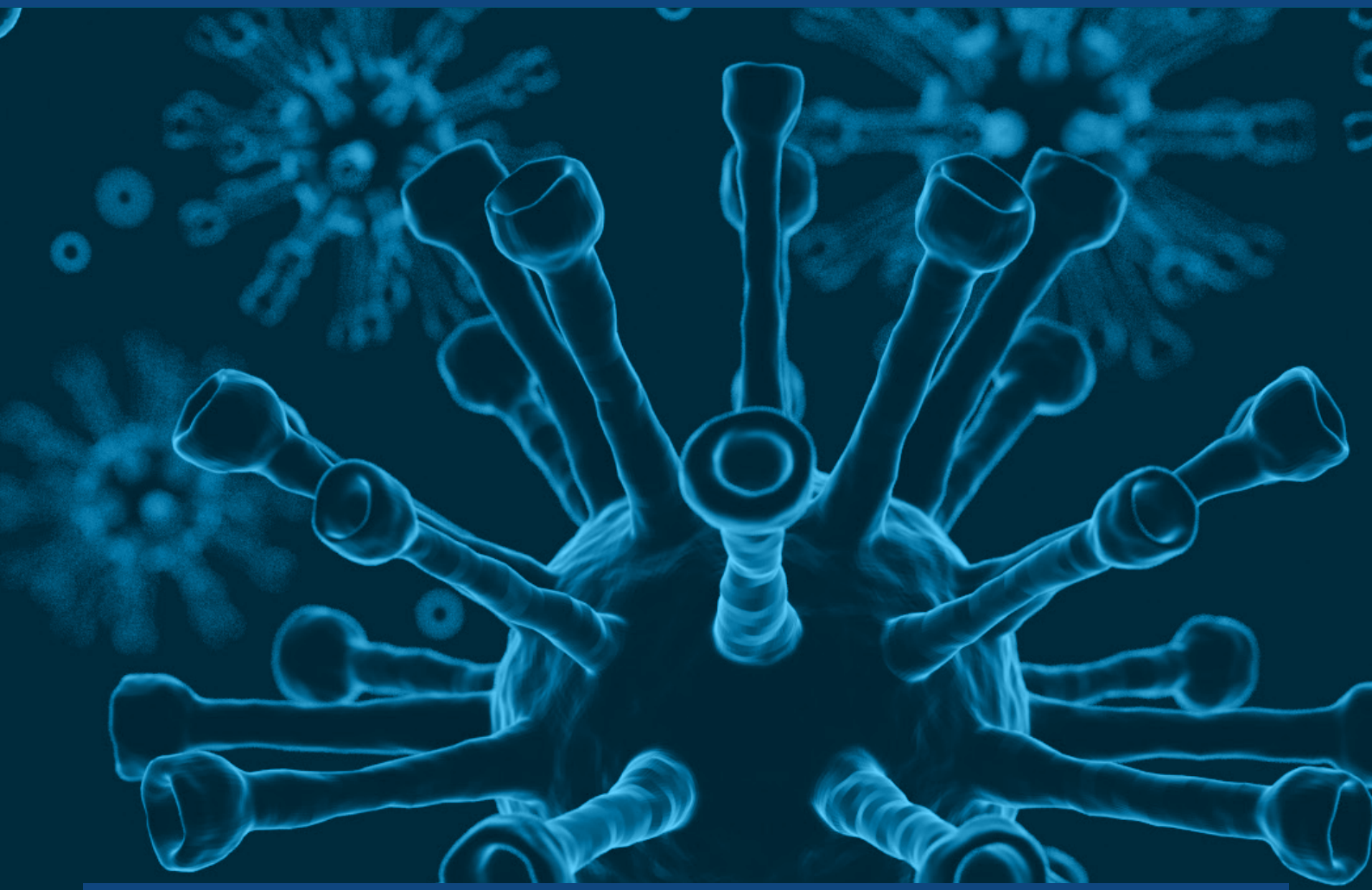
The Annual Report of the **Director of Public Health**

NHS Highland

2020



Coronavirus (COVID-19) in the NHS Highland area

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Contents

Introduction

This is my first annual report as Director of Public Health for NHS Highland. I am delighted to have joined a team, organisation and partners clearly committed to improving the health and wellbeing of the local population. I am also delighted to be living and working in this area. I have found the people of Highland & Argyll and Bute friendly and helpful and there are great opportunities for improving and protecting health and ensuring efficient and effective health and social care services.

2020 has been a difficult and challenging year, where the impact of COVID-19 and the efforts to control it have been at the forefront of all our minds. This report shows the spread and impact of COVID-19 and the challenges that it has brought to the people of the NHS Highland area. The direct effects of the virus have been severe in terms of illness and death. These effects are sadly likely to continue for some time and will include the longer-term effects of infection - long COVID. Indirect effects of the pandemic are also hugely important including loss of jobs, reduced income, poor mental health and substance use. Addressing these issues through social mitigation is a vital task and just like tackling acute COVID-19 infection it needs effective work across organisations and communities.

The pandemic has demonstrated the importance of public health in all our lives. Improving health and wellbeing is fundamental for the good of our communities and public health work should continue to be at the centre of the work of both NHS Highland and of partners.

2021 begins with more work to control COVID-19 but also with the opportunity for vaccination and a return to a more normal way of life. I am looking forward to maintaining public health as a central element of the work of NHS Highland and partners, continuing to address the impact of COVID-19 but also improving and protecting the wider health and wellbeing of the population.

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Chapter One - Epidemiology

Background

Coronavirus disease 2019 (COVID-19) is an infectious acute respiratory disease caused by a new strain of coronavirus called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)[1]. The disease was first identified in Wuhan, China in December 2019 and has subsequently spread rapidly around the world[2]. The World Health Organisation (WHO) formally declared the disease a pandemic on 11 March 2020[3].

The clinical presentation of COVID-19 varies. Most cases present symptoms including fever, cough, myalgia (fatigue) and shortness of breath[4]. Other symptoms include loss of normal sense of smell or taste, diarrhoea, headache, nasal congestion and rash[4,5]. While the majority of cases are asymptomatic or result in mild symptoms, one in five people develop severe illness including viral pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and/or multi-organ failure. Older people (aged 65 years and over) and those with pre-existing health conditions are at higher risk of death[5,6]. Uncontrolled spead of the virus risks placing demands on health services that exceed their available capacity, particularly for oxygen therapy and high dependency and intensive care provision[7].

The spread, or transmission, of COVID-19 mainly occurs through person-to-person close contact, through respiratory droplets produced when an infected person exhales, sneezes, or coughs, and by contact with contaminated surfaces and objects[8]. Studies report that proximity and ventilation are the key determinants of transmission risk[9]. The virus is most contagious when people are symptomatic, especially within the first three days from onset of symptoms[10]. Spread is also reported to be possible in the one to three days before symptoms appear.

A number of factors are reported as increasing vulnerability to infection and poorer clinical outcomes from COVID-19. These risks include older age, male sex, black and minority ethnic (BME) background, presence of health conditions such as diabetes, hypertension, cancer and cardiovascular heart disease, smoking, obesity, population density, living in a more deprived area and working in an occupation with a high risk of transmission[5,11,12,13]. These risks are multifactorial and reflect existing vulnerabilities and inequalities in health[14].

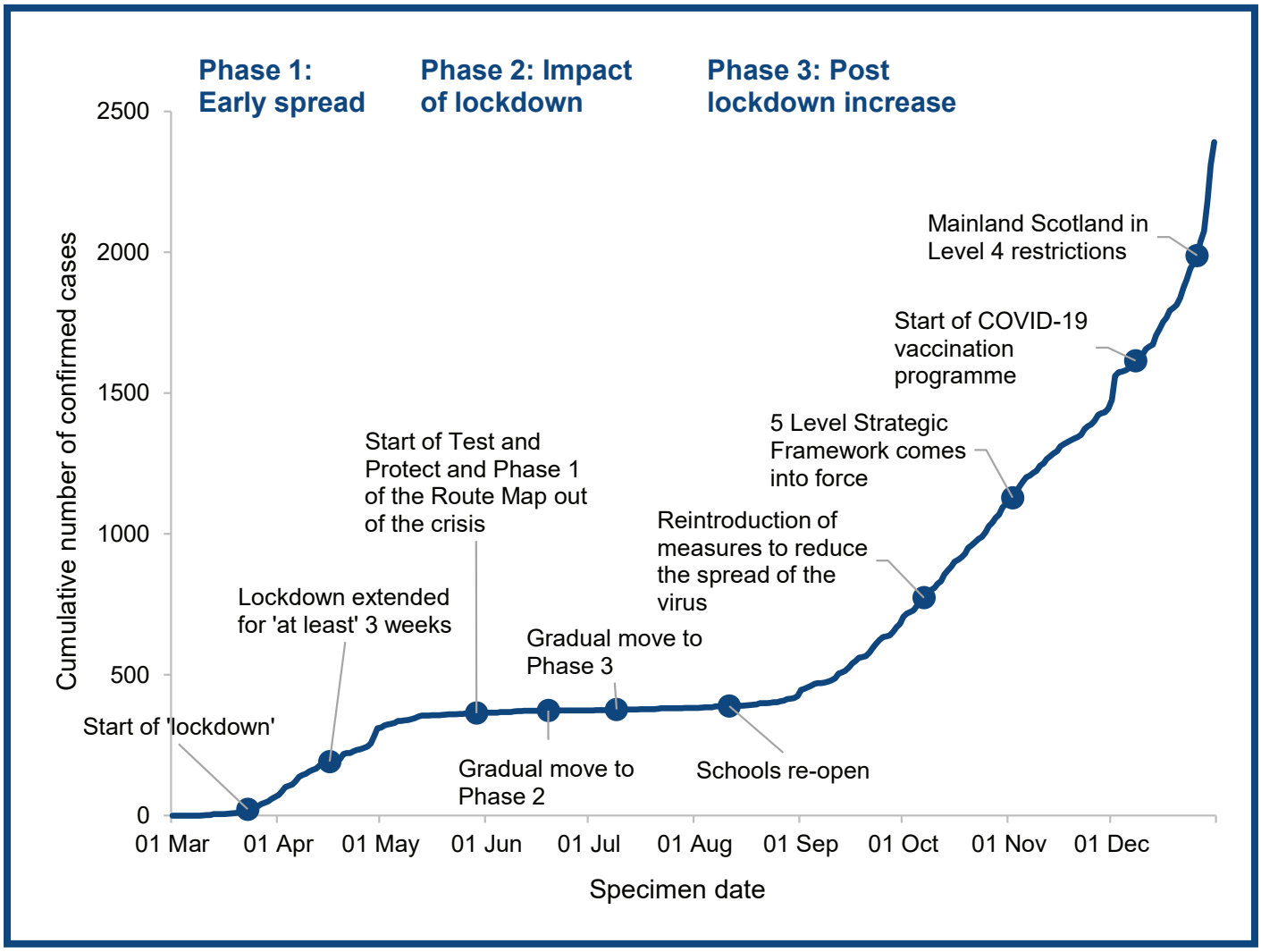
There is limited information on the likely impact of COVID-19 in rural areas. Although lower population density is likely to decrease the risk of transmission, assumptions of relative safety may encourage fewer adherences to social distancing in rural areas[15]. Older populations common in rural areas may experience a greater impact from cases that do occur[16], and some international rural populations have relatively poor health[17]. A small number of serious cases may overwhelm limited local resource at a time when urban areas may be less able to help than normal, because of the impact of cases there[18,19].

The pandemic has caused widespread global health and economic harm. Governments across the world have sought to mitigate its effects using different combinations of social restrictions[20,21]. Containment approaches to decrease the infection rate in the UK, including social isolation, social distancing measures and a national ‘lockdown’ will have indirect impacts on the health of communities, as well as the direct effects of the virus.

Spread of the disease in NHS Highland

The experience of COVID-19 in NHS Highland during 2020 falls into three broad periods: the initial spread of the virus before lockdown, the gradual diminution in cases as Government restrictions took effect, and the increase in cases after the easing of restrictions (Figure 1). These figures will be an underestimate of the true number of cases because not everyone with COVID-19 will display symptoms and not all those with symptoms are tested.

Figure 1: Cumulative number of confirmed cases of COVID-19 in NHS Highland by specimen date and dates of key interventions and policy changes, 2020

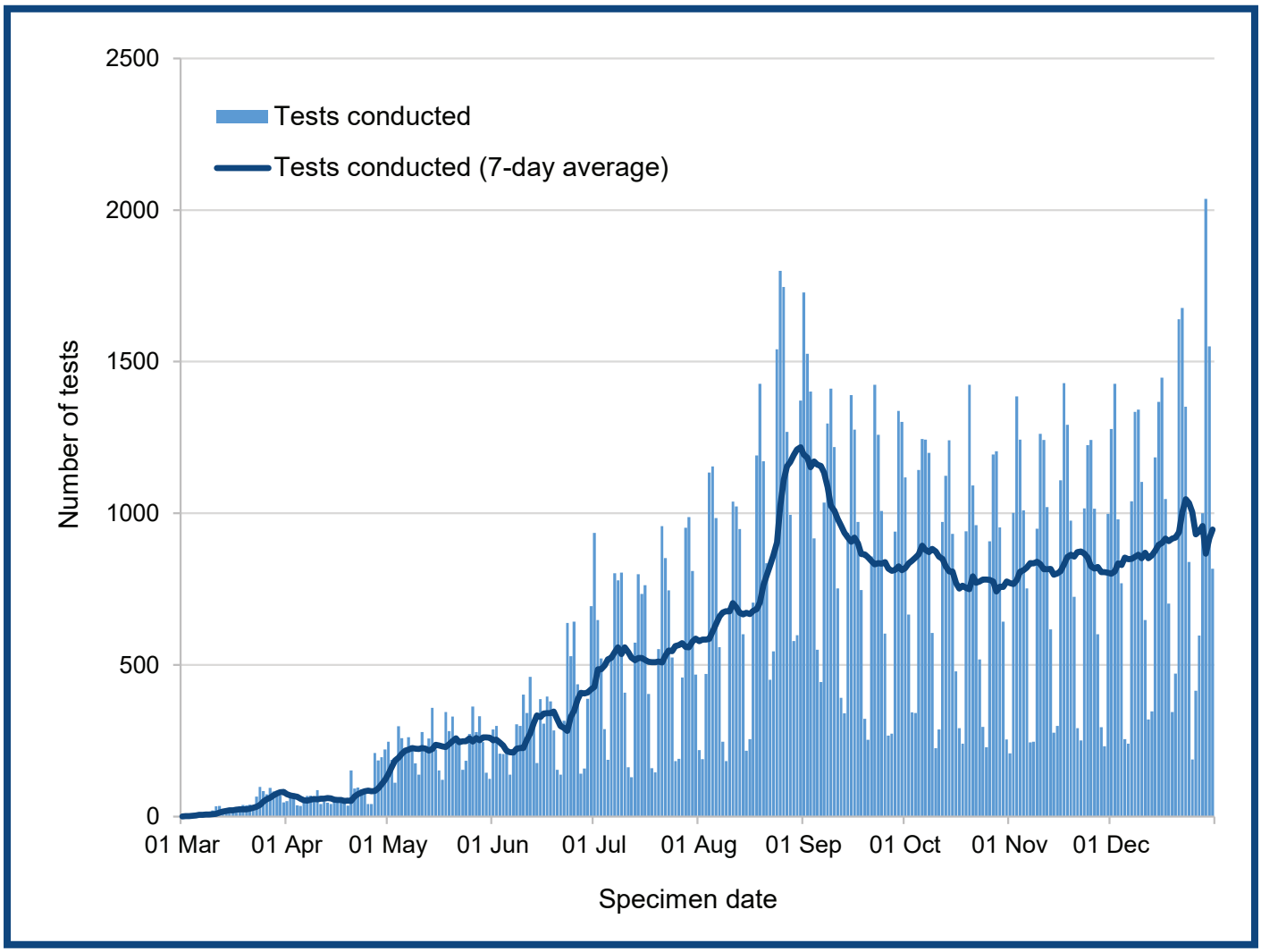


Source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

The case numbers across the course of the pandemic are not directly comparable. During the early spread of the virus, there was no test available until Public Health England (PHE) developed a diagnostic test in early February[22]. Initial testing capacity was limited and only some overseas travellers and people admitted to hospital were tested[23]. During the lockdown phase, testing capacity gradually increased and national policy changes increased testing in care homes and for care home staff, and for some groups of healthcare staff[24]. The capacity to provide wider public testing through the UK Government laboratory system developed steadily, although there are continuing access issues for community tests in some parts of the NHS Highland area.

Figure 2 shows the best available count of test numbers, illustrating the very marked increase in testing across the course of the pandemic. The figures include tests processed through NHS Scotland laboratories and UK Government Regional Testing Centre (RTC) laboratories, including drive through centres, mobile units and home testing kits.

Figure 2: Number of COVID-19 tests conducted by NHS or UK Government laboratories each day with 7-day rolling average, NHS Highland, 2020

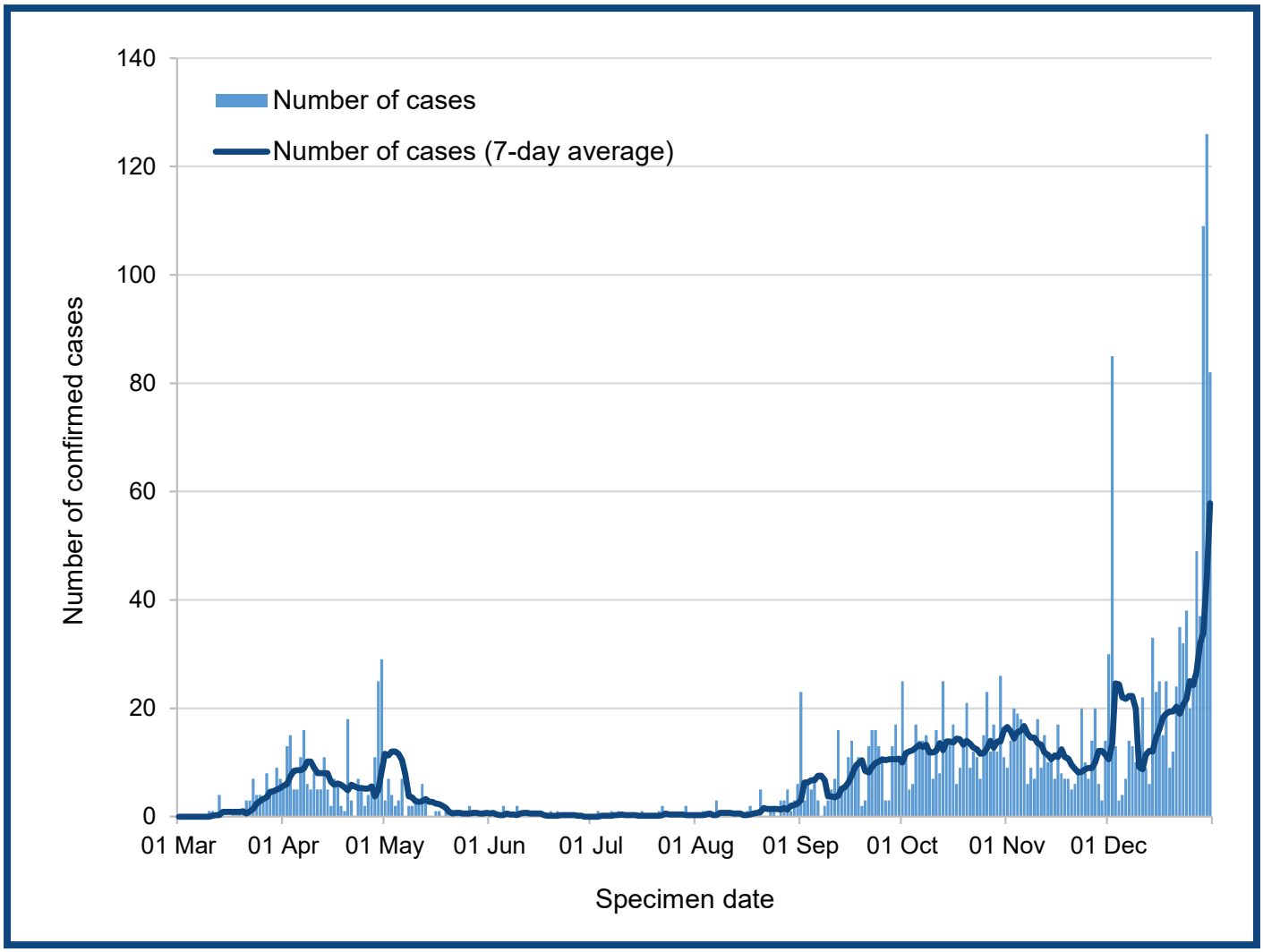


Source: Scottish Health and Social Care Open data platform[25]

Phase One: Early Spread

The numbers of confirmed COVID-19 cases occurring in NHS Highland residents on a daily basis are shown in Figure 3. The first positive case was tested on 10 March 2020. The number of confirmed cases in early March in particular will markedly underestimate the true number of infections spreading in the population prior to the UK lockdown that came into effect on 24 March 2020.

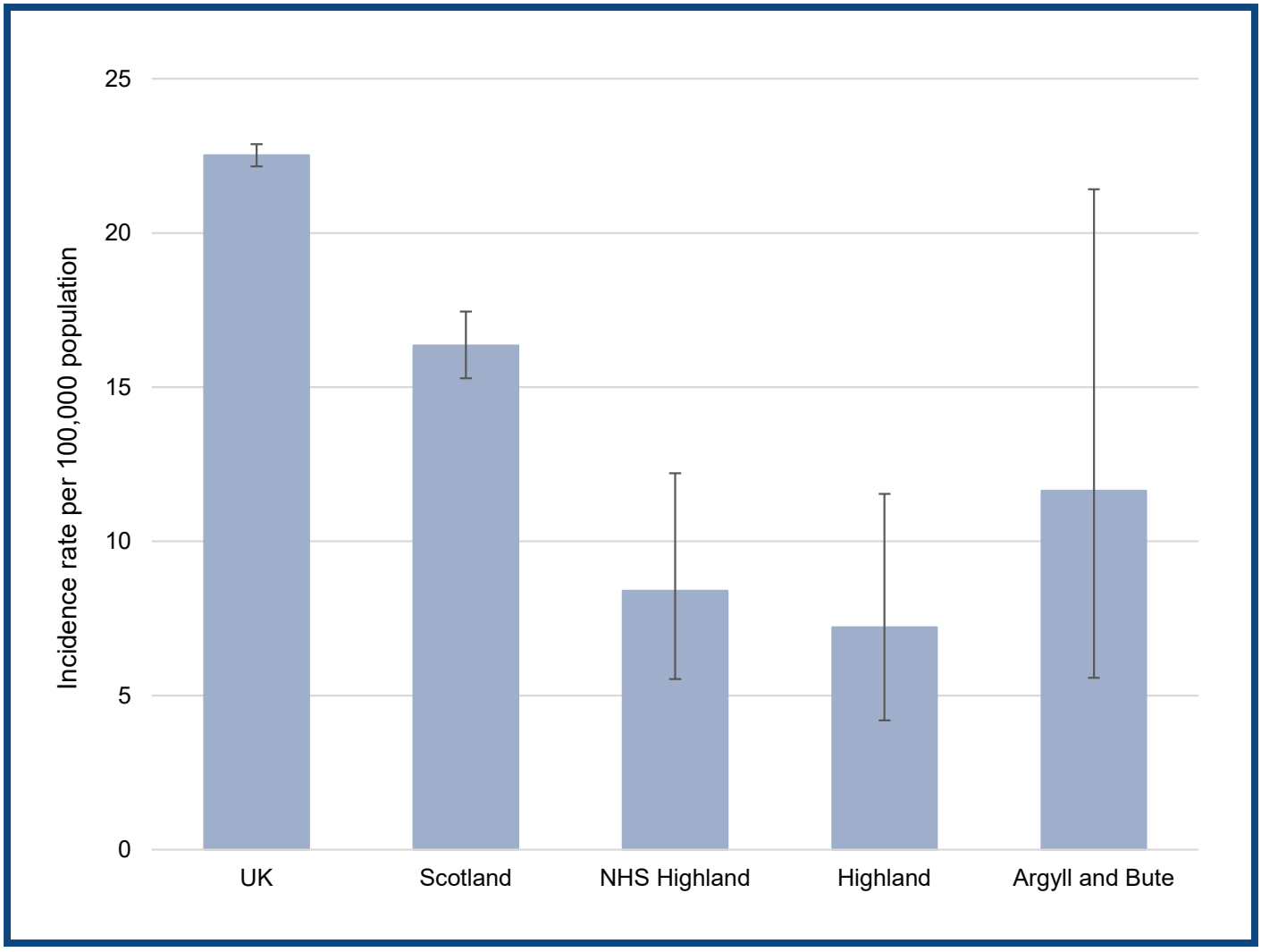
Figure 3: Number of new confirmed cases of COVID-19 by specimen date, with 7-day rolling average, NHS Highland, 2020



Source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

At the time of the lockdown restrictions, the incidence rate in the NHS Highland area was lower than the rate in Scotland, which was in turn lower than the UK average overall (Figure 4). This meant that the lockdown came earlier in the spread of the disease in NHS Highland, which resulted in a marked limiting of spread. The figures conceal differences across the NHS Highland region. The Argyll and Bute council area experienced higher rates than the Highland council area, most likely because of relative proximity to larger population centres in the Central Belt.

Figure 4: Incidence rate per 100,000 population of confirmed COVID-19 cases between the first reported case in England (30 January 2020) and the first day of the UK lockdown (24 March 2020); UK, Scotland and areas of NHS Highland



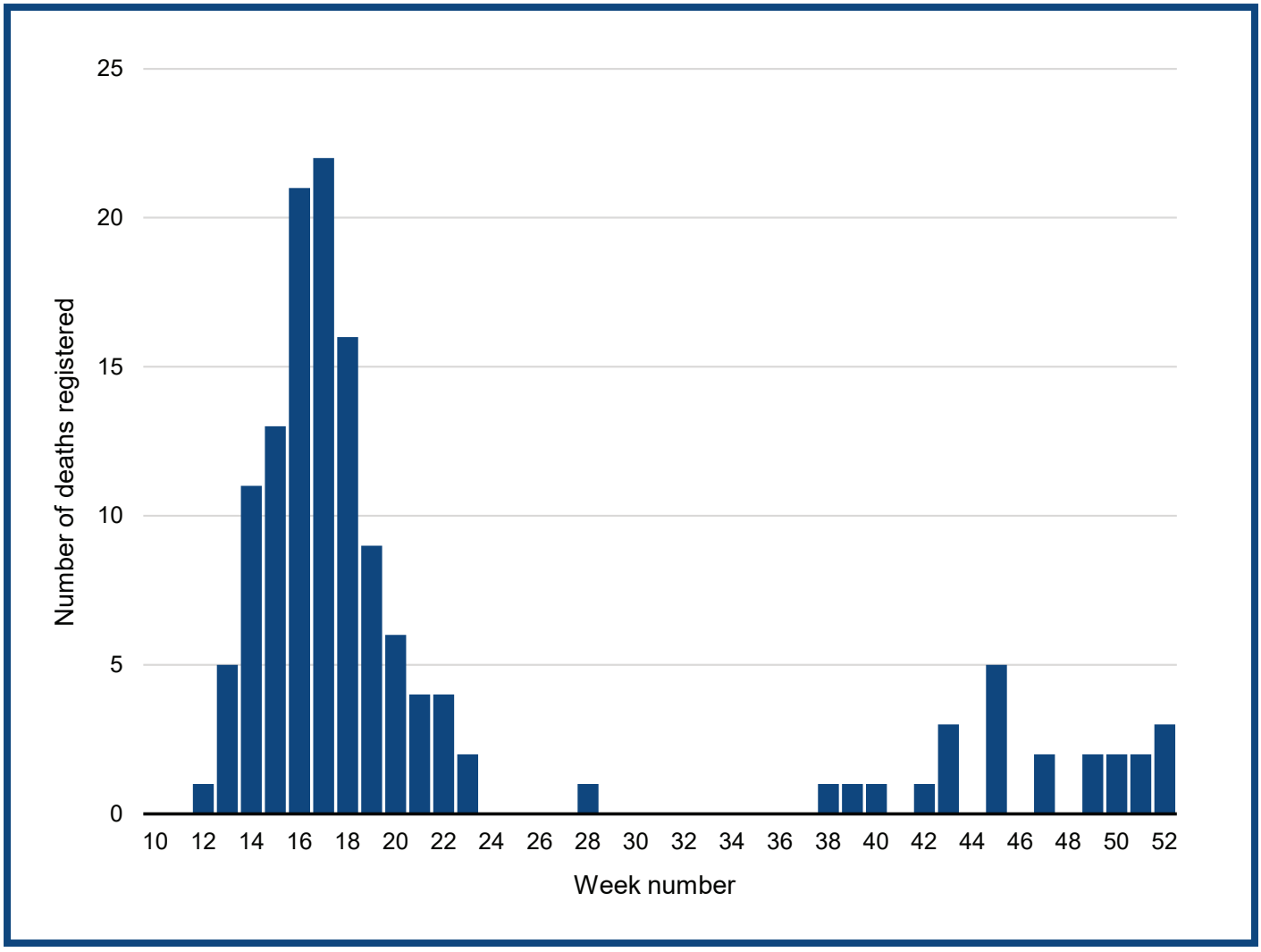
Source: Public Health England Coronavirus tracker[26], Scottish Health and Social Care Open data platform[25]

The number of deaths involving COVID-19 in NHS Highland by location or usual area of residence are shown in Figure 5. The first mention of COVID-19 in a registered death certificate in NHS Highland was the week beginning 16 March 2020 (week 12). Deaths lagged new case identifications and peaked in week beginning 20 April 2020 (week 17).

As tests were mainly only conducted on people admitted to hospital in the early stages of the pandemic, the gap between diagnosis and death is shorter than would be likely to be the case in Phase Three, as testing is often undertaken earlier in the course of the illness.

The proportion of deaths to cases is higher in Phase One and early in Phase Two because tests were not available for people with milder symptoms. Understanding of the disease and the gradual availability of evidence on treatment effectiveness will also have played a role in this.

Figure 5: Number of deaths involving COVID-19 by week of registration in 2020, NHS Highland

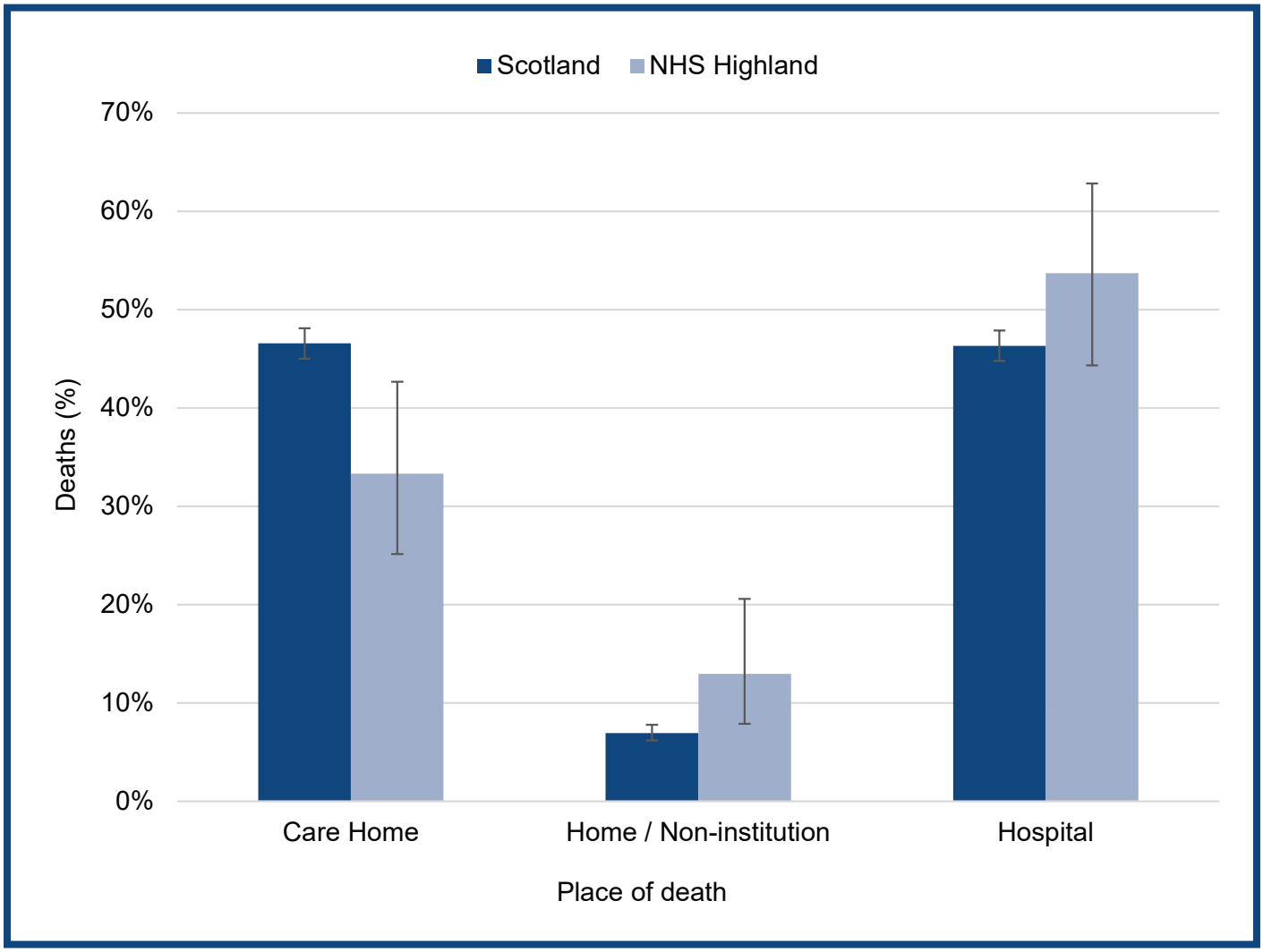


Source: NRS reporting for weekly death registrations to Week 52, week ending 27 December 2020[27]

Phase Two: Lockdown

The lockdown had a large impact in NHS Highland as in the rest of Scotland. Deaths of residents in care homes dominated public concerns during this period. Compared to Scotland as a whole, the NHS Highland area had proportionally fewer deaths occurring in care homes compared to hospitals, although this may reflect available hospital capacity in Highland (Figure 6). An outbreak at a care home on Skye was widely reported in the press during this period[28]. This gave a clear indication that the NHS Highland area is vulnerable to cases spreading to care homes from the community, and that rurality is not an absolute protection from spread of the virus.

Figure 6: Proportion of deaths involving COVID-19 by location between the first reported death in Scotland (week 12) and the easing of lockdown restrictions (week 23), Scotland and NHS Highland



Source: NRS weekly data[27] and NRS weekly death files for NHS Highland

Deaths involving COVID-19 can be measured in three ways:

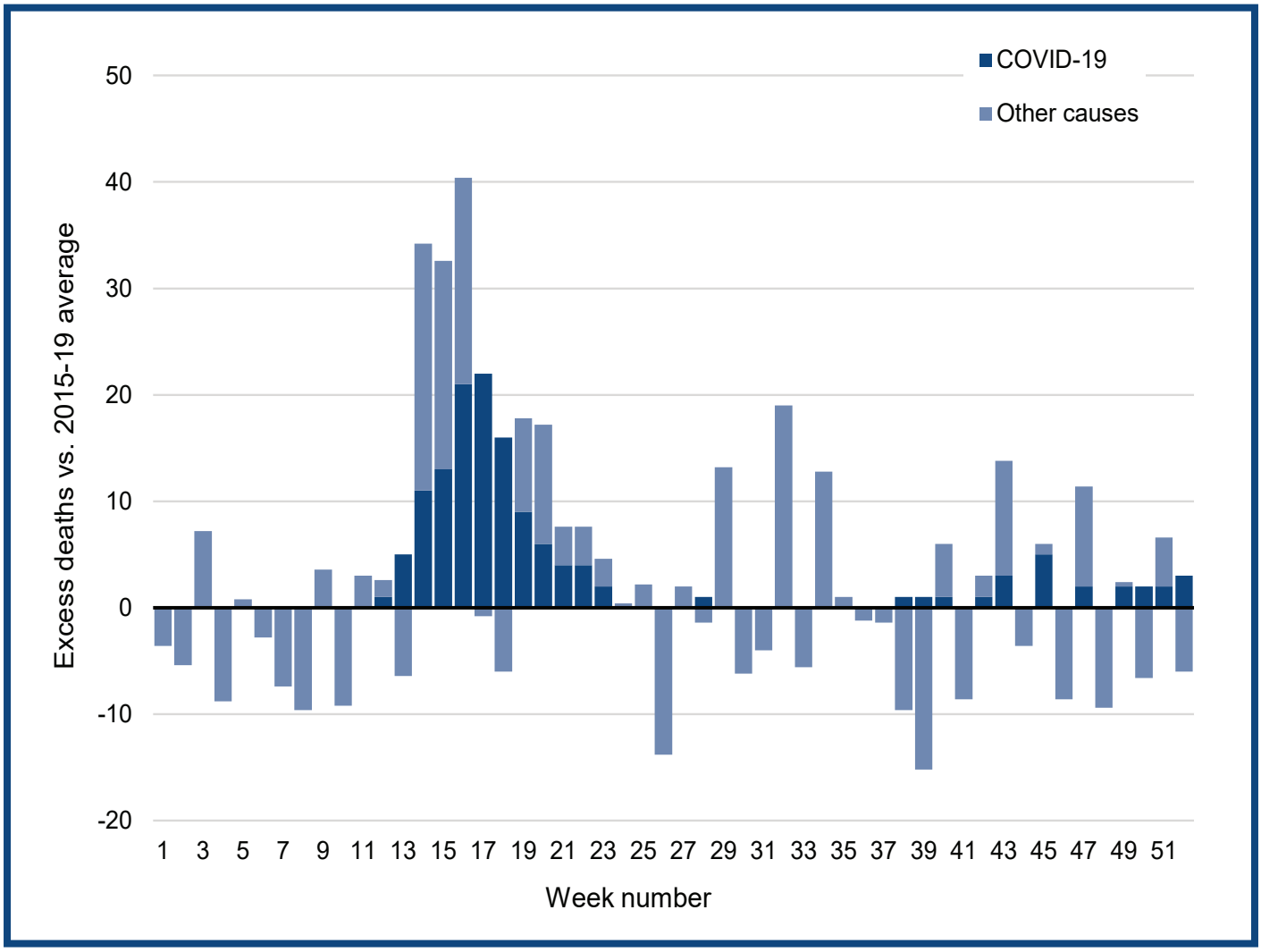
- People who died within 28 days of their first positive COVID-19 test result
- people in whom a doctor has listed COVID-19 as the main or contributory cause of death on the death certificate
- the number of deaths compared to deaths occurring over the previous five years.

This later measure is sometimes referred to as 'excess deaths'.

Figure 7 shows the number of deaths in the NHS Highland area in 2020, compared to the average number of deaths in the corresponding week over the previous five-years 2015 to 2019. The number of excess deaths can only be partly explained by the number of deaths involving COVID-19. They could be caused by people being reluctant to seek help, or by disruption to services, or by the unintended consequences of interventions to control COVID-19 on physical and mental health[29].

Figure 7 does give a strong impression of the impact on COVID-19 on deaths in NHS Highland, whether direct or indirect. When set beside the number of confirmed cases up to the end of the March lockdown (Figure 3), the association between the increase in cases and the number of deaths, and the delay between diagnosis and death, can be seen.

Figure 7: Number of deaths by week of registration in 2020 compared to the average number of deaths over the five-year period 2015-2019, NHS Highland

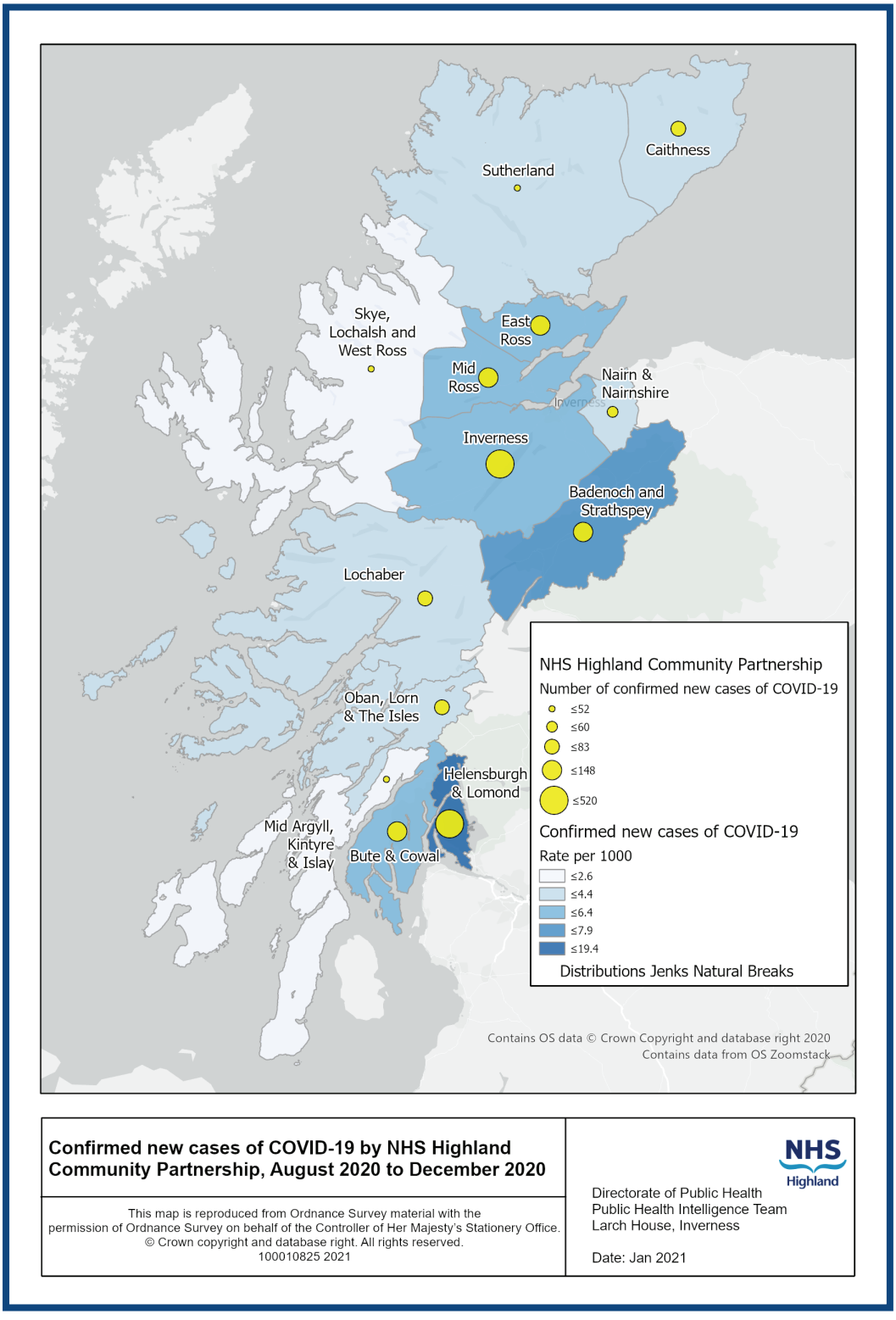


Source: NRS weekly death files for NHS Highland, week ending 27 December 2020

Phase Three: Post lockdown

Phase 3 of the Scottish Government's route map out of the coronavirus crisis saw the phased easing of restrictions throughout July and August 2020[30]. The period since the lockdown ended has shown a gradual spread of the virus within the NHS Highland area (Figure 3). All areas within NHS Highland have experienced cases of COVID-19 (Figure 8). Higher case rates in the Argyll and Bute council area resulted in the area being placed under Level 2 protection levels introduced by the Scottish Government on 02 November 2020 to suppress the spread of the virus[31].

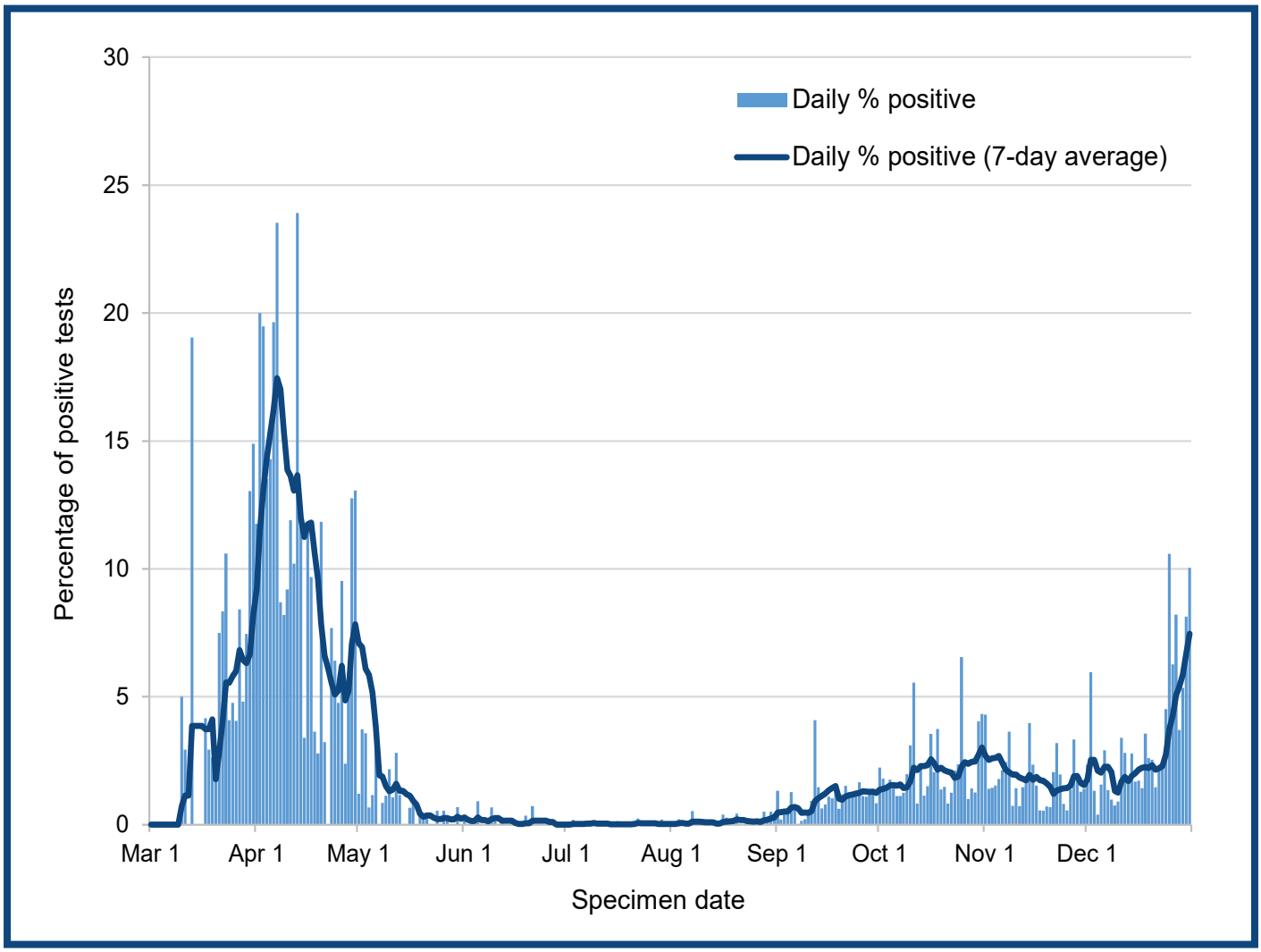
Figure 8: Incidence rate per 1,000 population and number of confirmed cases of COVID-19 in NHS Highland areas; 01 August 2020 to 31 December 2020



Source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

As testing has become more widespread, the rate of positive tests has become an important indicator of the progression of the virus over time. The rate of positive tests in NHS Highland is shown in Figure 9. The indicator reflects both the amount of testing and the prevalence of the virus and is one of the criteria used by the World Health Organisation to determine whether an epidemic is controlled[32].

Figure 9: Percentage of COVID-19 tests that were positive in NHS Highland by specimen date, with 7-day rolling average, 2020



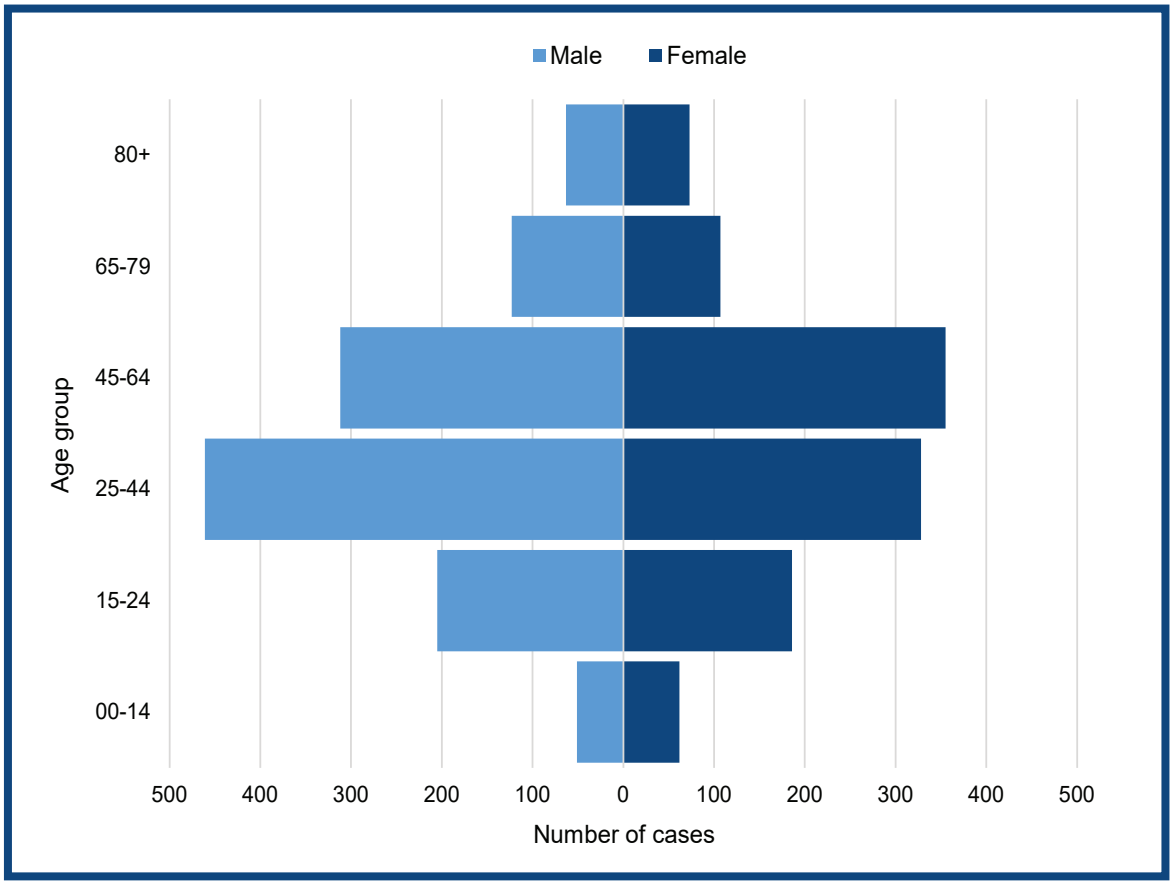
Source: Scottish Health and Social Care Open data platform[16]

The age profile of cases over the course of the pandemic in NHS Highland is shown in Figure 10. People of all ages have been affected, with the majority of cases occurring in those aged 25 to 44 years.

People who were confirmed as having COVID-19 at the onset of the pandemic tended to be older, because milder cases were not identified. As testing has become more widely available, cases in younger people are being identified more reliably. The gradual increase in the age of confirmed cases is apparent, suggesting that as the virus has spread more widely, it has again spread to older age groups who are more likely to experience severe symptoms (Figure 11).

In the post-lockdown phase, tests have become more widely available, with all people who have COVID-19 symptoms eligible for routine testing. Testing routes include a drive-through centre in Inverness and at Glasgow Airport (used by some Argyll and Bute council area residents); mobile sites in more rural areas; testing at COVID-19 Assessment Centres and postal tests delivered by the UK Government testing programme.

Figure 10: Number of confirmed cases of COVID-19 by age group and sex, NHS Highland, 2020



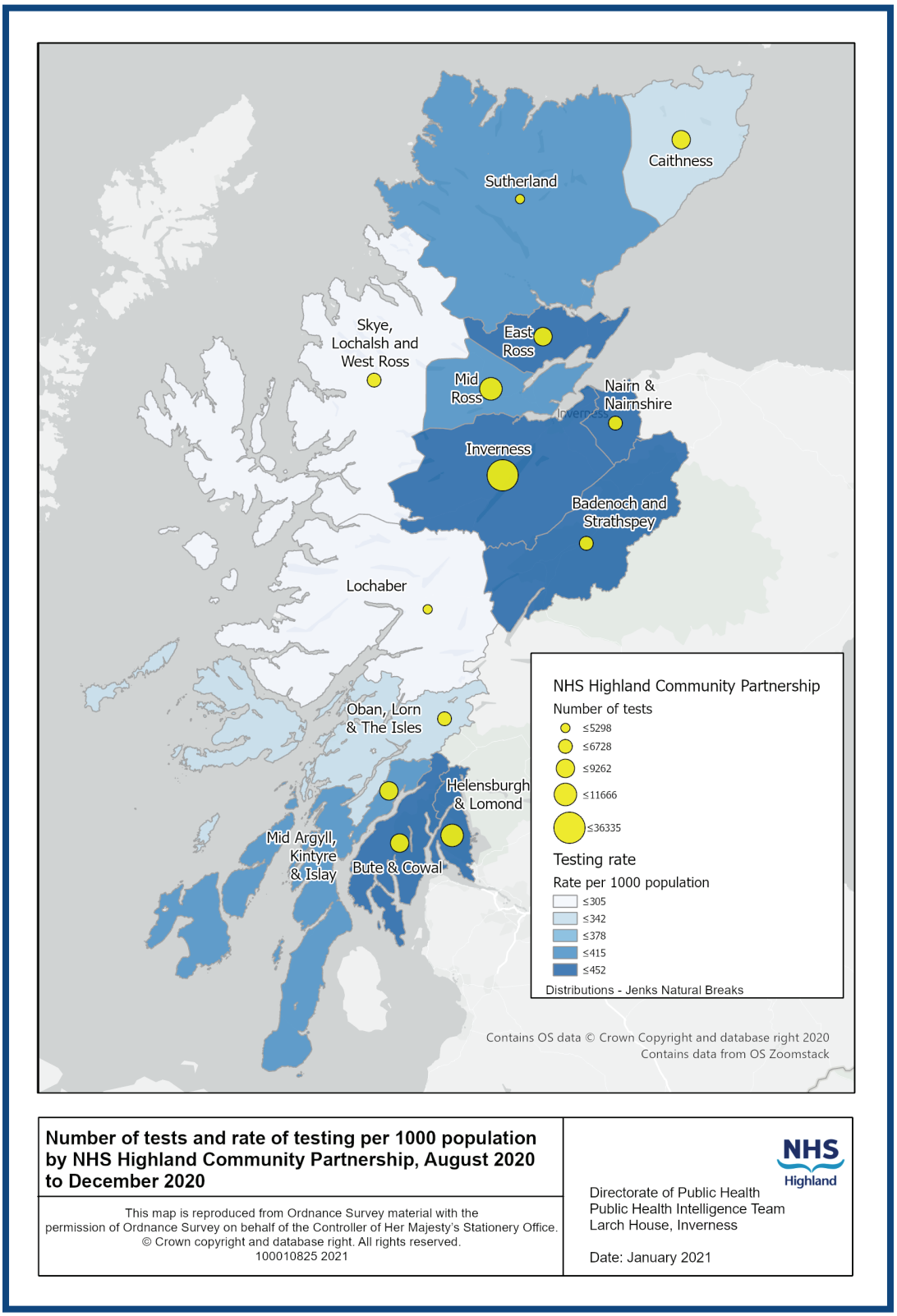
Source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

Figure 11: 7 day number of confirmed cases of COVID-19 by age, NHS Highland, 2020

Source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

Figure 12 shows the distribution of testing by area in NHS Highland over the period since 01 August 2020. The overall rates of testing could be expected to be similar, assuming that viral illnesses will be present in all areas. In some areas of NHS Highland, there are still considerable distances to travel for a test and postal tests are not delivered to all parts of the region. This may be leading to lower take up of testing in parts of NHS Highland where access is more difficult. Access to testing is crucial in continuing to control the spread of the virus.

Figure 12: Rate of testing for COVID-19 per 1,000 population and number of tests by NHS Highland Community Partnership; 01 August 2020 to 31 December 2020



Source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse
Includes polymerase chain reaction (PCR) test results only. Does not include lateral flow test (LFT) results.

Chapter Two - Social mitigation

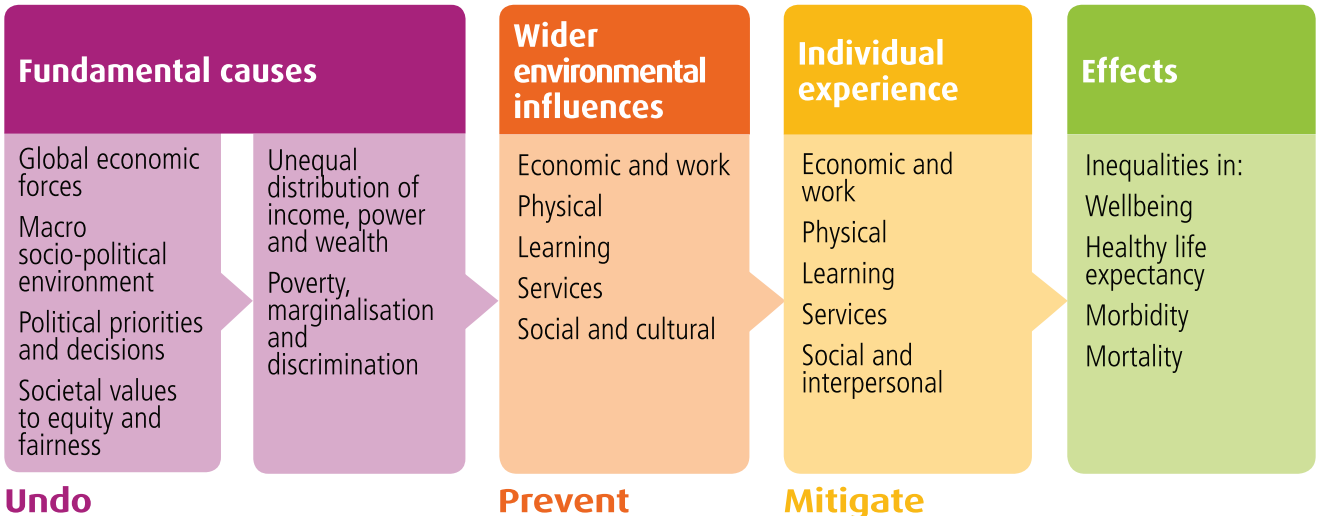
The measures to tackle COVID-19 will have many indirect and unintended impacts on population health and wellbeing, with some communities being disproportionally affected. These impacts can result in loss of income and uncertainty regarding future earnings, the severing of important social support and connections, reduced access to essential information, goods and services, and fear, loneliness, anxiety, increased stress and other adverse psychological impacts. These appear to be the main drivers of vulnerability among some communities, although there may be more[1].

> "It is important to broaden the concept of vulnerability to COVID-19 beyond that of clinical risk. Vulnerable communities may experience disproportionate direct and indirect adverse impacts of COVID-19. Vulnerable communities include both infected and non-infected individuals."[1]

COVID-19 has demonstrated that we are not "all in this together" but that our poorer communities have experienced greater exposure to and impact from COVID-19[2].

Poverty is a root cause of health inequalities[3] and its impact has been seen over the years in the gap in health outcomes between different communities. Having sufficient income is essential to be able to participate fully in society and maintain health:

Figure 1: Health Inequalities: What are they How do we reduce them?



Source: Reproduced with kind permission from NHS Health Scotland.

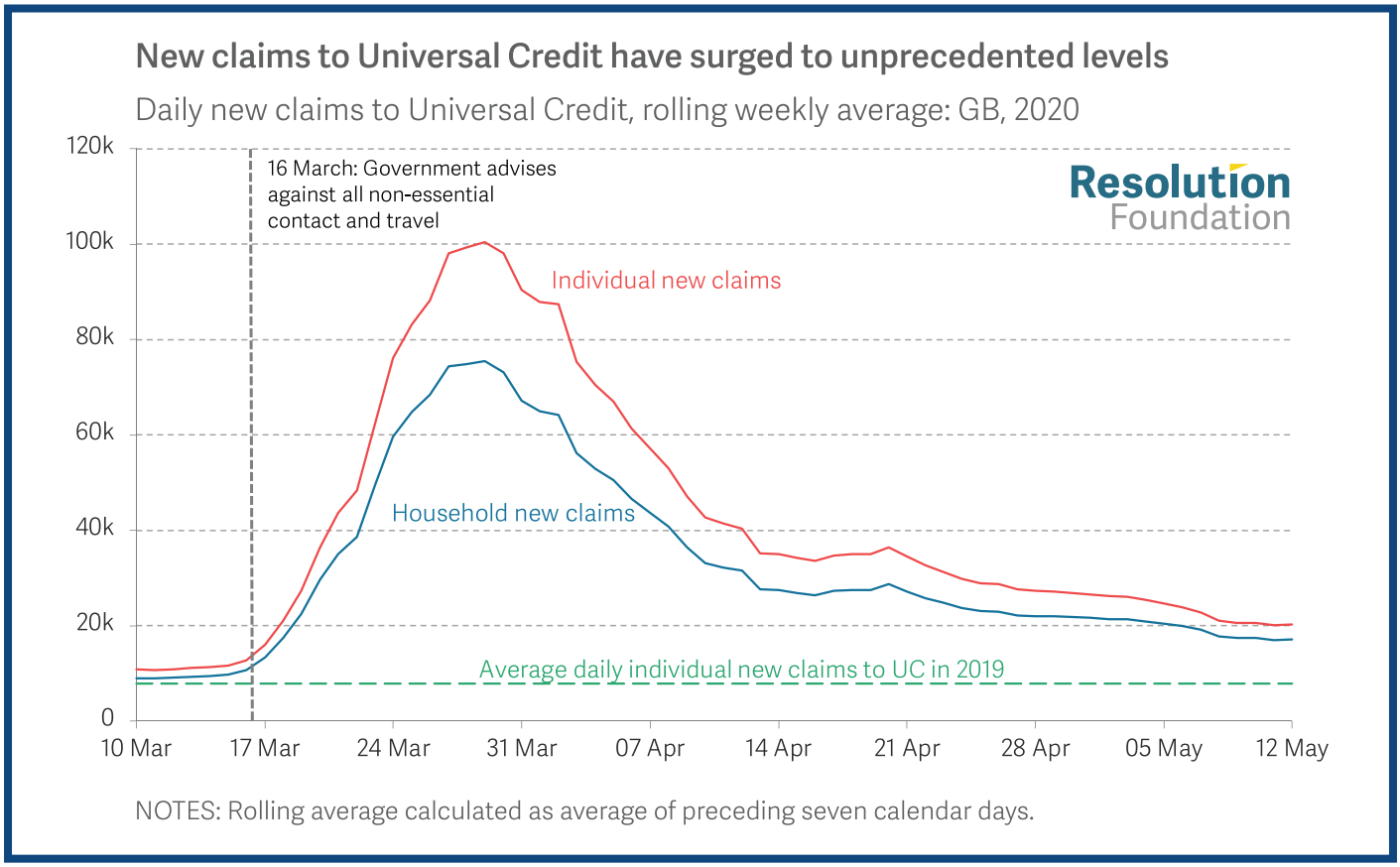
The financial impacts of COVID-19

Unemployment and the economy

Whilst the impact on the economy cannot yet be fully measured, it is likely that unemployment will increase. Some businesses may not survive, resulting in further job losses. Sectors such as hospitality, tourism, social enterprise, third sector and self-employment experience particular challenges. These form a considerable element of both the Highland & Argyll and Bute economies. Unemployment has a negative impact on both physical and mental health, leading to an increase in all-cause mortality in people who are unemployed over a period of time[4]

The lockdown and subsequent restrictions resulted in an increase in unemployment and claims for Universal Credit. Figures show that applications to Universal Credit in May 2020 were double the average claims in 2019.

Figure 2: "The Safety Net in action? Universal Credit's role in the crisis and the recovery. Presentation supported through Resolution Foundation and the Standard Life Foundation.



Source: Data from DWP: Management Information[5]

Household income and financial security

Around 60% of adults who were living in poverty prior to COVID-19 were in working households[6]. The Government's Job Retention Scheme, whilst welcome in ensuring people can remain in employment and receive a salary, nevertheless, results in a cut of 20% in household income.

A survey commissioned by the Joseph Rowntree Foundation found that *"almost a third of households (31%) across Scotland have reported a drop in incomes since March 2020. In the Highlands and Islands this rises to 44%"*[7].

The Highland Council Welfare Support Team and local Citizens Advice Bureaux reported significant increases in enquiries for finance and money advice; welfare benefits and school meal vouchers; employment issues; advice on the support available; existing debt concerns; rent arrears and advice on decisions already made relating to claims for Personal Independence Payments (PIP)[8].

Within Argyll and Bute, there have been similar increases related to household income and financial security issues. For example, between April and October 2020, there was an increased volume of Crisis Grant applications as a result of COVID-19; an increase of 23% in the volume of awards made and a 45% increase in their value. Increasing volumes of Universal Credit claims were made to the Department for Work and Pensions (DWP) in Argyll and Bute after the initial lockdown period. There was a 100% increase in the average claims per week between March and August 2020.

This experience has not been shared equally but has been felt most acutely by those who were already in the lowest earning category. According to a report from the Joseph Rowntree Foundation: "*33 per cent of employees who were in the bottom quintile of weekly earnings before coronavirus have experienced furloughing, job loss or hours reductions associated with reductions in pay, compared to 15 per cent in the top quintile.*"[7].

The Poverty Alliance looked at workers in the tourism sector, which has been significantly affected by COVID-19 and the restrictions: "*Pre-crisis, they were on one of the lowest paid sectors with an average take-home income that was around 15% lower than the Scottish average, and a poverty rate of 28% which is much higher than the Scottish average of 19%. For children with parents who work in the sector, the poverty rate was 41% compared to the Scottish average of 24%.*"[9]

The Health Improvement Team conducted a rapid consultation exercise in May 2020 contacting various different third sector and community organisations as well as services provided by Highland Council, who were involved in supporting the emergency response. Many of these contacts reported that recipients of their service, who were coping on low incomes prior to the pandemic, were experiencing increasing and often overwhelming financial difficulties driven by a change of employment circumstances resulting in reduction in income and exacerbated by many having to wait for 5 weeks or more for Universal Credit payments[8].

Child Poverty

40% of families with two or more children, a group already more vulnerable to poverty, have been hit by the economic impact of lockdown, experiencing a drop in net income since March 2020[6]. Of these, more than four in five (85%) are facing higher costs. Another recent poll by the Joseph Rowntree Foundation found that more than half (55%) of families in receipt of Universal Credit or Child Tax Credit in Scotland have been pushed to borrow money since the start of crisis, and that seven in 10 of these families have had to cut back on food and other essentials[7]. Child poverty can have negative effects on the health, wellbeing and educational attainment of the children who experience it.

In 2017, the Scottish Government introduced the Child Poverty (Scotland) Act[10]. This replaced the previous UK Child Poverty Act 2010 and included duties on both the Scottish Government and local partners to address child poverty. The Act sets out ambitious targets for the reduction of child poverty by 2030 and further sets out how it intends to meet these targets within its delivery plan "Every Child, Every Chance". Part of the delivery of this lies in the responsibilities of NHS Boards and Local Authorities to deliver on jointly developed and agreed Child Poverty Action Plans.

The pandemic will have a direct impact on meeting these targets. Future preparation and reports for the local Child Poverty Action Plan will need to give consideration to both the immediate impact of COVID-19 on child poverty, but will equally need to plan ahead for recovery. Three main drivers are identified within the Child Poverty (Scotland) Act which include actions to impact on (1) income from employment; (2) costs of living and (3) benefits in kind and income from social security.

Living costs such as food, fuel, travel.

The cost of living is higher in remote and rural areas of Scotland than in urban areas. Analyses by Highlands and Islands Enterprise (HIE) in 2013 and 2016 found all living costs to be between 10% and 33% higher in rural areas. Notably, food not only costs more in rural areas, but reduced availability results in costs being incurred in travelling to food retailers. The 2013 study estimated a typical shopping basket cost 40% more in remote rural Scotland than in the central belt and even more on the islands[27].

Between the start of the COVID-19 crisis and 9 April 2020, 14% of adults in Scotland were estimated to have experienced food insecurity. In the five weeks following lockdown, 20% of Scottish households with children were estimated to have experienced food insecurity[11]. Food insecurity can arise for individuals who are isolating or shielding due to an inability to access available food. However, the data above relates to people who experienced difficulties in accessing food as a result of insufficient income to buy food and requiring help with this.

Highland & Argyll and Bute, in common with many remote, rural and Island communities across

Scotland, have high levels of fuel poverty and extreme fuel poverty[12]. Measures to mitigate the pandemic and ongoing economic challenges, may result in increased fuel bills for already hard-pressed household incomes. This can result in increased rationing of energy use or food.

Digital Exclusion

The pandemic resulted in increased provision of services and support online. As a result, digital access and inclusion has become a key issue. As well as cost, barriers can include: literacy; geography and infrastructure. A key theme reported across Scotland by community organisations is the impact of digital exclusion either through lack of access to internet services and/or low levels of digital literacy in how to make best use of it[13].

Locally, reliance on digital communications both to deliver services and provide information was reported to be inappropriate and ineffective in some cases. Several services commented that their service users had limited financial resources and did not have access to the necessary devices, Wi-Fi, data or credit. Others services mentioned that the current restrictions on movement and closures meant that individuals who previously relied on accessing public or shared digital facilities were currently prevented from doing so[8].

Services were acutely aware of the inequity of this situation and the increased risk of exclusion and isolation it placed on their service users. In addition, there were concerns that access to a safe private space to participate in remote support was not necessarily available to all and this presented an additional risk for some.

Low-income families who responded to a survey into the cost of learning during lockdown were twice as likely to say that they lacked all the resources they needed to support learning at home, with 40% saying they were missing at least one essential resource. Low-income families were more likely to report having had to buy educational resources for their children, compared to those in better-off homes: a third of people most worried about money reported having to purchase a laptop, tablet or other device during lockdown[14].

Impact Of COVID-19 on vulnerable communities

The pandemic, lockdown, social distancing measures and ongoing restrictions, whilst applying to everyone, have not been experienced in the same way by all individuals or groups. Some impacts may be long-lasting: the impact of COVID-19 on older people, and those living with long-term health conditions or disability will be realised over the medium to long term. This includes people recovering from COVID-19 and the unknown impacts of 'long Covid' as well as those experiencing other physical and mental ill-health.

> Pandemics do not affect all communities or social groups equally[1].

Vulnerable groups include[1,4,15]:

- Young people (18-25): lockdown disrupted education at a critical time and in the longer-term young people are most at risk of poor employment and associated health outcomes in an economic downturn. Those working in sectors most affected are younger: nearly two in five of working 16-24 year-olds work in affected sectors and for those born after 2000 this figure is more than three-fifths.
- Women: more likely to be carers, likely to have lost income during lockdown if providing childcare during school hours. Key workers are disproportionately likely to be female, with employed women more than twice as likely to be in this group as employed men. Parents are more likely to be key workers than non-parents, and mothers even more so; 39% of working mothers were key workers before this crisis began, compared to just 27% of the working population as a whole.

- Older People: impact of isolation and loneliness, and ageism. Concerns have been raised about both the immediate and long-term impact that highlighting over 70s as an 'at risk' category might have. It was felt that measures taken to manage the pandemic had effectively disbarred older people from community participation and prevented essential support normally provided by community groups and organisations. There is concern that this could lead to future discrimination and exacerbate isolation.
- People with a disability: concerns about the impact of self-isolation and shut down of support services; some may struggle with understanding and applying information provided (specifically people with a learning disability); difficulties around impact on economy and future employment opportunities. However, working from home may open up new opportunities.
- People who are homeless: challenges in being able to self-isolate; disruption to normal support services
- People in criminal justice system: difficulties in self-isolating in a prison setting; loss of contact with family
- People who are part of the Black, Asian and Minority Ethnic (BAME) community: a higher percentage of this community work within the sectors most affected by measures put in place e.g. hospitality industry; a higher percentage of this community may also be in lower paid jobs and therefore at greater risk of moving into poverty.

Impact of COVID-19 on mental health and wellbeing

Groups affected by socioeconomic inequalities have been more likely to experience anxiety, panic, hopelessness, loneliness, and to report not coping well with the stress of the pandemic. Most worryingly, as of the end of June, one in ten people in the UK reported having had suicidal thoughts or feelings in the past two weeks, and in certain disadvantaged groups there are even higher proportions of people with suicidal thoughts and feelings[16].

Research suggests that the mental health and wellbeing of the UK adult population does appear to have been affected in the initial phase of the COVID-19 pandemic, with increasing rates of suicidal thoughts across waves, especially among young adults[17]. Whilst the pandemic does not appear to have had an immediate impact on suicide rates, it may later lead to increases in suicide due to an increase in risk factors such as economic concern[18].

It is reported that people living in financial hardship are at increased risk of mental health problems and poor mental wellbeing[19] therefore the financial impact of the pandemic also raises concern in relation to mental health and wellbeing.

Access to nature around one's home is important element of mitigating the negative mental health impacts of COVID-19[20], and inequalities of access among some groups[21] compound those negative mental health impacts.

Local engagement with organisations supporting individuals with ongoing mental health issues reinforces these concerns.

Impact of COVID-19 upon physical activity and active travel

There have been some gains made from COVID-19 including the impact on the environment and an increase in people enjoying getting out and about in open spaces. The increase in sales of bikes[22] demonstrates that some people are willing and able to use (and afford) alternative means of travel. Travel restrictions imposed by lockdown have increased the proportion of local journeys,

presenting more opportunities for active travel. During the early stages of lockdown, the dramatic reduction in traffic on the roads increased feelings of safety to walk and cycle, including in remote and rural locations. However, the return of traffic has resulted in many people reporting that they have stopped walking and cycling. Local Authorities have utilised Spaces for People funding to install temporary infrastructure along key local routes for walking and cycling that support relocation of road spaces, traffic diversions, signage, etc. Whilst these have been installed in key towns across the region, remote and rural locations continue to see an increase in traffic and a further reduction in confidence to travel actively along rural routes. This creates a dilemma where encouraging tourism to support local recovery may adversely impact on walking and cycling journeys made by local people.

Being physically active is important for physical and mental health and wellbeing. Lockdown restrictions presented many barriers to regular participation, particularly group activities and use of indoor facilities. Continued physical distancing requirements limit the return to previous choices; and reduced income due to furlough or unemployment will impede the ability of many to recommence paid-for physical activity opportunities.

Free, outdoor, facilitated activities (for example volunteer led health walks) present opportunities going forward, however we must ensure that we build on current opportunities, supporting new and additional volunteering capacity and ensure that we maximise access for all. Access to and use of outdoors space has become even more important and relevant to maintaining health and wellbeing during COVID-19. Whilst overall visits to the outdoors increased, we saw a decrease in accessing green space in people living in more socio-economically deprived areas and those with poor health or long-term conditions. Residents of the most deprived areas were more likely to report a lack of quality green spaces as being an issue[23].

A survey of over 2,000 adults in Scotland found a mixed picture in relation to activity levels since the coronavirus outbreak. The survey found that 41% reported reduced levels of physical activity, whilst around one third reported that they were more active compared to before COVID-19 restrictions were introduced[24]. A similar survey in England found that at the beginning of 'lockdown' 41% of adults did less physical activity after restrictions were introduced compared to before restrictions were in place[25].

Impact of COVID-19 on food security

During lockdown, a number of organisations provided emergency food parcels or supplies and hot meals. Referral or eligibility criteria varied widely. Some organisations actively sought solutions and provided support to address the underlying causes of food poverty to avoid creating a dependency on the service. Other providers focused on addressing the immediate needs of people they believed to be *'slipping through the welfare net'*.

NHS Health Scotland defines food poverty as: 'The inability to acquire or consume an adequate or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so.'[26] Food insecurity can be described as running out of food due to lack of money or other resources[27].

In the most recent 2019 Scottish Health Survey, published pre-COVID-19, 9% of adults in Scotland had worried about running out of food in the previous 12 months due to lack of money and other resources[28]. This will have increased since COVID-19 but a report published in June 2020 found that the provision of emergency food was working well overall but there were concerns of what might happen longer term[26]. In Highland, the main providers of emergency food supplies have been the Highland Council which distributed 263 tonnes of food; the equivalent of approximately 626,000 meals and FareShare with 384 tonnes of food distribution; equivalent to approximately 914,000 meals.

Within Highland, the Highland Poverty Action Network (HPAN) surveyed 25 food providers to gain

a snap shot of current food provision. The results detailed which areas provision were operating in, type of provision, where supplies were being sourced, estimations on numbers accessing the service and whether the provision intended to continue operating longer term. NHS Highland Health Improvement Team helped to analyse the response and to make recommendation for future work. The survey did not specifically ask about increased referrals and demands on the service but research and surveys continue to be published highlighting that COVID-19 has exposed, or increased existing issues of food insecurity and/or inequalities[29].

All the organisations who responded to the survey indicated they would want to be part of a Community Food Network (CFN) and work is underway to establish this. Other areas for future work include:

- Identify known and unknown projects that didn't respond and invite then to join the CFN
- support the establishment of the CFN as a peer-led network of transparency, shared learning and collaboration
- support HPAN members in considering the role of community food provision within the context of reducing inequality in the Highlands.

Argyll and Bute Community Food Forum was launched in February 2020**.** This Argyll and Bute Council supported initiative was a network through which existing independent food-banks, food waste and community food initiatives could share experience, advice and ideas. It was also a forum for those considering setting up a food-bank or community food initiative including food waste projects or those wishing to volunteer. Today they have a wide membership covering the whole of Argyll and Bute, including several islands.

Partnership working has been critical to meeting the demand for food for those in need across Argyll and Bute and for providing feedback about this demand. Food bank demand increased however, this was somewhat mitigated by national and local food provision for children over the holidays. By the end of July, the Community Food Forum had delivered a total of 44,811 fresh and ambient parcels to vulnerable, shielding and free school meal households across Argyll and Bute. Entitlement to free school meals, in Argyll and Bute, has increased by 11% compared with September last year and is likely to rise still further.

Impact of COVID-19 on smoking and use of alcohol and drugs

In Highland, 17% of people over the age of 16 smoke regularly[30]. It was reported that across the UK, one million people had stopped smoking since the COVID-19 pandemic[31]. Most smoke-free services within Community Pharmacies in the NHS Highland area were initially stalled to cope with other services provided however our smoke-free advisers continued supporting those who wanted to stop smoking albeit remotely. Those making quit attempts dropped at the start of lockdown but have slowly increased as the months have passed.

Whilst reports of people using the pandemic to make a health behaviour change are welcome, we need to be mindful of the fact that this change may not be equally seen across our population. There were concerns that children and young people might be further exposed to second hand smoke during lockdown, if living in homes in which people smoke. In addition, there was concern about the increased risk of house fires for vulnerable people. Scottish Fire and Rescue Service reported a doubling of house fire deaths during the first three months of lockdown as well as a 12% rise in house fires classed as 'high severity' compared to the previous year. However, there was a 7% reduction in the number of blazes throughout Scotland[32].

Alcohol use in Scotland varied during lockdown. One million (29%) adults in Scotland were drinking more in lockdown, with the same proportion drinking less. For those that were drinking less, they reported benefits such as improved mental and physical health, being more productive, sleeping better and having more energy. For those that were drinking more, the opposite was found[33].

Impact of COVID-19 on violence against women

Since March 2020, there has been a wide variety of public health measures put in place by the Scottish Government to combat the impact of COVID-19. Lockdown, social distancing, the closure of many services and homeworking, whilst providing opportunities for communities to mitigate the effects of COVID-19, has also provided an environment where violence against women and girls can thrive[34]. The Highland Violence Against Women Partnership (VAWP) provided a robust and coordinated Highland wide response to the impact of COVID-19 on violence against women. The Partnership Coronavirus (COVID-19) Response and Action Plan was fully developed early in the pandemic and provides a reflective tool for long-term learning. The plan reflects the Coronavirus (COVID-19) Supplementary National VAW Guidance produced by the Scottish Government, COSLA, Public Health Scotland and Improvement Service for local VAW Partnerships.

Front line support services reacted instantly to adapt their service provision at the start of the pandemic. Claiming 'key worker status' also provided additional help to access childcare. They implemented a wide range of changes including a swift move to supported home working and an increase in on line support to service users via text, email and social media. Some service users have responded positively to digital support, finding it easier to access, especially those who are particularly isolated. Services are continuing to offer telephone support to ensure those that have no or limited access to digital platforms are still able to access support at this crucial time. Initially, referrals to some agencies appeared to dip, causing concerns about the ability of those needing help to find ways to safely access it. However, following spikes in demand during the summer months, this has now settled. Front line services and Multi Agency Risk Assessment Conferences (MARAC) are all now showing a marked increase in referrals although police referrals have remained consistent throughout.

Following lockdown in March, MARACs across Highland and Islands switched immediately from in-person meetings to audio conferencing and then Microsoft Teams, allowing the frequency of the meetings to continue. Agencies appear to be prioritising MARAC during lockdown and in some areas agency attendance at the meetings has increased. The early lockdown period presented many challenges as the identification of high-risk victims proved more difficult due to the reduced number of services being able to offer face-to-face sessions and victim's not being easily visible to services. The MARAC Independent Domestic Abuse Advocates (IDAA) services experienced complications in being able to safely contact victims due to many perpetrators being continually present in the home and a lack of contact for victims to their usual support networks, friends and families. In recognition of this the Partnership provided additional information to statutory front line service personnel who were still able to access many isolated people. This included information on recognising VAW, appropriately responding and how and where to signpost for help.

The VAW Partnership has now successfully re-launched the delivery of its training programme which is an essential part of our preventative work. The training programme had been delayed significantly this year due to the inability to provide face-to-face training which was the traditional delivery method. Much work and research has been undertaken to develop a digital delivery format. Training materials have been adapted to ensure training is appropriate for the on-line environment. Online training has been delivered during late autumn to smaller groups to keep the training manageable with more planned for the rest of the financial year.

VAW Partners report that work with perpetrators has continued throughout the COVID-19 pandemic. Initially group work was suspended with one-to-one online work being increased. The Caledonian System has restarted and some group work is also now taking place within closely monitored restrictions. Specialist support services have increase contact with Multi Agency Tasking and Coordination (MATAC) and are able to share information on repeat perpetrators.

The recently completed annual review of the Highland VAWP Plan for 2018-21 will be used to inform the development of the next three-year plan from 2021-2024 as well as incorporating learning from

the pandemic and other new initiatives and actions. The Plan will provide the implementation of the Scottish Government's Equally Safe Strategy at a local level reflecting the needs of Highland.

All organisations who are members of the VAW Partnership have worked hard to ensure consistent and accessible messaging throughout the pandemic; promoting that no one experiencing VAW is alone, that services are still available to support and help those that need it throughout the pandemic and that perpetrators of Gender Based Violence will be held to account for their behaviours. As well as social media, partners were able to engage with the press and local radio to get key messages out to the public.

The partnership regularly shared data throughout the pandemic to develop an integrated and coherent Highland strategy. Further work is now underway to analyse a full six months of data to look at the impact of the various changes in restrictions and environment and the wide range of mitigating actions across the Highlands. This analysis will inform the medium and long-term response.

Responses to COVID-19

> The narratives that initially surrounded the pandemic were largely driven by infectious disease epidemiologists and economists; and media and political representations thereof. It is crucial and timely to also emphasise the concepts of 'community recovery and resilience' within the narratives surrounding the COVID-19 pandemic[1].

Community Planning and community-led approaches:

In Scotland, Community Planning Partnerships (CPPs) are already sighted on working in a place-based way and are mobilising around the recovery agenda. Communities across NHS Highland have risen to the challenges of the pandemic resulting in inspiring community responses. The structures to support community planning and community-led approaches across NHS Highland are:

Highland Health and Social Care Partnership area:

- Highland Community Planning Partnership
- Nine local Community Partnerships

Argyll and Bute Health and Social Care Partnership area:

- Four health and social care locality planning groups
- Four area community planning groups
- Eight Living Well Networks

In Argyll and Bute, the first two structures are requirements of Scottish legislation for the integration of health and social care and the Community Empowerment Act. The latter networks are locally led under the banner of Argyll and Bute's Living Well Strategy.

A vibrant third sector exists in Highland & Argyll and Bute but this is within the context of concerns about sustainability and unequal provision across the area. Recovery from the COVID-19 emergency sits alongside existing community plans to develop the economies of Highland & Argyll and Bute by increasing inward investment and providing young people with education and employment opportunities

Effective renewal will be built on effective empowerment of communities to work together to fulfil their own aspirations in partnership with statutory organisations like the NHS and local authorities.

Capacity and Community Resilience

As part of the community consultation work undertaken in May 2020 by the Health Improvement team, many voluntary and third sector organisations and groups reported increased demand for their services and described the impact that this had on staff and volunteers[35].

During the lockdown, organisations adopted creative solutions to ensure they were able to continue supporting communities and service users: providing telephone, VC and sometimes 'doorstep' support. These adaptations have in themselves created capacity issues in some cases, by slowing down response times[8].

Some organisations referred to the need to provide more intensive, frequent or lengthy support sessions and described managing "repeated phone calls" and "monthly or fortnightly support now requiring weekly or even daily support"[23].

In many cases there was concern that demand may outstrip capacity following lockdown due to the impact that social isolation and trace and protect restrictions may have on people's socio-economic circumstances. For some organisations their capacity had been further impacted by; the need to furlough staff, funding cuts, limitations on fundraising and recruitment difficulties due to restrictions put in place to manage the pandemic.

Some small organisations expressed frustration at the expectations and timescales of funders, which were described as being 'unrealistic' and outstripping the capacity of small organisations. There were safety concerns in relation to social distancing with many premises described as unsuitable for providing services that met Government guidelines. Many were concerned about the impact the crisis would have on future efforts to recruit volunteers given the sudden rise in volunteering opportunities and impact social distancing measure would have on the over 70 population.

Caring for People COVID-19 response

In March 2020, a community response to ensure people still had access to food, medicine and other supplies, become vital. Caring for People groups were formed to coordinate the urgent community response to the COVID-19 pandemic. Local Authorities and Health Boards are classed as category one responders, and as resilience professionals responsible for ensuring that Scotland is safe, secure and that can cope with and recover from period emergencies under the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005. Looking after people affected by an emergency is an essential element of an emergency response. The Scottish Government has a suite of guidance called Preparing Scotland that includes a requirement to care for people.

Local communities across Highland and Argyll & Bute had already started to mobilise and form local resilience groups, to protect those most at risk from COVID-19 in the community. Highland & Argyll and Bute Public Health teams worked with partners to form Caring for People groups which coordinated local community response and provided guidance to support local activity. The work of the Caring for People groups included setting up help lines for people self-isolating/vulnerable and whose usual support network was no longer available. This ensured that everyone had access to food, medicines, other essential supplies and support, as well as responding to needs such as getting access to the internet.

Linking to community food projects and other local resilience groups, food parcels were distributed to those shielding and in vulnerable groups, medicine collection and delivery services were developed, information on signposting to help on money worries, mental health and other supports were developed and distributed direct to households and local community groups. Other resources were also developed, such as guidance on how to volunteer safely and websites with information about businesses and groups who were providing local support.

The Caring for People Partnerships were made up of colleagues from Public Health team, Council colleagues and the Third Sector Interface. These partners were identified as those with skills in asset-based planning and service delivery, community development and community engagement.

In Highland, a network of 10 local community hubs, and a food distribution centre were established. Over 300 community bodies registered their offers of support with the Council and many worked closely with local hubs on referrals. Individual offers by volunteers were directed to the Highland Third Sector Interface and around 2,000 people registered as volunteers although relatively few were deployed due to the huge support already in place across communities.

Since March 2020, the Highland Council's COVID-19 Helpline has taken 7,500 calls with just under 1,000 calls during the busiest week. During May there were also over 5,000 outbound calls made to those on the shielding list to ensure 'no-one was left out'. In support of test and protect, the Highland Council has made almost 1,000 calls to those self-isolating since mid-October.

There are currently (December 2020) over 7,500 people registered on the shielding list within the Highland Council area. Over 1,200 shielding people have been assisted to access Government food boxes, over 1,000 people have accessed food support from the Council with almost 16,000 food bags distributed (60 tonnes of food) and 4,500 children across Highland were supported weekly with free school meals support between April and August 2020. Medicines were delivered to over 400 people; over 170 people were referred to the welfare team for support and over 200 for social support. The Council also continues to support community groups through the COVID-19 ward discretionary budget. By 9th November 2020, £161,344 had been spent on 347 separate awards from the Council's Supporting Community Resilience fund.

Going forward, there is a focus on mental health and wellbeing, and financial, food and fuel insecurity and what can be done to mitigate and support people whilst the area recovers from the pandemic.

Within Argyll and Bute, key outputs included the Caring for People helpline, which supported over 3,400 people and took over 5,500 calls. Those shielding were all offered support. The Community Food Team delivered 44,811 food parcels to vulnerable, shielding and free school meal households. Over 990 volunteers were registered by The Third Sector Interface which included volunteer coordinators. Local community organisations that had already started a local response were contacted and included in the referral process. There was also recognition of the impact the pandemic was having on mental health and wellbeing and there was work undertaken to signpost to support for loneliness and mental health problems. The Argyll and Bute Caring for People team was nominated as a People's Choice finalist in the Scottish Health Awards.

The greatest asset in the community responses was the staff from statutory and third sector organisations, volunteers and communities, who came together in a way that was beyond anything previously experienced and who had direct links to the community. This proved to be vital to the speed and scale of the response. Community responses continue to ensure that community support is available. They continue to monitor, review and adapt the responses based on local need for as long as required. Evaluations are taking place to shape how future humanitarian responses will be developed while identifying any improved required for ongoing COVID-19 responses.

Information for people leaving hospital after a positive test

The Public Health Team identified the need to provide individuals with information on their discharge from hospital after testing positive for COVID-19. As well as providing information on physical health, a resource was developed that provided information on social support including how to access welfare advice, food parcels, support for alcohol and drug issues, and support for domestic abuse. The resource was made available electronically and over 9,000 printed copies were requested and distributed through NHS Highland's Health Information and Resources Service.

Smoking, drugs and alcohol

Across NHS Highland, services to help people stop smoking have continued to support people to make quit attempts, using telephone, text and digital technology although carbon monoxide (CO) monitoring has currently stopped.

In collaboration with the Scottish Fire and Rescue Service, the Health Improvement Team supported a number of initiatives to encourage people to stop smoking and reduce the risks of smoking in the home. This included the Scottish Fire and Rescue Service 'Make the Call' campaign. This campaign appeals to those who are at risk of serious injury, or death, because of an accidental fire in their home. This includes those aged over 50, who smoke and either have mobility issues, live alone, or use medical oxygen. Information about our Smoke-free Homes and Cars Challenge was also shared. The challenge encourages people to make their home and car smoke-free using a stepped approach; bronze, silver, gold and diamond. This allows everyone, regardless of their circumstances, to reduce the risks from smoking in the home and car.

Fetal Alcohol Spectrum Disorder (FASD) was raised as a particular concern given the potential for reduced access to emergency contraception. A FASD scoping exercise is being completed with partners to identify local improvements for best practice. In addition, in conjunction with Highland Alcohol and Drugs Partnership (HADP) and Alcohol Focus Scotland, messages for FASD Awareness Day have been developed to support awareness raising and signposting to support.

Staff Health and Wellbeing

The increased pressure on NHS services because of the pandemic, combined with having to quickly implement new ways of working has made a focus on staff health and wellbeing more crucial. NHS Highland recognises that staff play a vital role in achieving its vision to provide Better Health, Better Care and Better Value to our population. Our staff have a direct impact on the health and wellbeing outcomes and experiences of our service users. We are clear that when our staff are feeling well and satisfied with their work, the experience of our service users improves.

Health and wellbeing is not just about being physically well, it is also about emotional and social wellbeing. It is about feeling able to cope with normal stresses and having a purpose in life as well as having a sense of control of your life. This can be affected by things like worries about money, work, family, the people around you and the environment in which you live, work and play. Wellbeing is also affected by whether or not you feel involved and connected to people and communities.

NHS Highland's new Health and Wellbeing website promotes and encourages self-care for a healthy mind and body with sections on workplace support, occupational health and financial health, along with information on services available at local and national level. The website uses the Moodzone tool which helps staff to recognise the warning signs of anxiety, stress and depression and signposts to advice. NHS Highland Staff Health and Wellbeing Group also sends out weekly Wellbeing Wednesday messages to all staff with up-to-date information and advice on particular topics.

NHS Highland's Employee Assistance Programme (EAP) was launched on 1st May 2020. This is a confidential service available 24/7 to assist NHS employees with personal or work-related problems that may be affecting their health, wellbeing or performance. The EAP service is free to use and delivered by The Validium Group, a professional and independent employee assistance provider who support over 350 organisations in the UK. It provides access to telephone counselling and a range of specialist information services.

The following services are also available from the EAP:

- Counselling and emotional support
- Family care information
- Health and wellbeing information
- Legal Information
- Money and debt Information

A staff Psychological Wellbeing Network service was launched in response to the expected psychological needs of staff during the pandemic, providing psychological first aid. This network provides advice and support to build and maintain the psychological wellbeing of our colleagues, to increase resilience and to reduce the likelihood of burnout, trauma, or other emotional injury during the COVID-19 pandemic. A member of the psychological team could be made available for staff debrief and support, on request.

In addition, Argyll and Bute's Health and Social Care Partnerships (HSCP) wellbeing group meets regularly to ensure provision of resources and support. This group links closely with the NHS Highland Wellbeing Group & Argyll and Bute Council's Wellbeing Team to support staff across the partnership and share and co-ordinate resources. Examples of the Argyll and Bute partnership work on staff health and wellbeing include:

- Web and hub-based information and resources
- Development and distribution of self-care and wellbeing posters
- Development of Wellbeing Champions to distribute information and resources locally, signpost people to additional support when required and provide feedback to the wellbeing group on how information and resources were being received and used

Equality and Diversity – Fair access to services

To ensure the safe and sustainable delivery of services throughout the pandemic there has been a rapid expansion in the use of digital technology to deliver services. In addition, there have been frequent changes to information and guidance as the situation has evolved. In order to ensure this has been accessible for our diverse NHS Highland population, for example those who are deaf and whose first language is not English, there has been a focus on addressing any barriers to both information and services by:

- Progressing the trial of Near Me to be used by language and British Sign Language (BSL) interpreters. This allows interpreters to be present at appointments over video avoiding the need for contact and travel.
- Producing information in British Sign Language (BSL) about changes to services and visiting guidelines.
- Advocating for and promoting accessible information about COVID-19 to both colleagues and partner organisations, including the NHS 24 Communications Toolkit.
- Advocating for and supporting Equality Impact Assessment on NHS Highland's policies and plans so that NHS Highland can fully understand the positive and negative consequences before implementation.

Future plans

> Fully mitigating, COVID-19 is estimated to prevent a loss of 5.63 years of life expectancy for the UK. Over 10 years there is a greater negative life expectancy contribution from inequality than around six unmitigated COVID-19 pandemics. To achieve long- term population health improvements it is therefore important to take this opportunity to introduce post-pandemic economic policies to 'build back better'[36].

Social mitigation

Improving the social determinants of health is an important part of Public Health work. A focus on the wider determinants of health will be even more important during the recovery phase of the COVID-19 emergency to mitigate the negative health effects of the economic and social impacts of the pandemic. Working with communities and partners to understand the impact COVID-19 has had on the lives of our population will be key to developing an appropriate response. Social mitigation is an important feature of NHS Highland's remobilisation plan. This plan recognises the need to understand the broader impacts of COVID-19 and highlights the need to work with partners across Highland & Argyll and Bute on issues such as employability, the economy and income maximisation. Actions that are likely to support social mitigation of COVID-19 include:

- The creation of more Fair Work employment opportunities targeted to meet the needs of at-risk groups.
- Use of procurement policy and practice to maximise benefits to the local economy.
- Development of job-matching approaches to recruit individuals from at-risk sectors.
- Exploration of the potential for community wealth building as an approach to deliver inclusive growth.

Across the NHS Highland area, there is already recognition of the broader impact of COVID-19 and the need to take action. In Argyll and Bute, the 'Build Back Better' plan includes a range of activity to mitigate the effects of the pandemic, including food security, digital inclusion and climate change. Additionally, the 'Living Well' strategy, a framework to promote wellbeing, is being adapted to include actions to address the emerging impacts of COVID-19. In Highland, the Community Planning Partnership has considered the impact of COVID-19 on individuals and communities and adapted locality and issue-based plans to mitigate the broader impacts of COVID-19 including action on the economy, employment, income and mental health.

- Food security: COVID-19 highlighted existing food insecurity and the reliance that vulnerable people had on fragile foodbank provision. For example, an Access to Food project led by Argyll and Bute Council is reviewing where people may be having financial difficulties and require access to food banks or free school meals.
- Digital inclusion: The Caring for People response highlighted the barriers to some people accessing information and support during the emergency, in particular in the shielding group. Local community led responses were developed to improve access to online information, including providing equipment to people and using volunteer support to improve digital skills.
- Climate change and environment: environment and climate can have a significant impact on access to food and supplies during an emergency response. This is a key area of work that also links to the work of local resilience partnerships and emergency planning. It also connects with existing climate change activity being led by the Community Planning Partnerships.

Across NHS Highland, there is ongoing work to ensure that we engage with those most affected by the pandemic.

- Proactive engagement with hard-to-reach groups will help to shape organisational responses that are based on lived experience.
- In recognition of the impact of COVID-19 on mental health and wellbeing, particularly in relation to loneliness and anxiety due to the pandemic, related loss of role or jobs and greater financial hardship, work is underway to identify needs in relation to support for emotional wellbeing.

Social mitigation work in practice -

Financial security

Through a partnership approach with Highland Council Welfare Team, and links to national work around income maximisation services in health settings, the issue of over 75's losing their free TV licence in April 2020 was identified as a major concern. Previous work had been done to provide home energy and income advice in several GP practice while flu vaccination clinics were being offered. It was felt that this model could be utilised again to provide income maximisation advice to over 75's. Working with the NHS Highland Public Health Intelligence team, GP practices with the highest levels of over 75's were identified in Invergordon and Alness. As part of the Primary Care Modernisation work, the Vaccine Transformation Programme was looking to test a community-based approach for flu vaccination and had identified two sites in Invergordon and Alness. This provided the impetus to focus on these two areas.

Highland Council Welfare Team agreed to cover all 17 clinics over the three-month pilot period. The outcome from this work resulted in the Welfare Team staff approaching 313 people, supporting 93 individuals review their benefits/entitlements and successfully support 18 individuals claim over £83,000 in total. This amounts to an average increased income of over £4,500 per person. This work was fully reliant on strong partnership working with the Highland Council and also demonstrated a collaborative public health approach, where all three domains (health protection, health intelligence, health improvement) were vital to the positive outcome

Members of the NHS Highland Health Improvement Team provide support to the Highland Third Sector Interface Poverty Action Network (HPAN) whose member organisations provide: home energy advice, food support, homeless and employment services, mental health support and voluntary services.

The Network members work with communities on a whole range of levels and many provide additional signposting to support which they might not offer themselves. It was agreed that to impact on one of the fundamental causes of health inequalities, income, individuals within organisations should feel confident and knowledgably around income maximisation service and support. NHS Highland is taking the lead for establishing a small working group looking at how to increase skills and confidence to ask about money worries. Work is at an early stage but an agreement has been reached to develop an online training course which will be delivered to organisation staff with the aim of increasing the number of conversations had about money matters.

Child Poverty Plans

Public Health is working with Highland Council and Argyll and Bute Council to develop an update of the current Child Poverty Action Plans and to set out desired actions for next year.

In Highland, the midwifery and health visiting pathways have been reviewed to ensure that information about money worries and resource materials to support signposting for women is provided during routine appointments with health staff. This has included raising awareness about these resources and the importance of asking about money worries within the training delivered as

part of our Breastfeeding Update training.

A year two review of the Argyll and Bute Child Poverty Action Plan is in progress; with future, planned work identified based on previous work and emerging priority needs due to COVID-19. Engagement with harder to reach groups in our communities and their support agencies affected by poverty is being carried out as part of the Building Back Better recovery work.

This work aims to set up a reference group for future engagement to ensure that Council, NHS and Community Planning partners continue to focus policies, etc, around the impacts that it has on poverty experienced people. Consideration is being given to developing and delivering a training package on poverty awareness to staff across Argyll and Bute. Work is also continuing on Financial Inclusion Referral Pathways, with a pilot project which links health visitors and money advice services continuing.

Equality & diversity - upcoming priorities

During the pandemic, NHS Highland has continued to centre its work on the principles of Equality and Human Rights by consulting on issues affecting people with protected characteristics. Their experiences of social inequality, discrimination and poverty have informed the ongoing development of NHS Highland's Equality Outcomes and Mainstreaming Report 2021-25. This report sets out how NHS Highland within its functions is addressing inequality and progressing equality for people who use our services and our workforce. This is particularly poignant this year as the pandemic has highlighted inequality and how people with certain protected characteristics continue to face poorer experiences and outcomes.

The report will be published on the NHS Highland website in April 2021, in accordance with duties under the Equality Act 2010 and will set out:

- Progress against current equality outcomes
- confirm new equality outcomes for the next four years
- summarise how the health board is mainstreaming and embedding equality within its functions
- workforce data including data segregated by protected characteristics
- the gender pay gap for NHS Highland.

To inform the development of the report national and local research and analysis is being reviewed and shared between partners. This will set the context and focus for this strategy. We are however talking to a range of stakeholders and partners. This includes:

- Carers' services
- sight loss and hearing loss services
- human resources
- nursing leads
- procurement
- children's commissioner
- health improvement
- mental health delivery group
- Violence Against Women Partnership
- Highland Council and community planning partners.

Active travel, Physical Activity and Green Health

Ongoing advice and guidance from Scottish Government around the use of public transport has encouraged the population to minimise that usage and adopt active travel where possible in order to leave safe space on public transport for those who have no alternative. In rural areas this raises further concerns over the commercial viability of services, and the risk to those already disadvantaged and isolated. It will be important to consider any lasting adverse impact on public transport in remote rural areas.

Developing people's connection and confidence to switch to active travel often begins with simple, health-related physical activities that can lead to reconsidering how we undertake everyday journeys. The Active People project, which began in Inverness but is expanding to Aviemore, Skye & Lochalsh and other areas of Highland, receives referrals through primary care and provides a person-centred, motivating, link-worker role to support individuals to be more active. More than just signposting, the staff are trained to enable patients to identify barriers to health and physical activity, and develop goals and plans to overcome these barriers.

Access to nature and quality outdoor spaces remains a key priority. Research from NatureScot shows that whilst participation in outdoor activities has risen in August/September compared to March/May, inequalities remain with four times as many people in the 10% most deprived areas reporting visits to the outdoors less than once a week or never (compared to the 10% least deprived areas)[35]. Walking is an accessible and no/low-cost opportunity that is being promoted and supported across the Highland region. NatureScot research shows walking less than two miles as the most popular and most increasing activity of choice[20].

In addition to existing health walk provision, 2020 has seen the Highland Green Health Partnership (led by NHS Highland) increasing capacity in remote and rural areas to support and develop volunteer led health walks. Highland Green Health Partnership have also provided match funding for a project on Skye that produced the winner of Paths for All's award for Active Travel Volunteer of the Year[37]. Initiatives like these continue to provide a focus for future expansion and implementation, with an ongoing keen awareness of inequalities and social mitigation considerations.

Internally, NHS Highland remains committed to facilitating active travel for staff, with a number of targeted and universal initiatives. The popular Cycle2Work scheme is an ongoing success, but our valuable cohort of bank staff are unable to enjoy the benefits of savings through salary sacrifice. In partnership with Cycling Scotland, we have provided grants for 41 bank staff to access bikes and essential accessories for commuting. Whilst interest in cycling has increased, concerns over bike theft are also a barrier for some, and so distribution of free security tagging kits has been offered across the Board area.

Sport England[19] found that the following groups were finding it harder to be active:

- Women
- older people
- people on low incomes
- people living alone
- people with a long-term condition or illness
- people self-isolating because they are at increased risk
- and people without access to private outdoor space.

A focus on physical activity in specific groups is necessary in order to prevent widening of inequalities.

Within Argyll and Bute, a multi-partner physical activity group is developing a strategic approach to support more adults to engage in physical activity for health and wellbeing benefits.

The group is focusing on physical activity communication with staff and public; developing and delivering education/training for staff on supporting and enabling physical activity; maximising use of resources across sectors by developing stronger links between local physiotherapy teams and Argyll Active exercise referral programmes including cardiac rehab and falls prevention.

Recommendations and actions

For NHS Highland

- Commit to implementation of a COVID-19 Social Mitigation Strategy involving all relevant services and partners and deliver specific actions with clearly defined governance and scrutiny and supported by a Non-Executive Director champion.
- Create more Fair Work employment opportunities targeted to meet the needs of at-risk groups.
- Use procurement policy and practice to maximise benefits to the local economy.
- Develop job-matching processes to recruit individuals from at-risk sectors.
- Support further development of Public Health work on income and employment; food insecurity, mental health and support to access nature and greenspace for health.
- Ensure frontline staff can signpost or refer vulnerable clients to sources of social and financial support.
- Assess impact of policies, plans and service changes upon at risk groups.
- Deliver specific actions to support health literacy
- Ensure that the roll-out of online digital services considers access and equality issues.
- Ensure that commissioning and support for third sector organisations takes account of the impact of COVID-19.

For community planning partners in Highland & Argyll and Bute

- Explore the potential for community wealth building as an approach to deliver inclusive growth[38].
- Identify local needs and enable flexibility and discretion over unallocated resources targeted towards groups and communities most at risk.
- Maximise impact of links with local and national networks addressing poverty, mental health and support to access nature and greenspace for health.
- Identify those who need digital support.
- Invest in community health development
- Develop and deliver initiatives to support active travel.
- Review the impact of lockdown and social distancing on public transport and how it relates to access to services.

Chapter Three - Alcohol and Drugs Partnership response to COVID-19

This section provides general background information about alcohol and drugs, and describes the impact and response to alcohol and drug related harms in the NHS Highland area during the COVID-19 pandemic.

> The Overseers are not there. We don't have the pubs open and we don't have people providing the right measures and we don't have people watching what we do'. (BBC 11.12.2020)[1]

At the start of the COVID-19 pandemic there was early recognition by the Scottish Government and Alcohol and Drug Partnerships that programmes and services with a remit of prevention, education and recovery outcomes to reduce the harms caused by alcohol and drugs had to be maintained[2]. This is because, prior to the pandemic the number of drug related deaths and alcohol related deaths were of concern throughout Scotland and it was anticipated this situation would be exacerbated by the pandemic.

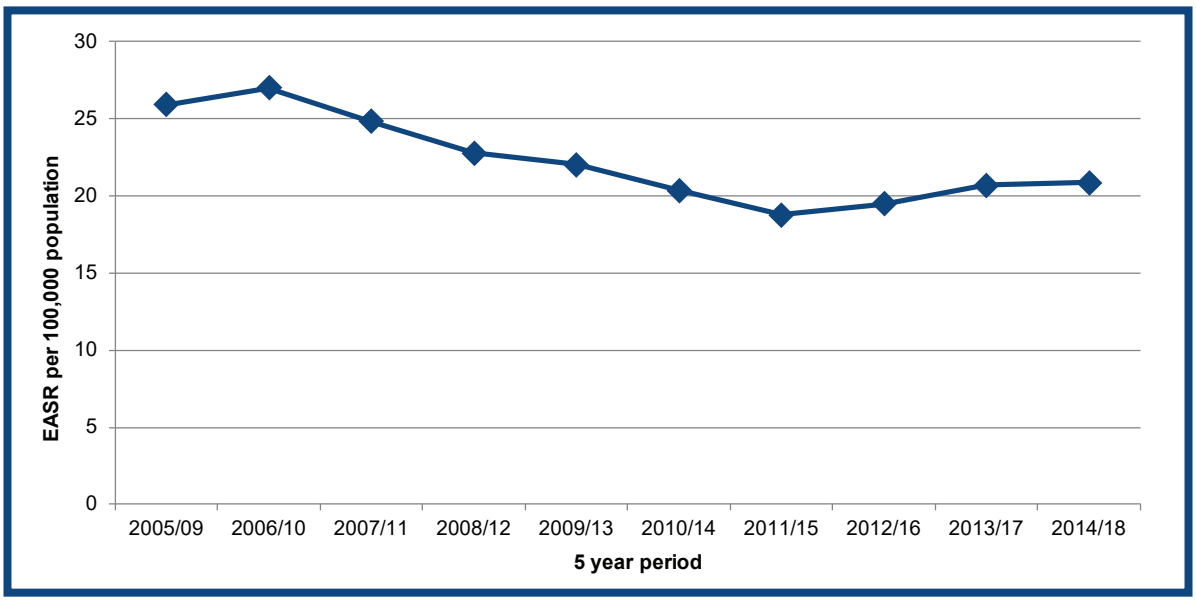
NHS Highland is responsible for two local authority areas each with an Alcohol and Drug Partnership which has co-ordination role; these are called the Argyll and Bute Alcohol and Drug Partnership (A&BADP)[3] and the Highland Alcohol and Drug Partnership (HADP)[4].

Mortality data, alcohol brief interventions and treatment times guarantee

It is important to note that data, for the time period of the first lockdown in March 2020 until December 31 2020, is not available for this report because of how it is collected nationally.

Figure 1 shows alcohol-specific death rates in NHS Highland. The horizontal axis shows five-year rolling averages and the vertical axis shows European age and sex standardised rates per 100,000. From 2006-2010 to 2011-2015 there was a steady downward trend in mortality rates followed by an upward trend 2014 -2018 but not reaching the numbers reported in 2006-2010.

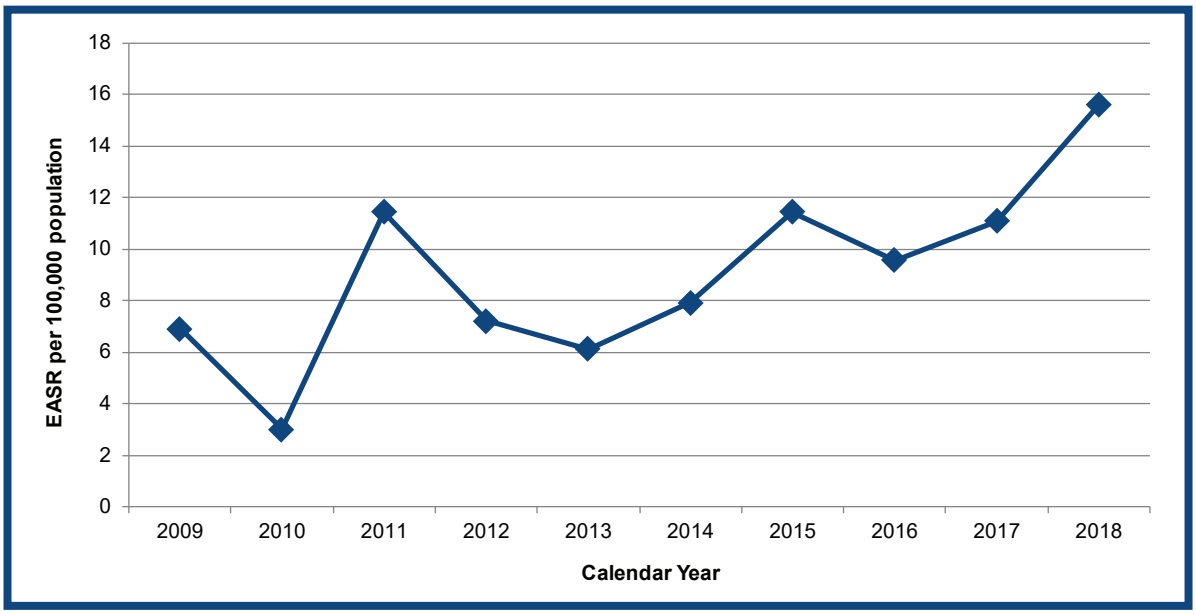
Figure 1: Alcohol-specific death rates in NHS Highland 2005/9-2014/18



Source: SMR01, Scottish Public Health Observatory[5]

Figure 2 shows drug-related mortality in NHS Highland. The horizontal axis shows annual points over a ten-year period from 2009-2018 and the vertical axis shows age and sex standardised rates per 100,000. From 2005 to 2018, there has been an overall increase in drug-related mortality in NHS Highland and in 2018 there were 16 deaths per 100,000 population. In 2018, the highest figure was recorded in this particular time frame.

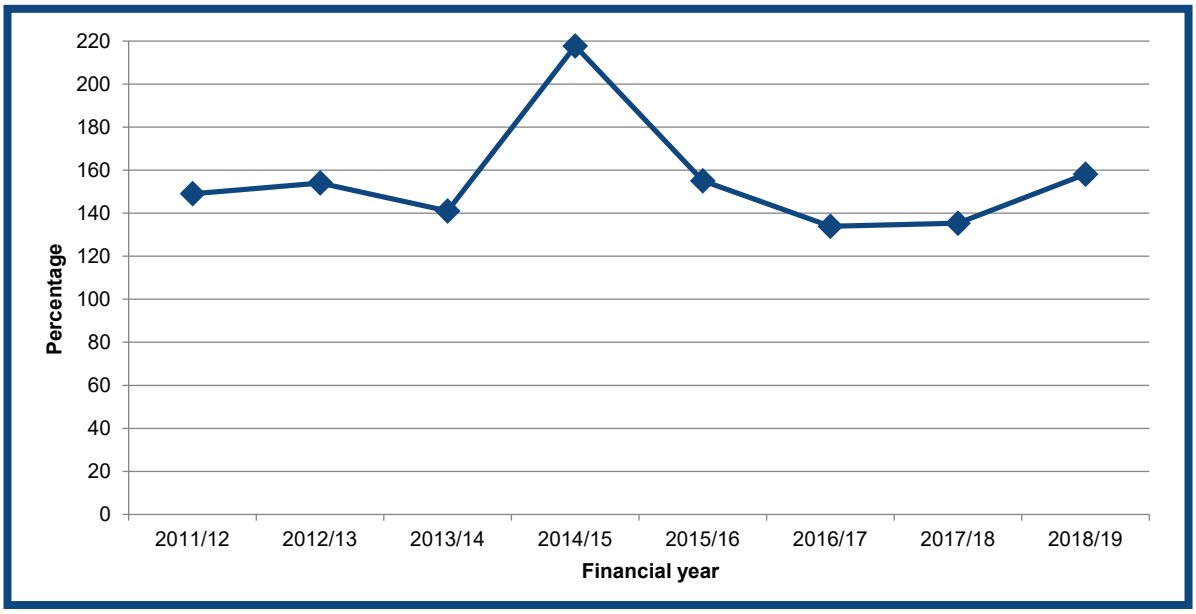
Figure 2: Drug-related mortality in NHS Highland 2009 -2018



Source: National Records of Scotland, Scottish Public Health Observatory[6]

Alcohol Brief Interventions (ABIs), a population-based approach, is a Scottish standard that all NHS Boards are required to meet. Figure 3 shows the percentage of the standard for the number of ABIs delivered in NHS Highland. An ABI is a brief evidenced based structured conversation about alcohol consumption with a patient/client in a non-confrontational way to motivate and support the individual to think about changing their drinking. These are carried out in three priority settings and they are; primary care, emergency departments and antenatal. NHS Highland has always met this standard.

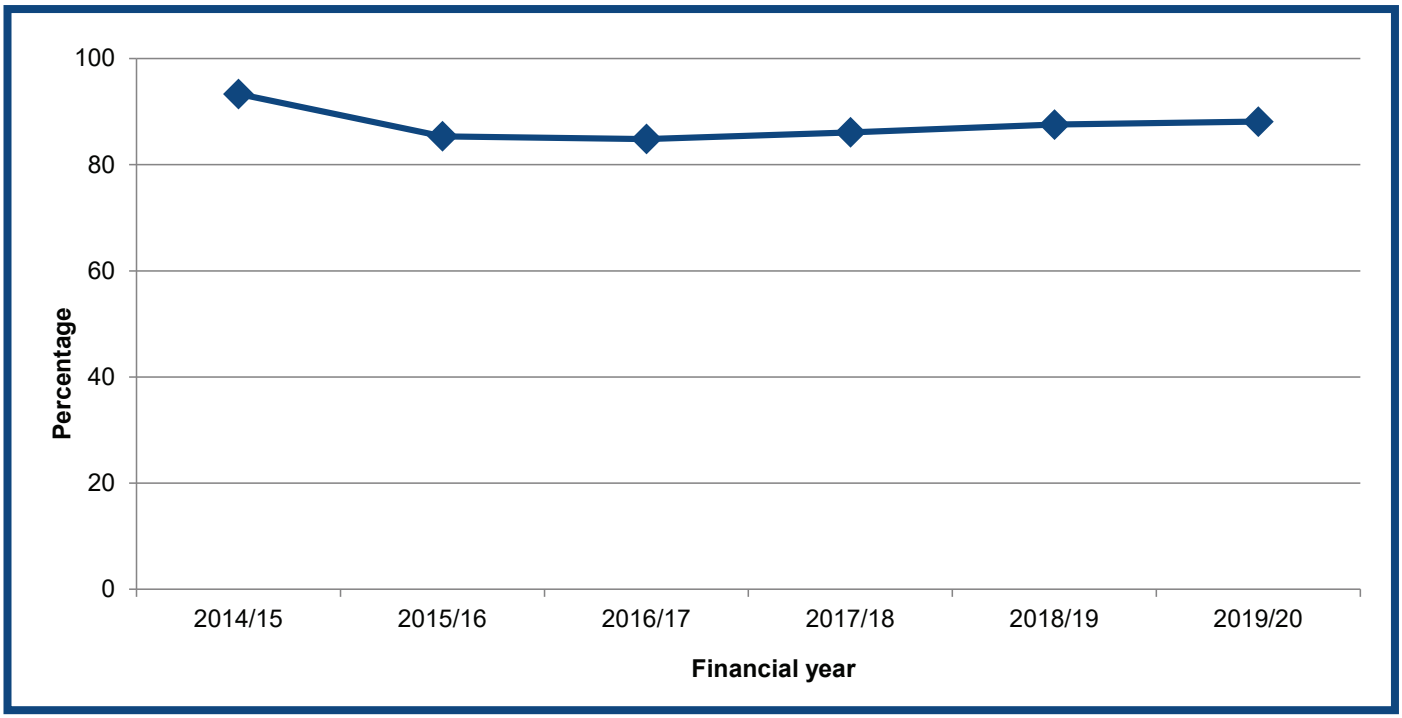
Figure 3: Alcohol Brief Interventions in NHS Highland 2011/12 – 2018/19



Source: Public Health Scotland, Scottish Public Health Observatory[7]

Figure 4 shows the Treatment Times Guarantee (TTG) which is a Scottish Government target that all Health Boards are required to meet. The definition for this target is the: *Number and Percentage (90%) of clients waiting no more than 3 weeks between referral to a specialist drug and alcohol service and commencement of treatment.* The horizontal axis shows the year and the vertical axis shows the percentage that has been met. The latest data reported at June 2020 shows Highland achieved a percentage of 89.5% which is 0.5% below the national target.[8]

Figure 4: Percentage of clients waiting no more than three weeks between referral to a specialist drug and alcohol service



Source: Drug and Alcohol Treatment Waiting Times Database, Public Health Scotland[9]

What has been the local response?

The way people changed their behaviour towards alcohol and drugs during the COVID-19 pandemic is complex and compounded by living and working conditions, for example, those living in poorer circumstances have been disproportionally affected. Some people during lockdown decided to decrease their alcohol consumption by rethinking their life style, but, in contrast the triggers of increased isolation, loneliness and financial hardship resulted in poorer health and wellbeing and an increase in harmful behaviours.

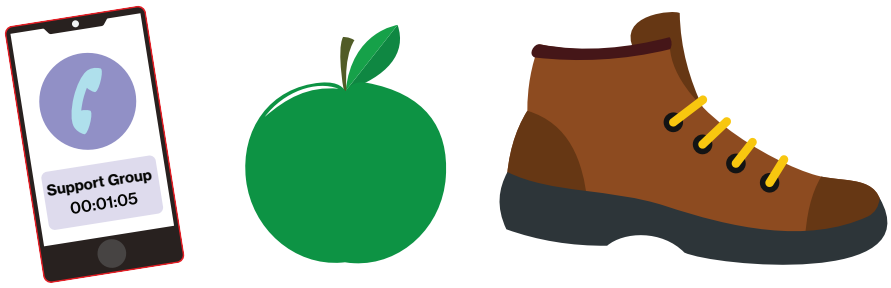
Unfortunately, many individuals are still experiencing stigma because of problematic alcohol and drug misuse and this continues to be a barrier for those accessing treatment and in recovery. Concern about an increase in domestic violence, mostly towards women and children, resulted in specific guidance being published by the Scottish Government[10].

The overall strategic direction for Alcohol and Drug Partnerships has been set by 'Rights, Respect and Recovery (2018)'[11] and the Alcohol Framework (2018)[12]. The role out of a number of projects, specifically funded to tackle the increase in drug-related deaths, was delayed and the delivery processes changed to reflect the various COVID-19 regulations. Recovery services, responded positively by changing how they provided services, for example, extending service hours into the evening, providing more online/digital methods for client contact and offering different types of treatment. The following is a highlight of some of the work and both Alcohol and Drug Partnerships have recently published a three-year strategy that can be found on their respective websites.

Community responses - Helensburgh Family Support Group

Helensburgh Family support group, supported by the A&BADP, has been running since October 2018 and has helped to support many families in Argyll and Bute over the years.

During the COVID-19 pandemic, the group has been supporting families to help with buying food and mobile phones. The group continued to deliver group sessions over the phone and offer one-to-one support at other times. They also set up a walking group to help support family members during this period.

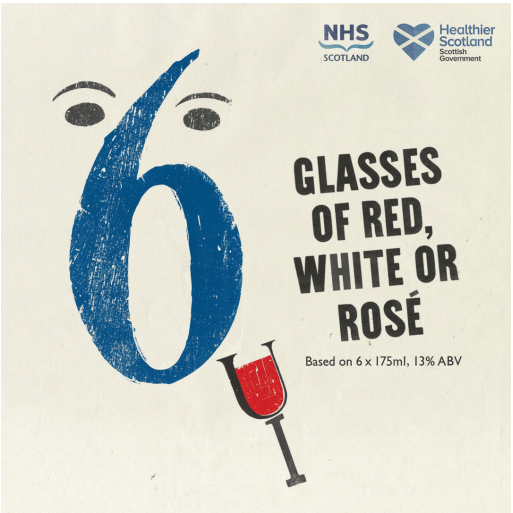


The Family Support group established an outreach service in Helensburgh & Lomond in partnership with the recovery service provider, 'We Are With You' and transport providers, in response to reports of people in crisis within the Helensburgh area. They are offering soup/hot drinks and sandwiches to those in need. They also have the opportunity to arrange safe distribution of naloxone and injecting equipment provision to people who would benefit from this service. The aim of this outreach is to support people in need and provide simple pathways into services. This has resulted in three people, previously unknown to services, being assessed.

Both Police Scotland and ScotRail are very supportive of this work as it has been identified that Helensburgh train station is where the people in need are congregating. The group are working hard to ensure safe distancing, use of personal protective equipment and are looking at ways to safely supports these high-risk individuals. The intension is to replicate this in all localities where vulnerable people care gathering and to offer support to access local services.

Raising Awareness

Throughout the pandemic, it has been recognised that people are likely to feel more stressed or worried than usual, and that in times of stress some people can drink more often or more heavily. To provide support at a population level both ADPs have supported a number of public awareness campaigns providing information and signposting.



The HADP worked in partnership with Public Health Scotland[13], Alcohol Focus[14] and others to provide good quality, accurate information on alcohol and drugs that is accessible to the public via the NHS Inform national website. The information provided includes how drugs and alcohol can impact on health and wellbeing, and in some situations increase risks and complications linked to COVID-19. Alcohol can, for example, reduce the immune system's ability to fight off infectious diseases and have an impact on the health of a person's heart and lungs. Harm reduction along with information on behaviour change and the Count 14 campaign on lower risk drinking has been promoted via the NHS Inform website[15] and local community partnerships across Highland to encourage the public to make informed choices and reduce potential risks to their health and wellbeing.

The HADP, throughout the pandemic, has continued to develop the People First – Language Matters[16] campaign in order to tackle stigma. The campaign promotes the use of People First language as a simple step we can all take to reduce stigma. It raises public awareness that the language used to describe people with drug and alcohol problems can have an impact on how they perceive themselves and how others view them. The campaign emphasises that inaccurate and derogatory use of language creates and perpetuates stigma and can act as a barrier to people accessing support and treatment.

For the HADP, using People First language matters, because it reminds us to be compassionate and that we are talking about human beings; people with rights, who deserve respect, and should be supported in their recovery. HADP is encouraging organisations across Highland to pledge[17] to become a supporter of People First – Language Matters.

Other prevention and early intervention examples include the HADP tool kit which provides online access to a broad range of quality resources aimed at young people, parents and professionals.

Recovery

Recovery is an individual journey, however, for many, recovery is about being able to achieve personal goals, and the development of relationships and skills that support a positive life. During COVID-19, there has been a range of responses to support individuals.

The NHS Highland Drug and Alcohol Recovery Service have remained opened throughout the pandemic. Services have continued to accept referrals, assess and implement treatment and recovery plans, which are supported by regular appointments with keyworkers. This has mainly been carried out using a telephone triage and assessment service and there are face-to-face appointments available where required. In-line with national guidance; flexible dispensing arrangements for medication has been introduced, with innovative outreach and postal options developed to further support people. A robust overdose awareness and naloxone programme has continued to be delivered with NHS Highland pioneering distribution of intranasal naloxone (Nyxoid). A centralised seven-day service based in Osprey House has been established with all locality teams working in partnership with the Third Sector to provide creative solutions to supporting people throughout the pandemic.

Housing First

In order to improve support to people experiencing homelessness, drug and alcohol problems & complex physical and mental health problems, HADP has collaborated with the Housing Department, Drug and Alcohol Recovery Service and the Salvation Army to pilot a Housing First project. The multi-agency project was launched during the pandemic and provides a locally responsive assertive outreach service underpinned by Housing First principles[18] in order to reach, engage and support people with problem drug and alcohol use and complex needs, particularly those at higher risk of drug and alcohol related death.

Conclusion

Although this does not describe all of the work carried out by the ADPs that has taken place during the ongoing COVID-19 pandemic, this section has highlighted the commitment by those delivering services and projects to be flexible in order to meet local circumstances and individual need. It is widely acknowledged that there are many lessons to be learnt, in particular, how the pandemic has disproportionately affected those living in deprived circumstances compared to those who live in more affluent areas. With a COVID-19 vaccination programme underway, it is time to take stock and build on the lessons learnt hearing from those with lived experience through to early intervention and prevention programmes. Finally, both ADPs, building on their expertise prior to and during COVID-19, have published a three-year strategy which is available on their respective websites.

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Chapter 3 - Alcohol and drugs

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Notes

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