The Highland Council / NHS Highland

Agenda Item	**7**
Report No	**JMC-03-26**

Committee: **Joint Monitoring Committee**

Date: **12 February 2026**

Report Title: **Integrated Children's Services Update**

Report By: **Chair Integrated Children's Services Planning Board**

1 Purpose/Executive Summary

1.1 This report provides an update on the progress being made to deliver the outcomes outlined within the Children's Services Planning Partnerships Integrated Children's Services Plan 2023–2026 here

1.2 The report also provides at **appendix 1**, The Children and Young People Joint Strategic Needs Assessment (JSNA) which has been designed to identify the priorities for the next iteration of the Integrated Children's Service Plan (ICSP) 2026–2029.

2 Recommendations

2.1 Members are asked to:

i. Note and comment on the work undertaken by the children's services planning partnership in delivering the Highland Integrated Children's Services Plan 2023-2026;

ii. Note the work of the delivery groups.

3 Implications

3.1 **Resource** - The Children's Services Planning Partnership will continue to identify future resource requirements and areas for improvement as delivery of the Integrated Children's Services Plan (2023–2026) progresses. Any additional resource implications arising during the lifetime of the plan will be assessed and brought forward through established governance processes.

3.2 **Legal** - Partnerships are legally required to produce an Integrated Children's Services Plan every three years. The plan is also underpinned by the duties set out in the United Nations Convention on the Rights of the Child, ensuring that children's rights are central to planning and delivery.

3.3 **Risk** - This iteration of the Integrated Children's Services Plan is delivered through the Community Planning Partnership infrastructure and aligned to the aspirations of the Highland Outcome Improvement Plan. Key risks therefore relate to ensuring continued alignment across partners, maintaining capacity for delivery, and managing interdependencies across wider strategic programmes.

4 Impacts

4.1 In Highland, all policies, strategies or service changes are subject to an integrated screening for impact for Equalities, Poverty and Human Rights, Children's Rights and Wellbeing, Climate Change, Islands and Mainland Rural Communities, and Data Protection. Where identified as required, a full impact assessment will be undertaken.

4.2 Considering impacts is a core part of the decision-making process and needs to inform the decision-making process. When taking any decision, Members must give due regard to the findings of any assessment.

4.3 This is a monitoring and update report and therefore an impact assessment is not required.

5 Developing the Integrated Children Service Plan 2026-2029

5.1 Work is underway to identify the priorities for the Integrated Children's Service Plan (ICSP) 2026–2029. The Children and Young People Joint Strategic Needs Assessment (JSNA) has been developed specifically to inform these priorities. Led by the NHS Health Improvement Team and undertaken in partnership across the system, this work builds on the 2023 JSNA and strengthens the overall evidence base to support strategic decision-making.

5.2 An initial development session has already taken place to review the 2023 JSNA, assess the data included, identify any gaps, and explore opportunities to enhance the analysis. Data collection across the partnership is now complete, and a draft JSNA is available for information at **Appendix 1**.

5.3 The Integrated Children's Services Board has scheduled a series of development sessions through until March to consider the updated evidence and use it to agree the key priorities for the new Children's Service Plan.

5.4 Importantly, the JSNA is informed not only by quantitative data but also by the lived experience of children and young people. A programme of engagement activity will ensure their voices meaningfully influence the priorities set for the next planning cycle**.**

6 Child Protection Committee

6.1 The Child Protection Committee (CPC) held a review session, supported by the Care Inspectorate link officer, to reflect on current arrangements and plan for future membership and functions. A series of improvement actions will be developed to strengthen the committee's governance and enhance its effectiveness.

6.2 The CPC endorsed the implementation of the Early Protective Messages (EPM) Programme for all Early Years providers in Highland. A local EPM Steering Group has been established—led by the Child Protection Learning and Development Officer and

the NHS Highland Senior Health Improvement Specialist—to coordinate delivery across the area.

6.3 Developed in 2013 by NHS Greater Glasgow and Clyde's Sexual Health and Relationships Team, and endorsed by Healthcare Improvement Scotland's Right Decision Service, the EPM Programme equips Early Years practitioners with the knowledge and tools required to deliver age-appropriate, consistent approaches to growing-up and relationships education. This includes agreed terminology for body parts, early consent messages, and recognising opportunities for teachable moments. Information and support for parents is also provided to help them mirror this approach at home.

6.4 By helping children understand their bodies, develop positive self-esteem, and build healthy, age-appropriate relationships, the programme aims to lay strong foundations for future relationships and sexual-health education, contributing to improved safety and wellbeing.

6.5 An implementation group has been established to oversee this work, with an initial pilot phase planned before wider rollout.

6.6 The Chair of the Child Protection Committee has confirmed the intention to stand down at the end of contract in July 2026, and recruitment for a new Chair is underway.

7 Whole Family Wellbeing Programme - Family Links 2.0 Update

7.1 The Whole Family Wellbeing Programme aims to transform how families in Highland access support, ensuring that help is earlier, more coordinated, and centred around whole-family needs. Within this programme, Family Links has been a key test of how a preventative, relationship-based model can operate in practice.

7.2 Family Links 1.0 has generated substantial learning as the first phase in developing a holistic whole-family support model for Highland. It has demonstrated how coordinated, relationship-based support can work on the ground and has provided a strong foundation for a model that could ultimately be scaled and made accessible to families across Highland who may benefit from it.

7.3 To build on this early progress, it is now essential to test the model in a wider range of contexts. This next phase - referred to as Family Links 2.0 - will run from April 2026 to March 2027. Family Links 2.0 will provide the further learning needed to support a phased rollout of the model over the following two to three years, ensuring future scaling is informed, sustainable, and responsive to local circumstances.

7.4 The next phase focuses on strengthening a new part of the system centred on very early intervention - where families are able to proactively access community-based resources, whole-family wellbeing approaches, and preventative supports already in place. Over time, as the early-prevention model becomes embedded, it will operate alongside the existing system until both are fully integrated.

7.5 The Whole Family Team recently presented the proposal to the Integrated Children's Services Board, seeking approval to expand Family Links into two additional areas of Highland (areas to be confirmed). The presentation set out progress to date, current outcomes, and key learning that will inform phase 2. The Board agreed to approve the

proposed funding for Family Links 2.0, noting that implementation will be phased and subject to regular review.

7.6 To ensure wider alignment with strategic priorities, it has been agreed that the programme will be presented to the Community Planning Partnership (CPP) Board in March 2026.

8 GIRFEC Strategic Group

8.1 Getting It Right for Every Child (GIRFEC) is Scotland's national approach to supporting children, young people, and families. It provides a clear framework for identifying and responding to wellbeing needs at the earliest opportunity, ensuring that children receive the right help, at the right time, from the right people.

8.2 Work is currently underway to consider the continuum from GIRFEC through to Child Protection, ensuring alignment with a broader continuum of need. This includes examining the role of the Named Person service, Lead Professional responsibilities, and the supports available to children and families in line with whole-family approaches. While no changes are proposed to existing guidance, the focus is on reflecting on strengths, pressures, and current practice, and agreeing consistent approaches across the partnership.

8.3 A workshop with colleagues and partners will be arranged to support this reflection and identify areas for improvement as the work progresses.

8.4 Highland GIRFEC Locality Groups are also being developed to offer a structured, multi-agency forum where professionals can collaborate, share information, and identify solutions when a Child's Plan is in place but needs remain unmet or are escalating. These groups aim to strengthen local partnership working and ensure effective and consistent use of services and community resources within the GIRFEC practice model.

This development work is at an early stage, with services currently identifying potential pilot areas. Initial discussions have clarified that the Locality Groups will not include:

- Child's Plan Meetings
- Discussions where no Child's Plan is in place.
- Any situation requiring immediate child protection action (these follow existing Child Protection procedures)

Further updates will be provided to the Integrated Children's Services Planning Board as this work develops.

8.5 Developing workstreams of the GIRFEC Strategic Group include:

- Establishing robust quality-assurance processes
- Developing a communication strategy to ensure consistent messaging and roll-out across the partnership
- Creating resources to inform children, young people, and families about GIRFEC and the practice model
- Ensuring children and young people's voices influence every stage of the pathway and are embedded within practice.

9 The Promise

9.1 The Promise remains a central commitment for Highland, delivered within a complex and evolving national context. Scotland's planning framework for this work, Plan 24–30, sets out a dynamic and continually updated structure consisting of 25 national Route Maps and the Promise Story of Progress. These Route Maps outline the current national position, the outcomes expected by 2030, the milestones and timescales required, and the responsibilities placed on specific agencies. Together, they translate the Independent Care Review's calls to action into measurable and time-bound commitments, organised across the five foundations of the Promise: Voice, Family, Care, People and Scaffolding. Nationally, The Promise Scotland continues to refine these Route Maps to reflect emerging learning, interdependencies and changing circumstances. During 2026, the emphasis will shift towards supporting local areas, including Highland, to translate these national ambitions into local implementation and embed the Promise as core operational practice rather than a standalone programme.

9.2 Engagement with the Regional Promise Networks has reinforced that not all Route Maps will be directly relevant to Highland and that the Route Maps themselves are not substitutes for local or organisational planning. Instead, they provide a shared national reference point to help align local ambitions, identify dependencies and understand sequencing—both in terms of what needs to happen first locally and what progress depends on nationally. Locally, action is being taken forward through the three Promise Delivery Groups—Family, Care and Doing Data Differently—which are developing detailed delivery actions that reflect local priorities for 2026. These groups continue to cross-reference local progress with relevant Route Maps, identify system pressures, and refine sequencing of activity to ensure realistic and sustainable delivery.

9.3 Governance for The Promise within Highland remains embedded within existing partnership structures. Strategic leadership is provided through the Promise Board, while operational responsibility in Highland Council for delivery sits across Social Work, Education and Child Health. Wider quality assurance, audit and practice improvement continue through the CPC Quality Assurance Subgroup. This continues to reflect national expectations that delivery of the Promise becomes part of core business, supported by existing leadership and accountability structures.

9.4 Across the Voice foundation, Highland has made significant progress. Work on language has included development of the Highland Language Guide, tests of change in residential case-note recording that have gained national recognition, and collaborative work with Each and Every Child to ensure the Highland Promise Plan reflects best practice in language framing. Improvements in participation and engagement include the development of the Voice Process, which enables children and young people to directly influence the Children's Services Planning Board; the use of the Better Meetings guidance to improve the quality of participation in statutory meetings; the introduction of My Journey Journal for care-experienced young people; implementation of the Mind of My Own digital participation tool; and ongoing work with the Reimagining Justice initiative to ensure lived experience shapes improvement activity. Child Health continues to strengthen approaches to capturing the voices of infants as part of wider trauma-informed practice.

9.5 Progress within the Family foundation includes the development of the HOST service, the establishment of the Kinship Team, reviews of commissioned intensive family support, and ongoing improvement activity within the Whole Family Wellbeing Programme, including the Family Links work and delivery of Parents Under Pressure. Early help continues to be strengthened through developments such as the Whole Family Support in Pregnancy quality-improvement project. Short breaks through the Orchard have also been reinstated. This work sits within a national emphasis on providing effective, responsive and preventative support at the earliest possible stage. Progress under the Care foundation includes the development of the Child's Rights and Participation Service, commissioned independent advocacy for care-experienced children and young people, the creation of the Has Answers app, and further embedding of Family Group Decision Making. Work continues to strengthen throughcare and aftercare pathways, including service review activity, relationship-based support and developments to increase stability. Improvements have been made to help brothers and sisters remain together safely, and local participation in the Bairns' Hoose Pathfinder continues.

9.6 Across the People foundation, Highland has maintained a strong commitment to trauma-informed leadership and practice, including the 2024 Trauma Summit and the establishment of the Trauma-Informed Implementation Group. Workforce wellbeing and practice support remain important themes, reflecting the wider expectation that all staff involved in caring for or supporting young people can provide stable, attuned and compassionate support.

9.7 Within the Scaffolding foundation, local work continues through the Doing Data Differently Group, which is developing a Promise dataset aligned with the national Promise Progress Framework and Highland's own ten vision statements. Work is ongoing to ensure that lived-experience evidence is incorporated meaningfully into measurement and evaluation, supported by longstanding datasets such as the Highland lifestyle survey. Highland's use of What Matters tools during development of its Promise Plan has been recognised nationally as an example of good practice. Additional developments are taking place across education, governance, health and justice, aligning local improvement activity with national expectations within the Route Maps.

9.8 The Promise Story of Progress, a core component of Plan 24–30, emphasises the need for consistent evidence combining national data, organisational learning and lived experience. Highland's Doing Data Differently dataset has been designed to meet these requirements and will be considered by the Promise Board on 10 February 2026.

9.9 Looking ahead, the main risks relate to the scale and pace of national expectations relative to local capacity, workforce pressures and financial constraints. These reflect the concerns raised nationally by COSLA and local authorities, particularly given the volume of overlapping policy agendas including UNCRC incorporation, the Care and Justice Act, and anticipated legislation on Care-Experienced children and GIRFEC. Meeting milestones within expected timescales remains a key challenge. Senior leaders will continue to work with COSLA and the Scottish Government to influence expectations and ensure that national policy remains deliverable in practice within the resources available.

10 The Vision 26 Roadshows

10.1 The Vision 26 event took place in Fort William at the Nevis Centre on 23 January 2026 and marked the final session in a three-part roadshow series. Focused on “Getting it right for children and families”, the event was a great success, creating strong connections with the Lochaber community and local organisations. More than 20 groups participated, and over 80 children and families attended, contributing to a vibrant day of play opportunities, engagement, and meaningful discussion.

As with the previous roadshows, the event provided an important platform to strengthen links with The Promise, the Integrated Children’s Services Plan, the Whole Family Wellbeing Programme, and the Child Protection Committee.

Designation: Chair, Integrated Children’s Service Board

Date: 12 February 26

Author: Chair, Integrated Children’s Service Board

Appendices: Appendix 1 – Draft Joint Strategic Needs Assessment

Appendix 7a

Highland Community Planning Partnership | Com-pàirteachas Dealbhadh Coimhearsnachd na Gàidhealtachd

Appendix 1

Highland Children and Young People's Needs Assessment

WORKING DRAFT 05/02/2026

February 2026

Authors and Contributors

To be completed

Acknowledgements

The Highland Children and Young People's Needs Assessment has been produced by NHS Highland Public Health Intelligence on behalf of the Highland Integrated Children's Services Planning Board and Highland Community Planning Partnership. We would like to thank colleagues across the partnership for providing data, advice and guidance in the development of this report.

If you require this document in an alternative format, such as large print or on a coloured background, please contact us by emailing nhsh.publichealthintelligence@nhs.scot.

Version	Issued	Summary of changes
1		
2		

Distribution	Method
Highland Integrated Children's Services Planning Board, Public Health Directorate, NHS Highland website	Email and intranet link

Contents

Executive Summary

To complete once main document content finished.

1. Introduction

Background

This report presents an overview of the population health and wellbeing needs of children, young people, and families in Highland. It has been developed as part of a programme of work to inform the strategic direction and priorities of the Highland Children's Services Plan for 2026 onwards.

The plan sets out, on behalf of the Highland Integrated Children's Service Planning Board (ICSB), the strategic direction and priorities of the Board. The ICSB sits within the structure of the Highland Community Planning Partnership (CPP) and leads the improvement of outcomes for all Highlands children and families.

This Joint Strategic Needs Assessment (JSNA) will inform and guide the planning and commissioning of children's services in Highland based on analysis and understanding of local population need.

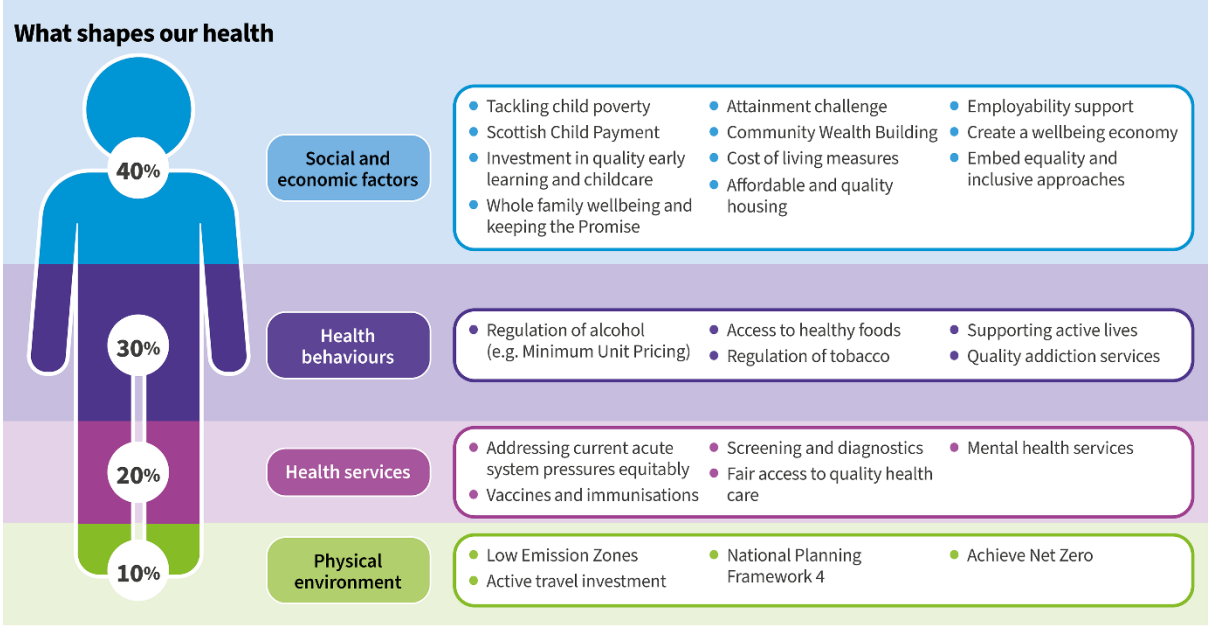
Scottish Government guidance defines the main goal of a JSNA is to 'accurately assess the care needs of a local population in order to improve the physical and mental health and wider wellbeing of individuals and communities'.[1]

Approach

Following agreement by the ICSB to commence the JSNA, a working group was formed to lead on the practical aspects of co-ordinating and implementing the process. Colleagues from NHS Highland Public Health Intelligence and Highland Council Performance and Improvement teams have been integral members of the working group, in addition to representation from ICSB members. The involvement of professional and operational leads was also sought to verify and review the accompanying narrative for the report.

The report considers some of the interconnected factors, or building blocks, which have an influence on physical and mental health and wellbeing. These factors are known collectively as the determinants of health.[2] Public Health Scotland highlight that the social and environmental conditions in which people are born, grow up, live, work and age, alongside behavioural risk factors, which mostly shape health and wellbeing for people and communities (Figure 1).

Figure 1: What shapes our health?



Source: Public Health Scotland.[2]

The building blocks include a focus on the earliest years of life (including preconception and during pregnancy), good education, fair work and income, healthy places, social networks and appropriate public services. Research shows that these social, economic and environmental factors are the primary drivers of health and health inequalities.[3]

Health inequalities are systematic, unjust and preventable and arise from factors which are mostly beyond individual control. The fundamental causes of health inequalities are the unequal distribution of income, power, wealth and opportunity which shape access to factors which determine health.[4] [5] 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 all children and young people in Highland.

The report structure also presents a life course approach from pre-birth to young adulthood. Adopting a life course approach is about addressing the protective and risk factors relevant to health and wellbeing at each stage of life. Evidence highlights the importance of appropriate action during critical life stages, settings and transition periods.

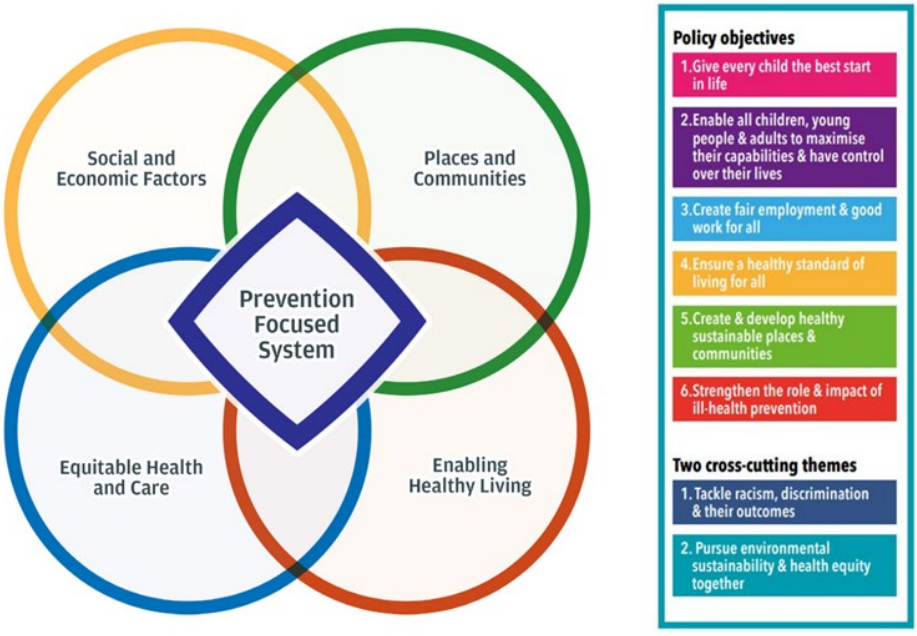
Strategic context

Scotland has experienced substantial changes in its policy and legislative landscape, which directly affect children and young people. Highland's Integrated Children's Services Planning Board are guided by the following overarching frameworks and strategies that apply to all aspects of this needs assessment.

Scotland's Population Health Framework 2025-2035:[6] The Framework promotes a whole system approach to improving health outcomes and reducing health inequalities by focusing on prevention of ill health and addressing the building blocks of health. The prevention drivers of health and wellbeing highlight five interconnected areas of focus which require collaborative action and accountability for population health outcomes and inequalities.

The drivers are influenced by the eight Marmot principles, developed by Professor Sir Michael Marmot and the Institute of Health Equity to guide evidence-based action on the social determinants of health and reduce health inequalities.[7]

Figure 2: Scotland's Population Health Framework drivers and Marmot principles



Source: Scottish Government, Institute of Health Equity.

United Nations Convention on the Rights of the Child (UNCRC): The UNCRC provides a rights-based framework to uphold the rights of children and young people. The UNCRC contains 54 articles which cover all aspects of a child's life. Examples of these rights include non-discrimination, right to be heard, protection from violence, abuse and neglect, right to a proper house, right to health, right to education and right to play.[8]

UNCRC Incorporation (Scotland) Act 2024: Embeds children's rights into Scots law, requiring public bodies to demonstrate rights-based practice and enabling children to challenge breaches of their rights legally.[9]

Getting it right for every child (GIRFEC): Scotland's long standing, national commitment to improve and uphold the wellbeing of children and their families. Refreshed guidance emphasises early intervention, multi-agency collaboration, and holistic wellbeing, with updated practice models and strengthened roles for named persons and child's plans.[10]

The Promise: The conclusions from the Independent Care Review, setting a national ambition that children 'grow up loved, safe and respected' and committing Scotland to implement the changes by 2030. The Promise is guided by five foundations: Voice, Family, Care, People, Scaffolding. While The Promise is rooted in transforming the people's experience of the 'care system', its foundations reinforce the principles of a whole-family, rights-based approach.[11]

Keeping the Promise: The Promise implementation plan sets out the actions and commitments to Keep the Promise for care experienced children, young people and their families.[12]

Local context

Highland Children's Services Plan 2023-2026 outlines local priorities and actions to improve outcomes for children, young people and families.

Highland Outcome Improvement Plan: Highland Community Planning Partnership's vision to maximise opportunities and tackle inequality, building a thriving Highlands for all. The vision is driven by three strategic priorities: People; Place; Prosperity.

NHS Highland Together We Care Strategy 2022-2027: Sets out NHS Highland's five-year strategy, including strategic outcomes to give every child the opportunity to start well in life and support children and young people to thrive, underpinned by an Annual Delivery Plan.

Highland Strategic Plan for Adult Services 2025-2027: The strategic plan for the delivery of integrated health and adult social care services in the region covered by the Highland Health and Social Care Partnership.

Highland Joint Strategic Needs Assessment: Provides an overview of population health and wellbeing needs of the adult population of the Highland council area. The JSNA sets out the overall context for individuals, families and communities living in Highland.

Data sources

The Children and Young People's Needs Assessment (CYPNA) draws on evidence from peer reviewed literature, research papers, non-commercial reports (grey literature) and recent statistical publications from local and national agencies.

Key sources include National Records for Scotland (NRS), Public Health Scotland (PHS), the Scottish Public Health Observatory (ScotPHO), particularly the ScotPHO Children and Young Peoples profiles. Data from Scotland's Census 2022 and 2011 have also been used extensively throughout the report. These sources enable meaningful comparisons over time and between areas, ensuring that population-level conclusions are grounded in reliable evidence and reflect wider demographic and epidemiological trends.

Additional published data from other national agencies have been used. These include Scottish Government sources, including school education and children's social work statistics, along with data from the UK Government, Police Scotland, Social Security Scotland and the Scottish Children's Reporter (SCRA).

The report incorporates findings from previous work undertaken in Highland and local strategic documents. This includes the Public Health children and young people's health and wellbeing profiles, which provide information across a wide range of topics for each of the nine localities (community partnerships) in the Highland Council area. NHS Highland's Director of Public Health annual reports have also been used, offering an overview of population health and ongoing work to improve health and wellbeing and reduce health inequalities. In addition, the Highland Children's Services Plan 2023-2026 outlines local priorities and actions to improve outcomes for children, young people and families. These strategic documents ensure that the CYPNA is aligned with current local priorities, service developments and policy commitments.

Data from local services and initiatives have also been used, such as information provided by the Highland Council, NHS Highland, and surveys including the Highland Lifestyle Survey and Planet Youth. These data offer more detailed insights into local need and are essential for identifying pressures on local services.

Evidence from peer-reviewed literature, research papers and grey literature strengthens the assessment by offering context and depth where quantitative data alone is insufficient. These sources help identify emerging or complex issues affecting children and young people and highlight determinants of health and wellbeing.

The data sources selected for the CYPNA were chosen to ensure that the findings are robust, comprehensive and reflective of the most accurate information available. The CYPNA is based upon data available at the time of development.

2. Population

Understanding of the numbers of children and young people living locally is important for assessing potential need and providing services. The demands vary with the size of each annual population cohort and the cumulative sum of the individuals making up consecutive age groups.

As a result of birth rates and migration, the absolute number of children and young people of different ages living in Highland changes each year.

In Scotland, the definition of a child varies in different legal contexts. Statutory guidance supporting the Children and Young People (Scotland) Act 2014 and the United Nations Convention on the Rights of the Child include all children and young people under the age of 18 years.[8] [13] The following section extends this definition to cover those aged 18 to 24.

Population of children and young people

In 2024, 56,779 children and young people under 25 years of age living in Highland comprised 24 percent of the area's population (Figure 3).

Children in their first year of life make up less than one percent of the total population of Highland and Scotland.

Figure 3: Children and young people living in Highland and Scotland by age group in 2024*

	Highland		Scotland	
	Number	**Percentage**	**Number**	**Percentage**
under 1 year	1,847	0.8	46,776	0.8
1-4	7,868	3.3	199,463	3.6
5-11	16,413	6.9	401,677	7.2
12-17	15,855	6.7	371,697	6.7
18-24	14,796	6.2	469,822	8.5
under 18	41,983	17.7	1,019,613	18.4
Total of children and young people	56,779	23.9	1,489,435	26.9

Source: National Records of Scotland, Mid-2024 population estimates
* Percentage of the total population of the area

Population change

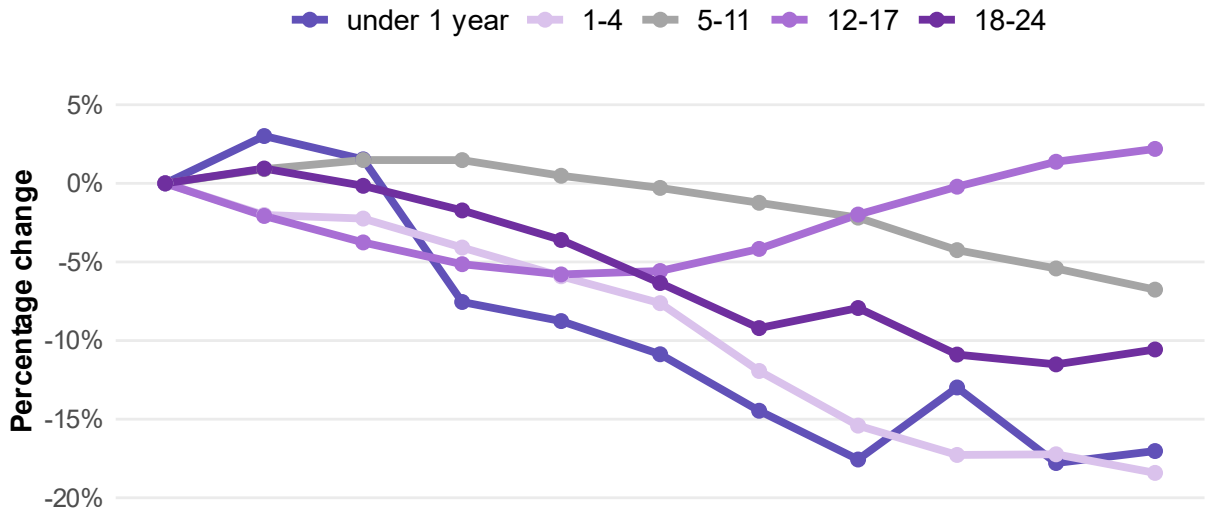
Over the last ten years, the population of children and young people under 25 in Highland has decreased from 61,532 to 56,779 (- 7.7 percent). There are substantial reductions in the number of children in the youngest age groups resulting from a sustained decline in annual births (Figure 4 and Figure 5). Birth rates are at similarly low levels in the Scottish population, with a consequent notable decline in younger children (Figure 6).

Figure 4: Number of children and young people living in Highland in 2014 and 2024 by age group

	Age						
	under 1 year	1-4	5-11	12-17	18-24	under 18	Total of children and young people
2014	2,226	9,644	17,603	15,515	16,544	44,988	61,532
2024	1,847	7,868	16,413	15,855	14,796	41,983	56,779
Percentage change	-17	-18.4	-6.76	2.19	-10.6	-6.7	-7.7

Source: National Records of Scotland, Mid-year population estimate time series data

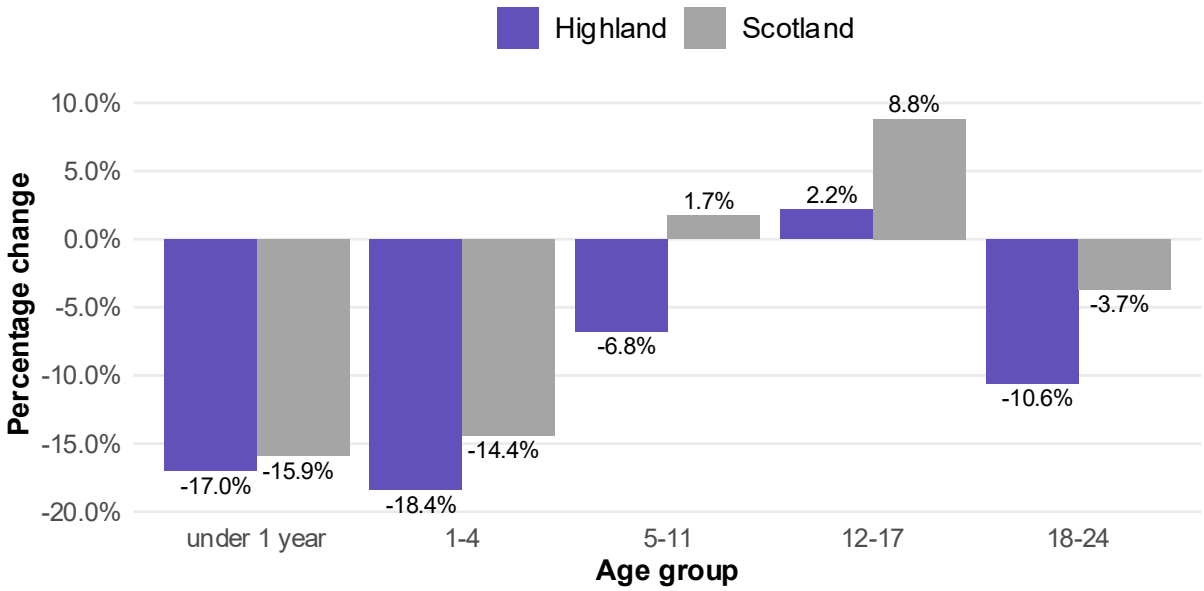
Figure 5: Percentage change in the number of children and young people living in Highland between 2014 and 2024 by age group



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
under 1 year	0	3.0	1.5	-7.5	-8.8	-10.9	-14.5	-17.6	-13.0	-17.8	-17.0
1-4	0	-2.0	-2.2	-4.1	-5.9	-7.6	-11.9	-15.4	-17.3	-17.2	-18.4
5-11	0	0.9	1.5	1.5	0.5	-0.3	-1.2	-2.2	-4.2	-5.4	-6.8
12-17	0	-2.1	-3.8	-5.1	-5.8	-5.6	-4.2	-2.0	-0.2	1.4	2.2
18-24	0	0.9	-0.2	-1.7	-3.6	-6.3	-9.2	-7.9	-10.9	-11.5	-10.6

Source: National Records of Scotland, Mid-year population estimate time series data

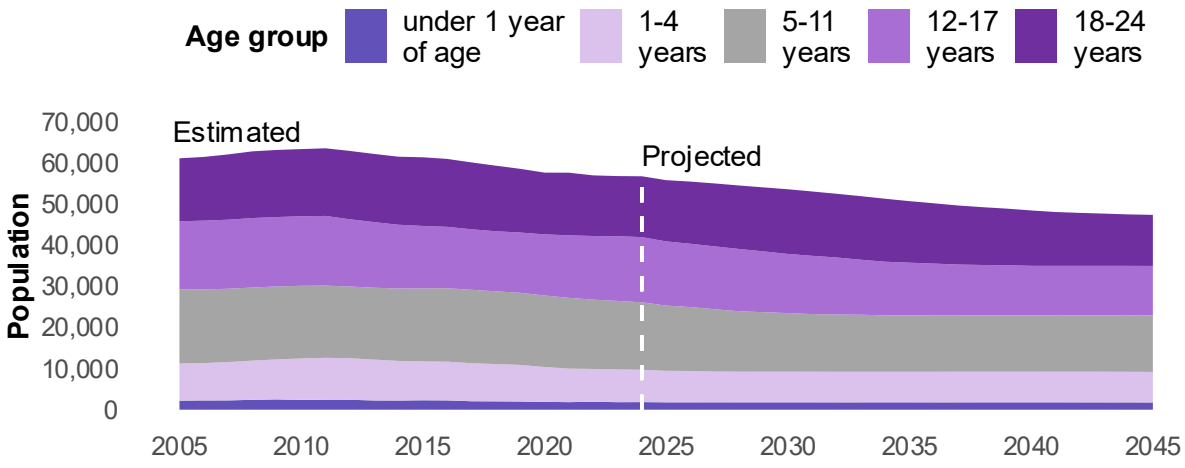
Figure 6: Percentage change in the number of children and young people living in Highland between 2014 and 2024 by age group



Source: National Records of Scotland, Mid-year population estimate time series data

The 2022-based population projections for Highland forecast a continued reduction in the size of the population of children and young people (Figure 7 and Figure 8).

Figure 7: Estimated and projected population of children and young people living in Highland by age group, 2005 to 2045



Source: National Records of Scotland, Mid-year population estimate time series data and Subnational Population Projections (2022-based)

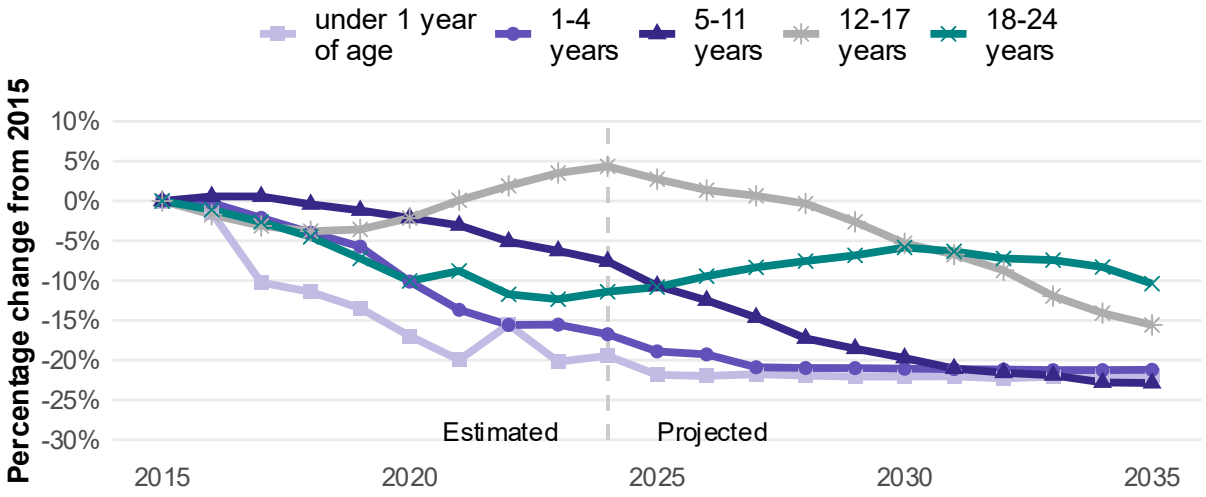
Figure 8: Estimated and projected population of children and young people living in Highland by age group, 2015, 2025 and 2035

	under 1 year	1-4	5-11	12-17	18-24	under 18 years	Total
2015	2,293	9,450	17,762	15,193	16,700	44,698	61,398
2025	1,792	7,664	15,868	15,611	14,893	40,935	55,828
2035	1,791	7,446	13,699	12,827	14,965	35,763	50,728

Source: National Records of Scotland, Mid-year population estimate time series data and Subnational Population Projections (2022-based)

Lower birth rates are the key factor contributing to the continued projected decline in the population of children and young people living in Highland (Figure 9). The projections suggest that the population aged under five, which has decreased considerably, will remain at or around its current level over the next decade. The 12-17 age group may see a slight increase followed by a further decline below the current level. The overall effect is a projected continued decline in the population aged under 18 years of age.

Figure 9: Percentage change in the estimated and projected population of children and young people living in Highland by age, 2015 to 2035



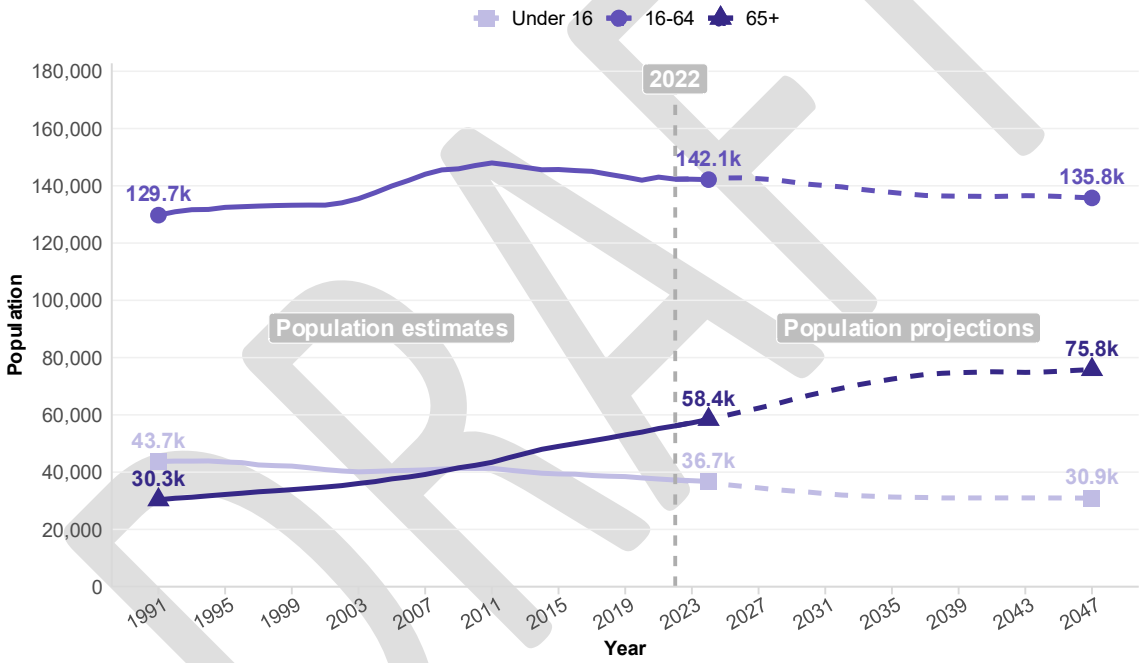
Source: National Records of Scotland, Mid-year population estimate time series data and Subnational Population Projections (2022-based)

Wider demographic context

Highland's wider demographic profile is marked increasingly by population ageing and a gradual contraction in the working-age base. Older age groups have grown faster than the working-age population both locally and nationally, raising the dependency ratio and placing sustained pressure on public service capacity.[14] [15]

This demographic shift forms the structural backdrop to all service planning for families. As the working-age pool narrows, the availability of staff to meet rising, increasingly complex needs is constrained, regardless of trends specific to the children and young people's population.[16] These wider demographic patterns shape the operating environment within which children's services function, influencing workforce availability, turnover, and resilience.

Figure 10: Population estimates (1991-2024) and projections (2022-2047) by age group, Highland



Source: National Records of Scotland, Mid-year population estimate time series data and Subnational Population Projections (2022-based)

Across Scotland and Highland, these population dynamics interact with longstanding workforce pressures affecting services relied upon by children, young people and families.[17] Recruitment and retention challenges are evident across health, social care and the early-years sector, with variation in age profiles, turnover and workforce stability across settings.[18] [19]

Early years staffing shows a differentiated pattern: the private sector workforce is generally younger, while the public sector workforce is older, each with distinct implications for continuity, succession, and skill mix.[20] The childminding workforce continues to age and

contract, reducing flexibility and geographic coverage, particularly in rural areas where childminders remain a vital part of local childcare infrastructure.[19] Together, these pressures reflect a widening gap between service demand and the available workforce, underscoring the structural fragility of provision across sectors that support children and young people.

These patterns underline the importance of maintaining awareness of workforce sustainability, including recruitment, retention, resilience, and the broader challenges associated with workforce flows, skills development, system-wide coordination, and adaptability, when shaping future service design and delivery.

Remoteness and rurality

The Scottish Urban Rural Classification (SGURC) is consistent with the government's core definition of rurality, which defines settlements of fewer than 3000 people as rural. It also classifies areas as remote based on drive times from settlements of 10,000 or more people.[21] Using population thresholds and access criteria creates layers of sophistication in the classification (Figure 11).

We focus on the population of Highland children and young people who potentially live at a distance from service points in our major population centres in remote and rural areas. These places include villages, islands, peripheral coastal communities, and small towns in remote and very remote locations.

Figure 11: Scottish Government Urban Rural Classification (8-fold)

Area Class	Definition
1. Large Urban Areas	Settlements of 125,000 people and over.
2. Other Urban Areas	Settlements of 10,000 to 124,999 people.
3. Accessible Small Towns	Settlements of 3,000 to 9,999 people, and within a 30-minute drive time of a Settlement of 10,000 or more.
4. Remote Small Towns	Settlements of 3,000 to 9,999 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more
5. Very Remote Small Towns	Settlements of 3,000 to 9,999 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more.
6. Accessible Rural Areas	Areas with a population of less than 3,000 people, and within a drive time of 30 minutes to a Settlement of 10,000 or more.
7. Remote Rural Areas	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more.
8. Very Remote Rural Areas	Areas with a population of less than 3,000 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more.

Source: Scottish Government Urban Rural Classification 2022

In Highland, almost one in four children and young people under 18 years reside in remote rural areas, with one in six living in very remote rural areas. In contrast, one in twenty-five children live in remote rural areas in Scotland, with around one in forty living in very remote rural areas.

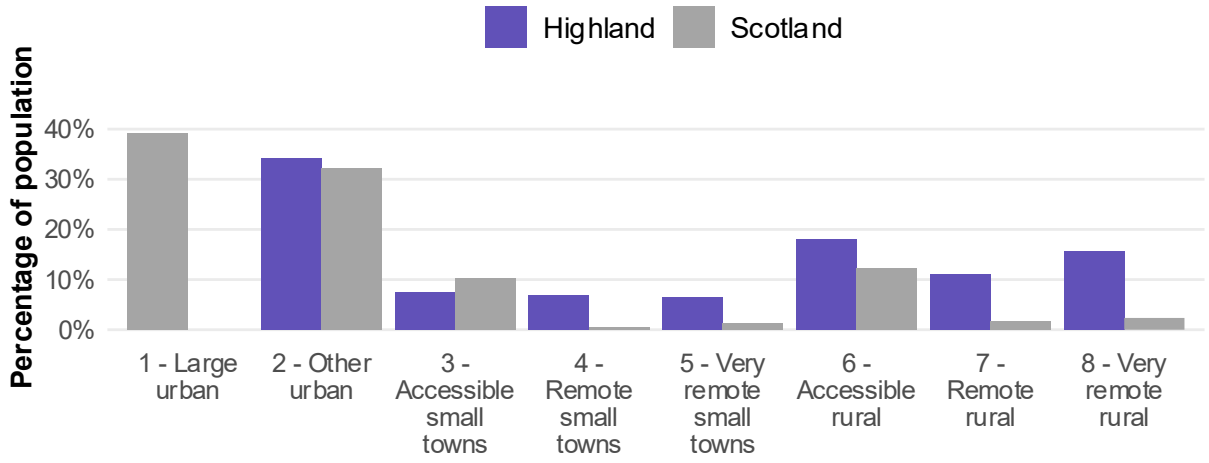
The table below shows the population under 18 years of age, but the distribution of children and young people is similar across the SGURC by age group in Highland (Figure 14).

Figure 12: Percentage of the population aged under 18 years of age living in urban and rural areas in Highland and Scotland in 2022

	Highland		Scotland	
	Population	**Percentage**	**Population**	**Percentage**
1 - Large urban			394,484	39.3%
2 - Other urban	14,439	34.3%	323,070	32.2%
3 - Accessible small towns	3,163	7.5%	103,223	10.3%
4 - Remote small towns	2,874	6.8%	5,833	0.6%
5 - Very remote small towns	2,716	6.5%	13,562	1.3%
6 - Accessible rural	7,601	18.1%	123,976	12.3%
7 - Remote rural	4,692	11.1%	17,005	1.7%
8 - Very remote rural	6,623	15.7%	23,611	2.3%
Total	42,108	100.0%	1,004,764	100.0%

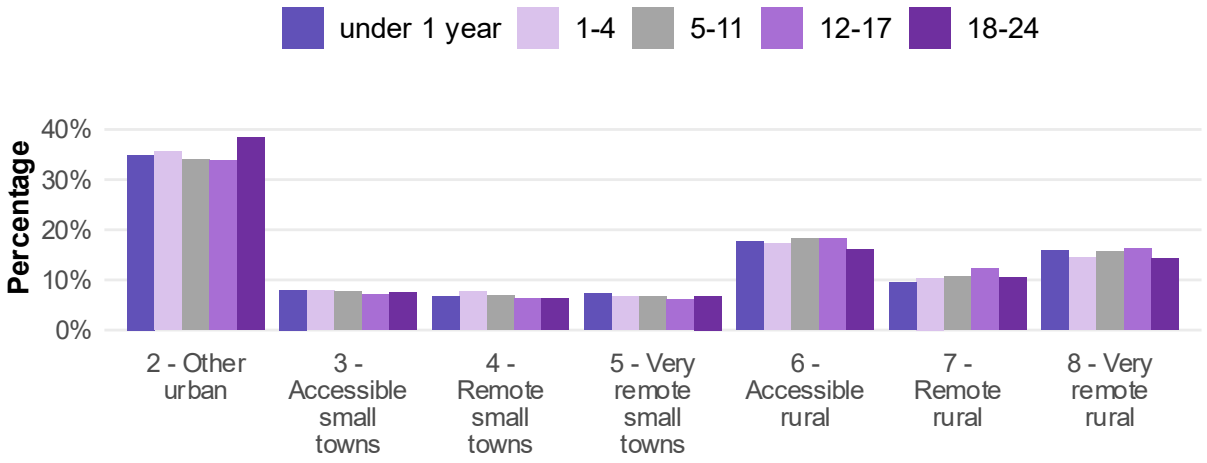
Source: National Records of Scotland. Output Area 2022 to Scottish Government Urban Rural Classification 2022. Scotland's Census 2022 Table UV103 – Age by single year

Figure 13: Percentage of the population aged under 18 years living in urban and rural areas of Highland and Scotland in 2022



Source: National Records of Scotland. Output Area 2022 to Scottish Government Urban Rural Classification 2022. Scotland's Census 2022 Table UV103 – Age by single year

Figure 14: Percentage of the population and young people living in urban and rural areas in Highland by age group in 2022



Source: National Records of Scotland. Output Area 2022 to Scottish Government Urban Rural Classification 2022. Scotland's Census 2022 Table UV103 – Age by single year

Policy concerns in rural and remote areas often focus on economic regeneration, employment, rural prices and poverty, housing and fuel poverty, and population ageing, particularly the retention of young adults in such communities. The needs of children and younger people living in these areas are often less directly recognised.[22]

Common issues experienced by children and young people, at varying intensity levels with increasing remoteness and rurality, are the impacts of poor transport infrastructure, limited local choices, isolation from peers and lack of opportunity to socialise outside school, and poorer digital connectivity. Remote and rural areas are also potential places where children and young people who differ from their peers because of protected characteristics are at higher risk of social isolation.[23]

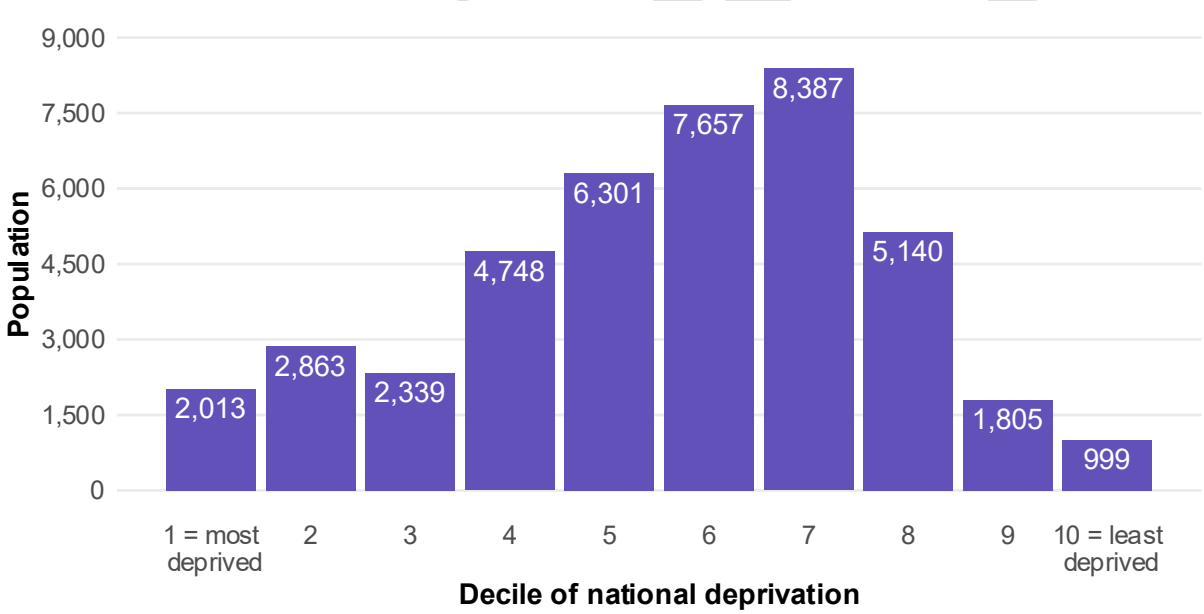
Research also points to the benefits of living in remote and rural areas, with people reporting a stronger sense of belonging and community than urban populations, better neighbourhood environments and higher levels of subjective wellbeing.[24] For organisations working in rural and remote locations, challenges to supporting children and young people are funding and achieving economies of scale in services, the availability of suitable premises and recruiting and retaining staff.[25]

Deprivation

National and local organisations can use the Scottish Index of Multiple Deprivation (SIMD) to identify areas of need and to allocate funding and resources. 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 similar populations of around 800 people. 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.[26]

Figure 15 shows a decile distribution of children and young people by national SIMD ranking. Most of the Highland population lives in areas ranked in deciles five to seven nationally. Targeting the most deprived ten percent would direct resources towards around 2,000 children and young people.

Figure 15: Number of children and young people aged under 18 years of age living in Highland in 2022 by national decile of the Scottish Index of Multiple Deprivation



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

There are 312 data zones in Highland, with 22 recognised as being in Scotland's most deprived 15 percent of areas. These 22 areas are seven percent of the Highland data zones and two percent of the national total. The locations have similar levels of deprivation as some of Scotland's most deprived urban areas.

Eight percent of Highland's children and young people live in these 22 areas. Most of this population lives in areas classified as urban (Inverness or Fort William) or remote and very

remote small towns. A single remote rural area in the Seaboard area of East Ross is identified. An estimated 152 children and young people live in this area, two percent of the total population in remote rural Highland (Figure 16).

Figure 16: The population of children and young people under 18 years of age who live in areas of Highland classed as the most 15 percent deprived in Scotland by the Scottish Urban Rural Classification

	Number living in the most deprived 15 percent of areas	Percentage of population living in the most deprived 15 percent of areas	Percentage of the population of the SGURC who live in the most deprived 15 percent of areas in Scotland	Percentage of the total population	Population total
1 - Large urban areas	0	0.0%	0.0%	0.0%	0
2 - Other urban areas	1,737	51.6%	12.0%	4.1%	14,439
3 - Accessible small towns	74	2.2%	2.3%	0.2%	3,163
4 - Remote small towns	865	25.7%	30.1%	2.1%	2,874
5 - Very remote small towns	523	15.5%	19.3%	1.2%	2,716
6 - Accessible rural	14	0.4%	0.2%	0.0%	7,601
7 - Remote rural	152	4.5%	3.2%	0.4%	4,692
8 - Very remote rural	0	0.0%	0.0%	0.0%	0
Total	**3,365**	**100%**	**8.0%**	**8.0%**	**35,485**

Source: Scottish Index of Multiple Deprivation 2020v2, National Records of Scotland Output Area 2022 to Scottish Government Urban Rural Classification 2022 and Scotland's Census 2022 Table UV103

The use of small areas in the SIMD helps to identify concentrations of deprivation potentially hidden in more extensive administrative geography, such as a Community Partnership or Council Ward. However, the Scottish Government acknowledge that the tool has limitations in rural areas where data zone populations are less socially and economically homogenous.

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 deprivation 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".[40]

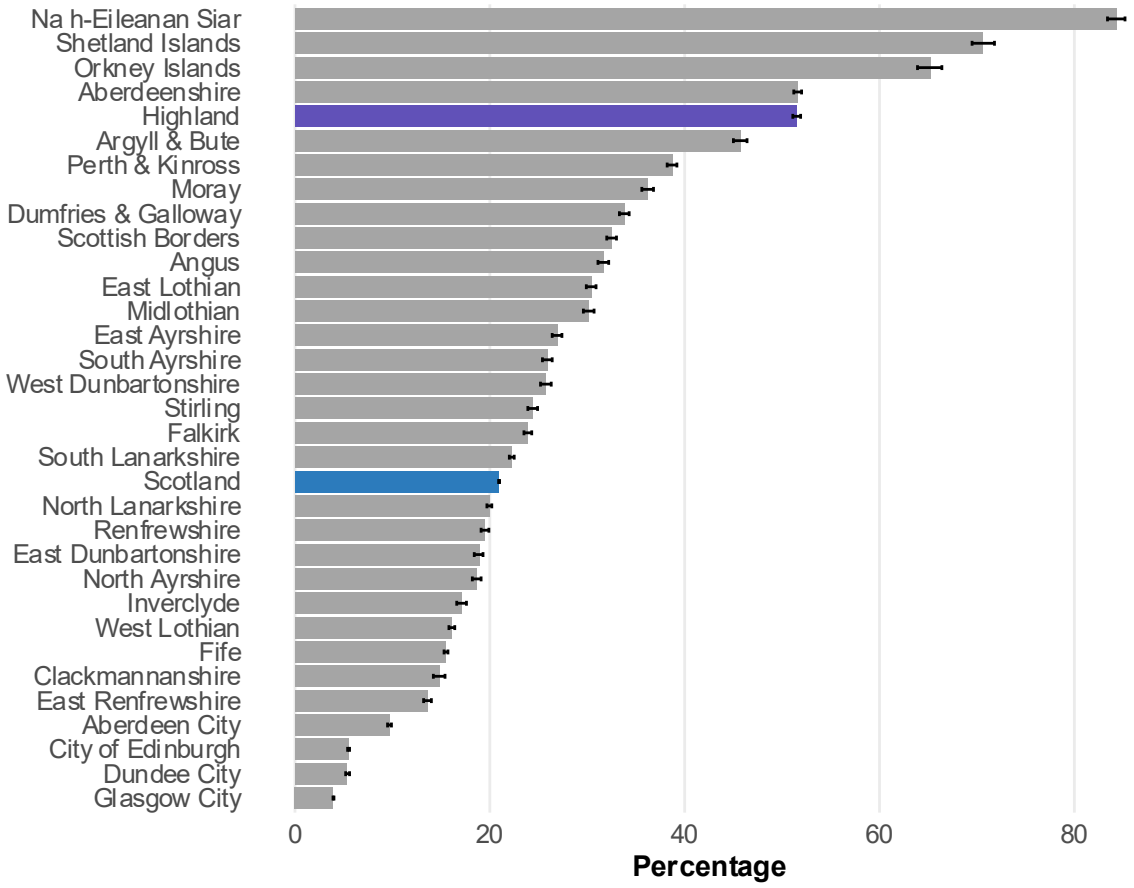
In Highland, more income deprived individuals live in places not identified among the most deprived areas by the SIMD.[27] Spatial targeting needs to consider the utility of the SIMD for that purpose, and, if necessary, use other data sources in conjunction.

Access deprivation

Rural areas have worse access in terms of distance to services, including health, public health and social care services. Transport is essential for children and young 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.[11]

The SIMD access domain identifies that fifty percent of children and young people live in the twenty percent most access deprived areas in Scotland, with residents experiencing longer travel times to local services and poorer digital access. The Highland area has many places among the very most access deprived nationally.

Figure 17: Young people living in the most access deprived quintile, aged 0-25 years in 2023



Source: ScotPHO Community Profiles - SIMD2020v2, Scottish Government and Public Health Scotland
1 Travel time indicators include drive times and public transport times. Drive times to GP surgery, Post Office, Retail Centre, Primary School, Secondary School and Petrol Station. Public transport times to GP surgery, Post Office and Retail Centre

3. Family Complexity and Children's Outcomes

• Family complexity is increasing in Scotland and in Highland, reflected in changes to household composition and family types captured by Scotland's Census 2022.

• Transitions matter: parental separation and re-partnering are associated with short-term increases in adolescent emotional/behavioural difficulties and with measurable stress responses.

• Kinship care is now the most common care setting among children who are looked after, with an informal kinship cohort existing outside looked after children (LAC) datasets; both require attention in planning.

• Children's voices emphasise participation, continuity and non-stigmatising support in complex family environments.

• The Promise is rooted in care-experienced children yet extends to prevention and whole-family support, making its foundations relevant to informal kinship and family complexity.

• The Community Planning Partnership (CPP) can coordinate early help, reduce fragmentation of services, and ensure voluntary, family-led pathways, while advocating on national levers (e.g., social security, housing supply, transport and workforce) that impact the most vulnerable families.

Family complexity and stability in children's lives

Family environments across Europe and the UK have become more complex, with higher rates of cohabitation, parental separation and re-partnering, blended households with half- or step-siblings, and informal care within wider family networks.[28] [29] [30] The increasing rates of family transitions, such as separation/divorce and re-partnering, are associated with greater risks of children internalising difficulties (e.g., anxiety/low mood), externalising difficulties (e.g., conduct problems), and measurable stress biomarkers, independent of socio-economic status and inter-parental conflict.[29] [31]

Scotland's Population Health Framework, the Promise and the Marmot principles provide an appropriate lens for planning support for families experiencing instability.

Family constructs in Highland

Family life in Highland is shaped by a mix of household forms and partnership statuses, with patterns that matter for how children experience daily routines, care, and access to services.

We use Scotland's Census 2022 as a common lens: household composition (table UV113) provides the population structure, and marital/civil status (tables UV104/UV104b) offers a wider context for parental arrangements. Together, they summarise the breadth of lived family settings.[32] [33]

What the household data tells us

Many homes in Highland remain one-family households, and a sizeable minority are one-person or other household types. The latter can reflect shared living or extended arrangements and, while small, are important where local informal support is limited.

Against this backdrop, multi-generational households are relatively uncommon. Using a cautious proxy from the Census 2022 based on "Other household types" with dependent children, shares are around 1.20 percent in Highland and 1.45 percent nationally. In practice, this suggests that informal intergenerational care (for example, regular grandparent support in the same home) is not widely available, so families rely more on flexible formal provision and on transport to access support in rural areas when parents are working or in education or training.[15]

Households with adult children at home are more visible. In Highland, 9.2 percent of households are one-family households with all children non-dependent, compared with 10.1 percent nationally. These proportions align with later educational attainment, housing constraints, and shifting labour markets, and they point to ongoing parental support into later adolescence and early adulthood.[21] [22]

What the partnership data adds

Partnership status provides helpful context for non-marital parenting and blended families. In Highland, around one-third of adults 16+ are never married, about half are married or in a civil partnership, with smaller shares separated, divorced, or widowed. While these are administrative categories, they help services recognise varied legal statuses and the practical realities of co-parenting or step-family arrangements.[34]

Transitions into parenthood continue to shift. Scotland-wide, about 55 percent of live births in 2022 were to unmarried parents, reflecting continued growth in cohabitation and non-marital registrations.

These structural changes have important implications for early years care, particularly where informal support is sparse, and household transitions are common.

Figure 18: Family constructs in Scotland and Highland at Census 2022

Construct/category	Scotland – Count	Scotland – %	Highland – Count	Highland – %
Household composition – people (Census 2022, UV113)				
All usual residents in households	5,196,386		228,364	
One person	823,314	15.84%	32,378	14.18%
One family only - total	3,949,167	76.00%	178,993	78.40%
• Married couple	2,321,902	44.68%	107,713	47.17%
• Cohabiting couple	600,237	11.55%	28,681	12.56%
• Lone parent	664,255	12.78%	24,940	10.92%
Other household types	423,905	8.16%	16,993	7.44%
Households with non-dependent children (i)	253,820	10.12%	10,283	9.20%
Multi-generational households (ii)	36,313,	1.45%	1,340	1.20%
Marital & civil status (Census, UV104b, age 16+)				
Total age 16+	4,548,588		198,110	
Never married and never registered in a civil partnership	1,734,437	38.13%	66,108	33.37%
Married or in a registered civil partnership	2,001,203	44.00%	93,250	47.07%
Separated (still legally married/in a civil partnership)	111,420	2.45%	4,815	2.43%
Divorced or civil partnership dissolved	381,245	8.38%	18,636	9.41%
Widowed or surviving civil partnership partner	320,296	7.04%	15,301	7.72%

Data sources
• Household composition (Census 2022, UV113) – people: all usual residents in households (persons).
• Marital & civil status (Census 2022, UV104/UV104b): persons aged 16+ (households and communal establishments)
Notes
I Definition (households with non-dependent children). Measure counts one-family households where all children are non-dependent (aged 16+ and not in full-time education). Households with both dependent and non-dependent children are classified under dependent-child categories and not captured here.
II. Proxy definition (multi-generational households). 'Multi-generational households (proxy)' are defined as Other household types with dependent children (one or two+). The proxy may undercount multi-generation arrangements and may include non-family co-residents.
III. Comparability and geography. Local authority results may mask neighbourhood-level variation due to rurality and small counts. Percentages use All households as denominators.

Evidence

Scottish evidence linking family structural transitions to child health, development and education outcomes is limited, with no dedicated published studies identified that quantify causal pathways; however, Scotland has longitudinal resources (e.g., the Scottish Longitudinal Study) capable of supporting such analyses in the future.[35]

The Growing Up in Scotland (GUS) cohort shows that around one in ten children (11 percent) experienced parental separation within the first five years of life, and that separation is associated with increased likelihood of low household income, maternal mental health difficulties, and housing instability. These risk factors are known to affect children's emotional wellbeing and developmental trajectories.[36] The GUS findings are associations rather than proven causal effects, given the complex interplay of timing, parental conflict, and wider socio-economic circumstances reported in the study.[25]

UK longitudinal evidence strengthens the associative picture. The Millennium Cohort analyses report detrimental short-term mental health impacts when separation occurs in late childhood/early adolescence, controlling for prior maternal/child mental health and family factors. The Avon Longitudinal Study of Parents and Children (ALSPAC) show adverse childhood experiences, including parental separation, are associated with lower GCSE attainment and higher depression, smoking and drug use by age 17 after extensive adjustment.[37] [38]

Children's voices on parental transitions

Accounts from young people in Scotland emphasise a clear preference to be heard and involved in decisions following parental separation or re-partnering, alongside concern about the emotional impact of changes to routines, living arrangements and contact with parents. A Scottish Youth Parliament survey collected first-hand accounts from young people (predominantly 12–25 years), describing distress linked to family change and advocating choice about participation in decisions that was captured in the prompt "Who should have a say? You." [39]

Qualitative syntheses of children's experiences in separation contexts similarly report that children want to be engaged in decision-making and value processes that recognise their views but note that adults and professionals often act as gatekeepers, which can limit the expression and practical influence of children's perspectives.[40]

A small study of children living in kinship care in northeast Scotland reported a strong sense of belonging - "just another home, just another family" - while also describing uncertainty about

identity, birth-parent contact and social perceptions.[41] UK research on new stepfamilies echoes this duality: children valued open communication and emotional access to both biological and step-parents, but reported daily stress in blending routines, negotiating roles, and managing loyalty conflicts, even in low-conflict households.[42]

The Promise

The Independent Care Review listened to over 5,500 experiences and concluded in February 2020 with The Promise, setting a national ambition that children 'grow up loved, safe and respected' and committing Scotland to implement the changes by 2030, guided by five foundations: Voice, Family, Care, People, Scaffolding.[43] While The Promise is rooted in transforming the system for care-experienced children, its foundations also extend to preventing unnecessary entry into care through whole-family support, making the principles relevant to informal kinship care and family complexity.[32] [44]

Kinship care

Kinship care refers to children living with relatives or close family friends when they cannot live with their parents, either as part of the looked-after system (formal kinship care) or through private/civil arrangements (informal kinship care).[45] In line with The Promise, Scotland's policy direction is to support children within their families and communities wherever safe and in their best interests, and the use of kinship care has grown substantially over the last decade.[35] However, Kinship carers often receive minimal training and support, even though they are approved and paid carers.

Within national administrative LAC statistics, the use of kinship care has risen markedly, from ~1 in 6 (2008) to ~1 in 3 (2023), but with substantial variation across local authorities and a higher prevalence in areas of greater deprivation.[35]

A national administrative-data linkage study published in 2024 by the Centre for Children's Care and Protection (CELCIS) and the Scottish Centre for Administrative Data Research (SCDAR) covering over 19,000 children who lived in formal kinship care between 2008 and 2019 reports that kinship care is now the most common care setting among children who are looked after, and that around 40 percent of children who lived with kinship carers did not experience any other alternative care (such as foster care or residential placements) during the period studied.[46]

While many children thrive in kinship care, kinship families often support children with the most complex needs, with these children more likely to have Additional Support Needs recorded than children in the general population (72 percent vs 31 percent) and around twice

as likely to have developmental concerns identified by their health visitors between the ages of 2.5 and 5 years old.[35] Children in kinship care also experience poorer educational outcomes and five times higher school exclusion rates than the general population.[32]

Census-based national statistics estimate 12,800 children under 18 in kinship care in 2022 (with around two-thirds in informal care), underscoring a large kinship cohort outside looked-after administrative datasets being cared for by families and friends.[47]

In Highland, Census-derived whole-population estimates suggest ~420 children were living in kinship care in 2022 (rate: 10.1 per 10,000), including both formal looked-after arrangements and informal kinship households.[48]

Taken together, the implications of whole-family support for Highland include the need for earlier identification of children in families in complex transitions, proportionate family support, financial advice and housing help, education support, and consistent carer support, with equivalent early-help pathways for informal kinship households who sit outside looked-after datasets.[32] [44]

Whole Family Wellbeing Programme (WFWP)

The Whole Family Wellbeing Programme is a Scottish Government initiative to transform family support through integrated, preventative and wraparound services, allowing families to access help early and for as long as needed, aligned with GIRFEC, The Promise and the UNCRC.[49]

In Highland, delivery is overseen by the Integrated Children's Services Planning Board and the Community Planning Partnership, with multi-agency implementation across the local authority, NHS and third-sector partners, focusing on coordinated, holistic support and system change.[50]

The programme's strategic fit within this chapter on changing family structures is clear: flexible, family-centred approaches are designed to address needs across single-parent households, blended families, and other family structures most likely to fall within the six nationally identified priority family types, strengthening resilience and reducing fragmentation in access to services.

The Scottish Government's Best Start, Bright Futures: Tackling Child Poverty Delivery Plan identifies six family types as being at the greatest risk of experiencing child poverty in Scotland.[51] These groups underpin the targeting approach of the Whole Family Wellbeing Programme and reflect structural changes in family composition and support needs:

- Lone-parent families: increased risk due to caring responsibilities, constraints on employment and wage gaps.
- Families with a disabled adult or child: higher living costs and barriers to employment, with greater demand for support.
- Larger families (three or more children): cumulative cost pressures, benefit caps and housing affordability issues.
- Minority ethnic families: additional barriers through labour market discrimination, insecure work and housing inequalities.
- Families with a child under one: elevated costs associated with parental leave, childcare and early years.
- Mothers aged under 25: disproportionate representation in low-income households, often with limited support networks and constrained employment.

Further information on the six family types is provided in Section of this report.

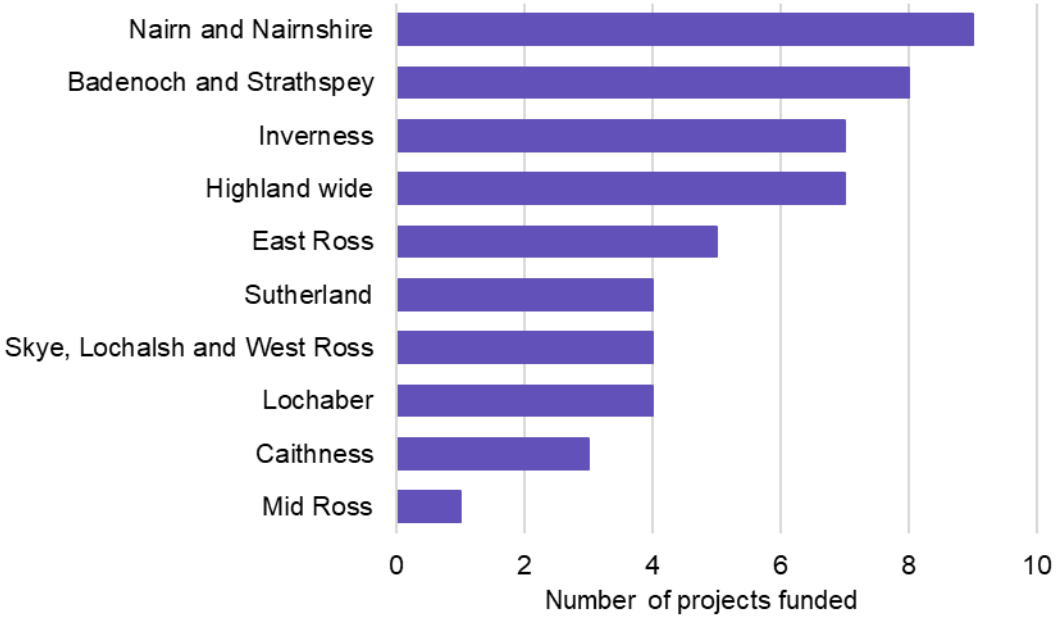
Delivery of the WFWP in Highland spans three funding elements:

- Element 1 supports small, community-led early help initiatives across the nine localities, and 52 awards have been issued, with the fund operating on a rolling basis.
- Element 2 comprises locality collaborative projects and whole-system tests of concept; Highland has funded 17 whole-system tests, with £3.379 million committed to date, and one locality test has been approved, with the locality fund largely uncommitted, providing scope to expand.
- Element 3 is being used to translate successful tests into longer-term strategic commissioning.

Funded activities support single parent, blended, and kinship households by addressing isolation, practical access barriers, and the need for early, holistic help close to home. Community-level small grants, under Element 1, provide flexible supports aligned with local needs, while whole-system tests, under Element 2, target multi-agency pathways that reduce fragmentation for families with multiple support needs, including kinship care arrangements.

The programme's focus on localities and its use of data on the distribution of priority family types provide a consistent framework for addressing structural inequality across Highland.

Figure 19: Distribution of community-led initiatives funded by the Whole Family Wellbeing Funding in Highland, January 2026



Source: Highland Whole Family Wellbeing Funding Activity

The Whole Family Wellbeing Funding (WFWF) is not an open grant scheme for individuals or organisations to apply to. Instead, funding is directed to Children's Services Planning Partnerships (CSPPs) to support local system change for families in line with GIRFEC and The Promise.

In Highland, proposals are developed and agreed upon within partnership governance, rather than through a public competitive call, to ensure alignment with locality-identified needs, the six national priority family types, and the national principles of holistic, whole-family support.

Data challenges for local identification of need

Measures of family complexity are unevenly recorded across administrative sources, with sibling composition and transitions (separation, re-partnering) under-captured, despite their association with child outcomes.[15 18 28 29]

Informal kinship arrangements are not adequately captured across data systems, and local administrative datasets rarely link guardianship/relationship indicators across education, health visiting and social care, reducing visibility until needs escalate.[32]

UK trauma-informed guidance supports using relational indicators alongside deprivation to anticipate multiple transitions and plan early, proportionate support.[52 53]

What this means for Highland

National policy sets ambitious goals for whole-family support under The Promise, but Community Planning Partnership (CPP) influence primarily lies in coordination, early identification, and local service alignment across health visiting, schools, primary care, housing, and advice partners.

CPPs cannot resolve structural poverty drivers, yet can mitigate impacts by ensuring timely, voluntary support and by reducing service fragmentation. Interventions should be enabling and proportionate, and consistent with The Promise's principle of support, not surveillance, and its emphasis on sustaining safe, loving family relationships and prevention through whole-family support.[32 44]

Given changing family structures and working patterns that limit informal childcare, CPP partners should ensure sufficient, flexible nursery and wraparound provision, and workforce capacity, adapted to distance and transport needs in rural settings, and aligned with Scotland's 1140 hours of early learning and childcare duties.

Consideration should be given to:

- Linking datasets spanning education, health visiting, and social care to enable early identification and proactive support for families undergoing transitions, supported by data-sharing arrangements under children's rights.
- Establishing a voluntary registration pathway for kinship and complex caregiving through schools, primary care, and community hubs, with clear messaging on benefits, confidentiality, and rapid connection to support.
- Implementing proportionate universalism by enhancing universal offers of care and support with greater intensity for families in deprived areas, for families in need identified within the six priority types that account for 90 percent of children living in poverty, and for families experiencing multiple or complex transitions.
- Strengthen third-sector partnerships to extend outreach and advocacy, ensuring provision across rural and remote communities where access barriers are higher.
- Tracking appropriate child wellbeing metrics to inform prevention and service design.

4. Child poverty

Child poverty is not only a social and economic challenge, but a breach of children's rights as set out in the United Nations Convention on the Rights of the Child (UNCRC). The UNCRC (Incorporation) (Scotland) Act 2024 places a legal duty on public bodies to act compatibly with children's rights, including a statutory obligation to reduce child poverty. Poverty undermines children's rights to an adequate standard of living, health, education, play, and protection from harm (UNCRC Articles 6, 24, 27, 28, 31). Tackling child poverty in Highland is therefore essential to fulfilling our responsibilities under the UNCRC and ensuring every child can thrive.

Why This Matters

- Around 22 percent of children in Highland live in relative poverty after housing costs, slightly below the Scottish average, but still significant.[54]
- Child poverty is strongly linked to health inequalities and life-course outcomes, influencing physical health, mental wellbeing, and educational attainment.[55]
- Drivers include low wages, high housing and childcare costs, and rural living expenses, with in-work poverty common in sectors such as hospitality and care.[56]
- Priority groups at higher risk include lone-parent families, minority ethnic households, families with disabled members, and those in remote rural areas.[57]
- Lived experience evidence highlights the cost of the school day, digital exclusion, and transport barriers as significant sources of stress and stigma.[58]
- National targets under the Child Poverty (Scotland) Act 2017 are not being met, requiring urgent action and investment in social security, housing, and childcare. [46]

Child poverty is a critical determinant of health and wellbeing. Experiences of poverty in childhood shape outcomes across the life course, influencing physical health, mental wellbeing, educational attainment, and future economic security.[48] Tackling child poverty is central to reducing health inequalities and achieving the ambitions of the Scottish Population Health Framework and Marmot Principles.

Policy Context

The Child Poverty (Scotland) Act 2017 sets statutory targets to reduce child poverty by 2030, supported by the Scottish Government's Tackling Child Poverty Delivery Plan and Best Start, Bright Futures.

From July 2024, the UNCRC (Incorporation) (Scotland) Act requires all public authorities, including Highland Council and NHS Highland, to ensure that decisions, policies, and budgets

uphold children's rights. This includes the statutory duty to produce Local Child Poverty Action Reports (LCPARs) that demonstrate how local actions contribute to realising children's rights.

Locally, the current Highland Child Poverty Action Plan aligns with these commitments, focusing on employment income, the cost of living, and income from social security.[47]

Despite progress, the Poverty and Inequality Commission reports that interim child poverty targets have been missed and calls for urgent, ambitious action.[49]

Definitions and Measurement

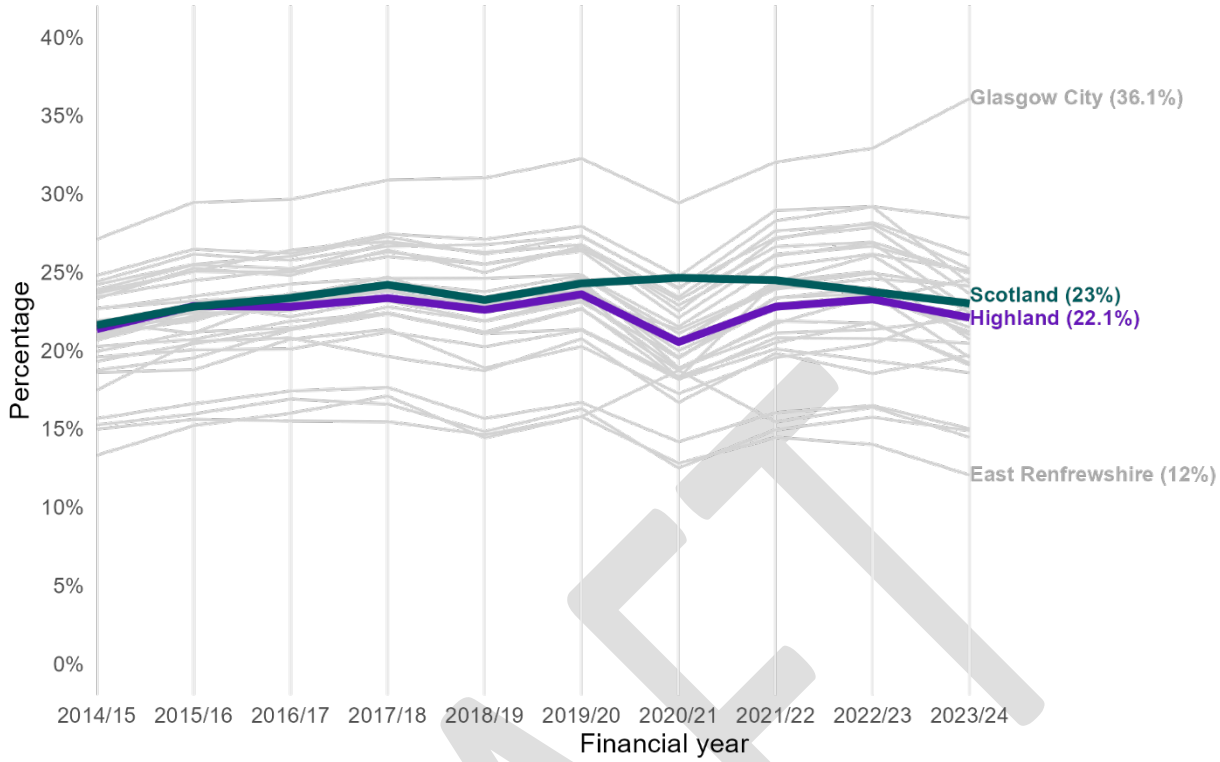
Child poverty is commonly measured as relative poverty after housing costs (AHC), defined as households with income below 60 percent of the UK median after housing costs are deducted. This measure reflects disposable income more accurately than before housing costs, particularly in rural areas where housing and transport costs are high.[48] Other indicators include material deprivation and persistent poverty.

Current Situation in Highland

An estimated 22 percent of children in Highland live in relative poverty AHC, compared to 23 percent nationally.[59] Trends have remained broadly stable over the past five years. At the national level, recent analysis suggests reductions in urban poverty and increases in rural poverty, but these changes may fall within sampling variability and should be interpreted cautiously. However, deep poverty - families far below the poverty line - is increasing across Scotland.[49]

Rurality adds complexity: higher living costs and limited access to affordable childcare and transport exacerbate disadvantage.[48] Although headline rural poverty rates remain lower than urban rates, the reported rise from 15 percent to 21 percent nationally highlights structural challenges in rural communities, including cost pressures and service access limitations.[60] These trends suggest that rural families may be disproportionately affected by economic stressors, even where overall prevalence appears stable.

Figure 20: Proportion of children in relative poverty after housing costs – Highland vs Scotland, trend over time



Source: End poverty coalition

Drivers of Child Poverty

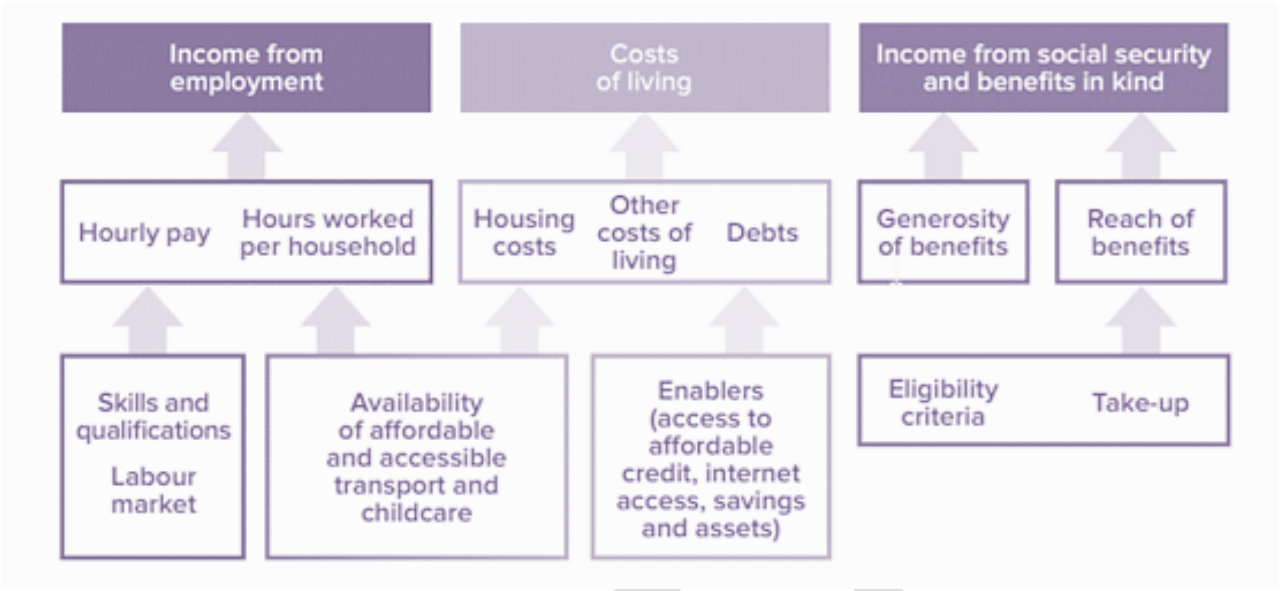
Actions in Best Start, Bright Futures focus on three key drivers of child poverty: employment income, living costs, and income from social security.[52]

However, essential costs for housing, energy and childcare have outpaced wage growth and benefit uprating, leaving many families unable to meet minimum living standards. The Child Poverty Action Group (CPAG) estimates the current cost of raising a child to age 18 at £250,000 for couples and £290,000 for lone parents, while out-of-work families can cover only 37 percent of basic costs.[61] Real-terms cuts to social security, the two-child limit, and the benefit cap deepen this affordability gap, particularly for larger families.[53]

Key drivers include:

- Low wages and insecure employment, particularly in hospitality, retail, and care sectors.[46]
- High housing and childcare costs absorb a large share of household income. [46]
- Transport and digital exclusion limit access to services and opportunities.[48]
- Structural factors such as social security adequacy and cost-of-living pressures. [46]

Figure 21: Drivers of child poverty



Source: Scottish Government, Every Child, Every Chance, 2018

The recent small, but not statistically significant, reduction in the proportion of children in poverty has been linked to the Scottish Government's use of the Scottish Child Payment to mitigate hardship.[49] In 2024/25, 1,075 children under 16 in Highland living in low-income families received the Scottish Child Payment from newly submitted applications.[62]

However, as noted by the Poverty and Inequality Commission, progress on the other drivers is less clear, given the restrictions on funding for other significant actions in *Best Start and Bright Futures*, including early learning and childcare and school-age childcare. [49]

Recent modelling indicates that increasing the Scottish Child Payment to £40 per week and removing the two-child limit for Universal Credit and Child Tax Credit could reduce child poverty in Scotland to below 15 percent by 2030. Under current policy plans, rates are projected to remain above 20 percent. The report emphasises that UK-level measures such as the two-child limit and the benefit cap continue to pose significant barriers, and it calls for sustained investment in social security, alongside childcare and housing interventions, to achieve long-term reductions in poverty.[63]

Impact on Children and Young People

Poverty affects every aspect of childhood, shaping health, education and wellbeing outcomes in ways that persist across the life course. Children living in low-income households are more likely to experience poor nutrition, chronic illness and mental health problems, with evidence linking poverty to higher rates of low birth weight, obesity and hospital admissions.[48] [64]

Educational attainment is consistently lower among children in poverty, compounded by reduced participation in extracurricular activities and limited access to enrichment opportunities.[51] [65] Beyond material deprivation, poverty exerts a profound psychosocial toll: stress, stigma and social isolation are recurring themes in children's voices, reflecting the emotional burden of financial hardship.[48] [53]

These disadvantages accumulate, leading to poorer outcomes in adulthood, including higher morbidity rates and reduced economic security.

Income instability and financial uncertainty

Poverty is not a fixed state for many families. Children often experience repeated transitions in and out of poverty due to insecure work, fluctuating hours of employment and changes in benefit entitlement. This financial uncertainty creates stress and anxiety for parents and children, undermining wellbeing and family stability. Evidence shows that even short periods of poverty can have lasting effects on health and educational outcomes, while deep and persistent poverty is linked to severe material deprivation and long-term disadvantage.[49] [50] [66]

Families in Highland received Best Start Grants and Best Start Foods, providing help with costs at key stages of childhood.[67] These payments reduce financial pressure on families at critical points, helping to improve nutrition, support early learning, and ease school costs -key factors in mitigating child poverty. 2024/25 applications:

- Pregnancy and Baby Payment (under 6months): 1,030
- Best Start Foods (Pregnant or child under 3): 1,370
- Early Learning Payment (2.6 years to 3.6 years): 340
- School Age Payment (around 4.5–5.5 years): 135

From 2019/2020 onward, Highland had a downward trend across all Best Start application types. The Pregnancy and Baby Payment remained relatively stable, falling slightly from 1,075 to 1,030, while Best Start Foods declined from 1,555 to 1,370 after peaking at 2,735 in 2020/2021, yet continued to be the highest overall application. In contrast, Early Learning and School Age Payments experienced steep drops, with Early Learning falling from 1,490 to 340 and School Age from 855 to 135. Nationally, overall applications also declined after an early peak, but the mix differs: Scotland saw School Age Payment grow to around one-third of applications and Pregnancy and Baby Payment fall to under one-fifth, whereas Highland moved in the opposite direction, maintaining high numbers for pregnancy-related and food support. Both Highland and Scotland share a marked decline in Early Learning Payment uptake, this may suggest less knowledge or promotion of this grant.

Highland Context

In Highland, the impact of poverty is amplified by geography and service access. Families in rural and remote areas face additional costs for transport and heating, alongside limited availability of affordable childcare and extracurricular opportunities.[49 68] Digital exclusion remains a barrier to accessing benefits and educational resources, particularly in communities with poor connectivity. [49] Health inequalities manifest in poorer health outcomes and challenges in accessing specialist care due to distance.[53] Local evidence suggests that stigma and isolation may be intensified in small communities, where poverty is more visible and support networks are fragmented.[49 57]

Groups at Higher Risk

There is a significant overlap between poverty and equality dimensions with age, gender, ethnicity and disability characteristics of families identified as placing children more at risk.[50]

Family types at disproportionate risk:

- Lone-parent households
- Families with disabled children or parents
- Minority ethnic families
- Larger families with three or more children
- Families with a child under one year of age
- Families where the mother is less than 25 years old
- Families in remote rural areas, where costs are higher and services are less accessible

Most children in one of the priority groupings live in family circumstances where they experience combinations of these overlapping factors that can result in long-term severe poverty.[58] For some multiple priority families, such as children in households with a baby under one and children with a mother under 25, over half of these family types are also in households in three or more other priority groups.[69]

These groupings do not cover all the family types at higher risk of poverty, with around one in ten children in poverty living in households with none of these characteristics.[58] There will also be children living in families where these circumstances apply who do not experience poverty.

Figure 22: Estimated number of households in priority risk groups for child poverty

Measure	Highland	Scotland
Households with dependent children[1]	13,200	556,900
Families with children receiving support from Universal Credit[2]	8,270	233,072
Lone parent families on Universal Credit [3]	5,962	173,451
Lone parent families with dependent children[4]	6,067	145,625
Large families (3+ children) on Universal Credit[5]	1,719	46,242
Households with dependant children where someone has a disability[6]	3,113	91,401
Children under 1[7]	1,748	45,763
Mothers under 25[8]	263	6,225
Ethnic minorities population under 25[9]	2,521	171,509

1: Nomis official census and labour market statistics, Annual population survey, 2023
2: Stat-Xplore, Households with dependent children receiving support from Universal Credit, August 2025
3: Stat-Xplore, Lone parent households with dependent children receiving support from Universal Credit, August 2025
4: Scotland's Census 2022, Lone parent households with dependent children
5: Stat-Xplore, Households with 3 or more dependent children receiving support from Universal Credit, August 2025
6: Stat-Xplore, Households with dependent children receiving support from Universal Credit with Disabled Child Entitlement and/or Limited Capability for Work Entitlement, August 2025
7: National Records of Scotland, Births Time Series Data,2024
8: National Records of Scotland, Births Time Series Data, 2024
9: Scotland's Census 2022, Ethnic minorities include: White: Gypsy/ Traveller, Mixed or multiple ethnic groups, Asian, Asian Scottish or Asian British: Total, African: Total, Caribbean or Black: Total, Other ethnic groups: Total.

Free school meals

Free school meals (FSM) are considered a critical tool for mitigating the adverse health effects of child poverty among low-income families. They can improve health and wellbeing and reduce health inequalities.

Since January 2015 all primary one to three pupils in Scotland attending schools run by the council have been entitled to receive free school meals during term time. In the 2021/22 school year this universal provision was extended to include all P4 pupils and was extended again from 2022/23 to include all P5 pupils and all pupils in special schools.

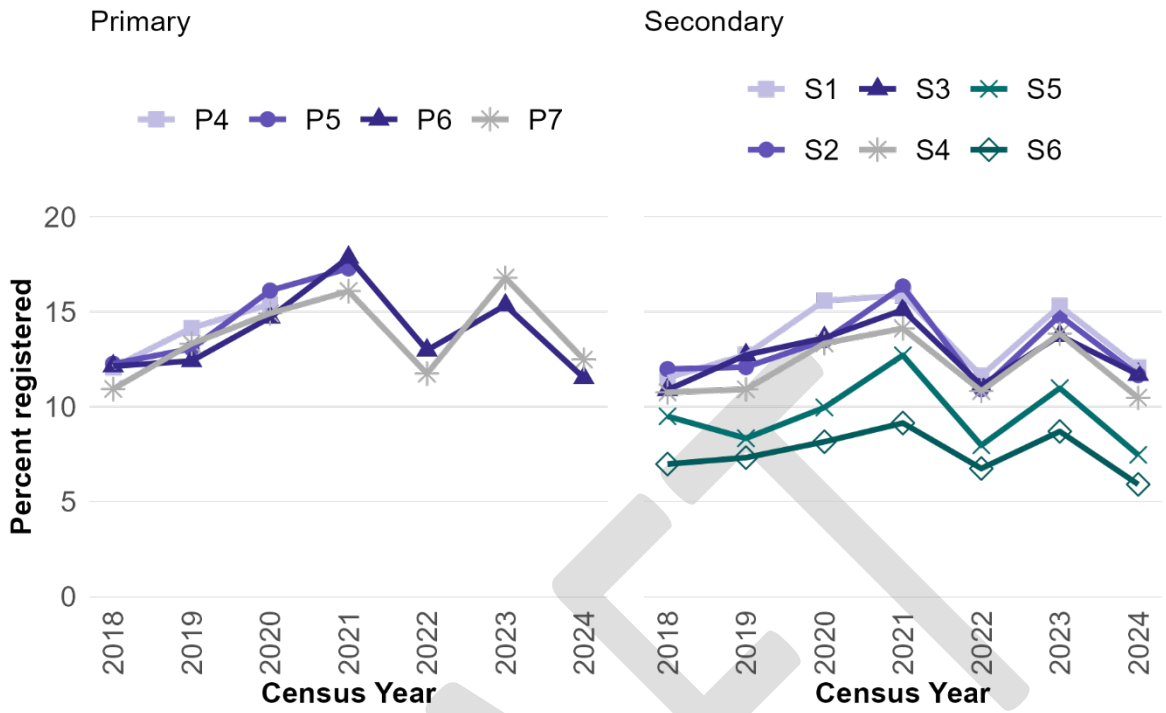
Currently primary six up to secondary year six pupils are only entitled to a free school meal if their household receives one of several qualifying benefits. For children in households that are experiencing financial hardship but not receiving a qualifying benefit (e.g. due to immigration status), FSM may still be provided.

Registration (with qualifying benefits) for free school meals is considered a marker of poverty due to its restrictive criteria. Children registered for FSM are more likely to be living in low-income households. However, evidence suggests that many poorer families are slipping through the FSM net due to restrictive eligibility thresholds, leading to greater levels of food insecurity among children.[70]

In 2024, around 12 percent of primary school and ten percent of secondary school pupils were registered (with qualifying benefits) for free school meals in Highland (Figure 21) but did vary between different schools. Across secondary school stages the lowest percentages registered are seen in secondary year five and six. In all school stages the percent of pupils registration for FSM (with qualifying benefits) has reduced over the last few years. Free school meal registrations are affected by changes to the eligibility criteria and the economic circumstances of pupils and their parents.

The Scottish Government has plans to continue expansion of the free school meals programme as a key driver in its national mission to eradicate child poverty. The latest phase of this is a trial offering FSM to S1 to S3 pupils who are in receipt of the Scottish Child Payment, at selected schools in eight local authority areas, which started in August 2025.

Figure 23: Percentage of pupils registered (with qualifying benefits) for free school meals by stage in Highland



Source: Scottish Government School Education Statistics, Pupil Census
Note: From 2015 onwards all P1-P3 pupils were entitled to FSM; from 2021 onwards all P4 pupils were entitled to FSM; from 2022 onwards all P5 pupils were entitled to FSM. These school stages are not plotted in the chart after the point at which all pupils became entitled to FSM as registration for this was no longer based on qualifying benefits.

5. Pregnancy and births

Giving every child the opportunity to start well in life requires a whole-system approach that integrates maternity, neonatal and early years services with wider action on the social determinants of health. Services should be person-centred, trauma-informed, and rights-based, with equitable access across urban and rural communities. Policy drivers include national maternity and newborn care guidance and standards, GIRFEC, the UNCRC, and local strategies to tackle health inequalities and child poverty.

In Highland, recent birth cohorts are characterised by small numbers, and the remote, rural settlement geography of the area further complicates the picture, particularly for children with specific needs. For some events and outcomes, numbers are small, making it difficult for service providers to achieve economies of scale and sometimes masking significant local variation in need and access. To address these challenges, services should be designed and delivered according to the principle of proportionate universalism, providing universal support while allocating additional resources and targeted approaches where need is greatest.

The section that follows sets out trends in pregnancy, birth and antenatal care, highlights vulnerability factors that influence outcomes, and signals the implications for service quality, capacity and workforce.

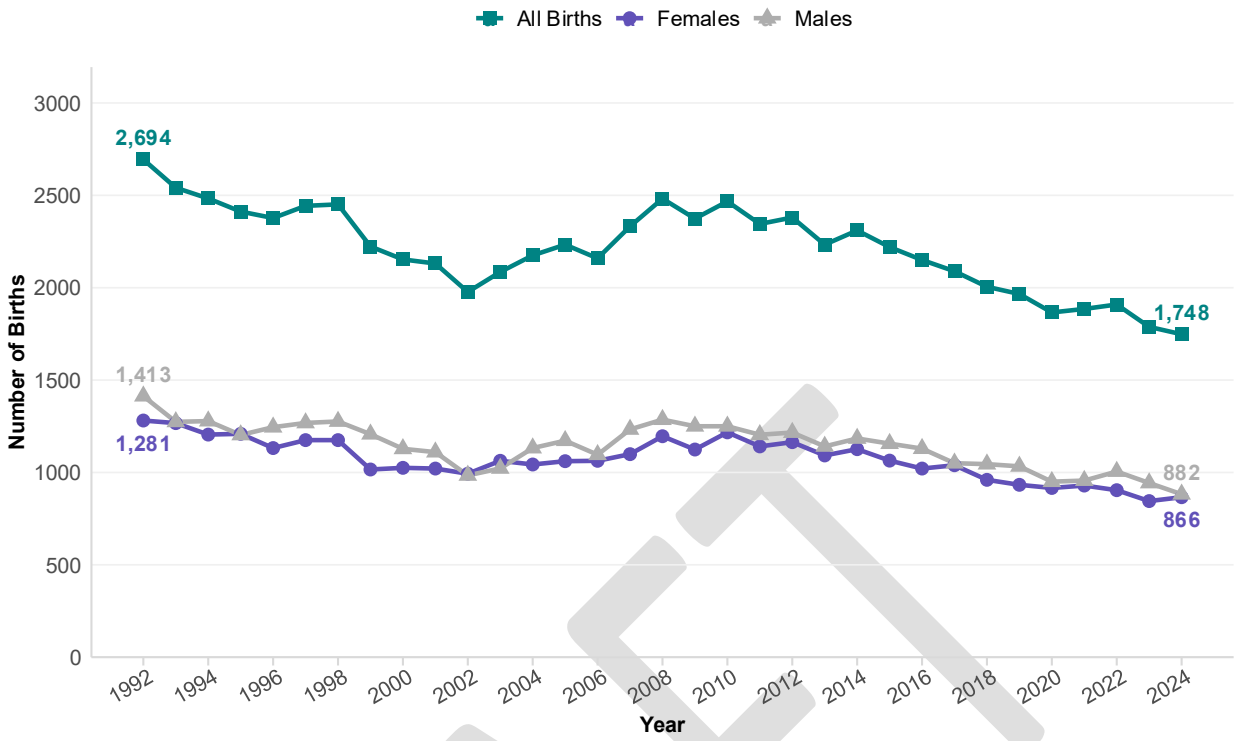
Births and fertility

In 2024, 1,748 live births were registered to Highland residents, a slight decrease from 2023, reflecting the sustained national decline in births reported by the National Records of Scotland.

General fertility rates in Highland have remained above Scotland overall but have followed the same post-2008 downward trend (Figure 25).

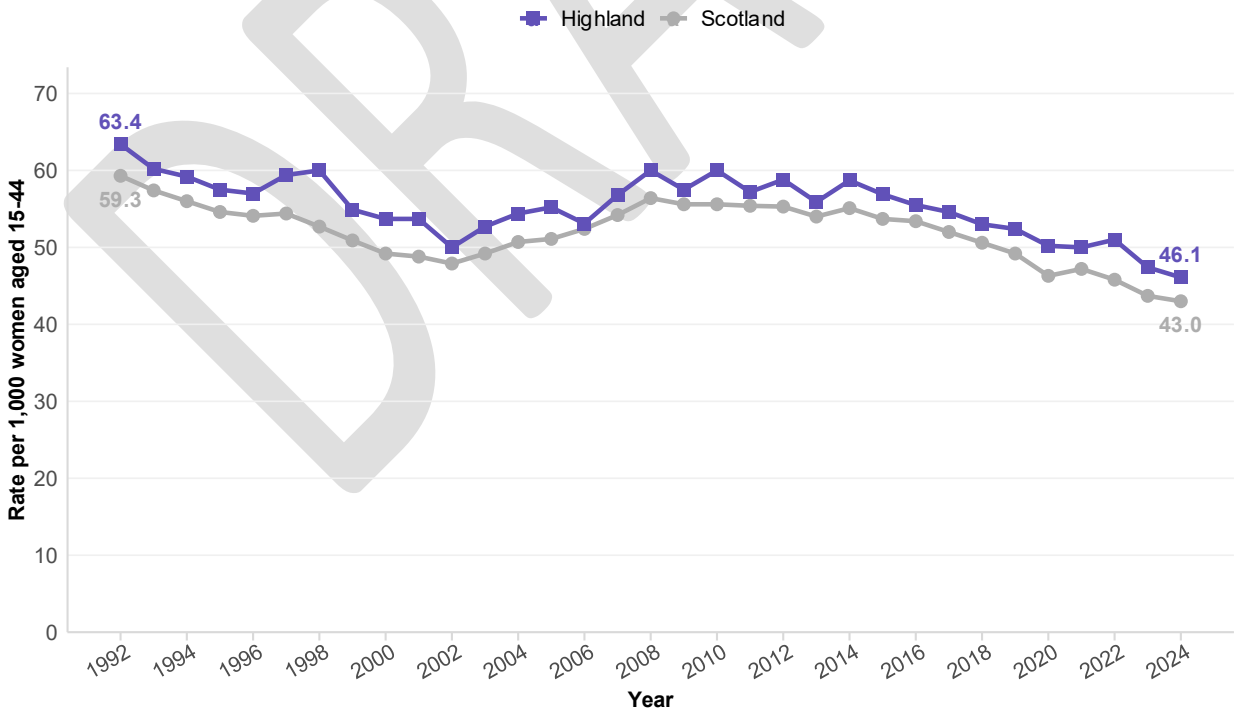
Lower birth volumes and geographic dispersion of the Highland population create capacity and access challenges, particularly for the continuity of carers and universal programmes. Service planning should account for the volatility of small numbers in rural areas and their impact on access, workforce coverage, and travel.

Figure 24: Annual number of live births in Highland by sex, 1992-2024



Source: National Records of Scotland Births (Time Series)

Figure 25: General Fertility Rate, total live births per 1,000 women aged 15 to 44 years, in Highland and Scotland, 1992-2024

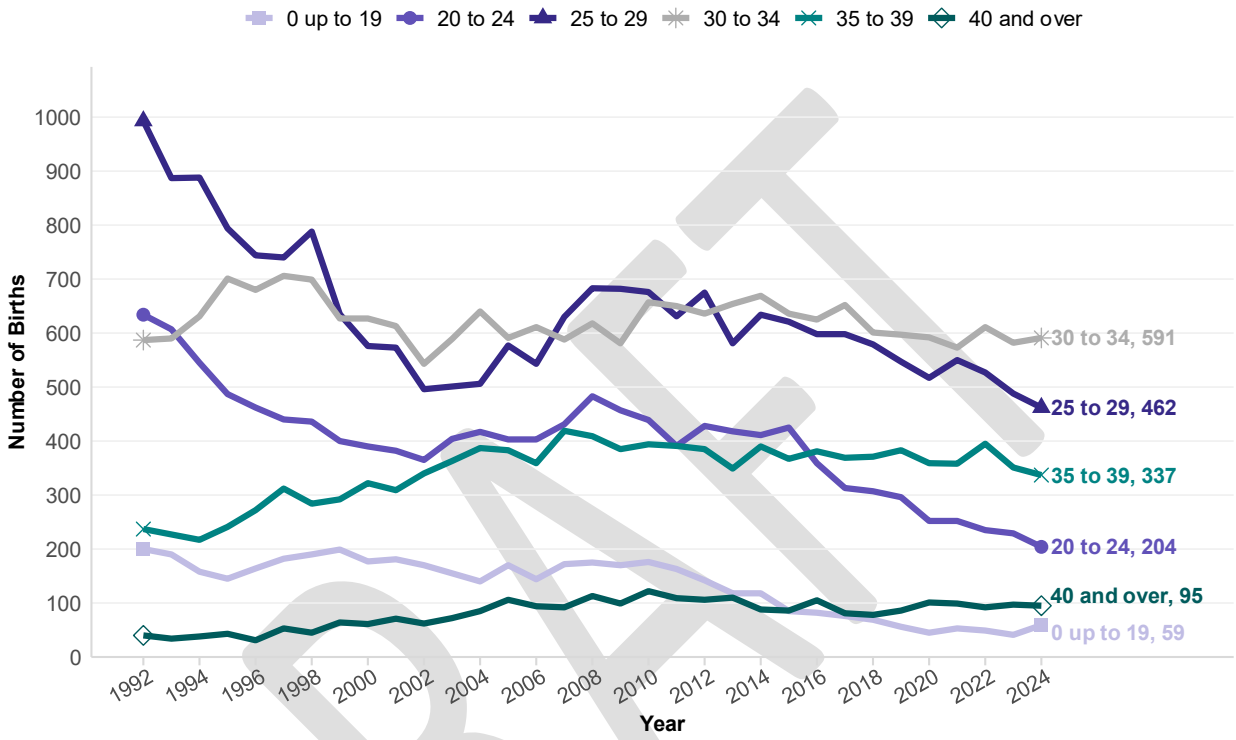


Source: National Records of Scotland Births (Time Series)

Births by the age of the mother

The decline in births in the 1990s was primarily due to women in their twenties delaying childbearing. From 2001 to 2008, the number of births rose, with increases noted among women in their twenties, coupled with women in their 30s and 40s who may have postponed starting a family (Figure 26).

Figure 26: Births to Highland residents by mother's age, 1992-2024



Source: National Records of Scotland Births (Time Series)

However, since 2008, the number of births has declined, possibly due to women leaving motherhood later in life, having fewer children, and experiencing periods of economic uncertainty. The beginning of the recent fall coincided with the banking crisis and financial crash.

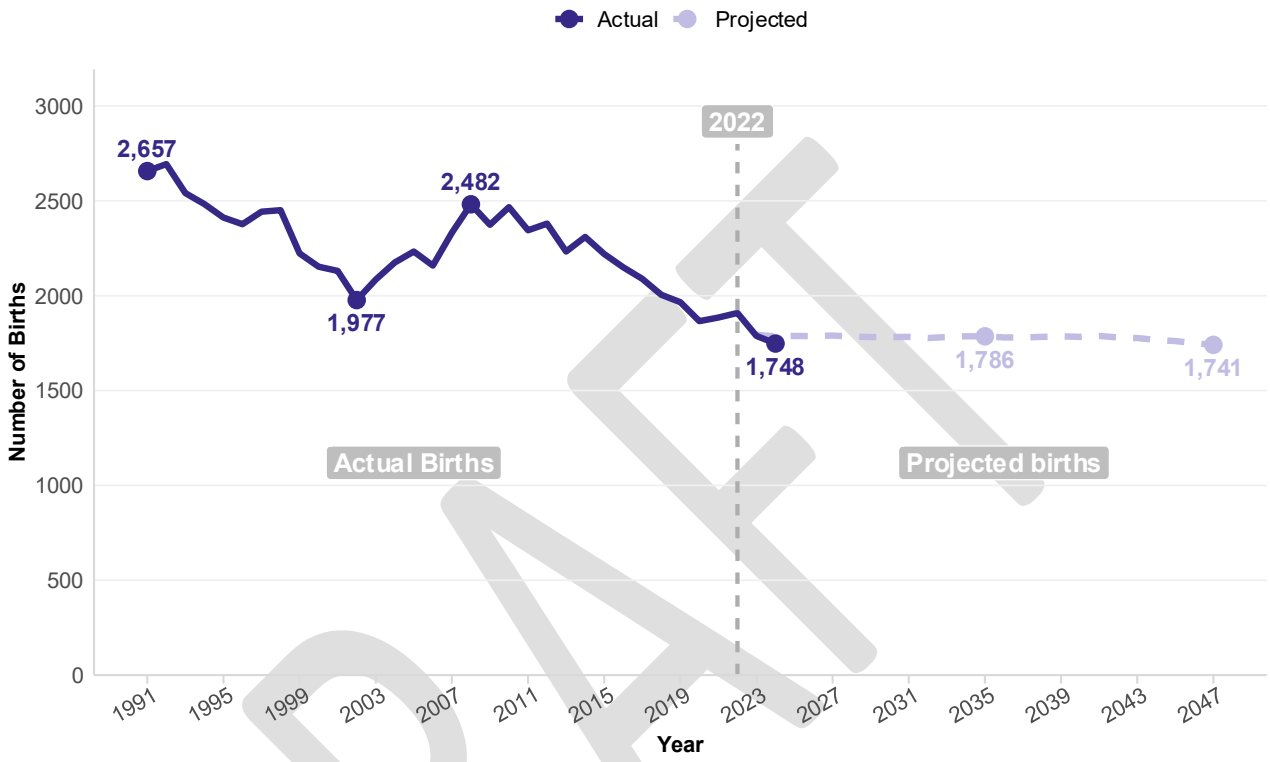
More recently, the immediate impact of the COVID-19 pandemic did not alter overall birth trends; however, the number of births to women in their 20s has continued to fall at both the local and national levels (Figure 24, Figure 26).

Currently, just under 100 women aged 40 or older who live in Highland give birth each year. According to the Royal College of Midwives, older women are more likely to require increased resources. Older mothers are more at risk of preeclampsia, miscarriage and complicated pregnancies that could result in forceps or caesarean section for delivery.

Projected number of births

In Highland, the annual number of births per year is projected to remain stable between 1,750 and 1,790 (Figure 27). However, the continuation of downward trends in births in the periods following the publication of the projections suggests that this scenario is relatively optimistic.

Figure 27: Actual and projected number of births in Highland, 1991-2047



Source: National Records of Scotland, Births (Time Series), Subnational Population Projections (2022-based)

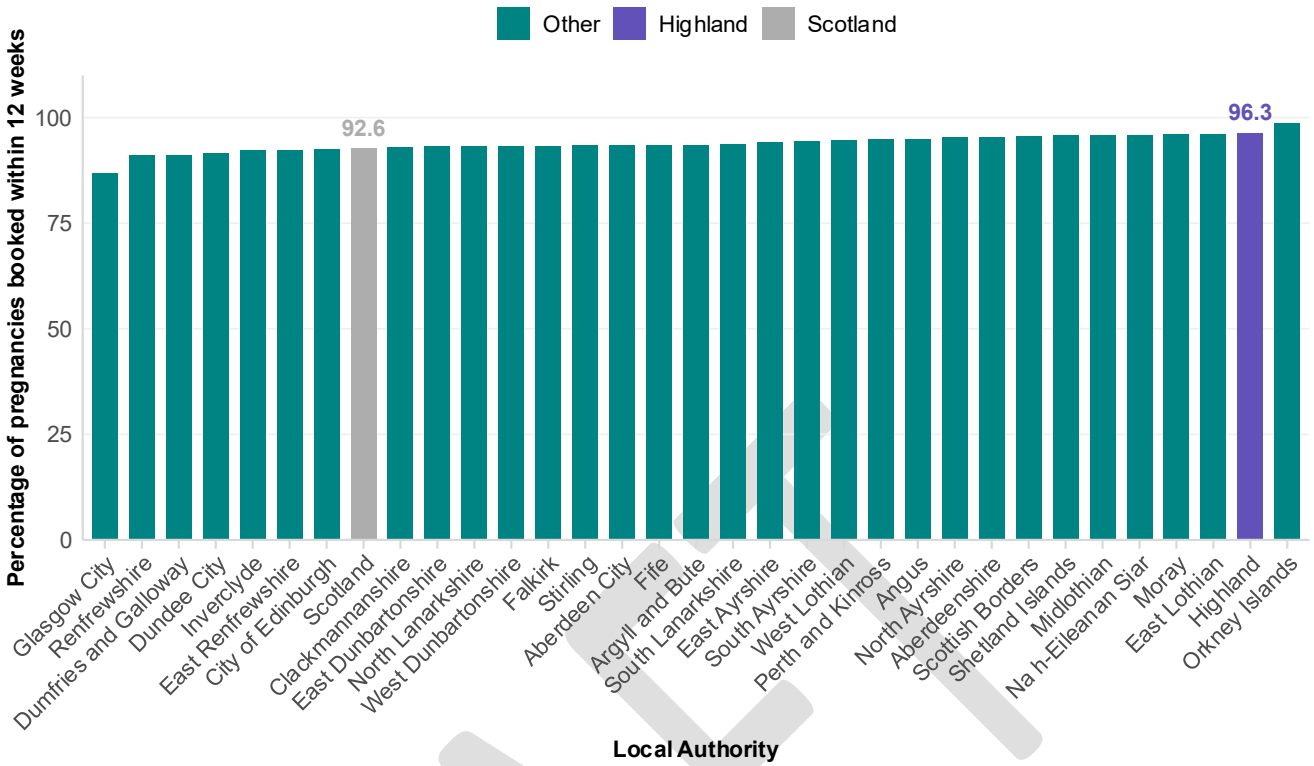
Antenatal care

Early access to antenatal care is associated with improved maternal and infant outcomes. The booking appointment establishes history, risk assessment, ultrasound, and screening, in line with NICE NG201 and national pathways.[Error! Bookmark not defined.,Error! Bookmark not defined.]

Guidance recommends booking by 10 weeks of gestation.**Error! Bookmark not defined.** In 2024, 96.3% of Highland resident pregnancies were booked within 12 weeks, above the Scottish average (92.6%), with most bookings by 10 weeks (Figure 28).

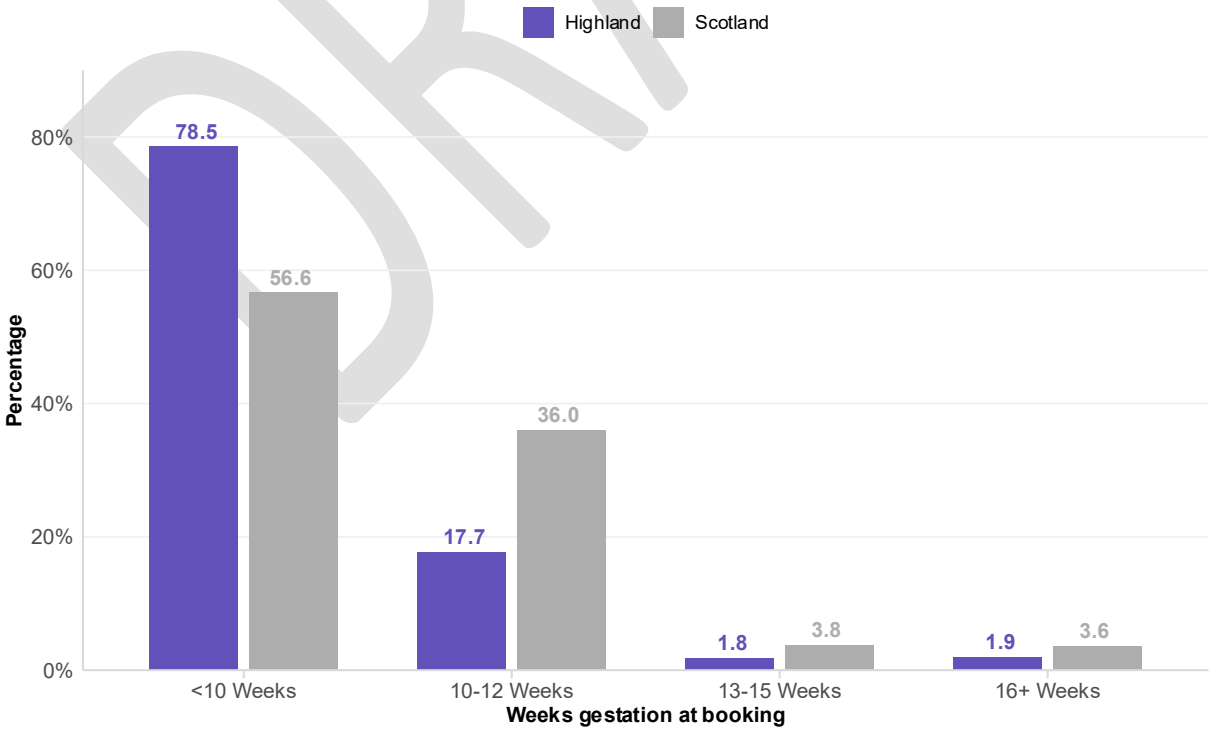
Women experiencing deprivation are at greater risk of complications in pregnancy, and families living in deprivation may have additional social support needs relevant to the resourcing of services. National and board-level analyses still indicate lower early booking among more deprived groups.

Figure 28: Percentage of pregnancies booked within 12 weeks by Local Authority in 2024



Source: Public Health Scotland Antenatal Booking Collection (ABC)
1 Percentage of those with a known gestation at booking, and 2024 data is provisional

Figure 29: Percentage of antenatal bookings by weeks of gestation in Highland and Scotland, 2024



Source: Public Health Scotland Antenatal Booking Collection (ABC)

Vulnerability factors during pregnancy

Antenatal care with complex social factors

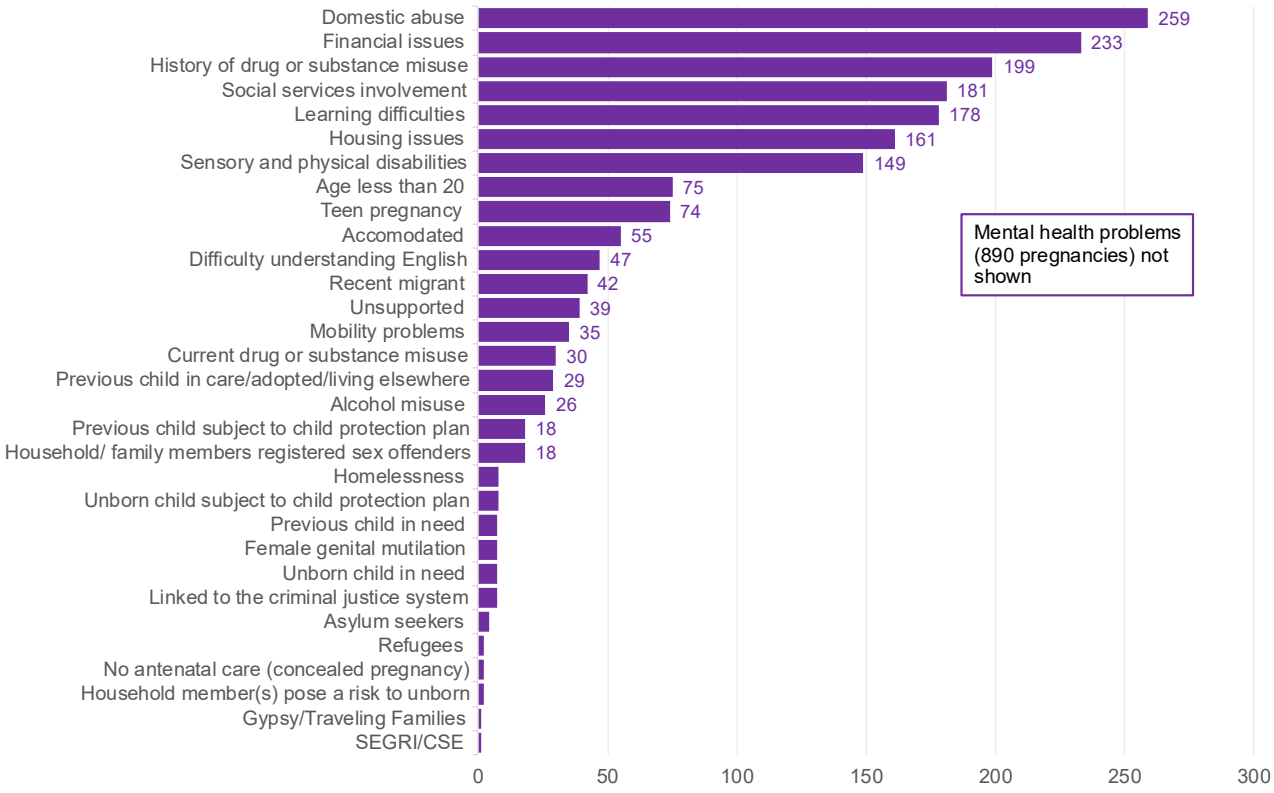
A substantial proportion of pregnancies in Highland involve complex social factors, including mental health, domestic abuse, financial stress, housing issues, substance use, learning difficulties and communication needs. NICE guidance and HIS Draft Standards emphasise integrated, trauma-informed pathways and continuity of care for those at highest risk.[71,Error! Bookmark not defined.]

In 2024, ~62% of booked pregnancies in Highland recorded at least one vulnerability; mental health was most frequent (~71% of those with vulnerability). Recording supports proactive, coordinated care, early referral and postnatal follow-up.

Common concerns (domestic abuse, income, housing, learning difficulties, disability) require multi-agency responses: maternity, health visiting, GP, mental health/psychology, social work, third sector, and income-maximisation support (Figure 30).

Vulnerability prevalence, particularly mental health, points to the need for perinatal mental health pathways, accessible bereavement/loss support, and triage and unscheduled care arrangements, as set out in the HIS Draft Standards (Standards 5 to 7).[Error! Bookmark not defined.]

Figure 30: Antenatal bookings with a vulnerability reported during pregnancy, 2024



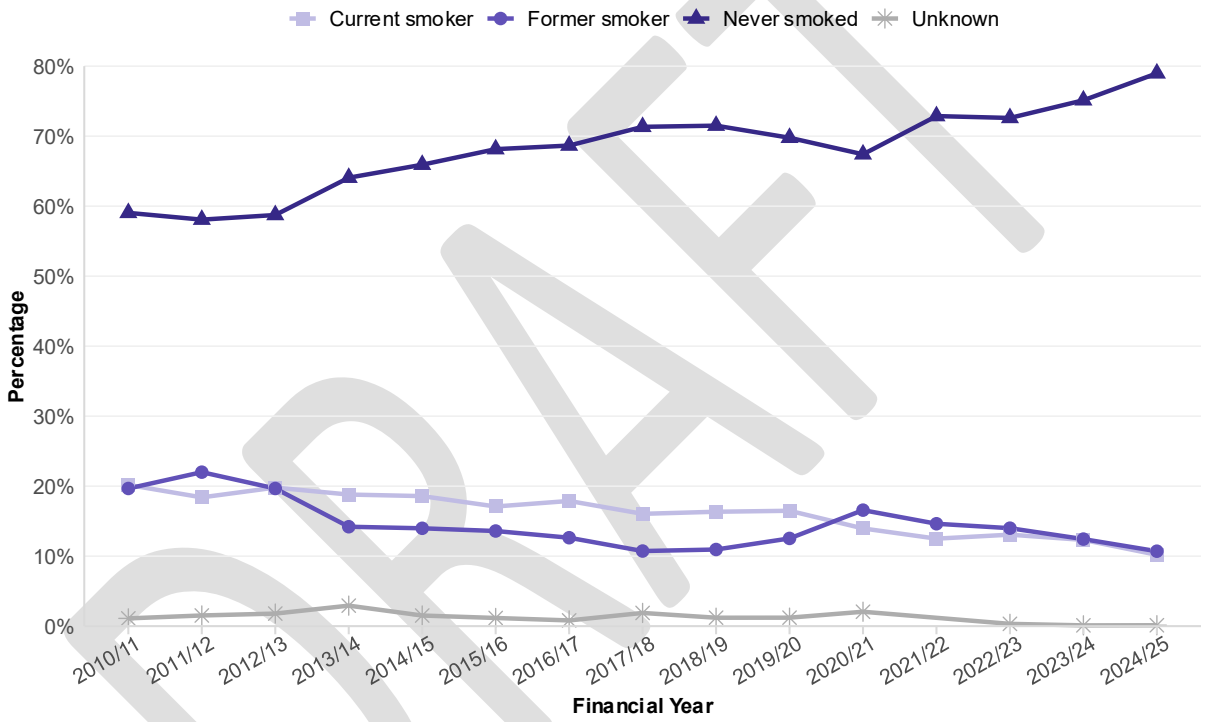
Source: BadgerNet Maternity
Note: Mental health problems are not shown to help with the reading of other categories

Smoking in pregnancy

Smoking in pregnancy increases risks of preterm birth, low birth weight, miscarriage, stillbirth, and sudden infant death syndrome (SIDS)[72]. It also increases the risk of the baby developing many respiratory conditions, attention and hyperactivity difficulties, learning difficulties, ear, nose, and throat problems, obesity, and diabetes.[73]

Around 1 in 10 women are recorded as smoking at booking in NHS Highland; self-report may under-estimate prevalence (Figure 31).

Figure 31: Percentage of women by smoking status at antenatal booking in Highland, 2010/11 to 2024/25

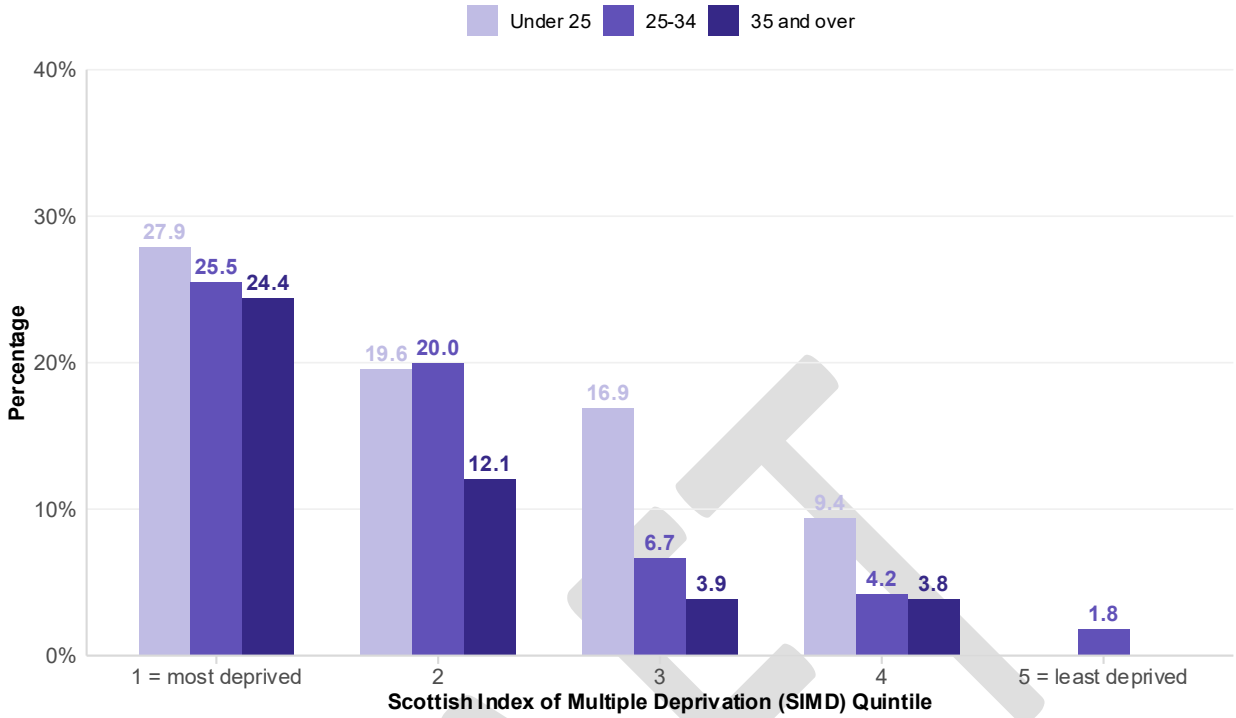


Source: Public Health Scotland (SMR02) Open Data, women who delivered in 2010/11 to 2024/25

Deprivation and younger age are key risk factors (Figure 35).

Giving every child the best start in life must include protecting babies from the damage of tobacco smoke, with the potential to target smoke-free pregnancy actions on younger and more deprived groups; providing specialist cessation support integrated with antenatal pathways and postnatal follow-up.

Figure 32: Percentage of women resident in Highland smoking at antenatal booking by age group and SIMD quintile, 2024/25



Source: Public Health Scotland (SMR02) Open Data, women who delivered in 2024/25
Note: Self-reported at booking

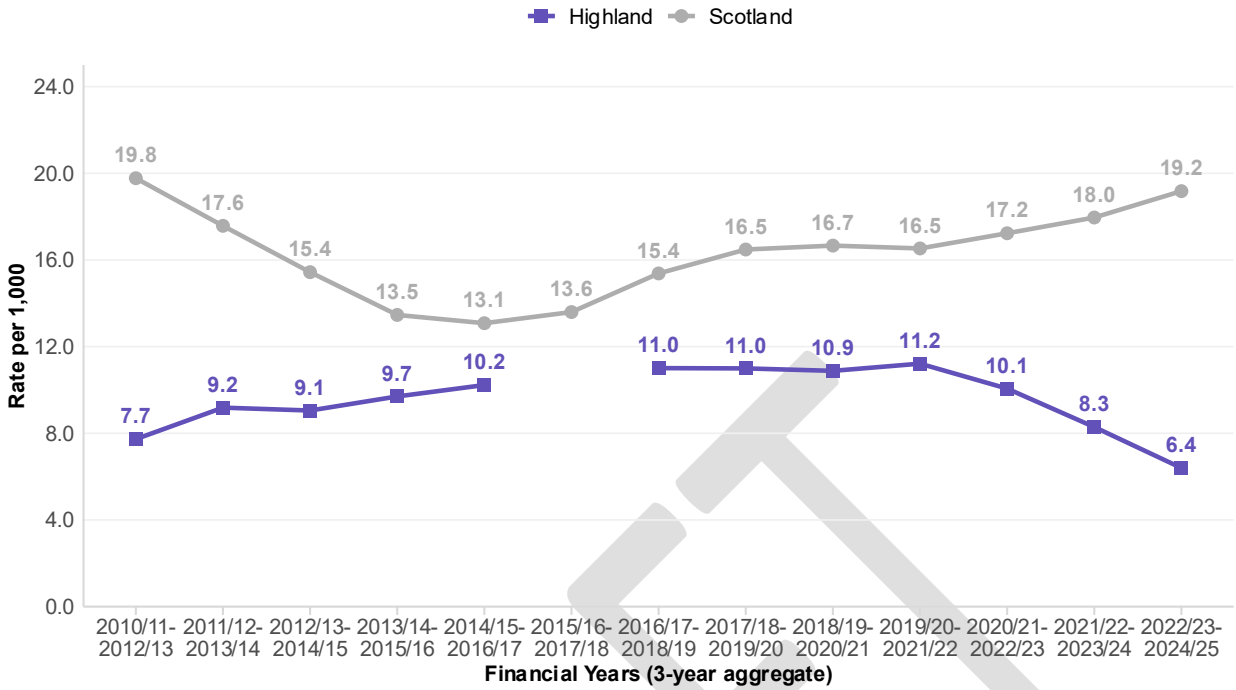
Alcohol and drug use in pregnancy

Alcohol and substance use are part of the 'complex social factors' covered by the NICE guidance on antenatal care for pregnant women. Problem alcohol or drug use in pregnancy is associated with fetal growth restriction, preterm delivery, stillbirth, neonatal death and longer-term neurodevelopmental harm.

Recorded drug use rates in Highland (2022/23–2024/25) were 6.4 per 1,000 maternities; the lowest rate for over a decade (Figure 33), but self-report can under-record actual exposure.

Care pathways should minimise stigma, ensure confidentiality, and offer rapid multidisciplinary support, with integrated drug and alcohol recovery and mental health input, and family-centred support.

Figure 33: Rate per 1,000 maternities recording drug use in Highland[1] and Scotland 2010/11-2012/13 to 2022/23-2024/25



Source: Public Health Scotland (SMR02) Open Data
[1] No data reported for Highland in the extract for 2015/16 – 2017/18

Maternal Body Mass Index at booking

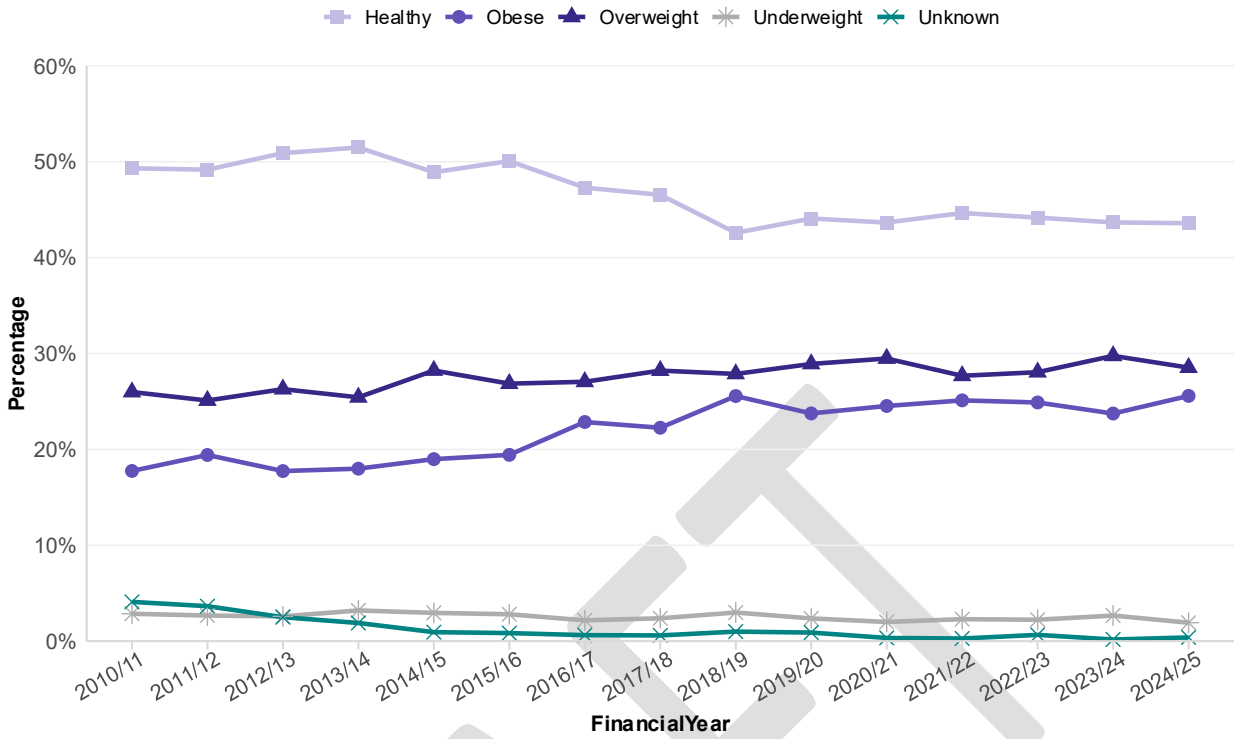
Elevated maternal Body Mass Index (BMI) increases risks of gestational diabetes, hypertension/preeclampsia, haemorrhage, operative delivery and macrosomia (high birth weight), requiring investment in pre-conception advice, early nutrition/weight support, and diabetes in pregnancy pathways.

Over half of women were overweight or obese at antenatal booking in 2024/25 in Highland. The percentage of women who are overweight or obese at booking had been increasing but has remained stable since 2018/19 (Figure 34).

The long-term trend toward fewer healthy-weight pregnancies has, until recent years, been similar in both Highland and Scotland (Figure 35). In Highland, however, the rate has been stable since 2020/21, leading to some divergence from the rate in Scotland as a whole.

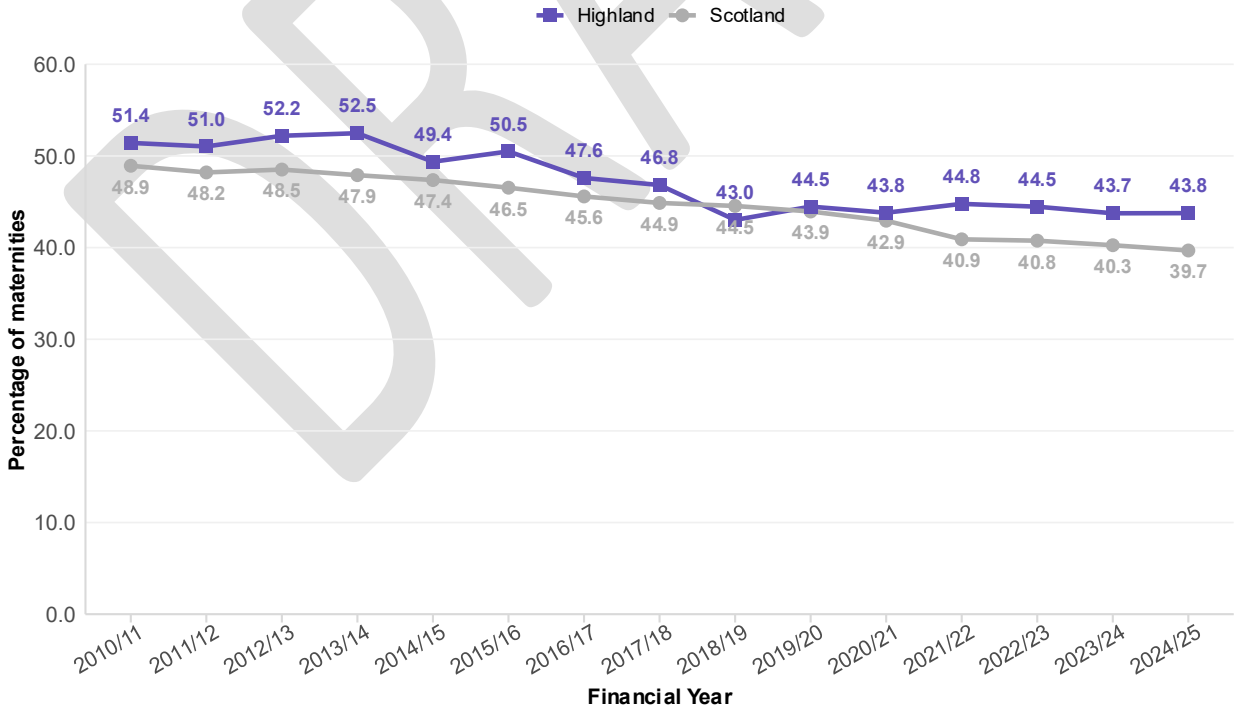
A high level of maternal obesity has implications for maternity and neonatal service provision. Increased resources are needed to care for these mothers (including equipment, staffing, theatre, and anaesthetics). There is a higher use of caesarean section associated with obesity.[74]

Figure 34: Percentage of maternities by BMI group in Highland, 2010/11 to 2024/25



Source: Public Health Scotland (SMR02) Open Data

Figure 35: Percentage of maternities of healthy maternal weight in Highland and Scotland 2010/11 to 2024/25



Source: Public Health Scotland (SMR02) Open Data

Gestation

Gestation refers to the number of completed weeks of pregnancy at the time of delivery.

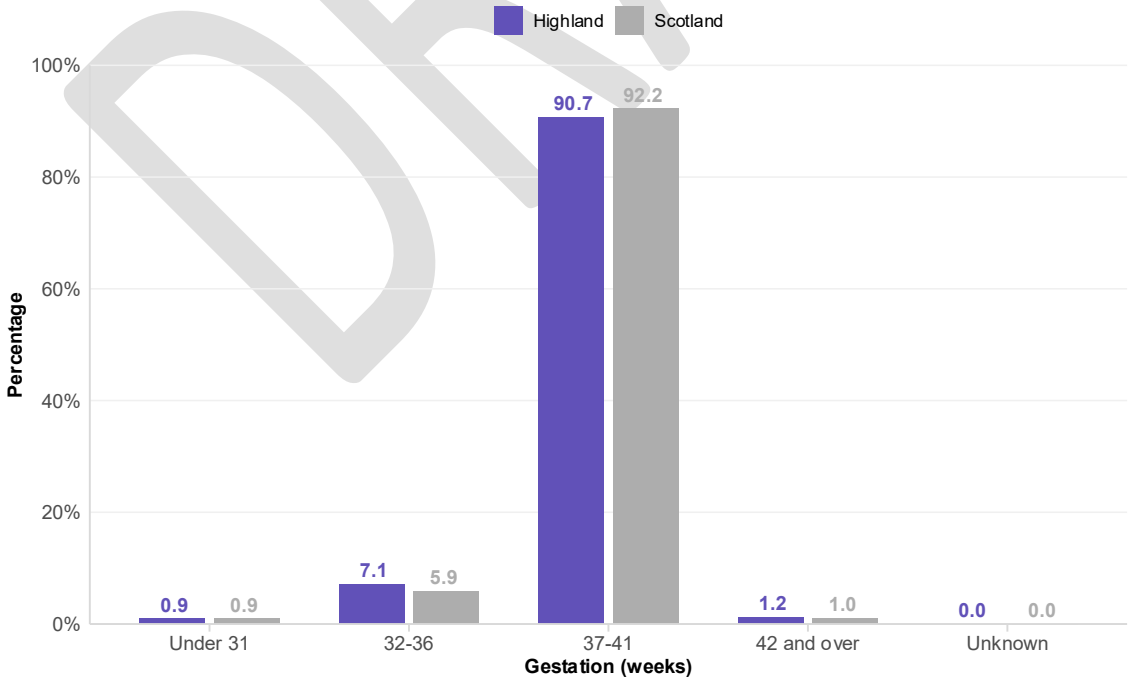
- Term birth: 37–41 completed weeks of gestation
- Preterm (premature) birth: Less than 37 completed weeks of gestation
- Post-term birth: 42 weeks or more of gestation

These categories are consistent with national reporting standards and are used to describe birth outcomes and trends. Gestational age at delivery is a critical determinant of neonatal and long-term child health. Preterm birth is the leading cause of neonatal admission and the single most significant cause of death in early infancy in Scotland.

Known risks for preterm delivery include maternal poverty, deprivation, stress, low or high maternal age or BMI, maternal substance use, previous preterm deliveries, multiple pregnancy (twins or more), maternal health issues or infections arising during the pregnancy.

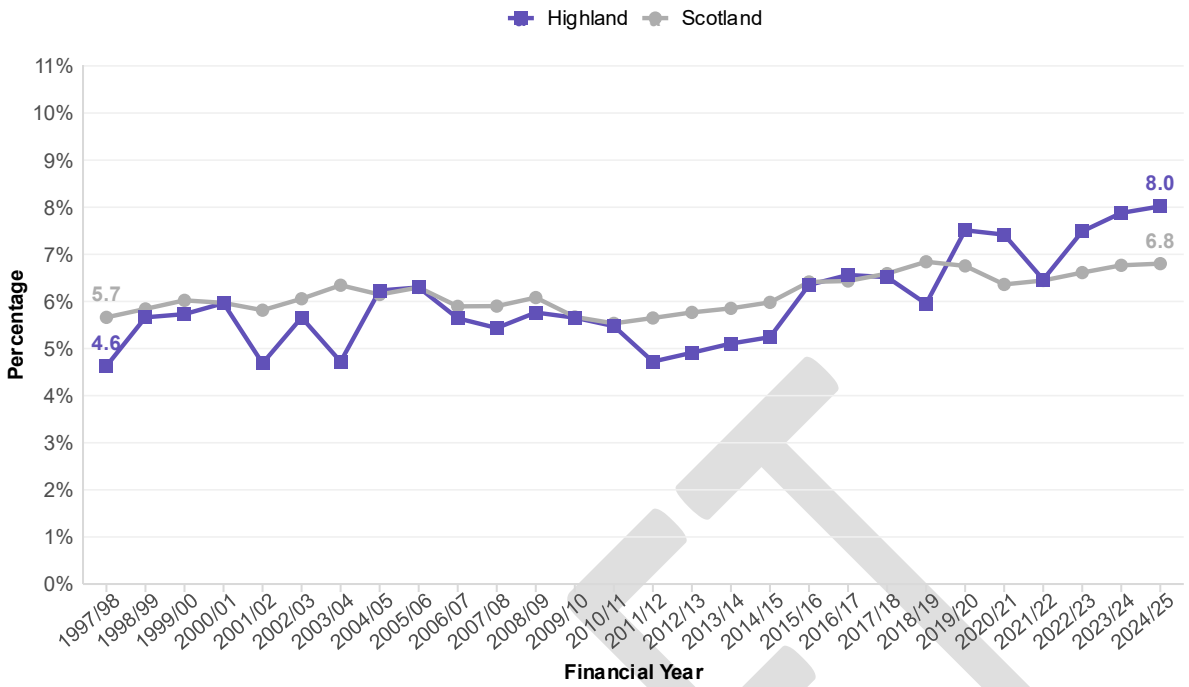
In Highland in 2024/25, 8.0% of live singleton babies were born prematurely (<37 weeks), slightly higher than the Scottish figure of 6.8% (Figure 36). Babies from multiple pregnancies are much more likely to be born prematurely, but the number of multiple pregnancies in Highland is small and varies year to year. The preterm singleton birth rate in both Highland and Scotland has increased over time (Figure 37).

Figure 36: Gestation in weeks of live singleton births in Highland and Scotland, 2024/25



Source: Public Health Scotland (SMR02) Open Data

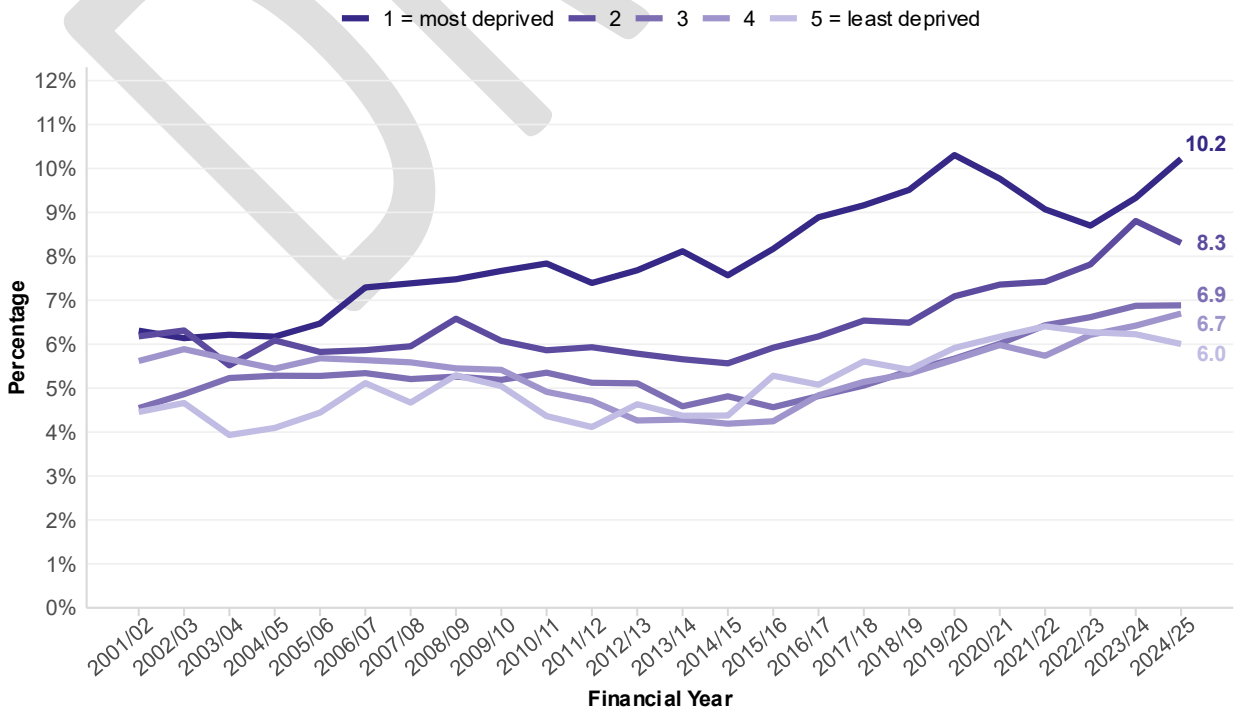
Figure 37: Percentage of premature births (under 37 weeks of gestation) in Highland and Scotland, 1997/98 to 2024/25



Source: Public Health Scotland (SMR02) Open Data

Preterm birth rates are higher for older mothers and for those living in more deprived areas. While rates by deprivation quintile are variable year to year due to small numbers, the 5-year aggregated rates show that those in the most deprived areas are more likely to give birth prematurely.

Figure 38: Percentage of premature births (under 37 weeks gestation) by SIMD in Highland, 2001/02 to 2024/25 (5-year aggregate)



Source: Public Health Scotland (SMR02) Open Data

Birth weight

Birth weight is the first weight of the newborn measured immediately after birth. Traditionally, babies have been classified by absolute birth weight:

- Low birth weight (LBW): Less than 2,500 grams
- Normal birth weight: 2,500–3,999 grams
- High birth weight (macrosomia): 4,000 grams or more

However, absolute birth weight does not account for gestational age. For example, a baby born prematurely will naturally weigh less than a baby born at term, even if they are growing appropriately for their gestational age. To address this, national reporting increasingly uses categories based on birth weight relative to gestational age:

- Small for gestational age (SGA): Birth weight below the 10th percentile for babies of the same gestational age
- Large for gestational age (LGA): Birth weight above the 90th percentile for babies of the same gestational age

This approach allows clinicians and public health teams to distinguish between babies who are small because they are premature (but growing normally) and those who are small because of intrauterine growth restriction. Similarly, it identifies babies who are unusually large for their gestational age, which may be associated with maternal diabetes or obesity. Monitoring should use both absolute birth weight and SGA/LGA categories to reflect the full spectrum of risk.

Risk factors for low birth weight include young maternal age, multiple pregnancies, previous LBW infants, poor nutrition, chronic illness, substance misuse, and insufficient prenatal care. Environmental risks include smoking and exposure to pollutants. [72,73]

SGA infants are at increased risk of perinatal morbidity, infection, delayed development, and learning disabilities. Conversely, LGA (macrosomia) is associated with maternal obesity, excessive pregnancy weight gain, and diabetes. LGA babies are at increased risk of birth injuries, metabolic complications, and later obesity.

In 2024/25, 5.6% of live singleton babies born to Highland residents had low birth weight (Figure 39).

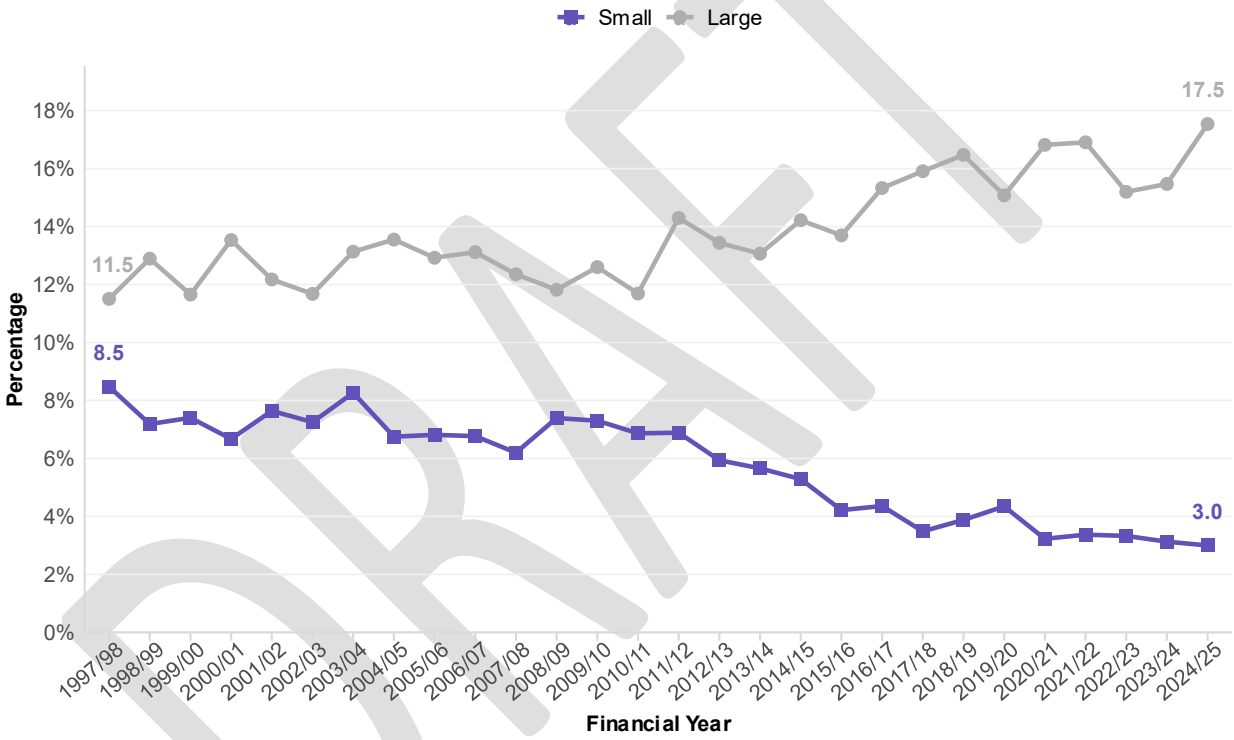
Figure 39: Birthweight of live singletons born to residents of Highland and Scotland in 2024/25

Financial Year	CA	Births	Under 1500g	1500-2499g	2500g and over	Unknown	Total
2024/25	Scotland	Number	360	2,034	39,431	14	41,839
		Percentage	0.9	4.9	94.2	0.0	100
	Highland	Number	10	75	1,449	0	1,534
		Percentage	0.7	4.9	94.5	0.0	100

Source: Public Health Scotland (SMR02) Open Data

The proportion of babies who were LGA has increased from 11.5% in 1997/98 to 17.5% in 2024/25, likely reflecting rising rates of maternal obesity and diabetes in pregnancy.

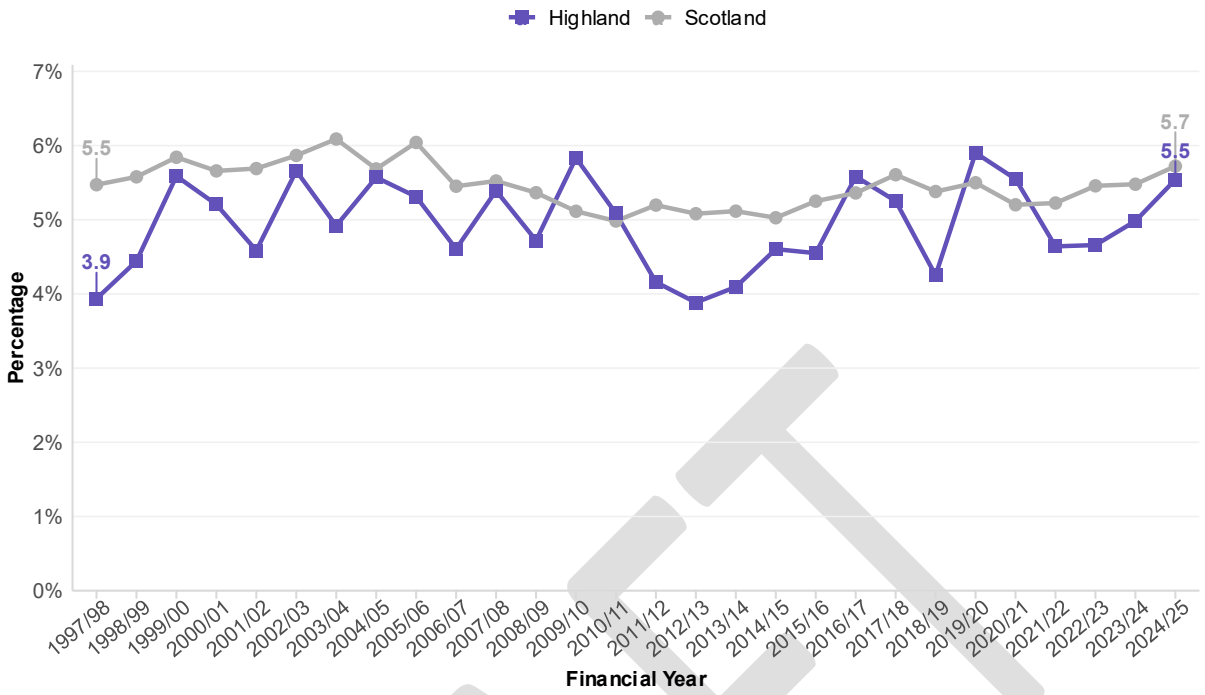
Figure 40: Babies that were small or large for gestational age in Highland, 1997/98 to 2024/25



Source: Public Health Scotland (SMR02) Open Data

While the proportion of singleton babies born preterm has increased, the proportion of singleton LBW babies has remained relatively consistent over time. On average, babies born at any gestational age have become slightly heavier over the same period.[72]

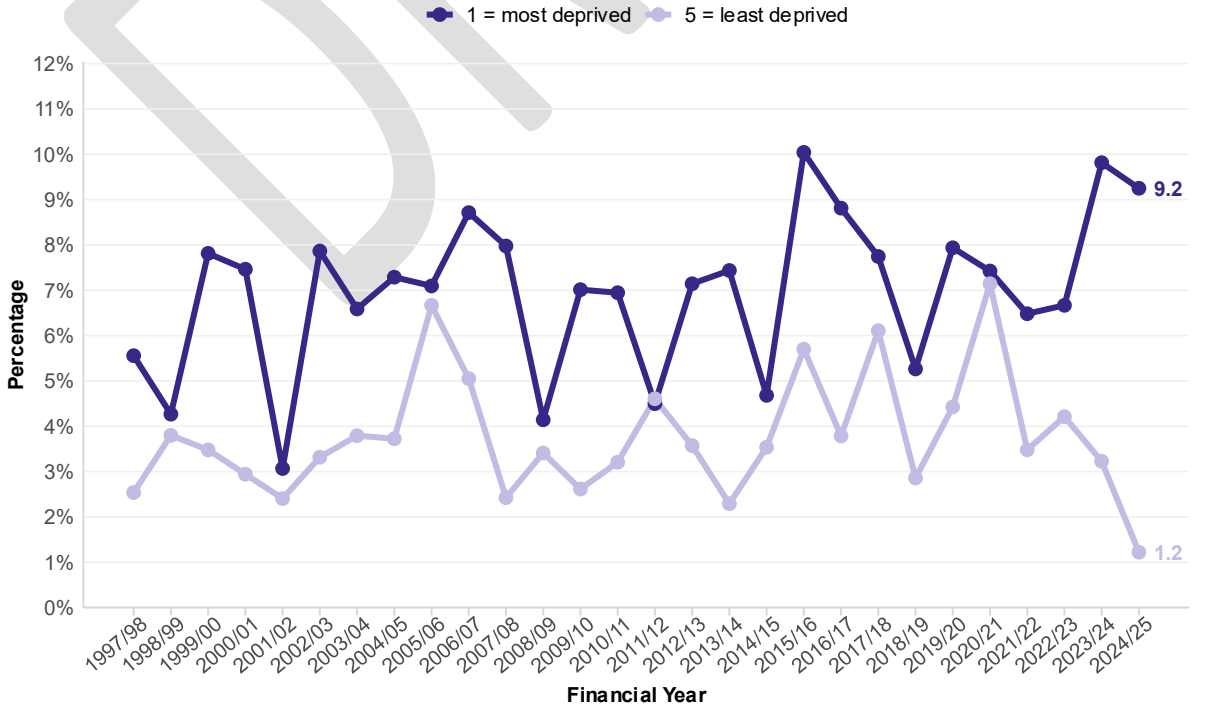
Figure 41: Live singleton births with low birth weight to residents of Highland and Scotland, 1998/98 to 2024/25



Source: Public Health Scotland (SMR02) Open Data

The relationship between LBW and deprivation is consistent over time in Highland, with higher proportions of LBW babies born to mothers' resident in the most deprived areas. However, annual variation in the gap reflects small numbers in these categories (Figure 42).

Figure 42: Live singleton births with low birth weight by deprivation quintile, Highland, 1997/98 – 2024/25



Source: Public Health Scotland (SMR02) Open Data

Improving birth weight and healthy pregnancy outcomes requires a coordinated, multi-agency approach that goes beyond clinical care. Community planning partners, including health, education, social care, housing, and the third sector, have a shared responsibility to address the intersecting risk factors that influence maternal and infant health. These include poverty, nutrition, physical activity, smoking, substance use, housing insecurity, and access to supportive services.

A population health approach means investing early and universally in environments that support healthy lifestyles from childhood through young adulthood, while also providing targeted interventions for those at higher risk of small-for-gestational-age or large-for-gestational-age births. Evidence shows that universal programmes, such as healthy schools, community food initiatives, active travel, and mental health support, can help establish lifelong habits that reduce risk by the time individuals reach childbearing age.[72,73] Targeted support for maternal nutrition, smoking cessation, and management of diabetes and obesity remains essential.

Maternal and neonatal screening

Maternal pregnancy screening aims to identify health conditions in pregnant women and health and chromosomal conditions in unborn babies. Pregnant women are offered testing for communicable diseases (HIV, syphilis and hepatitis B) and for haemoglobinopathies (Sickle cell and Thalassemia), for which the father may also be tested to improve the assessment of risk in the child. Maternal blood count, blood group and Rhesus status are also routinely offered to enable early intervention and prevention of harm in the mother and/or unborn child.

Uptake and results of these tests are not published nationally but local KPIs are calculated using data from pregnancy booking system. In 2024/25, uptake of maternal blood tests was over the essential target of 95 percent but under the desirable target of 99 percent. Women are also offered a foetal anomaly scan with over 99 percent uptake for this. Screening tests depend on women being aware of and reporting their pregnancy to health services.

Pregnancy maternal blood tests and/or scans are offered for the chromosomal conditions Down's syndrome and/or, Edwards' syndrome and Patau's syndrome in the infant. This testing is not diagnostic and provides a risk score. Diagnostic testing, where offered, is invasive and includes a small risk of miscarriage. Therefore, the choice of these tests is discussed with woman and uptake is monitored locally with no set targets.

Neonatal blood spot testing is offered to all infants around 4-5 days of birth. This tests for the presence of rare conditions including cystic fibrosis, sickle cell conditions, congenital hypothyroidism and a series of metabolic conditions. Early detection can allow interventions

that improve health and prevent disability or early death. Coverage of newborns in 2024/25 was over the essential target of 95 percent but under the 99 percent desirable.

Newborns are given a physical examination and a hearing test which aims is to identify all babies born with a permanent bilateral hearing loss of greater than 40dB. By addressing hearing deficits from the earliest point in time, the impact of hearing impairment on growth, development and wellbeing can be minimised. The essential target is for 98 percent newborns to receive hearing testing and provisional data suggest that this was met in 2024/25, but not the desirable target of 99.5 percent.

Challenges for pregnancy and newborn screening programmes include staffing, recording and sharing of booking information, and requirements in some cases for travel across rural areas.

There is a need to promote uptake of pregnancy and maternal screening programs and to understand and minimise any inequalities in update.

6. Infant feeding

Breastfeeding is part of the natural reproductive process and remains a core public health priority due to proven short and long-term benefits for both infants and mothers.[75] The Scottish Government's Breastfeeding and Infant Feeding Strategic Framework 2025–2030 emphasises equity, proportionate universalism, and rights-based support, with a clear focus on addressing inequalities in initiation, exclusivity, and duration.[76] Locally, NHS Highland's Infant Feeding and Breastfeeding Support Services provide specialist, peer, and digital support to families, aligning with national best practice and UNICEF Baby-Friendly standards.

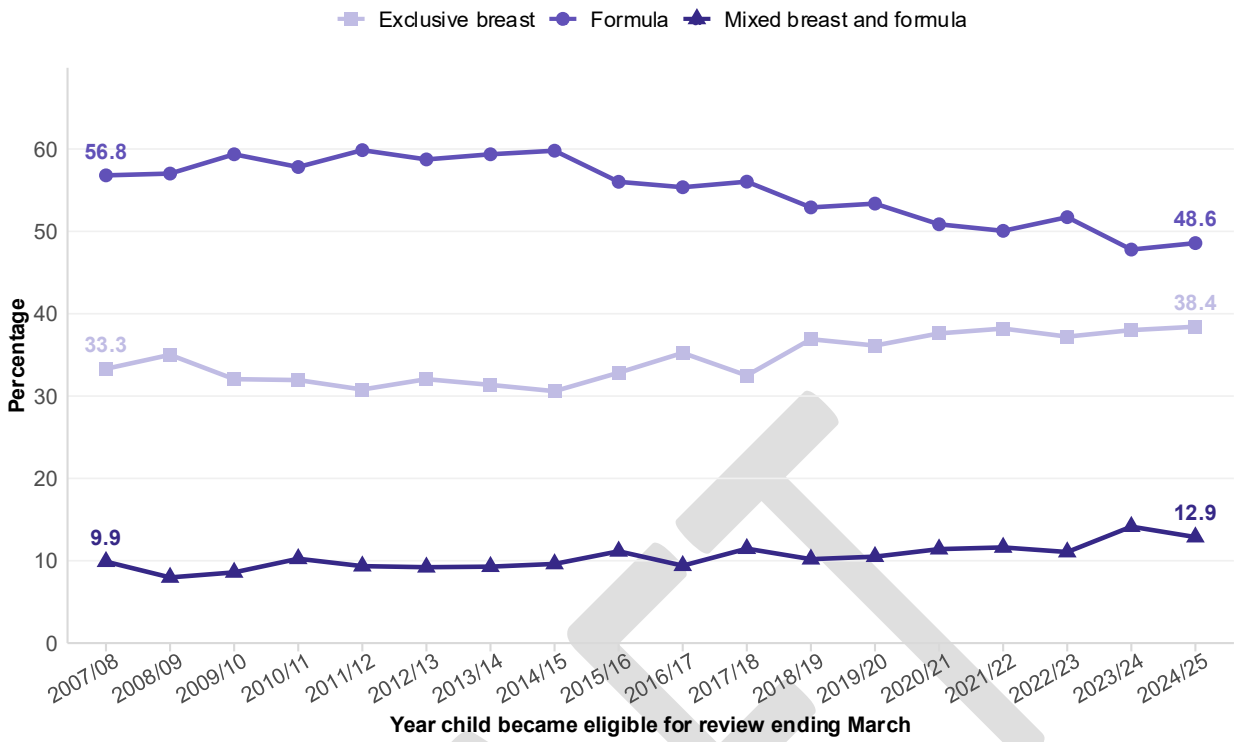
Increasing breastfeeding rates and reducing inequalities are shared priorities for all community planning partners, consistent with a rights-based and population health approach that invests early and supports families proportionately to need.[76] [77]

NHS Highland provides a range of supports, including specialist clinics, peer support networks, helplines, and digital resources, tailored, where possible, to the needs of families in remote and rural areas. Service developments continue to focus on accessibility, continuity and skills maintenance, in line with national standards and local ADP commitments.

Public Health Scotland routinely reports infant feeding statistics, including hospital initiation, Health Visitor (HV) ‘First Visit’ and HV 6–8 week exclusivity and mixed feeding. In Highland, 71% of babies born in 2024/25 started breastfeeding at HV First Visit; by 6–8 weeks, 38% were exclusively breastfed, and 13% were mixed breast- and formula-fed (Figure 47).[77]

Hospital initiation rates are higher than HV First Visit rates, reflecting drop-off in the early postnatal period and the importance of transition support from maternity to community services.

Figure 43: Infant feeding at health visitor 6-8 week review in Highland, 2007/08 to 2024/25



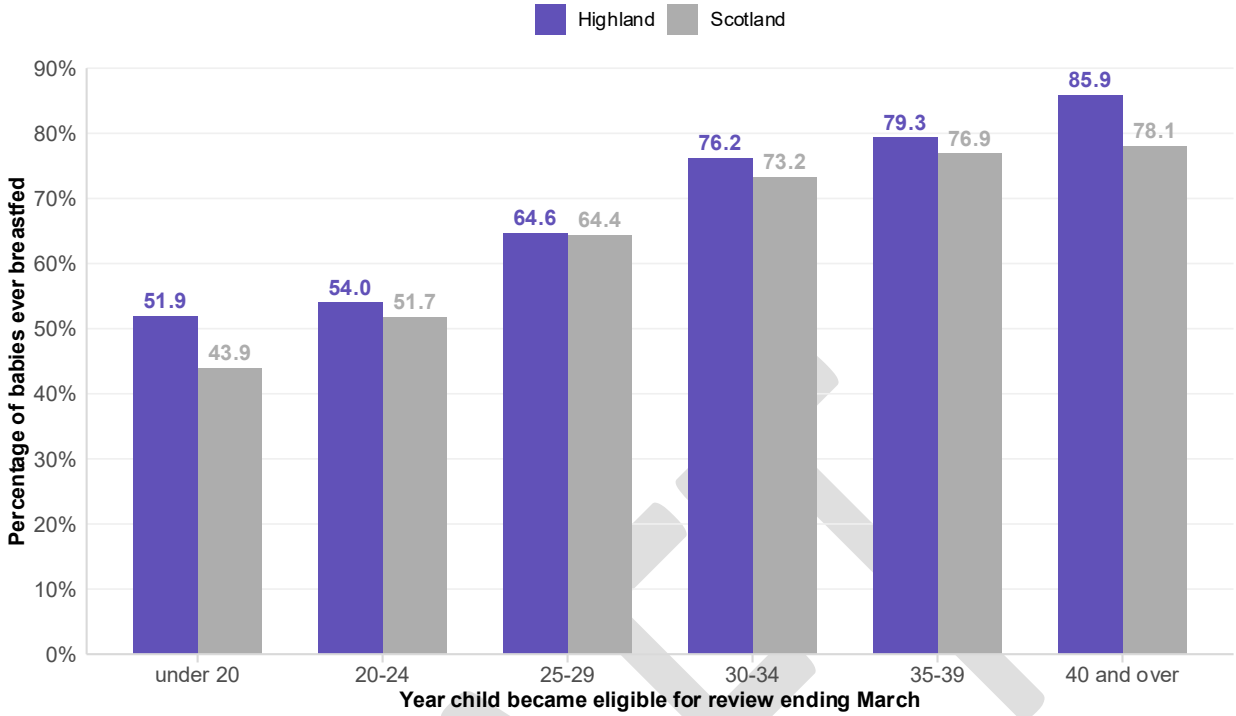
Source: Public Health Scotland Infant Feeding Open Data

Infant feeding patterns are shaped by social determinants including deprivation, age, ethnicity, lone parenthood, employment conditions, and smoking behaviour, with barriers such as transport, digital exclusion, housing insecurity, and limited workplace flexibility often intersecting.[76]

A rights-based approach aligned to the UNCRC requires universal supports with additional, proportionate inputs for groups facing the most significant barriers to ensure access to accurate information, practical help, peer networks, and culturally sensitive services.[76]

In Highland and Scotland, breastfeeding rates at First Visit generally increase with maternal age. While just over half of mothers aged under 25 were breastfeeding at First Visit in Highland in 2024/25, this increased to over three quarters of mothers over the age of 25 (Figure 44).

Figure 44: Breastfeeding initiation recorded at First Visit by maternal age in Highland and Scotland in 2023/24



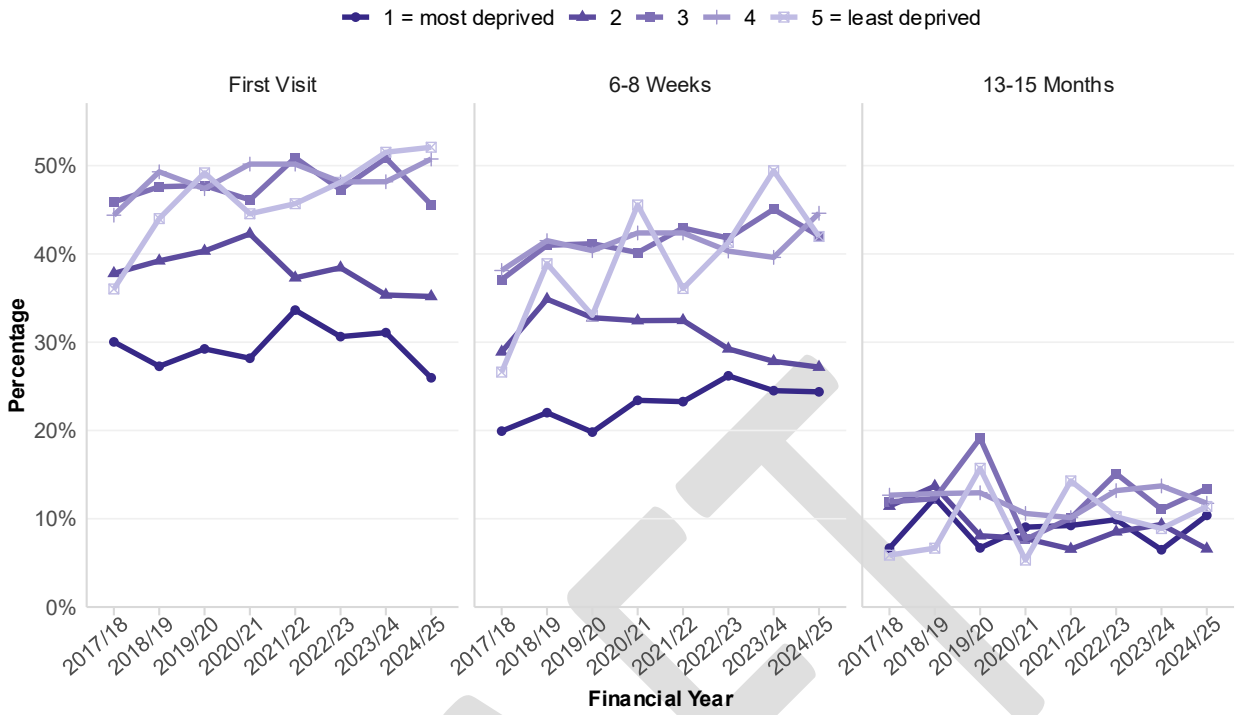
Source: Public Health Scotland Infant Feeding Open Data

Breastfeeding rates continue to have a strong social gradient with babies from more deprived areas less likely to be breastfed and more likely to experience early cessation of breastfeeding compared to those living in more affluent areas. This is particularly evident in Highland when comparing exclusive breastfeeding rates in the most and least deprived areas at First Visit and 6-8 week review. While rates in the most deprived quintile have increased since 2017/18, particularly at the 6-8 week review, these rates still fall significantly below the least deprived areas (Figure 49).

The Scottish Government has adopted the World Health Organisation's (WHO) recommendation that babies are exclusively breastfed for the first six months of life. However, between 6-8 week and 13-15 month review exclusive breastfeeding rates fall significantly across all deprivation quintiles (Figure 49).

Although the difference in rates between deprivation quintiles is narrower, the lowest rates still tend to be in the most deprived areas. NHS Scotland has introduced a new target aimed at further increasing the number of babies who are breastfed at six to eight weeks old by introducing a target to reduce the 'drop-off rate' – the number of mothers who stop breastfeeding – by a further 10% by 2031.[78]

Figure 45: Exclusive breastfeeding rates in Highland by Scottish Index of Multiple Deprivation (SIMD) quintile and review point, 2017/18 to 2024/25



Source: Public Health Scotland Infant Feeding Open Data

Improving infant feeding outcomes requires coordinated, multi-agency action that invests early and addresses intersecting social determinants. Partners should combine universal interventions (health visiting, healthy schools, peer support, active travel, workplace policies) with targeted supports for higher-risk groups—using stratified monitoring (SIMD, age, rurality) to guide proportionate universalism and continuous improvement.[76] Early investment in breastfeeding and responsive feeding reduces morbidity, narrows inequalities, and contributes to best start outcomes across Highland.

7. Early years

Child developmental reviews

All children in Scotland are offered a sequence of universal home visits and formal child health reviews from pre-birth to school entry, delivered by Health Visitors under the Universal Health Visiting Pathway and recorded in the Child Health Surveillance Programme Preschool. Reviews support health promotion and parenting, early identification of developmental concerns, and timely intervention.[79]

In Scotland, every preschool child has a named person, usually their Health Visitor, who acts as a single point of contact within universal services under the GIRFEC approach. The named person supports wellbeing, helps families access the right services at the right time, and coordinates information where additional needs are identified, although families are not required to accept this support.

Scotland's Health Visiting Action Plan 2025 to 2035 sets national direction on workforce skills and capacity, integration with wider services, and the consistent delivery of the Universal Health Visiting Pathway, with key performance indicators that include review coverage and the recording of meaningful developmental data.[80]

The Phase 1 national evaluation found that a structured eleven-visit schedule, relationship-based practice, and coordinated work with partner agencies enable early identification of developmental concerns and support families.[81]

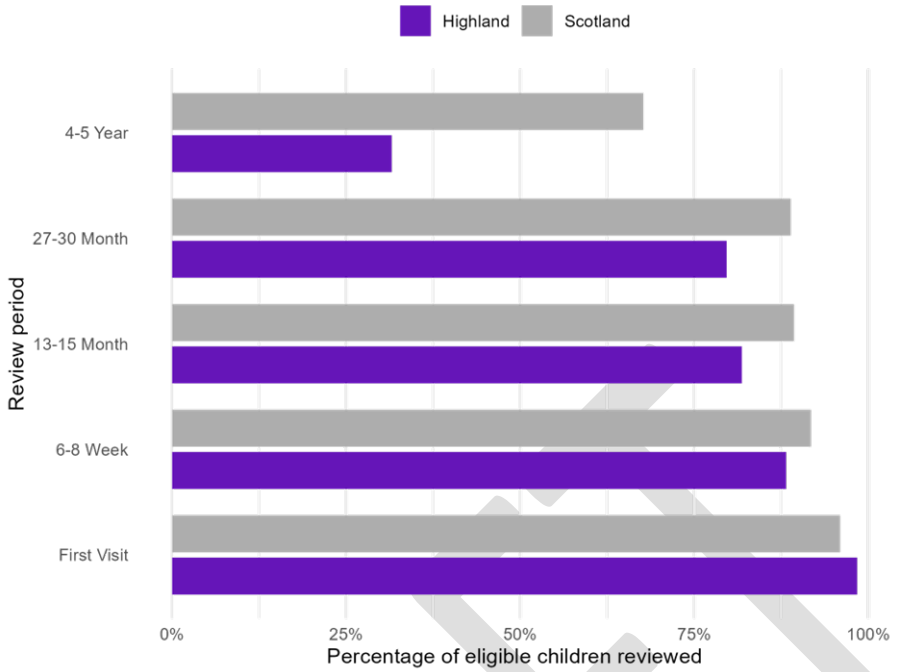
What the coverage statistics mean

Review coverage is defined as the proportion of children who became eligible for a review in the period and received it, with the result recorded in the national child health information system. Statistics are provided by NHS boards and local authorities, with breakdowns possible by sex, deprivation, and other characteristics. Operational age windows include: first visit (11 to 14 days); 6 to 8 week review (6 to 12 weeks); 13 to 15 months review (12 to 20 months); 27 to 30 months review (24 to 35 months); 4 to 5 year review (47 to 70 months).

Coverage in Highland with national comparison

Highland coverage remains very high for the first visit, with near universal completion among eligible children each year. Local monitoring indicates about 98 percent for the financial year 2024-25 compared with around 96 percent nationally (Figure 46).[82]

Figure 46: Universal child review coverage in Highland and Scotland for children eligible for review in 2024-2025



Data source: NSS Discovery, April 2019- March 2025 (extracted December 2025)

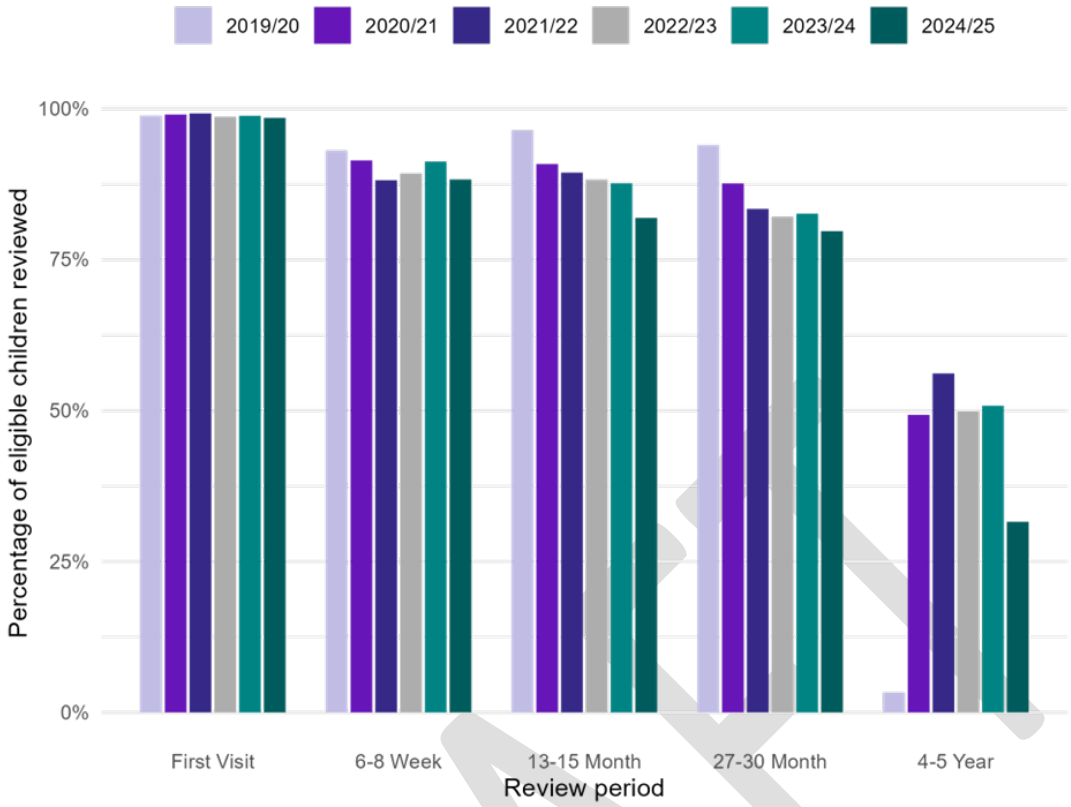
Highland figures for the other review periods in 2024-25 should be treated as provisional pending national publication, with eventual coverage anticipated to be in line with that reported for the programmes in financial year 2023-24 (Figure 47).

Programme coverage reduces in both Scotland and Highland at older age review points, and Highland has consistently reported reduced coverage compared to Scotland for review ages from 13 to 15 months, based on national publications and local extracts.

For the 4 to 5-year review, Highland delivers a reduced programme. Local monitoring suggests that once data for the financial year 2024-25 are complete, coverage will be closer to 50 percent, as in other recent years (Figure 48). The Scotland-wide figure of about 75 percent in 2023-24 is considerably higher than the Highland figure, acknowledging council-area-level variation and data-lag effects.[82]

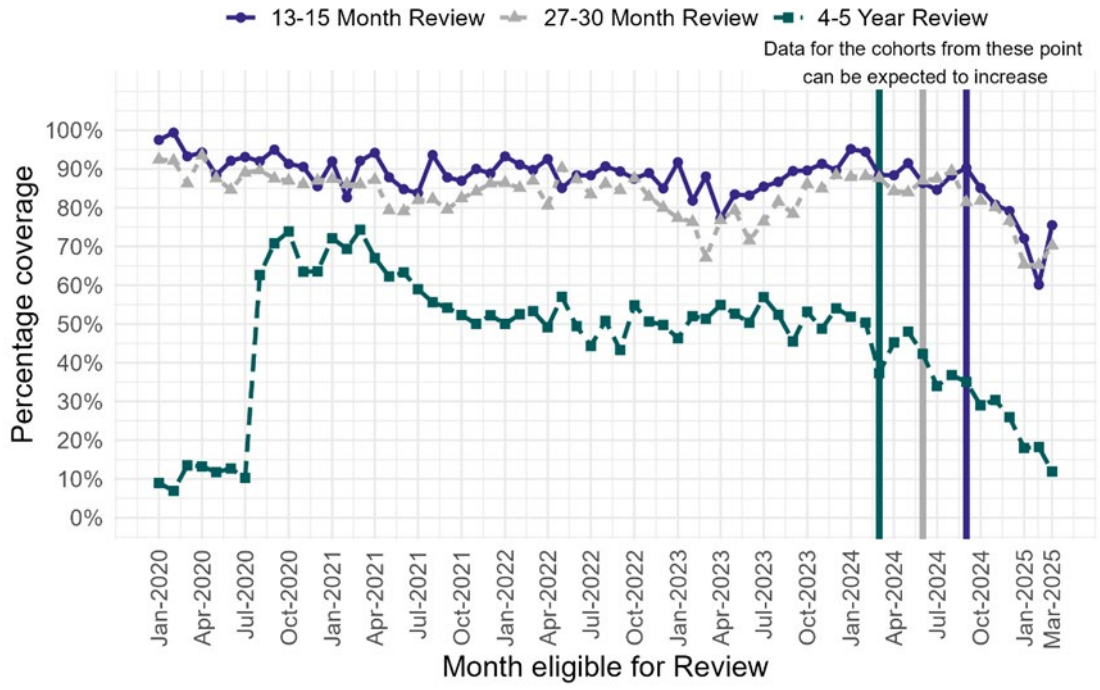
From April 2020, national guidance permitted remote delivery for some reviews, with the gradual restoration of in-person contact aligned with Scotland's Route Map (from COVID-19). In December 2021, national clinical guidance indicated the resumption of the complete service pathway, unless professional prioritisation required otherwise during periods of workforce pressure.[83] [84] [85]

Figure 47: Universal child review coverage in Highland by review point and financial year



Data source: NSS Discovery, April 2019- March 2025 (extracted December 2025)

Figure 48: Child health review coverage in Highland reported by the month children are eligible for review, January 2020 to March 2025



Data source: NSS Discovery, April 2019- March 2025 (extracted December 2025)
1 The 4-5 year review was implemented in Highland from January 2020.

Coverage and deprivation

Nationally, coverage of preschool child health reviews shows relatively small differences by deprivation, with only modest gaps between the most and least deprived areas.[82] In Highland, the gradient by deprivation is also generally flatter than seen for many other child health indicators (Figure 49).

The implication for interpretation is that Highland does not display a strong socioeconomic gradient in overall review uptake. Higher participation in areas of deprivation may reflect targeted engagement efforts or differing parental uptake patterns, but monitoring of lower uptake at the smaller-area level is required for future planning. Given the geography of Highland, patterns of uptake may also be influenced by rurality, longer travel times and the distribution of the Health Visiting workforce.

Figure 49: Universal child review coverage in Highland by review point and quintile of deprivation, 2024-25

Data source: NSS Discovery, April 2019- March 2025 (extracted December 2025)

Although current national publications do not include workforce-adjusted coverage measures, local intelligence suggests that recruitment, retention and periods of staff illness can create pressures that fall unevenly across rural and remote areas. Understanding the extent to which variation in uptake reflects these structural factors would help inform sustainable planning of Health Visiting capacity.

Developmental concerns recorded at child health reviews

Early child development describes the progressive acquisition of motor, communication, social and problem-solving skills in the first years of life, shaped by biological, social and environmental influences.[86]

From the 13 to 15 month review onwards, Health Visitors record children's development across eight domains: gross motor, fine motor, speech, language and communication, vision, hearing, social and emotional, behaviour, and self-care. The most frequently recorded concerns vary by review stage: speech, language and communication features are more often noted from 27 to 30 months, while emotional and behavioural problems are more commonly observed at 4 to 5 years.[87]

These reviews provide opportunities to assess children's development, offer support to families, and identify needs that may benefit from early intervention. Developmental concerns are associated with longer-term risks in health, education and wellbeing, and early identification improves outcomes.[79]

Children identified at Health Visitor review with concerns in two or more developmental domains are referred to paediatrics for diagnostic assessment, in line with NHS Highland's developmental-concerns pathway.[88]

Thirteen to fifteen-month review

In the Highland Council, the proportion of children recorded as having a developmental concern at the 13 to 15-month review increased during the pandemic period to 2022, followed by a period of relative stability. This pattern is similar to the national trend, although Highland remains slightly below the national average (Figure 50).

Nationally, the rise in recorded concerns between 2019 and 2022 coincides with increased completeness of developmental recording, more consistent use of validated developmental screening tools such as the Ages and Stages Questionnaire (version 3) (ASQ-3), and the resumption of in-person reviews following the pandemic.[87]

Twenty-seven to thirty-month review

The 27 to 30 month review is the most sensitive point in the child health programme for detecting developmental concerns and typically has the highest recorded prevalence. Highland shows a pattern broadly consistent with Scotland overall: developmental concerns increased gradually, peaking around 2021 to 2022, and, while continuously showing considerable monthly variation, stabilising by 2023 to 2024 at a level below that of Scotland.

Four to five-year review

Coverage at the 4- to 5-year review is lower and more variable than at earlier stages. Among those reviewed, Highland's recorded developmental concerns are similar to or slightly below the national level. Emotional and behavioural difficulties become more prominent by this stage, reflecting both developmental expectations and wider influences on school readiness.

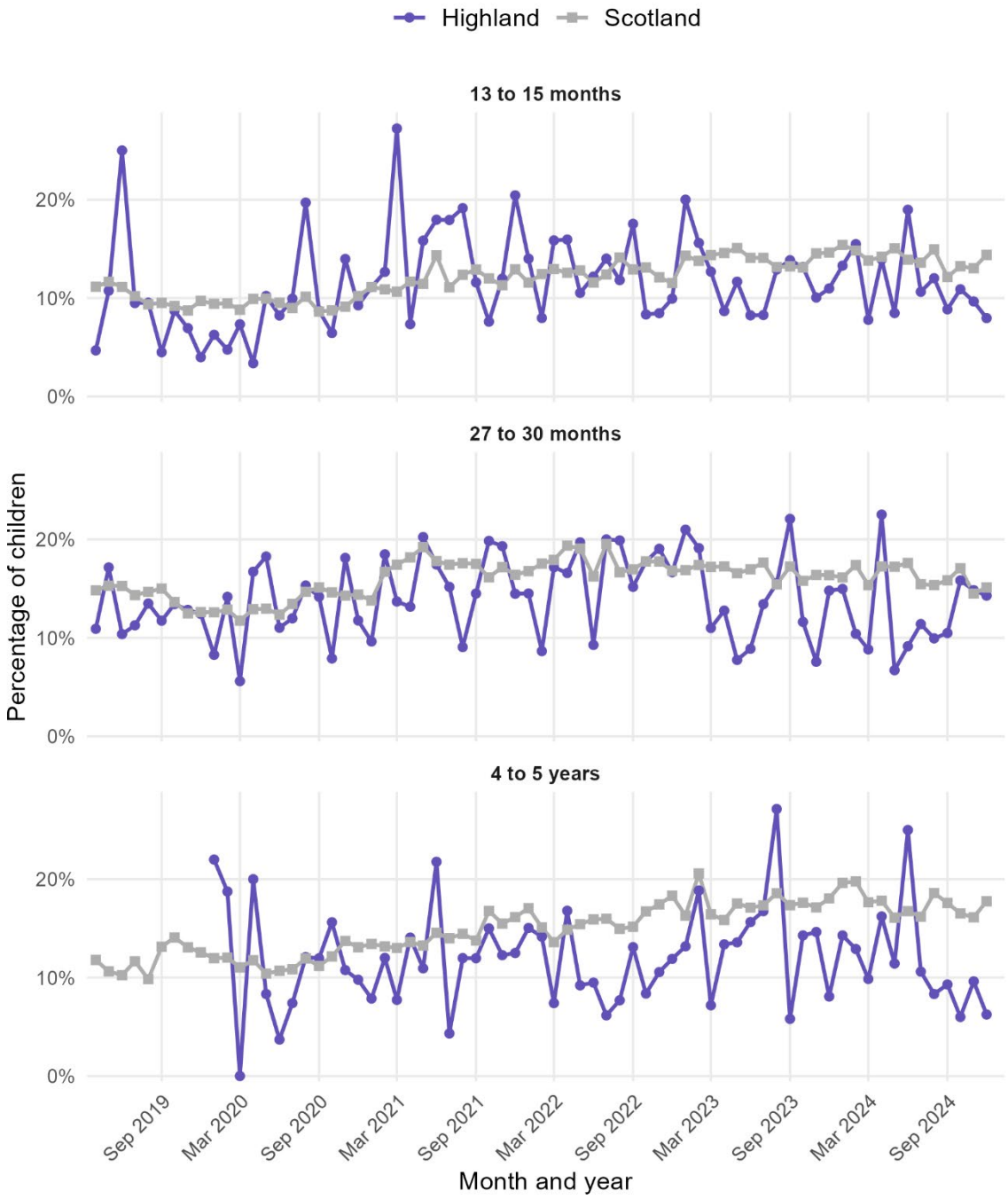
Developmental concerns identified at 4 to 5 years are strongly associated with engagement in early learning and childcare, social disadvantage, and the broader context of the early years system. Highland's developmental profile at this stage is shaped by factors such as remoteness, access to early support, and variation in preschool experiences.

Overall interpretation in Highland

Highland consistently sits slightly below the Scottish average at all three review stages. Speech, language and communication concerns are the most common at the early review points, with emotional and behavioural concerns increasing in prominence by the 4 to 5 year review.

Data completeness has improved across the period, reducing the proportion of reviews with missing developmental domain information. This improvement contributes to more reliable estimates of developmental need. However, coverage, particularly at 4-5 years, remains a concern.

Figure 50: Percentage of children with at least one concern recorded on any developmental domain at review by month, Highland and Scotland



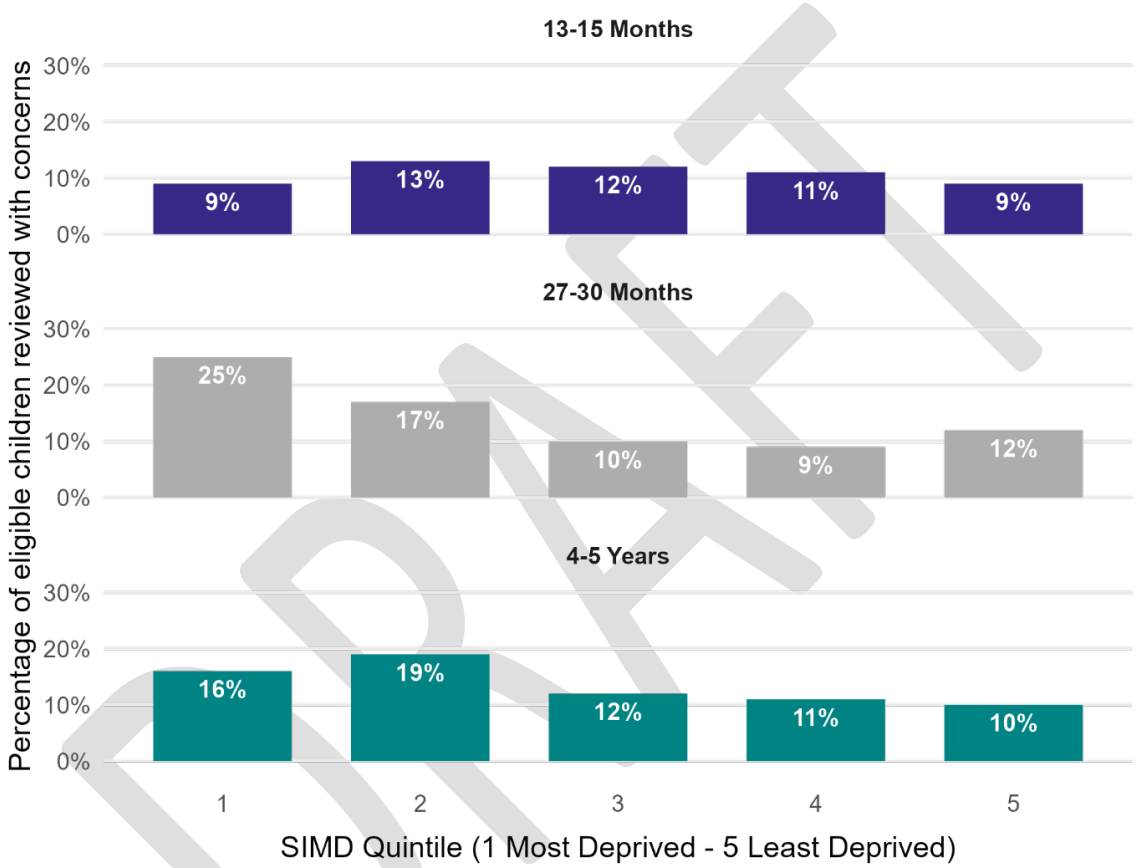
Data source: NSS Discovery, April 2019- March 2025 (extracted December 2025)

1 Reviews with no developmental assessment recorded are treated as assessment incomplete and excluded from development statistics.

Deprivation and developmental concerns in Highland

The socioeconomic gradient in developmental concerns is evident in Highland, particularly at the 27-30-month and 4-5-year reviews. Children living in the most deprived neighbourhoods remain significantly more likely to have developmental concerns recorded, a pattern consistent with national evidence. Ensuring equitable access to early years support, high-quality early learning, and family support services will remain important in addressing this gradient.

Figure 51: Percentage of children with at least one concern recorded on any developmental domain at review by deprivation quintile, Highland



Data source: NSS Discovery, April 2019- March 2025 (extracted December 2025)

The Health Visitor model in Highland

In Highland, Health Visitors are employed by Highland Council within the lead agency model, where the Council is responsible for children's health and social care, while NHS Highland leads adult services. Delivery of the universal child health review programme therefore operates through local authority employment structures while remaining aligned with national clinical standards set by the Universal Health Visiting Pathway and the Health Visiting Action Plan.[79 80 89]

Governance arrangements for Health Visiting operate across both organisations. Earlier partnership reviews highlighted the need for strengthened joint scrutiny and shared oversight of children's services, including Health Visiting, within the integration framework. Operational oversight of the Universal Pathway is supported by an NHS-chaired implementation group and a Highland Council operational implementation group, both of which meet monthly.[81 90]

The reports highlight workforce recruitment pressures and pay-scale implications for the Highland Council arising from the revision of the national job description and Health Visitor bandings; these findings relate to earlier years and should not be interpreted as evidence of the current workforce position.[91]

Workforce and budgetary transparency

Public Health Scotland provides high-quality information on coverage of child health reviews and the recording of developmental concerns. However, interpreting variation in these outcomes also requires an understanding of the local context, including the size of the Health Visiting workforce, the available budget, and the operational factors that influence delivery. These inputs are not routinely published at service level for Highland, which limits the ability to assess whether differences in coverage, including at 13 to 15 months and at 4 to 5 years, reflect need, geography, local configuration or capacity. For this reason, the JSNA does not cover service performance; instead, it focuses on describing population needs and their implications for future planning. Understanding the relationship between population needs and the workforce and resources available to meet them is important for effective planning.[80 82 87]

The role of the CPP and the broader value of the Universal Pathway

The programme of Health Visiting contacts provides an entry point for understanding the broader circumstances in which young children grow and develop. Regular visits enable Health Visitors to identify strengths and pressures within families and to recognise early signs of need relating to poverty, housing, unpaid care, parental mental health, and family stability.

Community planning partners can support this work by ensuring that Health Visitors have clear referral routes into local support for income maximisation, housing advice, early learning and childcare, family support, and carers' services. The CPP can also strengthen cross-agency coordination so that the information shared through Health Visiting contributes to broader prevention, early intervention, and place-based planning. Aligning community planning priorities with the Universal Pathway and ensuring that local services are easy to access can help ensure that every contact creates opportunities to reduce inequalities and improve outcomes.

Childhood Immunisations

Universal immunisation in the early years is a core public health function that prevents severe, vaccine-preventable diseases and supports equitable child health outcomes. Scotland's national immunisation programme aims for 95 percent coverage for key vaccines by school entry to maintain herd immunity and protect vulnerable children.

Public Health Scotland (PHS) reports gradual declines in uptake over time, alongside inequalities by deprivation, ethnicity, and urban-rural classification, indicating the need for locally tailored strategies to improve coverage. Variation in uptake by place, notably lower coverage in more remote settings for some pre-school boosters, strengthens the case for a partnership-supported approach that addresses both access to immunisations and confidence in vaccinations.[92]

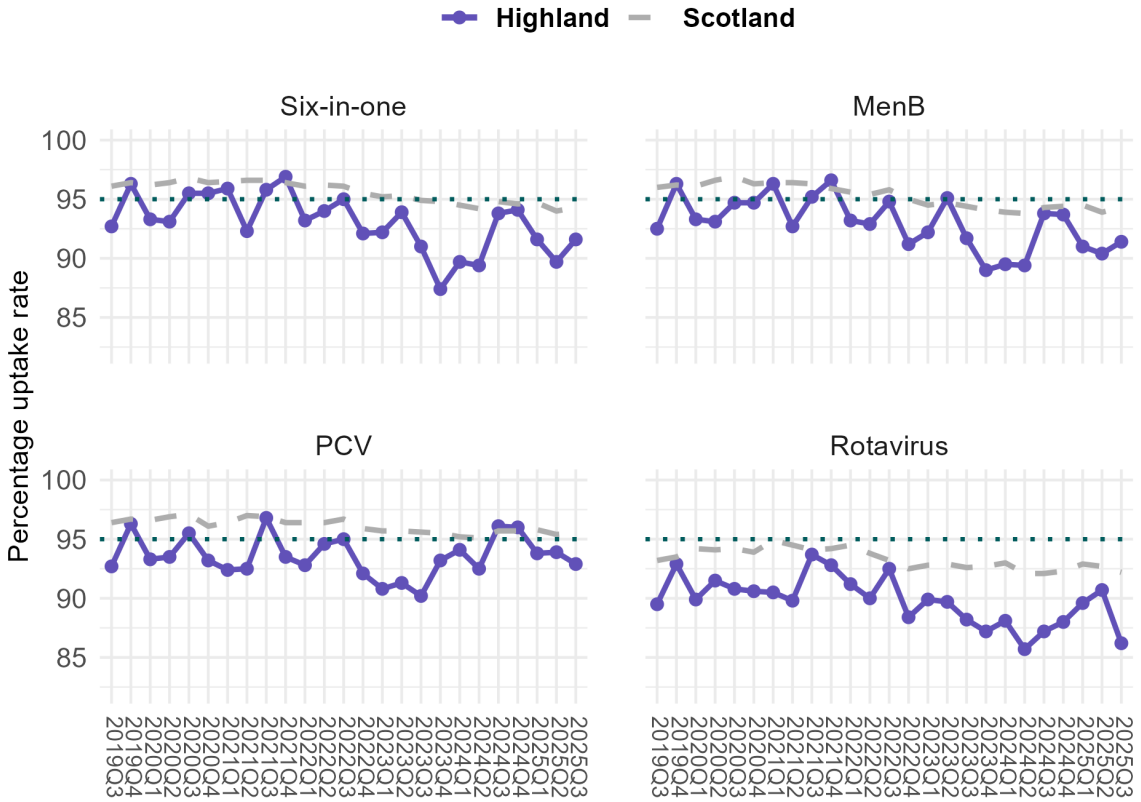
Scotland's five-year Vaccination and Immunisation Framework and Delivery Plan sets the system direction for Scottish Vaccination and Immunisation Programme (SVIP) partners and outlines three national goals: improve uptake, reduce inequalities, and avert illness.[93] [94]

Highland Position and Recent Trends

Quarterly PHS statistical updates show Scotland-level primary course uptake at 12 months remains high (>92%), while pre-school boosters and second MMR doses at 5–6 years are closer to 90–91%, with urban–rural differences that disfavour remote small towns.[1,95]

Highland's performance sits among the lower-performing local authority areas for most early years' immunisations (Figure 52).

Figure 52: Trend in primary immunisation uptake rates by 12 months of age in Highland and Scotland*, by quarter

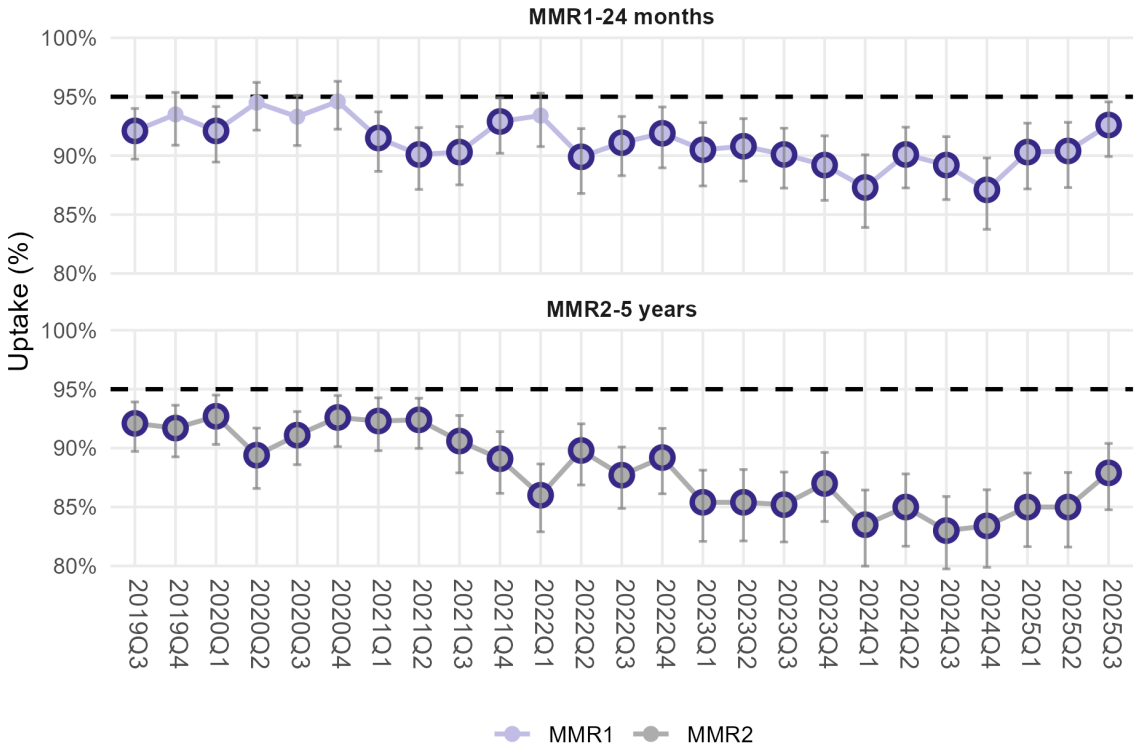


Data source: Scottish Health and Social Care open data platform, Childhood Immunisation Statistics
*Children turning 12 months of age in the relevant quarter, e.g. for Jul-Sep 2025, this would be children born during Jul-Sep 2024.

For pre-school boosters and MMR2, local reports drawing on PHS data releases highlight notable declines (Figure 53).[96]

These signals matter, given measles's resurgence across the UK and the increase in Scottish laboratory-confirmed measles cases in 2024–25, underscoring the importance of raising MMR1/MMR2 completion rates to protect school and community settings.[97,98,99]

Figure 53: Trends in MMR1 and MMR2 uptake rates at 24 months and 5 years in Highland, by quarter



Source: Scottish Health and Social Care open data platform, Childhood Immunisation Statistics Scotland
1 The dashed line shows he 95% uptake standard.
2 Error bars show 95% confidence intervals
3. Dark purple outline marker points significantly below 95% by Wilson CI.
4 Reported by the quarter in which the cohorts of children reached 24 months and five years of age

In January 2026, Scotland introduced the varicella (chickenpox) vaccine into the routine early years' immunisation schedule, with a two-dose combined MMRV programme offered at 12 and 18 months. This change aims to reduce chickenpox cases, prevent severe complications and hospitalisations, and align Scotland with international best practice in childhood vaccine protection.[100]

Geography, Delivery Model Change, and Vaccine Confidence

Highland's geography and service configuration interact in distinctive ways. PHS reports urban-rural variation in immunisation uptake, with lower coverage for pre-school boosters in remote small towns compared with accessible rural areas.

Internal and public-domain analyses of the Vaccination Transformation Programme (VTP), which transferred routine vaccination delivery from GPs to health boards, identified operational fragility when teams travel long distances to deliver small clinic volumes, raising sustainability and timeliness concerns. These considerations informed Scottish Government approval of

local flexibility in Highland, allowing development of a mixed model, including commissioning GP practices for pre-school immunisations, to improve accessibility and restore trusted points of care.[101]

Confidence and vaccination hesitancy also feature in the national and local picture. PHS reporting describes widening inequalities and highlights the need to strengthen access and communication to support uptake, while programme updates emphasise person-centred delivery and clearer engagement with families.

Issues discussed in national updates, including misinformation, appointment logistics, and concerns about multiple injections at one visit, sit alongside practical access barriers. In Highland longer journeys, fewer appointment options, and weaker personal continuity with services can compound reluctance. In practice, restoring accessible pre-school pathways and communication through trusted professionals is consistent with national programme aims and with Highland's exceptional local flexibility approval.

Risks and implications for population health

Sustained low vaccination uptake among pre-school children increases the risk of outbreaks of highly transmissible infections, such as measles, with impacts on schools, families, and health services. For Highland, the combination of place-based access barriers and an evolving delivery model means that strategic collaboration between Public Health Scotland, NHS Highland and multi-agency partners remains essential.

The strategic implication is clear: raising early years immunisation uptake rates requires accessible, trusted pathways, reliable data, and consistent messaging, each adapted to Highland's geography and supported through the agreed mixed delivery model.

The CPP can support the strategic direction with candour about geography, access, and vaccine confidence; while recognising that detailed operational design and staffing plans will follow through established governance routes.

Pre-School Vision Screening

Pre-school vision screening is a universal clinical programme designed to identify visual problems at an age when intervention is most effective. The programme focuses on detecting amblyopia, refractive errors, and strabismus, all of which can impair learning, development, and long-term well-being if left untreated early. Evidence from national audit data demonstrates high test performance, supporting screening as a preventive public health measure that contributes to equitable outcomes across Scotland.[102,103]

Vision screening aims to ensure that children begin school with optimal visual capacity, reducing avoidable barriers to learning and supporting early childhood development. Early detection allows for timely treatment, which is most effective in the pre-school years and can prevent long-term visual impairment. National reporting provides transparency on programme reach and variation across areas, supporting improvement and accountability.

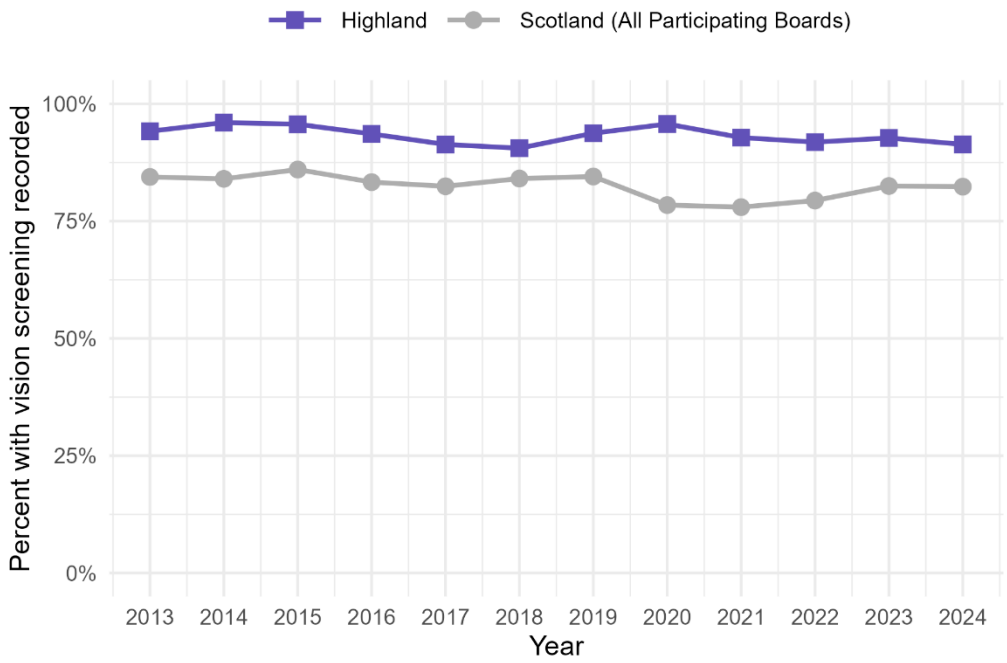
Children are offered vision screening during their pre-school years, typically between four and five years of age. This timing follows national guidance informed by the Hall 4 framework, which recommends orthoptist-delivered screening before school entry.[104] The structure supports a consistent approach across Scotland and provides a defined point for identifying visual needs before formal education.

Within the Highland Council area, vision screening is delivered in nurseries during term time. Children who do not attend nursery are offered an appointment at a local eye clinic, supporting accessibility across a large, geographically dispersed area while maintaining consistent assessment standards.[105]

Public Health Scotland reports variation in uptake by socioeconomic deprivation and ethnicity at the Scotland level. Coverage is higher in the least deprived areas than in the most deprived areas, and is slightly higher among children recorded as White Scottish than among other groups.[103] These patterns highlight the importance of monitoring inequalities within a universal programme and ensuring that operational delivery continues to reach all groups equitably.

The Highland Council area typically records higher uptake than Scotland as a whole, which supports early identification and timely referral across rural and remote communities. High coverage indicates strong coordination between the orthoptic service, early years settings, and families, and reduces the likelihood of missed or late detection of visual problems that could affect learning and development.

Figure 54: Pre-school vision screening coverage recorded in Highland and Scotland (All participating Boards), 2013 - 2024



Source: Public Health Scotland Child Health Pre-school Review Coverage, Table 27 – Vision
1. Scotland-wide coverage fell during the COVID-19 pandemic as several boards paused nursery-based screening and used catch-up invitations via community optometry, whereas NHS Highland maintained term-time orthoptist screening with clinic fallback for children not attending nursery. Differences in local service continuity and delivery routes likely contributed to Highland's comparatively higher coverage in 2020–2022.

The new child health information system

NHS bodies are leading the national modernisation of child health information systems, aiming to replace multiple legacy platforms with a more integrated, coherent system that supports all aspects of the early years pathway. This programme includes the transition to the National Child Health Information System, improvements to the Community Health Index infrastructure, and the integration of the Scottish Immunisation Recall System to support unified scheduling, reminders and follow-up for childhood immunisations.

The modernised system is designed to improve data quality, ensure that key health information follows the child across services, and strengthen interoperability between Health Visiting, immunisation, early learning and childcare, and wider child health programmes.

Although NHS Scotland drives these developments, they have direct implications for partner agency services, including Health Visiting teams employed by Highland Council, which rely on NHS-governed child health systems for assessment, documentation, and follow-up.

The current system is used for:

- Call and recall for essential vaccination appointments for infants, children and young people in accordance with the immunisation schedule for Scotland.
- To record Newborn Bloodspot results and provide reports to Newborn Screening Services.
- To allocate pre-school children to a Health Visiting team and schedule health review visits in accordance with the Universal Pathway for Health Visiting in Scotland.
- To facilitate national and local reporting by Public Health Scotland on Children's Health.
- To record newborn hearing screening results.
- To support vision screening, scheduling, and result recording.
- To record and report on vaccination outcomes and immunisation histories.

Existing users of the current Child Health Surveillance Programme (CHSP) Pre-School, School, and SIRS systems include Health Visitors, Midwives, School Nurses, Paediatricians, Vaccination teams, Child Health teams, Allied Health Professionals, Audiology, and Screening.

Once fully embedded, the new national system is expected to reduce missing information, support more consistent use of structured assessment tools, and provide a more reliable basis for monitoring early child development and wider child health outcomes.

Governance of child health information systems in Highland is complex. Highland Council employs Health Visiting staff under the lead agency model, but the clinical systems they rely on are governed, maintained and quality-assured by NHS Highland and national bodies. The separation can create ambiguity in lines of accountability, particularly around data quality and system performance.

7.1. Early Learning and Parenting

The ages of zero to five are crucial to child development and early learning is linked to later educational achievement, health and well-being.[106] Babies and young children need stable, caring relationships and stimulating experiences to flourish.[107] At 27-30 months, x percent children in Highland have a developmental concern [And/or link to section on developmental reviews] and these challenges affect their ability to learn and thrive through the early years and beyond. These challenges are not experienced equally across society. Those living in the most deprived areas more likely to have an identified developmental concern and, furthermore, they are more likely to face multiple different concerns. Boys are more likely to have a developmental concern than girls, particularly those residing in the most deprived areas. Nationally, 40 percent care-experienced children have an identified developmental concern at 27-30 months compared to 17 percent in those without care-experience, and the percentage of care-experienced with a developmental concern has increased over time.[108] Children aged three are more likely to fall into the bottom 20 percent for either (or both) of cognitive development and emotional and behavioural problems if maternal educational attainment is low, there is a high level of maternal psychological distress, for some ethnic minority groups and in one compared to two parent households.[109] Inequalities in outcomes for young children highlight the importance of early intervention to support families to provide the environment needed to enable all children to develop to their full potential.[110] Interventions at this stage are cost-effective compared to support that may be needed later to mitigate early disadvantage.

Adults can provide appropriate play and stimulation to promote early development. The environments in which infants and young children develop varies in both material resources and environmental factors such as maternal vocabulary, daily reading to infants and young children and the emotional closeness between parent and child and conflict.[107] Parents, and particularly the primary care giver, have the most influence on a child's life at this stage, but quality childcare can improve early learning and development and is particularly beneficial to those from the most disadvantaged backgrounds. The Scottish Government fund 1,140 hours of Early Learning and Childcare for all three and four year olds and eligible two year olds in Scotland in 2021. Eligible two year olds include those with experience of care and households with low income and/or on certain benefits.[111] Whereas for three and four years olds, registration for early learning and childcare was 100 percent, only 53 percent of eligible 2 year

olds were registered in Highland.[112a] This is similar to the Scottish average (55 percent) but far lower than in some other council areas, two of which had over 80 percent of eligible 2 year olds registered. Childminders and/or wider family members may also contribute to childcare. For Scotland, the Scottish Household Survey (2024) found that 71 percent of families use childcare to allow an adult to work.[113] However, 30 percent cite their child's social and development and 25 percentage their learning and language development as reasons for using childcare.

Family and parenting support, including pre-birth and during pregnancy, can positively impact on child early learning and development. Supporting families can improve mental health, reduce isolation and better enable people to be effective parents. Statutory support is provided via social care and health visiting services who may also refer to third sector partners such as Home Start, which provides family support across Caithness and Southeast Highland (East, Mid and West Ross, Inverness and (shire), Badenoch and Lochaber).

Parenting programs have also been shown to improve parenting skills and improve early child outcomes.[107] Scotland's parenting strategy aims to strengthen the support on offer to parents and make it easier for them to access this support.[114] There are national parenting support initiatives aiming to improve early outcomes. Play, Talk, Read aims to encourage parents, grandparents and carers to interact with their young children. Read, Steady, Baby is a resource provided to all pregnant women and aims to improve the health and wellbeing of parents and their young children by providing information about pregnancy, childbirth, and early parenting up to age 12 months.[115] Bookbug provides free books and sessions to share songs, stories and rhyme to families across Scotland.[116] Further access to family and parenting support could improve outcomes for children in Highland and reduce inequalities.

[a] Children are counted once for each centre they are registered with, so the same child may be counted multiple times if they attend more than one centre. Children may also attend centres outside of the local authority they live in, which would also affect these figures.

8. Health and wellbeing across childhood

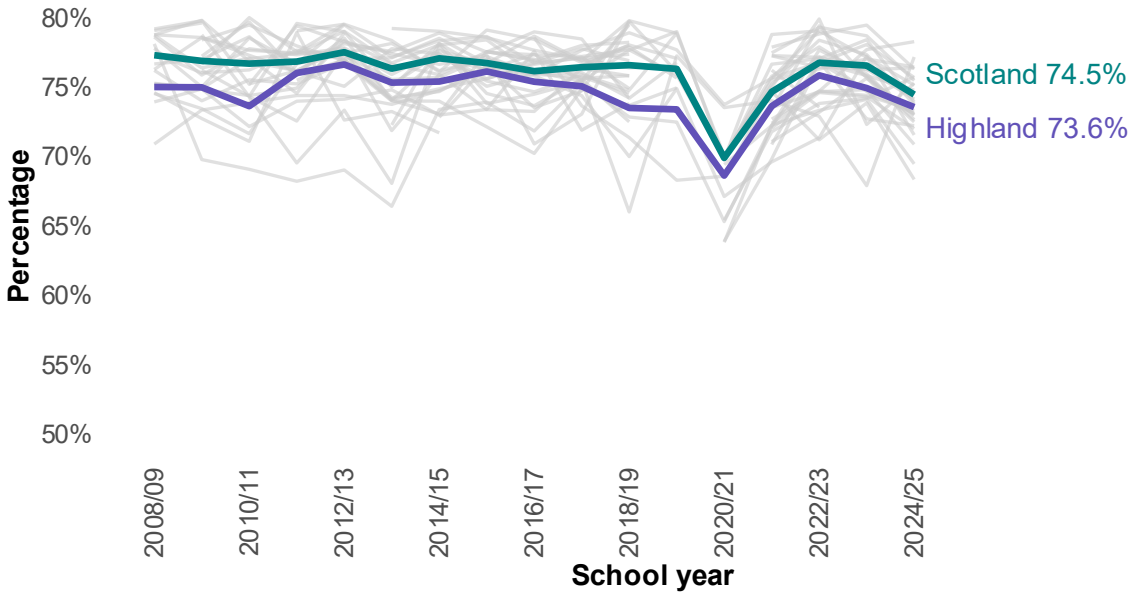
Health and wellbeing across childhood creates the foundations for lifelong health and wellbeing. Activities that enhance health and wellbeing at all ages include eating a varied and balanced diet, limiting consumption of health harming products and being physically and mentally active. Evidence-based priorities identified in Scotland's Population Health Framework recognise that increasing access to environments that support health are key to improving health and wellbeing and creating the conditions for children to thrive.

Healthy weight

Monitoring healthy weight in childhood is a way of seeing how well the needs of children are being met. Maintaining a healthy weight throughout childhood is associated with many health and wellbeing benefits and prevention of health problems later in life, including type 2 diabetes and cardiovascular disease. The early years are critical for establishing good nutrition and healthy eating habits and preventing obesity in later life.

Child height and weight are measured in Primary 1 (P1) children and used to monitor those at risk of unhealthy weight. In the school year 2024/25, 73.6 percent of P1 children measured in Highland had a healthy weight compared to 74.5 percent in Scotland (Figure 55).

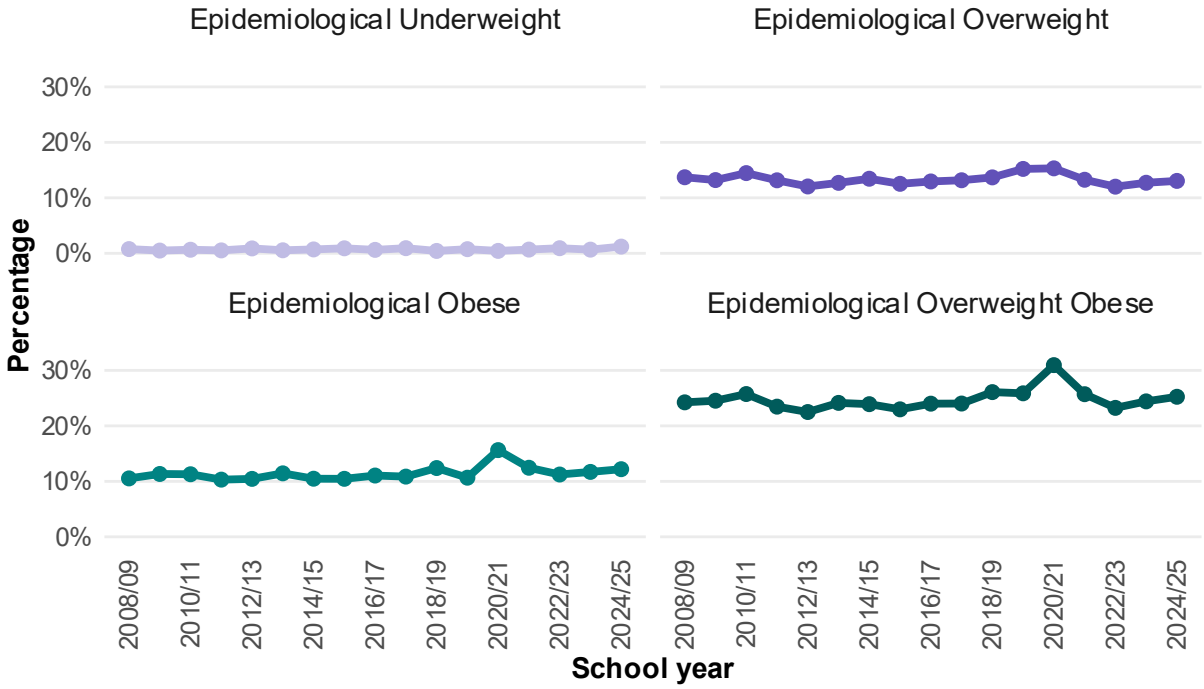
Figure 55: Percentage of Primary 1 children with a healthy weight by Local Authority



Source: Public Health Scotland, Child Health Systems Programme School (CHSP-S)
1 Children in Primary 1 receiving a review whose BMI falls within the epidemiological threshold for healthy weight (BMI >2nd and <85th centile)
2 Coverage was lower in 2019/20 and 2020/21 due to COVID-19

In Highland, as in Scotland, the proportion of children at risk of overweight or obesity increased in both 2023/24 and 2024/25. Nationally and locally, the BMI distribution of P1 children in 2024/25 suggests around one in four children are already at risk of overweight or obesity (Figure 56).

Figure 56: Trend in selected BMI measures (epidemiological categories) in Highland



Source: Public Health Scotland, Child Health Systems Programme School (CHSP-S)
Children in Primary 1 receiving a review whose BMI falls within epidemiological categories: underweight (BMI <2nd centile), overweight (>=85th and <95th centile), obese (>=95th centile), overweight and obese combined (>=85th centile).

Policy actions to improve healthy weight include developing a whole system approach to improve food environments; ensure a healthy, balanced diet is accessible and affordable to all; and support the provision of healthy food in early years and school settings.[117]

Physical activity

Regular physical activity is essential for good health and wellbeing. In children, physical activity contributes to bone health, cognitive function, cardiovascular fitness, muscle fitness, healthy weight as well as mental health benefits including reduced risk of depression.[118] Insufficient physical activity is a major risk factor for non-communicable diseases, causing significant loss of quality of life through avoidable disability. Over 3,000 deaths in Scotland each year have been attributed to low physical activity.[119]

UK physical activity guidelines are that children aged 5 to 18 years should participate in an average of at least an hour of moderate to vigorous physical activity per day across the

week.[118] Moderate to vigorous physical activity is that which makes you breathe faster and feel warmer. Children and young people should include engage in a variety of activities which build bone strength, muscular fitness and movement skills. In addition, they should minimise sedentary time and break up periods of not moving.

For younger children, the guidelines are slightly different with those aged 2-4 recommended to spend at least three hours being active a day, with at least one hour of moderate to vigorous activity. Those aged 1-2 are also recommended to spend at least three hours a day being active. More than three hours activity is better.

Policy context

One of Scotland's Public Health priorities is to have "A Scotland where we eat well, have a healthy weight and are physically active" and the Scottish Government has a clear ambition to improve levels of physical activity in Scotland.[120] Physical activity plays an important role in healthy weight, which is a priority in the Population Health Framework.

The Active Scotland Delivery Plan (2018) sets out an outcome to develop physical confidence and competence from the earliest age. Participation in and positive experiences of physical activity in children and young people encourages lifelong activity and can prevent future poor health.

There is a need to increase physical activity levels in many children and young people, to minimise sedentary time, and to reduce identified inequalities for girls, teenagers and those from more deprived backgrounds. Barriers to participation in physical activity include cost, transport and accessibility, and inclusivity e.g. for those with disabilities and for LBGTQ+ people, for girls and for ethnic minorities.[121]

Evidence

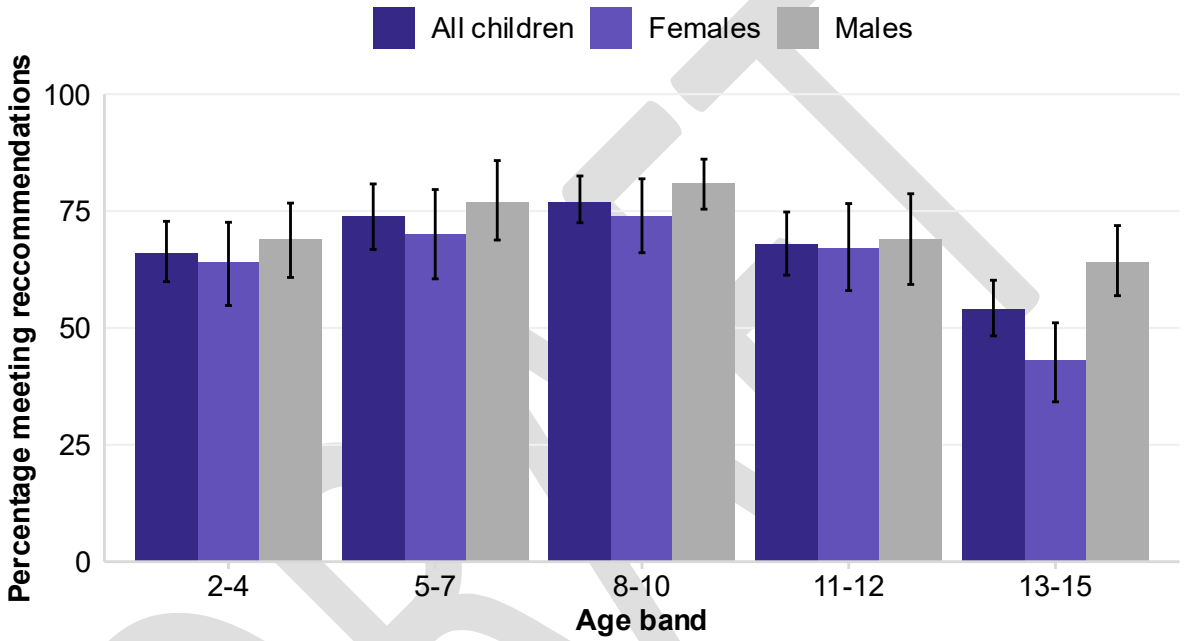
In the 2025 Highland Lifestyle Survey for P7, S2 and S4 pupils, 62.3 percent reported usually having 60 minutes or more physical activity in a day.

The Scottish Health Survey (SHeS) is the main source of physical activity evidence; results are published for Scotland and are not routinely available by council area. The SHeS asks children aged under 16 about their participation in activities such as sport, active play and walking, and this is used to estimate the proportion of children meeting the physical activity guidelines.

In the 2024 survey year, 68 percent of children met recommendations, with 8 percent meeting these due to the impact of school activities. For school-aged children, the opportunity to be physically active in school hours is an important contributor to their activity levels. The

percentage meeting guidelines reduced between the ages of 8-10 (77 percent) and 13-15 (54 percent) and was lower in girls compared to boys across all age bands. Less than 50 percent of girls aged 13-15 meet physical activity recommendations (Figure 31). Those living in the most deprived quintile in Scotland were less likely to meet physical activity guidelines (61 percent) than those in the least deprived quintile (81 percent).

Figure 57: Percentage of children in Scotland meeting physical activity recommendations by age and sex, 2024



Source: Scottish Government, Scottish Health Survey
Data are published for Scotland and not routinely available by council area. Error bars represent 95% confidence intervals.

Results from the Health Behaviour in School-aged Children (HBSC) survey in 2021/22 reported that 23.3 percent children in Scotland (aged 11 to 15 years, covering P7, S2 and S4) participated in an hour of more moderate to vigorous physical activity daily.[122] In common with the SHeS. the percentage of children meeting physical activity guidelines was higher for boys than for girls, decreased with increasing age and was higher for those in more affluent families.[a]

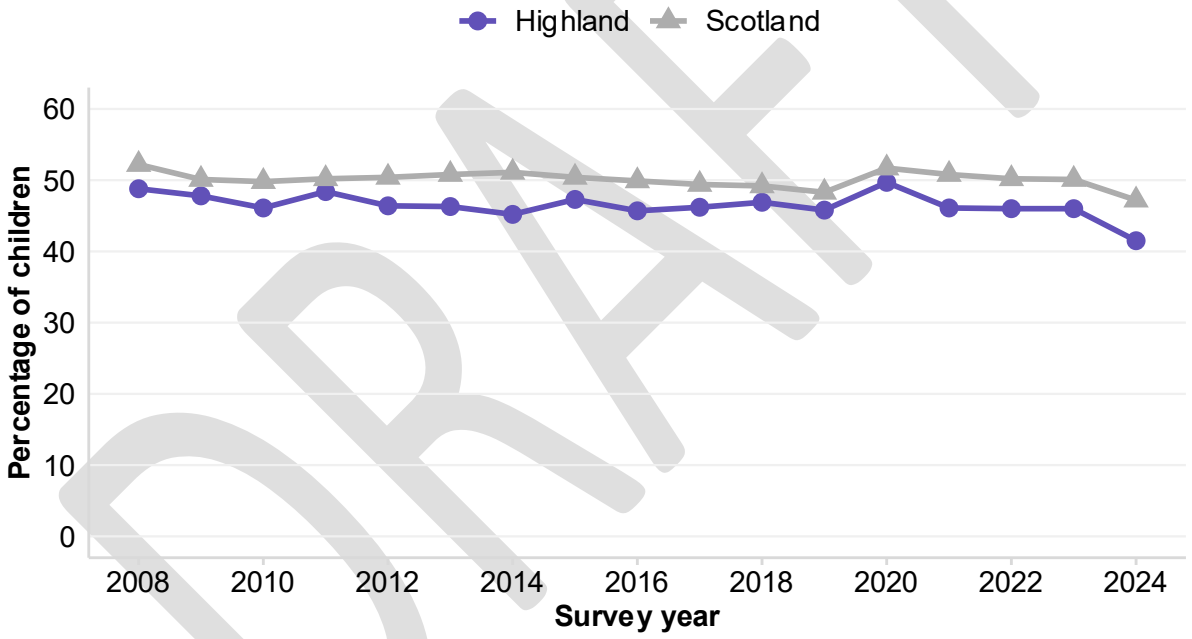
[a] Use of a single question asking about the number of days physically active for at least an hour in the Health Behaviour in School-aged Children survey can explain the lower estimate than in the Scottish Health Survey, as participants may not recall their activity without additional prompts.

Physical activity in young people can be achieved through physical education at school, after-school clubs and activities, active travel, playing both indoors and outdoors, and involvement in sports.

Participation in sport is linked with deprivation; 55 percent of those in the most deprived areas in Scotland are estimated to participate in sport compared to 78 percent in the least deprived areas. Participation in sport by age follows a similar pattern to overall physical activity, but with lowest sporting participation in the early years.

Active travel includes walking, cycling, and using a scooter, skateboard or inline/roller skates. In 2024/25, 42 percent of children in Highland were estimated to use active travel to commute to school, lower than the Scottish average of 47 percent (Figure 58).

Figure 58: The percentage of primary and secondary children who report they normally travel to school in an active way, Highland and Scotland, 2008 - 2024



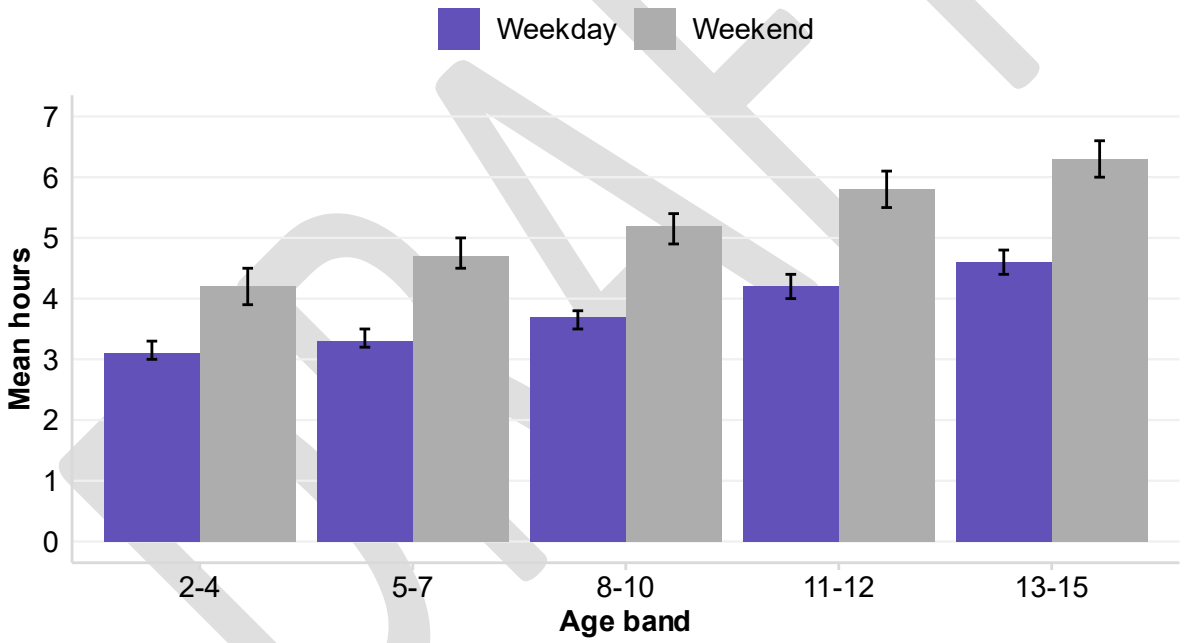
Source: Hands Up Scotland Survey (HUSS), Sustrans (Official Statistic), ScotPHO profiles tool

Geographic factors play an important role in shaping travel behaviours. The dispersed settlement pattern and long travel distances in rural Highland mean that many pupils rely on motorised transport, including buses and private vehicles, to reach school. While initiatives such as the Young Persons' Free Bus Travel Scheme have increased bus use among young people, active travel remains less feasible in areas lacking safe walking and cycling infrastructure.[123]

Inequalities in active travel are influenced by factors such as gender, age, income, and disability.[124] Women and disabled people often report feeling unsafe walking or cycling, particularly in poorly lit or isolated areas. Infrastructure that fails to meet the needs of all groups can exacerbate health inequalities. Place plays an important role in enabling physical activity through safe active travel routes, access to play parks and sports amenities and open (green and blue) spaces.[125]

Sedentary behaviour such as sitting, reclining or lying is linked with poor health outcomes.[119] Children in Scotland were estimated to spend an average (mean) of 5.2 hours sedentary at the weekend and 3.8 hours on a weekday. The average number of hours spent sedentary has increased since 2013. Sedentary behaviour increases through childhood and is higher in older children (Figure 59).

Figure 59: The average (mean) number of hours Scottish children aged 2 to 15 spend being sedentary at the weekend and in the week by age band, 2024



Source: Scottish Government, Scottish Health Survey
Data are published for Scotland and not routinely available by council area. Error bars represent 95% confidence intervals.

Increasing use of mobile phones and other computing devices is a public health concern due to time spend sedentary, concerns regarding the mental health impact of social media and potential exposure to online harms. The HBSC survey found that 93 percent of 15-year-old boys and 94 percent of 15-year girls keep their smartphone in their bedroom at night. Problematic social media use increased between the 2022 and 2018 surveys in all age groups and was estimated to affect one in four 13 and 15-year-old girls. Boys were more likely than girls to experience problematic gaming, estimated to affect 19 percent of 15-year-old boys.[121]

Substance use

Preventing harm caused by alcohol, tobacco and other drugs among young people is a national and local priority and central to the GIRFEC approach to improving outcomes and supporting the wellbeing of children and young people.[126] [127] Collectively, the avoidable harms from these substances are a major influence on preventable ill health across the life course.

Problematic use of drugs and alcohol is associated with multiple risk factors and vulnerabilities. Evidence highlights that children and young people at higher risk for alcohol and drug problems include care experienced children, homeless younger people, young offenders, children who have experienced trauma, children and young people in families with problem drug use, children experiencing deprivation, and younger people not in work or education.[128]

Planet Youth, the Icelandic Prevention Model, is an evidence based primary prevention approach that aims to reduce and delay alcohol, tobacco and other drug use among young people.[129] The approach has achieved success in reducing substance use among young people in Iceland by focusing on increasing protective factors and reducing risk factors associated with substance use. Planet Youth is a universal prevention model, which means reaching all young people, not just those already at risk. Focusing on strengthening protective factors also has benefits for many other areas of a young person's life.

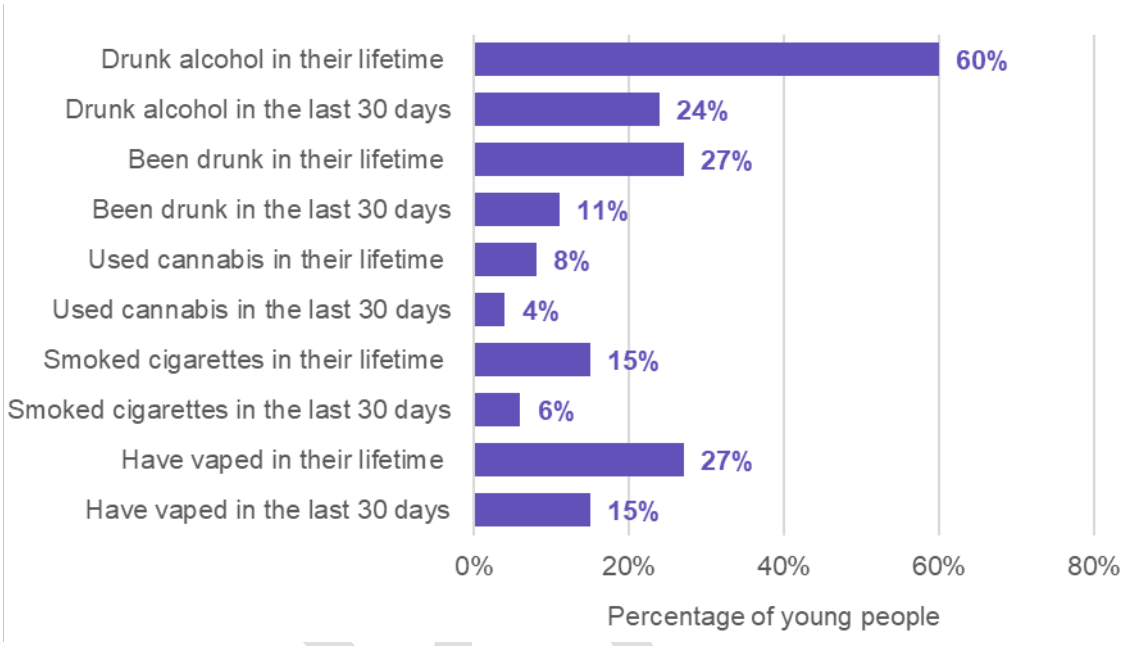
Examples of protective factors include:

- In families, protective factors include having clear boundaries, parents disapproving of their child using substances, and families that spend time together.
- With peers, protective factors include friends that don't use substances and avoiding other risky behaviours.
- For schools, protective factors include being motivated to learn and to feel safe at school.
- For leisure time, protective factors include being involved in structured activities, having meaningful use of time, and being involved in communities.

In Autumn 2025, Planet Youth surveys were completed by over 2,200 pupils from schools in Highland to better understand the experiences of young people growing up in the area. Participants were from S3 and S4 year groups, so principally aged 14 or 15 at the start of the school year.

The survey highlights that substance use harms continue to start early for many young people in Highland: 60 percent of pupils reported they have consumed alcohol at some point in their lives, 24 percent in the past month. In addition, 45 percent of pupils reported having been drunk at least once in their lifetime. Although most young people reported never using drugs, 8 percent reported they had used cannabis substances at least once, 6 percent in the past year and 4 percent in the past month. One in four (27 percent) of pupils reported using vaping products at least once and 15 percent have smoked cigarettes in their lifetime (Figure 60).

Figure 60: Findings from the Highland Planet Youth Survey, 2025



Source: Planet Youth Survey

In 2021, a review of drug related deaths in younger people in Highland identified risk factors for early death. Most of this cohort of young people experienced multiple adversities throughout their short lives − poverty, poor quality and insecure housing, educational disadvantage, unemployment, social exclusion and isolation, violence and imprisonment. Almost all experienced adverse and traumatic life circumstances growing up with a parent with substance use and/or mental health problems.[130]

A summary of risk and protective factors for young people, identified by Planet Youth and the review report, is shown in Figure 61. Continued co-ordination of activities between Alcohol and Drugs Partnerships and Integrated Children's Services is essential for ensuring the development and delivery of a holistic whole family approach and family inclusive practice for children, young people and families affected by drug and alcohol use.[131]

Figure 61: Protective and risk factors for drug and alcohol related harm in young people

Source: Highland Alcohol and Drugs Partnership Health Needs Assessment 2025

Between 2023-2025, a programme of work to establish consensus and describe the key themes that contribute to a national approach to substance use harm prevention among children and young people in Scotland was undertaken.[132] The findings advocate for an approach that incorporates prevention, early identification and intervention, and harm reduction measures.

The work identified the need for both universal and targeted prevention measures, the role of community and environmental factors in substance use harm prevention, the importance of relationship-based, trauma-informed practice and the need for a whole-systems approach that fosters collaboration. It also recognised the need to involve children and young people in the development and implementation of prevention strategies and approaches.

In 2025, the Scottish Government also published Standards for Young People Accessing Treatment or Support for Alcohol or Drugs.[133] The standards recognise that a comprehensive system of prevention and early intervention is essential to reduce drug harms amongst young people. Identifying and supporting young people at risk provides an invaluable opportunity to intervene early and prevent more serious harms later in life.

The 2025 Highland Alcohol and Drugs Partnership (HADP) health needs assessment provides further evidence to support understanding of alcohol and drug related harms for children and young people in Highland, linked to agreed priorities identified in the HADP Strategic Plan.

Mental wellbeing

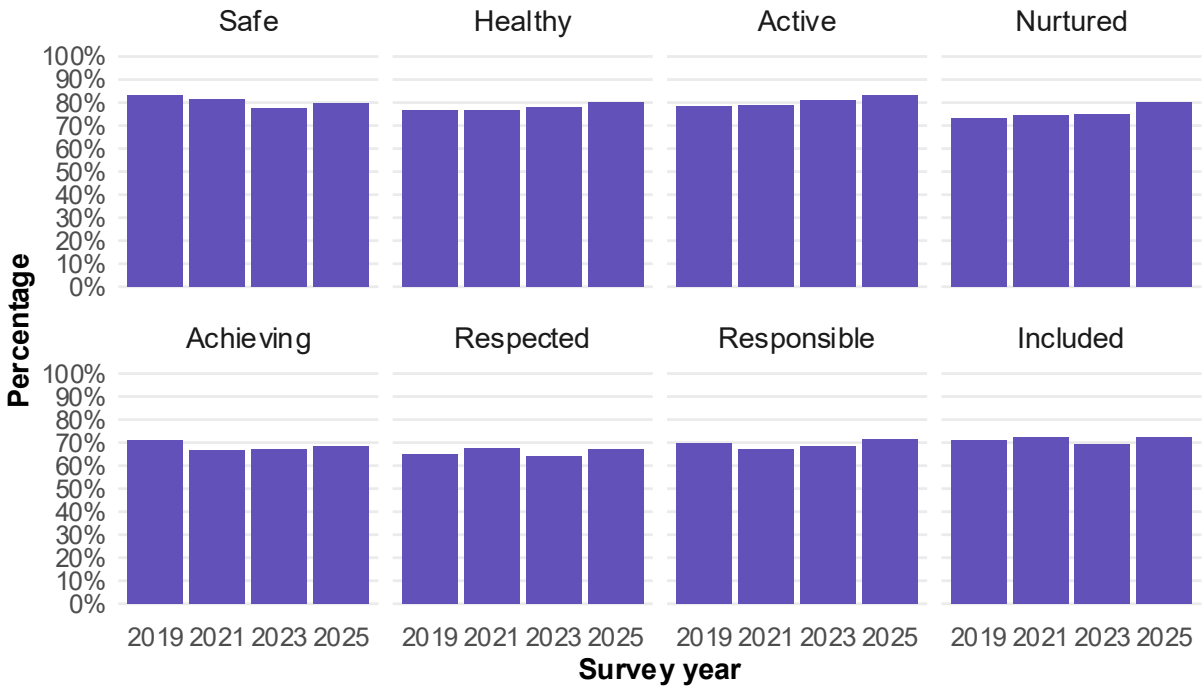
The mental wellbeing of children and young people has been identified as a concern across Scotland. Multiple indicators suggest an increase in prevalence of mental health and wellbeing stressors for children and young people, and that many young people are experiencing mental health stigma and discrimination.

The Getting it Right for Every Child (GIRFEC) principles use an approach to considering children and young people's wellbeing that is rights-based, strengths-based, and adaptable to take account of stage of development and the complexity of each child or young person's life or circumstances. The approach uses eight wellbeing indicators: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included (SHANARRI). When considered together, they provide a holistic view of the wellbeing needs of each child or young person.

The National Practice Model within GIRFEC also offers a framework to help identify wellbeing needs and identify the risk and protective factors that contribute to mental health and wellbeing.

Data from the Highland Lifestyle Survey are used as an ongoing measure of the progress made in the whole school approach to supporting mental health and wellbeing (Figure 62).

Figure 62: Percentage of Highland children reporting their wellbeing needs are met using the SHANARRI principles, 2019 to 2025



Source: The Highland Council, Highland Lifestyle Survey 2025

Sleep health

Sleep for children and young people is essential for their physical, mental, and social health. Sleep problems and a lack of sleep have been linked to issues such as developmental delays, and long-term health risks.[134] In a study of 4,000 children, those who experienced insufficient sleep at ages 9 and 10 developed more mental health and behavioural challenges during adolescence.[135]

Sleep problems in children and young people may be caused by behavioural and environmental factors and/or an underlying medical condition.[136] Key factors influencing sleep health include parenting, screen time, physical activity and nutrition, with increasing evidence linking social media use to poor sleep.[137] [138] A 2025 study recommended that sleep health should be a public health priority, requiring a multisectoral and life-course approach to address the barriers to healthy sleep.[139]

Clinical and practice guidelines highlight that the need for sleep varies according to children's age. NHS Highland has developed a children's clinical guideline and pathway on sleep.[140]

The pathway was developed to encourage a standardised approach to referring to community paediatric services any child or young person in Highland who is experiencing sleep problems. The recommended number of hours needed by children of different ages are shown in Figure 63.

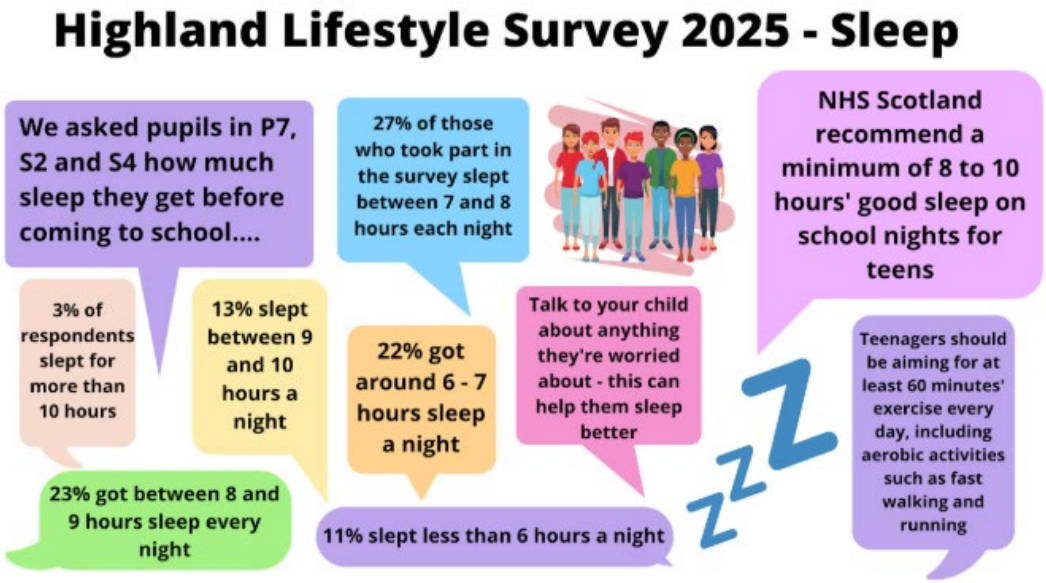
Figure 63: Recommended number of hours needed by children of different ages

Age	Hours of sleep
Babies 4 to 12 months old	12 to 16 hours including naps
Toddlers 1 to 2 years old	11 to 14 hours including naps
Children 3 to 5 years old	10 to 13 hours including naps
Children 6 to 12 years old	9 to 12 hours
Teenagers 13 to 18 years old	8 to 10 hours

Source: NHS Highland Sleep pathway

In Scotland, the Health Behaviour in School-Aged Children survey indicated that the proportion of children getting sufficient sleep and quality sleep was reported as 59.6 percent and 3.6 percent respectively.[141] In Highland, results from the 2025 Highland Lifestyle survey reported that 39 percent of pupils met the recommended minimum of 8 to 10 hours sleep on school nights for teenagers (Figure 64).

Figure 64: Findings from the Highland Lifestyle Survey 2025 on sleep



Source: The Highland Council, Highland Lifestyle Survey 2025

Key messages for Highland

9. Oral health

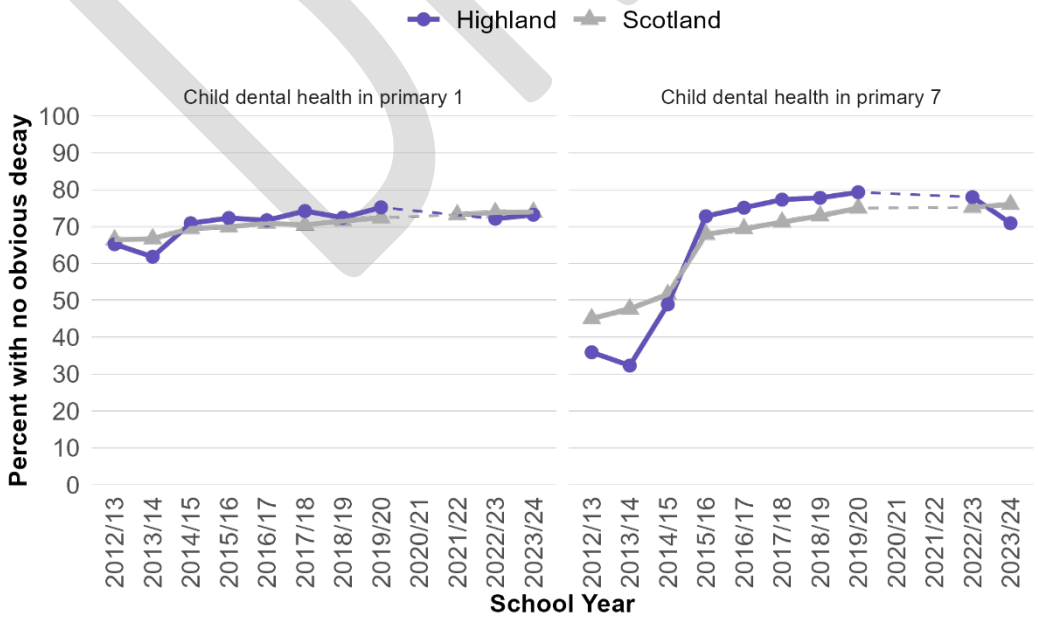
Oral health forms part of children's general health and wellbeing, influencing pain, nutrition, sleep, speech development, school readiness and social participation. Poor oral health can lead to pain, infection, difficulties eating nutritious foods and maintaining healthy growth, problems with speech, and increased school absence due to discomfort or dental appointments. These impacts can affect learning, social confidence and wider wellbeing. Dental problems observed in children may also indicate unmet health or care needs and should be considered within broader wellbeing assessments.

Prevention and surveillance

Two national pillars support oral health improvement in Scotland. The Childsmile programme delivers universal and targeted prevention through supervised toothbrushing in early years and primary school settings, and prevention activity in primary care. The National Dental Inspection Programme (NDIP) provides population-level surveillance of oral health in Primary 1 and Primary 7 pupils. Together, these programmes offer a preventive and monitoring framework across all NHS boards in Scotland.[142] [143]

NDIP estimates for Highland show a long-term improvement in the proportion of children with no obvious decay. For Primary 1, the proportion free of obvious decay has increased since 2012/13, and for Primary 7, a sharp improvement in 2015/16 was followed by a more gradual change (Figure 65).

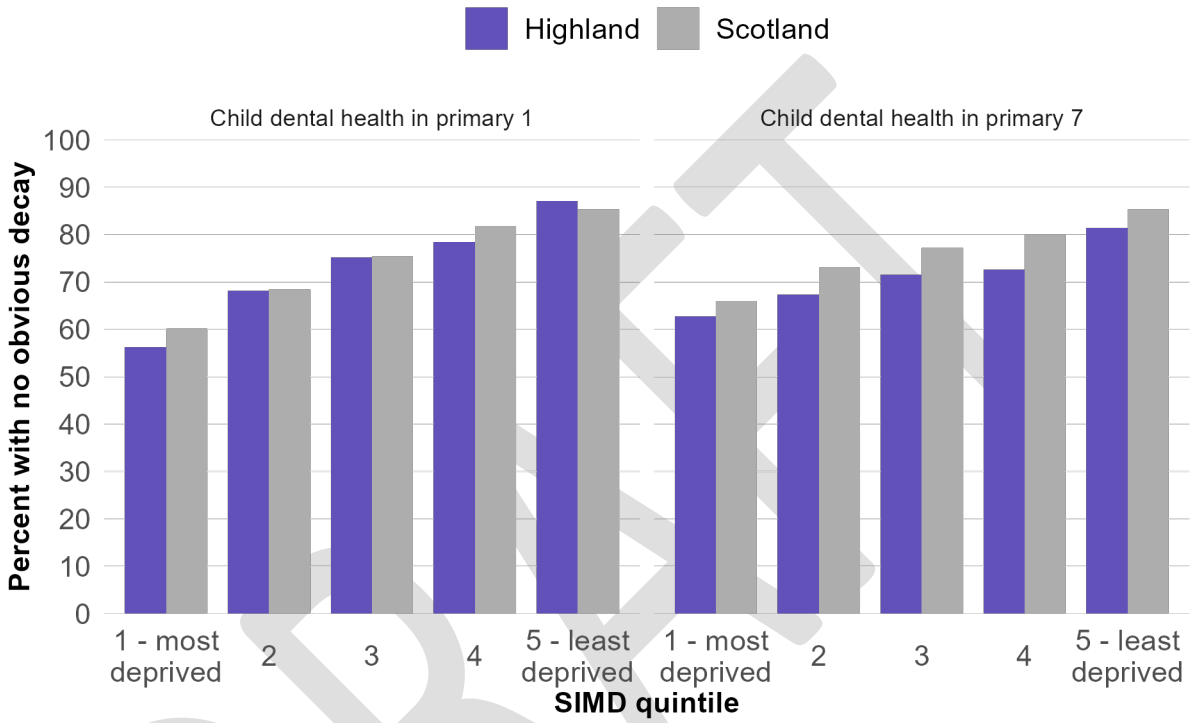
Figure 65: Percent of Primary 1 and Primary 7 children with no obvious dental decay experience in Highland and Scotland, 2012/13 to 2023/24



Source: National Dental Inspection Programme, Scottish Public Health Observatory profiles
1 Comparable data for 2020/21 & 2021/22 is missing due to COVID-19 restrictions.
2 No obvious dental decay experience means no obvious decayed, missing and filled primary teeth.

Socioeconomic inequalities remain evident. Scotland and Highland continue to show a gradient in the experience of decay in the Scottish Index of Multiple Deprivation (SIMD), consistent with wider determinants of health and differences in service use (Figure 66). Childsmile plays an essential role in mitigating these inequalities through universal toothbrushing and targeted fluoride varnish activity.

Figure 66: Percent of Primary 1 and Primary 7 children with no obvious dental decay experience by Scottish Index of Multiple Deprivation (SIMD) quintile in Highland and Scotland, 2023/24



Source: National Dental Inspection Programme, Scottish Public Health Observatory profiles
1. Based on Scotland level SIMD 2020v2 quintiles. No obvious dental decay experience means no obvious decayed, missing and filled primary teeth

NDIP does not measure access to care; it is important to view prevention coverage and service participation alongside NDIP outcomes.

Registration and participation with NHS dental services

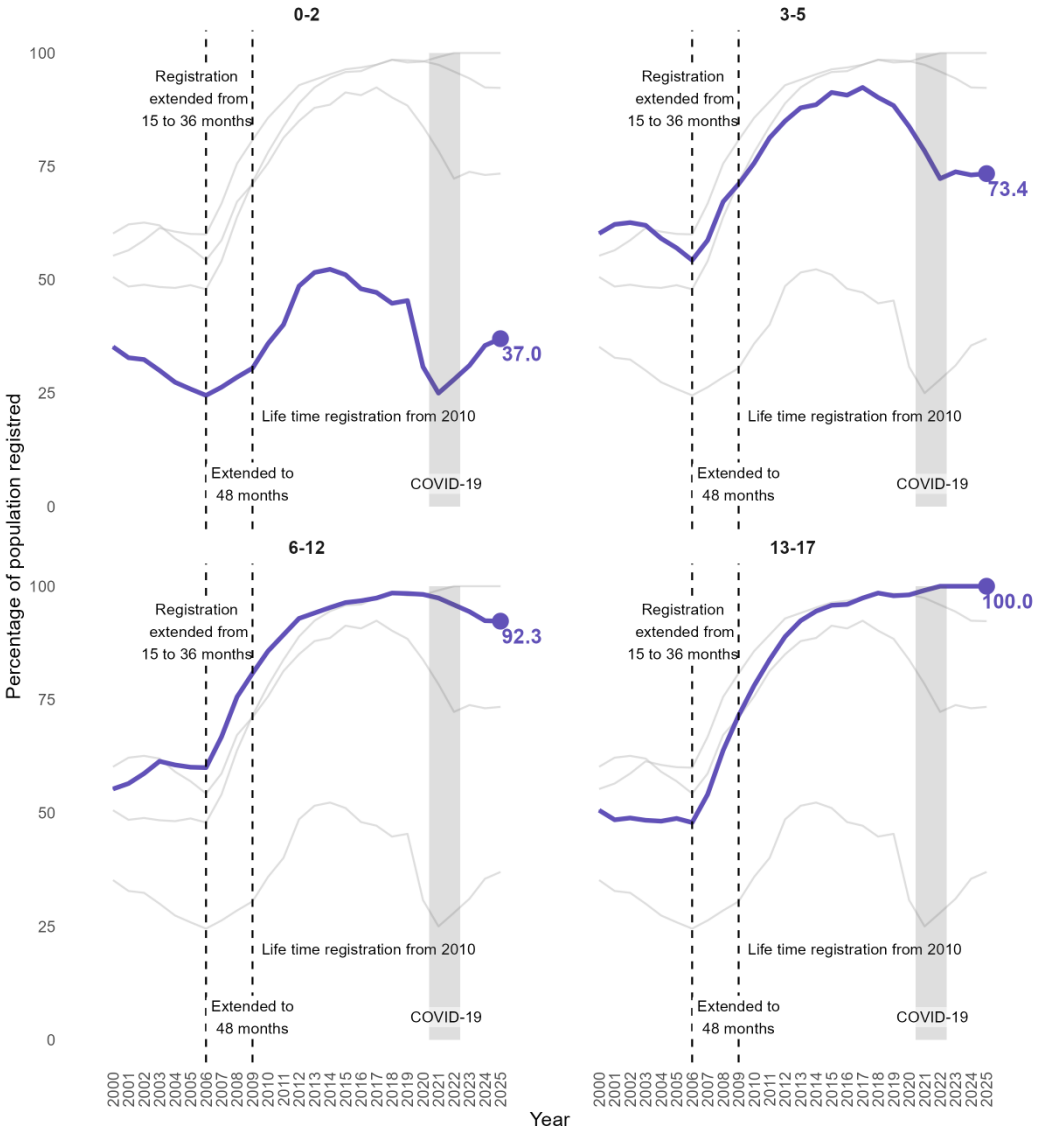
Registration is a coverage measure against the resident population. Participation is a utilisation measure among registered patients and uses a 24-month look-back from the snapshot date in reporting.[144,145]

PHS registration and participation metrics do not include private-only activity; they report NHS pathways and define participation as contact within the previous 24 months among registered patients with General Dental Services (High Street Dentists).

Registration coverage among children in Highland remains high overall, consistent with the national position under the lifetime registration policy. However, the youngest age groups (0–2 and 3–5 years) show slower, lower recovery in registration compared with older cohorts. National reporting notes that new patient registrations fell during the pandemic, particularly among younger children, and subsequent recovery has been slower in these ages compared with older, already-registered cohorts who retained their status under lifetime registration.[144,146]

Because lifetime registration keeps most older children "on the register" even when access is constrained, system recovery is most visible where new registrations are initiated. The 0–2 and 3–5 cohorts provide the clearest signal for monitoring reengagement with dental services after COVID-19 service disruption. Slower growth in these cohorts likely reflects residual barriers for first registrations and the timing of initial dental contacts (Figure 67).[144]

Figure 67: Children's registrations with General Dental Services in the Highland Council area by age-groups, 2001-2025



Source: PHS Dental Statistics; local extracts provided to NHS Highland

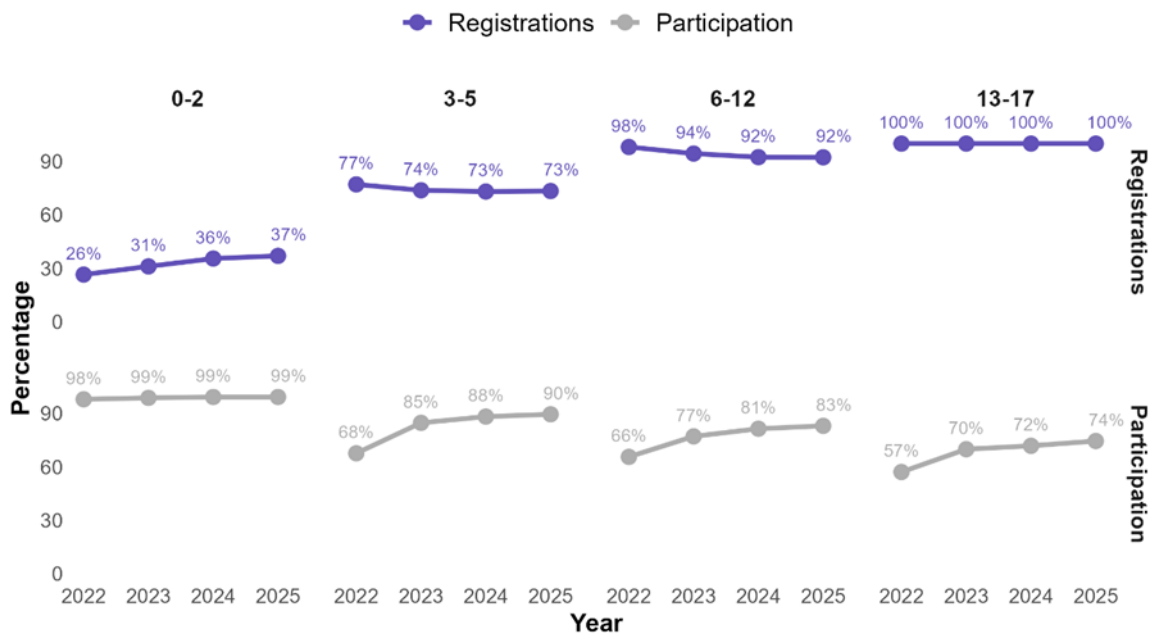
The pattern in Figure 66 aligns with national evidence and is consistent with local service experience following the pandemic restrictions.

Where registration among 0–2 and 3–5 lags historic trajectories, this suggests opportunities to strengthen early-years pathways into dental care, including antenatal and health visiting contacts, supervised toothbrushing messages via Childsmile, and clear routes to first registration with a dental practice.[142,145]

Participation among registered children remains below historical norms nationally, reflecting pandemic-era service disruption and slower recovery in parts of Scotland.[145,146.]

Highland patterns over the last four years indicate continued high registration in older age groups, with a lower participation share than registration, suggesting a pool of registered children not seen in the preceding two years. The size of this gap is a practical indicator of potential unmet need and delayed treatment.

Figure 68: Comparison of registration and participation in General Dental Services in the Highland Council area by age-group over the last four years



Source: PHS Dental Statistics; local extracts provided to NHS Highland

System context and risks

Highland relies on a network of primary, community and secondary services that collectively sustain access to prevention and treatment for children and young people. The configuration includes a local dental training clinic in Inverness, Public Dental Service (PDS) clinics that provide community care and act as the backstop for urgent and emergency needs, hospital-

based secondary care at Raigmore Hospital, and a local orthodontic specialist service for onward referral and treatment.

GDS remains the pivotal determinant of routine access and participation. Lifetime registration keeps headline coverage high, but participation depends on practices having the capacity to offer timely examinations and preventive care to children. Some GDS practices operate mixed NHS and private models and, at times, may not have the capacity to accept new NHS patients, offering private care instead. GDS capacity and service decisions interact with the resilience of NHS pathways and influence equity of access and the participation of children.

Fragility in GDS risks widening inequalities if children in more deprived or remote communities find it harder to obtain routine appointments and preventive care. Scottish evidence linking poor oral health to higher school absence highlights the broader educational impact and the importance of sustaining prevention and access, particularly in more deprived communities.[147]

Key messages for Highland

- NDIP trends indicate continued long-term improvement, with persistent inequalities by deprivation.
- Registration is higher across older child age groups; participation within 24 months remains lower than pre-pandemic norms nationally and locally, leaving a cohort of registered children without recent dental contact.
- The registration-participation gap is an actionable indicator for CPP partners, reinforcing the need to prevent through Childsmile and to protect appointment availability in GDS.

10. Sexual health and relationships

Sexual health forms part of general health and wellbeing for children and young people, within UNCRC rights to health, information, and non-discrimination. Addressing inequalities in sexual health aligns with proportionate universalism, recognising the role of broader social determinants in shaping young people's opportunities and access to care, with prevention and equity central priorities.

Key Findings from Young People's Sexual Health Needs Assessment

Phase 1 of a Young People's Sexual Health Needs Assessment for Highland and Argyll and Bute's remote and rural communities was completed in 2025.[148] The assessment focused on quantitative evidence, including demographic analysis, service activity, and trends in sexual health outcomes, as well as examining sexual health service provision, access, and outcomes for young people aged 25 or under within the two HSCP's.

The content below highlights the Phase 1 findings most relevant to understanding current needs and informing priorities within the wider determinants and strategic context for Highland's Children and Young People. Phase 2 of the assessment, currently in progress, involves qualitative engagement with young people and stakeholders to explore lived experience and co-produce recommendations for service improvement.

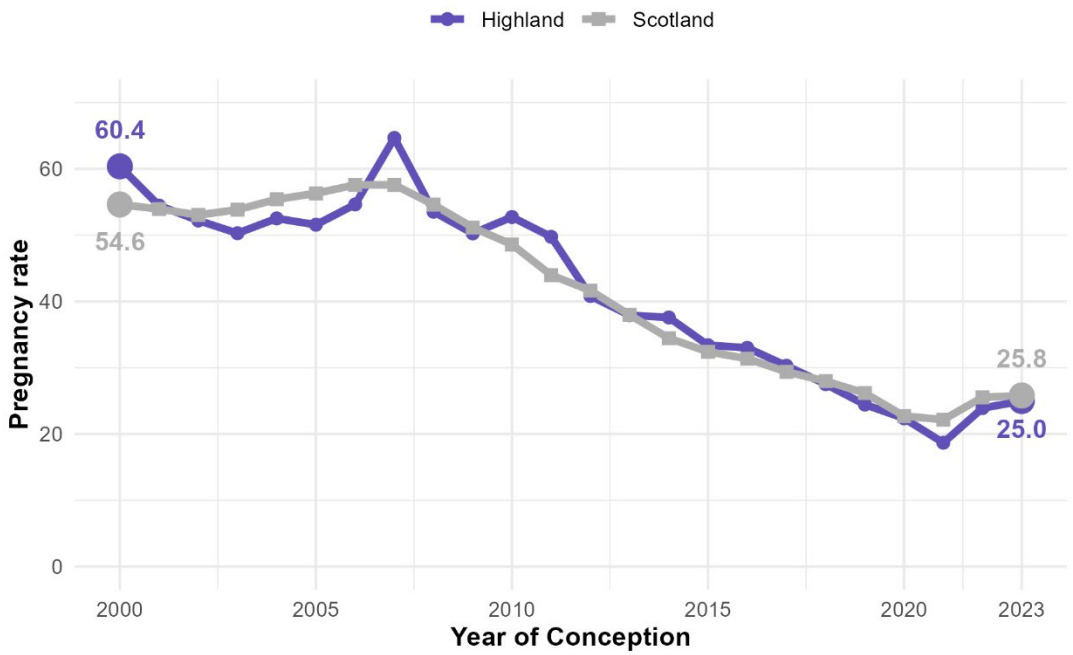
Trends in Sexual Health Outcomes

Chlamydia remains the most common sexually transmitted infection (STI), with cases dropping sharply during the pandemic (2019–2020), then rising again as services resumed. Gonorrhoea cases follow a similar pattern, with a notable increase in 2024.[148]

Teenage pregnancy rates in Highland follow the national long-term decline, with a recent increase that mirrors Scotland's overall trend (Figure 69). In 2023, Scotland recorded a teenage pregnancy rate of 25.8 per 1,000 (3,801 pregnancies) in women under twenty; Highland's rate was 25.0 per 1,000, equivalent to 147 pregnancies. As with all Council-level figures, local year-to-year movements should be interpreted cautiously, given the small number of events.

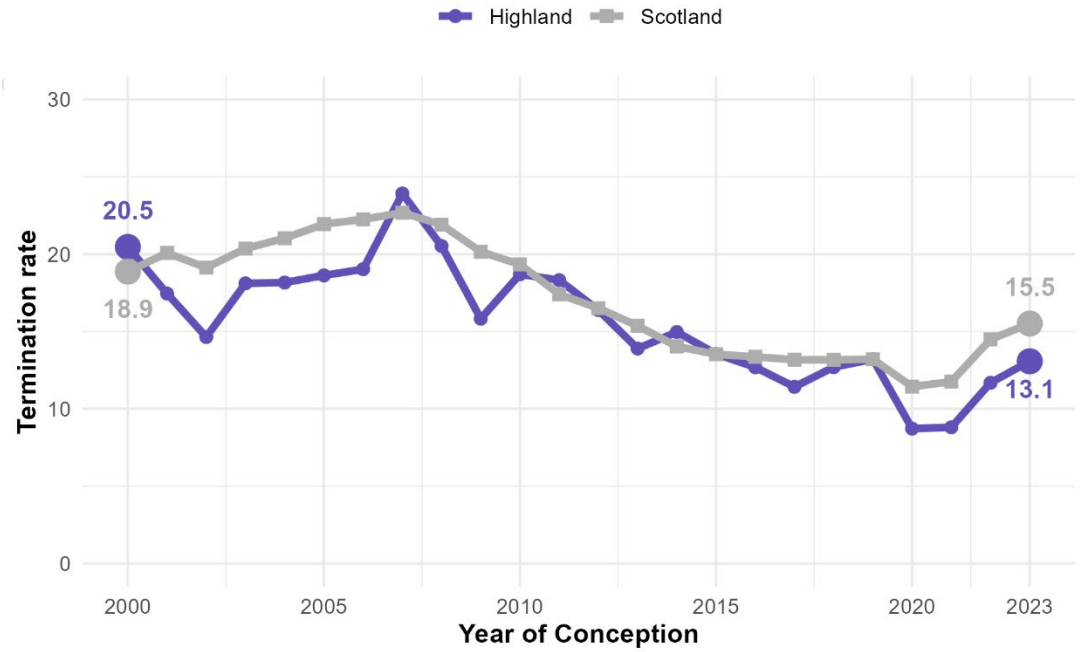
Among under-20 conceptions, termination rates have increased nationally since 2022 (with 60.1% of teenage pregnancies ending in termination in 2023). For Highland, the under-20 termination rate in 2023 was 13.1 per 1,000, corresponding to 77 cases (Figure 70). These outcome patterns reflect access, pathways, and choice within the teenage conception cohort and should be interpreted cautiously in Highland, given the small number of events.

Figure 69: Teenage pregnancies in women under twenty (ending in delivery or termination) in Highland and Scotland by year of conception, rate per 1,000 women aged 15 to 19



Source: Scottish Health and Social Care Open Data – Teenage Pregnancies by Council area
1 Teenage pregnancy statistics are based on age at likely conception and year of conception, including pregnancies ending in birth or termination (miscarriages excluded). The series now uses the Scottish Linked Pregnancy and Baby Dataset (SLiPBD)

Figure 70: Teenage pregnancies in women under twenty – termination rate per 1,000 women aged 15 to 19 in Highland and Scotland by year of conception



Source: Scottish Health and Social Care Open Data – Teenage Pregnancies by Council area
1 Teenage pregnancy statistics are based on age at likely conception and year of conception, including pregnancies ending in birth or termination (miscarriages excluded). The series now uses the Scottish Linked Pregnancy and Baby Dataset (SLiPBD)

Although most teenage pregnancies occur among young people aged 17–19, for whom sexual activity is lawful, the under-20 pregnancy rate continues to be used in public health as a marker of inequality, early transition and service access, rather than behaviour. The indicator captures a phase of life in which education, economic independence, and access to youth-friendly health services remain critical, and in which outcomes are strongly patterned by deprivation.

Termination rates provide important complementary insight into access, autonomy and pathways of care, but cannot be interpreted in isolation as they reflect service availability and social context as much as underlying need.

Pregnancies among girls under 15 are now very rare at the local level, and, for confidentiality reasons, Highland data are not routinely reported as a standalone figure in national reporting.

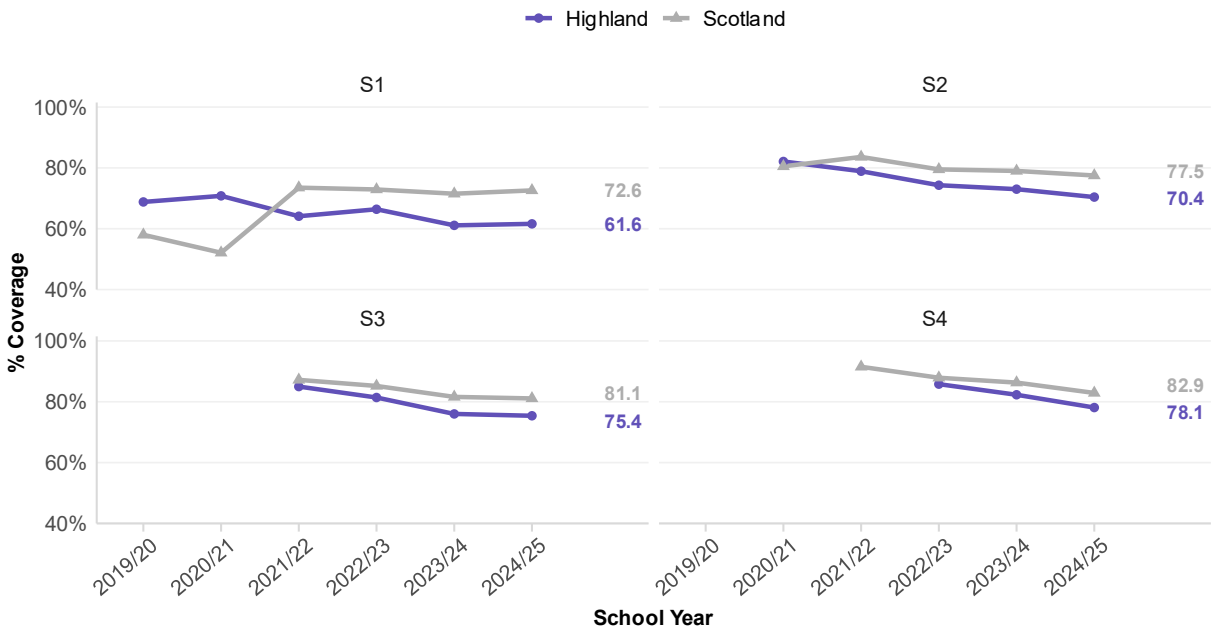
As overall numbers decline, particularly in areas such as Highland, pregnancy under 20 is therefore best understood as a sentinel indicator to be interpreted cautiously alongside qualitative insight.

HPV vaccination coverage

Phase 1 of the recent NHS Highland needs assessment did not discuss immunisation against the Human Papillomavirus (HPV), but it is a primary preventive intervention against a sexually transmitted infection and its long-term consequences, including cervical cancer. Inclusion alongside relationships, sexual health and parenthood (RSHP) education and access to sexual health care is therefore appropriate. Uptake is shaped by consent, attendance, logistics of school sessions and catch-up, and perceived confidentiality, which are the same factors influencing other young people's sexual health outcomes.

HPV vaccination is offered first in S1 with catch-up opportunities through later school years. In 2024/25, Highland's S1 coverage was 61.6% (1,568 of 2,547 pupils), compared with 72.6% nationally, and coverage remained lower in Highland for both girls (64.6% compared to 75.7%) and boys (58.7% compared to 69.7%). By S4, coverage was higher but still short of the national level, at 78.1% in Highland (2,022 of 2,590 pupils) compared with 82.9% for Scotland, with a similar pattern of lower coverage among boys than girls. In practical terms, this equates to around 979 unvaccinated pupils in Highland S1 in 2024/25 (540 boys and 439 girls) and around 568 unvaccinated pupils in S4 (321 boys and 247 girls), figures that help illustrate the scale of opportunity for improvement when consent, timing and attendance align.

Figure 71: Trends in HPV immunisation coverage rates, pupils in S1 to S4, Highland and Scotland, 2019/20 to 2024/25



Source: Public Health Scotland, Vaccination Surveillance Dashboard, HPV Immunisation Coverage
[1] The Covid-19 pandemic impacted coverage rates for school years ending in 2020 and 2021
[2] The y-axes do not start at zero

Service provision and access issues identified

Specialist sexual health services are concentrated in urban areas, notably Inverness, with limited provision in rural and remote communities. Many more remote and rural places rely on enhanced GP provision.

Although contraception is widely available through clinical, pharmacy and digital routes, in some Highland areas, service visibility and confidentiality concerns in smaller communities may affect practical access, particularly for time-sensitive provision such as emergency contraception.

Digital services, such as Live Chat and self-sampling kits (SSKs), have expanded, but uptake is highest in urban areas. Several rural postcodes show little or no engagement, highlighting ongoing digital exclusion.

Attendance at specialist clinics by under-25s in Highland peaked in 2023, while Live Chat interactions rose from 112 (2021) to 753 (2023), then dipped slightly in 2024.

Barriers and inequalities

Young people continue to face significant barriers to accessing sexual health services. Limited availability of local clinics, particularly in very remote and rural areas, combined with transport

difficulties, digital exclusion, concerns about confidentiality, and fear of judgment, reduces engagement with services. These constraints contribute to consistently lower rates of STI testing and service use among young people living in the most geographically isolated communities, even after adjusting for population size.

Enablers and opportunities

Several service features support better engagement. Youth-friendly, confidential, and flexible models of care are associated with higher uptake, and digital services such as Live Chat and SSKs offer meaningful alternatives where in-person provision is limited. However, these digital options require reliable access, local awareness, and appropriate support systems, which remain uneven. The Phase 1 assessment also highlights that locally tailored models, sensitive to the distinct challenges of rural and island communities, are essential for addressing unmet needs and improving equitable access.

Recommendations and next steps from Phase 1

Phase 1 identifies several priorities for improving young people's sexual health services. Service planning should be geographically informed, with specific attention to underserved rural and remote communities. Strengthening digital inclusion and widening access to self-sampling kits and virtual services are key to addressing persistent inequalities.

Expanding young people's-specific clinic hours and diversifying delivery models would further enhance accessibility. Robust monitoring and evaluation are required to track outcomes and support continuous improvement. Looking ahead, Phase 2 will focus on qualitative engagement with young people and stakeholders to co-produce services that are responsive, equitable, and sustainable across the region.

Understanding children's and young people's views through engagement

In Scotland, youth-appropriate access, safeguarding, and confidentiality are core expectations for sexual health services and education, reflected in national standards and RSHP guidance.[149] [150] Local engagement with children and young people in Highland has repeatedly found that confidentiality and visibility in small communities deter help-seeking, a finding previously reported and echoed by the Phase 1 assessment.[148]

Phase 2 of the needs assessment is now gathering first-hand views from children and young people (13–25) via the NHS Highland Engagement Hub to inform service design and address these barriers.[151]

Sexual health and relationships education

Sexual health and relationships education provides an important preventive context for children and young people's sexual health outcomes, supporting awareness, confidence, and understanding of how and when to seek information or care. In Scotland, RSHP education sits within the Health and Wellbeing area of the Curriculum for Excellence and forms part of the broader framework shaping access to accurate information and trusted support.[152]

In Highland, education settings represent one of the most consistent points of contact for sexual health information, particularly in rural and remote areas where specialist service access is more limited. Education, therefore, complements service provision by helping to normalise conversations about sexual health and signposting routes to support, alongside digital and community-based provision.[153]

Alignment among education, health services, and local partners is essential to ensure that information translates into timely access to care where required. The Scottish Government's draft statutory guidance on RSHP sets this context and links to supporting policy and resources.[154]

Changing and emerging risks

A fast-moving digital environment is shaping children's and young people's sexual health needs. Evidence points to earlier exposure to sexual content online, growth in image-based harms, and increased online grooming and exploitation.[148] [155] Adolescent media use is high and increasingly mediated by algorithmic feeds, so risk is influenced by platform design as much as by time online.[155] UK evidence suggests accidental exposure to pornography is common and can occur at early ages; at the same time, the Online Safety Act has introduced age-assurance requirements for specific harms (for example, pornography), with Ofcom beginning enforcement and early signs of reduced visits to major adult sites.[156] [157] [158]

Alongside exposure, image-based harms continue to increase. Reports to national helplines indicate growth in self-generated sexual imagery and coercive re-sharing (sextortion) affecting both girls and boys and linked to distress and ongoing exploitation, underlining the importance of youth-friendly, confidential early-help pathways.[159] Police and third-sector sources also report rising volumes of online grooming and cyber-enabled sexual crimes against children in Scotland. Police Scotland recorded 2,055 cyber-enabled sexual crimes against children in 2023/24 (up on the prior year), with most offences relating to exposure to sexual content, indecent communication, and image offences; national analyses point to multi-year increases in grooming offences.[160] [161] [162]

Evidence relating to online and digital sexual health risks is fragmented across service, education, safeguarding, and policing systems, each reflecting only partial views of need. Even at a national level, recorded crime data primarily reflect reporting behaviour, enforcement capacity, and prevailing legislation, rather than the underlying prevalence of harm.[155] In Highland, recorded crime, service use, and laboratory-confirmed infections should therefore be interpreted as signals influenced by access, disclosure, and system configuration, not as direct measures of risk or exposure.[148] Qualitative engagement with children and young people is essential to understand lived experience, barriers to disclosure, and emerging pressures.

Phase 2 should explore views, lived experience, and implications for access to trusted information, participation, and safety, alongside any new evidence from UK or international evaluations of proposals to restrict access to social media for under-16s.[151]

Key messages for Highland

In summary, the response to children and young people's sexual health needs in Highland should prioritise:

- Youth-friendly, confidential access across both in-person and digital channels, recognising the additional barriers created by rurality and small communities.
- Universal prevention through RSHP education, with clear and consistent signposting to trusted support.
- Modest improvements in consent return, on-the-day attendance, and mop-up access would move coverage measurably for those unvaccinated against HPV.
- Joined-up safeguarding pathways that can respond proportionately to online-related harms, including image-based abuse and grooming, while minimising duplication and re-traumatisation for children and young people.
- Workforce capability matched to the changing digital risk environment, supporting earlier recognition, appropriate advice, and timely escalation where required.
- An intelligence approach that integrates children and young people's voices with multi-source interpretation of quantitative signals, given the limitations of routine data, and small numbers of events.

Taken together, this approach emphasises access, prevention, proportionality, and learning, ensuring that service planning remains responsive to emerging risks while grounded in lived experience and local context.

11. Health conditions

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

All children have the right to the highest possible levels of health including access to healthcare services. Those with a physical or mental disability have the right to support and assistance, including the right to education, which may need to be adapted to be accessible to those with disability or undergoing hospital or healthcare treatment.

Congenital conditions

Congenital conditions develop in the womb and are present from birth. Babies with a major congenital condition are registered with the Congenital Conditions and Rare Diseases Registration and Information Service for Scotland (CARDRISS).[163] Data are published for NHS Highland but not for Highland council area as the numbers are relatively small: 51 babies were registered in 2023, 62 in 2022 and 61 in 2021. The most common conditions recorded in 2023 were congenital heart disease and genetic conditions such as Down's syndrome. Nervous system conditions include neural tube defects such as Spina Bifida (Figure 72).

Figure 72: The number and prevalence rate of babies registered with a major congenital condition, NHS Highland and Scotland, 2023

	NHS Highland		Scotland
Condition	Number of births	Prevalence rate (per 10,000 births)	
All conditions	51	213.2	248.3
Nervous system conditions	6	25.1	28.4
Eye conditions	0	0.0	6.3
Ear, face and neck conditions	0	0.0	0.7
Congenital heart disease (CHD)	22	92.0	76.3
Respiratory conditions	[c]	[c]	4.1
Oro-facial clefts	[c]	[c]	18.4
Gastro-intestinal conditions	6	25.1	21.3
Abdominal wall defects	[c]	[c]	8.5
Kidney and urinary tract conditions	6	25.1	28.4
Genital conditions	0	0.0	18.0
Limb conditions	5	20.9	29.9
Genetic conditions	22	92.0	66.8

Source: Public Health Scotland, CARDRISS, Oct 2025
[c] confidential due to small numbers

Although many congenital conditions cannot be prevented, some have known risk factors which can be reduced. The preconception period presents an opportunity for intervention, reducing the chance that babies will be born prematurely, have low birth weight, birth defects or other birth-related conditions that hinder optimal child development.

A preventative approach in the preconception period includes taking vitamin D and folic acid supplements to help prevent birth defects known as neural tube defects, including spina bifida. Promoting maternal health, including uptake of vaccinations, healthy eating, quitting smoking and ceasing alcohol consumption will reduce risks to babies. There is need to promote maternal health before and during pregnancy to improve maternal and child outcomes and enhance long-term child health.

Long-term conditions

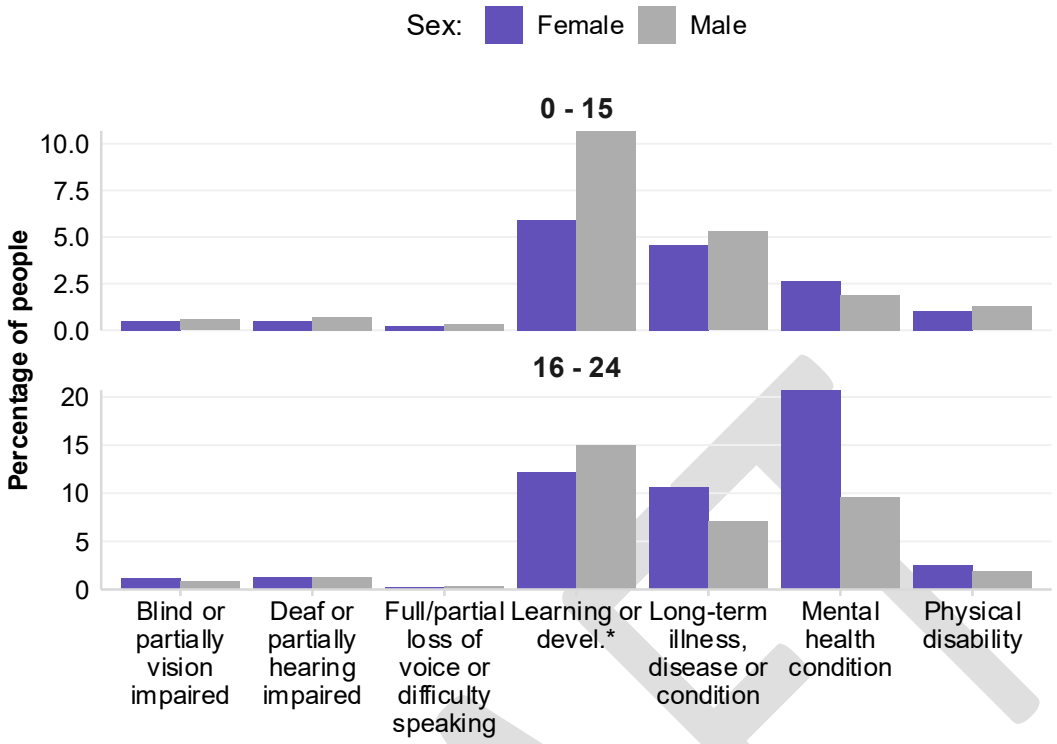
For those aged 0 to 15, the most common long term condition reported in the census 2022 was one or more of a learning disability, learning difficulty or developmental disorder, which were more common in males than females (Figure 73, Figure 74). Mental health conditions were most common in those aged 16 to 24 with over 20 percent of females and ten percent of males reporting a mental health condition. Mental health conditions and developmental disorders more than doubled between 2011 and 2022 in the 0-15 and 16-24 age bands (Figure 75). This may be explained by higher rates of awareness and identification, higher underlying prevalence, or a combination of these factors.

Figure 73: The number of Highland residents who reported a named long-term condition at the 2022 census, by sex and age band

Condition	Female		Male	
	0 - 15	16 - 24	0 - 15	16 - 24
Total	18,152	9,140	19,088	10,412
Deaf or partially hearing impaired	90	120	139	135
Blind or partially vision impaired	91	107	112	92
Full/partial loss of voice or difficulty speaking	45	19	67	35
Has one or more of learning disability, learning difficulty or developmental disorder	1,071	1,113	2,040	1,564
Physical disability	189	229	242	195
Mental health condition	478	1893	359	1000
Long-term illness, disease or condition	828	973	1012	744
Developmental disorder	573	452	1350	795
Learning difficulty	673	793	1105	971

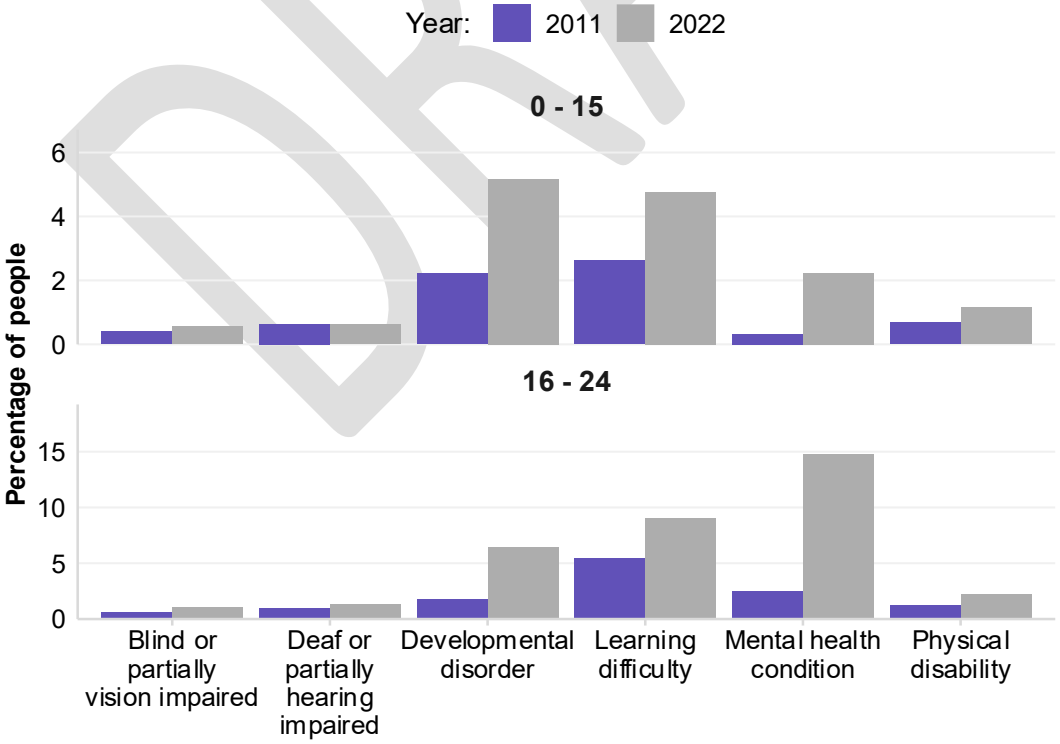
Source: National Records of Scotland, Scotland's Census 2022

Figure 74: The percentage of Highland residents who reported a named long-term condition at the 2022 census, by sex and age band



Source: National Records of Scotland, Scotland's Census 2022
* Has one or more of learning disability, learning difficulty or developmental disorder

Figure 75: The percentage of Highland residents who reported a named long-term condition at the 2022 census, by sex and age band



Source: National Records of Scotland, Scotland's Census 2011 and 2022
* Has one or more of learning disability, learning difficulty or developmental disorder

Many of the conditions reported in the census, including sensory impairments, developmental disorders and learning difficulties require additional support in schools (see section x).

Conditions recorded in general practice

General practice disease prevalence data provides information on health conditions that children and young people are living with in Highland. Asthma is the most prevalent condition with six percent of those aged 10-14 treated for asthma in the past 12 months. Epilepsy, diabetes (predominantly Type 1) and eating disorders typically require treatment and each impact around one percent of those aged 15 to 19.

Depression increases markedly in prevalence at ages 15 to 19, with 1.2 percent diagnosed in this age group, rising to 5.5 percent in those aged 20 to 24.

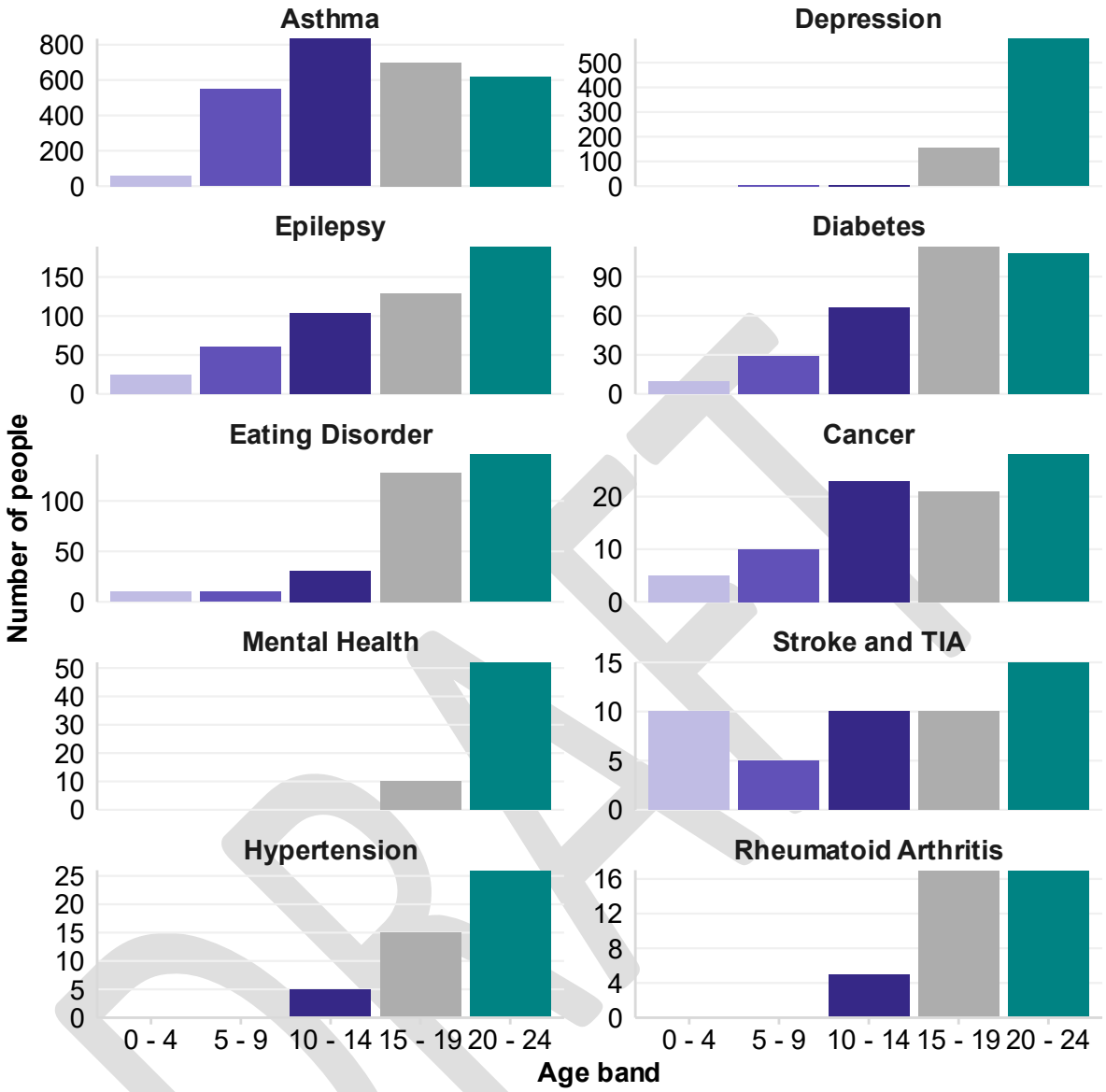
Although less common, a small number of children and young people in Highland are diagnosed with cancer, hypertension, stroke and transient ischemic attack (TIA), rheumatoid arthritis and serious mental health conditions (Figure 76, Figure 77).

Figure 76: Number of people registered in a Highland GP practice and diagnosed with selected diseases, by age band, 1st April 2025

	Age band				
Disease	**0 - 4**	**5 - 9**	**10 - 14**	**15 - 19**	**20 - 24**
Asthma*	60	547	834	699	619
Cancer	5	10	23	21	28
Depression	0	5	5	154	597
Diabetes	10	29	66	113	108
Eating Disorder	10	10	31	128	146
Epilepsy	25	60	104	129	189
Hypertension	0	0	5	15	26
Mental Health^	0	0	0	10	52
Rheumatoid Arthritis	0	0	5	17	17
Stroke and TIA	10	5	10	10	15

Source: Public Health Scotland Disease Prevalence in General Practice
* Number with asthma who have had treatment within 12 months
^ Includes Serious Mental Health conditions such as schizophrenia, bipolar affective disorder and other psychoses
Data are available for 97.8 % of NHS Highland GP practices meaning that counts may differ from the real figure. GP engagement was 97.8%. Data less than 10 shown as either 0 or 5.

Figure 77: Number of children and young people registered in a Highland GP practice and diagnosed with selected diseases, by age band, 1st April 2025



Source: Public Health Scotland Disease Prevalence in General Practice
* Number with asthma who have had treatment within 12 months
^ Includes Serious Mental Health conditions such as schizophrenia, bipolar affective disorder and other psychoses
Data are available for 97.8 % of NHS Highland GP practices meaning that counts may differ from the real figure. GP engagement was 97.8%. Data less than 10 shown as either 0 or 5.

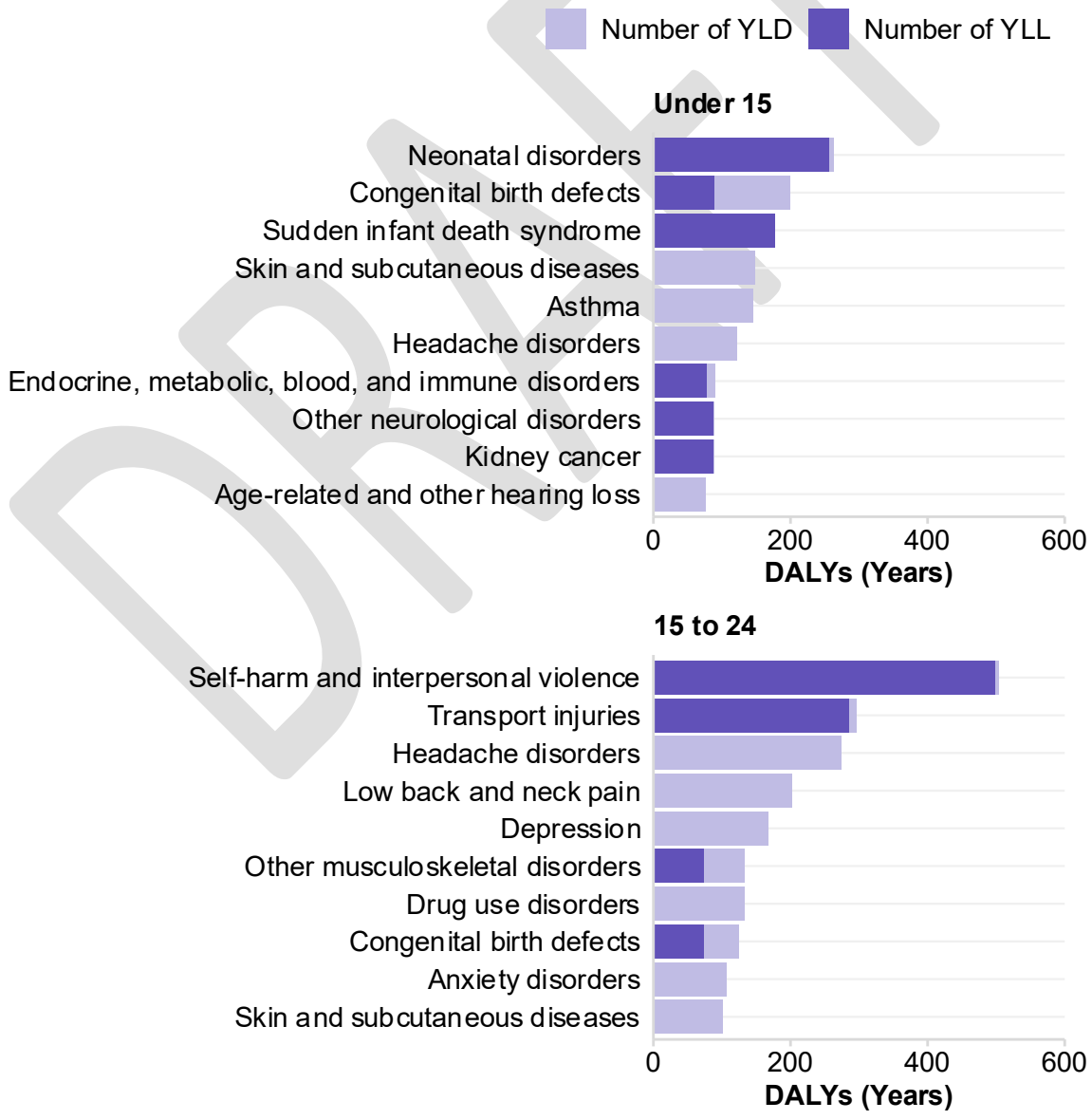
Health status

Some health conditions, particularly once treated, have minimal impact on quality of life. Others have a more significant impact or sadly cause loss of life. 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.[164] DALYs are calculated using the prevalence of each health condition and the estimated number of healthy years of life lost through early death (YLD) or reduced quality of life (YLL).

The leading causes of health loss for children and young people in Highland are shown in Figure 78. For those under 15, the main causes of YLL are neonatal disorders and sudden infant death syndrome (SIDS). Although rare, they contribute a relatively large numbers of years of healthy life lost. For those aged 16 to 24, self-harm, interpersonal violence and transport injuries account for most YLL.

Figure 78: Top ten causes of DALYs attributed to Highland residents, by age band and whether they are from years of life lost (YLL) or years lost due to Disability (YLD)

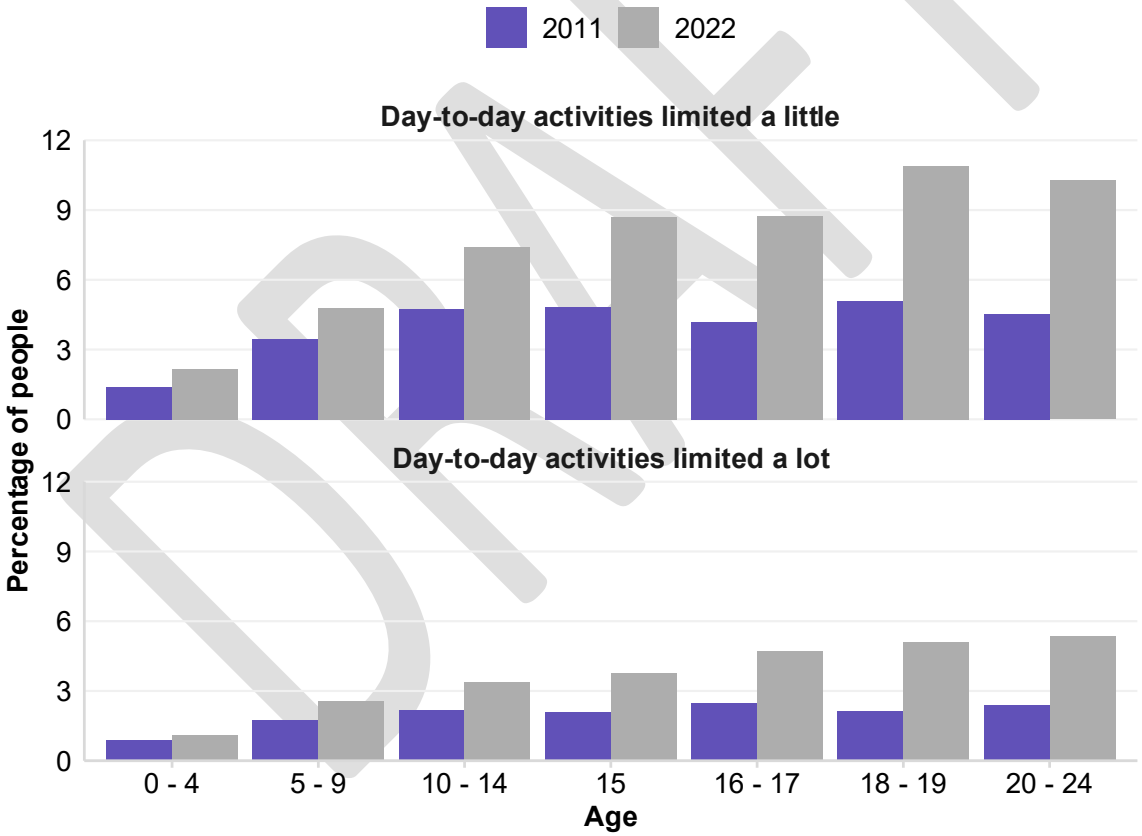


Source: Scottish Public Health Observatory, Local Burden of Disease 2019.
1 DALY: Disability adjusted life year

The leading causes of YLD also differ by age. In those age 0 to 15, skin conditions such as eczema, asthma and headache disorders were the leading causes of health loss. The five main causes of YLD for those aged 16 to 24 were headache, low back and neck pain, depression, drug use and anxiety.

In the most recent censuses, people were asked if their daily activities were limited by a long-term health problem or disability. The percentage reporting their activities being limited increases with age and was higher in the 2022 census than in 2011. In 2022, around 950 children aged under 15 and 1,000 young people aged 16 – 24 reported being limited a lot in day-to-day activities in Highland. Around 2,000 children aged under 16 and a further 2,000 aged 16-24 report their activities were limited a little.

Figure 79: The percentage of Highland residents who reported that their day-to-day activities were limited a little or a lot at Census 2011 and 2022, by age



Source: National Records of Scotland, Census 2011 and 2022

Disability

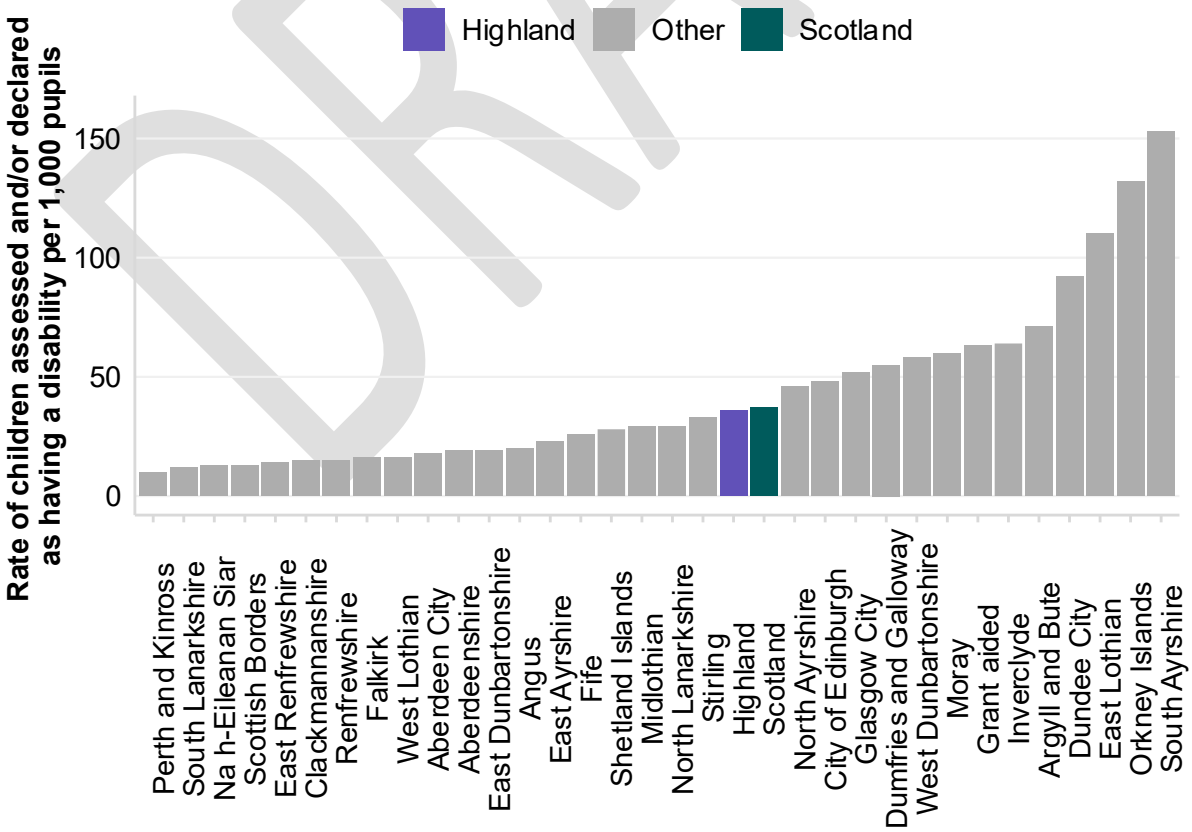
Disability is defined under the Equality Act (2010) as a 'physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities'.

In the 2024 school census, 1,069 pupils across Highland schools were assessed by a professional or declared by parents as having a disability. By law, reasonable adjustments must be made for disabled pupils.

The rate of school children with a disability was similar in Highland and Scotland. Rates vary considerably across local authority areas suggesting different interpretations of disability and/or potential inequalities in recognition of disability across areas (Figure 80).

Data from Social Security Scotland indicated that 3,380 children in Highland were in receipt of Child Disability Payment at September 2025.[165] Child Disability Payment is a benefit for disabled children and young people who have a terminal diagnosis or who have lived with a disability for at least three months and who can expect to continue to have this disability for at least six months. It is designed to help with the extra costs a disabled child may have, including for care and for support with mobility.

Figure 80: Rate of children assessed or declared as having a disability per 1,000 pupils, by council, 2024



Source: Scottish Government, Pupil census supplementary statistics 2024

Neurodiversity and neurodevelopmental needs

The term ‘neurodiversity’ describes the natural variation in brain function and development. The specific brain functions that neurodiversity relates to are called neurocognitive functions and include language development, the ability to regulate attention and emotions, social behaviours and processing sensory stimuli.

Children with neurodevelopmental needs are those where selective aspects of their neurocognitive functions fall out with the typical range for their age. Assessment may identify one or more specific neurodevelopmental conditions. These include Autism, Attention Deficit-Hyperactivity Disorder (ADHD), Developmental Language Disorder, Developmental Co-ordination Disorder, Dyslexia and dyscalculia and Foetal Alcohol Spectrum Disorder. Some people with these conditions lead fully independent lives, while others require varying degrees of support.[166]

Evidence provided to the 2023 Scottish Government consultation on the Learning Disabilities, Autism and Neurodivergence Bill estimates 10-15% of people in Scotland are neurodivergent. Prevalence has increased over the last decade.[167] ADHD affects around 5% of school aged children in Scotland, while autism is estimated to affect around 3% of this age group.[168] [169]

The National Neurodevelopmental Specification for Children and Young People sets out the support and standards of care that children and young people (up to age 25) with neurodevelopmental conditions should receive. The Specification aligns with the GIRFEC framework and reflects the principles of UNCRC and the Universal Health Visiting Pathway.

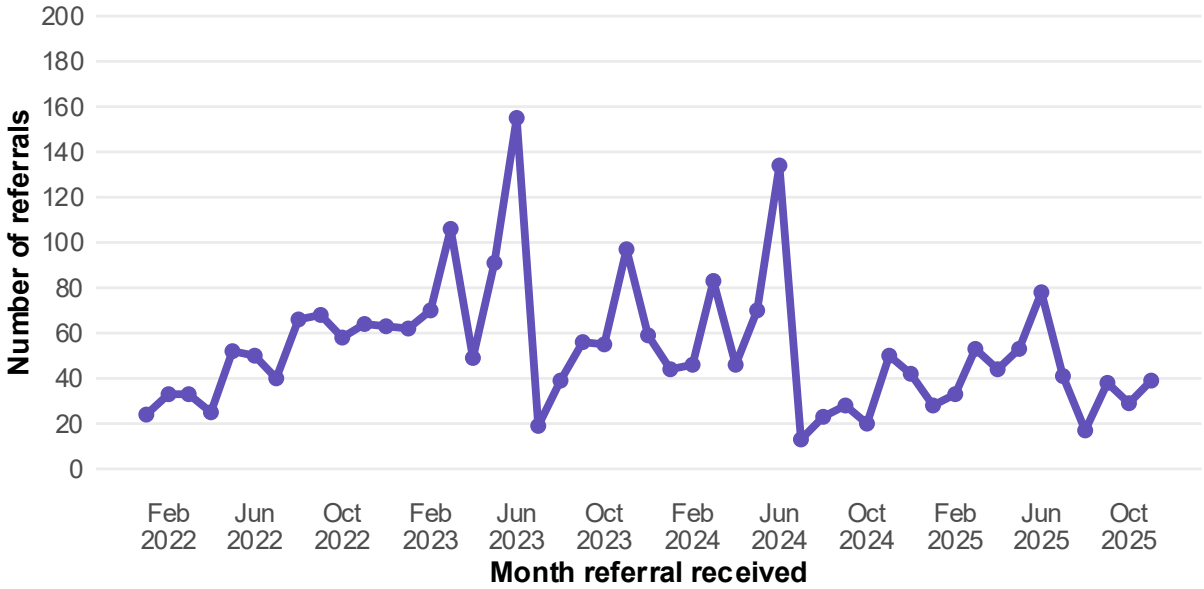
The Specification aims to ensure that children, young people and their families receive timely access to support and services that meet their neurodevelopmental needs, in line with the GIRFEC approach. For many children such support is likely to be through universal services, such as the named person, and community based mental health and wellbeing services. Neurodevelopmental services provide support to children and young people with more complex needs.

In Highland, the Neurodevelopmental Assessment Service (NDAS) is a joint, multi-agency service delivered by NHS Highland and The Highland Council. The service assesses and diagnoses, through a multi-disciplinary approach, neurodevelopmental disorders in children and young people in Highland. The service contributes to local compliance to the National Neurodevelopmental Services Specification.

The service has operated under sustained pressure since it was established. The number of children and young people on the waitlist for assessment has grown, while referrals to the

service remain consistent, adding to the overall demand (Figure 81). Children are frequently waiting multiple years to receive a neurodevelopmental assessment, with waiting times of over four years reported in some cases.

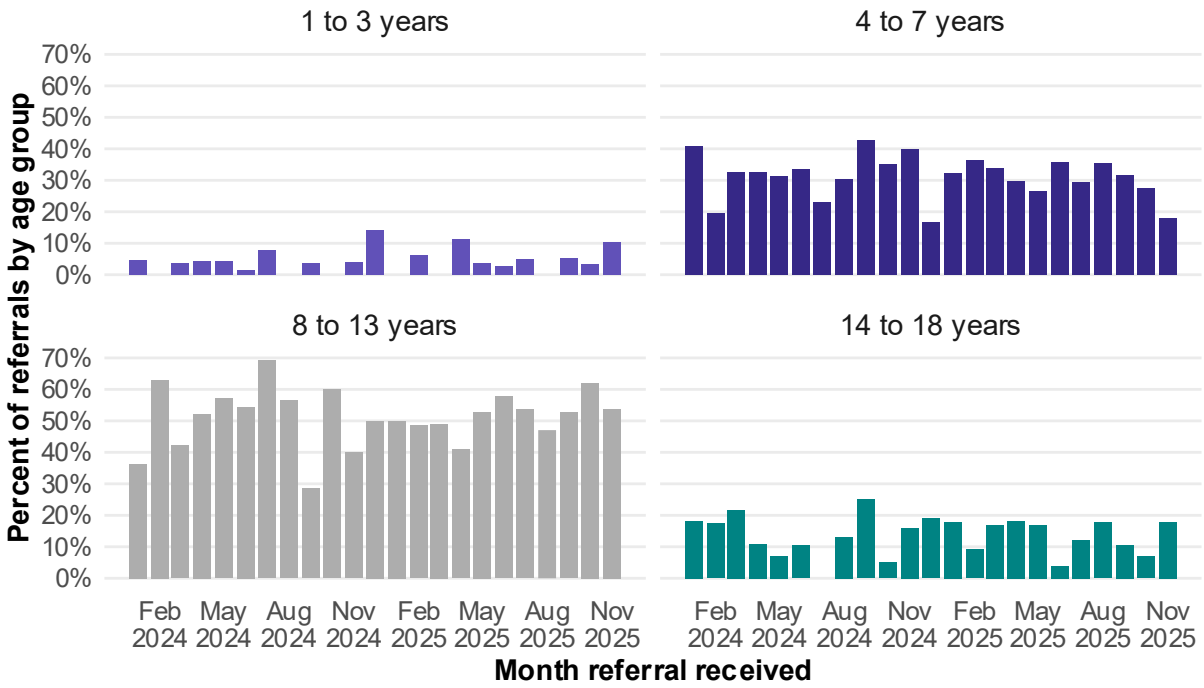
Figure 81: Number of referrals to NDAS by month, Highland, Jan 2022 to Nov 2025



Source: NHS Highland Management Information

Most referrals for neurodevelopmental assessment are for children aged 4-7 and 8-13 years of age (Figure 82).

Figure 82: NDAS referrals by age group, Highland, Jan 2024 to Nov 2025



Source: NHS Highland Management Information

The local picture is consistent with national evidence showing increasing demand for neurodevelopmental assessment, driven by increased awareness of neurodivergence and how it presents.[170]

In alignment with the National Neurodevelopmental Service Specification, NHS Highland and The Highland Council are progressing towards a neuro-affirming Highland that places neurodivergent children and young people at the centre of a strengths-based, inclusive, and coordinated system of support.

This will involve implementation of the Children's Neurodevelopmental Pathway Practice Framework alongside established GIRFEC principles. The approach will ensure that neurodevelopmental pathways are clinically robust and affirming of neurodivergent identities, experiences, and needs.

The approach will be aligned with the Whole Family Wellbeing Programme to deliver early intervention and prevention, strengthen multi-agency collaboration, and embed neuro-affirming practices across education, health, and social care.

Childhood and Adolescent Mental Health Services

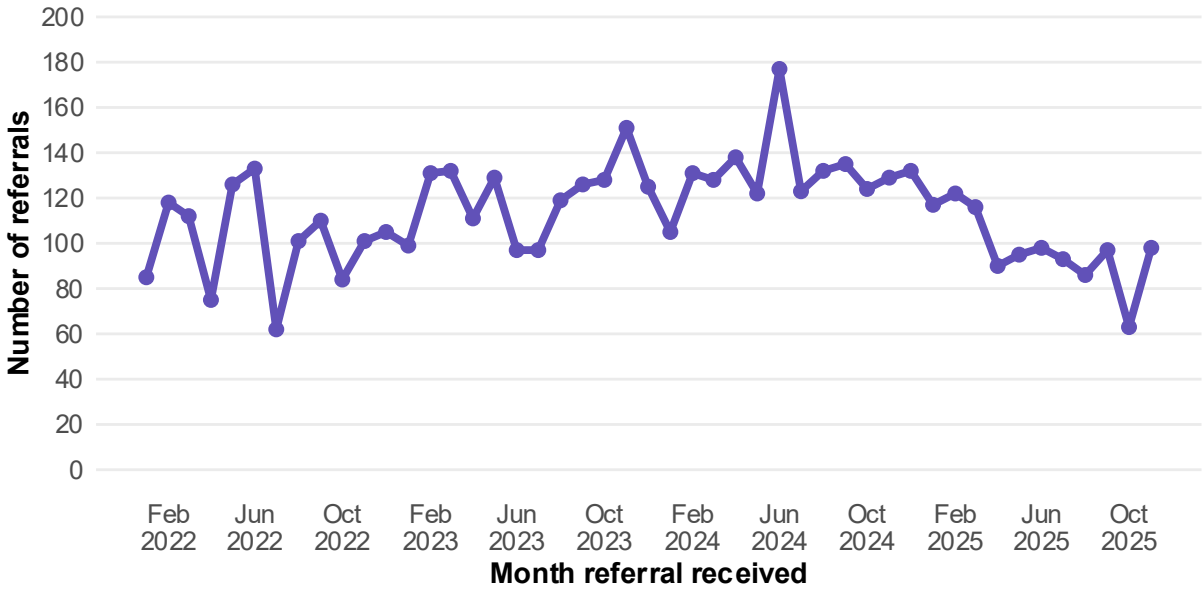
Child and Adolescent Mental Health Services (CAMHS) are multi-disciplinary teams that provide treatment and/or interventions for children and young people experiencing mental health problems.

The CAMHS national service specification sets provisions young people and their families can expect in receiving support and services that are appropriate to their needs. For many children and young people, such support is likely to be community based and should be easily and quickly accessible.[171]

CAMHS have an important role in supporting the mental health capability of the wider network of children's services, working within the GIRFEC model and taking a rights-based approach for children, young people and their families.

There were 1,576 referrals to CAMHS in Highland in 2024, and 1,075 as at November 2025. The average number of referrals a month was 115 (range 63 to 177).

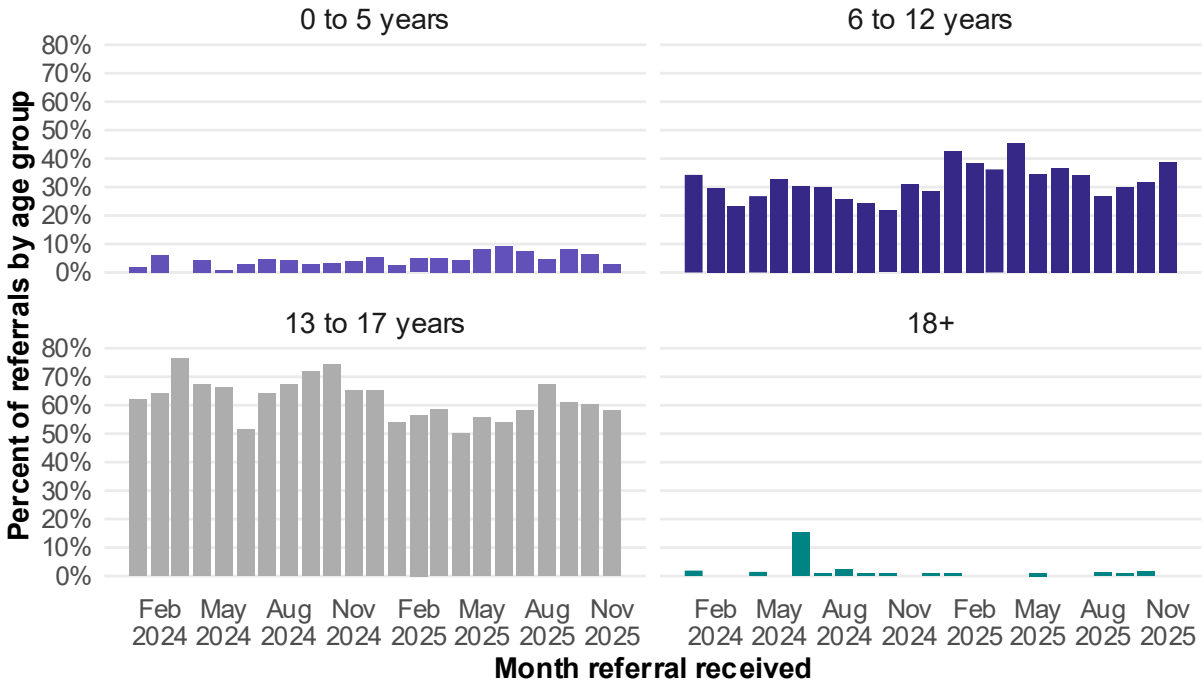
Figure 83: Referrals for CAMHS in Highland by month, Jan 2022 to Nov 2025



Source: NHS Highland Management Information

At least 50 percent of referrals each month were for children and young people aged 13 -17 years of age (Figure 84).

Figure 84: CAMHS referrals by age group, Highland, Jan 2024 to Nov 2025

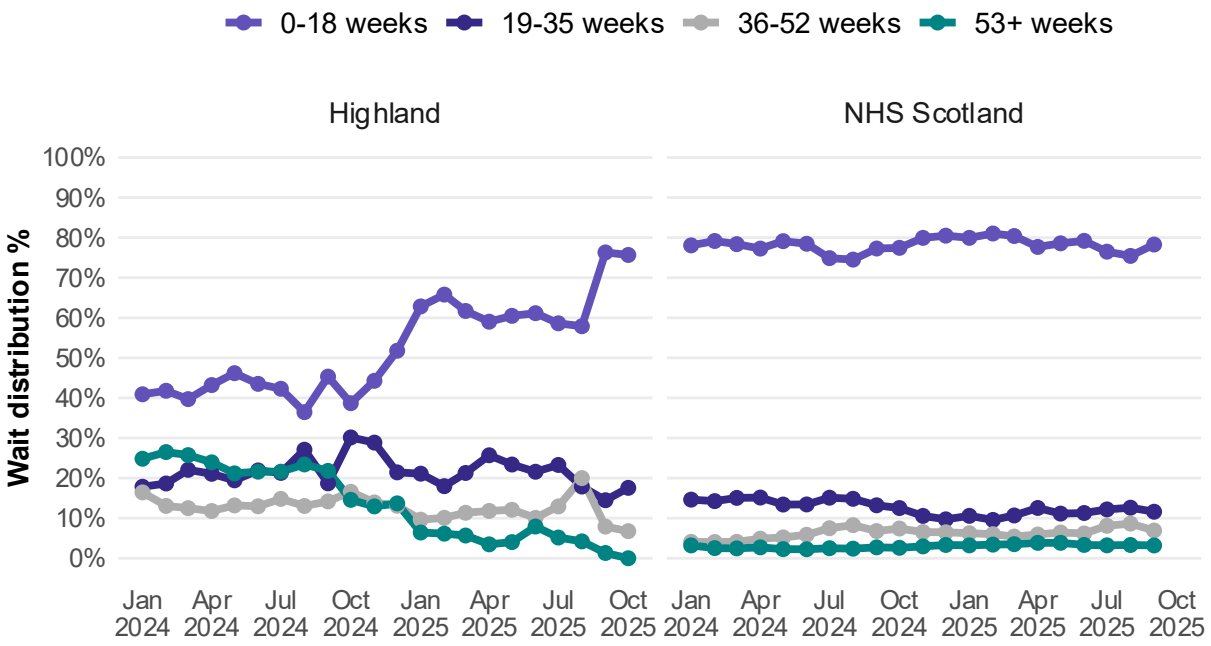


Source: NHS Highland Management Information

CAMHS have been subject to an 18 week wait target from referral to treatment for specialist services since December 2014. The national target is that 90 percent of young people will commence specialist CAMHS services within 18 weeks of referral.

Although the percentage of children waiting 18 weeks or less from referral to starting treatment has increased in Highland from around April 2025, some children and young people still face very long waits for CAMHS. Benchmarking shows a higher-than-average distribution of long waits to access services in Highland compared to Scotland in 2024, but the position improved towards the end of 2025 (Figure 85).

Figure 85: Wait distribution (%) of children and young people waiting for treatment for CAMHS in Highland and Scotland, Jan 2024 to Jun 2025



Source: NHS Highland Management Information, Public Health Scotland CAMHS Open Data

Child deaths

The death of a child is a profoundly distressing event for families and communities. Childhood mortality is also an important indicator of broader population health. Across Scotland, childhood deaths are rare and have declined over many decades; however, infant mortality remains the highest of all childhood age groups, particularly within the first 28 days of life. National analyses continue to report recent fluctuations in infant and neonatal mortality and a persistent gradient by socioeconomic deprivation.[172] [173]

In Highland, the annual numbers are very small and vary from year to year. Interpretation, therefore, relies on multi-year pooled data. Figure 86 presents the average annual number of

child and young person deaths in Highland over 2015–2024, showing around six infant deaths per year and approximately ten further deaths per year across ages 1 to 19.

Infancy (under 1 year)

Most childhood deaths nationally occur in the first year of life, with the neonatal period accounting for the majority. Public Health Scotland highlights that mortality is highest in the first days after birth and is strongly associated with extreme prematurity and severe congenital anomalies.[172] National syntheses also emphasise the contribution of congenital and perinatal causes to Scotland's infant mortality trends.[173] [174] In Highland, an average of six infant deaths per year occurred over the last decade, consistent with national patterns in which congenital, perinatal and preterm-related factors play a major role.[175]

Children aged 1 to 9 years

Deaths among children aged 1 to 9 are rare in Scotland. Nationally, causes include severe infections, congenital and chromosomal conditions, malignancies and unintentional injuries. In Highland, the combined average across these age groups is between one and two deaths per year, and individual years frequently record zero deaths.

Young people aged 10 to 19 years

Among older children and adolescents, external causes become more prominent nationally. Scotland-level analyses identify trauma, road traffic incidents and self-inflicted harm as relatively more common causes in this age range.[175]

In Highland, an average of around six deaths per year occurred among young people aged 15 to 19, with substantially fewer in the 10 to 14 age group. The absolute numbers are small locally and not suitable for cause-specific analysis. The national evidence remains important for contextual understanding of risk.

Figure 86: Average annual number of deaths among children and young people in Highland, 10-year average 2015–2024

Age group	Male	Female	Persons	Summary
0 year	3–4	2–3	6	Neonatal causes dominate
1–4	1	1	2	Minimal numbers; high volatility
5–9	0–1	0	1	Deaths are rare
10–14	1	1	2	Small numbers; pooled data only
15–19	4–5	2	6	External causes are more common
Total 0–19	**~10**	**~7**	**~17 per year**	**Combined 10-year total = 164**

Source: National Records of Scotland: Deaths Time Series data, 2024

Children with life-shortening and complex conditions

A proportion of child deaths in Scotland occur among children with life-shortening or complex conditions. National child health intelligence indicates that these children often experience severe multi-system impairment associated with congenital anomalies, neurological conditions or complications of prematurity.[172] [175] These conditions contribute substantially to the national distribution of deaths under one year of age.[173] [174]

In Highland, the 10-year averages in Figure 86 show that infant mortality constitutes the largest share of childhood deaths, reflecting national evidence that life-shortening congenital and perinatal conditions dominate early childhood mortality. Many surviving children require long term coordinated input across health, community and social care.

Learning from child death reviews

Every child death in Scotland is subject to a structured review. The National Hub synthesises findings from reviews undertaken by NHS boards and local authorities, identifying themes that support system learning. These include the need for explicit recognition of clinical deterioration, coordinated care for children with complex needs, effective inter-agency communication, and attention to environmental and transport-related risks. Local numbers in Highland are too small to identify distinct patterns, but national learning themes remain relevant to quality and safety actions across child health and care services.

Inequalities

Scotland has a persistent socioeconomic gradient in infant and child mortality. National analyses show higher infant mortality in the most deprived areas than in the least deprived areas, reflecting broader social determinants, including maternal health, living conditions and access to services. Highland's small local numbers do not allow inequality analysis, but the national pattern remains important when planning prevention and support. Ethnicity data for child deaths are limited nationally and cannot be meaningfully interpreted for Highland.

Summary for Highland

Across the decade from 2015 to 2024, Highland experienced approximately six infant deaths per year, around ten deaths per year across ages 1 to 19, and a combined average of about 17 child and young person deaths per year. These small absolute numbers demonstrate why year-to-year percentage changes are not meaningful. Interpretation instead relies on Scotland-wide age-specific patterns, national learning from child death reviews, and alignment with JSNA sections on perinatal health, unintentional injuries, mental health, safeguarding, and disability.

Health and social care transitions

Paediatric health and social care is organised differently to adult services and the transition between these can be difficult for young people.[176] [177] Scottish Government guidance recognises that appropriate planning should be in place to support this transition and adopts the Principles of Good Transitions 3 as follows:[178]

- Principle 1: Planning and decision making should be carried out in a person-centred way.
- Principle 2: Support should be co-ordinated across all services.
- Principle 3: Planning should start early and continue at least to age 25.
- Principle 4: Young people should get the support they need.
- Principle 5: Young people and their families must have access to the information they need.
- Principle 6: Families need support.
- Principle 7: A continued focus on transitions across Scotland

There is a need to ensure that those adolescents living with disabilities in Highland, and their families and carers are supported through the transition to adult services.

What this means for Highland

12. Unintentional injury

Unintentional injuries among children and young people are a significant public health concern in Highland and across Scotland, with national strategies (including Scotland's Road Safety Framework) and Child Accident Prevention Trust guidance emphasising prevention through education, environmental safety, and multi-agency collaboration.[179] [180]

Prevention of unintentional injury is closely aligned with the Marmot Principles, particularly: giving every child the best start in life (safe home and community environments), strengthening ill-health prevention (injury as a preventable harm), creating healthy places and communities (safer road and play infrastructure), and tackling discrimination and social inequality (recognising the effect of deprivation on injury risk).[181] [182] [183]

Locally, the Highland Community Safety Partnership (a subgroup of the Community Planning Partnership) is active, bringing partners together to coordinate local action on road safety, home safety, and community resilience, and supporting multi-agency efforts to reduce injury and enhance emergency response capacity.

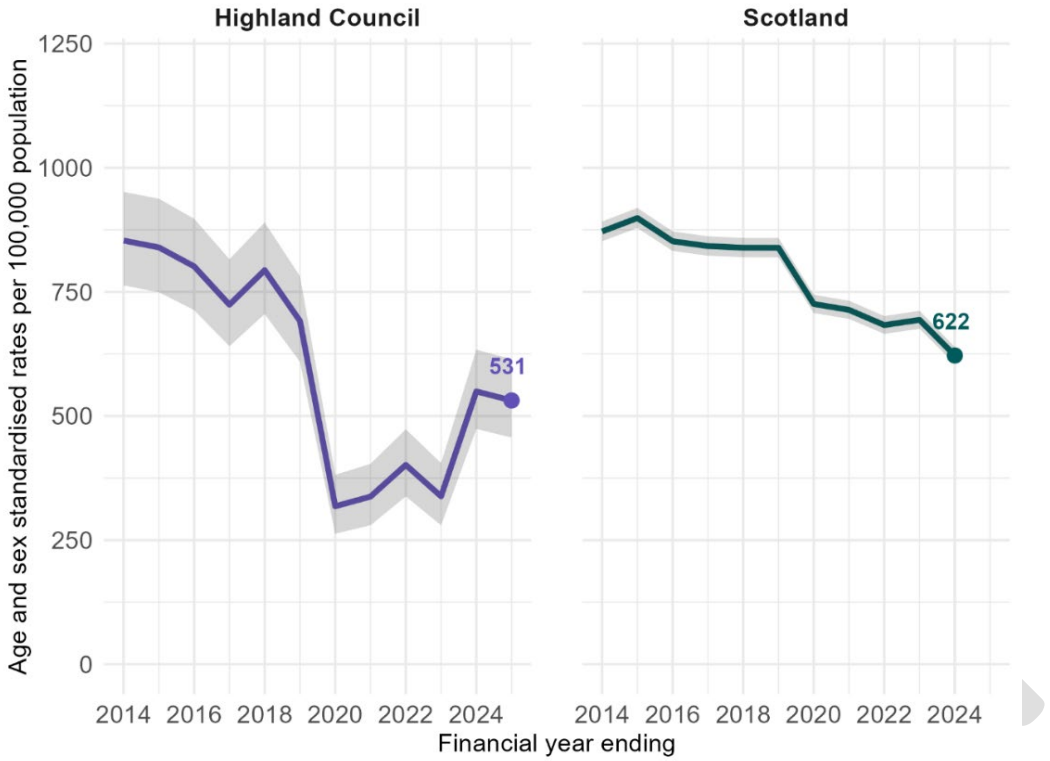
Local Headline Statistics

- In the financial year ending 2025, there were 182 emergency admissions for unintentional injuries in children under 15 in NHS Highland (105 male).
- The emergency admission rate for under-15s was 549 per 100,000 in Highland, compared to 622.7 per 100,000 in Scotland in the financial year 2023/24.
- Over the past ten years, admission rates for under-15s in Highland have declined steadily, with a notable reduction in 2019–2020 (pre-pandemic).
- There were 12 deaths in children under 15 in Highland from unintentional injuries over 2015–2024, with six due to motor transport and nine in under-fives.
- Males are more likely than females to be admitted for unintentional injury in all age groups, though the gap is narrowing for road traffic incidents.

Data Trends

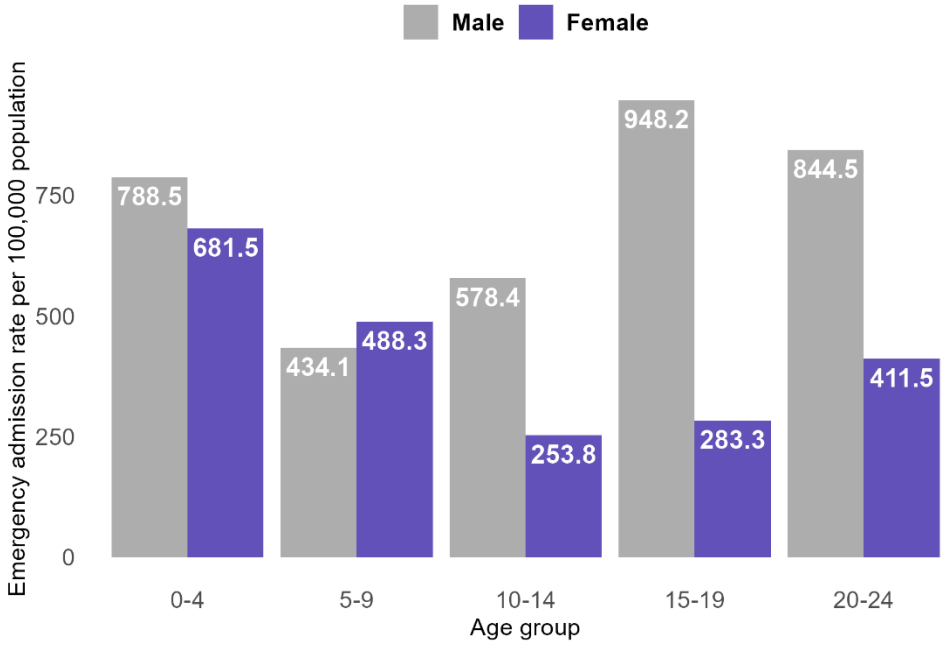
Routine surveillance of unintentional injuries in children and young people relies primarily on hospital admissions and death registrations, while many accidental injuries are treated in General Practice, Accident & Emergency, or by families and carers; sources that do not provide comprehensive surveillance data. Available statistics, therefore, underestimate the true burden of injury, and changes in coding or admission practices can affect observed trends.[184]

Figure 87: Emergency hospital admissions as a result of an unintentional injury; rates per 100,000 population for children under 15 by area of residence, 2014-2025



Data source: SMR01 Hospital Discharges and National Records Scotland Population Estimates
1 The rate per 100,000 is directly age and sex standardised using the European standard population (2013).
2 Data for the financial years ending 2024 and 2025 are provisional.
3 The shaded area shows the 95 percent confidence interval ranges of the rates.
4 Data for Scotland for the financial year ending 2025 is not available.

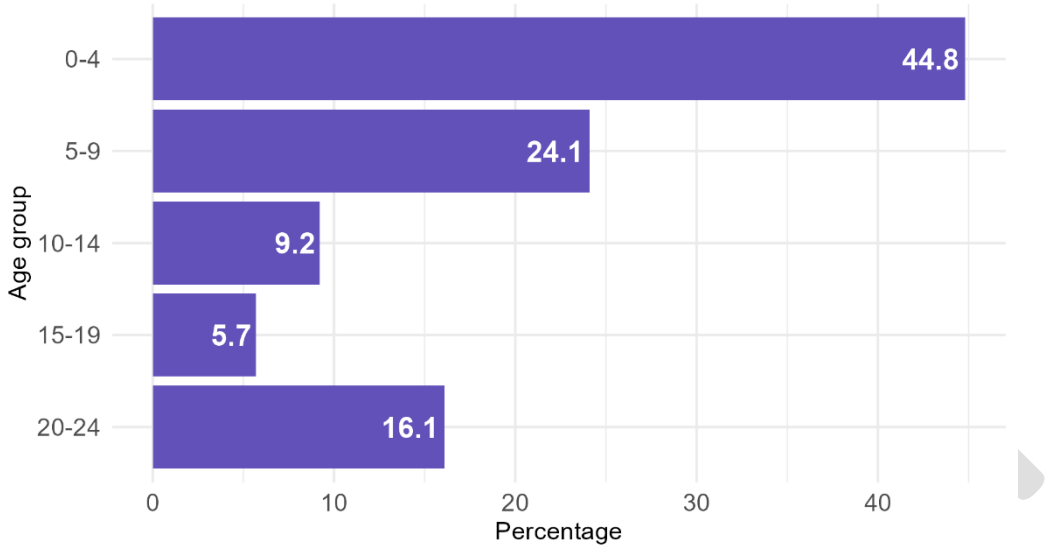
Figure 88: Emergency hospital admissions as a result of an unintentional injury; rates per 100,000 population by age group and sex, Highland, year ending March 2025



Data source: SMR01 Hospital Discharges and National Records Scotland Population Estimates
1 The rate per 100,000 is directly age and sex standardised using the European standard population (2013).
2 Data for the financial year ending 2025 are provisional.

Hospital admissions for unintentional injuries in children aged 0–15 remain a significant burden; falls, road traffic accidents, and poisoning are the most common causes of emergency admissions, with Highland's rural geography contributing to distinct patterns, including road traffic injury risk.

Figure 89: Percentage of injuries occurring in the home resulting in an emergency hospital admission by age group in Highland, 2023-2025



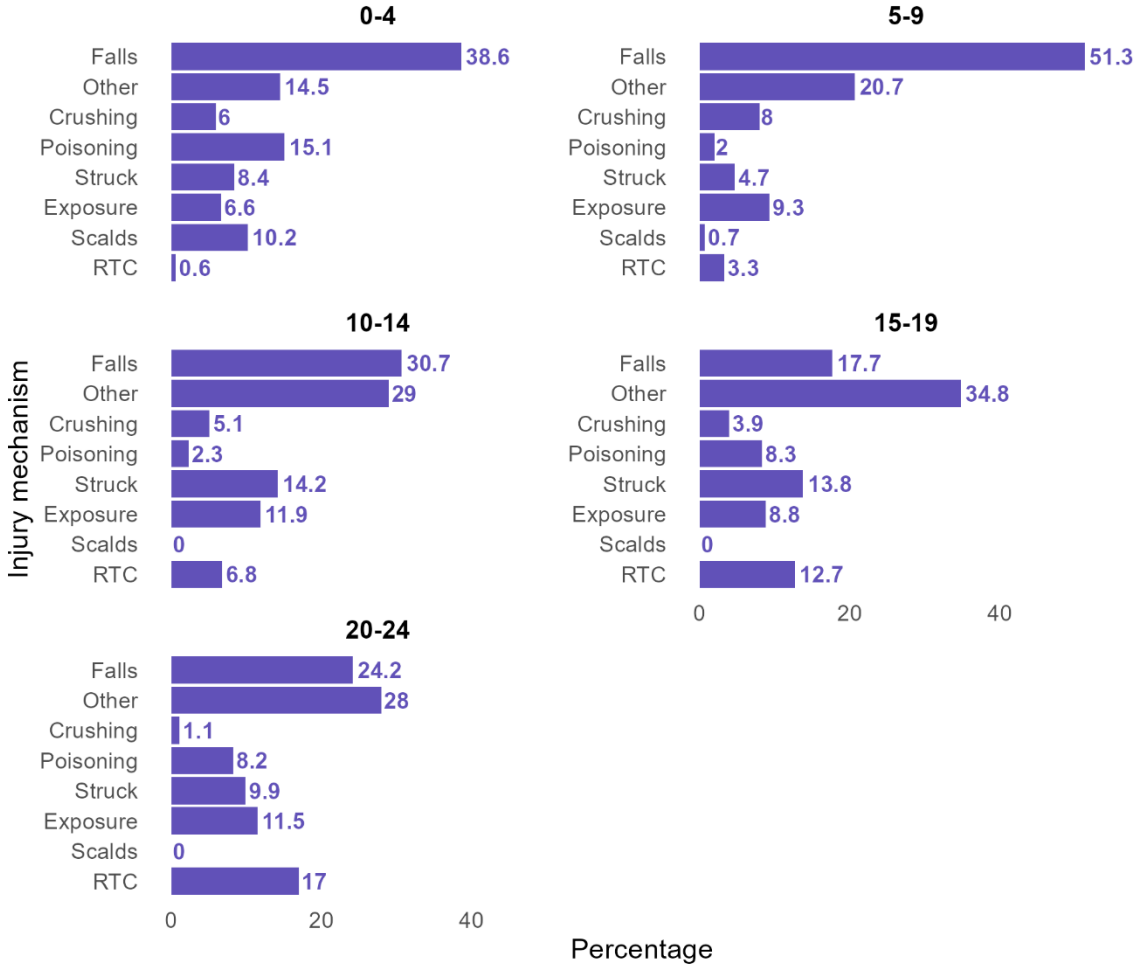
Data source: SMR01 Hospital Discharges and National Records Scotland Population Estimates
1 Data for the financial years ending 2024 and 2025 are provisional.

In Scotland, around one in nine emergency admissions among children and one in fifteen child deaths were attributable to unintentional injuries, with under-fives at the highest risk in home settings.[185]

- Falls account for the largest proportion of injuries in children under five; around four in ten under-15 admissions are due to falls, with forearm fractures the most common primary diagnosis among fall admissions (Figure 91).

- Road traffic injuries are more prevalent among older children and adolescents. There has been a long-term decline in road traffic admissions in under-15s and 15–24s, but recent trends in Highland are relatively flat; males remain at higher risk.

Figure 90: Percentage of injuries to Highland residents by mechanism resulting in an emergency hospital admission by age group, 2023-2025



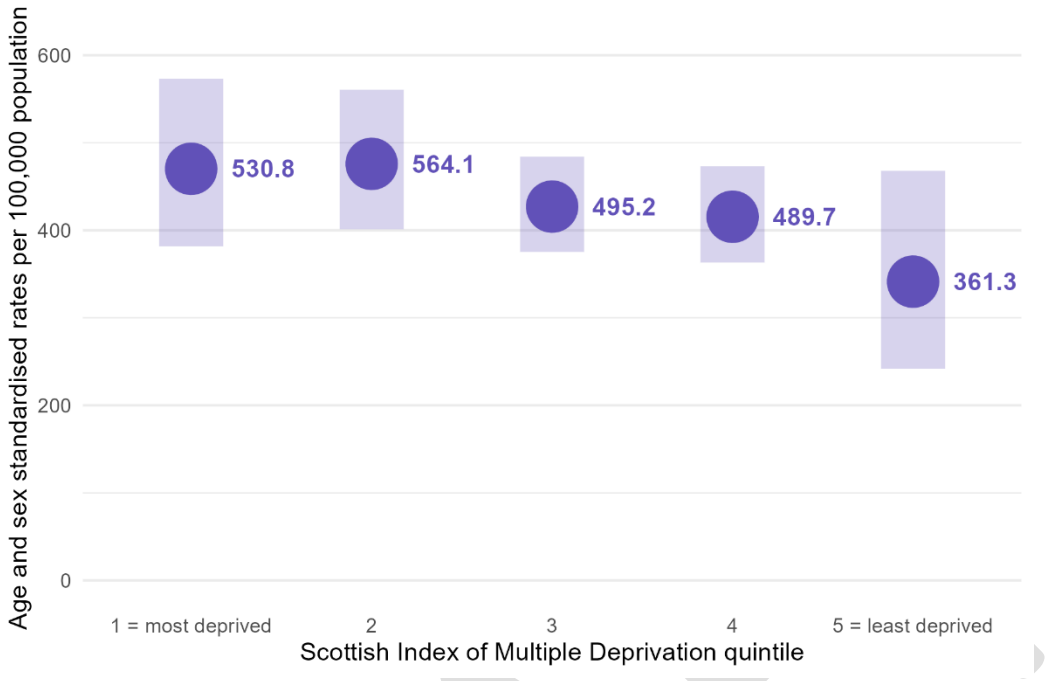
Data source: SMR01 Hospital Discharges and National Records Scotland Population Estimates
1 Data for the financial years ending 2024 and 2025 are provisional.

Inequalities

Children living in areas of higher deprivation experience a greater risk of unintentional injuries due to environmental hazards and limited access to safety resources. Rurality introduces additional challenges, including longer emergency response times and increased exposure to agricultural hazards, including those associated with farm transport.[186] Mountain and outdoor activities also contribute to the injury burden.

Nationally, boys and children in disadvantaged settings (including low-income or social/rented housing, and areas with dense traffic or limited play facilities) have higher admission rates; in Highland, deprivation quintile confidence intervals overlap, so the pattern is less distinct locally.

Figure 91: Emergency hospital admissions as a result of an unintentional injury; children and young people under 15 years of age resident in Highland by quintile of deprivation, rates per 100,000 population, 2023-2025



Data source: SMR01 Hospital Discharges and National Records Scotland Population Estimates
1 Data for the financial years ending 2024 and 2025 are provisional.
2. The rate per 100,000 is directly standardised using the European standard population (2013).
3 The shaded area shows the 95 percent confidence interval ranges of the rates.

Voices from the Home – Children's and Families' Perspectives on Unintentional Injury Risk

- **Parental perceptions**: UK qualitative studies show parents often distinguish between "acceptable" (minor) and "unacceptable" (serious) injuries, sometimes allowing controlled risk-taking for learning. Supervision strategies and risk tolerance vary by gender, age, and socioeconomic context.[187,188]
- **Barriers to prevention**: Families in lower-income settings report challenges such as the cost of home adaptations, limited access to safety equipment, and concerns about professional scrutiny.[186]
- **Children's voices**: Direct research with children on injury risk is limited, but national guidance (e.g. NSPCC, RCPCH) emphasises the importance of listening to children's lived experiences and involving them in safety planning.[189,190]
- **Understanding family and child perspectives** can help tailor prevention strategies, address practical barriers, and ensure interventions are relevant and acceptable.

Implications

Different injury mechanisms arise from distinct combinations of hazards, environments, and behaviours, meaning that no single intervention can address all patterns of risk. Falls in the home, transport-related incidents, or outdoor activity accidents each reflect different exposures and levels of parental or carer supervision, requiring targeted health-improvement approaches tailored to specific settings, age groups, and family circumstances.

Home Safety Assessments in Highland

Home safety assessments in Highland are mainly delivered through the Scottish Fire and Rescue Service's Home Fire Safety Visit (HFSV) programme, which provides free in-home checks, tailored fire-risk advice, escape-planning support, and, where needed, installation or testing of smoke and heat alarms in line with Scottish legislation. This service also identifies wider risks and can refer households to partner organisations when additional support is required.

Scotland's strengthened fire alarm standards require all homes to install interlinked smoke alarms in living areas and circulation spaces, plus heat alarms in kitchens, underscoring the importance of accessible safety guidance for families.[191] Complementary national advice, including practical installation and maintenance guidance for homeowners, helps families meet these standards.[192]

For residents who may struggle with installation or wider safety needs, particularly older people, disabled householders, or families experiencing low income, Highland Council's Low Income Home Owners Assistance Scheme and local Care and Repair services provide help with fitting alarms, carrying out adaptations, and improving home safety.[193] [194] These services extend the reach of injury-prevention efforts into homes where risks are higher and resources may be limited.

Role of the Third Sector

Community and voluntary-sector organisations are key partners in injury prevention across Highland. They provide practical support to families, including home-based assistance and guidance delivered through networks coordinated by the Highland Third Sector Interface (HTSI).

The Highland Directory of Support Services, jointly developed by NHS Highland and HTSI, lists a wide range of local organisations offering family support, wellbeing activities, and practical assistance in the home, demonstrating the breadth of third-sector involvement in strengthening day-to-day support for families.[195] This includes organisations that provide parenting support, work with families experiencing poverty or isolation, and help connect

households to services that can mitigate risks arising from housing conditions or limited access to resources.

Third-sector groups also play an important role in reaching families who may be underserved by statutory services, particularly in Highland's rural and remote areas, ensuring that community support is embedded within local settings and responsive to local needs. These organisations contribute to injury prevention not only by supporting families directly, but also by strengthening community resilience structures.

Third-sector organisations working with children and young people also influence injury risk by reducing harmful or risk-taking behaviours. Programmes such as Planet Youth Highland, delivered in partnership with NHS Highland and communities, use youth voice and environmental approaches to reduce substance use and other risky behaviours among adolescents, factors that contribute to injury incidence.

Additional services, such as the Highland Council Youth Action Service and other youth support organisations, provide safe spaces, structured activities, and family support for young people at risk of offending, substance use, or unsafe behaviours, offering protective environments that help reduce preventable harms.

Through these combined roles of family support, rural outreach, community resilience, youth engagement, and locally-tailored insight, the third sector provides essential capacity for place-based prevention across Highland.

The Highland CPP role

The Highland Community Planning Partnership (CPP) and its subgroups have a strategic role in:

- Expanding home safety programmes for families with young children, especially in areas affected by housing poverty or poor-quality accommodation, where risks such as unsafe stairs, lack of safety equipment, and overcrowding are more prevalent.
- Addressing poverty-related barriers by supporting families to access safety resources and adaptations and integrating injury prevention into wider anti-poverty initiatives.
- Enhancing road safety education and infrastructure, particularly in rural and deprived areas, and linking to transport planning to reduce risks associated with long travel distances, unsafe routes, and agricultural vehicles (e.g. quad bikes).
- Strengthening data linkage to identify high-risk households and communities, enabling targeted interventions that reflect local patterns of deprivation, housing need, and transport access.

- Supporting multi-agency initiatives through the CPP to address environmental and social determinants of injury risk, ensuring that strategies for housing, poverty reduction, and transport improvement are integrated with child safety priorities.

The Whole Family Wellbeing Programme's (WFWP) focus on early help, family capacity, and addressing socioeconomic and home-environment risks aligns closely with the major determinants of childhood injury. Evidence shows that home safety, parental supervision, and poverty-related environmental hazards underpin many injury mechanisms, suggesting a potential opportunity for WFWP to support prevention efforts as the programme develops.

13. Education and transitions

The UNCRC states that children have a right to an education to develop their personality, talents and mental and physical abilities to their fullest potential, and to learn about human rights, the environment and their culture and that of others. Educational attainment is associated with higher income, better health and wellbeing and provides children with opportunities to live life to their maximum ability.

Early learning and childcare

Early learning and childcare (ELC) provision is funded, for three to five year olds, up to 1,140 hours annually. Two year olds also receive funded provision if they are looked after or their families receive certain benefits. Suitable early learning provision can improve outcomes for young children, particularly those who experience disadvantage.

In 2025, 3,939 children were registered for ELC in Highland, 217 of whom were aged two years. Highland had a similar proportion of eligible two-year olds registered as nationally, but a lower proportion than some council areas, suggesting that uptake of funded places for two year olds could be higher.[196] In contrast, uptake of places for three- and four-year-olds was 100 percent.

The Scottish Government has an aim to increase the uptake of entitlement for eligible two-year-olds. Reasons that parents may not place their two-year-olds in ELC include lack of awareness of the provision and feeling that their child is too young for such care.[197] CPP partners have a role in identifying eligible children, breaking down barriers for access and highlighting the positive benefits on learning and development.

In 2025, Highland had 181 providers of ELC which offered funded places; 137 (76 percent) were local authority centres and around one quarter were partnership settings (private or voluntary run settings in partnership with the local authority to provide funded ELC). Nationally 63 percent are local authority run, with those areas with significant remote and rural geographies, including Highland, more likely to have a higher proportion of local authority-run centres. This can be explained due to a lack of economy of scale making other provision less viable for smaller population sizes.

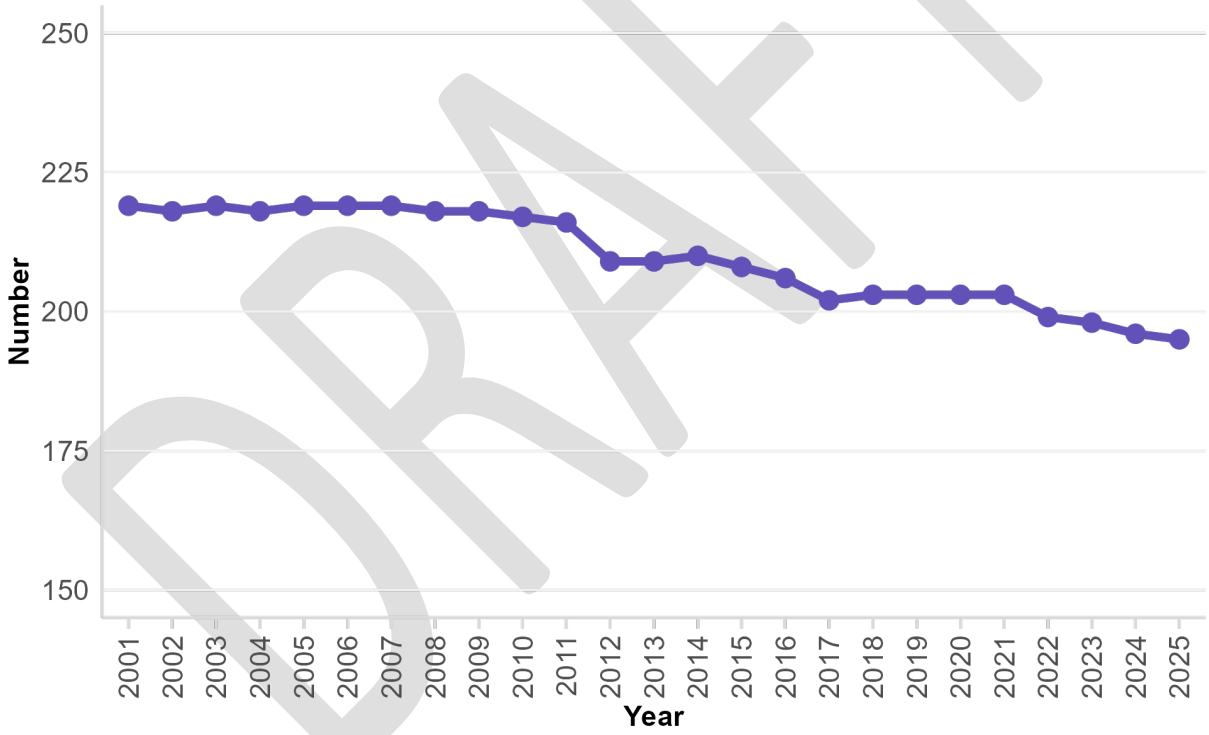
Gaelic medium provision was offered by 18 (10 percent) centres in Highland, the second highest proportion in Scotland after Na h-Eileanan Siar. These are culturally important in enabling and promoting use of Gaelic language and offer the cognitive benefits of being bi-or multi-lingual, assuming English will be learnt elsewhere.

Childminders and wider family also contribute to childcare and early learning. There were 141 childminders registered in Highland at 30th November 2025. After school care and holiday playschemes also contribute to the childcare available in Highland. This could represent a more accessible form of childcare particularly in remote and rural areas although many areas of Highland do not have a registered ELC provider.[198] After school care and holiday playschemes also contribute to childcare available in Highland, although again these are not available in all areas.

Teaching provision

The number of publicly funded primary, secondary and special schools in Scotland is assessed annually in the pupil census. The number of schools in Highland has decreased from 219 In 2001 to 195 in 2025 (Figure 92).

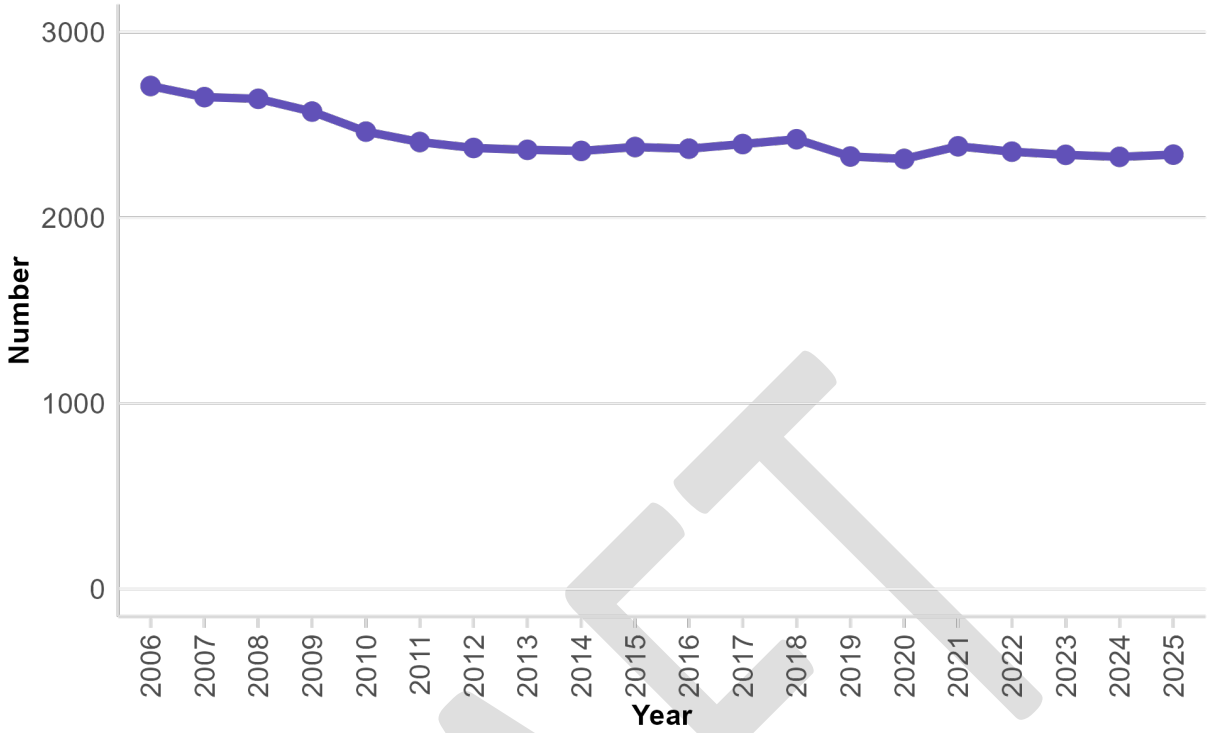
Figure 92: Number of publicly funded schools in Highland, 2001-2025



Source: Scottish Government, School education statistics
1 Note that the y-axis does not start at zero

The number of full-time equivalent teachers in publicly funded schools, including ELC centres, in Highland decreased from 2,710 in 2006 to 2,340 in 2025. The number decreased most strongly from 2006 to 2012, after which it stayed more stable (Figure 93).

Figure 93: Number of teachers in publicly funded schools (including ELC) in Highland, 2006-2025



Source: Scottish Government, School education statistics

The decrease in the number of schools and teachers is consistent with a declining population of children and young people. This inevitably means that some children will need to travel further to access their school. Alongside a decreasing population of working-age adults, there will be fragility in education provision in some parts of Highland, particularly in rural settings.

School attendance

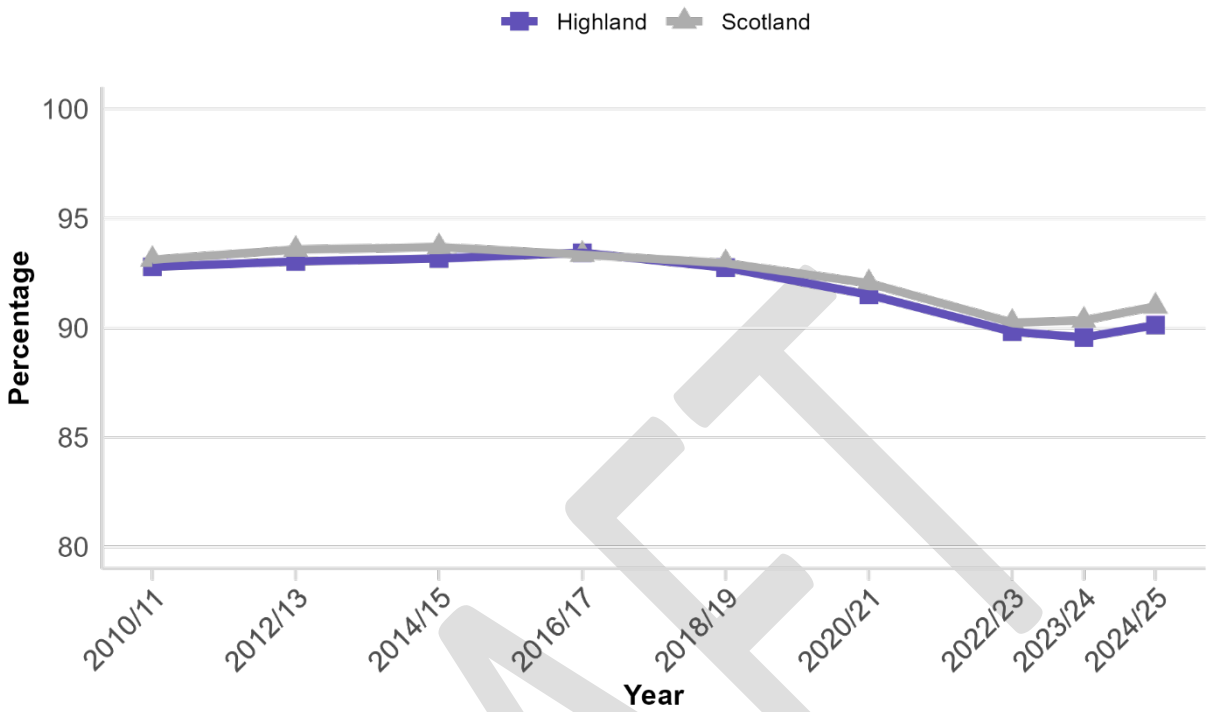
Being in school is important to children's achievement, wellbeing, and wider development. Evidence shows that pupils with the highest attendance throughout their time in school achieve better educational outcomes and develop essential social skills.[199]

The percentage of school attendance describes the number of days pupils attended schools compared to the number of possible school days they could have attended, i.e. days the school was open.

Figure 94 illustrates the percentage of school attendance for all publicly funded primary and secondary schools in Highland compared to Scotland. For Highland and Scotland, the attendance rate during the COVID-19 pandemic, starting in 2020/21 and in the following years, was consistently lower than recorded before the pandemic. For 2024/25, school attendance in Highland was 90.1 percent, which marked a small increase from 89.6 percent in

2023/24. For Scotland, the attendance rate showed a small increase from 90.3 percent in 2023/24 to 91 percent in 2024/25.

Figure 94: Percentage of school attendance in Highland and Scotland, 2010/11 – 2024/25



Source: Scottish Government, School education statistics, 2024/2025
1 Note that the y-axis does not start at zero
2 The COVID-19 pandemic impacted the attendance reporting for 2020/21; data for this year is based only on periods the schools were open

The higher the school absence rate, the greater the impact on attainment, and is a particular concern for those with less that 90 percent attendance. Due to concerns regarding lower attendance following the COVID-19 pandemic, Education Scotland examined issues underlying school attendance.[199] Those at higher risk of poor attendance include:

- children and young people impacted by poverty
- secondary-aged pupils
- young people from Gypsy and Traveller communities
- pupils with additional support needs
- children and young people who have experienced care
- young carers
- children and young people who have experienced exclusion
- anxious children and young people.

Although local authorities play a key role in monitoring attendance and supporting young people to attend, multi-agency partners have a role in working together to support those who are at risk of, or who are not, attending school.

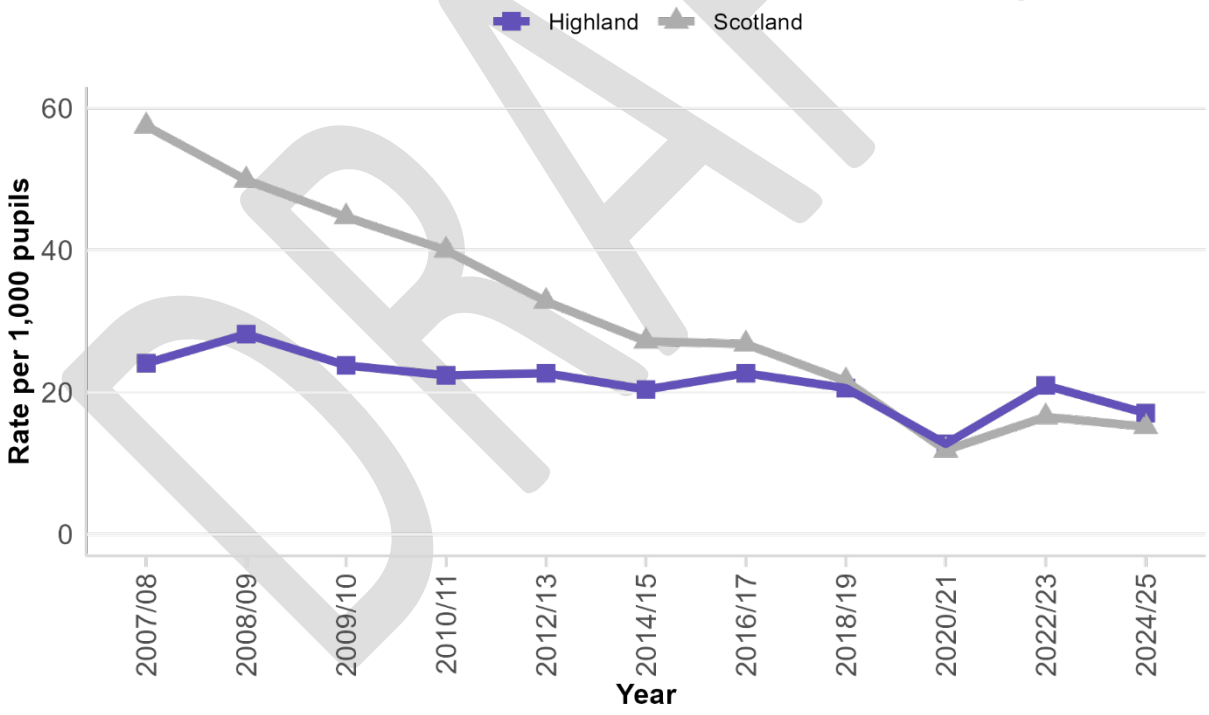
School exclusions

In Scotland, a school exclusion is a disciplinary measure whereby a pupil is sent home and not allowed to attend school. This can be either for a fixed period ('temporary exclusion') or permanently ('removed from register').

Between 2010/11 and 2018/19, the rate of exclusions from school in Highland stayed mostly stable in the range of 20 to 24 per 1,000 pupils. In 2020/21 the rate dropped to its lowest point in the time series (12.7 per 1,000), likely influenced by the COVID-19 pandemic. Between 2020/21 to 2024/25 the rate increased back to 17.1 (Figure 95).

Scotland previously had higher rates of exclusion which fell consistently from 57.5 in 2007/08 to 11.9 in 2020/21. In 2020/21 the rate for all local authorities fell below the Highland rate for the first time in the time series. It followed a similar trend but stayed below the Highland rate up to 2024/25 (15.2 per 1,000 pupils).

Figure 95: Rate of cases of exclusion per 1,000 pupils by local authority, 2007/08 to 2024/25



Source: Scottish Government, School education statistics, 2025
1 Since 2010/11 information are collected biennially

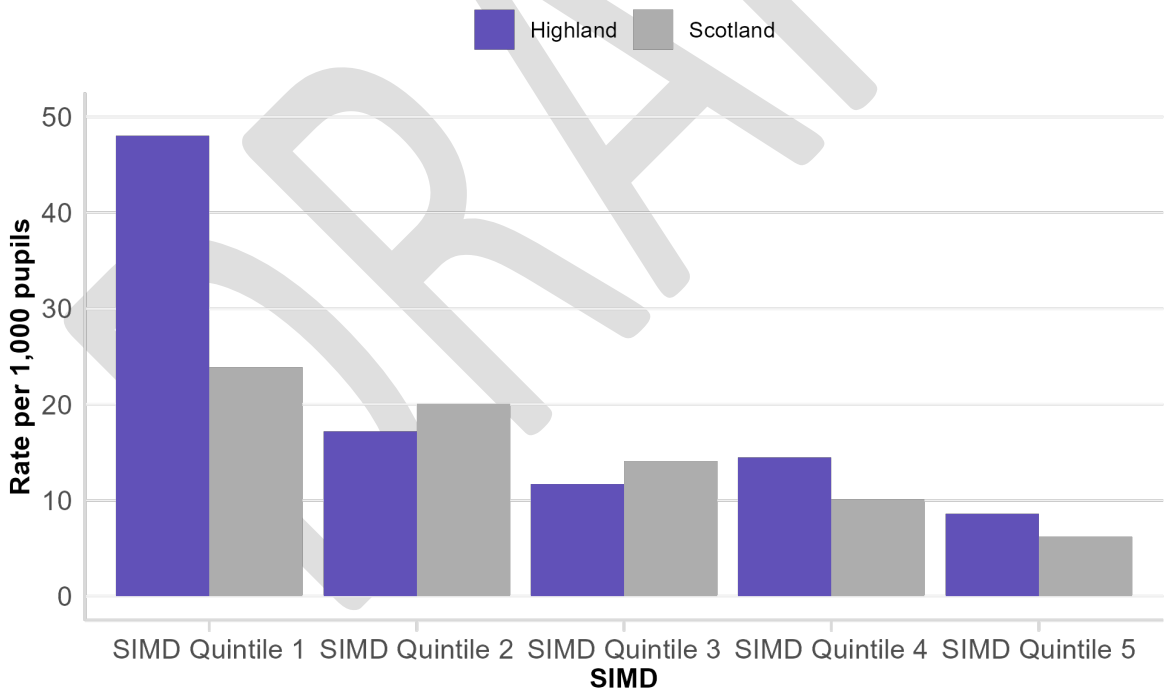
School exclusion means that the learning of the excluded child is negatively impacted, alongside creation of stigma. Scottish policy has been to use exclusions as a last resort, where there are no alternatives measures to be taken.[200] Permanent school exclusions are almost zero in Scotland.

Children at higher risk of exclusion have experience individual and structural factors, such as socioeconomic status, which are beyond their control.[201] These include those who:

- have been assessed or declared as having a disability
- are (or have been) care-experienced
- come from the most deprived areas or are in receipt of free school meals
- are identified as having an additional support need, or have an additional support need specifically identified as social, emotional, and behavioural in nature
- are male compared to female.

In 2024/25, the rate of exclusion in the 20 percent most deprived areas in Highland was 48.0 compared to 8.6 in the 20 percent least deprived areas (Figure 96). Although Highland has a lower proportion of children living in the most deprived areas in Scotland, the rate of exclusion for these children was higher than nationally. This describes a wider inequality for children in Highland and need for action to prevent exclusions, particularly for those experiencing deprivation.

Figure 96: Cases of exclusion from school per 1,000 pupils by SIMD quintile, Highland and Scotland, 2024/25



Source: Scottish Government, School education statistics, 2025

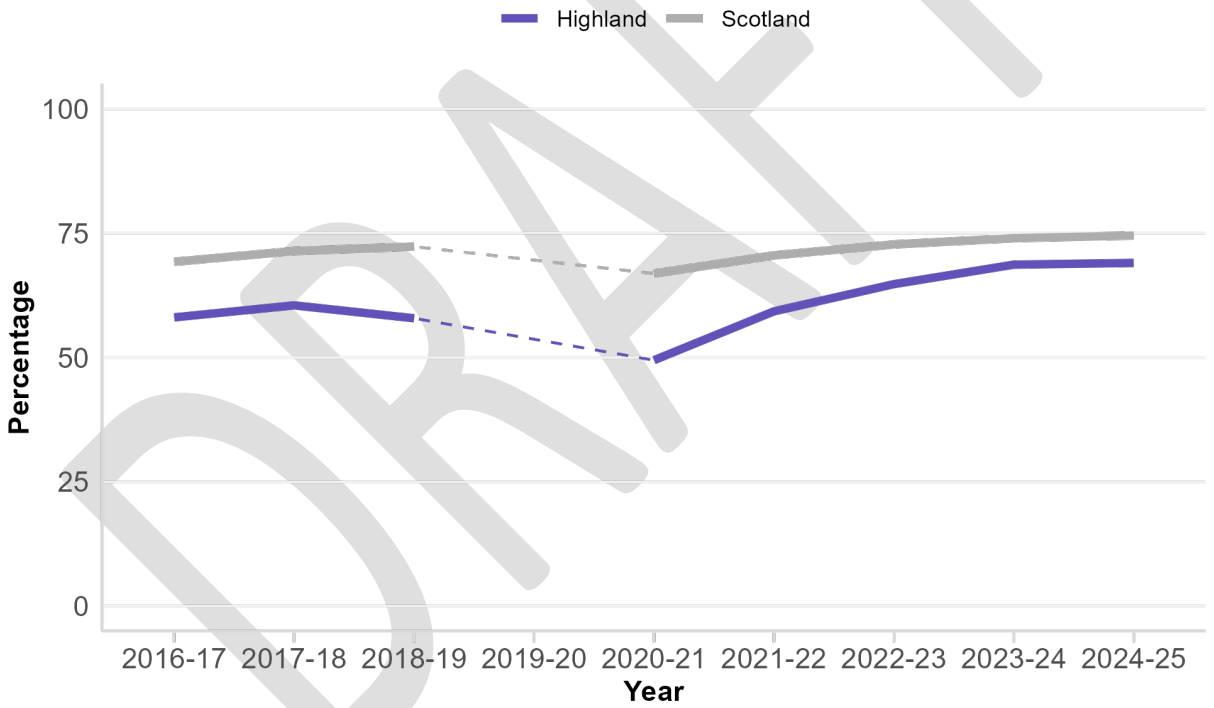
There has been a shift towards understanding problem behaviours as a consequence of distress rather than deliberately aggression or antisocial intent. While schools have a duty to work with young people and families to reduce exclusions, multi-agency partners play a vital role in working to mitigate the underlying circumstances that are outside family's control and which negatively impact children and young people and their ability to remain in school.

School attainment

For primary school pupils, the achievement of Curriculum for Excellence (CfE) levels provides information on school pupils attainment of expected levels of numeracy, reading, writing, listening, and talking. Literacy comprises three components: reading, writing, and listening and talking. It covers all P1, P4 and P7 pupils.

The percentage of pupils achieving the expected CfE levels in literacy increased from 49 percent in 2020/21 to 69 percent in 2024/25 in Highland, which was higher than the pre-pandemic levels. The recent increase narrows the gap between the levels in Highland and Scotland. School attainment in Scotland rose from 67 percent in 2020/21 to 75 percent in 2024/25 (Figure 97).

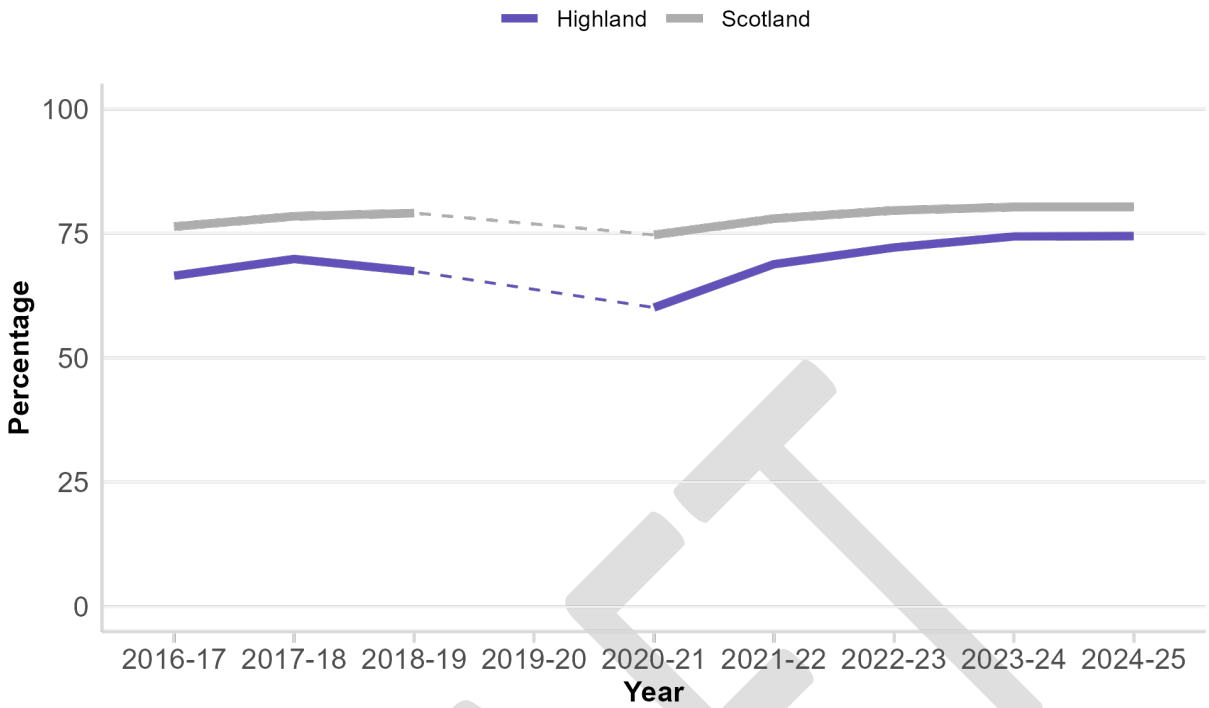
Figure 97: Percentage of P1, P4 and P7 pupils achieving expected Curriculum for Excellence levels in literacy, 2016/17-2024/25



Source: Scottish Government, School education statistics, 2025

The percentage of P1, P4 and P7 pupils in Highland achieving expected CfE levels in numeracy was higher overall than for literacy. The percentage increased from 60 percent in 2020/21 to 74 percent in 2024/25, exceeding pre-pandemic levels and narrowing the gap to the national average. For Scotland, the increased from 75 percent in 2020/21 to 80 percent in 2024/25. The percentage of numeracy stayed on the same level between 2023/24 to 2024/25 (Figure 98).

Figure 98: Percentage of P1, P4 and P7 pupils achieving expected Curriculum for Excellence levels in numeracy, 2016/17-2024/25

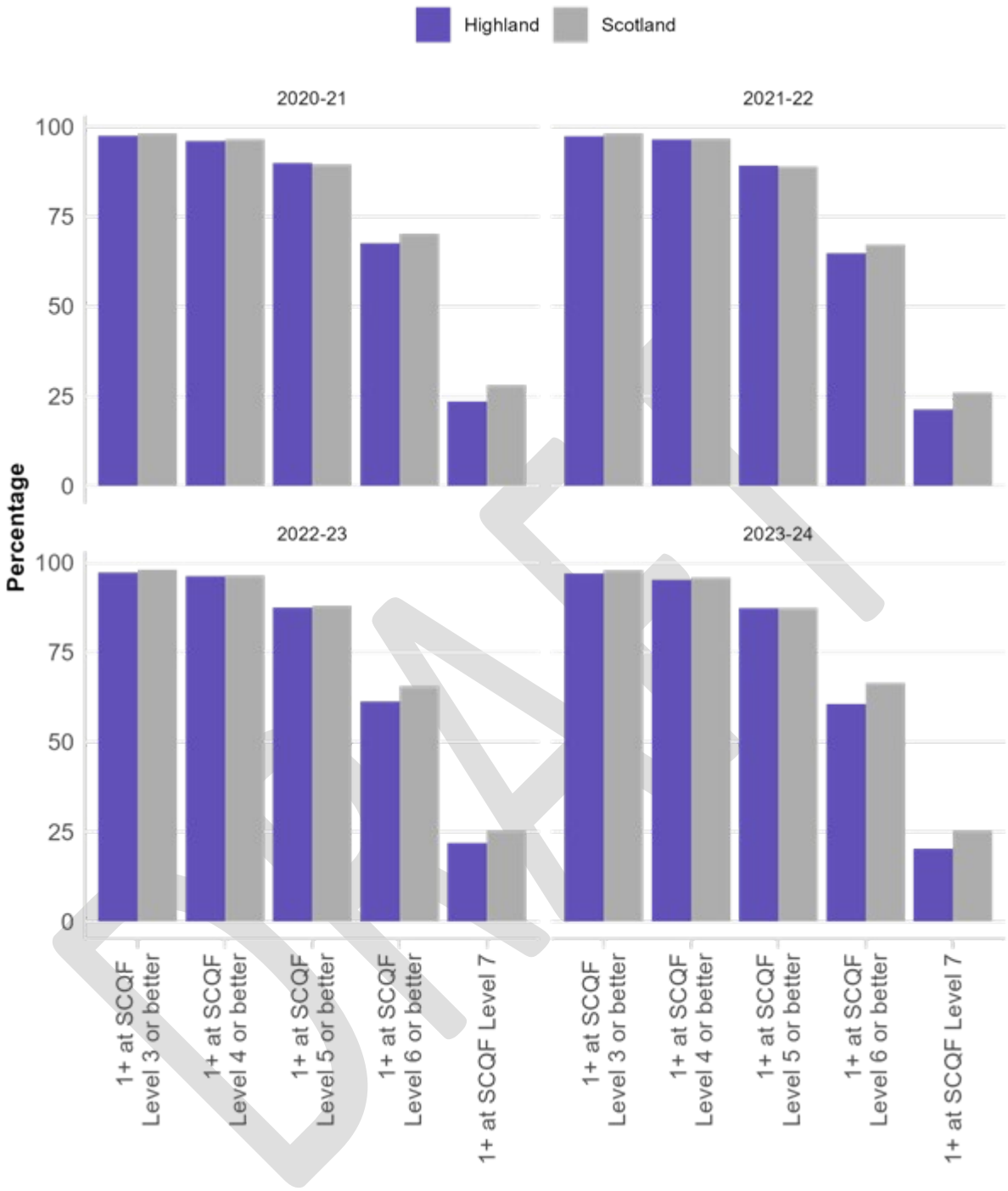


Source: Scottish Government, School education statistics, 2024

The Scottish Credit and Qualifications Framework (SCQF) allows a comparison between qualifications by ordering them into 12 levels of increasing difficulty. The qualifications in the All SCQF measure include National Qualifications along with other qualifications provided by Scottish Qualification Authority (SQA), e.g. National Progression Awards. For this measure a grade D at a given SCQF level is counted as a pass at that level.

From 2020/21 to 2023/24 the percentage of school leavers from years S4 to S6 with one pass or more at SCQF Level 5 or better, Level 6 or better or Level 7 decreased each year. For Highland, the percentage of school leavers with one pass or more at SCQF Level 5 or better decreased from 89.9 percent to 87.3 percent (Figure 99).

Figure 99: Total secondary school leaver attainment under the All SCQF measure by local authority, percentage of leavers; 2020-21 to 2023-24

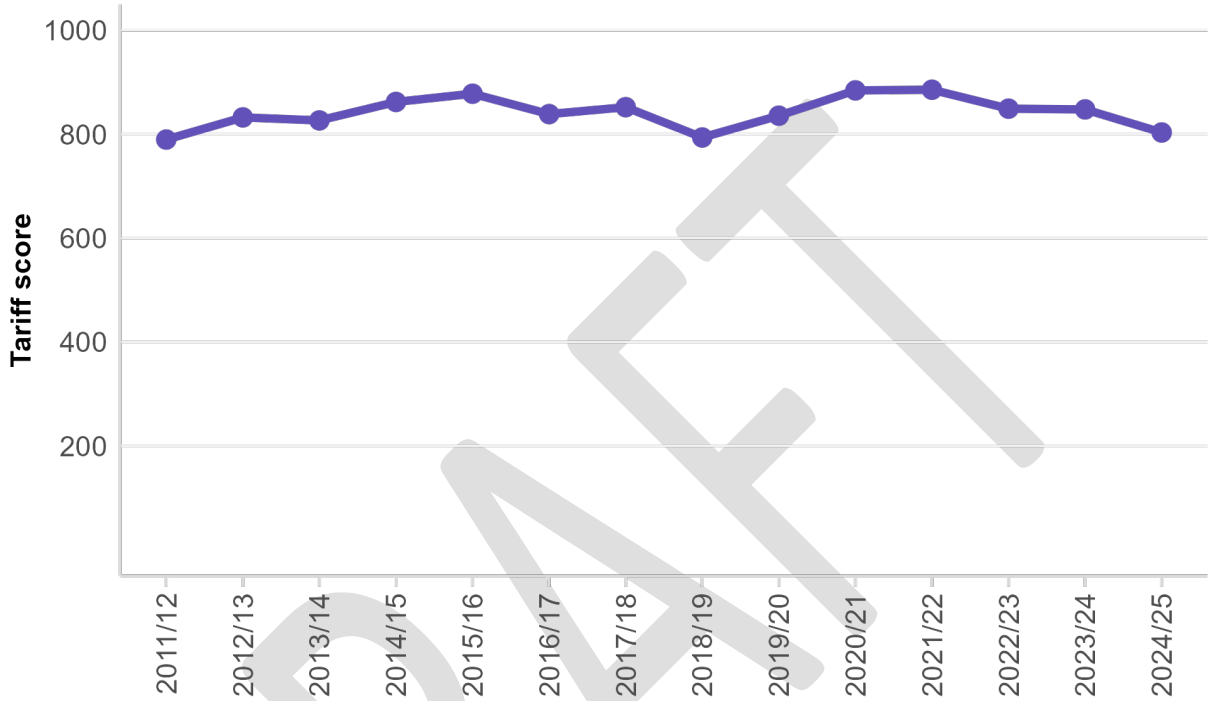


Source: Scottish Government, School education statistics, 2024

Educational attainment is associated with improved outcomes in later life. The overall tariff scale measures the latest and best achievement in each subject area for national qualifications and wider awards. Qualifications are awarded tariff points based on their Scottish Credit and Qualifications Framework (SCQF) level.

In Highland, the average tariff score was lowest in 2010/11 with 790. After some improvement it decreased back to 794 in 2018/19, followed by a multiple year improvement. In recent years, the average Tariff Score decreased from 886 in 2020/21 to 803 in 2024/25 (Figure 100). Pass rates increased during COVID-19 and thresholds have since been gradually adjusted so that pass rates are more in line with the pre-pandemic period.

Figure 100: Overall Average Tariff Score in Highland, 2010/11 - 2024/25



Source: Highland Council Education statistics, 2025

Pupils with Additional Support Needs

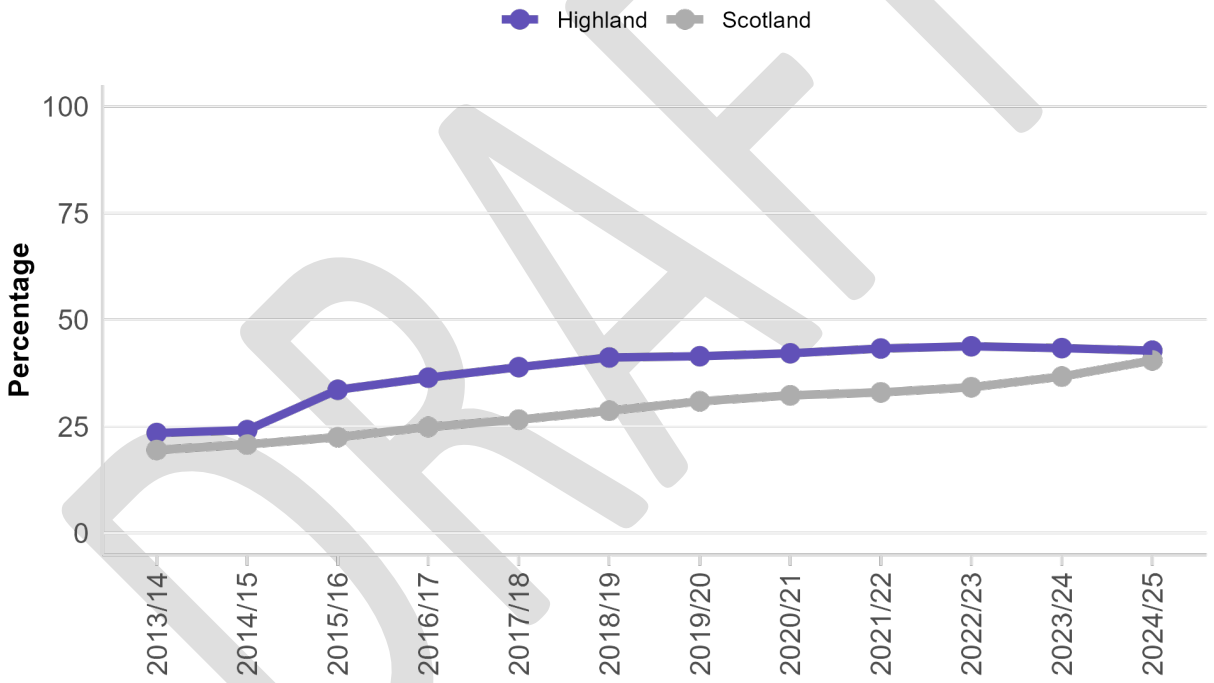
All children and young people have the right to get the support they need to reach their full learning potential. The Education (Additional Support for Learning) (Scotland) Act 2004 sets out the duties of education authorities and the rights of parents, children and young people to additional support for learning.

According to the Act education authorities must have arrangements in place to identify pupils who need additional support to participate and benefit from school education without barriers. Additionally, they need to be able to identify the reason or reasons why the additional support is needed. Some pupils with additional support needs (ASN) may require a specific support plan.[202]

In 2024/25, 410 children (10 percent) in early learning ad childcare settings in Highland had additional support needs compared to 19 percent nationally, with a range from eight to 28 percent across local authorities. Of these, 180 children (4 percent) had a support plan. Five percent of those registered for ELC (210 children, 4 percent) had a home language which was not English, Gaelic, Scots, or Sign Language, lower than the national average (11 percent).

The Scottish pupil census provides information on the number of students with ASN in publicly funded primary, secondary and special schools. In Highland, the proportion of the school roll with ASN for learning increased from 23 percent in 2013/14 to 43 percent in 2024/25. Since 2020/21 the proportion stayed mostly stable. The proportion in Scotland steadily rose from 20 percent in 2013/14 to 41.5 percent in 2024/25 (Figure 101).

Figure 101: Proportion of school roll (primary, secondary, special school) with additional support needs in Highland and Scotland, 2013/14 to 2024/25

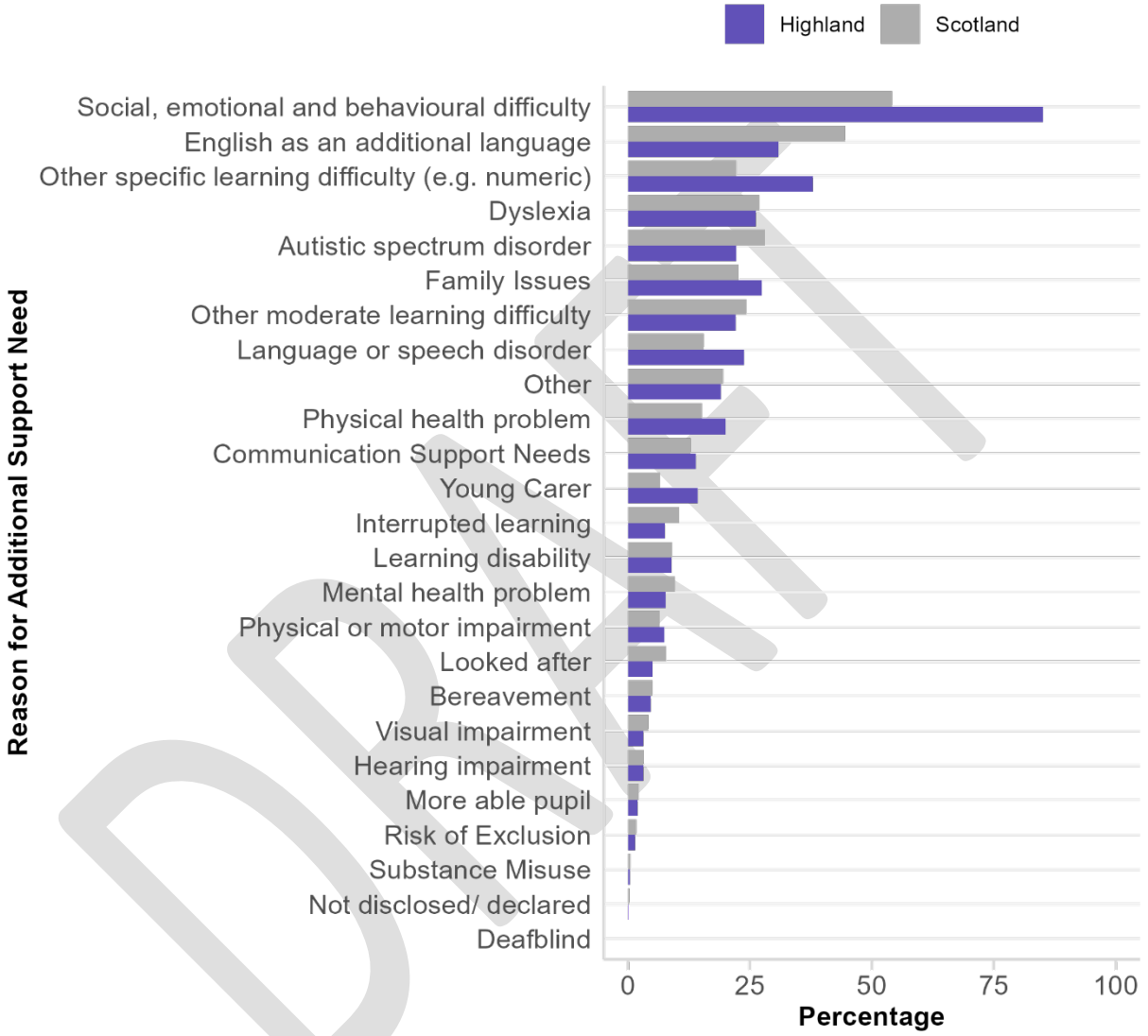


Source: Scottish Government, Pupil Census 2024

In 2024 social, emotional and behavioural difficulties were the most common reason for an additional support need when looking at the combination of primary, secondary and special school settings in Highland and Scotland. In Highland, it was noted as the reason for an ASN for 85 percent of all pupils for whom a reason for support was reported. This was noticeably higher than in Scotland, where it was the reason in 54 percent of school children with additional support needs (Figure 102).

In Highland, the second most common reason for ASN were other specific learning difficulties (e.g. numeric) (38 percent), followed by English as a second language (31 percent) and family issues (27 percent). English as a second language was a more common reason (45 percent) in Scotland, followed by autism spectrum disorder (28 percent) and dyslexia (27 percent).

Figure 102: Proportion of Additional Support Needs by reason in primary, secondary and special school setting, Highland and Scotland, 2024

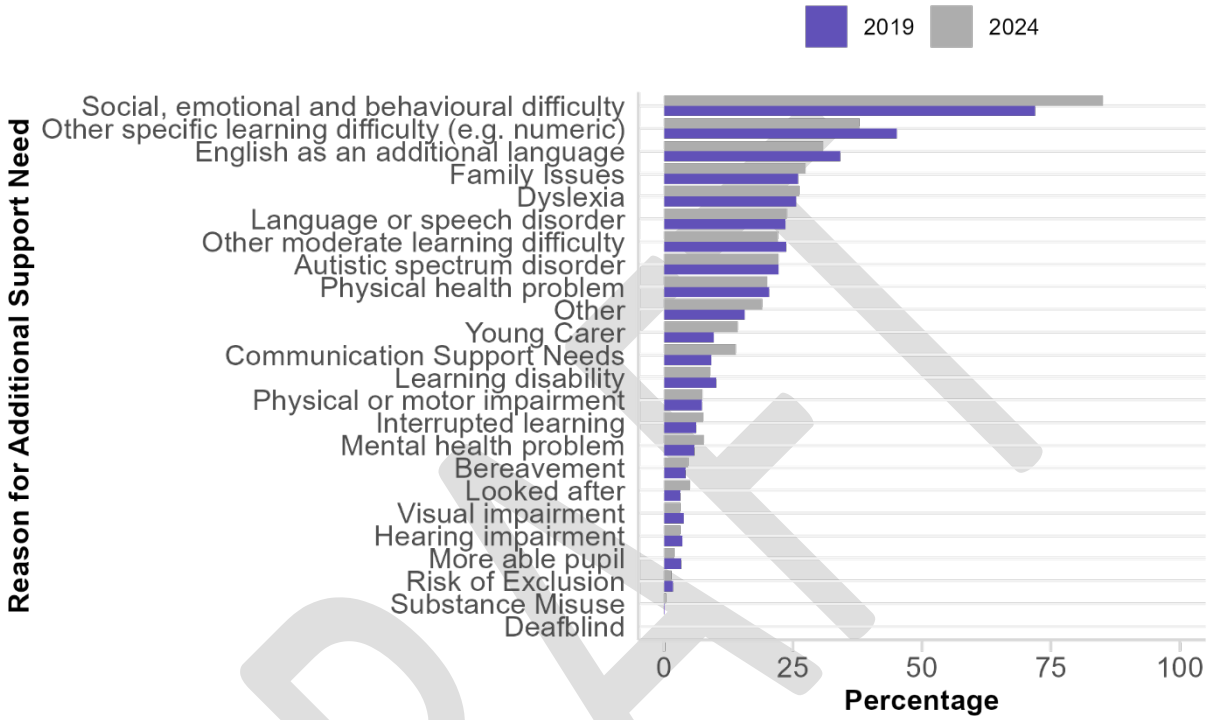


Source: Scottish Government, Pupil Census 2024

In Highland, the main reasons for additional support needs remained consistent between 2019 and 2024. Social, emotional and behavioural difficulties increased from 72 percent to 85 percent, while other specific learning difficulties decreased from 45 percent to 38 percent. Being a young carer and having communication support needs increased from 10 percent to 14 percent respectively between 2019 and 2024 (Figure 103).

As discussed regarding school exclusions, behavioural problems can be viewed as a distress response, with children and young people experiencing disadvantage or trauma more likely to display these behaviours. Multi-agency partners provide a role in supporting families and children exposed to structural factors causing adversity.

Figure 103: Proportion of Additional Support Needs by reason in primary, secondary and special school setting in Highland, 2019 and 2024



Source: Scottish Government, Pupil Census 2024

Transitions between education stages

Educational transitions are important milestones in children and young people's lives. They can impact social and academic outcomes, affect life at school and home, and can impact upon friends, families and teachers.[203] Negative transition experiences can have a long-term impact on educational outcomes.[204]

The Growing Up in Scotland (GUS) study explores the experience of transition of children and their families in Scotland. In the absence of similar studies on the local level the findings on influencing factors can give important insights into how to shape a positive educational journey in Highland.

Most parents in the GUS study perceived their children to be ready when entering primary school, that their children had had an easy transition to school, and that the pace of learning was right for them.[205] Engaging in some form of school preparation for their children, such as

visiting or talking about the school or practicing reading, writing or numbers, was common for most parents. The transition experience was influenced by the socio-economic background of the child's family. Children in more socio-economically disadvantaged households tended to have lower perceived readiness and parents with higher income tended to engage in more preparation activities. Children with lower perceived adjustment were more likely to also have poorer social, emotional and behavioural development and cognitive ability.[205]

Children start school between 4.5 and 5.5 years old. Parents may defer entry for four-year-olds they feel are not ready, and all deferred children can now remain in funded early learning and childcare (ELC). In 2025, 49 percent of eligible Highland children deferred, compared with 35 percent nationally (ranging from 23 percent to 71 percent across local authorities).[206] Nationally, children in the most deprived areas have historically been less likely to defer, suggesting additional factors influence parental decisions. In Highland, past council ELC funding practice, local guidance, childcare availability, and affordability may all shape parents' choices. Multi-agency partners can have a role in supporting parents to be able to make the most appropriate decisions for their children.

International studies show the transition from primary to secondary school can reduce educational outcomes.[207] In Scotland, GUS data indicates most pupils experience a positive or moderate transition, but outcomes vary by gender, family structure, socioeconomic status, additional support needs, and social relationships. Boys, children from single-parent or larger families, and those facing greater socioeconomic disadvantage are more likely to have negative transitions.[208] Multiple studies have found that children with additional support needs are more likely to have a negative transition experience.[209] [210]

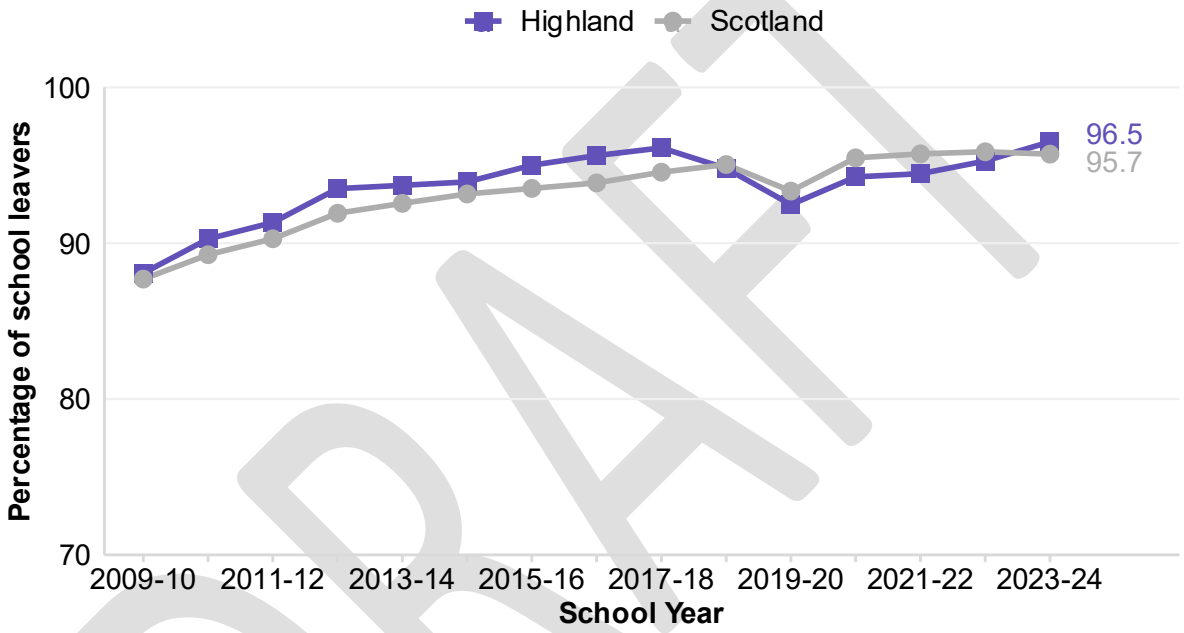
Regular participation in sports, youth groups or other activities, a good parent-child relationship and peer relationships after starting secondary school were all associated with a positive transition experience. Equally, regular parent-school communication and engagement both with the primary and the secondary school were strongly associated with the positive transition experience of the child.

Increasing access to protective factors, supporting parents with parenting and providing more support for those at greater need could improve experiences of primary to secondary transitions.

Post-school destinations

Participation in work, education or training is largely positive for young people in what is a transitional phase in life upon leaving school. 96.5 percent of school leavers in the 2023/24 school year in Highland entered a positive initial destination (Figure 104). National data shows that those living in the most deprived areas in Scotland, those with additional support needs and those declared or assessed as disabled are less likely to have a positive initial destination on leaving school.

Figure 104: The percentage of mainstream school leavers in an initial positive destination, by school year of leaving school and area

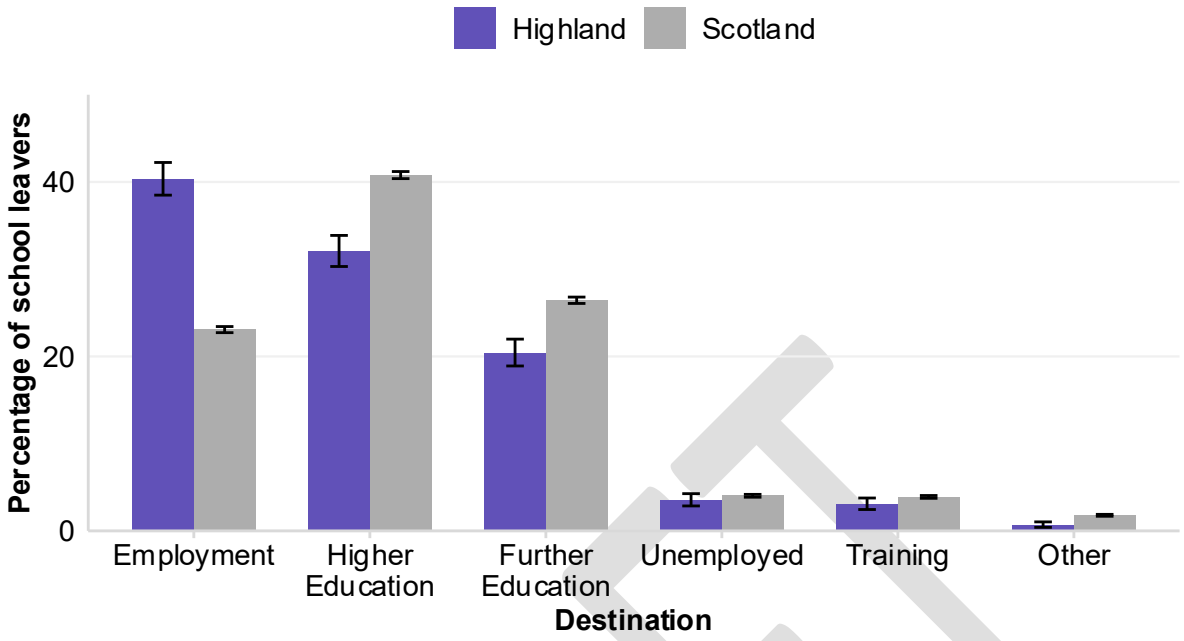


Source: Scottish Government. Summary Statistics for Attainment and Initial Leaver Destinations
1 The y-axis does not start from zero.

2023/24 was the first school year following the start of the COVID-19 pandemic that Highland returned to having a higher percentage in positive destinations than Scotland. Sectors such as hospitality, which make up a higher proportion of Highland employers, were particularly affected by measures designed to reduce the spread of Sars-Cov-2, and this may have impacted on employment opportunities for school leavers.

Highland has a higher proportion of school leavers entering employment than nationally, and a lower proportion entering further or higher education (Figure 105). Positive school leaver destinations in Highland may therefore be more susceptible changes in the employment market.

Figure 105: The percentage of mainstream school leavers in the 2023-24 school year by initial destination and area



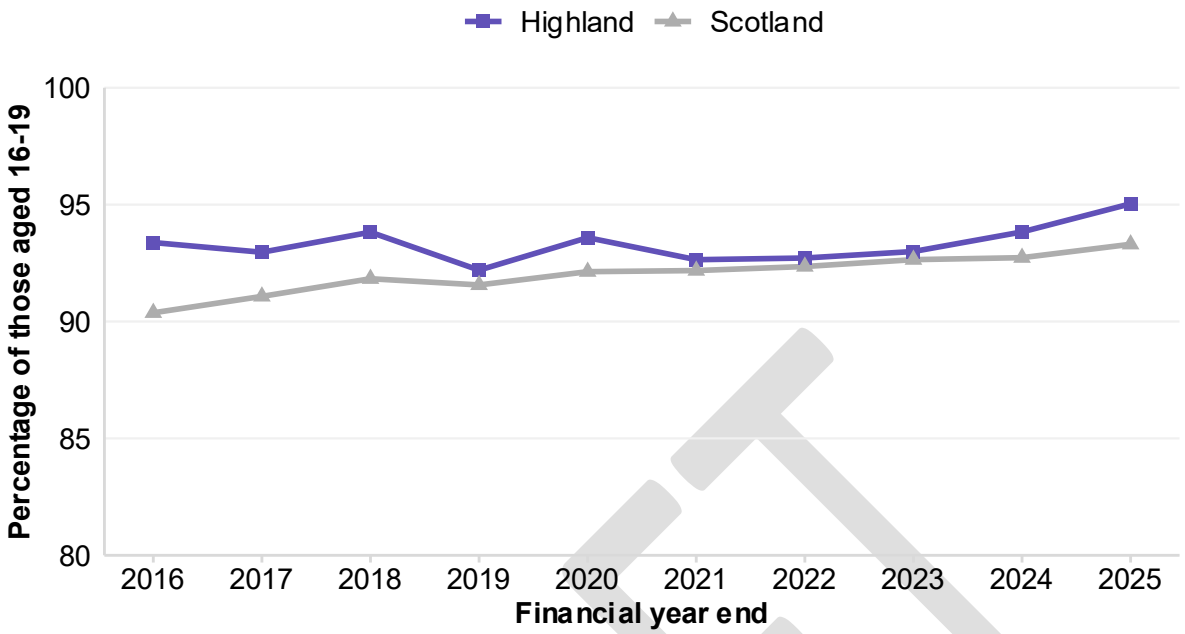
Source: Scottish Government. Summary Statistics for Attainment and Initial Leaver Destinations
1 Error bars indicate 95% confidence intervals.
2 Other category includes positive destinations of voluntary work and Personal Skills Development as well as those for whom their destination was unknown. Unemployed include both those seeking and not seeking employment.

Across Scotland, those leaving school in S6 are most likely to enter higher education whereas those leaving in S4 and S5 are more likely to enter employment or further education. Young people living in the most deprived areas are less likely to leave school to enter higher education but more likely to enter further education, employment and other positive destinations, such as training.

Young people are vulnerable to difficulties entering the workforce during this transitional stage, particularly when economic conditions are weak.[211] The Scottish Government, through 'Opportunities for All', has pledged a place in learning or training for every young person aged 16 to 19. Education, in its broadest sense, is linked to better employment, higher income, and improved physical and mental health.

In 2024/25, 95.0 percent of those aged 16-19 in Highland were in education, employment or training (known as annual participation), higher than for Scotland (Figure 106).

Figure 106: Annual participation (aged 16-19) in education, training or employment by year, Highland and Scotland



Area	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Highland	93.4	93.0	93.8	92.2	93.6	92.6	92.7	93.0	93.8	95.0
Scotland	90.4	91.1	91.8	91.6	92.1	92.2	92.4	92.6	92.7	93.3

Source: Skills Development Scotland
1 The y-axis does not start from zero.

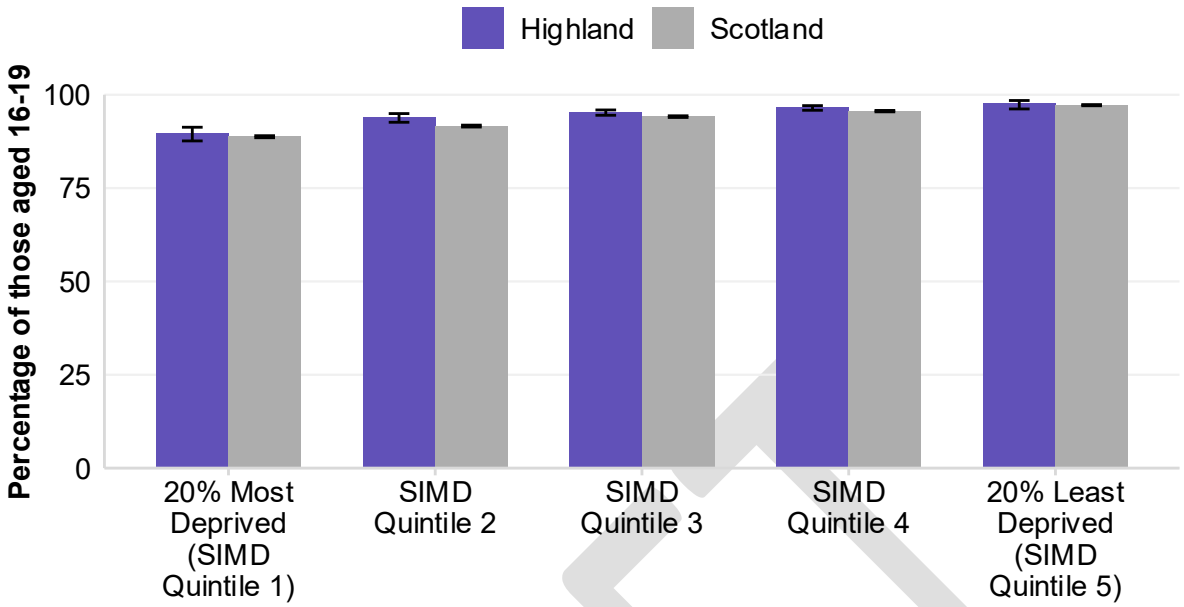
Through ages 16 to 19, participation decreases, dropping from 99.4 to 90.3 percent in Highland. Disabled young people are less are likely to be participating than those not identified as disabled (Figure 107). Participation also varies by deprivation with the lowest percentage in the most deprived SIMD quintile, illustrating socioeconomic inequality (Figure 108). Secure employment, skills development, and social inclusion are all protective factors against poor health. There is need to increase equality of opportunity and uptake of education, employment or training for all those aged 16-19.

Figure 107:Annual participation (percentage) in education, training or employment by age and by disability, Highland and Scotland, 2024/25

Local Authority	Age					Disability (aged 16-19)	
	16	17	18	19		Disabled	not Identified as Disabled
Highland	99.4	96.5	96.5	90.3		90.6	95.4
Scotland	99.0	95.3	95.3	87.4		89.2	93.5

Source: Skills Development Scotland

Figure 108: Annual participation (aged 16-19) in education, training or employment by SIMD quintile, Highland and Scotland, 2024/25



Highland	89.6	93.9	95.3	96.5	97.6
Scotland	88.8	91.6	94.1	95.6	97.2

Source: Skills Development Scotland
Error bars represent 95% confidence intervals using the Wilson method.

Modern apprenticeships offer structured work-based learning alongside formal qualifications. They provide an alternative to academic study and can help reduce inequalities by offering more accessible routes into work, especially for people from disadvantaged backgrounds.

Highland has had consistently higher rates of apprenticeship starts than the Scottish average, with a higher proportion of apprenticeships within the hospitality and tourism sectors than the Scottish average, reflecting the region's economy.[212] Nationally, in 2024/25, the achievement rate for apprentices from the most deprived areas increased and representation from ethnic minority and care-experienced groups reached record highs.

These trends suggest that apprenticeships can be a strategic lever for reducing health and economic inequalities, particularly when aligned with local labour market needs and supported by inclusive recruitment practices.[213]

What this means for Highland

Educational outcomes from early childhood onwards are shaped by structural factors such as deprivation and socio-economic status, as well as individual factors including additional support needs and disability.

Services need to be provided which target those most in need whilst supporting all pupils and families. Support targeted at the earliest stages are likely to have the biggest impact and be most cost effective but may also need to be continued through the transitions to primary school, secondary school and beyond. CPP partners have an essential role in working together to mitigate the impacts of disadvantage and its impact on educational outcomes.

14. Vulnerability and protection

Keeping children safe and protected from harm are critical determinants of health and wellbeing for children and young people. The UN Convention on the Rights of the Child (UNCRC) sets out the specific rights for all children relating to protection from violence, abuse and neglect (Article 19), children unable to live with their family (Article 20), exploitation (Articles 33, 34, 35) and youth justice (Article 40).

These dimensions are integral to the national approach in Scotland to improving outcomes and supporting the wellbeing of children and young people through Getting it right for every child (GIRFEC), The Promise, Best Start Bright Futures and national guidance for Child Protection in Scotland.

Collectively, these interlinked legislative and policy initiatives aim to ensure that all children, particularly those with care experience, grow up to reach their full potential in a Scotland where they are loved, safe and respected. Upholding children's rights can help to realise corporate parenting duties and improve the whole system to achieve better outcomes for children's health and wellbeing.

Looked after children

Looked after children are those in the care of their local authority, as defined in the Children (Scotland) Act 1995. There are many reasons for children becoming care experienced which can include neglect and trauma, having complex disabilities requiring specialist care, involvement in the justice system or being an unaccompanied child seeking asylum.

Corporate Parenting is a key strand of the improvement journey to keeping The Promise. The Highland Promise Board provides the partnership governance for corporate parenting responsibilities.

The Highland Promise Plan 2025-2028 provides the framework for embedding the values and principles of The Promise within Highland's policies, practices, and partnerships. [214] The plan has a strong focus on the five foundations of the Promise (Voice, Family, Care, People, Scaffolding) with Voice being at the heart of aspirations and ambitions for Highland's children and families.

Many children in care are likely to have been brought up in circumstances which make them more vulnerable and at risk of poorer outcomes than other children. A 2025 review by the Promise Data and Evidence Group found that care experienced children and young people face persistent health inequalities compared to other children. This included higher risks of developmental concerns, substance use, hospitalisation and mortality. Mental health

challenges were particularly pronounced, including higher rates of self-harm and suicide. The review highlighted that the period of transition out of care was associated with heightened health vulnerabilities.[215]

The review recommended further development of Children Looked After Statistics and work across sectors to develop linked data, including across housing, education, and justice. This would enable intersectional analysis to explore variation in outcomes and better understand health and wellbeing outcomes for some of the most vulnerable children.

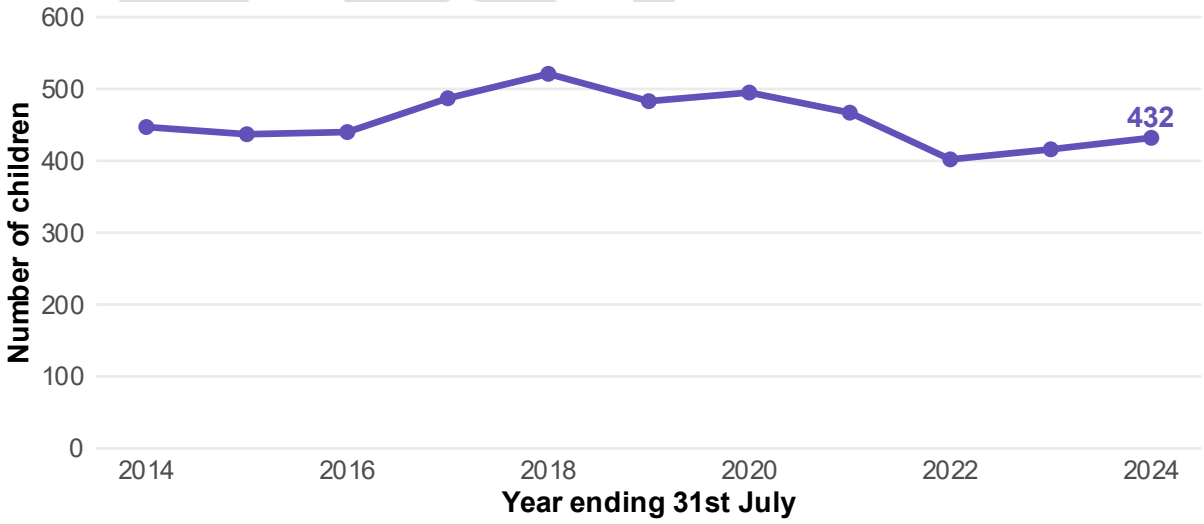
Highland data trends

In July 2024, there were 432 looked after children and young people in Highland, representing one percent of the population aged 0-17 years (Figure 109). This was a small increase in the number of looked after children compared to 2023 and included 27 unaccompanied asylum-seeking children.

The latest demographic information shows one fifth (20 percent) of looked after children in Highland were aged under five and a similar proportion were aged over sixteen. More than half (58 percent) were male, and 19 percent had a known disability.

In 2024, 145 children and young people started and 128 ceased to be looked after during the year, a similar proportion to that nationally. Of these, almost 40 percent (51 children) returned home with their biological parents.

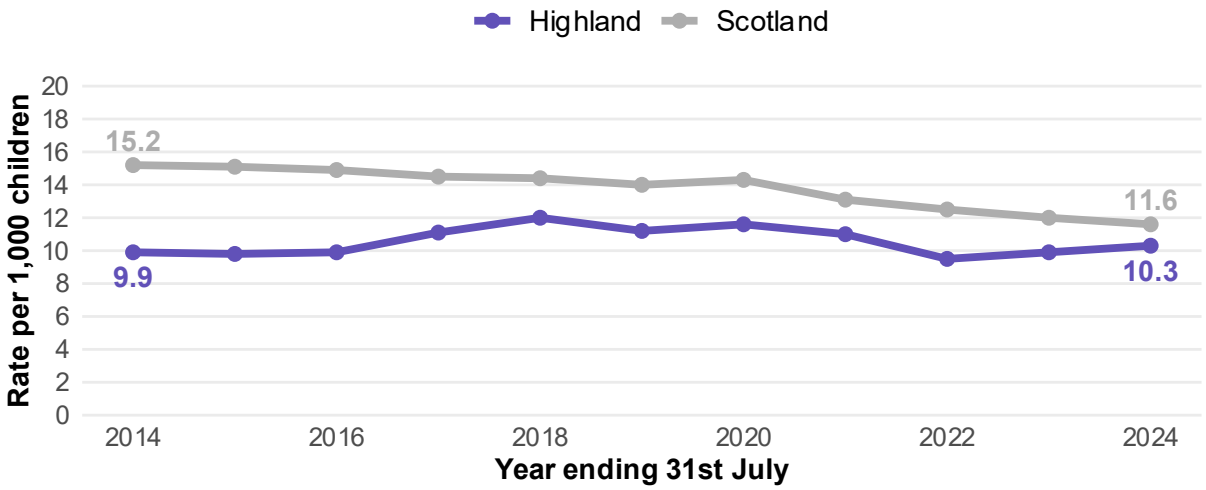
Figure 109: Number of looked after children on 31st July in Highland, 2014-2024



Source: Scottish Government Children's Social Work Statistics

Rates of looked after children in Highland remain lower than for Scotland (Figure 110).

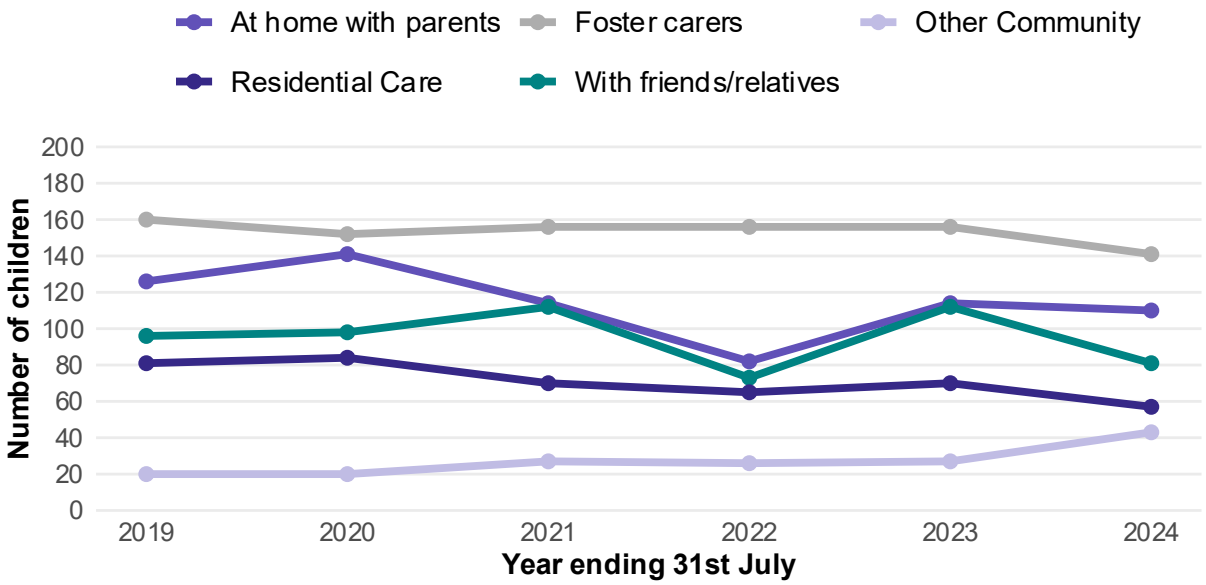
Figure 110: Rate of looked after children per 1,000 children aged 0-17 years, Highland and Scotland, 2014-2024



Source: Scottish Government Children's Social Work Statistics, Scottish Public Health Observatory profiles tool

There are several types of settings in which looked after children or young people may be placed, including at home, foster care, with prospective adopters, kinship care (where they are placed with friends or relatives) or residential accommodation. In 2024, the most common placement was with foster carers or prospective adopters (Figure 111). The number of children placed in residential care settings has decreased since 2020. In Highland, around 13 percent of placements were in residential care settings compared to 11 percent for Scotland.

Figure 111: Number of looked after children by type of placement in Highland, 2019 - 2024



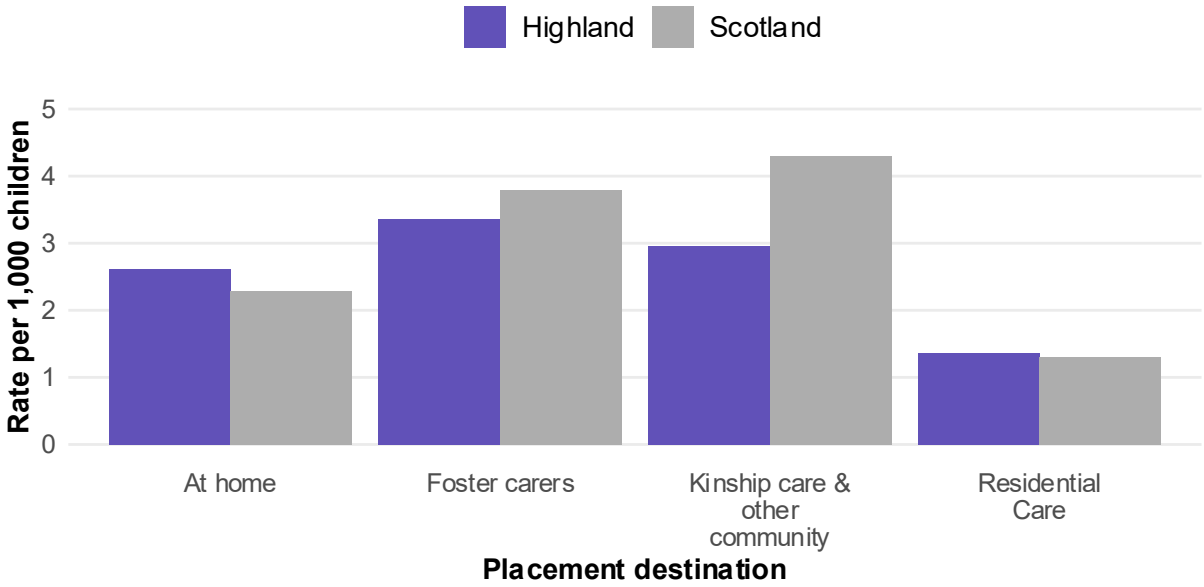
Source: Scottish Government Children's Social Work Statistics

In 2024, Highland had a higher rate of children being placed at home compared to Scotland as a whole. Rates of kinship care and other community placements were higher in Scotland than in Highland, while rates of children placed in residential care were similar (Figure 112).

Overall, there is some evidence of a shift in the balance of care in Highland, indicating that family approaches are achieving positive impact. The total number of looked after children has decreased by 17 percent (521 in 2018 compared to 432 in 2024), with a 32 percent decrease in residential care placements (84 compared to 57).

Since 2019, more than 80 percent of placements in Highland have been within community settings, reflecting a consistent commitment to supporting children to remain in family-based environments wherever possible. This aligns with The Promise and national policy priorities to reduce reliance on residential care.

Figure 112: Rate of looked after children by placement type, Highland and Scotland, 2024



Source: Scottish Government Children's Social Work Statistics

The Highland Promise Board delivery plan has a commitment to enhance the collection, monitoring, and analysis of data to inform service improvements. This includes both quantitative and experiential data that captures the voice of children and young people. Partnership data developments should align with the 'Doing Data Differently' developments of The Promise and review of system developments for reporting relevant to the care experience, including equity of access for care experienced children and young people.

Child Protection

Child protection describes the processes involved in safeguarding where there are concerns that a child may be at risk of harm from abuse, neglect or exploitation. These factors have significant effects on children's emotional and physical health, social development, education and future opportunities.

Child protection in Highland is overseen by the Child Protection Committee (CPC), which leads the multi-agency partnership and reports to the Chief Officer Group for Public Protection. The CPC is responsible for training, learning reviews, multi-agency referrals, and ensuring local child protection processes and procedures are effective.

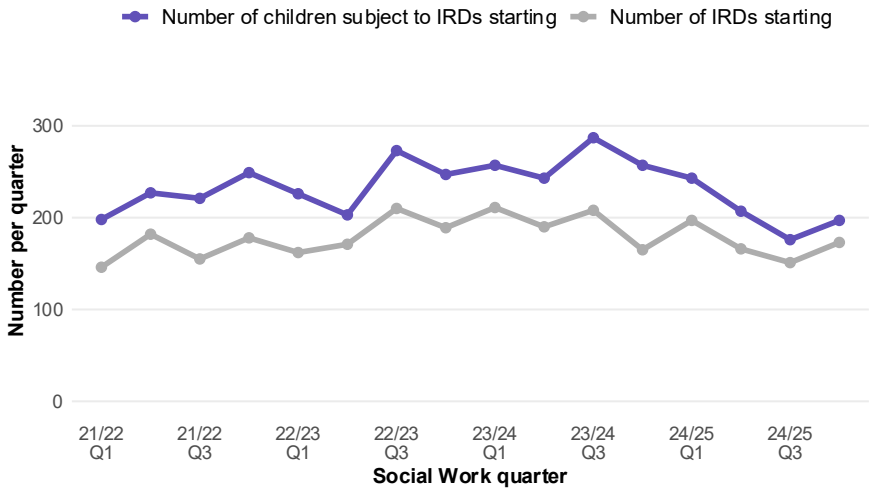
A child protection concern can be raised by a family, nursery, school or the child themselves. Many concerns are passed to the named person who will consider if early assistance is appropriate. For more serious concerns, an interagency referral discussion (IRD) is held.

Following an IRD a decision will be made that no further action is required, to approach the child and family for more information, or to progress to a formal child protection investigation including any concerns that may involve criminal actions. Consideration of the whole process gives an indication of the number of children at risk.

Interagency referral discussions

The interagency Referral Discussion (IRD) is the first stage in the formal process of information sharing when it is believed a child, including an unborn infant, or young person has suffered or may suffer harm. IRDs may consider several children at one time, for example, sibling groups. This means that there will always be a greater number of children considered than there are IRDs.

Figure 113: Inter-Agency Referral Discussions, Highland, 2021/22 to 2024/25

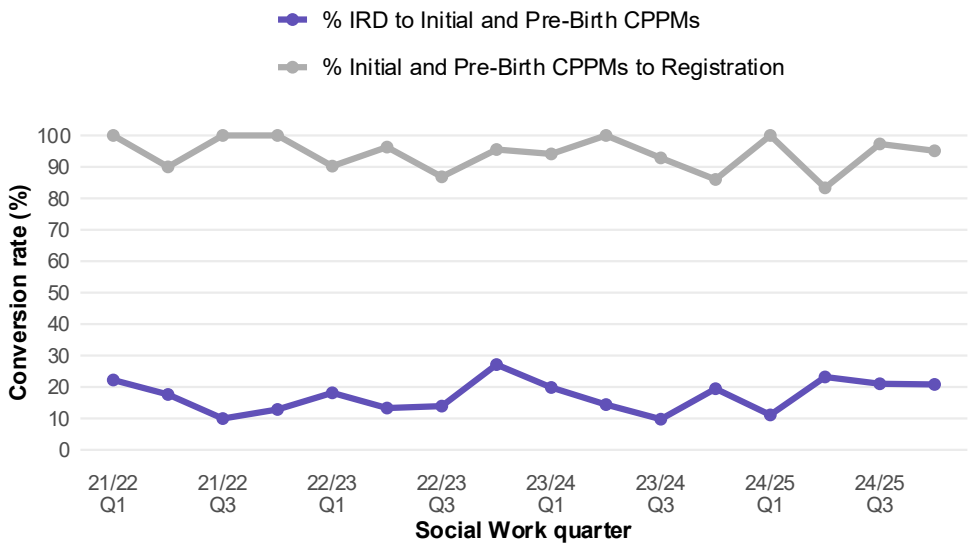


Source: Highland Council Social Work Information System
1 Social Work quarters: Q1 represents August-October time period

Less than one in five children that are subject to interagency referral discussions become subject to a child protection planning meeting. However, the majority of children who are subject to a child protection planning meeting progress to being registered for child protection (Figure 117).

Suspected physical abuse is the most common reason for IRD, accounting for around half of all meetings. For unborn children, of 32 pre-birth child protection planning meetings in 2025, 22 (69 percent) involved concerns raised around gender-based violence and 18 (56 percent) about parental substance use. The multi-agency partnerships in Highland play a key role in supporting prevention activities for alcohol and drugs and gender-based violence.

Figure 114: Conversion rates relating to Child Protection Planning Meetings, Highland, 2021/22 to 2024/25



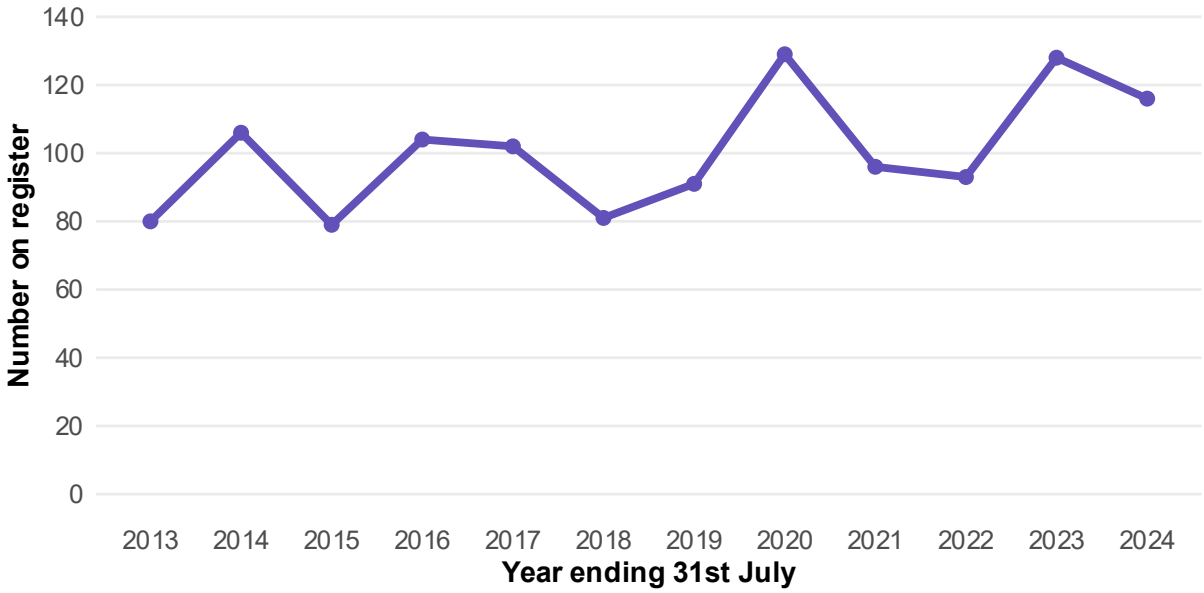
Source: Highland Council Social Work Information System
1 Social Work quarters: Q1 represents August-October time period

Child Protection Register

In Highland, there were 116 children on the child protection register on 31 July 2024, a rate of 2.8 per 1,000 children aged 0-17 years. Quarterly data presented to the Highland CPC shows registrations peaked during the final quarter of 2022/23. High numbers of sibling groups may have contributed to the increase. The number of children on the child protection register was highest in the first quarter of 2023/24 (144 children).

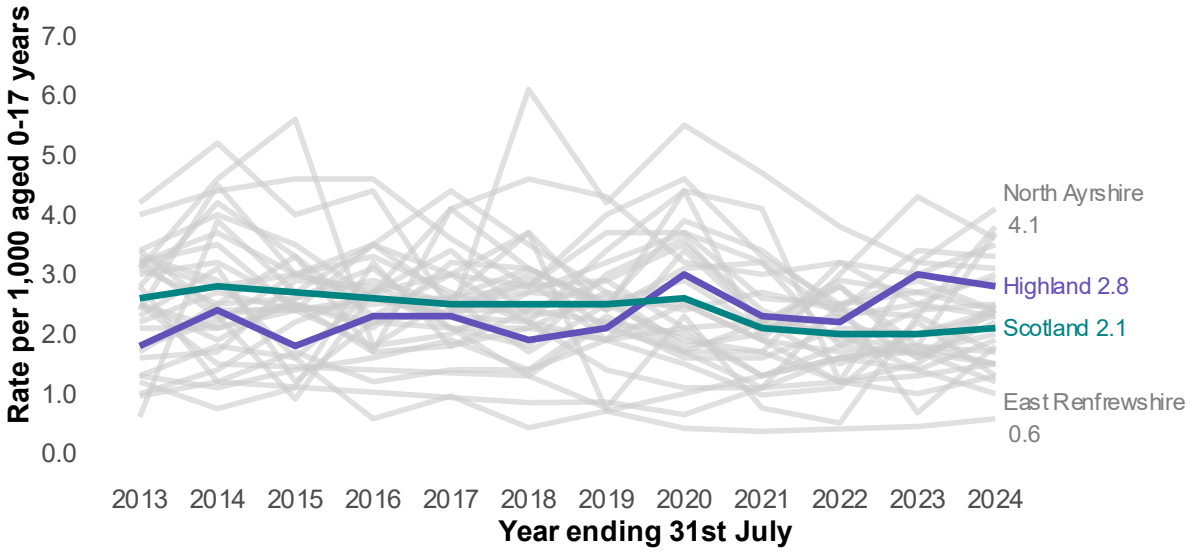
The rate of child protection registrations in Highland was higher than the rate for Scotland in 2024 (Figure 116). Rates of child protection registrations over the period 2012/13 to 2023/24 have been recalculated to include children aged up to 17 years.

Figure 115: Number of children under 18 years on the child protection register in Highland, 2012/13 to 2023/24



Source: Scottish Government Children's Social Work Statistics, Table 1.2a

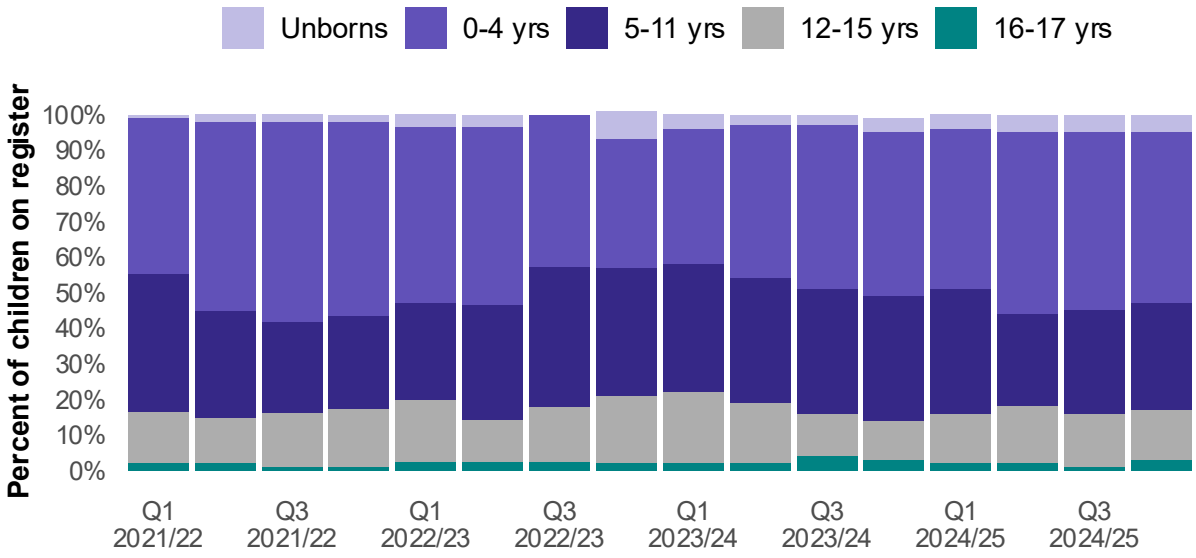
Figure 116: Children on the child protection register by Council area, rate per 1,000 children under 18 years



Source: Scottish Government Children's Social Work Statistics, Table 1.2a

Most children on the child protection register in the two-year period 2022/23 and 2023/24 were aged ten years or below, with the highest proportions aged 4 years or below (Figure 117).

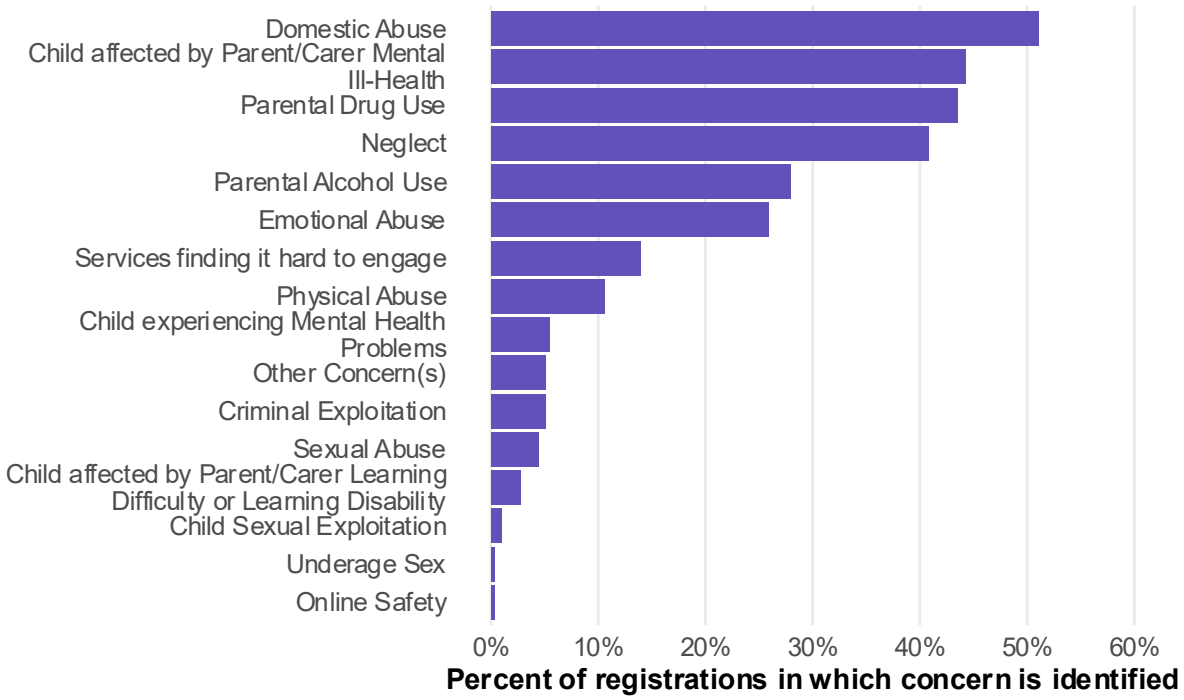
Figure 117: Percentage of children on the Child Protection Register in Highland by age and quarter, 2021/22 to 2024/25



Source: Highland Council Social Work Information System

In total, 438 concerns were identified in child protection registrations in 2023 and 2024. Of the concerns identified, the most common were domestic abuse, parental mental health, parental drug use, neglect and emotional abuse (Figure 118).

Figure 118: Concerns identified as percent of all child protection registrations in Highland, 2023 and 2024

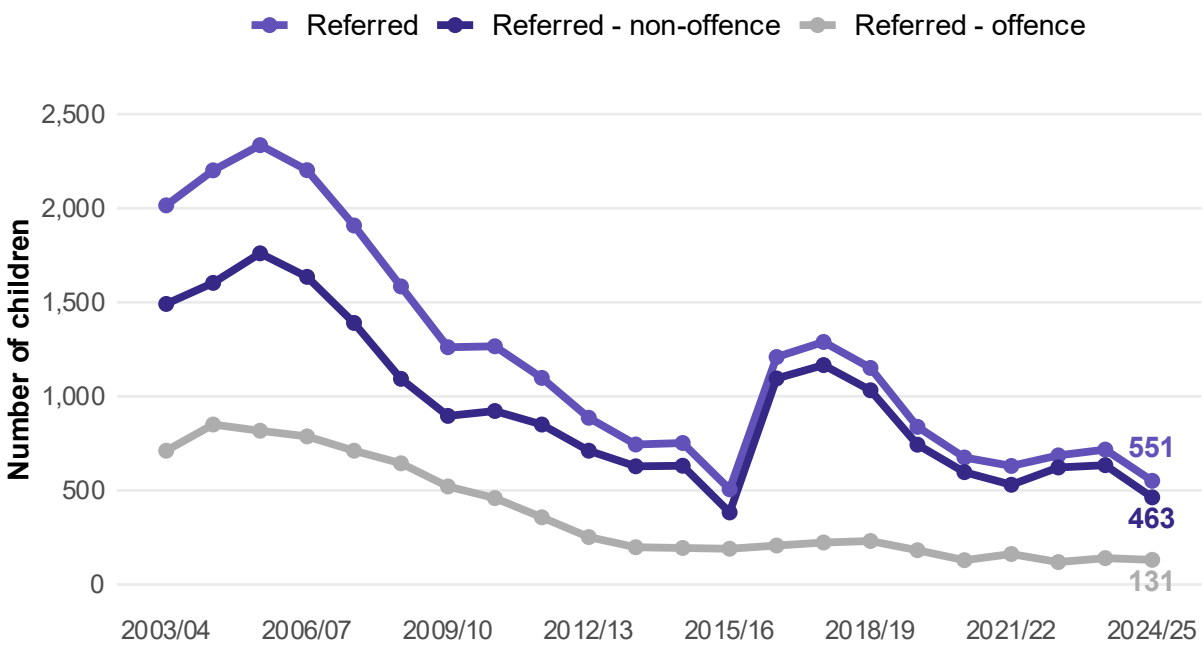


Source: Highland Council Social Work Information System

Scottish Children's Reporter Administration

The Scottish Children's Reporter Administration (SCRA) are focused on children and young people most at risk. In Highland, 551 children were referred to the SCRA in 2024/25. Four in five referrals (84 percent) were on care and protection (non-offence) grounds. A small number of children were referred to the Reporter on both non-offence and offence grounds (Figure 119).

Figure 119: Children referred to the SCRA by referral type in Highland

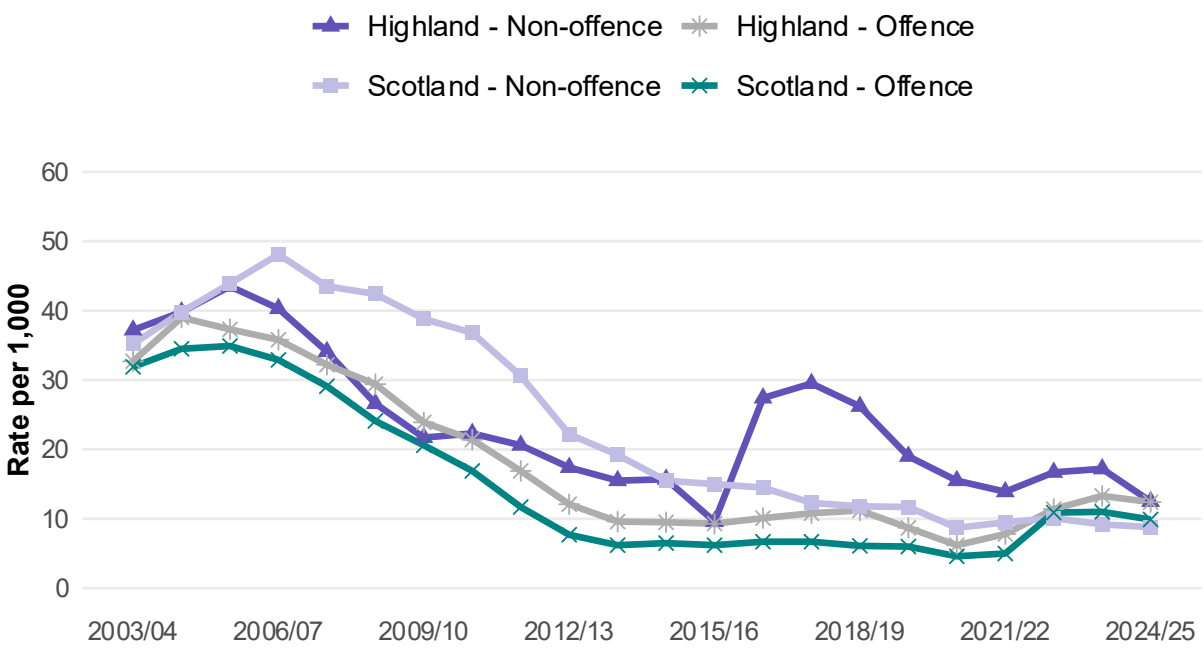


Source: Scottish Children's Reporter Administration (SCRA) Online Statistical Dashboard

Referral rates to the SCRA have decreased since 2005/06, except for an increase in referrals for care and protection in Highland between 2016/17 and 2018/19 (Figure 120). The reasons for the trends in referrals to the SCRA are a complex combination of changes in legislation, changes within the Children's Hearing System, changes in guidance and changes arising from the implementation of Getting it Right for Every Child (GIRFEC).

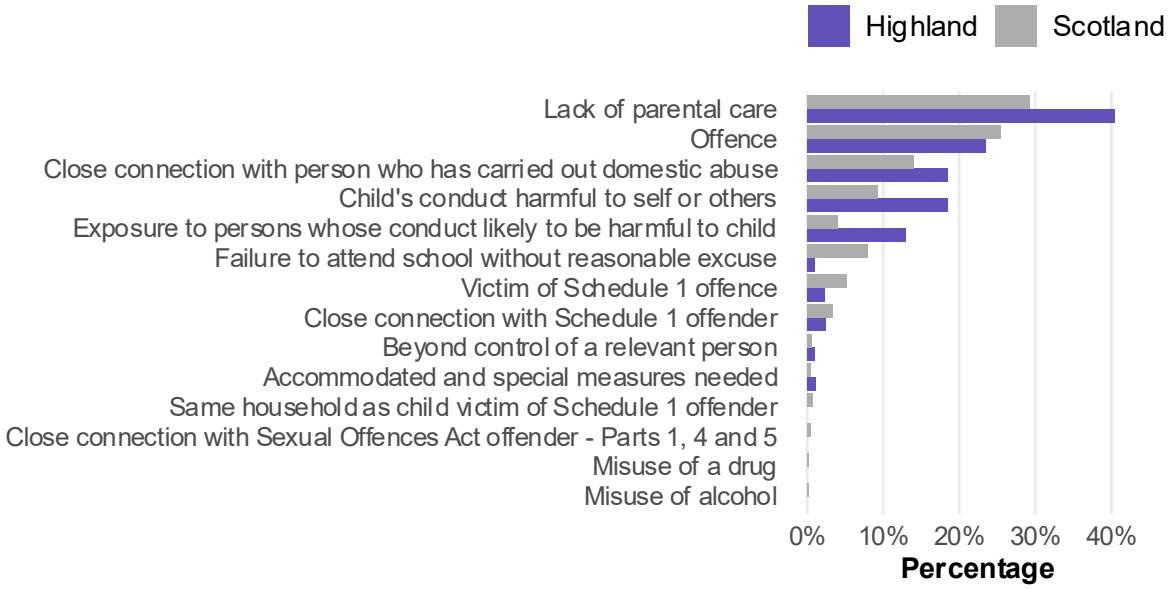
In 2024/25, the most common ground assigned by Reporters to children referred was lack of parental care, followed by offence, close connection with a person who has carried out domestic abuse, and child's conduct harmful to self and others (Figure 121). The police were the main source of referrals to the SCRA. In Highland, 93 compulsory supervision orders (CSOs) were made as a result of children's hearings in 2024/25.

Figure 120: Rate of referrals to the SCRA by referral type in Highland and Scotland



Source: Scottish Children's Reporter Administration (SCRA) Online Statistical Dashboard
1 Non-offence: Rate per 1,000 population aged under 16 years
2 Offence: Rate per 1,000 population aged between 8 and 16 years

Figure 121: Grounds for referral to the SCRA in Highland and Scotland, 2024/25



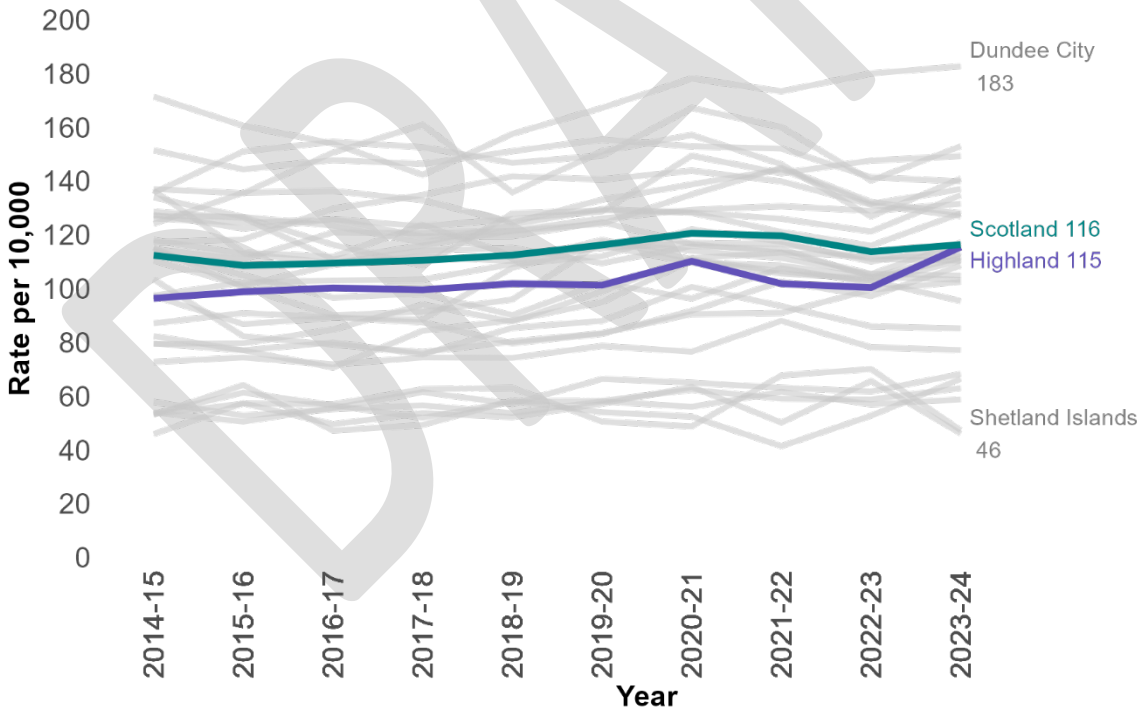
Source: Scottish Children's Reporter Administration (SCRA) Online Statistical Dashboard

Gender based violence

Gender based violence can take many forms including domestic abuse, relationship abuse, sexual abuse, sexual harassment or intimidation, honour-based violence (e.g. female genital mutilation) and trans- homo- or bi- phobic bullying.[216] Witnessing, or being targeted in, gender based violence (GBV) is an adverse experience that can impact a child or young person's mental health, ability to concentrate and socialise, physical (including sexual) health, and result in educational outcomes below their potential. GBV is most commonly perpetrated by men, but children and young people of all genders can experience and be affected by GBV.

Children are often present in cases of domestic abuse even if not directly involved.[217] In 2023-24, the police recorded 2,728 domestic abuse incidents in Highland, a 15 percent increase compared to 2,365 incidents the previous year. The reported data are likely to be a considerable underestimate of the true extent of the issue. Rates of recorded domestic abuse were consistently lower in Highland than in Scotland until the last year (Figure 122). Domestic abuse is one of the most common concerns for children on the child protection register.

Figure 122: Rate of incidents of domestic abuse recorded by the police per 10,000 population, by local authority, 2014-15 to 2023-24



Source: Scottish Government, Domestic abuse recorded by the police in Scotland statistics

During 2024-25 there were 149 crimes of rape and attempted rape, and 227 crimes of sexual assault recorded by the police in Highland.[218] These numbers are for all ages, and in Highland are not available broken down further. In Scotland in the same year data shows that 18 percent of rape and attempted rape victims were aged under 16 (16 percent female and 2

percent male), whilst 31 percent of sexual assault victims were aged under 16 (25 percent female and 6 percent male).

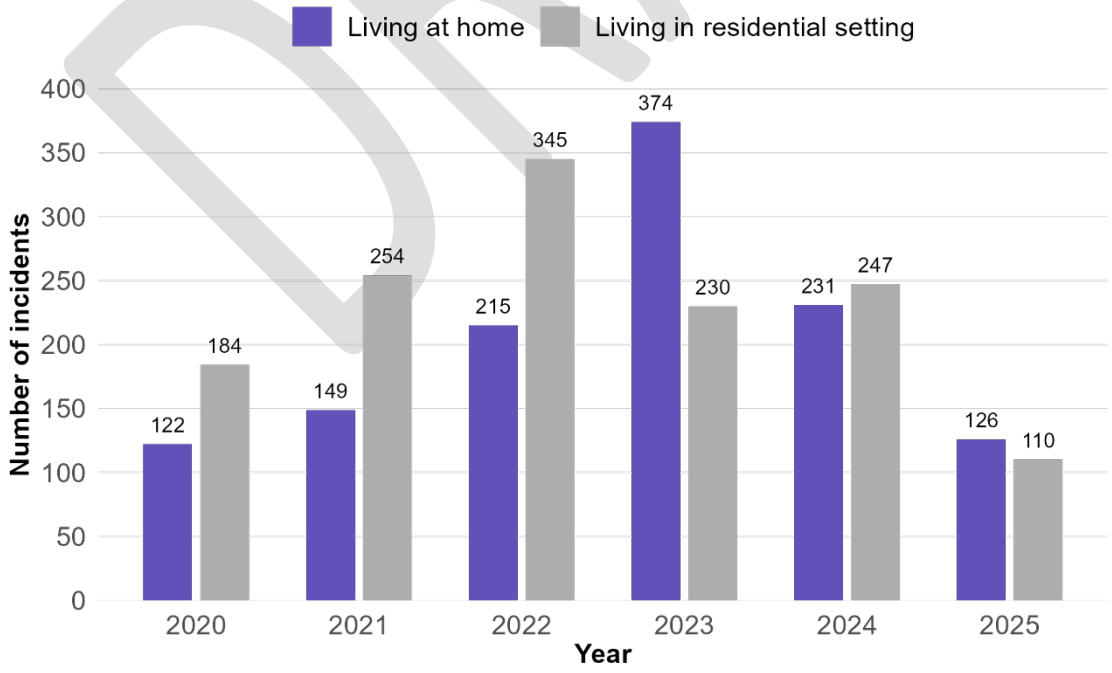
Female Genital Mutilation (FGM) procedures are mostly conducted on young girls between infancy and 15 years of age.[219] There are no clear robust figures for prevalence of FGM in Scotland. Those at risk of FGM have a link with one of 30 countries where the practice is most common in parts of Africa, Asia and the Middle East. Ethnicity data from the Census may therefore provide some understanding of populations at risk in NHS Highland, however, not all those from or with connections to certain countries will be at risk.

Children missing from home

In Scotland during 2024-25 approximately 7 out of 10 missing persons investigations involved children and young people (62 percent aged 17 and under; 7 percent aged 18-25). Care experienced children and young people are often at higher risk of going missing on multiple occasions.[220]

Police Scotland recorded 2,588 incidents of missing children in Highland over the six-year period since 2020. Of the recorded incidents just over half (1,370, 53 percent) involved children from a residential setting. The number of incidents reported has declined in the last two to three years for both children living at home and those living in residential settings (Figure 123).

Figure 123: Number of incidents of missing children recorded by the police, Highland, 2020-2025



Source: Police Scotland management report from the National Missing Persons Application (NMPA)
1 Number of incidents recorded refer to the number of police reports not the number of missing children. Children may be reported as missing on multiple occasions and for different time periods.

The numbers reported in 2020 and 2021 were likely affected by periods of lockdown enforced during COVID-19 restrictions. Recent reductions in numbers have been suggested to be due to collective efforts between the Police Scotland Public Protection Unit and frontline officers. Efforts include better partnership working, encouraging other agencies (health, education and social work) to use their own policies for missing children before reporting incidents to the Police, greater awareness and confidence in use of the National Missing Persons Application (NMPA), and building positive relationships and open lines of communication with families.

The 2025 refresh of the Scottish Government's National Missing Persons Framework for Scotland restates the importance of multi-agency working as being fundamental to preventing people from going missing and limiting any harm when they do.[220]

Child Trafficking and Exploitation

Child exploitation is a form of child abuse and necessitates a child protection response.[221] It occurs where a child under 18 years of age is taken advantage of to the gain of another individual or group, who use an imbalance of power to their benefit.[222] It is an offence under the Human Trafficking and Exploitation (Scotland) Act 2015.

Child exploitation can involve:

- criminal activity (Child Criminal Exploitation) e.g. county lines, begging, theft
- human trafficking (recruiting, transporting, transferring, harbouring, receiving, exchanging or transferring control over another person)
- sexual exploitation (Child Sexual Exploitation and Abuse)
- slavery, servitude and forced labour
- removing organs

Children can believe that they are freely choosing to engage in the activity they are exploited for. There may an exchange or promise of things which are, or perceived to be, of benefit to the child. These can be physical or emotional e.g. of money, clothing, reduction of debt, protection from threat of or actual abuse or violence, attention from adults or increased status. However, in law, a child under 18 cannot consent to their exploitation. Lack of recognition from those being exploited and shame or fear of the consequences of disclosing illegal activity contributes to under-recognition and under-reporting of child exploitation.

Perpetrators of child exploitation take advantage of children's unmet needs, exploiting their vulnerability. Risk factors for exploitation and potential harms to children are outlined in Figure 124. Criminal gangs sometimes target children who are less likely to be identified as exploited, and who may not have any risk factors.

Figure 124: Risk factors for and potential harms from child exploitation

Risk factors for exploitation	Potential harm to exploited children
School exclusion Lack or educational or employment opportunities Missingness e.g. from home Care experience and/or known to Social Care Special educational needs, developmental disabilities and learning disabilities Mental health issues or physical disability Drug or alcohol use Poverty Adverse Childhood Experiences (ACEs) and trauma Existing links to gangs or crime e.g. via family, friends or peers Transitions e.g. between schools or locations Lack of English language or not a UK citizen Social isolation Debt Homelessness, insecure or unregulated accommodation Absence of protective factors	Violence – witnessing, conducting violence and threat of violence and carrying weapons Sexual abuse Trauma Behavioural deterioration and risk taking Health issues - through sexual abuse, violence, exposure to drugs, time in damp or squalid places, mental anxiety and fear Criminal record Missed education Deterioration of relationships with family and friends

There is a requirement to notify the UK Home Office of potential victims of modern slavery, including in children, via the National Referral Mechanism.[223] In 2024, there were 256 child referrals in Scotland. The most frequent type of exploitation was criminal, followed by labour, sexual and domestic exploitation. Victims of criminal and labour exploitation were more likely to be male than female, whereas child sexual exploitation was more likely, but not exclusively, to occur in females. Referrals were most commonly for children of UK nationality. Exploitation may occur in the UK or overseas and increasingly may involve digital means.[224]

Across the UK, adult and child exploitation has increased over the past ten years.[225] The Home office report that this may represent increased awareness as well as increases in exploitation. Increases in referrals flagged as county lines has driven some of this increase.

Child Criminal Exploitation (CCE)

The most common form of Child Criminal Exploitation (CCE) is through 'county lines' where organised criminals and gangs exploit children to store, move and sell illegal drugs.[226] Five children on the Highland child protection register during 2023-24 had an identified concern of CCE.

For a scoping review on CCE in Scotland published in 2023, Police Scotland reported that there were 40 reports with markers for Child Criminal Exploitation in Highland between 20 March 2022 and 15 February 2023, involving both males and females.[227] The most common reasons for a CCE marker were exploitation by adults, drugs (including drug use, drug dealing and county lines), shoplifting, theft, theft of vehicles, road traffic offences, gang related violence, anti-social behaviour and missing person incidents. Interviews with professionals identified geographical links between Inverness and Ayr, Stirling, Alloa, Wick and Thurso involving transporting drugs and/or county lines activity.

The review also noted that:

- The model of CCE in Highland is no different to that seen in other areas
- It is more difficult to identify victims in more rural areas of Highland due to fewer professionals working in these areas
- Inverness has been an increase in children coming up from London to sell drugs
- A professional noted that, as Inverness is not as multi-cultural as other areas, it is easier to identify children who have come from out of area.

Although evidence was anecdotal, this does indicate that Highland is not too remote or rural to be impacted by CCE. In addition, the North of Scotland is highlighted within the Scottish Multi-agency Strategic Threat Assessment 2022 as disproportionately impacted by county lines.[228]

Child Sexual Exploitation (CSE)

Scottish Government Child Protection guidance defines Child Sexual Exploitation (CSE) as follows:

Child sexual exploitation (CSE) is a form of child sexual abuse in which a person or persons of any age take advantage of a power imbalance to force or entice a child into engaging in sexual activity, in return for something received by the child and/or those perpetrating or facilitating the abuse. As with other forms of child sexual abuse, the presence of perceived consent does not excuse or mitigate the abusive nature of the act.

It can include unlawful sexual activity, prostitution or pornographic performances and materials. All those aged under 18 may be victims of CSE, where they are manipulated by a

perpetrator or perpetrators, even where those aged 16 or 17 consented to sexual activity. Child sexual exploitation can occur both in person and/or online.[229] Use of online tools to groom children and young people is concerning.[230] [231] One child registered on the Highland child protection register during 2023-24, and six children in 2022-23, had an identified concern of CSE.

Preventing and reducing harm from child exploitation

In additional to action to effectively deter, disrupt and prevent perpetrators, Scotland's Trafficking and Exploitation Strategy takes a public health approach to tackling abuse. This involves preventing exploitation from occurring by working to reduce the risks facing children and to create an environment which provides and promotes protective factors. It means acting to improve early identification of children exploited and to work to reduce the harms when exploitation unfortunately occurs, not further victimising or criminalising the child, and including work with families and other children that are impacted.

Support for those experiencing risk factors, and contextual safeguarding to improve social environments outside the home, including online, can help reduce child exploitation. Inter-agency working and information sharing is critical to the child protection response, and this should lead to an inter-agency referral discussion (IRD). Improving awareness of child exploitation is important to improving early identification; recent guidance and toolkits have been published to support practitioners.[232] [233]

Conclusions and key messages

To be completed

15. Equity and inclusion

Ethnicity and cultural diversity are fundamental aspects of identity and belonging for children and young people in Highland. The United Nations Convention on the Rights of the Child (UNCRC) recognises every child's right to non-discrimination (Article 2), to preserve their identity (Article 8), and to participate in decisions affecting them (Article 12). Article 30 specifically protects the rights of children from minority or indigenous backgrounds to enjoy their own culture, religion, and language.

The Marmot Principles for reducing health inequalities emphasise the need to give every child the best start in life and to enable all children to maximise their capabilities, regardless of background.[234] Understanding and responding to the needs of an increasingly diverse population is essential for promoting equity, inclusion, and wellbeing across Highland.

Why This Matters

Ethnic and cultural diversity enriches communities and brings opportunities for learning and growth. However, children and young people from minority ethnic backgrounds may face barriers to health, education, and participation, including racism, discrimination, and language barriers.[235] These barriers can contribute to health inequalities, lower educational attainment, and reduced access to services.[236] Addressing these challenges is essential to uphold children's rights under the UNCRC and to deliver on the Marmot Principles of fairness and social justice.

Policy Context

Equality, diversity, and inclusion are central commitments shared by all major public sector partners in Highland. Nationally, the Race Equality Framework for Scotland 2016–2030 and the Equality Act 2010 provide the legal and strategic foundation for tackling discrimination and advancing equality of opportunity. Locally, both NHS Highland and Highland Council have published clear equality outcomes and strategies, setting priorities to ensure fair access to services, eliminate discrimination, and promote participation for all, including minority ethnic children and young people.[237] NHS Highland's Equality Outcomes and Workforce Strategy emphasise person-centred care, respect, and empowerment, while Highland Council's Equality Outcomes and Mainstreaming Reports focus on removing barriers and fostering inclusion across all services.

The Highland Community Planning Partnership (HCPP) brings these agencies together with other partners to deliver a coordinated approach to reducing inequalities. While the HCPP does not publish separate equality outcomes, the Highland Outcome Improvement Plan

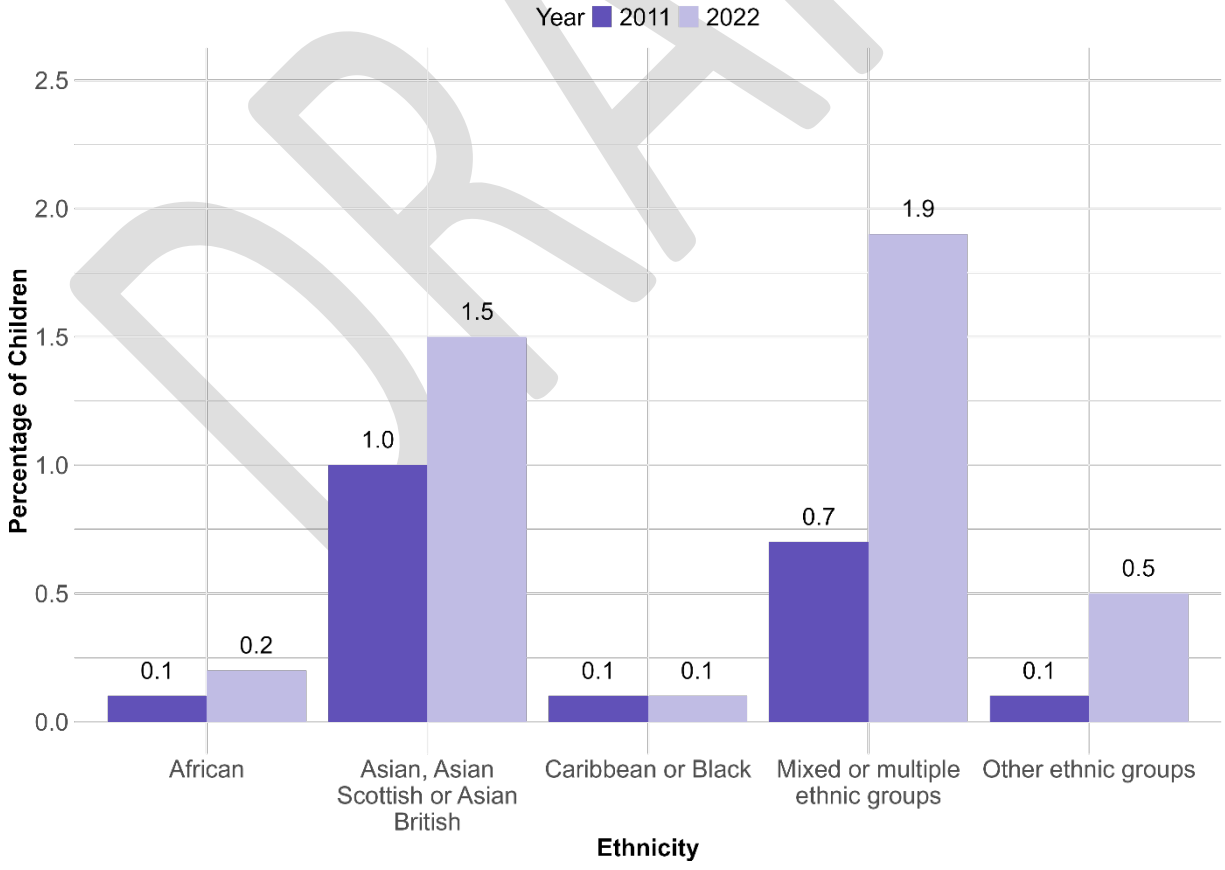
embeds equality and tackling inequalities as core priorities, supported by an active Equality and Diversity Group.[238] This group works across agencies to promote equal opportunities, eliminate unlawful discrimination, and ensure that services are responsive to the needs of all communities. All partners operate within the framework of the Community Empowerment (Scotland) Act 2015, which requires a focus on reducing inequalities and promoting equal participation in community life.

Together, these policies and collaborative structures reflect a strong, shared commitment to building a fairer Highland, one in which the rights and needs of children and young people from all ethnic and cultural backgrounds are recognised, respected, and actively promoted.

Population Profile

Highland is experiencing a marked increase in ethnic and cultural diversity among its children and young people. According to the 2022 Census, 4.2 percent of those aged 0–24 in Highland identified as being from black or minority ethnic (BME) backgrounds, more than doubling from 1.9 percent in 2011.

Figure 125: Change in the proportion of children and young people (0–24 years) in Highland identifying with ethnic broad groups: Census 2011 and 2022



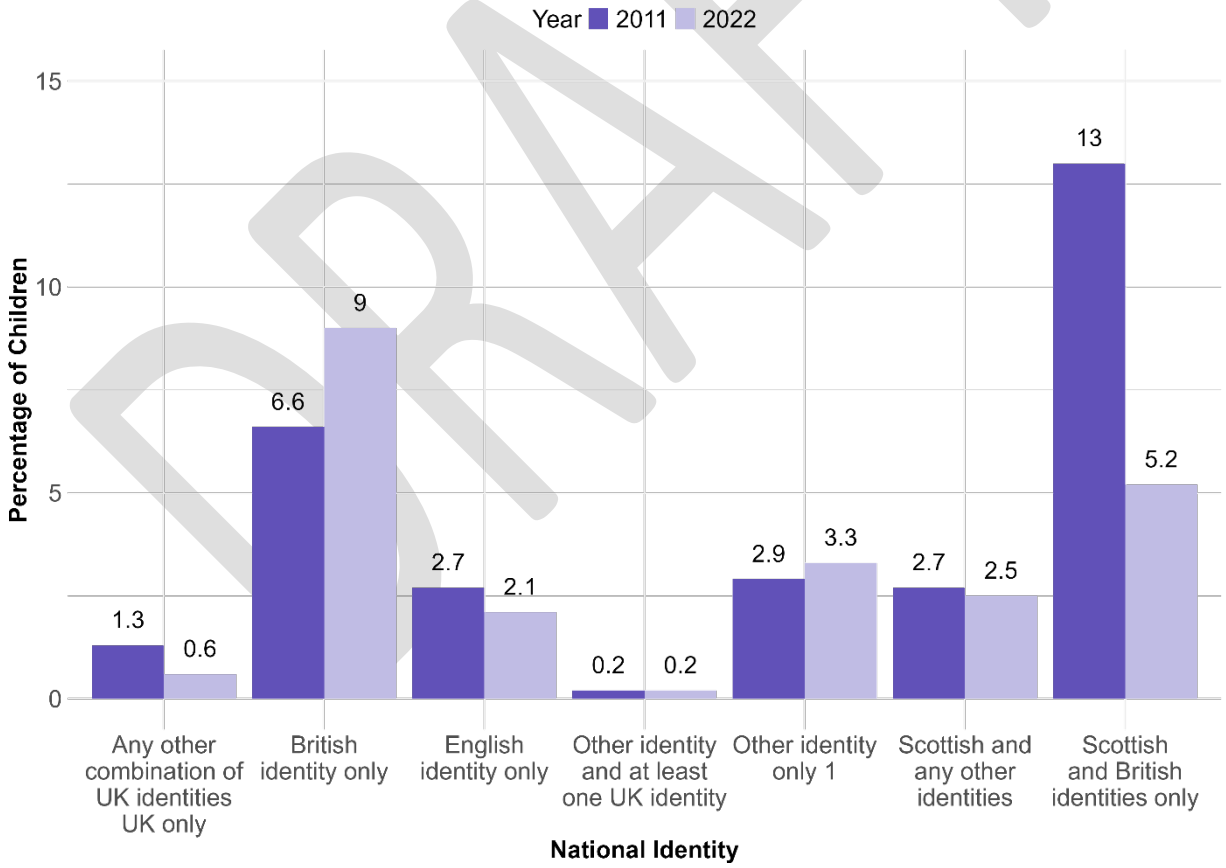
Source: Scotland's Census 2011 (Table KS201SC) and Scotland's Census 2022 (Table UV201)

While the absolute numbers remain small compared to urban areas, the rate of change is significant, highlighting a trend towards greater diversity.

The increase is not limited to a single group: the proportion of children from white minority ethnic backgrounds has also risen, except for the White Irish category, which has remained relatively static. The most notable growth has been among children and young people with origins in EU countries, South and Eastern Africa, Southern Asia, and South-East Asia. This is reflected in both ethnicity and country-of-birth data, with a growing number of children residing in Highland who were born outside the UK.

National identity among children and young people in Highland is becoming more mixed, with a slight increase in those reporting multiple or non-Scottish identities. While the majority continue to identify as Scottish-only, these trends reflect the region's growing diversity and the importance of recognising and supporting multiple identities.[239] [240]

Figure 126: Change in the proportion of national identities of children and young people (0 – 24) in Highland: Census 2011 and 2022



Source: Scotland's Census 2011 (Table LC2102SC) and Scotland's Census 2022 (Table UV202)

Language diversity is also increasing. In 2024, 2,310 pupils in Highland schools reported a primary language other than English, Gaelic, Scots, Doric, or British Sign Language, with 74 different languages represented. The most common were Polish, Latvian, Russian, Ukrainian, and Arabic.[241] This linguistic diversity presents both opportunities and challenges for schools and services, requiring targeted support for English as an Additional Language (EAL) learners and culturally sensitive approaches to communication. Nationally, Scottish schools are seeing similar trends, with dozens of languages now spoken by pupils and a growing need for language support.[242]

Although the number of asylum-seeking and refugee children remains small (39 asylum seekers and 117 refugees in Highland schools in 2024), these groups have distinct needs, including support for trauma, disrupted education, and language barriers.

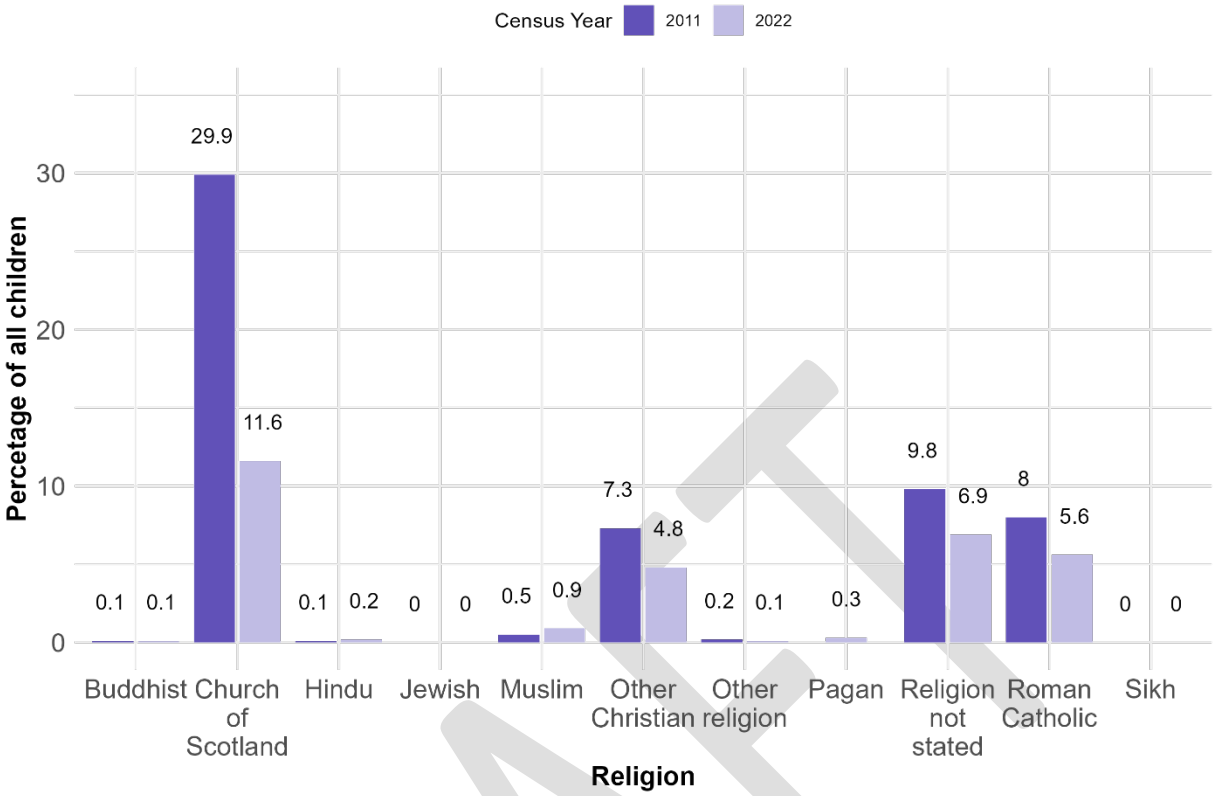
Religion and belief

Alongside increasing ethnic and linguistic diversity, Highland's children and young people are also reporting a wider range of religious affiliations, with Census data showing that religious diversity among children and young people in Highland is increasing. There has been a marked decline in those identifying with the Church of Scotland and a rise in those affiliating with non-Christian faiths such as Islam, Hinduism, and Buddhism (Figure 127).[243] The proportion of children who do not identify with any religion has also increased from 45.7 percent in 2011 to 69.5 percent in 2022.

These changing patterns reflect broader trends in which secularisation and religious pluralism are reshaping the cultural landscape.[244] The United Nations Convention on the Rights of the Child (UNCRC) guarantees every child's right to freedom of thought, conscience, and religion (Article 14), and to non-discrimination and participation in decisions affecting them (Articles 2 and 12).

For education, these changes mean schools must be equipped to support pupils from a range of faith backgrounds, including provision for religious observance, dietary requirements, and the right to withdraw from faith-based activities.[245] In health and community services, culturally sensitive approaches are essential to ensure equitable access and positive experiences for children and families, recognising the impact of faith on health beliefs, practices, and support needs.[246] National guidance emphasises the importance of staff training, inclusive policies, and active engagement with faith communities to promote respect, understanding, and effective service delivery.[247]

Figure 127: Proportion of all children and young people (0 – 19) in Highland by religious group: Census 2011 and 2022



Source: Scotland's Census 2011 (Table DC2107SC) and Scotland's Census 2022 (Table UV205a)
1 The 'Pagan' option was added in 2022 so there is no comparable data for 2011.

Overall, the evidence shows that Highland's population of children and young people is becoming more ethnically, culturally, and linguistically diverse, with important implications for service planning, resource allocation, and the promotion of equity and inclusion.

Experience and outcomes

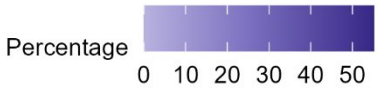
Children and young people from minority ethnic backgrounds in Highland, as in the rest of Scotland, can experience a range of outcomes shaped by both structural and interpersonal factors. While increasing diversity brings opportunities for cultural enrichment and community cohesion, it also highlights persistent inequalities that require targeted action.

Across Highland and Scotland, evidence shows that minority ethnic communities are disproportionately concentrated in the most deprived areas and face persistent barriers in access to economic, social, and health resources, with implications for health, educational attainment, and community participation.[248] [249].

Deprivation among Highland children by ethnic group

This analysis uses the Scottish Index of Multiple Deprivation (SIMD) 2020v2 to profile deprivation among children aged 0–15 years in Highland by ethnic group. Ethnicity data are drawn from Scotland's Census 2022, specifically table UV201b, which provides population counts by ethnic group at output area level. These counts were aggregated to the data zone level and linked to SIMD2020v2 to determine, for each ethnic group, the proportion of children living in the most deprived quintile (20 percent) of areas for each SIMD domain (income, employment, health, education, access, crime, housing) and for overall SIMD in Highland. This approach enables a domain-specific, within-Highland comparison of deprivation exposure across ethnic groups.

Figure 128:Proportion of children aged 0–15 years in Highland living in the most deprived SIMD quintile for each deprivation domain, by ethnic group (Census 2022)



	Income	Employment	Health	Education	Access	Crime	Housing	Overall
All people	20.9	20.4	21.0	21.6	17.6	20.3	19.0	21.3
White: Scottish/British/Irish/Other	20.1	19.6	20.1	20.8	18.3	19.6	18.2	20.4
White: Polish	41.7	40.2	42.1	45.7	4.6	39.6	39.6	44.5
White: Gypsy/Traveller	46.0	40.0	44.0	44.0	24.0	24.0	40.0	34.0
Mixed or multiple	23.2	21.2	21.6	20.5	13.3	22.5	23.0	21.1
Asian: Indian	28.9	29.4	33.9	24.4	0.0	27.2	31.1	28.9
Asian: Pakistani	20.9	21.8	23.6	30.9	7.3	23.6	22.7	24.5
Asian: Bangladeshi	38.5	48.7	39.7	35.9	5.1	55.1	33.3	38.5
Asian: Chinese	28.9	30.9	29.9	25.8	3.1	29.9	23.7	27.8
Asian: Other	23.3	24.0	24.7	20.7	7.3	23.3	19.3	21.3
African	29.6	24.1	26.9	21.3	10.2	25.9	36.1	26.9
Caribbean or Black	48.0	36.0	44.0	40.0	8.0	48.0	40.0	48.0
Arab	38.2	34.3	52.0	53.9	10.8	38.2	21.6	50.0
Other ethnic group	26.8	25.6	34.1	35.4	9.8	34.1	28.0	29.3

Source: Scottish Index of Multiple Deprivation 2020v2 and Census 2022 (Table UV201b)

The analysis reveals marked inequalities in exposure to deprivation among children from different ethnic groups. While around one in five children overall in Highland live in the most deprived quintile for each domain, several minority ethnic groups experience substantially higher rates of deprivation.

Children from White: Polish, White: Gypsy/Traveller, Caribbean or Black, Arab, and Asian: Bangladeshi backgrounds are consistently more likely to live in the most deprived 20 percent

of areas across multiple domains. For example, over 40 percent of White: Polish and Gypsy/Traveller children live in the most deprived quintile for income, employment, health, education, crime, and housing. Rates for Arab and Caribbean or Black children are also notably high, with half or more exposed to deprivation in several domains. In contrast, children from the majority White: Scottish/British/Irish/Other group have rates close to the Highland average.

The pattern is not uniform across domains. For instance, White: Polish and Gypsy/Traveller children have particularly high exposure to education and housing deprivation, while Asian: Bangladeshi and Arab children are more likely to experience deprivation in health, education, and crime domains. Access deprivation (reflecting rurality and transport barriers) is generally lower for minority groups but remains significant for Gypsy/Traveller children.

Health and Wellbeing

- Minority ethnic groups are disproportionately affected by socio-economic deprivation, a key determinant of health status and inequalities.[250] This can lead to higher risks of poor physical and mental health outcomes.
- Racism and discrimination are recognised as significant contributors to poorer health and wellbeing among minority ethnic children and young people.[251] Experiences of racism, whether direct or indirect, can result in increased stress, anxiety, and reduced self-esteem.
- National data indicate that children from some minority ethnic groups are less likely to access health services and may face barriers to culturally appropriate care.[252]

Education and Attainment

- Language barriers can impact educational attainment. In Highland, a substantial minority of children lack some English language skills, with 15.7 percent of females and 18.7 percent of males affected (2022 Census). Nationally, pupils with English as an Additional Language (EAL) may require additional support to achieve their potential.[253]
- Research suggests that children from some minority ethnic backgrounds may be at greater risk of exclusion or lower attainment, particularly where schools lack resources for targeted support.[254]

Access to Services

- Minority ethnic families may face barriers in accessing health, education, and social care services, including a lack of information in appropriate languages, limited cultural competence among staff, and fear of discrimination.[255]

- Asylum-seeking and refugee children, though small in number in Highland, often have complex needs related to trauma, disrupted education, and social isolation.[256]

Community Participation and Representation

- Minority ethnic children and young people are often under-represented in decision-making forums and community activities, limiting their ability to influence services and policies that affect them.[257]

Refugee and asylum-seeking children

Although the number of asylum-seeking and refugee children in Highland is small, these children often face multiple and complex challenges that require coordinated support. Many have experienced trauma before or during migration, including exposure to conflict, violence, or displacement, which can affect emotional wellbeing and mental health.[258] [259] Disrupted education is common, with gaps in learning due to time spent in transit or in temporary accommodation, and language barriers can further hinder integration into schools.[260] Social isolation is another significant risk, as families may lack established networks and face cultural and linguistic barriers to participation in community life.

The New Scots Refugee Integration Strategy 2024 emphasises the importance of inclusive education, trauma-informed practice, and culturally sensitive services to meet these needs. Schools and local authorities are encouraged to provide tailored language support, access to mental health services, and opportunities for social connection through community and extracurricular activities.

Health and social care services must also recognise the impact of trauma and migration on health behaviours and ensure equitable access to care. Partnership working between education, health, housing, and third-sector organisations is critical to delivering holistic support and promoting resilience among refugee and asylum-seeking children and their families.

Conclusions and key messages

Highland's population is becoming increasingly ethnically, culturally, and linguistically diverse, a trend that is reflected among children and young people but also extends across all age groups. As communities change, all children and young people, regardless of their own ethnicity, identity, or background, are experiencing and adapting to greater diversity in their schools, neighbourhoods, and services. This evolving context brings opportunities for learning, inclusion, and cultural enrichment, but also presents challenges in ensuring equity and positive outcomes for every child.

The evidence presented in this chapter demonstrates both the opportunities and challenges associated with these changes, including persistent inequalities in health, education, and access to services for minority ethnic groups. It is essential that community planning partners recognise the impact of increasing diversity on all children and young people, and respond with strategies that promote inclusion, understanding, and fairness across the whole population.

16. Young carers

Young carers are children and young people who provide care for someone, often a family member, who, due to illness, disability or mental health challenges, cannot cope without their support. Caring responsibilities can range from emotional and mental health support to practical tasks such as shopping, administering medication, and personal and physical care.[261]

Young carers are disproportionately female, and prevalence increases with age—older children (13–15 years) are more likely to provide care than younger children.[262]

Under the Carers (Scotland) Act 2016, young carers are defined as those aged under 18 or aged 18 who are still in school.[263] The term 'young adult carer' (typically referring to those aged 16–25) is commonly used in policy and service contexts to reflect transitional needs, but it does not have formal recognition in legislation.[264]

Supporting young carers is a matter of children's rights under the UNCRC, which guarantees every child the right to education, health, rest, leisure, and development. Caring roles can compromise these rights if support is absent, making early identification and proportionate help essential.

Young carers often experience cumulative disadvantage—poverty, housing stress, transport barriers, and limited access to services—so interventions must address these structural factors alongside direct support. National policy, including the National Carers Strategy, recognises both the positive aspects of caring (skills, resilience) and the risks to health, education, and life chances.

Impact on health and wellbeing

Evidence indicates that young carers often experience isolation, bullying, anxiety, low self-esteem, and fatigue, with consequent risks to mental and physical health.[265] [266] Reviews and surveys report higher rates of stress, depression, and poorer general health among young carers compared to peers, with greater risk for females and for those providing more than 20 hours of care per week. Early identification and proportionate support are therefore central to prevention and improved outcomes.

Impact on education and development

Caring responsibilities can disrupt school attendance, concentration and attainment, particularly where schools are unaware of a pupil's caring role. Young carers report inconsistent and often insufficient support in school: at the Scottish Young Carers Festival

(SYCF) 2024, 44 percent did not feel supported in school, 36 percent received some support, and 20 percent felt support was infrequent or not valuable.[267] Young carers value a dedicated contact in school, daily check-ins and quiet spaces, and ask for more flexible approaches to balance schoolwork and caring.

Awareness of health-agency roles is limited: 86 percent of respondents were unaware of school nurses' responsibility to support young carers, yet young carers want school nurses to help with stress, anxiety, panic attacks, and balancing schoolwork with caring.

Carers Census data reinforce these concerns: 91 percent of young carers supported by services reported emotional wellbeing impacts in 2023–24, with health impacts rising sharply at higher caring intensities (e.g. 72 percent among those providing 50+ hours/week).[268]

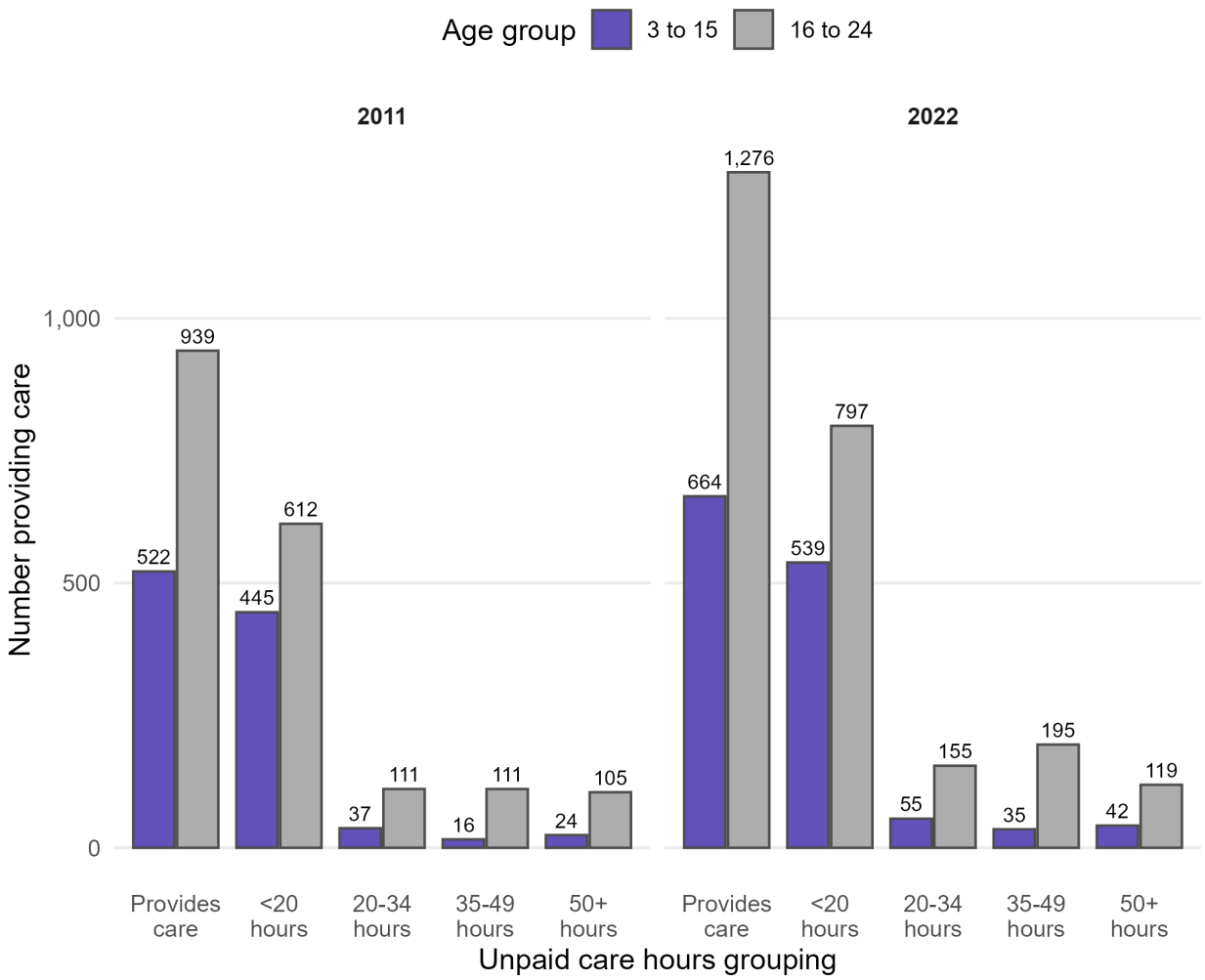
Voices from Young Carers and alignment with UNCRC rights

- **Article 3 (Best interests):** Many young carers do not feel their best interests are considered in decisions affecting them; **66 percent** said they were **not considered at all** in decision-making.
- **Article 4 (Implementation):** Rights awareness is mixed—**only 50 percent** reported good knowledge of their rights as young carers; requests include **easy-to-follow guides**, and more rights education in schools and on social media.
- **Article 12 (Participation and voice): 67 percent** said there are opportunities to share their views, but **56 percent** want **more chances** to speak, be heard, and recognised; young carers want proof their opinions are valued and acted upon.
- **Article 17 (Access to information): 77 percent** felt they had access to the information they needed, mainly via local carer services; they want more **visible information** in schools, GPs and community settings.
- **Article 26 (Social security):** YCG awareness is relatively high, but young carers want **clearer information** on grants and broader financial support; recipients report **positive impacts** for care breaks and security.
- **Articles 28/29 (Right to education/goals of education):** Young carers ask for **flexible, consistent support** in education to balance learning with caring; impacts on attainment and attendance are well documented.
- **Article 31 (Leisure, play, culture):** Breaks are **crucial**; frequency and access vary, with many asking for **simple, achievable** breaks (e.g., spending time with friends).

Prevalence and trends

Scotland's Census provides the most comprehensive measure of unpaid caring among children and young people. Between 2011 and 2022, the proportion of children reporting unpaid care increased, particularly among older age bands. Highland mirrors this trend, with some young people reporting 20+ hours per week, highlighting risks for health and education outcomes (Figure 129). These figures set the baseline for strategic planning and demonstrate structural inequalities, including higher prevalence in more deprived areas (Figure 130).

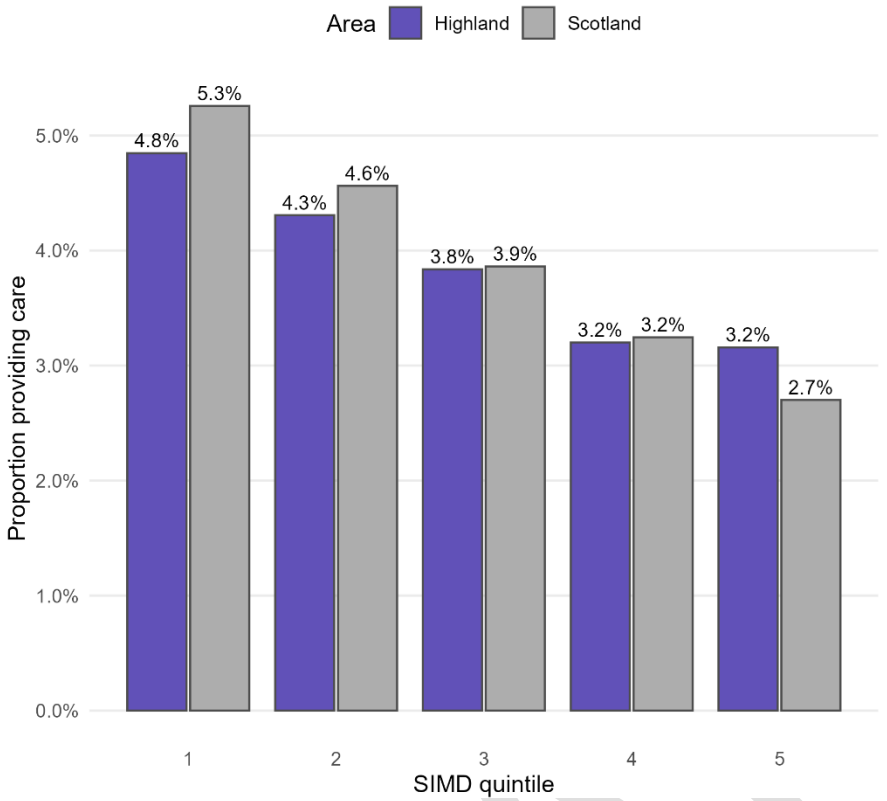
Figure 129: Children and young people providing unpaid care in Highland – counts of care hours by age grouping at Census 2011 and 2022



Source: Scotland's Census 2022 (Table UV301b) and Census 2011 (Table LC3103SC)

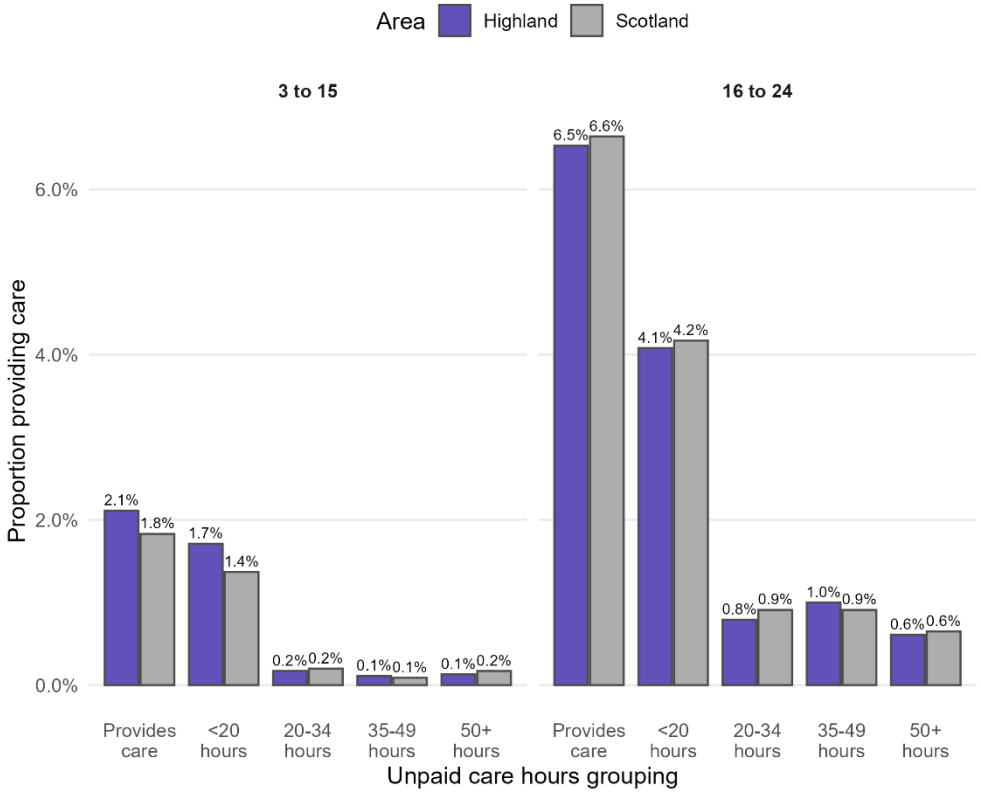
The proportion of young carers at the Census in 2022 was similar in Highland and Scotland by age group and hours of care provided (Figure 131).

Figure 130: Children and young people aged 3 to 24 years providing unpaid care in 2022 – comparison of Highland and Scotland by Scottish Index of Deprivation (SIMD) quintile



Source: Scotland's Census 2022 (Table UV301b)

Figure 131: Proportion of children and young people providing unpaid care at the Census in 2022 – comparison of Highland and Scotland by age group and care hours



Source: Scotland's Census 2022 (Table UV301b)

While Census data provides robust prevalence estimates, it is collected only once every decade, and there is a paucity of granular, population-wide data on unpaid caring roles between censuses, limiting the ability to monitor short-term trends or evaluate the impact of policy and service changes. Administrative datasets, such as the Carers Census, help track those supported by services, but they do not capture the full population of young carers, particularly those who remain hidden or unsupported.

Young Carer Grant: A Rights-Awareness Indicator

The Young Carer Grant (YCG) offers a complementary lens during the intra-census period. It is:

- A flat-rate annual payment (currently £390.25) for eligible applicants aged 16–19, caring 16+ hours/week for at least 3 months.[269]
- Not a prevalence measure, but an indicator of rights awareness and engagement.
- Valuable for monitoring the reach of policy and identification efforts between censuses.

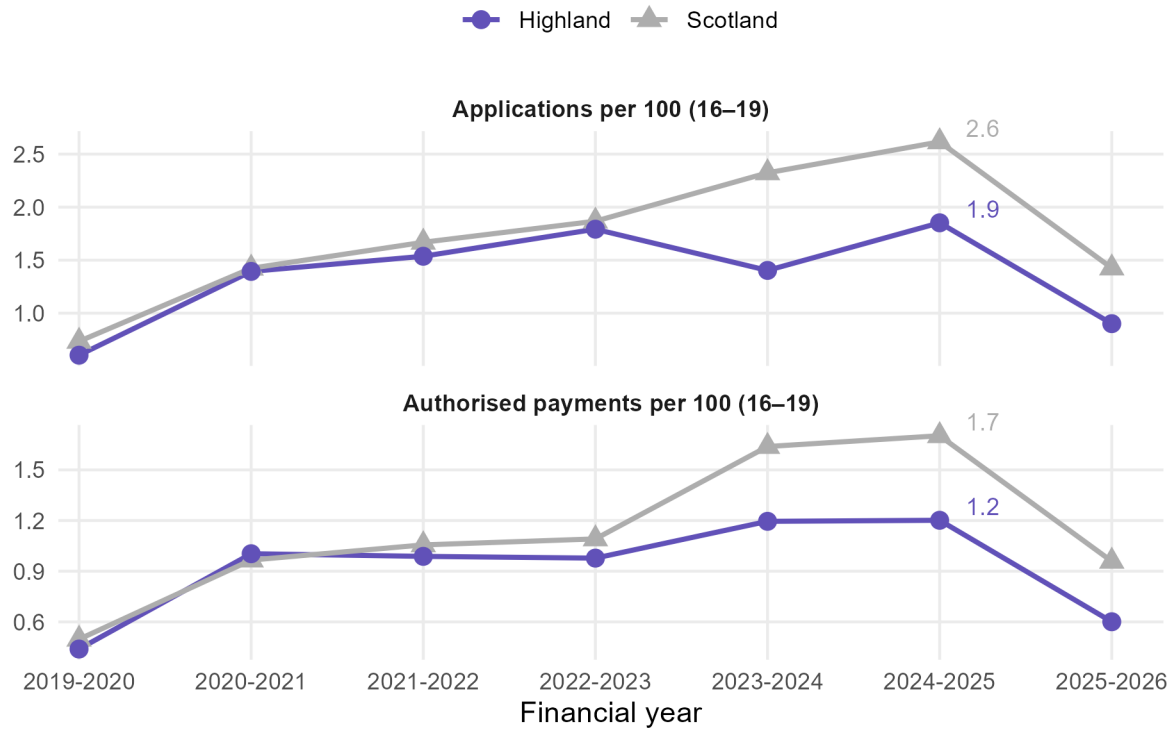
If YCG uptake is low, this suggests barriers to awareness or to its application. Conversely, rising YCG applications may indicate improved identification and outreach. Comparing Highland's uptake with national trends helps assess whether local identification and support efforts are translating into tangible benefits. There is some evidence that a more effective promotion of the grant process is required in Highland.

Figure 132: Young carer grant applications and payments from 2019-20 to Q3 2025 in Highland and Scotland

Metric	Highland	Scotland
Total applications received	900	28,960
Authorised applications	610	18,995
Percentage of processed applications authorised	69	68
Percentage of processed applications denied	30	31
Application rate per 100 (16-19)	1.4	1.7
Authorisation rate per 100 (16-19)	0.9	1.1

Source: Social Security Scotland, Young Carer Grant statistics; internal analysis

Figure 133: Rates of young carer grant applications per 100 population (16-19) in Highland and Scotland, financial years 2019-2020 to 2025-2026 (to quarter three)



Source: Social Security Scotland, Young Carer Grant statistics; internal analysis

School Identification and Young Carer Statements

Under the Carers (Scotland) Act 2016, every identified young carer has a statutory right to be offered a Young Carer Statement. The responsible authority, often the local authority via schools, must prepare the Statement if the young carer consents or requests one.

Education Scotland guidance and national programmes recommend whole-school approaches, staff training, and recording in the Scottish Government's Education Management system (SEEMiS) to ensure recognition and tailored support.

Highland has adopted a digital, accessible Young Carers Statement template, along with a Young Carers Statement & Strategy (2024–26). Schools offer Statements, record identified young carers in SEEMiS, and work with third-sector partners through a termly Improvement Group to promote equitable coverage and consistent practice.[270] [271]

Highland Council reports that 643 young people are currently recorded on education systems as young carers. Even allowing for definitional caution, this is proportionately low compared with national estimates, and the Council rightly commits to awareness-raising and more consistent recording across SEEMiS and children's planning pathways. While providing a

credible baseline to address data gaps, the CPP should make greater use of education datasets, including SEEMiS records and Young Carer Statement uptake data, within a local monitoring framework. Linking education records with health contacts would strengthen visibility of young carers and support integrated planning.

Strategic Alignment

The NHS Highland Unpaid Carers Assurance Report and refreshed Carers Strategy 2025–28 commit to improved early identification, emotional support, and access to meaningful breaks for unpaid carers, including those previously unengaged.[271] Although primarily adult-focused, the Strategy's principles—early identification, co-production, and holistic support—apply equally to young carers.

The Highland Council's Young Carers Statement & Strategy 2024–26 (Education & Learning), centres on statutory rights, school-led identification and delivery of Young Carer Statements, with governance through Integrated Children's Services and a Young Carers Improvement Group.[270]

Taken together, there is a non-trivial risk that children and young people who provide care fall between the two remits in Highland, with a need for more consistent multi-agency support, as found by the Scottish Young Carers Festival in 2024.

The CPP should recognise the overlap in strategic alignment between health and education, and the opportunity to share outcomes for children who provide care, embed Young Carer Statements within the broader unpaid carers framework, extend respite and emotional support options suited to children and young people, and involve young carers directly in co-production activities to shape services and monitor outcomes.

17. Housing and homelessness

A secure and nurturing home is a foundation for children's health, education, and life chances. Housing influences wellbeing through affordability, quality, energy efficiency, and its role as a base for social connection. The Marmot Principle of creating healthy and sustainable places is an ambition reflected in national and local housing policy, including Housing to 2040 and the Ending Homelessness Together Action Plan. [272] [273]

Article 27 of the United Nations Convention on the Rights of the Child (UNCRC) clearly states that every child has the right to an adequate standard of living and that public bodies have a duty to provide this, particularly housing, if parents cannot.

Why Housing Matters for Child Development

- Children spend most of their time at home, especially in the early years and adolescence. The home environment influences cognitive development, emotional security, and socialisation.[274]
- Unsafe or overcrowded housing increases stress and limits opportunities for play and learning.[275]
- Neighbourhood safety and access to green space are linked to physical activity and social development.[276]

Housing and Health Pathways

Housing affects health inequalities through affordability, quality, fuel poverty, and location. Stable and secure housing supports child development and educational attainment. Conversely, housing insecurity and homelessness are associated with adverse health and wellbeing outcomes.[277] [278] Research consistently shows that institutional or hotel-like temporary accommodation can negatively affect children's physical and mental wellbeing, disrupt education, and undermine stability.

Fuel Poverty affects health as cold homes heighten the risk of respiratory illness and developmental delays in children. [279] [280] Energy efficiency improvements help reduce these risks and enhance family wellbeing.[281]

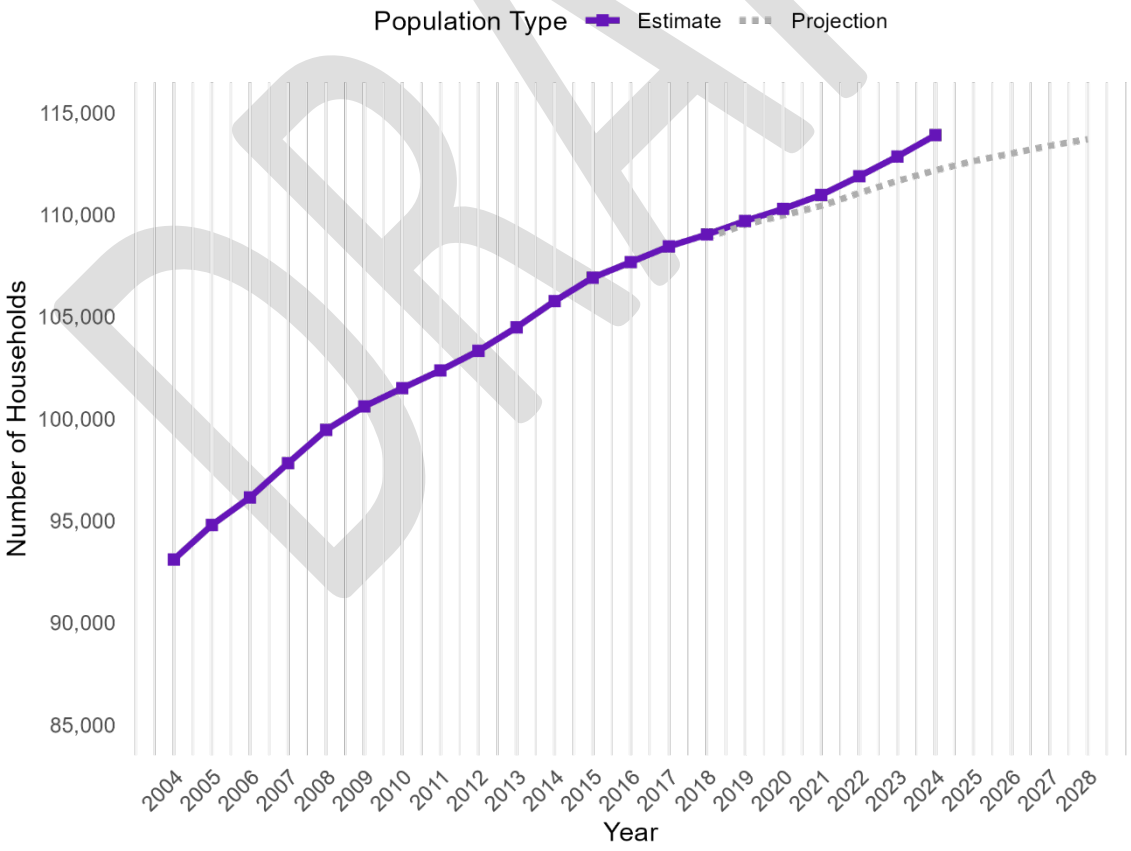
The home environment is a key setting for child safety. Poor housing conditions, such as unsafe stairs, lack of smoke alarms, and overcrowding, are associated with higher rates of unintentional injuries, including falls, burns, and poisoning.[282] [283] Children in temporary accommodation may face additional risks due to unfamiliar layouts and limited space for safe play. Improving housing safety standards and supporting families with adaptations can reduce injury risk and promote wellbeing.[284] [285]

Demographic and Housing Trends in Highland

Highland's household structure has changed markedly over the past two decades. In 2024, there were an estimated 113,906 households, a 22 percent increase since 2004, yet the average household size fell from 2.27 to 2.04, compared to 2.08 nationally.[286] This shift reflects more single-person households and smaller family units, meaning more homes are required for the same population.

Although the available household projections are dated and have underestimated the total number of households in Highland, the underlying assumptions still reflect the principal demographic drivers of existing population ageing and historically low birth rates, resulting in smaller household sizes anticipated over the next ten years. When published, they indicated a three percent reduction in households with children between 2018 and 2028, with these households comprising only 20–25 percent of all households by 2028. In contrast, households with residents aged 65 years and over were expected to make up 30–35 percent,[287] driving demand for accessible and adapted housing (Figure 134).

Figure 134: Change in household numbers in Highland



Source: National Records of Scotland. Household estimates 2024, Household projections (2018-based).

Housing Pressures and Economic Development

These demographic changes coincide with an acknowledged housing crisis in Scotland and the Highland area, driven by under-supply and affordability challenges. In Highland, pressures are potentially amplified by economic development initiatives such as the Inverness and Highland City Region Deal and the Green Freeport, which aim to attract workforce migration without fully addressing housing capacity. Many remote rural areas face housing stock fragility, with older properties requiring significant investment to meet modern standards.[288] Additional pressures arise from second homes and short-term holiday lets, reducing availability for local families and inflating prices.

The scale of the housing challenge in Highland is acute, with an estimated need for 24,000 new homes over the next decade, double the normal build rate. The shortage of affordable and social housing, rising costs, and rural market failures are recognised by the Highland Council and its partners as a strategic emergency, with significant implications for families and children.[289]

Affordability pressures are acute. In Highland, average private rents reached £716 per month in 2025, rising faster than the Scottish average, while house prices climbed to £216,000, well above the national mean.[290] [291] Housing costs are a key driver of poverty: 22.1 percent of children in Highland live in households in poverty after housing costs, equating to over 9,000 children.[292] Families face additional strain from fuel poverty and limited affordable housing options. In rural areas, housing markets are fragile because small communities often have limited stock, older properties needing investment, and fewer new builds. This fragility, combined with the prevalence of second homes and short-term lets, further reduces the availability of housing for local families.

Housing Affordability and At-Risk Households in Highland

Housing affordability is a critical determinant of health and wellbeing. Under the UNCRC, children have the right to an adequate standard of living (Article 27) and to have their best interests considered in all decisions affecting them (Article 3). Housing costs that consume a disproportionate share of household income are discussed in Figure 135 and Figure 136, and can compromise these rights, limiting resources for food, heating, education, and participation.

Figure 135: Comparative table of private and council rent affordability in Highland

Tenure	Annual Rent (£)	Income Level (£, before housing costs)	Housing Cost Burden (%)
Private Rent	8,592[1]	15,000	57.3
		25,000	34.4
		35,000	24.5
Council Rent	4,654[2]	15,000	31.0
		25,000	18.6
		35,000	13.3

1. Private rent estimate: ONS Highland average private rent (£716/month) as of September 2025
2. Council rent estimate: Highland Council average weekly rent for 2025/26 (£89.50/week)

Figure 136: Estimated households at risk of poverty given housing cost burden

Income Band (£, before housing costs)[i]	Estimated Households[1,(ii,iii)]	Risk with Private Rent	Risk with Council Rent	Descriptor
<15,000	~22,000	Very high (57%)	High (31%)	Very deep poverty[2]
15,000–25,000	~27,000	High (34%)	Moderate (19%)	Low income[3]
25,000–35,000	~22,000	Moderate (25%)	Low (13%)	Around median[4]

1. Household estimates: Based on the NRS household count for Highland (110,743 households in 2024).
2.'Very deep poverty' reflects households below 60% of the median income after housing costs, aligned with Scottish Government poverty definitions.
3. 'Low income' refers to households between 60–80% of the median income, based on Family Resources Survey thresholds.
4. 'Around median' reflects households close to the Scottish median income (~£35,000). Highland-specific median income is not published in open datasets

i. The income bands shown are before housing costs, consistent with Scottish Government poverty definitions. Actual disposable income after housing costs will be lower, meaning affordability pressures may be underestimated in this analysis.

Ii Estimated household numbers in each income category are based on Scottish Household Survey and Family Resources Survey proportions applied to the Highland household count (approximately 110,743 households). These figures are indicative and intended to illustrate relative scale rather than precise counts.

Iii These estimates do not account for household composition, such as the number of children. Data sources like the Scottish Household Survey or Family Resources Survey could provide proportions of households with children by income band, but this level of granularity is not available at the Highland level without microdata. Therefore, figures should be interpreted as indicative of overall household poverty risk, ***not specifically child poverty.***

Benefits such as Housing Benefit and Universal Credit housing element help reduce housing costs for low-income households. For social housing tenants, support generally keeps pace with council rent increases. For private tenants, support is capped by Local Housing Allowance (LHA). Because the same LHA cap applies across the Highland & Islands area, families in Inverness face much larger shortfalls than those in some remote and island locations, creating uneven affordability pressures and increasing the risk of poverty after housing costs.

Better data on individual household income, housing tenure, and actual housing costs are essential to identify families most at risk and to design effective prevention strategies.

Housing strategy in Highland

In Highland, housing policy is shaped by the Local Housing Strategy 2023–2028, which sets the strategic direction to tackle housing need and demand, prioritising increased housing supply, reduced homelessness, and tackling fuel poverty.[293] The forthcoming Highland Local Development Plan will align with National Planning Framework 4, focusing on sustainable communities and housing land supply.[294] [295]

A new Highland Housing Need and Demand Assessment (HNDA) has been commissioned to inform future housing strategies.[296] A rights based approach means the HNDA should not only be inclusive of all individuals but should explicitly consult with children and young people and incorporate their perspectives on housing environments that support safety, play, and social interaction; neighbourhood quality and access to services; and adaptations for children with disabilities or complex dependencies.

Embedding children's voices in housing assessments recognises housing as a strategic determinant of health and educational outcomes across all agencies. Consultation should be meaningful, age-appropriate, and designed to capture lived experience, ensuring that housing policy contributes to the fulfilment of children's rights and to reducing inequalities.

Homelessness

Recent research by Shelter Scotland, centring on children's own voices, reveals that Temporary Accommodation (TA) is often overcrowded, poorly maintained, and lacking basic amenities.[297] Children describe living with damp, mould, vermin, broken heating, and inadequate space for play or privacy. These conditions can lead to:

- Physical health problems**:** Increased risk of asthma, infections, and poor nutrition due to lack of cooking facilities and food storage.

- Mental health impacts: Anxiety, depression, sleep deprivation, and behavioural changes, often persisting even after families move to permanent housing.
- Disrupted education: Frequent moves, long commutes, and tiredness undermine school attendance, concentration, and attainment.
- Social isolation and stigma: Children report being unable to have friends over, losing contact with peers, and feeling ashamed of their living situation.
- Loss of control and agency: Repeated moves, loss of belongings, and lack of say in decisions contribute to a sense of instability and powerlessness.

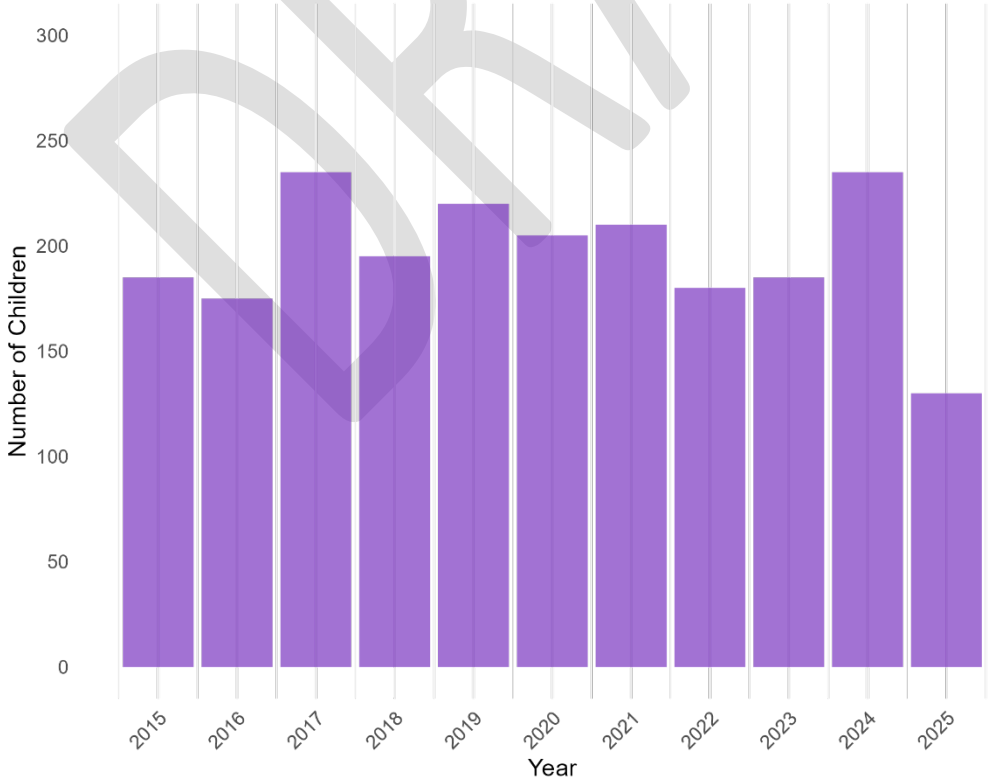
Shelter Scotland's research highlights that families in TA often spend a disproportionate share of income on housing, with debt and poverty compounded by the high cost and poor quality of TA. These dynamics increase the risk of homelessness and housing instability for vulnerable groups, including families with children.

In summary, homelessness is both a cause and consequence of poverty and disadvantage.

The local system and responses

In Highland, 130 children were in temporary accommodation at the end of March 2025 compared to 235 in 2024. Numbers have remained relatively stable over the past five years, though the latest figure represents a marked reduction.[298]

Figure 137: Number of children in temporary accommodation in Highland, 2015 – 2025



Source: Scottish Government, Homelessness in Scotland

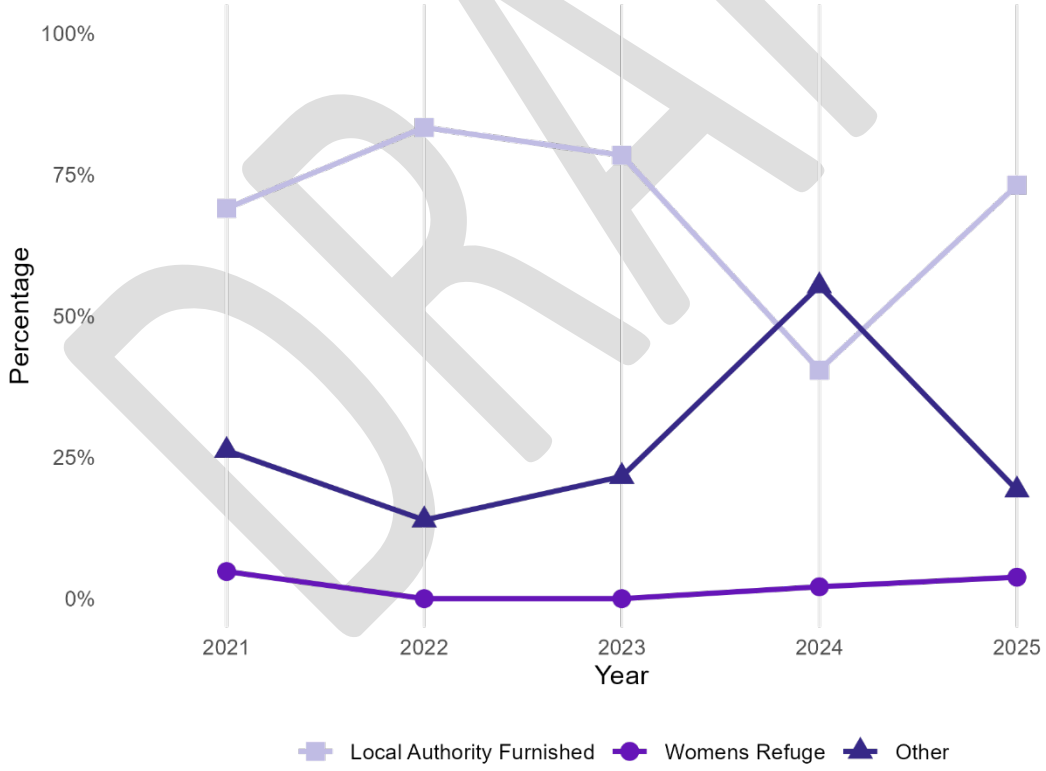
Highland Council's current Local Housing Strategy commits to expanding affordable housing supply, delivering Rapid Rehousing Transition Plans, and improving housing quality and energy efficiency to tackle fuel poverty.

The Council has prioritised compliance with the Unsuitable Accommodation Order, ensuring that, as of March 2025, all 70 households with children in TA were in community-based, furnished accommodation rather than hotels or hostels, with no history of this type of accommodation being used for families with children in recent years (Figure 138).

By ensuring community-based, furnished housing, Highland aligns with Marmot Principles on creating healthy environments and reducing health inequalities and meets UNCRC obligations to provide adequate housing for every child. This approach reduces exposure to the stressors associated with unsuitable accommodation and supports better life chances.

Highland's pattern reflects a reliance on local authority housing and refuge accommodation rather than commercial or institutional settings.

Figure 138: Children in temporary accommodation in Highland, percentage of children by type of accommodation



Source: Scottish Government, Homelessness in Scotland

1 The "Other" category includes hostels, bed-and-breakfast (B&B) accommodation, and private-sector leased properties. While these types are used elsewhere in Scotland, Highland has reported **no children living in hotels, hostels, or B&Bs** during the period 2019–20 to 2024–25, contrasting with some other local authorities where such placements remain common, often associated with short-term emergency provision.

Despite pressures, Highland performs better than the national average in resolving homelessness cases: average resolution time is ~36 weeks, compared to ~40 weeks nationally, and ~26 weeks for households with children, compared to ~33 weeks nationally.

The Highland approach aligns with best practice and the recommendations of Shelter Scotland and the Children's Rights and Homelessness in Scotland briefing, which call for an end to the use of hotel-like TA for children and for all TA to meet the same standards as permanent social housing.

However, national and qualitative research highlight that the experience of temporary accommodation (TA) can have profound and lasting impacts on children's health, wellbeing, and life chances, regardless of headline numbers. Meeting demand remains particularly challenging for children with complex needs, including those unable to access specialist care, households with no recourse to public funds, language barriers, and families with complex dynamics.

By ensuring community-based, furnished housing, Highland aligns with Marmot Principles on creating healthy environments and reducing health inequalities and meets UNCRC obligations to provide adequate housing for every child. This approach reduces exposure to the stressors associated with unsuitable accommodation and supports better life chances, even as challenges remain for families with complex needs.

Inequalities and Vulnerable Groups

Housing is a critical enabler when life is most challenging. Secure, stable housing can buffer crises such as poverty, family breakdown, or health emergencies.[299] Children in care or leaving care often face heightened vulnerability to homelessness. Families experiencing domestic abuse require rapid access to safe accommodation. Children with disabilities and neurodivergent children depend on housing adaptations that allow participation and reduce dependency. The Shelter Scotland report also highlights the challenges faced by children with complex needs, with evidence of placement in unsuitable environments, and the importance of trauma-informed, person-centred support.

Hidden Homelessness and Minority Groups

Official statistics undercount the scale of child homelessness, particularly among minority ethnic groups, migrants, Gypsy/Traveller families, and young people experiencing "hidden homelessness" (e.g. sofa surfing, overcrowding, or unsafe conditions). Intersectionality is important: overlapping vulnerabilities (e.g. poverty, ethnicity, disability, immigration status)

compound risk. These groups face additional barriers to accessing support, including discrimination, language barriers, and “no recourse to public funds” status.

Proactive outreach, culturally competent services, and improved data collection are needed to identify and support these children, in line with the UNCRC and the Scottish Government’s Child Rights and Wellbeing Impact Assessment (CRWIA) recommendations.[300] [301]

Using data to support improvements

Data collection should capture the full range of children’s experiences, including hidden homelessness and intersectional vulnerabilities, to enable early identification and support for at-risk children.

Current local data systems do not capture the links between housing, health, and educational outcomes, limiting preventive action. Integrated datasets across housing, health, and education are needed to identify at-risk households early and monitor the impact on child wellbeing.[302] Predictive analytics could flag risk factors before a crisis occurs.[303]

Standardised affordability measures should link housing costs to poverty and wellbeing. Shared outcomes frameworks and ethical data-sharing protocols would allow the Community Planning Partnerships to move from reactive responses to proactive prevention strategies.

18. Transport and access

Transport is a critical determinant of health and wellbeing for children and young people. It shapes access to education, healthcare, social care, and leisure, and influences physical activity, social connection, and mental health.[304] These dimensions are closely linked to rights set out in the UN Convention on the Rights of the Child (UNCRC), including the right to education (Article 28), health (Article 24), and leisure and play (Article 31). Planning and delivery of transport services should also reflect the best interests of the child (Article 3) and ensure that children's voices are heard in decisions affecting them (Article 12).

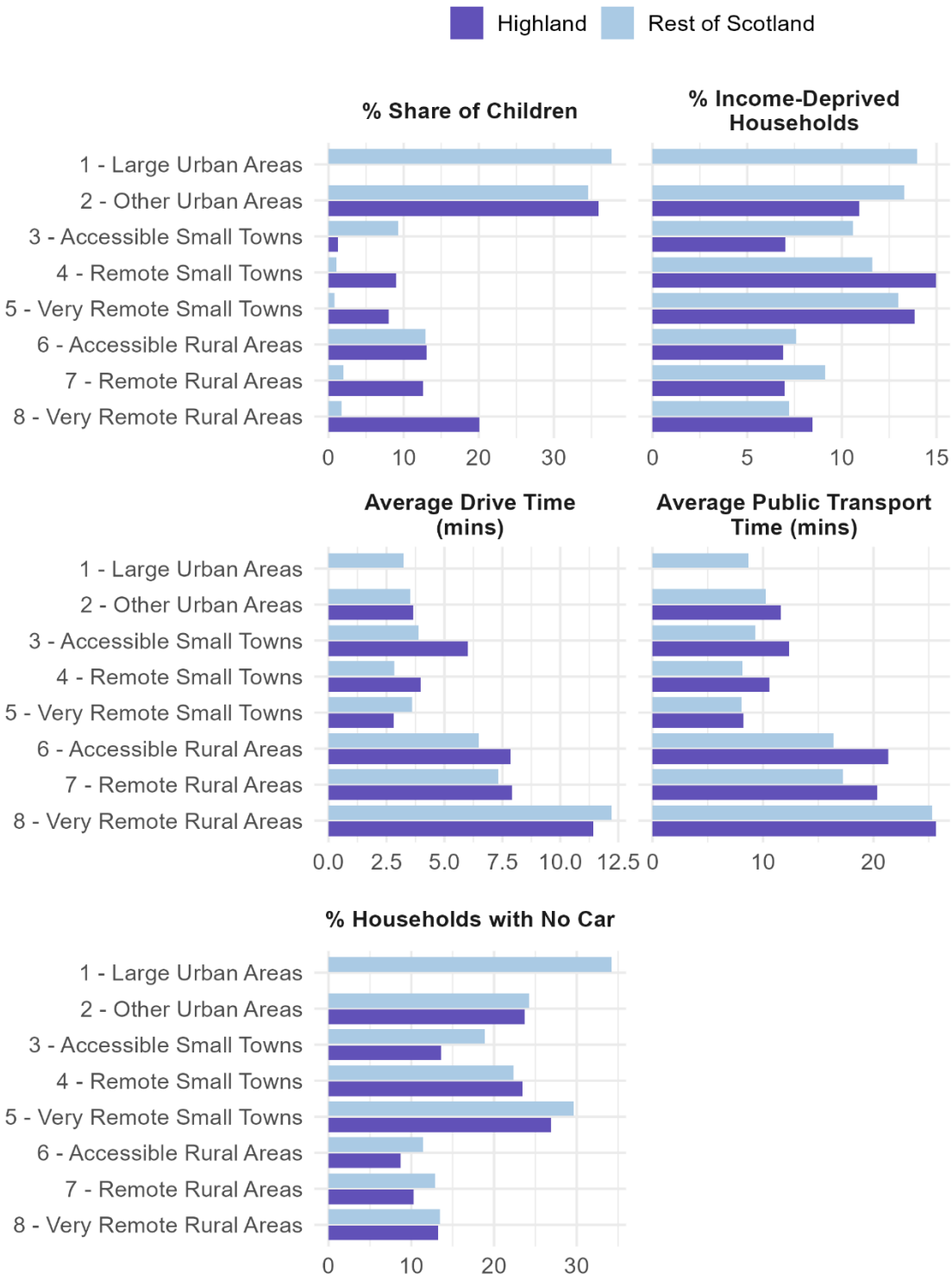
In Highland, long travel distances and limited public transport options amplify these challenges, particularly for families living in poverty or in remote areas. Transport barriers can also contribute to social isolation and poorer mental health outcomes, especially for children in rural communities and those with additional support needs. While digital technology offers potential alternatives, transport poverty and fragmented transport systems continue to limit access.[305] [306]

Transport Access and Inequality for Children in Highland

Figure 139 shows that transport access patterns in Highland differ markedly from those in the rest of Scotland, particularly in rural areas. Drive times to local services in Highland's very remote rural areas average 11.4 minutes, slightly shorter than the 12.2 minutes seen in equivalent areas elsewhere, but still far higher than the 3–4 minutes typical of urban settings. Public transport access shows a similar pattern: very remote rural Highland averages 25.6 minutes, almost identical to the rest of Scotland (25.3 minutes), and more than double the time in accessible rural areas.

These figures confirm that rural access disadvantages are a national issue, but Highland's geography and settlement patterns mean that large numbers of children experience these barriers daily. While averages provide a helpful summary, they obscure extremes—some communities face significantly longer travel times than the mean suggests.

Figure 139: Highland and Scotland: transport and child population indicators by urban–rural category



Source: Scottish Index of Multiple Deprivation (SIMD 2020v2, Income and Access domains); Scottish Government Urban Rural Classification (SGURC 2020, 8-fold); Scotland's Census 2022 (Table UV405 – Households by car or van availability); National Records of Scotland Small Area Population Estimates (2022).

The car ownership patterns shown in Figure 139 also reveal similarities and differences. In Highland's very remote rural areas, 13.3% of households lack a car, close to the Rest of

Scotland figure (13.4%). However, the potential consequences are more severe in Highland because alternative transport options are limited. Income deprivation shows a more pronounced divergence: urban Highland averages 10.9%, lower than in large urban areas elsewhere (14%), but rural deprivation in Highland is similar to that in the rest of Scotland

Children are unevenly distributed across these geographies. Highland's very remote rural areas account for around 7,500 children (20%), compared to less than 2% in equivalent areas elsewhere in Scotland. Accessible and remote rural areas together add another 9,500 children, meaning around half of Highland's child population lives in places where transport barriers are most acute.

The potentially cumulative factors of long travel times, limited public transport, reliance on private vehicles, and income constraints shape many children's daily lives, influencing access to education, health care, and social opportunities. For some, these barriers translate into missed appointments, reduced participation in extracurricular activities, and heightened social isolation, amplifying inequalities in wellbeing and life chances.

Transport and Child Poverty

Evidence shows that transport costs can account for up to 15% of household income for low-income families in rural Scotland.[307] Transport poverty compounds child poverty by restricting access to essential services and opportunities.[308] Families without cars in rural or remote areas face particularly high barriers to accessing education, healthcare, and employment because public transport options are limited. For children, transport poverty reinforces cycles of exclusion and can limit participation in extracurricular activities, widening inequalities in health and development.[309]

However, particularly in rural and remote areas, car ownership is often a necessity rather than a choice, and in these circumstances, it should not be interpreted as a marker of affluence but as a contributor to financial strain for low-income households.

Policy Context and Structural Inequality

National and local transport strategies aim to promote inclusive and sustainable systems.[310] [311] However, rural areas often face structural disadvantages, and urban bias in infrastructure investment means rural communities rely heavily on private vehicles, which increases costs and limits opportunities for active travel.[312] These inequalities intersect with child poverty because transport costs take up a much larger proportion of income in low-income households, reducing resources for other essentials. Satisfaction with public transport is much

lower in accessible rural areas (46%) and remote rural areas (47%) compared to larger urban areas (72%) in Scotland in 2023.[313]

Transport planning also contributes to Scotland's climate targets by reducing car dependency and promoting low-carbon travel options, shaping healthier environments for future generations. The concept of 20-minute neighbourhoods, which aims to ensure access to essential services within a short walk or cycle, is challenging in rural Highland but offers a guiding principle for improving local accessibility.[314] [315]

HITRANS role as a Community Planning Partner

HITRANS (Highlands and Islands Transport Partnership) is a statutory Regional Transport Partnership and a Community Planning Partner in Highland. It works with local authorities, NHS Highland, and other agencies to integrate transport priorities into planning. For children and young people, HITRANS supports school-based active travel initiatives, demand-responsive transport schemes (e.g. Moove Flexi), and digital connectivity projects under the Highland City Region Deal.

National concessionary travel scheme for children and young people

Since January 2022, Scotland's Young Persons' Free Bus Travel Scheme has provided free bus travel for all residents aged 5–21 through the National Entitlement Card (NEC). By October 2025, more than 250 million free bus journeys had been taken nationwide, and over 80% of eligible young people were registered. In Highland, 26,902 young people hold a valid NEC for free bus travel, representing a significant uptake in a region where long travel distances and limited public transport options often create barriers to education, employment and social opportunities.[316],[317]

The NEC scheme helps address child poverty by removing a significant cost barrier, as transport costs account for a higher share of income in low-income households. Free bus travel reduces this burden while also improving access to services and leisure.

Travel to School and Active Travel

School transport provision is vital for rural children, and active travel to school is not an option for all, particularly those living at a distance or with additional support needs. Active travel, walking, cycling, and wheeling, offers physical health benefits, including improved cardiovascular fitness and reduced obesity risk. [318] [319] However, uptake is low in Highland due to geography, weather, and infrastructure limitations.[320]

Public Health Scotland's scoping of active travel strategies calls for safe, accessible routes and integration with health improvement initiatives.[321] HITRANS complements this by promoting behaviour change campaigns and investing in safer routes to school.[322] Highland Council encourages every school to develop a School Travel Plan to improve safety, support walking and cycling, and reduce car use, with funding and guidance available to schools that produce one.

Safety and unintentional injuries

In Highland, rural isolation and transport poverty intersect with risk: long travel distances, reliance on private vehicles, and limited active travel infrastructure amplify vulnerability. Safe travel environments are essential for reducing unintentional injuries among children and young people, as set out in Scotland's Road Safety Framework to 2030 and the Highland Council Road Safety Plan to 2030. Interventions such as cycle proficiency training, traffic calming near schools, improved pedestrian crossings, and well-maintained walking and cycling paths have been proven to reduce injury risk and encourage active travel.[323] [324]

Measuring Transport Disadvantage

The SIMD access domain measures proximity to local services but often underrepresents the transport challenges faced by remote rural families and the additional costs, by focusing on travel times that capture geographic remoteness rather than affordability and transport availability.[325] Composite indicators combining travel time, cost, and service potentially could provide a more accurate picture of transport disadvantage, and data gaps remain in measuring transport poverty at a meaningful level.[326]

Data integration and local intelligence

Identifying transport-related access deprivation for children and young people in Highland requires moving beyond area-based measures like SIMD. Rural poverty is often hidden within communities, and traditional indices fail to capture individual-level barriers such as transport affordability, digital exclusion, and fragmented service pathways. A more effective approach could combine linked administrative data with local intelligence to create a granular picture of need, identifying children at risk of poor access outcomes, and design targeted interventions such as subsidised transport or digital alternatives following the SAVVI (Scalable Approach to Vulnerability via Interoperability) framework that is designed to help organisations share and use data ethically to identify and support vulnerable individuals.[327] [328] [329]

Community Transport and Third Sector Role

Community transport schemes play an important role in addressing gaps left by limited public transport, particularly for children and families in remote areas. Highland Council currently funds 28 organisations through its Community Transport Grant scheme, with allocations ranging from £1,200 to £40,000 per year and a total budget of £398,000 for 2024–2025.[330] Provision includes volunteer-led services, demand-responsive transport (DRT), and school transport contracts. However, there is no comprehensive dataset on usage or coverage, and monitoring relies on quarterly reports from funded organisations rather than standardised metrics, limiting understanding of equity and reach, despite strong evidence of need in rural communities.

Digital Alternatives and Connectivity

Digital solutions—such as telehealth and online learning—can mitigate transport barriers, but connectivity gaps persist. One in nine Scottish households lacks internet access, and 15% of adults lack basic digital skills.[331] In Highland, poor broadband coverage and affordability issues limit the effectiveness of virtual alternatives, reinforcing inequalities in access to care and education.[332] Around 16% of Highland residents have no broadband access, mainly in rural areas. Evidence shows that digital exclusion among children and young people leads to missed learning opportunities, reduced participation, and feelings of isolation. Studies highlight that care-experienced children and those in rural communities are disproportionately affected, with digital poverty compounding educational and social inequalities.[333],[334],[335]

The Scottish Government has commissioned research and published reports on developing a Scottish Minimum Digital Living Standard (MDLS).[336] The initiative aims to define the minimum digital goods, services, and skills households need to participate fully in society.

- The Phase 2 report (July 2025) confirms that MDLS is seen as crucial for tackling digital exclusion and promoting social inclusion, especially for households with children.[337]
- It acknowledges rural connectivity gaps, affordability issues, and the need for coordinated policy efforts as significant challenges.
- MDLS is intended to inform policy and delivery frameworks, aligning with Connecting Scotland and digital inclusion strategies.

Highland Council's own Digital Schools Strategy acknowledges MDLS related barriers despite investment in devices and connectivity support.[338]

Emerging Technologies

Emerging transport technologies offer potential benefits for rural connectivity but also raise equity concerns. Electric vehicle (EV) uptake is increasing nationally, yet Highland faces barriers such as limited charging infrastructure and long travel distances, which may deepen transport poverty for families without access to private EVs.[339] [340] [341] For low-income households, inability to transition to EVs means reliance on older petrol or diesel vehicles—often less efficient and more costly to run—while policy and market shifts towards electrification risk amplifying these financial pressures. While the shift from diesel and petrol supports climate change priorities, the transition risks widening inequalities in rural areas.

Mobility-as-a-Service (MaaS) platforms, such as the Go-Hi pilot, which aim to provide a single digital interface for planning, booking, and paying across multiple modes of travel - including buses, community transport, and taxis - have struggled to capture the necessary data from public transport operators and to sustain community interest.[342] Tensions exist between the commercial viability of such products for urban transport networks and for social benefit applications for rural services or catering for particular groups, such as students.

Other emerging technologies include connected and autonomous vehicles (CAVs) and shared autonomous vehicles (SAVs), which could transform rural mobility by reducing reliance on private car ownership and improving access to school and health services.[343] Parents perceive potential benefits for children's mobility, but safety concerns, connectivity gaps, and low rural demand density remain significant barriers. Micro-mobility solutions such as e-bikes and cargo bikes can support family mobility, but affordability and lack of safe cycling infrastructure remain obstacles.

Without targeted support, emergent technologies risk creating a two-tier system—where households with digital access and private EVs benefit most, while those already experiencing transport poverty fall further behind.

19. Community, Environment and Sustainability

Placeholder for section

20. Improving the use of data to support the needs of children

Improving the use of data to identify and support children's needs is a critical priority for public services in Scotland. National strategies emphasise the importance of integrated intelligence to tackle inequalities and deliver person-centred services. For Highland, where remote and rural geographies with small settlements create unique challenges for service delivery, better use of locally collected data can enable earlier intervention, more targeted support, and improve outcomes for children and families.

Current Challenges

Despite the availability of rich administrative data across health, education, housing, and social care, significant barriers limit its use for integrated analysis:

- Fragmentation across systems: Different architectures and identifiers (CHI in health, SEEMiS in education, council references in housing) make straightforward data linkage difficult.
- Data sharing: Data sharing between different agencies is complex due to concerns about breaching legislative requirements. Agencies interpret GDPR differently, and existing data-sharing agreements are outdated.
- Capacity constraints: Skilled data analysts and technical teams are in high demand, raising questions about resourcing and sustainability.
- Limited qualitative insight: Quantitative indicators alone cannot capture lived experience, with qualitative insights required to develop effective interventions.

Opportunities and Innovations

Innovative practice in Scotland demonstrates what is possible. Glasgow's Centre for Civic Innovation (CHiCS) has developed child poverty dashboards integrating administrative data.[344] The CHiCS project links data across social care, education, and health to monitor outcomes for care-experienced children.[345]

Consistent data standards and information governance can support earlier identification of children experiencing multiple vulnerabilities. The Scalable Approach to Vulnerability via Interoperability (SAVVI) offers structured definitions, shared taxonomies, and interoperable data structures for lawful, secure information sharing.[346]

Pilots in Scotland demonstrate SAVVI's potential to create individual-level vulnerability profiles beyond area-based measures such as SIMD. Linked datasets include free school meal eligibility, attendance, health contacts, and social care interactions. The work has clear

relevance for Highland, where dispersed rural disadvantage may be hidden within larger geographies.[347]

Transport poverty consistently appears in the Scottish pilots, where remoteness and limited transport were linked to missed appointments, reduced service access, and lower educational participation. SAVVI provides a way to incorporate distance to services, lack of private transport, and weak digital alternatives within wider vulnerability assessments.

SAVVI could offer Highland a practical model for early identification of children and families within a framework of consistent data standards, aligned governance, and proactive intervention across Community Planning Partnership agencies.

Disaggregated data

Greater availability of disaggregated data is essential identifying inequalities, informing service improvements and improving outcomes for children. This should include data broken down by age group, as well as ethnicity, disability, socioeconomic status, access to services, and other categories that will allow for more targeted interventions and specific outcome planning.

Shared outcomes framework

There are multiple outcome frameworks for children and young people used across the public sector in Scotland. In Highland, the Integrated Children's Services Board use a balanced scorecard approach to monitor progress. Developments identified in this needs assessment include work to develop a set of measures aligned to The Promise. There is also a need to identify measures for a UNCRC-aligned monitoring framework that the partnership can collectively sign up to.

Strategic context

The opportunities outlined here align with Scotland's Population Health Framework, which promotes a whole-system approach to prevention and reducing inequalities through integrated action across sectors. The Framework emphasises data-driven decision-making and collaboration to tackle the root causes of disadvantage.

Scotland's National Digital Strategy and Vision for Public Sector Data set out ambitions for interoperable systems, shared platforms, and common standards to enable proactive, person-centred services.[348] [349] These strategies call for breaking down silos and embedding digital thinking to deliver better outcomes.

The Public Service Reform Strategy reinforces these principles, highlighting efficiency, integration, and prevention as essential to meet rising demand and maintain sustainability.[350]

Finally, Scotland's AI Strategy demonstrates how advanced analytics and automation can support transformation—by enabling predictive modelling, freeing staff from repetitive tasks, and improving service targeting—while ensuring ethical and transparent use of technology.[351]

Implications for Highland

For the Highland Community Planning Partnership, improving data use requires:

- A CPP-wide data strategy and updated GDPR-compliant data sharing agreements.
- Investment in workforce capacity and technical infrastructure, including safe haven options.
- Collaboration with national initiatives such as Research Data Scotland, ADR Scotland, and the Data for Children Collaborative to leverage expertise and avoid duplication.
- Embedding qualitative insight and community voice alongside quantitative analysis to ensure interventions reflect lived experience.
- Development of a UNCRC-aligned monitoring framework.

21. Recommendations

To be completed after ICSB Development workshop

Abbreviations

Acronym	Full Name
ALSPAC	The Avon Longitudinal Study of Parents and Children
ASN	Additional Support Needs
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Services
CARDRISS	Congenital Conditions and Rare Diseases Registration and Information Service for Scotland
CELCIS	Centre for Children's Care and Protection
COVID-19	Coronavirus Disease 2019
CPP	Community Planning Partnership
CPPMs	Child Protection Planning Meetings
CSOs	Compulsory Supervision Orders
CfE	Curriculum for Excellence
DALYs	Disability Adjusted Life Years
FSM	Free School Meals
GBV	Full Name TBD
GCSE	General Certificate of Secondary Education
GIRFEC	Getting it right for every child
GUS	Growing Up in Scotland
HNDA	Housing Need and Demand Assessment
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSCP	Health and Social Care Partnership
ICSB	Highland Integrated Children's Service Planning Board
IRDs	Inter-agency Referral Discussions
JSNA	Joint Strategic Needs Assessment
LBGTQ+	Lesbian, Gay, Bisexual, Transgender, Queer (and others)
LHA	Local Housing Allowance
NDIP	The National Dental Inspection Program
SCDAR	Scottish Centre for Administrative Data Research
SCQF	Scottish Credit and Qualifications Framework
SCRA	The Scottish Children's Reporter Administration
SGURC	The Scottish Urban Rural Classification
SHANARRI	Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included.
SIDS	Neonatal Disorders and Sudden Infant Death Syndrome
SIMD	Scottish Index of Multiple Deprivation
SQA	Scottish Qualifications Authority
TA	Temporary Accommodation
UNCRC	United Nations Convention on the Rights of the Child
YLD	Years Lived with Disability
YLL	Years of Life Lost

References

[1] Scottish Government. Health and Social Care Integration Strategic plans: statutory guidance. 2024. https://www.gov.scot/publications/strategic-plans-statutory-guidance/

[2] Public Health Scotland. The building blocks of health and wellbeing. https://publichealthscotland.scot/about-us/what-we-do-and-how-we-work/public-health-approach-to-prevention/the-building-blocks-of-health/

[3] Public Health Scotland. Fundamental causes of health inequalities. 2024. https://publichealthscotland.scot/population-health/social-and-economic-impacts-on-health/equity-and-justice/health-inequalities/fundamental-causes-of-health-inequalities/

[4] Public Health Scotland. What are health inequalities? https://publichealthscotland.scot/population-health/social-and-economic-impacts-on-health/equity-and-justice/health-inequalities/what-are-health-inequalities/

[5] McCartney G, Dickie E, Escobar O, Collins C. Health inequalities, fundamental causes and power: towards the practice of good theory. Sociol Health Illn. 2021;43:20-39. https://doi.org/10.1111/1467-9566.13181

[6] Scottish Government. Scotland's Population Health Framework 2025-2035. 2025. https://www.gov.scot/publications/scotlands-population-health-framework/

[7] Institute of Health Equity. Marmot Places. https://www.instituteofhealthequity.org/taking-action/marmot-places

[8] United Nations. Convention on the Rights of the Child. Office of the High Commissioner; 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

[9] United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024. https://www.legislation.gov.uk/asp/2024/1/

[10] Scottish Government. Getting it right for every child Policy statement 2022. https://www.gov.scot/publications/getting-right-child-girfec-policy-statement/

[11] Independent Care Review. The Promise. 2020. https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf

[12] Scottish Government. Keeping the Promise implementation plan. 2022. https://www.gov.scot/publications/keeping-promise-implementation-plan/

[13] Children and Young People (Scotland) Act 2014. https://www.legislation.gov.uk/asp/2014/8/

[14] National Records of Scotland. Highland Council area profile: Population estimates and structure (mid-2024). Edinburgh: NRS; 2025. https://www.nrscotland.gov.uk/statistics-and-data/council-area-profiles/highland/

[15] Highland Health and Social Care Partnership. Highland HSCP – Joint Strategic Needs Assessment. 2025. Available from: https://www.nhshighland.scot.nhs.uk/about/highland-health-and-social-care-partnership/highland-hscp-publications/

[16] Audit Scotland. NHS in Scotland 2025: Finance and performance. Edinburgh: Audit Scotland; 2025. https://audit.scot/uploads/2025-11/nr_251204_NHS_in_Scotland_2025.pdf

[17] NHS Education for Scotland. NHSScotland Workforce 31 Mar 2025. Edinburgh: NES; June 2025. https://turasdata.nes.nhs.scot/media/5muongvs/workforcereport_june2025_revised-19082025.pdf

[18] Royal College of Nursing (RCN) Scotland. The Nursing Workforce in Scotland 2025. Edinburgh: RCN; 2025. https://www.rcn.org.uk/-/media/Royal-College-Of-

Nursing/Documents/Countries-and-regions/Scotland/2025/The-Nursing-Workforce-in-Scotland-2025.pdf

[19] Scottish Social Services Council (SSSC). ***Scottish Social Service Sector: Report on 2024 Workforce Data*** (includes median ages by sector) and ***2023 Children's Services Workforce Tables*** (ELC/Day Care detail). Dundee: SSSC; 2025 Sep 30 and 2025 Mar 24. Available from:
– Workforce Data Reports index: https://data.sssc.uk.com/data-publications/22-workforce-data-report [cited 2026 Jan 16].
– 2023 Children's Services Workforce Tables: https://data.sssc.uk.com/local-level-data/381-2023-children-s-services-workforce-tables [cited 2026 Jan 16].

[20] Scottish Government. Childminding workforce trends: qualitative research report. Edinburgh: Scottish Government; 2022. https://www.gov.scot/publications/childminding-workforce-trends-qualitative-research-report/

[21] Scottish Government. Scottish Government urban/rural classification 2020. Edinburgh: Scottish Government; 2022. https://www.gov.scot/publications/scottish-government-urban-rural-classification-2020/

[22] Shucksmith M, Champan P, Glass J, Atterton J. Rural Lives: Understanding financial hardship and vulnerability in rural areas. 2021. https://www.rurallives.co.uk/rural-lives-final-report.htm

[23] The space between us: Children's mental health and wellbeing in isolated areas. Centre for Mental Health; 2020. https://www.centreformentalhealth.org.uk/publications/space-between-us

[24] Bailey N, Bramley G, Gannon M. Poverty and social exclusion in urban and rural areas of Scotland: Poverty and Social Exclusion UK Survey 2012 Working Paper. Glasgow: PSE, ESRC, University of Glasgow and Heriot-Watt University; 2016

[25] Public Health England. Health and Wellbeing in rural areas. Local Government Association; 2017.
https://www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf

[26] Scottish Government. Scottish Index of Multiple Deprivation: SIMD 2020 technical notes. 2020. https://www.gov.scot/publications/simd-2020-technical-notes/

[27] Clelland D, Hill C. Deprivation, policy and rurality: The limitations and applications of area based deprivation indices in Scotland. Local Economy, 2019;34(1),33–50. https://doi.org/10.1177/0269094219827893

[28] Brown SL, Manning WD, Stykes BJ. Family Structure and Child Well-Being: Integrating Family Complexity . National Centre for Family & Marriage Research Working Paper; 2014 Jul. https://www.bgsu.edu/content/dam/BGSU/college-of-arts-and-sciences/NCFMR/documents/WP/WP-14-02.pdf

[29] Gambaro L, Joshi H. The Impact of Complex Family Structure on Child Well-being: Evidence From Siblings. J Marriage Fam. 2018;80(4):902–918. https://www.jstor.org/stable/26647609

[30] Monostori J, Szabó L, Kopcsó K. The Impact of Family Complexity on the Risk of Developmental Delay and Socio-Emotional Difficulties in Early Childhood. Societies. 2023;13(8):192. https://www.mdpi.com/2075-4698/13/8/192

[31] Kleinschlömer P, Kühn M, Bister L, Vogt TC, Krapf S. Analyzing the Impact of Family Structure Changes on Children's Stress Levels Using a Stress Biomarker. J Health Soc Behav. 2024;65(3):449–465. https://journals.sagepub.com/doi/pdf/10.1177/00221465231223953

[32] National Records of Scotland; UK Data Service. UV113 – Household composition (Households), Council Area 2019 (LA CSV) https://www.scotlandscensus.gov.uk/

[33] National Records of Scotland. Household composition metadata (HH_COMP_CAT_H) Scotland's Census metadata. https://www.scotlandscensus.gov.uk/

[34] National Records of Scotland. Marital and civil partnership status (UV104/UV104b) metadata Scotland's Census metadata. https://www.scotlandscensus.gov.uk/

[35] Williamson L. An Introduction to the Scottish Longitudinal Study (SLS). International Journal of Population Data Science. 2025;10(4). https://ijpds.org/article/view/3283

[36] Scottish Government. Growing up in Scotland: change in early childhood and the impact of significant events – Chapter 3: Parental separation Edinburgh: Scottish Government; 2011 Jun 6. https://www.gov.scot/publications/growing-up-scotland-change-early-childhood-impact-significant-events/pages/5/

[37] UCL Centre for Longitudinal Studies. *Timing of parents' split matters for children's mental health.* 2019 Jan 17. https://cls.ucl.ac.uk/timing-of-parents-split-matters-for-childrens-mental-health-new-research-reveals/

[38] Houtepen LC, Heron J, Suderman MJ, et al. Associations of adverse childhood experiences with educational attainment and adolescent health: ALSPAC cohort. PLOS Med. 2020 Mar 2. https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003031

[39] Campbell E. *Young People and Family Separation in Scotland* . Scottish Youth Parliament; 2020. https://www.sharedparenting.scot/wp-content/uploads/2020/11/Young-People-and-Family-Separation-in-Scotland.pdf

[40] Birnbaum R, Saini M. A scoping review of qualitative studies about children experiencing parental separation. Childhood. 2013;20(2):260–282. https://doi.org/10.1177/0907568212454148

[41] Burgess C, Daniel B, Rossvoll F, Wallace B. *Children's Voices in Kinship Care: Scotland* . 2010. https://cwlibrary.childwelfare.gov/discovery/fulldisplay/alma991000859139707651/01CWIG_INST:01CWIG

[42] Smith M. *Outcomes for children in new stepfamilies* . Institute of Education; 2003. https://www.researchgate.net/profile/Marjorie-Smith-5/publication/228389761_Outcomes_for_children_in_new_stepfamilies/links/53dfa1b70cf2a768e49bb8dd/Outcomes-for-children-in-new-stepfamilies.pdf

[43] Independent Care Review. The Promise . 2020 Feb. https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf

[44] The Promise Scotland. Plan 21–24. 2021 Mar 31. https://thepromise.scot/resources/2021/plan-21-24.pdf

[45] Scottish Government. Kinship Care Statistics: Introduction. 2025 Jul 29. https://www.gov.scot/publications/kinship-care-statistics/pages/introduction/

[46] CELCIS/SCADR. Growing Up in Kinship Care. 2024 Oct 8. https://www.celcis.org/application/files/1017/2831/4415/Growing_Up_In_Kinship_Care_Report_-_CELCIS_8_October_2024.pdf

[47] CELCIS. New data gives clearer picture of kinship care in Scotland (Census 2022 context) . 2025 Jul 29. https://www.celcis.org/news/news-pages/new-data-gives-clearer-picture-kinship-care-scotland

[48] Scottish Government. Kinship Care Statistics: Local authority . 2025 Jul 29. https://www.gov.scot/publications/kinship-care-statistics/pages/local-authority/

[49] Scottish Government. Whole Family Wellbeing Funding – Getting it right for every child (GIRFEC). Edinburgh: Scottish Government; 2025. https://www.gov.scot/policies/girfec/whole-family-wellbeing-funding/

[50] Highland Community Planning Partnership. Highland Whole Family Wellbeing Programme – Funded Activity Overview and Analysis. January 2026. https://highlandcpp.org.uk/wp-content/uploads/2026/01/WFWP-Funding-Activity-Overview-and-Analysis-January-2026.pdf

[51] Scottish Government. Best Start, Bright Futures: Tackling Child Poverty Delivery Plan 2022–2026. Edinburgh: Scottish Government; 2022. https://www.gov.scot/publications/best-start-bright-futures-tackling-child-poverty-delivery-plan-2022-26

[52] Emsley E, Smith J, Martin D, Lewis NV. Trauma-informed care in the UK: where are we? BMC Health Serv Res. 2022;22:1164. https://link.springer.com/article/10.1186/s12913-022-08461-w

[53] NHS England. A good practice guide to support implementation of trauma-informed care in the perinatal period. 2021 Feb 19. https://www.england.nhs.uk/wp-content/uploads/2021/02/BBS-TIC-V8.pdf

[54] Highland Council. Highland Child Poverty Action Plan Year 7 Report 2024/25 . Inverness: Highland Council; 2024. https://www.nhshighland.scot.nhs.uk/media/am3guybv/highland-local-child-poverty-action-update-report-2024-25.pdf

[55] Public Health Scotland. Child Poverty and Health Inequalities . Edinburgh: Public Health Scotland; 2023. https://publichealthscotland.scot/publications/child-poverty-and-health-inequalities/

[56] Poverty and Inequality Commission. Child Poverty Scrutiny Report 2024-25 . Edinburgh: Poverty and Inequality Commission; 2025. https://povertyinequality.scot/publication/poverty-and-inequality-commission-child-poverty-scrutiny-report-2024-25/

[57] Joseph Rowntree Foundation. Children Being Left Behind: Deep Poverty Among Families in Scotland . York: JRF; 2024. https://www.jrf.org.uk/child-poverty/children-being-left-behind-deep-poverty-among-families-in-scotland

[58] Children and Young People's Commissioner Scotland. Child Poverty – Children and Young People's Voices . Edinburgh: CYPCS; 2025. https://www.cypcs.org.uk/wpcypcs/wp-content/uploads/2025/07/Scottish-version-Child-Poverty-Children-and-Young-Peoples-Voices.pdf

[59] End child poverty. 2024/2025. https://endchildpoverty.org.uk/

[60] Scottish Health Equity Research Unit (SHERU). New child poverty data and updates on methodological changes. https://scothealthequity.org/new-child-poverty-data-and-updates-on-methodological-changes/

[61] Child Poverty Action Group. The Cost of a Child in 2025. London: CPAG; 2025. https://cpag.org.uk/news/cost-child-2025

[62] Social Security Scotland. Scottish Child Payment. Social Security Scotland - Scottish Child Payment statistics to 30 June 2025. https://www.socialsecurity.gov.scot/publications

[63] WPI Economics. Modelling Child Poverty in Scotland. London: WPI Economics; 2025. https://povertyinequality.scot/wp-content/uploads/2025/06/WPI-Economics_Modelling_Child_Poverty_in_Scotland_May-2025.pdf

[64] Royal College of Paediatrics and Child Health. Child health inequalities driven by child poverty in the UK – position statement. London: RCPCH; 2024. https://www.rcpch.ac.uk/resources/child-health-inequalities-position-statement

[65] Royal College of Paediatrics and Child Health. Health inequalities tool 1 – Improve your understanding of child poverty and health inequalities. London: RCPCH; 2024. https://www.rcpch.ac.uk/resources/health-inequalities-tool-1-improve-your-understanding-child-poverty-health-inequalities

[66] Joseph Rowntree Foundation. Poverty in Scotland 2025. York: JRF; 2025. https://www.jrf.org.uk/poverty-in-scotland-2025

[67] Social Security Scotland. Best Start Grant and Best Start Foods. https://www.socialsecurity.gov.scot/reporting/publications/best-start-grant-and-best-start-foods-statistics-to-30-september-2025

[68] Poverty and Inequality Commission. Advice on the Scottish Government's Child Poverty Delivery Plan 2026–2031. Edinburgh: Poverty and Inequality Commission; 2025. https://povertyinequality.scot/publication/advice-on-the-scottish-governments-child-poverty-delivery-plan-2026-2031/

[69] Poverty and Inequality Commission. Child Poverty Delivery Plan Progress 2023-2024. Poverty and Inequality Commission, 2024 June. https://povertyinequality.scot/publication/poverty-and-inequality-commission-child-poverty-scrutiny-report-2023-24/

[70] Yang T, Power M, Moss R, et al. Are free school meals failing families? Exploring the relationship between child food insecurity, child mental health and free school meal status during COVID-19: national cross-sectional surveys. BMJ Open 2022;12:e059047. https://doi.org/10.1136/bmjopen-2021-059047

[71] National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (Clinical Guideline CG110) [Internet]. London: NICE; 2010 Sep 22. https://www.nice.org.uk/guidance/cg110

[72] Scottish Public Health Observatory. Risk factors during pregnancy [Internet]. Edinburgh: ScotPHO. https://www.scotpho.org.uk/population-dynamics/pregnancy-births-and-maternity/risk-factors-during-pregnancy/

[73] Public Health Scotland. *Births in Scotland*—risk factor analyses (smoking, low birthweight). 2022; 2025 updates. https://publichealthscotland.scot/publications/births-in-scotland/births-in-scotland-year-ending-31-march-2025/

[74] Public Health Scotland. Births in Scotland. November 2022. https://publichealthscotland.scot/media/16548/2022-11-29_births_report.pdf

[75] World Health Organisation. Infant and young child feeding [Internet]. Geneva: WHO; 2023. https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding

[76] Scottish Government. Breastfeeding and Infant Feeding Strategic Framework 2025–2030 [Internet]. Edinburgh: Scottish Government; 2024. https://www.gov.scot/publications/breastfeeding-infant-feeding-strategic-framework-2025-2030/pages/6/

[77] Public Health Scotland. Publications—Infant feeding statistics Scotland [Internet]. Edinburgh: PHS; 2024. https://publichealthscotland.scot/publications/show-all-releases?id=20563

[78] Scottish Government. *The First National Good Food Nation Plan*. December 2025. https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2025/12/first-national-good-food-nation-plan/documents/first-national-good-food-nation-plan/first-national-good-food-nation-plan/govscot%3Adocument/first-national-good-food-nation-plan.pdf

[79] Scottish Government. Universal Health Visiting Pathway in Scotland: pre-birth to pre-school. Edinburgh. https://www.gov.scot/publications/universal-health-visiting-pathway-scotland-pre-birth-pre-school/

[80] Scottish Government. Health visiting: action plan 2025 to 2035. Edinburgh; 26 March 2025. https://www.gov.scot/publications/enhancing-delivery-health-visiting-service-scotlands-health-visiting-action-plan-2025-2035/

[81] Doi L, Eunson J, Ormston R, Morrison K, Astbury R, Jepson RG. ***Universal Health Visiting Pathway evaluation, phase 1: main report***. Scottish Government; 21 December 2021. gov.scot/publications/evaluation-universal-health-visiting-pathway-scotland-phase-1-main-report-primary-research-health-visitors-parents-case-note-review

[82] Public Health Scotland. ***Child health pre-school review coverage 2023 to 2024***. 29 April 2025. publichealthscotland.scot/publications/child-health-pre-school-review-coverage/child-health-pre-school-review-coverage-2023-to-2024

[83] Scottish Government. ***Coronavirus (COVID-19): Scotland's route map through and out of the crisis***. 21 May 2020. https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2020/05/coronavirus-covid-19-framework-decision-making-scotlands-route-map-through-out-crisis/documents/covid-19-framework-decision-making-scotlands-route-map-through-out-crisis/covid-19-framework-decision-making-scotlands-route-map-through-out-crisis/govscot%3Adocument/covid-19-framework-decision-making-scotlands-route-map-through-out-crisis.pdf [cited 14 January 2026].

[84] Scottish Government. ***Coronavirus (COVID-19): Scotland's Strategic Framework***. 30 October 2020. gov.scot/publications/covid-19-scotlands-strategic-framework

[85] Scottish Government. ***National Clinical Guidance for Community Child Health Services staff during COVID-19: update letter***. 17 December 2021. publications.scot.nhs.uk/files/dc20211217covid-19.pdf

[86] Sharma A, Cockerill H, Sanctuary L. Mary D Sheridan's From Birth to Five Years. 5th edition. Routledge; 2021.

[87] Public Health Scotland. ***Early child development statistics: Scotland 2023 to 2024***. 29 April 2025. publichealthscotland.scot/publications/early-child-development/early-child-development-statistics-scotland-2023-to-2024

[88] NHS Highland. *Developmental concerns for preschool aged children (Paediatric Guidelines).* Right Decisions: TAM NHS Highland; [cited 14 January 2026]. https://www.rightdecisions.scot.nhs.uk/tam-treatments-and-medicines-nhs-highland/paediatric-therapeutic-guidelines/community-paediatrics-development-paediatric-guidelines/developmental-concerns-for-preschool-aged-children-paediatric-guidelines/

[89] Health and Social Care Scotland. ***Highland HSCP overview: lead-agency model***. hscscotland.scot/hscps/highland.html

[90] The Highland Council. ***Update on the Implementation of the Refreshed Universal Pathway for Health Visiting***. Education, Children and Adult Services Committee; 18 May 2016.

highland.gov.uk/download/meetings/id/70219/item_10_update_on_the_implementation_of_the_refreshed_universal_pathway_for_health_visiting

[91] The Highland Council. NHS Highland Assurance Report. Care, Learning and Housing Committee; 14 March 2019. highland.gov.uk/download/meetings/id/75031/item_7_nhs_highland_assurance_report

[92] Public Health Scotland. Childhood immunisation statistics Scotland: quarter ending 30 September 2025. Edinburgh: PHS; 16 Dec 2025. https://publichealthscotland.scot/publications/childhood-immunisation-statistics-scotland/childhood-immunisation-statistics-scotland-quarter-ending-30-september-2025/

[93] Public Health Scotland. Scotland's 5-year Vaccination and Immunisation Framework and Delivery Plan. Edinburgh: PHS; 2024. https://publichealthscotland.scot/publications/scotlands-5-year-vaccination-and-immunisation-framework-and-delivery-plan/

[94] Public Health Scotland. Scottish Vaccination and Immunisation Programme, Scotland's 5-year plan, goals and links. 2025. https://publichealthscotland.scot/population-health/health-protection/immunisation-vaccine-and-preventable-disease/scottish-vaccination-and-immunisation-programme-svip/scotlands-5-year-plan/

[95] Scottish Public Health Observatory. Immunisations: children, data and inequalities [Internet]. Glasgow: ScotPHO; 2025. Available from: https://www.scotpho.org.uk/health-conditions/immunisations/data/children/

[96] NHS Highland Public Health Intelligence. Childhood Immunisation Uptake in NHS Highland: Quarterly Report: NHSH; 22 Dec 2025. Data available from: https://www.opendata.nhs.scot/dataset/childhood-immunisation-statistics [cited 9 Jan 2026]

[97] Public Health Scotland. Measles, data and surveillance: disease surveillance [Internet]. Edinburgh: PHS; updated 18 Dec 2025. Available from: https://publichealthscotland.scot/population-health/health-protection/infectious-diseases/measles/data-and-surveillance/disease-surveillance/ [cited 9 Jan 2026].

[98] Public Health Scotland. Protecting the population of Scotland from vaccine-preventable diseases: Vaccination and Immunisation Report in 2024. Edinburgh: PHS; 2025. https://publichealthscotland.scot/publications/protecting-the-population-of-scotland-from-vaccine-preventable-diseases-vaccination-and-immunisation-report/protecting-the-population-of-scotland-from-vaccine-preventable-diseases-vaccination-and-immunisation-report-in-2024/

[99] BBC News. Vaccination plea after measles cases rise in Scotland. London: BBC; 28 May 2025 [updated 29 May 2025]. https://www.bbc.co.uk/news/articles/c5y5lwlxxp5o

[100] Public Health Scotland. Further changes to childhood vaccinations in Scotland. 2025. https://publichealthscotland.scot/news/2025/december/further-changes-to-childhood-vaccinations-in-scotland/

[101] NHS Highland. Immunisation and vaccines: local flexibility and mixed model for Highland. Inverness: NHS Highland; 2025. https://www.nhshighland.scot.nhs.uk/health-and-wellbeing/immunisation-and-vaccines/

[102] Pentland L, Patel S. Scottish pre-school vision screening: first three years of national data. British and Irish Orthoptic Journal. 2020;16(1):13–18. https://bioj-online.com/articles/10.22599/bioj.138

[103] Public Health Scotland. Child health pre-school review coverage 2023 to 2024. Official statistics. 2025-04-29. https://publichealthscotland.scot/publications/child-health-pre-school-review-coverage/child-health-pre-school-review-coverage-2023-to-2024/

[104] Scottish Executive. Health for All Children 4: Guidance on Implementation in Scotland. Edinburgh: Scottish Executive; 2005. https://www.gov.scot/publications/health-children-4-guidance-implementation-scotland-2005/

[105] NHS Highland. Pre-school vision screening. Service information page. https://www.nhshighland.scot.nhs.uk/your-services/all-services-a-z/screening-programmes/pre-school-vision-screening/

[106] NESTA. Why do the early years matter so much for later life? https://www.nesta.org.uk/toolkit/why-do-the-early-years-matter-so-much-for-later-life/

[107] NESTA. A fairer start The Challenge https://www.nesta.org.uk/fairer-start/

[108] Public Health Scotland. Early child development Scotland 2023 to 2024 https://publichealthscotland.scot/publications/early-child-development/early-child-development-statistics-scotland-2023-to-2024/

[109] Cattan.S, Fitzsimons.E, Goodman.A, Phimister.A, Ploubidis.G.B, Wertz.J, Early childhood inequalities, *Oxford Open Economics*, Volume 3, Issue Supplement_1, 2024, Pages i711–i740, https://doi.org/10.1093/ooec/odad072

[110] NESTA. Inequality and early child development in Scotland - three insights from the data 2025 https://www.nesta.org.uk/blog/inequality-and-early-child-development-in-scotland-three-insights-from-the-data/

[111] Scottish Government. MyGov.Scot Funded early learning and childcare for 2 year olds. https://www.mygov.scot/childcare-costs-help/funded-early-learning-and-childcare-for-2-year-olds

[112] Scottish Government Funded Early Learning and Childcare Statistics 2025 https://www.gov.scot/publications/funded-early-learning-and-childcare-statistics-2025/

[113] Scottish Government. Scottish Household Survey 2024 Childcare. 2025

https://www.gov.scot/publications/scottish-household-survey-2024-childcare/

[114] Scottish Government National parenting strategy: making a positive difference to children and young people through parenting. https://www.gov.scot/publications/national-parenting-strategy-making-positive-difference-children-young-people-through/

[115] NHS Inform. Read Steady Baby! https://www.nhsinform.scot/ready-steady-baby/

[116] Scottish Book Trust. About Bookbug https://www.scottishbooktrust.com/reading-and-stories/bookbug/about-bookbug

[117] Scottish Government. A healthier future: Scotland's diet and healthy weight delivery plan. 2018. https://www.gov.scot/publications/healthier-future-scotlands-diet-healthy-weight-delivery-plan/

[118] UK Chief Medical Officers' Physical Activity Guidelines. (2019). Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf

[119] Public Health Scotland. (2025, 09 17). Estimating the burden of disease attributable to physical inactivity in Scotland. Retrieved from Public Health Scotland: https://publichealthscotland.scot/publications/estimating-the-burden-of-disease-attributable-to-physical-inactivity-in-scotland/estimating-the-burden-of-disease-attributable-to-physical-inactivity-in-scotland-17-september-2024/

[120] Scottish Government Physical activity for health: framework Published 2024 https://www.gov.scot/publications/physical-activity-health-framework/pages/8/

[121] Meir. D & Scott.D. Getting the inactive active: Barriers to physical activity and potential policy solutions

https://digitalpublications.parliament.scot/ResearchBriefings/Report/2025/9/11/49052aad-e322-4a0e-9ba2-c8c37b8ecc61#Introduction

[122] University of Glasgow Health Behaviour in School-aged Children (HBSC) Scotland Study Report 2022 https://www.gla.ac.uk/schools/healthwellbeing/research/mentalhealth/projects/healthbehaviourinschool-agedchildrenhbscscotlandstudy/

[123] Gale A, Teuton J. Place and Well-being Outcomes Briefing: Movement Theme. Improvement Service; 2024. https://www.improvementservice.org.uk/__data/assets/pdf_file/0024/51873/Place-and-Wellbeing-Outcomes-Briefing-Movement.pdf

[124] Public Health Scotland. Health Impact Scoping of Active Travel Strategy Guidance. Edinburgh: Public Health Scotland; 2023. https://publichealthscotland.scot/media/17878/health-impact-scoping-of-active-travel-strategy-guidance-feb23.pdf

[125] Scottish Government Physical activity for health: framework; 2024 https://www.gov.scot/publications/physical-activity-health-framework/

[126] Scottish Government. Public Health Priorities for Scotland. Edinburgh: Scottish Government; 2018. https://www.gov.scot/publications/scotlands-public-health-priorities/documents/

[127] Highland Alcohol and Drugs Partnership. Highland Alcohol and Drugs Partnership 2025/2026 – 2029/2030 Strategic Plan. 2025. https://www.highland-adp.org.uk/wp-content/uploads/2025/11/Highland-Alcohol-and-Drugs-Partnership-Strategic-Plan-2025-2030.pdf

[128] Scottish Government. A Review of the Existing Literature and Evidence on Young People Experiencing Harms from Alcohol and Drugs in Scotland. 2021. https://www.gov.scot/publications/review-existing-literature-evidence-young-people-experiencing-harms-alcohol-drugs-scotland/

[129] Planet Youth. Planet Youth and the Icelandic Prevention Model. https://planetyouth.org/the-icelandic-prevention-model/

[130] O'Gorman A, Govenden S, Matthewson F. Drug-Related Deaths Among Young People in a Scottish Region: A Socio-Ecological Autopsy Approach to Understanding the Context of Drug Deaths. Nordic Studies on Alcohol and Drugs. 2025;42(5-6):499-513. https://doi.org/10.1177/14550725251370436

[131] Scottish Government. Families Affected by Drug and Alcohol Use in Scotland: A Framework for Holistic Whole Family Approaches and Family Inclusive Practice. 2021. https://www.gov.scot/publications/improving-holistic-family-support-towards-whole-family-approach-family-inclusive-practice-drug-alcohol-services/

[132] Public Health Scotland. Consensus approach on prevention of substance use harm among children and young people. 2025. https://publichealthscotland.scot/publications/consensus-approach-on-prevention-of-substance-use-harm-among-children-and-young-people/

[133] Scottish Government. Young people accessing support or treatment for alcohol and drugs: standards 2025. https://www.gov.scot/publications/standards-young-people-accessing-treatment-support-alcohol-drugs-november-2025/

[134] Paruthi S, Brooks LJ, D 'Ambrosio C. et al. Recommended amount of sleep for pediatric populations: a consensus statement of the American Academy of Sleep Medicine. *Journal of Clinical Sleep Medicine*. 2016;12(06):785-786. Available at: https://doi.org/10.5664/jcsm.5866 and at https://jcsm.aasm.org/doi/pdf/10.5664/jcsm.5866

[135] Yang FN, Xie W, Wang Z. Effects of sleep duration on neurocognitive development in early adolescents in the USA: a propensity score matched, longitudinal, observational study. *Lancet Child Adolescent Health.* 2022;6(10):705-712. Available at: https://doi:10.1016/S2352-4642(22)00188-2 and at https://pmc.ncbi.nlm.nih.gov/articles/PMC9482948/pdf/nihms-1828368.pdf
[136] NHS Scotland. *Right Decisions: NHS Highland Sleep pathway (Paediatric Guidelines)*. NHS Scotland, Edinburgh, 2025. Available at: https://www.rightdecisions.scot.nhs.uk/tam-treatments-and-medicines-nhs-highland/paediatric-therapeutic-guidelines/community-paediatrics-development-paediatric-guidelines/sleep-pathway-paediatric-guidelines/.
[137] Allen SL, Howlett MD, Coulombe JA et al. ABCs of SLEEPING: a review of the evidence behind pediatric sleep practice recommendations. *Sleep Medicine Reviews* 2016; 29:1–14. Available at: https://doi.org/10.1016/j.smrv.2015.08.006
[138] Keys E, Kendzerska T. Promoting sleep health in children and youth: application of the population health promotion model. *European Journal of Public Health*. 2025; 35(4):594-596. Available at: https://doi:10.1093/eurpub/ckaf094 . and at https://pubmed.ncbi.nlm.nih.gov/40740018/
[139] Johnson DA, Stranges S. Time to act: dismantling social barriers to healthy sleep across the life-course. *European Journal of Public Health*. 2025; 35 (4):593–594. Available at: https://doi.org/10.1093/eurpub/ckaf093

[140] NHS Scotland. *Right Decisions: NHS Highland Sleep pathway (Paediatric Guidelines)*. NHS Scotland, Edinburgh, 2025. Available at: https://www.rightdecisions.scot.nhs.uk/tam-treatments-and-medicines-nhs-highland/paediatric-therapeutic-guidelines/community-paediatrics-development-paediatric-guidelines/sleep-pathway-paediatric-guidelines/
[141] Scottish Public Health Observatory (ScotPHO). Children and Young People ScotPHO Profiles. Scottish Public Health Observatory. Edinburgh, 2025. Source data available at: https://scotland.shinyapps.io/ScotPHO_profiles_tool/
[142] Childsmile. Childsmile National Headline Data Report. Glasgow: University of Glasgow; 2024. https://www.childsmile.nhs.scot/wp-content/uploads/Childsmile_National_Headline_Data_Report-December-2024.pdf

[143] Public Health Scotland. National dental inspection programme 2025**.** Edinburgh: PHS; 2025. https://publichealthscotland.scot/publications/national-dental-inspection-programme/national-dental-inspection-programme-2025/

[144] Public Health Scotland. **Dental statistics: NHS registration and participation**. A National Statistics publication for Scotland; 24 Jan 2023. Available from: https://publichealthscotland.scot/publications/dental-statistics-registration-and-participation/dental-statistics-nhs-registration-and-participation-24-january-2023 [cited 18 Jan 2026].

[145] Public Health Scotland. NHS dental data monitoring report – Quarter ending September 2025. Edinburgh: PHS; 25 Nov 2025. Denominator note: coverage percentages use NRS 2022 mid-year estimates. Available from: https://publichealthscotland.scot/publications/nhs-dental-data-monitoring-report/nhs-dental-data-monitoring-report-quarter-ending-september-2025/ [cited 18 Jan 2026].

[146] Public Health Scotland. **NHS dental data monitoring report – Quarter ending September 2024**. Edinburgh: PHS; 26 Nov 2024. Denominator note: coverage percentages use **NRS 2021** mid-year estimates. Available from: https://publichealthscotland.scot/publications/nhs-dental-data-monitoring-report/nhs-dental-data-monitoring-report-quarter-ending-september-2024 [cited 18 Jan 2026].

[147] Goulart MdA, Sherriff A, Conway DI, McMahon AD. **Poor child oral health and school absences: a population-wide data linkage study**. ***J Epidemiol Community Health.*** 2025; Epub ahead of print. Available from: https://jech.bmj.com/content/jech/early/2025/07/06/jech-2025-223754.full.pdf [cited 18 Jan 2026

[148] NHS Highland. Young People's Sexual Health Needs Assessment for Highland and Argyll & Bute's Remote and Rural Communities. Phase 1 (2025).

[149] Healthcare Improvement Scotland. Sexual Health Standards. Jan 2022 (v4 PDF Feb 2024). [cited 2025 Nov 28] Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/02/SH-Standards-v4.0-1.pdf

[150] Scottish Government. Delivery of RSHP education in Scottish schools: draft guidance. 2023. https://www.gov.scot/publications/guidance-delivery-relationships-sexual-health-parenthood-rshp-education-scottish-schools/

[151] NHS Highland Engagement Hub. ***Young People's Engagement – Let's Talk About Sexual Health (Phase 2).*** Page updated 6 Jan 2026.[cited 2026 Jan 20]. Available from: https://nhsh.uk.engagementhq.com/young-people-sexual-health-services

[152] Education Scotland. Health and Wellbeing – Curriculum for Excellence (Curriculum areas overview). Updated 31 Oct 2025 [Internet]. [cited 2026 Jan 20]. Available from: https://education.gov.scot/curriculum-for-excellence/curriculum-areas/health-and-wellbeing/

[153] RSHP *Home – RSHP.scot (national teaching and learning resource aligned to CfE)* [Internet]. [cited 2026 Jan 20]. Available from: https://rshp.scot/

[154] Scottish Government. *Delivery of RSHP education in Scottish schools: draft guidance.* Aug 2023 [Internet]. [cited 2026 Jan 20]. Available from: https://www.healthyrespect.co.uk/wp-content/uploads/2023/08/guidance-delivery-relationships-sexual-health-parenthood-rshp-education-scottish-schools.pdf

[155] NSPCC Learning. Online risks to children: evidence review (2017–2023). Nov 2023 [Internet]. Available from: https://learning.nspcc.org.uk/research-resources/2023/Online-risks-to-children-evidence-review [cited 2026 Jan 20].

[156] The Guardian. ***Children's exposure to porn is higher than before the 2023 Online Safety Act, a poll finds.*** 18 Aug 2025 [Internet]. Available from: https://www.theguardian.com/society/2025/aug/18/children-exposure-to-porn-online-safety-act-commissioner [cited 2026 Jan 20]

[157] The Independent. ***Ofcom investigates 34 pornography sites under new age-check rules.*** 31 Jul 2025 [Internet]. Available from: https://www.independent.co.uk/tech/ofcom-peter-kyle-b2799503.html [cited 2026 Jan 20].

[158] The Guardian. ***UK porn traffic down since the beginning of age checks but VPN use up, says Ofcom.*** 10 Dec 2025 [Internet]. Available from: https://www.theguardian.com/society/2025/dec/10/uk-porn-traffic-down-age-checks-vpn-use-up-ofcom [cited 2026 Jan 20].

[159] NSPCC. ***Increase in number of 'sextortion' contacts received by Childline.*** 6 Sep 2024 [Internet]. Available from: https://www.nspcc.org.uk/about-us/news-opinion/2024/sextrortion-contacts-increase/ [cited 2026 Jan 20].

[160] Police Scotland. ***Get Help or Get Caught: tackling online child sexual abuse and exploitation.*** News; 1 Jul 2024 [Internet]. Available from: https://www.scotland.police.uk/what-s-happening/news/2024/july/get-help-or-get-caught-tackling-online-child-sexual-abuse-and-exploitation/ [cited 2026 Jan 20].

[161] Police Scotland. ***Online Child Sexual Abuse – campaign overview and figures (2023/24).*** 2024 [Internet]. Available from: https://www.scotland.police.uk/what-s-happening/campaigns/2024/online-child-sexual-abuse/ [cited 2026 Jan 20]

[162] NSPCC. ***Online grooming crimes against children have increased by 89% in six years.*** 1 Nov 2024 [Internet]. Available from: https://www.nspcc.org.uk/about-us/news-opinion/2024/online-grooming-crimes-increase/ [cited 2026 Jan 20].

[163] Public Health Scotland Congenital Conditions and Rare Diseases Registration and Information Service for Scotland (CARDRISS). 2025. https://publichealthscotland.scot/population-health/conditions-and-diseases/disease-registration/congenital-conditions-and-rare-diseases-registration-and-information-service-for-scotland-cardriss/overview/

[164] Public Health Scotland. Scottish Burden of Disease Study 2019 Summary of health loss in Highland. 2021. https://www.scotpho.org.uk/media/2321/2021-09-21 scottishburdenofdisease-highland-revised.pdf

[165] Social Security Scotland. Nov 2025. Child Disability Payment: statistics to 30 September 2025 https://www.socialsecurity.gov.scot/publications/2025/11/child-disability-payment-statistics-to-30-september-2025

[166] Scottish Government. National Neurodevelopmental Specification for Children and Young People: Principles and Standards of Care. 2021. https://www.gov.scot/publications/national-neurodevelopmental-specification-children-young-people-principles-standards-care/

[167] Scottish Government. Learning Disabilities, Autism and Neurodivergence Bill: consultation. 2023. https://www.gov.scot/publications/learning-disabilities-autism-neurodivergence-bill-consultation/

[168] Scottish ADHD Coalition. ADHD in Scotland. 2025. https://www.scottishadhdcoalition.org/adhd-in-scotland/

[169] Maciver D, Rutherford M, Johnston L, Roy A. Prevalence of neurodevelopmental differences and autism in Scottish primary schools 2018–2022. Autism Research, 2023:16(12), 2403-2414. https://doi.org/10.1002/aur.3063

[170] Adam B. SPICe Briefing: Neurodevelopmental Pathways and Waiting Times in Scotland. 2025. https://digitalpublications.parliament.scot/ResearchBriefings/Report/2025/6/24/

[171] Scottish Government. Child And Adolescent Mental Health Services: national service specification. 2020. https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/

[172] Public Health Scotland. Child health data and intelligence: deaths. Glasgow: PHS; 2024. Available from: https://publichealthscotland.scot/population-health/early-years-and-young-people/child-health-data-and-intelligence/information-on-child-health-held-across-phs/deaths/ [cited 2026 Jan 16].

[173] ScotPHO. Pregnancy outcomes: stillbirth, neonatal and infant deaths, and maternal deaths. Edinburgh: ScotPHO; 2024. Available from: https://www.scotpho.org.uk/population-dynamics/pregnancy-births-and-maternity/data/pregnancy-outcomes-stillbirth-neonatal-and-infant-deaths-and-maternal-deaths/ [cited 2026 Jan 16].

[174] Sands and Tommy's Joint Policy Unit. Saving Babies' Lives 2024: Scotland briefing. London: Sands and Tommy's; 2024. Available from: https://www.sands.org.uk/sites/default/files/Saving_Babies_Lives_2024_Scotland_Briefing.pdf [cited 2026 Jan 16].

[175] Healthcare Improvement Scotland and Care Inspectorate. National Hub for reviewing and learning from the deaths of children and young people: data release, year ending 31 March 2024. Glasgow: HIS; 2025. Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2025/05/National-Hub-for-reviewing-and-learning-from-the-deaths-of-children-and-young-people-data-release.pdf [cited 2026 Jan 16].

[176] Health and Social Care Alliance Scotland and Scottish Government Directorate for Children and Families. May 2017. Experiences of Transitions to Adult Years and Adult Services https://www.alliance-scotland.org.uk/wp-content/uploads/2017/11/ALLIANCE-GIRFEC-Experiences-of-Transitions-to-Adult-Years-and-Adult-Services-2017-1.pdf

[177] Scottish Government, 2023. Transitions to adulthood for disabled young people: literature review. https://www.gov.scot/publications/literature-review-transitions-adulthood-disabled-young-people/

[178] ARC Scotland. Scottish Transitions Forum 2017. Principles of Good Transitions 3. https://arcscotland.org.uk/resource/principles-of-good-transitions-3/

[179] Transport Scotland. Scotland's Road Safety Framework to 2030 [Internet]. Edinburgh: Scottish Government; 2021. Available from: https://www.transport.gov.scot/publication/scotland-s-road-safety-framework-to-2030/ [cited 2026 Jan 12].

[180] Child Accident Prevention Trust (CAPT). Policy and guidance [Internet]. Available from: https://www.capt.org.uk] [cited 2026 Jan 12]

[181] Public Health Scotland. Unintentional injuries in Scotland (annual summaries and resources) [Internet]. Available from: https://publichealthscotland.scot/healthcare-system/urgent-and-unscheduled-care/unintentional-injuries/introduction/ [cited 2026 Jan 12].

[182] Local Government Association. Building fairer towns, cities and regions: Insights from Marmot Places [Internet]. Available from: https://www.local.gov.uk/topics/social-care-health-and-integration/building-fairer-towns-cities-and-regions-insights-marmot [cited 2026 Jan 12

[183] South Lanarkshire CPP / Improvement Service. Collaboration for Health Equity in Scotland (CHES) — Marmot 8 principles in practice [Internet]. Available from: https://www.southlanarkshire.gov.uk/cp/info/3/learning_in_communities/165/collaboration_for_health_equity_in_scotland [cited 2026 Jan 12]

[184] NHS Highland Public Health Intelligence. Unintentional injuries in children and young people — supplementary report. Publication date: 22 July 2024. [Internal NHS Highland Public Health Intelligence report.] [cited 2026 Jan 12].

[185] Scottish Public Health Observatory (ScotPHO). Unintentional injuries: a short evidence briefing [Internet]. 2018 Sep 05. Available from: https://www.scotpho.org.uk/media/1686/efa-unintentional-injury-short-evidence-briefing-20180905.pdf [cited 2026 Jan 12].

[186] NFU & HSE. Quad bikes on farm – health & safety reminder [Internet]. 2025 Jul 21. Available from: https://www.nfuonline.com/news/quad-bikes-on-farm-health-and-safety-reminder/ [cited 2026 Jan 12].

[187] Ablewhite J, McDaid L, Hawkins A, Peel I, Goodenough T, Deave T, et al. Parental perceptions of barriers and facilitators to preventing child unintentional injuries within the home: a qualitative study. BMC Public Health. 2015;15:280. [Available from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1621-2] [cited 2026 Jan 12].

[188] Morrongiello BA, Klemencic N, Corbett M. Interactions between child behaviour patterns and parent supervision: implications for children's risk of unintentional injury. Child Dev. 2008;79(3):627–638. [Available from: https://doi.org/10.1111/j.1467-8624.2008.01147.x] [cited 2026 Jan 12]

[189] NSPCC Learning. Case reviews – hearing the voice of the child. 2024. [Available from: https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/voice-child] [cited 2026 Jan 12].

[190] Royal College of Paediatrics and Child Health. State of Child Health 2020 – Resources [Available from: https://stateofchildhealth.rcpch.ac.uk/] [cited 2026 Jan 12].

[191] Scottish Government. *Fire and smoke alarms: the law* [Internet]. Updated 2024 Aug 14 [cited 2026 Jan 12]. Available from: https://www.gov.scot/publications/fire-and-smoke-alarms-in-scottish-homes/

[192] mygov.scot. *Fire safety if you own your home* [Internet]. Updated 2025 Jul 22 [cited 2026 Jan 12]. Available from: https://www.mygov.scot/home-fire-safety

[193] The Highland Council. *Low Income Home-Owners Assistance Scheme: Fire alarms* [Internet]. [cited 2026 Jan 12]. Available from: https://www.highland.gov.uk/firealarmgrant

[194] The Highland Council / ILM Highland. *Sutherland Care & Repair Service* [Internet]. [cited 2026 Jan 12]. Available from: https://www.highland.gov.uk/download/downloads/id/15703/sutherland_care_and_repair_leaflet.pdf

[195] NHS Highland & Highland Third Sector Interface. *Highland Directory of Support Services* [Internet]. 2025 Jun 3. Available from: https://www.nhshighland.scot.nhs.uk/signposts/highland-directory-of-support-services/

[196] Children and young people improvement collaborative. Tow year old uptake https://cypic.co.uk/focus/early-child-development/two-year-uptake/ [Accessed 29/01/2026]

[197] Scottish Government. Drivers and barriers Drivers and barriers to uptake of early learning and childcare among two year oldshttps://www.gov.scot/publications/drivers-barriers-uptake-early-learning-childcare-amongst-2-year-olds/

[198] Highland Council. Early Learning and Childcare Providers in Highland https://experience.arcgis.com/experience/c7209e75aa1f46f2802e1de469eefbb9 [Accessed 29/01/2026]

[199] Education Scotland. Improving attendance: understanding the issues. 2023. https://education.gov.scot/media/3kdenpq4/improving-attendance-understanding-the-issues-101123-pw.pdf

[200] McCluskey, G., Robertson, L., & Taylor, A. (2025). School Exclusion Policy in Scotland: Investigating Policy Levers, Drivers and Warrants. Scottish Educational Review, 55(1-2), 87-110. https://doi.org/10.1163/27730840-bja10009

[201] Administrative Data Research UK. 2024. Data Insight: Understanding exclusions in Scottish secondary schools https://www.adruk.org/news-publications/publications-reports/data-insight-understanding-exclusions-in-scottish-secondary-schools/

[202] Scottish Government. Education (Additional Support for Learning) (Scotland) Act 2004.

[203] Jindal-Snape D. Transitions from Early Years to Primary and Primary to Secondary Schools in Scotland. In T. Bryce, W. Humes, D. Gillies, & A. Kennedy (Eds.), *Scottish Education* (5th ed.). Edinburgh: Edinburgh University Press; 2018.

[204] West P, Sweeting H, Young R. Transition matters: pupils' experiences of the primary–secondary school transition in the West of Scotland and consequences for well-being and attainment. Research Papers in Education . 2010 Sep 10;25(1):21–50. http://eprints.gla.ac.uk/82559/

[205] Bradshaw P, Hall J, Hill T, Mabelis J, Philo D. Growing up in Scotland : early experiences of primary school : the transition to school. Edinburgh: Scottish Government; 2012.

[206] Scottish Government 2020 Deferred entry to primary school: statistics https://www.gov.scot/publications/deferred-entry-primary-school-statistics/

[207] Divya Jindal-Snape, Cantali D, MacGillivray S, Hannah E. Primary-Secondary Transitions: A Systematic Literature Review. Discovery - the University of Dundee Research Portal. Scottish Government; 2019. https://discovery.dundee.ac.uk/en/publications/primary-secondary-transitions-a-systematic-literature-review

[208] Gilbert A, Smith N, Knudsen L, Divya Jindal-Snape, Bradshaw P. Transition from Primary to Secondary School. 2021.

[209] Hannah EF, Topping KJ. Anxiety Levels in Students with Autism Spectrum Disorder Making the Transition from Primary to Secondary School. Education and Training in Autism and Developmental Disabilities. 2012 Jun;47(2):198–209.

[210] Hannah EF, Topping, KJ. The transition from primary to secondary school: Perspectives of students with autism spectrum disorder and their parents. International Journal of Special Education. 2013;28(1), 1-16.

[211] Scottish Government. 2012 Opportunities for All: supporting all young people to participate in post-16 learning, training or work https://www.gov.scot/publications/opportunities-supporting-young-people-participate-post-16-learning-training-work/

[212] Skills Development Scotland. Modern Apprenticeship Statistics Financial Year 2024/25 https://www.skillsdevelopmentscotland.co.uk/media/qqqn3kz4/modern-apprenticeship-statistics-quarter-4-2024-25.pdf

[213] Public Health Scotland. Publications and resources – Health inequalities. Edinburgh: PHS; 2024 Oct 22. https://publichealthscotland.scot/population-health/social-and-economic-impacts-on-health/equity-and-justice/health-inequalities/publications-and-resources/

[214] Highland Community Planning Partnership. Highland Promise Board 2025-2028. https://highlandcpp.org.uk/wp-content/uploads/2025/04/Highland-Promise-Plan-2025-2028.pdf.pagespeed.ce.yIyl57eCfx.pdf

[215] Scottish Government. Longitudinal quantitative evidence review for Keeping The Promise: health and wellbeing of care experienced children and young people. 2025. https://www.gov.scot/publications/longitudinal-quantitative-evidence-review-keeping-promise-health-wellbeing-care-experienced-children-young-people/

[216] Scottish Government. Preventing and responding to gender based violence: a whole school framework. March 2024. https://www.gov.scot/publications/preventing-responding-gender-based-violence-whole-school-framework/

[217] Save The Children. Children and Gender-based violence: An overview of existing conceptual frameworks (Discussion paper). 2007. https://resourcecentre.savethechildren.net/pdf/1530.pdf

[218] Scottish Government. Recorded Crime in Scotland 2024-25. Supporting documents. June 2025. Supporting documents - Recorded Crime in Scotland, 2024-25 - gov.scot

[219] Scottish Government. Scotland's national action plan to prevent and eradicate FGM. February 2016. Scotland's national action plan to prevent and eradicate FGM - gov.scot

[220] Scottish Government. National Missing Persons Framework for Scotland 2025. September 2025. https://www.gov.scot/publications/national-missing-persons-framework-scotland-2025/

[221] Scottish Government. 2023. National Guidance for Child Protection in Scotland 2021 - updated 2023 https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021-updated-2023/

[222] Scottish Government. 2025. Scotland's Trafficking and Exploitation Strategy 2025 https://www.gov.scot/publications/scotlands-trafficking-exploitation-strategy-2025/

[223] UK Government Home Office. 2025. National referral mechanism guidance: adult (Northern Ireland and Scotland)https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/national-referral-mechanism-guidance-adult-northern-ireland-and-scotland

[224] NSPCC. https://www.nspcc.org.uk/about-us/news-opinion/2025/data-shows-how-criminals-are-using-private-messaging-platforms-to-manipulate-and-groom-children/

[225] UK Government Home Office. 2025. Modern slavery: National Referral Mechanism and Duty to Notify statistics UK, end of year summary 2024 https://www.gov.uk/government/statistics/modern-slavery-nrm-and-dtn-statistics-end-of-year-summary-2024/modern-slavery-national-referral-mechanism-and-duty-to-notify-statistics-uk-end-of-year-summary-2024

[226] National Crime Agency. County Lines https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines

[227] Dixon, N. 2023 Understanding Child Criminal Exploitation in Scotland: A Scoping Review https://www.cycj.org.uk/wp-content/uploads/2023/05/Understanding-Child-Criminal-Exploitation-in-Scotland.pdf

[228] Police Scotland. 2022 Scottish Multi-agency Strategic Threat Assessment 2022 Overview https://www.scotland.police.uk/spa-media/5itlmput/smasta-2022-official-july-2022.pdf

229 McGinty.J, Scott.J, Welsh. J and Sills.R. 2024 Child Sexual Abuse and Exploitation 2024. Overview analysis to inform prevention and response. Centre for Excellence for Children's Care and Protection https://www.celcis.org/application/files/5717/3168/8745/CELCIS_Child_Sexual_Abuse_and_Exploitation_2024_Overview_Analysis_Report_-_November_2024.pdf

[230] The NSPCC. 2025 Data shows how criminals are using private messaging platforms to manipulate and groom children https://www.nspcc.org.uk/about-us/news-opinion/2025/data-shows-how-criminals-are-using-private-messaging-platforms-to-manipulate-and-groom-children/

[231] The NSPCC. 2024 Online grooming crimes against children increase by 89% in six years

https://www.nspcc.org.uk/about-us/news-opinion/2024/online-grooming-crimes-increase/

[232]Scottish Government. 2023. Criminal exploitation: practitioner guidance

https://www.gov.scot/publications/practitioner-guidance-criminal-exploitation/pages/1/

[233] Children and Young people's centre for Justice. 2025 The Criminal Exploitation of Children. Scotland's Framework for Practice https://www.cycj.org.uk/wp-content/uploads/2025/08/Scotlands-Framework-for-Practice-The-Criminal-Exploitation-of-Children-2025.pdf

[234] Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. Fair Society, Healthy Lives: The Marmot Review . London: Institute of Health Equity; 2010. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

[235] Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. Annu Rev Public Health . 2019;40:105-125. https://doi.org/10.1146/annurev-publhealth-040218-043750

[236] Safia Mirza H, Warwick R. Race and ethnicity. London: Institute for Fiscal Studies, 2022. https://ifs.org.uk/sites/default/files/2022-11/Race-and-ethnicity-IFS-Deaton-Review-of-Inequalities.pdf

[237] NHS Highland. Equality Outcomes 2025–2029 . Inverness: NHS Highland; 2025. https://www.nhshighland.scot.nhs.uk/media/rsdm0e2k/equality-outcomes-2025-2029.pdf

[238] Highland Community Planning Partnership. Highland Outcome Improvement Plan 2024–2027 . Inverness: HCPP; 2024. https://highlandcpp.org.uk/revised-highland-outcome-improvement-plan/

[239] Scotland's Census 2011. Table LC2102SC – National identity by Census Output Areas. Edinburgh: National Records of Scotland; 2013. https://www.scotlandscensus.gov.uk/search-the-census#/topics/list?topic=Ethnicity,%20Identity,%20Language%20and%20Religion&categoryId=4

[240] Scotland's Census 2022. Table UV202 – National identity by Census Output Areas. Edinburgh: National Records of Scotland; 2023. https://www.scotlandscensus.gov.uk/search-the-census#/topics/list?topic=Ethnic%20group,%20national%20identity,%20language%20and%20religion&categoryId=1

[241] Scottish Government. School Pupil Census 2024. Summary statistics for schools in Scotland. https://www.gov.scot/collections/school-education-statistics/

[242] British Council. Language trends Scotland 2024/25 . https://scotland.britishcouncil.org/sites/default/files/language_trends_2024_scotland_report.pdf

[243] Scotland's Census 2022. Table UV205a – Religion by Census Output Areas. Edinburgh: National Records of Scotland; 2023. https://www.scotlandscensus.gov.uk/census-results/

[244] Office for National Statistics. Religion in England and Wales: Census 2021 . London: ONS; 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/bulletins/religionenglandandwales/census2021

[245] Children and Young People's Commissioner Scotland. Rights of Religion and Belief Consultation. Edinburgh: CYPCS; 2025 Jan. https://www.cypcs.org.uk/wpcypcs/wp-content/uploads/2025/01/RO-Consultation-Jan-2025-FINAL.pdf

[246] Scottish Government. Faith and Belief Guidance for Health and Social Care Staff . Edinburgh: Scottish Government; 2023. https://www.gov.scot/publications/faith-and-belief-guidance-health-social-care-staff/

[247] NHS Education for Scotland. Religion and Belief: A Guide for NHS Staff . Edinburgh: NES; 2019. https://www.nes.scot.nhs.uk/media/bxoddw5x/religionandbelief.pdf

[248] Diversity Scotland. Scotland's Diversity Revolution. https://www.diversityscotland.co.uk/post/scotlands-diversity-revolution

[249] CRER. Ethnicity and Socio-economic Deprivation in Scotland. https://www.crer.org.uk/blog/ethnicity-and-deprivation

[250] Safia Mirza H, Warwick R. Race and ethnicity. London: Institute for Fiscal Studies, 2022. https://ifs.org.uk/sites/default/files/2022-11/Race-and-ethnicity-IFS-Deaton-Review-of-Inequalities.pdf

[251] Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. Annu Rev Public Health. 2019;40:105-125. https://doi.org/10.1146/annurev-publhealth-040218-043750

[252] Public Health Scotland. Monitoring racialised health inequalities in Scotland . Edinburgh: Public Health Scotland; 2023 May. https://publichealthscotland.scot/media/19763/monitoring-racialised-health-inequalities-in-scotland-may2023-english.pdf

[253] British Council. Language trends Scotland 2024/25. https://scotland.britishcouncil.org/sites/default/files/language_trends_2024_scotland_report.pdf

[254] Scottish Government. Achievement of Curriculum for Excellence (CfE) Levels 2022–23 . Edinburgh: Scottish Government; 2023. https://www.gov.scot/publications/achievement-of-curriculum-for-excellence-cfe-levels-2022-23/

[255] CRER. Ethnicity and Socio-economic Deprivation in Scotland. https://www.crer.org.uk/blog/ethnicity-and-deprivation

[256] Scottish Government. New Scots Refugee Integration Strategy 2024: Education and Learning . Edinburgh: Scottish Government; 2024. https://www.gov.scot/publications/new-scots-refugee-integration-strategy-2024/pages/10/

[257] Scottish Government. Race Equality Framework for Scotland 2016–2030: Education . Edinburgh: Scottish Government; 2016. https://www.gov.scot/publications/race-equality-framework-scotland-2016-2030/pages/11/

[258] United Nations High Commissioner for Refugees (UNHCR). Mental health and psychosocial support for refugees, asylum seekers and migrants on the move in Europe . Geneva: UNHCR; 2021. https://www.unhcr.org/uk/publications/mental-health-and-psychosocial-support-for-refugees-asylum-seekers-and-migrants-on-the-move-in-europe

[259] Mental Health Foundation. Mental health of asylum seekers and refugees: 2025 report . London: Mental Health Foundation; 2025 Apr https://www.mentalhealth.org.uk/sites/default/files/2025-04/MHF%20Mental%20health%20of%20asylum%20seekers%20and%20refugees%20-%202025%20report.pdf

[260] Scottish Refugee Council. Family Integration Practice Guide . Glasgow: Scottish Refugee Council; 2019 https://scottishrefugeecouncil.org.uk/wp-content/uploads/2019/10/Family_Integration_Practice_Guide_FINAL.pdf

[261] What a young carer is – mygov. scot. https://www.mygov.scot/young-carer-grant/what-a-young-carer-is

[262] Scottish Government. Young carers: review of research and data – health and wellbeing. 2017. https://www.gov.scot/publications/young-carers-review-research-data/pages/8/

[263] Carers (Scotland) Act 2016. https://www.legislation.gov.uk/asp/2016/9/contents

[264] Scottish Government. National carers strategy – 5. Young Carers. https://www.gov.scot/publications/national-carers-strategy/pages/7/

[265] Education Scotland. Supporting Young Carers in Education – resource hub and 2025 booklet. https://education.gov.scot/resources/supporting-young-carers-in-education/ and https://education.gov.scot/media/iulao1my/supporting-young-carers-in-education-booklet-apr25.pdf

[266] Lacey RE, Xue B. The mental and physical health of young carers: a systematic review. Lancet Public Health. 2022;7(9):e787–e796. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667%2822%2900161-X/fulltext

[267] Carers Trust Scotland. Scottish Young Carers Festival 2024 Report. https://education.gov.scot/media/zygemrts/sycf-2024-report.pdf

[268] Scottish Government. Carers Census, Scotland, 2022–23. https://www.gov.scot/publications/carers-census-scotland-2022-23/

[269] Social Security Scotland. Young Carer Grant statistics to 30 September 2025: Publication. https://www.socialsecurity.gov.scot/binaries/socialsecurity/publications/2025/11/young-carer-grant-statistics-to-30-september-2025/young-carer-grant-statistics-to-30-september-2025/publishing%3AcontentBlocks/publishing%3Adocument/Young-Carer-Grant-to-September-2025-Publication.pdf

[270] Highland Schools Young Carers – Young Carer Statement guidance and SEEMiS recording. https://sites.google.com/highlandschools.net/highlandschoolyoungcarers/yc-statement. https://sites.google.com/highlandschools.net/highlandschoolyoungcarers/seemis

[271] NHS Highland. Unpaid Carers Assurance Report and Refreshed Carers Strategy 2025–28. https://www.nhshighland.scot.nhs.uk/media/45bfosq3/3-2-unpaid-carers-assurance-report.pdf

[272] Scottish Government. Housing to 2040. https://www.gov.scot/publications/housing-2040-2/

[273] . Scottish Government. Ending Homelessness Together Action Plan. https://www.gov.scot/publications/ending-homelessness-together-updated-action-plan-october-2020/

[274] UNICEF. Early Chidl Development: Home Environment: https://unicefstats.jjcbigideas.com/ecd/home-environment/

[275] Hock, E.S., Blank, L., Fairbrother, H. *et al.* Exploring the impact of housing insecurity on the health and wellbeing of children and young people in the United Kingdom: a qualitative systematic review. *BMC Public Health* **24**, 2453 (2024). https://doi.org/10.1186/s12889-024-19735-9

[276] Public Health Scotland. Evidence behind the place standard tool and the place and wellbeing outcomes. https://publichealthscotland.scot/publications/evidence-behind-place-standard-tool-and-place-and-wellbeing-outcomes/evidence-behind-place-standard-tool-and-place-and-wellbeing-outcomes/

[277] Lee A, Sinha I, Boyce T, Allen J, Goldblatt P. Fuel poverty, cold homes and health inequalities in the UK . London: Institute of Health Equity; 2022 Aug. https://www.instituteofhealthequity.org/resources-reports/fuel-poverty-cold-homes-and-health-inequalities-in-the-uk/read-the-report.pdf

[278] World Health Organization. Housing and health guidelines. https://www.who.int/publications/i/item/9789241550376

[279] Balogun B, Rankl F, Wilson W. Health inequalities: Cold or damp homes . London: House of Commons Library; 2023 Feb 16. Report No.: CBP-9696. https://researchbriefings.files.parliament.uk/documents/CBP-9696/CBP-9696.pdf

[280] Lee A, Sinha I, Boyce T, Allen J, Goldblatt P. Fuel poverty, cold homes and health inequalities in the UK . London: Institute of Health Equity; 2022 Aug. https://www.instituteofhealthequity.org/resources-reports/fuel-poverty-cold-homes-and-health-inequalities-in-the-uk/read-the-report.pdf

[281] Department for Business, Energy & Industrial Strategy. Heat, energy efficiency, smart technology and health: evidence review . London: BEIS; 2020 Jul. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/905837/heat-energy-efficiency-smart-technology-health-evidence-review.pdf

[282] Public Health England. Reducing unintentional injuries in and around the home among children under five years . London: PHE; 2018 Mar. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/696646/Unintentional_injuries_under_fives_in_home.pdf

[283] Royal College of Paediatrics and Child Health. Accidental injury . London: RCPCH; 2020 Mar [updated 2021 May]. https://stateofchildhealth.rcpch.ac.uk/evidence/injury-prevention/accidental-injury/

[284] National Institute for Health and Care Excellence (NICE). Unintentional injuries: prevention strategies for under 15s . London: NICE; 2010 Nov 24. https://www.nice.org.uk/guidance/ph29

[285] National Institute for Health and Care Excellence (NICE). Unintentional injuries in the home: interventions for under 15s . London: NICE; 2010 Nov 24. https://www.nice.org.uk/guidance/ph30

[286] National Records of Scotland. Households and dwellings in Scotland: 2024 . Edinburgh: NRS; 2025 Jun 26. https://www.nrscotland.gov.uk/publications/households-and-dwellings-in-scotland-2024/

[287] National Records of Scotland. Household projections for Scotland: 2018-based . Edinburgh: NRS; 2019 Mar 20. https://www.nrscotland.gov.uk/publications/household-projections-for-scotland-2018-based/

[288] Highland Health and Social Care Partnership. Highland Joint Strategic Needs Assessment. Inverness: NHS Highland; 2025 Jun. https://www.nhshighland.scot.nhs.uk/media/1gvjjkwg/highland-joint-strategic-needs-assessment-highland-health-and-social-care-partnership.pdf

[289] Highland Council. Declaring the Highland Housing Challenge and identifying solutions to resolve it . Inverness: Highland Council; 2024 Jun 27. https://www.highland.gov.uk/meetings/meeting/5003/highland_council/attachment/83515

[290] Office for National Statistics. Housing prices in Highland . ONS; 2025 Nov 18. https://www.ons.gov.uk/visualisations/housingpriceslocal/S12000017/

[291] Scottish Government. Private Sector Rent Statistics, Scotland, 2010 to 2025 .. Scottish Government; 2025 Nov 25. https://www.gov.scot/publications/private-sector-rent-statistics-scotland-2010-to-2025/

[292] Stone J. Local indicators of child poverty after housing costs, 2023/24: estimates of child poverty after housing costs in parliamentary constituencies and local authorities . Loughborough: Centre for Research in Social Policy, Loughborough University; 2025. https://endchildpoverty.org.uk/wp-content/uploads/2025/05/Local-indicators-of-child-poverty-after-housing-costs_2025_final-1.pdf

[293] Highland Council. Local Housing Strategy 2023–2028. https://www.highland.gov.uk/info/917/housing/658/housing_strategy

[294] Highland Council. Highland Local Development Plan. https://www.highland.gov.uk/info/178/development_plans/1101/highland_local_development_plan

[295] Scottish Government. National Planning Framework 4. https://www.gov.scot/publications/national-planning-framework-4/

[296] Highland Council. Housing Needs and Demand Assessment (HNDA) 2025: HNDA FAQs. https://www.highland.gov.uk/downloads/file/30648/housing_needs_and_demand_assessment_faqs

[297] Svirydzenka N, Lakhanpaul M, Williams J, et al. In Their Own Words: Children's Experiences in Temporary Accommodation. Shelter Scotland; 2025. https://downloads.ctfassets.net/6sqqfrl11sfj/7fSJxsqgmhFgYYeqKrH3Zd/a57139d368636ff5d954861899a3b823/-Digital-Shelter_Scotland-_In_Their_Own_Words.pdf

[298] Scottish Government. Homelessness in Scotland: 2024–25. Edinburgh: Scottish Government; 2025. https://www.gov.scot/publications/homelessness-in-scotland-2024-25/documents/

[299] Szloboda F, Spillane R, Snowden M, James L, McKenna M. Children's Rights and Homelessness in Scotland. Improvement Service; 2025. https://www.improvementservice.org.uk/__data/assets/pdf_file/0035/56996/Childrens-Rights-and-Homelessness-in-Scotland.pdf

[300] Scottish Government. Homelessness prevention: child rights and wellbeing impact assessment. Edinburgh: Scottish Government; 2024. https://www.gov.scot/publications/homelessness-prevention-child-rights-wellbeing-impact-assessment/documents/

[301] Scottish Human Rights Commission. Child Rights and Wellbeing Impact Assessment: Homelessness and Minority Groups. Edinburgh: SHRC; 2025. https://www.scottishhumanrights.com/media/3010/crwia-24032025.pdf

[302] Smart Data Research. Cold homes and child health: How smart data could protect our most vulnerable. https://www.sdruk.ukri.org/2025/05/28/cold-homes-and-childrens-health/

[303] UrbanTide. uZero to provide fuel poverty data for pioneering new health study . Edinburgh: UrbanTide; 2024 Jun 27. https://urbantide.com/uzero-fuel-poverty-data-study

[304] Public Health Scotland. Transport and health pathways. Available from: https://publichealthscotland.scot/population-health/environmental-health-impacts/transport-and-health/pathways-from-transport-to-health/

[305] Lucas K. Transport and social exclusion: Where are we now? Transport Policy. 2012;20:105–113. Available from: https://doi.org/10.1016/j.tranpol.2012.01.013

[306] Scottish Government. Tackling Child Poverty Delivery Plan: Best Start, Bright Futures. Available from: https://www.gov.scot/news/tackling-child-poverty-delivery-plan-2022-26/

[307] Transport Scotland. Social and Equality Impact Assessment (SEQIA) – National Transport Scotland(2) Delivery Plan. Available from: https://www.transport.gov.scot/publication/social-and-equality-impact-assessment-seqia-nts-delivery-plan/

[308] Public Health Scotland. Transport poverty: a public health issue. Available from: https://publichealthscotland.scot/media/24759/transport-poverty-briefing_jan2024.pdf

[309] McHardy F, Robertson L. Transport and child poverty – beyond the pandemic. Edinburgh: Transport Scotland; 2021. Available from: https://www.transport.gov.scot/media/49932/transport-and-child-poverty-beyond-the-pandemic.pdf

[310] Transport Scotland. Transport and Travel in Scotland 2023. Available from: https://www.transport.gov.scot/publication/transport-and-travel-in-scotland-2023/

[311] HITRANS. Regional Transport Strategy. Available from: https://hitrans.org.uk/regional-transport-strategy/

[312] HITRANS. Equalities Outcomes Report 2023. Available from: https://hitrans.org.uk/wp-content/uploads/2023/04/Item_15_Appendix_B_-_HITRANS_Equalities_Outcomes_Report_April_2023.pdf

[313] Scottish Government. Trend in Rural Scotland 2025: a working paper. Edinburgh, 2025. Available online: https://www.gov.scot/publications/trends-rural-scotland-working-paper-2025/pages/8/

[314] Scottish Government. Local living and 20-minute neighbourhoods: planning guidance. Available from: https://www.gov.scot/publications/scottish-government-planning-guidance-local-living-20-minute-neighbourhoods/

[315] HITRANS and SUSTRANS. Living well locally: 20-minute communities in the Highlands and Islands. Available from: https://hitrans.org.uk/wp-content/uploads/2022/07/Living_Well_Locally.pdf

[316] Transport Scotland. Year 1 evaluation - Young Persons' Free Bus Travel Scheme. Available from: https://www.transport.gov.scot/publication/year-1-evaluation-young-persons-free-bus-travel-scheme/

[317] Transport Scotland. Over 250 million free bus trips made by young people across Scotland. Available from: https://www.transport.gov.scot/news/over-250-million-free-bus-trips-made-by-young-people-across-scotland/

[318] Transport Scotland. Benefits of active travel. Available from: https://www.transport.gov.scot/active-travel/benefits-of-active-travel/

[319] Place and Wellbeing Collaborative. Place and Wellbeing: Movement theme – evidence informed links from transport to health. Edinburgh, 2024. Available from: https://www.improvementservice.org.uk/__data/assets/pdf_file/0024/51873/Place-and-Wellbeing-Outcomes-Briefing-Movement.pdf

[320] Highland Council. Active travel strategy 2024 – 2030. Available from: https://www.highland.gov.uk/download/downloads/id/28781/active_travel_strategy.pdf

[321] Public Health Scotland. Health impact scoping of active travel strategy guidance. Edinburgh, 2023. Available from: https://publichealthscotland.scot/media/17878/health-impact-scoping-of-active-travel-strategy-guidance-feb23.pdf

[322] HITRANS. Active travel and sustainable transport behaviour change strategy, 2024 – 2030. Available from: https://hitrans.org.uk/wp-content/uploads/2025/04/Active-travel-and-sustainable-transport-behaviour-change-strategy-2024-2030-final.pdf

[323] Scottish Government. Tackling the school run: research study. Edinburgh, 2017. Available from: https://www.gov.scot/publications/tackling-school-run-research-study/pages/5/

[324] Transport Scotland. Literature review – best practice in active travel and its associated benefits. Edinburgh, 2023. Available from: https://www.transport.gov.scot/publication/literature-review-best-practice-in-active-travel-and-its-associated-benefits/

[325] Scottish Government. Scottish Index of Multiple Deprivation. Available from: https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/

[326] Scottish Government. Scottish Index of Multiple Deprivation: Rural deprivation evidence review. Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2017/02/scottish-index-of-multiple-deprivation-rural-deprivation-evidence-and-case-studies/documents/rural-deprivation-an-evidence-review/rural-deprivation-an-evidence-review/govscot%3Adocument/rural%2Bdeprivation%2Bevidence%2Breview.pdf

[327] iStandUK. Scalable Approach to Vulnerability via Interoperability (SAVVI). Local Digital Funded Project [Internet]. London: Ministry of Housing, Communities and Local Government; 2020–2025. Available from: https://www.localdigital.gov.uk/funded-project/savvi/

[328] Improvement Service. SAVVI: Empowering Scotland to Support Vulnerable People, Sooner [Internet]. Improvement Service Insights; 2025. Available from: https://www.improvementservice.org.uk/insights/2025/savvi-empowering-scotland-to-support-vulnerable-people-sooner

[329] iStandUK.Reusing Data to Find Cases of Rural Child Poverty in Scotland. SAVVI, 2025. Available from: https://coda.io/d/SAVVI_d_6Lee77c0_/Reusing-Data-to-Find-Cases-of-Rural-Child-Poverty-in-Scotland_sumR0U-8

[330] Highland Council. Award of Community Transport Grants: Economy and Infrastructure Committee Report No ECI/59/2023. Inverness: Highland Council; 2023 Nov 16. Available from: https://www.highland.gov.uk/download/meetings/id/82403/item_9_award_of_community_transport_grants

[331] Scottish Government. Scottish Household Survey 2023 results: Internet. Edinburgh: Scottish Government; 2024 Dec 9. Available from:

https://www.gov.scot/publications/scottish-household-survey-2023-results-internet/

[332] Highland Council. Digital Connectivity Report: Highland Council Meeting HC/17/25. Inverness: Highland Council; 2025 May 29. Available from: https://www.highland.gov.uk/download/meetings/id/85115/item_4_digital_connectivity

[333] Laurenson J. Digital Lives of Care Experienced Children: Digital Poverty and Exclusion in Scotland. Scottish Children's Reporter Administration; 2023. https://www.scra.gov.uk/wp-content/uploads/2024/02/Digital-Lives-of-Care-Experienced-Children.pdf

[334] Glass J, Bynner C, Chapman C. Children and young people and rural poverty and social exclusion: A review of evidence. Glasgow: Children's Neighbourhoods Scotland; 2020. https://pure.sruc.ac.uk/files/49268428/improving_understanding_child_poverty_rural_island_scotland.pdf

[335] Hilton C. Joining the dots: Child poverty and the digital divide in Scotland. Good Things Foundation; 2025. https://www.goodthingsfoundation.org/discover/digital-inclusion-insights/digital-inclusion-insights-2025/child-poverty-and-digital-divide-scotland

[336] Scottish Government. Towards a Scottish Minimum Digital Living Standard: Interim Report. Edinburgh: Scottish Government; 2025. https://www.gov.scot/publications/towards-scottish-minimum-digital-living-standard-interim-report/

[337] Scottish Government. Towards a Scottish Minimum Digital Living Standard: Phase 2. Edinburgh: Scottish Government; 2025 Jul 24. Available from: https://www.gov.scot/publications/towards-scottish-minimum-digital-living-standard-phase-2/pages/4/

[338] Highland Council. Highland Schools Digital Strategy 2023–26. Inverness: Highland Council; 2023 Feb 15. Available from: https://www.highland.gov.uk/download/meetings/id/81160/item_7_highland_digital_schools_strategy_2023-26

[339] Transport Scotland. Electric Vehicle Infrastructure Fund. Available from: https://www.transport.gov.scot/our-approach/environment/electric-vehicle-infrastructure-fund/

[340] Scottish Government. Climate Change Plan 2026 - 2040. Available from: https://www.gov.scot/publications/scotlands-climate-change-plan-2026-2040/

[341] Energy Saving Trust. Barriers to EV adoption in rural Scotland. Available from: https://energysavingtrust.org.uk/advice/electric-vehicles-and-charging/

[342] Transport Scotland. MaaS Investment Fund Evaluation Final Report. Available from: https://www.transport.gov.scot/publication/investment-fund-evaluation-final-report-mobility-as-a-service-maas/

[343] Transport Scotland. Connected and Autonomous Vehicles Roadmap. Available form: https://www.transport.gov.scot/media/46708/a-cav-roadmap-for-scotland-final.pdf

[344] Centre for Civic Innovation. Child Poverty Report. Available from: https://cciglasgow.org/reports/child-poverty-report-25.pdf

[345] Allik, M., Brown, D., Gedeon, E., Leyland, A. H. and Henderson, M. (2022). CHiCS: Main findings from population-wide research. University of Glasgow. Available from: https://www.gla.ac.uk/media/Media_989673_smxx.pdf

[346] iStandUK. Scalable Approach to Vulnerability via Interoperability (SAVVI). Local Digital Funded Project [Internet]. London: Ministry of Housing, Communities and Local Government; 2020–2025. Available from: https://www.localdigital.gov.uk/funded-project/savvi/

[347] Improvement Service. SAVVI: Empowering Scotland to Support Vulnerable People, Sooner [Internet]. Improvement Service Insights; 2025. Available from: https://www.improvementservice.org.uk/insights/2025/savvi-empowering-scotland-to-support-vulnerable-people-sooner

[348] Scottish Government. Scotland's Digital Strategy: A Changing Nation. https://www.gov.scot/publications/a-changing-nation-how-scotland-will-thrive-in-a-digital-world/

[349] Scottish Government. Back to the future: Building a vision for public sector data. https://blogs.gov.scot/digital/2024/07/11/back-to-the-future-building-a-vision-for-public-sector-data/

[350] Scottish Government. Scotland's Public Service Reform Strategy: Delivering for Scotland. https://www.gov.scot/publications/scotlands-public-service-reform-strategy-delivering-scotland/

[351] Scottish Government. Artificial intelligence strategy: trustworthy, ethical and inclusive. https://www.gov.scot/publications/scotlands-ai-strategy-trustworthy-ethical-inclusive/