

**Falkirk Health & Social Care  
Partnership**

**Draft**

**Joint Strategic Needs Assessment**

**September 2015**

## Table of Contents

1 Introduction .....	11
1.1 Background .....	11
1.2 Joint Strategic Needs Assessment .....	17
2 Population .....	19
2.1 Current Population.....	19
2.2 Projections of future population.....	24
2.3 Dependency Ratio .....	25
2.4 Population Considerations/Implications.....	26
3 Life Circumstances .....	27
3.1 Scottish Index of Multiple Deprivation .....	27
3.2 Housing .....	28
3.3 Fuel Poverty .....	29
3.4 Employment, Benefits and Financial Issues .....	31
3.5 Life Circumstances Considerations/Implications .....	33
4 Lifestyle/Risk Factors .....	34
4.1 Smoking.....	34
4.2 Alcohol .....	36
4.3 Drugs .....	38
4.4 Diet and Obesity.....	38
4.5 Lifestyle/Risk Factor Considerations/Implications.....	40
5. Population Health .....	40
5.1 General Health .....	40
5.2 Life Expectancy and Healthy Life Expectancy .....	41
5.3 Long Term Health Conditions .....	43
5.3.1 Dementia.....	44
5.3.2 Cancer .....	45
5.4 Projected Long Term Conditions.....	46
5.5 Multi-Morbidity.....	47
5.6 High Resource Individuals .....	51
5.7 Disability.....	53
5.8 Mental Health and Wellbeing .....	56

5.9	Premature Mortality .....	59
5.10	Cause of Death .....	60
5.11	Population Health Considerations/Implications .....	62
6	Current Provision of Health and Social Care Services .....	62
6.1	Workforce (Waiting for data from HR Work Stream project) .....	62
6.2	GP Services .....	62
6.3	Unscheduled Care .....	63
6.3.1	Emergency Department Attendances.....	63
6.3.2	Emergency Admission to Hospital .....	65
6.4	Delayed Discharges from hospital .....	69
6.5	Care at Home .....	71
6.6	Intermediate Care – In progress – Required? .....	73
6.7	Self-Directed Support.....	73
6.8	Care Homes .....	74
6.9	Telecare.....	76
6.10	Equipment – In Progress .....	77
6.11	Day Care – In Progress .....	77
6.12	Supported and Sheltered Housing – In Progress .....	77
6.13	Experience of Care Recipients.....	77
6.14	End of Life Care .....	78
6.15	– Respite Care – In progress.....	79
6.16	– Community Care Assessments In progress.....	79
6.17	- Provision of Health & Social Care Services Considerations/Implications .....	79
7.	Carers .....	79
7.1	Overview .....	79
7.2	Characteristics of Carers .....	79
7.3	Experience of Carers .....	81
7.4	Carers Implications/Considerations.....	82
8.	Conclusions and Next Steps .....	82

# 1.

## Executive Summary

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-centeredness
- 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 client (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

## 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-centeredness

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**

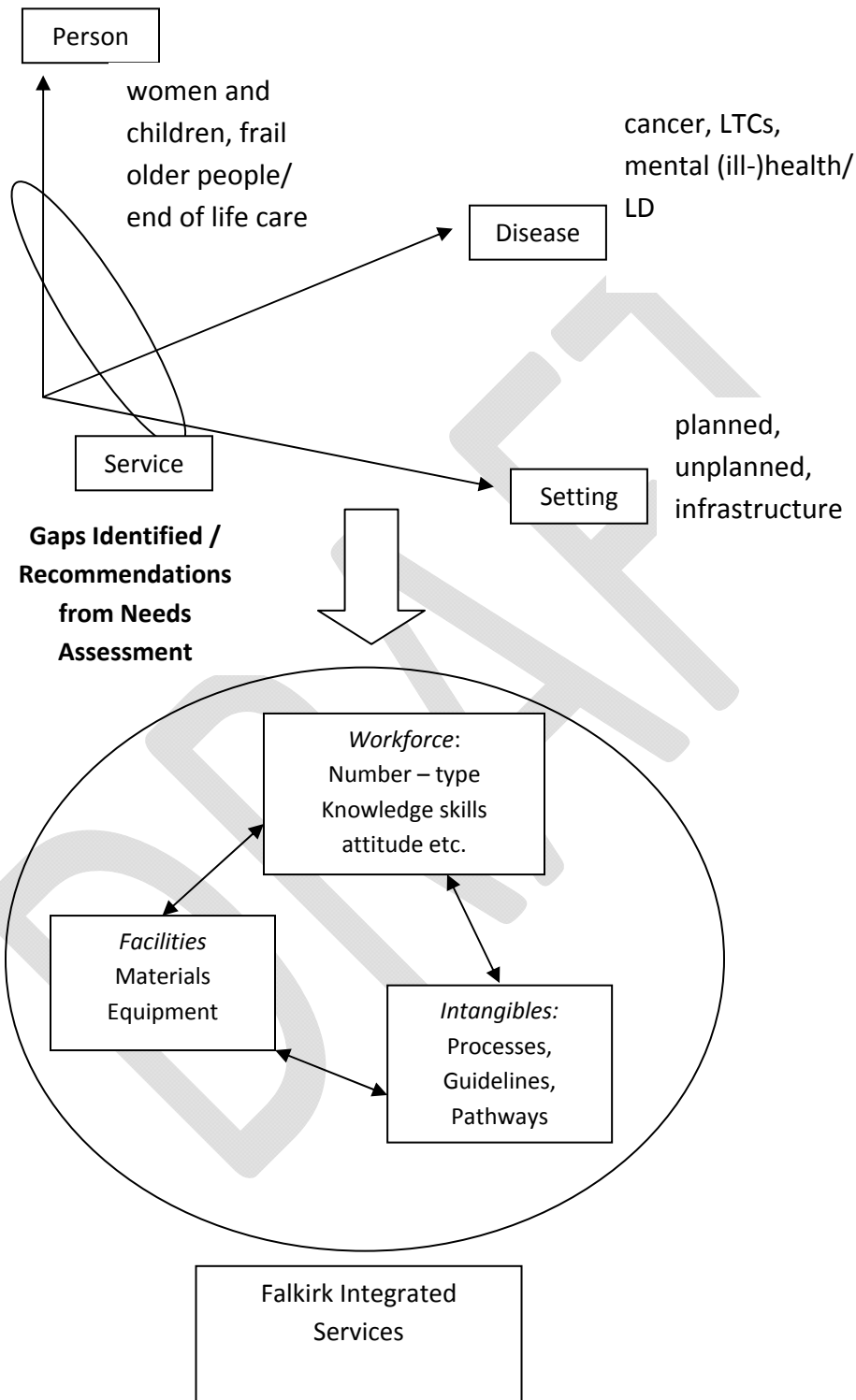
The ontological basis of our needs assessment helps in defining types of need. Within this report we have described

- 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:





Assessment

that tends to be one-size-fits-all whereas working  
we want everyone to be treated as individuals –  
personal health plans

is iterative (encompassing impact assessment, e

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# 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 9 high-level statements of what health and social care partners are attempting to achieve through integration have 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

Outcome:	Information Section					
	Population	Life Circumstances	Risk Factors	Population Health	Provision of Health and Social Care	Carers
Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer	● <sup>1</sup>	● <sup>2</sup>	● <sup>3</sup>	● <sup>4</sup>	● <sup>5</sup>	● <sup>6</sup>
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	● <sup>7</sup>	● <sup>8</sup>	● <sup>9</sup>	● <sup>10</sup>	● <sup>11</sup>	● <sup>12</sup>
Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected		● <sup>13</sup>			● <sup>14</sup>	
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		● <sup>15</sup>	● <sup>16</sup>		● <sup>17</sup>	
Outcome 5: Health and social care services contribute to reducing health inequalities		● <sup>18</sup>			● <sup>19</sup>	
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						● <sup>20</sup>
Outcome 7: People using health and social care services are safe from harm					● <sup>21</sup>	
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					● <sup>22</sup>	
Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services					● <sup>23</sup>	

### 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.

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

- Culture
- Understanding
- Responsibility
- Values, value, valuing
- Enterprise

## **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 client needs. Within the public sector there is increasing recognition that client rights need to be balanced with responsibilities (as described in the recent Patient Charter for the NHS in Scotland, which is derived from legislation)

Interaction between the themes:

	<b>Culture</b>	<b>Understanding</b>	<b>Responsibility</b>
<b>Culture</b>	-	Cultural understanding	Cultural responsibility
<b>Understanding</b>	Understanding culture	-	
<b>Responsibility</b>	Responsibility for culture	Responsibility for understanding	-

### **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 clients, 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?'

### **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 proposed localities for strategic planning purposes are:

**Add locality details once agreed**

DRAFT

## 2.

# 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.

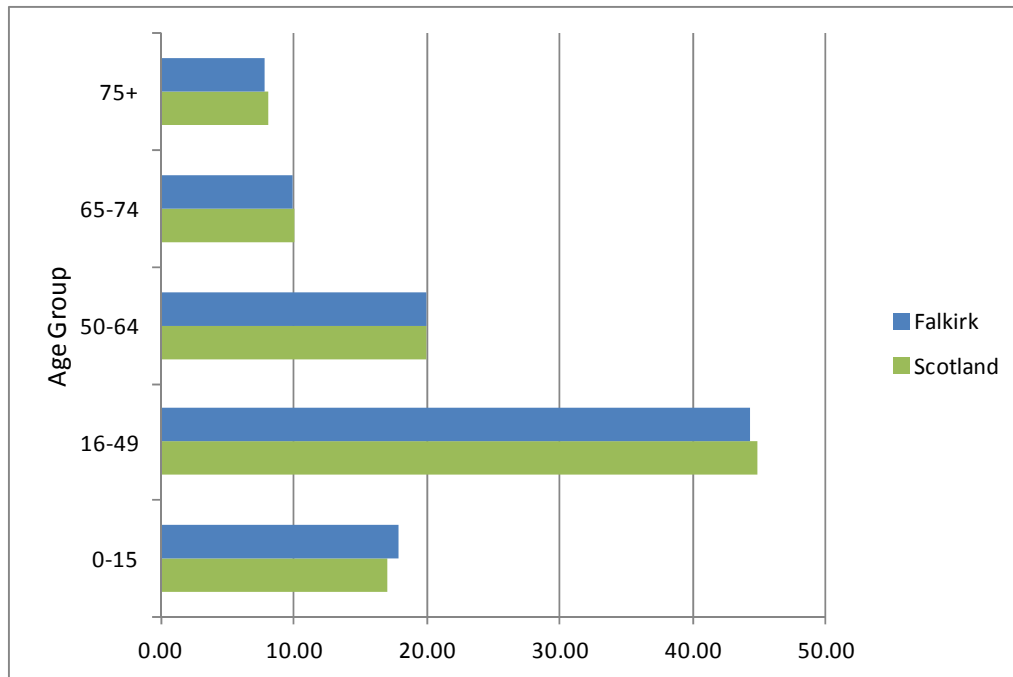
**Table 2.1a Falkirk Population Profile**

Age Group	Falkirk		
	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

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. Roughly 64% of the population are aged between 16 and 64, 17% under 16, 10% aged 65-74 and roughly 8% aged over 75.

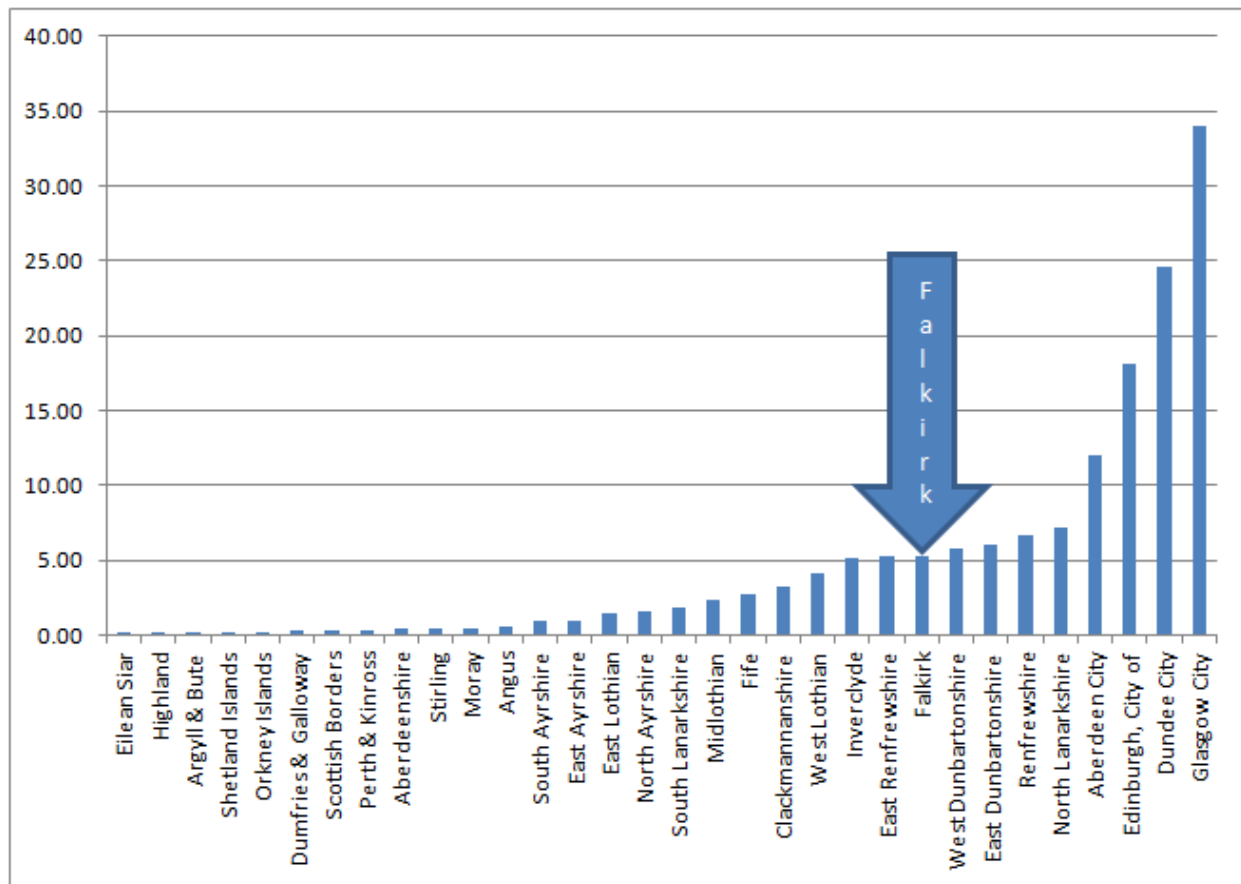
**Figure 2.1a Falkirk age distribution compared to Scotland**



Source: NRS Population Estimates 2014

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

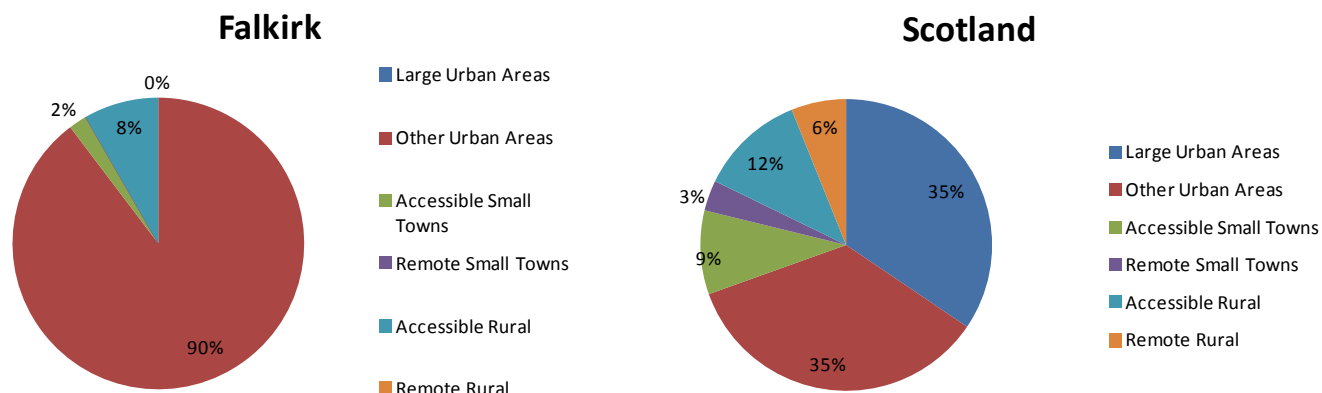
**Figure 2.1b Population Density (persons per hectare) 2011**



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 area.

**Figure 2.1c Population Density (persons per square kilometre) 2011**



Source: Census 2011

**Table 2.1b - Urban/Rural Classifications**

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.

**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 Religion in Falkirk is the Church of Scotland (36.5%). In both cases Falkirk has a larger percentage than Scotland on the whole; coincidentally 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

It is not possible to accurately report sexual orientation either at national or local level and it is likely that the numbers of LGB (Lesbian, Gay and Bisexual) are under-represented. The health needs of the LGB population are not well understood since they are not routinely identified in health surveys or population-based surveys. The Scottish Household Survey 2013 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 population; however the Falkirk population is primarily heterosexual with around 1% of the male population reporting themselves as Gay or Bisexual.

**Table 2.1e – Sexual Orientation by Gender for Falkirk and Scotland 2013**

Sexual Orientation	Falkirk (%)*		Scotland (%)*	
	Male	Female	Male	Female
Heterosexual / Straight	99	100	98	99
Gay / Lesbian	1	-	1	0
Bisexual	1	-	0	0
Other	-	-	0	0
Refused / Prefer not to say	-	-	1	1
Base (Population Examined)	240		9920	

Source: 2013 Scottish Household Survey

\*In general, percentages in tables have been rounded to the nearest whole number. Zero values are shown as a dash (-), values greater than 0% but less than 0.5% are shown as 0%, and values of 0.5% but less than 1% are rounded up to 1%. In line with the Code of Practice for Official Statistics base numbers have been rounded to the nearest 10.

## 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 & social care services. The NRS population projections (Table 2.2a) show the estimated change in the population to 2037.

**Table 2.2a Population projections to 2037**

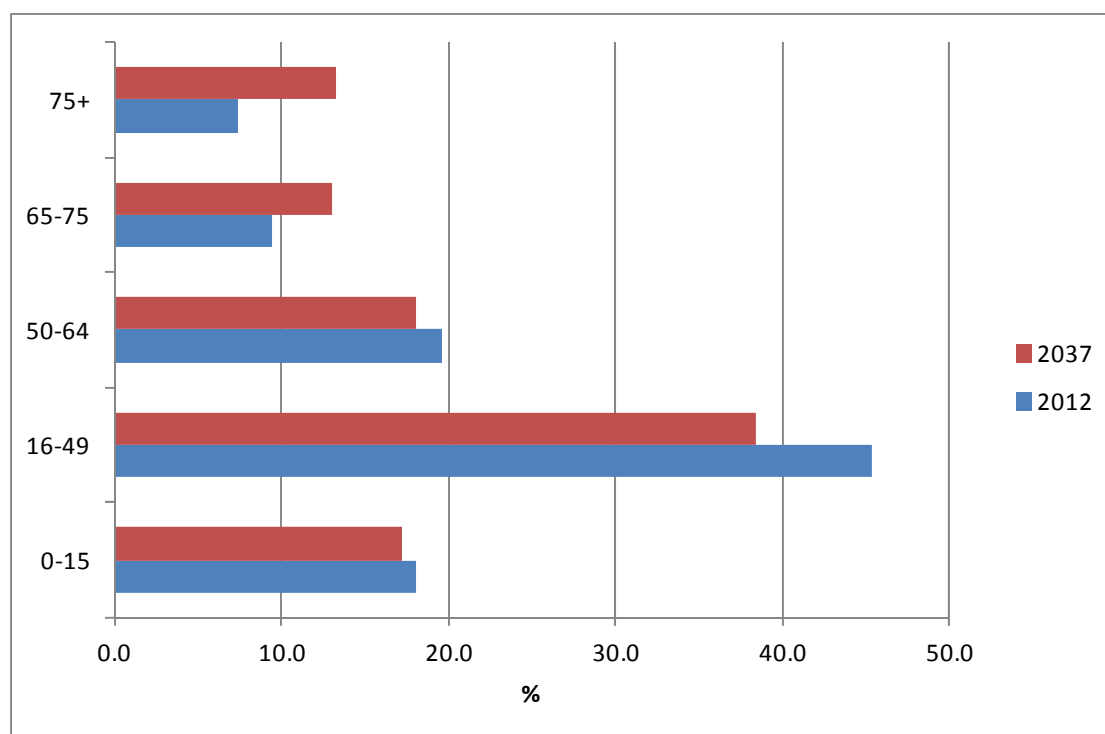
Age Group	2012		2032		2037	
	#	%	#	%	#	%
0-15	28,423	18.1	29,525	17.3	29,771	17.2
16-49	71,097	45.3	66,086	38.7	66,623	38.5
50-64	30,820	19.7	33,433	19.6	31,253	18.1
65-75	14,871	9.5	21,457	12.6	22,560	13.0
75+	11,589	7.4	20,117	11.8	22,923	13.2
Total	156,800	100	170,618	100	173,130	100

Source: NRS Population Estimates

The size and shape 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**



Source: NRS Population Projections

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.

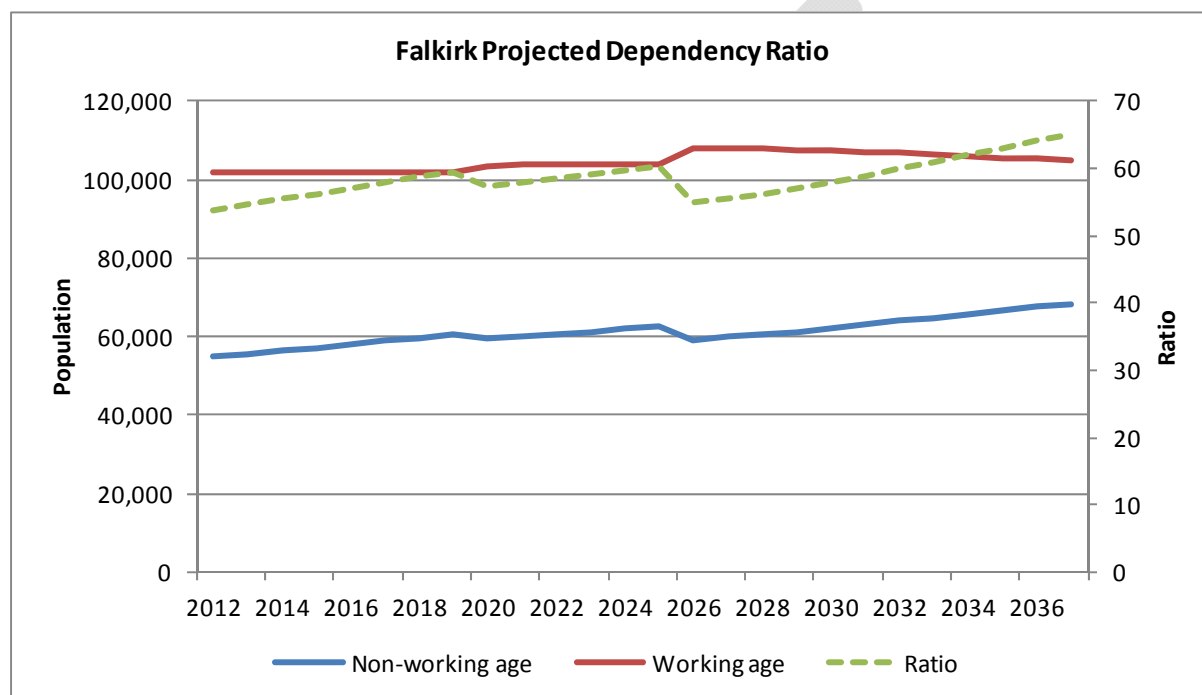
**Table 2.3a – Projected Dependency Ratios to 2037**

Year	2014	2015	2020	2025	2030	2035
Falkirk	55.5	56.2	57.4	60.3	58.0	63.1
Scotland	54.2	54.8	55.8	59.8	57.8	61.7

Source: NRS Population Projections

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.

**Figure 2.3a – Falkirk Projected Dependency Ratios to 2037**



Source: NRS Population Projections

## 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.

## 3 Life Circumstances

### 3.1 Scottish Index of Multiple Deprivation

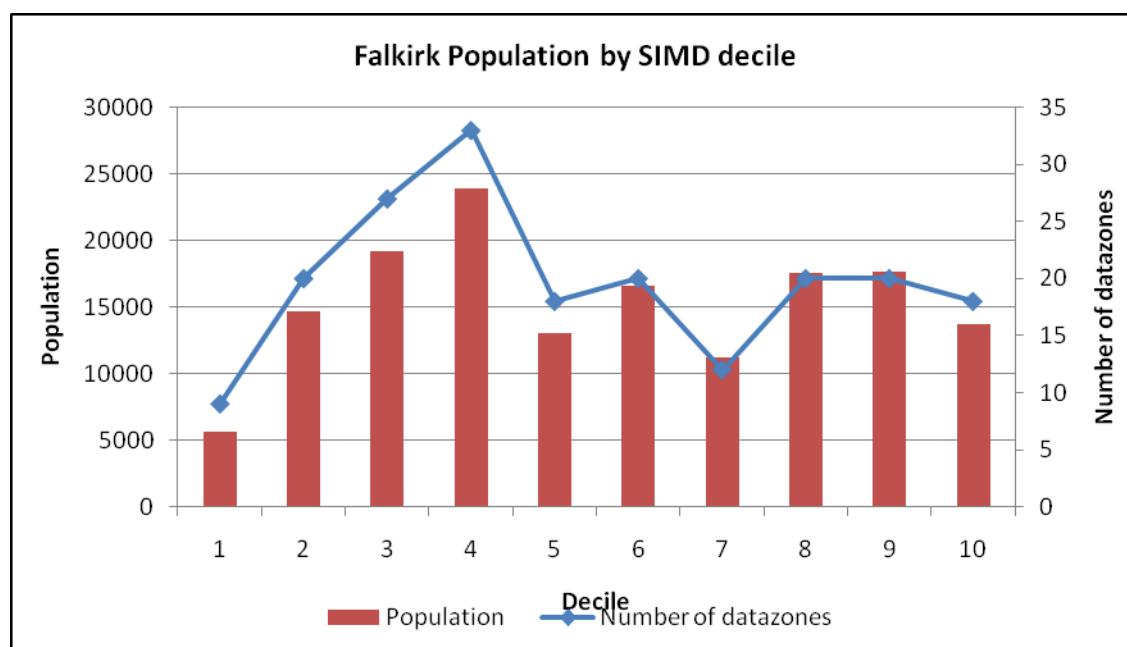
The Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations of multiple deprivation across all of Scotland. It ranks small areas called datazones from the most deprived (ranked 1) to the least deprived (ranked 6,505). One way ISD uses these is to divide all of the datazones in Scotland into 10 equal deprivation deciles, by calculating each individual zone's rank 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 area, with 76,540 people in 107 different datazones. In contrast, the 76,740 people in the highest five deciles are in 90 different 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

This section will provide an overview of the housing issues in Falkirk.

- The National Records of Scotland household projections predict that household numbers will increase between 2012 and 2037 Falkirk's increase will be lower (16%) than Scotland's (17%).
- The percentage of those households headed by someone aged 75 and over is estimated to increase from 2012-2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 83%.

- In 2013 home ownership 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%.
- Since 1999 there has been an 8% increase in private renting and a 14% decrease in social renting in Falkirk (Scottish Household Survey 2013).  
In Scotland, private renting has increased by the same figure, 8% but social renting has only decreased by 9%.
- 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).
- <https://www.falkirk.gov.uk/services/homes-property/policies-strategies/local-housing-strategy.aspx>
- 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, and of that 100 were to be new-build affordable housing and 133 that were to make best use of existing housing stock.

### 3.3 Fuel Poverty

Fuel poverty is a measure based on a calculated spend on energy and fuel compared to the annual household income. If the energy spend is greater than 10% of the household income then the household is considered to be fuel poor. This includes spending for heating, lighting and appliances, and cooking. The implication for being fuel poor is that the household would be unable to use appliances or heat and light their property to a suitable standard. 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 it.

Extreme fuel poverty is where the cost to fuel the household to the required standard would be greater than 20% of the annual household income.

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.

**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 helps to reduce fuel poverty 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 unlikely 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 return 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 couple of 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 (actively seeking work)	Economically inactive (includes retirees & students)	Long-term sick or disabled
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.

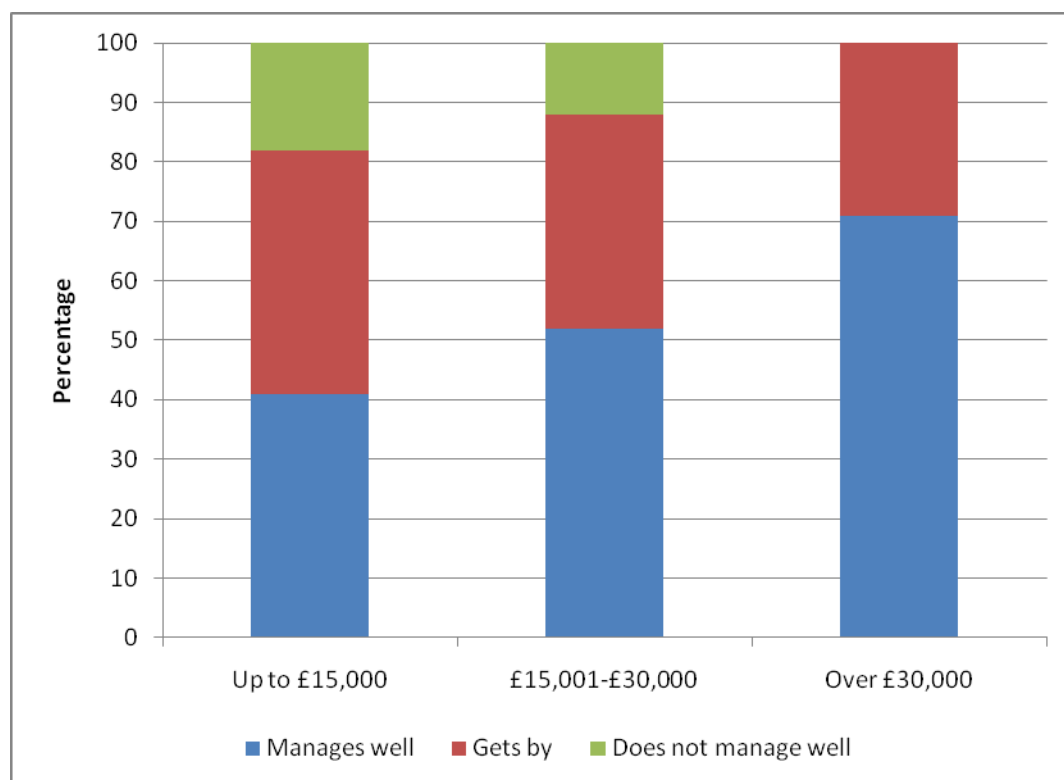
**Table 3.4b Housing benefit claims by local authority May 2015**

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, 20% of households whose main income is through benefits do not manage well either. *Are these the same people?*

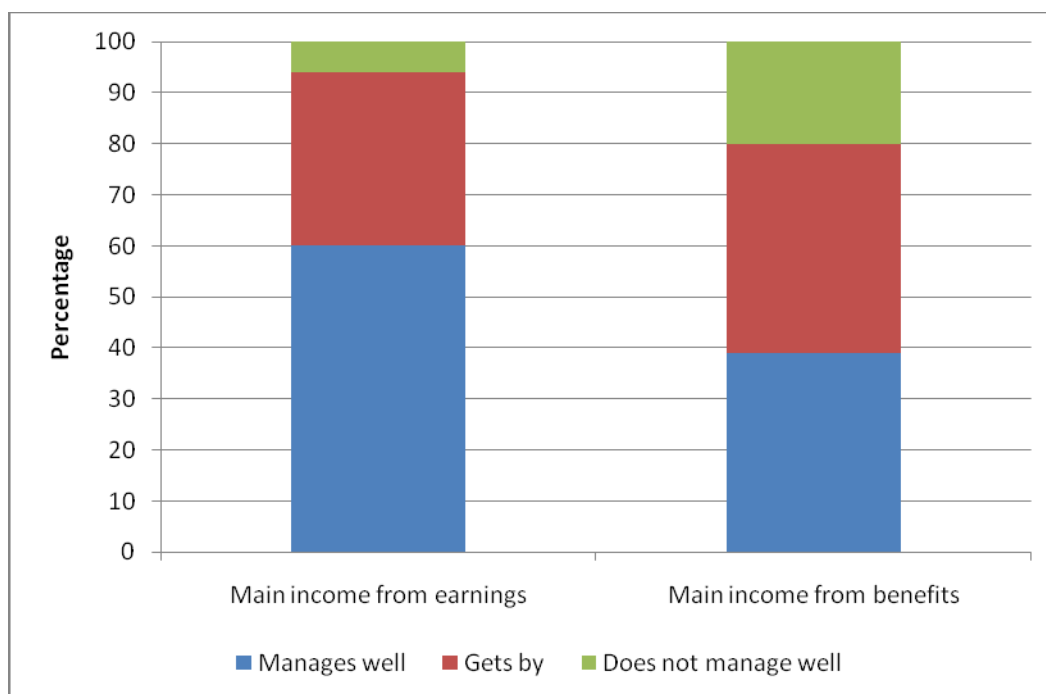
**Table 3.4c Household management by annual household income – Falkirk 2013**



Source: Scottish Household Survey

**Table 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 2012-2037 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, 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 a hugely 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 indulge in 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 health 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.<sup>1</sup> Reducing the number of people who smoke will therefore help an individual but also reduce the pressure on health services.

**Table 4.1a** shows the percentage of the adult population who smoke in Falkirk compared with the Scotland average from 1999 to 2013. Data for individual local authorities for 2011 is not available.

**Table 4.1a - Percentage adult smokers 2013**

Area	1999-2000	2001-2002	2003-2004	2005-2006	2007-2008	2009-2010	2011	2012	2013
Falkirk	31.3	30.7	28	27.1	30.3	28.1		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

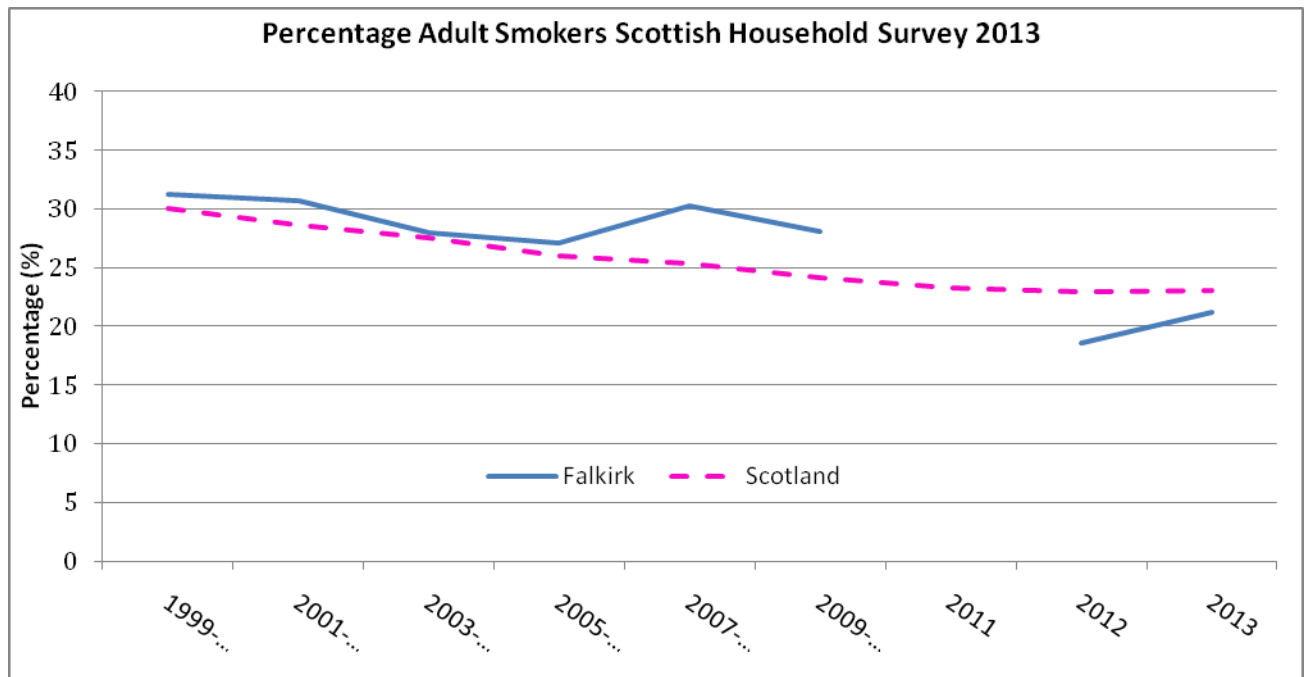
The percentage of the adult population who smoke has decreased between 1999/2000 and 2013, but there was a slight increase between 2012 and 2013 in Falkirk and Scotland as a whole.

In 1999/2000, 31.3% of adults in Falkirk smoked; by 2013 this had fallen to 21.1%. This is comparable to the trend for the total Scotland figures in the years between 1999/2000 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.

<sup>1</sup> ScotPHO Smoking Ready Reckoner – 2011 Edition

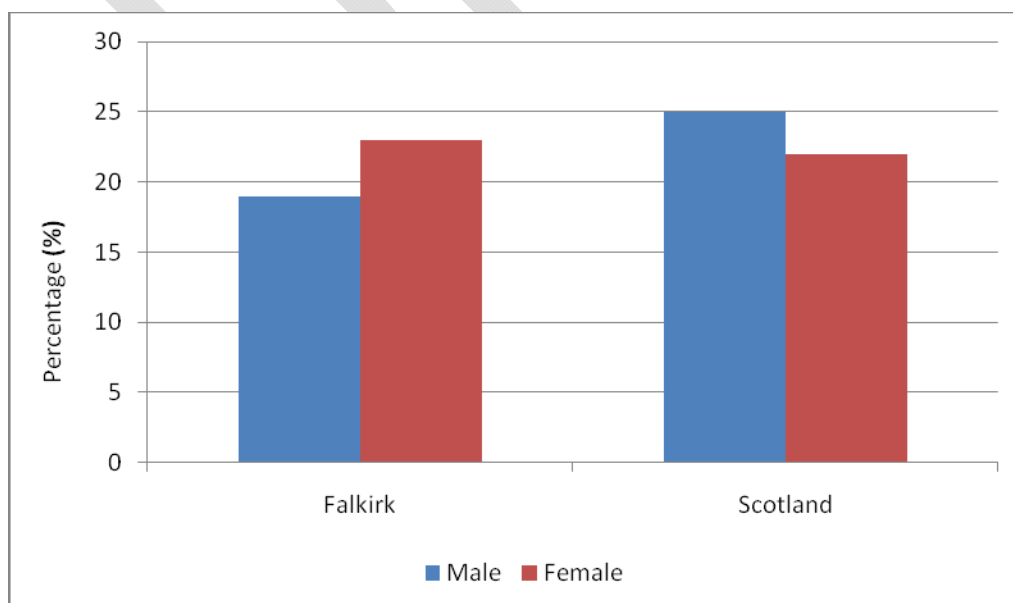
**Figure 4.1a - Trend in the percentage of adults who smoke from 1999/2000 to 2013**



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**



**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 Scotland rate.

**Table 4.1c - Age standardised rate 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

## 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.

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. 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	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

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 chart

4.2c.

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.

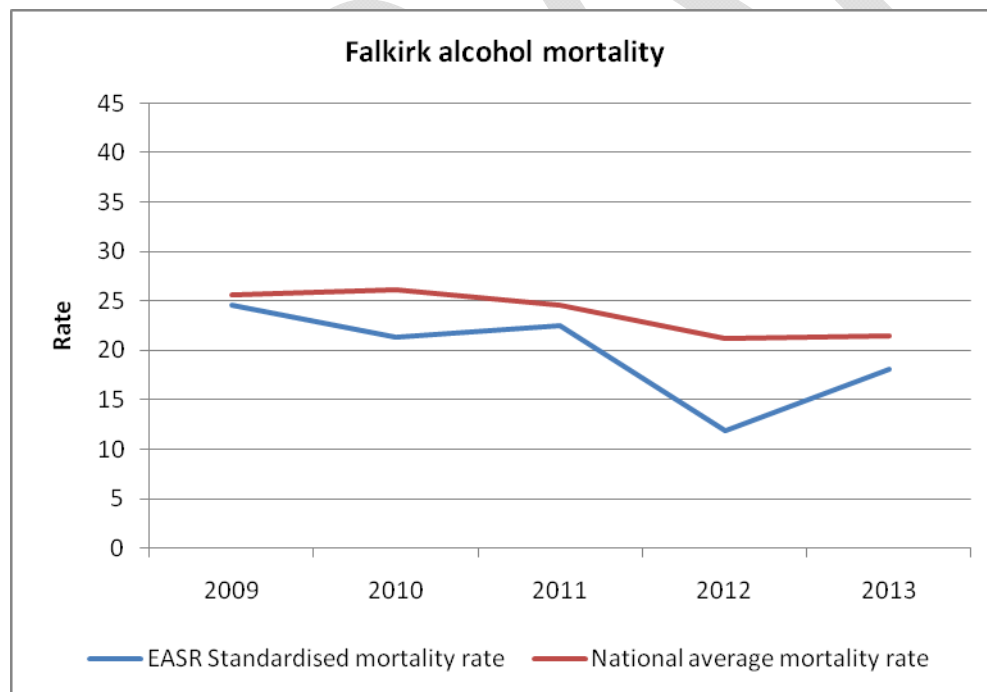
The alcohol related mortality rate has been below the Scottish average in each year from 2009 to 2013.

**Table 4.2b - Alcohol related mortality**

Falkirk	EASR Standardised mortality rate	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

**Figure 4.2a - Alcohol related mortality**



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 fell slightly.

**Table 4.3a - Estimated prevalence of problem drug use by Council area (ages 15-64)**

Council Area	Estimated Prevalence 2009/10	Estimated Prevalence 2012/13
	%	%
Falkirk	1.00	1.63
Scotland	1.71	1.68

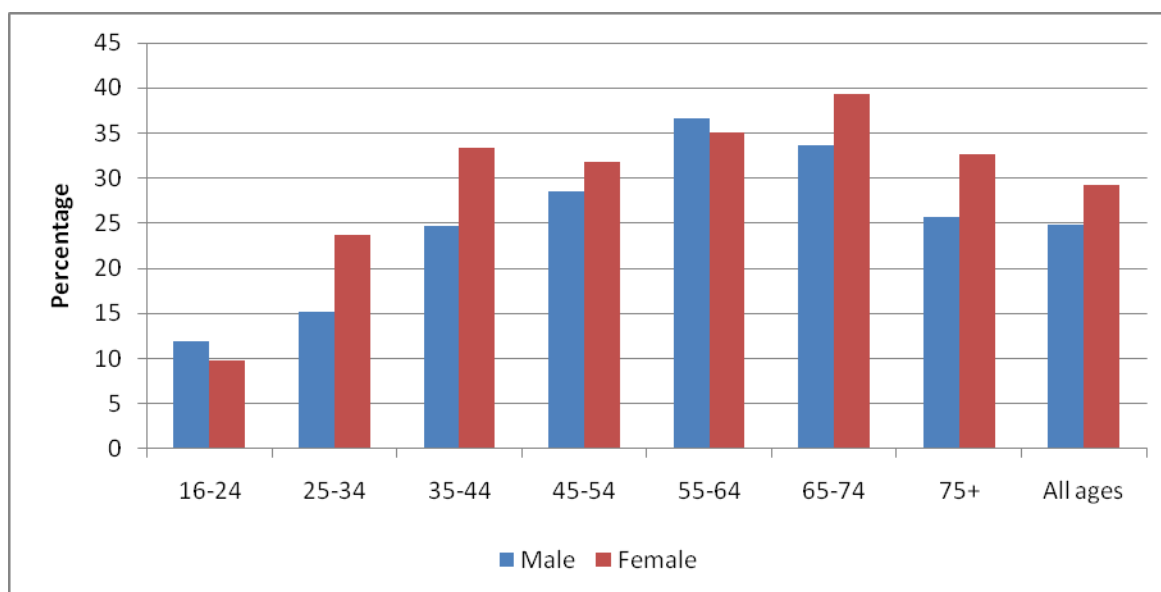
Source: ISD Scotland

### 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 causes an individual to become obese is poor diet.

For Scotland in 2013 it was estimated that 27% of the adult population aged 16+ were classified as being obese (a Body Mass Index 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 55-64, and for women between the ages of 65-74.

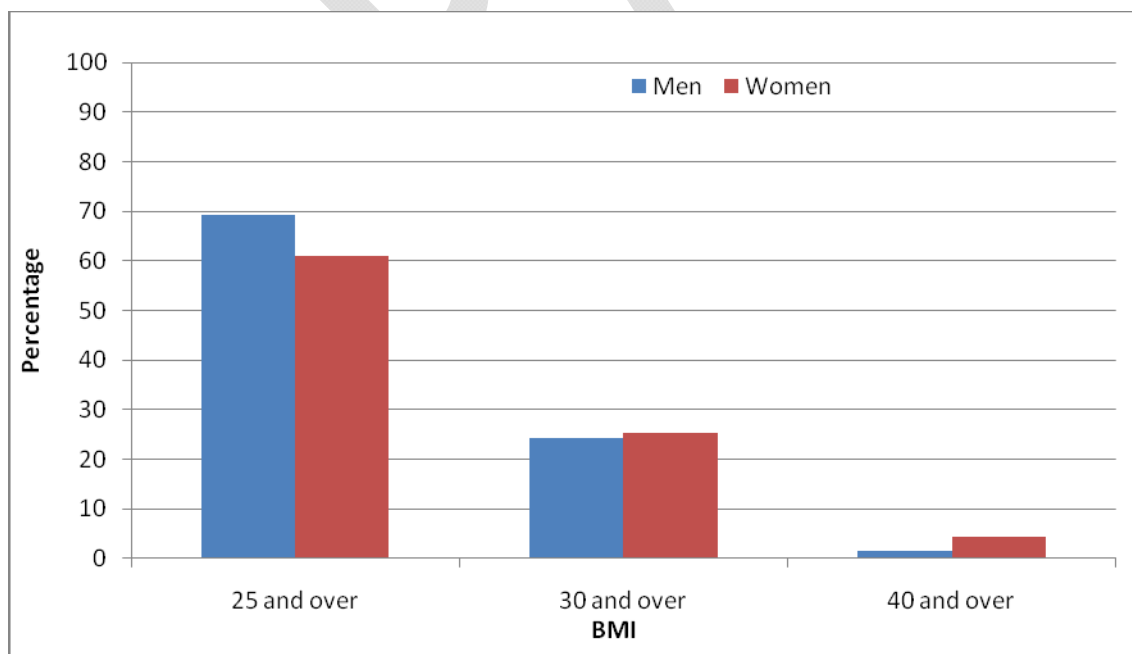
**Table 4.4a - Percentage of population with a BMI of 30 plus – 2013**



Source: The Scottish Health Survey 2013

Data and information concerning diet and obesity is not regularly published at the 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 table 4.4b.

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



## 4.5 Lifestyle/Risk Factor Considerations/Implications

There is evidence to suggest that people living in more deprived areas are more likely to adopt unhealthy behaviours such as smoking and alcohol and drug use and this can impact on the level of services required in local areas.

## 5. Population Health

### 5.1 General Health

According to the 2011 Scotland 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 nominal percentage bad or very bad.

**Table 5.1 – General Health by population and age**

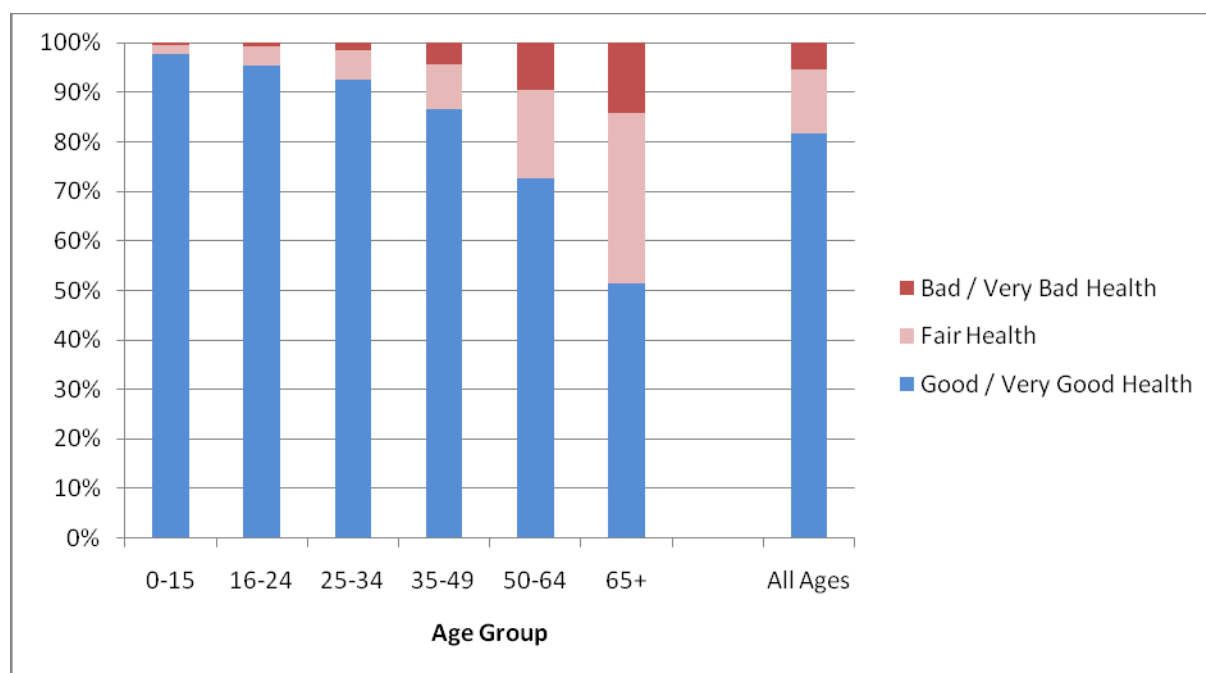
	Good/Very Good Health (%)	Fair Health (%)	Bad/Very Bad Health (%)
<b>Falkirk</b>	81.8	12.7	5.5
<b>Scotland</b>	82.2	12.2	5.6

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 of population in 2011 by age group**



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 life expectancy has increased by a greater percentage over the same period though it has not increased at the same rate as Scotland on the whole.

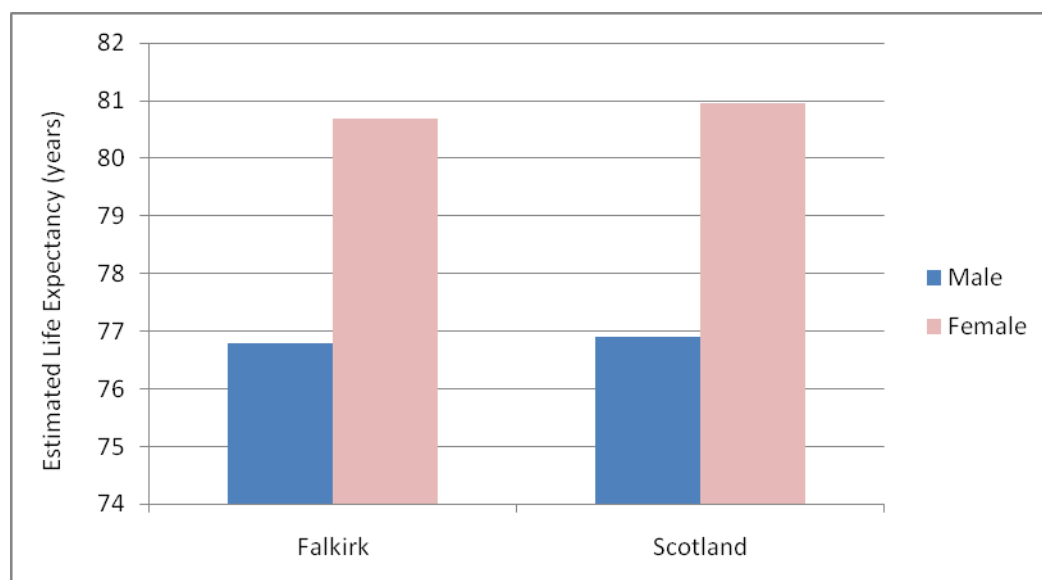
**Table 5.2a - Life Expectancy at Birth, Falkirk and Scotland 2001-03 and 2011-13**

	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
% Change over 10 years	4.1	2.7	4.6	2.7

Source: National Records for 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 for 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 almost 2 years longer in poor health than Males (Table 5.2b).

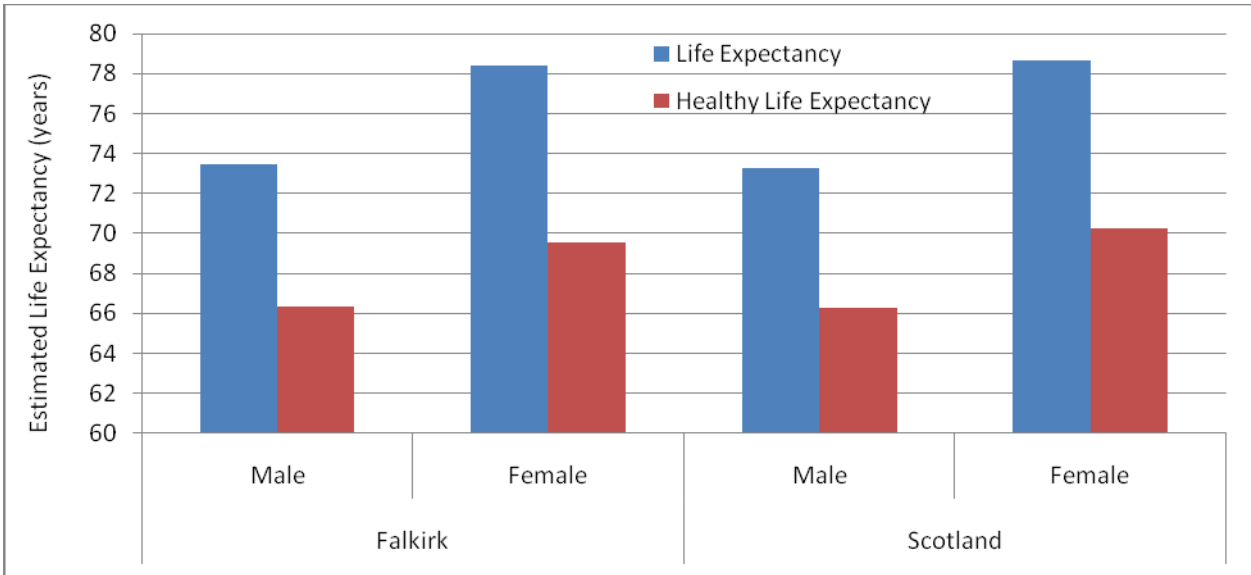
**Table 5.2b - Life Expectancy & Healthy Life Expectancy, Falkirk Community Health Partnership and Scotland for the 5-year period 1999-2003**

	Falkirk		Scotland	
	Male	Female	Male	Female
Life Expectancy	73.5	78.4	73.3	78.7
Healthy Life Expectancy	66.4	69.5	66.3	70.2
Expected Years "Not healthy"	7.1	8.9	7.0	8.5

Source: Scottish Public Health Observatory

The estimated years “Not healthy” for the Falkirk population are very similar to the Scotland figures and significantly 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 1999-2003**



Source: Scottish Public Health Observatory

### 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 conditions as at March 2014.

**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](http://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 2480 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 areas 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.

### 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 elderly population means that the number of cancer registrations is set to rise.

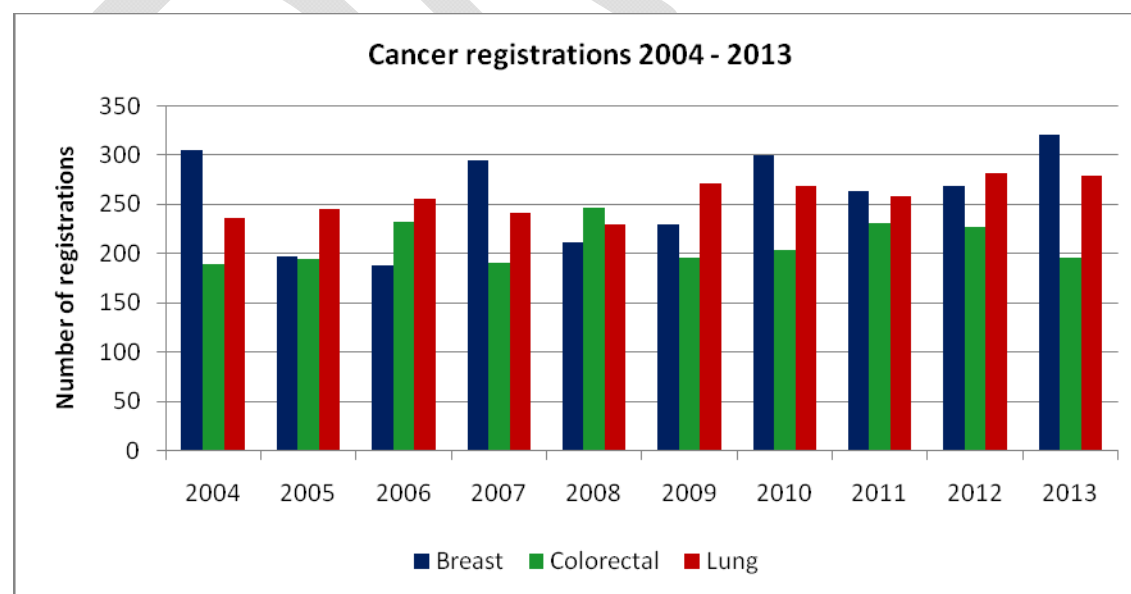
**Table 5.3.2A Cancer registrations in NHS Forth Valley from 2004-2013**

Cancer registrations	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
All cancers	1611	1445	1530	1512	1606	1648	1660	1605	1624	1665

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 out of 100,000 people, in NHS Forth Valley it was 556 out of 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 2100 new cancer cases in the board area annually.

## 5.4 Projected Long Term Conditions

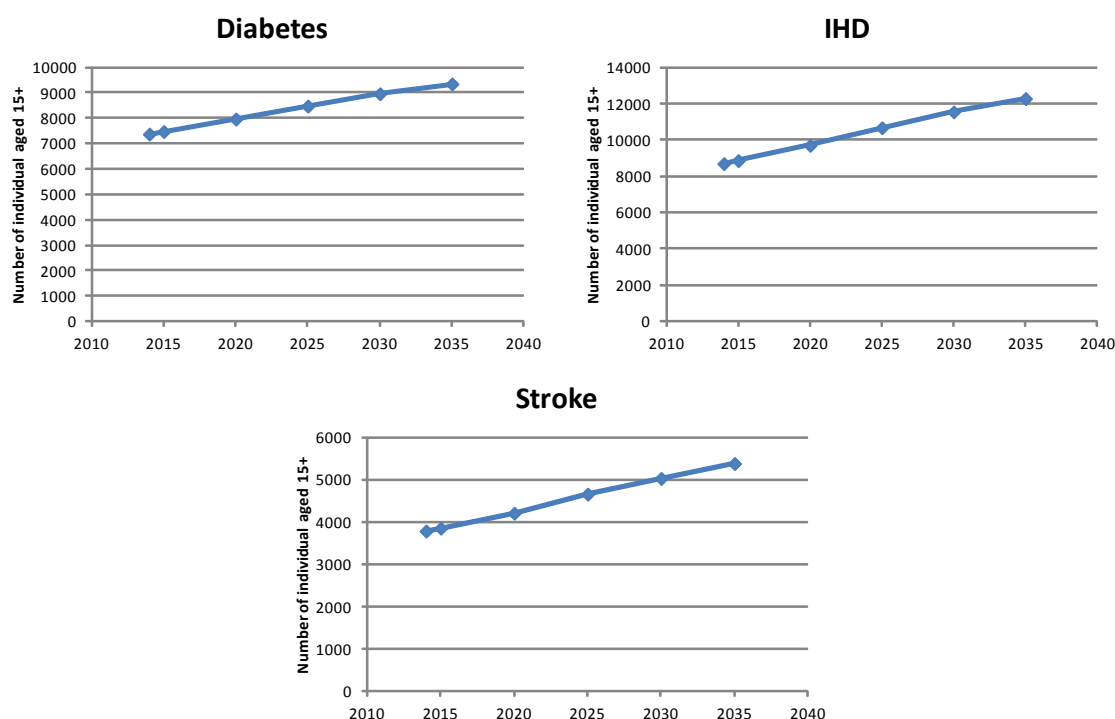
Forecasting disease prevalence can provide information regarding where resources might be needed in the future or where preventative interventions could reduce disease. There are a range of factors which influence the prevalence of disease. These are:

- 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. This may be mediated through stress (the socio-psycho-neuro-immuno-pathological pathway).
- 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 some extent. 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 forecasted

prevalence of disease. The assumption has been made that the age-specific prevalence remains constant.

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

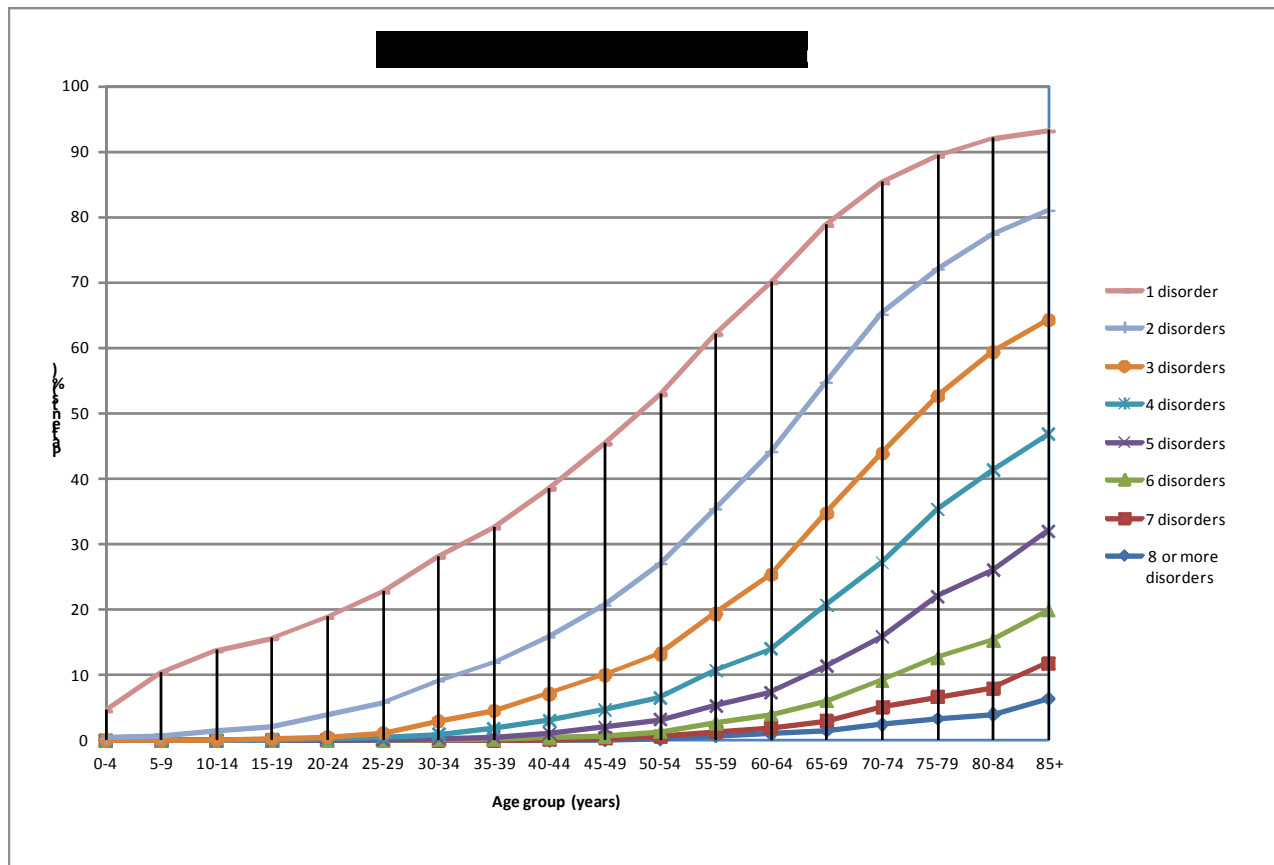


Source: Scottish Health Survey (prevalence rates) and NRS population Estimates

## 5.5 Multi-Morbidity

In light of ageing populations 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 number of long term conditions is forecasted to increase between 2015 (figure 5.5b) and 2037 (figure 5.5c).

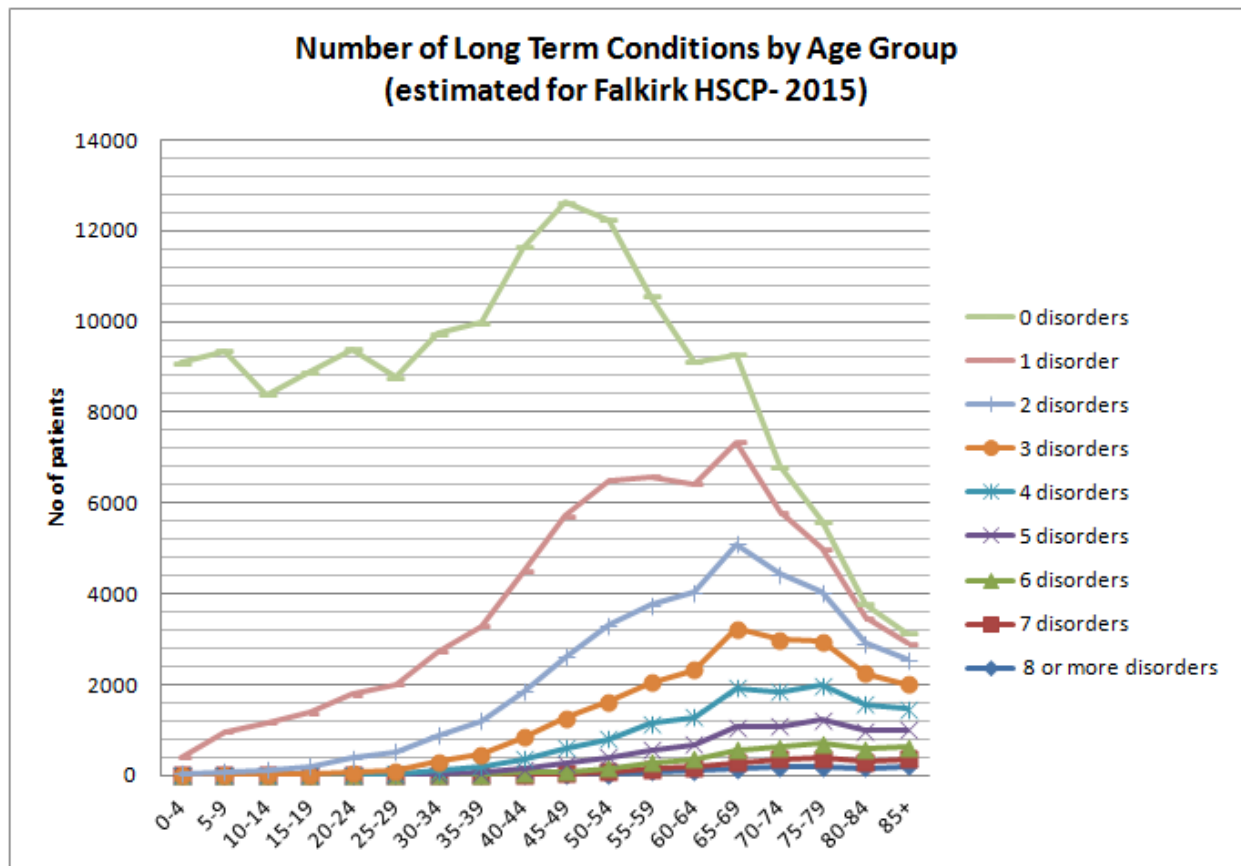
**Figure 5.5a – Estimated number of conditions by age group.**



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

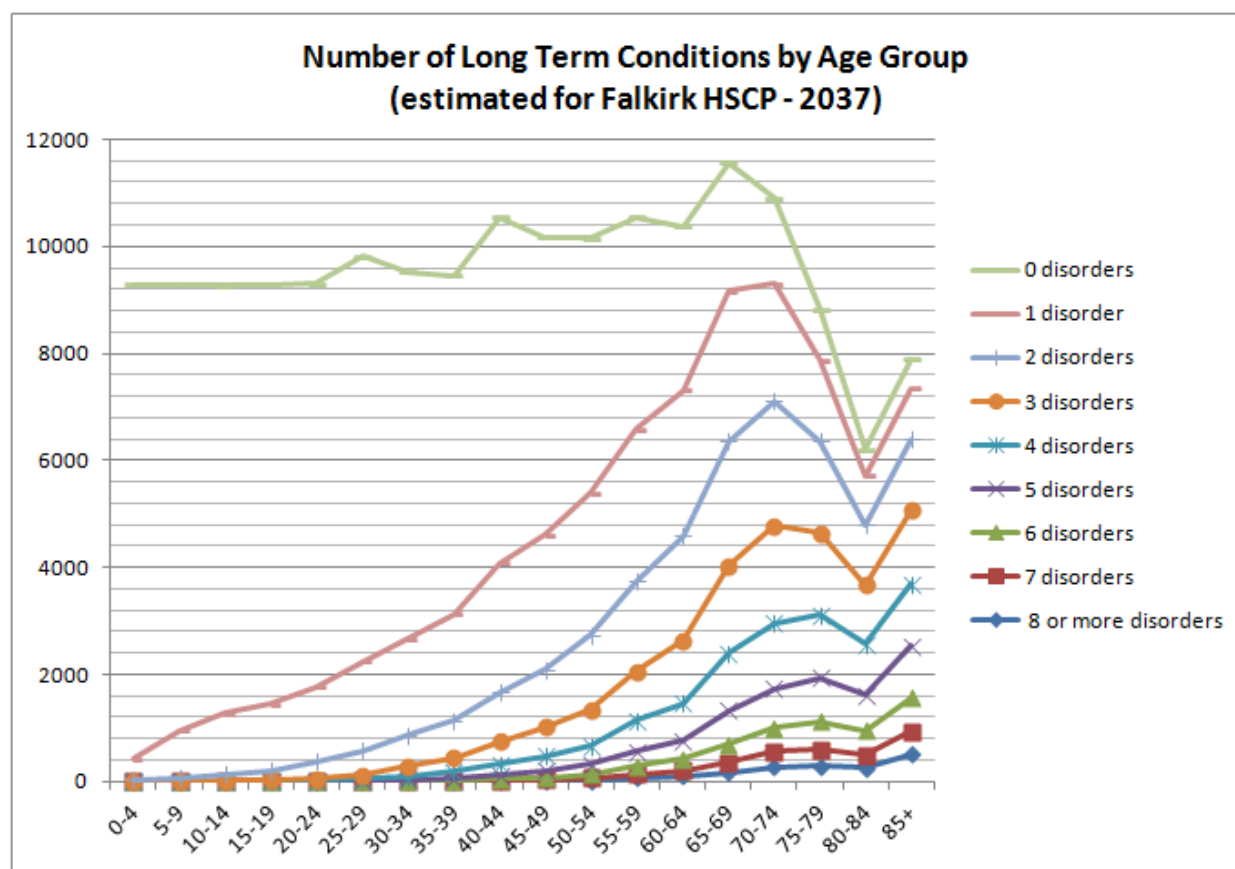


**Figure 5.5b - Estimated number of people within Falkirk with various numbers of conditions (2015)**



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 estimates 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 multiple 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 patients do not have to unnecessarily attend five different, disjointed, specialists for the five different conditions that they have.

## 5.6 High Resource Individuals

This section is currently using old data. To be updated

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. Consequently it is vital that the data is used effectively at local level to ensure in the planning and delivery of the right services to the right people in the community.

Analysis for the financial year 2012/13 reported that **3011** individuals accounted for 50% of health expenditure in the Falkirk area. There were 129,275 patients for that same period in Falkirk meaning that **2.3%** of patients accounted for 50% of health expenditure. This matches the Scotland data where 2.3% of patients are considered to be HRIs. Table 5.6a shows the important figures relating to HRIs at Falkirk and Scotland level. While a similar percentage of the population were categorized as HRIs in Falkirk and Scotland, the number of bed days attributed to HRIs is considerably higher for Falkirk (78.5% vs. 72.9%).

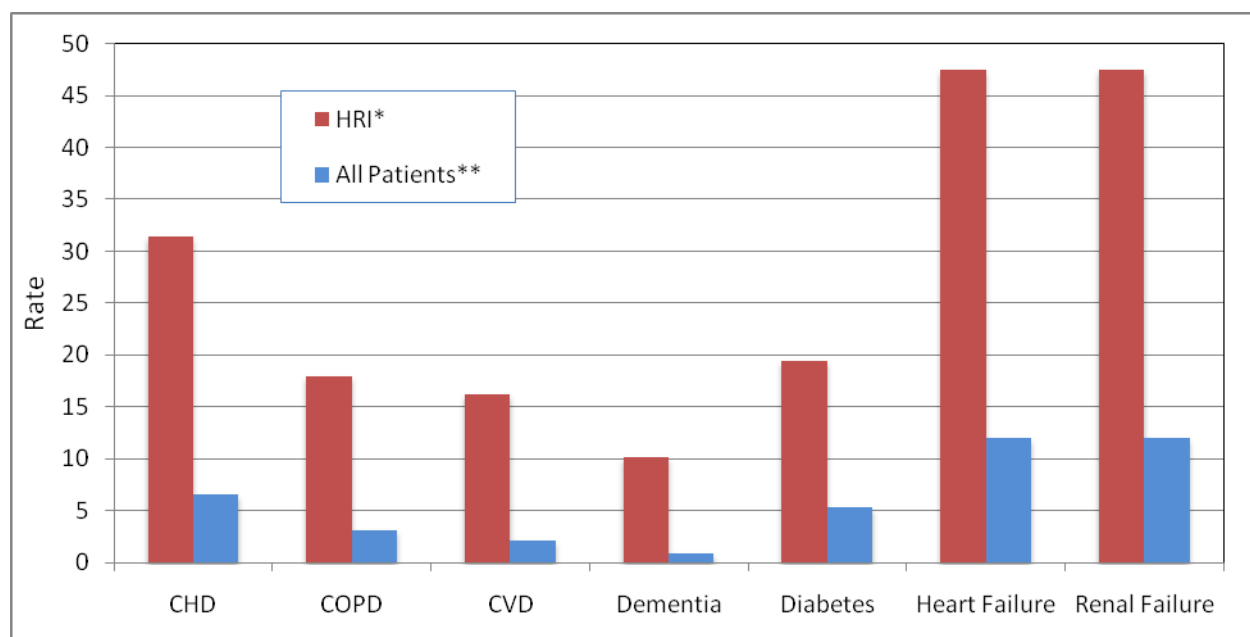
**Table 5.6a – Breakdown of All Activities for HRIs and All Patients in Falkirk and Scotland for both genders, all ages**

Financial Year 2012/13		Falkirk	Scotland
Number of patients	HRIs	3011	103715
	All Patients	129275	4,425,174
	% HRI	<b>2.3%</b>	<b>2.3%</b>
Number of bed days	HRIs	159,986	5,419,968
	All Patients	203,869	7,439,396
	% HRI	<b>78.5%</b>	<b>72.9%</b>
Episodes/Attendances/ Items <sup>2</sup>	HRIs	205,694	7,397,856
	All Patients	2,798,870	96,720,899
	% HRI	<b>7.3%</b>	<b>7.6%</b>
Cost (£)	HRIs	£71,024,900	£2,558,775,992
	All Patients	£142,060,615	£5,117,568,466
	% HRI	<b>50%</b>	<b>50%</b>
Cost per capita (£)	HRIs	£23,588	£24,671
	All Patients	<b>£1,099</b>	<b>£1,156</b>

Source: Integrated Resource Framework, ISD Scotland

There is often a close link between HRIs and Long-term Conditions (LTC) such as Chronic Heart Disease (CHD), Diabetes or Dementia. The 2012/13 data showed that 69.3% of HRIs in the Falkirk area had at least 1 LTC with the majority suffering from 2-4 different LTCs. Figure 5.6a below shows the prevalence of 7 common LTCs in HRIs compared to the rate in All patients.

**Figure 5.6a – Rate (per 100 population) of individual long-term conditions for HRIs and all patients in Falkirk, in both genders and all ages**



## 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**

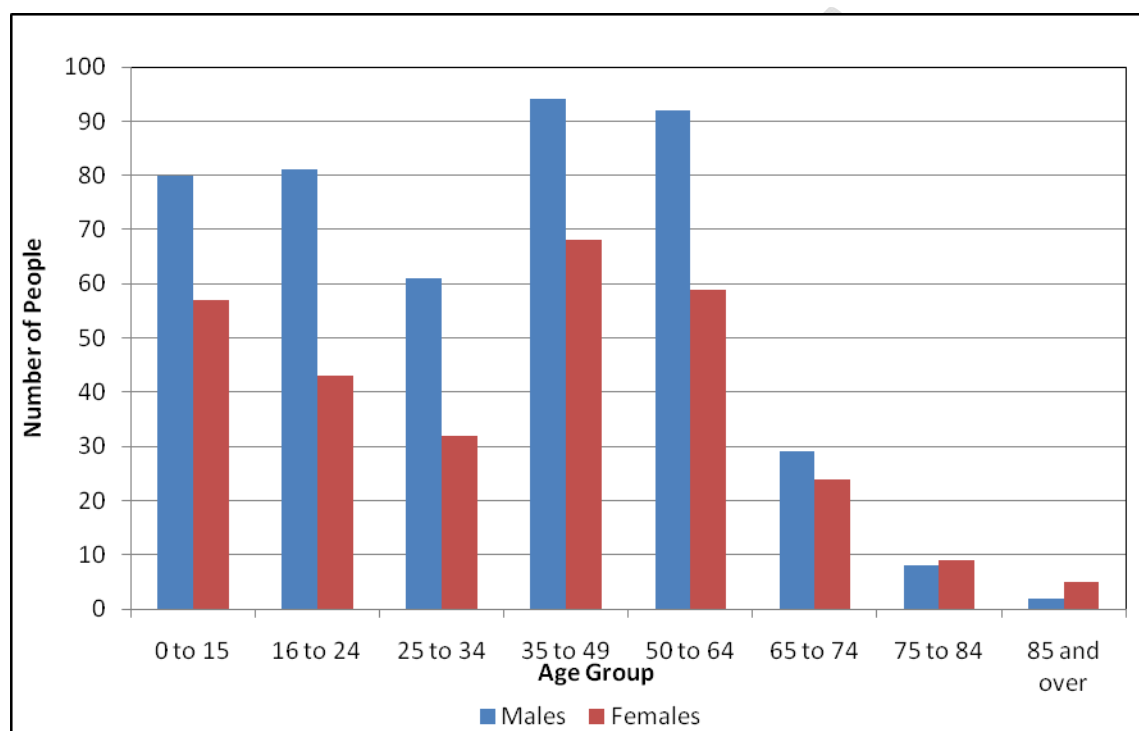
Area	2010	2011	2012	2013	2014
Falkirk	6.0	5.3	5.6	5.8	7.7
Scotland	6.4	6.0	6.0	5.9	6.0

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 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 handful of people aged 85 and over in the Falkirk area with a learning disability in 2011.

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



Source: Scotland Census 2011

### Physical disabilities

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

The Scottish Government has recently announced (8<sup>th</sup> 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 5.7c Number of people with a physical disability**

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 5.7d 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 5.7d 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	1410	13.0%	3.9%
50-64	1540	1689	3229	29.7%	10.6%
65-74	1194	1279	2473	22.8%	17.6%
75-84	846	1235	2081	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 boards attempted to move from predominantly inpatient services to services where care and treatment can be delivered mostly in the community.

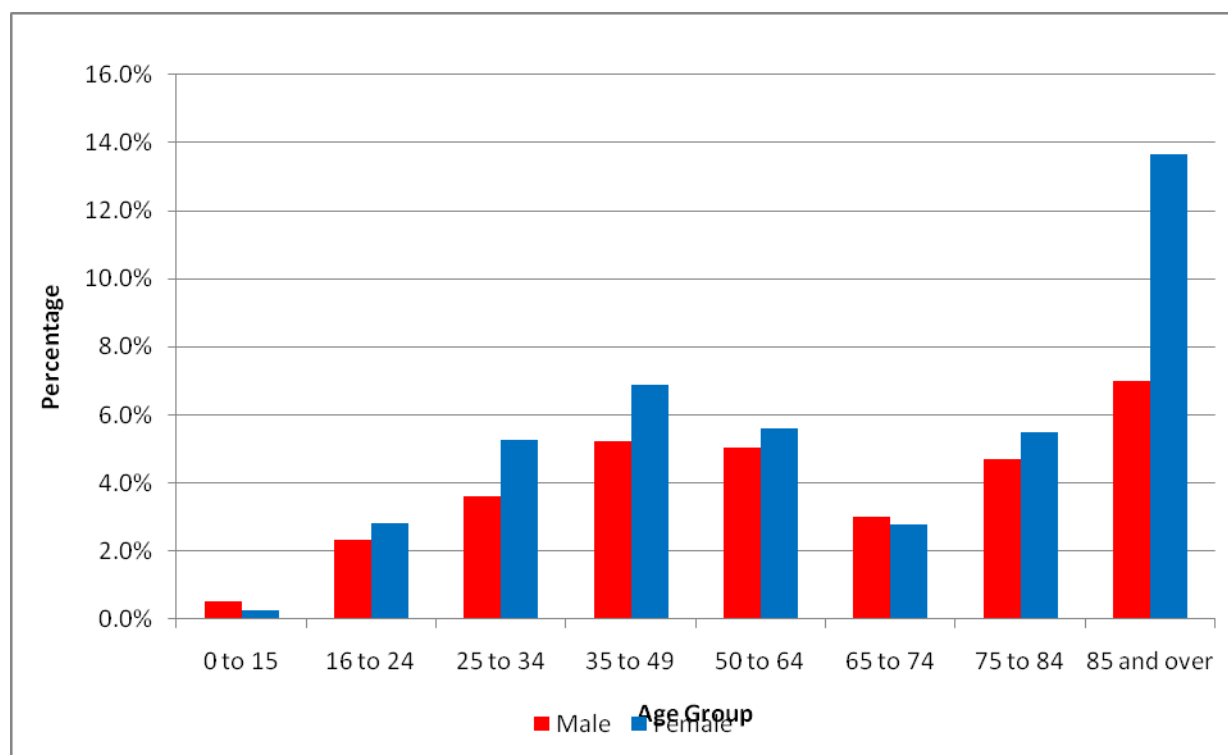
Mental health services in Falkirk are provided as part of the Forth Valley Community Health Partnership.

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 return 6375 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. Table 5.8b below shows information from the Quality and Outcomes Framework register.

A crude prevalence rate of the number of people in Falkirk and Scotland with a mental health condition per 100 patients is shown in the table. 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 5.8b - Rate of people with mental health issues in Falkirk and Scotland 2013/14**

Area	Depression	Schizophrenia, Bipolar affective disorder and other psychoses
Falkirk	6.64	0.79
Scotland	5.81	0.88

Source: QOF, ISD Scotland

### Wellbeing

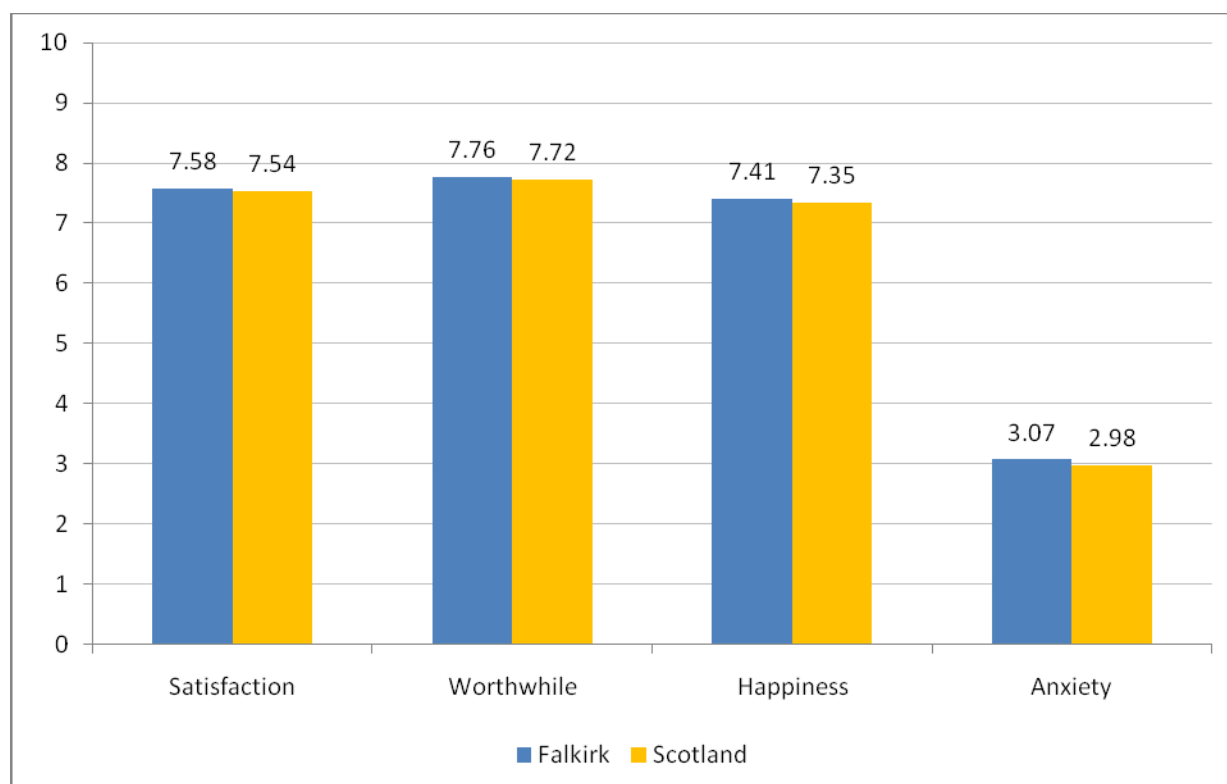
Wellbeing is linked to mental health in that it attempts to measure how happy and content people are in their everyday lives. This data has been collected by the Office for National Statistics as part of their UK Annual Population Survey since 2011. Four questions are asked concerning wellbeing and are 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 Table 5.8C below. Falkirk has a marginally better average score than the whole of Scotland except in the anxiety score where it is only slightly worse.

**Table 5.8c Wellbeing estimates 2011-2014**



Source: Office for National Statistics

## 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

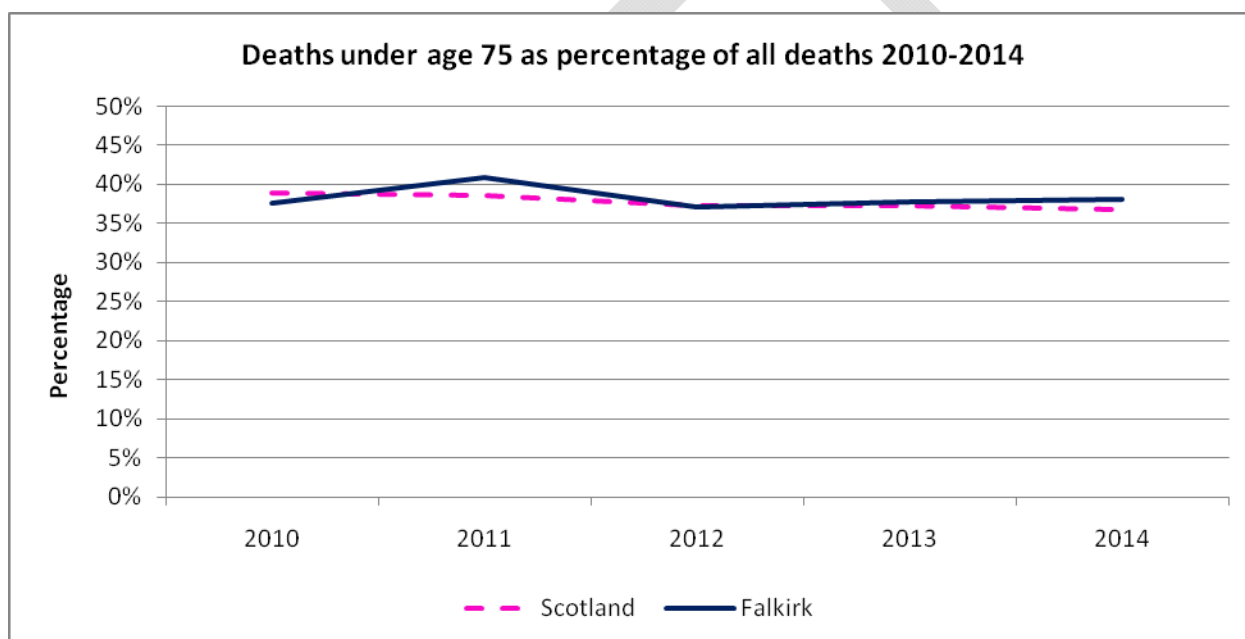
**Table 5.9b Deaths under the age of 75 as percentage of all deaths, 2014**

Area	Deaths under age 75	Total Deaths	% Deaths under age 75
Falkirk	578	1519	38.1%
<b>Scotland</b>	<b>19961</b>	<b>54239</b>	<b>36.8%</b>

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 1519 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 (all ages) 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%
<b>Total</b>	<b>1519</b>	<b>100.0%</b>	<b>100.0%</b>

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 2015.**

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

**Table 5.10c Percentage of deaths caused by cancer and diseases of the circulatory system in Scotland between 2010 and 2015.**

Scotland	2010	2011	2012	2013	2014
Cause of death	%	%	%	%	%
Cancer	28.9%	29.3%	29.4%	29.5%	29.8%
Diseases of the circulatory system	30.6%	29.7%	28.9%	28.5%	27.7%

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 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 (Waiting for data from HR Work Stream project)

Information from project led by HR Work Stream Lead to populate this section.

### 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 130 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	131	130

Source: ISD Scotland

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 effectively 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 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 dept 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 accident and emergency department.

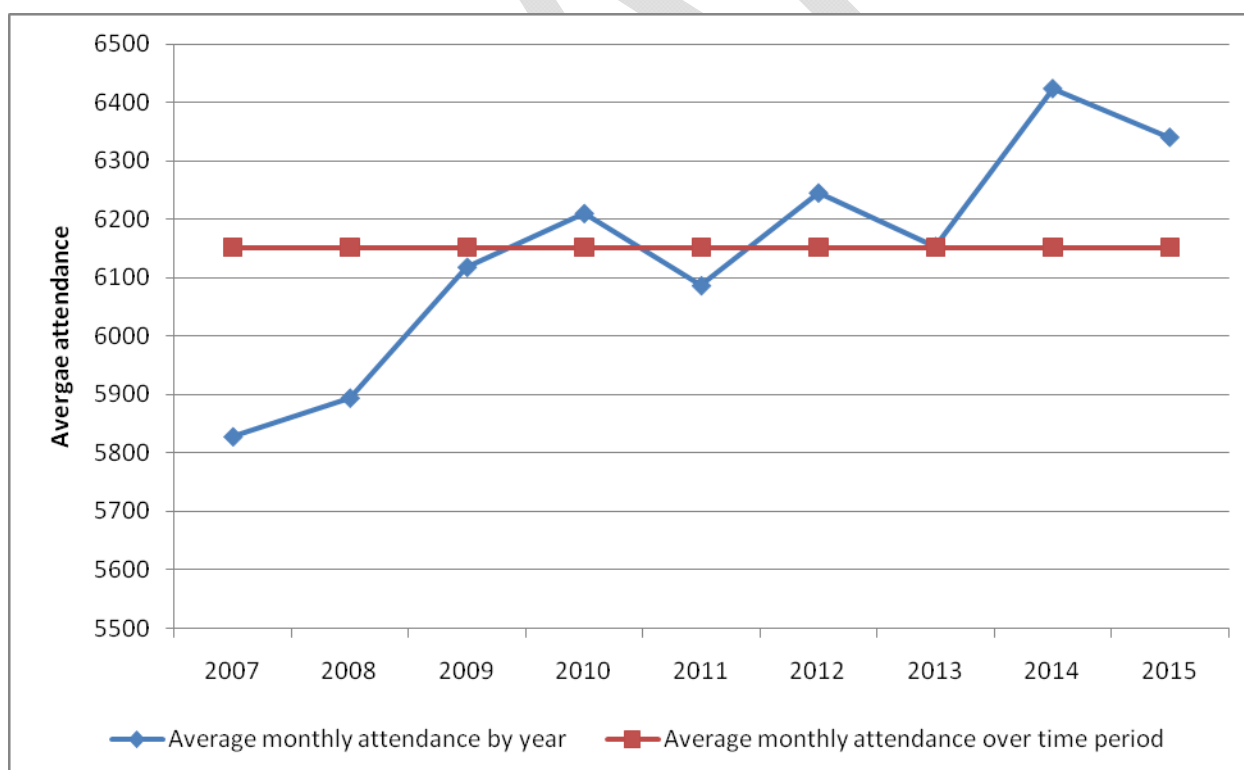
The average monthly attendance at an emergency department between 2007 and 2015 rose from 5,828.2 in 2007 to 6340.2 by June 2015. This represents an 8.8% increase in the average monthly attendance over the time period.

**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 9.3%. During the same period the percentage of patients 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

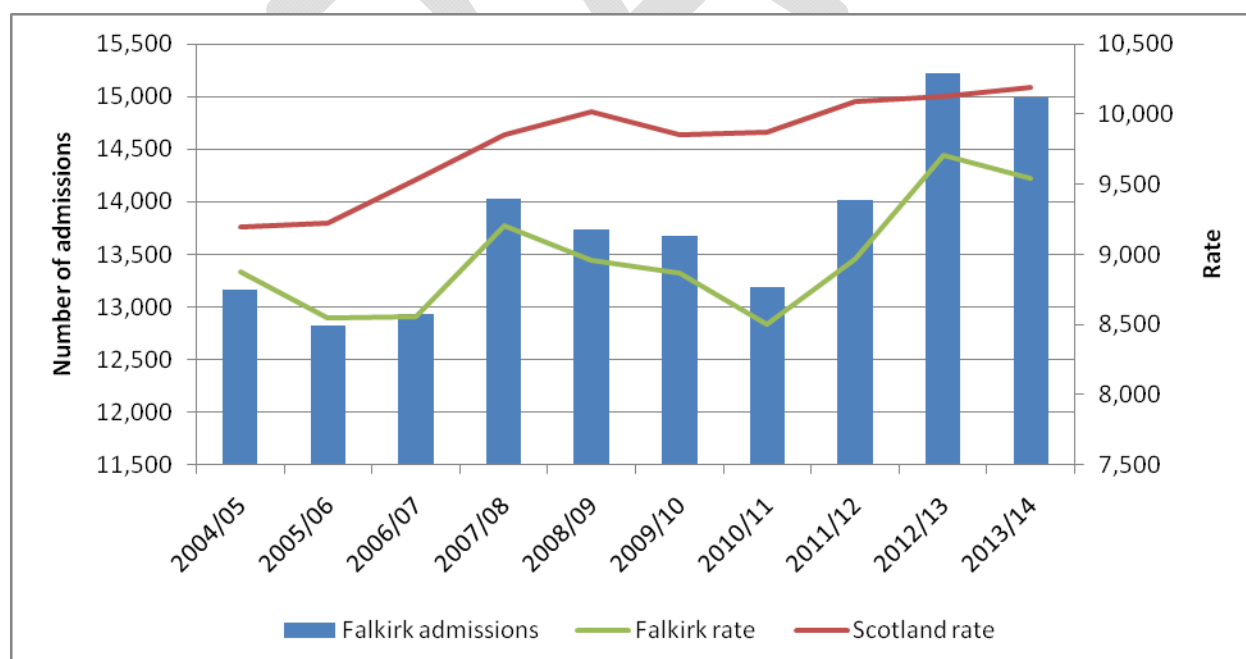
The number of emergency admissions to hospital has risen in the years between 2004/5 and 2013/14. Despite this, the rate of emergency admissions to hospital in the Falkirk area has been lower than the rate for Scotland. *Note - the figures for admissions are based on the patient's home postcode.*

**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	8,876	8,543	8,558	9,208	8,959	8,870	8,501	8,970	9,709	9,542
Scotland rate	9,196	9,222	9,537	9,849	10,021	9,849	9,874	10,090	10,130	10,188

Source: ISD Scotland

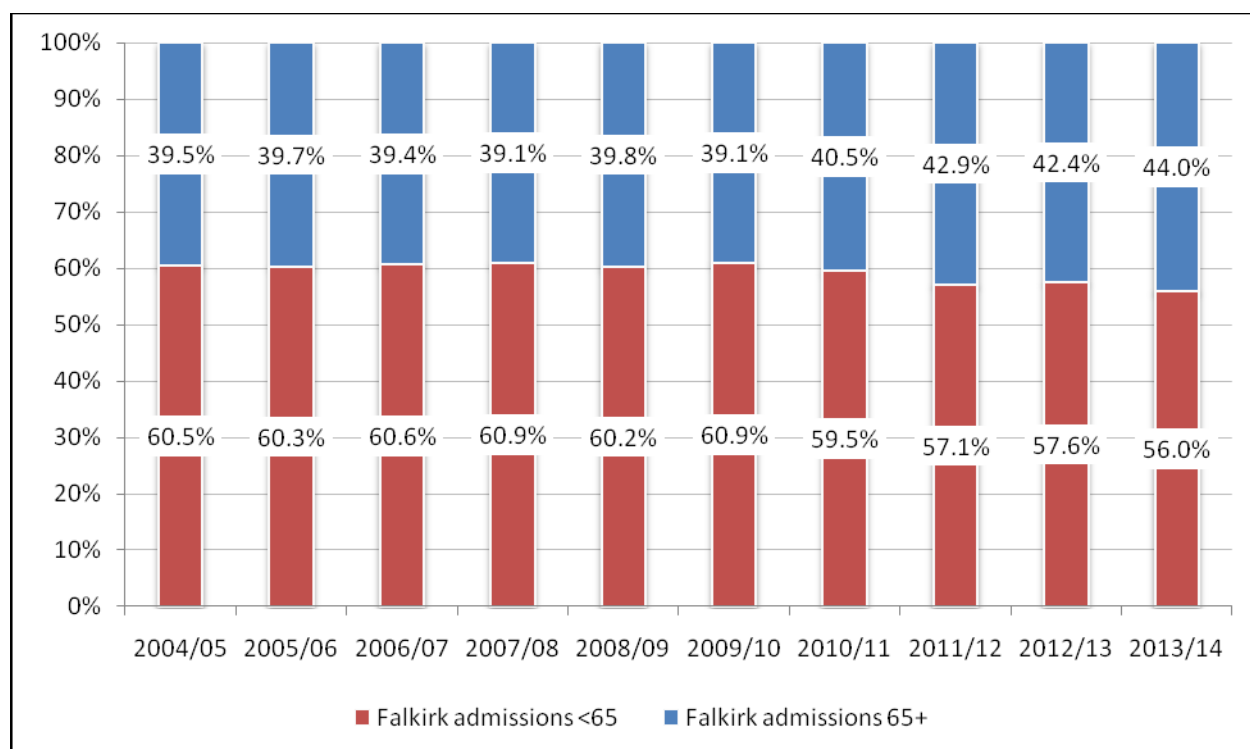
**Figure 6.3.2a Emergency admissions to hospital – Falkirk 2004/05 to 2013/14**



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 on 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 3 or more) has been increasing since 2004.

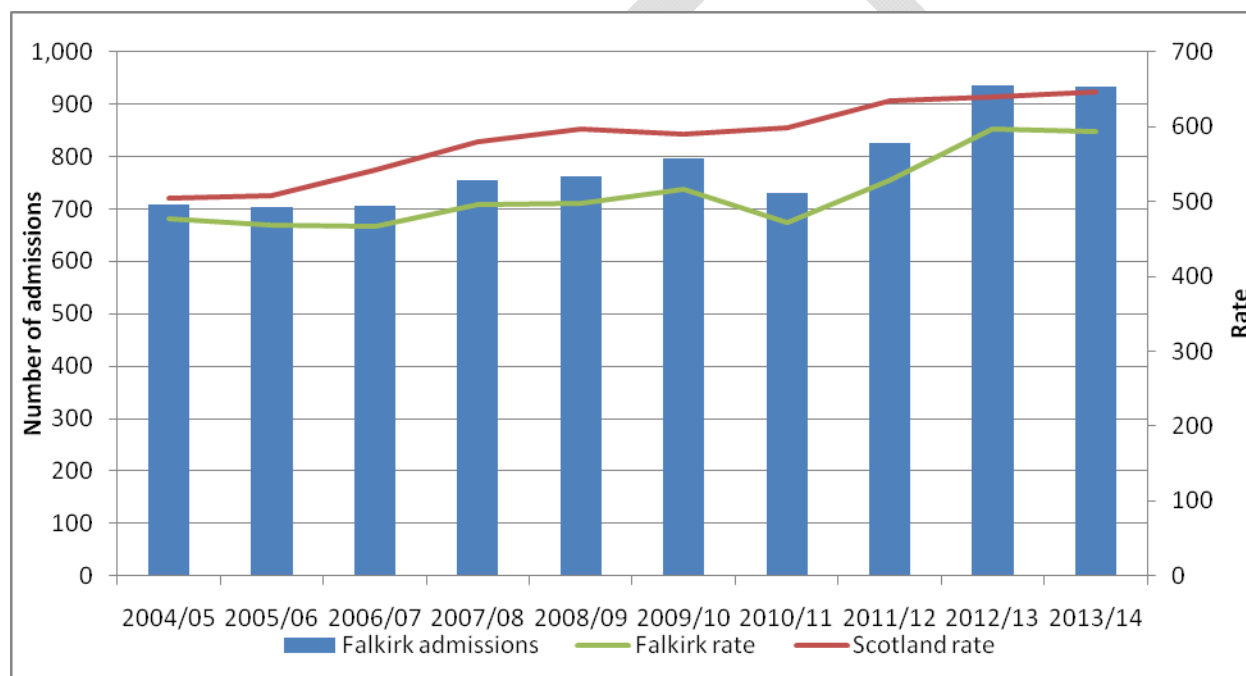
In Falkirk the rate for patients who have had 3 or more emergency admissions is higher in 2013/14 than in 2004/05. This information is shown in the table below.

**Table 6.3.2b Rate and number of patients with 3 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	477	468	467	496	498	517	471	529	598	594
Scotland rate	504	508	542	579	596	591	598	635	640	646

Source: ISD Scotland

**Figure 6.3.2c - Rate and number of patients with 3 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 the rise 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.

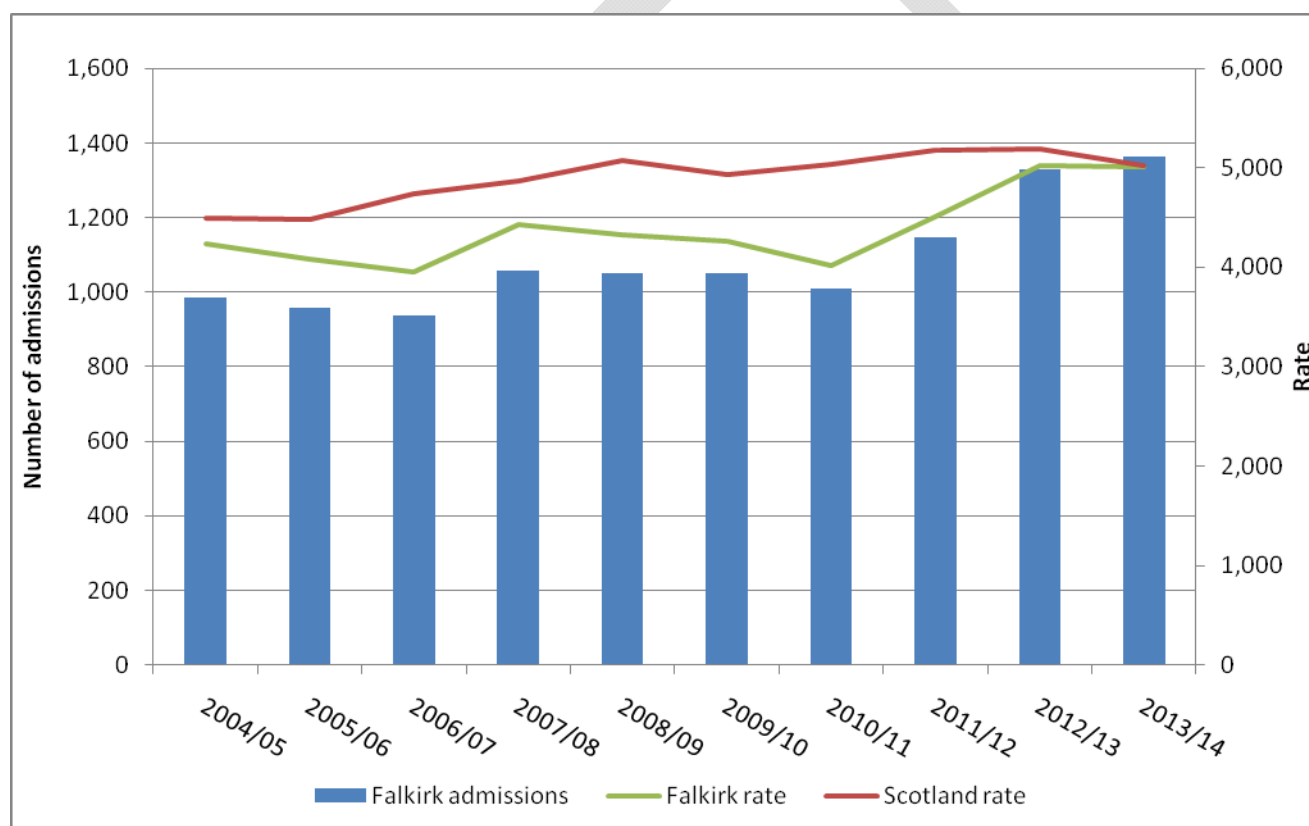
**Table 6.3.2c - Increase in multiple emergency admissions 2004/05 to 2013/14**

	All ages*		Age 65 +	
	N	%	N	%
Falkirk	474	22.3%	380	38.6%

\*Patients with either 2, or 3 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 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 due to a number of potential issues. 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 August 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 RRD – "Ready for Discharge" date.

The table shows for the August 2015 census a greater number of delayed discharges in Falkirk are 'over 2 weeks' (64%) compared to the Scotland average (55%). Falkirk compares more favourably in the longer delay categories where only 8% of people in Falkirk were delayed over 6 weeks in comparison to 22% in Scotland.

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

	Total Standard Delays	Under 2 weeks	Over 2 weeks	Over 4 weeks	Over 6 weeks
Falkirk <sup>1</sup>	25	9	16	8	2
% of All Delays		36%	64%	32%	8%
Scotland	879	398	481	306	195
% of All Delays		45%	55%	35%	22%

**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 August 2015**

Delay Type	April 2015	May 2015	June 2015	July 2015	August 2015
Standard Delay <sup>1</sup>	6	19	24	23	25
Code 9 Delay <sup>1</sup>	11	9	9	7	8
<b>Total Delays</b>	<b>17</b>	<b>28</b>	<b>33</b>	<b>30</b>	<b>33</b>

Source: ISD Scotland Delayed Discharges Census

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

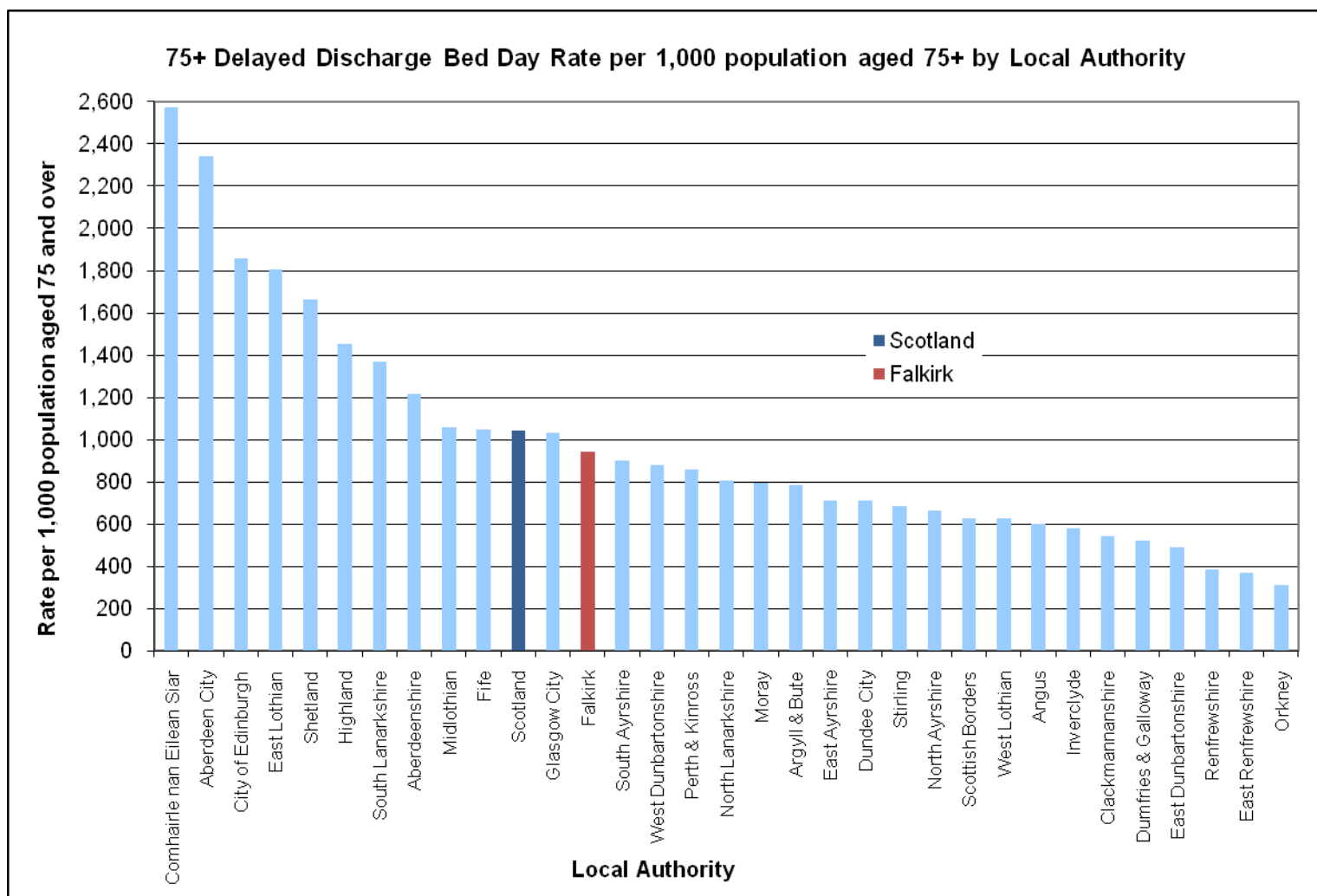
Local Authority of residence <sup>1</sup>	All Ages					18 - 74 years					75 + years				
	Total	Std Delay	%	Code 9	%	Total	Std Delay	%	Code 9	%	Total	Std Delay	%	Code 9	%
Falkirk	1,034	810	78.3	224	21.7	163	125	76.7	38	23.3	871	685	78.6	186	21.4
<b>Scotland</b>	<b>47,797</b>	<b>37,844</b>	<b>79.2</b>	<b>9,953</b>	<b>20.8</b>	<b>14,081</b>	<b>10,580</b>	<b>75.1</b>	<b>3,501</b>	<b>24.9</b>	<b>33,716</b>	<b>27,264</b>	<b>80.9</b>	<b>6,452</b>	<b>19.1</b>

Source: ISD Scotland Delayed Discharges Census

The number of bed days occupied by delayed discharge patients in the July 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 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+, July 2015**



Source: ISD Scotland Delayed Discharges Census

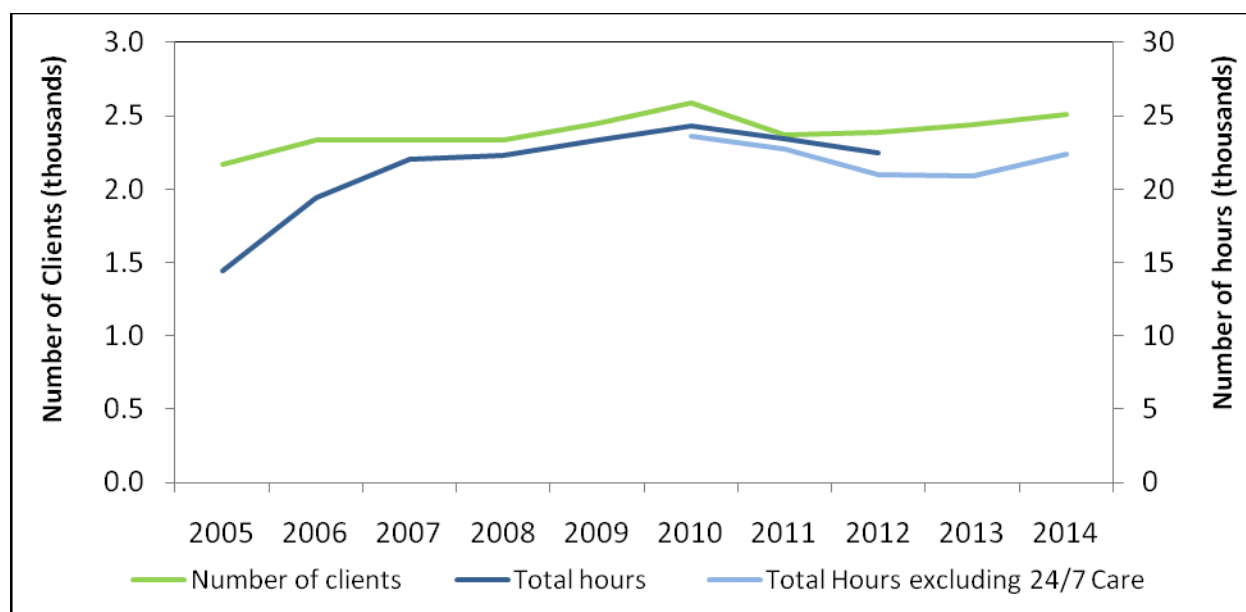
## 6.5 Care at Home

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 home care clients 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, this 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. 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 – Home Care Clients and Hours provided, 2005-2014**



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

Source: Social Care Survey 2014

**Table 6.5a: Home Care clients and age, 2014**

Local Authority	0-64		65-74		75-84		85+		Total
	No	%	No	%	No	%	No	%	
Falkirk	608	24.2	405	16.1	782	31.1	716	28.5	2511

Source: Social Care Survey 2014

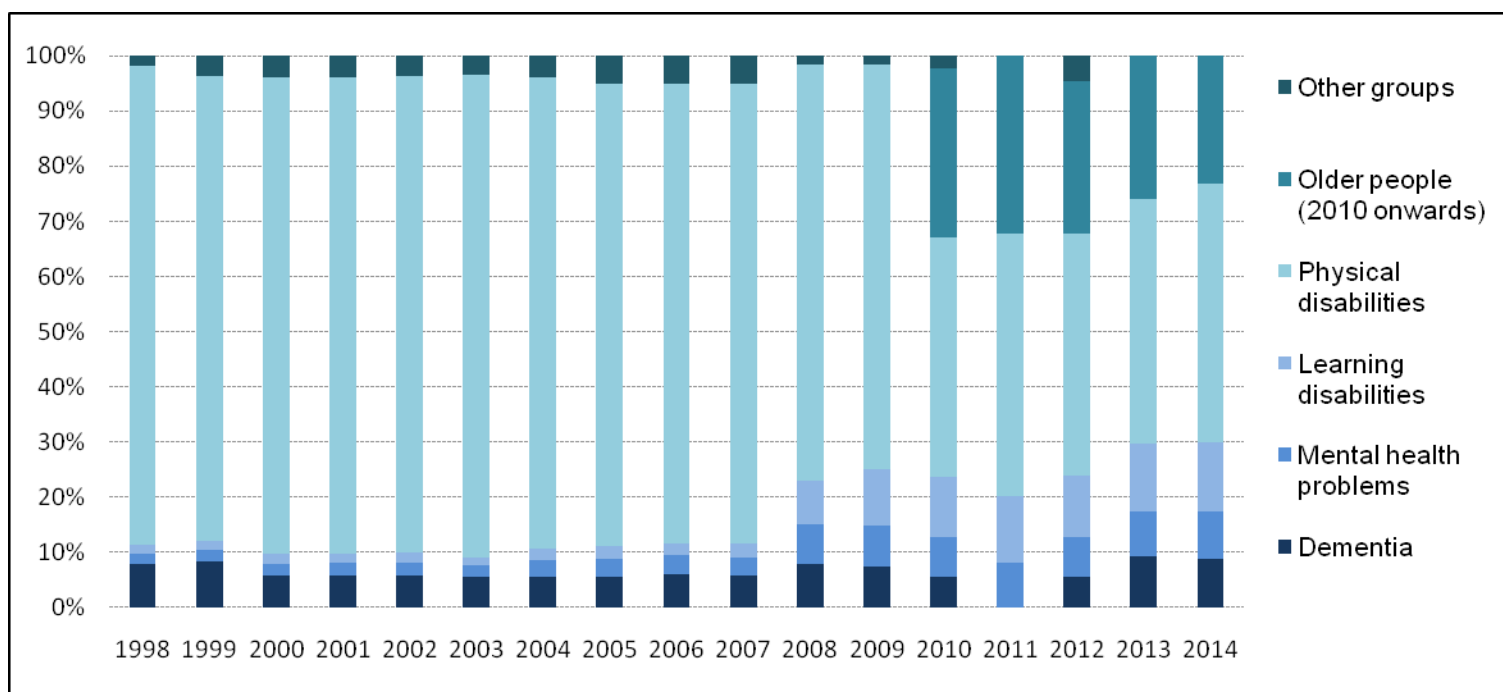
In 2014, nearly 60% of patients were over 75+ years and there was almost twice as many people receiving home care in the age bracket 75-84 years compared to 65-74 years.

The older age groups (65+) received 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 (Mean = 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 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

Home Care reported in the Social Care Survey excludes people receiving home care with a direct payment. Only 63 people received a direct payment in Falkirk during the 2013/14 financial year, down from 128 two years previously.

## 6.6 Intermediate Care – In progress – Required?

## 6.7 Self-Directed 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

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 who it is spent.

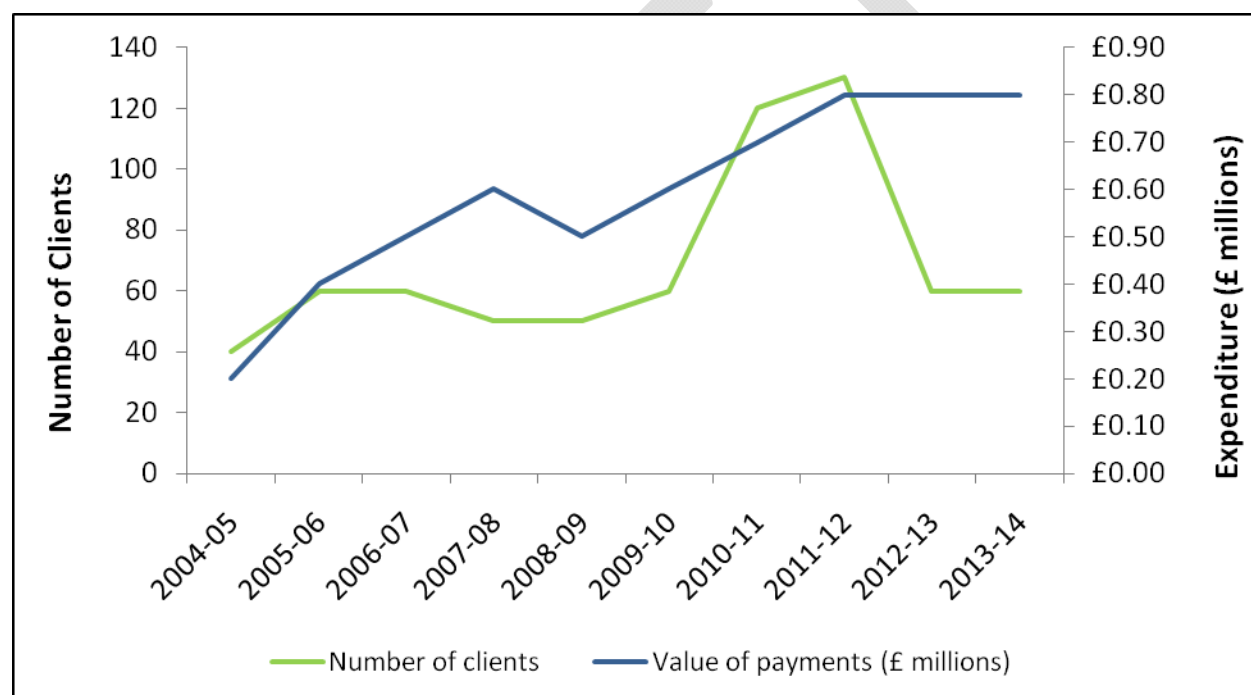
Option 3: The council can arrange a service chosen by the individual.

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

### Direct Payments (Option 1)

Home Care reported in the Social Care Survey excludes people receiving home care with a direct payment, in recent years the Social Care Survey has combined Home care data with SDS data due to increasing numbers of people receiving direct payments. Falkirk has bucked the trend in the past 2 years with Only 63 people received a direct payment during the 2013/14 financial year, down from 128 two years previously. Notably the expenditure on direct payments has remained the same.

**Figure 6.7 – Number of people receiving Direct Payments (and value of payments) 2004-05 to 2013-14**



\*Clients can receive more than one Direct Payment in the year.

Source: Social Care Survey 2014

## 6.8 Care Homes

The 2014 Care Home Census reported a total of 36 care homes currently operating in the Falkirk local authority with the facilities for 1121 residents. The total number of residents in these care homes at the time of the Census was 967, giving an occupancy rate of 86% (Scotland occupancy rate – 86%). The vast majority of patients were long-stay residents with only 3% short-stay residents across NHS/LA, Private and voluntary care homes.

**Table 6.8a – Summary of Care home facilities in Falkirk, 2014 (Year as at 31<sup>st</sup> March)**

Care Home Type:	Number of care homes	Patient Capacity	Current Residents	Occupancy (%)
LA/NHS	8	184	144	78
Private	20	848	737	87
Voluntary	8	89	86	97
<b>Total</b>	<b>36</b>	<b>1121</b>	<b>967</b>	<b>86</b>

For 2014 the number of long stay residents remained similar to Care homes to 2013 and was lower than the figure in 2012. Nearly 70% of the long-stay residents required nursing care and over half of care home residents suffer from dementia (Med. Diagnosed), rising to over 60% when those not yet medically diagnosed are included.

**Table 6.8b – Key Statistics for Long Stay Residents in Care Homes for Falkirk, 2012-2014 (Year (as at 31st March)**

Type of Resident	2012	2013	2014
<b>Total Number of Long Stay Residents</b>	<b>982</b>	<b>927</b>	<b>932</b>
Characteristics of Long Stay Residents	%	%	%
Requiring Nursing Care	62	68	69
Visual Impairment	23	25	26
Hearing Impairment	14	15	17
Acquired Brain Injury	2	2	2
Other Phys.Dis. Or Chronic Illness <sup>2</sup>	35	38	41
Dementia (Medically Diagnosed)	53	57	56
Dementia (Not Medically Diagnosed)	4	4	5
Mental Health Problems	15	12	11
Learning Disability	15	12	9
Alcohol Related Problems	*	*	*
Drugs Related Problems	*	*	*
None of these	*	*	*

2. 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: Source: Scottish Care Homes Census, 2014

In 2014 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 81.5 years

and the Median age was 85 years. At the time of the 2014 census, the Mean complete length of stay at a Falkirk care home was 2.5 years while the incomplete length of stay (for those still living at the care home at the time of the census) was 3.2 years

## 6.9 Telecare

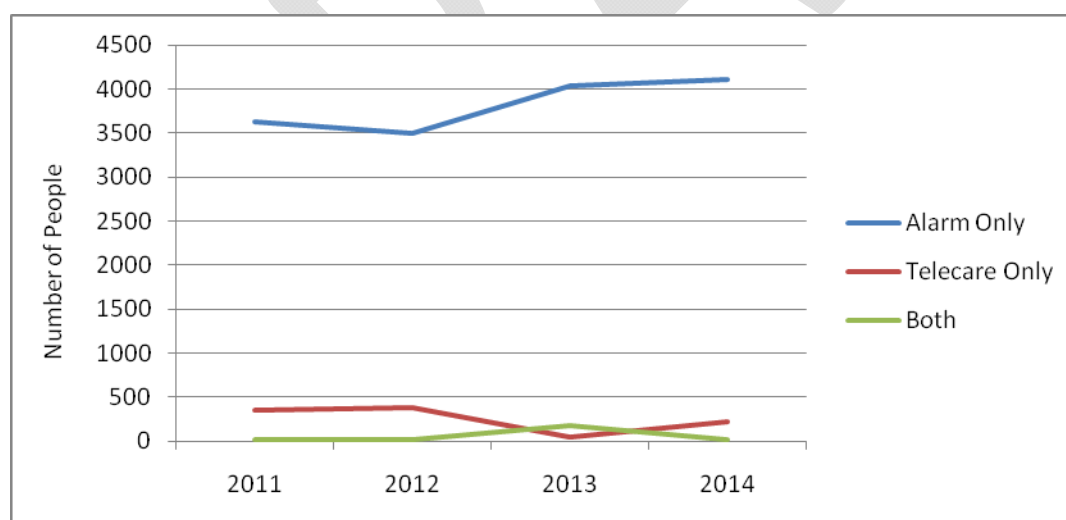
Telecare is a 24-hour monitoring system that uses a range of sensors and alarms to help people live safely and independently in their own home, with the reassurance that help is at hand in an emergency. A Telecare service can consist of a community alarm, a Telecare phone or a combination of both.

According to the 2014 Social Care Survey there were 4353 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 6.9 – Breakdown of Telecare Services in Falkirk, 2011-2014**



Source: Social Care Survey 2014

## 6.10 Equipment – In Progress

## 6.11 Day Care – In Progress

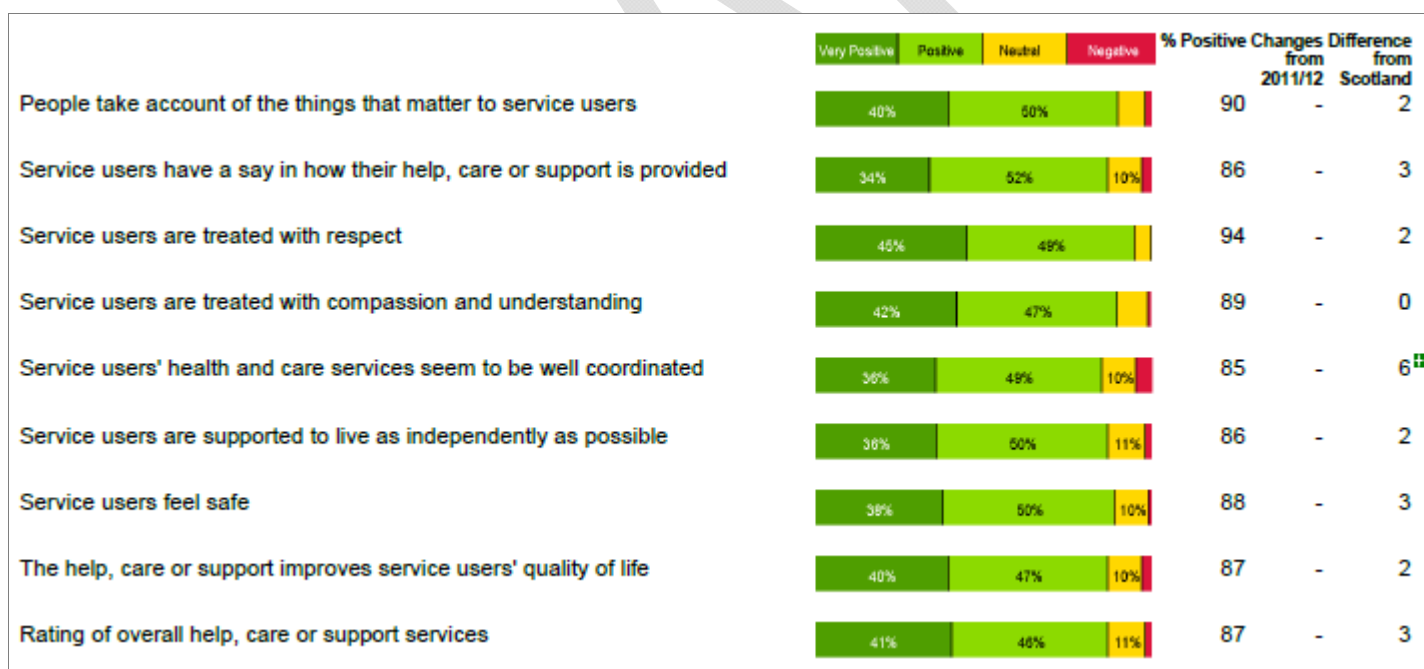
## 6.12 Supported and Sheltered Housing – In Progress

## 6.13 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 15146 people registered with a GP in the Falkirk area and received a total of 3054 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 6.13.

**Figure 6.13 – Summary of Care Recipients Experience in Falkirk – 2013/14**



Source: Health and Care Experience Survey 2013/14

## 6.14 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.

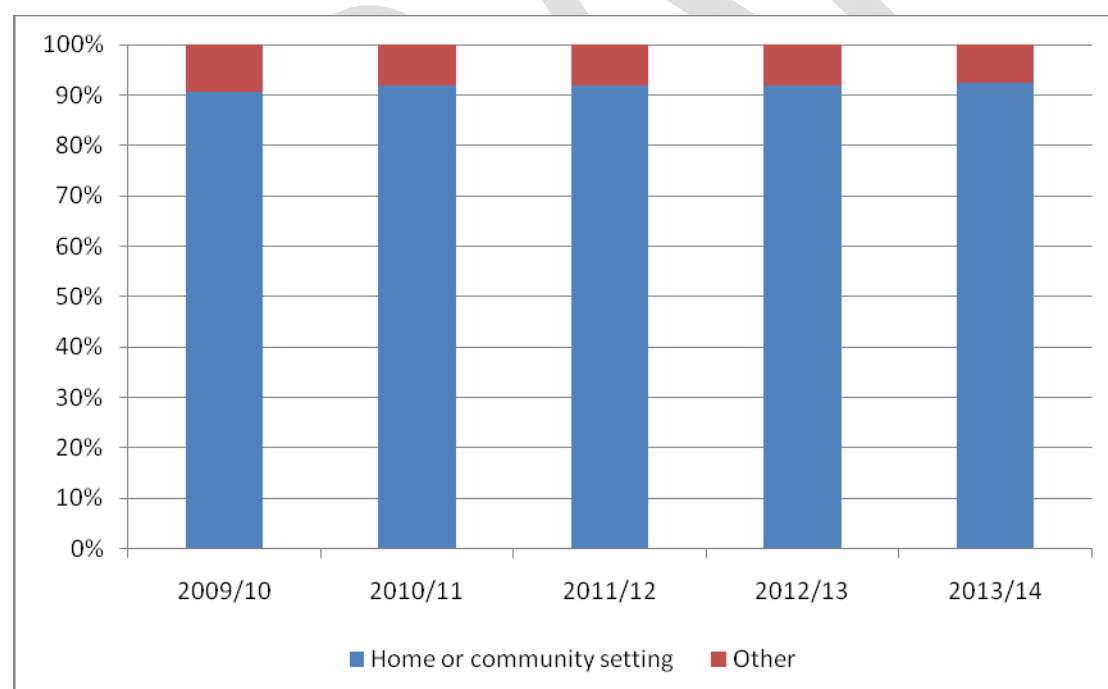
Just over 9 out of every 10 patients in Falkirk spend the last six months of their life at home or in the community, this has been the case for every year between 2009/10 and 2013/14. The percentage nationally is similar.

**Table 6.14a - 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

**Table 6.14b - 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

## **6.15 – Respite Care – In progress**

## **6.16 – Community Care Assessments In progress**

### **6.17 - Provision of Health & Social Care Services Considerations/Implications**

- The number of GPs in the Falkirk area is on the rise (130 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 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.
- Over 65's also show a much greater rise in multiple admissions (38.6% from 2004/5-2013/4) compared to just a 22.3% rise for All ages.
- 1034 bed days were lost in July 2015 due to delayed discharges, over 75's accounted for 84% of those bed days.
- Home care clients in Falkirk are largely over 65's (75.8%), receiving on average 7.1 hours of home care per week.
- Expenditure on Direct Payments has risen considerably from £0.1 million in 2004/5 to £0.8 million in 2013/14.

## **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.

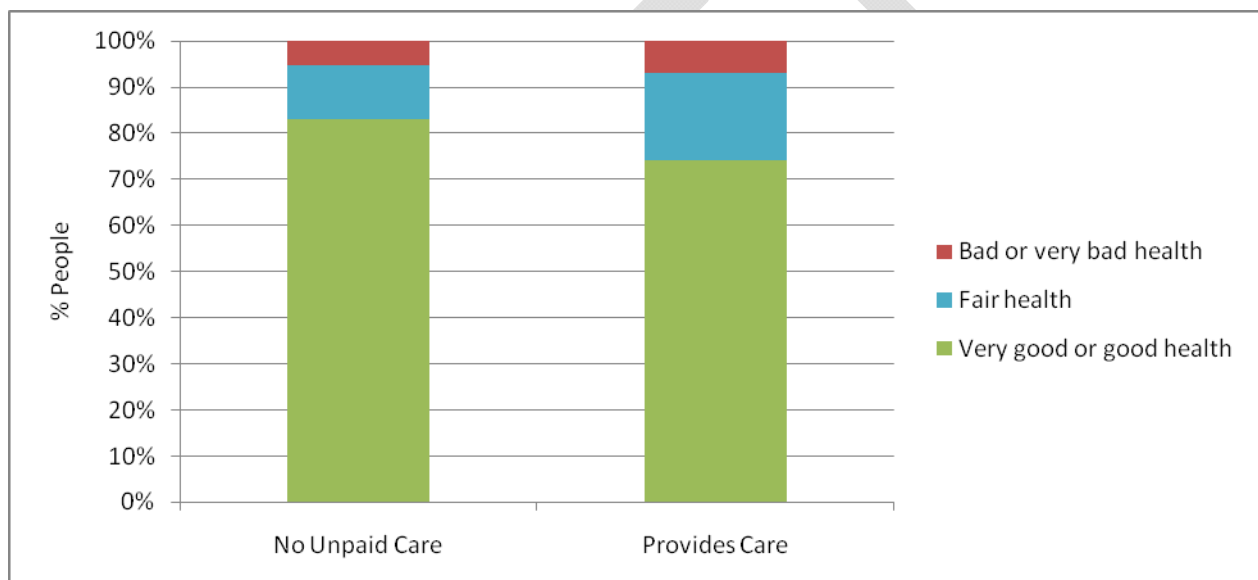
The provision of unpaid care is a key indicator of care needs and has important implications for the planning and delivery of health and social care services.

### **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 15056 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 2/3rds (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 those 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 & general health in Falkirk, Scotland's Census 2011**



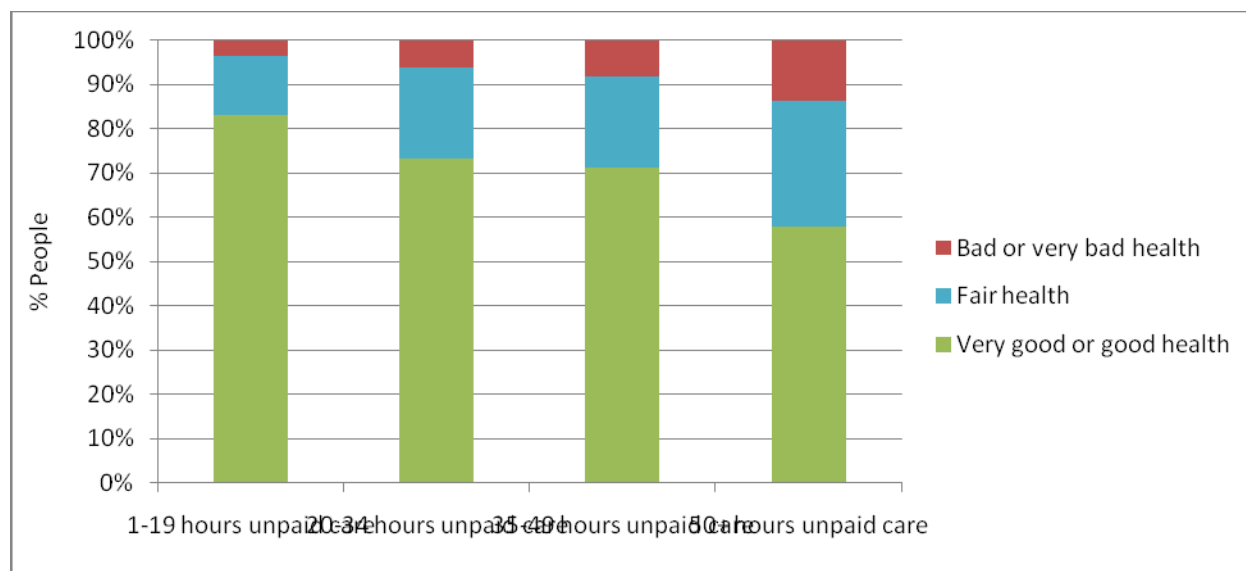
Source: Scotland Census 2011

Figure 7.2a shows that the proportion of those who'd 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 ultimately 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**

	Very Positive	Positive	Neutral	Negative	% Positive	Changes from 2011/12	Difference from Scotland
Carers have a good balance between caring and other things in their life	21%	48%	18%	12%	70	-	0
Carers are still able to spend enough time with people they want to spend time	20%	62%	17%	12%	71	-	-1
Caring has had a negative impact on carers' health and wellbeing	12%	30%	28%	28%	43	-	1
Carers have a say in the services provided for the person they look after	11%	35%	34%	20%	46	-	-3
Services are well coordinated for the people carers look after	11%	38%	36%	15%	49	-	1
Carers feels supported to continue caring	12%	34%	40%	14%	45	-	1

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.
- The majority believe that being a carer has a negative effect on their health and wellbeing, less than 50% of over 65's considered themselves to be good health.
- 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. Conclusions and Next Steps

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

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

Engagement with all stakeholders will also be required in identifying how to progress. A process of needs prioritisation is required – through multi-criteria decision making and similar democratic processes – the two main categories of criteria being importance and feasibility.