**NHS Education for Scotland**

**Equality Impact Assessment Report**

**Name of function, policy or programme:** COVID-19 – shielding SMS service

**NES directorate or department:** NES Digital Service (NDS)

**Name of person(s) completing EQIA:** Helen New, Blythe Robertson

**Individuals or groups contributing to EQIA:** Doug Kidd, Kristi Long, Alistair Ewing, Rafal Chmielarski

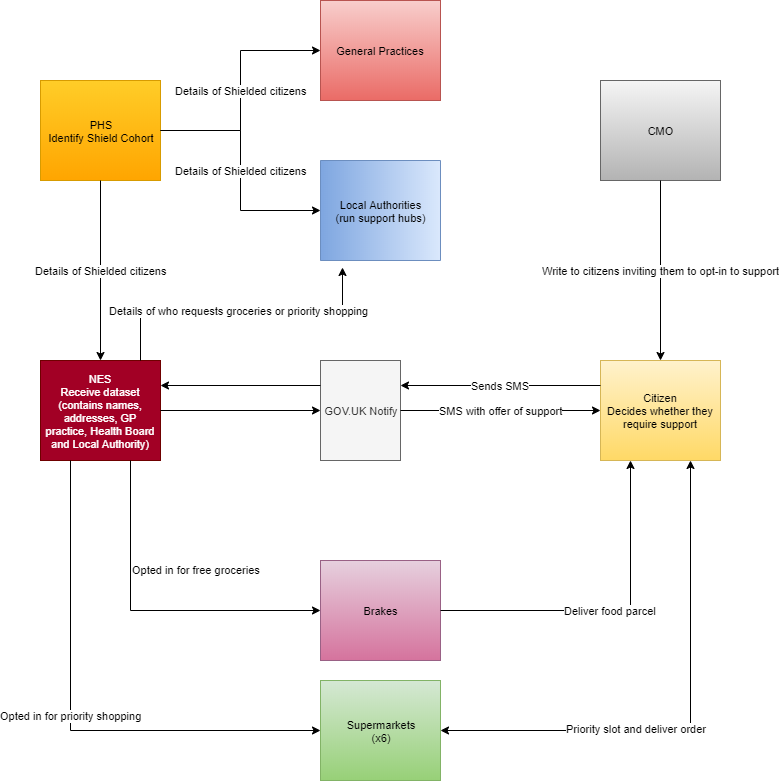
**Date Report Completed:** July/August 2020

**1. Define the function[[1]](#footnote-2)**

1. The national digital platform (NDP) seeks to enhance health and care services across Scotland by ensuring the right information is available to the right people, in the right way, at the right time.
2. At a time of global COVID-19 pandemic, significant consideration has been given to how digital health solutions can be deployed to support improved interaction between people and healthcare services. The development and deployment of simple messaging solution to support a wider shielding service has been identified as a key strand.

1. The Scottish Government have identified the need to have two-way communication with people in the most at-risk group – known as the shielding group – to ensure that they have food and medication while they are staying at home. The Scottish Government also identified the need to provide the very latest, reliable information directly to people so they can use it to protect themselves and self-isolate effectively. An additional requirement emerged to connect people in the shielding group to supermarket priority shopping slots provided by six different supermarket services.

1. The NES Digital Service (NDS) has developed an SMS notification application. The selected provider for the SMS/email gateway is [GOV.UK Notify](https://www.notifications.service.gov.uk/). The intended flow of data is summarised in the diagram, below:



1. The service that has been developed is a generic process that could be used for sending SMS at volume for any stated, valid purpose. As and when the service is extended, there will be a need to revisit this initial equality impact assessment.
2. The scope and duration were unclear at the outset given the fast-moving developments around the pandemic, although it was thought the service would be needed a 12-month period originally identified as the likely period for which initial shielding advice would run.
3. Although it was hard to predict the rate of uptake of the service, an initial 10,000 people quickly signed up for the service. This grew to around 100,000 during the initial shielding period.
4. The function is aimed at addressing information deficits for the most vulnerable and at-risk members of the community at a time of great uncertainty. Improving the efficient distribution of basic food and groceries could have enormous impact for at-risk groups. Accordingly, an initial assessment of equalities impact was undertaken in March 2020, prior to the service going into live running.
5. It was vital that any digital solution could be used by as wide an audience as possible, so needed to be designed to meet very diverse needs. It was important to make the service accessible to those without means of digital interaction or a mobile phone. Accordingly, an additional service was added to allow people to register by phoning their local authority contact centre. Data was then recorded there and sent to NDS to co-ordinate with the delivery partners and supermarkets in the same way as data from the SMS service. This was a key element in making the service as accessible as it could be.
6. At a time when the general population was experiencing a high level of uncertainty and anxiety, a service that more quickly provided access to basic groceries and vital shielding information was likely to have a positive impact, both for clinicians and people.

**2. Evidence used to inform assessment**

1. The focus of evidence gathering has been across three areas: the response to the current pandemic including the shielding approach; digital inequalities more generally; and the interplay between redesigning health processes – often considered the ambit of health literacy and service design in the healthcare context – and supporting them with digital solutions.
2. We examined how the application would meet widely understood and adopted accessibility standards. We undertook research on available materials related to digital inequalities. We also examined design approaches that form part of the wider work of NDS and have been a key part of product development.

**3. Results from analysis of evidence and engagement**

1. Equalities issues have often been poorly considered by digital and technology programmes across the public sector. While there is strong understanding and adherence to equalities legislation and regulation at organisational level, the fragmentation of the approach to technology development – as identified in reports such as the [Expert Panel report](https://www2.gov.scot/Resource/0053/00534667.pdf) on digital health and care in Scotland – has led to a lack of clarity on who is responsible for maintaining high standards of accessibility. This is often heightened by a lack of clarity around “ownership” of parts of processes being supported and the products and tools used to support those processes.
2. The NDS approach to bringing greater consistency to digital services for health and social care means it has an excellent opportunity to address this fragmentation and lack of clarity to create conditions where diverse needs are both recognised and met.
3. The Scottish Government commissioned Healthcare Improvement Scotland to undertake an equality impact assessment of the support required by people who are at clinically higher risk of severe illness from COVID-19. An advanced draft of this is included at Annex A.
4. During the current pandemic period, those people who are most at risk of serious severe illness from COVID-19 are drawn from groups that will have greater or lesser familiarity with both healthcare interactions and digital services. It is a diverse group featuring those most often thought of in the vulnerable population, such as the frail and elderly, but also including those living with respiratory conditions such as chronic obstructive pulmonary disease (COPD), those with compromised immune systems, and those living with rare metabolic diseases.
5. The need to meet communication and support needs across this led to both the choice of SMS as the underpinning technology and the inclusion of a telephone route to accessing the services.
6. As the service has developed over the initial shielding period, a common thread for all has become the elevated need for consideration of what living with your conditions looks like as the current pandemic moves to restart, readjust and reboot phase. In particular, the need to build clearer understanding across the population on the impact of particular behaviours as we move beyond population-level “everyone stay at home” advice, to more nuanced advice linked to risks and mitigations is vital. Careful consideration needs given to the role that collaborative conversations such as those that form part of NDS’ work on an Essential Anticipatory Care Plan (EACP).
7. When documenting equality impacts of a given policy, particularly one with as potentially wide-ranging applicability as shielding, it is important to consider things from a breadth of perspectives. We have an obligation to consider things from viewpoint of protected groups. We know there are also a range of cross-cutting factors that go beyond these groups. We have structured evidence of those issues under an emerging “barriers to access” framework, which sets out challenges from the perspective of the motivations that drive people to engage or not with particular activities.

**Protected characteristics**

1. Equalities impact for the following protected groups was considered as part of the shielding SMS service development:

* age
* disability (for example ongoing respiratory conditions)
* gender reassignment
* marriage and civil partnership
* pregnancy and maternity
* race
* religion or belief
* sex
* sexual orientation

1. While the breadth of the work could impact across most or all of these groups, we looked in detail at **age, disability, race** and **religion.**
2. In terms of **age**, older people within the general population and more specifically the shielding population may experience particular issues. These may include:

* lower levels of digital enablement, with fewer people likely to have access to and/or be proficient in the use of technologies which could support them;
* frailty may lead to lower engagement with the programme due to poorer health and greater sensitivity to stressors;
* there may also be practical issues around participating. These may relate to things like access to technology, but they may relate to other issues – explored in more detail in the next section – related to motivations and willingness to participate.
* maintaining physical and social distancing during the pandemic period may have strong impacts for older people. Aside from the effects of isolation on mental health, practical challenges of daily living – food preparation for example – may have an impact on physical wellbeing. Priorities and preferences around What Matters to You are likely to be impacted by the current constraints on movement and interaction with the community.

1. In terms of **disability** people could experience a number of barriers. These could include:

* information in inaccessible formats or languages. Various accessible formats need to be considered, including plain English, easy read, coloured background (dyslexia), braille, image-driven approaches, BSL and clear verbal communications or tactile communications.
* people with dementia and with neuro-diverse conditions such as autism may feel distressed by interactions with the SMS shielding service. Accommodating these concerns has an applicability to all cases, recognising that healthcare interactions are often intrinsically stressful or anxiety-inducing.
* Again, issues relating to shielding and isolation may create increased practical barriers to supporting everyday health and wellbeing.

1. In terms of **race** people of black, Asian and minority ethnic (BAME) backgrounds may experience particular barriers:

* There is emerging evidence of much greater impact of COVID-19 in terms of infection and mortality in BAME populations. This will have a correlation to socioeconomic factors alluded to above, but we will need to monitor further evidence for additional impacts. It further emphasises the need to design the service to meet a diverse set of needs.
* culturally diverse dietary needs may have been impacted by the current social isolation. This links back the points previously made about the practical challenges to maintaining good physical and mental wellbeing being heightened during the pandemic period.
* There may be a greater number of people for whom English is not a first language. They may therefore be unable to understand any information provided or engage fully in collaborative conversations if services are not designed to be responsive to those needs.
* Black and minority ethnic people are more likely to live in poverty and therefore the issues around digital access noted above could also apply.

1. While **religious belief** plays a strong role in general attitudes to health and care, it is less clear that digital approaches to support this area of practice have a significant positive or negative impact. We know that religious views often have to be considered sensitively during routine healthcare interactions. We need to ensure that this aspect is handled in a highly responsive and sensitive way.

**Design and technology choices**

1. At the start of the development of the SMS shielding service, the required progress to delivery meant that design decisions were focussed around three major constraints:
   * Pace of delivery;
   * Ease of use; and
   * Need to connect with as high a percentage of the shielded group (although the exact composition was not fully understood) as possible.

1. The SMS approach was therefore highly suited given the general coverage of mobile devices using this service – 90% of over 60s, and over 95% of the population have access to this technology.
2. SMS offers significant advantage over a smartphone app, for example. SMS works on all mobile phones, not just smartphones, and as it does not require wi-fi access, has lower data requirements and could be satellite enabled, improving access for those in remote and rural areas.
3. Further benefits of lower data requirements, are highlighted in research from Ofcom into digital marginalisation, suggesting SMS is the most accessible form of communication for those facing socio-economic barriers, are homeless or lack stable housing situations.
4. In addition, we know that SMS is often a preferred route of communication for people living with deafness and hearing loss, as they can customise their devices or use assistive technology to access the content.

**Barriers**

1. For the development of the SMS shielding service, the priority was to rapidly deploy elements from the NDS approach to service design to ensure inclusive, user-centred approaches to involving those directly impacted upon by the implementation of the new product in its design and delivery.
2. A strand that is well-aligned to equalities thinking has started to formulate a series of challenges that relate to what may influence whether people engage with health-related activities. These reflect ongoing discussions with the Government Digital Service (GDS) on this and other topics.
3. These barriers have been identified to help wider considerations about the needs of those interacting with the NDP. They include:

* Enthusiasm
* Emotional states
* Awareness
* Self-confidence
* Access
* Comprehension skills
* Interface & interaction skills
* Trust
* Time
* Evidence
* Finance

1. These have some resonance with the domains of digital inclusion outlined in the [New Zealand government’s blueprint](https://www.digital.govt.nz/assets/Documents/113Digital-Inclusion-BlueprintTe-Mahere-mo-te-Whakaurunga-Matihiko.pdf) which articulates them both as barriers and areas for action.
2. We undertook an analysis against these barriers and how they applied to the SMS shielding service.
3. In terms of **emotional state**, people could experience barriers such as:

* During the current pandemic period, it is likely that those with significant long-term health conditions as part of the shielding group, will feel very isolated due to the lack of social and health care interactions and anxieties around COVID-19 infection risk.
* While everyone is different, it should be expected that the emotional challenges this brings may mean that people feel less resilient.
* However, as the pandemic period progressed we started to gather evidence on experience, particularly via a survey conducted by Public Health Scotland. This showed that 70% of people have reported they are coping OK with staying at home during the current phase.
* Mental health is an area of particular concern, as isolation is a recognised contributor to decreased mental health wellbeing and resilience. Set against the figure of 70% of people feeling they are coping OK with shielding is the fact that 76% of people reported a negative impact on their mental health. The move of mental health support services to an online/digital/telephone options will be a sizeable shift for those previously accessing face to face support.
* Third sector organisations such as Scottish Huntington’s Association, are providing online and telephone support such as ‘[virtual hubs](https://hdscotland.org/sha-takes-action-amid-fears-of-mental-health-crisis-in-scotlands-hd-community/)’ to support the various mental health, financial, caring responsibilities and other challenges in the current situation. Evaluations of these services will be important to track any shifts in preference for service delivery channels.
* Evidence from previous pandemics such as the [2001 UK foot and mouth disease epidemic](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1289318/), highlight the challenges public health emergencies put on mental health and people’s ability to cope with the uncertainties associated.

1. In terms of **awareness**:

* Communication of current advice and guidance on population level behaviours during the pandemic period has become a key part of the SMS shielding service.
* Ensuring messages are written in as accessible language as possible, in line with [Scotland’s health literacy action plan](https://www.gov.scot/publications/making-easier-health-literacy-action-plan-scotland-2017-2025/), has been vital.
* Changes in messaging and health advice, as the pandemic moves through different phases is an area for particular attention. Once messages move beyond short, sharp population-level slogans such as “Stay Home”, conveying effective, tailored advice becomes more complex.
* As new research and evidence emerges, understanding of the interaction of multiple health conditions and factors relating to vulnerability to COVID-19 in different populations will change the guidance people are given. Efforts need to be redoubled to ensure everyone receives clear communication explaining any changes of guidance, what this means to the individual, and what actions need to be taken.
* Awareness of the personal risks and benefits arising from changes in advice and behaviours, should be addressed and supported in collaborative conversations. Again, this has great coherence with our emerging work on EACP.

1. **Self-confidence**, or the lack of it, may be a barrier to engagement. This has many facets to it, some of which have been emphasised during the current pandemic period:

* A decline in self-confidence and self-belief may correlate to lower resilience to uncertainty. Reduced mental and physical health as indirect consequences of shielding and the associated social isolation would be expected to lead to people experiencing lower self-confidence.
* Employment and financial uncertainty may impact self confidence and self-esteem. This is a major concern at the current time for many people. Younger people shielding may have significant concerns around continuing engagement with education or employment. The immediate and longer-term financial effects may affect their self-belief and self-esteem.
* Disability, physical and mental health conditions, particularly long-term ones, can have a range of positive and negative impacts on self-esteem. These alone, aside from social isolation and anxieties, are significant factors in people’s self-belief to understand complex and sensitive subjects, such as future treatment preferences.
* These were all motivating factors in putting the SMS shielding service in place, to provide access to vital supports to those most at risk. It has also raised the bar on the clarity of communication required.

1. **Access** covers many aspects and is both sweeping and nuanced:

* In terms of the digital aspects, much of the existing evidence in relation to digital equalities relates strongly to socio-economic factors – income, status, access to technology devices such as smartphones etc – and location-based factors – network coverage in remote/rural areas (and for ambulances in transit), broadband availability, service accessibility – and digital skills and usage.
* These were major motivating factors in choosing SMS as the technology for the shielding messaging service.

1. **Comprehension skills** are another potential barrier to consider:

* The ability to fully understand spoken advice or written content is fundamental, but we know that there are widespread difficulties. Health literacy statistics are stark on the subject – 43% of people struggling with basic written dosage information rising to 61% when numbers and calculation are included. So this is a population level issue with the burden firmly on the health and care system to make itself more understandable and accessible, in line with Scotland’s [health literacy action plan](https://www2.gov.scot/Resource/0052/00528139.pdf).
* This drove the efforts to ensure messages sent using the SMS shielding service were as clear as possible.
* The inclusion of the local authority contact centres allowed us to provide a more inclusive access route for those for whom SMS was not preferred, digital solutions not available or accessible, or for those with a range of supported communications needs.

1. **Interface and interactions skills** may be experienced as barriers to care planning conversations. These could include:

* Lack of digital skills. A recent [NHS Digital report](https://digital.nhs.uk/about-nhs-digital/our-work/transforming-health-and-care-through-technology/empower-the-person-formerly-domain-a/widening-digital-participation) into widening digital participation highlighted [the most frequent users of the NHS also most likely to be socially as well as digitally excluded](https://digital.nhs.uk/about-nhs-digital/our-work/transforming-health-and-care-through-technology/empower-the-person-formerly-domain-a/widening-digital-participation). [Digital exclusion](https://ilcuk.org.uk/straddling-the-divide-digital-exclusion-during-covid-19-and-beyond/) risks exacerbating existing health inequalities.
* [One in five adults lack basic digital skills](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/796393/Improving_adult_basic_skills_-_equality_impact_assessment.pdf), with age and disability identified in the same report as being the protected characteristic groups disadvantaged most by digital services.
* A [recent SCVO report](https://storage.googleapis.com/scvo-assets/test/digitalparticipation/documents/eds-measuring-understanding.pdf?version=0.0.18) identified the most common reason for not using the internet is a lack of confidence, motivation or understanding. Action is needed to ensure the move to digital services enables participation for all.
* In some instances and stages of conditions, some citizens may not be able to advocate for themselves while at others times they may be well placed to cope. This variation in ability to interact needs to be supported.
* [16% of people age 60-79 use the internet for managing physical and mental health conditions.](https://www.lloydsbank.com/assets/media/pdfs/banking_with_us/whats-happening/lb-consumer-digital-index-2020-report.pdf) Digital engagement is highest in younger adults, with this engagement declining with age.
* For age, a recent [Office of National Statistics report](https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2019) says that 47% of adults aged 75 years and over were recent internet users, set against 95% of adults aged 16 to 74 years. This highlights a fact that lower digital usage is linked to increasing age.
* In terms of disability, the same report says that the number of disabled adults who were recent internet users reached over 10 million for the first time. This represents 78% of disabled adults. We need to factor-in how well represented people living with conditions such as dementia are in disability adult statistics. This may reflect a much lower percentage than that quoted in this study. In addition, as statistics emerge from various initiatives supporting citizen access to health information and services, these may provide more accurate and/or relevant evidence.
* Against this background, a simple service to connect people to vital sources of practical support and ongoing clear information has to be as responsive to their needs as possible.

1. When considering **trust** and [collaborative relationships](https://www.sitepoint.com/4-elements-of-trust-for-collaboration/), four of the most [common elements](https://wellcome.ac.uk/sites/default/files/wtp057474_0.pdf) needed to develop trust are **competence, reliability, integrity and communication**. These have a complex interplay and without any one of these, it can be difficult to create the trust needed for a sustainable trust relationship. People may experience a number of trust barriers to engaging with the SMS service such as:

* Mistrust of the unfamiliar, particularly during a time of great uncertainty. In the main, this was addressed by aligning with official guidance issued by the Scottish Government. It also involved including the term GOV.SCOT at the start of each text message sent. In addition, where possible we minimised the inclusion of link weblinks in text messages, to address any concerns around potential phishing activity.
* There may be a lack of confidence in the technology in terms of protecting personal data.

1. In terms of **evidence**, this barrier could be experienced in a number of ways:

* During the current pandemic period, the question of evidence is somewhat less clear, particularly given the fast-moving pace at which new evidence is emerging.
* In terms of how the current shielding group has been defined, there is evidence that this may not include everyone who is or considers themselves at highest risk. The list of those shielding is likely to change over time. There is a need to be clear on how needs are being prioritised to reduce the stressors of these engagements.
* Differences in public and policymakers’ understanding of the wide range of disabilities, sensory impairments and numerous health conditions leading to the need to shield or isolate have resulted in [situations](https://www.pocklington-trust.org.uk/news/priority-supermarket-deliveries-announced-for-blind-shoppers) such as blind and partially sighted people being [unable to access](https://www.rnib.org.uk/campaigning/campaigning-news/government-plans-expand-shopping-access) priority supermarket deliveries.

1. In terms of **finance**, people may experience barriers such as:

* Additional costs accessing information and services. This could include device and infrastructure barriers to engaging digitally or online.
* In the current pandemic period, consideration has and continues to be given to ensuring services such as the SMS shielding service, use the most economical/least data costly means.
* As the guidance on shielding and managing conditions becomes more nuanced, there may be pressure for those initially isolating, to return to work earlier than they feel appropriate. Impact on income, benefits and other financial support, requires elevated consideration to avoid both anxiety and economic-induced stressors.

**4. Actions taken or planned in response to issues identified in the analysis**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Issue identified** | **Action to be taken in response to issue** | **Responsibility** | **Timescale (indicate whether actions have already been completed, or provide timescale for carrying out the action)** | **Resources required** | **What is the expected outcome?** |
| Need to ensure accessibility standards met | Accessibility factored into the development and release of all messages | SMS shielding service team | ONGOING – a core part of the service | Development time – factored into product management | Product fully meets accessibility standards |
| Need to ensure that experiences with the shielding and of delivery the SMS shielding service information what comes next in terms of communication with the population during the “restart” phase of the pandemic | Document key lessons; continue dialogue with Scottish Government on next steps for shielding more generally and the SMS shielding service specifically | NDS team | ONGOING | Development time – factored into product management | Learning from initial service delivery informs strategic thinking |

**5. Risk Management**

1. In this assessment, have you identified any equality and diversity related risks which require ongoing management? If so, please attach a risk register identifying the risks and arrangements for managing the risks.
2. High-level risks and mitigations have been identified, summarised below:

* The SMS shielding service fails to meet user needs due to accessibility issues.

**Mitigation** – accessible design principles adopted into application development.

**Mitigation** – readability reviews a key part of message development and release

* Users of the SMS shielding service do not have the required digital skills to use the application

**Mitigation** – user-focussed design principles adopted in choice of technology

**Mitigation** – highly accessible and widely used technology used to deliver the service

**Mitigation** – further access channels provided through local authority contact centres

**6. Consideration of Alternatives and Implementation**

1. The requirement to meet the needs of a diverse population drove the initial technology choice then how it was implemented. Various more complex, technically more sophisticated solutions were considered but rejected in favour of the simplicity and accessibility of SMS.

**7. Monitoring and Review**

1. This EQIA is a continuing part of the documented output from NDS’ wider programme of equalities activity. It sits as part of the NDS compliance approach, which documents various aspects of impact activity (clinical safety review, data protection impact assessment, system security protocol etc) to ensure that NDS products meet a series of quality criteria.
2. Both the compliance and equalities strands are ongoing parts of NDS activity, with continuous improvement, regular monitoring and review a core part of the work.
3. Continuous monitoring against standards (such as accessibility) will be undertaken as part the product release strategy.

**Sign off (by accountable director):**

**Geoff Huggins**

14 August 2020

Annex A – Healthcare Improvement Scotland EQIA of shielding policy approach

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**An Equality Impact Assessment of**

**The support required by people who are at clinically higher risk of severe illness from COVID-19 (Shielding Programme)**

**01 April 2020**

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1. **Introduction**

Public bodies are required to assess the impact of applying a proposed new or revised policy, against the needs of the general equality duty, namely the duty to:

* Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act 2010;
* Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
* Foster good relations between people who share a protected characteristic and people who do not share it

The relevant protected characteristics are:

* age
* disability
* gender reassignment
* pregnancy and maternity
* race
* religion and belief
* sex
* sexual orientation
* marriage and civil partnership (relates to the elimination of discrimination only)

The recommendations made in this report seek to improve equality and to help meet the specific needs of all people who are at clinically higher risk of severe illness from COVID-19 (Shielding Programme), where possible. In Scotland this is estimated to be up to 200 000 people.

This assessment also considers if the ways in which support is provided to people at clinically higher risk of severe illness from COVID-19 has the potential to impact on health inequalities.

Health inequalities are disparities in health outcomes between individuals or groups. Health inequalities arise because of inequalities in society, in the conditions in which people are born, grow, live, work, and age.

Health inequalities are influenced by a wide range of factors including access to education, employment and good housing; digital readiness; equitable access to healthcare; individuals’ circumstances and behaviours, such as their diet and how much they drink, smoke or exercise; and income levels.

The potential impact of the support provided to people at clinically higher risk of severe illness from COVID-19 on an individual’s human rights has also been considered.

Giving due regard to these factors is also intended to help meet the Fairer Scotland Duty, which requires public bodies to reduce inequalities of outcome caused by socioeconomic disadvantage.

**2. Aim/Purpose of the** national and local programme of support to people at clinically higher risk of severe illness from COVID-19

The purpose of the programme is to ensure that support is provided to people at clinically higher risk of severe illness from COVID-19, by ensuring that they continue to receive essential medicines and food.

The people who have been identified to be at clinically higher risk by the UK Chief Medical Officers are:

1. Solid organ transplant recipients
2. People with specific cancers
   1. People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer
   2. People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
   3. People having immunotherapy or other continuing antibody treatments for cancer
   4. People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
   5. People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs.
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD
4. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell)
5. People on immunosuppression therapies sufficient to significantly increase the risk of infection
6. People who are pregnant with significant heart disease, congenital or acquired.

In Scotland it is estimated that there are around 200 000 people in the group that are at clinically higher risk if they contract COVID-19. Letters are going out to people advising them to strictly self-isolate, avoid contact with anyone with COVID-19 symptoms and to stay home and minimise contact with other people in their household. They should not go out for shopping or medication and should arrange for delivery to the doorstep to minimise contact. They should make use of telephones and technology to keep in touch with people and to contact GP or other essential services.

Not everyone who falls into this category will need support as many will have their own support structures through family, friends or neighbours. However many will not have their own support structures and therefore it is necessary to assess individuals’ needs to ensure support is provided.

Scottish Government intend that this will be done in 3 ways:

* By setting up a national SMS text messaging service that allows 2 way exchanges with individuals to establish need
* By using data from these exchanges to share with Local Resilience Partnerships
* By the Local Resilience Partnerships themselves setting up local phone lines to allow contact with people to make their own local assessment of needs

Scottish Government and the Local Resilience Partnerships will co-ordinate support to people in these groups who have been advised to remain at home for 12 weeks and who may not have family members or others who can collect medicines or do essential food shopping for them.

It is intended to ensure that people have free basic supplies of food during the first few weeks and at this stage this is being offered without providing a choice or tailoring contents to take account of dietary restrictions, allergies, cultural or religious requirements.

This needs assessment is intended to support Local Resilience Partnerships to gather information from those for whom they will be co-ordinating food deliveries, so that essential supplies are available to all who require them and so that they best meet their needs.

**3. Assessment of impact**

The policy is intended to impact all people living with the conditions outlined above. These conditions affect people with a diversity of characteristics and so we expect this policy to impact within each protected group. Below is an outline of specific equality considerations identified. These are organised by protected group, with cross-cutting issues highlighted underneath.

**Sex**

There may be a particular consideration around accessing victims of domestic violence (DV), who are most likely to be women. Women who are disabled or have long-term health conditions – including those this policy is targeted at – are at even greater risk of DV. DV organisations have warned of an increase in DV during lockdown conditions. DV can include withholding resources and restricting access to goods and services and the means of communicating with others. Scottish Government has provided special guidance for people who are experiencing domestic violence during the COVID-19 pandemic.

**Age**

Older people within the beneficiary groups may experience particular issues, including:

* **Digital enablement** – fewer are likely to have access to and/or be proficient in the use of technologies which could support them at this time.
* **Frailty** may lead to lower engagement with the programme due to poorer health and greater sensitivity to stressors.
* There may also be **practical issues** around participating. For example, the letter issued very clearly directs carers/visitors to leave items at the door and to minimise contact. Many older people will be physically unable to lift deliveries into their home and put them away safely.
* Older people may struggle with **food preparation** – particularly if they are concerned about maintaining social distancing and/or have a reduced or volatile care network due to illness in family/friends/neighbours or the pressures of local health and social care organisations.

**Disability**

Disabled people could experience a number of barriers to engaging with the programme. These include:

* Information issued by the programme may be inaccessible to some disabled people, including Deaf users of British Sign Language (BSL), Deafblind people, blind people, people with learning disabilities and people with dyslexia. Accessible formats which may need to be considered include: Plain English, Easy Read, coloured background (dyslexia), braille, BSL and clear verbal communications or tactile communications.
* People with dementia and with neuro-diverse conditions such as autism may feel distressed around the expected timing of a delivery, who will be making the delivery and/or who will assist with taking the delivery into the home – specifically because the situation will be unexpected and unfamiliar.
* Disabled people are less likely to have regular access to the internet and are more likely to be living in ‘poorer’ households (disability employment gap/more likely to be getting Employment and Support Allowance) where phone services are also restricted (pay as you go, instead of contract).
* There may also be practical issues around participating. For example, the letter issued very clearly directs carers/visitors to leave items at the door and to minimise contact. Some disabled people will be physically unable to lift deliveries into their home and put them away safely.
* Food preparation may be an issue, particularly if the shielding person is without support from family / friends / neighbours / social care organisations, and / or is alarmed by the social distancing measures advised in the letter.
* Some disabled people may eat specific diets in order to manage their condition. In some cases, failing to provide food that is suitable could result in illness, malnutrition, hospitalisation or non-compliance with the shielding measures outlined.
* Some disabled people may have experienced disability hate crime/local harassment and feel that leaving food or medicines on their doorstep makes them more vulnerable.
* As a result of mental illness, learning disability, dementia or communication difficulties some disabled people may be unable to understand and/or respond to the letter and its directions.

**Race**

People who are black or from minority ethnic backgrounds may experience particular barriers:

* Racially aggravated hate crime is the most frequently recorded category of hate crime in Scotland. Therefore, where people feel vulnerable they may be concerned that leaving food or medicines on their doorstep makes them more vulnerable.
* Diets differ culturally and people may respond less well to standard Western ingredients that are not easily adaptable across cultures. This could result in poorer health outcomes and introduce the risk of non-compliance with the shielding measures advised.
* There may be a greater number of people for whom English is not a first language. They may therefore be unable to understand the information sent and engage with it fully.
* Black and minority ethnic people are more likely to live in poverty and therefore the issues around digital access noted above could also apply.

**Religion or belief (diet/prejudice)**

* Some religions mandate particular dietary restrictions e.g. halal or kosher.

**Pregnancy and maternity**

* Some pregnant people and new parents will be eligible for the Scottish Government’s Healthy Start initiative, meaning consideration should be given as to how these two initiatives work together.
* A pregnant lone parent may be physically unable to lift packages into the home and put items away safely (underlying heart condition, bump, round ligament / pelvic girdle / back issues) and may require different or additional items.

**Sexual orientation**

* Lesbian, gay and bisexual people experience hate crime and may feel it is less safe to leave items on their doorstep where they have been victimised within their neighbourhood.
* Lesbian, gay and bisexual people are more likely to be isolated from their families and therefore more likely to require the help offered. The practicalities noted for disabled and older people above may be conflated for lesbian, gay and bisexual disabled or older people due to homophobic / biphobic attitudes and abusive behaviours from carers or support staff.
* LGB people may also experience homophobic / biphobic attitudes within a family home, which will make them vulnerable.

**Gender reassignment**

* Trans people experience hate crime and may feel it is less safe to leave items on their doorstep where they have been victimised within their neighbourhood. They may be feeling especially vulnerable within their community due to a recent rise in transphobic hate crime.
* Trans people are more likely to be isolated from their families. The practicalities noted for disabled and older people above may be conflated for trans disabled people and older trans people due to transphobic attitudes and abusive behaviours f from carers or support staff.
* Trans people may also experience transphobic attitudes within a family home, which will make them vulnerable.

General and cross-cutting issues are as follows:

* **Communications / identification of affected individuals**

For some disabled people, older people and people from BME backgrounds or minority language groups, information will need to be provided in accessible formats (outlined above) in order to ensure uptake.

It should also be considered that people who are eligible may not engage immediately, and may lose the information about how to access support, while some people who are eligible may not have taken in the information and be able to act on it.

* **Special dietary requirements.**

In relation to protected characteristics, these are most likely to apply to people practicing certain religions, some disabled people including people with diabetes, and pregnant people. However, across all characteristics a proportion of people are likely to follow vegetarian/vegan diets, and have food allergies/intolerances/sensitivities. It will be important to cater as far as possible to these requirements in order to avoid poorer health, malnutrition and non-compliance with social distancing advice.

There may additionally need to be consideration for the composition of households and care arrangements. If the vulnerable person is also a carer or parent and does not have other support in place, they may require additional or different items. Some disabled people may have increased need for certain everyday items to help manage their condition(s).

* **Health literacy**

The stress of the current COVID-19 environment has added to the existing conditions of the individuals who are supported by this programme, as well as the nature of communications may mean that some people find information more difficult to engage with or absorb, and as a result may not engage, or else engage later.

* **Digital enablement**

Digital enablement is an issue for both older people and disabled people, as well as for any person living in poverty. It will be important to offer a range of ways that people can access this programme as well as other support services.

* **Poverty**

People living in poverty have less access to the internet and phone services.

Social distancing to the extent advised in the letter is less practically possible for people living in poverty. The letter suggests actions such as separate beds and towels and increases in cleaning activity. People may lack a range of resources (products, access to a washing machine/dishwasher/spare bed etc) that would enable this. It is likely to cause stress and anxiety and may result in increased enquiries or contribute to health literacy issues. Likewise, and with some overlap between the groups, disabled people may also find this too demanding or impracticable and experience heightened health concerns as a result.

While the shielding programme aims to support a specific group of individuals who are highly vulnerable to COVID-19 other individuals in the community will also be vulnerable and lack essentials. There is a risk that leaving essentials on a person’s doorstep may encourage theft and create a barrier to the targeted person receiving help.

* **Safety**

There are safety issues relating to the security of leaving household items, food and medicines on people’s doorsteps. These arise in relation to social victimisation as well as the needs of other people who are not being targeted as part of this shielding programme and who may appropriate unattended items.

* **People living in temporary accommodation**

Victims of domestic violence who are living in refuges, homeless people and people with insecure leases may need particular consideration in terms of what to do if there is a change of address during the period that shielding is being advised

**4. Recommendations for change**

The following actions are recommended.

1. **Communications**

Scope the variety of ways in which people identified for shielding may require the information, identify individuals who require information in alternative formats and provide this. Formats required may include:

* Easy Read (people with learning disabilities and health literacy issues)
* BSL (Deaf people)
* Braille (blind people)
* Clear verbal communication or tactile communication (Deafblind people)
* Alternative languages as appropriate (people for whom English is not a first language)

Consider opportunities to disseminate information about the programme through diverse channels and on multiple occasions. This could include, for example, local and national radio and TV as well as in different phases of the programme.

Consider ways of enabling a wider variety of contact methods and providing information about the different channels for getting support (e.g. breathing space operates a phoneline as well as online resource).

Alongside the local resilience partnerships, Disabled People’s Organisations (DPOs), disability organisations and other relevant third sector organisations providing local-level support may be able to help identify individuals who have received a letter. They may also be able to help collect intelligence to inform improvements in the programme as it continues.

Create and communicate a mechanism through which individuals identified by the programme can register a change of address.

1. **Dietary requirements and food preparation**

As early as possible, avoid including known and popular allergens such as nuts and eggs.

As early as possible, include foods with universal appeal such as rice, pasta, vegetables and fruits. Note that non-alcohol vegan items are halal, and most vegan items are kosher.

As early as possible, include foods that can be easily prepared by people who may have minimal resources/assistance including the provision of freshly-prepared ready meals which can be frozen for later use.

Enable people to notify the programme where items they have received are unsuitable, and suggest an appropriate replacement. This may include, for example, requests for dairy milk to be replaced with a non-dairy alternative and for gluten containing products to be replaced with gluten free ones.

Consider how the programme links with the Healthy Start scheme.

1. **Health literacy**

Follow up with people who have received a letter in order to discuss concerns, provide reassurance, scope potential issues and sign-post to other relevant services.

1. **Digital enablement**

Provide a broader range of contact details within the second letter. For example, the first letter sign-posts support organisations. However, with the exception of Age Scotland, only web addresses are provided.

Those contacted about shielding should be advised as to whether the phone number (text response of automated helpline) is free in order to ease anxiety and access. Tablets or other devices provided to people to support their digital access should be internet enabled for a suitable duration. This is especially important where people may be living in poverty.

Form links with the ‘No-one left behind in a digital Scotland’ project to increase the capacity of those receiving digital support to benefit fully from the Shielding Programme.

1. **Poverty**

Follow up with people who have received a letter in order to discuss concerns, provide reassurance, scope potential issues and sign-post to other relevant services.

Scope ways to alert people to the estimated delivery time of their box.

1. **Safety**

Provide the option for people to notify the programme if they feel they are unable to safely receive items that have been left on their doorstep, and consider how those delivering items can safely assist.

Scope ways to alert people to the estimated delivery time of their box and to provide some information about who will be making the delivery / who will assist them. This could include the use of a password system such as those set up by large providers such as British Gas, etc. In some cases it could also include agreement of a ‘safe place’ as is used by delivery companies currently.

Ensure that PVG or safety checks are carried out on those who may be in direct contact with the shielding individuals identified as part of the programme.

It is not believed the changes recommended will create any new, adverse, impacts.

**5. Monitoring and review**

**NOT COMPLETED for v0.4 on 02/04/2020**

**6 Who carried out the impact assessment**

The impact assessment of was carried out by

**EQIA v0.4 completed by Rosie Tyler-Greig**

**EQIA reviewed by -**

**7. Contact Information**

If you have any comments or questions about this report, or if you would like us to consider producing this report in an alternative format, please contact our Equality and Diversity Advisor:

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1. In this document, 'function' is used broadly to cover all the areas of work for which impact assessment is required, as defined in the Regulations. This includes policy, programme, project, service and function, among others. [↑](#footnote-ref-2)