FREQUENT CALLERS POLICY

South Central Ambulance Service NHS Foundation Trust
Unit 7 & 8, Talisman Business Centre, Talisman Road,
Bicester, Oxfordshire, OX26 6HR

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Author: Tim Churchill, Demand Management Lead
Dave Sherwood, Assistant Director of Patient Care

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Responsibility for review Patient Care and Service Transformation

1.0 INTRODUCTION

1.1 South Central Ambulance Service is committed to providing a patient-centred and clinically safe service for callers accessing 999 or 111, appropriately matched to patient's needs, each time a patient or caller accesses, or presents to SCAS for emergency or urgent care.

1.2 Different terminology 'frequent caller' 'repeat caller' or 'persistent caller' are sometimes used to describe these patients who frequently access either 999 or 111 services. Nationally the terminology adopted for this patient cohort is Frequent Callers.

1.3 Communities within the SCAS region rely on the emergency (999) and urgent (111) services to provide emergency and urgent care. There is a large group of patients who use the 999-emergency ambulance and 111 urgent care service more frequently or regularly than others and become 'known' to SCAS. The large majority of these patients have genuine urgent care or unmet needs, albeit not emergency ambulance needs and SCAS can support and manage these patients more appropriately with alternative care pathways, plans and provision, delivered by our partner providers.

1.4 In recent years the numbers of Frequent Callers across both services have increased, requesting either emergency, urgent care or support from both services.

1.5 Many patients present with an acute exacerbation of a long-term condition (LTC), have an urgent care need, or may require additional support to manage their condition appropriately at home or in the community setting. They may be experiencing a specific episode of ill-health or difficulty, have unmet health or social care needs, alcohol or mental health related illness or crisis. They may be unaware of more appropriate entry points into the NHS, or are unable to access urgent care, primary care or locality provision, particularly when they are experiencing an acute event or crisis, or a third party may have made the emergency or urgent call to SCAS on the patient's behalf.

1.6 There are a small minority of patients who misuse the emergency (999) and urgent (111) services, generating calls which may be determined as being inappropriate. SCAS need to have effective policy and processes in place for safely managing these patients, as well as to safeguard and preserve valuable emergency and urgent resources for patients with genuine life threatening, emergency or urgent care needs. Some Frequent Callers call a substantial number of times a day or night and consume valuable CCC resources (call handlers and clinicians), as well as frontline emergency ambulances.

2.0 FREQUENT CALLING PATIENTS

2.1 The profile of Frequent Callers has changed in recent years and a large

proportion of these patients are in the age group 75 – 95 years.

2.2 There are many reasons why patients become Frequent Callers to either 111, 999 or both services:

- Chronic illness (particularly multiple conditions) which are either difficult to control or where the patient's needs are not effectively met or managed
- Mental ill-health, personality disorders and dependency conditions
- Poor engagement with health and social care providers, meaning either 999 or 111 becomes the patient's provider of choice
- A lack of understanding or misunderstanding of the services provided by 999 and 111
- Difficulty in accessing other providers and services
- Patients lack confidence in managing their conditions
- Frequent fallers and non-modifiable fallers
- Frail elderly patients
- EOL patients
- Patients with unmet health or social care needs
- A 'perceived' need
- Social isolation
- Chaotic lifestyles
- Anxiety
- Malicious callers.

3.0 SCOPE OF THE POLICY

3.1 This policy defines the standards expected and the procedures to be followed by all South Central Ambulance Service NHS Foundation Trust staff to support the effective provision of the service, particularly the triage, referral, examination, treatment, consultation and transportation of patients.

3.2 This policy outlines the processes SCAS use to manage patients who present as 'Frequent Callers' and who are at risk of repeat emergency or urgent incidents.

4.0 DUTIES

4.1 Executive Director of Patient Care and Service Transformation

The Executive Director of Patient Care and Service Transformation has Board level responsibility for Frequent Callers Policy management within South Central Ambulance Service NHS Foundation Trust. The Executive Director of Patient Care and Service Transformation also chairs the Patient Safety Group.

4.2 Assistant Director of Patient Care

The Assistant Director of patient care has senior management responsibility for the review, updating and forwarding to the relevant committees as amendments

are made. The role also has a co-ordinating function to ensure the smooth review, audit and dissemination of the policy.

4.3 Complex Care Lead

The Complex Care Lead has senior management responsibility for Frequent Callers. The role also has a co-ordinating function between other departments to ensure the effectiveness of the policy.

4.4 All Staff

All staff have a responsibility to read and understand this policy.

4.5 Quality and Safety Committee

The Quality and Safety Committee will approve and monitor the implementation of the Frequent Caller policy. Record any rejection of relevant recommendations on the Risk Register, within the Trust's governance structure. The Quality and Safety Committee will monitor the financial implications of this policy, ensuring that the Trust Board is aware of any risks associated with its implementation.

4.6 Clinical Review Group

The Clinical Review Group, which is chaired by the Medical Director, with all Medical Directors as membership, which forms the committee with responsibility for reviewing the Frequent Callers Policy and assessing its effectiveness and co-ordinate the production of gap analysis and action plans for the Quality and Safety Committee to monitor, should policy review be required.

4.7 Patient Safety Group

The Patient Safety Group will discuss any CCC or Operational management of Frequent Callers generally or evolvement of systems and processes and forward to CRG for approval. Individual patient cases may be brought to PSG, for discussion and determination of further actions

4.8 Patient Safety Group

The purpose of the mental Health Steering Group is to advise on management of frequent callers with mental health including pathways of care and key contacts with Mental Health Teams and CCG leads for mental health.

5.0 MONITORING

5.1 The Policy will be monitored for its effectiveness by the Assistant Director of Patient Care and the Complex Care Lead through the

following:

5.2 Responsibilities of staff will be monitored through attendance at meetings, management of systems, development of reports and the management of Frequent Callers:

- Reports and audits
- Compliance with systems and processes.

6.0 DEFINITIONS

6.1 A person or patient is defined as a 'Frequent Caller' to 999 as determined by Frecann / AACE:

- Over 18 years of age
- 5 or more emergency incidents in a month
- 12 or more emergency incidents in a quarter.

6.2 SCAS work to the above parameters and in addition, review and refer for assessment, care and support all those patients that present:

- Ten (10) or more times to 999 in any twelve (12) month period
- Twenty (20) or more times to 111 in any twelve (12) month period
- SCAS Frequent Caller management and review is applicable to all patients (not over 18's only).

6.3 The Frecann / AACE definition is determined by location (postcode), not by NHS number. The Frecann / AACE definition enables a patient to have 44 emergency ambulance incidents in twelve months, without meeting the definition or identifying the patient as a Frequent Caller.

7.0 STRATEGIC AIMS

7.1 The aim of this policy is to create a consistent, safe and appropriate approach to managing and supporting Frequent Callers, who are maintained by our CCC clinicians (111 and 999) and emergency ambulance response.

7.2 SCAS needs to ensure that it meets the genuine needs of Frequent Callers, as well as preserving CCC and Operational resources, where the resource is not the most suitable response to a Frequent Caller. Nurses and clinicians must be able to safely deliver their role and meet the clinical and governance standards required by the SCAS Quality and Safety Committee and the Clinical Review Group, when managing this sometimes challenging cohort of patients. This can be achieved by providing policy (Frequent Callers), systems and processes, care planning material and referral pathways for SCAS clinicians to utilise, to ensure safe and appropriate care for these patients aligned to need.

7.3 The Frequent Caller's triage disposition in Pathways should be followed, unless an appropriate Care Plan / Special Patient Note (SPN) or Patient Management Plan (PMP) exists (supporting the patient's 'normal' presentations), or a different disposition is determined by a CCC clinician, based on clinical need and presentation at the time of the call.

The process to be followed in pathways is;

The call is answered and the Emergency Call Taker (ECT) will ask the Pre-Sieve Triage questions to reach a Nature of Call (NOC)

The NHS Pathways triage button will be selected which will launch the triage system

The ECT will ask the Module 0 questions this includes, is the patient Conscious and breathing, is the patient fitting, chocking, bleeding red blood heavily.

The next screen is then presented asking if this call relates to a Patient management plan and has an option for a frequent caller

In the case of a patient management plan it asks who they require as per the plan, ie 999 ambulance, Emergency referral to Emergency Department (ED), Palliative Care service or General Practitioner (GP) in or Out of Hours (OOH)

In the case of a frequent caller the options presented are to then, transfer to a clinician immediately or 10 min call back if no clinician available. Or an emergency ambulance or a non-emergency ambulance. This is a call taker level screen, so they have the ability to arrange an ambulance if appropriate.

Positive responses to any of the questions regarding breathing, unconscious will generate an Emergency response (Cat 1 or 2)

Positive answers to Choking, severe bleeding or fitting will generate an ambulance response (cat 1 or 2)

The option for a PMP or frequent caller plan exists within NHS Pathways to enable appropriate help to be arranged quickly for an individual without having to go through a full triage, so a terminal care patient does not have a symptom based assessment and receive an inappropriate response/service.

8.0 OBJECTIVES

8.1 The objectives of the Frequent Caller policy are to:

- Reduce the level of risk for Frequent Callers and have a standard

process for managing their care when they access SCAS 111 or 999 services

- Provide an enhanced level of continuing care and access to urgent care for Frequent Callers, in partnership with our partner providers

- Enhance the identification, management and monitoring of patients who are vulnerable or present with Safeguarding risks

- Enhance the identification and management of patients who have complex clinical needs and become dependent on 111 and 999 services for access to healthcare

- Enhance the identification and management of patients who may present as a risk or threat to the safety of Operational Ambulance Clinicians or partner Responders

- Support CCC clinicians to manage Frequent Callers effectively, with appropriate information and insight into the patient's qualified needs
- Define the process which identifies Frequent Callers and the process for referring and proactively managing Frequent Callers

- Support Primary Care and community provider services in providing Care plans / SPNs or PMP information to enable appropriate triage and management

- Create a local multi-disciplinary approach to managing Frequent Callers with regular MDT meetings supported by local health and social care providers, primary care, provider services, police and commissioners

- Periodically complete 'Frequent Caller Profiles' for all patients who SCAS identify to understand the evolving profile of this patient cohort and their continuing care needs

- Establish the patient's root cause of need or needs (health or social)

- Develop Patient Management Plans (PMPs) with primary care and partner providers for patients

- Support and navigate Frequent Calling patients with relevant health and social care professionals and providers to get their health or social care needs met

- Provide Primary Care with regular quality information to enable patients to be proactively managed upstream, improving their life quality and reduce their dependence on emergency or urgent care

- To improve clinical outcomes, safety and governance

- To demonstrate intervention that supports an individual's well-being

- To reduce health inequalities across the dependent population
- To ensure that services are delivered in the most efficient way
- To preserve CCC and Operational resources, to enable effective triage and timely response to patients with greatest need
- To provide support to the Mental Health practitioners in the CCC to manage frequent callers with mental health.

9.0 IDENTIFICATION OF FREQUENT CALLERS

9.1 SCAS use the Patient's NHS number as the unique identifier for reporting.

9.2 There are two methods of identifying Frequent Callers:

- Clinician referral
- Incident activity data

9.3 Referrals are made to the Complex Care Practitioner team by CCC staff and Operational crews. CCC staff (111 and 999 services) use a Frequent Caller referral template and Operational staff utilise automated electronic Patient Record (ePR) functionality, which refers the patient directly to the Complex Care Practitioners.

9.4 A number of reports are used for identification and management of Frequent Callers:

- VHIU activity
- CARS
- INet Viewer
- Anfield Link

10.0 SUPPORTING and MANAGING FREQUENT CALLERS

10.1 Routine management of Frequent Callers is the responsibility of the Complex Care Practitioner team, supported by managers, team leaders, CCC Clinicians and Operational staff, aligned to this policy.

10.2 CCC support Frequent Caller care and management, by providing a lead from each of the following areas, 111 North, Clinical Support Desk (CSD) North, 111 South and CSD South to enable the Complex Care Practitioners to have dialogue and meetings.

10.3 Each time a patient accesses SCAS 111 a summary / information is automatically sent to the patient's GP for review and follow up.

10.4 Each time an Ambulance attends or conveys a patient and there is an EPR, a summary is provided to Primary Care for review and follow up.

10.5 On a quarterly basis, all patients that meet the threshold of 10 x 999 incidents or 20 x 111 incidents in a twelve (12) month period are routinely referred back to primary care for review by SPN Admin, for assessment of needs and care planning.

10.6 All patients who are referred to the Complex Care Practitioners are reviewed and referred to Primary Care for assessment of needs by the GP or are supported by a Complex Care Practitioner in conjunction with Primary Care and relevant providers

10.7 The GP referral includes a statement of 12 months patient activity, which provides insight and supports the GP's review of the patient and to make an assessment of needs.

10.8 Patients that meet the Frecann / AACE definition of a Frequent Caller are reviewed as follows:

10.9 Stage 1 – Assessment of patient needs

Twelve months activity data is reviewed to support an assessment of needs. This includes a discussion with the patient's GP, review of electronic patient record system information and direct discussion with the patient (if appropriate). This enables the Demand Practitioner to have an understanding and identify the root cause/s of need and potential solutions. The patient and relevant professionals are engaged with to discuss solutions to need and a resolution of the patient's dependency on emergency and / or urgent care.

10.10 Stage 2 – Intervention

There are various types of intervention: referral to alternative specialist services e.g. Mental Health, Alcohol & Substance misuse team, community provider or social services. On occasions Multi-Disciplinary Team meeting (MDT) are initiated to ensure collaborative

care planning to support the patient and providers. Many localities have HIU meetings, where a number of patient cases are discussed.

The information, partnership support and insight from the patient and professionals is utilised to create a Patient Management Plan (PMP). The decision to create a PMP is determined on a case by case basis, with shared risk management and a qualified onward referral pathway if the patient presents as 'Normal' when accessing 111 or 999. There are many factors which determine if a PMP would be beneficial for supporting and aligning the patient's care, as well as supporting SCAS CCC and Operations with efficient and effective utilisation of resources aligned to patient's needs.

10.11 Stage 3 – Evaluation of intervention

To ensure that patient's genuine needs are being met or managed by appropriate providers, or the patient is self-caring, or their needs are

evidenced to have changed, periodic review of PMPs and demand activity takes place. This supports the patient to be able to access appropriate alternative care aligned to changing needs. Complex Care Practitioner intervention and / or a PMP may result in the patient reducing their contact with 999 or 111 services, if the root cause of need has been identified and resolved with partner providers.

Evaluation will consider the patient's activity, referral pathways, SPNs and PMP, if a PMP was determined to be beneficial to the patient and to SCAS, in supporting the management of the patient's interactions.

10.12 Patient Management Plans (PMPs)

The decision to create a PMP is determined by the Complex Care Practitioner team, when reviewing Frequent Caller referrals and cases. There are various reasons why a PMP will be created in partnership with relevant Health and Social Care professionals:

- Support the patient aligned to genuine need
- Medical need
- Social need
- Safeguarding requirements
- Risk management – patient
- Risk management – staff (assault, abuse, harm, alarm, distress)
- Referrals from CCC or Operations
- Request or recommendation of a Dr or HCP
- Demand activity / activity impact on 999 / 111 services
- The impact of the patient's demand activity on other patients
- Vexatious demand activity (putting other patients at risk) PMP sharing with the Patient

PMP sharing with the Patient

The patient's GP is responsible for sharing the PMP with the patient, if the GP feels that this is appropriate, or supports the patient's best interest. There may be occasions when the GP may determine that it is not appropriate to share the PMP with their patient.

PMP Sign off

The PMP will have internal clinical sign off by a SCAS clinician other than the author, a responsibility delegated from the Trusts Medical Director. Any PMP that has not been agreed with the GP, Consultant or primary health care/social care provider will be agreed and signed off by a SCAS Medical Director or Senior level clinician prior to implementation.

PMP Review

PMPs are reviewed on a case by case basis by the Demand Practitioner team. Some patients may require weekly review as their care needs, behaviours and access to services change, whilst others may not require review for a number of months. The maximum period of time a patient will have a PMP prior to review is six months.

PMP Removal

PMPs will be removed from the system, when there is no further requirement for a PMP to support patient care or SCAS provision, based on a Demand Practitioner's review of the patient case and consultation with the GP and relevant providers.

10.13 Abusive and Vexatious Callers

Unfortunately, there are a very small minority of Frequent Calling patients who access SCAS 999, 111 and Patient Experience services and seek to misuse and / or abuse services or staff. SCAS will take robust action in these cases, to protect CCC, Operational and Patient Experience resources for other patients and to protect our staff from abuse, intimidation, threats and assaults.

Persistent, Abusive and Vexatious callers will be managed in the CCC utilising the Persistent, Abusive and vexatious caller, Standard Operating Procedure (SOP). The SOP is a section within the CCC Standard Operating Procedures manual, and a copy is in appendix B. The SOP is to enable CCC staff to manage a PAV caller to protect staff or other service users within a minimal timeframe by ensuring that the process is safe for the caller if there is a genuine emergency or clinical need, whilst ensuring that the inbound call lines are not blocked to other service users.

11.0 PATIENT CHOICE

11.1 It is important that we understand the Frequent Calling patient's views on what they think their individual problems and care needs are and the potential solutions to getting their needs, or perceived needs met and managed. Shared decision making is an important element of managing Frequent Callers and reviewing options that are available, with the patient actively participating with health or social care professionals, is preferable when appropriate. This should include any voluntary and community sector (VCS) providers who may support the patient.

11.2 Shared decision making has many benefits for patients and clinicians, with the potential to reduce demand and costs and improve outcomes for the patient.

12.0 FREQUENT CALLER ACTIVITY DATA (VHIU DATA)

12.1 The VHIU activity data identifies all patients who have had ten (10) or more emergency incidents in the previous twelve (12) months, or twenty (20) or more 111 incidents in the previous twelve (12) months. The patient's NHS number is used as the unique identifier. VHIU activity data is used for case finding and as a component of the referral of patients back to their GPs and locality teams for review and management. This process supports the

procurement of Care Plans / SPNs for Frequent Calling patients from GPs, Social Services, Community Matrons, District Nurses and Specialist Nurses.

12.2 Providing primary care with the insight into their patient's activity supports proactive and improved assessment of needs and helps to address unmet health and social care needs and reduce the patient's dependency on urgent or emergency provision.

12.3 Monthly Frequent Caller activity data will be reviewed at the Patient Safety Group (PSG) or a nominated sub committee or group, which upwardly reports to the PSG.

12.4 All Datix incident reports involving a frequent caller where the incident involves concern around the type or timeliness of the response will be clinically reviewed.

12.5 All deaths in ambulance service care or in the defined contact period (as per the Leaning from Deaths Guidance) for frequent callers subject to a PMP will be clinically reviewed.

12.6 All SI's involving frequent callers should have a clinical review of the appropriateness the PMP and any role in the route cause of the incident.

13.0 SAFEGUARDING

13.1 Many patients who are Frequent Callers are vulnerable or have risks associated with safeguarding. The Safeguarding team and Demand Practitioners work closely together and utilise the VHIU activity data for case finding as well as supporting patients already referred to the Safeguarding team. Safeguarding policy should be followed for any patients where safeguarding concerns are identified.

14.0 PATIENT EXPERIENCE TEAM

14.1 Some Frequent Callers are also known to the Patient Experience (PE) Team. The PE team and Complex Care Practitioners review any Frequent Callers that are known to both services, to ensure a comprehensive review of the case / needs and identify opportunities to support the patient or SCAS.

15.0 MULTI – DISCIPLINARY WORKING

15.1 The effective care and management of Frequent Callers often involves a range of skills and providers. As well as underlying clinical needs, these patients can have social problems including addictions, housing, financial, relationship or chaotic lifestyles.

15.2 For some patients a range of support is required involving a number of

providers. It is essential that care and support is coordinated.

15.3 Many localities have High Intensity User MDTs where cases are assessed and reviewed. These meetings will cover Frequent Callers / Presenters to Ambulance, Emergency Department, Housing and Police.

16.0 CARE PLANS / SPNS / PMPS

16.1 Care planning information is essential for the effective management of Frequent Callers.

16.2 Care Plans and SPNs (special patient notes) provide information which can support the appropriate management of Frequent Callers. These are usually written by GPs, District Nurses, Community Matrons and Community Providers. Overall, it is the responsibility of the patient's GP supported by community providers / specialists to determine the patients care needs, which when articulated in a care plan / SPN can ensure the appropriate care or referral pathway aligned to need.

16.3 Patient Management Plans are written by Demand Practitioners, in partnership with the patient's GP and other relevant health or social care providers. A PMP enables the effective management of a Frequent Caller by CCC, if the patient presents as 'Normal' by providing an alternative care pathway aligned to need. The PMP sets out the information and insight required to manage the patient safely and follows CCC processes.

16.4 The information can support care aligned to the patient's needs, the patient's wishes, existing community provision, safeguarding requirements, the management of risk and decision making to determine the most appropriate resource / response to the patient.

17.0 COMPLEX CARE PRACTITIONER

17.1 Demand Care Practitioner is a role created to support, navigate and manage Frequent Callers.

17.2 Complex Care Practitioners are dedicated staff whose role is to support the effective management of Frequent Callers. These staff are involved both internally and externally in the development of systems, processes and care planning for Frequent Callers and includes the following:

- Analysis of the patient's demand activity and determination of root cause
- Patient support and navigation aligned to clinical, social or other needs
- Organise and Lead an MDT approach to having the patient's needs met
- Encourage shared provider responsibility
- Development a patient management plan (PMP) with relevant providers
- Monitoring and review of Frequent Callers.

17.3 It is essential that we understand the Patient's root cause of demand, (drivers for the demand) and seek to get them resolved for the patient. The

root cause may be a third-party caller or other provider who initiates the demand.

17.4 There are two components – supporting the patient aligned to need and creating the PMP

- Acting for the patient to engage the relevant professionals to get the root cause of need resolved, ie diagnosis, meds, specialist care, interventions, care or social aspects
- Align the patient's needs to the care / professionals involved in the PMP, so that the patient can be effectively managed by SCAS and the most appropriate provider to need, by CCC clinicians, or Operational crews at scene.

17.5 The function of the PMP is to enable clinicians to have 'insight' to the patient, the patient's previous and known presentations to 999 and 111 (what's 'Normal' for the patient) PMH, medications, existing provision and risks.

17.6 This enables the clinician to provide effective triage earlier in the incident cycle, i.e. Hear and Treat then onward referral, as agreed with the relevant provider.

17.7 The referral and review of the patient cohort to appropriate professionals, enables the patient's needs to be understood and their care aligned. This includes the management of some patients 'perceived' needs, as this presentation still requires effective management.

18.0 ALERTS ON CAD AND ADASTRA

18.1 Alerts are provided on CAD (999) and ADASTRA (111) which will alert CCC that a care plan or PMP is available for a patient.

19.0 INFORMATION SHARING AND GOVERNANCE

19.1 The Data protection Act 1998 and GDRP 2018 allows the sharing of confidential patient information where it is necessary for medical purposes and is carried out by medical professionals for the continuation of the patient's health or social care and where this will contribute towards relevant and appropriate care planning to support the patient.

19.2 Frequent Caller information and referrals are shared in line with the SCAS Information Sharing Policy, IG Policy and bound by Caldicott principles

APPENDIX 1: PATIENT OR PREMISES REFERRAL & EQUALITY IMPACT ASSESSMENT

Patient or Premises Referral

The 'Patient or Premises Referral' is an electronic form for Internal use by CCC and Frontline SCAS Staff. The purpose of the referral for a Patient is to highlight frequent use of 999 / 111. While for a Premises it is to highlight inappropriate use of the Ambulance Service

It can be accessed internally via our Staff Intranet.

Equality Impact Assessment

The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of the aforementioned protected characteristics, whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor.

By committing to a policy encouraging equality of opportunity and diversity, The Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

Where there are barriers to understanding; for example, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the HR Department.

Employees exercising their rights and entitlements under these regulations will suffer no detriment as a result.

A full Equality Impact Assessment has been carried out on this policy and is available on request to the public and internally via our Staff Intranet.