



Falkirk
Health and Social Care
Partnership

Joint Strategic Needs Assessment Refresh

December 2018

Website: <https://falkirkhscp.org/>

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Executive Summary

This needs assessment provides a comprehensive description of health and social care data relevant to Falkirk Health & Social Care Partnership.

The following key issues have emerged from the needs assessment:

- Population projections show that working age groups (16-49 and 50-64) make up a smaller proportion of the population in 2041 than they do in 2016. The effect of this must not be underestimated as it is two-fold; a greater proportion of the population in the older age group categories could lead to a far greater requirement for health & care service provisions, while a reduction in the working age population will ultimately reduce the number of people able to provide such services.
- Projections suggest that the Falkirk population will increase over the next 25 years, with the elderly population in particular seeing a large increase. With an increased population comes the potential for a greater number of deaths in any year, and consequently a greater number of older people dying. It also predicted a greater number of individuals with multiple LTCs so there is the potential for both a greater number of deaths but also greater number of more complex deaths. It is essential that palliative and end of life care services are optimised to cope with this.
- In Falkirk, all cause mortality has been increasing for the most deprived areas (SIMD 1), and declining for the least deprived areas (SIMD 5). This shows that health inequalities in Falkirk, not only exist, they are widening.
- Across the health and social care services in Falkirk there is an aging workforce with many staff potentially nearing retirement. Long term workforce planning will be essential to ensure future services are sustainable. This theme is particularly relevant in primary care where there is an anticipated shortfall in newly-qualified GPs combined with the fact that GPs often retire prior to state retirement age.
- Mental health is identified as a priority in the current strategic plan, and should remain a priority as it remains a challenge in terms of understanding the level of need. A large number of people suffering from minor mental health issues are unlikely to interact with services until they reach a crisis however conditions such as depression and anxiety can have an equally negative effect on health as long term physical health conditions.
- Alcohol and drugs remain a challenge in Falkirk. While Alcohol related hospital admissions have simply fluctuated over the years, the number of alcohol related deaths have continued to decrease. The picture for drugs is more concerning with drug related hospital admissions consistently on the rise and the number of drug related deaths has tripled in Falkirk over the past decade.

1. Introduction

1.1 - Background

This document aims to provide an update to sections of the previous iteration of the joint strategic needs assessment where it is deemed there has been meaningful change, and attempts to cover gaps that have been identified in the period since the last JSNA report was published. Many of the findings from the original Needs Assessment will still be relevant. This document is designed to sit alongside and compliment the original work.

The original Joint Strategic Needs assessment, produced for the 2016-19 Strategic Plan is available here:

<https://falkirkhsc.org/wp-content/uploads/sites/9/2018/01/Joint-Strategic-Needs-Assessment.pdf>

1.2 - Joint Strategic Needs Assessment

In order for the partnership to produce a detailed strategic plan that best meets the needs of its local population we first require a clear understanding of the health and care needs of the population, from both the perspective of the NHS and Local Authority, and other key stakeholders.

Need is the discrepancy between “what is” and “what should be”. This document aims to bring together the available data in order to describe the current pattern and level of supply of these services and where possible identify the extent of the gap between need and supply.

2. Population

2.1 - Current Population

A key aspect for determining the need of many health and social cares services is the size and age distribution of the local population. Table 2.1a below, illustrates the population profile in Falkirk. Falkirk has an estimated population of 160,130 made up of 78,396 (49%) males and 81,734 (51%) females. Current population estimates suggest there has been an increase in the Falkirk population of 1.6% in the past 3 years.

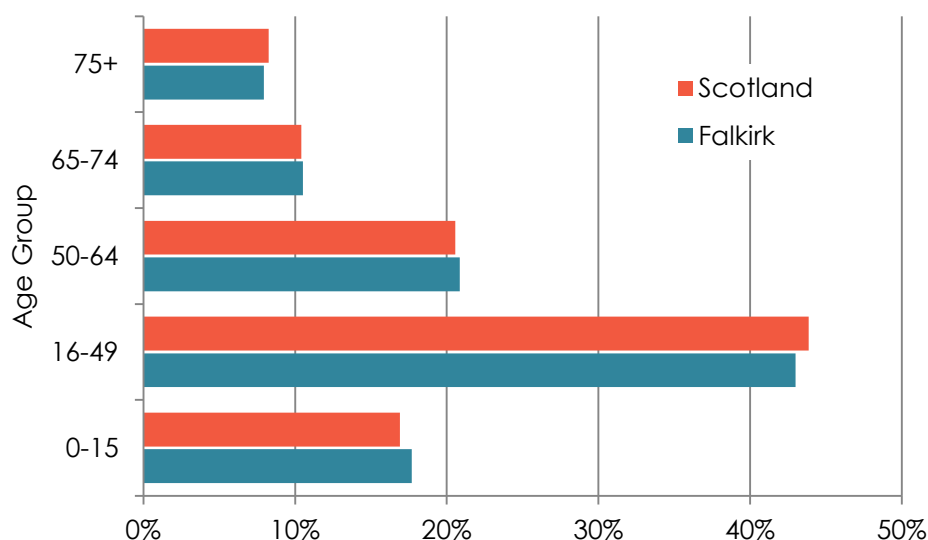
Table 2.1a Falkirk Population Profile

Age Group	Falkirk		
	Total	Males	Females
0-15	28,329	14,587	13,742
16-49	68,867	34,085	34,782
50-64	33,404	16,394	17,010
65-74	16,826	8,101	8,725
75+	12,704	5,229	7,475
Total	160,130	78,396	81,734

Source: NRS Population Estimates Mid-2017

Figure 2.1a, below, illustrates the age distribution in Falkirk compared to Scotland. The age profile is very similar to that of Scotland as a whole. Approximately 64% of the population are aged between 16 and 64, 18% under 16, 11% aged 65-74 and 8% aged over 75.

Figure 2.1a - Falkirk age distribution compared to Scotland



Source: NRS Population Estimates Mid-2017

2.2 - Locality Area Population

For detailed information on the population at a Locality level please see the Falkirk HSCP locality Profiles:

<https://falkirkhscp.org/wp-content/uploads/sites/9/2018/01/Locality-Profiles.pdf>

2.3 - Projections of future population

The size and make-up of the population going forward is a key consideration when planning and delivering health and social care services. The National Records of Scotland population projections (Table 2.3a) show the projected change in the population to 2041.

Table 2.3a - Falkirk Population & Proportion by age group projections to 2041

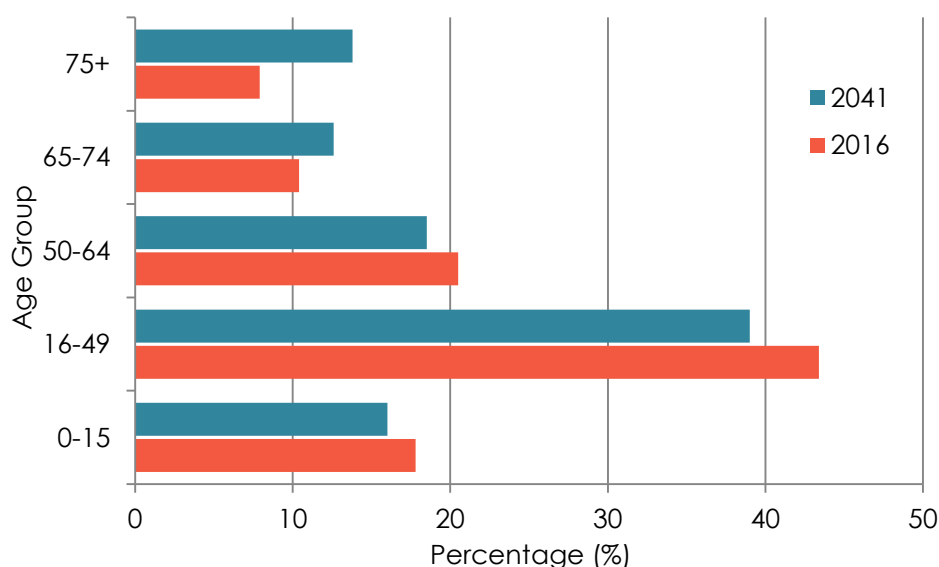
Age Group	2016		2036		2041	
	No	%	No	%	No	%
0-15	28,359	17.8	27,534	16.1	27,542	16.0
16-49	69,190	43.4	67,774	39.7	67,222	39.0
50-64	32,674	20.5	31,940	18.7	31,887	18.5
65-75	16,604	10.4	22,763	13.3	21,716	12.6
75+	12,553	7.9	20,805	12.2	23,852	13.8
Total	159,380	100.0	170,816	100.0	172,219	100.0

Source: NRS Population Projections (2016-Based)

The size and age structure of the Falkirk population is projected to experience significant change between now and 2041. The overall population is projected to increase by over 12,000 to 172,219. The age distribution is also projected to experience significant changes. The number of individuals aged 75+ is expected to almost double to 23,852 and the number of individuals aged 65-75 is also expected to rise from 16,604 to 21,716.

It is interesting to note that the total estimated Falkirk population for 2041 is lower than the projected 2037 figure (2012-based NRS projections) in the first iteration of the Falkirk HS&C JSNA. This suggests that population growth has not continued at the same rate as determined in 2012. In any case it is important that strategic planning decisions take account of the expected shift in population make-up over the next 20 years. This is explored in Figures 2.3a and 2.3b below.

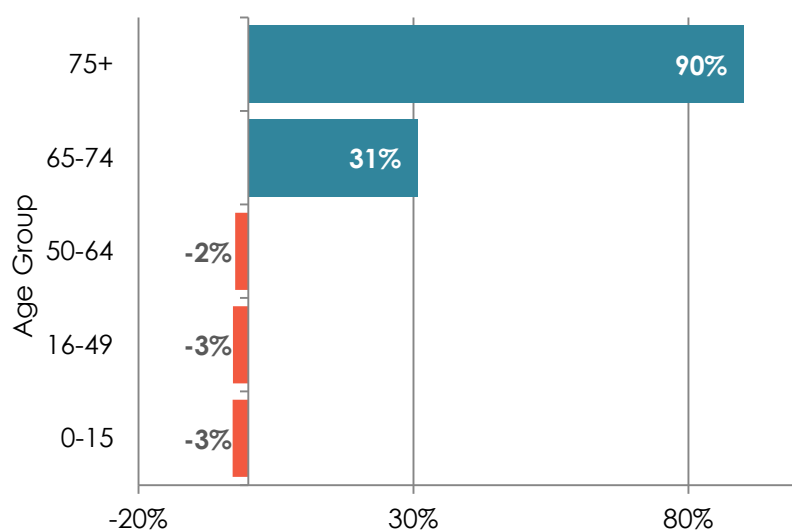
Figure 2.3a – Projected Population Age distribution in Falkirk, 2016 to 2041



Source: NRS Population Projections (2016 based)

Figure 2.2a, above, illustrates the projected change in the distribution in the population as opposed to the change in the actual size as just discussed. The chart shows that the working age groups (16-49 and 50-64) make up a smaller proportion of the population in 2041 than they do in 2016. The effect of this must not be underestimated as it is two-fold; a greater proportion of the population in the older age group categories could lead to a far greater requirement for health & care service provisions, while a reduction in the working age population will ultimately reduce the number of people able to provide such services. The population change by 2041 as a percentage is shown by age group in Figure 2.3b below:

Figure 2.3b – Projected percentage population change by age band, 2016 to 2041



Source: NRS Population Projections (2016 based)

3. Life Circumstances

3.1 - Scottish Index of Multiple Deprivation

The terms 'deprivation' and 'poverty' are sometimes used interchangeably. However, in this context, deprivation is defined more widely as the range of problems that arise due to lack of resources or opportunities, covering health, safety, education, employment, housing and access to services, as well as financial aspects.

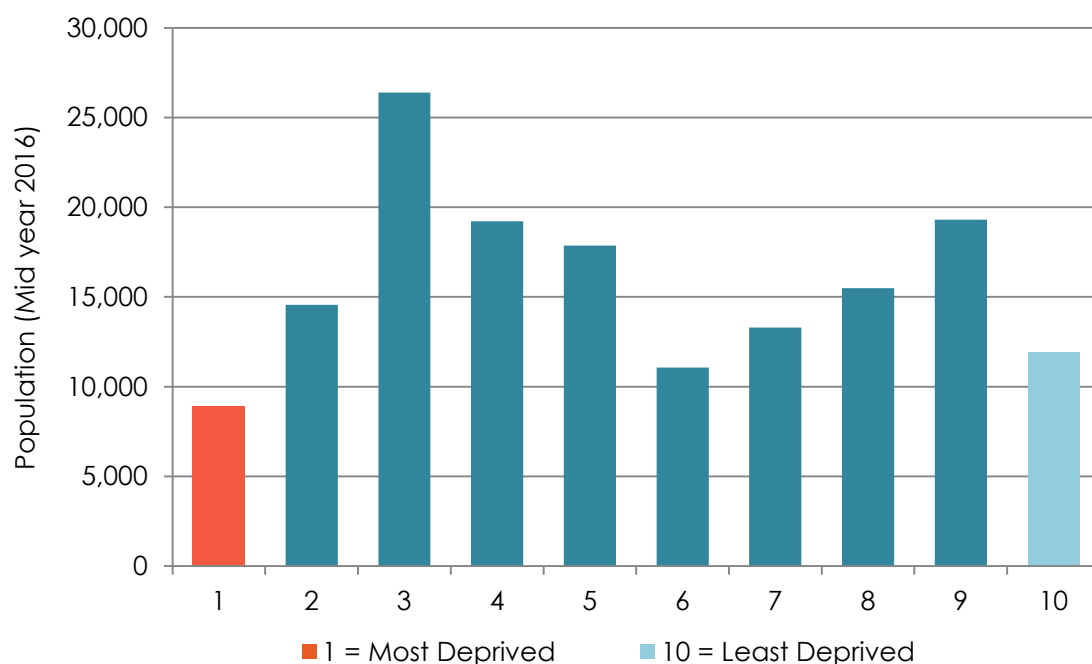
The Scottish Index of Multiple Deprivation (SIMD) is the Scottish Government's official tool for identifying those places in Scotland suffering from deprivation. It incorporates several different aspects and combines them into a single index. It divides Scotland into 6,976 small areas, called datazones, each containing around 350 households. The Index provides a relative ranking for each datazone, from 1 (most deprived) to 6,976 (least deprived). By identifying small areas where there are concentrations of multiple deprivation, the SIMD can be used to target policies and resources at the places with greatest need.

One way ISD (Information Services Scotland) uses these is to divide all of the datazones in Scotland into 10 equal deprivation deciles, by calculating each individual zone's decile from the distribution of all ranks. For example if a zone in Falkirk is ranked 517, it is in the bottom 7.4% of all zones so would be in the first decile which encompasses values between 0 and 10%. If a zone is ranked 1985, it would be in the bottom 28.4%, and in the third decile for values between 20% and 30%.

Within the deciles, 1 is the most deprived and 10 the least deprived (this categorisation is applicable for SIMD 2009v2, SIMD 2012, SIMD 2016 and future releases). Figure 3.1a below illustrates the number of people in each decile in Falkirk.

A total of 86,944 Falkirk residents live in datazones which are ranked in the bottom 50% of datazones, in contrast 71,053 people live in datazones ranked in the top 5 deciles nationally. Just under 9,000 people (8,911) live in datazones ranked in Scotland decile 1 (the most deprived 10% nationally) while just under 12,000 live in datazones ranked in the top 10%. Four datazones in Bainsford & Langlees and three in Camelon East are included in the 14 Falkirk datazones which fall into the most deprived decile nationally.

Figure 3.1a - Falkirk population by SIMD decile



Source: SIMD 2016 / NRS mid-year populations 2016

The distribution of the population in Falkirk across the different decile groups shows some variation. The percentage of the population in deciles 1 to 10 ranges from 5.6% in the most deprived decile, to 16.7% in the 3rd decile.

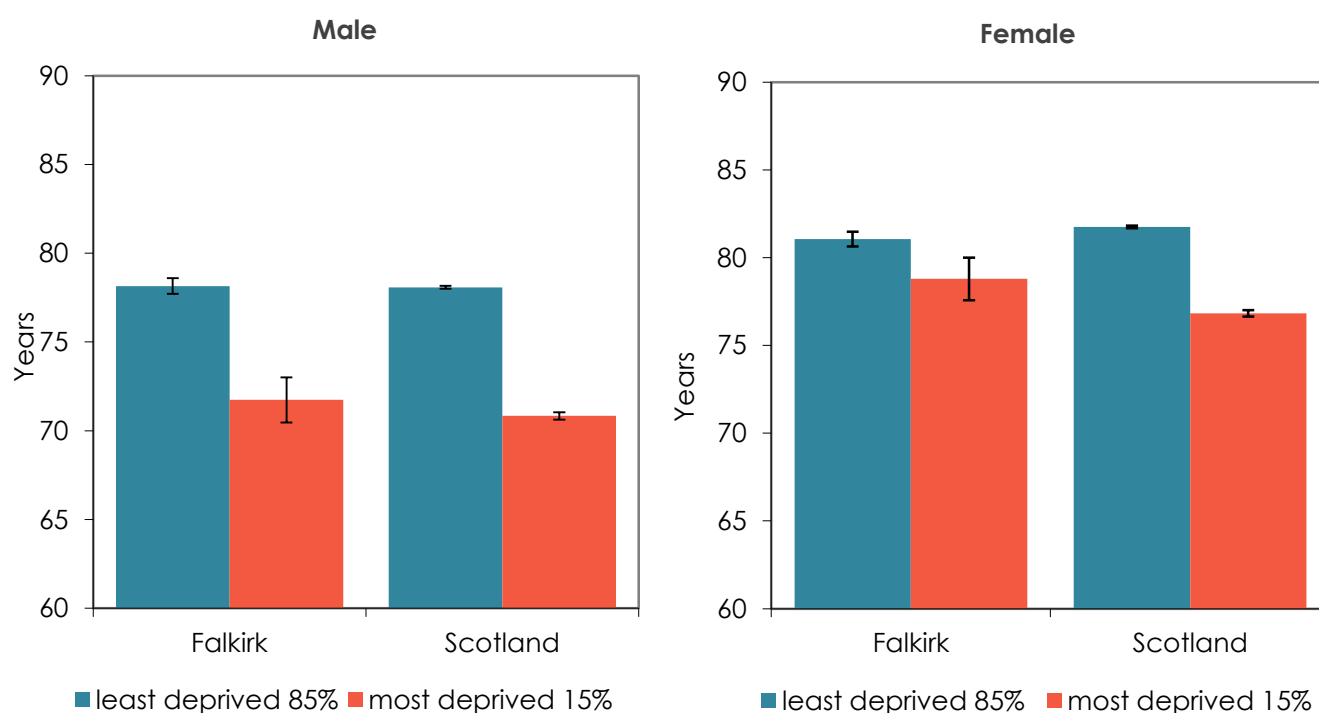
SIMD data provides opportunities for strategic planners to combat small areas of multiple deprivation with targeted funding and interventions. The following section on health inequalities expands on how deprivation is related to health and highlights inequalities between the most deprived and least deprived areas.

3.2 - Health Inequalities

One of the key objectives of the strategic planning process should be to make informed decisions which help to reduce health inequalities. Health inequalities shouldn't exist but figures suggest that there are still significant health inequalities across all of Scotland dependant on where a person is born. A number of health inequality indicators have been developed focussing on life expectancy and early mortality.

The charts below look at life expectancy at birth by sex and level of deprivation for Falkirk and Scotland. Deprivation is categorised by the SIMD 15% most deprived datazones by area and 85% least deprived datazones.

Figure 3.2a - Expectation of Life at Birth for Falkirk & Scotland, by Sex, split by level of deprivation for the period 2011-2015



Source - National Records of Scotland (NRS)

Note on Input data - Small Area Population Estimates for 2011-2015 and death counts at the data zone level (obtained from NRS Vital Events) were used as input data. The population and death data was aggregated over a five year period (as opposed to the three year period used for other life expectancy statistics published by NRS) to ensure a higher level of statistical robustness.

Error bars signify 95% confidence intervals.

Key points on above charts:

1. Male and Female life expectancy at birth is broadly similar for Falkirk and Scotland.
2. The difference between Male life expectancy at birth for the most deprived 15% and the least deprived 85% is much greater than the for females.
3. Life expectancy at birth for Males and Females in the most deprived 15% datazones in Falkirk is higher than the most deprived 15% of Scotland's datazones.

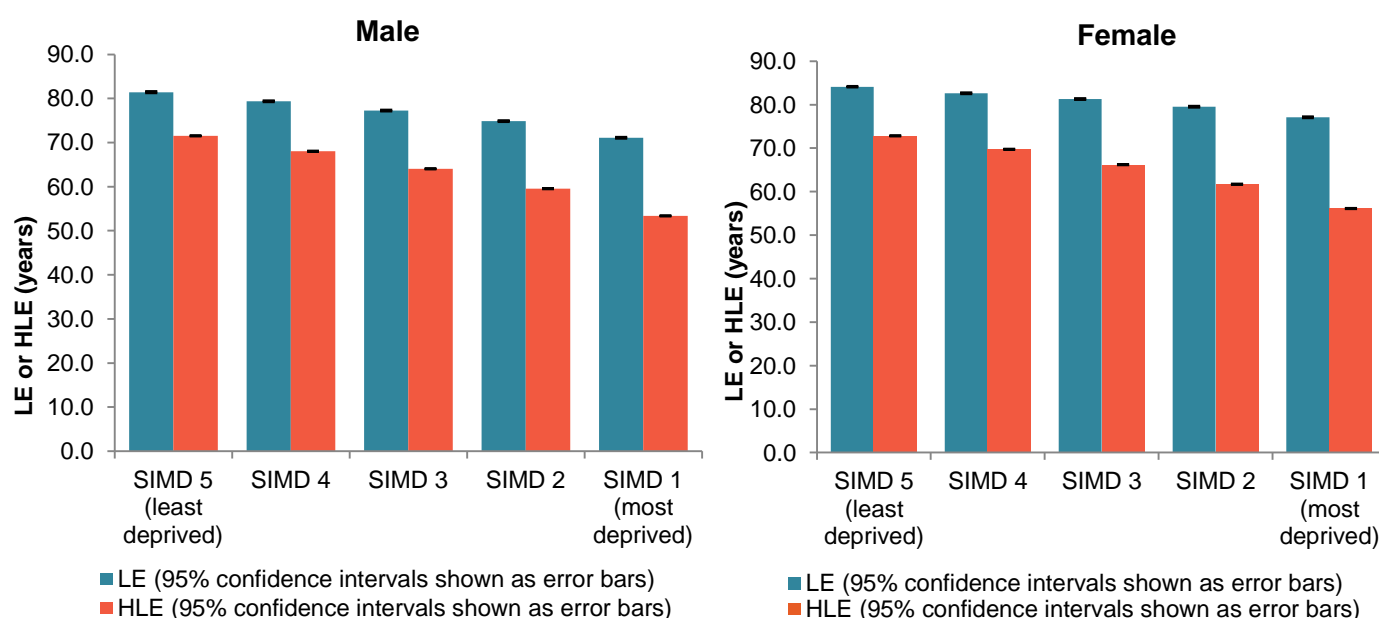
4. Estimates suggest a 6.4 year difference of life expectancy at birth between men in Falkirk's most deprived 15% and least deprived 85%.
5. For females in Falkirk, the difference is only 2.3 years difference in life expectancy at birth between the 15% most deprived and 85% least deprived.

Life Expectancy and Healthy Life Expectancy

While life expectancy (LE) is an estimate of how many years a person might be expected to live, healthy life expectancy (HLE) is an estimate of how many years they might live in a 'healthy' state. In Scotland, males are expected to live both shorter lives, and shorter healthier lives compared with females. As figure 3.2b below show there is also a difference between areas of deprivation with those in the most deprived areas having both a lower life and healthy life expectancy.

It is not possible to break this data down to Falkirk HSCP level but the pattern experienced at Scotland level is expected be representative of what happens in Falkirk. For males there is a difference of 18 years healthy life expectancy and 10 years life expectancy between the least deprived and most deprived areas. For females the difference in Life expectancy is less extreme with a gap of 7 years. However the difference in the number of years of life in a 'healthy' state is just under 17 years for Females between the least and most deprived areas, just one year less than for males.

Figure 3.2b: Male and Female Life Expectancy (LE) and Healthy Life Expectancy (HLE) at Birth in Scotland, by deprivation quintile, 2009-2013.



Source: abridged life tables, using:

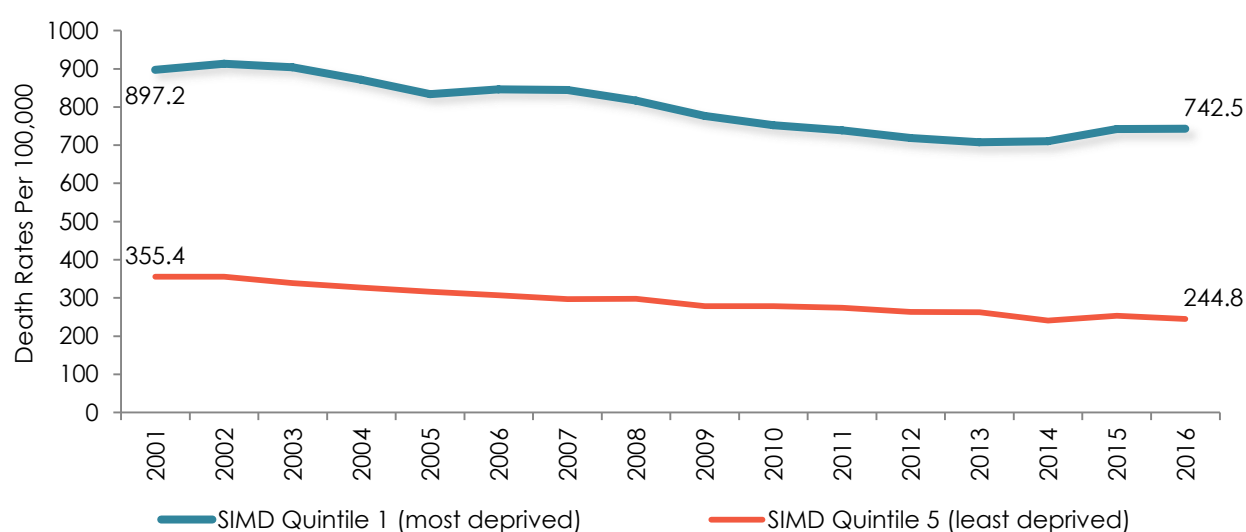
- a) National Records of Scotland (NRS) mid-year population estimates
- b) NRS death registrations (by year of registration of death)
- c) Self-assessed health (SAH) from Census 2011 (5-point question)
- d) Deprivation quintiles based on the Scottish Index of Multiple Deprivation (SIMD), unweighted for population, SIMD 2009 v2 for 2009, and SIMD 2012 for period 2010-2013.

Premature Mortality and Deprivation

Premature mortality, people who die under the age of 75, is an important indicator of the overall health of the population. The fewer deaths that occur under the age of 75, the healthier the population is judged to be. Scotland has the highest rates of premature mortality in the UK and while premature mortality has been declining there has been a consistent large gap between the most and least deprived areas.

Again Falkirk level data is not available but the Scotland Chart below should be reasonably representative of Falkirk since the Falkirk population is similar in terms of age profile.

Figure 3.2c: Under 75 Age-Standardised Death Rates by SIMD Quintile, Scotland, 2001 to 2016



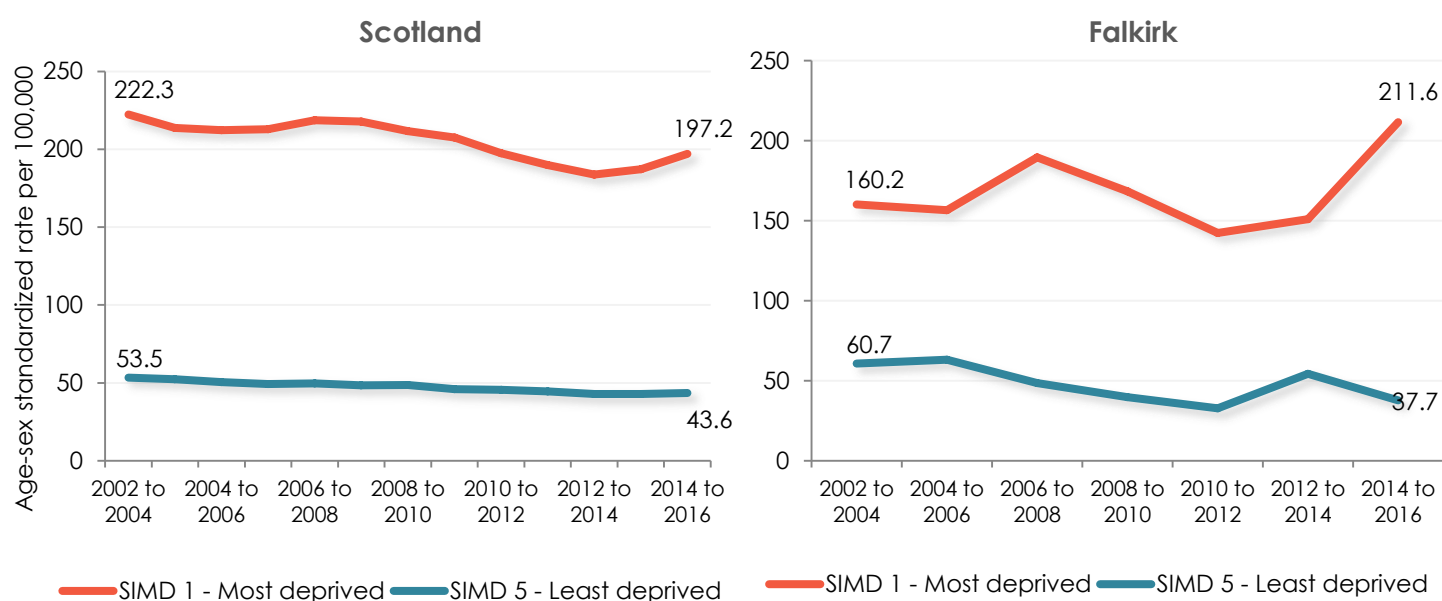
Source: National Records of Scotland (NRS)

Mortality among 15-44 year olds and Deprivation

All cause mortality among 15-44 year olds, is defined by the number of deaths from all causes of people between 15 and 44 years of age. In Scotland, this has been declining but as the figure 3.2d below shows there are significant inequalities with there being a consistent large gap between the most and least deprived areas.

In Falkirk, all cause mortality rates have increased between the years 2002 to 2004 and 2014 to 2016 for the most deprived area (SIMD 1). Whereas, the least deprived areas (SIMD 5) rate has been declining for the same time period. While in Scotland on the whole the 15-44 all cause mortality has been reduced since 2002-2004 for both the most deprived and least deprived population. This is significant for Falkirk as it not only shows that health inequalities exist but they are also widening.

Figure 3.2d: All Cause Mortality among 15-44 year olds, Falkirk and Scotland

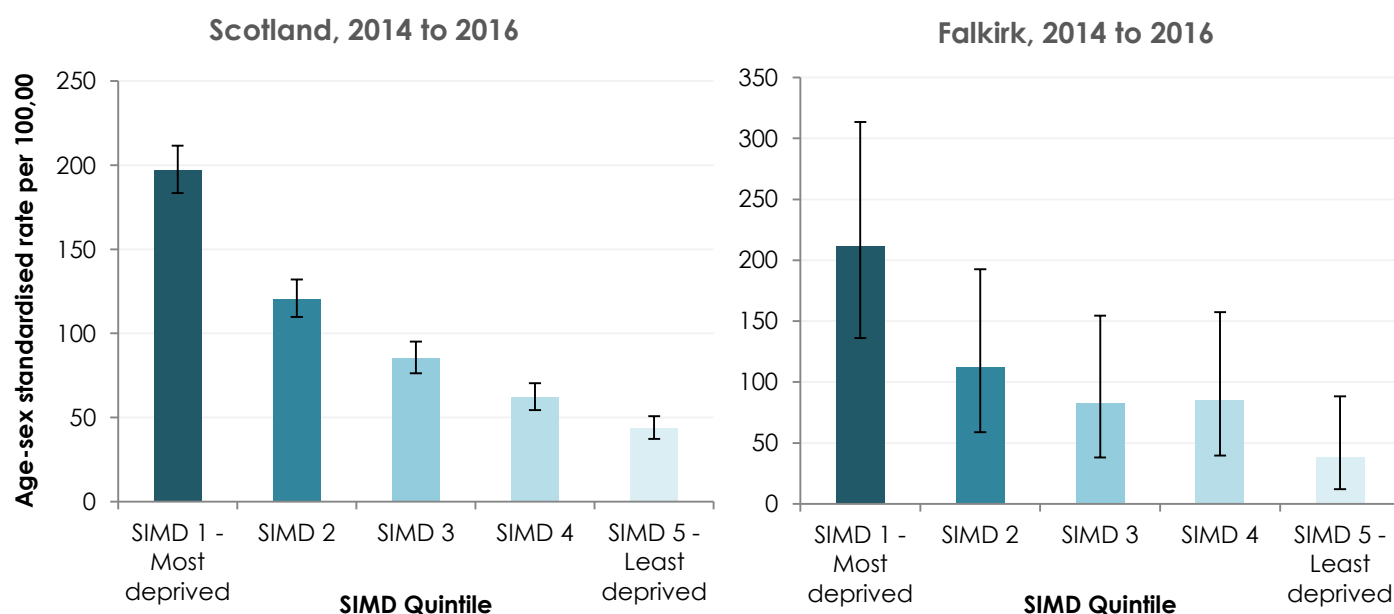


Notes: Falkirk has data points every 2nd year whereas Scotland has data points each year. Calendar Years displayed as 3-year aggregates.

Source: National Records of Scotland (NRS)

The charts in figure 3.2e below show a stark increase in mortality rate of 15-44 year olds for the most deprived SIMD quintiles of the population. A note of caution is however required when interpreting this. Error bars are used to indicate the range that a true value may lie with small error bars indicating a greater confidence in the value. There is a risk that when numbers are small this range may be large which will make interpretation difficult. However, a similar pattern can be observed from the Scotland figures.

Figure 3.2e: All Cause Mortality among 15-44 year olds by SIMD, Falkirk and Scotland



Note: 2014 to 2016, Calendar Years; 3-year aggregate.

Source: National Records of Scotland (NRS)

Health Scotland has published a paper on [The Role of Health & Social Care Partnerships in Reducing Health Inequalities](#). The paper outlines a number of practical actions that the HSCP could take to reduce health inequalities. It is recommended that the HSCP consider these actions against current priorities and assess if there any gaps.

4. Housing

Housing plays a pivotal role in the health and wellbeing of the population and it is imperative that the Strategic Plan reflects the need to provide sufficient quality housing provision to those who need it. The World Health Organisation (WHO) considers “physical environment” to be one of the 3 determinants of health, alongside the social and economic environment, and the person’s individual characteristics and behaviours. It is argued that these factors have a greater impact on the health of the population than commonly considered factors such as access to health and care services.¹

Housing Need & Demand Assessment (HDNA)

It is a statutory requirement that estimates be made on the future numbers of additional homes required to meet existing and future demand - the report for Falkirk is available at the link below:

<http://www.falkirk.gov.uk/services/homes-property/policies-strategies/docs/hnda/01%20Housing%20Need%20and%20Demand%20Assessment.pdf?v=201612051407>

The HNDA identified the number of households in the Falkirk area will increase over the next 20 years. In terms of population the biggest increase is projected to take place in people over retirement age. This means an increase in demand for additional housing, including affordable and specialist housing for people with a disability or mobility issues.

The areas with the greatest need are Central Locality, followed by West Locality and the Polmont Braes (area of East Locality).

After consideration is given to need and demand it is necessary to consider factors which impact on new house building including:

- Resources to build housing
- Land constraints (for example flooding)
- Capacity of the construction sector to build housing
- Planned new housing
- Empty properties brought back into use

¹ WHO – Health Impact Assessment, Determinants of Health - <http://www.who.int/hia/evidence/doh/en/index4.html>

Taking account of the above it is recognised that new build housing will not address all current and future housing demand. It will therefore be important to consider the following in order to meet demand:

- New build private and affordable properties
- Bringing empty private homes back into use
- Buying former Council and Registered Social Landlords (RSL) properties which are for sale

In relation to specialist housing, there is a need for additional wheelchair accessible properties across Falkirk Council area, across all tenures. There is a target that at least 5-10% of all new build affordable housing is accessible.

4.1 Housing Options for Older People

The HNDA identifies a potential need for Extra Care Homes or Housing with Care.

Table 4.1 below details the different levels of housing provision available (including RSL properties) to older people. The table splits provision by health and social care locality areas to show how the provision is spread across the partnership.

Table 4.1 – Falkirk Housing options for Older People – March 2018

Accommodation Type	East	% of accom type	West	% of accom type	Central	% of accom type	Total
Nursing Care beds ¹	214	28%	229	30%	315	42%	758
Residential beds ²	90	42%	31	15%	91	43%	212
Housing with Care 1&2 tenants receiving care from on-site staff ³	0	0%	35	27%	97	73%	132
RSL very/ sheltered properties ⁴	97	37%	35	13%	131	50%	263
RSL retired/amenity properties ⁵	126	47%	111	41%	32	12%	269
Housing with Care 3 properties re LHS definition ⁶	201	37%	220	41%	116	22%	537
Total	728		661		782		2171

Source: Falkirk Council (2018) - Housing Services Report to Housing Contribution Statement Group March 2018

¹ Falkirk Council (2018) Position Statement on Care Homes & Supported Accommodation for Older People

² Falkirk Council (2018) Position Statement on Care Homes & Supported Accommodation for Older People

³ Falkirk Council (2018) Housing Services

⁴ Falkirk Council (2018) Information supplied to Housing Services by RSLs

⁵ Falkirk Council (2018) Information supplied to Housing Services by RSLs

⁶ Falkirk Council (2018) LHS 2017-2022 definition

In terms of population, the East Locality is substantially larger than the other two localities, yet for the accommodation types which provide a higher level of care (Nursing homes, residential homes, HwC 1&2 and RSL very/sheltered) most of this provision is provided in the more urban central locality. Conversely there are more HwC level 3 and RSL retired/amenity properties in the East and West localities and proportionately less in the Central locality.

4.2 Housing Support – Adaptations

The HNDA highlights the increasing numbers of older people, particularly with physical disabilities and it was estimated that there will continue to be a demand for disabled adaptations in around 2% of properties.

For people who experience functional difficulties due to health or mobility problems there are a number of options to support continued independence. Options include equipment to facilitate independence, minor or major adaptations, or even moving to a more suitable property.

Basic adaptations could consist of things like internal/external grab rails, banister rails, lever taps or relocation of difficult to reach plug sockets. For more complicated major adaptations it will be necessary to complete a formal assessment through social work.

The following table details the number of adaptations carried out in the past two financial years.

Table 4.2 – Number of Adaptations funded by Falkirk Council

Number of Adaptations (by budget)	Year to 31 st March 2017	Year to 31 st March 2018
Housing Revenue Account (Local Authority tenancies only)	942	864
Scheme of Assistance Grant (adaptations over £500, private sector only)	86	75
Social Work Community Care Teams (Under £500, private sector only. Plus large maintainable equipment and temporary ramps all tenure types)	457	578
Social Work (Joint Loan Equipment Service)	494	617*
TOTAL	2079	2134

Note – figures exclude Registered Social Landlord (RSL) properties.

* Grab rails purchased (Actual installation figures for 2017/18 not yet available)

Source: Falkirk Social Work Adult Services

4.3 Housing Developments

The table below (4.3a) details the number of affordable housing properties delivered between 2011 and 2018 by the Council and RSLs (Registered Social Landlords) broken down by mainstream and specialist units. This highlights that there were 778 units built in that time with 217 (28%) specialist units and 561 (72%) mainstream units.

Table 4.3a – Number of properties delivered since 2011 by category and locality

Locality	Number of Specialist Units	Number of Mainstream Units	Total Units
Central	91	169	260
East	98	127	225
West	28	265	293
Total	217	561	778

Note - Mainstream housing is for people who have general needs and specialist housing is for people who have a disability or mobility issues.

Source - Falkirk Council – Corporate & Housing Services

The majority of units built were in the West (38%) then Central (33%) and East (29%). When the number of units delivered is broken down by mainstream and specialist units it highlights that only 10% of the units built in the West were specialist whereas for the East it was 44% and Central 35%.

Future priorities for affordable housing are set out annually in the Strategic Housing Investment Plan and this is available on the link below:

<http://www.falkirk.gov.uk/services/homes-property/policies-strategies/docs/local-housing-strategy/Strategic%20Housing%20Investment%20Plan%202019%20to%202024.pdf?v=201810261217>

Table 4.3b highlights the number of proposed units in the Strategic Housing Investment Plan (2019/20- 2023/4) broken down into specialist and mainstream across each of the locality areas.

Table 4.3b – Number of proposed units by Category and Locality

Locality	Number of Specialist Units	Number of Mainstream Units	Total Units
Central	194	109	303
East	67	65	132
West	378	108	486
Total	639	282	921

Source: Falkirk Council – Corporate & Housing Service

4.4 Homelessness

Homelessness is defined as not having a home. It does not mean living on the street, but could involve a number of situations.

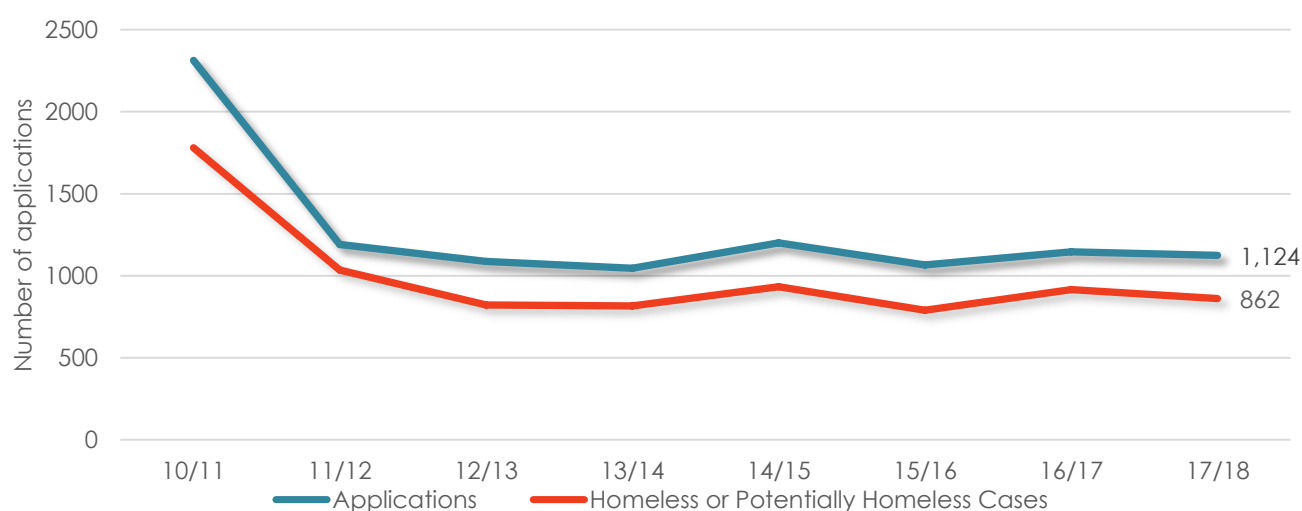
You might be defined as homeless if you are¹:

- sleeping on the streets
- staying with friends or family
- staying in a hostel or bed and breakfast hotel
- living in overcrowded conditions
- at risk of violence in your home
- living in poor conditions that affect your health
- living in a house that is not suitable for you because you are sick or disabled.

The Scottish Government releases annual reports on homelessness in Scotland with some analysis broken down by Local Authority area. The data collected records homeless application information such as age, sex, family compliment and reason for homelessness. Use of temporary accommodation is also recorded.

The number of people presenting as homeless in Falkirk has remained relatively consistent over the last few years. In 2017-18, 1124 applications were made for assistance. Falkirk Council had a duty to rehouse 862 (76.6%) of those who submitted an application and were found to be homeless or threatened with homelessness.

Figure 4.4a - Number of applications under the Homeless Persons legislation and Homeless or Potentially Homeless cases in Falkirk 2010-2018



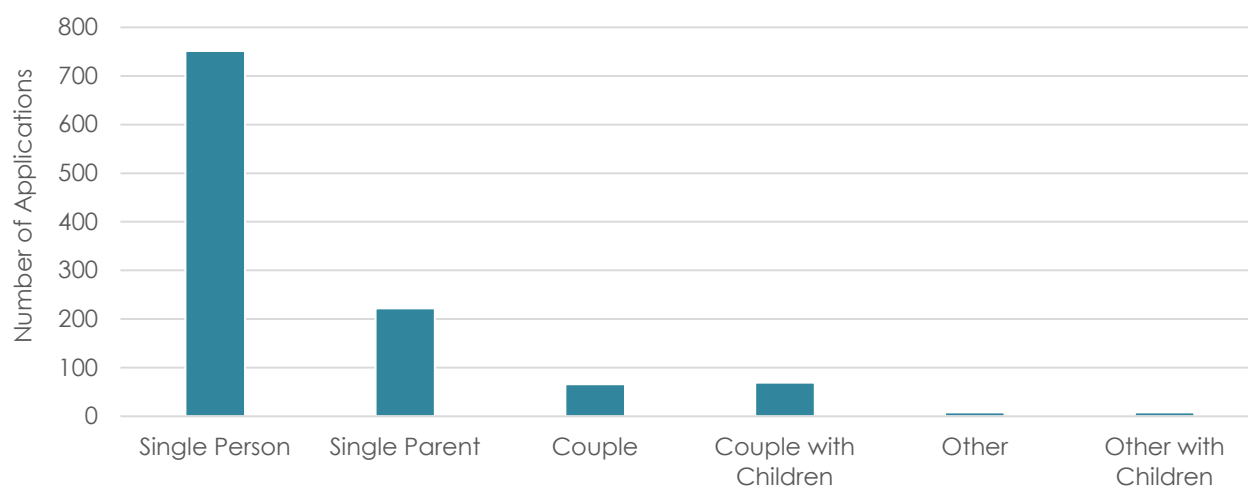
Source: Scottish Government – Falkirk Council HL1 Annual Report

¹ Shelter - What is Homelessness?

https://scotland.shelter.org.uk/get_advice/advice_topics/homelessness/what_is_homelessness

In Falkirk the majority of homeless applicants are single (66.8%). The single persons group is made up of 482 (64%) male, 269 (36%) female. Single Parents are the next largest group seeking assistance (19.7%).

Figure 4.4b – Applicants by Household type in Falkirk 2017/18

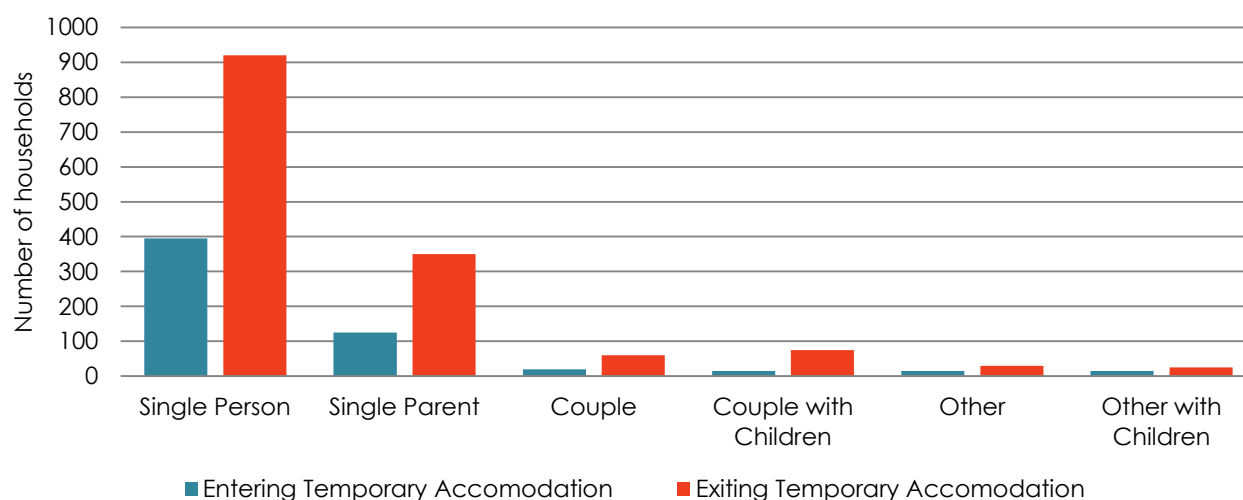


Source: Scottish Government – Falkirk Council HL1 Annual Report

The use of temporary accommodation is also closely monitored by the Scottish Government and it aims to introduce rapid rehousing plans nationwide. It is anticipated that this will reduce the time homeless applicants spend in temporary accommodation and lessen the negative impact being homeless has on their health and wellbeing.

Figure 4.4c below displays the number of household types entering and exiting temporary accommodation in Falkirk in 2017/18.

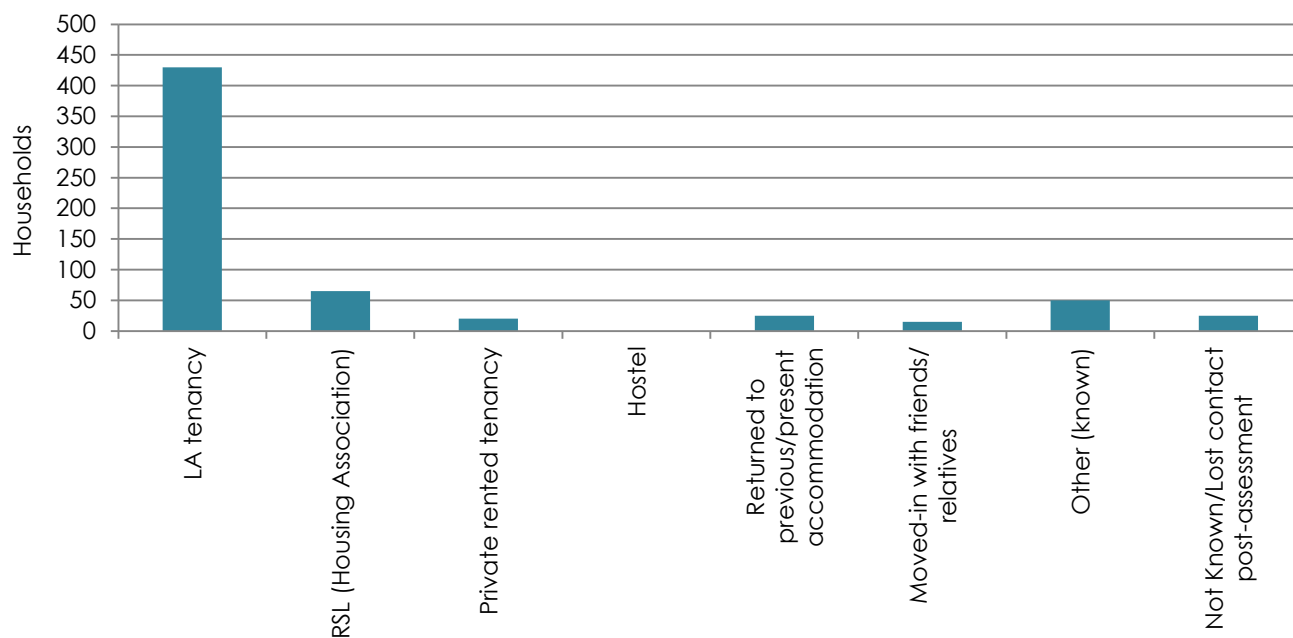
Table 4.4c – Number of households entering and exiting temporary accommodation, by household type, Falkirk, 2017/18



Source: Scottish Government – Homelessness in Scotland 2017-18

The following chart shows the housing outcome for homeless people assessed as having a statutory duty for housing. The vast majority (82%) moved into council housing.

Figure 4.4d – Outcomes for households assessed as unintentionally homeless or unintentionally threatened with homelessness, Falkirk, 2017/18



Source: Scottish Government – Homelessness in Scotland 2017-18

5. Population Health

5.1 - Dementia

Due to the nature of Dementia it is very difficult to quantify the true population who have a type of Dementia. Different types of dementias can affect people in different ways and therefore people will experience different symptoms with different degrees of severity. Symptoms are often mild to start with and get worse over time, these are likely to be categorised as “minor cognitive impairments” (MCI) and a person is unlikely to be diagnosed with Dementia. There is also the potential that many people may experience symptoms but do not visit their GP or hospital and consequently will not be known to services.

For the reasons mentioned above and due to complexities in how health data is recorded, it is not possible to determine the exact incidence rate, or the number of people currently diagnosed with Dementia in Falkirk. It is well known that Dementia rates are likely to increase due to increasing older population, considerable investment in research and greater awareness of the condition by the general public.

Alzheimer Scotland estimated the prevalence of Dementia in the Scotland population (2017) using NRS Scotland (and Office for National Statistics for age 90+) population projections (2012-based) applied to two models (EuroCoDe¹ study for ages 60+, Harvey² for the under 60 age group).

Table 5.1a – Alzheimer Scotland Estimated Dementia Population – Falkirk 2017

Population Group	Estimated Number of People with Dementia
Males	914
Females	1,684
Total	2,598

Source – Alzheimer Scotland

1 - Alzheimer Europe (2009) *EuroCoDe: prevalence of dementia in Europe* <http://www.alzheimer-europe.org/index.php?Im3=CEE66BE91B37>

2 - Harvey R (1998) *Young onset dementia: epidemiology, clinical symptoms, family burden, support and outcome* Imperial College London

Dementia Post Diagnostic Support (PDS)

In December 2012 the Scottish Government published a revised list of national HEAT targets for 2013/14. One of the targets was for “all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan”. This HEAT target was intended to align with Alzheimer Scotland's Five Pillars of Dementia Post Diagnostic Support:

- **Supporting Community Connections** - Support to maintain and develop social networks.
- **Peer Support** - From other people with dementia, their families and carers to help come to terms with ill and maintain wellbeing and resilience.
- **Planning for Future Care** - Support, when they are ready, to plan the shape of their future care from their own perspective together with those around them, developing a personal plan with their choices, hopes and aspirations which can guide professionals.
- **Understanding the Illness and Managing the Symptoms** - Support to come to terms with dementia and learn about self-management of the condition.
- **Planning for Future Decision Making** - Support to set up powers of attorney and other legal issues.

ISD Scotland has been collecting Dementia PDS data since 2014. The number of referrals by financial year is presented for Falkirk in the table 5.1b below:

Table 5.1b – Number of PDS referrals by financial year – Falkirk residents

Financial Year	Number of Dementia PDS referrals
2014/15	233
2015/16	241
2016/17	268
2017/18	199*

Source - NSS Public Health and Intelligence National Dementia PDS Team (*2017/18 figures are provisional)

The table above does not reflect the level of demand for Dementia PDS services in Falkirk. As of October 2018 there were approximately 115* people awaiting PDS services. The average wait time for services is around 7 months, and this is a key issue when the delivery of these services is time sensitive for the individual. Due to the Scottish Government requirement to provide a minimum of one year PDS support, rather than what is required on a person-by-person basis, it is challenging to provide timely service to all those newly diagnosed with Dementia. In addition, people with a late diagnosis may only require a short period of support. It is therefore important that the HSCP considers the current situation and projections on Dementia Prevalence when drafting the new strategic plan.

*Source Alzheimer's Scotland – November 18

5.2 – Mental Health & Wellbeing

Mental Health is an umbrella term used to encompass both mental health problems/illness and mental wellbeing. Mental Health problems or illnesses are clinically diagnosed symptoms which affect the way that a person thinks, feels or behaves. Mental wellbeing can be a mix of subjective and psychological factors. It is important to note that it is possible to have poor mental wellbeing without a mental health illness – equally it is possible to have a diagnosed mental illness but still experience good mental wellbeing.

There is considerable debate as to the true prevalence of Mental Health issues in Scotland but the Scottish Government estimate that approximately 1 in 4 people will experience some form of mental health issue in their lifetime.

There is a high likelihood that many people who are experiencing mental health issues will not interact with any services in their time of crisis and therefore a substantial proportion of the population may be dealing with mild to severe mental health issues at any one time with no professional or informal supports.

Societal stigma attached to mental ill health has meant that people with mental health problems have traditionally suffered discrimination in numerous aspects of their life¹. This could be difficulties in getting and retaining employment, social isolation, difficulties maintaining decent housing, or being delayed access to the appropriate help and treatment.

A number of national campaigns (such as SeeMeScotland.org) aim to challenge societal stereotypes and end stigma and discrimination against people with mental health problems. At the same time, the Scottish Government has made mental health one of its public health priorities and recently released a 10-year vision for mental health in Scotland (2017-2027)². This document sets out 8 priorities for the new mental health strategy:

1. Focus on prevention and early intervention for pregnant women and new mothers
2. Focus on prevention and early intervention for infants, children and young people
3. Introduce new models of supporting mental health in primary care
4. Support people to manage their own mental health
5. Improve access to mental health services and make them more efficient, effective and safe – which is also part of early intervention
6. Improve the physical health of people with severe and enduring mental health problems to address premature mortality
7. Focus on '**All of Me**': Ensure parity between mental health and physical health
8. Realise the human rights of people with mental health problems.

¹Mental Health Foundation - <https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination>

² Mental Health in Scotland – a 10 year vision - https://consult.gov.scot/mental-health-unit/mental-health-in-scotland-a-10-year-vision/supporting_documents/mentalhealthstrategy.pdf

Mental Wellbeing

Mental wellbeing describes mood and how well a person can cope with day-to-day life. Someone with low mental wellbeing may struggle to cope with the stresses of daily life, to build and maintain relationships, to interact with the world around them and live and work productively. If a person experiences low mental wellbeing over a long period of time, they are more likely to develop a mental health problem¹.

Life events such as bereavement, loneliness, loss of employment and money worries can all lead to low mental wellbeing. People who are socially excluded, who have a long term condition, are homeless or living in poor housing, or socially disadvantaged are more vulnerable in terms of mental wellbeing, and consequently poor mental health in the long term. It is imperative that the health and social care partnership tackles inequalities not just in physical health, but also mental health and wellbeing.

It is also important to remember that poor physical health can negatively affect mental wellbeing. Similarly, poor mental wellbeing can negatively impact on physical health. Mental and physical health should be considered hand in hand when making key strategic decisions.

Data Landscape

While high quality mental health data exists for those patients who are hospitalised with a more serious mental health diagnosis, the vast majority of people who have mental health issues will not reach hospital, and many will not interact with any services. If people do not interact with services, there is no means of collecting information on this cohort, and as a result there is a significant gap in non-hospital Mental Health data. Without data, it is more difficult to plan & deliver services locally.

While people with common mental health issues are likely to interact with Primary care services, the data is not as accessible as secondary care data, and as such it is not currently possible to use this data for a reliable estimate of the population with mental health problems.

Priority number 7 of the Scottish Government's 10 year vision for Mental Health states that there should be parity between mental and physical health. It is important that the partnership endeavours to improve collection of mental health data to a similar level as physical health data to help inform the planning and delivery of services.

The following sections look at the data that is available around mental health and wellbeing.

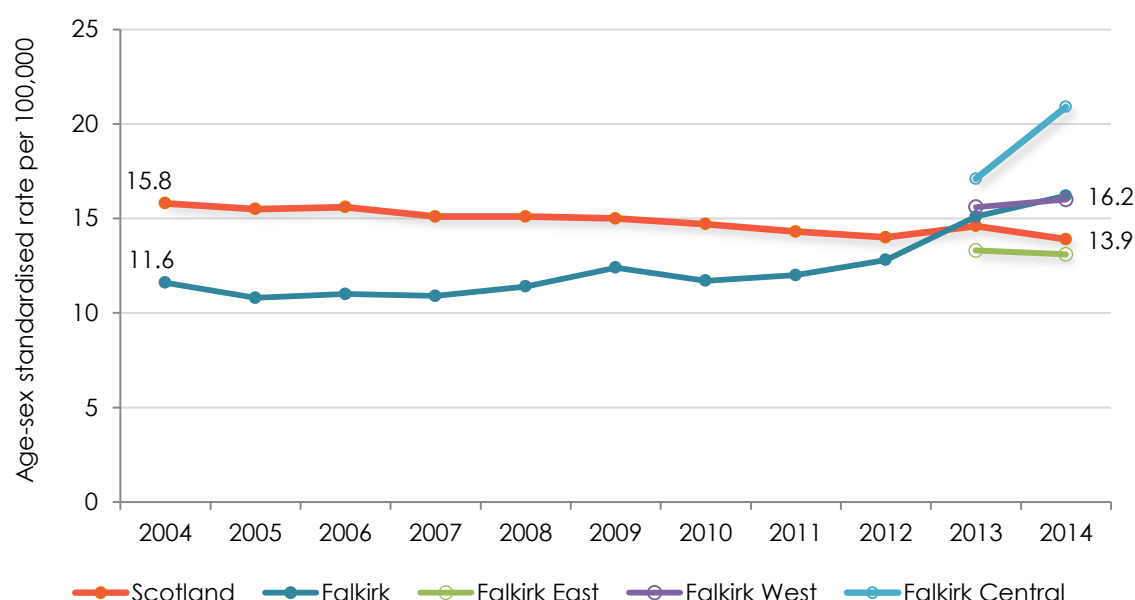
¹ Mind.org – Wellbeing - <https://www.mind.org.uk/information-support/tips-for-everyday-living/wellbeing/>

Deaths from Suicide

Suicide is a significant public health issue in Scotland and there are inequalities in suicide risk with those in lower socio-economic positions at a higher risk. There is also a well-known link between unemployment and suicide, with a study carried out by the University of Zurich suggesting that one in five suicides are linked to unemployment¹. The chart below shows that, based on a five year rolling average number, there has been a slight decrease in the rate of suicide over a ten year period (2004-2014) nationally. In Falkirk, there has been an increase from 11.6 in 2004 to 16.2 in 2014 with most of this increase happening in the most recent years.

Two years of data is available at Falkirk HSCP locality level. Falkirk Central locality rate is higher than that of the other two localities.

Figure 5.2a: Deaths from Suicide, Falkirk and Scotland, 5 year averages - 2004 to 2014



Definition: 5-year rolling average number and directly age-sex standardised rate per 100,000 population

Note: Calendar years; 5-year aggregates (e.g. 2014 is the aggregation of 2012 to 2016)

Source: National Records of Scotland (NRS)

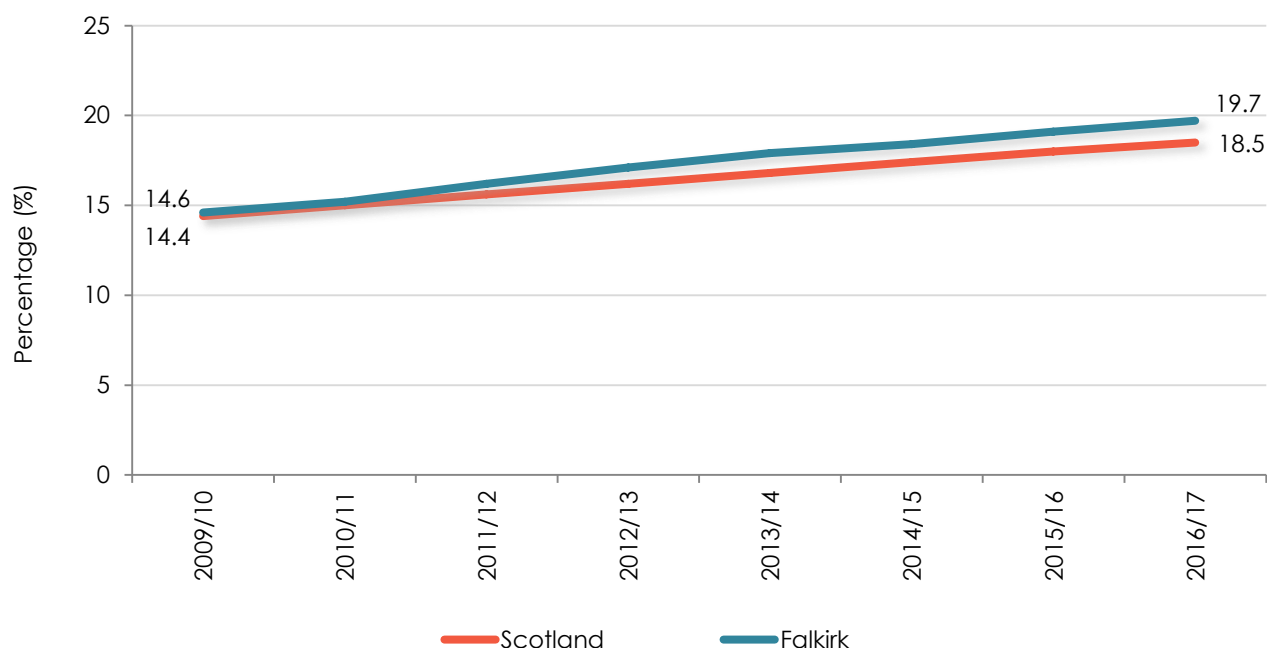
Depression, sometimes referred to as unipolar depression, is a common mental health problem characterised by sadness, loss of interest in activities and by decreased energy. It is estimated that 5.8% of men and 9.5% of women will experience a depressive episode in any given year.²

¹ Nordt C, Warnke I, Kawohl W. [Modelling suicide and unemployment: a longitudinal analysis covering 63 countries, 2000–11](#). The Lancet Psychiatry - Published online February 11 2015

² The world health report 2001 - Mental Health: New Understanding, New Hope - <http://www.who.int/whr/2001/en/>

The figure 5.2b below looks at the percentage of people prescribed drugs for anxiety, depression or psychosis. It shows that in 2016/17 19.7% of the population in Falkirk were prescribed drugs for anxiety/depression/psychosis which is higher than the national average.

Figure 5.2b: Percentage of people prescribed drugs for anxiety/depression/psychosis, 2011/12-2016/17



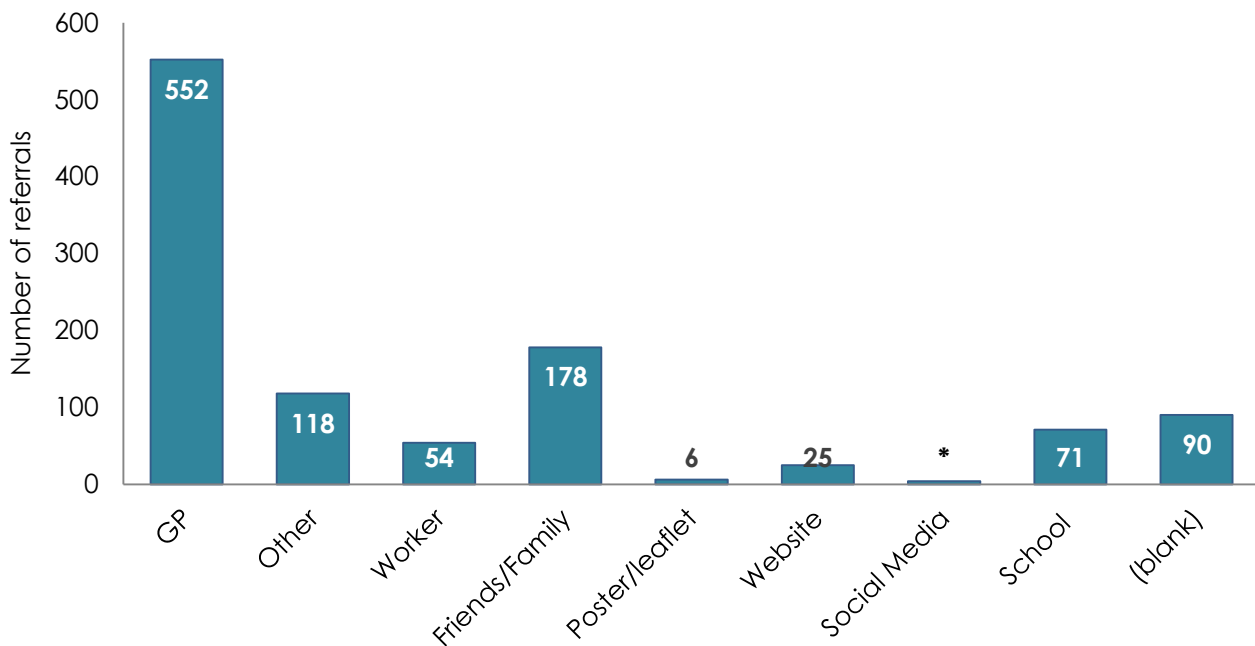
Source: The Scottish Public Health Observatory (ScotPHO)

FDAMH Immediate Help Service (IHS)

The FDAMH Immediate help service exists to provide Falkirk residents with immediate help or support when they are in crisis. Data collected on the IHS Service is presented in the charts below for financial year 2017/18.

Figure 5.2c below shows the number of referrals to IHS by referral source in 2017/18. Out of a total of 1,098 referrals, just over half were made by GPs. The next most common source of referral was from family and friends accounting for 16% of all referrals. It is worth noting that 6% of all referrals came from Schools.

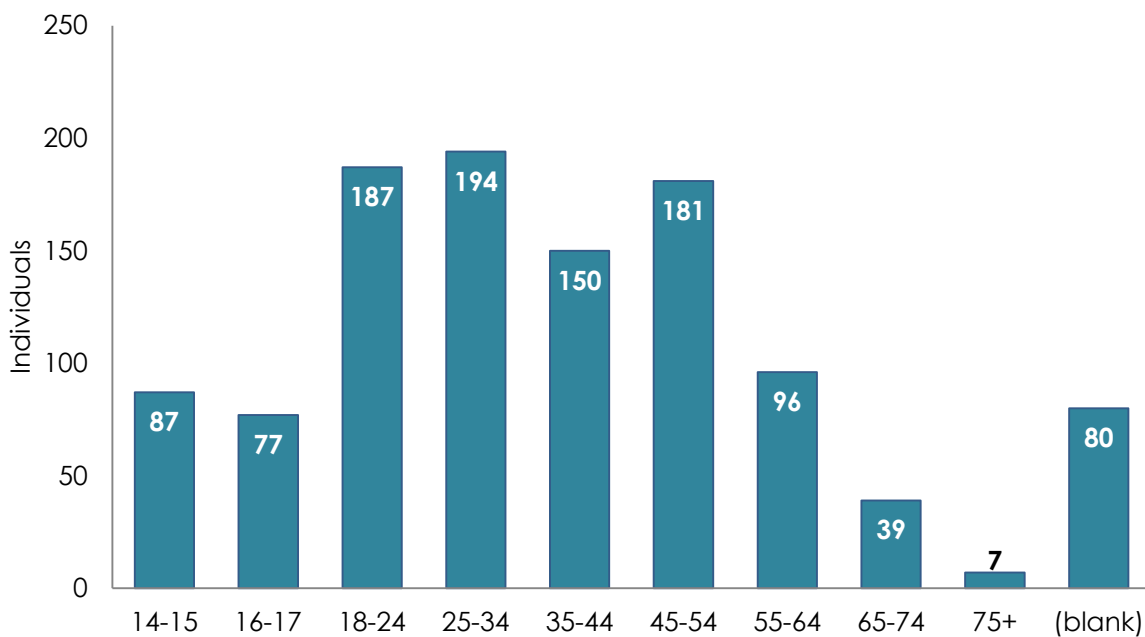
Figure 5.2c – IHS Service – Referrals by referral source 2017/18



Source: FDAMH

The following figure 5.1d breaks down referrals into age categories. The spread across age bands from Age 14 to age 75+ shows that a wide range of the population seeks help and support from the IHS. Over 50% of referrals came from the 18-24 (17%), 25-34 (18%) and 45-54(16%) age categories. Additionally a significant number of referrals came from the 14-15 and 16-17 age ranges, making up 15% of all referrals.

Figure 5.2d – IHS Service – Referrals by Age Range 2017/18



Source: FDAMH

Social Isolation

Social isolation and loneliness are often discussed together. However, they are not necessarily connected as people who are socially isolated may not feel lonely, and people who have many social connections may feel lonely.

Social isolation refers to the quality and quantity of the social relationships a person has at individual, group, community and societal levels. Loneliness is a subjective feeling experienced when there is a difference between an individual's felt and ideal levels of social relationships.¹

Anyone can experience social isolation and loneliness at any stage throughout their life. In Scotland, adults and children who are socio-economically disadvantaged and those experiencing poor physical and mental health are at risk of social isolation and loneliness, as are adults who are living alone, widowed or separated.

Lack of access to transport can lead to social exclusion and poor social capital. In contrast, public and green spaces benefit health through promoting social interactions and physical activity.²

A range of services provided by the public sector, private sector, third sector and community and voluntary services may have the potential to impact on social isolation; even if it is not their primary aim.³

Falkirk's Mental Health Association (FDAMH) provides a range of services, each of which help with social isolation in different ways. The social spark service aims at tackling the social isolation commonly experienced with mental health issues, this provides small social groups and one-to-one support to help regain confidence and build connections.⁴ They help people both with and without a mental health diagnosis. FDAMH's website is available through the link below:

<https://www.fdamh.org.uk/>

It is not currently possible to directly quantify numbers of people who are socially isolated in Falkirk (or at Scotland level) but a number of indicators from national surveys can be used as proxies.

- Social contact – 6%* of adults had contact with family, friends or neighbours less than once or twice a week (SHeS 2013/15 data combined).¹
- Social support – 14% had fewer than three people they could turn to for comfort and support in a personal crisis (SHeS 2013/15 data combined).¹
- Sense of belonging – in 2015, over a fifth of adults (22%) said they felt they belonged not very/not at all strongly to their immediate neighbourhood (SHS).¹

Source – Health Scotland (Scottish Household Survey, Scottish Health Survey)

¹ <http://www.healthscotland.scot/media/1712/social-isolation-and-loneliness-in-scotland-a-review-of-prevalence-and-trends.pdf>

² <https://www.sciencedirect.com/science/article/pii/S2214140515002224>

³ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/460708/3b_Reducing_social_isolation-Briefing.pdf

⁴ <https://www.fdamh.org.uk/wp-content/uploads/2018/05/FDAMH-Leaflet-May-2018.pdf>

5.3 - Burden of Disease

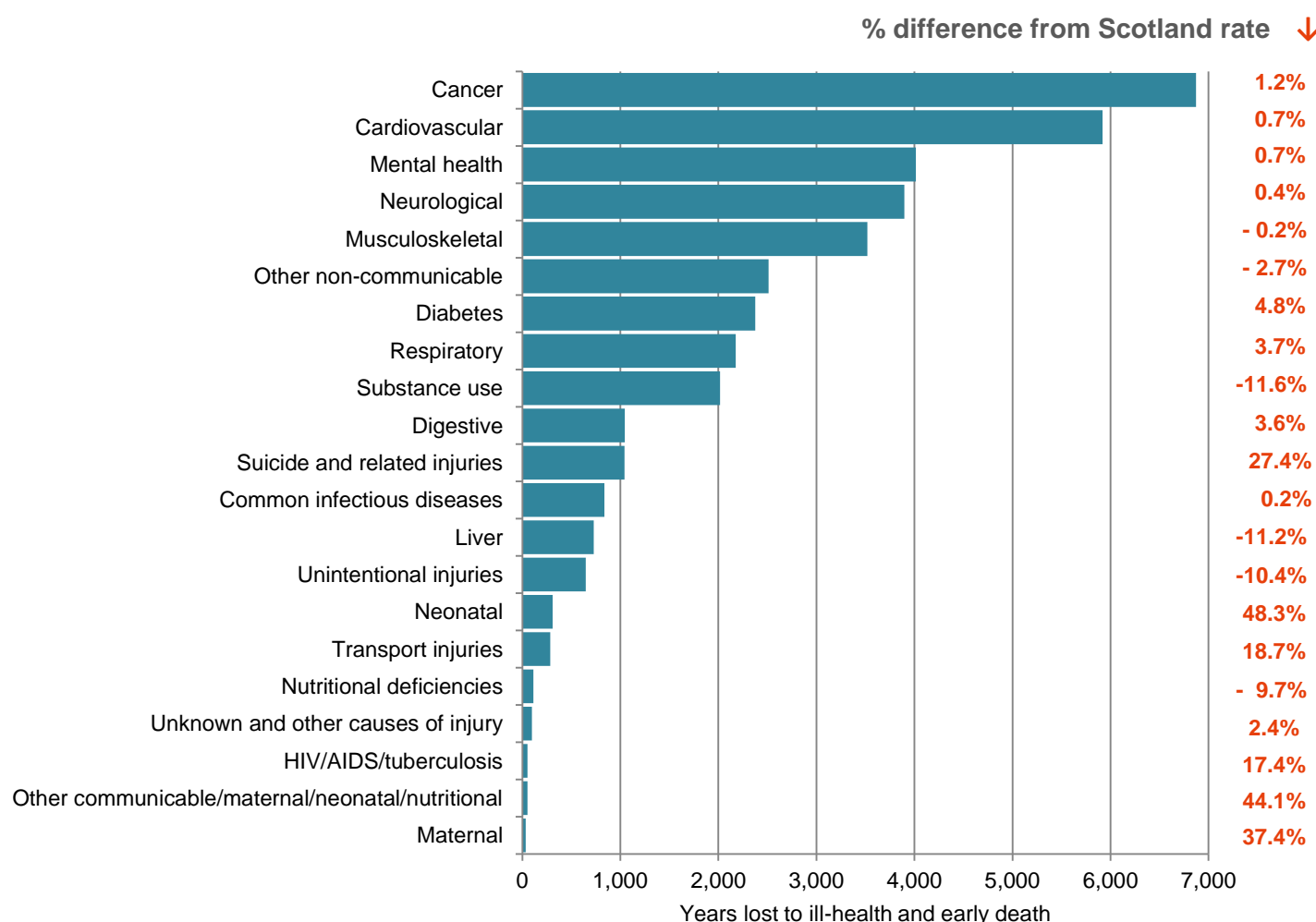
Burden of disease is a measure of the health of the population. It aims to quantify the difference between living to old age in good health, and the situation in which healthy life is shortened by illness, injury, disability and early death.

Burden of disease studies use a single measure which combines fatal burden [i.e. years lost because of early death - years of life lost (**YLL**)] and non-fatal burden (i.e. years lost because they are lived in less than ideal health - years lived with disability (**YLD**)). The measure used to describe the overall burden of disease is called the disability-adjusted life year (**DALY**) and was calculated by adding together the **YLL** (fatal burden) and **YLD** (non-fatal burden) for each disease, condition or injury.

Leading causes of ill-health and early death in Falkirk

The three leading causes of ill-health and early death are cancer, cardiovascular diseases and mental health disorders. Overall, the rate of ill health and early death in Falkirk is 0.7% higher than the Scottish rate. The rate due to substance use disorders is lower than the Scotland rate whereas the rate due to suicide, self-harm and interpersonal violence related-injuries is higher.

Figure 5.3a – Leading causes of ill-health and early death in Falkirk



Source – ScotPHO <https://www.scotpho.org.uk/comparative-health/burden-of-disease/overview/>

*Ranking based on the number of DALYs and the % difference is based upon the age-standardised DALYs rate per 100,000 population. Note that a -ve % figure indicates that Falkirk is lower than the national figure, a +ve value indicates that the Falkirk has a higher proportionately higher DALY figure than Scotland.

The figure 5.3b below presents the top ten leading causes of ill health and early death in Falkirk in 2016 and the variation with the Scottish rate. While ranking differs these mirror the top ten leading causes nationally although there is greater variation in the leading causes of early death, particularly in suicide, self-harm and interpersonal violence related injuries, which is higher than the Scotland rate.

Figure 5.3b - Leading causes of ill-health and early death in Falkirk in 2016

Leading causes of ill-health in 2016			Leading causes of early death in 2016		
	% difference with Scottish rate			% difference with Scottish rate	
1	Mental health	+0.6%	1	Cancer	+1.3%
2	Musculoskeletal	+0.6%	2	Cardiovascular	+0.6%
3	Neurological	+0.9%	3	Neurological	-0.1%
4	Other non-communicable	-0.1%	4	Respiratory	+4.8%
5	Cardiovascular	+1.1%	5	Diabetes	+11.2%
6	Diabetes	+0.6%	6	Suicide and related injuries	+30.0%
7	Substance use	-4.3%	7	Substance use	-18.4%
8	Respiratory	+1.2%	8	Common infectious diseases	+0.3%
9	Cancer	+0.1%	9	Liver	-12.1%
10	Digestive	+0.9%	10	Digestive	+5.5%

*Ranking based on number of YLD.

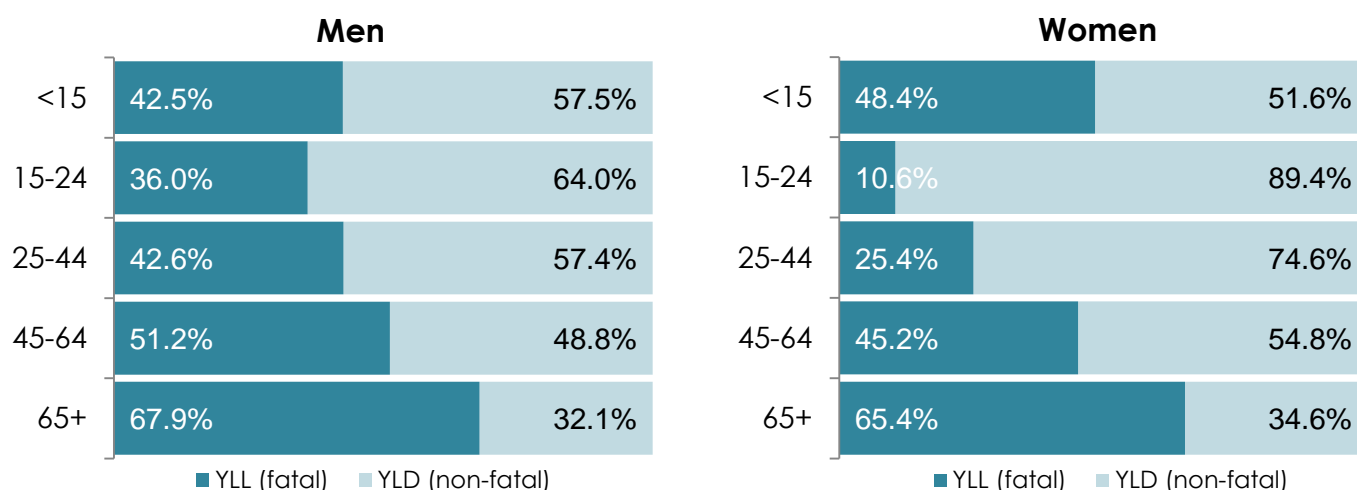
Percentage difference based on age-standardised YLD rates.

*Ranking based on number of YLL.

Percentage difference based on age-standardised YLL rates.

Overall in Falkirk, the non-fatal burden accounted for more DALYs in each group until the age of 65 and over in women and in men age 45 and over. The fatal burden was notably higher among men than women in the 15-24 and 25-44 age groups (Figure 5.3c).

Figure 5.3c - Percentage contribution of YLL (fatal) and YLD (non-fatal) by gender and age group, Falkirk 2016



*Based on number of DALYs by gender and age group.

The local area estimates and the Scottish Burden of Disease Study Overview report and Deprivation report can be accessed [here](#). The Deprivation report highlights that the disease burden in the most deprived areas in Scotland was more than double that found in the least deprived areas and the burden increased with each level of deprivation. In addition, nearly a third of the disease burden in Scotland could be avoided if the whole population had the same rate of burden as those in the least deprived areas.

The Infographic below shows a worked example of how the DALY figure is calculated.



Source – ScotPHO <https://www.scotpho.org.uk/comparative-health/burden-of-disease/overview/>

5.4 – Sensory Impairment

Sensory impairment includes varying degrees of hearing loss, sight loss and loss of both of these senses. It can be a recognised sensory impairment; a risk of sensory loss or hidden and untreated sensory loss. The World Health Organization has recognised that children and adults with disabilities, including those with a sensory impairment, have poorer health outcomes, lower educational achievements, less economic participation and higher rates of poverty than people without a disability.¹

Unfortunately data on prevalence of sensory impairment is very limited. A register of blindness and partial sightedness (Registered Blind and Partially Sighted Statistics – Scottish Government) was collected at a local authority level until 2010 but has since been discontinued. This was a useful source of the population registered with a visual impairment, and the number of new cases in each year. The main caveat with this data source is that it is not compulsory to register with the local authority so only counts those who have come forward. It is thought that between a quarter and a third of those who are partially sighted are registered with their local authority.

Data on the population who are deaf or have a hearing impairment is even more limited. There is no national data collected on numbers of people who are deaf or have a hearing impairment.

Visual Impairment Figures

The most recent data on visual impairment collected at a National level was in 2010. The figures for Falkirk are presented in table 5.4a below. It is important to bear in mind that registration was not compulsory and it is thought that only a quarter to a third of people who are partially sighted registered with their local authority.

Table 5.4a – Number registered blind & visually impaired with local authority, Falkirk, 2010

	Under 65 years		Over 65 years		All Ages	
	Male	Female	Male	Female	Total	Rate per 1,000 pop.
Registered Blind	79	68	130	203	480	3.1
Registered Visually Impaired	130	119	220	423	892	5.8

Source: Scottish Government's Registration of Blind and Partially Sighted Persons Return

¹ World Report on Disability. World Health Organization, 2011. - http://www.who.int/disabilities/world_report/2011/report/en/

Hearing Impairment - Crude Estimations

Due to the limited data available hearing impairment in Scotland it is not possible to provide prevalence figures for the Falkirk population. Some estimations do exist at a national level so with a number of assumptions, it is possible to make a very crude estimation for Falkirk.

These estimations assume:

- The Scotland level estimates are accurate.
- The Falkirk population profile is identical to the population profile for Scotland.

Table 5.4b – Crude Estimations on Hearing Impairment in Falkirk

Population Type	Population (2017) ¹	Estimated number of people with hearing loss ^{2,3} (% of population)	Estimated number People in Scotland with severe/profound hearing loss ^{2,3} (% of population)
Scotland	5,295,000	945,000 (17.8%)	76,000 (1.4%)
Falkirk	160,130	28,500 (17.8%)	2,200 (1.4%)

1 – NRS Mid-year populations 2017.

2 - The estimates of prevalence of hearing loss in this section are based on the most robust and best available data for prevalence at each age group (Davis, 1995), updated with population estimates for 2014 (ONS, 2015), and rounded to the nearest 500. Includes those under the age of 17.

3 – Estimates are rounded to the nearest hundred.

Source: Action for Hearing Loss – Hearing Matters Report/ NRS population estimates.

Forth Valley Sensory Centre

The Forth Valley Sensory Centre is located in Camelon in the Central Falkirk Locality so is well placed to serve Falkirk residents with visual or hearing loss. It provides a base for statutory and third sector organisations to provide quality services and advice to those with a sensory impairment. The centre gets over 500 visitors a week on average (all Forth Valley) who could be attending a specific service, a social activity or using the enterprise cafe or garden.

The centre is not simply there to provide an access point for support and advice. The centre runs many social activities to provide a place for people with a sensory impairment (and their families) to socialise and meet new people.

Falkirk Council has representatives on site to help people with a sensory impairment to undertake an assessment of needs, to obtain necessary equipment or undertake training to improve their quality of life. National Charities such as the Royal National Institute of Blind People (RNIB) and Action for Hearing Loss maintain resources at the centre to help people with welfare questions and advice on employment.

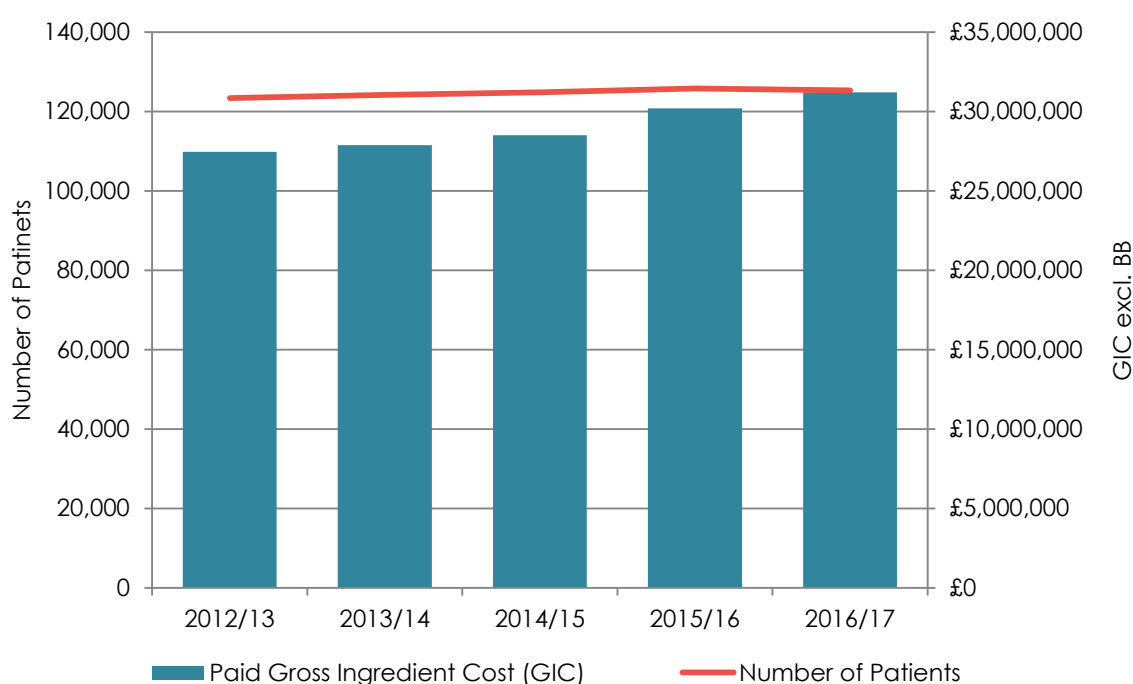
The centre also provides a link to NHS Forth Valley services and if need be, the sensory team can refer to outpatient services. A Low Vision clinic runs within the centre with a comprehensive team of ophthalmic specialists who can review a person with a visual impairment.

6. Health & Social Care Services

6.1 – Community Prescribing

Approximately 15% of Health & Social Care spend in Falkirk relates to primary care prescribing. While this is a significant proportion of the total spend effective prescribing helps individuals to manage their conditions and may help prevent attendance or admission to hospital. Figure 6.1a, below, shows the number of people prescribed items has been relatively stable over the past five years however costs have been increasing. We also know that the elderly population is expected to rise as well as the number of individuals living with complex conditions and it is likely that this will also impact on the longer term prescribing patterns for the partnership.

Figure 6.1a: Number of People Prescribed Items and Gross Ingredient Cost, 2012/13 to 2016/17



Source: Primary Information System, ISD Scotland (extracted 18/09/18)¹

Table 6.1a, below, gives the number of people prescribed items and the associated costs by British National Formulary (BNF) category by locality and Partnership for 2016/17. The top five chapters for patients and costs have been highlighted and people can be counted in more than one category. It shows that some of the highest activity in terms of patients and costs are the Central Nervous System, Gastro-Intestinal System and Cardiovascular System.

¹ Footnotes include: Includes patients resident in Falkirk HSCP who had an item prescribed. Includes all prescriber and dispenser types and is for that dispensed within the community only and data is based on items which have been prescribed, dispensed and submitted for payment. Includes items prescribed in England and dispensed in Scotland and excludes items prescribed in Scotland and prescribed in Scotland and dispensed in England. Excludes private prescriptions (other than control drugs), hospital and direct supply of medicines to patients. Paid Gross Ingredient Cost excludes broken bulk discount, paid financial year is the year in which payment is claimed and number of patients is based on a count of valid Unique Patient Identifiers (UPIs) (UPI is not always captured therefore there may be a small amount of underestimation). Data is based on BNF hierarchy and not clinical usage and information on postcode is not a unique count as patients may have had different postcodes within the timeframe.

Some of the most expensive areas per person however are Stoma Appliances, and Malignant Disease. The table is split by HSCP locality. There are a variety of different reasons why prescribing patterns can vary from area to area. For instance, different practices serve different people; some have greater numbers of older adults, more children or higher levels of deprivation for example. For these reasons comparisons between areas should be undertaken with caution.

Table 6.1a: Number of People Prescribed Items by BNF Chapter, 2016/17, Falkirk HSCP

Chapter	BNF Chapter	Falkirk Central	Falkirk East	Falkirk West	Falkirk HSCP		
		Number of Patients	Number of Patients	Number of Patients	Number of Patients	Cost to the nearest £	Cost Per Person
1	Gastro-Intestinal System	13,693	19,944	14,431	48,068	£2,198,700	£46
2	Cardiovascular System	12,437	18,226	13,235	43,898	£3,761,688	£86
3	Respiratory System	9,456	14,044	10,220	33,720	£3,995,941	£119
4	Central Nervous System	18,836	27,267	19,199	65,302	£7,703,086	£118
5	Infections	13,806	20,395	14,765	48,966	£1,058,776	£22
6	Endocrine System	7,487	10,691	7,496	25,674	£3,921,173	£153
7	Obstetrics, Gynae & Urinary Tract Disorders	5,892	9,218	6,914	22,024	£1,293,821	£59
8	Malignant Disease & Immunosuppression	532	826	602	1,960	£779,277	£398
9	Nutrition & Blood	5,561	7,780	4,927	18,268	£1,239,536	£68
10	Musculoskeletal and Joint Diseases	9,128	13,936	9,932	32,996	£783,912	£24
11	Eye	3,499	5,535	3,891	12,925	£372,866	£29
12	Ear, Nose & Oropharynx	6,060	9,153	6,895	22,108	£314,473	£14
13	Skin	12,224	17,659	13,415	43,298	£1,083,186	£25
14	Immunological Products & Vaccines	335	742	440	1,517	£39,788	£26
15	Anaesthesia	520	679	499	1,698	£206,870	£122
19	Other Drugs & Preparations	437	599	440	1,476	£31,219	£21
20	Dressings	1,092	1,535	1,020	3,647	£389,323	£107
21	Appliances	5,661	8,444	5,821	19,926	£824,240	£41
22	Incontinence Appliances	344	475	329	1,148	£196,085	£171
23	Stoma Appliances	558	633	413	1,604	£786,635	£490
	Blank	557	699	578	1,834	£229,936	£125

Source: Prescribing Information System, ISD Scotland (extracted 27/03/18). See footnotes of Figure X (above).

There has also been an increase in patients prescribed items from Anaesthesia (1,103 patients in 2012/13 to 1,698 in 2016/17), Appliances (13,176 in 2012/13 to 19,926 in 2016/17) and Stoma Appliances (1,276 in 2012/13 and 1,604 in 2016/17) and a decrease in patients prescribed items from Infections (57,092 in 2012/13 to 48,966 in 2016/17).

The Prescribing Support Team works with individual GP Practices to help them optimise their prescribing and keep up to date on the latest prescribing practice. In some larger health board run practices, advanced practice pharmacist support diverts some pharmacy work away from GPs allowing GPs to focus on more important patient facing work. Practice pharmacists are also able to identify unnecessary or unusual prescribing patterns and reduce prescribing for certain patients.

The Pharmacy First scheme in Forth Valley allows community pharmacists to access treatment for certain conditions such as COPD, urinary tract infections or Impetigo. This locally agreed scheme for certain conditions aims to provide medication-themed advice and access to medicines within GP opening hours and out of hours.

6.2 – Forth Valley Alcohol & Drugs Partnership

The Forth Valley Alcohol & Drugs Partnership carried out an extensive needs assessment of Alcohol & Drug misuse in Forth Valley in 2015/16. The report is available at the link below:

http://forthvalleyadp.org.uk/wp-content/uploads/2016/06/Forth_Valley_Alcohol_Drugs_Needs_Assessment_Report_amended.pdf

This section does not attempt to replicate the considerable work involved in the dedicated alcohol and drugs needs assessment but highlights a few key points. For a more in-depth look at Alcohol & drugs please refer to the Forth Valley ADP Needs Assessment.

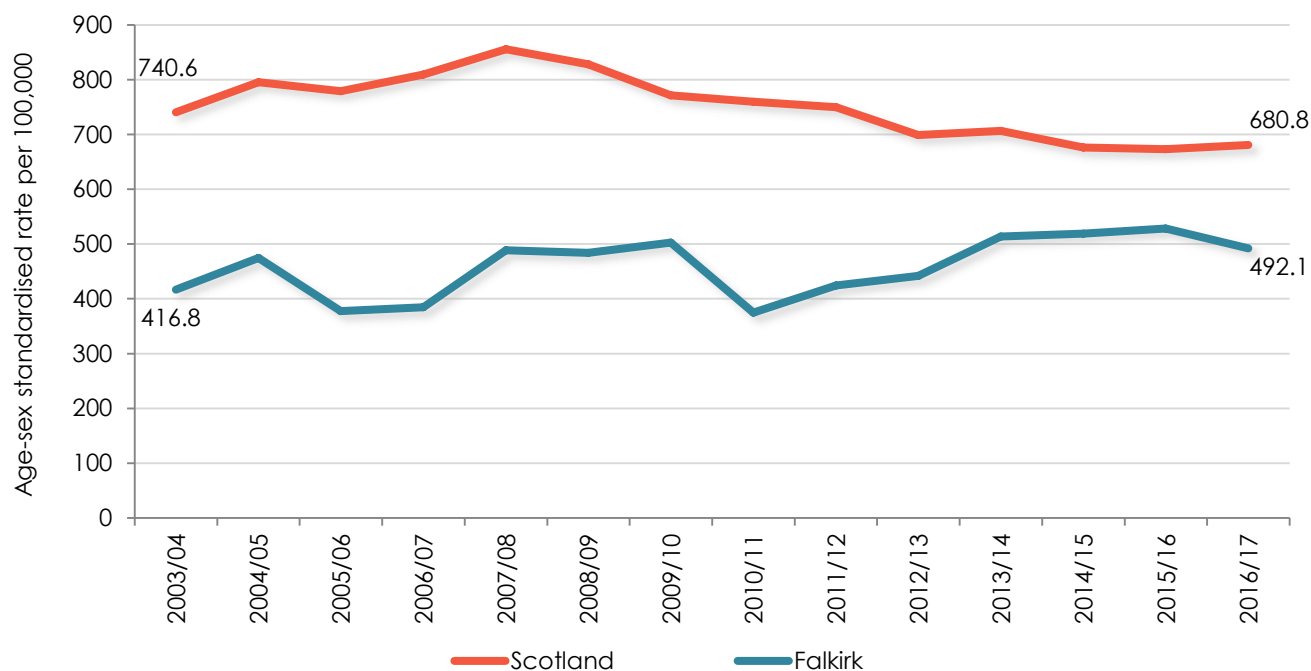
Alcohol-related problems have been estimated to cost the Scottish economy more than £3.56 billion per year and, in fact, this is thought to be an underestimate. More than half of this figure is due to the economic cost to society of people being absent from work, being less productive when they are working, or dying at a younger age from illnesses caused by alcohol consumption¹.

Alcohol-related Hospital Stays

Alcohol misuse causes a number of problems for society but it is not often possible to quantify the effect. We can measure the effect alcohol has on hospital (to some extent – there will be other A&E attendances that involve alcohol misuse but aren't the main recorded reason). The chart below shows a relatively flat trend and remains lower than the national average.

¹ Scottish Government Social Research. The Societal Cost of Alcohol Misuse in Scotland for 2007. York Health Economics Consortium, University of York; 2010. www.gov.scot/Publications/2009/12/29122804/0

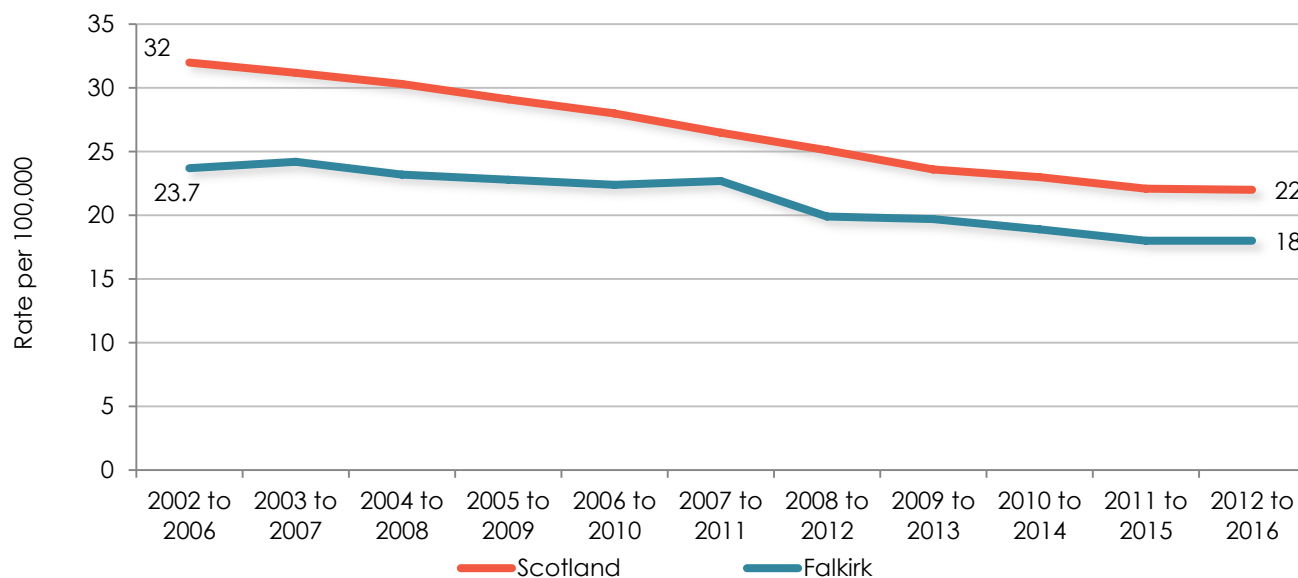
Figure 6.2a - Alcohol-related Hospital Stays - All alcohol conditions (European age standardised rate)



Source: ISD Scottish Morbidity Record 01 (SMR01)

In terms of deaths due to alcohol conditions Falkirk has seen a consistent decline in mortality rate. The decline also follows closely with the trend seen in Scotland as a whole.

Figure 6.2b - Alcohol-related Deaths - All alcohol conditions



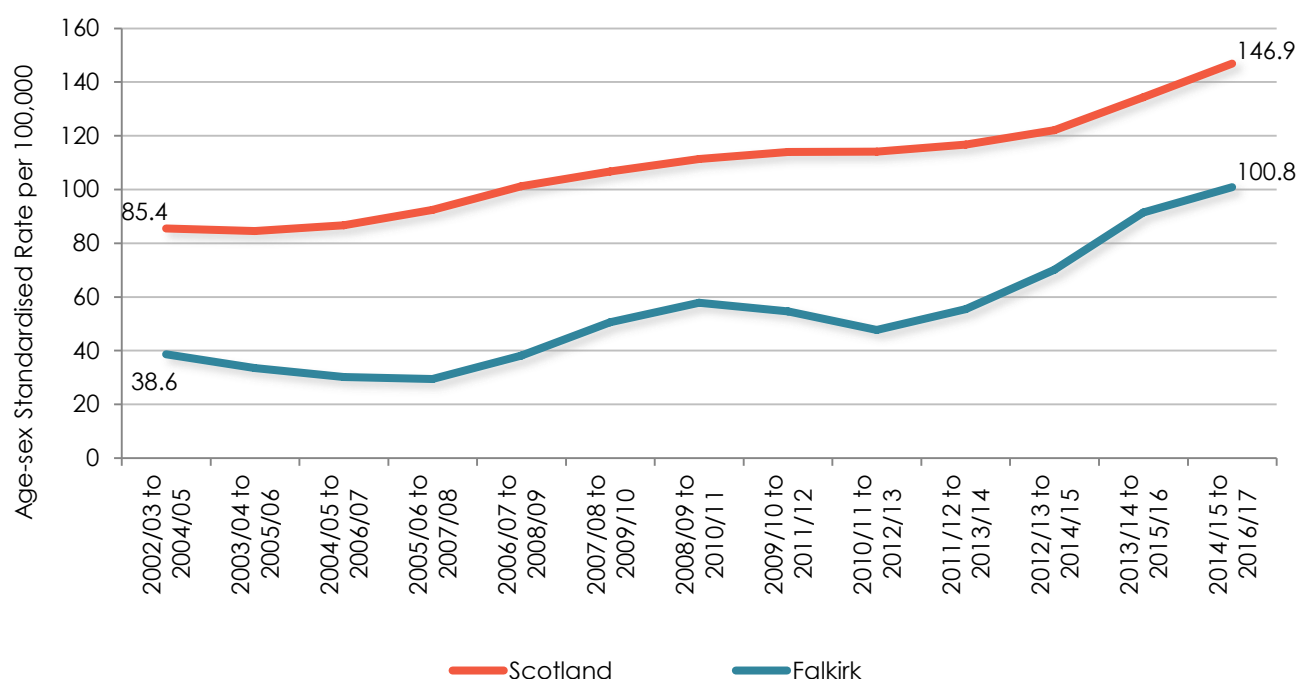
Source: ISD Scottish Morbidity Record 01 (SMR01)

*Five year rolling average – directly standardised rate per 100,000

Drug-related Hospital Stays

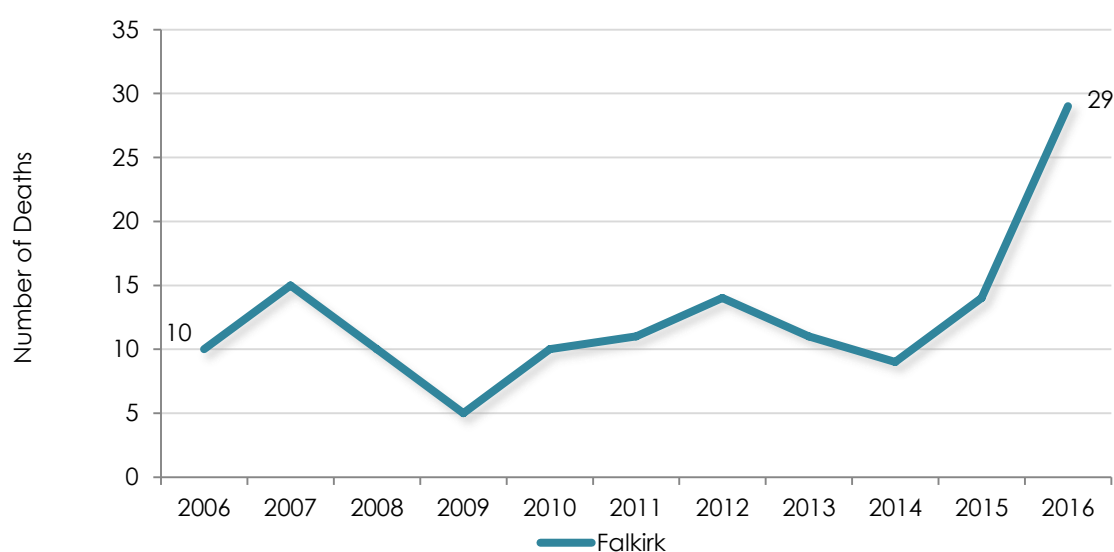
The picture for drug-related hospital stays is less positive than for alcohol. Despite some dips along the way, the rate of drug-related hospital stays has more than doubled for the Falkirk population over the past decade. The number of drug-related hospital stays has also increased at a faster rate than the national figure, however it has remained consistently lower.

Figure 6.2c - Drug-related Hospital Stays - All alcohol conditions (European age standardised rate)



Source: ISD Scottish Morbidity Record 01 (SMR01), (3 year rolling averages).

Figure 6.2d - Drug-related deaths, Falkirk 2006-2016



Source: NRS Drug related deaths

Additionally the number of drug related deaths has almost tripled over the last decade, with a significant jump in the last 2 years. While it seems alcohol related deaths may be on the decline, drug related deaths seem to be showing an alarming increase.

Alcohol Brief Interventions

The Alcohol Brief Interventions (ABI) Local Delivery Plan (LDP) standard for 2017-18 states that:

NHS Boards and their Alcohol and Drug Partnership (ADP) partners will sustain and embed alcohol brief interventions in the 3 priority settings of primary care, A&E and antenatal and broaden delivery in wider settings.¹

While there is no formal definition on a brief intervention, national guidance describes an ABI as “a short, evidence-based, structured conversation about alcohol consumption with a patient/client that seeks in a non-confrontational way to motivate and support the individual to think about and/ or plan a change in their drinking behaviours in order to reduce their consumption and/or their risk of harm”.

ABIs are given to individuals aged over 16 who are drinking at hazardous and harmful levels. This is identified through screening. The aim of the intervention is for individuals to moderate their level of drinking and thereby reduce their risk of developing more serious alcohol-related problems.²

Screening is a structured conversation focused on obtaining an accurate picture of the client’s alcohol consumption to assess whether they are suitable for an ABI, whether they should be signposted to another service, or if no action is required. Screening tools appropriate to specific settings provide an objective and validated way of assessing whether a client is a hazardous, harmful or a dependent drinker. Screening is an important part of delivering ABIs and this alone may help the client recognise that they have a problem and start the process of thinking about change, or provide the motivation to change.³

Data is not available at Falkirk level but In 2017/18, 8,219 ABIs were carried out in Forth Valley. This is 241% higher than the 3,410 ABIs required in the LDP standard. The target for ABI delivery was not only met but exceeded within Forth Valley. At a national level the target for ABI delivery was also exceeded.

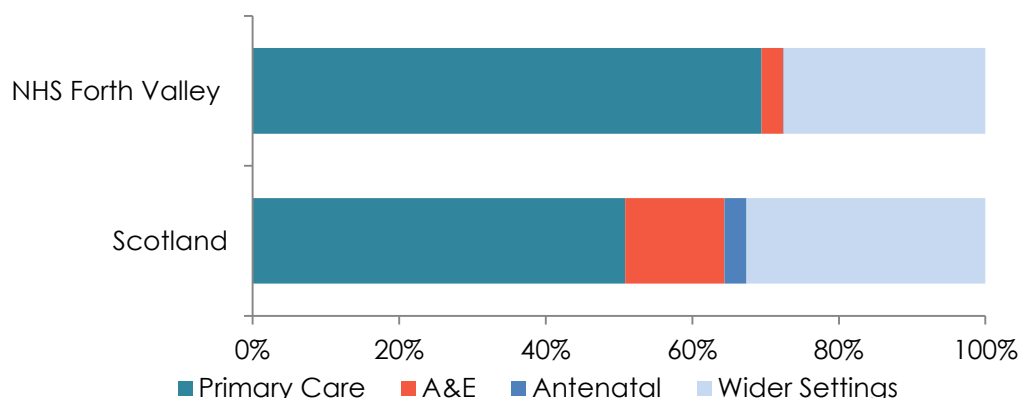
In Scotland 50.9% of ABIs were delivered in primary care, 13.5% in Accident & Emergency (A&E), 3.0% in antenatal settings and 32.6% in wider settings. In Forth Valley 69.5% of ABIs were delivered in primary care, 2.9% in Accident & Emergency (A&E), 0.1% in antenatal settings and 27.5% in wider settings.

¹ Local Delivery Plan Standard: Alcohol Brief Interventions National Guidance: 2017-18. The Scottish Government <http://www.gov.scot/Resource/0052/00520646.pdf>

² Alcohol Brief Interventions 2016/17. Information Services Division <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2017-06-27/2017-06-27-AlcoholBriefInterventions-Report.pdf>

³ Alcohol Brief Interventions 2017/18. Information Services Division <https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2018-06-26/2018-06-26-AlcoholBriefInterventions-Report.pdf>

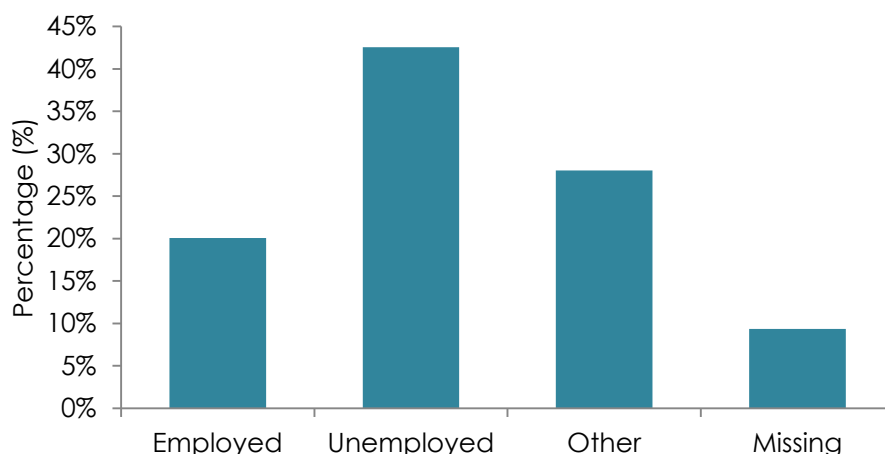
Figure 6.2e: Percentage of ABIs carried out in each setting during 2017/18, NHS Forth Valley and Scotland.



Source: ISD Scotland

The Scottish Drugs Misuse Database (SDMD) is a unique and widely used national information source on the misuse of drugs in Scotland. It provides information on individuals presenting for Initial Assessment of specialist drug treatment services. During 2016/17, 43% of individuals known to Falkirk's Alcohol and Drug Partnership (ADP) were unemployed, 20% employed and a further 28% classified as other.

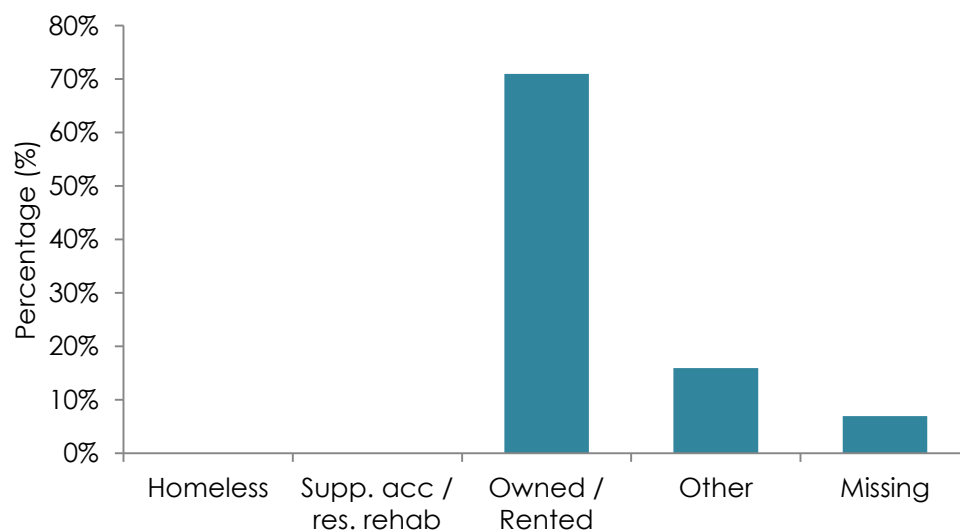
Figure 6.2f: Percentage of individuals presenting for assessment by employment status, Falkirk ADP 2016/17.



Source: Scottish Drugs Misuse Database (SDMD), ISD Scotland

Figure 6.2g below shows that in 2016/17, 71% of individual's known to the Falkirk ADP either owned or rented their accommodation.

Figure 6.2g: Percentage of individuals presenting for assessment by accommodation status, Falkirk ADP 2016/17

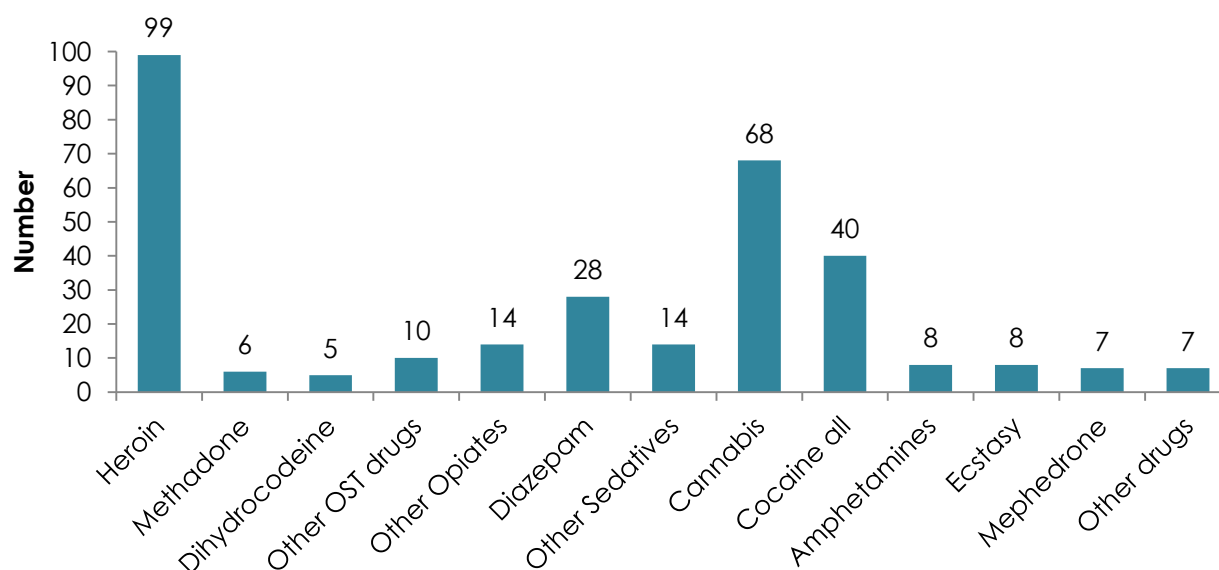


Note: Suppressed values are not shown

Source: Scottish Drugs Misuse Database (SDMD), ISD Scotland

The number of individuals in Falkirk ADP in 2016/17 who have used an illicit drug during the month prior to initial assessment is shown in Figure 6.2h below. The most common illicit drug used was heroin with 99 individuals having used this, followed by cannabis with 68 individuals using this type of drug.

Figure 6.2h: Number of individuals presenting for assessment by currently used illicit drug (reported in any position), Falkirk ADP, 2016/17.



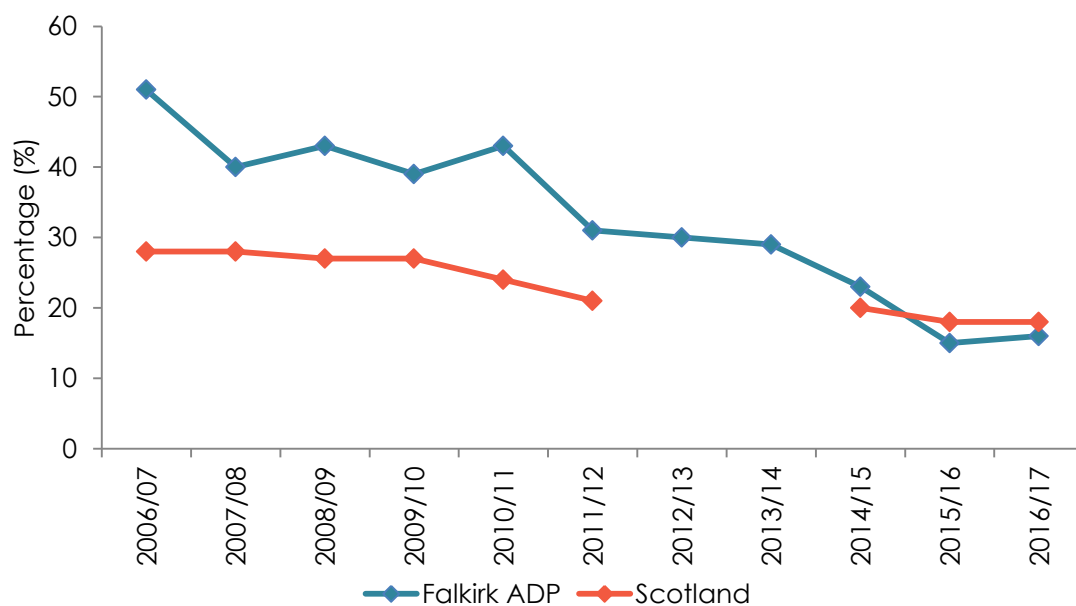
Notes:

- Individuals may have reported use of more than one drug, therefore the total of individuals may be counted in more than one NHS Board or ADP.
- An illicit drug is any drug that has not been prescribed for the user. This includes illegal drugs, volatile substances, 'novel' or new psychoactive substances (NPS)/ legal highs, and inappropriate use of over the counter medicines.

Source: Scottish Drugs Misuse Database (SDMD), ISD Scotland

Injecting information was available only for individuals who self-reported injecting. In Falkirk ADP in 2016/17, 42 individuals were reported to be current injectors and 70 individuals injected in the past and 157 individuals have never injected. Current injectors include individuals who reported injecting during the month prior to initial assessment, and in the past includes individuals who reported injecting previously but not in the month prior to initial assessment. Figure 6.2i below shows the percentage trend of individuals currently injecting between 2006/07 and 2016/17 in Falkirk ADP and nationally. Falkirk's ADP has seen a large percentage decrease of individuals currently injecting from 51% in 2006/07 to 16% 2016/17.

Figure 6.2i: Percentage of individuals presenting for assessment currently injecting, 2006/07 to 2016/17.

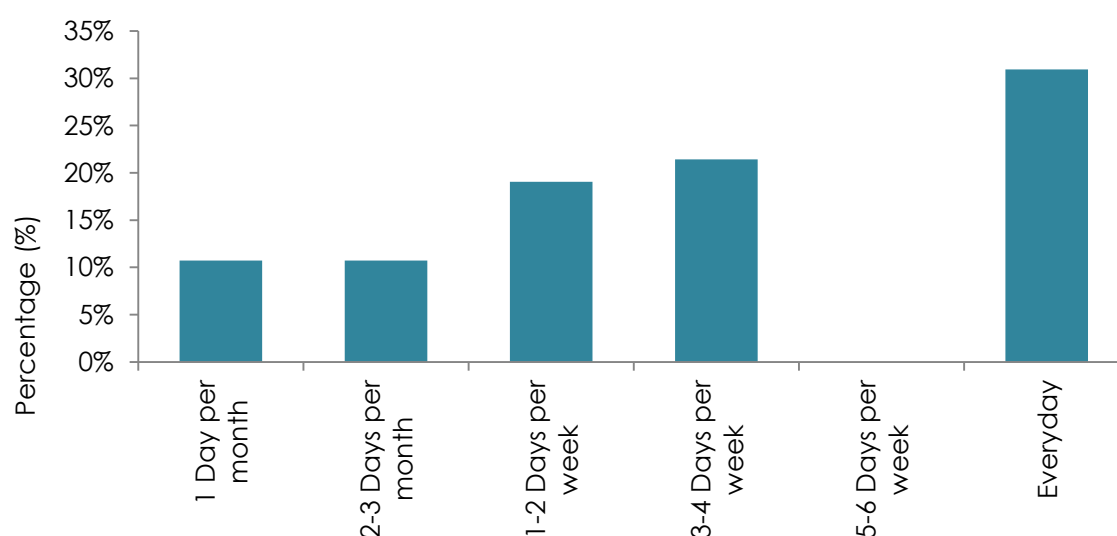


Notes: suppressed values are not displayed

Source: Scottish Drugs Misuse Database (SDMD), ISD Scotland

Alcohol consumption was completed for individuals who were assessed for specialist drug treatment. The frequency of alcohol consumption refers to the consumption in the month prior to initial drug treatment. In 2016/17, 31% of individuals known to Falkirk ADP consumed alcohol everyday and 11% consumed alcohol 1 day per month. The figures below show the number and percentage of individuals by frequency of alcohol consumption in Falkirk's ADP in 2016/17.

Figure 6.2j: Percentage of individuals presenting for assessment by frequency of alcohol consumption, Falkirk ADP, 2016/17



Notes: Suppressed values are not shown

Source: Scottish Drug Misuse Database (SDMD), ISD Scotland

6.3– Primary Care

With the implementation of the 2018 General Medical Services Contract in Scotland there is expected to be considerable changes in how primary care services are delivered. The new contract aims sets out plans to achieve:

- A clear role for Scotland's GPs
- A manageable workload
- Better care for patients
- Reduced risk
- Better health in communities

Service redesign is a major theme in the new GMS contract and a number of services will be reconfigured at scale to support a manageable workload for GPs, and allow GPs to see those with the most urgent need. These include:

- vaccinations services
- pharmacotherapy services
- community treatment and care services
- urgent care services
- Additional professional clinical and non clinical services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services.¹

There are currently 26 GP practices (excluding Direct Patient Care Service at FVRH) spread across the main settlements in the Falkirk area. Increased emphasis on joint-working has seen the development of 5 GP clusters. GP clusters will have a clear role in quality planning, quality improvement and quality assurance. Each GP practice will have a nominated practice quality lead and there will be an overall cluster quality lead. It is expected that the GP cluster leads will make an important contribution to their geographically aligned health and social care locality area.

Primary Care Workforce

Increased workload and reducing investment in primary care had contributed to a projected shortfall of over 800 GPs in Scotland by 2021². Difficulties in recruiting and retaining GPs is a current issue across Forth Valley and the strategic plan must consider how primary care is going to be delivered in Falkirk in the coming years. The Scottish Government invested £72 million during 2017/18 on Primary Care transformation, one of the schemes aims is to “address issues around

¹ The 2018 General Medical Services Contract in Scotland - <https://beta.gov.scot/publications/2018-gms-contract-scotland/documents/00527530.pdf>

² Royal College of General Practitioners - <http://www.rcgp.org.uk/about-us/news/2017/september/over-160000-patients-affected-as-scotland.aspx>

GP recruitment and retention through the GP recruitment and retention fund and promote general practice in Scotland as a positive career choice”¹.

In 2017 ISD (on behalf of the Scottish Government) carried out a National Primary Care Workforce survey consisting of “in-hours” General practice and GP out of hours services to support workforce planning in primary care. Although there is no contractual arrangement for practices to respond to this survey, Forth Valley had a 100% response rate in 2017 so this survey should provide a reasonably accurate picture of current primary care workforce in Falkirk.

Table 6.3a – Estimated Headcount of GPs in post in general practices, by GP Designation – Falkirk GP Practices, 2017 & 2015

Designation	2017		2015	
	Headcount in responding practices	Estimated headcount for whole area ¹	Headcount in responding practices	Estimated headcount for whole area ¹
Partner/Senior Partner	96	96	81	95
Retainee	2	<5	2	<5
Returner	0	0	0	0
Salaried GP	14	14	11	15
Enhanced Induction	2	<5	-	-
Total	114	114	94	110

Table 6.3b – Estimated WTE of GPs in post in general practices, by GP Designation – Falkirk GP Practices, 2017 & 2015

Designation	2017		2015	
	WTE in responding practices	Estimated WTE for whole area ¹	WTE in responding practices	Estimated WTE for whole area ¹
Partner/Senior Partner	80	80	67	80
Retainee	1	<5	1	<5
Returner	0	0	0	0
Salaried GP	10	10	8	10
Enhanced Induction	1	<5	-	-
Total	92	92	76	90

Source – ISD National Primary Care Workforce Survey

¹ – The estimated headcount and WTE numbers for the whole area (in absence of 100% survey response) are derived by multiplying up the headcount and WTE numbers for responding practices on the basis of size of the patient population they serve, relative to the size of the patient population for all practices in that area. Pre 2017 estimates have been rounded to the nearest 5 as per previous publications. Estimates for 2017 have not been rounded to the nearest 5.

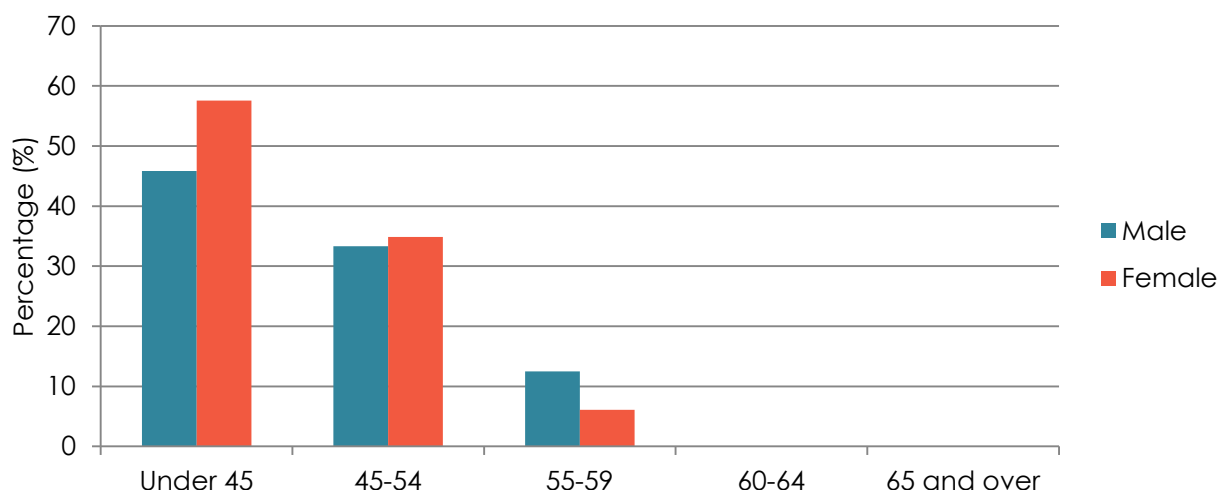
2 – Falkirk response rate was 100% in 2017 but only 83% in 2015.

¹ Scottish Government Primary Care Transformation - <https://www.gov.scot/Topics/Health/Services/Primary-Care/Strategy-or-Primary-Care>

Due to the differences in survey completion rate between the two years it is not possible to say exactly how workforce levels have changed, but the 2015 estimated figures provides an opportunity to make a rough comparison. An increase of 4 GPs (amounting to 2 WTE) is observed since the 2015 figure (estimated) across the 26 practices in Falkirk.

Figure 6.3a below shows the age profile of GPs in post in Falkirk at August 31st 2017.

Figure 6.3a – Headcount of GPs in post in General Practices, by gender and age group (2017)



Source – ISD National Primary Care Workforce Survey

Note - These figures are based upon the data received from responding practices only. There was a 100% response rate in Falkirk in 2017. Categories “60-64” and “65 and over” are blank as the values have been suppressed due to the potential risk of disclosure.

The age of a workforce has to be a key consideration in strategic planning, with GPs playing a pivotal role in Primary Care and the wider Health and Social Care arena. While the chart above shows the majority of the workforce is in the younger age brackets, it is important to consider that GPs may retire earlier than other professions. The average age of retirement for GPs in the UK was 58.5 years in 2016/17¹, This is lower than the current state pension retirement age for both men and women. In the above chart 15% of male GPs and 6% of Female GPs fall into the 5 year age category which includes the average UK retirement age for GPs.

Table 6.3c, below, highlights that while there has been small increases in the number of GPs (and WTEs) in the 2 years between surveys, there has been no change in the number of GP sessions, per 10,000 registered patients, provided every week by practices in Falkirk. Equally there hasn't been any change in the GP WTE input per 10,000 registered patients required to deliver these sessions.

¹ <http://www.pulsetoday.co.uk/news/gp-topics/pensions/great-escape-why-gps-are-drawing-pensions-at-a-younger-age/20036084.article>

Table 6.3c: Number of GP sessions^{1,2} per week and total GP WTE per 10,000 registered patients³

	Average number of GP sessions per week (responding practices)	GP sessions per week for every 10,000 registered patients (responding practices)	Total GP "WTE" input to practices (responding practices)	GP "WTE" input for every 10,000 registered patients (responding practices)
At 31 st Aug 2015	679	50	83	6.1
At 31 st Aug 2017	809	50	99	6.1

Source – ISD National Primary Care Workforce Survey

Notes:

1. The total weekly GP sessions reflect the weekly sessional commitments of GPs in post, the time input by sessional/locum GPs and the time input by the practice's own GPs when working extra sessions over and above their normal commitments. Excludes Specialist Trainee GPs and any GP inputs to GP Out of Hours services.
2. Sessional commitment to the practice and all other professional activities except any time spent in Out of Hours service provision.
3. Patients registered to general practices as at 1 Jul 2015 (2015 results), 1 Jul 2017 (2017 results) per year of census. These figures are based upon the data received from responding practices only.

As mentioned earlier in this section, Primary Care transformation and the new GMS contract will mean GPs are better supported with additional clinical professional and non-clinical services. Level of service will vary depending on GP Practice size and local population needs but could involve Advanced Practice Physiotherapists or Mental Health Nurses being based in practice, or support in the form of Pharmacists carrying out pharmacy reviews.

Table 6.3d below covers headcount and WTE for Nurses, Healthcare support worker/assistants and Phlebotomists in Falkirk GP practices. As survey response was not 100% in 2015, the 2017 figures are compared to the estimated 2015 figures, please note that the 2015 figures are rounded to nearest 5, whereas the 2017 figures are not. Although the rounding of 2015 figures may have distorted comparisons slightly, it seems there has been an increase in General Practice/Treatment room Nurses and Healthcare support workers/assistants.

Table 6.3d: Reported headcount and WTE numbers of Nursing, HCSWs and phlebotomy staff in post in general practices, by HSCP

	2017		2015	
Designation	Headcount in responding Practices	WTE in responding Practices	Estimated Headcount ^{1,2}	Estimated WTE ^{1,2}
Registered Nurse - Nurse Practitioner / Advanced Practitioner	11	9	20	15
Registered Nurse - General Practice Nurse or Treatment Room Nurse	44	27	35	20
Healthcare Support Worker / Healthcare Assistant	24	12	15	10
Phlebotomist	10	3	15	5
Total	89	50	85	45

Source – ISD National Primary Care Workforce Survey

Note that 2017 reported figures are compared to the 2015 estimates as the 2015 survey for Falkirk did not have a 100% response rate.

1. The estimated headcount and WTE numbers for the whole area (in the absence of a 100% survey response rate) are derived by multiplying up the population for all practices in that area.
2. Pre 2017 estimates are rounded to the nearest 5 for headcount or WTE over or equal to 25, and to the nearest 1 for headcount or WTE under 25. Estimates for 2017 have not been rounded.

6.4 – Palliative & End of Life Care

The World Health Organisation (WHO) defines Palliative care as:

“Palliative care is 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. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.”¹

End of life care is an important, integral aspect of the health care provided to those living with and dying from any advanced or progressive and life-threatening condition. It is now possible to predict the progress of many of these conditions, enabling a planned approach to end of life care in ways which reflect, as far as possible, the needs and wishes of patients, carers and their families.²

Palliative care is explicitly recognised under the human right to health. It should be provided through person-centred and integrated health services that pay special attention to the specific needs and preferences of individuals. The Scottish Government’s Strategic Framework for Action on Palliative and End of Life Care (SFA) states the by 2021 everyone in Scotland who requires palliative care will have access to it.³

It can be difficult to determine if an individual’s preferred place of death and actual place of death is the same. ISD use the measure “percentage of last six months spent at home or in a community setting” as an indication of progress of the national action plan. The measure was calculated by subtracting the number of bed days spent in an acute, mental health or geriatric long stay hospital in the six months prior to death from the maximum number of bed days that could have been spent in hospital in six months prior to death (182.5 days).

In Scotland, for individuals who died during 2017/18, 88.6% of their last six months of life was spent, either, at home or in a community setting and the remaining 11.4% in hospital. This is equivalent to each individual spending an average of 21 days in hospital in the six months prior to their death. Over the past eight years, the percentage of time spent at home or in a community setting has gradually increased from 85.5% in 2010/11 to 88.6% in 2017/18. This equates to an average of an extra five days per person within the last six months of life being spent at home or in a community setting in 2017/18 compared to 2010/11.

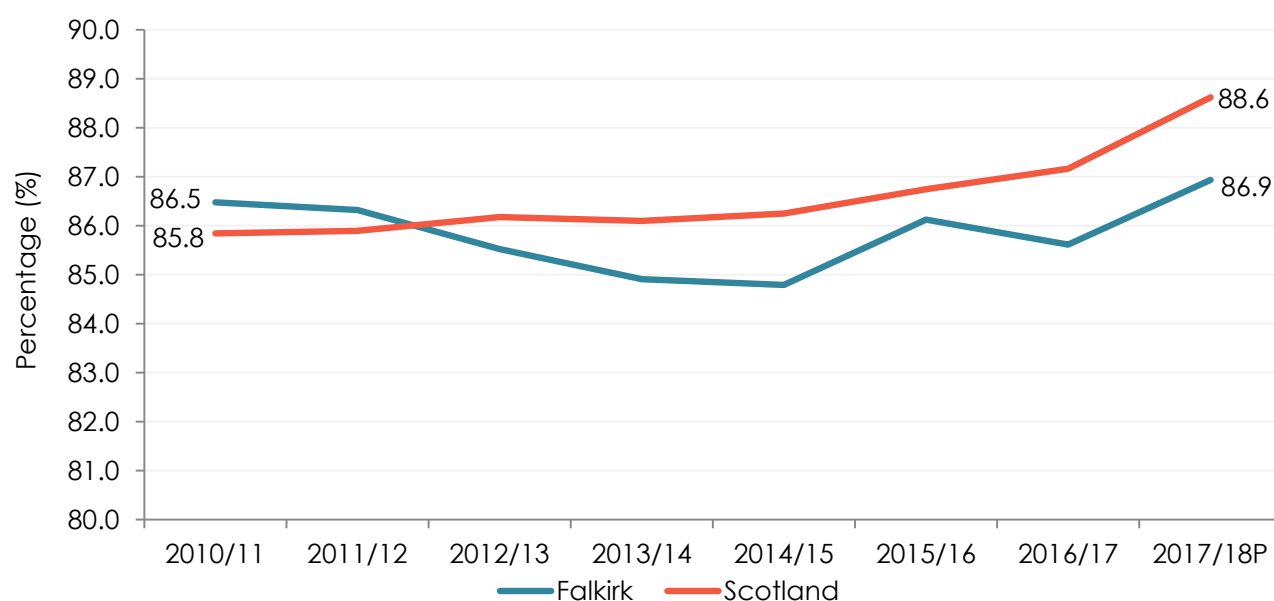
Whereas, in Falkirk, for individuals who died during 2017/18, 86.9% of their last six months of life was spent, either, at home or in a community setting and the remaining 13.1% in hospital. This is equivalent to each individual spending an average of 24 days in hospital in the six months prior to their death. The percentage of time spent at home or in a community setting increased from 84.8% in 2014/15, to 86.9% in 2017/18. This equates to on average an extra four days within the last six months of life being spent at home or in a community setting in 2017/18 compared to 2014/15.

¹WHO fact sheet on palliative care <http://www.who.int/mediacentre/factsheets/fs402/en/>

² ISD Scotland: <http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/>

³ Strategic Framework for Action on Palliative and End of life care - Scottish Government: <http://www.gov.scot/Publications/2015/12/4053>

Figure 6.4a: Percentage of last six months of life spent at home or in a community setting, Falkirk and Scotland



Notes:

1. y-axis does not start at zero
2. external causes of death excluded from analysis (e.g. unintentional injury)

Source: SMR01, SMR04 and NRS Death Records

Healthcare Improvement Scotland has developed four palliative and end of life care indicators.

Indicator 1: Increase in the number of people with palliative and end of life care needs who are identified

Indicator 2: Increase in the number of people with palliative and end of life care needs who are assessed and have a care plan

Indicator 3: Increase in the number of electronic palliative care summaries accessed

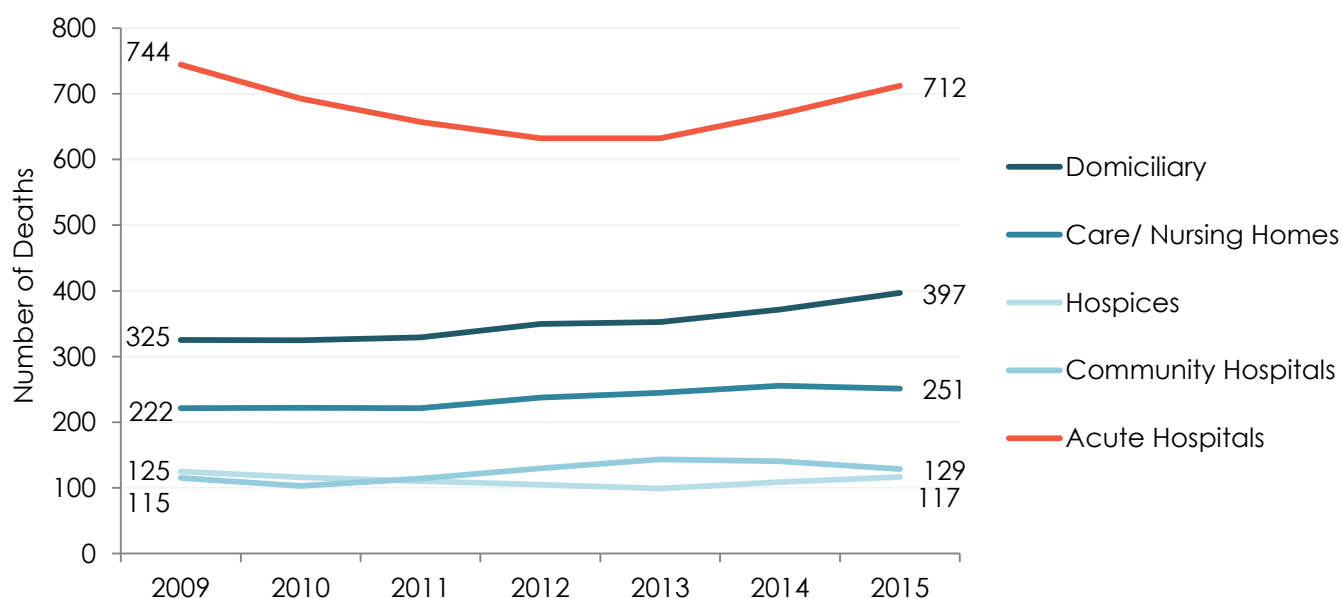
Indicator 4: Place of death¹

As mentioned before, it is difficult to measure if an individual's actual place of death matches their preferred place of death. An increase in the proportion of people who die in their usual place of residence and a decrease of people dying in hospital would suggest that people's preferred place of death is being met. Indicator 4 is used as a proxy to measure if this is being achieved.

Figure 6.4b shows the number of Falkirk residents dying at home (Domiciliary) has increased from 325 in 2009 to 397 in 2015. The number of people dying in an acute hospital decreased between the years 2009 and 2013, and then started to rise again. Whereas, the number of people dying in a hospice or community hospital has remained relatively stable.

¹ Health Improvement Scotland: Palliative and end of life care, 2013 - http://www.healthcareimprovementscotland.org/our_work/person-centred_care/palliative_care/palliative_care_indicators.aspx

Figure 6.4b: Number of Falkirk resident deaths by location, 2008 to 2016, 3-year rolling average

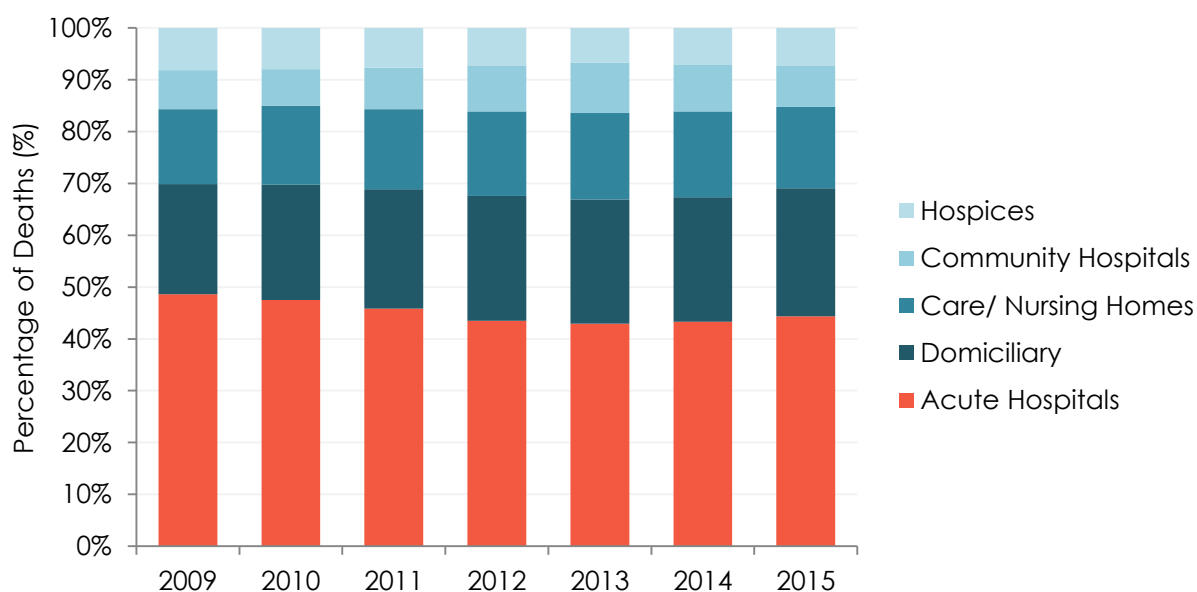


Source: GRO Death Files

*Note that the figures above are three year averages e.g. 2015 is an average of 2014-2016.

The proportion of Falkirk residents dying in a hospital setting has decreased from 48.6% in 2009 to 44.3% in 2015, as shown in figure 6.4c. In contrast the proportion of Falkirk resident's who have died at home (Domiciliary) has increased from 21.2% in 2009 to 24.7% in 2015. If we assume that most people would want to die at home (rather than a hospital) then this indicates that the proportion of people's preferred place of death being achieved has increased.

Figure 6.4c: Percentage of Falkirk deaths by location, 2008 to 2016, 3-year rolling average



Source: GRO Death Files

*Note that the figures above are three year averages e.g. 2015 is an average of 2014-2016.

Palliative Care Directly Enhanced Service (DES)

In keeping with the Scottish Government's '*Living Well and Dying Well, a national action plan for palliative and end of life care in Scotland*' (2008) the DES supports practices in taking a systematic approach to Palliative and end of life care, to ensure that they identify appropriate patients for the Palliative care register and that these patients have electronic Palliative Care Summaries completed and available in the out of hours period.¹

All patients on the palliative care register for a practice should have a completed ePCS (or Key Information Summary (KIS)). This electronic summary document will provide the necessary information to all professionals involved in the patients care in and out of GP working hours.

It is not mandatory for GP practices to take part in the directly enhanced service, however all but 4 Falkirk GP practices completed a palliative care register in 2016/17. Table 6.4a details the number and percentage of patients who were on the palliative care register for a practice and died in 2016/17 split by Cancer and "Other Long Term Conditions (LTC).

Table 6.4a – Numbers on Palliative Care Register / with ePCS/KIS by cause of death for Falkirk 2016/17

	Total Deaths (2016/17)	Number on Palliative Care Register	Number with ePCS/KIS	% on Palliative Care Register	% with ePCS/KIS
Cancer and LTC Deaths	827	423	599	51%	72%
Cancer Deaths	375	269	299	72%	80%
LTC other than Cancer Deaths	452	154	300	34%	66%

Source: NRS Scotland - Vital Events, NHS Forth Valley Palliative Care DES.

Note – As 4 practices do not participate in the Palliative Care DES, deaths from these practices have been excluded from the totals.

An Audit Scotland report on Palliative Care in Scotland estimated that approximately three quarters of people could benefit from some form of palliative care.² The table above shows that only 51% of those who died in Falkirk in 2016/17 were on the Palliative Care register (from the participating practices) so there is room for improvement in terms of identifying those who could be registered. A greater number of those who died had a ePCS or KIS in place, however there was still a quarter of people dying from Cancer or another long term condition who did not have one in place.

It is also important to note the people dying from cancer were far more likely to be on the palliative care register and have an ePCS/KIS than those who died from another long term condition.

¹ The Primary Medical Services (Scottish Government) – Directly Enhanced Service (Scotland) Palliative Care - [http://www.sehd.scot.nhs.uk/pca/PCA2012\(M\)06.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2012(M)06.pdf)

² Review of Palliative care services in Scotland (Audit Scotland) - http://www.audit-scotland.gov.uk/docs/health/2008/nr_080821_palliative_care.pdf

7. Workforce

A data collection exercise was undertaken by the HR Workgroup to gather information about the in-scope workforce for health and social care integration. It was conducted in 2016 and again in 2017.

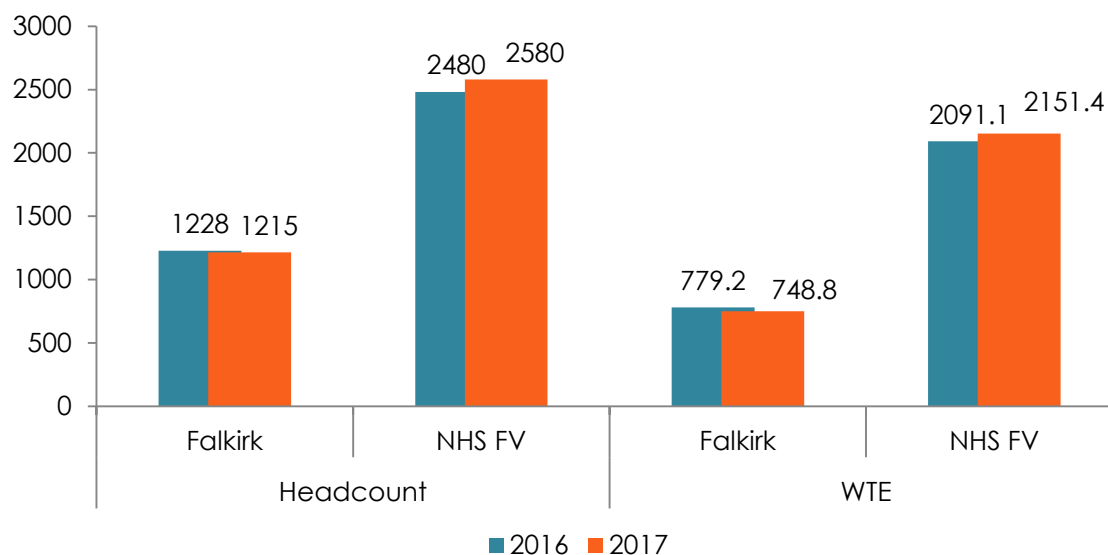
Methodology

Information was extracted based on the Integration Joint Board (IJB) Budget Model with a cost centre recorded for each member of staff. Each job title was allocated to a high level job family by each employer due to the number of individual job titles. In relation to the NHS Forth Valley staff it was only possible to allocate staff to a particular partnership area (Falkirk and Clackmannanshire & Stirling) if the budget code was one which was directly allocated. These included District Nursing, Community Hospitals, some Community Learning Disability and some Community Mental Health Services. All other services in the IJB Budget Model use a percentage apportionment to split the total budget between partnerships which is not possible to use for identifying individual staff members.

7.2 – Workforce Profile

In 2017 there were 1,215 posts (748.8 WTE) in Falkirk Council and 2,580 (2151.4 WTE) in NHS Forth Valley. A quarter of NHS Forth Valley posts could be directly allocated to either Integration Joint Board and just over half of those allocated to Falkirk IJB were for the community hospitals.

Figure 7.2a - Falkirk HSCP Headcount & Whole Time Equivalent Year Comparison



Note - In 2016 the data was as at 31 May 2016 for Falkirk Council and 5 July for NHS Forth Valley. In 2017 it was as at 31 March 2017 for both.

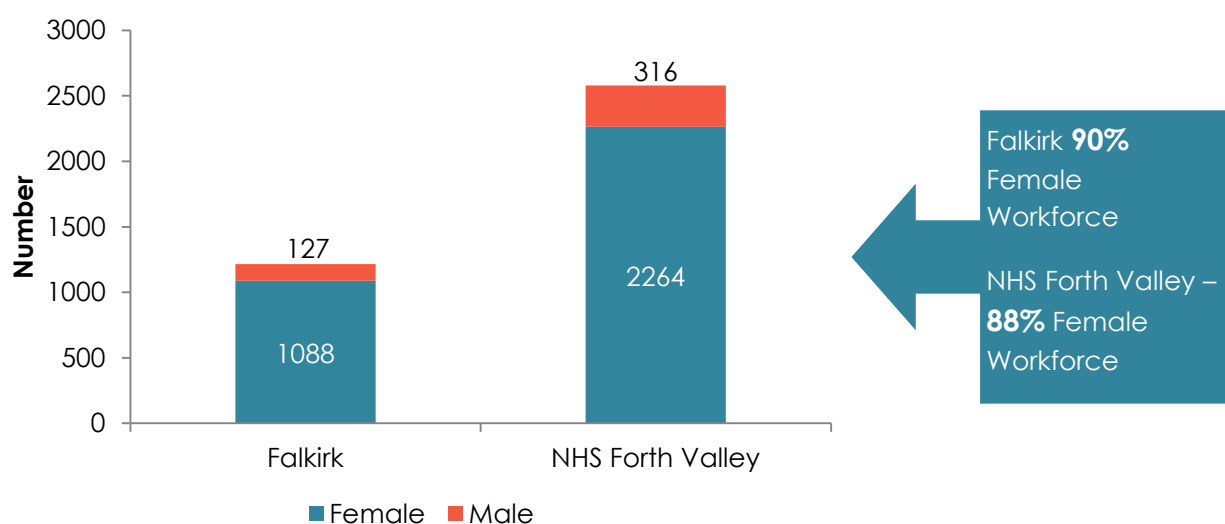
Source – Falkirk HSCP HR Workgroup

The number of posts had decreased from the previous year in Falkirk Council (the largest number being in Care at Home Services) and increased in NHS Forth Valley.

Based on job family, the largest group of health staff were those categorised as Nursing/Midwifery and over half of Falkirk Council posts were classed as either Care at Home or Residential Adult Care Home Services.

The workforce was predominately female and while predominately on permanent contracts in the NHS, there was around a third on temporary or casual contracts in Falkirk Council.

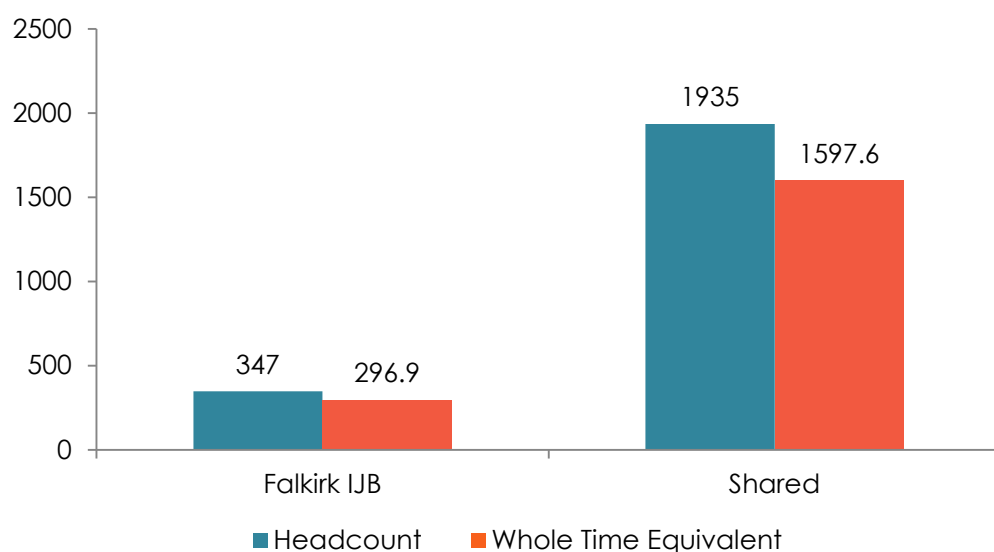
Figure 7.2b – Falkirk HSCP Workforce Gender Profile



Source – Falkirk HSCP HR Workgroup

It was only possible to identify a small proportion of the NHS in-scope workforce. All other services in the IJB Budget Model use a percentage apportionment to split the total budget between Partnerships which is not possible to use for identifying individual staff members. It was therefore not possible to give a total workforce figure for the Partnership.

Figure 7.2c - NHS Forth Valley Staff by Cost Centre Code Allocation - Headcount and Whole Time Equivalent

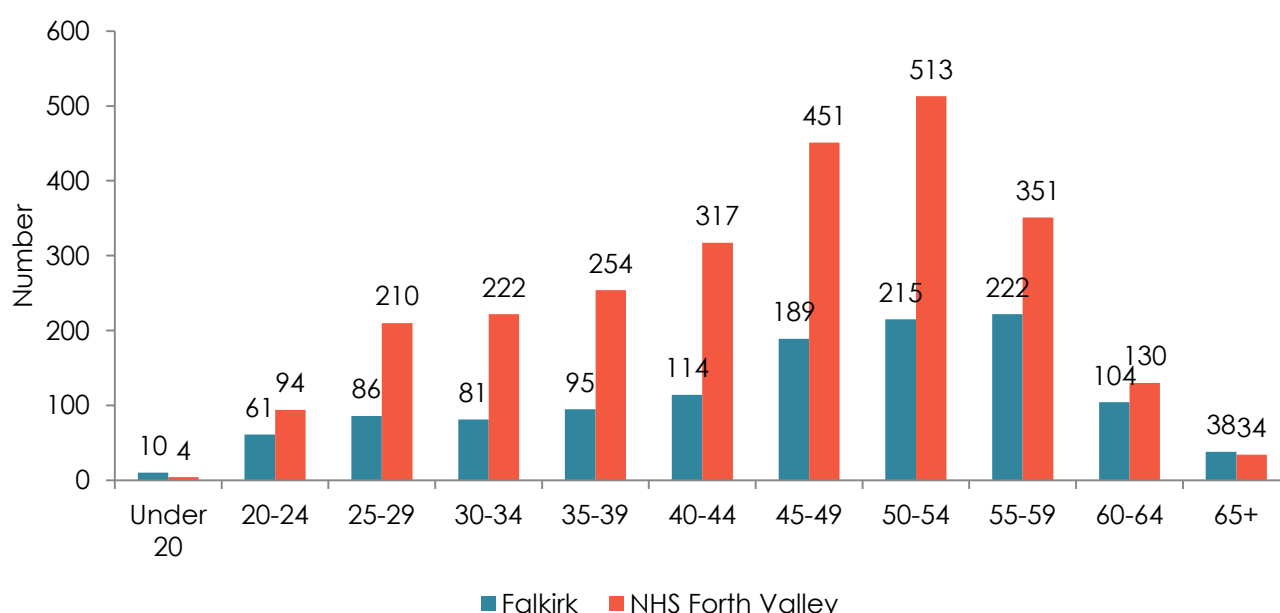


Source – Falkirk HSCP HR Workgroup

7.3 – Workforce Planning

Staff potentially retiring is a consideration in workforce planning. While a greater proportion of staff in the Local Authority have an increased likelihood of retiring in the next five to ten years there is a large number of NHS staff, particularly Nursing/Midwifery staff, who may potentially be in the same position which will also have implications for succession planning.

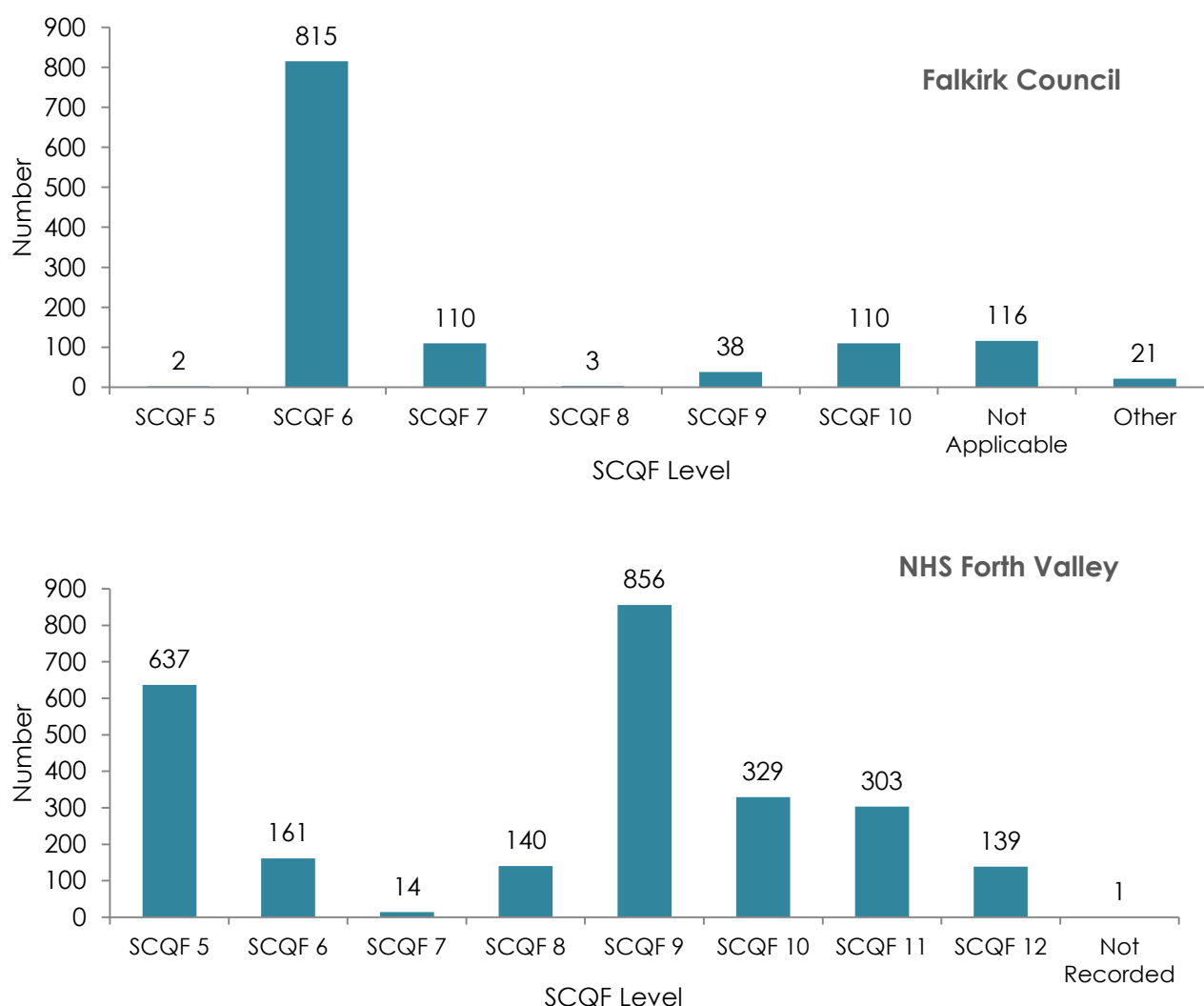
Figure 7.3a – Falkirk HSCP workforce in 5-year age bands



Source – Falkirk HSCP HR Workgroup

Information was provided on the qualified level of staff based on the Scottish Credit and Qualifications Framework (SCQF) and showed that a high proportion of posts require (or will require) a formal qualification. The range of qualifications required for Falkirk Council differed from the previous year's analysis. Further exploration of the data may be beneficial to determining future training requirements.

Figure 7.3b – Qualification Required for post based on SCQF – Falkirk Council & NHS Forth Valley Staff



Source – Falkirk HSCP HR Workgroup

Sickness Absence

Recording practice of sickness absence varied across employers so the figures may not be truly representative of actual levels of sickness absence. As may be expected the largest job families accounted for the highest proportion of sickness absence.

Care at Home Services account for about 40% of both the Falkirk Council workforce and sickness absence. Nursing/Midwifery (70% of the NHS workforce based on headcount) accounted for 85% of all hours lost to sickness absence.

8. Third/Voluntary Sector

The Third/Voluntary sector plays a pivotal role in how the partnership delivers services to the Falkirk population. Without these organisations it would be impossible for Falkirk HSCP to deliver current or future service provision. CVS Falkirk conducted an annual survey (the third of its kind) across Falkirk's third sector organisations and received responses from 89 organisations – Third Sector Impact Report 2017:

<https://www.cvsfalkirk.org.uk/wp-content/uploads/2015/08/Third-Sector-Impact-Report-2017.pdf>

This report takes a look at the social and economic impact of the third sector in Falkirk*. A summary of key points can be found below:

- Third sector organisations in Falkirk had a total income of over £89 million in 2017.
- 2,900 volunteers delivered over 2,000 hours of service per week in 2017.
- There is 288 full-time and 413 part-time staff working in third sector organisations in the Falkirk Council area.
- It is estimated that the third sector in Falkirk includes at least 800 organisations
- Nearly all responding organisations stated that they rely on volunteers. A number are completely reliant on volunteers.

It is important that the partnership maintains strong links with Falkirk's third sector organisations, particularly with an increasing population, and inevitable budgetary constraints.

** The third sector impact report is only based on a small proportion of organisations, so while it provides a helpful overview, it may not be completely representative.*

9. Unpaid Carers

Unpaid Carers Needs Assessment

Falkirk Health & Social Care Partnership commissioned a needs assessment on unpaid carers in the local area in March 2018. This report considers current service provision and the factors which may impact on demand.

<https://falkirkhscp.org/wp-content/uploads/sites/9/2018/04/Unpaid-Carers-Needs-Assessment.pdf>

Key figures:

- In 2016/17 there were 2,047 adult carers across Falkirk known to the Falkirk and Clackmannanshire Carers Centre.
- The Young Carers Project is currently in contact with 171 young carers.
- The Carers Centre completed 273 Adult Carer Support Plans for Falkirk Carers and there were 1,624 Carer Assessments carried out by Falkirk Council (includes carer assessments incorporated into client assessment).
- As at February 2017 there were 3,572 carers entitled to Carers Allowance in Falkirk.
- The 2011 Census showed there is a greater proportion of carers in the most deprived areas in Falkirk and the highest number of carers and proportion of the population providing unpaid care was in the East locality.
- An increasing number of carers in Falkirk are accessing information and/or support from the Carers Centre and the number claiming carers allowance has been increasing.
- Many factors will impact on demand and indications are the cared for population in Falkirk is likely to grow. Falkirk's older age population is expected to increase considerably and people are living for longer. Long term conditions including dementia, diabetes and stroke as well as those with multiple long term conditions are all projected to increase. The majority of people with a physical disability are also older. The potential for the number of people providing unpaid care in turn is likely to increase as will the number who may require help and support.

Frank's Law

The Scottish Government have announced that as of 1st April 2019, everyone who requires it, regardless of age will be entitled to free personal care. This change in the law will allow people aged under 65, who are disabled or who are diagnosed with a degenerative condition such as early-onset dementia, multiple sclerosis, motor-neurone disease and cancer to claim free personal care. This is likely to impact a number of families in Falkirk.

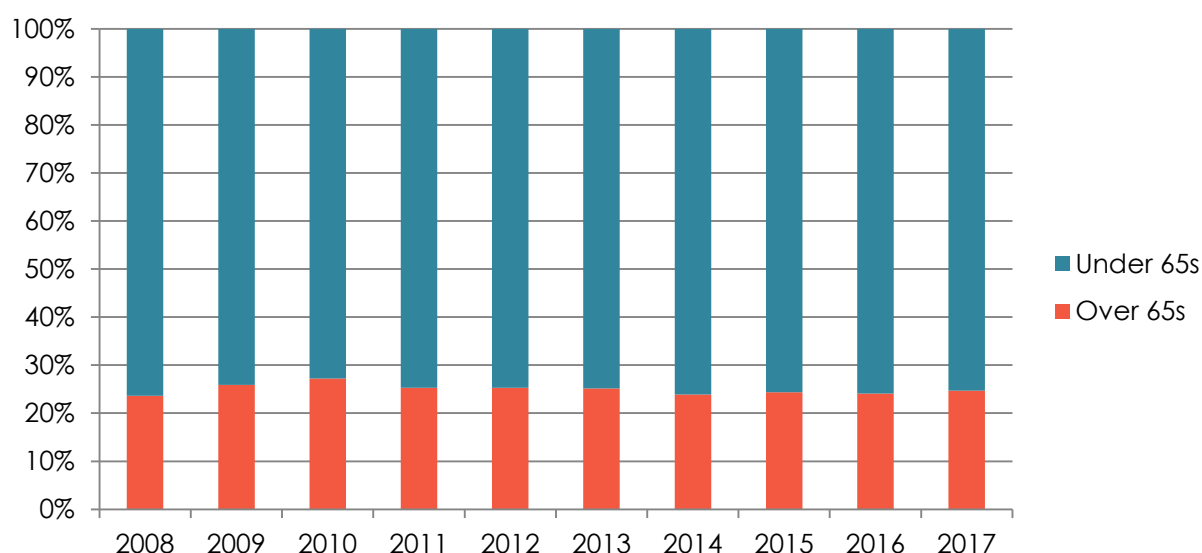
A feasibility study carried out by the Scottish Government on extending free personal care to under 65s states that younger adults (between the ages of 18 and 64) get on average 18 hours care per week and older adults (over 65s) receive on average 8 to 9 hours per week. Most young adults who receive personal care are people with physical or learning disabilities.

In Scotland around 95% of older home care clients receive personal care (up from 55% at the introduction of Free Personal Care in 2002), while fewer than 75% of younger adult clients receive personal care. This could be an indication that the proportion of younger adults who receive personal care will increase when Free Personal Care is extended to include anyone who requires it.

Extending Free Personal Care to all could contribute to the reduction of poverty, increasing disposable income for disabled people, encouraging greater social and economic participation in society, and closing the inequality gap.¹

The charts below look at the how much home care is currently provided to those aged under 65 in Falkirk.

Figure 9.1a – Home Care Recipients by Age – Falkirk 2008 to 2017



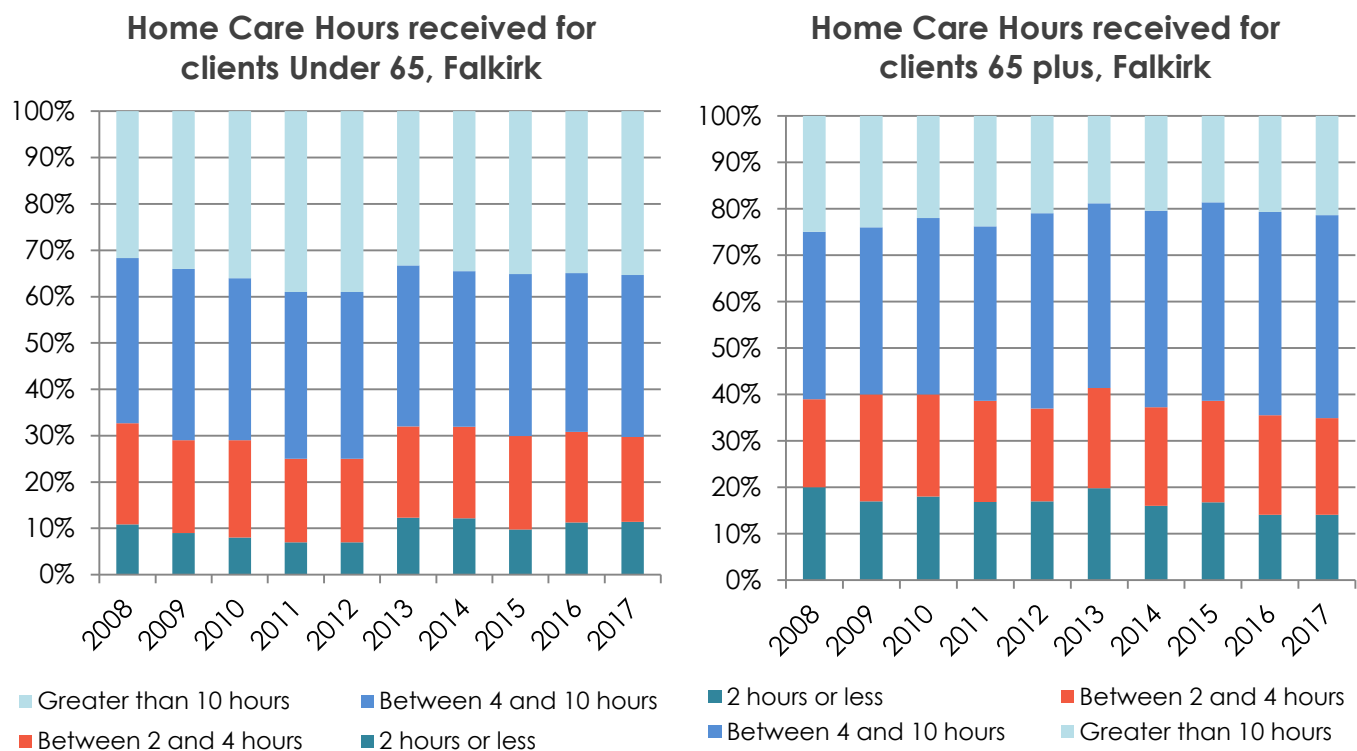
Source: Social Care Survey 2017

The above chart shows that approximately a quarter of people receiving home care in Falkirk are under 65. Many in this cohort may soon be eligible for free personal care when the new law comes into place.

Figure 9.1b, below, shows that approximately one third of under 65s receive more than 10 hours of home care, and a further 10% receive 2 hours or less. In comparison, roughly 20 percent of clients 65 plus, receive greater than 10 hours of care and around another 17 percent receive 2 hours or less. While there will likely be substantially less under 65s receiving free personal care than the numbers of over 65s already in the scheme, it is anticipated that the soon to be eligible under 65s will require more intensive support.

¹ Feasibility Study into Extending Free Personal Care to Under 65s - <https://www.gov.scot/Publications/2017/09/6559/downloads#res524157>

Figure 9.1b, Proportion of Home Care Hours received by Age – Falkirk 2008 to 2017



Source: Social Care Survey 2017