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**Equality Impact Assessment (EIA)**

**Please refer to the guidance available from the** [**Equality Policy Unit webpages**](https://equality.leeds.ac.uk/equality-inclusion-framework/equality-impact-assessments/) **for advice on how to complete this assessment template.**

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## Section 1: Information about the person completing this assessment

**Name:** Sarah Ward (Equality and Inclusion Adviser, EPU),

Steve Scott (Chair of University E&I Delivery Group)

**Faculty/Service Area:** EPU

## Section 2: About the policy, procedure or practice

**Title of the policy, procedure or practice:**

COVID-19: Phase 1 return to work

**Please describe the aims and purpose of the policy, procedure or practice in roughly 100 words or less:**

The policy addresses the initial phase of safe return to work on campus, beginning in mid-June through until end of September. This return will focus on activities that reflect institutional priorities, including in particular the needs to recruit and register students for 2020-21, to develop the delivery of student education for 2020-21, and to resume critical areas of research.

The return to work will primarily involve staff from five key groups:

* Student Education Service
* Post-Doctoral Researchers (PDRAs)
* Facilities Directorate
* Technicians
* Academic staff

Additionally, there will be smaller numbers of staff from Purchasing, HR, Marketing, IT, Well-being, Safety & Health and some other professional groups required to prepare for and support the on campus activity

Activities will be variously in office and research lab environments, and also include those needed to maintain the campus and to prepare the campus for further re-entry of colleagues/students in September (to be determined).

Separate work is underway to complete appropriate health and safety risk assessments and local protocols to ensure the University is providing a safe working environment for staff in those situations where re-entry is expected and complies with government guidelines relating to COVID-19 (see Section 6 Addressing impact below).

This EIA will ensure that University complies with equality legislation, identifying potential differential impact so the University Executive Group can develop appropriate mitigating actions.

This EIA has been completed through the analysis of quantitative staff data, through qualitative evidence collected through consultation with staff equality network leads and trades union representatives and from recent published reports.

**Other partners/decision-makers involved in the development of the policy, procedure or practice (if any):**

**Partners:** Well-being, safety and health service, HR service.

**Decision maker:** Francesca Fowler, Director of HR

**Who will this policy, procedure or practice apply to? For example, staff, students, visitors, the general public:**

Staff from groups outlined above

## Section 3: Involvement and Consultation

**What involvement and consultation activity has been undertaken or is planned in relation to this policy, procedure or practice? For example, you may have used focus groups, surveys or one to one interviews, to collate feedback from relevant groups about the policy, procedure or practice.**

1. EPU gathered equality data relating to staff in the five areas covered by Phase 1, to obtain a good understanding of the make-up of those particular groups and the likely scale of impact of a return to on-campus working.
2. EPU consulted with the staff networks and trades unions to gather information on the challenges that colleagues with one or more of the protected characteristics may experience when returning to on-campus working.
3. We worked closely with members of the WS&H team to ensure that risk assessments and local protocols are in place for each area and/or role that colleagues will be undertaking.
4. Review of all-staff survey ‘free text’ comments to ascertain particular issues/concerns about a return to on-campus working.

Input and evidence has been taken from the following sources amongst other:

* ‘Disparities in the risk and outcomes of COVID-19’ published by Public Health England
* ‘COVID-19 Post-lockdown position paper’ – National Association of Disabled Staff Networks (NADSN)
* ‘Supporting Black, Asian Minority Ethnic (BAME) staff during the COVID-19 crisis’. HERAG
* ‘BAME Women, mental health and COVID-19’. Business in the Community Factsheet.
* ‘Hidden Figures: The Impact of the COVID-19 Pandemic on LGBT’; ‘The Essential Briefing on the Impact of COVID-19 on LGBT Communities in the UK’; ‘Hidden Figures: LGBT Health Inequalities in the UK’; LGBT Foundation reports.
* ‘Briefing Note: Mothers and fathers balancing work and life under lockdown’, Institute for Fiscal Studies.

## Section 4: Gathering data and evidence

**Have you identified relevant evidence (qualitative and quantitative) to establish whether this policy, procedure or practice could potentially affect some equality groups more than others? This might include analysing equality data for each of the groups identified in Section 5 and/or identifying/researching anecdotal or alternative evidence. Please include any relevant evidence when submitting this assessment.**

Equality data has been analysed for each of the groups identified in Section 2.

We have identified/researched anecdotal or alternative evidence; relevant links have been included in the assessment and more will be added as evidence in gathered on an ongoing basis.

## Section 5: Assessing the impact

**Using examples from the evidence you have collected and using the list below for reference, how might different equality groups be affected by this policy, procedure or practice? Where possible please describe the impact as ‘positive’, ‘negative’ or ‘neutral’.**

**Age**

*Overall: 41 people under 20 years (0%), 1373 aged 20-29 (15%), 2691 people aged 30-39 (29%), 2389 aged 40-49 (26%), 1972 aged 50-59 (21%), 836 aged 60+ (9%)*

| Age range | <20 | 20-29 | 30-39 | 40-49 | 50-59 | 60+ |
| --- | --- | --- | --- | --- | --- | --- |
| SES |  | 144 (17%) | 283 (33%) | 227 (26%) | 159 (18%) | 50 (6%) |
| FD | 16 (1%) | 243 (22%) | 198 (18%) | 202 (18%) | 274 (25%) | 180 (16%) |
| Technical | 5 (1%) | 94 (21%) | 108 (24%) | 109 (24%) | 98 (21%) | 5 (10%) |
| PDRAs |  | 220 (23%) | 509 (53%) | 159 (17%) | 63 (7%) | 10 (1%) |
| Academic |  | 98 (3%) | 819 (27%) | 942 (31%) | 804 (26%) | 403 (13%) |

There are above average proportions of staff over 60 compared to the institutional average in FD and academic staff whilst the age distribution amongst PDRAs is towards younger groups.

COVID-19 diagnosis rates increase with age for both males and females and have a slightly older age distribution particularly for males. Amongst people testing positively for COVID-19, those over 80 are seventy times more likely to die than those under 40.

At the other end of the spectrum, younger staff may feel more concerned about longer-term employment prospects and redundancy and, therefore, under more pressure to return to work sooner.

**Disability**

*Overall: 378 members of staff (4%) have a declared disability*

| Declared disability | Yes | No | Unknown |
| --- | --- | --- | --- |
| SES | 83 (10%) | 706 (82%) | 74 (9%) |
| FD | 57 (5%) | 893 (80%) | 163 (15%) |
| Technical staff | 39 (9%) | 366 (80%) | 54 (12%) |
| PDRAs | 37 (4%) | 729 (76%) | 195 (20%) |
| Academic | 121 (4%) | 2282 (74%) | 663 (22%) |

There are higher than institutional average levels of declared disability amongst SES and technical staff.

Several medical conditions lead to staff being ‘vulnerable’ to COVID-19.

The intersectional impact of diabetes on BAME groups is described in the race/ethnicity section below. Other indicators of higher risk include obesity, hypertensive diseases, chronic kidney disease, obstructive pulmonary disease and dementia.

Disabled staff may not have been able to attend regular medical appointments/clinics or have had limited/interrupted access to medication to manage some conditions during the recent lockdown stage and may also have limited or delayed access during this period of ‘re-opening’ of the NHS.

Vulnerable staff with some conditions are likely to have enhanced use of toilet facilities where infection rates may be higher and may have similar concerns about working in other small, confined spaces. Uncertainties around the return to work environment may be leading to increased mental health issues in this group.

Staff with mobility issues or visual impairments may find it harder to work to an unfamiliar working environment with ‘one-way’ systems introduced to support social distancing.

In addition to safety on campus, vulnerable and disabled staff may also face challenges travelling safely to campus in the current circumstances. Staff travelling under the ‘Access to Work’ scheme typically rely on taxis and may be additionally exposed through there.

People with some mental health conditions may have found the initial changes in routine and services brought about by lockdown very challenging and may find re-entry similarly difficult. This may create stress and anxiety not only for the individual, but also their colleagues.

**Race/ethnicity**

*Overall, the University has 12% BAME staff who have declared this ethnicity*

|  | BAME | White | Unknown |
| --- | --- | --- | --- |
| SES | 63 (7%) | 742 (86%) | 58 (7%) |
| FD | 189 (17%) | 762 (69%) | 162 (15%) |
| Technical staff | 52 (11%) | 348 (76%) | 59 (13%) |
| PDRAs | 207 (22%) | 545 (57%) | 209 (22%) |
| Academic | 364 (12%) | 2027 (66%) | 675 (22%) |

BAME staff are over-represented compared to the institutional average in the Facilities Directorate and amongst PDRAs.

The recent report on ‘Disparities in the risk and outcomes of COVID-19’ published by Public Health England confirms a disproportionate impact of covid-19 on BAME people. People from Black ethnic groups were most likely to be diagnosed and death rates from COVID-19 were highest amongst people of Black and Asian ethnic groups. Analysis of survival amongst confirmed cases shows that after accounting for other effects, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity, whilst other ethnicities have between 10 and 50% raised risk of death. Evidence also indicates that when other comorbidities are taken into account, the difference in the risk of death amongst hospitalised patients is greatly reduced.

Factors contributing to the enhance risk are identified as: higher representation of BAME individuals in groups working in situations with greater exposure to infection (job-based risks), and to social deprivation and housing issues.

BAME staff are highly represented in some areas of the Facilities Directorate where their work has a higher potential for exposure (cleaning, security) and are also likely to be more dependent on public transport to travel to campus.

Diabetes is a significant contributing factor to risk of death from COVID-19: it is mentioned on 21% of death certificates and is a higher co-morbidity for all BAME groups compared to White ethnic groups.

People whose first language is not English may have limited understanding of challenges brought about by COVID-19.

**Gender**

*At the institutional level, 54% of staff are female.*

|  | Female | Male |
| --- | --- | --- |
| SES | 640 (74%) | 223 (26%) |
| FD | 567 (51%) | 546 (49%) |
| Technical staff | 166 (36%) | 293 (64%) |
| PDRAs | 465 (48%) | 496 (52%) |
| Academic | 1319 (43%) | 1747 (57%) |

Female staff are over-represented compared to the institutional average in SES and under-represented in technical and academic staff.

The majority of caring responsibilities are taken on by women. Single parents are more likely to be women.

In some of the lower-paid groups concerned where female staff are highly represented there may be additional pressures to return-to-work. Such staff may also be particularly reliant on public transport to travel to campus.

Working age males diagnosed with COVID-19 are twice as likely to die as females.

With fewer people on campus, female staff in particular may feel less secure – potential for increased incidence of ‘lone working’

**LGBT+/Gender reassignment**

4% of staff have declared as LGBT+: 27 members of staff (0.3%) record a gender different from that assigned at birth.

Colleagues may not have been able to attend regular medical appointments/clinics or have had limited/interrupted access to medication to manage their transition.

LGBT+ individuals more generally have a higher propensity for requiring medication and again there may have been interrupted access – 16% report being unable to access healthcare for non-COVID related issues, 34% have had a medical appointment cancelled and 23% have been unable to access medication or were worried about such access.

**Caring responsibilities**

Overall: 2203 (24%) of University of Leeds staff have registered as having caring duties

By staff group

|  | Yes | No | Not known or prefer not to say |
| --- | --- | --- | --- |
| SES | 253 (29%) | 494 (57%) | 116 (13%) |
| FD | 206 (19%) | 505 (45%) | 402 (36%) |
| Technical staff | 99 (22%) | 244 (53%) | 116 (25%) |
| PDRAs | 160 (17%) | 527 (55%) | 274 (28%) |
| Academic | 902 (29%) | 1047 (34%) | 1117 (38%) |

The SES team and academic staff are over-represented compared to the institutional average in this category.

Variable availability of schools and nurseries will affect the ability of parents and those caring for children to return to on-campus working. Schools are be closed for most pupil groups during the current term and then over the normal summer holiday period to early September. Parents will typically have summer childcare arrangements during normal school holiday periods although some of these, e.g. with grandparents who are in the vulnerable group, may be significantly affected by the on-going COVID-19 situation.

People caring for vulnerable/disabled/elderly relatives or dependants (‘shielding’) may be experiencing limited or changed access to support (e.g. day care centres, health visitors, case workers).

External evidence indicates that caring duties fall disproportionately on female staff (see ‘gender section’ above).

## Section 6: Addressing any impact: action planning

**Please describe any actions you will take as a result of undertaking this assessment, including the timescale for each action and who will be responsible for the action.**

**Action 1:** Health and Safety Services have undertaken a formal risk assessment ‘UOL COVID-19 Risk Assessment Final 8th June 2020’. This has the following sections: 1. Buildings; 2. Social Distancing; 3. People at higher risk; 4. Psychological wellbeing; 5. Cleaning and hygiene measures; 6. Travel, 7. Fieldwork/study abroad/work placements. This document will define a set of standards that should be achieved.

**Timescale:**

**Responsibility:**

**Action 2:** Supporting the risk assessment above, a pre-entry checklist will be completed before any area/building is to be reoccupied and will be signed off by the University Re-entry Group. This will include the need for local assessments and process to have reviewed assessments to map against COVID-19.

COVID-19 Pre-Entry Inspection Checklist – Final 8th June.

**Timescale:**

**Responsibility:** URG, WBSH

**Action 3:** The document ‘University of Leeds: COVID19 and Social Distancing’ sets out principles and guidance and specific plans and an information sheet on ‘the requirements for working on campus’.

**Timescale:**

**Responsibility:**

**Action 4:** Implement risk assessments according to ‘Coronavirus (COVID-19) Risk Assessment Guidance Returning to Work on Campus’. Part A: staff groups at increased risk from COVID-19; Part B risk assessment and workplace adjustment. Include checklists for vulnerable staff, staff over 70, pregnant people, staff with complex health problems (extremely vulnerable), staff with vulnerable household members, BAME staff.

**Timescale:** Immediate on return

**Responsibility**: Line Managers. Policy developed by Well-Being, Health and Safety/ Occupational Health team.

**Action 5:** University services to support staff with disabilities and medical conditions are still operating as normal. Counselling and OH provision remain at the same levels as we would on campus but without the face to face provision. We can still deal with illness, absence, people recording stress etc and manage it as a normal OH referral.

**Timescale:**

**Responsibility:** Counselling, OH: WBSH

**Action 6:** Staff information will be produced and issued on first return to buildings that will map out the provisions available etc and strict hygiene rules around one-out-one-in for toilets etc. Advice will also be provided for the provision of single use toilets for vulnerable staff. This information will include details of local ‘one-way’ systems where possible which will also be clearly signed.

**Timescale:**

**Responsibility:** WBSH

**Action 7:** HR guidance will be provided to local managers to advise staff the best place for people to work – ‘Coronavirus (COVID 19) – HR Guidance for Heads of School /Service re Returning to Work on Campus’. This will address decisions, amongst others, around staying off campus or working in different locations to support them. Line managers will be supported by local HR and H&S teams in making decisions.

**Timescale:**

**Responsibility:** HR, WBSH

**Action 8:** Cleaning services will install sanitisers meeting requirements in all spaces: hand pump points and hand gel bottles. Options for wheelchair users will be provided.

**Timescale:**

**Responsibility:** Cleaning service

**Action 9:** Face masks will be provided where this is required for staff for safe work purposes.

**Timescale:**

**Responsibility:**

## Section 7: Approval & Publishing

**Signature of person completing this Equality Impact Assessment (an electronic signature will be accepted):**

Sarah Ward (Equality and Inclusion Adviser, EPU)

Steve Scott (Chair of University E&I Delivery Group)

**Date:** June 2020