EQUALITY IMPACT ASSESSMENT RECORD

Title of policy	Review of routine COVID-19 testing guidance in health, social care and prison settings	
Minister	• Minister for Social Care, Mental Wellbeing and Sport • Cabinet Secretary for Justice and Home Affairs • Cabinet Secretary for NHS Recovery, Health and Social Care	
Officials involved in the EQIA	**name**	**team**
	[redacted s.38(i)(b)]/ [redacted s.38(i)(b)]	Adult Social Care Oversight and Assurance Team
	[redacted s.38(i)(b)]/ [redacted s.38(i)(b)]	Healthcare Associated Infections Policy and Strategy Team
	[redacted s.38(i)(b)]	Population Health Resilience and Protection Team
	[redacted s.38(i)(b)]	Prisons Team, Directorate for Justice
	[redacted s.38(i)(b)] [redacted s.38(i)(b)]	Health Workforce
Directorate: Division: Team	**Adult Social Care Oversight and Assurance Team,** Social Care and National Care Service Development Directorate **Healthcare Associated Infections Policy and Strategy Team** Chief Nursing Officer's Directorate **Population Health Resilience and Protection Team,** Directorate for Population Health **Prisons Team,** Directorate for Justice **Health Workforce Directorate**	
Is this new policy or revision to an existing policy?	Removal of a temporary policy	

Aim of the Strategy

Context

Test and Protect has been one of the key interventions over the course of the last three years in Scotland to reduce the impact of COVID-19 on our health, and on the wider social and economic harms caused by the pandemic.

In March 2022, the Test and Protect Transition Plan outlined how testing was changing from May 2022 to move away from population-wide testing and to adapt to the endemic phase of the COVID-19 pandemic – with thanks to additional population-wide immunity from vaccination and additional protection from new Covid treatments.

In September 2022, testing eligibility changed again to pause routine asymptomatic testing in health and social care settings against a backdrop of reducing risk and prevalence. In May 2023, the World Health Organization announced the end of Covid-19 as a global health emergency.

Current policy advises routine testing for COVID-19 in specific situations, including:

- health and social care staff when symptomatic;
- symptomatic patients, residents and prisoners;
- pre-admission to a care home from a hospital or upon admission to a care home from the community; and
- patients who are considered immunocompromised prior to surgery.

The Scottish Government commissioned Infection Prevention and Control and public health advisers from Antimicrobial Resistance & Healthcare Associated Infection (ARHAI Scotland) and Public Health Scotland (PHS) to review remaining routine testing measures in health, social care and prison settings and make recommendations.
The findings of the review were:

- That we are in a different phase of pandemic (WHO – that COVID-19 was no longer a Public Health Emergency of International Concern, 5 May 2023)
- Recommended the cessation of all routine COVID-19 testing
- That we should return to a person-centred risk-based approach
- That we should no longer treat COVID-19 under separate guidance but follow the existing guidance (National Infection Control IPC Manual-NIPCM) and risk assess as required, taking into account all respiratory pathogens
- That the ability to test for COVID-19 will not be removed; testing should still happen when appropriate as per NIPCM

These findings were endorsed by the Scottish Government's (SG) Infection Prevention and Control (IPC) professional advisors and SG's Professional Advisory Group. Ministers agreed to the advice submitted, while maintaining testing for discharge to care homes.

Ministers recently agreed to transition Scotland's management of COVID-19 from an emergency pandemic response to an enhanced business as usual approach, proportionate to the current calmer phase of the pandemic.

Testing when it is not proportionate can cause harms. For example, routine symptomatic testing of patients, residents and prisoners can result in false positives when risk of transmission is low. This is because prevalence of COVID-19 affects the pre-test probability of a disease being present and consequently impacts on the positive predictive value (PPV; the probability that subjects with a positive test truly have the disease) and the negative predictive value (NPV; the probability that subjects with a negative test truly do not have the disease). As the prevalence increases, the PPV increases but the NPV decreases. Similarly, as the prevalence decreases the PPV decreases while the NPV increases. Therefore adverse outcomes associated with false positive results will be proportionally greater during periods of low prevalence.[1] However, the individual impact of false positive results are significant at all times. – it may result in unnecessary isolation as well as unnecessary medical intervention or indeed delay of an intervention. Similarly, false positive from testing care home residents prior to discharge from hospital may also lead to people being delayed in hospital. This can lead to other harms e.g., worsening of mobility, sense of isolation, confusion and/or cognitive deterioration as well as reducing bed capacity in hospital. Furthermore, testing of health and social care staff with respiratory symptoms may also result in a false positive and unnecessary time off work leading to pressures on the health and social care sector and for some loss of earnings.

The purpose of pausing these temporary policies is to revert to the robust processes and policies that were in place pre-pandemic that are now proportionate to the phase that we are currently in and in line with the current evidence on management of COVID-19. This is broadly in line with the approach taken in other UK nations.

The aim is therefore to have the appropriate interventions in place for the current stage of the pandemic, that are based on the best available evidence, balance risks and harms, and are aimed at protecting the highest number of people**.**

The following national outcome is considered to be the most relevant:

- That people are healthy and active

The EQIA considers impacts on equalities groups based on the three tests:

- Does this policy change eliminate discrimination for each of the 9 protected characteristics (PC). If not is the discrimination justifiable? Can it be mitigated?
- Does this policy change advance equality of opportunity for PC groups?

[1] See explanation here: The impact of false positive COVID-19 results in an area of low prevalence - PMC (nih.gov)

- Does this policy change foster good community relations between people of PC groups?

Who will it affect?
The changes will affect staff, patients and residents, and visitors in health and care settings as well as prison settings. Some groups of people will be tested for COVID-19 less frequently. It would move from the current temporary policy of routine COVID-19 testing and return to a person-centred, risk-based approach i.e. testing as clinically required as was in place pre-pandemic.

What might prevent the desired outcomes being achieved?

There may be concerns from some social care providers about the removal of routine testing. For example some care home providers may still have tests in stock and decide to use them until they are gone.

However based on our engagement with stakeholders we know that for the most part there is support for the changes which are commensurate with the current calmer phase of the pandemic. This is summarised below.

Engagement with social care and public health stakeholders

We met social care/ care home sector representatives with whom we have had considerable engagement around ongoing reviews of remaining COVID-19 measures (e.g. recently face masks and now the review of testing). From recent conversations with representatives, including Scottish Care, there was support for the testing changes, including the removal of testing pre-discharge from hospital for care home residents given the clinical and public health advice at this stage in the pandemic. However, they acknowledged the sensitivities of the move and stressed the importance of sensitive handling and sector engagement.

PHS's strong view remains that routine asymptomatic testing pre discharge to care homes cannot now be justified on infection control grounds since COVID-19 no longer presents the risk of severe outcomes as it had during the height of pandemic and because retaining it would contrast with the established practice of 'no testing' of residents on their return from a day visit or overnight stay and (soon to be paused) pre-admission to care home from the community. In addition staff and visitors (who make up much more of the footfall in a care home than residents discharged from hospital) are not being testing routinely. We also met with Care Home Relatives Scotland who appear to have concerns about the ongoing use of testing given the potential for people needing to isolate in the care home (albeit with guidance now in place which supports visits from a named person in most circumstances). CHRS consider that Anne's Law (care home visiting) is essential to protect the rights of "essential care givers" in every aspect of their loved one's lives.

Engagement with National Staffside (NHS)

Head of Staff Side has indicated that any such change to testing guidance would be understandable given where we are at now. Furthermore, he thinks we need to continue to follow what the current evidence is telling us, which is exactly what the review of testing is doing. However, there is a possibility that the removal of testing may push some staff to seek protection in other ways. This in turn could translate into higher occupational health referrals. He has also raised the issue of Long Covid and the claims for industrial injury that have been lodged.

Engagement with NHS HR Directors

The testing review in Scotland has been on the radar of NHS HR Directors. There has been no feedback to suggest they wouldn't support a removal of testing at this stage.

Engagement with NHS Occupational Health Leads

The collated view of NHS Occupational Health Leads in Scotland were that the current level of testing needs to be stood down and instead we need to reinforce for staff symptom assessment and staying away from the workplace if unwell.

Engagement with SPS and prison network

SPS and Prison care network are content with clinical recommendation for ending of routine symptomatic COVID-19 testing within prisons. Both are of the view that retuning back to arrangements in place before pandemic is now a more suitable approach within prisons as decision relating to testing will be taken at local level based on risk assessment and advice from Health Protection Teams(HPTs).

The routine symptomatic testing is ending however, there is safety net within the current recommendations as HPTs can recommend testing based on localised risk assessment; therefore the provision of outbreak testing will be able to effectively manage any risk of transmission within close settings.

Further, HMIPS have criticised the COVID-19 rules within prisons doesn't align with that of community which means unnecessary restrictions are placed upon prisoners, impacting their human rights. Any changes to ease testing will assist SPS towards opening up of the regime and guidance within prisons will now be more closely aligned to community guidance.

Stage 1: Framing

Results of framing exercise

- Will directly affect people
- Will impact areas where there are inequalities – e.g. access to healthcare
- Will potentially prevent harm

- Could inadvertently disadvantage some people

While proposal to remove routine testing policy for health, social care and prison settings reflects the stage that we are in the pandemic and is proportionate, some people in these settings who were previously identified as being more vulnerable to COVID-19 due to the disproportionate effect of COVID on race, age, ethnicity, gender, medical / health conditions, may worry about the removal of routine testing. However the proposals are justified on the basis that there are harms from continuing routine testing which could result in unnecessary isolation, medical intervention or delays to interventions. In addition there will continue to be COVID-19 testing in place for these settings as clinically required.

Extent/Level of EQIA required

An EQIA is being carried out given the impacts on people and to help us consider the potential inadvertent disadvantage to some groups.

Stage 2: Data and evidence gathering, involvement and consultation

Include here the results of your evidence gathering (including framing exercise), including qualitative and quantitative data and the source of that information, whether national statistics, surveys or consultations with relevant equality groups.

The table below considers the evidence / data as well as potential differential impacts for health & social care and prison settings.

Characteristic[2]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
AGE	**1. BACKGROUND - Health Social Care and Prison settings** It is well recognised that older people, people who have long term health conditions or who find mobility challenging and who are more likely to use or reside in health and social care services, may be particularly vulnerable to COVID-19 and more likely to have complex co-morbidities which place them at greater risk of complications if they contract COVID-19. Older people are more likely to be worried about their health and the risks of contracting COVID-19, and are also more likely to experience loneliness and digital exclusion. YouGov polling[3] on behalf of the Scottish Government in June 2022 showed differing levels of concern about coronavirus between age groups, with 28% of those aged 18–24 agreeing with the statement 'I feel worried about the coronavirus situation' compared with 44% of those aged 75+. Similarly, one third of those aged 18–24 were worried about the number of COVID-19 cases in Scotland, while over half (52%) of those aged 75+ were worried. **2. EVIDENCE / DATA** **i) Health and social care settings**		

[3] Public attitudes to coronavirus, cost of living and Ukraine: tracker - data tables - gov.scot (www.gov.scot)

	Staff in Health and Social Care As at 31 March 2023, there were 156,178.7 Whole Time Equivalent (WTE) staff employed by NHS Scotland. The median age of the people employed in NHS Scotland on 31 March 2023 was 44. The age distribution of people employed in NHS Scotland varies between job families. There were 208,360 employed in Social Care in Scotland, The WTE measure of the workforce is 159,150. Median age of the Social Care workforce is 43. To put this into context, the median age for the total Scottish population aged 16 and over is 49 years and the median age for those between 16 and 65 years old (the traditional working age population) in Scotland is 41 years. For this reason, the sector's workforce is on average older than would be expected given the age profile of Scotland's working age population. Source: NHS Scotland Workforce Source: SSSC: Workforce data 2021 Service users in Health Care and Social Care As of 6 October 2020, Scotland's population was at 5.46 million. It is expected at some point that each individual will receive some form of Health Care. Source: Scotland's Population | National Records of Scotland In terms of Social Care, an estimated 1 in 25 people in Scotland were reported as receiving social care support and services at some point during 2020/21. In 2020/21 the rate per 1,000 population of people receiving social care support through any self-directed supported		

option was 19.4 people per 1,000 population. An estimated 68,000 people in Scotland received home care for the quarter ending 31 March 2021. This is equivalent to 12 people per 1,000 population. Some 44,000 people received funding towards a long stay care home place in Scotland during 2020/21. In addition, a further 6,300 people were supported during a short stay in a care home, such as for respite or for reablement during this time. In 2020/21, an estimated 130,000 people had an active community alarm and/or a telecare service.

Source: Insights in Social Care

As at 31 March 2022 there were 33,352 adults resident in Care Homes and their ages were as follows:

Category (years)	**2022**
Mean Age	81
Mean Age At Admission	79
Mean Age At Discharge	85
Median Age	84
Median Age At Admission	82
Median Age At Discharge	87

Source: Care home census for adults in Scotland

ii) Prison settings

As of December 2022, the prison population was around 7302 with the following age break-down:

Age Range	Population Nov 2022
Under 18	4
18-21	217
22-30	1717

31-40	2653
41-50	1496
51-60	801
61-70	285
over 70	129

Source: Public Information Page (PIP) Quarter 3 2022/2023 (sps.gov.uk)

3. DIFFERENTIAL IMPACTS - health social and prison settings

The positive impacts of the policy of moving from routine COVID-19 testing of people who use health and social care and prison services to a person-centred risk based approach are that the approach will be based on the needs of individuals rather than a blanket approach. It will remove unnecessary testing and isolation which can be harmful and potentially lead to false positives which is more likely to happen when prevalence of COVID-19 in the population is low.

However, there is also a possibility of potential negative impacts around perceived risks. People of all ages, but particularly older people, may be concerned about increased health risks from removal routine COVID-19 testing in health social care and prison settings both for service users and for staff in health and social care services. These concerns may be mitigated by staff following 'stay at home' guidance if symptomatic. In their review, PHS/ AHRAI emphasised that it would be important to consider reinforcing this messaging for staff who work in these settings.

Also it is mitigated by our vaccination programme which has always been guided by the expert advice provided by the JCVI[4]. Vaccine uptake amongst older people including care home residents has been consistently high. The 2023 Spring booster programme saw over 82%

[4] JCVI statement on the COVID-19 vaccination programme for 2023: 8 November 2022 - GOV.UK (www.gov.uk)

	of those aged 75 and over and 90.6% of older adult care home residents receive a fourth dose of the COVID-19 vaccine up to July 2023[5]. Vaccination levels among the prisoner population has generally been lower. As per PHS Covid-19 statistical report[6] May 2022, by the 13 April 2022, 73% (1st dose), 64% (2nd dose) and 43% (3rd/booster dose) of those in prison had been vaccinated compared with 73%, 68% and 48% in general population matched controls. The review of testing arrangements in H&SC and prisons settings recommended continued comprehensive efforts at ensuring high vaccination coverage across all settings but that particular efforts may be needed for prison settings. Finally it will be important to emphasise that robust COVID-19 testing will still take place as required clinically and through risk assessment.		
DISABILITY	**1. BACKGROUND – Health Social Care & Prison settings** Disabled people are more likely to experience ill health from contracting COVID-19 than the general population, due to pre-existing health conditions and poorer overall health. Many disabled adults have a range of long-term physical health conditions, such as those affecting the heart and respiratory system, with some people being immunocompromised. This are linked to increased vulnerability to COVID-19[7]. Of the 14,106 people whose deaths were recorded as involving COVID-19 between March 2020 and March 2022, 93% had at least one pre-existing condition[8]. However, the COVID-19 Highest Risk List ended on 31 May 2022 and this was because of the success of the vaccination programme and the availability of new medicines to treat COVID-19 meant that the		

[5] Flu and COVID-19 vaccination uptake in Scotland dashboard - National respiratory infection and COVID-19 statistics 13 July 2023 - National respiratory infection and COVID-19 statistics - Publications - Public Health Scotland
[6] publichealthscotland.scot/media/13184/22-05-11-covid19-publication_report.pdf
[7] https://www.gov.scot/publications/scottish-health-survey-2021-volume-1-main-report/
[8] Deaths involving coronavirus (COVID-19) in Scotland, Report (nrscotland.gov.uk)

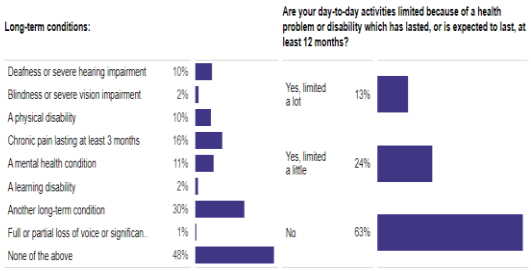
	majority of people on the list were at no greater risk from COVID-19 than the general population. According to the 2021 Scottish Health Survey[9], a third (34%) of adults in Scotland reported living with a long-term condition that limited their day-to-day activities. For people aged 75 and over, 60% had a limiting long-term condition. 1 in 5 Scots identify as disabled, and more than a quarter of working age people have an acquired impairment. People with learning/intellectual disabilities are also at higher risk of severe COVID-19. The Scottish Learning Disabilities Observatory produced research looking at COVID-19 infection and severe outcomes for people with learning (intellectual) disabilities in Scotland[10]. They found that throughout the COVID-19 pandemic, data indicated that people with learning disabilities were more likely to contract COVID-19, have a more severe case of COVID-19, and were at least three times more likely than people without learning disabilities to die from COVID-19. **2. EVIDENCE / DATA** **i) Health and social care settings** Staff in Health Care and Social Care According to NHS staff respondents to iMatter 2022, when it asked "Do you consider yourself to be disabled within the definition of the Equality Act 2010?" 88% responded with 'no', 6% with 'yes' and 6% provided no comment. As per the Scottish Social Services Council (SSSC) social care workforce data 2021, 81% reported a disability, 2% reported no and 17% was unknown.		

[9] https://www.gov.scot/publications/scottish-health-survey-2021-volume-1-main-report/
[10] http://www.sldo.ac.uk/our-research/solutions-focused-research/covid-19-and-intellectual-disabilities/coronavirus-and-people-with-learning-disabilities-study-the-impact-of-the-covid-19-pandemic-on-people-with-learning-disabilities-waves-1-3/

The data on whether workers regard themselves as having a disability is difficult to interpret due to a large proportion of unknown responses.

Source: [SSSC: Workforce data 2021]

<u>People engaging with healthcare services</u>
Health and Care experience survey 2022



<u>Service users in Social Care</u>
People living in care homes are more likely than the rest of the population to have a disability / and or condition as shown in the care home census

Health Characteristic	**2022**
Acquired Brain Injury	758
Alcohol Related Problems	1305
Dementia - Medically Diagnosed	17014
Dementia - Not Medically Diagnosed	1493
Drug-Related Problems	110
Hearing Impairment	2161
Learning Disabilities	2029
Mental Health Problems	2780
Neurological Conditions	2003
Other Physical Disability or Chronic Illness	10341
Requiring Nursing Care	20233
Visual Impairment	3379

None of These	1948

Source: Care home census for adults in Scotland

ii) Prison settings

As of December 2022, ten percent of the people in prisons have reported that they have a disability. Another 87.9% did not report any disability and 2.1% opted not to disclose.

Disability Status	Number
Yes	730
No	6422
Opted not to Disclose	150

Source: Public Information Page (PIP) Quarter 3 20228975_3912 (13).pdf

3. DIFFERENTIAL IMPACT – health social care & prison settings

A higher proportion of people with disabilities and/ or long term conditions access health and social care services. As noted above, the positive impacts of the policy of moving from routine COVID-19 testing of people who use health and social care and prison services to a person-centred risk based approach are that the approach will be based on the needs of individuals rather than a blanket approach.

Routine testing, especially for asymptomatic immunocompromised patients prior to surgery, can lead to delays to surgery and staff returning to work, leaving clinical teams short staffed. At this stage in the pandemic when prevalence is low, vaccination high for example in care home residents and a different clinical picture from the disease, the risks associated with COVID-19 are considerably lower. That said as noted above it will be important to ensure continued

	comprehensive efforts at ensuring high vaccination coverage in national programmes for staff and the population in both wider and closed settings and particular efforts may be needed for prison settings. However there may be perceived negative impacts for people who are disabled and / or are immunocompromised. Some people may be concerned about removal of routine COVID-19 symptomatic testing of staff and asymptomatic testing of patients who are considered immunocompromised prior to surgery. This is because they may perceive that they are more at risk from getting COVID-19, or more at risk of poorer clinical outcomes if they have surgery whilst unknowingly COVID-19 positive. The COVID-19 Highest Risk List ended on 31 May 2022. This was because of the success of the vaccination programme and the availability of new medicines to treat COVID-19 meant that the majority of people on the list were at no greater risk from COVID-19 than the general population. There is advice for people with a weakened immune system as defined under “immunosuppression” in the Green Book Chapter on COVID-19, tables 3 and 4. Some people with a weakened immune system may still be at higher risk from COVID-19. They might not develop the same level of immunity from the vaccination as others, although many do get protection. It will be important that people or their representative in health, social care or prison setting are able to discuss this with their GP or nurse. advice for people with a weakened immune system. As noted above these concerns may be mitigated by staff following ‘stay at home’ guidance if symptomatic. PHS/ ARHAI emphasised that it would be important to consider the messaging for staff who work in these settings. Also it is mitigated by our vaccination programme, although particular efforts will be required to encourage greater uptake among the prison population who often have complex co-		

	morbidities and where the risk of transmission is much higher due to living in such close quarters. Work continues on how we can encourage Covid, flu and routine vaccination in the prison population to keep them safe and protected and to promote the value of immunisation to their health, long after they leave the prison estate. Finally it will be important to emphasise that COVID-19 testing will still take place as required clinically and through risk assessment		
SEX	**1. BACKGROUND – Health social care and prison settings** Evidence from the ONS[11] shows that men are at greater risk of becoming seriously ill or dying from COVID-19 than women, however women's overall wellbeing has been more negatively affected. Men are more likely than women to have certain underlying health conditions which increase clinical vulnerability to COVID-19, including cardiovascular disease, diabetes and ischaemic heart disease[12]. In line with expert advice provided by the JCVI[13], the COVID-19 vaccination programme has been offering primary course and booster vaccinations to protect those at higher risk of severe COVID-19. Additionally, COVID-19 treatments are available for specific groups of people with coronavirus who are thought to be at greater clinical risk. As at July 2023 NHS Scotland may offer additional doses of the coronavirus vaccine to those at higher risk of coronavirus later this year, in line with JCVI advice. Women are disproportionately represented in health and social care occupations[14], with increased risk of exposure to COVID-19. Within the prison population, there are more men (nearly 96% men). Risk of		

[11] Coronavirus (COVID-19) and the different effects on men and women in the UK, March 2020 to February 2021 - Office for National Statistics (ons.gov.uk)
[12] https://www.gov.scot/publications/scottish-health-survey-2021-volume-1-main-report/
[13] JCVI statement on spring 2023 COVID-19 vaccinations, 22 February 2023 - GOV.UK (www.gov.uk)
[14] Scotland's Labour Market: People, Places, and Regions - Statistics from the Annual Population Survey 2019 - gov.scot (www.gov.scot)

	exposure to COVID-19 in health and social settings is mitigated by the fact that testing will still take place as clinically required, alongside other infection prevention and control measures. Additionally, health and social care workers have been eligible for COVID-19 vaccination as advised by the JCVI[15]. **2. EVIDENCE / DATA** **i) Health and social care settings** <u>Staff in Health and Social Care</u> Females account for 78.8% of people employed in NHS Scotland, although this varies between job families, 48.9% of staff in ambulance support services are female compared with 90.0% of staff in nursing and midwifery. Within social care, the workforce has a very high proportion of female staff with only around one in six being male: 83% females, 15% males, 2% unknown. There are some areas where men have a higher representation, namely criminal justice (fieldwork services for offenders and offender accommodation services) and residential children's services (residential child care and school care accommodation), where they can make up around one third or more of people working in those sub-sectors. Non-residential children's services (adoption services, child care agencies, childminders, day care of children and fostering services) have the highest proportion of female workers at 88% or higher. Source: NHS Scotland Workforce Source: SSSC: Workforce data 2021 **Patients/ service users in health and social care** From the health and care cross-sectional survey 2022		

[15] JCVI statement on the COVID-19 vaccination programme for 2023: 8 November 2022 - GOV.UK (www.gov.uk)

	 **ii) Prison settings** As of December 2022, women constitutes 3.63%(265) of the total population and men constitute 96.12% (7019)and are housed in their respective estate. **Source:** Public Information Page (PIP) Quarter 3 20228975_3912 (13).pdf **DIFFERENTIAL IMPACTS** There is no evidence to suggest that individuals are adversely affected by this policy as a result of their sex.		
PREGNANCY AND MATERNITY	**1. BACKGROUND – health social care & prison setting** Pregnant women are at increased risk of severe illness from COVID-19 compared with non-pregnant women[16]. In December 2021 the JCVI added pregnant women to the list of groups considered clinically vulnerable to COVID-19 disease, and hence prioritised for vaccination. In response to this, the Chief Medical Officer for Scotland asked NHS Boards to consider ways to further increase provision of vaccination for pregnant women, for example by establishing dedicated antenatal vaccination clinics. In line with expert advice provided by the JCVI[17], the COVID-19 vaccination programme has		

[16] Coronavirus (COVID-19), infection in pregnancy | RCOG
[17] JCVI statement on spring 2023 COVID-19 vaccinations, 22 February 2023 - GOV.UK (www.gov.uk)

continued to offer primary course and booster vaccinations to those at higher risk of severe COVID-19, including pregnant women. As at July 2023 NHS Scotland may offer additional doses of the coronavirus vaccine to those at higher risk of coronavirus later this year, in line with Joint Committee on Vaccination and Immunisation (JCVI) advice.

Live births per 1,000 women, by age of mother, in Scotland in 2019 is as follows:

Year	Age		
	15-29	30-39	40-44
2019	43.4	71.0	12.8

Source: Data Tables | National Records of Scotland

2. EVIDENCE/ DATA
i) Health & social care settings .

Service users in Health and Social Care

No information available

Staff in Health and Social Care

According to the NHS staff respondents to iMatter 2022, when it asked: 'Have you been on maternity/parental or shared parental leave in the last 12 months?', 3% responded as 'yes', 90% responded as 'no' and 7% provided no answer.

ii) Prison settings

No Information available.

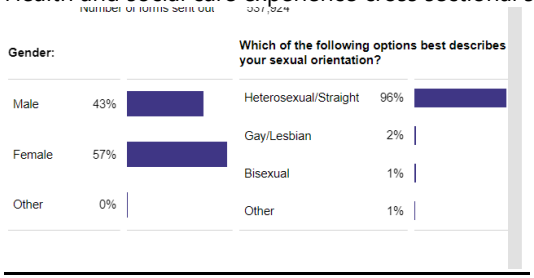
	3. DIFFERENTIAL IMPACTS – Health, social care & prison settings We believe there will be no impacts on women because of pregnancy and maternity. The policy focuses on a person-centred risk-based approach to testing in different settings as was in place pre-pandemic It is not specifically linked to people's pregnancy or maternity status. However when someone is pregnant there may be occupational health risk assessments which may result in them being diverted from a role if considered to have increased risk.		
GENDER REASSIGNMENT	**1. BACKGROUND - health social care & prison settings** Research by the LGBT Foundation on the impact of COVID-19 on LGBT people in the UK found a range of impacts outlined in the section on Sexual Orientation below, also including disruption to trans and non-binary specific healthcare[18]. **2. EVIDENCE / DATA** **i) Health and Social Care settings** Staff According to NHS staff respondents to iMatter 2022, when it asked "Do you consider yourself to be trans, or have a trans history?", 90% responded as 'no', less than 1% responded as 'yes' and 7% provided no answer. **ii) Prison settings**		

[18] LGBT Foundation - Hidden Figures: The Impact of the Covid-19 Pandemic on LGBT Communities

	As of December 2022, there are a total of 15 transgender individuals within prisons comprising around 0.2% of the total populations. **Source:** Public Information Page (PIP) Quarter 3 20228975_3912 (13).pdf **3. DIFFERENTIAL IMPACTS – health, social care & prison settings** There is no evidence that people in health, social care and prison settings who have undergone, are undergoing, or are considering gender reassignment are adversely affected by this policy.		
SEXUAL ORIENTATION	**1. BACKGROUND - health, social care & prison settings** Research conducted early in the pandemic by the LGBT Foundation examined the impact of COVID-19 on LGBT people across the UK[19]. Key issues identified included mental health; isolation; substance misuse; eating disorders; living in unsafe environments; financial impact; homelessness; access to healthcare; and access to support. The removal of pandemic restrictions and the return to a more normal way of life, with reduced isolation and improved social connections and access to services, may have positive impacts for LGBT people. 2% of the Scottish population identified as LGBQ in 2017 (see Sexual orientation in Scotland 2017). **2. EVIDENCE/ DATA** **i) Health and social care settings** Service users in health and social care		

[19] LGBT Foundation - Hidden Figures: The Impact of the Covid-19 Pandemic on LGBT Communities

Health and social care experience cross sectional survey 2022 -



Staff in health and Social Care

According to NHS staff respondents to iMatter 2022, when it asked "Which of the following best describes your sexual orientation?", 88% responded as 'straight/heterosexual', 2% responded as 'gay or lesbian', 1% responded as 'bisexual', 1% 'preferred to self-describe' and 7% provided no answer.

No data available for social care workforce or service users

ii) Prison settings

As of December 2022, the majority of the people in prisons declared themselves as heterosexual, 92.3%. Bisexuals, gay men and gay women comprised 2.1%. Another 3% preferred not to disclose while a further 2.4% were not obtained.

Source: Public Information Page (PIP) Quarter 3 20228975_3912 (13).pdf

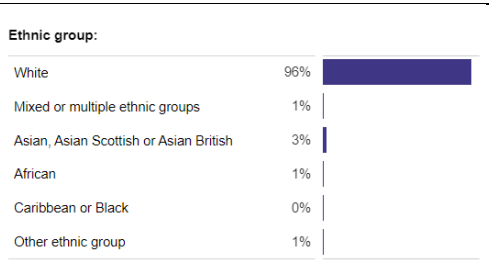
3. DIFFERENTIAL IMPACTS – health, social care & prison settings

	There is no evidence to suggest that individuals working, engaging with or living in health, social care and prison settings are adversely affected by this policy as a result of their sexual orientation.		
RACE	**<u>1. BACKGROUND - health, social care & prison settings</u>** Scottish data have shown an increased risk of serious illness and death from COVID-19 among many minority ethnic groups. This mirrors similar trends seen in other countries of the UK[20]. A report by the UK Cabinet Office's Race Disparity Unit (RDU), drawing on evidence from the Scientific Advisory Group for Emergencies ethnicity subgroup, found that a range of socioeconomic and geographical factors, coupled with pre-existing health conditions, contributed to the higher infection and mortality rates for minority ethnic groups[21]. The RDU reported that the main factors behind the higher risk of COVID-19 infection for minority ethnic groups included occupation (particularly for those in frontline roles, such as NHS workers), living with children in multigenerational households, and living in densely populated urban areas with poor air quality and higher levels of deprivation. Once a person was infected, factors such as older age, male sex, having a disability or a pre-existing health condition (such as diabetes) were likely to increase the risk of dying from COVID-19. The risk of severe COVID-19 is higher for people with certain underlying health conditions. Prevalence of some of these health conditions (including diabetes, coronary heart disease and cardiovascular disease) is known to be higher in certain minority ethnic groups[22]. Vaccination is the best way to protect against the known risks of COVID-19 for those with pre-existing conditions.		

[20] Monitoring ethnic health inequalities in Scotland during COVID-19 (publichealthscotland.scot)
[21] Final report on progress to address COVID-19 health inequalities - GOV.UK (www.gov.uk)
[22] Inequalities by ethnicity in the context of Covid-19 (slide-pack) - gov.scot (www.gov.scot)

	However, although there has been a high uptake of COVID-19 vaccinations in Scotland overall, uptake levels have not been equal across all population groups. Uptake has been lower in most minority ethnic groups, with Polish, Gypsy/Traveller and African groups having particularly low levels of uptake[23]. This could increase inequality in vulnerability to COVID-19. Minority ethnic individuals are over-represented in jobs with increased exposure risks to COVID-19, including health and social care and other key worker roles[24]. Risk of exposure to COVID-19 in health and social care settings is mitigated by the fact that testing will still take place as clinically required, alongside other infection prevention and control measures.. Additionally, health and social care workers have been eligible for COVID-19 vaccination as advised by the JCVI[25] . **2. EVIDENCE/ DATA** **i) Health and Social Care** <u>Staff in health and social care</u> In response to the iMatter 2022 survey, NHS staff identified themselves as; White 90%, Mixed or multiple ethnic groups 1%, Asian, Scottish Asian or British Asian 2%, African, Scottish African or British African %, Caribbean or Black less than 1%, another ethnic group, less than 1% and no answer given was 7% , when asked 'what is your ethnic group?' <u>Service users in Health and Social Care</u> From the health and care cross-sectional survey 2022		

[23] Evaluation of the COVID-19 vaccination programme (publichealthscotland.scot)
[24] Inequalities by ethnicity in the context of Covid-19 (slide-pack) - gov.scot (www.gov.scot)
[25] JCVI statement on the COVID-19 vaccination programme for 2023: 8 November 2022 - GOV.UK (www.gov.uk)



Little data is available about service users in health and social care settings. However National Records of Scotland analysis of population data suggests that “Scotland is becoming more ethnically and religiously diverse, with an increasing number of people who live in Scotland being born outside of the UK”. This greater diversity among the Scottish population, will be reflected in health, social care prison populations. A note of caution around the data as it draws from the 2011 Census.

Source: Census 2011: Key results on Population, Ethnicity, Identity, Language, Religion, Health, Housing and Accommodation in Scotland – Release 2A | National Records of Scotland (nrscotland.gov.uk)

ii) Prison settings

As of December 2022, 94.4% of the prison population declared themselves as white. African comprised 1.1% while Asian, Asian Scottish or Asian British comprised 2%. Those who declared themselves Caribbean or Black were 0.8%. Other Ethnic Group and Mixed or Multiple represented 1.2% and 0.5%, respectively.

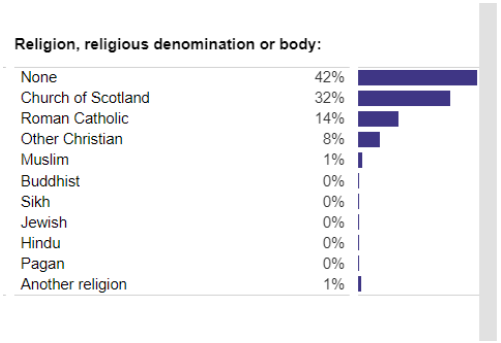
Source: Public Information Page (PIP) Quarter 3 20228975_3912 (13).pdf

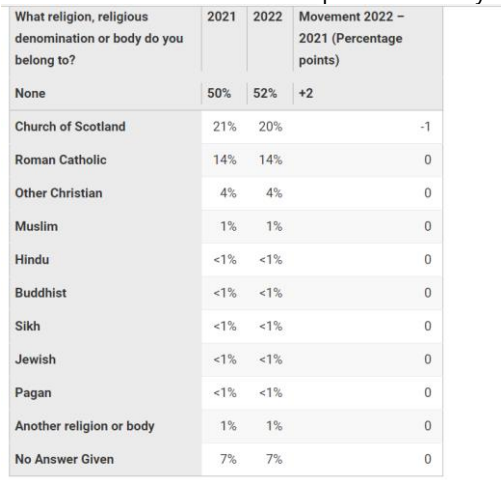
3. DIFFERENTIAL IMPACTS - health, social care & prison settings

	We believe there will be no impacts on people because of their race. The policy focuses on a person-centred, risk-based approach to testing in different settings as was in place pre-pandemic It is not specifically linked to people's race. The engagement with sector representatives across health, social care and prison settings did not reveal any impacts on this characteristic.		
SOCIO-ECONOMIC DISADVANTAGE	**1. BACKGROUND - health, social care & prison settings** Throughout the pandemic people on lower incomes or insecure work, without the protections provided by contractual or statutory sick pay, have been impacted. There are also intersectional considerations, such as the increased risk Black, South Asian or disabled people face with regard to being on lower than average incomes. Social care staff are generally on lower incomes and taking sick leave due to COVID may mean that staff are only paid statutory sick pay. During the pandemic Scottish Government top-up funding (Social Care Staff Support Fund) ensured staff who needed to isolate were paid the real living wage while off sick due to COVID. The fund ended on 31 March 2023. In prisons, majority of the prisoners are from lower socio-economic background and are from most deprived areas of Scotland. **2. EVIDENCE / DATA** **i) health and social care settings** Health care staff Social care staff		

	Social care staff tend to earn have lower wages than other healthcare professions, although Scottish Government funding ensures that staff are paid the real living wage. **ii) Prison settings** The 10% most deprived areas of Scotland accounted for 31% of all arrivals to prison in 2021-22 as per Scottish prison population stats 2021-22. **3. DIFFERENTIAL IMPACTS - health, social care & prison settings** In relation to income, there will be positive impacts; the pause of testing will remove the risk of false positives which would result in individuals having to isolate unnecessarily thereby staff less likely to lose income now that the SCSSF has ended. Staff will need to stay at home if they are symptomatic however, in line with advice for the public and advice generally for other infections.		
RELIGION OR BELIEF	**1. BACKGROUND - health, social care & prison settings** Analysis of data from England and Wales by the ONS[26] indicated that risk of death involving COVID-19 early in the pandemic varied across religious groups, with those identifying as Muslims, Jewish, Hindu and Sikh showing a higher rate of death than other groups. However, for the most part the elevated risk of certain religious groups was explained by geographical, socio-economic and demographic factors and increased risks associated with ethnicity. **2. EVIDENCE/ DATA** **i) Health and social care settings**		

[26] Coronavirus (COVID-19) related deaths by religious group, England and Wales - Office for National Statistics (ons.gov.uk)

	Service users in Health and Social Care Population wide data from census shows that 7% of people did not state their religion and 36.7% of people (1,941,116) said they had no religion. Church of Scotland, 1,717,871, Roman Catholic, 841,053, Other Christian, 291,275, Muslim, 76,737, Hindu, 16,379, Buddhist, 12,795 Sikh, 9,055 Jewish, 5,997 and other religion was 15,196 Source: Religion | Scotland's Census Health and care experience cross sectional survey 2022  Health and Social Care Workforce According to NHS staff respondents to iMatter 2022, when asked 'What religion, religious denomination or body do you belong to?', None was 52% Church of Scotland 20%, Roman Catholic 14%, Other Christian, 4% Muslim 1%, Hindu, Budhist, Sikh, Jewish and Pagan		

	was less than 1%, another religion or body was 1% and no answer given was 7%. Health and Social Care staff experience survey 2022 - cross sectional data.  **ii) Prison settings** No Data available **<u>3. DIFFERENTIAL IMPACTS - health, social care & prison settings</u>** There is no evidence to suggest that individuals are adversely affected by this policy as a result of their religion or faith.		
MARRIAGE AND CIVIL PARTNERSHIP (the Scottish Government does not require assessment against this protected characteristic	**<u>1. BACKGROUND -– health, social care & prison settings</u>** The numbers of marriages and civil partnerships in Scotland in 2019 are as follows: **Year** | **Number of marriages**		

What religion, religious denomination or body do you belong to?	2021	2022	Movement 2022 – 2021 (Percentage points)
None	50%	52%	+2
Church of Scotland	21%	20%	-1
Roman Catholic	14%	14%	0
Other Christian	4%	4%	0
Muslim	1%	1%	0
Hindu	<1%	<1%	0
Buddhist	<1%	<1%	0
Sikh	<1%	<1%	0
Jewish	<1%	<1%	0
Pagan	<1%	<1%	0
Another religion or body	1%	1%	0
No Answer Given	7%	7%	0

unless the policy or practice relates to work, for example HR policies and practices - refer to Definitions of Protected Characteristics document for details)

2019	26,007

Year	Partnerships	Male partnerships	Female partnerships
2019	83	50	33

Source: Data Tables | National Records of Scotland

2. EVIDENCE / DATA

i) Health and Social Care settings

Patients/ Service users
There is no data available for patients/ service users

Health and social care staff

According to NHS staff respondents to iMatter 2022, when asked 'What is your legal marital or registered civil partnership status?' Never married and never registered in a civil partnership was 28%, Married 51%, in a registered civil partnership 1%, Separated, but still legally married 3%, Separated, but still legally in a civil partnership, less than 1%, Divorced 8% and no answer given, 8%.

ii) Prison settings

As of December 2022, majority of the individuals in prisons reported themselves as single 77.9% and 7.5% and 6.8% reported as "cohabitation with a partner" and married, respectively.

Source: Public Information Page (PIP) Quarter 3 20228975_3912 (13).pdf

	3. DIFFERENTIAL IMPACTS - health, social care & prison settings There is no evidence to suggest that individuals working, using or living in health, social care and prison settings are adversely affected by this policy as a result of their marriage or civil partnership status.		

Stage 3: Assessing the impacts and identifying opportunities to promote equality

Having considered the data and evidence you have gathered, this section requires you to consider the potential impacts – negative and positive – that your policy might have on each of the protected characteristics. It is important to remember the duty is also a positive one – that we must explore whether the policy offers the opportunity to promote equality and/or foster good relations.

Do you think that the policy impacts on people because of their age?

Age	Positive	Negative	None	Reasons for your decision
Overall	**X**	**X**		**Potential positive impacts – it will mean testing is not being carried out when there is no need to and prevents false positives thereby reducing the risk of people needing to isolate in those settings, mitigating effects of loneliness. Some potential perceived negative impacts for older people as a result of the policy in that they may feel more at risk, but these are mitigated by vaccination coverage, availability of COVID-19 treatments, testing still taking place based on clinical need and risk assessment, reinforcing of robust infection prevention and control measures and staff will be asked to follow 'stay at home' guidance if symptomatic.**
Eliminating unlawful discrimination, harassment and victimisation			X	No evidence of a differential impact identified at this time
Advancing equality of opportunity			X	No evidence of a differential impact identified at this time
Promoting good relations among and between different age groups			X	No evidence of a differential impact identified at this time

Do you think that the policy impacts disabled people?

Disability	Positive	Negative	None	Reasons for your decision
Overall	**X**	**X**		**Potential positive impacts in relation to guidance changes. It will mean testing is not being carried out when there is no need to and prevents false positives thereby reducing the risk of people needing to isolate in those settings, mitigating effects of loneliness.** **Some potential negative impacts as a result of the policy but these are mitigated by vaccination coverage, availability of COVID-19 treatments, testing still taking place based on clinical need and risk assessment, reinforcing of robust infection prevention and control measures and staff will be asked to follow 'stay at home' guidance if symptomatic.**
Eliminating unlawful discrimination, harassment and victimisation			X	No evidence of a differential impact identified at this time.
Advancing equality of opportunity			X	No evidence of a differential impact identified at this time.
Promoting good relations among and between different age groups			X	No evidence of a differential impact identified at this time.

Do you think that the policy impacts on men and women in different ways?

Sex	Positive	Negative	None	Reasons for your decision
Overall			**X**	**We believe there will be no impacts on people because of their sex. The policy focuses on a person centred risk based approach to testing in different settings as**

				was in place pre-pandemic. It is not specifically linked to people's sex. **The engagement with sector representatives across health, social care and prison settings did not reveal any impacts on this characteristic.**
Eliminating unlawful discrimination			X	
Advancing equality of opportunity			X	
Promoting good relations between men and women			X	

Do you think that the policy impacts on women because of pregnancy and maternity?

Pregnancy and Maternity	Positive	Negative	None	Reasons for your decision
Overall			**X**	**We believe there will be no impacts on women because of pregnancy and maternity. The policy focuses on a person centred risk based approach to testing in different settings as was in place pre-pandemic. It is not specifically linked to people's pregnancy or maternity status.**
Eliminating unlawful discrimination			X	
Advancing equality of opportunity			X	
Promoting good relations			X	

Do you think your policy impacts on people proposing to undergo, undergoing, or who have undergone a process for the purpose of reassigning their sex? (NB: the Equality Act 2010 uses the term 'transsexual people' but 'trans people' is more commonly used)

Gender reassignment	Positive	Negative	None	Reasons for your decision
Overall			**X**	**We believe there will be no impacts on people because of gender reassignment. The policy focuses**

				on a person centred risk based approach to testing in different settings as was in place pre-pandemic. It is not specifically linked to people's gender reassignment.
Eliminating unlawful discrimination			X	
Advancing equality of opportunity			X	
Promoting good relations			X	

Do you think that the policy impacts on people because of their sexual orientation?

Sexual orientation	Positive	Negative	None	Reasons for your decision
Overall			**X**	**We believe there will be no impacts on people because of their sexual orientation. The policy focuses on a person centred risk based approach to testing in different settings as was in place pre-pandemic. It is not specifically linked to people's sexual orientation.**
Eliminating unlawful discrimination			X	
Advancing equality of opportunity			X	
Promoting good relations			X	
			X	

Do you think the policy impacts on people on the grounds of their race?

Race	Positive	Negative	None	Reasons for your decision
Overall			**X**	**We believe there will be no impacts on people because of their race. The policy focuses on a person centred risk based approach to testing in different settings as was in place pre-pandemic. It is not specifically linked to people's race. The engagement with sector representatives across health, social care and prison**
Eliminating unlawful discrimination			X	
Advancing equality of opportunity			X	

Promoting good race relations			X	**settings did not reveal any impacts on this characteristic.**

Do you think the policy impacts on people because of their religion or belief?

Religion or belief	Positive	Negative	None	Reasons for your decision
Overall			**X**	**We believe there will be no impacts on people because of their religion or belief. The policy focuses on a person centred risk based approach to testing in different settings as was in place pre-pandemic. It is not specifically linked to people's religious background. The engagement with sector representatives across health, social care and prison settings did not reveal any impacts on this characteristic.**
Eliminating unlawful discrimination			X	
Advancing equality of opportunity			X	
Promoting good relations			X	

Do you think the policy impacts on people because of their marriage or civil partnership?

Marriage and Civil Partnership[27]	Positive	Negative	None	Reasons for your decision
Overall			**X**	**We believe there will be no impacts on people because of their marriage / civil partnership status. The policy focuses on a person centred risk based approach to testing in different settings as was in place pre-pandemic. It is not specifically linked to people's relationship status. The engagement with sector representatives across health, social care and prison settings did not reveal any impacts on this characteristic.**
Advancing equality of opportunity			X	
Promoting good relations among and between different age groups			X	
Eliminating unlawful discrimination			X	

[27] In respect of this protected characteristic, a body subject to the Public Sector Equality Duty (which includes Scottish Government) only needs to comply with the first need of the duty (to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010) and only in relation to work. This is because the parts of the Act covering services and public functions, premises, education etc. do not apply to that protected characteristic. Equality impact assessment within the Scottish Government does not require assessment against the protected characteristic of Marriage and Civil Partnership unless the policy or practice relates to work, for example HR policies and practices.

Stage 4: Decision making and monitoring

Identifying and establishing any required mitigating action

Have positive or negative impacts been identified for any of the equality groups?	There is no unlawful discrimination identified. However for two equality groups there may be perceived concerns about the removal of the temporary policy of routine testing in health, social care and prison settings. This relates to older people and people with disabilities. While there are positive impacts for all equality groups as it will mean testing is not carried out when there is no need to and prevents false positives, older people and those with disabilities may feel more vulnerable. However this is mitigated by: vaccination coverage; availability of COVID-19 treatments, reinforcing of infection prevention and control measures, robust testing approaches still taking place based on clinical need and risk assessment which is proportionate to the phase that we are currently in; and staff following 'stay at home' guidance if symptomatic. In their review, PHS/ ARHAI emphasised that it would be important to consider reinforcing 'stay at home' messaging for staff who work in these settings and to continue to encourage vaccination uptake especially in prison settings. Therefore in staff communications around the changes to testing, we will reinforce the above messaging and continue to promote vaccination programmes among the relevant populations.
Is the policy directly or indirectly discriminatory under the Equality Act 2010[28]?	No
If the policy is indirectly discriminatory, how is it justified under the relevant legislation?	No
If not justified, what mitigating action will be undertaken?	

[28] See EQIA – Setting the Scene for further information on the legislation.

Describing how Equality Impact analysis has shaped the policy making process

The EQIA has reinforced the need to continue to promote 'stay at home' messaging for staff who work in health, social care and prison settings and to continue to encourage vaccination uptake especially in prison settings. Therefore in staff communications around the changes to testing, we will reinforce the above messaging and continue to promote vaccination programmes among the relevant populations, particularly among the prison population.

Monitoring and Review

We will monitor the impact of the removal of routine COVID-19 testing guidance in health, social care and prison settings. This will involve monitoring Covid-19 data in health, social care and prison settings, continuing to monitor cluster and outbreak data, and the COVID population status as well as stakeholder feedback.

Stage 5 - Authorisation of EQIA

Please confirm that:

- ♦ This Equality Impact Assessment has informed the development of this policy:

  Yes ☒ No ☐

- ♦ Opportunities to promote equality in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation have been considered, i.e.:

  - ○ Eliminating unlawful discrimination, harassment, victimisation;
  - ○ Removing or minimising any barriers and/or disadvantages;
  - ○ Taking steps which assist with promoting equality and meeting people's different needs;
  - ○ Encouraging participation (e.g. in public life)
  - ○ Fostering good relations, tackling prejudice and promoting understanding.

  Yes ☒ No ☐

- ♦ If the Marriage and Civil Partnership protected characteristic applies to this policy, the Equality Impact Assessment has also assessed against the duty to eliminate unlawful discrimination, harassment and victimisation in respect of this protected characteristic:

  Yes ☐ No ☐ Not applicable ☒

Declaration

I am satisfied with the equality impact assessment that has been undertaken for the Review of routine COVID-19 testing guidance in health, social care and prison settings and give my authorisation for the outcome of this assessment to be shared with Scottish Ministers.

Name: Derek Grieve, Daniel Kleinberg, Jason Birch, Catriona Dalrymple
Position: Deputy Directors
Authorisation date: July 2023