STANDARD OPERATING PROCEDURE
HUMBER COMMUNITY SPECIALIST SERVICES
SPEECH AND LANGUAGE THERAPY

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*18/04/24*	*New SOP. Approved at Community Clinical Network Group (18 April 2024).*

Contents

1. INTRODUCTION

Following the transformation work in 2022 to create a One Community approach, there has been a review of all community specialist services to ensure a standardised and equitable approach to patient care across the community. This document enables identification of the processes within each of the specialist services, aligned to commissioned service delivery, and bringing together all relevant processes and resources for the specialist service. Once agreed they are found on the intranet under clinical policies, procedures and SOPs under "C" for community link:

Clinical Policies, Procedures and SOPs

2. SCOPE

This Standard Operating Procedure (SOP) explains the process to follow for Humber community services in Scarborough. Ryedale, Whitby and Pocklington for Community Speech and Language Therapy for adults with acquired communication and or swallowing difficulties. It has been developed in order to provide guidance and clarity for clinical teams within HTFT services regarding process and expectations. It will also support partners in understanding the scope of service.

This document should be shared as part of the induction process for new starters or temporary workers, students, to ensure consistent compliance with the systems and processes. It does not replace professional judgement, which must be used at all times when managing referrals and patient intervention.

3. DUTIES AND RESPONSIBILITIES

Service Managers, Therapy Lead and appropriate Clinical/ Professional Leads will ensure dissemination and implementation of the policy within the sphere of their responsibility. They should also ensure staff are supported in attending relevant training and that time is dedicated to the provision and uptake of training and sign off competencies.

Therapy Lead /Service managers / Advanced Speech and Language Therapists have responsibility for ensuring the quality of clinical interventions and record keeping by their staff and monitoring compliance with this policy and procedure through the supervision and audit process.

All relevant Clinical Staff will familiarise themselves and follow the agreed SOP and associated guidance. They will use approved documentation on SystmOne as per policy and Standard Operating Procedures. They will make their line managers aware of barriers to implementation and completion. The service is staffed by Community Speech and Language Therapists and Community Speech and Language Therapy Assistants, at a variety of bandings.

4. PROCEDURES

4.1. Referrals

All referrals into the Speech and Language Therapy (SLT) Specialist Service will be via the HTFT Community Single Point of Access (SPOC). SPOC contact details are telephone 01653 609609, Email hnf-tr.csspoc@nhs.net , link for further information and the latest referral form https://www.humber.nhs.net/services/adult-community-integrated-services.htm

Referral sources

1. Patients can be referred into the service via GP/self/Allied health professionals (AHPs)/nurses/other medical professionals from in and out-with of Humber NHS.
2. Referrals are accepted via email / letter / electronic or telephone. SPOC will add all referrals to the Triage Speech and Language therapy caseload.

4.1.1. Inclusion criteria:

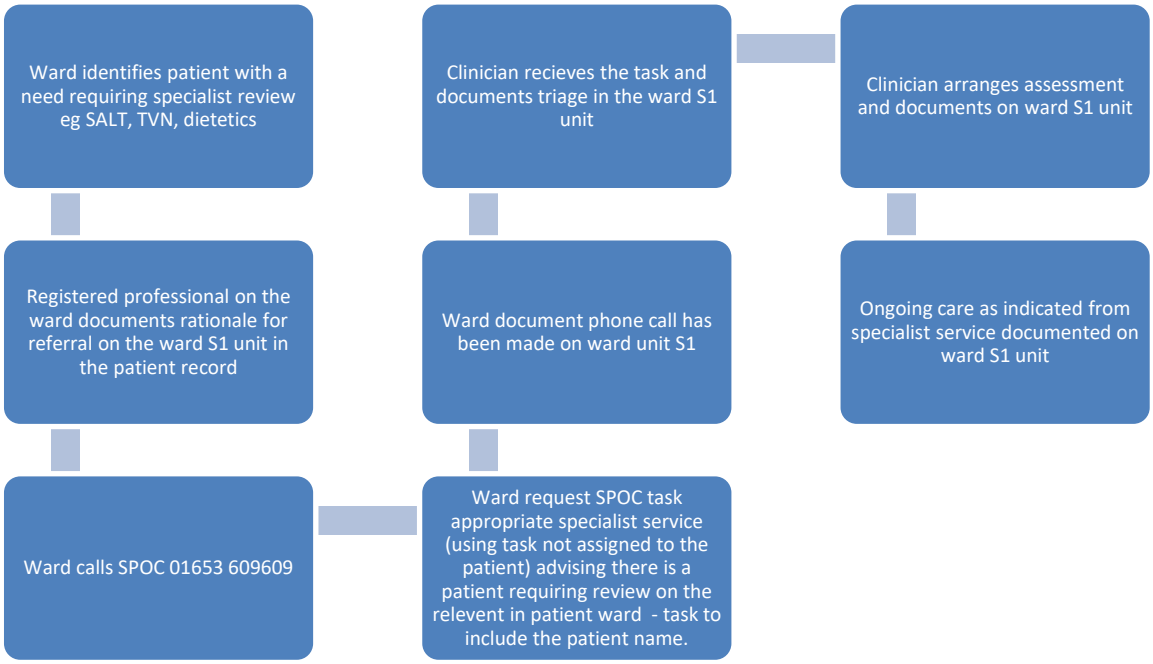
- Adults (18 and over) with an acquired communication and/or swallowing difficulty that has been gained or changed due to an acquired condition as an adult.
- Patients in St Catherines Hospice will be accepted and triaged in line with agreed process if they are from a Scarborough / Ryedale / Whitby / Pocklington GP practice.
- Patients receiving care on Malton or Whitby In-Patient unit.
- Stroke and non-stroke patients

4.1.2. Exclusion criteria:

- Patients with a diagnosis of a Learning disability (signpost to TEWV)
- Voice problem who has not been assessed by ENT.
- A head and neck cancer, currently receiving input from specialist Head and Neck services (signpost to YDH/ HUFT / JCUH)
- Patients under the age of 18
- Dysfluency (signposted for GP to refer to Airedale for video consultation service)
- Patients with developmental difficulties since childhood who are now adults.
- Patients not registered with a Scarborough / Ryedale / Whitby / Pocklington GP
- Patients in Cross Lane inpatient unit (in house speech therapy via TEWV available)
- Trache Patients

4.1.3. Ward Request to Specialist Services

This process will apply to both Fitzwilliam ward (Malton) and Memorial ward (Whitby) and covers requests to SLT. This process will be used across all teams, Hubs and community inpatient units within Humber Teaching NHS Foundation Trust. It includes both registered and unregistered staff who are permanent, temporary, bank or agency staff.



4.1.4. Clinical Triage

1. Referral received in to the “Triage Speech and Language” or “Triage speech therapy stroke” System one folder.
2. If there is inadequate information in the referral to complete triage consider rejecting the referral or complete an entry in the tabbed journal under the heading “SLT triage” with the information known and then, task SLTA group with who to telephone, whether you are asking for swallow or communication screen or both, write any specific questions in the task. If there is not a sharing agreement, ask for consent to share. Update triage handover on teams.

3. SLT documents “Triage SLT” and includes the date of referral, source of referral and content of referral. This will also include if the patient has previously been known to SLT, past medical history, clinical information, patient location if appropriate. If there is enough information to adequately triage then code the information via use of the triage matrix V:\PCC\S&R - Specialist Services\Shared\Speech and Language Therapy\Triage. Also document to denote routine or priority waiting list, then select the priority code of high, medium or low and then code for home visit (HV), or for clinic or telehealth and if so location of that clinic (Whitby, Scarborough, Malton, Pocklington).

   For HVs document if for SLT, B3 or B4:
   - B4 coded non-complex patients, or oral stage dysphagia likely around changes to textures of diet, within the competency framework for International Dysphagia framework level 4. The band 4 will liaise with the registered SLT prior to any recommendations being made.
   - B3 coded patients are linked to an assessment being completed by the remote SLT and not the band 3. The band 3 facilitates the remote consultation. This group would need to tolerate a video consultation. They therefore need to be able to engage with video consultation with B3 support, have a non- complex social/family situation., not have any significant positional issues or be a complex presentation.
   - SLT coded would be the complex social/bedside presentation that would require qualified face to face assessment.

   The referral then needs to be amended from “Waiting for triage” to “waiting for assessment”.
   Add to the correct waiting list “Priority for high code patients” or “Routine” for medium or low patients. Stroke patients are added to the Priority or routine stroke waiting list.
   Add the referral date, change the due date to 3 weeks (high), 5 weeks (medium) 10 weeks (low).
   Write the code in the notes section e.g., Med S HV (SLT) [Medium priority, Scarborough, Home visit for SLT]. Add referral acknowledgement letter to documents and task SPOC to send. Save the record using the appropriate triage activity template.
4. Patients on the Malton and Whitby IPU will be triaged according to the guidance in the triage matrix if the patient is coded as high priority, they will be booked into the next slot to be seen. If they are coded as routine, they will wait until they reach the top of the waiting list. Usually this is when they are back home.
5. If the referral is rejected due to being out of area task SPOC to advise of this and to ask them to reject the referral. Member GP practices - NHS North Yorkshire CCG
6. If inappropriate referral as it falls in the exclusion criteria, then reject back to the referrer with reasons for rejection and end the referral on S1 with appropriate accompanying documentation.
7. If SLT requested support from the SLTA with information gathering they will open the patient record. They will complete the triage screen as per task direction from the SLT with the patient/family/carer/friend and update the triage handover on teams to state the triage screen has been completed.
8. SLT in triage will see the screen has been completed and will then complete the clinical triage as per above steps.

4.1.5. Role of the Triage/Duty SLT

- Update Microsoft team’s handover
- Triage new referrals either for patients who have never been seen by SLT or have been discharged over 1-2 months prior.
- Send and receive triage screens from and to SLTA.
- Support SLTA as required with time and clinical management.
- Process tasks regarding patients on the waiting list or patients in triage
- Look at tasks that are for patients on a colleague’s caseload, if assigned to the group, and if the colleague is on annual leave, day off or sick leave. This may not necessarily be to

complete the job but to consider if the job can wait while they return or if it needs dealing with or at the least exploring and then passing back to them for their return.
- Waiting list management e.g., telephone discharges
- Processing deceased patient's tasks- either discharge if on waiting list or assign to managing SLT if on colleague's caseload.

4.1.6. Jobs to Transfer to Colleagues by Duty SLT

- If the managing SLT is in work and the is task for a current patient but has been assigned by admin to duty- simply assign to managing SLT.
- If a new referral has come through for someone on a colleague's open caseload, end the referral and task the colleague to direct to the new information.
- If there is a new referral or a new task for a patient who has been discharged roughly in the last month and the colleague is in work. Assign this task or make a task to the previously managing SLT. They may complete processing the new referral in their triage session or outside of it. The exception would be if they are not in work (day off, AL, SL) and it is clear that the message needs urgent attention. If the colleague isn't in work and it is not urgent it could wait for their return. Please update the triage handover with this in mind or if it is a task, rather than a new referral, then simply assign the task to the SLT who managed the patient.

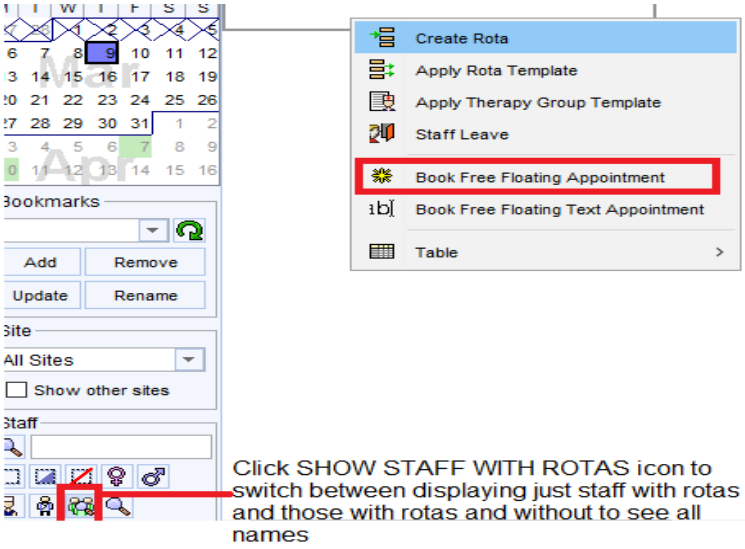
4.1.7. Patient Pathway Referral to Discharge

Booking in

1. When SLT have an available appointment take the patient off the waiting list or ask admin/SLTA/do it yourself to book the patient in.
2. Book the patient on System 1 dairy. Put the patient on the excel caseload spreadsheet. If you are booking into an upstream slot text the appropriate device through upstream for the appropriate date/time so the appointment is on your upstream ledger. Or if a Microsoft teams call then emailing the appropriate email.
3. Remove the patient from the waiting list. Click on visits and add the patients name and the visit date and time. This will book it in your S1 diary. If the appointment is clinic or via video consultation right-click in the appointment ledger with the patient record open and book the appointment. Add upstream to the notes section if your appointment is via upstream.
4. Right click on SLT referral and change the caseload from the waiting list to your caseload. Save the action.

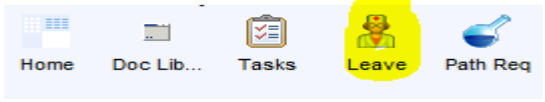
The visit diary or appointment ledger on S1 will be used to record all clinical activity.
Further guidance can be found here Appointments and Visits (humber.nhs.uk)

- Visits should only be used for patient visits (at home or non-clinic based) remember that visit duration should reflect the travel time to the visit, the visit time and the documentation time. You should have no past visits uncompleted on the system as these should be documented within 24hrs – this will ensure that both your professional standards are being met with regards to defensible documentation but also trust standards are being met.
- If a telephone appointment is required, this can be booked as a free-floating appointment on the diary screen on S1
- Right click on blank part of the screen under existing appointment
- Or if you do not have a rota/appointment already and cannot see your name along the top of ledger screen

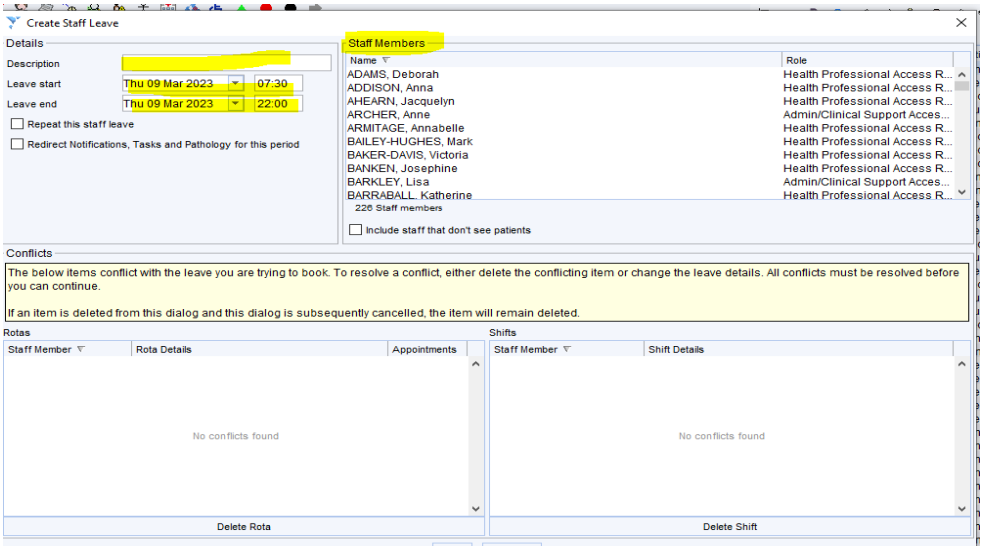


"<u>Textual visits</u>" should not be being used regularly by staff. If time is required to be blocked so it not available to be booked clinically this should be done as follows as staff leave

- Click STAFF LEAVE on toolbar.



- Click ADD leave
- **YOU MUST ADD DESCRIPTION** and select leave dates from/to and staff member who is on leave. This can be used for annual leave, off duty, long term sick etc.
- **Please note if staff member has any conflicts e.g., Appointments booked during the leave period S1 will not allow you to book the leave until the appointments are rescheduled.**



<u>Preparing for your appointment</u>

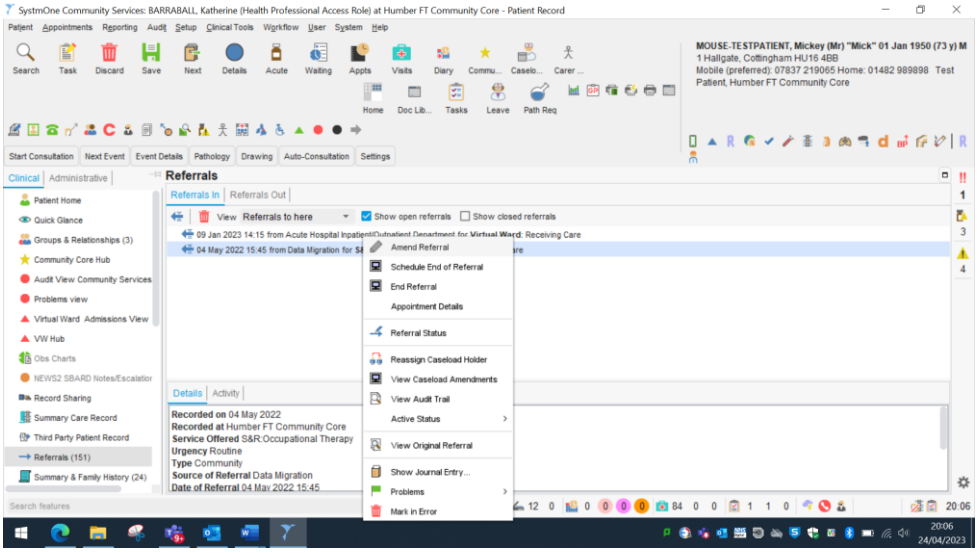
5. Check the tabbed journal, the communication and letters and problem view, in preparation for your visit to gain history. Check tabbed journal entries and letters. For Whitby and Pocklington patients click on the "Third party record", which will link you to GP EMIS system.

<u>Consultation</u>

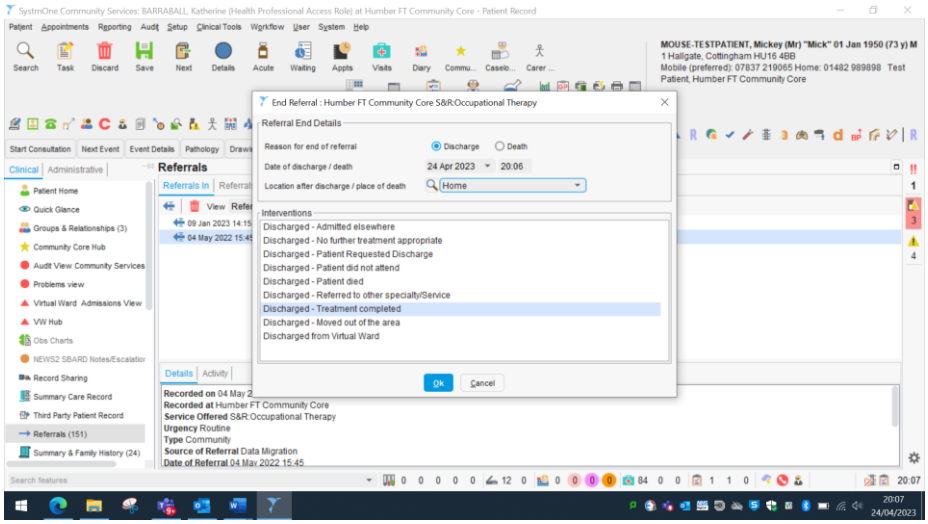
6. On the diary / ledger screen right click and click on consultation. This will bring up the box for you to write your notes. To include:

a) Head with SLT
b) Type of appointment e.g., telephone, home visit, clinic, video. Write if initial assessment or follow up.
c) For initial assessment include who referred and date of referral and for what purpose
d) Consent gained and how/unable to consent carried out in best interests if unable to demonstrate capacity to consent with known reason to doubt capacity.
e) Who was present and where the patient was e.g., in bed?
f) Medical history
g) A description of their communication status e.g., mildly dysarthric in connected speech
h) Baseline diet and fluid using international dysphagia diet standardisation initiative (IDDSI) framework.
i) Oromotor assessment- if unable e.g., due to cognition then state this
j) Chest history- e.g., recurrent chest infections, COPD, asthma, no chest infections
k) Nutrition status- no change in weight, weight gain, weight loss- BMI, weight and height if able
l) Diet and fluid assessment
m) SLT Diagnosis- e.g., mild to moderate oropharyngeal dysphagia
n) Recommendations in IDDSI levels, including number of scoops, to amount of fluid and thickener product as appropriate.
o) Plan with specific actions and time frame of review if indicated.
p) If appropriate task the GP surgery to request thickener stating level, product and number of scoops or include this in a report if to Pocklington or Whitby GP

7. In saving your consultation you will be asked what time, date, the nature of the consultation. Complete this for the time you did the action. E.g., if you did your visit 1400-1500 then the start time will be 1400 not when you wrote your notes at e.g., 1700.
8. All new patient assessments should be recorded as an Assessment and then any follow up / re assessments are recorded as clinical intervention. There are activity templates available on S1 for use to standardise recording. See Appendix 2.
9. You may wish to task a Humber staff member, St. Catherines staff or a GP to direct them to your consultation if appropriate.
10. After an initial assessment the SLT may need to write a report. This would be required if the referrer is from the Acute hospital or if the referrer is a GP, but you need to feedback to another individual e.g., ENT/Gastro/Stroke/Parkinson's/Neurology service. Or to a GP if the patient has declined a sharing agreement or if the patient lives in Pocklington or Whitby.
11. After initial swallowing assessment for those in nursing or residential care the SLT will write in the care home notes and leave the written eating and drinking recommendations/IDDSI leaflets- This is essential. If this consultation is completed via upstream you must email IDDSI leaflets and post out the patient recommendation letters if you are changing recommendations. Ensure you follow the secure email procedure or send info without patient info on the if non-secure. Document this in your notes and attach the email to the S1 record. If the homes notes are online and you are unable to access them then complete eating and drinking recommendations sheet and document, you have done this.
12. For those patients requiring thickener the SLT must task the GP to request this. In the task/letter you must include IDDSI level, number of scoops per 200ml fluid and the specific product requested. The thickener product of choice in this area is Resource thicken up clear.
13. After initial swallowing assessment for those in their own home, consider leaving written eating and drinking recommendations/IDDSI leaflets.
14. After follow-up review, the SLT may feel a report is required again if there is something new to share. This may not be clinically necessary if it is not necessary then document this.
15. Leave a patient pack with the patient for their information.
16. If you discharge the patient, then go back into the patient record. Right click on referral and end referral with the appropriate reason for ending the referral. This patient will then be removed from the caseload. Remove from your current excel caseload to your discharge tab.



17. Select the appropriate reason for ending the referral and location of the patient.



18. Alternatively, this can be done when saving the record in the event details page by selecting end referral.

19. Clinicians are then responsible for ensuring all goals are reviewed, outcome measures reviewed and relevant care plans (if any are ended).

The record should then be saved with the appropriate activity recorded.

4.1.8. Upstream Appointment Booking

<u>Clinician establishes upstream required:</u>

- Task SLTA/SPOC with the date and time of the appointment. Assume the appointment is an hour unless stated otherwise.

<u>Admin and the patient:</u>

- On receipt of the task call the patient/relative/carer
- Check they are happy to book in video consultation with SLT.
- Check if patient has a smartphone/ tablet / laptop with a camera for the video consultation.
- Check if the patient has internet/data.
- Confirm phone number if using a mobile or email if using a tablet or computer **unless this is to a care home tablet which runs off a mobile number** (consultations via a tablet / laptop are better quality than a mobile)

- If not, see if a family member has one and could be available for the appointment date and time.
- For care homes their email/tablet phone numbers are on the shared drive: Speech therapy: Care Homes and Nursing Homes in Scarb, Rye, Whitby: Excel spreadsheet Care homes Scarborough and Ryedale
- If unable to make the appointment because the wrong date/time for the patient contact SLT
- If declines a video appointment contact SLT and a home visit or clinic may be considered.
- Confirm the date and time of the appointment and put this onto the clinician's system 1 appointment with "upstream" in notes.

When booking on upstream:

- Sign in via your mobile number and password.
- Click on "Appointments"
- (Top right) "View Diary" and select the therapists name who you are booking the appointment for.
- Click on "all" then the calendar symbol to select the appointment date.
- Select the time of the appointment in the diary.
- Visit type: video consultation.
- Duration: select time (likely 1 hour)
- Click on the magnifying glass to search for the patient via NHS number.
- Check the patient's details correspond.
- When you click search, there may be more than one patients found. Double check the patients date of birth against S1.
- Enter mobile or email address of the patient on which you agreed when speaking to the patient or relative.
- Send the appointment email/text via click on confirm appointment.
- You will be able to see the booked appointment in the diary.
- If you click on the patient's name, the appointment details are noted. The system lets you know if the patient has received the link or if it hasn't sent yet. Options to cancel/schedule appointment or resend link if needed. (Care homes / nursing homes often need prompts to switch tablet on to receive the notification)
- You can copy and paste a link to send to a second person to join e.g., student/other clinician.

To change the appointment or resend the appointment email/text:

- Click on the patient when it is booked on the diary page.
- The box comes up with the appointment information.
- On the right of the box there is an option to resend the link, cancel the appointment, copy the link or reschedule. Click on the corresponding option.

4.2. Equipment

There are loan procedures available to patients and these should be discussed with the advanced SLT with regards to appropriate devices and applications.

4.2.1. Voice and Message Banking Process

1. Identify the person may be appropriate to voice or message bank, but they have limited or no knowledge of what it is.
2. During initial assessment demonstrate via text to speak app what voice and message banking will achieve.
3. They may or may not have technology to complete it.
4. Check they have the equipment in which to voice bank- they need a laptop, a microphone and access to the internet. If they don't consider sending a request to MNDA or if a person is choosing to buy their own headphones or SLTA support.

5. If they want to do it consider requesting loan of equipment or if they have their own if it is appropriate. Equipment Loan request form | MND Association , consider use of SLTA to support this.
6. Consider if they have the skills to do it independently. If they do give them the direction list and talk through.
7. If they don't have the skills to do it independently then agree SLTA/SLT will make contact or book a further appointment to support completing this.
8. Check if the patient has an open referral to Barnsley AAC or DH2 or if they are appropriate to refer.

7D - Voice banking (mndassociation.org)

AAC for MND | MND Association

4.2.2. Videofluoroscopy (VFS) Referral Process

1. Identify clear clinical rationale for a VFS during home visit, telephone consultation or video appointment. Document this in SLT notes.
2. Consider sitting / mobility and if the patient is appropriate for the assessment.
3. Consider any food allergies, mobility and if the patient has diabetes as this needs documenting on the referral form.
4. If you are unsure about the appropriateness of the referral, check with senior clinician or the SLTs in SGH/YDH who complete the assessment or read the position paper from the RCSLT saved in the shared drive under VFS.
5. Gain consent from the patient, explaining rationale to them for the assessment or their NOK.
6. Provide an information leaflet from the VFS service at SGH.
7. Complete the referral form on the shared drive from Scarborough hospital if Scarborough, Ryedale or Whitby. If Pocklington, then the YDH form. Ensure you have completed all the relevant information. They are on the shared drive under VFS.
8. Email the form to the secure SGH/York SLT nhs.net email as per location above and attach the referral form to the system 1 record. Add the referral form to record attachments on S1.
9. Add the patient to the VFS excel spreadsheet on the shared drive in VFS including name. NHS number and date referred.
10. Await date for the assessment and add this to the spreadsheet.
11. Once the VFS report has been received check it is on S1 and if not add it to the patient record.
12. Add the date report received to excel spreadsheet.
13. Arrange to feedback with the patient as directed by the report.

4.3. Documentation

Documentation will be completed as per Community Services Assessment and Documentation SOP22-007

4.3.1. Activating sharing agreement on S1

Record Sharing

4.3.2. Service information for patients and families –

On initial appointment give to the patient/carer the patient pack, which includes:

a) SLT information leaflet
b) Electronic health records leaflet
c) complaints and feedback leaflet t
d) SPOC contact card

4.4. Patient Attendance

The HTFT SOP for patients not attending appointments must be followed awaiting finalisation and upload to the intranet.

4.4.1. If Patients on this Service Caseload are Admitted to Hospital

If the SLT become aware your patient is in hospital, then consider if you need to contact the ward the patient is on or the SLT team that covers this ward. For some patients contact will not be required if for example the admission is unrelated to your episode of care. You may need to contact the ward to establish this. If it becomes apparent the patient has acute needs, then request the ward refers to the acute SLT or refer yourselves via contacting the appropriate team and providing the handover including reason for referral. Agree with the clinician you are handing over to if you will keep on your caseload or discharge for re-referral from the acute. If the patient is in triage or the waiting list and you need to refer to the acute SLT it is likely you will discharge from community and the acute will re-refer if required following their intervention. If the patient is a long-standing community patient and will likely be transferred back to you it is likely you will keep them on your caseload for handover back.

4.5. Staff 'Wellbeing and Safety

The Trust policy on lone working must be followed:
Lone Worker Policy

4.6. Patient Feedback, Outcomes and Service Evaluation

This service has the following processes for evaluating and improving patient care:

4.6.1. Friends and Family Test (FFT)

This service FFT code is – SC014 Speech and Language Therapy Service (Scarborough).

The process for distributing FFT is on discharge from the service. To do this task admin to send out with a self-addressed envelope. Alternatively, if intervention has been online and the patient would prefer completing via email link then email the link to the patient to complete.

FYI the SAE will be written to:

FAO: Lisa Arnold
Friends and Family Tests
Humber Teaching NHS Foundation Trust
Willerby Hill
Beverley Road
Willerby
HU10 6ED

The service reviews FFT information and feeds back at 6 weekly team meetings.

4.6.2. Useful Contact Details

Scarborough Hospital SLT salt.sgh@nhs.net 01723 342237 01723 342250
York Hospital SLT yhs-tr.yorkslt@nhs.net 01904 725768
HRI SLT hyp-tr.slt@nhs.net 01482 604331
JCUH SLT 01642 854497
JCUH SLT Head and Neck 01642 854039
Learning Disability team Scarborough, Ryedale, Whitby 01723 580940
Parkinsons Specialist nurses SGH 01723 385054
Fitzwilliam Ward 01653 604540 01653 531632
Whitby IPU 01947 899200

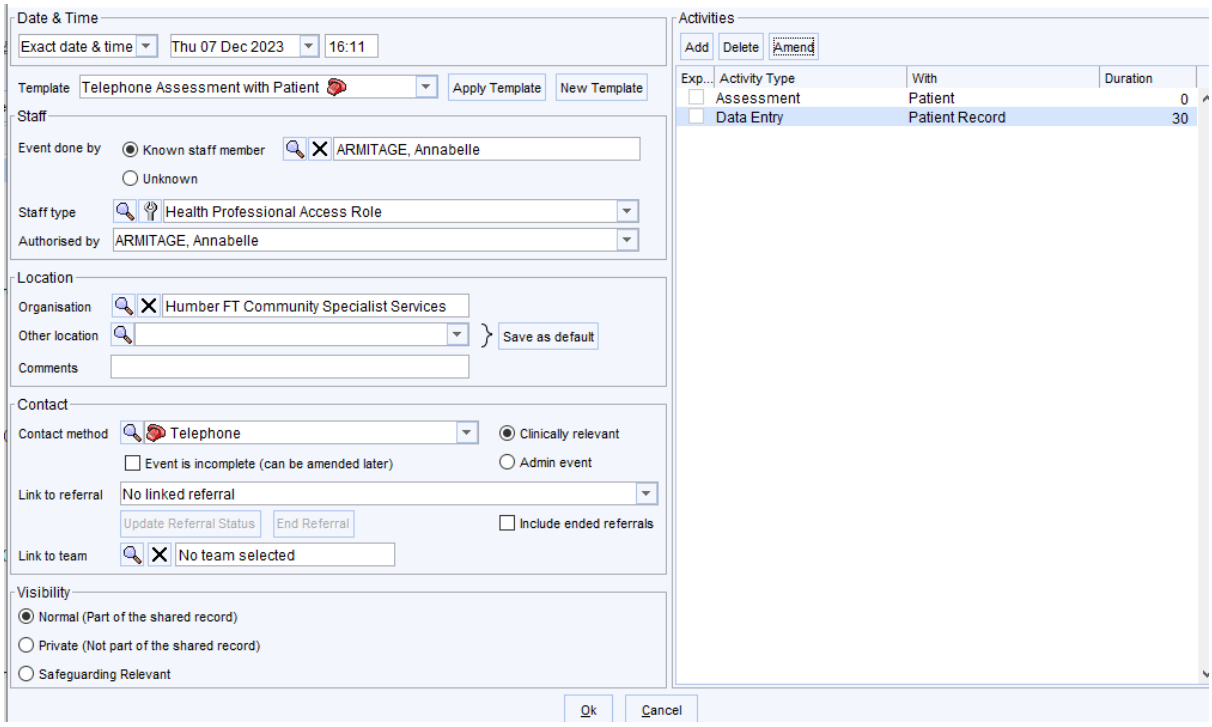
Appendix 1: Patient Pathway Mapping

One Community - Future State Process Model

Appendix 2: Activity saving on SystmOne (Dec 23)

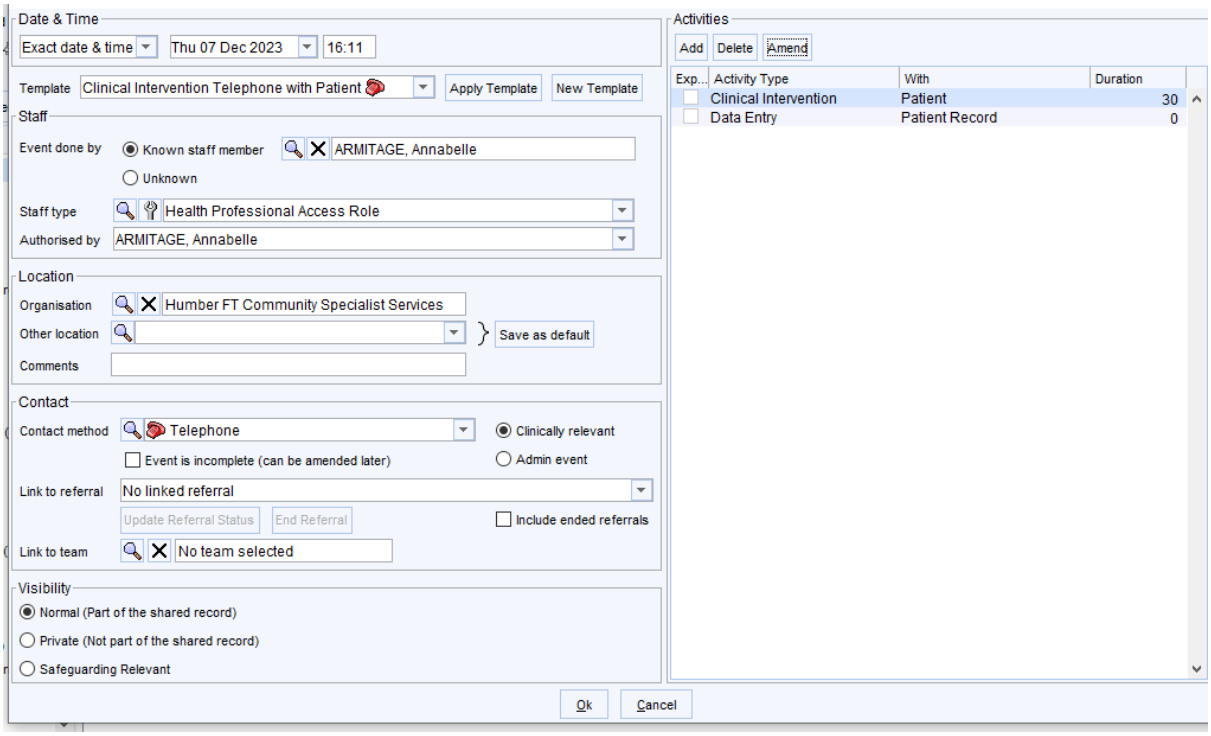
It is important to save **every** activity with a patient so that it correlates with what is in S1 ledger and for good governance.

The templates add to S1 have been designed to help you do this in a consistent manner. Selecting the drop-down box shown below will give you access to frequently used activities that need to be recorded. All templates are set to 0 minutes, and you need to amend them to reflect the time you spend with the patient and on the documentation.
Assessment is the first clinical contact with the patient and follow up appointments (both FTF and telephone) are clinical intervention.
Eg Initial telephone assessment is recorded by selecting telephone assessment with patient and pressing apply template it populates info into the right-hand box- you then need to amend the time spent both the patient facing time / telephone time and the documentation time.
If what you need to record doesn't have an activity template, you can still add an activity as you did previously using the add button on the right.

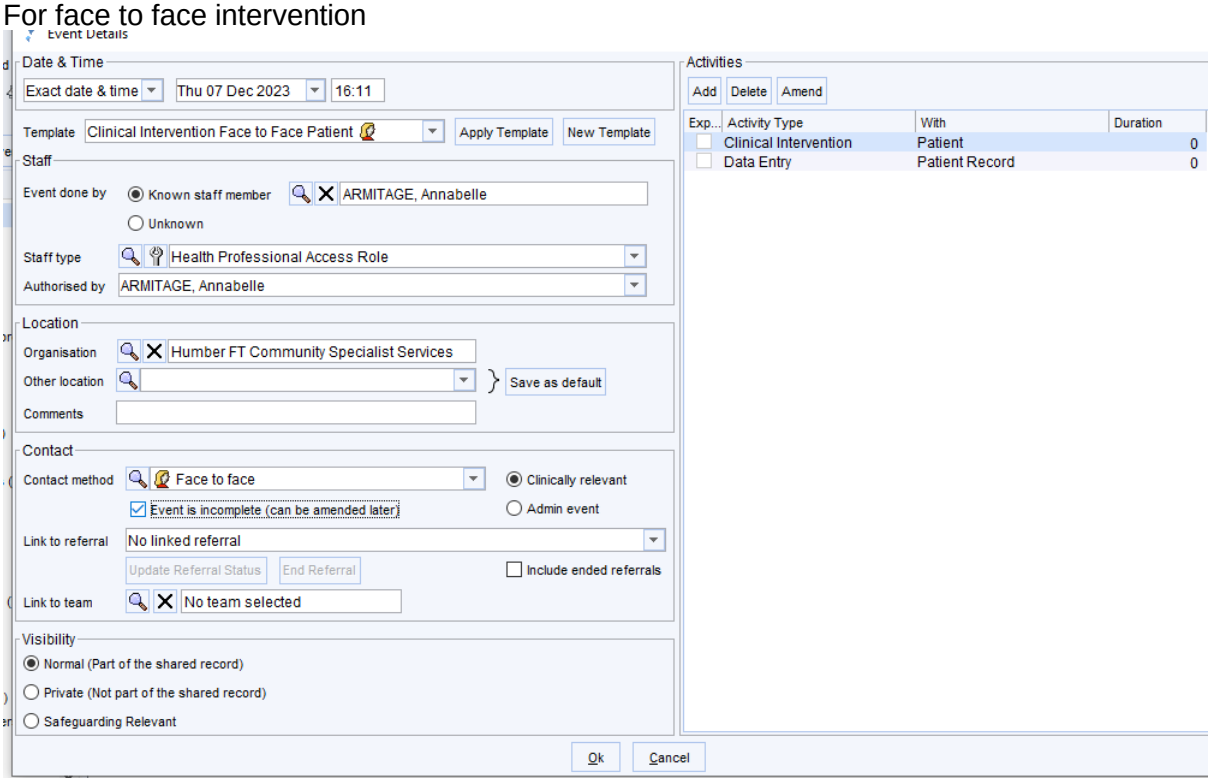


Remember to ensure it is linked to the referral.

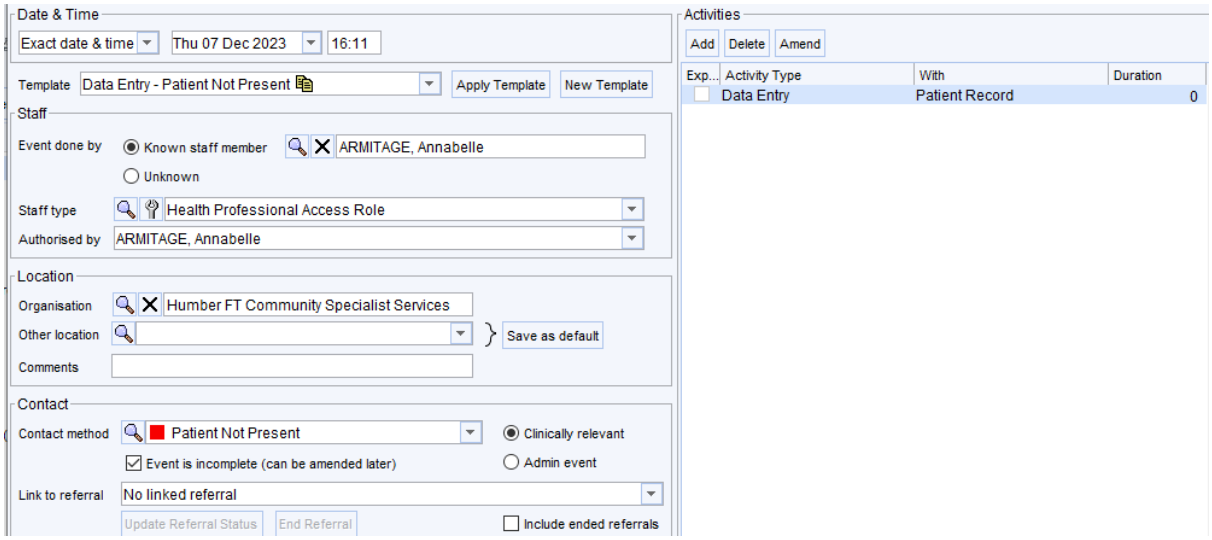
For a telephone review



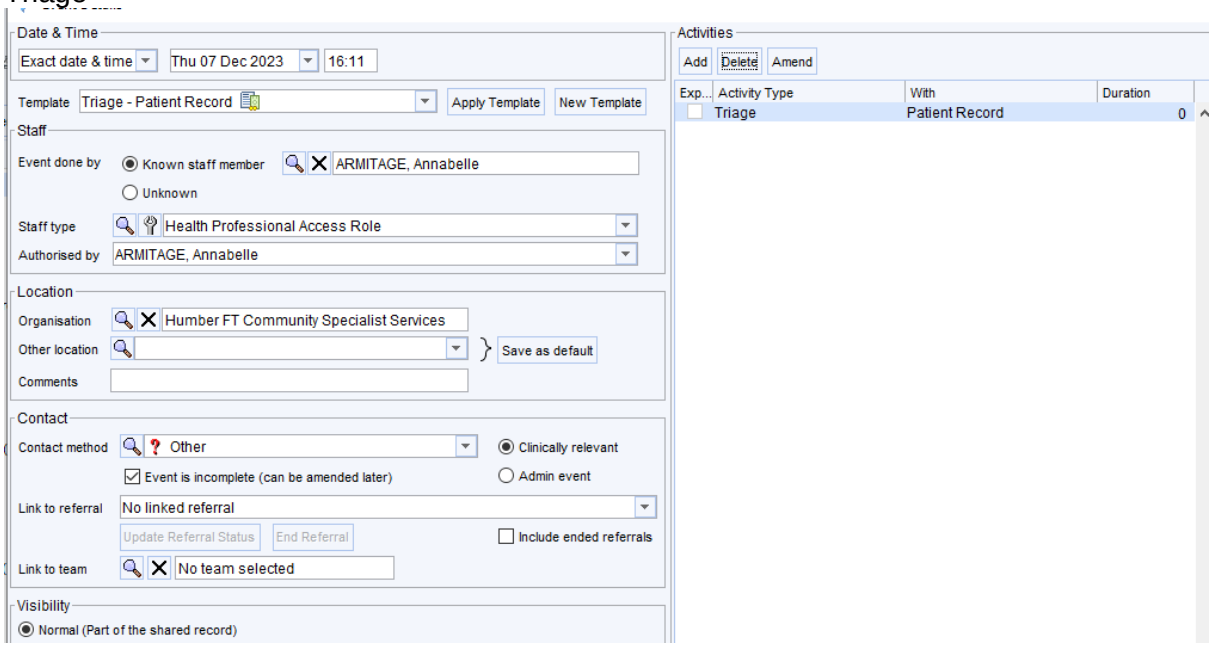
For face to face intervention



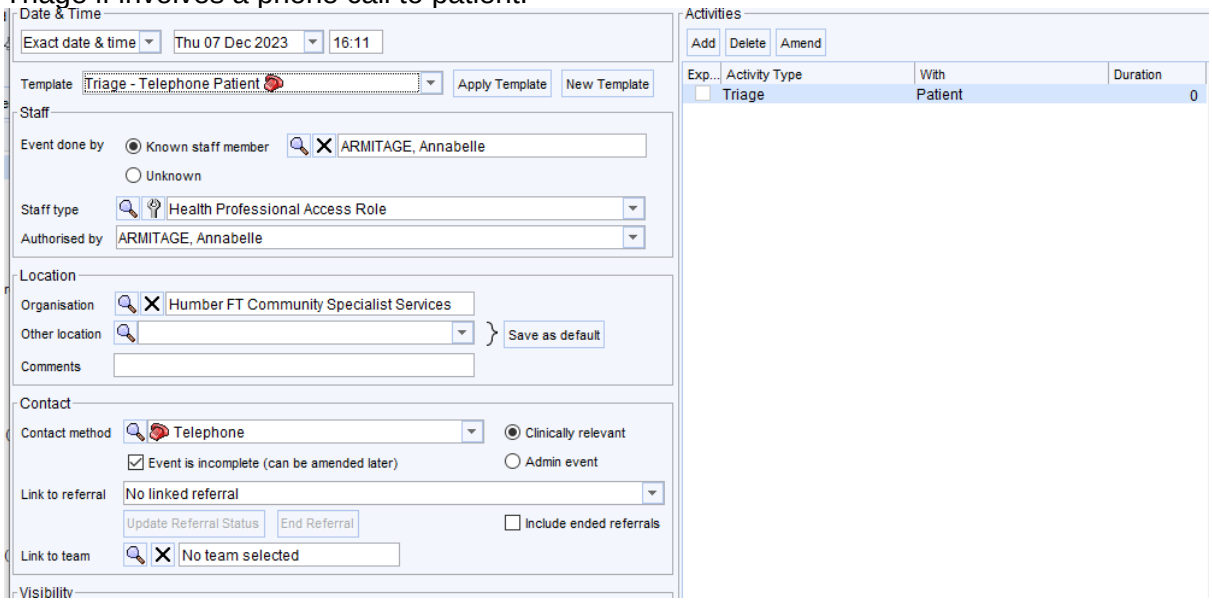
Data entry – this would include any documentation with patient record when patient not present ie task to GP, email to consultant, letters etc, this includes DNA D/C and D/C off open access list.



Triage



Triage if involves a phone call to patient.



Appendix 3: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name:
2. EIA Reviewer (name, job title, base and contact details):
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?

Main Aims of the Document, Process or Service
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Medium	SLT Service commissioned criteria includes exclusion of people below 18 years of age being cared for by the service
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	Incorporate adaptions to support patient need to maximise equality
Sex	Men/Male Women/Female	Low	No potential or actual differential impact with regards to equality related to this equality target group
Marriage/Civil Partnership		Low	No potential or actual differential impact with regards to equality related to this equality target group
Pregnancy/ Maternity		Low	No potential or actual differential impact with regards to equality related to this equality target group
Race	Colour Nationality Ethnic/national origins	Low	No potential or actual differential impact with regards to equality related to this equality target group
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	No potential or actual differential impact with regards to equality related to this equality target group
Sexual Orientation	Lesbian Gay men Bisexual	Low	No potential or actual differential impact with regards to equality related to this equality target group
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	No potential or actual differential impact with regards to equality related to this equality target group

Summary

Please describe the main points/actions arising from your assessment that supports your decision. See above.	
EIA Reviewer: Katie Barraball	
Date completed: 13/05/24	Signature: K. Barraball