Title: Ward Staffing Review 2013 outcomes (for 2014/15 budget setting)

Date: 4th March 2014

Report to: Trust board

Report from: Rosemary Chable – Associate Director of Nursing

Sponsoring Executive: Judy Gillow – Director of Nursing

Sponsoring Divisional Director: N/A


Recommendation(s) / Action Required:
- To discuss the report at open board as a requirement of the National Quality Board expectations around safe staffing assurance.
- To note the expectations outlined in the National Quality Board paper on staffing and how the Trust can demonstrate achievement of these.
- To note the compliant areas related to national guidance on staffing.
- To note the priority shortfall areas by Division supported by TEC to go forward for consideration as part of the Divisional budget setting process.
- To note the revised proposals supported by TEC as part of budget setting for year 2 rollout (of the 3 year plan) of the supervisory ward sister/charge nurse model linked to Francis recommendations.


Related Trust Objectives: Objective 1. Trusted on Quality
Objective 2. Delivering for Tax payers
Objective 3. Excellence in Healthcare

Board Assurance Framework / Risk Register Reference: Corporate risk 585 - Staffing levels and skill mix not always matched to case mix, demand and capacity.

Financial and resource implications: Rollout of proposals for year 2 supervisory ward leader model would require £504K revenue recurring with a phased in-year cost of £294K. (See section 3.5.14)

Legal implications: Recommendations in this report link to the statutory responsibilities arising from the National Quality Board (2013) expectations on ensuring staffing capacity and capability (see section 3.2)

Equality and diversity See Appendix A.
implications:

Staff and patient involvement: A patient representative is included in the Nursing and Midwifery Staffing review group where the annual staffing review is co-ordinated.

Partnership working and public engagement implications: N/A

1 Purpose

1.1 The purpose of this paper is to report on the investment outcomes from the 2012 annual staffing review agreed at TEC in 2013 and present the findings of the annual ward staffing review 2013 carried out as part of the systematic review of staffing resources to ensure safe staffing levels to effectively meet patient care needs.

1.2 The report also outlines progress on year 1 of the 3 year rollout of the supervisory ward sister/charge nurse model agreed at TEC in 2013 and includes proposals for the priority areas for year 2 rollout.

1.3 This paper focuses specifically on a review of in-patient ward areas. A more detailed review of intensive care and high care areas will be included as part of the mid-year report on staffing establishments. Other non-ward nursing posts are reviewed separately by each Division’s DHN.

1.4 The specific detail is separated into 2 sections. The first section reports on the impact of the 2013/14 funding agreed as part of the 2012 staffing review and outlines the background, process and findings from the 2013 ward staffing review. It includes detail on the outstanding risks and recommendations being proposed for consideration at budget setting. The second section outlines the progress on implementing the supervisory ward sister/charge nurse model and identifies the priorities for the rollout in year 2.

1.5 This report fulfils expectation 1, 5, 6 and 7 of the National Quality Board requirements for trusts in relation to safe nurse staffing.

2 Key Issues/Executive summary

2.1 Ensuring the appropriate level of staffing is available within ward settings is imperative for assuring the quality of safe, high quality care given to our patients and achieving regulatory compliance. It is also key to achieving the aspirations in our 20:20 Vision and supports the objectives outlined in the enabling strategies of:

- Patient Experience
- Staff Experience
- Developing Defining Clinical Services
- Achieving financial balance
- Patient Safety

2.2 Matching resource to need, in order to manage safe, effective and efficient care, is key to delivering a safe and improved patient experience and a quality service that our commissioners want to buy.

2.3 Recent high profile reviews e.g. Francis Report (2010) on the Investigation into Mid-Staffordshire have highlighted staff shortages and the lack of a co-ordinated approach to staffing as a significant contributory factor to the poor quality of care delivered. Specific findings around the need to review staffing levels systematically were included in the Francis report and key recommendations have emerged in Hard Truths.

2.4 In November 2013 as part of the national response to the Francis enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) ‘How to ensure the right people, with the right skills, are in the right place at the right time’. This has key implications for the trust which are addressed by the systematic approach to ward staffing reviews which has been established in the organisation.
2.5 UHS has developed a sustainable model for systematically reviewing staffing levels on the wards which has been strengthened year on year and uses nationally recognised methodologies. The review for 2013 has shown that whilst overall the areas broadly meet the national recommendations, there are some areas, particularly linked to out of hours ratios, which require continued focus to ensure the staffing levels remain safe and effective.

2.6 Year 1 of the 3 year rollout of the supervisory ward leader model has already started to yield tangible benefits to quality and patient care. Sustaining the rollout of this approach will remain key in moving forward with the improvements in patient care.

3 Specific Detail

3.1 Ward staffing review methodology

3.1.1 In 2006 UHS established a systematic, evidence based and triangulated methodological approach to reviewing ward staffing levels on an annual basis linked to budget setting and to review the staffing requirements for any developments planned in-year. All this was aimed to provide safe, competent and fit for purpose staffing to deliver efficient, effective and high quality care and has resulted in year on year increases in the nursing workforce matched by increased investment.

3.1.2 This approach utilises the following methodologies and has been undertaken annually:

- Safer Nursing Care Tool Acuity/Dependency staffing multiplier (A nationally validated tool reviewed in 2013 previously AUKUH acuity tool)
- Professional Judgement
- Peer group validation
- Benchmarking and review of national guidance (Paediatric, Adult and Older Persons)
- Review of eRostering data (since 2011)

3.2 New national guidance

3.2.1 In 2013 as part of the national response to the Francis enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) ‘How to ensure the right people, with the right skills, are in the right place at the right time.’

3.2.2 This paper includes 10 key expectations of NHS organisations with the 4 detailed below having key relevance to this paper. (The remaining expectations were outlined in the staffing status report presented to TEC in December 2013 and ongoing compliance will be monitored through the monthly staffing status report.)

3.2.3 Expectation 1: Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality take full and collective responsibility for nursing, midwifery and care staffing capacity and capability – In place

3.2.4 Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments

- Director of Nursing to lead nursing establishment review process - In place
- Establishments need to be set in collaboration with finance, medical director and others - In place

3.2.5 Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties

- Recommendation on adequate headroom allowance - In place (reported via staffing status report)
- Recommendation on supervisory time for ward leaders - Included in this report

3.2.6 Expectation 7: Boards receive monthly updates on workforce information and staffing capacity and capability is discussed at a public board meeting at least every six months on the basis of a full nursing and midwifery establishment review - In place but requires more refinement and detail

3.2.7 Additionally as part of the Hard Truths report – work has been commissioned by the National Institute of Health and Care Excellence to provide more national guidance on staffing establishment methodologies and recommended staffing levels. This is due to be published in summer 2014. The Trust is already seen as an exemplar site for the methodology use for the
staffing reviews and is actively working as part of national groups to influence and further standardise the approach.

3.2.8 A robust systematic approach to assessing the required level of staffing on wards has now been well embedded within the Trust. This has put the Trust in a strong position to provide assurance around the ongoing staffing requirements, using a nationally recognised methodology.

3.2.9 This approach will be kept under constant review and refreshed annually as part of the budget setting process.

3.2.10 This approach is supported by emerging research which is very clear in identifying the links between appropriate staffing levels and high quality patient care outcomes. The systematic approach taken in this review and the investment plan ensures that the Trust is well positioned to drive forward the identified quality benefits and fulfil regulatory requirements.

3.3 **Staffing review 2012 recommendations and 2013/14 investment outcomes**

3.3.1 In February 2013, TEC agreed to support, through budget setting for 2013/14, the uplift in the identified priority shortfall areas put forward in the review paper. Table xxx shows the hotspot areas, the overall shortfalls identified and the impact of funding in these areas.

<table>
<thead>
<tr>
<th>Division</th>
<th>2012 review recommendations</th>
<th>2013/14 Ward Staffing investment (wte)</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division A: Surgical</td>
<td>E7 – Increase in beds has reduced the nurse: bed ratio to 1.2 (below national guidance) since previous investment and reduced the skill mix to 58:42 (against 65:35 benchmark)</td>
<td>2 wte (registered)</td>
<td>Nurse to bed ratios increased to benchmark level of 1.3 ✓. Skill-mix increased to 60:40 ✓. Ratios of patient to registered nurse within national recommendations ✓.</td>
</tr>
<tr>
<td></td>
<td>Division B: Unscheduled Care</td>
<td>D6 – Nurse: bed ratio at 1.16, reduced skill-mix to 64:36 (against 65:35 benchmark) and Safer Nursing Care Tool (acuity) recommendations show higher acuity than staffing model. D7 – Nurse: bed ratio at 1.2 which does not reflect casemix requirements</td>
<td>7 wte (mixed registered/unregistered)</td>
</tr>
<tr>
<td></td>
<td>Division C: Bramshaw ward</td>
<td>Nurse: bed ratio 1.16</td>
<td>1.2 wte (mixed registered/unregistered)</td>
</tr>
<tr>
<td></td>
<td>Division D: Specialist Services</td>
<td>E3 – Nurse: bed ratio 1.1 and increased acuity due to casemix changes E4 – Nurse: bed ratio 1.2 and increased acuity due to casemix changes</td>
<td>7.2 wte (mixed registered/unregistered uplift required)</td>
</tr>
</tbody>
</table>

3.4 **Annual Ward Staffing review 2013 - Outcomes and recommendations for budget setting 2014/15**

3.4.1 The annual systematic ward staffing review was commenced in November 2013. This review followed the same triangulated methodology applied in previous reviews and updated the
requirements needed across the trust. As a key part of the review additional staffing metrics were reviewed resulting from recommendations in the RCN evidence-based nurse staffing levels report published in December 2010 and further developed through the safer care alliance in 2013 and the RCN recommendations for children’s areas published in June 2013.

3.4.2 A separate review has been undertaken against midwifery staffing which has identified that they are within the recommended national levels – no recommendations are therefore included for midwifery services.

3.4.3 Trust wide risks and issues considered in the review

3.4.3.1 Increasing patient acuity/dependency

The development of our defining services continues to result in an evidenced increase in the complexity, acuity and dependency of the patients cared for in our general ward beds (confirmed by 4 monthly systematic acuity/dependency reviews). This is a situation which is expected to continue as more activity moves to the community, impacting on the staffing and skill mix levels required.

3.4.3.2 Fig. 1 shows the trust averages for acuity/dependency over the previous 4 years since systematic recording 3 times a year commenced. This demonstrates a steady increase in both acuity and dependency trust wide. (Level 0 represents patients requiring general ward care, level 1a represents highly acute patients, level 1b represents highly dependent patients and level 2 represents patients on general wards who should be cared for in a high care or intensive care facility).

Fig. 1 Average Trust Wide Acuity 2010-2013

3.4.3.3 Bariatric patients – Recent reporting of patients within the hospital exceeding 150kg/BMI 50 has shown that there are on average 30 patients at any one time and this appears to be an increasing trend. This group of patients (dependent on care needs) will inevitably require a higher level of staff input and more staff available for mobility.

3.4.3.4 Specialling demands - The annual average level of specialling requirement is 22 wte ranging from 7.4 wte to a peak of 44.8 wte in June 2013. This shows a further significant rise on the previous year (highest peak in the previous year of 25 wte experienced in May 2012). This is consistent with the rise in acuity/dependency levels reported for the year and the increase of patients with dementia.

3.4.3.5 Vacancies and temporary staffing - Total reported nursing vacancies across the inpatient areas at the time of the staffing review were running at 292 wte (December 2013). A key action for all divisions in 2014/15 is to continue to concentrate efforts to fill these vacancies.

3.4.3.6 Temporary staffing usage to offset these additional pressures for the same period was 259 wte (December 2013).
3.4.3.7 Further consolidation on filling substantive posts and reducing underlying vacancies will need to be a focus in 2014/15 which will support the overall staffing position and reduce the reliance on temporary staffing solutions.

3.4.3.8 The table at Appendix 1 shows the detailed review of current staffing ward by ward mapped against the standards identified in the RCN guidance. This demonstrates that there are still areas where there are shortfalls against one or more of the identified metrics and which will require consideration as part of the budget setting process and constant review by the clinical areas to manage the staffing resource effectively to mitigate the shortfalls.

3.4.4 Key emergent trust themes

3.4.4.1 Whilst investment over previous years in ward staffing has improved a number of staffing metrics there are still some key outstanding areas, particularly linked to out of hours ratios, that require further consideration.

3.4.4.2 Table 2 highlights the ‘hotspot’ areas that have emerged from the review and where further internal reallocation of the existing funding resource cannot mitigate these shortfalls. Divisions are presenting these issues as part of the considerations for budget setting and TEC have agreed to support the identified priority areas.

Table 2

<table>
<thead>
<tr>
<th>2013 Areas reviewed</th>
<th>2013 Review - Recommendation overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division A</td>
<td>COMPLIANCE</td>
</tr>
<tr>
<td>14 areas reviewed</td>
<td>ACTION NEEDED</td>
</tr>
<tr>
<td>Division B</td>
<td>COMPLIANCE</td>
</tr>
<tr>
<td>13 areas reviewed</td>
<td>ACTION NEEDED</td>
</tr>
<tr>
<td>Division C</td>
<td>ACTION NEEDED</td>
</tr>
<tr>
<td>Child Health and Gynaecology reviewed</td>
<td></td>
</tr>
<tr>
<td>Division D</td>
<td>COMPLIANCE</td>
</tr>
<tr>
<td>15 areas reviewed</td>
<td>ACTION NEEDED</td>
</tr>
</tbody>
</table>

3.4.4.3 Ratio of staff to patients at night.
Increases in the acuity and dependency of patients requiring interventions and monitoring across the 24 hour period, the rising levels of patients requiring 1:1 special nursing due to complexity or mental health issues, the rise in the number of bariatric patients and the increase in the number of patients requiring escort from the wards for investigations out of hours has all led to a need to re-balance the staff available overnight. In 19 adult wards, registered nurses are caring for 10 or more patients at a time. In some cases the staff available overnight can be adjusted by re-allocation of existing staff but some ward areas will require an uplift to enable them to provide additional cover.

3.4.4 Support staff availability to ward areas

The provision of ward clerk and housekeeper support to the ward areas has a key impact on the ability of the nursing staff to provide direct care to the patients. In a number of areas extending the support provided in these roles would have a key impact on the wards. This is a particular issue for areas in division B who have a high ratio of patients providing supervision at mealtimes and in the acute admission areas where ward clerk cover is not provided at weekends or out of hours.

3.4.4.5 Responding to new emergent national guidance

In 2013 new guidance was produced making recommendations on staffing for child health areas. A detailed review has been undertaken and a professional judgment approach used to benchmark UHS against this guidance which has shown some key shortfalls in some areas. It has been agreed that budget setting will focus initially on addressing issues within the Paediatric Medical Unit and supporting the supervisory model as a more detailed business case is developed linked to income.

3.4.5 Quality, Safety and Financial Benefits

3.4.5.1 The Mid-Staffordshire Review highlighted the lack of systems to review ward staffing as a contributory factor to the quality deficiencies within the Trust. The systematic approach adopted within UHS, and actioned through investment has provided a clear audit trail for UHS of management of these risks.

3.4.5.2 A range of validated research has linked higher proportions of registered nurses on the ward with the best clinical and quality patient outcomes. This has been further reinforced by the recent international research study (RN4Cast – of which UHS was a participant).

3.4.5.3 Financial benefits linked to the reduction in high cost agency; reduced sickness levels, improvements in retention, improvements in length of staff and improvements in other quality metrics have all been demonstrated following the 3 year investment but have deteriorated in the last year linked to a higher vacancy rate. If recruitment to establishment can be secured and maintained this will sustain and further enhance these benefits.

3.4.6 Financial Information

3.4.6.1 The Divisions have included the shortfalls identified against the hotspot areas noted in this paper as part of the budget setting planning process. A review of priorities has been overseen by the Director of Nursing to further inform budget setting.

3.4.6.2 TEC has agreed that these areas of shortfall continue to be addressed through the budget setting process and have agreed that phased investment in staffing is aligned to the overall vacancy/recruitment trajectory plan for each Division.

3.5 Progress on the introduction of the supervisory ward sister/charge nurse model and priorities for year 2 implementation

3.5.1 In February 2013 TEC agreed a 3 year implementation plan for the delivery of a full supervisory ward leader model across all inpatient ward areas by 2016.

3.5.2 This implementation plan has positioned the Trust well in responding to what has now emerged as a key recommendation in the Francis report and further validated through Hard Truths.

3.5.3 The Francis report (2013) outlined the recommendation for supervisory ward leadership as a separate resource to the baseline staffing numbers on a ward (recommendation 195) as one of
the key actions arising from the review – this has now been incorporated into the Hard Truths response as part of the national quality board expectations.

3.5.4 The UHS model is based on the following principles/priorities for the ward sister/charge nurse:
- Being additional to the baseline numbers of staff required per shift to support direct patient care
- Being visible and accessible in the clinical area to the clinical team
- Working alongside the team in different ways – supporting junior colleagues and facilitating the learning in and from practice
- Monitoring and evaluating standards of care provided by the clinical team
- Providing regular feedback to the clinical teams on standards of care provided
- Creating a culture for learning and development which sustains safe and effective person centred care
- Directly impacting the quality, patient safety, patient experience and staff experience outcomes

3.5.5 Introduction of the full supervisory model will have a key impact on achievement of the quality strategic goals of the organisation and will release the ward sisters/charge nurses to focus on assuring delivery of the quality metrics for improving patient safety, experience and outcomes and to effectively run the ward.

3.5.6 This original 3 year implementation plan covered 55 inpatient areas and enabled 19 wards to go live in 2013/14 with a further 27 wards scheduled for 2014/15 and the remaining 9 wards in 2015/16.

3.5.7 A total of 19 wards have been designated with supervisory status during 2013/14 with the remaining 36 wards planned for years 2 and 3.

3.5.8 The overall supervisory ward leader model has also been developed during 2013/14 with clear job descriptions, competencies and training launched and a new uniform introduced. A key set of key outcome indicators was also agreed to monitor the success and impact of the scheme.

Table 3: Early Benefits of Introduction of supervisory model - Pilot ward outcomes

<table>
<thead>
<tr>
<th>Expected outcome</th>
<th>Pre-supervisory</th>
<th>Post-supervisory</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in complaints</td>
<td>6</td>
<td>2</td>
<td>Reduction of 4</td>
</tr>
<tr>
<td>Improved FFT response</td>
<td>Net promoter 80</td>
<td>Net promoter 100</td>
<td>Increased by 20</td>
</tr>
<tr>
<td>Improved clinical cleanliness</td>
<td>97%</td>
<td>99%</td>
<td>Increase of 2%</td>
</tr>
<tr>
<td>Decrease in avoidable grade 4 pressure ulcers</td>
<td>3</td>
<td>1</td>
<td>Decrease of 2</td>
</tr>
<tr>
<td>Decrease in falls</td>
<td>5 per month</td>
<td>2 per month</td>
<td>Reduction of 3 per month</td>
</tr>
<tr>
<td>Decreased sickness rates</td>
<td>5%</td>
<td>1.8%</td>
<td>Reduction of 3.2%</td>
</tr>
<tr>
<td>Increase in pre 11am discharges</td>
<td>11%</td>
<td>16%</td>
<td>Increased by 5%</td>
</tr>
<tr>
<td>Full accreditation or exemplar CAS</td>
<td>N/A</td>
<td>Achieved exemplar</td>
<td></td>
</tr>
</tbody>
</table>
3.5.14 Priorities for year 2 rollout

3.5.14.1 Priorities presented in table 4 for rollout in year 2 recognise that proposals need to be considered in the wider context of all the budget setting pressures and priorities.

3.5.14.2 For 2014/15 this is seen as the top nursing priority and the 3 year plan has therefore been reviewed with the proposal to rollout the scheme to 18 wards in year 2 (previously 27) and 18 wards in year 3 (previously 9).

Table 4

<table>
<thead>
<tr>
<th>Division Rollout 2014/15</th>
<th>Priority Ward Areas – Supervisory Ward Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division A = 6</td>
<td>2 Cancer (C4, CMH)</td>
</tr>
<tr>
<td></td>
<td>4 Surgical (F5, F6, F7, E7)</td>
</tr>
<tr>
<td>Division C = 6</td>
<td>4 Child Health (PMU, PAU, Piam Brown, G4, G3)</td>
</tr>
<tr>
<td></td>
<td>1 Gynae (Bramshaw)</td>
</tr>
<tr>
<td>Division D = 6</td>
<td>4 Neurosciences (C Neuro, D Neuro, Stanley Graveson, F8)</td>
</tr>
<tr>
<td></td>
<td>2 T &amp; O (F3, F4)</td>
</tr>
<tr>
<td>Total</td>
<td>18 wards</td>
</tr>
</tbody>
</table>

3.5.14.3 This would require funding of 14.4 wte band 5 posts at a cost of £35K. The year 2 rollout would be phased over quarters across the year to reduce the full year effect. This would give a full-year cost of £504K with a phased in-year cost of £294K (see table 5).

Table 5

| 14/15 cost:            |                |                |                |                |                |
|------------------------|----------------|----------------|----------------|----------------|
|                        | No. of Wards   | WTE            | 14/15 Cost     | FYE            | Total cost     |
| Qtr 1                  | 4              | 3.2            | £ 112,000      | £              | £ 112,000      |
| Qtr 2                  | 4              | 3.2            | £ 84,000       | £ 28,000       | £ 112,000      |
| Qtr 3                  | 4              | 3.2            | £ 56,000       | £ 56,000       | £ 112,000      |
| Qtr 4                  | 6              | 4.8            | £ 42,000       | £ 126,000      | £ 168,000      |
| Total                  | 18             | 14.4           | £ 294,000      | £ 210,000      | £ 504,000      |

4 Next Steps / Way Forward

4.1 A robust systematic approach to assessing the required level of staffing on wards has now been well embedded within the Trust. Since 2011 this annual review approach has been further enhanced by the inclusion of eRostering data and review of the metrics in the RCN national nurse staffing policy documents.

4.2 Research is very clear in identifying the links between appropriate staffing levels and high quality patient care outcomes. The systematic approach taken in this review and the continued rollout to enable the ward sisters/charge nurses to be truly supervisory ensures that the Trust is well positioned to drive forward the identified quality benefits and therefore the associated cost effectiveness and efficiency benefits.

4.3 The 2013 review has demonstrated that there are key shortfalls in a few areas that need to be considered in the budget setting priorities to bring these areas to an establishment level that is within national recommendations and enables the wards to provide safe and effective care.

4.4 It is key to maintain the momentum and rollout of the supervisory ward leader model, linked to the emerging benefits which are directly impacting on the quality of patient care delivered.

4.5 TEC has supported the revised rollout plan as a key priority at budget setting, enabling the trust to...
clearly demonstrate an ongoing implementation plan to deliver against a key Francis recommendation.

5 Recommendations

5.1 To discuss the staffing proposals at open board as a requirement of the national quality board expectations around safe staffing assurance.

5.2 To note the expectations outlined in the National Quality Board paper on staffing and how the Trust can demonstrate achievement of these.

5.3 To note the compliant areas related to national guidance on staffing.

5.4 To note the priority shortfall areas by Division supported by TEC to go forward for consideration as part of the Divisional budget setting process.

5.5 To note the revised proposals supported by TEC for year 2 rollout (of the 3 year plan) of the supervisory ward sister/charge nurse model linked to Francis recommendations.
This Impact Assessment relates to:

A Trust Policy (which impacts across the whole organisation)  
A new service development, service change or change management proposal  
A commissioning or procurement proposal

<table>
<thead>
<tr>
<th>Title of policy / proposal</th>
<th>Supervisory Ward Sister/Charge Nurse proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person initiating policy / proposal</td>
<td>Rosemary Chable</td>
</tr>
<tr>
<td>Name of authorising committee</td>
<td>TEC</td>
</tr>
<tr>
<td>Name of person with authority to approve this EIA (chair of committee)</td>
<td>Fiona Dalton</td>
</tr>
<tr>
<td>Date EIA approved</td>
<td></td>
</tr>
<tr>
<td>Details of stakeholders consulted in the assessment process</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the policy / proposal affect one group more or less favourably than another based on the 9 protected characteristics?</th>
<th>More favourably Yes / No</th>
<th>Less favourably Yes / No</th>
<th>Comments / Information considered to reach this decision.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sex / Gender</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability (mental, physical and learning disability should be included in this section)</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Race / Ethnicity</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

If you have answered yes to any of the above, you **MUST** complete the comments column explaining what information you have considered which has led you to reach this decision. Please continue overleaf if required.

How would you rate the level of impact / risk to the organisation?  – **Low** (delete as appropriate).