EQUALITY IMPACT ASSESSMENT - RESULTS

Title of Policy	Behavioural Insights: Facilitating the Reduction of Risk of COVID-19 Transmission in Hospitals by Identifying Barriers and Avenues to Safe Behaviour
Summary of aims and desired outcomes of Policy	Scotland's overall pandemic strategy is set out in COVID 19: A Framework for Decision Making, the aim of which is to suppress the virus - driving the number of cases to the lowest levels possible and effectively eliminate it - and therefore enable as close to normal life as possible to resume and continue. The main aim of this particular project is to facilitate the reduction of risk of COVID – 19 transmission in hospitals by identifying barriers and avenues to safe behaviours in high-risk workplaces.
Directorate: Division: team	Chief Nursing Officer Hospital Associated Infections Covid-19 response team

Executive summary

The University are seeking to identify the factors influencing worker-to-worker COVID-19 transmission in hospitals, to determine how to make workplaces safer for staff. They will develop and trial a behavioural change intervention to reduce transmissions. Proof of concept will be provided at the Royal Infirmary of Edinburgh and Queen Elizabeth University Hospital Glasgow using interviews, behavioural and qualitative data to identify barriers and avenues to safe behaviour for NHS staff.

This will help to facilitate the reduction of the risk of COVID -19 transmission by identifying key barriers and the facilitators of safe behaviour and other risk reducing behaviours

Once the methodology has been established, the aim is to provide a similar approach which could be used in other areas which have been identified as 'high risk' by the Scottish Government, such as care homes, food processing hubs. This would help to enable swift identification of factors impacting on (for example) physical distancing.

Background

The Programme for Government 2020 - 2021 recognises that Infection Prevention and Control (IPC) was a key issue pre-COVID-19 and the experience of NHS Boards in dealing with COVID-19 has reinforced how fundamentally important this is. The focus on protecting and supporting the healthcare workforce is key to this project.

The Scope of the EQIA

We regard this as an interim equality impact assessment. It is not intend to be a full assessment of impact, due to the nature of the work.

However, we have identified through this process that it will (initially) affect people with the protected characteristics of sex and potentially disability. We have also identified that at the roll out stage, further exploration will be needed and a more in depth EQIA to cover further group. Areas which we may be impacted in this initial scoping exercise cover initial conversations with health care staff, building relations, facilitating access to questionnaires, surveys, group participation and the development of materials (at Phase 2).

Key Findings

Sex

We know that women dominate the health and social care profession, so they will be those most likely to be involved in this project. We also know that they are more likely to self-report.

There have been more confirmed cases of COVID-19 among women, and women's over-representation as unpaid carers and in health and social care jobs is likely to put them at higher risk of contracting COVID-19.

There are a higher ratio of women to men in older age groups. 65% over people 85+ years are women.

Evidence was drawn from:

Women and Equalities Committee Inquiry on coronavirus (Westminster) May 2020; Response to the Scottish Parliament's Equalities and Human Rights Committee inquiry into the impact of the COVID-19 pandemic on Equalities and Human Rights;

THE IMPACTS OF COVID-19 ON EQUALITY IN SCOTLAND Scottish Government;

Coronavirus (COVID-19) Impact on equality (research) Sept 2020 Inequalities by gender in the context of Covid-19, Scottish Government.

Disability
some of the health care workers may have a learning disability, may be hard of hearing or d/Deaf, or may have a hidden disability. Once the toolkit is developed, we would want to consider how accessible this is for disabled people. If we are considering an electronic possibility, we will need to consider disability or age.

Disabled people in Scotland have been disproportionately impacted by Covid-19. People in the learning/intellectual disabilities population were more than 3 times more likely to die from COVID-19 than those in the general population.

People with learning/intellectual disabilities were twice as likely as those in the general population to become infected with COVID-19. Therefor any toolkit developed that would help slow transmission of Covid-19 should be beneficial to the community, subject to accessibility measures which will be explored thoroughly when the toolkit is developed.

Evidence was drawn from:

National Records of Scotland;

Women and Equalities Committee Inquiry on Coronavirus (Westminster) May 2020;

Response to the Scottish Parliament's Equalities and Human Rights Committee Inquiry into the impact of the COVID-19 pandemic on Equalities and Human Rights;

THE IMPACTS OF COVID-19 ON EQUALITY IN SCOTLAND Scottish Government;
Coronavirus (COVID-19) Impact on equality (research) Sept 2020;
Research from The Scottish Learning Disabilities Observatory (SLDO)

Race
Potential to cover different languages
Accessible to people whose first language is not English. At this proof of concept, this is unlikely to apply, but in future, an easy read version or a BSL format should be considered appropriate.

Around 5%, or one in twenty, of Scotland's population self-identified as a non-white minority ethnic group in 2018.

Recent studies, primarily in England but with some evidence from Scotland, have shown that mortality rates from COVID-19 are higher amongst the minority ethnic population.

Higher employment in NHS and other key worker industries which may increase risk of infection to individuals and their families but also create additional anxieties around child care.

Higher rates of underlying illness especially diabetes and cardio-vascular disease, which may mean there are higher numbers in shielded groups and may indicate a need for some specialised advice and support.

Barriers to effective communication, because of language, stigma, prejudice or other cultural differences in health and social care settings are likely to lead to negative outcomes.

Evidence was drawn from:

Inequalities by ethnicity in the context of Covid-19, Scottish Government;
Scottish Surveys Core Questions 2018

Religion and belief

The 2011 Census recorded a rise in people with no religion between 2001 and 2011, while Church of Scotland numbers dropped. Religion was an optional question. In 2011, 7% of people did not state their religion.
37% of people said they had no religion.
That is an increase from 28% who said they had no religion in 2001.
39% of males and 34% of females said they had no religion.
The number of people identifying with the Church of Scotland dropped to 32%. This was a decrease of 10 percentage points from 42% in 2001.
Muslims, Buddhists, Hindus and Sikhs all increased in number from 2001.
1.4% of people said they were Muslim. That's an increase of 0.6 percentage points since 2001.
Buddhists, Hindus and Sikhs made up 0.7% of the population. Each of these also increased between 2001 and 2011.
The number of Jewish people declined lightly to just under 6,000.

Potential for toolkit to be rolled out in areas such as church settings/funeral gatherings
Will need to explore this more thoroughly We will ascertain to include statistics of different faiths and beliefs in Scotland when if the toolkit is rolled out.

Evidence was drawn from:

2011 Census

Recommendations and Conclusions

Undertaking the assessment has helped us to consider how this could potentially affect different groups (and in particular those from ethnic minorities and with characteristics relevant to age and disability) . Clearly greater exploration will be needed once the toolkit is developed and rolled out. This of course will depend on the areas where it is may take place e.g. care homes, food processing outlets. We have added additional elements around disability (in terms of accessibility – technology in particular) and around race (possibility that the current formats could be less or inaccessible to people whose first language in not English.). This is particularly relevant to any toolkit that will be developed which should be adapted to respond to the interests of the nine groups.

This initial EQIA will therefore help us think through any further work , allow us to be more sensitive to the needs of all protected characteristic groups and potentially ensure that we consult timeously and appropriately.

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