


Clackmannanshire and Stirling

Strategic Plan

Strategic Needs Assessment

2016 - 2019

Health and Social Care Partnership

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1.

Executive Summary

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

The following key issues have emerged from the needs assessment:

- **Both Clackmannanshire and Stirling have an ageing population.** The number, and proportion, of older adults across Clackmannanshire & Stirling is projected to double. Older people are generally more intensive users of health and social care services. Therefore this could impact significantly on demand for these services in years to come. Both Clackmannanshire & Stirling are projected to see an increase in the ratio of non working aged people to people of working age. Clackmannanshire is also projected to experience a decrease in the number of people of working age living in the area. This means that at the same time as demand for services could be increasing, it could be more challenging to employ the workforce to meet this demand.
- **It is projected that Clackmannanshire and Stirling will have growing numbers of individuals living with long term conditions, multiple conditions and complex needs.** There is a need to rebuild services in such a way to better meet the requirements of people with complex needs. Patients with several complex long term conditions are currently making multiple trips to hospital clinics to see a range of uncoordinated specialist services. A proposed way forward could be to look at developing new pathways and guidelines away from the current disease specific models to generic approaches focused on the holistic needs of patients (Lunt, 2013, p. 17).
- **Reducing unplanned, emergency, hospital care will benefit the service as well as the individual.** The average monthly attendance at Accident & Emergency has increased by 8.8% over the years 2007-2015 and the rate of emergency hospital admissions in Clackmannanshire and Stirling has remained broadly similar over the past decade. However, the elderly population in Clackmannanshire and Stirling account for a growing percentage of emergency admissions. Given the projected increase in the elderly population Emergency Departments could struggle to meet this demand. Early intervention and community based services could help ease the pressure.
- **Supporting unpaid carers is a priority.** One of the aims of health and social care integration is to keep people living independently in the community for longer. The projected increase in the elderly population is likely to mean there will be an increasing need for unpaid carers. In turn, these unpaid carers will need to be supported.

- **Reducing risky behaviours such as smoking, alcohol consumption, drug use and poor diet could have a positive effect on an individual's health**. Latest estimates suggest 28.9% of people in Clackmannanshire smoke. The corresponding figure for Stirling is 20% and for Scotland is 23.1%. The alcohol related mortality rate in Clackmannanshire in 2013 was 38.85 per 100,000 population, which was significantly worse than the average rate of 21.43 for Scotland. The estimated prevalence of those with a problem drug use has increased in Clackmannanshire and Stirling when comparing the data from 2009/10 and 2012/13. There is likely to be variation across both Clackmannanshire and Stirling and further work on locality profiles may help to identify these areas. Continuing efforts around health promotion and early intervention could assist people to improve their own health and wellbeing, and live in good health for longer.

1 Introduction

1.1 Background

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

A list of 9 high-level statements of what health and social care partners are attempting to achieve through integration have been produced. These are known as the National Health and Wellbeing Outcomes.

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

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

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

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

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

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

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

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

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

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

Linking the Information presented to the Intended Outcomes

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

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services					●[23]	

Comments on connections and gaps:

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

health and social outcomes for those experiencing deprivation. However the 'inverse care law' applies – those with less need are better able to access services (see items 2 and 13)

20 Carers have health and social care needs, which when met also have a positive impact on the person being cared for.

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

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

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

1.2 What is a Strategic Needs Assessment

Each health and social care partnership is required by the legislation to produce a detailed Strategic Plan. Clackmannanshire & Stirling's Strategic Plan will explain how the partnership will make changes and improvements to develop health and social services for adults over the coming three years.

In order for the partnership to produce a detailed Strategic Plan that best meets the needs of its local population we first require a clear understanding of the health and care needs of the population, from the perspective of stakeholders.

Need is the discrepancy between "what is" and "what should be". This document aims to bring together the available data in order to describe the current pattern and level of supply of these services and where possible identify the extent of the gap between need and supply. This will be an ongoing process and over the next year work will continue on the needs assessment to build upon it.

Locality Needs

Understanding the differing levels of need and service provision across the partnership will be key to its future success. Therefore the ability to assess need at locality level is extremely important. This document will focus on information and analysis at partnership/local authority level and will sit alongside a locality profile document. There is likely to be variation across both Clackmannanshire and Stirling and the work on locality profiles may help to identify these areas. The three localities for Strategic Planning purposes are:

- Clackmannanshire;
- Stirling City with the Eastern Villages, Bridge of Allan and Dunblane;
- Rural Stirlingshire.

1.3 Identified Gaps

The partnership recognises that there are a number of gaps in the Strategic Needs Assessment and these will be considered over the coming year. These include information on: Adult Support and Protection; Children's Services; Diet and Nutrition; Young Carers; Capacity Planning; Neurological Conditions; Suicide and Blood borne viruses. This is an ongoing process and work will also continue to build upon those areas included in the needs assessment, including mental health and alcohol and drug use.

2 Population

2.1 Current Population

A key aspect for determining the need of many health and social care services is the size and age distribution of the local population. Table 2.1a, below, illustrates the population profile across Clackmannanshire and Stirling. Clackmannanshire and Stirling as a whole has an estimated population of 142,770 with Stirling accounting for 64% (91,580) and Clackmannanshire accounting for 36% (51,190).

Table 2.1a Clackmannanshire & Stirling Population Profile

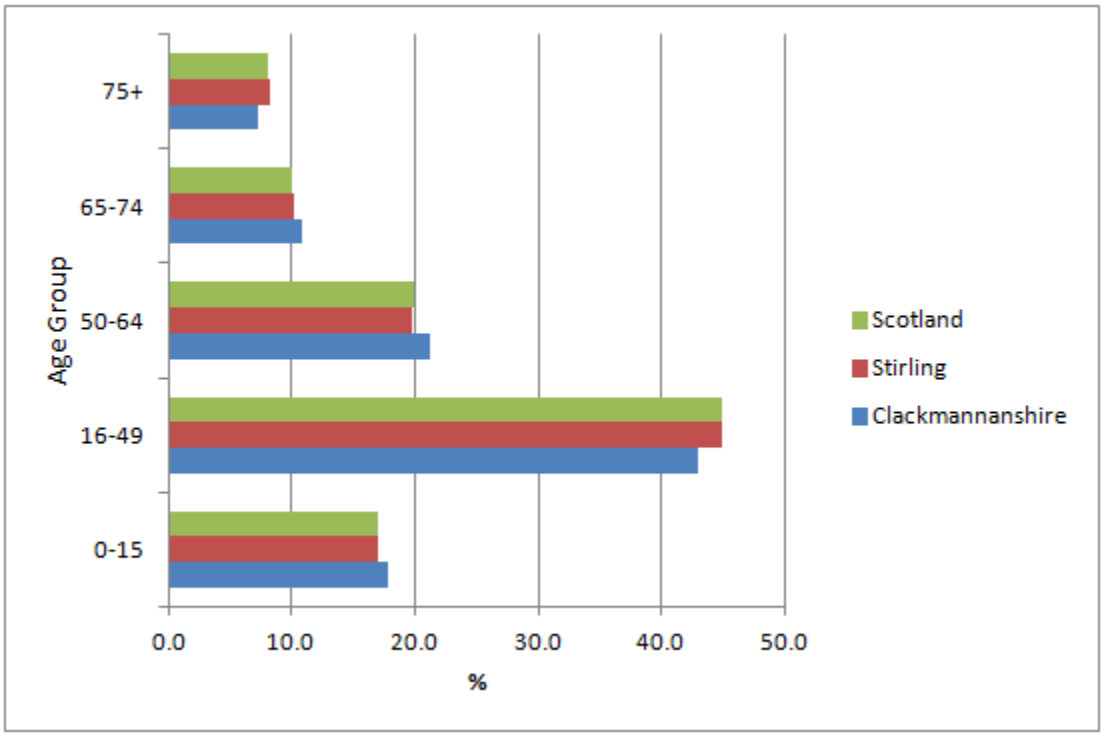
	Clackmannanshire			Stirling			Clackmannanshire and Stirling		
	Total	Males	Females	Total	Males	Females	Total	Males	Females
0-15	9,082	4,670	4,412	15,536	7,956	7,580	24,618	12,626	11,992
16-49	21,938	10,972	10,966	41,083	19,685	21,398	63,021	30,657	32,364
50-64	10,841	5,297	5,544	18,085	8,840	9,245	28,926	14,137	14,789
65-74	5,569	2,629	2,940	9,373	4,447	4,926	14,942	7,076	7,866
75+	3,760	1,551	2,209	7,503	3,049	4,454	11,263	4,600	6,663
Total	51,190	25,119	26,071	91,580	43,977	47,603	142,770	69,096	73,674

Source: National Records of Scotland (NRS) mid-year population estimates 2014

Figure 2.1a, below, illustrates the age distribution in Clackmannanshire and Stirling compared to Scotland. The age profile in both areas is very similar to that of Scotland as a whole. Roughly

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

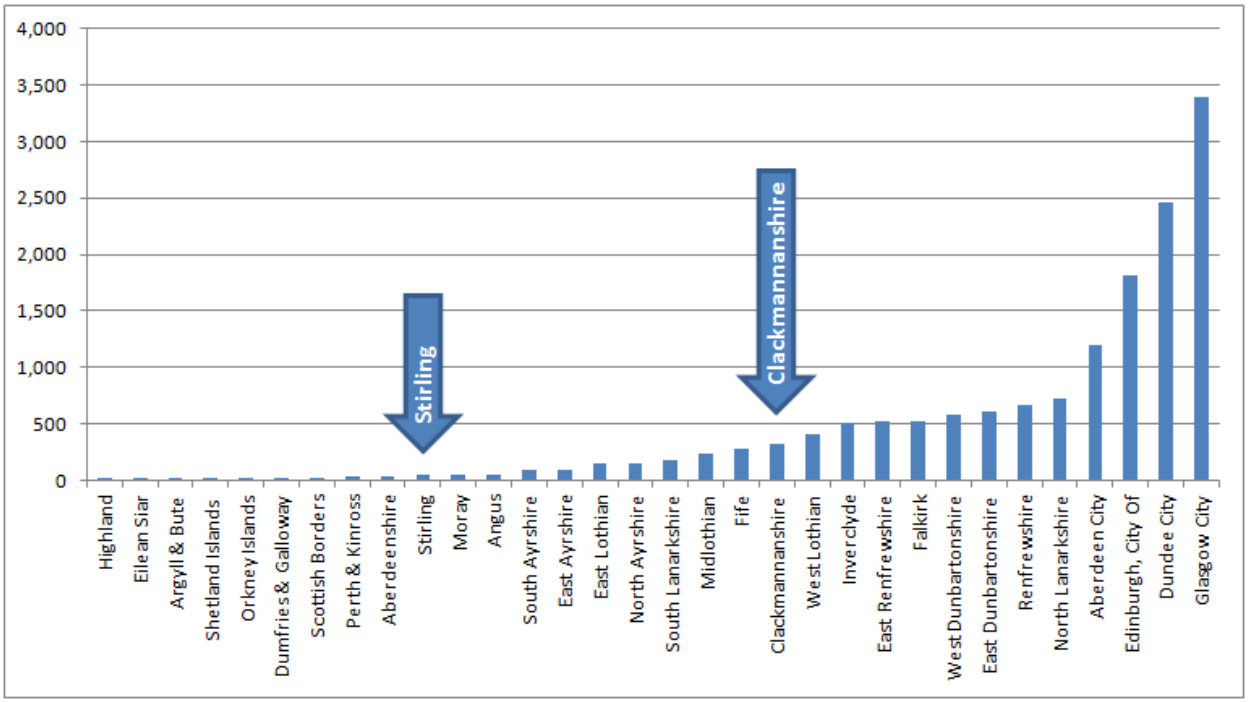
Figure 2.1a Clackmannanshire & Stirling age distribution compared to Scotland



Source: National Records of Scotland (NRS) mid-year population estimates 2014

In terms of population density, Stirling is one of the most sparsely populated regions of Scotland with 41 people per square kilometre (Figure 2.1b). This compares with Clackmannanshire where there are 324 people per square kilometre.

Figure 2.1b Population Density (persons per square kilometre) 2011

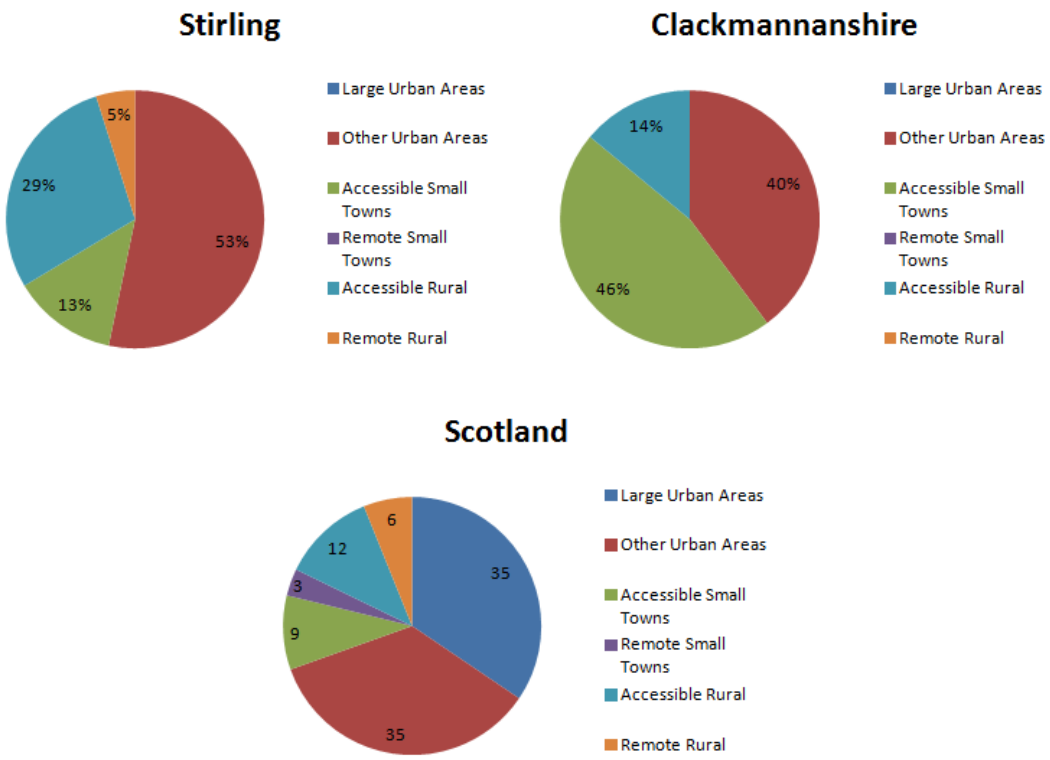


Source: Census 2011

There are no 'Large Urban areas' in Stirling or Clackmannanshire. Fifty three per cent of Stirling residents live in 'other urban areas' and a significant proportion (34%) live in rural communities compared to the Scotland figure of 18% (Figure 2.1c). Forty six percent of Clackmannanshire residents live in 'accessible small towns' and 40% live in 'other urban areas'.

Stirling has a higher percentage of residents living in rural areas compared to Scotland as a whole. This combined with Stirling's low population density may impact on the ability to plan and deliver services compared to more densely populated areas such as Glasgow or Edinburgh.

Figure 2.1c Urban/Rural Classifications



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

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

2.1.1 Ethnic Origin

Table 2.1.1a shows that in the 2011 Census Clackmannanshire had a less diverse population than Scotland on the whole, with a greater 'White – Scottish' population and a smaller proportion of Black and Minority Ethnic (BME) groups (1.5%) compared to 4.0% at national level. Stirling has a lower 'White – Scottish' population than Clackmannanshire or Scotland though this seems to be offset by a larger 'White – Other British' population. Stirling is also home to a greater Black and Minority Ethnic (BME) population than neighbouring Clackmannanshire though it is still less than the Scotland average.

Table 2.1.1a – Ethnicity in Clackmannanshire, Stirling and Scotland 2011

Ethnicity	Stirling (%)	Clackmannanshire (%)	Scotland (%)
White – Scottish	82.0	88.2	84.0
White - Other British	10.8	7.4	7.9
White – Irish	0.9	0.6	1.0
White – Polish	0.6	1.0	1.2
White – Other	2.5	1.2	2.0
Asian, Asian Scottish or Asian British	2.3	1.0	2.7
Other ethnic groups	0.9	0.5	1.3

Source: 2011 Census

2.1.2 Religion

The 2011 Census reports that the Clackmannanshire population is largely non-religious (43.5%), this compares to 36.7% at Scotland level. The Church of Scotland is the largest religion within the Clackmannanshire population and there are no other religions representing more than 10%. The Stirling population was found to be more closely aligned with the Scottish population for most religions. There was however a smaller Muslim population of just 0.6% in Stirling compared to 1.4% in Scotland which is also reflected in Clackmannanshire.

Table 2.1.2a – Religion in Clackmannanshire, Stirling and Scotland 2011

Religion	Stirling (%)	Clackmannanshire (%)	Scotland (%)
Church of Scotland	35.0	34.5	32.4
Roman Catholic	12.3	9.4	15.9
Other Christian	6.1	5.0	5.5
Muslim	0.6	0.6	1.4
Other religions	1.0	0.5	1.1
No religion	37.8	43.5	36.7
Not stated	7.1	6.5	7.0

Source: 2011 Census

2.1.3 Sexual Orientation

It is not currently possible to accurately report sexual orientation either at national or local level and it is likely that the numbers of Lesbian, Gay, Bisexual and Transgender (LGBT) are under-represented. The health needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) population are not well understood since they are not routinely identified in health surveys or population-based surveys. The Scottish Household Survey 2013 does include a question on Sexual Orientation but the results of this have not been included as the survey only covers a small sample of the population and are not representative.

2.2 Projections of future population

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

Table 2.2a Population projections to 2037

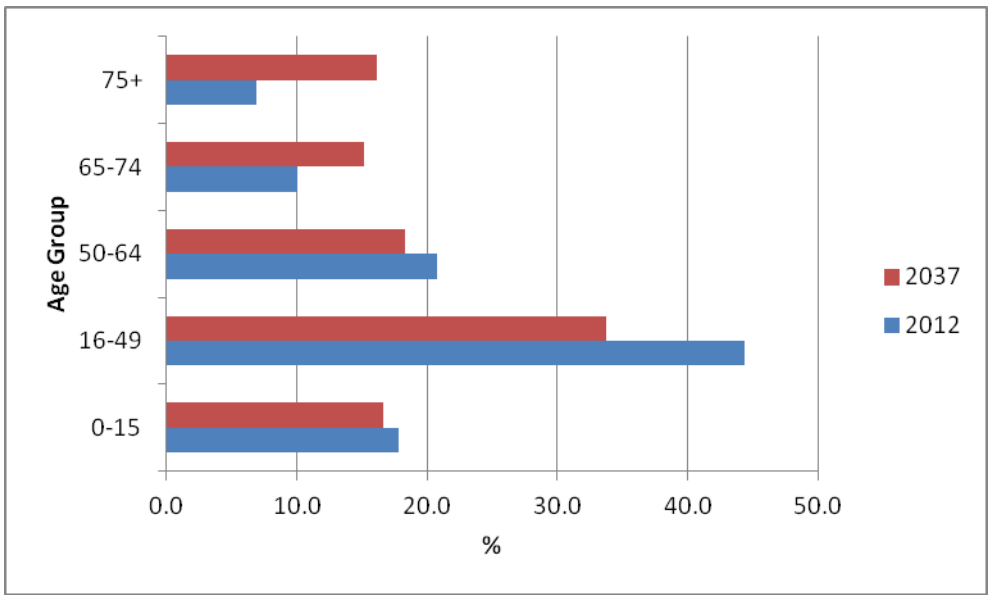
		2012		2032		2037	
Age Group		Number	%	Number	%	Number	%
Clackmannanshire	0-15	9,166	17.9	8,702	17.1	8,320	16.6
	16-49	22,747	44.4	17,449	34.3	16,886	33.7
	50-64	10,636	20.7	10,259	20.2	9,174	18.3
	65-74	5,163	10.1	7,336	14.4	7,590	15.2
	75+	3,568	7.0	7,149	14.0	8,073	16.1
	Total	51,280	100.0	50,895	100	50,043	100
Stirling	0-15	15,923	17.5	17,559	17.0	17,952	17.0
	16-49	41,309	45.4	44,395	43.0	46,184	43.6
	50-64	17,517	19.2	16,432	15.9	15,141	14.3
	65-74	9,022	9.9	12,223	11.8	12,426	11.7
	75+	7,249	8.0	12,565	12.2	14,157	13.4
	Total	91,020	100	103,174	100	105,860	100

Source: National Records of Scotland (NRS) population projections

It is projected that Clackmannanshire and Stirling will experience different changes in both population size and age distribution. The Clackmannanshire population size is projected to remain at a similar level to the 2012 size, but will experience a small decrease (1,200) by 2037. Despite the size of the population remaining similar the age distribution is expected to experience significant changes (Figure 2.2a). The percentage of individuals aged 16-49 is

expected to drop from 44% to 34%. Whereas the percentage of individuals aged 65-75 and 75+ is expected to increase from 10% and 7% respectively to 15% and 16%. This means that although the general population levels are projected to remain stable there will be a large increase in those in the elderly categories with numbers in the 75+ age group expected to double.

Figure 2.2a – Projected Population Age distribution in Clackmannanshire

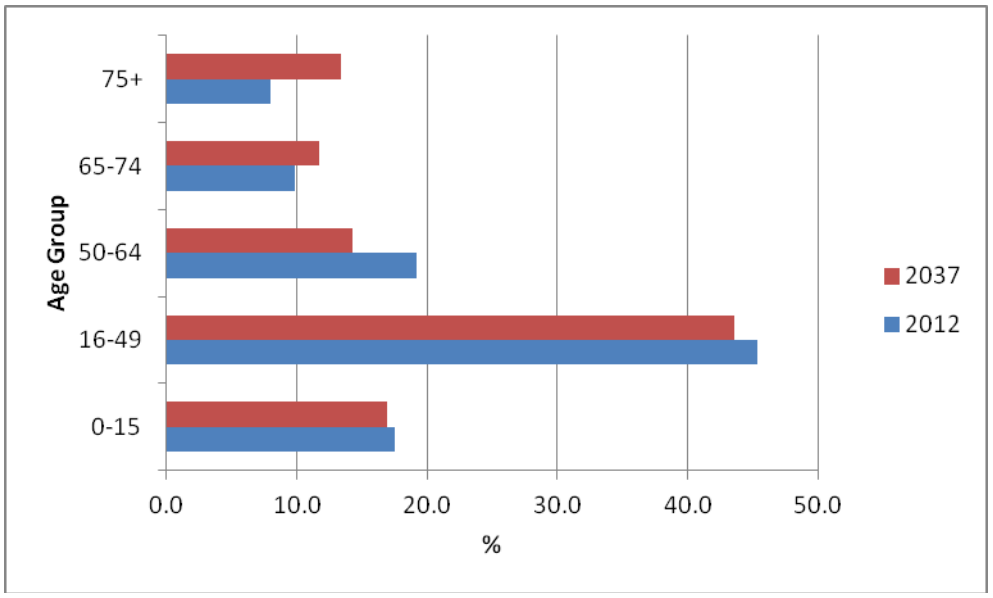


Source: National Records of Scotland (NRS) Population Projections

The size of the Stirling population is expected to grow by approximately 16% from 91,000 to approximately 106,000 by 2037. As well as a change in population size there is a projected change in the age distribution of Stirling (Figure 2.2b). The percentage of children and 16-49 year olds that make up the population is expected to remain similar. It is expected that the percentage of 50-64 year olds will experience a decrease from 19% to 14%. The two older adult age groups, 65-75 and 75+, are expected to experience an increase from 10% to 12% and 8% to 13% respectively. Older people make a valuable contribution to our society, both economically and socially, through, amongst other contributions, taxes, spending power, provision of social care and the value of their volunteering (WRVS, 2011[1]).

[1] WRVS (2011). Gold Age Pensioners, Valuing the Socio-Economic Contribution of Older People in the UK.

Figure 2.2b – Projected Population Age Distribution in Stirling



Source: National Records of Scotland (NRS) Population Projections

2.3 Dependency Ratio

The dependency ratio is a measure of the proportion of the population seen as economically 'dependant' upon the working age population. The definition generally used in Scotland is: 'those aged under 16 or of state pensionable age, per 100 working age population'. Table 2.3a illustrates the projected change in dependency ratio for Stirling, Clackmannanshire and Scotland to 2037. Stirling, Clackmannanshire and Scotland have similar ratios for 2012 with Stirling and Scotland following a similar upwards projection rising from 55% and 53%, respectively, to 63%.

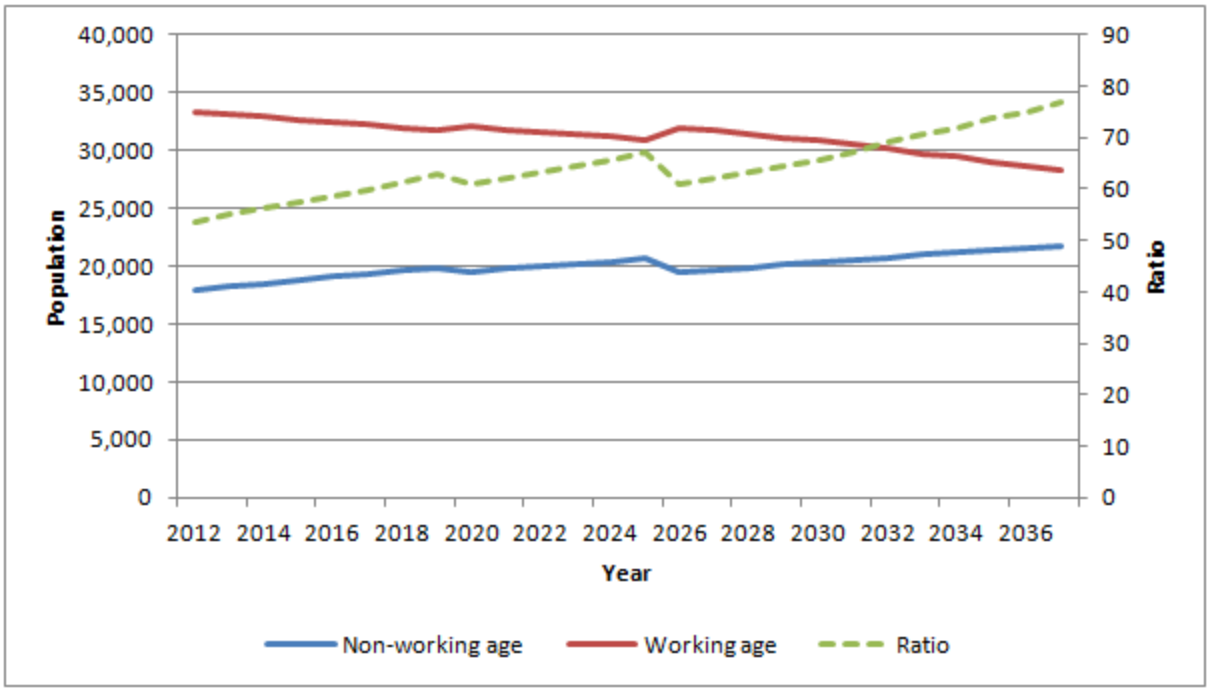
Table 2.3a – Projected Dependency Ratios to 2037

Year	2012	2015	2020	2025	2030	2035	2037
Stirling	54.7	55.0	54.3	57.7	57.0	61.8	62.8
Clackmannanshire	53.6	57.6	61.0	67.0	65.8	73.6	77.0
Scotland	53.0	54.8	55.8	59.8	57.8	61.7	62.9

Source: National Records of Scotland (NRS) population projections

While Stirling is projected to follow a similar upwardly pattern to Scotland as a whole, Clackmannanshire is projected to experience a more accelerated upwardly trend. Figure 2.3a examines this trend more closely. The green dotted line represents the increasing dependency ratio. There are some dips in the projected trend but these can largely be explained by changes to the state pension age. Figure 2.3a helps to explain why Clackmannanshire has an accelerated projected increase in its dependency ratio as the solid red line illustrates a decreasing population of working age individuals and the solid blue line illustrates a steadily increasing population of people of non-working age. This increase of non-working age people can be largely attributable to the fact that the number of people over 75 is projected to more than double in Clackmannanshire by 2037 (Table 2.2a).

Figure 2.3a – Clackmannanshire Projected Dependency Ratios



Source: National Records of Scotland (NRS) population projections

The projected increases in dependency ratios could potentially have a significant impact on both areas. Both areas are projected to have more individuals of a non-working age as a proportion of those of a working age and this will impact upon the services required locally as with the potential increase in service demand. This effect is potentially exaggerated in Clackmannanshire as not only is there a projected increase in non-working age people but there is a projected decrease in working age people. This means that the demand for services could

be increasing and at the same time it could be more challenging to employ the workforce to meet this demand.

2.4 Population Considerations/Implications

- Stirling has a high percentage of people living in rural areas. This will need to be considered when planning and delivering services.
- Older people are generally high users of services. The number, and proportion, of older adults across Clackmannanshire & Stirling is projected to double and this could impact significantly on demand for services.
- Both Clackmannanshire & Stirling are projected to see an increase in the ratio of non working aged people to people of working age. Clackmannanshire is also projected to experience a decrease in the number of people of working age living in the area. This means that the demand for services could be increasing and at the same time it could be more challenging to employ the workforce to meet this demand.

3 Life Circumstances

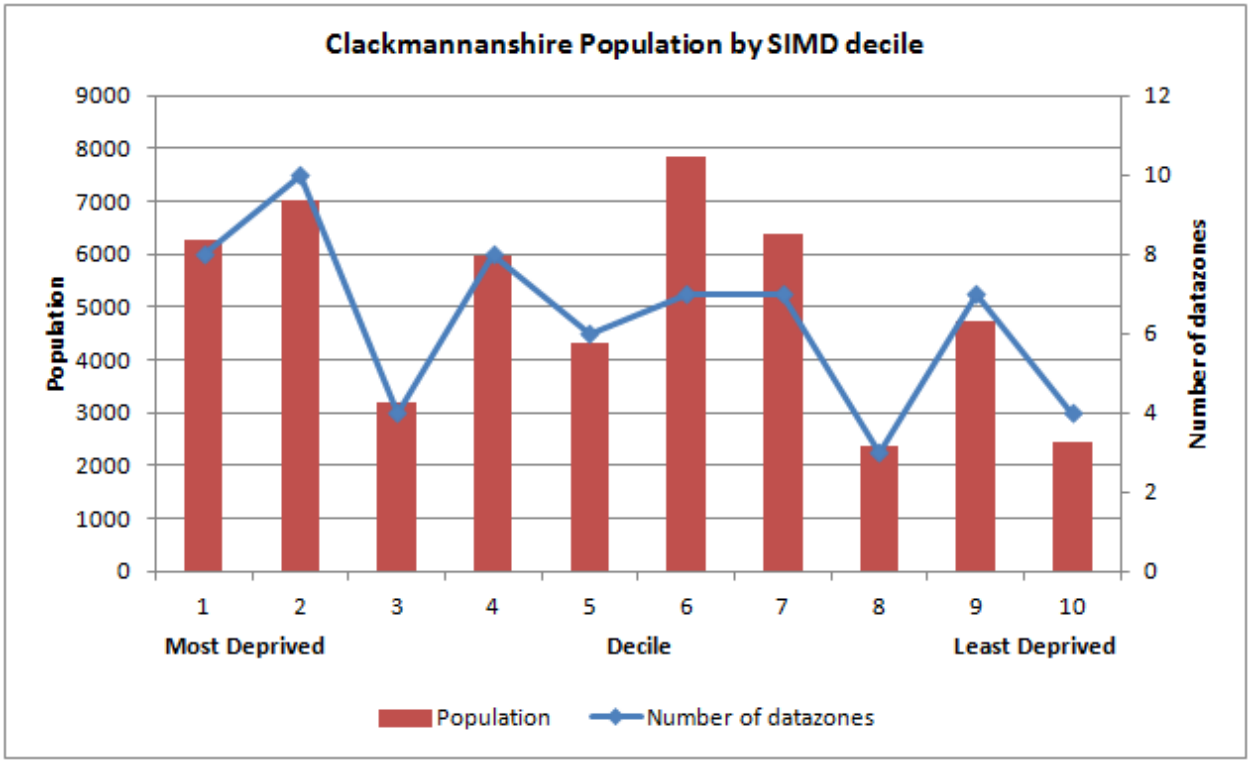
3.1 Scottish Index of Multiple Deprivation

The Scottish Index of Multiple Deprivation (SIMD) identifies small areas concentrations of multiple deprivation across all of Scotland. It ranks small areas called datazones from the most deprived (ranked 1) to the least deprived (ranked 6,505). One way ISD (Information Services Division) uses these is to divide all of the datazones in Scotland into 10 equal deprivation deciles, by calculating each individual zone's rank from the distribution of all ranks. For example if a zone in Stirling is ranked 517, it is in the bottom 7.9% of all zones so would be in the first decile which encompasses values between 0 and 10. If a zone is ranked 1985, it would be in the bottom 30.5%, and in the fourth decile for values between 30 and 40.

Within the deciles, 1 is the most deprived and 10 the least deprived (this categorisation is applicable for Scottish Index of Multiple Deprivation 2009v2, 2012 and future releases). Figures 3.1a and 3.1b below illustrate the number of people and data zones in each decile in Clackmannanshire and Stirling. The first highlights the range of deprivation in Clackmannanshire with more people living in 20% of the most deprived areas than in 20% of

the least deprived areas. On the other hand in Stirling there are more people living in the least deprived areas.

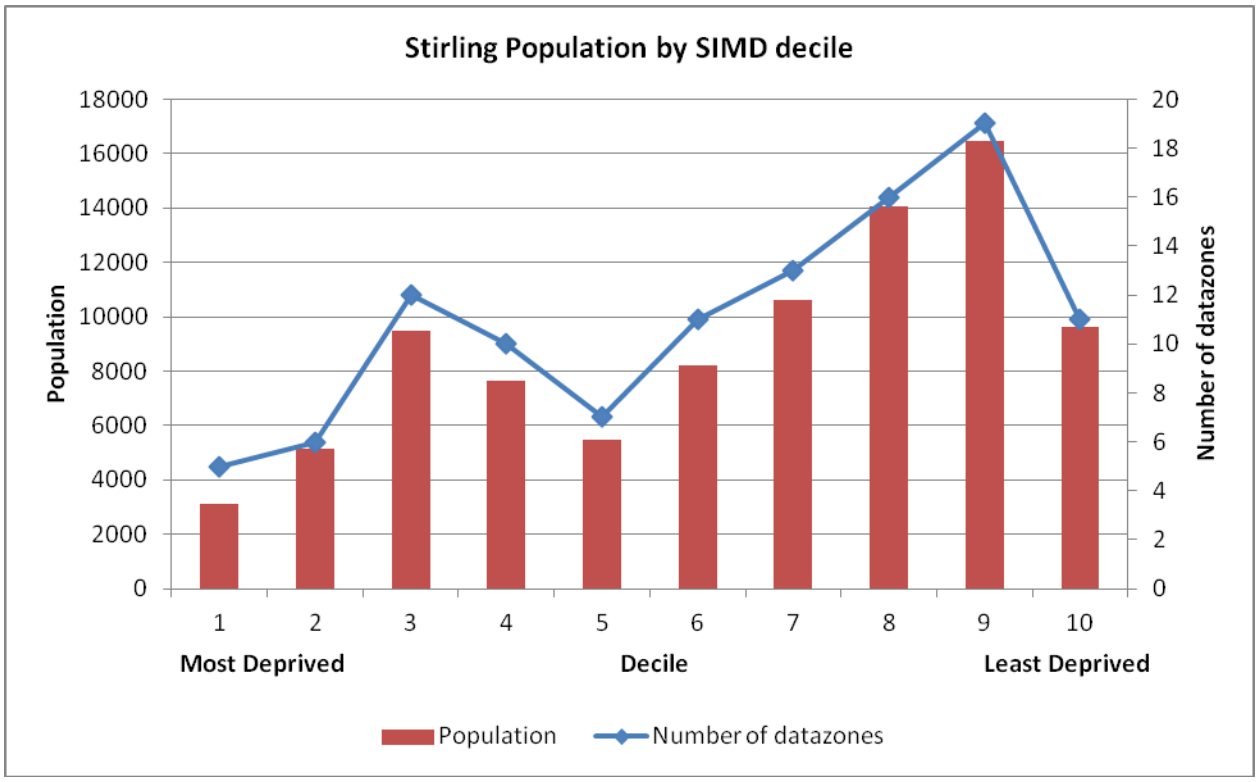
Figure 3.1a Clackmannanshire population by Scottish Index of Multiple Deprivation decile



Source: Scottish Index of Multiple Deprivation (SIMD) 2012

http://www.gov.scot/Topics/Statistics/SIMD/DataAnalysis/Background-Data-2012

Figure 3.1b Stirling population by Scottish Index of Multiple Deprivation decile



Source: Scottish Index of Multiple Deprivation 2012

http://www.gov.scot/Topics/Statistics/SIMD/DataAnalysis/Background-Data-2012

3.2 Housing

This section will provide an overview of the housing issues in Clackmannanshire and Stirling. A Housing Contribution Statement has been prepared by Clackmannanshire and Stirling Councils which can be found on the Integration web pages.

- The National Records of Scotland household projections predict that while household numbers in both local authorities will increase between 2012 and 2037 Stirling's increase will be greater (25%) than both Clackmannanshire's (5%) and Scotland's (17%).
- Households headed by someone aged 75 and over is estimated to increase from 2012 to 2037 by 121% in Clackmannanshire and 91% in Stirling, greater than in Scotland (82%).
- The number of households with one adult only is predicted to increase by 41% in Stirling between 2012 and 2037, higher than in Scotland (35%) and Clackmannanshire (24%).

The predicted increase in households with one adult and one or more children is similarly greater in Stirling (54%) than in Scotland (27%) with there being very little increase in Clackmannanshire.

- In 2013 home ownership accounted for 64% of households in Clackmannanshire and 68% in Stirling, comparable to Scotland (61%). (Scottish Household Survey 2013). Social renting was the second largest accounting for 27% in Clackmannanshire and 18% in Stirling. Private renting accounted for a smaller percent although half in Clackmannanshire (7%) than in Stirling (14%)
- In 1999 2% of households were privately rented in Clackmannanshire which had increased to 7% in 2013. In Stirling 6% of households were privately rented in 1999 which had increased to 14% in 2013. Over the same period social renting had decreased from 36% to 27% in Clackmannanshire and 29% to 18% in Stirling. (Scottish Household Survey 2013)
- There are a greater proportion of houses than flats in both Clackmannanshire (78%) and Stirling (72%) than in Scotland (63%). More households in Stirling were built before 1945 (34%) than in Clackmannanshire (22%). (Scottish House Conditions Survey, 2011-2013, Local Authority Analyses).
- Evidence from the Clackmannanshire Housing Need and Demand Assessment (2011) showed that over the next 10 years there will need to be an additional 5,724 properties provided across all tenures (tenure provides information about whether a household rents or owns the accommodation that it occupies). Of these around 4,546 (three quarters) require to be affordable and 1,178 for sale on the open market. The Clackmannanshire Housing Strategy 2012-2027 advises that in the current climate this is not considered to be realistic and achievable and the preferred option, in the short term, is to target the Land Audit figures aiming to complete around 173 new private and 31 affordable houses each year (as opposed to 118 private and 454 affordable houses each year as proposed in the HDNA).
- The Scottish Government guidance on Local Housing Strategies requires them to set housing supply targets for the council's Local Development Plans. These targets derive from the Housing Need and Demand Assessment and enable the Local Development Plans to identify their housing land requirement. Stirling's Local Housing Strategy (2012) advises that the Council has set the housing supply target for private housing at 328 units a year and for affordable homes at 88 a year in the Stirling Local Development Plan area.
- Further work will be taken forward to identify specialist housing/supported housing models for the older adult population.

3.3 Fuel Poverty

The term fuel poverty refers to a situation where a household is unable to heat its home at a reasonable cost. A person is living in fuel poverty if, to heat their home to a satisfactory standard[2], they need to spend more than 10% of their household income on fuel. Extreme fuel poverty is where they need to spend more than 20% of their household income on fuel. This affects households greatly especially during the winter months, as the colder outside temperature and lack of suitable heating inside increases the risk of developing health problems such as cardiovascular and respiratory conditions. Fuel poverty also means that the dwelling is more susceptible to issues such as damp and mould, which in turn affects the quality of life and health of the people living in that environment.

Table 3.3a below shows the percentage of households in Clackmannanshire and Stirling that can be considered fuel poor and extreme fuel poor compared to the Scottish average (the fuel poor figure includes the extreme fuel poor). Whilst Clackmannanshire is slightly below the Scottish average, the percentage of households in Stirling that are fuel poor is higher than the Scottish average, in both categories. Both Clackmannanshire (36%) and Stirling (35%) have a similar proportion of owner-occupied houses considered to be fuel poor than the Scottish average (34%) whereas the proportion of social housing considered to be fuel poor in Stirling (44%) is more than the Scottish average (40%) which is more than in Clackmannanshire (36%).

Table 3.3a Fuel Poverty in Clackmannanshire & Stirling – All Households

All households	Fuel Poverty (required fuel costs >10% of income)	Extreme Fuel Poverty (required fuel costs >20% of income)
Clackmannanshire	35%	8%
Stirling	38%	13%
Scotland	36%	10%

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

Table 3.3b shows the percentage of older adult households in Clackmannanshire and Stirling that are fuel poor and extreme fuel poor. Whilst approximately half of these households in both local authorities are fuel poor, fewer than 1 in 10 in Clackmannanshire are extreme fuel poor whilst over 1 in 5 in Stirling are extreme fuel poor. The proportion of owner-occupied and social housing in Clackmannanshire (9% and 6%, respectively) and Stirling (12% and 9% respectively) that are extreme fuel poor are around the Scottish average (11% and 7%, respectively).

[2] An adequate standard of warmth is usually defined as 21ºC for the main living area, and 18ºC for other occupied rooms.

Table 3.3b Fuel Poverty in Clackmannanshire & Stirling – Pensioner Households

Pensioner households	Fuel Poverty (required fuel costs >10% of income	Extreme Fuel Poverty (required fuel costs >20% of income)
Clackmannanshire	49%	8%
Stirling	52%	21%
Scotland	54%	15%

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

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

- In Stirling, a third of the dwellings were built before 1945, and older properties are more likely to have no insulation or be poorly insulated. This increases heating and fuel costs as well as affecting the quality of life for inhabitants. In 2011/13 an average of only 59% of the dwellings in Stirling were wall insulated (cavity and solid/other). In comparison, 22% of the properties in Clackmannanshire were built before 1945, and 71% of all dwellings had wall insulation in 2011/13.

- The Stirling area also includes a higher proportion of rural households (33.6%) compared to those in Clackmannanshire (14%). Rural properties tend to be older properties, and their location makes them more exposed to the elements than those in urban areas. Exposure to wind, rain, and snow makes the household more expensive to heat. Additionally, rural locations are less likely to be connected to the mains gas lines, with energy being provided by other methods including heating oil and gas bottles. These types of energy supply are less efficient than mains gas, thus increasing fuel costs. In Stirling in 2011/13, 18% of properties were off the gas grid, whereas in Clackmannanshire only 8% were not connected.

The energy efficiency of the dwelling also affects the fuel costs. The lower the efficiency of the dwelling, the higher the fuel costs. In Stirling 4% of properties are in the lowest groupings for energy efficiency, this is the same as the Scotland average. In Clackmannanshire, only 2% of dwellings are classed as having low energy efficiency.

3.4 Employment, Benefits and Financial Issues

The 2011 Census return details the economic activity of respondents. This is categorised into those who are economically active (in or seeking employment) and those who are economically inactive (not in or seeking employment).

Table 3.4a below shows the percentage of the population aged 16-74 by their economic activity in Clackmannanshire, Stirling, and Scotland as a whole. The percentage of people who are economically active is about 62% of the population, but in Clackmannanshire there are a slightly higher percentage of people who are unemployed. Similarly, for those inactive economically, the percentage of people who are long-term sick or disabled is highest in Clackmannanshire.

Table 3.4a Percentage of total population by economic activity

Area	Economically active	Unemployed (actively seeking work)	Economically inactive (includes retirees & students)	Long-term sick or disabled
Clackmannanshire	62.3%	5.8%	37.7%	5.5%
Stirling	62.0%	4.8%	38.0%	3.9%
Clackmannanshire & Stirling	62.1%	5.2%	37.9%	4.5%
Scotland	62.8%	5.1%	37.2%	4.8%

Source: 2011 Census

Figures from the Department for Work and Pensions show that there were 10,489 housing benefit claimants in Clackmannanshire and Stirling in August 2015, a decrease from the previous month.

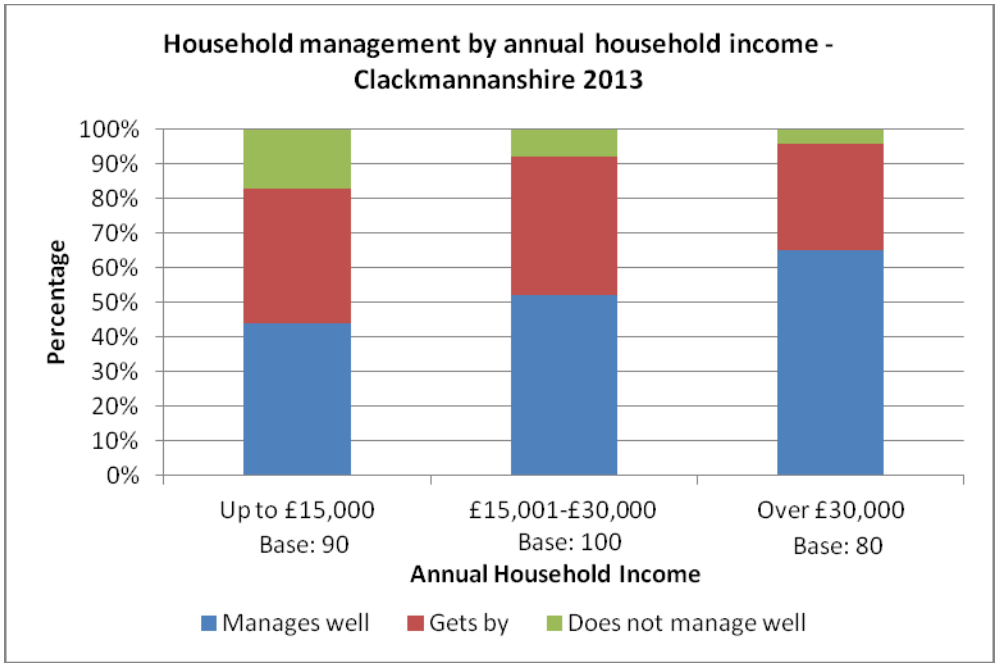
Table 3.4b Housing benefit claimants by local authority July-August 2015

Housing benefit claimants	Jun-15	Jul-15	Aug-15
Clackmannanshire	5150	5152	5092
Stirling	5464	5465	5397
Total	10614	10617	10489

Source: Department for Work and Pensions Stat-Xplore

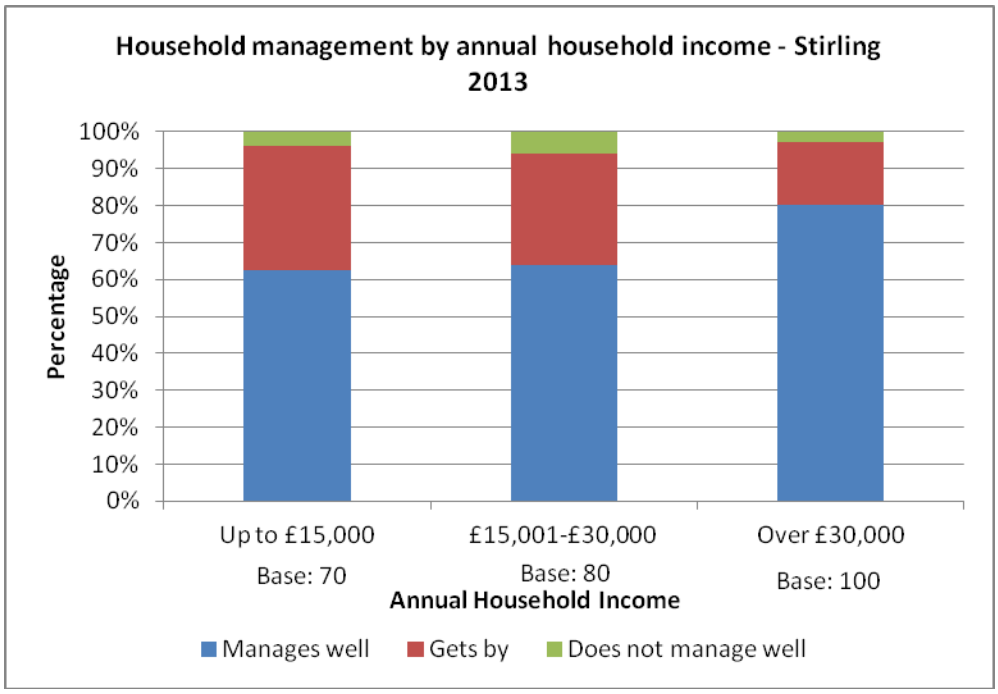
Financial issues and concerns can cause health and social problems. Job insecurity, redundancy, debt and financial problems can all cause emotional distress, affect a person's mental health and contribute to other health issues. Information from the 2013 Scottish Household Survey shows statistics for how well households manage finances. The charts below show how well households managed their finances by the amount of income and also by the main source of income. They show that more households in Clackmannanshire report that they manage finances less well than those in Stirling, especially households who have an annual income up to £15,000 and those whose main income is from benefits.

Figure 3.4a Household management by annual household income - Clackmannanshire



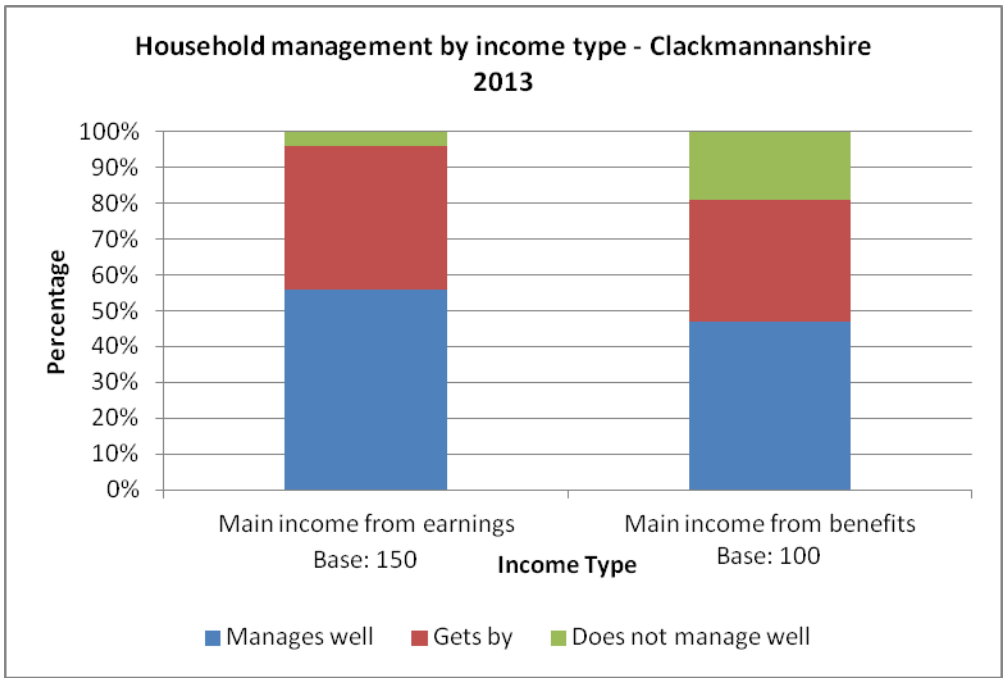
Source: Scottish Household Survey

Figure 3.4b Household management by annual household income - Stirling



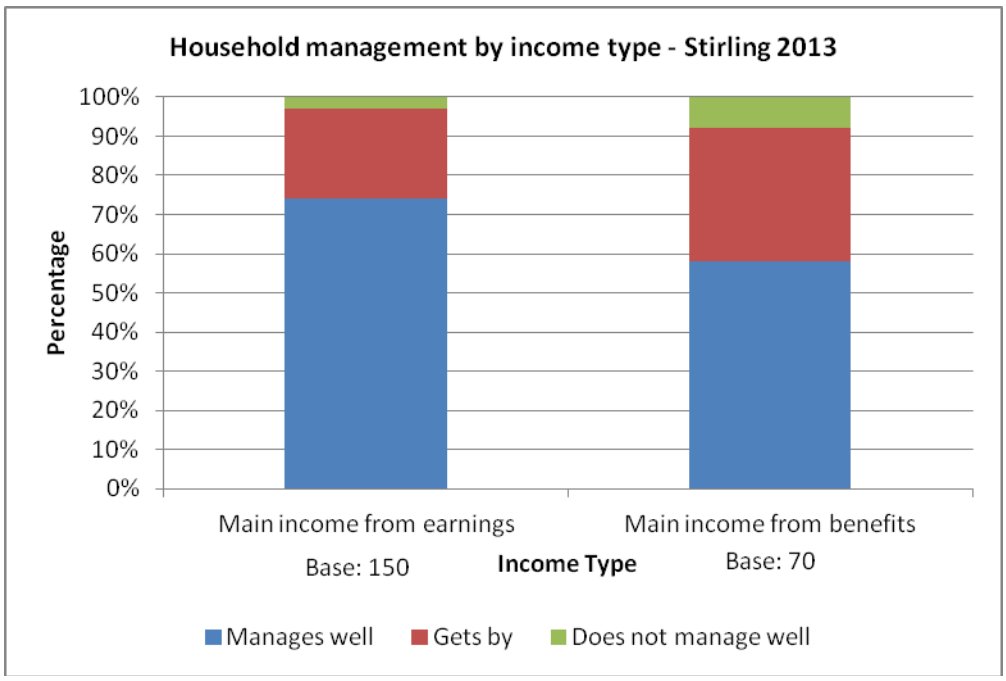
Source: Scottish Household Survey

Figure 3.4c Household management by income type - Clackmannanshire



Source: Scottish Household Survey

Figure 3.4d Household management by income type - Stirling



Source: Scottish Household Survey

3.5 Life Circumstance Considerations/Implications

- Deprivation can be a key contributing factor in the health of a population. Clackmannanshire and Stirling have very different Scottish Index of Multiple Deprivation profiles with Clackmannanshire containing a higher proportion of its residents living in more deprived areas.
- Households headed by someone aged 75 and over is estimated to increase from 2012 to 2037 by 121% in Clackmannanshire and 91% in Stirling, greater than in Scotland (82%).
- Stirling has a higher proportion of the population living in fuel poverty than in Clackmannanshire and Scotland as a whole.
- Clackmannanshire has a higher proportion of residents unemployed and actively seeking work than in Stirling and in Scotland as a whole.
- More households in Clackmannanshire report that they manage finances less well compared to households in Stirling, especially households who have an annual income up to £15,000 and those whose main income type is from benefits.

4 Risk Factors

Risk factors have an effect on a person's health and well-being. Behaviours such as smoking, alcohol consumption, drug use, and poor diet can have an adverse effect on health.

4.1 Smoking

Smoking related illnesses not only affect an individual's health but also result in higher demands on health services. It is estimated that in NHS Forth Valley in 2009 there were 2,187 hospital admissions as a result of smoking and that over £15 million was spent treating smoking related illness.[3] Continued focus on prevention is important to improve health and to reduce pressures on services.

Table 4.1a shows the percentage of the adult population (16 years of age and over) who smoke in the Local Authorities, both separately and combined, compared with the Scotland average from 1999 to 2013. Data for individual local authorities for 2011 is not available.

The percentage of the adult population who smoke decreased between 1999/2000 and 2013, but there was a slight increase between 2012 and 2013 across all local authorities and Scotland as a whole.

In 1999/2000, 33.8% of adults in Clackmannanshire smoked, by 2013 this had fallen to 28.9%. In Stirling, the percentage of adults who smoked had fallen from 26.9% to 20.1% over the same time period. This is comparable to the trend for the total Scotland figures in the years between 1999/2000 and 2013.

In 2013, the percentage of adults who smoked was higher in Clackmannanshire than in Stirling and this figure was also greater than the Scottish average (see Figure 4.1b).

Table 4.1a Percentage of adult smokers 1999-2013

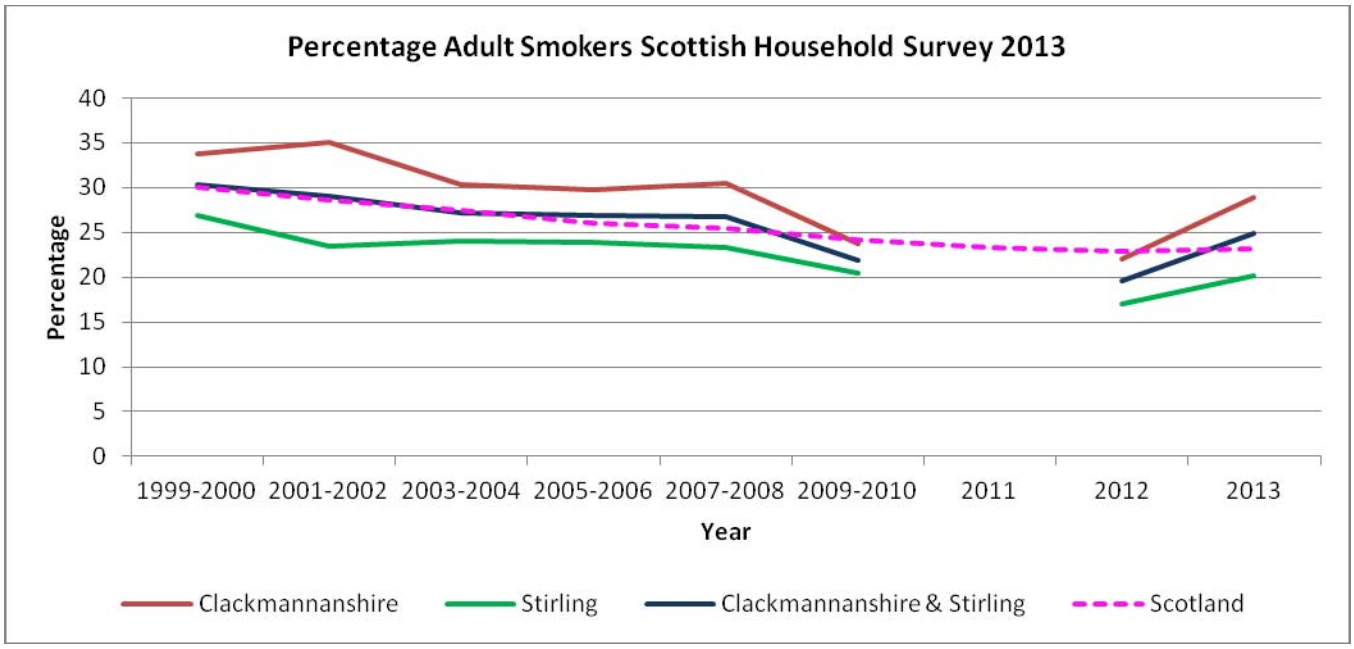
Area	1999-2000	2001-2002	2003-2004	2005-2006	2007-2008	2009-2010	2011	2012	2013
Clackmannanshire	33.8	35.0	30.3	29.8	30.4	23.7		22.0	28.9
Stirling	26.9	23.5	24.1	23.9	23.3	20.4		17.0	20.1
Clackmannanshire & Stirling	30.3	29.0	27.2	26.8	26.7	21.9		19.5	24.8
Scotland	30.0	28.6	27.5	26.0	25.4	24.2	23.3	22.9	23.1

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

[3] ScotPHO Smoking Ready Reckoner – 2011 Edition

Figure 4.1a shows the trend in the percentage of adults who smoke from 1999/2000 to 2013.

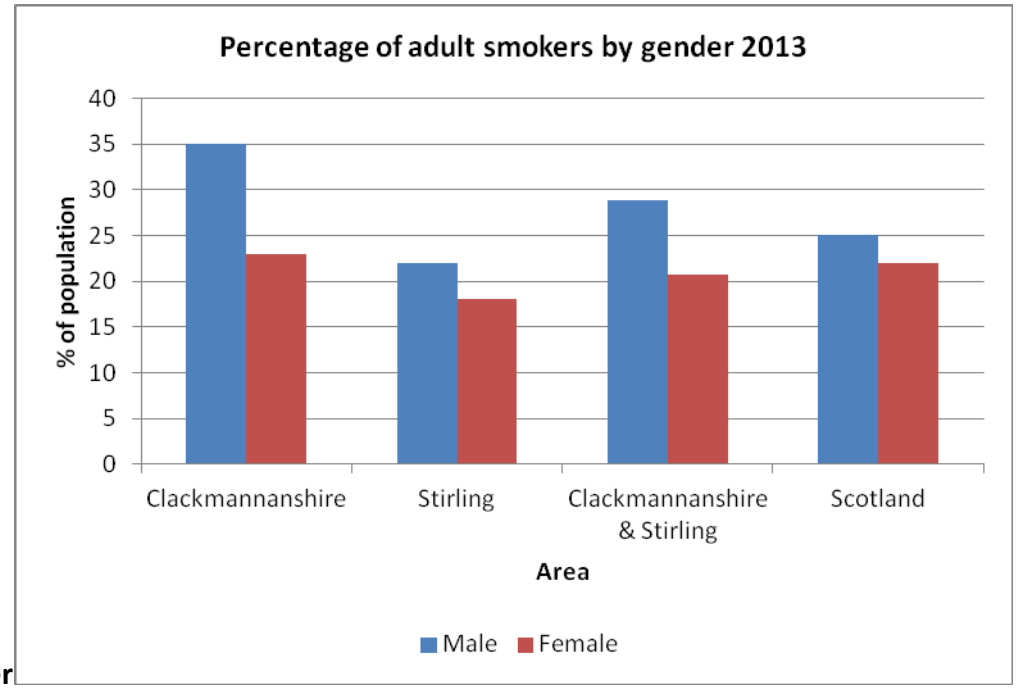
Figure 4.1a Percentage of adults who smoke, 1999/2000 to 2013



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

Figure 4.1b shows a breakdown of those who smoked in 2013 by gender. It demonstrates that in all localities fewer women smoked than men. Also, in Clackmannanshire 35% of the adult male population smoked, this is 10% higher than the Scottish average where in 2013 25% of the adult male population smoked.

Figure 4.1b Smoking by gender



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

Tables 4.1b and 4.1c show the rates of smoking related illnesses in Clackmannanshire and Stirling compared to the Scotland rate.

In Clackmannanshire in 2012 the rates for smoking related deaths, lung cancer deaths and chronic obstructive pulmonary disease (COPD) deaths were higher than the rate for Scotland. In Stirling, the rates for these measures were lower than the rates for Scotland.

Table 4.1b Age standardised rate of smoking related illnesses

Measure	Year	Clackmannanshire	Scotland
Smoking attributable admissions	2012	1,955.9	3149.4
Smoking attributable deaths	2012	329.3	325.9
Lung cancer registrations	2011	124.6	133.3
Lung cancer deaths	2012	145.2	107.1
COPD incidence	2012	364.3	391.1
COPD deaths	2012	99.7	77.9

Source: ScotPHO Tobacco Control Profile

Table 4.1c Age standardised rate of smoking related illnesses

Measure	Year	Stirling	Scotland
Smoking attributable admissions	2012	1,912.10	3149.4
Smoking attributable deaths	2012	272.5	325.9

Lung cancer registrations	2011	114.9	133.3
Lung cancer deaths	2012	97.8	107.1
COPD incidence	2012	267.8	391.1
COPD deaths	2012	57.0	77.9

Source: ScotPHO Tobacco Control Profile

4.2 Alcohol

Alcohol related health issues are a major concern for public health in Scotland. Excessive consumption of alcohol can cause both short-term and long-term health and social problems. This includes liver and brain damage, as well as mental health issues, and it is also a contributing factor in cancer, stroke and heart disease.

The rate of alcohol related hospital admissions in Clackmannanshire has increased slightly in the five years between 2009/10 and 2013/14 from 497.7 to 510.5. The number of hospital stays has remained relatively static over those five years, in 2013 there were 265 stays related to alcohol.

In Stirling the rate of hospital admissions has fallen from 610 in 2009/10 to 456.2 in 2013/14. Nevertheless, the number of alcohol related hospital stays in Stirling has fallen since 2009/10 although the number of hospital stays is higher than in Clackmannanshire. In 2013 there were 397 alcohol related hospital stays in Stirling. For information on Substance Misuse Support Services please see section 6.16.

Tables 4.2a and 4.2b show the figures for the different measures from 2009/10 to 2013/14.

Table 4.2a Alcohol Related Hospital Statistics 2013/14

Clackmannanshire	EASR Standardised rate	Number of hospital stays
2009/10	497.7	260
2010/11	441.2	230
2011/12	499.6	260
2012/13	502.4	260
2013/14	510.5	265

Source: ISD Scotland

Table 4.2b Alcohol Related Hospital Statistics 2013/14

Stirling	EASR Standardised rate	Number of hospital stays
2009/10	610.0	516
2010/11	453.6	387
2011/12	483.5	410
2012/13	409.0	358
2013/14	456.2	397

Source: ISD Scotland

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

The alcohol related mortality rate in Clackmannanshire in 2013 at 38.85, was significantly worse than the average rate of 21.43 for Scotland. Alcohol related mortality is the rate per 100,000 people where alcohol is the underlying cause of death. The rate in Clackmannanshire had been slightly above the national rate in 2009, and fallen below the national average in the intervening years only to rise above it in 2013.

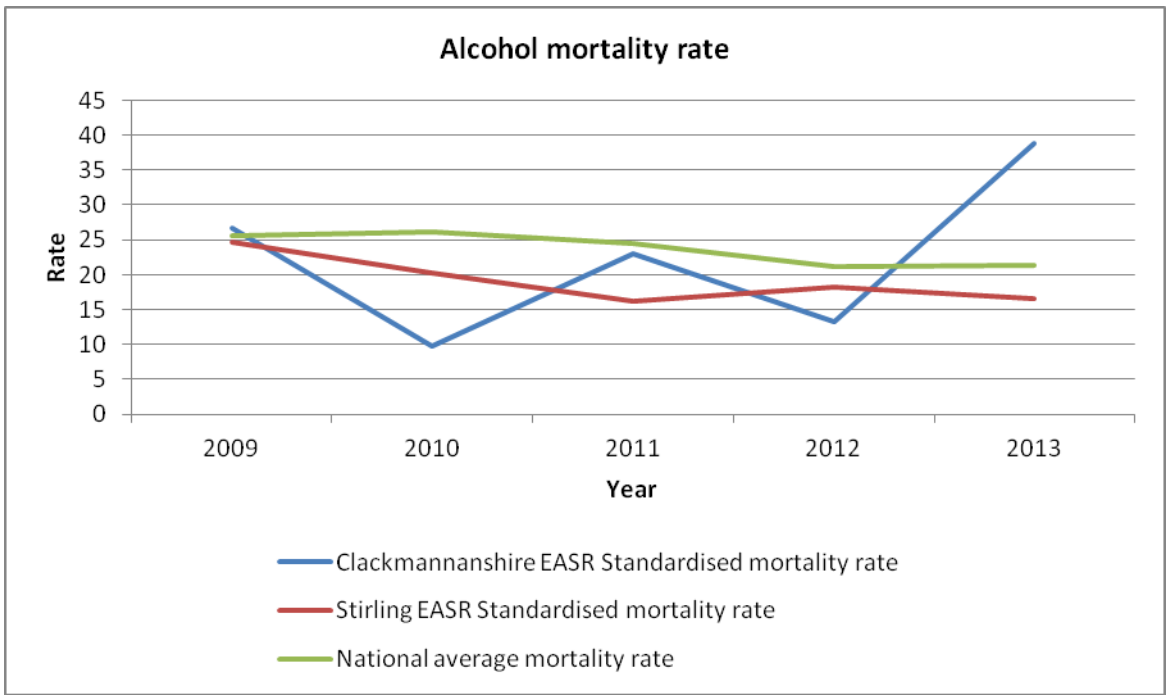
In Stirling, the alcohol related mortality rate has been below the Scottish average in each year from 2009 to 2013.

Table 4.2c Alcohol related mortality

Year	Clackmannanshire EASR Standardised mortality rate	Stirling EASR Standardised mortality rate	National average mortality rate
2009	26.73	24.59	25.65
2010	9.75	20.27	26.14
2011	23.01	16.26	24.56
2012	13.22	18.19	21.19
2013	38.85	16.67	21.43

Source: ISD Scotland/National Records of Scotland (NRS)

Figure 4.2a Alcohol related mortality



Source: ISD Scotland/National Records of Scotland (NRS)

4.3 Drugs

In 2012/2013 across Clackmannanshire and Stirling there were an estimated 1,450 people aged 15-64 with a problem drug use. Problem drug use can lead to a number of health and social problems.

Table 4.3a Estimated number of individuals with problem drug use by Council area (ages 15 to 64); 2012/13

Council area	Estimated number of people with a problem drug use
Clackmannanshire	630
Stirling	820

Source: ISD Scotland

The estimated prevalence of those with a problem drug use has increased in Clackmannanshire and Stirling when comparing the data from 2009/10 and 2012/13. This is in contrast to Scotland as a whole, where the estimated percentage of the population with a problem drug use fell slightly.

Table 4.3b Estimated prevalence of problem drug use (ages 15 to 64)

Council Area	Estimated Prevalence 2009/10	Estimated Prevalence 2012/13
	%	%
Clackmannanshire	1.52	1.84
Stirling	1.23	1.36
Scotland	1.71	1.68

Source: ISD Scotland

The rate of drug related deaths (European age and sex standardised rate per 100,000 population) has been above the national average every year from 2011 to 2014 in Clackmannanshire but below it in Stirling.

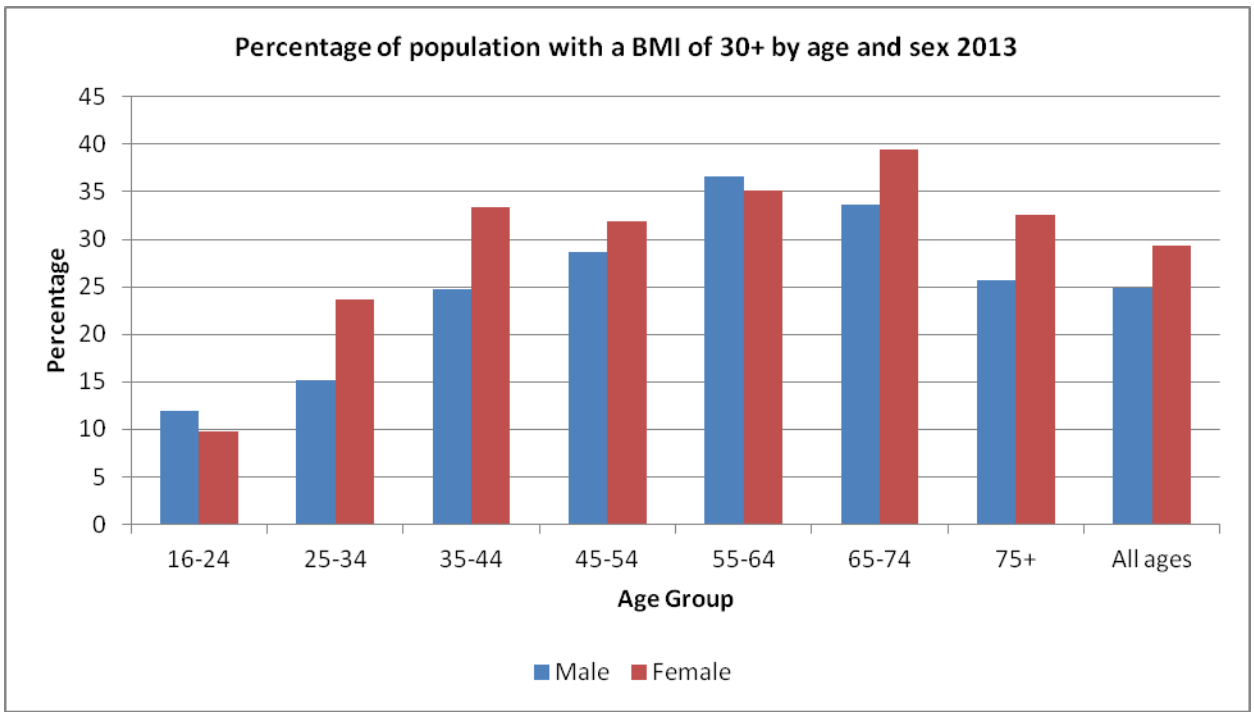
The local Alcohol and Drug Partnership are currently undertaking a needs assessment specifically relating to substance misuse. Once this work is complete any relevant considerations will be taken on board by the Health and Social Care partnership.

4.4 Diet and Obesity

Obesity is when a person's weight increases to an extent that it could potentially cause health problems. Having a Body Mass Index (BMI) of over 30 is considered to be obese. Obesity is linked to a number of health problems and diseases and common complaints include cardiovascular disease and diabetes. One of the major factors that cause an individual to become obese is poor diet.

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

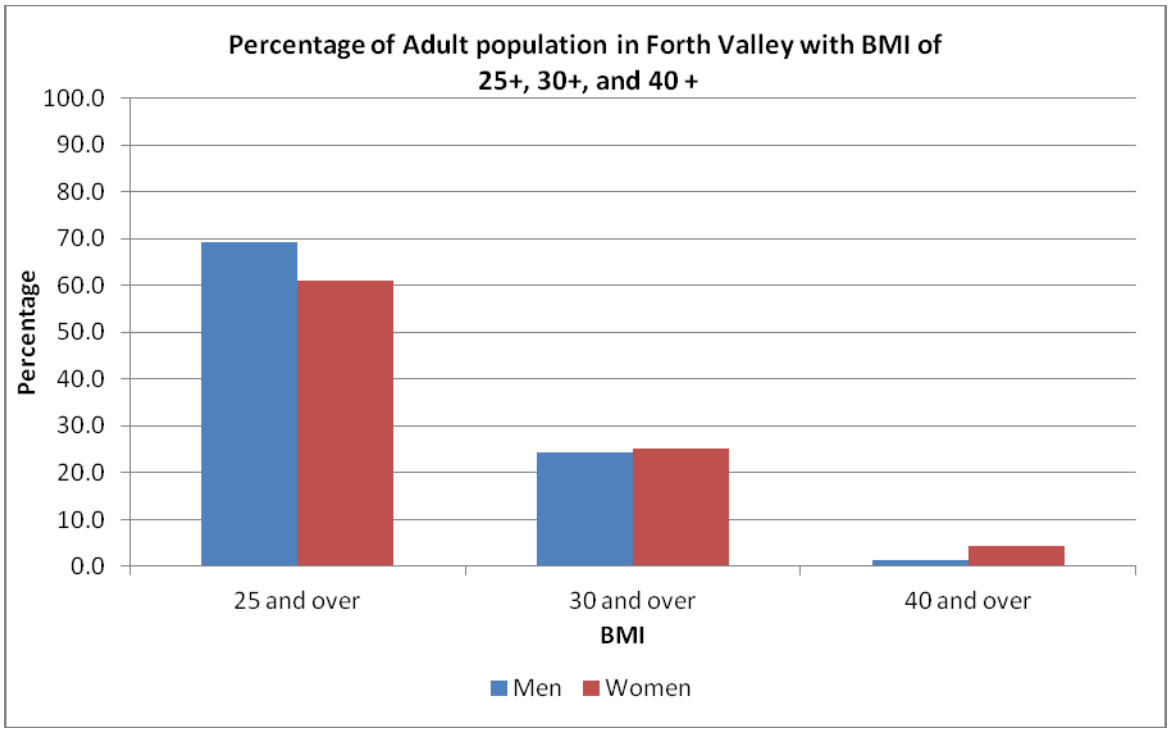
Figure 4.4a Percentage of population with a BMI of 30 plus - 2013



Source: The Scottish Health Survey 2013

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

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



Source: The Scottish Health Survey 2011

4.5 Risk Factors Considerations/Implications

- Despite the introduction of the smoking ban in public places in 2006, latest estimates suggest 28.9% of people in Clackmannanshire still smoke. The corresponding figure for Stirling is 20% and for Scotland is 23.1%. Tobacco smoking is the main risk factor for lung cancer, accounting for an estimated 80-90% of cases in developed countries and is linked to other cancers and Chronic Obstructive Pulmonary Disease (COPD).
- The alcohol related mortality rate in Clackmannanshire in 2013 at 38.85, was significantly worse than the average rate of 21.43 for Scotland. In Stirling, the alcohol related mortality rate has been below the Scottish average in each year from 2009 to 2013.
- The estimated prevalence of those with a problem drug use has increased in Clackmannanshire and Stirling when comparing the data from 2009/10 and 2012/13. This is in contrast to Scotland as a whole, where the estimated percentage of the population with a problem drug use fell slightly.

- Obesity is a major problem nationally and the most recent data suggests approximately 25% of the NHS Forth Valley population are considered obese. Obesity is known to be a key contributor to long term conditions such as Type 2 Diabetes and coronary heart disease, both of which are life-limiting for the patient and costly to the joint services.

Often it is the combination of risk factors rather than a single risk factor that is important. This and the interaction with diseases and conditions can be complex. For example alcohol and drug use often co-exist and combine with mental health and wider social problems.

Some of the lifestyle/risk factor indicators included in Chapter 4 suggest that riskier behaviour/lifestyles may be more prominent in Clackmannanshire than in Stirling. There is likely to be however, variation across both Clackmannanshire and Stirling. Further work on locality profiles may help to identify these areas.

5. Population Health

5.1 General Health

According to the 2011 Census the majority of people in both Clackmannanshire and Stirling considered their general health to be good or very good (Table 5.1a) and only a small percent bad or very bad.

Table 5.1a: General health for Clackmannanshire and Stirling

Local Authority	Good / Very good health	Fair health	Bad / Very bad health
Clackmannanshire	81.6	12.7	5.7
Stirling	84.7	10.8	4.5

Source: 2011 Census

In both Clackmannanshire and Stirling there is an increase in people considering their general health to be fair or bad/very bad with age.

5.2 Life Expectancy and Healthy Life Expectancy

Life expectancy is an estimate of how many years a person might be expected to live. As table 5.2a illustrates female life expectancy at birth is greater than male life expectancy in Clackmannanshire, Stirling and Scotland. Both male and female life expectancy at birth is higher in Stirling that the Scottish average. In Clackmannanshire female life expectancy at birth is lower than the Scottish average.

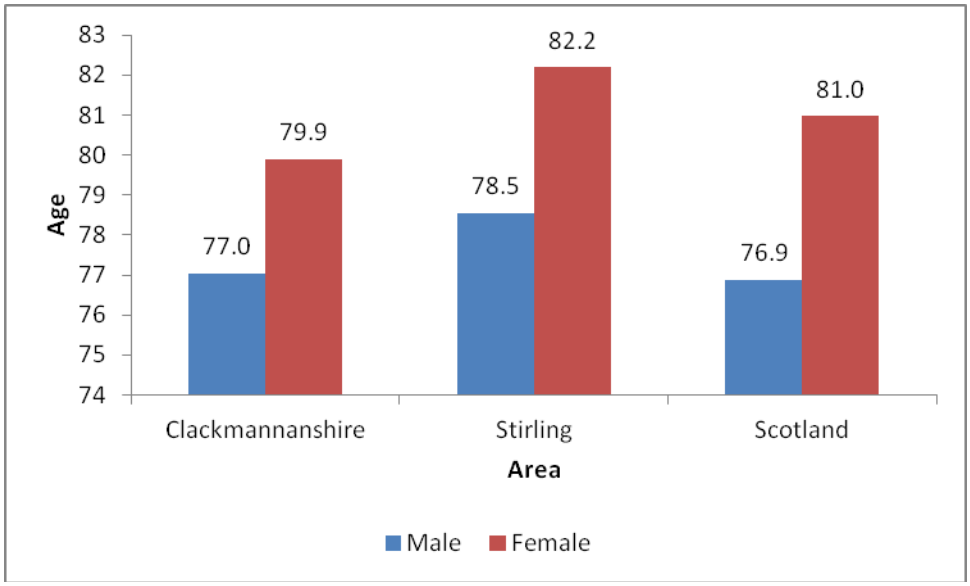
While life expectancy at birth has improved for both males and females in Clackmannanshire and Stirling since 2001-2003 there has been a more rapid improvement for males.

Table 5.2a: Life Expectancy for Clackmannanshire, Stirling and Scotland, 2001-2003 and 2011-2013

	Clackmannanshire		Stirling		Scotland	
	Life expectancy at birth		Life expectancy at birth		Life expectancy at birth	
	Male	Female	Male	Female	Male	Female
2011-13	77.0	79.9	78.5	82.2	76.9	81.0
2001-03	73.5	78.7	75.5	79.3	73.5	78.8
% change between 2001-2003 and 2011-2013	4.7	1.6	4.0	3.7	4.6	2.7

Source: National Records of Scotland (NRS)

Figure 5.2a: Life expectancy at birth in Clackmannanshire, Stirling and Scotland, 2011-2013

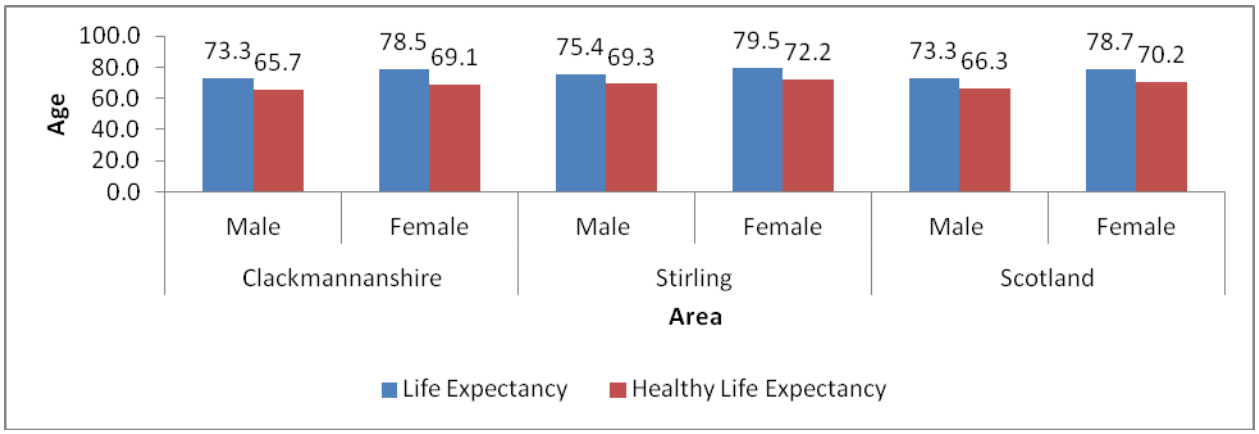


Source: National Records of Scotland (NRS)

Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. The chart below (Figure 5.2b) compares life expectancy and healthy life expectancy in Clackmannanshire, Stirling and Scotland based on data for the five year period 1999-2003. It shows that both life expectancy and healthy life expectancy is higher in Stirling than the

Scottish average. In Clackmannanshire while both male and female life expectancy is comparable to Scotland both are expected to have a lower healthy life expectancy.

Figure 5.2b: Life Expectancy and healthy life expectancy at birth in years for the five year period 1999-2003 for Clackmannanshire and Stirling Community Health Partnerships and Scotland



Source: Scotpho (http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/community-health-partnerships)

5.3 Long Term Health Conditions

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

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

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

QOF register	Numbers as at March 14	Percentage of all practice patients at March 2014	Numbers as at March 13	Numbers as at March 12
Asthma	5,100	5.65	5,034	5,025
Atrial Fibrillation	1,530	1.69	1,464	1,415
Cancer	2,129	2.36	1,989	1,861
CHD (Coronary Heart Disease)	3,714	4.11	3,755	3,812
CKD (Chronic Kidney Disease)	3,010	3.33	3,046	3,067
COPD (Chronic Obstructive Pulmonary Disease)	1,564	1.73	1,527	1,489
Diabetes	3,963	4.39	3,843	3,705
Epilepsy	598	0.66	592	596
Heart Failure	701	0.78	664	682
Hypertension	12,324	13.65	12,221	12,140
Hypothyroidism	3,007	3.33	3,003	2,939
Osteoporosis	135	0.18	N/A	N/A
Peripheral Arterial Disease	593	0.66	N/A	N/A
Rheumatoid arthritis	431	0.48	N/A	N/A
Stroke & Transient Ischaemic Attack (TIA)	1,866	2.07	1,824	1,887

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

Table 5.3b - Numbers of patients on selected QOF registers of Clackmannanshire GP practices

QOF register	Numbers as at March 2014	Percentage of all practice patients at March 2014	Numbers as at March 2013	Numbers as at March 2012
Asthma	3,435	6.09	3,480	3,384
Atrial Fibrillation	879	1.56	835	819
Cancer	1,309	2.32	1,222	1,178
CHD (Coronary Heart Disease)	2,688	4.77	2,726	2,745
CKD (Chronic Kidney Disease)	1,882	3.34	1,890	1,822
COPD (Chronic Obstructive Pulmonary Disease)	1,258	2.23	1,197	1,122
Diabetes	2,891	5.13	2,753	2,606
Epilepsy	429	0.76	412	407
Heart Failure	501	0.89	488	493
Hypertension	8,329	14.77	8,282	8,158
Hypothyroidism	1,816	3.22	1,775	1,724
Osteoporosis	76	0.13	N/A	N/A
Peripheral Arterial Disease	546	0.97	N/A	N/A
Rheumatoid arthritis	303	0.54	N/A	N/A
Stroke & Transient Ischaemic Attack (TIA)	1,294	2.30	1,268	1,269

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

Stirling had a slightly lower prevalence rate than Scotland for 12 out of 15 conditions listed above. Whereas Clackmannanshire had a slightly higher prevalence rate compared to Scotland for 11 out of 15 conditions listed.

The following subsections will look at particular long term conditions in more detail.

5.3.1 Dementia

Dementia presents a significant challenge to individuals, their carers and health and social care services across Scotland. As at March 2014 there were 424 individuals known to GP practices as having dementia in Clackmannanshire and 649 in Stirling. This equates to 0.72% and 0.75% of all patients registered to a GP practice in Stirling and Clackmannanshire respectively.

However, it is suspected that dementia is under diagnosed in Scotland. Alzheimer Scotland has produced estimates, by local authority, of the number of people living in Scotland in 2015 with Dementia (Table 5.3.1a). This suggests that around 50% of individuals with dementia are not yet diagnosed by their GP.

Table 5.3.1a – Estimated number of people in Clackmannanshire and Stirling with Dementia in 2015

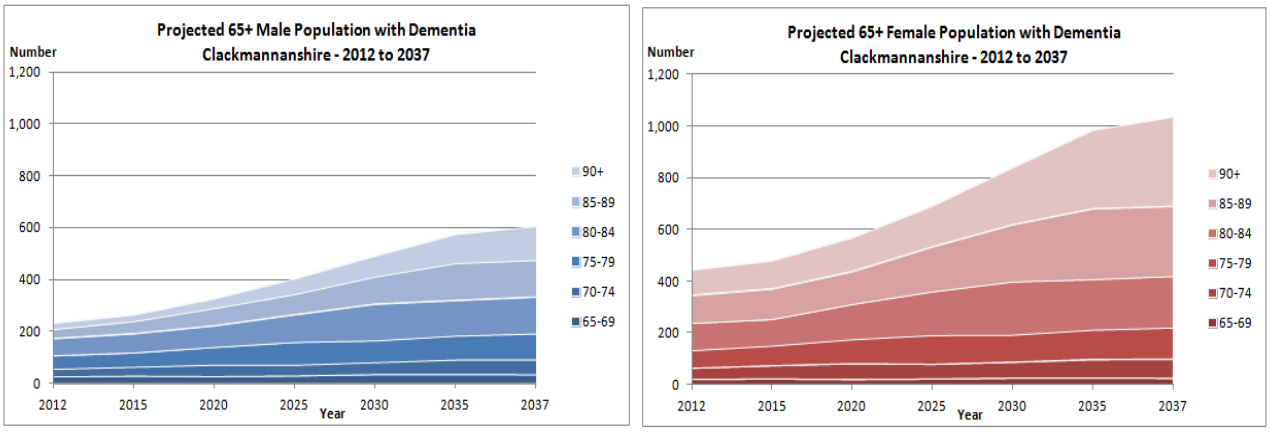
	Under 65	65+	Total
Clackmannanshire	32	725	757
Stirling	53	1,535	1,588
Clackmannanshire & Stirling HSCP	85	2,260	2,345

Source: Alzheimer Scotland

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

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

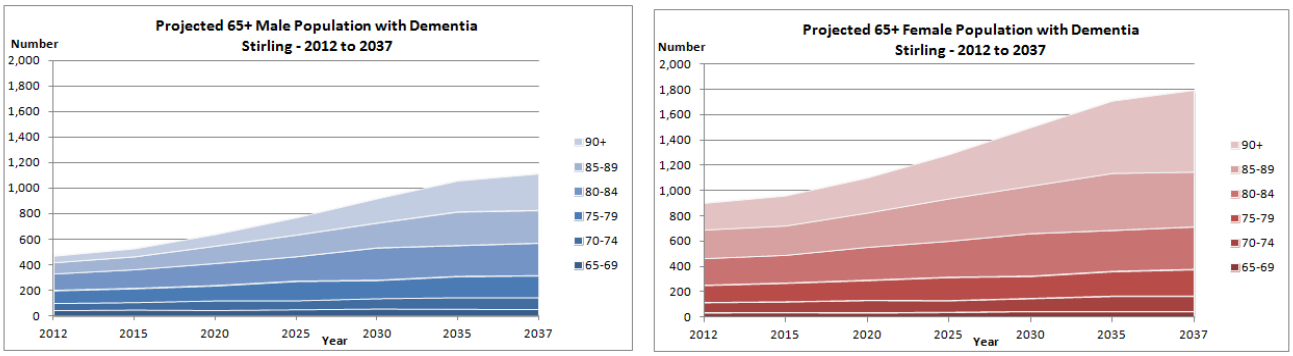
Figure 5.3.1a Male and Female Dementia Projections for Clackmannanshire, 2012-2037



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

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

Figure 5.3.1b Male and Female Dementia Projections for Stirling, 2012-2037



Source: National Records of Scotland Population Projections (2012-Based) and Alzheimer's Scotland

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

5.3.2 Cancer

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

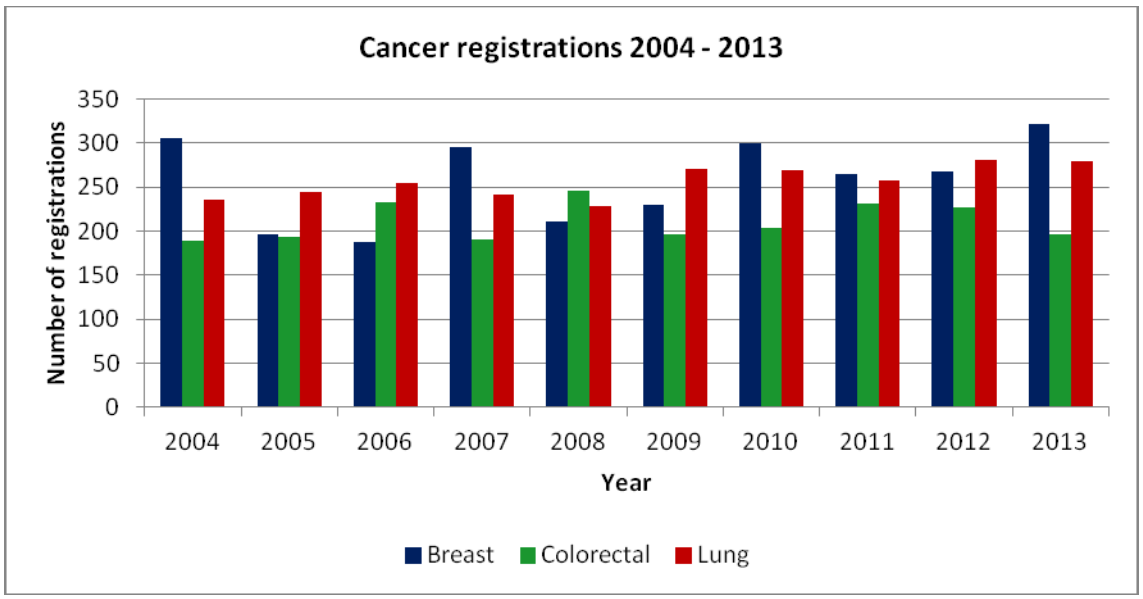
Table 5.3.2a Cancer registrations in NHS Forth Valley from 2004-2013

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

Source: Scottish Cancer Registry, ISD Scotland

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

Figure 5.3.2a Cancer registrations, 2004-2013



Source: Scottish Cancer Registry, ISD Scotland

The rate of cancer registrations in NHS Forth Valley is below the Scottish average although it is not significantly so. In 2013, the crude rate across Scotland was 630 out of 100,000 people, in NHS Forth Valley it was 556 out of 100,000 people.

The mortality rate for cancer in Forth Valley is very close to the rate for Scotland as a whole. In 2013, the figure for Scotland was 296 per 100,000 people, and in Forth Valley it was 290 per 100,000 people. The mortality rate in Forth Valley was relatively stable between 2004 and 2013; it was at its lowest in 2008 at 259, and highest in 2012 when it was 309. Despite an overall increase in the number of new registrations of people with cancer, they are able to live with cancer for longer and this affects the mortality rate.

Cancer incidence in Scotland is projected to rise by a third over the next 10 years. In the five years between 2023 and 2027, it is estimated that there will be over 204,000 new cases of cancer across the whole country.

Presently, about 5% of new cancer diagnoses in Scotland are registered in NHS Forth Valley and if this was to continue to be true by 2027, it would mean that there would be over 2,100 new cancer cases in the board area annually.

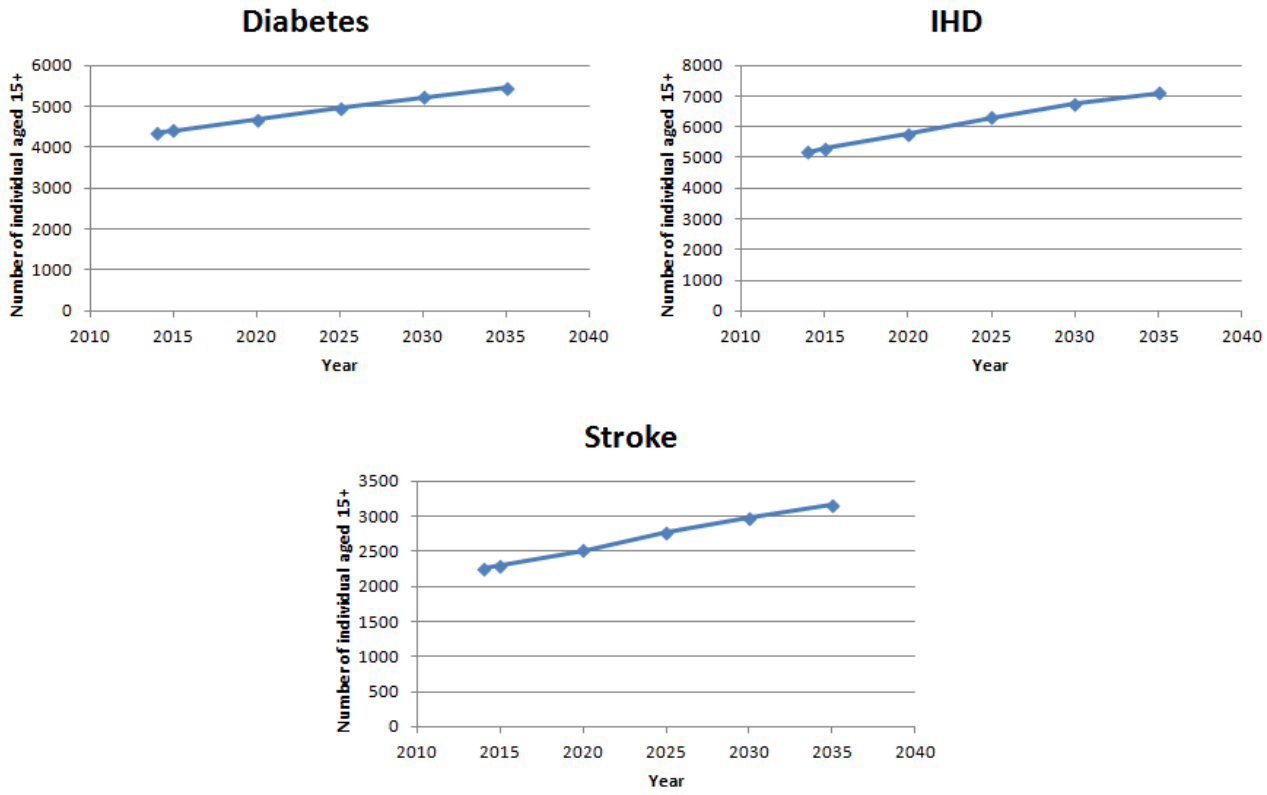
5.4 Projected Long Term Health Conditions

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

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

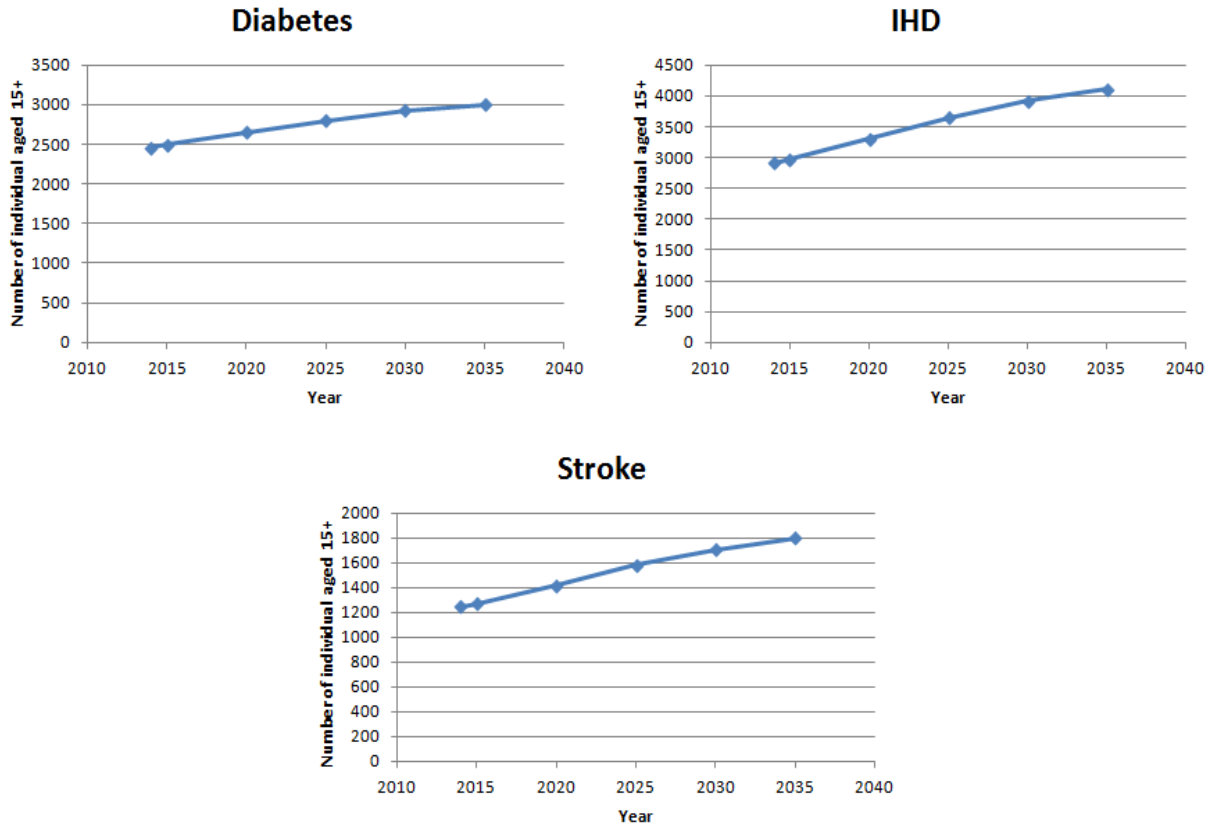
It is easy to assume that disease trends will continue. However the trends could change to some extent. For example an increase in healthy behaviours or a change in socio economic circumstances could impact on the projected trends. To apply a crude method consisting of the application of age-specific prevalence rates to population projections gives the forecast demonstrated in Figure 5.4a and 5.4b, for Stirling and Clackmannanshire respectively, for Diabetes, Ischaemic Heart Disease (IHD) and Stroke. The figures show an increase in the forecasted prevalence of disease. The assumption has been made that the age-specific prevalence rates remain constant.

Figure 5.4a – Estimated projections of Diabetes, IHD and Stroke in Stirling



Source: Scottish Health Survey (prevalence rates) and National Records of Scotland population Estimates

Figure 5.4b – Estimated projections of Diabetes, IHD and Stroke in Clackmannanshire

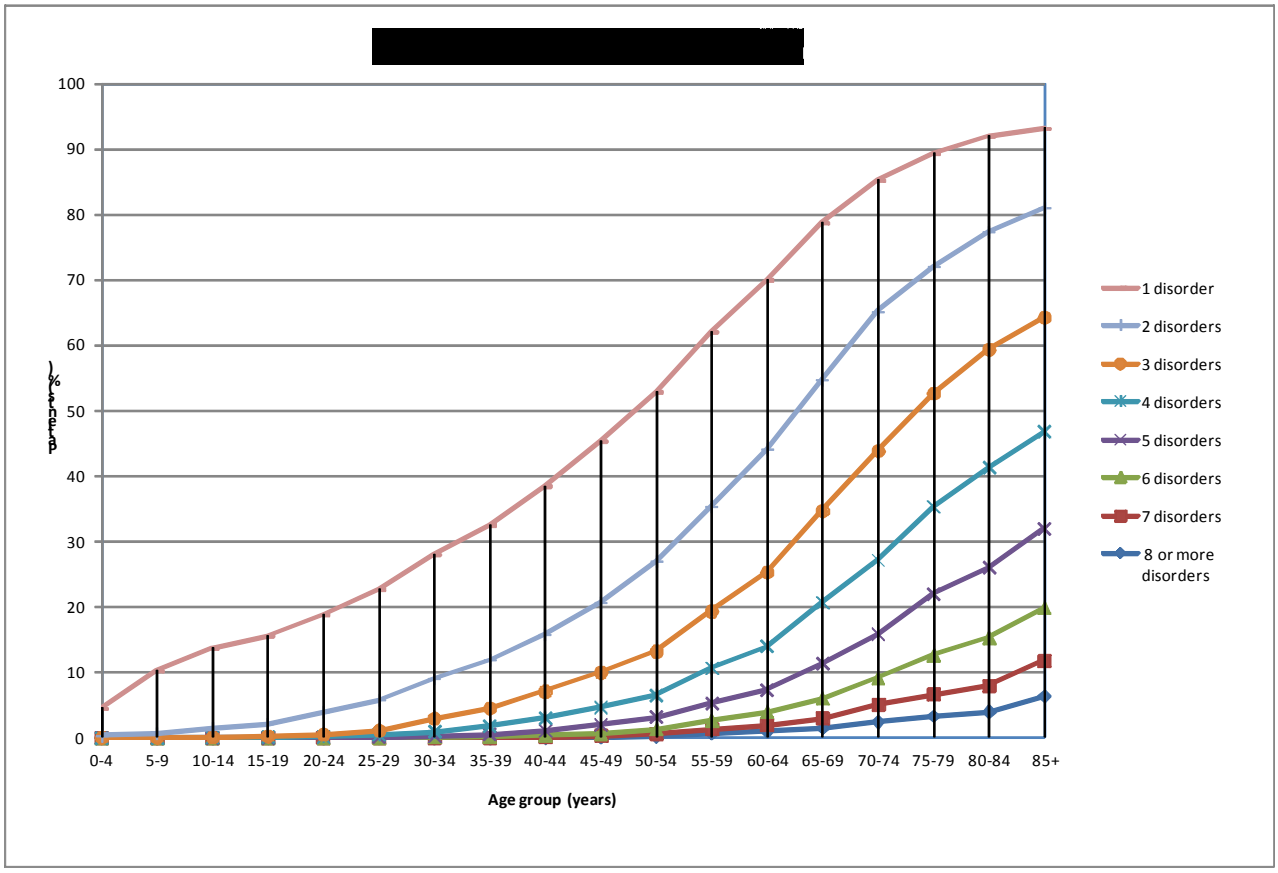


Source: Scottish Health Survey (prevalence rates) and National Records of Scotland (NRS) population Estimates

5.5 Multi-Morbidity

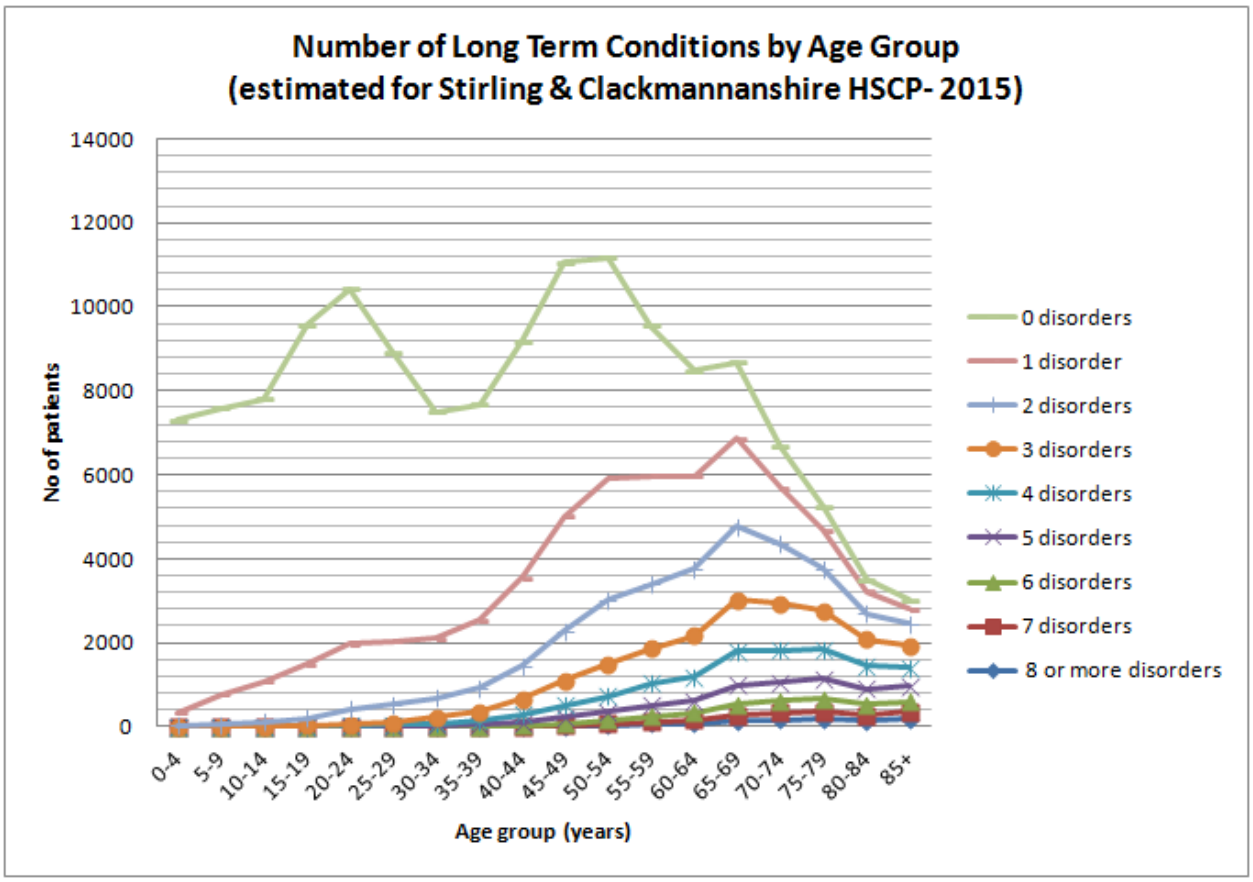
In light of an increasing older adult population there will potentially be more people with multiple long term conditions (also referred to as multi-morbidities) in both Clackmannanshire & Stirling. Figure 5.5a demonstrates that patients have more conditions as they age. The estimated number of people in Clackmannanshire and Stirling with various numbers of long term conditions is forecasted to increase between 2015 (Figure 5.5b) and 2037 (Figure 5.5c).

Figure 5.5a – Estimated number of conditions by age group



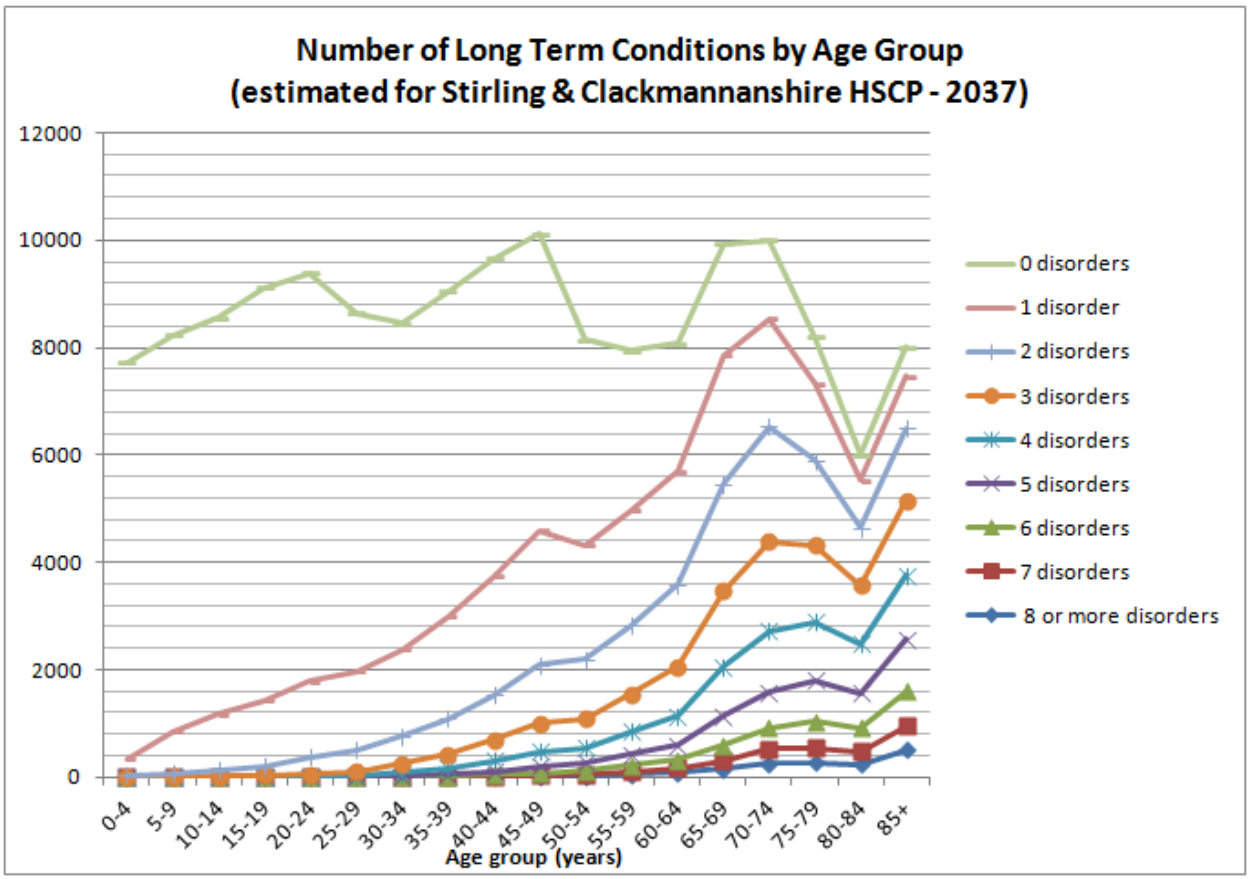
Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer

Figure 5.5b - Estimated number of people within Clackmannanshire & Stirling HSCP with various numbers of conditions (2015)



Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to National Records of Scotland (NRS) population estimates for Clackmannanshire and Stirling

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



Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to National Records of Scotland (NRS) population estimates for Clackmannanshire and Stirling

The estimated and projected number of individuals with multiple long term conditions has been produced using prevalence rates from a study by Professor Stewart Mercer. The study looked at data from 310 GP practices (covering 1,754,133 patients) to produce prevalence rates of multiple long term conditions. These prevalence rates have then been applied to the Clackmannanshire & Stirling populations. These are an estimate and do not take account the different circumstances, such as deprivation, in Clackmannanshire & Stirling to the population used in Professor Mercer's study

While this will be challenging it is important to recognise the value that older people bring to our society, both economically and socially. The multiple morbidities demonstrated in Figures 5.5b and 5.5c bring both person-centred as well as financial challenges (Christie, 2011). Patients with multiple complex long term conditions are currently making multiple trips to hospital

clinics to see a range of uncoordinated specialist services. A proposed way forward could be to look at developing new pathways and guidelines away from the current disease specific models to generic approaches focused on the holistic needs of patients (Lunt, 2013, p. 17). The latter ties in with the Scottish Government's 2020 Vision (Scottish Government, 2011) that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting, and the values of designing the services around the person. For example, we need to make sure that people do not have to unnecessarily attend five different, disjointed, specialists for the five different conditions that they have.

5.6 High Resource Individuals

Health and Social Care resources are not utilised evenly across the population and gaining a better understanding about the cohort of individuals who account for disproportionate levels of resource could allow for more effective planning and delivery of services and an improved service user experience.

ISD Scotland have undertaken cost per patient analysis on Inpatient and day case hospital admissions (including all acute specialties, maternity, geriatric long stay inpatient care, and psychiatric inpatient care), A&E attendances, consultant led outpatient clinics and community prescribing in order to define "High Resource Individuals (HRIs)". High Resource Individuals have been defined as the cohort of individuals who account for 50% of total health and social care expenditure.

Analysis on 2012/13 expenditure found that 1,037 individuals in Clackmannanshire (2% of the population) and 1,606 individuals in Stirling (1.8% of the population) accounted for 50% of expenditure across the services mentioned above. Table 5.6a shows the figures relating to High Resource Individuals in Clackmannanshire, Stirling and Scotland.

Table 5.6a Breakdown of all activities for HRIs and all patients in Clackmannanshire, Stirling and Scotland 2012/13

		Financial Year 2012/13		
		Stirling	**Clackmannanshire**	**Scotland**
Number of patients	HRIs	1,606	1,037	103,715
	All Patients	73,352	42,882	4,425,174
	% HRI	**2.2%**	**2.4%**	**2.3%**
Number of bed days	HRIs	82,680	47,652	5,419,968
	All Patients	106,134	60,828	7,439,396
	% HRI	**77.9%**	**78.3%**	**72.9%**
Episodes/Attendances/ Items[1]	HRIs	119,804	66,888	7,397,856
	All Patients	1,662,511	917,079	96,720,899
	% HRI	**7.2%**	**7.3%**	**7.6%**
Cost (£)	HRIs	£37,922,431	£22,440,642	£2,558,775,992
	All Patients	£75,845,095	£44,890,562	£5,117,568,466
	% HRI	**50.0%**	**50.0%**	**50.0%**
Cost per capita (£)	HRIs	£23,613	£21,640	£24,671
	All Patients	**£1,034**	**£1,047**	**£1,156**

[1]Episodes and attendances apply to inpatient, day case, outpatient and A&E activity. Items apply to prescribing only.

There is a strong association between High Resource Individuals and long term conditions. Seventy per cent of High Resource Individuals in Stirling had at least one long term condition compared to 68% in Clackmannanshire in 2012/13.

As health & social care integration progresses and more information becomes available at patient/service user level from different sources this analysis will be expanded. This will allow a more detailed look at the combinations of services that High Resource Individuals use and to explore opportunities to improve pathways of care.

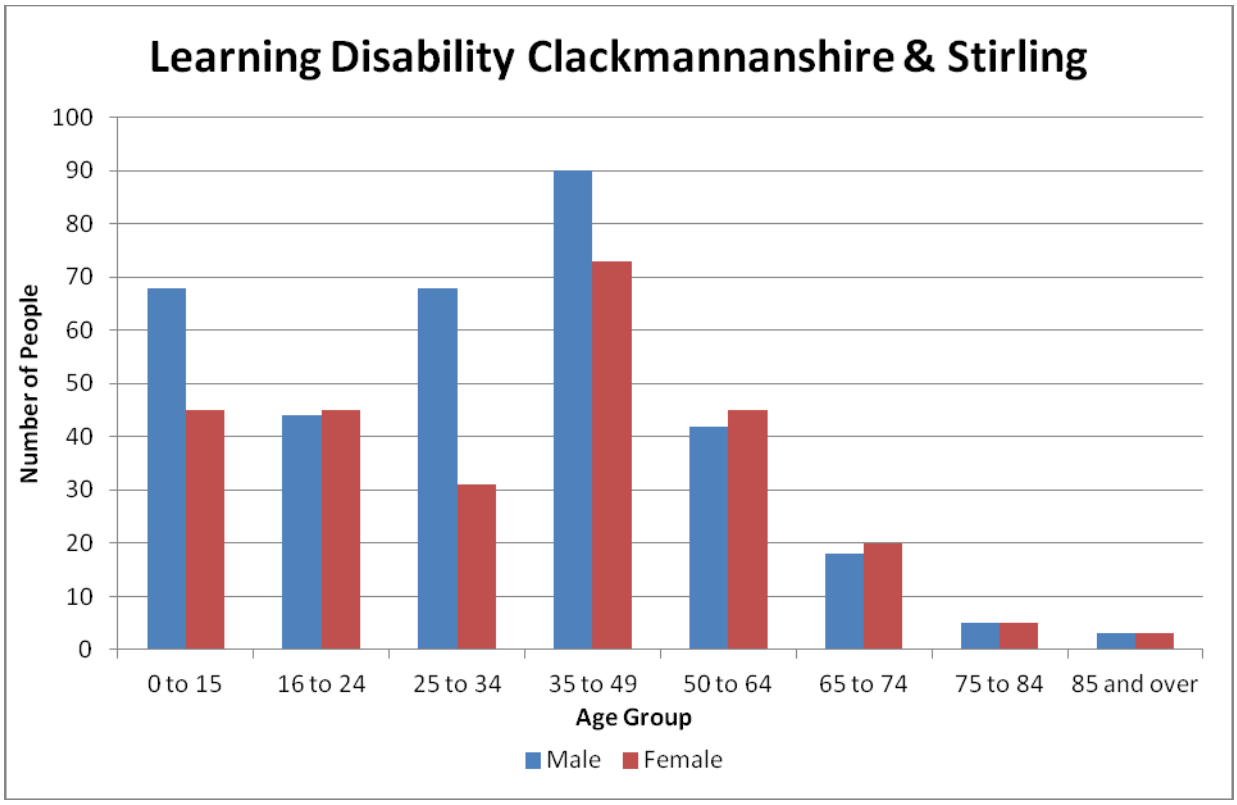
5.7 Disability

5.7.1 Learning Disability

Figure 5.7.1a shows the number of people in Clackmannanshire and Stirling who were recorded as having a learning disability by gender and age group at the time of the census in 2011. The

age group with the highest number of people with a disability for both genders is the 35-49 age group. The number of men with a learning disability drops by 53% between those aged 35-49 and those aged 50-64, and 38% for women between the same age groups. After the age of 49 the number of people with a learning disability steadily decreases for both genders. This reflects research that tells us that people with learning disabilities are more likely to die at an early age than the general population, on average 20 years before[4]. It is a similar picture in Clackmannanshire and Stirling individually although in Clackmannanshire there is a similar number of people with a disability in the 0-15 age group than the largest 35-49 age group (Figures 5.7.1b and 5.7.1c). The Forth Valley Joint Learning Disability Strategic Framework is being developed which will highlight the local position ensuring consistency with the Scottish Government's Learning Disability Strategy (2013), *The Keys to Life.*

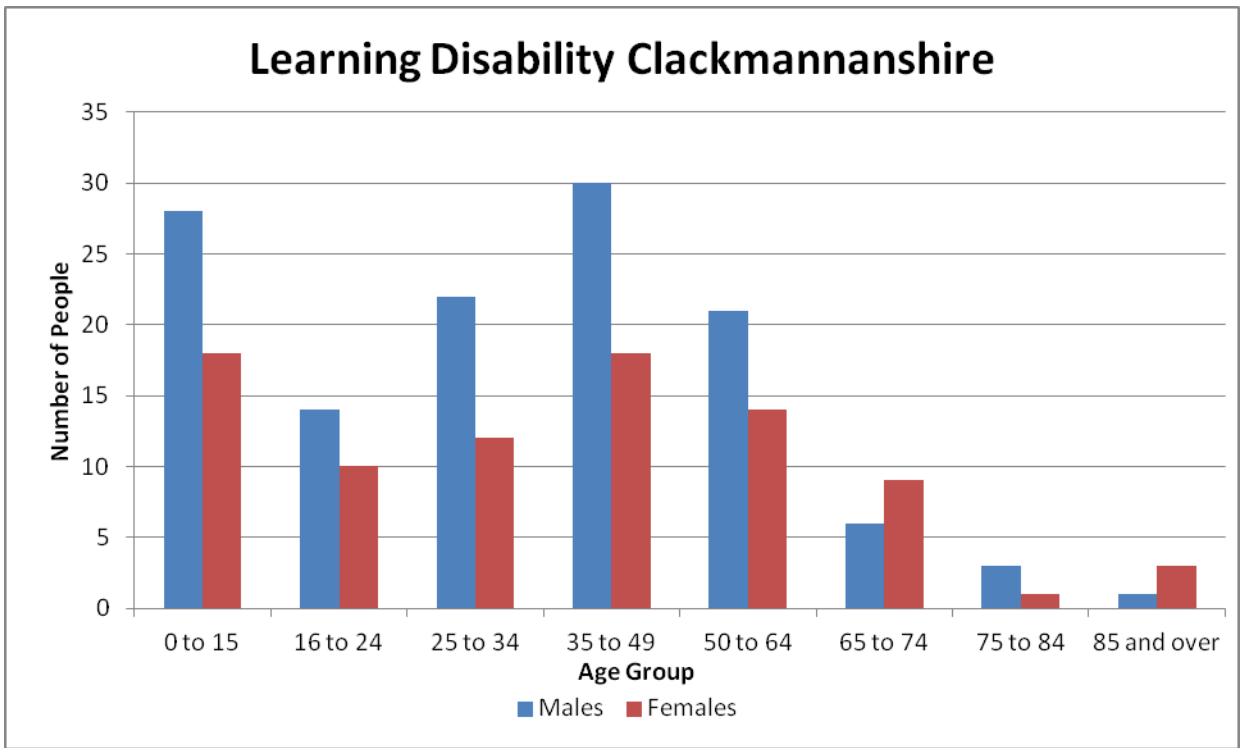
Figure 5.7.1a Number of people in Clackmannanshire and Stirling with a learning disability, 2011.



Source: 2011 Census

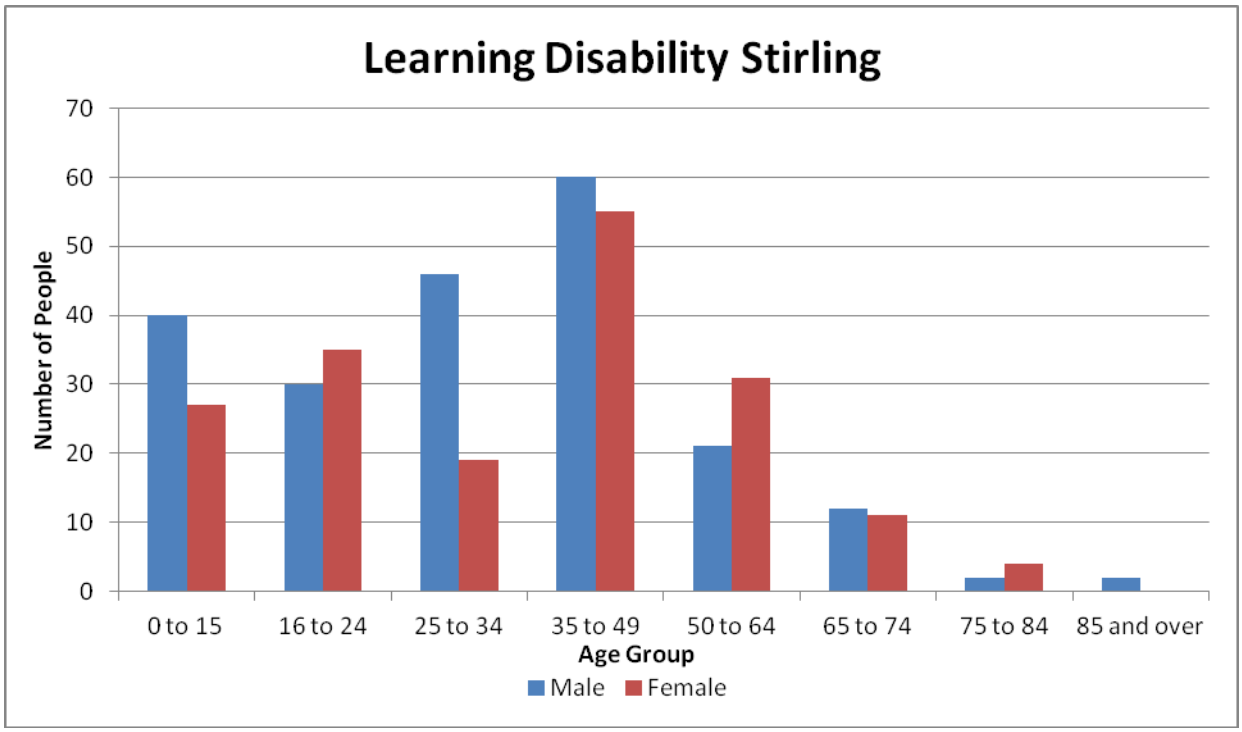
[4] Tyrer F et al, Journal of Intellectual Disability Research, 2007; 51:520-7.

Figure 5.7.1b Number of people in Clackmannanshire with a learning disability, 2011.



Source: 2011 Census

Chart 5.7.1c Number of people in Stirling with a learning disability, 2011.



Source: 2011 Census

5.7.2 Physical Disability

The Scottish Government has recently announced (September, 2015) a plan, The Scottish Government's Draft Delivery Plan 2016-2020, to address inequality and advance disabled people's human rights.

Some of the key aspects of the plan are:

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

In Clackmannanshire and Stirling there were over 9,200 people recorded as having a Physical Disability in the 2011 Census.

Table 5.7.2a Number of people with a physical disability

Area	Physical disability	Percentage of total population
Clackmannanshire CHP	3717	7.2%
Stirling CHP	5535	6.1%
Clackmannanshire & Stirling	9252	6.5%

Source: 2011 Census

The majority of people who have a Physical Disability in Clackmannanshire and Stirling are over the age of 50. Table 5.7.2b below also shows that the proportion of those with a physical disability increases as people age. Only 1% of the population aged 16-24 had a Physical Disability in 2011, compared to 35.4% for those aged 85 and over.

Table 5.7.2b Number of people in Clackmannanshire and Stirling with a Physical Disability by age and gender

Age	Male	Female	All	Percentage of total with physical disability	Percentage of age group with physical disability
0-15	121	92	213	2.3%	0.8%
16-24	94	91	185	2.0%	1.0%
25-34	150	132	282	3.0%	1.8%
35-49	605	610	1215	13.1%	3.9%
50-64	1236	1302	2538	27.4%	9.0%
65-74	1034	1103	2137	23.1%	15.9%
75-84	704	1041	1745	18.9%	22.7%
85+	259	678	937	10.1%	35.4%

Source: 2011 Census

5.8 Mental Health and Wellbeing

Mental health and wellbeing strategies and targets were established by the Scottish Government in 2012 (The Scottish Government, Mental Health Strategy for Scotland: 2012-2015). Among the key areas of change outlined were:

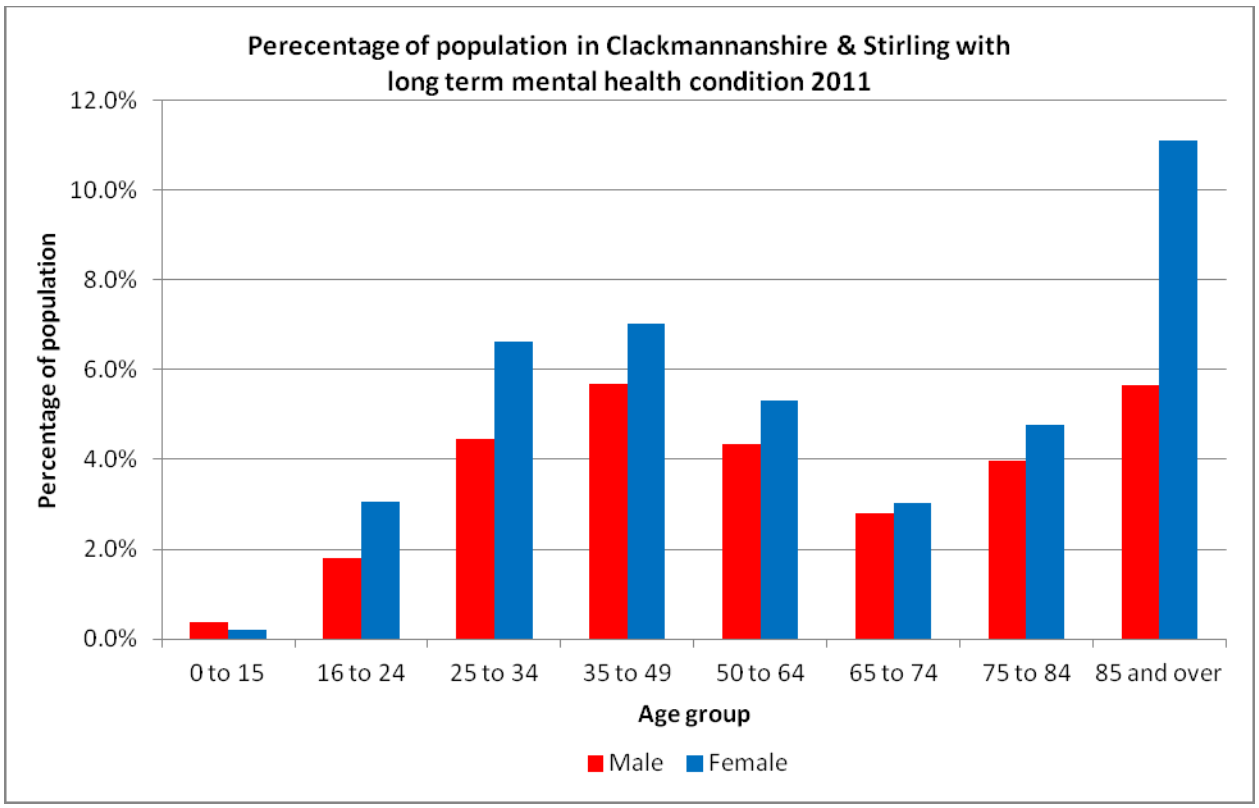
- Community, inpatient and crisis mental health services
- Work with other services and populations with specific needs.

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

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

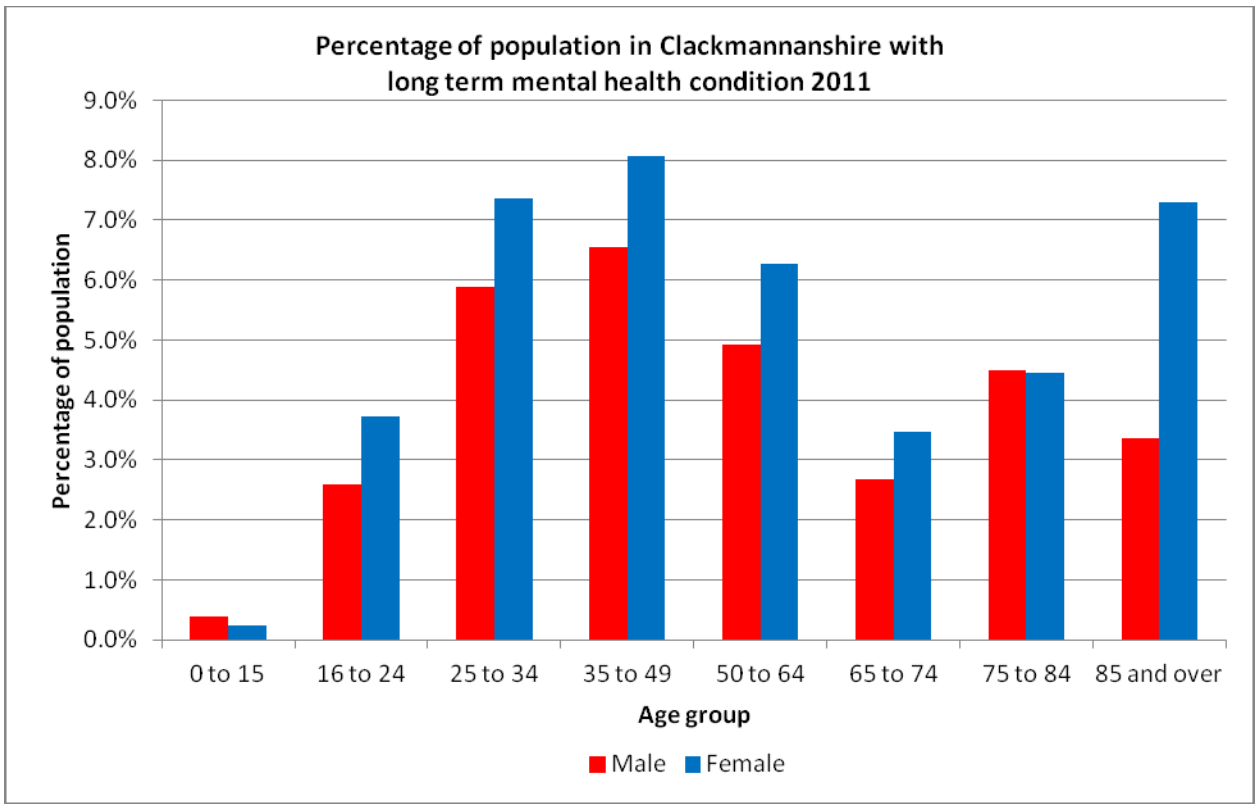
In the 2011 Census, 2,374 people in Clackmannanshire and 3,319 people in Stirling identified themselves as having a mental health condition. This is 5,693 people in total, 4% of the total population. The distribution of this group by age group and gender for Clackmannanshire and Stirling combined and separately is shown in Figures 5.8a, 5.8b and 5.8c.

Figure 5.8a Percentage of population with long term mental health condition in Clackmannanshire & Stirling by age group and gender 2011



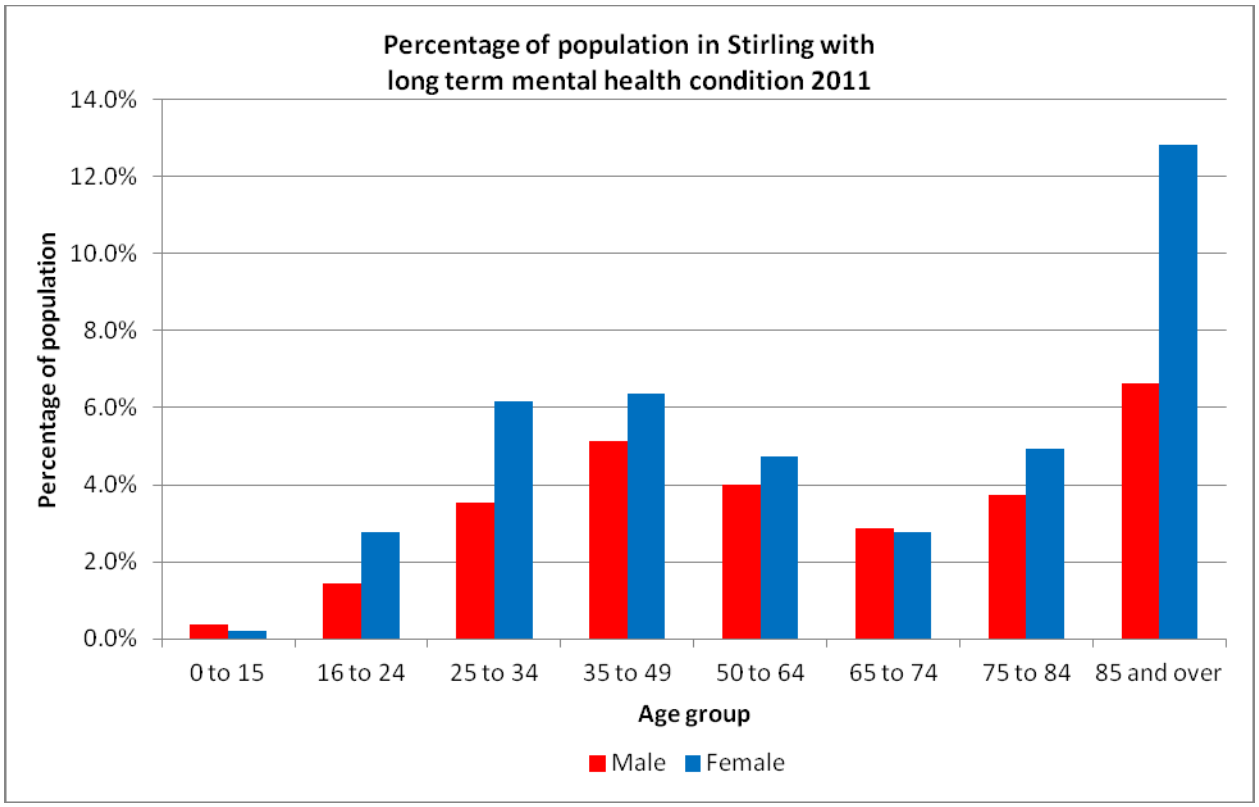
Source: 2011 Census

Figure 5.8b Percentage of population with long term mental health condition in Clackmannanshire by age group and gender 2011



Source: 2011 Census

Figure 5.8c Percentage of population with long term mental health condition in Stirling by age group and gender 2011



Source: 2011 Census

Note- This information is taken from the 2011 census. Households are asked to self identify if they or someone within the household has a mental health condition. The question does not define a mental health condition or take into account multiple mental health conditions.

Further information on mental health and illnesses comes from the Quality and Outcomes Framework (QOF) for General Practices. Participation by general practices in the Quality and Outcomes Framework is voluntary but it measures achievement for general practitioners against a range of evidence-based indicators, and includes prevalence data for a range of conditions. Table 5.8a below shows information from the Quality and Outcomes Framework register.

A crude prevalence rate of the number of people in Clackmannanshire, Stirling and Scotland with a mental health condition is shown in Table 5.8a. It shows that the rate of people with a new diagnosis of depression is slightly higher than the Scottish rate in both areas.

Table 5.8a Rate of people (per 100 patients) with mental health issues in Clackmannanshire, Stirling and Scotland 2013/14

Area	New diagnosis of depression	Schizophrenia, Bipolar affective disorder and other psychoses
Clackmannanshire	6.28	0.80
Stirling	5.94	0.81
Scotland	5.81	0.88

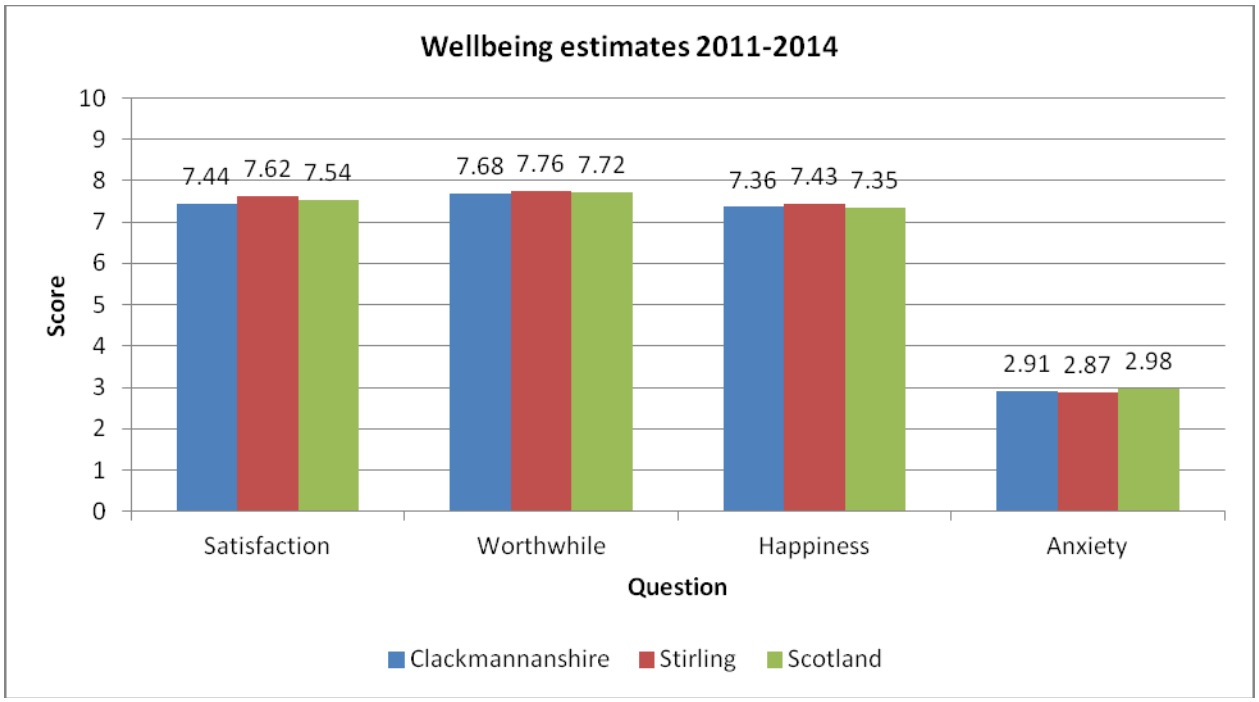
Source: ISD Scotland

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

These are:
1) Overall, how satisfied are you with your life nowadays? Where 0 is 'not at all satisfied' and 10 is 'completely satisfied'.
2) Overall, to what extent do you feel the things you do in your life are worthwhile? Where 0 is 'not at all worthwhile' and 10 is 'completely worthwhile'.
3) Overall, how happy did you feel yesterday? Where 0 is 'not at all happy' and 10 is 'completely happy'.
4) Overall, how anxious did you feel yesterday? Where 0 is 'not at all anxious' and 10 is 'completely anxious'.

The average scores for Clackmannanshire, Stirling and Scotland between 2011 and 2014 are shown in Table 5.8b below. The Stirling scores show that on average people there have better mental health wellbeing than people living in Clackmannanshire and in Scotland.

Table 5.8b Wellbeing estimates 2011-2014



Source: Office for National Statistics

5.9 Premature Mortality

Premature mortality is a measure of the number of deaths that occur under the age of 75 and can be used as an indicator of the poor health of a population. The fewer deaths that occur under the age of 75, the healthier the population is judged to be. In 2014 there were 497 deaths under the age of 75 across Clackmannanshire and Stirling, 35.9% of the total deaths. This is lower than the Scottish figure in 2014, which was 36.8%. The figures for each individual area can be found in Table 5.9a and Table 5.9b.

Table 5.9a Deaths under the age of 75, 2014

	Deaths under age 75		
Area	**Male**	**Female**	**Total**
Clackmannanshire	118	82	200
Stirling	166	131	297
Clackmannanshire & Stirling	284	213	497
Scotland	11749	8212	19961

Source: National Records of Scotland (NRS)

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

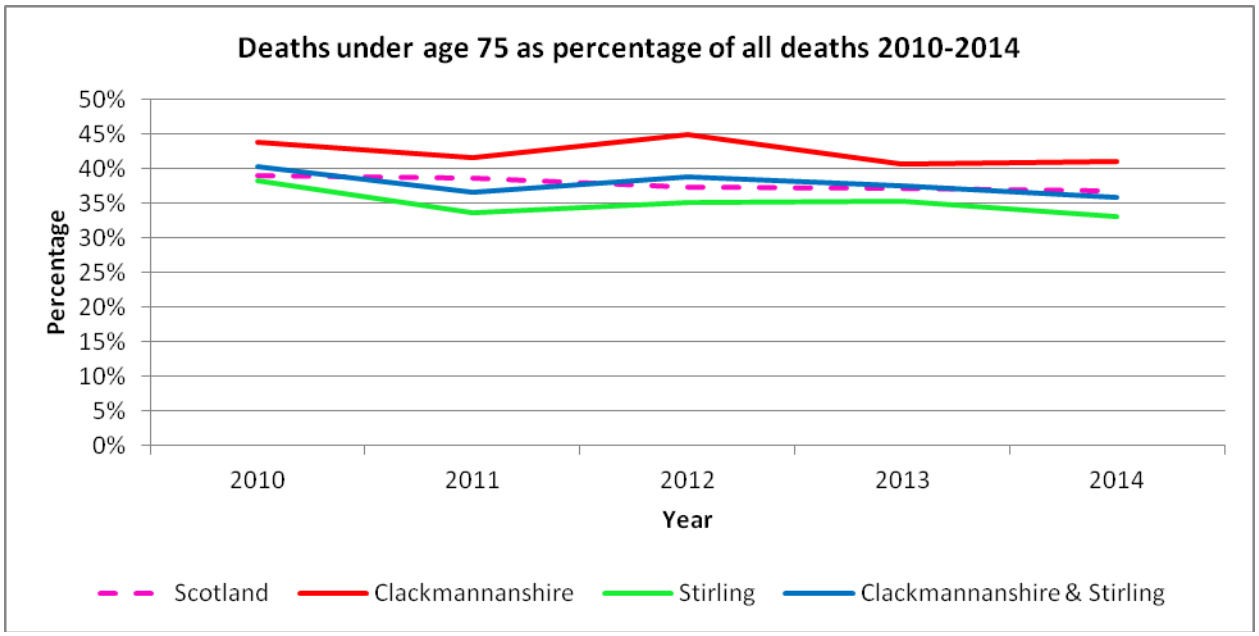
Under 75s as % of all deaths

Area	Deaths under age 75	Total Deaths	% Deaths under age 75
Clackmannanshire	200	488	41.0%
Stirling	297	898	33.1%
Clackmannanshire & Stirling	497	1386	35.9%
Scotland	**19961**	**54239**	**36.8%**

Source: National Records of Scotland (NRS)

The percentage of deaths occurring under the age of 75 has been gradually decreasing across Scotland between 2010 and 2014. Over the same time period the percentage of deaths under 75 fluctuated in Clackmannanshire and Stirling, but it was lower in 2014 than it was in 2010. Examining Clackmannanshire alone shows that it had a higher percentage of deaths under the age of 75 than Stirling and Scotland and this trend has continued from 2010 to 2014. Figure 5.9a shows this and compares the percentage deaths under 75 between the different areas.

Figure 5.9a Trend in deaths under age 75 as a percentage of all deaths between 2010 and 2014



Source: National Records of Scotland Births, Deaths and Other Vital Events

5.10 Cause of Death

In 2014 there were 1,386 deaths registered in Clackmannanshire and Stirling. Sixty percent of this total number of deaths were caused by cancer and diseases of the circulatory system (including cardiovascular disease and strokes).

Table 5.10a Number and percentage of deaths (all ages) by cause 2014

Cause of death	Clackmannanshire	%	Stirling	%	Combined	%
Cancer	158	32.4%	263	29.3%	421	30.4%
Mental and behavioural disorders	34	7.0%	58	6.5%	92	6.6%
Diseases of the nervous system	20	4.1%	48	5.3%	68	4.9%
Diseases of the circulatory system	142	29.1%	272	30.3%	414	29.9%
Diseases of the respiratory system	55	11.3%	107	11.9%	162	11.7%
Diseases of the digestive system	26	5.3%	41	4.6%	67	4.8%
External causes	23	4.7%	45	5.0%	68	4.9%
Other	30	6.1%	64	7.1%	94	6.8%
Total	**488**	**100.0%**	**898**	**100.0%**	**1386**	**100.0%**

Source: National Records of Scotland (NRS)

The percentage of all deaths caused by cancer and diseases of the circulatory system in Clackmannanshire and Stirling has not significantly changed in the years between 2010 and 2014. Each cause accounts for approximately 30% of all deaths, and this is comparable with the figures for Scotland as a whole.

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

Clackmannanshire and Stirling	2010		2011		2012		2013		2014	
Cause of death	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Cancer	402	30.8%	390	31.0%	442	31.9%	440	31.1%	421	30.4%
Diseases of the circulatory system	378	28.9%	382	30.3%	416	30.0%	421	29.7%	414	29.9%

Source: National Records of Scotland (NRS)

Table 5.10c Number and percentage of deaths caused by cancer and diseases of the circulatory system in Clackmannanshire between 2010 and 2014.

Clackmannanshire	2010		2011		2012		2013		2014	
Cause of death	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Cancer	130	28.2%	145	30.4%	159	31.4%	165	29.6%	158	32.4%
Diseases of the circulatory system	137	29.7%	150	31.4%	163	32.2%	157	28.2%	142	29.1%

Source: National Records of Scotland (NRS)

Table 5.10d Number and percentage of deaths caused by cancer and diseases of the circulatory system in Stirling between 2010 and 2015.

Stirling	2010		2011		2012		2013		2014	
Cause of death	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Cancer	272	32.2%	245	31.3%	283	32.2%	275	32.0%	263	29.3%
Diseases of the circulatory system	241	28.5%	232	29.7%	253	28.8%	264	30.7%	272	30.3%

Source: National Records of Scotland (NRS)

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

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

Source: National Records of Scotland (NRS)

5.11 Population Health Considerations/Implications

- In Clackmannanshire while both male and female life expectancy is comparable to Scotland both are expected to have a lower healthy life expectancy.
- Assuming age-specific prevalence remains constant for long term conditions it is projected we will see greater numbers of individuals with these conditions as the proportion of older adults in the population rises. This will impact on both health and care services.
- It is also projected that the number of people with multi-morbidities, i.e. more than one long term condition, will increase. This means there will be more individuals attending

hospital with complex needs. Currently services are un-coordinated and may mean people are making multiple visits to hospital. A re-organisation of services to ensure a more joined up approach could help to reduce the number of visits to a hospital and improve efficiency.

- Currently around 2% of the population account for 50% of the hospital and GP prescribing spend. Gaining a better understanding about this cohort of high resource individuals could allow for more effective planning and delivery of services and an improved service user experience.

6 Current Provision of Health and Social Care Services

6.1 Workforce

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

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

Table 6.1a below provides an overview of the staff relevant to the Clackmannanshire & Stirling Health and Social Care Partnership.

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

Employing Body	Headcount	Whole Time Equivalent/ Full Time Equivalent
Clackmannanshire Council	255	186.3
Stirling Council	316	269.0
NHS Forth Valley	2484	2086.3

Source: Forth Valley Workforce Project

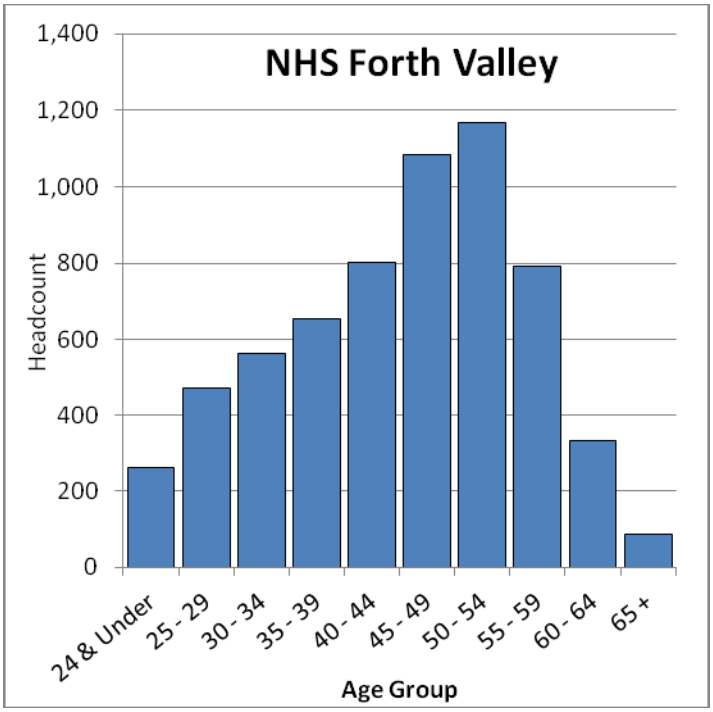
*Note – Forth Valley headcount/WTE refers to all staff in scope for integration and not just those considered relevant to the Clackmannanshire and Stirling population. The NHS Forth Valley figures refer to the workforce covering Falkirk, Stirling and Clackmannanshire.

Age Profiles

Age of the workforce must be considered to ensure that planned future services are sustainable. Data were not available for NHS Forth Valley and the two local authorities using the same age bandings (age bands have been aligned as best possible). Figure 6.1a, below,

illustrates that 56% of the NHS Forth Valley workforce are aged over 45. Data provided direct by Clackmannanshire and Stirling Councils indicate that 64% of the Social Services workforce in Clackmannanshire are over the age of 45 and 58% of the Social Services workforce in Stirling are over the age of 46. Please note this may include individuals not in scope for Health & Social Care Integration.

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



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

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

6.2 General Practice Services

General Practitioner and primary care services are an integral aspect of the provision of healthcare. In 2014 in Clackmannanshire and Stirling there were 30 practices served by 137 General Practitioners.

The number of GPs increased between 2006 and 2014 but this disguises the fact that the number of GPs in the Stirling area has been falling for the last two years whilst in Clackmannanshire the number has been rising (Table 6.2a).

Table 6.2a The number of GPs (All GPs, headcount) in Clackmannanshire and Stirling 2006-2014

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Clackmannanshire	41	45	45	45	43	46	45	48	49
Stirling	84	90	94	94	97	94	95	90	88
Clackmannanshire & Stirling	125	135	139	139	140	140	140	138	137

Source: ISD Scotland

In 2014, Clackmannanshire had the third largest average practice list size in Scotland. The seven GP practices had an average list size of 8,075 people, whereas in Stirling the 23 practices had an average of 4,259 people on their lists.

Only one of the practices in Clackmannanshire had a patient list where over 85% of the population lived in rural area[5]s, as opposed to 10 of the 23 practices in Stirling. This may affect the use of primary care services as people who live further away from the GP surgery may be less likely to engage with the services there.

The practices with the highest percentage of patients in the most deprived datazones are in Clackmannanshire. There are three practices where over a quarter of patients on the practice list are living in datazones defined as the 15% most deprived.

In both areas the age of the practice population is rising and in 2014 both had a higher percentage of the practice population aged 65 and over than the average figure for Scotland.

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

Area	% of practice population aged 65+	
	2010	2014
Clackmannanshire	15.8%	18.2%
Stirling	16.2%	17.5%
Scotland	15.9%	17.2%

Source: ISD Scotland

[5] Based on the Scottish Government Urban Rural Classification

6.3 Unscheduled Care

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

6.3.1 Accident &Emergency Attendances

Since July 2011, Clackmannanshire, Stirling and Falkirk have been served by a single Accident and Emergency department at Forth Valley Royal Hospital in Larbert, with a minor injuries unit at Stirling Community Hospital. This provides minor injury services across the health board for people in Clackmannanshire, Falkirk and Stirling between 09:00 and 21:00 hours, 7 days a week.

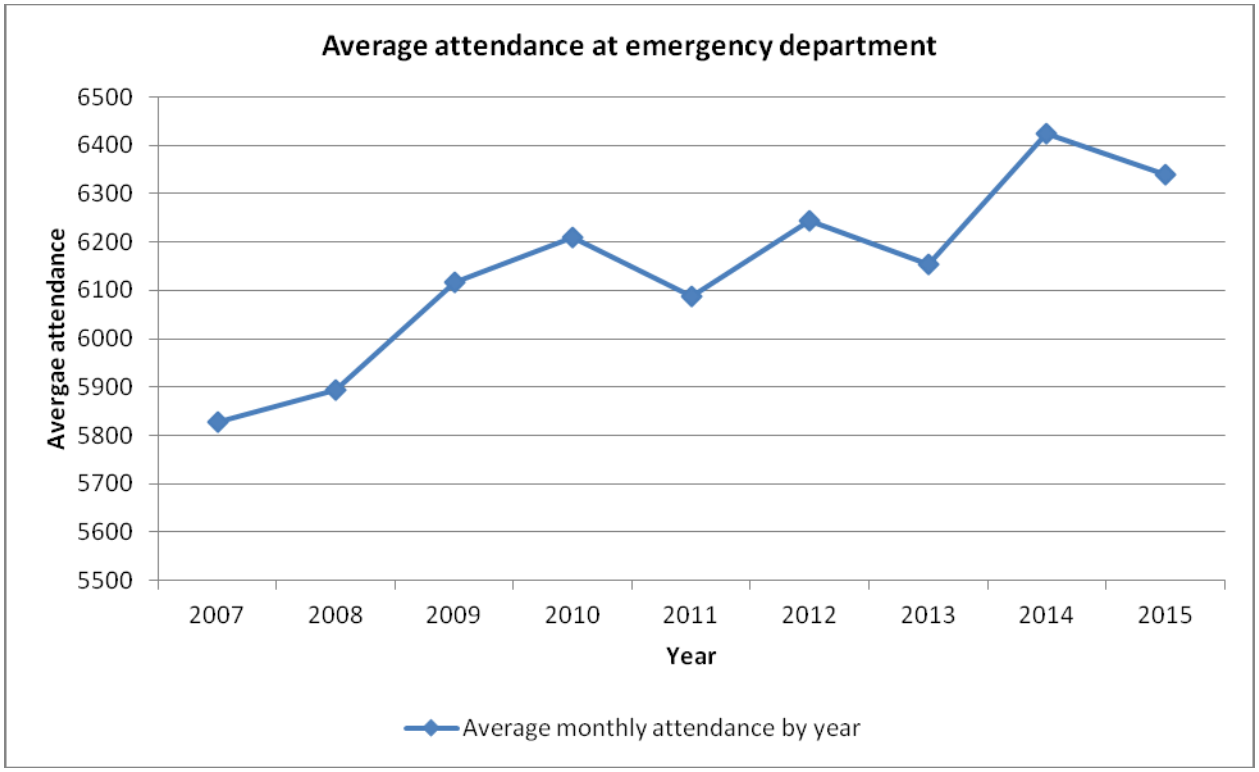
The average monthly attendance at an emergency department (at Stirling Royal Infirmary or Falkirk Community Hospital before July 2011 and the Accident and Emergency at Forth Valley Royal Hospital or the minor injuries unit at Stirling Community Hospital after this) between 2007 and 2015 rose from 5,828.2 in 2007 to 6,340.2 by June 2015. This represents an 8.8% increase in the average monthly attendance over the time period. During this time the percentage of people who were waiting less than 4 hours in Accident and Emergency each month ranged from a high of 97% in February 2014 to a low of 81.2% in December 2014.

Table 6.3.1a Average monthly attendance at emergency department by year

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

Source: ISD Scotland

Figure 6.3.1a Average monthly attendance at emergency department by year



Source: ISD Scotland

The average monthly attendance at the Accident and Emergency department at Forth Valley Royal Hospital had risen from 4,603 in 2011 to 5,023 by June 2015. This is an increase of 9.3%. At the same time the average monthly attendance at the minor injuries unit at Stirling Community Hospital had risen from 1,037 when it opened in 2011 to 1,309 by June 2015. This is a 26% increase in the average monthly attendance at the unit. There has been no issue with waiting times at the minor injuries unit as each month, between 98.9% and 100% of people were waiting less than 4 hours and so within the waiting times target.

Table 6.3.1b Average monthly attendance at minor injuries unit Stirling Community Hospital

Year	Average monthly attendances
2011	1037

2012	1217
2013	1192
2014	1203
2015	1309

Source: ISD Scotland

6.3.2 Emergency Admission to Hospital

The rate of emergency admissions to hospital (per 100,000 population) in Clackmannanshire and Stirling has been lower than the Scotland rate for the last ten years. The actual number of admissions has risen and fallen over the time period in both local authority areas. The figures for admissions are based on the person's home postcode.

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

Clackmannanshire	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Clackmannanshire admissions	4,049	4,059	4,151	4,623	4,537	4,345	4,182	4,100	4,470	4,621
Clackmannanshire rate (per 100,000 pop.)	8,319	8,257	8,379	9,136	8,863	8,471	8,147	7,961	8,717	9,011
Scotland rate (per 100,000 pop.)	**9,196**	**9,222**	**9,537**	**9,849**	**10,021**	**9,849**	**9,874**	**10,090**	**10,130**	**10,188**

Source: ISD Scotland

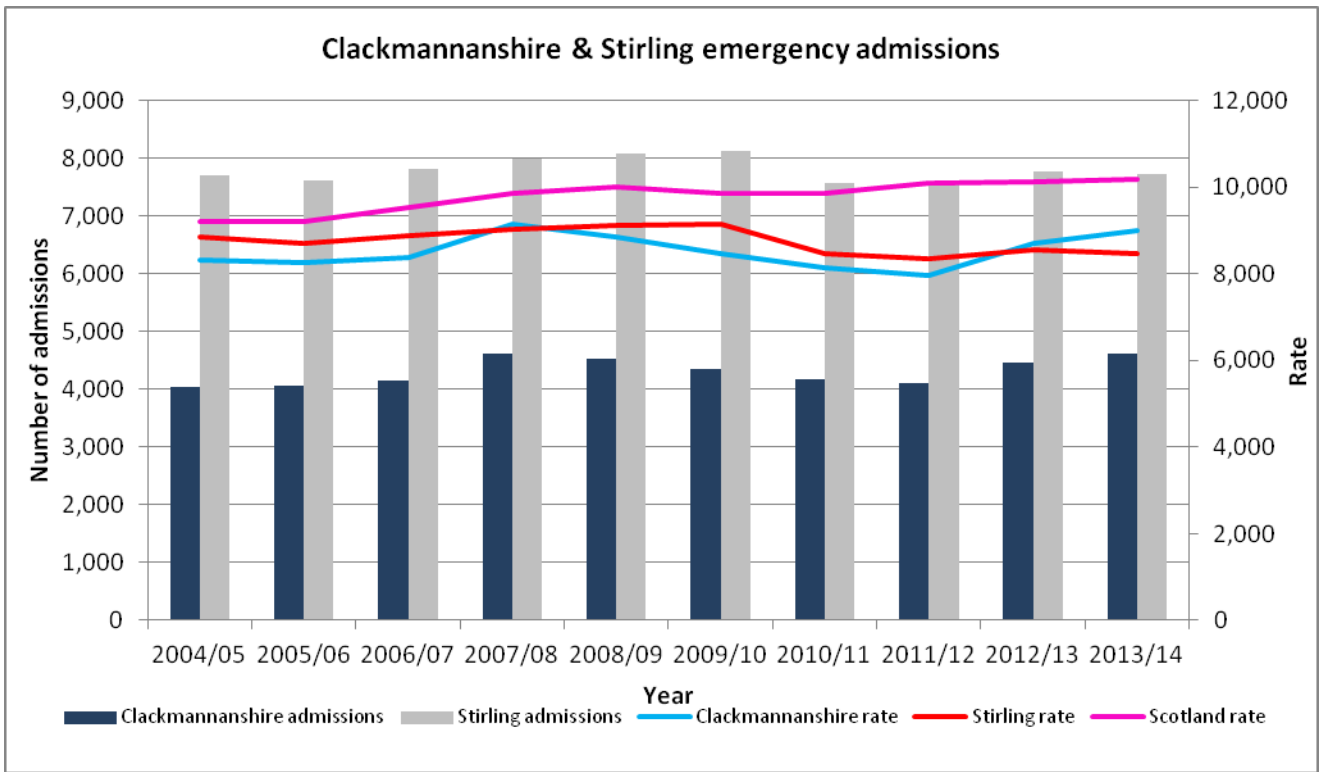
Table 6.3.2b Emergency admissions to hospital – Stirling 2004/05 to 2013/14

Stirling	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Stirling admissions	7,698	7,625	7,820	7,987	8,074	8,126	7,584	7,545	7,781	7,730
Stirling rate (per 100,000 pop.)	8,857	8,713	8,877	9,032	9,119	9,162	8,469	8,353	8,549	8,470
Scotland rate (per 100,000 pop.)	**9,196**	**9,222**	**9,537**	**9,849**	**10,021**	**9,849**	**9,874**	**10,090**	**10,130**	**10,188**

Source: ISD Scotland

The figure below shows the information in the tables above in chart form.

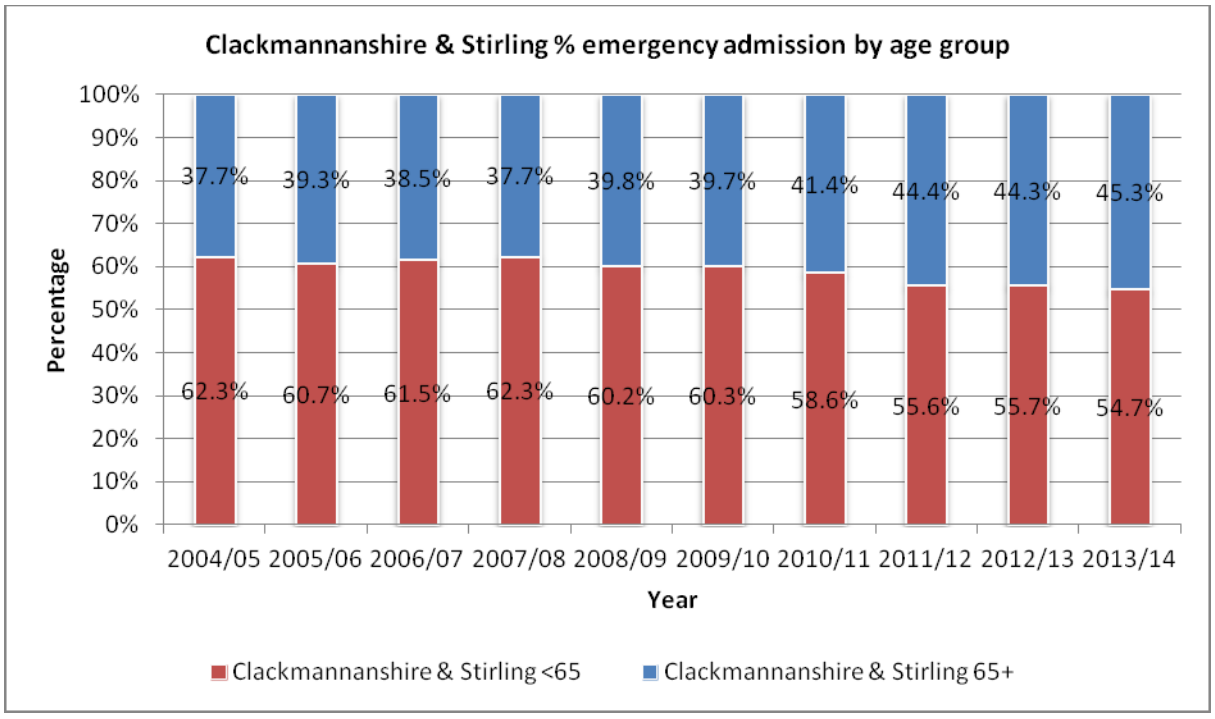
Figure 6.3.2a Emergency admissions to hospital – Clackmannanshire & Stirling 2004/05 to 2013/14



Source: ISD Scotland

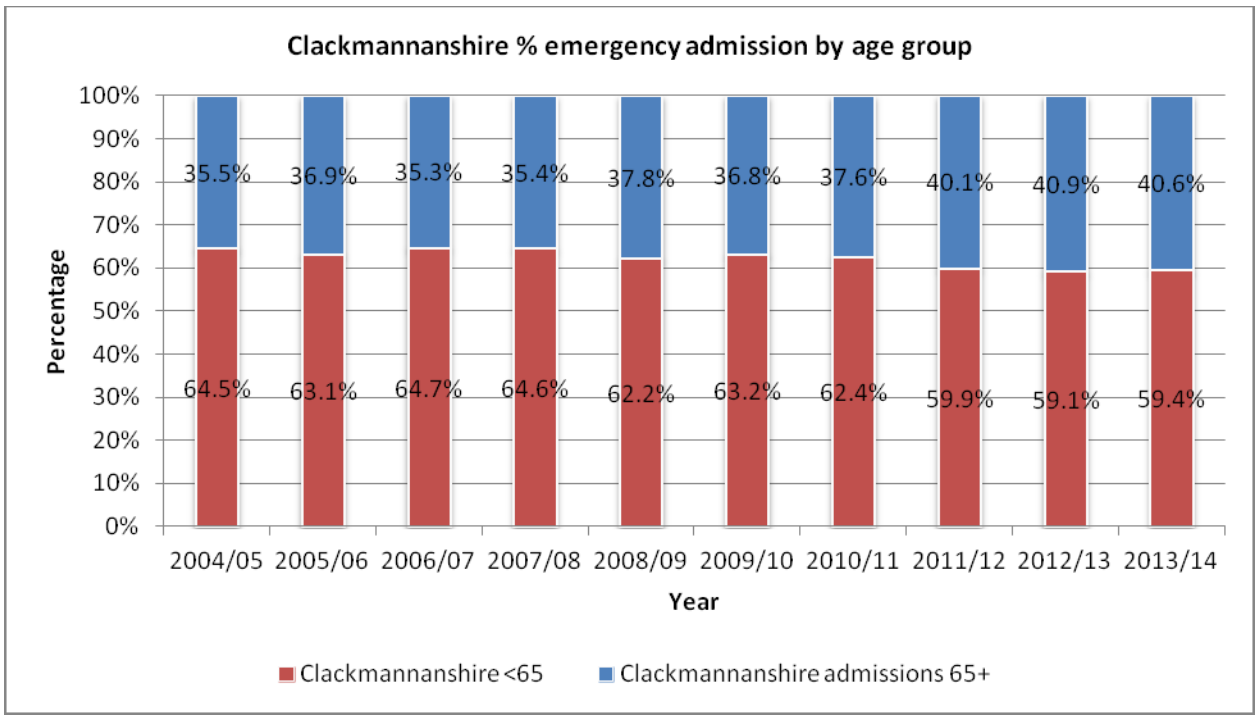
Within the increase in the number of emergency admissions is an increase in the number of admissions for people aged 65 and above. A greater proportion of all admissions now come from this cohort of patients. Figure 6.3.2b below shows the increase of this group from 37.7% of all admissions in 2004/2005 to 45.3% in 2013/2014. Figures 6.3.2c and 6.3.2d show that the increase of this group was greater in Stirling than Clackmannanshire.

Figure 6.3.2b Percentage emergency admissions by age group 2014/05 – 2013/14



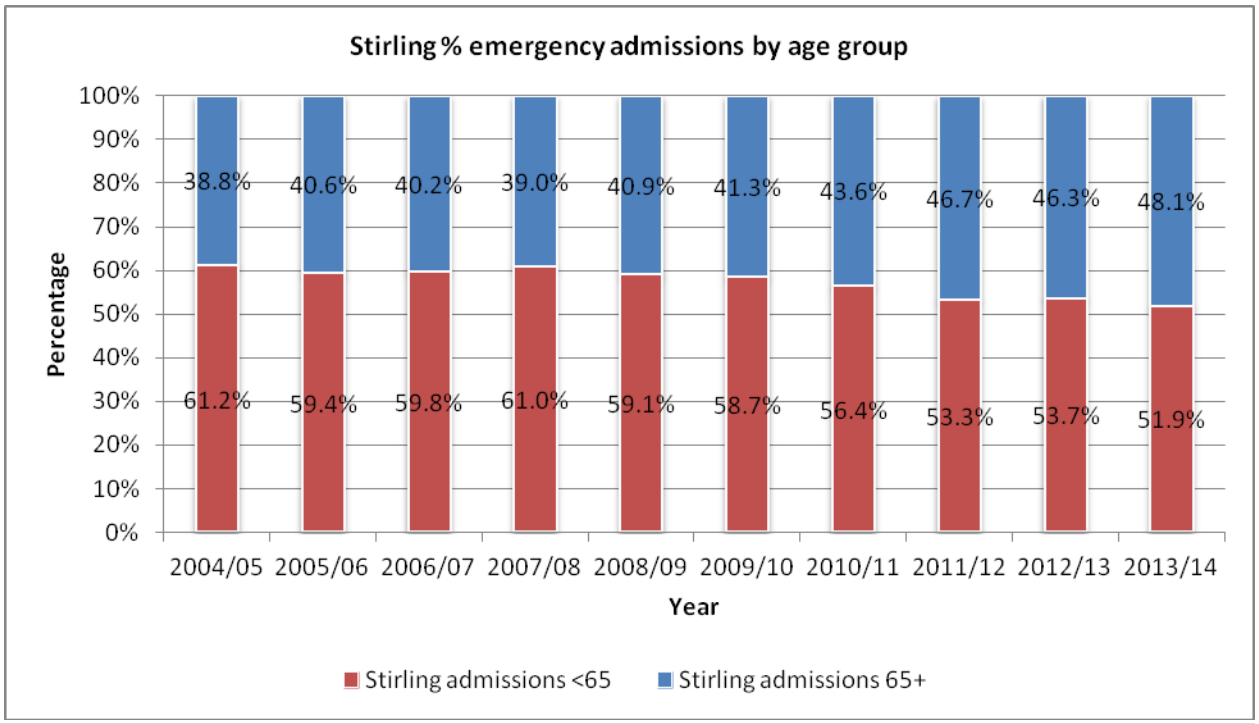
Source: ISD Scotland

Figure 6.3.2c Percentage emergency admissions by age group, Clackmannanshire 2014/05 – 2013/14



Source: ISD Scotland

Figure 6.3.2d Percentage emergency admissions by age group, Stirling 2014/05 – 2013/14



Source: ISD Scotland

Multiple admissions

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

In Clackmannanshire and Stirling the rate for people who have had 2 or more emergency admissions was higher in 2013/14 than in 2004/05. This information is shown in the tables below for both local authority areas.

Table 6.3.2c Rate and number of people with two or more emergency admissions Clackmannanshire 2004/05 – 2013/14

Local Council Area	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Clackmannanshire admissions	615	602	655	771	724	698	661	672	729	751
Clackmannanshire rate (per 100,000 pop)	1,264	1,225	1,322	1,524	1,414	1,361	1,288	1,305	1,422	1,465
Scotland rate (per 100,000 pop)	**1,493**	**1,495**	**1,566**	**1,639**	**1,695**	**1,664**	**1,682**	**1,737**	**1,762**	**1,771**

Source: ISD Scotland

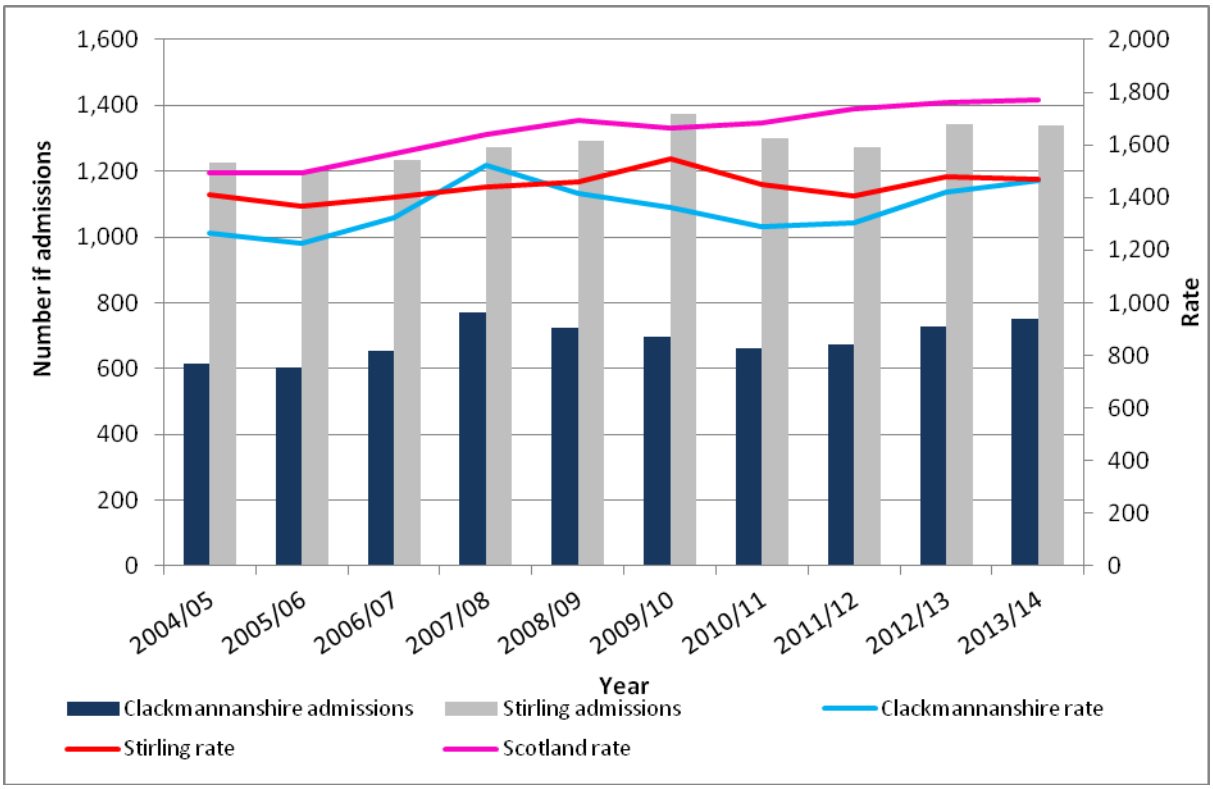
Table 6.3.2d Rate and number of patients with two or more emergency admissions Stirling 2004/05 – 2013/14

Local Council Area	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Stirling admissions	1,227	1,197	1,233	1,274	1,293	1,374	1,299	1,272	1,344	1,339
Stirling rate (per 100,000 pop.)	1,412	1,368	1,400	1,441	1,460	1,549	1,451	1,408	1,477	1,467
Scotland rate (per 100,000 pop.)	**1,493**	**1,495**	**1,566**	**1,639**	**1,695**	**1,664**	**1,682**	**1,737**	**1,762**	**1,771**

Source: ISD Scotland

Figure 6.3.2e shows the number of admissions for Clackmannanshire and Stirling and the rates for the two areas compared to the Scotland rate. The admissions rate for Clackmannanshire has risen steadily over the last four years.

Figure 6.3.2e Rate (per 100,000 population) and number of patients with 2 or more emergency admissions Clackmannanshire & Stirling 2004/05 – 2013/14



Source: ISD Scotland

As with the number of total emergency admissions, the number of multiple emergency admissions for people aged 65 and above is also increasing in Clackmannanshire and Stirling. The percentage increase of admissions for patients aged 65 plus is greater than the percentage increase for all ages.

The table below shows the percentage increase for all ages and those aged 65 plus between 2004/05 and 2013/2014. The percentage increase for multiple admissions was greatest for those aged 65 and above in Stirling, which went up by 32.3%.

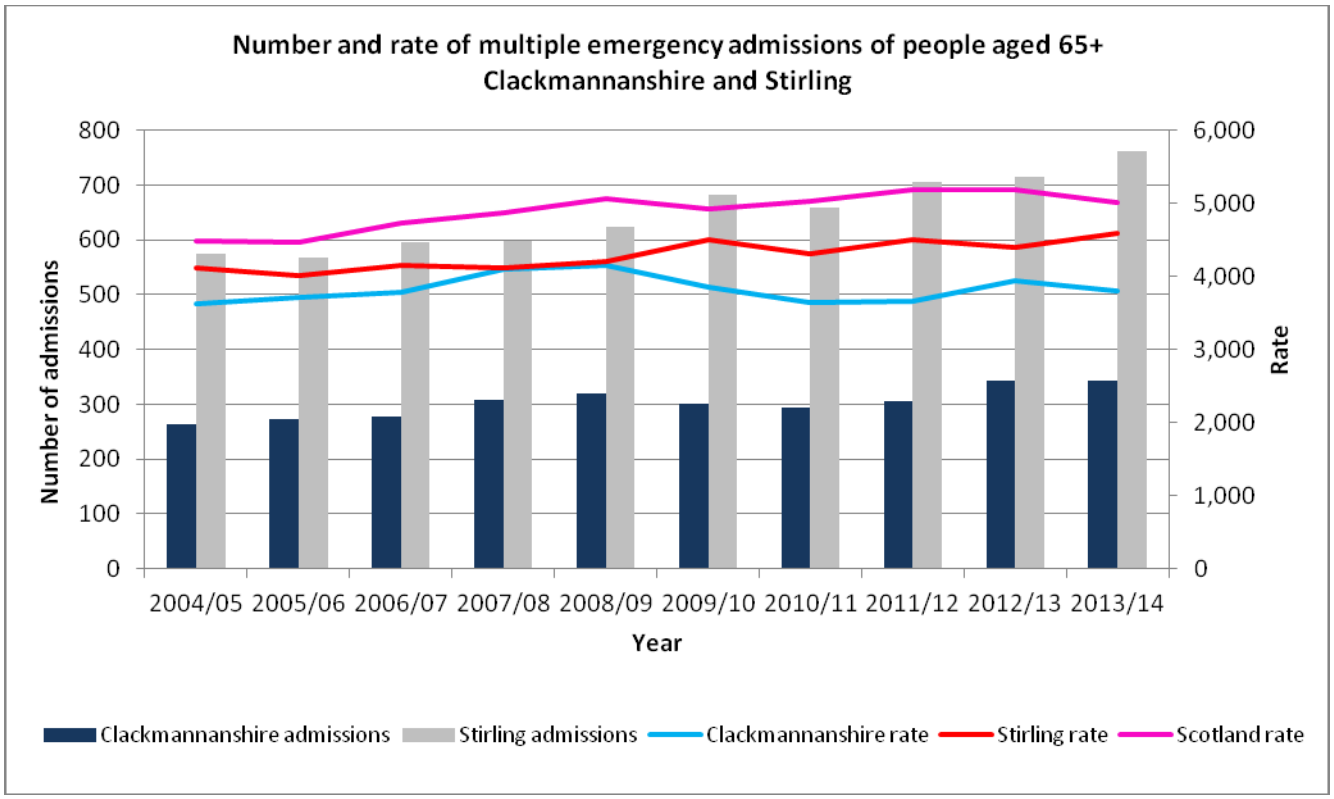
Table 6.3.2e Increase in multiple emergency admissions 2004/05 to 2013/14

	All ages*		65 +	
Area	N	%	N	%
Clackmannanshire	136	22.1%	79	29.9%
Stirling	112	9.1%	186	32.3%
Clackmannanshire & Stirling	248	13.5%	265	31.6%

*Patients with 2 or more admissions
Source: ISD Scotland

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

Figure 6.3.2f Number and rate of multiple emergency admissions for people aged 65+ in Clackmannanshire and Stirling 2004/05 to 2013/14



Source: ISD Scotland

6.4 Delayed Discharges from Hospital

A delayed discharge occurs when a person, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available. The following provides an overview of delayed discharges for Clackmannanshire and Stirling.

At the October 2015 census the total number of standard delays for Clackmannanshire was three. There were zero delays over six weeks, one was more than four weeks and one was more than two weeks. In Stirling there were 10 standard delays, three were delayed more than six weeks, five were more than four weeks and 10 were more than two weeks.

Table 6.4a Delayed Discharges by Length of Delay, October 2015

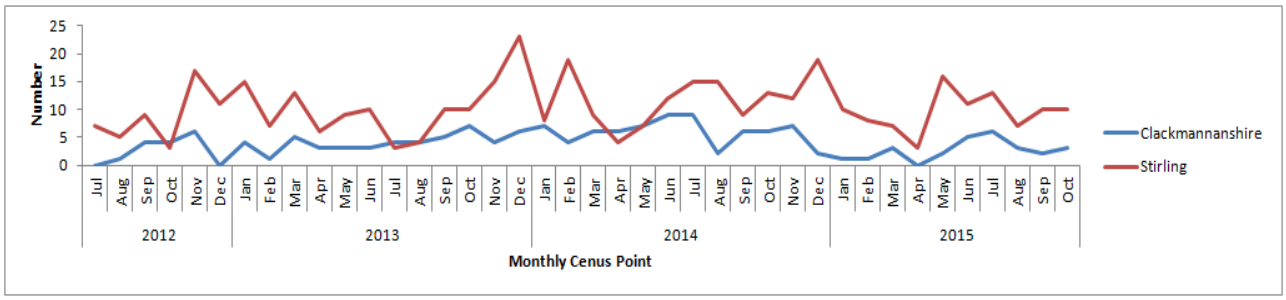
	Total Standard Delay	More than 6 weeks	More than 4 weeks	More than 2 weeks
Clackmannanshire	3	0	1	1
Stirling	10	3	5	10
Clackmannanshire & Stirling HSCP	13	3	6	11

Source: ISD Scotland

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

Figure 6.4a illustrates the low and fluctuating levels of delayed discharge patients in Clackmannanshire and Stirling from July 2012 to October 2015.

Figure 6.4a Total number of standard delays, July 2012 – October 2015.



Source: ISD Scotland

Table 6.4b shows the number of bed days lost in the quarter July 2015 to September 2015, 1,197 in Clackmannanshire and 1,748 in Stirling. There were a greater proportion due to Code 9 delays in Clackmannanshire (51.1%) than in Stirling (28.7%) and Scotland (20.8%). Code 9 was introduced for very limited circumstances where NHS Chief Executives and Local Authority Directors of Social Work (or their nominated representatives) could explain why the discharge of people was out with their control. Around two thirds (64.1%) of all people delayed in Clackmannanshire, between July 2015 and September 2015, were aged 75 and over compared to 82.3% in Stirling and 70.5% in Scotland.

Table 6.4b Bed Days Occupied by Delayed Discharge Patients by Age Group and Delay Type: July 2015 to September 2015

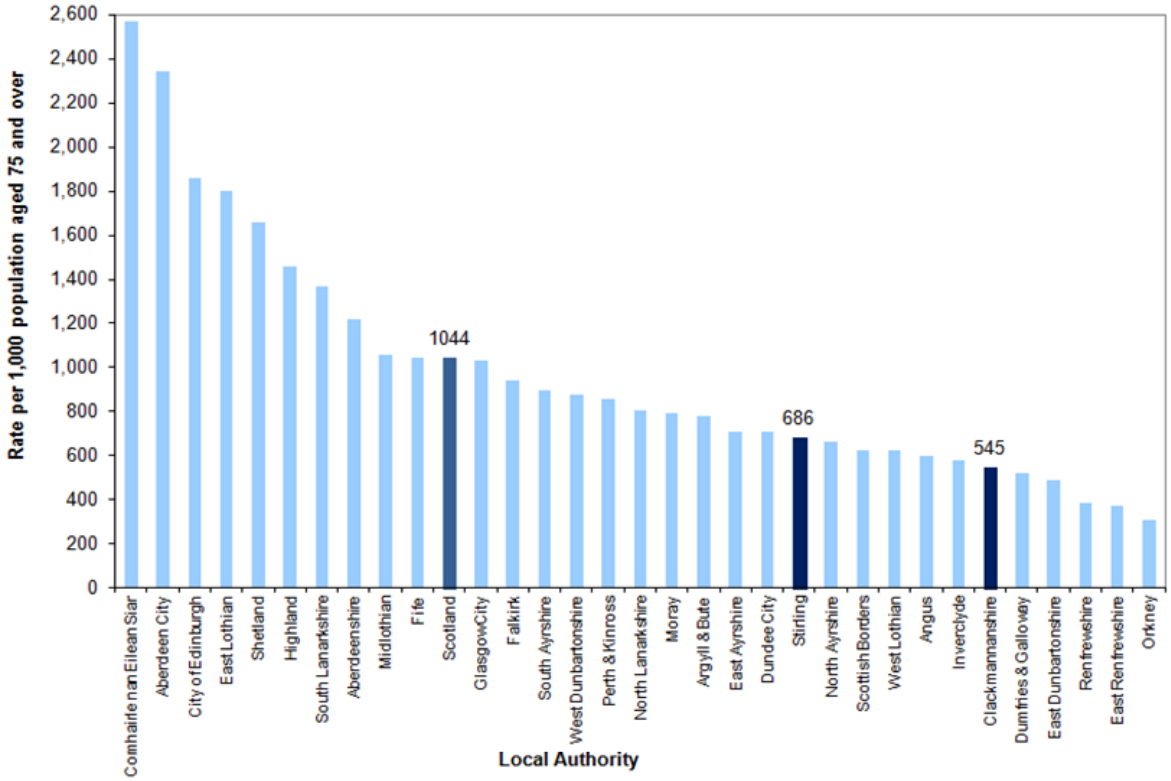
	All Ages					18 - 74 years					75 + years				
Local Authority of Residence 1	Total	Standard	%	Code 9	%	Total	Standard	%	Code 9	%	Total	Standard	%	Code 9	%
Clackmannanshire	1,197	585	48.9	612	51.1	430	66	15.3	364	84.7	767	519	67.7	248	32.3
Stirling	1,748	1,247	71.3	501	28.7	310	231	74.5	79	25.5	1,438	1,016	70.7	422	29.3
Clackmannanshire & Stirling HSCP	2,945	1,832	62.2	1,113	37.8	740	297	40.1	443	59.9	2,205	1,535	69.6	670	30.4
Scotland	144,414	114,435	79.2	29,979	20.8	42,646	31,420	73.7	11,226	26.3	101,768	83,015	81.6	18,753	18.4

Source: ISD Scotland

Figure 6.4b (below), is taken from the ISD delayed discharge publication. This particular chart is updated annually and the latest available information is presented for the year April 2014 to March 2015. Both Stirling and Clackmannanshire have a lower delayed discharge rate per 1,000 population aged 75+ than Scotland with Clackmannanshire having the 6th lowest rate.

Figure 6.4b Bed days occupied by delayed discharge patients per 1,000 population aged 75+, April 2014 to

March2015



Source: ISD Scotland

6.5 Community Care Assessments

The number of community care assessments completed and the number of people receiving one gives an indication of the volume of activity in social care services.

Between April 2013 and March 2014 there were 2,626 people that had a community care assessment completed in Clackmannanshire, less than 1% of whom were under 18. Of the remaining 2,606, 31% were aged between 18-64 and 69% were 65 years of age or more.

For those aged 18-64, the largest care group was those with a physical disability (66.3%), followed by those with a learning disability (17.6%). For those aged 65 and over the largest care group similarly were those with a physical disability (63.5%) followed by older adults (20.2%) and those with dementia (11.5%). Two thirds of those with a physical disability were 75 and over as were the majority with dementia (88.5%). The number of people (aged 18 and over) with a completed care assessment has been decreasing annually over the past five years, from 3,096 in 2009/10 to 2,606 in 2013/14 (this includes all assessments including reviews).

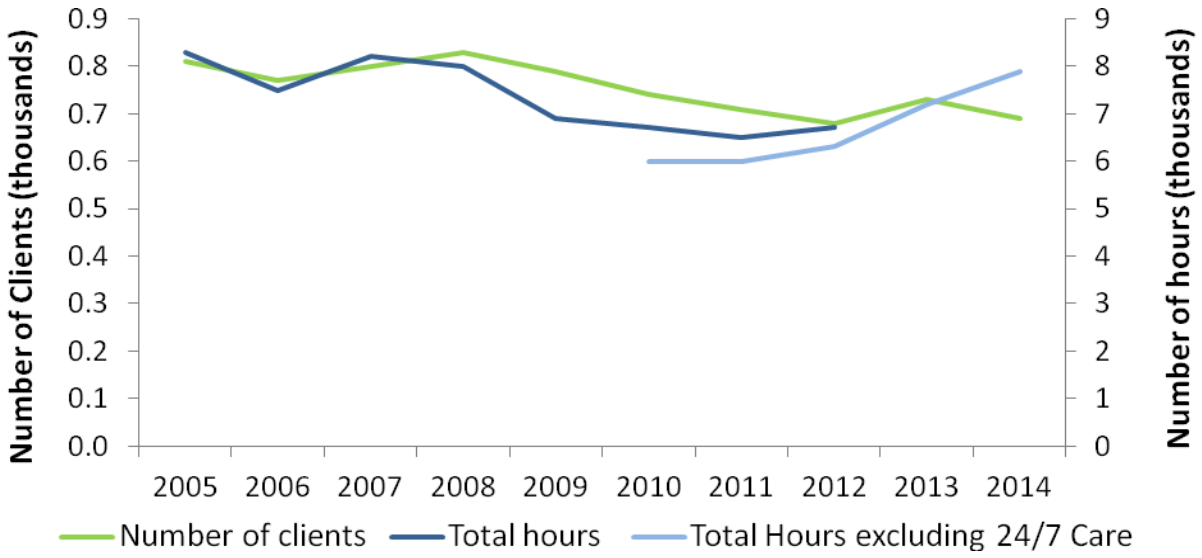
In the same twelve month period in Stirling 2,771 people received a community care assessment and similarly less the 1% were under 18 years of age. Of the remaining 2,749 20% were aged 18-64 and 80% 65 and over. For those aged 18-64 the largest care group was those with a physical disability (41.4%) followed by those with a learning disability (18.4%). For those aged 65 and over the largest care group were those classed as Frail Elderly (58.7%) followed by those with a physical disability (16.3%). Two thirds of those with a physical disability were aged 75 and over as were the majority of the Frail Elderly group (91%). The number of people (aged 18 and over) with a completed care assessment has risen from 2,610 in 2010/11 to 2,749 in 2013/14.

6.6 Care at Home

Care at home is care provided in a person's own home to enable them to maintain their independence. It involves regular visits from a care at home worker and may include personal care, shopping, preparing meals and the collection of items such as pensions and prescriptions. According to the 2014 Social Care Services report, there were 693 people receiving care at home in Clackmannanshire and 1,245 in Stirling during the March 2014 census week. Figure 6.6a illustrates that in Clackmannanshire the number of people receiving care at home has been decreasing since 2008 (withstanding an increase in 2013) and has fluctuated around 700 for the last five years. In contrast the number of hours of care provided decreased in 2009 but has increased in the past few years. The past five years has seen the average hours per client increase from 9.1 in 2010 to 11.4 in 2014.

In Stirling both the number of people and hours have been increasing (Figure 6.6b) and in March 2014 the average hours per client was 14.9.

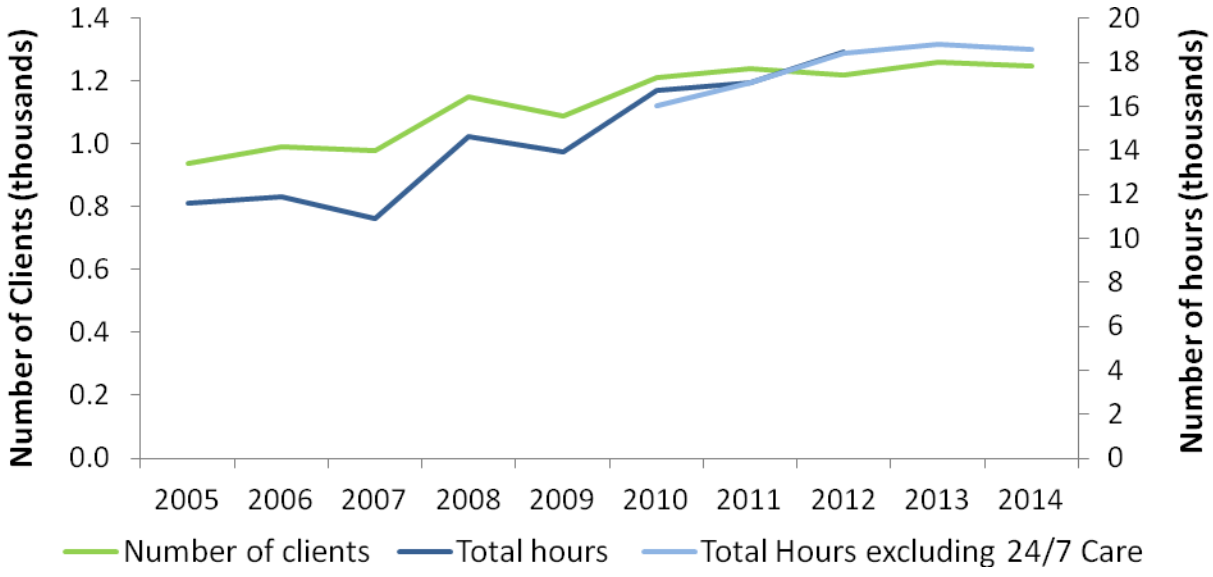
Figure 6.6a Care at Home Clients and Hours provided, 2005-2014, Clackmannanshire



* from 2013 local authorities were asked to class 24-7 care as Housing Support, not Home Care. Figures rounded to the nearest 10.

Source: Social Care Services, 2014

Figure 6.6b Care at Home Clients and Hours provided, 2005-2014, Stirling



* from 2013 local authorities were asked to class 24-7 care as Housing Support, not Home Care. Figures rounded to the nearest 10.

Source: Social Care Services, 2014

Table 6.6a Care at home clients and age, 2014

Local Authority	0-64		65-74		75-84		85+		Total
	No	%	No	%	No	%	No	%	
Clackmannanshire	153	22.1	108	15.6	206	29.7	226	32.6	693
Stirling	383	30.8	157	12.6	335	26.9	370	29.7	1245

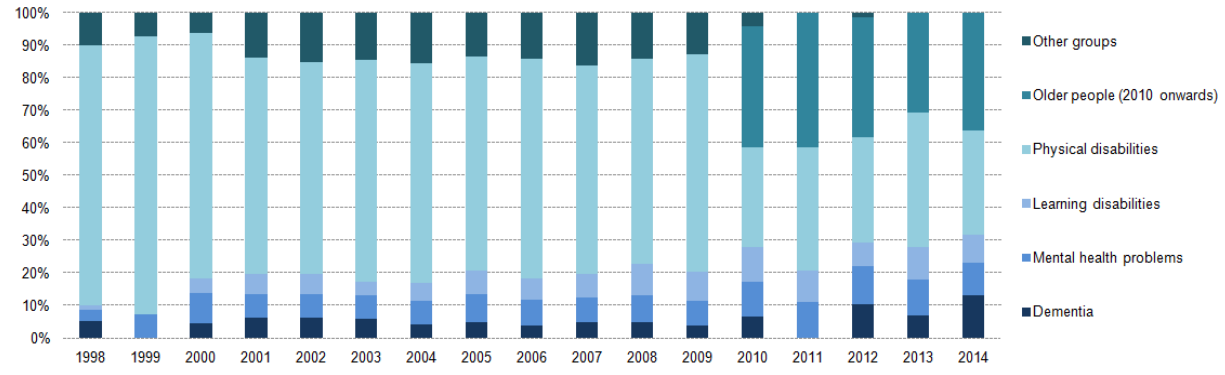
Source: Social Care Services, 2014

At March 2014 of those receiving care at home in Clackmannanshire 22.1% were aged under 65 and 77.9% were aged 65 and over. A third (32.6%) of all those receiving care at home were aged 85 and over. A smaller proportion of people were aged 65 and over in Stirling (69.2%) and similarly almost a third (29.7%) were aged 85 and over.

Of those people aged 65 and over a third in both Clackmannanshire (36%) and Stirling (35%) were receiving 10 hours or more a week comparative to Scotland (33%). In both local authorities half of those aged under 65 were receiving 10 hours or more a week (52% in Clackmannanshire and 51% in Stirling), slightly more than in Scotland (46%).

Figures 6.6c and 6.6d show that in March 2014 while the greatest proportion of all clients receiving care at home in Stirling were Older people, in Clackmannanshire the greatest proportion were either Older people or those with a physical disability.

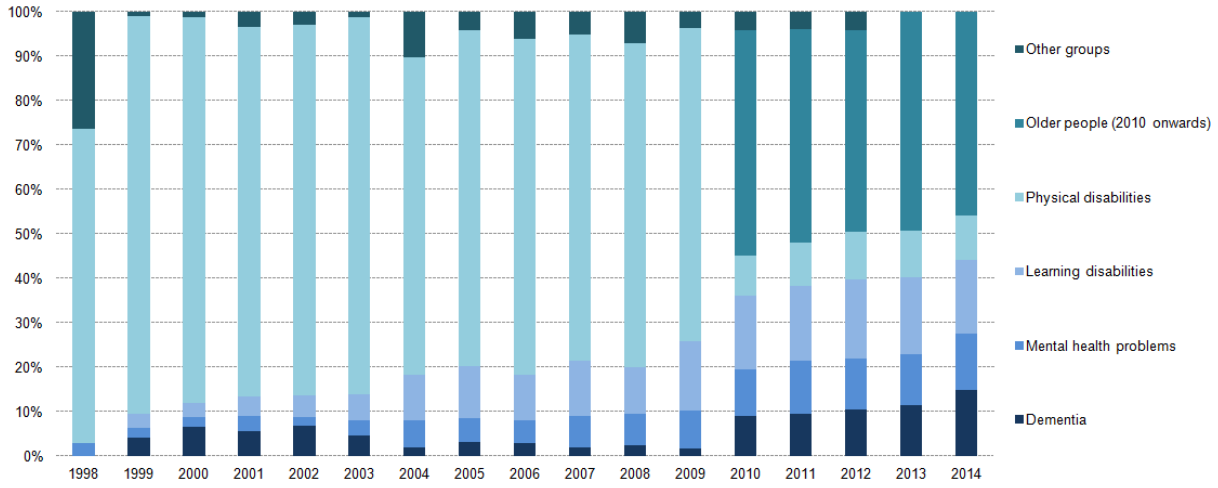
Figure 6.6c Client group breakdown of clients receiving Care at home in Clackmannanshire, 1998-2014



Notes: Figures rounded to the nearest 10. Some figures have been suppressed with a "" to protect small numbers.*

Source: Social Care Survey 2013 and 2014 (Home Care Census prior to 2013)

Figure 6.6d Client group breakdown of clients receiving Care at home in Stirling, 1998-2014



Notes: Figures rounded to the nearest 10. Some figures have been suppressed with a "" to protect small numbers.*

Source: Social Care Survey 2013 and 2014 (Home Care Census prior to 2013)

The following tables, taken from the Social Care Survey 2014, provides details of the number of hours of care at home older adults in Clackmannanshire and Stirling received between 2005 and 2014. They show that since 2005 more older people have received less than ten hours of care at home than greater than ten hours but that the proportion of those receiving more than ten hours has increased over this period with Stirling showing the greater increase.

Table 6.6b Care at home hours received for people aged 65 plus in Clackmannanshire, 2005-2014

Hours taken	Number /	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
2 hours or less	of Clients	80	70	70	90	110	90	80	90	100	80
	% of total	13%	13%	13%	15%	18%	16%	15%	16%	17%	14%
Between 2 and 4 hours	of Clients	160	160	160	140	150	120	120	90	110	90
	% of total	27%	28%	28%	24%	26%	22%	21%	17%	20%	16%
Between 4 and 10 hours	of Clients	190	200	190	180	190	210	220	200	180	180
	% of total	31%	35%	33%	31%	32%	38%	39%	36%	32%	34%
Greater than 10 hours	of Clients	170	140	150	170	130	140	140	170	180	190
	% of total	29%	24%	27%	29%	23%	24%	25%	32%	31%	36%
Total clients		**590**	**570**	**570**	**590**	**580**	**560**	**560**	**550**	**570**	**540**

Source: Social Care Survey 2013 and 2014 (Home Care Census prior to 2013). Figures rounded to the nearest 10.

Table 6.6c Care at home hours received for people aged 65 plus in Stirling, 2005-2014

Hours taken	Number /	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
2 hours or less	of Clients	210	220	210	240	200	180	180	130	150	170
	% of total	32%	31%	30%	30%	29%	22%	22%	16%	17%	19%
Between 2 and 4 hours	of Clients	180	170	160	200	150	160	130	130	170	130
	% of total	27%	25%	23%	25%	21%	20%	16%	16%	20%	15%
Between 4 and 10 hours	of Clients	180	210	200	220	220	240	230	230	240	260
	% of total	27%	29%	30%	28%	31%	29%	29%	29%	27%	31%
Greater than 10 hours	of Clients	100	110	110	140	140	240	260	300	310	300
	% of total	14%	15%	16%	17%	20%	29%	33%	38%	36%	35%
Total clients		**670**	**710**	**670**	**800**	**710**	**810**	**800**	**800**	**870**	**860**

Source: Social Care Survey 2013 and 2014 (Home Care Census prior to 2013). Figures rounded to the nearest 10.

The following tables present information on the number of older people who are either receiving intensive home care, resident in a care home or in continuous hospital care from 2006 to 2015. They show that in 2014 of this group a greater proportion were receiving intensive care at home than in a hospital or care home setting in both Clackmannanshire (47.3%) and Stirling (39.2%). While this proportion has increased in both since 2006, Stirling has seen the greatest increase.

Table 6.6d Percentage aged 65 plus receiving 10+ hrs of care at home in Clackmannanshire, 2006 to 2015

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Home Care 10+ hrs	137	154	172	132	136	140	172	180	193	*tbc*
Long stay care home residents	262	257	246	240	233	225	214	219	214	197
Continuing care census	19	15	18	8	10	7	4	4	1	2
Total	**418**	**426**	**436**	**380**	**379**	**372**	**390**	**403**	**408**	***tbc***
Percentage 10+ hrs home care	32.7%	36.1%	39.4%	34.8%	35.9%	37.6%	44.1%	44.7%	47.3%	*tbc*

Sources : Scottish Government Quarterly Monitoring, Social Care Survey and Continuing Care Census.

Source: Scottish Government, Health and Social Care Data

Table 6.6e Percentage aged 65 plus receiving 10+ hrs of care at home in Stirling, 2006 to 2015

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Home Care 10+ hrs	108	110	136	141	239	262	303	315	301	*tbc*
Long stay care home residents	546	522	524	523	515	474	459	447	459	436
Continuing care census	59	58	50	2	23	23	9	7	7	9
Total	**713**	**689**	**709**	**666**	**777**	**759**	**771**	**769**	**767**	***tbc***
Percentage 10+ hrs home care	15.1%	16.0%	19.2%	21.2%	30.7%	34.5%	39.3%	41.0%	39.2%	*tbc*

Sources : Scottish Government Quarterly Monitoring, Social Care Survey and Continuing Care Census.

Source: Scottish Government, Health and Social Care Data

Care at home reported in the Social Care Survey excludes people receiving care at home with a direct payment (Option 1 under Self Directed Support). To give an indication of the level of care at home provision for all clients, including those who receive it with a Direct Payment, information from Clackmannanshire Council showed that between April 2013 and March 2014 there were 1,094 people receiving 433,005 hours of care at home (Source: Clackmannanshire Council Community Care Information System).

Reablement is a care at home service that works with people for up to six to eight weeks to give them the support, skills and confidence to stay at home or be able to return after a stay in hospital. During the financial year 2014/15 there were 280 people who received the reablement service in Clackmannanshire and 600 in Stirling. Stirling's figure also includes people who received rehabilitation which is defined as the process of the restoration of skills by a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible.

6.7 Self-Directed Support

The implementation of the Social Care (Self Direct Support) (Scotland) Act 2013 has required a major change in how social care services are assessed, planned and delivered. The shifting expectations of people, who will want more choice and control and an enabling rather than a 'doing to' attitude and approach, was a key driver behind the Act. The ten year SDS Strategy will drive a cultural shift on the delivery on services that views people as equal citizens with rights and responsibilities. Principles mean a right to practical assistance and support to participate in society and lead an ordinary life (SDS National Strategy for Scotland, 2010).

The principles are: Involvement; Informed Choice; Collaboration; Dignity; Participation (Control) through improving Outcomes using a personalisation approach and providing safe, sustainable and economically viable responses to support planning.

The Local Authority have a duty to give the Supported Person (SP) the opportunity to choose from one of four options and an explanation of the nature and effect of each of the options. The Options are:

Option 1 – Direct Payment

Your Individual Budget will be paid (in instalments) into a dedicated bank account. This gives you the flexibility and the choice to use this money to buy your own support.

Option 2 – Individual Service Fund

You can ask Social Services or a Provider organisation to hold your Individual Budget. You will direct them on how you wish to spend this money.

Option 3 – Arranged Service

You can ask Social Services to arrange for, and directly pay for, the support you need.

Option 4 – Combined Support

You can have a combination of options 1, 2 and/or 3. For instance some services arranged by Social Services and some by yourself.

The section below provides information on Direct Payments (Option 1).

Direct Payments (Option 1)

The number of people receiving Direct Payments increased from 30 in March 2005 to 44 in March 2014 in Clackmannanshire and from 25 to 99 over the same period in Stirling.

In March 2014 over a third (38.6%) in Clackmannanshire and over half (51.5%) in Stirling were aged 65 and over.

(Source: Social Care Services 2014, www.gov.scot/Publications/2014/11/1085/downloads)

6.8 Day Care

Day care offers personal care during the day for those who are assessed as needing it and is usually provided in a day care centre for those with complex physical and social care needs. Table 6.8a provides an overview of clients in Clackmannanshire receiving Day Care in 2013/14. It shows that almost two thirds (63.3%) were aged 65 and over and the highest proportion of clients (39%) were those with a Physical Disability followed by those with a Learning Disability (22.8%). While the older adults (65+) accounted for a greater proportion of the client group it was the younger adults (18-64) who received the greatest proportion of the total number of days provided (55.3%). This may be because the second largest client group, those with a Learning Disability, had the highest proportion of days provided (38.7%) and the majority of these people were under 65 years of age (95%).

Table 6.8a Day Care in Clackmannanshire by care group and age, 2013/14

	18 to 64		65+		Total	
	Number of People	Number of Days	Number of People	Number of Days	Number of People	Number of Days
Alcohol Problem	1	104	0	0	1	104
Autistic Spectrum Disorder	2	130	0	0	2	130
Dementia	2	148	55	3772	57	3920
Dual Sensory Impairment	0	0	4	193	4	193
Elderly	0	0	40	2109	40	2109
Hearing Impairment	2	416	7	441	9	857
Learning Disability	75	11090	4	312	79	11402
Mental Health	3	301	7	311	10	612
Physical Disability	42	4100	93	5464	135	9564
Terminal Illness	0	0	2	86	2	86
Visual Impairment	0	0	7	454	7	454
Total	127	16289	219	13142	346	29431

Source: Clackmannanshire Council, Adult Care Bulletin, 2013/14

In the past five years both the number of clients and days provided have been declining in Clackmannanshire, from 414 clients in 2009/10 to 346 in 2013/14 and 32,642 days in 2009/10 to 29,431 in 2013/14.

Table 6.8b provides an overview of day care provision in Stirling and shows that there were 181 clients attending day care during 2013/14, 63% of whom were under 65 years of age. The largest group of people attending were those with a learning disability who accounted for just over half (51.5%) of the weekly planned hours.

Table 6.8b Day Care in Stirling by care group and age, 2013/14

	18-64		65+		Total	
	Number of People	Number of weekly planned hours	Number of People	Number of weekly planned hours	Number of People	Number of weekly planned hours
Alcohol Misuse	0	0	0	0	0	0
Dementia Diagnosed	0	0	10	12	10	12
Frail Elderly	0	0	29	38	29	38
Learning Disability	88	117	12	14	100	131
Palliative Care	0	0	2	3	2	3
Physical Disability	16	31	12	22	28	53
Other	10	15	2	2	12	17
Total	**114**	**163**	**67**	**91**	**181**	**254**

Source: Stirling Council intranet site

Over the past four years while the number of clients attending day care initially rose (from 299 in 2010/11 to 351 in 2010/11) it has been declining in the past two years.

6.9 Telecare

Telecare is the remote or enhanced delivery of care services to people in their own home by means of telecommunications and computerised services. The basic level of telecare is a community alarm (a basic package which consists of a communication hub plus a button/pull chords/pendant which transfers an alert/alarm/data to a monitoring centre or individual responder) while a more advanced package can include technology such as linked pill dispensers, linked smoke detectors and linked key safes. According to the 2014 Social Care Services report, the majority of telecare clients in Clackmannanshire have a community alarm only with a few having telecare only which has been the case for the last four years. In Stirling however, there has been a shift away from having community alarms only to having them in conjunction with telecare.

In March 2014 of those receiving a community alarm and/or other telecare service in Clackmannanshire 16.2% (229 clients) were aged under 65 and 83.8% (1,185 clients) were 65 and over. In Stirling 12.6% (246 clients) were aged under 65 and 87.4% (1,709 clients) were 65 and over.

6.10 Care Homes

A care home is a place where people can live in a homely setting and have their needs met by trained staff. The 2015 Care Home Census reported that there were 11 Care Homes in Clackmannanshire and 25 in Stirling with 342 and 691 registered places, respectively. The total number of residents in these care homes at the time of the census was 318 in Clackmannanshire (93% occupancy) and 609 in Stirling (88% occupancy). The majority of people were long stay residents in both Clackmannanshire (94.3%) and Stirling (91.8%).

The census reports on all people resident in the care home at the time of the census. The number of people placed in these care homes by each council during the same period however was much lower, 236 in Clackmannanshire and 359 in Stirling. The difference between these figures and the number of residents at the time of the census reflects that number of people who were not placed in care homes by the local authority.

Of the 11 care homes in Clackmannanshire, five are for people over the age of 65, four are for people with physical or learning disabilities and two are specifically for people with a mental health problem. Three of the five care homes for older people provide nursing care whilst the other two provide residential or intermediate care. All other homes in the area provide residential care only.

In Stirling, 17 care homes are specifically for older people, of which eight provide nursing care, three provide intermediate care and the remainder provide residential care. In addition there are four residential care homes that provide support to people with mental health problems and a further four homes that provide residential care to people with disabilities. One of these is a national resource for people with Prader-Willi syndrome and thus not specific to the area and a further two are not currently used by Stirling Council.

For the 2015 census the number of long stay residents decreased slightly from the previous year in both Clackmannanshire and Stirling (from 331 and 579, respectively).

The census reported that 71% of long stay residents in Clackmannanshire required nursing care compared with 42% in Stirling and around a third of long stay residents in both had medically diagnosed dementia. In 2014 68% of long stay care home residents in Clackmannanshire required nursing care and half of those in Stirling.

Table 6.10a Characteristics of Long Stay Residents, March 2015

Type of Resident	Clackmannanshire	Stirling
Total Number of Long Stay Residents	**300**	**559**
Characteristics of Long Stay Residents	**%**	**%**
Requiring Nursing Care	71	42
Visual Impairment	7	8
Hearing Impairment	6	5
Acquired Brain Injury	2	3
Other Phys.Dis. Or Chronic Illness	26	28
Dementia (Medically Diagnosed)	32	34
Dementia (Not Medically Diagnosed)	5	1

Mental Health Problems	9	10
Learning Disability	17	19
Alcohol Related Problems	*	*
Drugs Related Problems	*	*
None of these	*	*

Residents may have more than one characteristic and so percentages will not add up to 100%.
* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain resident confidentiality.
Source: Care Homes Census, 2015

At the time of the 2015 census long stay residents in Clackmannanshire were 63% female (37% male) and 59% female (41% male) in Stirling. Their average age was 75 years in Clackmannanshire and 71 years in Stirling. The mean complete length of stay was 2.5 years in Clackmannanshire and 2.8 years in Stirling while the mean incomplete length of stay (for those still living at the care home at the time of the census) was 5.2 years in Clackmannanshire and 4.9 years in Stirling. Tables 6.10b and 6.10c show how the mean and median complete and incomplete length of stay has changed over the past five years.

Table 6.10b Mean and Median Complete and Incomplete Length of Stay for Long Stay Residents in Clackmannanshire, 2011-2015

Mean and Median Complete and Incomplete Length of Stay (years)	2011	2012	2013	2014	2015
Mean Complete Length of Stay	4.2	3.0	1.9	2.2	2.5
Median Complete Length of Stay	1.9	1.9	0.6	1.1	1.7
Mean Incomplete Length of Stay	6.1	3.6	5.4	5.1	5.2
Median Incomplete Length of Stay	3.7	2.3	2.5	1.9	2.2

Source: Care Home Census, 2015

Table 6.10c Mean and Median Complete and Incomplete Length of Stay for Long Stay Residents in Stirling, 2011-2015

Mean and Median Complete and Incomplete Length of Stay (years)	2011	2012	2013	2014	2015
Mean Complete Length of Stay	3.4	3.0	2.2	2.9	2.8
Median Complete Length of Stay	2.1	2.3	0.9	2.1	2.2
Mean Incomplete Length of Stay	4.0	3.9	4.2	4.6	4.9
Median Incomplete Length of Stay	2.7	2.6	3.0	3.1	3.3

Source: Care Home Census, 2015

6.11 Equipment

Even simple equipment can help people to live independently at home. During the 2013/14 financial year 1,636 people in Clackmannanshire received equipment, over two thirds of whom (67.5%) received more than one item. Seventy percent were aged 65 and over and a large proportion (70%) had a Physical Disability. The types of equipment that can be provided include bath and shower, eating and drinking, seating and toileting equipment. Over the past four years the number of people receiving equipment although initially slightly rose from 1,716 in 2010/11 has been decreasing over the last two years. (Source: Clackmannanshire Council Community Care Information System).

In Stirling 2,065 people received community care equipment in the same year and in total 5,961 items/equipment were issued (these relate to daily living aids). Eighty percent were aged 65 and over and (based on the main category) almost half (49%) were categorised as Frail Elderly and a third (34%) as having a physical disability. Over the past four years the number of people receiving community care equipment has been annually increasing, with 1,244 receiving equipment in 2010/11. (Source: Stirling Council Community Care Database).

6.12 Specialist Accommodation

Clackmannanshire's Housing Strategy 2012-2017 advises that Clackmannanshire's Housing Need and Demand Assessment (2011) showed there was a lack of variety of specialist accommodation in Clackmannanshire. It tells that of the 812 properties available at that time, the majority were for older people with only 4% (32) for people with learning disabilities and 4% (33) for people with a physical disability. In addition, of the 354 registered care places available at that time the majority were for older people and a quarter were for people with complex needs and a quarter for those with learning disabilities, many of these being older people. There were very few places for those with mental health issues and young people. The Housing Strategy also advises that the number of major adaptations carried out within the private sector had risen from 11 in 2007/08 to 18 in 2011/12.

Stirling's Local Housing Strategy 2012 advises that the existing accommodation for older people at that time was 18 residential care and nursing homes providing 608 places and 770 places in houses suitable to the needs of older people (including sheltered housing and amenity older person's houses). The council and its partners undertake adaptations in several ways sourced from funding for adaptations to private homes (100-120 a year), to council homes (140 a year), Social Services budget (80 a year) and (in recent years) Scottish Government funding (around 50 a year). The needs of people with physical disabilities were met by a limited amount of

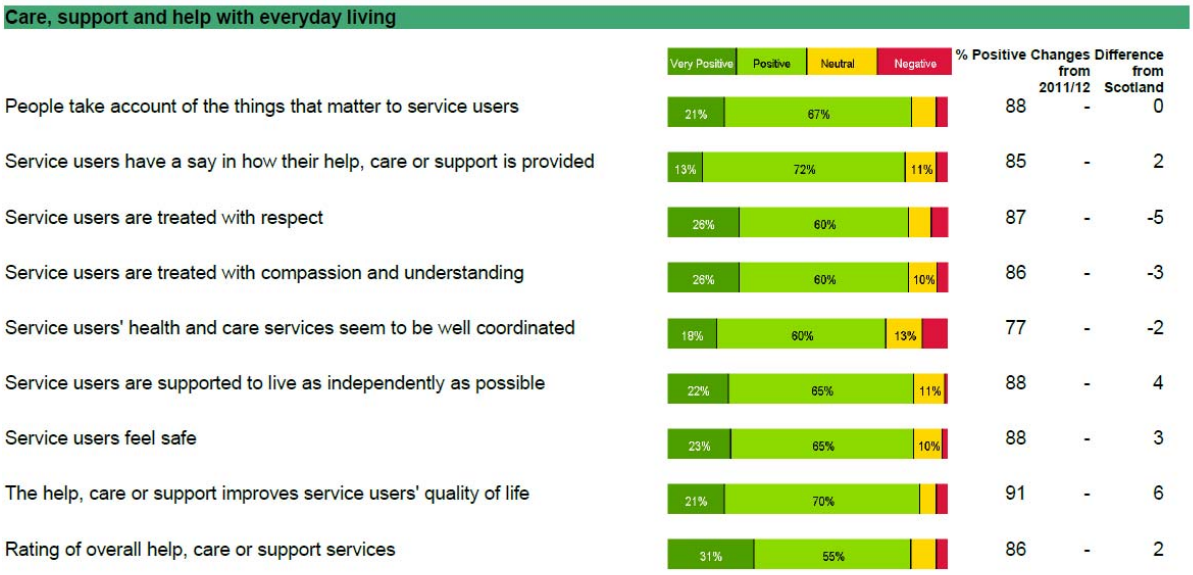
specialist grouped accommodation, housing built to specific needs, adaptations and privately developed lifetime homes.

Further work will be taken forward to identify specialist housing/supported housing models for the older adult population.

6.13 Experience of Care Recipients

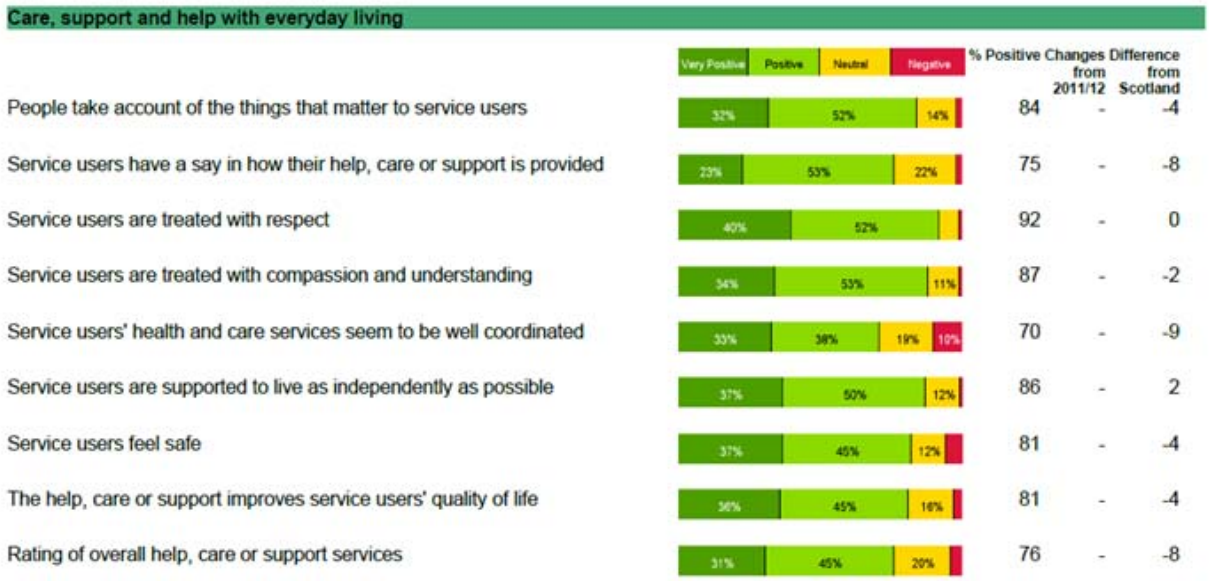
The Scottish Health and Care Experience survey aims to provide local and national information on the quality of health and care services from the perspective of those using them. It is a postal survey sent to a random sample of patients who were registered with a GP in Scotland asking about their experiences of access and using GP practice and out-of-hours services and their outcomes from NHS treatments. Eight hundred and sixty patients in Clackmannanshire and 2,624 patients in Stirling took part in the 2013/14 survey. Of those people who completed the section on Care, support and help with everyday living, 18% in Clackmannanshire (162 people) and 19% in Stirling (468 people) indicated that they had had help or support with everyday living in the last 12 months. Participants in Clackmannanshire rated their overall experience of the help, care or service they received higher (86%) than those in Stirling (76%).

Figure 6.13a Health and Care Experience Survey 2013/14, Clackmannanshire



Source: Health and Care Experience Survey 2013/14

Figure 6.13b Health and Care Experience Survey 2013/14, Stirling



Source: Health and Care Experience Survey 2013/14

6.14 End of Life Care

End of life care is the care experienced by people who have an incurable illness and are approaching death. There are in-patient, day care and home-care services staffed by people with specialist training which enable them to help people with complex needs. It can be an important measure to indicate whether adequate plans and structures have been put in place to allow patients to spend their last six months of life at home or in the community and not in an acute hospital setting.

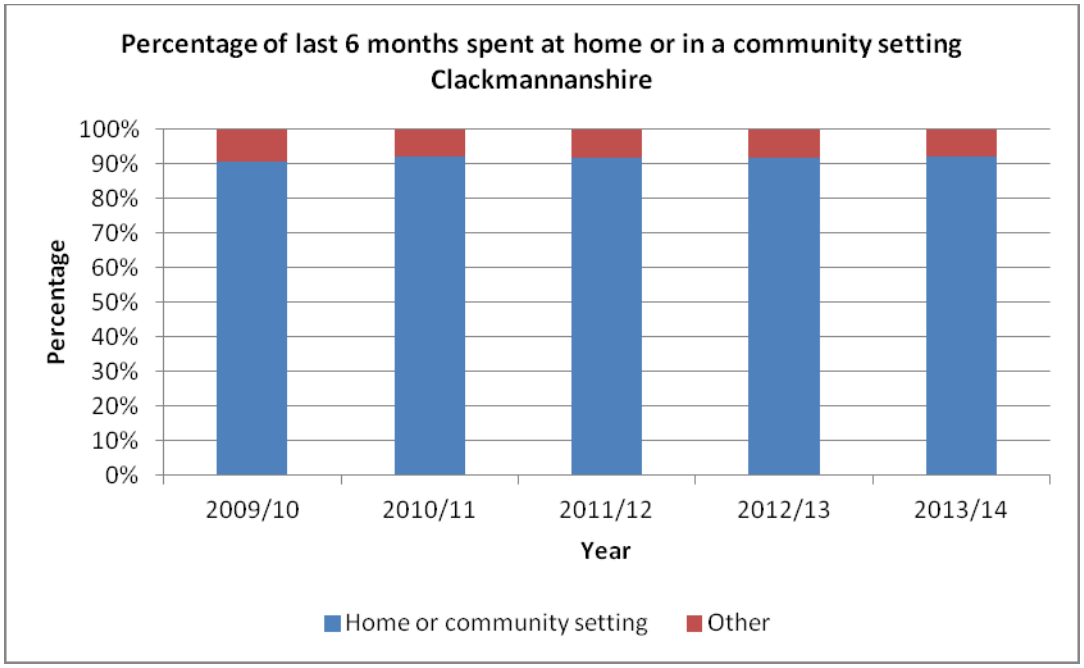
Just over 9 out of every 10 people in Clackmannanshire and Stirling spend the last six months of their life at home or in the community, this has been the case for every year between 2009/10 and 2013/14. The percentage nationally is similar. The percentage of the last six months spent in home or a community setting is calculated by determining the number of days a person has not spent in an acute hospital setting.

Table 6.14a Percentage of last six months of life spent at home or in a community setting

Council Area	2009/10	2010/11	2011/12	2012/13	2013/14
Clackmannanshire	90.6%	92.0%	91.9%	91.8%	92.3%
Stirling	91.2%	91.5%	91.9%	91.4%	90.5%
Scotland	**90.5%**	**90.6%**	**91.0%**	**91.1%**	**90.8%**

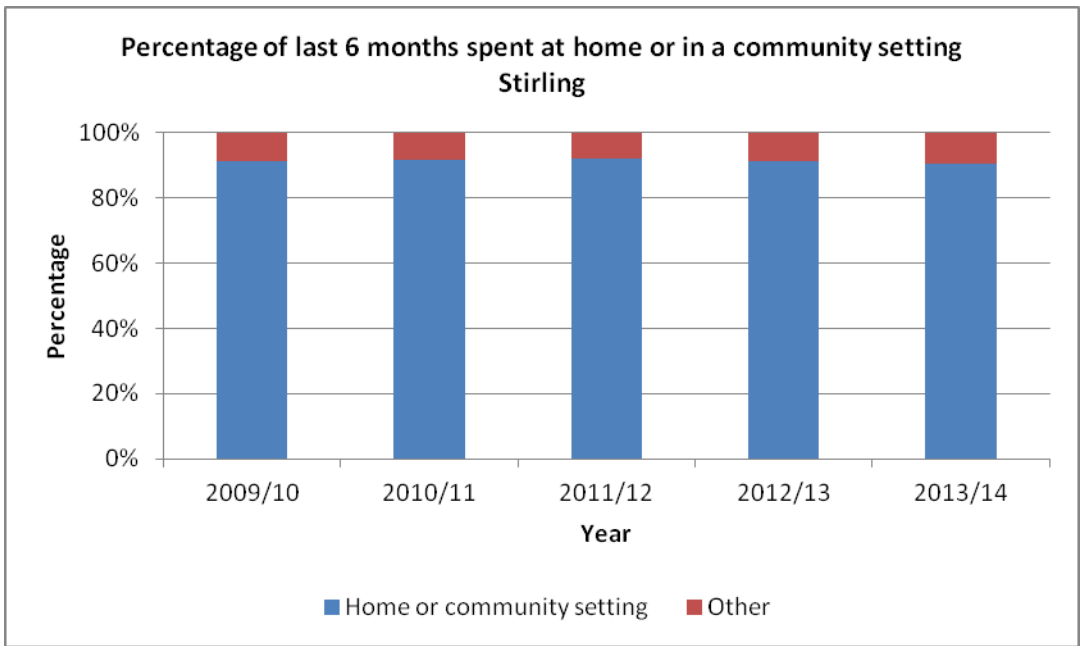
Source: ISD Scotland and National Records of Scotland (NRS)

Figure 6.14a Percentage of last six months of life spent at home or in a community setting in Clackmannanshire



Source: ISD Scotland and National Records of Scotland (NRS)

Figure 6.14b Percentage of last six months of life spent at home or in a community setting in Stirling



Source: ISD Scotland and National Records of Scotland (NRS)

6.15 Respite Care

Respite care is a service intended to benefit a carer and the person they care for by providing a short break from caring tasks. This section aims to provide an overview of respite care and the following figures have been taken from the most recent Respite Care report (2014). Figures in this report are rounded to the nearest ten. Table 6.15a shows that the total number of respite weeks have increased in Clackmannanshire and decreased in Stirling between 2012/13 and 2013/14. Both overnight and daytime respite weeks have increased in Clackmannanshire but in Stirling while the number of overnight respite weeks have increased daytime respite weeks have decreased.

Table 6.15a: Overnight and Daytime respite weeks, 2012/13 to 2013/14

	Overnight respite weeks provided		Daytime respite weeks provided		Total respite weeks provided	
Local Authority	**2012/13[4]**	**2013/14[4]**	**2012/13[4]**	**2013/14[4]**	**2012/13[4]**	**2013/14[4]**
Clackmannanshire	720	730	2,150	2,220	2,870	2,940
Stirling	1,390	1,650	840	500	2,230	2,150
Scotland	**65,760**	**65,030**	**139,320**	**138,060**	**205,080**	**203,090**

*All figures rounded to the nearest ten. Total may not add up to the sum of components due to rounding. 4-Same methodology used in 2012/13 & 2013/14 making the figures comparable.

Source: Respite Care, Scotland, 2014

The report also details respite care provided for the benefit of carers. Table 6.15b and 6.15c detail the number of respite weeks (total, overnight and daytime) provided to support unpaid carers in Clackmannanshire, Stirling and Scotland for the years 2012/13 and 2013/14. In Clackmannanshire the total number of respite weeks has increased for those aged 18-64 and

decreased for those aged 65 plus. In Stirling the total provision has increased for both age groups, particularly for overnight respite in the younger age group and daytime respite in the older.

Table 6.15b Respite weeks provided for the benefit of the carers of adults aged 18-64, 2012/13 to 2013/14

	Total respite weeks provided		Overnight respite weeks provided		Daytime respite weeks provided	
Local Authority	2012/13[4]	2013/14[4]	2012/13[4]	2013/14[4]	2012/13[4]	2013/14[4]
Clackmannanshire	1,000	1,150	130	140	870	1,010
Stirling	340	490	230	410	110	80
Scotland	**73,300**	**72,540**	**17,750**	**16,970**	**55,560**	**55,560**

*All figures rounded to the nearest ten. Total may not add up to the sum of components due to rounding. 4-Same methodology used in 2012/13 & 2013/14 making the figures comparable.

Source: Respite Care, Scotland, 2014

Table 6.15c Respite weeks provided for the benefit of the carers of older people aged 65+, 2012/13 to 2013/14

	Total respite weeks provided		Overnight respite weeks provided		Daytime respite weeks provided	
Local Authority	2012/13[4]	2013/14[4]	2012/13[4]	2013/14[4]	2012/13[4]	2013/14[4]
Clackmannanshire	1,470	1,410	470	470	1,000	950
Stirling	1,340	1,470	1,100	1,130	240	350
Scotland	**107,720**	**108,490**	**40,250**	**40,740**	**67,470**	**67,750**

*All figures rounded to the nearest ten. Total may not add up to the sum of components due to rounding. 4-Same methodology used in 2012/13 & 2013/14 making the figures comparable

Source: Respite Care, Scotland, 2014

In the 2013/14 financial year there were 208 people receiving overnight and 247 receiving daytime respite care in Clackmannanshire. A large proportion in both overnight (78%) and daytime (66%) respite care were those aged 65 and over and the largest client group in both

were those with a physical disability (44% of those in overnight respite and 39% of those in daytime respite) (Source: Clackmannanshire Council Community Care Information System).

In the 2013/14 financial year in Stirling there were 238 people receiving respite care, the majority (86%) being aged 65 and over. The largest proportion were people with a physical or sensory disability (61%) followed by those with dementia (25%). (Source: Stirling Council intranet site)

6.16 Substance Misuse Support Services

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

Clackmannanshire is achieving a high standard for drug and alcohol treatment times with 99.1% of people commencing treatment within 3 weeks, the figures show that Clackmannanshire is performing better than Scotland (Table 6.16a). Stirling is performing at a similar level to Scotland with 94% of its drug and alcohol clients starting treatment within 3 weeks.

Table 6.16a – Clackmannanshire & Stirling Alcohol & Drug treatment waiting times, 2013/14

	Drugs & Alcohol		Alcohol		Drugs	
	No. of completed waits	% seen within 3 weeks	No. of completed waits	% seen within 3 weeks	No. of completed waits	% seen within 3 weeks
Clackmannanshire	1168	99.1	670	99	498	98.2
Stirling	299	94	131	93.9	168	94
Scotland	46430	95.7	29515	96.4	16915	94.4

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

6.17 Provision of Health & Social Care Services Considerations/Implications

- It is apparent that there is an increasing demand on all services, particularly for those aged 65 and over. This is reflected in both hospital and community services and given that the proportion of younger people (those aged 16-49) is projected to either remain similar (as in Stirling) or drop (as in Clackmannanshire) it could be more challenging to employ the workforce to meet this demand.
- The average monthly attendance at Accident & Emergency and Minor Injury Unit has increased by 8.8% over the years 2007-2015. The rate of emergency hospital admissions in Clackmannanshire and Stirling has remained broadly similar over the past decade. However, the elderly population in Clackmannanshire and Stirling (over 65s) account for a growing percentage of emergency admissions. Given the projected increase in the elderly population Emergency Departments in their current form could struggle to meet the demands of the increasing elderly population.
- Just over 9 out of every 10 people in Clackmannanshire and Stirling spend the last six months of their life at home or in the community which has been the case for every year between 2009/10 and 2013/14.
- The number of individuals with long term conditions and multi-morbidities is projected to increase. This will have an impact on both health and care services. There will be more individuals with complex need requiring health and care services in hospital, care and at home.

7. Carers

7. 1 Characteristics of Unpaid Carers

Unpaid carers are people who provide care and support to family members, other relatives, friends and neighbours. Some carers are life-long carers while others may care for shorter periods of time and a carer does not need to be living with the person they care for to be considered a carer. The most recent Scotland's Carers report (The Scottish Government, March 2015) brings together statistical analysis and research on caring, drawing from recent population surveys such as Scotland's 2011 Census and the Scottish Health Survey. The following overview is taken from the report.

- There are an estimated 759,000 carers aged 16+ in Scotland, 17% of the adult population. This is currently the best estimate of the number of carers in Scotland (Scottish Health Survey 2012/13).
- There are an estimated 29,000 young carers in Scotland, 4% of the child population (aged 4-15) (Scottish Health Survey 2012/13)
- There are estimated to be over 171,000 carers in Scotland aged 16+ caring for 35 hours a week or more.

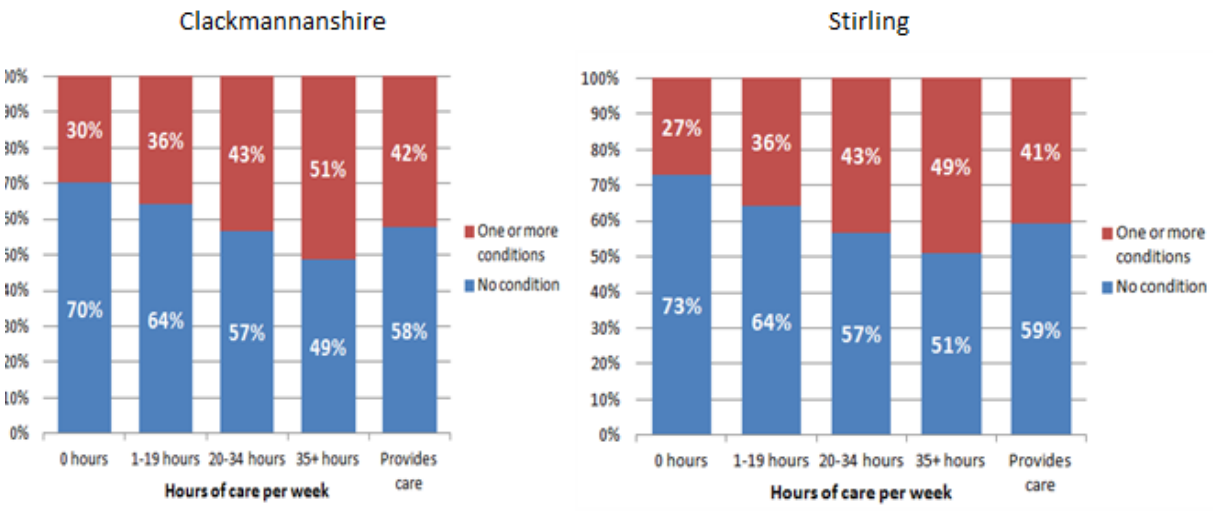
Scotland's census, which showed that 11% of the adult population (aged 16+) are carers, is thought to underestimate the extent of low level caring but does provide a good estimate of people with substantial caring responsibilities. Differences in the results from the Census and Scottish Health Survey may be because people do not often recognise themselves as a carer or due to differences in the surveys design.

The following section, taken from Scotland's Census 2011, provides an overview of carers in both Clackmannanshire and Stirling.

- According to the 2011 Census there were 4,693 unpaid carers in Clackmannanshire and 8,265 in Stirling, 9% of the population in both.
- A greater proportion of females report that they have carer responsibilities than males (59% in Clackmannanshire and 60% in Stirling).
- Of those providing unpaid care around two thirds were aged between 35 and 64 (67% in Clackmannanshire and 64% in Stirling)
- Over half were providing under 20 hours of unpaid care (52% in Clackmannanshire and 59% in Stirling).
- Thirty eight percent of carers in Clackmannanshire and 32% in Stirling were providing 35 hours or more unpaid care. Of this group 28% in Clackmannanshire and 31% in Stirling were aged 65 and over.
- A large proportion in Clackmannanshire (30%) and Stirling (24%) were providing 50 hours or more of unpaid care and of this group around a third (and the largest proportion) were those aged 65 and over (32% in Clackmannanshire and 36% in Stirling).
- Forty two percent of carers in Clackmannanshire and 41% in Stirling have one or more long term condition. The percent of carers with one or more long term condition increases with the increasing amount of unpaid care provided (Figure 7.1a).
- Of those who rated their general health a greater percent of those who provided no unpaid care rated their health as good or very good compared to those who provided

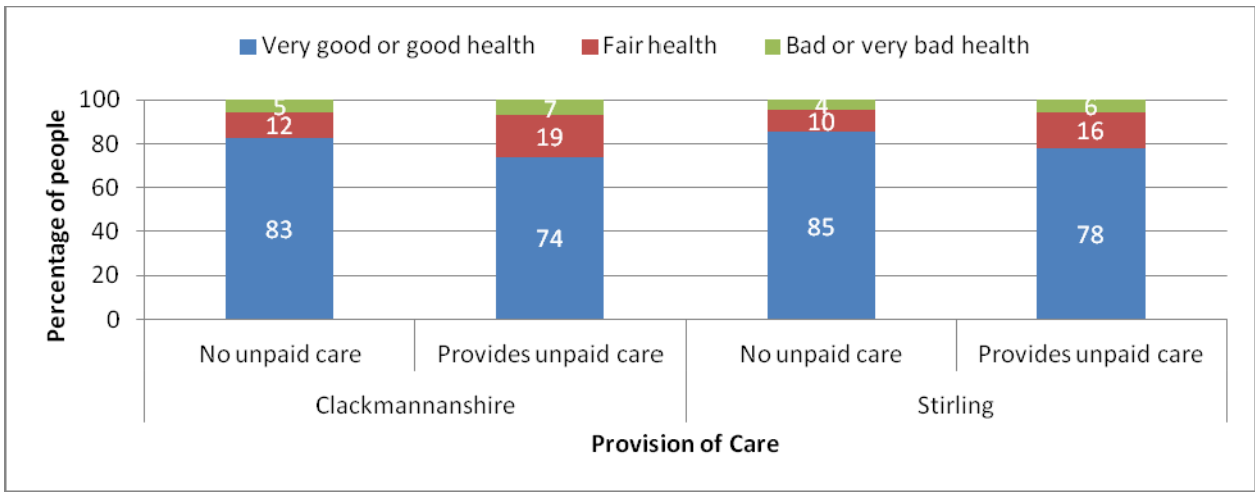
unpaid care. The percent of those rating their health as bad or very bad increases with the increasing amount of unpaid care provided (Figures 7.1b and 7.1c).

Figure 7.1a Percentage of unpaid carers who have one or more condition by level of care in Clackmannanshire and Stirling (Scotland's Census 2011)



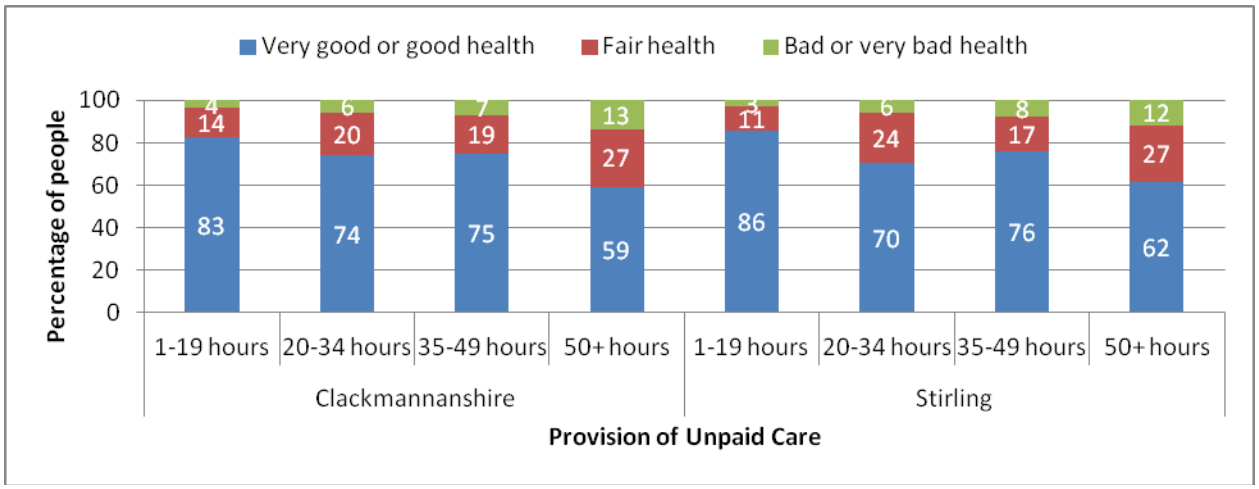
Source: Scotland's Carers, 2015

Figure 7.1b: Provision of care by general health, Scotland's Census 2011



Source: 2011 Census

Figure 7.1c: Provision of unpaid care by general health, Scotland's Census 2011



Source: 2011 Census

7.2 Experience of Carers

The Health and Care Experience Survey 2013/14 asks people's experiences of accessing and using primary care services and includes aspects of care, support and caring to support the draft national outcomes for health and well being proposed under The Public Bodies (Joint Working) (Scotland) Act 2014. While the sample is small it does provide useful information on the experiences of adult carers.

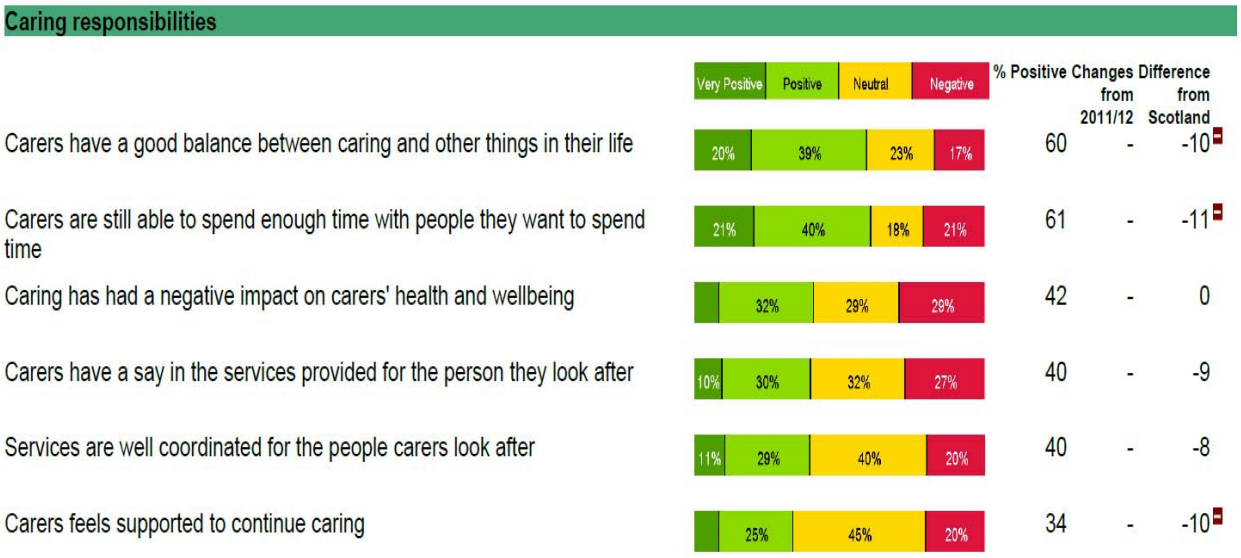
In Clackmannanshire 816 completed the section on Caring Responsibilities with 15% (123) indicating that they provided care with 33% (41) of them saying that this care was 35 hours a week or more.

In Stirling 2,496 completed the section on Caring Responsibilities with 15% (382) indicating that they provided care with 34% (129) of them saying that this care was 35 hours a week or more.

The results from both (Figures 7.2a and 7.2b) indicate that there is scope for improvement.

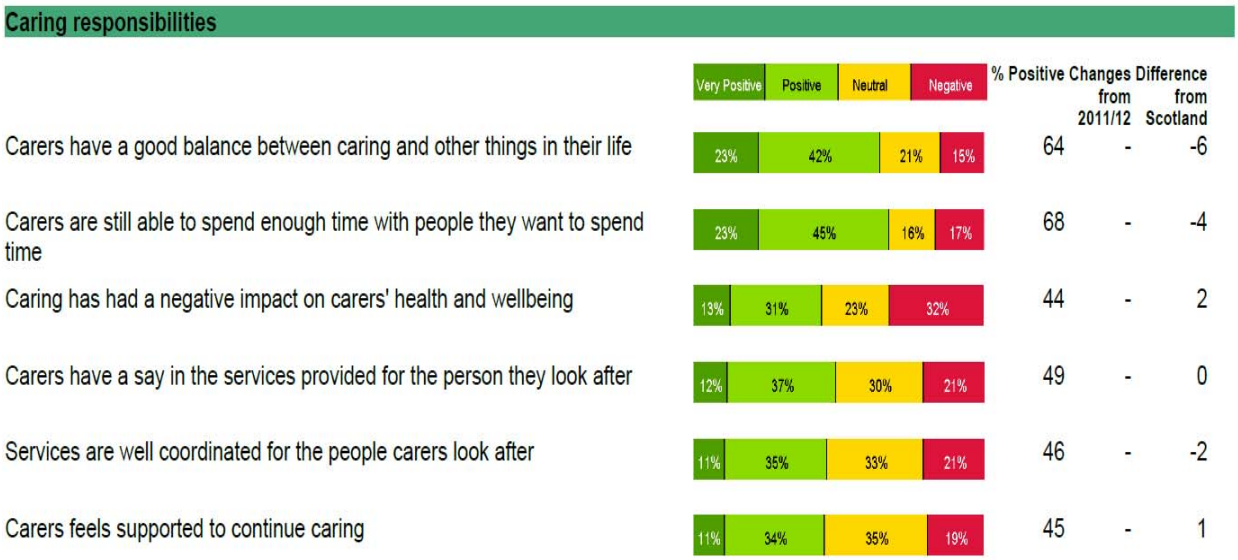
- 29% of carers in Clackmannanshire and 32% in Stirling felt that caring had had a negative impact on their health and wellbeing which is comparable to Scotland (32%).
- Only 34% of carers in Clackmannanshire felt supported to continue caring, less than in Stirling (45%) and Scotland (44%).
- 40% in Clackmannanshire and 46% in Stirling felt the services were well coordinated for the people they looked after, less than in Scotland (48%).
- Less carers in Clackmannanshire (40%) felt that they had a say in the services provided for the person they looked after than Stirling and Scotland (both 49%).

Figure 7.2a Experience of a sample of Unpaid Carers in Clackmannanshire, 2013/14



Source: Health and Care Experience Survey 2013/14
www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

Figure 7.2b Experience of a sample of Unpaid Carers in Stirling, 2013/14



Source: Health and Care Experience Survey 2013/14

www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

7.3 Carers Considerations/Implications

- There is an estimated 759,000 carers aged 16+ in Scotland, 17% of the adult population. This is currently the best estimate of the number of carers in Scotland (Scottish Health Survey 2012/13).
- There are estimated to be over 171,000 carers in Scotland aged 16+ caring for 35 hours a week or more.
- According to the 2011 Census there were 4,693 unpaid carers in Clackmannanshire and 8,265 in Stirling, 9% of the population in both.
- Thirty eight percent of carers in Clackmannanshire and 32% in Stirling were providing 35 hours or more unpaid care. Of this group 28% in Clackmannanshire and 31% in Stirling were aged 65 and over
- 42% of carers in Clackmannanshire and 41% in Stirling have one or more long term condition. The percent of carers with one or more long term condition increases with the increasing amount of unpaid care provided.
- The results from the Health and Care Experience Survey 2013/14 indicate that there is scope for improvement in supporting unpaid carers and service provision.

8. Summary and Conclusion

Summary

This needs assessment has presented information describing current health and social care needs in Clackmannanshire and Stirling, and has forecast a significant increase in these needs. This summary aims to re-iterate some of the implications and considerations presented at the end of each section.

Section 2 presented information on the demographics as well as the current and projected populations for Clackmannanshire and Stirling. The number, and proportion, of older adults across Clackmannanshire & Stirling is projected to double. Older people are generally more intensive users of health and social care services. Therefore this could impact significantly on demand for these services in years to come. Both Clackmannanshire and Stirling are projected to see an increase in the ratio of non working aged people to people of working age. Clackmannanshire is also projected to experience a decrease in the number of people of working age living in the area. This means that at the same time as demand for services could be increasing, it could be more challenging to employ the workforce to meet this demand. The information presented also showed that Stirling has a high percentage of people living in rural areas. This will need to be considered when planning and delivering services.

Life Circumstances (Section 3) can be a key contributing factor in the health of a population. Clackmannanshire and Stirling have very different Scottish Index of Multiple Deprivation profiles with Clackmannanshire containing a higher proportion of its residents living in more deprived areas. That said, both Clackmannanshire and Stirling will have pockets of higher deprivation. One of the next stages of the strategic planning process is to analyse the available data at locality level to better understand the needs of the population at a more local level. Stirling has a higher proportion of the population living in fuel poverty than in Clackmannanshire and Scotland as a whole and this may be partly due to Stirling having a higher proportion of houses built before 1945, and older properties are more likely to have no insulation or be poorly insulated. This can increase heating and fuel costs as well as affect the quality of life for inhabitants. The ability to find work is an important contributing factor to the health and well-being of the population. The information presented showed that Clackmannanshire has a higher proportion of residents unemployed and actively seeking work than in Stirling and in Scotland as a whole.

Risk factors (Section 4) have an impact on a person's health and well-being. Behaviours such as smoking, alcohol consumption, drug use, and poor diet can have an adverse effect on health.

The figures presented show that 28.9% of people in Clackmannanshire smoke. The corresponding figure for Stirling is 20% and for Scotland is 23.1%. Tobacco smoking is the main risk factor for lung cancer, accounting for an estimated 80-90% of cases in developed countries and is linked to other cancers and Chronic Obstructive Pulmonary Disease (COPD). The alcohol related mortality rate in Clackmannanshire in 2013 was 38.85 per 100,000 population, which was significantly worse than the average rate of 21.43 for Scotland. In Stirling, the alcohol related mortality rate has been below the Scottish average in each year from 2009 to 2013. The estimated prevalence of those with a problem drug use has increased in Clackmannanshire and Stirling when comparing the data from 2009/10 and 2012/13. This is in contrast to Scotland as a whole, where the estimated percentage of the population with a problem drug use fell slightly.

Section 5 contains an extensive presentation of data of the current, and where possible, the projected health needs of the Clackmannanshire and Stirling populations. The information shows that in Clackmannanshire while both male and female life expectancy is comparable to Scotland both males and females are expected to have a lower healthy life expectancy. Information was presented on the prevalence of long terms conditions in the Clackmannanshire and Stirling populations. If current prevalence rates continue it is expected we will see greater numbers of individuals with these conditions as the proportion of older adults in the population rises. It is also projected that the number of people with multi-morbidities, i.e. more than one long term condition, will increase. This means there will be more individuals attending hospital with complex needs. Currently services are un-coordinated and may mean people are making multiple visits to hospital. A re-organisation of services to ensure a more joined up approach could help to reduce the number of visits to a hospital and improve efficiency. Some early analysis undertaken by Information Services Division (ISD) suggested around 2% of the population account for 50% of the hospital and GP prescribing spend. Gaining a better understanding about this cohort of individuals could allow for more effective planning and delivery of services and an improved service user experience.

Section 6 presents information on the current provision of health and social care services. It is apparent that there is an increasing demand on all services, particularly for those aged 65 and over. This is reflected in both hospital and community services. Projections show that the elderly population, who are the most intensive users of services, is expected to rise significantly. The average monthly attendance at Accident & Emergency (A&E) and Minor Injury Unit (MIU) has increased by 8.8% over the years 2007-2015. The rate of emergency hospital admissions in Clackmannanshire and Stirling has remained broadly similar over the past decade. However, the elderly population in Clackmannanshire and Stirling (over 65s) account for a

growing percentage of emergency admissions. Given the projected increase in the elderly population Emergency Departments in their current form could struggle to meet this demand.

Unpaid carers (Section 7) are people who provide care and support to family members, other relatives, friends and neighbours. According to the 2011 Census there were 4,693 unpaid carers in Clackmannanshire and 8,265 in Stirling, 9% of the population in both. These figures may be an under representation of the actual number of carers in Clackmannanshire and Stirling as many carers do not recognise themselves as cares. The results from the Health and Care Experience Survey 2013/14 indicate that there is scope for improvement in supporting unpaid carers and service provision. It is likely, given the population projections that more carers will be required locally and it is important that they receive the appropriate levels of support.

It should be noted that although the projected increase in older people will have an impact on services older people make a valuable contribution to our society, both economically and socially, through, amongst other contributions, taxes, spending power, provision of social care and the value of their volunteering.

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

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

Conclusion

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

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

Since that time there has been great change:

- Demographic change (in part a result of the success of the welfare state)
- People living longer and healthier

- (This despite an increase in the prevalence of Long Term Conditions (LTCs) - due to a combination of new conditions and better/ earlier-diagnosis)
- So, the population of Clackmannanshire and Stirling is growing in size, ageing and increasing in complexity and multiplicity of health and social problems such that demand is exceeding supply in the present model
- There are rising costs and debt (national and personal)

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

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

The new paradigm needs to:

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

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

'Engagement' is key

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

The service implications, therefore are:

- real engagement ++
- workforce development in person-centredness
- wholesale, continuous redesign of public / third sector

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

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

Engagement:

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

Redesign

- Wholesale public sector/ third sector redesign, outcomes-focussed yes, but recognising that process is key.
- Linking with engagement work – MCDM (Multi-criteria Decision Making), PSP (Public Social Partnerships) to reach a common understanding of goals and how these may be met
- Person-centred redesign – based on the above and work on person-centred care developed locally
- Working with CPPs (Community Planning Partnerships) on the 'determinants of health' with the aim of improving structural approaches and reducing the tendency for 'lifestyle drift'. And emphasising work as key to health (not just paid employment, but caring and volunteering) which is often the basis for meaning and purpose in people's lives.
- 'Integrated anticipatory care' – whereby the value of each of: prevention, early identification, treatment, management etc. is recognised in a spectrum of help/ intervention from a range of contributors – not least the person themselves (self-care).

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

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

The findings of this needs assessment have informed the development of our strategic plan which emphasises the following:

- A need to consider prevention and early intervention, and shift the emphasis of activity upstream.
- Understand and build on the important role of carers
- Develop staff and services to provide support to individuals who need it, and further improve on this to maximise rehabilitation, resilience and recovery. This will be done in partnership across all sectors including the public sector and Third sector.

Appendix A

Framework and Methods

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

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

Data

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

Models

- As discussed above models may be of different types – static or dynamic
- The findings section includes a large number of models, some of which are class models, others the beginnings of dynamic models (produced in a qualitative way but may be developed to using data)

- There is potential to use more sophisticated modelling techniques:
- Data envelopment analysis is used for assessing efficiency. Rather than simply benchmarking, it allows various data items to be combined as 'inputs', and others as 'outputs'. Plotting inputs against outputs for a range of 'decision making units' gives an 'efficiency frontier'. The advantage of this is that it gives a better idea of the scope for improvement for individual units, should inputs be increased.
- The origins and development of benchmarking have recognised the need to consider values, and processes in addition to a simple comparison of outcomes or outputs
- Discrete event simulation is used to forecast the results of changes in process or capacity at an operational level (see paper on modelling stroke beds)
- Systems dynamic modelling is higher level, considering 'stocks and flows' and might be used for modelling at the population level.

Needs assessment methods

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

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

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

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

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

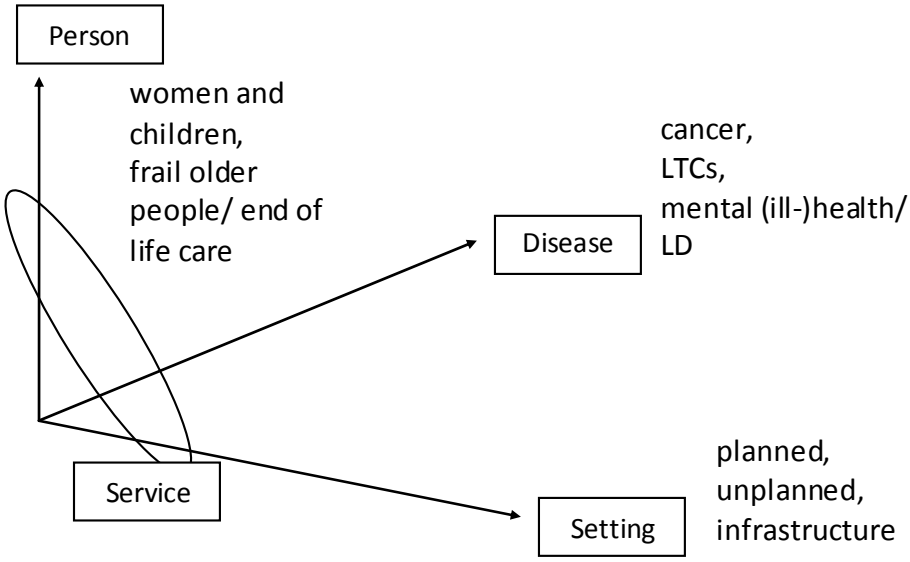
Types of need

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

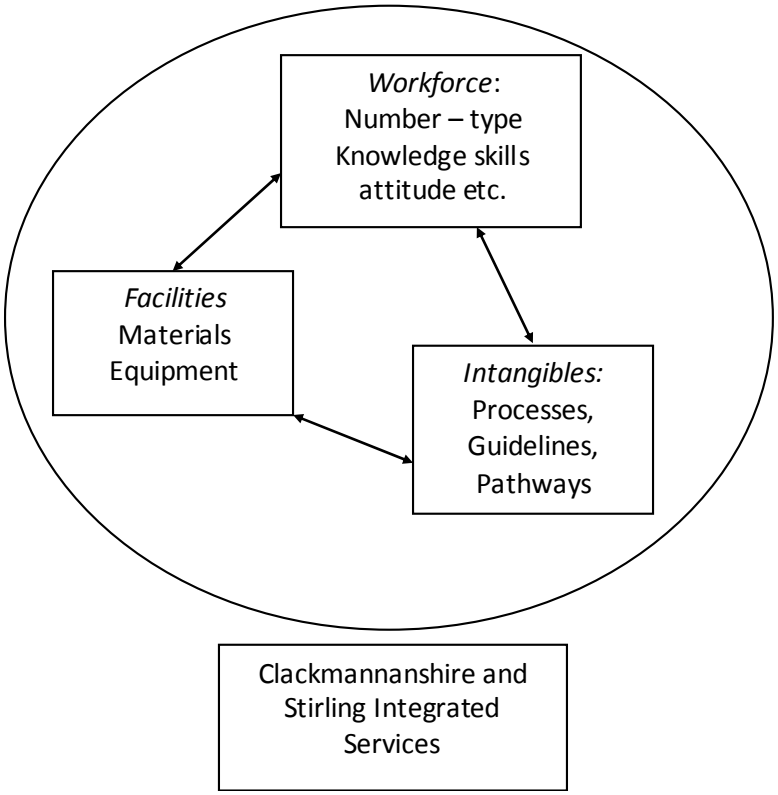
- the people in our communities – demographics, but also their attributes in terms of life circumstances, risk factors, disease and long term conditions.
- The services and their attributes – including capacity

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

These elements come together as illustrated in the diagram below:



Gaps Identified / Recommendations from Needs Assessment

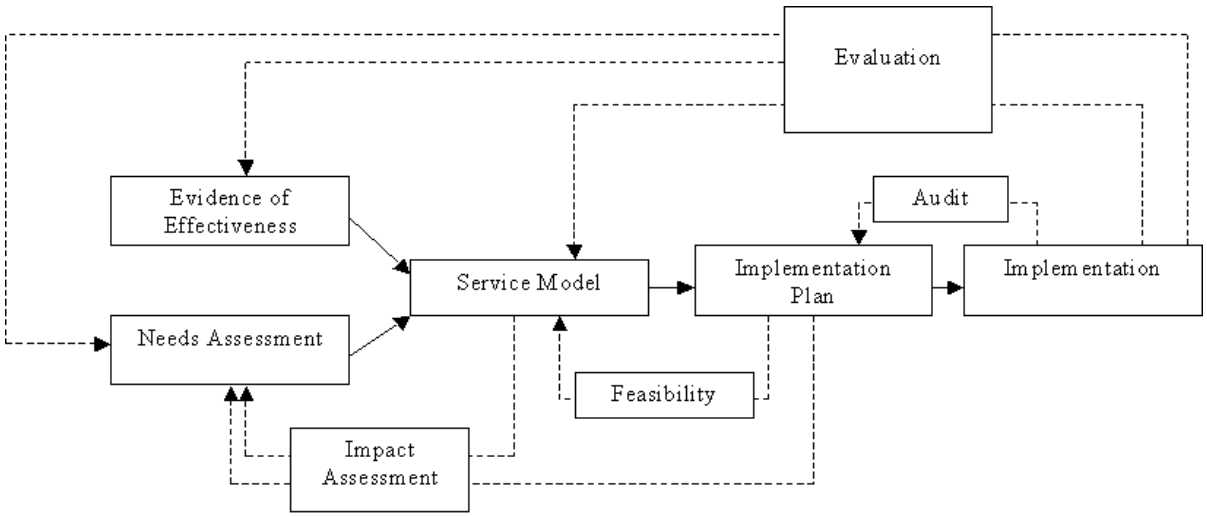


Beyond these needs, other types of need can be described, e.g. the 'engagement' needs of individuals – i.e. improvement in attitude and motivation in regard to the individual's own health, and for services organisational needs and redesign needs. In many ways a needs assessment is not required for us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

Further Description of needs assessment

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

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



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

Curve Model

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

CURVE is

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

Culture

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

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

Collective:

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

Culture change

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

- Diversity
- Information flow
- Connectivity
- Reducing barriers or inhibitors
- Enhancing or increasing catalysts
- Watchful waiting
- Positive intent

Understanding

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

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

Responsibility

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

Values, value, valuing

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

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

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

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

Enterprise

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

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

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

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

Implementation

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

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

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