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1 Introduction

Our Community Teams provide care and treatment the majority of patients within mental health services and are increasingly supporting individuals with complex, long-term needs. National policy, including the NHS Long Term Plan and Community Mental Health Transformation programme, emphasises the need for integrated, recovery-focused, community-based care, delivered close to home.

Caseload management is a structured approach to ensuring that care is safe, effective, and responsive to changing patient need. It provides routine oversight of caseloads, supports proactive risk management, and ensures that interventions remain aligned with agreed care pathways and recovery goals.

The policy aims to support a fair, transparent and equitable approach to caseload management, recognising the diverse needs of the population served and the importance of reducing health inequalities through personalised and inclusive care



Caseload Management is distinct from clinical supervision and focuses specifically on caseload oversight, prioritisation, allocation and progression of care.

This policy aligns with and supports delivery of Our Journey to Change: the next chapter.

2 Why we need this policy

2.1 Purpose

The purpose of this policy is to ensure all Community Mental Health Team (CMHT) staff providing clinical care receive structured, consistent, and effective caseload management supervision. Caseload Management supports safe, high-quality, patient-centred care by ensuring appropriate oversight, prioritisation, and alignment of interventions with patient needs. It also provides a framework for supporting staff wellbeing, equity, consistency of decision-making, reasonable adjustments, reducing inequalities and maintaining professional standards.

2.2 Objectives

This policy ensures that:

- All patients on caseload are reviewed regularly and systematically
- Risk is actively monitored and escalated where necessary

- Care planning is current, recovery-focused and aligned to need
- Caseloads are managed safely, proportionately and equitably
- Staff are supported to manage workload, complexity and wellbeing
- There is consistent practice across teams, reducing unwarranted variation
- Patients receive fair and equitable access to care, with consideration given to protected characteristics, individual circumstances and factors contributing to health inequalities

3 Scope

3.1 Who this policy applies to

This policy applies to all staff within Community Mental Health Teams (specific list) who hold responsibility for a clinical caseload. This includes:

- Registered and unregistered staff in the following disciplines:
- Nursing
- Medical
- Therapies: Allied Health Professionals, Psychological Professionals, Peers and Social Workers

The policy covers all patients with an active allocation.

3.2 Roles and responsibilities

Role	Responsibility
Clinical Leadership Team	Ensure implementation, compliance monitoring, and escalation of risks relating to caseload safety and workforce capacity
Team Manager	Ensure staff receive monthly caseload management supervision, maintain compliance, and address capacity or performance issues
Supervisor	Prepare for and lead caseload management supervision, review caseload data and documentation, agree actions and escalation
Supervisee	Prepare caseload information, engage actively in supervision, implement agreed actions, maintain accurate records

4 Our Approach

4.1 Standards

- All staff with a caseload must receive monthly caseload management supervision
- Supervision must be protected time within job plans

- Caseload Management must be informed by the standard electronic caseload dashboard
- All patients must be reviewed at least annually through supervision processes

4.2 Standard Structure

Caseload Management must include the following components:

- Review any barriers to engagement and required reasonable adjustments
- Caseload overview
- Use dashboard to identify risk, overdue contacts, or gaps in care
- Use dashboard to ensure caseload stratification has been undertaken
- Review of care documentation
- Alignment to care pathway
- partnership working with other agencies
- Carers involvement
- Clinical prioritisation
- Identify patients requiring escalation, MDT review or intervention
- Actions - Agree clear next steps and associated actions
- Staff wellbeing
- Review workload, pressures, and support needs

4.3 Escalation

Agreed escalation steps and associated clinical actions must be put in place where:

- Risk significantly increases
- Care is not progressing appropriately
- Caseload size is above safe capacity, determined by clinical discussion rather than a fixed number.
- Staff wellbeing impacts safe delivery of care
- Barriers to engagement, unmet reasonable adjustments, or factors contributing to health inequalities are identified that may impact access to care, safety, or outcomes

4.4 Integration with Team Processes

Caseload Management must be supported by:

- Daily MDT huddles for immediate concerns
- Allocation meetings for equitable workload management
- Quality Assurance processes reviewing documentation and compliance

Together these provide a whole-system approach to caseload safety and effectiveness.

Caseload Management is distinct from clinical supervision and focuses specifically on caseload oversight, to support safe, effective equitable service delivery prioritisation, and progression of care. For some Therapies staff groups caseload supervision may be delivered within clinical supervision. It is the responsibility of the clinical supervisor and Professional Lead to ensure caseload management is carried out.

5 Caseload Stratification

5.1 Purpose of Stratification

Caseload stratification provides a consistent, needs-based approach to segmenting patients within Community Mental Health Team caseloads. It enables:

- Improved oversight of patient need and risk
- Delivery of clinically effective intervention
- Proportionate allocation of clinical resources
- Consistent decision-making across teams
- Enhanced staff wellbeing through clearer workload understanding
- Identification of individuals who may require reasonable adjustments or additional support to ensure equitable access to care
- Stratification supports reflective discussion during caseload management supervision

5.2 Stratification Model AMH Community, CAMHS Community and MHSOP Functional Patients

All patients must be stratified into one of four needs-based groups:

5.2.1.1 Group 1 – Assertive and Intensive Needs - Patients requiring the highest level of support, characterised by:

- Presenting with psychosis symptoms: do not need to have diagnosis of a psychotic illness
- Psychosis is enduring or they experience frequent relapses
- Deterioration/relapse may result in increased risk of violence and aggression and/or risk to self
- Have multiple social needs (self- neglect, social isolation, accommodation, finance) which likely requires multi-agency involvement to maintain functioning.
- Difficulty engaging with treatment or maintaining stability, despite appropriate support and reasonable adjustment
- Children and young people who require frequent contact, multi agency coordination, and high intensity intervention to maintain safety or stability.

- Children and young people whose needs cannot be met through therapy and who require intensive, multi-agency risk management because they remain a significant concern despite extensive input.

Additional indicators may include:

- Co-occurring drug and alcohol problems
- Criminal justice or safeguarding involvement
- Hospital admissions, crisis contact, home-based treatment or CTO

5.2.1.2 Group 2 – Patients with significant ongoing needs:

- History of frequent admissions or crisis contacts
- Vulnerability to deterioration or relapse
- Co-existing social, psychological, and physical health needs
- Moderate to high risk requiring active monitoring and relapse planning
- Children and young people with multiple interacting difficulties, often requiring involvement from multi-disciplinary team (MDT)/several services, but not at the level of daily or crisis intervention.
- Children and young people with significant, overlapping difficulties that affect day-to-day functioning. They require sustained, specialist CAMHS involvement from an MDT, coordinated across services, to address severe, complex, or persistent mental health and/or learning disabilities needs.

Patients may:

- May experience barriers to engagement requiring additional support or reasonable adjustments
- Require multi-agency involvement
- Need regular review but with less intensity than Group 1

5.2.1.3 Group 3 – Patients with stable but persistent mental health needs:

- Ongoing symptoms with some functional impairment
- Require regular but predictable support
- Occasional urgent care input
- May have co-morbid physical health or social issues
- Support is focused on maintenance, recovery and preventing deterioration.
- Children and young people with mental health and or learning disability needs that impact functioning but do not require multi agency coordination or intensive risk management.

5.2.1.4 Group 4 – Patients requiring low-intensity support:

- Stable mental health and functioning

- May require ongoing reasonable adjustments or support to maintain recovery and service engagement'
- Limited risk and low service involvement
- May require medication monitoring (e.g. depot clinics)
- Able to self-manage with minimal support
- These patients should be supported through planned reviews and recovery-focused care.
- Children and young people with mild, early stage, or situational difficulties who may benefit from brief intervention, psychoeducation, signposting, or early help rather than specialist CAMHS.

5.2.2 Process for Stratification AMH Community and MHSOP Functional Patients

Patients must be allocated to a stratification group through:

- Caseload management supervision
- Clinical supervision discussions
- Daily huddles and MDT forums
- Multi-agency meetings (e.g. high-risk panels)

Key principles:

- Patients identified as Group 1 (Assertive & Intensive) or Group 2 (Complex) must be formally agreed and recorded at the earliest opportunity
- Movement out of Groups 1 or 2 requires clinical leadership oversight
- Patients in Groups 3 and 4 may be re-allocated through routine caseload management supervision or MDT discussion
- Stratification level should be recorded within the standard caseload management system/dashboard
- Stratification decisions must take account of any reasonable adjustments, communication needs, and barriers to engagement to ensure equitable and person-centred care

5.3 Stratification Model MHSOP Organic Patients

Organic (MHSOP) patients must be allocated to one of the following three groups:

5.3.1.1 Group 1 – Diagnostic Assessment

- Patients who are referred to the service and are undergoing assessment for cognitive impairment or suspected dementia.
- At initial stages of pathway
- Undergoing assessment, investigation, or awaiting diagnostic review
- Limited or no ongoing intervention required at this stage

- Low immediate risk or complexity
- Examples:
    - A patient awaiting their initial assessment with appropriate keeping-in-touch arrangements in place
    - A patient who has completed initial assessment and is awaiting diagnostic review with no additional identified needs

5.3.1.2 Group 2 – Diagnosis and Early Post-Diagnostic Support

- Patients who have received a diagnosis of dementia or Mild Cognitive Impairment and are receiving early post-diagnostic support.
- Confirmed diagnosis (e.g. Alzheimer's disease, mixed dementia, MCI)
- Requires coordinated intervention and support
- May involve multiple professionals and services
- Moderate level of complexity and support needs
- Examples:
    - A patient attending a titration clinic following a diagnosis of Alzheimer's disease, awaiting therapy, with carer support in place
    - A patient with Mild Cognitive Impairment receiving risk-reduction and monitoring interventions
    - A patient with mixed dementia receiving interventions to support cognition, independence and wellbeing

5.3.1.3 Group 3 –Complex Needs / Extended Involvement

- Patients requiring extended or intensive involvement due to complexity, diagnostic uncertainty, or high level of need.
- Significant behavioural and psychological symptoms of dementia (BPSD)
- Diagnostic complexity (e.g. younger onset, atypical presentation, co-morbidities)
- High level of risk, vulnerability, or carer breakdown
- Multi-agency involvement and/or frequent review required
- May include patients with variable or limited engagement
- Intensive MDT input and coordination
- Implementation of specialist pathways (e.g. Behaviours That Express Need pathway)
- Regular review of medication, risk, and care arrangements
- Close liaison with carers, care providers, and external agencies
- Coordination of physical health, social care, and risk management
- Examples:
    - A patient with mixed dementia re-referred due to deterioration, presenting with behavioural symptoms and carer strain
    - A care home resident with Alzheimer's disease requiring regular review of antipsychotic treatment for BPSD
    - A patient with alcohol-related dementia and ongoing substance dependence requiring joint working with addiction services

- A patient with complex physical health conditions (e.g. diabetes, vascular complications) and recurrent delirium requiring intensive support and reassessment

5.3.2 Process for Stratification MHSOP Organic Patients

Patients must be allocated to a stratification group through:

- Initial assessment and diagnostic pathways
- MDT discussion and clinical decision-making
- Ongoing review through caseload management supervision and care planning

Key principles:

- Allocation should reflect the current stage in pathway and level of need
- Patients may move between groups as their condition progresses or stabilises
- Movement into Complex Needs / Extended Involvement (Group 3) should occur promptly where risk or complexity increases
- Group allocation must be clinically justified and agreed within the MDT
- Group allocation must take account of any reasonable adjustments, communication needs, sensory impairments, carer involvement, and barriers to engagement to ensure equitable and person-centred care

5.4 Stratification Model ALD Patients

All patients must be stratified into one of four needs-based groups:

Group 1 –Intensive Needs

People requiring the highest level of support, characterised by:

- Complex risk profiles, including harm to self or others.
- People with behaviours that cause harm or distress to themselves or others.
- Frequent risk escalation.
- People with variable or limited engagement.
- Inpatient admission, especially at discharge / transfer of care.
- Intensive, proactive, unpredictable Multi-Disciplinary Team (MDT) input and coordination, potentially requiring the allocation of 2 staff.
- Involvement of Intensive or Enhanced Support Team and / or being on the local Dynamic Support Register.
- At risk of placement break-down.
- Managing uncertainty.

Additional indicators may include:

- Frequent contact with crisis and urgent care services and / or with their community team
- Mild learning disability, capacitous and engaging in risky behaviours.
- Involvement of criminal justice; Safeguarding; Court of Protection; Guardianship; Deprivation of Liberty Safeguards (DOLs); Prevent.

- 'Out of Area': Moving into our area, away from their home, with intensive needs.

Group 2 – Complex Needs

Patients with significant ongoing needs but more stable than Group 1:

- Vulnerable to deterioration which may be a pattern they have experienced in the past.
- Complex social, psychological, and physical health needs requiring skilled, holistic, expert care. Always MDT, often multi-agency.
- Intensive MDT input and coordination which is planned and paced according to needs.
- Implementation of specialist pathways e.g. Positive Behaviour Support CLiP
- Requiring skilled interventions delivered consistently by experienced, expert staff.

Additional indicators may include:

- Variable engagement with services.
- Need regular review but with less intensity than Group 1.
- Trauma focused support.
- Transfers of care & transitions – new home; new team.

Group 3 – Moderate Needs

Patients with stable but persistent health needs characterised by:

- Low intensity, psychologically informed pieces of work e.g. managing emotions.
- Ongoing concerns with negative impact on the person, which can be addressed through ongoing treatment and intervention.
- Predictable episodes of care requiring set or prescribed number of sessions over a number of weeks.
- Requires regular but predictable support and maybe occasional urgent care input.
- Support and education of family and carers – in relation to the person in their care.

Additional indicators may include:

- Health Facilitation.
- Close liaison with carers, care providers and external agencies.

Group 4 – Low Needs

Patients where support is focused on maintenance, preventing deterioration, wellbeing and social connection, characterised by:

- Medication monitoring e.g. depot clinics
- Stable health, wellbeing and activities of daily living.
- Risk of harm is limited.
- Able to largely self-manage with minimal support.
- Health screening and advice including education and desensitisation.
- Dementia Screening.

Additional indicators may include:

- Group work with a focus on relationships, quality of life and skill building.
- Short term piece of work to address significant life events.
- Partnership working – advice and guidance.

5.4.1 Process for Stratification ALD Patients

Patients must be allocated to a stratification group through:

- Initial assessment: allocation should reflect the current stage in pathway and level of need.
- People may move between groups as complexity increases or stabilises, according to their needs.
- MDT discussion and clinical decision-making in huddles and appropriate MDT forums.
- Ongoing review through caseload supervision and care planning.

Stratification level must be recorded within the standard caseload management system/dashboard, describing the rationale.

5.5 Resource Demand Overlay

In addition to need-based grouping, a resource demand rating (1–4) should be considered, based on:

- Frequency of contact required
- Level of MDT / multi-agency involvement
- Time spent on coordination and administration
- Crisis activity or unplanned work
- Statutory processes (e.g. tribunals, safeguarding)
- Reasonable adjustments, communication needs, accessibility requirements, and factors affecting engagement with services

6 Caseload Management Dashboard (IIC)

The Caseload Management Dashboard, available on the IIC platform, enables staff to conveniently view their own caseload as well as the collective caseload of their team. This tool enhances the caseload management process by providing a visual summary of key information, such as the date each patient was last seen by their allocated staff member and the most recent contact with any team member. Furthermore, the dashboard allows users to record caseload stratification, resource demand levels, outstanding tasks, actions agreed during caseload management meetings, and the planned discharge date for each patient. By consolidating these elements, the dashboard supports informed decision-making and facilitates an informed caseload management discussion.

Caseload Management PTL V1



7 Definitions

Term	Definition
Caseload Management	Caseload management is the structured process by which community colleagues organise, monitor, and oversee their assigned patients. It ensures appropriate allocation of resources, timely interventions, and supports deliver high-quality care.
Community Caseload	Those patients that have been assessed and allocated to receive treatment or interventions.
Huddle	The daily process that considers the needs of the patients seen in the last 24 hours and those being seen that day where help and support may be required. It is attended by all practitioners of the team to have a shared appreciation of the caseload, staff wellbeing & support discussion
Caseload Dashboard	A quick & interactive visual display that gives you & your team the essential information that is needed to enable effective caseload management supervision. It promotes patient flow and informs the Caseload Management discussion.

8 Related documents

Clinical Supervision Policy
Safeguarding Adults Policy
Safeguarding Children Policy
Personalised Care Planning Policy
Clinical escalation procedure

9 How this policy will be implemented

- The Policy will be available on the Trust's website and intranet.
- The service management tier (operational and clinical) will ensure that the policy is disseminated across community teams.
- The community team clinical leadership set will ensure that all community staff understand the requirements of the policy.
- Operational managers will support the allocation of diary time to ensure access to caseload management supervision.

9.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
Webinar to introduce new policy and IIC Dashboard	• Inform community colleagues on new Policy • Provide a live demonstration of the new IIC Dashboard	3 Webinars to be completed by end of November 2026	Policy Lead	MS Teams meeting

9.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All community Staff with a Caseload and Community Team managers.	Webinar to inform on: • Use of the IIC caseload dashboard • community colleagues on new Policy	1 hour session	Single episode to introduce new way of working, expectation that Community team managers share policy requirements with new starters.

10 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	This staff questionnaire will seek feedback on the effectiveness of the Community Caseload Management Policy, the quality and regularity of caseload management supervision, and the usefulness of the IIC Dashboard in supporting safe and effective community mental health services. It will explore staff confidence in applying the policy, whether supervision processes provide sufficient oversight of caseload size, clinical risk, patient flow and documentation, and how well current arrangements support increasing service demands. The questionnaire will also evaluate the usability and effectiveness of the IIC Dashboard, gathers views on training and support needs, and invites suggestions for future improvements, best practice sharing, and enhancements to policy, supervision and caseload management processes.	Frequency = Annual Method = Annual MS Teams Survey Responsible = Policy Lead	Care Group and Speciality Governnace Groups

11 References

Ervin, NE (2008) ‘Caseload management skills to improve efficiency’. Journal of continuing education in nursing.

12 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	03 November 2026
Next review date	03 November 2029
This document replaces	CLIN-0105-v1 'Community Caseload Supervision Policy
This document was approved by	Executive Clinical Leaders Subgroup
This document was approved	21 October 2026
This document was ratified by	Executive Directors Group
This document was ratified	03 November 2026
An equality analysis was completed on this policy on	30 July 2026
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
2	03 Nov 2026	Full revision with major changes: Changed the name from 'Community Caseload Supervision Policy' to 'Community Caseload Management Policy'. The revision moves from a primarily supervision and compliance-based framework to a broader, structured approach to oversight and progression of care across community caseloads. It retains the requirement for monthly protected caseload management supervision and annual review of every patient, while strengthening expectations for	ratified.

		risk escalation, care progression, staff wellbeing, reasonable adjustments and equitable access. The revised policy introduces standard needs-based stratification. Adult Mental Health, CAMHS and MHSOP functional caseloads use four groups; MHSOP organic caseloads use three pathway and complexity groups. It also introduces a resource-demand overlay and expands the IIC Caseload Management Dashboard to support recording of stratification, demand, actions and planned discharge dates. Caseload management is explicitly linked with daily huddles, allocation meetings and quality-assurance processes.	

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Trustwide
Title	Community Caseload Management Policy
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	The purpose of this policy is to ensure all Community Mental Health Team (CMHT) staff providing clinical care receive structured, consistent, and effective caseload management supervision.
Start date of Equality Analysis Screening	22 May 2026
End date of Equality Analysis Screening	30 July 2026

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Colleagues and patients within our community teams
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO**

	• **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO**
Describe any negative impacts / Human Rights Implications	No significant negative impact has been identified. The potential risk that some individuals, particularly those with disabilities, learning disabilities, cognitive impairment, sensory impairments, communication needs, language barriers, neurodivergence, or complex social circumstances, may be disadvantaged if stratification, prioritisation or caseload management decisions do not fully consider individual needs and required reasonable adjustments is mitigated through clinical oversight, MDT decision-making, person-centred care planning, and consideration of equality, diversity and inclusion throughout the caseload management process / policy.
Describe any positive impacts / Human Rights Implications	The Community Caseload Management Policy is expected to have a positive impact by promoting a consistent, transparent and equitable approach to the oversight, prioritisation and management of community mental health caseloads. The policy supports the delivery of person-centred, recovery-focused care based on clinical need and risk, while encouraging consideration of reasonable adjustments, communication needs, carer involvement and barriers to engagement. This should help improve access to services, reduce variation in practice, and support better outcomes for people from diverse backgrounds and those with protected characteristics

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Policies and procedures in NHS Trusts, National best practice guidance and staff feedback
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	Patient representative on the policy design event
If you answered No above, describe future plans that you may have to engage and involve people from different groups	N/A

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	N/A
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Are people involved in the development identified?	Yes	
Has relevant expertise has been sought/used?	Yes	
Is there evidence of consultation with stakeholders and users?	Yes	
Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	
Are supporting documents referenced?	Yes	

6. Training		
Have training needs been considered?	Yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	Yes	
Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9. Approval		
Does the document identify which committee/group will approve it?	Yes	
10. Publication		
Has the policy been reviewed for harm?	Yes	No harm
Does the document identify whether it is private or public?	Yes	public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	Yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Yes	