Fact or Fantasy? Your Health 2020?

A Consultation Draft

Annual Report of the Joint Director of Public Health 2011-2012

NHS Borders

Scottish Borders Council

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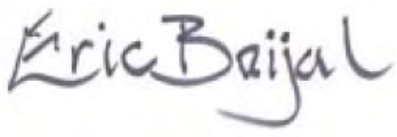

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Key Points

Structure of the Report

- What health is
- What it might be like in the Borders in ten years time
- Consultation on readers' views of what is described
- Community Planning as a way to improve health
- Health Impact Assessment – how will what is done affect our health

In this, my third Annual Report as Director of Public Health for the Scottish Borders, I build a picture of what health has been like in the Borders in the past and now in the present.

The People's Charter for Health describes health as "a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence, and injustice are at the root of ill-health and the deaths of poor and marginalised people".[1] This description brings together the various strands that combine to promote health or conspire to produce ill-health. In this report, I expand on these and how they are being tackled as well as how they might be in the future.

I set out some scenarios as to what health might be like in the Borders in the next ten years or so in the light of changes that are underway, planned, or predicted. I invite you, the reader, to comment on them. I would welcome thought about interventions that we should be putting in place but currently are not. This is a very ambitious and challenging project; elsewhere, teams of experts have sought to do the same. With the support of colleagues locally I have produced similar work for the Borders. I believe that it will be a valuable basis for planning how to improve and protect health and to measure the impact of enacting those plans.

I have used trends in a number of indicators and where possible make comparisons with the rest of the UK and Europe. I extrapolate from trends in

[1] twnside.org.sg/title/charter.htm

aspects of health in each of the different community planning themes in the Borders. Almost all the indicators I use are drawn from the English Public Health Outcomes Framework.[2] In some instances I use different definitions to these because the most relevant local or Scottish data are defined differently. Some of the indicators in the English framework are not available as yet in either England or Scotland; there are relevant Scottish indicators which are not regularly measured in England. In some cases I also use different indicators because they are relevant to building the picture of health and are routinely available for the Borders as well Scotland, although not for the rest of the UK. I share the view of many others that, out of all the measures we have, health inequalities and healthy life expectancy are together the best summary that we have of the state of a population's health.

The World Health Organisation (WHO) defines healthy life expectancy as the 'average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury'.[3] I have used the state of health in the Borders as a baseline and looked at main sources of information which help us understand what health will be like in the future. These are trends in important measurable markers of health and factors which will impact on health, such as the economic downturn and the welfare benefit reform. Where possible I want to make comparisons with Scotland as a whole, the UK and Europe. I have developed these scenarios from trends in a number of indicators, and, where possible, comparisons with the rest of the UK and Europe.

Community Planning is crucial as a way of intervening to protect and improve the health of the local population. It is the process by which Councils and other Public Bodies work together, with local communities, the business and voluntary sectors to plan and deliver better services and improve the lives of people who live in the Scottish Borders. In the Borders, Community Planning is being delivered through a series of joint work programmes organised under four themes. These are Early Intervention and Prevention, Place and Communities, the Economy and Infrastructure; and the Future Delivery of Public Services. Equalities, sustainability, health and sensitivity to the needs of more rural areas impact on each of these themes. Assessment of the health impact of community planning is therefore vital. WHO describes Heath Impact Assessment (HIA) as "a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques. HIA helps decision-makers make

[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

[3] http://www.who.int/healthinfo/statistics/indhale/en/

choices about alternatives and improvements to prevent disease/injury and to actively promote health."[4]

For the purposes of this report, the important issues are:

- What have we been doing to tackle the problems of ill-health in the Borders?
- What success have we had?
- What should we be doing in the future?
- What impact do we think we will have?

This is a consultation document and therefore I would like views from individuals, the public, politicians and professionals as well other groups and organisations. I want to know what they think of what is described. For this to be meaningful, the document must be understandable to a wide range of people. I therefore hope that the public, politicians and professionals alike will grasp what this document is about and feel able to comment on it. Distilling responses will help us to get a better view of what health might be like in the future. On that basis we will be better able to plan how we achieve that. We need to place the health of our citizens at the forefront of our planning, developing excellent practice in understanding our needs, developing innovative approaches to improving and protecting health, and commissioning excellent services from within the Council, the NHS and externally from other partners, including the Third Sector.

The aim is to produce a picture of what health could be like in the Borders in the next ten years or so. I want to use this as a basis for consultation and discussion.

I welcome your comments!

Our Scottish Borders
Your inspiration

[4] http://www.who.int/hia/en/

Chapter 2

What is the Population of the Borders like?

Key Points

- Sparse population of almost 113,000
- Many smaller settlements
- Growing ethnic diversity
- Increasing population, particularly pensioners and children
- Low increase in the working age population

The Scottish Borders is home to just under 113,000 people and proud of its achievements and the improvements already made to the health and wellbeing of its diverse communities. A largely rural area, it has a sparse population density of 24 people per square kilometre compared with 67 persons per square kilometre over Scotland as a whole.[5] Two thirds of the population live outside the eight main towns. This in itself brings about its own challenges for community staff. The low population density means the communities struggle to register in the official statistics in terms of identifying indicators of socio-economic need. There are small areas where people's life chances are disproportionally poor due for example to poverty, poor housing, illness, social environment or access to services even when available information shows the region as a whole to have a relatively healthy socioeconomic profile.

Looking further at our demographics, over the last ten years the population has risen by almost 5%. There is a particularly high elderly population but also rising numbers in those aged 0-15yrs. The Scottish Borders makes up 2.2 % of Scotland's total population.

Ethnicity

Traditionally, the Scottish Borders has had a large white Scottish population but over recent years the ethnic mix within the region has continued to increase. The largest groups of migrants are Polish (32%), Chinese (21%) and Portuguese (8%). In 2008 the Borders Equality Forum released a summary of

[5] http://www.gro-scotland.gov.uk/files2/stats/population-estimates/mid-2010/mid-year-pop-est-2010.pdf

"Cultures in the Borders". It provided a snapshot of the numbers of people from different ethnic backgrounds living within the Scottish Borders. The information was collected from members of the Borders Equality Forum. It indicated that there were a number of people living in the Borders from different ethnic backgrounds. The information suggested there were a significant number of people from a variety of countries and regions, as Table 1 below shows.

Table 1: Estimate of numbers in different ethnic groups in the Borders

Africa - Zambia, Ivory Coast, Congo, Ethiopia	85	Chinese - Cantonese / Mandarin	650
Bangladesh	150	West Indies	14
Indian	200	Colombia	10
Pakistan	200	Poland	1000
Asia - Burma, Thailand, Philippines, Malaysia	167	Eastern Europe -Russia, Latvia, Lithuania, Romania	250
Japan	30	Portugal	250
Turkey	45	Scandinavian	30
Greek	17		

Although this data is based on the work of the Equality Forum and is not necessarily quantitative, its findings are supported by the outcomes of the ScotXed census which is conducted by the Scottish Government. The census surveys the racial background and languages spoken by the children that attend the schools across the Borders region. Of pupils at school, 1.3% are from ethnic minorities. We know that the number of pupils from minority ethnic groups in the Scottish Borders between 2003 and 2008 has increased by 62.6%, from 551 to 896; this is compared to a 2.3% drop in the number of pupils from minority ethnic groups in Scotland. The 'white other' group had the biggest increase of 222 pupils equating to a 147% increase. In September 2010, 92% of the pupils on the Scottish Borders School Roll classed themselves as White- UK.

Changes in Population Size and Structure

On 29 February 2012 the National Records of Scotland (NRS) released the "Population Projections for Scottish Areas (2010-based)".[6] What do these 2010-based Population Projections mean for the Scottish Borders? The NRS projects that between 2010 and 2035 Scotland will increase in population by 10.2% and the Scottish Borders by 10.6%. The Scottish Borders is expected to have an above-average population increase. The projected change is based on both natural change and net migration. Natural change is the

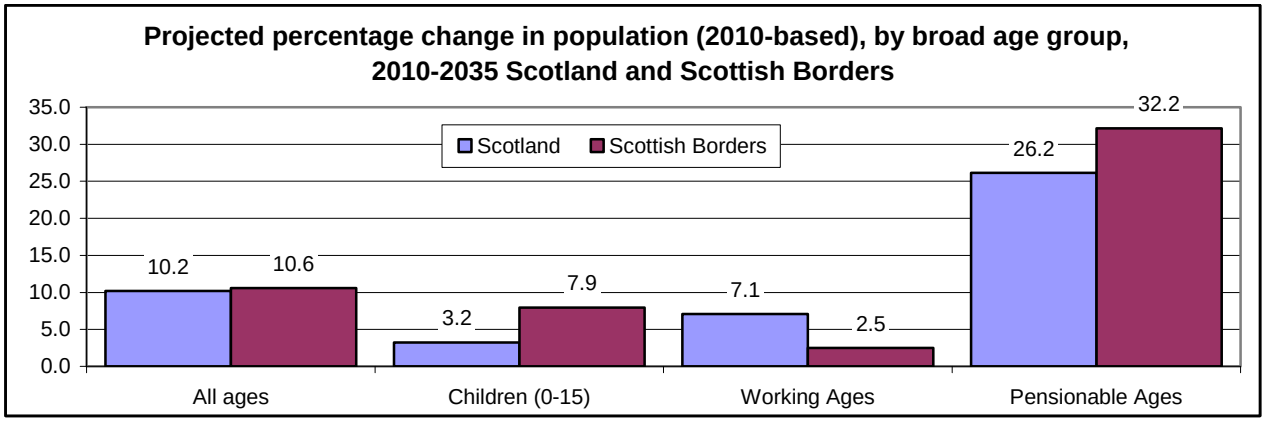
[6] http://www.gro-scotland.gov.uk/statistics/theme/population/projections/sub-national/2010-based/tables.html

change in population caused by births and deaths only and excludes migration. For Scotland the natural change during the 25 year period is expected to increase the population by 1.3%. The natural change is expected to decrease the population in the Scottish Borders by 3.4%. The projected increase in population for both Scotland and the Scottish Borders comes from projected net migration; 8.9% and 14.0% respectively.

Migration is the most difficult component of population change to estimate or project. Migration is estimated and projected based on information from multiple sources and these sources are not all directly comparable.

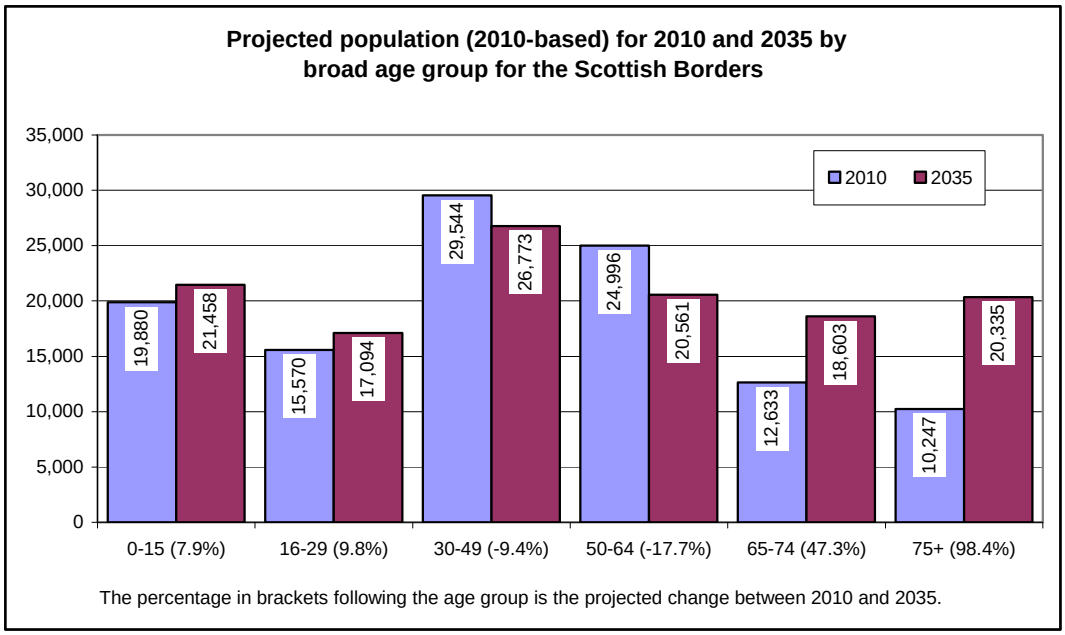
The graph below shows the projected percentage change in population by the broad age groups for the Scottish Borders compared to Scotland 2010-2035. From the graph it can be seen that there is a projected increase in all broad age groups, but that the increase in the Working Age population is comparatively low and is mainly due to the changes in the state pension age.[7] In the Scottish Borders the projected population increase is primarily due to the expected increase in pensioners and children, caused by migration and natural ageing. This means that the Working Age population will be under increased pressure to provide economic and social support.

Figure 1: Projected percentage change in population for 2010 and 2035 by age group in Scotland and the Scottish Borders



[7] Pensionable age is 65 for men, 60 for women until 2010; between 2010 and 2020 pensionable age for women increases to 65. Between 2024 and 2046, state pension age will increase from 65 years to 68 years for both sexes.

Figure 2: Projected population for 2010 and 2035 by age group in the Scottish Borders



These projections have serious implications for Scottish Borders Council, NHS Borders as well as other public and third sector services. Primarily, the dependency ratio[8] is expected to increase, from 0.61 dependents for every 1 non-dependent in 2010, to 0.94 in 2035. This means that there are fewer people supporting a greater number of dependent people (under 15s and over 65s). Within the dependent population it is projected that the number of people age 75 and older will grow by 98.4%, well above the 81.9% Scottish increase. The Scottish Borders is also expected to have an increase in the number of children (aged 0-15) by 7.9%, above the 3.2% figure for Scotland.

These projected changes mean there will be additional financial and usage pressures on services for older people and a need for additional services for children in the Scottish Borders. How the Scottish Borders Council, NHS Borders and their partners plan for the future with the community is essential for sustainability of public services.

NRS has also published "variant" population projections. Variant population projections present alternative scenarios, depending on whether estimated fertility, life expectancy or migration levels are higher or lower than the "principal", or expected population projections. The table below shows the principal projection compared to the different variant projections for Scotland and the Scottish Borders. For example, in the (unlikely) event of zero

[8] Dependency Ratio: A measure of the portion of a population which is composed of dependents (people who are too young or too old to work). The dependency ratio is equal to the number of individuals aged below 15 or above 64 divided by the number of individuals aged 15 to 64, expressed as a percentage

migration between 2010 and 2035 in the Scottish Borders, the population would be expected to decrease by 3.0%.

Regardless of migration, the number and proportion of people aged 75 is going to increase over the next 25 years and the public, private and third sectors needs to be prepared.

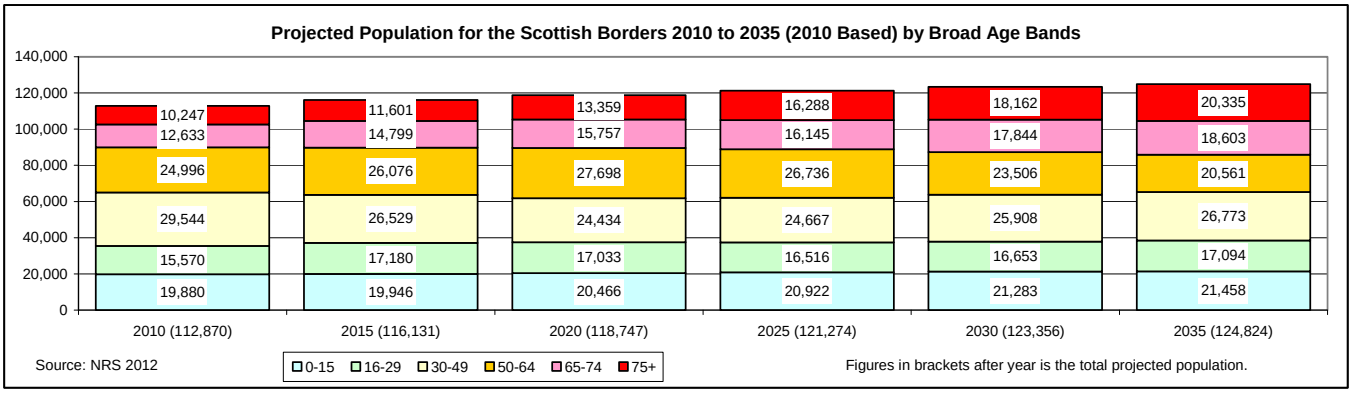
Table 2: Principal population projection compared to the different variant projections for Scotland and the Scottish Borders

Area	2010	2035							
		Zero migration	Low migration	Low fertility	Low life expect-ancy	Principal	High life Expect-ancy	High fertility	High migration
Scotland	5,222,100	5,165,178	5,498,701	5,590,821	5,684,544	5,755,477	5,823,788	5,909,410	6,012,285
Scottish Borders	112,870	109,541	118,409	121,345	123,087	124,824	126,447	127,982	131,068
Projected percentage population change (2010-2035)									
Scotland		-1.09%	5.30%	7.06%	8.86%	10.21%	11.52%	13.16%	15.13%
Scottish Borders		-2.95%	4.91%	7.51%	9.05%	10.59%	12.03%	13.39%	16.12%

Source: NRS 2012

The graph below shows the projected population, by broad age group, at five year intervals, showing how the population is expected to change over the next 25 years.

Despite all we can learn from these statistics, they do not give the complete picture of the population of the Borders. They do not give the picture of a population divided by health inequalities, but these health inequalities cut across our Scottish Borders. I discuss this issue further in the next chapter



Chapter 3

Health Inequalities in the Scottish Borders

Key Points

- What inequalities are
- The different ways of measuring inequalities
- Inequalities in the Borders
- Current initiatives to tackle inequalities in the Borders
- Walkerburn as a case study
- Inequalities in the future
- Impact of welfare benefit reform
- Future government initiatives
- The value of community planning in tackling inequalities

Introduction to inequalities

The population statistics in the previous chapter give us some small indication of different groups within the population. There are different types and degrees of ill-health between these groups, but these bald figures present a very incomplete picture of a Borders community divided by health inequality.

What are inequalities?

Health inequalities are the differences found in various aspects of health between different groups, especially between those who are best off and those who are worst off in society but also those who are stigmatised or hard to reach in other ways. Health inequalities caused by relative poverty devastate the communities we serve on an enormous scale. The poorest communities are blighted by poor mental health and wellbeing, long term physical ill health and early death.

What is the best way to measure inequalities?

Much expert thought has gone into the issue of measuring inequalities.[9] One approach is to look at statistical index such as the Scottish index of multiple

[9] http://www.scotland.gov.uk/Publications/2004/03/19045/34233 - Inequalities in Health - Report of the Measuring Inequalities in Health Working Group

deprivation which summarises the degree of disadvantage in geographical areas. Another approach is to compare various parameters of health between different populations. I do this in the sections that follow. One good summary measure is healthy life expectancy (HLE), but this is difficult to estimate for very small populations. It is possible to use other indicators to describe differences within the Borders itself which I do in the following pages.

Scotland has one of the lowest life expectancies (LEs) in Western Europe. However, underlying trends in both LE and HLE at birth show a general improvement in Scotland over recent years; but LE and HLE both tend to be worse (lower) in Scotland than in the UK as a whole. [10] The most recent figures comparing LE in Scotland with that in the Borders are for males to live 74.5 years on average in Scotland compared with 76.6 years in the Borders, and females 79.5 years on average in Scotland compared with 80.7 in the Borders.[11] In broad terms about 60 of these years will be in a healthy state.

Current Inequality in the Borders

Audit Scotland's recent work on inequalities[12] showed that patterns of health inequalities are highly localised and deprivation remains a major factor - more affluent people live longer and have enjoy better health. Age, gender and ethnicity are also significant. The distribution of public services and access to these across Scotland do not reflect the higher levels of ill health and the need for preventative approaches.

In my last Annual Report[13] I demonstrated how these findings are true of the inequalities in the Borders, particularly amongst the disadvantaged geographic communities. In it I illustrated some of the significant variations in health between different towns in Scottish Borders – breastfeeding rates, hospital admissions, smoking and so on.

Poverty and low income are already significant problems within the Borders:

- a rising proportion of the Scottish Borders population is income deprived, although this is below the average for Scotland
- 10% of working age population are employment deprived compared to Scottish average of 13%

[10] http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/key-points
[11] http://www.scotpho.org.uk/comparative-health/profiles/2010-chp-profiles
[12] http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf
[13] http://www.scotborders.gov.uk/news/article/22/director_of_public_healths_2011_annual_report

- 3% of working age population in Scottish Borders (2,053 people) are claiming Job Seeker's Allowance. This rate is rising, but still below average for Scotland

- The Scottish Borders has a consistently higher percentage of young people claiming Job Seekers Allowance compared to Scotland and numbers are increasing

- 40% of children live in benefit dependent households in Scottish Borders, similar to the figure for Scotland as a whole

- Wage levels in Scottish Borders are relatively low. Public sector organisations are the main large employers. A significant proportion of those in work are employed in small and medium-sized enterprises (SMEs) and micro-businesses or are self employed

Current Initiatives to Tackle Inequality in the Borders

There is a large array of initiatives already underway to tackle inequalities in the Scottish Borders. These include work on adult literacy by Community Learning and Development as well is implementing work from the Antipoverty Strategy including poverty sensitive housing policy and work on fuel poverty.

The Healthy Living Network

In my view the Healthy Living Network (HLN) has been one of the most important approaches to tackling geographical disadvantage in the Borders. It is a Scottish Borders example of creativity through collaboration in the context of continued recession in the UK. This virtual network of activities was created by a collaboration of partners with the community. This approach to health improvement could effectively mitigate the impact of reduced public sector spending, long term, by "taking demand out of the system through preventative actions and early intervention" (The Christie Commission, 2011).[14]

The HLN is located in what were the five most 'deprived' communities in Scottish Borders. Its main aims are to reduce inequalities in health and increase community capacity for health improvement, and currently mitigate the impact of continued recession. The HLN works alongside individuals and communities, outwith traditional health settings, to identify and mobilise assets for health improvement. HLN has worked in partnership to build a diverse health programme that meets the needs of local people.

[14] http://www.scotland.gov.uk/Publications/2011/06/27154527/0

Complementary community development and capacity building work has contributed to the strengths in these areas today but much has still to be done to ensure we narrow the gap in the Scottish Borders.

HLN was established in 2003 with Big Lottery funding and mainstreamed in 2007. Ten years on the smallest of the five communities, Walkerburn, no longer scores highly on the Scottish Index of Multiple Deprivation. Although complex to measure, the HLN will have contributed to this change.

The HLN's biggest asset is its reach in communities; effective collaboration ensures staff work creatively, producing innovative programmes that engage the 'hard to reach'. Muir Gray (1977) suggested, "The failure to promote public health may be due not to political or economic opposition, but to the fact that the arguments used to persuade people to change their behaviour or to agree to the passage of enabling legislation are set in the linguistic framework which has no meaning for them - namely, the concept of the future".

HLN has created a 'ripple' in communities and supported engagement by taking the time to get to know people. Building trusting relationships has generated an enthusiasm for health. HLN staff work autonomously and with a small budget which enables them to be more creative and remove barriers to participation. Providing positive experiences, creating connections and supporting others to develop and build on their strengths are key indicators of the assets based approach, additional strengths of HLNs. HLN staff are enthused by and committed to the assets approach. This promotes community resilience by enabling individuals to improve their own health and the health of their communities.

Case Study – Walkerburn

Walkerburn is the smallest of the five most deprived Borders communities. This case study illustrates the change process in Walkerburn by focusing on the conditions and influences on creativity and collaboration.

The HLN's starting point is the community, often referred to as a 'bottom up' or community development approach. This requires a neutral position and no pre-determined prescription for how people should behave although striving for a healthier lifestyle. Working within a partnership of organisations and operating in this way requires, amongst other things, collaborative leadership, a long term view and a context to enable change. The HLN's primary concern is health improvement; contributing to national health targets influences its work.

The Walkerburn Experience

A two year consultation process with the community led up to confirmation of lottery funding in 2003. A set of targets were agreed across the five localities, detailed below:

Walkerburn in 2003:

- One of the five most deprived communities in Scottish Borders
- Known as a 'dumping ground' by residents who felt that people were re-housed there if they could not find other accommodation
- Described in the HLN business plan as having a 'weak sense of community integrity'
- A fragmented community with unusually low levels of participation in local activities
- An area where wages were low and unemployment high with residents feeling isolated and like 'second-class citizens'
- Walkerburn was "apparently held in low self esteem by outsiders and consequently its residents, especially the young people of secondary school age"

(Borders Healthy Living Network Business Plan 2000)

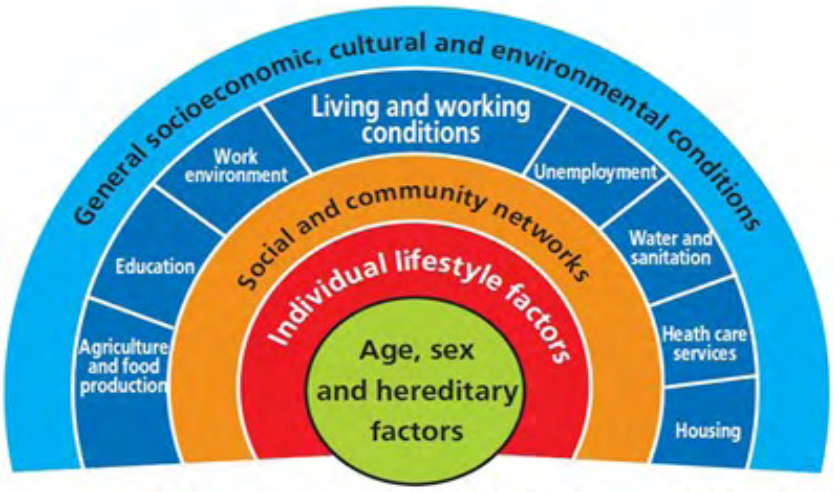
This highlights the extent of the wider influences on community health in Walkerburn in 2003 including physical, emotional, economic, social, political and hence, cultural issues as detailed below in a 'social model of health'

Walkerburn had its own set of problems including one of the highest incidences of:

- Episodes of coronary heart disease in the under 75s in the Borders (39.6-47.2 per 1000 population, 1997-2000)
- Premature death from CVA/stroke (0.14-0.17 per 1000, 1997-99)

Big Lottery needs assessment work in 2003 provided a basic overview of the activities in Walkerburn at that time. This needs assessment created an enthusiasm for HLN and for health. Working in partnership NHS Borders and

partner agencies co-created a vision for the future health of Walkerburn by identifying what needed to change.



The Determinants of Health (1992) Dahlgren and Whitehead

Walkerburn – Activities

Walkerburn 2003

Youth Club
Tennis Club
Evergreen club and pensioners association
Girl Guides
Crusaders
Women's guild/rural
Walkerburn Area Vision Evolvers
Guid Fettle

Focusing on assets in 2003, Walkerburn had:

- A pre-existing community activity
- A vision for change in Walkerburn
- A small population of around 620
- A vibrant older people's population
- An expectation and enthusiasm resulting from two years of needs assessment
- A limited range of area based partners
- An opportunity to create a team in the community

- An opportunity to raise the profile of the areas at all levels
- New ideas for old problems

HLN Targets 2003

Linked to national targets, these were to be backed up by drop-in services, social support and community development work. Although critical, and achieved, these targets were almost secondary to the community development process. With no firm guidance on how to achieve these targets, these became an overarching framework. With reference to the 50% increased uptake of healthier foods this was open to interpretation and is what gave way to a creative approach in Walkerburn. The figures below are for the five HLN areas; it was estimated that 2,000 people would use the project in its timescale.

- **250 people stop smoking for 6 months or more**
- **1,500 adults and 500 children to increase their physical activity levels by 50%**
- **1,200 people to gain new cooking skills**
- **A 50% increased uptake of healthier foods**
- **2,000 people to improve their ability to cope with stress**

What does the HLN contribution look like?

HLN Contribution

- **Early Years**
  Breastfeeding Information & Advice, Bump to Baby, Weaning, One Stop Shop Legacy, Community Food Work, Vegetable Distribution

- **Children & Young People**
  Cooking Skills, Physical Activity, Emotional Well Being, Community Food Work, Schools Programme

- **Working Age Adults**
  Community Food Work, Low Level Healthy Weight Work, Physical Activity, One Stop Shop Legacy, Smoking Cessation

- **Older People**
  Community Food Work, Lunch Club, Carpet Bowls, Seated Keep Fit, Walking Group, Smoking Cessation, Vegetable Distribution

- **Community Development & Capacity Building**
  Community Health Volunteering
  Consultation
  Health Issues in the Community
  Elementary Food Hygiene
  First Aid Training (Basic/Babies & Children)
  Walkerburn Allotments/Community Garden
  Horticulture Training

The community were experienced and used the HLN staff team as a resource and worked well in partnership with services.

HLN staff created a volunteer team, of older people, parents, young people and interested others. Older people set up a tooth brushing programme for pupils in the school, a gentle exercise class for their age group and we offered microwave cookery to provide positive experiences. Participatory appraisal methods, where members of the community give their views, were used to create a ripple in the community around the 50% uptake of healthier

foods. Locals drew out a map detailing food access and availability and suggested solutions. This research formed the basis for developing community food work at all levels, early years, schools, working age and older people. Many other activities were delivered and it was about consistently building momentum, building on success and developing a positive reputation for HLN and health in the community. Partnership working became an integral feature with other services coming on board as appropriate. New relationships were established between HLN, the community and statutory services including health, social work, education, housing and local authority.

This summary sounds like a logical process. While there was overwhelming support and enthusiasm, there was also resistance to change. Using the Walkerburn Allotments as an example, this was perhaps the biggest change in the area. The Walkerburn Community Development Trust focused on alleviating fears and communicating the vision for reducing Walkerburn's carbon footprint. The HLN concentrated on the health benefits and the training opportunities a community garden would bring to the area, increasing employability. The 'early adopters' who became the 'Walkerburn Allotments Society" worked hard to overcome the challenges during the planning phases and engaged well with services to meet their needs. The community garden and the allotments society are not without their politics and other service providers are interested in how their service users can benefit from the opportunities Walkerburn has to offer. However, this has been a significant change in Walkerburn and the community need time to form, storm, norm, and perform before they can broaden their horizons.

Thematic headings have been used to group programmes of work and within each programme of work are a variety of activities. It would be impossible to detail the list of partners and activities over a ten year period however this gives a clear flavour of the programmes of work already established.

Seated Keep Fit: HLN Walkerburn Village Hall

Walkerburn in 2012:

Walkerburn in 2012 is significantly different with a number of other agencies collaborating effectively with the community and a Healthy Living Network firmly established. Perhaps the most significant change relates to who is running the groups in Walkerburn, the community themselves. Walkerburn is a role model for other Borders communities.

- No longer scores highly on the Scottish Index of Multiple Deprivation
- Do not define themselves as a deprived community
- Are proud of their achievements and contribution to the development of the area
- Have an active locality volunteer team who deliver and support additional activities
- Volunteers and participants have taken part in local consultations and health related events
- Have solved the complex problem of 'a 50% increased uptake of healthier foods' by increasing the access and availability fruit and vegetables in the area
- Are running health improving activities themselves
- Latest unemployment figures suggest there are a total of 30 unemployed people living in Walkerburn, ten of which are on a work training programme, leaving 20 people looking for work.

This is a significant transformation over a ten year period. It is important to consider here the potential cost benefits. Financial risk was minimised in the first five years through the big lottery 'pilot', we are now seeing the added value and reaping the benefits with improved health status in year 10. The impact of collaboration and the assets approach is demonstrable in Walkerburn through the statistical and other qualitative changes in social conditions in the community. It is however important to note that the issues in Langlee, Burnfoot, Eyemouth and Selkirk will be significantly different, deprivation statistics will help us to identify a starting point and focus for each area.

Evaluation

On evaluation, the Walkerburn community have worked well together to resolve significant problems and are a model for other communities in the Borders. The HLN staff team have been less visible in Walkerburn over the last fifteen months and activities are ongoing. Trained community health volunteers are well placed to ensure sustainability while there is need, they are continuing to promote and engage others and they are now asking for what they need.

It is very difficult to compare like with like as what we have in Walkerburn today does not reflect Walkerburn ten years ago. The improvement in Walkerburn could be a reflection of deterioration in other areas; however, social conditions have improved alongside other changes in the make up of the community and the opportunities available making it difficult to tease out exactly. With reference to a social model of health the improvements may relate to any one of the influences and their interrelationship with health. The other factor to take into account is deprivation and what that actually means today in comparison to what it meant in Walkerburn in 2003. Walkerburn always appeared asset deprived on the surface, yet the community were the single biggest asset and mobilising them has created new opportunities that have contributed to the change.

Conclusions

Building healthy living networks in communities is a long term approach that requires long term investment and partnership working creatively to produce lasting health benefits. Walkerburn is a model that could be rolled out to other communities in Borders, and central to this is the role of local leadership. The Walkerburn experience had all the right conditions, mobilising them created the 'magic' that is Walkerburn in 2012.

Annual Health Awards: Nicola Sewell, Health Improvement Specialist - HLN & Inequalities and HLN Walkerburn Ladies

Inequalities in the future

In addition to Scottish Government policies, there are other interrelated social, economic and environmental drivers detailed below which will continue to fuel inequality:

Key Local and National Drivers

- Reduced Public Sector Spending
- Welfare Reform
- Increasing Poverty & Inequality
- Technology
- Increasing Ageing Population
- Rurality
- Unemployment
- Debt – Local & National
- Research – Genetics/Deprivation
- Vulnerable Groups
- Communities and Changing Demographics
- Carbon Footprint & Carbon Efficiencies Work
- Transport
- Whole Town Planning, The SOA & Community Planning
- Partnership Working
- Low Wage Economy
- Obesity Epidemic
- Commitment to the Early Years

Taken together, this complex set of drivers will ensure that the welfare state and our communities are in a state of change for a considerable time. Such changes are a public health issue. The future impact of the Welfare Benefit Reform on health inequality is a matter of considerable concern.

Effects of the Welfare Benefit Reform

The changes which are of particular concern in terms of health impact are the proposed changes to Disability Living Allowance (DLA), Incapacity Benefit and Housing Benefits, as a result of changes in conditionality, in the mechanisms for claims and payment and in the underlying assumptions about the availability of work. There will be a significant net financial loss to individuals and to the Scottish Borders economy

Illustrations of the likely effects in Scottish Borders of the reforms:

There are 4,290 Incapacity Benefit claimants currently in Scottish Borders. New criteria for the assessment of work capability are likely to mean that over 3,000 of these will be required to find work. The loss of income to the Borders resulting from these benefit changes is estimated to be in the order of £3m. The job market is not growing to accommodate this flow of new entrants.

Replacement of Disability Living Allowance by Personal Independence Payments will mean a 20% cut by 2015/2016 in the budget and tighter qualifying criteria. SBC has estimated that the potential loss of income in Scottish Borders will be in the order of £4m. This is likely to have considerable impact on individuals in terms of support for daily living and of mobility and care costs.

Universal credit will be paid as one monthly payment to one individual in a couple, will include housing costs and be subject to a ceiling. Claims processing will be digital by default. This stands to disadvantage those who are not IT literate or lack computer access. The single monthly payment assumes financial literacy that not all have. Financial insecurity, debt and financial exclusion may result. This would have significant detrimental impacts on dependents, including children. For example, it has been estimated that the combined impact of changes to benefits and tax credits mean that a family on low income having a second child will be worse of by £4,500 in the year following birth than they would have been in 2009.

Housing Benefit changes mean that more than 75% of the 1,100 local claimants will be affected, with an anticipated loss of income of over £500,000. Housing insecurity will arise from changes to the costs covered and for some there will be a mismatch between assessed housing requirements and current housing.

Social Fund payments will be affected by a reduction in funding nationally from £30m to £23m and responsibility for crisis loans is to be devolved to local authorities. There are concerns that insufficient resources to respond to need will produce pressure on social work and housing budgets.

The overall consequences of the reforms are likely to include:

- further reduction in income for those already on relatively low incomes, including families with school age children and those with long term health conditions and disabilities
- increase in income inequalities within the Borders as well as nationally
- possible migration into the area of households seeking more affordable housing
- increase in debt, financial insecurity, financial exclusion and fuel poverty

Assessing the health impact

There is evidence that greater inequalities in society exercise a 'downward drag' effect on wider population outcomes including health outcomes. The general health of the population in more unequal societies is worse than in societies which are more equal.

Low income is associated with poorer health outcomes, including poorer mental health. It is likely that the welfare benefit reforms will contribute to: increases in inadequacy of housing; reductions in dietary quality; increase in fuel poverty; possible adverse changes to health risk behaviour including smoking, alcohol and drug use; increases in stress and anxiety and suicidal behaviour.

Predicting or quantifying the health impacts is very difficult in view of the interplay of many different factors. Nevertheless, the research literature demonstrates that illnesses in adults and children that require treatment and care are likely to increase [15] as follows:

- poorer mental health, increased cardiovascular and respiratory illness (associated with low income, income inequalities)
- increases in obesity-related illnesses such as diabetes, arthritis and cancer arising from poorer nutrition (associated with low income, income inequalities)
- poorer mental and general wellbeing, reductions in / disruption to health care access (associated with housing difficulties / housing insecurity)

[15] NHS Highland. The financial implications for NHS Highland of the UK Welfare Reform Act. Written submission to the Scottish Government Finance Committee for the Evidence Session 20 06 2012

- potential increases in avoidable winter mortality (associated with fuel poverty)

These consequences would have significant financial impacts on local NHS Boards in Scotland and on demands on primary and secondary health care.

Similarly, increasing demands can be envisaged on the need for informal carer support, against a background of potential reduced availability. As fewer people are likely to receive disability benefits, it is also likely that fewer will receive carers' benefits. Lower incomes and pressures on informal caring capacity may well reduce ability to self-manage, with consequent effects on demand for formal support services and rehabilitative and therapeutic services.

There is likely to be a widening of health inequalities as a result of the disproportionate impact on groups with certain groups, including those with protected characteristics under equalities legislation: women; on those with caring responsibilities; people with a disability; and certain age groups i.e. young adults.

Future Initiatives to Tackle Inequality in the Borders

We need to make the best use of information available to refine our understanding of health inequalities in the Borders. The development of a Health Strategy would provide an opportunity to review this information and to listen to local communities and groups about the health related issues that affect them.

The Audit Scotland review of progress across Scotland by Community Planning Partners in tackling health inequalities has flagged a number of important messages and recommendations that partners in Scottish Borders will need to consider in developing the new Single Outcome Agreement and related action plans. New guidance from the Scottish Government urges local Community Planning Partnerships to mobilise the assets, activities, and resources of the public sector with those of the voluntary and private sectors and local communities to foster early intervention and preventative approaches. An assessment of the impact on health inequalities must guide decisions about resource allocation and service redesign. This may include resources being shifted from more affluent areas to poorer ones to tackle persistent health inequalities. Only in this way can inequalities in outcomes, including health outcomes be narrowed.

In Scottish Borders the new Community Planning structures and the policy priorities identified create the means to make stronger links across different sectors. A good example is the work underway to mitigate the impacts locally of welfare benefits reform.

Future initiatives to tackle health inequalities in the Borders must clearly take account of the drivers that are almost certain to exacerbate them over the coming years. Given that history has demonstrated the intractable nature of inequalities as a "wicked" issue, a far more radical approach will be required.

We now need to set clear achievable outcomes that will make a difference to health inequalities. One of the questions we have to answer is how ambitious the targets we set should be. Does that mean we should aim to close the inequalities gap by delivering health equity in a generation? Whatever our answer to that question, we must aim to reduce avoidable differences dramatically, to the point where they do not represent the appalling and systemic unfairness we now face. For example, it means reducing the years of life lost annually to poverty from being measured in thousands to being measured in hundreds. To achieve such goals requires fundamentally different approaches to health not just working harder at our current efforts.

Recession has health consequences, some of which are irreversible. In this context, early intervention is one route to the long term well-being of communities and the next generation of children, young people and families in the Scottish Borders.

Implications for Community Planning Partners in the Borders

Planning and delivery

Reducing inequalities in health is identified as a corporate objective. We need to monitor health needs and demands on services as the changes in the UK welfare system take effect. In addition, it will be incumbent on organisations to assess the impact on health inequalities of service redesign.

For service delivery, front line staff need to be aware of the possible impacts of the welfare reforms on their patients or service user groups and able to provide information on where to get advice and support with benefits issues and with financial worries. There are good examples of work locally, plus learning from elsewhere such as the Inequalities Sensitive Practice programme.

Effective liaison arrangements are required with local employment service providers to enable those on employment support programmes to access appropriate health care and support services and to facilitate effective information exchange between health care and employment service providers.

Several services have access to dedicated welfare benefits advise e.g. mental health; Macmillan. It will be critically important to ensure these key

resources are sustained as demand on specialist advice and advocacy grows.

As an employers

The reforms will affect staff in a variety of ways:

- increasing financial insecurity for some staff whose household incomes are affected
- those on part time hours may be seeking additional hours to qualify for tax credits
- staff who also have family caring responsibilities may come under additional pressures in balancing work and home life
- it will be important to ensure that staff are made aware of financial advice services and other supports available

In the local labour market

Work is recognised as a key social determinant of health[16]. Waddell and Burton (2006) state that "Worklessness and not disease is the biggest cause of health inequality, social exclusion, deprivation, and mortality".[17] *Health Works* outlined the actions that Boards were required to take to help address inequalities in this area[18]. NHS Borders developed a "*Health Improvement Strategy for the Working Age Population"* to progress a range of activity that supports this agenda.

Partners all have a role in promoting employability by providing training and work opportunities for those seeking entry or returning to the labour market and by maximising the retention of staff who have or develop health conditions.

As contractors of services in the local economy, Scottish Borders Council and NHS Borders can commit to supporting local businesses and maintain jobs in the local economy, as far as possible.

In conclusion, it is possible to identify the main areas of Public Sector services likely to be significantly affected by the welfare benefits reforms although the magnitude of these impacts cannot be readily quantified. What is clear is

[16] CSDH, 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of health. World Health Organisation, Geneva.
[17] Department for Work and Pensions, *Is Work Good for Your Health and Well-being?* Gordon Waddell and Kim Burton (HMSO London, 2008)
[18] http://www.scotland.gov.uk/Resource/Doc/295517/0091521.pdf

that changes will affect most those with poorer health. There is therefore a considerable risk that inequalities in local population health outcomes widen. Scottish Borders Council and NHS Borders, with their partners, should therefore plan and implement appropriate mitigating actions as outlined to offset this risk.

Key recommendations are that:

- Scottish Borders Council and NHS Borders affirm their commitment to work in partnership with each other and the third sector to mitigate and manage impacts through Community Planning under the Tackling Poverty and Financial Exclusion strategy
- Continue to monitor the impact of the reforms and review implications for population health and health care delivery and risks for the organisations involved
- Ensure services gear up in the areas most likely to be affected by the reforms
- Raise awareness in services of likely health related impacts of the reforms in the short and longer term
- Ensure that front line staff are equipped to provide information on where to get advice and support with benefits issues and with financial worries. and have the necessary competencies in inequalities sensitive practice
- Promote the exchange of knowledge and learning with wider public health networks e.g. through the Directors of Public Health Network; Healthier Wealthier Children programme in Greater Glasgow; and community led health development
- Proactively exploit links with JobCentrePlus and other employment services to ensure effective pathways are in place between health care and employability service providers

- Investigate the feasibility of commissioning or collaborating in research to quantify the impact on local services

Chapter 4

Early Interventions in the Early Years

Key Points

- Inequalities in health in children
- Poorer maternal health in pregnancy
- Shift in spend to prevention - focus on early intervention
- Work to improve antenatal education
- Efforts to improve breastfeeding rates
- Successful immunisation programme
- Smoke free homes initiative
- Tackling the childhood obesity challenge

The health of future cohorts of people will be influenced by the lifestyle choices and environment of their parents made during their life course. What do we mean by early interventions? We don't just mean the things we encourage parents and carers to do for their children early in life such as ensuring they have their immunisations or attend nursery or school. We are talking about doing things before people's health starts to deteriorate, to protect or, even better, improve it. So we can intervene early at any point in someone's life. Early interventions need to begin before things start to go wrong or as soon as we know they are going wrong for the biggest impact.

The big question is can we do current early interventions better or are there other things we are not doing that we should be. Our answers to these questions will have a significant impact on our health and the health of people of all ages in the future.

In this and the following chapters I describe the early interventions that are in place, at every stage of life for people in the Borders, and examine their impact on improving our health in the future. In this report I have sought to focus on what I think will be, realistically, the most optimistic picture of our health in the future in the Borders.

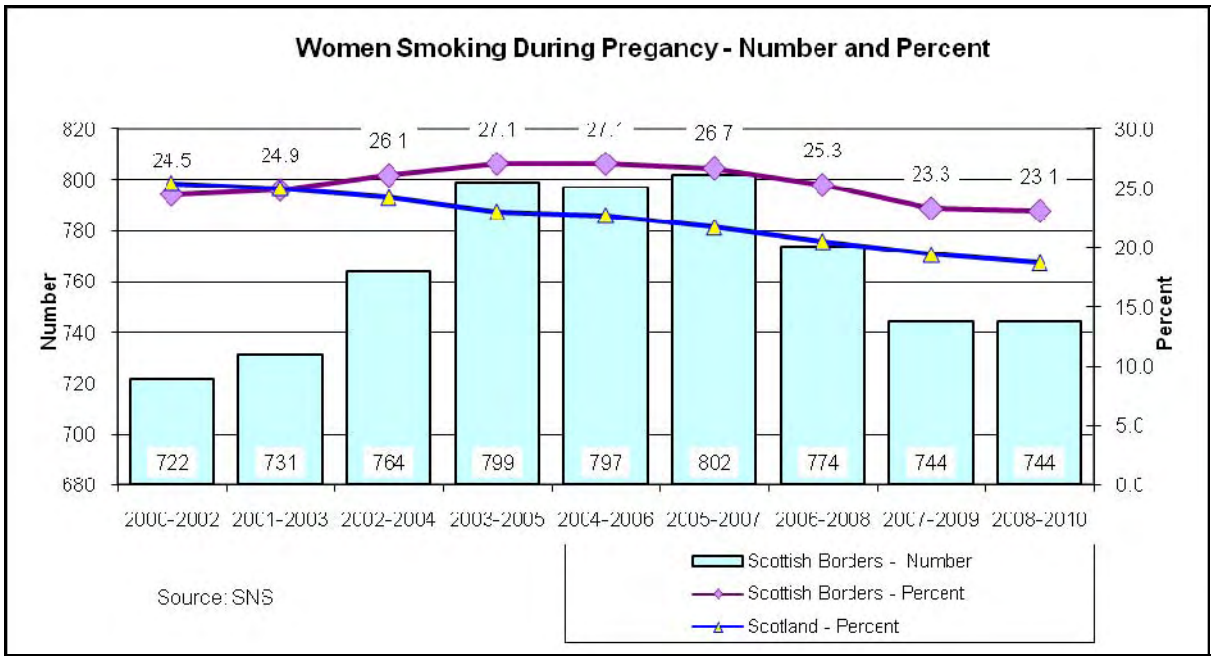
Health in the Early Years

A picture of the health of children today helps us to determine where to target the most appropriate early interventions. There are a number of pieces of the jigsaw of that picture.

Ensuring preconceptional health is fundamental to good outcomes for women and babies. However, the first two trimesters following conception are also vitally important. They are the most vulnerable periods of significant fetal development. This is the time when the fetus most at risk to the impact of adverse maternal circumstances, for example maternal stress, use of tobacco, drugs and alcohol and poor nutrition. Pregnant women are highly motivated to do all they can to ensure the best outcomes for their babies. They are therefore more likely to respond to support and information to modify behaviour, including how they intend to feed their baby. Despite this the evidence that follows shows that, for a significant proportion of babies, their life chances are prejudiced before they are even born.

While the graph below shows that there is a downward trend in the proportion of women smoking during pregnancy it is still a grave concern that over the latest three years in the graph around about 750 pregnant women are smoking.

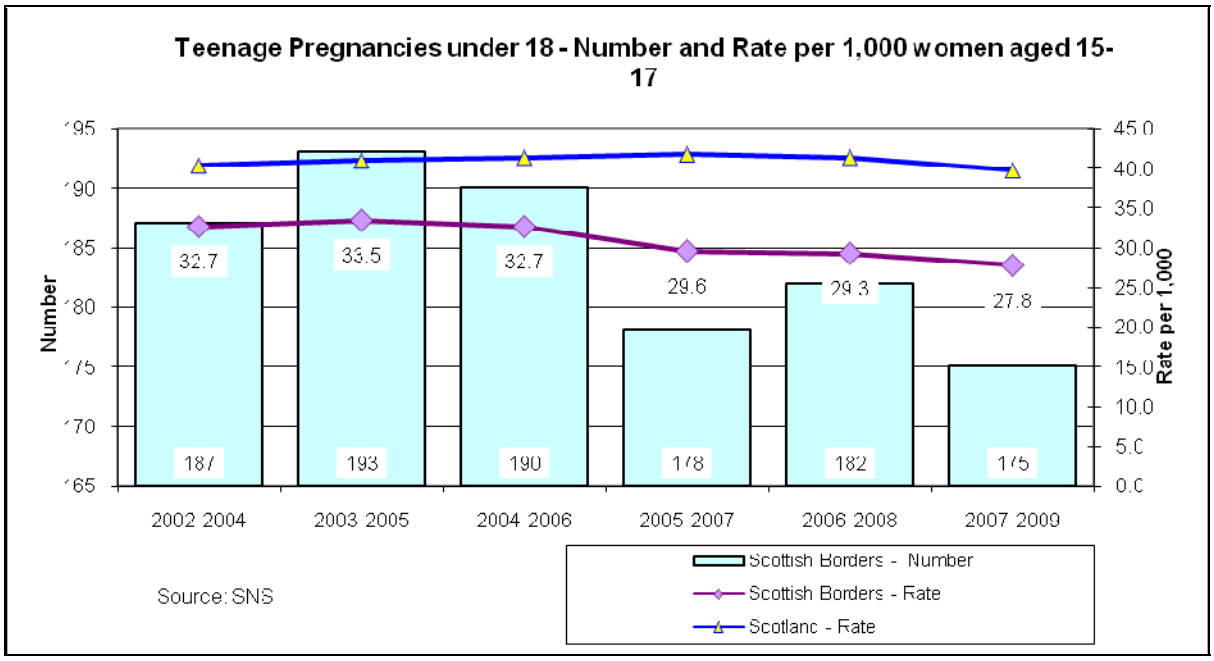
Figure 3: Women Smoking During Pregnancy



It is therefore crucial that we intervene as early as possible in pregnancy to support such women in stopping smoking.

Another disturbing part of the picture is the steady number of teenage pregnancies in the Borders, as the graph below shows.

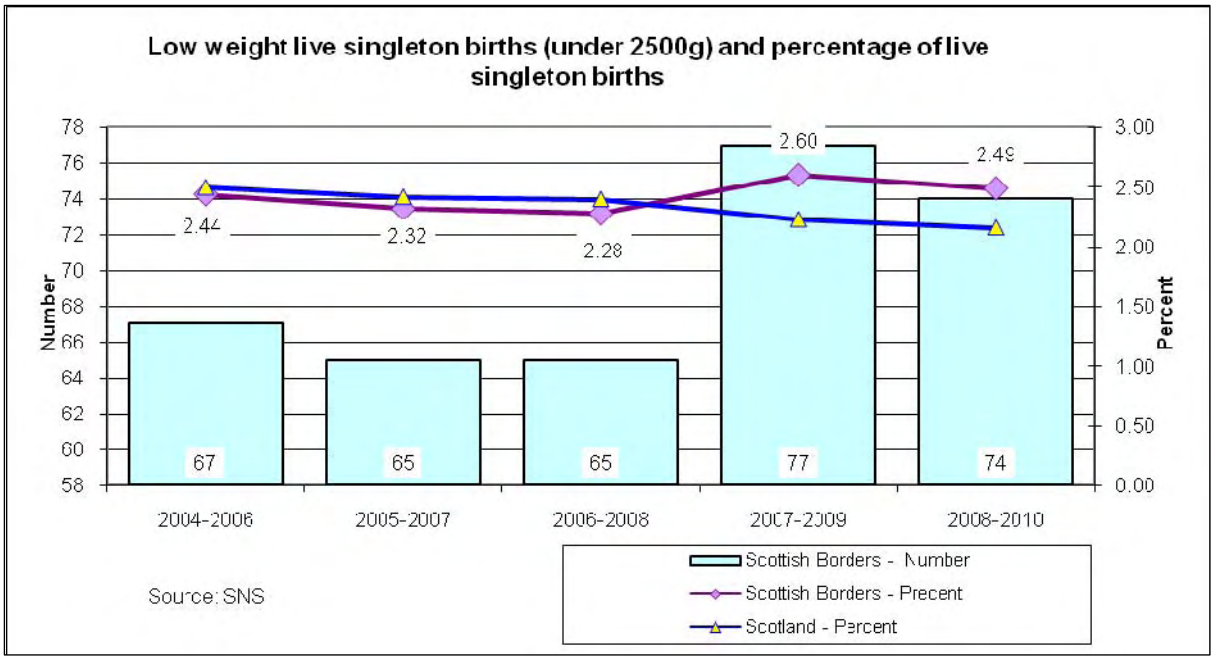
Figure 4: Teenage Pregnancies under 18 – Number and Rate per 1,000 women aged 15-17



We know that such young mothers have more complications and poorer outcomes in their pregnancies. We therefore need to encourage would-be parents to give thought to the age at which they have children.

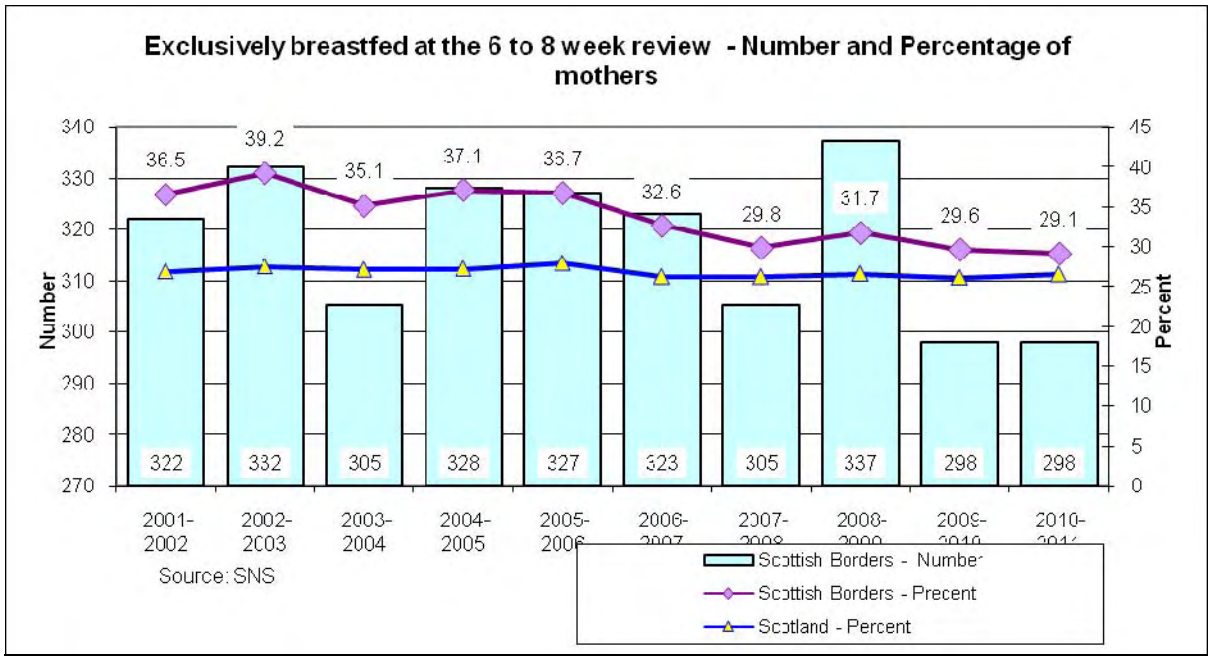
I find the similar picture in relation to low birthweight babies, as shown in the graph below, equally disturbing. While the proportion of low birthweight babies is declining, we continue to have a steady 70 odd low-birth-weight babies born to Borders residents each year.

Figure 5: Low Weight Singleton Births (under 2500g) and percentage of live singleton births



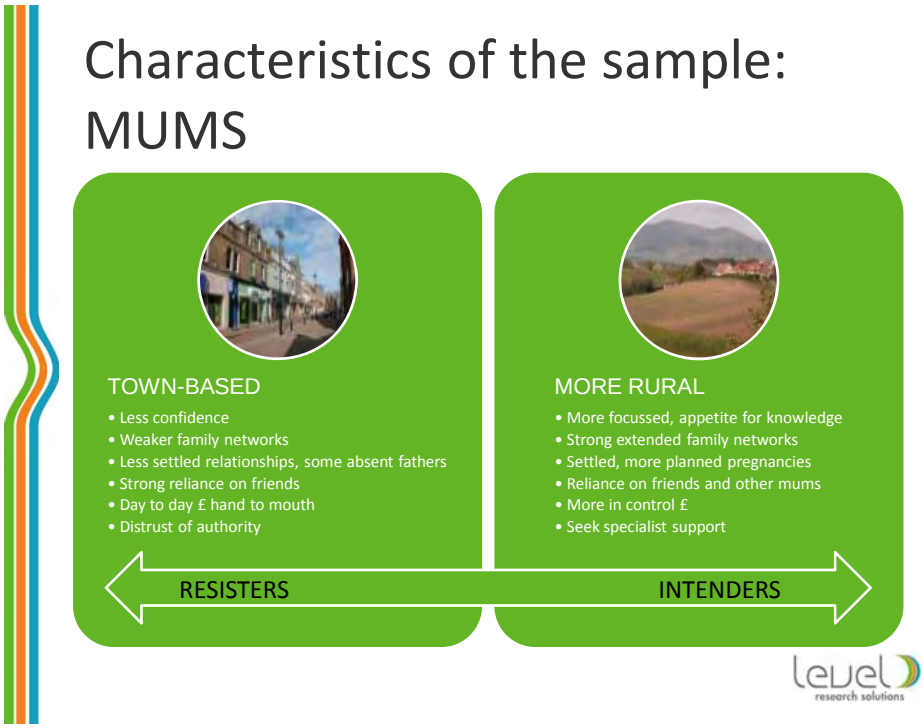
Another marker of health in infancy is the rate of breastfeeding, which the graph below shows is not only disappointingly low across Scotland, but in the Scottish Borders

Figure 6: Exclusively breastfed at the 6 to 8 week review – Number and Percentage of mothers.



The evidence demonstrates that this is one of the highest impact and cost effective early interventions we can make to improve child health in infancy and beyond. The annual rates for 2011/12 show that 32.4% of babies in Borders were being exclusively breastfed at 6-8 weeks, just below the standing target of 33.3%. This puts the Borders second behind Lothian (33.9%) amongst mainland Health Boards. NHS Borders' performance remains higher than the Scottish average of 26.2%. In 2008 the worst rate of breast feeding at 6-8 weeks for the deprived areas was 18.8% (10% for exclusively breast fed) compared with 63.1% (35% for exclusively breast fed) in the most affluent community in the Borders.[19] These findings are validated by the statistically more robust work of the Audit Scotland which found that exclusive breastfeeding rates at 6 to 8 weeks ranged from 15% in the one fifth most deprived to 40% in the one fifth least deprived areas.[20] This may reflect the older age of more affluent mothers. This inequality between the deprived and the affluent is compounded by inequality between the urban and rural, demonstrated by local qualitative research as Figure 7 below illustrates:

Figure 7: Characteristics of the Sample : MUMS



I am therefore gravely concerned at the low proportion of children breastfed in the Borders, particularly in deprived areas. What is even more worrying is

[19] http://www.scotborders.gov.uk/news/article/22/director_of_public_healths_2011_annual_report

[20] http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf

the wide inequality in breastfeeding rates between the most disadvantaged and most affluent areas in the Borders. While the measurement of breastfeeding is confounded by different definitions overall, international evidence demonstrates that it is possible to have rates up to 90% and beyond.

On a more positive note, the graphs below show that there has been good uptake of the childhood immunisation programme. The benefits of this may have been forgotten by many but we need to remember the programme has saved many lives and much illness, including the prevention of rubella syndrome which is due to "German measles" in the unborn baby.

Figure 8: Immunisation uptake at 24 months – MMR - Percent

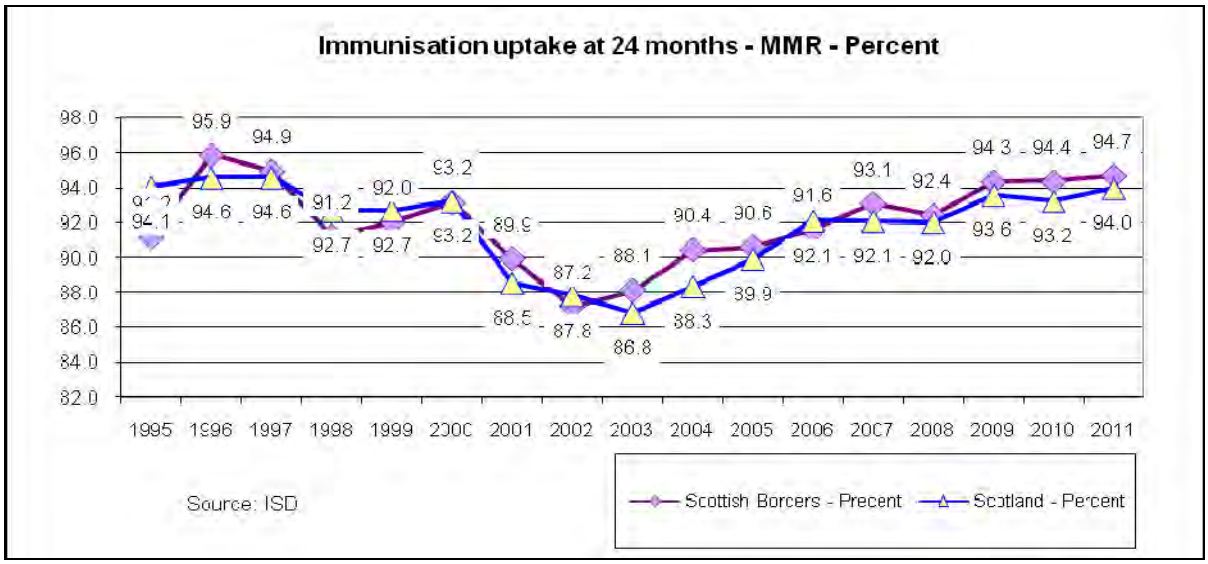
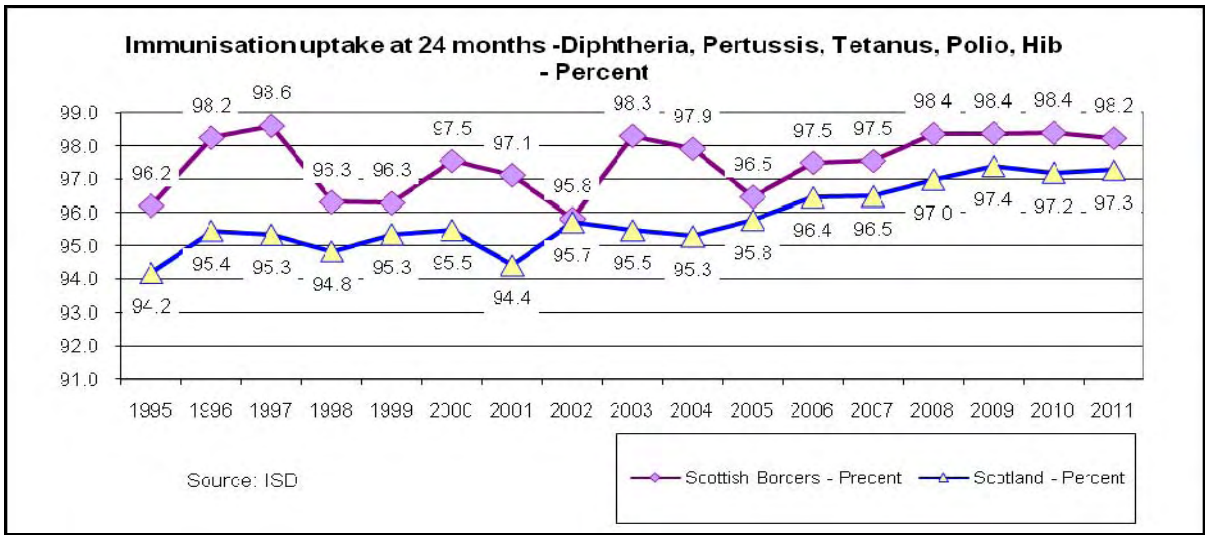
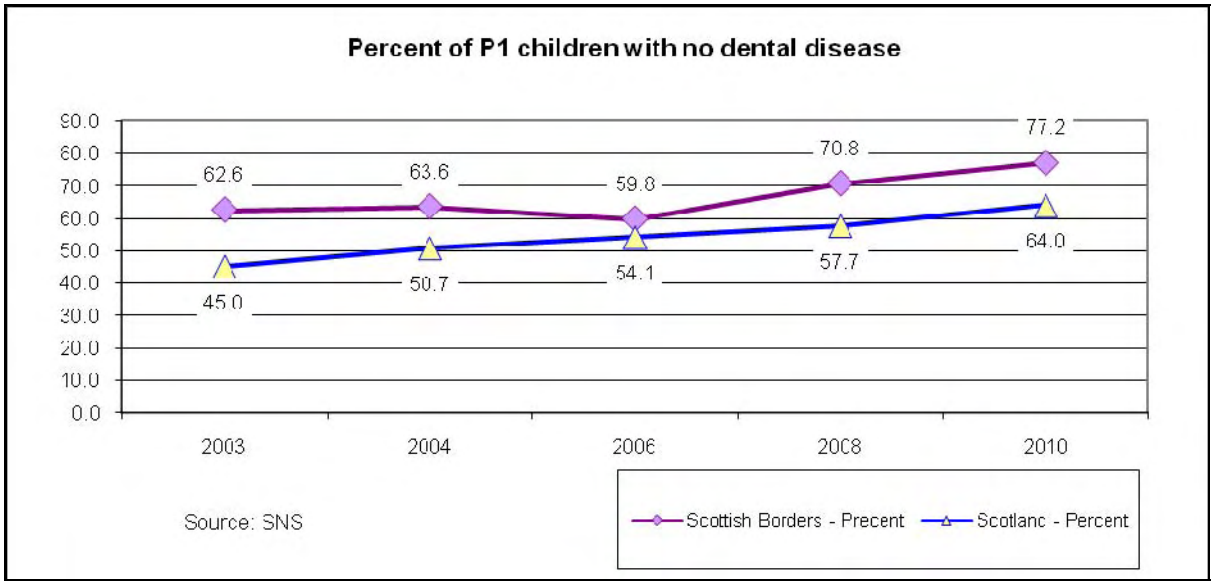


Figure 9: Immunisation Uptake at 24 months – Diphtheria, Pertussis, Tetanus, Polio, Hib - Percent



Another measure of health in children is dental health. As the graph below shows this has slowly but steadily been improving in the Borders and is consistently better than for Scotland as a whole.

Figure 10 : Percentage of P1 children with no dental disease



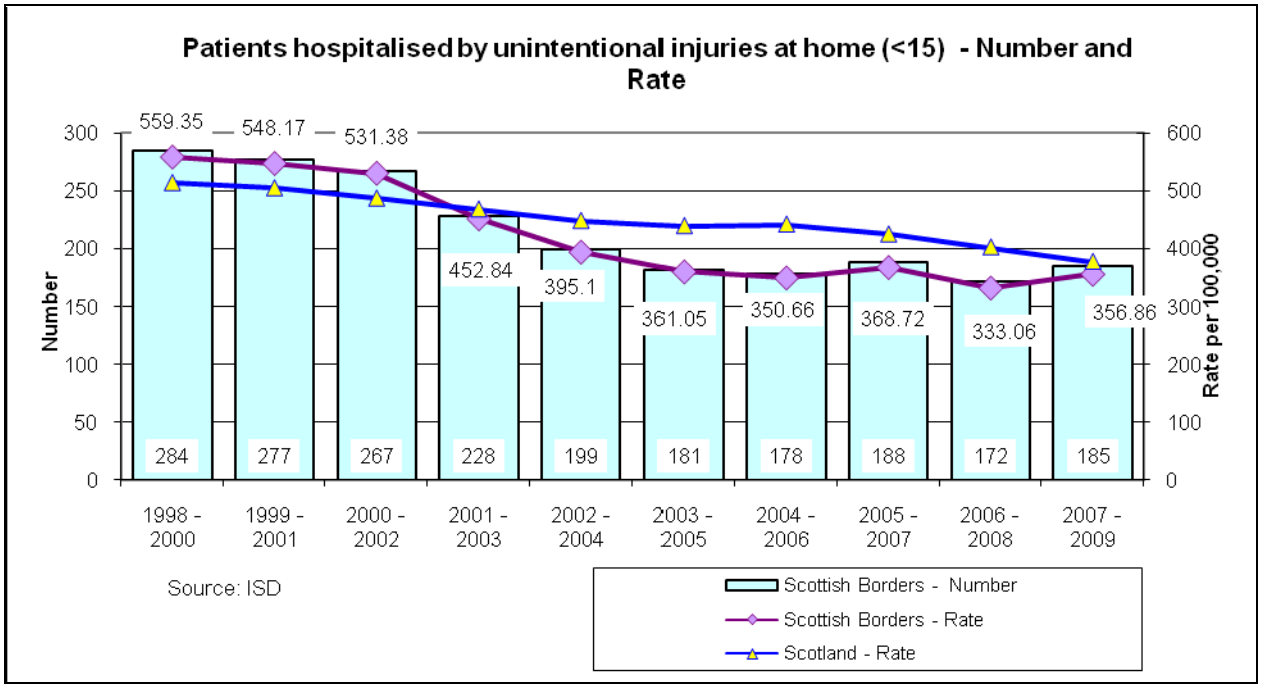
In the 2012 the National Dental Inspection Programme (NDIP) survey, 33.0% of P1 children in Scotland had obvious decay experience in their primary teeth. For those children, the mean number of affected teeth was 4.10. This ranged across the Boards from 3.28 in Borders to 4.38 in Greater Glasgow & Clyde. The number of teeth affected at the individual child level ranged from one to 20 teeth.[21]

The graph opposite, illustrative of the evidence, shows no significant trend for better or worse in the proportion of P1 children who are overweight, about a fifth.

While the number of children hospitalised as a result of unintentional injuries at home declined in the late 1990s it is disappointing that in the subsequent decade numbers have plateaued.

[21] http://www.scottishdental.org/index.aspx?o=1019&newsitem=1105

Figure 11: Patients hospitalised by unintentional injuries at home (<15) – Number and Rate



In summary, in relation to child health, we have a picture in the Borders of about one in three mothers smoking during pregnancy, significant numbers of teenage mothers, babies born with a low-birth-weight, about one in three infants being breast fed, and a steady rate of hospital admission for unintentional injury at home but improving dental health and almost all children having appropriate immunisation.

Current Early Interventions

As I explained at the beginning of this report, given the picture of health in the early years, the earliest interventions should target health before conception. Good health in mothers even before they have their babies is crucial to good health in their children. So, the importance of education about health in and outside of school is crucial as is effective antenatal care as early as possible in pregnancy. Good health in mothers even before they have their babies is crucial to good health in their children. Over the past year, the "Healthy Start" campaign has continued to provide women on low income with vitamins and vouchers for healthy food.

I welcome the Scottish Government's initiative of the "Early Years Change Fund", money to enable community planning partners use money better, shifting towards preventative spending. This should be with a view to shifting investment upstream and to developing a clear strategy to make

anticipatory and preventative approaches that we know work and that help to reduce the demand for more formal, higher intensity care in the future. T

Health in the Early Years of Life

Health in Pregnancy

Early access to antenatal care is being promoted in local communities, with the tailoring of information for high risk groups. The Healthy Living Network, with input from Health Improvement specialist on Maternal and infant Nutrition, run regular Bump to Baby events within local communities for expectant and new mothers and professionals. In 2011 – 12, the Joint Health Improvement Team planned and delivered three "Bump to Baby" events run in Hawick, Peebles and Eyemouth. These events bring together a wide range of services and professionals, to provide information and contacts for expectant and new parents. Take up has been developing gradually – 30 women attended in all. Feedback indicates these are useful sources of information, advice and signposting.

The local antenatal education (ANE) programme is under review to align with new national syllabus. As part of developing work on the new antenatal education programme, links are being established with community services and organisations who are likely to be in contact with high risk groups of women. This will be aided by the establishment of Early Years locality networks. To date, two thirds of community midwives, along with other staff involved in ANE have been trained in adult learning approaches. External verifiers have commended the standard of course delivery among Borders staff. One of our aims in updating the antenatal education programme is better to integrate the health information provided and support offered so that pregnant women get simple, clear messages to help them enjoy a positive pregnancy and have healthy babies. Good nutrition, stopping smoking, maintaining a healthy active lifestyle is all important. Through the Maternity Patient Safety Programme, a renewed emphasis is being placed on carbon monoxide monitoring with pregnant women and providing smoking cessation support for those who need it. That support is currently under review. The aim is to incorporate guidance coming in early 2013 from Healthcare Improvement Scotland and will be integrated into new antenatal education package.

Currently three ANE programmes are delivered per year in each of the five localities across Borders. Each programme has five sessions. The added value of an additional session, earlier in pregnancy is being evaluated. Agreement has recently been reached that physiotherapists will be involved in the ANE programme across Borders. From three to twelve mothers

participate in each programme. They are run during day time and in evenings. Evenings are increasingly popular.

The two "Surestart" midwives in the Early Years Assessment Team deliver the same antenatal education programme on a one to one basis with more vulnerable women. We intend that the breastfeeding volunteer peer supporters will work closely with this client group. The aims of the SureStart programmes are provide enhanced midwifery services to women from vulnerable and disadvantaged groups in the area, reduce inequalities for children up to the age of four, improve social and emotional health of women, increase user involvement in midwifery services, focusing on the provision of information, choice, continuity and control in care processes and strengthen families' ability to cope with childbirth and parenting. This would also improve breastfeeding rates and reduce the number of women smoking during pregnancy.

Barriers to early access – particularly in relation to women in known high-risk groups – are addressed through the Early Years Assessment Team, which has extensive networks and links with community services and resources to support women who may be at risk. Clear pathways are in place between maternity services and alcohol and drugs services and mental health services.

Breast Feeding

In another step to improve the health of children NHS Borders signed up to the UNICEF Baby Friendly Initiative (BFI) in late 2011. This is a public declaration of its commitment to high standards of care for mothers and babies. It is the first stage of implementing BFI in both maternity and community services. Promoting breastfeeding is central to the UNICEF programme for good reason; NHS Borders and its partners are working actively to increase the rates of sustained breastfeeding in Borders, currently on average 29% of six week old babies are exclusively breastfed. However, this average hides a wide variation from 18.8 percent to 63.1 percent across the Scottish Borders. It is clearly crucial to improving the health of babies and young people in the Borders to bring up the worst rates of breastfeeding to the level of the best. This is one of a small number of challenges that could make a big difference to inequality in health in the Scottish Borders.

BFI Stage 1 accreditation was achieved in early 2012 and an extensive training programme on breastfeeding management is now being rolled out with maternity and community nursing staff.

The principles of the BFI programme are consistent with the Early Years Strategy that NHS Borders, SBC and partners have agreed. The strategy aims,

through prevention and early intervention, to give every child the best possible start in life.

The success of the pilot of the "*Breastfeeding in Borders Support"* (BIBS) project has boosted breastfeeding information and advice for new mothers. Seven mothers were recruited from central Borders through existing breastfeeding support groups and contacts with health professionals. The training for these volunteers was completed by June 2012. The Health Improvement Team provides resources to support healthy weaning and works with nurseries and other early year's providers to promote nutrition and active play.

Support for vulnerable families on health and related issues are provided through the multiagency Early Years Assessment Team. This is a good example of how a mix of skills and professional backgrounds can be effective in providing more intensive support for the challenges that some families have in bringing up their children. Such support helps create the conditions for such children to have a good start in life. I am very pleased that the breastfeeding rates for babies supported by the team are high compared to the average for Borders.

Teenage Pregnancy

Rates of teenage pregnancy in the Borders are relatively low compared to other parts of Scotland. However, the absolute numbers are still a matter of grave concern. The chances of becoming a teenage parent are higher for some young people, such as those who have been looked after. The provision of information, advice and support on relationships and sexual health has been bolstered by the introduction of the C Card condom distribution scheme in the School Health Service and in youth settings. The primary focus of all such work with young people is the promotion of respectful relationships free from coercion and harm, including, importantly, counteracting the discrimination and stigma experienced by young people who identify as LGBT. NHS Borders is a signatory to the Stonewall good practice programme.

Following the publication of the Young Carers' Strategy, in 2011, work began to plan a short programme for young carers involved with Action for Children, a third sector organisation, being delivered in 2012. It covers practical first aiding and looking after your own mental health. Further plans to promote health and wellbeing of young carers include opportunities for physical activity outdoors.

Smoke Free Homes

The Borders Smoke Free Homes initiative aims to reduce exposure to second-hand smoke by encouraging people to protect their families by preventing or reducing smoking in their home. Families are asked to sign up to a Smoke Free Homes Pledge – Bronze, Silver or Gold:

- Bronze: Never smoke in the presence of children or other non smokers within your home
- Silver: Never smoke in the presence of children and smoke only in one well ventilated room
- Gold: Make your home totally smoke free at all times

Promotional activity for the initiative took place in Eyemouth, Hawick and Galashiels resulting in 229 pledges made during 2011-2012. These areas were selected because of the higher deprivation here. I am very pleased that this is a significant increase on the 58 sign ups that took place in the previous year when the Smoke Free Homes initiative ran for the first time in Borders in these towns and several others across the Borders.

Healthy Weight in Children

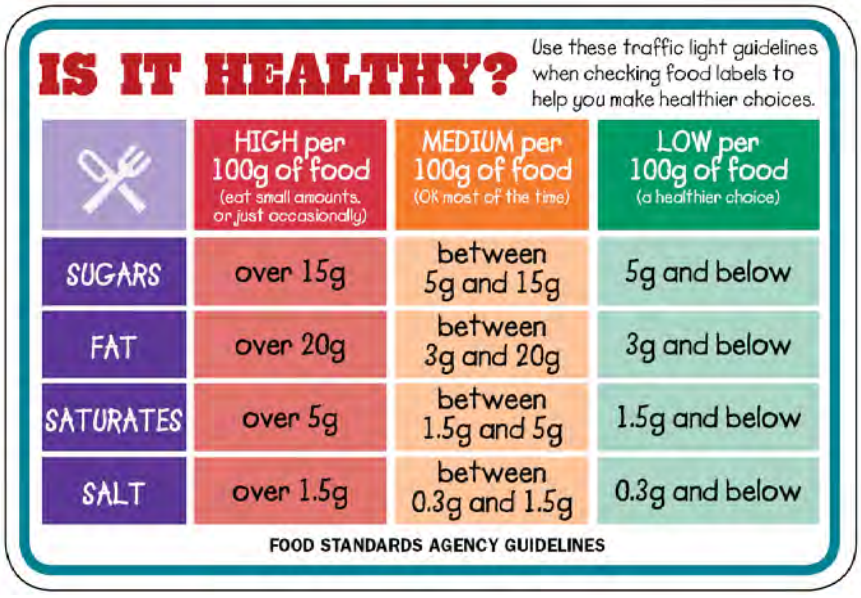
We know that keeping a healthy weight from childhood onwards will prevent a number of diseases such as diabetes and high blood pressure. Because of that my team have continued to oversee the Child Healthy Weight Programme developed in Borders, Fit4 Fun. This involves primary school classes in an eight week programme of fun activities on food, nutrition and physical activity. The Fit4 Fun team currently has capacity to work in only one school at a time.

Past experience in the Borders of previous Child Healthy Weight programmes highlighted the importance of taking am inclusive approach to avoid stigmatising participants and maximise engagement with those children who are overweight and obese. Our Fit4fun programme works with whole classes rather than seeking to target overweight or obese children. This non stigmatising approach has allowed the programme to engage effectively with those who are overweight and obese. We targeted those schools with higher deprivation catchments and those schools with higher than average rates of obesity, based on Child Health Surveillance Program Primary 1 data. Good partnerships with the participating schools have also been an

important factor. Fit4Fun, has been designed to comply with the guidelines from the Scottish Government and Health Scotland on effective interventions.

In 2011 – 12, the programme was delivered in three primary schools in areas of higher deprivation, involving 543 children across all classes. This programme meets the Scottish Government criteria for evidence based healthy weight interventions for children who are obese (BMI > 91 centile). In the current year, Fit4 Fun is being delivered to a further 3 – 4 primary schools.

We exceeded the target the government set for Scottish Borders. One hundred and twelve children in this weight range completed the eight week programme. This success is only part of what we need to do to avoid our children growing up with the detrimental consequences of overweight and obesity: we need to promote sport and physical activity in and out of school, healthy lunch options during school, developing young people's skills and knowledge about nutrition, cooking, food labelling, and marketing.



The local evaluation of the programme was positive and the feedback elicited from children participating, school staff and other partners was resoundingly positive. There was some evidence of participating schools adopting aspects of the programme within their mainstream curricular programme. Minor amendments have been made to improve the programme in the light of the local evaluation. After the Fit4 fun programme has been delivered in a school, the Joint Health Improvement Team then support FitBorders, a not for profit organisation, to deliver activity sessions in the school as a follow up. With two new Community Food worker posts, we will also have capacity to offer additional support to Fit4 fun schools. In the coming year, this will include an initiative on packed lunches and snacks. In

addition, from 2013, the Child Healthy Weight programme is offering Fit4 fun schools a follow-on grant to enable them to do work of their choosing on nutrition and physical activity in ways that further Child Healthy Weight objectives.

In addition other initiatives are being developed to support the Child Healthy Weight goals, looking in particular at information and resources for schools, nurseries and out of school clubs on healthy snacks, packed lunches and at the transitions between nursery and primary and primary and secondary settings.

Future Early Interventions to Improve Health in Early Years

There is evidence that those women at highest risk of poor pregnancy outcomes are less likely to access antenatal care early and /or have a poorer experience of that care. High quality, relationship based antenatal care with a strong focus on prevention, promotion of health, early intervention and support as early as possible in pregnancy is therefore vitally important. Consequently, there is a new national target in Scotland for antenatal access. At least 80% of pregnant women in each SIMD quintile are to have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.

The intention is that, in addition to booking arrangements for where the baby will be born, there will be a comprehensive assessment of a pregnant woman's health needs including an assessment of social and life style behavioural risks. The assessment, carried out by a registered, practising midwife, should be the start of a therapeutic relationship which will carry on throughout the pregnancy. The Universal Pathway of Care for Vulnerable Families highlights the important nature of routine universal contacts with women throughout pregnancy and in the early days after birth[22]. The booking appointment is the first and most crucial of these contacts as it should identify the appropriate pathway of care for the woman including where appropriate support from social care or third sector services.

NHS Education Scotland has produced new material to shape antenatal education. My team and others will be taking a close look in the coming year at the information advice available locally for expectant parents. This is important for with families where there is often a combination of really serious difficulties such as alcohol or drug misuse, mental health problems, domestic violence, or debt and financial insecurity

[22] http://scotland.gov.uk/Publications/2011/03/22145900/0

My team plans to extend the reach of "Bump to Baby" events in the future. In one area, the event led to the development of a weekly Bumps and Babies group. The establishment of Early Years locality networks, which aim to improve information sharing among services who are working with young families in each locality, will provide wider opportunities to integrate health improvement more fully into services for early year's families and strengthen partnerships.

The local Early Years Change Fund will support agreed priorities within this joint strategy:

- Development of locality based Early Years Networks, led by community nursing - being established in each of the 5 localities across Borders to encourage communication and coordination of service delivery. Community nurse managers convene monthly meetings for those working directly with families: education; social work and health. Quarterly extended meetings bring together wider community services involved within young families.

- Redesign of the locality model for Early Years Services **-** will focus on the implementation of GIRFEC named person, integrated assessment, single care plan and associated staff training needs

- Workforce development in line with the common core skills framework - using the national statement of common core skills for the children's workforce, local partners (NHS and SBC + third sector) have developed shared induction processes and materials for new staff in early year's services. A cross sector group is looking at workforce development

- Development of capacity within communities through volunteering and peer mentoring

The Scottish Government's recent consultation on the Children and Young People Bill signals a continuing commitment to creating the best possible start in life for children in Scotland. The proposals would give public authorities a duty to promote the wellbeing of children and young people and to ensure that their rights are realised. Specific measures proposed to increase the provision of early learning and child care recognise the singular importance of the early stages of life for social and emotional development.

Children start out in life from a wide variety of very different circumstances. The Bill acknowledges this in putting forward measures to tackle disadvantage, for example through additional support for 2 year olds who are looked after. Any legislation which may follow will therefore be of considerable significance for the Scottish Borders and will underpin our

continuing work locally to promote health and wellbeing from the earliest stages in life.

Building on the proven success of current immunisation programmes, it is likely there will be major developments to these in Scotland from 2013/14 through to 2015/16. This based on evidence that such changes will provide effective protection of the health of children and young people. The Scottish Government has asked Scottish Boards to prepare to implement these changes which will affect the childhood, adolescent and adult immunisation programmes. In particular,

- The seasonal flu immunisation programme will be extended to all children and young people aged 2-16 years
- Rotavirus immunisation will be added to the universal infant programme
- Meningococcal C vaccine will be offered to adolescents (1 dose) with a concomitant decrease in the number of doses offered to infants from two to one as well as offering a Meningococcal C booster to those entering further education establishments.

This means that:

- The number of people being offered vaccination each year will double (from approximately 1 million to approximately 2 million) reinforcing the immunisation programme's position as the largest preventive service offered by the NHS in Scotland;
- Communicating with the public over the benefits and risks for the extension will require careful consideration and the engagement of a range of professionals;
- It will be important to ensuring that the public health benefits from these developments are secured and evaluated.

Young People

Past surveys of young people in schools have shown that they have been looking for more advice and support with emotional issues, in my previous report I drew attention to the Suicide Prevention Team's production of a DVD, "*That's Not Me"*. This tells the story of two young people's experiences of their worries and anxieties at school and at home. Told from the perspective of the young people themselves the film challenges viewers to think about

emotional wellbeing and how we can give and get support when it is needed. The DVD production actively involved young people. In the last 12 months, an educational resource and training for teachers and youth workers has been created. I am delighted that others working in the same field in Scotland and beyond have commended it. The resource is now being piloted and evaluated in one high school before being introduced elsewhere.

Increasingly research suggests that messages about health targeted at young people are likely to be more effective if they themselves are actively involved. My Joint Health Improvement Team is therefore looking carefully at peer-led approaches in preventing smoking, in education on alcohol and drugs and in promoting mental health and healthy relationships. The team have worked closely with Community Learning and Development in the Council with input from young people on a smoking prevention resource for staff and volunteers working with them. We have also engaged AXIOM, an independent organisation with expertise in health education and research, to investigate the feasibility of peer education approaches to smoking prevention and will be taking forward the findings of this in the coming year.

In 2011 my Joint Health Improvement Team, the Police, School Health Service, schools, Community Learning and Development in the Council and the Third Sector started to develop and test a common framework for substance misuse education for young people. The model will include peer-led approaches. This work will actively involve young people and parents. The outcomes will shape the curriculum for this work and the roles of partner agencies across Borders, led by the Directorate of Education and Lifelong Learning.

What could the health of children in the Borders be like?

In summary, if we had sufficient coverage of the population of the Borders with effective early interventions I would expect to see children who have been breastfed, subsequently learned good lifestyle habits such eating healthily, taking advantage of opportunities for physical exercise and education, who have learnt how to make healthy relationships. They would be growing up into adults in employment living in quality housing in areas of economic activity. Such people would be taking advantage of opportunities provided by a range of organisations including communities themselves. The screening programs provided by the NHS would have an even more positive impact on their health.

Borders Healthy Living Network

Chapter 5

Early Interventions in the Middle Years

Key Points

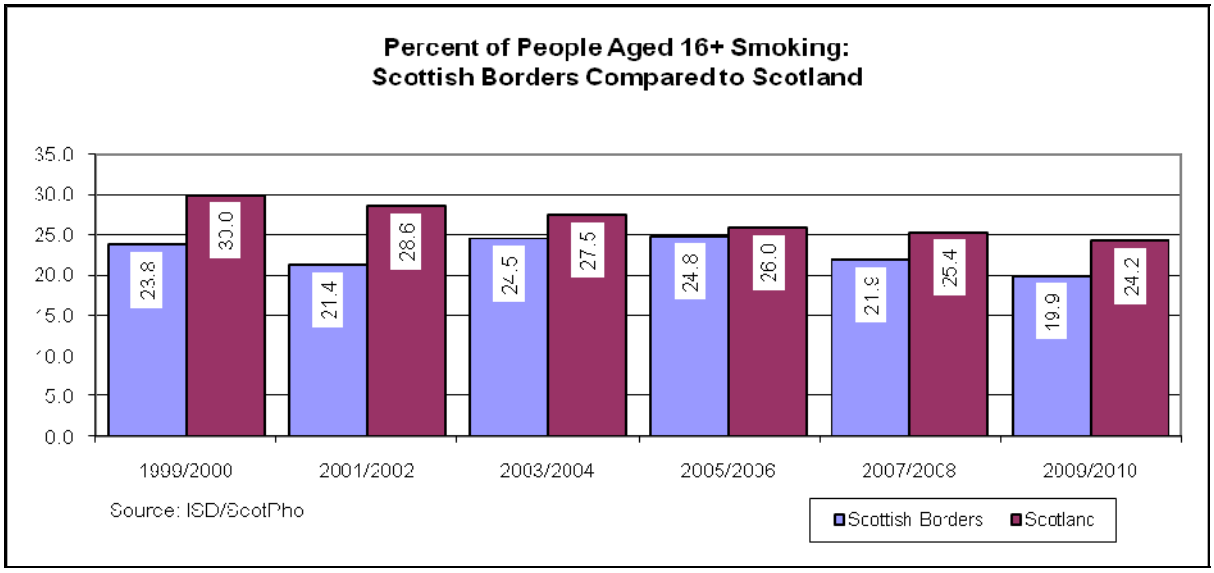
- Smoking continues to damage health
- Almost half of adults drink alcohol or recommended levels with a huge impact on health and social well-being
- Current interventions include alcohol brief interventions and minimum pricing
- Survival from cancer is still poorer than much of the rest of Europe
- Nutrition and obesity are being tackled through a Food Network
- A local strategy promotes physical activity and sport
- There is a very successful Lifestyle Adviser Support Service
- The Health Promoting Health Service initiative is being reinvigorated
- Detect Cancer Early is an ambitious new national initiative
- Effective screening programmes are in place and need to continue
- The role of the local licensing board is developing
- A new national strategy for a Smoke Free Scotland is being launched

Health in the Middle Years

Smoking

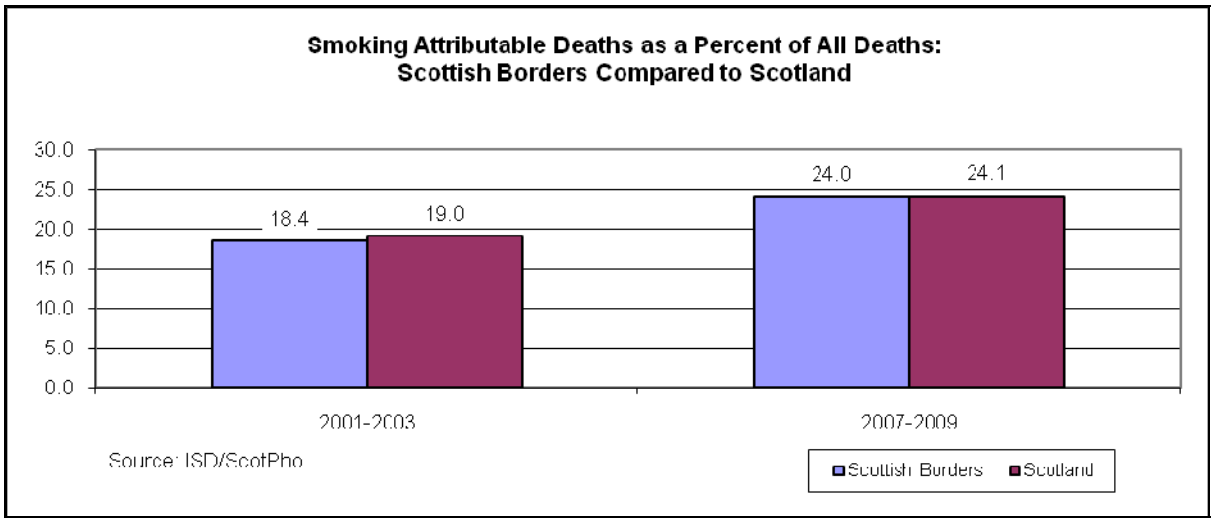
Different challenges compromise the health of those in the middle years of their life to those in their early years. Smoking is one. The graph below shows that almost one in four of the population aged 16 or over smoke.

Figure 12: Percentage of People Aged 16+ Smoking: Scottish Borders Compared to Scotland



Although smoking prevalence has reduced the proportion of deaths attributable to smoking has not as the graph below shows.

Figure 13: Smoking Attributable Deaths as a Percentage of All Deaths: Scottish Borders Compared to Scotland



Alcohol and Drugs

Many of us are aware that as a nation Scotland experiences a high level of alcohol related harm, we consume more alcohol per person than the rest of the United Kingdom and in 2010 it was estimated that we were the eighth highest consumer of alcohol per head of population. Enough alcohol is

currently sold in Scotland to enable every adult (16+) to exceed weekly safe drinking limits for men. (Health Scotland, 2012)

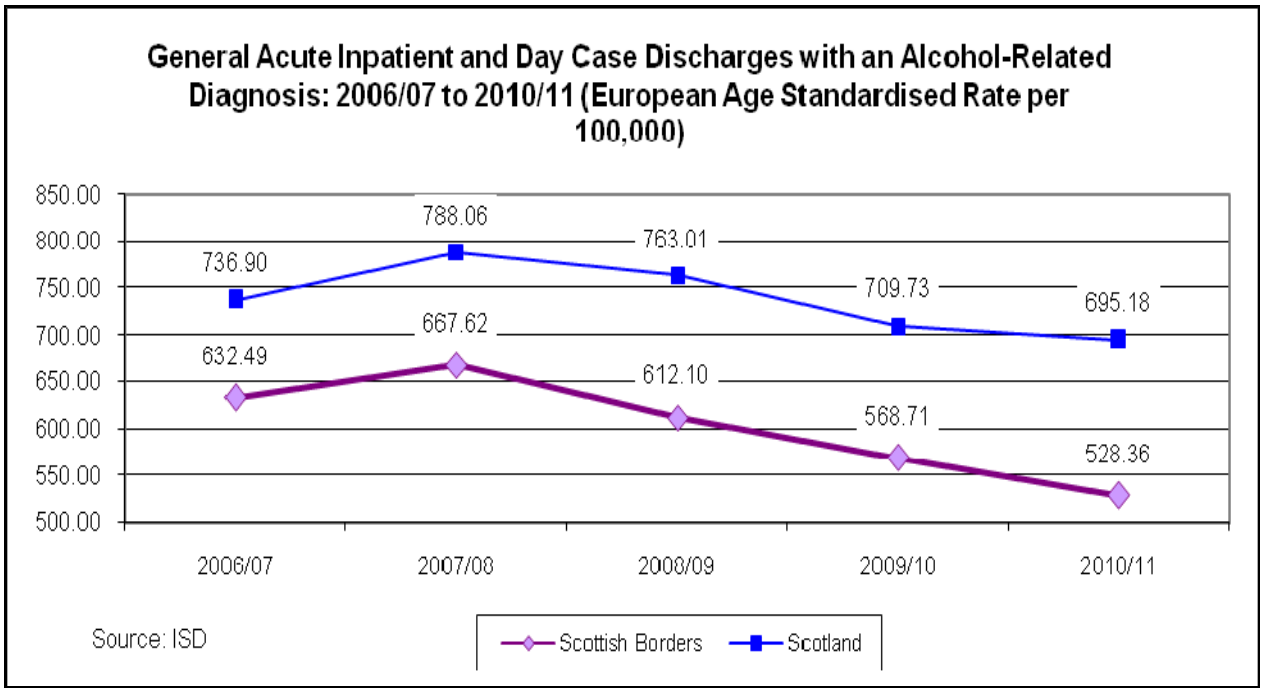
In real terms, alcohol sold in Scotland is more affordable and readily available than is has been over the last 30 years. The result is that too many of us are drinking too much, too often.

The Scottish Health Survey for 2008-2011 shows that within Scottish Borders:

- 43% of adults drink out with the recommended government limits
- 25% of adults drink to hazardous or harmful levels

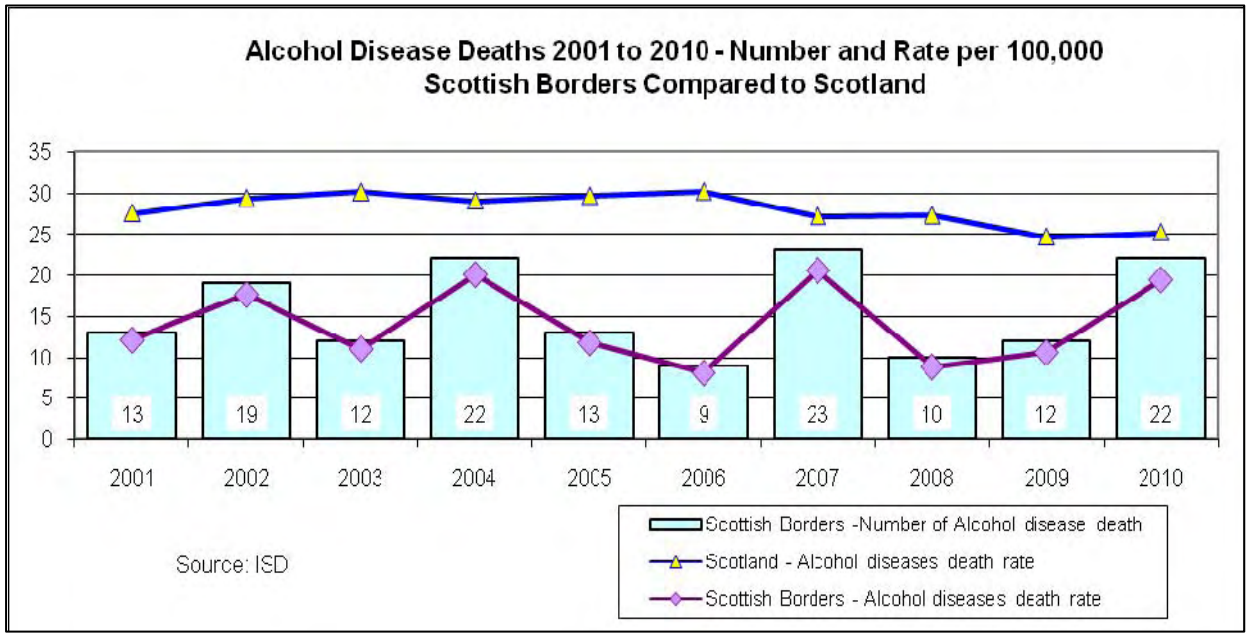
Problem alcohol use puts a severe burden on health services, although the figure below shows a small decline over time in Borders and Scotland:

Figure 14: General Acute Inpatient and Day Case Discharges with an Alcohol-Related Diagnosis: 2006/07 to 2010/11 (European Age Standardised Rate per 100,000)



Alcohol is also a significant contributor to mortality, as the following figure shows:

Figure 15: Alcohol Disease Deaths 2001 to 2010 – Number and Rates per 100,000 Scottish Borders Compared to Scotland



At an individual level the harm caused by drinking too much can lead to a range of serious and sometimes life threatening illnesses including liver problems, reduced fertility, high blood pressure, increased risk of various cancers and heart attack as well as problems with anxiety and depression. It is also the case that drinking in pregnancy can cause harm to unborn babies. In all cases the risk of harm increases as intake of alcohol goes up.

The more we drink, the social problems related to alcohol use increase. Excessive alcohol consumption also impacts on the wider community through, for example, violence, accidents and house fires (See Chapter 7 - Place and Communities for more detail)

The table below shows the percentage of crimes where the offender was under the influence of alcohol. This data demonstrates Lothian and Borders to have a lower level of alcohol fuelled crime than the national rate for the latest year:

Police Force work area	2009/10	2010/11
Lothian and Borders Police	23.0%	18.0%
Scotland	23.0%	22.0%

Source: ISD

The table below shows the percentage of people spontaneously reporting 'alcohol abuse' as a negative aspect of their neighbourhood. Although the Borders figure is lower than the national figure, we have experienced an increase in this indicator.

Area	2007/08	2009/10
Scottish Borders	1.0%	2.0%
Scotland	4.0%	4.0%

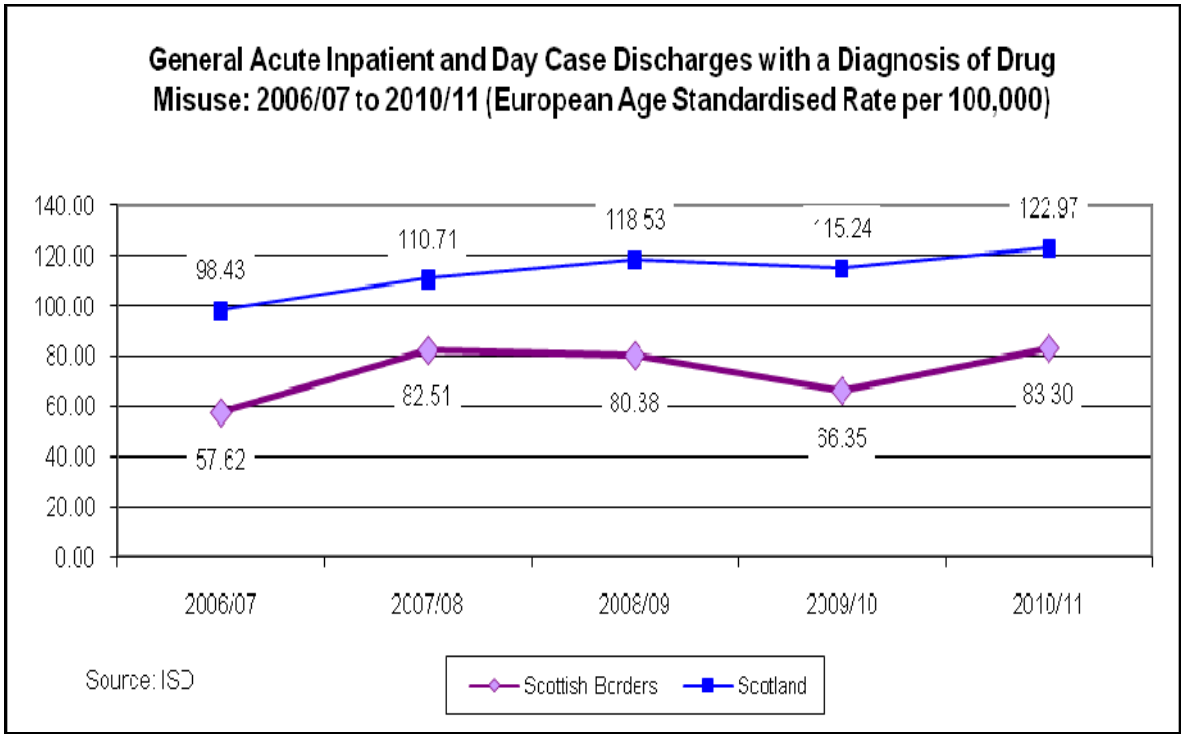
It has been estimated that during 2010-11 alcohol related harm in Borders cost £30.50million. (Alcohol Focus Scotland, 2012) This sum was made up of:

Health	£4.31m	Hospital admissions, casualty attendances, GP consultations, outpatient attendances, alcohol services and ambulance journeys.
Social Care	£5.27m	Estimated level of social work caseload due to problem alcohol use, community service orders and probation orders related to alcohol, and care home expenditure for people with alcohol addictions.
Crime	£10.62m	Alcohol specific offences such as drink driving and drunkenness and offences where alcohol is recognised as being a contributory factor, such as violence
Productive capacity	£10.29m	This covers the estimated cost of alcohol to the economy in the form of negative performance at work due to alcohol consumption, absenteeism, unemployment and premature mortality

Much of this cost could be avoided if we reduced the amount and frequency with which people drink.

Again, problem drug use puts a significant burden on health care, as the figure 16 illustrates.

Figure 16: General Acute Inpatient and Day Case Discharges with a Diagnosis of Drug Misuse: 2006/2007 to 2010/11 (European Age Standardised Rate per 100,000



Road Traffic Accidents

After a peak in 2005 – 2007, rates for road traffic casualties have continued to decline both for Scotland and the Borders. However absolute numbers for the Borders have continued to hover around about 350 per year, a serious situation.

Obesity

Applying national rates of overweight and obesity to the population of Scottish Borders, over 62,000 of the adult population are overweight or obese. While slightly more adults report participating in sport in the Borders compared with Scotland as a whole, there has been a decline from almost 80% to 75% in the two years for which we have the most recent information. However, it is positive that about 30% of journeys to work by Borderers are by active travel such as walking or cycling, much the same as the proportion in Scotland. It is disappointing that this has stayed fairly static for some time. One of the

consequences of obesity is increasing numbers of people developing diabetes - almost 5% or nearly 5500 of the Scottish Borders population now have diabetes.

Cancer & other Long Term Conditions

The number and rate of registrations for all cancers in both Scotland and the Borders have slowly but steadily increased over nearly a decade now. Currently there are about 3,500 registrations per year.

The picture in relation to rates of hospitalisation for other conditions is interesting. There is a slight upward trend in the rate of hospitalisation for Respiratory Chronic Obstructive Pulmonary Diseases. Rates for asthma have been rising but may now be plateauing. Rates for an emergency admission show a similar picture. On the other hand, there has been a sharp decline in hospitalisations for coronary heart disease and a slight decline for cerebral vascular disease.

Survival from cancer in Scotland still lags behind that in many European countries. Late-stage diagnosis accounts for most of this variation in survival and the high rate of avoidable deaths from cancer is due to people being diagnosed when their cancer is at a stage when treatment will not contain its impact and spread. Cancer care provision in Scotland is already high quality but earlier diagnosis will result in fewer recurrences, improvement in cancer mortality rates and longer term wider societal benefits.

Current Early Interventions in the Middle Years

Smoking Cessation

NHS Borders Smoking Cessation Service, Quit4Good, operates Borders-wide and is delivered by Specialist Smoking Cessation Advisors, in General Practices (e.g. by Practice Nurses) and by local Pharmacies. Smoking rates are highest in men and women aged 25 -34 and tend to decline with age. Over time smoking rates have been dropping in adults as the first figures in this chapter demonstrated.

NHS Borders was set a target to achieve 1525 quitters over the 3 years April 2011 – March 2014. The Scottish Government specified that 55% of quitters were to be from the most deprived areas. The target set for April 2011- March 2012 was 508 quits, 280 (55%) of which should be from the most deprived areas of Borders.

In 2011 – 12, NHS Borders out-performed its target, supporting 857 quitters, of whom 474 (55%) were from the most deprived areas. Success reflects raising the profile of the Quit4Good Service. This has included using positive links within communities. The proportion of our smoking population quitting at 4 weeks is the second highest in Scotland, an achievement to be proud of.

Alcohol and Drugs

A 'whole population approach' to reducing alcohol related harm refers to measures we can take to reduce harmful and hazardous drinking in the general population, thus reducing individual and societal harm.

Evidence shows us that the most effective whole population approaches are:

- alcohol control measures (price and availability)
- brief interventions for "risky" and harmful drinkers

Price – the Scottish Government's current position on Alcohol Minimum Pricing is based on strong evidence that as alcohol becomes relatively more affordable then consumption increases. This proposed legislation is currently being challenged in European courts. If this challenge is successful it will be a lost opportunity to legislate to improve the public health.

A recent study in Canada showed that a 10% increase in the minimum prices reduced total consumption by 8%, but resulted in bigger drops in consumption of higher strength products e.g. premium strength beer.

Availability – Availability refers to how easy it is to buy alcohol either from pubs and clubs or from off-sales premises. Before being able to sell alcohol premises must be in possession of an alcohol license. It is the role of local Licensing Boards to develop licensing policy in line with five licensing objectives[23] and consider these objectives when making decisions on licence applications, licence reviews and whether there is overprovision within their area. Therefore availability is controlled by Licensing Boards and can support a change in local environments through controlling the number and type of alcohol outlets, opening hours and conditions of sale. If we are to see a change in harmful drinking we need to ensure local environments support this.

In Borders we are supporting the gathering and analysis of evidence to inform and strengthen local licensing policy in line with the policy review. This data will create a local alcohol profile that can be built on annually and provide

[23] Licensing Objectives: Preventing crime and disorder, Securing public safety, Preventing public, nuisance, Protecting and improving public health Protecting children from harm

information against each licensing objective for example, indicators of alcohol-related crime, accidental fires where alcohol/drugs are suspected, and alcohol-related emergency admissions to hospital. Over time, data from across the region will help to support Licensing Boards in deciding if particular localities have more concerning indicators than other areas.

Initial data has shown that between April 2010 and August 2012, 20% of all police incidents in the Borders had alcohol as a contributing factor, with half these incidents taking place between midnight and 03:00hours. In 4% of primary fires within Scottish Borders (2011/12), alcohol/drugs were suspected to have been a contributory factor. Between June 2012 and October 2012, there were 513 attendances at the Emergency Department, BGH where alcohol was a contributing factor (5% of all attendances).

One 'whole population' approach to reducing alcohol related harm is to have conversations with people who are drinking to harmful or hazardous levels in the form of an alcohol brief intervention. An Alcohol Brief Intervention (ABI) involves having a structured conversation with individuals who are identified via a screening tool as potentially being at risk of harm from their drinking. The aim of an ABI is to help the person understand that their alcohol use is putting them at risk, therefore giving them an opportunity to consider reducing their drinking and preventing associated harm.

Evidence suggests that an ABI can reduce both an individual's overall intake and frequency of binge drinking. In Borders 2,727 ABI's were delivered in 2011-12. The majority of these ABI's were delivered in priority settings including GP surgeries and the Borders General Hospital. Going forward we aim to expand the setings where ABI are performed and increase the range of people who are given this opportunity to change their behaviour.

The Scottish Government's Drugs Strategy – *the Road to Recovery* (2008) and the subsequent *Changing Scotland's Relationship with Alcohol (*2009) reinforced the need for substance misuse services to move away from focussing solely on becoming abstinent or reducing drug or alcohol use by also helping people to 'recover'. This was to be achieved by rebuilding relationships and becoming engaged with wider community and activities.

Obesity

Because obesity is a result of a complex interplay between the individual and the physical and socio-economic environment we have a wide raft of interventions in place to address this challenge. These include work around nutrition, physical activity and anticipatory care services described in the next few pages.

Nutrition

Multiagency partners have been collaborating to identify priorities and practical actions to address the problem of overweight and obesity which challenges the Scottish Borders as much as other parts of Scotland. This is a complex area which includes but also extends far beyond individual choice, habits and lifestyles. We are also looking at what can be done to promote access for more people to fresh, affordable local food, learning from existing local growing projects and community food initiatives. The Borders has wonderful natural environments which can be harnessed to promote health and wellbeing. Work places, education and care services are being encouraged to review meals provision, staff skills and knowledge about nutrition and opportunities for keeping active. My Health Improvement Team continues to provide advice and training on nutrition and active living and over the past year has delivered accredited training for care staff, volunteers and family carers. The team has also delivered a range of sessions on cooking skills in local communities. It has catalysed the formation of a "Food Network" to bring about collaboration to improve nutrition and tackle obesity.

Physical Activity

The past year has seen exciting developments to promote health and wellbeing in the outdoors, in partnership with the Borders Forest Trust and the Forestry Commission, focusing on opportunities for people who use mental health services and are likely to face particular barriers in marshalling the confidence to access and use the outdoors. "Branching Out" and "Natural Connections" are woodland therapy programmes for adults with mental health problems. They aim to help participants experience wellbeing and express creativity through participation in bushcraft, nature conservation, environmental art, green exercise and relaxation. These programmes take place in a woodland setting and consist of weekly sessions lasting three hours for 6-12 weeks. Each programme can accommodate up to twelve participants. This adds to established resources such as the Walk It project outlined below. There is an increasing range of community based physical activity opportunities in local communities designed to encourage wider participation by all age groups, both individuals and families.

There are currently a number of programmes of work taking place within NHS Borders that will contribute towards achieving the actions described in the Health Promoting Health Service CEL 01 (2012) and Allied Health Professions Pledge. This work is supported by the Joint Health Improvement Team.

Scottish Borders Physical Activity, Sport and Physical Education Strategy

The Scottish Borders Physical Activity, Sport and Physical Education Strategy (PASPE) aims to set the framework for the development of physical activity, sport and physical education in the Borders. Theme 1 of this local strategy aims to promote wellbeing through physical activity. The overall priority for this theme is to focus upon those who are currently inactive to support and encourage them to change, and upon those who are more active to maintain or increase their activity levels. The following actions will support implementation of the Health Promoting Health Service initiative:

Target individuals with specific health needs and incorporate physical activity into support and treatment programmes.
Provide individually tailored advice and support to increase physical activity levels of those at risk of developing chronic disease.
Workplace lifestyle advice - Increase the provision of individually tailored advice on physical activity and other healthy lifestyles.
Support programmes that encourage participation in physical activity in the workplace.
Support "Walk/ Cycle to Work" initiatives and promote active travel in workplaces.
Provide training for a range of professionals and volunteers working with people across the life stages to cover essential theoretical and practical knowledge, skills required to promote physical activity in their setting, and to develop successful interventions.

Walk it Project

The Walk It Project is the "Scottish Borders Paths to Health" walk project which provides health walks to encourage inactive people to increase their activity. They run health walks in all the major settlements in the Borders and many smaller communities, and in 2011/12 ran 548 health walks across the region. A health walk can be defined as any walk which is specifically designed and carried out to improve ones health. Typically they are targeted at those people who are inactive or have low

levels of activity. Health walks aim to help people meet the recommended level of physical activity of 30 minutes of moderate intensity activity on five days of the week.

NHS Borders fund the project co-ordinator who works closely with the Joint Health Improvement Team. Many NHS staff have been trained to become walk leaders which enables them to lead health walks in their workplace and local communities. In addition the "Walk it" project runs regular health walks for a number of patient groups including people with mental health problems, adults with a learning disability and a recently started pregnant mums walking group.

Integrated Anticipatory Care Services

Integrated Anticipatory Care Services in the Border were born out of motivational interview training for community staff before 2000, followed by a successful pilot lifestyle advice service in Kelso practice in 2004, and then rollout of the "**Lifestyle Adviser Support Service**", affectionately known as LASS, to all practices by 2011. The LASS provides advice and support to help clients make changes to their lifestyle risk factors, such as diet and physical activity. The target group is adults (over 16 years) at higher risk of developing heart disease, diabetes and other long term conditions and health problems because of lifestyle and other risk factors like high blood pressure and impaired glucose tolerance (precursor of diabetes).

The LASS approach uses health behaviour change theory, brief interventions and motivational interviewing techniques, and the provision of dedicated time to support clients to make and maintain changes to their lifestyles. The service focuses on physical activity, healthier eating, smoking, safer alcohol use, mental health and emotional well being.

The service is available within all primary care teams and since 2004 it has supported over 3,000 patients across the Borders. Approximately 30% of referrals are men and the mean Body Mass Index (BMI) of those attending is over 35 (over 30 is considered obese). The service is successfully targeting individuals from disadvantaged communities - 45% of referrals falling into the partly skilled, unskilled and unclassified socio-economic groups, almost twice that in the general population (where these groups constitute 23%).

Since the service started in 2004 positive changes have been consistently reported after LASS support - in lifestyle behaviours such as physical activity levels and alcohol consumption, and in physiological measures such as BMI (mean reduction of 1) and blood pressure (mean reduction of 4.5/2.5 mmHg). Such changes have been shown to reduce the incidence of long term conditions like diabetes, and therefore they will contribute to further improvements in healthy life expectancy and reduction in inequalities in health. There is also evidence that such changes reduce drug prescriptions and attendance within primary care, and therefore they will reduce future demand on health services.

Keep Well

"Keep Well" (KW) started in 2010 and integrated with LASS later that year. It is part of a national programme designed to reduce health inequalities by targeting 40-64 year olds from deprived and disadvantaged communities. Keep Well provides health checks assessing cardiovascular disease risk and a range of lifestyle and wider life circumstances factors, and for those needing it, onward referral for treatment and/or lifestyle advice to support behaviour changes.

The Borders Keep Well service is delivered mainly in primary care by the LASS and exceeded its national HEAT target to undertake 390 checks in 2011/12. Since starting it has identified 9% of checked patients as being at high risk (ASSIGN 10 year CVD risk score ≥20%) and referred 12% to GPs for clinical assessment and management, and 6% to other services such as the mainstream LASS or Quit4Good.

Finally Counterweight (CW), a national evidence-based adult weight management programme, began in Borders in 2010 as part of the wider LASS. Over 350 clients have been helped through Counterweight with higher rates of attendance and follow up than other services in Scotland at 6 and 12 months, and higher weight loss and higher percentages losing ≥5% of their body weight at 12 months compared to other services in Scotland.

The new integrated LASS/KW/CW service has gone from strength to strength - some of the key facts and outcomes being achieved are shown below:

	LASS	Keep Well	Counterweight
Service outline	~ 400 referrals p.a. Good uptake in deprived communities Mean BMI=35	Heat target=390 CVD checks in 2011/12 Focus on disadvantaged communities	Structured calorie deficit or goal oriented programme 350 clients since 2011
Outcomes	Increased physical activity Decreased alcohol intake Reduction in BMI (mean=1) BP reduction (mean=4.5/2.5mmHg)	Exceeded Heat target 2011/12 50% checks in 16% most deprived population High risk pickup 6% in 10/11 - 15% in 11/12 12% referred to GP 6% referred to other service	Higher attendance than nationally (36v32% @ 12m) Mean wt loss= 3.9kg@12m (3kg nationally) ≥5% body wt loss = 38% @12m (31% nationally)

NHS Borders has responsibility to implement a national initiative, "The Health Promoting Health Service.

This programme aims to improve well-being and so prevent ill health. It targets patients, staff and visitors in Borders General Hospital and our community hospitals. It will bring together a range of themes: physical activity, smoking, sexual health, food and healthy weight, alcohol harm reduction and active travel. While there is established work to build on, we

can do more to make sure that we use our hospitals to make every contact an opportunity for health improvement.

Healthy Working Lives

Scottish Borders Council and NHS Borders promote physical activity opportunities to their staff in a variety of ways including making use of the intranet, Workplace Health and Wellbeing Newsletter, notice boards, emails and by providing incentives. Activities are planned through the Healthy Working Lives Award Working Group, whilst all staff can promote physical opportunities or events through the intranet and on notice boards in their own area. Other programmes may also promote physical activity such as the NHS Efficiency Programme encouraging reduced car usage and increased active travel, and the Council's car share scheme.

NHS Borders currently hold the Silver Award as part of the Healthy Working Lives Award Scheme and are working towards achieving the Gold Award. As part of the award scheme there is a requirement to raise awareness and promote opportunities and events to encourage staff to be more active.

Detect Cancer Early

Detect Cancer Early (DCE) is an ambitious new national programme of work for Scotland; which was launched in February 2012. The focus of previous cancer targets has been to improve access by reducing waiting times. The Detect Cancer Early Programme however will focus on improving outcomes; taking a whole systems approach that involves the third sector, public health, primary care and the acute sector.

The Detect Cancer Early Programme will last four years; and is initially concentrating on tackling the three most common cancers in Scotland – Breast, Bowel and Lung cancer. The programme will focus on

- Getting the best from the national cancer screening programmes for Breast and Bowel Cancer
- Raising the public's awareness of the early signs and symptoms of cancer and encouraging them to seek help earlier

- Working with GPs on early referral or investigation of patients who may present with a suspicion of cancer

- Getting screening, diagnostic and treatment capacity right

- Making sure data collection and performance reporting is in place to monitor progress

The Detect Cancer Early (DCE) target; which has been set by the Scottish Government, is to increase the numbers of patients with cancer diagnosed at Stage 1 by 25% by March 2014. The baseline figures are still to be finalised and agreed, but initial estimates for NHS Borders is that we will have to diagnose an additional 15 patients by the target date.

As part of the national Detect Cancer Early Programme, an awareness raising campaign was launched in Feb 2013 by the Scottish Government. This highlights the importance of the national colorectal screening programme which invites all men and women between the ages of 50 and 74 years who are registered with a GP. Every one receives a Faecal Occult Blood test (kit) by post to their home address. The kit is completed at home and returned to the national Bowel Screening Centre for Scotland, which is based in Dundee at King's Cross Hospital. The centre tests all the completed screening kits and then notifies:

- all participants of their results
- all GP practices of positive results
- all NHS Boards of positive results requiring further investigations

If the overall result of screening is positive, then the individual is referred to their local hospital for further assessment and may be offered a colonoscopy if appropriate. The national awareness campaign is being complemented by our own NHS Borders communication plan, to ensure we target our local population, in particular some of the more disadvantaged groups; and to make use of the success of some of the existing networks such as the Healthy Living Networks and Lifestyle Advice and Support Service.

In terms of health impact a positive effect would be an increase in the uptake in screening, an increase in referrals particularly amongst the more disadvantaged and hard to reach communities, and also evidence that people with cancer were presenting at an earlier stage in the disease, making their condition more amenable to treatment. It is too early to tell if there has been an increase in the number of referrals because of the DCE campaign. Ultimately, I would like to see a significant improvement in overall survival rates. However, it will take a number of years before we have evidence in relation to these issues.

Screening

Background

Screening is a process of identifying people who are at high risk of disease in order to prevent or treat early disease, thus reducing mortality and morbidity. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. NHS Borders is committed to ensuring that the function of service provision for screening programmes is providing high quality outcomes, is efficient, effective and sustainable and relevant to the people we serve. There are a number of set screening criteria which need to apply for a programme to be effective;

- the condition being screened for should be an important one
- the screening test is offered at regular intervals with the frequency of the test depending on the natural progression of the disease or condition
- the screening test for the condition is highly 'sensitive' (good at correctly identifying people with the disease) and highly 'specific' (good at identifying those without disease)
- there is sufficient disease in the population to make it worth running a widespread programme
- treating the disease at an early stage when it is likely to be more effective and less invasive - earlier rather than later will make a difference to the outcome
- the screening test is 'acceptable' to the population and there is confidence in the value of the process
- a multidisciplinary team working across all components of a screening programme to ensure a seamless patient journey through the screening process
- Safe - the programme does no harm
- the programme is cost-effective
- public participation in development of information is essential

- the programme must reach all eligible people irrespective of their status, race or any special needs requirement

Organisation

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

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

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

Current screening programmes provided by NHS Borders include:

- cervical cancer
- breast cancer
- pregnancy and newborn (including antenatal, newborn bloodspot, neonatal hearing and haemoglobinopathies)
- diabetes retinopathy
- colorectal cancer
- abdominal aortic aneurysm

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

A summary of the operation of performance and key issues for each of the screening programmes is provided below. No screening test can be 100% accurate, and it is important to manage the risks of errors at any stage in the screening process, be it clinical or nonclinical.

Cervical Cancer Screening

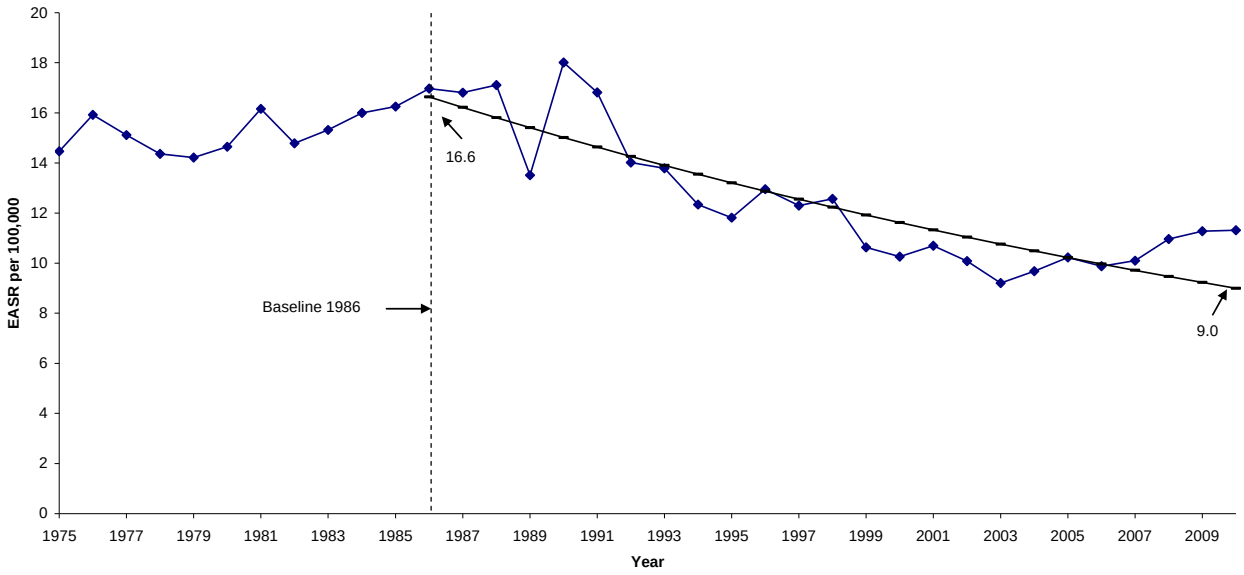
Cervical screening has proven to be an effective method of reducing the incidence and mortality of cervical cancer. Screening provides a test that involves checking cells in the cervix (neck of the womb). The test is designed to pick up any changes so that they can be simply and effectively monitored or treated. Cervical screening saves around 5,000 lives in the UK every year and prevents 8 out of 10 cervical cancers from developing.

In Scotland cervical screening is routinely offered every three years to women aged between 20 and 60 years of age. Where previous screening tests indicate additional follow up is required, women may be recalled more frequently up to the age of 68.

Following the successful pilot, from 30 April 2012, all women who have had treatment for abnormal smears in Scotland are also tested for HPV at their next cervical screening test. This normally takes place six months after treatment. The evidence and data for the Scottish Cervical Screening Programme is regularly reviewed to ensure the best care. We now know that women who have a test that shows normal cervical cells and no HPV (HPV negative) six months after treatment for CIN can return to routine three yearly screening.

Figure 17 below shows that cervical cancer incidence in Scotland has been decreasing since the introduction of a Scotland wide programme in 1987.

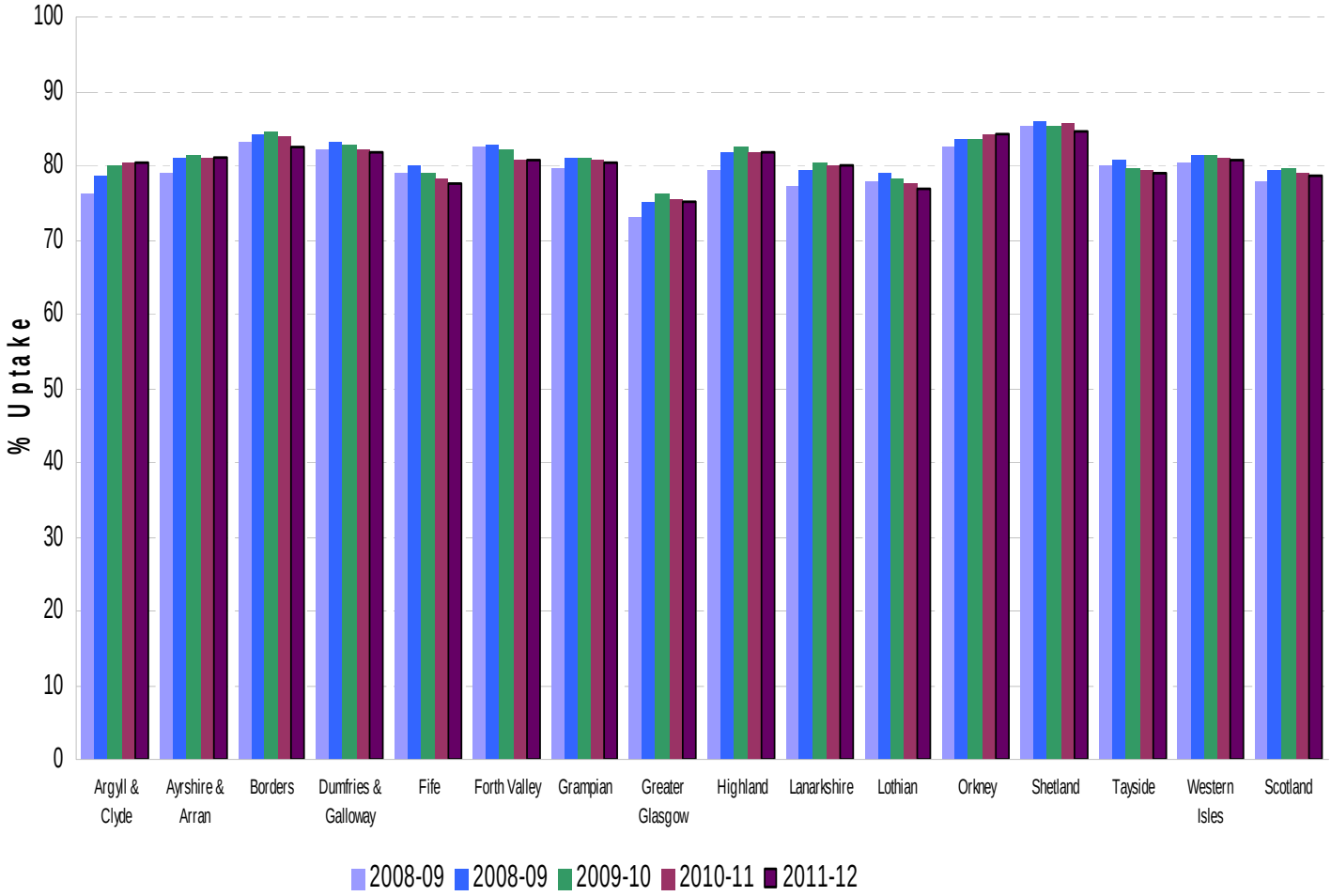
Figure 17: Cervical Cancer Incidence (European Age Standardised Rates) Females of All Ages, Scotland 1975-2010



During the period 2006-2010 there were 27 cervical cancers in Borders. Survival after diagnosis for cervical cancer has improved in Scotland over the past 30 years. The 5-year survival rate in 1983-87 for the 15-74 year group was 58.3% and for 2002-2007 was 64.7%.

Figure 18 below shows the uptake for Cervical Screening by Health Board in Scotland. This shows that during 2011/12, 82.6% of Borders women in the target group had a smear during the last 5.5 years compared to a Scottish figure of 78.7%. The national target for coverage is at least 80%.

Figure 18: Uptake for Cervical Screening by Health Board in Scotland 2008 to 2012 for females aged 20-60 who had a record of a previous screening test taken within last 5.5 years



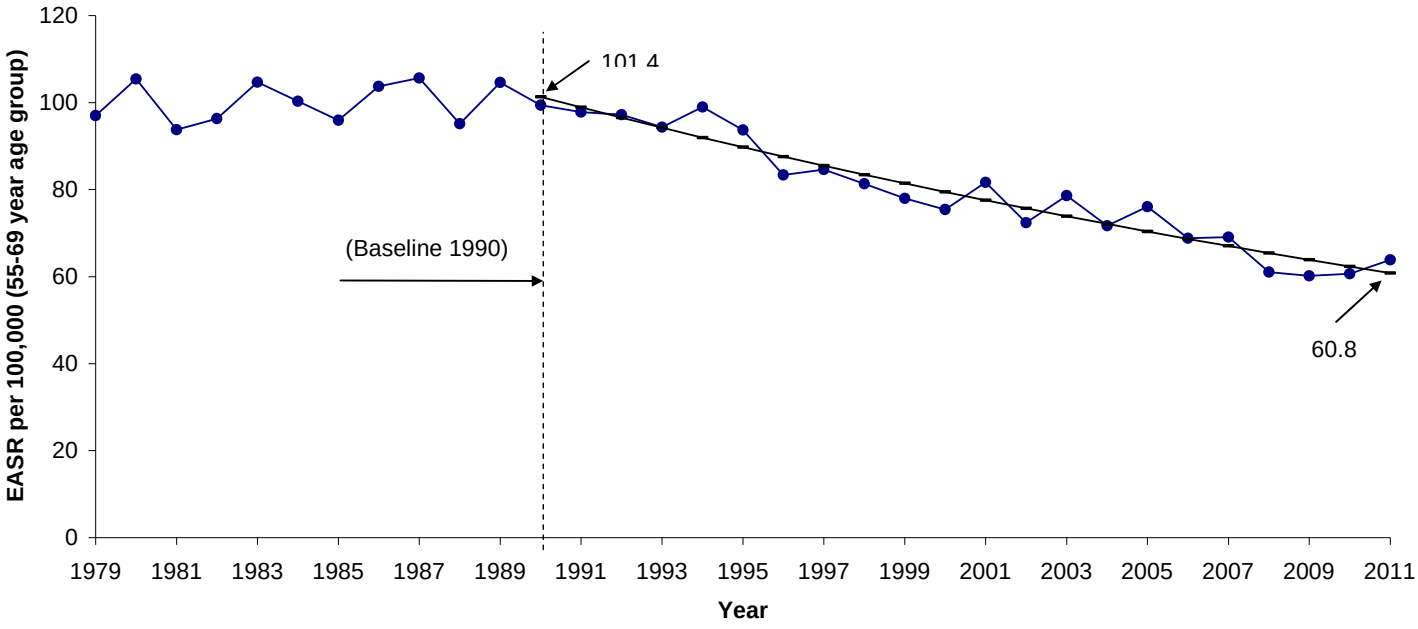
The Scottish Programme differs in the age that women are called for cervical screening compared to England and most other countries. The main difference relates to screening under the age of 25. The Scottish Government has however recommended changing the age that Scottish women receive their first invitation for cervical screening from 20 to 25 years. Woman over 50 who are routinely called for screening will be invited every five years rather than three years and the upper age for screening will be extended to 64 years of age. The changes will be implemented from 2015 when the first cohort of girls vaccinated with the Human Papilloma Virus (HPV) vaccination will reach screening age. The impact of the HPV vaccination programme for school age girls will not be realised for some years and it is very important that eligible women continue to be invited for screening.

Breast Cancer Screening

Breast cancer will affect about one woman in 10 in Britain at some point in her life. It is the most commonly occurring cancer amongst women in Scotland and Britain. In Britain, of all cancers in women, breast cancer is the leading cause of death although in Scotland lung cancer has that distinction. The incidence of breast cancer increases with age, being uncommon before the age of 30, but increasing rapidly after the menopause. Between 2006 and 2010 there were on average around 92 new cases of breast cancer each year in the Borders (screen detected and non screened detected cases).

Figure 19 below shows that breast cancer mortality has been declining in Scotland since breast screening achieved national coverage in 1991.

Figure 19: Breast cancer mortality for females aged 55-69 years in Scotland 1979-2011.

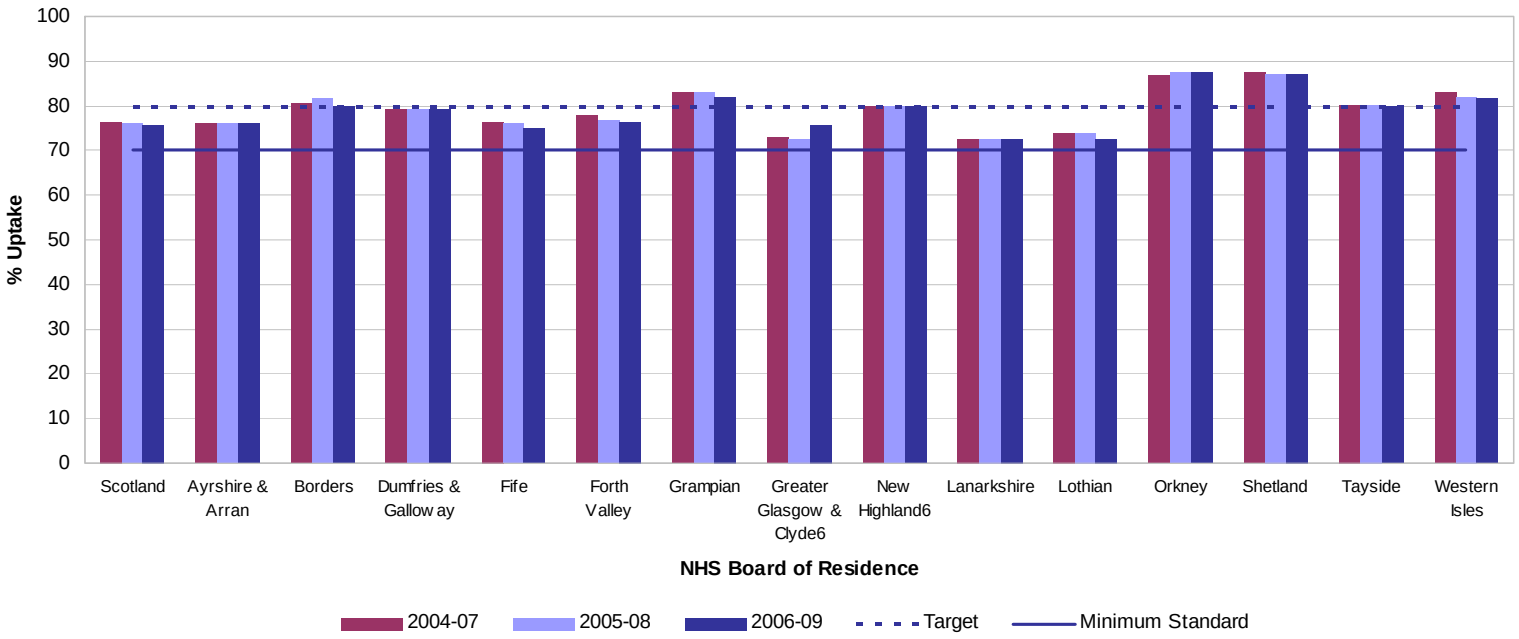


The Scottish Breast Screening Programme (SBSP) targets women without symptoms, inviting them every 3 years for a mammogram, and recalling them for further tests if their breast X-rays show anything different from normal.

Breast screening to the Borders is provided by the South East of Scotland Breast Screening Programme (SESBSP) and the service offers mammography to women aged 50 to 70 years every three years. Mobile mammography units visit 15 locations in all parts of the Health Board area during each screening round. Women over 70 years are encouraged to attend by contacting the screening centre to arrange an appointment.

Figure 20 below shows the uptake of breast screening in the Borders compared to Scotland as a whole for three year periods. The average attendance rate for the Borders during the eighth round of screening in 2010/11 was 79.1% (the same uptake as in 2008) which is slightly below the target of 80% but still higher than Scotland as a whole at 74.9%. Of those who attended, 4.4% were referred for assessment to the SESBSP Centre in Edinburgh. All NHS Boards continued to exceed the minimum performance attendance standard of > 70% of women invited during the previous three years.

Figure 20: Breast Screening Uptake in Scotland 2004-2011



There has been a considerable amount of controversy in recent years about the risks and benefits of breast screening. The most recent analysis of breast screening by the Independent Breast Screening Review in Oct 2012 stated:

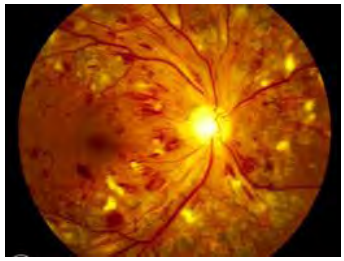
"The Panel concluded that the screening programmes have contributed to reducing deaths from breast cancer in women. But they have also resulted in some overdiagnosis among women who go for screening. It is now vital to give women information that is clear and accessible before they go for a mammogram so they can understand both the potential harms and benefits of the process."

The Scottish Breast Screening Programme is currently modifying information resources to reflect this message.

Pregnancy and Newborn Screening

I describe the universal pregnancy and newborn screening programmes for Borders residents in Chapter 2.

Diabetic Retinopathy Screening

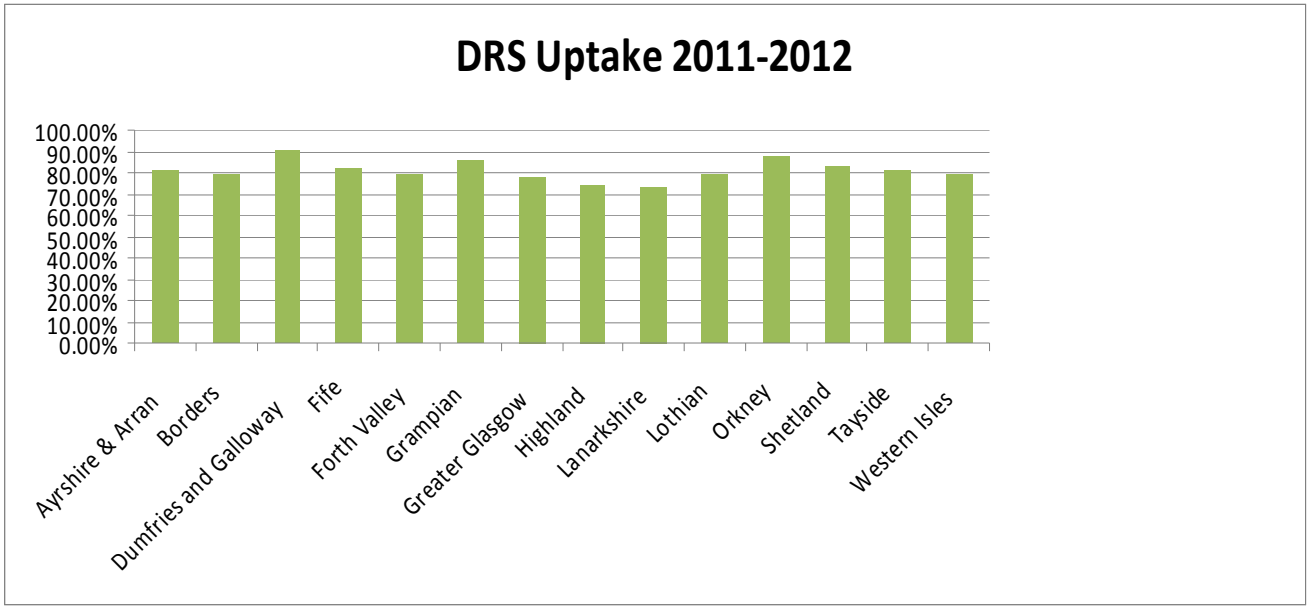


Diabetes is a chronic disease with very serious potential consequences, and is recognised as a national priority area. Diabetes retinopathy is the biggest single cause of blindness and visual impairment among people of working age in Scotland. The primary objective of the retinopathy screening is to detect potentially sight-threatening retinopathy so that it can be treated at a stage where the probability of preservation of vision is high. In its early stages diabetic retinopathy is asymptomatic but progression can be prevented by laser treatment. It is estimated that 5-10% of all people with diabetes have sight-threatening retinopathy.

The Borders Diabetes Retinopathy Digital Photography Screening (DRS) programme commenced in March 2007 with the availability of service provision in a number of community sites as well as the Borders General Hospital. All patients with diabetes over the age of 12 are offered an annual retinopathy screening using a mobile digital photography service to take photographs of their retina, where images are then sent to the Edinburgh Regional Grading Unit for examination. A small number of patients will be referred to slit lamp examination if photography is not possible. In addition to the DRS screening, diabetic patients are advised to attend an optometrist once a year for a general eye check.

Figure 21 below shows that the percentage of the currently eligible population (4705) successfully screened in year 1 April 2011 to 31st March 2012 was 79.3% similar to Scotland as a whole at 79.4% (target 80%).

Figure 21: Diabetes Retinopathy Screening 2011-13 for Scottish Health Boards



Bowel Cancer Screening

Colorectal cancer (CRC) is a major public health problem in Scotland, which has a higher rate of colorectal cancer than most other countries in the western world. It is the third most commonly diagnosed cancer in men after lung and prostate cancer and in women after breast and lung cancer. Incidence of the disease is increasing among males. Approximately 3,400 new cases are diagnosed in Scotland every year (100 each year in the Borders) and 95% of these are in people aged over 50 years. CRC is the second most common cause of cancer deaths for men and third for women. Approximately 1,600 people die of this disease in Scotland each year (33 in the Borders). The five-year survival rate has improved over the last ten years but is still poor at 45%. Early diagnosis dramatically increases chance of cure. Cancer is thought to arise in colonic polyps after several years. Bowel screening allows early diagnosis of cancer before it causes symptoms and allows polyp removal before cancer develops.

The main UK evidence for colorectal screening by faecal occult blood tests (FOBts) comes from UK trials and other international studies. These found:

- A positive faecal occult blood test is associated with an approximately 1:10 chance of cancer or a 37% chance of a polyp.
- Use of faecal occult blood tests every two years to screen normal risk individuals reduces mortality from colorectal cancer by 15-18%.
- 2% of screened persons would require further investigation.

As a result of these findings the Scottish Bowel Screening programme was established in 2007 to offer the FOB test every two years to all men and women between the ages of 50 and 74 years who are registered with a GP. Other eligible individuals who are not registered with a general practice such as prisoners, armed forces, homeless and individuals in long-stay institutions will also be able to participate.

The Borders Bowel Screening programme commenced in December 2009. A central laboratory in Dundee posts out FOB tests. These cards are used to collect a small sample of stool which is posted back to Dundee. Often a second more specific faecal immunohistochemical test (FIT) is required. People with a positive test are then referred electronically to the BGH for pre assessment and colonoscopy. Colonoscopy allows identification and biopsy of tumours and the removal of colonic polyps (polypectomy).

Figure 22 below shows that for the period 1st November 2009 and 31st October 2011 (May 2012 submitted data) Borders had an uptake of 59.4% compared to 54.5% for Scotland as a whole (target 80%). Borders men had a lower uptake than women: 53.6% v 61.3. This figure contains data for NHS Boards in their prevalence and incidence rounds and at different points within the rounds so any direct comparison of figures between NHS Boards must be treated with caution. For example, Fife did not submit data at all during this period.

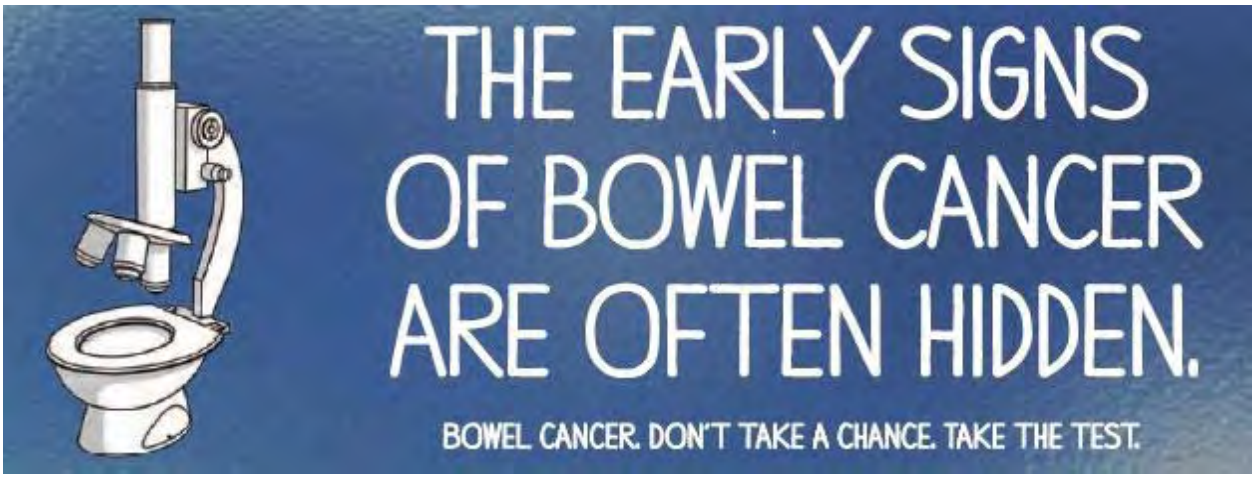


Figure 22: Overall uptake of screening, by NHS Board and sex for invitations sent between 1st November 2009 and 31st October 2011.

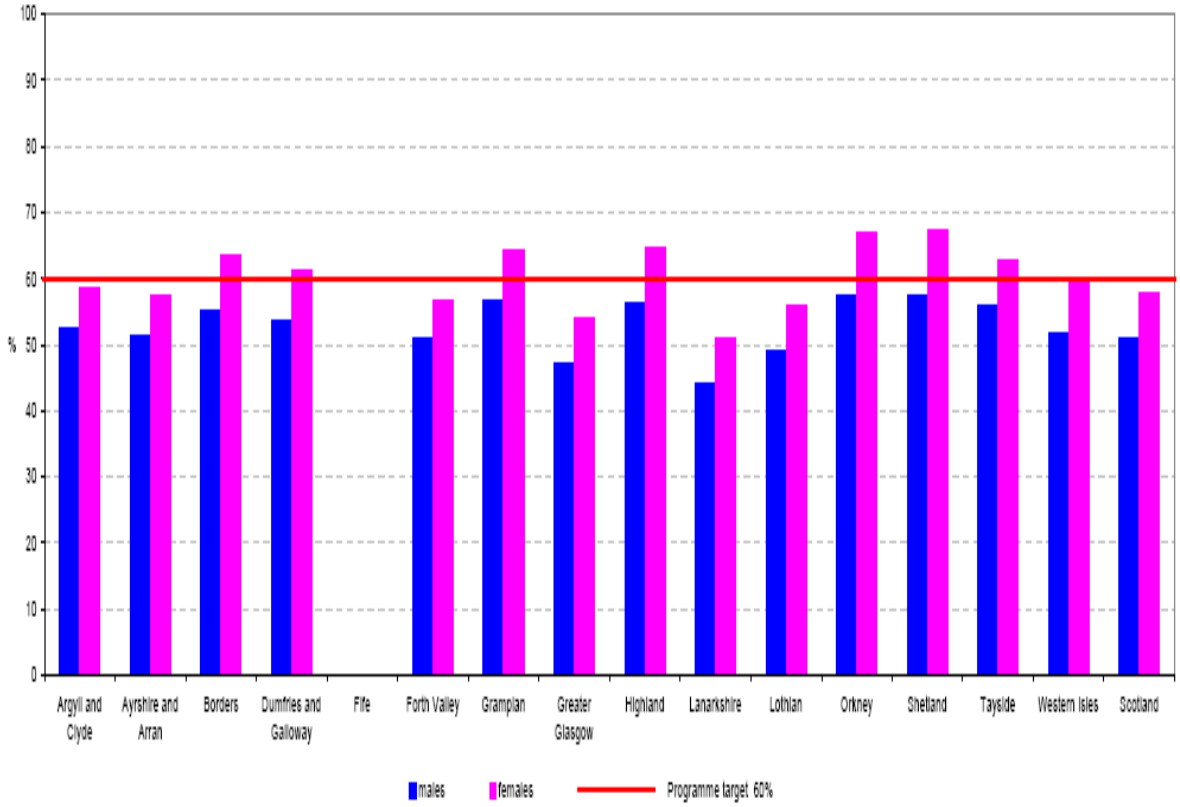
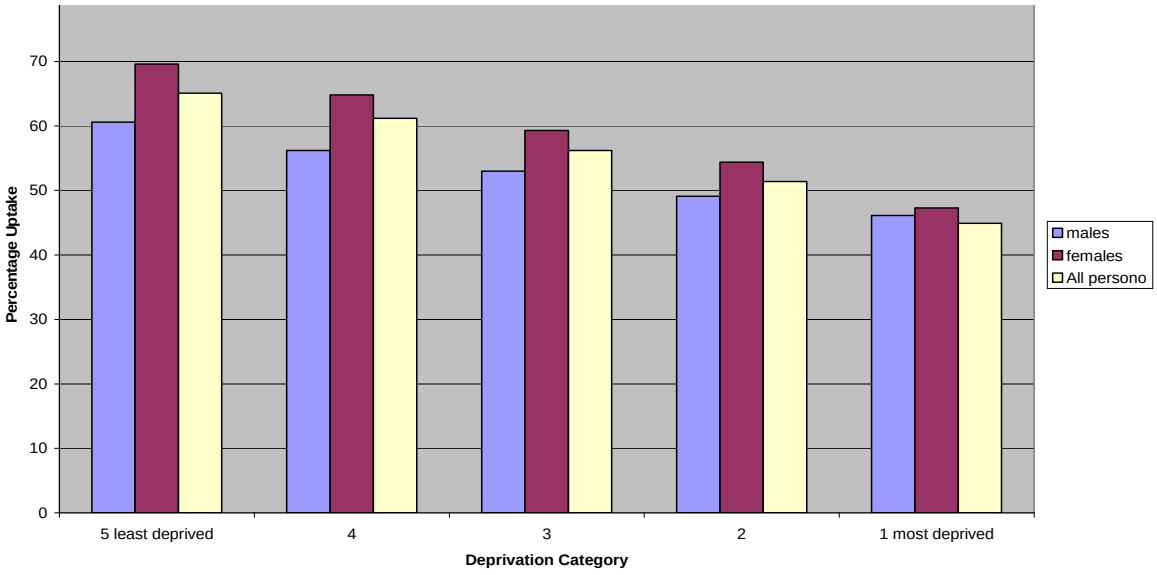


Figure 23 shows colorectal screening uptake in the Borders for deprivation grouping. This demonstrates that screening uptake amongst deprived groups in the Borders is significantly lower than for more affluent individuals.

Figure 23: Colorectal Screening Uptake in Borders by Deprivation Group



In 2010 there were 267 positive test referrals with 228 colonoscopy procedures performed. In 2011 a total of 327 positive test referrals with 287 colonoscopy

procedures performed. 2011 figures show an increase of 22% in positive referrals and 26% in colonoscopy procedures performed. Twenty-seven percent of referrals were from people aged 70-75 years.

In 2011, the programme identified 27 patients with cancer; 11% of whom were staged as early stage A polyp cancer. The overall cancer detection rate for the programme – percentage of patients with cancer out of those with a positive screening result- was 8%. The cancer detection rate for colonoscopy patients - of those undergoing colonoscopy 10% of patients had cancer.

Table 3 below shows the number of symptomatic and screen detected patients diagnosed with colorectal cancer over the last two year period. This shows that the percentage of all cancers detected by screening has significantly increased during the first two years of the programme.

Table 3: Symptomatic and screen detected patients diagnosed with colorectal cancer 2010 and 2011

Colorectal Cancer Patients	2010 (%)	2011 (%)
Bowel Screen Detected	16 (14)	27(29)
Symptomatic (50-75 age band)	50(42)	33(36)
Symptomatic (>75 years, <50)	52(44)	32(35)
	118(100)	**92(100)**

Overall the bowel screening programme is delivering the expected benefits to the Borders population by detecting a significant number of early stage cancers and this will ultimately result in a reduction in mortality from this disease. However the relatively poor uptake in deprived groups is a matter of concern and it is hoped that this will be increased by the Detect Cancer Programme.

Abdominal Aortic Aneurysm (AAA)

It is estimated around 5% of men in Scotland aged between 65 and 74 years have an abdominal aortic aneurysm (AA) and most will not know they have the condition. The risk of rupture increases with the size of the aneurysm and around 50-85% of those who do rupture will die despite access to emergency surgery.
For the period 2001-2005, an average of 284 men aged 65 years and older died from AAA each year in Scotland, with around 60% of these deaths being preventable with ultrasound screening. Ultrasound scanning is easily

undertaken using portable scanning machines, it accurately measures the aorta, and it indicates whether referral to vascular services is needed. After referral, a patient will be considered for either open surgery or insertion of a stent-graft in a procedure known as an endovascular aneurysm repair (EVAR).

Over the last two decades an extensive evidence base has been established that has shown that offering screening to men ages 65-74 years is a cost effective way to save lives. On this basis the National Screening Committee recommended screening men aged 65 years and this recommendation has been accepted by SGHD with a view to a national rollout of screening by 2013.

AAA screening commenced in the Borders on the 12 October 2012 and all men in their 65th year will be invited to attend for an abdominal ultrasound to screen for the presence of an aneurysm. Men aged 66-74 are able to self-refer for a scan. In summary there are 3 possible outcomes:

- No aneurysm – no follow-up, letter to attendee and to GP
- Aneurysm 3.0 – 5.3 – planned follow-up (surveillance) within AAA screening programme
- Aneurysm >5.4 detected – referral for clinical assessment to an appropriate specialist vascular surgery until.

Table 4 below shows that there is likely to be around 16 screen detected aneurysms each year as a result of the new screening programme of whom 10 will undergo a surgical repair.

Table 4: Estimated numbers of referable aneurysms likely to be detected by the Borders screening programme each year by operation type.

Operation Type	Estimated Number of Referrals per Year	Estimated Number of Operations per Year
Open Operation	8	4
EVAR	8	6

Although it is too early at the moment to comment on uptake rates for this new Borders programme with any certainty, early indications are that the uptake and referral rates will be at the higher end of expected values.

Future Early Interventions in the Middle Years

Physical Activity

NHS Physical Activity Care Pathway Feasibility Pilot

The Royal College of General Practitioners and NHS Health Scotland are to run a national pilot assessing the feasibility of integrating a physical activity care pathway delivering brief advice and brief interventions into the Health Care system. The initial pilot will focus on primary care settings, with a view to expanding the approach to secondary care in the future.

NHS Borders were successful with their proposal to take part in this national pilot which will take part in nine sites across Scotland and will commence in January 2013 and last for one year. The Borders proposal will be conducted through the Lifestyle Advisor Support Service (LASS) which is based in all GP practices across the Borders. The target group is adults aged over 16 – 74 who are at risk of developing chronic disease/ illnesses and those with long term conditions who want to reduce the risk of further problems.

The pilot will involve screening patients to assess current levels of physical activity and assess their motivation to change. They will be offered brief advice and brief interventions which have been found to be one of the most cost effective ways of increasing activity levels and improving health. Those patients wanting to increase their activity levels will be signposted to a number of options to become more active. These will include: local activity class's run by the Borders Sport and Leisure Trust and other providers; a supported 12 week graduated walking programme; or independent "free living" e.g. walking, cycling, and gardening. Patient's progress will be reviewed at 3, 6 and 12 months.

The results of this pilot will inform the national implementation and integration of physical activity brief advice and brief interventions in Primary and Secondary care across Scotland and will enable us to roll out physical activity care pathways across the wider health care system in the Borders.

Allied Health Professions Pledge

The Allied Health Professions pledge made in 2012 will assist in reinforcing the important role that Allied Health Professionals (AHPs) play in promoting physical activity and will create additional opportunities for joint working with health improvement and other health professionals. Additionally, the joint monitoring framework for the Health Promoting Health Services CEL that has recently been developed will be a useful tool in helping to monitor progress in encouraging staff and patients to be more physically active.

Healthy Working Lives

Healthy Working Lives, a national commendation award scheme that aims to promote health in the workplace, has a large part to play in improving staff health and wellbeing. I am pleased that both Scottish Borders Council and NHS Borders are committed to this initiative as they are the largest employers in the Scottish Borders. Recent initiatives in the NHS include the introduction of a staff Cycle Purchase scheme, subsidised opportunities for a range of physical activity sessions such as Zumba, challenge programmes for staff, for example Step Count Challenge where teams competed on the number of steps taken over an eight week period, and a recent programme for staff on mental health, wellbeing and stress management.

Future Early interventions in the Middle Years

Smoking

In the coming year, the Smoking Cessation Services will be reviewing their reach. I want to make sure that we are doing all we can locally to support pre-operative patients and pregnant women who smoke to make use of the cessation support available.

I welcome the publication of a new draft strategy for a Smoke Free Scotland which must lead to meaningful action in the future. I am pleased to see the ambitious target of 5% prevalence but this will need to be matched by bold interventions to achieve this. The strategy requires further detail of how we will work towards becoming Smoke-Free and in particular, there needs to be greater emphasis on how NHS Boards will contribute towards this.

In addition, there ought to be clear guidance on how we work with other partners towards prevalence targets and reducing health inequalities. I believe that this strategy reflects current practice which is supportive of the good work which is currently on-going. The strategy would benefit from further detail in terms of specific timescales and outcomes and related budgets, to aid NHS Boards and partner agencies in forward planning.

The summary of actions is helpful and would be of further benefit if the actions could be prioritised in terms of timescales. In reviewing existing strategy we must be brave enough to review existing interventions and question the evidence for their cost effectiveness. For example, are smoking cessation clinics the best investment?

Alcohol and Drugs

Into the future the local Licensing Board must ensure that there are measures in place to keep the risk of alcohol harm both to individuals and society to a minimum. With the evidence base to support and facilitate ongoing decisions and policy making, the Board will have a more informed role in tackling alcohol related harm.

Looking forward, it is extremely challenging to predict the likely route of Scotland and Borders' future relationship with alcohol. We know that price is a key influence on consumption; if the minimum pricing legislation is passed we will see a downward trend in alcohol use. It is also possible that in the challenging economic climate, which looks set to continue for the short term, price could also be an inhibiting factor as people are challenged to manage on constrained incomes.

In relation to other drugs, in Borders we recognise that recovery will mean different things for different people. Local services have responded to that challenge and during 2012-13 we will invest in some pilot projects to support the recovery agenda including employability work and psychological therapies. We will also investigate how we can improve on actually measuring outcomes for people in our services by using a tool which charts progress in areas including community and other relationships, physical and emotional health and meaningful use of time. We will be able to show the differences our services make but also, most importantly, allow our service users to make plans and be supported in their own recovery journey.

Obesity

Physical activity is a crucial plank in our strategy to tackle obesity and confers many other health benefits. The following actions will require further consideration and plans put in place in order to deliver on them;

- Develop staff training plan for employees responsible for the delivery of the Local Physical Activity Pathway for Brief Advice and Brief Interventions (plans are already in place for Lifestyle Advisors as part of the national pilot).

- Develop monitoring arrangements to record the number of patients being provided with brief advice/ and or brief interventions (this will be informed by our participation in the national pilot where we are currently looking at ways of doing this)

- Develop a plan to increase opportunities for staff to be more active

- Explore options for utilising the NHS estate to provide increased physical activity opportunities for staff and patients such as walking paths and allotments

- Develop active travel plans for workplaces, and indeed, leisure facilities.

Integrated Anticipatory Care Services

The Integrated Anticipatory Care Services are a worthwhile investment as they have not only had a demonstrable impact locally but also reach disadvantaged communities.

Screening

Overall, current screening programmes are working effectively and in many instances realising a greater benefit than anticipated. However, the lower uptake amongst disadvantaged and hard to reach groups remains a matter of concern and effective measures to ensure higher uptake to the same level as the more affluent in the population need to be developed and implemented. While there are thoughts about new screening programs none have even reached proof of concept at the present time.

Conclusions

In conclusion, this chapter focuses very much on issues around lifestyle and behavioural choices but I do recognise the importance of the physical and socio-economic environment in determining health. These issues are dealt with in greater depth in the following chapters.

We have a number of interventions in place to protect and promote the health of those in their middle years. A number of these are of proven benefit and merit ongoing investment. My caveat around this ongoing investment is a need for these programs to have better reach and coverage of disadvantaged and excluded groups.

What is not immediately apparent is what step changes can be made to further cost effective investment. A number of initiatives, such as those around physical activity, require minimal investment for a very major long term return and should not be disregarded.

Chapter 6

Early Interventions in the Older Years

Key Points

- There will be increases of almost 50% in the number of 65 to 74 year olds and almost 100% in the number of over 75-year-olds by 2035
- An estimated 2,905 people have dementia
- Older people eat poorly, tend to be physically inactive and socially isolated
- They are heavy users of health and social care
- "Living Well with Dementia" project in place
- "Housing with Care" developments planned
- Falls Prevention Project and Osteoporosis Service in place
- Ongoing work to prevent admission and readmission to hospital
- Potential of tele-healthcare still to be fully exploited

Health in the Older Years

The Scottish Borders is expected to have an above-average population increase of 47% amongst 65 – 74 year olds (male and female) between 2010 and 2035 . For the over 75s, the overall projected increase over this period is greater at 98% (over 80% for females, and 120% for males whose life expectancy is starting to catch up with females). I deal with population projections in more detail in Chapter 1, "What is the population of the Borders like?" Projections use past trends to deduce future trends - they do not include the impact of behavioural or policy changes (e.g. local or central government policy) or the impact of unexpected events.

Many older people continue to live healthy and active lives without needing to access health or social care services, but growing numbers of older people bear an increasing burden of disease.

This underlines the need for effective preventative measures to be in place to delay and reduce the onset of disease, and promote healthy and independent living. If these measures are of sufficient impact they should reduce the growing demands placed on services to support older people to live as well as possible.

Dementia is arguably one of the greatest challenges faced by older people and indeed society. Alzheimer's Scotland estimates there are 2,095 individuals with dementia in the Scottish Borders (Action on Dementia 2011). However, local data shows there were only 912 with a diagnosis of dementia registered with local GP practices in 2011; a rise from 717 patients in 2010. (ISD - Quality & Outcomes Framework 2012).

National data indicate that 18% of those aged 65 years and over consume five or more portions of fruit and vegetables per day, compared with 22% of respondents aged 16-64 years

Of respondents aged 65 years and over, 14% reported meeting the recommended weekly physical activity levels, compared with 44% of respondents aged 16-64 years. The proportion of older people reduced with each increasing age band from 22% of those aged 65-69 years to 3% of those aged 85 years and over.

Although obesity is an increasing concern generally, malnourishment is more often an issue for older people; a serious condition that occurs when a person's diet does not contain enough nutrients to meet the demands of their body. Those suffering from malnutrition are likely to experience significantly more hospital admissions, and longer lengths of hospital stay. Malnourishment is also a concern at home, with recent research showing that 60% of carers worry about the nutrition of the person they care for (Carers UK 2012).

Loneliness and isolation are also significant determinants of health and social care needs in older populations, contributing to the development of a range of chronic conditions, including hypertension, depression, and dementia, and resulting in a poorer quality of life ('Campaign to End Loneliness Toolkit' 2012).

When thinking about the health of older people we must not forget the health of their carers which can have a significant impact on those they look after. There are an estimated 12,502 adult carers living in the Scottish Borders (Carers Strategy for 2012 – 2015 sourcing Scottish Household Survey 2007/8 and the Scottish Census 2001). They further estimate that 19% of carers are

aged 60 – 69 years, and 18% are aged 70 and over; 70% of all adult carers have been in a caring role for over 5 years. Almost 29% of individuals with intensive care needs are cared for at home in Scottish Borders; slightly below the rate for Scotland of 32% (2010/11). The rate for Scotland has gradually risen since 2002: for the Scottish Borders, there has been a slow but fluctuating rise over this period.

Use of healthcare resources by older people remains a significant issue. The rate per 1,000 of emergency bed days for the over 75s in Scottish Borders has consistently been above that of Scotland, although local older people stay in for fewer bed days.

The rate of multiple admissions to hospital has shown an overall trend of rising gradually since 1997, and until 2008, Borders has been consistently higher than the national rate.

The rate of admissions to hospital for the over 65s resulting from a fall is significantly higher in the Scottish Borders than for Scotland, and consistently so for several years. Osteoporosis and falls are significant health problems in older people, particularly since mortality is high at 20% after 1 year following hip fracture and 50% of those that remain go into institutional care. In the Borders, over 2011/12, fractured femur was a far more common discharge diagnosis in the over 75s (281) compared to the 65-74 year olds (45).

Hip replacement cannot be regarded as an early intervention yet data for all Borders residents show a consistently significant number of hip replacements each year as shown in the table below (average number 127).

Table 5: Hip replacements carried out on Scottish Borders residents from 2008/9 to 2012/13 (YTD):
Source: NHS Borders (Acadme download 11/02/13).

Year	Total	Percentage female
2008/9	110	63%
2009/10	134	57%
2010/11	158	65%
2011/12	152	63%
2012/13 YTD	83	60%

The majority of hip replacements are carried out on females in the 65-74 age group (ranges from 57% in 2009/10 up to 65% in 2010/11).

There is a projected increase of 47% in the numbers of people aged 65-74 years; and of 98% in the over 75s. If we apply these estimated increases to the number of procedures carried out this suggests between 187 (an increase of 47%) and 251 (an increase of 98%) procedures per annum in 20 years

time. The fact that most procedures have consistently been done on the 65-74 year olds may suggest an increase at the lower end of this estimate.

Work being done by the NHS South East and Tayside Regional Planning Group shows the Borders has the highest treatment rate in Scotland for this procedure, suggesting a lower treatment threshold. Reviewing the threshold and clinical guidelines for this could therefore influence the number of procedures carried out.

These interesting data emphasise the importance of falls prevention and the osteoporosis service, particularly the high mortality and institutional care rates following hip fracture.

Future cohorts of older people may therefore experience better or worse health than older people at present, depending on the choices made during their life course. This has important implications for primary and secondary prevention and the development of a life course approach to healthy ageing.

In addition there are emerging concepts of 'co-production', 'recovery', and 'resilience', which are 'asset-based', as well as 'deficit-based' concepts of frailty.

Current Early Interventions in the Older Years

A number of prevention and early intervention initiatives are already in place that aim to improve the health and reduce the health inequalities of those living in deprived communities or who have additional support needs, for example those with mental health or learning disabilities. These focus on reducing the risks associated with unhealthy lifestyles by promoting healthier diets and increasing physical activity; reducing smoking and alcohol consumption; promoting mental health, and strengthening connectedness to local social and community activities. Few of these activities are specifically tailored to meet the needs of older people although effective prevention is relatively low cost, reduces the burden of chronic disease, and helps to address health inequalities. They also contribute to a reduction in the use of expensive health and social care services.

For older people there are a number of potential barriers to looking after their general health and well-being, including physical disability, increasing frailty, sensory impairment, and confusion, all resulting in mobility problems and lack of confidence. Other factors include poverty, poor transport and access to services, plus loneliness and isolation.

Although probably without the strongest health economic support for its introduction, the programme of Herpes Zoster (shingles) vaccination for all

those aged 70 years, with a catch-up for 70-79 years will bring meaningful quality-of-life benefit to older people.

Dementia

I am pleased to report that there is considerable activity already underway to increase the early detection and provision of early support for those with dementia.

One such project is the "Living Well with Dementia" project. This will deliver post-diagnostic support for people with dementia and their families, supporting people to live better with the condition. It should help avoid crises by building and strengthening informal support networks, links with agreed 'signposted' services and enhancing effective uptake of these services. The project aims to deliver the following outcomes:

- An increase in the number of individuals receiving a diagnosis of dementia
- Evidence early planning and continuing engagement with pre-existing supports
- Establish Peer Support/Dementia Cares across the Borders
- A reduction in crisis care
- Improved quality of life indicators
- Ownership of specific objectives in the Integrated Care Pathway (ICP)

Housing with Care

One of the crucial issues for the well-being of older people is the type of accommodation they have to live in. The Borders "Reshaping Care" Board has oversight of a project to plan and implement Housing with Care developments to provide a viable alternative to Care Home provision. This aims to increase the number of Housing with Care tenants by 84 by introducing on-site care and support teams in identified sheltered housing schemes in six towns in the Borders. The goal of the project is to allow people to be supported in their own tenancy for longer than was previously possible; each tenant will live in an environment designed for the needs of older people which will, for example, reduce the risk of falls.

Falls Prevention Project and Osteoporosis Service

These two services aim to develop a co-ordinated approach to falls prevention and bone health service provision in order to prevent avoidable

falls and fractures in the Borders elderly population and therefore reduce the number of avoidable hospital admissions.

A financial benefit would be realised from reduced admissions to the Borders General Hospital of patients who fall at home and in care homes. Based on the numbers of admissions (178) for hip fracture in 2010 and the costs identified of £25,000 per patient, a 5% reduction in admissions over a 12 month period would equate to savings of £225,000.

Prevention of Admission and Readmission

One of the big issues to tackle in preventing admission and readmission of older people to hospital is their pharmaceutical care. I am therefore pleased that we already have a Pharmaceutical Care in the Community project. This aims to prevent avoidable medication-related hospital admissions (for example, falls and adverse drug reactions) or deaths, optimise medicines use, and reduce the number of potentially inappropriate medicines. It also promotes enhanced integrated working between health and social care to enable safe medicine administration, and to support others to identify patients at high risk of medication-related adverse events.

Another approach is to use risk scoring to predict which individuals have a high likelihood of admission to hospital and to provide anticipatory care to prevent deterioration and the need for hospital admission. The nationally available scoring system is "Scottish Patients at Risk of Readmission and Admission" (SPARRA).

SPARRA - The development of SPARRA reflects the growing recognition of the need to shift from a healthcare system geared towards reactive, hospital-based treatment of acute conditions to one that is more community based with a preventative and anticipatory approach. SPARRA is a method developed by the Information Services Division (ISD) of the NHS in Scotland to predict a patient's risk of being admitted to hospital as an emergency in a particular year.

The current SPARRA algorithm, SPARRA Version 3 (which was implemented in January 2012), links data relating to hospital admissions, prescriptions (dispensed items), new outpatient attendances, Emergency Department attendances and psychiatric hospital admissions in order to predict an individual's risk of emergency hospital admission in the outcome year.

SPARRA scores are calculated for approximately 3.3 million individuals in Scotland (95% of patients experiencing an emergency hospital admission during a year appear in the SPARRA Version 3 cohort). The Information Services Division of the NHS in Scotland provides health boards with a list of individuals whose SPARRA scores indicate they are at or above a particular

level of risk for emergency hospital admission. In the Borders this information is one tool used by GPs to help identify which patients would benefit from an anticipatory care plan which would be activated in the event of a crisis out of hours.

The Stow Anticipatory Care Community Assessment Tool - The Stow Anticipatory Care Community Assessment Tool (STACCATO) is an ambitious and novel service improvement that aims to provide better anticipatory care planning for frail older people living at home. It has been developed through innovative collaboration between primary care and social care teams in NHS Borders and is currently being piloted across the Scottish Borders. It is a computer based assessment tool for patients who are at high risk of hospital admission. The comprehensive social, functional and nursing assessment will automatically give a risk prediction for three different scenarios

1. Current situation

2. Should the patient become unwell and, for example immobile

3. If they are dependent to some degree on a non-professional carer such as their spouse and that person is absent e.g. admitted to hospital

The system holds the essential details of their current homecare package if they have one and uses all the information to predict problems and suggest appropriate interventions utilising health, social care and the voluntary sector. There is a section devoted to assessing the main carer if there is one.

1. "Current situation" is about identifying issues and unmet need and adequately addressing these to try and prevent crises occurring

2. "Patient unwell" is about trying to predict the likely problems should the patient become unwell and therefore logically constructing an anticipatory care plan in advance to try and keep the person at home providing this is medically safe and reasonable.

3. "Carer unavailable" is about preventing admission for care should a person's non-professional carer be absent e.g. for persons with dementia or a significant disability. It identifies what the carer does, potential risks, and whether it is safe to maintain that person at home. If so, it enables an anticipatory care plan to be constructed in advance. It encourages the involvement of family members, getting their advance agreement to help out if required in such a situation

Final plans are shared with Social Work and The Primary Care Out Of Hours Service. Once agreed with Social Work they are stored on the Social Work IT

system and can be activated by a single phone call to Bordercare (part of Social Work) 24/7.

The assessment is designed for nurses and social workers and complements any medical anticipatory care pathways, for example, for chronic obstructive pulmonary disease or heart failure. A Phase 2 pilot is about to begin, testing software modifications and implementing the lessons learned first time around.

Future early interventions in the Older Years

There is an issue of appropriate local primary care capacity. Based on current figures, the percentage of over 65s registered with individual GP practices varies significantly across the region, ranging from 11% in one of the Galashiels practices to 29% in Coldstream, inevitably having some impact upon their capacity to respond. Similarly, available capacity constrains what social work services can deliver. These issues must drive creative thinking and step changes in public sector and third sector services.

Although this report does not present evidence in detail, better interfaces between primary and secondary care, social work services and the third sector will improve the effectiveness of care when it is necessary. I discuss the issue of health and social care integration later in the report.

Telehealthcare

Telehealthcare is a developing technological journey full of promise and needs to be exploited. It is another important strand of work to enable older people to live independently in their own homes, with effective support. I am pleased to report that there is work ongoing to continue the expansion of both the volume and the scope of home based Telehealthcare solutions. This has a particular emphasis on supporting acute long term conditions. The project is expected to demonstrate a return of investment of £560,000 in efficiencies against the planned investment of £140,000.

I am delighted that these and so many other pertinent issues are being swept up in the work being taken forward by the new community planning partnership arrangements in the Borders. One of the four main strategic themes is Early Intervention and within that there is a programme relating to older people, covering reshaping care and promoting well-being in the elderly. The programme aims to:

- Identify and address preventable needs

- Provide information support and advice with a view to supporting people to live healthier lifestyles, prevent progression of their illness or disability and anticipate future health and social care needs

- Develop a tiered exercise system specifically targeted at improving strength, mobility and balance in older people

There is a range of specific outcome indicators for the programme and also specified outputs. Intended impacts on health are:

- Maintain people with long term conditions at home

- Promote self care and ambulatory care

- Monitoring and proactive early intervention

- Promote healthy ageing

- Support carers

- Encourage use of local facilities that promote health and wellbeing

- Enhance community development

- Promote participation in intergenerational activities

One issue that we have yet to tackle is health promoting end of life care. As a society we are not accustomed to or comfortable with talking about death, dying or grief. As part of the human condition they have to be faced by us all. A group of professionals in NHS Borders and Scottish Borders Council are therefore working together to promote the idea of Health Promoting Palliative Care. This initiative aims to foster a more open attitude to death, dying and grief so that people are able to talk about death and end of life and make plans for themselves and their families.

This initiative also needs to involve NHS staff, helping and supporting them to raise the sensitive issue of whether active or more conservative care is required with patients and their relatives. There is a danger that, by default, older people receive active investigation and treatment when they would prefer a focus on making them comfortable, and on promoting their quality of life rather than prolonging life. This is about agreeing with the patient what success in treatment would be and sparing them treatment that has a low probability of success. This could improve their last few months or years and reduce unnecessary health service activity, releasing resources for more early intervention work, for example to keep older people fit and well.

The Health Promoting Palliative Care work is also aiming to encourage support for dying and bereaved people. In the coming year, this group will be seeking to engage with services and with local communities and use the information available through the Good Life, Good Death, Good Grief programme.[24]

Given the increasing numbers of older people and of those who have complex health problems and long term conditions, it would seem sensible to build into care and treatment plans some form of routine discussion about preparations for the end of life in a broader sense well before the last few days.

Likely Future Impact

"Demographic change means health and social care needs cannot be met in the way same way as at present. Change in the provision of health and social care services is inevitable. The choice for stakeholders amounts to either watching the change happen, or facilitating change to make the most of opportunities and assets, to optimise health and wellbeing of older people and others."

Health in this age group is compromised in a very different way to those of younger age groups. From a deficit perspective they are very often afflicted by dementia, malnourishment, insufficient physical activity, loneliness and place a considerable burden on their carers and health and social care resources. However, there are promising models to not only protect but improve health in this age group; it is very helpful to consider these from an assets based perspective. The healthy living network experience has shown how much can be done to support this age group not only from their own resources but from resources within their community. I am convinced that success in supporting healthy older people will come from work within communities themselves.

[24] www.goodlifegooddeathgoodgrief.org.uk

Chapter 7

Place and Communities

Key Points

- Realising the potential health gain in Place and Community requires a collaborative approach
- Promoting access to the natural environment
- Whole Town Plans can impact positively on health
- Violence as a public health problem
- The Community Resilience Programme is praised as best practice by Scottish Government
- A Community Engagement Programme is being implemented
- What is the best way forward for "Place Making" to improve health?

The Place and Communities theme of the Scottish Borders Community Plan is one of four main themes as described in my introduction to this report. The Place and Communities theme of the Scottish Borders Community Plan comprises four main programmes, all impacting on health and wellbeing. These are Whole Town Plans, Community Safety, Community Resilience, and Community Engagement. These all contribute to opportunities for physical activity and sport, and acknowledge the role of the Forestry Commission, Sports and Leisure Trusts, libraries and museums. Particularly the latter two contribute to literacy, so crucial to wellbeing. Beyond the confines of the programmes there are a number of considerations in terms of the impact of "place" on health in the Borders.

The Natural Environment

The natural environment of the Borders provides a rich resource to encourage physical activity and sport of many types for local people and visitors to the area. Partners are working together to promote access to places and spaces, ensuring these can be accessible to as many people as

possible whilst also protecting the diversity and quality of the environment. As described earlier in the report, we now have several promising programmes developed in partnership with the Scottish Forestry Commission, Borders Woodland Trusts and Borders Environmental Education Services. These aim to engage people in outdoor activities, encouraging them to experience the outdoors in new ways and develop skills and confidence in the process.

The facilities and resources in our local communities help sustain healthy, vibrant and well connected communities where people can engage with arts and cultural activities, sports and recreation, and learning.

Possible relevant indicators or data sources include:

- % who visit the outdoors more than once a week (national indicator)
- Volunteering
- Data on visits to arts / culture / leisure facilities

Whole Town Plans

The Whole Town Plans programme aims to maximise the synergy between community, voluntary, businesses and public bodies in developing and regenerating towns. This links very closely with maintaining and developing the local economy, crucial to employment and the health benefits that go with it. I explore these issues in more detail in the next chapter.

I am keen to add value by forging stronger links between health improvement activity in the Borders and efforts to enhance the environmental and economic sustainability of the area. The concept of whole town planning offers a means towards this, as it brings together key services that focus on one community. Another opportunity lies in the arena of public sector procurement to ensure that spending has a positive impact on the local economy for example by sourcing local food and reducing food miles. The preparation for the Borders Railway allows us to draw on experience in other parts of Scotland to ensure suicide prevention is considered in the development of the railway infrastructure and in staff training and development from the outset.

Community Safety

Violence as a Public Health Issue - Violence is not a new public health concern. The impact of violence on the health of individuals, families and wider society adds to an increasing burden of ill-health and cost to health and other welfare services. The box below lists some of the key issues from a Public Health perspective.

From DoH Report: Protecting People, Promoting Health - a public health approach to violence prevention for England (2012)
www.cph.org.uk/showPublication.aspx?pubid=809

1. ***Much like many infections, violence is contagious.*** *For instance, exposure to violence, especially as a child, makes individuals more likely to be involved in violence in later life.*
2. ***Violence shows one of the strongest inequalities gradients*** *with emergency hospital admission rates for violence being around five times higher in the most deprived communities than in the most affluent.*
3. ***By adopting a public health approach violence can be prevented.*** *A range of different interventions throughout the life course can reduce individuals' propensity for violence, lower the chances of those involved in violence being involved again and ensure that those affected by violence get the support they require.*
4. ***A wide range of interventions are available to public health practitioners.*** *Programmes that support parents and families, develop life skills in children, work with high-risk youth and reduce the availability and misuse of alcohol have proven effective at reducing violence. Measures to ensure appropriate identification, care and support mechanisms are in place are important in minimising the harms caused by violence and reducing its recurrence.*
5. ***In many cases health economic analyses are already available*** *that demonstrate significant cost savings where violence prevention programmes have been established. Some areas in England are already employing these measures. If other areas followed suit financial and health benefits would be substantial*
6. ***Violence prevention is a critical element in tackling other public health issues.*** *Violence impacts on mental wellbeing and quality of life, prevents people using outdoor space and public transport and inhibits the development of community cohesion.*
7. ***Changes to public health and other public structures should help facilitate violence prevention.*** *The establishment of Public Health England and locally accountable health and wellbeing boards; the movement of public health teams into Local Authorities and the election of police and crime commissioners, can be used to create multi-agency plans for violence prevention in all localities. Such plans should use the strong evidence base behind public health approaches to violence prevention to ensure public sector, private sector and community assets all contribute to violence prevention and benefit from less violence.*

In the Scottish Borders, within this subject, one of the matters causing most concern is gender based violence, with domestic abuse identified as a priority. Incidents of domestic abuse have increased on average by around 20% from 2008-09, with the current year on a par with the previous three-year average. The table below shows the total number of incidents year on year, along with the three year averages.

	2008/09	2009/10	2010/11	2011/12	3yr average
No. of incidents	665	817	778	801	**799**
Yearly Movement No	86	152	-39	23	
Yearly Movement %	15	23	-5	3	
Variance to Average %	-17	2	-3	0	

A significant increase was evidenced between 2008-09 and 2009-10 and since then the volume of reporting has remained fairly steady within 3% of the average. Despite this increase, recent work carried out by the Safer Communities Partnership suggests that under-reporting of domestic incidents may be around 60% while the national figure is likely to be much lower at 40%.

Under-reporting in a rural community is thought to be higher than more urban areas, in the main due to lack of services and support, and potentially further exacerbated by local attitudes. We see this within Scottish Borders with the more rural communities in the east estimated to have higher under-reporting rates than the north and south where larger towns are located.

Plans to address under-reporting and service and support provision issues will take a dramatically different focus under the Pathway Project (Pathway) that has been funded by the Big Lottery and Scottish Government. Pathway has brought together, in a coordinated way, the key services required to develop a "coordinated community response" (CCR) to addressing domestic abuse in the Scottish Borders. The project will deliver three services – 1) the Domestic Abuse Advocacy Support (DAAS) service, 2) the Domestic Abuse Community Support (DACS) service and 3) the Children Experiencing Domestic Abuse Recover (CEDAR) Group work programme.

The three new services will work alongside existing service provision to achieve project and programme outcomes for victims of domestic abuse and their children. The DAAS service will consist of a 13-15 week service of 24/7 support modelled on the Independent Domestic Violence Adviser

(IDVA) services and the current Advice Support Safety Information Services Together (ASSIST) domestic court support service.

The DACS service is a 'moving on' service, and is based in the five locality areas (Teviot/Liddesdale, Cheviot, Berwickshire, Eildon and Tweeddale) of the Borders and will support victims to reconnect with their communities.

The CEDAR Workgroup programme will also work across the five locality areas of the Borders and will support children and mothers.

Pathway will provide beneficiaries with increased access to a more comprehensive range of support services, help families to feel safer and better supported, and help children affected by domestic abuse to feel less isolated and more able to cope. Children and their mothers will also have a greater understanding of domestic abuse, how to stay safe and have a greater sense of self-worth and emotional well-being. In addition, Pathway will enable communities and agencies in the Borders to have a greater understanding of the difficulties faced by individuals and children affected by domestic abuse and will be more able to respond to their needs. Partner agencies will better understand the complexity of domestic abuse and its impact on children, leading to a better response across the multi-agency environment.

The three new services operating alongside the remaining existing services will maximize opportunities to replicate multi-agency good practice and actively involve the participation of beneficiaries. The Pathway aims to deliver a model of services that supports victims through a pathway of interventions from initial crisis to resettlement in the community.

Crimes of violence

Crimes of violence include the following crime types:

- Group 1 (Crimes of Violence; excluding motoring offences)
- Group 2 (Sexual Crimes)
- Group 6 (Minor Assaults)

The information contained in this report was gathered from crimes of violence occurring between 1st April 2010 and 30th November 2012. During the analysis period, the overall number of violent crimes recorded totalled 2125 crimes and broken into the different crime groups as shown in the table below.

Fiscal Year	Group 1	Group 2	Group 6	Total
2010-2011	107	66	516	689
2011-2012	124	110[25]	694	928
2012-2013 YTD	44	67	397	508

Sexual crimes (group 2) are showing increases. This is, in part, due to changes in legislation in 2009 now coming through to recorded crime. Around 90% of victims of sexual crimes are female, making this a gender-based violence.

Violent crimes are showing a decreasing trend overall, however this is being driven by decreases in Group 6 (minor assaults), while more serious violence (Group 1) has shown increasing trends. However, the current year to date is much improved with a decrease of around 42% so far.

Prevention work has taken place over the current fiscal year with regard to tackling public space violence with an emphasis on alcohol, since this is recognised as a trigger. The decreases evidenced are undoubtedly influenced by this positive activity with particular decreases seen over the spring and summer months (Borders 7's and Common Riding events) when violence tends to peak in the Scottish Borders. Almost half of all recorded violence (excluding sexual crimes) is recorded with alcohol as an aggravator.

Turning to the victims of violent crime, the table below shows the age range and gender showing a fairly even split over all age ranges. Group 2 crimes predominantly involve female victims (around 90%) and analysis shows that males are more likely to be victims of Group 1 serious assaults (around 70%).

Age Range	Male	Female	Total
Under 18	174	159	333
18 to 29 yrs	275	244	519
30 to 44 yrs	187	161	348
45 to 59 yrs	82	75	157
60+ yrs	9	11	20
Total	**727**	**650**	**1377**
%age	**53**	**47**	**100**

Prejudice based crimes continue to be very low in Scottish Borders with the majority of these involving verbal abuse or breach of the peace. Prejudice based violence is extremely rare.

[25] It should be noted that a high number of historical sexual offences were recorded in 2011-2012 and this has boosted the numbers here.

During the analysis period a total of 134 hate crimes were recorded. Of these, 12% (16 crimes) involved violence with all but one being a minor assault.

The table below gives a breakdown of the gender and age groups of victims, with young females, typically around 14 years of age being the majority victim. Analysis of these crimes shows that in general, the offender is of a similar age and gender. This is consistent with general minor assault crimes.

Age Range	Male	Female	Totals
Under 18	1	8	9
18 to 29 yrs	2	0	2
30 to 44 yrs	2	0	2
45 to 59 yrs	1	1	2
60+ yrs	1	0	1
Total	**7**	**9**	**16**
%age	**44**	**56**	**100**

So far, 70% of these crimes of violence were the result of race discrimination. This is also true of the non-violent hate crimes.

The Community Safety Programme aims to assess the adequacy and effectiveness of the Scottish Borders Policing Plan, the Scottish Borders Fire and Rescue Plan, and the Scottish Borders Safer Communities Plan. These will be considered in terms of priorities, community engagement and performance related measures to provide reasonable assurance of effective and efficient implementation and operation. They will also be assessed for their contribution to the delivery of the Scottish Borders Single Outcome Agreement (SOA), in particular the local outcome indicators and programme in relation to the national outcome "We live our lives safe from crime, disorder and danger".

Community Resilience

The Community Resilience programme aims to assist communities in periods of severe weather and during emergencies. The Initiative is the first of its kind in Scotland and has been developed as a model for use by other local areas. Its key objectives are to:

- Raise awareness and understanding of the local risk and emergency response capability in order to motivate and support self-resilience
- Increase individual, family and community resilience against all threats and hazards

- Support and encourage effective dialogue between the community and the practitioners supporting them

- Assess and develop communication systems to ensure communities are given appropriate warnings of severe weather etc

- Provide a framework and support to enable the creation and delivery of a resilient community plan

The Initiative involves a three year programme which hopes to achieve a target of 50%, or 33 community councils, having Resilient Community Plans in place by October 2014. It is recognised that this is a medium to long term project in that communities will need continued support in working alongside emergency responders.

The initiative has featured in the Scottish Government's 'Preparing Scotland' web site as best practice to deliver Community Resilience. The Community Councils that have implemented plans are now aware of the specific risks that their community could encounter from flood, severe weather, utility failure, fire etc, and are now prepared, trained, and equipped to deal with emergencies.

The Initiative has resulted in the development of stronger communication with Communities and their volunteer teams through the alert systems that are utilised. They are alerted at an early stage of weather warnings, or general occurrences within the community i.e. bogus callers, metal thefts etc.

Due to the success of the Initiative it is now being progressed through the education system, with support from Education Scotland and the Scottish Government. A funding grant of £4,000 from Scottish Government's 'Education for Emergencies' curriculum is to be piloted within 2 High Schools in the Scottish Borders. The project will seek the participation of S4 to S6 pupils in their local resilient community plans. They will assist in volunteer recruitment and be rewarded for their participation via the Saltire Award Scheme.

In my view the concept of Community Resilience goes beyond communities dealing with emergencies themselves. It may not be named as such, but in reality it is being taken forward practically by, for example, Community Asset Transfer, the reinvigoration of Community Councils and the establishment of Area Forums.

To some extent Community Resilience is supported by the resilience of the public sector organisations communities collaborate with. Both Scottish Borders Council and NHS Borders have emergency planning functions which not only dovetail well together but mean that interdependencies can be effectively managed. Both organisations also have business continuity

arrangements. These allow major emergencies which threaten the public's health to be dealt with effectively on a multiagency basis while, as far as is possible, it is "business as usual". Both organisations work closely with other public sector and voluntary agencies, in particular Lothian & Borders Emergency Planning Strategic Coordinating Group and Scottish Government. They have a regular programme of exercises, many of which are multiagency.

Conceptually the resilience of a community depends on its community capacity which can be viewed in four main dimensions:

- **Social capital** is defined as the sum of resources that each person has as a result of their relationships, and includes both support from and obligations to groups to which they belong; thus, family membership provides supports but will also entail commitments and obligations to the other family members.

- **Physical capital** is defined in terms of tangible assets such as property and money that may increase options (e.g. being able to move away, or to fund other opportunities. Specific examples include opportunities for physical activity and sport, the role of the Forestry Commission, Sports and Leisure Trusts, libraries, museums and so on.

- **Human capital** includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem-solving that is required during an individual's life course.

- **Cultural capital** includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours

Our strategic aim should be increased capital in communities which will give them a greater sense of control which in turn will augment the increased well-being which comes from greater social capital. Clearly, the four main programmes of the Place and Communities theme of the Scottish Borders Community Plan will do much towards the delivery of these aspirations.

Community Engagement

The Community Engagement programme aims to develop a Scottish Borders Community Planning Engagement Strategy. This should ensure the five Area Forums established in the Scottish Borders engage effectively with local communities; develop appropriate and effective consultation processes,

particularly with community councils, equalities and hard-to-reach groups, and to ensure Community Capacity Building is in place to support

- Local projects
- The Community Asset Transfer policy
- Opportunities for the community and voluntary sector to procure public services.

Community engagement is crucial to understanding the needs of the community as it sees them and then on that basis to know how to work with them in genuine "co-production". Working with communities to design and deliver services and supports that build on strengths, skills and knowledge of community members and enable them to have an active role (co-production) is becoming all the more important for the public sector and the third sector.

Community Planning partners recognise the need to listen to communities about their experiences and concerns about what affects their health. This approach is based on the principle of Localism, but results in diversity which centralist and hierarchical parts of the public sector find challenging to accommodate or indeed promote. Yet these are some of the key ingredients to successful community development. In terms of the relevance of that to health I refer back to the "People's Charter" definition of health and well-being which I quoted at the beginning of this report.

The work of the Healthy Living Network is a good example of community engagement. People in the Borders often have strong ties with their local communities. A sense of belonging, of being connected and being able to contribute to the wellbeing of others increases our chances of maintaining good health and dealing with adversity. The Healthy Living Network continues to tap into local needs, engaging local people in planning and delivering programmes, involving community members and seeking to find innovative solutions together.

Some examples:

In Langlee and Burnfoot, HLN is currently exploring how these communities could develop initiatives to address food poverty.

A small group of mothers in central Borders is taking part in a Mum's Wellbeing project to develop information and peer support for other mothers. In another area a group of young people who did not have positive destinations beyond school have been supported by HLN, Community Learning and the local school to develop life skills and basic qualifications in food hygiene, first aid and food preparation.

Tackling stigma and discrimination helps reduce barriers to engagement with some groups. Work is being carried out on tackling homophobia through awareness raising in schools, public services, in sports clubs and associations and in local communities. 2011 marked the first Borders LGBT film festival and there are plans for this to become an annual fixture.

Indicators

During 2011-12, the Borders Healthy Living Network recorded 1494 registrations /contacts across the 5 areas. This covered a wide range of programmes and includes a wide spread of age ranges.

Conclusions

In terms of "place making" for health benefit and developing community well-being there are a raft of logically focused measures in place in the Borders. Currently the questions that appear unanswered are: Do we need to do more of the same? Do we need to do something differently as well as or instead of what we are currently doing? At the moment we have a narrow range of sentinel markers to demonstrate progress towards success although we have a vast array of indicators in a number of specific fields that show good achievement. These questions must be the basis for further debate.

Chapter 8

Economy and Infrastructure

Key Points

- Economic strategy is an investment in health
- How resources are used determines health
- Effective public health measures are potential economic engines
- A healthier workforce is more productive
- Unemployment compromises health
- Recession impacts on the wider dimensions of well-being
- The health impact of the recession is compounded by the Welfare Benefits Reform
- Infrastructure is critical to health improvement

Introduction

The economy is the state of a country or region in terms of the production and consumption of goods and services and the supply of money, and as such is an important determinant of health in the Borders. There are many links between health and the economy. Richer nations generally have better overall health conditions than do poorer nations—and that, within a country, more affluent individuals have, on average, better health than do poorer individuals. However, we know too that the bigger the inequalities gap the worse the overall country's population health will be. Most countries continue to gauge 'success' in terms of economic growth. However recent debates highlight the importance of also taking account of other dimensions, in particular well-being and sustainability.

While there is a large body of literature about the impact of the economy on health care systems there seems to be a relatively little literature about the impact of the economy on health itself. We also have evidence of the impact of recession or economic downturn on health from which we can infer that economic growth should have a positive effect on health.

Why is the economy important from a Public Health point of view? American work[26] shows that more than 17 percent of the US Gross Domestic Product is spent on health care - in many cases, for conditions that could be prevented or better managed with public health interventions. Yet only 3 percent of the US government's health budget is spent on public health measures. A 2012 study in Health Affairs notes that since 1960, US health care spending has grown five times faster than GDP. Clearly the greater the focus the economy has on public health the greater the state of health of the population will be. Thus it is not just the state of the economy, but how its wealth and resources are used, that will determine health.

The Institute of Occupational Medicine estimates that cutting the prevalence of adult obesity by 50% - roughly the same reduction across the population as was achieved through public health's multipronged attack on smoking in the late 20th century - could cut annual U.S. medical care expenditures by $58 billion.

Put simply, effective public health measures, including those aimed at improving health systems, have the potential to be economic engines. But these engines have been chronically underfunded and have received too little attention from politicians, professionals and the public. We have already reached the point of diminishing returns in some areas of medical care, but we can still see very good returns for many public health interventions that are currently underutilised.

But what about the impact of the population's health on the economy?

First, a healthier workforce is a more productive workforce. A healthy population spurs economic growth. Healthier people are more economically productive. Better health also leads to an increase in savings rates - because healthier people expect to live longer and are naturally more concerned with their future financial needs. According to an April 2012 report from the Institute of Medicine, the indirect costs associated with preventable chronic diseases - costs related to worker productivity as well as the resulting fiscal drag on the nation's economic output - are vastly underestimated. A 2007 study from the Milken Institute found that when unhealthy workers turn up for work, as many must to survive financially, the effects of their lower productivity on economic health are immense, several times greater than the business losses accrued when employees take actual sick days. Avoidable illness also diverts the economic productivity of parents and other caregivers. Secondly, education is a bridge between health and the economy. Unhealthy children may enter school with physical and cognitive disadvantages, miss more days of school, attend school for fewer years, and

[26] http://www.hsph.harvard.edu/news/magazine/public-health-economy-election/

learn less when they're in school. By contrast, healthy children are more likely to be able to take advantage of whatever education is available to them - and a good education has profound economic consequences throughout an individual's life. These consequences include a higher starting wage and larger salary increases over the course of one's working life - earnings that ripple out into the larger economy. So, skills and training come with attendant health benefits.

Thirdly, the costs of health care are built, indirectly, into the price of every product, and that spending does not generate improved spending on education, roads, and other goods and services that the community values.

If the Borders can reduce the costs of health care over the long term - by preventing diseases that require costly medical procedures to treat and by making the existing health system more efficient - the costs of Borders products can become more competitive in the marketplace. The Scottish Borders economy must focus on already successful areas where it can increase the level of competitive advantage.

Economic strategy

Why have an economic strategy? Given that the economy is so important for so many reasons, particularly as a driver of health, it is of crucial importance to take a strategic approach to sustaining and developing the economy. In that economy, from a public health point of view, we need to treat Health as the Borders' Number One Asset – of the individual as well as the community. With that strategic priority, we can be explicit about the delivery of necessary infrastructure and about how we will manage risks to the local economy and therefore to health. Spending on the promotion and protection of health is a productive and necessary investment rather than consumption expenditure. We know that investment in the health of the population yields long lasting social and economic returns that benefit all.

Risks to Economic strategy

Currently, the health impact of the economic downturn or recession compounded by the welfare benefit reform seems to be the biggest threat to implementing a positive economic strategy in the Borders as well as elsewhere.

Health effects during a recession need to be distinguished from health effects in the longer term, as even when an economy moves out of recession, unemployment levels remain high and the cumulative effects of prolonged unemployment accrue[27].

[27] Audit Commission (2009) When it comes to the Crunch… Responding to the economic downturn: the role and potential of partnerships.

The evidence suggests that the way in which an economic downturn impacts on people's health is complex and depends on the nature, depth and extent of the recession, the employment market, welfare arrangements and prevailing culture and values [28]. What is clear is that economic recessions affect health, but the effects can be positive as well as negative. The effects are specific to different types of health problem and to different groups, not least because the impact of recession is not evenly distributed. For example, the number of people in ***under***employment i.e. in work but on lower incomes than they need is rising. But these effects are not inevitable - they can be mediated by the policy response – resources permitting.

Social and economic factors, including income and income inequality, are strongly associated with health inequalities. More unequal societies have poorer health outcomes for all socio-economic groups not only those who are most disadvantaged[29]. However those in the lower socio-economic groups have the poorest health outcomes and poor health occurs earlier in the life course[30]. Poverty, insecure employment and unemployment are recognised risk factors for infectious disease. In some countries there have been marked rises in infectious disease incidence during previous economic crises and downturns, raising concerns about the current situation. So what does the evidence say about the impact of the current recession on communicable disease?

Neil Craig, Health Scotland, recently scrutinised work in this area. A systematic review of economic crises on communicable diseases in high and middle income countries found that out of 37 studies, 30 identified adverse outcomes in association with economic crisis; the remaining 7 found better outcomes or no significant effect. However, none looked specifically at the UK and most looked at middle income rather than high income countries.

One survey of experts from national agencies for communicable disease control from EU and EFTA countries found few specific national policies and programmes aimed at mitigating the impact of the economic crisis were identified. Further, the respondents did not identify any research underway or any datasets that would enable monitoring of the effects of the crisis on communicable disease in vulnerable groups, still less to attribute any changes observed to the effects of recession. Prevention services were deemed

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[28] Elliot E et al (2010) The Impact of the Economic Downturn on Health in Wales: A Review and case Study. Working Paper 134. Wales Health Impact Assessment Support Unit.
[29] Wilkinson R and Pickett K (2009), The Spirit Level: Why More Equal Societies Almost Always Do Better. London: Allen Lane
[30] The financial implications for NHS Highland of the UK Welfare Reform Act. Written submission to the Scottish Government Finance Committee for the Evidence Session 20 06 2012

particularly susceptible to budget cuts; services targeted at vulnerable and hard-to-reach population groups were perceived to be at particular risk

However, looking at the last period of recession, falls in income have helped reduce the affordability of alcohol, which has translated into falling sales. However, aggregate data can disguise variations between groups. A New Zealand review of the links between alcohol abuse, drug use and recession found one study that had looked at illicit drug use and the economy. The study found strong evidence that teenage drug use increases during weaker economic times. Depending on the type of drug use, there are potential infectious disease implications.

A recent analysis of suicides associated with the current recession in England found that regions with the largest rises in unemployment had the largest increases in suicide, particularly among men. Similar associations between deprivation and suicide risk have been found for Scotland. There are many more examples of studies looking at the impact of recession on non-communicable disease. Some have looked at what can be done to reduce the effects of recession and concluded that these effects can be mediated by policy responses. But how likely is that in the current climate?

The UK government is not adopting a policy of countercyclical spending – it continues to try and reduce borrowing and the size of the deficit. This is leading to spending cuts so the likely impact of recession will depend on where the cuts are made and the impact this has on the drivers of health.

Various drivers have been suggested by which recession might affect infection rate:

- Evidence that workers have been reluctant to take sick days, more likely in fearing unemployment, while increasing the risk of disease transmission at work

- Mechanisms: removal rate – evidence that some countries have cut budgets for infectious disease control and pharmaceutical companies report declines in sales of prescription drugs, especially in countries with high reliance on out-of-pocket spending.

Recession also has a negative effect on wider social factors that are important influences on health:

- Reduced household budgets mean that those on lower incomes have to spend proportionately more on food

- Fuel poverty which affects close to one in three households in Borders

- Increases in transport costs reduce mobility and can increase social isolation, which is known to damage health

So although policy responses can offset the effects of recession they can also make them worse. Some predictions are that austerity will last until 2018. So the infrastructure and policies that have the potential to offset the effects of recession on health are themselves diminished by the recession, such that its effects on health more generally will increase. The concern is that the policy response may magnify the effect of recession, via macroeconomic policy that deepens the recession further and increase people's vulnerability to a range of health problems, and through spending cuts that weaken the capacity of the infrastructure to cope.

International comparisons point to the importance of social protection systems (for example social insurance and welfare programmes) in protecting against the extremes of economy growth and downturn[31]. Welfare support systems can have a buffering effect in maintaining living standards and in reinforcing social solidarity by pooling risks and by reducing the unequal impacts of decreased income and increased insecurity. Hence the timing of the current welfare benefits reform is perverse. In previous UK recessions we did not witness comparable reductions in benefit levels on the current scale.

From a public health perspective, employers giving insufficient attention to their duty of care in terms of ethics, not just legislation, can mean that the health of their workforce is not optimal. This makes health improving initiatives like Healthy Working Lives important and also the provision of an adequate occupational health service. Good management of sickness absence is a win-win for both management and workforce.

While economic strategy should be designed to protect against recession the impact of the national economy on the local economy may mean that downturn is inescapable, as is true in so many ways at the present. For a public health perspective, the major impacts of a recession on health are a major concern. Individual and community assets, which contribute so much to well-being, depend to a large extent on work, whether in the manufacturing or service industries.

The Scottish Borders Economy

The Scottish Borders workforce is characterised by low unemployment, high reliance on small to medium sized businesses and dominance in sectors such as Tourism, Agriculture, Property/Business services, Retail and Construction[32].

[31] Bezruchka, S 2009 The effect of economic recession on population health. Canadian Medical Association Journal: 181 (5): 281- 5.

[32] Source: Labour Market Statistics, Scottish Borders (2011).Accessed 1 October 2012 at *http://www.scotland.gov.uk/Topics/Statistics/Browse/Labour-Market*

Small and Medium sized employers (SMEs) are central to the Borders economy with 97% of all registered businesses falling into this category and employing 76% of the total working population. Studies have shown that SMEs are less likely to have access to dedicated work place health services (Mansel Aylward[33]). To be more specific about the principles I have already described, employers with effective health and productivity programmes yield 20 per cent more revenue per employee than those without.

The current turbulent financial climate sees a number of changes that will affect the Borders economy. Welfare reform may increase the number of individuals who are deemed capable of work. Local businesses, in an attempt to remain competitive, have been forced to reduce their overheads. In some cases this has led companies to reduce their manpower either by imposing redundancies or reducing contracted hours with the latter creating a sub-class of employment - the "underemployed". This all leads to an increase in the availability of a workforce but unfortunately this is not matched by an increased need for manpower.

Unemployment is not good for your health. Indeed, long-term unemployment of more than six months has been demonstrated to impose health risks to an individual that is equivalent to smoking 200 cigarettes per day[34].

Of those individuals deemed unable to work due to their health, in any one year it is estimated that 2.5% of the working age population will go onto Employment Support Allowance with Mental Health problems accounting for 50% of referrals. Furthermore:

"surveys tell us that given the right support approximately half of these would like to work and almost all people moving onto incapacity benefits each year want and expect to return to work. For most, there is nothing about their health condition that makes this ambition unrealistic." [35]

In addition, Dame Carole Black, in her report *"Working for a Healthier Tomorrow"*[36] notes that the longer someone was in receipt of a health related benefit the less likely they are to return to employment. NHS Borders Work Place Health Services (WPHS) aim to provide service users with timely and appropriate input to offset the factors which cause and prolong sickness

[33] Professor Sir Mansel Aylward, Chairman of Public Health Wales, Conference proceedings, Academy Health: Wales's Health Economy conference organised by the IWA in Cardiff 2012.

[34] Ibid number 3

[35] Waddell G & Aylward M, The Scientific & Conceptual Basis of Incapacity Benefits (TSO 2005)

[36] Black Dame C. *Working for a Healthier Tomorrow: Review of the Health of Britain's Working Age Population* (The Stationery Office, London, 2008)

absence which may, in some cases, mean that employees move out of work and onto benefits.

Infrastructure

In terms of infrastructure, two issues stand out, although they are not the only ones. Firstly there is the issue of access to high-speed broadband because of the benefits of social media and the information and advice it can provide. Secondly, the issue of transport, particularly public transport, and access to opportunities is a recurrent theme.

Social Media and Literacy for health: Broadband is of growing importance to wellbeing because of the importance of social media. Access to broadband is becoming a prerequisite for modern life. Yet access to broadband in the Scottish Borders is below the national average. Uptake ranges from 80% among younger age and working age sectors of the population to below 20% among older age groups.

Increasingly IT literacy is now a crucial part of health literacy. Both require literacy and numeracy and allow access to the wealth of information and resources available locally and on the internet. As information becomes increasingly available through social media, then these variations in access and engagement with internet based technologies become an issue. Apps that can be adapted and customised for individual preferences to support healthy lifestyles may well increasingly appeal to younger generations. This will mean that health professionals need to review established practices.

The public sector and its third sector partners have a responsibility to ensure that those who may face challenges in relation to literacy, including IT literacy, have opportunities to develop skills and confidence, as this will have benefits for health.

Current Interventions

Social Media and Literacy for health: The intention is to ensure over 85% of the Borders is covered by next generation broadband; this is a programme within the Economy and Infrastructure Theme of the Borders Community Planning Partnership.

Public Transport: the Reshaping Care Board is currently overseeing two projects. One is to support the development of integrated transport solutions for older people accessing health and social care services. The aim is provide users with a single point of contact booking system with resources being utilised in an effective way which will provide the best transport option for the service user. This should translate into improved access to health and social

care, enhanced independence and well-being, and support to unpaid carers.

The other is to investigate Access to Transport for Communities in Rural Hinterlands. It will do this by reviewing the barriers to accessing transport for elderly people living in rural hinterlands around 5 locality hubs (Peebles, Hawick, Kelso, Duns and Eyemouth), and to develop and test models of transport provision that meet the needs of the localities. The intended outcomes are:

- Reduced Emergency in-patient bed day rates for people aged 75+ - 50 per annum
- Reduced patients whose discharge from hospital is delayed – 100 per annum
- Reduced accumulated bed-days for people delayed – 50 per annum
- Increased prevalence rates for diagnosis of Dementia
- Reduction in use of Scottish Ambulance Service vehicles as a result of people being able to access better transport - 20 to 30%

Work Place Health Services: an overview: Activity supporting the health and employability agenda is underpinned by the unified approach taken to work place health within NHS Borders with a co-ordinated, co-located team under a single management structure. The Work Place Health Services team is made up of several elements which in other health boards operate as stand-alone facilities. This allows a 'one-stop shop' approach to be taken to service delivery with satellite sessions and on-site visits undertaken based on client need. WPHS also works to ensure it is up-to-date and informed about the range of services from public, private and third sectors that are available to people in the Borders.

Healthy Working Lives Activity: The Healthy Working Lives Team provides a range of health & safety and health-related advisory services to all businesses in the Scottish Borders. The team continues to work in partnership with local networks and agencies such as Business Gateway, Scottish Borders Chamber of Commerce, Scottish Borders Council Economic Development and Federation of Small Businesses, to reach businesses in the Borders. In 2011/12 there was an increase of 36% in awards achieved, 34% in work place visits and 14% in training courses delivered compared to the previous year.

Healthy Working Lives offers a range of training for businesses to help them support their staff in the workplace on a wide range of topics including:

- Mentally Healthy Workplace
- Drugs and Alcohol Awareness
- Stress Management Workshops
- Health & Safety
- Healthy eating

During the report period, 16 courses were delivered with 217 people attending.

The Healthy Working Lives award programme consists of four levels of award – bronze, silver, gold and mental health commendation award in recognition of businesses that look after the health, safety and wellbeing of their staff. 15 Awards were gained in the reporting period of which six were Bronze, six Silver, one Gold and two Mental Health Commendation Awards

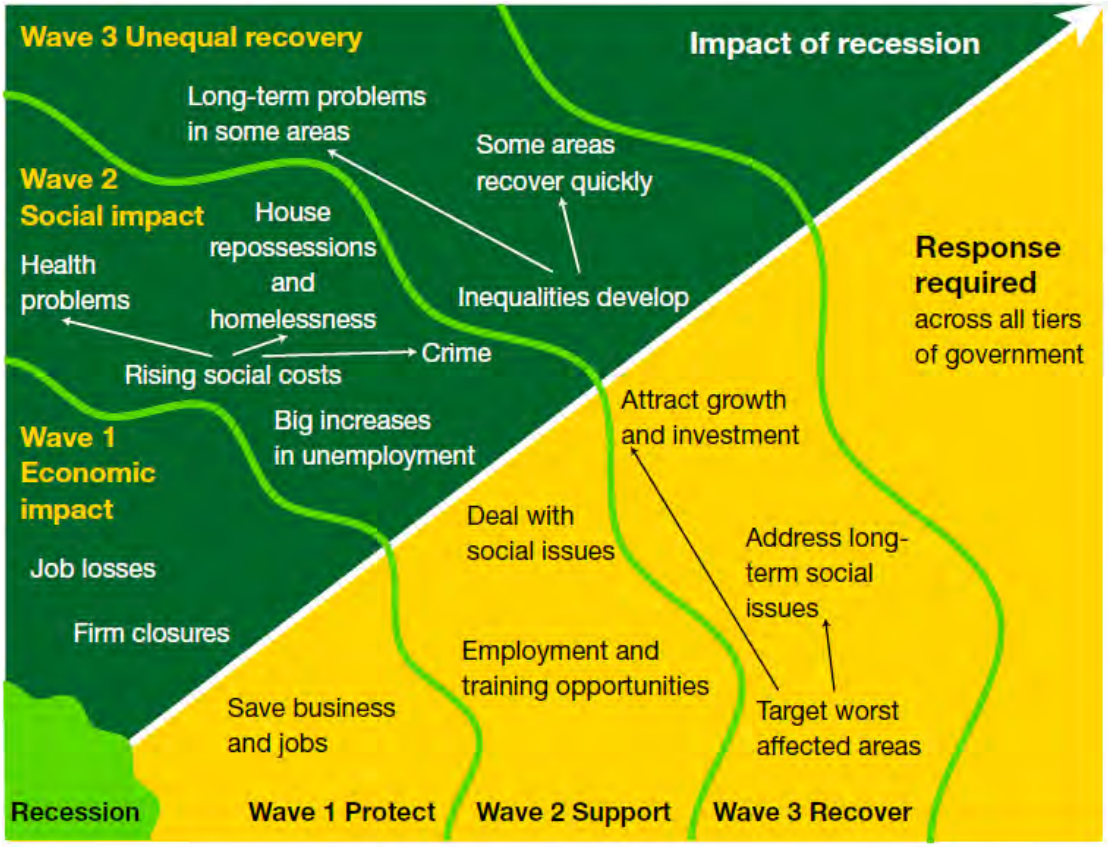
Workplace Visits are carried out for a number of reasons including Health and Safety advice and support in developing health related policies. In total 113 visits were carried out in 2011/12 with 96% of these to SMEs.

Work Place Lifestyle Assessment / Keep Well: linked into the 'Keep Well' project offering health checks in the work environment for individuals who meet the criteria. A total of 332 lifestyle assessments have been undertaken over the year with 44 meeting the 'Keep Well' criteria. This is a particularly popular service which allows one-to-one discussion of lifestyle issues between an employee and a trained nurse. Advice and support is provided to help individuals make sustained changes to improve health. Onward referral is made if appropriate to GPs or other specialist services. A total of twenty six companies supported the provision of this service to their employees.

Future Interventions

The Audit Commission report of 2009 makes very clear the prime role of partnerships working together effectively in tackling recession. The issues are elegantly summarised in Figure 24 below.

Figure 24: 'When it comes to the Crunch… Responding to the economic downturn: the role and potential of partnerships' *(Source: Audit Commission, 2009)*



Looking to the future there is a continuing challenge of increasing partnership working with employers, employees, statutory agencies and the third sector to maximise the health of the working age population, support employment, reduce dependence on benefits and reduce inequalities. Public health measures must be seen as significant contributors to the local economy. Developing infrastructure such as transport is critical to improving health. The Council and its partners need to continue to mitigate the impact of the welfare benefits reform of well-being in the Borders.

Chapter 9

The Future Delivery of Public Services

Key Points

- Partnership between organisations is crucial for public services to support the delivery of good health outcomes
- Partners must appreciate and value their differences of culture, governance and accountability
- Transformational change is essential for a step change improvement in health outcomes
- The Health and Social Care Partnership must be made a valuable tool to protect and promote health

In recent years there have been a number of significant shifts in policy at central government level on the delivery of public services. One of the main priorities is a reduction in health inequalities.

The Public Health agenda as opposed to the healthcare system agenda can now be summarised as inequalities driven by poverty and poor education. In the future public services must deliver improved outcomes for a number of priorities, including:

- Dementia
- 24/7 services
- Spatial planning particularly in relation to the obesogenic environment.
- Economic Development – good jobs
- Education – very early intervention

This may be an overly simple analysis but it illustrates that although there is challenge to the NHS as a health care system there is an even greater one for Local Authorities. Yet there is a big overlap in agendas. This has been

recognised by reports such as that of the Christie Commission[37] which have promoted collaboration rather than structural reform and have emphasised localism.

Implementation of these ideas is compromised by a cultural and functional divide locally and nationally. The Scottish Government Health Department has a tight performance management focus driven by outcomes to deliver quality in NHS Scotland as well as financial control. On the other hand Scottish Local Authorities, through the Convention of Scottish Local Authorities (COSLA), have very much a partnership relationship with Scottish Government Local Government and the Communities Directorate. That department has a light touch oversight to ensure that each local authority has robust performance management arrangements in place. This approach is an appropriate part of the democratic process - the accountability of elected members to their local community. Both NHS and Local Authority are subject to regular external scrutiny of by various bodies - Audit Scotland, Health Improvement Scotland, and Education Scotland, for example.

Locally serious efforts are being made to bring about a Health and Social Care Partnership. This can only be for the good of the immediate target groups such as older people. However, this work is being compromised by the Welfare Benefit reforms which are doing more harm than good and driving more people including children into poverty.

For successful partnership working, the NHS and the Local Authority, must understand and value each other's cultures and ways of working. Scottish Government has sought to enable development of this partnership working by putting in place a "Change Fund" for older people and children. These are intended to act like a bridging loan while one type of service transforms into something new that is targeted at delivering greater and more cost effective impact in what are now recognised as priority areas. My concern is whether there has been the disinvestment and dismantling of old models of service to allow new and transforming services to flourish.

In partnership working we need to move beyond the "storming" behaviours to the "norming". This means moving beyond emotional perceptions to accepting the evidence from research on partnership working as well as action learning from the working of joint posts (such as mine)and joint teams. Effective partnership working will contribute to a noticeable reduction in health inequalities and increased healthy life expectancy. We must bear in mind that these are long-term gains with few quick wins. Despite this I think these current reforms have exciting potential and we are beginning to exploit them. I firmly believe that together we will improve health and wellbeing through partnership working.

[37] http://www.scotland.gov.uk/Publications/2011/06/27154527/0

Chapter 10

Conclusions – Health in the Future

Key Points

- The early interventions that are in place across the life course have a worthwhile positive benefit
- There is the potential for more to be done
- Early intervention to shape the local economy and place have a huge potential for health again
- Collaboration with communities as equal partners will bring about genuine "co-production" of significantly better health and well-being

I think this report on what health in Borders could be like in 5 – 10 years time is best drawn together in the stories of three different Borderers; Jodie, Bruce and Betty.

Jodie, now 17, was born into really difficult circumstances – a large family where her mother was regularly abused by an alcoholic father. Thanks to the work of the Violence Against Women Partnership her mother was able to move into a refuge, but this disrupted Jodie's schooling. With her mother's attention distracted by so many competing priorities Jodie received little care. She was frequently absent from school despite the efforts of her teacher and her key worker in improving her attendance. Jodie had her first child at 14 with no support from the father. However, she did receive a lot of input from the Surestart Midwife before and after the birth.

As a result she managed to give up smoking before the baby was born, succeeded in breast feeding for the first four weeks of her baby's life. She is making sure her baby is getting the appropriate immunisations and through the help of Community Learning and Development is starting an access course.

Bruce is a middle aged man who lost his job several years ago when the weaving company he worked for had to close down. All his best efforts to find another job have been unsuccessful, leaving him increasingly depressed, gaining weight and drinking more

heavily. However, his GP arranged for him to have a Keep Well check. With that plus an "alcohol brief intervention" he has been motivated to lose weight, drink responsibly and has been helped to find work as a volunteer by the local Community Development worker. The worker also arranged for him to get advice as to how best to manage the cuts to benefits he will have to take as a result of the Welfare Benefit Reforms – as his children have left home he is liable for the "Bedroom Tax". There are no smaller houses available.

Betty is an 81 year lady who lives alone in a three bed roomed house. The bathroom and toilet are upstairs and she is in the early stages of dementia. Her GP has been proactive in her surveillance of older patients and identified her as someone who would benefit from being involved in the falls prevention project. She has also used a risk scoring tool to identify what can be done to prevent Betty being admitted to hospital, particularly if the care being provided by her neighbours breaks down. This has involved Social Work and Occupational Therapy. So far Betty has not had to go into hospital and her neighbours coming in and out have helped break her social isolation; they and carers have encouraged her to eat better; her diet had been poor and she had been loosing weight.

What do these stories tell us? What does this report mean?

It means early intervention at each stage of the life course produces worthwhile benefit, particularly amongst the disadvantaged, improving healthy life expectancy. Early intervention in shaping the local economy and environment will be a significant determinant in protecting and improving health. The way in which public services are delivered in the future is crucial to further success. Organisations need to work better together.

I think the evidence tells us we must drive forward with the work of "Early Interventions" but we need to keep asking if there are other things we can do which will help make an even bigger improvement in the health and wellbeing of communities in the Borders. The truism holds that if we only do what we have always done we will only get what we have always got. We need radical public health![38]

[38] http://www.afternow.org.uk/

More could be done!

Do you agree?

I really want to know what you think!

Please let me know

Dr Eric Baijal
Joint Director of Public Health
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The survey is at http://www.nhsborders.org.uk/news/fact-or-fantasy-is-the-challenge-for-health-in-borders

You can email me at publichealthconsultation@borders.scot.nhs.uk or write to me at the address above.

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Artwork by Andrew Lowe, Director of Social Work, Scottish Borders Council

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