From: eforms@moray.gov.uk
To: Localdevelopmentplan
Subject: EL_OPP11 - 001965
Date: 18 January 2019 21:52:55

Moray Local Development Plan - Proposed Plan 2019

Your Place, Your Plan, Your Future

Your Details

Title: **Mrs**

Forename(s): **Pamela**

Surname: **Napolitano**

Your Address

[redacted]

Contact Details

[redacted]

Agent Details

Do you have an agent: **No**

Response

Do you want to object to a site?: **Yes**

Do you want to object to a policy, the vision or spatial strategy: **No**

Other: **No**

Supporting information: Download supporting document Available also via link at bottom of this email.

Site Objections

Name of town, village or grouping: **Elgin**

Site reference: **Cooper Park**

Site name: **Walled garden**

Comments: **I object to the proposed hotel being developed at this site. The walled garden is currently used by Greenfingers Training Service, Moray College and REAP who all do fantastic work. Greenfingers? trainees are adults with learning difficulties, on the autistic spectrum and those in recovery of mental health issues. The site is essential for the growing of the thousands of plants wchich are used in local community areas and our war memorials. There is no need for another hotel in Elgin unless the existing hotels are at 100% capacity all year round. There IS a need to retain this site for vulnerable adults.**

Please use this link to view and retrieve the uploaded attachments.

[redacted]

1st March 2019

Dear local Development Plan Team,

Thank you for your letter of 7th Jan 2019 informing me of the plans to extend the boundaries of Hopeman Caravan Park inviting comments.

I wish to object.

Potential Conflicts of Interest.

1) I have no family, personal, financial or business links to the council.
2) I have communicated with the council intermittently over the last 10 years raising concerns about the elevation of the land bordering the south wall of my garden.
3) I am adversely affected financially by the current position, with loss of value to my property and garden. Further loss of value is likely should there be a business development 2.0m above the height of my land.
4) Mr. and Mrs. Scott communicated with my solicitor by e mail on 13.2.19. They informed my solicitor that they had purchased the narrow strip of

land in front of my house extending from the stone work of the bay windows to the low kerb of the road, a strip some 4m wide, the length of the strip extending to the north and south boundaries of my home. (To those who know Hopeman this is part of the land in front of the tall terraced houses of 52/54 Harbour St. with 1-3 Lancaster Court i.e. at the bottom of Harbour St. on the left over looking the park.)
The e mail refers to this strip of land as "a ransom strip" "as the use of this piece of ground clearly has an impact on the value and use of the adjacent property". The e mail complains that we have made "a barrage of spurious complaints to the local authority" is a neighbour dispute and states "It would be extremely welcome if your clients became more neighbourly." I perceive this as harassment and an attempt to block free speech in order to prevent me raising my legitimate concerns with you over the proposed plans.

Objection

I object to the plan to extend the boundary of the caravan to the east and the west.

In particular I object to the eastward

extension of the caravan park to include the Platform Cottage with its garden and the land running north towards the south boundary wall of my home, [redacted]

I object on the grounds of

1) Safety

a) The stability of the land uplifted to a height of 2.0m above the gardens of 52 and 54 Harbour St. and the flat ground of the surrounding area, without engineering or structural design or Building Warrant, is in doubt. The stability of the land is crucial if vehicles, heavy plant vehicles, caravans, double decker buses or social events are planned for the sites.

b) There is a risk to the safety of people, particularly children, who are now able to gain easy access to the top of the 2.0m high garden wall bounding the south and western limits of the gardens of [redacted] Children were not able to get on to the top of this wall in the past when the ground level was the same on either side of the wall. Children risk a fall of 2.0m into our back garden (with risk of minor or serious injury or a fatal outcome depending on the landing). If this area is included in the designation of the caravan site there will be increased risk due to the increased numbers of people on site.

Objections continued.

2) <u>loss of privacy and ammenity</u> to the private back garden of [redacted]
Privacy to the garden was through a 2.0m high wall enclosing the garden with land height the same and at the base of all sides of all the boundary walls. The elevation of the land to [redacted] 2.0m high south of the garden wall means that we look up to the underside of vehicles and caravans placed there. Intrusion into our privacy is currently through the placement of a double decker bus on this land. At other times vehicles, heavy vehicles, mobile homes and a static van have been placed there. If the land is designated for business use for the caravan park there will be an exponential increase in land use and loss of privacy.

3) <u>Potential circumnavigation of usual planning regulations.</u>

The Platform Cottage was a rented residential home. The building has been converted already, possibly without planning consent, into a venue, and advertised as such. It is inappropriate to change this building into a designated caravan site building without the usual rigorous planning

Objections continued.

considerations being undertaken.
The land to the north of Platform Cottage has been elevated to the height of the adjacent wall without planning process and may not be safe to support the decking. It is inappropriate to site venues for caravan park social gatherings within the village with potential disturbance to surrounding homes. It is not as if the caravan park is in an isolated location miles from venues or shops. Facilities are already available locally.

The caravan park extended to the west into rough scrub land in the past. My recall is that the caravan bays over-extended into the scrub land by a significant amount. The westerly extension of the caravan park has had an overbearing effect on the meandering coast path. The foreshore path should be available to be enjoyed by all not just caravans.

4) Parking and Traffic flow

Harbour St. is a busy road and the only access to the beach with usual traffic including haulage vehicles, coach trips, boats being towed to and from the harbour and caravan traffic.
It would be inappropriate to site a social venue (Platform Cottage or on

Objections continued

the elevated land south of the [redacted] without dedicated parking.

Harbour St. is particularly narrow at the bridge near the steep steps leading from the caravan park. The pavement also narrows considerably here (and cannot accommodate a push-chair). There is little capacity for increased safe pedestrian passage. There is no room for additional street parking.

The road seems unlikely to be able to take increased traffic with towed or static caravans moving up and down. It would seem inappropriate to inconvenience local residents or businesses by using yellow lines to prioritise traffic to the caravan site.

Background.

It is not in doubt that the level of the ground on the area of land south of the south wall of [redacted] has been elevated from zero (ground level) to 2.0m high, i.e. to a level at the top of the garden wall. This was done by the previous caravan site owners without planning permission and without engineering design. I know the land has been elevated as I have lived in my house for 25 years and saw it done. I saw the

Background continued.

crude unbutressed single breeze block walls going up and the area being infilled. I know the level of the land was the same on both sides of the wall as I used to climb over the wall when my children knocked shuttlecocks over the wal. I could scale the wall on my side standing on the compost bin but I could not scale the wall from the scrub land side as it was too high. I could not see over the wall into my garden.

The previous caravan site owners elevated the land with the intention of siting static caravans there. As the level of the land was now 2.0m above ground level, and level with the top of our 2.0m high garden wall, this would have given uninterrupted views to the fifth and uninterrupted views into adjacent back gardens.

The council will have reams of documents on objections to the unauthorised elevation of this site including reports from visits made by the Reporter on at least three occasions. The council was invited to restore the site to its former status but chose not to do so. The Reporter indicated the elevation of the land had a significant detrimental effect on adjacent gardens, was outwith permitted development without

Background continued.

engineering input and failing to comply with statutory building regulations.

I now turn to the Platform Cottage. This was a rented home fronting on to the platform. The rear garden, north facing, and between the house and the caravan site field for tents and towed caravans that now has fixed static vans in it, sloped steeply downwards towards the boundary wall. The garden was largely useless due to its steep gradient. I saw the man who rented the house tip innumerable hand barrow loads of rubble down this steep bank eventually bringing the land up almost to the top of the high wall bounding the caravan site field. I do not believe there were any planning applications or council involvement over this.

Current Situation

The land to the south of the garden wall of [redacted] remains elevated to the level of the top of the 2.0m high wall. There has been some scraping away of the infill immediately adjacent to the wall so the level of the land falls towards the wall. (The infill has not

Current situation continued.

been removed nor has the level of the land been restored to its former state. A recent letter from the council implies that it has been). A portion of the breeze block wall has been removed. As instructed by the Reporter the wooden fence which had been put up at the edge of the elevated land (increasing the fencing height to 2.0m wall plus wooden fence of about 1.2m tall) has been removed. Hayland trees planted along the edge of the wall at a height of 2.0m up have been removed. I believe the services of water, sewerage and electricity remain in place contrary to instructions from the Reporter for these services to be removed A double-decker bus sits on the elevated land along with two robust wooden picnic table and bench sets.

Children gain access to the top of my 2.0m high wall, walk along it, and risk falling.

The development of Platform Cottage includes a large north-facing wooden decking area on elevated land.

It is unreasonable to have a double-decker bus (local rumour indicates this is being converted for social events)

Current situation continued.

or picnic tables located at a height of 2.0m above a private back garden. I doubt anyone in the council would tolerate their neighbours increasing the height of their neighbour's back garden to the top of their boundary fence and the parking vehicles or caravans or picnic benches at that height)

It is unreasonable to park vehicles of any description on this land.

It is unreasonable to change this land, previously low lying scrub land, to an elevated area of caravan site with financial gain to the caravan site and financial loss to neighbouring properties.

It is unreasonable to designate Platform Cottage and the land south of [redacted] garden as caravan site to facilitate the by passing of usual planning regulations.

Summary

Objections are raised, with explanations given, to the extension of the caravan site to include Platform Cottage, the area of land to the south of [redacted]

Summary continued

southern boundary wall, and into scrub area at the western limits of the current caravan site.

Objections centre on the suitability of the raised land (raised without regard to statutory planning regulations, without permission and without technical oversight), b) the risk of people falling 2.0m into adjacent garden as the land has been elevated to the top of the height of the boundary wall and children can now access the top of this boundary wall with ease, c) the loss of privacy and ammenity to the garden of [redacted] d) the potential circumnavigation of planning process by designating a residential property and elevated land as caravan site facilitating business development e) problems with increased traffic and parking difficulties.

Significant issues are raised under conflict of interest.

Thank you for considering these issues.

Yours faithfully

Carey Nash

Dr. C. H. Nash (retired)

From Squadron Leader Mark A Nash BSc MBA RAF (Retd)

Local Development Plan Team
Development Services
Moray Council
High Street
ELGIN
IV30 1BX

13 March 2019

MORAY LOCAL DEVELOPMENT PLAN 2020

SECTION OF PLAN TO WHICH MY COMMENT RELATES

Volume: Volume 2 | Settlements | Hopeman

Heading: Tourism

Page Number: 237

Site/Policy Reference: T1 Hopeman Caravan Park

DEVELOPMENT PROPOSAL

1. I received a Notification of Proposed Plan dated 7 January 2019 because proposed for inclusion in the Proposed Moray Local Development Plan 2020. I was notified of a '*proposal for development of T1 Hopeman Caravan Park*' and specifically of the '*designation of site for caravan park*'.

REASON FOR COMMENTING

2. The reason for me commenting on the Proposed Local Development Plan is to seek assurances from Moray Council about the rigour with which the Council will apply and enforce planning policies and regulations on Hopeman Caravan Park, which is known as West Beach Caravan Park, in the event of further development of the Caravan Park.

EXAMPLES OF ABUSES OF THE PLANNING SYSTEM BY THE OWNER OF WEST BEACH CARAVAN PARK

3. It is relevant and a matter of public record that the owner of West Beach Caravan Park, Mr Scott, is a serial abuser of the planning system. Three examples come to mind as follows, all of which are already known to Moray Council:

60% Expansion of Site Extension Without Prior Planning Consent

a. The site to the west of the Caravan Park was developed without prior planning permission for an additional 7 touring caravan pitches; an increase of almost 60% on the permitted development of 12 pitches. Moray Council is on record as declaring this breach of planning procedure as '*regrettable*'[1] (meaning undesirable, or unwelcome) because it extended beyond the permitted boundary and involved a breach of the ENV8 amenity.

Platform Cottage Converted Without Prior Planning Consent

b. The residential dwelling known as
has
been converted to a public venue without prior planning permission. I believe the venue is now known and publicised as The Old Station (or similar name) and was used by West Beach Caravan Park to host a Findhorn Bay Festival event in October 2018. To date, no action has been taken by Moray Council to enforce planning regulations in relation to this unlawful development neighbouring my home.

Positioning of Caravan on Unlawfully Raised Site Without Prior Planning Consent

c. Mr Scott positioned on the unlawfully-raised site

a static caravan without prior planning permission. Moray Council said that the caravan breached my amenity and privacy and should be removed. Mr Scott went to the Press & Journal[2] to assert that he would resist enforcement action ('*we'll just appeal it; we can't lose*') and went on to declare, '*we could move [the caravan] somewhere else, but why should we?*'.

1. Moray Council Report of Handling 17/00509/APP dated 10 May 2017.
2. .

ANCILLARY FACILITIES

Suitable Uses

4. At Page 237 of the Proposed Local Development Plan, under the heading '*Suitable Uses*', the Plan states that '*ancillary facilities appropriate to tourist development such as a shop, café, laundry and shower facilities will be supported within this area*'.

Bistro

5. My concern in respect of Ancillary Facilities is that Mr Scott has publicised on social media that he intends to convert a double-decker bus into a bistro for the Caravan Park. The double-decker bus is currently positioned on the unlawfully-raised site

   breaching my amenity and privacy as previously identified by Moray Council vis-à-vis the static caravan.

6. The static caravan was removed under enforcement action. However, the double-decker bus remains *in situ* and conversion to a bistro would appear to be work in progress;

GREEN INFRASTRUCTURE

7. As stated earlier, Mr Scott breached the ENV8 amenity when he developed his Caravan Park extension by a further 60% without planning permission. I note that recently Mr Scott has also

breached Hopeman ENV6 (Natural/Semi-Natural Greenspace) by cutting a swathe through the West Foreshore sand dunes from the Caravan Park to Hopeman West Beach; see the image below:

FURTHER DEVELOPMENT OF WEST SIDE OF CARAVAN PARK

8. The substance of the '*Proposal for development at T1 Hopeman Caravan Park*' will be to increase the number of pitches on the Caravan Park. Therefore, I should like to seek reassurance from Moray Council that the following factors will be taken into account as/when proposals are considered by the Planning Committee:

   a. **Disrespect for Planning Policies**. The fact (for it is a fact) that Mr Scott has little or no respect for planning policies and regulations; the evidence for this is a matter of public record. Mr Scott appears not to realise or recognise that he has not only property *rights*, but also property *obligations* in the context of his neighbours and the community at large *vis-à-vis* amenity and privacy, and environmental impact.

   b. **Transport Impact**. The transport impact on Harbour Street in particular if the volume of pitches on the Caravan Park is increased still further. I would suggest that the bridge near the Ice House is at significant loading risk in future. I would also suggest that the risk to public safety in Hopeman is increasing all the time as the number of tourism-related and other vehicles in Harbour Street increases,

notwithstanding the reasonable objective of supporting tourism in Moray.

c. **Environmental Impact**. Mr Scott has already demonstrated his disdain for the ENV8 and ENV6 areas of Hopeman. I trust, therefore, that Moray Council will look carefully at the potentially adverse impact on the environment and community amenity of permitting yet more development of West Beach Caravan Park.

DEVELOPER RESPONSE TO PLANNING COMMENTS & OBJECTIONS (HARASSMENT)

9. I should like to go on record and make it known to Moray Council that the developer, Mr Scott, has recently instructed me, through my solicitor, to be '*more neighbourly*'. This is relevant to my response to the Proposed Local Development Plan because Mr Scott is, I believe, irritated that he does not have unfettered rights to develop his land regardless of the potential impact of his actions on the environment, the community and his neighbours; . As I've already explained above, Mr Scott appears to have little time for planning policies and regulations.

10. Mr Scott has in the past identified me on his West Beach Caravan Park Facebook page as a . He has red-ringed a photograph of my home, pointing out that it's where I live; unpleasant comments are made about me on the Facebook page.

11. Last month Mr Scott purchased from the laird of Hopeman the pavement area . Mr Scott then informed my solicitor that he viewed his purchase of the land as a useful '*ransom strip*'. Mr Scott pointed out that his ownership of the land '*has an impact on the value and use of property*'.

12. Mr Scott went on to say that he was '*currently considering what future use we may put it to. We have no immediate plans but clearly this may change depending on many factors. Given that we now , it would be extremely welcome if your clients became more* ', which I took to be a thinly-veiled threat to desist from seeking through Moray Council the protection of my amenity and privacy and the reasonable enjoyment I might expect to gain from living in my home. Mr Scott was in effect telling me, through my solicitor, that if I continued to seek to protect my amenity and privacy, he would use his '*ransom strip*' to harass me accordingly.

WEST BEACH CARAVAN PARK DEVELOPMENT

13. Notwithstanding the comments I've made above, I should like to commend Mr Scott on much of the work that he's carried out on West Beach Caravan Park. He has made significant improvements to the site. The Park is visually pleasing and there is little doubt that Mr Scott's customers enjoy the setting and experience of visiting the site. Well done.

14. It's good that people want to come and visit Hopeman and enjoy all that we get to enjoy ourselves here throughout the year as residents. It's pleasing to see tourists in the village during the summer and knowing that they're adding to the local and, indeed, wider Moray economy. I'm aware too of Mr Scott's willingness to stage events in the Park which further attract people to the village and which Mr Scott uses to raise money for charity. This is all good stuff and in these respects I support Mr Scott's actions.

SUMMARY & REQUEST FOR ACTION

15. In summary, I'm anxious that any proposals for the development of West Beach Caravan Park should be properly controlled by Moray Council and seen to be as such. Mr Scott is clearly prepared to flout planning policies. Mr Scott is also prepared to intimidate me for having the temerity to ask Moray Council to apply and enforce planning policies.

16. It's distressing for me knowing that Mr Scott treats with contempt and is prepared to harass me for my reasonable expectations of having my amenity and privacy protected by Moray Council through the proper application and enforcement of planning policies.

17. Therefore, I request an assurance from Moray Council that the Council's handling of any proposals for the development of West Beach Caravan Park will take into account the comments I've made in this response to the Proposed Local Development Plan 2020. Thank you very much.

Yours faithfully

From: eforms@moray.gov.uk
To: Localdevelopmentplan
Subject: AU_SITEA - 002132
Date: 10 March 2019 11:40:05

Moray Local Development Plan - Proposed Plan 2019

Your Place, Your Plan, Your Future

Your Details

Title: **Mr**

Forename(s): **David Bowden**

Surname: **Naylor**

Your Address

[redacted]

Contact Details

[redacted]

Agent Details

Do you have an agent: **No**

Response

Do you want to object to a site?: **Yes**

Do you want to object to a policy, the vision or spatial strategy: **No**

Other: **No**

Supporting information: Download supporting document Available also via link at bottom of this email.

Site Objections

Name of town, village or grouping: **Auchbreck, Glenlivet**

Site reference: **Site A**

Site name: **Auchbreck Site A**

Comments: **This site has previously been rejected for development due to the land becoming waterlogged and subject to flooding. Further objections as follows:- Proposed access to site very very close to busy road junction B9008/9 (Similar application on opposite side of road refused due to proximity to this junction. No local transport would result in any properties requiring motor vehicles - 3 properties - 6 cars minimum Refuse containers x 3 proposed properties = 15 containers placed at roadside near said busy road junction. Septic tank drainage virtually impossible due to waterlogged nature of land. Bearing these factors in mind, surely Moray Council cannot in all conscience allow development at this location. I believe Government policy discourages development on land subject to flooding as insurance of such properties is hard to obtain and expensive. I have photographs of this site completely flooded and covered in soil washed down from land above - this also flooded my garden!**

Please use this link to view and retrieve the uploaded attachments.

Moray Council
Planning and Development, Environmental Services,
High Street,
Elgin
IV30 1BX

By email.

151 St Vincent Street
Glasgow
G2 5NW

Lisa Cameron, Town Planner

Telephone: 07730 354296
E-Mail: Lisa.cameron@networkrail.co.uk

13th March 2019

Dear Sir/Madam

Moray Council Proposed Plan 2020

This letter comprises Network Rail's response to the consultation on the above plan.

Introduction

Network Rail is the statutory undertaker which owns, operates, maintains, renews and enhances the country's railway infrastructure and associated estate. This includes track; bridges, viaducts and tunnels; signals; level crossings; maintenance and stabling depots and stations.

Current projects taking place in, and benefitting, the Moray area include the Aberdeen to Inverness Rail project.

The rail industry's Long-Term Planning Process which takes a high-level view of funder and market requirements over a 30-year planning window is informed by the connectivity aspirations set out in Scottish Government transport policy comprising the Infrastructure Investment Plan; the National Transport Strategy; Scotland's Railways; and the Strategic Transport Projects Review.

The process is also informed by Network Rail's forecast of rail demand on individual corridors and the likely capacity constraints that are likely to arise as a result of increases in passenger and freight demand. This long-term, high-level view informs the more detailed work required to make investment decisions in the short and medium terms. Because Network Rail is funded and regulated in five-year Control Periods this process typically has a ten-year window. The next Control Period (CP6) runs from April 2019 to March 2024. Following the Rail Industry initial response to Scottish Ministers 'Scotland's

Rail Infrastructure' consultation the High-Level Output Specification was published in July 2017. Further work is being done to develop the interventions proposed in the Scotland Route Study as Choices for Funders in CP6 and CP7 (2019-2029).

The Vision

The rail network can make a key contribution to the achievement of the Vision of the plan. We note that one of the key aims of the vision is in relation to identifying and providing for new or upgraded physical infrastructure to support the expanding population whilst safeguarding existing infrastructure and we support this.

The importance of the railway to sustainable development and of railway stations to successful placemaking is gaining wider understanding. This is implicit in the Proposed Plan's Strategic Context where Transport proposals (TSP) are shown in the settlement statements and policies have an emphasis upon promoting alternatives to the car, to encourage active travel and exercise as part of healthy living. For development plan objectives relying on sustainable transport and improved rail connections to be realised, Network Rail must rely on Plan policy and guidance which ensures the impacts of proposals on rail infrastructure are clearly assessed and that delivery, including funding, responsibilities are clear.

To enable Moray Council to achieve the vision of the LDP we strongly recommend that comments provided within this representation are considered.

Primary Policies

PP1 Placemaking

Policy PP1 seeks to ensure healthy and sustainable placemaking for housing developments of 10 or more units and provides specific requirements for these types of development proposals. Part (iv) of Policy PP1 covers open spaces/landscaping and it is requested that this be amended to ensure that in the development of land that any landscaping proposals along the boundary with the railway line should have fencing 1.8m high. Network Rail's existing boundary fences are provided and maintained for current land uses. Rural, arable, woodland or open land generally has a much lower requirement for fencing than developed or urban environments. Significant areas of new housing land have been identified in the proposed plan and where this is located adjacent to the railway it introduces potential increased risk of encroachment on the railway line that needs to be mitigated with appropriate boundary fencing. This approach is supported in Scottish Planning Policy (SPP), Designing Streets, Creating Places and the Public Health Priorities for Scotland in ensuring that successful places are safe.

We would also request that careful regard is made on tree planting near the railway line to ensure that the tree species chosen does not adversely affect the operation of the railway. This is further detailed below under comments on Policy DP1.

PP3 Infrastructure and Services

We support the requirement that development be planned and co-ordinated with infrastructure to ensure that places function properly and proposals are adequately served by infrastructure and services. It is therefore vital that rail is explicitly included in the Supplementary Guidance on Developer Obligations in relation to the additional housing and employment land supply put forward by the proposed plan. In addition, whilst accepting that the possible mitigations to the transport network listed in policy PP3 a.iii) is not intended to be exhaustive, it is noted that this list is made up exclusively of road transport interventions. This is likely to lead developers to assume that these are the primary type of intervention sought by this policy. It is considered that for balance and to focus developers' attention on the possible need for other potential transport interventions that listed of interventions should include level crossing upgrades and that it is made explicit that Transport Assessments are required to consider the impact of new development on level crossings, bridges, station car parking and walking and cycling routes to railway stations.

Policy PP3 b. states that development proposals will not be supported where they vii) compromise the economic viability of bus or rail facilities. We would support this policy however it is requested that it also includes provision that development proposals that adversely impact upon the operational safety of the rail network and cannot be adequately mitigated should also not be supported.

Network Rail generally supports the approach of Policy PP3 d. It is right that where the impact of new developments will exacerbate a current, or generate a future, need for additional infrastructure that appropriate contributions are made by developers. We understand the need for local planning authorities and infrastructure providers to work closely together to understand development impacts and appropriate mitigations and to ensure effective delivery.

Network Rail should be clearly excluded from having to make developer contributions as a publicly owned company arm's length body of the Department for Transport (DfT).

Development Policies

DP1 Development Principles

Network Rail generally supports the provisions of Policy DP1 and in particular the requirement for applicants to provide impact assessments in order to

determine the impact of a proposal upon the transport network and provide mitigation to address these impacts. In this respect Network Rail requires the continued support of the local authority in safeguarding and improving the railway network, and to meet demands, from new development. It is important that Transport Assessments should be required to consider the impacts of proposed development on the demand for rail services. This increased demand may result in the requirement for upgraded rail infrastructure or of facilities at stations and is particularly important given the extent of development proposed in the vicinity of Elgin, Keith and Forres.

We recommend that Policy DP1 (ii) c. be strengthened, or supplementary guidance provided, to define the circumstances in which developers will be required to prepare a Transport Assessment; and that the requirement to fully assess the impacts of the development on all modes of transport, including the rail, is made clear.

This is particularly important in relation to those TSP's identified near to the railway or potentially affecting the volume of type of traffic using level crossings or railway bridges including, but not limited to:

- TSP3(Elgin) where the existing bridge has a Road Vehicle Incursion (RVI) risk ranking score that is borderline high for current traffic levels. If the development were to generate additional traffic on this section of road, this could affect the risk score and could trigger the need for further mitigation measures that should be funded by the developer(s).

- TP27 (Elgin) where impacts on the safety and operation of the level crossing at The Wards needs to be carefully considered.

The safeguarding of TSP51 (Elgin Station), TSP3 (Forres Station) TSP3 and 4 (Keith Station and railway sidings) is welcomed.

Elgin and Keith are Strategic Freight Sites and should be protected for future freight use. Any proposals that would affect these sites or the road network that might have an adverse impact on the use of these facilities requires to be assessed and, where appropriate, mitigated.

Level Crossings

Level crossing safety is of the utmost importance to Network Rail and we are committed to reducing the risk at level crossings where reasonably practicable. In addition, increase in usage of a level crossing may impact on line speed conflicting with a main Government objective for faster journey times. Increase in road traffic across a level crossing may also have an adverse effect on the road network as a result of longer journey times and queueing while level crossings are closed to allow trains to pass. Only in exceptional circumstances will we permit new crossings to be introduced onto the network.

In recognition of these issues Network Rail is a statutory consultee in the development management process in respect of proposals which may impact on level crossings.

We work with local councils to reduce level crossing risk and encourage planning authorities to co-operate in securing level crossing closures or improvements in connection with new developments through development management and through clear development plan policy and supplementary guidance.

We would request specific references to reduction of level crossing risk and the potential requirement for the closures or improvements of level crossings in Policy DP 1.

Network Rail generally agrees that the strategy for new tree provision should follow the principles of the "Right Tree in the Right Place". However, we would request that Policy DP1 and the specific Development Strategies/Placemaking Objectives be refined where they include proposals to plant trees along the railway boundary, for example at Barmuckity, Elgin or at Springfield West, Forres. If the wrong tree species are selected this can contribute to leaf fall on the railway and cause train delays during autumn. Additionally, when the trees reach maturity they can be difficult for third parties to maintain (due to the close proximity with an operational railway) and ultimately can become a safety risk in high winds or adverse weather. To mitigate against these risks, it is therefore requested that consideration is given to ensuring that trees species planted near to the railway line are included within the Network Rail approved planting list and that an adequate buffer is maintained between the planting and the railway line.

Network Rail would be happy to discuss any of the issues raised above.

Yours faithfully

[redacted]

Lisa Cameron
Network Rail Town Planner

From: [redacted]
To: Localdevelopmentplan
Subject: EL_ENV4 - 002124
Date: 05 March 2019 21:27:33
Attachments: emails 6 July 16 N Goodchild.pdf
Item 12-App 3 Fields in Trust.pdf
July 2016 Roddy Burns.pdf

Please accept this on behalf of New Elgin JFC

Regarding the area EL24 of the proposed site for Hendry Hydraulics extending onto the playing fields - can the following please be taken into serious consideration.

1. Emergency vehicle access from Ashgrove Road down path at side of pitches should not be obstructed and full access to the pitches will remain for this purpose. This access is required for the safety of ALL players and users of the pitches at Pinefield. This access is essential for the Health and Safety of users of the pitches and is an essential part of risk assessment in accordance with SFA regulations.
2. Assurance that access to pitches for users is maintained at all times.
3. Green space educational land - can this be sold for industrial purposes?

We have also voiced concerns today regarding proposed allotment site and the Health & Safety issues this raises.

Please find attached previous communications regarding the playing fields at Pinefield:
1. Item 12 Appendix 3 was the original area discussed at a meeting regarding Centenary Fields in 2015
2. Letter July 2016 - The subject of how this area changed without further consultation - request it be returned to committee.
3. emails to and from Educational Services

We also had recent communication with Councillors Brown & Ross regarding the issue EL24 and also the GREEN space Educational Services land at Pinefield playing fields.

Regards

Joyce Rose
New Elgin JFC

From: eforms@moray.gov.uk
To: Localdevelopmentplan
Subject: 000632 - Moray Local Development Plan - Proposed Plan 2019: LAV8HAX6- Rural Groupings Woodside of Ballintomb
Date: 10 February 2019 15:13:28

Moray Local Development Plan - Proposed Plan 2019

Your Place, Your Plan, Your Future

Your Details

Title: **Dr**

Forename(s): **Malcolm**

Surname: **Newbould**

Your Address

[redacted]

Contact Details

[redacted]

Agent Details

Do you have an agent: **No**

Response

Do you want to object to a site?: **Yes**

Do you want to object to a policy, the vision or spatial strategy: **Yes**

Other: **No**

Supporting information: Download supporting document Available also via link at bottom of this email.

Site Objections

Name of town, village or grouping: **Woodside of Ballintomb**

Site reference: **page 47**

Site name: **Woodside of Ballintomb**

Comments: **This is a long running saga, the developer has been refused planning, appealed, lost the appeal. Applied again for planning, had it approved with conditions, let this lapse, as the conditions were too onerous I assume. Now Moray council continue to put this totally unsuitable piece of land down as suitable for development. I am pleased to not that even the council admit drainage is problematic. On the last planning application a ditch was described as a tributary of the Spey in order to achieve planning consent, I hope this will not happen again. Not only is drainage a problem but access to the site to and from the unclassified road is and continues to be a problem.**

Policy Objection

Policy:

Comments:

Please use this link to view and retrieve the uploaded attachments.

Moray Local Development Plan 2020

Representation to The Moray Council

Personal Details

Name: NHS Grampian

Address: 2 Eday Road, Aberdeen, AB15 6RE

Tel No: (01224) 558734

Email address: allan.robertson1@nhs.net

1. Introduction

1.1. NHS Grampian welcomes the opportunity to submit representations on Moray's Local Development Plan 2020. Representations were made in May 2018 on The Main Issues Report of the proposed plan and should be read in conjunction with this paper. NHS Grampian have also taken the opportunity to seek responses from NHS Grampian Public Health Directorate and Health & Social Care Moray and have included their comments within our response.

1.2. NHS Grampian is generally supportive of the vision and objectives set out in the proposed plan as well as the spatial strategy that is proposed. NHS Grampian acknowledges the ongoing work between NHS Grampian and The Moray Council ensuring adequate provision is made for health facilities to serve existing and emerging communities which is recognised throughout the plan. NHS Grampian recognises the significant work that has gone into developing this comprehensive suite of documents. They are attractive to read and well laid out, and make clear The Moray Council's vision and ambitions, planning principles, and practical proposals. The maps make the proposed development areas accessible, and the guidance on flood prevention is very welcome from a civil contingencies perspective.

2. General

2.1. As indicated in previous MIR and LDP responses to The Moray Council, NHS Grampian had requested further recognition of the importance of healthcare as a fundamental component in establishing and extending communities, and that this should be considered with the same level of importance as that of education, transport and community facilities. NHS Grampian feels that the plan does reflect this recognition and welcomes this.

2.2. NHS Grampian notes that a Joint Strategic Needs Assessment 2018 (JSNA) has been drawn up in partnership with The Moray Council and focuses on 9 topics affecting the population of Moray including ageing, mental health and access challenges to name but a few. The JSNA supports the direction of the plan and is included as part of our response.

3. The Vision

3.1. The vision for Moray is set out under 8 points and includes a placemaking approach to developments to create sustainable, welcoming, well connected places that are safe, healthy and inclusive and NHS Grampian fully supports this approach. The vision also highlights, where appropriate, the need for new or upgraded infrastructure whilst safeguarding existing infrastructure to support expanding population. NHS Grampian welcomes the inclusion of Healthcare infrastructure which is a fundamental component of a community which is also reflected throughout the plan

4. Spatial Strategy

4.1. NHS Grampian supports the Growth Strategy and the changes to Keith and Lossiemouth from secondary to Tertiary Growth Areas. NHS also welcomes the use of the placemaking tool which sets out social, environmental and economic requirements when planning residential developments. NHS Grampian is fully supportive of this approach which includes healthier living and wellbeing (physical and Mental), encouraging people to live healthier lifestyles, provision of walking and cycle routes and look forward to providing continuing support and advice where required.

5. Strategic Context

5.1. In light of the new General Practice (GP) contract and the significant changes that are required to ensure sustainability of services, as a consequence NHS Grampian will require a more flexible approach to infrastructure requirements to accommodate future service delivery. Rather that extending existing premises or providing new we may wish to consider an alternative approach in some areas with care and treatment services being delivered in alternative locations (these would of course still be Health Services). The use of technology will also need to be considered which would improve access to health facilities for patients in rural/remote areas and would also have a positive impact by potentially reducing the need for patients to travel where appropriate.

5.2. With reference to the table 5 - Healthcare Infrastructure, we confirm that the requirements are generally in line with information previously shared, however the works to increase capacity at Rothes is now complete for the time being, with the works at Aberlour ongoing and due to be complete May 2019, again for the time being. These works have been progressed to take account of all additional patients identified within the current LDP. NHS Grampian would still be requiring retrospective developer obligations from settlement sites within the current LDP to go toward the cost of the NHS providing these improvements and flexibility to cope with the future demand as expressed in The Moray Local Development Plan 2020.

6. Primary Policies

6.1. PP1 Placemaking

NHS Grampian applauds the recognition that the creating of healthy places to live (in line with Scottish Government policy) will support good physical and mental health and improves people’s wellbeing and welcomes the requirement for a placing making statement to be provided for developments

over 10 units. The inclusion of active travel routes, green and open spaces that encourage activity and social interaction will without doubt have a positive impact on new & emerging communities.

6.2. PP3 Infrastructure and Services

NHS Grampian welcomes that development proposals will need to provide infrastructure and services which include healthcare alongside education, transport and other infrastructure providers. As indicated during the MIR stage, many existing healthcare facilities are presently under pressure and will either require internal alteration, expansion or the provision of new facilities to cater for many of the areas that are proposed for development. Developer contributions and land for development of new facilities will be essential in order to mitigate the impact arising directly from those new developments.

6.3. Information Communication Technology

NHS Grampian welcomes the inclusion of Information Communication Technology (ICT) and that fibre optic broadband is to be provided for all premises. The use of technology will play a big part in the future provision of healthcare within new and emerging communities and ensuring the digital infrastructure is in place will enable further opportunities as to how healthcare is provided and will ensure healthcare is easily accessible by all.

6.4. Developer Obligations

NHS Grampian will continue to work closely with The Moray Council to identify those areas currently under pressure, where new facilities are required and the scale of contribution required mitigating the impact of residential development. The provision of new technologies by way of developer obligations also needs be considered which would not only improve access to health facilities in rural areas but would also have a positive impact on travel with the potential to reduce the number of car journeys for patients in rural areas, therefore further aiding healthcare in the Moray area by reducing CO^2 emissions.

7. Settlement Statements

7.1. NHS Grampian welcomes the provision for Healthcare within the proposed plan and can confirm the mitigation measures set out against healthcare infrastructure is in line with NHS Grampians future infrastructure requirements. However as highlighted under item 5.2 works to increase capacity at Rothes is now complete for the time being, with the works at Aberlour ongoing and due to be complete May 2019, again for the time being.

7.2. NHS Grampian wishes to object to the unit allocation indicated on site R22 Spynie Hospital. NHS Grampian feel that the numbers are too low, even lower than sites with low density housing and is also lower than indicated on adjacent sites that have been allocated for housing. NHS Grampian appreciate that this is only an indication at this stage, however this will obviously have a negative effect on the valuation of the site; therefore NHS Grampian would like the unit numbers revised to be in line with adjacent sites, and feel that residential units around 75-80 would be more appropriate and more in keeping with other surrounding sites.

7.3. NHS Grampian welcomes the retention of the Dr Grays hospital as an allocated site for community facilities which includes safeguarding the site for health services.

8. Delivery Programme Action Plan

8.1. NHS Grampian welcomes the preparation of the delivery plan/action programme which sets out the actions, responsibilities and timescales for infrastructure delivery. NHS Grampian will continue the joint working with The Moray Council to ensure healthcare infrastructure is delivered in the right location at the right time to support the housing development needs within Moray.

8.2. The recognition that early engagement with developers on developer obligations is also welcomed, as is the continuing engagement with children and young people.

9. Public Health Comments

9.1. When reviewing the plan Public Health Directorate have made use of Public Health England's Spatial Planning for Health review (www.gov.uk/government/publications/spatial-planning-for-health-evidence-review) to consider the content. Comments provided under the headings have used in that review below:

9.2. Neighbourhood Design

The main criteria of 'walkability', 'completeness' and 'safe infrastructure'. These are positively addressed under the sections headed Placemaking (pp.22-31) and Development Policies (p.36).

9.3. Housing

The main criteria are 'high quality' and 'affordability'. These are positively addressed under the sections headed Housing (pp.38-39) and Rural Housing (pp.44-54), and Housing (p.38, 40-41), respectively.

9.4. Natural and sustainable environment

The main criteria are 'reduced hazards', 'access to greenspace' and 'climate mitigation and adaptation'. These are positively addressed under the sections headed Development Policies (p.37), ...Water Environment (pp.97-100), Foul Drainage (p.101), Pollution etc.… (pp.101-102); Placemaking (p.28), Infrastructure & Services (pp.32-34), Natural Heritage Designations (pp.74-76), Biodiversity (p.77), Special Landscape Areas… (pp.78-79), Countryside Around Towns (p.79), Open Space (pp.80-87), Forestry Woodland and Trees (pp.88-92); and Renewable Energy (pp.61-72), respectively.

9.5. Transport

The main criteria of 'active travel infrastructure', 'public transport provision', 'priority to active travel and road safety'. These are positively addressed under the sections headed Strategic Context (p.18), Infrastructure & Services (pp.32-34), Development Policies (p.36).

However clarification is required on where within The Moray Council does the responsibility for local bus services sit? It may not be with the planning department and NHS Grampian Public Health are very aware that bus transport is a live issue for many who live in Moray, and that the absence of regular services can leave many people isolated. NHS Grampian, through the Health Transport Action Plan would welcome the ability to better promote public transport and voluntary transport initiatives in The Moray Council area.

9.6. Healthier Food
The main criteria are 'healthy food outlets' and 'community food infrastructure'. The latter (in terms of allotments and community growing) are positively addressed through pages 80 and 86.

Clarification is required on whether there is any provision within The Moray Council for addressing the density of unhealthy food outlets?

NHS Grampian Public Heath welcomes the intention in the Action Plan to search for a Gypsy Traveller halting site. This is an important population from a public health perspective, as they are a potentially marginalized and excluded group, and the lack of halting sites can impair their access to healthcare services.

10. Conclusion

10.1. NHS Grampian fully supports the objectives and policies set out in the Moray Local Development plan and welcomes the recognition that healthcare is a fundamental component of a community. NHS Grampian will continue to work with The Moray Council and key agencies to ensure opportunities to share facilities are considered fully to reduce build and operating costs where possible. This will also ensure our infrastructure requirements provide the right services in the right locations and are accessible to all.

10.2. NHS Grampian is pleased to see proposals on the creation of healthy places and the impact on the health and wellbeing of the residents of Moray continuing on from the MIR stage. The importance of improved opportunities for social interaction and activities is recognised throughout the plan as is the view that health should play a big part in the designing of homes, street and open spaces which is welcomed by NHS Grampian. The continued recognition that encouraging healthier lifestyles and more physical activity can improve the quality of life and mental wellbeing is also welcomed.

Allan Robertson
Property Planning Manager
14 March 2019

Joint Strategic Needs Assessment (2018)

To inform the development of the HSCM strategic plan 2019/20 – 2021/22

Version 1.1 November 2018

Produced by the Joint Needs Assessment Short-Life Working Group under the auspices of Health and Social Care Moray's (HSCM) Strategic Planning & Commissioning Group (SP&CG)

UNCONTROLLED WHEN PRINTED

Version control		
Version	**Date**	**Notes**
1.0	18 October 2018	Presented to HSCM SP&CG
	November 2018	Additional analysis added: • Population projections (p14) • Drug use (pp 29-31) • Mortality (pp 41-46) • Life lived with disability (pp 47-50) • Mental health admissions (p54) • Exec summary & conclusions (p3, p77)
1.1	20 December 2018	Returned to HSCM SP&CG and approved

EXECUTIVE SUMMARY

This Joint Strategic Needs Assessment (JSNA) has been produced to inform the development of Moray Integration Joint Board strategic plan 2019/20 – 2021/22. The strategic plan is being developed through a participative and collaborative workshop programme. The JSNA does not contain any review of the effectiveness of service configurations or health and social care interventions, in the expectation that any required work in this area will be identified and undertaken through a wider strategic programme.

The JSNA was developed by a short-life working group comprising representatives from Health and Social Care Moray, The Moray Council, the Moray Health and Wellbeing Forum, NHS Information Services Division Scotland, and NHS Grampian. The JSNA did not formally use a corporate needs assessment methodology to capture the views of wider stakeholders, recognising that this will be undertaken as part of the strategic programme, but the views of wider stakeholders on the data assembled were sought through the Moray Health and Wellbeing Forum. Nine areas are highlighted from amongst the wealth of intelligence compiled.

1. There are continuing **inequalities in health** status across Moray, with an evident association between level of neighbourhood affluence and morbidity and mortality.

2. The population is predicted to continue **ageing**, with a growing proportion represented by adults over the age of sixty-five, and growing numbers of adults aged over eighty, with implications for increasing morbidity.

3. Significant demand for health and social care services arise from **chronic disease**, and a growing proportion of the population is experiencing more than one condition ("**multi-morbidity**").

4. There is significant morbidity and mortality due to **mental health** problems.

5. There is significant morbidity and mortality due to **lifestyle exposures** such as smoking, alcohol and drug misuse

6. A small number of individuals require half of healthcare spending ("**high-resource individuals**"). This warrants further detailed analysis.

7. Moray is characterised as **remote and rural**, and there are significant **access challenges** for some in the population to access health services.

8. Care activity is highly demanding of **informal carers**, and there is evidence of distress in the informal carer population.

9. Moray's **military and veteran population** constitute a significant group, requiring both general health services and specific services.

These nine areas are highlighted for consideration by the workshops developing the strategic plan.

CONTENTS

JOINT STRATEGIC NEEDS ASSESSMENT 2018
INTRODUCTION

Health and Social Care Moray (HSCM) have developed a strategic programme to support the development of the Moray IJB strategic plan 2019/20 – 2021/22. The programme sets out a process involving a series of strategic workshops, which will allow the drafting of the strategic plan using a participative and collaborative approach. This Joint Strategic Needs Assessment (JSNA) has been produced to inform this process.

The JSNA solely focuses on the collation and analysis of data from a range of sources to inform the identification of priorities, and subsequent decision-making regarding service provision and development, through the strategic workshops. The JSNA does not contain any review of the effectiveness of service configurations or health and social care interventions, in the expectation that any required work in this area will be identified and undertaken through the wider strategic programme.

The JSNA was developed by a short-life working group comprising representatives from HSCM, Moray Council, Moray Health and Wellbeing Forum, Information Services Scotland, and NHS Grampian. The JSNA did not formally use a corporate needs assessment methodology to capture the views of wider stakeholders, recognising that this will be undertaken as part of the strategic programme, but the views of wider stakeholders on the data assembled were sought through the Moray Health and Wellbeing Forum.

Context for the development of the JSNA

The population comprises **individuals** experiencing the full spectrum of health states.[1] At one end are those who are generally healthy, experiencing no impairment(s) in functioning or body structure, no limitations on activity, no restrictions on participation in daily life. At the other end are those with permanent impairment(s), significant limitations, and or significant restrictions. People's health can be affected by innate factors (such as their genotype) and by external factors (such as exposure to microbiological agents or chemicals, or lack of exposure to essential nutrients).

At times people will have **felt needs** for health and care, often in response to an experience of symptoms. Felt needs can be physical, psychological, social, or spiritual/existential. Some of these will become **expressed needs**, when people seek care. The expression of need is influenced by a range of factors, including individual perception of symptoms, awareness of services, and the cultural norms of those around them. People also seek care in response to **normative needs**, which are those identified by professionals, such as monitoring through chronic disease clinics, or invitation to attend for screening or vaccination. People can seek care in different ways and with differing degrees of urgency.

In turn, individuals live in **communities**, whether of geography, interest, or identity. Communities offer resources and infrastructures to their members, which give context to the decisions made within them. In an analogous way to individuals, communities can experience felt, expressed, and normative needs.

[1] www.who.int/classifications/icf/en/

INTRODUCTION

In order to provide services that are appropriate to the needs of individuals and communities, **planners and commissioners** require analysis and evidence to inform their decision-making. Strategically assessing care and treatment services requires an understanding of current provision, and the gap between this and future requirements. The starting point must be broad enough to reflect the entire system, yet succinct enough to facilitate comprehension. From an initial simplified overview, priority areas for detailed work can then be identified.

Content of the JSNA

First, we set out the demographic profile of the Moray population. This includes two fundamental health statistics, namely how long people live (life expectancy) and what proportion of life is lived without disease or disability (healthy life expectancy).

Second, we consider the determinants of health in Moray. These are necessarily wider than the health and social care system but are intimately related to the nature and level of demand that that system faces.

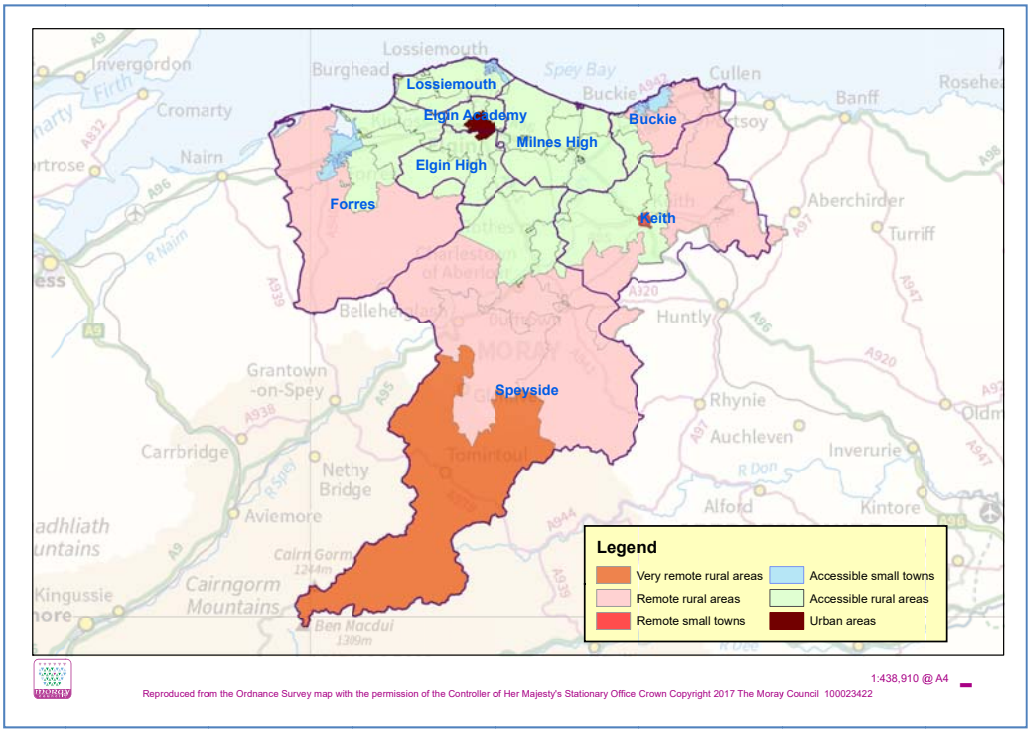
Third, we provide an overview of illness, disease and disability. We present epidemiological data relating to conditions and disease groups in the Moray population, and we provide aggregate service data on where demand is arising across the health and social care system.

Fourth, we focus on people's reported experiences of the health and social care system in Moray, including those with caring responsibilities.

Finally, we provide a high-level summary of the most striking issues identified by the short-life working group's analysis.

Geography and demographics

Moray covers an area of 223,756 hectares (864 square miles), making it the eighth largest area in Scotland. Moray is predominantly rural[2], with a mixture of "remote" and "accessible" rural areas and one "very remote rural" area in South Speyside. There are a number of "accessible small towns", one "remote small town" (Keith), while Elgin is the only settlement classified as "urban".

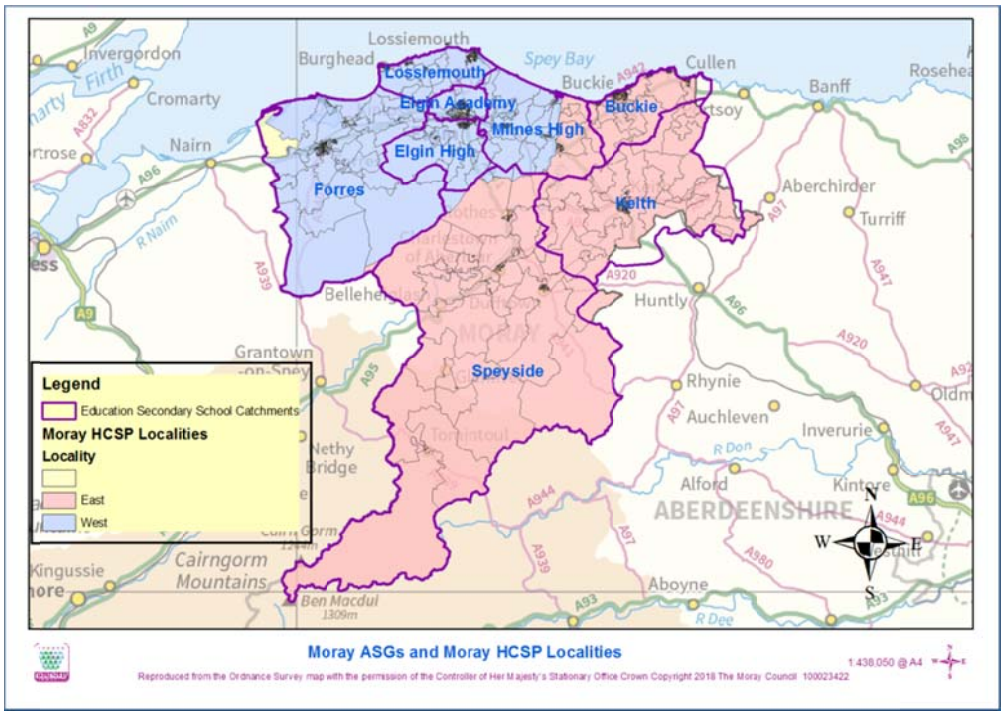


Moray's urban/rural classification for intermediate zones

Moray Council commonly uses Associated School Group (ASG) areas for delivering and monitoring some of its services. Each of the ASGs is based around the eight secondary school and their catchment areas and they correspond approximately to the main centres of population. Three of the ASGs lie with in the East Locality, four are within the West Locality and one ASG includes areas within each locality.

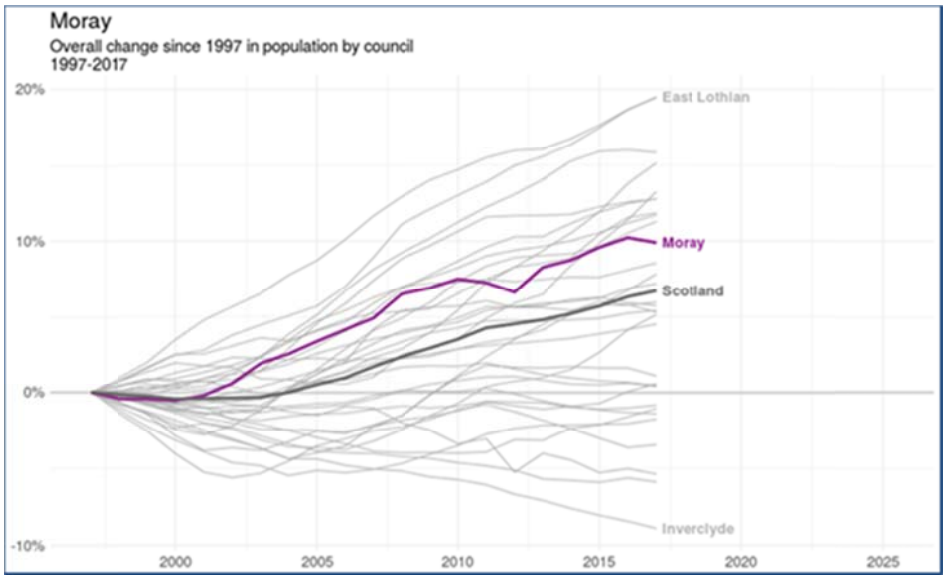
a. Moray HCSP East Locality covers Buckie, Keith, Speyside and part of Milnes' High School ASGs
b. Moray HCSP West Locality covers Forres, Lossiemouth, Elgin High, Elgin Academy and the remainder of Milne's High School ASGs

[2] Using the Scottish Government's 8 fold Urban Rural Classification



Moray Council Associated School Groups and Moray HCSP Localities

Moray's population has grown significantly in the past 20 years from 87,160 in 1997 to an estimated 95,780 in 2017; an increase of 9.9%. The population of Moray is growing faster than the national rate, and has experienced the 11th highest rate of growth amongst the 32 Scottish local authorities. Note, however, that the population in Moray is estimated to have reduced by 3% from 2016 to 2017[3].

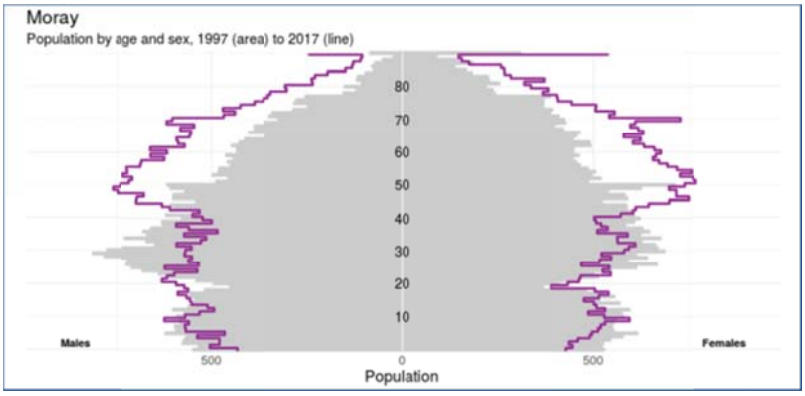


Moray – Population growth since 1997 compared to other councils (NRS)

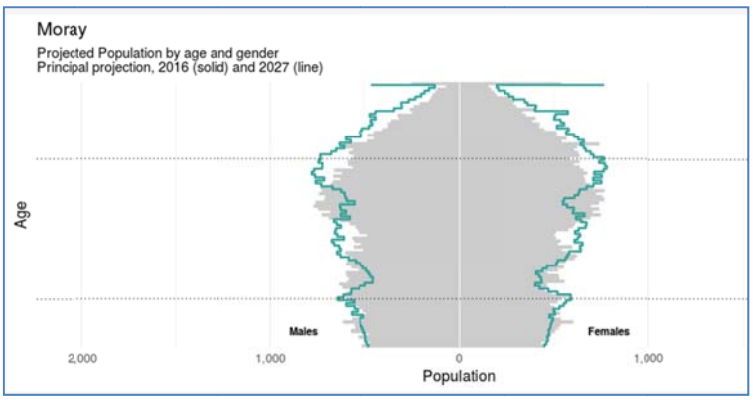
However, in addition to this growth the demography has also changed markedly over the past 20 years. The population as a whole has aged, with a growing number of

[3] National Records of Scotland, 2017 mid-year population estimates

over 50 year-olds. The declining birth rate suggests that the trend over the next 10 years is unlikely to change significantly, without other interventions. Note also that over this period the proportion of males in their early 20s has increased, while the proportion of females in this age group has remained low. The National Records of Scotland suggest the trend for an older population will continue.

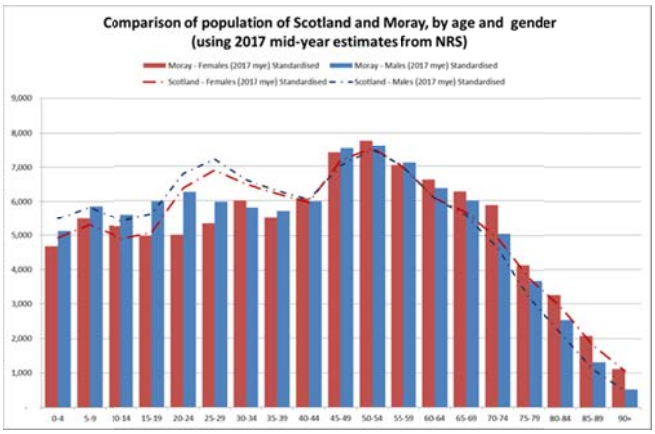


Moray - Population by age and sex 1997 to 2017 (NRS)



Moray – Principal population projection by age and sex 2016-2027 (NRS)

The demographic profile of Moray has some significant differences from Scotland, particularly amongst the under 40s. In order to illustrate the differences in the structure between the populations of Scotland and Moray the rates for age and gender have been standardised using the European Standard Population 2013 version.

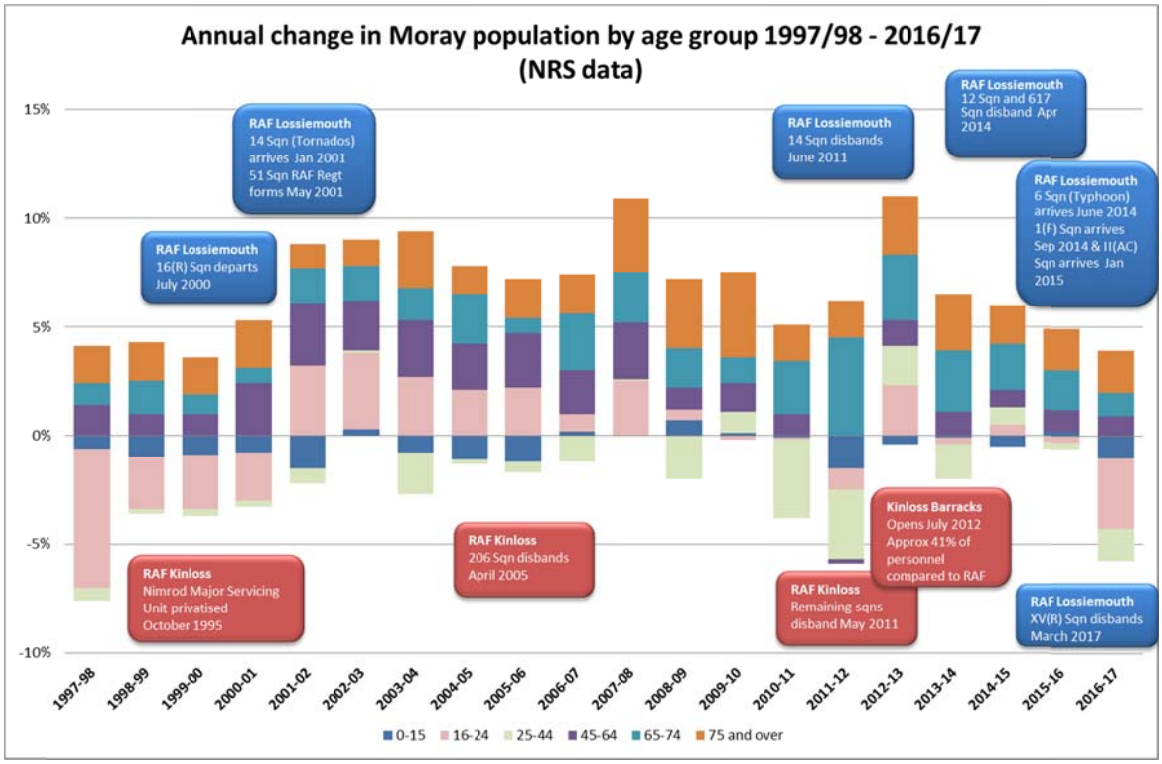


Comparison of population of Scotland and Moray, by age and gender (NRS)

The main differences between the 2 populations are:

- Lower proportion of 20-39 year olds in Moray compared to Scotland
- Lower proportion of 20-29 year old females in Moray compared to males
- Higher proportion of over 60 year old females in Moray compared to males (similar to national rates)
- Higher proportion of 70-74 year old females in Moray compared to Scotland

The two military bases in Moray[4] have a disproportionate impact on the population of Moray having generally a younger age profile and more working- age males under 30 years old. A review of key events at both bases and significant changes in the make-up of the Moray population show a striking correlation.



Annual change in Moray population by age group 1997/98 - 2016/17 and comparison with significant events at Moray's military bases (NRS data)

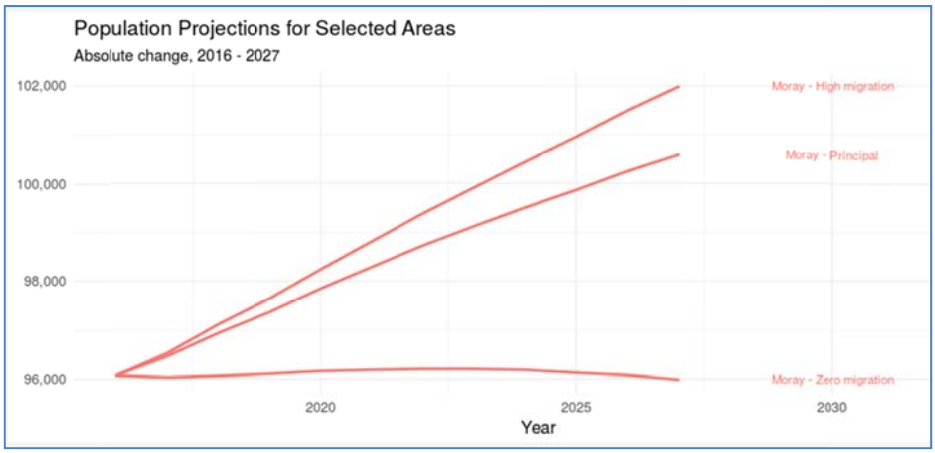
Given this historical background it is highly likely Moray will remain sensitive to changes at either base. Recent announcements have confirmed that additional aircraft, personnel and their families will be arriving at RAF Lossiemouth in the short term:

- An extra 470 personnel will be posted to RAF Lossiemouth when the Poseidon P8 is deployed to the base; currently due in 2020.
- A fourth Typhoon Squadron is due to arrive in 2018/19 and will be operational from April 2019.

[4] Kinloss Barracks (39 Engineer Regiment) and Royal Air Force Lossiemouth

Furthermore, the Ministry of Defence have given a long-term commitment to Kinloss Barracks.

National Records of Scotland produce a range of population projections which take into account various different factors. Figure 8 shows the highest, lowest and principal projections for Moray for the period 2016 – 2027. The highest forecast depends upon a high level of inwards migration and would see Moray's population rise by just over 6% to around 102,000 residents. If there is no inwards migration the population will be at or slightly below current levels. The most likely projection suggests an increase of 4.6% to between 100,000 and 101,000 Moray residents in 2027.



Population projections for Moray 2016-2027 (NRS)

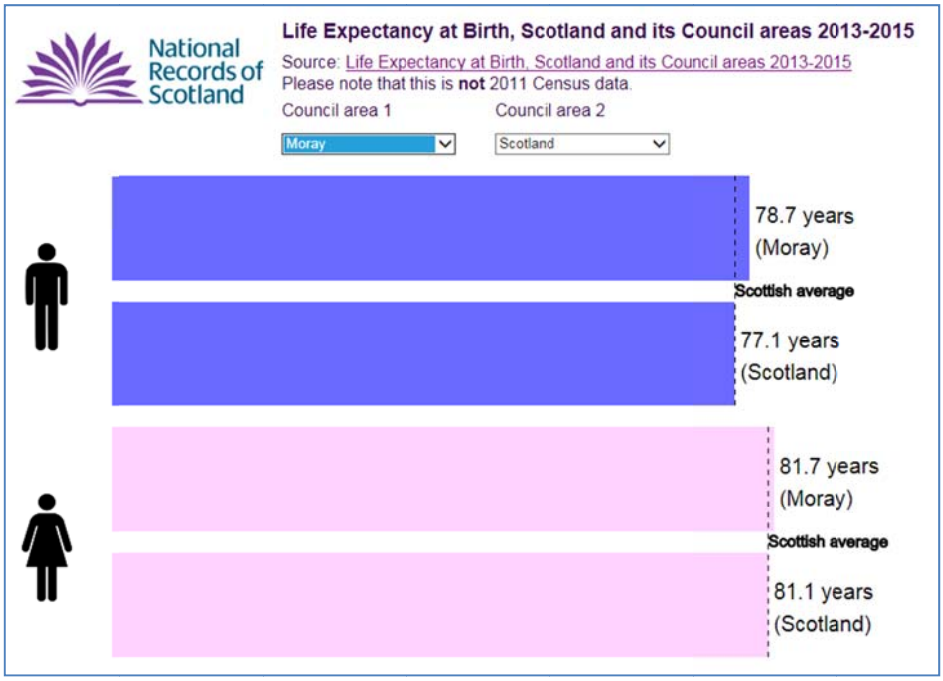
The most significant population growth over the next two decades is projected to occur amongst older adults. The table below sets out projected population growth based on a 2016 baseline.[5] There is a projected reduction in children, limited change in the working age population, but significant growth in adults of pensionable age, including a near doubling of those aged 75 and over by 2041.

AGE GROUP	YEAR	Projected population change from 2016
All ages	**2021**	2%
	2026	4%
	2031	6%
	2036	7%
	2041	8%
Children (aged 0 to 15)	**2021**	1%
	2026	-1%
	2031	-3%
	2036	-3%
	2041	-5%
Working age	**2021**	4%
	2026	5%
	2031	6%
	2036	4%
	2041	3%
Pensionable age and over	**2021**	-2%
	2026	7%
	2031	14%
	2036	26%
	2041	34%
Aged 75 and over	**2021**	14%
	2026	34%
	2031	**49%**
	2036	**67%**
	2041	**90%**

[5] https://www.nrscotland.gov.uk/files//statistics/population-projections/sub-national-pp-16/tables/pop-proj-principal-2016-all-tabs.xlsx

Life expectancy and healthy life expectancy

Typically, people in Moray of both sexes have a greater life expectancy at birth than their counterparts across Scotland.

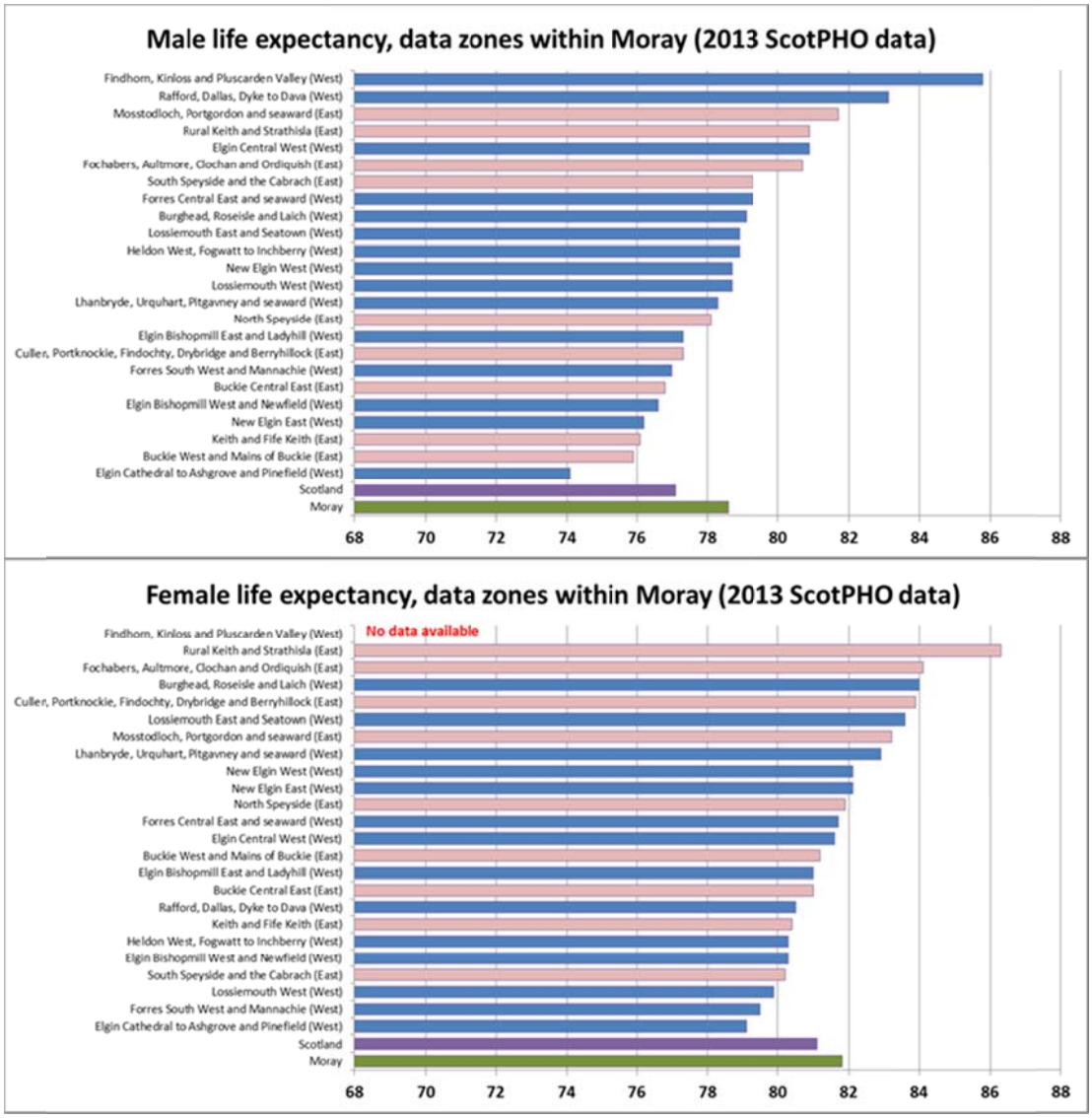


Life expectancy at birth, comparison between Moray and Scotland 2013-15 (NRS)

- Females in Moray have 3 years greater life expectancy than males on average
- Males in Moray have 1.6 years greater life expectancy than males in Scotland, on average
- Males in Moray have 7 months greater life expectancy than females nationally, on average

However, these averages hide the significant differences between different areas of Moray:

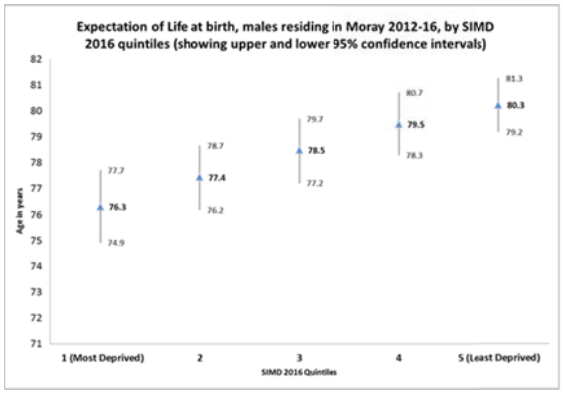
- For males there is almost 12 years difference in life expectancy (11.7) between a boy born in Elgin Cathedral to Ashgrove and Pinefield (In West Locality) and a boy born in Findhorn, Kinloss and Pluscarden Valley (also in West Locality).
- Females born in Elgin Cathedral to Ashgrove and Pinefield also have the lowest life expectancy, 7.2 years lower than girls born in Rural Keith and Strathisla (East Locality)
    - Note that no data is available for life expectancy for females born in Findhorn, Kinloss and Pluscarden Valley, which is likely to be higher.
- The discrepancy between males with the lowest life expectancy and females with the highest is 12.2 years.
- Males living in 17 of the Moray intermediate data zones (71%) have greater life expectancy than the average Scottish male.
- Females living in 13 of the Moray intermediate data zones (57%) have greater life expectancy than the average Scottish female.

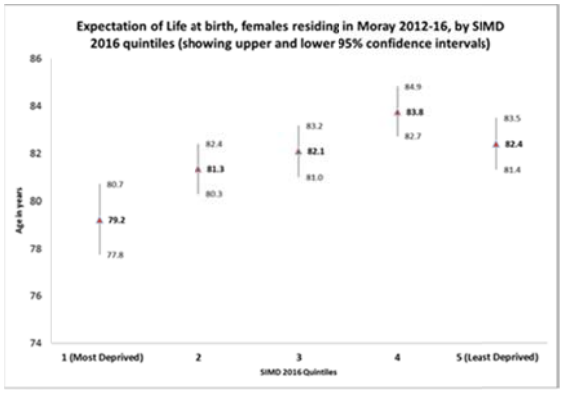


Life expectancy for data zones in Moray Male and Female (2013 ScotPHO data)

There is a clear link between the level of deprivation in the areas people live in and their life expectancy; the less deprived the area the longer males live on average. For females the situation is generally similar. In the most deprived areas females have lower life expectancy than their counterparts in less deprived areas. However, females living in areas in the least deprived quintile (the 20% of data zones with the lowest levels of deprivation) have a lower life expectancy than females living in data zones in the second least deprived quintile.

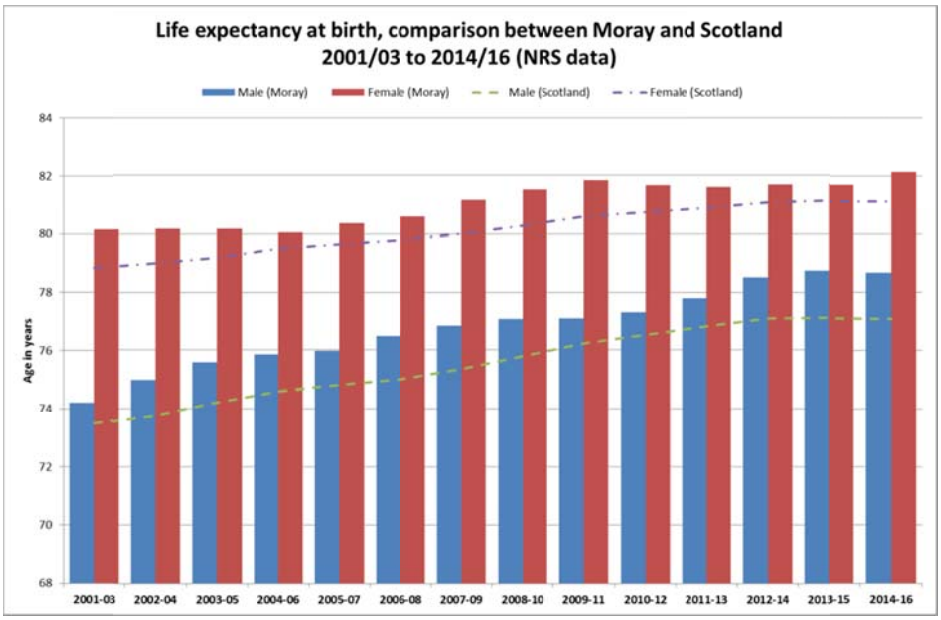
Males in the least deprived areas (quintile 5) typically lived 4 years longer than males living in the most deprived areas (quintile 1), based on 2012-16 data. For females living in the second least deprived areas (quintile 4) life expectancy is 4 years 7 months longer than females in the most deprived areas.





Expectation of life at birth for residents in Moray by SIMD 2016 quintile, males and females (2012-16 SIMD data)

Between 2001/03 and 2014/16 the life expectancy for babies born in Scotland has gradually increased, although there appears to have been a levelling off, or slight reduction, since 2013/15. Over this period males in Moray could expect to live 4.5 years longer on average to the age of 78 years and 8 months (a 6% increase), and females in Moray an additional 2 years to the age of 82 years and 1 month (a 2% increase). For Scotland the average baby boy in 2014/16 had a life expectancy of 77 years and 1 month (a 5% increase since 2001/03) and baby girls 81 years and 1 month (a 3% increase since 2001/03).



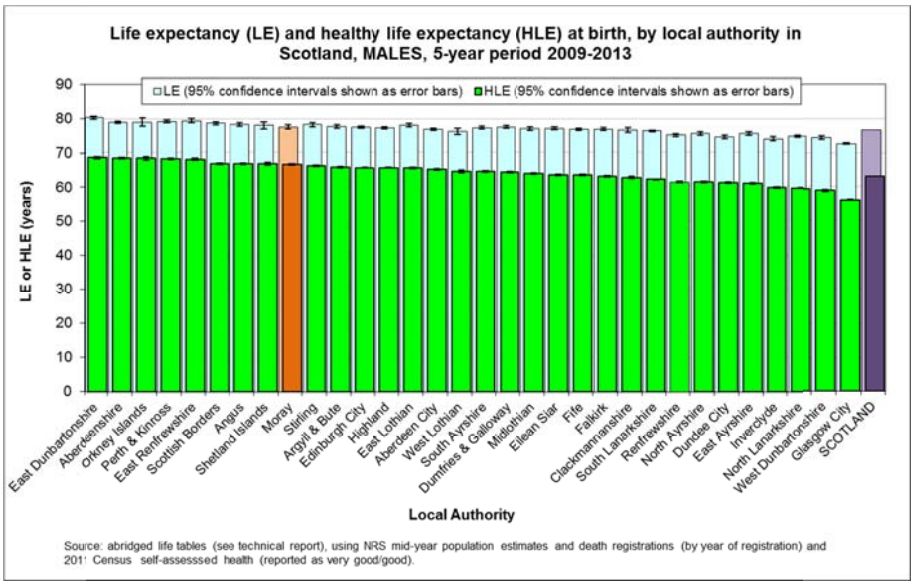
Life expectancy at birth, Moray and Scotland 2001/03 to 2014/16 (NRS)

It appears likely that the Moray population will continue to increase in number and there will be a higher proportion of older people potentially living longer. This has implications for the type and amount of care that will be required in the next 10 years and raises questions about who will be available to provide that care.

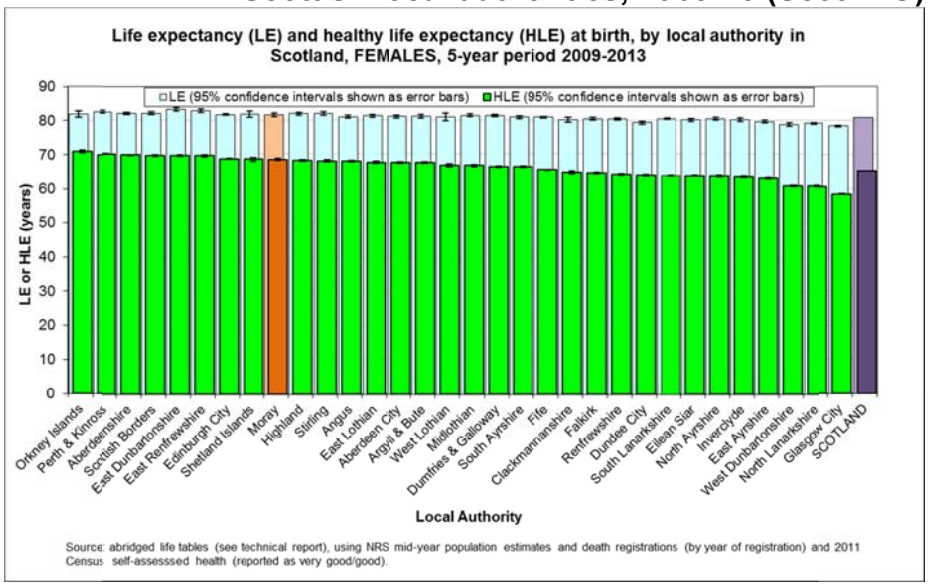
Healthy Life Expectancy trends within and across Moray

The latest data published by the Scottish Public Health Observatory for the healthy life expectancy (HLE) of residents of each of the 32 Scottish local authorities is based on an average for the 5-year period 2009-13. Males in Moray on average had an HLE of 66 years and 5 months, giving them an average of slightly more than 11 "not healthy" years. For females the HLE was 68 years and 5 months on average, giving them 13 years and 5 months "not healthy".

Both these HLE ages are above the Scottish average of 63 years and 1 month for men, and 65 years and 4 months for women. On average people in Moray live longer in good health than is typical for Scotland. Moray has the 9th highest HLE for both males and females out of all the Scottish local authorities.



Life expectancy and healthy life expectancy at birth for male residents of Scottish local authorities, 2009-13 (ScotPHO)



Life expectancy and healthy life expectancy at birth for female residents of Scottish local authorities, 2009-13 (ScotPHO)

Healthy places – income, wealth and poverty

Income and wealth (and the individual and social power associated with access to increasing income and wealth) are fundamental determinants of population health. In short, populations with least suffer worse health, at an earlier age, than populations with most.[6]

Unemployment is low in Moray…

Four out of five adults (78%) work in Moray.[7]

Fewer than one thousand adults are claiming out-of-work benefits in Moray (less than 2% of the working age population).

One in twenty adults are claiming Employment Support Allowance and Incapacity Benefit (5% of the working age population).

…but not all employment provides a living wage

One in four employees (25%) in Moray earn less than the 'real living wage'.[8,9]

People earn less in Moray than the national average. The average full-time wage in Moray in 2016 was £498 per week, compared with £548 for Scotland.[10]

Low wages make it more difficult to save and contribute to a pension.

There is a higher rate of part-time employment than nationally (38% versus 33%).[11]

Most families receiving tax credits are in work.[12]

Not everyone has qualifications

Over one in four adults in Moray have no qualifications. There is geographical variation, ranging from around one in ten (11%) with no qualifications in Kinloss to over one in three (37%) in Keith and Dufftown.[13]

Women earn less than men in Moray – and are more likely to be lone parents

Women working fulltime earn £430 per week, compared to men working fulltime who ear £540 per week.[14]

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[6] www.healthscotland.scot/health-inequalities/fundamental-causes
[7] *NOMIS* - 2017
[8] http://scottishlivingwage.org/ - £8.75 per hour as at November 2017
[9] ONS - ASHE
[10] *NOMIS* – July 2016-June 2017
[11] *ONS* - 2016
[12] HM Revenues and Customs, *Personal Tax Credits: Finalised Award Statistics* – August 2015 figures, published November 2017
[13] NHS Health Scotland, *Lone parents in Scotland* - November 2016
[14] ONS, *Annual Survey of Hours and Earnings* – 2007-2016

Nearly one in three (29%) women work part-time in Moray, compared to one in thirty-three men (3%).
Women's lower wages and fewer working hours increase the risk of poverty for women, and nine out of ten (90%) lone parents in Scotland are women.[15]

Child poverty exists in Moray today

Recent estimates identify 3,049 children living in relative poverty in Moray.[16]

This represents one child in six (17%). This is lower than the interim target of 18% in the child poverty act, but higher than the ultimate target of 10%.

School attainment is not equal

Pupils living in less affluent communities in Moray generally do less well at school than those in the more affluent areas.[17]

Moray's population is ageing

One in five adults are of retirement age.[18]

One in seven retirees are in receipt of pension credits.[19]

An aging population and a low wage economy increase the need for a preventive approach for the future.

People facing additional challenges require more help

Looked after children do less well at school.[20] Fewer than one in six achieve level five literacy and numeracy at secondary school. Fewer looked after children go on to further education, training or employment after school.

Disability is a known obstacle to employment, with less than half of adults with a disability are in employment.[21] Disability is associated with poverty.[22]

Poverty and poor mental health are related. Suicide rates are higher in more deprived populations.[23] Suicide is more common in Moray than nationally.[24]
One in five households have no access to a car.[25]
Food and fuel are prohibitively expensive for some households

[15] Scottish Government, *Equality characteristics of people in poverty in Scotland* - 2015/16
[16] *End Child Poverty*, http://www.endchildpoverty.org.uk/poverty-in-your-area-2016/ – November 2016
[17] *SIMD* - 2016
[18] Research Information Officer; *Growth Bid – Moray – Supplementary Information* – Aug 2017
[19] Department for Work and Pensions - May 2017
[20] Research Information Officer: *stats provided* – December 2017 and January 2018 (email)
[21] *Annual Population Survey* - 2016
[22] Scottish Government, *Equality characteristics of people in poverty in Scotland* - 2015/16, June 2017
[23] ScotPHO, *Suicide: Deprivation* - 07.09.17
[24] Moray Health Profile 2015 (five year average)
[25] *Census* - 2011

Increasing numbers of people are seeking help from Moray food bank. Over two thousand people sought help last year.[26]

A household is said to be in fuel poverty if it has to spend more than 10% of its income on fuel, to heat their home to a satisfactory level. The Scottish House Condition Survey estimates that fuel poverty in Moray is higher than the Scottish average. 32% of Moray households (over 13,000 households) are in fuel poverty, compared with a Scottish average of 28%.

Where people live matters

The experience of poverty is not equally distributed across Moray.

In some neighbourhoods the number of children living in poverty is less than one in twenty (<5%); in other neighbourhoods it is as high as one in five (20%).[27]

While over one thousand school pupils (P1 to S3) received means tested free school meals last year, some neighbourhoods have much higher proportions of children receiving free school meals than others.[28]

[26] https://www.pressandjournal.co.uk/fp/news/moray/elgin/1356831/surge-in-demand-at-moray-food-bank/
[27] *Community Planning Outcomes Profile Tool*
[28] http://www.gov.scot/Topics/Statistics/Browse/School-Education/SchoolMealsDatasets/schmeals2017

Healthy places – housing and homelessness

The Moray Council *Housing Need and Demand Assessment 2017* sets out a comprehensive analysis of future housing types and includes an assessment of implications for health and social care.[29] The most affordable housing in Moray is council housing, on average under half the cost of private rentals.[30] The council housing waiting list is over three thousand and rising.[31]

Housing Stock Conditions

- Disrepair is the owner-occupied sector is a significant issue in Moray. The Scottish House Condition Survey (SHCS) estimates that approximately 30% of private housing is in despair.

- 23% of private sector stock was in critical disrepair (1998 survey carried out by MC)

- The SHCS estimates that 5% of Moray's dwellings are below tolerable standard.

  February 2017 TMC aware of 337 private sector prosperities that were BTS (1% of private sector stock). Slight reduction from 372 in 2011.

  Disproportionate number of BTS properties in Keith, Speyside and Cairngorms.

  Only 12% of households occupying BTS properties were on the Council's Housing List at 1 April 2017.

Overcrowding

- The Scottish House Condition Survey shows that overcrowding is much more prevalent in social housing than the private sector: prevalence's are similar in Moray to the Scottish average and most neighbouring local authorities.

Adaptations

- The top five reasons for housing adaptations are: multiple sclerosis; stroke; amputee; motor neurone disease; road traffic accident/workplace accident.

Specialist Provision

- **Gypsy/Travellers** There are no official Gypsy/Traveller sites in Moray. Moray operates an Unauthorised Encampments Policy in the absence of any official sites.
- **People with learning disabilities** are often among those with the poorest health in Scotland, and on average have a life expectancy 20 years lower than that of

[29] The HNDA 2017 is available to download at www.moray.gov.uk/moray_standard/page_95565.html
[30] Scottish Housing Regulator, *Landlord Report Moray Council* - 2015/16
[31] Moray Council, *Homelessness in Moray Annual Report* - 2016/17

the general population. Just over a third of adults with learning disabilities live with a family carer, often in general needs housing, often in the private sector, with additional care and support to enable them, and their carers, to sustain independent living. However there is a need to ensure sufficient provision of appropriately supported housing for those where family care is no longer available. The Scottish Commission for Learning Disability 2015 report states that across Scotland there are 6.1 adults (16+) with learning disabilities per 1,000 adult population. Moray has a marginally higher rate at 6.4. The distribution of ages varies little across local authority areas.

Homelessness

Key service user groups

The main service user groups for non-permanent accommodation are likely to be homeless households and persons fleeing domestic abuse but will also include students; refugees and asylum seekers; and migrant workers. These latter groups are discussed at Para 5.16.

Evidence

The following tables describe trends in homeless presentations over the last 5 years. These tables have been populated from Moray Council database (iWorld) Scottish Government HL1 data. 2016/17 data have been included in this HNDA prior to publication by the Scottish Government. These data can be subject to change, particularly as a result of any appeal actions, and so there may be some discrepancies between these figures and the Scottish Government's figures when published. Moray Council believe these differences to be minimal and therefore do not impact significantly on the conclusions drawn relevant to this HNDA. The number of homeless applications and assessments has remained stable (between 500-600 per year) for many years.

Homeless applications and assessments in Moray					
	2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Applications received in period	553	533	564	536	578
Assessments completed in period	546	554	581	579	580

Source: Applications received HL1 stats from Scottish Government (Moray)

Over the last five years:

- The group most likely to become homeless are aged 18 to 49 (80%)
- The majority of applicants are single person households (53%)
- The main reason for homelessness is being "asked to leave", followed by a "non-violent dispute within the household"
- The vast majority of households presenting as homeless have a local connection to Moray. The local connection is mainly associated with residency and family association.
- Approximately 60% of presentations were found to be statutorily "homeless/ potentially homeless unintentional".
- Repeat homelessness is generally lower than the Scottish average.

These trends have remained relatively stable over the last 5 years.

Healthy places – loneliness and social isolation

Scottish Government strategy highlights, "Social isolation and loneliness can affect anyone – at all ages and stages of life. We know there is also a link between loneliness and poor physical and mental health and that this can impact on everyday life."[32] Factors in Moray that exacerbate these issues include lack of welcoming spaces, transport and self-stigma.[33] This can be compounded by misconceptions around loneliness and isolation only affecting certain groups in society, such as older people. Isolation affects all ages and all groups of people. For example, nine million people (almost one-fifth of the population) reported in a 2016 survey they are always or often lonely.[34]

Stigma

Stigma can also act as a barrier to supported self-management and to accessing resources within the community. Research has suggested that structural stigma is a cause of health inequalities[35], and that stigma can be considered a fundamental cause on a population level[36], with social isolation as the pathway through which its effects are mediated.

There are specific issues in which rurality can have an impact, as can the ability of individuals – perceived or otherwise – to access services. An example of structural stigma within Scotland is that people within the most deprived areas are 2.5 times more likely to be prescribed anti-depressants that people in the least deprived[37]. Furthermore, whilst there are limitations on locally available data in relation to stigma, the Our Voice Citizens' Panel 4th Survey Report (2018)[38] found that 69% of people had witnessed someone being treated unfairly because of their mental health.

[32] https://beta.gov.scot/publications/connected-scotland-tackling-social-isolation-loneliness-building-stronger-communities/

33 Isolation affects all ages and all groups of people

[34] Co-op (2016) Trapped in a Bubble: An investigation in to triggers for loneliness in the UK

[35] Hatzenbuehler, M. L. (2016) *American Psychology*. Structural stigma: research evidence and implications for psychological science. 71:742

[36] Hatzenbuehler, M. L., Phelan J. C., and Link, B. G. (2013) *American Journal of Public Health*. Stigma as a Fundamental Cause of Population Health Inequalities

[37] Medicines used in Mental Health, 2006/07 to 2016/17, ISD

[38] Our Voice Citizens' Panel (2018) – 4th Survey Report: Survey on HIV awareness, mental health and wellbeing and inclusive communication

Alcohol consumption

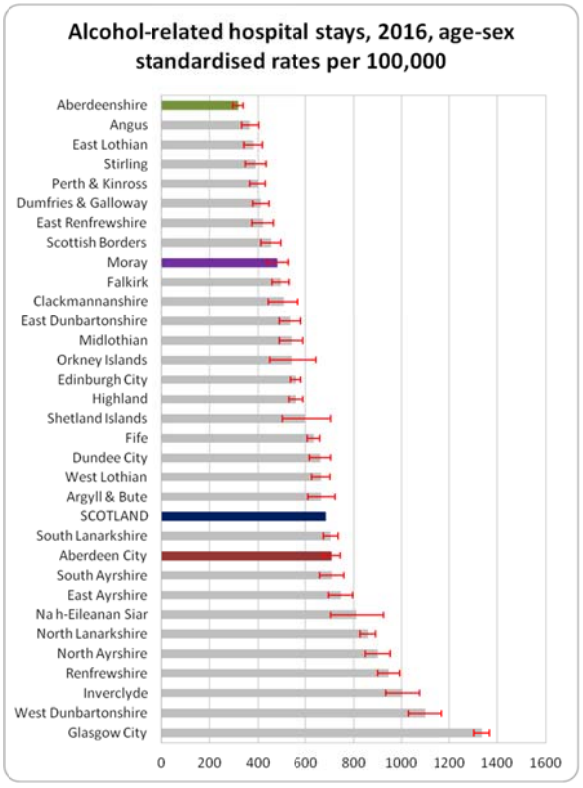
Hazardous alcohol consumption is reducing in Moray, but one in four adults are still drinking above hazardous levels

Ethanol is a dose-related risk exposure for a range of physical and mental diseases and disorders.

The Scottish Health Survey reveals that around one quarter of the adult population in Moray drinks more than the recommended fourteen units of alcohol per week. While lower than a decade ago, a significant proportion of the Moray population remains exposed to hazardous levels of alcohol consumption.

Moray has below average alcohol-related hospital stays

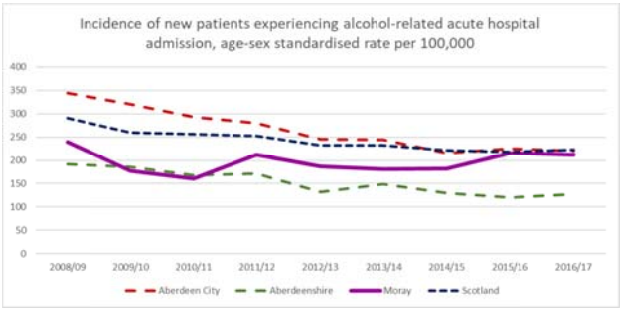
A range of metrics are available to measure alcohol-related harm. Alcohol-related hospital admissions are of particular importance for a number of reasons. The metric represents a measure of significant alcohol-related health harm in the population. Standardised coding of hospital admissions allows for robust comparisons across time and geography, albeit that hospital admission rates are likely to be a function of supply and clinical practice as much as need (i.e. admission rates can increase in populations with greater access to hospitals, which can also vary by time and geography).



Moray compares favourably to the national average, with an alcohol-related acute hospital admission rate in the lower half of local authority areas in Scotland.

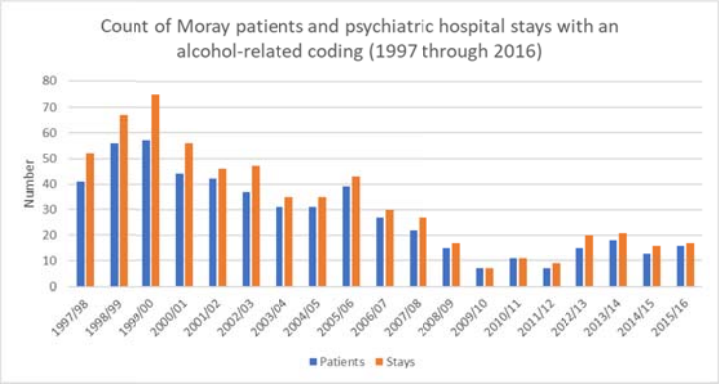
Over time, the incidence of alcohol-related admissions to acute hospitals has reduced in Moray, as it has elsewhere in Scotland.[39]

[39] http://www.isdscotland.scot.nhs.uk/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/data-tables2017.asp?id=2044#2044



However, in contrast to the rest of Scotland, the incidence of new patients admitted each year in Moray has remained static.

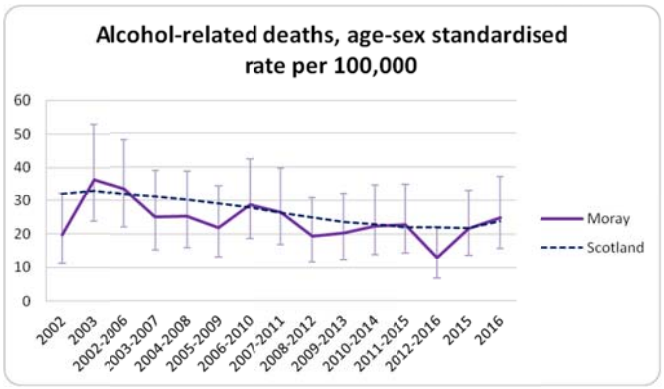
In absolute terms, there were 359 individual patients who were admitted for 459 acute hospital stays with an alcohol-related diagnosis, during 2016/17 in Moray. Of these patients, over half (n=199; 55%) were admitted for the first time.

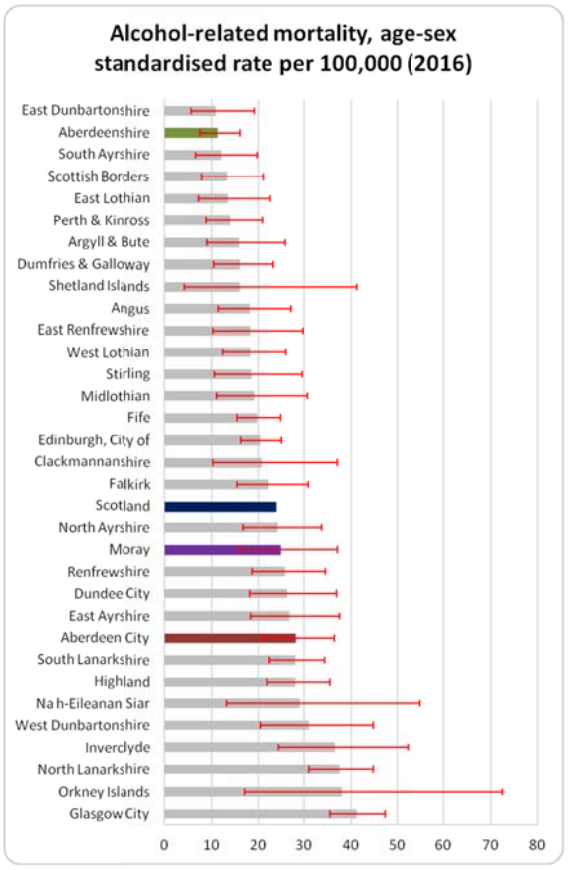


In relation to alcohol-related psychiatric admissions, the number of Moray residents being admitted and the number of stays have reduced over the past two decades. The data does not reveal whether this reflects a reduction in need in the population or a reduction in psychiatric in-patient facilities.

One in forty deaths is alcohol-related

Over the past decade an average of 960 people die from all causes in Moray every year.[40] In 2016 ScotPHO recorded 24 alcohol-related deaths (2.5% of all deaths).





Moray's alcohol-related mortality rate is similar to the national average and has reduced over time in a similar manner. It remains unclear whether a recent upturn represents a reversal in the declining trend.

[40] www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/deaths-time-series-data

Problem drug use

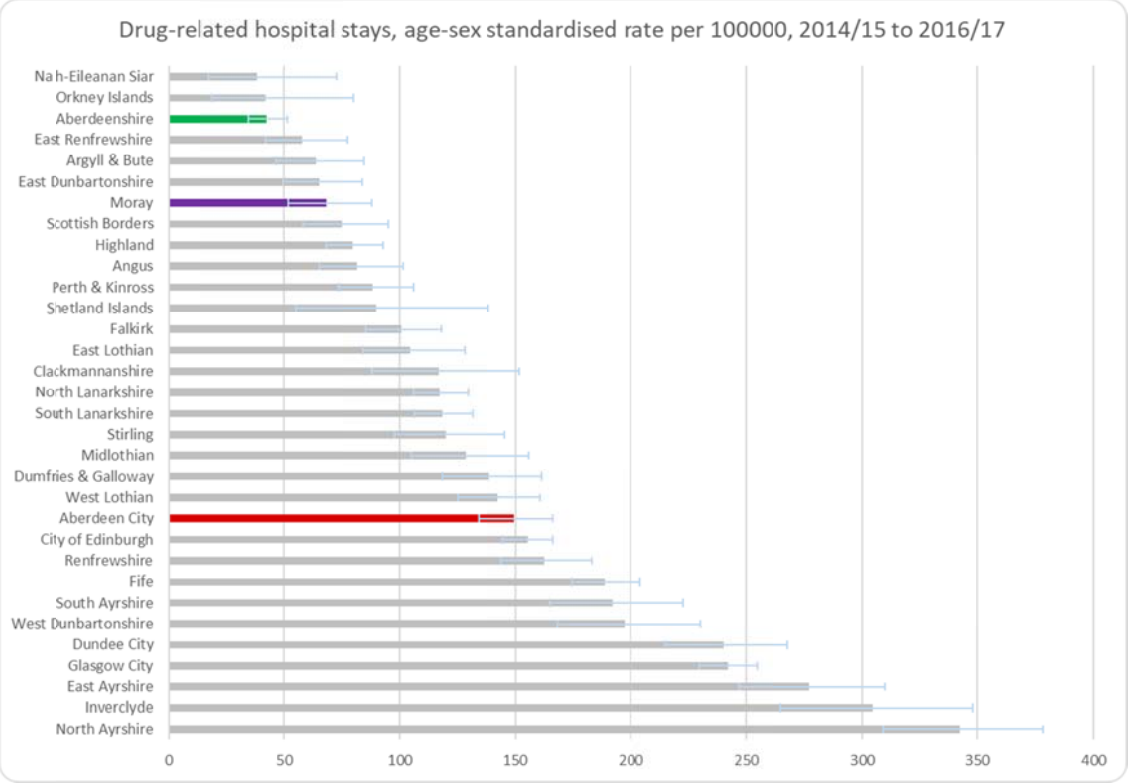
An estimated 350 people in Moray experience problem drug use

"Problem drug use" is defined as use of illicit opiates, prescribed and illicit methadone, and illicit benzodiazepines. It excludes "recreational" drug use. Prevalence estimates for people who use drugs (based on 2015/16 data) will be updated in early 2019.[41] The previous estimates were calculated for 2012/13, when the estimated prevalence rate was 0.59% (95%CI 0.44%, 0.86%). This translates into an estimate of 350 Moray residents aged 15 to 64 using drugs, with females representing over one fifth (n=80; 23%) of the total. Age-related estimates were provided for males, demonstrating the largest proportion were aged 25 to 34, with a third over the age of 35.

	Age Group (% of total)				
	All (15 to 64)	15-24	25-34	35-64	Unknown
Males	270 (100%)	70 (26%)	100 (37%)	90 (33%)	10 (4%)

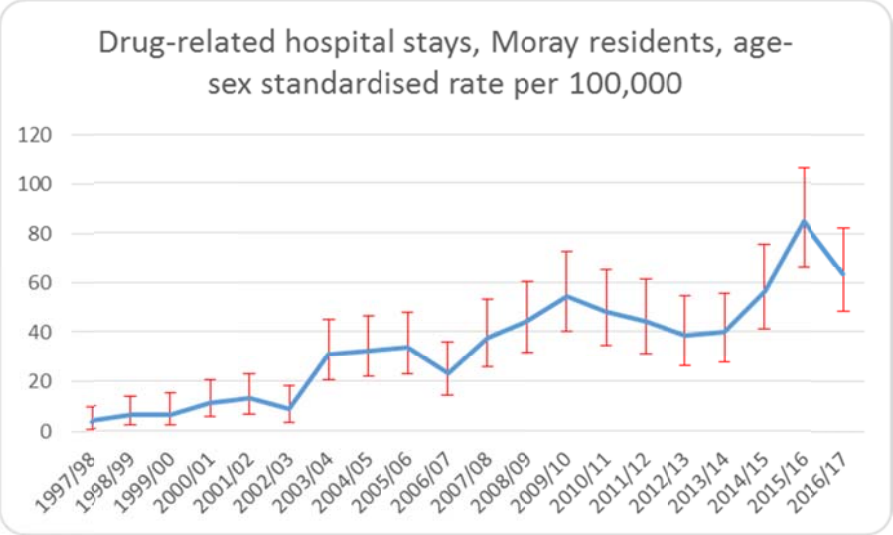
Drug-related hospital admissions have been traditionally low but are increasing

Moray's mean rate of drug-related hospital admissions is in the lowest quarter of alcohol and drug partnership areas across Scotland.[42]

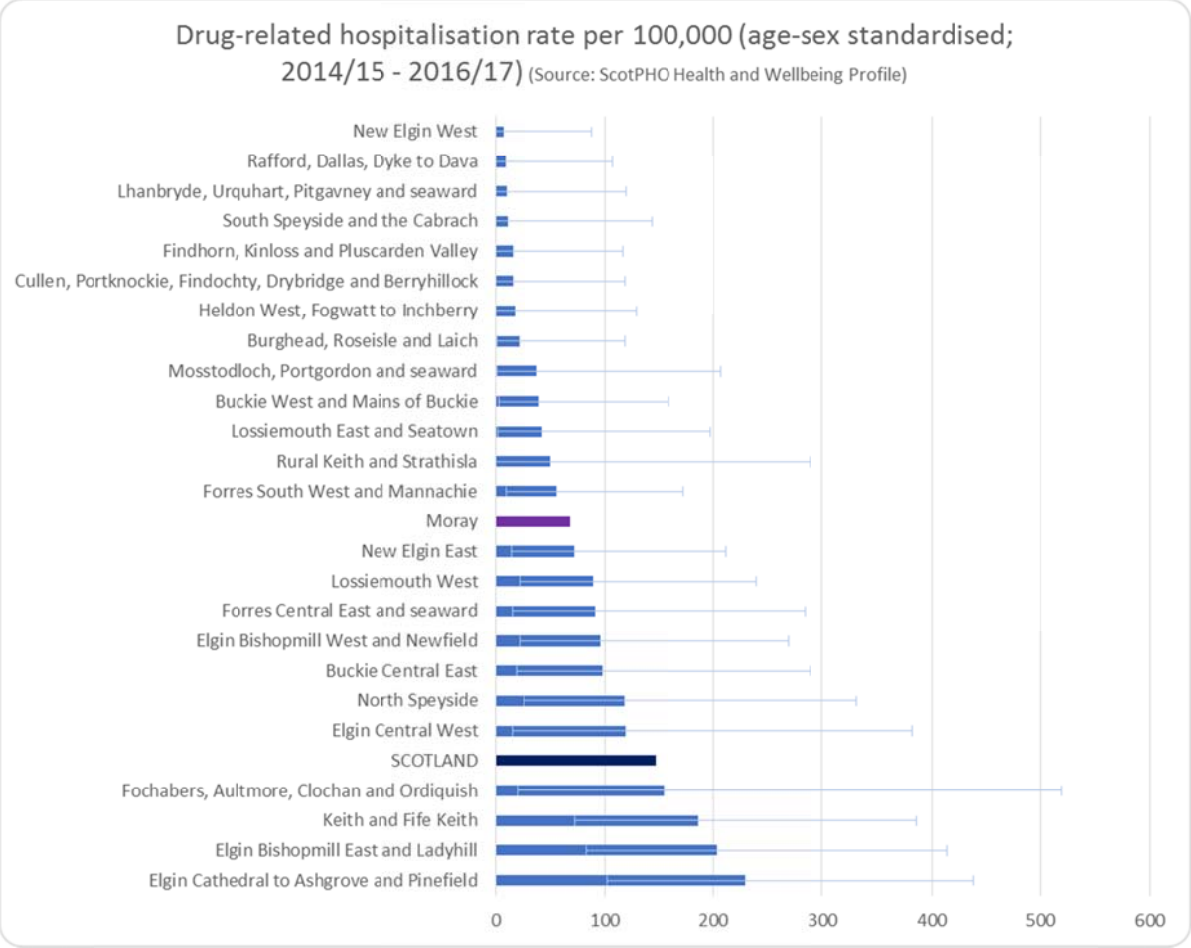


[41] http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Drugs-Misuse/Prevalence-of-Problem-Drug-Use/
[42] https://scotland.shinyapps.io/ScotPHO_profiles_tool/

Moray's mean drug-related hospital admission rate has demonstrated an upward trend over the past two decades.

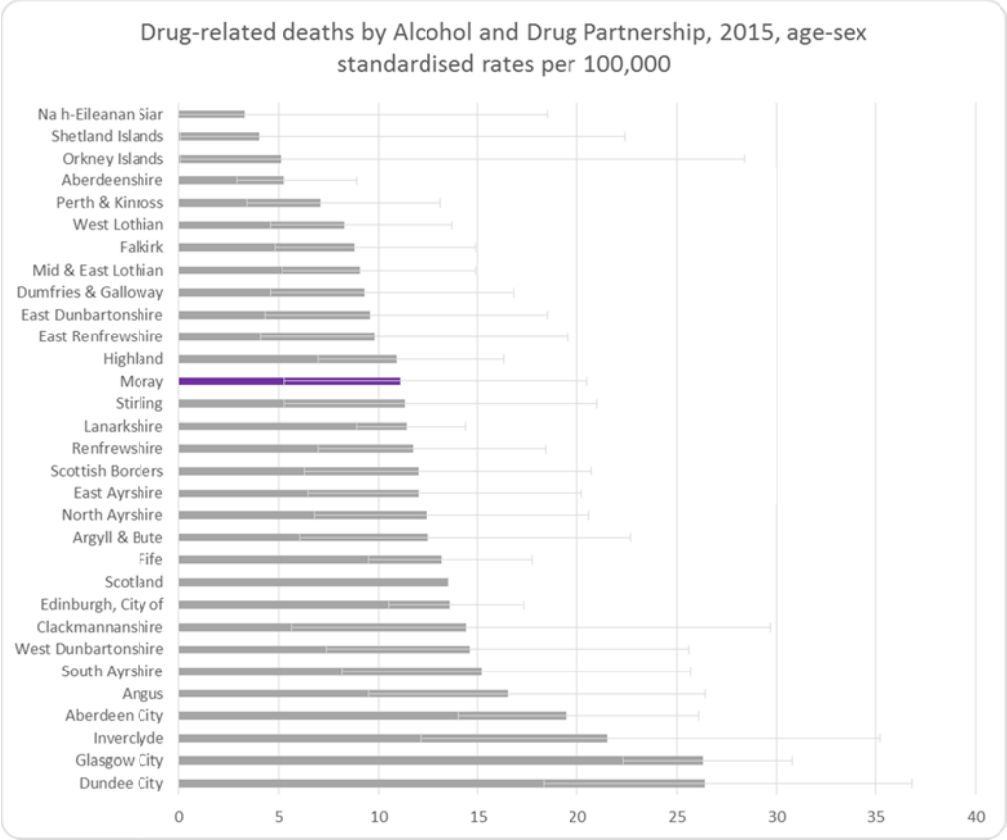


Moray's mean drug-related hospital admission rate masks significant variation at the intermediate geography level. Drug-relayed admission rates in some parts of Moray approach the mean rates seen elsewhere in Scotland.

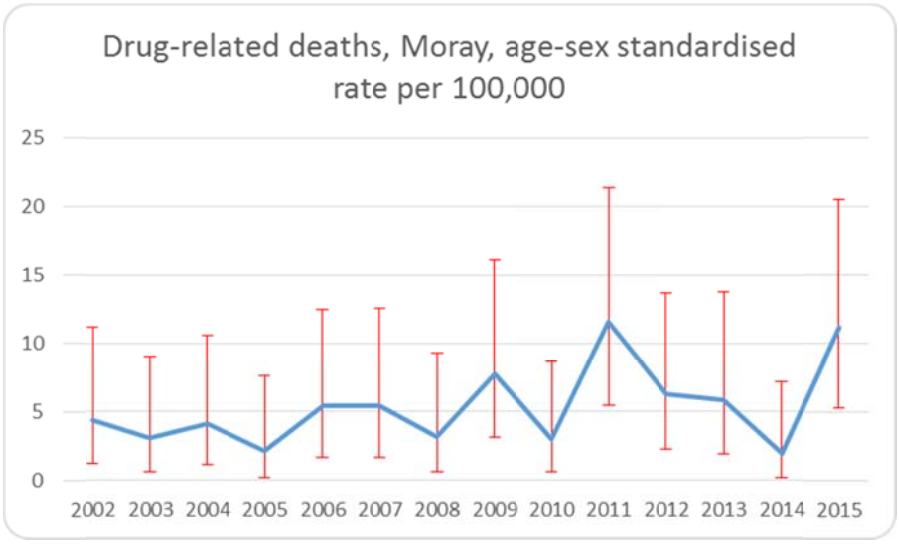


Drug related deaths may be showing an upward trend

Drug-related deaths have increased across Scotland in recent years.[43] Moray's drug-related death rate is in the lower half of alcohol and drug partnership areas in Scotland.



There is evidence of recent spikes in annual drug-related deaths in Moray.

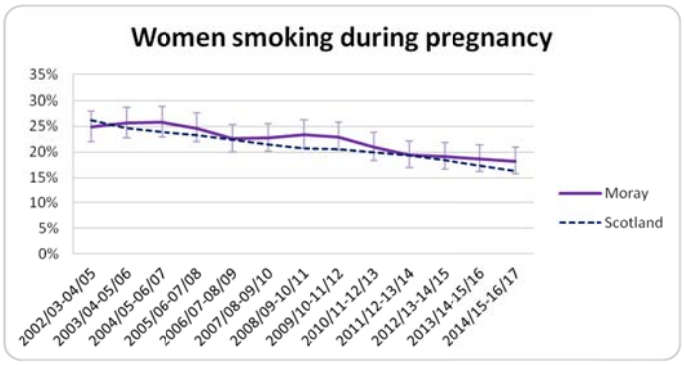


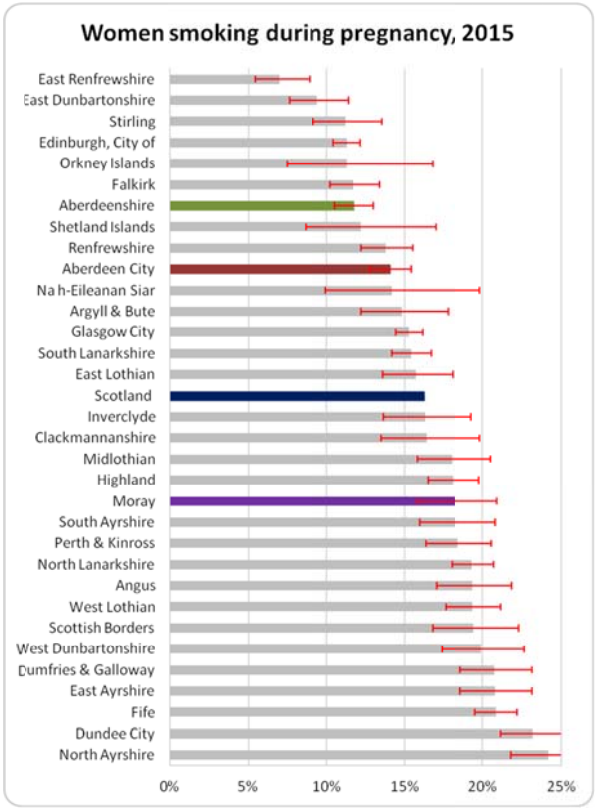
[43] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland/2017

Tobacco smoking

160 unborn infants are exposed to maternal smoking each year

Almost one in five pregnant women (18%) report smoking at their booking appointment with their community midwife. In absolute terms, out of 900 annual births, this is 160 women reporting smoking at their booking appointment. This rate has reduced over the past decade, and remains significantly higher than Aberdeen City and Aberdeenshire.

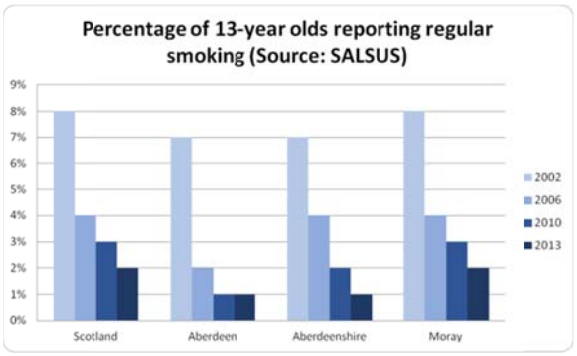


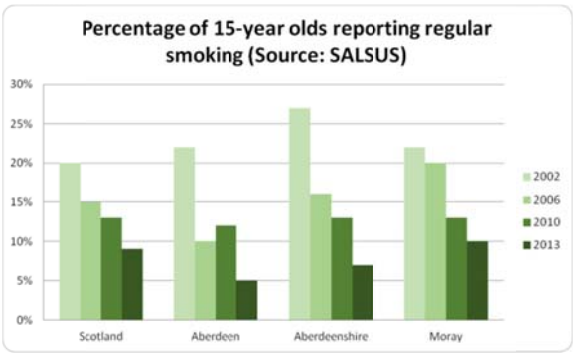


There are an estimated 200 teenage smokers in Moray

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)[44] defined "regular smoking" as smoking one or more cigarettes every week. During the period that SALSUS reported local authority results, there were significant reductions in the proportion of 13 and 15-year olds reporting being regular smokers.

Moray's prevalence data appears similar to that seen nationally. Based on the population estimate for 2013, the prevalence data suggests around two hundred teenage smokers in Moray.





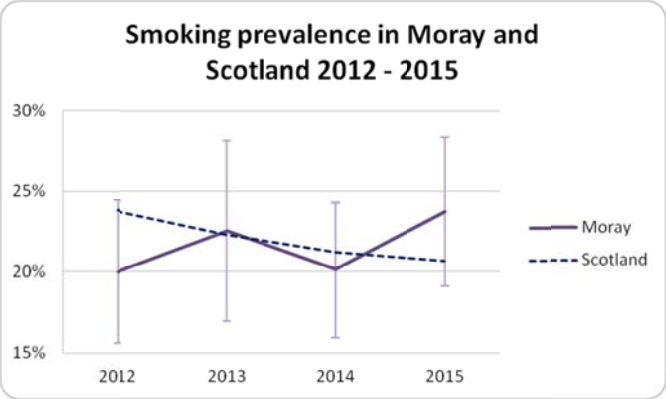
[44] www.gov.scot/Topics/Research/by-topic/health-community-care/social-research/SALSUS

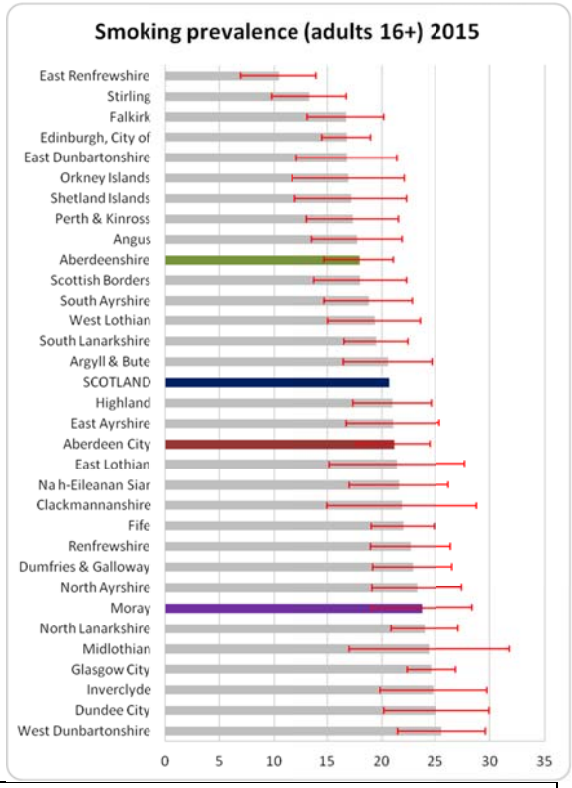
HEALTH BEHAVIOURS

One in four adults smoke in Moray, equal to more than 18,000 adult smokers

Almost one in four adults aged 16+ in Moray smoke,[45] higher than the national average (figure)

This proportion has increased in recent years, up from one in five in 2012/13 (figure, table).





Adult smokers (age 16+) in Moray					
Year	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Smokers (number)[46]	15,372	17,739	15,739	18,725	18,852
Population estimate (number)[47]	76,256	77,749	78,179	79,008	79,543
Crude smoking prevalence	20%	23%	20%	24%	24%

[45] https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do

[46] Data download via www.isdscotland.org/Health-Topics/Public-Health/Publications/2017-10-24/visualisation.asp

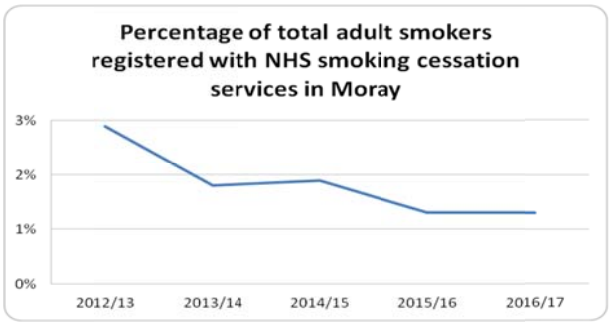
[47] www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates

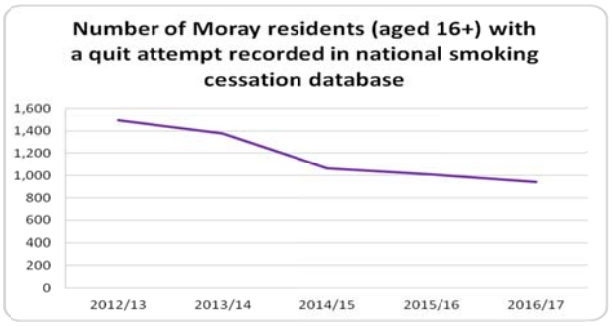
Uptake of NHS smoking cessation support is declining

Adults accessing free NHS smoking cessation support from Community Pharmacies and specialist public health services are recorded on a national database. The number of adults accessing NHS smoking cessation services has reduced nationally and locally.

Proportion of adult smokers registering for NHS smoking cessation services					
Year	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Scotland	11.1%	9.3%	7.2%	7.0%	6.4%
Moray	9.6%	7.7%	6.7%	5.4%	5.0%

The proportion of smokers registered with NHS smoking cessation services per year has fallen from nearly 3% of smokers to just over 1% in the past five years. The number of quit attempts have likewise reduced.





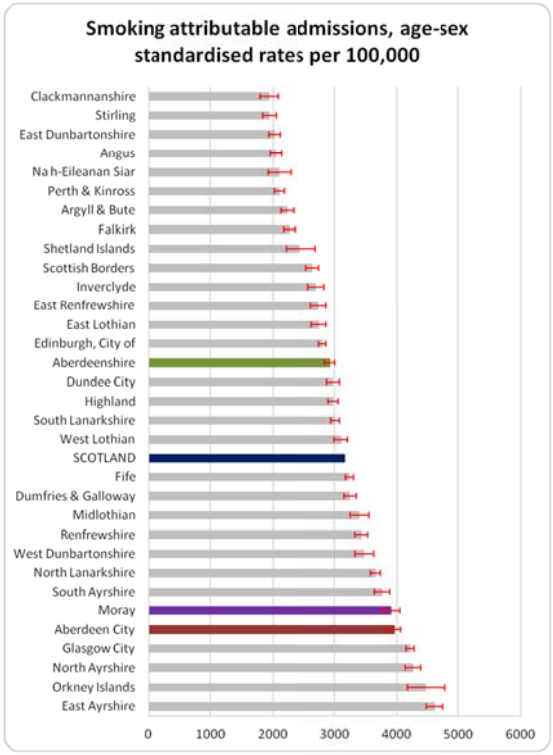
The proportion of adults who remain stopped smoking at twelve-week follow-up has remained similar during this period.

Moray smoking cessation rates			
Year	Number of quit attempts	Number of 12-week quits	12-week quit rate (%)
2012/13	1,499	444	29.6%
2013/14	1,379	321	23.3%
2014/15	1,065	306	28.7%
2015/16	1,012	249	24.6%
2016/17	945	242	25.6%

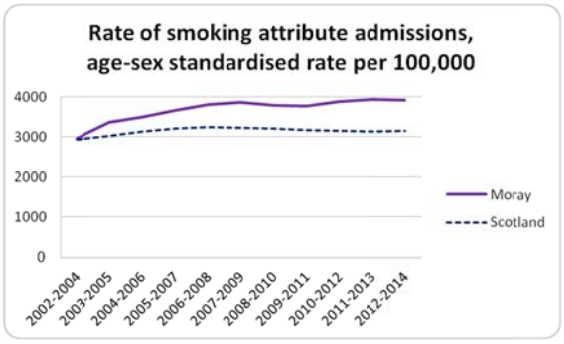
It is hypothesised that the increased availability of e-cigarettes is one factor in the reduced numbers of adults seeking smoking cessation support.

Smoking-attributable hospital stays are higher than average

Consistent with a higher smoking prevalence, Moray has a higher rate of smoking-attributable hospital admissions compare to the national average. In absolute terms this equates to around 3,000 hospital stays per year.[48]



While smoking-attributable hospital admissions have remained static nationally over the past decade, the rate has gradually increased in Moray.

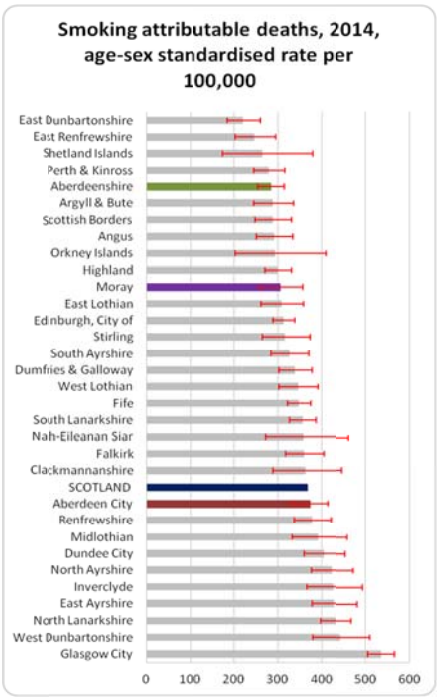


One in six deaths is attributable to smoking

Over the past decade an average of 960 people die die from all causes in Moray every year.[49]

In 2014, ScotPHO estimated that 165 deaths (17% of all deaths) were attributable to smoking.

Moray's smoking-attributable mortality rate is significantly lower than the national average.



[48] SOURCE: ScotPHO tobacco control profile (data 2012 – 2014)
[49] www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/deaths-time-series-data

Diet and nutrition

Data is not available at the Moray level. Most people do not meet dietary recommendations in Scotland. An estimated 20% of daily calories are from discretionary foods.[50]

Most adults and children in Grampian only eat three portions of fruit and vegetables per day, while across Scotland:[51,52]

- 17% of adults and 33% of children eat crisps once a day or more
- 28% of adults and 51% of children have chocolate or sweets at least once a day
- 20% of adults and 35% of children drink non-diet soft drinks at least once a day
- About 22% of the Scottish population's sugar intake is from sugary drinks
- Fruit and vegetable intake is associated with increasing income

Moray food bank provided emergency food aid to 2,759 people in 2017.

Physical activity and exercise

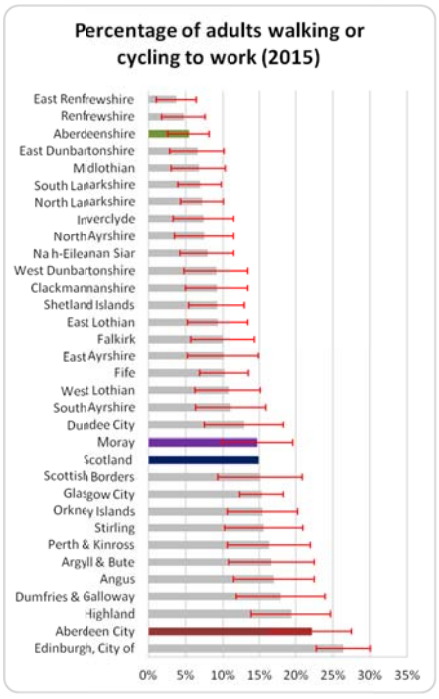
One in five adults report low levels of physical activity

One fifth of adults in Grampian report very low levels of physical activity, more commonly reported by women than men, and particularly by adults over the age of 75.[53]

One in seven commutes to work are by foot or bicycle

The percentage of commuter journeys made on foot or by bicycle in Moray is similar to the national average.

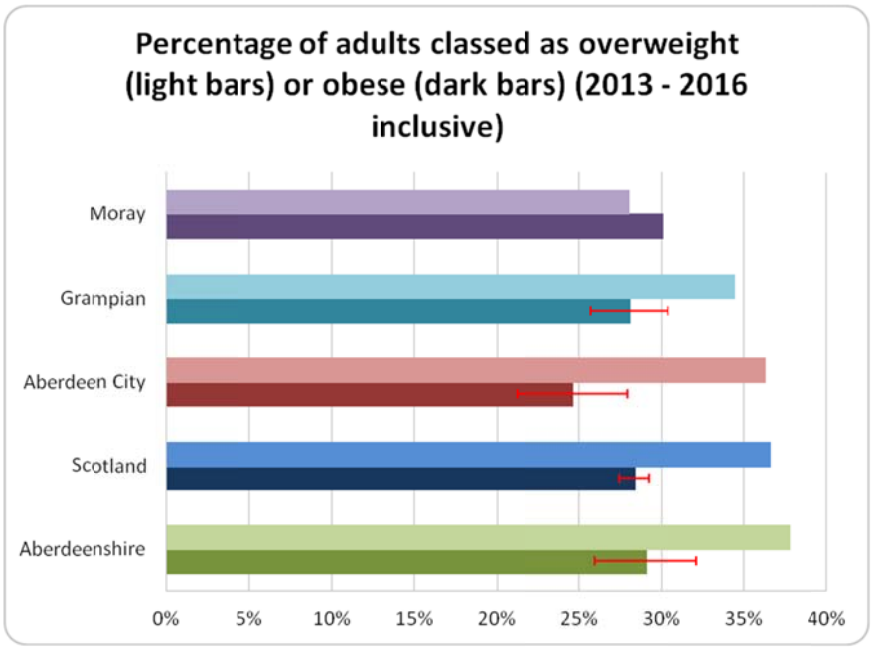
There has been an increase in the proportion of people walking for at least 30 minutes once a month over the past decade, but participation in other exercise and sports has not changed significantly.[54,55]



[50] www.foodstandards.gov.scot/publications-and-research/the-scottish-diet-it-needs-to-change
[51] www.gov.scot/Publications/2017/10/6398
[52] www.gov.scot/Resource/0052/00525472.pdf
[53] www.gov.scot/Publications/2017/10/6398
[54] www.gov.scot/Resource/0052/00525472.pdf
[55] www.gov.scot/Resource/0052/00525075.pdf

Healthy weight

Over one in four (28%) adults in Moray are overweight, and almost one in three (30%) are obese.[56]



In absolute terms, this translates into an estimated 22,000 adults who are overweight, and 24,000 adults who are obese.[57]

Obesity is associated with increased risk of type 2 diabetes, non-alcoholic fatty liver disease, cancers, heart disease, and sleep apnoea.

[56] www.gov.scot/Publications/2017/10/6398
[57] Based on 2017 Population Mid Year Estimate, adults aged 16+, Moray

Gambling

Information on the scale of gambling in Moray is limited. Some national data is available from the Scottish Health Survey (SHS), and this has been extrapolated to provide an estimate of the number of at-risk and problem gamblers in Moray.
In the 2016 Scottish Health Survey, 66% of adults had spent money on gambling activity in the 12 months prior to interview. This is a decrease compared to 2015 (68%) and 2012 (70%). In 2016 a higher proportion of men (71 per cent) spent money on gambling compared to women (62 per cent).

If those who had only gambled by playing the national lottery are excluded then the proportion of adults spending money on gambling in 2016 was 49 per cent (the same proportion as reported in 2015).

The 2016 Scottish Health Survey, using a sample size of 3,598 adults (over 16 years old), estimated that 0.95 per cent of the Scottish adult population are problem gamblers. In 2014 4 per cent of all those surveyed were at risk, according to either the PGSI[58] or DSM-IV[59] (SHS 2014).

In the absence of any local data the national rates have been extrapolated for Moray. The 2017 mid-year population estimates for Moray suggests that the number of 16 year olds and older living in Moray was 79,418. The number of problem gamblers and at-risk gamblers in Moray could potentially be:

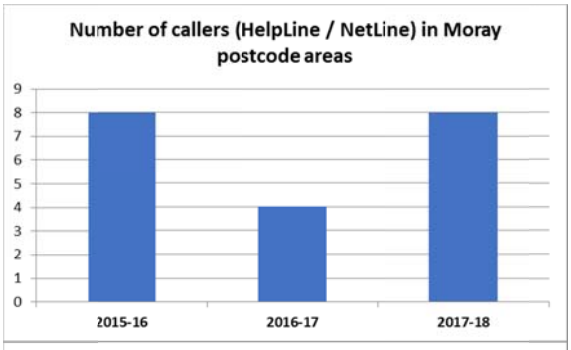
- 0.95% = 754 problem gamblers
- 4% = 3,177 at-risk gamblers

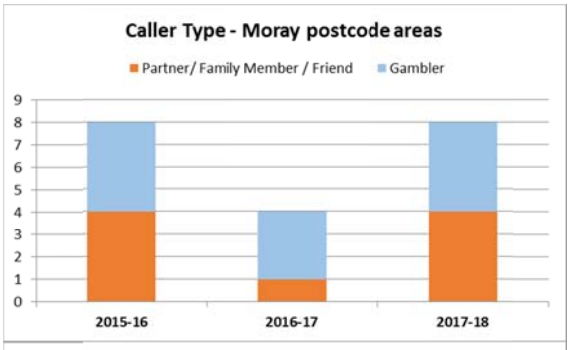
National Gambling Helpline - Analysis of Calls from Moray postcodes

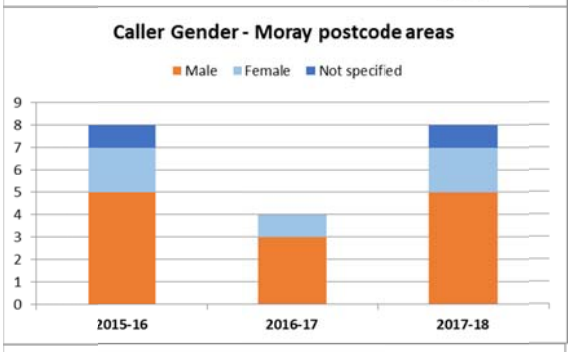
GamCare[60], the organisation that runs the national gambling helpline, have provided a breakdown of people in the Moray area who have called the helpline during the last 3 financial years. While the figures do not provide an indication of the overall scale of the gambling problem in Moray they do provide a useful baseline that can be used to assess whether measures to control gambling are having a positive impact.

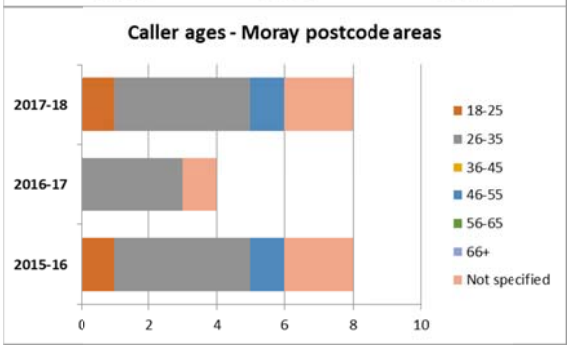
There have been relatively few callers from Moray, and over the past 4 years almost as many calls have been made by partners/families/friends as have been made by gamblers themselves. There have been 2 and a half times as many male callers as there have been female callers, with the majority being between 26 and 35 years old (55% of all callers). 80% of callers did not specify the level of debt, and of the 20% who did 2 callers reported no debts and 2 reported debts of under £5,000.

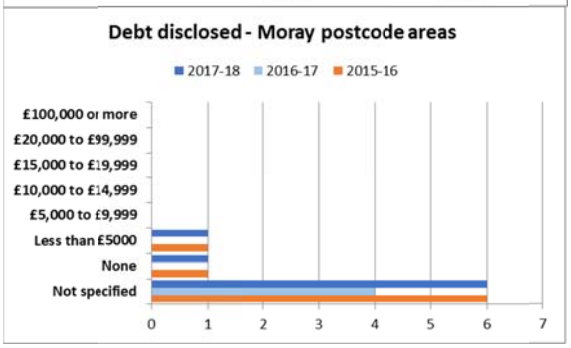
[58] Problem Gambling Severity Index
[59] Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, published by the American Psychiatric Association
[60] **GamCare** is the leading provider of information, advice, support and free counselling for the prevention and treatment of problem gambling. They operate the National Gambling Helpline, provide treatment for problem gamblers and their families, create awareness about responsible gambling and treatment, and encourage an effective approach to responsible gambling within the gambling industry.









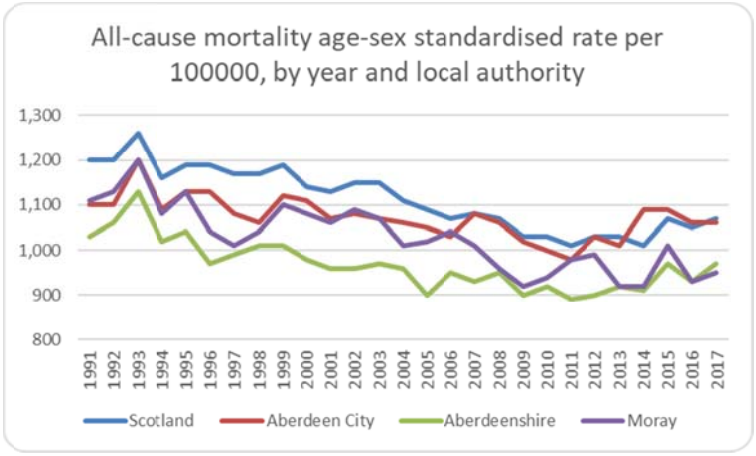


The location where callers stated that their gambling activity takes place is fairly evenly split between betting shops (32%), online (37%) and shops (26%). Just one caller mentioned fruit/slot machines in pubs (5%).

The callers identified a number of impacts that gambling had on their help and personal circumstances. The three most common issues were financial difficulties (29%), anxiety/stress (25%) and family/relationship difficulties (23%). Mental health and feeling isolated each accounted for 8% if the impacts discussed and problems with general health were identified by 3 callers (6%).

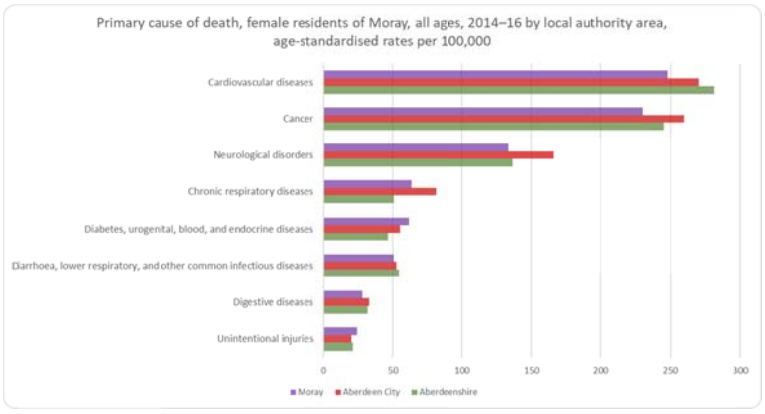
Population mortality

NHS Health Scotland have recently published work demonstrating increasing mortality rates amongst working age adults[61] and increasing winter mortality.[62] This mirrors recent UK analyses revealing a stalling of previously falling mortality rates, with increased rates for some age groups.[63,64] In the figure below, the Moray rate varies upwards and downwards each year, but with an overall downward trend,[65] although it seems likely that the increasing mortality rates confirmed nationally will also be evident in the Moray population.



Condition-specific mortality rates – females

Female disease-specific mortality rates appear broadly similar across Grampian. Rates in Moray tend not to be as high as in Aberdeen City



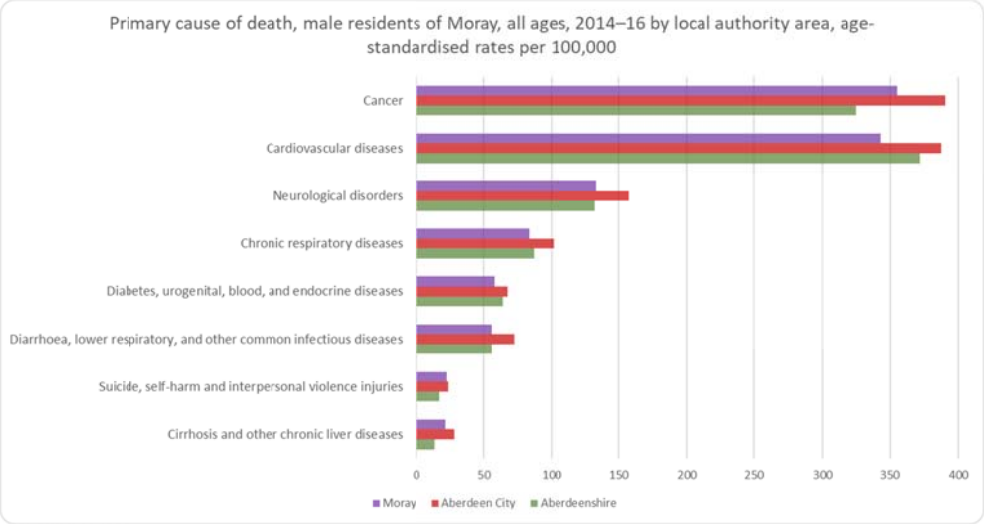
[61] http://www.healthscotland.scot/publications/working-and-hurting
[62] http://www.healthscotland.scot/news/2018/october/winter-mortality-rates-show-health-is-worsening
[63] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/changingtrendsinmortality/acrossukcomparison1981to2016
[64] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/changingtrendsinmortalityaninternationalcomparison/2000to2016
[65] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/deaths-time-series-data

Amongst younger age groups of female residents of Moray, the relatively small number of deaths each year mean that the proportion of deaths by cause show large variance, however the main causes of death between 2014 to 2016 were:

Age group	Significant causes of death by age group
• <15	Neonatal disorders, transport injuries
• 15 – 24	Cancers, substance use, unintentional injuries
• 25 – 44	Cancers, substance use, suicide
• 45 – 64	Cancers, cardiovascular disease, respiratory disease, cirrhosis, diabetes, suicide

Condition-specific mortality rates – males

Male disease-specific mortality rates appear broadly similar across Grampian. Rates in Moray tend not to be as high as in Aberdeen City



Amongst younger age groups of male residents of Moray, the relatively small number of deaths each year mean that the proportion of deaths by cause show large variance, however the main causes of death between 2014 to 2016 were:

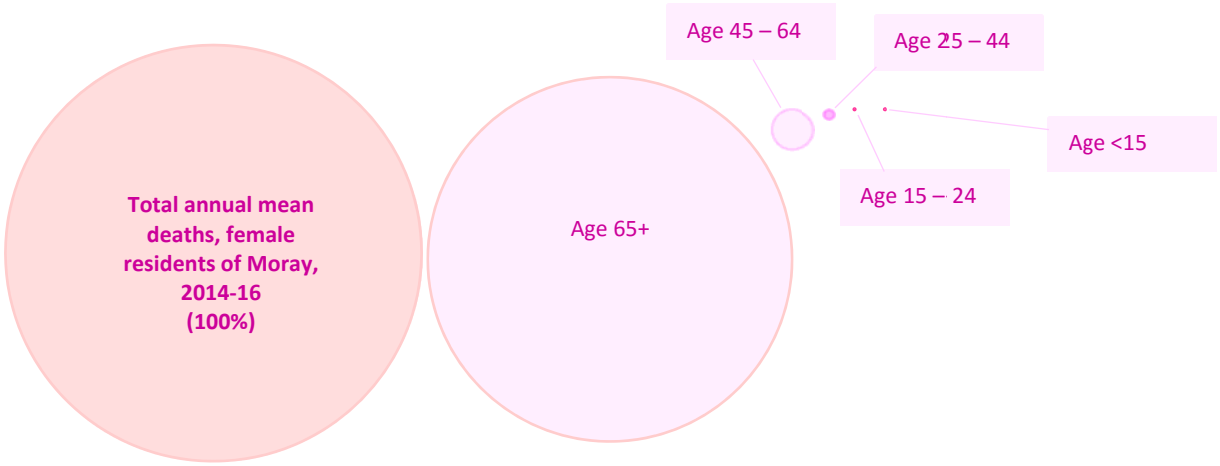
Age group	Significant causes of death by age group
• <15	Neonatal disorders, digestive disease, cancers
• 15 – 24	Transport injuries, suicide, violence, substance use, cancers
• 25 – 44	Cancers, substance use, cirrhosis and chronic liver disease
• 45 – 64	Cancers, cardiovascular disease, cirrhosis, substance use, suicide, violence

Condition-specific mortality counts – female

There were an average 500 deaths per year amongst female residents of Moray between 2014 and 2016 inclusive. Deaths increase with age, with the large majority occurring over the age of sixty-five.[66]

Age group	Mean annual number of deaths (2014 – 2016)	
• < 15	<5	(<0.5%)
• 15-24	<5	(<0.5%)
• 25-44	11	(2.2%)
• 45-64	49	(9.7%)
• 65 +	438	(87.5%)
Total	**500**	**(100%)**

The age group "bubbles" show the proportionate share of deaths relative to total annual mean deaths:

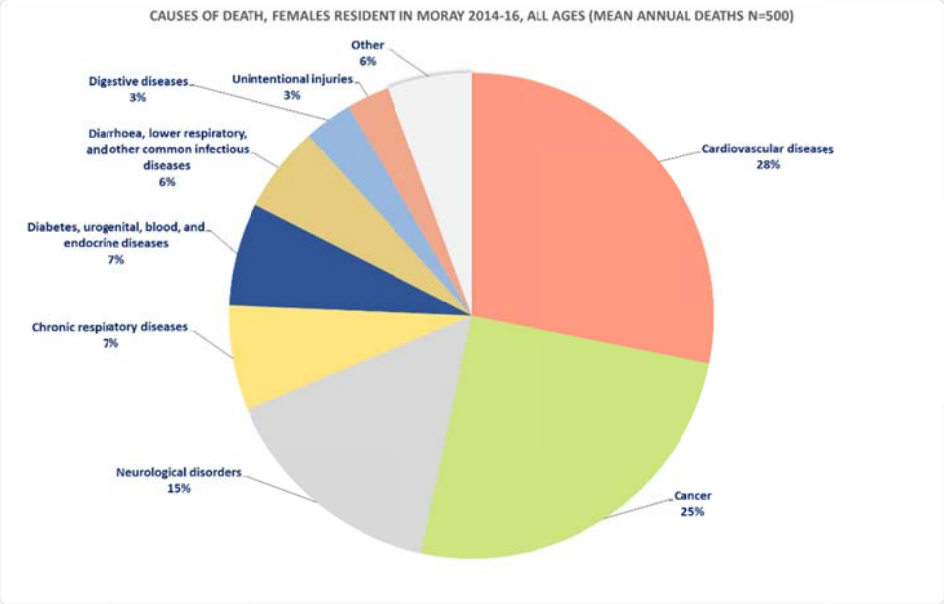


Most deaths were due to conditions in eight main disease groups:

Disease group	Annual deaths (% of total deaths)	
• Cardiovascular diseases	141	(28%)
• Cancer	126	(25%)
• Neurological disorders	77	(15%)
• Chronic respiratory diseases	35	(7%)
• Diabetes & endocrine disease	34	(7%)
• Common infectious diseases	29	(6%)
• Digestive diseases	16	(3%)
• Unintentional injuries	14	(3%)
• Other[67]	28	(6%)
Total deaths	**500**	**(100%)**

[66] Sources: National Records for Scotland vital statistics https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events; ScotPHO Burden of Disease local area estimates https://www.scotpho.org.uk/comparative-health/burden-of-disease/overview/

[67] "Other" represents conditions in thirteen further disease groups

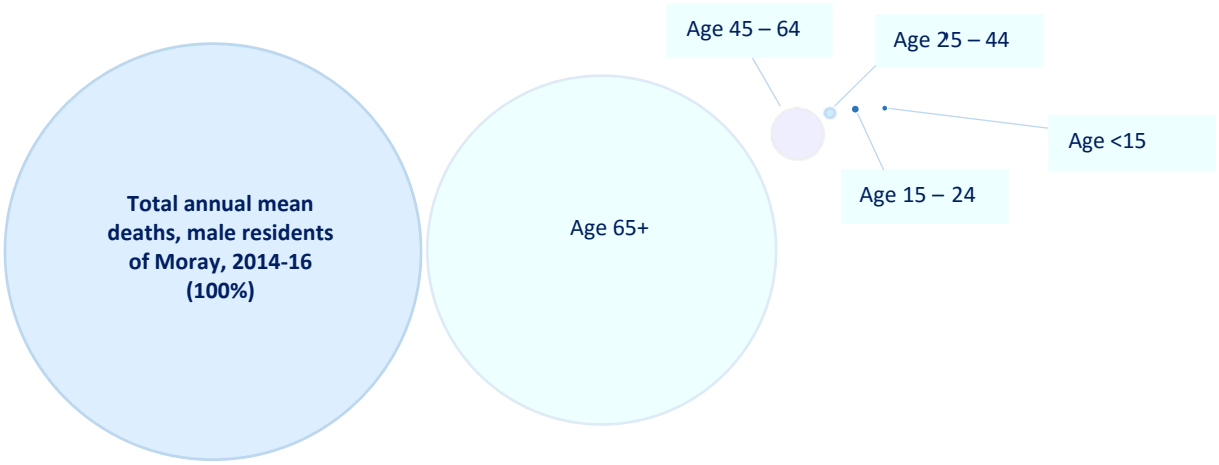


Condition-specific mortality counts – male

There were an average 482 deaths per year amongst male residents of Moray between 2014 and 2016 inclusive. Deaths increase with age, with the large majority occurring over the age of sixty-five.[68] More males die younger than females.

Age group	Mean annual number of deaths (2014 – 2016)	
• < 15	<5	(<0.5%)
• 15-24	<5	(<1%)
• 25-44	11	(2.3%)
• 45-64	60	(12.5%)
• 65 +	404	(83.8%)
Total	**482**	**(100%)**

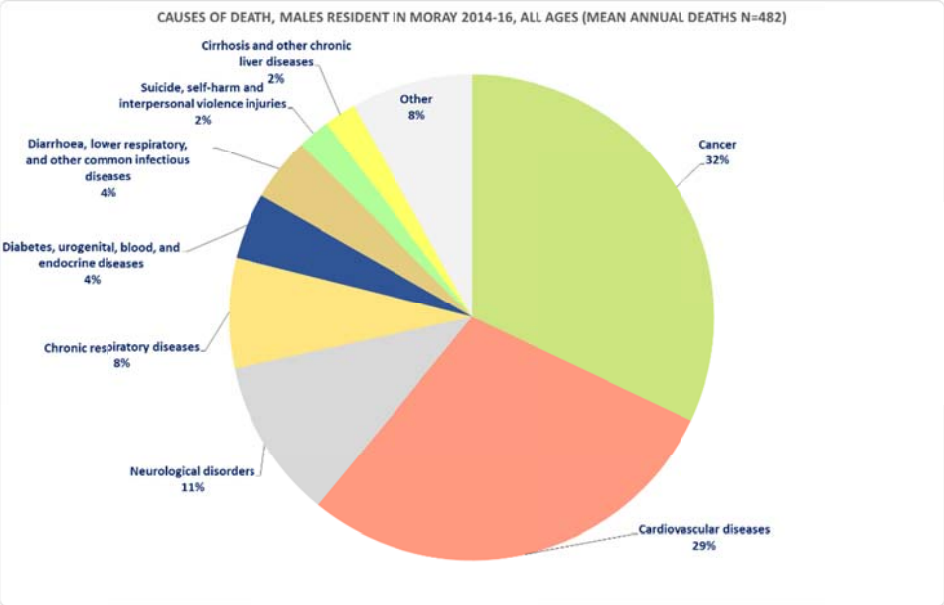
The age group "bubbles" show the proportionate share of deaths relative to total annual mean deaths:



[68] Sources: National Records for Scotland vital statistics https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events; ScotPHO Burden of Disease local area estimates https://www.scotpho.org.uk/comparative-health/burden-of-disease/overview/

Most deaths were due to conditions in eight main disease groups:

Disease group	Annual deaths (% of total deaths)	
• Cancer	154	(32%)
• Cardiovascular diseases	140	(29%)
• Neurological disorders	51	(11%)
• Chronic respiratory diseases	36	(7%)
• Diabetes & endocrine disease	21	(4%)
• Common infectious diseases	21	(4%)
• Suicide, self-harm and violence	10	(2%)
• Cirrhosis / chronic liver disease	10	(2%)
• Other[69]	39	(8%)
Total deaths	**482**	**(100%)**



[69] "Other" represents conditions in thirteen further disease groups

Mortality (by suicide)

The mortality analysis above revealed that deaths from suicide occur in younger age groups for both women and men and are a significant cause of death for men on an annual basis. Information Services Division (ISD) provides additional analysis on suicide deaths, aggregating numbers over a seven-year period to allow for meaningful analysis.[70]

Deaths by probable suicide, Moray, women and men aged ≥16, 2009 – 2015 inclusive				
	Single	Married / civil partnership	Other	Total
Women	10 (32%)	6 (19%)	15 (49%)	31 (100%)
Men	39 (45%)	30 (34%)	18 (21%)	87 (100%)

Deaths by probable suicide, Moray, women and men aged 16 to 64, 2009 – 2015 inclusive				
	Employers, managers, foremen	Independent means, no occupation, disabled	Self-employed / students	Total
Women	22 (73%)	8 (27%)	-	30 (100%)
Men	56 (76%)	10 (14%)	8 (10%)	74 (100%)

Deaths by probable suicide, Moray, females and males aged ≥5, 2010 – 2015 inclusive Contact with services in year prior to death (number, % of females / males)				
	Receiving mental health prescription	A&E (within 3 months of death)	Specialist contact	No previous contact
Female	20 (77%)	5 (19%)	13 (50%)	*
Male	37 (50%)	14 (19%)	12 (16%)	32 (43%)

Nineteen people attended A&E in the three months prior to their death by probable suicide, eight of whom (42%) attended in the week prior to their death.

[70] www.isdscotland.org/Health-Topics/Public-Health/Publications/2017-11-14/2017-11-14-ScotSID_supplementary_tables.xlsx?14:09:10

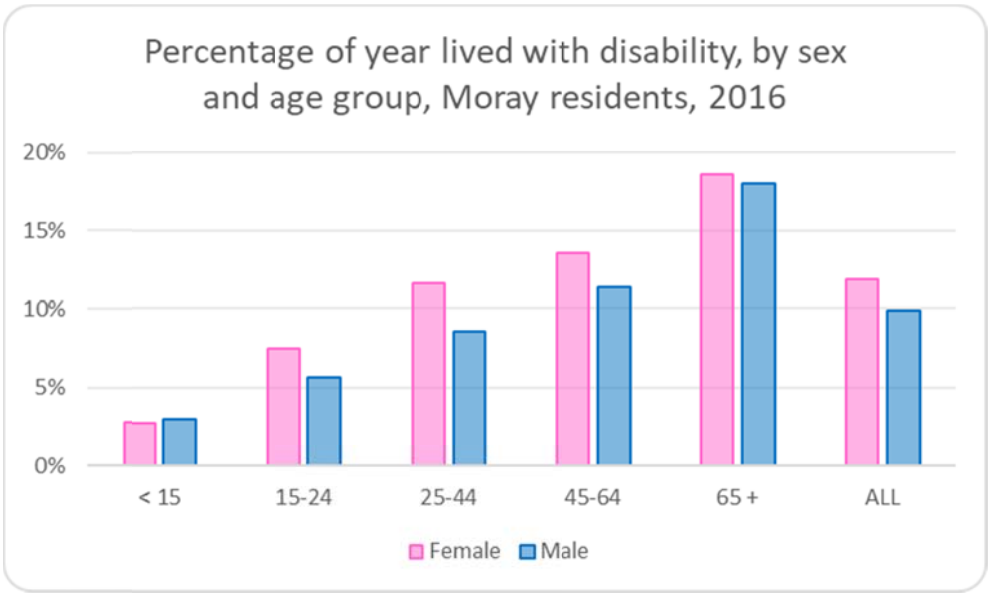
Life lived with disability (morbidity)

Years of life lived with disability (YLD) is an epidemiological construct used to quantify morbidity in the Global Burden of Disease study. Each person in a population contributes one year of life to the year of study. Each person's year, minus months lost to death, is weighted by a standardised set of disability weights and intensity modifiers, reflecting the duration of any health conditions experienced during that year. This methodology has been used to calculate the burden of disease on the population of Scotland for 2016.[71]

If every person lived the full year in perfect health, then YLD would equal zero (and the years of life lived without disease would equal the population size). In Moray in 2016 there were 48,417 females and 47,653 males, contributing a gross 96,070 years (not adjusted for deaths during the year). The YLD calculation for the same year is 5,781 years for females and 4,693 years for males.

	Years of life (gross)	Years of life lived with disability	%
• females	48,417	5,781	12%
• males	47, 653	4,693	10%

In other words, averaged across the whole population of Moray in 2016, 11% of the available years of life were lived with disability. By exploring YLD by age group, it is apparent that the burden of disability increases with age and is consistently greater amongst females than males.



[71] https://www.scotpho.org.uk/comparative-health/burden-of-disease/overview/

Condition-specific morbidity – females

Morbidity rates have been calculated in terms of 21 overarching disease groups. The tables and figures below demonstrate the growing burden of morbidity with age for both females and males, and the changing causes of morbidity across the age groups.

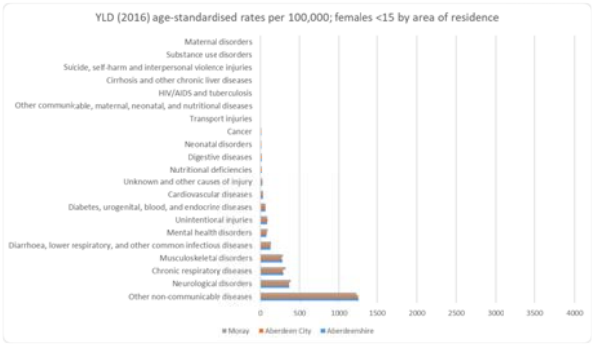
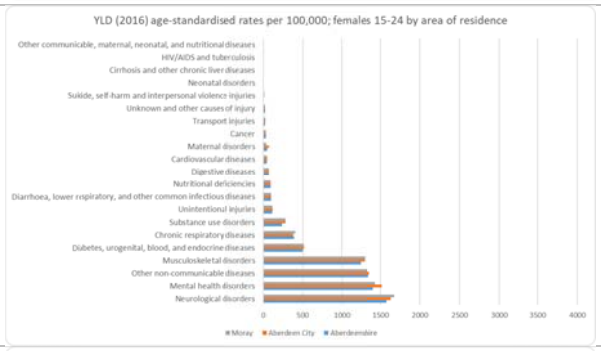
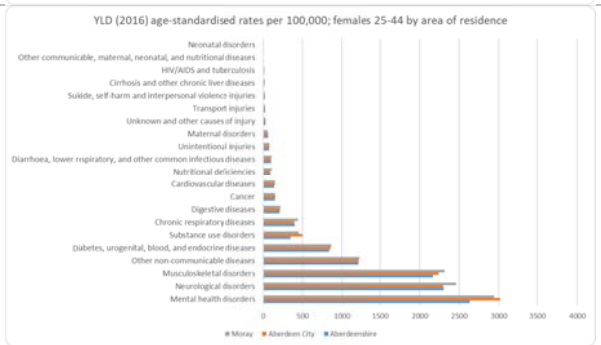
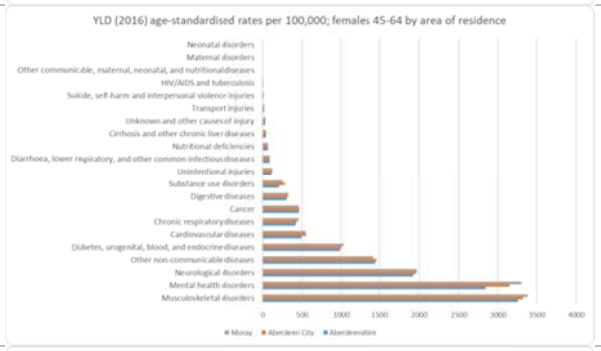
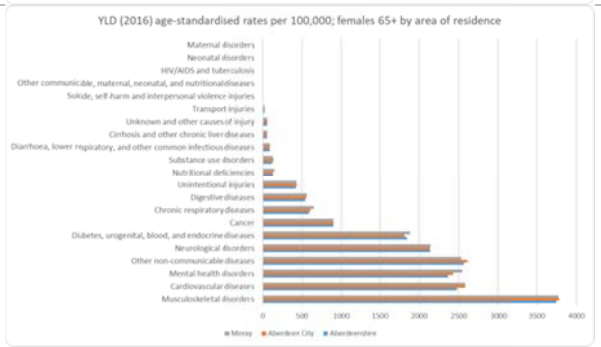
FEMALES

Age group	Three leading causes of morbidity
• <15	non-communicable disease neurological disorders chronic respiratory disorders
• **15 to 24**	**neurological disorders** **mental health disorders** **non-communicable disease**
• 25 to 44	mental health disorders neurological disorders musculoskeletal disorders
• **45 to 64**	**musculoskeletal disorders** **mental health disorders** **neurological disorders**
• 65+	musculoskeletal disorders cardiovascular diseases mental health disorders

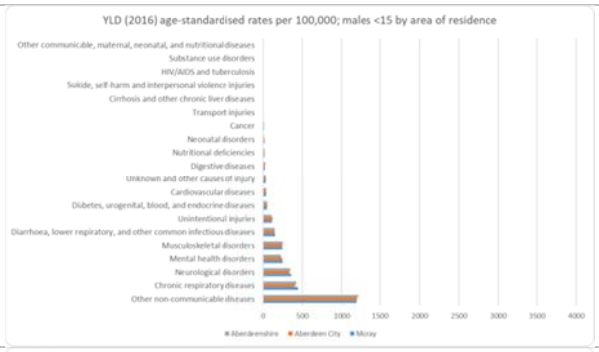
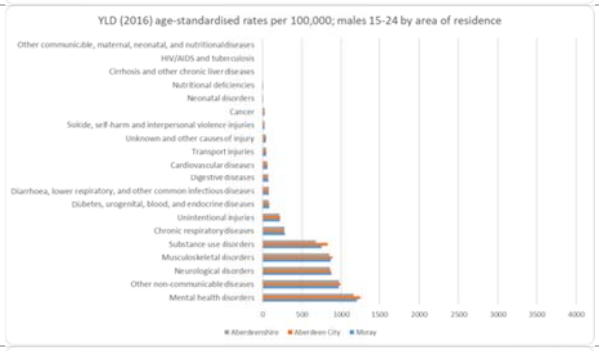
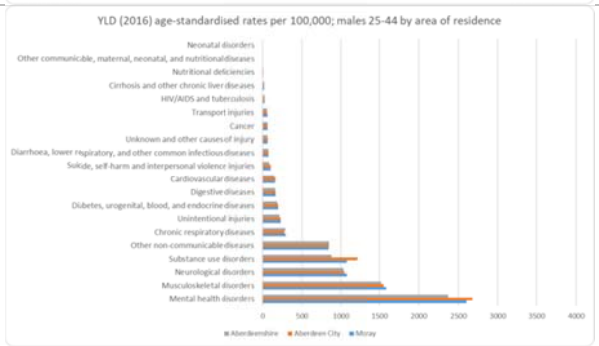
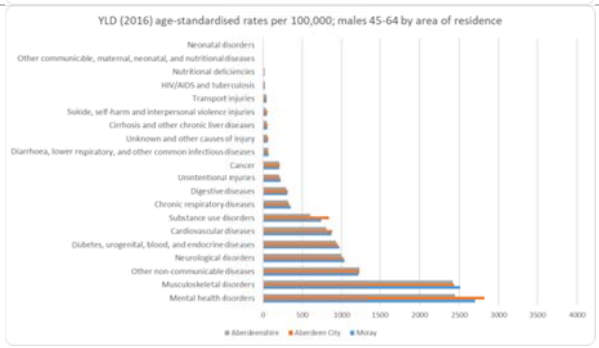
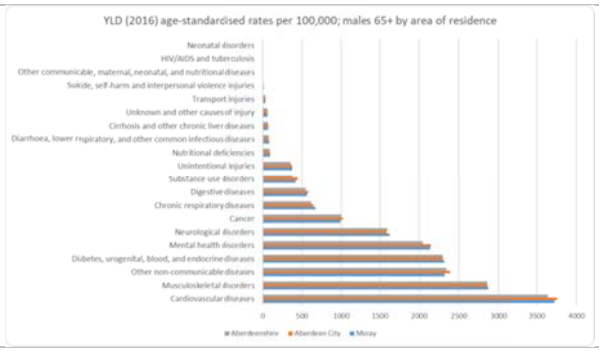
MALES

Age group	Three leading causes of morbidity
• <15	other non-communicable diseases chronic respiratory disorders neurological disorders
• **15 to 24**	**mental health disorders** **other non-communicable diseases** **neurological disorders**
• 25 to 44	mental health disorders musculoskeletal disorders neurological disorders
• **45 to 64**	**mental health disorders** **musculoskeletal disorders** **other non-communicable diseases**
• 65+	cardiovascular diseases musculoskeletal disorders diabetes, urogenital, blood, and endocrine diseases

JOINT STRATEGIC NEEDS ASSESSMENT 2018
ILLNESS, DISEASE AND DISABILITY

Number of YLD in 2016 by disease group		Age-standardised rates of YLD by disease group
Females <15		
Other	**28**	
Infectious diseases	10	
Musculoskeletal disorders	**21**	
Chronic respiratory diseases	24	
Neurological disorders	**28**	
Other non-communicable diseases (NCD)	92	
Total	**203**	
Females 15 to 24		
Other	**64**	
Diabetes, urogenital, blood, and endocrine diseases	26	
Musculoskeletal disorders	**66**	
Other NCD	68	
Mental health disorders	**72**	
Neurological disorders	84	
Total	**380**	
Females 25 to 44		
Other	156	
Substance use disorders	**50**	
Diabetes…	97	
Other NCD	**137**	
Musculoskeletal disorders	259	
Neurological disorders	**277**	
Mental health disorders	334	
Total	**1310**	
Females 45 to 64		
Other	200	
Cardiovascular diseases	**75**	
Diabetes…	142	
Other NCD	**195**	
Neurological disorders	271	
Mental health disorders	**454**	
Musculoskeletal disorders	465	
Total	**1868**	
Females 65+		
Other	**236**	
Cancer	97	
Diabetes…	**205**	
Neurological disorders	235	
Other NCD	**276**	
Mental health disorders	279	
Cardiovascular diseases	**284**	
Musculoskeletal disorders	407	
Total	**2020**	

JOINT STRATEGIC NEEDS ASSESSMENT 2018
ILLNESS, DISEASE AND DISABILITY

Number of YLD in 2016 by disease group		Age-standardised rates of YLD by disease group
Males <15		
Other	**38**	
Musculoskeletal disorders	19	
Mental health disorders	**20**	
Neurological disorders	28	
Chronic respiratory diseases	**35**	
Other NCD	95	
Total	**235**	
Males 15 to 24		
Other	40	
Chronic respiratory diseases	**17**	
Substance use disorders	45	
Musculoskeletal disorders	**52**	
Neurological disorders	52	
Other NCD	**58**	
Mental health disorders	71	
Total	**335**	
Males 25 to 44		
Other	132	
Chronic respiratory diseases	**33**	
Other NCD	94	
Substance use disorders	**120**	
Neurological disorders	121	
Musculoskeletal disorders	**177**	
Mental health disorders	292	
Total	**969**	
Males 45 to 64		
Other	**194**	
Substance use disorders	101	
Cardiovascular diseases	**116**	
Diabetes…	130	
Neurological disorders	**140**	
Other NCD	164	
Musculoskeletal disorders	**338**	
Mental health disorders	366	
Total	**1550**	
Males 65+		
Other	295	
Neurological disorders	**139**	
Mental health disorders	189	
Other NCD	**203**	
Diabetes…	205	
Musculoskeletal disorders	**256**	
Cardiovascular diseases	316	
Total	**1603**	

At home and in the community

Mental health and wellbeing

Mental wellbeing can be measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). In Moray as across Scotland, people living with a limiting long-term condition have lower mental wellbeing scores than those without.

Health status	2014	2015	2016
Limiting long term physical or mental health condition	23	23	23
No limiting condition	26	25	25

In Moray as across Scotland, people living in a home they own outright tend to have higher scores than those living with a mortgage, who in turn tend to have higher scores than those who live in rental accommodation. Housing tenure is often taken as a proxy for affluence, suggesting higher mental wellbeing is associated with greater affluence.

Tenure	2014	2015	2016
Rented	26	24	23
Mortgaged	24	24	25
Owned outright	25	25	25

Thus, those with long-term health conditions and/or living in poorer circumstances tend to have poorer self-reported mental wellbeing than those without such conditions and/or living in better off circumstances.

At home and in the community

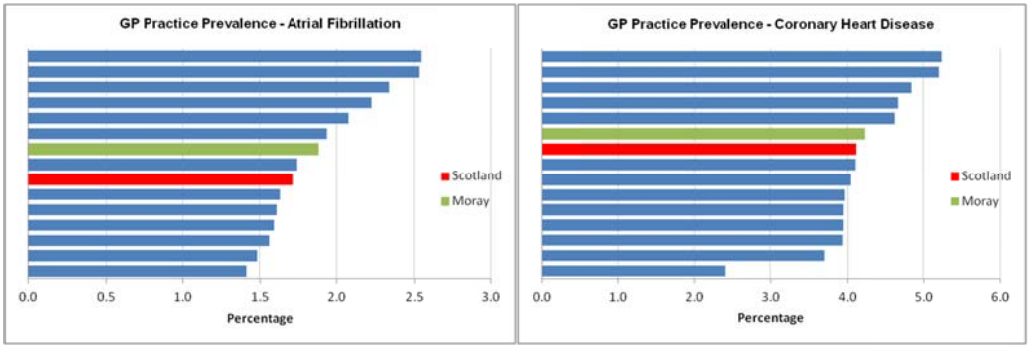
Physical health conditions

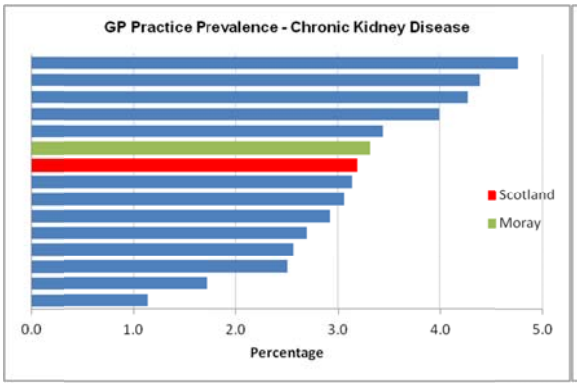
The Quality and Outcomes Framework (QOF) was a major part of the new General Medical Services (GMS) contract, it was introduced on 1st April 2004 and retired on the 31st March 2016, and it remains a unique data source. Participation by general practices in the QOF was voluntary. For those that did participate, the QOF measured achievement against a range of evidence-based indicators. All 13 practices in Moray participated in 2015/16.

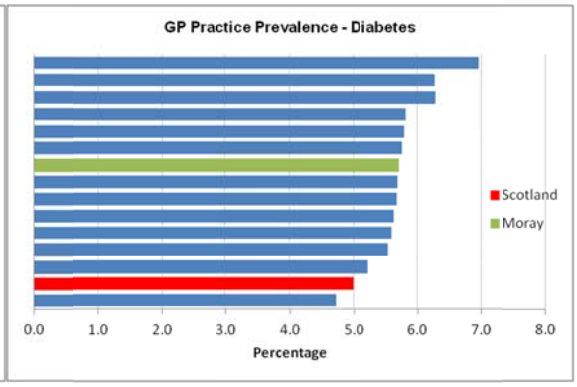
The last reported data for Moray covered 16 indicators, when compared to Scotland, Moray performed better on 7 indicators and worse on 9. A green background for the prevalence rate indicates Moray performed better than Scotland, red is the opposite.

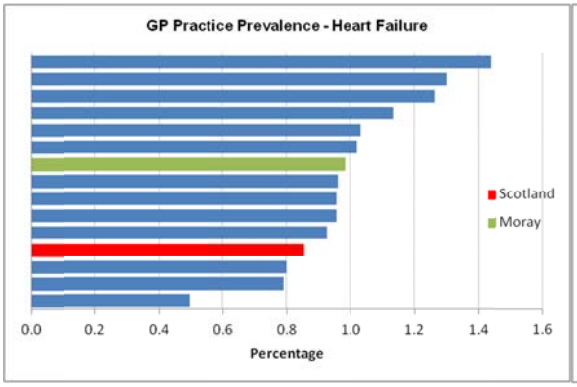
Indicator	Prevalence Rate	Scotland Rate
Asthma	6.35	6.39
Atrial Fibrillation	1.88	1.71
Cancer	2.39	2.44
CHD	4.21	4.10
CKD	3.31	3.19
COPD	1.84	2.29
Dementia	0.78	0.80
Depression	5.79	6.80
Diabetes	5.70	4.97
Heart Failure	0.98	0.85
Hypertension	14.85	13.93
Mental Health	0.84	0.90
Osteoporosis	0.18	0.15
Peripheral Arterial Disease	0.83	0.87
Rheumatiod Arthritis	0.80	0.60
Stroke/TIA	2.28	2.20

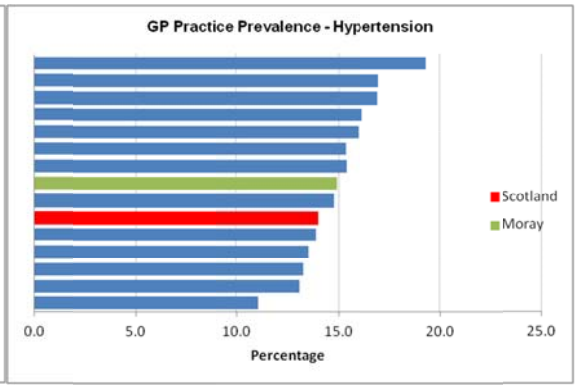
The following charts show the range across practices for the indicators that Moray did not perform as well as Scotland. Where there are missing bars this indicates that numbers were too low to publish.

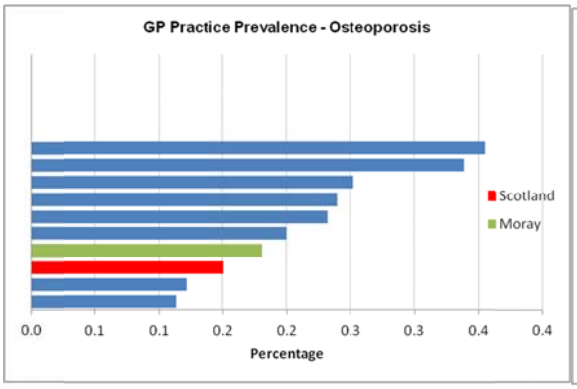


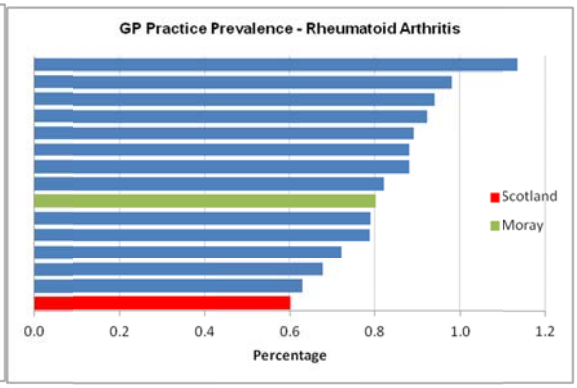

GP Practice Prevalence - Chronic Kidney Disease
Scotland
Moray
0.0 1.0 2.0 3.0 4.0 5.0
Percentage

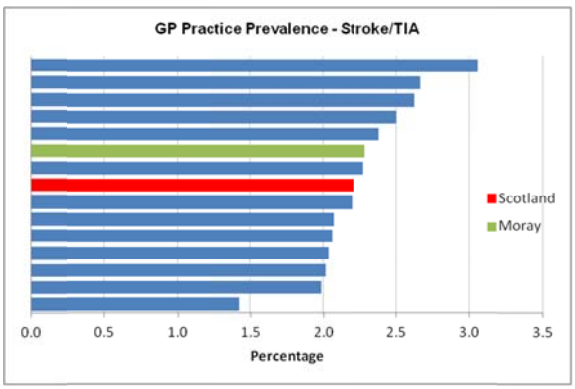

GP Practice Prevalence - Diabetes
Scotland
Moray
0.0 1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0
Percentage


GP Practice Prevalence - Heart Failure
Scotland
Moray
0.0 0.2 0.4 0.6 0.8 1.0 1.2 1.4 1.6
Percentage


GP Practice Prevalence - Hypertension
Scotland
Moray
0.0 5.0 10.0 15.0 20.0 25.0
Percentage


GP Practice Prevalence - Osteoporosis
Scotland
Moray
0.0 0.1 0.1 0.2 0.2 0.3 0.3 0.4 0.4
Percentage


GP Practice Prevalence - Rheumatoid Arthritis
Scotland
Moray
0.0 0.2 0.4 0.6 0.8 1.0 1.2
Percentage

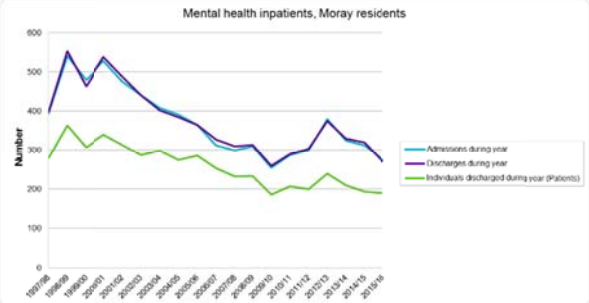

GP Practice Prevalence - Stroke/TIA
Scotland
Moray
0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5
Percentage

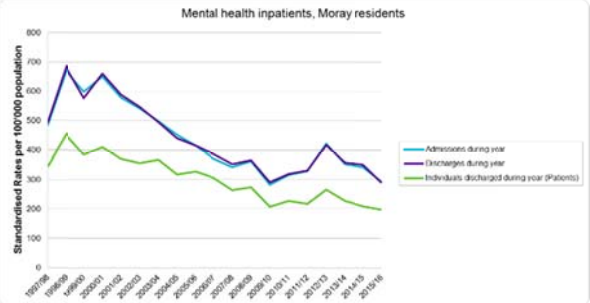
Use of health and social care services

Hospital services (mental health)[72]

Mental health services

Mental health services – Moray residents – 2006/07 through 2015/16 inclusive										
	2006 /07	2007 /08	2008 /09	2009 /10	2010 /11	2011 /12	2012 /13	2013 /14	2014 /15	2015 /16
Admissions during year	312	299	310	254	287	300	380	324	312	275
Discharges during year	327	310	313	260	289	303	375	330	319	270
Individuals discharged during year (Patients)	253	232	233	186	207	200	240	209	193	190





Hospital services (Acute outpatients, A&E, inpatients)

Hospital services are designated elective (planned) or unscheduled (emergency).

Elective care follows a planned pathway of care, usually involving a referral from a GP or other healthcare professional for initial assessment by a hospital consultant, usually at an outpatient appointment. This may result in subsequent investigations and/or admission into hospital for treatment.

Unscheduled care is the result of an emergency referral either by a healthcare professional or directly by the patient themselves (e.g. via Accident & Emergency, or Scottish Ambulance Service).

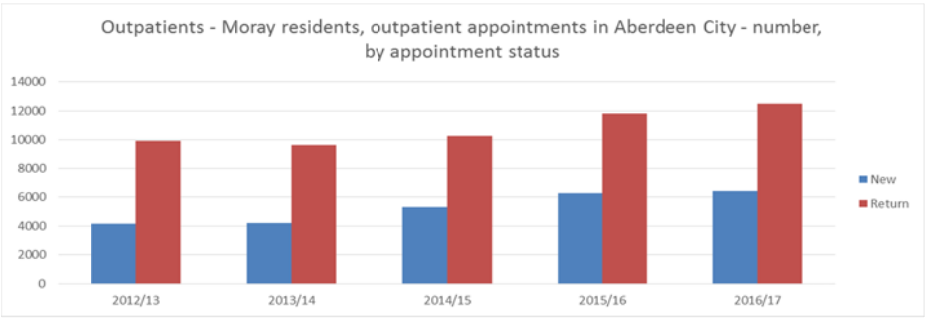
Outpatient Departments[73]

[72] www.isdscotland.org/Health-Topics/Mental-Health/Publications/2017-03-14/Section-2-1-Scotland-NHSboard-LA.xls?14:56:48

Two-thirds (64%) of Moray residents requiring an outpatient appointment are offered an appointment at Dr Gray's Hospital, Elgin.

Over one-third (37%) of Moray residents requiring an outpatient appointment are offered appointments in Aberdeen City. **The number of new and return outpatient appointments in Aberdeen City each year is increasing.**

Number of new and return outpatient appointments for Moray residents in Aberdeen City, by year and appointment type		
Year	**New**	**Return**
2012/13	4167	9941
2013/14	4214	9641
2014/15	5286	10286
2015/16	6258	11801
2016/17	6402	12477

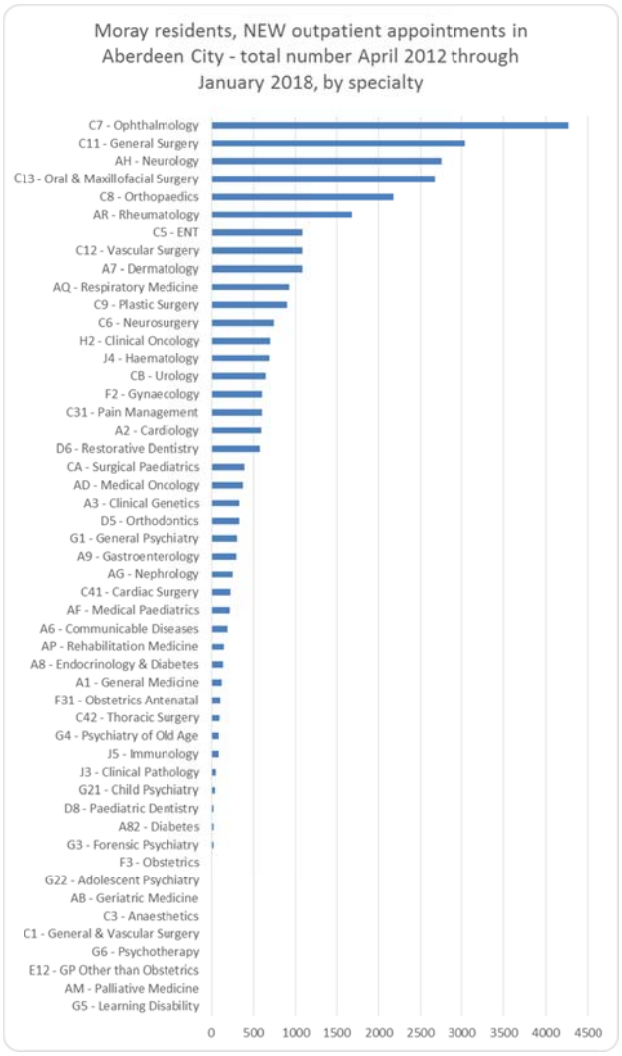


[73] Extracted from TrakCare by Health Intelligence

JOINT STRATEGIC NEEDS ASSESSMENT 2018
ILLNESS, DISEASE AND DISABILITY

The table and figure below show the number of new outpatient appointments attended by Moray residents in Aberdeen City, by medical specialty.

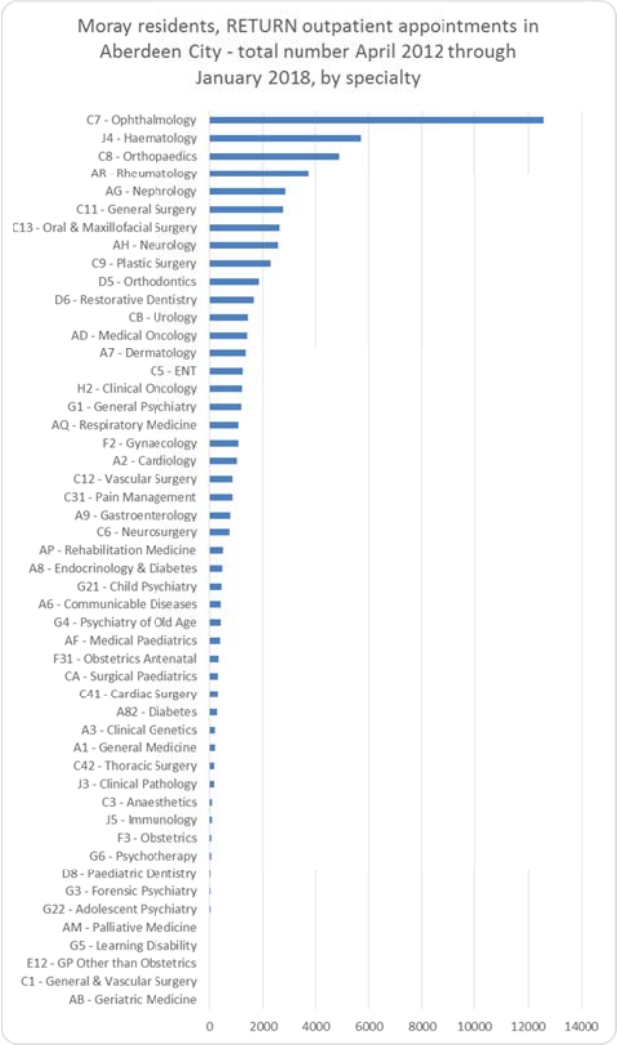
Moray residents – new outpatient appointments in Aberdeen City, by specialty	
Specialty	**Number of appointments**
C7 - Ophthalmology	4267
C11 - General Surgery	3038
AH - Neurology	2749
C13 - Oral & Maxillofacial Surgery	2671
C8 - Orthopaedics	2178
AR - Rheumatology	1681
C5 - ENT	1083
C12 - Vascular Surgery	1078
A7 - Dermatology	1077
AQ - Respiratory Medicine	925
C9 - Plastic Surgery	895
C6 - Neurosurgery	740
H2 - Clinical Oncology	696
J4 - Haematology	685
CB - Urology	640
F2 - Gynaecology	604
C31 - Pain Management	596
A2 - Cardiology	588
D6 - Restorative Dentistry	577
CA - Surgical Paediatrics	388
AD - Medical Oncology	373
A3 - Clinical Genetics	330
D5 - Orthodontics	327
G1 - General Psychiatry	306
A9 - Gastroenterology	297
AG - Nephrology	248
C41 - Cardiac Surgery	229
AF - Medical Paediatrics	221
A6 - Communicable Diseases	194
AP - Rehabilitation Medicine	143
A8 - Endocrinology & Diabetes	141
A1 - General Medicine	122
F31 - Obstetrics Antenatal	106



JOINT STRATEGIC NEEDS ASSESSMENT 2018
ILLNESS, DISEASE AND DISABILITY

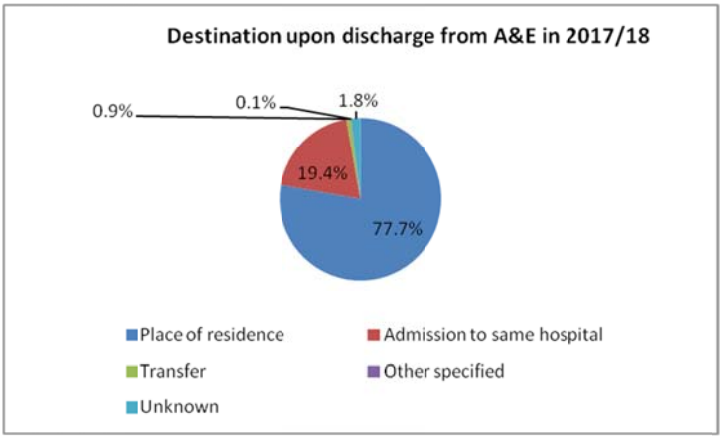
The table and figure below show the number of return outpatient appointments attended by Moray residents in Aberdeen City, by medical specialty.

Moray residents – return outpatient appointments in Aberdeen City, by specialty	
Specialty	**Number of appointments**
C7 - Ophthalmology	12579
J4 - Haematology	5710
C8 - Orthopaedics	4882
AR - Rheumatology	3730
AG - Nephrology	2842
C11 - General Surgery	2754
C13 - Oral & Maxillofacial Surgery	2602
AH - Neurology	2557
C9 - Plastic Surgery	2280
D5 - Orthodontics	1844
D6 - Restorative Dentistry	1665
CB - Urology	1433
AD - Medical Oncology	1420
A7 - Dermatology	1368
C5 - ENT	1258
H2 - Clinical Oncology	1217
G1 - General Psychiatry	1199
AQ - Respiratory Medicine	1081
F2 - Gynaecology	1069
A2 - Cardiology	1031
C12 - Vascular Surgery	856
C31 - Pain Management	855
A9 - Gastroenterology	774
C6 - Neurosurgery	742
AP - Rehabilitation Medicine	507
A8 - Endocrinology & Diabetes	491
G21 - Child Psychiatry	455
A6 - Communicable Diseases	436
G4 - Psychiatry of Old Age	432
AF - Medical Paediatrics	408
F31 - Obstetrics Antenatal	335
CA - Surgical Paediatrics	327
C41 - Cardiac Surgery	305
A82 - Diabetes	295
A3 - Clinical Genetics	219
A1 - General Medicine	205
C42 - Thoracic Surgery	178
J3 - Clinical Pathology	169



Accident and Emergency Department[74]

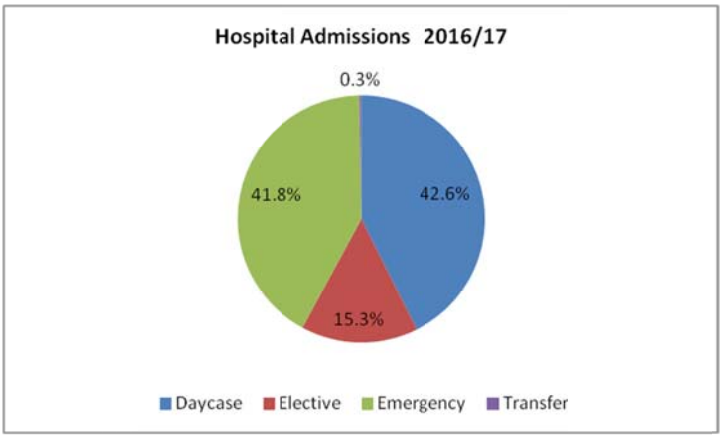
Since 2011 attendances at the A&E department in Dr Gray's Hospital has remained relatively stable at around 2,000 attendances per year (for new and unplanned return attendances). At least 95% have been seen within 4 hours over the last 2 years. Around 80% of patients are discharged to a place of residence with around 20% admitted for further treatment, there are other small numbers where destination is unknown or the patient is transferred to another healthcare provider. The figure below shows the breakdown of discharge destination from A&E for the latest year.



Acute Hospital Admissions[75]

Although much hospital-based care is carried out on an outpatient basis, a significant number of people have to be admitted to hospital for diagnosis or treatment. This can be part of a planned pathway of care, such as the requirement for an operation following a consultation at an outpatient clinic or a requirement for further diagnosis. Alternatively the admission could be as a result of an emergency, for example, due to an accident or perhaps an acute exacerbation of a condition. When admitted to hospital, the patient is either treated on a same day basis, often referred to as a day case, or as an inpatient, when the patient will normally spend at least one night in hospital. Some inpatients may be discharged from hospital on the same day as their admission. There were around 19,000 stays in hospital by Moray residents in 2016/17, with some people having more than one stay during this time. There were just under 11,000 planned admissions into hospital and around 8,000 were admitted as an emergency. A small number of people had both planned and emergency admissions within the year. The figure below shows the breakdown of planned visits i.e. day case and elective inpatients and emergency admissions, there are also a very small number of transfers, where it has not been possible to determine whether the original admission was planned or not.

[74] ISD Scotland: http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/data-tables2017.asp?id=2152#2152
[75] ISD Scotland: https://www.isdscotland.org/Health-Topics/Hospital-Care/Publications/2017-11-07/2017-11-07-Annual-QuarterlyAcuteActivity-Report.pdf



If we wanted to compare Moray to Scotland for acute admissions to hospitals, the rate per 100,000 population for Moray for 2016/17 is 19,440, below that of Scotland at 22,625.

There are many reasons why a person might have to be admitted to hospital. It could, for example, be due to an underlying health condition which requires treatment, monitoring or further diagnosis; it could be as a result of a sudden deterioration in health status; or it could be following a trauma incident. The five most common diagnosis groupings, accounting for 61% of all admissions are shown in the table below.

Diagnosis grouping	Specific conditions	No of admissions	Percentage
Diseases of the digestive system	*For example:-* Appendicitis, pancreatitis	3,163	17%
Neoplasms	*For example:-* Non-Hodgkin lymphoma, benign tumour, breast cancer	2,937	16%
Symptoms, signs and ill defined conditions, not elsewhere classified	*For example:-* Pain in throat and chest, abdominal and pelvic pain	2,373	13%
Injury, poisoning and certain other consequences of external causes	*For example:-* Fracture of forearm, burns and corrosions, poisonings and toxic effects of substances.	1,476	8%
Diseases of the respiratory system	*For example:-* Pneumonia, asthma, chronic obstructive pulmonary disease (COPD)	1,370	7%

Scotland also has those diagnosis groupings in the top five although in a different order, neoplasms move up one as do diseases of the respiratory system.

Looking at the specialties on admission, the five most common for all admission types making up 80% of all admissions are, General Surgery, General Medicine, Gastroenterology, Trauma and Orthopaedic Surgery and Urology. The split by planned and emergency admissions is shown in the table below.

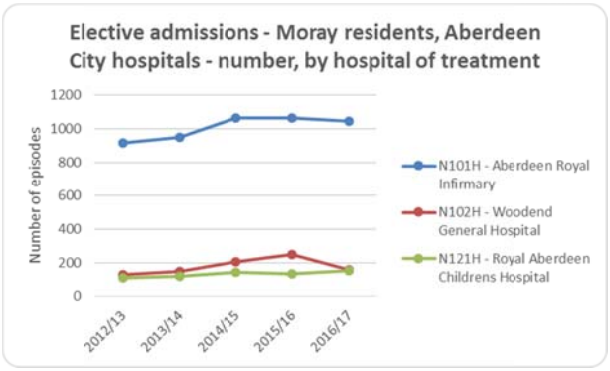
Elective Admissions (day case & inpatient)	Emergency Admissions

General Surgery	General Medicine
Gastroenterology	General Surgery
Urology	Paediatrics
Trauma & Orthopaedic Surgery	Trauma & Orthopaedic Surgery
Medical Oncology	GP other than Obstetrics

Acute Hospital Admissions – Aberdeen City hospitals

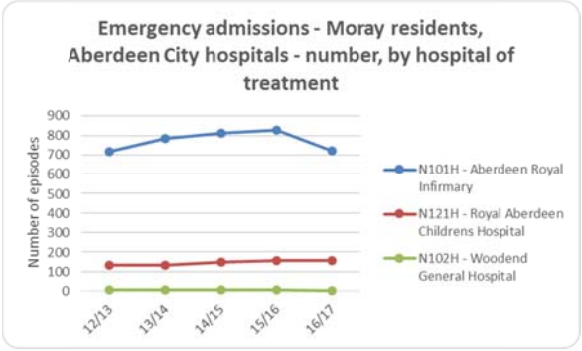
The number of Moray residents experiencing elective hospital admission to a hospital in Aberdeen City each year has increased in recent years.

Moray residents – elective hospital admission to Aberdeen City hospitals					
Hospital	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
N101H - Aberdeen Royal Infirmary	915	950	1067	1064	1047
N102H - Woodend General Hospital	127	150	204	251	156
N121H - Royal Aberdeen Children's Hospital	108	121	145	134	154



The number of Moray residents experiencing emergency hospital admission to a hospital in Aberdeen City each year has increased in recent years, although emergency admissions to Aberdeen Royal Infirmary reduced in the last year of complete data.

Moray residents – emergency hospital admission to Aberdeen City hospitals					
	12/13	**13/14**	**14/15**	**15/16**	**16/17**
N101H - Aberdeen Royal Infirmary	717	784	810	827	721
N121H - Royal Aberdeen Children's Hospital	131	131	150	157	157
N102H - Woodend General Hospital	7	5	5	6	2



JOINT STRATEGIC NEEDS ASSESSMENT 2018
ILLNESS, DISEASE AND DISABILITY

Use of health and social care services

High resource individuals (HRI)

The health expenditure figure for Moray in 2016/17 was £86 million. Half of this was spent on the care of just 2,100 patients; 2.9% of all health care users. This patient cohort is referred to as High Resource Individuals (HRI).

Understanding why less than 3% of patients have an average cost of care that is nearly 34-times higher than the majority of service users is crucial to being able to deliver a high quality service. Looking at the how high resource use differs across health service sector provides a useful initial insight.

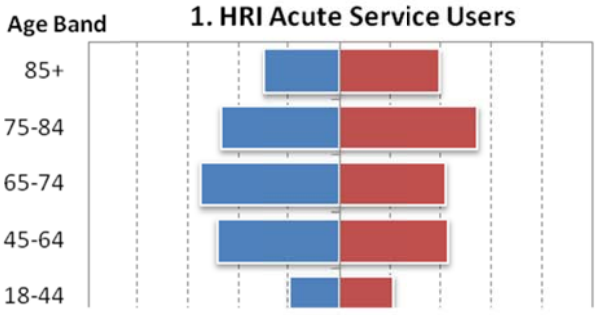
	High Resource as Percentage of Total			
	Patients	Cost	Events	Bed Days
Acute	17%	64%	38%	78%
A&E	8%	12%	12%	
Maternity	8%	26%	15%	28%
Mental Health	72%	96%	77%	92%
Outpatients	6%	9%	8%	
PIS	3%	15%	8%	
All Sectors	3%	50%	9%	78%

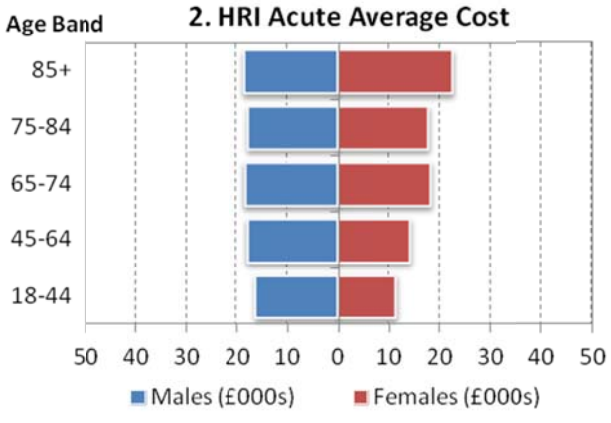
High resource patients comprise 17% of total Acute service users but utilise 64% of total Acute expenditure, 38% of total Acute hospital episodes and 78% of total Acute Bed Days.

Nearly three-quarters of mental health inpatients are within the HRI cohort. These patients account for all but 4% of total Mental Health (inpatient) cost, over three-quarters of hospital episodes and 92% of bed days. Further analysis has shown that the average annual cost per patient for Mental Health HRI is over £31,500; 9-times higher than non-HRI patients and 1.5-times higher than the average HRI cost per patient for all service sectors.

However expenditure on Mental Health Inpatient services add up to less than 5% of total health service costs whilst spending on Acute services make up 40%. Also only 6% of high resource patients use MH inpatient services whilst over 90% use Acute services.

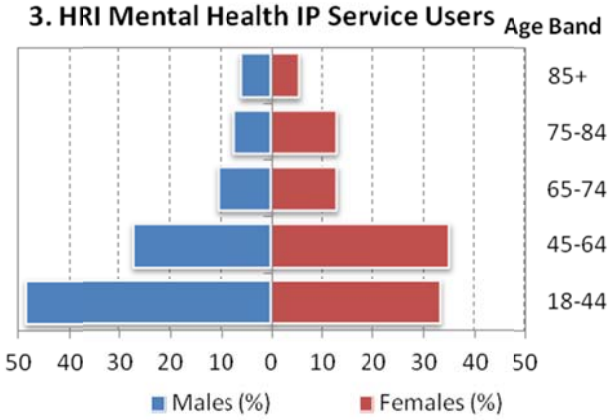
Acute services account for 81% HRI expenditure and Mental Health services account for 9%. Over two-thirds of Acute service users are aged 65+, with the highest proportion of males in the 65-74 age bracket and females in the 75-84 age group (figure 1).





Looking at indicative average cost per patient per year for Acute services (figure 2), there is surprisingly little variation with age for male patients, ranging from about £16k at the younger age bracket to £18.5k for those aged 85+. Cost does however appear to increase with age for female patients; the £11.5k for 18-44 year olds nearly doubling for 85+ cohort.

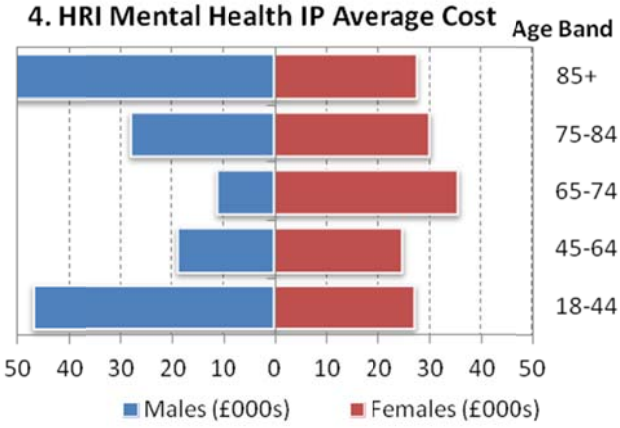
3. HRI Mental Health IP Service Users



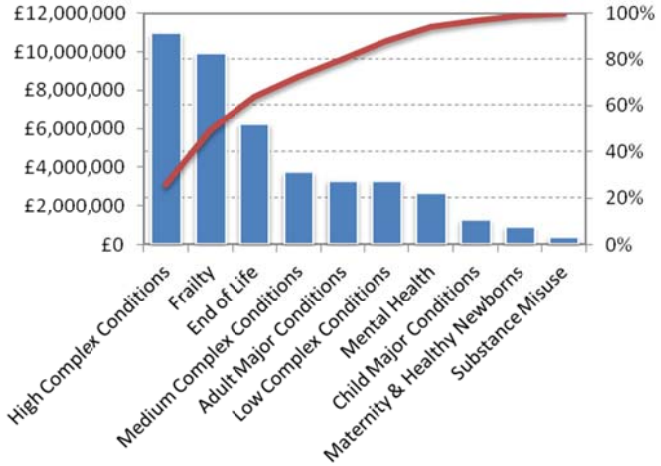
Almost three-quarters of high resource Mental Health users are aged under-65. Nearly half of all male patients are in the 18-44 age range whilst over two-thirds of female patients are aged between 18 and 64 years (figure 3).

In contrast to male Acute patient costs, average costs for male Mental Health patients varies considerably across age bands, ranging from £11k (65-74) to £50k (85+). Nearly half of male mental health patients (18-44 age bracket) average £47k per person per year. Female mental health patients display less variance in cost, with the 65-74 age group having highest average cost at £35.6k and those aged 45-64 lowest at £25k.

4. HRI Mental Health IP Average Cost



5. HRI Total Cost by Demographic Class



Demographic Classification assigns the population to a ranked demographic segment based on their highest level of health care need, or age and cost of services, in a given year. The Pareto Chart

(figure 5) shows that 80% of HRI total cost is accounted for within five categories; High Complex Conditions, Frailty, End of Life, Medium Complex Conditions, Adult Major Conditions. It should be noted that the Low Complex Conditions category was only marginally smaller than Adult Major Conditions.

In a similar vein, each patient can be assigned a Service-use Class on the basis of the main service type or form of care with the highest cost in the given year. Figure 6 indicates that 80% of HRI total cost is accounted for by Multiple and Single Emergency Admissions and Elective Inpatient stays. Both Emergency Admissions categories account for over 60% of HRI total cost.

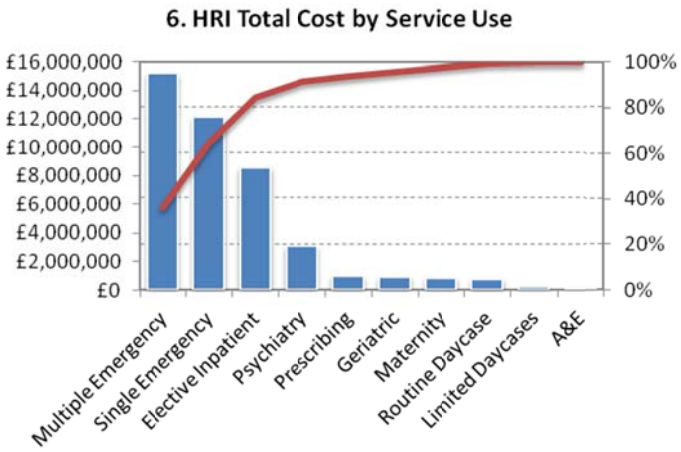
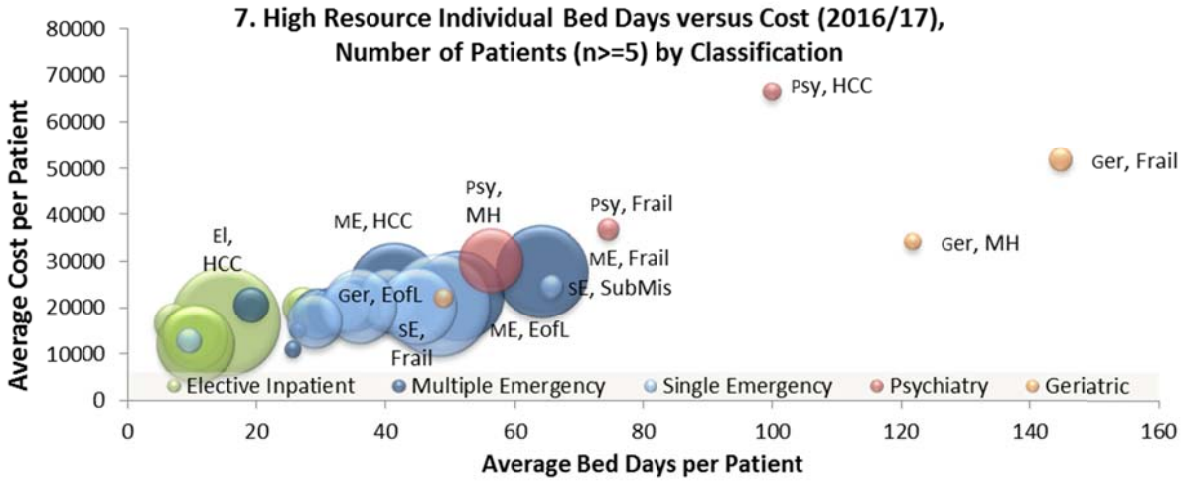
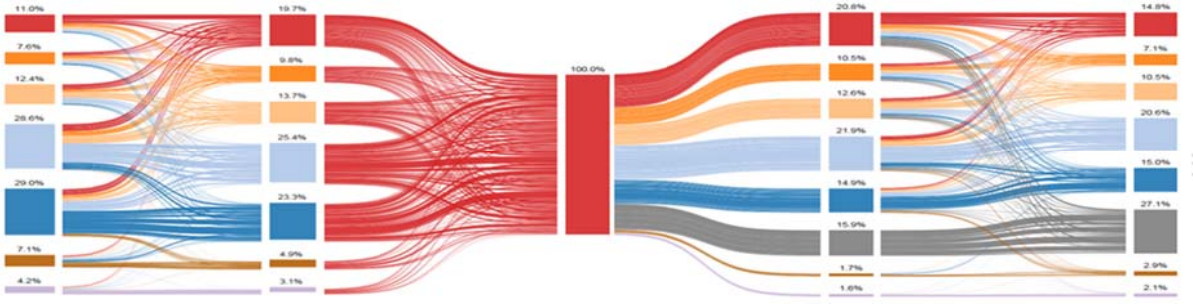


Figure 7 combines the Service-Use and Demographic classifications with the average cost and bed days per patient, with the size of bubble indicating the number of patients.



Whilst Elective Inpatient stays for patients in the High Complex Conditions category is the largest group, Single and Multiple Emergency admissions for Frailty patients together contain more patients with higher average cost and bed days. Attention is drawn to the Multiple Emergency/End of Life cohort which is the fifth largest HRI category.

Pathway analysis shows flow between resource use categories with time. Whilst the numbers in figure 8 are indicative rather than actual, what is noticeable is that the



year immediately prior to becoming a HRI, 50% of patients were in the medium-low or low user categories (blue), so greater understanding of the factors that trigger these patients into the highest service use is vital to implementing effective prevention programmes.

HRI Year -2	HRI Year -1	**HRI Year**	HRI Year +1	HRI Year +2

A greater proportion of patients remain HRI the year after than was the case the year before and the same applies for two years before and two after. A sixth of patients die the year following their categorisation in the HRI cohort whilst two years on over a quarter of patients have died.

Pathway analysis is a very powerful tool and can be combined with demographic and service-use classification to gain greater insight into the nature of high resource use.

There are three predictive tools that offer great potential for health and social care professionals in Moray to tackle high resource use:

SPARRA Scottish Patients at Risk of Readmission and Admission is a risk prediction tool developed by ISD which predicts an individual's risk of being admitted to hospital as an emergency inpatient within the next year. The latest version of the SPARRA tool (Version 3) provides data for three sub-cohorts of the SPARRA population: frail elderly; long-term conditions and; younger emergency department. These sub-cohorts each have their own specific set of risk factors tailored to the characteristics of these particular populations.

pHHG The Potential High Health Gain tool identifies patients who are predicted over the next year to become high resource users. From summer 2018 the tool became available to GP practices via an interactive dashboard, offering greater opportunity to focus on specific patient cohorts; by the same Demographic Classification mentioned above for example.

eFI The Electronic Frailty Index uses primary care data held in GP practices to detect and assess the severity of frailty. It uses a cumulative deficit model of frailty, in which frailty is defined through the accumulation of deficits, which can be clinical signs, symptoms, diseases and disability. A patient's eFI score is a reliable predictor of those who are at risk of adverse outcomes, such as care home admission, hospitalisation and mortality. The eFI enables services and treatments to be targeted on the basis of people's frailty status, rather than their chronological age and has the potential to transform care for older people living in the community. eFI is available via Vision Plus and a refined version will become available via SPIRE.

Use of health and social care services

Social care

As noted in sections above, poverty and inequality are important factors that affect people's ability to participate fully in society. Meaningful participation is influenced and shaped by employment and leisure activity, through family involvement and a network of friends or neighbours in communities. Older people living with frailty and poor health are disadvantaged several times over: through not working, difficulty in travel, sensory and physical incapacity that prevents participation, loss of friends and family through death, and isolation and bereavement. Social service intervention is designed to mitigate these factors.

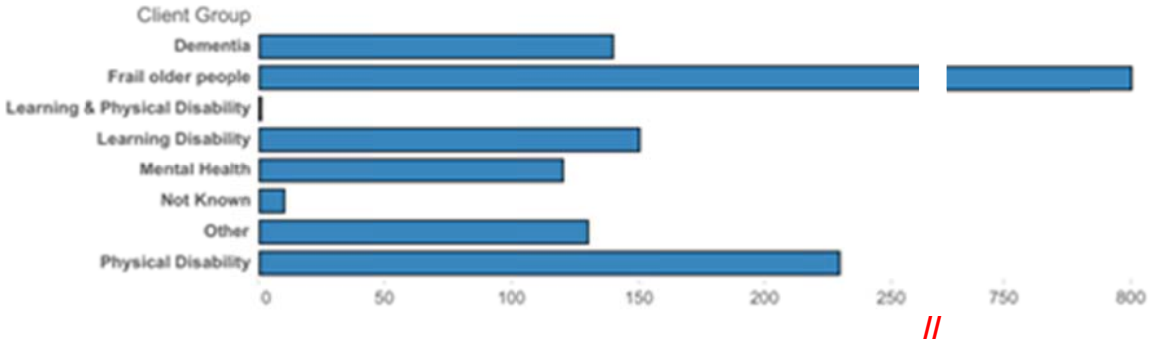
The Moray Council *Housing Need and Demand Assessment 2017* sets out a comprehensive analysis of future housing types and includes an assessment of implications for health and social care.[76]

People assessed as requiring social care are given a choice over how their individual budget is used to meet their agreed health and social care outcomes. This is called self-directed support (SDS).[77]

There are around 1,500 people who are receiving SDS in Moray, although the need for social care increases with age.

The highest category of need is *frailty*, followed by *physical disability*, *learning disability*, *dementia*, *other*, and *mental health*.

[76] The HNDA 2017 is available to download at www.moray.gov.uk/moray_standard/page_95565.html
[77] www.selfdirectedsupportscotland.org.uk



Social care services

Across Moray, the number of adults aged 65 and over resident in care homes has decreased by around twenty percent over the past decade, from 590 adults in 2006 to 470 adults in 2017.

Over the same period, the number of adults aged 65 and over who are receiving ten hours or more of social care at home each week across Moray has increased by around seventy percent, from 220 adults in 2006 to 370 in 2017.

This is consistent with the policy environment which seeks to support people to live independently in their own homes.

Number and % of people aged 65 and over with long-term care needs receiving social care in Moray												
Type of care	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**[78]	**2017**[79]
Home Care 10+ hours	220	230	250	290	300	320	340	340	390	370	370	370
Long stay care home residents	590	550	480	500	510	510	510	520	540	490	470	470
Continuing care census/HBCCC[1]	0	0	0	10	10	0	0	0	0	0	0	10
Percentage % receiving 10+ hours Home Care	**27**	**29**	**34**	**36**	**37**	**38**	**40**	**40**	**42**	**43**	**44**	**43**

Source: Scottish Government Quarterly Monitoring, Survey, Scottish Government Social Care Survey, ISD Continuing Care Census and Hospital Based Complex Clinical Care Census

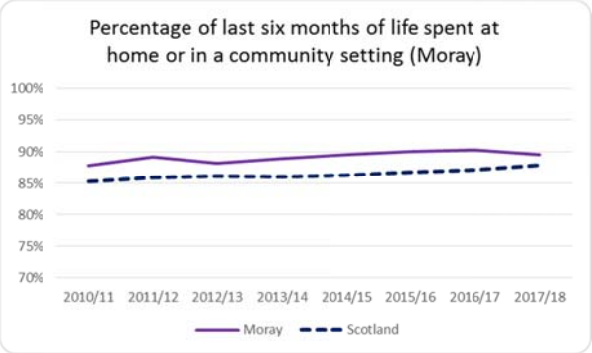
[78] Previous guidance (CEL 6 (2008)) on NHS Continuing Care was replaced on the 1st June 2015 with DL (2015)11 - Hospital Based Complex Clinical Care (HBCCC) . As a result, the previous NHS Continuing Care Census was ended in June 2015 and replaced by the Hospital Based Complex Clinical Care publication from 2016.

[79] The definition of HBCCC changed between the 2016 and 2017 Census. The figures here for 2017 use a similar methodology to 2016 for comparison purposes.

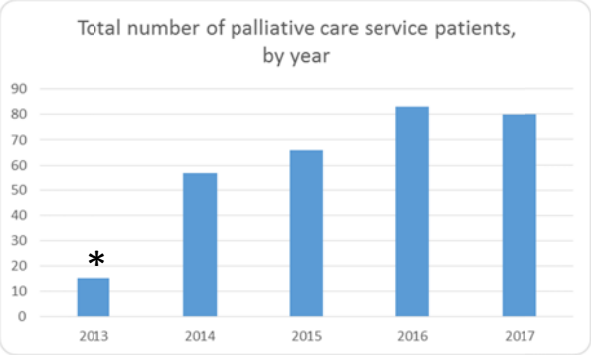
Palliative care services

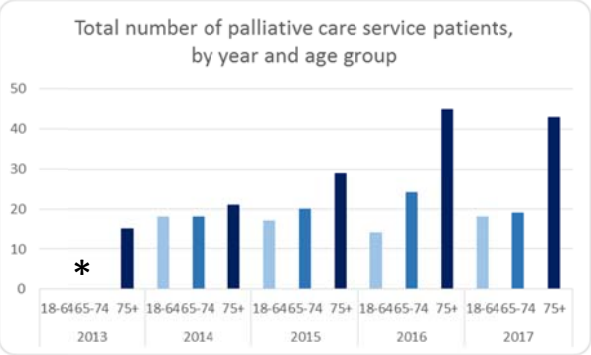
The proportion of people who spend their last six months of life at home or in a community setting has remained stable in the past five years, and slightly greater than the national average.

In Moray, this proportion is around 90%.



Demand for palliative care service has increased in recent years, predominantly due to an increase in the number of people in the 75+ age group using the service.

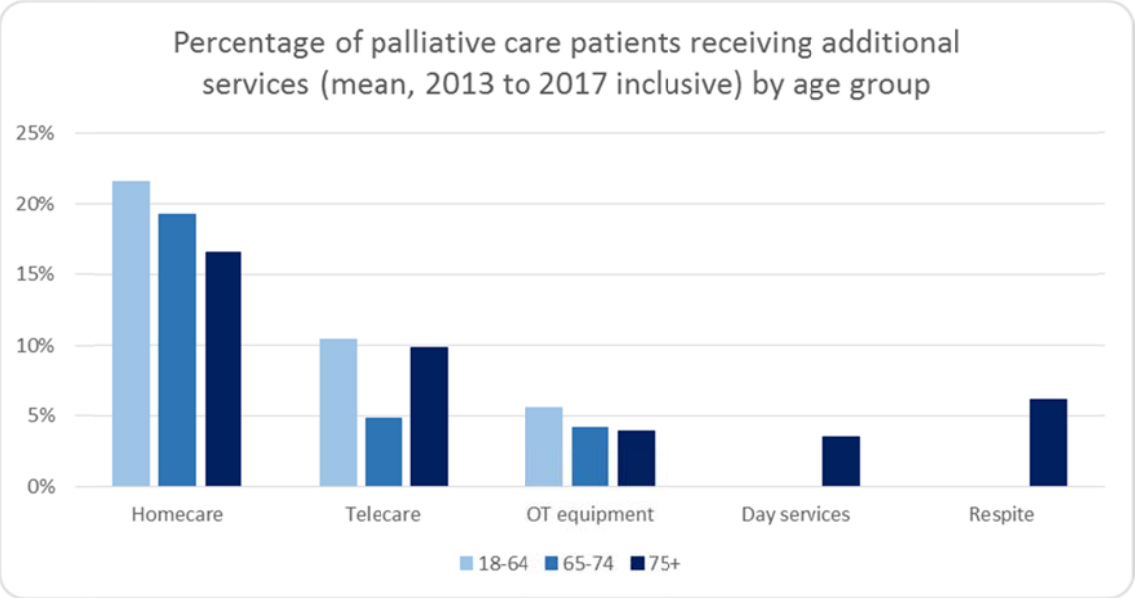




Number using palliative care service by yea, age group and sex															
	2013			2014			2015			2016			2017		
Age group	18-64	65-74	75+	18-64	65-74	75+	18-64	65-74	75+	18-64	65-74	75+	18-64	65-74	75+
Female	9	*	7	9	9	10	9	9	13	9	10	22	6	9	19
Male	*	5	8	9	9	11	8	11	16	5	14	23	12	10	24
Total	*	*	15	18	18	21	17	20	29	14	24	45	18	19	43
* values <5 have been suppressed															

Additional services received by those using the palliative care service include homecare, telecare, OT equipment, day services and respite.

	Age Group		
	18-64	**65-74**	**75+**
Homecare	22%	19%	17%
Telecare	10%	5%	10%
OT equipment	6%	4%	4%
Day services	0%	0%	4%
Respite	0%	0%	6%

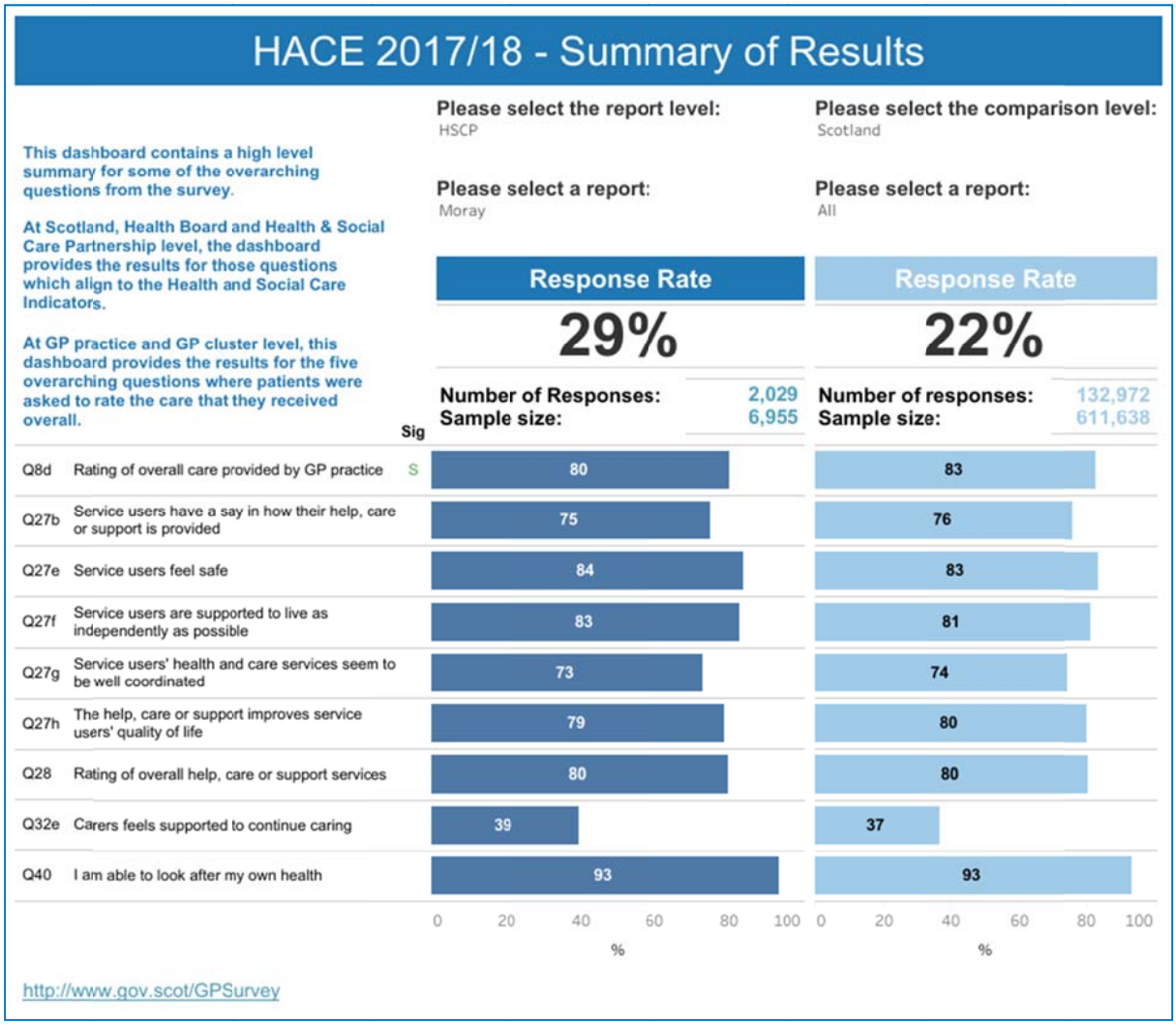


Health and Care Experience survey results

The Health and Care Experience survey (HACE) was sent to a random sample of 6,955 patients who were registered with a GP in Moray in October 2017, who were requested to complete the questionnaire between November 2017 and January 2018. A total of 2,029 patients completed the survey (29%).

From a positive perspective, more than nine out of ten patients reported being able to look after their own health, and up to four out of five patients were positive about their experiences of primary care.

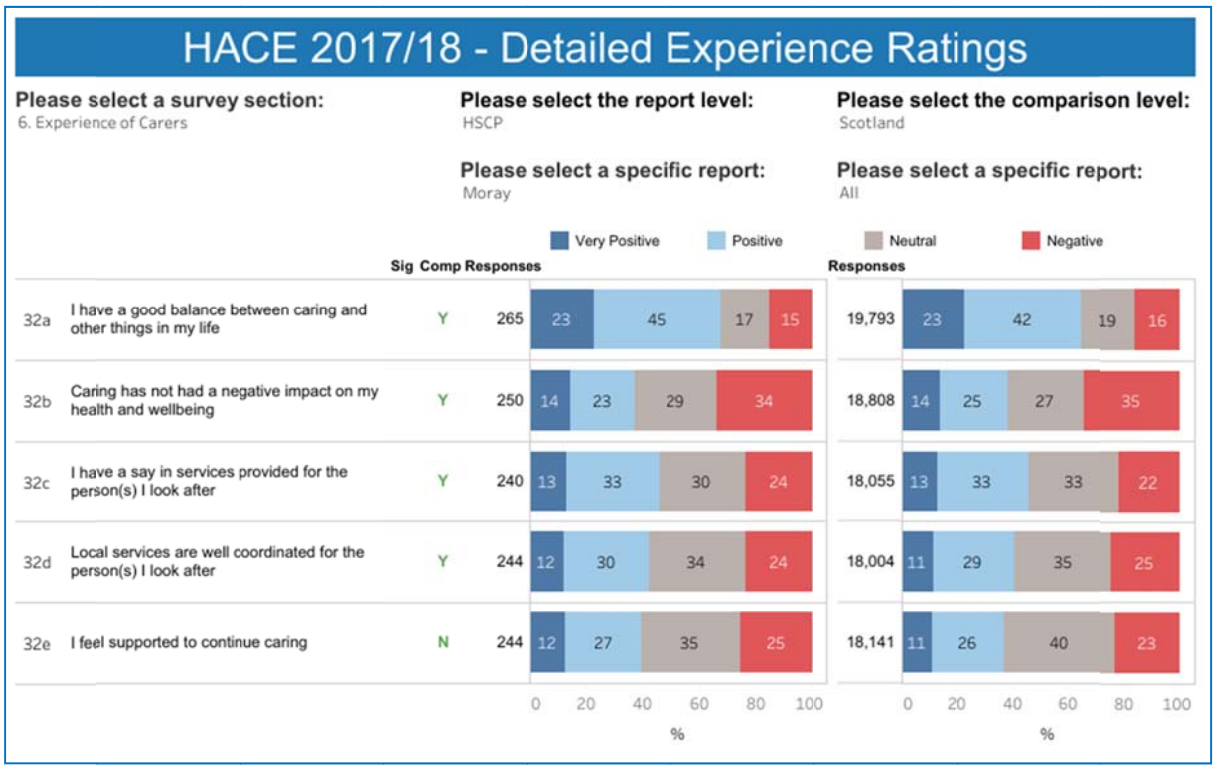
The most striking finding from the survey, in Moray as across Scotland, was that three out of five patients with caring responsibilities did not report being supported to continue caring.



The experience of people with caring responsibilities

One in three patients with caring responsibilities report that caring has had a negative impact on their health, and one in four report negative experiences of care coordination and availability of support.

Compared to survey results in 2014 and 2016, negative responses have significantly worsened for questions about life balance, about impact of caring on health, about having a say in services provided, and about feeling supported to care across Scotland. (The Moray sample size is too small to detect statistically significant changes, but the direction of change has been similar to that seen nationally.)



The experience of people living with learning disabilities

Health and Social Care Moray is developing the *Progression Model* for planning and delivery of services to people living with learning disabilities. The Progression Model is a person-centred developmental approach that seeks to support each adult with a learning disability to achieve their aspirations for independence. It is a relational change from traditional care management approaches by focussing on the individuals' hopes and choices, using these as the basis to co-develop care and support plans that enable each person to reach their potential.

The assessment underpinning this development is based on the recognition of four broad elements of care.

The first element recognises the additional freedom that individual care budgets have afforded people, and the decline in "block funded" contract arrangements. People are moving from residential care and supported accommodation to living in independent accommodation with personalised support.

The second element recognises that many people live with, and are supported by, their families. When circumstances change, for example when family members develop health problems, people may have to move to independent accommodation, and can then require additional, personalised support.

The third element recognises that some people who have lived outwith Moray, for example in residential educational facilities, who return to Moray in early adulthood.

The fourth element is people who transition from children's services to adult services at age 18.

Each of these elements have recently been assessed and budgetary arrangements estimated.

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The experience of veterans of the armed forces

The Armed Forces Covenant is a national pledge that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy and society they serve with their lives.

There are over six thousand service personnel and their dependents, and over nine thousand veterans and their dependents living in Moray.[80] As a result, one sixth (16%) of the population of Moray is covered by the Arms Forces Covenant. Active service personnel and their dependents represent 6.5% of the Moray population.

Service population	
Regular & reserve personnel plus dependants	6,189
Veteran population	
Veterans	4,707
Veterans' dependents	4,712
Total veterans plus dependents	9,419
Armed Forces Covenant population	
Service, veterans and dependents	15,608

Health needs of service personnel and veterans[81]

Veterans and service personnel have higher rates of certain health conditions, giving rise to greater need for services that in the general population. These conditions include:

- Mental health problems (e.g. PTSD, suicide, substance misuse)
- Severe and enduring physical health conditions (e.g. multiple, complex injuries; ongoing support through the national trauma network)
- Amputees, impaired mobility
- Musculoskeletal disorders
- Chronic pain
- Severe sensory impairment

[80] Source: Moray armed forces covenant self-assessment tool kit – March 2018
[81] Scottish Government (2018) *Veterans' Health & Wellbeing - A Distinctive Scottish Approach* [http://www.gov.scot/Publications/2018/04/2093]

SUMMARY AND CONCLUSIONS

The following nine issues are particularly evident from across the assembled intelligence:

1. There are continuing **inequalities in health** status across Moray, with an evident association between level of neighbourhood affluence and morbidity and mortality.

2. The population is predicted to continue **ageing**, with a growing proportion represented by adults over the age of sixty-five, and growing numbers of adults aged over eighty, with implications for increasing morbidity

3. Significant demand for health and social care services arise from **chronic disease**, and a growing proportion of the population is experiencing more than one condition ("**multi-morbidity**").

4. There is significant morbidity and mortality due to **mental health** problems.

5. There is significant morbidity and mortality due to **lifestyle exposures** such as smoking, alcohol and drug misuse

6. A small number of individuals require half of healthcare spending ("**high-resource individuals**"). This warrants further detailed analysis.

7. Moray is characterised as **remote and rural**, and there are significant **access challenges** for some in the population to access health services.

8. Care activity is highly demanding of **informal carers**, and there is evidence of distress in the informal carer population.

9. Moray's **military and veteran population** constitute a significant group, requiring both general health services and specific services.

It is proposed that the strategic planning process address these issues through the development of the strategic plan 2019/20 – 2021/22.

JOINT STRATEGIC NEEDS ASSESSMENT 2018

Produced by the Joint Needs Assessment Short-Life Working Group under the auspices of Health and Social Care Moray's Strategic Planning & Commissioning Group

From: eforms@moray.gov.uk
To: Localdevelopmentplan
Subject: NM_R1 - 000617
Date: 04 March 2019 22:16:14

Moray Local Development Plan - Proposed Plan 2019

Your Place, Your Plan, Your Future

Your Details

Title: **Mrs**

Forename(s): **Sheila**

Surname: **Nicoll**

Your Address

[redacted]

Contact Details

[redacted]

Agent Details

Do you have an agent: **No**

Response

Do you want to object to a site?: **Yes**

Do you want to object to a policy, the vision or spatial strategy: **No**

Other: **No**

Supporting information: Download supporting document Available also via link at bottom of this email.

Site Objections

Name of town, village or grouping: **Newmill**

Site reference: **R1**

Site name: **Newmill**

Comments: **Isla Road is very narrow and would be unsuitable for increased traffic due to 6-10 houses being built. It is already unsafe when the refuse lorry drives down it to empty bins. There is nowhere for the bin lorry to turn and it reverses back up the road to the school. If more houses are built with more children there would be the chance of someone being knocked over. It is already a dangerous practice when this happens.**

Please use this link to view and retrieve the uploaded attachments.

From: eforms@moray.gov.uk
To: Localdevelopmentplan
Subject: WB_SITEA - 002158
Date: 12 March 2019 15:13:57

Moray Local Development Plan - Proposed Plan 2019

Your Place, Your Plan, Your Future

Your Details

Title: **Mr**

Forename(s): **Keith James**

Surname: **North**

Your Address

[redacted]

Contact Details

[redacted]

Agent Details

Do you have an agent: **No**

Response

Do you want to object to a site?: **Yes**

Do you want to object to a policy, the vision or spatial strategy: **No**

Other: **No**

Supporting information: Download supporting document Available also via link at bottom of this email.

Site Objections

Name of town, village or grouping: **Woodside of Ballintomb**

Site reference: **Woodside of Ballintomb**

Site name: **Woodside of Ballintomb**

Comments: **The drainage of surface and foul water is a serious problem as there is no depth soil or suitable water course to assist. The previous plan showed the drain from septic tanks crossing my back garden. A plan showing my ground has been submitted. One of the most serious concerns is the change in the nature of this small settlement. Our previous objection was supported by the Scottish Executive Inspector. We appreciate that houses need to be built, although there are many empty sites in the area, but an additional property to the west end of our frontage would be less detrimental.**

Please use this link to view and retrieve the uploaded attachments.

From: eforms@moray.gov.uk
To: Localdevelopmentplan
Subject: AB38 7QT - 000165
Date: 11 February 2019 15:49:18

Moray Local Development Plan - Proposed Plan 2019

Your Place, Your Plan, Your Future

Your Details

Title: **Mrs**

Forename(s): **M Patricia**

Surname: **North**

Your Address

[redacted]

Contact Details

[redacted]

Agent Details

Do you have an agent: **No**

Response

Do you want to object to a site?: **Yes**

Do you want to object to a policy, the vision or spatial strategy: **No**

Other: **No**

Supporting information: Download supporting document Available also via link at bottom of this email.

Site Objections

Name of town, village or grouping: **Woodside of Ballintomb**

Site reference: **Woodside of Ballintomb**

Site name: **Woodside of Ballintomb**

Comments: **The proposed siting of three new properties would drastically alter the nature of this community. Although there is some recognition of the drainage problems, the problem with both surface water and foul water are so severe that these sites are unsuitable for development. If wanted I can supply photographic evidence of periodic surface water flooding around [redacted] To risk increasing this is not acceptable. Previous planning applications have not had any convincing answer to this problem. On your diagram, you show amenity land behind some properties. Since that was originally taken from the OS map, [redacted] Access to the road continues to be a problem with insufficient visibility splays. If a site was offered alongside the road, beyond the current properties, the access problem could be overcome, and although drainage is still going to be problematic, at least it would not affect existing properties so severely, nor would it have the same devastating effect on the nature of this community.**

Please use this link to view and retrieve the uploaded attachments.