Business Services Organisation

Providing Support to Health and Social Care

Equality and Human Rights Screening Template

The BSO is required to address the 4 questions below in relation to all its policies.

What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor/major/none)

Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

As part of the audit trail documentation needs to be made available for all policies and decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

For information (evidence, data, research etc.) on the Section 75 equality groups see the Equality and Human Rights Information Bank on the BSO website:
http://www.hscbusiness.hscni.net/services/1798.htm

For advice and support on screening contact:
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Belfast BT2 8DQ

Tel: 028 9536 3814/ 9536 3023
email: Anne.Basten@hscni.net or Karen.Beattie@hscni.net

SCREENING TEMPLATE

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template.

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Guidance for Line Managers: COVID-19 / Long COVID Absence Support Process

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example financial, legislative or other)**

As part of the emergency response to the current COVID-19 pandemic, HSC employers in conjunction with Department of Health (DoH) introduced temporary workforce guidance as part of its strategy to support the response to COVID-19.

To support infection control measures, DoH introduced a temporary enhanced provision of 'COVID-19 Sick Pay' to financially support staff, as a short term measure, who require time off work when they are ill with COVID-19. At the time the workforce guidance was introduced it was not anticipated that COVID-19 would lead to long term sickness absence, referred to as Long COVID. As we continue to understand Long COVID, research shows one in ten people reporting symptoms beyond 3 weeks.

We are aware that within the HSC there is a number of staff who continue to suffer long term illness due to COVID-19 resulting in long term absence from work or several periods of intermittent absences from work.

To help clarify the wording and intent of the DoH guidance, the Regional HSC Absence Leads have produced guidance for Line Managers to support employers with the management of long term COVID-19 sickness absences.

This guidance highlights key principles in managing Long COVID and outlines the support process Line Managers should follow to support the effective management of sickness attributable to Long COVID and facilitate the return of individuals back to the workplace, where possible in accordance with their absence procedures.

Possible Constraints:

- Impact on service provision due to absence of staff with COVID-19/Long COVID

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

HSC Employees
Managers of all Levels in HSC
Regional and Local Trade Union Side and BMA
DoH
Service Users

1.4 Other policies or decisions with a bearing on this policy or decision

- **what are they?**
- **who owns them?**

Policies & Procedures:

- Attendance at Work Policy
- Attendance at Work Procedure

All owned by BSO.

Regional HSC Covid Q&A – owned by Regional HR / PHA colleagues

Department of Health: At the time of writing this guidance, the current COVID-19 Sick Pay arrangements remain unchanged in that employees who remain absent due to COVID-19 continue to be recorded as “Public Service Duties Paid” and this will not count towards absence triggers. This arrangement will remain under review by the Department of Health.

Disability Discrimination Act (DDA) 1995

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

Regional HSC Absence Leads have produced this guidance to support employers with the management of long term COVID-19 sickness absences**,** through agreement with Regional Staff Side Leads agreed with Trade Union Side and HSC Organisations. Additionally consultation with Occupational Health was used to inform guidance.

Workforce Data (HRPTS)

NI HSC Workforce Census March 2020 (health-ni.gov.uk)

coronavirus-related-health-inequalities (health-ni.gov.uk)

Office for National Statistics (ONS). (May 2021) Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 4 June 2021. Available at https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/4june2021#prevalence-according-to-socio-demographic-characteristics

Rubin, R. (2020) As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts. Medical News and Perspectives (Sep 23, 2020). Available at: As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts | Infectious Diseases | JAMA | JAMA Network.

Evans RA, McAuley H, Harrison EM, et al; (2021) PHOSP-COVID Collaborative Group. Physical, cognitive and mental health impacts of COVID-19 following hospitalisation: a multi-centre prospective cohort study. MedRxiv (March 24 2021). Available at: Physical, cognitive and mental health impacts of COVID-19 following hospitalisation – a multi-centre prospective cohort study | medRxiv

Torjesen, I. (2021). COVID-19: Middle aged women face greatest risk of debilitating long term symptoms. BMJ, 2021;372:n829. Available at: **Covid-19: Middle aged women face greater risk of debilitating long term symptoms | The BMJ**

The Observer (2021). Why are women more prone to Long Covid? Pub 13 June 2021. Available at**: Why are women more prone to long Covid? | Long Covid | The Guardian**

TUC (2021) Workers' experience of long Covid. Available at: **Workers' experiences of long Covid | TUC**

ACAS. Long COVID – advice for employers and employees. Available at: https://www.acas.org.uk/long-covid

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both. Also give consideration to multiple identities.

ONS data shows that as a proportion of the UK population, prevalence of self-reported long COVID was greatest in people aged 35 to 69 years, females, those living in the most deprived areas, those working in health or social care, and those with another activity-limiting health condition or disability.

Category	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	**Staff Profile – BSO (March 2021)** Male 44.23% Female 55.77% Unknown 0.00% **Coronavirus Related Health Inequalities – DOH (May 2020)** The rate among females (308 cases per 100,000 population) was a third higher than males (234 cases per 100,000 population). Of those that tested positive to a laboratory completed test, more than a quarter (27%) were admitted to hospital for treatment, with males that tested positive being twice as likely to be admitted as females. While acute cases of Covid-19 – particularly those hospitalised with the disease – tended to be mostly male, long Covid sufferers were, by contrast, mainly female. Females were 1.3 times more likely to report long COVID than males. ONS data show that people working in the health and social care sector are more likely to report long COVID than those working in other sectors. Again, women tend to be over-represented in HSC sector in NI. **Population profile:** **Census 2011:** The proportion of females in 2011 is 51.00% (923, 540). The male population is 49.00% (887, 323) in 2011.

<table>
<tr><td></td><td>Mid-year population estimate (2018; published June 2019):

The size of the resident population in Northern Ireland at 30 June 2018 is estimated to be 1.88 million people. Just over half (50.8 per cent) of the population were female, with 955,400 females compared to 926,200 males (49.2 per cent).

https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/MYE18-Bulletin.pdf

• The Gender Identity Research and Education Society (GIRES) estimate the number of gender nonconforming employees and service users, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014):
○ gender variant to some degree 1%
○ have sought some medical care 0.025%
○ having already undergone transition 0.015%

The number who have sought treatment seems likely to continue growing at 20% per annum or even faster. Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age. Yet, presentation for treatment among young people is growing even more rapidly (50% p.a.). Organisations should assume that there may be nearly equal numbers of people transitioning from male to female (trans women) and from female to male (trans men).

Applying GIRES figures to NI population (using NISRA mid-year population estimates for June 2018) N=1,881,600:

• 18,816 people who do not identify with gender assigned to them at birth
• 470 likely to have sought medical care
• 282 likely to have undergone transition.</td></tr>
<tr><td>Age</td><td>Staff Profile – BSO (March 2021)

<table>
<tr><td>0-15</td><td>0.06%</td></tr>
<tr><td>16-24</td><td>3.55%</td></tr>
<tr><td>25-29</td><td>9.26%</td></tr>
<tr><td>30-34</td><td>12.94%</td></tr>
<tr><td>35-39</td><td>13.45%</td></tr>
<tr><td>40-44</td><td>14.91%</td></tr>
<tr><td>45-49</td><td>12.75%</td></tr>
<tr><td>50-54</td><td>14.28%</td></tr>
<tr><td>55-59</td><td>12.31%</td></tr>
<tr><td>60-64</td><td>4.95%</td></tr>
<tr><td>>=65</td><td>1.52%</td></tr>
</table>
</td></tr>
</table>

Coronavirus Related Health Inequalities – DOH (May 2020)

Seven out of ten persons aged 65 and over that tested positive were admitted to hospital compared with just 16% of those aged 25 to 64 year.

The standardised infection rate among those aged over 65 in the 10% most deprived areas (1,027 cases per 100,000 population) was almost two-fifths higher than the rate in the 10% least deprived (750 cases per 100,000 population) and almost three quarters higher than the NI average (598 cases per 100,000 population)

The standardised infection rate among those aged 65 and under in the 10% most deprived areas (222 cases per 100,000 population) was not significantly different from the rate in the least deprived (212 cases per 100,000 population) but was 15% higher than the NI average (192 cases per 100,000 population).

Although research into long-covid is still relatively rare, studies from 2020 suggest that the average age was around 40, and women afflicted by the longer-term effects of Covid-19 outnumbered men by four to one.

2021 ONS data shows that as a proportion of the UK population, the prevalence of self-reported long COVID resulting in activity limitation was greatest in people aged 50 to 69 years (1.06% for limited a little and 0.51% for limited a lot) and 35 to 49 years (1.01% for limited a little and 0.45% for limited a lot).

Population profile:
Mid-year population estimates published by NISRA in 2019 show that:

0-19 yrs (inclusive) = 485,064 (25.7% of all NI population)
20 – 34 yrs = 364,623 (19.3%)
35 – 49 yrs = 366,967 (19.5%)
50 - 64 yrs = 356,790 (19.0%)
65 – 74 yrs = 169,725 (9.0%)
75 – 89 yrs = 125,334 (6.6%)
90+ yrs = 13,138 (0.7%) https://www.nisra.gov.uk/statistics/population/mid-year-population-estimates

Age projections

NISRA Estimated and projected population by age, mid-2016 to mid-2041 show that in 2016, 20.8% of the NI Population were aged 0-15 years, and this is projected to decrease 18.2% in 2041. The proportion of adults aged 16-64 in 2016 was 63.2% of the whole population, set to decrease to 57.2 by 2041. However, the proportion of people aged 65 years and over is projected to rise

	from 16.0% in 2016 to 24.5% in 2041, overtaking the numbers of children. https://www.nisra.gov.uk/publications/2016-based-population-projections-northern-ireland-statistical-bulletin-charts

Religion	**Staff Profile – BSO (March 2021)** Perceived Protestant: 2.16% Protestant: 29.00% Perceived Roman Catholic: 2.47% Roman Catholic: 40.04% Neither: 5.33% Perceived Neither: 0.00% Not assigned: 21.00% **Population profile:** Religion or Religion brought up in • 45.14% (817, 424) of the population were either Catholic or **brought up** as Catholic. • 48.36% (875, 733) stated that they were Protestant or **brought up** as Protestant. • 0.92% (16, 660) of the population belonged to or had been **brought up** in other religions and Philosophies. • 5.59% (101, 227) neither belonged to, nor had been brought up in a religion. (Census 2011)
Political Opinion	**Staff Profile – BSO (March 2021)** Broadly Nationalist: 4.06% Other: 5.01% Broadly Unionist: 4.57% Not assigned: 79.82% Do not wish to answer: 6.54% **Population profile:** **Nationality** • British only – 39.89% (722, 353) • Irish only – 25.26% (457, 424)

<table>
<tr><td></td><td>

Northern Irish only – 20.94% (379, 195)
British and Northern Irish only – 6.17% (111, 730)
Irish and Northern Irish only – 1.06% (19, 195)
British, Irish and Northern Irish – 1.02% (1847)
British and Irish only – 0.66% (11, 952)
Other – 5.00% (90, 543)

(Census 2011)
</td></tr>
<tr><td>Marital Status</td><td>
Staff Profile - BSO (March 2021)
<table>
<tr><td>Divorced</td><td>2.47%</td></tr>
<tr><td>Mar/CP</td><td>41.88%</td></tr>
<tr><td>Other</td><td>0.95%</td></tr>
<tr><td>Separt</td><td>0.57%</td></tr>
<tr><td>Single</td><td>15.80%</td></tr>
<tr><td>Unknown</td><td>37.31%</td></tr>
<tr><td>Widw/R</td><td>0.82%</td></tr>
<tr><td>Not assigned</td><td>0.19%</td></tr>
</table>
Population profile:

47.56% (680, 840) of those aged 16 or over were married
36.14% (517, 359) were single
0.09% (1288) were registered in same-sex civil partnerships
9.43% (134, 994) were either divorced, separated or formerly in a same – sex partnership
6.78% (97, 058) were either widowed or a surviving partner

(Census 2011)

Northern Ireland Life and Times (2018)
Single (never married) 32%
Married and living with husband/wife 51%
A civil partner in a legally-registered civil partnership 0%
Married and separated from husband/wife 3%
Divorced 6%
Widowed 7%

Civil partnerships
Annual Reports of the Registrar General for NI show that Between 2005 and 2018 inclusive, there have been 1298 civil partnerships registered in NI. (Available at https://www.nisra.gov.uk/statistics/births-deaths-and-marriages/registrar-general-annual-report)
</td></tr>
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Dependent Status

Staff Profile - BSO (March 2021)

Yes	12.18%
Not assigned	79.57%
No	8.25%

Population profile:
CarersNI

- 1 in every 8 adults is a carer
- 2% of 0-17 year olds are carers, based on the 2011 Census
- There are approximately 220,000 carers in Northern Ireland (
- Any one of us has a 6.6% chance of becoming a carer in any year
- One quarter of all carers provide over 50 hours of care per week
- People providing high levels of care are twice as likely to be permanently sick or disabled than the average person
- 64% of carers are women; 36% are men.

CarersNI State of Caring 2019 Annual survey (UK wide, including NI)

1) 2 in 5 carers (39%) responding reported being in paid work.
2) 38% of all carers reported that they had given up work to care.
3) 18% had reduced their working hours.
4) 1 in 6 carers (17%) said that they work the same hours but their job is negatively affected by caring, for example because of tiredness, lateness, and stress.
5) 12% of carers said they have had to take a less qualified job or have turned down a promotion to fit around their caring responsibilities.
6) Just over 1 in 10 carers (11%) said they had retired early to care.
7) Only 4% of respondents of all ages said that caring has had no impact on their capacity to work.
8) Only one quarter (25%) of carers who aren't yet retired and had an assessment in the last year felt that their need to combine paid work and caring was sufficiently considered in their carer's assessment.
9) Carers who are not yet retired were also asked about their future plans and 53% said they are not able to save for their retirement.
10) Some carers are saving or have saved less for their retirement with 17% saying they did this because their working hours were reduced.

Disability

Staff Profile - BSO (March 2021)

No	48.41%
Not assigned	49.68%
Yes	1.90%

Population profile:
20.69% (374, 668) regard themselves as having a disability or long – term health problem, which has an impact on their day to day activities.

68.57% (1, 241709) of residents did not have long – term health condition.

- Deafness or partial hearing loss – **5.14% (93, 078)**
- Blindness or partial sight loss – **1.7% (30, 785)**
- Communication Difficulty – **1.65% (29, 879)**
- Mobility or Dexterity Difficulty – **11.44% (207, 163)**
- A learning, intellectual, social or behavioural difficulty - **2.22% (40, 201)**
- An emotional, psychological or mental health condition - **5.83% (105, 573)**
- Long – term pain or discomfort – **10.10% (182, 897)**
- Shortness of breath or difficulty breathing – **8.72% (157, 907)**
- Frequent confusion or memory loss – **1.97% (35, 674)**
- A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy. – **6.55% (118, 612)**
- Other condition – **5.22% (94, 527)**
- No Condition – **68.57% (1, 241, 709)**

(Census 2011)

Health Survey NI (2017/18 – published 2019)

- 43% longstanding illness (32% limiting and 11% non-limiting illness)
- Females (44%) were more likely than males (40%) to have a long-term condition.
- Prevalence also increased with age with 22% of those aged 16-24 reporting a long-term condition compared with 70% of those aged 75 and over.
- A fifth (21%) reported high levels of anxiety, while 45% reported very low levels

The most recent ONS data on long COVID shows that people who have a pre-existing health condition or disability are more likely to report long-COVID. Disabled people whose day-to-day activities were limited a lot or a little were 3.6 and 2.5 times more likely to report long COVID, respectively, than those without a disability or health condition.

<table>
<tr>
<td>Ethnicity</td>
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Staff Profile - BSO (March 2021)
<table>
<tr><td>Not assigned</td><td>71.51%</td></tr>
<tr><td>White</td><td>28.11%</td></tr>
<tr><td>Other</td><td>0.13%</td></tr>
<tr><td>Black African</td><td>0.00%</td></tr>
<tr><td>Indian</td><td>0.06%</td></tr>
<tr><td>Chinese</td><td>0.06%</td></tr>
</table>
Population profile:
1.8% (32,596) of the usual resident population belonged to minority ethnic groups:

White – 98.21% (1, 778, 449)
Chinese – 0.35% (6, 338)
Irish Traveller – 0.07% (1, 268)
Indian – 0.34% (6, 157)
Pakistani – 0.06% (1, 087)
Bangladeshi – 0.03% (543)
Other Asian – 0.28% (5, 070)
Black Caribbean – 0.02% (362)
Black African – 0.13% (2354)
Black Other – 0.05% (905)
Mixed – 0.33% (5976)
Other – 0.13% (2354)
(Census, 2011)
</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>
Staff Profile - BSO (March 2021)
<table>
<tr><td>Do not wish to answer</td><td>1.71%</td></tr>
<tr><td>Not assigned</td><td>80.58%</td></tr>
<tr><td>Opposite sex</td><td>16.56%</td></tr>
<tr><td>same sex</td><td>1.08%</td></tr>
<tr><td>Both sexes</td><td>0.06%</td></tr>
</table>
Population profile:
In 2016, estimates from the Annual Population Survey (APS) showed that:

• 93.4% of the UK population identified as heterosexual or straight and 2.0% of the population identified themselves as lesbian, gay or bisexual (LGB). This comprised of:
  ○ 1.2% identifying as gay or lesbian
  ○ 0.8% identifying as bisexual
• A further 0.5% of the population identified themselves as “Other”, which means that they did not consider themselves to fit into the heterosexual or straight, bisexual, gay or lesbian categories. A further 4.1% refused, or did not know how to identify themselves.
• The population aged 16 to 24 were the age group most likely to identify as
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	LGB in 2016 (4.1%). • More males (2.3%) than females (1.6%) identified themselves as LGB in 2016. • The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%. There are no accurate statistics on sexual orientation in the community as a whole, it is however estimated that between 5% and 10% of the population would identify as lesbian, gay or bisexual.

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both. Also give consideration to multiple identities (such as single parents for example).

Category	***Needs and Experiences***
Gender	Long COVID-19 affects all genders; however evidence suggests that COVID-19 may impact more on women than men. Additionally pregnant women may be at increased risk of becoming severely unwell compared to non-pregnant women. The differential impact of Long Covid on women within specific Section 75 groups is discussed below.
Age	Research shows that although older people are more likely to be hospitalised with COVID, Long COVID is more prevalent in younger/ middle-aged people, although all age groups are at risk, and the severity and longevity of symptoms can vary.
Religion	There is no data to suggest that the needs and experiences of staff and service users differ on the basis of Religious Status.
Political Opinion	There is no data to suggest that the needs and experiences of staff and service users differ on the basis of Political Opinion.
Marital Status	Research shows that single parents (who are predominantly women) are more likely to be living in relative poverty compared to the rest of the population. Single parents who are unable to work, and do not have the support of a partner or spouse, are more likely to experience financial hardship and fall into poverty if they are unable to work due to illness.
Dependent Status	Data from UK post-COVID care clinics found that around 66% of patients were women. A lot of them were in full-time jobs, have young children, and now more than a quarter of them are unable to work because they're so unwell, causing huge financial distress. Also, research as shown that households with one or more disabled people are more likely to be living in relative poverty. Most carers are women, and again if they are unable to work due to illness, this will cause severe financial hardship.

	Also, linked to the point above, data has shown that most “sandwich” carers (i.e. those looking after both children and an elderly relative or parent) are women, and aged in their 40’s – the group most prone to developing Long Covid. Again, this will have severe financial repercussions should these women be unable to work.
Disability	Given that one of the most common symptoms of Long Covid is extreme tiredness/ fatigue, it may be that individuals who are based in manual jobs (e.g. cleaning, warehouse based duties) may be less likely to be able to return to these than someone who can take regular breaks or is working from home. Individuals with learning disabilities may be more likely to be concentrated in these lower paid, manual jobs and therefore disproportionately affected. They may find it harder to reallocate other work or redeployed. Some disabled staff members may have a weakened immune system, leaving them more vulnerable to getting an infection. Individuals with a mental health condition may feel increased levels of anxiety and stress. One of the symptoms of Long Covid is Depression and Anxiety, which may be exacerbated in those already experiencing or prone on mental health conditions. The current situation of the COVID-19 pandemic could bring further challenges for some staff with disabilities in terms of amending / altering any reasonable adjustments – and this should be assessed and explored as part of any risk assessment process, which is outlined in the principles of this guidance.
Ethnicity	The causes of ethnic inequalities in COVID-19 are unclear, however there is evidence that people from minority ethnic backgrounds have been disproportionately affected. It is unclear to what extent the risk of COVID-19 is caused by social, economic, biological or existing health conditions. COVID-19 in ethnic minorities may present differently: from exposure, symptoms, severity and ongoing symptoms or Long COVID.
Sexual Orientation	There is no data to suggest that the needs and experiences of staff and service users differ on the basis of Sexual Orientation.

2.4 Making Changes

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Where it is appropriate for workers with long Covid to return to workplaces, their condition will be factored into risk assessment and management, by conducting an individualised risk assessment. Certain activities may need adjustment on account of symptoms, to avoid risk of injury to the worker or others. For example, some safety-critical functions may not be appropriate for an individual suffering fatigue or so-called 'brain fog'. **Gender** Long COVID-19 is not limited to any specific gender, whilst it may be more prevalent in women, that is in line with the Population Profile. This guidance and supporting resources will act as guidance for Line Managers in dealing with absence due to COVID-19/Long COVID. **Age** Whilst evidence shows COVID-19 to be a higher risk in those aged 65+, severity or longevity of symptoms is not limited to that age group. In many cases it is an individual experience, not comparable with colleagues of the same age or circumstance. This guidance contains key principles that will give the Line Manages guidance that applies to all employees irrespective of their age bracket. Some measures may be more appropriate to those individual's within the 65+ bracket to include Ill Health Retirement. **Disability** COVID-19 itself is not a disability, however, depending on the severity and longevity of	This guidance shall be reviewed: • following receipt of new information and guidance from DOH; • upon implementation of new agreements which may affect the principles and process • Regular communication to staff on new information and health and wellbeing support available • Consultation with appropriate groups via Regional Absence Leads & Trade Union Colleagues

COVID-19 related symptoms experienced by the individual it may be classified as such. Reasonable adjustment(s) will be considered in line with relevant policies and related legislative provisions such as the DDA 1995. Case law has also recognised the importance of putting in place 'timely' reasonable adjustments for staff with a disability. **Ethnicity** Given the lack of clarity surrounding COVID-19 and ethnic minority groups, this guidance will be updated as and when new information is made available. However the principles still apply and are there as a support process for both Managers and Employees. This guidance sets out the key principles to which BSO should adhere to, to ensure that individuals affected by COVID-19/Long COVID are treated fairly and given the appropriate support and any reasonable adjustments if applicable.	

2.5 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

Group	***Impact***	***Suggestions***
Religion	N/A	
Political Opinion	N/A	
Ethnicity	N/A	

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	X
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	X

Please give reasons for your decisions:

It is not felt that a full EQIA will highlight any further issues with regards to equality of opportunity for the Section 75 groups.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	*What else could you do to encourage disabled people to participate in public life?*
N/A	N/A

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	*What else could you do to promote positive attitudes towards disabled people?*
The guidance will increase support for Line Managers and employees who have been absent with ongoing COVID-19 symptoms. Where Long COVID affect a person's day to day activities; can last or come and go for several months; may be characterised by variability of and diurnal variation of symptoms and/or cause other impairments, reasonable adjustments will be considered and provided for in line with the DDA 1995.	The BSO will be introducing a Disability Toolkit in 2021/22 that will support staff who have a disability. Guidance and protocol for managers and how to converse with staff who have a disability will also be provided.

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

ARTICLE	Yes/No
Article 2 – Right to life	No
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	No
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	No
Article 5 – Right to liberty & security of person	No
Article 6 – Right to a fair & public trial within a reasonable time	No
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	No
Article 8 – Right to respect for private & family life, home and correspondence.	No
Article 9 – Right to freedom of thought, conscience & religion	No
Article 10 – Right to freedom of expression	No
Article 11 – Right to freedom of assembly & association	No
Article 12 – Right to marry & found a family	No
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	No
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	No
1st protocol Article 2 – Right of access to education	No

*If you have answered no to all of the above please move on to **Question 6** on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise legal issues?* Yes/No
N/A			

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

N/A

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights)?

Equality & Good Relations	Disability Duties	Human Rights
Monitored through monthly absence reports and feedback from Occupational Health, Line Managers and Staff and DOH guidance.	Monitored through monthly absence reports and feedback from Occupational Health, Line Managers and Staff and DOH guidance.	Monitored through monthly absence reports and feedback from Occupational Health, Line Managers and Staff and DOH guidance.

Approved Lead Officer: Peter Laverty

Position: Senior HR Manager

Date: 28/06/2021

Policy/Decision Screened by: Vikki Thompson

Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.

Please forward completed template to: Equality.Unit@hscni.net

Any request for the document in another format or language will be considered. Please contact the Equality Unit:

2 Franklin Street; Belfast; BT2 8DQ; Email: Anne.Basten@hscni.net or Karen.Beattie@hscni.net; Phone: 028 9536 3814/ 9536 3023