Highland Joint Strategic Needs Assessment

Highland Health and Social Care Partnership

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Contributors

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1	28/01/2025	First draft
2	24/03/2025	Final version with minor updates following feedback
3		

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Contents

1. Executive Summary

This Joint Strategic Needs Assessment (JSNA) aims to provide an overview of population health and wellbeing needs of the adult population of the Highland council area. A JSNA looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services within a partnership area.

The following main points are identified:

- Highland has an ageing population, with increasingly large cohorts living to older age. Population projections forecast a continued increase in the size of the population aged 75 years and over.
- As a result of lower birth rates and migration patterns that see people leaving the area for education and employment, the working-age population is declining in size and ageing.
- The proportion of older people is expected to increase substantially often in areas where population numbers are static or decreasing. These changes are having a significant and increasing impact on the provision of health and care services.
- Highland has a significant remote and rural geography and a high proportion of areas in the most access deprived in Scotland. Older age dependency ratios are higher in remote and rural areas.
- Scotland's Census 2022 provides a detailed picture of the characteristics of our people and communities, showing Highland is increasingly ethnically diverse. All protected characteristics should be considered in planning health and care services.
- In Highland, most income deprived people live in places not identified among the most deprived areas by the SIMD. This distribution is a significant consideration for policy, strategy and the spatial targeting of resources, particularly in rural areas.
- As an Anchor Institution, the role of the HSCP is pivotal to designing and delivering health and care that has the population and local communities as the focus, particularly in the context of the wider determinants of health.
- Current needs and future requirements for housing should be aligned to HSCP strategic commissioning and planning to support people at all stages of life and support the shift in the balance of care closer to people's homes.

- The health concerns facing Highland are common. An ageing population is increasing demand on health and care services as more people are living with one or more long-term health conditions and with increasingly complex needs.
- Evidence from Scotland's Census 2022 suggests a decline in general health and a growth in people reporting a mental health condition, notably in females at younger ages.
- The underlying epidemiological trends forecast an increase in annual disease burden over the next 20 years. An anticipated rise in a range of diseases including cancer, cardiovascular disease, diabetes and neurological conditions will inevitably place additional pressure on health and care services.
- There is limited data available on the prevalence of different mental health conditions in Highland. Further work is required to review population needs in this area.
- The harmful use of substances (tobacco, alcohol and drugs) are a major cause of preventable ill-health and early death. Reducing these risk factors presents a sizeable opportunity to improve health and wellbeing and reduce health inequalities.
- The number of people providing unpaid care increased over the last decade. In the context of increasing demand and growing levels on unmet need, more unpaid care is being relied upon to support people to live at home.
- Care home capacity has reduced during a period of growth in the older population. Pressure on the care home market is recognised to be associated with challenges of rural operation, smaller size of operation and workforce availability.
- Combined, the data for delayed discharges, care at home and care home capacity reflects the challenge of providing services across the Highland geography and high levels of unmet need.
- People at end of life have relatively high use of health and social care services and demands are forecast to increase. Experience of end of life care should be good, irrespective of where people live or what they die from.
- Improving the health of our population requires a fundamental shift towards prevention and mitigating the underlying issues that can impact on health, such as poverty and deprivation.
- To shift the balance of care closer to people's homes, change is needed in how we approach the delivery of health and care, driving investment in prevention and early intervention.

2. Introduction

2.1. Background

The integration of health and social care is a 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.

In Highland a partnership arrangement had been in place since 2012 through a Partnership Agreement. In 2014, to comply with the legislation, NHS Highland became the lead agency for integrated adult health and social care while Highland Council became the lead agency for integrated health and social care for children.

Since its inception, Highland Health and Social Care Partnership (HHSCP) has delivered integrated adult health and social care services across Highland on behalf of the Joint Monitoring Committee.

The Highland Health and Social Care Partnership Adult Services Strategic Plan 2024-2027 sets out the vision and ambitions to improve the health and wellbeing of adults living in the area over the next three years[1]. HHSCP's key objective is to contribute to the achievement of the Scottish Government's National Health and Wellbeing Outcomes[2].

The plan does not distinguish between groups of people, for example by condition or age. The vision and aims of the plan look to address inequalities and improve opportunities and outcomes for all local people and communities.

This Joint Strategic Needs Assessment (JSNA) aims to provide an overview of population health and wellbeing needs of the adult population of the Highland council area. A JSNA looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services within a partnership area.

Scottish Government guidance defines the main goal of a JSNA is 'to accurately assess the care needs of a local population in order to improve the physical and mental health and wider wellbeing of individuals and communities'[3].

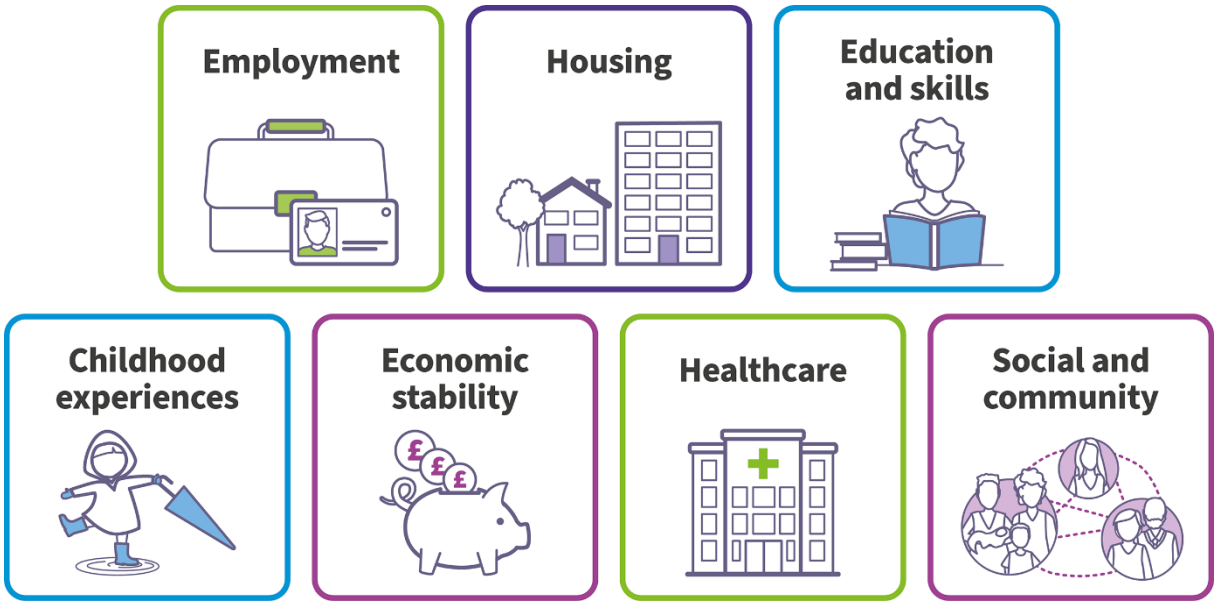
2.2. Approach

This report represents the first step of the JSNA process in Highland HSCP and covers the population of the Highland council area. The report has been developed as a rapid 'desk-

based' needs assessment, drawing together information gathered from local and national data sources. It uses epidemiological and comparative approaches to explore trends and inequalities in outcomes for adults and older people in Highland.

The report considers some of the interconnected factors, or building blocks, which have an influence on physical and mental health and wellbeing (Figure 1). These factors are known collectively as the determinants of health. Public Health Scotland highlight that unfair differences in income, wealth and power are important drivers of health and health inequalities[4]. It is the social and environmental conditions in which people are born, grow, live, work and age, alongside behavioural risk factors, which mostly shape health and wellbeing for people and communities.

Figure 1: The building blocks of health and wellbeing



Source: Public Health Scotland, The building blocks of health[5]

Throughout the report, intelligence is provided on health inequalities. Health inequalities are the systematic, avoidable and unfair differences in people's health outcomes across the population or between social groups within the same population[6] [7]. Unfair differences in health outcomes can be experienced by people by a range of inter-related factors including: protected characteristics such as sex, ethnicity or disability; socioeconomic status and deprivation; disadvantaged or excluded groups of society; geography and place (Figure 2).

Health inequalities are not caused by a single issue but are the result of a complex mix of factors which play out in local areas and generate a social gradient. People experience different combinations of these factors, which is often referred to as intersectionality. The

existence of health inequalities means that the right to the highest possible standard of physical and mental health is not being achieved equally for people in Highland.

Figure 2: Dimensions of health inequalities

Protected characteristics	Socio-economic deprivation	Geography and Place	Under-represented groups
e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief, sex (gender), sexual orientation	e.g. poverty, unemployment, low income, multiple deprivation	e.g. urban, rural and island communities and neighbourhoods	e.g. Homeless people, people living in prison, people with problem substance use, people with mental health problems

2.3. Data sources

The report incorporates evidence from peer reviewed literature, research papers and non-commercial reports (grey literature) and recent statistical publications from national agencies. These include National Records for Scotland (NRS), Public Health Scotland (PHS), the Scottish Public Health Observatory (ScotPHO) and Scottish Government health and social care analytical services.

The report also uses findings from previous work undertaken in Highland. These include the NHS Highland Director of Public Health annual reports which provide an overview of population health and work being undertaken to improve health and wellbeing and reduce health inequalities.

Public health partnership profiles present information across a range of health and wellbeing topics for each of the nine localities (community partnerships) in the Highland local authority area. In addition, the Highland Childrens Services Plan 2023-2026 and Joint Strategic Needs Assessment set out local plans to improve outcomes for children, young people and families.

The Highland Alcohol and Drugs Partnership health needs assessment sets out information to improve outcomes for people, families and communities impacted by drug and alcohol related harm and recovery.

The JSNA is based upon data available at the time of development. There are limitations in available data, for example, outputs from Scotland's Census 2022 that provide evidence of health and wellbeing needs at a local level were not published at the time of writing. In addition, sub national population projections by National Records of Scotland have not been updated since 2018. Projections in relation to health needs and how these influence demand for health and care services will be updated as new data becomes available.

3. Population and geography

The Highland Health and Social Care Partnership (HSCP) provides a health and care service to a resident population of 236,330 people, 4.3 percent of the national population in an area that is 33 percent of the landmass of Scotland. The area is one of two HSCPs within the NHS Highland Health Board, the other being Argyll and Bute HSCP which has a population of 87,810[8].

The geographical area covered is diverse. It includes the City of Inverness and other urban centres around the Inner Moray Firth and the most remote and socio-demographically fragile communities in both island and mainland locations. Inverness has experienced a substantial population increase and has been one of the most rapidly expanding populations in the UK. Population growth in Inverness is expected to continue, with new housing developments in both the eastern and western periphery of the city. In contrast, other parts of Highland are recognised as being economically and demographically fragile.

Fragile areas are characterised by declining population, under-representation of young people within the population, lack of economic opportunities, below-average income levels, problems with transport links, and other issues reflecting their geographic location.

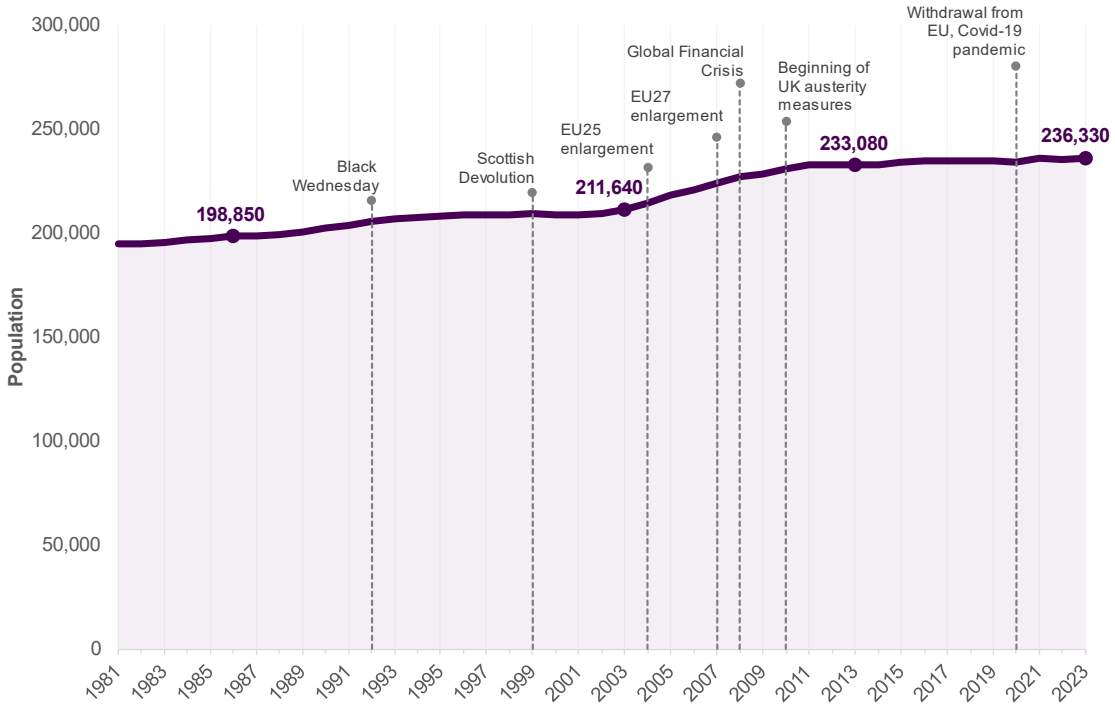
The geography of the area has important implications for service accessibility. While services are relatively accessible for a large proportion of the population, four in ten live in remote rural places where physical barriers such as coastlines, mountains and lochs extend travel times and access to public transport links is minimal. Scattered settlements, particularly on the west and north coast mainland and on island communities such as the Isle of Skye and the Small Isles, reduce the potential to achieve equity in service provision with increased service delivery costs across remote rural areas.

3.1. Population

The Highland population has increased reaching a peak of 236,330 people in 2023[9] (Figure 3). The rate of increase has been lower in the last decade compared to the decade prior. Between 2003 and 2013 the population increased by 10.1 percent (21,440 people), while in the period 2013 to 2023 the population increased by only 1.4 percent (3,250 people).

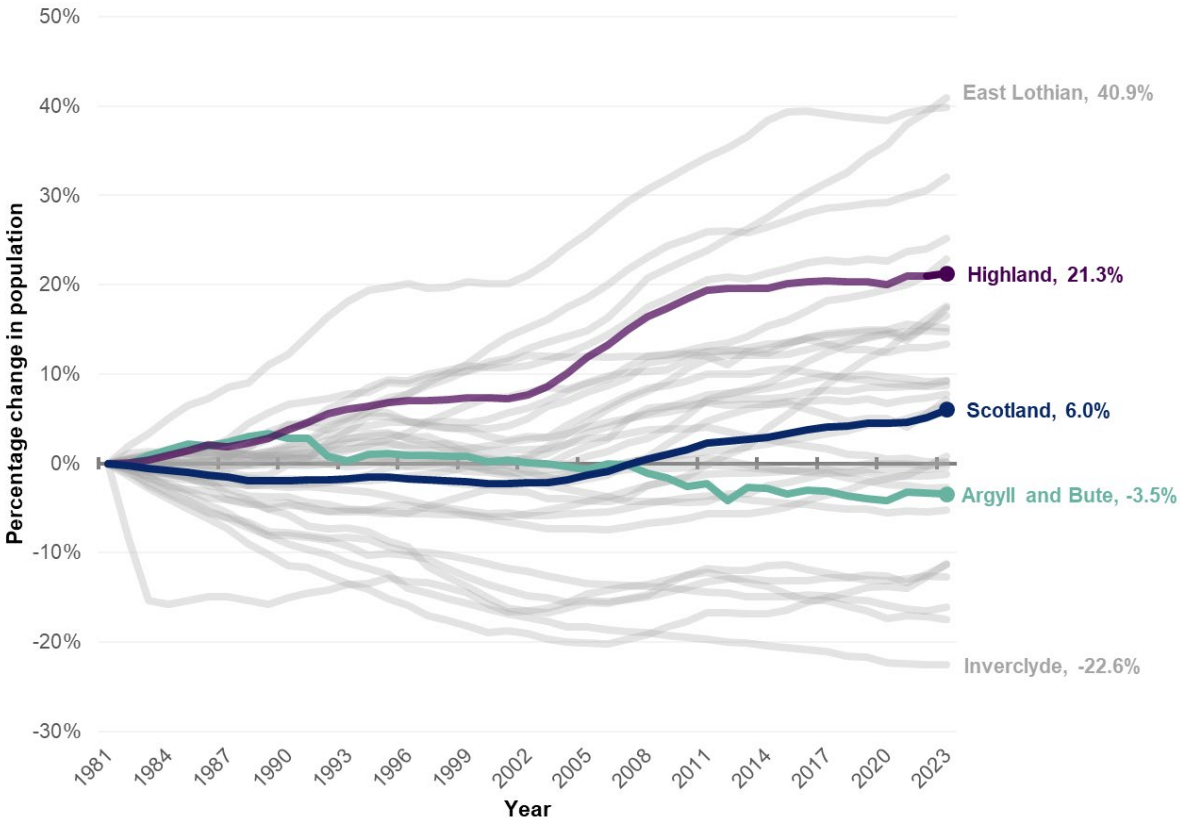
Population dynamics are complex, however the effects of migration and economic conditions have played a significant role in population change. The population growth rate in Highland is higher than Scotland and Argyll and Bute (Figure 4), but the rate has slowed since the onset of the global financial crisis in late 2007 and UK austerity in 2010.

Figure 3: Population of Highland and key events timeline, 1981 to 2023



Source: National Records of Scotland Mid-Year Population Estimates, 1981 to 2023

Figure 4: Percentage change in population by Local Authority from 1981 to 2023

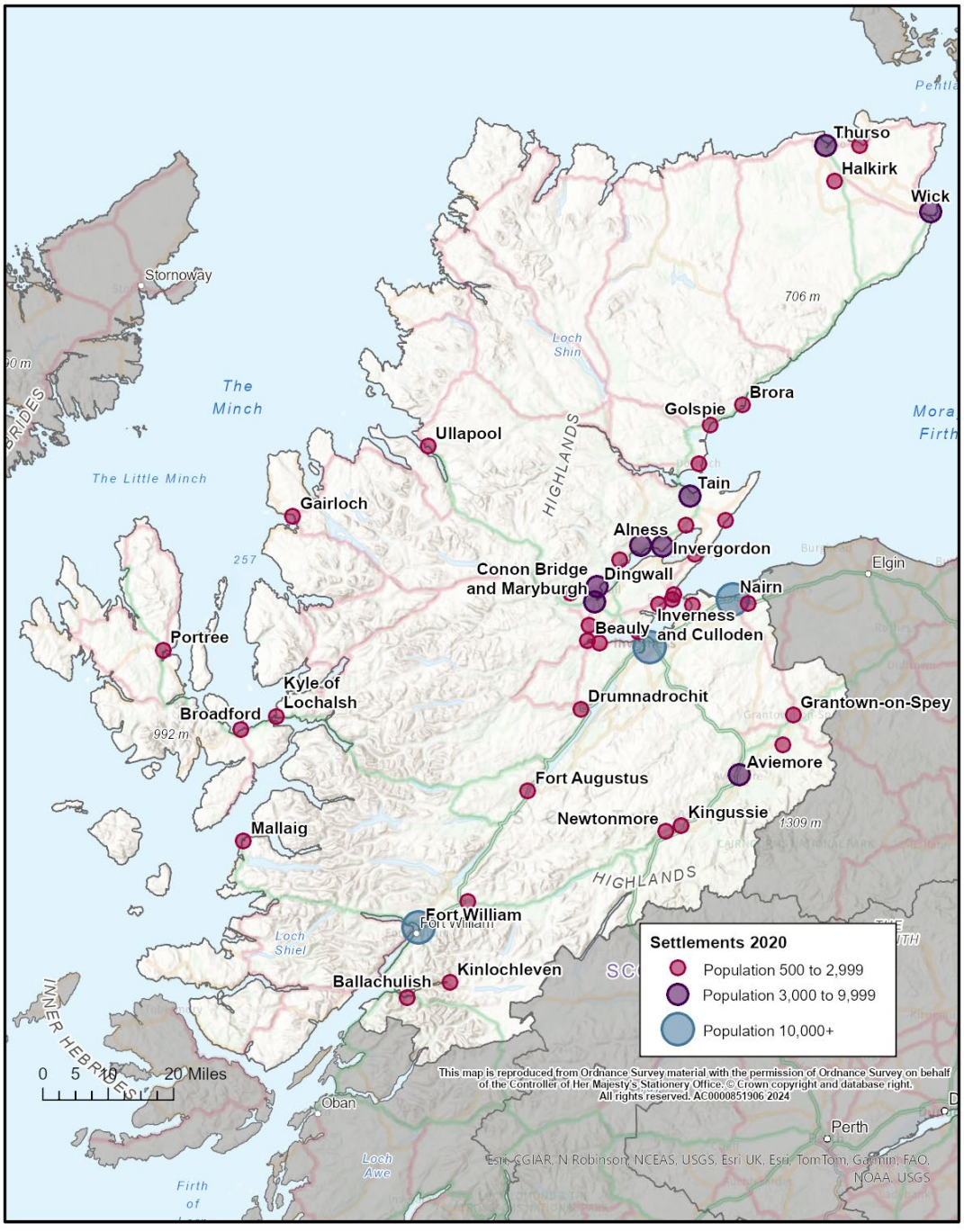


Source: National Records of Scotland, Mid-Year Population Estimates, 1981 to 2023

3.2. Settlement populations

Highland is one of the least densely populated areas in Scotland and the UK with around 9 persons per square kilometre, and most population centres concentrated around the Inner Moray Firth basin and other coastal settlements (Figure 5). In 2020, around seven in ten people (69.2 percent) lived in a settlement in Highland, contrasting with over nine in ten (91.9 percent) in Scotland as a whole[10].

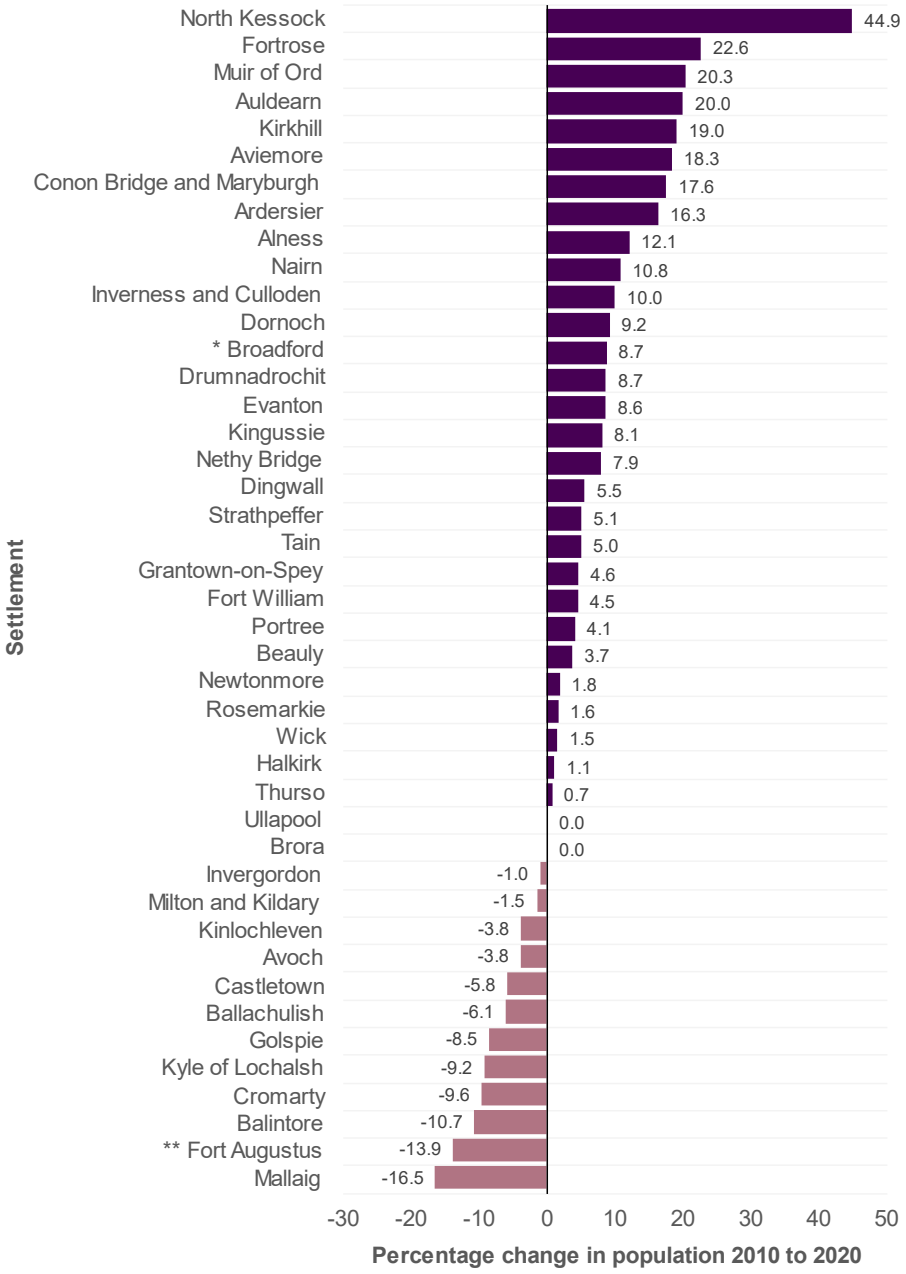
Figure 5: Map of Highland showing topography and settlement size



Source: National Records of Scotland (NRS) mid-year estimate Settlement and Locality populations

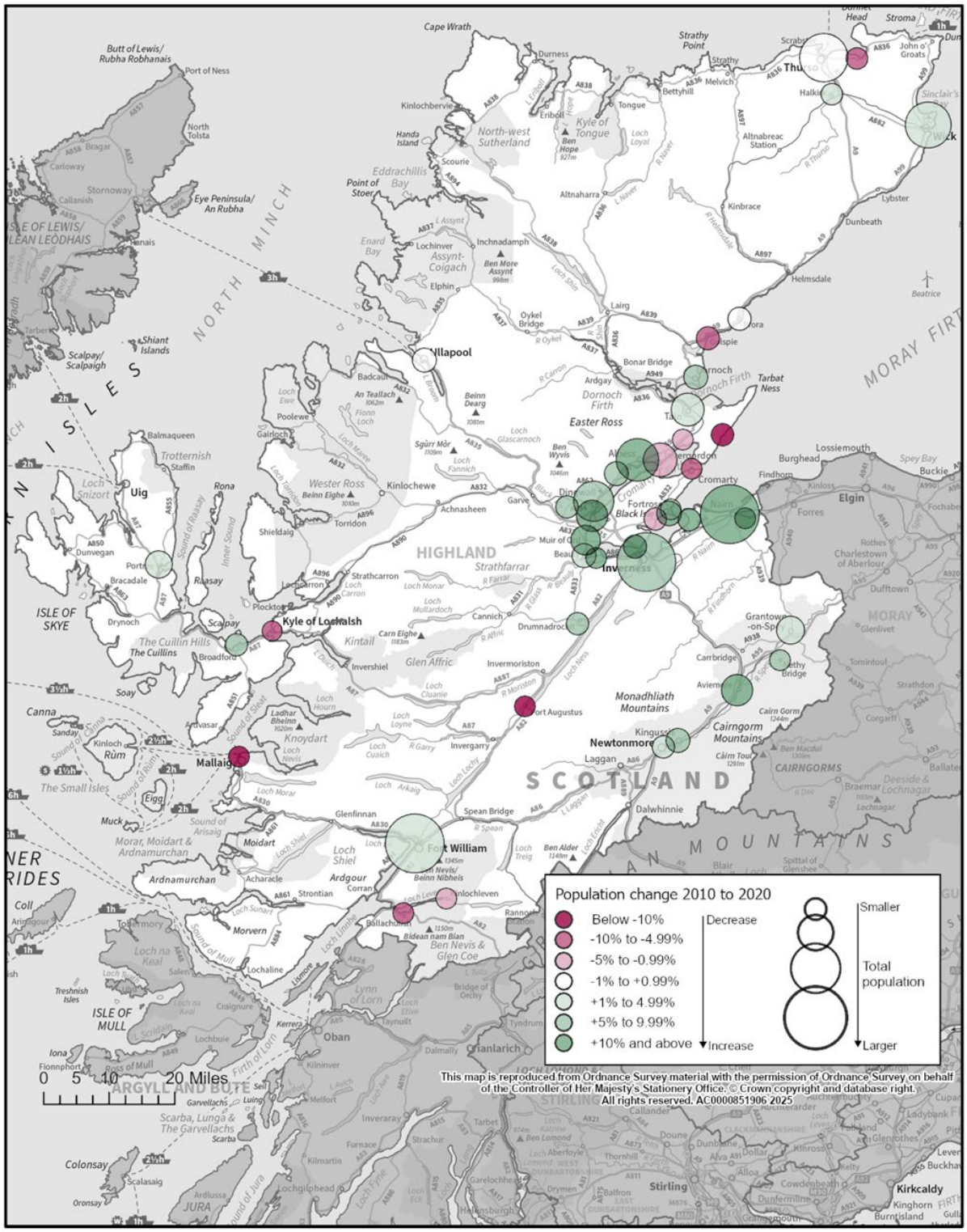
Of the forty-three settlements in Highland, twenty increased in population by 5 percent or more between 2010 and 2020. North Kessock, in very close proximity to Inverness has increased in population at a significantly greater rate than any other (Figure 6). The top five in this list are all roughly within a 30-minute drive of Inverness.

Figure 6: Settlement population change between 2010 and 2020 in Highland



Source: National Records of Scotland (NRS) mid-year estimate Settlement and Locality populations
1. NRS estimates suggested an increase of 56% caused by the inclusion of additional small communities in the Broadford settlement boundary from 2016 onwards. Population change in this instance is based on Community Health Index (CHI) populations at April 2010 and April 2020 extracts using the 2010 settlement boundary.
2.The Glendoe hydro scheme project brought several hundred temporary residents to the area including Fort Augustus between 2006 and 2010. Included in this value will be the subsequent loss of these residents when the project ended.
Note: Where a settlement's population was previously or is now below the 500 person threshold they will not feature in this graphic.

Figure 7: Change in settlement population from 2010 to 2020 in Highland



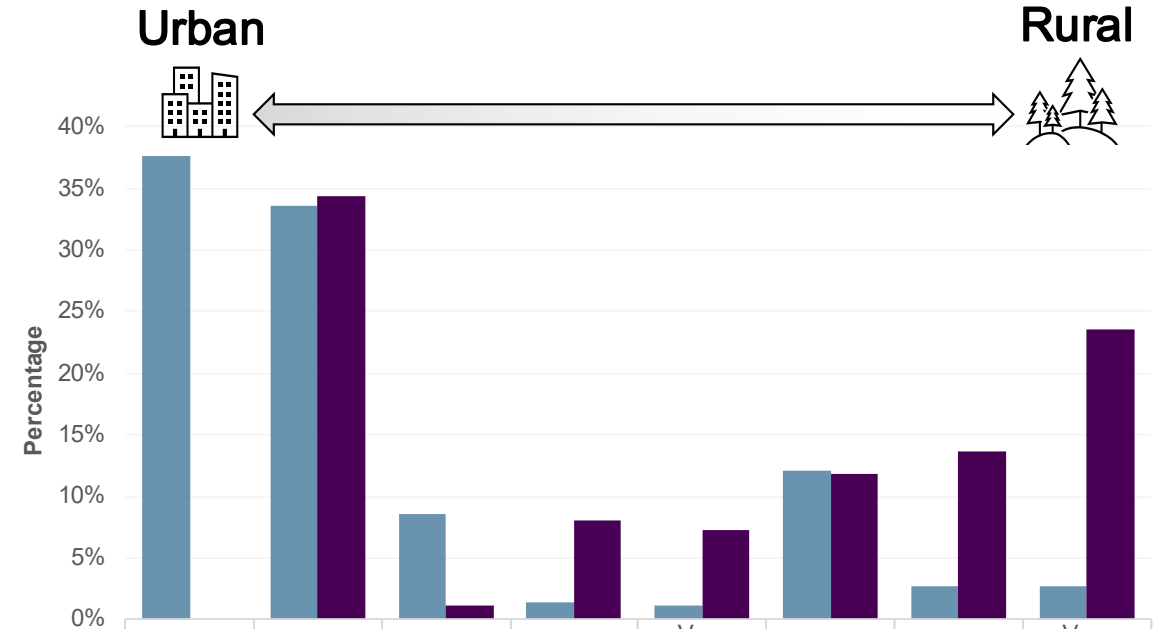
Source: National Records of Scotland (NRS) mid-year estimate Settlement and Locality populations

3.3. Remoteness and rurality

The Scottish Government Urban Rural Classification (SGURC) is consistent with the government's core definition of rurality, which defines settlements of 3,000 or fewer people as rural. It also classifies areas as remote based on drive times from settlements of 10,000 or more people. Using population thresholds and access criteria creates layers of sophistication in the classification.

Almost four in ten of the population of Highland live in remote rural areas and almost one in four of the population lives in areas that are classified as very remote rural. In contrast, one in twenty of the Scottish population lives in a remote rural area, with one in forty residing in very remote rural areas (Figure 8).

Figure 8: Percentage of the population living in urban and rural areas by the Scottish Government Urban Rural Classification, Scotland and Highland



	Large Urban Areas	Other Urban Areas	Accessible Small Towns	Remote Small Towns	Very Remote Small Towns	Accessible Rural Areas	Remote Rural Areas	Very Remote Rural Areas
	1	2	3	4	5	6	7	8
Scotland	37.6%	33.6%	8.6%	1.4%	1.2%	12.1%	2.7%	2.8%
Highland	0.0%	34.4%	1.2%	8.1%	7.3%	11.8%	13.7%	23.6%

Source: Scottish Government Urban Rural Classification 2020, National Records of Scotland Small Area Population Estimate 2021

Figure 9: Population distribution by the Scottish Government Urban Rural Classification, Scotland and Highland

	Scotland		Highland	
	Population	*Percentage of population*	Population	*Percentage of population*
1 Large Urban Areas	2,061,049	37.6%	0	0.0%
2 Other Urban Areas	1,843,792	33.6%	82,008	34.4%
3 Accessible Small Towns	470,529	8.6%	2,740	1.2%
4 Remote Small Towns	79,455	1.4%	19,238	8.1%
5 Very Remote Small Towns	65,059	1.2%	17,309	7.3%
6 Accessible Rural Areas	660,901	12.1%	28,108	11.8%
7 Remote Rural Areas	148,076	2.7%	32,568	13.7%
8 Very Remote Rural Areas	151,039	2.8%	56,089	23.6%
Total	**5,479,900**	**100.0%**	**238,060**	**100.0%**

Source: Scottish Government Urban Rural Classification 2020, National Records of Scotland Small Area Population Estimate for 2021

Island populations

National Records of Scotland published Census 2022 population data for both island groups and individual islands[11] [12]. At the time of the 2022 census there were 12 inhabited islands, a reduction of two since the previous census in 2011[13]. A total island population of 10,876 was reported, an increase of 4.5 percent (Figure 10). The Highland island population represents 4.6 percent of the population of Highland HSCP. Over 96 percent of Highland's island population live on the Isle of Skye where the population increased by 4.9 percent.

Figure 10: Inhabited island usual resident population and households from Scotland's Census 2022 and 2011

			Census population		
HSCP	**Island group**	**Island name**	**2022**	**2011**	**change (N)**
Highland	Eigg	Canna	9	12 ▼	-3
		Eigg	95	153 ▼	-58
		Muck	28	27 ▲	1
		Rùm	31	22 ▲	9
		Sanday (Canna)	4	9 ▼	-5
	Isle of Raasay	Isle of Raasay	187	161 ▲	26
		Rona / Ronaigh (Skye)	2	3 ▼	-1
	Isle of Skye	Isle of Skye	10,496	10,008 ▲	488
		Scalpay (Skye)	-	4 ▼	-4
		Soay	3	1 ▲	2
	Mainland of Scotland	Eilean Shona	9	2 ▲	7
		Eilean Tioram	5	6 ▼	-1
		Isle of Ewe	7	7 ▲	0
		Tanera More / Tannara Mòr	-	4 ▼	-4
			10,876	**10,408** ▲	**468**

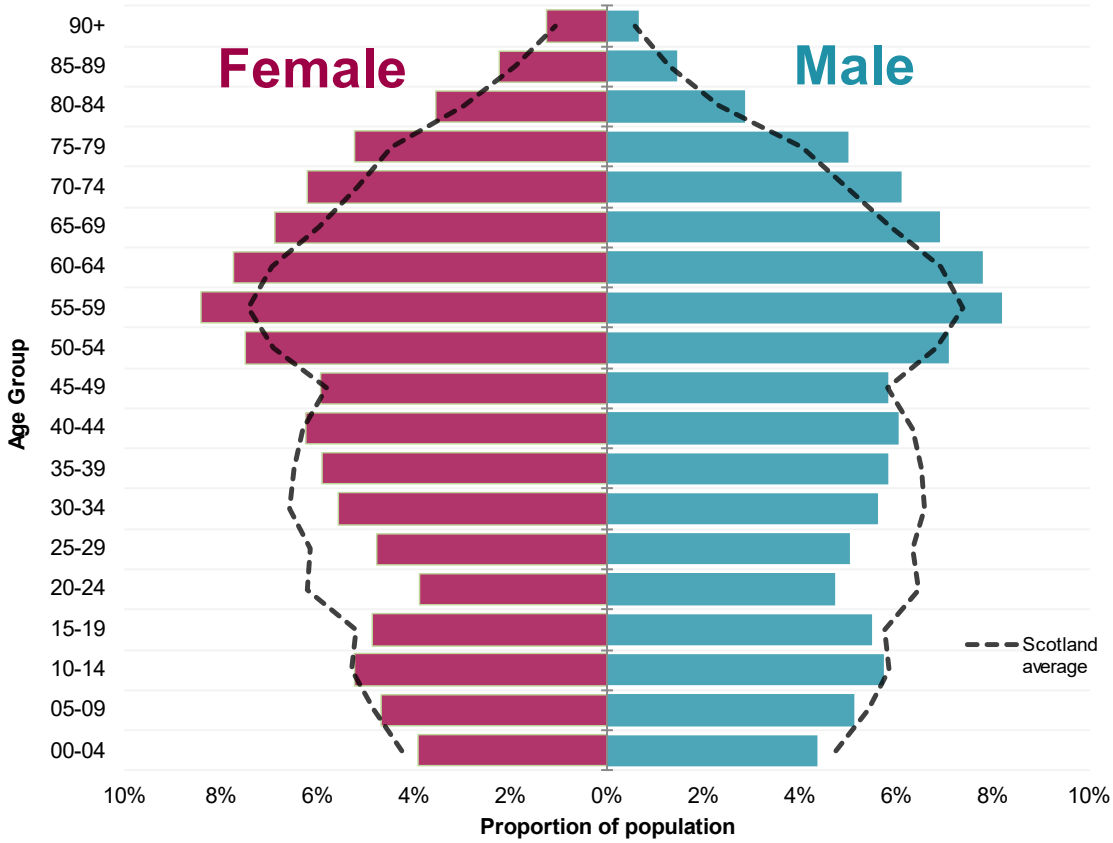
Source: National Records of Scotland, 2022 Census Supporting Information, Islands

3.4. Population structure

Highland has an older age structure with comparatively fewer people in the 20-24, 25-29, 30-34 and 35-39 age groups than the Scotland average (Figure 11). These are key ages for migration, with educational and work opportunities being prime influencing factors.

A large proportion of 20-24 year olds in Highland who are studying at universities in Scotland do so outside of the Highlands and Islands. Many also leave, or stay away following their education, to pursue a broader range of employment and career progression opportunities. Whilst many young people do choose to return to the region later in life, the out-migration of young people has an important impact on overall population size[14].

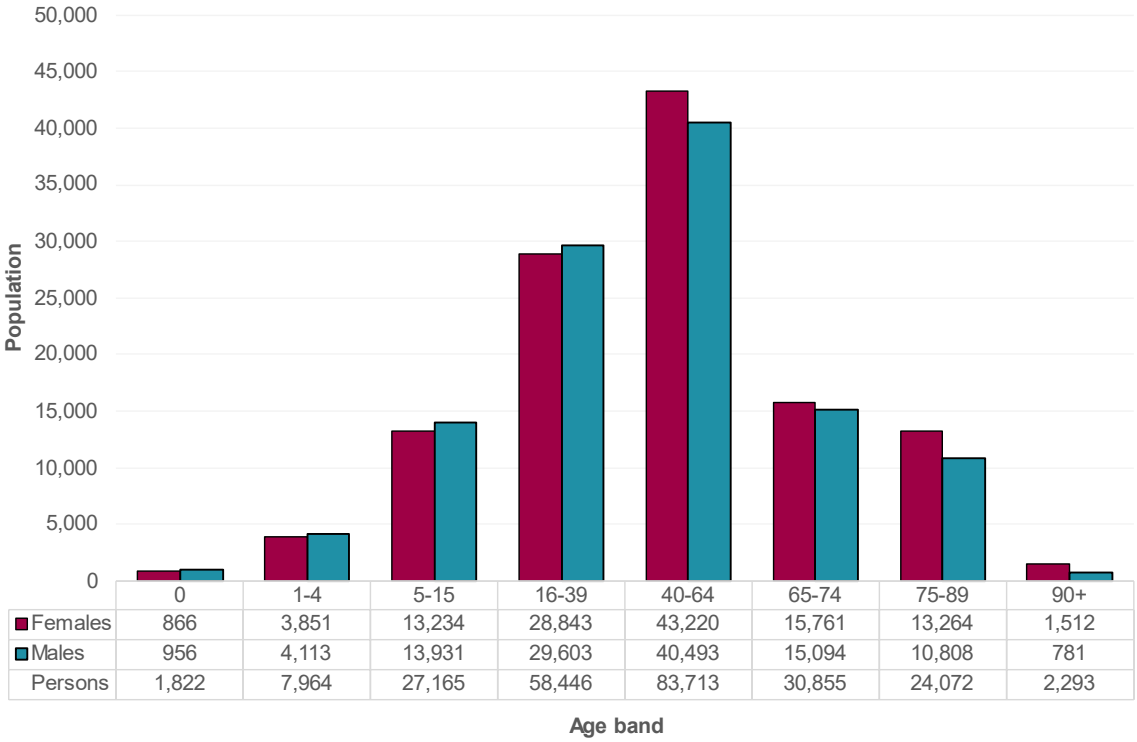
Figure 11: Population distribution by age and sex in Highland and Scotland, 2023



Source: National Records of Scotland, Mid-Year Population Estimates, 2023

In the 75-89 and 90+ age groups in particular there is a higher proportion of females (56 percent) than males (44 percent) in Highland (Figure 12). Higher life expectancy in females is the main driver for this differential.

Figure 12: Highland population by age group and sex, 2023

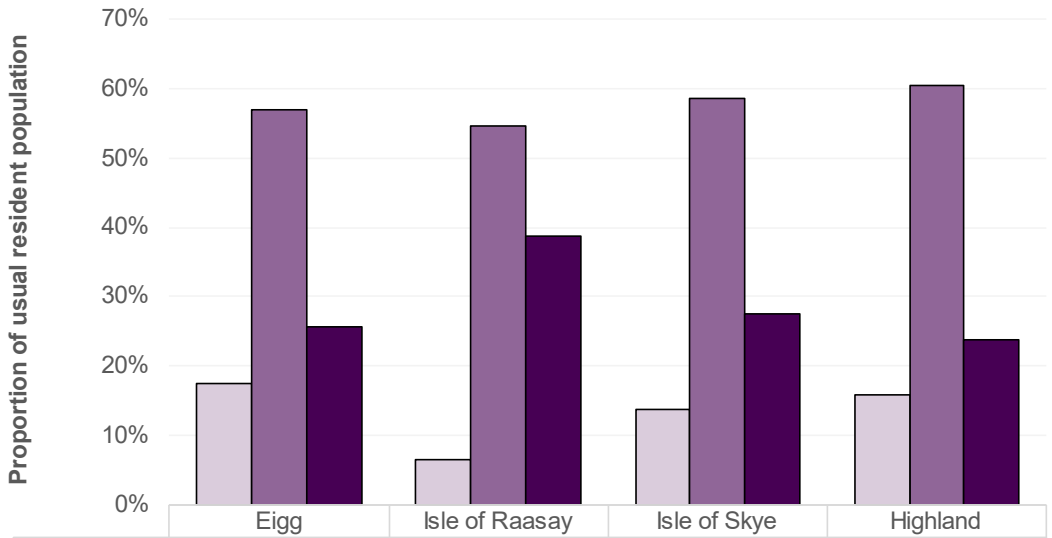


	0	1-4	5-15	16-39	40-64	65-74	75-89	90+
Females	866	3,851	13,234	28,843	43,220	15,761	13,264	1,512
Males	956	4,113	13,931	29,603	40,493	15,094	10,808	781
Persons	1,822	7,964	27,165	58,446	83,713	30,855	24,072	2,293

Source: National Records of Scotland, Mid-Year Population Estimates, 2023

Age group data for Island Groups shows the Raasay island group had a similar working age population, but fewer young people and a higher proportion of people aged 65 and over than the other island groups and Highland overall (Figure 13).

Figure 13: Proportion of population by broad age group for Island Groups in Highland, 2022



	Eigg	Isle of Raasay	Isle of Skye	Highland
0 - 15	17.5%	6.6%	13.9%	15.8%
16 - 64	56.9%	54.6%	58.5%	60.4%
65 and over	25.7%	38.8%	27.6%	23.7%

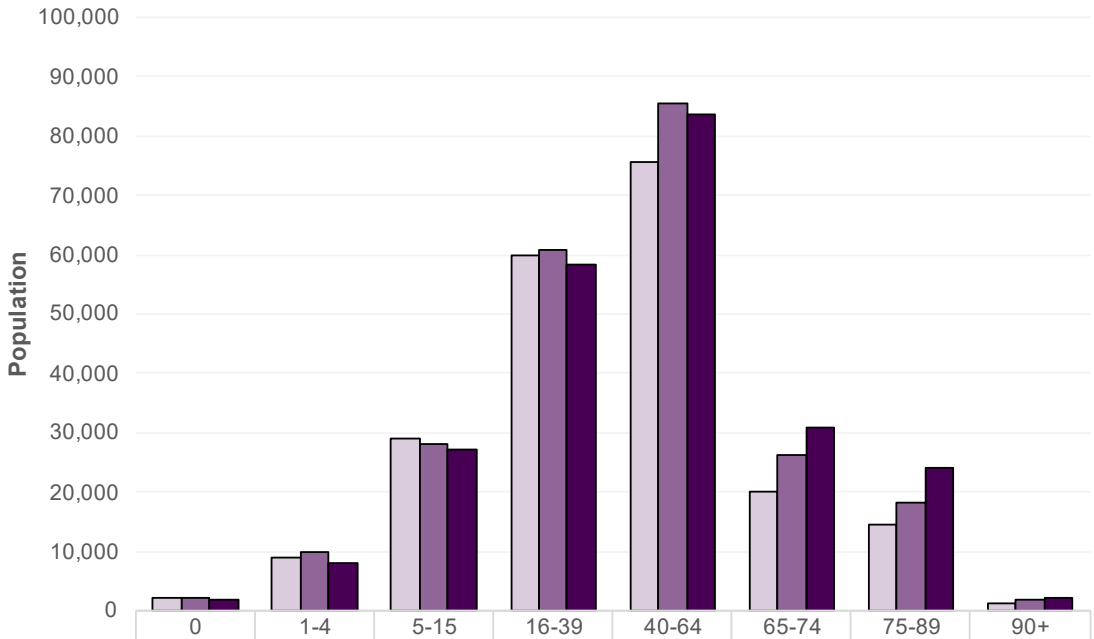
Source: National Records of Scotland, 2022 Census Supporting Information, Islands
The islands of Eilean Shona, Eileam Tioram, Isle of Ewe and Tannara Mòr form part of the 'Mainland of Scotland' group and do not have age group data available from the Census 2022

3.5. Population change

The population of Highland is ageing, with increasingly large cohorts living to older age and fewer children and young people. As a result of lower birth rates in the past and migration patterns that see young people leaving the areas for education and employment, the working-age population is declining in size and ageing.

Between 2003 and 2023, the population aged 65 and over increased by 58.8 percent, while the working age population aged 16-64 increased by only 4.9 percent (Figure 14). Around one in six of the population were 65 and over in 2013, increasing to one in four in 2023.

Figure 14: Population in Highland by age group, 2003, 2013 and 2023



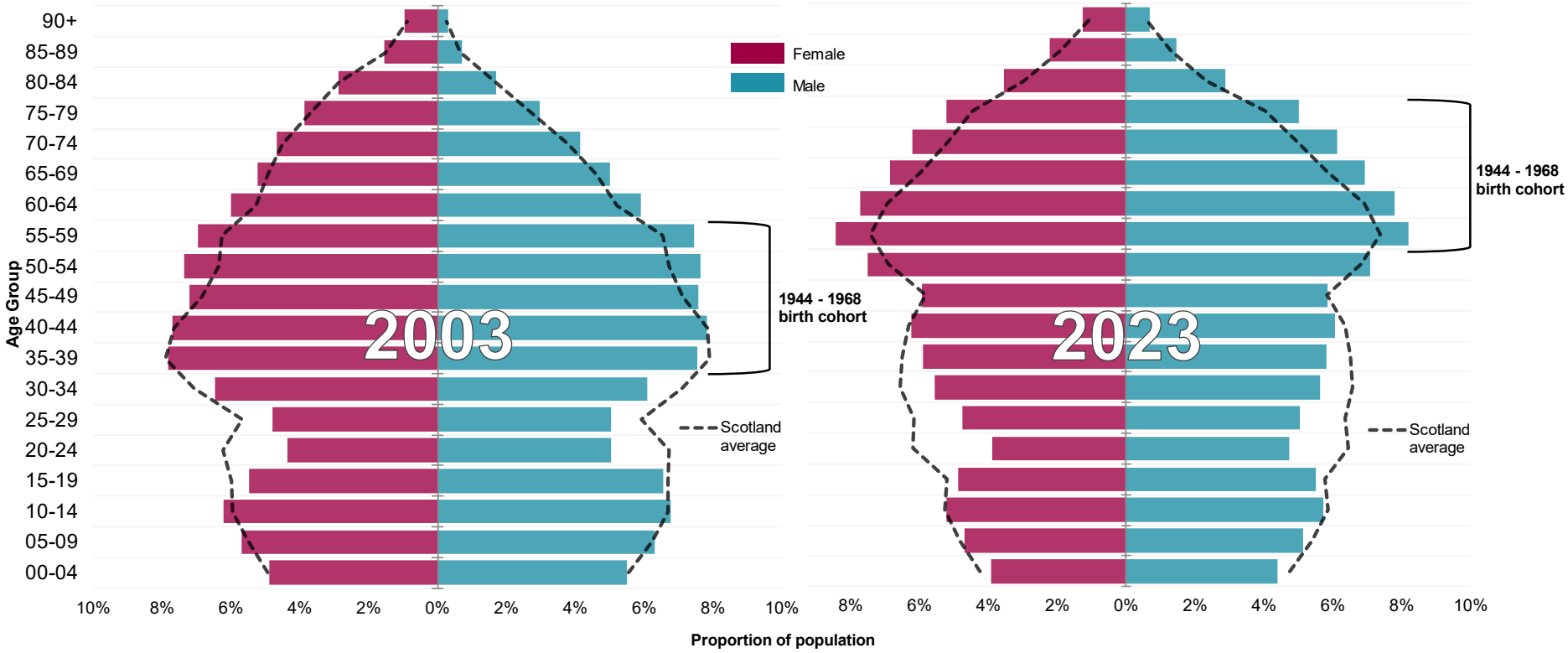
	0	1-4	5-15	16-39	40-64	65-74	75-89	90+
2003	2,065	8,897	29,139	59,794	75,703	20,143	14,553	1,346
2013	2,243	9,946	27,976	60,834	85,584	26,360	18,346	1,791
2023	1,822	7,964	27,165	58,446	83,713	30,855	24,072	2,293

Source: National Records of Scotland Mid-Year Population Estimates, 1981 to 2023

This increasingly ‘top-heavy’ population structure is apparent when comparing the age distribution for 2003 and 2023 population estimates with older age-cohorts making up an increasingly large proportion of the total population (Figure 15).

The generation born in the post-war period from the mid 1940s to mid 1960s are commonly referred to as “baby boomers”. As these people age, and there are not equivalent numbers of people in the generations behind them, the pool of people potentially available to offer support is reduced. However, many older people are not dependent on others, work over the age of 65, or care for others so the future outlook is complex.

Figure 15: Population distribution by age and sex in Highland and Scotland, 2003 and 2023

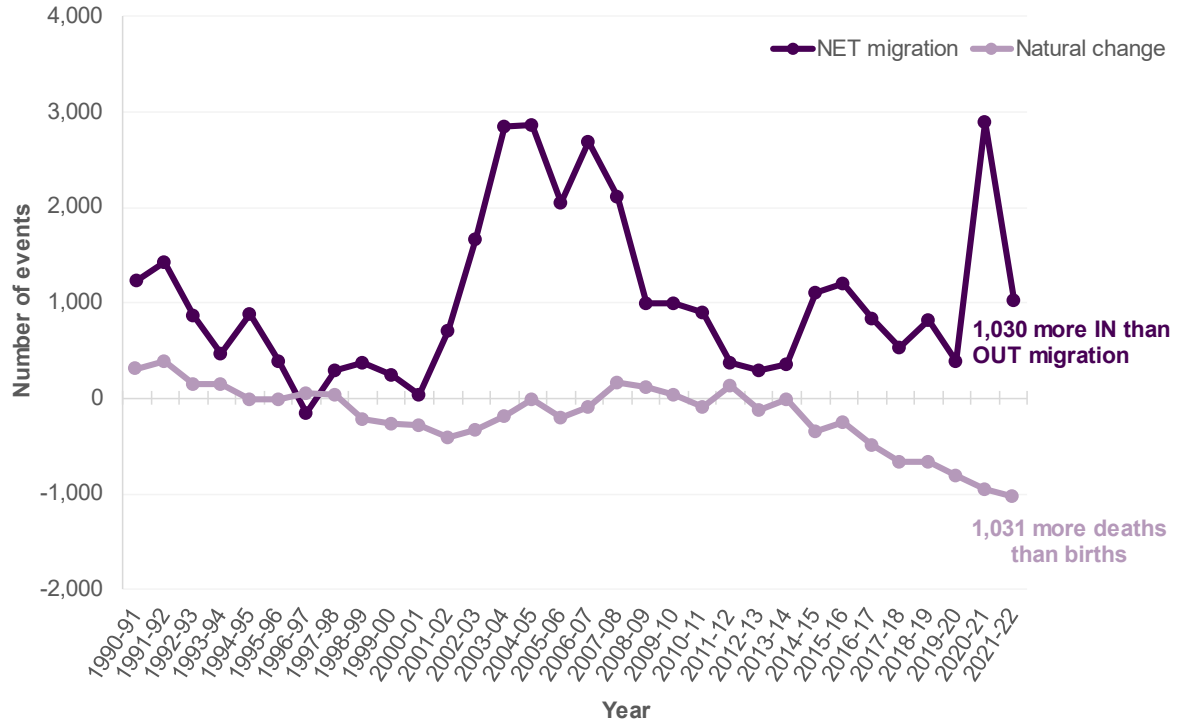


Source: National Records of Scotland Mid-Year Population Estimates, 1981 to 2023

3.6. Population dynamics

Population change is driven by births, deaths and migration. Between 2013 and 2023 there were 22,421 live births and 28,805 deaths registered in Highland[15]. Without migration the population would have decreased by 6,384 people. Future population growth is dependent on a net migration balance that attracts new residents and retains existing populations to offset what is a declining trend in the gap between births and deaths (Figure 16).

Figure 16: Natural population change and net migration in Highland, 1990-91 to 2021-22



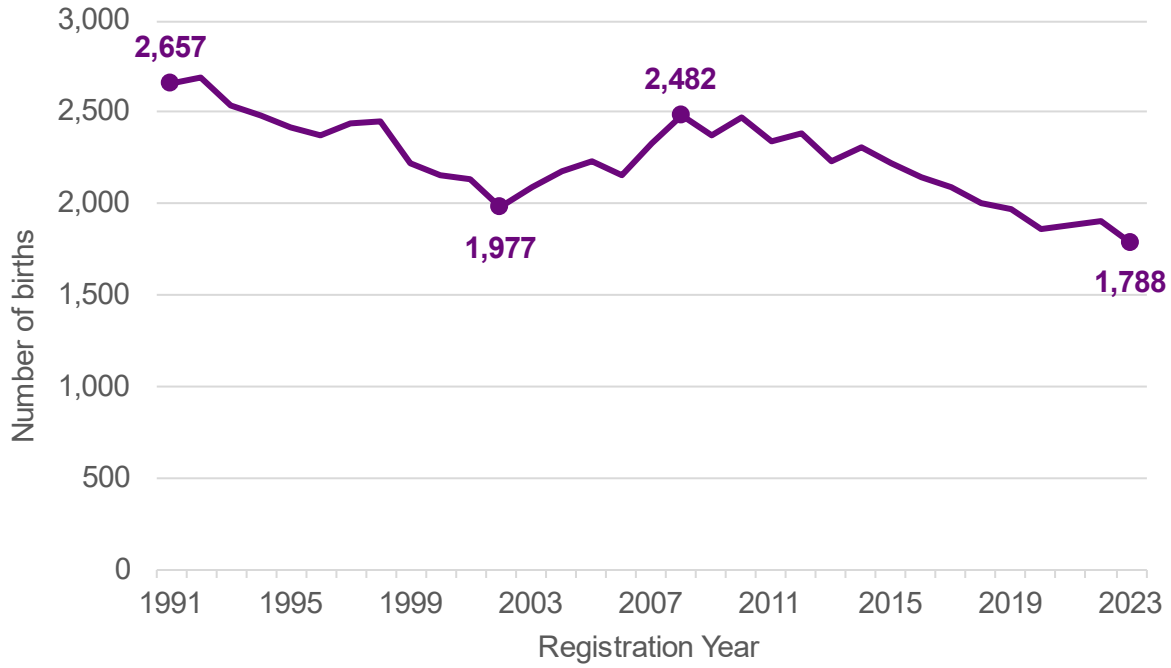
Source: National Records of Scotland, Births and Deaths Time Series Data and Migration Flow, Total migration to or from Scotland, mid-1952 to mid-2022

The number of children born to residents in the Highland area is historically low. There were 1,788 live births registered to Highland residents in 2023, lower than in 2022 (Figure 17). This followed two years of increases following the Covid-19 pandemic. There has been a longer-term decline which began around the onset of the global financial crisis in 2008.

Standardised birth rates have been slightly higher in Highland than Scotland over time. However they have both followed the same downward trend, particularly since 2008.

There are many factors that influence people's decisions to start or expand their family. Some of these include financial stability and uncertainty, adequate housing provision, and personal choices such as focus on education or career development.

Figure 17: Number of live births in Highland by year, 1991 to 2023



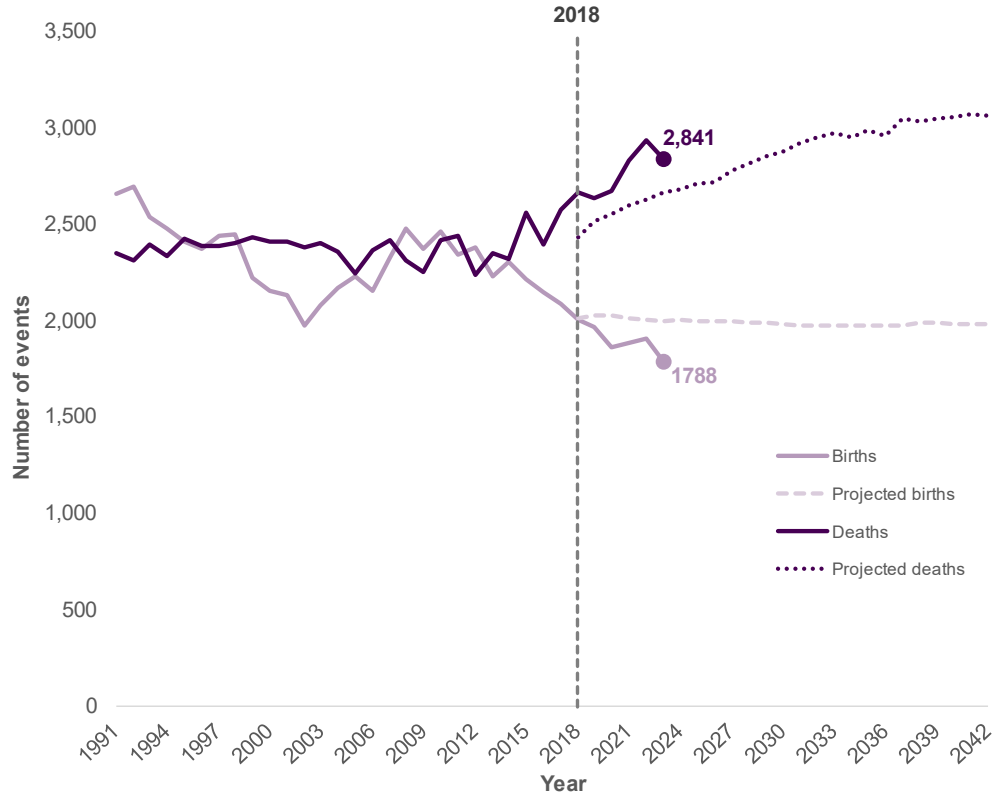
Source: National Records of Scotland Births Time Series Data, 1991-2023

According to the 2018-based projected number of births published by National Records of Scotland (Figure 18), there may be 1,979 births to Highland mothers in 2033[16]. The 2018-based projection depends upon more optimistic fertility assumptions than those that would now apply in 2024. The number of births since 2018 has been below the projected number, and current fertility rates, particularly in women aged 20-24 and 25-29, suggest that future birth projections will be revised downward.

The number of deaths have been above the 2018-based projections. There has been a longer-term trend of increasing numbers of deaths linked to an aging population and stalling life-expectancy. Future projections will take further account of the aging population of Highland and changing migration patterns.

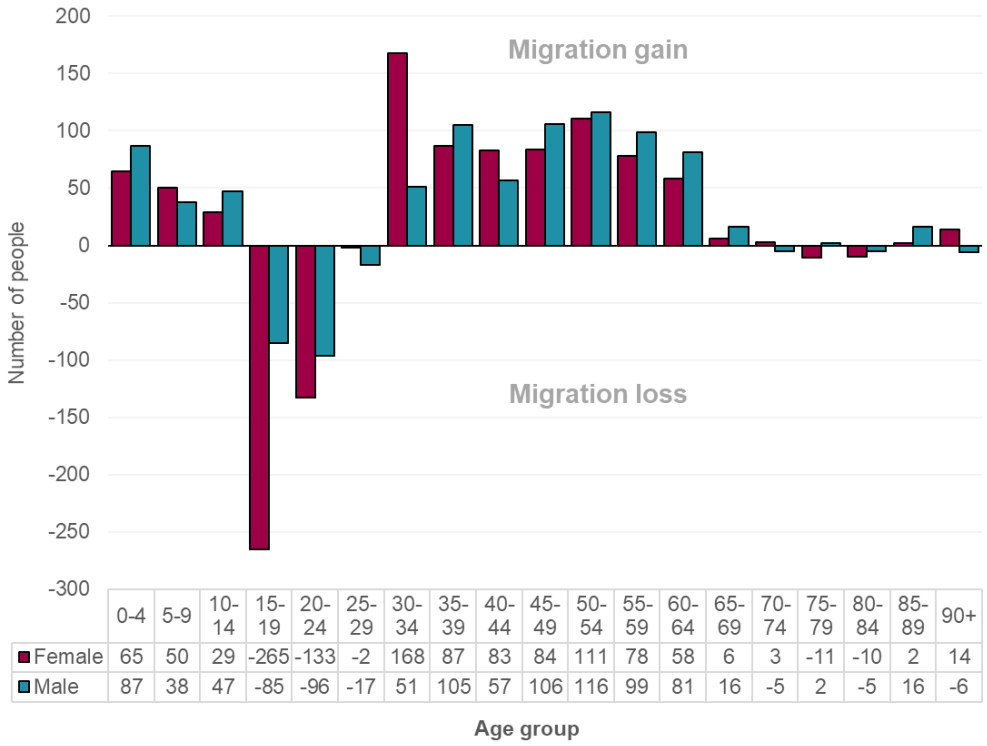
Figure 19 illustrates the total net migration by age group and sex in Highland between mid-2021 and mid-2022[17]. There was a peak loss in the population aged 15-19 years that most likely reflects young adults moving from the area for education and employment. The largest net gains in population occurred in people aged between 30 and 64 years of age. These gains include people with families and is therefore reflected in the child population.

Figure 18: Actual and projected number of births and deaths in Highland, 1991-2043



Source: National Records of Scotland, Births and Deaths Time Series Data and 2018-based population projections council area summary tables

Figure 19: Net migration by age group by sex, Highland, 2021-22



	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
Female	65	50	29	-265	-133	-2	168	87	83	84	111	78	58	6	3	-11	-10	2	14
Male	87	38	47	-85	-96	-17	51	105	57	106	116	99	81	16	-5	2	-5	16	-6

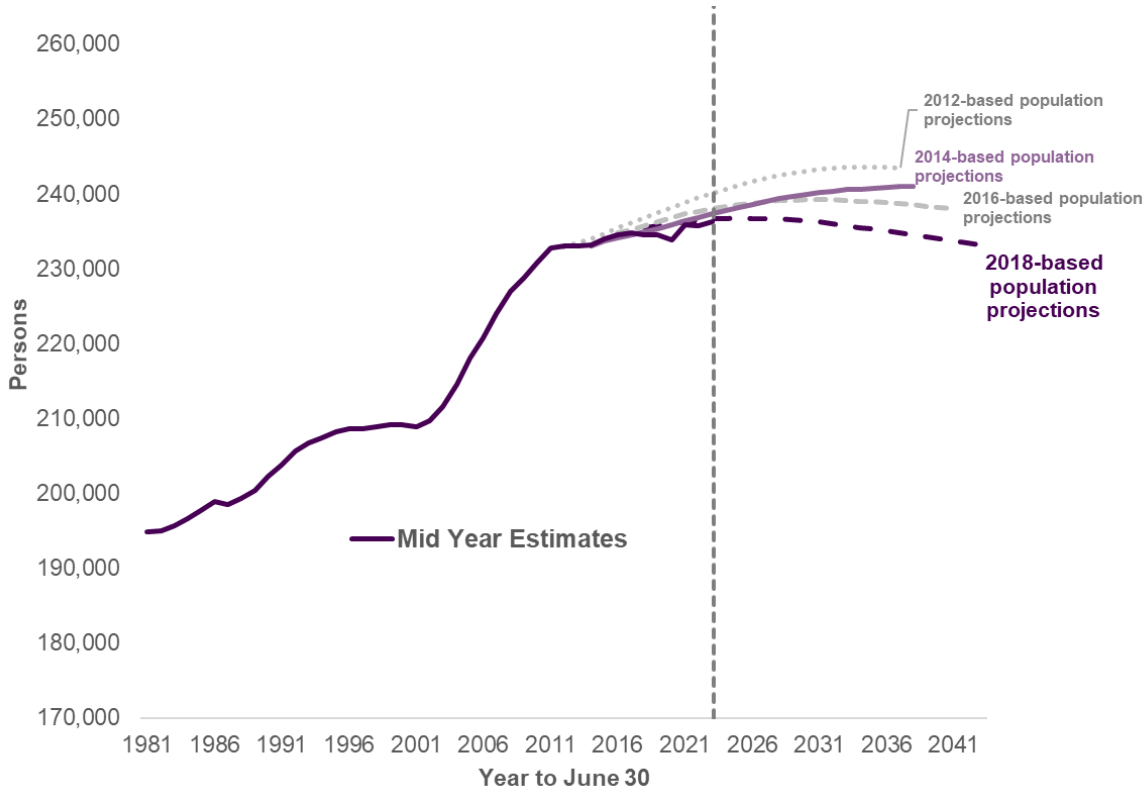
Source: National Records of Scotland, Migration Flows - Total net migration mid-2021 to mid-2022

3.7. Population projections and trends

The 2018-based sub-national population projections predicted a steady decline in Highland's population from 2026 onwards (Figure 20). Recent estimates of international migration have been incorporated into the 2020-based national projections published by NRS and the Office for National Statistics (ONS).

Due to higher migration assumptions, the population of Scotland is projected to increase until around mid-2033[18], rather than mid-2028 suggested by the original 2020-based projections. These assumptions are likely to impact the sub-national, 2022-based population projections due to be released in Summer 2025. The Highland projections below should be interpreted with care.

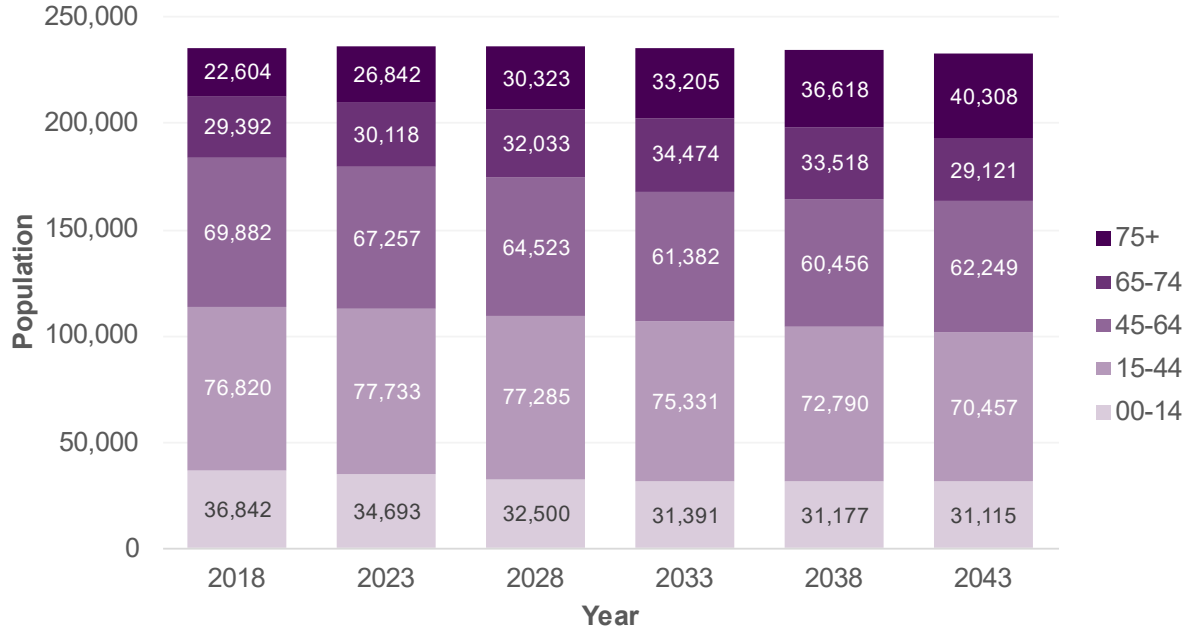
Figure 20: Comparison of the 2018-based population projections with previous projections for Highland



Source: National Records of Scotland, sub-national population projections

What is more certain is that, given the current population structure, population ageing will continue to occur as larger cohorts age and are replaced by smaller numbers. The proportion of older people is expected to increase substantially, often in areas where population numbers are static or decreasing. Between 2023 and 2043 the 65 and over population is projected to increase by 21.9 percent while the under 65 population is projected to decrease by 8.8 percent (Figure 21). The level of change depends on future migration and birth rates.

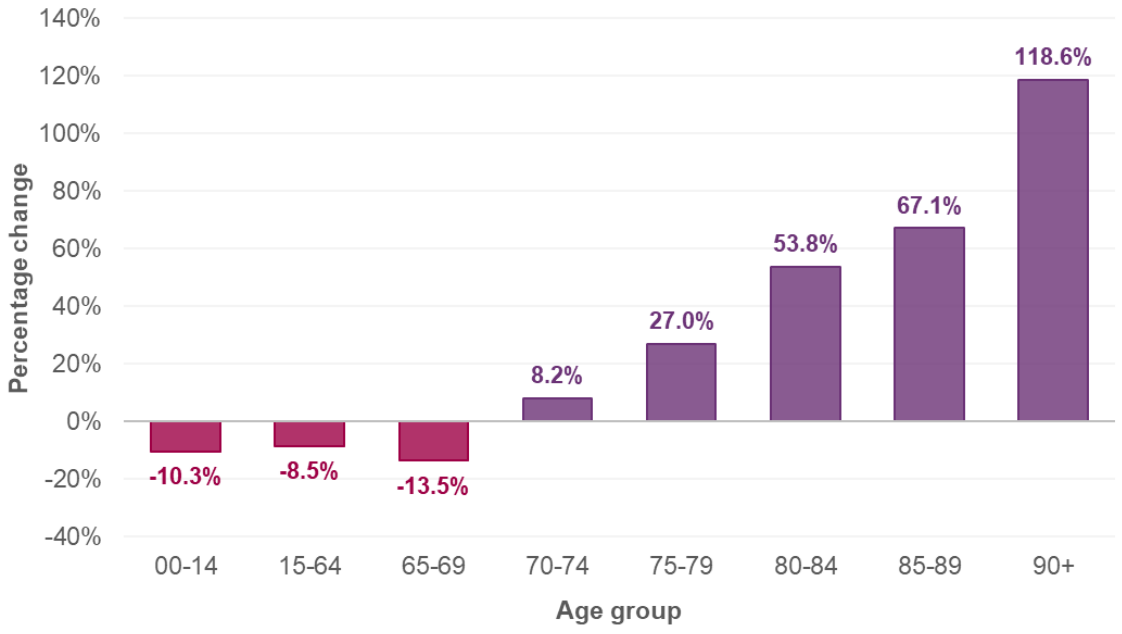
Figure 21: Projected change in population 2018 to 2043 by age group in Highland



Source: National Records of Scotland, 2018-based sub-national population projections

Projections predict progressively higher percentage increases in population in the older age groups (Figure 22). Household projections suggest that, in the future, many older people will live in smaller or single households and there will be fewer inter-generational households[19]. The impact on informal and formal care and appropriate housing supply is discussed later in the report.

Figure 22: Projected percentage change in population by age group in Highland, 2023 to 2043

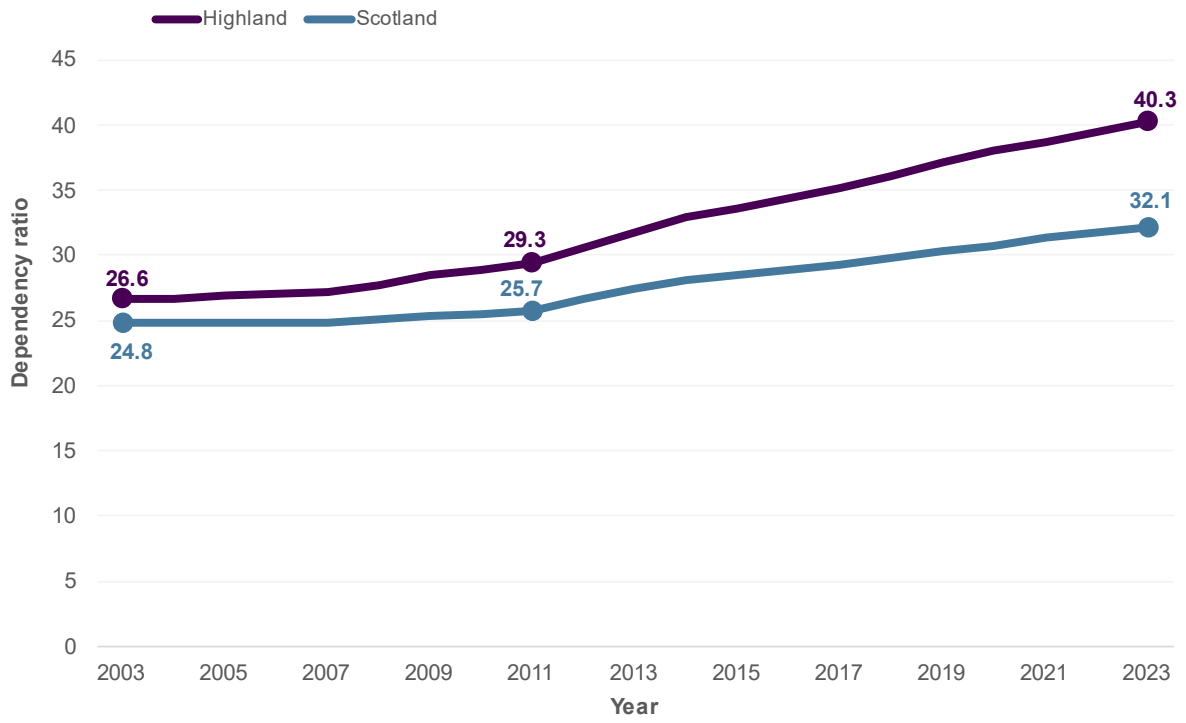


Source: National Records of Scotland, 2018-based sub-national population projections

3.8. Older age dependency

The older age dependency measure shows the ratio of people aged 16-64 years of age, who are assumed to be economically active, compared to older people aged 65 and over. In Highland there were 40 people of older age to every 100 people of working-age in 2023, higher than the Scotland average (Figure 23).

Figure 23: Older age dependency ratios in Highland and Scotland, 2003 to 2023



Source: National Records of Scotland Mid-Year Population Estimates, 1981 to 2023

The ratio has increased at a faster rate in Highland in comparison to Scotland in the period 2003 to 2023 (Figure 24). This highlights the potential impacts on workforce supply and service demand in health and social care settings. However increasingly people are working until later in life, continuing to contribute economically, so it is important to take other factors into account when assessing the impact of an aging population.

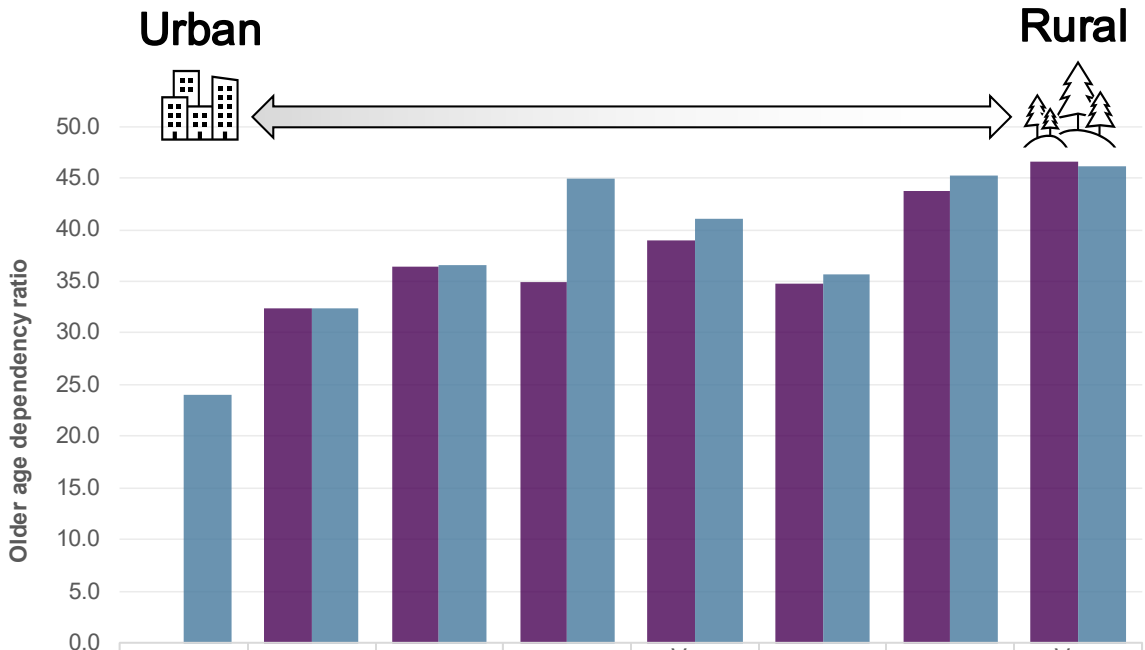
Figure 24: Change in old age dependency ratios between 2003 and 2023

Area	2003	2023	change	% change
Highland	26.6	40.3	13.7	51.3%
Scotland	24.8	32.1	7.3	53.9%

Older age dependency ratios are higher in remote rural areas in Highland and Scotland. In the very remote rural areas in Highland, there was around one person of older age to every two people of working-age, in comparison to one in three in urban areas (Figure 25).

An issue of key concern to older people living in rural areas is the importance of access to services in general and to health and care services in particular. This raises questions concerning the costs (both public and private) of providing such services given the distances involved, the difficulty of recruiting staff and the viability and disproportionate costs that arise from serving a more dispersed rural population[20].

Figure 25: Older age dependency ratios by Urban Rural class in Highland and Scotland, 2021



	Large Urban Areas	Other Urban Areas	Accessible Small Towns	Remote Small Towns	Very Remote Small Towns	Accessible Rural Areas	Remote Rural Areas	Very Remote Rural Areas
	1	2	3	4	5	6	7	8
Highland		32.4	36.4	34.9	38.9	34.8	43.7	46.6
Scotland	24.1	32.4	36.6	44.9	41.1	35.7	45.2	46.2

Source: National Records of Scotland, Small Area Population Estimates 2021, Urban Rural Classification 2020

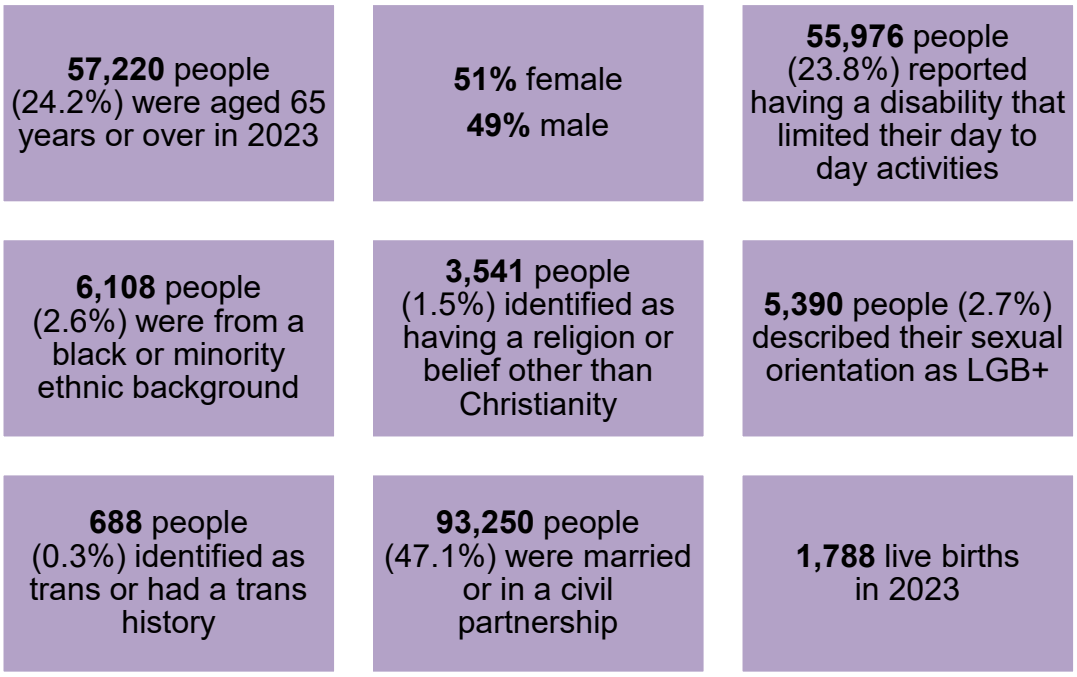
3.9. Equality and diversity

Under the Equality Act 2011, public bodies have a legal duty to ensure that people from different groups are treated equally and fairly and to reduce inequalities for people from different groups.

There are nine protected characteristics identified in Scottish equality legislation: age, sex, disability, race, religion or belief, sexual orientation, gender reassignment, marriage or civil partnership, pregnancy and maternity.

It is important that all protected characteristics are taken into account when planning services for the future. Estimates of the number of people in Highland with each protected characteristic are summarised in Figure 26.

Figure 26: An overview of the number of people with the nine protected characteristics in Highland



Source: Scotland's Census 2022, National Records of Scotland mid 2023 population estimates, National Records of Scotland Births. All data from Census 2022 except age, sex and pregnancy (births).
The term LGB+ refers to people who described their sexual orientation as Gay or Lesbian, Bisexual, or Other sexual orientation.

3.10. Ethnic minorities

Ethnicity is a complex concept that refers to the social group a person belongs to and either identifies with or is identified with by others based on cultural and other factors, including language, diet, religion and geographical and ancestral origins[21 22].

Everyone, not just those in minorities, has an ethnicity; however, categorisation is problematic, generalising complexities to produce common descriptions that are potentially valuable labels for research or policy but more limiting for delivering culturally sensitive services and identifying the causes of ethnic variations in disease[23].

Most ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status in all communities. Establishing the causes of ethnic inequalities in health is complicated, with many factors involved, including deprivation, the environment, health-related behaviours and the healthy migrant effect related to the selective inward migration of relatively more healthy individuals [24].

Racism and discrimination can also harm the physical and mental health of people from ethnic minority groups. Structural racism can reinforce inequalities, for example, in housing, employment and the criminal justice system, which in turn can harm health[25]. There are many opportunities to improve the health of minority ethnic groups by ensuring that services and initiatives are inclusive, equitable and delivered in culturally sensitive ways.

Comprehensive and good-quality data are essential to identifying the specific needs of different ethnic minority groups, understanding differences in health and healthcare experience, and monitoring progress. The disproportionate impacts of the COVID-19 pandemic on minority ethnic populations brought data deficiencies in monitoring their health experiences sharply into focus.

In 2022, the Scottish Government published updated guidance for public bodies about collecting data on ethnicity[26]. Previous attempts to increase the coverage and quality of data routinely collected on ethnicity have had some success, and data is now being more widely used in reporting health and care outcomes[27].

The standard classification of ethnic groups in the UK is set out in the Census, and definitions have changed over time to include common self-descriptions. Census 2022 codes are to be adopted across NHS Scotland data sets.

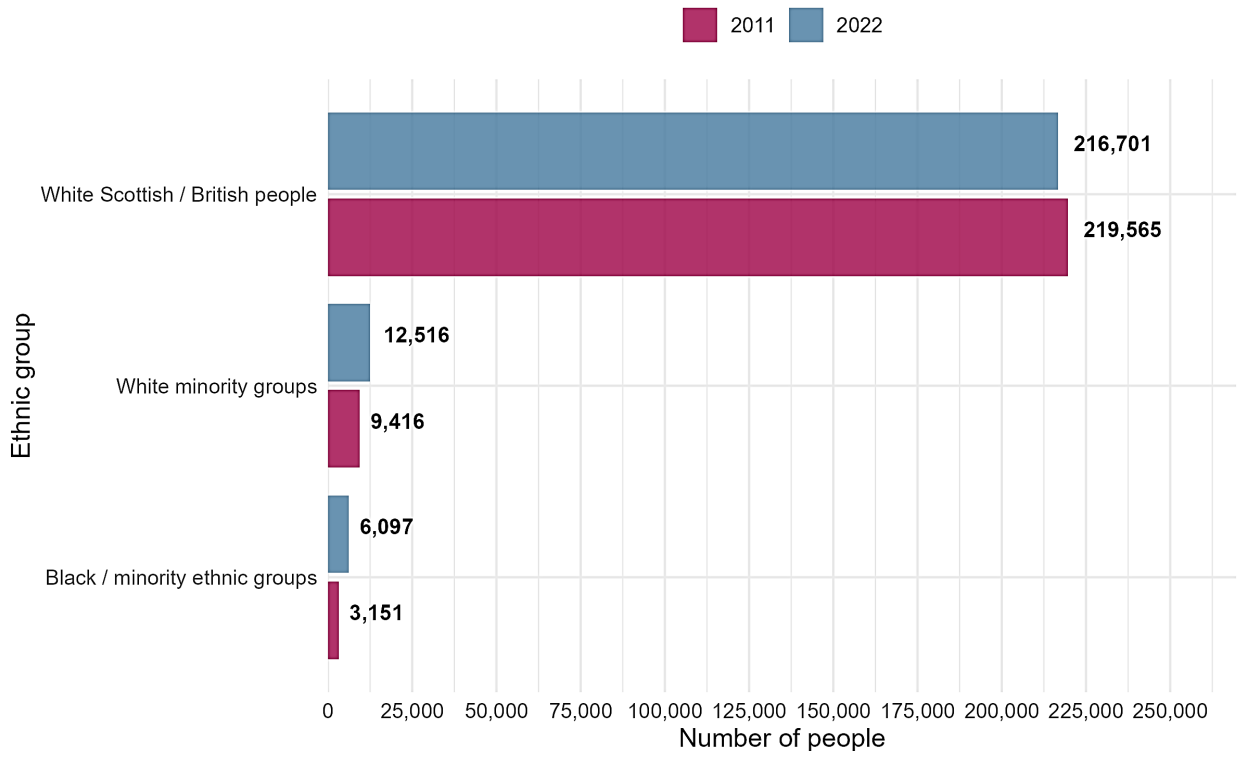
The Race Equality Framework for Scotland sets out the Scottish Government's strategy for promoting race equality and tackling institutional racism and inequality[28].

Insights on ethnic minority populations from the 2022 Census

According to the 2022 Census, 235,314 people lived in Highland; of these, 6,097 or 2.6 percent came from Black/minority ethnic backgrounds – a 93 percent increase from the previous Census 2011. In Scotland, 7.1 percent of the population identified as having a Black/minority ethnic background – an 84 percent increase in the inter-census period (Figure 27).

White minority ethnic groups, such as those with white Irish and Polish, have also grown significantly since the last census, with 5.4 percent of the Highland's current population coming from a white minority background compared to 4.1 percent in 2011 (Figure 28).

Figure 27: Highland's population by broad ethnic group, 2011 and 2022



Source: Scotland's Census 2011 (KS201SC – Census Output Areas) and 2022 (Table UV201 – Census Output Areas)
The **white minority group** category includes people from the following ethnic groups: white Irish, white Polish, Gypsy/Traveller, and other white non-British backgrounds. **Black/minority ethnic** include those of mixed/multiple ethnicities, Asian groups, Black and African groups, and those of another non-white background.

Figure 28 provides a more detailed overview of Highland's ethnic diversity. Some ethnic categories have changed since 2011, making a direct comparison difficult, and comparisons of the breakdowns of African groups and the Caribbean or Black category have been omitted.

Although small in absolute numbers, Highland is increasingly ethnically diverse, and this presence needs to be embraced by policies and services that consider those needs and promote equality of access and representation.

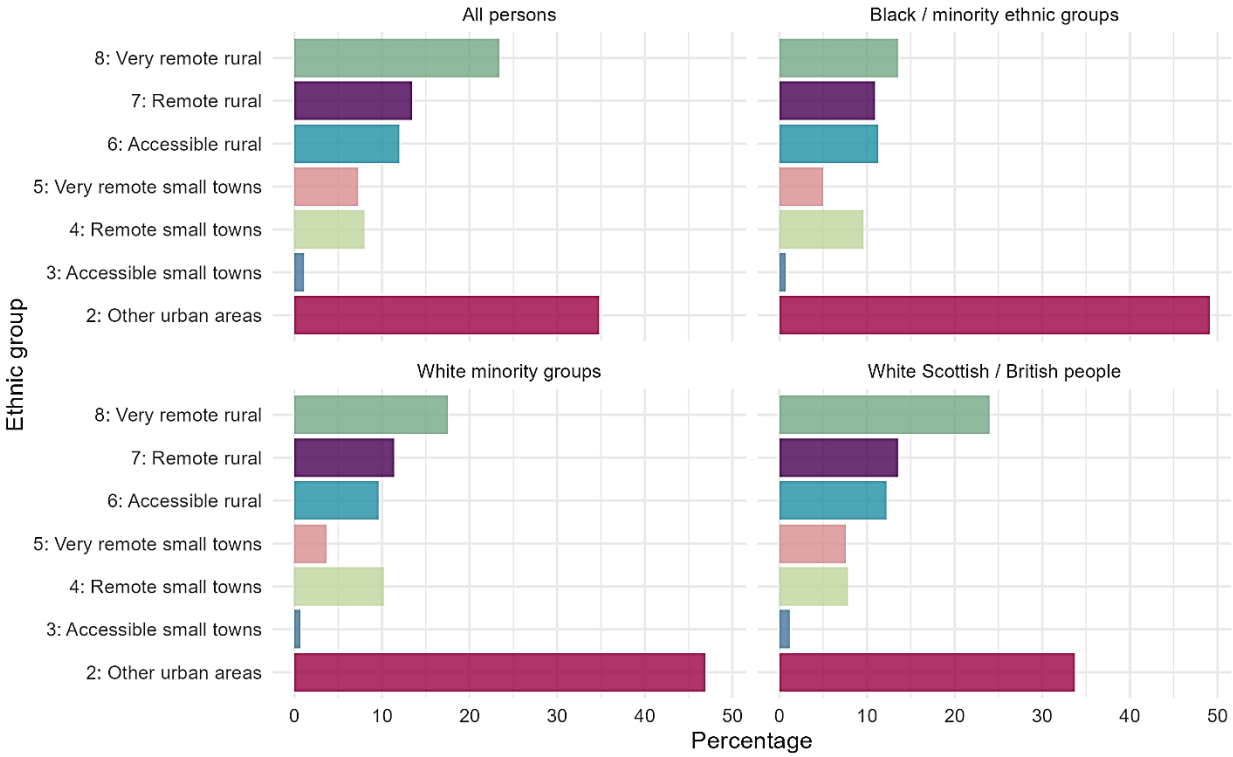
Figure 28: An overview of Highland's ethnic diversity in 2022

Ethnic group	Population count 2022	Percentage of the population	Percentage change since 2011
All People	235,336	100.0%	1.4%
White	229,104	97.4%	0.0%
White Scottish	178,561	75.8%	-3.8%
Other White British	38,140	16.2%	11.8%
White Irish	1,543	0.6%	11.0%
Gypsy/ Traveller	264	0.2%	-9.2%
White Polish	4,513	2.0%	31.8%
Other White	6,196	2.6%	43.8%
Mixed or multiple ethnic group	1,931	0.8%	190.8%
Pakistani, Pakistani Scottish or Pakistani British	388	0.2%	65.8%
Indian, Indian Scottish or Indian British	719	0.4%	55.6%
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	256	0.2%	18.0%
Chinese, Chinese Scottish or Chinese British	494	0.2%	30.4%
Other Asian	878	0.4%	53.0%
African	421	0.2%	102.4%
Caribbean or Black	210	0.0%	5.6%
Other ethnic groups	800	0.4%	273.8%

Source: Scotland's Census 2011 (KS201SC – Census Output Areas) and 2022 (Table UV201 – Census Output Areas)

Nearly 50 percent of the minority ethnic populations in Highland live in areas classified as ‘other urban’, including Inverness, Fort William and Nairn. However, ethnic minority groups populations are widely spatially distributed, with individuals and families living in all areas of Highland (Figure 29).

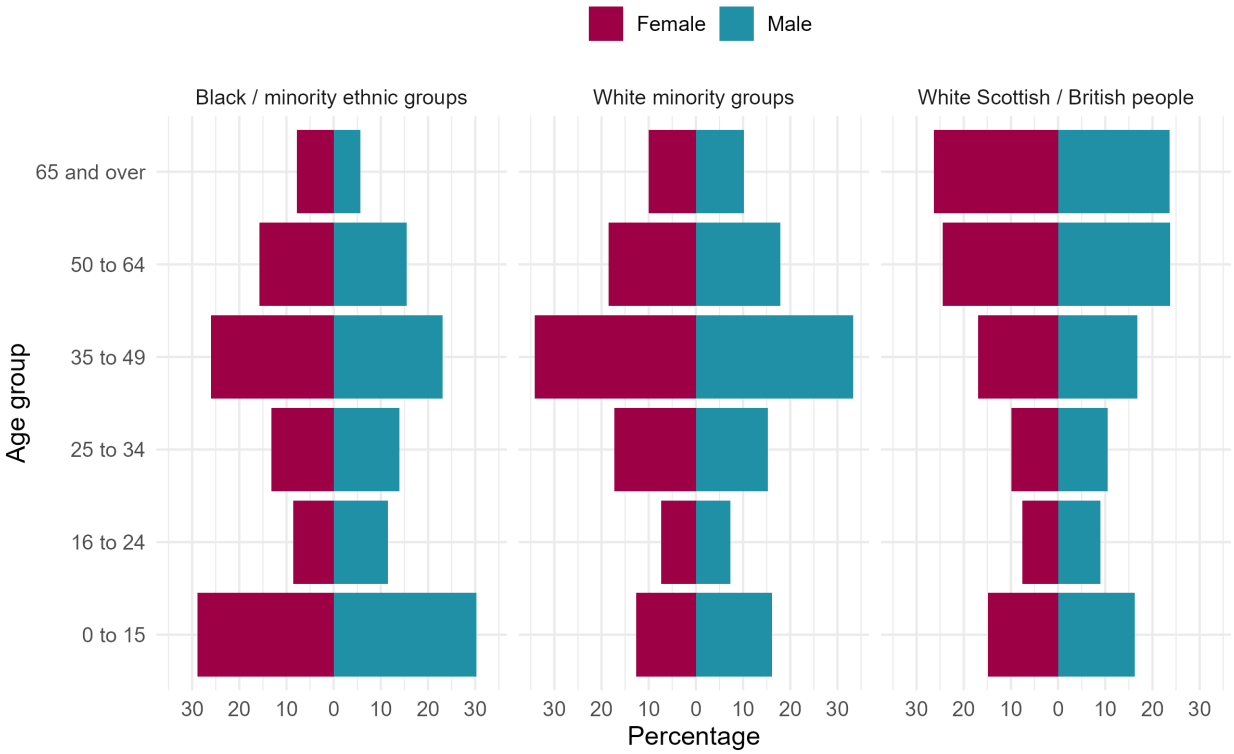
Figure 29: Proportion of ethnic groups living in areas defined by the Scottish Urban Rural 8-fold classification in Highland at the census 2022



Source: Scotland’s Census 2022 (Table UV201 – Output Areas) and the Scottish Government Urban Rural Classification 2020
The **white minority group** category includes people from the following ethnic groups: white Irish, white Polish, Gypsy/Traveller, and other white non-British backgrounds. **Black/minority ethnic** include those of mixed/multiple ethnicities, Asian groups, Black and African groups, and those of another non-white background.

The census also collects details of people’s age and sex. Minority ethnic groups are younger than the general population. Figure 30 highlights the generational differences in the diversity of the Highland population. These are similar to the picture observed nationally.

Figure 30: Proportion of the Highland population by age, sex and broad ethnic group at the census 2022



Source: Scotland's Census 2022 (Table UV201b)
The **white minority group** category includes people from the following ethnic groups: white Irish, white Polish, Gypsy/Traveller, and other white non-British backgrounds. **Black/minority ethnic** include those of mixed/multiple ethnicities, Asian groups, Black and African groups, and those of another non-white background.

4. Social Determinants

4.1. Deprivation

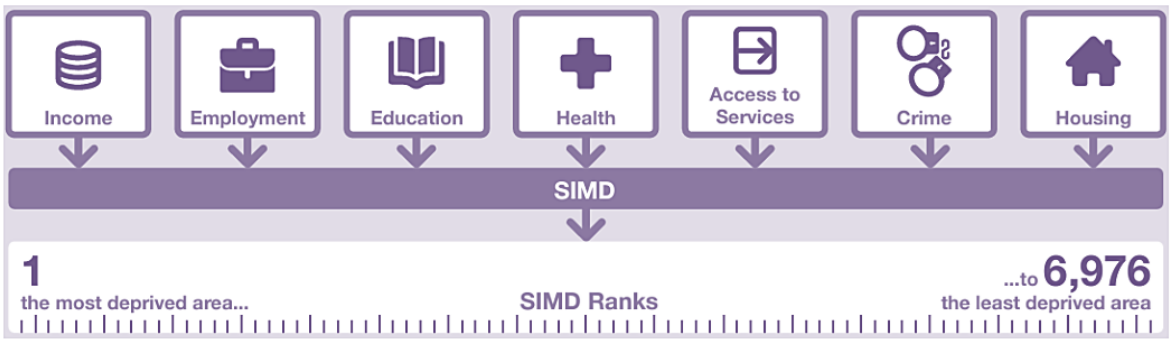
As the Scottish Government's preferred measure of deprivation, national and local organisations use the Scottish Index of Multiple Deprivation (SIMD) to identify areas where people experience the most material and socio-economic disadvantage to allocate funding and resources[29 30].

The index is based on Townsend's theorisation of relative deprivation that people are deprived if they[31]:

> *"lack the types of diet, clothing, housing, household facilities and fuel and environmental, educational, working and social conditions, activities and facilities which are customary, or at least widely encouraged and approved, in the societies to which they belong"*[32]

The SIMD combines 33 indicators across seven domains – income, employment, health, education, housing, geographic access and crime – into a single index for 6,976 small areas (data zones) with populations of around 800 people.

Figure 31: Scottish Government figure explaining the Scottish Index of Multiple Deprivation



Source: Scottish Index of Multiple Deprivation (SIMD) 2020v2

Each data zone is ranked according to the overall SIMD score. For analysis and making funding decisions, ranks can be grouped into categories such as quintiles, deciles or the 15 percent most deprived areas in Scotland[33]. As well as grouping areas into national quintiles and deciles, distributions can be calculated within NHS boards and Local Authorities to distribute resources for local initiatives or monitoring inequalities.

In the absence of data about the deprivation experienced by individuals, area deprivation is often used as the best available evidence. However, this can classify individuals into the wrong deprivation category even when using small areas such as the data zone[34 35 36].

The tool has limitations in rural areas where data zone geographies are larger, populations are less socially and economically homogenous, and problems of transport and distance are more significant to deprivation.

The index also does not capture important aspects of the deprivation experience in rural areas, such as social isolation and population loss. Therefore, the metric can overlook people and households experiencing multiple deprivations in remote or rural areas.

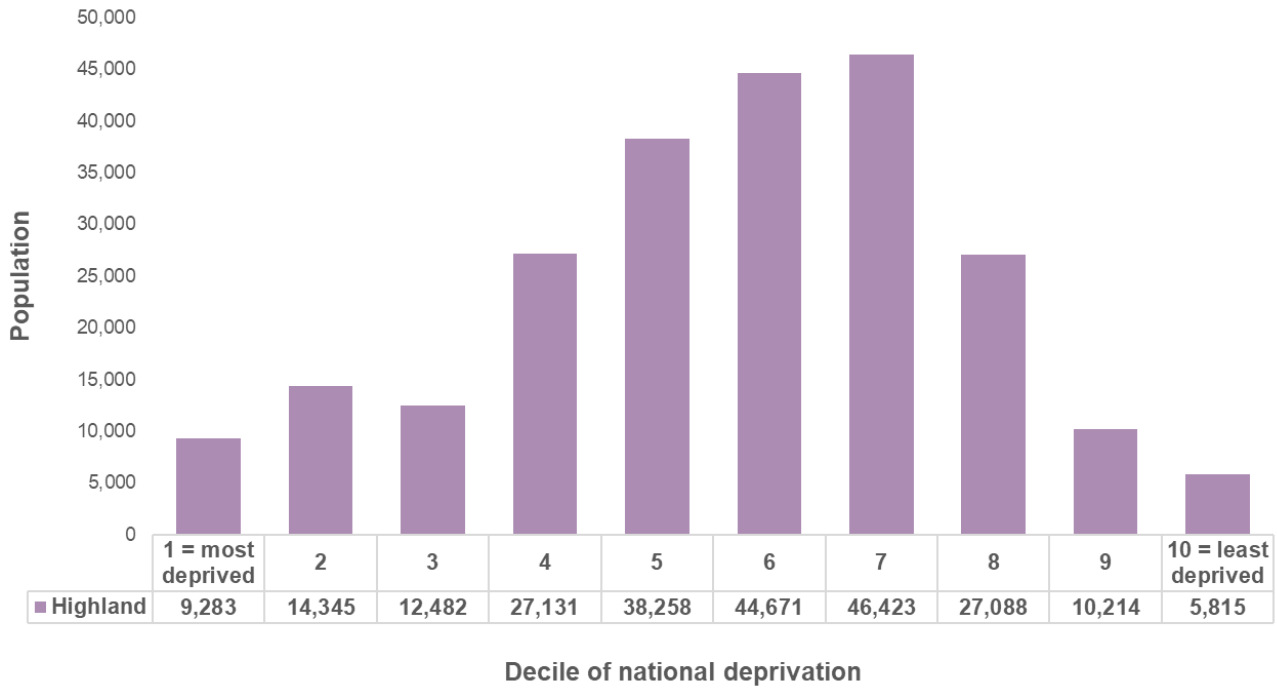
It is important to remember the official guidance to users of the SIMD that 'not everyone living in a deprived area is deprived, and not all deprived people live in deprived areas'[37].

Deprivation in Highland

There are 312 data zones in Highland, with 22 recognised as being in Scotland's most deprived 15 percent of areas (n =1,046). These 22 areas are seven percent of Highland data zones and two percent of the national total[38]. The locations have levels of deprivation similar to some of Scotland's most deprived urban areas.

Figure 32 shows the decile distribution of the Highland population by national SIMD ranking. The majority of the Highland population lives in areas ranked in deciles five to seven nationally. Targeting the most deprived ten percent of areas directs resources towards around 9,000 people, not all of whom will be deprived.

Figure 32: Number of people living in Highland in 2022 by national decile of the Scottish Index of Multiple Deprivation (SIMD 2020v2)

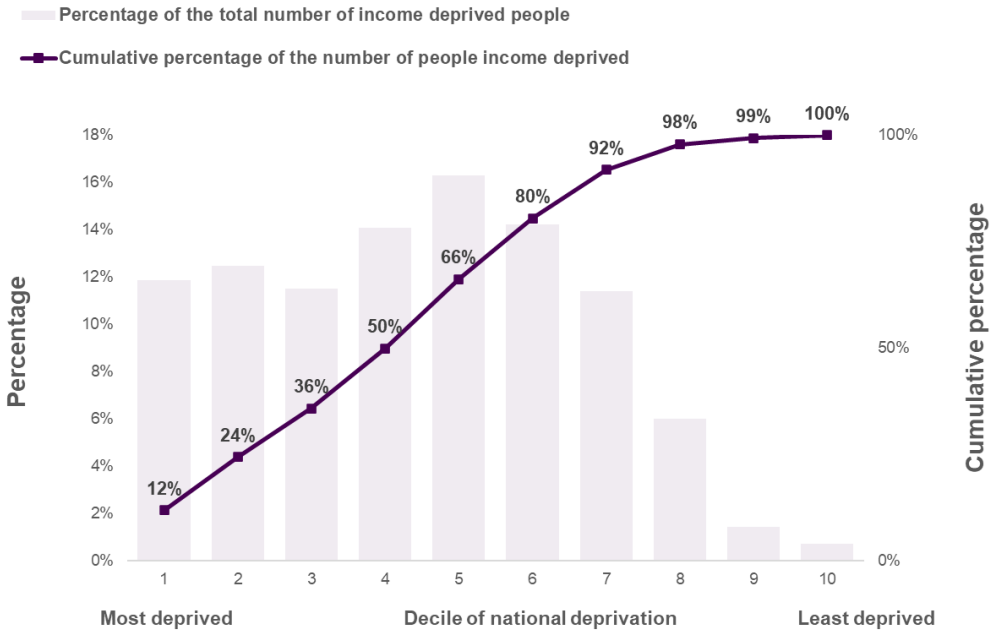


Source: Scottish Index of Multiple Deprivation (2020v2), National Records of Scotland Small Area Population Estimates 2022

Income deprivation

The income and employment domains of the SIMD include counts of individuals based on benefits data. Using the income data, Figure 33 shows that in Highland, more income-deprived individuals live in places not identified among the most deprived areas by the SIMD[39]. Seventy-six percent of income-deprived people live outside of areas in the most twenty percent deprived areas (national deciles one and two).

Figure 33: Percentage of people income deprived in Highland by Scottish Index of Multiple Deprivation (SIMD2020v2) national decile



Source: Scottish Index of Multiple Deprivation (2020v2)

Figure 34 highlights that one in five income-deprived people in Highland live in very remote rural areas, in places categorised in deciles four to seven of the SIMD. Recent research has shown that the SIMD 'misses' a higher percentage of income and employment-deprived people in remote, rural, and island areas across deprivation thresholds, irrespective of whether national or local distributions are used[40].

There are small areas in Highland that consistently rank among the most deprived areas nationally and require ongoing policy attention. However, given the wide distribution of income-deprived people across areas, those commissioning services and local managers should use the SIMD cautiously to assess population needs, particularly in rural areas. Spatial targeting needs to consider the utility of the SIMD for purpose and, if necessary, use other data sources in conjunction[41].

Figure 34: Percentage of people income deprived in Highland by Scottish Index of Multiple Deprivation (SIMD2020v2) national deciles and the Scottish Government Urban Rural 8-fold Classification 2020[1]

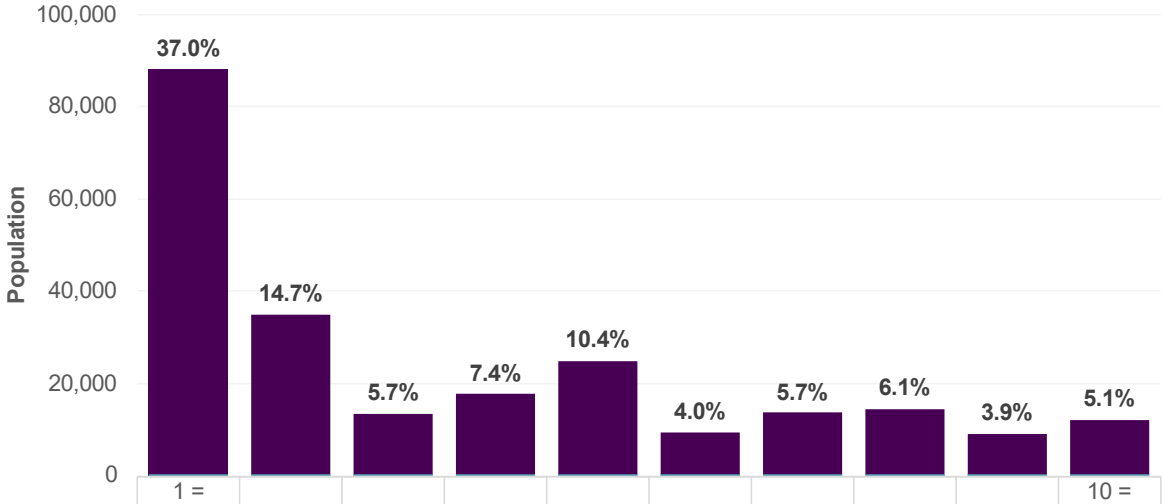
Urban / rural classification	Decile of national deprivation										Total
	1 = most deprived	2	3	4	5	6	7	8	9	10 = least deprived	
2: Other Urban Areas	8.2%	5.7%	5.2%	4.3%	5.3%	2.0%	3.1%	2.7%	1.3%	0.7%	38.4%
3: Accessible Small Towns	0.0%	0.0%	0.5%	0.0%	0.0%	0.2%	0.0%	0.1%	0.1%	0.0%	0.9%
4: Remote Small Towns	1.5%	3.9%	0.4%	2.7%	1.2%	1.5%	0.6%	0.2%	0.0%	0.0%	12.1%
5: Very Remote Small Towns	1.5%	1.2%	3.6%	1.2%	1.3%	0.7%	0.6%	0.6%	0.0%	0.0%	10.7%
6: Accessible Rural Areas	0.0%	1.0%	0.9%	0.3%	1.4%	1.9%	1.5%	1.0%	0.0%	0.0%	7.9%
7: Remote Rural Areas	0.0%	0.7%	0.0%	1.8%	0.6%	2.7%	3.0%	1.0%	0.0%	0.0%	9.7%
8: Very Remote Rural Areas	0.7%	0.0%	1.0%	3.7%	6.5%	5.2%	2.7%	0.4%	0.0%	0.0%	20.3%
Total:	**11.9%**	**12.5%**	**11.5%**	**14.1%**	**16.3%**	**14.2%**	**11.4%**	**6.0%**	**1.4%**	**0.7%**	**100%**

Source: Scottish Index of Multiple Deprivation (2020v2) and the Scottish Government Urban Rural 8-dold classification 2020
1. Highland has no settlement of over 125,000 people to be classified in category one as a Large Urban Area

4.2. Access

Highland has many places among the most access-deprived areas nationally. Rural and particularly remote rural areas have worse access in terms of distance to health and social care services. Transport is essential for people to access education, health services, employment, shopping, and leisure. Access problems compound other disadvantages, including higher daily living costs in rural and remote places[42].

Figure 35: Population access to local services in Highland by national decile of access deprivation



	1 = Most deprived	2	3	4	5	6	7	8	9	10 = Least deprived
Number	88,110	34,971	13,558	17,670	24,782	9,489	13,641	14,555	9,204	12,080
Percentage	37.0%	14.7%	5.7%	7.4%	10.4%	4.0%	5.7%	6.1%	3.9%	5.1%

Source: Scottish Index of Multiple Deprivation (SIMD 2020v2) Access Domain and National Records of Scotland Small Area Population Estimate 2021

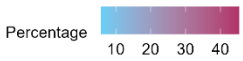
The Scottish Index of Multiple Deprivation access domain identifies that over half of the population of Highland (51.7 percent) live in the twenty percent most access deprived areas in Scotland, with residents experiencing longer travel times to local services and poorer digital access (Figure 35).

4.3. Ethnicity and socio-economic disadvantage

Combining outputs by ethnicity from the census of 2022 with the Scottish Index of Multiple Deprivation suggests that minority ethnic groups in Highland are disproportionately likely to be exposed to a range of barriers and disadvantages in their lives where they live, therefore potentially having poorer outcomes in their health, employment, and living standards than someone living in a less deprived area.

Figure 36 shows the proportion of each ethnic group living in the most twenty percent deprived areas in Highland for each domain of the SIMD, providing an estimate of which aspects of deprivation affect minority ethnic groups the most.

Figure 36: Percentage of ethnic groups[1] living in the most deprived[2] quintile of the Scottish Index of Multiple Deprivation by domain in Highland at census 2022



	Income	Employment	Health	Education	Access	Crime	Housing	Overall
All People	18.9	19.1	18.9	18.7	20.1	19.2	19.2	19.4
White Scottish/British	18.4	18.6	18.3	18.2	20.6	18.5	18.5	18.9
White minority groups	25.7	25.9	26.1	26.4	16.1	27.9	29.3	26.6
BME (combined)	23.4	24.2	24.6	22.2	11.4	26.6	25.6	24.2
White Scottish	19.7	19.7	19.7	19.7	18	19.9	19.1	20
Other White British	12.4	13.4	11.6	11.1	32.6	12.1	15.6	13.7
White Irish	11.2	12.8	12.1	11.8	23.6	15.2	15.9	12.2
White Polish	39.8	39	39.6	42.5	5.8	40.5	38.6	42.1
Other White	19	19.8	19.5	18.5	21.6	22.2	26	19.3
Mixed	22.4	21.7	20.8	20.5	15.2	22	22.7	21
Pakistani	25.8	27.6	24	28.9	7.5	27.3	25.8	26.5
Indian	22.7	25.5	28.2	18.6	6.1	26.8	26.8	23.1
Bangladeshi	30.9	38.3	35.9	31.2	5.9	45.3	31.2	32.4
Chinese	23.9	25.3	26.1	20.4	8.7	33.8	31.2	25.7
Asian other	23.6	25.4	22.8	19.5	10.8	27.8	28.1	23.5
African	25.9	24.9	28.3	24.7	9.3	24.9	27.6	28
Caribbean or Black	30	26.2	28.1	24.3	8.6	29.5	30.5	28.6
Other ethnic groups	19.4	20	25.4	25.5	15.2	25.6	21	25.8

Source: Scotland's Census 2022 (Table UV201 – Output Areas), Scottish Index of Multiple Deprivation 2020v2
1. The **white minority group** category includes people from the following ethnic groups: white Irish, white Polish, Gypsy/Traveller, and other white non-British backgrounds. **Black/minority ethnic** include those of mixed/multiple ethnicities, Asian groups, Black and African groups, and those of another non-white background.
2. In the above chart, a definition of **within** the Highland Council area deprivation quintile is used.

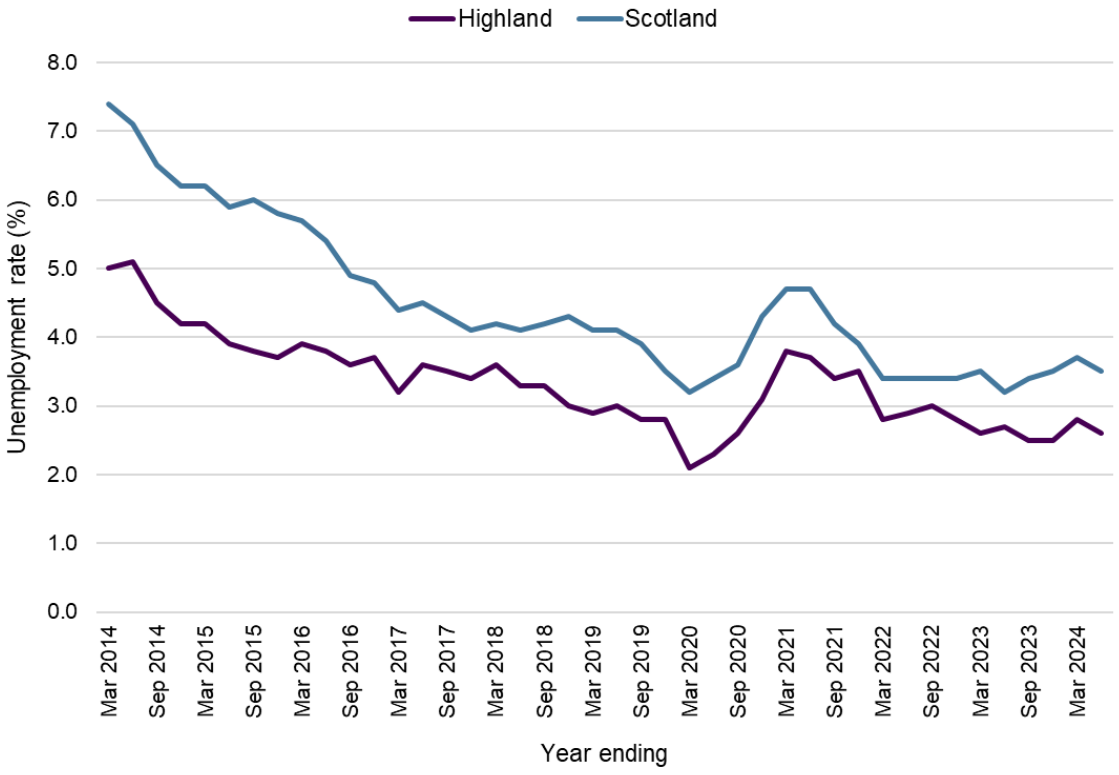
4.4. Employment and benefits

Employment is one of the most important social determinants of physical and mental health. Those who experience long-term unemployment have lower life expectancy and increased risk of morbidity. Effects are not only seen in the unemployed individual but also in others within their lives such as family members[43] [44].

Children growing up in low-income households experience many disadvantages which can impact negatively throughout their life on outcomes such as health, social-behavioural development, cognitive development, and education[45]. All those living in poverty at any age find it harder to live healthy lives and access NHS services leading to inequalities in health outcomes[46].

In Highland there were approximately 126,000 people aged 16 years and over who were economically active as of June 2024. Unemployment rates in Highland and Scotland have halved since 2014 (Figure 37). During the COVID-19 pandemic rates almost doubled but returned to pre-COVID levels in 2022 and are now 2.6 percent for Highland and 3.5 percent for Scotland[47].

Figure 37: Unemployment rate (%) in Highland and Scotland, 2014 to 2024



Source: NOMIS Official Census and Labour Market Statistics
Note: Unemployment rates are estimates (model based) for those who are economically active aged 16 and over.

Although good work can protect against and reduce the risk of morbidity and premature mortality not all work is good for health. To reduce health inequalities, jobs need to be sustainable and offer a minimum level of quality. Factors that matter most in determining whether work is good or bad are job security, pay and hours, physical work environment, job design, impact on worker's mental health and the balance of power between workers and employer[44].

According to the 2022 Census, Highland had a higher proportion of people working in the agriculture, forestry and fishing sector (3.9 percent) and accommodation and food services (9.4 percent) than Scotland as a whole[48]. This reflects a higher reliance on seasonal industries, particularly in some Highland communities, with potential impacts on job security for those employed.

Five high-priority industries have also been found to play a key role in maintaining in-work poverty, these being retail, hospitality, manufacturing, health and social work, and administration and support services, many of which are large employers in Highland. It is reported that 80 percent of people locked in low pay are working in one of these industries[49].

In work poverty

With over 10 percent of workers in Scotland locked in persistent low pay (i.e. paid below the real Living Wage), there are increasing proportions of people in poverty who have one or more adults in their family in work. Over one in five people experiencing in-work poverty are in families where everyone works full-time[49].

Families most likely to experience in-work poverty are those who are single parents, families with three or more children, from a minority ethnic background, or have someone in the household who is disabled or a carer[49]. Even working full-time on the National Living Wage is often not enough to meet the UK Minimum Income Standard for many families[50]. In work poverty is a key issue in low paid care work, particularly in care at home, where fuel costs are a compounding factor.

In remote rural areas of Scotland, the Minimum Income Standard is typically 10 to 40 percent higher than elsewhere in the UK[51]. With lower full-time median incomes and higher proportions of part-time workers in Highland these percentages are likely to be higher.

Benefits

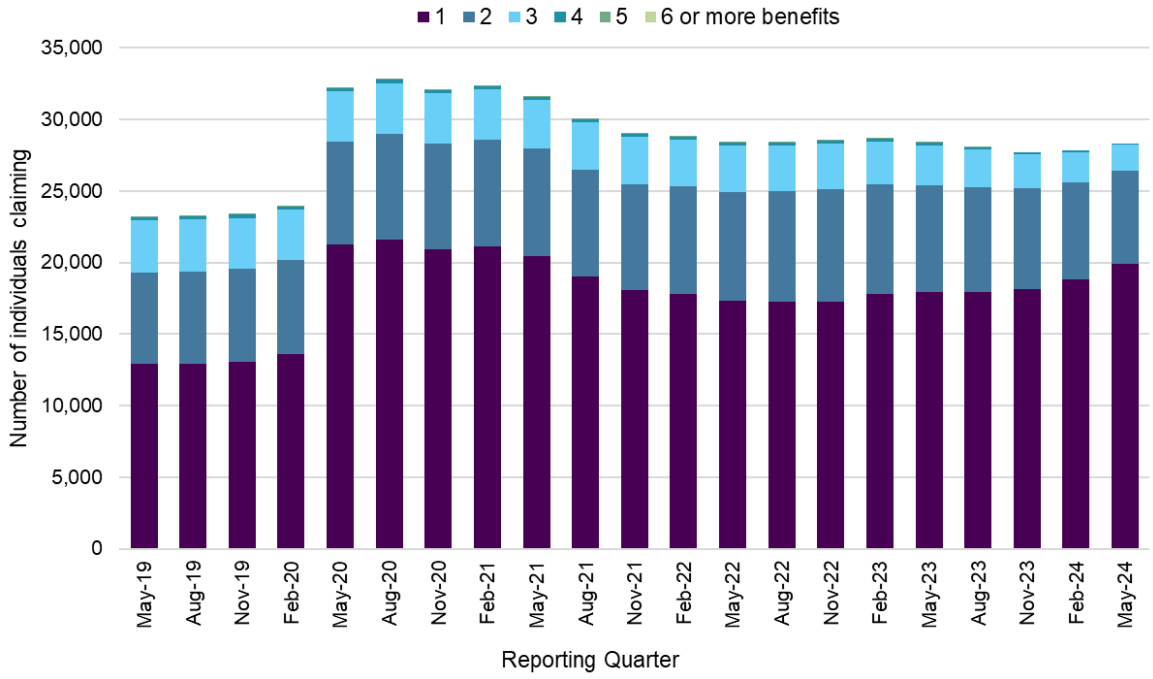
Those who are unemployed, or unable to work due to long term ill health, disability or caring responsibilities may need to rely on the social security system for their income, at least

temporarily. Some people in low paid work are also eligible to claim benefits to supplement their income.

In the UK, ill-health amongst the working-age population has increased in recent years, with musculoskeletal and mental health conditions the most common work-limiting health conditions reported[52]. In Highland the number of people economically inactive due to long term sick has more than doubled in the last five years, from 6,900 in June 2019 to 16,300 in June 2024. Scotland saw a 15 percent rise in numbers during the same period[47].

Figure 38 shows the number of people of working age in Highland claiming a Department of Work and Pensions (DWP) benefit. In May 2024 there were 28,341 claimants in Highland, a 22 percent increase over the last five years. Of these 86 percent were claiming a single benefit, compared to 56 percent in May 2019, and 69 percent were claiming Universal Credit (Out-of-work 16 percent, Working 23 percent or No work requirement 31 percent). More than half of claimants were female (57 percent), and claimants were seen across all age bands[53].

Figure 38: Number of working-age people in Highland claiming DWP benefits by quarter (May 2019 – May 2024) and the number of benefits claimed



Source: Department of Work and Pensions, Stat-Xplore, Benefits Combinations for Scotland Dataset

As an Anchor Institution, the role of the Highland HSCP is pivotal to creating a 'Wellbeing Economy' in our local community[54]. This means supporting equal access to fair work for people within our own and other organisations and supporting local businesses through procurement processes to create local job opportunities. The services provided also need to recognise and support those on low incomes to make healthier choices and access health

and social care when needed, and to enable those economically inactive due to long term illness return to work where possible.

4.5. Place and community

A Scotland where we live in vibrant, healthy and safe places and communities is one of the six public health priorities in Scotland[55]. There is growing evidence on how differences in the design and function of neighbourhoods impacts on the health and wellbeing of communities and contributes to health inequalities.

Place based approaches to improve health and wellbeing and reduce health inequalities acknowledge the link between the physical and economic environment and its impact on the people who live, work, play and learn there[56] [57] [58]. The elements within a place that are likely to help improve health and wellbeing, and tackle inequalities are described in a set of Place and Wellbeing Outcomes[59].

People in the most deprived areas are often exposed to poor-quality housing in combination with air and noise pollution, with more restricted access to open space, limited employment opportunities and services, and fewer safe and accessible options for active travel.

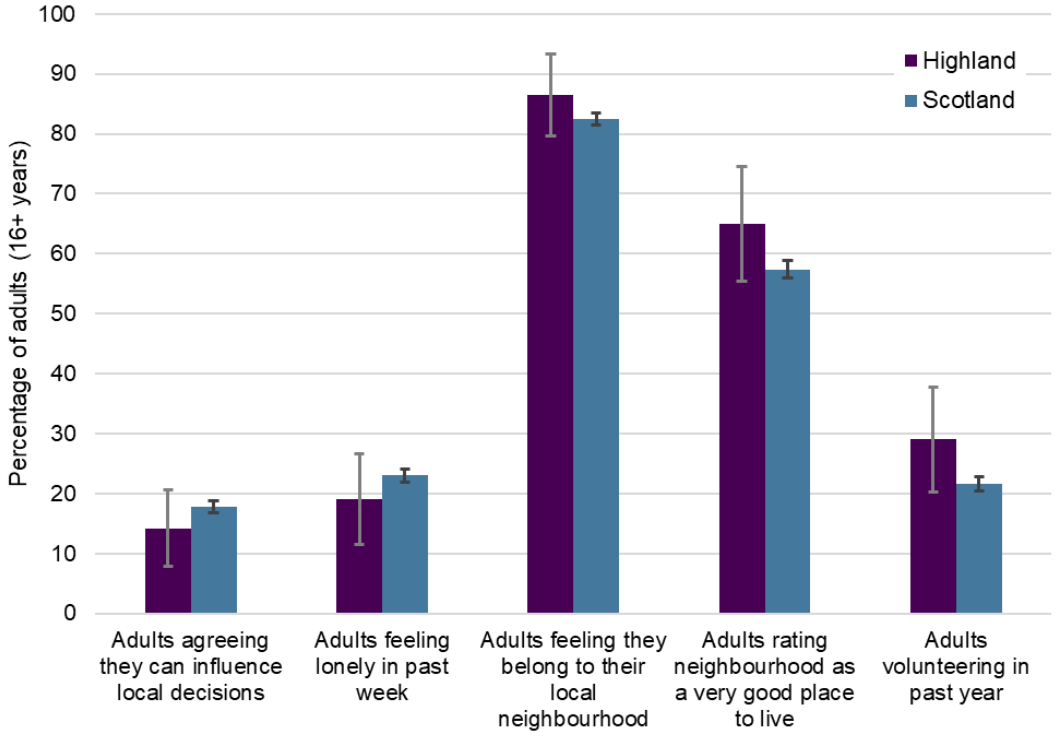
Figure 39: Place and wellbeing outcomes

Source: Improvement Service, Place and wellbeing outcomes

As key drivers of overall health and wellbeing, indicators of community wellbeing and neighbourhood satisfaction are reported in the National Performance Framework[60].

In general, the Highland population reports a more positive view of their place and community through these indicators than the Scottish population, although differences are not significant (Figure 40). Neighbourhood satisfaction is commonly lower in urban and deprived places and higher in rural and less deprived places.

Figure 40: Self-reported indicators of place and community in Highland and Scotland, 2022



Source: Scottish Household Survey, Scottish Public Health Observatory (ScotPHO) online profiles

'Marmot Places' is a place-based approach to improving health and reducing health inequalities focusing on involving places and communities to identify local priorities[61]. The approach, led by the UCL Institute of Health Equity (IHE), has built on work by Sir Michael Marmot and the report on health equity in England in 2010.

The work recognises that the social determinants of health mostly influence and drive health outcomes[62]. The approach is now being piloted in Scotland and is likely to provide future opportunities for learning and lessons to be put into practice within local areas.

As an Anchor Institution, NHS Highland and Highland HSCP can contribute to strengthening the building blocks of health and have a positive impact on local communities. The Anchors Strategic Plan sets out actions to progress anchor activity in relation to workforce; local procurement; and use or disposal of land and assets for the benefit of the community.

5. Housing

5.1. Housing and health

Housing is an essential social determinant of health, and the built environment can support physical and mental health or negatively impact it[63 64]. Housing is central to the Scottish Government's ambitions, 'including eradicating child poverty and homelessness, ending fuel poverty, tackling the effects of climate change and promoting inclusive growth'[65].

The condition and nature of homes, including space, tenure, and cost, can significantly impact people's lives and influence their well-being and health [66 67 68 69].

A healthy home should be a safe and accessible environment, free from hazards, efficiently heated to a healthy temperature, and provide a sense of security. The availability and affordability of high-quality, appropriate housing can reduce social care and health service demands[70 71].

The impacts of poor housing, which are an immediate health hazard, are not in reasonable repair, lack modern facilities, or are not effectively insulated or heated, do not affect the population equally and disproportionately impact the most vulnerable, increasing health inequalities and limiting life chances across a range of domains, such as education, employment and welfare[72].

People living in damp, cold or mouldy dwellings are at greater risk of respiratory conditions, meningococcal infection, and asthma. Thermally efficient housing reduces the likelihood of cold-related death or illness[73 74].

Poor housing conditions have a long-term impact on health, increasing the risk of severe ill health or disability by up to 25 percent during childhood and early adulthood. One in three adults who grew up in overcrowded housing has respiratory problems in adulthood. Children living in damp, mouldy homes are between one and a half and three times more likely to cough and wheeze[75].

5.2. The Highland Housing Challenge

Highland and the rest of Scotland are in the grips of a housing crisis, with a lack of housing affordability and availability related to people's ability to pay for and access housing that suits their needs and circumstances[76 77].

National policy context

The Scottish Government's 20-year strategy, Housing to 2040, sets a vision:

Everyone should have a safe, high-quality home that is affordable and meets their needs in the place they want to be.

The National Planning Framework (NPF4) is required by law to contribute to:

• Meeting the housing needs of people living in Scotland, including, in particular, the housing needs for older people and disabled people

• Improving the health and wellbeing of people living in Scotland

• Increasing the population of rural areas of Scotland

The national dementia strategy, Everyone's Story, is committed to ensuring that people living with dementia can live in homes designed or adapted to meet their needs.

The 2024 Housing Bill requires public bodies to be more proactive in considering housing needs, rent controls, and homelessness prevention.

In July 2024, the Highland Council declared a Housing Challenge in recognition of further pressures on the housing market over the next ten years from economic growth associated with the Inverness and Cromarty Firth Green Freeport. Affordable and midmarket properties are required to house key workers, retain young people and families, and support the inward migration of new workers[78] [79].

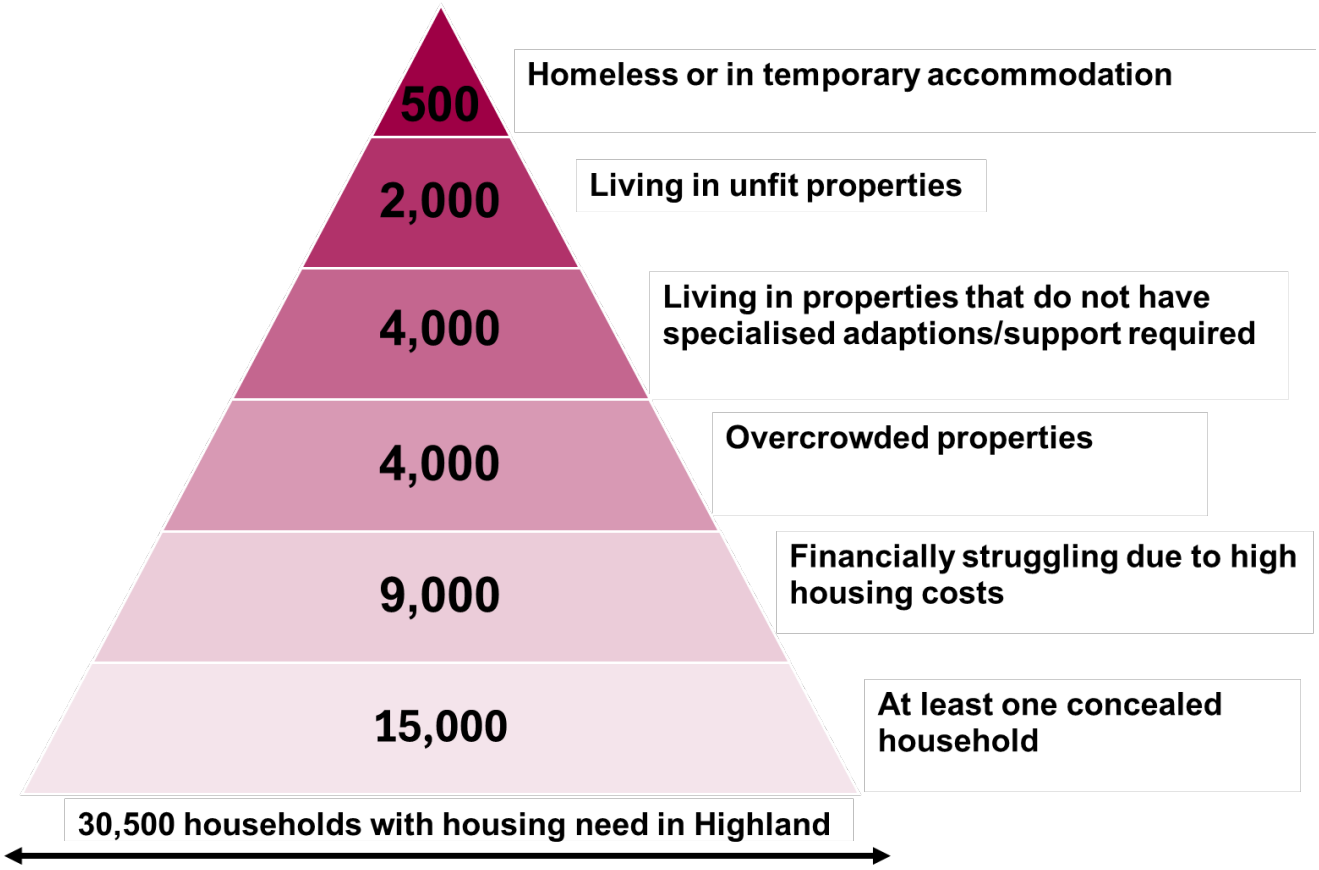
Estimates commissioned by Homes for Scotland published in 2024 to inform local Housing Need and Demand Assessment (HNDA) across Scotland suggest that around 27 percent of Highland, or 30,500 households, currently have some form of housing need (Figure 41) [80] [81].

Further analysis suggests that in-situ repairs could reduce the headline figure of 30,500 by 4,700, and around 10,000 households can afford a market housing option, leaving a housing backlog of .around 15,500 households in Highland currently requiring an affordable housing solution[80].

The Highland Council has a shared housing register with Highland Housing Associations. On 31 March 2024, 8,388 applicants were registered with a social housing need, and the number is gradually increasing. Almost one in five on the housing register lives in accommodation that does not meet their current health or mobility needs[82].

In addition to building new homes, solving some of these housing needs could be helped by addressing the under-occupancy of existing homes, promoting available housing in low-demand areas, bringing empty homes back into use, and converting second homes and short-term lets into longer-term occupations.

Figure 41: Summary of estimates of existing housing needs in Highland[6364]



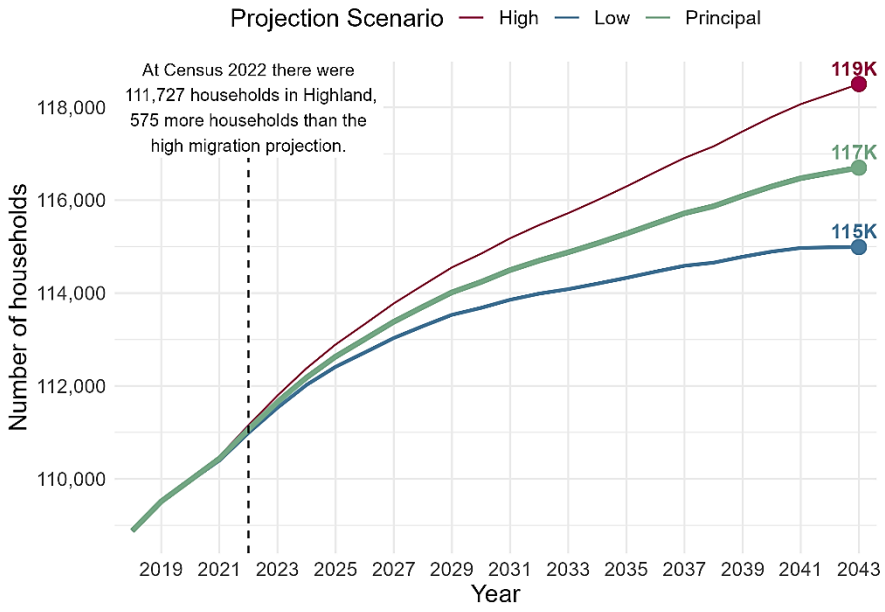
Source: Diffley Partnership/Rettie & Co. Existing Housing Need in Highland 2024
1. Six hundred homes overlap between overcrowded accommodation and at least one concealed family household
2. Concealed households identify an individual or a group of people in an existing household who want to move out to form their own household but are currently unable to do so.
3. The figure for homeless or temporary accommodation only includes an estimate of those in temporary accommodation. Current data in the Scottish Government's Homeless in Scotland statistics for 2023-24 suggest over 800 open homeless household applications in Highland.

The ageing population with changes in household sizes and family types also has implications for the demand for housing, particularly housing adapted to meet the care needs of older people who want to live independently or to be supported to remain at home (Figure 42,Figure 43,Figure 44)[83].

Social housing providers are on the frontline of the impact of population ageing on health and social care. Older people spend a significant amount of time in their homes, and housing designed with accessibility or adapted to meet care needs can reduce demand for primary and secondary health care or unplanned moves to care homes.

People living in unsuitable housing are more likely to have a trip or fall, resulting in the need for medical treatment or hospital admission, and loss of independence can result in a crisis move to a care home rather than a more planned caring journey.

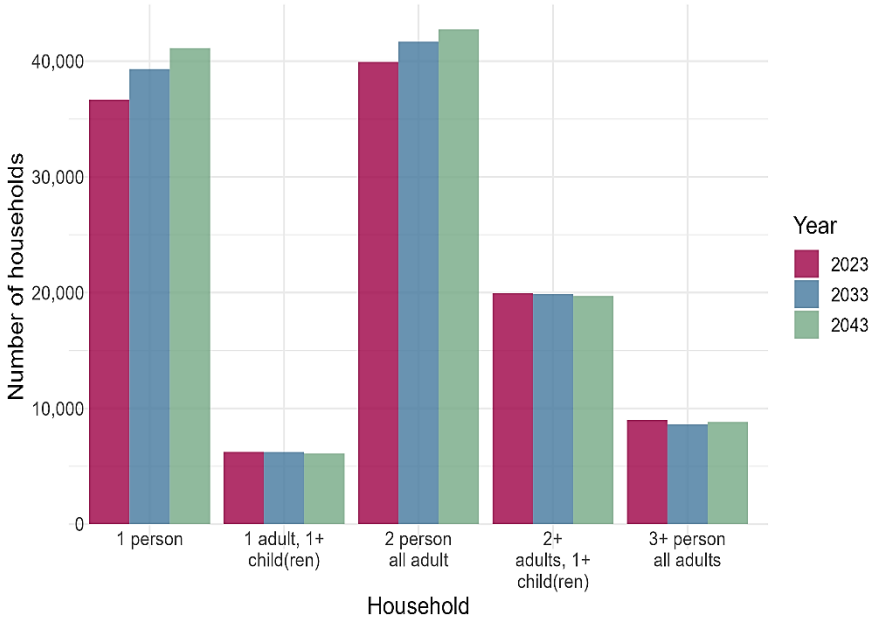
Figure 42: Projected number of households in Highland, 2018 to 2043: 2018-based principal and variant migration projections



Under all projection scenarios, the number of households in Highland will continue to increase. Evidence from the 2022 Census indicates that growth has occurred faster than the high projection scenario.

Source: National Records of Scotland Household Projections for Scotland (2018-based)
1. The y-axis scale does not start at zero.

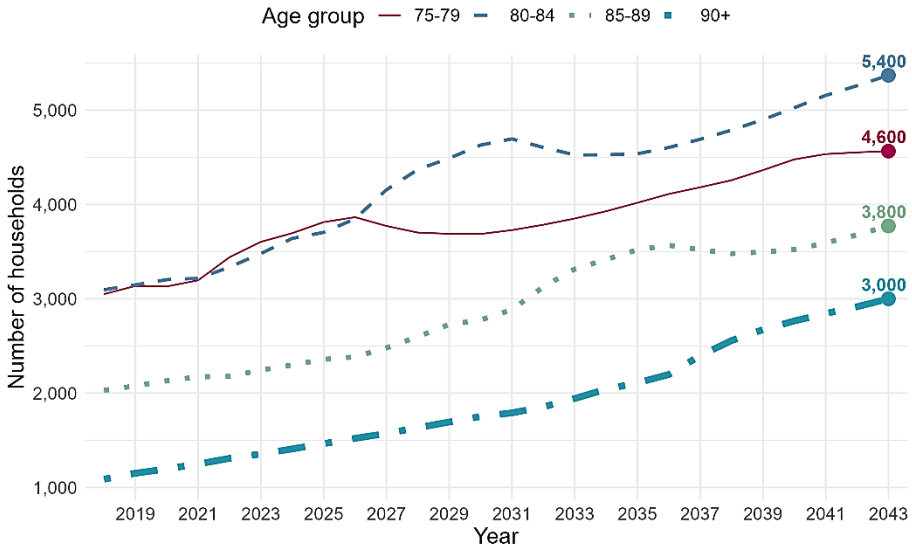
Figure 43: Projected number of households in Highland by household type, 2023, 2033 and 2043



People are increasingly living in smaller households or alone. As a consequence, projected household growth is faster than population growth. One-person households are projected to have the largest increase.

Source: National Records of Scotland Household Projections for Scotland (2018-based)
1. Figure shows the high migration scenario in line with the assumptions of the Highland HNDA.

Figure 44: Projected number of single households in Highland where the household reference person is aged 75 or over



The increase in one-person households is principally due to the number of people in cohorts reaching older age. Older people are more likely to live alone or in small households.

Source: National Records of Scotland Household Projections for Scotland (2018-based)
1. Figure shows the high migration scenario in line with the assumptions of the Highland HNDA.

The Scottish Government's 20-year strategy, Housing to 2040, acknowledges that homes must be more accessible and adaptable to support people at all stages of life[65]. Housing should be central in providing services for older people[84].

The Highland Council Local Housing Strategy (2023-2028) highlights that:

There is increasing recognition that planning for housing in later life is about ageing in place and staying in the home of your choice for as long as possible. Increasing the supply of accessible housing is fundamental to promoting independence, flexibility and social inclusion. This can only be achieved by building accessible dwellings or adapting the existing housing stock to meet the needs of Highland's older people as they age[85 86].

Given the scale of needs arising from population changes nationally and locally, with people living longer with multiple health conditions and the anticipated increase in older people living in single households, it is essential that housing strategies and housing markets are aligned with the need for new homes designed and built and existing properties adapted to enable people to be supported to age in place, potentially helping to avoid or defer long-term social care requirements[87 88].

A Housing Contribution Statement (HCS) is part of the Joint Commissioning Plan in Highland. It should link to the Local Housing Strategy and define current needs and future requirements for housing and related social care services to explain how services are aligned.

5.3. Housing stock

In 2023, it was estimated that there were 123,568 dwellings in Highland, a 22.3 percent increase from 2003[89]. This figure exceeded population growth of 12 percent over the same years and reflected smaller average household sizes, with more people living alone or as couples[90].

On the same date, 92.4 percent of dwellings were occupied, 35.9 percent had a single adult council tax discount, and 4.5 percent were vacant[89]. The Highland area had the fourth highest proportion of second homes per council area at 3 percent, with the Scottish average being 0.9 percent[89]. The volume of ineffective housing in Highland influences housing needs, reducing the available residential properties, impacting the stock condition and contributing to the housing challenge[85].

The 2022 Census reported that of all occupied households in Highland, 85 percent lived in a house, 14 percent in a flat, and under 1 percent in a caravan or other mobile or temporary structure[91].

The Census in 2022 showed that 68 percent of households in Highland were owned, 11 percent privately rented, and 19 percent socially rented[92]. From Census 2011 to the 2022 Census, there was an increase in 9 percent of owned homes (including those with a mortgage), 1 percent in privately rented homes, and 11 percent in socially rented homes[92 93].

The private rented sector in Highland is slightly smaller than in Scotland but has played a key role in meeting housing needs locally. However, the Highland Local Housing Strategy suggests that there is evidence that the cost of private renting is increasingly out of reach for low-income households[86].

In Highland, the requirements of most households in circumstances of housing needs are met through social housing. According to the Scottish Housing Regulator, there are 22,862 socially rented properties in Highland, 15,004 of which are provided by the Highland Council and the others by Housing Associations[94].

The Highland Council Housing Strategy highlights that Highland has proportionally less socially rented housing than Scotland. Social rented housing comprised around 18 percent of all housing in Highland, while the national average is around 23 percent. The most recent Highland Council Housing Register Allocation Monitoring Report (HRAMR) of August 2024 concludes that the demand for social housing in Highland remains high, with significant housing needs not resolved quickly because of the limited housing supply[95].

Highland Housing Register Prospects reported that during the financial year of 2023/24, 5,795 first-choice applications were made to the Highland Council for social housing[96]. Most first-choice housing requests in Highland require a one-bedroom/bedsit property (67 percent), and 20 percent need a two-bedroom property. A quarter of all first-choice applications were for Inverness City, with 26 percent being for a one-bedroom/bedsit property[96].

5.4. Specialist housing

There are a small number of specialist housing units in Highland, including settings offering low levels of support to help with independent living, such as amenity (retirement) or sheltered housing, and settings providing a higher level of support and, often, care, such as very-sheltered housing (Figure 45).

The 2024 HRAMR report suggests there were 603 applicants for sheltered housing in 2023/24. No details of allocations or throughput are provided, but previous reports indicate that 60 to 100 sheltered housing units are allocated a year. The total stock of such properties amounts to fewer than 800 self-contained units[95].

Figure 45: Social housing units in Highland reported by the Scottish Housing Regulator in 2023/24

Provider	General	Sheltered	Very sheltered	Amenity housing	Community alarm	Wheelchair housing	Ambulant housing	Other specially adapted	Total
Highland Council	14,323	478	0	0	86	12	95	10	15,004
Housing Association	6,405	276	36	768	0	183	190	0	7,858
Total	20,728	754	36	768	86	195	285	10	22,862

Source: Scottish Housing Regulator

In 2019, the Scottish Government issued guidance to all local authorities requiring them to confirm targets to support the development of more wheelchair accommodation across all tenures[97]. The Highland SHIP target is to provide at least ten percent of the affordable houses built to a 'wheelchair liveable' standard, meeting essential and desirable target criteria[82].

The number of lets to households that required wheelchair-adapted property was 44 in 2022/23, but 103 applicants required accommodation, indicating a relatively large unmet need. Over the same period, there were 643 applications requiring level access accommodation and 241 lets, highlighting the supply limitations[98].

The Highland Council Scheme of Assistance helps private sector homeowners to make disabled adaptions and repairs to their properties[99]. The total number of private sector disabled adaption grants approved in 2022/23 was 337, worth £1.83 million.

Evidence from the most recent series of Highland HRAMRs suggests that a consistent unmet need for specialist and adapted housing exists, with further demand pressures inevitable[95 98]. The need to keep people at home safely is vital, with data showing a 22 percent decrease in the number of care homes and an eight percent fall in the number of registered places in Highland over the last ten years. Specialist housing needs to be supported by care services, with the workforce to deliver it.

Increasing supported housing availability would not guarantee that the needs of those living with complex conditions like progressive dementia can be met in place, but without planning targets for any increase in specialist housing and associated support services, the alternatives to ever-increasing formal and informal care in the home and the move to a care home as health needs progress are limited.

The challenges of managing adapted housing stock and coordinating housing and care needs should not be understated. While these challenges are recognised, they are not quantified in the current Highland HNDA[100].

Estimating the number of people requiring specialist or adapted housing is difficult, particularly with the transformational potential of technologies, digital innovations and data to improve the lives of those living at home[101]. Housing supported by appropriate care technology will be essential to enable people to remain in remote and rural areas where workforce provision is scarce.

5.5. Housing conditions

Estimated costs to the NHS of substandard housing in the context of other common hazards in the UK suggest that the quality of people's homes has a similar effect on health services as smoking or alcohol[102].

People who spend a high proportion of time in the home, including older people, children, people who are disabled or have long-term conditions, and socially isolated people, can be disproportionately affected by poor-quality housing, increasing health inequalities. The most common extreme hazards in the home are those associated with cold and home accidents, mainly falls on stairs[103]. Such hazards harm the most vulnerable, especially older people and those living with younger children.

The age of construction and building forms of dwellings affects energy performance, improvement potential, affordability of heating, and housing conditions. Highland has a lower percentage of older housing stock than Scotland, but 23 percent of all dwellings were built pre-1945, with nine percent of social housing constructed before this date[104].

Limited data exist on housing quality other than survey evidence, with no data collected during the pandemic by the Scottish House Condition Survey. The last report at the Local Authority level covers 2017 to 2019. Nationally, data for 2023 shows little change from 2019.

Figure 46: Selected house condition indicators in Highland and Scotland, 2017-2019

Scottish House Condition Survey (2017-2019)	Highland	Estimated number of households or dwellings in Highland	Scotland
Adaptations for disabled occupants present*	26.0%	28,000	20.8%
Adaptations for disabled occupants required*	3.2%	3,000	3.3%
Below Tolerable Standard	2.4%	3,000	1.5%
Central Heating	88.9%	97,000	96.0%
Condensation	6.7%	7,000	8.0%
Damp	2.3%	2,000	2.5%
Disrepair: Any	77.8%	85,000	70.8%
Disrepair: Urgent	15.7%	17,000	28.3%
Dwelling Age - built before 1945	22.7%	25,000	30.4%
Fuel Poverty*	32.9%	36,000	24.4%
Fuel Poverty: Extreme*	21.5%	24,000	11.9%
Off Gas Grid	60.8%	66,000	17.3%
High Energy Efficiency Ratings (SAP 2012)	25.0%	27,000	44.6%
Loft Insulation meeting standards	4.0%	4,000	6.1%
Low Energy Efficiency Ratings (SAP 2012)	13.6%	15,000	4.4%
Number of Bedrooms - 3 or more	62.3%	68,000	50.2%
Restriction of movement - daily activities of one or more occupants	6.1%	7,000	6.7%
Scottish Housing Quality Standard (failing)	45.2%	49,000	41.4%
SHQS E: Healthy, Safe and Secure (failing)	4.8%	5,000	11.7%
Wall insulation (cavity and solid)	55.0%	60,000	59.2%

Source: Scottish House Condition Survey
* Denotes households
1 A dwelling's energy efficiency rating is scored between 1 and 100 using the Standard Assessment Procedure (SAP). Energy Performance Certificates (EPC) display these ratings.
2 The SHQS is a common standard for assessing the condition of Scotland's social sector housing. Private owners and landlords are not obligated to bring their properties up to this standard.

Improving poor housing has multiple benefits beyond the health of the occupants, reducing energy costs and carbon emissions, increasing residual asset values and creating local job opportunities[103]. Installing or upgrading insulation is one of the most effective ways to improve the energy efficiency of a building.

The potential for better housing as an agent to improve population health and to increase energy efficiency to limit climate changes are national infrastructure priorities. Rectifying hazards related to cold and home accidents is relatively inexpensive compared with the long-term costs to the health service and society if ignored[103].

5.6. Housing and poverty

More than one in five of the population of Scotland currently lives in poverty[105]. In Highland, 9,800 children and young people live in households in poverty after housing costs, equivalent to almost one in four aged under sixteen[106].

Difficulty paying rent or a mortgage can cause stress and affect mental health, while spending a high proportion of income on housing leaves less for other essentials that influence health, such as food and social participation. Therefore, housing has a direct impact on health inequalities.

Housing costs are a key determinant of poverty, particularly among renters. Two in three people in poverty live in a rented home. Data from Scotland shows that 44 percent of social renters and 22 percent of private renters lived in poverty after housing costs. However, a quarter of social renters and a third of private renters in poverty were only in poverty after their housing costs were factored in[107].

The weakening of the UK social security safety net since 2010 has contributed to rising levels of poverty and problem debt across the UK, thereby intensifying the fundamental drivers of severe poverty and homelessness[108]. For those who rely most on social security, such as single-parent households or households where someone is disabled, this has increased inequalities, locking people into poverty[107].

The Scottish Government has taken steps to counteract this by fully mitigating the Bedroom Tax and Benefit Cap via Discretionary Housing Payments, investing in the Scottish Welfare Fund and other discretionary support, and introducing the Scottish Child Payment. However, severe poverty continues to grow, especially among single-person households of working age[109].

Analysis of housing tenure and poverty in older age project continued increases in relative poverty among older people over 65 years to 2040 in Scotland from 17.1 percent to 18.6 percent, with the most significant relative increase in those living in the social rented sector from 37 percent currently to 70 percent in 2040[110].

Increasing levels of housing insecurity and poverty will present significant challenges to ambitions of healthy ageing and supporting older people and those with a disability to live independently with attendant consequences for health and social care services and those who provide unpaid care[111].

5.7. Fuel Poverty

Fuel poverty is a complex issue linked to socioeconomic circumstances, the built environment, and macroeconomics[74]. It is a considerable and long-standing problem in Highland and Scotland, particularly in rural areas.

The Fuel Poverty Act (2019) aims to ensure that, where reasonable, by 2040, no household will be in fuel poverty, with no more than five percent being fuel poor and one percent being in extreme fuel poverty. To be formally classified as living in fuel poverty, a household must spend more than ten percent of its net income after housing costs on heating, or 20 percent for extreme fuel poverty. The current national strategy, Tackling Fuel Poverty in Scotland was published in 2021[112].

Many households struggle to afford fuel and risk experiencing cold and damp housing or sacrificing other vital expenditures to stay warm. Choices between eating and heating are a reality for some families, with clear implications for health inequalities.

Babies, children, older people and those with pre-existing health problems are at the greatest risk of health problems as a result of living in cold homes and, therefore, are particularly at risk of the health consequences of fuel poverty.

Groups with intersecting demographics who also experience other types of deprivation are also at risk of experiencing fuel poverty and fuel insecurity: minority ethnic households, students, low-income renters, disabled people, and those living in rural and off-grid housing.

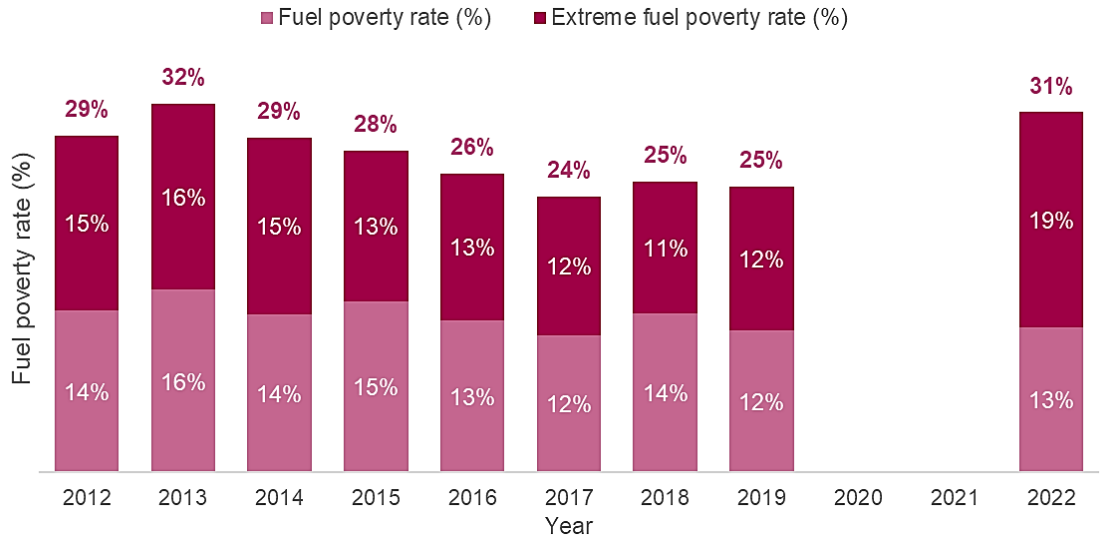
In combination, four main factors create fuel poverty: energy performance (the physical structure and thermal performance of the building), the cost of fuel, how fuel is used within the home, and household income.

The current metrics for monitoring fuel poverty in Highland are limited, with the Scottish House Condition Survey (SHCS) only providing output at the local authority level, and the most recent data pre-dating the pandemic, the rapid increases in energy prices and the cost of living crisis.

The 2017/2019 Scottish House Condition Survey (SHCS) reported that 33 percent of households in Highland were in fuel poverty, with 22 percent being in extreme fuel poverty, higher rates than nationally[104]. Extrapolation of estimates of fuel poverty levels by Energy Action Scotland suggests that in 2022, 47 percent of Highland households were in fuel poverty.

More recent national data from the SHCS shows that rapid household energy price inflation has led to increasing numbers of households entering fuel poverty and a deepening of fuel poverty for those already exposed, potentially worsening their health and quality of life (Figure 47).

Figure 47: Fuel poverty and extreme fuel poverty rates, Scotland, 2012 to 2022

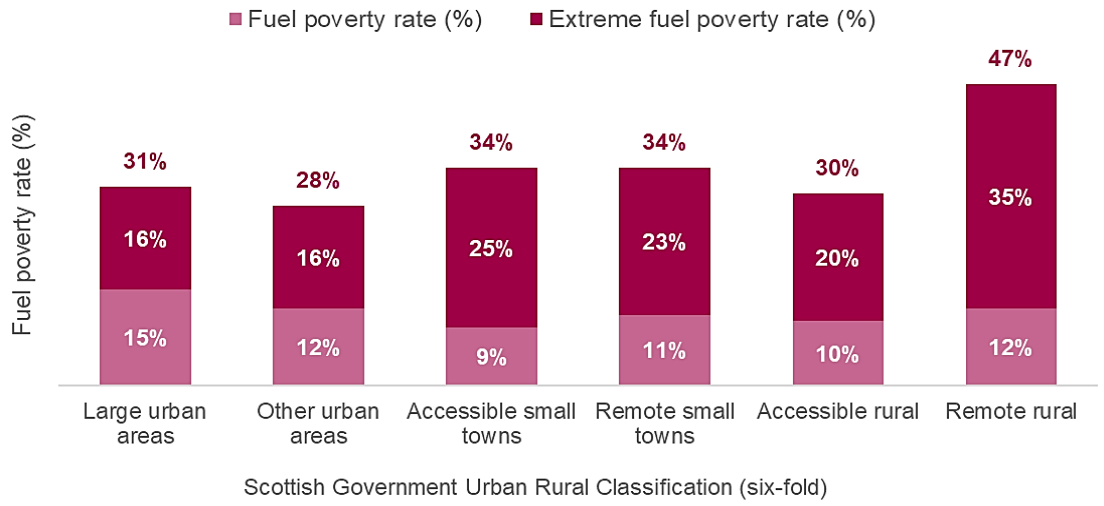


Source: Scottish House Condition Survey, 2022
1. No comparable data was collected for the Scottish Household Survey during the COVID-19 pandemic in 2020 and 2021.

Fuel poverty is disproportionately high in rural Scotland. Populations in rural areas are at additional risks of experiencing fuel poverty from comparatively colder and wetter climate conditions, higher costs of living, with the highest additional cost being transport, lower pay levels with low-skilled and seasonal employment, the lack of affordable housing and uptake of welfare support tends to lower and support services are less available (Figure 48).

As the Scottish Government attempts to accelerate the transition to low-carbon heating systems to support net-zero climate change commitments by creating more efficient and warmer homes, there are potential impacts on fuel-poor households in Highland, with electricity costs four times higher than gas.

Figure 48: Fuel poverty and extreme fuel poverty rates by the Scottish Government Urban Rural Classification (six-fold), 2022



Source: Scottish House Condition Survey, 2022

The Scottish Fuel Advisory Panel report for 2023-2024 emphasises that Scotland's ambition to eradicate fuel poverty by 2040 will be in the context of continuing high energy prices.

5.8. Homelessness

At the most fundamental level, having a home is a crucial determinant of health. There are very significant negative health impacts associated with homelessness[113].

The causes of homelessness are complex. They usually include a combination of structural factors (such as poverty and lack of affordable housing) and individual vulnerabilities (such as relationship difficulties, mental health problems, or substance use)[114].

Homeless people may live in a variety of situations, including sleeping outdoors (rough sleeping), staying in hostels, bed and breakfasts and temporary supported accommodation, staying with acquaintances (sofa surfing), and living in overcrowded housing.

The 2018 report Health and Homelessness in Scotland found that eight percent of the Scottish population had experienced homelessness at some stage in their life[115]. The study linked routine data to compare the outcomes of people who had been assessed as homeless with those from the least and most deprived areas of Scotland who had not experienced

homelessness. Almost half of those who had experienced homelessness at some point in the study had evidence of health conditions related to alcohol, drugs or mental health, much higher than the comparator groups.

Recent research has highlighted the extent to which long-term homeless populations experience a range of chronic health conditions, with mental illness and substance misuse often co-morbidities[113].

Mental health problems are a particular concern[113]. Families who are housed in temporary accommodation start to suffer a range of adverse health outcomes after approximately two weeks[113]. Mental health problems and substance misuse increase the risk of homelessness as well as being caused or exacerbated by homelessness[115].

Homeless people are much less likely to be registered with a GP and more likely to go to emergency services than the wider population[116].

There is an increase in interactions with health services before people become homeless and a peak in interactions around the time of the first homelessness assessment[117].

The benefits system is crucial to protecting people from homelessness, covering housing costs for people with low incomes, and providing income when people are not working. However, significant changes, known as "welfare reform," have reduced the protection available[118].

If a household is unintentionally homeless (or threatened with homelessness), the local authority must offer settled accommodation. Until this is available, the local authority must provide temporary accommodation. A refused offer would fulfil a local authority's duty to secure accommodation for unintentionally homeless people, provided that the offer is reasonable[119].

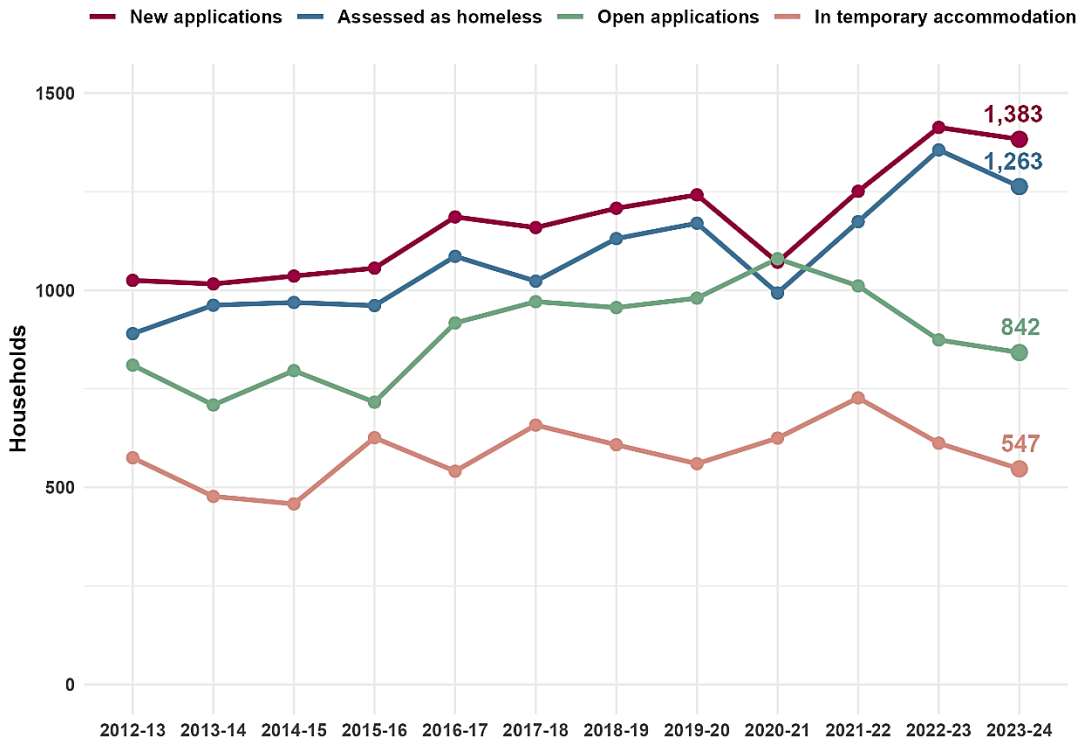
The 2020 Ending Homelessness Together Action Plan outlines how the national government, local government and other partners will work collaboratively to end homelessness[120]. NHS boards can support the role of housing and homelessness services within Community Planning and Health and Social Care Partnerships and addressing the health needs of homeless people, children, and families as part of the Health and Social Care Partnership strategic commissioning and locality planning[121].

Homelessness in Highland

The volume of applications and households assessed as homeless remains high in Highland following increases during and after the pandemic, pressures related to availability and affordability in the current housing system and the cost of living crisis adding numbers (Figure 49)[122].

However, open homeless applications have been reducing, and the number of households in temporary accommodation has decreased from a recent high point in 2021-22 following the easing of restrictions that limited household moves during the COVID-19 pandemic.

Figure 49: Homeless applications, assessment, open applications, and households in temporary accommodation in Highland, 2012-13 to 2023-24



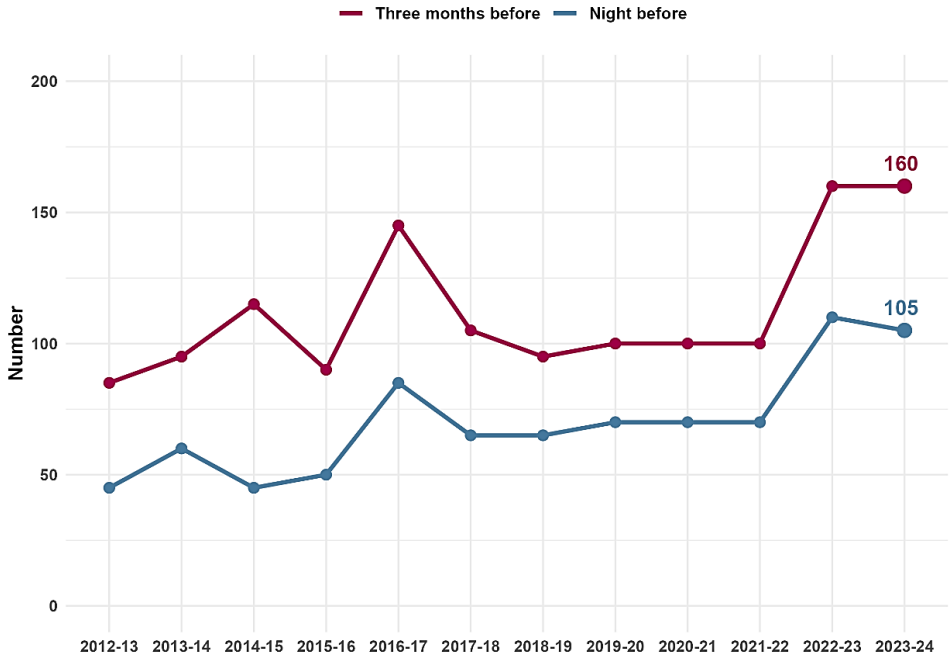
Source: Homelessness in Scotland, 2023-24

The 1,263 applications assessed as homeless or as threatened with homelessness in 2023-24 were associated with 2,042 people, of which 606 were children and 329 households had at least one identified support need.

Many homeless people in Highland live in temporary accommodation, and a small proportion sleep rough.

In 2023-24, 160 households in Highland had experienced rough sleeping three months before their homelessness application (Figure 50).

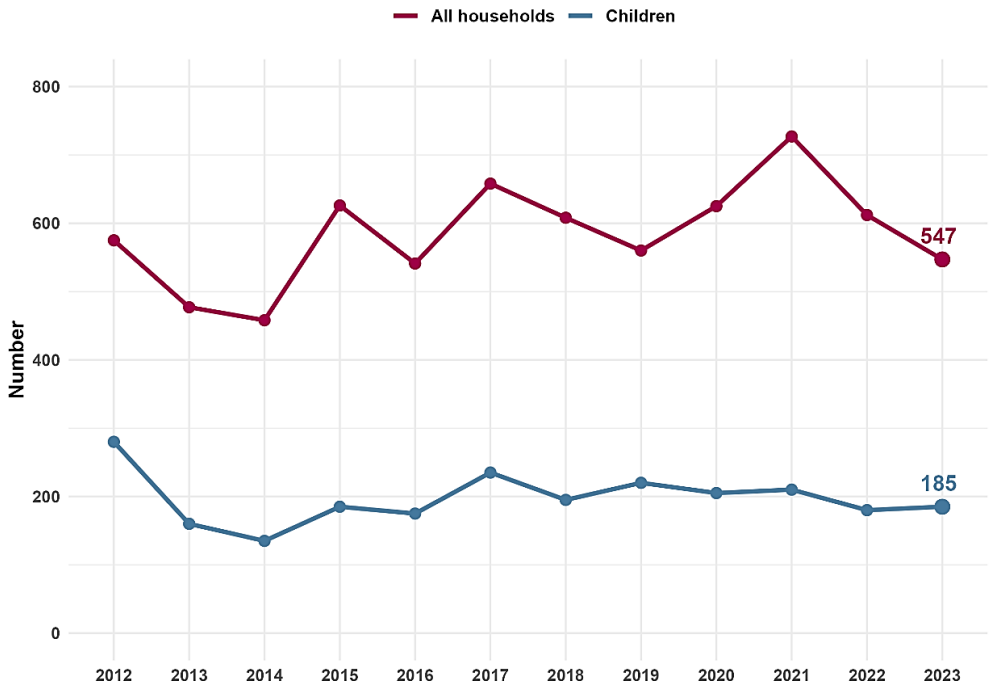
Figure 50: Applications in Highland with at least one member of the household experiencing rough sleeping, 2012-13 to 2023-24



Source: Homelessness in Scotland, 2023-24

Figure 51 suggests that around 185 children live in temporary accommodation in Highland at any time. The average time spent in temporary accommodation was 228 days in Highland in 2023-24.

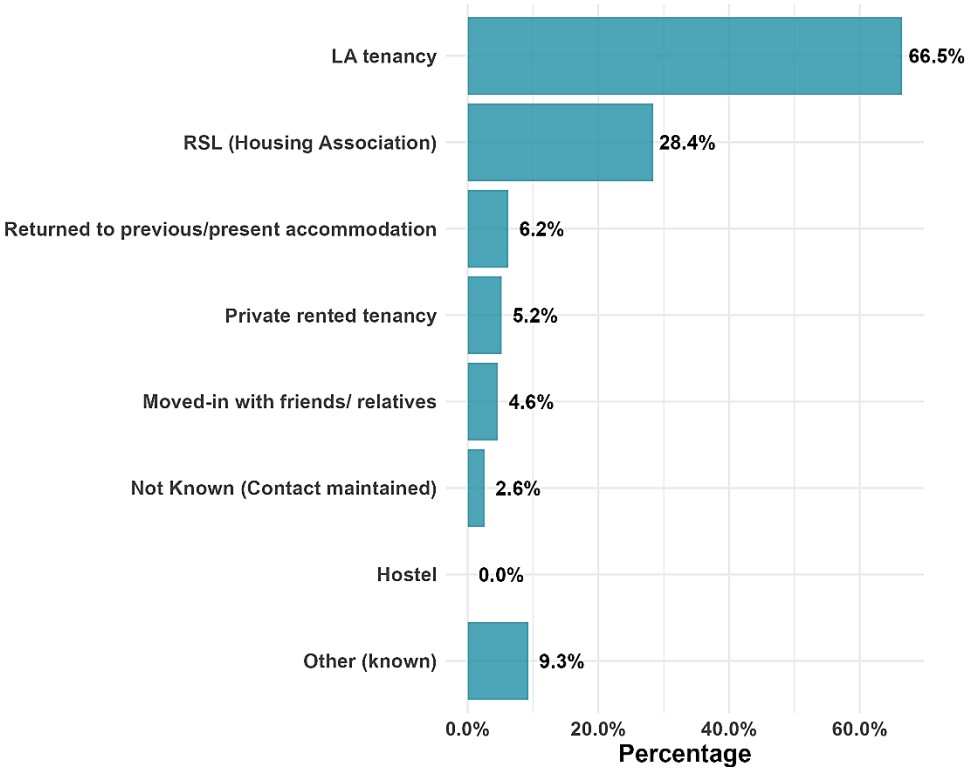
Figure 51: Number of households and children in temporary accommodation (as of 31 March) in Highland, 2012 to 2023



Source: Homelessness in Scotland, 2023-24

In 2023-24, 83 percent of unintentionally homeless households in Highland secured settled accommodation. The average time to case closure was 237 days, and two-thirds of households were provided with a home in a local authority property.

Figure 52: Tenancy of resettled homeless households in Highland in 2023-24



Source: Homelessness in Scotland, 2023-24

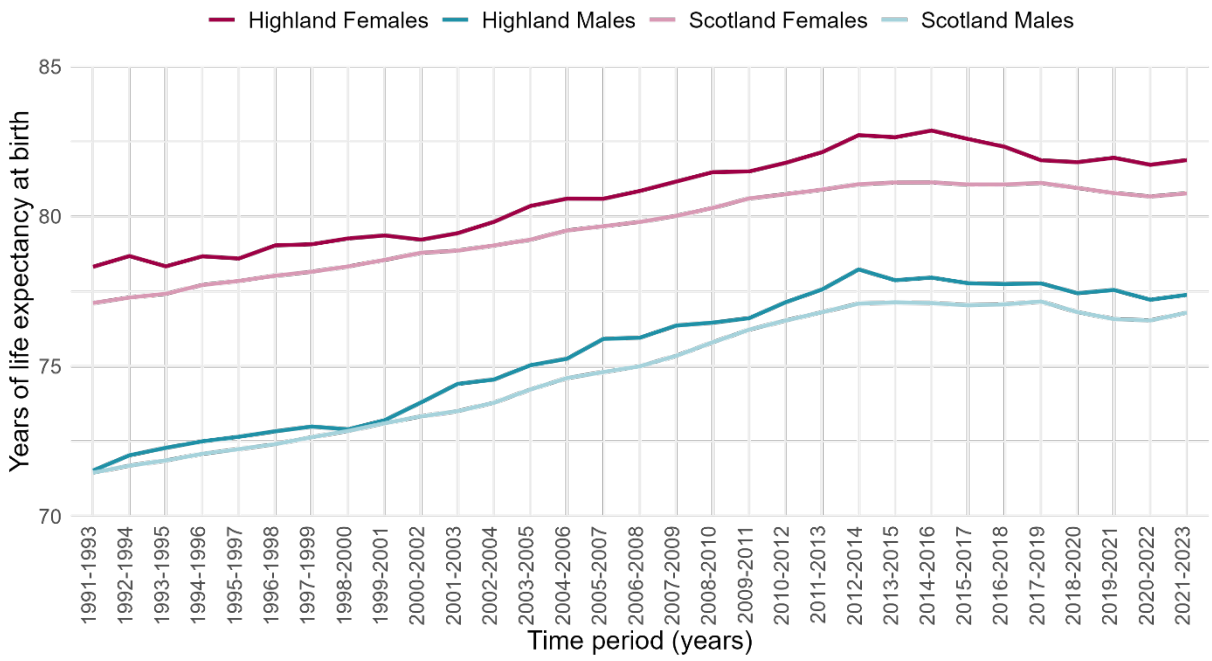
6. Health and Wellbeing

6.1. Life expectancy and healthy life expectancy

Life expectancy at birth is an important high-level measure of the health of a population and is the average age at death, for people who die during the period it is calculated. Healthy life expectancy measures the number of years lived in good health. It combines life expectancy with survey data on the proportion of people who report being in good health, by age and sex. Increasing healthy life expectancy is more desirable than increasing life expectancy lived in poor health.

People are living longer than in previous generations. Life expectancy in Highland had increased over time for both males and females, with only minor variation from year to year. Since 2012-2024, and following the pattern in Scotland, average life expectancy has stopped improving. Life expectancy in Highland has decreased for both males and females (Figure 53).

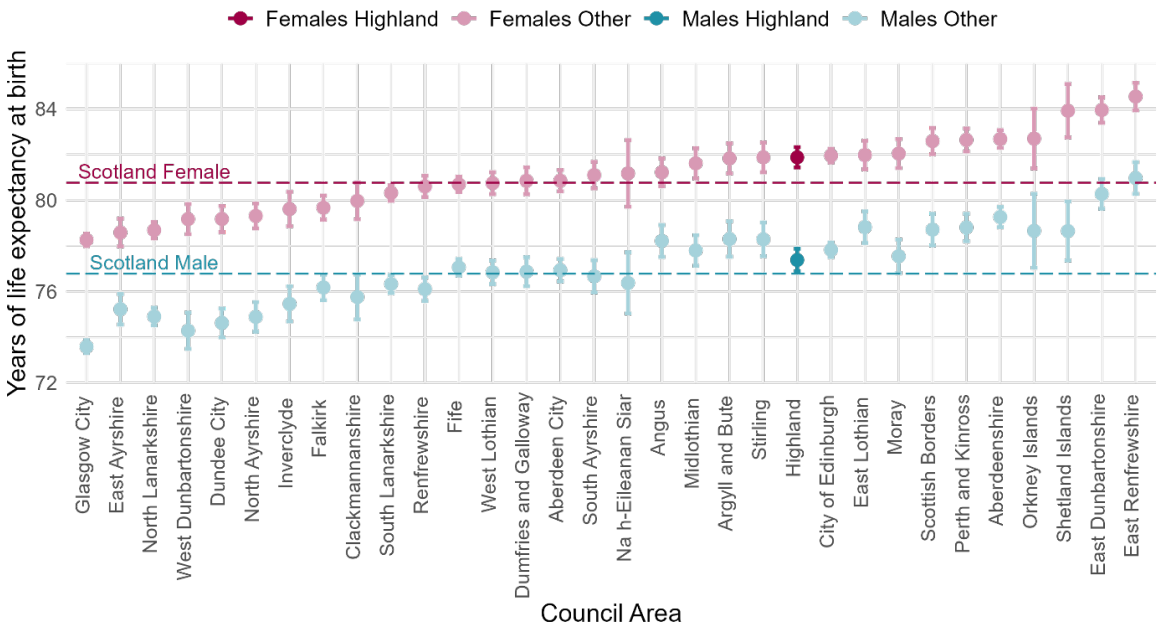
Figure 53: Life expectancy at birth, Highland and Scotland from 1991-1993 to 2021-2023



Source: National Records of Scotland

Life expectancy varies across council areas in Scotland with Highland experiencing life expectancy higher than Scotland (Figure 54). Female life expectancy is consistently higher for females than for males, describing a persistent inequality in health between the sexes.

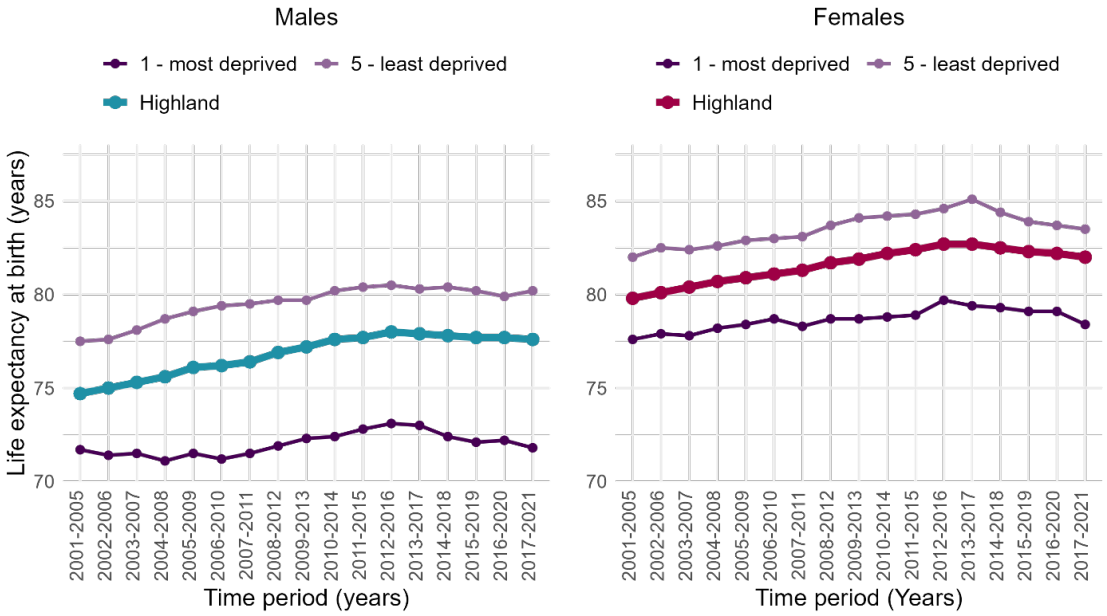
Figure 54: Life expectancy at birth by council area, 2021-2023



Source: National Records of Scotland. Error bars display 95% confidence intervals

Gaps in life expectancy between the most and least deprived areas of Highland highlight significant health inequalities. People in our poorest neighbourhoods are dying younger than their peers. In 2017-2021, the gap in life expectancy between the most deprived and least deprived areas of Highland was 8.4 years for males and 5.1 years for females (Figure 55). Gaps in life expectancy have increased over time for both sexes and highlight widening inequalities in society.

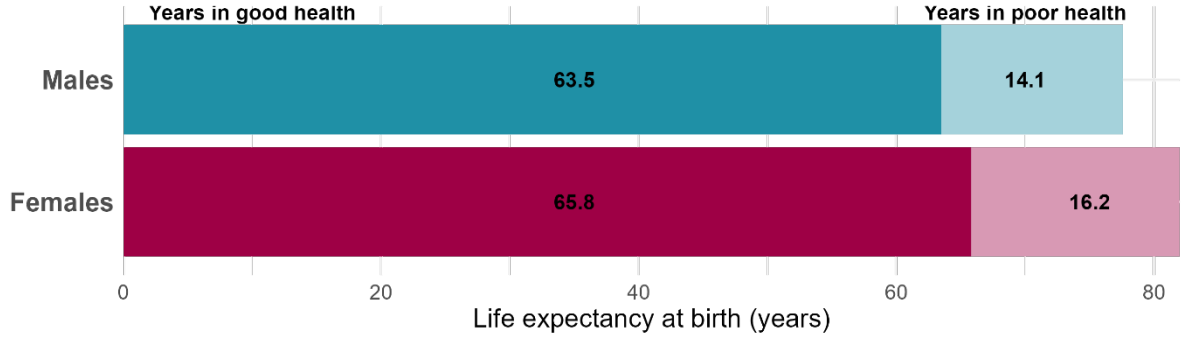
Figure 55: Life expectancy at birth by deprivation quintile within Highland, 2001-2005 to 2017-2021



Source: National Records of Scotland, Public Health Scotland, Scottish Public Health Observatory online profiles

Healthy life expectancy has decreased in Scotland in the last decade. Figure 56 shows the difference in the average number of years lived in good health compared to the average number of years lived in poor for the Highland population. It is estimated that in Highland the average proportion of life spent in poor health is 18.2 percent (14.1 years) for males and 19.8 percent (16.2 years) for females.

Figure 56: Estimated number of years spent in good health and poor health in Highland in 2019-2021



Source: National Records of Scotland, Public Health Scotland, Scottish Public Health Observatory online profiles

6.2. Health status

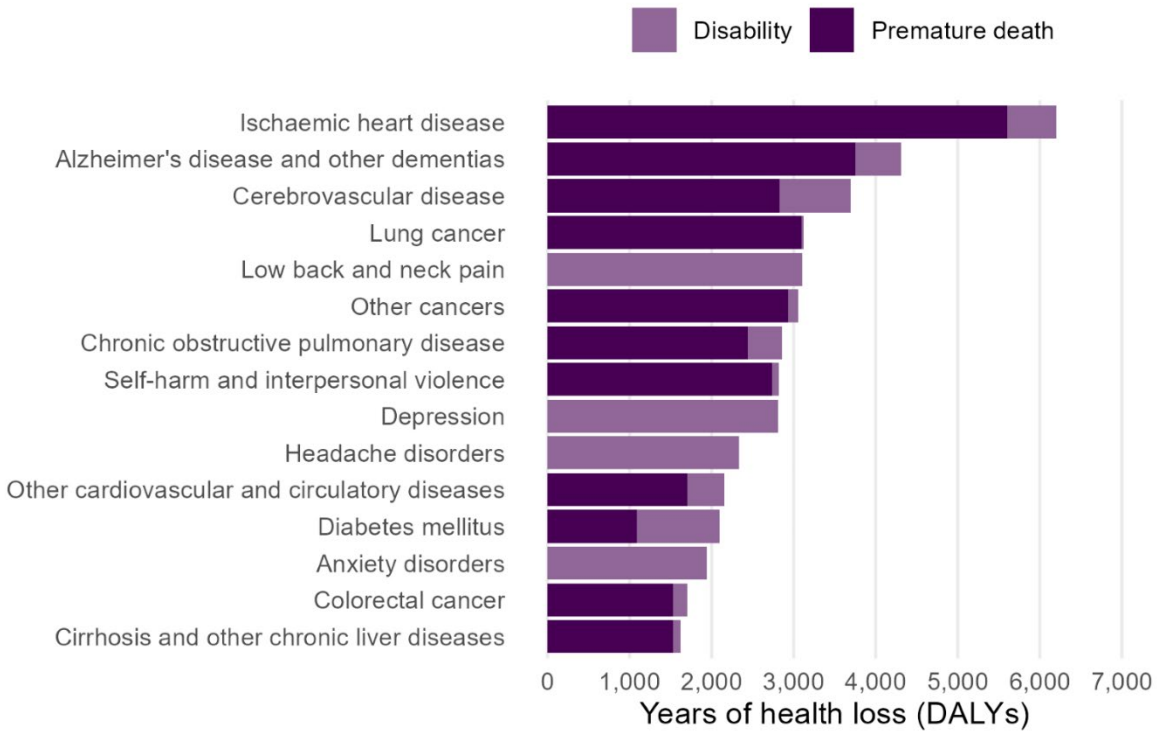
Understanding which health conditions, diseases and injuries impact on population health is essential to inform priorities for health and care service planning and redesign, and for prioritising areas for disease and injury prevention.

The Scottish Burden of Disease study monitors how diseases, injuries and risk factors prevent the population from living longer and healthier lives. The study measures health loss using disability-adjusted life years (DALYs). DALYs are a summary measure of population health that combine the impact of morbidity and mortality in a comparable way[123].

In 2019, the three leading groups of causes of ill-health and early death in Highland were cancers, cardiovascular diseases and neurological disorders. These groups of causes accounted for 50 percent of the total burden of health loss.

The leading individual causes of health loss were ischaemic heart disease, Alzheimer's and other dementias, cerebrovascular disease, lung cancer and low back and neck pain. Mental health conditions such as anxiety and depression and injuries associated with self harm and interpersonal violence also contributed substantially to health loss in Highland (Figure 57).

Figure 57: Leading individual causes of health loss in Highland, 2019

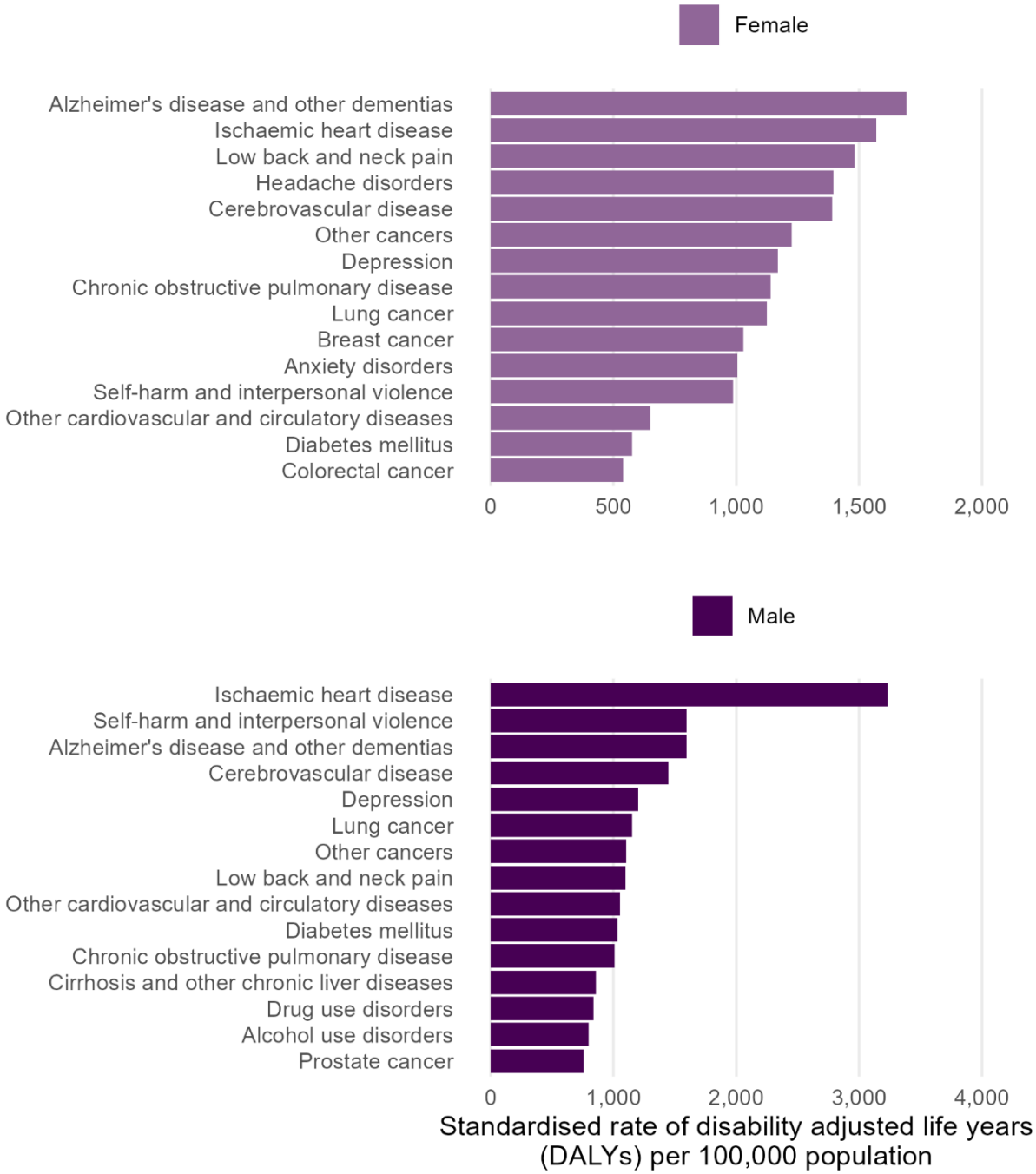


Source: Public Health Scotland, Scottish Burden of Disease study 2019
Number of Disability adjusted life years (DALYs), all ages, both sexes

The most common causes of health loss differ for females and males. Females experienced higher rates of health loss due to Alzheimer's disease and other dementias, low back and neck pain and headache disorders. By comparison, males had higher rates due to ischaemic heart disease, self-harm and interpersonal violence and cerebrovascular disease (Figure 58).

Cancers overall are the leading cause of death and poor health in Scotland and are forecast to increase. Although there have been significant advances in improving mortality and survival rates from cancer in recent years, cancer remains one of Scotland's biggest health challenges. The latest estimates suggest that 3.5% of men and 4.1% of women in Scotland are living with cancer, and that two in five people (40%) will be diagnosed with cancer during their lifetime. As with other conditions there is an important relationship between cancer and health inequalities.

Figure 58: Leading individual causes of health loss by sex in Highland, 2019



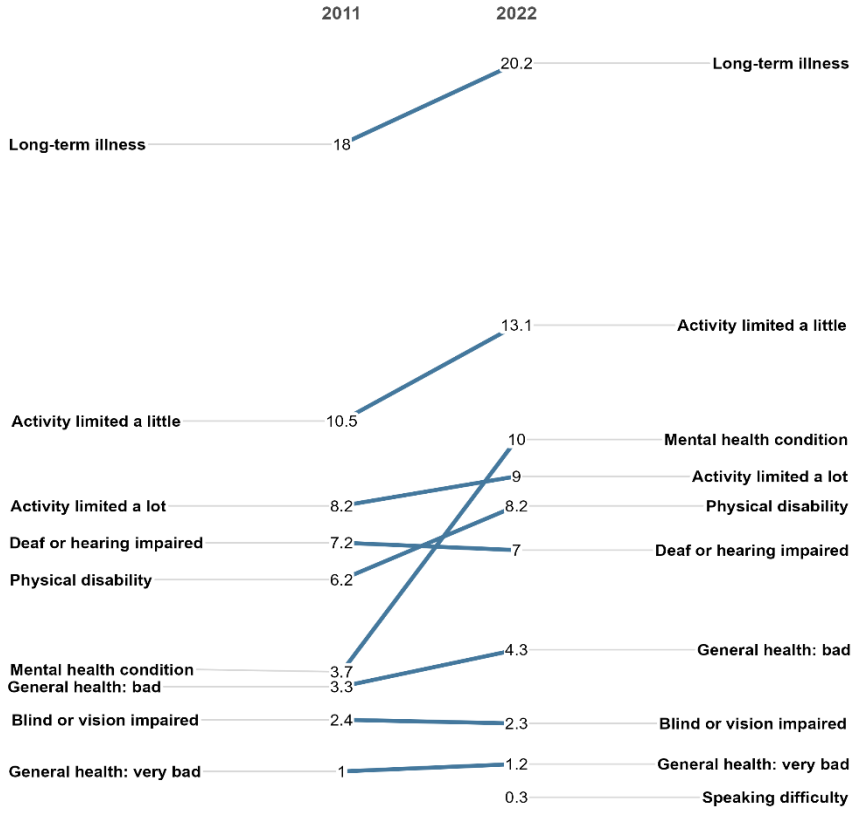
Source: Public Health Scotland, Scottish Burden of Disease study 2019

6.3. Changes in health and disability

Essential data to understand population health, exploring how people assess their general health, the prevalence of health conditions, and the impacts of disability and long-term illness, are available from the census. Census health measures have been validated against physician-reported diagnoses, shown to predict morbidity and mortality and correlated with healthcare use[124] [125] [126]. The data has a history of application in health and social care policy, planning, and resource allocation[127]. Additionally, the measures of health and disability help us to understand how people assess their ability to participate fully in society, including their fitness to work.

The responses from the last two censuses indicate that ill-health and disability increased in the Highland population between 2011 and 2022, with comparable changes observed nationally[128]. A growing proportion of the population in Highland is living with one or several chronic health conditions that increase demands on health and social care provision (Figure 59).

Figure 59: Slopegraph summary of age-standardised percentage responses to census health questions in 2011 and 2022, Highland



- In 2022 there were over 52,000 people living with a long-term illness, disease or condition compared to 42,000 in 2011
- There were over 22,000 with a mental health condition in Highland in 2022, ten percent of the population compared with under four percent in 2011.
- In total, in 2022, 56,000 people were living with a long-term health condition or disability that limited their activity a little or a lot.

Source: National Records of Scotland, Scotland's Census 2022 – Health, disability and unpaid care supplementary table

The lack of improvement in health in the intra-census period may not appear surprising simply on the grounds of population ageing over the period, as older people tend to experience more health issues than younger people. However, after adjusting prevalence percentages to account for differences in younger and older people in the population between 2011 and 2022, the increase in ill health and disability remains (Figure 59).

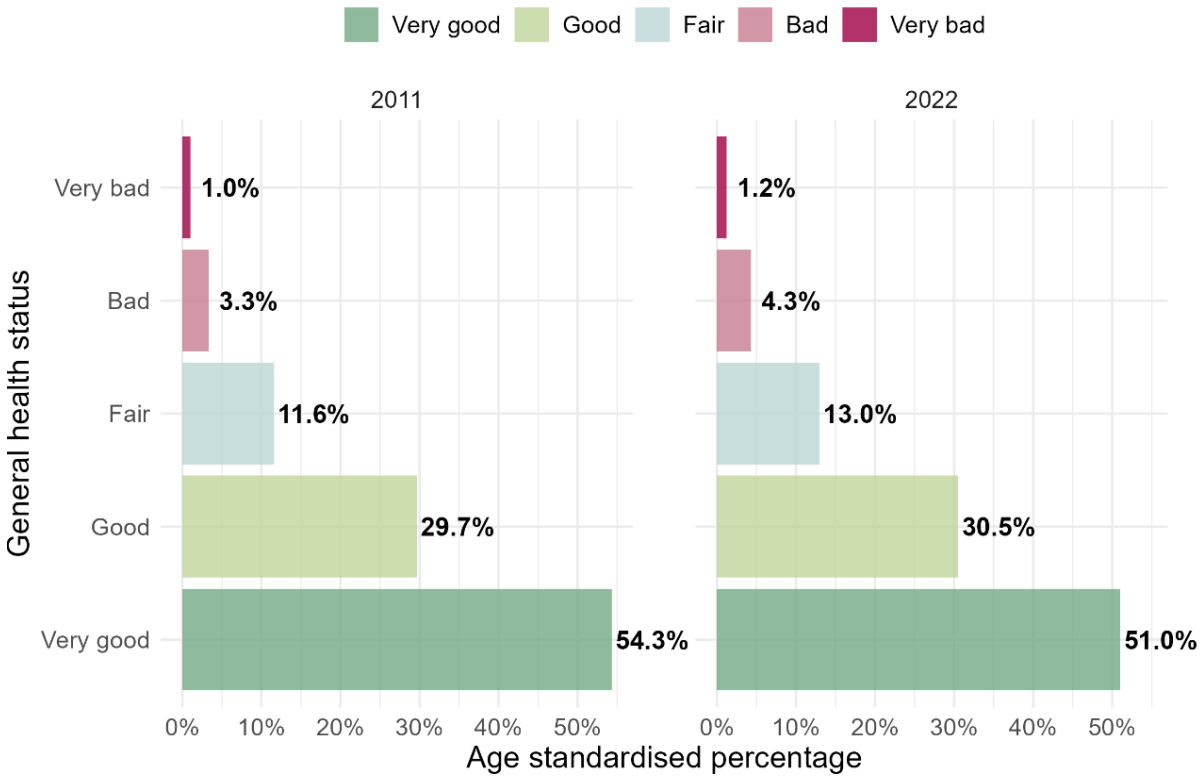
Particularly worrying are increases in younger age ranges of people experiencing poorer general health and mental health conditions, which potentially affect the likelihood of being able to work and lead fulfilling lives.

General Health

In 2022, in Highland, 187,779 (79.8 percent) people considered their health good or very good, compared to 195,036 (84 percent) in 2011. For those who said their health was bad or very bad, 14,249 (6.1 percent) were in these categories, an increase from 4.4 percent in 2011 of 4,095 people (Figure 60).

There is a strong link between age and general health; worse health is anticipated in a population with more older people. However, after adjusting for the age differences between the population of Highland in 2011 and 2022, the decline in general health remains.

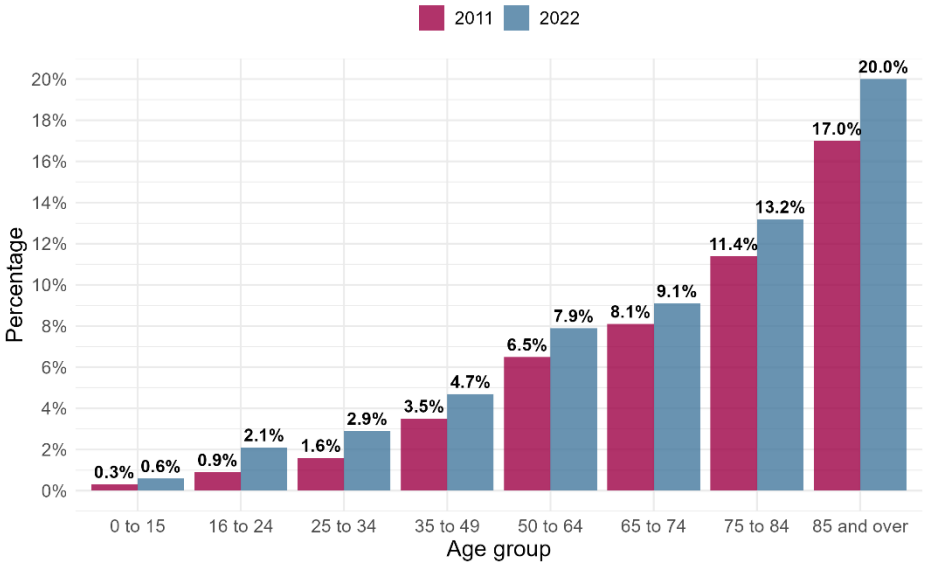
Figure 60: Age-standardised percentage responses to the General Health questions in the 2011 and 2022 censuses in Highland



Source: National Records of Scotland, Scotland's Census 2022 – Health, disability and unpaid care supplementary table

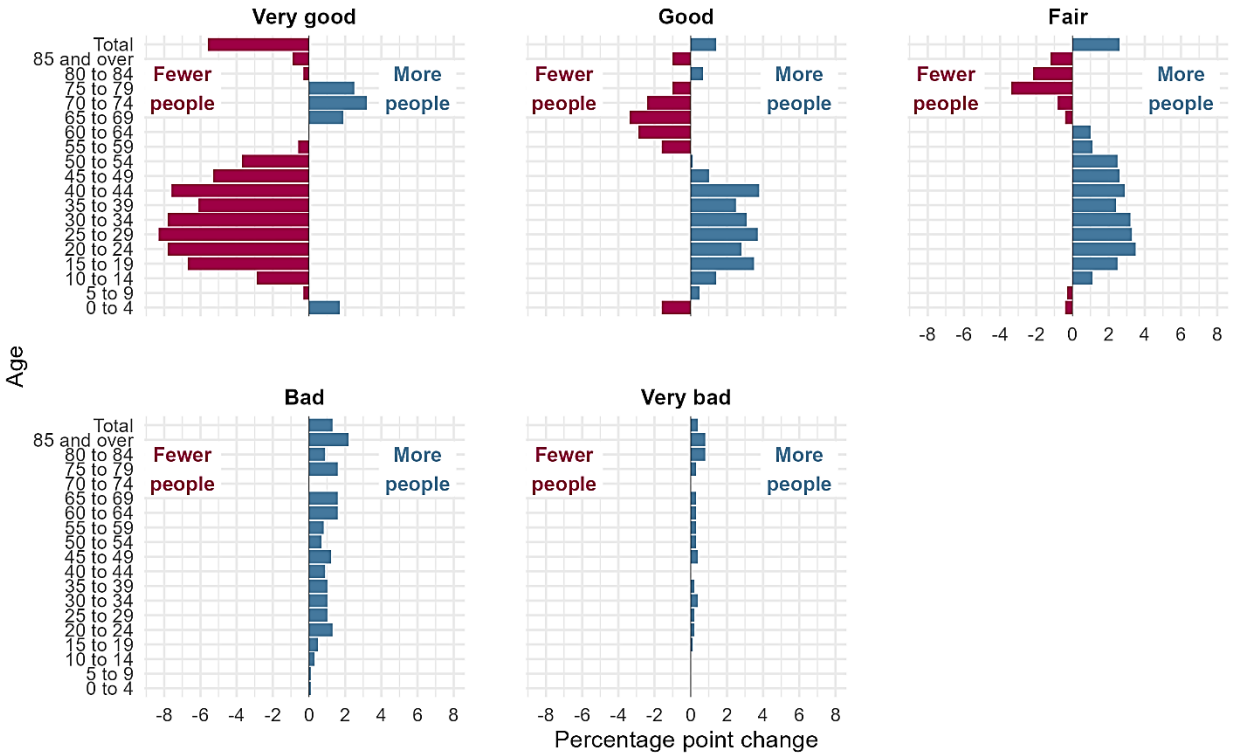
Figure 61 shows that there were increases in the percentage of people reporting bad or very bad health in all age groups, similar to Scotland. Analysis by age band in Figure 62 highlights the deterioration in those considering themselves in very good health in the younger and working-age population.

Figure 61: Percentage of people reporting bad or very bad health by age group in the 2011 and 2022 censuses in Highland



Source: National Records of Scotland: Census 2011 table DC3102SC and Census 2022 table UV302a

Figure 62: Age-specific percentage point change in general health status between Census 2022 and 2011 in Highland



Source: National Records of Scotland: Census 2011 table DC3102SC and Census 2022 table UV302a

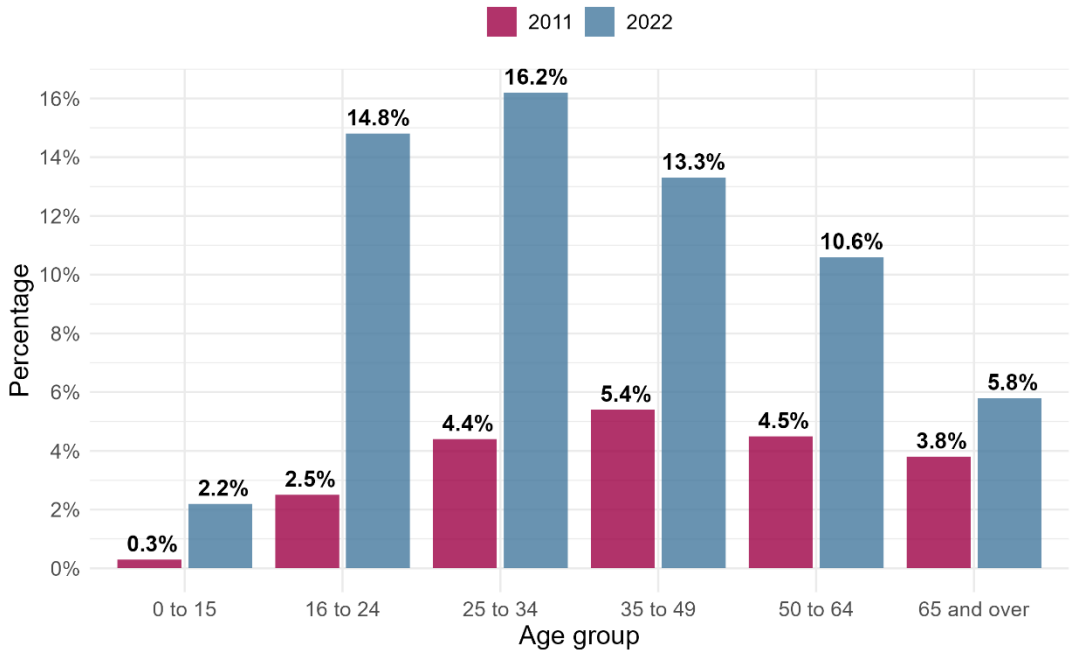
Health conditions

The most common type of health condition reported in the census was a long-term illness or disease, a condition that someone may have for life that may be managed with treatment or medication and is not in one of the specified question categories. It is a broad description that includes a range of conditions such as arthritis, cancer, diabetes and epilepsy, with just over one in five of the Highland population reporting having such a long-term illness (Figure 59).

The second most common condition reported in 2022 was a mental health condition. The age-standardised percentage of people in Highland was 10 percent compared to 3.7 percent in 2011, showing a three-fold increase, comparable to the rise in Scotland (Figure 59).

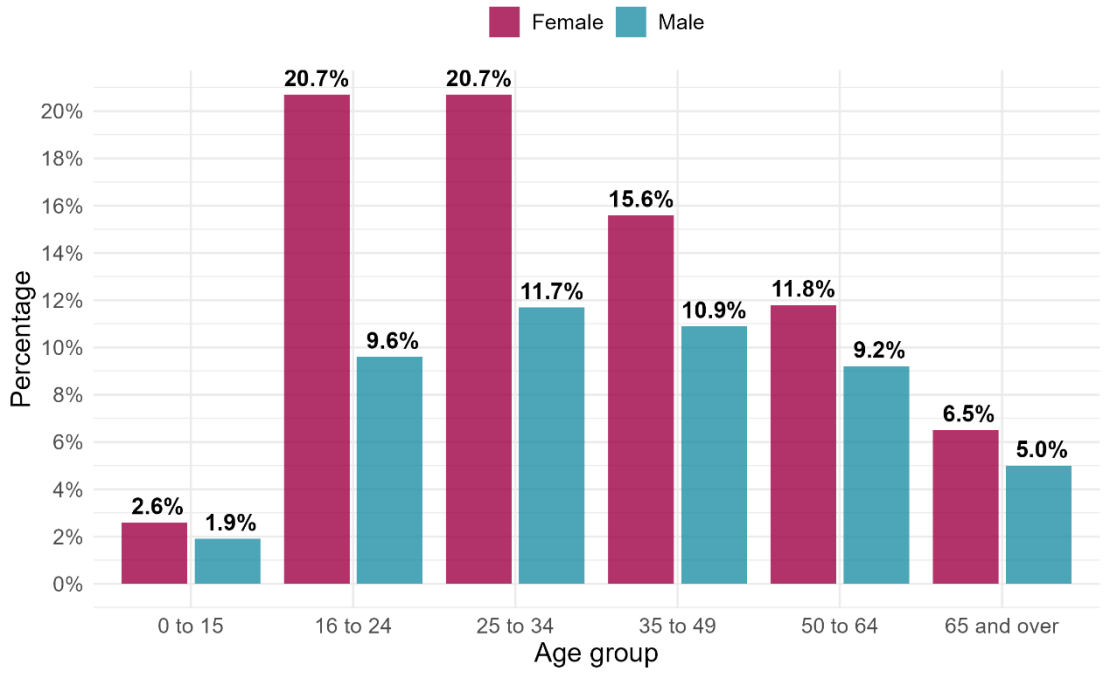
The growth in the prevalence of mental health conditions at younger ages largely explains the overall increase in rate over the period (Figure 63). The highest rates were reported by 25 to 34-year-olds in 2022. The largest increases were in the 16 to 24 age group, where the percentage of females in Highland reporting a mental health condition was more than double the number for males (Figure 64). As in 2011, the 2022 census identified a higher percentage of females reporting a mental health condition across all age groups.

Figure 63: Percentage of people who reported a mental health condition by age group in the 2011 and 2022 censuses in Highland



Source: National Records of Scotland: Census 2011 table DC3106SC and Census 2022 table UV304a

Figure 64: Percentage of people who reported a mental health condition by age group and sex in the 2022 census in Highland



Source: National Records of Scotland: Census 2011 table DC3106SC and Census 2022 table UV304a

Changes in reporting self-assessed health may reflect a greater willingness to report conditions over time. During the intra-census period, there may have been greater awareness of mental health well-being and reduced stigma about reporting[128]. However, over the same period, adverse changes in life circumstances driven by inequalities in the social determinants of health have put some groups at more risk of physical and mental health harm, with poverty the single biggest driver of poor mental health and women and girls disproportionately impacted[129].

Learning disability, learning difficulty or developmental disorder

The census found that the percentage of people reporting a learning disability, learning difficulty, or developmental disorder increased from 2.6 percent in 2011 to 5.1 percent in 2022 in Highland. In November 2024, data was only published as a combined measure for these three categories because of concerns over how people interpreted the question layout, resulting in unrealistic combinations of responses[130].

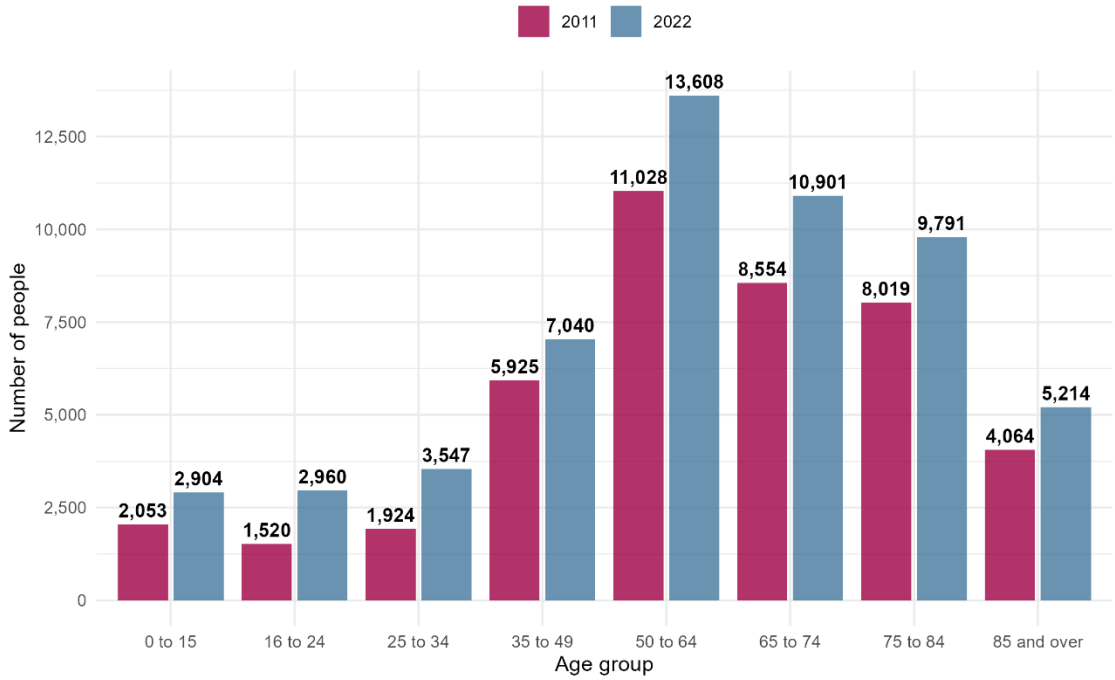
Limiting long-term health conditions or disability

The population with long-term health conditions or disabilities that limit daily activity increased between 2011 and 2022 in Highland (Figure 65). Those reporting activities as limited a lot will be among those most needing regular support from health and social care services, family members, and voluntary services.

In 2022, 55,976 or 24 percent of people in Highland indicated that they had either a health condition or disability that limited their day-to-day activities a little (32,936 (14 percent)) or a lot (23,040 (10 percent)). There is a strong relationship between the measure and age.

Figure 65 shows that the number of people with a health problem that limited their day-to-day activities increased across all age groups from 2011 to 2022.

Figure 65: Number of people in Highland with a health condition or disability that limited their day-to-day activities a little or a lot

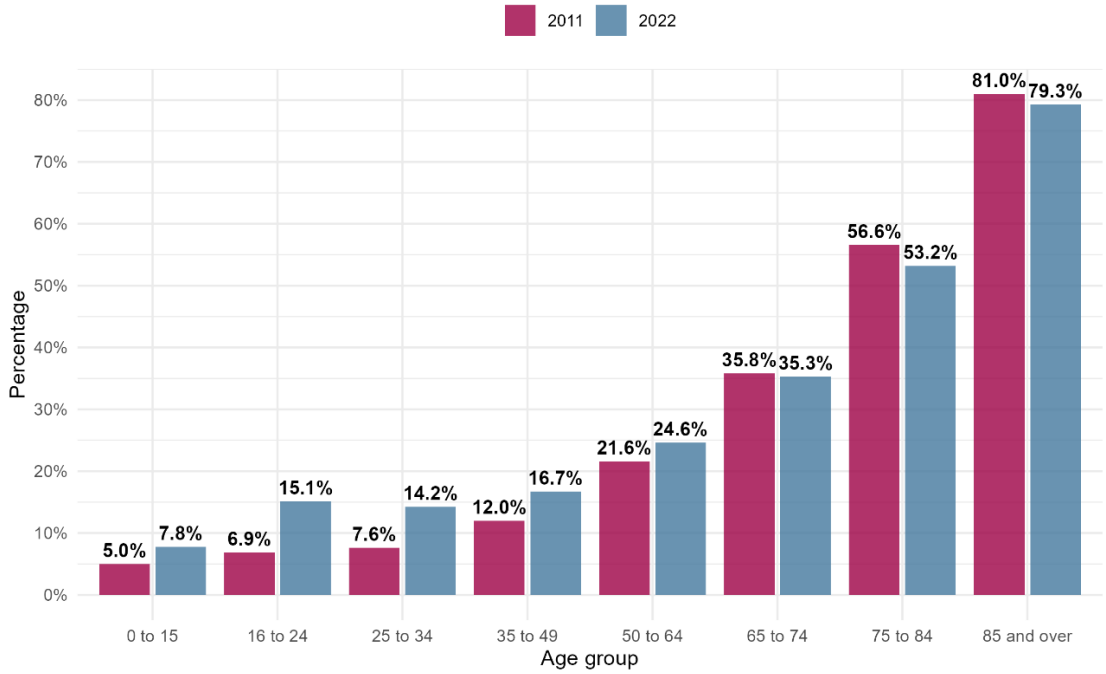


Source: National Records of Scotland: Census 2011 table DC3101SC and Census 2022 table UV303a

However, over the period, it appears that the percentage of people over 65 years of age with an activity-limiting health condition or disability decreased, while in younger age groups, there were increases. In particular, the 16 to 24 age group rates more than doubled.

Figure 67 looks at these changes in more detail. There are improvements in health at older ages, with the census 2022 cohorts over 70 years experiencing fewer limitations of the type that restrict day-to-day activities a lot compared to those in 2011. The improvement is particularly notable in those over 85 years old.

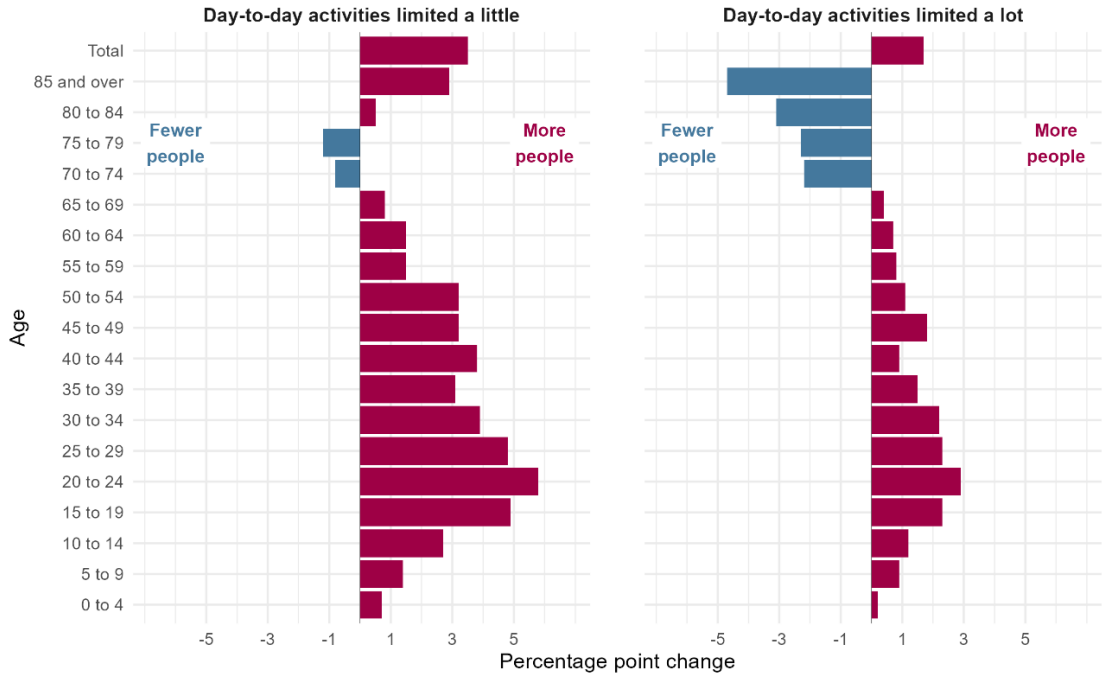
Figure 66:Percentage of people in Highland with a health condition or disability that limited their day-to-day activities a little or a lot



Source: National Records of Scotland: Census 2011 table DC3101SC and Census 2022 table UV303a

However, there has been a very concerning deterioration at younger ages, which has implications for current and future health and social care service demand, the resilience of the workforce, participation in society and whether a large proportion of the population can fulfil their potential.

Figure 67: Age-specific percentage point change in health conditions or disability that limit day-to-day activity between the census of 2022 and 2011 in Highland



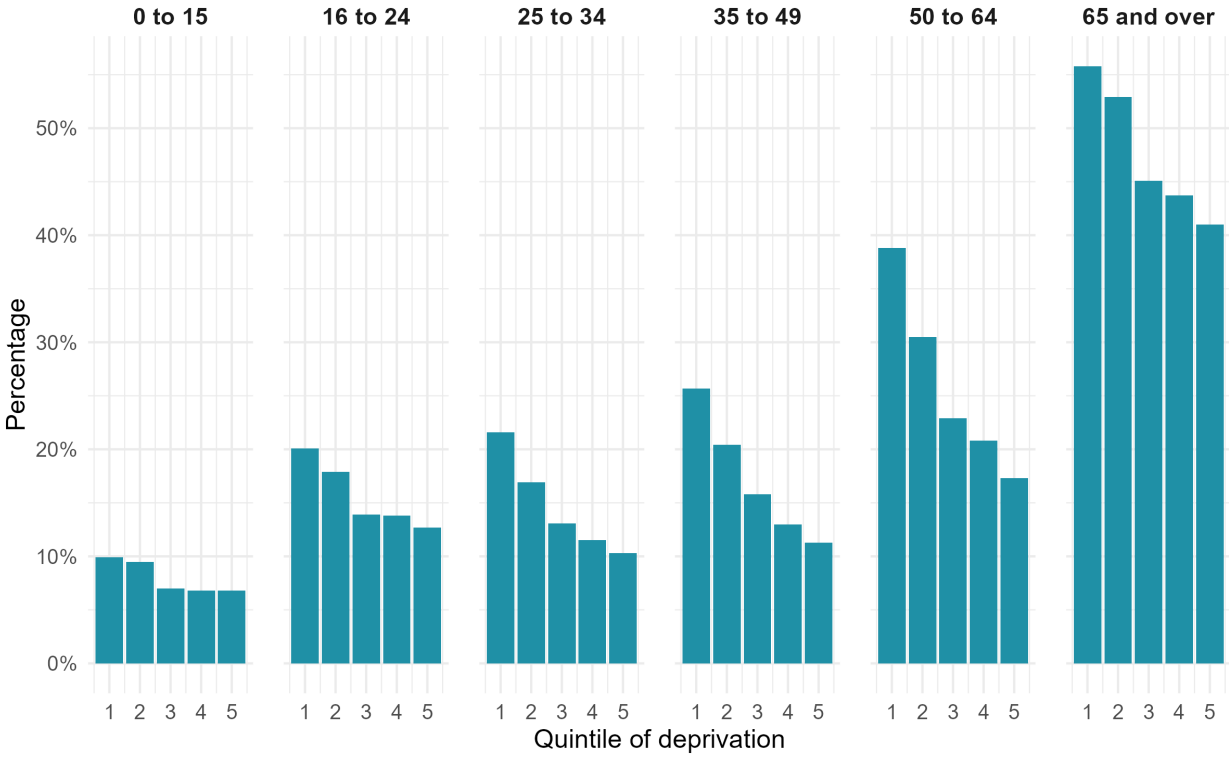
Source: National Records of Scotland: Census 2011 table DC3101SC and Census 2022 table UV303a

Figure 68 explores how the impact of long-term conditions and disabilities are socially patterned. Across Highland, people in the most deprived areas were more likely to report having a long-term condition or disability that limits day-to-day activity.

Population health is known to be more favourable in some geographical locations than others, influenced by factors such as income, unemployment, housing, education, and access to services. Below, area measures of deprivation from the Scottish Index of Multiple Deprivation (SIMD 2020) are compared with variations in limiting long-term health conditions and disabilities with age.

In the most deprived areas of Highland, a higher percentage of people are disabled at younger ages compared to the least deprived areas. For example, in 2022, in the most deprived area, 20.1 percent of the 16 to 24 population had a limiting long-term condition or disability compared to 12.7 percent in the least deprived quintile. People living in the least deprived areas do not experience this level of health and disability until they are 65 years old.

Figure 68: Percentage of people in Highland with health conditions or disabilities that limit day-to-day activity by age group and quintile of deprivation at census 2022[1]



Source: National Records of Scotland: Census 2022 table UV303b (Output areas) and the Scottish Index of Multiple Deprivation 2020v2 (SIMD2020v2)
National deprivation quintiles are used, where one is the most deprived and five the least deprived areas in the country.

6.4. Multimorbidity and long term health conditions

As the population of Highland continues to age, the underlying epidemiological trends mean there will likely be more people with multiple long-term conditions and more people with complex care needs.

A Public Health Scotland report reviewed how health needs in Scotland's population are expected to change over the next 20 years[131]. The research found that the annual disease burden in Scotland is forecast to increase 21 percent between 2019 and 2043, with the largest increases for the 65 to 84 years age group. This is due to the interaction between the extent of health needs and increasing size of this population group. In terms of overall health needs, the largest absolute increases are forecast for cardiovascular diseases, cancers, and neurological diseases.

The research considered projected demographic changes (i.e. the expected changes in the number of people and their ages) and assumed that disease prevalence rates remained the same in 2043 as in 2019. The estimates did not consider any underlying improvements, or worsening, in the underlying disease trends, access to services or advances in prevention and treatment. Preventative activity, alongside early intervention and improved treatments would all need to be acted upon for these forecasts not to become a reality.

Understanding of multimorbidity is especially important and has many implications for health and care services. Multimorbidity (two or more medical conditions simultaneously) increases demand for services in primary and secondary care, is strongly associated with receipt of social care, and impacts overall mortality[132] [133].

Multimorbidity is common, affecting between 23 percent and 27 percent of the population[134]. Prevalence increases with age and socio-economic deprivation. A 2012 study, based on Scottish general practice data, estimated 81 percent of people were multimorbid by the age of 85 years[135]. More recent research, which linked national health and social care data to explore multimorbidity and social care use in those aged over 65 years, estimated that 93 percent of people receiving social care had multimorbidity[136].

Projections of multimorbidity suggest that there will be greater numbers of people with multimorbidity in the future. The prevalence of complex multimorbidity (four or more conditions) is forecast to increase and two-thirds of those with four or more conditions will have mental ill-health including dementia, depression, and cognitive impairment[137].

In 2019, a report for Alzheimer's UK provided projections of the number of older people (aged 65 and over) with dementia and the costs of healthcare, social care and unpaid care

for older people with dementia from 2019 to 2040. The research estimated a 74 percent increase in the number of people with dementia in Scotland over the next two decades. The number of people with severe dementia was projected to more than double. The costs associated with supporting older people with dementia were estimated to increase by 164 percent, with a 184 percent increase in social care costs[138].

Although the research does not take account of any prevention, intervention or treatment advances that may delay or prevent the onset or progression of dementia, the increase in people with dementia is likely to be substantial. The national dementia strategy sets out a vision for how life with dementia might be experienced and the policy, service and societal changes that are needed to support this[139].

In Highland, the 2019 NHS Highland Annual Report of the Director of Public Health presented an overview of past, current and future trends in health and wellbeing. The report highlighted there are likely to be substantial increases in the number of frail people, people with dementia and in older people with multiple conditions. This is likely to result in a substantial increase in the number of people who will be very dependent on care[140].

It is recommended this work is reviewed when updated sub-national population projections are available.

6.5. Mental health and wellbeing

Poor mental health is a significant public health challenge and improving mental health and wellbeing is a public health priority in Scotland[55]. Mental health is an integral part of overall health and wellbeing. Good mental health can foster improved physical health, healthier lifestyles, strengthen resilience, and improve overall quality of life[141].

Good mental wellbeing includes both mental wellbeing and mental health. It covers aspects of wellbeing such as feeling good, functioning effectively, maintaining positive relationships, and having a sense of purpose, as well as common mental health conditions (e.g. anxiety, depression) and more severe enduring mental illnesses (e.g. schizophrenia, affective psychosis)[142].

Mental health and wellbeing are influenced by an interaction of social, economic, environmental, physical, and individual factors throughout life. Mental health inequalities mean that people who experience disadvantage or have complex needs are more likely to have poorer mental health.

The importance of mental health in the population is demonstrated by overall levels of health loss reported in the Scottish Burden of Disease Study. In 2019, mental health disorders were the fifth leading cause of ill-health and early death in Highland[123].

There is evidence that mental health conditions have increased since the pandemic. The Scottish Mental Illness Stigma Study reported mental health inequalities increased, with young adults and women at greater risk of symptoms of depression, anxiety, and suicidal thoughts[143].

In Highland, the percentage of people reporting a mental health condition in the census increased from 3.6 percent in 2011 to 9.6 percent in 2022. The increase was driven by large increases in younger females, as discussed in the previous section of this report.

Mental wellbeing

Self-reported measures of mental health and wellbeing are collected annually in the Scottish Health Survey. In recent years these indicators have been deteriorating in both Scottish and Highland populations.

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) measures mental wellbeing in the population. Possible scores for WEMWBS range from 14 to 70, with higher scores reflecting greater wellbeing. The mean score for Highland in 2019-2023 was 49.6, lower than mean scores reported before the pandemic (50.6 in 2012-15 and 51.1 in 2016-19). Scores

for Highland males and females are generally higher than the Scottish average, while Highland males consistently report lower wellbeing than females[144].

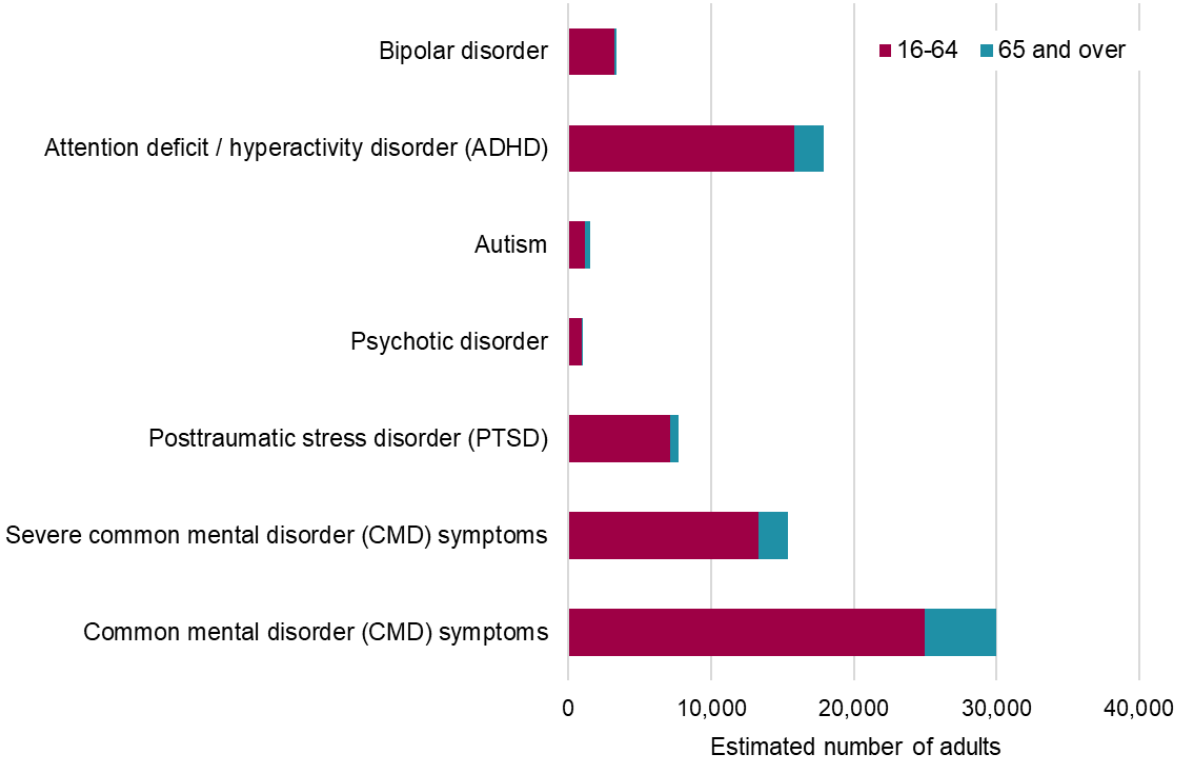
The General Health Questionnaire (GHQ-12) is a widely used screening tool for assessing mental health. In Highland, 20 percent of males and 15 percent of females reported a score of four or more in the 2019-2023 Scottish Health Survey, indicating potential mental health problems.

Mental illness

There is limited data available on the prevalence of mental illness in Highland. The best available data comes from the Adult Psychiatric Morbidity Survey (APMS). The most recent data from this survey is from 2014 but is due to be updated in 2025. Whilst the 2014 survey was only conducted in England, findings are equally relevant for Scotland and Highland[145].

Age-sex specific prevalence rates from the survey were used to estimate the number of people in Highland with different mental health conditions (Figure 69). These indicate that at any time there may be around 45,000 adults with symptoms of common mental disorders (CMD) and more than 30,000 with other specific mental health conditions[146].

Figure 69: Estimated number of adults with common mental disorder (CMD) symptoms and specific mental health conditions by age in Highland



Source: NHS Highland Director of Public Health Annual Report 2021. Derived from Adult Psychiatric Morbidity Survey 2014 by application of age-sex specific prevalence to NRS 2020 mid-year population estimates. Conditions with low prevalence (autism, psychosis) may be over or underrepresented.

In line with national trends, the percentage of the Highland population prescribed drugs for anxiety, depression and psychosis has increased since 2010/11. In 2023/24, an estimated 19.1 percent of the Highland population were prescribed drugs for these conditions, lower than the Scotland estimate (20.9 percent). There is a clear link with deprivation, with those in the most deprived areas being more likely to be prescribed drugs for anxiety, depression and psychosis. The gap between most and least deprived areas has remained similar over recent years.

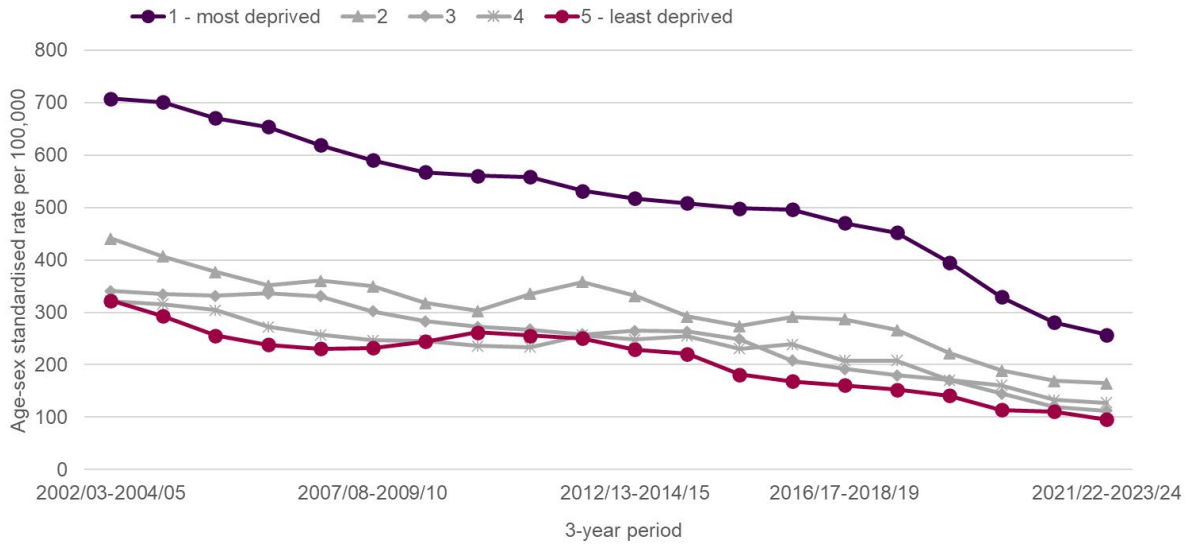
Mental health hospitalisations

Mental health illness results in many patient hospitalisations each year. The admission rate to psychiatric specialities has reduced significantly over the past 20 years in Scotland and Highland.

Psychiatric admission rates show people living in the most deprived areas of Highland are more likely to have an inpatient admission to a psychiatric specialty. There has been a downward trend across all deprivation quintiles in Highland, with the gap between the most and least deprived areas narrowing over time (Figure 70).

The rate of discharges for mental health conditions in non-psychiatric specialities in Highland has increased over the last decade. In 2023-24 the Highland rate of discharges for mental health diagnoses was 427.4 per 100,000 population for non-psychiatric specialities compared to 298.2 per 100,000 in 2013-14[147].

Figure 70: Trend in psychiatric patient hospitalisations by deprivation quintile in Highland, three-year periods 2002/03-2004/05 to 2021/22-2023/24



Source: Public Health Scotland, Scottish Public Health Observatory
Patients discharged from psychiatric hospitals: 3-year rolling average number and directly age-sex standardised rate per 100,000 population. Scottish Index of Multiple Deprivation local quintiles.

Suicide

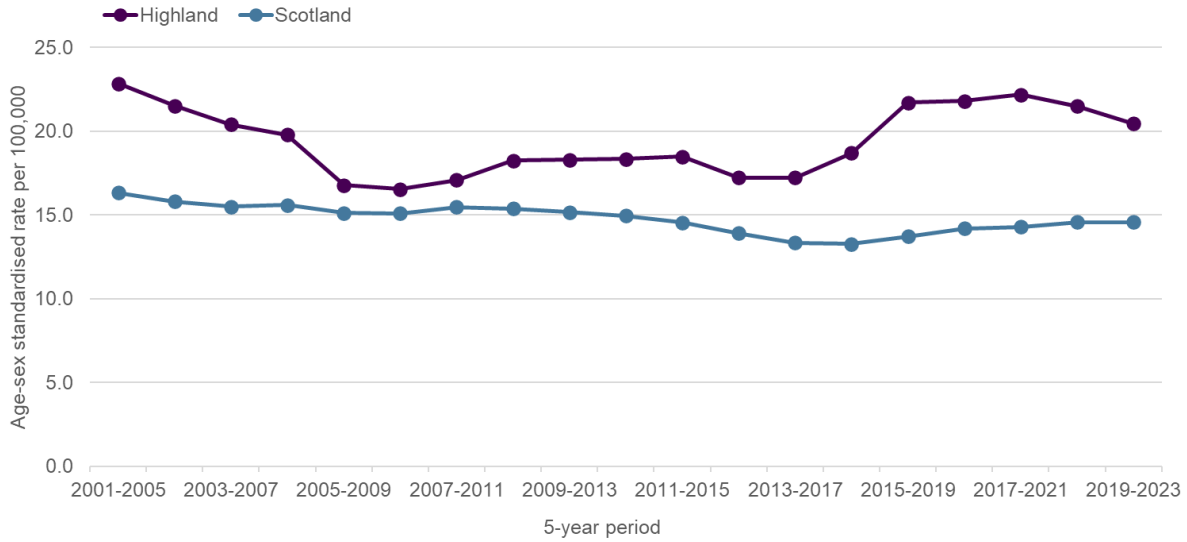
Suicide is a significant issue for public health and healthcare services in Scotland[148]. There is no single explanation of why people die by suicide and there are many academic and other models of suicide and risk. Suicide affects all age groups and communities.

There are very substantial socio-economic and socio demographic inequalities in suicide risk. Suicide is more common in men than women, with men around three times more likely to die from suicide. Mental illness increases the risk of death by suicide and most people who die by suicide are thought to have a mental illness at the time of their death[149] [150].

Evidence from the Scottish Suicide Information Database and the National Confidential Inquiry into Suicide and Safety in Mental Health found most people who die by suicide in Scotland have no contact with specialist mental health services in the 12 to 16 months before they die[151] [152].

In 2019-2023, the age-standardised rate of suicide in Highland was the second highest of any council area in Scotland, a rate significantly higher than the national average. Over the last fifteen years, suicide rates in Highland have been consistently significantly higher than those nationally (Figure 71).

Figure 71: Rate of probable suicide deaths in Highland and Scotland, 2001-2005 to 2019-2023



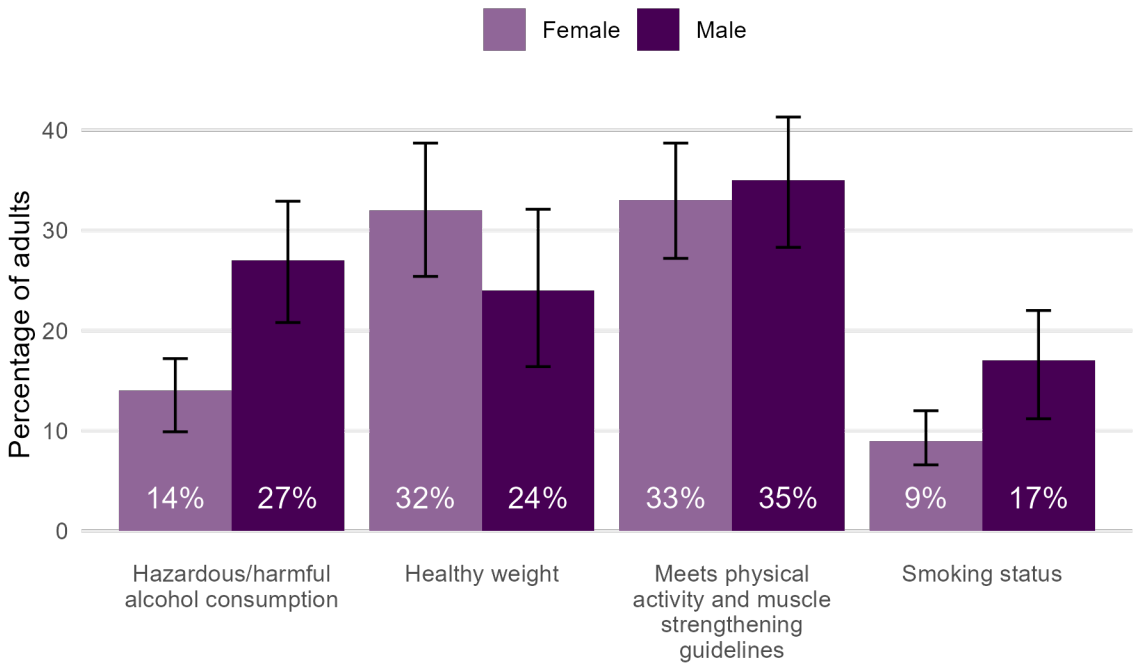
Source: National Records of Scotland

Suicide prevention requires a coordinated, collaborative and integrated approach across all partners in Highland. Demand for services to improve and treat people's mental health and wellbeing is increasing, even if this is partially being driven by more awareness and less stigma around mental health issues[153].

6.6. Health Behaviours

The World Health Organisation have identified four key behavioural risk factors for the prevention and control of noncommunicable diseases: tobacco, harmful use of alcohol, unhealthy diet and physical inactivity[154]. These, together with problem drug use and unhealthy weight, are two of the six public health priorities in Scotland[155]. Collectively, the avoidable harm from these issues is a major influence on preventable ill health across the life course.

Figure 72: Estimated prevalence of behavioural risk factors in adults aged 16 years and over by sex in Highland, 2019-2023 combined



Source: Scottish Health Survey. Healthy weight data from 2016-2019. All other data 2019-2023.

Evidence highlights behavioural risk factors reflect underlying inequalities and the social and economic environments in which people live[156] [157]. Public Health Scotland emphasise that social and economic factors shape health more than individual health behaviours[158]. This includes access to healthy food, safe streets, good quality housing and the exposure to chronic stress caused by unstable incomes and poverty.

Understanding these risk factors presents a sizeable opportunity to improve health and wellbeing, reduce health inequalities and understand service needs in our communities.

Smoking

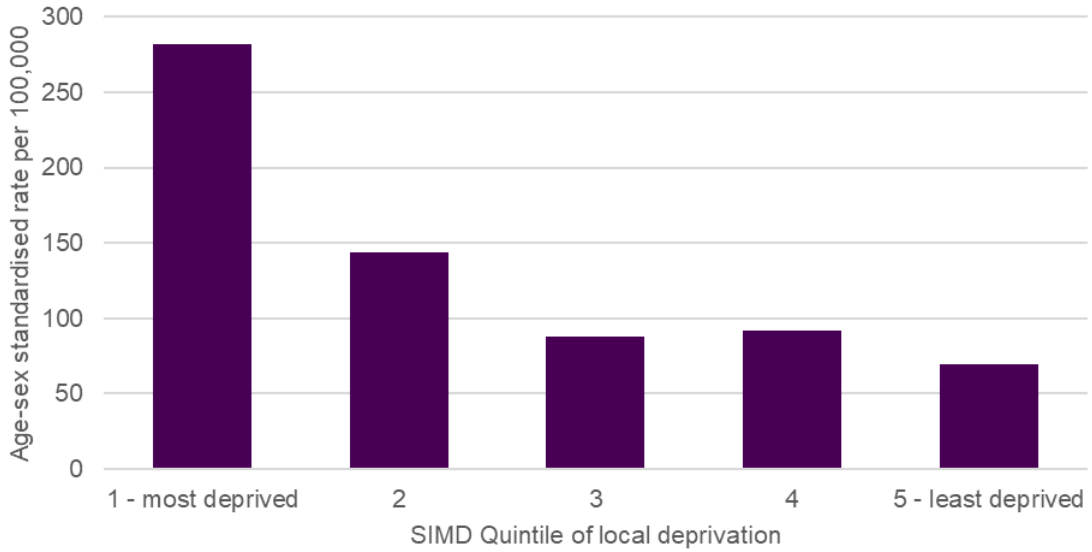
Tobacco smoking remains the primary cause of preventable ill health and early death in Scotland. Tobacco smoking is a major cause of respiratory diseases, heart disease and preventable cancer and increases the risk of dementia. It is estimated that half of all people who smoke regularly will die prematurely because of smoking. The risk of developing smoking-related diseases increases with how long and how much someone has smoked, with the risks falling substantially if smoking is stopped[159].

The Scottish Government ambition is for a tobacco free Scotland, lowering smoking rates in our communities to 5 percent or less by 2034[160]. The latest figures for Highland showed smoking rates have declined, with 13 percent of adults (16+) identifying as a current smoker in 2019-2023 compared with 18 percent in 2012-2015. Men were more likely to be current smokers (17 percent) than women (9 percent)[144].

Public Health Scotland estimated there were 364 deaths and 1,788 hospital admissions from causes wholly or partially attributable to smoking in people aged 35 and over in Highland for the two-year period 2020 to 2022. Nationally, smoking-attributable conditions accounted for 21 percent of all deaths and 29 percent of hospital admissions in 2022.

Tobacco use is a major contributor to health inequalities, with some of the highest rates of smoking and smoking-related diseases found in the most disadvantaged communities. In Highland, chronic obstructive pulmonary disease (COPD) hospitalisations were four times higher in the most deprived areas compared to the least deprived (Figure 73).

Figure 73: Chronic obstructive pulmonary disease (COPD) patient hospitalisations by deprivation quintile in Highland, 2021/22-2023/24



Source: Scottish Public Health Observatory Online Profiles. Patients aged 16 and over discharged from hospital with COPD: 3-year rolling average number and directly age-sex standardised rate per 100,000 population.

Alcohol

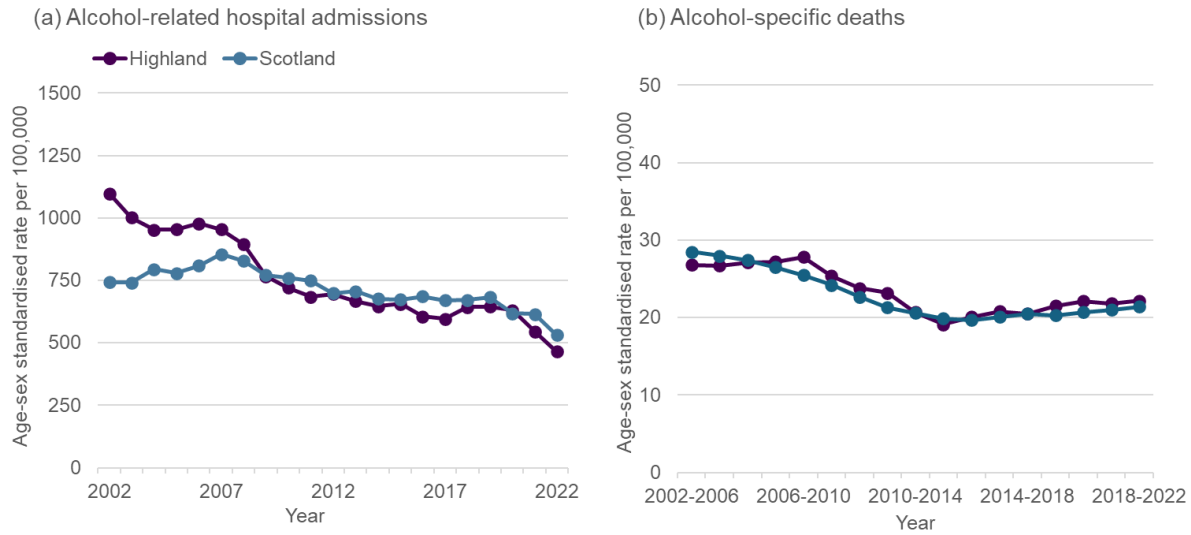
Reducing the harmful use of alcohol is a national and local public health priority[155] [161]. The UK Chief Medical Officers low risk drinking guideline advise there is no safe level of alcohol consumption and recommends that adults drink no more than 14 units a week on a regular basis to keep health risks from alcohol to a low level[162].

In 2019-2023, 20 percent of adults in Highland (27 percent of males and 14 percent of females) reported consuming alcohol at hazardous and harmful levels compared to 22 percent in Scotland. The mean weekly alcohol consumption reported in Highland was 11 units compared to 11.9 units in Scotland.

Alcohol consumption has been identified as a component cause of more than 200 health conditions including alcohol use disorders, cancers, heart disease, injuries, depression and anxiety. It is also associated with range of social consequences including domestic violence, child protection issues, financial difficulties and crime and disorder. It is estimated that around 8 percent of health loss in Scotland is attributable to alcohol[163].

Alcohol-specific deaths and alcohol-related hospital admissions are routinely used to understand the impact of alcohol on the health of the population. The rate of alcohol-related hospital admissions in Highland has decreased over the last decade. Alcohol-specific death rates have seen a small increase over a similar period. In Highland both measures follow the overall trend seen for Scotland (Figure 74).

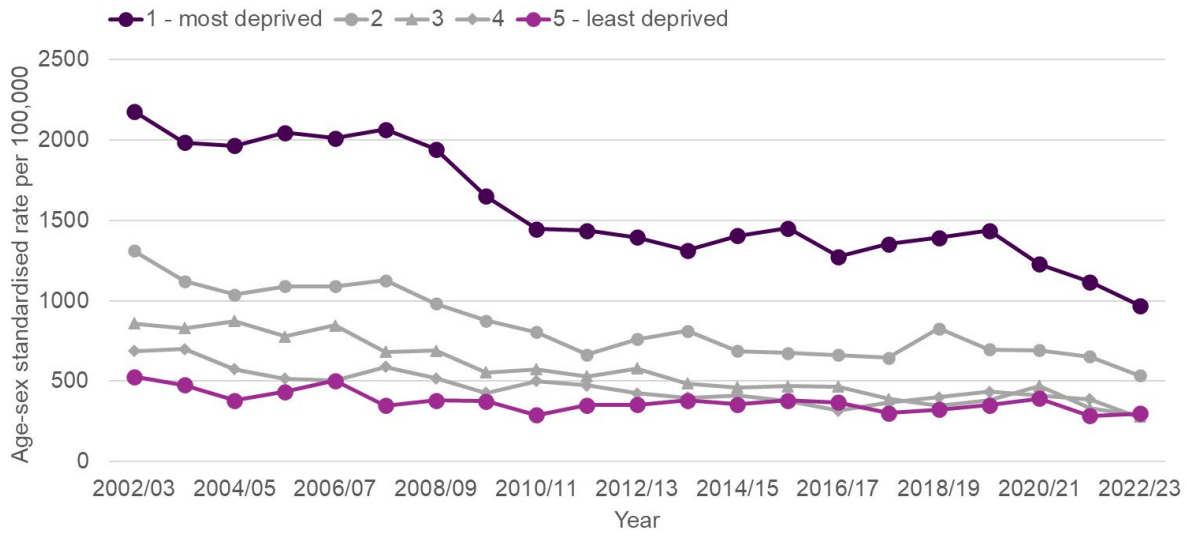
Figure 74: Trend in alcohol-related hospital admissions and alcohol-specific deaths in Highland and Scotland, 2002 to 2022



Source: Public Health Scotland, National Records of Scotland, Scottish Public Health Observatory
Alcohol-related hospital admissions by financial year of discharge; Alcohol-specific deaths 5-year aggregate calendar years

The harms caused by alcohol contribute to significant health inequalities and are more pronounced in areas of high deprivation (Figure 75). It is well documented that people living in deprived areas with lower socioeconomic status show greater susceptibility to the harmful effects of alcohol, sometimes known as the alcohol harm paradox[164] [165]. The increased risk is likely to relate to the effects of other issues affecting people in lower socioeconomic groups (poverty, income, complex health factors, smoking etc). People who use alcohol also experience stigma, which is a major barrier to people seeking support and services, compounding the negative impacts on health, wellbeing, employment and social outcomes.

Figure 75: Trend in alcohol-related hospital admissions by deprivation quintile in Highland, 2002/03 to 2022/23



Source: Public Health Scotland, Scottish Public Health Observatory
Alcohol-related hospital admissions by financial year of discharge, directly age-sex standardised rate per 100,000 population. Scottish Index of Multiple Deprivation local quintiles.

Harms caused by alcohol are largely preventable for the population as a whole and as part of a reduction in health inequalities. The World Health Organisation 'best buys' advocates for a whole system approach for interventions to reduce the harmful use of alcohol[166].

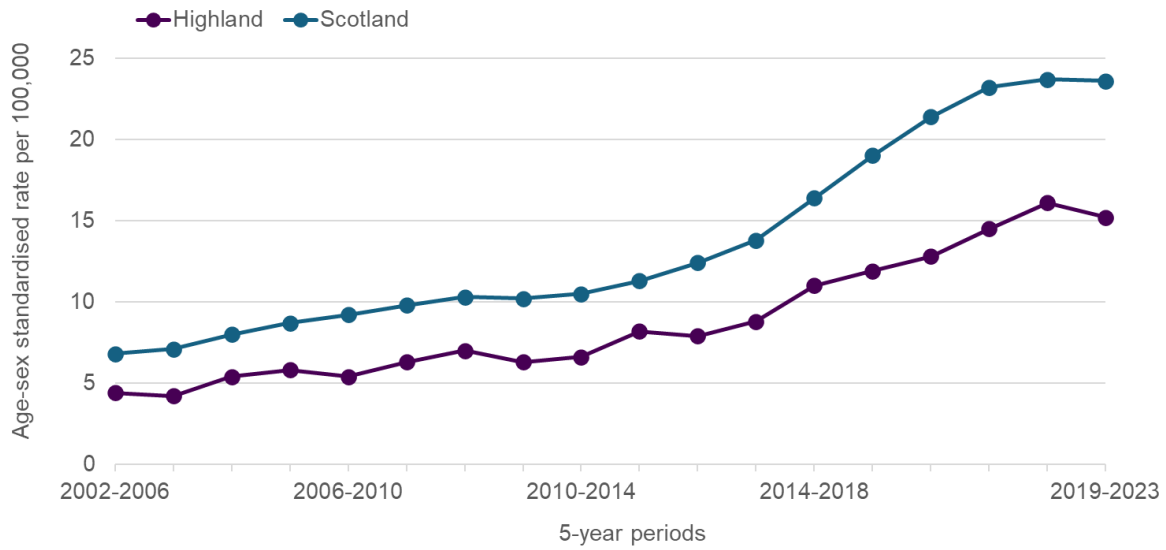
Actions that can be undertaken by the HSCP include delivering the actions set out in Rights, Respect and Recovery, the national alcohol and drug treatment strategy[167] and the recent Medication Assisted Treatment Standards for Scotland[168]. The Highland Alcohol and Drugs strategy and needs assessment sets out actions to reduce alcohol harm in Highland.

Drug use

Problematic use of drugs and other substances is a significant issue in Highland as in Scotland. A National Mission was announced by the Scottish Government in 2021 to reduce deaths and improve lives impacted by drugs[169]. The National Mission was a response to Scotland having one of the highest levels of drug deaths in the developed world, with a trend towards polydrug use and people with increasingly complex needs and co-morbidities.

Drug related health harms in Highland have generally been increasing. The number of drug related deaths in a five-year period have doubled over the last decade. There were 69 deaths between 2009 and 2013 compared to 162 deaths between 2019 and 2023. Although the drug related death rate in Highland is lower than the Scotland rate, the increase has followed a similar overall trend (Figure 76).

Figure 76: Rate of drug related deaths in Highland and Scotland for 5-year periods, 2002-2006 to 2019-2023

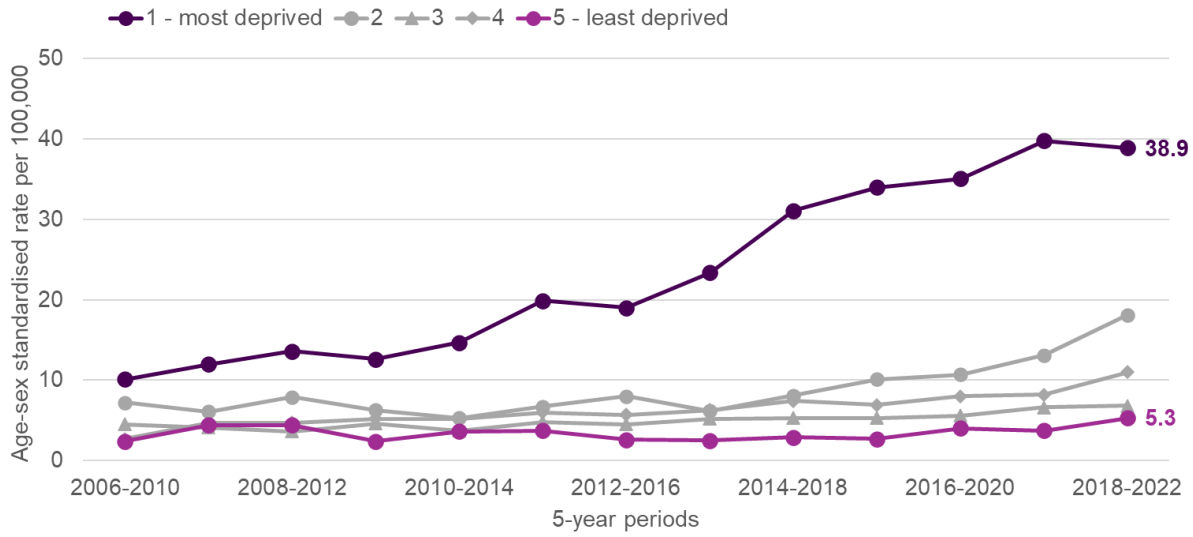


Source: National Records of Scotland Table C4

There are significant inequalities in drug-related health harms. In the 5-year period 2018-2022 the drug related death rate was nearly eight times higher in the most deprived areas of Highland (38.9 per 100,000) compared to the least deprived areas (5.3 per 100,000). The increasing trend suggests the gap between the most and least deprived areas is growing (Figure 77).

Problematic substance use and drug-related deaths are associated with multiple risk factors and vulnerabilities. The evidence highlights multiple disadvantage (e.g. poor housing, crime, trauma in the early years, poverty) contributes to substance use, which in turn contributes to further disadvantage[170] [171].

Figure 77: Trend in drug-related deaths by deprivation quintile in Highland, 5-year periods 2006-2010 to 2018-2022



Source: National Records of Scotland, Scottish Public Health Observatory
Scottish Index of Multiple Deprivation local quintiles.

The Medication Assisted Treatment (MAT) standards, introduced in 2021, are evidence-based standards to enable the delivery of safe, accessible high quality drug treatment[167]. MAT refers to the use of medication alongside psychological and social support in the treatment of people who are experiencing issues with their drug use. The approach aims to prevent and reduce drug-related harms and improve lives for people impacted by drugs. Implementation of the MAT standards is an ongoing priority for partnership and service action in Highland.

6.7. Severe and multiple disadvantage

Severe and multiple disadvantage (SMD) describes the experience of people facing multiple disadvantages such as homelessness, substance dependence, offending, domestic violence and abuse, and mental health problems. People facing SMD have a very poor quality of life, including sharply increased risks of morbidity and mortality, poverty and multiple deprivation, and social and economic exclusion[171]. Their experiences impact on families and communities and future generations.

Offending is considered the most ‘core’ disadvantage as it involves the highest proportion of cases with overlapping current SMD, although affects the smallest number of people. Mental health problems involve by far the largest number of people but the least with overlapping SMD experiences[171].

The highest risks for experiencing SMD are associated with being younger (under 40 years), single, white and male. There are also links with current household poverty and material deprivation, and a history of poverty and adverse childhood experiences. Violence can also often play a continued role throughout the life course of those experiencing SMD.

Hard Edges Scotland research estimated that, each year in Scotland, 191,000 adults experience one or more of the three 'core' forms of SMD (homelessness, offending and substance dependence) and 5,700 people experience all three. Higher rates of most aspects of SMD are generally found in urban areas. As a largely rural area, Highland had a lower rate of people experiencing two or more current forms of SMD (12 per 1,000 adult population) compared to Scotland (18 per 1,000 adult population)[171].

The complexity of needs and poor outcomes for people experiencing SMD creates a challenge for providing services that cover the multiple disadvantages people face rather than addressing single issues. A programme of work, with the aim of developing a national framework for cross-sector and integrated service delivery, was started in 2024[172].

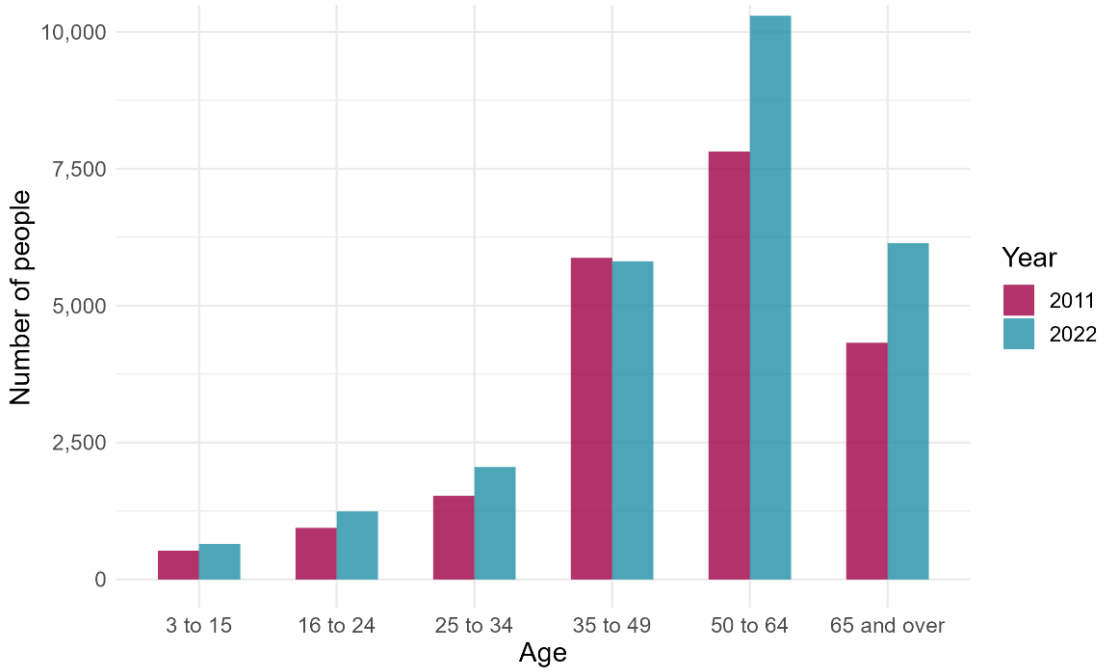
7. Unpaid care in Highland

The functioning of the health and social care system in Highland, as in the rest of Scotland, depends on the care and support provided by unpaid carers[173]. The 2022 Census indicates that over twenty-six thousand people regularly provide unpaid care to a family member, friend or neighbour to support that person to live in their community in Highland.

Between 2011 and 2022, the number of people providing informal, unpaid care in Highland increased by 24 percent, with the greatest percentage increase in those 65 years and over (Figure 78). In Highland at the Census in 2022, there were 650 very young carers under fifteen. Research by the charity Carers UK reports that three in five people will provide unpaid care at some point during their lifetime[174].

Although not all older adults will require social care support, against the context of increasing demand for formal care support from an ageing population and the number of older adults with ill health and disability living longer in the community, creating growing levels of need not met by services, more unpaid care is being relied upon to support individuals to be looked after at home.

Figure 78: Number of people who reported that they provided unpaid care by age, 2011 – 2022 in Highland[1,2]



Source: Census 2011 (Table DC3103SC - Provision of unpaid care by sex by age (6 groups)) and Census 2022 (Table UV301a - Provision of unpaid care by sex by age (6 groups))
1. These counts will likely underestimate numbers as many people do not self-identify as a carer.
2. Census counts relate to a single point in time and ignore the extent to which carers move into and out of caring roles, potentially underestimating the need of a larger group when planning, commissioning and funding services for carers.

The National Carers Strategy published in 2022 suggests that unpaid care in Scotland is worth £13.1 billion a year, equivalent to two-thirds of the national budget for NHS Recovery, Health and Social Care in 2024-25[175].

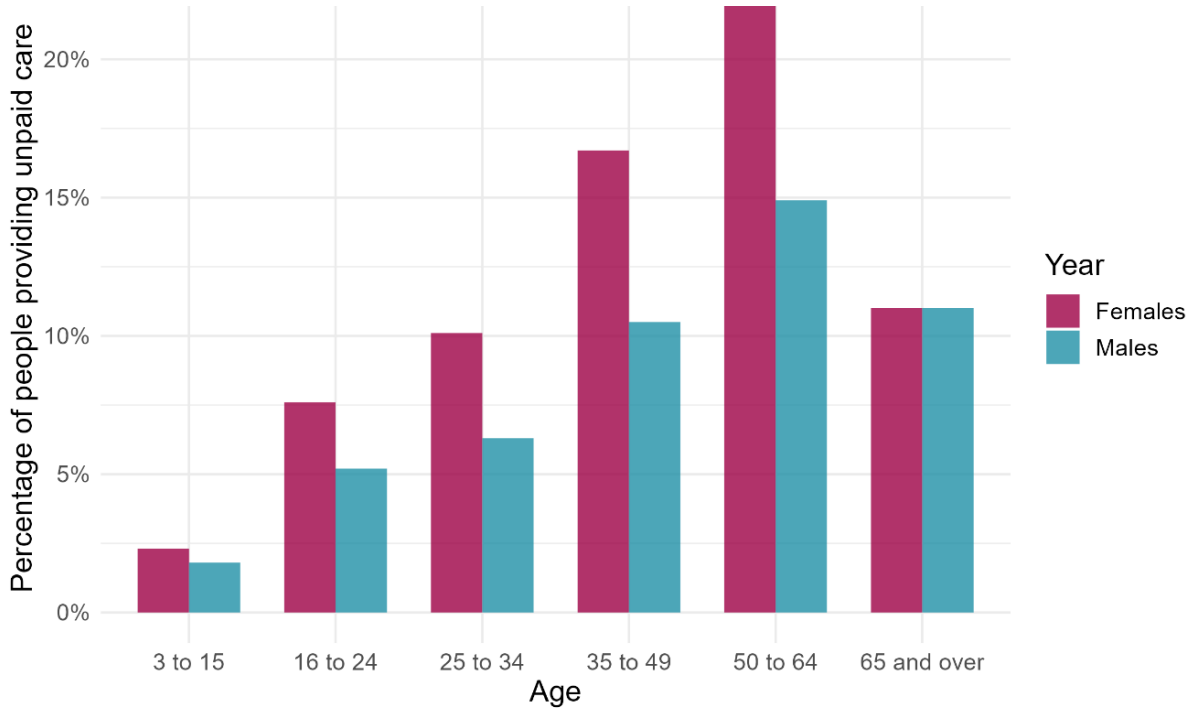
Prevalence of unpaid care

Carers are diverse, given the complexity of caring relationships and the tasks performed[176] [177]. Women make up the majority of unpaid carers and are more likely to care early in life than men, with the percentage of carers who are women increasing with care intensity (Figure 79). Caring commitments often affect the participation of women in paid work, reducing lifetime earnings and therefore contributing to gender inequalities in later life.

The percentage of the population providing care and the intensity of caring changes with age, with the number of people providing unpaid care peaking in the 50 to 64 age group (Figure 79 and Figure 80).

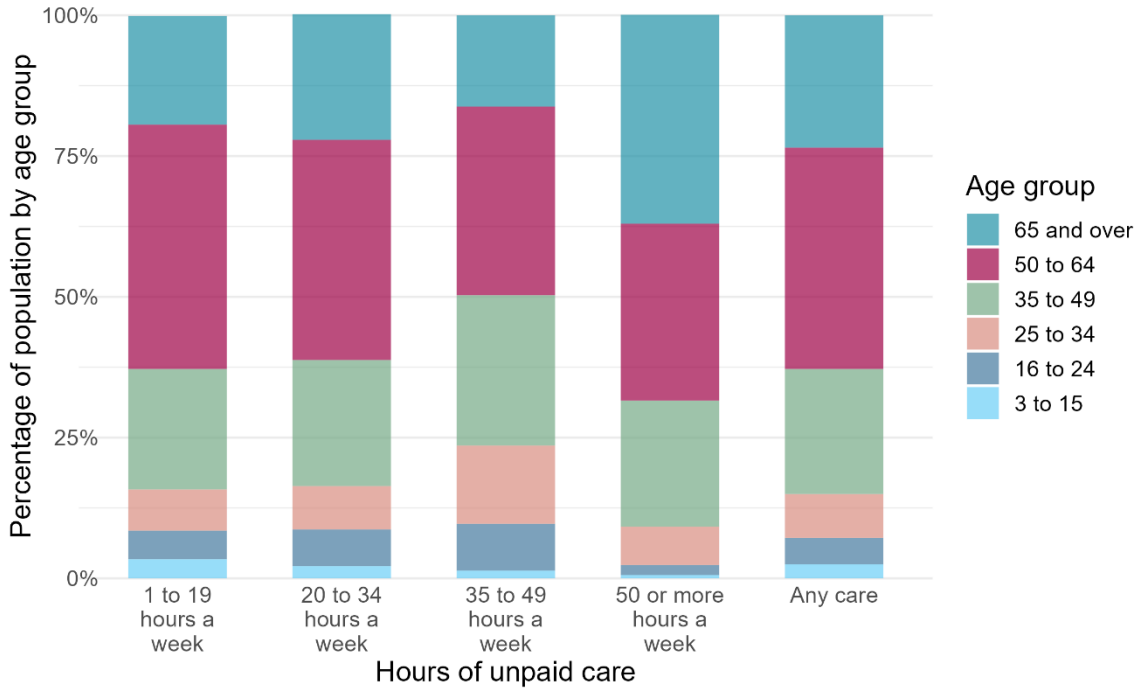
Many carers are older, and this group is likely to care at higher intensity levels, especially those caring for a co-resident partner.

Figure 79: Percentage of people who reported that they provided unpaid care by sex and age in Highland in 2022



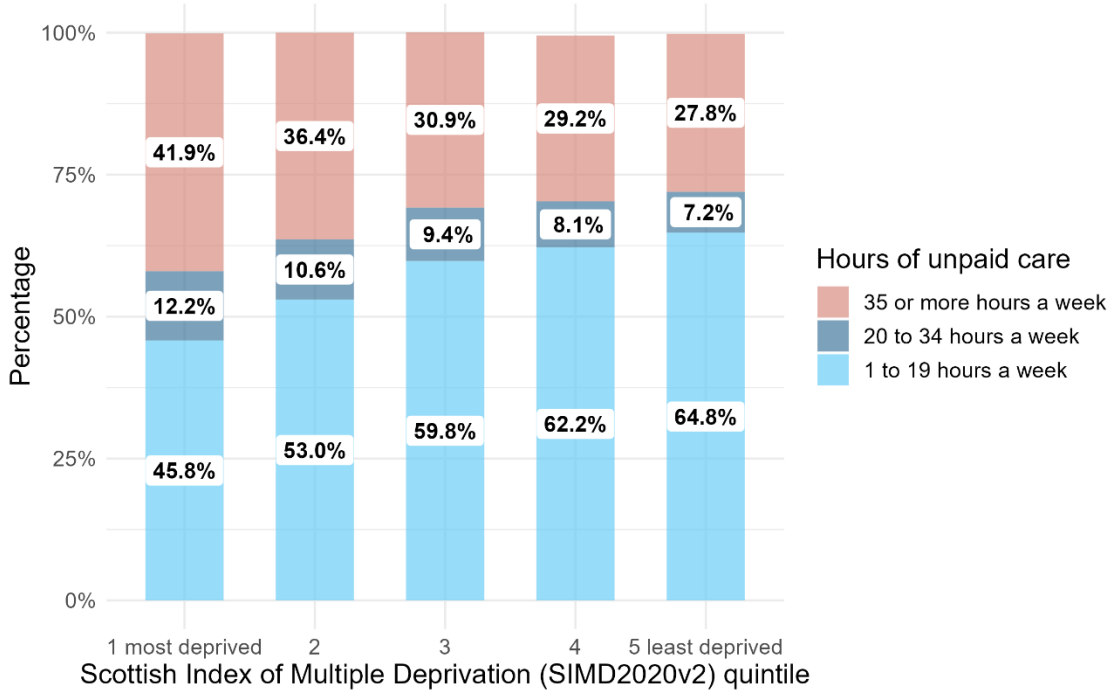
Source: Census 2022 (Table UV301a - Provision of unpaid care by sex by age (6 groups))

Figure 80: Age structure of the population by weekly hours of unpaid care in Highland in 2022



Source: Census 2022 (Table UV301a - Provision of unpaid care by sex by age (6 groups))

Figure 81: Percentage of the population providing unpaid care by quintile of deprivation and hours of care in Highland in 2022[1]



Source: Census 2022 (Table UV301a - Provision of unpaid care by sex by age (6 groups)) and the Scottish Index of Multiple Deprivation 2020v2

1. These counts will likely underestimate numbers as many people do not self-identify as a carer.

At the Census in 2022 in Highland, 11.2 percent of the population of the most deprived areas were providing unpaid care, compared to 11.6 percent in the least deprived. However, the intensity of care provided is much higher in the most deprived areas in Highland, with 41.9 percent of people providing over 35 hours of unpaid care compared with 27.8 percent in the least deprived areas, suggesting additional caring needs exacerbated by lower income, poorer population health and lack of alternatives options to informal care support (Figure 81).

Future Care

Care recipients generally prefer to be looked after by family and friends. However, there may not be sufficient informal caregivers in the future to meet demand, with factors such as increasing female employment, increasing pension ages, fewer children, and higher divorce rates amongst men over 60 years affecting the future availability of unpaid care[178] [179] [180].

Helping those who provide informal care

Caring responsibilities can negatively impact the physical and mental health and employment potential of those who provide care, resulting in poorer quality of life. Unpaid caregiving is associated with reduced employment, higher risks of poverty, and risks to the Carer's health[181] [182].

Over 50 percent of carers feel lonely often or always[183]. As evidenced by their satisfaction levels and health status, there are increasing pressures on unpaid carers, with significant challenges for health and social care providers to improve the integration of services to help sustain the unpaid caring workforce[184] [185].

Types of support for carers can include financial and employment support, respite care, education and training (for example, on using hoists and other mobility equipment) and emotional and social support, such as counselling[186] [187]:

The Carers (Scotland) Act 2016 that came into force in April 2018 sets out a range of rights intended to improve the support given to carers. Adult carers have a right to an Adult Carer Support Plan and Young carers have a right to a Young Carer Statement. Carers have a right to support to meet any ‘eligible needs’, a right to be involved in services and to be involved in the hospital discharge process of the person they are or going to be caring for.

In the 2022 National Carers Strategy and Carers’ Charter, the Scottish Government set out plans to add: Carers’ rights to information and advice, Rights of Carers of people with terminal illness and, and if approved by the Scottish Parliament the right to breaks from caring. The Highland Partnership is currently progressing a new Carers Strategy for Highland.

8. Health and Care Services

8.1. Secondary health care

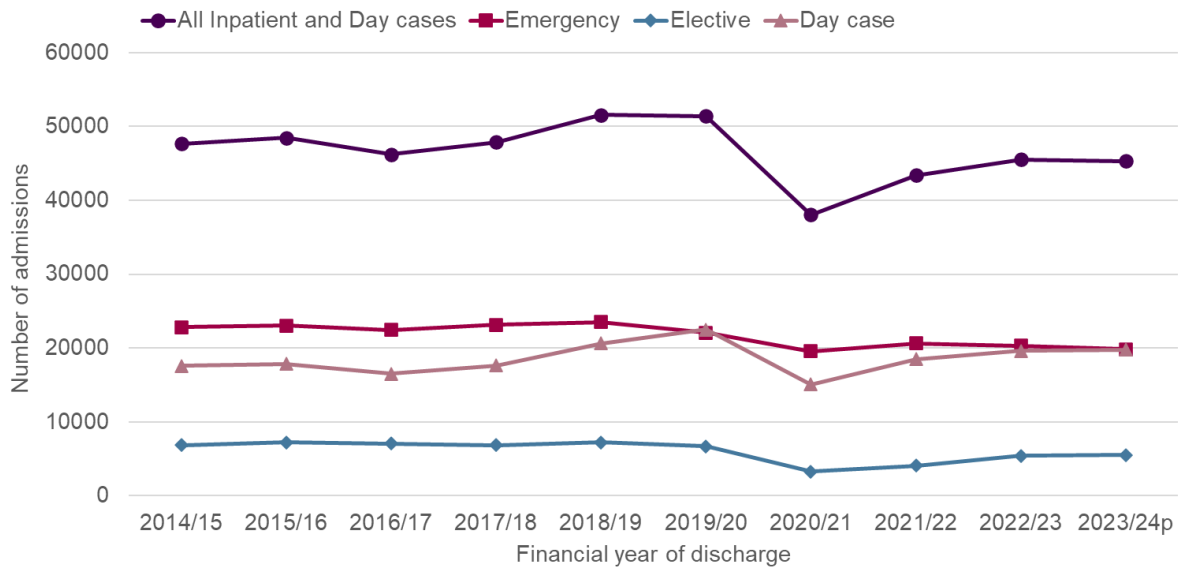
Secondary care activity describes the demand for specialist services, usually provided in a hospital setting. Having timely access to health care services is an important part of supporting people to stay in good health.

Access to community support, primary care and secondary care are inherently linked. High emergency or multiple admissions rates can indicate that primary and community services may be under pressure or not in place to prevent hospital admission. Reducing emergency admission rates can indicate that people are being supported in managing their care appropriately at home with less reliance on hospital use.

8.2. Hospital stays

Around 27 thousand Highland residents (one in nine people) were admitted to hospital in 2023/24. Of these, over half of patients (54 percent) had an emergency admission to hospital, with more than one in five people (23 percent) having more than one emergency admission. The number of patients and volume of hospital activity observed in Highland residents for all admission types remain lower than the levels seen prior to the pandemic and continue to be impacted by post-pandemic and recovery trends[188].

Figure 82: Number of patients admitted to hospital by admission type, Highland, 2014/15 to 2023/24

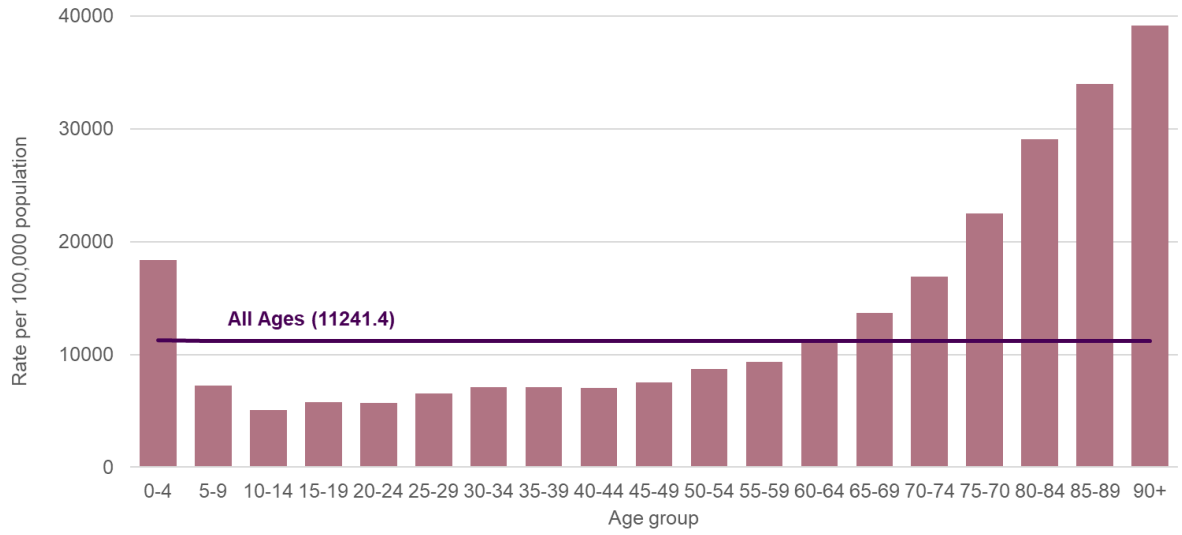


Source: Scottish Morbidity Record SMR01 (inpatients and day cases), Public Health Scotland
Excludes admissions to maternity wards and mental-health hospitals. Patient numbers counted once in each admission type group but only once in the total.

The likelihood of being admitted to hospital is highly correlated with age, reflecting the health status of the population. Generally, patient admission rates increase with age from early adulthood and are highest in people aged 75 years and over (Figure 83).

In 2023/34, one quarter (27 percent) of Highland residents admitted to hospital were in the age group 75 years and over.

Figure 83: Patient inpatient and day case admission rate by age group, Highland, 2023/24



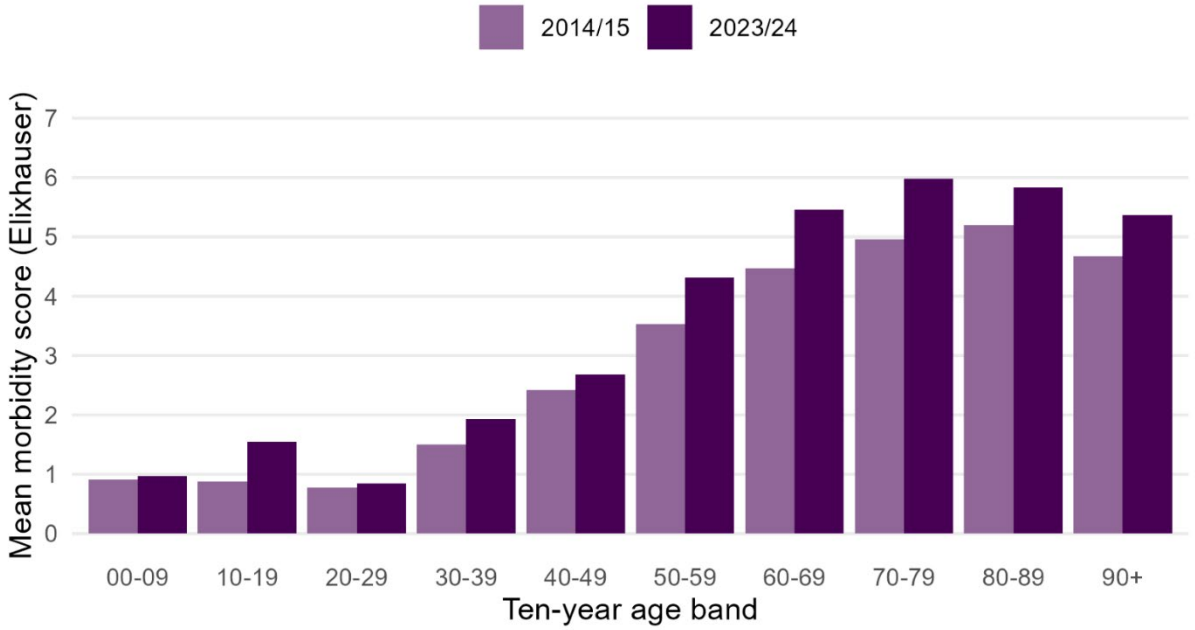
Source: Scottish Morbidity Record SMR01 (inpatients and day cases), Public Health Scotland
Excludes admissions to maternity wards and mental-health hospitals. Rate per 100,000 population in each sex and age band.

The health status of hospital patients can be estimated by using a comorbidity score derived from diagnosis codes. A higher score indicates the presence of conditions that are more closely associated with mortality[189].

Analysis of Highland resident hospital admission data shows the number of health conditions (comorbidities) identified in hospital inpatients increases with age. Older patients are more likely to have multiple health conditions than younger adults. The average number of comorbidities increased over the last ten years (Figure 84).

In Highland, the population aged 75 and over is expected to increase by 50 percent between 2023 and 2043. Based on the current age profile and health profile of patients needing hospital services, this demographic change will have significant implications for future demand on hospital services.

Figure 84: Comorbidity score using the Elixhauser method for inpatient admissions by age group, Highland, 2014/15 and 2023/24



Source: Scottish Morbidity Record SMR01 (inpatients and day cases)
Elixhauser comorbidity index: comorbidity measure based on 31 conditions identified using International Classification of Diseases 10th edition (ICD-10) codes

Emergency admissions

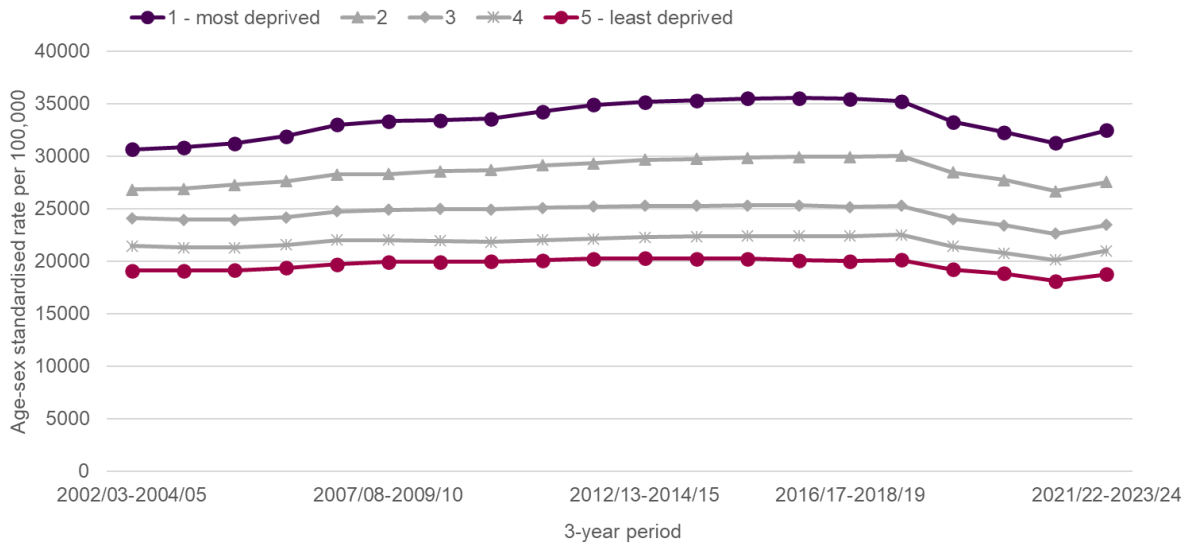
Reducing emergency hospital admissions in older people has been a long-term national policy objective through shifting the balance of care and the integration of health and social care.

The aim is to ensure that people are supported at home to live independently for as long as possible, that people's care needs are anticipated and planned, there is a focus on prevention and early intervention and resource is moved to primary and community care services.

With an aging population, the number of emergency admissions in people aged 65 years and over has increased over the last decade. The rate of emergency hospital admission in older people decreased from the period 2018/19 to 2020/21. Rates for 2020/21 are affected by changes in admission patterns during the pandemic.

Emergency admission rates in patients aged 65 year or greater show people living in the most deprived areas of Highland are more likely to have an emergency hospital admission. Relative differences between the most deprived and least deprived areas of Highland have stabilised in recent years (Figure 85).

Figure 85: Emergency admission rates age 65+ years by deprivation quintile in Highland, 2002/03-2004/05 to 2021/22-2023/24



Source: Public Health Scotland, Scottish Public Health Observatory
Emergency hospitalisations in patients aged 65 year or greater; 3 year rolling average number and directly age-sex standardised rate per 100,000 population. Scottish Index of Multiple Deprivation local quintiles.

8.3. Delayed discharges

Timely discharge from hospital is recognised as an important indicator of quality and of person-centred, effective, integrated and harm-free care. Evidence shows that any delay in discharge can have a severely detrimental effect on a person's health and wellbeing[190]. Lengthy periods of unnecessary bed rest can lead to pressure sores, muscle wastage, loss of independence, and can ultimately lead to premature need for long term care.

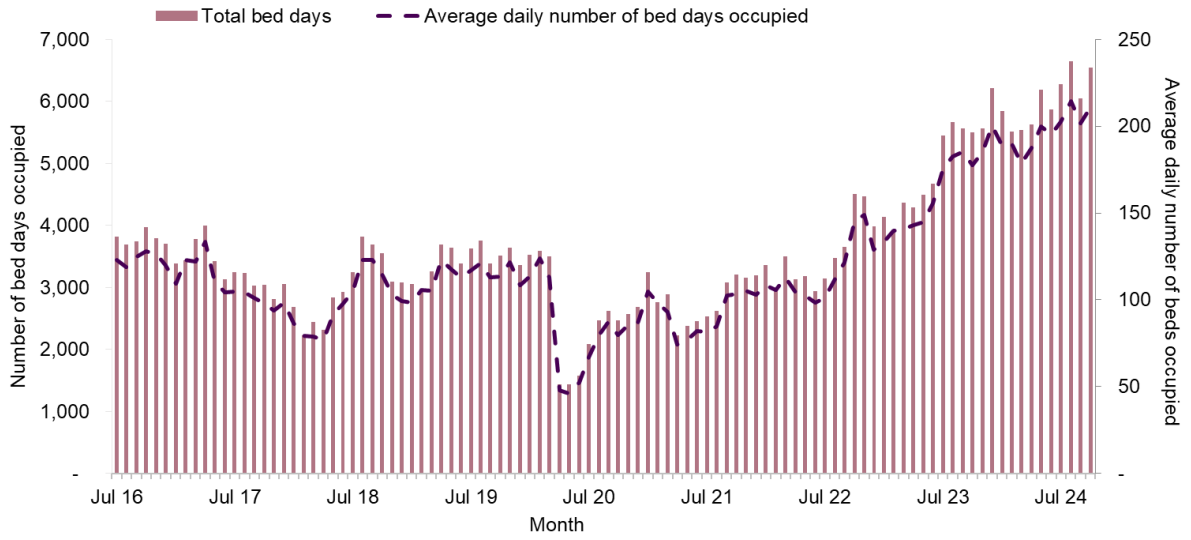
A delayed discharge occurs when a hospital patient, clinically ready for discharge, cannot leave hospital because the required care, support or accommodation arrangements are not in place. Delays can occur for a variety of reasons but are usually an indicator of pressures and demand on social care services and the provision of care home beds.

Trends in delayed discharges show a marked decrease in the number of delays during the early pandemic period. This was due to a reduction in non-Covid related hospital admissions during this period, along with efforts to move patients out of hospital to free up hospital capacity.

The number of bed days occupied by people delayed in their discharge have trended higher since this period and are now at historically high levels (Figure 86). For the most recent

month available (October 2024), delays at census per head of population were the highest of all local authorities and more than double the Scotland average.

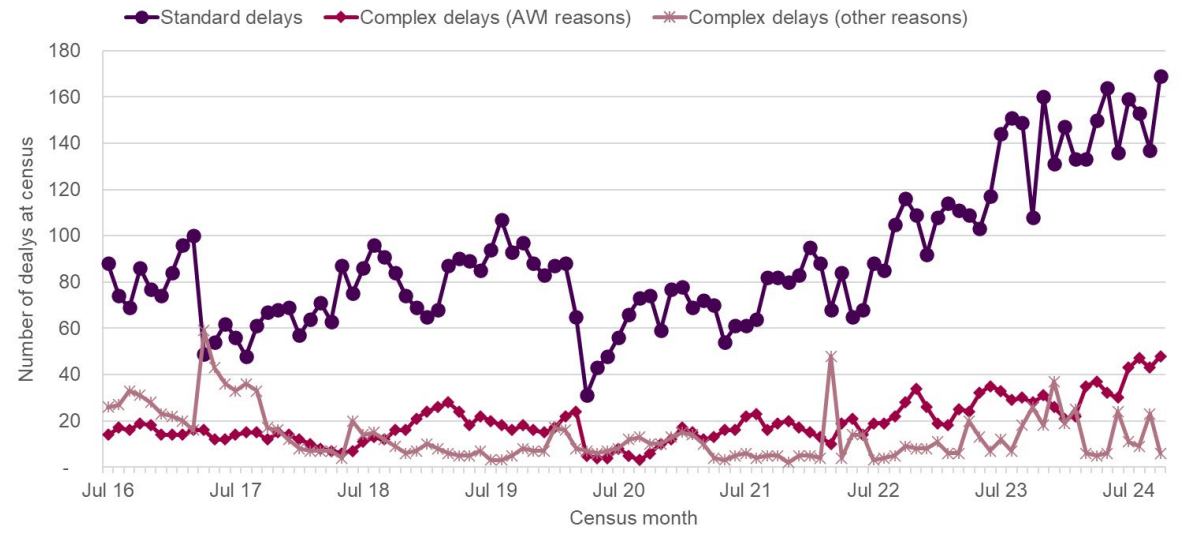
Figure 86: Bed days occupied by delayed discharges, Highland, July 2016 to October 2024



Source: Public Health Scotland, Delayed Discharges in NHS Scotland

Most recent increases in delayed discharges are for standard delay reasons, principally health and social care reasons where a person is waiting for place availability, care arrangements or assessment. There was also an increase in complex cases due to the specific care needs of adults with incapacity (Figure 87).

Figure 87: Delayed discharges at census by delay reason, Highland, July 2016 to October 2024



Source: Public Health Scotland, Delayed Discharges in NHS Scotland
AWI: Adults with incapacity

Delayed discharges are a national concern and work to reduce delayed discharges has been an area of sustained focus for the Highland HSCP. The partnership continues through a variety of measures to monitor and manage delayed discharges. This includes improvement work through the NHS Highland Urgent and Unscheduled Care Programme. It is widely recognised that the Highland HSCP is constrained by social care sector capacity, including ten permanent or temporary care home closures since March 2023 and a reduction in independent sector care at home capacity due to recruitment and retention challenges.

Ensuring timely discharge from hospital to an appropriate setting is complex and requires health and social care services to work in an integrated way. Waiting unnecessarily in hospital is a poor outcome for the individual and is particularly bad for the health and independence of older patients.

8.4. Care at Home

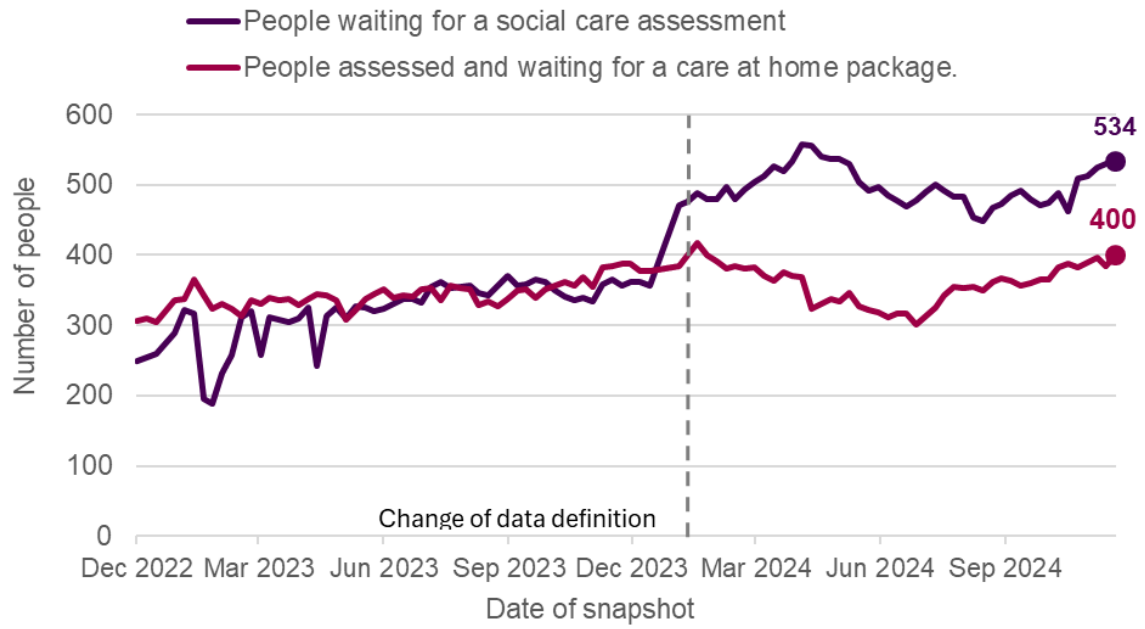
Care at Home describes the practical services which assist people with assessed support needs to live at home, including in sheltered housing or equivalent accommodation. This includes people who are frail, have long term conditions or disabilities.

The types of support vary depending on the individual's needs and circumstances. Packages of care can include support with personal care and a range of practical support to enable a person to function as independently as possible in the community, for example, cleaning or meal preparation.

The data available relates to services and support where a Health and Social Care Partnership has an involvement, such as providing the care and support directly or by commissioning the care and support from other service providers. Data on care and support that is paid for and organised entirely by the persons themselves (i.e. self-funded) are not generally available.

Information on demand for social care is published weekly by Public Health Scotland[191]. The number of people in Highland waiting for a social care assessment or for a care at home package is shown in Figure 88. In 2024, the majority of waits on a social care assessment or care home package were in the community, 94 percent and 90 percent respectively.

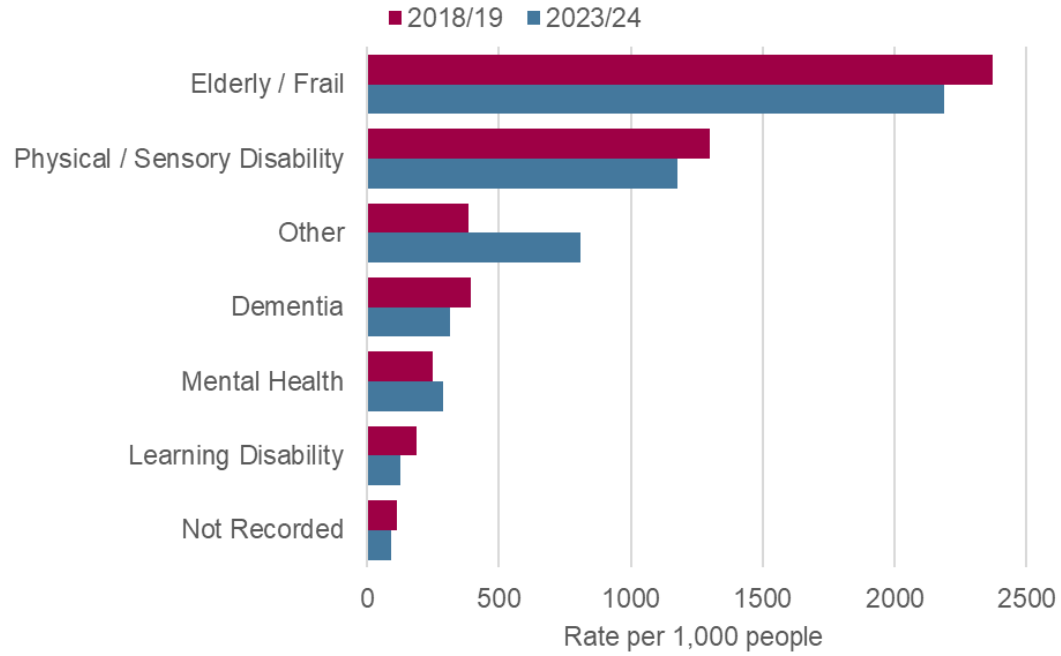
Figure 88: Number of People waiting for a social care assessment or assessed people waiting for a care at home package in Highland, December 2022 to November 2024



Source: Public Health Scotland, People requiring a social care assessment and care at home services Statistics. Data definition changes came into effect from 15 January 2024 to improve reporting.

In 2023/24, there were 2,785 people in Highland who received care at home support. This was a rate of 11.8 per 1,000 people, lower than the Scotland rate of 17.8 per 1,000. Most people supported with care at home services were frail elderly clients or people with physical and sensory disabilities (Figure 89).

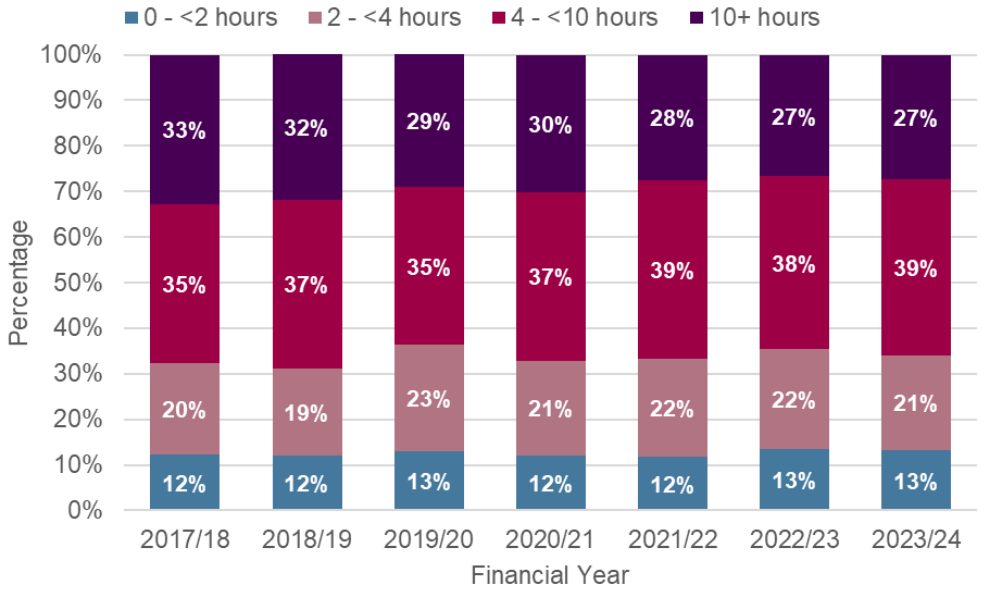
Figure 89: People supported with Care at Home services as a rate per 1,000 Care at Home clients in Highland, by Client Group, Financial year 2018-19 and 2023-24



Source: Public Health Scotland, Care at Home Statistics

The estimated number of hours of care at home received by people in Highland in 2023/24 was 708,980 hours. In 2023/24, 27 percent of clients in Highland received over 10 hours of care at home and 39 percent received between four hours and less than 10 hours of support (Figure 90). The trend shows a decrease in the proportion of care at home clients who received ten hours or more support a week.

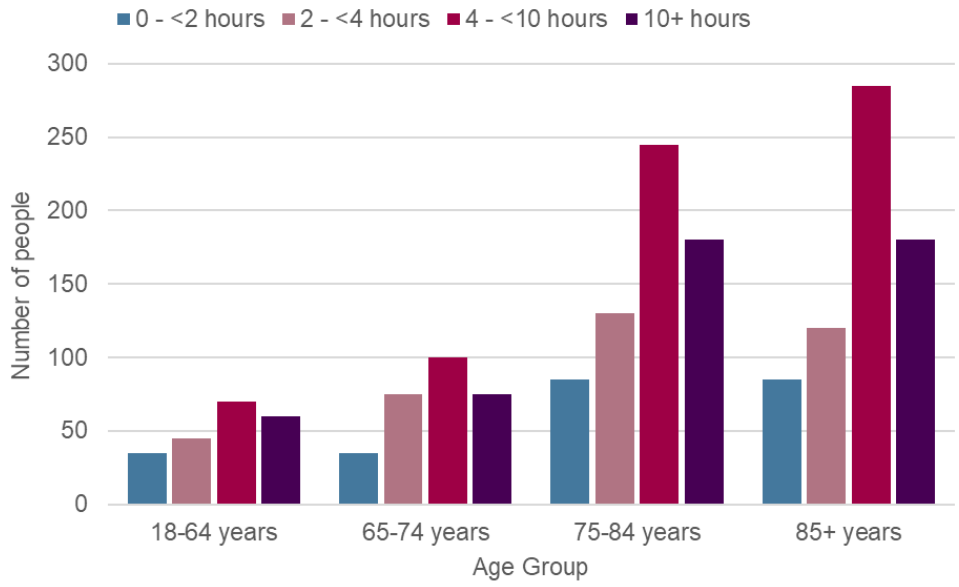
Figure 90: Percentage of people receiving care at home by average weekly hours, Highland, 2017/18 to 2023/24



Source: Public Health Scotland, Care at Home Statistics

A higher level of support is provided to people aged 75 years and over, reflecting the care and support needs of this client group (Figure 91).

Figure 91: Number of Care at Home clients by level of service and age group, Highland, 2023/24



Source: Public Health Scotland, Care at Home Statistics

8.5. Care homes

Information about care homes and care home residents is based on the Scottish Care Home Census (SCHC), an annual data collection by the Care Inspectorate[192]. The Care Inspectorate is the independent regulator for care services in Scotland. The census includes all care homes for adults in Scotland and includes both public and privately funded residents.

Care homes for adults are designed to care for adults (aged 18 years and over) with complex healthcare and functional needs and who need a complete package of 24-hour care. Care homes provide accommodation, nursing, personal care or personal support to vulnerable adults who are unable to live independently. Each care home is assigned a main client group, which relates to the care needs of most residents in the care home.

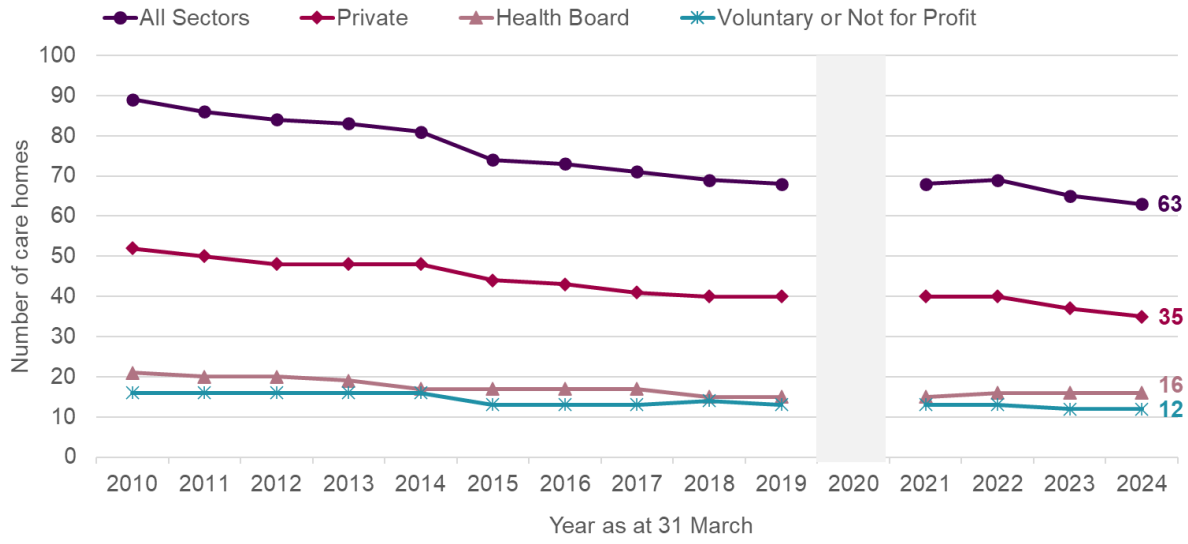
Care Homes for Adults

On 31 March 2024, there were 63 care homes for adults in Highland, of which 47 were operated by independent sector care home providers and 16 were in-house care homes operated by NHS Highland. These numbers include Cradlehall, which closed in April 2024.

Most care homes (50) were designated as care homes for older people, with the remainder classed as care homes for learning disabilities (6), mental health problems (4), physical and sensory impairment (2) and drug and alcohol recovery (1).

From 2014 to 2024, the number of care homes in Highland fell by 22 percent with the greatest decrease occurring in the independent sector provision of care homes for older people. The facilities provided 1,937 registered places, a fall of 8 percent from 2014 to 2024.

Figure 92: Number of care homes for adults by sector, Highland, 2014 to 2024

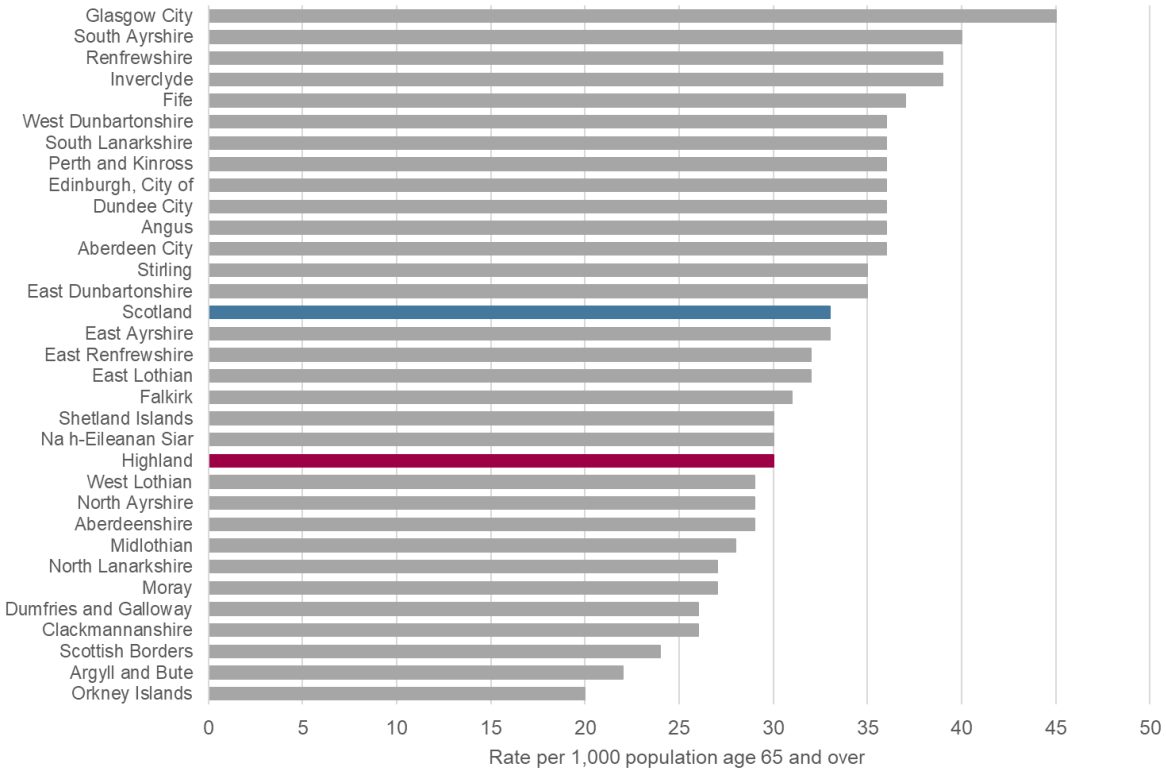


Source: Public Health Scotland, Scotland's Care Home Census
No data collected in 2020 due to Covid-19 pandemic

The average size of a care home across all sectors was 31 beds with percentage occupancy estimated at 90 percent. The National Care Home Contract (NCHC) is based on a 50-bed care home operating at 100 percent capacity. The majority (85 percent) of independent sector care homes in Highland were not in this category. There were seven independent sector care homes with 50 beds or more, with three of these being over 80 beds. Most care homes were under 50 beds, with half operating with 30 beds or less.

The decrease in the number of care home places has occurred during a period of growth in the older population. From 2014 to 2024, the rate of care home places for older people decreased by nine percent, despite growth of 23 percent in the overall population of this age. This suggests more people with care and support needs are living at home over the period, reflecting policy changes in the care of older people. Highland had the twelfth lowest rate of care home places for older people per capita of local authorities in Scotland (Figure 93).

Figure 93: Rate of registered places in care homes for older people per 1,000 population aged 65 and older by local authority in Scotland, as at 31 March 2024



Source: Public Health Scotland, Scotland's Care Home Census

Since March 2022, there has been significant and sustained pressure in the care home market related to operating on a smaller scale, and the challenges associated with rural operation. Staff availability, recruitment and retention of staff, securing and relying on agency

use, increased agency costs and subsequent financial impacts have all been contributing factors leading to temporary suspensions and care home closures.

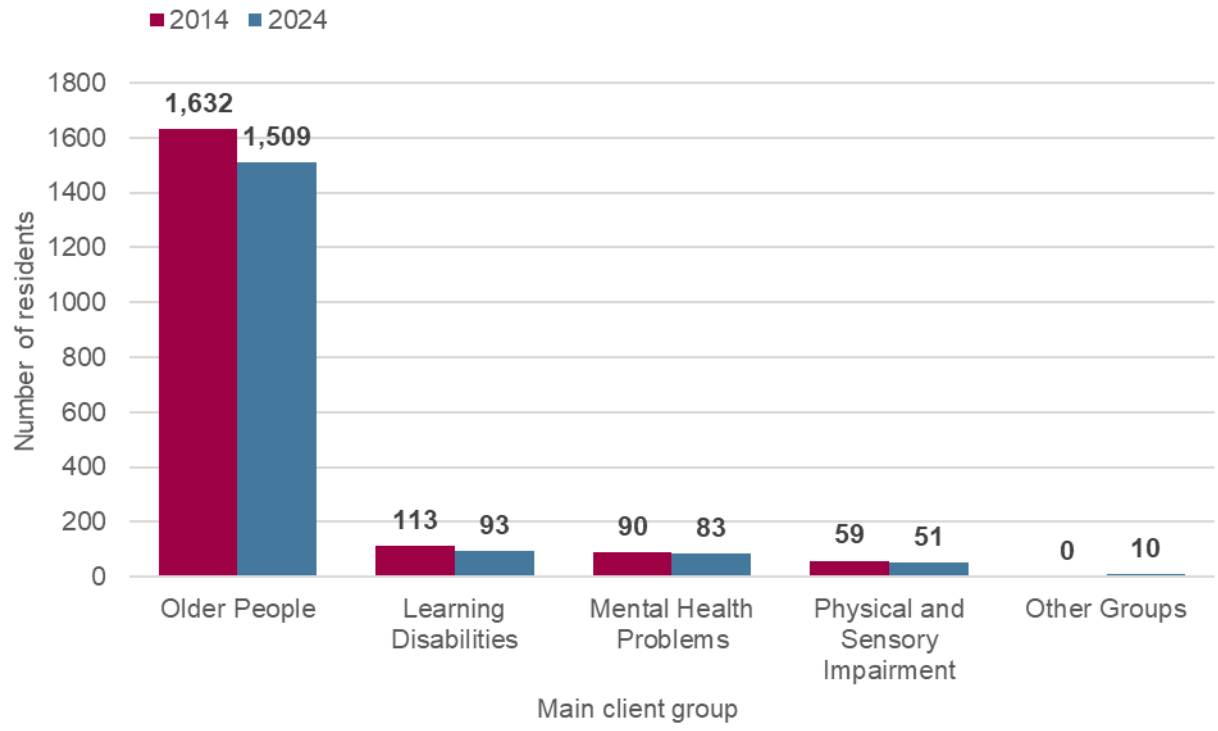
Operational capacity and availability of places is also impacted by quality concerns, infection control measures and public health closures in line with national guidance.

The reduced bed availability has had an impact on the wider health and social care system and the ability to discharge patients timely from hospital. Combined, the data for delayed discharges, care at home and care home provision reflects unmet need in the Highland population.

Care Home Residents

At the March 2024 care home census there were 1,746 people being supported in care homes for adults in Highland. Most people (1,509, 86 percent) were residents in care homes for older people. People with learning disabilities and mental health problems were the next two largest client groups (Figure 94).

Figure 94: Estimated number of residents in care homes for adults, by main client group in Highland, 2014 and 2024

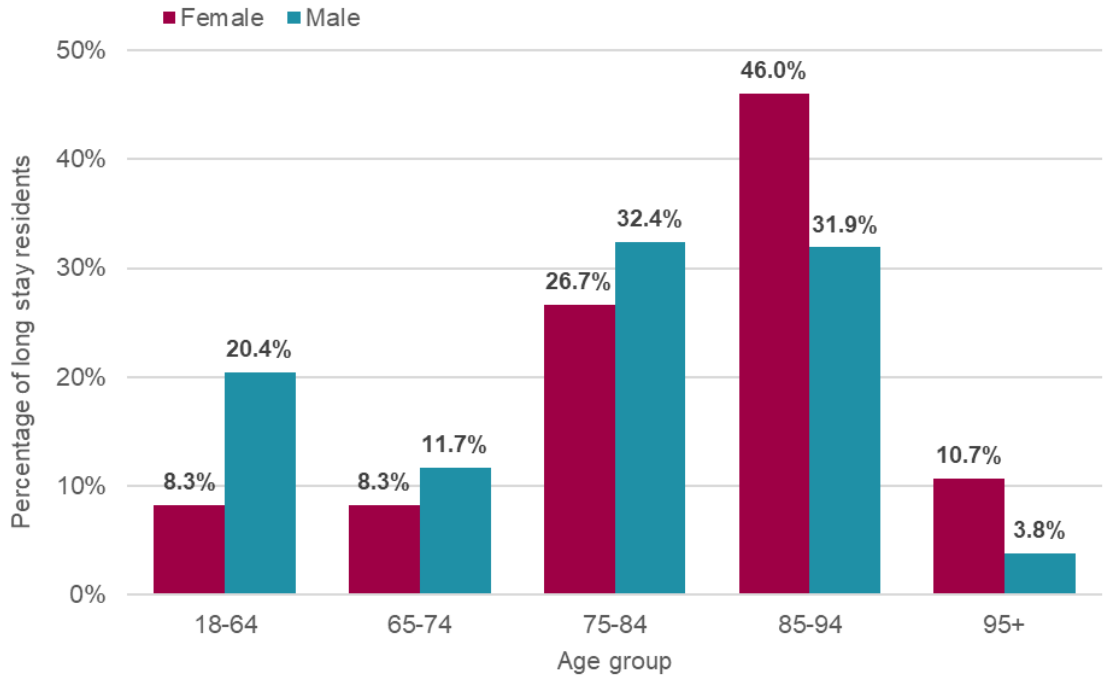


Source: Public Health Scotland, Scotland's Care Home Census

Most people (97.8 percent) were long stay residents, whose intention on admission to a care home was to stay for at least six weeks. Two thirds (69 percent) were female and over half (58 percent) were aged 85 years or over (Figure 95).

Increasingly the care home population is becoming older. The median age at admission has increased from 81 to 83 years and the median age at discharge from 84 to 87 years over the last decade.

Figure 95: Percentage of long stay care home residents by age group and sex in Highland, March 2024

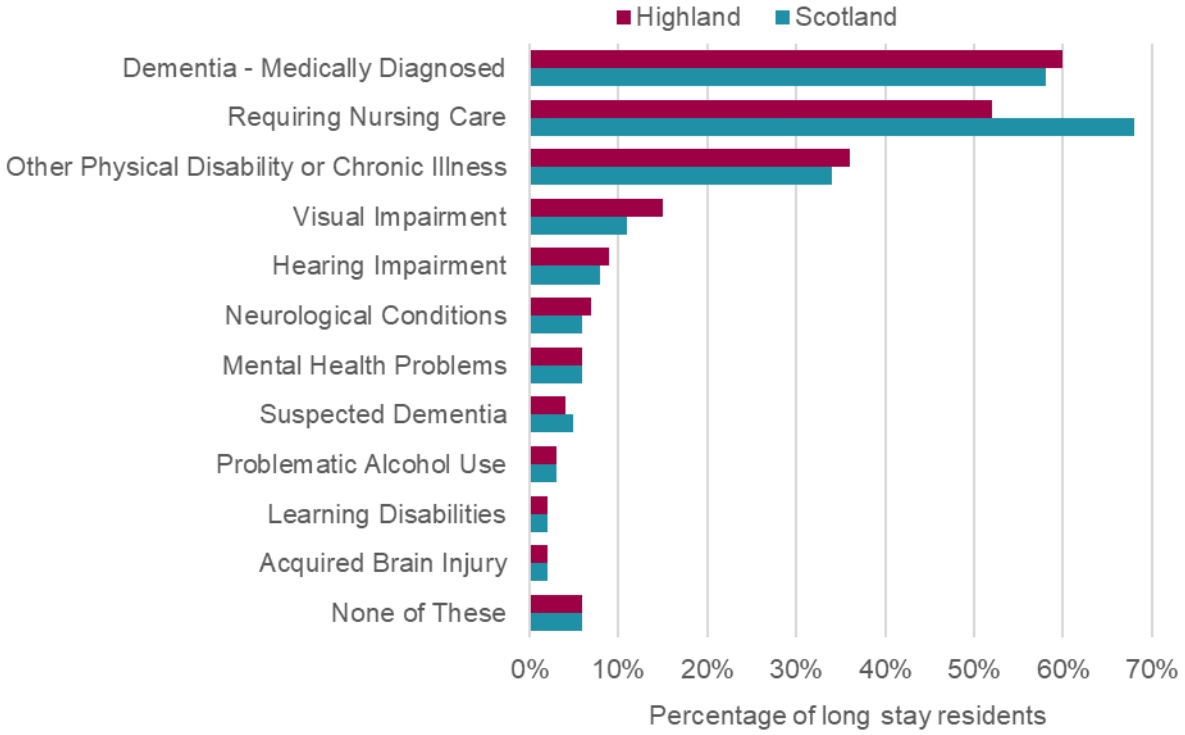


Source: Public Health Scotland, Scotland's Care Home Census

There is considerable overlap in health status and need for care and support amongst residents in care homes for adults. There is a high prevalence of cognitive impairment, co-morbidity and sensory impairment.

Increasingly care homes are for people with complex health care needs who are very frail or are dependent on others for all aspects of personal care. In 2024, almost two thirds (60 percent) of care home residents had medically diagnosed dementia, an increase of 12 percent since 2014 (Figure 96).

Figure 96: Estimated percentage of long stay care home residents by health characteristic, Highland and Scotland, March 2024



Source: Public Health Scotland, Scotland's Care Home Census
Ranked in descending order of health or social care need in Highland

8.6. Prison health care

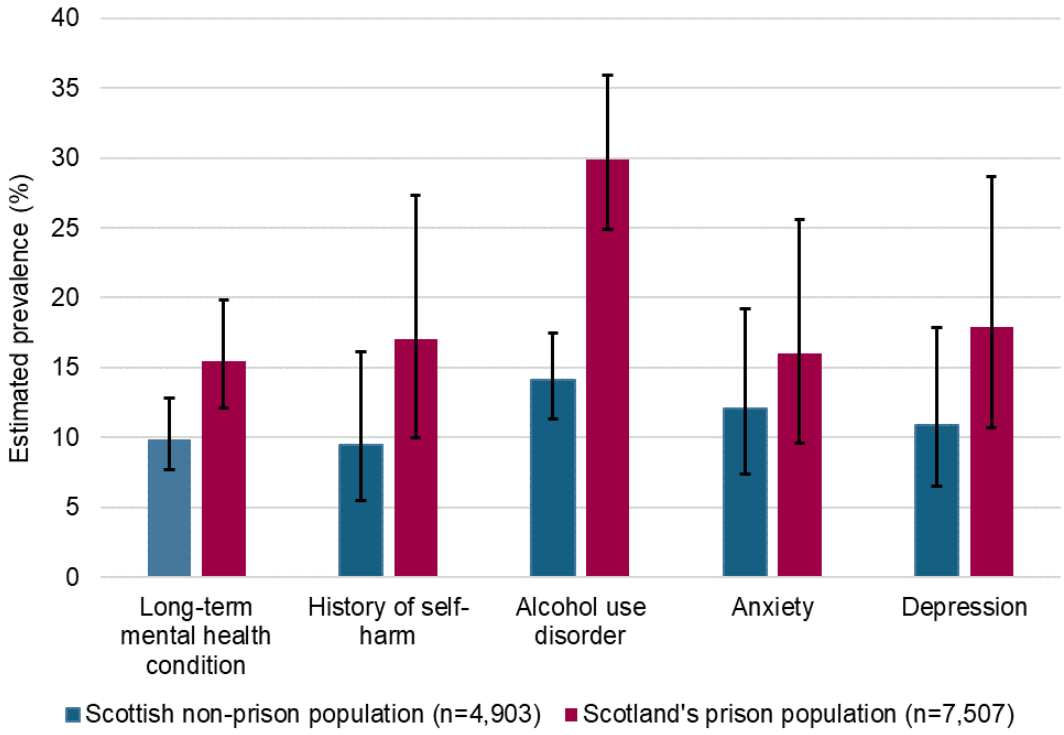
NHS Boards have been responsible for the provision of healthcare services for people in prison within their geographical boundary since 2011. Recent national and local needs assessments highlight that the mental and physical health of many in the care of prisons is poorer than in the general population and often involves multiple and complex needs requiring high levels of health and social care[193] [194].

Studies on the health needs of Scotland's prison population reported prison populations experience greater prevalence of many physical health conditions particularly epilepsy, asthma, chronic obstructive pulmonary disease, hepatitis C and poor oral health[195].

There is also increasing need for social care support among prisoners with recent estimates being seven to ten percent of Scotland's prison population. Key drivers for this are physical disabilities, growing numbers of older increasingly frail prisoners, prevalence of mental health and substance use issues, and frequency of hidden disabilities and head injuries[196].

Mental health issues are a key area of concern for those in prison with levels being greater than in the general population and often multiple and complex (Figure 97)[197].

Figure 97: Estimated prevalence (with 95% confidence intervals) of mental health problems in Scotland's non-prison and prison population



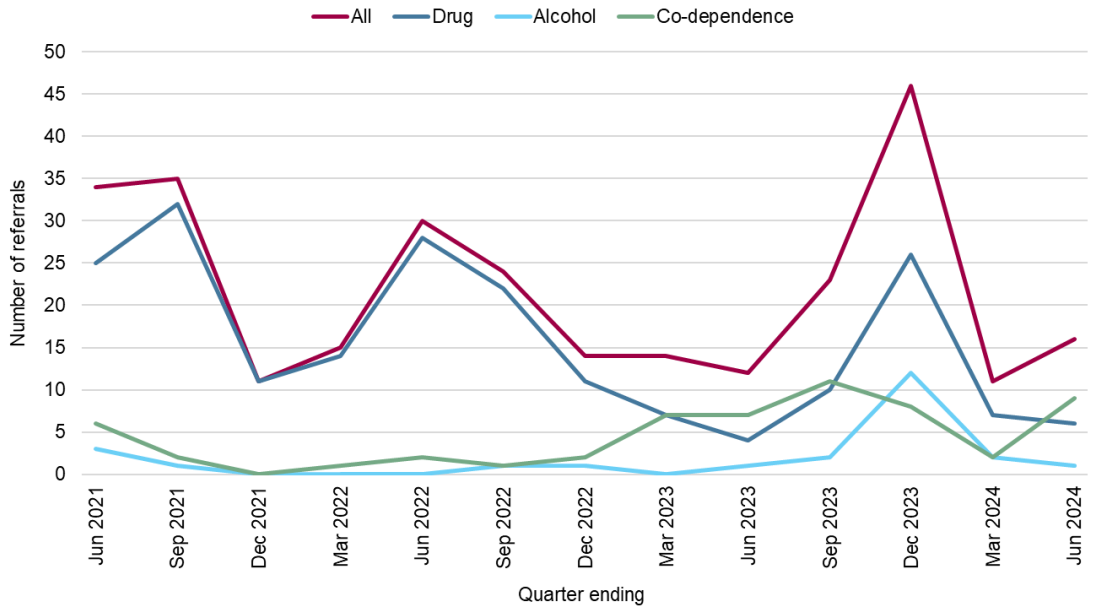
Source: Scottish Government, Understanding the Mental Health Needs of Scotland's Prison Population

In 2019, a local needs assessment was undertaken to understand the health and health care needs of those in the care of the prison and make recommendations for improvement. The needs assessment also considered future needs to support the planning for a planned new facility. The new HMP Highland, due to be completed in 2026, will be able to accommodate 200 prisoners, over 100 more than the design capacity of the prison it will replace.

The needs assessment for Inverness Prison identified a number of key health concerns, including smoking, drugs and alcohol, injecting steroids, gambling, low mental wellbeing, high prevalence of prescribed antidepressant drugs, and low levels of general health.

Problematic drug and alcohol use is higher in those living in prison compared to the general population and often a contributory factor to being in prison[198]. Use of drugs and alcohol prior to admission is reported by many people in the care of HMP Inverness, with subsequent referrals to drug and alcohol recovery services (Figure 98).

Figure 98: Number of referrals to prison-based drug and alcohol services in Highland



Source: Public Health Scotland, Drug and alcohol treatment waiting times dashboard.
1. Where people are referred to more than one service provider, they will have more than one referral. The number of referrals does not directly reflect the number of people being referred.
2. Includes continuation of care referrals. Continuation of care referrals were introduced with Daisy, and capture when people who are already in treatment move from one service to another.

Time in prison presents a unique opportunity to address health and social care needs often for those who are vulnerable or hard to reach. Due to the transient nature of this population, it is important that any health and social care provided supports throughcare into the community. Whilst recent needs assessments recognise significant improvements in prison health and social care, they also provide numerous recommendations for unmet needs and service improvements.

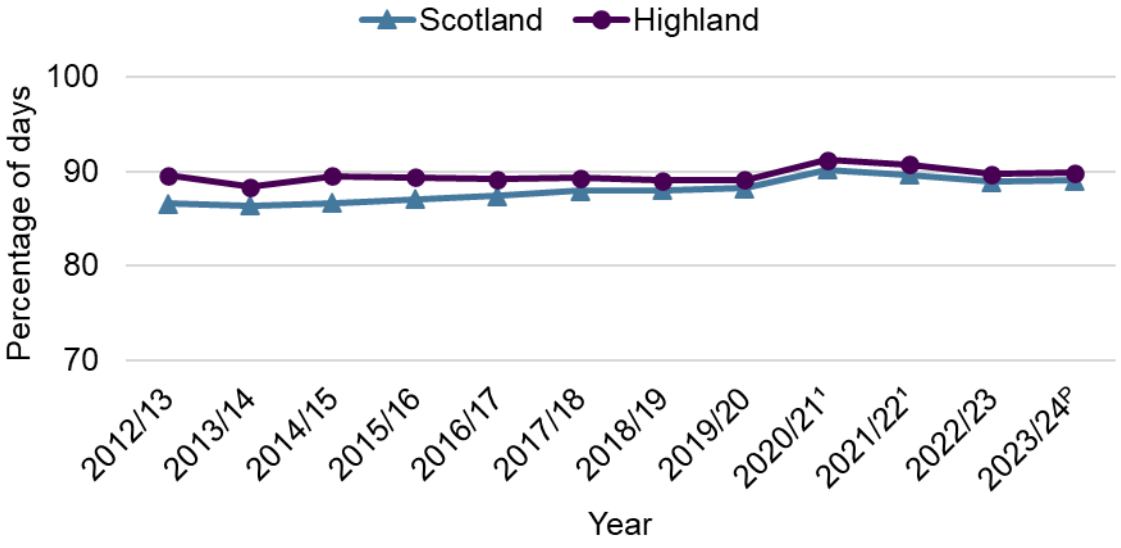
8.7. End of life care services

Palliative care aims to prevent and alleviate suffering in those with a life-shortening condition and can be provided at home, in hospital, in a hospice or in any setting. It is delivered and supported by many different professionals including general practitioners, nurses, allied health professionals, specialist palliative care doctors, social care and social work staff, and by volunteers, and takes a holistic approach to assessing and meeting physical, mental, practical and spiritual needs.

Research estimates that up to 90 percent of deaths are likely to benefit from palliative care[199]. The numbers of deaths in Highland are projected to increase in the next ten years, driving an increase in the future need for palliative care. Due to the increasing number of older people in the population, a larger proportion of people needing palliative care are likely to have dementia and/or frailty[200].

As a group, people at end of life have relatively high use of health and social care services. It is estimated that over 90 percent of adults in Scotland use unscheduled care in the last year of life[201]. People at end of life occupy 30 percent of hospital beds which are filled by unplanned (emergency) admissions in Highland[200]. Public Health Scotland estimate that 89.9 percent of the last six months of life is spent at home or in a community setting in Highland (Figure 99). This is equivalent to an average of 19 days spent in hospital in the last six months of life.

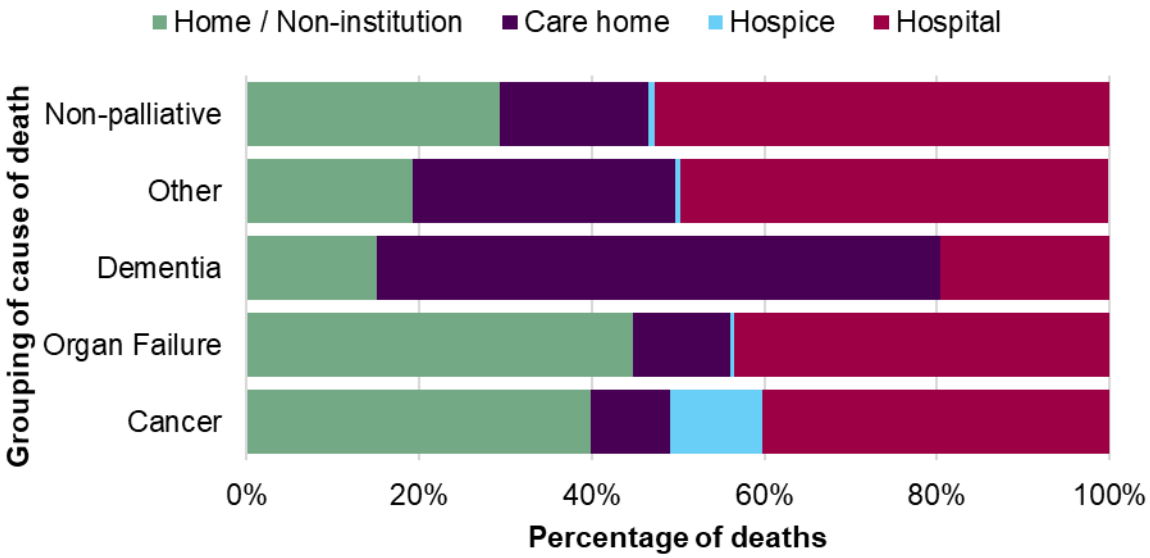
Figure 99: Percentage of last six months of life spent at home or in a community setting in Highland and Scotland, 2012-13 to 2023-24 [1,2]



Source: Public Health Scotland.
People who died where an external cause of death is coded on the death record have been excluded from the analysis. 1. Figures for 2023/24 are provisional. 2. Figures in 2020/21 and 2021/22 are likely to have been affected by the impact of COVID-19 pandemic on hospital stays. Note y-axis starts at 70%.

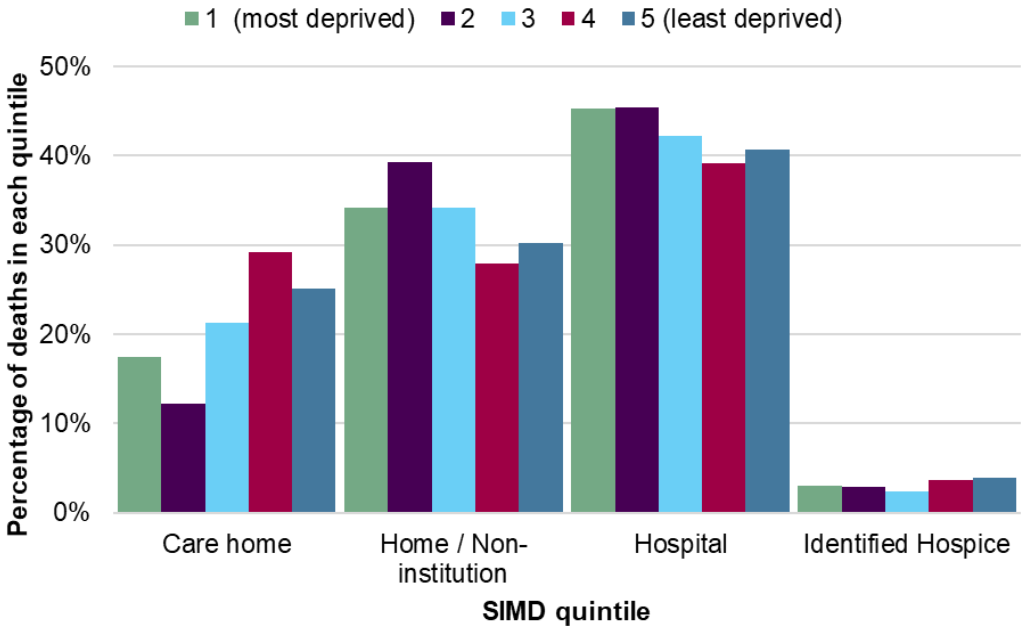
There is variation in the provision of end of life care across Highland[200]. Those with a cancer cause of death were more likely to die in a hospice location (Figure 100). Hospice care was also more likely to be accessed by those living in closer proximity to Highland Hospice in Inverness. People living in more deprived neighbourhoods were more likely to die in hospital than those living is less deprived neighbourhoods (Figure 101).

Figure 100: Percentage of deaths by cause of death grouping and location, 2022 and 2023



Source: National Records of Scotland deaths as provided by Public Health Scotland.
Notes: Groupings of underlying cause from Finucane et al. 2021. Hospice identified from a list maintained by Public Health Scotland and by the word 'Hospice' in the location name. 'Other institutions' excluded from the chart. Data are deaths of Highland usual residents.

Figure 101: Percentage of deaths in each deprivation quintile by location, 2022 and 2023



Source: National Records of Scotland, deaths as provided by Public Health Scotland.
Note: Data are deaths of Highland usual residents and Highland deprivation quintile.

It is important that experience of end of life care is good, irrespective of where people live or what they die from. The variation observed does not necessarily indicate that experience of support and care at end of life is inappropriate or worse for some areas or groups than others. There is a need for better patient reported experience measures.

The strategy 'Palliative Care Matters for All sets out the Scottish Government's ambition that everyone who needs it can access well-coordinated, timely and high-quality palliative care, care around dying and bereavement support[202]. Highland HSCP has a role in delivering this strategy which aims to ensure that, by 2030:

- adults and children in Scotland have more equitable access to well-coordinated, timely and high-quality palliative care, care around dying and bereavement support based on what matters to them, including support for families and carers.
- Scotland is a place where people, families and communities can support each other, take action and talk more openly about planning ahead, serious illnesses or health conditions, dying and bereavement.
- adults and children have opportunities to plan for future changes in their life, health and care with their families and carers.

Highland Hospice provides specialist consultant-led palliative care in Highland, including inpatient and community services. NHS Highland, along with Highland Hospice, is a lead partner in the End-of-Life Care Together partnership, which aims to improve end of life care across NHS Highland, and to shift the balance of end of life care from acute hospital to community settings[203].

The partnership has captured ten outcomes that matter to people at end of life. These highlight that to enable person-centred palliative care to be delivered, there is need for improved identification of people at end of life and the completion and sharing of anticipatory care plans.

To reduce waits for home care at end of life, End-of-Life Care Together have initiated a palliative care response service to deliver timely home care in Inverness for adults in their last three months of life. To provide expert support to professionals, people, their families and carers at end of life, a palliative care helpline is open 24 hours, 7 days a week.

9. Conclusions

This needs assessment summarises data for adults in the Highland local authority area to support the planning of integrated health and social care services. A rapid review cannot provide a complete picture of the population needs of adults and older people. It highlights key points to help inform the planning and improvement of adult services in Highland.

The following main points are identified:

- Highland has an ageing population, with increasingly large cohorts living to older age. Population projections forecast a continued increase in the size of the population aged 75 years and over.
- As a result of lower birth rates and migration patterns that see people leaving the area for education and employment, the working-age population is declining in size and ageing.
- The proportion of older people is expected to increase substantially often in areas where population numbers are static or decreasing. These changes are having a significant and increasing impact on the provision of health and care services.
- Highland has a significant remote and rural geography and a high proportion of areas in the most access deprived in Scotland. Older age dependency ratios are higher in remote and rural areas.
- Scotland's Census 2022 provides a detailed picture of the characteristics of our people and communities, showing Highland is increasingly ethnically diverse. All protected characteristics should be considered in planning health and care services.
- In Highland, most income deprived people live in places not identified among the most deprived areas by the SIMD. This distribution is a significant consideration for policy, strategy and the spatial targeting of resources, particularly in rural areas.
- As an Anchor Institution, the role of the HSCP is pivotal to designing and delivering health and care that has the population and local communities as the focus, particularly in the context of the wider determinants of health.
- Current needs and future requirements for housing should be aligned to HSCP strategic commissioning and planning to support people at all stages of life and support the shift in the balance of care closer to people's homes.

- The health concerns facing Highland are common. An ageing population is increasing demand on health and care services as more people are living with one or more long-term health conditions and with increasingly complex needs.
- Evidence from Scotland's Census 2022 suggests a decline in general health and a growth in people reporting a mental health condition, notably in females at younger ages.
- The underlying epidemiological trends forecast an increase in annual disease burden over the next 20 years. An anticipated rise in a range of diseases including cancer, cardiovascular disease, diabetes and neurological conditions will inevitably place additional pressure on health and care services.
- There is limited data available on the prevalence of different mental health conditions in Highland. Further work is required to review population needs in this area.
- The harmful use of substances (tobacco, alcohol and drugs) are a major cause of preventable ill-health and early death. Reducing these risk factors presents a sizeable opportunity to improve health and wellbeing and reduce health inequalities.
- The number of people providing unpaid care increased over the last decade. In the context of increasing demand and growing levels of unmet need, more unpaid care is being relied upon to support people to live at home.
- Care home capacity has reduced during a period of growth in the older population. Pressure on the care home market is recognised to be associated with challenges of rural operation, smaller size of operation and workforce availability.
- Combined, the data for delayed discharges, care at home and care home capacity reflects the challenge of providing services across the Highland geography and high levels of unmet need.
- People at end of life have relatively high use of health and social care services and demands are forecast to increase. Experience of end of life care should be good, irrespective of where people live or what they die from.
- Improving the health of our population requires a fundamental shift towards prevention and mitigating the underlying issues that can impact on health, such as poverty and deprivation.
- To shift the balance of care closer to people's homes, change is needed in how we approach the delivery of health and care, driving investment in prevention and early intervention.

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