Lincolnshire Community Health Services NHS Trust

Chaperone Policy

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Chaperone Policy

Version Control Sheet

Version	Section / Para / Appendix	Version / Description of Amendments	Date	Author / Amended by
1		New Policy	January 2014	Michelle Johnstone
2	1 & 4	Introduction Role of healthcare professional Change of policy number from P_CS_28 to P_SG_01	March 2016	Michelle Johnstone
3		Full policy review and update	March 2018	Barbara Mitchell
4		Full Policy review	Jan 2020	Vicki Lightfoot
	Whole document	Minor Formatting changes	Jan 2020	Vicki Lightfoot
	8.7	New section	Jan 2020	Vicki Lightfoot
	Equality Analysis	Reviewed	Jan 2020	Vicki Lightfoot
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Chaperone Policy

1. Introduction

1.1 The relationship between a patient and their practitioner is based on trust. A practitioner may not have doubts about a patient they have known for a long time and may feel it is not necessary to offer a formal chaperone. Similarly studies have shown that many patients are not concerned whether a chaperone is present or not. However this should not detract from the fact that every patient is entitled to a chaperone if they feel one is required and the practitioner should not become complacent in their relationship with that patient and assume this as a given.

1.2 Lincolnshire Community Health Services NHS Trust is committed to the provision of high quality health care in all aspects of its services to patients, visitors; local community's and staff members. It attaches the highest importance to ensuring that a culture that values patient privacy and dignity is embedded within the organisation.

1.3 The Trust recognises that clinical consultations, examinations and investigations have the potential to cause some people distress. Consultations can lead to people feeling vulnerable, for example where lights are required to be dimmed, there is need for close proximity, or where a patient needs to undress or to be touched for intensive periods of time.

1.4 Intimate and personal care is key to a person's self-image and respect. The apparent intimate nature of many health care interventions, if not practiced in a sensitive and respectful manner, can lead to misinterpretation and occasionally allegations of abuse, such as neglect, physical injury, emotional or sexual abuse.

1.5 Not understanding the cultural background of a patient can lead to confusion and misunderstanding with some patients believing they have been the subject of abuse. It is important that all health care professionals are sensitive to these issues and are alert to the potential for patients to feel abused and/or violated.

1.6 Very careful consideration should be given to patients who have had a previous traumatic examination or have been a victim of sexual assault in the past.

1.7 This policy sets out guidance that must be followed for the use of chaperones and the procedures that should be in place for consultations, examinations and investigations and is for the protection of both patients and staff.

1.8 This policy also includes the key principles of communication and record keeping in relation to chaperoning to ensure that the practitioner/patient relationship is

maintained and to act as a safeguard against formal complaints, or in extreme cases, legal action.

1.9 Clinical professional judgment should be utilised at all times: each situation will require a risk assessment by the clinician with clear decision making processes reflected within the patient's record.

2. Purpose & Scope

2.1 Chaperoning in the clinical environment is an essential role within Lincolnshire Community Health Services (LCHS). This policy has been developed to ensure that all LCHS staff undertaking chaperoning duties/responsibilities conform to current legislation and that there is a co-ordinated approach to the use of chaperones during consultations, examinations and procedures Trust wide.

2.2 It should be used in conjunction with existing guidance from Professional bodies with reference to the following LCHS Policies:

- Consent to Examination and Treatment
- Clinical Record Keeping
- Freedom to speak up: raising concerns (whistleblowing) policy for the NHS
- Mental Capacity Act 2005
- Safeguarding Children and Safeguarding Adults
- Personal Safety & Lone Worker Policy
- Incident Reporting Policy
- Confidentiality and Data Protection Policy
- Infection prevention and Control Policy
- Promoting Equality, Valuing Diversity and protecting Human Rights

2.3 This policy applies to all healthcare professionals working within LCHS including medical staff, nurses, healthcare assistants, allied health professionals, medical students, radiographers and complementary therapists working with individual patients in surgeries, clinic situations, wards, departments, outpatients and in the patient's home, this list is not exhaustive.

2.4 This guidance also covers any non-medical personnel who may be involved in providing care. In this policy all staff groups covered will be referred to as the "healthcare professional". The use of the feminine gender equally implies the male and similarly the use of the male gender equally implies the female.

2.5 This policy will be disseminated via LCHS website to all staff. Managers will be expected to discuss the policy with staff at team meetings and the policy will also be available on the Trust website.

3. Responsibilities

3.1 **Chief Executive**
Has ultimate responsibility for the implementation and monitoring of all policies in use across the Trust.

3.2 **Non/Executive Directors**
Will support the implementation of this policy and ensure that staff are compliant with its implementation

3.3 **Director of Nursing AHP and Operations**
The Director of Nursing AHP and Operations, has delegated accountability for ensuring that appropriate arrangements for chaperoning are in place across the trust and for providing 'Board' assurance

3.4 **Heads of Clinical Service**
Are responsible for the implementation of the chaperoning policy; ensuring staff receive appropriate training, and investigating any incidents relating to the use of chaperones.

3.5 **Ward/ Clinical Team Leaders**
Are responsible for the implementation of the chaperoning policy within their department and for ensuring that all staff are aware of, and comply with the policy within the clinical setting. They are also responsible for ensuring that patients/clients are aware that the Trust has a Chaperone Policy and that all patients can request one.

3.6 **All Trust Healthcare Professionals**
Must be aware of, and comply with, the chaperone Policy. All Staff are responsible for reporting any incidents or complaints relating to the use of chaperones, via the Datix system.

4. Definitions

For this policy, the following definitions are used:

4.1 **Chaperone**
There is no common definition of a 'chaperone': the role varies according to the needs of the patient, the healthcare professional, and the examination or procedure being carried out.

4.2 **Formal Chaperone**
A formal chaperone is a healthcare professional, who has undertaken appropriate chaperone training, i.e. all medical and registered staff and healthcare support workers.

4.3 **Informal Chaperone**.

A relative or friend of the patient is usually an impartial observer and would not be a suitable formal chaperone, however you should comply with any request to have such a person present, as well as a chaperone if the patient so wishes.

5. Principles of Chaperoning

5.1 This policy advocates that wherever healthcare services are provided that patients are aware that they can access a chaperone to support their care treatment and examination.

5.2 No family member or friend of a patient should be routinely expected to undertake any formal chaperoning role in normal circumstances.

5.3 The presence of a chaperone during a clinical examination and treatment must be the clearly expressed choice of a patient *(*however the default position should be that all intimate examinations are chaperoned).

5.4 Chaperoning should not be undertaken by anyone other than chaperone-trained staff: The use of untrained administrative staff as a chaperone in a GP surgery for example, is not acceptable.

5.5 The patient must have the right to decline any chaperone offered if they so wish (see section 10 page 11).

5.6 The 'Trust' recognises that it is essential that members of staff are confident in their responsibilities and their ability to chaperone. The need for training should be identified via the Behaviour Based Appraisal process and is delivered through competency based training. (Appendix 1)

5.7 It is recognised that for primary care, developing and resourcing a chaperoning policy will have to take into account issues such as one to one consultations in the patient's home and the capacity of individual practices to meet the requirements of the policy.

5.8 Reported breaches of the chaperoning policy should be formally investigated through the Trust's risk management and clinical governance arrangements and treated, if determined as deliberate, as a disciplinary matter.

5.9 Chaperoning Services will be advertised in each environment where healthcare is provided by displaying appropriate notices within clinical areas.

6. The Role Of The Formal Chaperone

6.1 The role of the chaperone may vary according to the clinical situation and can include:

- Providing the patient with physical and emotional support and reassurance
- Ensuring the environment supports privacy and dignity
- Providing practical assistance with the examination
- Safeguarding patients from humiliation, pain, distress or abuse
- Providing protection to healthcare professionals against unfounded allegations of improper behaviour
- Identifying unusual or unacceptable behaviour on the part of the healthcare professional or the patient
- Providing protection for the healthcare professional from potentially abusive patients
- Provide protection to healthcare professionals against unfounded allegations of improper behaviour made by the patient.

7. Chaperones Should Be:

- Sensitive and respectful of the patient's dignity and confidentiality
- Familiar with the procedures involved in routine intimate examinations and will be able to identify any unusual or unacceptable behaviour on the part of the health care professional
- Prepared to ask the examiner to abandon the procedure if the patient expresses a wish for the examination to end
- Ensure their presence at the examination is documented by the examining professional in the patient's notes or electronic record
- Prepared to raise concerns if misconduct occurs and immediately report any concerns to a senior colleague, and via the Datix system

8. Offering a Chaperone

8.1 All patients should be routinely offered a chaperone during any consultation or procedure. This does not mean that every consultation needs to be interrupted in order to ask if the patient wants a third party present. For instance patients on a caseload of the community nursing teams the requirement for a chaperone should be clearly documented in the electronic record

8.2 It should not be assumed that a patient does not require a chaperone and clinical staff should use their professional clinical judgement to assess the clinical situation, at each consultation provided.

8.3 The offer of a chaperone should be made clear to the patient prior to any procedure, ideally at the time of booking the appointment.

8.4 If the patient is offered and does not want a chaperone it must be recorded in the patients notes that the offer was made and declined. If a chaperone is refused a healthcare professional cannot usually insist that one is present and many will examine the patient without one (see sec.10)

8.5 Patients decline the offer a chaperone for a number of reasons: because they trust the clinician, think it unnecessary, require privacy, or are too embarrassed. However, there are some cases where the (usually male) doctor may feel unhappy to proceed.

- This may be where a male doctor is carrying out an intimate examination, such as cervical smear or breast examination.
- Other situations are where there is a history of violent or unpredictable behaviour on behalf of the patient to see another doctor or health professional.

8.6 For some patients, the level of embarrassment increases in proportion to the number of individuals present.

8.7 If a patient were to requests a specific gender of healthcare professional or chaperone we will endeavour to accommodate this request and if unable to do so we will try to find a mutual arrangement to support the patient.

9. The Chaperone Process

9.1 In order for patients to exercise their right to request the presence of a chaperone, a full explanation of the examination, procedure or treatment to be carried out must be given to the patient. This should be followed by a check to ensure that the patient has understood the information and gives consent.

9.2 The healthcare professional is responsible for:

- Establishing the patient's needs for a chaperone during their explanation about the clinical examination, consultation or treatment.
- Ensuring a suitable chaperone is present should the patient choose to have one
- Consideration should be given to the chaperone being of the same sex as the patient wherever possible to protect the patient from vulnerability and embarrassment.
- Seeking and recording the patient's consent to have relatives or carers present during examinations or procedures.
- The involvement and continued presence of a chaperone during a clinical examination, consultation or treatment.

- Recording the presence of, and the name of the chaperone in the patient's healthcare record.
- Recording whether a patient has declined a chaperone at any point during the process in the patient's healthcare record.
- Identifying and recording any preferences or objections resulting from diverse religious, cultural or ethnic backgrounds as early as possible to avoid the potential for causing offence. The individual requirements of the patient regarding choice of chaperone should be respected.
- Ensuring that facilities are available for patients to undress in a private, undisturbed area. There should be no undue delay prior to examination once the patient has removed any clothing.
- Infection control measures must be adhered to when using blankets or drapes.
- Staff must ensure curtains/doors are closed during all examinations and procedures. Where curtains/doors are closed staff will gain permission before entering to ensure privacy
- Staff will ensure patients do not feel vulnerable to intrusion and that curtains, which do not remain tightly closed, do not compromise privacy and dignity
- The patient will not be asked to take off more clothing than is necessary and will be provided with an appropriate gown/garment that is acceptable to them in order to protect their modesty.
- Patients will be given privacy to dress and undress and should not be assisted in removing clothing unless it has been clarified that assistance is needed.
- Staff should be aware and sensitive to religious customs and beliefs.
- Following any physical examination, patients will have an opportunity to re- dress before the consultation continues

10. Where A Chaperone Is Declined By A Patient

10.1 If a patient prefers to undergo an examination/ procedure without the presence of a chaperone this should be respected and their decision documented in their clinical record.

10.2 The only exclusion to this is when intimate examinations or procedures are performed, where it is mandatory to have a chaperone as outlined in this policy

10.3 If the patient has declined a chaperone for an intimate examination where it is mandatory to have a chaperone, the practitioner must explain clearly to the patient why a chaperone is necessary. In this case, the patient may wish to consider requesting referral to an alternative care provider. The examination should not proceed without a chaperone.

9.4 Any discussion about chaperones and the outcome should be recorded in the patient's notes or electronic record. That the offer of a chaperone was made and declined should always be recorded.

11. Where A Chaperone Is Needed And Not Available

11.1 Every effort should be made to provide a chaperone and where possible a chaperone of the same sex as the patient should be offered.

11.2 On occasions where it is not possible to provide a chaperone of the same sex as the patient the following considerations will be taken into account:

- The wishes of the person requiring the examination
- The consequences if the person does not receive the care
- Whether the urgency of the care needed makes it an immediate necessity e.g. resulting from an episode of incontinence
- The length of time before a same gender member of staff can be present.

11.3 If the patient has requested a chaperone and none are available at that time the patient must be given the opportunity to reschedule their appointment within a reasonable timeframe.

11.4 If either the practitioner or the patient does not want the examination to go ahead without a chaperone present, or if either is uncomfortable with the choice of chaperone, the examination may be delayed to a later date when a suitable chaperone will be available, as long as the delay would not adversely affect the patient's health

11.5 If the seriousness of the condition would dictate that a delay is inappropriate then this should be explained to the patient and recorded in their notes.

11.6 A decision to continue or otherwise should be jointly reached. In cases where the patient lacks Mental Capacity to make an informed decision then the healthcare professional must make a decision in the patients' best interests and record and be able to justify this course of action (see sec 13)

11.7 It is acceptable for a doctor (or other appropriate member of the healthcare team) to perform an intimate examination without a chaperone if the situation is life threatening or speed is essential in the care or treatment of the patient. The rationale for undertaking this must be recorded in the patients' medical records

12. Training For Chaperones (Appendix 1)

12.1 It is recommended that members of staff who undertake a formal chaperone role have undergone training such that they develop the competencies required for this role. These include an understanding of:

- What is meant by the term chaperone?
- What is an “intimate examination”?
- Why chaperones need to be present?
- The rights of the patient
- Their role and responsibility e.g. advocate
- Policy and mechanism for raising concerns

12.2 Induction of new non registered staff should include training on the appropriate conduct of intimate examination, and the role of the chaperone, if appropriate for their role and clinical area.

12.3 All registered clinical staff should have an understanding of the role of the chaperone and the procedures for raising concerns.

12.4 This ‘one off’ training is accessed via the ESR website.

13. Consent

13.1 Consent is a patient’s agreement for a health professional to provide care. Before examination, treatment or care for any person you must obtain their consent, and this will be recorded in the care record.

13.2 Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing.

13.3 For the consent to be valid, the patient must: be competent to make the particular decision, and have received sufficient information to make it, and not be acting under duress.

13.4 Every adult has the right to make his/her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability

13.5 Before proceeding with an examination however it is vital that the patient’s informed consent is obtained. This means that the patient must; be competent to make the decision; have received sufficient information to reach a decision and is not acting under duress.

13.3 When patients are not able to consent for themselves you must always act in their best interest; involve the person in the decision making; have regard for past and present wishes and feelings and consult with others who are involved in the persons care. There must be no discrimination

13.4 Children over 16 can consent for themselves without their decision being referred to their parents or guardians; however it is good practice to involve the parents if possible

13.5 A person with parental responsibility can consent for a child under 16 unless the child is deemed to be competent as per the Fraser guidelines (Gillick competent)

13.6 Further information can be obtained by referring to the Lincolnshire Community Health Services Trust consent to treatment and examination policy
https://www.lincolnshirecommunityhealthservices.nhs.uk/Staff/content/policies

14. Issues Specific to Religion, Ethnicity or Culture

14.1 The ethnic, religious and cultural background of some women can make intimate examinations particularly difficult, for example, some patients may have strong cultural or religious beliefs that restrict being touched by others, particularly members of the opposite sex

14.2 Patients undergoing examinations should be allowed the opportunity to limit the degree of nudity by, for example, uncovering only that part of the anatomy that requires investigation or imaging.

14.3 It would be unwise to proceed with any examination if the healthcare professional is unsure that the patient understands what is being communicated due to a language barrier.

14.4 In life saving situations every effort should be made to communicate with the patient by whatever means available before proceeding with the examination.

14.5 An interpreter is not to be used as a chaperone under any circumstances. If interpretation is required during a procedure or examination, the patient should be shielded from the interpreter by use of curtains or screens, or by use of the telephone interpretation service.

15. Issues Specific to Learning Difficulties / Mental Health Problems

15.1 All patients with communications needs, learning disabilities or mental health problems that affect capacity must have a formal chaperone for all intimate examinations/procedures.

15.2 Family or friends who understand their communications needs and are able to minimise any distress caused by the procedure could also be invited to be present throughout any examination if the patient so wishes.

15.3 A careful simple and sensitive explanation of the technique is vital. This patient group is a vulnerable one and issues may arise with initial physical examination, “touch” as part of therapy, verbal and other “boundary-breaking” in one to one “confidential” settings and indeed home visits.

15.4 Adult patients with learning difficulties or mental health problems who resist any intimate examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned.

15.5 In life threatening situations the healthcare professional should use professional judgment and where possible discuss with a member of the Mental Health Care Team and this discussion and rationale to proceed documented within the patient record.

15.6 All Staff must be aware of the implications of the Mental Capacity Act (2005) (‘MCA’) and cognitive impairment. If a patient’s capacity to understand the implications of consent to a procedure, with or without the presence of a chaperone, is in doubt, the procedure to assess mental capacity must be undertaken.

15.7 This should be fully documented in the patient’s notes or electronic record, along with the rationale for the decision. (see the Mental Capacity Act 2005 Policy including the Deprivation of Liberty Safeguards)

16. Children

16.1 Children over 16 years can consent to clinical examination, consultation or treatment themselves, without their decision about a chaperone being referred to their parents or guardians. However it is good practice to involve the parents in this decision, if the young person agrees.

16.2 A person with parental responsibility can consent for a child under 16 years unless the child is deemed to be “Gillick competent”.

16.3 Children can be accompanied by a parent, guardian or friend, but this does not negate the need for a properly trained chaperone to be present in accordance with policy.

16.4 Children and Young Adults who are being prepared for 'Transition' to adult services who may be seen without their parents/carers at their request, must be examined in the presence of a chaperone. If they specifically request review without a chaperone, this must be discussed and documented in the notes

16.5 The healthcare professional should be aware however that very occasionally there may be issues around coercion/grooming/abuse involving a "trusted adult". GMC guidance (2007) also states that practitioners should 'avoid giving the impression that young people cannot access services without a parent. They advise practitioners to think carefully about the effect a chaperone can have, as their presence can deter young people from being frank and from asking for help'.

In respect of children all healthcare professionals must:

- Explain information to the child in age appropriate language.
- Record in the health record where parents, carers, other trusted adults or member of staff have acted as an informal chaperone.
- Record in the health records where the offer of chaperone has been declined.
- Ensure an appropriate chaperone is present during examination for child protection procedures.
- Ensure an appropriate chaperone is present during the assessments of patients with sexual genitor-urinary and elimination disorders requiring perineal examination.
- Ensure an appropriate chaperone is present for children who are not accompanied by an individual with parental responsibility, or where this individual (parent/carer) requires support/guidance whilst accompanying the child or young person.

17. Lone Working

17.1 Where a healthcare professional is working in a situation away from other colleagues' e.g. home visit, out-of-hours centre, the same principles for offering and the use of chaperones should apply.

17.2 Where it is appropriate family members/friends may take on the role of informal chaperone. In cases where a formal chaperone would be appropriate, i.e. intimate

examinations, the healthcare professional would be advised to reschedule the examination to a more convenient time or location.

17.3 In cases where this is not an option, for example due to the urgency of the situation or because the practitioner is community based, the rationale for proceeding without a chaperone present and what examination was carried out must be documented in the patient record as soon as possible.

17.4 Healthcare professionals should note that they are at an increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present.

17.5 Further information can be obtained by referring to the Lincolnshire Community Health Services Trust lone worker policy.

18. Offender Health

18.1 Clients/patient in prison or custody who use LCHS services will be afforded all of the principles in this policy.

18.2 The appropriate risk assessment will be undertaken by all parties present with regards to clients that are accompanied by security/prison officers.

19. Communication and Record Keeping

19.1 The most common cause of patient complaints is a failure on the patient's part to understand what the practitioner was doing in the process of treating them.

19.2 It is essential that the healthcare professional explains the nature of the examination to the patient and offers them a choice whether to proceed with the examination at that time.

19.3 The patient will then be able to give an informed consent to continue with the consultation. Where English is not the 1st language the use of an interpreter should be advocated/ offered. This discussion must be recorded in the patient's record.

19.4 Details of the examination including the presence/absence of a chaperone and information given to the patient must be documented in the medical records. cards.

19.5 The chaperone should write their name, date and sign the record

19.6 For GP records appropriate READ coding is available on S1, free text should also be utilized as appropriate:

- XaEiq Chaperone Offered
- XaEir Chaperone Present
- XaEis Chaperone Refused
- XaF0C Nurse Chaperone
- XaMe5 Chaperone Not Available

19.7 If the patient expresses any doubts or reservations about the procedure and the healthcare professional feels the need to reassure them before continuing then this must be recorded in the patients record The records should make clear from the history that an examination was necessary.

19.8 In any situation where concerns are raised or an incident has occurred a Datix report is required this should be completed immediately after the consultation and concerns raised with Line Manager.

Appendix 1

CHAPERONING COMPETENCY FRAMEWORK

The aim of this competency framework is to affirm that an individual is competent i.e. has the skill, knowledge and attitude to undertake the role of formal chaperone

Any individual wishing to act in the role of chaperone will be assessed for their competency by a registered member of staff in the relevant service who acts in a supervisory role and/or a teaching capacity or holds a recognised adult teaching qualification

Following training the chaperone will be able to:

- Describe the principles for offering a chaperone
- Understand what is meant by, and how to, maintain privacy and dignity
- Help determine the needs of the patient during an examination, procedure or treatment
- Recognise individual diversity and equality needs
- Describe and understand the term “informed consent”
- Describe and understand record keeping requirements
- Describe and understand their duty under the incident reporting policy and what action to take to escalate were a concern or potential concern is recognised
- Describe and understand how to advise on the Trust complaints procedure

FRAMEWORK

The categories within this framework are broad and designed to stimulate discussion. The registered professional completing the assessment is responsible for being assured that the individual is competent and for amending and/or adding to the categories dependent of the service area requirements

COMPETENCE	EVIDENCE	Learning outcome achieved: Y/N		Deferred: Action Required Review date
Can give overview of mental capacity act?				
Can explain what consent is and why it is needed?				
Can describe ways to confirm informed consent?				
Can demonstrate verbal, non-verbal and active listening skills?				
Can describe appropriate communication skills?				
Can identify barriers to communication?				
Can describe the role of the chaperone in a manner suitable for a range of patient needs?				

Can describe how to maintain patient dignity and privacy?				
Can demonstrate the importance of and process for making appropriate healthcare record entries?				
Can identify how to raise concerns?				
Can describe a range of scenarios that may give cause for concern?				
Can describe the Trust complaints process in a manner suitable for a range of patient needs?				
Can describe what is meant by patient confidentiality?				

Chaperone	Signature	Date
Supervisor		

Equality Analysis Carried out by: Vicki Lightfoot

Equality & Human rights Lead: Rachel Higgins

Director\General Manager: Tracy Pilcher

Date: Jan 2020

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	This policy advocates that in all areas throughout LCHS where healthcare services are provided all patients are aware that they can access a chaperone to support their care treatment and examination		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	As above		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	

	Religion or Belief		X	
	Carers		X	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Vicki Lightfoot		
Date:		Jan 2020		