Falkirk Health & Social Care Partnership

Joint Strategic Needs Assessment

March 2016

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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:

- **The Falkirk area has an ageing population.** The 75+ year population is projected to increase by 98% by 2037. This has significant implications for service provision as over 75's are generally intensive users of health and social care. Corresponding with the growth in the older population, the working age population is expected to decrease. This has the potential to affect the ability to provide services. However, it is important to note that people are living longer and healthier lives. Many people aged over 60 years are contributing to society through volunteering within their community and caring for relatives.

- **Workforce.** The local demographics demonstrate an ageing workforce; subsequently, the Falkirk Partnership must consider the workforce to ensure that planned future services are sustainable. The raising of the retirement age also emphasises the need to develop strategies which meet individual and the Falkirk Partnership's expectations; enabling people to work longer with both energy and good health so that vital skills are retained.

- **It is projected that the Falkirk area will have growing numbers of people living with long term conditions, multiple conditions and complex needs.** There is a need to redesign services to better meet the needs of people with complex needs. People with several complex long term conditions are currently making multiple trips to hospital clinics to see a range of specialist services that are sometimes uncoordinated. This would suggest that a focus should be on the holistic needs of people and developing new pathways and guidelines rather than the current disease specific models.

- **Early intervention and prevention can make a difference.** If current disease trends continue then there are likely to be increasing numbers of people requiring support for their disease or condition. These trends could be influenced positively through a continued focus on health improvement, early intervention and prevention.

- **Carers.** One of the aims of Health and Social Care Integration is to keep people living independently in the community for longer. The projected increase in the older population and people with complex care needs is likely to mean there will be an increasing need to support carers.

- **Deprivation, housing and employment.** High levels of public resources are spent each year on alleviating health and social problems related to people and families who are trapped in cycles of ill health *(Christie, 2011)*. Consideration will be given to other important factors, such as housing, unemployment and poverty. The Partnership will adopt a whole-systems approach to improve health and social care outcomes and will work alongside Community Planning partners to address these wider issues.

1. Introduction

1.1 Background

The integration of health & social care is a key Scottish Government Programme of reform designed to improve care and support for those who use health and social care services. The legislation relating to the integration of health and social care is set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

A list of nine high-level statements of what health and social care partners are attempting to achieve through integration has been produced. These are known as the National Health and Wellbeing Outcomes.

By working with individuals and local communities, health and social care partnerships will support people to achieve the following outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Outcome 5: Health and social care services contribute to reducing health inequalities

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

Outcome 7: People using health and social care services are safe from harm

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services

Linking the Information presented to the Intended Outcomes

	Information Section					
Outcome:	**Population**	**Life Circumstances**	**Risk Factors**	**Population Health**	**Provision of Health and Social Care Services**	**Carers**
Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer	●[1]	●[2]	●[3]	●[4]	●[5]	●[6]
Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	●[7]	●[8]	●[9]	●[10]	●[11]	●[12]
Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected		●[13]			●[14]	
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services		●[15]	●[16]		●[17]	
Outcome 5. Health and social care services contribute to reducing health inequalities		●[18]			●[19]	
Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being						●[20]
Outcome 7. People using health and social care services are safe from harm					●[21]	
Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide					●[22]	
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services					●[23]	

Comments on connections and gaps:

1 The total population and demographic profile impacts on the number of people whose self-care and longevity are under consideration
2 Life circumstances impact on ability to look after oneself and improve health. This may be through mental wellbeing or less tangible concepts such as resilience
3 Health improvement often requires the addressing of risk factors
4 Longevity is strongly affected by the development of individual diseases and multiple conditions
5 Provision of health and social care should be enabling and health improving, and increase longevity
6 Carers can enable individuals to improve their health, reduce risk factors and live longer
7 The total population and demography impact on the number of people living at home or in homely settings
8 Life circumstances include a consideration of the home setting and extent to which housing needs can be and are met
9 People, including those with long term conditions have opportunities for health improvement through addressing risk factors
10 Population health includes a consideration of the epidemiology of long term conditions and frailty etc,
11 Provision of health and social care should be enabling and encourage rehabilitation
12 The role of carers is important and may be crucial in helping people continue to live at home
13 Life circumstances are an important factor in individuals' attitudes to and therefore use of health and social care services
14 Good information on health and social care service activity is available. Information on the quality of provision in terms of experience is collected through more qualitative means such as surveys (not presented here)
15 Health and social care services can have a positive impact on life circumstances
16 Health and social care services can be health improving through addressing risk factors
17 The provision of health and social care is based on evidence of effectiveness (which may be variable). Direct impact in terms of health and social outcomes may need to be inferred.
18 Experience of deprivation and other equality / inequality factors come under life circumstances
19 Health and social care services should reduce health inequalities through positive health and social outcomes for those experiencing deprivation. However the 'inverse care law' applies – those with less need are better able to access services (see items 2 and 13)
20 Carers have health and social care needs, which when met also have a positive impact on the person being cared for.

21 The information presented may not quite capture the ‘safe from harm’ aspect. More qualitative data from inspectorate reports or patient safety initiatives could provide further evidence

22 The information on workforce is fairly basic and quantitative. Further information from staff surveys etc. would be useful. Workforce development is key to achieving the nine outcomes.

23 The information presented does not quite capture effectiveness and efficiency – this may need to be implied or extrapolated. More complex methods such as benchmarking, data envelopment analysis or economic evaluation such as (social) return on investment may be required.

1.2 Joint Strategic Needs Assessment

Each health and social care partnership is required by the legislation to produce a detailed strategic plan. Falkirk's strategic plan will explain how the partnership will make changes and improvements to develop health and social services for adults over the coming years.

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.

Understanding the differing levels of need and service provision across the partnership will be key to future success. Therefore the ability to assess need at locality level is extremely important. This document will focus on information and analysis at partnership/local authority level and will sit alongside a locality profile document. The HSCI Partnership has identified its locality areas for service planning purposes. There will be three localities within the Falkirk Council area:

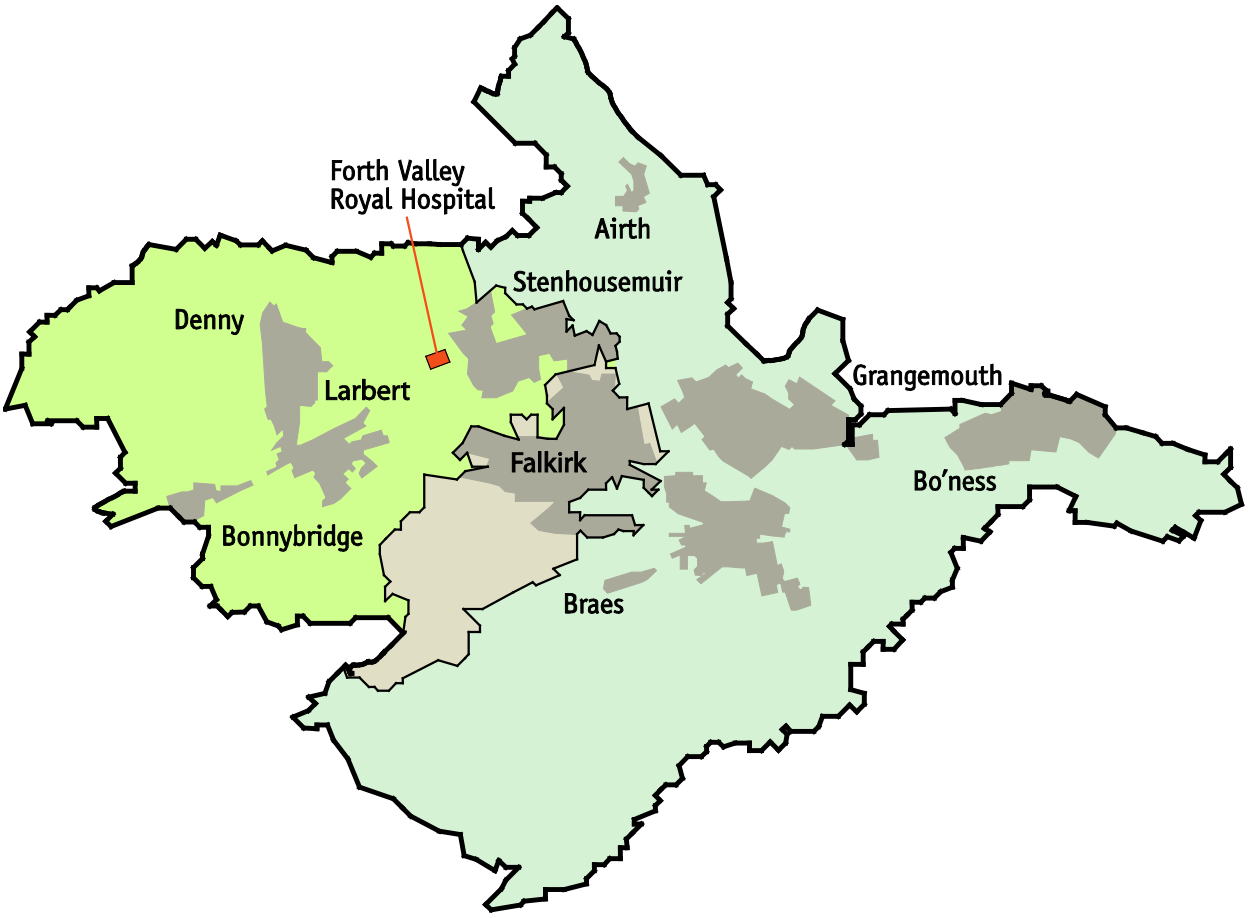
- **Falkirk**
  The Falkirk Locality is the smallest and most compact of the three Health and Social Care Localities with a population (including Hallglen) of just under 40,000. It is centred on the ancient burgh of Falkirk itself which is the main retail and administrative centre for the Council area as well as having the main campus of Forth Valley College. Falkirk town centre is a main source of employment and other major employers are the public sector and vehicle manufacturing. Some of the most deprived areas within the Council area lie in Falkirk, in particular parts of Camelon, Bainsford and Langlees, as well as in Hallglen. The recent major projects of the Falkirk Wheel and the Kelpies have promoted the area across the whole of Scotland and beyond.

- **Grangemouth, Bo'ness and Braes**
  This is the largest of the three Heath and Social Care Localities, both in terms of area (176 sq km) and population (over 65,000). It lies along the coastline of the River Forth and extends southwards into the higher land of the Slamannan Plateau. It contains the former burghs of Grangemouth and Bo'ness as well as the villages of the Braes such as Polmont, Westquarter, Redding and the more isolated villages such as Slamannan and Avonbridge. Grangemouth is a major industrial town based largely on the petro-chemical industry and is also

Scotland's premier port. The M9 motorway runs through the area and the Kincardine and Clackmannanshire bridges connect the area to Fife and beyond. The locality includes some the Falkirk Council area's most prosperous estates as well as areas of deprivation in Grangemouth, Bo'ness, Maddiston, Westquarter and Slamannan. The Braes area is a popular location for home buyers and considerable housing development has taken place and is expected to continue.

- **Denny/Bonnybridge/Larbert/Stenhousemuir**
  This Health and Social Care Locality lies in the north west of the Council area and has a population of around 53,000. It includes the towns of Denny, Bonnybridge, Larbert and Stenhousemuir and a number of smaller settlements. The population is growing with major new housing developments in Denny and Larbert. Forth Valley Royal Hospital is a major employer and is located close the motorway network with the M80 and M876 connecting the area to the rest of Scotland. There are small pockets of deprivation in Denny and Stenhousemuir but this is a fairly prosperous area which has good commuting links.

Figure 1.2a – Falkirk Health & Social Care Locality Areas



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 157,640 made up of 77,022 (49%) males and 80,618 (51%) females.

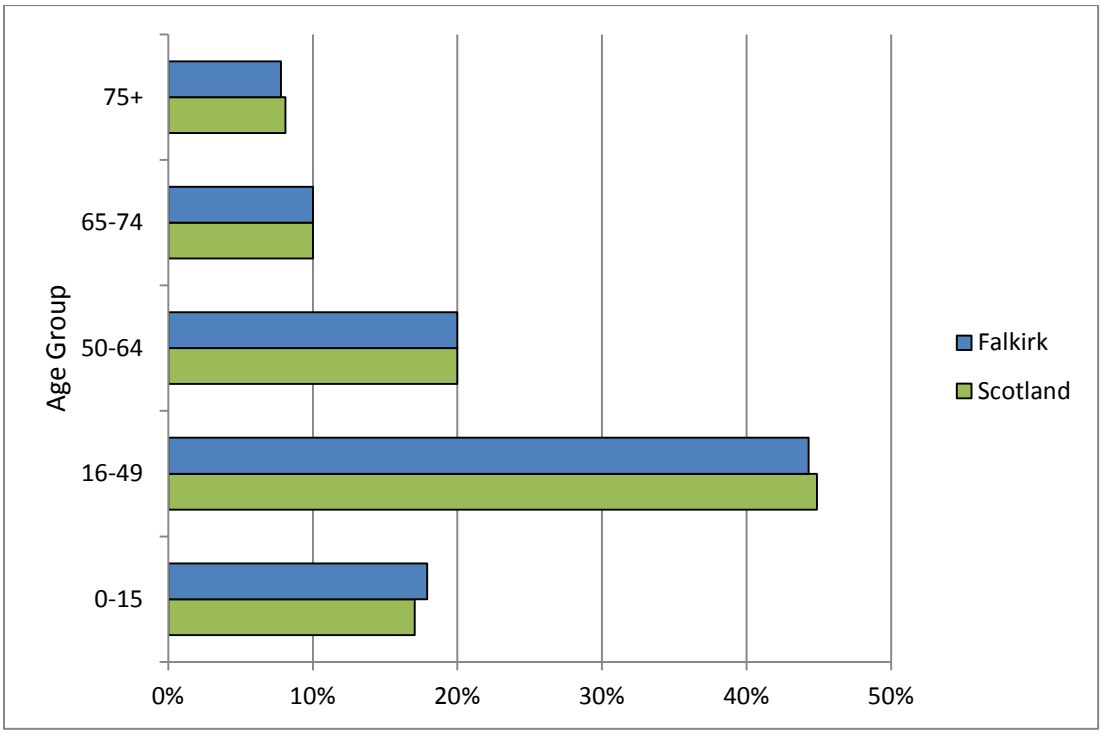
Table 2.1a Falkirk Population Profile

	Falkirk		
Age Group	**Total**	**Males**	**Females**
0-15	28,278	14,382	13,896
16-49	69,850	34,639	35,211
50-64	31,551	15,490	16,061
65-74	15,729	7,521	8,208
75+	12,232	4,990	7,242
Total	157,640	77,022	80,618

Source: NRS Population Estimates Mid-2014

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, 17% under 16, 10% aged 65-74 and 8% aged over 75.

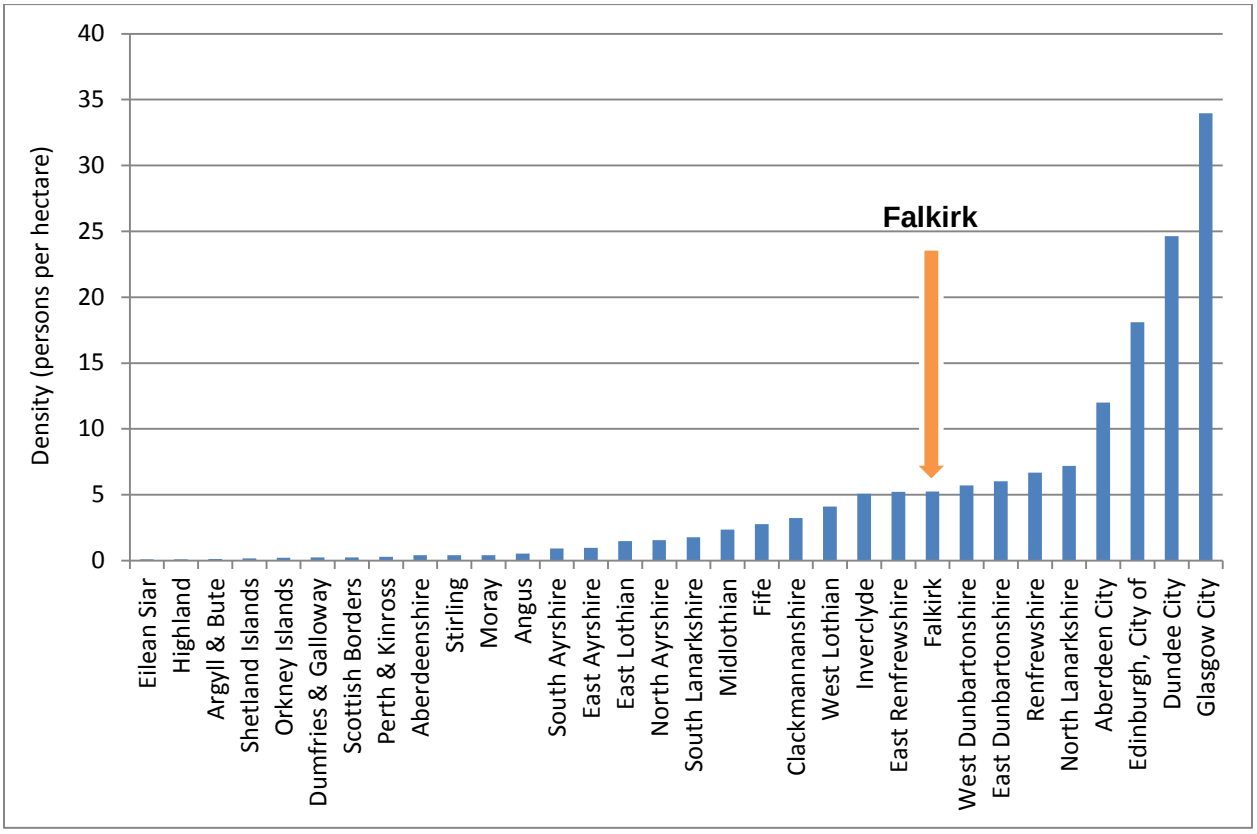
Figure 2.1a - Falkirk age distribution compared to Scotland



Source: NRS Population Estimates 2014

Figure 2.1b, below, illustrates the population density of Local Authorities across Scotland. Falkirk is the 9th most densely populated area in Scotland with 5.25 persons per hectare.

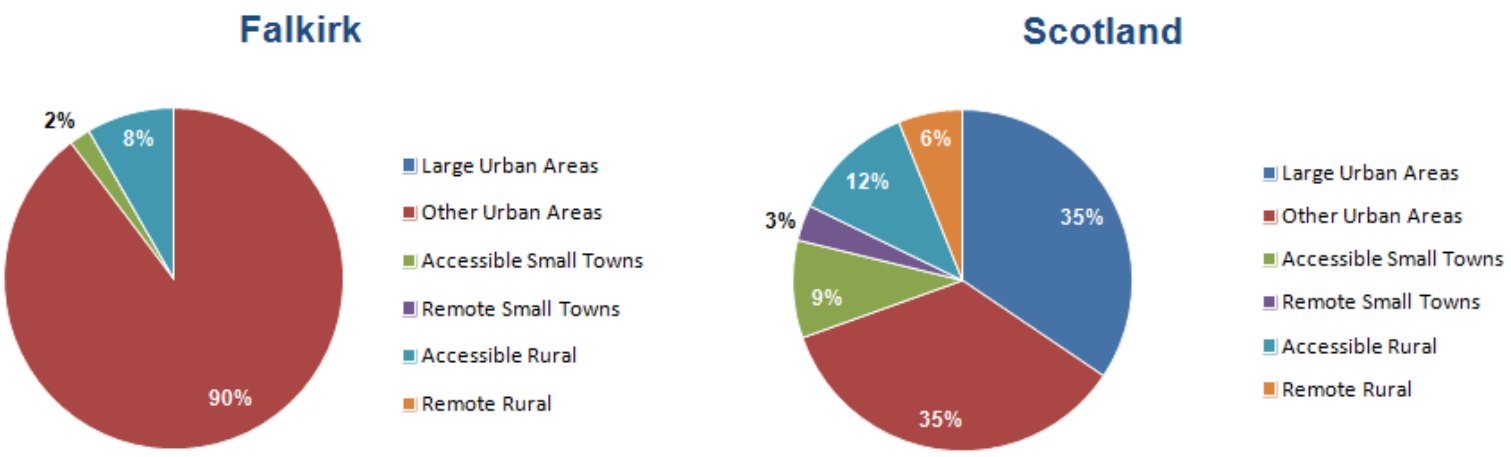
Figure 2.1b - Population Density (persons per hectare) 2011



Source: Census 2011

The vast majority (90%) of Falkirk's population live in Urban Areas of between 10,000 and 124,999 people (figure 2.1c). There are no Large Urban Areas in Falkirk. 2% of the population live in Accessible Small Towns and 8% live in Accessible Rural areas.

Figure 2.1c – Percentage of Population by urban/rural type, 2011



Source: Census 2011

Table 2.1b - Urban/Rural Classification

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

Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland.

Ethnic Origin

Table 2.1c shows that in the 2011 Census Falkirk had a less diverse population than Scotland on the whole, with a greater 'White – Scottish' population and a smaller proportion of BME (Black and Minority Ethnic) groups (1.9%) compared to 4.0% at national level.

Since the 2001 Census, the population had become slightly more diverse. In 2001 97.1% of the local population were either White-Scottish or White-British; by 2011 this had dropped to 95.8% of the population. (*Ethnicity Categories were changed for the 2011 census so it is not possible to do a direct comparison for all Ethnic Groups*)

Table 2.1c – Ethnicity in Falkirk and Scotland 2011

Ethnicity	Falkirk (%)	Scotland (%)
White - Scottish	91.3	84.0
White - Other British	4.5	7.9
White - Irish	0.6	1.0
White - Polish	0.7	1.2
White - Other	1.0	2.0
Asian, Asian Scottish or Asian British	1.3	2.7
Other ethnic groups	0.6	1.3

Source: 2011 Census

Religion

Of the Falkirk population, the largest group would consider themselves to be non-religious (39.0%) while the most common religious group in Falkirk is the Church of Scotland (36.5%). In both cases Falkirk has a larger percentage than Scotland on the whole; while the percentage of people from other religious backgrounds is less than the Scottish average.

Table 2.1d – Religion in Falkirk and Scotland 2011

Religion	Falkirk (%)	Scotland (%)
Church of Scotland	36.5	32.4
Roman Catholic	12.3	15.9
Other Christian	4.1	5.5
Muslim	0.9	1.4
Other religions	0.6	1.1
No religion	39.0	36.7
Not stated	6.6	7.0

Source: 2011 Census

Sexual Orientation

Information on sexual orientation, either at national or local level, is limited and it is likely that the numbers of LGBT (Lesbian, Gay, Bisexual and Transgender) are under-represented. The health needs of the LGBT population are not well understood since there is no robust data available.

The Scottish Household Survey 2014 included a question on Sexual Orientation and the results are shown in Table 2.1e below. The results should be interpreted with caution as the survey only covers a small sample of the Falkirk population; however 2.9% of females reported themselves as lesbian or bisexual with around 1.5% of the male population reporting themselves as Gay. In both cases this is slightly higher than the Scottish average, though it again be noted that the household survey only considers a small sample size.

Table 2.1e – Sexual Orientation by Gender for Falkirk and Scotland 2014

	Falkirk (%)		Scotland (%)	
Sexual Orientation	**Male**	**Female**	**Male**	**Female**
Heterosexual / Straight	98.0	97.1	98.1	98.6
Gay / Lesbian	1.5	0.9	1.0	0.6
Bisexual	-	2.1	0.2	0.2
Other	-	-	0.0	0.1
Refused	0.5	-	0.7	0.6
Don't Know	-	-	-	-
Base (Sample size)	*260*		*9800*	

Source: 2014 Scottish Household Survey

2.2 Projections of future population

The size and make-up of the population going forward will be a key consideration when planning and delivering health and social care services. The National Records of Scotland population projections (Table 2.2a) show the projected change in the population to 2037.

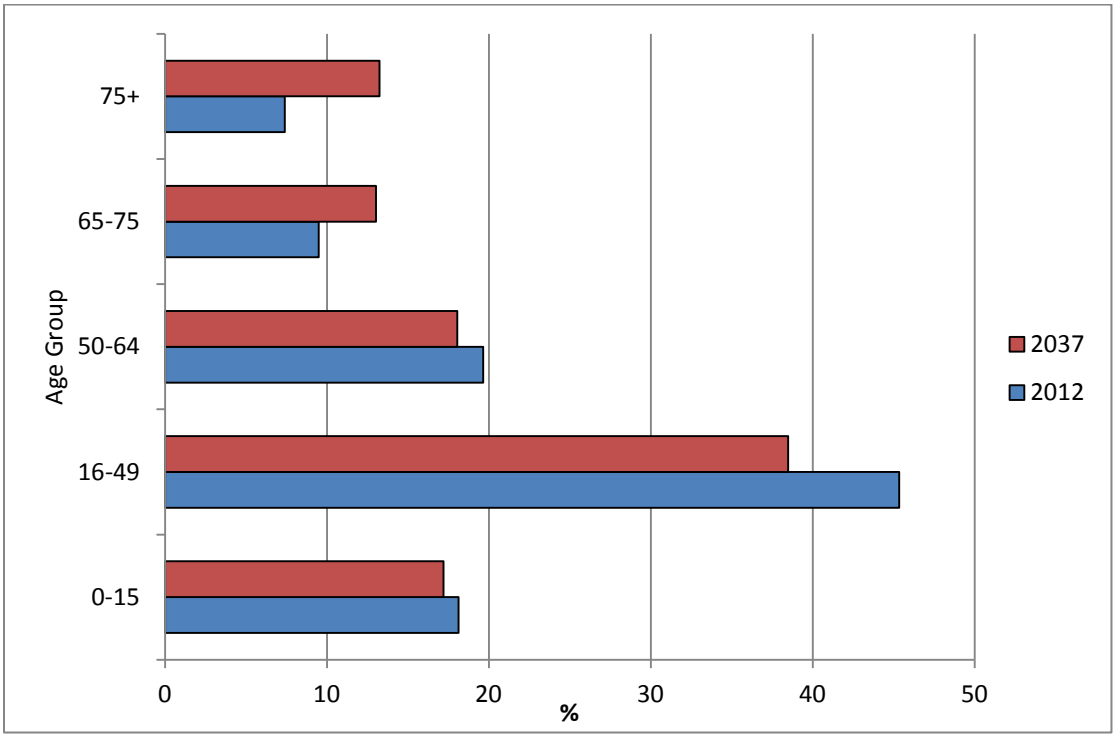
Table 2.2a - Falkirk Population projections to 2037

	2012		2032		2037	
Age Group	No	%	No	%	No	%
0-15	28,423	18.1	29,525	17.3	29,771	17.2
16-49	71,097	45.3	66,086	38.7	66,623	38.5
50-64	30,820	19.7	33,433	19.6	31,253	18.1
65-75	14,871	9.5	21,457	12.6	22,560	13.0
75+	11,589	7.4	20,117	11.8	22,923	13.2
Total	156,800	100	170,618	100	173,130	100

Source: NRS Population Projections (2012-Based)

The size and age structure of the Falkirk population is projected to experience significant change between now and 2037. The overall population is projected to increase by over 16,000 to 173,130. The age distribution is also projected to experience significant changes. The number of individuals aged 75+ is expected to double to 22,923 and the number of individuals aged 65-75 is also expected to rise from 14,871 to 22,560.

Figure 2.2a – Projected Population Age distribution in Falkirk, 2012 to 2037



Source: NRS Population Projections (2012 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 2037 than they do in 2012.

2.3 Dependency Ratio

The dependency ratio is a measure of the proportion of the population seen as economically 'dependant' upon the working age population. The definition generally used in Scotland is: 'those aged under 16 or of state pensionable age, per 100 working age population'. Table 2.3a illustrates the projected change in dependency ratio for Falkirk and Scotland to 2037.

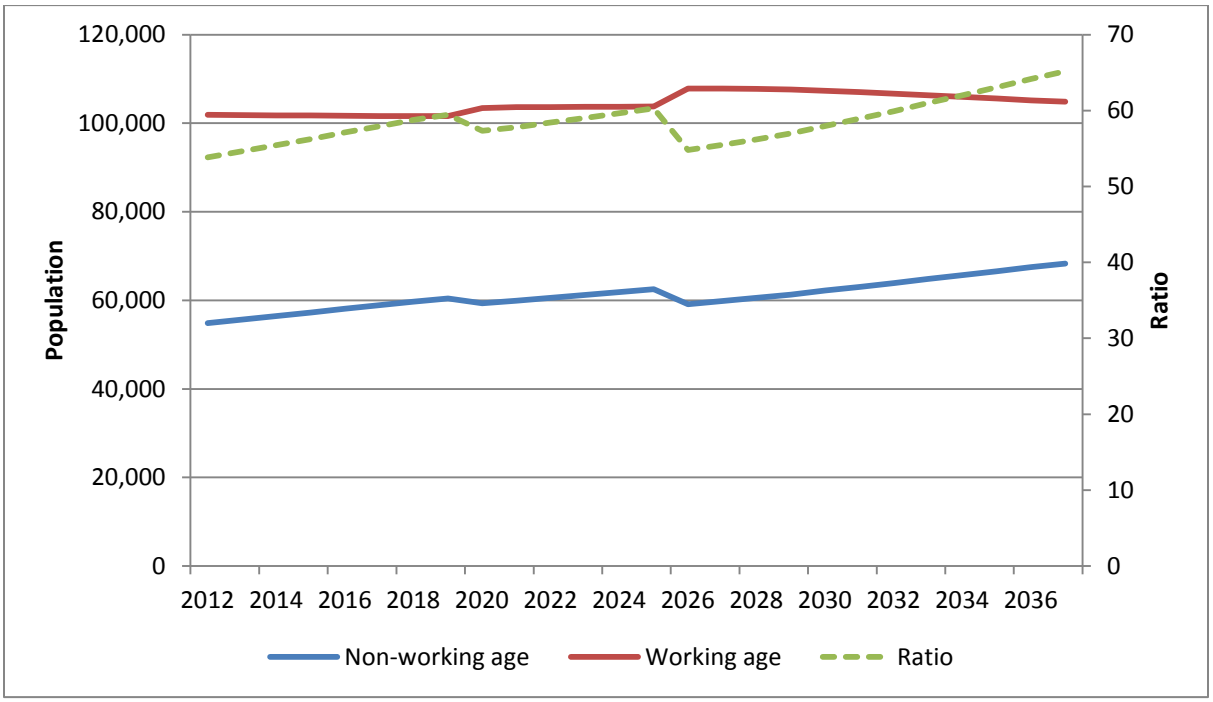
Table 2.3a – Projected Dependency Ratios to 2037

Year	2012	2015	2020	2025	2030	2035	2037
Falkirk	53.9	56.2	57.4	60.3	58.0	63.1	65.2
Scotland	53.0	54.8	55.8	59.8	57.8	61.7	62.9

Source: NRS Population Projections (2012 based)

Falkirk is projected to follow a similar trend to Scotland but will have a slightly higher projected dependency ratio in 2037. Figure 2.3a examines this trend more closely. The projected increases in dependency ratio could potentially have a significant impact on the area. Falkirk is projected to have more individuals of a non-working age as a proportion of those of a working age and this will impact upon the services required locally as well as on the economy. Note that the kinks in the graph reflect the planned changes in pension age.

Figure 2.3a – Falkirk Projected Dependency Ratios to 2037



Source: NRS Population Projections (2012-based)

2.4 Population Considerations/Implications

- Older people are generally high users of services. The number, and percentage, of older people across Falkirk is projected to double and this could impact significantly on demand for services.
- There is a projected increase in the ratio of non working aged people to people of working age. This may impact on the local economy as well as the ability to recruit in order to deliver services.

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.

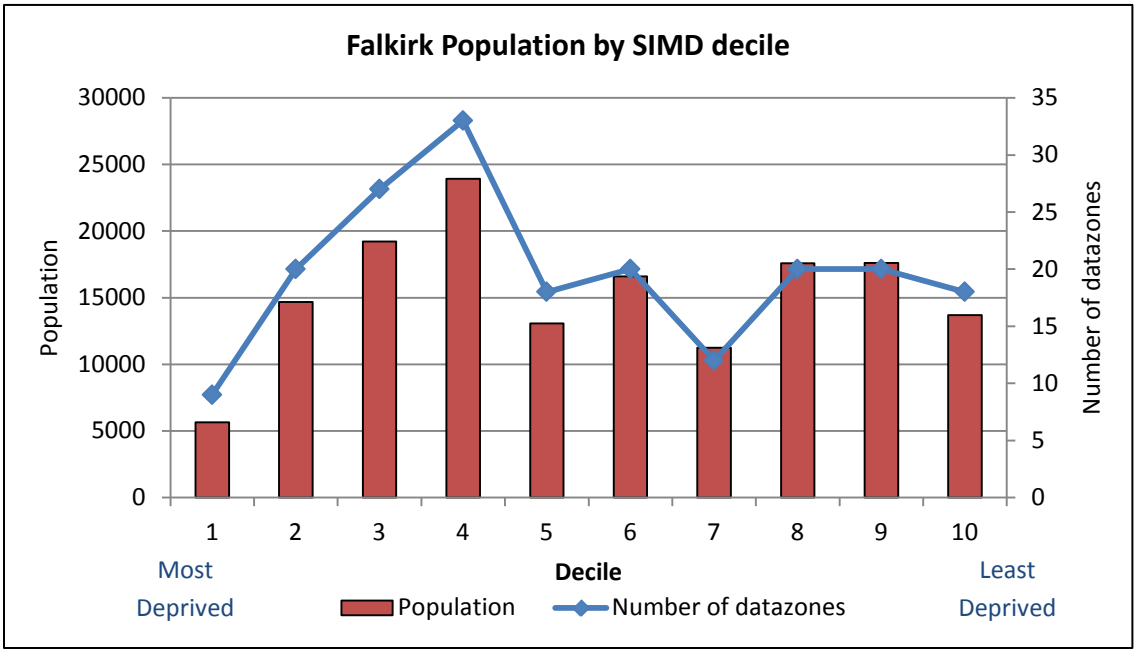
The Scottish Index of Multiple Deprivation (SIMD) is the Scottish Government's official tool for identifying those places in Scotland suffering from deprivation. It incorporates several different aspects of, combining them into a single index. It divides Scotland into 6,505 small areas, called datazones, each containing around 350 households. The Index provides a relative ranking for each datazone, from 1 (most deprived) to 6,505 (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 7.9% 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 30.5%, and in the fourth decile for values between 30% and 40%.

Within the deciles, 1 is the most deprived and 10 the least deprived (this categorisation is applicable for SIMD 2009v2, SIMD2012 and future releases). Figure 3.1a below illustrates the number of people and data zones in each decile in Falkirk.

The population in Falkirk can almost be split right down the middle, half of the population live in the lowest five deciles, and the other half in the highest five deciles. The population in the lowest five deciles are spread across a greater number of datazones, with 76,540 people in 107 datazones. In contrast, the 76,740 people in the highest five deciles are in 90 datazones. Four percent of the population in Falkirk are in the lowest decile group, this is approximately 5,600 people. The lowest scoring datazone is in Dunipace, the other zones in this decile include areas in Camelon, and Bainsford and Langlees.

Figure 3.1a - Falkirk population by SIMD decile



Source: SIMD 2012

The distribution of the population in Falkirk across the different decile groups is relatively even, excepting those in the lowest decile. The percentage of the population in the decile groups from 2 to 10 ranges from 7% in the seventh, to 16% in the fourth.

3.2 Housing

In relation to strategic planning, the Local Housing Strategy (LHS) is the sole housing strategic document for the local area. The LHS 2011-16 highlighted 5 key areas in relation to older people and those with disabilities:

- There needs to be a co-ordinated approach between housing, social care and health to enable older people to live in the community for longer
- There is a need for accommodation for older people with particular needs
- The current model of housing with care does not meet current aspirations.
- There is an increasing demand for aids, adaptations, support and advice
- There have been advances in technology to enable people to live in their own home which should be utilised.

Investment in specialist housing, housing improvements, care & repair services, adaptations and housing support services has significant potential to bring about positive health and quality of life outcomes for older people and their carers.

The following section provides an overview of housing in Falkirk.

- The National Records of Scotland household projections predict that household numbers will increase from 69,230 to 80,210 between 2012 and 2037 with Falkirk's increase being lower (16%) than Scotland's (17%).
- The number of those households headed by someone aged 75 and over is estimated to increase from 2012 to 2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 82%.
- In 2013 owner occupation accounted for 65% of households in Falkirk, comparable to 61% in Scotland. (Scottish Household Survey 2013).
  Social renting was the second largest group accounting for 27%, and private renting 8%.
- Between 1999 and 2013 there was a 7% increase in private renting and a 14% decrease in social renting in Falkirk (Scottish Household Survey 2013).
- In Scotland, private renting has increased by 7% and social renting has decreased by 9% over the same period.
- There are a greater proportion of houses than flats in Falkirk (73% compared to 27%) than in Scotland (63% compared to 37%).
- The same proportion of dwellings were built before 1945 in Falkirk as in Scotland, which is 20% (Scottish House Conditions Survey 2013).
- The Falkirk Local Housing Strategy 2011-2016 set out a number of key target outcomes for housing in the area. As well as establishing that best use was to be made of existing housing stock to address local needs, the strategy outlined that new affordable housing stock was required. By 2016, there were to be 725 new residencies per year, and of that 100 were to be new-build affordable housing and 133 that were to make best use of existing housing stock.
  https://www.falkirk.gov.uk/services/homes-property/policies-strategies/local-housing-strategy.aspx

3.3 Fuel Poverty

Fuel poverty is a measure based on a calculated spend on energy and fuel compared to the annual household income. The term fuel poverty refers to a situation where a household is unable to heat its home at a reasonable cost. A person is living in fuel poverty if, to heat their home to a satisfactory standard, they need to spend more than 10% of their household income on fuel. Extreme fuel poverty is where they need to spend more than 20% of their household income on fuel. This affects households greatly especially during the winter months, as the colder outside temperature and lack of suitable heating inside increases the risk of developing health problems such as cardiovascular and respiratory conditions. Fuel poverty also means that the dwelling is more susceptible to issues such as damp and mould, which in turn affects the quality of life and health of the people living in that environment.

Table 3.3a below shows the percentage of households in Falkirk that can be considered fuel poor and extremely fuel poor compared to the Scottish average. All households in Falkirk are below the Scottish average for both measures.

Table 3.3a – Fuel Poverty in Falkirk and Scotland 2011-2013 (All Households)

All households	Fuel Poverty	Extreme Fuel Poverty
Falkirk	32%	5%
Scotland	36%	10%

Source: Scottish House Condition Survey Local Authority Tables 2011-2013

Table 3.3b shows the percentage of pensioner households in Falkirk that are fuel poor and extremely fuel poor. Whilst half of pensioner households are fuel poor, only 8% are extremely fuel poor. These are lower than the figures for Scotland as a whole, but higher than the figures for the whole population.

Table 3.3b – Fuel Poverty in Falkirk and Scotland 2011-2013 (Pensioner Households)

Pensioner households	Fuel Poverty	Extreme Fuel Poverty
Falkirk	50%	8%
Scotland	54%	15%

Source: Scottish House Condition Survey Local Authority Tables 2011-2013

There are a number of factors that contribute to fuel poverty.

- In Falkirk, 21% of the dwellings were built before 1945, and older properties are more likely to have no insulation or be poorly insulated. This increases heating and fuel costs as well as affecting the quality of life for inhabitants. Between 2011/13 an average of 70% of the dwellings in Falkirk were wall insulated (cavity and solid/other).
  In comparison, across Scotland 32% of properties were built before 1945, and only 52% of all dwellings had wall insulation in 2011/13.

- The Falkirk area also includes a higher proportion of urban households (89.6%) compared to Scotland as whole (69.6%). This means that fuel poverty is likely to be lower as urban properties tend to be newer properties, and their location makes them less exposed to the elements than those in rural areas. Exposure to wind, rain, and snow, which is more likely in rural locations, makes the household more expensive to heat.
  Additionally, rural locations are less likely to be connected to the mains gas lines, with energy being provided by other methods including heating oil and gas bottles. These types of energy supply are less efficient than mains gas, thus increasing fuel costs. In Falkirk in 2011/13, 15% of properties were off the gas grid.

- The energy efficiency of the dwelling also affects the fuel costs. The lower the efficiency of the dwelling, the higher the fuel costs. In Falkirk 2% of properties are in the lowest groupings for energy efficiency, this is lower than the Scotland average which in 2011/13 was 4%.

3.4 Employment, Benefits and Financial Issues

The 2011 Census details the economic activity of respondents. This is categorised into those who are economically active (in or seeking employment) and those who are economically inactive (not in or seeking employment).
Table 3.4a below shows the percentage of the population aged 16-74 by their economic activity in Falkirk, and Scotland as a whole. The percentage of people who are economically active is 65% of the population in Falkirk, a few percentage points higher than the national average. As a result the proportion of those economically inactive is lower than the Scottish figure, although the percentage of people who are disabled or long-term sick is the same.

Table 3.4a Percentage of total population by economic activity

Area	Economically active	Unemployed - seeking work (included in economically active)	Economically inactive	Long-term sick or disabled (included in economically inactive)
Falkirk	65.0%	5.2%	35.0%	4.8%
Scotland	62.8%	5.1%	37.2%	4.8%

Source: 2011 Census

Figures from the Department for Work and Pensions show that there were 13,104 claims for housing benefit in Falkirk in May 2015.

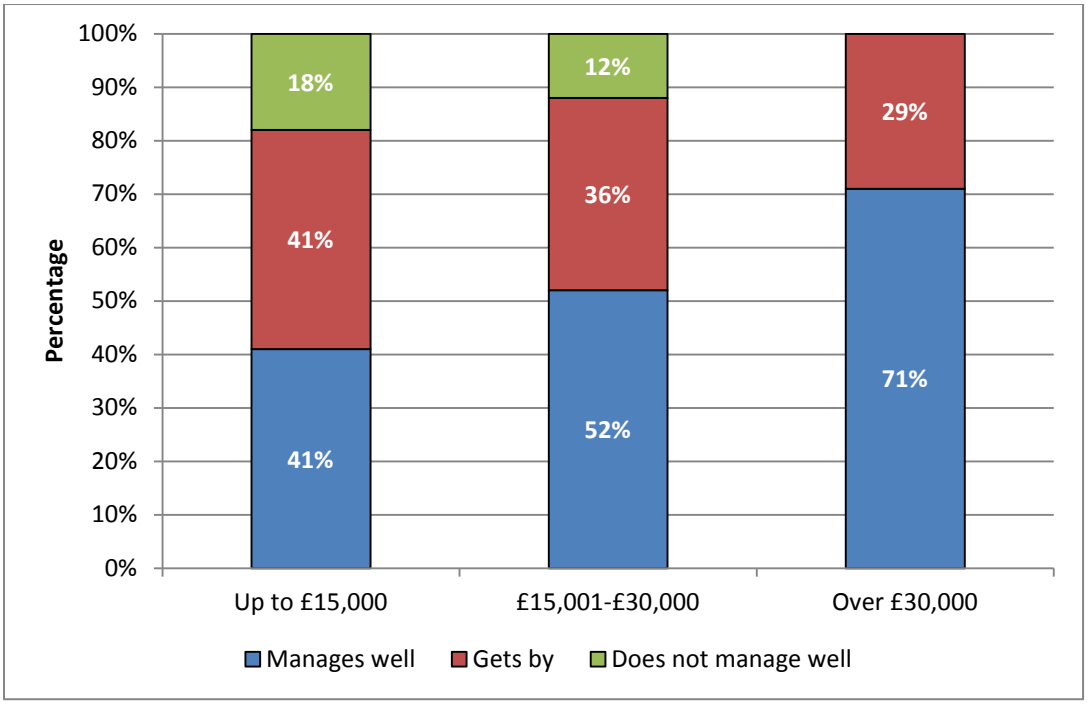
Table 3.4b Housing benefit claims by local authority May 2015

Housing benefit claims	May 2015
Falkirk	13,104

Source: Department for Work and Pensions Stat-Xplore

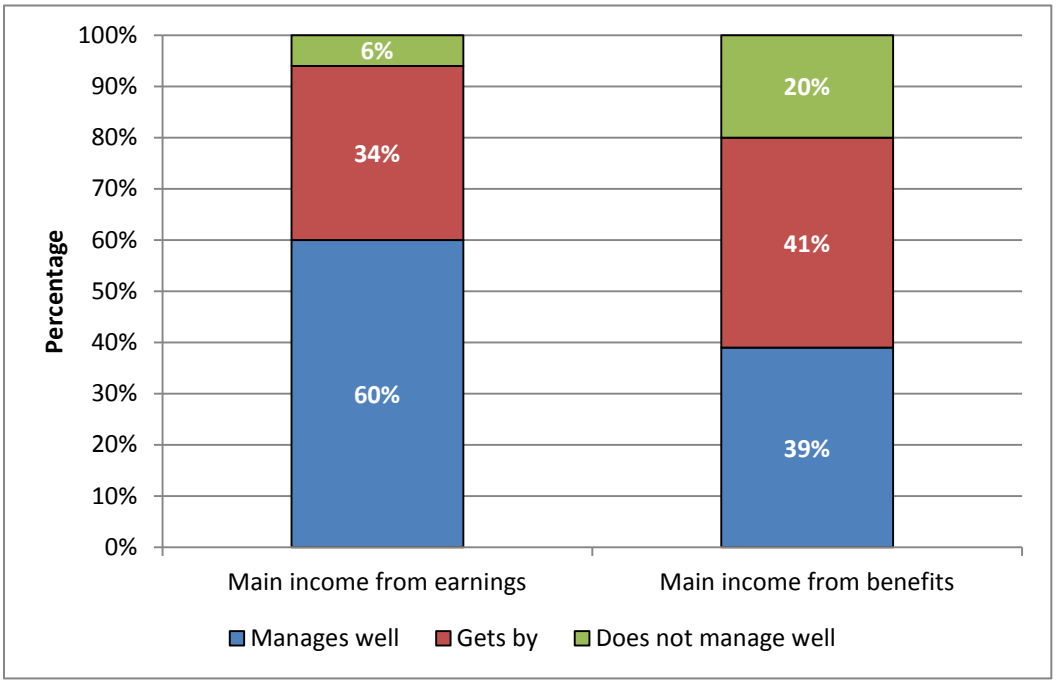
Financial issues and concerns can cause health and social problems. Job insecurity, redundancy, debt and financial problems can all cause emotional distress, affect a person's mental health and contribute to other health issues. Information from the 2013 Scottish Household Survey shows statistics for how well households manage finances. The charts below show how well households managed their finances by amount of income, and also by the main source of income. 18% of households in Falkirk where the income is less than £15,000 do not manage their households well. Similarly, of the households whose main income is through benefits, 20% do not manage well.

Figure 3.4c - Household management by annual household income – Falkirk 2013



Source: Scottish Household Survey

Figure 3.4d - Household management by income type – Falkirk 2013



Source: Scottish Household Survey

3.5 Life Circumstances Considerations/Implications

- Deprivation can be a key contributing factor in the health of a population.
- The percentage of those households headed by someone aged 75 and over is estimated to increase from 2012 to 2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 83%.
- The Falkirk Local Housing Strategy 2011-2016 set out a number of key target outcomes for housing in the area. As well as establishing that best use was to be made of existing housing stock to address local needs, the strategy outlined that new affordable housing stock was required. By 2016, there were to be 725 new residencies per year, and of that 100 were to be new-build affordable housing and 133 that were to make best use of existing housing stock.

4. Lifestyle/Risk Factors

Lifestyle and risk factors have an important effect on a person's health and well-being. Behaviours such as smoking, alcohol consumption, drug use, and poor diet can have an adverse effect on health. People from less well-off and more deprived areas and communities are more likely to have these behaviours which have a negative impact on health.

4.1 Smoking

Smoking related illnesses not only affect an individual's health but also put a strain on services. It is estimated that in NHS Forth Valley in 2009 there were 2,187 hospital admissions are a result of smoking and that over £15 million was spent treating smoking related illness.[1] Continued focus on prevention is important to improve health and to reduce pressures on services.

Table 4.1a shows the percentage of the adult population who smoke in Falkirk compared with the Scotland average from 1999 to 2013

Table 4.1a - Percentage adult smokers 1999-2013

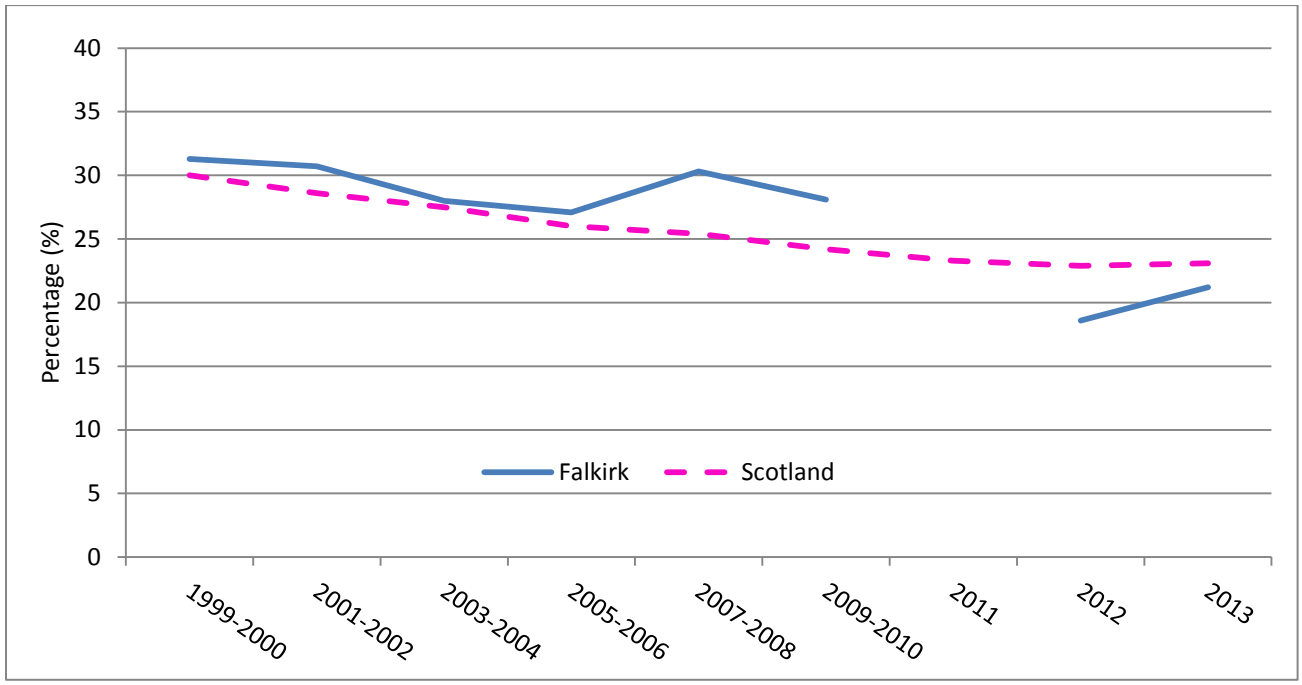
Area	1999-2000	2001-2002	2003-2004	2005-2006	2007-2008	2009-2010	2011	2012	2013
Falkirk	31.3	30.7	28.0	27.1	30.3	28.1	n/a	18.6	21.2
Scotland	30.0	28.6	27.5	26.0	25.4	24.2	23.3	22.9	23.1

Source: Scottish Household Survey - Annual Report 2013 - LA Tables

In 1999, 31.3% of adults in Falkirk smoked; by 2013 this had fallen to 21.2%. This is comparable to the trend for the total Scotland figures in the years between 1999 and 2013.
In 2012, the percentage of adults who smoked in Falkirk fell below the Scottish average. The percentage of adult smokers increased the next year but it still was less than the Scottish average.

[1] ScotPHO Smoking Ready Reckoner – 2011 Edition

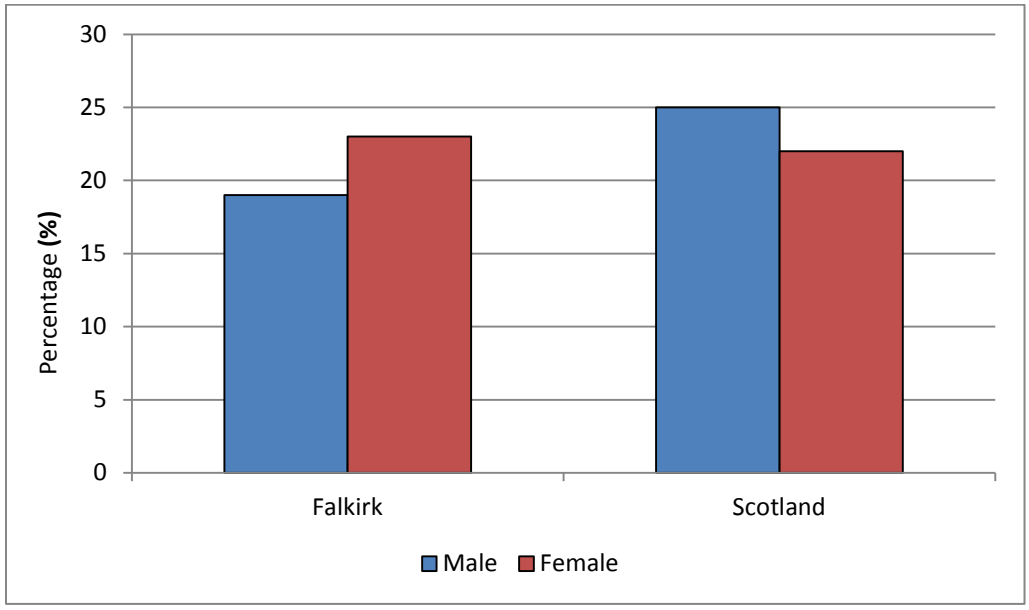
Figure 4.1a - Percentage of adults who smoke - 1999/2000 to 2013



Source: Scottish Household Survey - Annual Report 2013 - LA Tables

Figure 4.1b shows a breakdown of those who smoked in 2013 by sex. In 2013, a higher percentage of women in Falkirk smoked than men. In Scotland as a whole, the reverse is true, more men smoke than women.

Figure 4.1b - Smoking by sex, 2013



Source: Scottish Household Survey - Annual Report 2013 - LA Tables

Table 4.1c shows the rates of smoking related illnesses in Falkirk compared to the Scotland rate. In Falkirk in 2012 the rates for smoking related deaths, lung cancer deaths and COPD deaths were higher than the Scottish rate.

Table 4.1c - Age standardised[1] rate (per 100,000) of smoking related illnesses

Measure	Year	Falkirk	Scotland
Smoking attributable admissions	2012	2,208.7	3149.4
Smoking attributable deaths	2012	340.6	325.9
Lung cancer registrations	2011	132.0	133.3
Lung cancer deaths	2012	114.8	107.1
COPD incidence	2012	400.3	391.1
COPD deaths	2012	97.0	77.9

Source: ScotPHO Tobacco Control Profile

1. Age-sex standardised rate per 100,000 population to ESP2013 (European Standard Population 2013)

4.2 Alcohol

Alcohol related health issues are a major concern for public health in Scotland. Excessive consumption of alcohol can cause both short-term and long-term health and social problems. This includes liver and brain damage, as well as mental health issues, and it is also a contributing factor in cancer, stroke and heart disease. A recent needs assessment carried out on Alcohol Related Brain Damage (ARBD) in Forth Valley recognised that the number being diagnosed underestimates the number with the condition and further work will be carried out on coordinating services to better meet the needs of this cohort in the future.

The rate of alcohol related hospital admissions in Falkirk has increased slightly in the five years between 2009/10 and 2013/14 from 503.5 to 513.7 per 100,000. The number of hospital stays fell in 2010/11 but have gradually been increasing since. In 2013 there were 791 stays related to alcohol.

Table 4.2a shows the figures for the different measures from 2009/10 to 2013/14.

Table 4.2a - Alcohol Related Hospital Statistics 2013/14

Falkirk	EASR Standardised rate (per 100,000 population)	Number of hospital stays
2009/10	503.5	759
2010/11	374.0	570
2011/12	423.7	649
2012/13	441.9	682
2013/14	513.7	791

Source: ISD Scotland

EASR - Age-sex standardised rate per 100,000 population to ESP2013 (European Standard Population 2013)

Table 4.2b displays the age standardised mortality rates for Falkirk compared to the national average between 2009 and 2013. The figures are also presented in the form of a chart in Figure 4.2a.

The alcohol related mortality rate in Falkirk in 2013 at 18.16, was not significantly different from than the average rate of 21.43 for Scotland. Alcohol related mortality is the rate per 100,000 people where alcohol is the underlying cause of death.
The alcohol related mortality rate has been below the Scottish average in each year from 2009 to 2013.

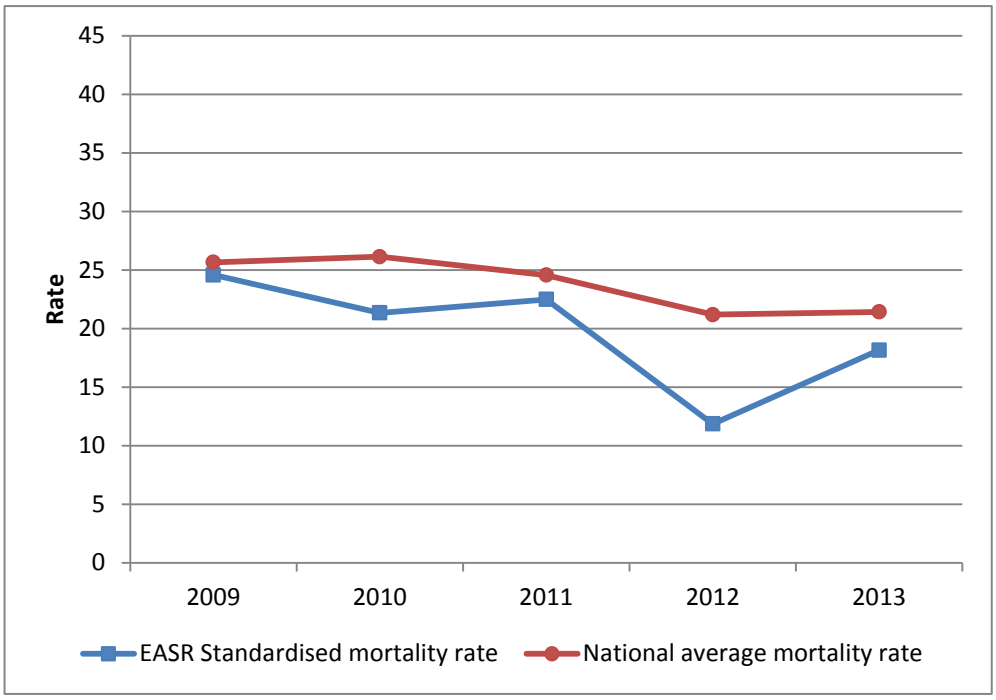
Table 4.2b - Alcohol related mortality

Falkirk	EASR Standardised mortality rate (per 100,000 population)	National average mortality rate
2009	24.58	25.65
2010	21.34	26.14
2011	22.49	24.56
2012	11.86	21.19
2013	18.16	21.43

Source: ISD Scotland/National Records of Scotland

EASR - Age-sex standardised rate per 100,000 population to ESP2013 (European Standard Population 2013)

Figure 4.2a - Alcohol related mortality (per 100,000 population)



Source: ISD Scotland/National Records of Scotland

4.3 Drugs

In 2012/2013 across Falkirk there were an estimated 1,700 people aged 15-64 with a problem drug use. Problem drug use can lead to a number of health and social problems.

The estimated prevalence of those with a problem drug use has increased in Falkirk when comparing the data from 2009/10 and 2012/13. This is in contrast to Scotland as a whole, where the estimated percentage of the population with a problem drug use has remained constant. This increase can be correlated to a substantial increase in male problem drug use in Falkirk since 2009/10, and a sizable increase in the corresponding female figure.

Table 4.3a - Estimated prevalence of problem drug use (ages 15-64)

		Falkirk %	Scotland %
All	2009/10	1.0	1.7
	2012/13	1.6	1.7
Male	2009/10	1.6	2.5
	2012/13	2.5	2.4
Female	2009/10	0.5	1.0
	2012/13	0.8	1.0

Source: ISD Scotland

Key Figures:

- 2013/14 data shows that the rate, per 100,000 population, of child protection with parental drug misuse is higher in Falkirk than the national average (10.7 vs 6.7 per 100,000 population).
- The percentage of people waiting more than 3 weeks between referral to a specialist drug service and commencement of treatment is much lower in Falkirk (0%) than Scotland (5.6%).
- The percentage of people at specialist drug treatment services in Falkirk who report funding their drug use through crime (21.7%) is higher than the national average (20.9%).
- Drug-related mortality has fluctuated over the past five years (2010-2014) but reached a low in 2014. The age-Standardised rate for Falkirk in 2014 was 5.7 per 100,000 population, less than half the Scottish average of 11.6 per 100,000.

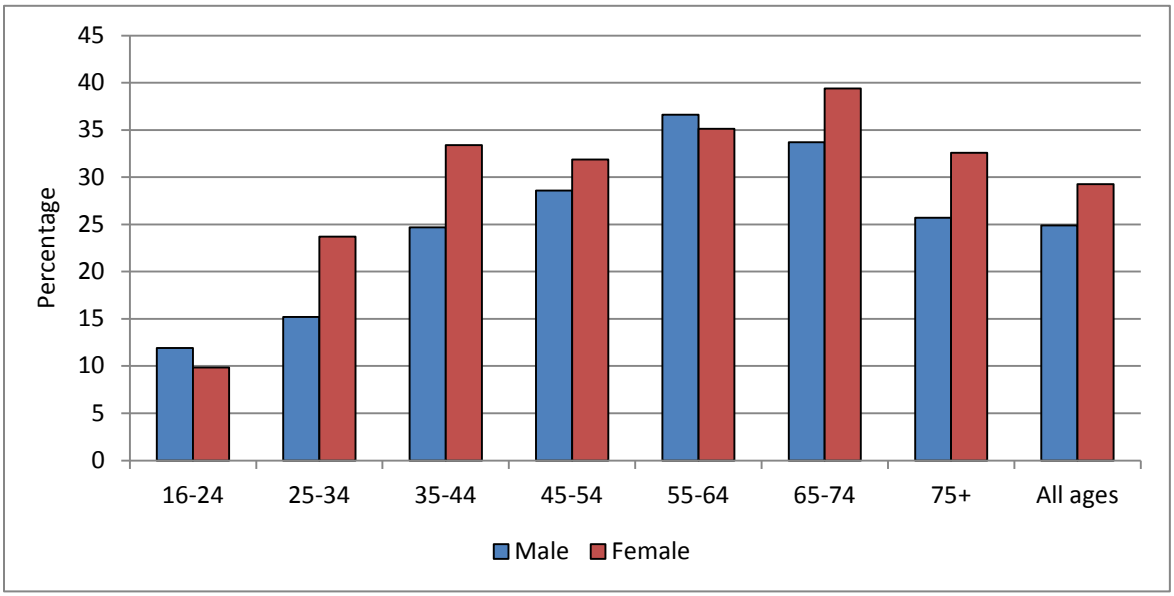
Source: ScotPHO Drugs Profile

4.4 Diet and Obesity

Obesity is when a person's weight increases to an extent that it could potentially cause health problems. Obesity is linked to a number of health problems and diseases. Common complaints include cardiovascular disease and diabetes. One of the major factors that leads to obesity is poor diet.

For Scotland in 2013 it was estimated that 27% of the adult population aged 16+ were obese (a Body Mass Index (BMI) of 30 or more). When this is broken down into different age groups and by sex, it shows that obesity is highest for men between the ages of 55 and 64, and for women between the ages of 65 and 74.

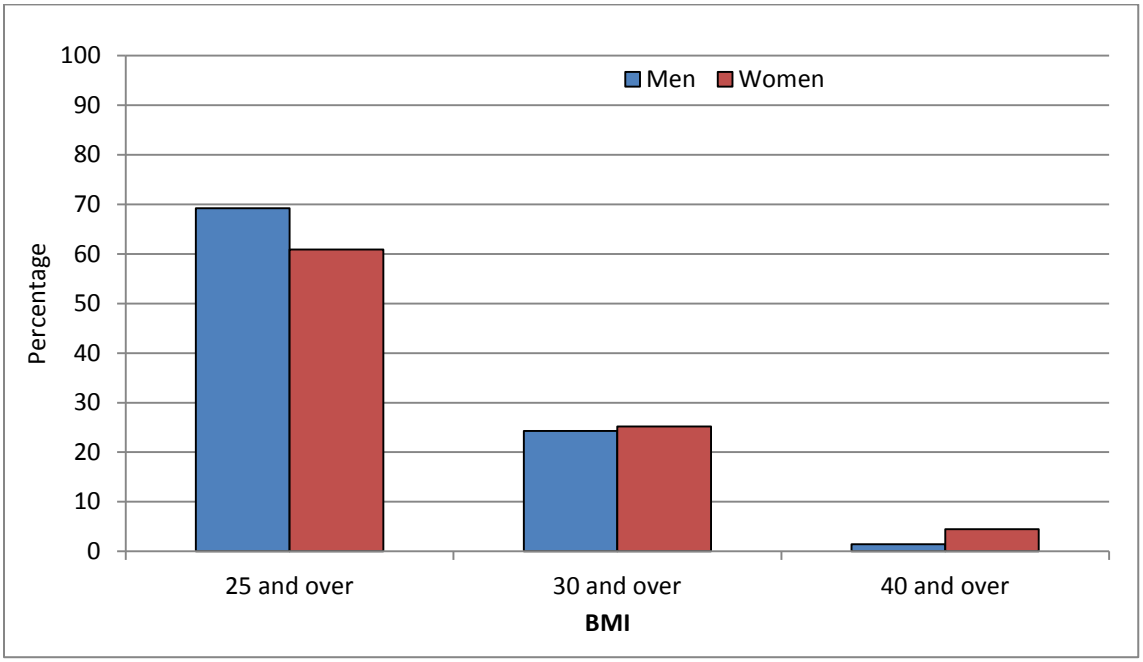
Figure 4.4a - Percentage of population with a BMI of 30 plus – 2013



Source: The Scottish Health Survey 2013

Data and information concerning diet and obesity is not regularly published at local authority or health board levels. Information from the Scottish Health Survey in 2011 showed a four year average of obesity rates in NHS Forth Valley. This information is shown in figure 4.4b.

Figure 4.4b - Percentage of the adult population in Forth Valley with a BMI of 25 plus, 30 plus and 40 plus - 2008-2011.



Source: The Scottish Health Survey 2013

4.5 Lifestyle/Risk Factor Considerations/Implications

- Despite the introduction of the smoking ban in public places in 2006, latest estimates suggest around 1-in-5 people in Falkirk still smoke. Tobacco smoking is the main risk factor for lung cancer, accounting for an estimated 80-90% of cases in developed countries and is linked to other cancers and COPD.
- Alcohol related mortality rates remain lower than the National average however alcohol can be a key factor in Emergency Department admissions. Targeting alcohol misuse could lead to benefits in unscheduled care.
- In recent years Falkirk has been successful in meeting the Government target for drug treatment waiting times, however the estimated prevalence of drug misuse in Falkirk has increased in previous years.
- Obesity is a major problem nationally and the most recent data suggests approximately 25% of the Falkirk population are considered obese. Obesity is known to be a key contributor to long term conditions such as Type 2 Diabetes and coronary heart disease, both of which are life-limiting for the patient and costly to the joint services.

5. Population Health

5.1 General Health

According to the 2011 Census the general health of people in Falkirk closely aligns with that of Scotland. The majority of people in Falkirk consider their health to be good or very good (Table 5.1) with only a small percentage bad or very bad.

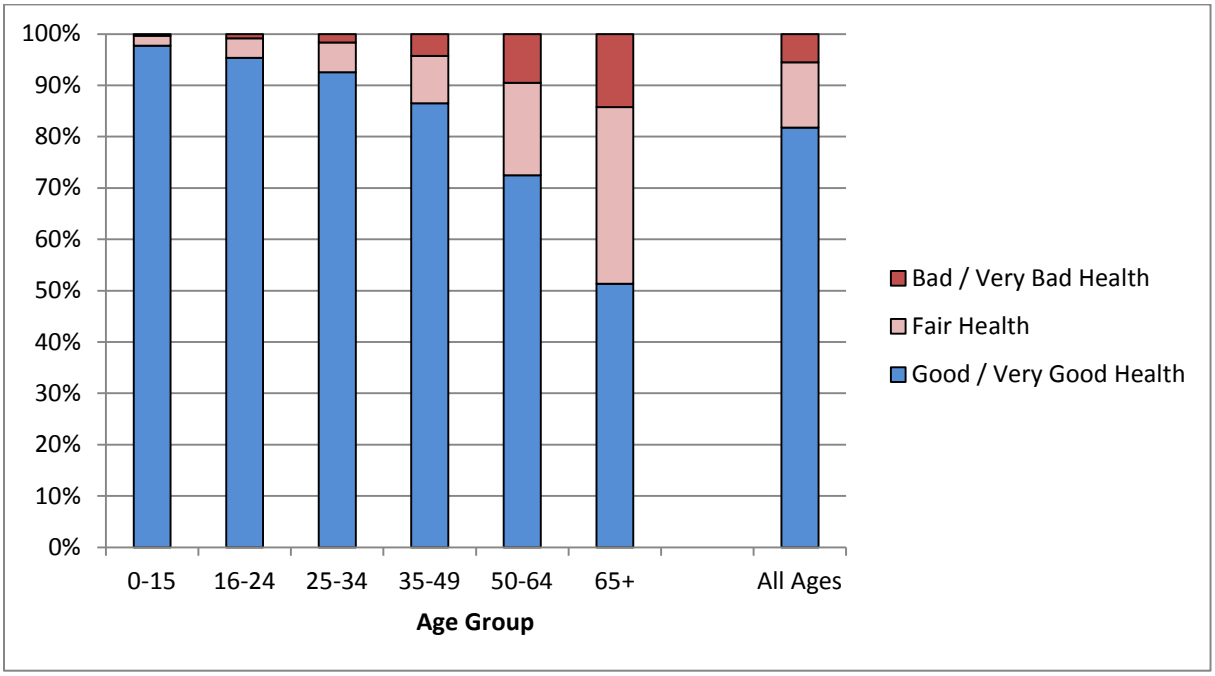
Table 5.1 – General Health by population and age

	Good/Very Good Health (%)	Fair Health (%)	Bad/Very Bad Health (%)
Falkirk	81.8	12.7	5.5
Scotland	82.2	12.2	5.6

Source: Scotland's Census 2011 - National Records of Scotland

Figure 5.1 shows that with increasing age, there is a considerable increase in the percentage of people who consider themselves to be in bad or very bad health. With the projected increase in elderly population, the proportion of people who consider themselves to be in bad or very bad health is expected to increase accordingly.

Figure 5.1 – Health Status by age group, Falkirk 2011



Source: Scotland's Census 2011 - National Records of Scotland

5.2 Life Expectancy and Healthy Life Expectancy

Life expectancy is an estimate of how many years a person might be expected to live. Figure 5.2a shows female life expectancy at birth is higher than for males both at Falkirk and Scotland level. Life expectancy is slightly lower in Falkirk than Scotland for both males and females. The estimate of female life expectancy has increased directly in line with Scotland between 2001-2003 and 2011-2013. The estimate of male life expectancy has increased by nearly a year more over the same period, though it has not increased at the same rate as Scotland on the whole.

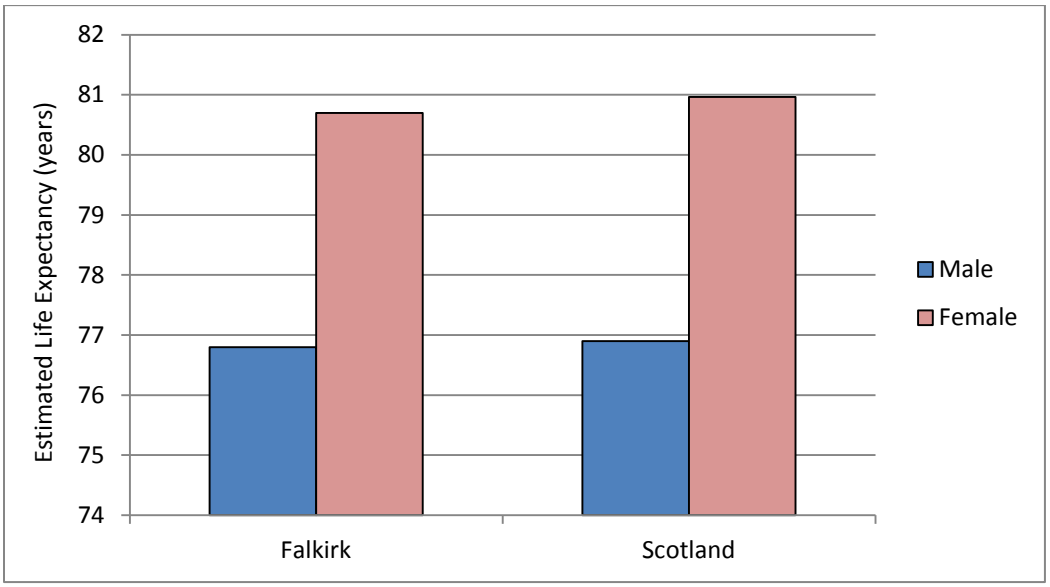
Table 5.2a - Life Expectancy at Birth, Falkirk and Scotland 2001-03 and 2011-13

	Falkirk		Scotland	
	Male	Female	Male	Female
2011-2013	76.8	80.7	76.9	81.0
2001-2003	73.8	78.6	73.5	78.8
Increase over 10 years	3.0	2.1	3.4	2.2

Source: National Records of Scotland

Figure 5.2a shows that estimated life expectancy at birth is just slightly under that of Scotland for both males and females in Falkirk.

Figure 5.2a - Life Expectancy at Birth, Falkirk and Scotland 2011-13



Source: National Records of Scotland

Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. The difference between life expectancy and healthy life expectancy for Falkirk and Scotland is presented in Table 5.2b and Figure 5.2b below. Healthy life expectancy for males is very similar at Falkirk and Scotland level while female life expectancy is less than the Scotland level. The difference between life expectancy and healthy life expectancy gives an estimate of years in "poor health". At both Falkirk and Scotland level there is a considerable difference in years not healthy between males and females, Females are expected to live approximately 2 years longer in poor health than males (Table 5.2b).

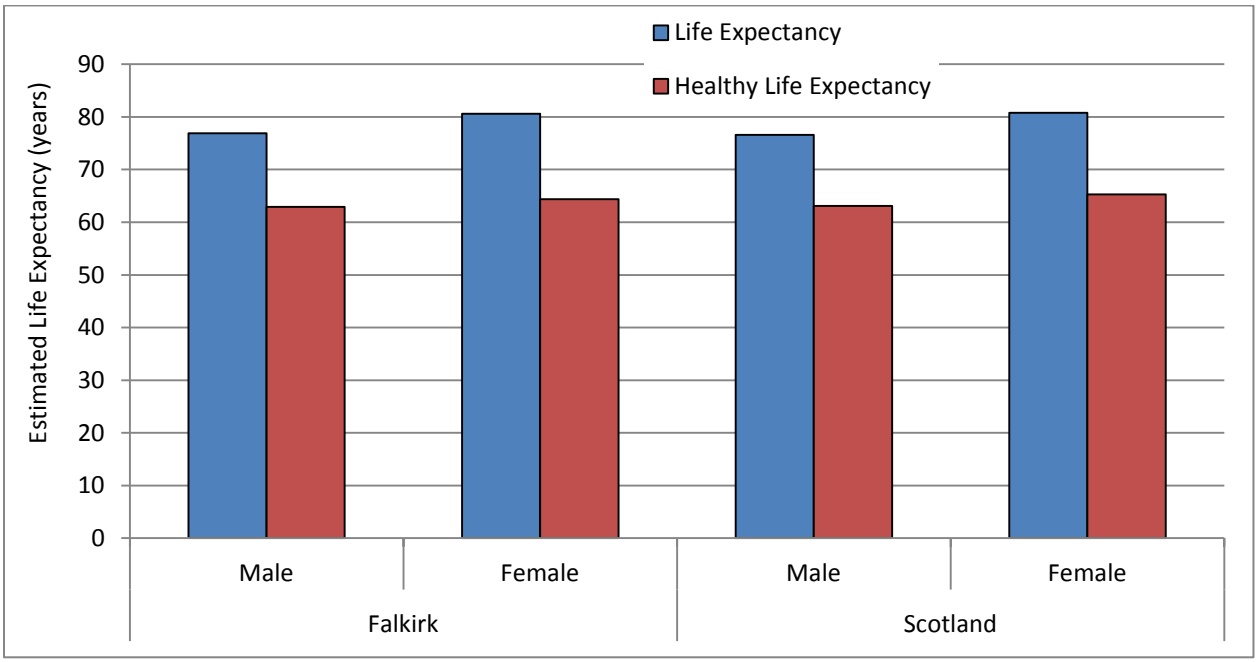
Table 5.2b - Life Expectancy & Healthy Life Expectancy, Falkirk Community Health Partnership and Scotland for the 5-year period 2009-2013

	Falkirk		Scotland	
	Male	Female	Male	Female
Life Expectancy	76.9	80.6	76.6	80.8
Healthy Life Expectancy	62.9	64.4	63.1	65.3
Expected Years "Not healthy"	14.0	16.1	13.5	15.6

Source:
a) National Records of Scotland (NRS) mid-year population estimates (see section 1.2 of the HLE technical paper for further details)
b) NRS death registrations (by year of registration of death)
c) self-assessed health (SAH) from Census 2011.

The estimated years "Not healthy" for the Falkirk population are higher than the Scotland figures and but considerably lower than in some other areas in Scotland.

Figure 5.2b - Life Expectancy & Healthy Life Expectancy, Falkirk Community Health Partnership and Scotland for the 5-year period 2009-2013



Source:
a) National Records of Scotland (NRS) mid-year population estimates (see section 1.2 of the HLE technical paper for further details)
b) NRS death registrations (by year of registration of death)
c) self-assessed health (SAH) from Census 2011.

5.3 Long Term Health Conditions

Long term conditions (LTCs) are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. LTCs can have a serious impact upon a person's personal life but can also have a serious economic impact on health and social care services. 60 per cent of all deaths are attributable to long term conditions and they account for 80 per cent of all GP consultations (http://www.gov.scot/Topics/Health/Services/Long-Term-Conditions).

As part of the Quality and Outcomes Framework (QOF), GP practices across the UK are funded to keep registers of all of their patients that they know to have certain health conditions. Table 5.3a illustrates the number of patients, in Falkirk, known to GP practices having selected long term conditions as at March 2014 and comparisons with 2012 and 2013.

Table 5.3a - Numbers of patients on selected QOF registers of Falkirk GP practices

QOF register	Numbers as at March 14	% of all practice patients As at March 14	Numbers as at March 13	Numbers as at March 12
Asthma	9,949	6.29	8,743	9,596
Atrial Fibrillation	2,415	1.53	2,086	2,203
Cancer	3,381	2.14	2,808	2,953
CHD (Coronary Heart Disease)	7,362	4.65	6,616	7,478
CKD (Chronic Kidney Disease)	5,662	3.58	4,851	5,288
COPD (Chronic Obstructive Pulmonary Disease)	3,708	2.34	3,130	3,389
CVD (Primary Prevention of Cardiovascular Disease)	4,390	2.77	3,035	2,551
Dementia	1,304	0.82	1,113	1,141
Diabetes	7,984	5.05	6,794	7,279
Epilepsy	1,115	0.70	992	1,097
Heart Failure	1,163	0.73	926	996
Hypertension	23,264	14.70	20,556	22,289
Hypothyroidism	5,308	3.35	4,624	5,014
Learning Disabilities	719	0.45	642	702
LVD (Left Ventricular Dysfunction)	357	0.23	630	702
Mental Health	1,257	0.79	1,095	1,193
Obesity	14,384	9.09	12,981	13,865
Osteoporosis	290	0.18	N/A	N/A
Palliative Care	391	0.25	330	312
Peripheral Arterial Disease	1,338	0.85	N/A	N/A
Rheumatoid arthritis	838	0.53	N/A	N/A
"Smoking" (conditions assessed for smoking)	41,193	26.03	36,189	39,342
Stroke & Transient Ischaemic Attack (TIA)	3,474	2.20	3,030	3,336

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

The following subsections will look at particular LTCs in more detail:

5.3.1 Dementia

Dementia presents a significant challenge to individuals, their carers and health and social care services across Scotland. As at March 2014 there were 1,304 individuals known to GP practices as having dementia in Falkirk. This equates to 0.82% of all patients registered to a GP practice in Falkirk.

However, it is suspected that dementia is under diagnosed in Scotland. Alzheimer Scotland has produced estimates, by local authority, of the number of people living in Scotland in 2015 with Dementia (Table 5.3.1a).

Table 5.3.1a – Estimated number of people in Falkirk with Dementia in 2015

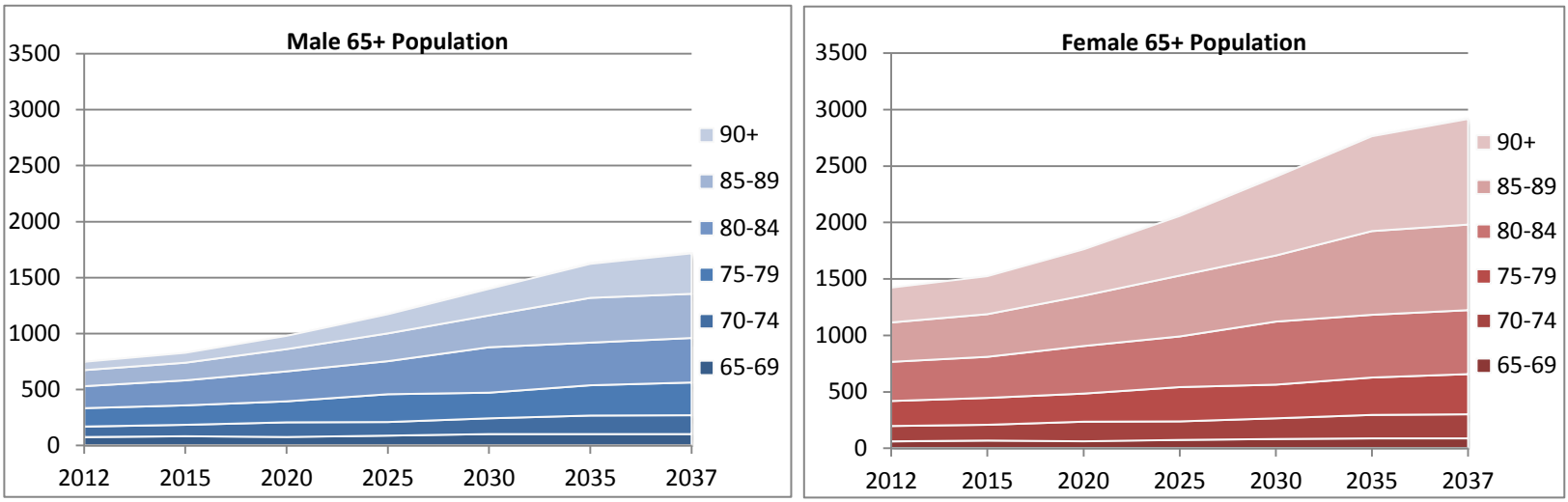
	under 65	65+	Total
Falkirk	95	2,386	2,480

Source: Alzheimer Scotland

If similar prevalence rates for dementia continue to occur we can expect to have significantly more cases of dementia in the local area due to the projected increase in people over the age of 65 to 2037. This is likely to have a significant impact across health and social care services due to the complex nature of care required.

Crude projections have been estimated below using Dementia Prevalence rates from Alzheimer's Scotland and National Records of Scotland population projections. These estimates rely on dementia prevalence remaining the same up to 2037. (Over 60's rates are calculated with prevalence rates from EuroCode[1], for under 60's prevalence rates are from Harvey[2]). These figures not only demonstrate that there will be a lot more people with a dementia if we see the expected increase in older adult population, but also the significant difference in the number of female cases compared to males. This variation can be attributed to higher dementia prevalence rates for females (particularly in the 90+ age group) and the projection that there will be more females aged 90+.

Figure 5.3.1 – Male and Female Dementia Projections for Falkirk, 2012-2037



Source: NRS Population Projections (2012-Based) and Alzheimer's Scotland

[1] Alzheimer Europe (2009) *EuroCoDe: prevalence of dementia in Europe* http://www.alzheimer-europe.org/index.php?lm3=CEE66BE91B37

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

5.3.2 Cancer

In 2013 there were 1,665 diagnoses of cancer in Forth Valley. This was a slight increase from the year before, and also meant that the number of registrations in 2013 was the highest it had been in ten years. The number of people diagnosed with cancer is predicted to rise in the future. The risk of developing cancer increases as a person gets older, and this, coupled with an increasing older adult population means that the number of cancer registrations is set to rise.

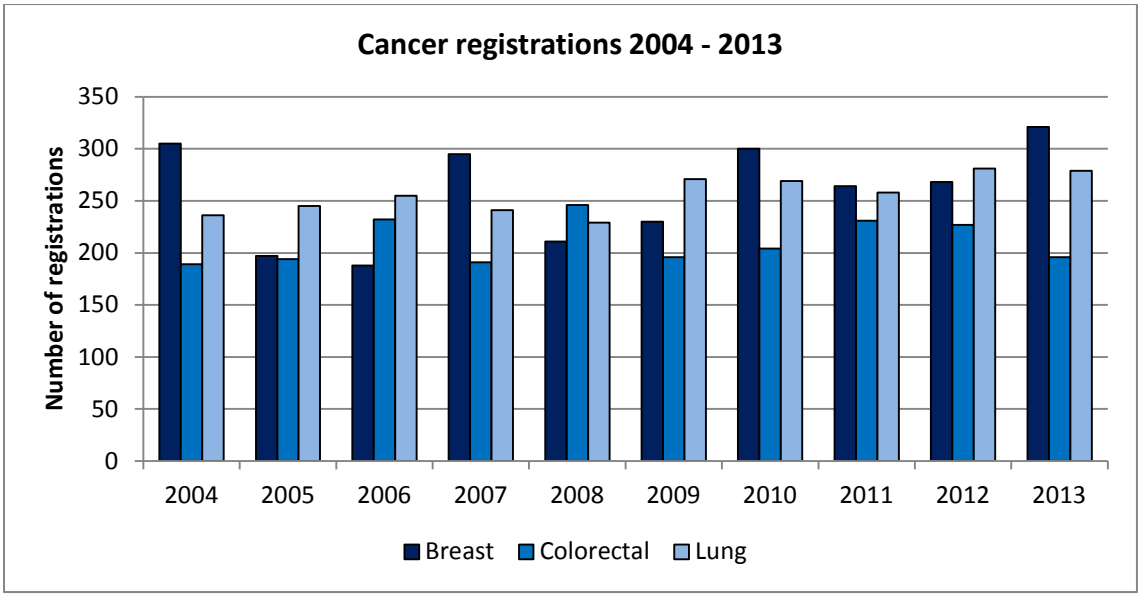
Table 5.3.2 - Cancer registrations in NHS Forth Valley from 2004-2013

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
All cancers	1,611	1,445	1,530	1,512	1,606	1,648	1,660	1,605	1,624	1,665

Source: Scottish Cancer Registry, ISD Scotland

Figure 5.3.2 shows the number of registrations for breast, colorectal and lung cancer from 2004 to 2013. These three cancers account for approximately 45% of all cancer diagnoses in NHS Forth Valley.

Figure 5.3.2 Cancer registrations in NHS Forth Valley from 2004-2013



Source: Scottish Cancer Registry, ISD Scotland

The rate of cancer registrations in NHS Forth Valley is below the Scottish average although it is not significantly so. In 2013, the crude rate across Scotland was 630 per 100,000 people, in NHS Forth Valley it was 556 per 100,000 people.
The mortality rate for cancer in Forth Valley is very close to the rate for Scotland as a whole. In 2013, the figure for Scotland was 296 per 100,000 people, and in Forth Valley it was 290 per 100,000 people. The mortality rate in Forth Valley was relatively stable between 2004 and 2013; it was at its lowest in 2008 at 259, and highest in 2012 when it

was 309. Despite an overall increase in the number of new registrations of people with cancer, they are able to live longer with the disease and this affects the mortality rate.

Cancer incidence in Scotland is projected to rise by a third over the next 10 years. In the five years between 2023 and 2027, it is estimated that there will be over 204,000 new cases of cancer across the whole country.
Presently, about 5% of new cancer diagnoses in Scotland are registered in NHS Forth Valley and if this was to continue to be true by 2027, it would mean that there would be over 2,100 new cancer cases in the area annually.

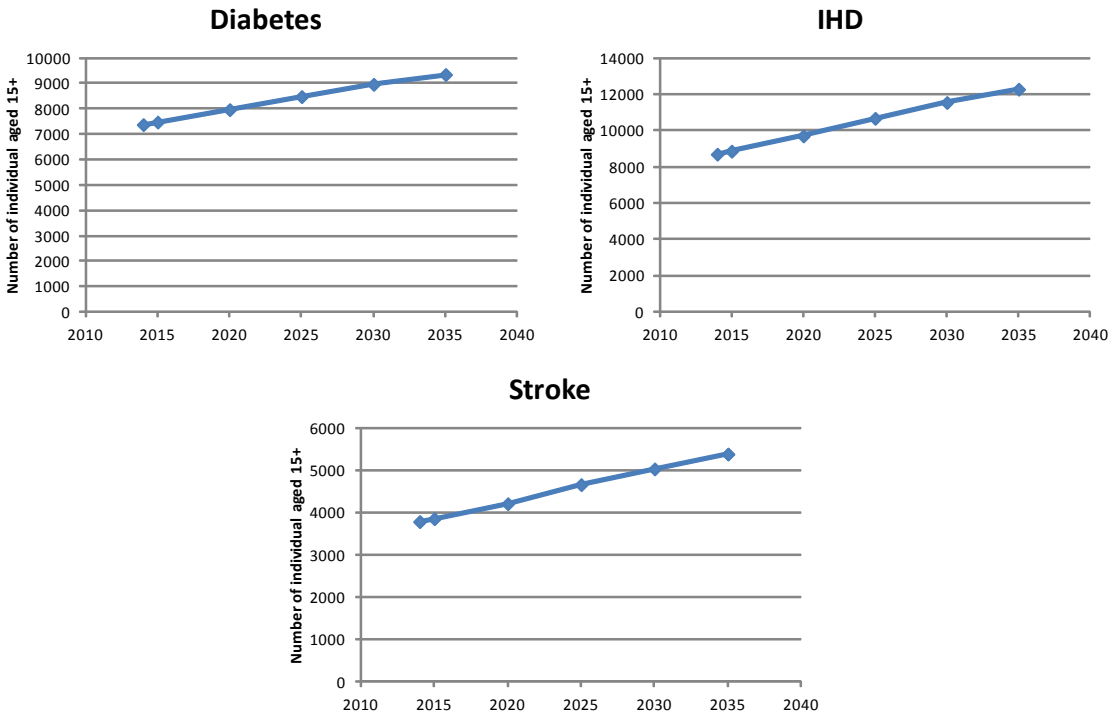
5.4 Projected Long Term Conditions

Forecasting disease prevalence can provide information regarding where resources might be needed in the future or where preventative interventions could reduce disease. There are a range of factors which influence the prevalence of disease. These are:

- Age - in general most conditions are age-related. Even if other risk factors are decreasing the effect of demographic change can be overwhelming.
- Genes – most diseases have at least some genetic component.
- Environment – physical and social.
- Deprivation – even accounting for differences in behaviour, most diseases are deprivation related.
- Health related behaviours.
- Underlying mental wellbeing/resilience/self-efficacy/confidence/motivation.
- Real engagement with life in general and personal wellbeing in particular.
- Options for intervention and organisation of this.

It is easy to assume that disease trends will continue. However the trends could change. To apply a crude method consisting of application of age-specific prevalence rates to Falkirk population projections gives the forecast demonstrated in Figure 5.4a, for Diabetes, Ischaemic Heart Disease (IHD) and Stroke. The figures show an increase in the forecast prevalence of disease. The assumption has been made that the age-specific prevalence remains constant.

Figure 5.4 – Estimated projections of Diabetes, IHD and Stroke in Falkirk.

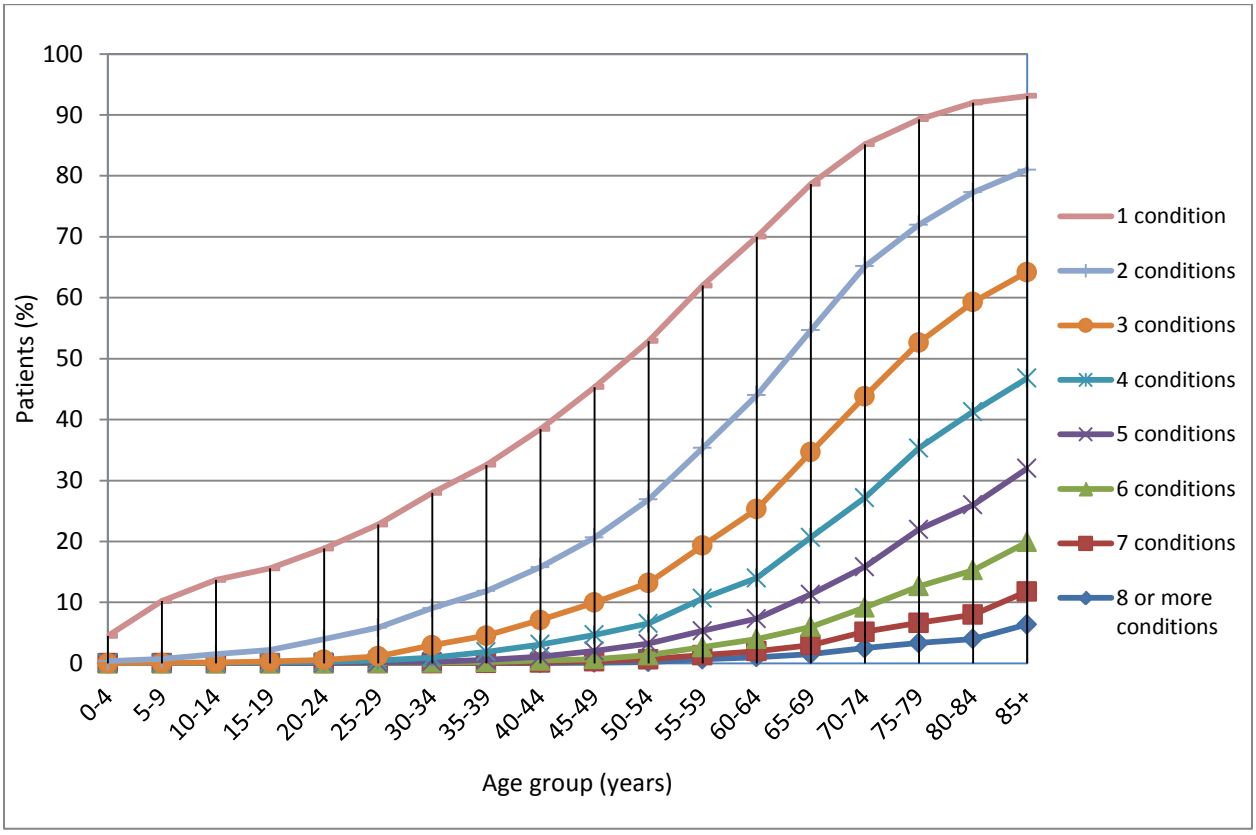


Source: Scottish Health Survey (prevalence rates) and NRS population Estimates

5.5 Multi-Morbidity

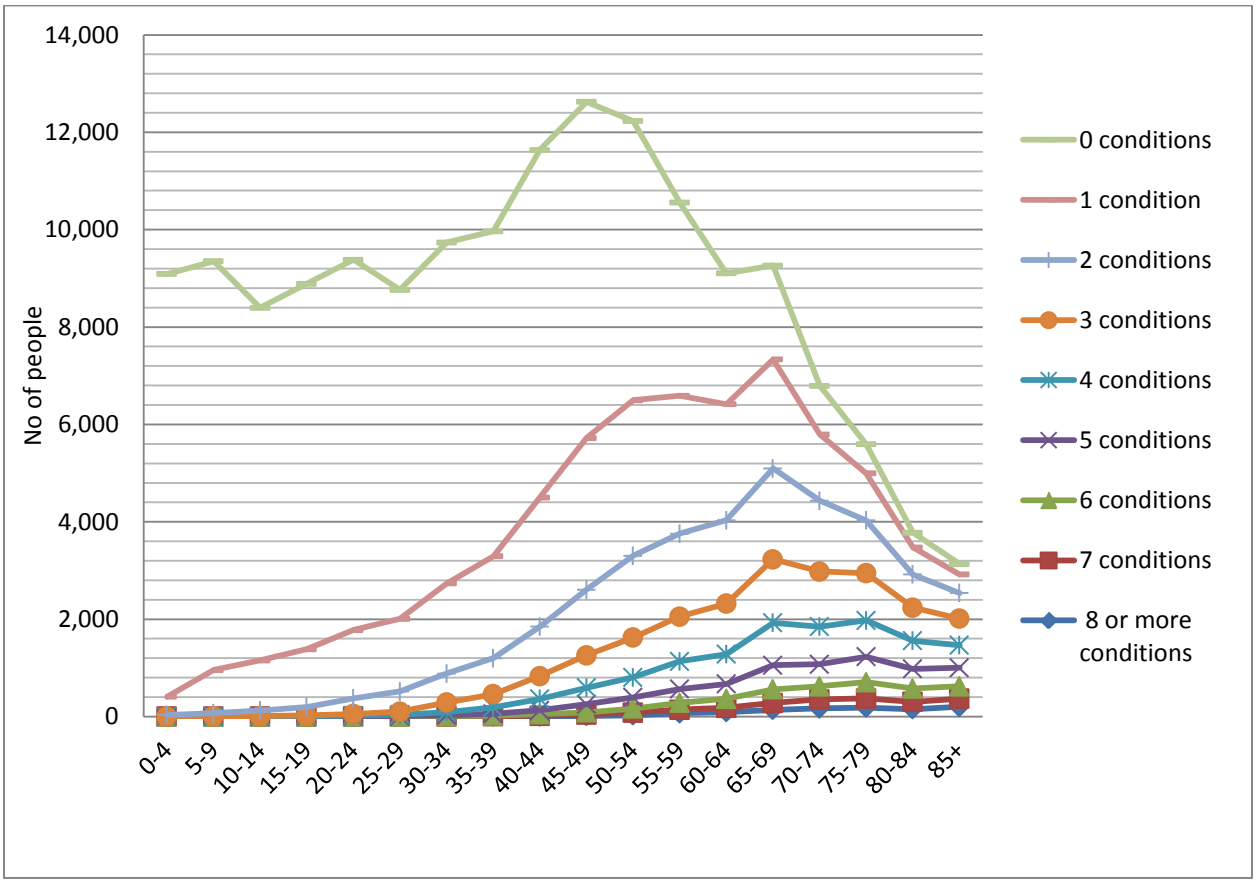
In light of an ageing population, Falkirk is facing more people with multiple long term conditions (also referred to as multi-morbidities). Figure 5.5a demonstrates that patients have more conditions as they age. The estimated number of patients within Falkirk with various numbers of long term conditions is forecasted to increase between 2015 (figure 5.5b) and 2037 (figure 5.5c).

Figure 5.5a – Estimated number of conditions by age group.



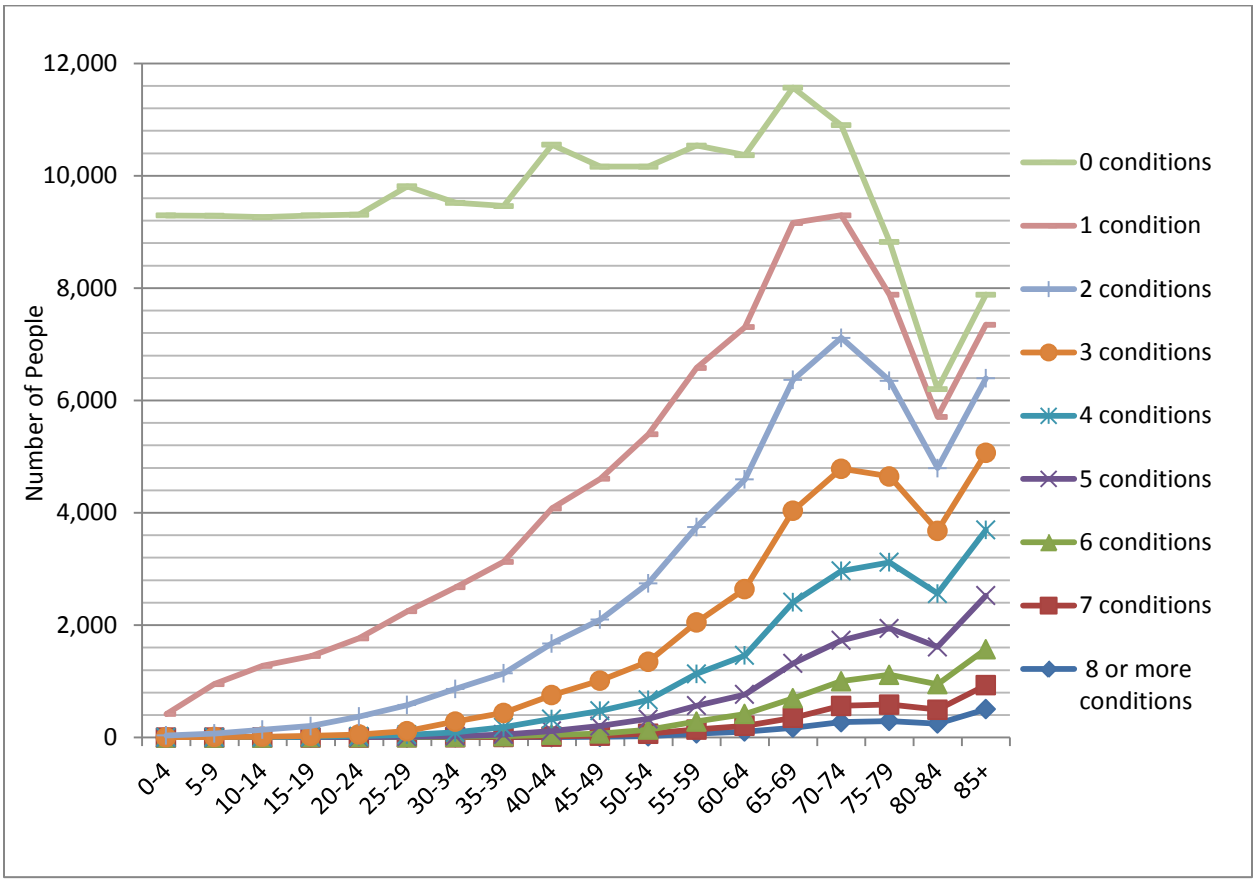
Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer

Figure 5.5b - Estimated number of people within Falkirk with various numbers of conditions (2015)



Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk

Figure 5.5c - Estimated number of people within Falkirk HSCP with various numbers of conditions (2037)



Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population projections for Falkirk.

The multiple morbidities demonstrated in Figure 5.5b and 5.5c bring both person-centred as well as financial challenges (Christie, 2011). Patients with several complex long term conditions are currently making multiple trips to hospital clinics to see a range of uncoordinated specialist services. A proposed way forward could be to look at developing new pathways and guidelines away from the current disease specific models to generic approaches focused on the holistic needs of patients (Lunt, 2013, p. 17). The latter ties in with the 2020 Vision and the values of designing the services around the patient. For example, we need to make sure that people do not have to unnecessarily attend five different, uncoordinated specialists for the five different conditions that they have.

5.6 High Resource Individuals

The term 'High Resource Individuals' (HRIs) refers to the population group who account for 50% of the total health expenditure. All service users are ranked highest to lowest in terms of their use of health resources and those at the top who collectively account for 50% of expenditure are categorised as High Resource Individuals.

ISD Scotland have undertaken cost per patient analysis on inpatient and day case hospital admissions (including all acute specialties, maternity, geriatric long stay inpatient care, and psychiatric inpatient care), A&E attendances, consultant led outpatient clinics and community prescribing.

A high resource individual in one area might not fall into the same category at Scotland level or indeed another local area. Further analysis, and therefore a greater understanding, of this cohort of individuals could lead to more effective and efficient planning and delivery of services to high resource individuals in the community.

Analysis for the financial year 2012/13 reported that **2,934** individuals accounted for 50% of health expenditure in the Falkirk area. There were 130,435 patients for that same period in Falkirk meaning that **2.2%** of patients accounted for 50% of health expenditure. Table 5.6a shows the figures relating to HRIs in Falkirk.

Table 5.6a – Breakdown of all activities for HRIs and all patients in Falkirk 2013/14

Financial Year 2013/14		Falkirk
Number of patients	HRIs	2,934
	All Patients	130,435
	% HRI	2.2%
Number of bed days	HRIs	149,009
	All Patients	189,478
	% HRI	78.6%
Episodes/Attendances[1]	HRIs	204,060
	All Patients	2,901,251
	% HRI	7.0%
Cost (£)	HRIs	£72,869,044
	All Patients	£72,878,302
	% HRI	50%
Cost per capita (£)	HRIs	£24,836
	All Patients	£1,117

Source: The Health and Social care dashboard – ISD Scotland

1 - Episodes and attendances apply to inpatient, day case, outpatient and A&E activity.

This same cohort of individuals (2.2%) accounted for 78.6% of the bed days in 2013/14 and 7.0% of episodes/attendances. High resource individuals pose different issues for different specialities, for example, this cohort of patients account for 96% of Mental Health bed days in Falkirk but only 10% of community prescribing expenditure. High resource individuals are predominantly older people and Table below shows rates of HRI's by age band.

Table 5.6b – Breakdown of HRIs by age group in Falkirk, 2013/14

	Age 18-64	Age 65+
Number of HRIs	1081	1712
All Service Users	79,746	26,681
Rate per 1,000 population	13.6	64.2

Source: The Health and Social care dashboard, ISD Scotland

5.7 Disability

Learning disabilities

The Learning Disabilities Statistics Scotland Report 2014 looked at the numbers of adults known to have learning difficulties across Scotland (adults with learning disabilities who are known to local authorities from contact in the last 3 years). The report also looked at the accommodation, education and employment situation for people with learning difficulties. In 2014 there were 990 people with learning disabilities known to the Falkirk local authority. The rate per 1000 population is shown in Table 5.7a below.

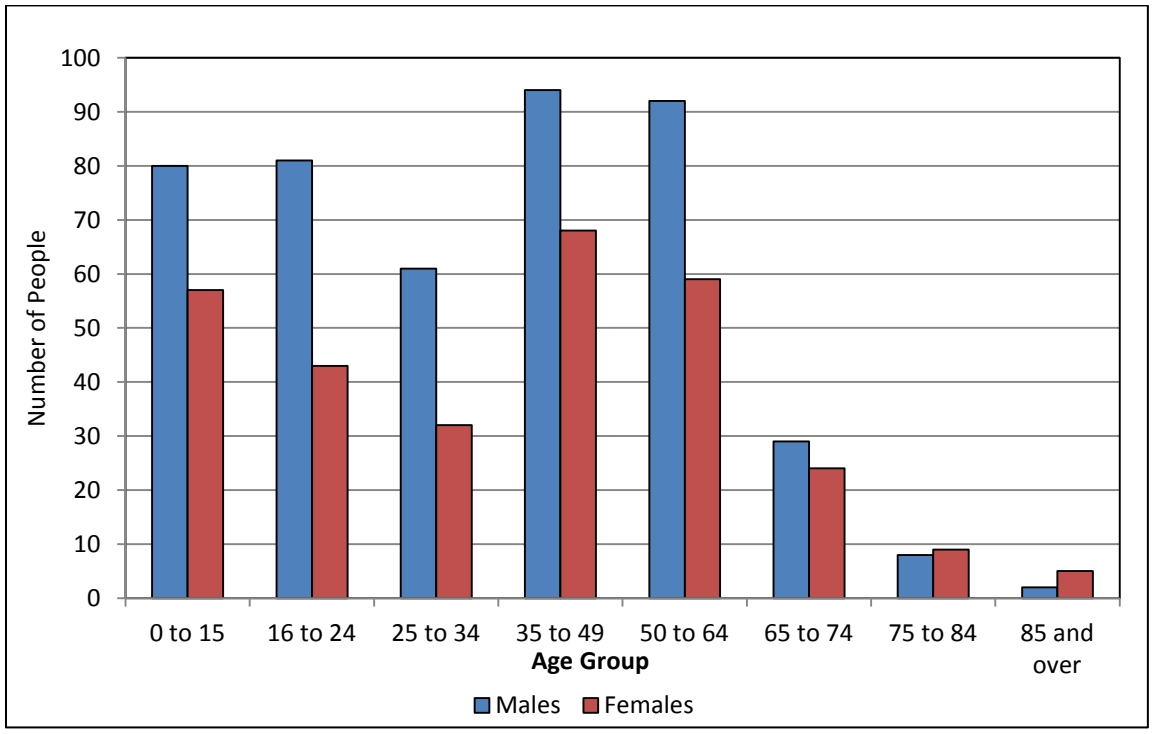
Table 5.7a Number of adults with learning disabilities known to local authorities per 1,000 population 2010 - 2014

Area	2010	2011	2012	2013	2014
Falkirk	6.0	5.3	5.6	5.8	7.7
Scotland	6.4	6.0	6.0	5.9	6.0

Source: Learning Disabilities Statistics Scotland, National Records of Scotland

The chart below shows the number of people who were recorded as having a learning disability by sex and age group at the time of the Census in 2011. The age group with the highest number of people with a learning disability for both sexes is the 35-49 age group. The numbers fall slightly for those aged 59 to 64 but drop by 68% for males and 59% for females in the next age group, those aged 65 to 74. The number of people declines steadily for both men and women after age 65; there were only a small number of people aged 85 and over in the Falkirk area with a learning disability in 2011.

Figure 5.7b - Number of people in Falkirk with a learning disability by age and sex, 2011



Source: Scotland Census 2011

Life expectancy

Due to significant developments in health care life expectancy of people with learning disabilities has improved considerably, in the 1930's life expectancy for a person with Down's syndrome was seven years, but it is now in the region of 50 to 60 years. Still people with learning disabilities are 58 times more likely to die before the age of 50 than the rest of the population (Emerson and Baines 2010)[2].

Autism

In 2014, 14.3% of those known to the local authority with a learning disability were on the Autism Spectrum (this is likely an under-representation of Autism numbers as it's possible to be on the autism spectrum without having a learning disability).

[2] Health Inequalities & People with Learning Disabilities in the UK: 2010 - Eric Emerson and Susannah Baines

Life Circumstances

Table 5.7b provides a summary of the key figures from the 2014 report by the Scottish Consortium of Learning Disability (SCLD). The proportion of people with learning disabilities who live in mainstream accommodation in Falkirk is substantially lower in Scotland, additionally there are a greater percentage of people with learning disabilities who live in a Falkirk Care home or supported accommodation. Figures for employment and day centre attendance also fall below the Scotland level, so there is scope for improvement to allow more people with learning disabilities to live independently in the community.

Table 5.7b – Summary of Learning Disability Statistics, Falkirk and Scotland 2014

	Falkirk	Scotland
Live with a Family carer (%)	31.6	34.7
Living in mainstream accommodation (with or without support) (%)	51.1	60.3
Living in Supported Accommodation or a Registered Adult care home (%)	23.8	17.6
In employment or training for employment (TFE) (%)	10.2	13.6
Attends a local day centre (%)	18.1	20.0

Source: Learning Disability Statistics Scotland, 2014

Physical disabilities

http://news.scotland.gov.uk/News/Taking-action-on-disability-1cb3.aspx

The Scottish Government has recently announced (September 2015) a plan to tackle inequality and advance disabled people's human rights.

In healthcare some of the key aspects of the plan are:

- More support for independent living for all disabled people who will have more say about how their support will be managed and provided
- Health, social care and other support services working together to remove the barriers faced by all disabled people
- Increased opportunities for disabled people to be involved in community development and service delivery

In the 2011 Census there were over 10,800 people in Falkirk recorded as having a physical disability.

Table 5.7b - Number of people with a physical disability in Falkirk

Area	Physical disability	Percentage of total population
Falkirk	10,868	7.0%

Source: 2011 Census

The majority of those who have a physical disability in Falkirk are over the age of 50, 80% of the total can be found in this age group. Table 5.7c below also shows that the proportion of those with a physical disability increases as people age. Only 1.2 % of the population aged 16-24 had a physical disability in 2011, compared to 32.8% for those aged 85 and over.

Table 5.7c - Number of people in Falkirk with a physical disability by age and sex

Age	Male	Female	Total	Percentage of total with physical disability	Percentage of age group with physical disability
0-15	122	112	234	2.2%	0.8%
16-24	105	98	203	1.9%	1.2%
25-34	163	161	324	3.0%	1.7%
35-49	678	732	1,410	13.0%	3.9%
50-64	1,540	1,689	3,229	29.7%	10.6%
65-74	1,194	1,279	2,473	22.8%	17.6%
75-84	846	1,235	2,081	19.1%	24.6%
85+	257	657	914	8.4%	32.8%

Source: 2011 Census

5.8 Mental Health and Wellbeing

http://www.gov.scot/Topics/Health/Services/Mental-Health/Strategy

Mental health and wellbeing strategies and targets were established by the Scottish Government in 2012 to cover the period 2012-2015. Among the key areas of change outlined were:

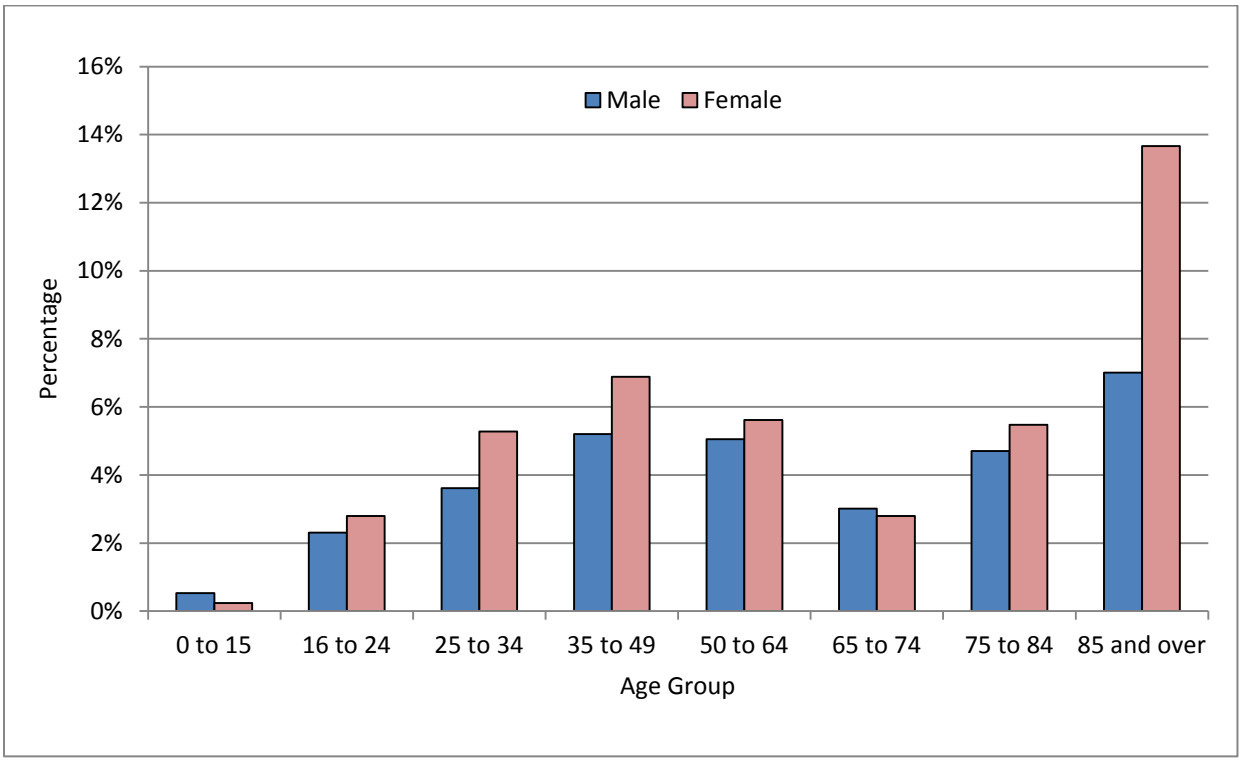
- Community, inpatient and crisis mental health services
- Work with other services and populations with specific needs.

A well functioning mental health system has a range of community, inpatient and crisis mental health services that support people with severe and enduring mental illness. Across Scotland there were variations in the pace of change, the delivery and the models of service for mental health as health boards attempted to move from predominantly inpatient services to services where care and treatment can be delivered mostly in the community.

Health issues that are included within the area of mental health range from common problems such as dementia, stress and depression, to more severe issues like schizophrenia, bipolar affective disorder and other psychoses.

In the 2011 Census, 6,375 people in Falkirk identified themselves as having a mental health condition. This is 4.1% of the total population. The distribution of this group by age group and sex is shown in Figure 5.8a.

Figure 5.8a - Percentage of population with long term mental health condition in Falkirk by age group and sex 2011



Source: 2011 Census

Further information on mental health and illnesses comes from the Quality and Outcomes Framework (QOF) for general practices. Participation by general practices in the Quality and Outcomes Framework is voluntary but it measures achievement for general practitioners against a range of evidence-based indicators, and includes prevalence data for a range of conditions.

A crude prevalence rate of the number of people in Falkirk and Scotland with a mental health condition is shown in Table 5.8a. It shows that in Falkirk the rate of people with a new diagnosis of depression is higher than the Scottish rate but that the rate for schizophrenia, bipolar affective disorder and other psychoses is lower.

Table 5.8a - Percentage of people with mental health issues in Falkirk and Scotland 2014/15

Area	Depression (%)	Schizophrenia, Bipolar affective disorder and other psychoses (%)
Falkirk	7.19	0.81
Scotland	6.28	0.88

Source: QOF, ISD Scotland

Depression

Estimating the true prevalence of Depression remains a challenge, but we can gain some insight from the QOF data. Historical data available on the GP QOF should be interpreted with caution as there were changes to the way depression was defined in 2012/13 which resulted in a drop in the prevalence.

Table 5.8b below contains the past 4 years data and clearly shows the drop prevalence in 2012/13 due to the introduction of a new definition for Depression. It is uncertain whether the increase over the past two years is a down to a familiarisation with the new definition or a true rise in the prevalence of depression. Nonetheless, it is important to note that over the past three years there has been a larger percentage of the population with Depression in Falkirk than Scotland.

Table 5.8b - Percentage of people Depression in Falkirk and Scotland 2014/15

	Prevalence of Dementia (%)			
Area	2011/12	2012/13	2013/14	2014/15
Falkirk	10.90	5.89	6.64	7.19
Scotland	9.02	5.31	5.81	6.28

Source: QOF, ISD Scotland

Wellbeing

Wellbeing is linked to mental health in that it attempts to measure how happy and content people are in their everyday lives. This data has been collected by the Office for National Statistics as part of their UK Annual Population Survey since 2011. Four questions are asked concerning wellbeing and are rated on a scale of 0 to 10.

These are:

1) Overall, how satisfied are you with your life nowadays? Where 0 is 'not at all satisfied' and 10 is 'completely satisfied'.

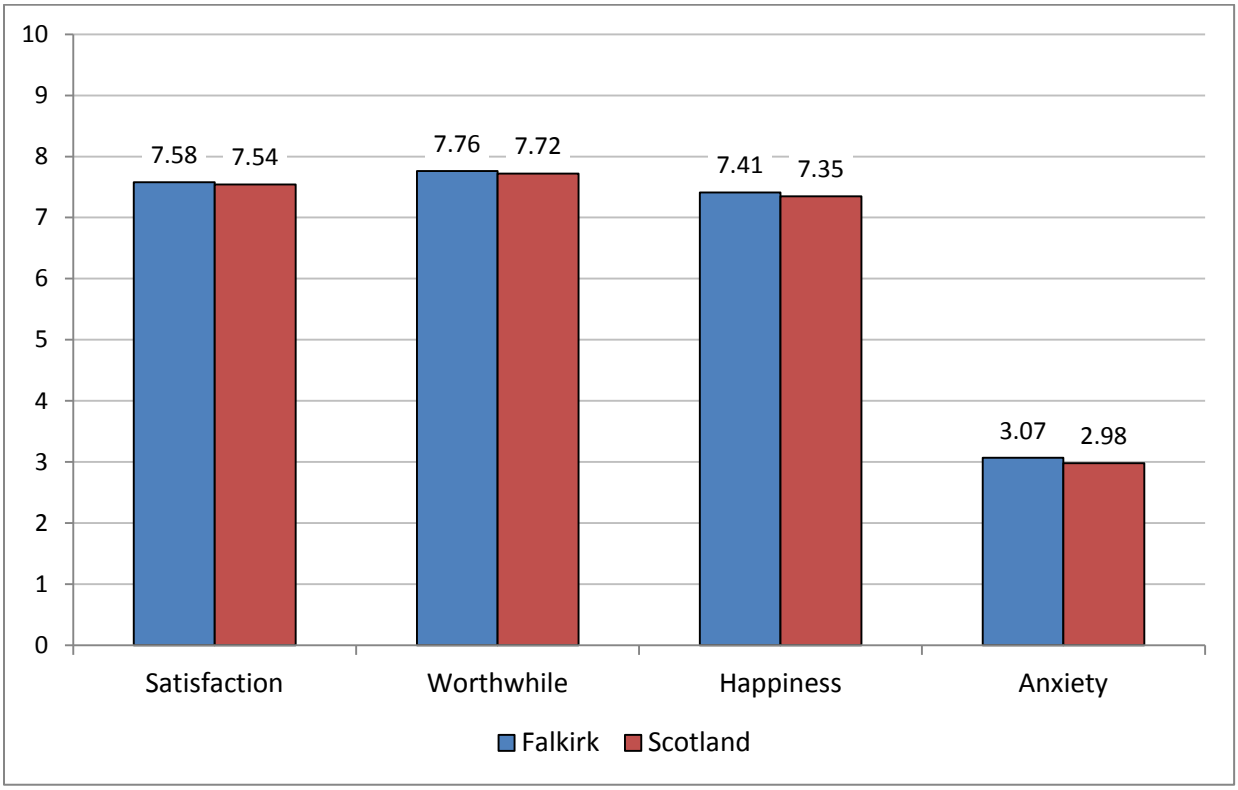
2) Overall, to what extent do you feel the things you do in your life are worthwhile? Where 0 is 'not at all worthwhile' and 10 is 'completely worthwhile'.

3) Overall, how happy did you feel yesterday? Where 0 is 'not at all happy' and 10 is 'completely happy'.

4) Overall, how anxious did you feel yesterday? Where 0 is 'not at all anxious' and 10 is 'completely anxious'.

The average scores for Falkirk and Scotland between 2011 and 2014 are shown in Figure 5.8b below. Falkirk has a marginally better average score than the whole of Scotland except in the anxiety score where it is only slightly worse.

Figure 5.8b - Wellbeing scores 2011-2014



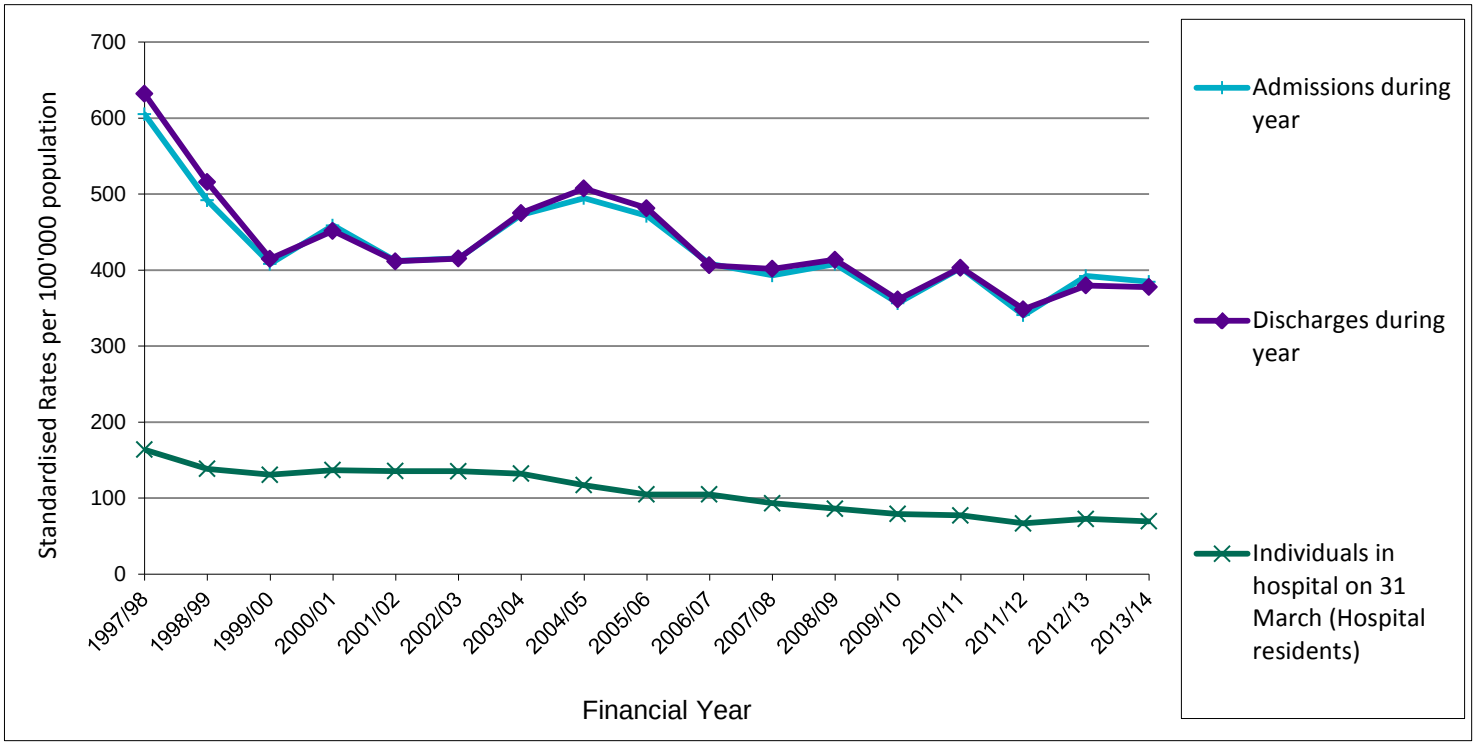
Source: Office for National Statistics

Mental Health Inpatients

Mental health inpatient stay data is recorded by ISD Scotland on the SMR04 database, data is available back to 1997/98 although there is some fluctuation in the rate (see Figure 5.8c), there is a clear downwards trend for mental health inpatient admissions and discharges in Falkirk. In alignment with this trend, the number of individuals resident in hospital at 31st March has also steadily decreased over the years.

These patterns reflect the shift in recent years in the care of people with mental health problems away from inpatient treatment towards various forms of care in the community e.g. community mental health teams and GP services.

Figure 5.8c - Mental health admissions and discharges in Falkirk, 1997/98 to 2013/14



* Admissions and Discharges in this chart refer to episodes rather than patients, a patient can have a number of episodes before being discharged home. If a patient is moved from one speciality to another, this will count as a discharge from the original speciality and an admission to the new speciality.

Source: Mental Health Hospital Inpatient Care Report (SMR04) (ISD)

5.9 Premature Mortality

Premature mortality is a measure of the number of deaths that occur under the age of 75 and can be used as an indicator of poor health of a population. The fewer deaths that occur under the age of 75, the healthier the population is judged to be. In 2014 there were 578 deaths under the age of 75 across Falkirk, 38.1% of the total deaths. This is marginally higher than the Scottish figure in 2014, which was 36.8%.

Table 5.9a Deaths under the age of 75, 2014

Area	Male	Female	Total
Falkirk	330	248	578

Source: National Records of Scotland

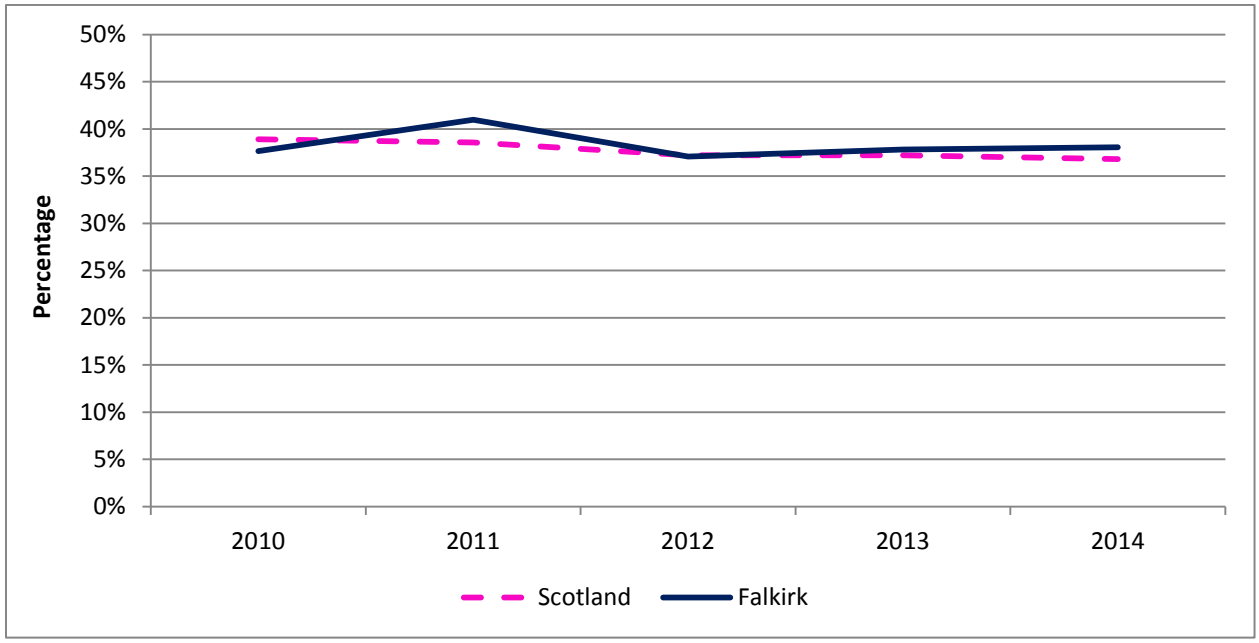
Table 5.9b Deaths under the age of 75 as percentage of all deaths, 2014

Area	Deaths under age 75	Total Deaths	% Deaths under age 75
Falkirk	578	1,519	38.1%
Scotland	19,961	54,239	36.8%

Source: National Records of Scotland

The percentage of deaths occurring under the age of 75 has been gradually decreasing across Scotland between 2010 and 2014. Over the same time period the percentage of deaths under 75 in Falkirk rose initially before falling. In 2014, it was slightly higher than the 2010 figure, but not significantly different than the Scotland percentage.

Figure 5.9 - Deaths under age 75 as percentage of all deaths 2010-2014, Falkirk and Scotland



5.10 Cause of Death

In 2014 there were 1,519 deaths registered in Falkirk. 57.1% of those deaths were caused by cancer and diseases of the circulatory system (including cardiovascular disease and strokes).

Table 5.10a - Number and percentage of deaths in Falkirk by cause 2014

Cause of death	N	%	Scotland %
Cancer	462	30.4%	29.8%
Mental and behavioural disorders	132	8.7%	7.3%
Diseases of the nervous system	68	4.5%	4.8%
Diseases of the circulatory system	406	26.7%	27.7%
Diseases of the respiratory system	198	13.0%	12.4%
Diseases of the digestive system	68	4.5%	5.4%
External causes	62	4.1%	4.7%
Other	123	8.1%	7.9%
Total	1,519	100.0%	100.0%

Source: National Records of Scotland

The percentage of all deaths caused by cancer and diseases of the circulatory system in Falkirk has not significantly changed in the years between 2010 and 2014.

Table 5.10b - Number and percentage of deaths caused by cancer and diseases of the circulatory system in Falkirk between 2010 and 2014.

Falkirk	2010		2011		2012		2013		2014	
Cause of death	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Cancer	443	29.4	444	28.7	509	32.3	461	29.1	462	30.4
Diseases of the circulatory system	459	30.5	497	32.1	439	27.9	452	28.6	408	26.7

Source: National Records of Scotland

5.11 Population Health Considerations/Implications

- Assuming age-specific prevalence remains constant for LTCs it is projected we will see greater numbers of individuals with these conditions as the proportion of older adults in the population rises. This will impact on both health and care services.
- It is also projected that the number of people with multi-morbidities will increase. This means there will be more individuals attending hospital with complex needs. Currently services are un-coordinated and may mean people are making multiple visits to hospital. A re-organisation of services to ensure a more joined up approach could help to reduce the number of visits to a hospital and improve efficiency in line with Outcome 9.
- Currently around 2% of the population account for 50% of the hospital and GP prescribing spend. Gaining a better understanding about this cohort of people could allow for more effective planning and delivery of services and an improved service user experience.

6. Current Provision of Health and Social Care Services

6.1 Workforce

In order to aid strategic planning of the integration of health and social care services it is important to understand more about the workforce.

A data collection exercise was undertaken in order to consolidate information about the in-scope workforce for health and social care integration in Falkirk. Data was gathered as at 30th September 2015.

Table 6.1a below provides an overview of the staff relevant to the Falkirk Health and Social Care Integration Partnership.

Table 6.1a - Number of staff (Headcount and WTE)

Employing Body	Headcount	WTE/FTE
Falkirk Council	1017	780.6
NHS Forth Valley	2484	2086.3

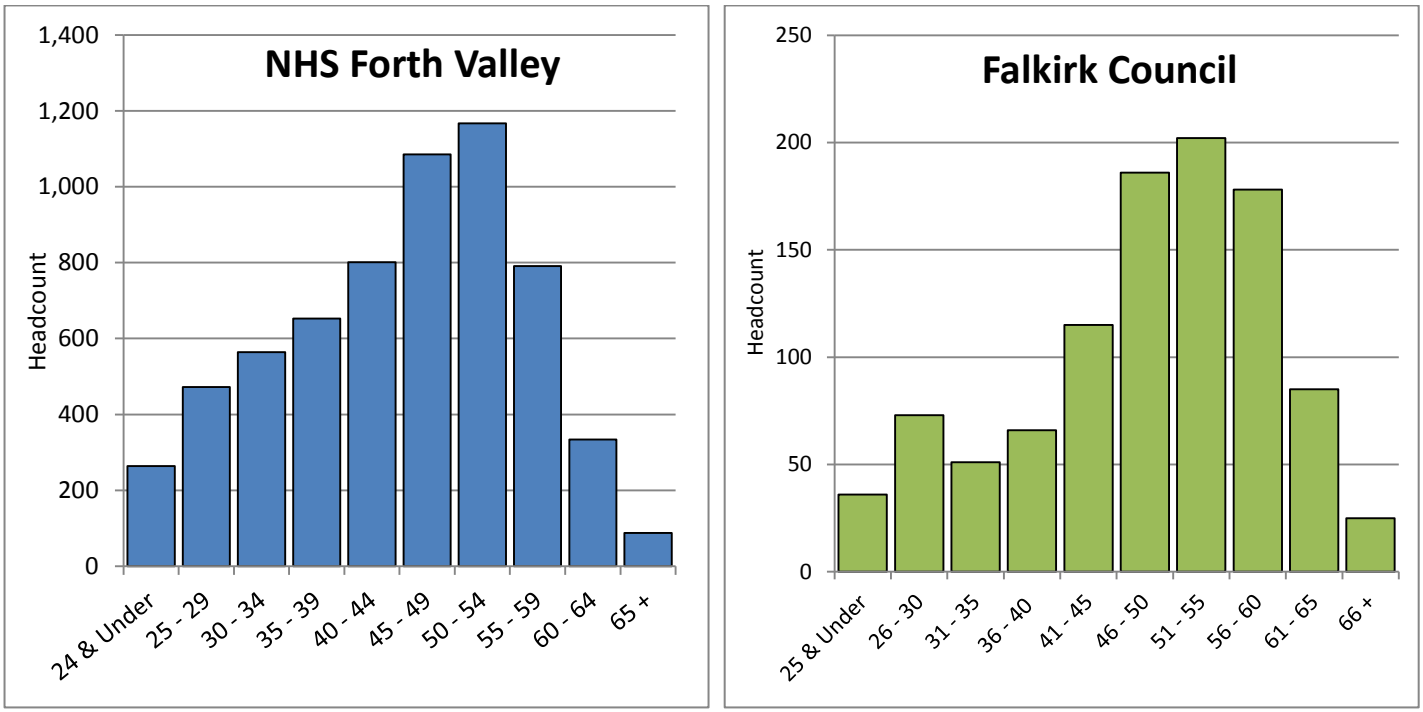
Source: Forth Valley Workforce Project

*****Note – Forth Valley headcount/WTE refers to all staff and not just those considered relevant to the Falkirk population. The NHS Forth Valley figures refer to the workforce covering Falkirk, Stirling and Clackmannanshire.

Age Profiles

Age of the workforce must be considered to ensure that planned future services are sustainable. Although it was not possible to gather NHS and Local Authority workforce age data and group under the same age bandings (age bands have been aligned as best possible), the figure below shows a similar picture on both sides. The majority are aged between 45 – 60 years, symbolising a predominantly ageing workforce. In NHS forth Valley 48.9% of the workforce are aged 45-59, while 55.7% of the council workforce fit into the 46-50 age bracket.

Figure 6.1a – Workforce age profiles for NHS Forth Valley and Falkirk Council – September 2015



Source: Scottish Workforce Information Standard System (SWISS) & Falkirk Council
Note – NHS Forth Valley figures represent the entire workforce, not just those in scope for integration, it is assumed that the relevant staff will share a similar age profile.

Information is not currently available on the size and profile of the workforce not employed by NHS Forth Valley or Falkirk Council but who provide care through private organisations. However, this is an important part of care delivery and it is recommended that future versions of this document consider the external workforce.

6.2 GP Services

General practitioner and primary care services are an integral aspect of the provision of healthcare. In 2014 in the Falkirk area there were 26 practices served by 132 General Practitioners.

Table 6.2a Number of GPs in Falkirk 2006-2014

Number of GPs (All GPs, headcount)	2006	2007	2008	2009	2010	2011	2012	2013	2014
	109	118	122	123	120	124	129	132	132

Source: ISD Scotland

The number of GP's in Falkirk has risen considerably over the past 9 years, however this only gives part of the picture as GP's are increasingly working fewer sessions than before and there are a substantial number of GP vacancies in the Falkirk area.

In 2014, the average practice size in Falkirk was 6,108 people.
Two practices in Falkirk served areas where approximately 40% of the population were living in datazones defined as the 15% most deprived. These were Slamannan Medical Practice and Carron Medical Centre. The practice in Slamannan is the only rural practice in the Falkirk area with 98% of the population living in a rural location, and in July 2015 it was operating under a 2C contract, which meant that it was being run by the health board.

The age of the practice population is rising and in 2014 Falkirk had a similar percentage of the practice population aged 65 and above to the average figure for Scotland.

Table 6.2b - Percentage of practice populations aged 65 plus - 2010 and 2014

Area	% of practice population aged 65+	
	2010	2014
Falkirk	15.7%	17.3%
Scotland	15.9%	17.2%

Source: ISD Scotland

6.3 Unscheduled Care

Unscheduled care is the unplanned treatment and care of a patient usually as a result of an emergency or urgent event. Most of the attention on unscheduled care is on accident and emergency attendances, and emergency admissions to hospital. The Scottish Government has made unscheduled care an important area of focus for the health service in Scotland, with reducing waiting times in A&E and reducing the number of emergency admissions as key targets.

6.3.1 Emergency Department Attendances

Since July 2011, Clackmannanshire, Stirling and Falkirk have been served by a single Accident and Emergency department at the Forth Valley Royal Hospital in Larbert. At this time the former A&E department in Stirling became a minor injury unit in Stirling Community Hospital. This provides minor injury services across the health board for people in Clackmannanshire, Falkirk and Stirling between 09:00 and 21:00 hours, 7 days a week. In June 2015, around 79.1% of accident and emergency attendees in NHS Forth Valley were at the A&E department. In June 2011, the month prior to the new structure being established, 76.9% of emergency attendances were to the A&E department.

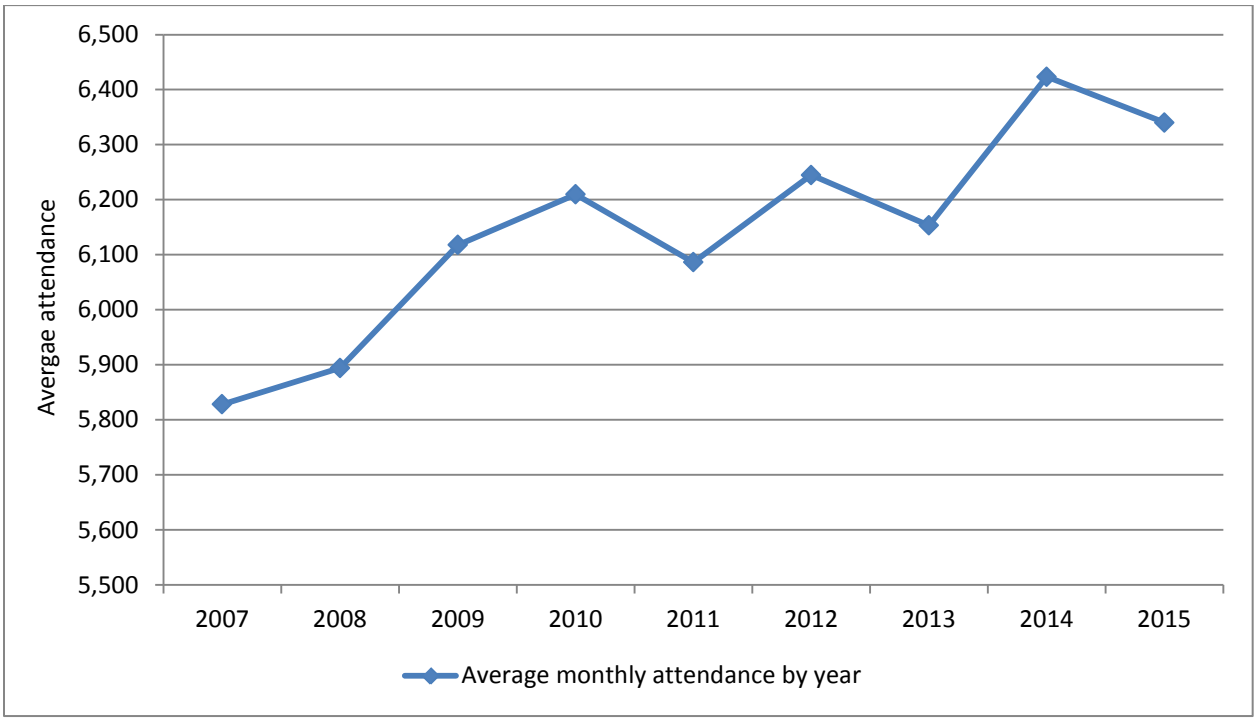
The average monthly attendance at an emergency department between 2007 and 2015 rose from 5828.2 in 2007 to 6340.2 by June 2015. This represents an 8.8% increase in the average monthly attendance over the time period.

Table 6.3.1b - Average monthly attendance at emergency department (A&E and MIU) by year

Year	Average monthly attendance
2007 (Jul-Dec)	5,828.2
2008	5,894.3
2009	6,117.9
2010	6,209.8
2011	6,086.3
2012	6,244.9
2013	6,153.4
2014	6,423.4
2015 (Jan-Jun)	6,340.2

Source: ISD Scotland

Figure 6.3.1c - Average monthly attendance at emergency department by year



Source: ISD Scotland

The average monthly attendance at the A&E department at Forth Valley Royal Hospital had risen from 4603 in 2011 to 5023 by June 2015. This is an increase of 9.1%. During the same period the percentage of people who met the 4 hour waiting times target each month ranged from a high of 97% in February 2014 to a low of 81.2% in December 2014.

6.3.2 Emergency Admission to Hospital

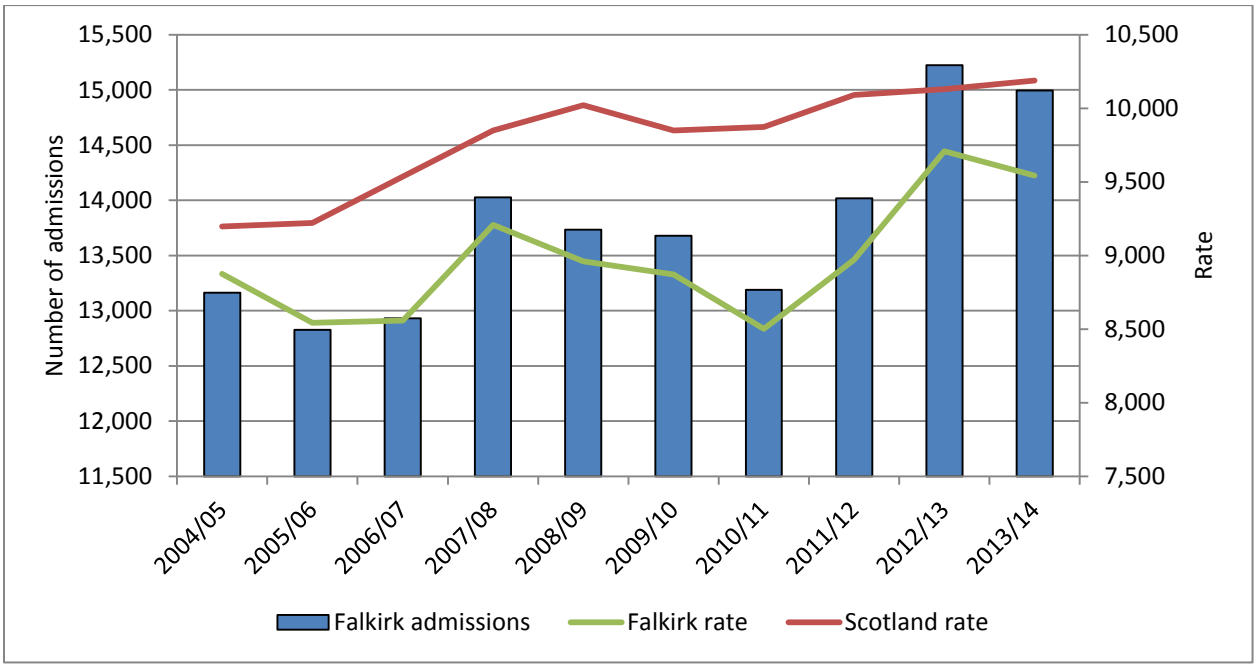
The number of emergency admissions to hospital has risen in the years between 2004/5 and 2013/14. Despite this, the rate of emergency admissions to hospital (per 100,000 population) in the Falkirk area has been lower than the rate for Scotland. *Note - the figures for admissions are based on the person's home postcode.*

Table 6.3.2a Emergency admissions to hospital - Falkirk 2004/05 to 2013/14

Local Council Area	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk admissions	13,163	12,825	12,931	14,025	13,734	13,678	13,189	14,016	15,223	14,995
Falkirk rate (per 100,000 pop.)	8,876	8,543	8,558	9,208	8,959	8,870	8,501	8,970	9,709	9,542
Scotland rate (per 100,000 pop.)	9,196	9,222	9,537	9,849	10,021	9,849	9,874	10,090	10,130	10,188

Source: ISD Scotland

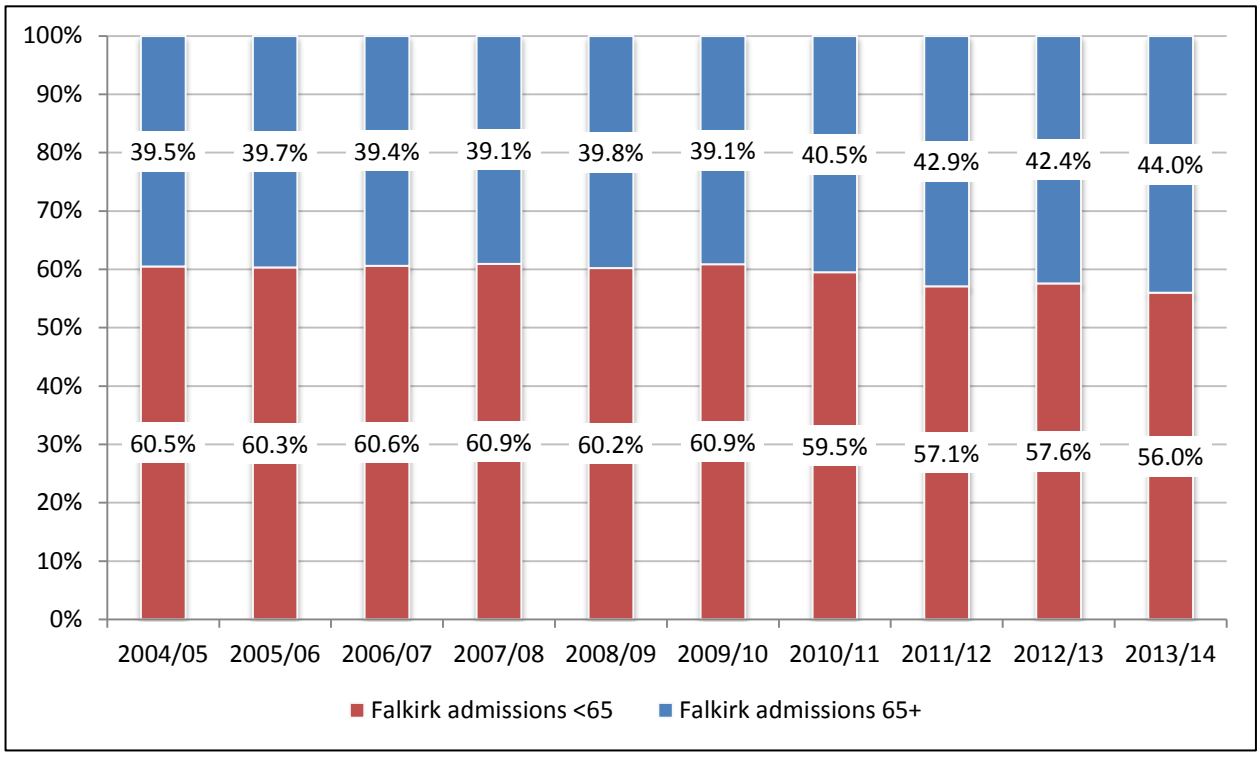
Figure 6.3.2a Emergency admissions to hospital – Falkirk 2004/05 to 2013/14



Source: ISD Scotland

Within the increase in the number of emergency admissions is an increase in the number of admissions for people aged 65 and above. A greater proportion of all admissions now come from this cohort of patients. Figure 6.3.2b below shows the increase of this group from 39.5% of all admissions in 2004/2005 to 44.0% in 2013/2014.

Figure 6.3.2b - Emergency admissions by age group Falkirk 2004/05 – 2013/14



Source: ISD Scotland

Multiple admissions

A primary focus of the work concerning emergency admissions is to reduce the number of patients who make multiple unplanned visits to hospital and who are then admitted. In Scotland the rate of patients who have multiple emergency admissions (2 or more) has been increasing since 2004.

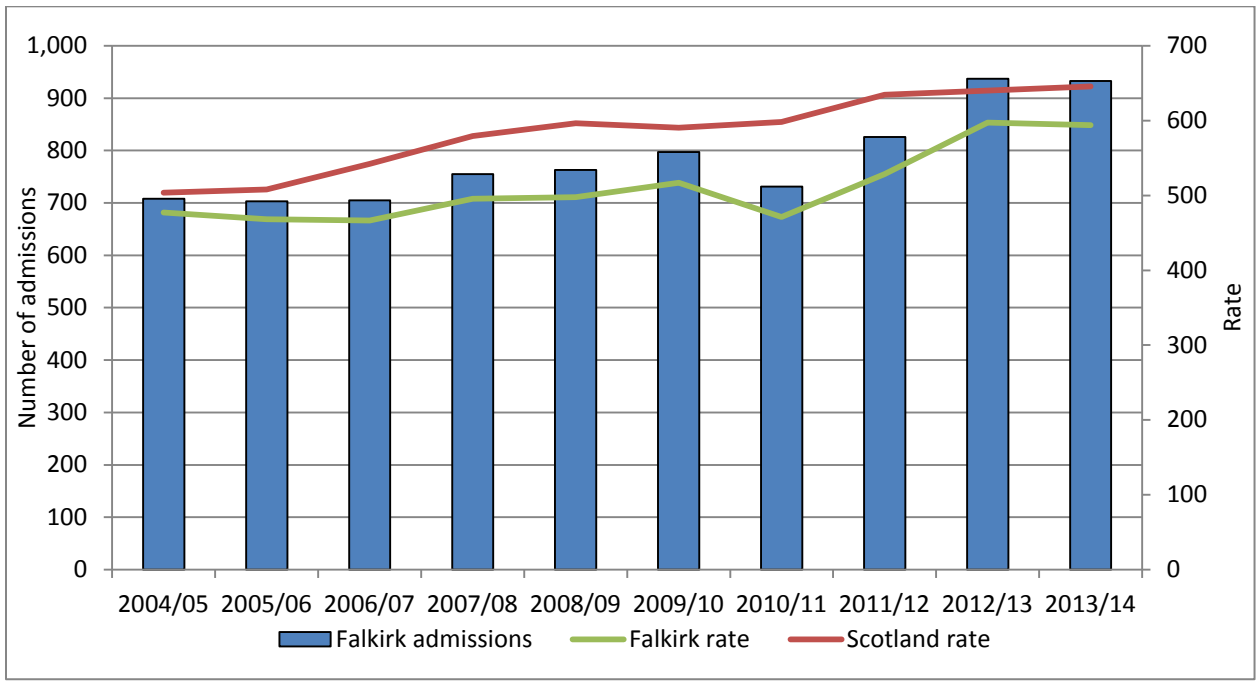
In Falkirk the rate for patients who have had 3 or more emergency admissions was higher in 2013/14 than in 2004/05. This information is shown in the table below.

Table 6.3.2b Rate and number of patients with two or more emergency admissions Falkirk 2004/05 – 2013/14

Local Council Area	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk admissions	708	703	705	755	763	797	731	826	937	933
Falkirk rate Per 100,000 pop.	477	468	467	496	498	517	471	529	598	594
Scotland rate Per 100,000 pop.	504	508	542	579	596	591	598	635	640	646

Source: ISD Scotland

Figure 6.3.2c – Rate (per 100,000 population) and number of patients with two or more emergency admissions Falkirk 2004/05 – 2013/14



Source: ISD Scotland

As with the number of total emergency admissions, the number of multiple emergency admissions for people aged 65 and above is also on increasing in Falkirk. The percentage increase of admissions for patients aged 65 plus is greater than the percentage increase for all ages.
The table below shows the percentage increase for all ages and those aged 65 plus between 2004/05 and 2013/2014.

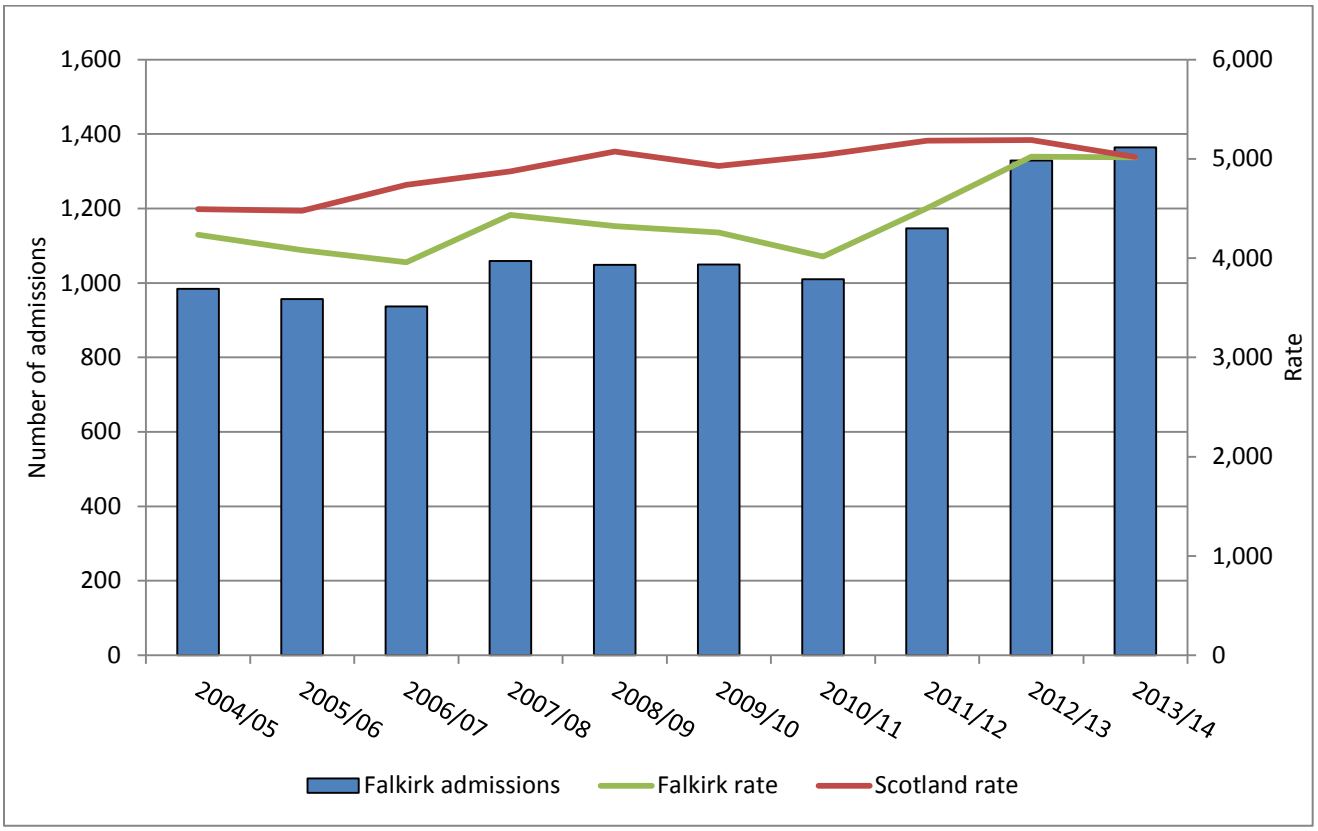
Table 6.3.2c - Increase in multiple emergency admissions 2004/05 to 2013/14

	All ages*		Age 65 +	
	No	%	No	%
Falkirk	474	22.3%	380	38.6%

*Patients with either 2 or more admissions
Source: ISD Scotland

Figure 6.3.2d below shows the trend of multiple admissions for people aged 65 and above from 2004/05 to 2013/14. It shows that in 2013/14 the number of multiple admissions in Falkirk was the highest it had been in a decade.

Figure 6.3.2d - Number and rate (per 100,000 population) of multiple emergency admissions for people aged 65+ in Falkirk 2004/05 to 2013/14.



Source: ISD Scotland

6.4 Delayed Discharges from hospital

A delayed discharge occurs when a patient, clinically ready for discharge, is prevented from being discharged back into the community because the necessary support or accommodation is not ready. Delayed discharge could be a result of social care issues, healthcare issues or patient/carer/family-related issues.

ISD Scotland routinely collects delayed discharge information in the Delayed Discharges Census and since June 2015 it has been reporting down to local authority level on a monthly basis. Table 6.4a below shows the figures for the most recent census in September 2015 at Falkirk and Scotland level. The table below focuses on longer delays but a delayed discharge is classed as the individual's discharge date minus the "Ready for Discharge" date.

The table shows for the September 2015 census a greater number of delayed discharges in Falkirk are 'over 2 weeks' (69%) compared to the Scotland average (59%). Falkirk compares more favourably in the longer delay categories where only a smaller percentage of people were delayed over 4 or 6 weeks in comparison to Scotland.

Table 6.4a – Number of delayed discharges in Falkirk and Scotland, ISD Census September 2015

	Total Standard Delays	Under 2 weeks	Over 2 weeks	Over 4 weeks	Over 6 weeks
Falkirk[1]	36	11	25	11	8
% of All Delays		30.6%	69.4%	30.6%	22.2%
Scotland	926	377	549	335	217
% of All Delays		40.7%	59.3%	36.2%	23.4%

Note: Percentages will not add to 100% as delays "over 6 weeks" are also over 2/4 weeks etc.
Source: ISD Scotland Delayed Discharges Census

1. Health Board figures are based on NHS board area of treatment. Local Authority figures are based on Local Authority of residence. There are a small number of patients experiencing a delay in discharge who are residents of local authorities out with the NHS board areas in which they are being treated. This may mean that the NHS board area of treatment is not responsible for the patient's post hospital discharge planning. This also means that the combined figures for local authorities within a particular NHS board area might not be equal to the corresponding total for that NHS board area.

Table 6.4b shows the number of standard and code 9 delays in Falkirk in the current financial year. Code 9 was introduced in July 2006, following discussions between ISD, the Scottish Government, health and local authority partners. This code was introduced for very limited circumstances where NHS Chief Executives and local authority Directors of Social Work (or their nominated representatives) could explain why the discharge of patients was out with their control.

Table 6.4b – All delayed discharges for Falkirk April 2015 to September 2015

Delay Type	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015
Standard Delay[1]	6	19	24	23	25	36
Code 9 Delay[1]	11	9	9	7	8	9
Total Delays	**17**	**28**	**33**	**30**	**33**	**45**

Source: ISD Scotland Delayed Discharges Census

Table 6.4c - Bed Days Occupied by Delayed Discharge Patients by age group and delay type – August 2015

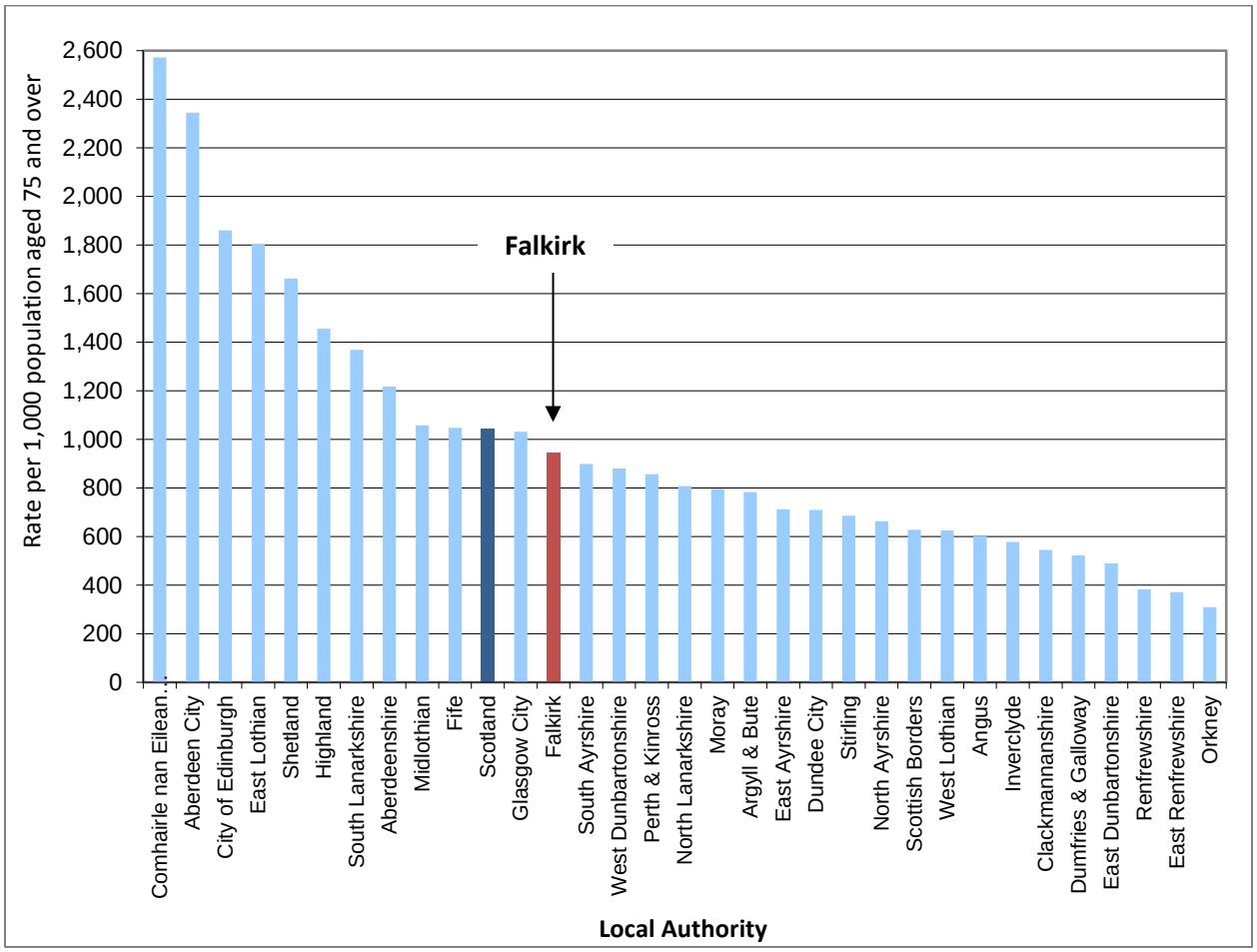
	All Ages					18 - 74 years					75 + years				
Local Authority of residence	Total	Standard	%	Code 9	%	Total	Standard	%	Code 9	%	Total	Standard	%	Code 9	%
Scotland	**48,526**	**38,144**	78.6	**10,382**	21.4	**14,435**	**10,468**	**72.5**	**3,967**	**27.5**	**34,091**	**27,676**	**81.2**	**6,415**	**18.8**
Falkirk	**1,125**	**918**	81.6	**207**	18.4	**196**	**196**	100.0	-	-	**929**	**722**	77.7	**207**	22.3

Source: ISD Scotland Delayed Discharges Census

The number of bed days occupied by delayed discharge patients in the August 2015 census is shown in the table above. There were in total 810 bed days occupied by delayed discharge patients in Falkirk with 84% of those patients aged over 75 years (compares to 69% at Scotland level). Code 9 delays made up a smaller proportion of 18-74 delays compared to Scotland though there was a greater percentage in the 75+ age group, on the whole Falkirk recorded a slightly greater percentage of Code 9 delays.

Figure 6.4a shows how the delayed discharge bed day rate (age 75+) for Falkirk compares to the Scotland average and neighbouring local authorities. The rate for Falkirk was slightly lower than Scotland on the whole.

Figure 6.4a –Delayed discharge bed day rate per 1,000 population aged 75+, April 2014 – March 2015



Source: ISD Scotland Delayed Discharges Census

Table 6.4d - Reasons for delayed discharges, Falkirk, April to September 2015

Month	Other	Healthcare arrangements	Awaiting place availability in a care home	Awaiting funding for a care home placement	Patients waiting to go home	Community Care Assessment reasons
April	1	0	2	0	1	2
May	1	0	9	0	2	7
June	0	0	16	0	2	6
July	1	0	15	0	1	6
August	1	0	14	0	4	6
September	0	0	28	0	2	6

Source: ISD Scotland Delayed Discharges Census

Table 6.4d shows gives a breakdown of the reasons for delayed discharges in Falkirk over the past 6 months. For the past 5 months there has been a significant increase in the number of delayed discharges due to care home availability. The most recent delayed discharges census highlights a 100% increase in care home availability delays for Falkirk, emphasising that this must be considered a priority area for improvement.

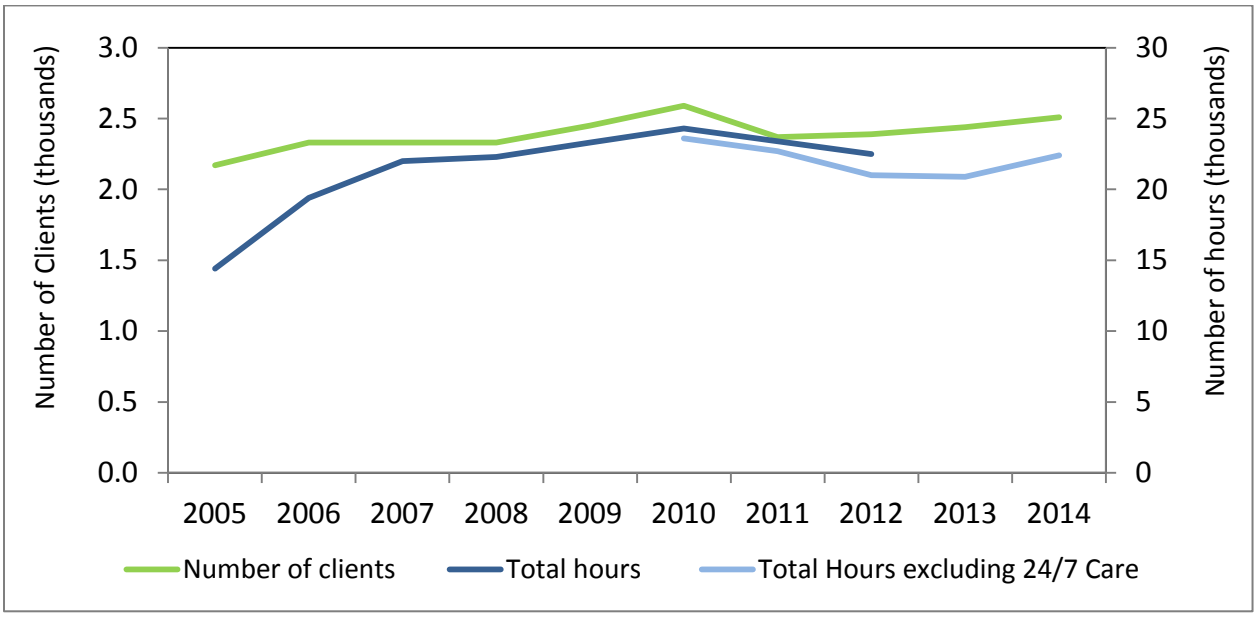
6.5 Care at Home

The 2014 Social Care Survey identified that there were 5,543 unique social care clients in the Falkirk area, of those clients, 2,511 were recorded as receiving care at home.

Figure 6.5a shows the number of people receiving care at home and the number of hours of home care provided over the period 2005-2014. Between 2005 and 2010 there was a clear rise in the number of hours of care at home which coincided with a rise in the number of people in the Falkirk area receiving care at home. In the following years there was a drop in people receiving care at home and a subsequent drop in hours of care provided. The number of people requiring care is again on the rise and in the past year the number of hours has followed suit.

In 2014 people receiving home care were provided with, on average 8.93 hours of home care.

Figure 6.5a – Number of people receiving care at home and hours provided, Falkirk 2005-2014



* from 2013 local authorities were asked to class 24-7 care as Housing Support, not Care at Home.

Source: Social Care Survey 2014

Table 6.5a: People receiving Care at home by age group, 2014

	0-64		65-74		75-84		85+		Total
Local Authority	No	%	No	%	No	%	No	%	
Falkirk	608	24.2	405	16.1	782	31.1	716	28.5	2,511

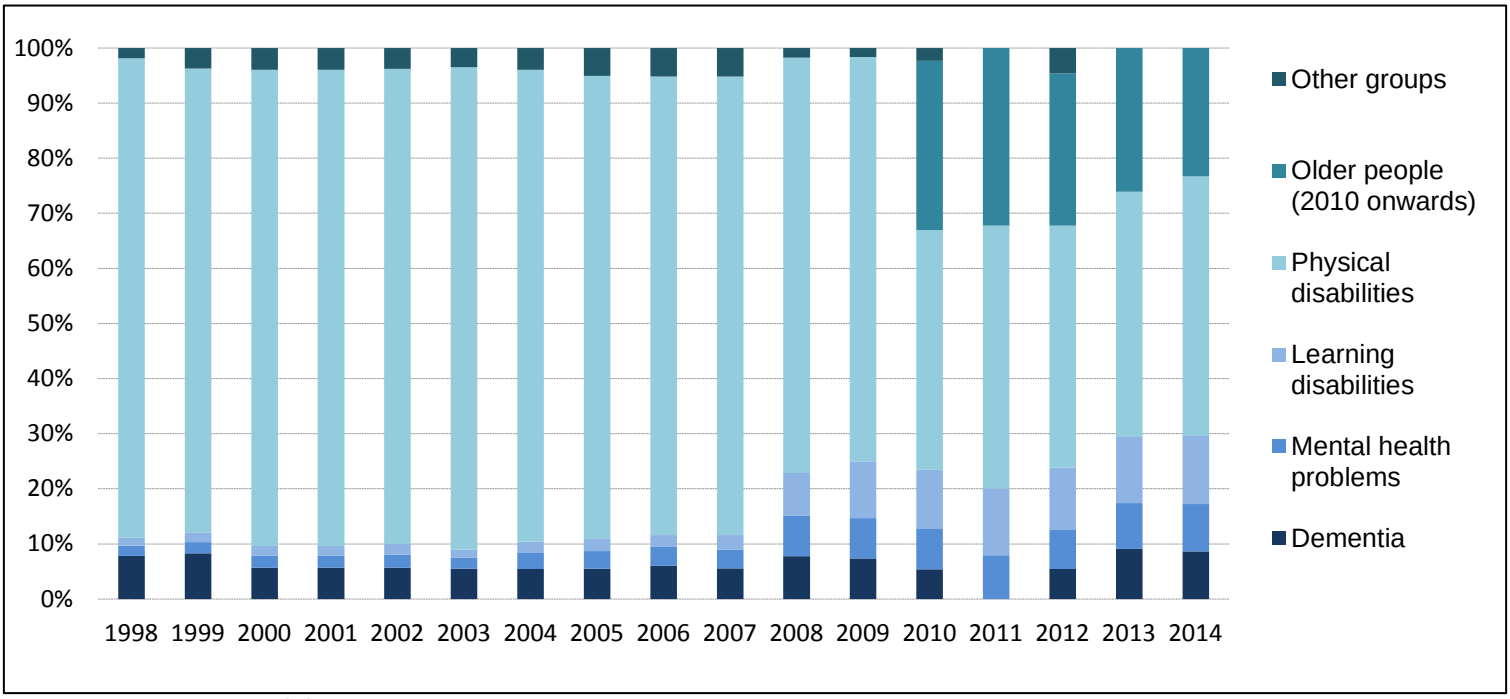
Source: Social Care Survey 2014

In 2014, nearly 60% of care at home clients were over 75 years and there was almost twice as many people receiving home care in the age bracket 75-84 years compared to 65-74 years.

The older age groups (65+) received 13,595 hours of care in 2014, on average 7.1 hours of home care per week in 2014, while those in aged 0-64 received on average twice as many hours home care per week (14.7 hours).

The chart shown below indicates that the people with a physical disability are the main users of home care services in the Falkirk area followed by older people. Dementia, mental health problems and people with learning disabilities make up around a third of the home care client base.

Figure 6.5b – Client group breakdown of home care services in Falkirk, 1998-2014



Source: Social Care Survey 2014

Note: Client group data is collected at initial assessment, it does not necessarily reflect the full needs of the patient. For example the patient may have physical disabilities and dementia, but could be designated in the physical disabilities client group.

Falkirk Social Work Services monitors a number of indicators which show the flexibility of home care services provided to the 65+ population. These are presented in the table below.

Table 6.5b – Falkirk home care performance indicators Age 65+, 2012/13 – 2014/15

	2012/13	2013/14	2014/15
Rate Home care hours per 1,000 population (65+)	490.2	526.5	483.6
% Receiving an Overnight Service	37.3%	42.4%	41.6%
% Receiving a Weekend service	77.4%	77.7%	77.9%
% Receiving a Personal Service	90.3%	91.6%	90.9%

Source: Audit Scotland – Community Care & Falkirk Social Work Annual Performance Statement

6.6 Self-Directed Support

Self Directed Support can help people live more independently by giving them choice, control, and flexibility over their support. In 2013 the Scottish Parliament passed a new law on social care support (the Social Care (Self-directed Support)(Scotland) Act 2013) which gives people a choice in how their social care and support is provided to them. Self-Directed Support (SDS) gives people control over an individual budget and allows them to choose how that money is spent on the support and services they need to meet their agreed health and social care outcomes. The options are described below:

Option 1: Taken as a Direct Payment (a cash payment)

Option 2: Allocated to a provider the individual chooses. The council or funder holds the budget but the person is in charge of how it is spent.

Option 3: The council can arrange a service chosen by the individual.

Option 4: The individual can chose a mix of these options.

The following table gives a breakdown of self-directed support options for the Falkirk population during the past year 2014/15. The vast majority of people chose option 3, only around 5% of people decided to take part or full ownership of their support funding.

Table 6.6a - SDS Breakdown for Falkirk - 1st April 2014 to 31st March 2015

SDS Options	No of Service Users (based on support plan)	%
Option 1	39	2.1
Option 2	27	1.4
Option 3	1788	95.2
Option 4	24	1.3
Total	1878	100

Source: Falkirk Council

6.7 Care Homes

The 2015 Care Home Census reported a total of 35 care homes currently operating in the Falkirk local authority with the facilities for 1,112 residents. The total number of residents in these care homes at the time of the Census was 977, giving an occupancy rate of 88% (Scotland occupancy rate – 86%). The vast majority of patients were long-stay residents with only 5% short-stay residents across NHS/LA, Private and voluntary care homes.

Table 6.7a – Summary of care home facilities in Falkirk, 2015 (Year as at 31st March)

Care Home Type:	Number of care homes	Patient Capacity	Current Residents	Occupancy (%)
LA/NHS	8	184	145	79
Private	20	848	749	89
Voluntary	8	89	83	93
Total	36	1121	**977**	**88**

Source: Scottish Care Homes Census, 2015

For 2015 the number of long stay residents rose slightly compared to the previous two years but was lower than the figure in 2012. The census reported that 70% of the long-stay residents required nursing care and nearly 60% of care home residents suffer from medically diagnosed dementia.

Table 6.7b – Key statistics for long stay residents in care homes for Falkirk, 2012-2015 (Year as at 31st March)

Type of Resident	2012	2013	2014	2015
Total Number of Long Stay Residents	**982**	**927**	**932**	**925**
Characteristics of Long Stay Residents	**%**	**%**	**%**	**%**
Requiring Nursing Care	62	68	69	70
Visual Impairment	23	25	26	24
Hearing Impairment	14	15	17	15
Acquired Brain Injury	*	*	*	*
Other Phys.Dis. Or Chronic Illness[1]	35	38	41	38
Dementia (Medically Diagnosed)	53	57	56	59
Dementia (Not Medically Diagnosed)	*	*	*	*
Mental Health Problems	15	12	11	9
Learning Disability	15	12	9	8
Alcohol Related Problems	*	*	*	*
Drugs Related Problems	*	*	*	*
None of these	*	*	*	*

1. The guidance for the physical disability/chronic illness question changed in 2009/2010 to include all age groups, therefore comparison with previous years is not appropriate.

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain resident confidentiality

Source: Scottish Care Homes Census, 2015

In 2015 the care home population in Falkirk was 69% female (31% male), identical to the Scotland population as a whole. The mean age of a care home resident in Falkirk was 81 years and the median age was 84 years. At the time of the 2015 census, the mean complete length of stay at a Falkirk care home was 2.8 years while the incomplete length of stay (for those still living at the care home at the time of the census) was 3.4 years.

6.8 Telecare

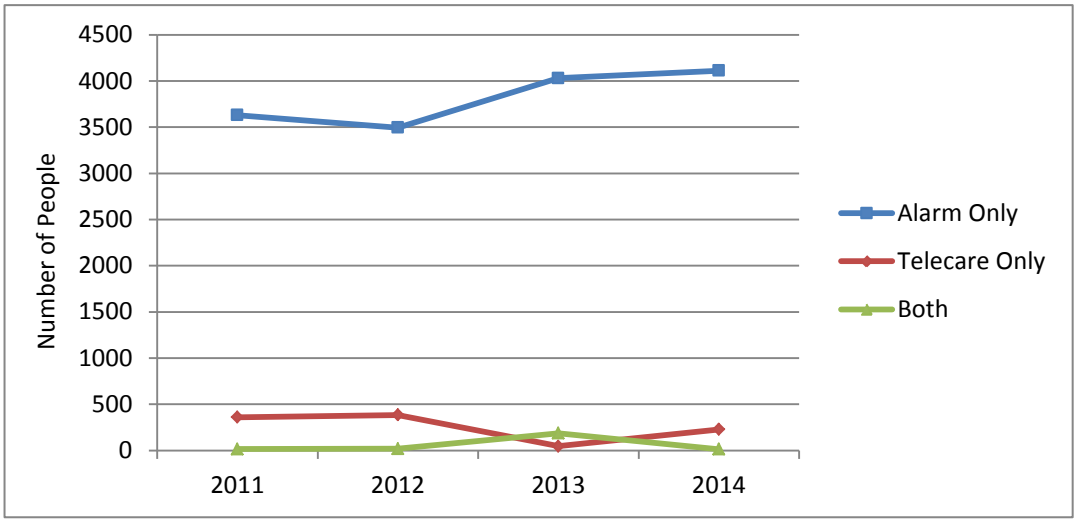
Telecare is a 24-hour remote monitoring system that uses a range of sensors and alarms to help people live safely and independently in their own home, with the reassurance that help is at hand in an emergency. Telecare systems can trigger a human response or shut down equipment to prevent hazards. The basic service is a community alarm (a basic package which consists of a communication hub plus a button/pull chords/pendant which transfers an alert/alarm/data to a monitoring centre or individual responder) while a more advanced Telecare package can be provided with technology such as linked Key Safes, linked smoke detectors or linked pill dispensers.

According to the 2014 Social Care Survey there were 4,353 people receiving some form of Telecare services in the Falkirk area in 2014, this is up by nearly 10% on the 2011 figure. The vast majority of these people (94%) had a community alarm in their home, and the remaining 6% had either Telecare only, or a combination of both.

The vast majority who receive Telecare services are elderly, disabled or vulnerable people. In 2014 85.5% of the recipients of the service in Falkirk were aged over 65.

The chart below shows the provision of Telecare services over the past 4 years.

Figure 6.8 – Breakdown of Telecare Services in Falkirk, 2011-2014



Source: Social Care Survey 2014

6.9 Equipment & Adaptations

Supplying elderly or disabled people with the appropriate equipment and/or aids can help them to live independently and safely at home. Equipment can also be of assistance to family or carers who care for someone who has, for example, difficulties with stairs or steps in their home.

Occupational Therapists work with people of all ages to help them overcome the effects of disability caused by physical or psychological illness, accident or ageing, and enable them to lead full and satisfying lives as independently as possible.

Falkirk social care services provided a total of 6,052 items of OT (Occupational Therapy) equipment in the last financial year. Despite an increase in 2012/13, the number of items provided has decreased over the past three years. In 2014/15, approximately a third of the items (66.8%) provided went to elderly people.

Table 6.9a - Number of OT equipment items provided, Falkirk 2011/12 to 2014/15

	Financial Year			
	2011/12	2012/13	2013/14	2014/15
Number of items	6,487	7,645	6,540	6,052
Rate per 1,000 Population (18+)	53.1	62.5	52.5	48.1

Source: Falkirk Social Services – Joint Loan Equipment Service (JLES)
OT – Occupational Therapy

If someone is having difficulty living in their current accommodation due to health or mobility problems, adaptations can be made to the property which helps to deal with these issues. Adaptations can take a number of forms such as grab rails or banisters, external lights or relocation of sockets for those who have trouble bending down.

Adaptations carried out by Falkirk Council over the past 5 years have been categorised in Table 6.9b below. Social Work funded adaptations are generally more simple adaptations, while owner occupier (grant-funded) and Council tenant activity refers to more expensive adaptations which have progressed via different funding routes.

The total number of adaptations has fluctuated over the past five years, but despite a drop in the last year, the number of adaptations has increased 9.5% since 2010/11.

Table 6.9b - Number of adaptations, Falkirk 2010/11 to 2014/15

Activity	2010/11	2011/12	2012/13	2013/14	2014/15
Social Work	566	552	719	682	714
Owner Occupiers	144	118	180	104	106
Falkirk Council Tenants	812	786	779	1,000	846
Total	1,522	1,456	1,678	1,786	1,666

Source: Falkirk Social Services – Abacus & Housing Service

6.10 Day Care

Table 6.10a shows the day care provided by the local authority in the past 3 years. There was a considerable rise in the number of day care days in 2014/15, though this reflects the even larger rise in people receiving day care services. On average the number of days per person has decreased from 3.3 days to 2.6 in the past 2 years.

Table 6.10a – Local authority day care provision, Falkirk 2012/13 to 2014/15

	2012/13	2013/14	2014/15
Days per week	560.5	551	791.5
Number of People	171	166	307
Days per person (Avg.)	3.3	3.3	2.6

Source: Falkirk Social Services (Abacus Financial System)

In addition to local authority day care, additional external day care was provided to 219 people in 2014/15 – this equates to 569 “sessions” per week.

6.11 Supported and Sheltered Housing

The Falkirk Housing Needs and Demand Assessment 2015 identified that there is a changing demographic profile in the area and the existing model of Housing with Care is not popular – the majority of older, vulnerable or disabled people would prefer to have their own home adapted and/or receive care at home (see associated rise in home care provision).

The main points from the Falkirk Housing Needs and Demand assessment are summarised below:

- In 2015 there were a total of 1,512 Housing with Care properties in Falkirk, most (758) were classified as Level 3 (Amenity), 673 were Level 2 (Sheltered) and 81 Level 1 (Very Sheltered).
- In addition to HWC properties there are also 20 elderly-specific properties.

- For 2013/14, a budget of c. £1.1m was committed towards adapting properties for people with disabilities or the elderly to meet their identified needs allowing them to remain in their homes.
- There are around 300 people with medical priority on the Council register. Using national research and the SHCS locally there is a need all tenure need for 510 wheelchair units locally[1].
- There was an increase of 21% in the number of people with learning disabilities known to the local authority over 2011-2014. Around 20% are over the age of 60. The majority of people with Learning Disabilities receiving services locally live in mainstream accommodation.

The housing support figures for the 2010/11 local housing budget is shown in the table below; they highlight an increase in expenditure on housing support for older people (9%) and those with a mental health issue (12%) compared to the 2007/08 budget.

Table 6.11 – Falkirk housing support expenditure 2007/08 – 2010/11

Group	2007/08 Budget	2010/11 Budget	% Change
Older People	£2,953,476	£3,208,495	9%
Sensory Impairment	£41,000	£41,820	2%
Learning Disabilities	£3,889,550	£3,859,304	-1%
Mental Health	£572,810	£642,996	12%
Physical Disability	£29,192	£29,661	2%

1 - Watson L et al (2012) *Mind the Step: an estimate of housing need among wheelchair users in Scotland,* Horizon Housing and Chartered Institute of Housing

6.12 Experience of Care Recipients

The Health and Care Experience Survey 2013/14 was commissioned by the Scottish Government as part of the Social Care Experience Survey Programme which aims to use the public's views on health and care services as a means to improve those services. This survey was sent to 15,146 people registered with a GP in the Falkirk area and received a total of 3,054 responses (44% Male, 56% Female). On the whole, service users responded very positively to the survey and the overall rating for help, care or support services was 87% positive.

A summary of the relevant indicators is presented below in Figure 6.12.

Figure 6.12 – Summary of care recipients experience in Falkirk – 2013/14

Source: Health and Care Experience Survey 2013/14

6.13 End of Life Care

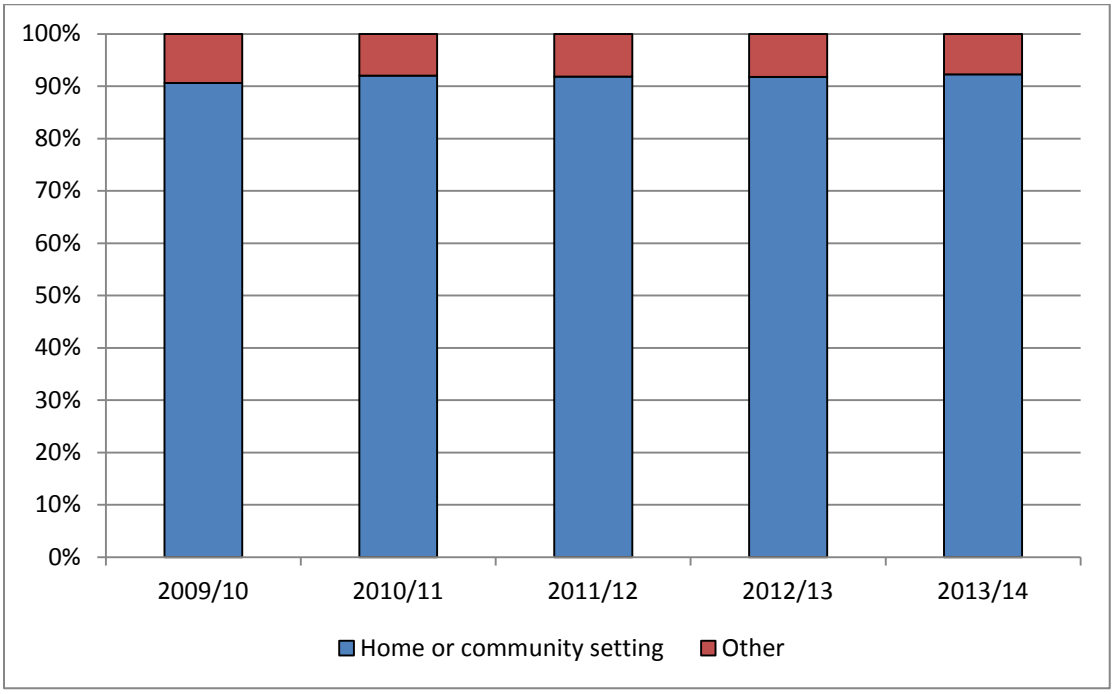
End of life care is an important measure to indicate whether adequate plans and structures have been put in place to allow patients to spend their last six months of life at home or in the community and not in an acute hospital setting.
Just over 9 out of every 10 patients in Falkirk spend the last six months of their life at home or in the community, this has been the case for every year between 2009/10 and 2013/14. The percentage nationally is similar.

Table 6.13a - Percentage of last six months of life spent at home or in a community setting

Council Area	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk	90.6%	92.0%	91.9%	91.8%	92.3%
Scotland	90.5%	90.6%	91.0%	91.1%	90.8%

Source: ISD Scotland and National Records of Scotland

Figure 6.13a - Percentage of last six months of life spent at home or in a community setting in Falkirk



Source: ISD Scotland and National Records of Scotland

6.14 Respite Care

The government report; Respite Care Scotland 2014 documents the level of respite care provided by local authorities in Scotland. Due to changes in recording and methodology over the years, not all years of data are comparable, however 2012/13 and 2013/14 are considered comparable and the figures for Falkirk are presented below. The number of daytime and overnight weeks of respite care decreased in Falkirk between 2012/13 and 2013/14, leading to an overall decrease of nearly 300 hours (8%).

Table 6.14a – Breakdown of total respite weeks provided in Falkirk 2012/13 – 2013/14

	Total Respite Weeks		Overnight Weeks		Daytime Weeks	
Local Authority	2012/13[1]	2013/14[1]	2012/13[1]	2013/14[1]	2012/13[1]	2013/14[1]
Falkirk	3,390	3,110	1,780	1,570	1,610	1,540

1 - Same methodology used in 2012/13 & 2013/14 making the figures comparable
Note – Figures are rounded to the nearest 10.
Source: Respite Care Scotland 2014

In 2013/14 the majority of respite care was provided to those aged over 65 (55.6%), more than the previous year (49.6%). There was also an increase in the number of overnight respite weeks for 65+ compared to the previous year. Respite care for the 0-17 age group is predominantly daytime respite care whereas there is significantly more overnight respite care provided for the 18-64 age group.

Table 6.14b – Breakdown of total respite weeks by age group, Falkirk 2012/13 – 2013/14

	Total Respite Weeks		Overnight Weeks		Daytime Weeks	
Age group	2012/13[1]	2013/14[1]	2012/13[1]	2013/14[1]	2012/13[1]	2013/14[1]
0-17	790	700	230	230	560	470
18-64	920	680	670	500	250	180
65+	1,680	1,730	890	840	790	890

1 - Same methodology used in 2012/13 & 2013/14 making the figures comparable
Note – Figures are rounded to the nearest 10.
Source: Respite Care Scotland 2014

Falkirk has one of the lowest levels of respite care provision and the rate per 1000 population is just over half of the Scotland figure. Increasing the provision of respite care in Falkirk could be fundamental in supporting, and providing relief for carers in the community.

6.15 Community Care Assessments

Community care teams conducted over 9,500 care assessments in the 2014/15 financial year, a slight increase on the past two years. Community care assessments are conducted for a number of reasons such as physical disability, visual impairment, elderly care and dementia.

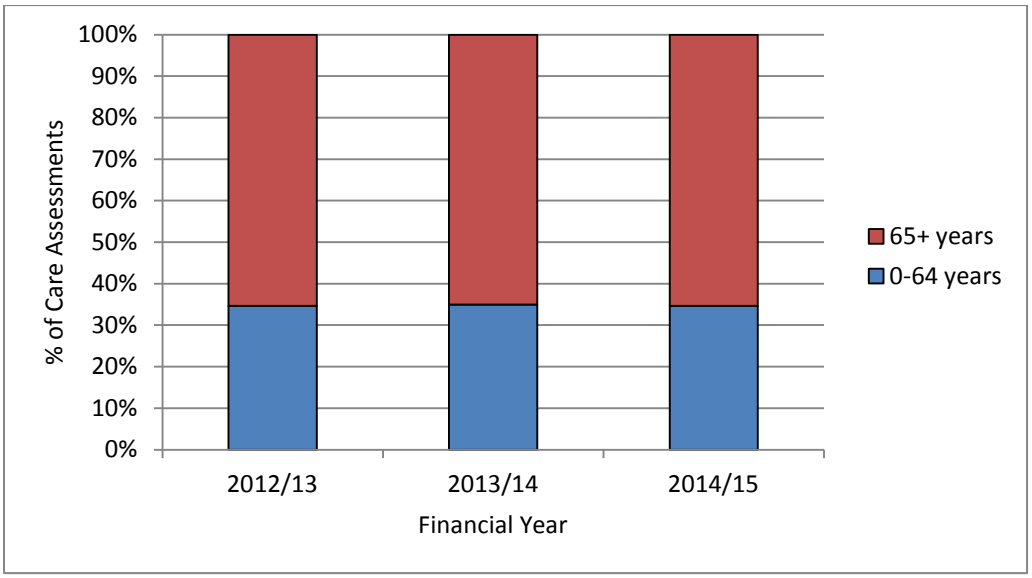
Table 6.15 shows that the number of community care assessments has increased over the past 3 years, though there has been little change in the proportions of assessments in the four age bands. Over 65's have accounted for roughly two thirds of care assessments in the past three years (Figure 6.15).

Table 6.15 – Number of community care assessments by age group, Falkirk 2012/13 – 2014/15

	Age Group				
	0-64	65-74	75-84	85+	Total
2012/13	3,099	1,622	2,473	1,740	8,934
% of Total	34.7	18.2	27.7	19.5	
2013/14	3,312	1,679	2,479	2,003	9,473
% of Total	35.0	17.7	26.2	21.1	
2014/15	3,293	1,566	2,667	1,978	9,504
% of Total	34.6	16.5	28.1	20.8	

Source: Falkirk Council Social Work Services
*Note that the figures above count initial assessments and reviews.

Figure 6.15 – Breakdown of care assessments by age Falkirk 2012/13 - 2014/15



Source: Falkirk Council Social Work Services

6.16 Adult Support and Protection

The Adult Support and Protection (Scotland) Act 2007 came into force in late 2008. The underlying ethos of the Act is the provision of timely support for adults at risk of harm. Falkirk Social Services submits adult protection data to the Forth Valley Adult Support and Protection Committee who produce an activity report based on submissions from Falkirk, Stirling and Clackmannanshire Councils. The key figures for Falkirk are shown in Table 6.16 below.

Table 6.16 – Adult Support and Protection Services, Falkirk 2012/13 to 2014/15

	2012/13	2013/14	2014/15
Number of Referrals	308	477	519
Number of Investigations	106	114	79
Number of Case Conferences	90	85	63
Number of Protection Plans in Place	26	17	21

Source: Forth Valley Adult Support & Protection Committee ASP activity report

The number of referrals for Falkirk has increased for the second year running and is up by 68.5% on the 2012/13 number. Despite the large increase in referrals,the corresponding numbers of investigations and case conferences are down over the past two years. The protection of vulnerable adults is top priority work; if extra social work

resource is required to accommodate the increasing number of referrals then other resources in other areas of social work could be impacted.

In the latest report, the most prominent care groups for referrals were dementia and learning disability while physical and financial harm were the most common types of harm reported. The rate of referrals increases with age, with the 85+ group receiving the most referrals.

6.17 Substance Misuse Support Services

The national HEAT (Health improvement, Efficiency, Access, Treatment) target stated that by March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. This was established to ensure more people recover from drug and alcohol problems so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy.

Falkirk is achieving a high standard for drug and alcohol treatment times with 99% of people commencing treatment within 3 weeks, the figures show that Falkirk is performing considerably better than Scotland (95.7%). Table 6.17a splits drugs and alcohol waiting times and shows that in 2014/15 Falkirk managed to commence treatment on 100% of clients within 3 weeks.

Table 6.17a – Falkirk Alcohol & Drug treatment waiting times, 2014/15

National Indicators	Falkirk		Scotland	
	N	%	N	%
Number & percentage of clients waiting more than 3 weeks between referral to a specialist **drug service** and commencement of treatment.	107	0.0%	16,915	5.6%
Number & percentage of clients waiting more than 3 weeks between referral to a specialist **alcohol service** and commencement of treatment.	184	1.6%	29,515	3.6%

Source: Drug and Alcohol Treatment Waiting Times Database (ISD)

Falkirk Alcohol and Drug Partnership's (FADP) main task is to identify what the main concerns are regarding local substance issues (Alcohol, Drugs, Tobacco, Solvents, Gases, over the counter or prescribed medicines that are used inappropriately and all illegal drugs. They also have an input in decisions about how monies identified for substance misuse services are spent covering education, prevention, treatment, availability & enforcement

Smoking Cessation

NHS Forth Valley Stop Smoking Support provides drop-in clinics that smokers can access without a referral or an appointment. These clinics provide advice, specialist support and where appropriate, free Nicotine Replacement Therapy (NRT). In Falkirk a drop-in clinic is held every Wednesday at Camelon Health Centre, with further Outreach clinic's provided at other practices in the area. All community pharmacies in Forth Valley also provide stop smoking support.

This section presents information on quit outcomes in 2014 compared to previous years, based on client follow-up at one and three months after the agreed quit date. Client follow up can be carried out face to face, by telephone or by letter/questionnaire and information on successful quits may either be self reported or validated using carbon monoxide (CO) breath testing.

Quit attempts and success rates for Falkirk and Scotland at 1 and 3-month follow ups are shown in Tables 6.17b and 6.17c. With the exception of 2014, Falkirk has fared well in comparison to Scotland at the 1-month stage; however success rates at 3-month follow up are considerably poorer than Scotland over the past 4 years. It is essential that efforts focus on helping people to sustain their attempt to quit smoking

Table 6.17b - Quit attempts and success rate at 1 month follow up; Calendar years 2009 - 2014

	2009	2010	2011	2012	2013	2014
Falkirk - quit attempts made	1,639	1,420	2,097	2,708	2,100	1,347
Falkirk - success at 1 month follow-up	706	651	919	1,167	838	453
Quit Rate - Falkirk	43.1%	45.8%	43.8%	43.1%	39.9%	33.6%
Quit Rate - Scotland	38.1%	39.2%	37.6%	38.4%	37.6%	35.4%
Comparison with Scotland	↑	↑	↑	↑	↑	↓

Source: NHS Smoking Cessation Service Statistics (Scotland) (ISD)

Table 6.17c - Quit attempts and success rate at 3 month follow up; Calendar years 2009 - 2014

	2009	2010	2011	2012	2013	2014
Falkirk - quit attempts made	1,639	1,420	2,097	2,708	2,100	1,347
Falkirk - success at 1 month follow-up	305	217	187	172	146	135
Quit Rate - Falkirk	18.6%	15.3%	8.9%	6.4%	7.0%	10.0%
Quit Rate - Scotland	16.8%	17.0%	15.8%	15.6%	14.2%	16.0%
Comparison with Scotland	↑	↓	↓	↓	↓	↓

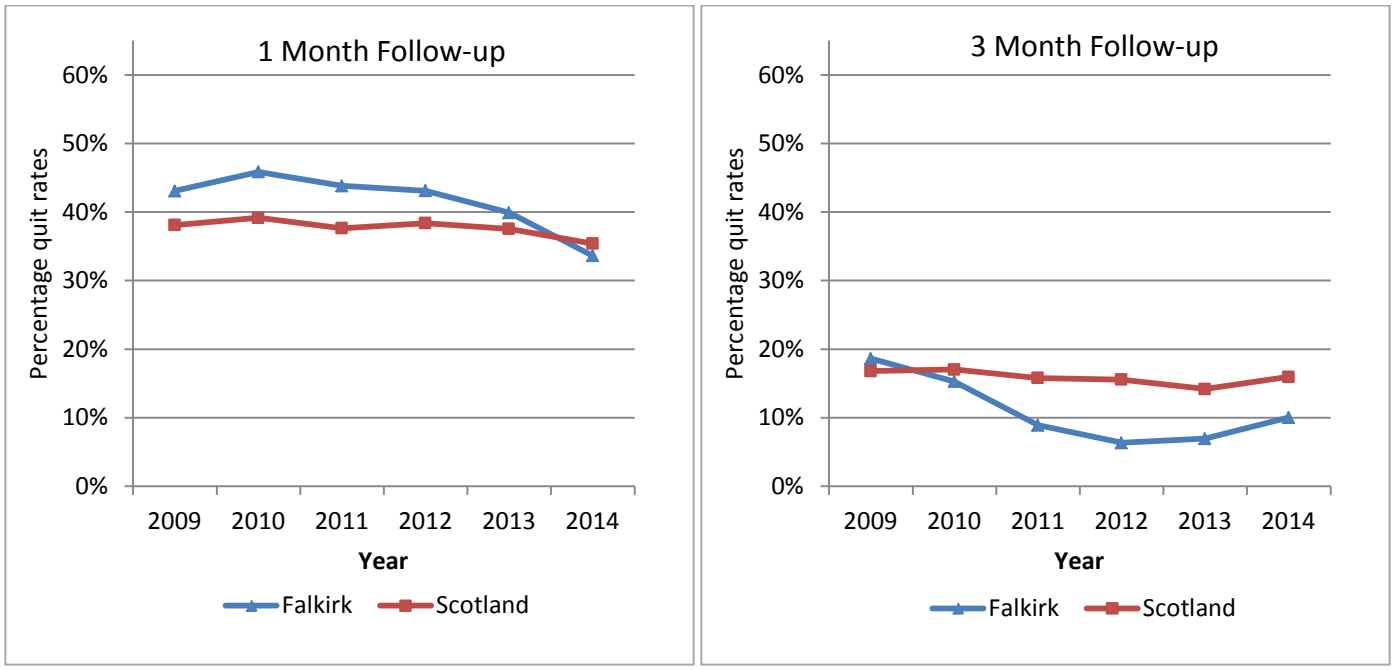
Source: NHS Smoking Cessation Service Statistics (Scotland) (ISD)

Key:

Achieved higher quit rate than Scotland	↑
Achieved lower quit rate than Scotland	↓

Tables 6.17b and 6.17c are presented below in a graphical format (Figure 6.17a), visibly showing that Falkirk smoking cessation services need to work towards sustaining the quit rate at 3-month follow ups.

Figure 6.17a - Quit success rates 1 and 3 month follow up, Falkirk and Scotland; Calendar years 2009 - 2014



Source: NHS Smoking Cessation Service Statistics (Scotland) (ISD)

6.18 Provision of Health and Social Care Services Considerations/Implications

- The number of GPs in the Falkirk area is on the rise (132 in 2014 compared to 109 in 2006), however the percentage of those aged over 65 is also increasing (up to 17.2% in 2014).
- The average monthly attendance at A&E and MIU has increased by 8.8% over the years 2007-2015. The rate of emergency hospital admissions has also increased over the past decade though it remains below the Scotland rate.
- The increase in rate of emergency admissions is accompanied by a greater proportion of over 65's being admitted, 39.5% in 2004/5 up to 44.0% in 2013/4.
- Emergency departments in their current form could struggle to meet the demands of the increasing elderly population, there has been a much greater rise in multiple admissions for over 65's (38.6% from 2004/5-2013/4) compared to just a 22.3% rise for all ages.
- 1,034 bed days were lost in July 2015 due to delayed discharges, over 75's accounted for 84% of those bed days.
- Over 65's received 13,595 hours of home care in 2014 (75.8% of the total home care hours), by 2037 the 65+ population is expected to have risen by over 72% (compared to 2012) – if home care provision was to remain at a similar level, almost 10,000 extra hours would be required.
- Expenditure on Direct Payments has risen considerably from £0.1 million in 2004/5 to £0.8 million in 2013/14, yet this not reflected in the number of people receiving direct payments, down by over 50% in the past two years.

7. Carers

7.1 Overview

A carer is a person who provides unpaid help or support to a family member, friend or neighbour who suffers from a disability, a long-term physical or mental illness or problems related to old age. There is no distinction made about whether that person provides that care within their own household or out with the household.

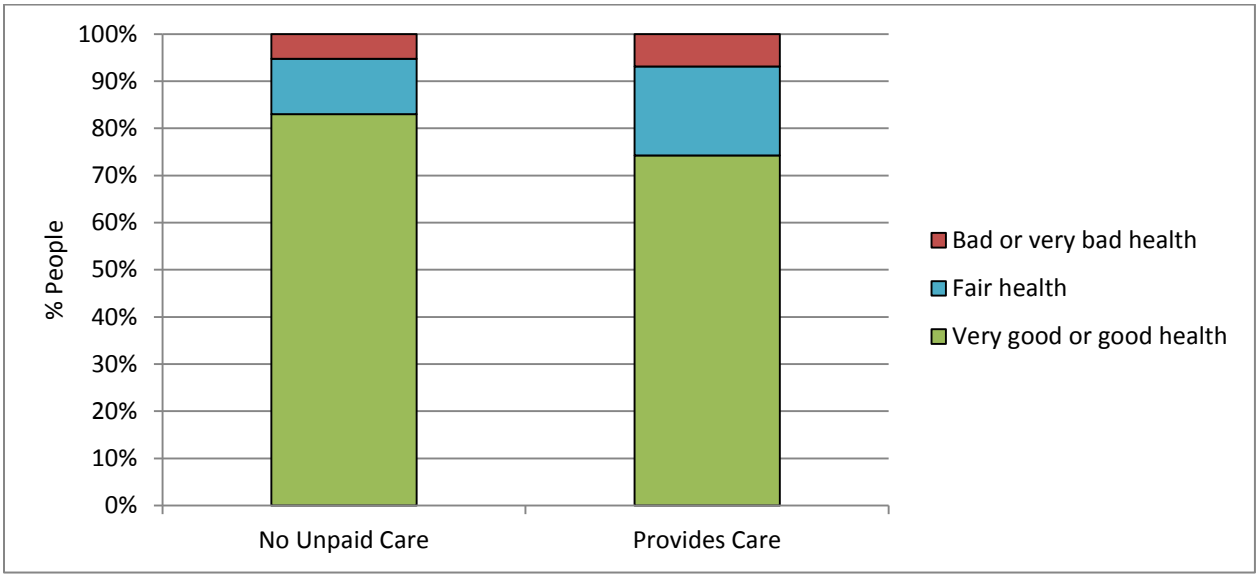
The provision of unpaid care is a key indicator of care needs and has important implications for the planning and delivery of health and social care services.

7.2 Characteristics of Carers

Utilizing data from the 2011 Scotland Census, an overview of carers in the Falkirk area is presented below:

- A total of 15,056 people were found to be providing unpaid care in Falkirk, 9.7% of the local population. The carer population was 59.5% female and 40.5% male.
- Approximately two thirds (65.4%) of those providing unpaid care are in the age band 35-64 years with those 65 years and over accounting for nearly a fifth (18.2%) of the carer population.
- Over a third (35.7%) of carers in Falkirk provide in excess of 35 hours unpaid care per week with 27.2% (of that 35.7%) providing over 50 hours unpaid care.
- 29% of those providing in excess of 35 hours care are aged 65 and over.

Figure 7.2a: Provision of unpaid care and general health in Falkirk, Scotland's Census 2011

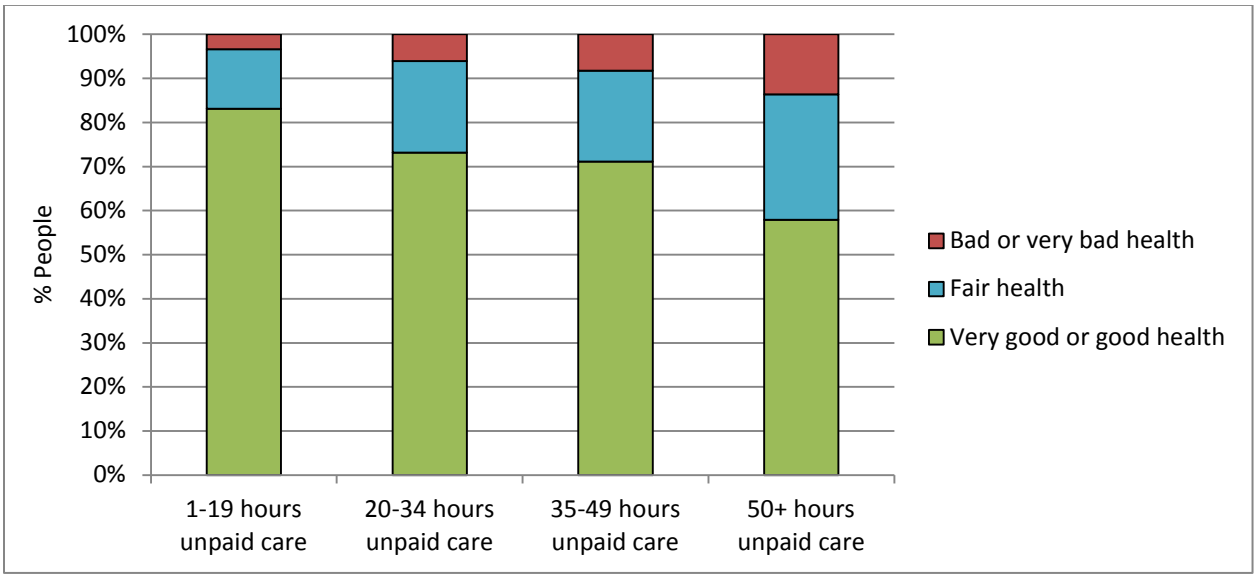


Source: Scotland Census 2011

Figure 7.2a shows that the proportion of those who class themselves as being of fair or bad/very bad health is greater for those providing unpaid care. Of the 18.2% of over 65s who provide care, only half (49.7%) would class themselves in good or very good health.

The chart below (Figure 7.2b) builds on the idea that the health of carers is worse than the population who do not provide unpaid care. There is a clear pattern showing that the health status of the carer deteriorates as the level of care provided increases. Less than 60% of those providing the highest level of care (50+ hours a week) consider themselves to be of good or very good health, compared to over 80% who do not provide unpaid care.

Figure 7.2b: General health by level of unpaid care provision - Falkirk, Scotland's Census 2011

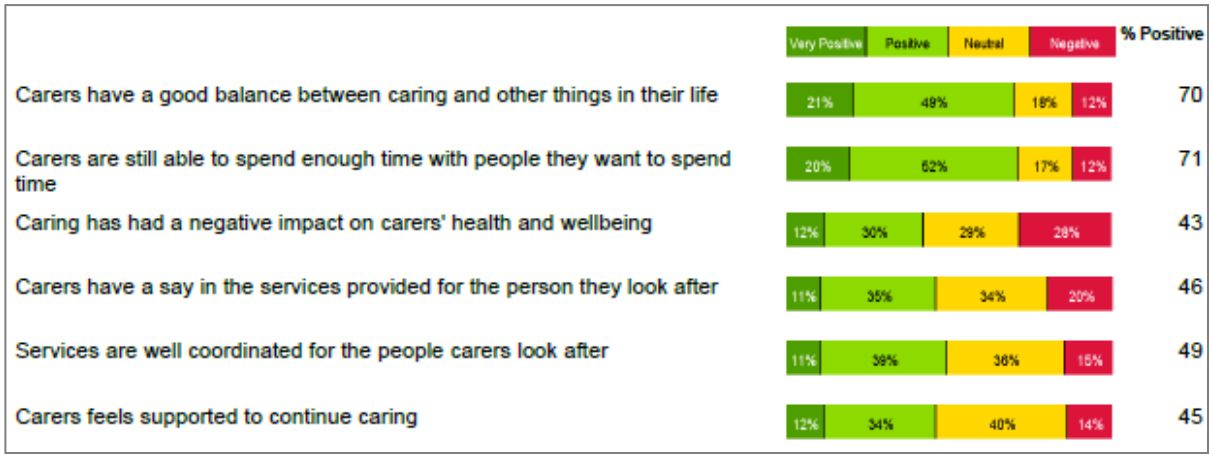


Source: Scotland Census 2011

7.3 Experience of Carers

The Health and Care Experience Survey not only looks at the experience of the care recipients but also the experience of those who provide unpaid care. Figure 7.3 provides a summary of responses from carers in Falkirk. Despite the majority of carers (70%) being positive about their caring/life balance, over 50% of people are neutral/negative about the impact caring has on their health and wellbeing. Less than 50% of carers responded positively when surveyed about the coordination of local care services and only 45% feel supported to continue caring.

Figure 7.3 – Summary of Carer Experiences in Falkirk 2013/14



Source: Health and Care Experience Survey 2013/14

7.4 Carers Implications/Considerations

- Over a third of carers in Falkirk (35.7%) provide greater than 35 hours care and nearly a third of those are over 65's. With over 50% of carers reporting that caring has a negative effect on their health and wellbeing, it is entirely possible that the over 65's carers of today will become those in need of care in years to come.
- The carer data from the 2011 Census showed a clear relationship between poor health and a greater number of hours care provided.
- The Health and Care Experience Survey 2013/14 highlighted that carers in Falkirk feel there is room for improvement in the services and support they receive.

8. Summary & Conclusion

8.1 Summary

This needs assessment has provided information describing current health and social care needs in Falkirk, and has forecast a significant increase in these needs.

Underpinning these needs are the concepts of engagement and redesign which are fundamental to making a real difference through integration.

Engagement with all stakeholders will also be required in identifying how to progress. This document has provided the basis for discussion on strategic planning and highlights the key areas of focus for the integrated services.

The following key issues have emerged from the needs assessment:

- Falkirk has an ageing population. Population projections forecast significant change in the age-profile of the local population over the next 25 years with the overall population expected to increase by over 10% while the 75+ population is projected to increase by 98% from the 2012 population. This has significant implications for service provision as over 75's are generally intensive users of health and social care. To coincide with the surge in the older population, the working age population is expected to decrease – crucially affecting the ability to provide services. The current models of health and social care will not be able to sustain this swing in population structure so there is a necessity for service redesign. It should be noted that although the projected increase in older people will have an impact on services older people make a valuable contribution to our society, both economically and socially, through, amongst other contributions, taxes, spending power, provision of social care and the value of their volunteering.
- There is a need to rebuild services in such a way to better meet the requirements of people with complex needs. Patients with several complex long term conditions are currently making multiple trips to hospital clinics to see a range of uncoordinated specialist services. A proposed way forward could be to look at developing new pathways and guidelines away from the current disease specific models to generic approaches focused on the holistic needs of patients (Lunt, 2013, p. 17).
- One of the aims of health and social care integration is to keep people living independently in the community for longer. The projected increase in the elderly population is likely to mean there will be an increasing need for un-paid carers. In turn, these un-paid will need to be supported.

- If current disease trends continue then there are likely to be increasing numbers of individuals requiring support for their disease or condition. However, these trends could be influenced positively through a continued focus on early intervention and prevention.

8.2 Conclusion

The traditional public service model – is to identify and 'assess' need and aim to meet it (on both an individual and population basis)

The public sector as we know it was established in the immediate post-war period where the population experienced poverty, overcrowding and slum housing. At this time the UK Welfare State was being established to ensure at least a minimum standard of living, through the National Assistance Act and a range of other legislation.

Since that time there has been great change:

- Demographic change (in part a result of the success of the welfare state)
- People living longer and healthier
- (This despite an increase in the prevalence of Long Term Conditions (LTCs) - due to a combination of new conditions and better/ earlier-diagnosis)
- So, the population of Falkirk is growing in size, ageing and increasing in complexity and multiplicity of health and social problems such that demand is exceeding supply in the present model
- There are rising costs and debt (national and personal)

However it may be argued that the traditional model for public services has often required individuals to abdicate responsibility, leading to ‘learned helplessness’ on the part of individuals, and risk aversion on the part of services / staff/ clinicians.

So there are positive consequences and negative consequences of current service provision. The changes experienced since 1945 are so great that the traditional model is no longer fit for purpose

The new paradigm needs to:

- put the individual person at the centre
- encourage individual responsibility and motivation for change to maximise wellbeing
- encourage ambition on the part of individuals, staff and all stakeholders
- encourage critical realism - the empathetic approach - based on intention, attention, mutual understanding, exploring options etc.

This is not to say that the individual is to be abandoned by public services, or that help will be with-held. Rather it is to recognise that intervention can be unintentionally disabling longer term, and that to maximise wellbeing longer term, we should provide support that is the minimum required to be effective, empathetic and enabling.

'Engagement' is key

- to recognise value as a key concept 'values-based value management'
- to consider how to maximise value generated by limited resources

The service implications, therefore are:

- real engagement ++
- workforce development in person-centredness
- wholesale, continuous redesign of public / third sector
- realistic access - e.g. consider signposting rather than referral (the onus is then on the individual to make the arrangements), but also a realistic increase in opportunities for access / addressing barriers (by working with carers and other stakeholders)
- realistic risk management - e.g. falls prevention (some risk of a fall needs to be accepted for the re-enablement process to occur)

The recommendations for the future therefore come under the following headings:

Engagement:

- Of the workforce in these issues, to generate understanding and a positive attitude to the future. And to build on workforce development in person-centred care (see appendix for examples)
- Of individuals – in their own health and wellbeing, facilitated by staff and other contributors and based on understanding, empathy, to improve connectedness, beliefs and values, knowledge and skills etc. (coming under the general heading of ‘resilience’). And thence to health improving behaviours – physical activity, diet and nutrition, no substance use; and also recognising adherence to medication and advice, for example, as a health behaviour.

Redesign:

- Wholesale public sector/ third sector redesign, outcomes-focussed yes, but recognising that process is key.
- Linking with engagement work – MCDM (Multi-criteria Decision Making), PSP (Public Social Partnerships) to reach a common understanding of goals and how these may be met
- Person-centred redesign – based on the above and work on person-centred care developed locally

- Working with CPPs (Community Planning Partnerships) on the 'determinants of health' with the aim of improving structural approaches and reducing the tendency for 'lifestyle drift'. And emphasising work as key to health (not just paid employment, but caring and volunteering) which is often the basis for meaning and purpose in people's lives.
- 'Integrated anticipatory care' – whereby the value of each of: prevention, early identification, treatment, management etc. is recognised in a spectrum of help/ intervention from a range of contributors – not least the person themselves (self-care).

If we make these changes....then we can expect

- better motivation in individuals - decreased risk factors, increased adherence to (minimal) intervention
- longer term, reduced disease (could be up to 40% or so)
- more efficient processes / less waste
- increased wellbeing, increased employability, increased work/ productivity of the population

Appendix A

Framework and Methods

A general philosophical framework considers ontology (what exists), epistemology (how knowledge is created) and logic (reasoning, causality and if...then relationships). The methods used attempts to work to the principles of applying these disciplines.

The following is a discussion of current and potential methods, in two groups – use of data items (usually singularly), and creation and development of models (using multiple data sources).

Data

- In using data it is important to consider their validity, which depends on the source, what the original intention was when they were generated, general reliability and validity etc.
- Population projections are based on modelling, using data from the census, modified to take into account various factors.
- Population projections tend to be inappropriately precise – down to single figures for single year of age – and are forecasts rather than predictions.
- Prevalence data often comes from a sample (e.g. through a survey) with the assumption that it is sufficiently representative, e.g. Scottish Health Survey
- Activity data relate to activity and any extrapolation to disease needs to be carried out with caution, e.g. data from ISD.
- Benchmarking is comparison with different areas' healthcare arrangements and again requires caution that the areas being compared are sufficiently alike.
- 'Synthesis' is applying data from one source to another to give an estimate – e.g. applying prevalence data to population projections (also known as spreadsheet modelling). It is important to be aware of the assumptions and caveats etc. with this kind of forecasting.

Models

- As discussed above models may be of different types – static or dynamic
- The findings section includes a large number of models, some of which are class models, others the beginnings of dynamic models (produced in a qualitative way but may be developed to using data)
- There is potential to use more sophisticated modelling techniques:
- Data envelopment analysis is used for assessing efficiency. Rather than simply benchmarking, it allows various data items to be combined as 'inputs', and others as 'outputs'. Plotting inputs against outputs for a range of 'decision making units' gives an 'efficiency frontier'. The advantage of this is that it gives a better idea of the scope for improvement for individual units, should inputs be increased.

- The origins and development of benchmarking have recognised the need to consider values, and processes in addition to a simple comparison of outcomes or outputs
- Discrete event simulation is used to forecast the results of changes in process or capacity at an operational level (see paper on modelling stroke beds)
- Systems dynamic modelling is higher level, considering 'stocks and flows' and might be used for modelling at the population level.

Needs assessment methods

What is need? One definition is the gap between 'what is' and 'what should be' – which is inherently a value judgement. Hence we need to be clear on the value base of this work.

NHS Forth Valley has specified 6 core values. These are:

- Respect
- Ambition
- Team work
- Supportiveness
- Integrity
- Person-centredness

It seems likely that in the process of integration these can be adopted by the whole of the public sector for Falkirk. A further value of 'fairness' could also be added, as our objectives include addressing inequalities.

The process of needs assessment could include expanding the agreed objectives, based on our values, to consider in more detail 'what is' and 'what should be'. For example, to be ambitious (a core value) about what 'should be' in regards to living longer and healthier lives we could say everyone should live a perfectly healthy life and die on or after their 100th birthday.

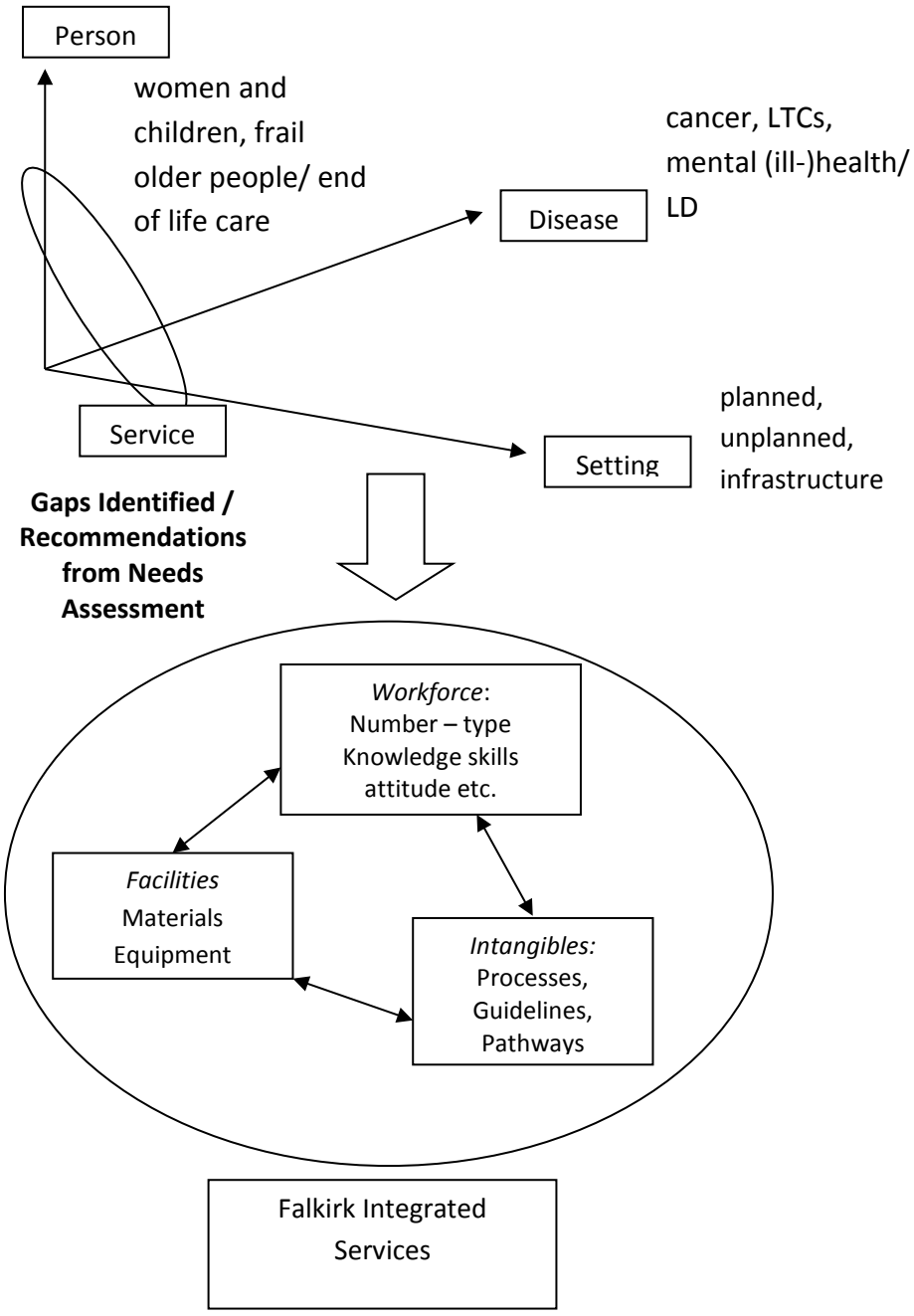
Types of need

The ontological basis of our needs assessment helps in defining types of need. Within this report we have described

- the people in our communities – demographics, but also their attributes in terms of life circumstances, risk factors, disease and long term conditions.
- The services and their attributes – including capacity

So need can be described at each level – population health and social care needs, which can be met by service activity; and service needs which require to be met in order to optimise service activity.

These elements come together as illustrated in the diagram below:

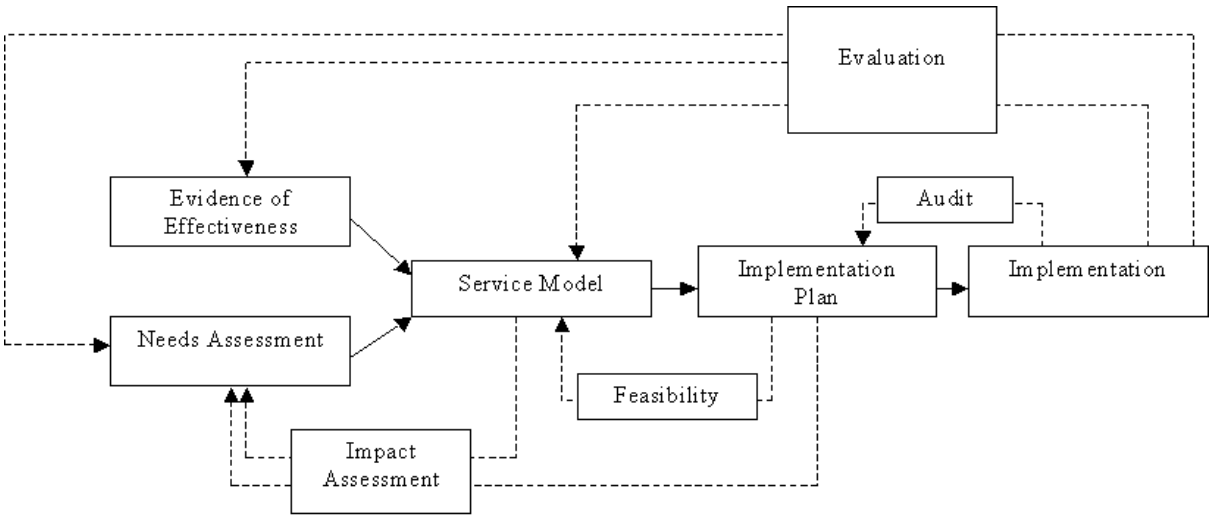


Beyond these needs, other types of need can be described, e.g. the 'engagement' needs of individuals – i.e. improvement in attitude and motivation in regard to the individual's own health, and for services organisational needs and redesign needs. In many ways a needs assessment is not required for us to know that there is significant room for improvement in each.

Further Description of needs assessment

Population based needs assessment tends to be one-size-fits-all whereas working from a person-centred holistic approach we want everyone to be treated as individuals – implies 150,000 or so needs assessments/ personal health plans

The process of needs assessment is iterative (encompassing impact assessment, evaluation etc.) – not just a one-off exercise



Interpretation of data can depend on perspective – is the glass half full or half empty? And identified need in terms of a gap does not imply that resources should be allocated to it necessarily – effectiveness, feasibility, fairness etc. must also be considered.

Curve Model

This needs assessment will feed in to a strategic planning process, for which there are a number of important factors to consider prior to implementation, summarised as the CURVE model for strategic improvement

CURVE is

- **C**ulture
- **U**nderstanding
- **R**esponsibility
- **V**alues, value, valuing
- **E**nterprise

Culture

Culture is defined as “what is learned, shared, and transmitted in a group – reflected in that group’s beliefs, norms, behaviours, communication and social roles” (Kreuter and Haughton, 2006)

Further it can be defined using the ‘model for a person’ and extending this to collective attributes of a group or community etc. – i.e.

Collective:

- Physical and social environment
- Behaviour and sensation / perception within this environment
- Memory, imagination, and emotion
- Knowledge, skills and creativity
- Beliefs, values and attitudes
- Identity
- Spirituality / sense of connectedness

Culture change

Culture changes over time. The extent to which this can be guided or facilitated is debatable. It has been suggested that certain factors can facilitate culture change at the ‘edge of chaos’. These are:

- Diversity
- Information flow
- Connectivity
- Reducing barriers or inhibitors
- Enhancing or increasing catalysts

- Watchful waiting
- Positive intent

Understanding

Knowledge is a personal attribute and collective knowledge is a community or cultural attribute. But to be really useful it needs to go deeper to form understanding. There are several senses to the term understanding:

- Awareness of a situation in context, its meaning – based on evidence. Being able to see how things relate to each other, often in complex ways.
- Having and demonstrating common understanding between individuals, which relates to empathy and positive intent.

Responsibility

Within the context of family support, for example, improvement ultimately relies on individuals taking responsibility. Such individuals may be children, parents, other family members, peers, public sector or third sector staff. A process of engagement and involvement may be required to facilitate this, as may the meeting of some basic needs. Within the public sector there is increasing recognition that individuals' rights need to be balanced with responsibilities (as described in the recent Patient Charter for the NHS in Scotland, which is derived from legislation)

Values, value, valuing

Fundamental to improvement work is the underlying set of core values to which we are working. NHS Forth Valley has defined its core values as:

- Respect
- Integrity
- Person-centredness
- Supportiveness
- Ambition
- Teamwork

Value is also an important concept, as improvement work / redesign is often aimed at increasing the value gained from the use of resources. Value can be subjective however and this needs to be considered.

Valuing can also be important in terms of appreciating resources or actions. For example if the services offered are not valued by people, uptake will decline as will value.

Enterprise

Organisations and partnerships are engaged in some form of enterprise – establishing a vision and working towards it. Entrepreneurship encompasses core skills that are relevant for improvement work in general:

- Establishing and developing networks, teamwork and collaboration
- Understanding value and value chains
- Identifying and developing personal skills
- Identifying and developing innovative practice
- Understanding motivation

The emergence of the concept of a 'Social Enterprise' is particularly important for the public and third sectors. In the field of social enterprise a "triple bottom line" is described consisting of the 3 'P's

- Profit (monetary value) – or value for money in public spending
- People (social value) – quality and effectiveness in making a real difference to people's lives
- Planet (ecological value) – long-term sustainability of public services

Implementation

Each element needs to be considered in some depth. The CURVE model sets out 'what?' but for implementation there needs to be a consideration of 'how?'

This strategic needs assessment document forms only the first part of a longer process which will involve:

- Further explication of needs from the information, in particular that produced down to locality level.
- Application of impact assessment processes, including Equality and Diversity Impact Assessment