East Suffolk and North Essex NHS Foundation Trust

Complaints and Concerns Handling Policy

Version 3.0

Purpose:	To advise and inform hospital and community staff of the process for handling complaints and concerns
For use by:	All hospital staff
This document is compliant with/supports compliance with:	• The Care Act 2014 • The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 • Data Protection Act 2018 • The Local Authority Social Services and National Health Service complaints (England) regulations 2009 • Public Interest Disclosure Act 1998
This document supersedes:	• IHT Complaints and Concerns Policy Version 6.0 ratified 15 Dec 2017 • CHUFT Complaints Policy and Procedure Document ref. no: PP(16)029 • Complaints and Concerns Handling Policy v2.0 - ESNEFT
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In case of queries contact Responsible Officer:	PALS and Complaints Manager
Directorate and Department	PALS and Complaints, Nursing and Quality, Corporate Division
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Version and document control:

Version	Date of Issue	Change of Description	Author
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0.2	22.06.2018	Second Draft – Changes to job titles Final amendments for ESNEFT – organisation name, role titles and internal references	S Higson / B Rudland
1.0	29.06.2018	Grammatical changes and removal of Associated Director of Clinical Governance as this role no longer exists.	
1.1	01.07.2021	Updated in accordance with Patient Safety Incident Response Framework	T Shepherd / D De'Cort
2.0	01.07.2021		A Rutland
3.0	12.12.2022	Updated to reflect changes following complaints workshop hosted by Chief Executive and Chief Nurse on 30 September 2022	T Shepherd

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Trust documents may be disclosed as required by the Freedom of Information Act 2000.

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Release of any strategy, policy, procedure, guideline or other such material must be agreed with the Lead Director or Deputy/Associate Director (for Trust -wide issues) or Business Unit/ Departmental Management Team (for Business Unit or Departmental specific issues). Any requests to share this document must be directed in the first instance to the PALS and Complaints Manager.

For further advice see the Development and Management of Trust wide Procedural Documents Policy

Contents

Section 1 - Introduction

1.1 Policy Statement and Rationale

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) is committed to ensuring that it is able to provide an effective method by which users of the service can make an enquiry, express their concerns, or raise a complaint regarding care and treatment received from the Trust.

Complaints are a valuable tool for an organisation to monitor its performance and review areas that require improvement. They therefore contribute an important mechanism as part of the Trust's overall approach to clinical governance and patient safety and experience.

The word "concern" is used and referred to in posters and leaflets, as it is a softer term. It is used with the intention of encouraging patients, relatives and carers to raise an issue that they may not deem to be a complaint but may still require an investigation.

For reporting purposes, concerns are recorded as complaints. Therefore, the word concern will not continue to be used or referred to furthermore in this policy.

This policy gives staff clear guidance on how complaints will be managed to ensure a consistent, fair and just approach to all those involved in a complaint.

The Trust is committed to promoting an environment that values diversity. Any patient who makes a complaint, or any other person involved in the investigation and resolution of a complaint, will be treated equally and fairly and not discriminated against because a complaint has been made or on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason.

Attention will be given to employees and service users for whom English is not their first language, who have a visual impairment or other disability, ensuring they understand and are able to benefit from this policy and in accordance with Accessibility Standards.

1.2 Key Principles

- Ease of access for people raising complaints
- Complaints will be dealt with efficiently and will be properly investigated
- To provide information, advice and support enabling people to understand the procedure for making a complaint
- Provision of a timely and appropriate response that will include the outcome of the investigation into the complaint
- Action will be taken if necessary in the light of the outcome of a complaint
- People raising a complaint and staff will be treated fairly, without apportioning blame
- Honest and thorough approach, with the prime aim of resolving complaints to the satisfaction of the complainant
- Complainants will be treated with respect and courtesy and should be reassured that they will not be treated differently as a result of raising a complaint

1.3 Background Information

Why do people complain? Complainants usually want information: an explanation of what happened and why, in a language they can understand. Generally, complainants ask for something to be done to prevent the same thing happening again. Complainants can also want action that includes remedy (such as faster or additional treatment) or financial compensation. However, this is rarely their primary goal.

A complaint should be raised within twelve months from the incident that caused the problem, or within twelve months of the date of discovering the problem, provided that this is within twelve months.

Note: There is discretion to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and when it is still possible to investigate the facts of the case. This discretion will lie with the PALS and Complaints Manager and the appropriate Associate Director of Nursing.

1.4 Definitions

Complaint	An expression of dissatisfaction from a patient or person acting on their behalf requiring a response. A complaint can be written, verbal or by email.
Complainant	A person raising a complaint.
Low, medium, and high level complaints	Complaints are triaged and recorded in accordance with national guidelines. The categories are low, medium and high levels. **Low-level complaints are defined as** - Unsatisfactory service or experience not directly related to care. No impact or risk to provision of care, or, unsatisfactory service or experience related to care, usually as a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation. **Medium level complaints are defined as -** Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation. **High-level complaints are defined as -** Significant issues regarding standards, quality of care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity. However, there is no assumption that one type of complaint is less important than another.
The Regulations	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
Division	The hospital is divided into areas of specialty and these are referred to as Divisions.
The Trust	East Suffolk & North Essex NHS Foundation Trust (ESNEFT)
CCG	Clinical Commissioning Group
CDG	Clinical Delivery Group
Ombudsman	Parliamentary and Health Service Ombudsman

Complaints Management System, Datix	The electronic complaints recording system that is used within ESNEFT. This system allows authorised members of staff access to information regarding complaints for their individual area of responsibility. This system means there is one central electronic complaint file with all of the relevant details contained within it.

Section 2 – Duties and Responsibilities

2.1 Front line staff

Patient feedback is essential to the continuous improvement of patient services. How patients perceive the organisation and their treatment is a matter of reputation to the Trust, as is the speed and sensitivity with which complaints are handled.

Staff should, where possible, deal with a complaint raised directly to them rapidly and always in a professional and sensitive manner.

Any complaint that cannot be resolved by the next working day after the day on which the complaint was made should be escalated initially to PALS for further action.

Staff should respond to requests for information in relation to the investigation of a complaint promptly and within the specified timeframe given.

2.2 Chief Executive & Managing Director

The Chief Executive or Managing Director (or designated deputy), has overall responsibility for complaints handling issues and sign off for all high level and medium level complaint responses.

The Chief Executive ensures the Trust meets its statutory and legal requirements and adheres to guidance issued by the Department of Health.

2.3 Chief Medical Officer

The Chief Medical Officer will offer advice in the event of complex cases involving medical staff. In cases of non-compliance with the Complaints Policy, doctors may be called to meet with the Chief Medical Officer

2.4 Chief Nurse

The Chief Nurse is accountable to the Chief Executive and has delegated responsibility for complaints and is a designated deputy to the CEO or Managing Director for signing complaint letters. The Deputy Chief Nurse will offer advice in the event of complex cases involving medical / clinical staff.

2.5 Deputy Chief Nurse, Quality

The Deputy Chief Nurse, Quality, is accountable to the Chief Nurse and is responsible for monitoring compliance and effectiveness of this policy and for ensuring that action plans are developed and implemented to improve compliance. They will work with the Head of Patient Experience and the PALS and Complaints Manager to review and ensure effective implementation.

2.6 Head of Patient Experience

The Head of Patient Experience is accountable to the Deputy Chief Nurse and is responsible for the line management of the PALS and Complaints Manager and the PALS and Complaints service sits within the patient experience department. They will work with the PALS and Complaints Manager to ensure the effective implementation of the policy.

2.7 PALS and Complaints Manager

The PALS and Complaints Manager is the responsible officer for this policy.

The PALS and Complaints Manager will:

- Manage the complaints procedure in accordance with The Regulations and this policy
- Ensure all complaints are triaged and will allocate the Division who will take the lead where a complaint involves more than one Division
- Provide training and support for front line staff in handling and resolving complaints
- Liaise with other NHS and adult social care services to provide a coordinated response where a complaint involves two or more organisations
- Provide appropriate reports, monthly, quarterly and annually.

2.8 Governance Committees

The Patient Experience Group, (PEG) which reports to the Quality & Patient Safety Committee, will receive reports on the PALS and Complaints services and activities. The Quality & Patient Safety Committee will provide assurance to the Trust Board on the Trust's compliance with its statutory responsibilities in relation to the PALS and Complaints Service.

The Quality & Patient Safety Committee will review and approve this policy prior to Board ratification. The Committee will receive reports on the compliance and effectiveness of this policy and will agree and monitor the implementation of any action plans to improve compliance.

2.9 The Patient Oversight Group

The Patient Oversight Group provides assurance to PEG that appropriate processes are in place and being regularly reviewed to demonstrate effective delivery of the complaints process and learning is undertaken and shared throughout the organisation.

2.10 Divisional Management Team

The Divisional Management Team is accountable for ensuring that the complaints process is followed within their portfolio of services. Concerns relating to non-compliance of the complaints policy and process will be escalated to the Deputy Chief Nurse. The Divisional Management Team is accountable for ensuring that all staff, including managers, involved in complaints handling understand their responsibilities in respect of the complaints process and the consequences of non-compliance.

2.11 Associate Directors of Nursing/Heads of Nursing/Midwifery and Service Leads

The Associate Directors of Nursing (ADoNs), Head of Nursing/Midwifery, and Service Leads are accountable for management of the complaints process within their service areas. The ADoNs, Head of Nursing/Midwifery, and Service Leads will support the Appointed Specialty

Leads to ensure complaints raised within their Division or area of Executive Support are investigated thoroughly, providing an appropriate response to the complainant within the agreed timeframe and in the format agreed with the complainant.

When an extension to the agreed timeframe is needed, the Complaints Coordinator will contact the complainant to request additional time. Should a further extension be required the Divisional Management Team must request this from the Chief Executive before any further extensions are requested from the complainant. The Associate Director of Nursing is responsible for contacting the complainant to offer an explanation and request any further extension to the timeframe. They will approve the responses before it is sent to the Complaints Coordinator.

2.12 Associate Director of Operations

The Associate Director of Operations is responsible for ensuring that complaints issues linked to operational working and staff within their line management responsibility are effectively responded to.

2.13 Clinical Delivery Group (CDG) Lead

It is the responsibility of the CDG Lead to ensure that complaints that relate to medical treatment and/or the actions or behaviour of medical staff are dealt with by the appropriate consultant or doctor.

2.14 Matron or Head of Service

The Matron or Head of Service, if appropriate, will take action to resolve enquiries and complaints raised within their areas.

2.15 Appointed Specialty Leads

Appointed Specialty Leads are responsible for managing the complaints process within their service area.

The Appointed Specialty Leads are responsible for providing divisional feedback / response, approved by the Associate Director of Nursing and Head of Nursing / Midwifery, to the Complaints Coordinator in an appropriate format for the response letter.

The Appointed Specialty Leads will ensure the Complaints Coordinator is kept informed of the progress of a complaint investigation and will notify them if the agreed timeframe for resolution of the complaint cannot be met.

The Appointed Specialty Leads are responsible for identifying lessons learned and actions taken and providing this information to the Complaints Coordinator ensuring that action plans for complaints relating to their Division are carried out within the specified timeframe and that progress is reported to the Complaints Coordinator and included on Datix.

2.16 Legal Services Manager

The Associate Director of Legal and Governance Services – Corporate and Legal will provide legal advice as appropriate.

2.17 PALS & Complaints Coordinators

The Complaints Coordinators will:

- Liaise between people contacting the service and hospital staff and will co-ordinate the resolution of complaints and enquiries
- Acknowledge receipt of all complaints within 3 working days in writing and forward details to the appropriate Head of Nursing / Midwifery and Appointed Specialty Lead and Governance Teams
- Monitor the progress of investigations into complaints and provide advice and support to investigating staff to ensure resolution of the issues
- Monitor Trust response times against the timeframe agreed with the complainant and prepare reports as required (**refer to Section 6 – Monitoring and Reporting**)
- The PALS and Complaints Coordinators will provide an immediate point of contact for patients, relatives and carers and will respond to straightforward requests for non-clinical information or to simple non-clinical issues that do not need further investigation
- The PALS and Complaints Coordinators will refer clinical enquiries and complaints raised by patients, relatives and carers to the most appropriate person to effect resolution ensuring the person contacting the service is aware of the action taken and time scale for response
- The PALS and Complaints Coordinators will liaise with other organisations such as conciliation and advocacy services, other Trusts, Clinical Commissioning Group, Adult Social Care Services, MP offices, and the Parliamentary and Health Service Ombudsman to ensure the fullest response is given.

2.18 Site Team

The Site Team will provide an out-of-hours service for patients, their relatives and carers. They will address issues that require immediate action and leave details of the person making the enquiry / complaint for the PALS and Complaints Service to follow up at the first available opportunity. The person making the enquiry / complaint will be informed of the action being taken and that their details have been passed to the PALS and Complaints Service.

Section 3 – Process for dealing with complaints

3.1 Supporting key documents

This policy is supported by the following key hospital documents:

- ESNEFT Policy for the Management of Incidents, Patient Safety Incident Response Framework
- Risk Management Strategy and Policy
- Being Open and Duty of Candour Policy and Procedure

3.2 Who may raise a complaint

A complaint may be made by a person who is affected by or likely to be affected by the action, omission or decision of the Trust or by a person who is receiving or has received services from the Trust.

A complaint may be made by a person acting on behalf of a patient where that patient has died, is a child, is unable by reason of physical or mental incapacity to make the complaint themselves or has requested the representative to act on their behalf.

If the patient or person affected has died or is incapable, the complainant (representative), must be in the opinion of the PALS and Complaints Manager, someone who had or

who has a sufficient interest in the individual's welfare and is a suitable person to act as representative.

Where a person raises a complaint on behalf of a child the PALS and Complaints Manager will only consider the complaint once satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child.

If a complaint is raised on behalf of a child or a person who lacks capacity within the meaning of the Mental Capacity Act 2005 the PALS and Complaints Manager must be satisfied that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is made.

If in any case the PALS and Complaints Manager is of the opinion that a representative does not or did not have a sufficient interest in the patient's welfare or is unsuitable to act as a representative, they must notify that person in writing, stating the reasons.

Access for Complainants with Impairment or Disability

Attention will be given to employees and service users for whom English is not their first language, who have a visual impairment or other disability, ensuring they understand and are able to benefit from this policy.

This procedure can be provided in other languages, Braille and large print if required.

Easy read leaflets are available

3.3 Consent

Written consent will always be obtained from the patient when a complaint is made by a third party unless they fulfil the aforementioned criteria. This is in accordance with the Data Protection Act 2018 / General Data Protection Regulations

Where the patient is an in-patient the PALS or Complaints Coordinator will visit the ward to gain written consent from the patient in order for the complaint to be investigated.

3.4 Disclosure of information

Any information disclosed about the patient must be confined to that which is relevant to the investigation of the complaint and only disclosed to those people who need to know it for the purpose of investigating the complaint.

3.5 Process for listening and responding to requests for information and / or advice

3.5.1 Patient Advice and Liaison Service – PALS

Patients, relatives, carers or visitors to the Trust can ask for information and / or advice verbally, in writing, by email or by visiting a PALS office at Colchester or Ipswich Hospital. The PALS Team aims to resolve problems and concerns raised by patients, relatives, carers and visitors to the Trust quickly before they become a major issue.

PALS will provide an immediate point of contact for patients, relatives and carers and will respond to straightforward requests for non-clinical information or to simple non-clinical issues that do not need further investigation.

Generally, requests for information and / or advice raised directly at the point of care can be resolved immediately and should be dealt with by the Ward Sister / Service Lead or an appropriate staff member acting on behalf of the Ward Sister / Service Lead. This is also known as 'informal resolution'.

PALS will refer clinical enquiries to the most appropriate person to effect resolution ensuring the person contacting the service is aware of the action taken and time scale for response.

All PALS contacts will be logged on the electronic complaints management system, Datix, and categorised as either:

- **PALS 1** – Non-complex advice or signposting.
- **PALS 2** – Matters that need to be investigated and feedback given.

PALS will contact the Divisional bleep holder should a difficult situation arise as this senior member of staff will offer advice or attend if necessary to help rectify the problem there and then.

PALS will make initial contact when matters are raised in relation to a patient who is an inpatient at the time of raising the concerns. If the matter cannot be resolved by the Ward Sister / Service Lead or PALS the option of raising a formal complaint should be discussed.

The PALS Team will highlight any trends or themes of concern to the PALS & Complaints Manager. Monthly PALS reports will be available to each Division and PALS information will be incorporated into quarterly reports to the Quality and Patient Safety Committee.

3.6 Process for listening and responding to Compliments

(see also 3.20: Other Feedback)

The Trust receives compliments and expressions of gratitude in many different ways, often in the form of chocolates, biscuits and cards personally delivered to the ward or department. These tokens of gratitude should be recorded by the ward or department concerned and reported accordingly.

When a letter of compliment is received by the Chief Executive Office or via the PALS and Complaints Service it will be logged on Datix and shared with the area.

3.7 Process for listening and responding to complaints

3.7.1 A good beginning

Patients, relatives, carers or visitors to the Trust can raise a complaint. Complaints may be received in writing, by email, or completing a complaint form or verbally.

The Trust is committed to the Accessible Information Standard and therefore the Complaints Department will support patients with submitting a complaint.

Complaint forms are available across the organisation in public areas or via staff and PALS / Complaints.

When complaints are received verbally the Complaints Coordinator will complete a complaint form and a copy of this will be sent to the complainant as confirmation of what has been discussed if required.

Each Division has a designated Complaints Coordinator within the Complaints Team.

Complaints will be assigned to the designated Complaints Coordinator within the Complaints Team. When the identified Complaints Coordinator is absent, the case will initially be handled by another Coordinator but upon return the designated Coordinator will take over handling the case.

In accordance with the complaint handling triage tool (Appendix 1) the complaint is triaged as low, medium or high level.

The complaint is logged using the complaints management system, Datix. The Head of Nursing / Midwifery, Appointed Specialty Lead and Governance Teams will be notified electronically. The electronic record will show the full details of the complaint along with confirmation of the response timeframe allocated to the individual case.

Courtesy telephone call

A courtesy call will be made by a Complaints Coordinator to the complainant by the end of the next working day, once logged on Datix, to confirm receipt of the complaint.

Three-day call back

A purposeful call back will then be undertaken by an appropriate member of the Divisional Team to discuss the complaint in further detail and offer the complainant the opportunity to meet with them and clinical teams to resolve their issues within three working days of receiving the initial contact made by the complainant.

The purpose of the call is to:-

- Gain insight to understand the key issues that need to be revolved
- Resolve the complaint
- Take time to understand the exact nature of the complaint as this will help to ensure a thorough and meaningful response
- Help build relationships with the complainant, help them to feel part of the process and demonstrate that we take their concerns seriously
- Explain the 28 working day timeframe for our response and establish the method in which the complainant would like to receive our feedback, for example a letter or a face to face meeting

Meetings with patients, carers and loved ones should be actively encouraged to support the outcome and resolution of the concerns raised.

It is accepted that not every complainant will be contactable by telephone but it is the Chief Executive's expectation that every effort will be made to speak with the complainant as soon as possible.

At least one attempt to call the complainant should be made by the end of the next working day by the Complaints Department and at least two further attempts at different times should be made. The three day call should also be attempted at least twice at different times.

It is acceptable to leave a brief voicemail message on a mobile phone voice mail if you are confident you have the correct telephone number. If, for example, the voicemail says “Hello this is [the name of the complainant]”, it is acceptable to leave a message along the lines of “Hello this is [your name and title] from the Hospital. I was just hoping to have a quick chat about the concerns you raised recently. I will call again later but in the meantime, if you would like to call me my number is [add your telephone number]”.

This approach meets with the approval of the Information Governance Team.

It is not advisable to leave a message on a landline as this is often a shared line and therefore the message could be accessed by someone else.

The Division are responsible for documenting on Datix details of all attempts and successful calls and uploading the completed call back form to Datix. Failure to update the Datix will result in the call being logged as failed. All failures are reported by specialty and will affect the Divisional Accountability Framework scorings.

Consent

Making the courtesy call before consent is received from the person affected meets with the approval of Information Governance on the basis that we are not sharing information at this stage, just clarifying the concerns raised and apologising for the need to contact us. In the event of there being any concern that making the call would be inappropriate (for example safeguarding issues) the case in question should be discussed with a member of the complaints team or the PALS and Complaints Manager.

When appropriate, a complaint form will be used to summarise and / or provide clarity of the issues to be investigated.

The Complaints Coordinator will be the primary contact within the Trust for the complainant.

If the complainant does not take up the offer to discuss their complaint, the timeframe for resolution will be set in accordance with the complaints assessment triage tool (Appendix 1). Consent is requested where necessary by the Complaints Coordinator in accordance with the Data Protection Act 2018 (GDPR).

The Complaints Coordinator will send a consent form to the complainant requesting written authorisation from the patient or their next of kin. The complaint, meanwhile, will be sent to the ADoN, Head of Nursing / Midwifery, Governance Teams and the Appointed Specialty Lead for information at this stage. The complaints process will commence when consent is received. If consent is not received within two weeks, a reminder will be sent indicating that if authorisation is not received within a further two-week period, then no further action will be taken by the Trust.

The complaint is acknowledged in writing within three working days from receipt by the Complaint Coordinator. An information leaflet providing further information on the complaints procedure is enclosed with the acknowledgement letter. This includes information about the complaints process, the NHS Advocacy Service and the Parliamentary and Health Service Ombudsman.

3.7.2 Medical Records/Notes

It is the responsibility of the appointed Specialty Lead to ensure that all relevant staff have access to the patient’s medical records.

3.7.3 Complaints involving more than one Division

If a complaint involves more than one Division, the Complaints Service will identify the lead Division, in the event of any issues arising, this will be flagged to the Deputy Chief Nurse, Quality or the Deputy Chief Nurse for further discussion. The ADoN, Head of Nursing / Midwifery, Governance Teams and Appointed Specialty Lead for all Divisions involved will be notified by the Complaints Coordinator. The lead Division is responsible for providing a full coordinated response for the complaint.

3.7.4 The Investigation - Thorough and Timely

The Division ADoN, Head of Nursing / Midwifery, Governance Teams and the appointed Specialty Lead will be notified of the complaint electronically.

The Division ADoN, Head of Nursing / Midwifery, Governance Teams and the appointed Specialty Lead will be responsible for ensuring that the complaint is investigated by the appropriate members of staff and that the response is completed or a meeting offered within the agreed timeframe. Unless otherwise stated, the timeframe will be 28 working days.

If there is likely to be a delay in providing a response within the agreed timeframe the appointed Specialty Lead must inform the Complaints Coordinator, no later than day 21, giving the reason for the delay and suggesting a new timeframe. The Complaints Coordinator will then contact the complainant to explain the delay and request a new timeframe. Should this new timeframe be likely to breach, it will be the responsibility of the Service Lead to discuss the case with a member of the Executive Team before contacting the complainant requesting any further additional time.

The appointed Specialty Lead will identify and notify the most appropriate Lead Investigator and is responsible for ensuring adherence to the process and timeframe.

The investigation must be conducted by someone who has not been directly involved in the events giving rise to the complaint.

The Complaints Coordinator will send a reminder email to the appointed Specialty Lead after 10 days if it appears that no action has been taken.

The appointed Divisional Governance Team will ensure that copies of supporting documents are saved to the complaints management system, Datix, at the same time as the written response. These are required for the complaints file in case there is a need for any further investigation. The appointed Specialty Lead should also advise the Complaints Coordinator via Datix of any meetings or telephone conversations.

The Clinical Governance Team is responsible for identifying lessons learned and actions taken and documenting this in the Complaints Action Module ensuring that actions for complaints relating to their Division are carried out within the specified timeframe and that actions allocated outside their Division are followed up across Governance Teams. The Divisions must use the Actions module on Datix and it is the responsibility of the appointed Specialty Lead to complete the Actions Module and discuss all actions with the relevant action owner. All overdue actions will be monitored via the Patient Experience Group.

3.7.5 Escalation process and consequences

The relevant Complaints Coordinator will liaise closely with the appointed Specialty Lead to monitor the progress of cases. Should additional time be necessary in order to complete the appropriate investigate and response, the Complaints Coordinator will inform the

Complaints Manager, this should be no later than day 21 of the investigation. Initially, it is the responsibility of the Complaint Coordinator to contact the complainant to explain the situation and request an extension to the timeframe. If it becomes apparent that the Division will fail to meet the revised timeframe it is the responsibility of the Service Lead to discuss the case with a member of the Executive Team before contacting the complainant requesting any further additional time.

All overdue complaints will be reported monthly to the Divisional and Trust Boards.

All overdue complaints will be reported according to Specialty and Lead Consultant.

The Division Clinical Director is accountable for ensuring that all staff, including managers, involved in complaints handling understand their responsibilities in respect of the complaints process and the consequences of non-compliance.

3.7.6 Response - Acknowledge, Apologise, Action

The response must be written in clear language acknowledging the distress / concern caused apologising for it and thanking the complainant for taking the time to write. The response must answer the questions, identify lessons learned and explain how we will prevent the same thing happening again. The response will also set out our next steps and timeframes.

- It is important that complainants receive a full and open response. An apology must be openly and freely offered. All complaints correspondence must be objective and not contain personal opinion.

- Any documentation obtained during the investigation of a complaint will not be subject to legal privilege in any future litigation and therefore can be disclosed. If there are any concerns on this issue the Legal Services Manager must be contacted for advice.

- Any actions or changes to practice identified are to be confirmed in the response and it is the responsibility of the appointed Specialty Lead Divisional Complaints Lead to ensure that actions are completed within the specified timeframe and that the Complaints Coordinator is informed when this has been done and included on Datix.

- A copy of the written response must be saved on Datix and upon closing the complaint record the Complaints Coordinator will check the Datix record to ensure the appropriate supporting documentation has been provided.

- All medium and high-level responses (written) must be signed by the Chief Nurse, Chief Executive Officer or appointed deputy.

- In the event of a verbal response being given, a file note detailing what has been discussed, along with any agreed actions, must be completed by the appointed Specialty Lead and saved on Datix along with copies of supporting documents from supporting the investigation. Any actions taken or required must be updated by the Divisional Governance Team on the Action Module in Datix.

- All staff involved in the complaint must be advised of the outcome. Either a copy of the response or appropriate feedback should be given to staff by the appointed Specialty Lead.

3.7.7 File Maintenance

The Complaints Coordinators will be responsible for maintaining Datix. These records will be kept for a minimum of ten years. They will be required for Parliamentary Health Service Ombudsman enquiries or review, internal monitoring reviews or in the case of litigation, when all papers must be considered disclosable to the patient, their representative and their solicitor. Correspondence relating to a complaint is not part of the patient's medical records and must not therefore be filed in their medical records.

3.7.8 If the complainant is dissatisfied with response: re-opened complaints

If the complainant is not satisfied with the response, in the first instance, the Division ADoN or Head of Nursing / Midwifery will be asked to review the complaint and the response.

The Complaints Coordinator will liaise with the appointed Specialty Lead Divisional Complaints Lead to arrange a further investigation and response.

If, after further investigation, the complainant is still not satisfied with the response given, the complainant can write to the Parliamentary and Health Service Ombudsman and ask them to consider taking the complaint further. This signposting will be included in the final Divisional written response and will require signature from the Chief Nurse or Chief Executive.

For habitual or repetitive complainers please refer to section 3.15

3.8 Management of complaints with multiple organisations

If a complaint is received, which includes issues relating to another service the Complaints Service will liaise with their counterparts in the Integrated Care Board (ICB), Ambulance Trust, other Hospital Trust or Social Care Service to ensure that the complainant receives a coordinated response to the complaint.

The organisations will agree which of the organisations should take the lead on

i) coordinating the handling of the complaint
ii) communicating with the complainant

Generally, unless otherwise requested by the complainant, the lead organisation will be the organisation with most issues or questions to be answered.

3.9 Discrimination as a result of raising a concern or complaint

The Trust is committed to ensuring that a person's care or treatment will not be adversely affected as a result of raising a complaint. Details of the issues raised will only be discussed with staff on a 'need-to-know' basis and kept confidential in line with paragraph 3.7.

All correspondence concerning complaints should be marked 'Private and Confidential' and kept securely using the complaints management system and retained in accordance with the Trust's Policy on the Storage and Retention of Records. In addition to this, all complaint response letters should also be marked for 'Addressee Only'.

Complaint correspondence must not be filed in the patient's medical records.

All statistical and other management reports will be anonymised. This is to ensure that the patient receives impartial treatment in the future and to prevent discrimination as a result of

making a complaint.

Any person concerned that their care or treatment has been adversely affected must raise this with the PALS and Complaints Manager.

3.10 Matters excluded from investigation as a complaint

- a complaint made by an NHS body which relates to the exercise of its functions by another NHS body
- a complaint made by an employee of an NHS body about any matter relating to his contract of employment
- a complaint which is being or has been investigated by the Health Service Commissioner
- a complaint arising out of an NHS body's alleged failure to comply with a data subject request under the Data Protection Act 2018 or a request for information under the Freedom of Information Act 2000
- a complaint about which an NHS body is taking or is proposing to take disciplinary proceedings in relation to the substance of the complaint against a person who is the subject of the complaint
- a complaint the subject matter of which has already been investigated and resolved.

3.11 Legal Issues

3.11.1 Litigation

The Complaints Procedure must continue even if the complainant explicitly indicates an intention to take legal action in respect of the complaint. If staff believe that there is a likelihood of legal action being taken, the Legal Services Manager must be informed.

Documentation obtained during the investigation of a complaint will not be subject to legal privilege in any future litigation and can therefore be disclosed.

3.11.2 Coroner cases

The fact that a death has been referred to the Coroner's Office does not mean that all investigations into a complaint need to be suspended. The Legal Services Manager will be contacted by the Division Operations Manager and advice on handling this sought. Discretion will be required in some instances on the timing of a reply to the complainant where this could be seen as pre-judging any comments, which the Coroner might make at the inquest. This does not mean, however, that all complaint investigations will be suspended until the inquest has been held.

3.12 Relationship to other policies/procedures

3.12.1 Disciplinary Procedure

Complaints procedures must be kept separate from disciplinary procedures. The purpose of the complaints procedure is not to apportion blame amongst staff but to investigate complaints with the aim of satisfying complainants (whilst also being fair to staff) and to learn lessons to improve service delivery. However, it is inevitable that there will be some complaints, which identify information about serious matters that will indicate a need for disciplinary investigation. A case for considering disciplinary investigation can be suggested at any point during the complaints procedure but consideration of whether disciplinary action is warranted is a separate issue for management, outside the complaints procedure, and must be subject to a separate process of investigation.

Reflective discussions and notes will continue to be undertaken which are meaningful and purposeful. These will not be stored on Datix, rather in the staff member's files.

Complainants have no right to be informed as to whether or not disciplinary action is being taken or its outcome due to the requirements to maintain staff confidentiality under the Data Protection Act 2018 / General Data Protection Regulations.

3.13 Support for staff

Staff involved in a complaint investigation often find it an upsetting experience. If staff need support through this process, they are to contact their Line Manager or Employee Relations.

3.14 Other Policies/Procedures

Where complaints involve or may need referral to bodies such as the police or professional organisations, advice must be sought from the Legal Services Manager and / or ADoN / Head of Nursing / Midwifery. To ensure full compliance with diversity legislation, this policy has been the subject of an Equality Impact Assessment to ensure there is no unlawful discrimination on the grounds of age, disability, gender, race, religion, belief and sexual orientation.

3.15 Managing habitual or repetitive complainants

Habitual or repetitive complainants are increasing, reflecting a pattern experienced throughout the NHS. The difficulty in handling such persons can place a strain on time and resources and can also cause undue stress for staff that may need support in difficult situations.

Staff will respond in a professional and helpful manner to the needs of all complainants, however, there are times where nothing further can reasonably be done to assist such persons or to rectify a real or perceived problem.

Situations where complainants might be considered to be habitual or repetitive must be recognised promptly and the decision to categorise a complainant as such will follow discussion between the Division Operations Manager or Associate Director, Clinical Governance and the PALS and Complaints Manager.

Complainants may be deemed to be habitual or repetitive where previous or current contact with them shows that they meet two or more of the following criteria:

- Persist in pursuing a complaint where the NHS Complaints Procedure has been fully and properly implemented and exhausted.

- Change the substance of the complaint or continually raise new issues or seek to prolong contact by repeatedly raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. *Care must be taken not to discard new issues that are significantly different from the original complaint; these might have to be addressed separately.*

- Do not clearly identify the issues they wish to be investigated, despite reasonable efforts by Trust staff and others (i.e. Advocacy Service) to help them specify their concerns.

- The complaint or issue is trivial or appears to consume an excessive amount of resources.

- Display unreasonable demands or expectations and fails to accept that these may be unreasonable (i.e. insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).

- Having in the course of pursuing their concerns had an excessive number of contacts with the Trust by telephone, letter, email, or in person. Staff should be instructed to keep a clear record of the number of contacts to demonstrate the excessive nature.

When the complainant has been aggressive and / or abusive consideration must be given as to the need for the completion of a Trust incident form. The person may become the subject of a Chief Executive Cease and Desist letter. In extreme or serious cases, the Trust will refer such matters to its Solicitor and / or the Police.

Staff can also refer to the Violence and Aggression Policy available on the Trust Intranet.

Where complainants have been identified as habitual or repetitive, the Chief Executive will determine what action to take. The Chief Executive will implement such action and will notify complainants in writing of the reasons why they have been classified as habitual or repetitive and the actions to be taken.

This notification may be copied for the information of others already involved in the complaint i.e. General Practitioners, Conciliators, Advocacy Service and Members of Parliament. A record must be kept for future reference of the reasons why a complainant has been classified as habitual, vexatious or repetitive.

The above action must only be taken as a last resort and after all reasonable measures have been taken to assist the patient/complainant.

3.16 Out of hours arrangements

The PALS and Complaints Service office is open from 8am to 4pm Monday to Friday. Outside of these hours, the Site Team can be contacted via the switchboard.

Information about the PALS and Complaints Service is available on the hospital website and intranet together with this policy, which is available for access by staff, patients and members of the public. PALS and Complaints Service leaflets are available in all public areas of the organisation including reception areas, in wards and departments, and posters are displayed giving information about the service.

Information to staff on changes to the PALS and Complaints Service are disseminated by Broadcast email and via staff training sessions.

3.17 Reporting and Improvement

3.17.1 Locally

Complaints provide valuable information on patient experience and the care patients receive and are an important tool in identifying areas for improvement.

Staff will routinely use data regarding complaints alongside other key patient experience indicators to identify areas for improvement. The ADoN / Heads of Nursing / Midwifery report regularly to the Patient Experience Group on action plans and improvements as a result of patient and public feedback. The Patient Experience Group reports to the Quality & Patient Safety Committee. The Patient Experience Oversight Group will also monitor compliance and shared learning throughout the organisation.

Division ADoN / Heads of Nursing / Midwifery are responsible for analysing complaints involving their departments; identifying trends and learning and implementing and monitoring resulting action plans affecting changes or improvements where appropriate. This will be an agenda item for discussion at the Divisional Governance & Quality meetings and disseminated to all areas within the Division.

3.17.2 Trust-wide

A report on Patient Experience (including PALS and Complaints) will be provided to the Patient Experience Group on a monthly basis. Highlighted issues and any areas for escalation will be presented to the Quality & Patient Safety Committee and Patient Experience Oversight Group.

The PALS and Complaints report will include:

- the number of complaints and concerns received during the month
- the severity of complaints and concerns received
- the top subject categories of complaints and concerns received
- qualitative information regarding the key themes to arise
- qualitative information on any specific areas for improvement
- the number of cases re-opened
- trend and theme analysis

The Quality & Patient Safety Committee will be responsible for:

- monitoring reporting and ensuring that actions for improvement have been completed
- assuring that any lessons learned are appropriately shared Trust-wide

3.18 Information leaflets

Leaflets outlining the PALS and Complaints Service are available across the organisation and its website. A copy of this leaflet should be offered to the complainant.

Easy read information is available in leaflet form and via the Trust website.

3.19 Information posters

Posters are placed in public areas across the organisation outlining the service provided, contact details and opening hours for the PALS and Complaints Service.

A poster with a QR code will be displayed throughout the organisation, which will support the patient, carer or loved one the opportunity to give feedback about their care or experience in real time.

3.20 Other feedback

The Trust receives feedback from a wide range of sources not just complaints and PALS. These include:

- Compliments (thank you letters, cards, gifts such as chocolates etc.) – most of these are directly given to wards and clinics. A number of formal thank you letters are also received.

- Comments cards, online feedback (e.g.; Care Opinion and Healthwatch Suffolk, Twitter etc.) and comments generated by FFT surveys and other surveys – these are monitored by the Patient Experience Office and Comms Team and responded to appropriately and shared via divisions etc.

When a letter of compliment is received by the Chief Executive Office or via the PALS and Complaints Service it will be logged as per the process for recording all comments.

Section 4 – Training and Education

Education / Training Need	Staff Group	Method of training / education	Responsibility for training	Timescale to complete
Customer care, including advice for front line staff on dealing with complaints	All front line staff	Face to face / online	Employee Relations	As and when required
Raising complaints	New staff	Trust Induction	Employee Relations	At each Trust induction
Complaints handling training	All staff dealing with complaints	Face to face / online	PALS & Complaints Manager	As and when required
Datix training	All staff dealing with complaints	Face to face / online	PALS & Complaints Manager	As and when required

Section 5 – Development and Implementation including Dissemination

This policy has been developed by the following staff who will lead on its implementation within the Trust:

- Head of Patient Experience
- PALS and Complaints Manager
- PALS and Complaints Coordinators
- Deputy Chief Nurse, Clinical Governance
- Chief Nurse
- ADoNs/Heads of Nursing/Midwifery
- Divisional Governance Managers
- Divisional Leadership teams

Consideration was given to the views of a Task and Finish Group, internal audit reports, stakeholders and service users, from feedback surveys and in writing, in the development of this policy.

Once ratified, the policy will be disseminated to all Senior Managers and placed on the Trust's Intranet. A broadcast will be sent out via email to all staff.

Section 6 – Monitoring Compliance and Effectiveness

Compliance to be measured	Monitoring Tools	Responsibility for training (nominated by department)	Timescale
Timeframes for response	Datix	PALS and Complaints Coordinators	The Complaint Coordinator and appointed Specialty Lead will ensure that the escalation process is followed and the Division

			ADoN and Head of Midwifery will be sent a weekly report of all overdue complaints. The responsibility for the compliance lies with the Division
Compliance with complaint response times	Accountability Framework(AF)	PALS and Complaints Manager	A monthly statistical report will be provided for the AF
Lessons learned.	Shared with Divisions. Improvements to practice are noted in the Trust's Annual Complaints Report, Quality Account and Annual Report	PALS and Complaints Coordinators	Monthly
Annual report to demonstrate compliance with CQC criteria and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16.	• the number of complaints received • the number of complaints referred to the Ombudsman • a summary of the subject matter of complaints received • any matters of general importance arising out of those complaints, or the way in which the complaints were handled • any matters where action has been or is to be taken to improve services as a consequence of those complaints	PALS and Complaints Coordinators	Annually

A Körner Return for the Department of Health will also be completed.

Section 7 – Control of document including archiving arrangements

Once ratified, the Responsible Officer will forward this document to the Information Governance Department for a document index registration number to be assigned and for the document to be recorded onto the central hospital master index and central document library of current documentation.

In order that this document adheres to the Hospital's Records Management Policy, the Information Governance Department will:

- Ensure that the most up-to-date version of this document is stored on the documentation library.
- Archive previous versions of this document.
- Retain previous versions of this guideline for a period of time in accordance with the NHS Records Retention and Disposal Schedule.

Section 8 – Supporting Compliance and References

- The Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Data Protection Act 2018 (GDPR)
- The Local Authority Social Services and National Health Service complaints (England) Regulations 2009
- Public Interest Disclosure Act 1998

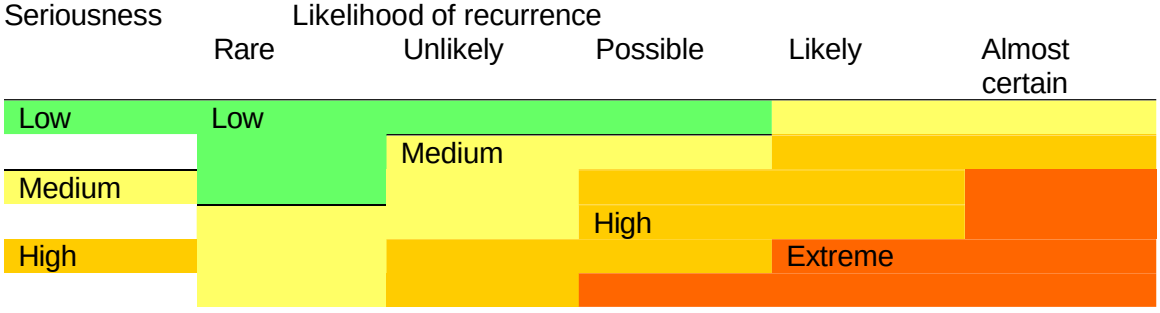
References

- Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Freedom of Information Act 2000
- Patient Briefing – Saying sorry when things go wrong ~ National Patient Safety Agency
- General Medical Council (GMC)-Good Medical Practice 2013
    - Acting on Concerns – paragraphs 19 – 22
    - Investigating concerns – paragraphs 23 – 25
- Ombudsman's Principles (Principles of Good Administration, Principles of Good Complaint Handling; Principles for Remedy) ~ Parliamentary and Health Service Ombudsman 2009.
- Francis Report 2013
- Clwyd and Hart Report 2013

Appendix A - Complaint Assessment - triage tool

Seriousness	Description
Low	Unsatisfactory service or experience not directly related to care. No impact or risk to provision of care. Or Unsatisfactory service or experience related to care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
Medium	Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.
High	Significant issues regarding standards, quality of care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity.
Extreme (SI)	Serious issues that may cause long-term damage, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.

Likelihood	Description
Rare	Isolated or 'one off' – slight or vague connection to service provision.
Unlikely	Rare – unusual but may have happened before.
Possible	Happens from time to time – not frequently or regularly.
Likely	Will probably occur several times a year.
Almost certain	Recurring and frequent, predictable.



Appendix B - Managing Concerns and Complaints

Level	Examples	Process	Timeframe	Level of Responsibility	Supporting Actions
Low (simple, non-complex issues)	Delayed or cancelled appointment Event resulting in minor harm (e.g. cut, strain) Loss of property Lack of cleanliness Transport problems Single failure to meet care needs	Contact from Complaints Coordinator by phone to discuss issues, obtain clarity, and if necessary, agree the method of response and timeframe. Investigation by Division. Letter composed and signed by Division to be sent out via the PALS and Complaints Service. Contact from Complaints	Initial contact within 3 working days Response required within 28 working days.	Any staff member with Line Manager support Head of Nursing/Midwifery/Matron/ Ward Sister Signed off by Division. Head of Nursing/Midwifery	Verbal or written response, identification of lessons learned and actions taken. Advice available from PALS and Complaints Service. Written response –
Medium (several issues relating to a short period of care)	Delayed discharge Failure to meet care needs Injury i.e. fracture Miscommunication or misinformation Medical errors Incorrect treatment Staff attitude or communication	Coordinator by phone to discuss issues, obtain clarity and, if necessary, agree the method of response and timeframe. Investigation by Division. Letter composed by Division, signed by CEO and sent out via PALS and Complaints Service. Contact from Complaints	Initial contact within 3 working days Response required within 28 working days.	Sign off by Chief Executive Officer Head of Nursing/Midwifery	identification of lessons learned and actions taken. Letter template provided by Complaints Coordinator. Advice available from PALS and Complaints Service. Written response – identification of lessons
High (multiple issues relating to a longer period of care - can be more than one	See medium list Event resulting in serious harm	Coordinator by phone to discuss issues, obtain clarity, and if necessary,	Initial contact within 3 working days		learned and actions taken.

organisation or individual)		Agree the method of response and timeframe. Investigation by Division. Investigation may be the Policy for the Management of Incidents, Patient Safety Incident Response Framework. Letter composed by Division, signed by CEO and sent out via PALS and Complaints Service.	Response required within 28 working days.	Sign off by Chief Executive Officer	Letter template provided by Complaints Coordinator. Advice available from PALS and Complaints Service.

Appendix C - Resources for Investigation of Complaints using the Complaint Assessment

Low	Medium	High	Extreme/(SI)
Minimal impact or relative minimal risk to the provision of healthcare or the organisation. No real risk of litigation.	Potential to impact on service provision/delivery. Legitimate consumer concern but not causing lasting detriment. Slight potential for litigation.	Significant issues of standards, quality of care, or denial of rights. Complaints with clear quality assurance or risk management implications or issues causing lasting detriment that require investigation. Possibility of litigation.	Issues regarding serious adverse events, long term damage, grossly substandard care, professional misconduct or death that require investigation. Serious patient safety issues. Probability of litigation high.
Suggested Resources	Suggested Resources	Suggested Resources	Suggested Resources
Refer to Health Records to gather facts: Patient records X-rays Results/Investigations Interview staff to establish the facts. Document the interviews with staff OR ask staff to provide a statement of their recollection of events. Refer to related Policies/Guidelines	Refer to Health Records to gather facts:- Patient records X-rays Results/Investigations Refer to other sources of information:- Lorenzo Ward Log Book Controlled Drugs Register Adverse Incident form Interview staff to establish the facts. Document the interviews with staff OR ask staff to provide a statement of their recollection of events. Refer to related Policies/Guidelines	Refer to Health Records to gather facts:- Patient records X-rays Results /Investigations Refer to other sources of information:- Lorenzo Regional Care Ward Log Book Controlled Drugs Register Adverse Incident form Interview staff to establish the facts. Document the interviews with staff OR ask staff to provide a statement of their recollection of events. Refer to related Policies/ Guidelines It may be appropriate to use some or all of the Root Cause Analysis tools available:- Time line - review health records 5 Why's, Fish Bone, Barrier Analysis Decision Tree	SI process to be followed. A Root Cause Analysis must be undertaken and the tools available are as follows:- Time line – Review health records and other sources of information. 5 Why's Fish Bone Barrier Analysis Decision Tree Interview staff to establish the facts. Document the interviews with staff OR ask staff to provide a statement of their recollection of events. Refer to related Policies/Guidelines

Equality Impact Assessment Form

The purpose of this Equality Impact Assessment form is to determine the extent to which policies, procedures and practices impact upon individuals and groups in relation to one or more of the equality categories.

If the policy, procedure or practice is found to have an adverse impact, the author/s must consider all other alternatives, which may more effectively achieve the promotion of equality of opportunity. This may include the development of specific measures to mitigate the adverse impact.

This Equality Impact Assessment form must be completed and forwarded to Human Resources Administration Office, Post Point N020 attached to the draft document prior to it being considered for approval. The Responsible Officer must retain the original. In the event that the document appears to be discriminatory, please refer to your Human Resources Manager/Adviser who will be able to advise you in accordance with employment legislation.

DOCUMENT TITLE:	Complaints and Concerns Handling Policy
BUSINESS UNIT:	Nursing and Quality
NAME AND JOB TITLE OF RESPONSIBLE OFFICER	Tammy Shepherd, Head of Patient Experience

1. SERVICE USERS – Check for DIRECT discrimination against any minority group						
Does your document contain any statements, which may exclude people from using services who otherwise meet the criteria under the grounds of:	Response		Action Required		Resource Implication	
	Yes	No	Yes	No	Yes	No
Age		X				
Gender		X				
Disability		X				
Race		X				
Religion or Belief		X				
Sexual Orientation		X				
If yes is answered to any of the above, the document may be considered discriminatory and requires review and further work to ensure compliance with legislation						

2. EMPLOYEES – Check for DIRECT discrimination against any minority group						
Does your document contain any statements, which may exclude employees from operating under the grounds of:	Response		Action Required		Resource Implication	
	Yes	No	Yes	No	Yes	No
Age		X				
Gender		X				
Disability		X				
Race		X				
Religion or Belief		X				
Sexual Orientation		X				
If yes is answered to any of the above, the document may be considered discriminatory and requires review and further work to ensure compliance with legislation						

3. SERVICE USERS – Check for INDIRECT discrimination against any minority group						
Does your document contain any conditions or requirements, which are applied equally to everyone, but may disadvantage certain individuals or groups because they cannot comply due to:	Response		Action Required		Resource Implication	
	Yes	No	Yes	No	Yes	No
Age		X				
Gender		X				
Disability		X				
Race		X				
Religion or Belief		X				
Sexual Orientation		X				
If yes is answered to any of the above, the document may be considered discriminatory and requires review and further work to ensure compliance with legislation						

4. EMPLOYEES – Check for INDIRECT discrimination against any minority group						
Does your document contain any statements, which may exclude employees from operating under the grounds of:	Response		Action Required		Resource Implication	
	Yes	No	Yes	No	Yes	No
Age		X				
Gender		X				
Disability		X				
Race		X				
Religion or Belief		X				
Sexual Orientation		X				
If yes is answered to any of the above, the document may be considered discriminatory and requires review and further work to ensure compliance with legislation						

5. Check for ACCESS Discrimination						
Is your document accessible:	Response		Action Required		Resource Implication	
	Yes	No	Yes	No	Yes	No
In a variety of languages		X		X		X
To specific disabled service users/employees		X		X		X
On request, the document can be translated into other languages or verbally translated in person, so no further action required.						