NHS
Scarborough and Ryedale
Clinical Commissioning Group

POLICY FOR THE REPORTING AND MANAGEMENT OF PATIENT COMPLAINTS

October 2017

Authorship:	Corporate Services Manager
Committee Approved:	Governing Body
Approved date:	September 2015 Reviewed Oct 2017 – minor change to policy
Review Date:	October 2018
Equality Impact Assessment:	Completed
Sustainability Impact Assessment:	Completed
Target Audience:	Staff, Public, Service Users
Policy Reference No:	SRCCG P105
Version Number:	V 3

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by & Date	Date on Intranet
1	YHCS	Addition of Appendix 5 – procedure for unreasonable persistent contacts	13.6.14	
1	YHCS for CCG review	Update to NHS guidance and best practice	SMT 04.08.2015	
2	Corporate Services Manager	General review of policy no amendments required	Not applicable	October 2016
3	Corporate Services Manager	Removal of reference to PHSO on Page 11	SMT	October 2017
3	Corporate Services Manager	Removal of Appendix 1 which referenced delegated authority to the PCU which no longer exists	SMT	October 2017

Contents

1 INTRODUCTION

NHS Scarborough and Ryedale Clinical Commissioning Group (SRCCG) is committed to working in partnership with patients, the public and other key stakeholders for the improvement of health across the local community.

This policy is based on the current national regulations issued by the Department of Health (DH) in 2009 and the best practice guidance as outlined in the 'Making Experiences Count' (MEC) document (2007). Further documents used to inform this policy are 'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture' (Clwyd, October 2013 'My Expectations for Raising Concerns' published in November 2014 and 'Complaints Matter' published in December 2014 and the House of Commons Select Committee, Health; Fourth Report - Complaints and Raising Concerns, 13 January 2015. The CCG takes a 'user-centred' approach to complaint investigation and management, as recommended by 'Complaints Matter', as detailed in Appendix 5.

Recognising that the information gained from complaints, concerns, comments and compliments contribute to the provision of high quality care for patients this document outlines the commitment of the S R CCG to co-operate with the wider health and social care community to ensure a patient centred outcome focused response to complaints is maintained

With a growing population of approximately 118,000 people, it is acknowledged that people will occasionally be dissatisfied with the services or the care they receive. We recognise the importance of using the information gained through complaints, concerns, comments and compliments to improve and develop services with the aim of maintaining and improving safety, improving effectiveness and thereby improving patient experience.

To achieve this SRCCG has embraced the approach developed through the Department of Health using its flexibility to respond to patient complaints on an individual basis, encouraging a culture that seeks to work with complainants in an open and honest way to achieve positive outcomes.

2 ENGAGEMENT

SRCCG staff have been involved in the development of this policy, which is based on NHS national guidance and best practice, including patient engagement exercises and research on effective complaints processes.

3 IMPACT ANALYSES

3.1 Equality

In developing this policy an equalities impact analysis has been undertaken. As a result of performing the analysis, this policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. SRCCG is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare professionals. All information in relation to the complaints process is available in alternative languages and formats upon request.

Every complainant is dealt with as an individual and spoken with to agree their preferred outcome and how the CCG will maintain contact. Adjustments are made on an individual basis.

The CCG seeks views of complainants at the end of the process for their input on whether the complaints process was followed to their satisfaction. An equality and diversity monitoring form accompanies the survey which is completed voluntarily.

A copy of the completed Equality Impact Analysis can be found on the CCG's website where it is published alongside this Policy.

3.2 Sustainability

A Sustainability Impact Assessment form for this policy has been completed and is attached at Appendix 2. There are no significant impacts on sustainability detailed from this assessment.

3.3 Bribery Act 2010

On review this policy, there are no implications under the provisions of the Bribery Act 2010 that should be taken in to account

4 SCOPE

This policy applies to all staff, CCG Members, temporary staff, seconded staff, contractors and others undertaking work on behalf of the CCG, and members of the public who are patients of the CCG.

5 POLICY PURPOSE & AIMS

The aim of the Policy for the Reporting and Management of Patient Complaints is to ensure a robust framework is in place for the management of patient complaints to maximise learning and inform and influence service redesign and future commissioning decisions. This policy and SRCCG 's Complaints Procedure aims to support staff to provide an outcome focused response to complainants concerns whilst ensuring fairness to practitioners and staff.

6 DEFINITIONS

A complaint can be defined as 'an expression of dissatisfaction or annoyance requiring a response'. This can include expressions as letters, emails, telephone calls, and face to face discussions.

7 Roles / Responsibilities / DUTIES

The Chief Officer as the Accountable Officer for the CCG is responsible for ensuring that SRCCG has a process for the management of patient complaints in accordance with the DH complaints regulations in relation to CCG functions.

The Associate Director of Corporate Services will ensure that the CCG's agreed process for complaints management and investigation is appropriately implemented and regularly reviewed.

SRCCG will delegate authority to a team or organisations where there are contractual and/and governance arrangements in place with a clear line of accountability from the delegate back to the CCG lead, to investigate and manage complaints, with the requirement to report to the CCG lead as per governance and contractual arrangements. Delegated authority is formally agreed for The Head of Partnership Commissioning Unit. Delegated teams and organisations will implement systems for ensuring that all investigations into complaints are tracked and monitored and target dates for responses are met (see appendix 1).

Investigating managers will be responsible for the management of the complaints investigation and response in line with this SRCCG Complaints Policy.

All staff are responsible for being aware of their obligations with regard to complaints as outlined in this policy.

8 IMPLEMENTATION

This policy will be placed on the CCG internet and will be shared with staff.

8.1 Duty of Candour - Being Open with Patients and Relatives

The CCG is committed to improving communication with patients and carers. When things go wrong, it is essential that the relevant parties are kept fully informed and feel supported.

The being open process underpins the local resolution stage of the complaints process.

The CCG has pledged the following, in relation to duty of candour and complaints;

- To work collaboratively to promote a culture of openness, transparency and inclusiveness, to drive the delivery of high quality care;
- To ensure we apply the values of transparency, honesty and candour within our own organisation and in our dealings with healthcare service providers
- To hold healthcare service providers to account on their contractual duty of candour
- To Ensure healthcare service providers engage with their workforce and genuinely challenge inappropriate attitudes and behaviours
- To support whistle-blowers, by providing easily accessible processes to allow all NHS staff to raise concerns

The CCG will also ensure that the actions taken as a result of complaints are implemented and published annually in its annual report.

8.2 "I" Statements - user- led vision for raising concerns and complaints

The CCG is supportive of a user- led vision for raising concerns and complaints and considers the "I" statements published in the following reports 'Complaints Matter' and 'My Expectations for Raising Concerns and Complaints' important to the complaints process in ensuring it is patient focussed. The following statements have been considered and aligned, where appropriate, with the policy:

1. I felt confident to speak up
2. I felt that making a complaint was simple
3. I felt listened to and understood
4. I felt that my complaint made a difference
5. I feel confident making a compliant in future

A diagrammatic version of this user-led vision can be found at Appendix 3.

9 TRAINING & AWARENESS

SRCCG will ensure that staff have relevant training at the appropriate level and should aim to attend one complaints training session upon appointment. Statistics on the number of staff attending the training will be collated and reported annually to the Quality and Performance Committee and the Communication and Engagement Committee.

Good complaint handling is not limited to providing an individual remedy to the complainant and all feedback and lessons learnt from complaints will contribute to service improvement.

The CCG will:

- Ensure that learning is identified through complaint investigations.
- Actively capture learning from complaints from all commissioned services and GP Practices to gather themes and interpret the findings to monitor the quality of commissioned services and to inform contracting and commissioning decisions.
- Monitor progression of action plans
- Ensure learning is disseminated internally and externally and recorded as part of a 'Closing the loop' report

10 MONITORING & AUDIT

All information from patient complaints is collated and recorded onto a management database from which anonymised reports are produced for internal and external reporting. The Quality and Performance Committee and the Communication and Engagement Committee will routinely receive these reports in order to triangulate patient feedback with other insight gathered by SRCCG, such as incidents, comments, compliments and user feedback.

Complaints information will be proactively considered as part of all service re-design projects to ensure patient feedback is routinely used to improve services and inform commissioning intentions.

11 POLICY REVIEW

This policy will be reviewed two years after agreement or sooner, should relevant national guidance change.

12 REFERENCES

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

NHS Litigation Authority Risk Management Standards

National Reporting and Learning Service Being Open Process Clwyd Report (2013)

CQC Complaints Matters Published December 2014

NHS England – A Guide to Good Handling of Complaints for CCGs – May 2013

House of Commons Select Committee, Health; Fourth Report - Complaints and Raising Concerns, 13 January 2015

13 ASSOCIATED DOCUMENTATION

None

14 APPENDIX 1 - THE MANAGEMENT OF UNREASONABLE, OR PERSISTENT CONTACTS

1. Purpose

The CCG and its complaints handling team, have contact with a small number of individuals who absorb a disproportionate amount of NHS resources, due to unreasonable persistent contact. The aim of the procedure for unreasonable, persistent contact is to identify situations where the contact might be considered to be unreasonable or persistent and to suggest ways of responding to these situations.
It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken, to try to resolve issues and complaints.

Judgement and discretion must be used in applying the criteria to identify potential unreasonable or persistent contacts, and in deciding action to be taken in specific cases.
The procedure should only be implemented following careful consideration by, and with the authorisation of the Chief Operating Officer.

Where deputies are nominated, the reason for the non-availability of the Chief Operating Officer and the Clinical Commissioning Group Clinical Chair should be recorded on the file.

2. Definition of an Unreasonable Persistent contact

- Individuals (and/or anyone acting on their behalf) may be deemed to be an Unreasonable Persistent Contact 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, or where investigation has been denied, as out of time.

- Change the substance of a complaint or concern, continually raise new issues or seek to prolong contact by continually raising further concerns upon receipt of a response, whilst the complaint or concern is being addressed. (Care must be taken not to discard new issues which are significantly different from the original contact. These might need to be addressed as separate concerns or complaints).

- Are unwilling to accept documented evidence of treatment given as being factual, such as drug records, General Practitioner records and nursing records. Deny receipt of an adequate response, in spite of correspondence specifically answering the complainants questions being received, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts by the CCG, Patient Relations staff and where appropriate, the Independent Contacts Advocacy Service supporting the complainant, or where the concerns identified are not within the remit of the CCG to investigate.

- Focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what a trivial matter is, can be subjective and careful judgment must be used in applying this criteria).

- Have threatened, or used actual physical violence towards staff, or their families or associates at any time - this will in itself cause personal contact with the individual and/or their representatives to be discontinued and the contact will, thereafter, only be pursued through written communication. (All such incidents should be documented).

- Have harassed, or been personally abusive, or verbally aggressive, on more than one occasion towards staff dealing with their concern or complaint, or their families or associates. (Staff must recognise that individuals may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They should document all incidents of harassment).

- Have in the course of addressing a concern or formal complaint, an excessive number of contacts with the CCG / CCG complaints-handling team service placing unreasonable demands on staff. (A contact may be in person or by telephone, email, letter or fax. Discretion must be used in determining the precise number of excessive contacts applicable under this section, using judgment based on the specific circumstances of each individual case).

- Are known to have recorded meetings, or face-to-face/telephone conversations, without the prior knowledge and consent of other parties involved.
- Display unreasonable demands, or expectations and fail to accept that these may be unreasonable (e.g. insist on responses to contacts or enquiries being provided more urgently than is reasonable or normal recognised practice).

3. Options for Dealing with Unreasonable Persistent contacts

The Chief Officer will determine what action to take where the CCG have identified individuals as unreasonable or persistent in accordance with the above criteria. The Chief Officer will implement such action and will notify individuals in writing of the reasons why they have been classified as unreasonable, persistent contacts and the action to be taken. This notification may be copied for the information of others already involved in the concern or complaint, e.g. Practitioners, ICA, Member of Parliament.

A record must be kept for future reference, of the reasons why an individual has been classified as unreasonable, or persistent.

The Chief Officer may decide to deal with individuals in one or more of the following ways:

- Try to resolve matters, before invoking this procedure, by drawing up a signed agreement with the individual, which sets out a code of behavior for all those involved if the CCG, or its complaints-handling team, is to continue processing the concern, or complaint.
- If these terms are contravened by the individual, consideration would then be given to implementing other action, as indicated in this section.

Once it is clear that any individual meets any one of the criteria above, it may be appropriate to inform them in writing that they may be classified as unreasonable or persistent contacts and provide a copy of this procedure to them. It is important to advise them to take account of the criteria in any further dealings with the CCG or its complaints-handling team. In some cases it may be appropriate, at this point, to copy this notification to others involved in the concern or complaint and to suggest that individuals seek advice in processing their concern or complaint, e.g. through ICA.

Decline contact with the individual either in person, by telephone, fax, letter, email or any combination of these, provided that one form of contact is maintained, or alternatively, to restrict contact to liaison through a third party. (If staff are to withdraw from a telephone conversation with the individual, it may be helpful for them to have an agreed statement available to be used at such times).

Notify the individual in writing that the Chief Operating Officer, has responded fully to the points raised and has tried to resolve the concern, or complaint, but there is nothing more to add and continuing contact on the matter will serve no useful purpose.

The individuals should also be notified that the correspondence is at an end and that further letters received, will be acknowledged but not answered. Inform the individual that in extreme circumstances the CCG reserves the right to pass unreasonable or persistent contacts on to their legal team and temporarily suspend all contact with the individual, or investigation of a complaint, whilst seeking legal advice, or guidance, from NHS England, or other relevant agencies.

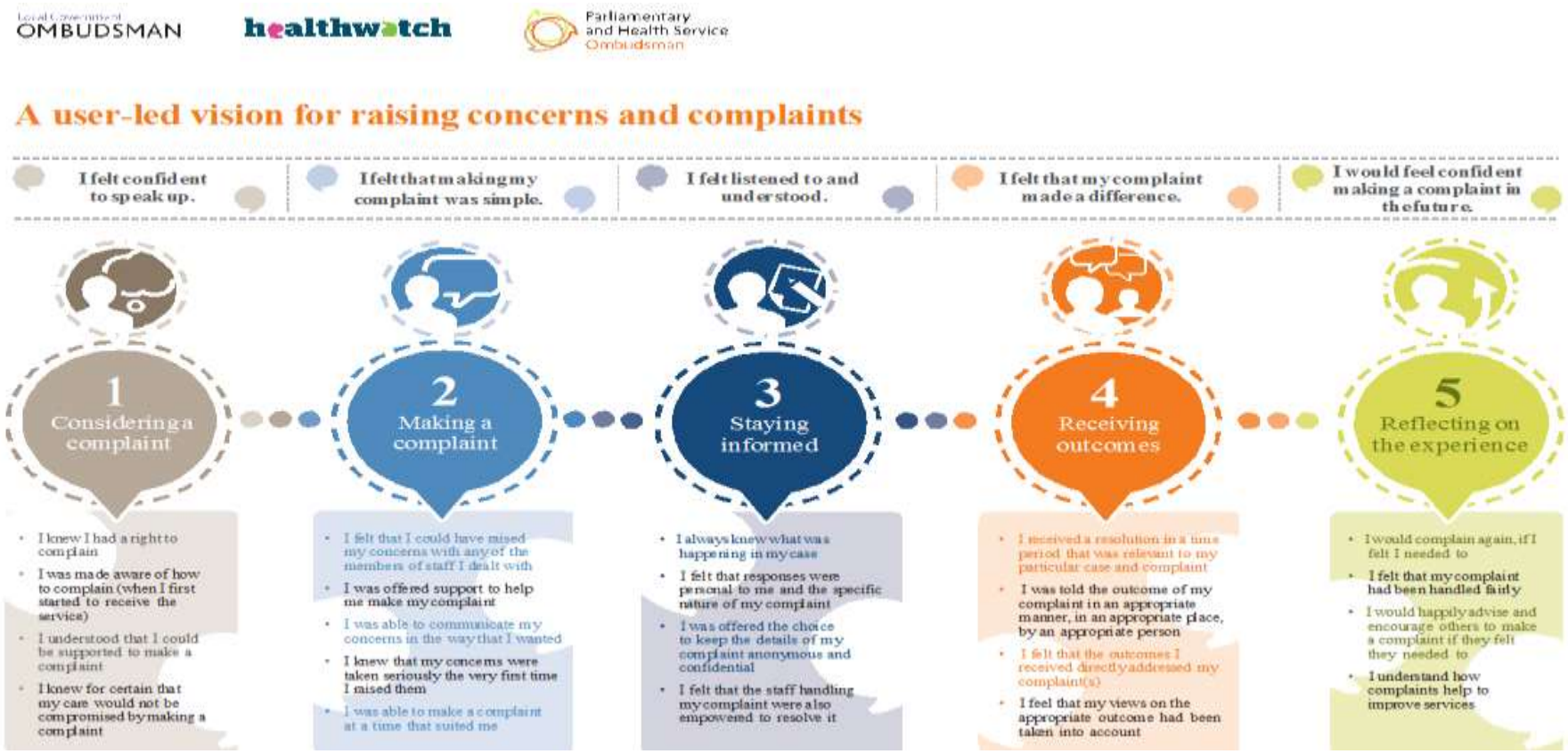
4. Withdrawing Unreasonable Persistent Contact Status

Once individuals have been determined as unreasonable or persistent there needs to be a mechanism for withdrawing this status, at a later date if, for example, they subsequently demonstrate a more reasonable approach, or if they submit a further concern, or complaint for which normal procedures would appear appropriate. Staff should previously have used discretion in recommending unreasonable or persistent status at the outset and discretion should similarly be used in recommending that this status be withdrawn, when appropriate. Where this appears to be the case, discussion will be held with the Chief Operating Officer. Subject to their approval, normal contact with the individual will be resumed.

When an individual has been classified as an Unreasonable Persistent Contact for one year, a review of the classification will be undertaken by the CCG / its complaints handling team to see if the classification is still appropriate. The individual will be advised of the outcome of the review and any change to their status. A further review will be held annually.

15 APPENDIX 2 - User-led vision for raising concerns and complaints

(Extracted from My Expectations for Raising Concerns and Complaints (2014)



16 APPENDIX 3 - Equality Impact Analysis

1. Equality Impact Analysis	
Policy / Project / Function:	Complaints Policy
Date of Analysis:	12 February 2014, reviewed 01 June 2015
This Equality Impact Analysis was completed by: (Name and Department)	Liz Vickerstaff RGN RMN Quality Lead Quality and Outcomes Team YHCS
What are the aims and intended effects of this policy, project or Function?	Complaints Policy for SR CCG
Please list any other policies that are related to or referred to as part of this analysis?	
Who does the policy, project or function affect? **Please Tick ✔**	**Employees** x☐ **Service Users** x☐ **Members of the Public** x☐ **Other (List Below)** ☐

2. Equality Impact Analysis: Screening					
	Could this policy have a positive impact on…?		**Could this policy have a negative impact on…?**		**Is there any evidence which already exists from previous (e.g. from previous engagement) to evidence this impact**
	Yes	**No**	**Yes**	**No**	
Race	☐	x☐	☐	x☐	
Age	☐	x☐	☐	x☐	
Sexual Orientation	☐	x☐	☐	x☐	
Disabled People	☐	x☐	x☐	☐	Where complainants may require support to make a complaint, this service is offered as part of the policy and process
Gender	☐	x☐	☐	x☐	
Transgender People	☐	x☐	☐	x☐	
Pregnancy and Maternity	☐	x☐	☐	x☐	
Marital Status	☐	x☐	☐	x☐	
Religion and Belief	☐	x☐	☐	x☐	

Reasoning	Complaints are managed in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and NHS Litigation Authority Risk Management Standards. The benefits of receiving and managing complaints is to support the complainant in reaching satisfaction and to enable the organisation to benefit from wider learning which can be shared across one or many organisations As a result of performing this analysis, the policy, project or function does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. NHS SR CCG promotes a culture of Equality and Diversity within its organisation and actively monitors themes arising from incidents for any potential discriminatory activity.
If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7	

3. Equality Impact Analysis: Local Profile Data	
Local Profile/Demography of the Groups affected (population figures)	
General	
Age	
Race	
Sex	
Gender reassignment	
Disability	**10870 persons where day-to-day activities is limited a lot**
Sexual Orientation	
Religion, faith and belief	
Marriage and civil partnership	
Pregnancy and maternity	

4. Equality Impact Analysis: Equality Data Available	
Is any Equality Data available relating to the use or implementation of this policy, project or function? **Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine *Protected Characteristics* – referred to hereafter as *'Equality Groups'.*** **Examples of *Equality Data* include: (this list is not definitive)** **1. Application success rates *Equality Groups***	**Yes** ☐ **No** ☐ **Where you have answered yes, please incorporate this data when performing the *Equality Impact Assessment Test* (the next section of this document).**

2. Complaints by *Equality Groups* **3. Service usage and withdrawal of services by *Equality Groups*** ***4.*** **Grievances or decisions upheld and dismissed by *Equality Groups*** **5. *Previous EIAs***	
List any Consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function.	
Promoting Inclusivity **How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation?**	

5. Equality Impact Analysis: Assessment Test				
What impact will the implementation of this policy, project or function have on employees, service Users or other people who share characteristics protected by *The Equality Act 2010* ?				
Protected Characteristic:	**No Impact:**	**Positive Impact:**	**Negative Impact:**	**Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists**
Gender (Men and Women)	**X**			
Race (All Racial Groups)	**X**			
Disability (Mental and Physical)			**X**	Some complainants, as a result of disability may require support to make a complaint. Advocacy services are offered as part of the policy and process, and records held to ensure audit demonstrates equity of access
Religion or Belief	**X**			

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?				
Protected Characteristic:	**No Impact:**	**Positive Impact:**	**Negative Impact:**	**Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists**
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	**X**			
Pregnancy and Maternity	**X**			
Transgender	**X**			
Marital Status	**X**			
Age	**X**			

6. Action Planning

As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010*

Identified Risk:	Recommended Actions:	Responsible Lead:	Completion Date:	Review Date:
Some complainants, as a result of disability may require support to make a complaint. Advocacy services are offered as part of the policy and process, and records held to ensure audit demonstrates equity of access	Ensure staff recognize where a complainant requires support from advocacy services	CCG	June 2015	At new staff induction, and when policy due for review 2017

7. Equality Impact Analysis Findings				
Analysis Rating:	□ **Red**	□ **Red/Amber**	□ **Amber**	**xGreen**

Approved By		
Job Title:	**Name:**	**Date:**
Chief Officer	**Simon Cox**	**04.08.2015**

17 APPENDIX 4 - SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document	NHS SR CCG Complaints Policy
What is the main purpose of the document	Management of feedback, concerns and complaints
Date completed	11 February 2014, Reviewed 01 June 2015
Completed by	Liz Vickerstaff

Domain	**Objectives**	**Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a**	**Brief description of impact**	**If negative, how can it be mitigated?** **If positive, how can it be enhanced?**
Travel	Will it provide / improve / promote alternatives to car based transport? Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)? Will it reduce 'care miles' (telecare, care closer) to home?	1	Use of teleconference facilities for meetings	

	Will it promote active travel (cycling, walking)? Will it improve access to opportunities and facilities for all groups?			
Procurement	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery? Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives? Will it promote ethical purchasing of goods or services? Will it promote greater efficiency of resource use? Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)? Will it support local or regional supply chains? Will it promote access to local services (care closer to home)? Will it make current activities more efficient or alter service delivery models	0		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled?	1	All documentation processed electronically, and	

	Will it reduce water consumption?		meetings conducted using “e” technology.	
Workforce	Will it provide employment opportunities for local people? Will it promote or support equal employment opportunities? Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)? Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development? Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	0		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)? Will it increase safety and security in new buildings and developments? Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)? Will it provide sympathetic and appropriate landscaping around new development?	0		

	Will it improve access to the built environment?			
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes? Will it promote prevention and self-management? Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available? Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	1	Feedback, concerns and complaints may result in improvements to care models and pathways.	

18 APPENDIX 5 - Bribery Act 2010 Guidance and Bribery Prevention Checklist

Areas for action	Expected Action	Evidence of Compliance/Assurance
1. Governance and Top Level Commitment	**The Chief Executive should make a statement in support of the anti-bribery initiative and this should be published on the organisation's website.** **The board of directors should take overall responsibility for the effective design, implementation and operation of the anti-bribery initiatives. The Board should ensure that senior management is aware of and accepts the initiatives and that it is embedded in the corporate culture.**	

Areas for action	Expected Action	Evidence of Compliance/Assurance
2. Due Diligence	**This is a key element of good corporate governance and involves making an assessment of new business partners prior to engaging them in business. Due diligence procedures are in themselves a form of bribery risk assessment and also a means of mitigating that risk. It is recommended that at the outset of any business dealings, all new business partners should be made aware in writing of the organisation's anti-corruption and bribery policies and code of conduct.**	

Areas for action	Expected Action	Evidence of Compliance/Assurance
3. Code of conduct	**The organisation should either have an anti-bribery code of conduct or a general code of conduct for staff with an anti-bribery and corruption element.** **The organisation should revise the Standards of Business Conduct Policy (or equivalent) and Declaration of Interests guidance (see point 4 below) to reflect the introduction of the Bribery Act.**	
4. Declaration of Interests/Hospitality	**The organisation should have in place a declaration of business interests/gifts and hospitality policy which clearly sets out acceptable limits and also a mechanism to monitor implementation.**	

Areas for action	Expected Action	Evidence of Compliance/Assurance
5. Employee employment procedures	**Employees should go through the appropriate propriety checks e.g. CRB (Criminal Records Bureau) and/or a combination of other checks before they are employed to ascertain, as far as is reasonable, that they are likely to comply with the organisation's anti-bribery policies.**	
6. Detection procedures	**The organisation should ensure Internal Audit/Counter Fraud check projects, contracts, procurement processes and any other appropriate systems where there is a risk that acts of bribery could potentially occur.**	
7. Internal reporting procedures	**The organisation should have internal procedures for staff to report suspicious activities including bribery.**	

Areas for action	Expected Action	Evidence of Compliance/Assurance
8. Investigation of Bribery allegations	**The organisation should have procedures for staff to report suspicions of bribery to NHS Protect (previously NHS Counter Fraud and Security Management Service) and the organisation's Local Counter Fraud Specialist for investigation/referral to the appropriate authorities.**	
9. Risk assessment	**MoJ (Ministry of Justice) guidance states"…organisations should adopt a risk-based approach to managing bribery risks…[and] an initial assessment of risk across the organisation is therefore a necessary first step". The organisation should, on a regular basis, assess the risk of bribery and corruption in its business and assess whether its procedures and controls are adequate to minimise those risks.**	

Areas for action	Expected Action	Evidence of Compliance/Assurance
10. Record keeping	**The organisation should keep reasonably detailed records of its anti-fraud and corruption initiatives, including training given, hospitality given and received and other relevant information.**	
11. Internal review	**The organisation should carry out an annual internal review of the anti-bribery and corruption programme.**	
12. Independent assessment and certification	**Proportionate to risks identified, the organisation should commission, at least every three years, an independent assessment and certification of its anti-bribery programme.**	

Areas for action	Expected Action	Evidence of Compliance/Assurance
13.Internal and External communications	**The organisation should publicise the NHS Fraud and Corruption Reporting Line (FCRL) and on-line fraud reporting facility.** **The organisation should publicise the Security Management role (theft and general security issues) and reporting arrangements.** **The organisation should work with its stakeholders in the public and private sector to help reduce bribery and corruption in the health industry.**	
14.Awareness and training	**The organisation should provide appropriate anti-bribery and corruption awareness sessions and training on a regular basis to all relevant employees.**	

Areas for action	Expected Action	Evidence of Compliance/Assurance
15. Monitoring: • **Overall Responsibility** • **Financial/Commercial Controls**	• **A senior manager should be made responsible for ensuring that the organisation has a proportionate and adequate programme of anti-fraud, corruption and bribery initiatives.** • **The organisation should ensure that its financial controls minimise the risk of the organisation committing a corrupt act.** • **The organisation should ensure that its commercial controls minimise the risk of the organisation committing a corrupt act. These controls would include appropriate procurement and supply chain management, and the monitoring of contract execution.**	