an opportunity for GPs to contribute to their patient's health by helping keep them in work.

It's not just GP and employer thinking that has to change however. We need to engage all healthcare professionals in widening their practice to consider their patients' health in relation to work. Focussed activity will go into educating clinicians to ask patients key questions about their needs. This will be followed by appropriate signposting to support services which can help people stay in work or return to work.

Earnings

The health benefits of employment, which are well-evidenced, are offset by lower than average earnings in the Borders. As with other rural areas weekly wages are lower than in urban areas. The median Scottish Borders weekly earnings for full-time workers are second lowest in Scotland at about £370 compared with Edinburgh at £496. An overall rise in earnings across Scotland of just 4% conceals an almost 3% drop in Scottish Borders between 2007 and 2008. *(Median Earnings for Scottish Local Authorities, 2007–08 Table – Appendix 3)*. This inevitably has an impact on health which again I will discuss further later in the report.

Housing

At this point I would highlight the important impact housing has on health. The ability of individuals to access affordable housing and warmth is key to good health and, in turn, educational achievement and future work opportunities. The Scottish Borders Council Planning Service uses population projections to identify how much housing land is required, (and where) and, as Strategic Housing Authority, the Council works with Housing Associations to bring forward sites for affordable housing, based on local needs analysis. Negotiation with private developers under the Affordable Housing Policy also delivers on-site affordable housing and funding contributions for local affordable housing elsewhere. The Planning Service provides advice to businesses and communities on direct energy saving measures to older properties – important to ensuring affordable warmth for many low wage residents and to retaining viable work outlets for many small firms.

Despite this, fuel poverty and the proportion of private dwellings meeting the Scottish Housing quality standards are slightly worse than Scotland as a whole. Worryingly, there is a greater proportion of social sector dwellings failing that standard.

Table 6: Household Conditions in the Borders.
(Source: Scottish Household Condition Survey, 2007)

Indicator	Scottish Borders	Scotland
Estimated percentage of dwellings in "Fuel Poverty", 2004–07 (Source: SHCS)	27%	22%
Estimated percentage of private sector dwellings that failed the Scottish Housing Quality Standard, 2004-07 (Source: SHCS)	76%	72%
Estimated percentage of social sector dwellings that failed the Scottish Housing Quality Standard, 2004-07 (Source: SHCS)	83%	71%

However, the Scottish Borders Single Outcome Agreement has an annual target of 100 new houses to be delivered by Registered Social Landlords. The key challenges are not only to have housing but housing that is future proof against changes in type of energy supply and the needs of an increasingly ageing population. I deal with these issues in greater depth in Chapter 4.

Travel

In new developments, the statutory Town & Country Planning process, working with colleagues in Scottish Borders Council's Roads Authority, seeks to enable a choice of transport modes to education outlets, to enable safe walking, cycling and use of public transport, rather than to rely wholly on private vehicles, and by negotiating the design and funding of 'Safer Routes to School' that are convenient, safe and attractive to users. This includes consideration of community safety and avoidance of unseen alleyways, (for example) that may enable anti-social or criminal activity. Despite this, the challenges of transport in a rural area remain. These are well-known and highlighted in the statistics in Table 7. Broadly speaking, four out of five households in the Borders have a car, compared with two out of three for Scotland as a whole. Tellingly, fuel consumption in the Borders is one and a half times what it is in Scotland as a whole.

Table 7: Transport and Travel

Road Transport Statistics		
	Scottish Borders	Scotland
% of households without access to a car : 2005-2006	23	28
% of household with access to one car : 2005-2006	52	45
% of household with access to two or more cars : 2005-2006	25	27
Percentage of roads needing maintenance (red and amber classification), 2007	41	37
Average rate of road usage (million vehicle km) per 1000 head of population, 2007	11	9
Rate of total Government expenditure (thousand pounds) on roads per 100 population, 2006	12 9	
Rate of petrol and diesel consumption (thousand tonnes) per 100,000 pop, 2006	88	61
Percentage of children walking or cycling to school, 2005-06	53	50
Source: SBC/ SNS		

On the road 15-24 year olds are most at risk of emergency hospital admissions. This is largely due to accidents involving young drivers and their passengers.

The next category of risk is 25-44 year olds. In 2008/09 they had 31 serious injuries - around half of these involved riders of powered two wheelers. Of the 34 deaths from unintentional injuries in 2008, 14 were due to road accidents.

Analysis of fatal and serious accidents over the five year period 2003-2007 reveals the following road user groups as key priority groups.

- Powered two wheelers 21% of all fatal serious accidents
- Older drivers 60+ 21% of all fatal serious accidents
- Goods vehicles 19% of all fatal serious accidents
- Young drivers 17-24 19% of all fatal serious accidents

A Safer Scottish Borders

A range of local and national targets have been set to focus strategies, resources and partnership working to achieve significant improvements in safety in the home and on the roads by 2020.

However, only one of the current government 2010 road safety targets, Target 3, is likely to be achieved.

Key Road Safety Targets

- 40% Reduction in fatal/serious casualties - *Highly unlikely to be achieved and sustained*
- 50% reduction in child fatal/serious casualties – *Highly unlikely to be achieved and sustained*
- 10% reduction in the rate of slight casualties per 100 million vehicle km – *actually achieved in 2005 and sustained*

The road safety targets for 2020 are based on a five year average of 2004-2008.

- to reduce road deaths by at least 40 per cent by 2020 compared with the baseline; (the target for 2020 is no more than 7 deaths per year)
- to reduce the annual total of serious injuries on our roads by 2020 by at least 55 per cent compared with the baseline: (the target for 2020 is no more than 42 serious injuries per year)
- to reduce the annual total of road deaths to children (aged 0–16) by at least 55 per cent compared with the baseline: (the target for 2020 is no more than 0.1 child deaths per year, this translates into no more than 1 child death on the road over the next decade, in other words a zero limit)
- to reduce the annual total of serious injuries to children (aged 0–16) by at least 65 per cent compared with the baseline (the target for 2020 is no more than 2 child serious injuries per year).

These are clearly very ambitious and will only be achieved by a consistent evidence-based action at national and local level.

While I would in no way under play the important health consequences of road accidents, the figures below show that they are responsible for a relatively small proportion of all accidents. One of our local priorities is that serious harm to individuals will be reduced. Minor accidents are estimated to be between six to eight times the numbers of killed and seriously injured. Between 8,000 and 10,000 people each year are thought to suffer minor injuries.

During 2008/09 there were 1,363 emergency admissions as a result of unintentional injury representing 11% of all emergency admissions.

The principle groups of unintentional injury are:

Home	37%
Road	8%
Other	55%

Teenagers and young adults ages 15 to 24 years of age are next most at risk of a serious injury. This age group are most at risk of an accident within the "Other" category, accounting for 167 emergency admissions, probably the result of leisure and sport accidents.

Key Home Safety Targets

A range of Local and National targets have been set to focus strategies, resources and partnership working to achieve significant improvements in safety in the home by 2020. Scottish Borders Safer Communities Partnership Targets are:-

For Over 65's A 10% reduction in the rate of Emergency hospital admission as a result of a home accident to over 65's per 1000 population based on the 2002-2007 baseline. The target for 2020 is a rate of no more than 12.66 hospital admissions per 1000 population.

For "Under Fives" Target 30% reduction in the number of emergency hospital admissions as a result of a home accident: (actual target no more than 31 Emergency hospital admissions per year).

CHAPTER 3
THE EARLY YEARS

The Early Years Framework[7] sets out an ambitious ten year vision for change that recognises the importance of the earliest years in life. These lay the foundations for later health and wellbeing, attainment and good social relationships. The Framework encourages local partners in the NHS and local authorities to focus efforts on achieving better outcomes for children and families whose opportunities and aspirations are limited by poverty, ill health, low educational attainment and insecure work or unemployment. The challenge is to find innovative ways to use our resources to prevent problems occurring and to intervene early and effectively when they do.

My Health Improvement Team is currently planning how to help develop capacity in the early years workforce to improve health, in the context of the current review of early years strategy locally.

Play is at the heart of a child's emotional, physical, and social development. It has therefore been exciting to see the recent introduction of play@home in the Borders.

The Health of Mothers and Children

Antenatal Care

One of the important initiatives to tackle issues in the early years is Sure Start. The Sure Start midwife works with less advantaged families to put in place support before the baby arrives to ensure better outcomes for both the child and parents. In 2009, 153 mothers thought to need additional support by their community midwife or others were referred to the Sure Start Midwife. Of the referrals, 50% were older and younger mothers, more likely to have low birthweight babies. This is important because birthweight is a good indicator of infant health. I am pleased to say that there are plans to improve the uptake of antenatal care of vulnerable mothers throughout the Scottish Borders, through both one to one support and group work.

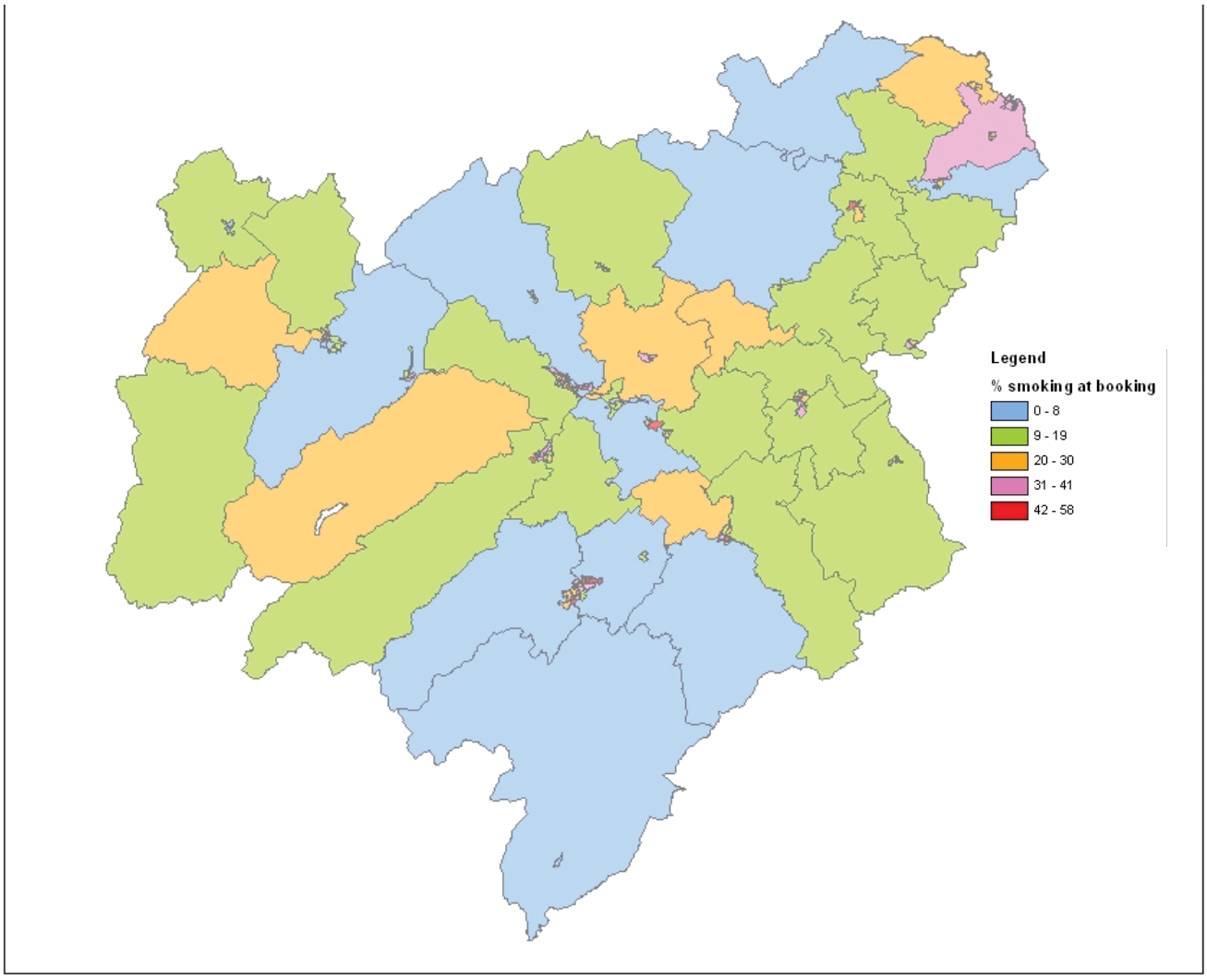
Maternal smoking in pregnancy is a major preventable cause of ill-health in babies and is linked to an increased risk of miscarriage and low birth weight, and ill-health in early years and later childhood. Across Scotland, one in five women smoke in pregnancy, a crucial time to influence the health of their child. Many mothers are unwilling to even contemplate stopping smoking during their pregnancy because of other stressors in their lives such as housing and financial problems. I am concerned that so few mothers stop smoking in pregnancy.

[7] The Early Years Framework, 2009, Scottish Government

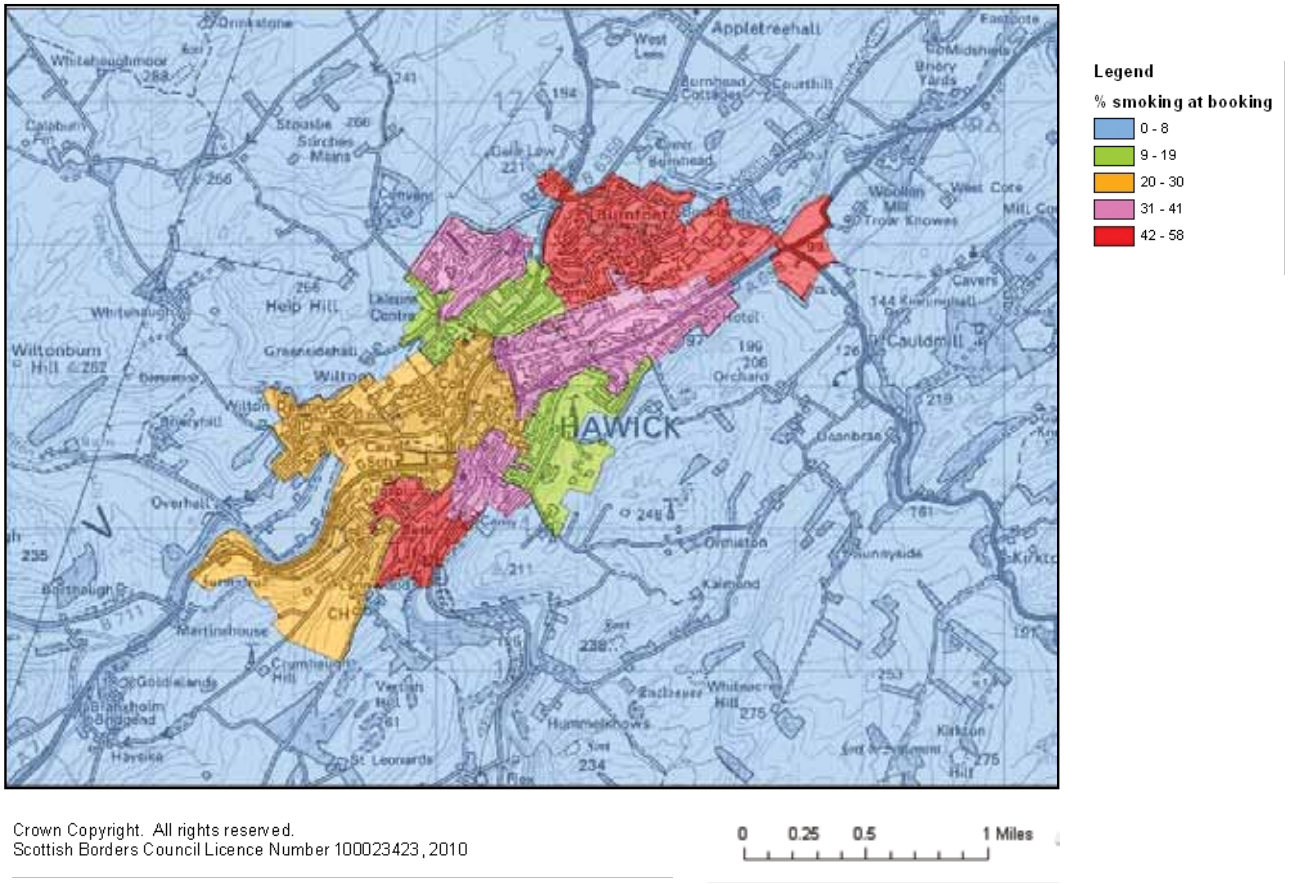
The map below shows how smoking in pregnancy varies by datazone across the Borders from 50% and over in parts of Hawick, Jedburgh and Selkirk to 0% in parts of Peebles, and in Bonchester Bridge and West Linton. The enlarged map of Hawick highlights some of the hot-spots with very high levels in that town.

Figure 12 : Percentage of Mothers-to-be who report at booking that they are current smokers, 2006-08: Scottish Borders datazones

Source: SNS



0 5 10 20 Miles



One to one advice and support is provided, including the "Stop Smoking" DVD which includes a section on pregnancy as well as onward referral to their local smoking cessation service.

Ways forward include better links with the smoking cessation service, and learning from other projects that are successful in supporting pregnant women and their families to stop smoking.

play@home

Play is at the heart of a child's emotional, physical, and social development. It has therefore been exciting to see the recent introduction of play@home in the Borders.

The need to promote physical activity in the early years is stronger now than it has ever been before. Developing good habits of regular physical activity in early childhood will lead to health enhancing behaviours throughout life (European Heart Network 2001). Children who are inactive in childhood are not likely to become active adults. Physical inactivity has an impact on weight gain and results in increasing numbers of overweight and obese children.

The aims of the play@home programme are to encourage parents/carers to participate in a programme of regular physical activity with their children in order to:

- Strengthen family bonds and communication
- Develop skills involving thinking, moving, socialising and imitating

- Stimulate curiosity, imagination and creativity
- Promote the benefits of positive praise and reassurance

From 1st April 2010 the play@home programme was introduced in the Borders where parents of all newborn children will be given the first of three play@home books. The baby, toddler, and pre-school books cover from birth to five years and include ideas for simple games and activities to help them develop.

There are families who are harder to reach and the presentation of the programme in a written format can present a barrier to them. The presentation of the books allows practical modelling of games for parents which is known to be effective and the use of inexpensive homemade toys reduces the barrier of lack of money.

As part of the preparation for the introduction of play@home in the Borders, 60 early years workers attended training sessions in Hawick, Peebles, Duns and Galashiels. The training helps workers link theory to practice, relate to current policy context, and develop partnership approaches at a local level. The training also considered approaches to tackling health inequalities and hard to reach families and groups.

In addition to the training of early years workers, resource materials on play@home are available to all Centres and Teams working in the early years sector across health, local authority and the Voluntary sector.

A Healthy Diet for Child and Mother

In collaboration with the Community Food Workers we plan to develop a range of practical food based initiatives (cookery skills around weaning and family meals) in new young parents groups. This will promote the importance of eating a healthy diet on a limited income for parents-to-be or carers with babies of weaning age. Further details on infant feeding in disadvantaged areas appear later in Chapter 4.

Home Safety

I remain concerned about the safety of children at home. I have touched on the issue of safety on pages 29 and 30. During 2008/09 there were 34 emergency hospital admissions involving under fives. Of serious injuries in children at home 1 in 5 are in under fives – 8 times the number of children injured on the roads. A range of local and national targets have been set to focus strategies, resources and partnership working to achieve significant improvements in safety in the home and on the roads by 2020. The Scottish Borders Safer Communities Partnership is targeting a 30% reduction in the number of emergency hospital admissions in 'under fives' as a result of a home accident (see page 30). This means no more than 31 emergency hospital admissions per year.

Weight Matters

Our children and young people now weigh more than at any other time in history. According to the Scottish Health Survey 2008, 32% of children aged between 2 and 15 are overweight including obese. That number is steadily increasing. Along with many others I am concerned about how this increase in weight will affect their health and wellbeing. In the Borders 21% of P1 children are overweight and obese. This is really no better than the Scottish average of 20%.

"I thought MEND was well run and have definitely found it helpful and will continue to put the programme into practice" .....Parent

For this reason, the Scottish Government has set a target (H3) for Health Boards to achieve agreed completion rates for a child healthy weight intervention programme by 2010/11 for the 5-15 age group. I am pleased to report that NHS Borders worked closely with Borders Sports and Leisure Trust, School Nurses and others over the past year to develop a family-based approach to healthy child weight.

For the past two years the H3 team have run Mind, Exercise, Nutrition and Do it! (MEND) programmes throughout the Borders. These are ten week family-based programmes focusing on feeling good and being healthy at any weight. They include: support for family relationships; healthy eating; physical activity and sustaining positive lifestyle choices. The team runs three programmes per school term. For those families who feel group sessions are not for them the NHS Nutrition and Dietetic Team runs a 1:1 programme throughout the year. Families and children can refer themselves or referral can be made through professional staff. The challenge for everyone involved is how best to engage with children, young people and families in a positive way without making them feel stigmatised on the basis of their weight. Recruitment to the programmes is a real challenge; various ways have been tried to encourage families onto the programme. School Nurses contacting families directly has been most effective.

Case Study - 12 year old boy

MEND Programme - 3 months + 9 months follow up

Before:	Waist - 110cm /43 inches Weight 89.6kg/14st 1.5lb	After:	Waist 103.5cm/40.5 inches Weight 85.4kg/13st 6.3lb

He said:
"Although I'm not really into sports I really liked the games on the programme. At the end of the 10 weeks I felt fitter and happier, especially as I had lost some weight too"

"I now enjoy cross country running and basketball at school, although I never liked sports before the programme"

His mum said:
"He now watches less TV and has changed what he eats. As a family we all eat healthier."
"Everyone else has noticed the changes in him, especially those who don't see him regularly. His t-shirts used to be tight and now they are loose around him"
"To those who are thinking of joining a programme I would say go for it!"

As Table 8 shows, of the 77 families who have been on the programmes, the majority saw their BMI, waist circumference, heart rate and screen time fall and their nutrition score and physical activity rise. BMI is a measurement that categorises whether people are overweight or obese - those with BMI between 25 and 30 are overweight and those over 30 are obese.

"The Nutrition Leader has taught me to be more aware of food and label reading. I now intend to do more home cooking .... Parent

Table 8 MEND Programme Outcomes

	Decrease	Increase	No change
BMI	84%	14%	2%
Waist Circumference	74%	14%	12%
Heart Rate	60%	36%	4%
Screen Time	66%	20%	14%
Nutition Score	94%	2%	4%

"I'm going to stop eating lots of crisps, sweets and fizzy juice" ..... Child

To maintain the healthy lifestyles after the programme each participant receives a Swim Borders card from Borders Sports and Leisure Trust allowing them free swim sessions for six months. A new programme is being developed for the following year based on lessons learnt. As this will demand less of families' time, I hope many more will take advantage of it.

Partners have agreed that the improved health of all children and young people needs to be a shared responsibility and a high priority, as an investment for the future.

The Health Improvement Team has been active providing support, information, and advice to colleagues in Learning Communities and Integrated Children's Services, drawing on its knowledge of relationships and sexual health, play and physical activity, tobacco, mental health and wellbeing and food and nutrition.

"I feel fitter and can run faster!".....Child

Education

The provision of accessible education facilities, relevant to the needs of local businesses and to foreseen employment opportunities, is a product of discussion between education providers, national funders, eg Funding Council and Skills Development Scotland, the Council's Economic Development service, Jobcentre Plus and Borders College under the Borders Learning & Skills Partnership. It is crucial that such discussions continue.

Appropriate education can help people obtain work opportunities that enable them to make active contributions to society. Learning skills and gaining work enhances people's mental health and wellbeing and enables them to play a more active role in societal, community, civic and democratic processes, as well as contributing to tax revenues.

The ability to read and write is clearly key to an individual understanding of health, how to improve and protect it as well as access services. We should take pride in our educational services and their achievement. Not only does it give people numeracy and literacy, but embeds teaching life skills to protect, sustain and improve health, all crucial areas of investment.

Primary School Education

I am pleased to be able to report continuous improvement over the seven year period between 2003 and 2009 in expected levels of attainment in reading, writing, and mathematics across Borders primary schools. Over the same period there has been continuous improvement in accelerated levels of attainment in reading, writing, and mathematics. The gap between boys' and girls' performance is close to the national figure. In reading and writing girls perform significantly better at all levels, and in mathematics performance is very close.

Targeted work on reading, writing, and maths has yielded significant improvements. In 2007, targeted work in reading, writing and mathematics for pupils not doing so well meant that in these areas improvements were significantly greater than overall progress.

Children and Young People

A recent review of Sexual Health and Relationships Education in secondary schools across the Borders highlighted that schools very much welcome the support and training on offer and are keen to continue working in partnership in this way. Recognising this, the Health Improvement Team has been working closely with the Scottish Borders Council Education and Lifelong Team to set up a Health and Wellbeing Network for schools as a means of sharing information and promoting good practice in working towards the Curriculum for Excellence Health and Wellbeing Outcomes.

Those working with children and young people have said that they often struggle to find resource material on health that is relevant and appropriate. This has led the Health Improvement Team to develop a toolbox, a web-based resource bringing information together in one place. This should be available by the summer of 2010.

Hearing from young people what they think are the important issues for their health is crucial and the last year has seen some exciting work on this front. The Borders Young People Survey asked over 1700 young people in 2009 what it is like to be young in the Borders and what would improve their quality of life and wellbeing. Young people told us they want more and better information and support to improve their health, particularly their emotional health, and their relationships with family, friends, and peers. Interesting comments included:

- 'We get Health and Wellbeing classes (in secondary school). I think we need them in Primary Schools.'
- 'I am not saying I'm perfect because I do drink some weekends, as there is nothing else to do, and I would really like something to do that doesn't involve alcohol.'

In addition, the Big HYPPE ('Helping Young People Participate & Engage') event brought together 80 young people from secondary schools across the Borders as well as the college in Sept 2009. They participated in a series of workshops to talk about what affects their health and wellbeing. This was an important opportunity for planners and decision makers to hear young people's views. Participants' comments included:

- 'I realised that there are many things that affect health'
- 'It was good to listen to people's ideas on health'
- 'Made me think deep about my health'
- 'Learned how important health is'
- 'If you know what's healthy you're able to make healthy choices – regardless of what friends are doing'
- 'What's important for your health is how you feel about yourself – that structures everything else.'

CHAPTER 4
INEQUALITIES IN HEALTH IN THE BORDERS

Health Inequalities

When we talk about health inequalities we mean those who are at most risk of ill-health through poverty or other forms of disadvantage. While conventional indicators of deprivation seem to show that people in the Borders are generally better off that the rest of Scotland (Table 7), I have shown in Chapter 2 that the Borders suffers, like similar areas, from the particular features of rural disadvantage. Within the Borders there is large variation. At township level, conventional indicators highlight the most disadvantaged communities as Burnfoot (Hawick), Eyemouth, Langlee (Galashiels), Selkirk , Walkerburn/ Innerleithen, Eyemouth and Coldstream. Three areas in Borders are identified as within 15% most deprived in Scotland. However, many people experience poverty and exclusion outside these areas. Poverty exists in the Borders hidden within smaller villages and the more affluent towns.

Table 7: Transport and Travel

Indicator	Scottish Borders	Scotland
% working-age population income-deprived, 2008	12.6 %	15.9%
% working-age population employment-deprived, 2008	8.4%	10.8%
% working-age population in the "Workless Client Group", 2006*	9.7%	13.6%
"Comparative Illness Rate" per 100,000 population, 2005*	9316	11,762

*Indicator is derived from claimant counts of a combination of key benefits and is used as an indication of deprivation.

Source: SNS

I am pleased to be able to report on a number of significant interventions to tackle these issues. I expand on these in the subsequent sections of this chapter.

Poverty

People experiencing poverty often face multiple problems, debt, housing or relationship difficulties as well as struggling on an inadequate income. These factors as well as lack of choice and control that accompanies poverty can cause stress, anxiety, and mental and physical health problems.

The aim for addressing health inequalities locally is to work in communities to make the healthy choice the easier choice. As well as this we aim to work with groups who benefit from additional support such as looked after children, people with mental health problems and learning disabilities.

Poor mental and physical health is both a cause and effect of social, economic, and environmental inequalities. Risk factors include individual behaviours such as smoking, alcohol misuse, diet and inactivity and also aspects of the wider social, economic, and physical environments that shape such behaviours, including educational achievement, income, relative poverty, the work environment and unemployment. Inequalities can also cross the generations, with children born and brought up in disadvantaged families being more likely to experience poorer health in later life.

The groups that are more at risk of experiencing poverty and being financially excluded are:

- Carers
- People with disabilities including people with learning disabilities
- Young people
- Older people
- People with mental health problems

According to the Scottish Government (2008), 17% of the Scottish population were living in poverty (840,000 people) and 21% of children were living in poverty. Although there is no definite measure of people experiencing poverty in the Scottish Borders, estimates would suggest that between 18,000 and 19,000 are living in poverty in the Scottish Borders at the current time.

Promoting financial inclusion requires a broad range of actions by key stakeholders who are committed to tackling poverty and financial inclusion. These include:

- Scottish Borders Council – Welfare Benefits, Home Energy Advice Service, Community Planning Partnership and Customer Services
- Registered Social Landlords (RSLs) – Eildon Housing Association, Waverley Housing, Scottish Borders Housing Association and Berwickshire Housing Association
- Citizens Advice Bureau
- NHS Borders
- Post Offices
- Utility Companies
- Banks
- Community Organisations/ Groups

The Housing Strategy Team are to be congratulated on the production of the "Tackling Poverty and Financial Inclusion Strategy", which is a Borders wide approach to tackle poverty and financial exclusion. The three aims of the strategy and some of the key actions that will tackle poverty and financial exclusion are described below:

Aim One: Reduce the number of households in the Scottish Borders currently in debt, or at risk of being in debt

- Increase access to debt counselling services for those in debt or at risk of debt
- Develop a poverty proofing policy to ensure that work does not inadvertently exacerbate the problems experienced by those living with poverty
- Establish the "Managing Money" pilot in Langlee, Galashiels

Aim Two: Improve access to affordable and manageable financial services in order that households manage their money efficiently

- Increase the number of people accessing the Capital Credit Union - promote the use of credit unions as a means of accessing financial services
- Promote the availability of social tariffs to eligible households

Aim Three: Improve access to information and advice to help maximise incomes

- Provide fuel poverty energy advice to disadvantaged households concentrating on issues of poor housing, inadequate heating/ insulation and dampness/ condensation
- Establish an extra Community Support Worker to provide additional support to vulnerable people
- Provide information advice and advocacy service on a full range of issues to all the people in the Borders with emphasis on benefit take up, terms and conditions of employment and minimum wage rights.

The Borders Macmillan Welfare Benefits Partnership

'Helped me cope' 'It has made a big difference to my life' 'Easing my financial problems has had a very positive effect on my health'

The Borders Macmillan Welfare Benefits Partnership is a joint project between the Welfare Benefits Service, Macmillan Cancer Support, NHS Borders Macmillan Centre and The Pension Service. The service has been operating between Scottish Borders Council's Welfare Benefits Service, Earlston and the NHS Borders Macmillan Cancer Centre, Borders General Hospital since commencement of the partnership agreement on 17th August 2009.

Research by Macmillan has shown that many cancer patients claim that money worries are second only to pain as a cause of stress; some even say financial concerns are greater.[8] It is also known that one in six patients had problems keeping up with their mortgages and rent and six per cent lost their home after they were diagnosed with cancer.[9]

Launch of the Borders Macmillan Welfare Benefits Partnership, Chaplaincy Centre, Borders General Hospital

The service offers a comprehensive welfare benefits service for people affected by cancer living in the Scottish Borders including their families and carers. Incomes are maximised by checking

[8] Quinn, A. (2002) Macmillan Cancer Relief Study into the Benefits Advice for People with Cancer, University of Reading

[9] Macmillans Better Homes research (2006)

entitlement to benefits, assisting with applications, representing at appeal tribunals for benefits and accessing grants. Patients can be seen at home, the Macmillan Centre or at an appropriate location of their choice.

The partnership target for the first reporting year is £800,000 annualised benefit gains for those affected by cancer. At 31 March 2010, the increased gains stood at £820,189. These figures include just over £10,000 in Macmillan Grants, which are most commonly used for increased fuel costs, travel and clothing. Just over half of the referrals to the partnership have been from the Borders Macmillan Cancer Centre, a quarter from self referral and the remainder a mixture of family and other health professionals. In the coming year it is planned to raise awareness of the service within Primary Care.

Mental Health Welfare Benefits Officer

A specialist mental health Welfare Benefits Officer post has been established on a temporary basis within Scottish Borders Council's Welfare Benefits Service. The post, funded through Fairer Scotland Fund for two years seeks to address increasing demand and to effectively tackle poverty for those affected by mental health issues. The nature of mental illness can mean increased anxiety for many. Welfare benefits assistance can be critical in contributing towards recovery by relieving anxiety and stress in relation to financial matters.

The specialist officer allows greater consistency in dealing with cases and as the officer is regularly working with those affected by mental health issues as well as health professionals in this field, a greater knowledge of how certain conditions affect individuals is gained which allows more detailed and relevant questioning in relation to disability related benefit claims and potentially a higher chance of success at the initial stages.

To date, presentations on the purpose of the project and the role of the officer have been made to health and social care professionals at the three NHS Borders mental health teams, to social care professionals and service users at the Galashiels Resource Centre, to a mixed group of health professionals and service users at the Borders Community Addiction Team, the Borders Voluntary Community Care Forum and the Well Being and Mental Health Winter Roadshow.

The target for increased financial gains to those accessing this service is £300,000 in the first 12 months (28.07.09- 27.07.10). As the annualised financial gains for the project currently stand at £226,937 at 31 March 2010, this target should be achieved.

The cases the officer deals with are often complex and involve a great deal of input. As an example, one recent case where the worker was dealing with a family, all of whom had mental health issues, required four home visits, one appeal tribunal, one community care grant review, several letters to health professionals and decision makers and numerous phone calls before matters were resolved. On the officers first visit to this house it was bare and unfurnished. The family now have kitchen appliances, a TV and comfortable sofa in the living room and beds to sleep in. Their incomes have all risen considerably and they seem content to settle in the Borders and re-engage with society.

When poverty gets worse...

While there is much commendable activity to tackle poverty we need to gear up to face the health impact of the recession we are moving into.[10, 11] This will tend to increase inequalities. It will be not only older people who will suffer the effects of fuel poverty but also families with children who have special needs, especially those whose finances are already under strain. Rates of alcohol use, drug use and mental health problems could all rise as people lose their jobs and experience feelings of hopelessness. Practical steps could include put in place programmes to create work for young people and the lower-skilled, councils to buy privately owned homes and rent them back to people in mortgage arrears rather than see them repossessed.

"Once upon a time, in a land not so very far away, dinner-table conversation revolved around the price of houses and the size of mortgages.

But then the economy went sour and recession arrived. As unemployment and inflation crept up month by month, the chattering turned to a fearful whisper as people wondered how they would manage, especially if they lost their job or their home"

Poverty and Housing

In total there are 55,579[12] households in the Scottish Borders, of these approximately 21% are social rented houses and 13% are private rented houses.

The level of social rented housing declined due to the number of "Right to Buy" sales which exceeds the level of new social rented developments being built; 44% of social rented housing stock has been lost through "Right to Buy" sales since 1980. With an increase in the number of applicants on housing lists and the loss of stock through "Right to Buy" the demand for social rented housing is increasing.

With such a high demand on the social rented sector and the rising costs of property in the owner occupied sector means that people turn to the private rented sector for their housing needs. The Scottish Household Survey suggests that the private rented sector is the least affordable rented tenure with almost 40% of tenants paying more that 25% of their income in rent. Around a third of tenants in the Scottish Household Survey 2008 noted that they found it difficult to afford the rent. The types of tenants experiencing difficulty included younger tenants, lone parents and those on partial benefits all of whom are more likely to be living in poverty or financially excluded.

The Housing Strategy Team produces the Local Housing Strategy which sets out exactly what Scottish Borders Council plans to do to tackle these issues:

'To make sure that every person in the Scottish Borders has a home in which they want to live, can live independently (with support if required) and that they have a home which is affordable, sustainable, in good condition and part of a vibrant community'.

[10] http://www.nursingtimes.net/public-health-in-a-recession/1931623.article
[11] "INpho 38: The impact of the recession on health", Eastern Region Public Health Observatory, 2009
[12] Revenues and Benefits SBC, July 2009

I am pleased to report some innovative actions by Scottish Borders Council to tackle some of these issues. In January 2005, Scottish Borders Council appointed a part time Home Energy Advisor to work in the Housing Strategy Team to provide energy advice, and make home visits to households across all tenures in the Scottish Borders. The Home Energy advisor provides energy efficiency talks to community groups, telephone advice and energy awareness days are planned to provide information to the whole community.

In 2009, the remit of the Home Energy Advice Service was extended, with financial support from NHS Borders and the four locally based Registered Social Landlords (Scottish Borders Housing Association, Berwickshire Housing Association, Eildon Housing Association and Waverley Housing). This was because of the growing demands placed on it as fuel poverty has become an increasingly important issue for many households.

The extended Home Energy Advice Service will bring the following benefits:

- Increased hours of the service from a part time post to four days per week
- A hardship fund for those living in fuel poverty who cannot access government grants
- Providing a home energy information leaflet to new social housing tenants
- Providing information surgeries at locations convenient to the public
- Training for staff in various organisations e.g. RSLs, Letting Agents, NHS Staff and e-referral form for sending information on clients to the service
- Providing a specialist service for those who are terminally ill/disabled to ensure they are warm in their home
- Providing information on various welfare benefits and poverty reduction services
- The service applying to various trusts/ utility suppliers for additional funding for fuel poverty and energy efficiency projects
- Undertaking outreach work in areas identified as having a high risk of fuel poverty

In particular I hope that the intervention fund will help households across all tenures in fuel poverty by helping for example, those with a disability, elderly or on low incomes, out of fuel poverty by making their home more energy efficient and by resolving debt problems.

Infant Feeding in Disadvantaged Areas

To improve infant feeding in disadvantaged areas I want to ensure ongoing support and delivery of existing programmes. These include, for example, weaning programmes in line with current government and WHO guidance, building on the existing models and experience in Healthy Living Network areas. I also want to see the skills of those involved with the target groups developed.

One of the most effective things we can do is to promote breastfeeding so that it is more widely used and for longer. Family and friends have a huge influence on our lifestyle choices, no more so than when we are very young when parents decide on our behalf. Breastfeeding is well known to reduce the risk of childhood diseases, particularly infections, reduce childhood obesity and

improve psychological development. We need everyone involved to understand the current picture of breastfeeding in the Borders. This is a vital element of any infant feeding strategy. Apart from the ethical imperative to increase the amount of breastfeeding there is a HEAT target, H7. This is to "increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11". I am disappointed to say that the provisional figure for the calendar year 2009 is 31.2%, no better than the previous calendar year, 2008. Only 29% of mothers in the Borders intend to breastfeed. However most of those (76%) who intended to breastfeed succeeded. What is even worse is that in 2007, breastfeeding rates varied widely from 11% in Selkirk to 60% in West Linton and Broughton area.

Breastfeeding is actively promoted to vulnerable mothers, their families and support networks, providing both one to one support at home and also within the young mothers groups throughout the Scottish Borders. The "Bump to Breastfeeding" DVD is very positively received. This is a userfriendly way of informing pregnant women and significant others about birth and breastfeeding using real mothers' stories.

Clearly, I am keen that we continue to provide one to one support and promote breastfeeding. The roll out of a peer support programme, where mothers who have had a positive breastfeeding experience, will provide informal parent to parent support.

We now have a Maternal and Infant Nutrition Team in the Borders. This team will plan and deliver a programme of activity on "Nutrition of women of childbearing age, pregnant women and children under five in disadvantaged areas" as directed by the Scottish Government. The team consists of a Programme Manager, Health Improvement Specialist and 2 Community Food Workers. Awareness raising sessions with community midwives stress the importance of vitamin D and folic acid supplements during pregnancy and breastfeeding.

Looked After Children

Looked after children are particularly disadvantaged in a number of ways and so have some very specific health needs. I'm pleased to say that NHS Borders has introduced a health assessment for looked after children within six weeks of their being accommodated. This is followed by annual reviews by their Consultant Paediatrician or School Nurse as appropriate. They are assisted in accessing services in primary care and also given information and advice on healthy lifestyles. Information on these children and their placements are shared with practitioners who are trained, supported, and informed on policy.

There is specific health input to residential care and initiatives to support the development of social skills and learning. I encourage carers and professionals in this area of work to see health and wellbeing as integral to a child's growth and development and not just focus on illness. An expert team provide discussions with adults working directly with looked after children, allowing time to think about the underlying mental health and emotional wellbeing issues that affect a child, not simply the behaviour presented.

Keep Well Borders

"Keep Well" is a Scottish Government funded programme to reduce health inequalities in the 45-64 year old population by providing a comprehensive health check for cardiovascular disease (CVD) in those 45-64 years with support to change lifestyles and, if needed, drug treatment. It was initially concentrated in inner city deprived areas of Scotland, running in primary care, but has subsequently been rolled out in three phases to the whole of Scotland, with Borders taking part in Phase 3 starting in December 2009. In the Borders individuals are being targeted in three settings - primary care, the workplace and the community (pharmacy and community venues).

The programme is coordinated with existing services. In NHS Borders, the Occupational Health Department have been operating a CVD risk assessment service for a number of years supported by funds from the Joint Health Improvement Team. This service incorporates the Keep Well principles, specifically to target people aged 45-64 years of age experiencing higher levels of deprivation. In addition the Borders already had the Lifestyle Advisor Support Service (LASS) a dedicated lifestyle coaching/support service to provide support to change lifestyles. Our overall aims are to identify the best way to reach people at high risk of ill health in most deprived households and improve their health and access to health care and other services.

"Uptake certainly increases over the day, as employees realise the check is benefiicial to them and their employer is happy for them to have time off the shop floor" says Rachael Forsyth, the lead nurse for workplace health checks.

In support of this, the HEAT target, H8, also requires NHS Borders to achieve the agreed number of inequalities-targeted cardiovascular health checks; 47 had been delivered by the end of 2009/10, against a target of 60.

Within the timescale of the project and the numbers involved it is unlikely that we will be able to measure long term improvements to health outcomes. However the project should identify current health status of those targeted, the number at risk, uptake of services, increase awareness of healthier lifestyles and gauge satisfaction with the health check.

"Most employees said they would take up the offer of a check again", says Rachael, "I did overhear employees talking about their results; many felt work is a good place to raise awareness of their health and wanted to know when we were coming back!"

For those making lifestyle changes we can measure increases in confidence and well being. We can also follow up behaviour change and how consistent it is. Comparison between the different strands of the project may show that one approach is better than the others.

Improving Physical Activity Opportunities for Excluded Groups

"Equally Well" highlights the need for the best start in life for vulnerable children and stresses the importance of physical activity and play for young children. At the same time locally the Poverty Commission's 2008 Report highlighted that families on low incomes appreciated services that were free, thereby making them much easier for themselves and their children to access.

Theme 1 of the Scottish Borders Physical Activity, Sport and Physical Education Strategy aims to promote well-being through physical activity and has identified children and young people as one of the priority groups.

The following projects have been supported through the Fairer Borders Fund with the aim of improving access to physical activity opportunities.

- Interest Link Borders Young Peoples Project; Dance Project- This service helps young people aged 16-25 who are in transition from children's to adults' learning disability services. Through Fairer Borders funding the service was able to run three Hip-Hop dance workshops.

- Activities Day for Young People who attend Youth Clubs/ Projects- Young people will be set the challenge of designing their own activity day. Youth clubs will compete against one another. All activities will be physically challenging with prizes for the best ideas.

- Family Centres – All Family Centres throughout the Scottish Borders have produced a range of ideas to enable children and families to experience some new physical activities free of charge. Some of the activities that will be on offer are: free swimming sessions, a cycling group for 5-8 year olds, walking groups and a "Shake and Wake up" drop-in group with breakfast and exercise.

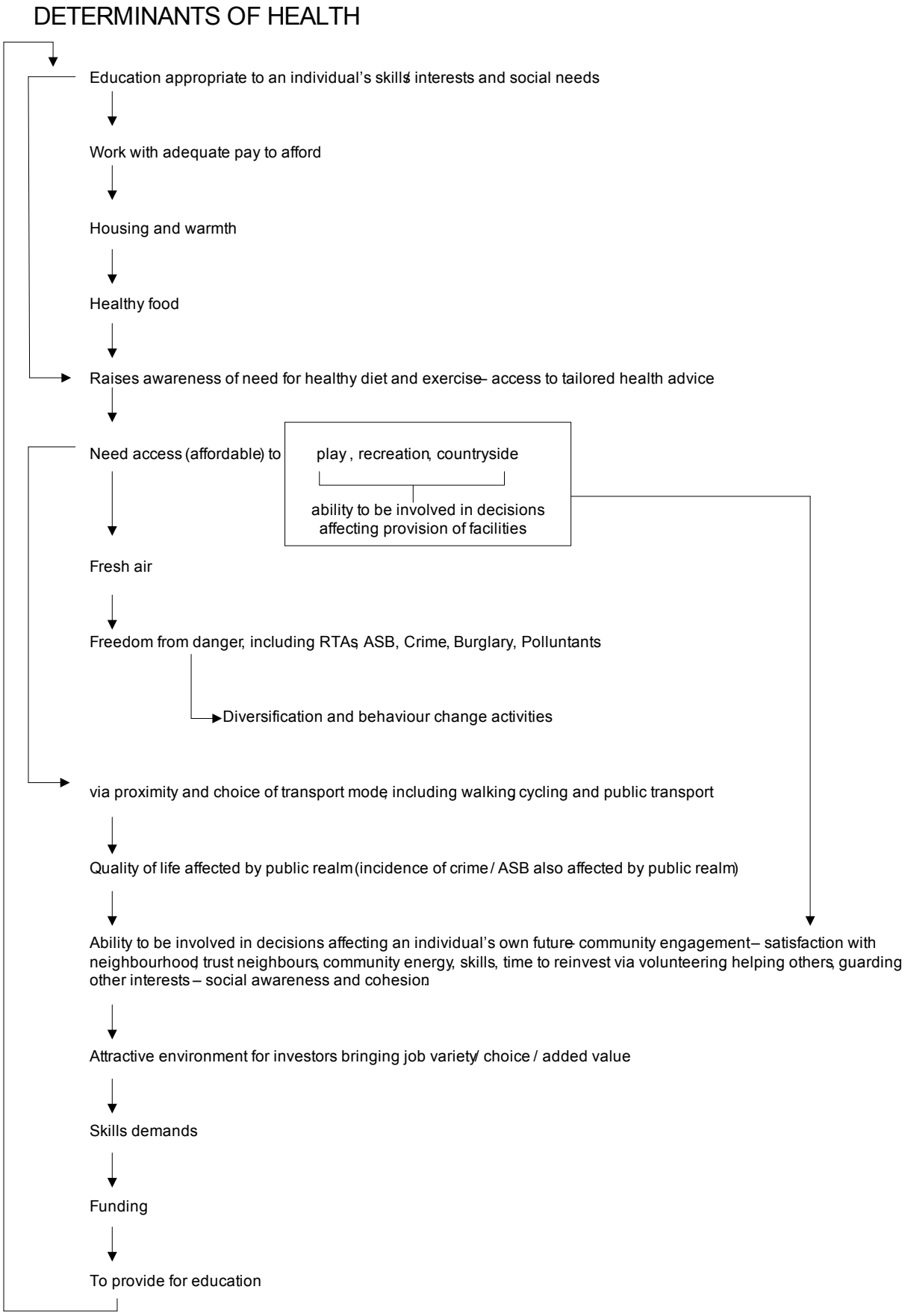
CHAPTER 5
HEALTHY COMMUNITIES

Determinants of Health

Health is not just about lifestyles and health-related behaviours; it is very much about our environment. We have a historical legacy of housing, very often in the private sector, which is of such a standard that it can only be detrimental to health. While progress is being made, creativity is needed to address this issue which is part of a whole tangle of other influences on health, such as disposable income, access to various opportunities, including education and physical activity. I have sought to point up the many, complex inter-relationships between health and communities, communities and their environments. Figure 14 focuses on the physical and socio-economic environment and its impact on health. These links are often reinforcing and whilst the relationships between issues are increasingly understood, the sheer complexity and sometimes lengthy timescales between cause and effect sometimes make it hard to gain support for the public health agenda. In my view such collaboration can best be achieved by specialists sharing what they already know with politicians and the public to jointly address gaps in understanding and by changing current practices to achieve better health in our populations.

In the following sections I explore a number of specific topics which are heavily influenced by our environment in its broadest sense: sexual health, mental health, nutrition, addictions, and physical activity.

Figure 14


DETERMINANTS OF HEALTH
Education appropriate to an individual's skills interests and social needs
Work with adequate pay to afford
Housing and warmth
Healthy food
Raises awareness of need for healthy diet and exercise – access to tailored health advice
Need access (affordable) to
play , recreation, countryside
ability to be involved in decisions affecting provision of facilities
Fresh air
Freedom from danger, including RTAs, ASB, Crime, Burglary, Polluntants
Diversification and behaviour change activities
via proximity and choice of transport mode, including walking cycling and public transport
Quality of life affected by public realm (incidence of crime / ASB also affected by public realm)
Ability to be involved in decisions affecting an individual's own future - community engagement – satisfaction with neighbourhood, trust neighbours, community energy, skills, time to reinvest via volunteering helping others, guarding other interests – social awareness and cohesion
Attractive environment for investors bringing job variety / choice / added value
Skills demands
Funding
To provide for education

Sexual Health

Sexual Health and Relationships Education (SHARE) training for Learning Disability staff

As part of the Health Improvement Strategy for People with Learning Disabilities, the "Making Choices - Keeping Safe" (MCKS) subgroup recommends that members of staff who have a role in the delivery of sexual health and relationships education and information to people with learning disabilities attend standardised training in order to ensure quality of information and education.

"All was really interesting - a good informative 3 day training session. Enjoyed participating in activities/case studies"

The nationally recommended NHS Health Scotland SHARE training is currently delivered across the region to school and youth provision staff.

"(I will now...) be open minded and listen, be confident in dealing with situations"

The mainstream training was adapted by the trainer for delivery to learning disability staff whilst maintaining its values based approach. The training was delivered to a group of 12 staff as a joint venture between Health Improvement and the Joint Learning Disability Service with the Health Improvement Specialist for People with Learning Disabilities co-facilitating and adding valuable expertise and information with reference to legal aspects of the work as well as local policy and procedural references.

Nine members of staff completed the course and the evaluation was overwhelmingly positive. The other staff will complete Day 3 at a later date. My team plan to run the course again in order to continue to build a workforce who are competent, comfortable and confident in the delivery of this sometimes sensitive area of health improvement and education

"I will not shy away from this area of work. I will be more confident talking to folk about this in the future"

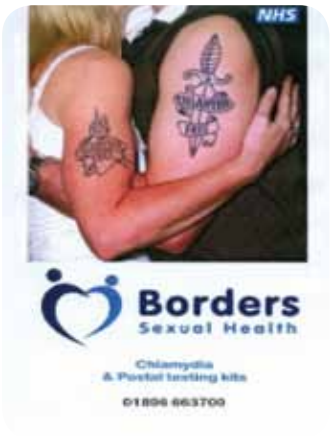
Making choices keeping safe

Chlamydia Postal Testing

Chlamydia is a common sexually transmitted infection (STI) affecting both men and women and is much more common in people under 25. In the Scottish Borders, about 1 in 10 people under the age of 25 has Chlamydia, this is the same nationally. It is most common in women between the ages of 15 and 19, and men under the age of 25.

About 80% of people with Chlamydia have no symptoms at all – so they don't know they have it. If untreated, an infection may lead to other serious problems including pelvic inflammatory disease and fertility problems in women; the infection may spread to the testicles and cause

discomfort in men who are not treated. These problems are rare but the risk increases every time a person gets Chlamydia. Because of this it is important that people get checked regularly as it is the only way a person will know if they have Chlamydia.



Borders Sexual Health has been running a campaign to raise the awareness of Chlamydia, to encourage people to get tested and to use condoms to prevent Chlamydia and other STIs. The campaign included advertising on local buses and on Radio Borders.

People can get tested at a Borders Sexual Health clinic and as an added convenience, for people who do not wish to attend a clinic or cannot attend for various reasons; Postal Testing Kits (PTKs) are also available. PTKs enable people to test themselves for Chlamydia at home by providing a sample of urine and sending it back to Borders Sexual Health. Everything required is in the kit including a sample bottle, instructions and secure packaging.

There are four choices for receiving the PTK results which include Borders Sexual Health phoning, emailing or texting them; the person can also call the clinic for their results, which should be available within two weeks.

Borders Sexual Health currently have 62 sites throughout the Scottish Borders distributing postal testing kits. In 2009 1260 kits were sent out. 287 tests were done of which 10.8% were positive.

Condoms are also available free from Borders Sexual Health and some settings within the community, supplied by Health Improvement.

Review of Relationships and Sexual Health Education (SRE) in secondary schools in the Scottish Borders

"Sexual Health And RElationships: Safe, HAppy and REsponsible" (SHARE) is a research based resource for professionals working with young people in S2-S4. It offers a comprehensive, evidence-based overview of sexual health and relationships education and addresses the complexities that surround this subject. It has consistently evaluated better than conventional sex education programmes and offers a balanced approach to sexual relationships. It is recognised that this approach to education about sexual relationships in partnership with a good general education or vocational programme leading to increased aspirations and expectations and motivation to avoid risk behaviour is likely to reduce the number of unintended pregnancies and sexually transmitted infections in young people. The training has been delivered to school and youth provision staff in the Scottish Borders for the last 5 years. The Health Improvement Team is responsible for building the capacity of organisations working with children and young people in the Scottish Borders to deliver this package. This partnership approach further strengthens the delivery of consistent and accurate messages about relationships to children and young people and enables those who are not in mainstream education to access the same information.

A review of SRE in secondary schools in the Scottish Borders was completed by Health Improvement, in partnership with the Education Department of Scottish Borders Council, in January 2010. The review was carried out in order to enable Scottish Borders Council and NHS Borders to, through its findings:

- Ensure that all young people in the Scottish Borders have a common level of education, understanding and opportunity to access information and advice
- Identify the most appropriate way of taking forward sexual health and relationships education in a robust and sustainable manner
- Plan future training and CPD that best meets the needs of those delivering sexual health and relationships education
- Identify how sexual health and relationships education might inform the delivery of other health and wellbeing outcomes in enabling young people to develop key social and emotional skills
- Establish an effective and meaningful method of evaluating sexual health and relationships education outputs and outcomes

Survey results indicated that 9 out of the 10 secondary schools in the region are currently delivering SHARE as the main curricular package for relationships education which is clearly a very positive figure. SHARE itself evaluated very well in the survey with schools rating it highly in terms of deliverability, acceptability and feedback from staff and pupils.

- It's recognised as being good, engaging and interactive"
- "... Staff really like using the resource – feel confident"
- "I found the course and the material very user friendly, and having piloted it with a group, accessible to our young people (SEBN)"
- "All of our staff are committed to use of SHARE, and all parents have so far been very supportive."

As a result of the survey SHARE should continue to be delivered in secondary schools in the Scottish Borders with a view to all schools delivering the programme by March 2011. In response to feedback from schools, SHARE training is to be delivered regularly, at least twice a year in order to facilitate requests for more staff training.

Towards a Mentally Flourishing Borders

Good mental health is not random nor is it equally distributed across the population. You are more likely to experience poor mental health, for example, if you live in poverty or debt, are unemployed or in insecure employment, experience discrimination, are socially isolated, have been exposed to violence or abuse, or are a carer. This can become a vicious cycle as poor mental health can leave you less able to cope effectively with pressures or to take positive steps to look after your own health and wellbeing and the health and wellbeing of those around you.

Working in partnership with local communities is important to address the challenges that affect mental health, and to support people to build on their strengths and skills to become more resilient.

Healthy Living Networks do a great deal of work to address mental health inequalities on many different levels: supporting groups and activities that people say they want, helping local communities to access resources and information, encouraging service providers to work more closely with local communities.

Another important strand of mental health improvement work is woven into the role of youth workers who reach out to disengaged young people to support them in developing the skills, confidence and tools needed to live life to the full. Over the last year, the Health Improvement Team has been working on a number of fronts with Community Learning and Development in SBC to offer information, advice and training for youth work with a strong focus on young people's emotional health and relationships.

Mental Health Initiatives

Our mental health and wellbeing is influenced by many different things throughout life: economic circumstances, the physical environment in which we live, the opportunities we have to learn, develop and be creative, our relationships with people around us at work, in our families and our communities, the extent to which we feel we have a say in what matters to us and how we are perceived by other people.

Mental health improvement is an important area as poor mental health has all sorts of consequences not only for the individuals concerned but also for families, local communities, the economy and for health and care services.

The Scottish Government's strategy and action plan "Towards a Mentally Flourishing Scotland" (TAMFS), encourages local areas to review what they are doing to improve mental health for everyone and to focus in particular on those groups of people who may be more likely to experience poor mental health.

In Scottish Borders, the NHS and SBC are working with other partners to develop a fresh plan for mental health improvement that will raise awareness of what we can do towards better mental health and wellbeing and identify the priorities that need to be tackled.

There is already a great deal of work happening within the Borders that can be built on, which contributes to mental health improvement. Social isolation can lead people to feel alone, unsupported and unhappy. People who are lonely often have poor health and recover from illness more slowly. An array of services and initiatives that reach out to those who are isolated – young mothers, older people who live alone, people who are unemployed –have a significant part to play in improving mental health. Examples range from the Neighbourhood Links scheme that supports people in their own homes to the promotion of resources such as playa home and Rhyme time that give parents encouragement and ideas for activities with their baby.

A signal of the interest in mental health and wellbeing is the wide range of practitioners from different sectors and services who have participated in the 'Promoting Mental Health Improvement' course run by the Health Improvement Team this year. The course has been reviewed and updated in the light of the renewed direction set nationally in TAMFS and feedback has been very positive.

A further exciting development in the past year, which grew out of work in schools with young people, led to the production of a DVD 'That's Not Me'. VOMO worked with the Suicide Prevention Development Officer to support a group of young people to write the script for and participate in the production of this short film. The film explores in a very sensitive manner the turmoil of emotions that can lead someone to consider suicide. It will be an extremely useful resource for training and awareness raising as part of the continuing programme of work on suicide prevention.

We continue to work towards the national target to reduce the suicide rate. This means ensuring that by the end of 2010, 50% of frontline health service staff have had training to help them to better identify people at risk of suicide and to offer support.

We Are What We Eat

In Chapter 2 I discussed the challenge of achieving a healthy weight in children. The Borders Community Food Grants had another successful year. With funding from a partnership of the Joint Health Improvement Team with Borders Childcare Partnership the project aims to provide small amounts of funds to community groups to promote healthier eating by providing basic cookery equipment, encouraging changes to established eating habits, overcoming reluctance to try new foods by changing behaviour and increasing knowledge, promoting positive attitudes to food and health and promoting availability of healthier foods such as fruit and vegetables.

"They can have a toastie, fruit and milk all for 50p - they concentrate better at school"

A total of 55 awards were made ranging from £500 - £50 to a variety of community groups for a variety of initiatives for example:

- Early Years – subsidise fruit snacks, grow, prepare and eat fruits and vegetables; prepare healthy lunches (church, community)
- Youth Sports Clubs (rugby, football, cricket) fruit available to all children after matches
- Youth Centre – subsidise fruit and vegetables to encourage uptake
- Apex Scotland – healthy eating and cookery courses
- Elderly – cookery demonstrations and "take away" packs of fruit and vegetables for one
- Learning Disabilities – fruit smoothie evenings for young people
- Women's Aid – healthy snacks for mothers and children

"The food grants have developed me as a worker. It encourages me to get young people to apply and get involved in grants and projects because I have had a good experience as when I started working I didn't have much experience"

The benefits are that the grants enable community groups to promote positive health by increasing the knowledge, skills and confidence around food and health for all age groups. It also makes possible easier access and availability to fresh fruit and vegetables.

Border Berries

The Border Berries Initiative has been running for 5 years as a small project to improve access to fruit in the Borders. The aims are to promote the consumption of berries, raise awareness of the consequent health benefits and support local farming. Community groups apply to visit local fruit farms to take part in a "Pick your own" experience. A free punnet of fruit for each child and a small grant towards travel is funded. A berry recipe book has been produced. Competitions have been organised to encourage children. The farmers give guided tours to the groups explaining the different varieties and how they are grown. In 2009 600 people, ranging from young children, people with learning disabilities, and mental health issues to young mums cookery groups took part. They all gained from the experience – young children were eating fruit they hadn't tried before, their knowledge around growing fruit increased and they enjoyed being active outdoors.

"Children were able to recognise ripe fruit and quickly learned what grew on bushes, up high or on the ground"

"The recipe book is a good idea as the service users made buns using the fruit they had picked"

Improving Oral Health

In the "Acton Plan for Improving Oral Health and Modernising NHS Dental Services" the NHS was to ensure that all secondary schools were offered an oral health programme which included prevention of sporting injuries to teeth. NHS Borders developed 'Give Teeth a Sporting Chance'. All nine secondary schools in the Borders have implemented it. All 1st year pupils were offered a professionally made mouthguard free, with 55% of pupils taking up the offer.

The Oral Health Promoters visited each school and delivered a presentation on the importance of wearing a mouthguard during contact sports and provided basic first aid advice should dental trauma occur. This included information on tooth decay, gum disease, oral hygiene, the importance of the use of plain water for hydration before, during and after sports and the damage sports drinks can cause to teeth along with more clinical photographs of tooth trauma, This was well received by both staff and pupils.

To support schools in meeting targets set out in the "diet action plan" and "improving oral health and modernising NHS dental services" and contributing to oral health policies both locally and at a national level the Oral Health Promotion Department were keen to promote the use of plain water as a safe drink for teeth at all times of the day but especially during and after sport or physical activity where the use of sports drinks are becoming increasingly more common. As it is unlikely that any child taking part in school sports activities will require anything more than rehydration with plain water we decided to target primary school age children to raise awareness of this.

We approached all the primary schools in the Borders and offered to visit each school and talk to P1-P7 children. The summer term was a good time to approach schools as many ran Health Weeks and also had their Annual Sports Day during this time.

From 65 schools we had 42 responses. Visits to the schools varied in format and time depending on how it could be worked into each school timetable. All children were reminded of the importance of drinking plain water in relation to good dental and general health and made aware of the contribution that juices (fizzy, squashes and sports drinks) make to dental decay and dental erosion.

In addition to the oral health talk we gave out clear water bottles to every child in all of the schools which were visited. In total we distributed 4,902 H2GO clear water bottles as part of the initiative.

To support schools in continuing this work they were signposted towards Scottish Water education website, Health Promoting Schools website and resources available in their School Oral Health Promotion Resource Box.

Mouthcare – training for Staff in nursing homes

This project piloted delivering the Mouthcare training within Care and Residential Homes Oral Health Support Workers supporting the implementation.

The aim of the project was to deliver training of Mouthcare (Mouthcare Pack). Mouthcare training includes Oral hygiene techniques, instruction in how to support residents to carry out oral hygiene and instruction in filling in a basic oral health assessment by care staff in the care home setting. This has allowed them access to training, to be more able to provide a high standard of oral healthcare, increased their knowledge and understanding of the importance of oral health and promoted a positive attitude to oral health.
It is hoped that the results of the pilot will support the rolling out of this training to all care homes in the Borders area. It should also provide evidence of the benefit of oral health support workers in the carehomes.

"Going to the Dentist"

"Going to the Dentist" is a communication resource produced by NHS Border's Oral Health Department and Learning Disability Services. It is part of the Action Plan for Improving Oral Health and Modernising NHS Dental Services. "Going to the Dentist" is designed to be used by anyone with a Learning Disability, Care Workers and Dental Service providers. It can be used with individuals to help reduce anxiety, explain treatment or improve their understanding of what happens at a dental visit. It can also be used as a familiarisation tool and to encourage discussion. Although specifically intended for special needs clients it can be used with people who have language and literacy problems to promote understanding. It has some worth as a resource to encourage access and attendance to dental services as well as being educational.

I commend this piece of work as an exemplary communication aid, working towards good practice regarding 'Equality and Diversity".

Tobacco

Quit4Good

While smoking remains a serious public health problem, NHS Borders is making good progress towards the Scottish Government target of 1,465 smokers successfully stopped at 4 weeks between April 2008 and March 2011. As of January 2010 1,264 confirmed 4 week 'quitters' had come through services and work is continuing to increase uptake of service.

Quit4Good is the new name for NHS Borders Smoking Cessation Services. Developed in consultation with smokers, this name reflects the fact that people who try to stop smoking by using a product such as Nicotine Replacement Therapy (NRT) and getting support from a trained worker are 4 times more likely to stop than people who go it alone. The new name was launched in December 2009 and followed by an intensive marketing campaign which aimed to maximise the profile of the new service and increase the number of people using it.

In partnership with Oral Health colleagues, successful training events were held with community dentist teams to support their skills in raising the issue of smoking with dentistry clients. Several new referrals have come through this route and further sessions are planned for 2010.

Smoking in Pregnancy

Maternal smoking is a major preventable cause of ill-health in babies and is a key factor in a range of conditions, from increased risk of miscarriage, low birth-weight, complications at birth and during the early years, to ill-health of the child in later life. According to ASH Scotland, 22.7% of pregnant Scots in 2006 were smoking when they were 3 months pregnant and 21.4% of mothers were current smokers at the health visitor's first visit. It is optimistic to interpret this as meaning that a very small number of pregnant smokers do succeed in giving up smoking during their pregnancy. Data on smoking are based on self-reported information and may not be entirely reliable. The most recent information for small areas is for 2003-05. This is not as up-to-date as information presented at a Scotland-wide level. However, it is the best data set at a local area level which is benchmarked against Scotland as a whole.

The data show that the average percentage of pregnant women who reported themselves as current smokers at booking in 2003-05 was 22.5%. This is similar to ISD Scotland's 2006 figure of 22.7%. The scores range from 10.4% in East Lothian to 34.4% in Dundee City. Disappointingly, Scottish Borders scores an above-average 27.1%, making it the 8th-worst Local Authority area in Scotland for smoking during pregnancy. This is better than Angus at 28.3% but worse than Glasgow City at 26.6%. The high average score is partly due to very high scores in the Langlee and the Burnfoot areas, with 52.6% and 51.1% respectively. These areas

have the highest levels of pregnant smokers by a considerable margin, meaning that more than half of all pregnant women are current smokers, according to the most recent figures available for these areas. Eyemouth, Coldstream, Jedburgh, other parts of Hawick and part of Kelso also have levels well above the Borders average.

In the last year this area for improvement has been challenging. Approximately 250 women report as smokers each year during booking appointments yet in 2009 only 33 accessed services. We have worked with maternity staff to raise the issue of smoking with pregnant women and refer people on to Quit4Good. This work will continue in 2010, supported by new publicity materials; other options to improve uptake will also be considered during this coming year to ensure that mothers are supported both to give their babies the best start in life but also to benefit from the health gains of stopping smoking.

Healthy Living Network

The Healthy Living Network (HLN) works in the most disadvantaged 5 communities in the Borders: Burnfoot (Hawick), Eyemouth, Langlee (Galashiels), Selkirk and Walkerburn and involves community members in developing health improvement programmes.

These programmes include cooking skills programmes, weaning classes, new physical activity opportunities as well as group's social and emotional wellbeing. Through the programmes HLN aims to increase the capacity of communities to identify and address health inequalities. To achieve this staff must be 'on the ground', maintaining contact with community members and staff from partner organisations.

Ongoing partnership working with, for example, Community Learning and Development, local schools, Citizens Advice, British Red Cross has included supporting Summer Activity Playschemes for children and families, delivery of an innovative programme to increase Physical Activity and Self Esteem in children (PASE), money management courses and First Aid training for parents.

Through support from Fairer Borders Fund HLN has delivered anti-poverty work in the area including Fuel Efficiency seminars for local people and developed a 'Back to Basics' cooking resource which will support people in cooking skills programmes to cook healthy, tasty meals on a budget.

Fairer Borders funding also supported innovative participatory research in the 5 localities into how people access and barriers to a healthy diet. Over 423 were interviewed in the research which highlighted the challenges for some communities in buying fresh, quality produce and provided useful information which will be used to inform HLN's food and health work over the next three years.

The Lifestyle Adviser Support Service

The Lifestyle Adviser Support Service (LASS) grew from a successful pilot in Kelso Health Centre in 2004. The target group is adults with identified risk factors such as: high blood pressure; increased BMI; smoking; problematic alcohol use; recently diagnosed type 2 diabetes or impaired glucose tolerance; other chronic illness or disease that may put them at risk of further health problems; underlying issues with emotional well being such as mild depression, low self esteem or anxiety.

Trained staff in primary care support patients to make health-enhancing lifestyle changes, with a focus on healthier eating, physical activity, tobacco use, safer alcohol use and emotional well being.

"Based on my own experience, I felt I had great benefit from the service and if it ain't broke don't fix it." Client, Galashiels

In 2009, agreement was made by all but one of the remaining GP practices within the Borders to adopt the service, and steps are now underway to roll the service out as a universal service, I am pleased to report, with effect from mid 2010. The evidence based approaches and techniques developed in LASS provide an invaluable primary care based resource for anticipatory care that complements other initiatives such as Keep Well and Counterweight.

Improving Health in Our Scottish Borders
In Partnership with NHS Borders, Scottish Borders Council & The Voluntary Sector

Active Borders

It is very positive that Scottish Borders Council Planning and Economic Development Department provides and promotes the use of access to the countryside and has created, signposted, and published details of the network of just under 4,000 km of rights of way. This, together with sensible use of the Right to Roam, provides a choice of local and long distance paths to support tourism and economic development and to provide for local enjoyment. The joint promotion by the Council and the NHS of this resource under the 'Walk it' banner or 'Paths to Health' initiative, is continuing to gain more new local recruits and referrals from Lifestyle Advisory Support Services and from Healthy Living Networks.

Vibrant communities also need access to play, sport and recreation resources. These are either provided directly by the Council, sometimes in association with education outlets, or are negotiated as part of new developments. Their standard and any relevant equipment is determined by the number of people in each age group (from toddler onwards) and through stakeholder engagement.

Common Health Legacy Plan

In September 2009 the Scottish Government launched the 2014 CommonHealth Games Legacy Plan which sets out the Government's aspirations for before, during and after the games to create a lasting legacy for the people of Scotland. The Legacy Plan aims to act as a catalyst to make faster progress towards a healthier nation. The plan is based around four themes:

- An Active Scotland
- A Connected Scotland
- A Flourishing Scotland
- A Sustainable Scotland

with health as the unifying theme.

Active Nation is a key programme within the *Games Legacy Plan*. The focus is on physical activity in its broadest sense (walking, cycling, jogging, sport, dancing, gardening etc). Its ambition is to encourage people across Scotland to become more physically active in their everyday lives in the run up to the 2014 Commonwealth Games and beyond.

Active Nation will help accelerate the progress towards achieving the national target to get 50% of Scottish adults and 80% of children up to the recommended levels of physical activity by 2022.

The development of **Community Sports Hubs** is another key programme within the *Games Legacy Plan* that aims to increase opportunities for people to take part in sport and physical activity by improving access to facilities and offering information, support and advice to local clubs and sports organisations.

Working in partnership will be a key part of creating a lasting legacy to the games and here in the Borders both NHS Borders and Scottish Borders Council have already begun the process of developing plans for how we will use the enthusiasm and interest in the games to improve the health of the people of the Borders. One of the key ways in which we will do this will be by incorporating this work into the Scottish Borders Strategy for Physical Activity, Sport and Physical Education.

Alcohol and Drugs

I am pleased to have become the Chair of the Borders Alcohol and Drug Partnership (ADP) and provide leadership to tackling the complex issue of alcohol misuse in Scotland. Reducing alcohol-related harm will require a range of actions in the short and longer-term to promote a change in our drinking culture.

In the Scottish Borders, the estimated prevalence of alcohol dependence in the total population is 5% (5,600 people). The percentage of 15 year olds drinking in the last week is 42%; this is above the national average of 36%. The findings from the recent needs assessment[13] suggest that the problems caused by alcohol and drug misuse, to the individual and the wider community in Borders are similar to, or less than, those of other comparable area populations. In contrast to Scotland as a whole, individuals living in some of the less deprived areas in the Borders are more likely to experience alcohol problems. In the broader context the demographic profile of Scottish Borders provides some protective factors; higher life expectancy; lower unemployment; lower deprivation rates and lower levels of criminality than the Scottish average. While the harm associated with alcohol misuse appears relatively low, this may reflect underreporting:

[13] Figure 8 Consultancy Services Ltd (2009) *Needs Assessment of Drug and Alcohol Problems in the Scottish Borders*

- The proportion of people drinking over the recommended weekly amount is lower than the Scottish average.
- The rate of drunkenness offences in Borders is lower than the number recorded in other local authorities of similar size.
- The death rate in Borders, where alcohol was a known underlying or contributing cause of death, is lower than the Scottish average for both men and women.
- Scottish Borders had a consistently lower rate per 100,000 population of general acute inpatient discharges with an alcohol-related diagnosis than Scotland. According to the Scottish Borders Health and Well Being area profile report, 41 between 1997/99 and 2004/06 an average of 788 people per 100,000 population per year were discharged from hospital with an alcohol-related diagnosis in the Borders, compared to the Scottish average of 859 people per 100,000 population per year over the same period. However, since 2003 the number of discharges in the Borders has increased by around 150 cases or 30%. Notably, year on year the Borders have had a consistently lower rate of general acute inpatient discharges with an alcohol-related diagnosis than the national rate.

Based on the needs assessment it appears that there is a need for increasing the capacity of alcohol and drug treatment services in equal measure. The barometer of need in the first instance is waiting times although this only indicates the gap between capacity and demand, not capacity and need.

Action on Alcohol and Drugs

The Borders ADP Action Plan describes specific outcomes for improving the health of adults based on the specific health needs described above. These are:

- Increased knowledge and changed attitudes to alcohol, drinking and drugs
- Fewer individuals drinking above the recommended daily and weekly guidelines
- A reduction in drug and alcohol use in the local area
- Individuals in need, receive timely, sensitive and appropriate support

Activities in place to achieve these outcomes, supported by increased funding from the Scottish Government over 2008-2011 include:

Delivery of alcohol screening and brief interventions (in Primary Care, antenatal care, and A&E). These are to increase the early identification of hazardous or harmful drinking and help individuals make changes before problems develop.

Development of drug and alcohol policies within organisations to manage drug and alcohol problems in the workplace. This should lead to a reduction in the number of drug and alcohol problems within the workplace such as drinking before or during work, poor attendance and under-performance.

Drug and alcohol training for staff working in front line and specialist services. This is important in ensuring the workforce able to identify and respond appropriately to substance misuse issues.

Programmes for young people who have started offending: 'face2face', the local drug and alcohol service for young people, works in partnership with the police to tackle underage drinking. The police send letters to parents of those either found drunk or in possession of alcohol to promote engagement with the service. Youth Offending Services also refer to Face2face where substance misuse is an issue; it works closely with Youth Justice staff where the young person will allow.

Support for parents: We have a new service for parents with substance misuse problems to support them to change their behaviour and reduce the harmful impact on their children. Although the focus is substance misuse, such parents often have a history of offending (particularly where they have drug problems), creating additional problems for the family. Children living in this environment have a higher chance of developing their own substance misuse problems. The service provides an opportunity to break the cycle of substance misuse for both parents and young people.

NHS drug treatment services: The ADP is working to improve access to and integration of services for those with drug or alcohol problems. The Integrated Care Pathway (for implementation over the summer 2010) will address the needs of (ex) offenders and those presenting with addictions and mental health problems. The NHS services now have a greater emphasis on recovery and links with wider services. The ADP has formed links with a new, national 'Recovery Consortium' to support development of the recovery element in local drug and alcohol services. The aim will be to help move people out of treatment and back into the community. The Big River Project (a local drug outreach service) has developed a new Employability Programme for those moving on from drug treatment.

Women and alcohol: Specialist alcohol services, plus practitioners trained in alcohol screening and brief interventions, have been made aware of the sharp rise in the percentage of women drinking above recommended alcohol limits and information promoting responsible drinking that targets women has disseminated widely.

Alcohol Awareness Week

Scotland's third Alcohol Awareness Week took place from the 4th-10th October 2009, and saw a joint programme of events designed to provide useful information to the public about responsible drinking. It brought together Scottish Government, the alcohol industry, health professionals, and the voluntary sector to promote a joined-up message about drinking alcohol responsibly. The aim of last years campaign was to increase awareness in people and demonstrate that by making positive lifestyle choices, changing drinking habits and drinking more responsibly it will enable you to get more out of your day, week or weekend.

I am pleased to report that Scottish Borders Council, NHS Borders, Lothian & Borders Police, Borders College, Heriot Watt University, Healthy Working Lives, Registered Social Landlords and Tesco were all involved in last years campaign. There were:

- Articles in organisations newsletters and intranet
- Stalls in local supermarkets providing information and home unit measures to members of the public
- Posters displayed out in the community and stalls in all health centres across the Borders
- Awareness sessions for NHS Borders Staff and SBC Staff
- Visits to local businesses with information for staff
- Launch of new Drug and Alcohol Service Directory

Alcohol Minimum Pricing

The Alcohol Scotland Bill was introduced to Parliament on the 25th November 2009 which included a proposal for introducing a minimum sales price for a unit of alcohol.

What is minimum pricing?

Minimum pricing for alcohol sets a 'floor' price, below which a unit of alcohol cannot be sold. Minimum pricing would apply to all alcoholic drinks but it would not result in an increase in the cost of all drinks, only those which are currently sold at below the 'floor' price. It would primarily affect low cost, high alcohol products such as ciders and low-grade spirits favoured by problem drinkers.

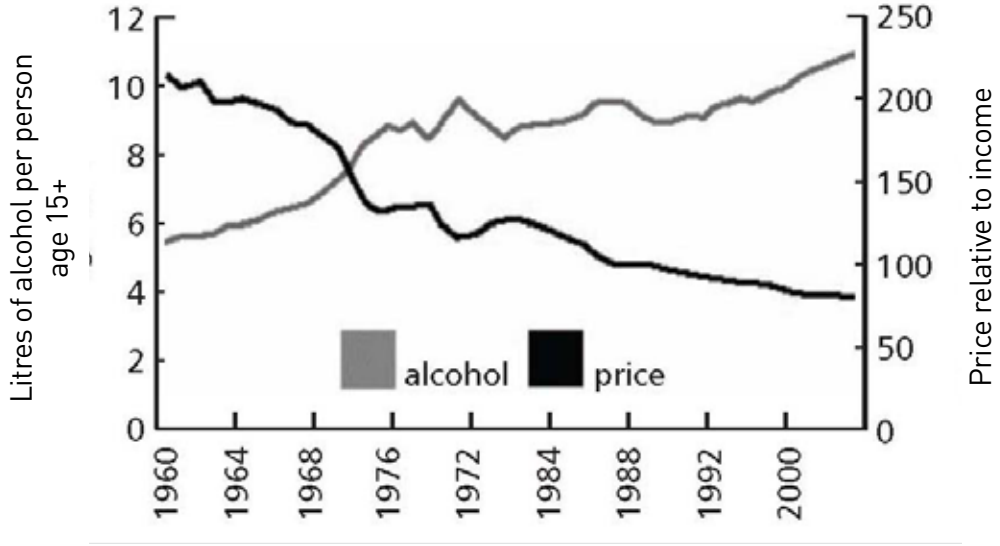
There is a clear relationship between the affordability of alcohol and consumption. This has been recognised across many countries over time. As the price of alcohol falls, consumption increases and this is exacerbated by plummeting prices and aggressive promotion. Since 1980 alcohol has become 70% more affordable. Over the same period, consumption has increased by around 20%. A minimum price for a unit of alcohol can help reduce alcohol consumption and harm as part of a wider package of measures, including education and diversion.

Figure 15 (below) illustrates that relationship.

Minimum pricing has the biggest impact on the consumption of harmful drinkers. They tend to choose cheaper alcohol, so if the price of the cheapest alcohol goes up then their consumption will fall as they can only afford to buy less alcohol. However all drinkers benefit in terms of reduced alcohol death rates and hospital admissions.

Figure 15

Consumption of alcohol in the UK (per person aged 15+) relative to its price: 1960-2002



Source: Tighe 2003

Raising the price of alcohol in Scotland is not the whole solution, but is without doubt a key part for an effective alcohol strategy which the World Health Organisation supports.

I am pleased to say Borders ADP supported the recommendation for the introduction of minimum pricing on health grounds by providing written evidence to the Health Committee of the Scottish Parliament.

Drugs

I remain gravely concerned at the impact of substance misuse in the Borders. In 2007/08, a higher than average number of 182 "new individuals in the Borders were reported to the Scottish Drugs Misuse Database (SDMD). The individuals reported to the SDMD in the Borders were more likely to be referred by a health professional or health service than drug users throughout Scotland. A lower proportion of drug users in the Borders self-refer to drug treatment services. More than three quarters of individuals reported to the SDMD in the Borders were unemployed and funded their addiction through benefits, a higher proportion than the Scottish average. A lower than average proportion of individuals in the Borders said that they funded their addiction through crime. A higher than average rate of psychiatric discharges related to drug misuse per 100,000 population was recorded in the Borders between 2002/03 and 2006/07. The rate of drug-related offences per 100,000 population in the Scottish Borders has been consistently lower than the Scottish average. However, a higher proportion of arrests in the Scottish Borders related to possession with intent to supply than in Scotland as a whole.

CHAPTER 6
PROTECTING HEALTH IN THE BORDERS

Implementation of the Public Health Act 2008

The new Act amends the law on public health, setting out the duties of the Scottish Ministers, Health Boards and Local Authorities to continue to make provision to protect public health in Scotland. Before the new Public Health Act 2008, the powers to control communicable disease lay with local authorities, subject to the advice of the designated medical officer. The new Act assigns functions on a corporate basis – health board or local authority –and sets out where professional 'competencies' are required. In broad terms boards are now responsible for control for communicable disease involving persons and local authorities are responsible for control of communicable disease involving premises. Action is no longer confined to notifiable diseases, but is to be taken on knowledge or suspicion of 'significant' risk to public health.

In summary the Act does the following:

- replaces current arrangements for the notification of infectious diseases and the reporting of organisms with a system of statutory notification of suspected or diagnosed infectious diseases, of health risk states and of organisms
- defines a "public health investigation" and sets out the powers available to investigators and how they may be appointed
- defines the public health functions of health boards and local authorities
- specifies statutory duties of health boards and local authorities with regard to the provision of mortuary and post-mortem facilities
- enables the Scottish Ministers, by means of a regulation-making power, to give effect to the International Health Regulations 2005, as they affect Scotland
- gives a power to the Scottish Ministers to require, by regulations, operators of sunbed premises to provide information to the users of those premises about the effects on health of the use of sun beds
- amends existing legislation in respect of statutory nuisances

National and Local Priorities

Health protection priorities in Borders are determined by national and locally identified potential hazards. The national priorities are communicated to Borders by letter from the Chief Medical Officer and through specific national strategic health protection plans and programmes. The local priorities are determined, within each of the Borders agencies, as part of annual planning process during which the most prevalent hazards or potential for serious hazards are identified. Some of these priorities are included in the national Health Improvement, Efficiency, Access, and Treatment (HEAT) targets and the Scottish Borders Council's Single Outcome Agreement.

National Priorities

The Chief Medical Officer for Scotland identified the 2008-2010 national health protection priorities as:

- pandemic influenza
- healthcare associated infections and antimicrobial resistance
- vaccine preventable diseases and the impact on them of current and planned immunisation programmes
- environmental exposures which have an adverse impact on health
- gastro-intestinal and zoonotic infections
- hepatitis C and other blood borne viruses

Local NHS Borders and Scottish Borders Council Health Protection Priorities

- To continue to implement actions for year 3 of Phase II of Hepatitis C Action Plan for Scotland. These are taken forward through the NHS Borders Blood Borne Virus Group.
- To continue to develop robust plans and ensure the Pandemic Flu Plan is kept up-to-date and amended in the light of the H1N1 experience and that arrangements are in place to offer vaccination against H1N1 virus as directed by Scottish Government.
- To continue to implement immunisation programmes in line with national guidance.
- To continue to address deficiencies in local TB services and to develop a local TB Plan in line with national guidance.
- To implement the recently published HIV Action Plan. This is being taken forward by the Sexual Health Coordination Group.
- To continue to support community infection control particularly in schools and care homes

These actions are drawn together in our Joint Health Protection Plan

NHS Borders Screening Programmes

Background

Screening is a process of identifying people who are at high risk of disease in order to prevent or treat early disease, thus reducing mortality and morbidity. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. There are a number of set screening criteria which need to apply for a programme to be effective:

- the condition being screened for should be an important one
- the screening test for the condition is highly 'sensitive' (good at correctly identifying people with the disease) and highly 'specific' (good at identifying those without disease)
- there is sufficient disease in the population to make it worth running a widespread programme
- treating the disease earlier rather than later will make a difference to the outcome
- the screening test is 'acceptable' to the population
- the programme does no harm
- the programme is cost-effective

Organisation

The scope of screening services in the Borders is determined largely by the UK National Screening Committee (NSC) which advises Ministers, the devolved national Assemblies and the Scottish Parliament on all aspects of screening policy.

In Scotland the NHS Scotland Screening Programmes Office, which is part of the National Services Division of the Common Services Agency, is responsible, in conjunction with NHS Boards, for taking forward appropriate national screening developments as well as the coordination and monitoring of the programmes.

NHS Boards are responsible for commissioning national screening programmes for their populations and for ensuring that the programmes meet the required standards and objectives. NHS Board coordinators are designated for each screening programme by the individual Boards to take responsibility for ensuring the effective delivery of screening programmes.

Current screening programmes provided by NHS Borders include those for:

- cervical cancer
- breast cancer
- disorders of pregnancy and the newborn (including antenatal, newborn bloodspot, neonatal hearing) - see Appendix 7
- diabetic retinopathy
- colorectal cancer

Programmes being planned include:

- haemoglobinopathies (a blood disease characterized by the presence of abnormal haemoglobins in the blood) screening programme to be implemented Oct 2010
- aortic aneurysm screening programme to be implemented Oct 2011

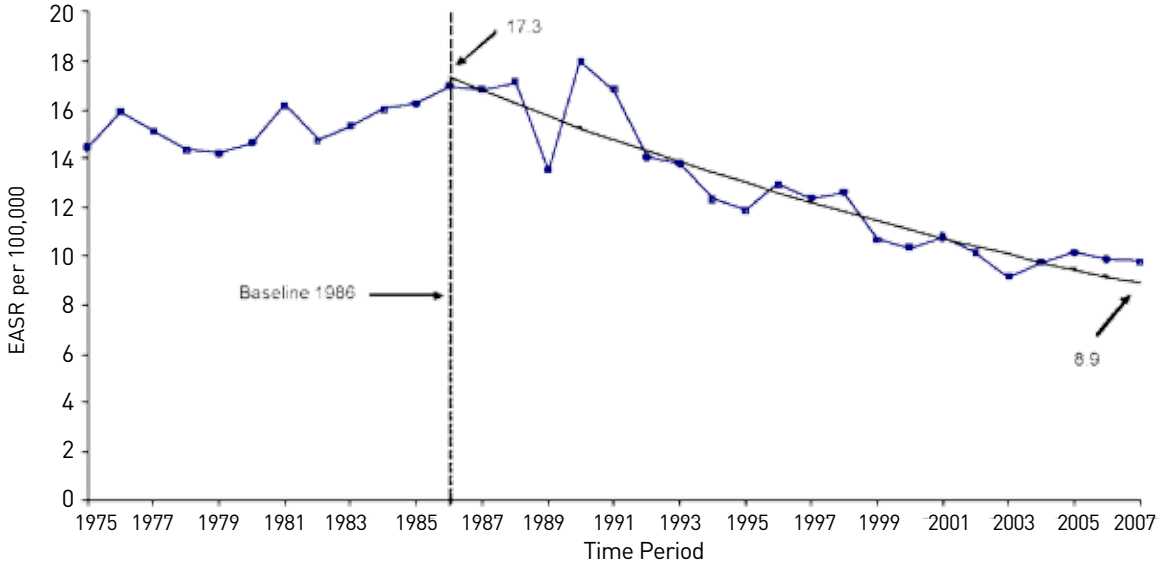
Each of the programmes is supported by a local multidisciplinary planning team and these teams have strong links with the appropriate national planning team.

The performance and key issues for each of the screening programmes are summarised below. No screening test can be 100% accurate, and it is important to manage the risks of errors at any stage of the screening process.

Cervical Cancer Screening

Figure16 below shows that cervical cancer incidence in Scotland has been decreasing since the introduction of a Scotland wide programme in 1987.

Figure 16: Cervical Cancer Incidence (European Age Standardised Rates) Females of All Ages, Scotland 1975-2007



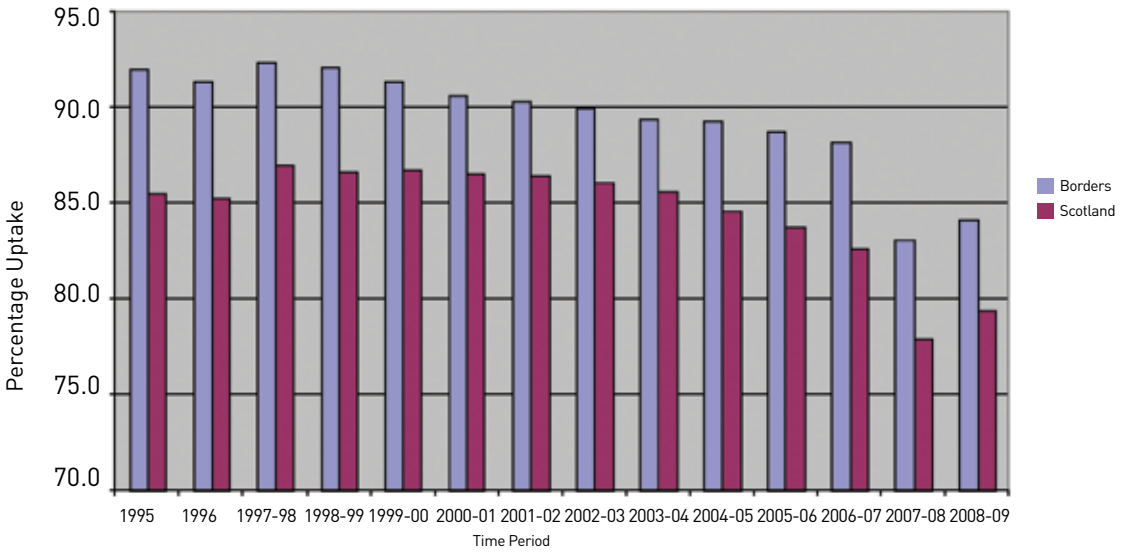
During the period 2003-2007 there were 24 cervical cancers in Borders.

Survival after diagnosis for cervical cancer has improved in Scotland over the past 30 years. The 5-year survival rate in 1980-84 for the 15-99 year group was 48.2% and for 2000-2004 was 56.5%.

The aim of the cervical screening programme is to reduce the number of women who develop invasive squamous cervical cancer and the number of the women who die from it. Normally, women aged between 20 and 60 years inclusive, are invited for a cervical smear three yearly. Invitations will cease at the age of 60 if the patient has had two negative smears within the last six years, i.e. a woman can be removed from the screening programme if she has had a normal smear taken on or after her 58th birthday and has had a normal smear taken within the previous three years.

No woman is too old to have her first smear and all women should have two negative smears before screening is stopped. There is no indication to screen women under the age of 20 unless it is clinically appropriate. Although not invited, women over 60 years of age are still eligible for cervical smear tests on a three yearly basis on request to their GP. Figure 17 below shows the uptake of cervical screening in the Borders January 1995 to March 2009.

Figure 17: Uptake of Cervical Screening for Borders Jan 1995 - March 2009 for females aged 20-60 years who had a record of smear within last 5.5 years



During 2008/9, 84.2% of women in the target group had a smear during the last 5.5 years compared to a Scottish figure of 79.4%. The national target for coverage is that at least 80%. The Borders clearly consistently exceeds this but I am concerned that the smear uptake rates in the Borders and in Scotland as a whole have reduced in recent years. The National Services Division of Scottish Government has commissioned research to explore attitudes leading to the reduction in the national uptake of cervical screening services in recent years. This will have a particular focus on how to improve uptake and address inequalities. This study will review what interventions are effective in encouraging uptake and interview samples of professionals and women who are eligible for screening to develop a way forward.

The new HPV vaccination programme for school age girls to protect against cervical cancer started in 2008. The impact of this programme will not be felt for a number of years and it is vital eligible women continue to be screened.

Table 9 below shows that the uptake in the Borders for 2008/9 was higher than Scotland as a whole.

Table 9: HPV immunisation uptake rates for school girls in S2, S5 and S6 for 2008/09

NHS Board	Number of girls in cohort	% uptake of 1st dose	% uptake of 2nd dose	% uptake of 3rd dose
Ayrshire and Arran	4 562	94.4	93.6	90.2
Borders	1 398	96.0	94.7	91.4
Dumfries and Galloway	1 972	95.1	94.4	92.5
Fife	4 519	91.8	90.9	87.0
Forth Valley	3 960	94.5	93.7	91.3
Grampian	6 845	93.4	92.5	89.2
Greater Glasgow & Clyde	15 218	94.6	93.4	88.7
Highland	4 324	91.7	90.4	85.2
Lanarkshire	7 949	90.8	89.2	80.7
Lothian	10 154	93.9	92.8	87.7
Orkney	268	94.0	92.5	89.6
Shetland	319	92.2	92.2	89.0
Tayside	5 178	94.5	93.4	89.0
Western Isles	398	91.5	87.4	81.7
Scotland	**67 240**	**93.5**	**92.4**	**87.7**

Breast Cancer Screening

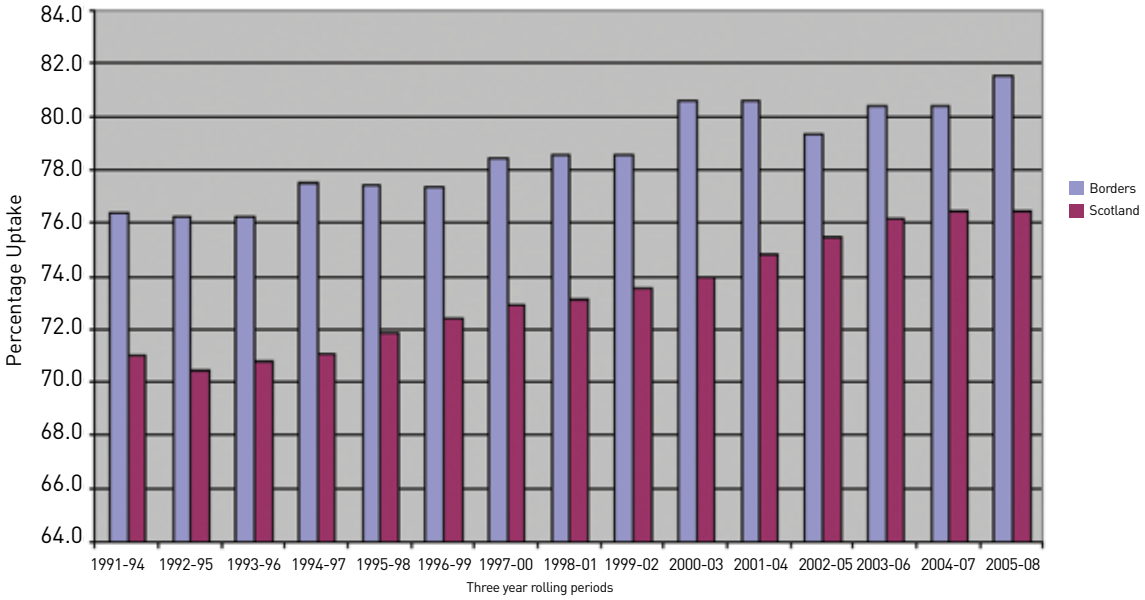
Breast cancer will affect about one woman in 10 in Britain at some point in her life. It is the most commonly occurring cancer amongst women in Scotland and Britain. In Britain, of all cancers in women, breast cancer is the leading cause of death although in Scotland lung cancer has that distinction. The incidence of breast cancer increases with age, being uncommon before the age of 30, but increasing rapidly after the menopause. Between 2000 and 2008 there were on average around 90 new cases of breast cancer each year in the Borders (screen detected and non screened detected cases).

The Scottish Breast Screening Programme (SBSP) targets women without symptoms, inviting them every three years for a mammogram, and recalling them for further tests if their breast x-rays show anything different from normal.

Breast screening to the Borders is provided by the South East of Scotland Breast Screening Programme (SESBSP) and the service offers mammography to women aged 50 to 70 years every three years. Mobile mammography units visit 15 locations in all parts of the Health Board area during each screening round. Women aged 71+ years are screened on request.

Figure 18 below shows the uptake of breast screening in the Borders compared to Scotland as a whole for three year periods. The average attendance rate for the Borders during the seventh round of screening in 2008 was 79.2% (compared to 81.1% in 2005) which is slightly below the target of 80%. 4.4% of those who attended were referred for assessment to the South East Scotland BSP Centre in Edinburgh.

Figure 18: Uptake of Breast Screening in the Borders compared to Scotland as a whole



The screening programme for the next round in 2010 will be for two views and the mobile units will be in the Borders area for longer than in previous rounds. This is due to changes to the organisation of the screening programme which will balance the demand on the diagnostic services throughout the South East Scotland area. At a practice level, this will mean that some practices may be screened slightly earlier and others will be slightly later than the previous screening round. It may also mean that some women are screened at an interval that is less than the recommended three year period. It should be noted that there has been a considerable amount of controversy in recent years about the risks and benefits of breast screening. The most recent analysis of UK data suggest that breast cancer screening saves the lives of two women for every one given unnecessary treatment. The English Breast Screening Programme is currently modifying information resources to reflect this message. The Scottish Programme is keeping this issue under review.

Universal Pregnancy and Newborn Screening Tests

A number of developments are currently being planned for the pregnancy and newborn screening programme. These are as follows:

- The replacement of the existing Pregnancy Screening Programme offered for Down's Syndrome and other congenital anomalies. The new programme will offer more robust risk estimation by offering a screening programme early pregnancy in which measurement of biochemical markers in the mother's blood is combined with ultrasound measurement. NHS Boards will be responsible for implementing these changes no later than 31 March 2011.

- The introduction of haemoglobinopathy screening both during pregnancy and for newborn babies by October 2010 (p69)

- The extension of the newborn bloodspot screening programme to include screening for Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD) an unborn error of metabolism by October 2010.

Diabetic Retinopathy Screening

Diabetes is a chronic disease with very serious potential consequences, and is recognised as a national priority area. Diabetic retinopathy is the biggest single cause of blindness and visual impairment among people of working age in Scotland. In its early stages diabetic retinopathy is asymptomatic but progression can be prevented by laser treatment. It is estimated that 5-10% of all people with diabetes have sight-threatening retinopathy. Early detection by screening with appropriate management can prevent blindness.

The Borders Diabetes Retinopathy Digital Photography Screening (DRS) programme started in March 2007. This mobile digital photography service invites diabetic patients 12 years and over to attend for digital photographs of their retina. These images are then sent to the Edinburgh Regional Grading Unit for examination. Diabetic patients are still advised to attend an optometrist once a year for a general eye check.

The percentage of the currently eligible population (4,666) successfully screened in year 2009/10 was 77% (target 80%). Of these patients 2% were referred to Ophthalmology on account of retinopathy.

Bowel Cancer Screening

Colorectal cancer (CRC) is a major public health problem in Scotland, which has a higher rate of colorectal cancer than most other countries in the western world. It is the third most commonly diagnosed cancer in men after lung and prostate cancer and in women after breast and lung cancer. Incidence of the disease is increasing among males. Approximately 3,400 new cases are diagnosed in Scotland every year (100 each year in the Borders) and 95% of these are in people aged over 50 years. CRC is the second most common cause of cancer deaths for men and third for women. Approximately 1,600 people die of this disease in Scotland each year (33 in the Borders). The five-year survival rate has improved over the last ten years but is still poor at 45%. The main UK evidence for colorectal screening by faecal occult blood tests (FOBts) comes from UK trials and other international studies. These found:

- A positive faecal occult blood test (FOBt) is associated with an approximately 10% chance of cancer or a 37% chance of a polyp.
- Use of faecal occult blood tests every two years to screen normal risk individuals reduces mortality from colorectal cancer by 15-18%.
- 2% of screened persons would require further investigation.

As a result of these findings a bowel screening programme has been established in Scotland and will invite all men and women between the ages of 50 and 74 years who are registered with a GP. Other eligible individuals who are not registered with a general practice such as prisoners, armed forces, homeless and individuals in long-stay institutions will also be able to participate.

The Borders Bowel Screening Programme commenced in November 2009. FOBts will be sent out to around 16,500 GP registered persons aged between 50-74 years each year by the Screening Centre in Tayside and specimens will be returned directly to the Centre. Positive results will then be sent to the Borders General Hospital who will invite an estimated 200 persons each year for assessment, of which an estimated 150 will have a colonscopy. Although it is too early at the moment to comment on uptake rates for this programme with any certainty, early indications are that the uptake and referral rates to colonscopy will be at the higher end of expected values.

Control of Communicable Disease in the Borders

The Communicable Disease and Environmental Health functions of NHS Borders and Scottish Borders Council aim to:

- reduce preventable illness and death from communicable disease
- identify potential outbreaks of communicable disease at an early stage so that effective control measures can be put in place as soon as possible, to improve the ability to prevent further outbreaks
- work with other agencies to reduce any adverse environmental impact on health

This section of the report provides an overview of the main communicable disease and environmental health issues affecting the Borders.

The Department of Public Health is made aware of cases of Communicable Disease in two main ways:

- from notifications made by general practitioners and other doctors when they suspect or become aware that a person is suffering from any of the 28 infectious diseases which they are required by law to notify to the health board
- from microbiological reports of certain organisms and diseases received from laboratories based in hospitals

These data provide an early warning of outbreaks of infectious diseases enabling prompt investigation and action. This must be as efficient as possible and efforts have made this year to modernise the systems of reporting and notification. Table 10 below shows that the overall number of reports of communicable diseases between 2004-2008 collated by the Public Health Department. Please note that these were diseases notified under the old public health regulations not the new Public Health Act 2008.

Table 10: Numbers of Cases of Communicable Disease Reported in the Borders between 2004-2009

Communicable Disease	2004	2005	2006	2007	2008	2009
Anthrax			1			
Bacillary Dysentery				4		
Chickenpox	615	458	538	368	364	360
Cholera				1		
Diphtheria						
Erysipelas			3	1	1	
Food poisoning (ex campylobacter)	50	107	96	59	119	80
Campylobacter	124	141	149	138	171	112
Total Food poisoning	174	248	245	197	290	
Legionellosis	1		1	2		1
Leptospirosis						
Lyme disease					1	
Malaria	1					
Mumps confirmed	2	40	34	61	20	34
Measles confirmed			8		1	3
Rubella confirmed			9	2	1	
Meningococcal Infection	1			1		3
Paratyphoid fever						
Plague						
Poliomyelitis						
Puerperal fever			1			
Rabies						
Relapsing fever						
Scarlet fever	3		7	3	5	5
Smallpox						
Tetanus						
Toxoplasmosis	1					
Tuberculosis (respiratory)	4	1	8	5	5	4
Tuberculosis (non respiratory)	3					3
Typhoid Fever						
Typhus						
Viral Haemorrhagic fevers						
Viral Hepatitis	10	12	15	11	19	27
Whooping cough	7	2		2		6

Source: Borders Public Health Department

Key points to note are:

- There have been substantial increases in the number of cases of mumps in the Borders as part of the national outbreak in recent years although this is now declining.
- Chickenpox remains a common disease and notified levels of this disease remain high. As chickenpox will no longer be a notifiable disease in the future these figures will no longer be collected at Board level.
- Food poisoning is still a significant health problem and more than half of those notified are due to campylobacter. Campylobacter is no longer a notifiable disease and therefore only laboratory reports will be reported in the future.
- This table only provides detail on notifiable disease and much community communicable disease goes unreported including cases of norovirus and rotavirus gastrointestinal disease.

Tuberculosis

As shown in Table 10 above, although the overall numbers remain small, there was an increase in Tuberculosis incidence in 2006 mainly related to cases in elderly Borders residents. Most of these were reactivations following infection in childhood many years ago.

BCG vaccination

The universal school programme offering the BCG vaccination of all secondary school students was stopped in 2006 because of the changing epidemiology of TB. When the schools' BCG programme started in 1953, most cases of TB were in young people. Since that time the number of cases has fallen significantly and the disease now mainly affects people with specific risk factors for TB. BCG vaccine is now only offered to people who have a greater chance of coming into contact with TB than most people in general. In 2007 a new targeted programme for children was introduced into the Borders and BCG is now only offered to those children in high risk groups. Agreements were also reached with some local practices to screen newly registered new entrant patients for TB.

Blood Borne Viruses and Hepatitis C Plan

The term "Blood Borne Viruses" refers mainly to Hepatitis B and C (HBV, HCV) and Human Immunodeficiency Virus (HIV). The true numbers of people infected with these viruses in the Borders is not known for certain as they often have minimal symptoms (sub-clinical infection) and chronic carriage. However the Borders have one of the lowest reported rates of blood borne viruses in Scotland. The main route of transmission for HIV locally is from homosexual sex. For HBV and HCV the main route locally and in Scotland as a whole is through blood-to-blood contact, predominantly through intravenous drug users sharing needles, syringes and other contaminated drug-injecting equipment.

Drug Misuse

The latest Drug Misuse Statistics Scotland 2009 report uses 2006 data and estimates a significant drop in the number of problematic drug users in the Borders although a dramatic rise in the number/percentage of intravenous drug users (IDUs). There are concerns however that this overall estimate is not a valid reflection of current drug use locally.
This is because:

- there has been a significant rise in referrals to drug services over the last 3 years
- the level of activity at Borders needle exchange services has increased
- drug-related deaths continue to occur

I am concerned that the Scottish Government is using this incomplete data as a basis for allocating funding.

The numbers reported in the 2009 report are as follows:

- a decrease in the number of problematic (heroin or benzodiazepine) drug users from 680 to 466 (31%)
- of those 466 individuals, an estimated 201 are injecting (43%)
- a prevalence rate for problematic drug use of 0.85% in the slightly extended 15-64 year age group

NEX (Needle Exchange) activity at the Big River Project (drug outreach service) and those provided by community pharmacies provides a more current assessment of the level of injecting. A report for the period April-Sept 2009 showed 212 clients accessing NEX services (62 of these were new clients). There was an 83% return rate for used equipment.

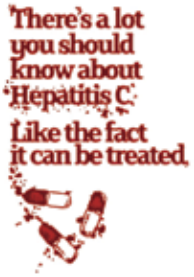
NEX clients demonstrated a 3:1 male to female ratio, and spanned the ages from the 16-20 age group up to 46-64. Most activity was in the Galashiels (52%), Eyemouth (20%) and Hawick (15%) areas, reflecting the biggest centres of the population and office base for the Big River Project.

Blood Borne Virus Action Plans

A vaccine is available for HBV but not HCV or HIV. The current policy is to provide selective HBV immunisation to those judged to be at increased risk, however it is estimated that nationally less than 30% of drug users have been immunised. There are no local data available at present.

In order to prevent and manage the impact of blood borne viruses in the Borders, a multi-disciplinary group has been established to:

- improve awareness of blood borne viruses
- reduce the spread of blood borne viruses infection through surveillance and prevention measures
- ensure effective diagnosis, control and management of infection



Hepatitis C Action Plan

The Scottish Government has produced an Action Plan to improve all services applicable to the prevention, diagnosis and care of persons with Hepatitis C. These range from those that provide education to young people in schools about the dangers of injecting drug use and Hepatitis C, to the treatment of infected persons with antiviral drugs and the associated social support required to support them and their families through what, often, is a challenging journey. Boards are now implementing Year 3 of this Plan and these actions are being taken forward through the NHS Borders Blood Borne Virus Group. Local action is detailed in Table 11 below.

Table 11 NHS Borders Hep C Action Plan activity

Prevention

Needle exchange services:

- NEX network meets regularly to monitor and review trends/services
- The range of services has been expanded via community pharmacies over last 2 years to increase access geographically (still some gaps)
- A young people's policy has been agreed to address the needs of younger, vulnerable clients.
- An audit of current practice and information disseminated has been agreed and due to take place in 2010

Awareness raising:

- Information resources are being reviewed to ensure current, consistent, quality information accessible to professionals and service users/carers (including vulnerable groups such as those with mental health problems, young people etc)
- These resources are to be Equality Impact Assessed to maximise accessibility amongst at risk population inc. minority ethnic groups, those with literacy problems etc

Testing, treatment, care and support

- Specialist drug services (statutory and voluntary sectors) now offer blood-spot testing as part of a national pilot. This has been very successful and has resulted in over 100 clients being tested for Hepatitis C
- Joint working between NEX, testing and treatment services are in progress to examine ways of increasing engagement with treatment
- Integrated Care Pathways have been developed across health and social care and voluntary sectors
- Hepatitis B immunisation is now being offered to IDUs presenting for testing
- Specialist services have increased capacity to treat 10-12 new patients/year
- Clients needs are regularly reviewed via existing and new services

Workforce Development

- Local training is being delivered for those working with vulnerable groups (evaluated well)
- A local training programme is being developed to address remaining training needs informed by national report (although this may be affected by funding cuts)

HIV Action Plan

In 2009, NHS Scotland laboratories reported positive HIV-antibody test results for 417 individuals not previously recorded as HIV-positive. The cumulative total of known HIV-positive individuals in Scotland is now 6247, of whom 4521 (72%) are male and 1726 (28%) are female. At least 1626 (26%) are known to have HIV. Of the 417 recently reported HIV-positive individuals, 291 (70%) are male, and 286 (69%) are aged between 25 and 44 years. The probable route of transmission was men who have sex with men (MSM) in 137 cases (including a small number who were also injecting drug users), heterosexual intercourse in 196 cases, and injecting drug use in 15 cases. Of the heterosexual cases, 109 probably acquired their infection abroad. For 60 cases, the transmission category is, as yet, undetermined. Greater Glasgow & Clyde accounted for 190 cases, 79 were from Lothian, 33 from Grampian, 26 from Lanarkshire and 24 from Tayside.

Borders had less than 10 new HIV cases during 2009 and cumulatively has had over 70 HIV cases reported to date. The characteristics of these infections reflect those of HIV infections in Scotland as a whole. In November 2009 the Scottish Government produced a new HIV Action Plan and has asked Borders to implement a number of objectives in this Plan.

Vaccination and Immunisation

Vaccination has probably prevented more suffering and saved more lives than any other medical intervention since last century. I remain convinced it is one of the safest and most cost-effective procedures in modern medicine.

Childhood Immunisation programmes

Every child has a right to be protected against infectious disease, and vaccination provides an effective means of achieving this. It is important to bear in mind that vaccination protects not only the individual child but also protects those in society that cannot for medical or other reasons have vaccination protection. In order to achieve this, a high proportion of the population needs to be immune in order to ensure a low risk of transmission to those who remain susceptible. Whilst the individual's right to accept or refuse vaccination must be respected, society also has a responsibility to protect those individuals who have not yet, or who are unable to, receive vaccination.

Table 12 below shows the rates of primary immunisation during 2009/10.

Table 12: NHS Borders Primary Immunisation percentage rates April 2009/March

Vaccine	Borders 12 months of age	Scotland 12 months of age	Borders 24 months of age	Scotland 24 months of age
Diphtheria	98	97	98	98
Tetanus	98	97	98	98
Pertussis	98	97	98	98
Polio	98	97	98	98
Hib	98	97	98	98
Men C	97	97	97	96
Hib/MenC booster	N/A	N/A	95	94
PCV	97	97	97	97
PCV booster	N/A	N/A	95	94
MMR1	N/A	N/A	94	94

Immunisation uptake rates in the Borders for primary childhood immunisations at 24 months of age in 2009/10 were broadly similar to those for Scotland as a whole. I am pleased that MMR rates in the Borders have risen to levels seen before the recent public concerns about this vaccine. This indicates that the public and health professionals have confidence in this highly effective and safe vaccine.

Adult Immunisation programmes

The main adult programmes relate to seasonal flu and pneumococcal vaccinations. Seasonal Influenza activity in Scotland during 2009/2010 stabilised at low levels. Flu vaccination is offered each year to persons over 65 years of age as well as to those with a serious medical condition of any age over 6 months. During 2009/2010 Borders general practices achieved one of the highest flu vaccine uptake figures of 78%. The numbers of persons under the age of 65 years with a serious medical condition being vaccinated was much lower at around 62% although this compares favourably with the 51% for Scotland as a whole.

Immunisation standards, education and audit

In recent years the quality of immunisation practice has been highlighted as an important development area. National concerns over incidents where there was a failure of the cold chain or problems with incorrect immunisations being given has led to a standard setting approach to immunisation and the development of national immunisation standards. NHS Borders will be auditing our processes against these standards in the near future. Health Protection Scotland has also supported the development of e-learning packages for immunisers and Borders has been very successful in supporting local vaccinators through this e-learning programme. Further work is however required to support the sustainability of this programme

H1N1 Pandemic Flu

As with all Scottish Boards the Borders has seen intense activity to combat the effects of pandemic flu including the use of antiviral medication and immunisation of at risk groups. NHS Borders achieved one of the highest H1N1 vaccination uptake rates in Scotland due to tremendous efforts of primary care teams, occupational health services and the Borders Pandemic Flu Vaccination and Delivery Group. Fortunately the pandemic has transpired to have far less impact on health services than was originally anticipated because the H1N1 virus has usually caused a relatively mild illness. If this had not been the case NHS Borders, like all other Boards, would have struggled to provide critical care services for adults and children. Further information can be found on the NHS Borders website at http://www.nhsborders.org.uk/

Environmental Health

The NHS Borders Department of Public Health and Scottish Borders Council Environmental Health team work together to risk assess and manage environmental risks to health from a variety of causes. In recent years these have included mercury spillages, lead soil contamination, sewage disposal problems and flooding of housing estates.

Air Quality

Air quality is monitored monthly in Galashiels, Peebles, Hawick, Kelso, and Melrose. Measurements are taken for nitrogen dioxide (NO^2), most of which comes from vehicle emissions. The screening undertaken found that, apart from one area in Galashiels town centre, there were no abnormally high levels.

Water and Health

Private water supplies

Within Scottish Borders Council's area there are approximately 1200 private water supplies. Of these, approximately 120 serve more than 50 persons or a commercial enterprise such as a hotel or restaurant (Type A). The remaining supplies are for private dwellings (Type B).

Clean Water. Healthy Life.

The Private Water Supplies (Scotland) Regulations 2006 require only that Type A supplies are routinely sampled and risk assessed. Type B supplies are sampled on request. All the Type A supplies were sampled and risk assessed in 2009/10 and where appropriate, remedial works to the supplies being carried out with grant aid being provided by Scottish Borders Council.

Private water supply grants totalling £118,852 were paid in 2009/10 and the number of premises where remedial works were undertaken totalled 131 with this work contributing to improving the quality of water consumed from the taps of the relevant premises. Funding for this initiative is provided by the Scottish Government and is delivered by Scottish Borders Council. It is anticipated that similar amounts of grants will be paid in 2010/11.

Public Drinking Water Supplies

Throughout the Borders area, Scottish Water supply large numbers of households from a variety of sources and supplies. Due to the rural nature of the area, there are differing types of treatment plants to deal with supplies serving large populations and those serving relatively few people.

Whilst generally the quality of water provided is of a very high standard, there are issues with Cryptosporidium, a parasite (a tiny organism) that causes an infection called cryptosporidiosis affecting people and cattle. Outbreaks of heavy rain can wash the organism into water sources, impacting on the quality of the water provided. The Cryptosporidium (Scottish Water) Directions 2003 provide for more widespread testing for Cryptosporidium to provide data about background levels in water supplies. Since June 2004, every supply in Scotland is tested at least once a month. The actual frequency of testing is based on the assessed risk and the volume of water passing through the works. Scottish Water is committed to implement these Directions and in the Borders area considerable investment continues to improve the quality of our supplies. NHS Borders and Scottish Borders Council Environmental Health meet regularly with Scottish Water to discuss developments in the public water supplies and to review the response to water incidents particularly those related to cryptosporidium.

Blue Green Algae

The NHS Borders, Scottish Borders Council Environmental Health Department, Scottish Water, the Scottish Environment Protection Agency (SEPA) in line with guidance given in the Scottish Office report (Blue-Green Algae (Cyanobacteria) in Inland Waters: Assessment and Control of Risks to the Public Health) work to monitor blue green algae blooms in Borders rivers and reservoirs.

Radon

A new map showing which areas of the Borders have the highest levels of the naturally-occurring radioactive gas radon has been published to help homeowners identify whether they need to take any action. Radon occurs in all rocks and most soils and while quickly diluted if it escapes into the air, it can get trapped inside buildings and, over time, exposure can increase the risk of lung cancer.

The map – produced by the UK Health Protection Agency (HPA) for the Scottish Government - shows 'Radon Affected Areas', where at least one house in a hundred can be expected to exceed the HPA's Action Level. The HPA advises that any house showing a radon build-up above this level should have work carried out to remedy the problem.

In response to the map's publication, the Scottish Government has announced free testing for homeowners in areas with a five per cent chance or more of houses being above the Action Level. In Scotland as a whole, around 62,000 homes are located in Radon Affected Areas, although it is estimated that only between 1,000 and 3,000 of these will have radon concentrations above the Action Level.

There are very few houses in the Borders with a high radon level and the risk to the health of the Borders is very low. However homeowners most at risk are encouraged to get their properties tested so they know whether works might be needed to address the problem.

Anyone in an area where the chance of their house being above the Action Level is five per cent or more will be entitled to a free test, to be carried out by the Health Protection Agency. The testing programme will be carried out on a rolling basis from Summer 2010, continuing until 2011. Home owners in these areas will be contacted by the Scottish Borders Council in the future with details of the testing scheme.

Infection Control

The Public Health Department provides clinical advice, guidance and support on infection control and prevention to the education sector, social care staff and partner organisations, including independent contractors and deals with any outbreaks of communicable disease that may occur in these settings.

The importance and recognition of this role has grown in recent years and as a result resources have been found to provide additional community infection control staff. This new exciting pilot development has been jointly funded by NHS Borders, Education and Social Services. However this area of work will require significant development in the future particularly around health care associated infections in care homes such as C. difficile infection and the challenge of antibiotic resistance.

CHAPTER 7
THE WAY AHEAD: RECOMMENDATIONS FOR BETTER HEALTH IN THE BORDERS

A number of priorities emerge from the stocktake of health in the Borders in my report and from the ongoing action to promote and protect health as well as caring for those who suffer from ill health. There are many positive aspects to health and well-being in the Borders but there are also many challenges for the future.

The pressing public health agenda

Life Circumstances:
- **Inequalities**
- **Early Years**
- **Poverty - Recession**
- **Older People's Health & Independence**

Lifestyles:
- **Alcohol - addictions**
- **Obesity**
- **Infant feeding**

I have sought to demonstrate in this report that health is not just about lifestyles and health-related behaviours; it is very much about our environment. There is a whole web of influences on health. I have drawn attention to the complex inter-relationships between individual health and communities, communities and their environments. The complexity and sometimes lengthy timescales should not deter support for the public health agenda. In many cases there are relatively quick wins.

Promoting health for our children and young people

Improving health for children and young people entails creating the conditions and opportunities for good health as well as encouraging children and families in healthy ways of life. The Children and Young People's Planning Partnership Health Improvement Group supports all services for children and young people to identify what they can contribute to better health outcomes by striving to create a service environment and an ethos that are conducive to health and by addressing barriers to health. The development of the health improvement agenda within the context of early years is seen as a particular priority to lay the foundations for good health and to tackle health inequalities.

NHS Borders and SBC Education and Lifelong Learning have established a firm basis for working in partnership to support health promotion in school and community settings through:

- Capacity building to support those responsible for health and wellbeing through training, professional development and support, advice and guidance
- Scoping work to benchmark key dimensions of health and wellbeing and identify priorities for development
- Developing and facilitating access to resources for staff and young learners
- Delivery of key health improvement programmes in partnership with schools and community learning and development as part of the ongoing implementation of Curriculum for Excellence

Recommendation 1

I recommend that NHS Borders and Scottish Borders Council continue to develop partnership approaches to health improvement for all our children and young people with a particular emphasis on the early years and the implementation of Curriculum for Excellence.

A Healthy Start

The importance of the early years to health throughout the whole of life is emphasized in Chapter 3 and the development of the national Early Years Framework. I am gravely concerned at the number of women in the Borders smoking in pregnancy, particularly within some localities where rates are very high. Another serious issue is the low level of breastfeeding in more disadvantaged communities. I am keen that we continue to promote breastfeeding, providing one to one support and roll out peer support programmes in these towns. Nutrition is also crucial in the development of childhood obesity, a topic I return to later.

Recommendation 2

I recommend that a range of interventions, including intensive support, are in place to reduce smoking in pregnancy and increase breastfeeding in the more disadvantaged Borders localities.

Promoting health in later life

In Chapter 1 I discussed the demographic challenge of increasing numbers of older people. We must do all we can to improve healthy life expectancy beyond the current levels in Appendix 2 by preventing long term conditions, such as stroke and dementia, and preventing specific problems in this age group such as falls.

My recommendations, will contribute to this effort and lead to a healthier retirement for many and reduce demands on health and social care services in the future. As we enter an era of austerity the tidal wave of demographic change will challenge health and social care budgets. We must rapidly put in place affordable, effective, and sustainable health and social care services and implement public health measures that will prevent health problems, help to maintain independence and limit demands on local services.

Recommendation 3

I recommend that NHS Borders and Scottish Borders Council should increase their efforts to promote and protect health as people age and should concentrate on the whole population over 50 years.

The Essentials for Health & Wellbeing

My report has highlighted the physical, social and economic necessities for life such as clean water and air (Chapter 6), housing, employment and an adequate income (Chapters 2 & 4). We are moving through if not deeper into a recession. This is likely to mean higher unemployment rates, not only affecting the individual, but also their immediate family and the community. Unemployment is a particular burden to the less well off who are also the most vulnerable to its effects. Poverty may be compounded by rising pressure on social rented housing and energy costs. Given all of this it is essential that Scottish Borders Council and NHS Borders work vigorously with other local partners to combat unemployment and poverty.

Recommendation 4

I recommend that Scottish Borders Council continue the excellent work with local partners to combat unemployment, poverty (including fuel poverty) and financial exclusion.

Inequalities in Health

I have clearly identified a small number of townships in the Borders that are deprived and disadvantaged. In these areas, people's life chances are disproportionately poor, due, for example, to poverty, illness, poor housing, social environment, or access to services. Chapter 4 identifies other groups who are disadvantaged, for example looked after children and those with mental health problems.

The recent national review of progress in implementing Equally Well (Ministerial Taskforce Report on Inequalities in Health) highlighted the need for a shift in resources toward early intervention services which address the range of causes and effects of deprivation and disadvantage. Even in austerity we must sustain services targeting disadvantaged communities, such as the Healthy Living Network and the Welfare Benefits Service, and develop new initiatives where current efforts are insufficient. Collaboration across local partnerships will be essential if this work is to have the impact we all wish.

Recommendation 5

I recommend that the Borders Community Planning Partnership should review its progress in addressing the three social policy frameworks and the recommendations in the recent Equally Well review as part of the Strategic Assessment leading to the next Single Outcome Agreement.

Some Key Health Behaviours

Whilst the physical, social and economic environments are important influences we must also recognise individual responsibility for health behaviours. In Chapter 1, I highlighted the importance of the continuing obesity trend, influenced by our modern diet and physical inactivity, whilst Chapter 5 raised the continued importance of smoking and alcohol to health in the Borders.

We have a successful and well developed smoking cessation service locally, delivering support above target levels. We also have a wide range of local services and initiatives to tackle alcohol and drugs. The local response to the obesity epidemic is less well developed, but a more coordinated approach is now emerging. Work across these three areas remains a high priority and must continue at a population level if we are to achieve sufficient impact, recognising that approximately 25% of the population still smoke, drink above recommended limits and are obese (and a further 50% are overweight).

Recommendation 6

I recommend that existing work on smoking and alcohol be sustained and local work to address obesity scaled up to meet the challenge.

The work of specialist public health practitioners to protect health, which I describe in Chapter 6, is often unrecognised until there is a crisis. Yet ensuring air and water quality is fundamental to health. Sustaining immunisation and screening programmes are crucial to health, as is the control of significant communicable disease.

Recommendation 7

I recommend that NHS Borders and Scottish Borders Council ensure the implementation of their Joint Health Protection Plan.

In conclusion

We must build on the assets of gains in health made over the past years. We need to sustain progress, for example in immunisation and in tackling smoking. I seek not only to inform but to galvanise. This report is a call to action!

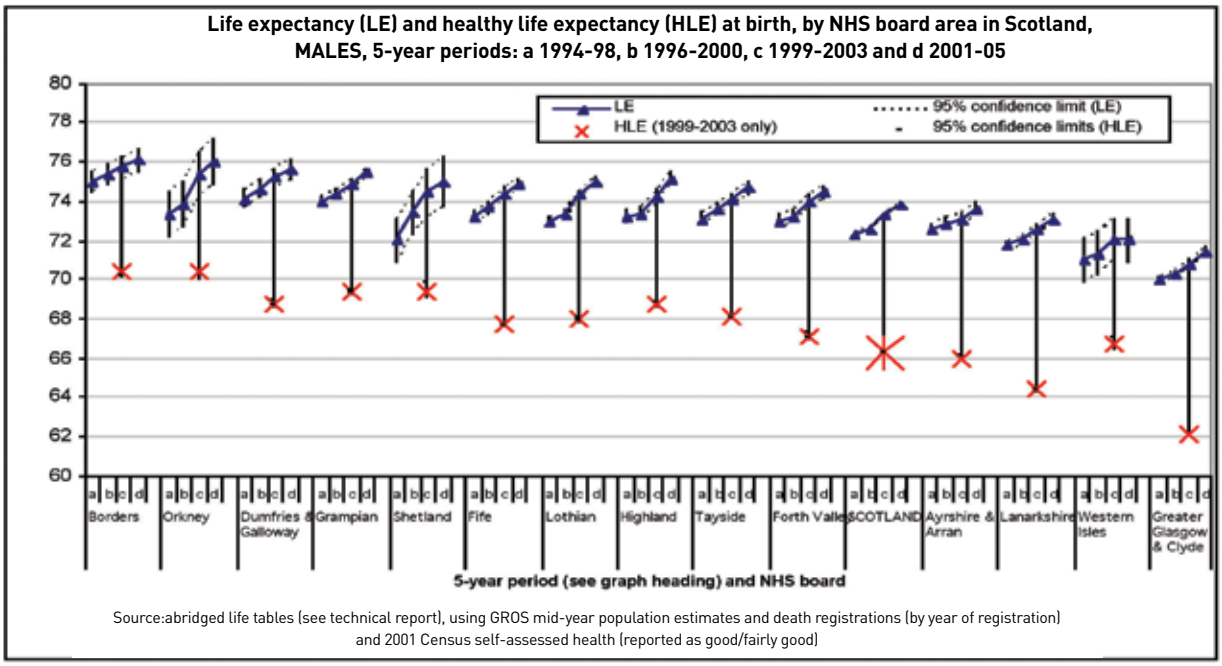
Appendix 1

Populations of Main Settlements in the Borders, 2007 (Includes settlements with a population of 500 or over)

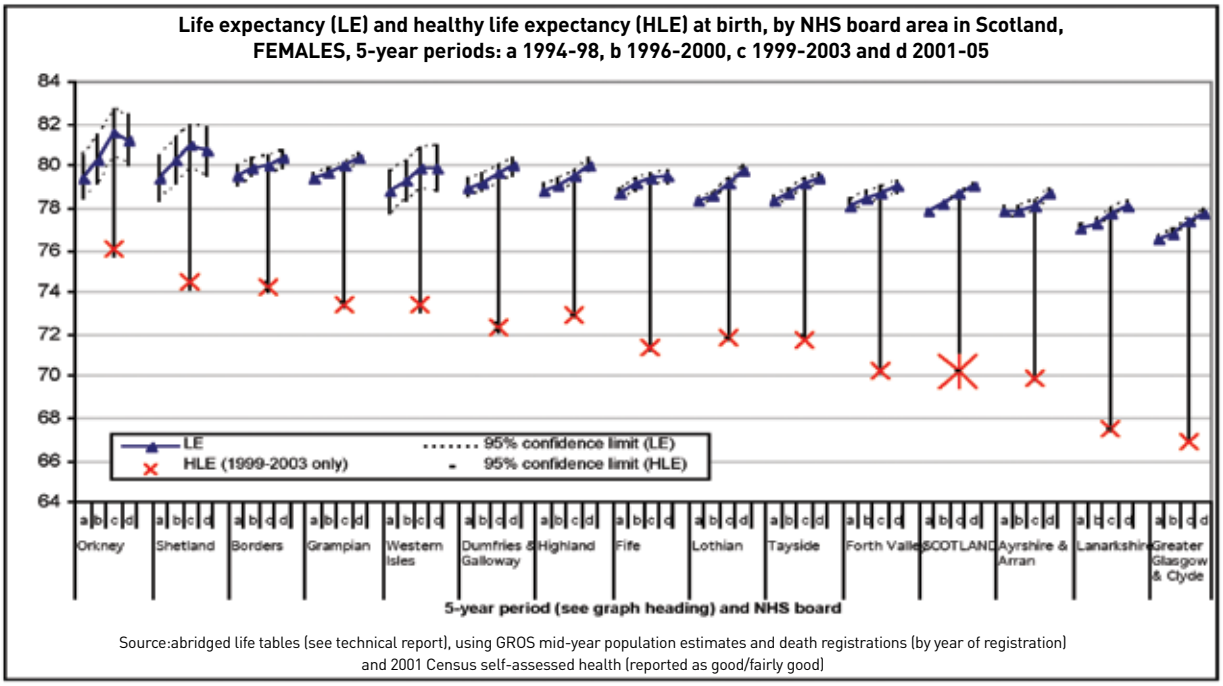
Settlement	Total Population	% Children	% Working Age	% Pensionable Age
Scotland	**5,168,500**	**18.0**	**61.4**	**20.6**
Scottish Borders	**112,430**	**17.9**	**58.8**	**23.3**
Ayton	540	16.1	53.9	30
Chirnside	1,237	19.9	56.4	23.7
Coldingham	643	13.5	54.6	31.9
Coldstream	1,977	14.8	52.7	32.5
Denholm	613	15.3	57.3	27.4
Duns	2,615	17	56.6	26.4
Earlston	1,834	20.5	56.7	22.7
Eddleston	1,032	17.7	62.6	19.7
Eyemouth	3,173	16.8	57.9	25.3
Galashiels	12,229	16.7	62.7	20.6
Greenlaw	636	18.1	55.7	26.3
Hawick	13,787	17.9	57.7	24.4
Innerleithen	2,975	18.5	55.8	25.7
Jedburgh	3,949	17.6	57.6	24.8
Kelso	6,276	16.6	55.7	27.7
Lauder	1,243	17.3	62.2	20.6
Melrose	2,028	20.6	54.6	24.7
Newcastleton	718	12.8	55.4	31.8
Newtown St Boswells	1,244	16.8	62	21.2
Peebles	8,006	18.1	57.6	24.3
Selkirk	5,590	17.9	58.2	23.9
St Boswells	1,152	14.2	55.2	30.6
Stow	608	21.2	62	16.8
Tweedbank	1,968	21.6	62.6	15.7
Walkerburn	620	15	60.2	24.8
West Linton	1,487	24.2	57.3	18.5
Yetholm	660	14.4	54.6	31.1

Appendix 2

Life Expectancy and Healthy Life expectancy at birth by NHS Board Area in Scotland for males and females



Source:abridged life tables (see technical report), using GROS mid-year population estimates and death registrations (by year of registration) and 2001 Census self-assessed health (reported as good/fairly good)



Source:abridged life tables (see technical report), using GROS mid-year population estimates and death registrations (by year of registration) and 2001 Census self-assessed health (reported as good/fairly good)

Appendix 3

Median Earnings for Scottish Local Authorities, 2007–08

The Median is the exact mid-point in the earnings scale, if all the salaries were placed on a line from low to high. It is preferred over the Mean as a measure of average earnings because it is less influenced by extremely low and high salaries than the Mean.

Scottish Local Authorities	Median Gross Weekly Earnings for Full Time Workers (work-place-based)					Change 2007-2008	
	£	2008		% of Scottish Average			
	2007	£	Rank Highest - Lowest	2007	2008	£	%
Shetland Islands	448.2	543.5	1	101.5%	118.1%	£95.30	21.3%
Aberdeen City	479.4	534.6	2	108.5%	116.2%	£55.20	11.5%
Renfrewshire	458.8	506.9	3	103.9%	110.2%	£48.10	10.5%
East Renfrewshire	451.9	503.6	4	102.3%	109.5%	£51.70	11.4%
Edinburgh, City of	488.0	496.1	5	110.5%	107.8%	£8.10	1.7%
East Dunbartonshire	438.0	493.8	6	99.2%	107.3%	£55.80	12.7%
South Ayrshire	410.4	492.0	7	92.9%	106.9%	£81.60	19.9%
East Lothian	476.4	471.4	8	107.9%	102.5%	-£5.00	-1.0%
Aberdeenshire	459.6	466.2	9	104.1%	101.3%	£6.60	1.4%
Dundee City	435.9	465.6	10	98.7%	101.2%	£29.70	6.8%
North Lanarkshire	453.6	464.9	11	102.7%	101.0%	£11.30	2.5%
Eilean Siar	447.6	464.1	12	101.3%	100.9%	£16.50	3.7%
South Lanarkshire	449.6	461.7	13	101.8%	100.3%	£12.10	2.7%
Glasgow City	430.6	457.4	14	97.5%	99.4%	£26.80	6.2%
North Ayrshire	426.2	455.5	15	96.5%	99.0%	£29.30	6.9%
East Ayrshire	444.1	454.8	16	100.5%	98.8%	£10.70	2.4%
Midlothian	463.1	453.5	17	104.8%	98.6%	-£9.60	-2.1%
Stirling	434.1	452.8	18	98.3%	98.4%	£18.70	4.3%
Argyll & Bute	410.5	443.2	19	92.9%	96.3%	£32.70	8.0%
Perth & Kinross	398.6	443.2	20	90.2%	96.3%	£44.60	11.2%
Angus	423.8	440.2	21	95.9%	95.7%	£16.40	3.9%
Fife	435.9	434.1	22	98.7%	94.3%	-£1.80	-0.4%
Falkirk	419.0	428.0	23	94.9%	93.0%	£9.00	2.1%
West Lothian	404.5	421.4	24	91.6%	91.6%	£16.90	4.2%
Clackmannanshire	471.0	420.5	25	106.6%	91.4%	-£50.50	-10.7%
Highland	406.1	417.3	26	91.9%	90.7%	£11.20	2.8%
Dumfries & Galloway	403.1	417.2	27	91.3%	90.7%	£14.10	3.5%
West Dunbartonshire	406.2	406.1	28	92.0%	88.3%	-£0.10	0.0%
Inverclyde	391.1	392.4	29	88.5%	85.3%	£1.30	0.3%
Moray	383.7	391.0	30	86.9%	85.0%	£7.30	1.9%
Scottish Borders	380.5	370.2	31	86.1%	80.5%	-£10.30	-2.7%
Orkney Islands*	#	#	N/A	#	#	#	#
Scotland	441.7	460.1		-	-	£18.40	4.2%
Great Britain	459.3	479.1		-	-	£19.80	4.3%

Source: Annual Survey of Hours and Earnings, Office for National Statistics.

*figures are statistically unreliable

Appendix 4

Universal Pregnancy and Newborn Screening Tests

Screening test	Pregnancy or newborn	Headline indicator
Down's Syndrome and neural tube defects (blood test for serum screening using alpha-fetoprotein (_FP) and intact human chorionic gonadotropin (hCG)) Nuchal Translucency Scanning (USS)	Pregnancy - from 15 weeks and before 20 weeks gestation Pregnant women 38 years and above at 12 weeks	In 2008 877 women had serum screening (2nd trimester) – this is equivalent to 69.4 % of those who booked for antenatal care.
Communicable disease in pregnancy (blood tests for HIV, Hepatitis B, syphilis, rubella)	Pregnancy – as early as possible, or as soon as woman arrives for care, including labour	All results during 2009 met quality targets apart from Rubella. This is due to having to await confirmatory second test results from Edinburgh Royal Infirmary.
Universal newborn hearing screening (non invasive Automated Auditory Brainstem Response testing)	Newborn – ideally before discharge from maternity unit, or within first four weeks of life unless born prematurely or ill	99% screened before 4 weeks for babies born between April 08 and March 09. 4 referrals made to specialist assessment unit at Sick Children's Hospital, Edinburgh
Bloodspot Screening in newborns (heel prick test for cystic fibrosis, congenital hypothyroidism and phenylketonuria)	Newborn – from the fourth day of life, and ideally before the seventh day of life	During 2009 only one mother refused screening. Of the rest only one positive result was reported.

Alternative Formats

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Sheila Patterson
Department of Public Health
NHS Borders
Rushbank
Newstead
MELROSE TD6 9DA

Telephone: 01896 825560
Email: sheila.patterson@borders.scot.nhs.uk

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