SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

NEEDS OF OUR COMMUNITIES: JOINT STRATEGIC NEEDS ASSESSMENT

SEPTEMBER 2022

Scottish Borders
Health and Social Care
PARTNERSHIP

TABLE OF CONTENTS

1. INTRODUCTION 4
2. DEMOGRAPHICS 6
Population 6
Life Expectancy and Healthy Life Expectancy 9
Migration 11
Ethnicity 12
Localities 13
3. INEQUALITIES 14
Rural Deprivation 16
Inequality across different groups 16
Summary 18
4. PREVENTION AND EARLY INTERVENTION 19
Education and Qualifications 19
Housing 21
Lifestyle Factors 32
Falls Prevention 38
Loneliness & Social Isolation 40
Substance Use 42
Community Justice 48
5. LONG-TERM CONDITIONS 50
Cancer 50
Respiratory Conditions 52
Neurological Conditions and Stroke 54
Coronary Heart Disease 57
Diabetes and Obesity 58
Sensory Impairment 60
Sexual Health & Blood-borne Viruses 63
COVID-19 and Long COVID 66

6. SERVICE USER GROUPS 69

Older People (65+) 69

Frailty 69

Dementia 70

Mental Health and Wellbeing 75

Physical Disability 81

Learning Disability 83

Adults with Autism Spectrum Disorders 84

Unpaid Carers 85

Palliative Care 86

7. SUPPORT AND RESOURCES 89

Primary Care 89

Adult Social Care 101

Hospitals 111

Workforce 116

Third Sector 118

Technology Enabled Care 120

1. INTRODUCTION

In order for the Scottish Borders Health and Social Care Partnership to commission and deliver services that best meet the needs of its local communities (and to intervene at an early stage to help address health and wellbeing issues), a clear understanding of the health and care needs of the population is required.

The purpose of this Joint Strategic Needs Assessment is to provide this clear understanding. It brings together information (qualitative and quantitative) on the health and care needs of the adult population of the Scottish Borders together in one place; to create a picture of the needs of our communities and to enhance and strengthen the intelligence available to the Health and Social Care Partnership to support our approach to commissioning, planning and delivery. This needs assessment will support the Health and Social Care Partnership and our wider Community Planning Partners to collectively and collaboratively continue to work to improve the outcomes of our communities across the Scottish Borders.

This first draft of the Joint Strategic Needs Assessment provides a summary of the key findings to date from a wide range of data on; demographics, population projections, health and social care provision, and long term conditions. The Joint Strategic Needs Assessment is supported by the 'We Have Listened' report, produced by the National Development Team for Inclusion which presents the results of what matters to our communities from a Health and Social Care perspective, based on comprehensive engagement undertaken in August 2022.

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

There are 5 localities within the Scottish Borders:

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

It is likely that people's health and wellbeing and use of health and care services will vary across these localities; and there is a need to understand more about this in order to plan services and provide support. Some of the data within this Joint Strategic Needs Assessment will reference localities; and the Joint Strategic Needs Assessment and we have listened reports will be shared with our Localities to inform our Strategic Commissioning Plan 2023-26, and further Integration Joint Board commissioning and service delivery on an ongoing basis.

Next steps

The information outlined in this Joint Strategic Needs Assessment will inform the Scottish Borders Health and Social Care Partnership 2023-2026 Strategic Commissioning Plan to deliver better outcomes for people, and better use of the significant resources we invest in health and social care provision. This Strategic Commissioning Plan will inform future directions issued from the Integration Joint Board to NHS Borders and Scottish Borders Council.

The content of this needs assessment has to be sufficiently broad to reflect the entire system of adult health and social care, yet succinct enough such that the key messages are easily understood.

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

To be delivered across these services:

ADULT SOCIAL CARE SERVICES*

- Social Work Services for adults and older people;
- Services and support for adults with physical disabilities and learning disabilities;
- Mental Health Services;
- Drug and Alcohol Services;
- Carers support services;
- Community Care Assessment Teams;
- Care Home Services;
- Adult Placement Services;
- Health Improvement Services;
- Reablement Services, equipment and telecare;
- Aspects of housing support including aids and adaptations;
- Day Services;
- Local Area Co-ordination;
- Respite Provision;
- Occupational therapy services.

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

- Accident and Emergency;
- Inpatient hospital services in these specialties:
  - General Medicine;
  - Geriatric Medicine;
  - Rehabilitation Medicine;
  - Respiratory Medicine;
  - Psychiatry of Learning Disability;
- Palliative Care Services provided in a hospital;
- Inpatient hospital services provided by GPs;
- Services provided in a hospital in relation to an addiction or dependence on any substance;
- Mental health services provided in a hospital, except secure forensic mental health services.

COMMUNITY HEALTH SERVICES*

- District Nursing;
- Primary Medical Services (GP practices)*;
- Out of Hours Primary Medical Services*;
- Public Dental Services*;
- General Dental Services*;
- Ophthalmic Services*;
- Community Pharmacy Services*;
- Community Geriatric Services;
- Community Learning Disability Services;
- Mental Health Services;
- Continence Services;
- Kidney Dialysis out with the hospital;
- Services provided by health professionals that aim to promote public health;
- Community Addiction Services;
- Community Palliative Care;
- Allied Health Professional Services

2. DEMOGRAPHICS

Population

Total Population

As recorded by National Records of Scotland (NRS), the mid 2020 population of Scottish Borders was **115,240.**

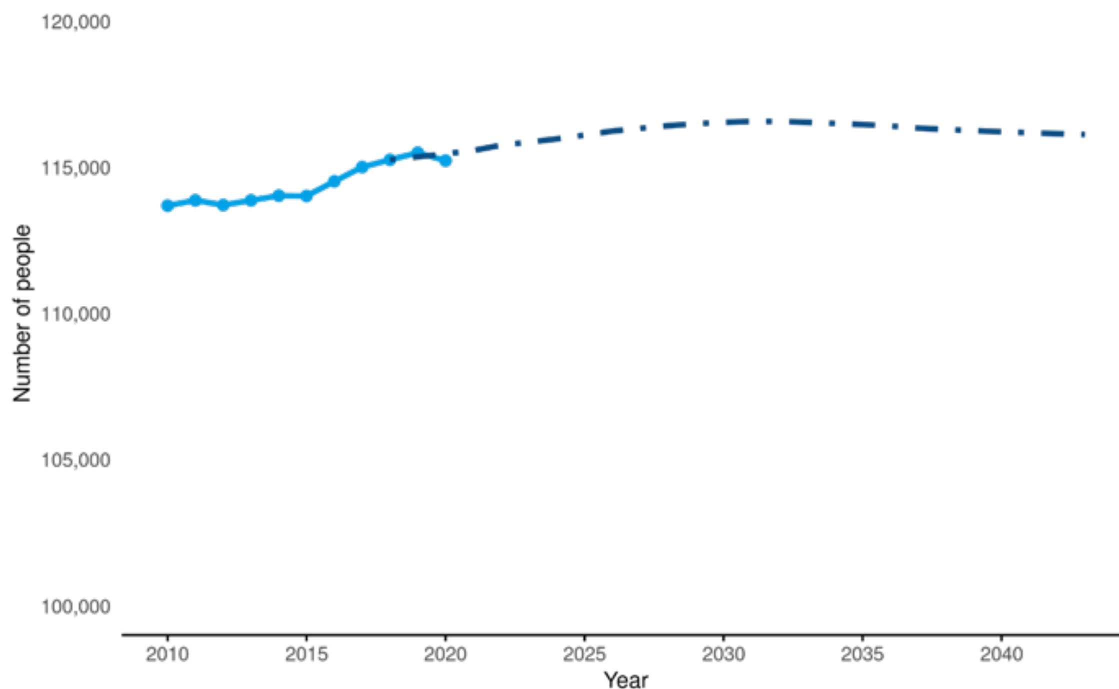
Projected Population

Population projections are estimates of the growth or decline in the number and characteristics of people living in an area. Factors like the local birth rate and how many people are coming to live in the area or leaving it each year are considered.

Between 2018 and 2028, the population of Scottish Borders is projected to increase from 115,270 to 116,435. This is an increase of 1.0%, which compares to a projected increase of 1.8% for Scotland as a whole. The data presented in the below figure shows in the decade to 2030, the population of the Scottish Border will increase by approximately 1%, and then decrease by 0.3% in the decade to 2040.

The largest percentage increase will be in those aged 75 and over. This is due to Scottish Borders having an ageing population by Scottish standards.

Figure 1: 2020-based population estimates and 2018-based population projections*



Data Source: *National Records Scotland* [Accessed May 2022].

**NB: To better express the projections in the above chart, the population is started at 100,000 (number of people).*

Between 2018 and 2028, the number of households in Scottish Borders is projected to increase from 54,413 to 56,443. This is a 3.7% increase, which compares to a projected increase of 4.9% for Scotland as a whole.

Birth and Death rates

The birth rate is the total number of live births every year per 1,000 population.
In 2020, there were 799 births in Scottish Borders. This was a decrease of 12.8% from 916 births in 2019. Of these 799 births, 360 (45.1%) were female and 439 (54.9%) were male.

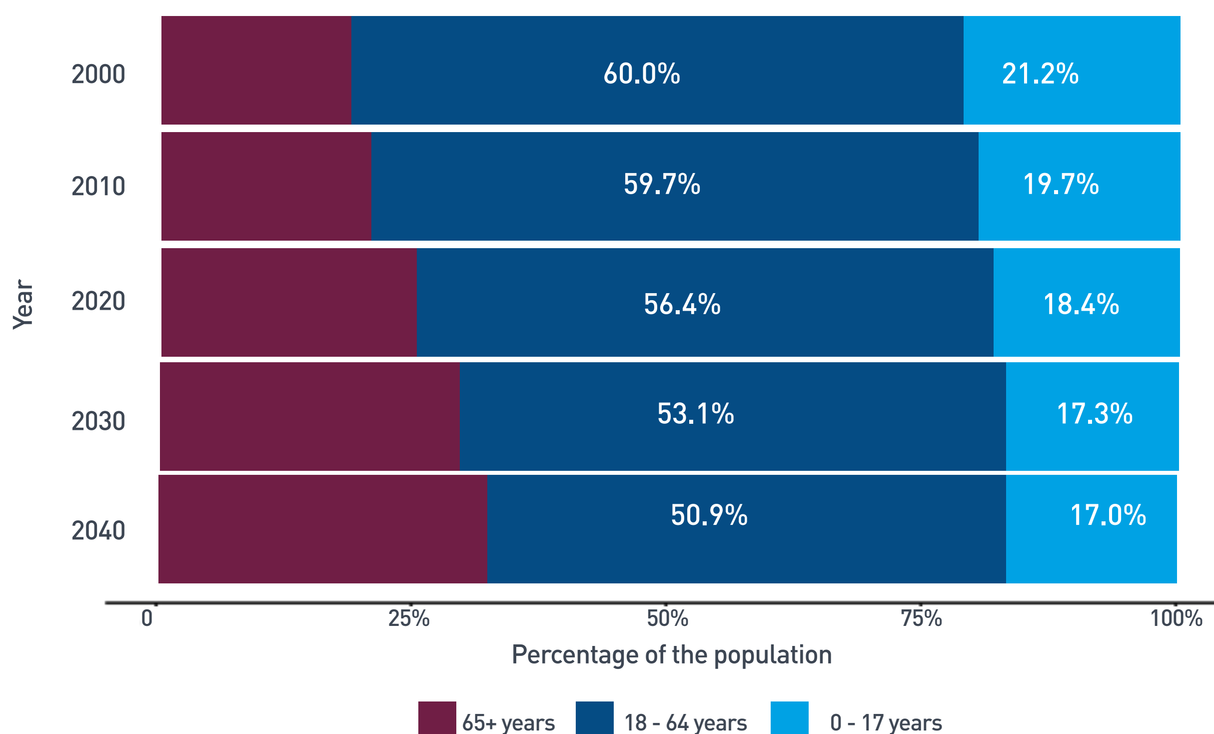
The death rate is the total number of deaths every year per 1000 population per year.
In 2020, there were 1,411 deaths in Scottish Borders. This was an 8.6% increase from 1,299 deaths in 2019. Of these 1,411 deaths, 701 (49.7%) were female and 710 (50.3%) were male.

Age & Gender

Age

Compared to the Scottish average, the Scottish Borders has a greater proportion of older and younger people and a smaller proportion of working-age people. The Scottish average in 2020 was: 18% older people, 17% children and 65% working age.

Figure 2: Age groups as a proportion of all Scottish Borders population, 2000-2040



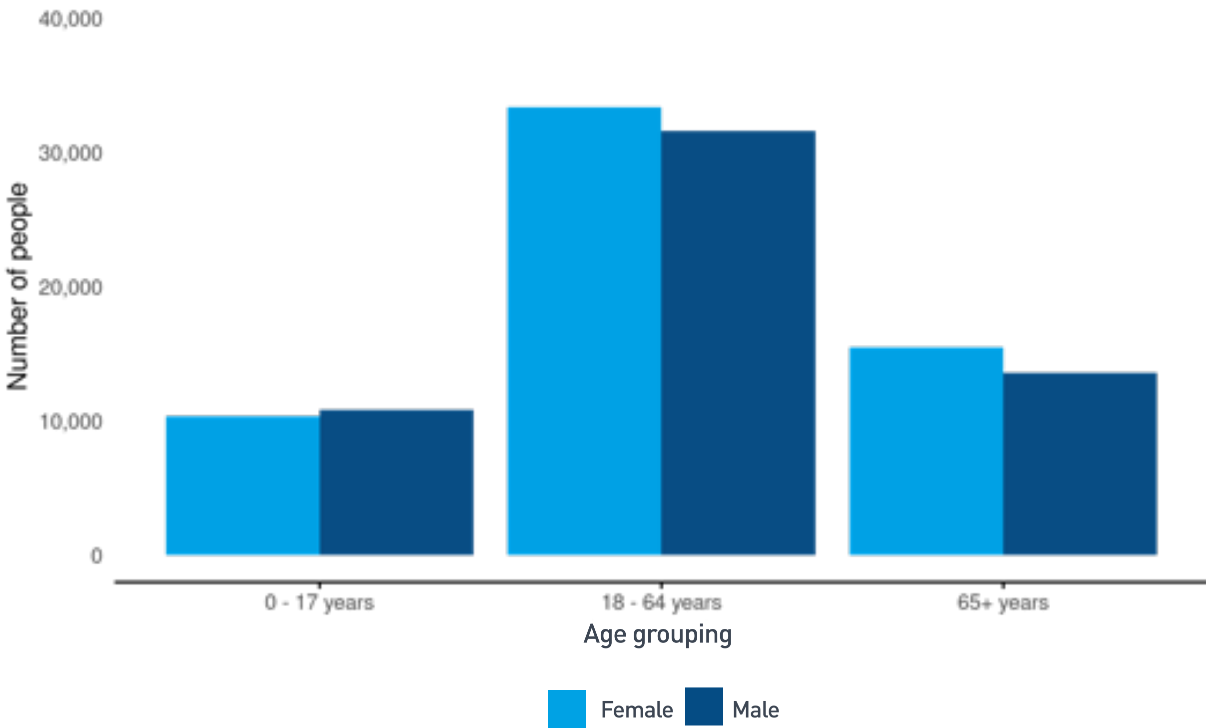
Data Source: *National Records Scotland* [Accessed May 2022].
NB: Due to rounding errors, not all values will necessarily equate to 100%.

The number of working age people, ages 18 to 64 is expected to decrease by almost 10% between 2020 and 2040, and account for 51% of the total population in 2040, compared to 56.5% in 2020.

An ageing population means more people in the Borders will be living with one or more complex conditions and therefore will require more support from health and social care as they age. There will also be fewer people of working age within the population to offer that support.

Gender
As with other council areas, the female proportion of the population increases with age, particularly in the 75+ age group where the proportion of females is 56% compared to 44% males. This has implications for pensioner poverty as, historically, women have smaller retirement pensions.[ii]

Figure 3: 2020-based population estimates by age and gender



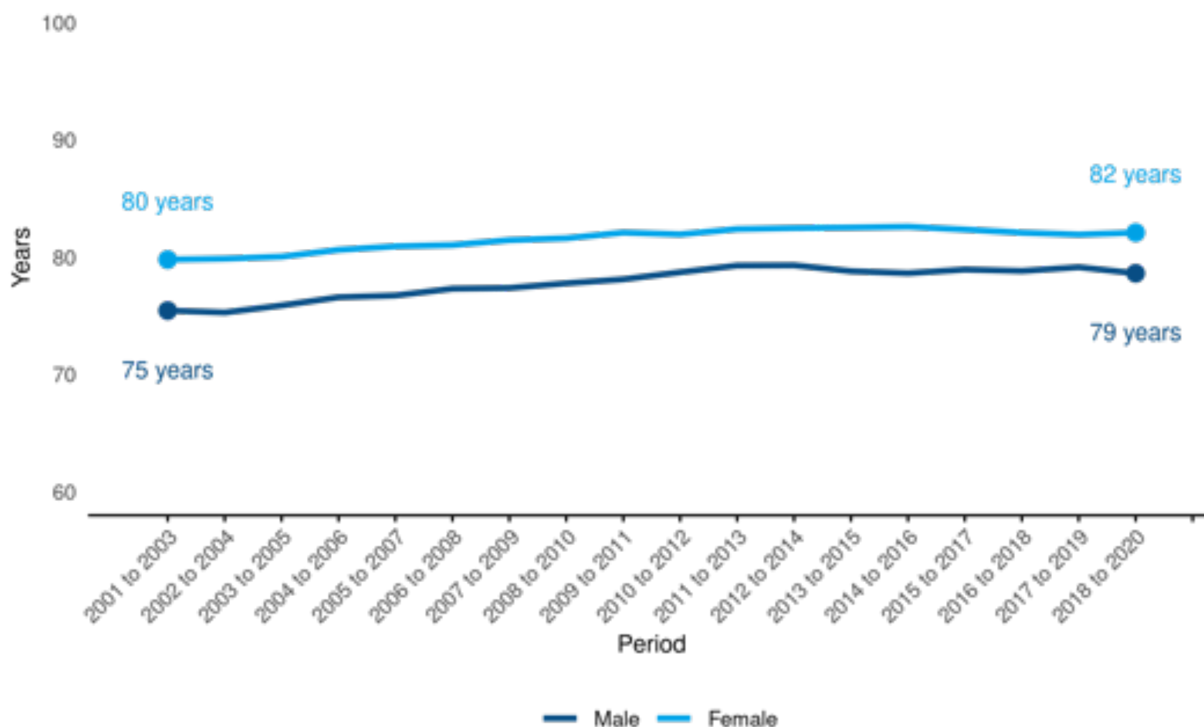
Data Source: *National Records Scotland* [Accessed May 2022].

There are no reliable local figures for Trans and other gender identities. The Scottish Government does not currently have a recommended survey question to collect information about gender identity.

Life Expectancy and Healthy Life Expectancy

Life expectancy is an estimate of how many years a person might be expected to live, whereas healthy life expectancy is an estimate of how many years they might live in a 'healthy' state. Both are a key summary measure of a population's health.

Figure 4: Life Expectancy at birth, 3-year aggregates, 2001 - 2020



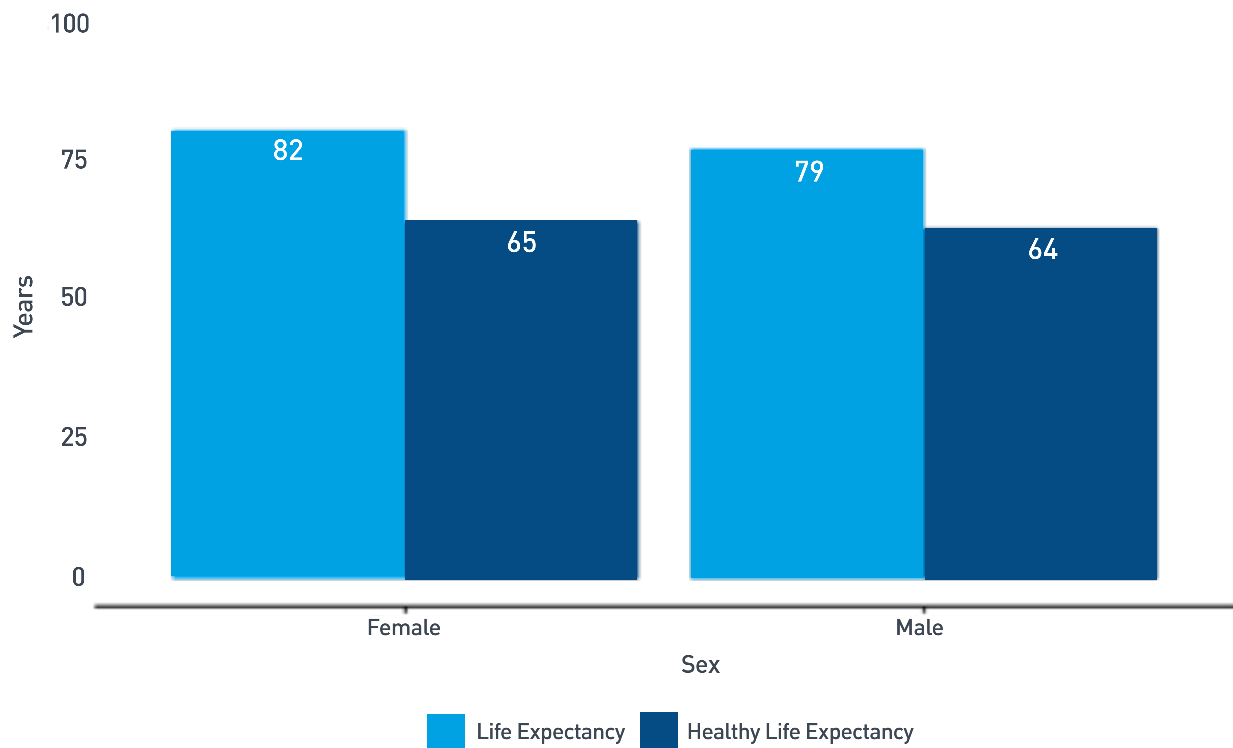
Data Source: *The Scottish Public Health Observatory* [Accessed May 2022].

In the Scottish Borders in 2018-2020 life expectancy at birth was 78.6 years for males and 82.1 years for females.

COVID-19 deaths have contributed to a drop in life expectancy, and drug-related deaths have also had a negative impact on life expectancy for males in Scotland. This is not evidenced in the data above due to data range.

Life expectancy at birth in the Borders is higher than at Scotland level for both females and males.

Figure 5: Life Expectancy v Healthy Life Expectancy at birth, 2018 - 2020



Data Source: *National Records Scotland*

In 2018 – 2020 the healthy life expectancy was 64 and 65 years for males and females respectively. This means that males can expect to live 81.5% of their life in good health, while females can expect to live 79.5% of their life in good health.

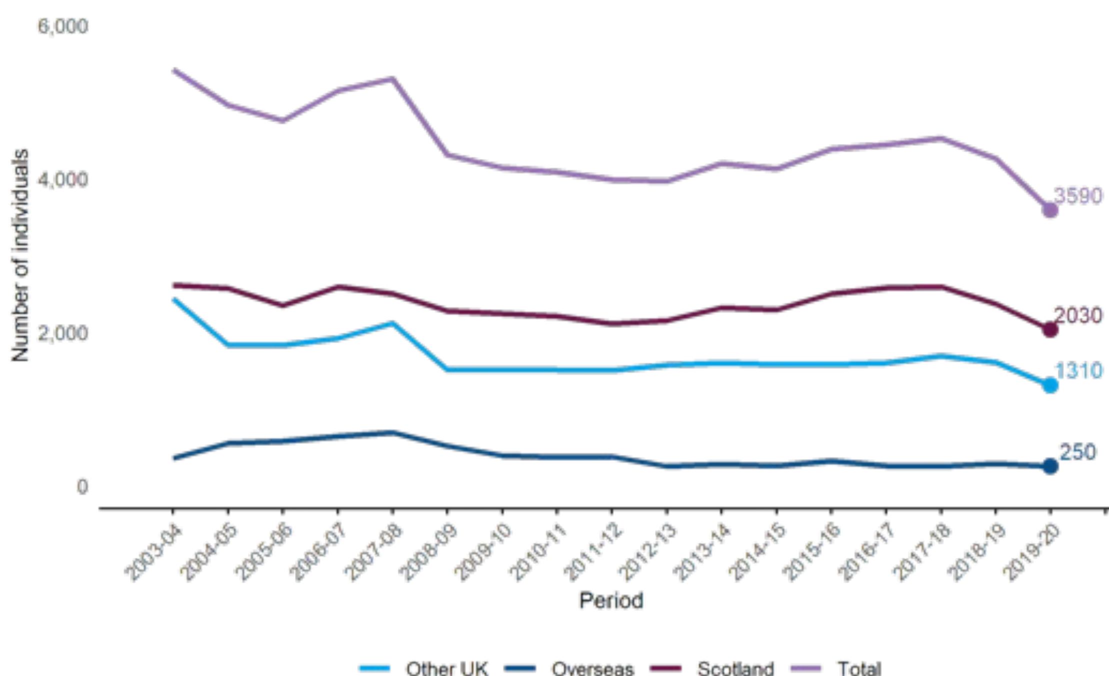
During the same time period in Scotland, male healthy life expectancy was 60.9 years, while for females it was 61.8 years; people in the Scottish Borders can therefore expect to live about 4 years longer in good health than the Scottish average.

The Inequalities section describes the differences in life expectancy associated to inequalities.

Migration

Migrants are people who have moved from their usual place of residence to live in another country or region for reason of work, education, family, socio-political persecution or war.[ii]

Figure 6: Individuals migrating into Scottish Borders from other areas



Data Source: *National Records Scotland* (AccessedJune 2022)

In 2019-20, a total of 3,590 people migrated into the Scottish Borders, of which 56.5% (2,030) came from other areas in Scotland, 36.5% (1,310) came from the rest of the UK, and 7% (250) came from overseas. From the previous year (2018-19) total migration was down by 16%, the lowest level since these records began. Migration in from the rest of the UK had the largest percentage drop at 19%, compared to falls of 14% each for Scotland, and overseas.

In 2019-20 an estimated 3,320 individuals migrated out of the Scottish Borders. This resulted in a net migration of +270 people. Of the people that migrated out, the majority (54.5%) went to other areas in Scotland, 30% went to other areas in the UK, and 15.5% went overseas.

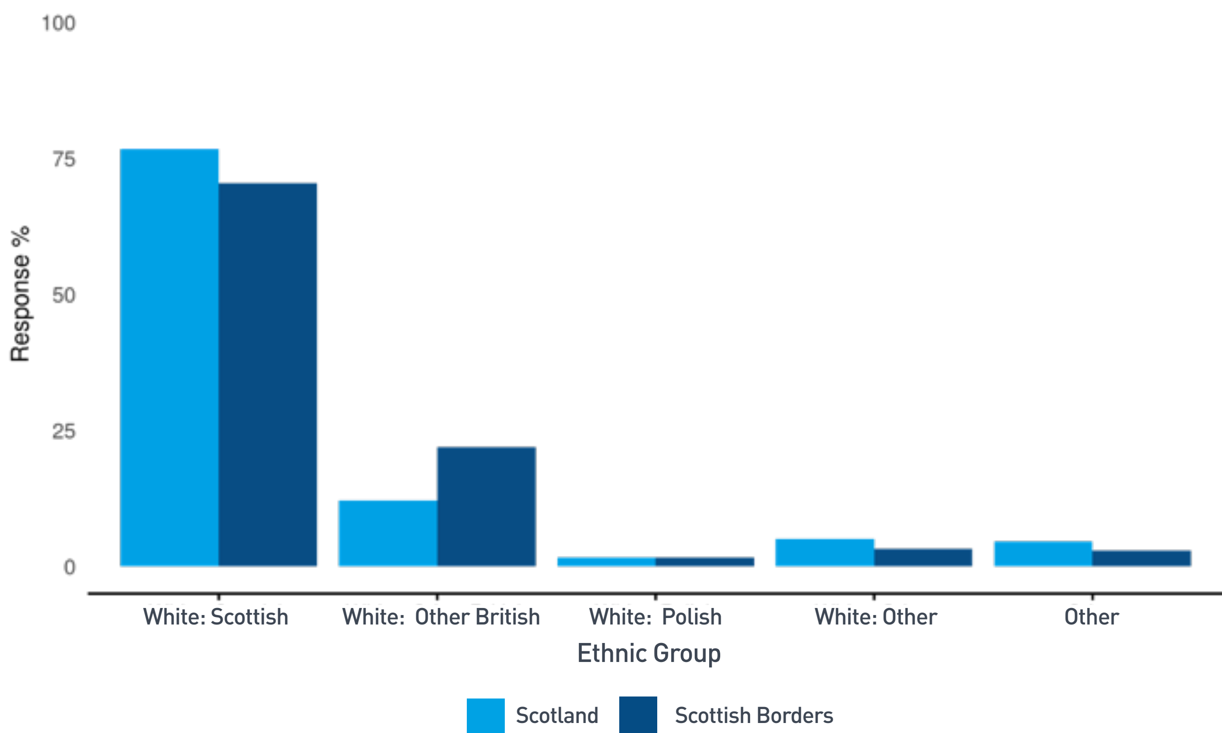
Although outward migration has been decreasing, it has not decreased enough to counter the decrease of inward residents. In 2020 there were also 566 more deaths than births, continuing a trend of increasingly negative natural change.

In 2022 there has been inward migration of displaced Ukrainians. In early October there were 138 individuals staying in the Scottish Borders. There are also 60 households who have accommodated displaced Ukrainians across the Borders. The Scottish Government has paused further visas while the current populations settle, 14,000 visas have been granted for people who are not yet in Scotland.

Ethnicity

Ethnicity is "the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race" .

Figure 7: SSCQ Ethnic group survey response, 2018



Data Source: *gov.scot* (Accessed June 2022)

The population of the Scottish Borders has a greater proportion of white British residents, and a smaller proportion of white Scottish residents compared to the Scottish average. This may be explained by the Scottish Borders proximity to England, with a slightly higher English population, and the way in which some Scottish people in the Scottish Borders identify. In 2018, 70.4% of Scottish Borders identified as white Scottish, compared to 76.7% in Scotland, and nearly 22% identified as white British compared to 12.1% in Scotland.

In the Scottish Borders, 1.6% of the population identified as white Polish, which is equal to the Scottish average. 3.2% of the population identified as "White: Other" which includes Irish, Gypsy/Traveller, and "White: Other Ethnic Group", compared to 5% in Scotland.

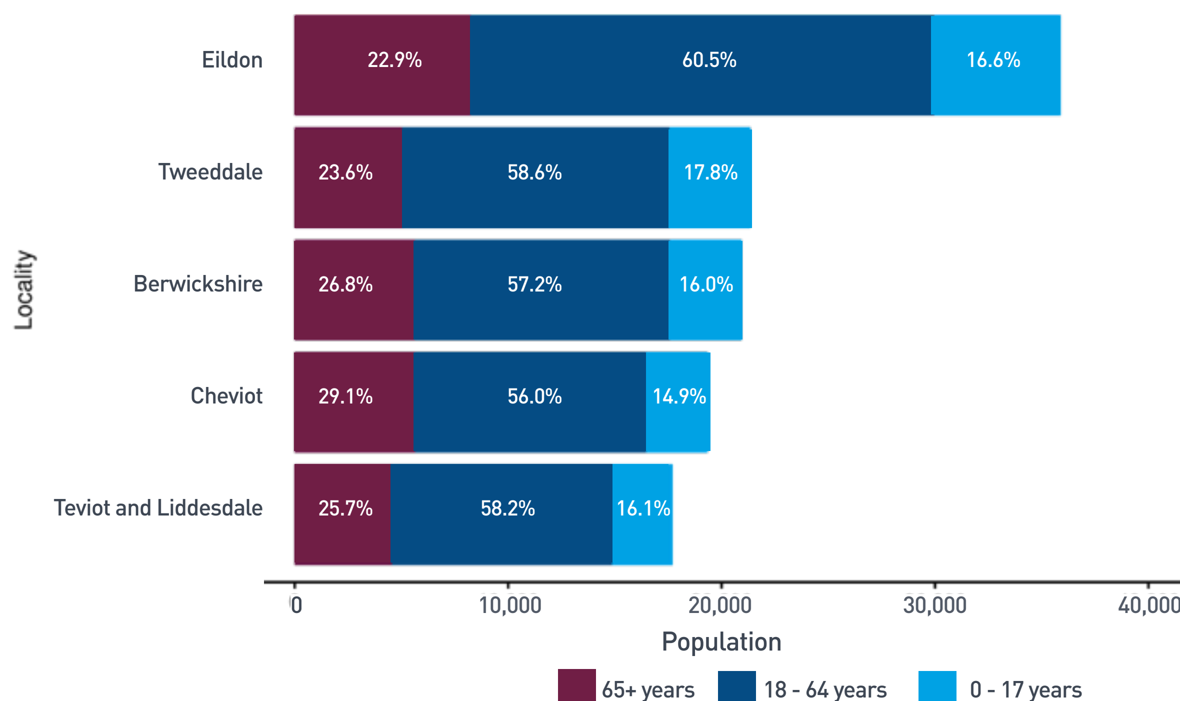
The remaining 2.9% of the Scottish Borders population (4.6% for Scotland) identified as Asian or "All other ethnic groups" which includes African, Caribbean or Black, and "Other Ethnic Group".

Localities

There are five localities in the Scottish Borders: Eildon, Tweeddale, Berwickshire, Cheviot and Teviot and Liddesdale.

Eildon is the largest locality by population, with a total of 35,899 in 2020 followed by Tweeddale with 21,354, Berwickshire with 20,931 and Cheviot with 19,345. Teviot and Liddesdale was the smallest locality by population, having nearly 18k people.

Figure 8: 2020 mid-year population estimates by Locality



Data Source: *National Records Scotland* (July 2022)

Cheviot, which includes the towns of Kelso and Jedburgh, had the largest proportion of its population in the 65+ age group at 29.1%, equating to 5,637 people. Eildon, which includes the towns of Galashiels, Tweedbank, and Selkirk, had the smallest proportion of its population in the 65+ age group at 22.9%, equating to 8,232 people.

Eildon had the largest proportion of working-age people at 60.5%, and Cheviot has the smallest proportion of working age people at 56%.

The locality with the largest number of children was Eildon, with 5,945 people in the 0 – 15 age group, accounting for 16.6% of its population. Tweeddale, which includes the towns of Peebles and Innerleithen, had the largest proportion of children at 17.8%, equating to 3,797 people.

Compared to the 2018 population estimates (not plotted), only Eildon and Tweeddale experienced population increases at 301 and 9 people respectively. The other localities all experienced declining populations: Teviot and Liddesdale – 214, Cheviot – 88, Berwickshire -38.

3. INEQUALITIES

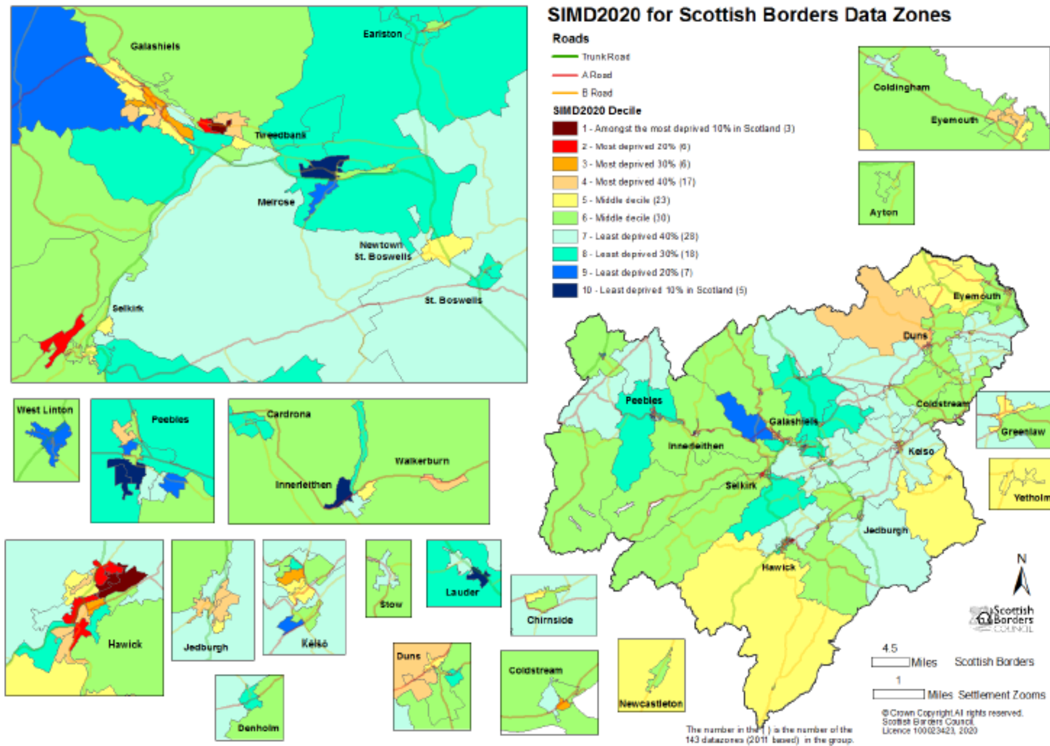
Through the last century, there has been considerable improvements in the overall health of the Scottish population. Much of this progress is a result of public health efforts and the provision of high quality healthcare to those who need it. People are now living longer than ever before, and that is a huge success.

However despite this tremendous progress, Scotland still has one of the lowest life expectancies in Western Europe and the lowest of all UK countries. There is also some evidence that progress is slowing. While life expectancy has been increasing overall, there are also significant differences between areas. Healthy life expectancy can also be significantly shorter than total life expectancy. These differences are strongly influenced by gender and ethnicity but also by circumstances into which people are born, the places where they live, their education, the work they do and their access to positive social networks.

The Scottish Index of Multiple Deprivation (SIMD) 2020 combines income, employment, health, education, skills and training, geographic access to services, crime, and to identify areas of deprivation by data-zone. SIMD is an area-based measure of relative deprivation: not every person in a highly deprived area will themselves be experiencing high levels of deprivation.

Poverty and inequality remain the biggest and most important challenges to health, as the majority of health differences find their root cause in differences in wealth and income. Within the Borders there are affluent areas and also pockets of deprivation. However there are also significant numbers of people living in deprivation outside of areas that statistics would recognise as deprived. This may cause issues for appropriate targeting of resource.

Figure 9: SIMD2020 for Scottish Borders Data Zones



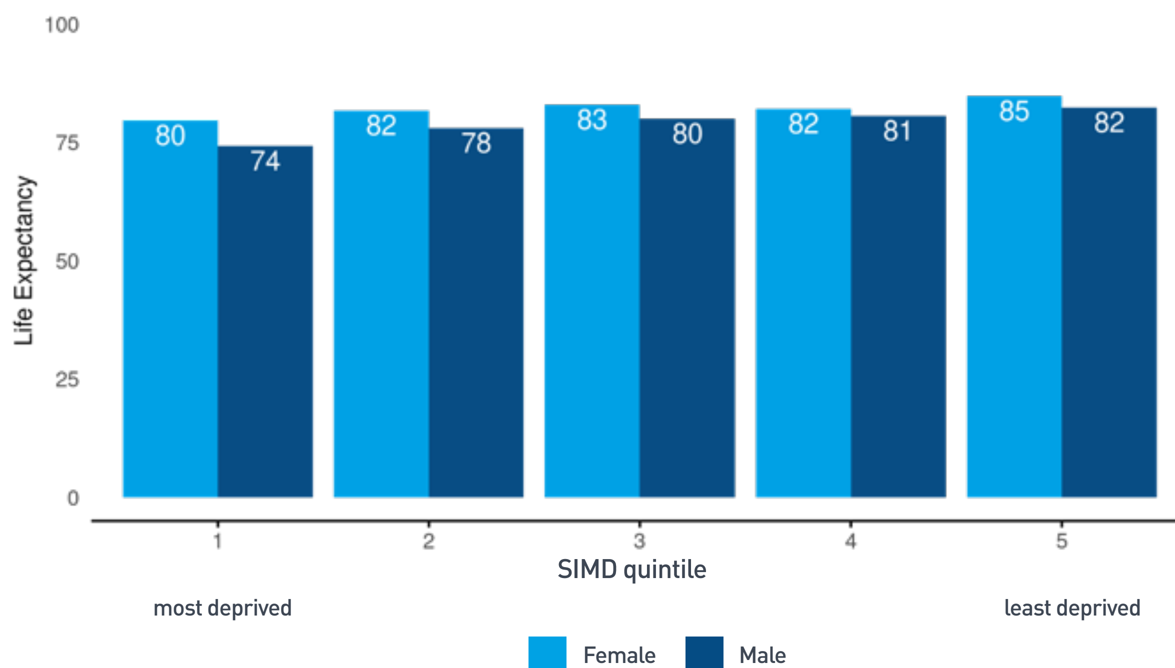
Data Source: *Scottish Borders Strategic Assessment 2020* (Accessed September 2022)

Scottish Borders Health and Social Care PARTNERSHIP

In general the Scottish Borders has fewer areas with significant deprivation than the Scotland average. The majority of the Scottish Borders population (41%) live in areas with SIMD 6 or 7 indicating they live in areas with a deprivation level of less than average.

There is a **9-10 year** life expectancy difference depending on where you live in Borders. Addressing these inequities requires a person centred life course approach.

Figure 10: Life Expectancy at birth by SIMD quintile, 2018-2020



Data Source: *National Records Scotland* (Accessed June 2022)

Areas with a low SIMD have lower life expectancy than areas of high SIMD. This is experienced by both men and women however the gap in life expectancy between the least and most deprived is slightly more pronounced for men.

The average for Scotland is the same for least deprived areas but for deprived areas the life expectancy is 70 years for males and 76 years for females. The Scottish Borders therefore have better life expectancy projections than the Scottish average for the least deprived areas.

People in deprived areas are more likely to suffer health conditions. Asthma hospitalisations for example are more prevalent in SIMD 1 (most deprived) areas than SIMD 5 (least deprived) areas. There has however been a significant improvement over time and a narrowing of inequalities for asthma hospitalisations. Preventable emergency hospitalisations for chronic conditions are also more common in SIMD 1 than SIMD 5.

Exposures to health behaviours may also be socially patterned, suggesting the need for targeted approaches. For example more than 25% of women living in SIMD 1 smoked during pregnancy compared to less than 5% in SIMD 5 areas in the Borders.

Rural Deprivation

Deprivation is experienced differently in rural and urban areas. Issues in rural areas include access to services, lack of affordable housing and higher fuel costs. There may also be a dependency on car ownership to travel in the area (leading to higher costs on those with less or increased difficulty in accessing services or amenities).

Area-level measures of deprivation (such as SIMD) fail to fully capture households experiencing disadvantage in rural areas. This is because rural deprivation can be more dispersed compared to urban areas. In rural areas people living in deprivation can be geographically close to areas of affluence, and a lack of neighbourhoods in the most deprived groups does not mean that there are no people living in deprivation, rather that they are mixed through the population as a whole. This can lead to inadequate resources and interventions being located in these areas [iv].

As well as statistically hiding the effects of deprivation this can also lead to an increase of stigma and fear of stigma as individuals may feel they have to keep up with their neighbours or hide the fact that they may be struggling from them. Furthermore individuals living in such circumstances may have limited support networks as they do not benefit from the identity of a larger neighbourhood as seen in more urban areas.

In delivering services a range of available data is needed to ensure that services are being delivered in an accessible way. This proportionate universalism may require targeting of resources to particular areas or communities. It also requires that data is recorded to understand who is using the service and if any groups are underrepresented.

Individuals living in deprivation will experience more ill health and more harm from it. Prevention is key to lowering high demands and in addressing issues at an early stage where they may respond better and with less input of resource. Preventative action avoids a number of health and social problems in the long run; they can also be used to narrow inequalities making for a fairer society.

Inequality across different groups

There are some groups which may experience health and social care services differently or be otherwise subject to inequity. It should be noted that in local systems ethnicity is often poorly recorded and similarly data on LGBT / LGBTQ+ status are not easily found in routine sources.

Consideration should be given to gaps in data and how to better capture this information to address inequity and evidence progress.

Table 11: Declared Ethnic Groups in Scottish Borders

	Scottish Borders		Scotland
	Number	%	%
TOTAL	**113,870**	**100**	**100**
White	112,400	98.71	96.02
White - Scottish	89,741	78.81	83.95
White – Other British	18,624	16.36	7.88
White - Irish	767	0.67	1.02
White – Gypsy/Traveller	64	0.06	0.08
White - Polish	1,302	1.14	1.16
White - Other	1,902	1.67	1.93
Mixed or Multiple Ethnic Groups	316	0.28	0.37
Asian, Asian Scottish or Asian British	733	0.64	2.66
African	207	0.18	0.56
Caribbean or Black	91	0.08	0.12
Other ethnic groups	123	0.11	0.27

Data Source: *Census 2011* (Accessed September 2022)

Table 12: Population Profile in the Scottish Borders

Age Structures	16% of the Scottish Borders population is under the age of 15. 58% of the Scottish Borders population is aged 15 – 64 years old and 25% of the Scottish Borders population is over the age of 65 (National Records of Scotland 2020).
Long Term Conditions	**30%** of the Scottish Borders population have a long-term health condition (2011 census Scotland).
LGBTQ+	**67%** of young people in the Scottish Borders said they knew someone who is **Lesbian, Gay, Bisexual or Transgender. 2.8% of Scottish Borders residents** (2.2% Scotland) identified **as LGB/ other** (Scottish Borders Council Equality Data Profile, 20212).
Religion	**39.4%** of people in the Borders are part of the Church of Scotland. **6.3%** are Roman Catholic, **7.6%** are other Christian and **0.2%** are Muslim. **37.8%** identified as not having a religion (2011 census Scotland).
Child Poverty	**12.6%** of children in the Scottish Borders live in **low-income** families however there are **10 areas** with **more than 15%** of children living in poverty (Scottish Borders Anti-Poverty Strategy 2021).
Fuel Poverty	Around **29%** of all Scottish Borders Households are **fuel poor** (25% Scotland). This equates to roughly **16,000 households** (Scottish Borders

Data Source: *Various* (Accessed September 2022)

Co-produced solutions can be used to reduce inequality and facilitate growth in community capacity. This results in better service design but also timely delivery as less translation between policy and implementation may be needed. Additional resource may need to be used to target services towards defined groups to allow equality of access; again co-production may result in services that are more readily accessible. This may be supported through the use of Health Inequality Impact Assessments, multiagency working and appropriate representation and the adoption of a Health in All Policies Approach. This will sustain inter-sectoral collaboration and enable policy decisions to be seen through a health and equity 'lens', with agreement around how success will be measured.

Interventions to reduce inequalities should have a low bar of uptake; opt-out interventions are more likely to work than opt-in, or those that require significant payment (for the service itself or in travel to access it for example). In rural areas travel and location of services are also critical factors in accessibility and therefore equity.

While it is important that in targeting resources areas of deprivation are taken into account, it should not be the sole focus as a significant proportion of people living in deprivation will be living in areas not defined as deprived by SIMD.

Inequality is multifactorial and it requires multiple agencies to work together with the community to consider and address unequal levels of power, influence, and wealth. Anchor institutes are in a unique position to influence this agenda with their own policies as well as by acting as advocates nationally.

In order to narrow inequalities systems should focus on the individual, with a no wrong door approach allowing linked up signposting between programmes. This requires good data, information and strong communication between partners, and in understanding need.

Summary

To address inequity, aligned policy and programmes are required which support the most vulnerable groups with appropriate signposting (e.g. to debt/money advice, food security, mental health and wellbeing support, employability, transport, energy efficiency advice). Opportunities and services need to be provided in a joined up fashion, targeted at areas of greatest need and ensured that voices are heard through co-production. It is important to also measure change, therefore data capture, intelligence and measurable outcomes are key requirements.

A whole systems approach is required. This needs to work across organisational structures, barriers and concepts of ownership to build a clear understanding of skills and roles. This partnership needs to work towards clear and agreed priorities.

All services need to be assessed through an inequality and inequity lens and preventative assessments and plans put in place.

4. PREVENTION AND EARLY INTERVENTION

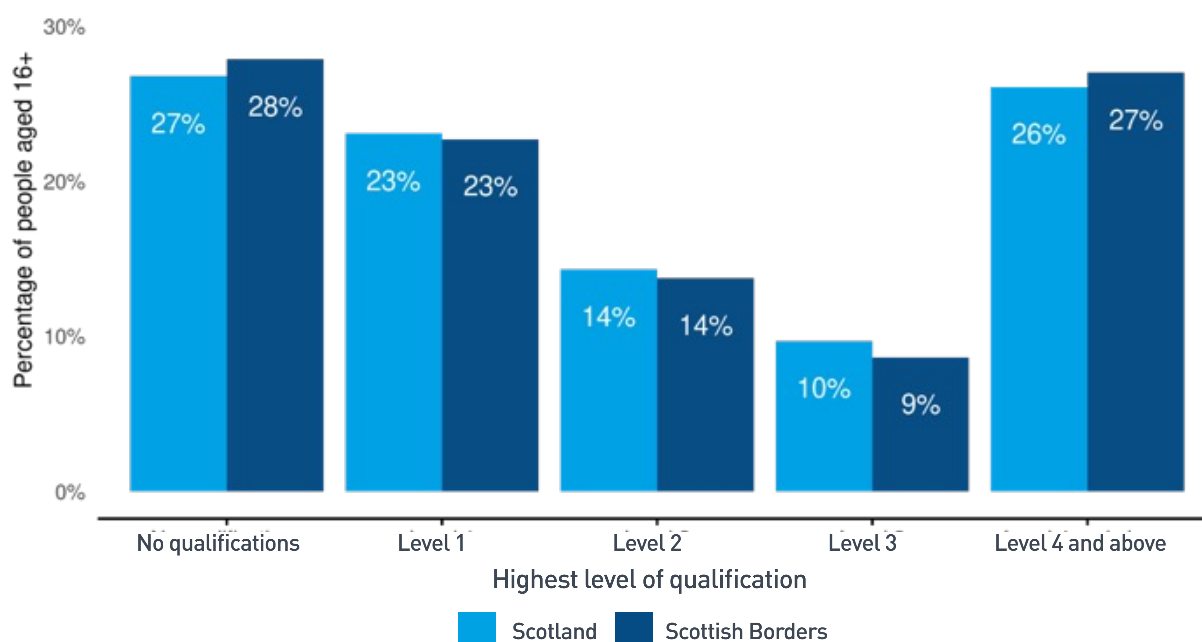
Education and Qualifications

A person's level of education plays a key role in shaping health and wellbeing over a lifetime. Education can impact on health and wellbeing in terms of developing values, emotional intelligence, self-esteem and social functioning skills and should not just be focused on formal qualifications.

Qualifications are records of achievement awarded on the successful completion of a course of training or passing an examination. The census uses the following descriptors:

- Level 1 - SVQ 1 or 2 (standard grades and similar like GCSE)
- Level 2 - SVQ 3 (Highers, advanced higher such as A level)
- Level 3 - SVQ 4 (HNC & HND)
- Level 4 - SVQ 5 (undergraduate and postgraduate degrees and professional qualifications)

Figure 13: Highest level of qualification for people aged 16+



Data Source: *Census 2011* (Accessed June 2022)

Overall in the Scottish Borders residents aged 16+ have a similar level of qualifications as the Scottish average. The percentage of males and females having low or no qualifications had been declining since a peak in 2004 of 18% for males and 20% for females. It reached its lowest value of 8% in 2014 for males and in 2018 for females. In recent years the initial decline has either stalled or started to reverse.

Educational Attainment and Destination of School Leavers:

In 2020/21, **96%** of school leavers in the Scottish Borders had achieved SCQF level 4, such as a general level standard grade . This was 1% below the rate in the previous two years which was 97%. In general the rate of school leavers with a standard grade or similar attainment has dropped slightly in the Scottish Borders over time.

In 2020/21, 65% of school leavers in the Scottish Borders had achieved SCQF level 6 such as a Higher. This was an increase of 2.1% in the previous year, but still slightly below the Scottish average at 66%.

Skills Development Scotland capture data on positive destinations of young people, of the 17 young people included in the snapshot 71% were in a positive initial destination and 88% were in a positive follow up destination. This compares to 86% and 71% nationally.

Annual Participation Measure

Participation measure is defined as the percentage of 16-19 year olds who are in employment, education or training. In 2022, there are **93.4%** of those aged 16-19 participating in the Scottish Borders, this is 1% more than national figures.

Table 14: Percentage of students participating in schools in the Scottish Borders versus Scotland.

	Participating	Not participating	Unconfirmed
National – 2022	92.4%	4%	3.6%
National – 2021	92.2%	3.2%	4.6%
Borders – 2022	93.4%	3.3%	3.4%
Borders - 2021	93.8%	2.5%	3.7%

Data Source: *Skills Development Scotland* (Accessed June 2022)

Overall there has been a 0.4% decrease in participation compared to last year in the Borders. There are 0.8% more 16-19 year olds not participating and 0.3% less with an unconfirmed status.

There is an 11.7% gap of those participating between most and least deprived areas which is a significant improvement from last year at 15.1% (nationally this figure was 9.3%).

Additional Support Needs and Looked After Children 2021/22

Students with **Additional Special Needs (ASN)** are young people who require extra support to learn. Examples of why a student may require extra help include bereavement or family illness, problems at home, bullying, being particularly gifted or able, have an illness, disability or impairment, having a learning disability or having English as their second language .

The Scottish Government defines **Looked After Children (LAC)** as "those in the care of their local authority – sometimes referred to as a 'corporate parent'". Majority of Secondary children who are looked after also have additional support needs (91%).

Those who are LAC or children with ASN are more likely to live in a more deprived area and more likely to be in receipt of free school meals and the free clothing grant.

Table 15: Comparisons across SIMD 1 and SIMD 10 for 2021/22 (secondary schools)

	SIMD 1	SIMD 10
Additional Special Need	57%	26%
Current Looked After Children	4.9%	←1%
Receiving School Meals	46%	←1%
Receiving Clothing Grant	52%	3.1%
English was 2nd language	10.1%	←1%

Data Source: *SBC Education data* (Accessed August 2022)

There were 326 pupils in secondary school where English was their second language. The most commonly spoken language after English is Polish. There is a Saturday school in Hawick for Polish speakers to continue learning their language.

Attendance and Exclusions 2021/22

Secondary attendance rates 2021/22 was 88%. For students living in areas of an SIMD score of 10 attendance was 89% while areas with an SIMD score of 1 had 79% attendance.

LAC pupils had an attendance rate of 86%. Those living away from home had a higher attendance (88%) than those who still lived with their parents (79%).

Exclusion is where the student is dismissed from school for unacceptable behaviour. There were 67 pupils excluded in the school year 2021/22, 47 cases were ASN students.

Housing

Housing plays an important role in ensuring good health and well-being. The housing environment can impact health physically and mentally. People need to feel safe and secure in their homes, live in a location where they can access the services and community they need, and be able to provide for all the household's requirements such as affording fuel and energy.

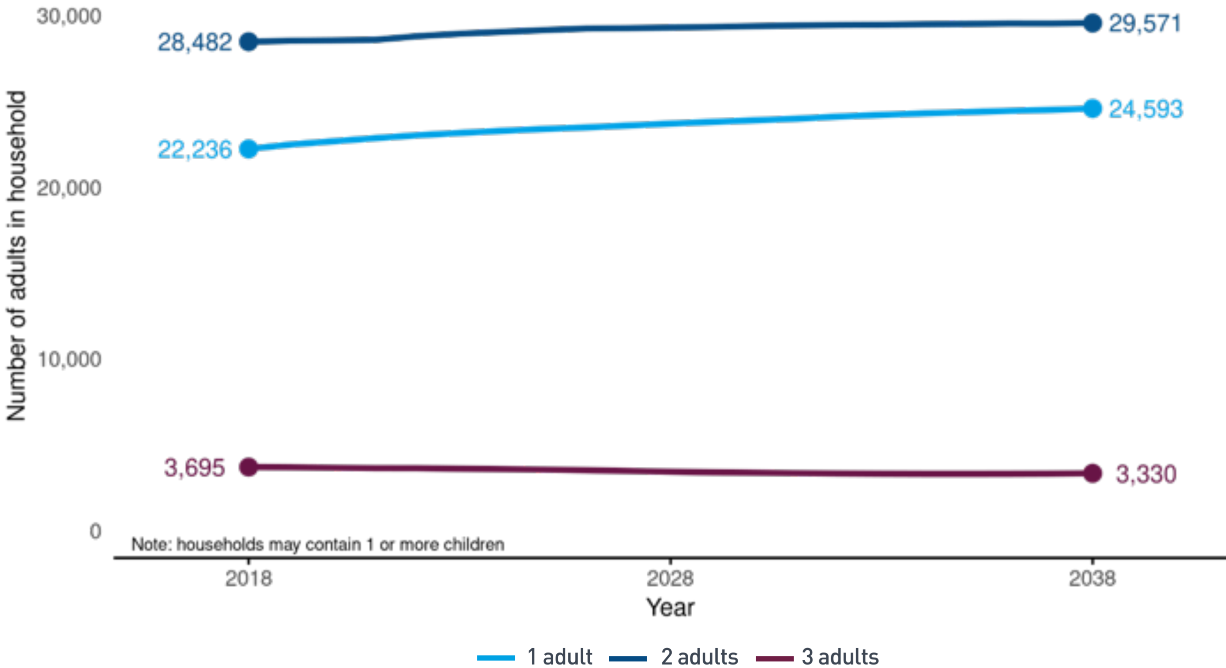
The Local Housing Strategy vision is that "every person in the Scottish Borders has a home which is secure, affordable, in good condition, energy efficient, where they can live independently and be part of a vibrant community." Four key priorities were defined:

1. The supply of housing meets the needs of our communities
2. More people live in good quality, energy efficient homes
3. Less people are affected by homelessness
4. More people are supported to live independently in their own homes

Housing: availability, suitability and affordability

The total number of households is projected to increase from 54,413 to 57,495 between 2018 and 2038. This represents an estimated 6% increase. A growth in population is the main factor in the increase in household numbers over the projection period. However, the household projections increase at a greater rate than the population projections, this is a result of more people living alone or in smaller households.

Figure 16: Projected change in household types, 2018 - 2038



Data Source: *National Records Scotland* (Accessed June 2022)

In 2018 there were an estimated 8,833 people aged 65+ living alone of which 68% were female and 32% were male. This number is projected to increase by 18% to 10,441 in 2028, with a 67% to 33% female to male split. As the gap in the average life expectancy of men and women decreases, the number of older men living alone is expected to increase more rapidly than that of females.

Housing Stock

The Scottish Borders has a significantly lower proportion of flatted accommodation in comparison with other areas and the national average. This is due to the Borders being a rural area so won't have as many flats as some of the more urban areas of Scotland. Around 90% of households in the Scottish Borders are of the single / smaller categories according to the Scottish Household Survey.

House size by tenure indicates there are larger house sizes in the owner-occupied sector and proportionately fewer large dwellings in the social sector. In terms of social housing, the profile of house size indicates a supply of dwellings with 3+ bedrooms quite substantially below both the regional and Scottish averages.

The Scottish Borders no longer has council houses, Registered Social Landlords (RSLs) (often called Housing Associations) are now the main providers of new and affordable rented housing.

Scottish Borders Housing Association holds nearly half of all social rented properties within the Scottish Borders (46.6%). Eildon (20.4%), Berwickshire (15.6%) and Waverley (11.8%) all own significant numbers of properties within the region. The five Registered Social Landlords with smaller stock levels operating within the region account for the remaining 5.5% of Registered Social Landlord properties.

Table 17: Number of properties by Registered Social Landlord provider 2020/21

Registered Social Landlord	No. of Properties	% of Total
Berwickshire	1,880	15.6
Bield	138	1.1
Cairn	111	0.9
Eildon	2,446	20.3
Hannover	238	2.0
Link	102	0.8
Scottish Borders Housing Association	5,603	46.5
Trust	87	0.7
Waverley	1,425	11.8
Total	12,045	100

Data Source: *RSL Annual Summary of Information* (Accessed June 2022)

The most common type of Registered Social Landlord property within the Scottish Borders is a flat accounting for 42% of all stock. Both the Central and Northern HMAs have a high proportion of flats, with over 46% of dwellings within both of these areas being flats. 44% of social housing is provided with 1 bedroom with this being the predominant house size across the region. 37% of social housing properties are provided with 2 bedrooms.

Terraced houses are the most common type of dwelling within the Berwickshire HMA. The southern HMA which is the most rural and sparsely populated of the areas has a high percentage of semi-detached and terraced properties. Both the Southern and Berwickshire housing market areas have a higher proportion of bungalows than the Central and Northern HMAs.

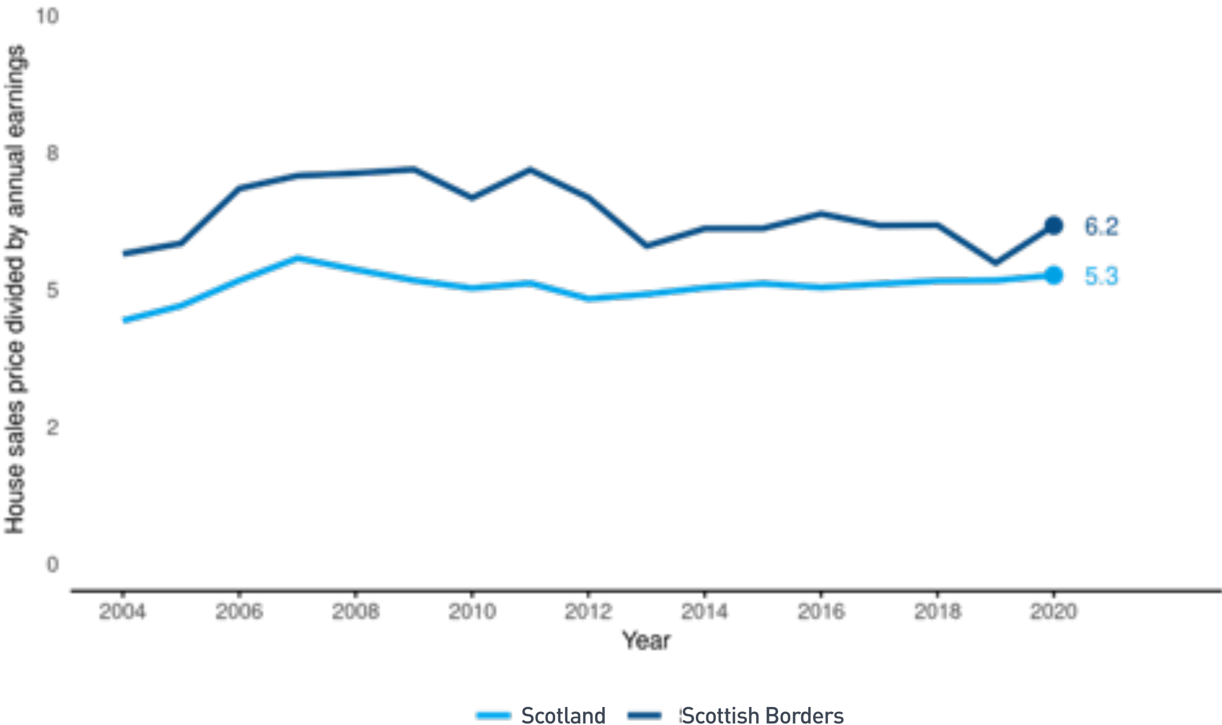
The Private Rented Sector within the Scottish Borders contains a large proportion of individual landlords. A snapshot of Landlord Registration taken in August 2020 shows that 70% of the approved landlords in the Scottish Borders own a single property. Within the region there are seven landlords with large portfolios, having over 50 properties registered to them. There is a higher proportion of rural properties within the Private Rented Sector than is found in Registered Social Landlord properties.

Housing Affordability

Since 2012 house prices in Scotland have been steadily increasing at an average rate of 3.5% per year to £162,000 in 2020.

In the Scottish Borders in 2020, full-time employees could expect to spend around 6.2 times their workplace-based annual earnings to buy a home, which increased from 5.5 times earnings in 2019. By comparison in Scotland, spend was around 5.3 times annual earnings in 2020, which hadn't changed much over the previous five years. The data implies that housing is less affordable in the Scottish Borders than in Scotland on average.

Figure 18: Housing affordability ration, full-time employees, 2004 to



Data Source: *statistics.gov.uk* (Accessed June 2022)

During the Local Housing Strategy 2017-22 consultation, roughly half of respondents noted the lack of affordable housing as a main housing issue. Other issues which emerged from the consultation included: the lack of specialist housing for older people, the poor accessibility of housing to allow younger people to remain in the Borders and the need for the supply of housing to reflect demand (the right housing in the right place) .

The housing market has been impacted by the COVID-19 pandemic and the Scottish Borders is showing a volume of sales growth between 2019-20 and 2020-21 of 5.3%; potentially due to movement out of more urban areas. This is reflected in the figures for the City of Edinburgh which showed the largest decline in the volume of sales and Scotland experienced a decrease of just -0.02%.

Fuel Poverty

Fuel poverty occurs when households cannot afford to keep their homes adequately warm because the cost of heating are higher than average and paying for those costs leave households below the poverty line. A household is considered to be in fuel poverty if it spends more than 10% of household income on fuel, and in extreme fuel poverty if it spends more than 20% of income on fuel.

Fuel poverty is a particular issue facing households in Scottish Borders. The extent of fuel poverty in the Scottish Borders is worse than is the fuel poverty across Scotland. This effects around 29% of households in the Borders (Extreme Fuel Poverty at 14%), where the rural nature of the area, the type of housing and the low wage economy, contributes to higher levels that the Scottish average.

From the previous national survey, fuel poverty levels has stayed the same, but extreme fuel poverty has decreased by 1%. Levels of Fuel Poverty remain a challenge and a priority. With energy cost increases and uncertainty within the energy markets Fuel Poverty is expected to increase across the country.

There is a much higher proportion of post 1945 housing in the Scottish Borders than pre-1945 housing. However the Scottish Borders has a higher proportion of older housing than is recorded nationally. Solid stone buildings are very energy inefficient and do not retain heat. Significant energy savings can be achieved by insulating these properties.

Table 19: Age of dwellings

	Dwelling Numbers	% Pre-1945 Dwellings	Pre-1945 No. Dwellings	% Post 1945 Dwellings	Post 1945 No. Dwellings
Scottish Borders	58,671	33.1	19,442	66.9	39,229
Scotland	2,636,871	30.4	801,872	69.6	1,834,999

Data Source: *National Records of Scotland (2020) Estimates of Households and Dwellings in Scotland 2019; Scottish Government (2021) Scottish House Conditions Survey 2017-19* [Accessed June 2022]

Scottish Government funding for private home energy efficiency improvements is known as the Energy Efficient Scotland Area Based Scheme (EES: ABS). The funding allocation, administered by Scottish Borders Council for 2021/22 was £1.7m enabling investment in: external and internal wall insulation; cavity wall insulation; loft insulation; and underfloor insulation. There were also renewable technology installed for the first time, with Air Source Heat Pumps and a Solar PV and Battery systems. This commitment to the decarbonisation of heat and the promotion of renewable technology is part of SBC and Scottish Government wider targets to reduce climate change impact.

The COVID pandemic had a massive impact on the delivery of Energy Efficient Scotland Area Based Scheme as work could not be undertaken during the lockdown restrictions and this is reflected in underspend. This was experienced across the entire country.

Existing Additional Needs Housing Provision

In total there are an estimated 1,946 homes provided as specialist housing by Registered Social Landlords. This accounts for 16% of all social housing. Amenity housing (which can also be referred to as medium dependency housing) makes up the largest proportion of specialist housing (50.7%).

Table 20: Breakdown of Types of Specialist Housing

Type of Specialist Housing	Total
Amenity	986
Disabled/ Wheelchair	187
Extra Care Housing	170
Sheltered	299
Very Sheltered Housing	139
Other Specialist Housing	165
Total	1,946

Data Source: *Registered Social Landlord Summary of Information, March 2021* (Accessed June 2022)

Extra Care Housing is suited to older people (over 60) with higher care needs. In Extra Care homes there are onsite staff teams who provide support for residents, meals are also available onsite. There are 170 Extra Care houses in the Scottish Borders.

Disability/Wheelchair Housing Provision

There has been increasing policy interest in the provision of accessible and adaptable housing for households that contain someone with a long-term health issue or disability. In 2019, the Scottish Government brought in the requirement for all local authorities to adopt a wheelchair target across tenures, and for progress to be reported annually through updates of Strategic Housing Investment Plans and Local Housing Strategies.

There is a minimum of 600 wheelchair user households where one or more persons have to use a wheelchair indoors. This sub-group is likely to be in most 'need' of a specifically designed or adapted accommodation to ensure their home is suitable for everyone in the household.

Assuming that wheelchair user households continue to make up around 3.5% of all households, NRS projections indicate that by 2028 there would be over 80 additional wheelchair user households seeking a suitable home.

New Additional Need Housing Provision

The Scottish Borders Integrated Strategic Plan for Older People's Housing, Care and Support (2018-28) sets out a vision where older people will have greater choice in terms of where and how they live, and the services they can access. The plan also sets out how over the next 10 years the Health and Social Care partners will aspire to deliver:

- 400 extra care houses (including 60 in a new retirement campus)
- 300 new build houses suitable for older people for sale and in the rented sector
- Existing housing, refurbished or remodelled - 300 houses in the social rented sector
- Housing support on site to be offered to 300 more older households across housing sectors
- Over 8,000 adaptations and small repairs to enable people to stay in their own home
- A minimum of an additional 20 specialist dementia spaces to meet the need identified in the emerging Dementia Strategy
- Investment in telecare / telehealth for over 800 households.

Scottish Borders Council commissioned consultations to develop a wheelchair housing study, in January 2020 the finalised report was published "A space to live – Wheelchair accessible housing in the Scottish Borders". The final report identified a wide range of issues and challenges which will need to be addressed at national as well as at a local level by Scottish Borders Council and partner agencies. A target of 20 homes per annum has been identified, of which 15 will be provided by Registered Social Landlords. The total planned number of units in the Strategic Housing Implementation Plan is 2021-26 is 1,256, of these 101 (8%) are wheelchair accessible houses.

Equipment and Adaptations

Equipment and adaptations play an important role in delivering the second national health and wellbeing outcome - allowing people to live independently and in the home for as long as is reasonably practicable.

There are an estimated 7,500 homes with adaptations in place in the Scottish Borders.

The Borders Care and Repair (C&R) Service helps homeowners or private sector landlord with adaptations that will enable those with a disability to stay in their own home. They offer a free service to either project manage an adaptation or offer advice to members of the public who wish to self-fund adaptations.

Tenants of private sector landlords may apply for funding through the Private Sector Housing Grant to receive necessary adaptations to meet their assessed needs in their home. The most common adaptations in the private sector were wet floor showers followed by stair lifts and ramps between 2019 and 2022.

Registered Social Landlords receive grants directly from the Scottish Government for adaptations (called Stage 3 funding). Adaptations to showers accounted for the majority of all Registered Social Landlord adaptations between 2019 and 2022.

An estimated 13% of dwellings have some form of adaptation in the Scottish Borders. The ambition for individuals to live at home for longer as they age, ensuring people can live in the community and not in institutions, points to an increased need for accessible housing for all. Even when the new Accessible Housing Standard comes into force in 2025-26, the provision of adaptations will continue to be in high demand for existing housing, and a broader range of clients, including those with physical disabilities, autism, learning disabilities and sensory impairments.

Equipment

The Community Equipment Service has spent £308,769 on core equipment and £248,818 on non-core stock in 2021/22. Common pieces of core equipment include hospital beds, pressure care, toileting equipment, bathing/showering equipment, rise recliner chairs and walking aides. Non-core equipment provided is more specialised or bespoke in nature.

Impact of COVID

During the pandemic, Occupational Therapists couldn't conduct their in person assessments and contractors also couldn't build adaptations due to COVID restrictions. This led to a backlog of applications and a low number of completed projects in 2020 compared to previous years.

Table 21: Number 2021. of completed adaptations 2019-

Major Adaptations completions*	2019-2020	2020-2021	2021-2022
Private Sector	88	39	35
Registered Social Landlords	116	45	72
Minor Adaptations completions**	**2019-2020**	**2020-2021**	**2021-2022**
Private Sector	400	264	353
Registered Social Landlords	128	93	107

*Major adaptations may include stair lifts or more specialist requests.
**Minor adaptations may include internal/external rails, grab rails and banisters.

Data Source: *Scottish Borders Council* (Accessed July 2022)

In January 2022, there remained a backlog of applications however the Care and Repair team have worked hard to reduce this number since. Difficulties obtaining contractors to build the adaptation has remained an issue post COVID for private sector landlords to complete adaptations.

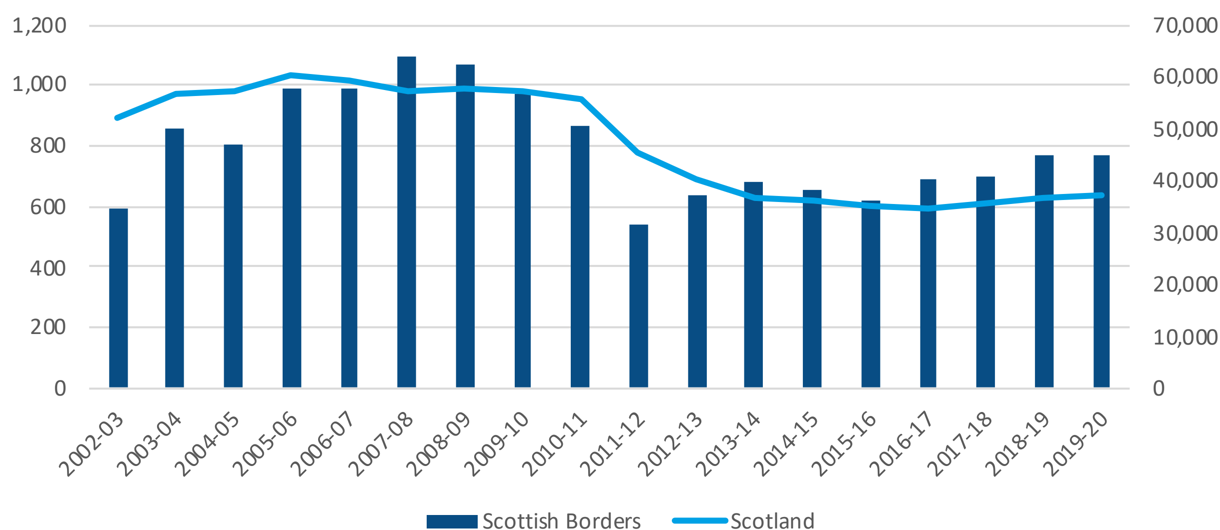
Most people in receipt of the Care and Repair service who completed the customer satisfaction survey, felt it made a difference to their independence and were pleased with the provision. Majority also felt the equipment helped prevent falls in the home. Overall there is high satisfaction among service users with the
work carried out.

Homelessness

Homelessness means not having a home. You are considered homeless if you have nowhere to stay and are living on the streets or if you are: staying with friends or family, staying in temporary accommodation provided by the local authority, a hostel or Bed and Breakfast. In 2019-20 there were 765 applications for homelessness in the Scottish Borders.

The number of homeless applications has remained steady since 2011/12 as a result of a proactive approach to prevention through the delivery of the Housing Options approach. In 2019/20, 84% were assessed as homeless, this is very similar to the national percentage (83%).

Figure 22: Homelessness applications, by local authority: 2022-03 to 2019-20



Data Source: *Scottish Government Homeless Statistics, 2021* (Accessed June 2022)

Significant government focus has been on specific groups at risk of homelessness, including people leaving prison, young care leavers, and women (with accompanying children) experiencing domestic abuse. The expectation is that local authorities should develop specific pathways for each of these groups to prevent them from entering the homelessness system.

In addition to the COVID-19 impacts on demand for temporary accommodation, some of the wider pressures in the Scottish Borders include:

- Young People - the number of young people presented as homeless has remained steady over the past five years but the Scottish Borders has the 5th highest number of young people assessed as homeless as a proportion of the population. It is 17 per 1,000
- Discharge from prison/ hospital/ care/ other institution - this accounts for 5% of homeless assessments in 2020/21.
- Veterans – the number of applications and assessments of veterans has remained at the same level over ten years
- Women experiencing domestic abuse – on average 64 women presented as homeless following incidences of domestic abuse each year in the Scottish Borders (over a ten year period). In 2018/19, 65 women presented as homeless, this is 22% of all single females and single female parents.

The number of repeat homelessness assessments has remained at a similar level over the past ten years, with the current percentage being 4%. The percentage in the Scottish Borders is lower than the national each year.

Table 23: Homelessness assessment decisions by reason: 2019-20

Technical Reason	Total	%
Applicant terminated secure accommodation	1	0.2%
Asked to leave	202	31.3%
Discharge from prison/ hospital/ care/ other institution	30	4.6%
Dispute with household/relationship breakdown: non-violent	130	20.1%
Dispute with household: violent or abusive	74	11.5%
Emergency (fire, flood, storm, closing order from Environmental Health etc.)	1	0.2%
Fleeing non-domestic violence	15	2.3%
Forced division and sale of matrimonial home	5	0.8%
Harassment	11	1.7%
Loss of service/tied accommodation	9	1.4%
Other action by landlord resulting in the termination of the tenancy	74	11.5%
Other reason for leaving accommodation/ household	42	6.5%
Other reasons for loss of accommodation	7	1.1%
Overcrowding	3	0.5%
Termination of tenancy/mortgage due to rent arrears/default on payments	42	6.5%
Total	646	100.0%

Data Source: *SBC HL1 data* (Accessed June 2022)

The most common reasons for homelessness relate to a dispute in the applicant household (20% non-violent and 12% violent); and the applicant being 'asked to leave' by their landlord or household (31%).

Key headlines on the homeless population in the Scottish Borders are as follows:

- Almost two thirds of homeless assessments are from single people (38% male and 21% female)
- Just over a fifth of homeless assessments are from single parents (18% female and 8% male)
- 33% of homeless assessments included households with children (212 households)
- 27% of homeless applicants were young adults aged 16-24 (176 households)

Homelessness prevention/housing options

Since 2012, homeless prevention has been very effective in the Borders. Within the prevention model, the Council recognises homelessness as a complex issue that encompasses health, employment, education, offending, finance, relationships and families. Dealing effectively with homelessness requires a multi-agency approach.

The main reason for approaching homeless prevention services is having to leave accommodation or household, accounting for 35% of approaches. This is lower than the national trend of 41%. Over half of approaches result in making a homelessness application (51%) which is similar to the national figure (52%). As a result of prevent approaches, 24% remain in the current accommodation, 7% get an Registered Social Landlord tenancy and 2% get a PRS tenancy, meaning 33% of all prevent approaches are helped to stay their current accommodation or to access a new tenancy.

Impact of COVID

Early actions in response to the pandemic were focused around ensuring homeless or potentially homeless households within the Scottish Borders had suitable accommodation available to them that allowed them to comply with the imposed lockdown measures.

Some of the impacts COVID-19 has had on homelessness services, include:

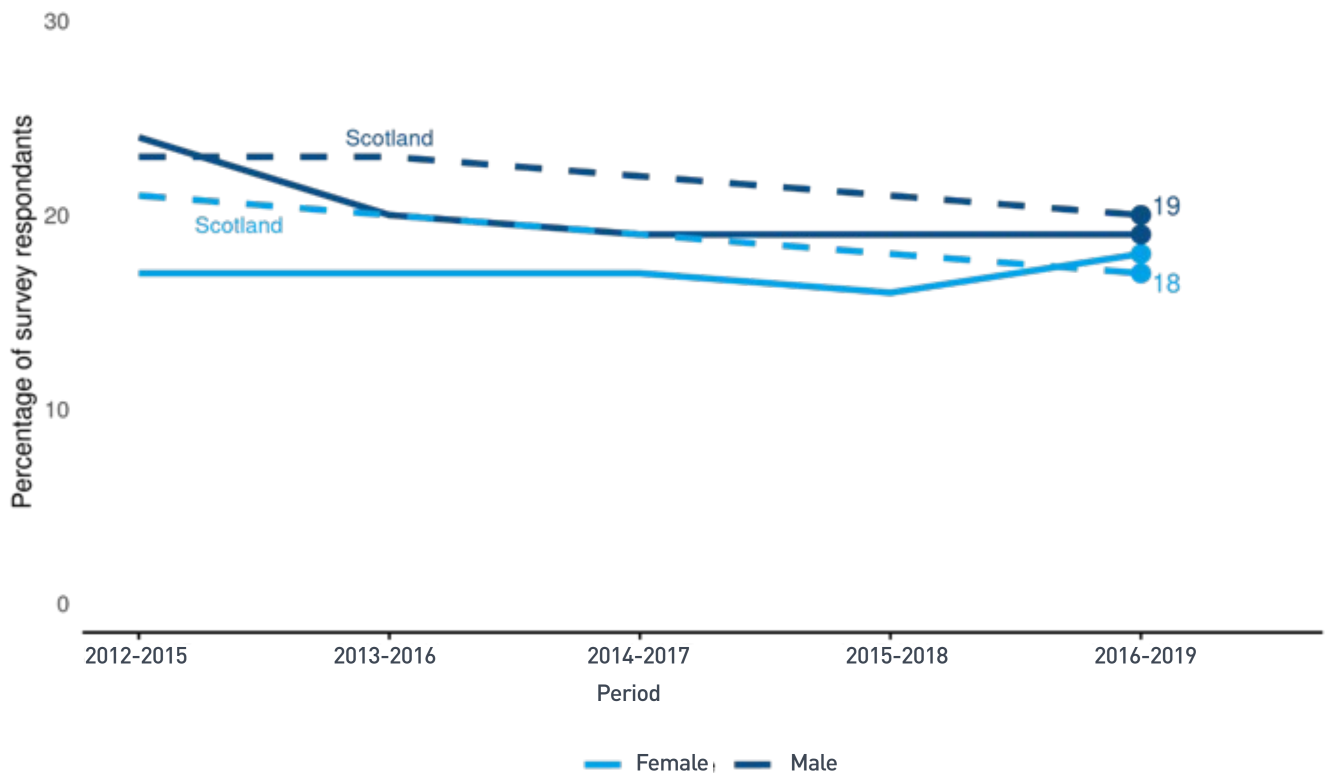
- A 29% increase in the 'Homeless Queue' (the number of applicants assessed as Homeless or threatened with homelessness) on the 31st March 2020 compared to 31st March 2022. This had been reducing prior to the pandemic.
- 30% increase in the number of households residing in temporary homeless accommodation. (31st March 2020 compared to 31st March 2022)
- 21 % reduction in available Registered Social Landlord housing stock in 2020/2021 when compared to 2019/2020 (data from 4 main Registered Social Landlords)

Lifestyle Factors

Smoking

Smoking prevalence is the number of people who smoke tobacco in an area at a point in time. In the Scottish Borders **17.8%** of people are smokers (2018/19), this is lower than **19%** in Scotland overall.

Figure 24: Smoking status (Scottish Health Survey): Current smoker, 2012-2019



Data Source: *Scottish Health Survey* (Accessed June 2022)

In 2016 – 2019 (the latest period), 19% of males said they were current smokers, and 18% of females said they were current smokers. While this rate remained constant with the previous value for males, it had increased for females from 16%.

By comparison the averages rates for males and females in Scotland was 20% and 17% in 2016 – 2019, and in Scotland the rates have been consistently falling since the start of these records.

Deaths and illness related to smoking:

There were around **1,437** smoking attributable hospital admissions per 100,000 of the population in Scottish Borders for the combined time-series from 2012 – 2013 to 2017 – 2018. This was lower than the Scottish average (1,724 per 100,000 population). In general, smoking-attributed hospital admissions had been falling, year-on-year, except for in 2015

– 2016 when the rate in the Scottish Borders increased by 3% before falling in the next two consecutive years.

The rate of smoking-related deaths has been steadily decreasing in the Scottish Borders and across Scotland as a whole. In 2017-18 the rate of smoking-related deaths in Scottish Borders was 267 per 100,000 people, unchanged from the previous year but overall down 10% from the initial rate since **2012**. By comparison the 2017-18 rate for Scotland was 328 per 100,000, down 3% from the previous year, and down nearly 12% since 2012. This implies that the rate of smoking-attributed deaths is declining slower in the Scottish Borders than in Scotland on average.

Smoking cessation support in the Borders is delivered through the Wellbeing Service and participating community pharmacies. Smoking prevalence is higher in more deprived areas. NHS Board areas have a Local Delivery Plan (LDP) target to achieve a number of successful quits at 3 months post quit date in the 40% most deprived areas.

The table below presents the most recent data relating to smoking cessation support in Borders including: number of quit dates set; number of Local Delivery Plan quits set; number of successful 3 month Local Delivery Plan quits percentage of Local Delivery Plan target achieved. The Local Delivery Plan target has been 124 since 2019-20.

Table 25: Smoking cessation quit attempts

Year	Total quit attempts	Local Delivery Plan quit attempts	3 month quits	3 month LDP quits	LDP quits as a % of 124 target
2021-22	524	314	152	99	80%
2020-21	486	274	144	79	64%
2019-20	766	418	180	96	77%

Data Source: *National Smoking Cessation Database* (Accessed August 2022)

The number of quit attempts made has decreased over time since 2011/12. There was a significant reduction locally in 2020-21 (during the pandemic) as fewer people came forward for support in pharmacy and the Wellbeing Service.

The rate of successful Local Delivery Plan quits based on the Local Delivery Plan quit attempts has increased from 23% in 2019-20 to 32% in 2021-22.

Statistics are based on total 'quit attempts' made during the year, rather than the total number of people with a quit attempt, so may include repeat quit attempts for the same person.

Smoking in pregnancy
The Scottish Borders rate of smoking in pregnancy is slightly higher than Scotland as a whole (**14.4%** compared to **13.1**[ix]). There is a significant difference in the rate of smoking in the most deprived quintile (34.48% compared to 26.84%) although it is recognised the potential impact of lower numbers locally. The number of pregnant women setting quit attempts through local services remains low.

Nicotine Vaping Products (NVP) ('electronic cigarettes')
Nicotine Vaping Product use declined for both adult males and females in the Scottish Borders between 2014-17 and 2016-19. In 2016-19, **5% of males** said they were users of e-cigarettes, while **9% of females** said the same. However, according to SALSUS (2015, 2018) the proportion of young people who have never smoked and who have used e-cigarettes has increased over time. NHS Smoking Cessation services do not supply Nicotine Vaping Products as a cessation aid but can support people using these devices to quit their nicotine habit.

Physical Activity and Exercise

Regular physical activity is an important part of living well. People who lead an active lifestyle are more likely to live longer and are less likely to develop serious illness and health conditions such as Type 2 Diabetes and heart disease. Research also suggests that regular physical activity can improve:

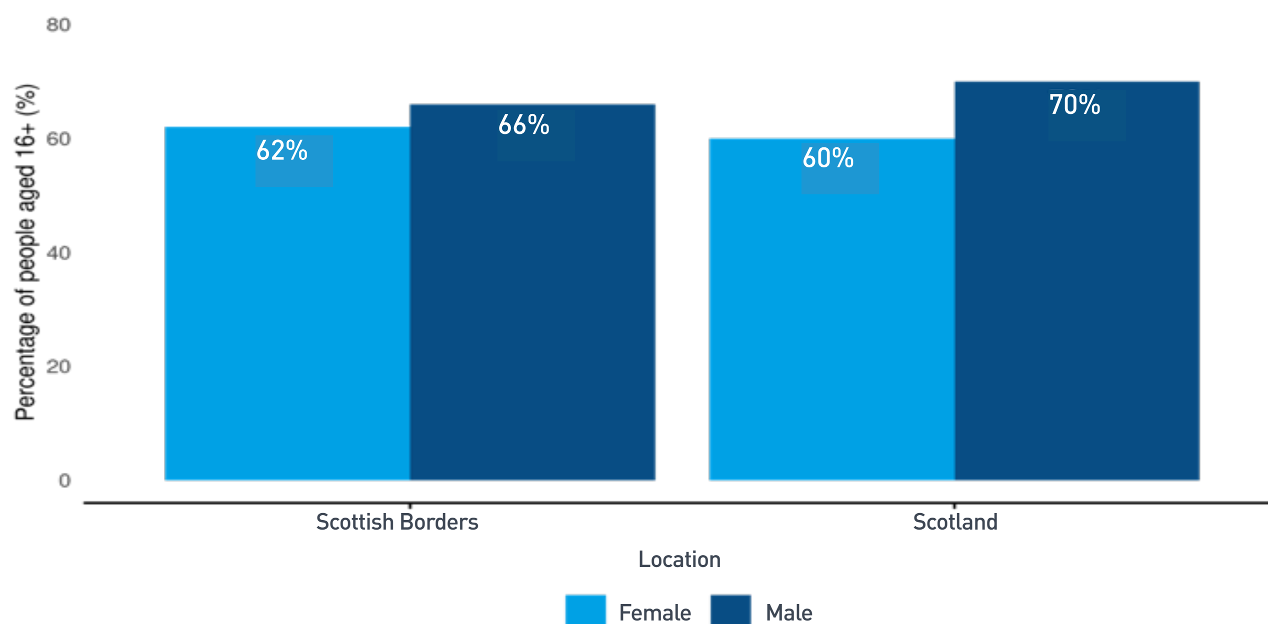
- General mood
- Self-confidence
- Sleep quality
- Energy levels

The Chief Medical Officers guidance is that to stay healthy, adults aged over 18 should try to be physically active every day and aim for one of the following:

- At least 150 minutes of moderate aerobic activity every week **and** strength exercises on two or more days a week that work all the major muscles (legs, hips, back, abdomen, chest, shoulders and arms).
- 75 minutes of vigorous aerobic activity **and** strength exercises on two or more days a week that work all the major muscles (legs, hips, back, abdomen, chest, shoulders and arms).
- A mix of moderate and vigorous aerobic activity every week. For example, two 30-minute runs plus 30 minutes of fast walking equates to 150 minutes of moderate aerobic activity **and** strength exercises on two or more days a week that work all the major muscles (legs, hips, back, abdomen, chest, shoulders and arms). Physical activity levels are influenced by a range of factors including access to affordable activities and facilities; transport and planning; stigma and wider social expectations.

Physical activity levels are influenced by a range of factors including access to affordable activities and facilities; transport and planning; stigma and wider social expectations.

Figure 26: Percentage of people aged 16+ who met the recommended level of physical activity per week, 2016-2019



Data Source: *Scottish Health Survey* (Accessed June 2022)

Comparing the Scottish Borders to the Scottish average, a higher rate of females in the Borders had met the recommended weekly activity requirements than Scotland, whereas a lower rate of males in the Borders had met the recommended weekly activity requirements compared to Scotland.

Since the previous period, 2015 – 2018, there was an increase for both males and females. This is a positive shift as it shows that a greater proportion of people in the Scottish Borders are meeting the recommended level of physical activity.

Low or very low activity is categorised as either up to 59 minutes of moderate physical activity or up to 29 minutes of vigorous activity per week. **25%** of Scottish Borders males aged 16+ reported engaging in low or very low activity. This rate was greater than the Scottish average for males at 21%.

By comparison **23%** of Scottish Borders females aged 16+ reported engaging in low or very low levels of physical activity per week, significantly less than the average for Scottish females which was 28%.

Compared to the previous period, 2015 – 2018, for males there was a fall of 3% from 28% to 25%, while for females there was a fall of 2% from 25% to 23%. This is again a positive change as it suggests that people in the Scottish Borders may be starting to engage in greater levels of physical activity.

Healthy Weight

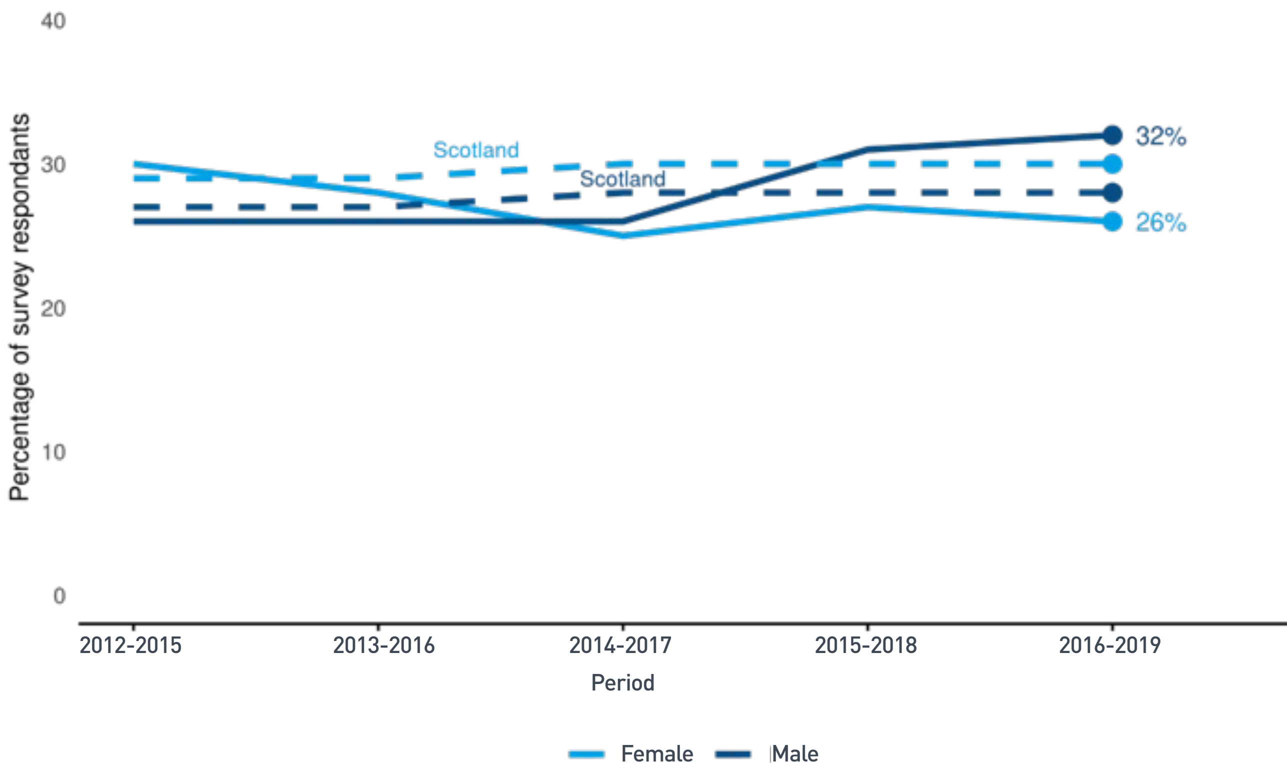
Food and diet play a major role in health and wellbeing and a healthy diet can be important in protecting people from a wider range of health conditions such as heart disease, Type 2 diabetes and some cancers.

The environments in communities live, play and work have a significant impact on their ability to choose a healthy diet. The food environment plays an important role in shaping what people buy and eat, and it is influenced by what is available, affordable and accessible. Inequalities in accessing a healthy diet contribute towards health inequalities.

The Adult Healthy Weight pathway in the Scottish Borders is led by dietetics and also provided through the Wellbeing Service and includes access to tailored physical activity.

The Body Mass Index (BMI) is used to calculate whether a person is underweight, a healthy weight, overweight or obese for their height. Adults are classed as overweight if their Body Mass Index is 25 to 29.9, obese if their Body Mass Index is 30 to 39.9 and morbidly obese if their Body Mass Index is 40 or more.

Figure 27: Obesity: Obese, 2012 - 2019



Data Source: *Scottish Health Survey* (Accessed June 2022)

Since 2012 the percentage of male obesity has increased from **26%**, while in the same time female obesity has decreased from **30%**. Compared to Scottish averages, the Scottish Borders performs better for females but not for males.

Oral Health

Oral health is an essential component of overall health and wellbeing and is important to enable people to eat, sleep and socialise without pain or embarrassment. Most oral health conditions are preventable and poor oral health shares "common risk factors" for example diet, tobacco and alcohol use with a number of other health issues. This presents opportunities to work together to improve both oral and general health. Good oral hygiene, particularly brushing twice a day with fluoride toothpaste is also key to maintaining good oral health.

The most robust data available to describe oral health is gathered through the **National Dental Inspection Programme (NDIP).** On an annual basis, all children in Primary 1 and Primary 7 attending local authority schools are offered a basic inspection to provide monitoring data and inform parents/carers of their child's oral health status.

In addition, in alternating years, a sample of children in Primary 1 or Primary 7 undergo a detailed inspection by trained and calibrated examiners which provides reliable information on the prevalence of dental decay.

In the most recent years for which data are available **79.3%** of children in Primary 1 in the Borders had no obvious decay experience in 2019-20 and **78.6%** of children in Primary 7 had no obvious decay experience in 2018-19[xii] .

The oral health of children has improved both locally and nationally in recent years and children in the Borders generally enjoy better oral health than the Scottish average. There are however still a significant proportion of children who do have experience of dental decay, with implications for their longer term oral health. Children living in more deprived areas are more likely to have experienced tooth decay.

There are no equivalent data on the oral health of adults in the Borders, however national data demonstrate improvements in oral health with increasing numbers of people retaining their natural teeth for longer. **93%** of the Scottish population had at least one natural tooth in **2019**[xiii] .

With an ageing population in the Borders, many of whom have retained their teeth, it is important to recognise the requirement to support day-to-day mouth care as part of fundamental personal care. This is essential to maintain their oral health and prevent dental problems developing.

An increase in the number of people with teeth also increases demand on dental services with a greater need for dental treatment. Treatment can become complex to provide as patients age and develop frailties or other medical conditions.

In 2021 **84.3%** of adults in the Borders were registered with an NHS dentist . There are **16 dental practices** in the Borders who provide NHS dental care, with additional NHS care provided by the Public Dental Service. While the primary purpose of the Public Dental Service is to provide care for patients with additional needs which make providing dental care more complex, the service in the Borders also provides some routine dental care to the general population.

Most dental practices in the Borders are working at capacity and at present very few are able to accept new NHS patients. This has become a particular challenge as a result of the COVID-19 pandemic which required practices to close for a period of time in 2020 and reduced throughput of patients due to the requirement for enhanced infection control and safety measures.

The Scottish Borders Health and Social Care Partnership has an active oral health improvement team who work with "priority groups" at greatest risk of poor oral health. This includes delivering the national Caring for Smiles programme for dependent older people and Open Wide for adults with additional care needs, which focus on supporting carers across various settings to deliver a high standard of daily oral care.

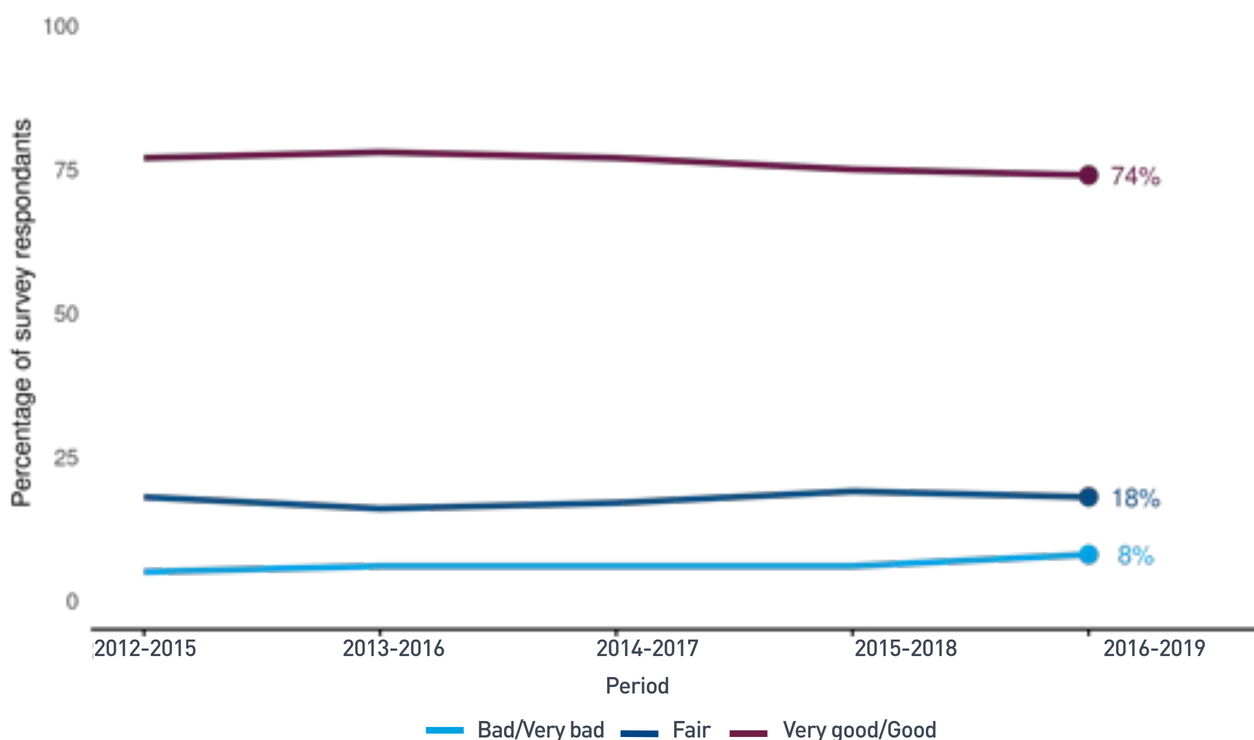
The team work with a wide range of partners across health, social care, the third sector and other agencies to maximise the oral health of vulnerable populations. They also deliver the national Childsmile programme, working with families, nurseries and schools to establish good oral health from a young age.

The Scottish Borders Oral Health Needs Assessment outlined a number of recommendations including: raising the profile of oral health, maintaining and improving oral health, meeting the oral health needs of ageing patients and other dental priority groups and promoting networking and engagement of dental teams with wider partners. A strategic plan for oral health and dental services will be developed to deliver on these recommendations.

General Health

This chart shows the percentage of survey respondents who rated their general health as "Bad/Very bad", "Fair", or "Good/Very good".

Figure 28: Self-assessed general health, 2012 - 2019



Data Source: *Scottish Health Survey* (Accessed June 2022)

In 2016 – 2019 **74%** of respondents rated their health as "Good/Very good", down 1% on the previous measurement and down 3% since the start of the time-series. **18%** of respondents selected "Fair" to describe their general health, which was also 1% down on the previous measurement, but equivalent to the level at the start of the time-series. **8%** of respondents rated their health as "Bad/Very bad" which was up 2% on the previous period, and up 3% overall since the start of the time-series.

This data shows that overall, Scottish Borders residents consider themselves to be in poorer health more recently than nearly a decade ago.

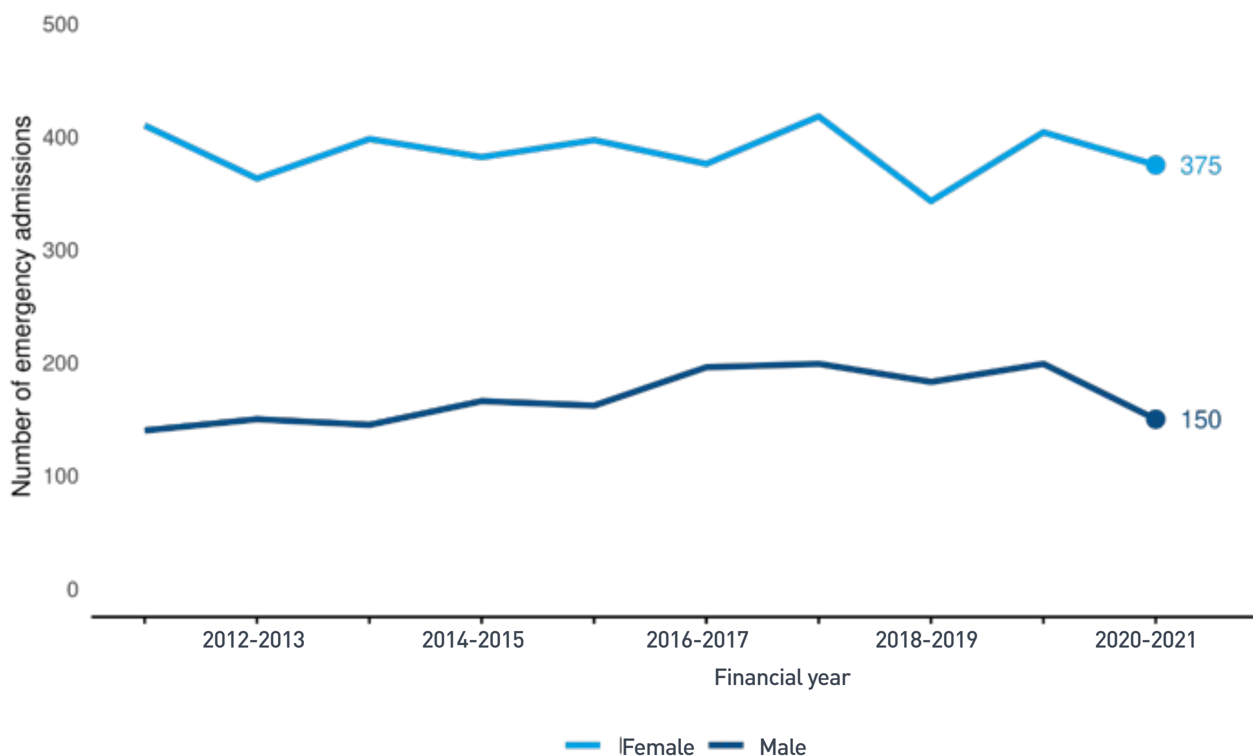
In Scotland (not plotted) in 2016-2019 72% of respondents rated their general health as "Good/Very good", while 19% rated it as "Fair", and 9% rated it as "Bad/Very bad". Scotland follows the same overall trend of a declining health perception. In comparison to Scotland, Scottish Borders residents rate their general health very slightly better, though not enough to be significant.

Falls Prevention

Harm from falls or fear of falling affect large numbers of people both physically and psychologically. Around 10% of falls result in a fragility fracture (a broken bone caused by a minor bump or fall) and 2% in a hip fracture . Following a fall a person might lose their independence and ability to do things they enjoy, impacting their mental health.

It is difficult to know the real numbers of people who fall each year as the numbers of falls recorded tend to be those who end up in emergency admission. In **2020/21** there were a total of **525** emergency admissions for unintentional injuries due to falls for people aged 65+.

Figure 29: Emergency hospital admissions following a fall (65+ years), 2011/12 to 2020/2



Data Source: *Public Health Scotland* (Accessed August 2022)

In 2020/21 in the Scottish Borders there were 18 emergency admissions per 1,000 people aged 65+, compared to 22 per 1,000 in Scotland. In the Scottish Borders the rate was 11 and 24 (per 1,000) for males and females respectively, meaning that females were more than twice as likely to have an emergency admission following a fall than males.

There was a decline in the numbers of emergency admissions due to falls between 2019/20 and 2020/21, most likely attributed to the COVID-19 pandemic and its wide-ranging effects. There are some service user groups who are at a higher risk of falling. The Falls and Fracture Prevention Strategy, 2019-2024 focuses on these key groups:

- Those who are ageing, which for some people, such as those with learning disabilities, may begin to have an impact earlier in life
- Those with underlying long-term conditions (such as dementia or stroke), visual impairment or frailty
- People with deconditioning caused by physical inactivity and/or being sedentary
- Those who have osteoporosis, affected adults are at higher risk of harm through fragility fractures.

The cost associated with falls is considerable. An economic evaluation published in 2013 estimated the annual cost to health and social care services in Scotland to manage the consequences of falls was in excess of £470 million .

Many falls and fractures could be prevented if multidisciplinary teams and organisations work together with the service user and their carer. Being physically active, improving muscle strength and balance, and ensuring good nutrition for bone health are all ways falls could be prevented.

With an ageing population and more people living longer with complex needs, falls prevention will become more important to ensure people live longer, healthier and active lives.

A multi-agency 'Falls Strategic Group' has been designed to support the development of falls prevention and management across the Borders Health and Social Care partnership. A Falls Strategy will be produced in 2022/23 in order to provide direction for services as they seek to develop pathways and services to support the prevention and management of falls and falls with harm.

Loneliness & Social Isolation

Feeling lonely is part of life, but feeling extended periods of loneliness can affect mental health and wellbeing.

Although they are related, there is a difference between loneliness and social isolation. Loneliness is a subjective experience, it is a feeling that there is a mismatch between the relationships people have and those they think they need. Social isolation is the objective lack of social contacts, which can be measured by the number of relationships a person has. Someone who is socially isolated isn't necessarily lonely and vice versa .

Around a third (33%) of people feel lonely or isolated in the Borders according to the Scottish Borders Household Survey, this ranges from 30% in Berwickshire to 35% in Cheviot. Around 7% often feel lonely and 23% feel lonely some of the time.

Table 30: Do you ever feel lonely or isolated?

Base	Overall 896	Berwickshire 148	Cheviot 158	Eildon 239	Teviot + Liddesdale 134	Tweeddale 195	Not known 22
Hardly, ever or never	61.6%	64.9%	60.8%	63.9%	56.7%	60.5%	63.6%
Yes, some of the time	22.8%	20.9%	25.3%	23.0%	23.9%	21.5%	18.2%
Yes, often	6.8%	6.1%	5.1%	8.8%	6.7%	7.2%	0.0%
Yes, at certain times of the year	3.2%	2.7%	4.4%	0.8%	3.7%	5.6%	0.0%
Prefer not to say	5.6%	5.4%	4.4%	3.8%	9.0%	5.1%	18.2%
Yes	**33%**	**30%**	**35%**	**33%**	**34%**	**34%**	**18%**

Data Source: *Scottish Borders Household Survey 2018* (Accessed June 2022)

The majority of people in the Scottish Borders meet socially with family, friends or neighbours at least once a week, with more of the 60 plus age group meeting socially at least once a week than the national average for Scotland. 7% of adults had met socially only a few times a year / very rarely or never.

While anyone can feel lonely there are some factors which may increase the likelihood such as living alone. The average household size in the Borders is projected to decrease by 6% to 1.98 by 2043. This is due to a rise in single adult and single pensioner households. Small adult families have increased since 2012 but remained largely similar for the previous few years. Since 2013 the number of older smaller households in the Scottish Borders has been significantly greater than Scotland as a whole. Large families and large adult groups have varied over the years but remained a small percentage of the population.

National levels of loneliness increased during the pandemic. People who were already feeling lonely before the pandemic were more affected during it. The pandemic was a particularly difficult time for older people or those with complex needs, who were generally considered more at risk of dying from the disease. This led to many people shielding and self-isolating for long periods of time.

The Borders Older Peoples Planning Partnership (BOPPP), engaged in a conversation to explore how older people have experienced the COVID 19 pandemic lockdown. During the lockdown period, 39% of respondents were on their own, 52% were with one other person. Of those considered 'vulnerable', 76% self-isolated most or all of the time. 30% of respondents felt they didn't receive enough support to meet their social needs. Although the engagement did not specifically ask about feelings of loneliness or isolation, it is known that social connections and support are a vital protective factor for mental health.

With an aging population in the Borders and many people (not just older people) living alone, loneliness and social isolation are issues that need to be addressed.

Substance Use

The **Borders Alcohol & Drugs Partnership (ADP)** is a partnership of agencies and services involved with drugs and alcohol. It provides strategic direction to reduce the impact of problematic alcohol and drug use. Membership includes lived experience representation and officers from the Scottish Borders Health and Social Care Partnership, Police Scotland and the Third Sector.

Drug Use

Problem drug use is the 'problematic use of opiates (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines and implies routine and prolonged use as opposed to recreational and occasional drug use' [Xviiii].

The most recent data collected nationally on problem drug is via the Prevalence of Problem Drug Use in Scotland: 2015/16 methods which states that 'much of problem drug using population is hidden therefore drug prevalence figures can only ever be estimated, combining data on observed cases with an estimate of the unknown population'.

Prevalence of drug use

The most recent estimation for Borders was provided from the 2015-16 report and shows a likely population of opiates/benzodiazepines drug users in Borders of **0.7%** of population aged 15 – 64 (510) compared with **1.62% in Scotland.**

Nationally males represent 68.5% of the estimated population compared to 31.5% females, this is reflected in Borders. This estimation is related to 'problem drug use' and, by its nature therefore does not estimate the more general and/or occasional use of drugs within the population.

The most recent Scottish Schools Adolescent and Substance Use Survey [xix] report on the percentage of 13 and 15 year olds using drugs in 2018 showed that 'drug use in the last month has been gradually decreasing since 2002, when 8% of 13 year olds and 23% of 15 year olds reported using drugs in the last month. However, between 2013 and 2018, there was an increase in the proportion of 13 year old and 15 year old boys who took drugs in the month prior to the survey (from 2% and 11% respectively in 2013, to 4% and 15% in 2018). Cannabis was the most widely used drug; 19% of 15 year olds had ever used cannabis. 6% of 15 year olds had ever taken ecstasy, 5% had ever taken cocaine and 5% had ever taken MDMA powder.'

Drug Related Deaths

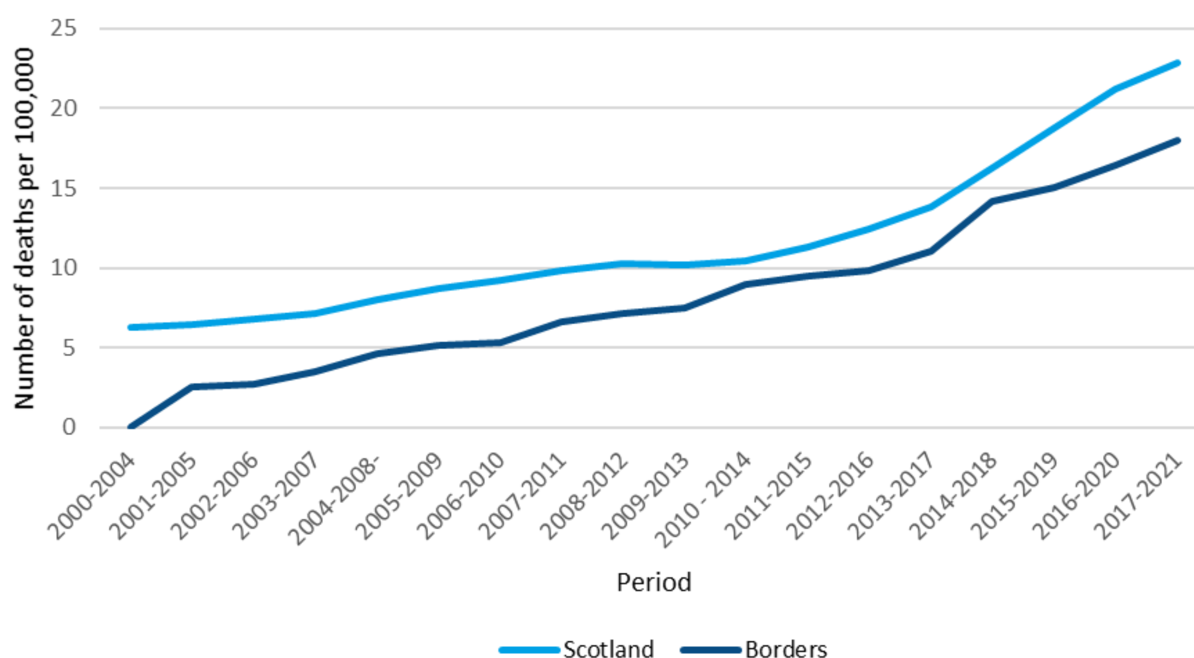
According to the annual National Records of Scotland's (NRS) Drug Related Deaths Report, 1,330 drug-related deaths were registered in Scotland in 2021, this was a 1% decrease on the previous year and the first decrease in seven years. This is, however, the second highest number ever recorded.

Males accounted for 70% of the drug-related deaths in 2021, a similar proportion to recent years. Males were 2.4 times as likely to have a drug-related death as females in 2021 but over time this gap has decreased; in the early 2000s males were more than 4 times as likely to have a drug related death as females.

Scotland's drug misuse death rate in 2020 was 3.7 times the rate for the UK.

In 2017-2021, Borders had a rate of 18 per 100,000 in comparison to 22.9 per 100,000 for Scotland.

Figure 31: Rate of Drug Related Deaths: 5 year average



Data Source: *National Records of Scotland* (Accessed August 2022)

Scottish Borders has a benchmarking 'family' which consists of seven similar local authority areas. The following table sets out how Borders death rates as a percentage of estimated prevalence of drug users compares with other councils in the same benchmarking family.

Table 32: Prevalence of drug users compared to benchmarking family

Area	Estimated number of problem drug users (2015/16)	Number of drug deaths according to NRS (2021)	Drug deaths as a percentage of the population at risk
Scottish Borders	510	17	3.3%
Angus	800	17	2.1%
Argyll & Bute	560	9	1.6%
East Lothian	920	16	1.5%
Highland	1,400	35	1.7%
Midlothian	760	23	2.5%
Moray	270	17	6.2%
Stirling	1,000	16	1.6 %

Data Source: *National Records Scotland* (Accessed August 2022)

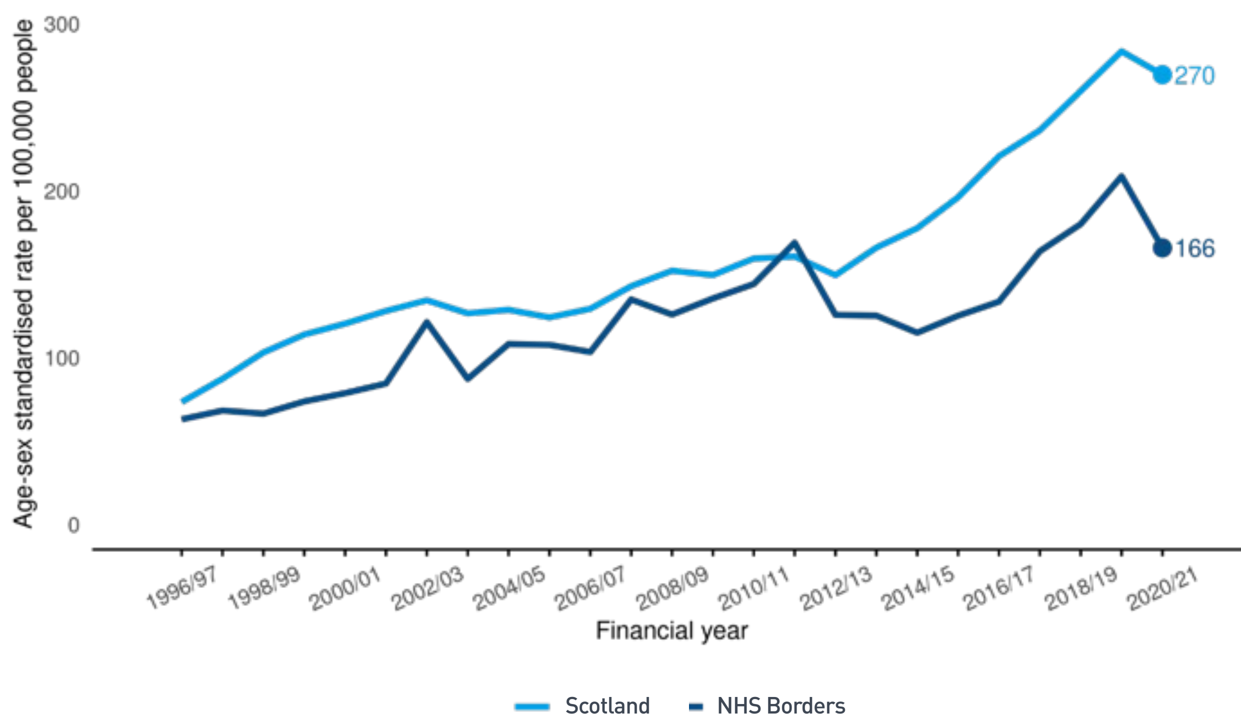
Drug Related Hospital Stays

Between 1996/97 and 2019/20, there was a greater than threefold increase in the rate of drug-related hospital stays in Borders from 63 per 100,000 population in 1996/97 to **209** stays in 2019/20. There is a sharper increase observed in recent years which is similar to the national trend.

In 2019/20, there were **81 new people** who were treated in the Borders (general acute hospital or psychiatric hospital) in relation to drug use for the first time. The drug-related new patient rate increased from 55 new patients per 100,000 population in 2006/07 (55 Scotland) to 86 new patients per 100,000 population in 2019/20 (103 Scotland).

Between 1996/97 and 2019/20, drug-related patient rates for males were consistently more than double the rates for females.

Figure 33: Drug – related hospital stays, age-sex standardised rate, 1996/7 to 2020/21 (any hospital type; any diagnoses; any drug type)



Data Source: *Public Health Scotland* (Accessed September 2022)

Alcohol Use

Alcohol is a drug that causes a wide range of negative impacts. A range of health problems can be seen as a result of excessive consumption of alcohol. Acute intoxication (drunkenness) or poisoning can be seen after a single episode of excessive consumption, while other long-term health related problems can occur, such as damage to the liver and brain. Alcohol use is also associated with certain cancers. The more people drink, the more the health and social problems caused by alcohol increase. The impact is not just on the person who drinks; family, friends, colleagues and strangers can be harmed by someone else's alcohol use.

Drinking at hazardous/harmful levels

In Scottish Borders, nearly 1 in 3 men **(31%)** and more than 1 in 6 women **(18%)** were drinking at hazardous/harmful levels (2016/19).

According to Scottish Health Survey (2016/2017/2018/2019 combined), 24% of all adults (aged 16 and over) in Borders are drinking above low risk guidelines (14 units per week) which is the same as Scotland average.

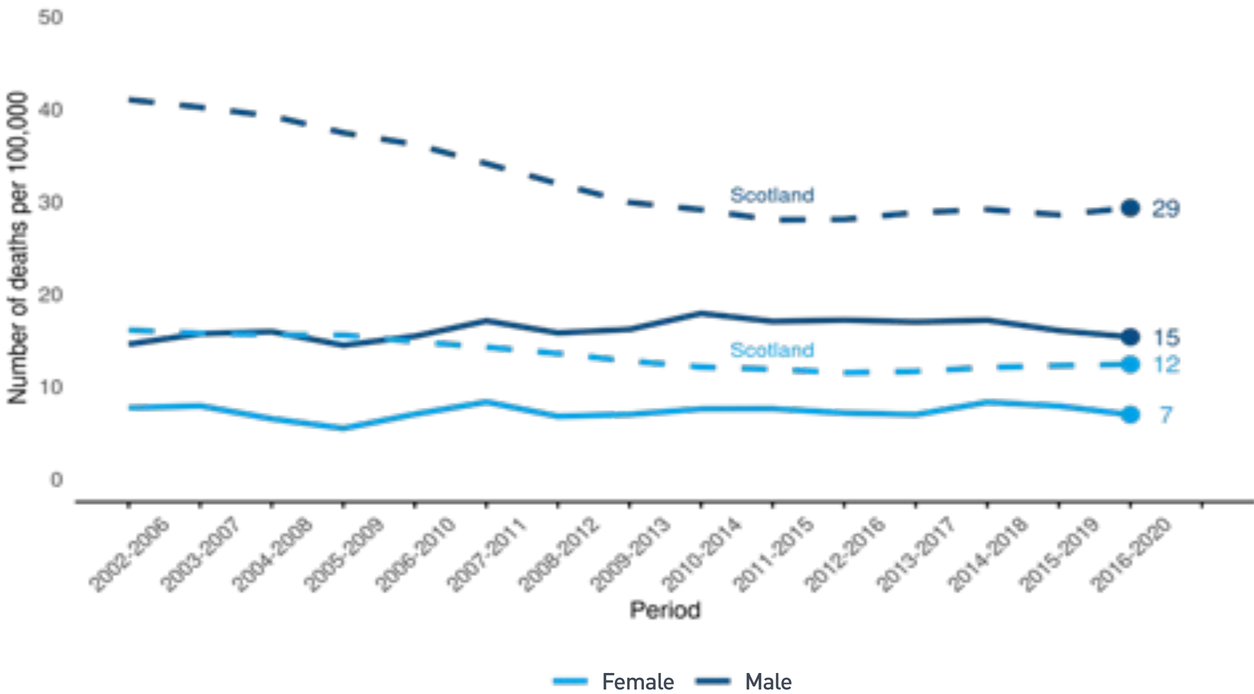
In all health boards, a higher proportion of men than women drank out with the guidelines.

The proportion of males drinking at harmful levels in Borders had a significant drop from 38% (2012/15) to 31% (2016/19). Scotland's male population drinking at harmful levels remained fairly stable (from 36% to 33%). There is minimal change in the proportion female population drinking at harmful level from 2012/15 (17% Scotland; 16% Borders) to 2016/19 (16% Scotland; 18% Borders).

Alcohol related deaths

Since 2002 – 2006 the rate of alcohol-specific deaths for Scottish Borders males and females has been relatively constant at 15 and 7 per 100,000, respectively. These rates have continuously been well below the Scottish average for males and females.

Figure 34: Alcohol-specific deaths, 5-year aggregates, 2002-2020



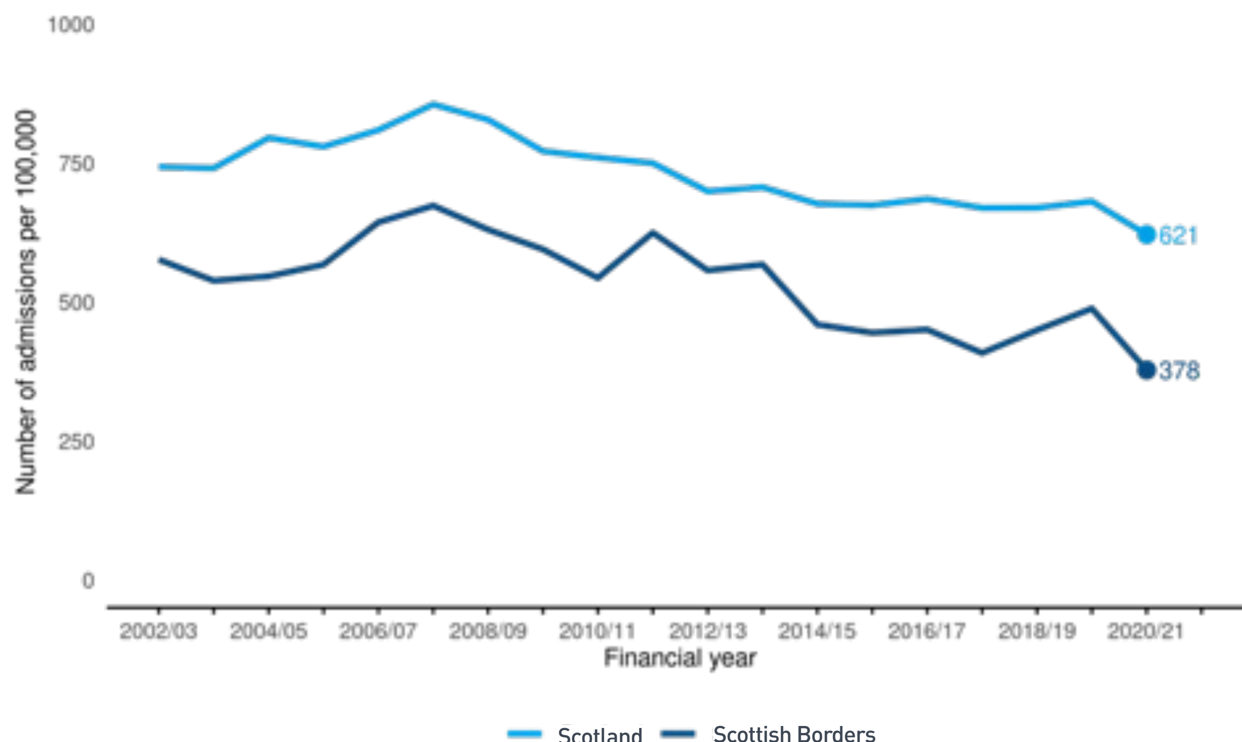
Data Source: *Scottish Public Health Observatory* (Accessed June 2022)

Alcohol related hospital stays

The rate of alcohol-related hospital admissions for the Scottish Borders has consistently been below the average for Scotland since 2002/03. In 2020/21 the rate of admissions per 100,000 people was 621 for Scotland, and 378 for the Scottish Borders, 40% less than the Scotland rate.

Scottish Borders Health and Social Care PARTNERSHIP

Figure 35: Alcohol – related hospital admissions per 100,000 people, 2002/03 to 2020/21



Data Source: *Scottish Public Health Observatory* (Accessed June 2022)

Number of people starting treatment in Drug & Alcohol Services
There are two alcohol and drug treatment services in the Scottish Borders: Borders Addiction Service and We Are With You.

Borders Addiction Service (BAS)

The average number of people who started treatment in 2021-22 was **28 per quarter** and is lower than in previous years. This reduction in number reflects the work the Borders Addiction Service has done during 2019-20 to reduce barriers to access and to retain people in treatment which resulted in an increase of people on Medication Assisted Treatment (MAT) and a reduction in unplanned discharges. The caseload in the Borders Addiction Service at end March 2022 was 420 compared to 352 at end March 2019 representing a 19% increase.

We Are With You (WAWY)

The average number of people who started treatment in 2021-22 was **114 per quarter** compared with 107 in previous year. The caseload in We Are With You at the end March 2022 was 267 compared to 189 at end March 2019 representing a 41% increase.

Community Justice

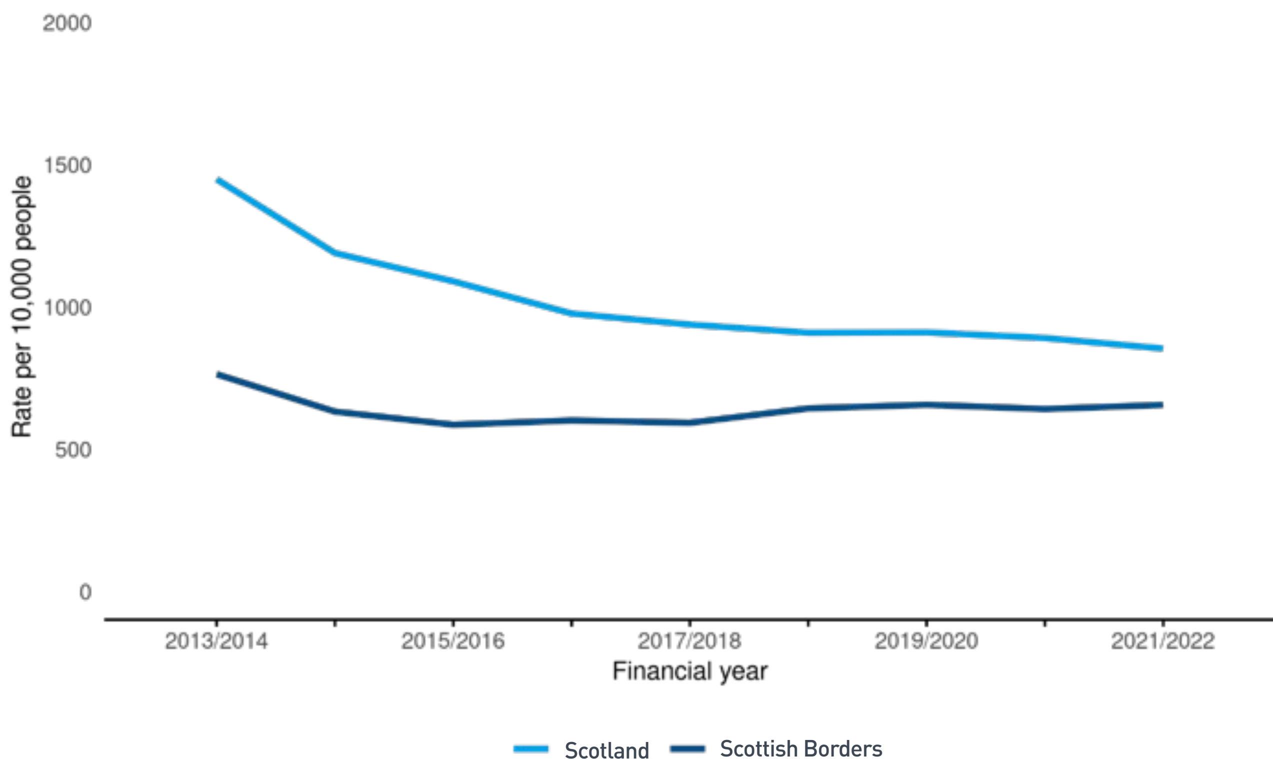
Community Justice seeks to prevent people committing crimes or reoffending. It builds on existing social work services and focuses on assisting people who have left prison or who are subject to a community court disposal to address social issues and improve poor decision making processes that contributed to their offending behaviour.

The Community Justice Scotland Act (2016) requires a range of statutory partners to co-operate in planning how local services are delivered to support prevention and a reduction in the number of people re offending. The list of statutory partners are:

- Police Scotland
- Health and Social Care Partnerships
- Integrated Joint Boards for Health & Social Care
- Scottish Courts and Tribunals Service
- Scottish Fire & Rescue Service
- Skills Development Scotland
- Crown Office & Procurator Fiscal Service
- Scottish Prison Service.

The rate of crimes and offences in the Scottish Borders has consistently been below the Scottish average, but in recent years the gap has narrowed.

Figure 36: All crimes and offences: Rate per 10,000 people, 2013/14 to 2021/22



Data Source: *Statistics.gov.scot* (Accessed August 2022)

In 2021/22 the rate of recorded crimes and offences per 10,000 people was **655** in Scottish Borders, compared to **853** in Scotland. In the Scottish Borders this was an increase on the previous financial year from 641.

In the most recent year, "crimes of dishonesty", "road traffic offences", and "non-sexual crimes of violence" were the sub-categories attributed to the greatest numbers of recorded crimes and offences, accounting for about 18% each. Crimes of dishonesty includes theft and fraud in various forms.

More specifically, "common assault", "threatening and abusive behaviour", and "vandalism" top the list of crimes/offences reported to the police in the last 3 financial years, at 13%, 12%, and 10%, respectively.

Key data about Community Justice in the Scottish Borders:

- There were 88 people in custody in July 2022.
- The majority of people leaving prison are on state benefits.
- Recorded Crime in the Scottish Borders has risen from 4,539 crimes in 2019/20 to 4,893 in 2021/22. Reports of common assault overall have increased by 60% since 2017/18.
- A number of people may present as homeless after leaving prison. Discharge from prison/ hospital/ care/ other institution accounted for 5% of homeless assessments in 2020/21 .

In February 2020 the Community Justice team asked Prisoners from the Scottish Borders how they felt the support network in the justice system was for them. A total of **37** people in the justice system participated in the process. Housing, support with mental health, employment and offending attitudes came out as having the greatest influence on future behaviour.

The Scottish Government Vision for Justice (2022) seeks to make the justice services more person-centred and focused on prevention and early intervention. There are four key aims as part of the Scottish Government National Strategy for Community Justice (2022):

1. Optimise the use of diversion and intervention at the earliest opportunity
2. Ensure that robust and high quality community interventions and public protection arrangements are consistently available across Scotland
3. Ensure that services are accessible and available to address the needs of individuals accused or convicted of an offence
4. Strengthen the leadership, engagement, and partnership working of local and national community justice partners

5. LONG-TERM CONDITIONS

Cancer

Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs.

Cancer sometimes begins in one part of the body before spreading to other areas. This process is known as metastasis.

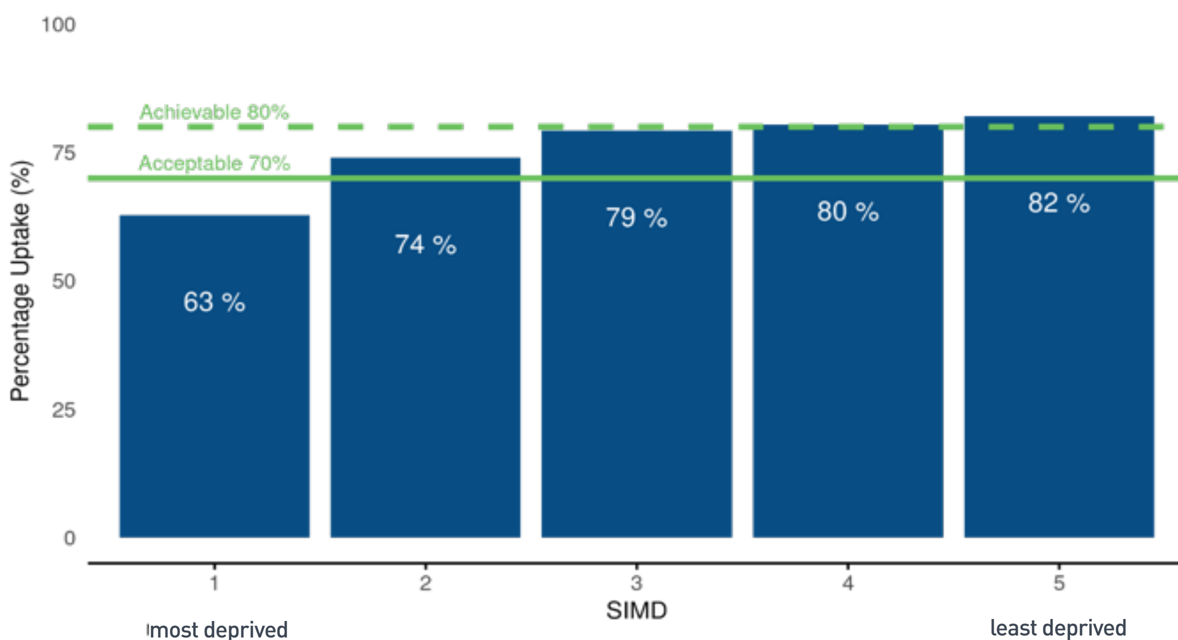
1 in 2 people will develop some form of cancer during their lifetime. There are more than 200 different types of cancer.

Between 2016-2020, there has been an average of **813** cancers diagnosed per year in NHS Borders, with the most common being Breast **(118)**, Lung **(117)**, Prostate **(111)** and Colorectal **(107)**.

Cancer is primarily a disease of old age, and although the Borders population is not predicted to increase significantly over the next 20 years, it is predicted that there will be an increase of over 30% in the number of residents aged over 65. It is projected that the average annual incidence of cancer in the Borders will increase to around **900** patients by 2022 and **1,000** by 2027[xxiv] .
In 2020, there were **414** deaths from cancer within the Scottish Borders.

In Scotland, for the last 10 years, **52.7%** of breast cancer registrations in women aged **50-79** were detected through the breast screening programme, but this figure dropped to **39%** in 2020.

Figure 37: Scottish Breast Screening Programme: Acceptance by SIMD quintile, 2018/19 to 2020/21 combined

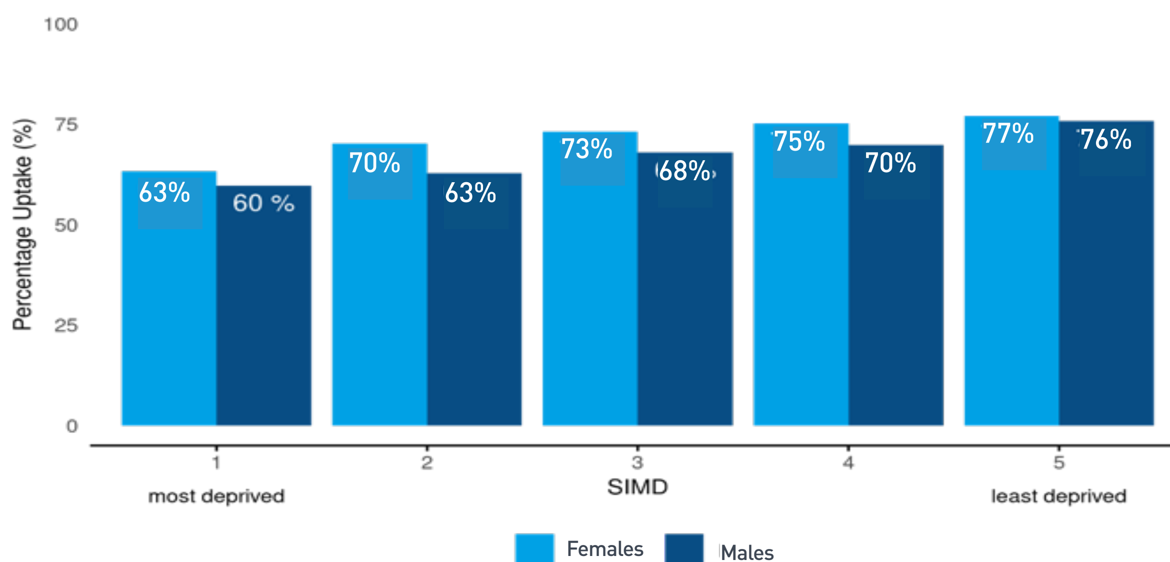


Data Source: *Public Health Scotland* (Accessed August 2022)

The standard set by Healthcare Improvement Scotland for bowel screening between 1st May 2019 and 30th April 2021 was **60%**. All eligible people were invited to screening between these dates. Scottish Borders rates met this standard in all SIMD quintiles.

The programme was paused in March 2020 due to the COVID-19 pandemic and resumed in October 2020. As a result, the screening population in this publication is smaller, at 1.4m compared with 1.8m for previous publications.

Figure 38: Uptake for bowel screening by SIMD quintile, 1st May 2019 to 30th April 2021



Data Source: *Public Health Scotland* (Accessed August 2022)

The number of people living with cancer at any one time is increasing, not only as a result of advances in cancer treatments, but also due to effective screening programmes, early detection and improved diagnostics. However, health inequalities remain evident with increased cancer incidence and mortality linked to deprivation and reduced uptake of screening programmes.

The cancer services provided within the Scottish Borders recognises the excellent track record not only in relation to ensuring patients are diagnosed and treated within recommended time frames but also in delivery of care as close to home as is safely possible. Services support and engage fully in the national screening and detect cancer early programmes acknowledging the importance of prevention and early detection in improving outcomes. Significant progress in the development of support services and programmes of care for patients during and after treatment has been made.

It is recognised that the increase in number of people diagnosed and living with cancer will place further demand on current services and that the increasing age profile of people using these services will bring further challenges as they are more likely to present with multiple and complex health and social care needs. The advent of new diagnostic methods, therapies and technology will bring further challenges as well as opportunities for local cancer services.

It is key that services continue to be reviewed to identify new and novel approaches to cancer care to ensure person centred, safe and sustainable services are provided which will meet the changing needs of people with cancer as well as meet the predicted increase in demand.

Respiratory Conditions

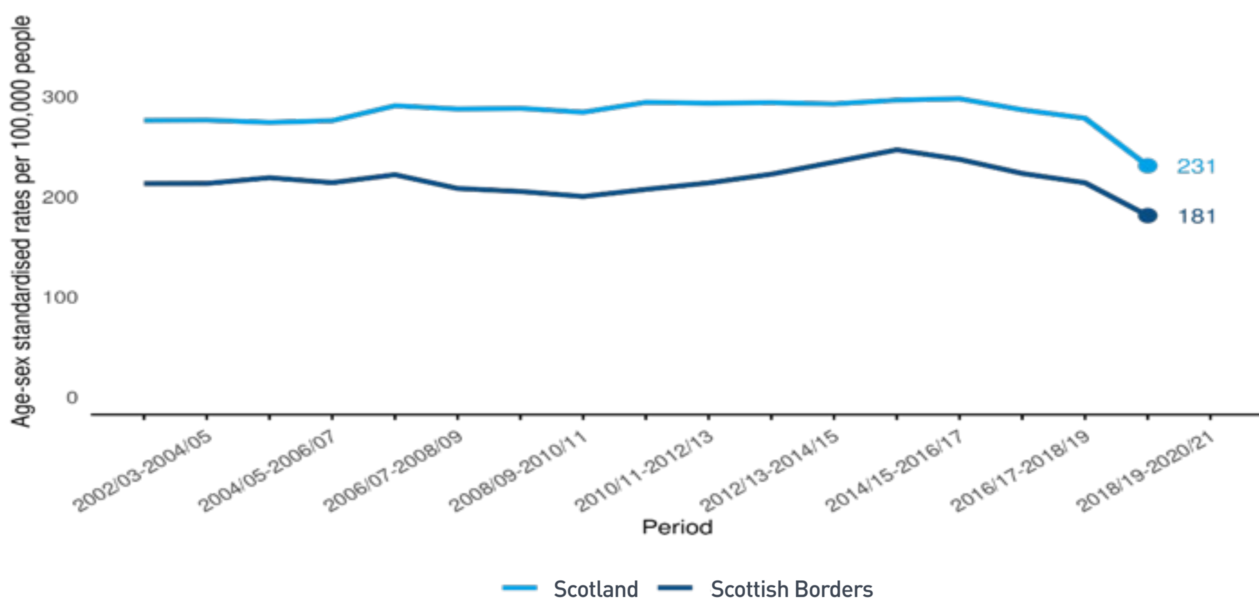
Respiratory conditions are diseases which affect the airways and structures of the lungs.

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease is an "umbrella" term for a number of progressive lung diseases such as emphysema, chronic bronchitis, and refractory (non-reversible) asthma. It is often characterized by persistent respiratory symptoms (such as breathlessness, cough and sputum production) and airflow obstruction (usually progressive and not fully reversible).

People suffering from Chronic Obstructive Pulmonary Disease can have acute episodes of worsening symptoms (exacerbations) requiring treatment with antibiotics and oral steroids. It is currently an incurable disease however with the correct diagnoses and treatments, those with Chronic Obstructive Pulmonary Disease can be supported to manage their condition and have a good quality of life.

Figure 39: COPD hospitalisations: Age-sex standardised rates, 3-year aggregates, 2022/03 – 2020/21



Data Source: *Scottish Public Health Observatory* (Accessed August 2022)

Chronic Obstructive Pulmonary Disease hospitalisation rates are based on a person's first Chronic Obstructive Pulmonary Disease related hospital admission each year. The Scottish Borders Chronic Obstructive Pulmonary Disease hospitalisation rates have remained consistently lower than the Scottish average. In 2018/19 to 2020/21 the rate of Chronic

Obstructive Pulmonary Disease -hospitalisations was 181 in 100,000, down from 214 in the previous period. In Scotland the rate was 231 in 100,000, down from 278. This decrease is likely due to the impact of COVID-19 on hospital admissions in 2020 and 2021.

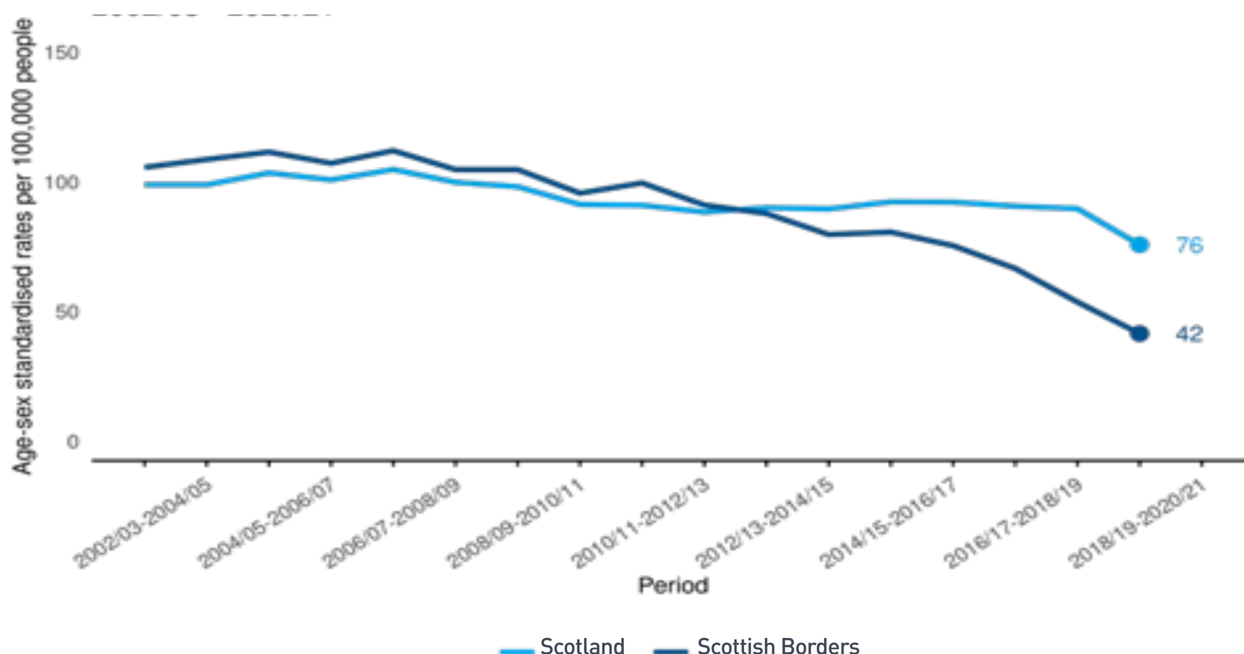
The death rate for those with Chronic Obstructive Pulmonary Disease was 53 in 100,000 for 2020, this is a large decrease since 2002-2004 where the death rate was 83 per 100,000. This is also below the Scottish average which had a death rate of 90 per 100,000 in 2002-2004 down to 67 in 2020.

Asthma

Asthma is a chronic respiratory condition associated with air way inflammation and hyper responsiveness. The disease is heterogeneous, with different underlying disease processes and variations in severity, clinical course and response to treatments.

Asthma is characterised by symptoms including cough, wheeze, chest tightness, and shortness of breath, and variable expiratory air flow limitation, that can vary over time and intensity. Acute Asthma exacerbation is a term used to describe the onset of severe asthma symptoms, which can be life threatening.

Figure 40: Asthma hospitalisations: Age-sex standardised rates in 3-year aggregates, 2002/03 – 2020/21



Data Source: *Scottish Public Health Observatory* (Accessed August 2022)

The rate for asthma related hospitalisations was initially greater than Scotland, starting at 106 per 100,000 in 2022/03 compared to 99 in 100,000 in Scotland. It has since declined far below Scotland averages to 42 per 100,000 in 2018/19 – 2020/21. The steep decline in recent years is again likely related to the impact of the COVID-19 pandemic on hospital admissions in 2020 and 2021.

Impacts of COVID-19

The COVID-19 pandemic brought huge challenges to the existing stretched and under resourced respiratory service, requiring the specialist nursing service to adapt to the challenges faced and deliver their service accordingly.

Regular telephone support was provided to Long Term Oxygen Therapy (LTOT) users and clinic attenders. Self-management plans, education and exacerbation awareness were shared with service users as well as psychological support regarding COVID-19 and its potential implications.

Although the worst effects of the pandemic have passed, appropriate infection control measures remain in place when delivering face to face reviews where it is deemed safe and appropriate. Service users also have the option to contact the service on an ad hoc basis with concerns or for crises management. This helps ensure admission avoidance to hospital through provision of advice and support.

Neurological Conditions and Stroke

Neurological conditions include a wide range of conditions, disorders and syndromes affecting the brain, spinal cord, nerves and muscles.

Well known conditions include migraine, multiple sclerosis, epilepsy, and Parkinson's disease.

Neurological conditions are caused by a range of diverse pathologies. These may be:

- congenital (e.g., cerebral palsy)
- hereditary/genetic (e.g., Huntington's disease)
- neoplastic (e.g., brain tumours)
- degenerative (e.g., motor neurone disease),
- infective (e.g., meningitis)

Neurological conditions range from the common to the very rare. The cause of many common conditions remains uncertain[xxv].

Multiple Sclerosis

The total number of patients in Scotland newly diagnosed and reported over a 12 year period was 5,898. Of these, 106 patients were Scottish Borders residents at the time the data was recorded. This number represents just under 2% of the total in Scotland.
In the Scottish Borders the average number of people recorded to be newly diagnosed with Multiple Sclerosis each year is around 9, although an above average number were newly

diagnosed in 2018 and 2020, at 15 respectively. In 2021 the Scottish Borders had one of the lower rates of new Multiple Sclerosis cases in Scotland, at 8.7 per 100,000 people. In Scotland the rate was 10.6 per 100,000.

In 2021, 80% of patients newly diagnosed with Multiple Sclerosis waited 2 weeks or less to make first contact with a specialist Multiple Sclerosis nurse, compared to 88% in Scotland. In the Scottish Borders this equated to 8 out of 10 people newly diagnosed.

In general, the number of people in Borders diagnosed with Multiple Sclerosis each year is statistically low, and therefore caution should be used when comparing statistics to Scotland. For example, individual circumstances could affect when people are able to see a specialist nurse.

Motor Neurone Disease and Parkinson's Disease

Motor Neurone Disease is a rare condition that affects around two in every 100,000 people in the UK each year. There are about 5,000 people living with the condition in the UK at any one time. Motor Neurone Disease can affect adults of all ages, including teenagers, although this is extremely rare. It's usually diagnosed in people over 40, but most people with the condition first develop symptoms in their 60s. It affects slightly more men than women.

Around 1 in 375 adults in Scotland are affected by Parkinson's Disease. Most people with Parkinson's start to develop symptoms when they're over 50, although around 1 in 20 people with the condition first experience symptoms when they're under 40. Men are slightly more likely to get Parkinson's disease than women. As the Scottish Borders population increases and the number of old people increases, it is expected that the number of people with Parkinson's Disease will increase.

Table 41: Number of diagnoses for Motor Neurone Disease and Parkinson's Disease 2019/20

Acute Outpatients		2019/20	2020/21	2021/22
Motor Neurone Disease	New Patients	0	0	0
	Total Patients	10	0	9
	Total Appointments Attended	29	0	10
Parkinson's Disease	New Patients	49	20	62
	Total Patients	198	105	401
	Total Appointments Attended	336	117	1348

Data Source: *NHS Borders* (Accessed September 2022)

Cerebrovascular Disease (CVD)

In 2020 the rate of Cerebrovascular Disease (CVD) hospitalisations was **603** per 100,000 for males and **414** for females. These rates had declined by **10%** and **27%** for males and females respectively from the previous year. In Scotland the rate of Cerebrovascular Disease hospitalisations had been increasing gradually since 2011, but from 2016 had

levelled out at a steady rate until 2020 (pandemic). Cerebrovascular Disease is more common in older people and men have a higher risk of Cerebrovascular Disease /stroke.

In 2020 there were **93** deaths of Scottish Borders residents caused by Cerebrovascular Disease, of which 59% were males.

Over the last decade the death rates from Cerebrovascular Disease have been decreasing in Scotland, by around **25%** for males and **28%** for females. The death rate for Scottish Borders females has followed a similar trend while staying slightly below the Scottish average in most years. The death rate for Scottish Borders males has fluctuated around the average and in 2020 was below the Scottish average by **22%**.

While the death rate from Cerebrovascular Disease in 2020 was greater for females than in males of all ages, the death rates in individual age groups vary. Females aged 65 to 74 years were at a lower risk of dying from Cerebrovascular Disease than males in the same age group, by 20%. Whereas females aged 75+ were 39% more likely to die from stroke than males aged 75+.

Stroke

A stroke occurs when the blood supply is cut off to part of the brain, killing brain cells. Damage to the brain can affect how the body works and it can also change how a person thinks and feels. The effects of a stroke depend on where it takes place in the brain, and how big the damaged area is.

There are various risk factors for stroke including:

- Age
- Medical conditions (e.g., high blood pressure, cholesterol and diabetes)
- Lifestyle factors (e.g., diet, weight, smoking and alcohol intake)

In 2020/21 the incidence rate for Stroke in Scottish Borders males was **178** per 100,000 people, and in females was **158**. These rates were **11%** and **2%** lower for males and females respectively compared to the previous year, a decline which may be related to the COVID-19 pandemic.

The incidence rates for males and females in the Scottish Borders have fluctuated high and low of the Scotland rates over time with the latest rate for females being **5%** greater and for males being **10%** lower in the Scottish Borders.

In 2020 the rate of hospitalisations for stroke was 369 per 100,000 for males and 296 for females. These rates had declined by 17% and 11% for males and females respectively from the previous year.

On average in the Scottish Borders the rate of stroke-related hospitalisations is 26% lower for females than males, though this value has fluctuated over the time-series. The gap is roughly the same between males and females in Scotland, and it has been gradually widening over the past ten years.

In the Scottish Borders the risk of stroke-related hospitalisations is **12** times greater in males aged 75+ than those aged under 75 years and is **19** times greater in females aged 75+ compared to those aged under 75 years. The rate increases with age.

In 2020 there were **65** deaths of Scottish Borders residents caused by stroke, of which **61%** were males. The death rate from stroke was greater in females than in males by **21%** at **50** per 100,000 for females and **41** per 100,000 for males.

Compared to the previous year the death rate had increased by **13%** for females and had decreased by **18%** for males.

Over the last decade the death rates from stroke have been decreasing in Scotland, by around **24%** for males and **28%** for females.

While the death rate from stroke in 2020 was greater for females than in males of all ages, the death rates in individual age groups vary. Females aged 65 to 74 years were at a lower risk of dying from stroke than males in the same age group, by 18%. Whereas females aged 75+ were 42% more likely to die from stroke than males aged 75+.

Coronary Heart Disease

Coronary Heart Disease (CHD), is the term that describes what happens when the heart's blood supply is blocked or interrupted by a build up of fatty substances in the coronary arteries.

Coronary Heart Disease cannot be cured but treatment can help manage the symptoms and reduce the chances of problems such as heart attacks.

The risk of getting Coronary Heart Disease can be reduced by making some simple lifestyle changes including:

- eating a healthy, balanced diet
- being physically active
- giving up smoking
- controlling blood cholesterol and sugar levels

In 2020/21 the incidence rate for Coronary Heart Disease was **399** in Scottish Borders males and **210** in Scottish Borders females. This means that males were almost twice as likely as females to be admitted to hospital or die from Coronary Heart Disease, which is a continuing trend since 2011/12.

In 2020/21 females in the Scottish Borders had an equivalent rate of incidence as the Scottish average for females, while the rate for males was slightly below the Scottish average for males by **9%**.

With respect to age, Scottish Borders males aged 75+ were twice as likely to have Coronary Heart Disease compared to those aged 65 – 64, while females aged 75+ were more than 3 times as likely to have Coronary Heart Disease as those aged 65 – 74.

In the last decade in the Scottish Borders the rate at which new cases of Coronary Heart Disease occurs has fallen by **26%** for males and **22%** or females.

Diabetes and Obesity

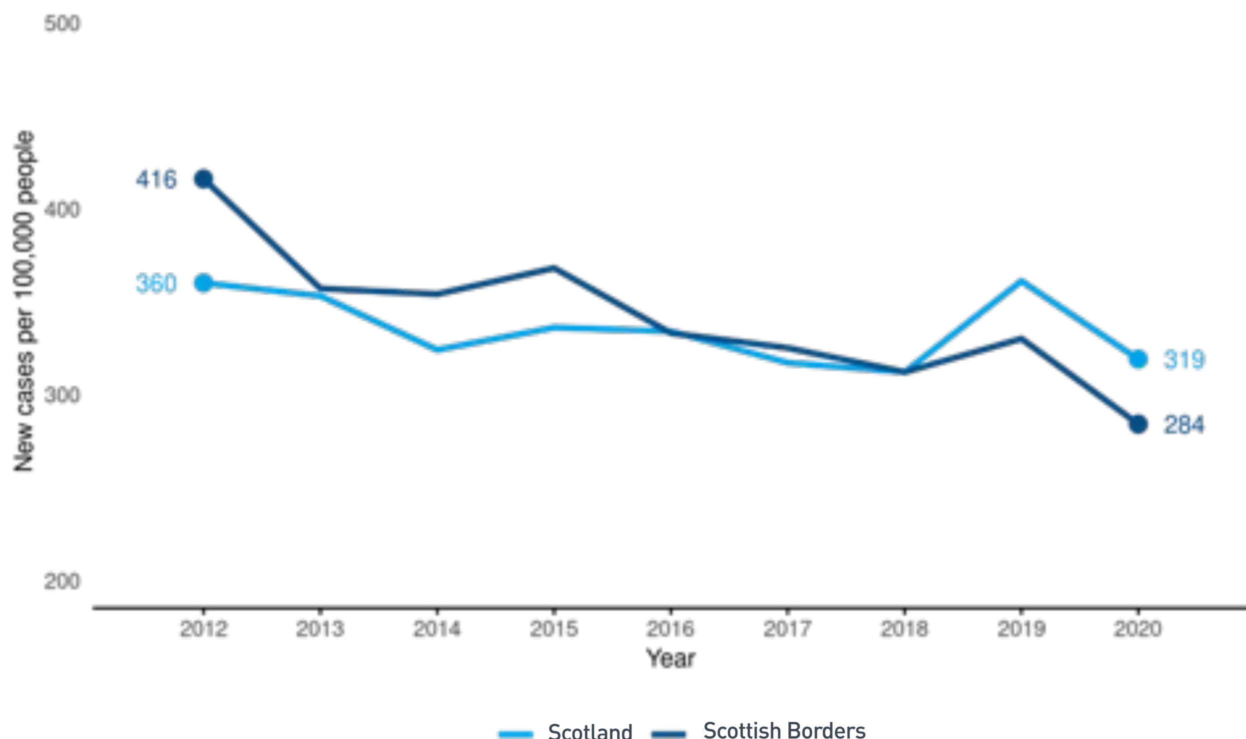
Diabetes is a long term condition where the pancreas cannot make insulin or a sufficient amount of insulin to keep blood glucose within normal limits . High glucose levels can cause damage to the body as well as major organ failure. It is a major cause of coronary heart disease, stroke, kidney failure, blindness, amputation and premature death.

Type 1 Diabetes is where the body's immune system attacks and destroys the cells that produce insulin[xxvii]. Type 1 Diabetes accounted for 10.7% of all cases of diabetes in Scotland in 2019[xxviii] .

Type 2 Diabetes is where the body does not produce enough insulin, or the body's cells do not react to insulin[xxix]. Type 2 diabetes accounted for 87.9% of all cases of diabetes in Scotland in 2019[xxx] .

In 2020, the total number of people on the Diabetes Register (all types) at the end of the year was **6,992**, 87% of which were Type 2. This is a crude prevalence of **5.2%** of the population (Scotland was 5.8%). This is a drop compared to 2019 where the total number was 7,032 in the Scottish Borders.

Figure 42: Diabetes type 2: New cases per 100,000 people, 2012 to 2020



Data Source: *Diabetes in Scotland Survey* (Accessed August 2022)

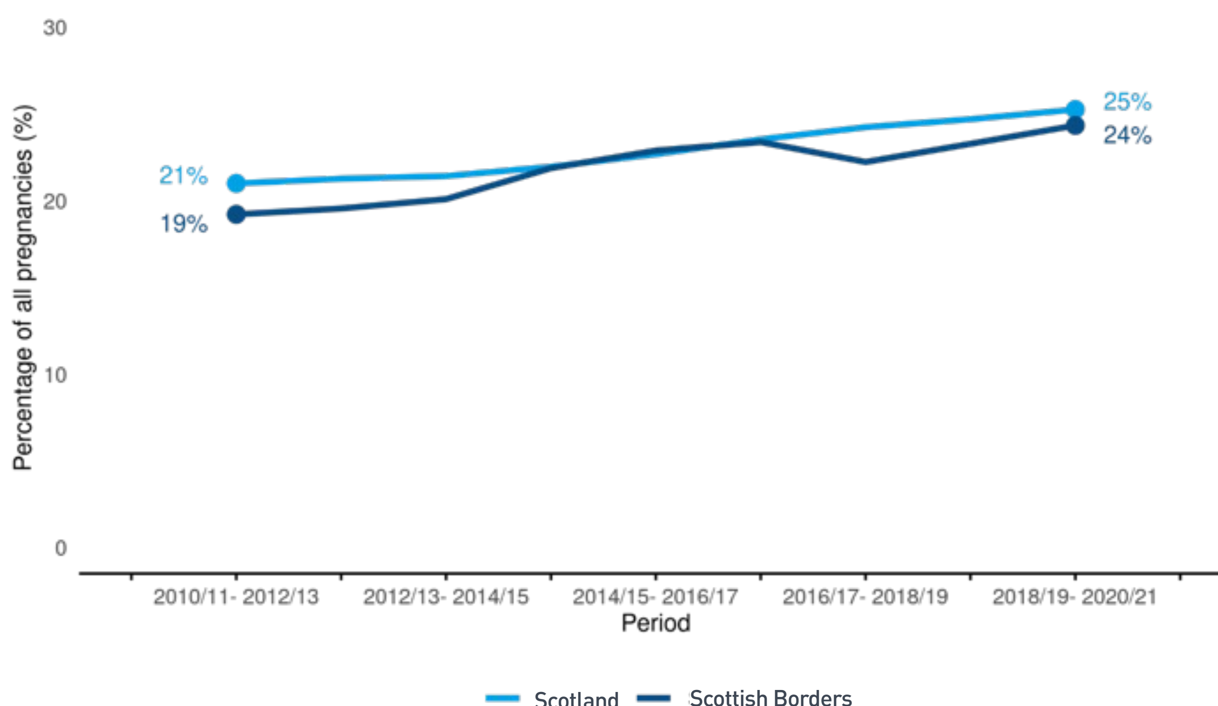
The rate of new cases of Type 2 Diabetes in the Scottish Borders has declined from 416 to 284 since 2012, a 31% reduction. The steep drop in 2019 is likely attributed to a disruption of screening services during the COVID pandemic.

Weight Management and Diabetes

Type 2 Diabetes Mellitus (DM) is associated with obesity[xxxi]. As the incidence of people living with obesity increases it is anticipated diagnoses of Type 2 diabetes will also increase. Roughly 20% of referrals to the Borders Weight Management team from 04/2021-03/2022 were later diagnosed with diabetes. Those considered at 'high risk' of getting diabetes also include those with pre-diabetes (who have Impaired Glucose Tolerance (IGT) or Impaired Fasting Hyperglycaemia (IFHG)) and those who have gestational diabetes or polycystic ovary syndrome (PCOS)[xxxii].

Gestational Diabetes Mellitus (GDM) is when women are diagnosed with diabetes during pregnancy, which usually disappears after birth. Up to 50% of women who have Gestational Diabetes Mellitus will develop impaired glucose metabolism within 10 years[xxxiii]. There were 66 referrals for those with Gestational Diabetes Mellitus from 04/2021-03/2022, 68% of whom had a BMI →30.

Figure 43: Maternal obesity as a percentage of all pregnancies, 3-year aggregates, 2010/11 – 2020/21*



Data Source: *Scottish Public Health Observatory* (Accessed August 2022).
*Data recorded by financial year – April to April

Maternal obesity is when pregnant women have a BMI ↗ 30 at antenatal booking. Maternal obesity rates in the Scottish Borders have increased from 19% to 24% since 2010. In the same timeframe the average rate of maternal obesity in Scotland has also increased year on year from 21% to 25%.

Recent research has shown that it is possible to reverse a diagnoses of type 2 diabetes if managed quickly post-diagnoses and through intensive weight management programmes.

Overall obesity is increasing in the Scottish Borders and in Scotland, this increases the likelihood of more diabetes becoming diagnosed in future. The Borders Weight Management team received 407 referrals in 04/2021-03/2022, an increase of 38% since before the pandemic (year 04/2019-03/2020 which had 294 referrals).

It is estimated that around 10% of cases of Type 2 Diabetes remain undiagnosed[xxxiv]. Delayed diagnoses of Type 2 Diabetes results in increasingly complex presentations requiring intensive treatment and interventions. It may also require the need for earlier prescription of oral hypoglycaemic medications. Consequences of undiagnosed and untreated diabetes may contribute to diabetes related complications. This is more costly to deliver and results in poorer outcomes for the patient.

Treatment for diabetes is estimated to cost around 9% of the Scottish NHS budget[xxxv], this figure is expected to grow as a result rising numbers of obesity and increasingly ageing populations. Early identification and prevention can reduce this high cost.

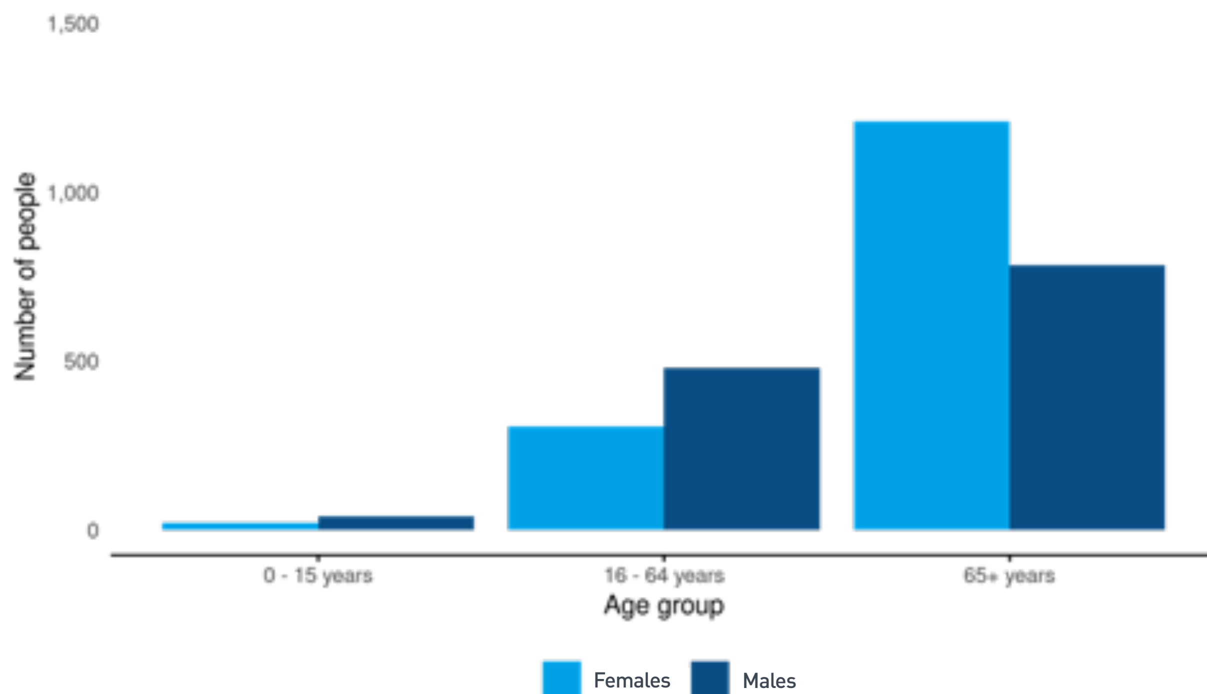
Sensory Impairment

Sensory impairment is a common term used to describe those who have a visual impairment (those who are registered severely sight impaired and partial sighted), a hearing impairment (those who are Deaf, deafened or hard of hearing) or both (Deafblindness).

Visual Impairment

There are an estimated 178,000 people living with a significant degree of sight loss in Scotland[xxxvi]. In the 2011 Census there were 2,839 people who responded that they experienced severe sight loss or partial sight loss, this represents 2.5% of the Scottish Borders population.

Figure 44: Number of people who registered as having severe or partial sight loss



Data Source: *National Resources Scotland* (Accessed August 2022)

Majority of those recorded having sight loss aged 16+ said they were retired (71%) A further 17% said they were employed (either full or part time, including self-employed), and 1.7% were unemployed.

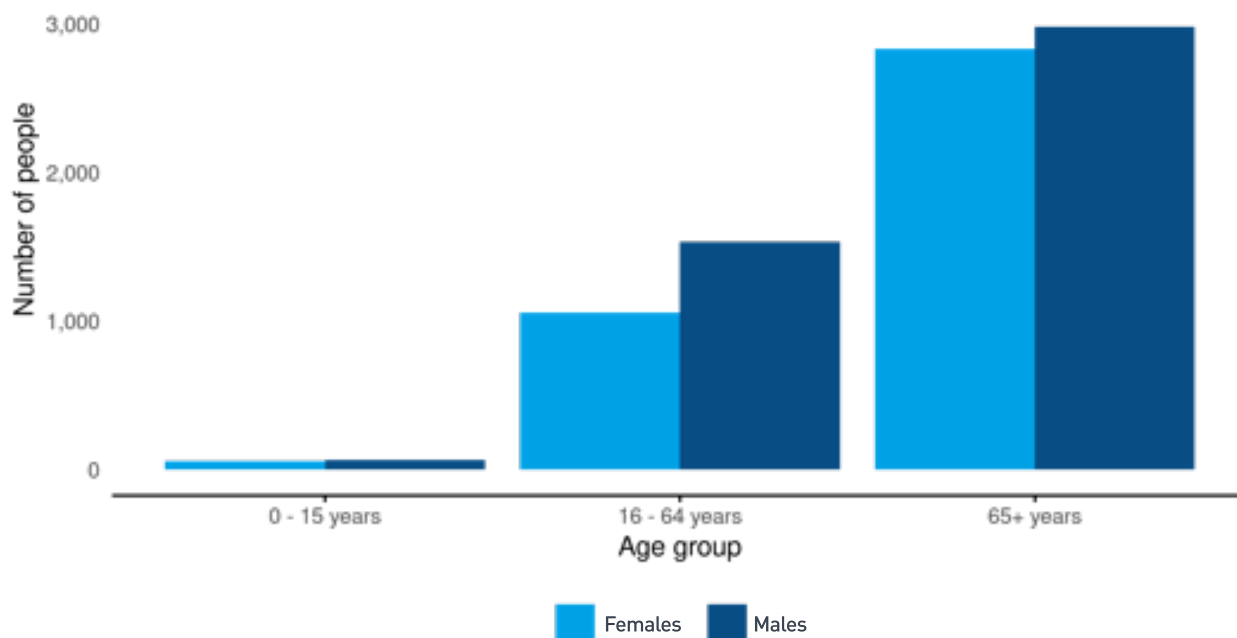
As of August 2022, 279 people in the Scottish Borders were registered as severely sight impaired and 280 as sight impaired[xxxvii]. 74% are over the age of 65 and most are female (57%).

Age Related Macular Degeneration (ARMD) accounts for the highest incidence of sight loss in Borders. Approximately 65% of people over 60 yrs of age registered in 2020 presented with some form of macular disease[xxxviii].

Hearing Impairment

There are an estimated 945,000 people living with hearing loss in Scotland[xxxix]. In the 2011 Census there were 8,528 people who responded that they experienced Deafness or partial hearing loss, this represents 7.5% of the Scottish Borders population.

Figure 45: Number of people who registered as Deaf or partially hearing impaired



Data Source: *Census 2011, National Resources Scotland* (Accessed August 2022)

Of those who identified as experiencing Deafness or partial hearing loss, most people (67%) were retired, a further 26% said they were employed (either full or part time, including self-employed), and 1.5% were unemployed.

Hearing loss increases sharply with age. About one third of the population aged between 60-70 years and three quarters of the population aged over seventy years have a hearing loss[xl].

There are 30 Deaf individuals in the Borders who are British Sign Language Users[xli].

Deafblindness

Deafblindness is a term used to describe people who are both sight and hearing impaired. Being Deafblind doesn't mean a person is entirely Deaf or blind, most individuals will have some useful sight and/or hearing.

There are an estimated 5,000 people in Scotland with significant combined visual and hearing lossx[lii].

A third of people living with sight loss and are over the age of 65 also have a hearing impairment.

Scottish Borders Health and Social Care PARTNERSHIP

Sexual Health & blood-borne viruses

Sexual Health

According to the current working definition, sexual health is:

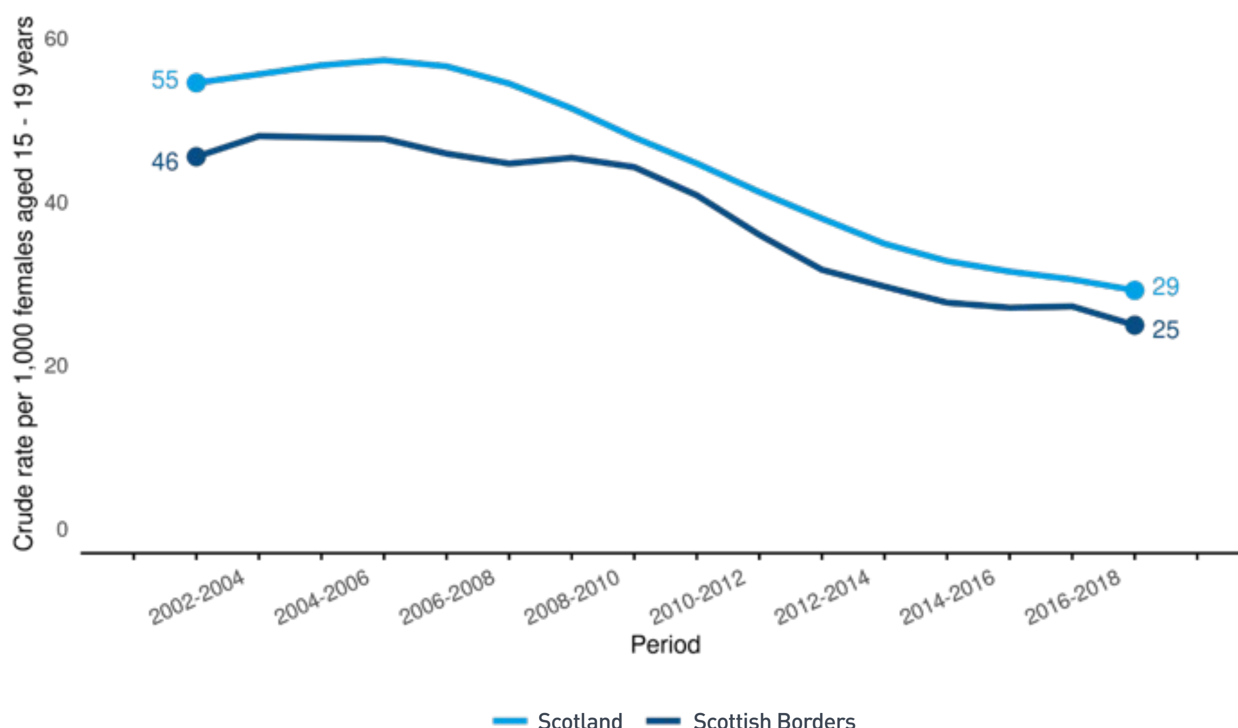
> "...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." [xliii]

The crude rate of teenage pregnancies (aged 15-19) in the Scottish Borders and in Scotland followed similar patterns of decline since 2002.

The rate in the Scottish Borders has declined by **45%** from **46 to 25** per 1,000 females (15-19 years), while in Scotland the rate has declined by **46.5%** from **55 to 29** per 1,000 females.

The rate of decline has been slowing in recent years.

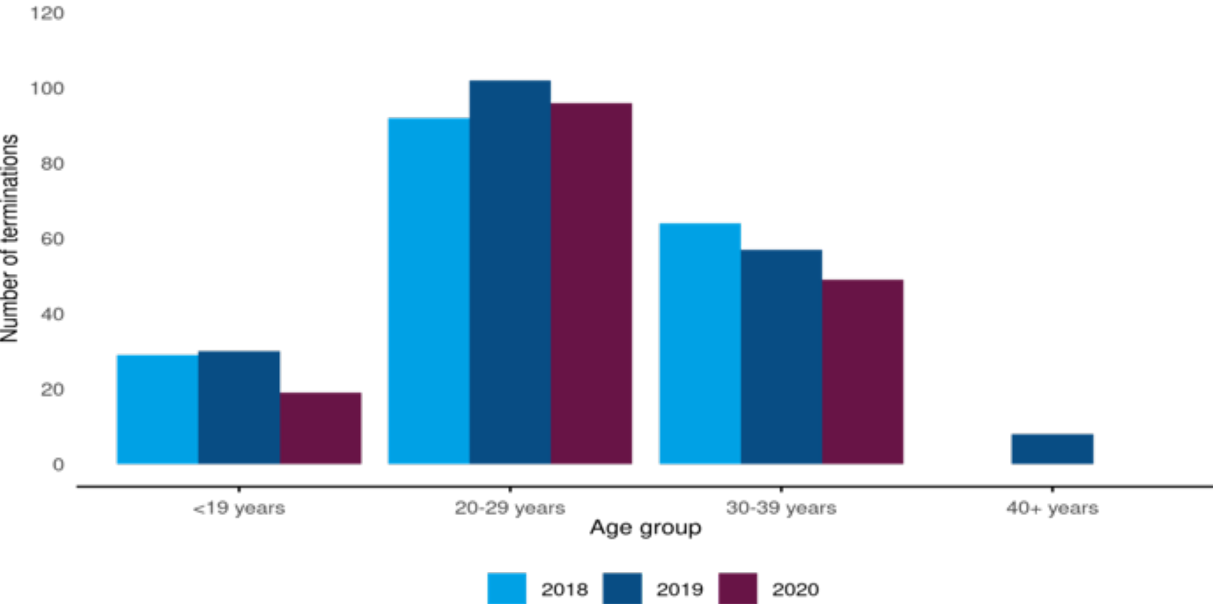
Figure 46: Teenage pregnancies: Crude rate per 1,000 females aged 15-19 years, 3-year aggregates, 2002-2018



Data Source: *Scottish Public Health Observatory* (Accessed August 2022).

Though absolute figures are not available (due to small numbers), teenage pregnancies experienced the greatest reduction in termination between 2019 and 2020, by up to **44%**, compared to the reduction for females aged 20-29 which was up to **24%**, and for those aged 30-39 which was up to **32%.**

Figure 47: Termination of pregnancy by year and age group

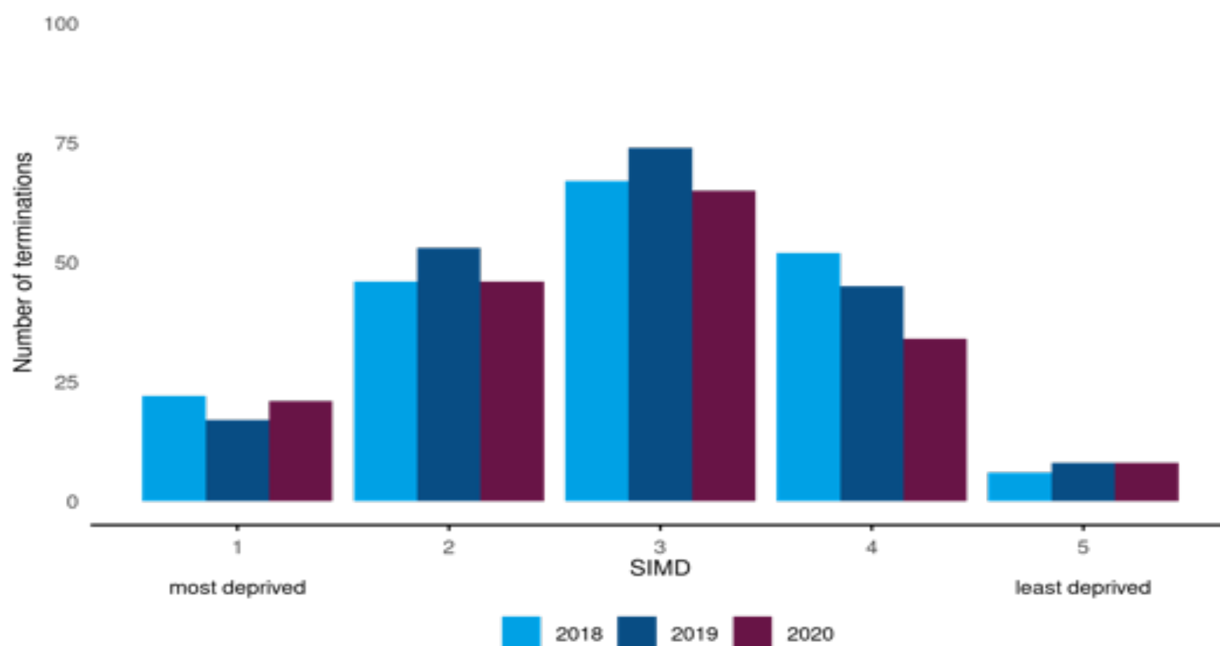


Data Source: *Public Health Scotland* (Accessed August 2022)

Rates of termination were more than twice as high in females from the most deprived areas compared with those from the least deprived areas and while rates for females in areas with SIMD 4 have been in decline, those for females in SIMD 2 have not followed the same trend.

The proportion of terminations for females in the least deprived areas grew by **1%** each year, while the proportion associated with females in the most deprived areas declined in 2019 before increasing again in 2020.

Figure 48: Termination of pregnancy by year and SIMD 2020 Quintile



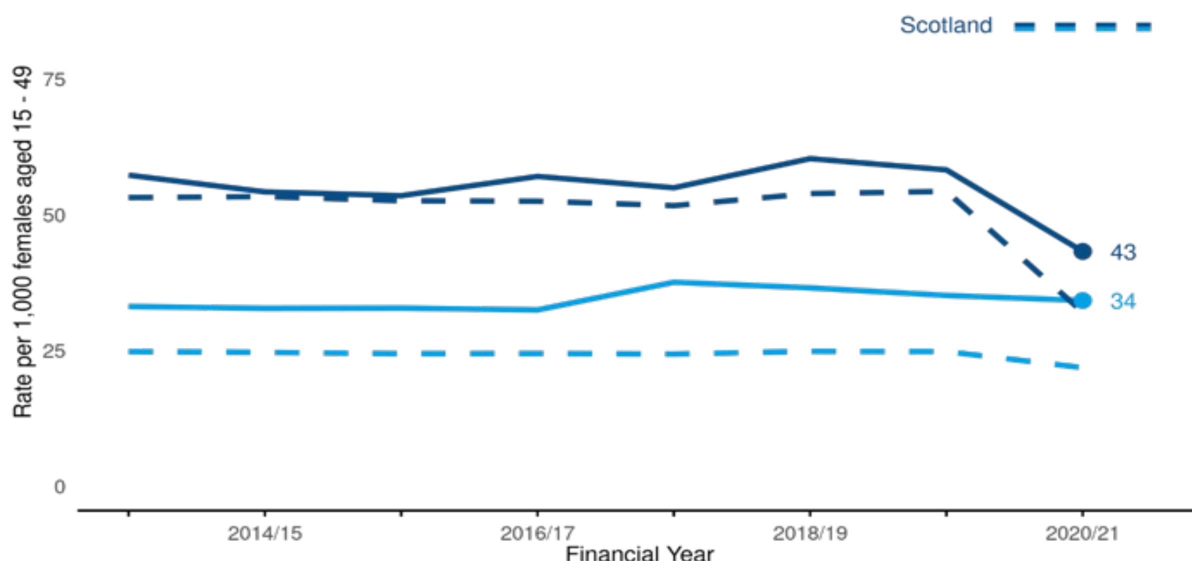
Data Source: *Public Health Scotland* (Accessed August 2022)

Long-acting reversible contraceptives are very effective birth control methods. The IUD, IUS, and implant are defined as "very" long-acting methods of contraception (lasting years), compared to the contraceptive injection which provides around 13 weeks of protection against pregnancy.

Prescribing of Intrauterine Device (IUD), Intrauterine System (IUS), and implants was significantly impacted by the COVID-19 pandemic.

In general rates of very long-acting methods of contraception have been greater than the contraceptive injection. The injection is still used more commonly in the Scottish Borders than in Scotland on average.

Figure 49: Long-acting reversible methods of contraception (LARC), 2013/14 to 2020/21



Data Source: *Public Health Scotland* (Accessed August 2022)

Blood Borne Viruses

Blood-Borne Viruses (BBVs) are viruses carried in the blood by some people and can be spread from one person to another. People infected with a Blood-Borne Virus may show little or no symptoms of serious disease, but other infected people may be severely ill. Some persistent viral infections do not cause symptoms. An infected person can transmit (spread) blood-borne viruses from one person to another by various routes and over a prolonged time period.

HIV

The numbers for first Human Immunodeficiency Virus (HIV) diagnoses by year are too small to have been reported for NHS Borders (likely less than **5**).

As of 15th August 2022, there were **52** individuals diagnosed and living with Human Immunodeficiency Virus in the Scottish Borders, of which **23** were exposed through men who have sex with men (MSM). The remaining were heterosexual or people who injected drugs.

As of 15th August 2022, of the **52** people living with Human Immunodeficiency Virus, all were attending specialist Human Immunodeficiency Virus services, and all were receiving antiretroviral therapy. **51** people **(98%)** had achieved undetectable viral load.

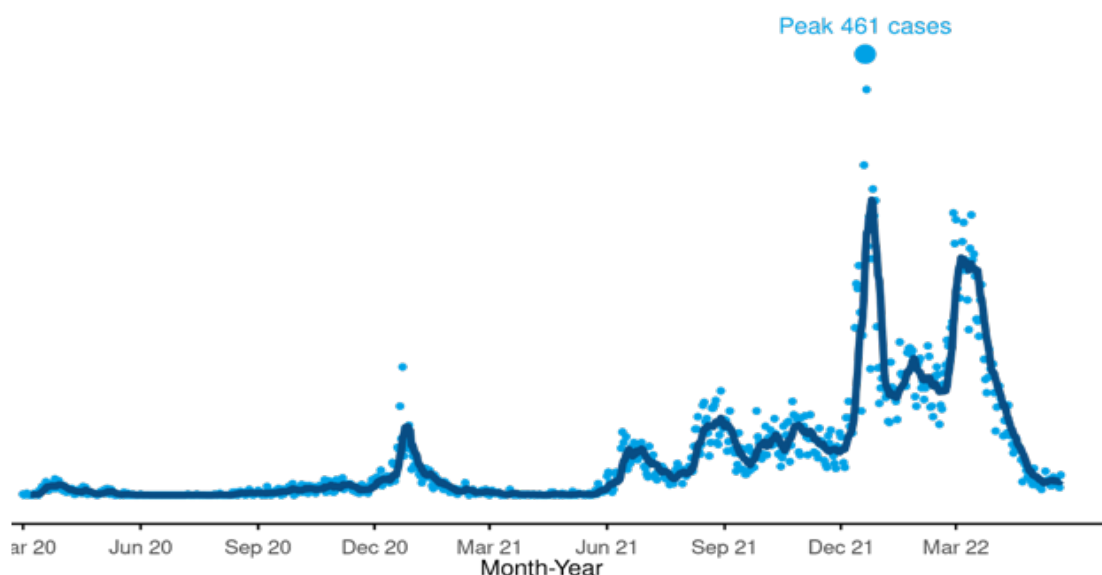
COVID-19 and Long COVID

COVID-19 is an easily transmissible, respiratory illness which has been linked to high death rates among those who are older in age and who may have pre-existing health conditions.

The first reported case of COVID-19 in the Scottish Borders was on 9th March 2020, 9 days after the first case in Scotland was confirmed.

Following this the reported daily cases remained relatively low (←20 on average) until 23rd December 2020 when the number increased to over 30 for the first time. This period marked the start of the first surge in cases leading to a peak of 134 new cases reported on 31st December. New cases then returned to low levels until mid-June 2021.

Figure 50: Daily COVID-19 cases, 9th March 2020 to 31st May 2022



Data Source: *Public Health Scotland* (Accessed August 2022)

The average number of daily cases was around 15 per day for most of May 2022 before testing centres closed.

Deaths from COVID-19

The first death linked to COVID-19 in Scotland occurred on 13 March 2020[xliv].

As of 31st May 2022 there had been a total of 200 deaths within 28 days of a COVID-19 infection, and there were had been no reported deaths since 16th May 2022.There were three distinct peaks in the monthly death totals, in April 2020 (22 deaths), January 2021 (25 deaths), and April 2022 (17 deaths).

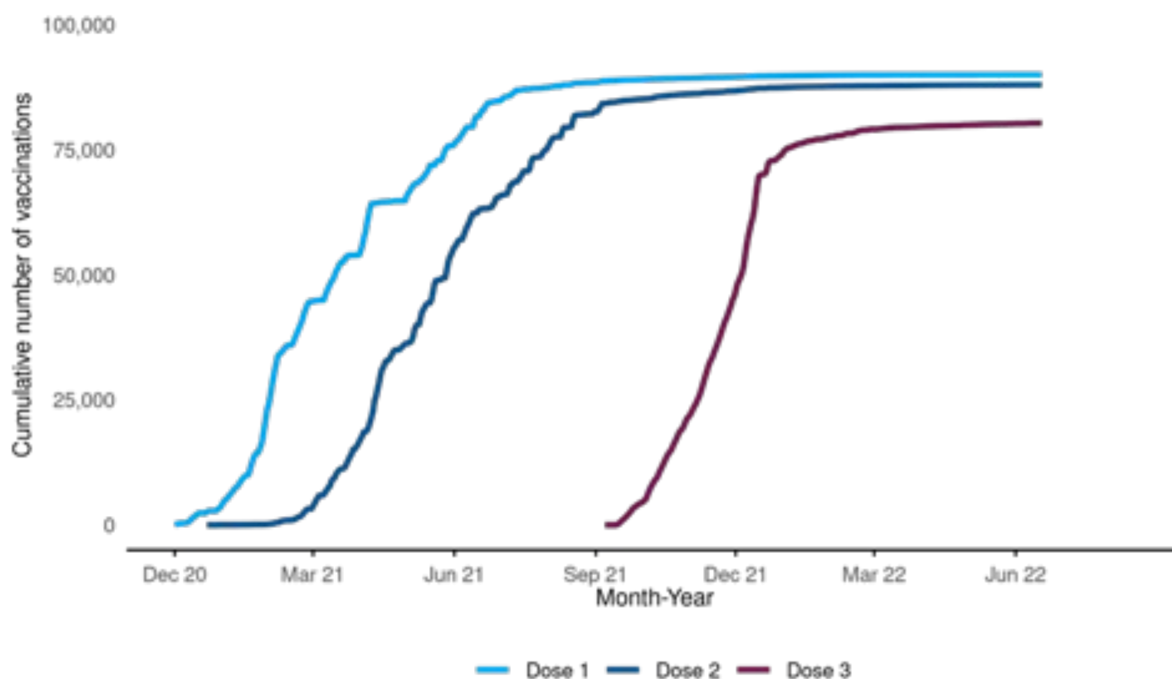
The crude death rate in the Scottish Borders remained lower than Scotland's. As of the 31st of May the cumulative rate of deaths remained at 173/100,000, compared to 226/100,000 in Scotland.

Public Health Scotland no longer reports the number of COVID-19 deaths within 28 days of a first positive test from 2nd June 2022.

COVID-19 Vaccinations

Vaccinations play an important role in preventing spread of the virus as well as reducing symptoms and the number of deaths by those who are affected.

Figure 51: Cumulative number of vaccinations by dose type, all adults aged 18+, 8th December 2020 to 26th June 2022



Data Source: Public Health Scotland (Accessed August 2022)

Roll out of the Pfizer/Biotech vaccine started on 8th December 2020, on this day 54 adults were vaccinated with their first dose (0.1% of adult population). Roll out of AstraZenica (Vaxzevria) was on 4th January 2021, and Moderna was rolled out from 7th April 2021.

Within the Scottish Borders, there have been high rates of COVID vaccine uptake. By June 2022 96% of adults in the Scottish Borders had received their first dose of one of the COVID vaccines. All those (100%) aged 80+ had received their first dose by 7th Feb 2020, while all those aged 65+ had received their first dose by 10th April 2020.

With regards to the second dose, the current vaccination rate for all adults is 93.6%, and is 96.5% for all those aged 40+.With regards to the third dose, the current vaccination rate for all adults is 85.5%, and is 92.3% for all those aged 40+.

Long COVID

COVID-19 symptoms normally resolve within 12 weeks, however as with many viral conditions, symptoms may persist for weeks or months and a variety of symptoms can develop.

Long COVID is defined as when people have "signs and symptoms that develop during or after an infection that is consistent with COVID-19, which continue for more than four weeks and are not explained by an alternative diagnosis"[xlv] . Common symptoms may include: fatigue, persisting high temperature, breathlessness, cognitive impairment, generalised pain, and mental health problems .

Nationally, Long COVID is being considered as a new 'long-term condition', with options for investigation, support and management based on an individual's signs and symptoms. As such the Scottish Borders Health and Social Care Partnership does not deliver specialist 'Long COVID' clinics and seeks to treat individuals in line with their symptoms within the appropriate primary of secondary care services.

The only funded clinical post within NHS Borders is within Clinical Psychology, under Cossette funding, for those hospitalised by COVID. This post will be funded for 3 years, at 1.5 days per week and commenced September 2021.

The Scottish Government has assigned £10million over 3 years to provide Health Boards/ Health and Social Care Partnerships the funding needed to support those with Long COVID. NHS Borders initially received circa £60K in the first year of funding. It is anticipated that funding will be used to appoint a clinical co-ordinator to develop robust patient pathways, develop links across clinical specialisms, and to act as a point of reference for the organisation and national link moving forward.

Funding would also be used to support a national approach in developing digital platforms to the support the self-management of ongoing symptoms.

Scottish Borders Health and Social Care PARTNERSHIP

6. SERVICE USER GROUPS

Older People (65+)

Total Population

Around **25%** of all people in the Borders are over the age of 65. By 2040 this will increase to **32%** of the population. The rising numbers in older people will have a big impact on health and care services.

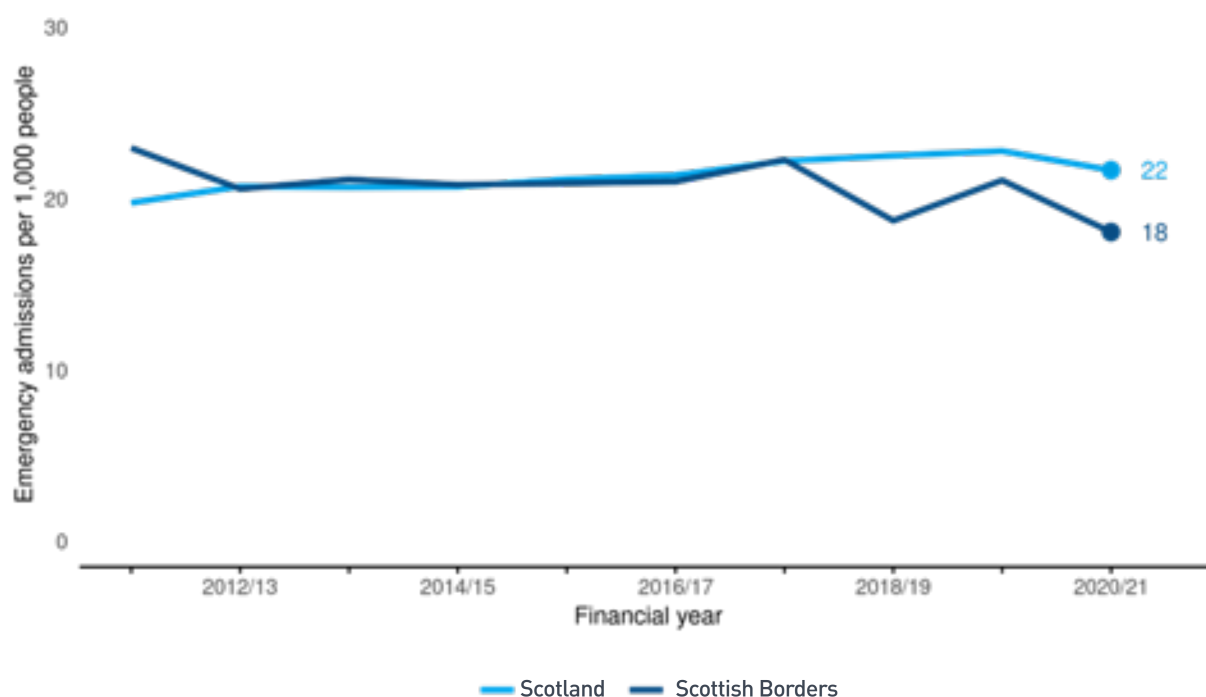
Fraility

The British Geriatrics Society defines frailty as "a state of increased vulnerability to poor resolution of homoeostasis after a stressor event"[xlvii] . Low energy, slow walking speed and poor strength are common characteristics of people who are frail.

Frailty is often associated with older people however young people may also be considered frail. In many cases a 'frail' person will also have multiple long term conditions, but it can also occur in absence of these.

People may only be diagnosed as 'frail' after a fall has occurred and they have attended hospital to deal with that fall. Older people lose bone density as part of ageing and therefore are at higher risk of bone fracture if they fall.

Figure 52: Emergency hospital admissions following a fall per 1,000 people aged 65+ years, 2011/12 to 2020/21



Data Source: *Public Health Scotland – Unintentional Injuries* (Accessed August 2022).

Prior to the pandemic, in Scotland the rates of emergency admissions due to falls had been increasing year-on-year from 20 per 1,000 in 2011/12 to 23 per 1,000 in 2019/20. In the Scottish Borders the rate has declined since 2017/18 however the decrease of rates in 2020/21 can be attributed to the COVID-19 pandemic.

The percentage of those aged 65% and older is expected to increase by 7% by 2040. The likelihood of more people being diagnosed as frail is therefore expected to increase as well. It is estimated that on average 7% of the population over 65 years are likely to be severely frailxl[viii].

There are several prevention strategies outlined by the British Geriatric Society to prevent people becoming frail which also support healthier ageing:

- Good nutrition
- Not too much alcohol
- Staying physically active
- Remaining engaged in local community/ avoiding loneliness
- Patients can be signposted to the NHS England and Age UK publications

For those already diagnosed with frailty, adverse effects can be mitigated by reducing the risk of falls and by taking medication.

Total Population

Around **25%** of all people in the Borders are over the age of 65. By 2040 this will increase to **32%** of the population. The rising numbers in older people will have a big impact on health and care services.

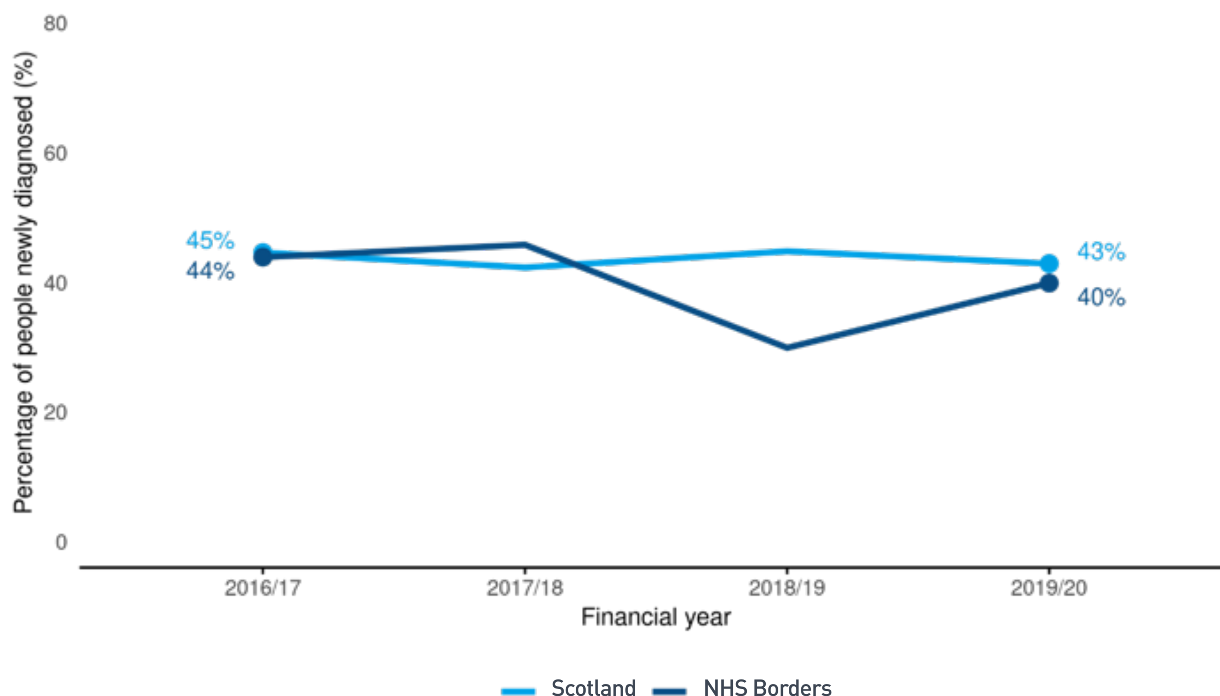
Dementia

Dementia is a broad category of degenerative brain diseases that cause long-term and permanent decrease in the patient's ability to think and remember, at a rate which is much higher than would normally be expected due to ageing. It also leads to behavioural and emotional problems, difficulties with language, physical frailty, apathy and, ultimately, death. The most common type of Dementia is Alzheimer's disease, which makes up **50-70%** of cases, followed by vascular dementia which makes up a quarter of cases.

Age is the biggest risk factor in developing dementia with people **over 85** most at risk. Dementia is life-limiting, with the average sufferer expected to live a further 8-10 years following diagnosis.

According to 2017 Cause of Death figures by National Registers of Scotland, Dementia and Alzheimer's Disease were the second-highest cause of deaths in Scottish Borders men (**7%** of all male deaths in the region) and the leading cause of deaths in Scottish Borders women (**12.8%** of all female deaths in the region).

Figure 53: Percentage of people estimated to be newly diagnosed with dementia and referred for post-diagnostic support, 2016/17 to 2019/20



Data Source: *Public Health Scotland* (Accessed August 2022).

Table 54: 2020 Projected Incidence Numbers of Individuals Diagnosed

	Total	Under 60	60-64	65-69	70-74	75-79	80-84	85-89	90+
Scotland	19,473	267	381	861	2,170	3,460	4,876	4,503	2,954
Scottish Borders	525	5	10	23	61	97	135	117	77

Data Source: *Scottish Government* (Accessed September 2022)

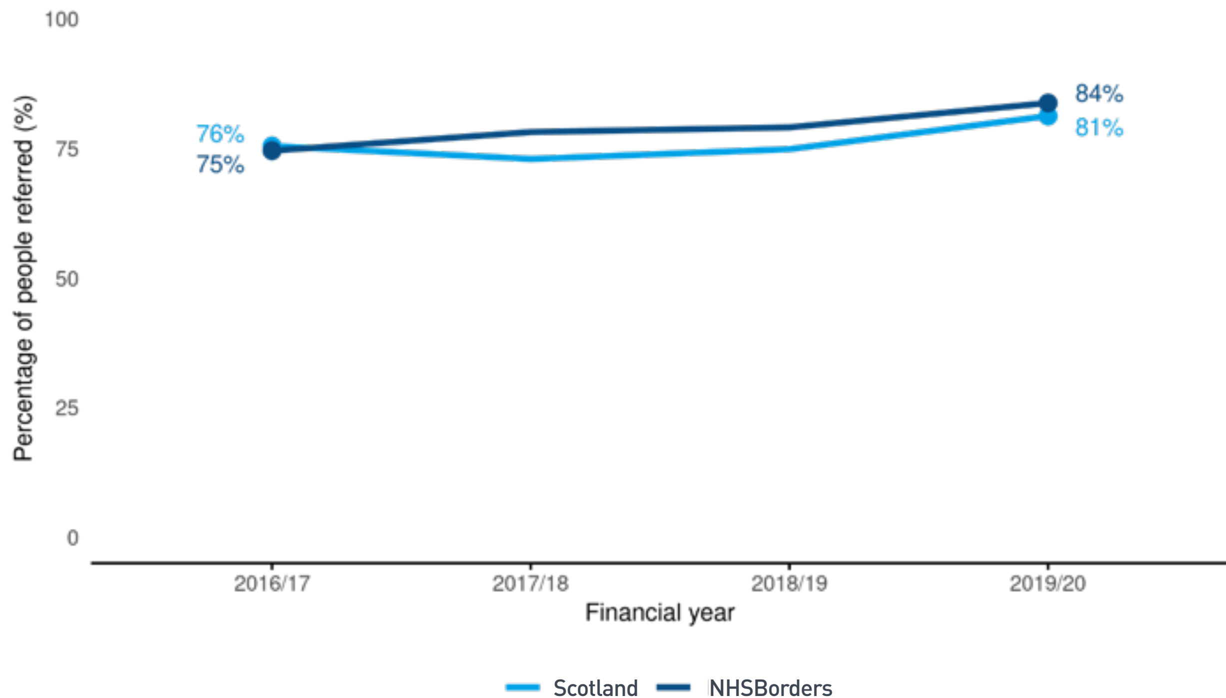
Post Diagnostic Support

Every person with a new diagnosis of dementia in Scotland is entitled to a minimum of one year of Post Diagnostic Support (PDS).

In 2019/20 there were an **estimated 511 people newly diagnosed with dementia.** Of the people who were referred for Post Diagnostic Support in 2019/20, **84%** received the minimum one-years support which is set as the standard. This was an increase on the previous financial year in which **79%** met the standard.

In general the rate of people referred to Post Diagnostic Support and receiving at least one-year of support has been increasing year-on-year.

Figure 55: Percentage of people who received a minimum of one year's post-diagnostic support after referral, 2016/2017 to 2019/20

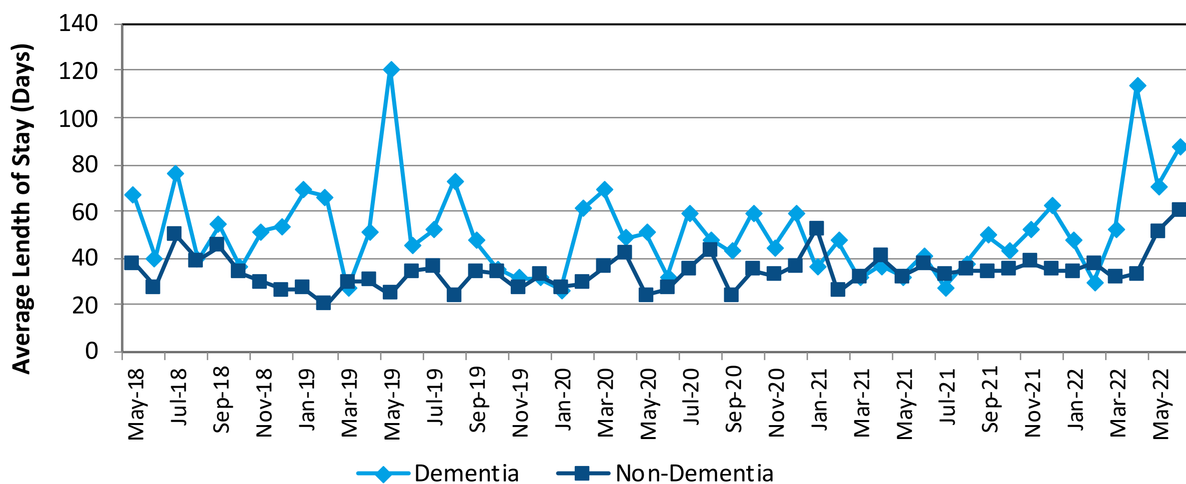


Data Source: *Public Health Scotland* (Accessed September 2022).

Hospital length of stay

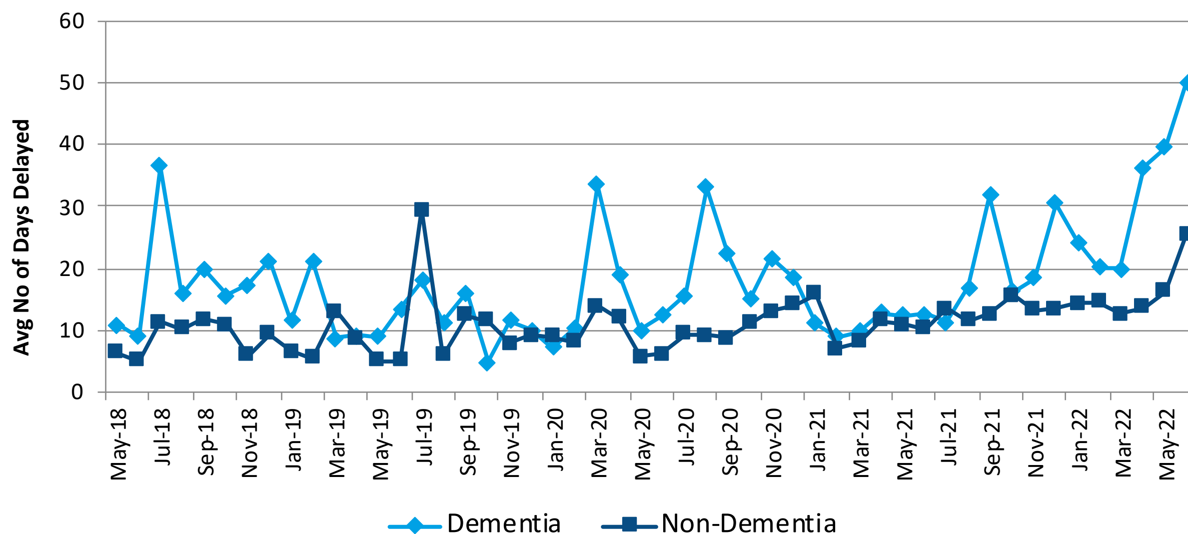
Within the Scottish Borders, the average length of stay is longer in hospital for those with a dementia diagnosis. Of the patients that are delayed in hospital, the delay is also longer with a dementia diagnosis.

Figure 556: NHS Borders – Average LoS for Cases with Dementia v Non-Dementia



Data Source: *NHS Borders* (Accessed August 2022).

Figure 57: NHS Borders – Average Delayed Days for Cases with Dementia v Non Dementia

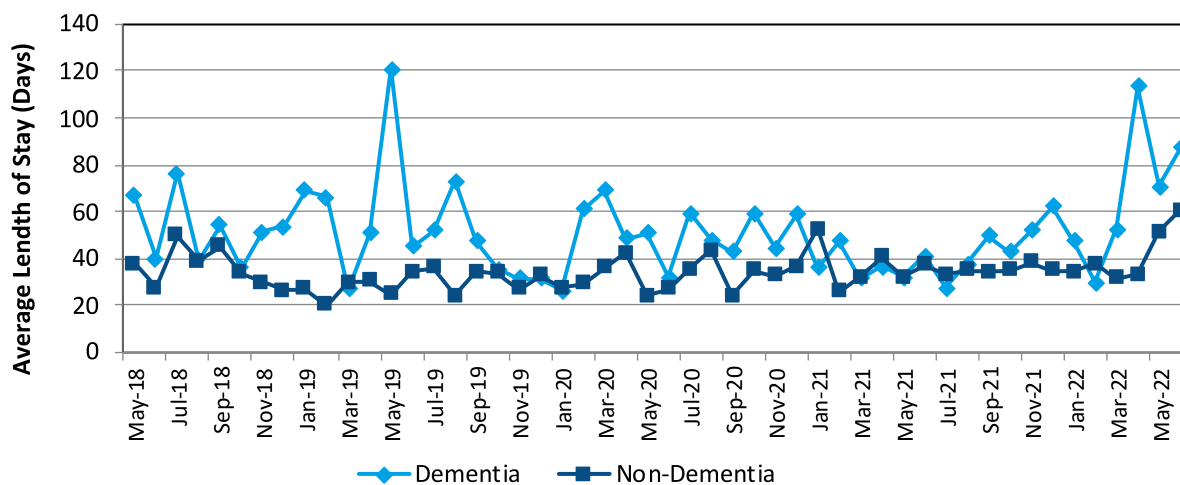


Data Source: *NHS Borders* (Accessed September 2022).

Hospital length of stay

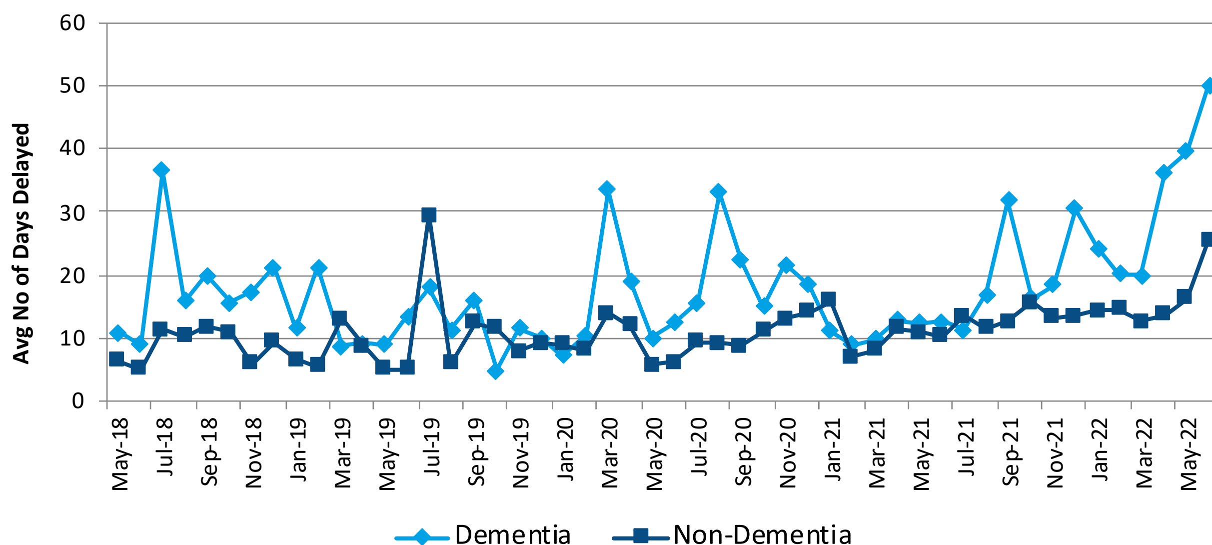
Within the Scottish Borders, the average length of stay is longer in hospital for those with a dementia diagnosis. Of the patients that are delayed in hospital, the delay is also longer with a dementia diagnosis.

Figure 58: NHS Borders – Average LoS for Cases with Dementia v Non-Dementia



Data Source: *NHS Borders* (Accessed August 2022).

Figure 59: NHS Borders – Average Delayed Days for Cases with Dementia v Non Dementia



Data Source: *NHS Borders* (Accessed August 2022).

Estimates of the prevalence of dementia in people with learning disabilities vary, in part because there has not always been good recognition, assessment and diagnosis.

Analysis of the data from a range of studies suggested that age-related dementia of all types is more common at earlier ages in people with learning disabilities (non Down's Syndrome) than in the rest of the population (about **13%** in the **60 to 65** year old age group compared with **1%** in the general population). Across all over-60 age groups the prevalence was estimated at 2 to 3 times greater in people with learning disabilities (non Down's Syndrome). People with Down's syndrome are at particular risk of early onset Alzheimer's disease.

Medication

In 2019/20 the rate of Defined Daily Doses per 1,000 people (aged 60+) per day was **27** in the Scottish Borders, compared to **18** in Scotland, on average.

Initially the rate of Defined Daily Doses in the Scottish Borders was below the average rate in Scotland, however between 2013/14 and 2014/15 the Scottish Borders rate exceeded the Scottish average and has continued to increase year on year, whereas in Scotland the rate plateaued around 2014/15 and has since declined to its current rate of 18 in 1,000.

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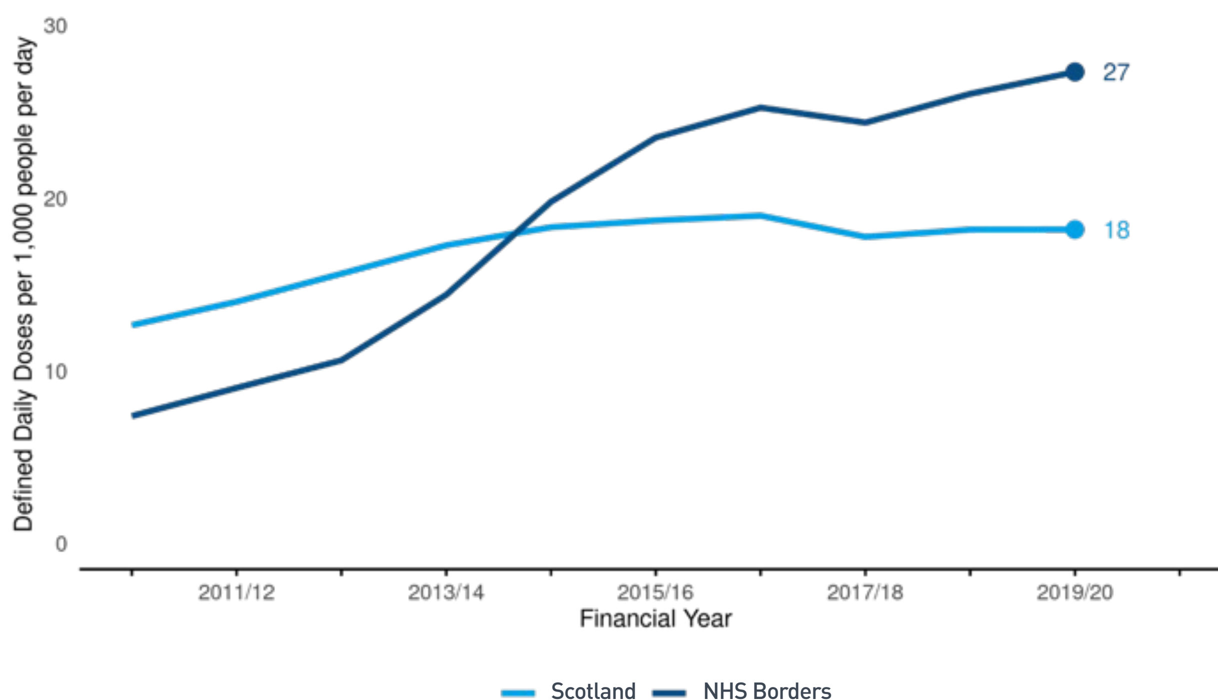
Figure 60: Drugs for Dementia: Defined Daily Doses per 1,000 people per day, 2010/11 – 2019/20



Data Source: *Public Health Scotland* (Accessed September 2022).

Summary

Having an elderly relative diagnosed with dementia has a serious impact on spouses and younger family members. By the time the family realises that something is wrong, the disease has often progressed beyond the mild cognitive impairment stage and the sufferer eventually needs constant supervision. As more people are living longer, dementia is becoming more common, placing increasing requirements on carers, and the Health and Social Care Partnership.

Mental Health and Wellbeing

Mental health is defined by the World Health Organisation as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of live, can work productively and fruitfully, and is able to make a contribution to his or her community.'[xlix]

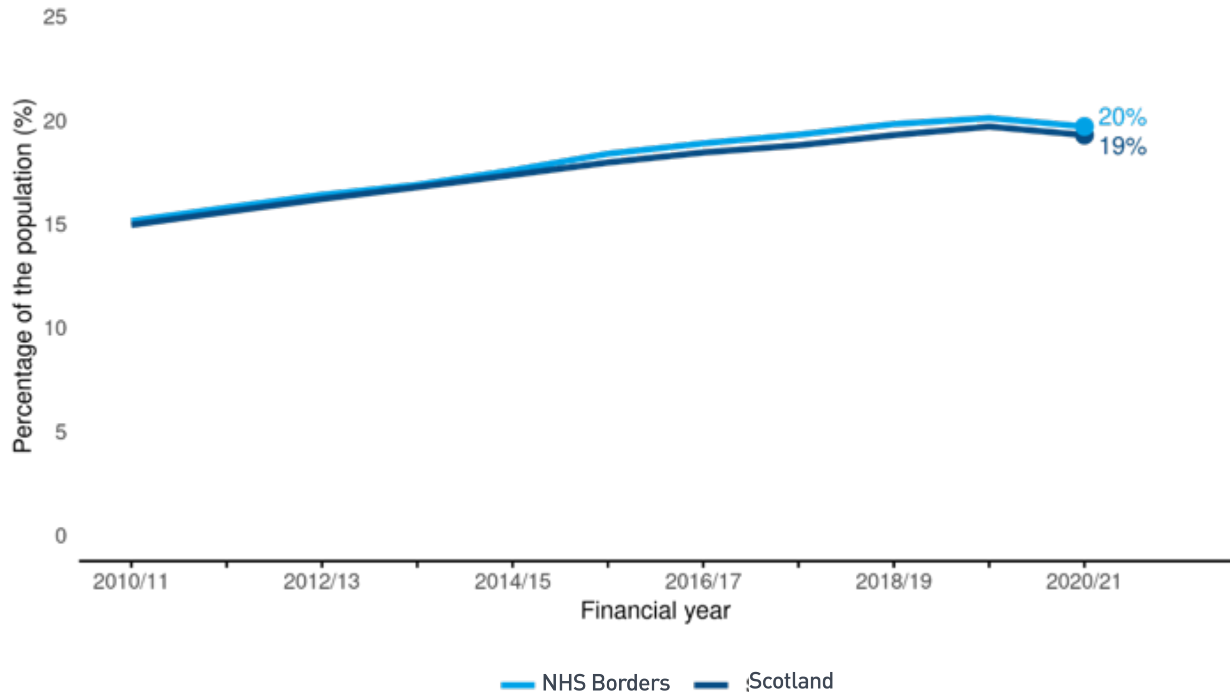
Mental health conditions affect one in three people in Scotland . Although more is understood about mental health, there is a still a lot of stigma and misinformation about what different diagnoses mean.

The Royal College of Psychiatrists defines wellbeing as: 'A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment'[li] . Those living in the most deprived areas in Scotland reported lower average wellbeing **(46.9)** compared to those living in the least deprived areas **(51.5)**. This pattern is likely to also be evident in the Scottish Borders. [lii]

Anxiety, Depression and Psychosis

There has been an increase of **5%** since 2010 in the percentage of those with moderate or high severity symptoms of depression and anxiety, as measured by the percentage of population prescribed drugs for anxiety, depression or psychosis.

Figure 61: Percentage of the population being prescribed drugs for anxiety, depression, or psychosis, 2010/11 to 2020/21



Data Source: *Scottish Public Health Observatory* (Accessed September 2022).

Overall trends are in line with Scotland averages, but there are significant differences between the localities. Teviot & Liddesdale has a higher average of around 23%, Cheviot and Eildon localities are also just above the national average while Berwickshire averages just below the national average at approximately 18% and Tweeddale is even lower at roughly 16% in 2020/21.

In Scotland there is a greater use of mental health drugs by people living in more deprived areas. This corresponds with evidence that people living in deprived areas report poorer mental wellbeing.

There are also substantially more mental health medicines dispensed to females than males in Scotland, for four out of the five groups of medicines (hypnotics and anxiolytics, antipsychotics and related drugs, antidepressants and, drugs for the treatment of dementia). The exception to this is ADHD, where almost 80% of dispensing is to males[liii].

Suicide

Between 2017 and 2021 there were **79 suicides** in the Scottish Borders, of which 52 (66%) were males, and 27 (34%) were females. The annual crude rate per 100,000 population was 13.7 in the Scottish Borders (compared to 14.1 in Scotland). In the Scottish Borders this rate was 18.6 males and 9.1 for females, males are twice more likely to die by suicide than females.

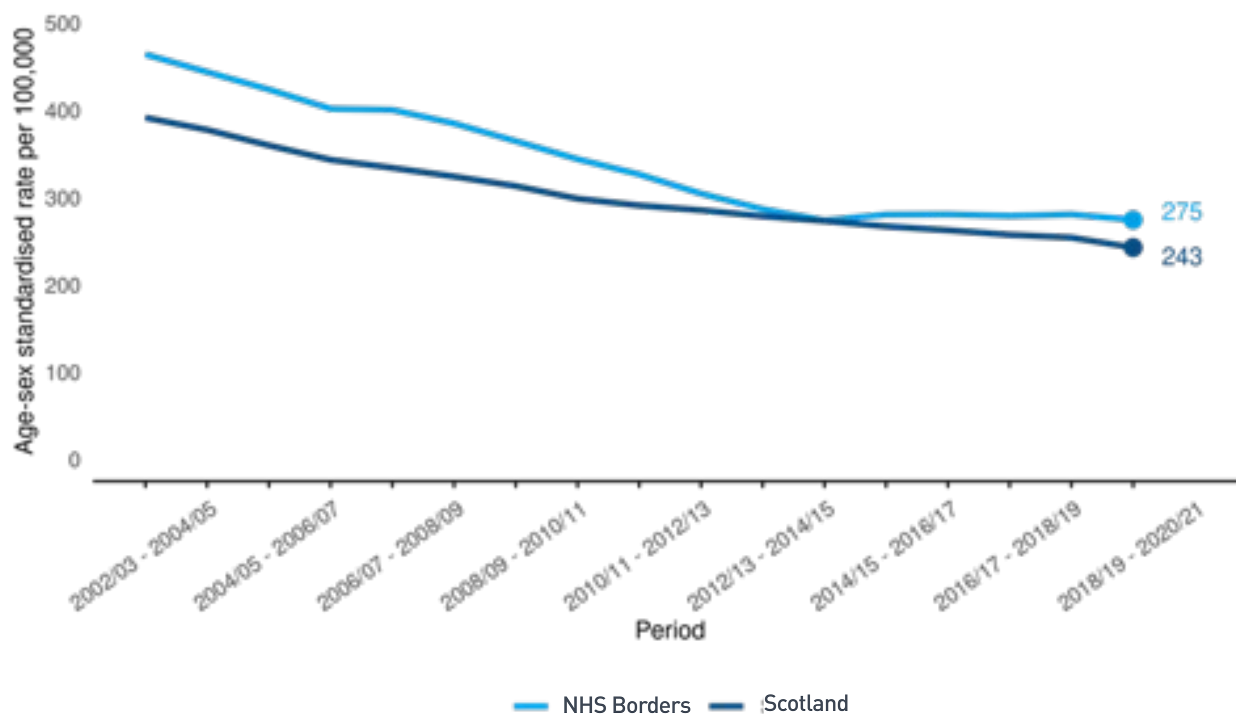
This is an increase from the previous reporting period (2016-2020) which recorded 69 suicides in the Scottish Borders. A smaller percentage of deaths (16%) were from individuals resident in the most deprived areas of the Borders, compared to 32% for Scotland.

More people died by suicide in the months of January, March and July. More than half (58.8%) of suicides took place in the home, which is in line with the national figures, this did not differ for males or females.

Psychiatric Patient Hospitalisations

There has generally been a reduction in the time spent as a psychiatric inpatient. This is due in part to the increase in community-based care. The number of mental health stays in non-psychiatric facilities has increased since 1997/98 but most of these stays have been quite short (between 1 and 7 days).

Figure 62: Percentage of the population being prescribed drugs for anxiety, depression, or psychosis, 2010/11 to 2020/21



Data Source: *Scottish Public Health Observatory* (Accessed September 2022).

Since 2022/03 the rate of hospital discharges from psychiatric specialties has declined by 41%, while in Scotland the rate has declined by 38%. In recent years the number of short-stays (1 – 7 days) in psychiatric specialties has exceeded the number of longer stays (8 – 28 days), while the number of stays lasting 1+ months have remained steady.

Medication

In 2019/20 the rate of Defined Daily Doses per 1,000 people (aged 60+) per day was **27** in the Scottish Borders, compared to **18** in Scotland, on average.

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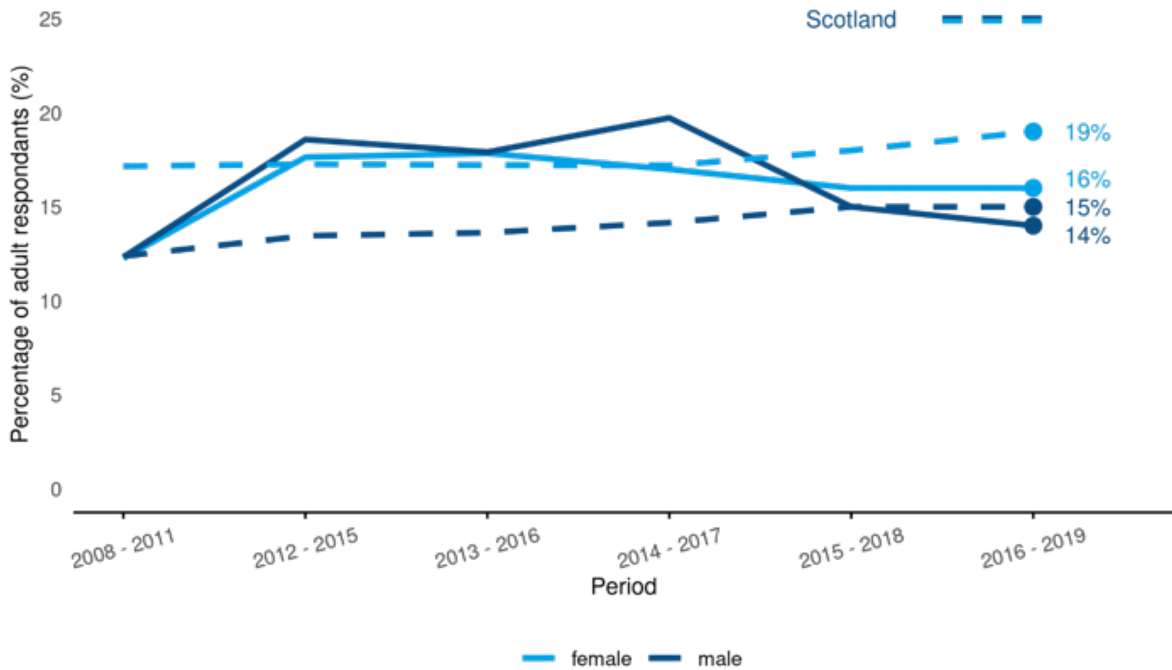
Mental Health and Wellbeing Surveys

General Health Questionnaire (GHQ-12)

The General Health Questionnaire (GHQ-12) consists of 12 items, each assessing the severity of a mental health problem over the past few weeks using a 4-point scale (from 0 to 3). The score was used to generate a total score ranging from 0 to 36, with higher scores indicating worse conditions.

Figure 63: Adults with a possible mental health problem (SHeS GHQ-12 score 4+), 4-year aggregates, 2008-2019



Data Source: *Scottish Health Observatory /Scottish Health Survey* (Accessed September 2022).

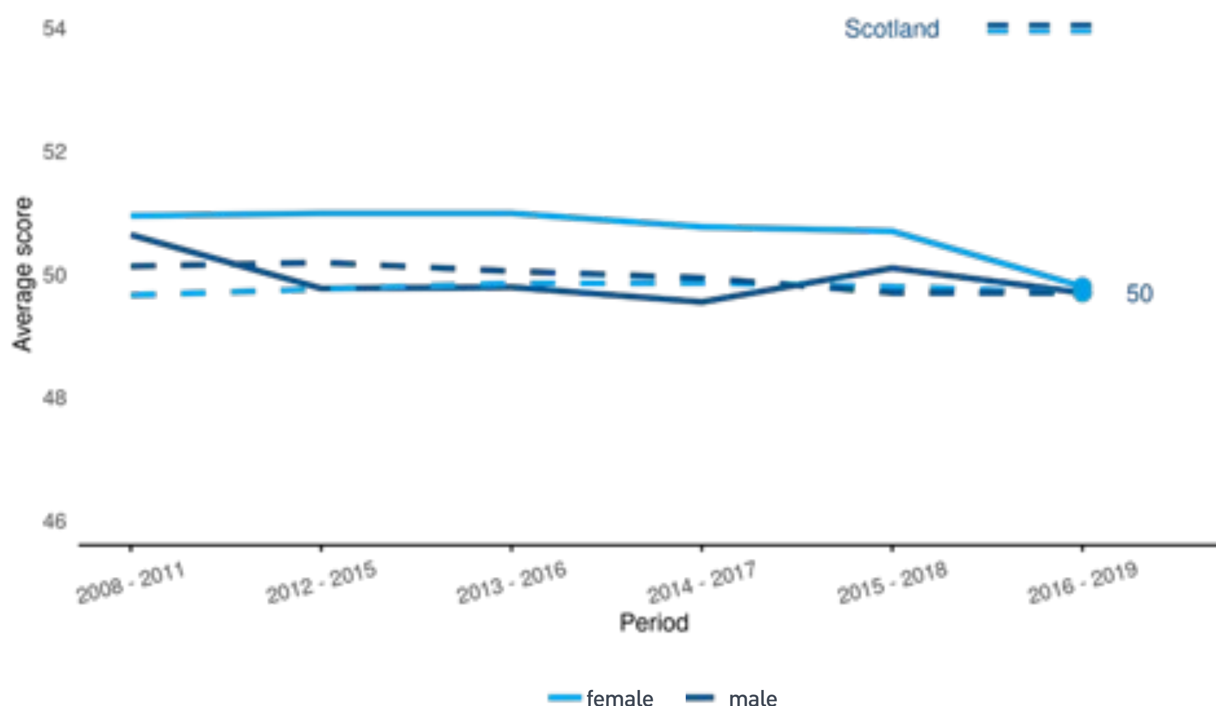
In the latest period, 2016 – 2019, 16% of female survey respondents scored 4 or more, indicating a possible MH problem, compared to 19% in Scotland overall. For males in the Scottish Borders the proportion was 14%, compared to 15% in Scotland.

Warwick-Edinburgh Mental Well-being Scale

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items for assessing a population's mental wellbeing. The scale can be used to assess the overall mental wellbeing of an adult population.

The Warwick-Edinburgh Mental Well-being Scale has a mean score of 51.0 in general population samples in the UK with a standard deviation of 7. In the most recent time-series (2016-2019) the average for both males and females was 50.

Figure 64: Warwick-Edinburgh mental-wellbeing score (WEMWBS), 4-year aggregates, 2008-2019



Data Source: *Scottish Health Survey* (Accessed September 2022).

A score of 41 – 44 is indicative of possible/mild depression. A score of 60+ is indicative of high wellbeing. In the Scottish Borders the Warwick-Edinburgh Mental Well-being Scale score has declined for both sexes since 2008. While for females the decline has been year-on-year from 50.9 in 2008 – 2011 to 49.7 in 2016 – 2019, for males the initial decline was interrupted by an increase in 2015 – 2018, and then a further decline into the latest period.

Warwick-Edinburgh Mental Well-being Scale data also shows that there is a relationship between mental wellbeing and level of deprivation with little variation over time. Those living in most deprived areas reported lower than average mental wellbeing (46.9 in 2019) compared to those living in the least deprived areas (51.5).

Determinants of Mental Health Outcomes

Mental health is influenced by a myriad of social, economic and environmental factors. Evaluating these conditions can indicate why some people have better mental health than others.

The average weekly wage for Scottish Borders residents is **£111** lower than the national average and the unemployment rate (and therefore workless population) in the Borders is higher than the national average. Most men in the 16-64 age group out of work want a job. A low number of people are homeless in the Scottish Borders compared to nationally. Worklessness, being income deprived and being homeless has a cyclical connection with poor mental health.

Being in work can also have an impact on mental health and the rate of work-related stress, depression or anxiety (new or long-standing) has also been rising. According to the Labour Force Survey (by HSE UK) work related stress was increasing year on year before COVID and there was a clear rise when the pandemic and lockdowns started in 2020.

Adverse experiences in both childhood and adulthood have also been shown to have a negative impact on mental health. Domestic abuse is one example of an adverse adult experience and ScotPHO data shows that although the rate of adult experience of abuse by a partner or ex-partner is lower in the Scottish Borders when compared to the national rate, this is rising in line with the national average and the gap is closing between the two figures. The total number of domestic abuse incidents reported to Police Scotland was 65,251 in 2021/21 and in the Scottish Borders a total of 1,295 incidents were recorded. This equates to 100 incidents per 10,000 population against the Scottish rate of 115 per 10,000 population.
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From 2017 onwards there has been a **6%** drop in percentage of population agreeing that they can influence decisions in their local area both nationally and in the Borders. Lack of ability to influence local decisions can impact feelings of belonging which in turn can impact negatively on mental health. However, pre-COVID data suggests there is a strong sense of belonging across the Borders and neighbourhood crime rates are low. There is also a low incidence of discrimination by gender, age and deprivation in the Borders. These are all good protective factors for mental health.

Most residents **(83%)** are satisfied with their local green or blue space however data pre-COVID suggests the least deprived areas were more satisfied compared to the most deprived with the gap slowly widening over time[liv]. Being in the outdoors is known to be positive for maintaining good mental health. This may have changed over the lockdowns which encouraged people to be outdoors locally.

Scottish Borders Health and Social Care PARTNERSHIP

Inequalities in Mental Health

Mental health problems are not equally distributed across the population and are strongly linked to health and social inequalities and are impacted by environmental and social factors. The link between social status and mental health problems is the level, frequency and duration of stressful experiences and the extent to which these are buffered by protective factors such as social and individual resources and sources of support. These stressful experiences (including poverty, family conflict, poor parenting, childhood adversity, unemployment, chronic health problems and poor housing) occur across the life course and contribute to a greater risk of mental health problems if they are multiple in nature and if there are no protective factors to mitigate against their negative impact.

COVID-19 had an impact on everyone and it is evident that the impact of the pandemic has been experienced very differently by different groups in society, exacerbating pre-existing inequalities and disproportionately affecting some groups of the population[lv].

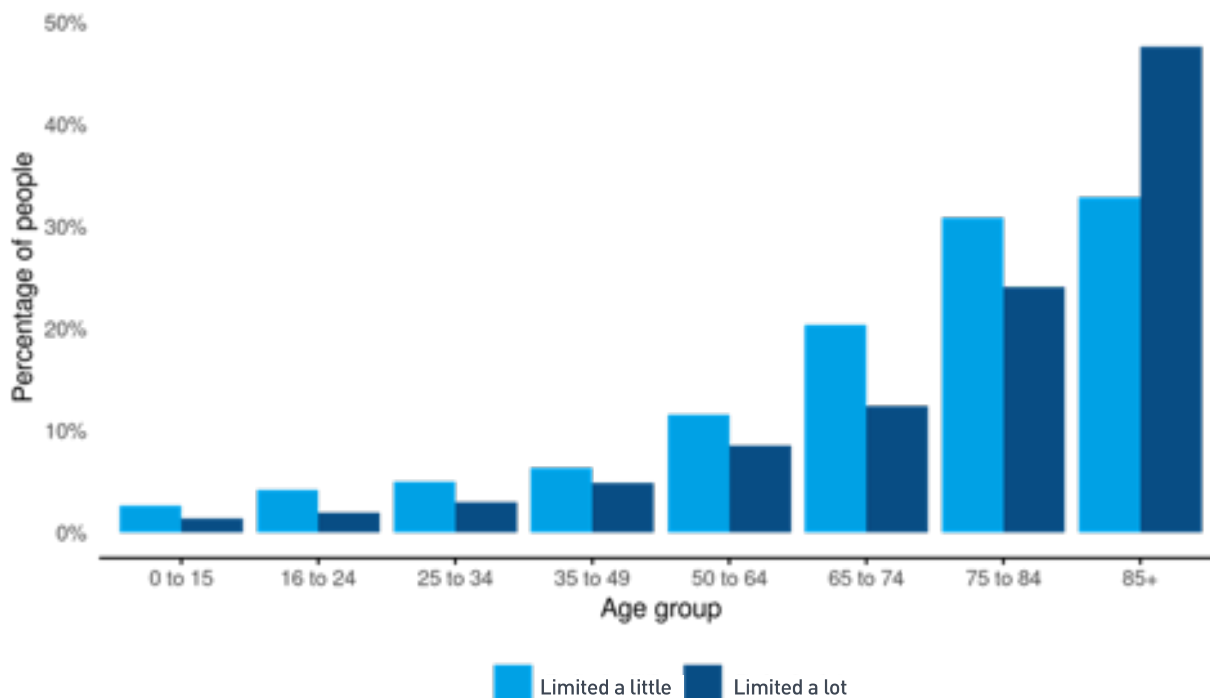
93% of people living in marginalised rural communities in Scotland believed that COVID-19 pandemic had an impact on their mental health and wellbeing[lvi], a figure that is likely to be similar in the Scottish Borders.

Physical Disability

A physical disability means having a physical impairment which has a substantial and long-term negative effect on your ability to do normal daily activities. Not all physical disabilities are visible or registered.

The Scotland Census 2011 defines a long-term health problem or disability as limiting a person's day-to-day activity, and lasting, or expected to last, at least 12 months. This includes problems related to old age. Overall in the Scottish Borders, almost **19%** of the population reported some level of disability-related limitation to their daily activities (a little or a lot). **6,995** people specifically said they had a physical disability specifically.

Figure 65: Percentage of people who reported their day-to-day activities were limited due to disability



Data Source: *Census 2011, National Records Scotland* (Accessed September 2022).

Older groups were more likely to consider their daily activities limited by disability than younger groups. Nearly 1 in 2 people aged 85+ said their daily activities were limited a lot (dark blue), compared to nearly 1 in 4 people aged 75 to 84, and 1 in 8 aged 65 to74. The 85+ age group was the only one in which a greater proportion of people reported more severe limitations (activities limited a lot), while in all other age groups less severe limitations were more common.

With respect to the working age-adult population (16 – 64 years), 9,337 people reported disability-related limitations on their daily activities, which equates to 13.2% of the adult population. Of these people, 42% (3,881) said their daily activities were limited a lot due to disability.

It is difficult to estimate the number of wheelchair users as this number varies depending on how the data has been collected. Estimates across a number of sources suggest that between 1,600 and 2,300 households contain at least one person that has to use a wheelchair, with a central figure of 2,000[lvii].

This range suggests that around 3.5% of all households in the Scottish Borders contain a wheelchair user.

The Scottish Borders Council wheelchair housing study titled "A space to live – Wheelchair accessible housing in the Scottish Borders" identified a target of 20 wheelchair homes

per annum to be built, of which 15 will be provided by RSLs. The total planned number of units in the Social Housing Implementation Plan for 2021-26 is 1,256, of these 101 (8%) are wheelchair accessible houses.

The Physical Disability working group have identified 7 key ambitions[lviii] which form the core of the current Physical Disability Strategy. The seven ambitions are:

1. Support services in the Scottish Borders are designed and delivered to support all people with a physical disability to live the life they choose, to have control, to make informed choices and to have support to communicate this when needed at every stage of their lives.
2. People with a physical disability are able to participate fully in education and paid employment enabling their talent and abilities to enrich the Scottish Borders.
3. People with a physical disability can live life to the full in their homes and communities with housing designed and adapted to meet their needs.
4. People with a physical disability can live life to the full in their communities with transport designed and adapted to enable people with a physical disability to participate as full and equal citizens.
5. People with a physical disability are confident that their rights will be protected and they will receive fair treatment at all times.
6. People with a physical disability participate as active citizens in all aspects of daily and public life in Scotland.
7. Informal carers of people with physical disabilities and long term conditions are acknowledged and supported to recognize their rights as a carer.

The current implementation plan will be concluding at the end of 2022. Both the strategy and its associated implementation plan are scheduled to be reviewed thereafter.

Learning Disability

People with learning disabilities have a significant, lifelong, condition that started before adulthood, which affected their development and which means they need help to understand information; learn skills; and cope independently[lix].

The number of people with learning disabilities is growing in Scottish Borders and there is an increase in the complexity and number of health and support needs requiring input from the Health and Social Care Partnership from both younger people living with more complex health conditions and people living longer into older adulthood.

Good health is vital to all of us, as is access to good quality care. However people with learning disabilities can experience substantial health inequalities. Over 95% have at least one additional health problem, and multiple co-occurring physical and mental health problems are typical .

Scotland's Census 2011 reported 26,349 people to have learning/intellectual disabilities, which is 0.5% of Scotland's population[lxi].

Data from the 2011 census and the 2014 Learning Disability statistical return (LDSS) found that 612 people in the Scottish Borders identified themselves (or were identified by a member of their household), as having a Learning Disability. In this group, 485 people (81%) were aged 16 or over in 2011. Meanwhile, the total number of adults with learning disabilities known to services across the Scottish Borders was higher than the figures captured through the Census. At March 2014, 599 people aged over 16 with learning disabilities were known to the Scottish Borders services, of whom 555 had confirmed addresses in this area.

Subsequent data was published by the LDSS relating to a single year reporting period from April 2018 to March 2019. In Scottish Borders this equated to 557 people which is 5.8 people per 1000 people above the national average of 5.2 per 1000 people in the general population.

More recently in the Scottish Borders, in 2021, there were 702 people known to the Health and Social Care Partnership with a learning disability, of whom 101 have a diagnosis of a learning disability and autism (14%). This is likely to be an underestimation of both population statistics. The Scottish Government cites that around 32.7% of people with a learning disability also have a diagnosis of autism[lxii].

30 adults with a learning disability are placed in support arrangements out of the Scottish Borders and of these, 8 people are a priority to return to the area when appropriate accommodation and support can be established.

In 2022 there are 96 young people between the ages of 14-18 identified to the learning disability service, where transition to adulthood support is needed.

The Learning Disability service currently funds 456 packages of support equating to a value of £2,550,734 in residential care costs and £18,370,939 in community care support.

Adults with Autism Spectrum Disorders

Autism is a lifelong developmental condition that affects the way a person communicates, interacts and processes information. Autism is present from birth, but it might not be recognised or diagnosed until later in a person's life. Early intervention, in the form of support for their individual needs, can be helpful for autistic children.

Every autistic person is different and has different experiences.

At least **1 in 100** people in Scotland are autistic. The overall number of autistic people in the Scottish Borders is unknown, however, if the above figure is applied rationally the estimate would be around **1,150**.

Currently, people assigned male at birth are diagnosed with autism more often than people assigned female at birth. People assigned female at birth can be more likely to 'mask' autism – they learn how to hide autism characteristics and copy what people without autism do, in order to fit into groups. This can make it harder to recognise that they might be autistic, and to receive a diagnosis[lxiii].

It is reported nationally that many autistic people experience mental health problems, particularly related to anxiety, low mood (depression) and sleep problems. Psychological therapies can help to manage conditions these conditions, but techniques must be adapted to suit the individual person's need.

Other common conditions which have been associated with Autism include Attention Deficit Hyperactivity Disorder (ADHD), dyslexia and dyspraxia, learning disabilities, epilepsy, Obsessive Compulsive Disorder (OCD) and problems with joints and other parts of the body. It would be beneficial to build a greater understanding of the number and needs of autistic people in the Scottish Borders so that further developments can be made to improve the quality of life for those living with autism.

Unpaid Carers

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

The numbers of unpaid carers in each Health and Social Care Partnership area are difficult to identify exactly and data can only be sourced from the Scottish Health Survey and the 2011 Scotland Census.

In the 2011 census, 10,346 people reported that they provide unpaid care. This was about 9.1% of the Scottish Borders population, and similar to Scotland (9.3%). The total number of carers aged 16+ will likely be higher than this, perhaps even as high as 15,000-16,000. This is based on Scotland-level estimates from the Scottish Health Survey 2012/13 of 17% of all people aged 16+ having a Carer responsibility.

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

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

Applied to the 2020 Scottish Borders population estimate (latest), 9.1% would equate to an extra 140 people providing unpaid care, but the actual number is likely greater than this, and indeed many people do not consider the care they provide to friends/relatives as being "unpaid care".

In 2022 the Scottish Government proposed plans to provide better financial support to Scotland's unpaid carers[lxiv].

Currently the precise number of unpaid carers in Scotland is unknown but recent survey work suggests the number of adult carers was around 839,000 (15.3%).

Palliative Care

The World Health Organisation (WHO) defines palliative care as "an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness" [i]. For those who have an illness which cannot be cured, palliative care is a holistic approach that ensures a person receives support with physical symptoms as well as social, psychological and spiritual support for the person, and those important to them. End of life care is a form of palliative care, it focuses on care when a person is nearing the end of their life.

Health and social care teams can deliver palliative and end of life care approaches with or without support from the specialist palliative care service, depending on the individual needs of the person. Worldwide the WHO estimates only 14% of people who need palliative care currently receive it.

The needs of palliative care service users and their carers is widespread and dependent on individual circumstances. The Scottish Partnership for Palliative Care[iii] summarises the following as key requirements:

- autonomy, honesty and the opportunity to explore personal preferences
- a sense of meaning, purpose and spiritual wellbeing
- empathy and support to cope with uncertainty and deteriorating health
- relief from distressing symptoms
- support to get the most out of whatever time is left with the people they care about
- support with financial, legal and other practical issues
- access to short breaks/respite
- understanding and support from family, friends, colleagues and communities when dealing with loss and bereavement
- access to support, advice and information

Scottish Borders Health and Social Care PARTNERSHIP

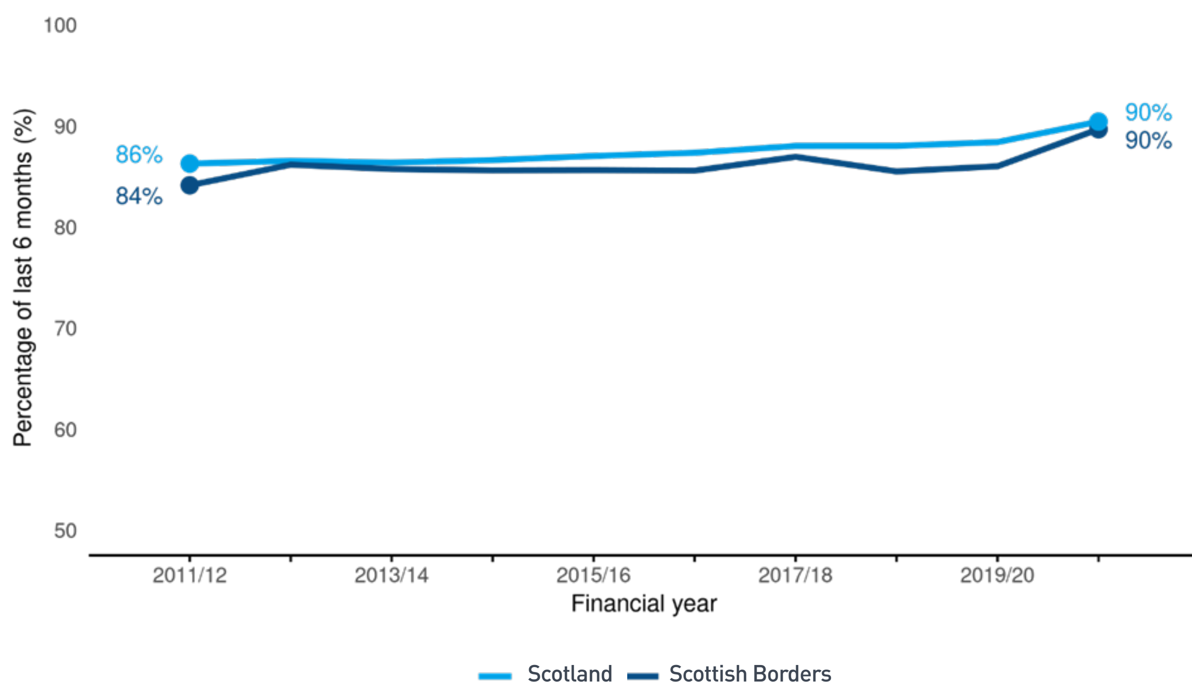
Palliative care services should also consider the needs of unpaid carers, families and surrounding communities who support those receiving end of life care. Most people will turn to family and friends for bereavement, but some people need more help to deal with grief. The bereavement charter for Scotland contains 13 statements for what bereavement should look like[iv].

Most people express a wish to remain in their homes as long as possible when receiving palliative care. It is important that people receive the right care at the right time in the right place. The percentage of time in the last 6 months (L6M) of life spent at home or in a community setting provides a high level indication of progress in implementation of the Scottish Government's strategy towards Palliative and End of Life Care. The Scottish Government is in the process of developing a new strategy for Scotland.

In 2020/21 there were 1,348 deaths in the Scottish Borders, including falls but excluding people who died from other external causes. For these individuals the percentage of the L6M of life spent at home or in a community setting was 89.7%, almost in-line with the Scottish average (90.4%).

In the Scottish Borders 10.3% of the days in the L6M were spent in hospital, which equates to an average of 19 days spent in hospital per person.

Figure 66: Percentage of last six months of life spent at home or in a community setting, 2011-12-2020/21



Data Source: *Public Health Scotland* (Accessed September 2022).

Before 2020/21 the percentage of L6M spent at home/in the community was roughly constant at 85%, while in Scotland the percentage was increasing by a small amount year on year. The increase from the previous financial year is likely related to the COVID-19 pandemic, during which there was an unprecedented lack of capacity in hospital ward beds.

As the data suggests, most palliative care in the Borders is delivered in a community or primary care setting in the last 6 months of life, however service users may also receive care in an acute setting. The Margaret Kerr Unit (MKU) based in the Borders General Hospital, is a specialist built palliative care unit which has 8 rooms and serves both inpatients and outpatients. The unit runs at 100% capacity.

In addition, the Palliative Care team cover acute hospital outreach. The outreach team may have up to 800 referrals per year ranging from advice only to complex care assessments and ongoing input. Finally the Community Clinical Nurse Specialist service covers a caseload of 120 patients in the community and in community hospitals.

It is estimated that by 2040 the number of people requiring palliative care in Scotland will increase by 14% and 20% if factoring in multi-morbidity[v]. With an ageing population and an increase of chronic conditions, it is likely more people will require palliative care in the next two decades.

7. SUPPORT AND RESOURCES

Primary Care

GPs

As of July 2022, there are **23** GP Practices in the Scottish Borders operating from **14** premises with a registered population of approximately 120k.

The upkeep of the primary care estates is significant, the geographical spread of the population means that services cannot be centralized and there is a need to maintain smaller services in more rural locations. This comes at additional cost and complexity in planning. There is a need to ensure that surgeries make the best use of the premises available.

Implementation of the Primary Care Improvement Plan (PCIP) requires additional space in community locations. This presents significant challenges as there are few locations suitable for service delivery and there is pressure in the cost to facilitate this.

Investment is required to bring current estate up to standard, make community locations an attractive and efficient environment to work in and also facilitate the delivery of PCIP along with shifting the balance of care.

NHS Borders recently commissioned an external organisation to complete a review of all Primary Care premises across the Scottish Borders. The recommendations of this report are currently under review to agree a phased/prioritised works programme to address all the required capital works.

Planning is currently underway for a joint premises with the Earlston Primary School campus development.

The Health and Care Experience Survey asks about people's experiences of accessing and using their GP practice and Out of Hours services; aspects of care and support provided by local authorities and other organisations; and caring responsibilities and related support.

- **66%** of respondents said that overall, they would rate the care provided by their GP practice was positive
- **88%** of respondents felt they were listened to
- **85%** of respondents felt they were treated with compassion and understanding
- **70%** of respondents said that the care experienced from the out of hour's service was positive
- **64%** of respondents rated their help, care or support services as positive
- **59%** of respondents said they had a good balance between caring and other things in their life

Nursing

There are **12** Advanced Nurse Practitioners (ANPs) /trainee ANPs in post within all four GP clusters of NHS Borders and a further three were successfully recruited and began post in August 2022. These Advanced Nurse Practitioners support the delivery of urgent care in the Scottish Borders.

Advanced Nurse Practitioners are employed across all 4 clusters (by whole time equivalent (WTE)):

Cluster	WTE
Scottish Borders South	5.0 WTE
Scottish Borders West	3.5 WTE
Scottish Borders East	1.0 WTE
Scottish Borders Central	2.0 WTE

Distribution of Trainee ANPs (by whole time equivalent (WTE)):

Location	WTE
Teviot Health Centre, Hawick	2.0 WTE
O`Connell Street, Hawick	1.0 WTE
Selkirk Health Centre	1.0 WTE
Roxburgh Street, Galashiels	1.0 WTE
Galashiels Health Centre, (50% split between Ellwyn and Waverley)	1.0 WTE
Eyemouth Health Centre	1.0 WTE
West Linton	1.0 WTE
St Ronan's Innerleithen	1.0 WTE
Neidpath, Haylodge Health Centre	1.0 WTE

Distribution of Qualified ANPs (by whole time equivalent (WTE)):

Location	WTE
Teviot, Hawick	0.6 WTE
Newcastleton	0.2 WTE

There is one lead Advanced Nurse Practitioner (1.0 WTE) with a 50/50 split between clinical in Tweed, Peebles & non-clinical.

Currently there is scope for over **800** practice-based appointments per week. The capacity for this varies depending on type of consultation and qualification level of the Advanced Nurse Practitioner. Appointments are conducted through telephone consultations (10 minutes), face to face appointments (20-30 minutes) and home visits (30 minutes).

Qualified Advanced Nurse Practitioners provide, on average, 18-20 consultations per day with trainee Advanced Nurse Practitioners providing an average of 10-12 consultations per day.

Allied Health Professionals

Allied Health Professionals (AHPs) comprise of the **14** professions recognised in Scotland by the Health Care Professions Council. The Health and Social Care Partnership employs the following professions providing services to the population of the Scottish Borders: Dietetics, Music Therapy, Occupational Therapy, Orthotics, Orthoptics, Paramedics, Podiatry, Physiotherapy and Speech and Language Therapy. These professionals provides services across the Health and Social Care Partnership, and Acute Services with approximately **225** WTE employees.

Across the partnership Allied Health Professionals deliver services within Community Hospitals, Health Centres, Care Homes, schools, community venues and in the homes of Scottish Borders residents. These services work across multi-disciplinary and integrated teams working alongside social work, care providers, GPs, community nurses, and third sector organisations amongst others.

Allied Health Professional services seek to provide a person-centred approach to promoting self-management, early intervention and prevention, as well as rehabilitation and therapy after medical or social care intervention. Allied Health Professionals are experts in promoting health and wellbeing through areas such as vocational and educational support, physical activity, diet, and mental health and wellbeing. Examples of this include physiotherapy services working alongside Live Borders to deliver physical activity classes, Dietetic services supporting weight management services in the community or Music Therapy services supporting Library services to deliver wellbeing programmes.

Allied Health Professional services are also critical to supporting the Borders population ageing well and are currently providing podiatry education into Care Homes to support foot care needs, community speech and language therapy supporting frail adults to stay at home rather than be admitted to hospital, and occupational therapists providing the functional support needed for people to remain independent in their own homes.
Allied Health Professionals provide a significant contribution to the wider health and social care system. They are critical to reducing the length of stay in hospital by providing quality rehabilitation, supporting timely discharge through ongoing reablement in the community, and by preventing unnecessary admissions by appropriate intervention within Primary Care. Advance Practice roles within Allied Health Professional services across the HSCP allow specialist support and intervention in areas such as Eating Disorders, Major Trauma, Musculo-skeletal Physiotherapy, Learning Disability, Mental Health and Specialist Rehabilitation.

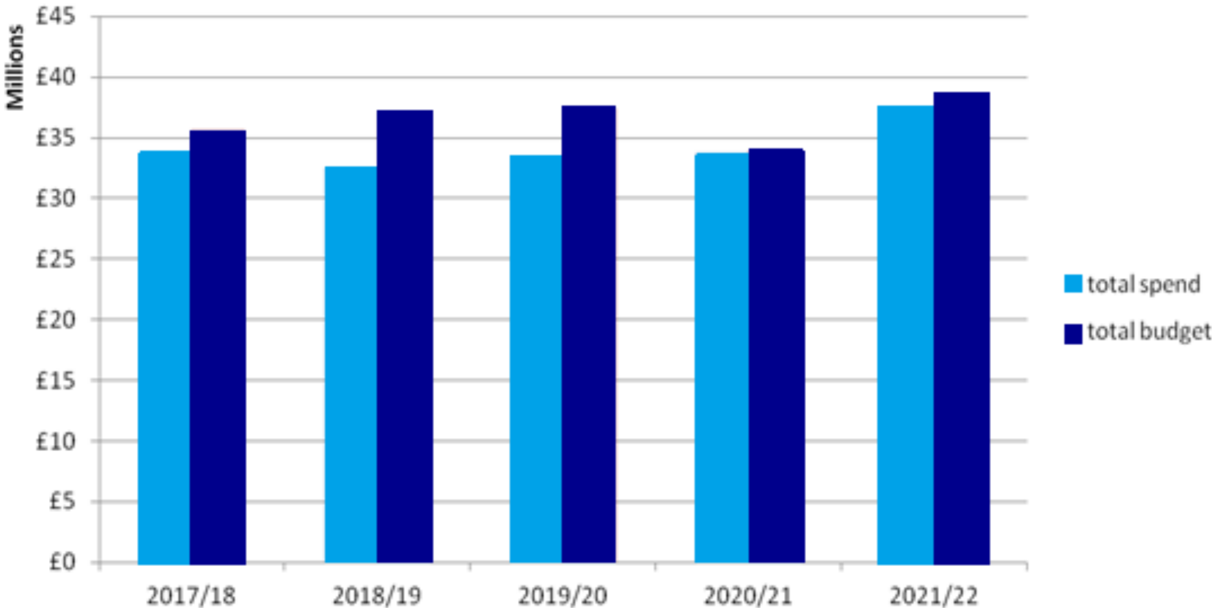
Safe Staffing Legislation and National Workforce Strategies are informing Allied Health Professional practice and service provision, and a National Allied Health Professional Workforce and Education Review is currently influencing local service reviews and service planning. A current national shortage of some Allied Health Professional professions, in combination with ongoing system-wide pressures is necessitating review of current workforce and skill mix to ensure safe, effective person centred care is continued to be provided to the Scottish Borders population. Allied Health Professional services remain essential to the Health and Social Care Partnership aims of supporting people to remain healthy and independent in their homes, in their communities, and to support the timely flow through health and social care systems.

Prescribed Medication

On average over the last 6 years, the Scottish Borders Health and Social Care Partnership has had an annual budget of **£36M** for prescribed drugs.

Efforts to reduce this cost safely whilst encouraging patient self-management of symptoms where appropriate include encouraging healthy lifestyles, the Wellbeing Service, "healthy reading" and exercise referral schemes.

Figure 67: Combined (Primary & Secondary Care) spend for Prescribed Medicine



Data Source: *GP surgeries* (Accessed August 2022).

£464 is the average GP prescribing spend per 1,000 patients per day (2021/22), higher than a Scotland average of £449 , which one might expect given the increased elderly population within the Scottish Borders. There is around a £100 difference in the range of cost per treated patient across practices in the Scottish Borders.

Table 68: Most frequently prescribed medicines of 2021/22

Scottish Borders top 5 by volume	Nationally by volume
Omeprazole	Omeprazole
Atorvastatin	Atorvastatin
Paracetamol	Co-codamol
Levothyroxine	Levothyroxine
Lisinopril	Paracetamol

Scottish Borders top 5 by spend	Nationally by spend
Apixaban	Apixaban
Freestyle Libre sensors	Sip feeds
Fostair & Luforbec ("generic" equivalent)	Fostair & Luforbec
Sip feeds	Abiraterone
Dressings	Freestyle Libre

Data Source: *GP surgeries-PRIMS Data* (Accessed July 2022).

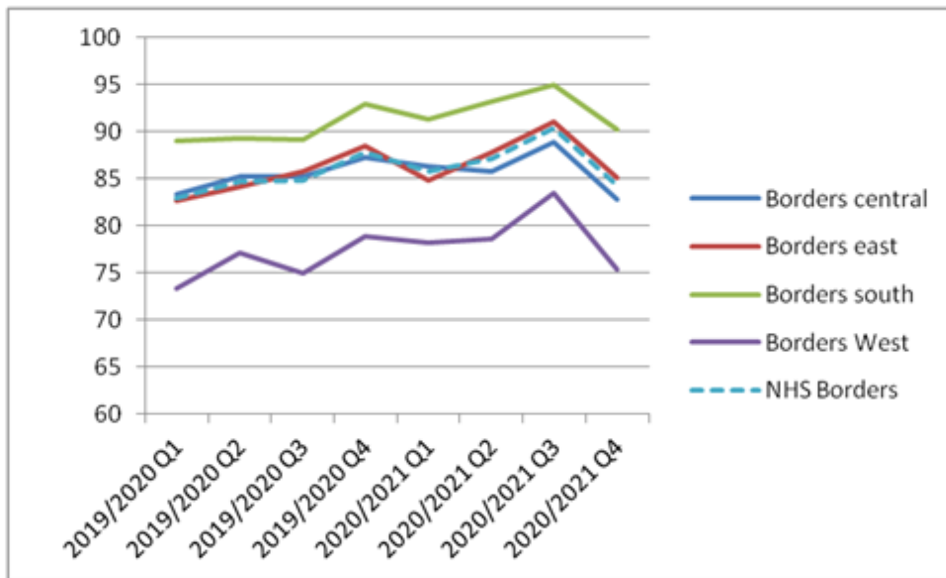
The slight variations in the top 5 reflect the differing local Formularies and population demographics. Borders has an increasing and ageing older population compared to the rest of nation, this combined with people are living longer with co morbidity and increasing issues around medicine shortages will mean regardless of savings made, the overall spend is expected to increase (albeit at a lower rate).

In NHS Scotland, **medication is by far the most common form of medical intervention. Four out of five people aged over 75 years take a prescription medicine and 36 per cent are taking four or more**[lxxiii].

The Scottish review of polypharmacy prescribing data (10+ BNF paragraphs plus a high risk medicine) by deprivation demonstrates that multi-morbidity, and its associated problems, presents 10 to 15 years earlier in more deprived communities[lxxiv].

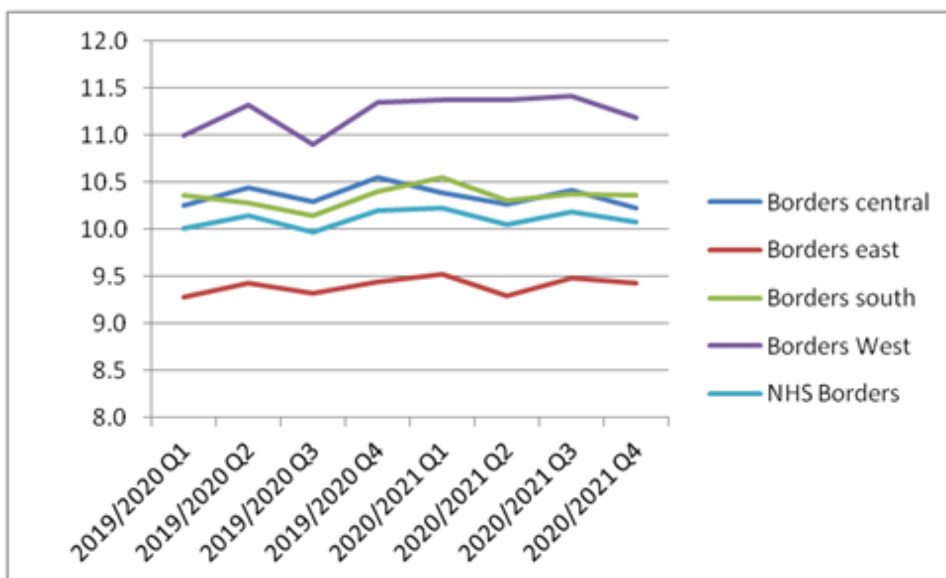
It is suggested that up to 50 per cent of drugs are not taken as prescribed, many drugs in common use can cause problems and adverse reactions to medicines are implicated in 5 - 17 per cent of hospital admissions[lxxv]. Furthermore it is estimated nationally that 50% of hospital admissions for adverse drug events for those aged 65 and over and on 5 or more medications are preventable.

Figure 69: Cost per Treated Patient



Data Source: *GP surgeries* (Accessed August 2022).

Figure 70: Cost per Item



Data Source: *GP surgeries* (Accessed August 2022).

Community Pharmacy

There are **29** community pharmacies in Scottish Borders and **2** dispensing practices.

General location is shown below in localities with multiple pharmacies in towns such as Galashiels, Hawick, Selkirk, Kelso, and Peebles.

Figure 71: Pharmacy locations in the Scottish Borders

*Numbers in square boxes are pharmacies in the locality. Numbers in circles are dispensing DR locations

Data Source: *GP surgeries* (Accessed August 2022).

The community pharmacy contract in Scotland has **5** core services[lxxxvi]:

- Pharmacy First – Management of minor ailments
- Quality Improvement – Improvements in service delivery
- Medicines Care and Review – Support for long term medical conditions
- Public Health Service – Emergency contraception, smoking cessation, health promotion
- Acute medication service – Dispensing of prescriptions

Whilst core services must be delivered by all community pharmacies, the national suite of services is optional. All pharmacies in NHS Borders offer these services: [lxxvii]

- Unscheduled Care – Support for patients during the out of hours period
- Gluten Free Food Service – Supply of gluten free food
- Stoma Service – Supply and support for patients who use products to collect urinary or digestive tract products.

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As well as the core and national services which community pharmacies in Scotland provide to their communities, there are a range of local services which have been developed in response to the needs of people living in the Scottish Borders. The compact nature of Health Boards also allows for controlled tests of change, with some of the most successful national services like Pharmacy First having their origins as local innovations. The Scottish Borders Health and Social Care Partnership negotiates locally with Community Pharmacy Borders on remuneration for the following pharmaceutical services:

- Advice to Residential Homes
- Support for people with taking their medicines
- Injecting Equipment Provision
- Take Home Naloxone
- Production of MAR charts to support carers
- Out of Hours rotas

The Pharmaceutical Care Services plan provides an overview of the provision of pharmacy services within NHS Borders and pharmacy focused programmes of work[lxxviii] . The actions in the Pharmaceutical Care Services plan that relate to Primary care services are outlined below:

- PLAN for Improve and Increase Use of Community Pharmacy Services
- PLAN for Pharmacy Teams Integrated into GP Practices
- PLAN for Pharmaceutical Care that supports Safer Use of Medicines
- PLAN for Improved Pharmaceutical Care at Home or in a Care Home
- PLAN for Enhanced Access to Pharmaceutical Care in Remote and Rural Communities
- PLAN for Enabling NHS Pharmaceutical Care Transformation

Pharmacotherapy

Pharmacotherapy services with the Scottish Borders involves embedding pharmacists and pharmacy technicians in primary care multi-disciplinary teams to deliver a range of services including:

- Repeat and serial prescribing
- Medication and polypharmacy reviews
- Medicines reconciliation
- Medication enquiries
- Monitoring lab results for high-risk medicines

All **23** NHS Borders GP practices have Pharmacotherapy input with **18** whole time equivalent staff (**94** WTE Technicians and **8.6** WTE Pharmacists).

The General Medical Services (GMS) 2018 contract Level 1 work is currently underway, with acute and repeat prescription prescribing, discharge letters, clinic letters and serial prescribing at the forefront of the changes.

The main pressures experienced within Pharmacotherapy include staff resource, administration and data gathering support and space in practice.

The delivery deadline has been extended to April 2023 and implementation of this work stream is ongoing. A General Practice Clinical Pharmacy Team is in place and delivery of Level 1 work is being prioritised.

Community Hospitals

As of July 2022, there are **4** Community Hospitals located in Hawick, Peebles, Duns and Kelso providing a total of **92** beds, with 23 beds in each Community Hospital.

There are **47.5** Registered General Nurses and **64.89** Unregistered Staff.

Community Hospitals provide intermediate care when an Acute Hospital Setting is not appropriate. All Scottish Borders patients should be able to access care which is most appropriate for them. In line with the aims of the national intermediate care framework[lxxix], the hospital can provide a bedded facility to enable people to recover and re-able after an acute episode. It can also allow people time to adjust to a care environment where a realistic assessment of long-term needs can be made.

- Patients requiring rehabilitation of usually 2 to 3 weeks and up to 6 weeks
- Management of patients with some challenging behaviours who may require periods of 1:1 support. Additional staff may be required to ensure patient safety.
- Intravenous (IV) Therapy – blood products and other IV medications following clinical risk assessment for suitability
- Longer term needs due to medical and, or social / domestic complexities which need to be resolved in order to progress the patient in achieving their optimum outcomes

- Medicines management/monitoring
- Post-operative rehabilitation care needs
- Palliative and end of life care where the Out of Hospital Team / Community Nursing Service is unable to safely support the patient at home or in a bed with care or it is the patients choice to die in hospital; this excludes specialist palliative care
- Anticipatory End of Life care and symptom control (e.g., breathlessness, constipation, pain, nausea)
- Safe and effective management of syringe drivers
- Short term but intensive rehabilitation needs such as unwell neurological patients
- Non weight bearing patients with potential for early rehabilitation interventions whilst still non weight bearing

Sexual Health

The Borders Sexual Health Team in the Scottish Borders offers a free and confidential service to everyone regardless of age, sexuality or gender expression. The specialist team provides contraception and sexual health testing, treatment, and advice. All of the services and treatments are free. Specialist services include;

- Sexually Transmitted Infections (STI's) testing and treatment; including Chlamydia Gonorrhea, Syphilis, HIV and Hepatitis B & C
- Self-testing kits
- Advice on a range of contraception options, including long acting contraception (LARC)
- Long-acting contraception including intrauterine devices (IUD and IUS), implants and inject able contraception
- Emergency contraception
- C Card & C Card +
- Pregnancy tests, advice on termination of pregnancy (abortion), and if needed, referral for termination
- PrEP (Pre-exposure prophylaxis for HIV) and PEPSE (post-exposure prophylaxis for sexual exposure to HIV)
- Care and treatment for people living with HIV
- Vaccination for Hepatitis B and HPV (wart virus)

Telephone advice clinics and self-testing kits are available through the service. People can ring for a telephone advice appointment where a person will be triaged to the appropriate booked clinic or managed on the telephone. There is also an online booking system. Clinics are held in different locations across the Scottish Borders. An individual can specify if the wish to be seen by a female or male clinician.

Forensic Suite

The sexual assault self-referral phone service is a 24 hours a days, 7 day a week service that can help to arrange care for survivors in the days following a rape or sexual assault. This is for everyone regardless of age, sexuality or gender expression. The service may be able to arrange for a forensic medical examination (FME) at the specially built suite within the Borders General Hospital campus without making a report to the police.

Further help, support and care will also be offered and will then be available locally should the survivor require or wish this. This service supports people immediately after a rape or sexually assault providing advice and treatment for injuries, STI Testing, preventative treatment for HIV and pregnancy.

The service consists of:

- 1.0 WTE Consultant
- 1.0 WTE Band 7 Lead Specialist Nurse
- 2.7 WTE Band 6 Registered Nurses
- 1.0 WTE Band 5 Business Support
- 1.1 WTE non registered staff

Community Optometry

As of July 2022, there are **11** optometrists in the Scottish Borders.

Dental

As of July 2022, there are **17** general dental practices in the Scottish Borders. The Public Dental Services operate over **4** premises and there is also an Oral Health Improvement department whose aim is to improve the oral health of the residents within the Scottish Borders.

A new general dental practice is due to open in Kelso in the coming months.

Vaccination

The Scottish Borders Health and Social Care Partnership has created a dedicated Vaccination Service to manage vaccination and immunisation.

All 115,000+ patients of the Scottish Borders are eligible for vaccinations at multiple points throughout their life.

The Vaccination Service is led by a dedicated Clinical Service Manager, supported by an Assistant Service Manager and the following teams:

- Clinical team including senior charge nurse, nurses and healthcare support workers
- Planning and performance team to manage planning and monitoring of uptake
- Clinic operations team
- Vaccination Hub for patient contacts and admin, including a coordinator, supervisors admin and call handlers
- Dedicated pharmacy technician to manage vaccine provision.

The Scottish Borders Health and Social Care Partnership Vaccination Service leads the delivery of programmes in partnership with public health, school immunisation, community nursing, occupational health, maternity services, child health, general practice, acute services, and the wider Scottish Borders Health and Social Care Partnership.

To date, the Vaccination Service has given over 370,000 vaccinations, including over 295,000 COVID-19 vaccinations since December 2020 and 75,000 vaccinations across routine childhood, pneumococcal, shingles, flu, selective and travel programmes.

Vaccinations are given in a range of venues including health centres, schools, care homes, hospitals and community venues.

Table 72: Clinical Staffing Breakdown

	Permanent		Fixed Term		As & When	
	In Post	Vacant	In Post	Vacant	In Post	Vacant
Vaccination Transformation Programme (Babies, Pre-School, Travel & Selective)	1.99	4.91	0.00	0.00	0.00	0.00
Adult Vaccinations (Shingles, Pneumonia, Flu & COVID-19)	2.10		1.95	8.08	0.47	0.00
School Immunisations	3.80 7.89	0.00 4.91	0.00 1.95	1.70 9.78	0.00 0.47	0.00 0.00

Data Source: *GP surgeries* (Accessed August 2022).

Primary Care Improvement Plan (PCIP)

The implementation of the Primary Care Improvement Plan (PCIP) is a priority and significant work is being put into the successful delivery of each of the identified work streams. An update on process is provided below; however, the significant issue is the gap in funding between the Primary Care Improvement Plan allocation and the actual cost of implementation.

The Memorandum of Understanding (MOU2) set out that whilst people should not disinvest in non-priority areas, they should use any available funding to prioritise the Vaccination Transformation Programme (VTP), Community Treatment and Care (CTAC) and Pharmacotherapy. All Primary Care Improvement Plan funding was allocated prior to the Memorandum of Understanding 2 being published, and for some work streams the services are fully operational, therefore reprioritisation of funding is not possible.

Adult Social Care

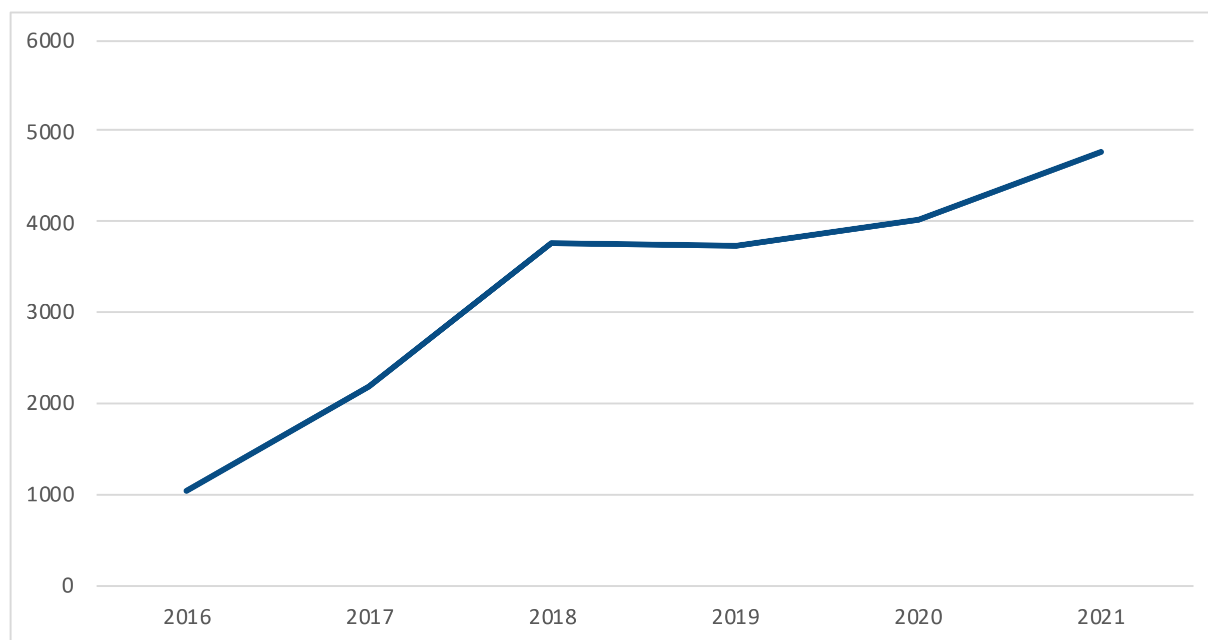
Adult Social Care refers to the support and care assessment and provision given to all adults, including older people.

According to Care Inspectorate data, there are 43 care at home and housing support services registered, employing a total of 793 staff [lxxx]. The third and independent sectors are collectively the largest employer of social care staff comprising of 67% of the staff delivering care to people living in their own homes and 83% of the beds provided in care homes. The remaining 33% of staff are employed by the Scottish Borders Health and Social Care Partnership, in the Scottish Borders Council.

Most care at home services are delivered by the organisation SB Cares. Until 1 December 2019, SB Cares was registered as a Limited Liability Partnership wholly owned by Scottish Borders Council, although Councillors have since approved the recommendation to bring the partnership back into full ownership of the Council.

There were a total of **6,466** referrals to Adult Social Services in 2021. Of these, 4,782 were new referrals (clients who are new to the service or whose case was previously closed). A further 1,680 referrals were for clients already known to the service.

Figure 73: Number of new referrals to Adult Social Services



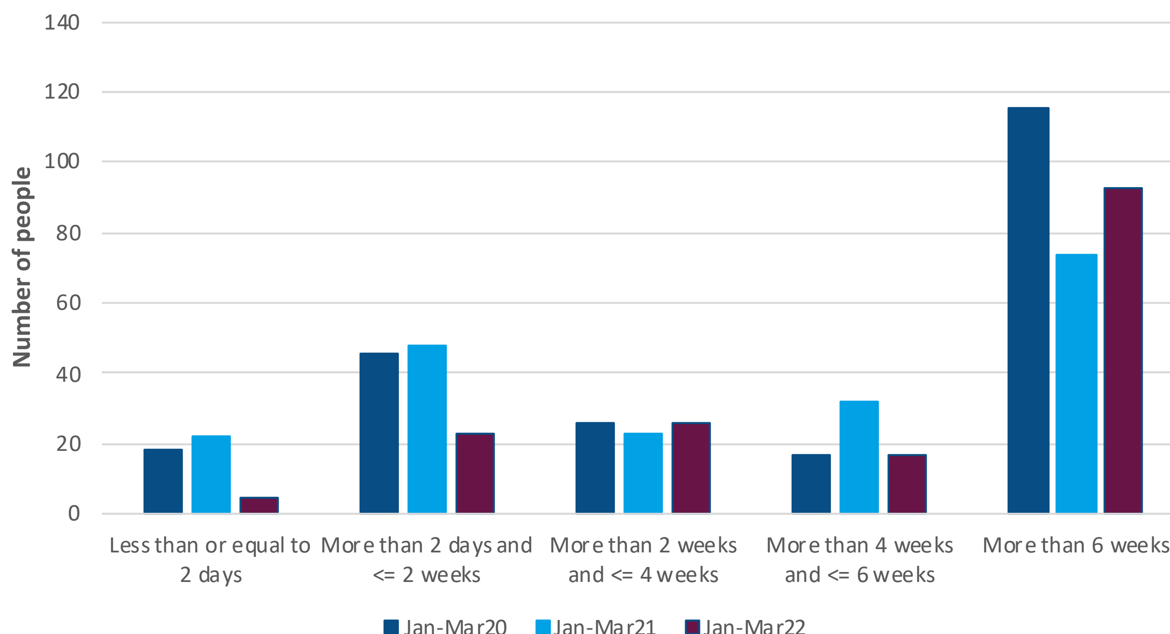
Data Source: Scottish Borders Council internal data. *Mosaic* (Accessed September 2022).

The number of new referrals has increased from 1,036 in 2016 to 4,782 in 2021. As most clients are older adults (→65 years in age) the expectation is that the number of new referrals will continue to increase in the next two decades.

For most cases, it took more than 6 weeks between first contact and completion of a community needs assessment. The majority of cases (→80%) were considered 'Critical'.

There were 173 community needs assessments completed in the first quarter of 2022. This is a decrease from the year before (198). In 2018 there were 317 completed assessments during the same time period.

Figure 74: Time intervals from first contact to completion of a community need assessment – All adults aged 16+, Jan-Mar 2020-2022



Data Source: Scottish Borders Council internal data. *Mosaic* (Accessed September 2022).

Until an assessment has been completed the adult's needs and risks will be responded to via the duty social work and duty OT system in each locality. Following assessment a support service may be required either at home or in a care setting. In Quarter 1 of 2020 60% of cases were assigned an individual service at home or in a 24 hour care setting within 2 weeks of the care assessment, in 2021 this decreased to 45% and in 2022 this has decreased again to 37%. The number of cases which were assigned personal support services more than 6 weeks after the care assessment has increased from 6% in Quarter 1 of 2020, to 15% in 2021 and 28% in 2022.

Residential Care

Care homes provide accommodation, nursing, personal and/or personal support to vulnerable adults who are unable to live independently. Residential Care services are open to people with a range of care needs. There is 24 hour care and support available to a person who may find it difficult to manage daily life at home and requires this level of service as per assessed need. Each resident has their own bedroom and there are communal living spaces.

According to the annual adult care home census, on 31st March 2022 there were **26 registered care homes** registered care homes in the Scottish Borders, the majority of which cared for people aged 65+, except for 3. Of the 26 total, 6 were local authority/Health and Social Care Partnership care homes, 17 were private sector, and 3 were voluntary/not-for-profit (these same 3 are dedicated to adults ←65 years only). Since 2012 there are the same number of LA care homes, but 2 fewer private sector, and 6 fewer voluntary/not-for-profit.

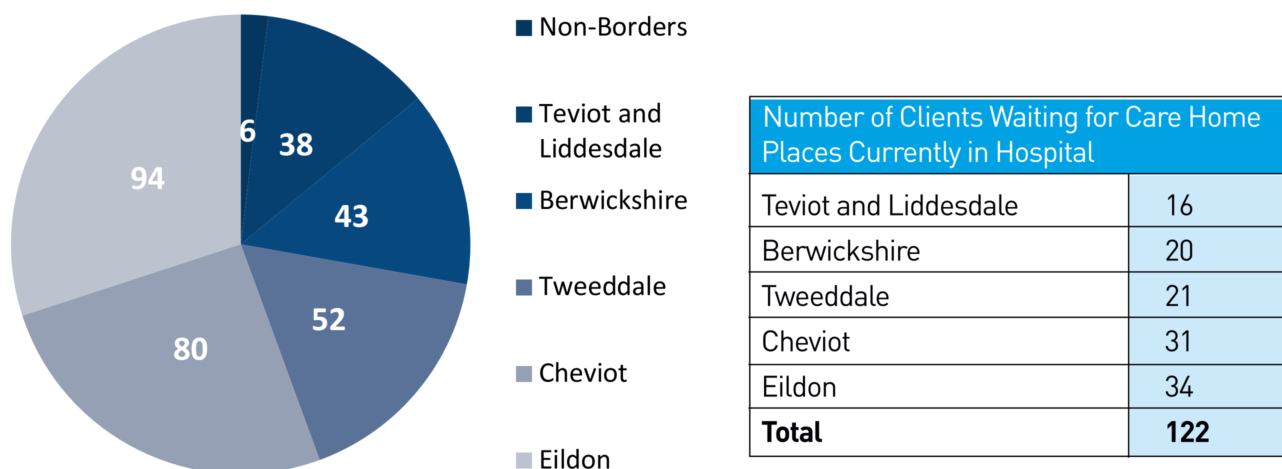
In 2021, there were on average **684** people residing in Care Homes each month in the Scottish Borders. Each month on average there were 21 new residents and 23 residents whose care home stay ended.

There are 12 specific categories for health characteristics of long-term residents, each resident can have more than one health characteristic. On 31st March 2022, of the 618 long-stay residents:

- 59% had dementia (including those waiting a medical diagnosis)
- 29% had physical disabilities not relating to sight or hearing
- 24% required nursing care
- 11% had learning disabilities
- 7% had mental health problems
- 11% had visual impairment and 9% had a hearing impairment.

In 2021 **60%** of long term residents had an emergency hospital admission in the 28 days before moving into a care home. There were 236 long term residents who died in 2021, 85% of these deaths occurred in the care home and 13% occurred in hospital. These figures are similar to Scottish averages.

Figure 75: Number of Clients Waiting for Care Home Places (any location) as at 17/10/2022



Number of Clients Waiting for Care Home Places Currently in Hospital	
Teviot and Liddesdale	16
Berwickshire	20
Tweeddale	21
Cheviot	31
Eildon	34
Total	**122**

Data Source: NHS Borders internal data. *Strata* (Accessed October 2022).

In October 2022, there were **313** clients awaiting Care Home places; 122 clients were in hospital at the time of waiting (note: not all were delayed discharges). The locality with the most people waiting for a place was Eildon with 94 clients waiting, 34 of which were in hospital at the time. Berwickshire had the highest percentage of clients waiting in hospital for a placement (46%) while Eildon had the lowest percentage (36%).

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Over 65

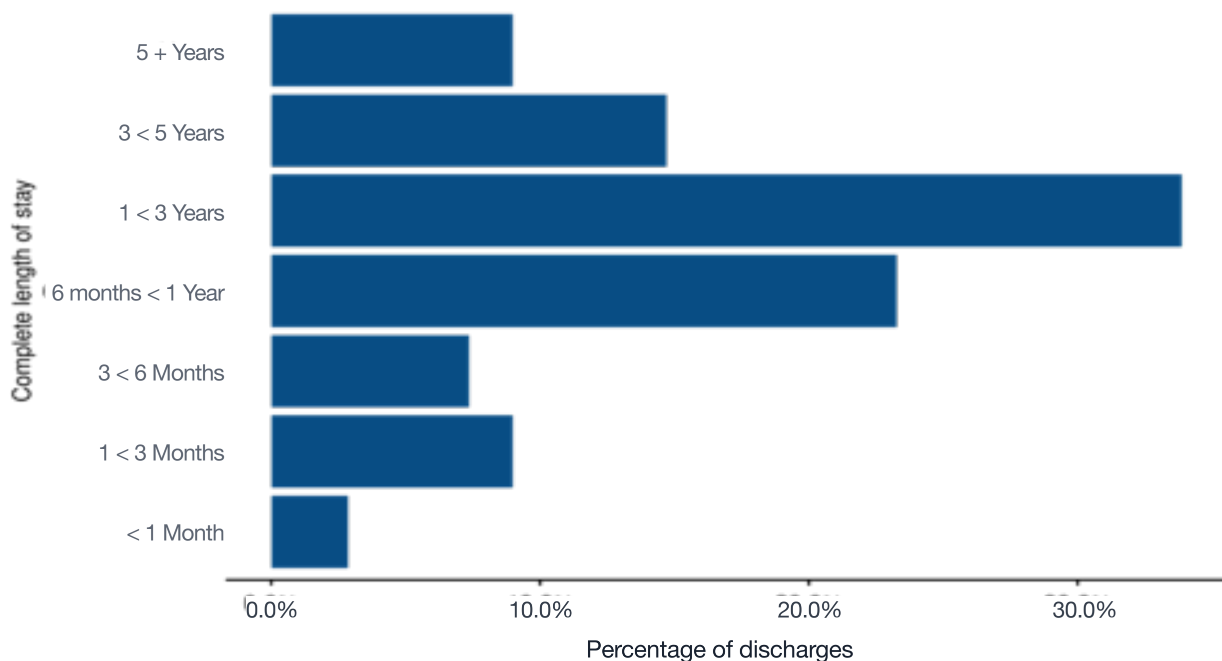
Most spaces in Care Homes are occupied by older people. By the end of March 2022 there were **798 registered/available places** in Scottish Borders care homes. Of these, 747 (94%) were places for older people aged 65+ years (22% in LA care homes, 78% in private sector).

According to the Adult Care Home Census, the median age for admission for all adults into a Care Home is **83 years** in the Borders (84 years for older people aged 65+ years). In 2012, it was 81 years (and 83 years for older people).

There were more places available 10 years ago. In 2012 there were 870 total available places of which 791 (91%) were for people aged 65+, therefore there has been a decline of 6% (-44 places) in care home places for the elderly in the last decade. Of this decline, 77% (34 places) were in LA care homes.

On 31st March 2022 the estimated percentage occupancy in all Scottish Borders care homes was **83%**, while Local Authority/HSCP care homes for people aged 65+ years were 73% occupied. This is compared to 2012 when the occupancy in Local Authority/HSCP care homes for the elderly was 83%.

Figure 76: Estimated percentage of complete stays for long-stay residents by length of stay, FY2021/22



Data Source: *Care Home Census* (Accessed September 2022).

Most of the people in care homes were long-stay residents (**618** total). Of these, 577 (93%) were people aged 65+ years. In addition there were 27 respite residents, of which 23 were aged 65+ years, and there were 17 short-stay residents which were all aged 65+ years. Compared to 2012, in 2022 there were 56 fewer long-stay residents, 10 fewer respite residents, and 11 fewer short-stay residents.

The majority (69%) of the long-stay residents aged 65+ years were mainly or fully publicly funded, with the remaining 31% being mainly or fully self-funded. This is compared to 2012 when 73% of long-stay residents aged 65+ were mainly or fully publicly funded. In Scotland, the National Care Home Contract rate is negotiated annually between the COSLA and Scottish Care. The 2021/22 standard weekly rates for fully publicly funded residents (in care homes for older people) were £681.34 without nursing care and £789.61 with nursing care.

Under 65
There are 3 voluntary/not for profit care homes which house adults under the age of 65 in the Scottish Borders. In the first quarter of 2022 there were 50 permanent/long-stay residents supported in care homes between the ages of 16-64, 26 of whom have a learning disability.

Estimated Demand
A modelling exercise was undertaken by Public Health Scotland in 2021 to evaluate the demand for and commissioning of care home beds in Scottish Borders up to 2030[lxxxi] .

The report concluded that there would be a need for 187 additional care home beds within the Scottish Borders by 2030. This represents an annual increase of 14 - 20 care home admissions per year. However, past experience has shown that care home demand does not always increase proportionately to demographic change. For example:

- Between 2009 and 2019, care home bed numbers in Scottish Borders increased by just 1%, despite a 20% increase in the population aged 75 and over. This disparity is shared across Scotland with a Scotland overall change of -1% during this period.
- Scottish Borders has the third lowest number of care home residents per head population in Scotland and has been amongst lowest 4 local authorities for past 10 years (2009 to 2019).

Studies also show that fewer older people enter care homes in rural areas compared to urban areas, possibly as a result of closer family support networks. This suggests older people in the Borders manage to remain at home longer than in other places. Some individuals however may be placed outside of the Scottish Borders due to a lack of availability.

Day Opportunities

Older People
There are currently no Day Services operating for Older People. Local Area Coordination has replaced this service. The position relating to older adult day services is being reconsidered following feedback from the carers survey and consideration by the Integration Joint Board Carers Workstream.

The Local Area Coordination team of local area coordinators and community link workers work with older adults, anyone with a physical or learning disability, anyone with a long term condition or mental health condition and their family / carers to link them to day activities provided by partner organisations.

Learning Disability
There are 5 Day Services provided by the council for those with a Learning Disability, and one Day Service provided by the third sector.

Table 77: Number of people with Learning Disability using Day Support and Predicted demand

Locality	No. of people using day support	Predicted demand 2023-2024	Predicted demand 2024-2025	Predicted demand 2025-2026	Predicted demand 2026-2027	Predicted demand 2027-2028
Eildon	17 (+3)	0	5 or 6	2	1	2
Cheviot	6 (+2)	1	2	2	1	2
Teviot	15 (+5)	4	0	2	1	0
Tweeddale	4	1	1	4	2	0
Berwickshire	8 (+1)	1	2	1	0	1
Predicted totals	50 (11)	7	10 or 11	11	5	5

Data Source: Scottish Borders Council internal data. *Mosaic* (Accessed September 2022).

It is estimated that an additional 38-39 people with Learning Disability will need day support by 2028.

Local Area Coordination

The Local Area Co-ordination Team provides a service to adults who are isolated in their community due to impact of learning disability, mental ill-health, physical disability or older age. The team encourage and enable individuals to live an active, more connected and purposeful life in their community. The team also work to build strong partnerships with a range of organisations and groups in local communities and to work collaboratively to create new opportunities.

The team comprises Local Area Co-ordinators and Community Link Workers covering the whole of the Scottish Borders area, and are locality based in the five Health & Social Care localities.

Figure 78: Local Area Coordination Referrals by Group

Month	Experiences Mental Ill-Health	Learning Disability	Older Adult	Physical Disability	Not Recorded	Total
Dec-21	17		10	1		28
Jan-22	20	1	16	1	1	39
Feb-22	22	2	23	6		53
Mar-22	30	8	24	3	1	66
Apr-22	28	8	27	7		70
May-22	29	11	18	5	2	65
Jun-22	27	7	15	2		51
Jul-22	24	11	19	3	1	58
Aug-22	41	12	24	5	1	83
Sep-22	25	14	16	2		57
Total	267	79	200	35	7	588

Data Source: Scottish Borders Council internal data. *Mosaic* (Accessed October 2022).

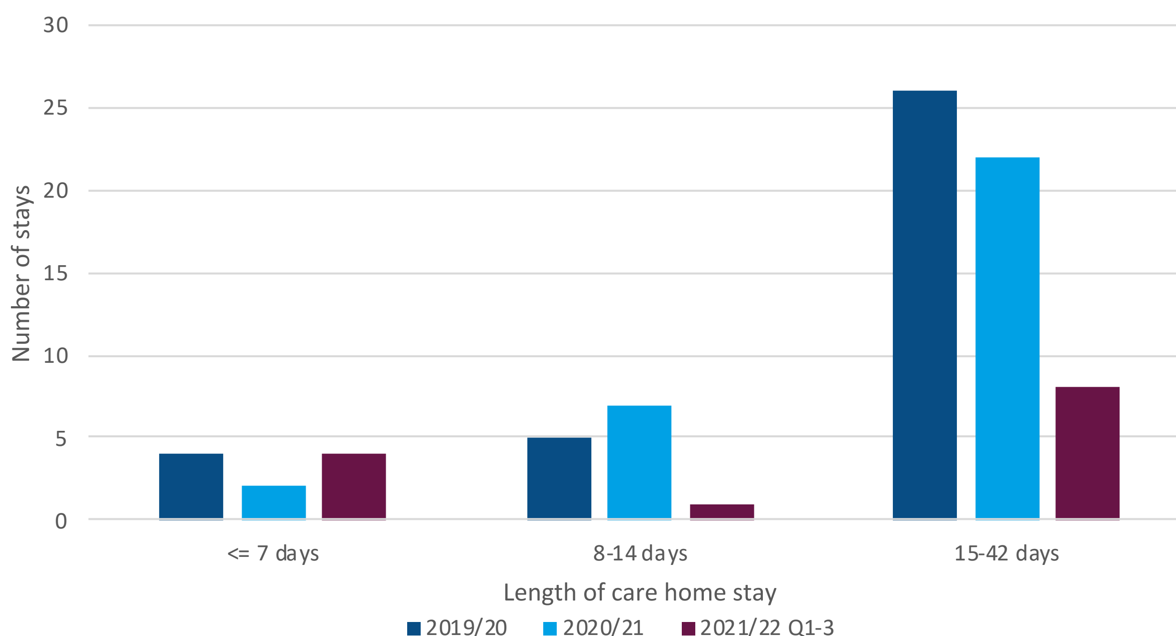
Data collection through the social care IT system (Mosaic) began in December 2021, prior data was not available to review further trends over time.

Respite

It is important for unpaid carers to have respite and take breaks from their caring duties. There are several ways respite is provided in the Borders[lxxxii]:

- In a care home – this can be in the Borders or further afield
- At home or going out locally with staff support to pursue an interest
- In the home of another person recruited to provide this support
- Using a day service
- Self-catering with support
- Using a direct payment to purchase a flexible break

Figure 79: Respite / Short stays by length of stay and financial year



Data Source: *Scottish Borders Council* (Accessed September 2022).

The Adult Care Home Census recorded 97 admissions for respite care in financial year 2021/2022, a reduction of 82% from 550 in 2011/12. This was impacted upon in part by the impacts of the COVID-19 pandemic.

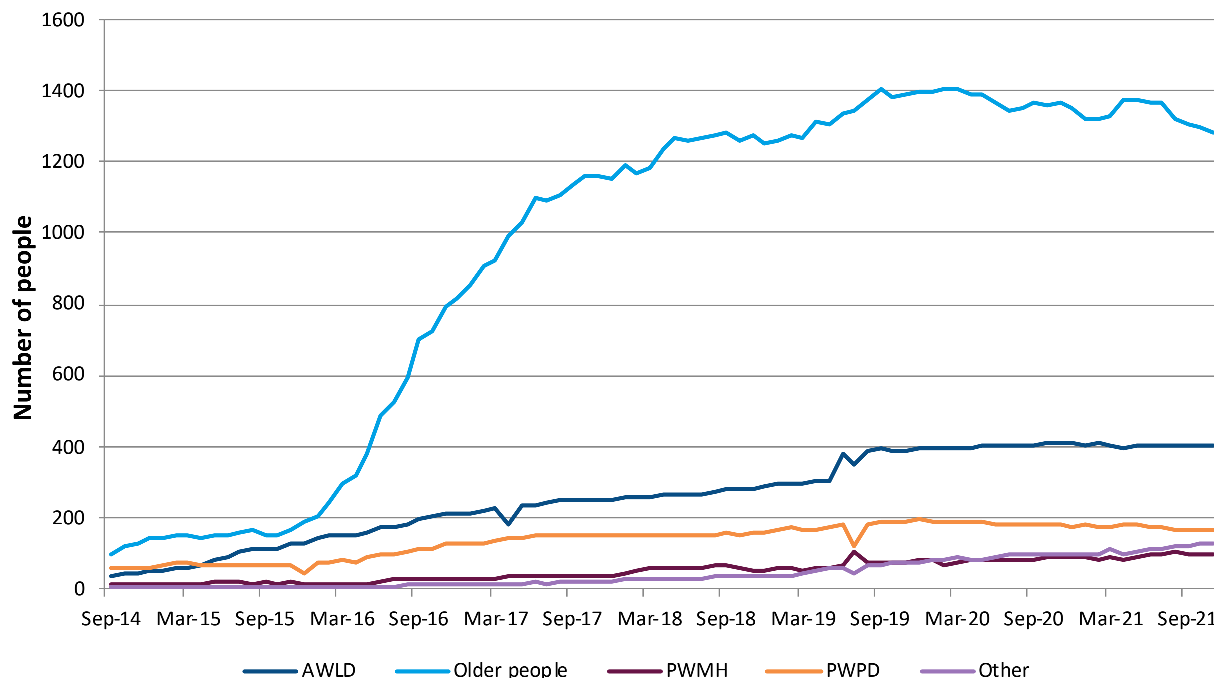
Self-Directed Support

Self-Directed Support (SDS) is an approach to social care that allows individuals more control and choice over the support they receive[lxxxiii]. All social work assessments leading to support use a self-directed approach which is built into the assessment process. There are 4 options with Self Directed Support:

1. Direct payment - People receive an individual budget to arrange their own support. People may employ who they choose and when/how the work is done. This option offers the most flexibility but may be challenging as it effectively makes the service user an employer for their care services.
2. Individual Service Fund – When the person's budget is paid directly to the service providing care for them.
3. Social Work Services – When local authority holds the budget and arranges any support needed.
4. A mix of the above options – People have choice to control some of the budget but not all of it.

The number of people using Self Directed Suppport has increased from **2360** in financial year 2017/2018 to **3,005** in 2020/21[lxxxii]. Since 2016, on average most people received option 3 (76%), followed by option 1(17%) then option 4 (7%). Less than one percent of people used Option 2.

Figure 80: Number of people using Self Directed Support by client group, Sept 2014 – Oct 2021



*Key: AWLD – Adults with Learning Disability, PWMH – People with Mental Health, PWPD – People with Physical Disability

Data Source: *Scottish Borders Council* (Accessed September 2022).

Overall there has been a significant increase in the number of people using Self Directed Supportsince 2014. Older people make up the largest group of users. In September 2014 there were 99 Older people using the service compared to 1,284 in November 2021. The number of those with a Learning Disability using Self Directed Support has also increased more than tenfold from 39 in September 2014 to 405 in November 2021.

Care at Home

As Scotland policy agenda moves away from institutional settings and congregate environments, the provision of community care and support is paramount to ensure individuals can live at home for as long as they want. Individuals may require care and support at different points in their life, or not at all.

There are two key service user groups to consider:

- Older People - people are living longer, leading to a higher incidence of frailty, dementia and co-morbidities, therefore needing more care.
- Individuals with short-term or long-term disabilities/conditions – this covers a range of people including those who have multiple and complex needs and require 24/7 care, to those who require weekly housing support or peer worker input.

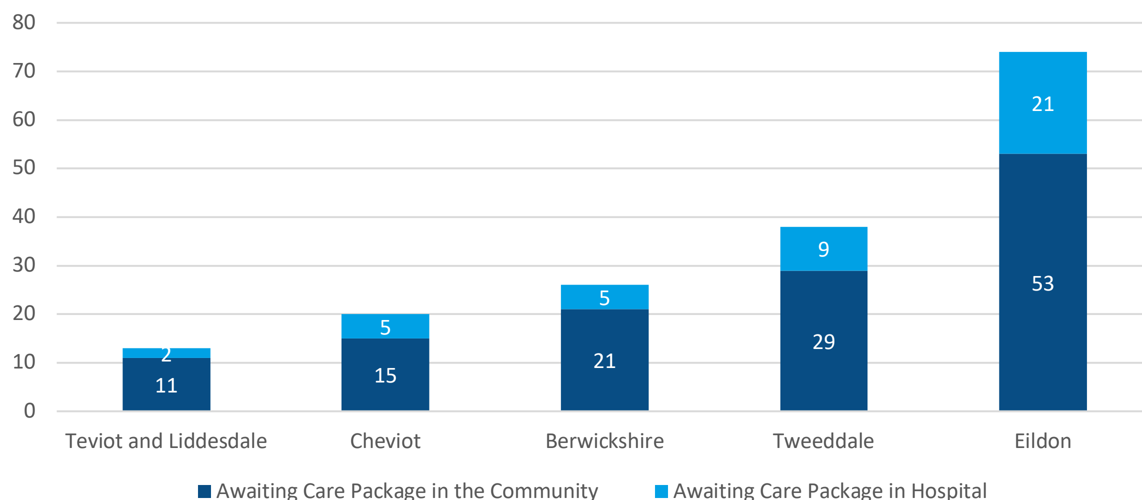
In 2021, there were **16,406** Home Care clients and 549,018 hours of care work delivered. Most Home Care clients are over the age of 65.

Figure 81: Number of people receiving Home Care services in last week of March 2014-2022

		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22
Age 18-64	Number of people receiving Home Care	113	99	99	91	102	-	144	133	130
	Number of hours of Home Care	981	867	828	982	1,072	-	1,791	1,683	1,606
	Number of people receiving personal care at home	101	85	90	83	93	-	-	-	-
	Number of hours of personal care	903	784	725	927	1013	-	-	-	-
Age 65+	Number of people receiving Home Care	1,259	1,165	1,167	1,095	1,047	-	1,230	1,210	1,112
	Number of hours of Home Care	8,213	7,577	7,584	7,073	7,518	-	9,986	9,785	7,704
	Number of people receiving personal care at home	1,244	1,150	1,161	1,089	1,040	-	-	-	-
	Number of hours personal care	7,976	7,332	7,013	6,879	7,245	-	-	-	-

Data Source: *Scottish Borders Council* (Accessed September 2022).

Figure 82: Number of Clients waiting for Packages of Care currently in the Community and Number of Clients waiting for Packages of Care currently in the Hospital as at 17/10/2022



Data Source: NHS Borderes internal data *Matching Unit* (Accessed September 2022).

In October 2022, there were 1**29** individuals awaiting a package of care in the community and **42** individuals awaiting a package of care in hospital.

In 2021, following an emergency admission, 67% of clients were discharged back to Home Care. In Scotland overall this percentage was 75%, an 8% difference. 14% of clients who were admitted to hospital died in 2021, this is one percent more than the Scotland figure for the same year.

The percentage of people with an emergency admission in the 28 days before starting home care was 27% in 2021, fallen from 43% in 2020. This is lower than the Scottish figure of 55% in 2021 and 51% in 2020. The percentage of people with an emergency admission after receiving homecare was 18% in 2021, 3% less than the 22% Scottish average.

Reablement

Reablement is the active process of an individual regaining the skills, confidence and independence to enable them to do things for themselves, rather than having things done for them. It helps people learn or re-learn the skills necessary for daily living, also known as Activities of Daily Living (ADL). These skills may have been lost through deterioration in health and / or through a change in circumstances.

Reablement was identified as an area of service transformation and savings in 2020. Discussions have been ongoing with the NHS Home First Service around creating a joint reablement service. These discussions have concluded with the decision that SB Cares will move to use a reablement approach for its 8 week pilot in the South homecare area. Once established and outcomes monitored, it will be reviewed to see how it can combine/ compliment the NHS Home First Service before expanding across the Borders.

Hospitals

Borders General Hospital

The Borders General Hospital (BGH), opened in 1988, is the district general hospital serving the Scottish Borders Region. It has 271 beds with 79 acute medical beds of which 12 are in a higher dependency area with monitoring and telemetry facilities. The hospital offers services in General Medicine, Haematology, Palliative Care, Medicine for the Elderly, Stroke Medicine, Paediatrics, Special Care Baby Unit, General Surgery, Orthopaedic Surgery, Ophthalmology, ENT, Obstetrics and Gynaecology. There is a 6 bedded ITU and an active outreach programme for critically patients. The Margaret Kerr Unit provides palliative care services in the Scottish Borders with a purpose-built environment from which to deliver specialist palliative care.

Within the Department of General Medicine there are specialists in Cardiology, Respiratory Medicine, Diabetes and Endocrinology, Gastroenterology, Neurology and Rheumatology. Visiting consultants provide clinics for Oncology, Dermatology, Renal Medicine and Clinical Genetics.

The Emergency Department (ED) provides facilities for the reception, resuscitation, examination and treatment of patients in the Scottish Borders who require emergency admission, or immediate care and discharge. The ED service is well integrated with the Borders Emergency Care Service (BECS), which is the Primary Care out-of-hours service for Borders.

There is an up-to-date laboratory service covering Haematology, Microbiology and Clinical Chemistry including blood transfusion with ready access to more specialised investigations in Lothian laboratories and other laboratories in Scotland.

Unscheduled Care

Unscheduled care is a term used to describe any unplanned assessment, diagnosis or treatment to patients in an emergency or urgent situation. It can occur at any time and crosses the traditional boundaries between general practice, community and social care services, and hospital services.
The Scottish Government has targets for unscheduled care, including Emergency Department (ED) attendances and unplanned hospital admissions.

With an ageing population in the Scottish Borders, pressure will continue to increase on acute hospital services and residential care placements unless further efforts are directed towards modernising service provision and the wider system collaborates to change the way services are delivered.

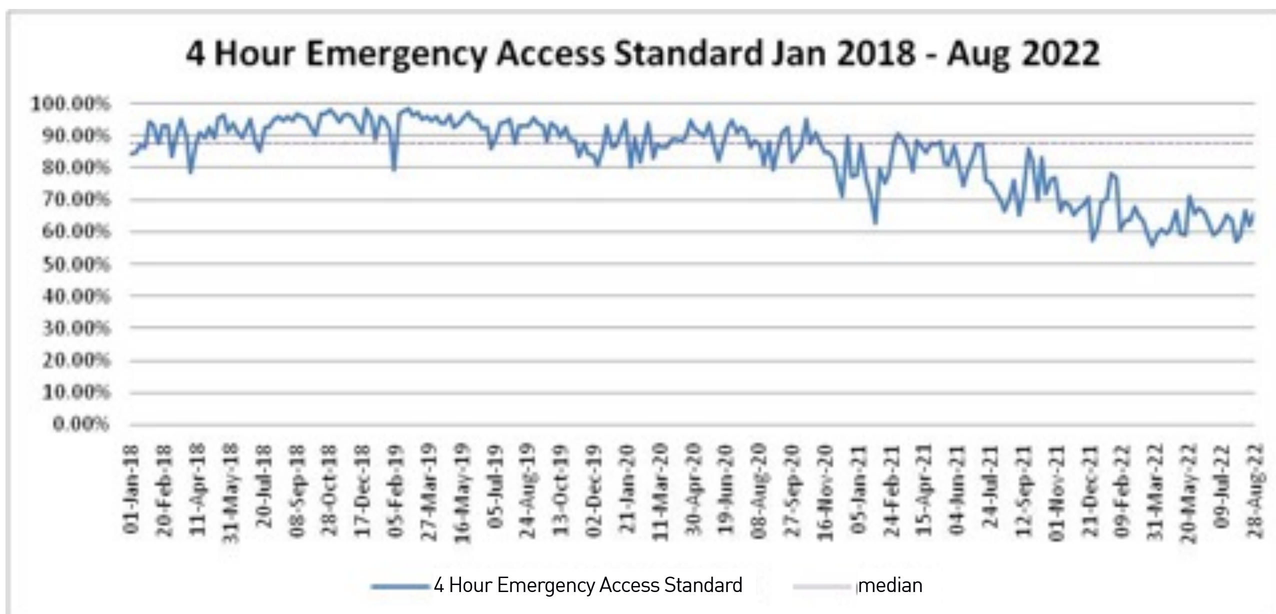
Emergency Department

The Emergency Department is located at Borders General Hospital with attendances of up to 30,000 patients per annum. Minor injury services were delivered in 4 community hospitals however this was paused during the pandemic in January 2020.
The 4-hour emergency access standard ("the standard") is a whole system measure; to either admit or provide definitive treatment and discharge for 95% of unscheduled care patients within 4-hours requires a collaborative approach from all parts of the health and social care system to provide patient flow.

The 4-hour emergency access standard is a barometer of whole system pressures and is not an Emergency Department standard.

The performance against the 4-hour emergency access standard (4EAS) is influenced by a range of factors including, but not limited to, the volume of ED attendances, the arrival of ED attendances i.e. high volumes within a short period causing crowding, patient acuity and bed pressures, including Delayed Discharges. Graph1 1, below shows this performance over time.

Figure 83: 4 Hour Emergency Access Standard vs. Median, (Jan 2018 - Aug 2022)



Data Source: *NHS Borders* (Accessed August 2022).

When patients leave the Emergency Department at the Borders General Hospital:

- Typically between **50-60%** of them go back to their place of residence (including private andresidential homes).
- Another **30-40%** are admitted to hospital within NHS Borders.
- Approximately **10%** are transferred to another NHS care provider or hospital including tertiary care in NHS Lothian or other health boards if the care cannot be delivered locally.

The National Redesign of Urgent Care (RUC) programme was launched in 2019 and set out a number of objectives over a phased approach to delivery. Phase 1 included:

- To establish a single access point through NHS 24 with early access to SDM 24/7 locally;
- Scheduling attendances with the right care provider to safely minimise crowding in the ED; and
- To reduce self-presentations to ED

Locally this was implemented through development of Borders Urgent Care Centre (BUCC) which included an Emergency Nurse Practitioner led Minor injuries service with scheduled and unscheduled activity.

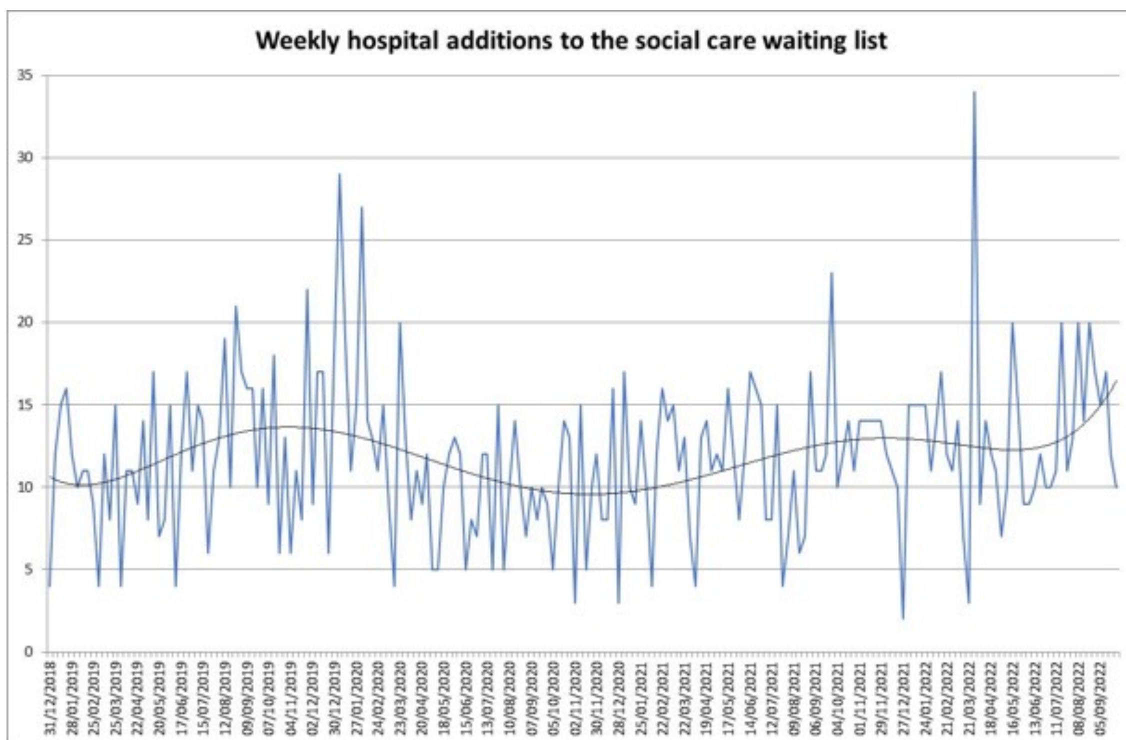
Delayed Discharge

A delayed discharge is a hospital inpatient who has been deemed clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patients discharge. The patient is termed delayed as they continue to occupy a bed beyond the ready for discharge date.

A number of factors impact on the number of people delayed waiting for care, including the number of people referred to social care services, the dependency of those individuals, hospital process and length of stay pre-referral, social work and social care process, and capacity in social care to meet the level of demand for care.

As can be seen from figure XX below, there has been growth in the level of referrals from the hospital system to social care since the end of the first year of the pandemic.

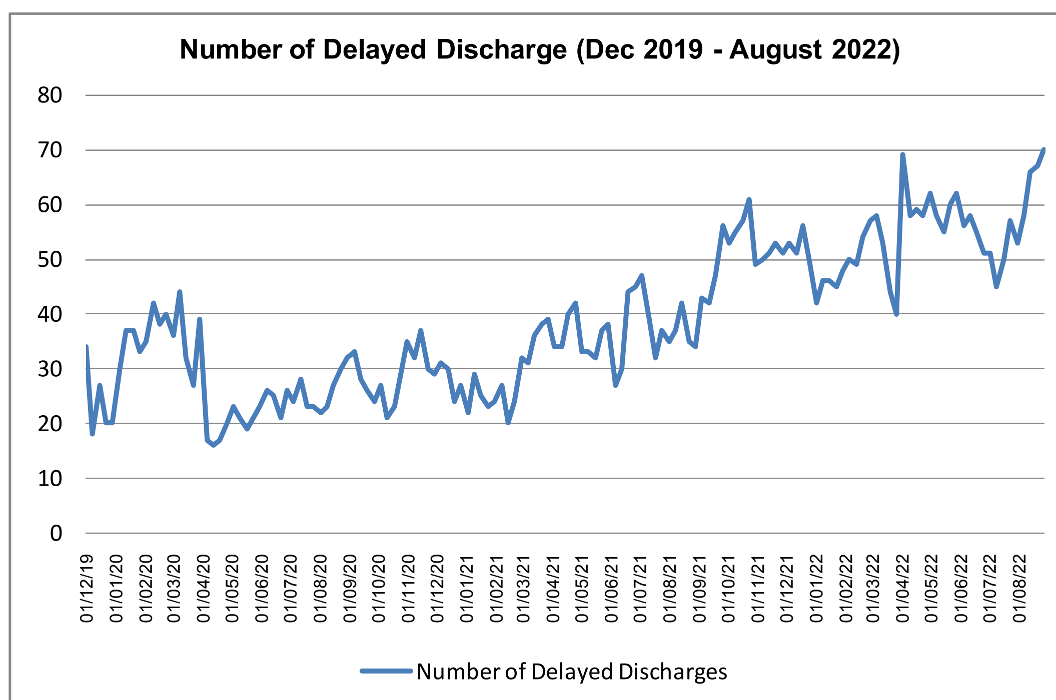
Figure 84: Number of Delayed Discharges (Dec 2019 – August 2022)



Data Source: *NHS Borders* (Accessed August 2022).

The number of delayed discharges has been steadily increasing since April 2020. This coincides with the initial impacts of Covid-19 on capacity in social care providers, increased demand, and challenges across both health and care settings in relation to staffing and care provider constraints.

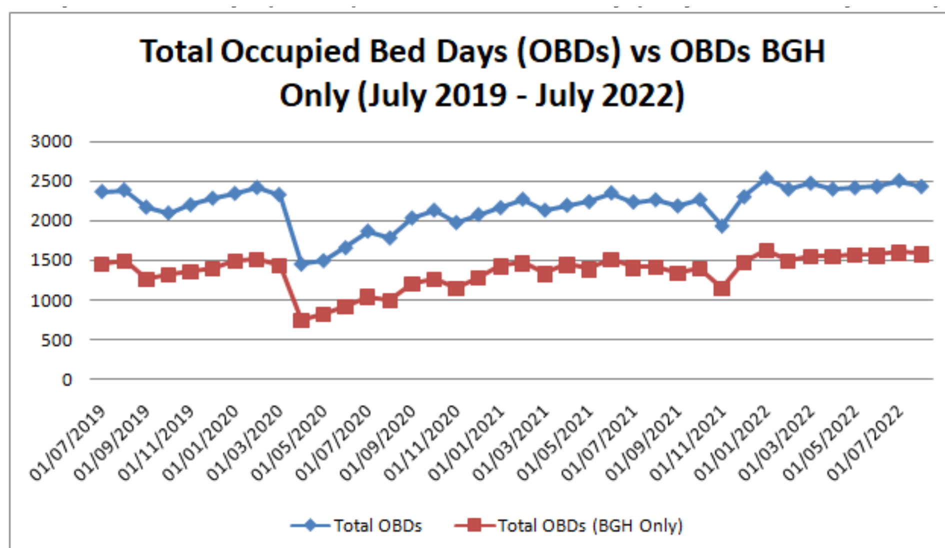
Figure 85: Number of Delayed Discharges (Dec 2019 – August 2022)



Data Source: *NHS Borders* (Accessed August 2022).

Below shows the Total Occupied Bed Days for people who are waiting for care across the Borders General Hospital, Community Hospital and Mental Health system from July 2019 – July 2022. Most of the increase in Occupied Bed Days due to delays accessing care has been experienced in the Community Hospitals.

Figure 86: Total Occupied Bed Days (OBDs) vs. OBDs BGH only (July 2019 – July 2022)



Data Source: *NHS Borders* (Accessed August 2022).

For delays across the health and care system to reduce, it is crucial for organisational teams to work in an integrated manner across boundaries. This includes health and social care staff in the hospital and communities.

Whilst some delays are due to a wait for healthcare arrangements (such as discharge planning, communication with patients and their families, equipment provided by the NHS or an NHS bed in another hospital or intermediate care facility), others can be due to patients waiting to go home on completion of social care arrangements, a wait for a place to become available in a care home or in homecare, or a wait for a community care assessment to be completed.

It is well known that hospital admission comes with increased risks including reduced musculoskeletal mass, increased risk of infection, increased risk of delirium, reduced function, increased dependence, reduced skin integrity, reduced oxygen consumption and circulation, reduced dignity and loss of independence. A long length of stay can also increase the risk of a person falling ill again. This could, in turn, lead to the loss of life skills, independence or mobility and increases the potential requirement of a care home placement due to deteriorating health and mobility. As a result, it is important that work is continued to reduce the length of stay as much as clinically appropriate, including those who may do not need social care, and those who do. As a result there needs to continues to be a focus in reducing all unnecessary bed days in the hospital system.

Historically, few people are delayed waiting for a social care assessment, however due to increased levels of referral to social work teams in the community and hospital and challenges recruiting, delays for assessment have continued to increase.

Care home placements are also an area of significant challenge, this is both for Residential and Nursing Home capacity. Teams are currently building on the moving on policy and ensuring it is applied.

However, it is important to recognise the challenge in securing Nursing Home placements within the Scottish Borders as there is a lack of availability.

The introduction of the Pathways Team within the Borders General Hospital (BGH) has been an excellent support to the clinical teams and ensures that patients are reviewed and referred on to their correct pathway in a timely manner so they can be transferred to the most suitable and safe environment.

A supporting the right direction worker is also working with the Social Work team within the BGH to support and facilitate conversations with patients and their families for their next steps in their care journey, in line with the principles of Self Directed Support option 1. It is important to recognise the delays out with the hospital setting which are also having a significant impact on the system.

An Urgent and Unscheduled Care Programme has been established to lead improvement and transformational change across Heath and Social Care services. This programme will include the Redesign of Urgent Care (above) and development of integrated urgent care services. The output of this exercise will form the basis for transformational work to improve pathways for patients.

Workforce

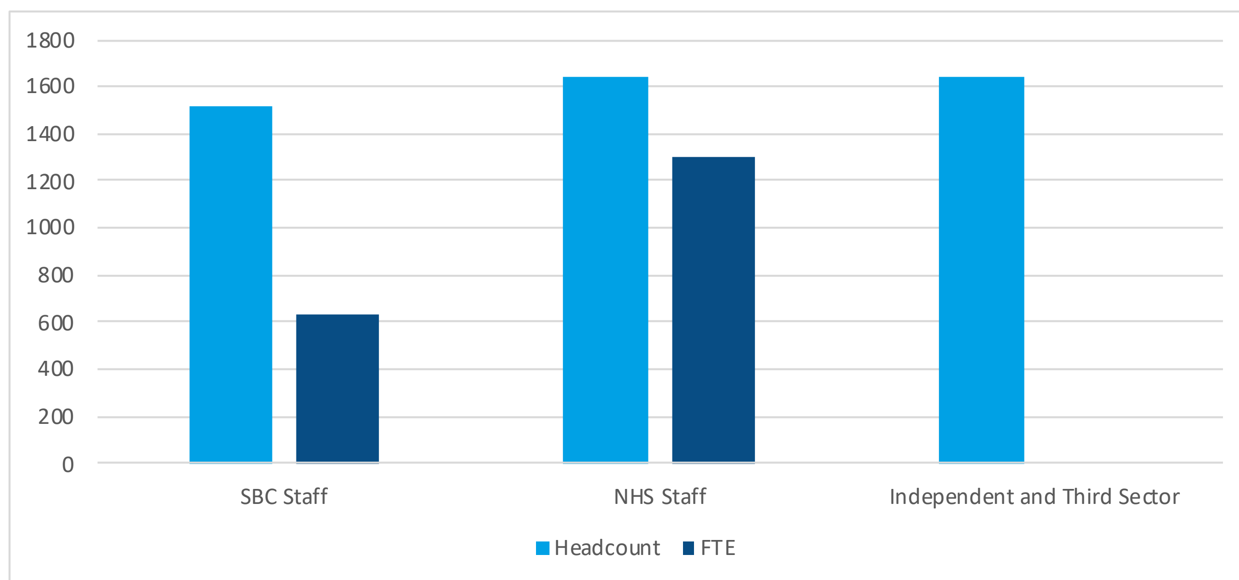
The Scottish Borders Health and Social Care Partnership is much more than a partnership between statutory partners. It is a partnership with all who need, use, advocate for, and provide health and social care services. The Scottish Borders Health and Social Care Partnership workforce includes Adult Social Work, Community Care Assistants and Care workers, Allied Health Professionals, Medical and Nursing staff, along with partners in Primary Care and the Independent and Third Sector.

The National Workforce Strategy for Health & Social Care in Scotland was published in March 2022 and sits within a wider planning landscape, supported at local level by HSCP and Health Board Strategic, Operational, Financial and Workforce Plans.

The core aim is to create a sustainable, skilled workforce with attractive career choices and fair work where all are respected and valued for the work they do by focusing on three objectives (Recovery, Growth and Transformation) as set out in the "Five Pillars of the workforce journey": Plan; Attract; Train; Employ; Nurture.

Scottish Borders Health and Social Care PARTNERSHIP

Table 87: Scottish Borders Health and Social Care Partnership Headcount & Full Time Equivalents (FTE)



Scottish Borders Health and Social Care Partnership Workforce	Overall Headcount	Sum of FTE
Scottish Borders Council Staff	1521	637.34
NHS Borders Staff	1639	1300.12
Independent and Third Sector	1447	

Data Source: NHS Borders and Scottish Borders respective workforce data 30 June 2022 and Care Inspectorate Data store 30 June 2022 *IJB Workforce Plan* (Accessed August 2022).

The Overall Headcount/FTE includes all employment and contract types offered by SBC and NHSB. SBC have a significantly higher proportion of staff working part-time hours than NHSB.

The age profiles across NHS Borders and the Scottish Borders Council show a very similar trend with a high proportion of staff between **45 and 59**. The proportion of staff who are 60 or over is increasing with 10% of NHS Borders staff and **15%** Scottish Borders Council staff within this category.

The proportion of male/female staff is similar across NHS Borders and Scottish Borders Council, with a significantly higher proportion of females **(over 85%)** within both organisations.

Challenges around Recruitment and Retention

A consistent challenge faced by all sectors is difficulty recruiting staff from entry level right up to registered professionals across Health and Social Care.

This difficulty is further compounded by the inequity in pay, terms and conditions. It is often the independent and third sector organisations registered with the Care Inspectorate who experience a disproportionate impact regarding both recruitment and more increasingly retention of staff.

To address the highly competitive recruitment markets, national shortages in many clinical fields and to establish the partnership's reputation as a good employer in a busy market, the Health and Social Care Partnership are looking at, finding and using their unique selling points. Many of the challenges and corresponding solutions will be consistent with partners across the Scottish Borders and the value in integrating and developing joint solutions is recognised.

Lack of availability and affordability of private rental accommodation locally is proving a limiting factor in attracting & retaining both UK and overseas workers.

Third Sector

Third Sector Interfaces (TSIs) provide a single point of access for support and advice for the third sector within local areas. There is a Third sector Interface in each local authority area in Scotland. Historically, in the Scottish Borders, the Third Sector Interfacehas been operating as a partnership between BAVS, The Bridge, Volunteer Centre Borders and Scottish Borders Social Enterprise Chamber – this is currently under review as part of the Borders Third Sector Interface Re-imagined project. The following framework is used to monitor Third Sector Interface work.

Table 88: Framework for Third Sector Interfaces

Source of local intelligence	Enabling voices to be heard	Connect: leadership, vision and coordination	Build capacity needs
Forums Events Advice and one to one Support to TS Websites (to share intelligence with others) Newsletters Annual conference	Third Sector forums and networks Responding to consultations Meetings with influencers Briefing papers Events bringing together people from different sectors	Forums and networks for third sector orgs or volunteers Annual conference Brokering connections Events Database of Third Sector organisations and services Support to find volunteer opportunities	Meetings with support agencies to identify gaps Sharing Good practice events Workshops/ Training Training/ support needs analysis

Data Source: *Third Sector Interface* (Accessed July 2022).

There are currently more than **24,000** charities in Scotland, ranging from small local charities to large international organisations. Charities in Scotland are regulated and awarded charitable status by the independent Office of the Scottish Charity Regulator (OSCR). There are **807** registered charities in the Scottish Borders, BAVS and The Bridge are the Community Development agency for the Borders, jointly they share a membership of over **500** organisations, including registered and unregistered voluntary groups and organisations.

The registered charities account for a total of **£16,961.668** turnover in the Scottish Borders. The Scottish Borders Third Sector Interface work closely and support agencies working or contracted with the Scottish Borders Health and Social Care Partnership. However, income or the number of charities who are currently under contract agreements with the Partnership is not monitored by them.

According to the latest stats from the Scottish Household Survey, 2020, **32%** of adults in Scottish Borders, an estimated **31,225** people, volunteer formally through an organization or group.

In the Scottish Borders, volunteers contributed **2.9 million** hours of help providing **£39.8 million** to the local economy (Volunteer Scotland, 2018).

Established in 2005, Volunteer Centre Borders (VCB) aims to develop and promote volunteering for all, improve volunteering opportunities, remove barriers to participation and to fulfil the five national outcomes of the Volunteering for All National Framework set out by the Scottish Government.

The Third Sector Interface work in partnership with many volunteer-involving organisations and projects, to promote good practice, recruit and place volunteers and to raise the awareness of the importance of volunteering. In 2021-22, Volunteer Centre Borders worked with and supported **134** organisations and community groups on volunteering, **140** new volunteers were identified and supported by Volunteer Centre Borders directly. Volunteer Centre Borders organized and advertised **606** volunteering opportunities by using the Scottish Borders Third Sector Interface website and different social media platforms. All volunteering opportunities are linked to the national database of Volunteer Scotland.

During the pandemic, the number of formal volunteering decreased due to social distancing, lockdown and shielding; and informal volunteering went up. According to the survey carried out by Volunteer Scotland, the **top five** volunteering activities between March and June 2020 were:

- Befriending and keep in touch
- Food shopping
- Household tasks, including cleaning and gardening
- Collecting prescription
- Food parcel delivery

Many volunteering opportunities have turned remote and digital due to social distancing and lockdown.

Technology Enabled Care

Technology Enabled Care (TEC) aims to empower people to better manage their health and wellbeing using digital solutions. It consists of providing equipment to support people to remain safe and independent at home or in a community setting. Equipment can range from personal alarms and devices to activity pattern monitors. A Technology Enabled Care assessment is available for anyone with a social care need.

There has been a big increase in those aged 65 years and over who received a community alarm from 2018/19 to 19/20.

Table 89: Telecare Data for Scottish Borders

	2016/17	2017/18	2018/19	2019/20
No. receiving community alarm or telecare aged 18-64	239	219	239	290
No. receiving community alarm or telecare aged 65+	1,690	1,445	1,637	2,564
Total	1,929	1,664	1,876	2,854

This includes information on single properties and does not include information on community based housing (ECH,

Data Source: *Scottish Bordeers Council* (Accessed June 2022).

The Scottish Borders Health and Social Care Partnership to deliver a Technology Enabled Care program of digital projects which will be applied across health, housing and social care practice. Below is a list of projects which form part of the Technology Enabled Care Programme:

Table 90: List of projects part of the Technology Enabled Care Programme

Project	High level scope
New Nurse Call System	• Upgrade of the care home nurse call system • Including standardisation of the systems • Exploration of digital system options
Sensor technology in Residential Care	Exploration and implementation of sensor technology including: • Enuresis (incontinence) • Motion/tracking • Sound
Dementia Technology Enabled Care	Sensors will also play a role in dementia care. Other Technology Enabled Care to be explored includes: • Environmental Technology Enabled Care • Activity Technology Enabled Care
Upgrade Residential home management system	• EMARS • Introduction of Electronic Support Plans • Staff use of iPads/tablets
Community Alarm upgrade	• Switch from analogue to digital • Future-proofing of the alarm technology
Virtual Home Care Technology Enabled Care	Introduction of Technology Enabled Careto deliver services without the requirement for a physical member of staff to be present. Areas to be explored include: • Technology Enabled Care alternatives to 15 minute carer visits • Technology Enabled Carealternatives to formal assessment (i.e.) trusted assessment via TEC • Use of phone, iPad/tablet (e.g.) Ethel, wristwatches, white-boards… • Creation of a digital support team
Night Support Technology Enabled Care	• Technology Enabled Carealternatives to physical Night Support
Other Service Technology Enabled Care	Exploration of increasing digital methods within the service including: • Hardware requirements • Software requirements • Reduction on paper recording/records • Increased use of staff Technology Enabled Care (I-pads etc…) • Clever Cogs

Data Source: *Scottish Borders Council* (Accessed August 2022).

To deliver this work, new and emerging workforce roles within the social care sector will be explored e.g. Care Technologists. The role of the Care Technologist is to support people who access care and support to benefit from appropriate technology solutions matched to their needs and aspirations[lxxxiv]

[i] Scottish Government (2015) Health and Social Care Integration – Localities Guidance, Scottish Government. https://www.gov.scot/publications/localities-guidance/ Accessed June 2022
[ii] Scottish Government (2019) Poverty and Income Inequality in Scotland 2015-2018. Gender and poverty - Poverty and Income Inequality in Scotland 2015-18 - gov.scot (www.gov.scot) Accessed October 2022
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