East Sussex Healthcare
NHS Trust

FOI REF: 25/232

17th April 2025

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FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

Could you please supply a copy of your current chaperoning policy, would you please comment if this policy is under review or being updated.

Please see attached East Sussex Healthcare NHS Trust's current policy for the use of Chaperones in the Trust – '00381_03_P'.

Please note that we have redacted the names of staff that no longer work within the Trust, and also signatures, within the policy.

I can confirm that we hold this information, but it is exempt under section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because disclosure of this information would breach the principles of the Data Protection Act.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

Please also note that it is the Trust's FOI policy to only provide the names of staff that are grade 8a or above, therefore staff that are below that grade have been redacted from the policy.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Cont…/

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Freedom of Information Department
esh-tr.foi@nhs.net

East Sussex Healthcare NHS Trust

Policy for the use of Chaperones in the Trust

Document ID Number:	381
Legacy ID Number:	1413
Version:	V3
Ratified by:	Integrated Governance Meeting (IGM)
Date ratified:	16 April 2025
Name of author and title:	Gail Gowland, Head of Safeguarding
Date originally written:	June 2013
Date current version was completed:	March 2024
Name of responsible committee/individual:	Gail Gowland, Head of Safeguarding
Date issued:	16 April 2025
Review date:	April 2028
Target audience:	All Clinical Staff in the Trust
CQC Fundamental Standard	Regulation 10: Dignity and Respect Regulation 12: Safe Care and Treatment
Compliance with any other external requirements (e.g. Information Governance)	N/A
Associated Documents:	Privacy and Dignity Policy Guidance for Staff on the Implementation of the Mental Capacity Act Consent to Treatment, Examination and Care Policy and Procedure Safeguarding Adults Policy & Procedure

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of procedural documents and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.3	October 2019		Change Review date from June 19	Extended the review date to April 2020
V2	April 2020	[redacted], Head of Safeguarding	Changed from Procedure to a Policy	Complete re-write to the whole document
V2.1	July 2023	Gail Gowland	Extension to review date to allow time to review	Extended the review date from April 2023 to September 2023
V3	March 2024	Gail Gowland	Update	Updated whole document

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Safeguarding Operating Group	-	May 2020
Safeguarding Operating Group		March 2024
Safeguarding Operating Group	-	September 2024
Dementia Care Specialists		20/09/2024
Sarah Feather	Equality, Diversity and Inclusion lead	25/09/2024
Safeguarding Strategic Committee		March 2025
Nursing and Governance IPR		March 2025

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

East Sussex Healthcare NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

This policy details how and when health care professionals (practitioners) use chaperones in all clinical departments of the trust.

Patients attending East Sussex Healthcare NHS Trust are seen by many healthcare professionals and may require examinations and procedures to be carried out. Some consultations, investigations or procedures may be distressing for the patient, and they may request the presence of a chaperone. It is good practice to offer a chaperone for any consultation, examination or procedure where the patient or practitioner feels one is required.

Any consultation or procedures involving the need to undress, the use of dimmed light or intimate examinations involving the breasts, genitalia or rectum may make the patient feel particularly vulnerable. Some patients may feel vulnerable having examinations of other areas, due to past history of trauma.

The intimate nature of many health staff patient interactions, if not practised in a sensitive and respectful manner, can lead to misunderstandings and the potential for allegations of sexual assault or inappropriate examinations. In these circumstances a chaperone will act as a safeguard for both the patient and the practitioner.

All patients have the right if they wish to have a chaperone present during an examination, procedure, treatment or any care irrespective of organisational constraints or settings in which they are carried out. Staff should be sensitive to the differing expectations with regard to race, culture, ethnicity, age, gender and sexual orientation and wherever possible the chaperone should be the preferred gender identified by the patient.

A chaperone may also be required for some intimate procedures involving children who are determined as having capacity to consent to treatment, Gillick Competent , GP mythbuster 8: Gillick competency and Fraser guidelines - Care Quality Commission (cqc.org.uk).

2. Scope

2.1. This policy applies to all clinical employees Trust-wide including locum, bank and agency staff working on behalf of the Trust.

3. Definitions

3.1. Whilst there is no common definition of a ‘chaperone’ the CQC cite that “A chaperone is an impartial observer present during an intimate examination of a patient” GP mythbuster 15: Chaperones - Care Quality Commission (cqc.org.uk)..However it should be noted that the role may vary according to the needs of the patient, the healthcare professional and the examination or procedure being carried out. For this policy the following definitions are being used:

3.2. **‘**Formal’ chaperone: A formal chaperone implies a suitably trained individual, such as a Nurse or a specifically trained staff member e.g. Health Care Assistant.
This individual will have a specific role to play in terms of the consultation and this role must be made clear to both the patient and the person undertaking the chaperone role. In most cases, it is not appropriate for a non-clinical or untrained member of staff to discuss the appropriateness of the procedure or examination; any consent aspect of this nor assist in the procedure.
The chaperone must have had sufficient training to understand the role expected of them and the knowledge and skills required to undertake the role.

Protecting the patient from vulnerability and embarrassment means that the chaperone is usually of the same gender or the patients preferred gender. The use, therefore, of a male chaperone for the examination of a female patient or of a female chaperone when a male patient is being examined could be considered inappropriate.
Chaperone preferences should be respected for all patients, including those who identify as transgender, non-binary, or gender non-conforming.

3.3. 'Informal' chaperone: Many patients feel reassured by the presence of a familiar person and request to have a relative or friend present, which must be documented in the patient's clinical records. GMC guidance advises "A relative or friend of the patient is not a trained impartial observer and so would not usually be a suitable chaperone. However, the presence of a chaperone does not override a patient's wish to be supported by a relative, friend or advocate. You should comply with a reasonable request from the patient to have such a person present as well as a chaperone". Intimate examinations and chaperones - GMC (gmc-uk.org)
This request in almost all cases will be accepted, unless there is a specified reason for refusing this by the practitioner, which must be documented. This informal chaperone may therefore be an adult family member or friend who is accompanying the patient; or the patient may request to defer the examination until a family member or friend can be present. The informal chaperone is required to observe the examination and therefore must be in full view of the patient and practitioner at all times.
From a safeguarding perspective caution should be applied when considering requests for the presence of friends/ relatives. Staff should also be alert to potential Domestic Abuse and Coercive Control, if the 'informal Chaperone' appears to answer questions or does not permit opportunity for discussion with the patient alone.
If a formal chaperone is not required or present, it is inappropriate to expect a family member or friend to take any active part in the examination or to witness the procedure directly. Positioning of the patient and the family member or friend therefore needs careful consideration. If an informal chaperone is used, a clear explanation of what is expected to happen during the examination must be provided

3.4. Intimate examinations: The GMC describes "Intimate examinations can be embarrassing or distressing for patients and whenever you examine a patient you should be sensitive to what they may think of as intimate. This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient". Intimate examinations and chaperones - professional standards - GMC (gmc-uk.org)
Furthermore, this is inextricably linked to consent processes, staff will need to be mindful that explicit consent should be sought for intimate examinations and additionally for children from whom consent should be taken.
Whilst it is important in intimate examinations, health care professionals need to be aware of the need to respect gender identity in all scenarios, not just in cases involving intimate examinations

4. Purpose of the Policy

The purpose of this policy is to ensure that there is consistency of approach in the use of chaperones for the protection of both patient and practitioner ensuring that the patient receives optimal care whilst undergoing any intimate physical examination with a chaperone present who understands the examination that is taking place.

4.2 Rationale

To ensure that patients' safety, privacy and dignity is protected during intimate examinations.
To minimise the risk of a clinician's actions being misinterpreted
To ensure the clinician's safety whilst carrying out intimate clinical examinations

5. Procedures and Actions to Follow

5.1 Explanation and obtaining consent for the examination

5.1.1 Offering a chaperone.

All patients should routinely be offered a chaperone during any consultation or procedure and should be made clear to the patient prior to any procedure. Written information detailing the chaperone policy is available to patients/caregivers. The organisation suggests that use of a chaperone is considered particularly:

- During gynaecological/intimate examinations or procedures.
- When examining the upper torso of a female patient.
- For patients with a history of unpredictable behaviour.
- For unaccompanied children.
- For adults who lack mental capacity to consent to the procedure.

For adults with learning disability /autism
For patients with complex needs including alcohol or substance misuse.
Patient's who have had a traumatic past history, staff should be cognisant of preventing re-traumatisation.

Additionally, the Royal College of Paediatrics and Child Health recommends the use of chaperones when a child protection medical is undertaken. cp-audit-2023-visual-representation-data.pdf (rcpch.ac.uk)

Ensure that patients are aware that a chaperone is available should they request one and that a chaperone will be offered. A chaperone should be available if required to all patients undergoing a procedure, treatment or examination regardless of age, gender, culture, ethnic background, sexual orientation or mental status.

A 'trauma informed approach' to sensitive practice will enable survivors of sexual violence to **get the appropriate care they require, without divulging information that they may wish to** keep private. This is covered more fully in 5.9.5.

5.2 The use of interpreters as chaperones

Official external Interpreters that are required to translate during appointments must not be used as chaperones under any circumstances.

5.3 The use of family/friends in chaperoning

Family members and friends cannot act as formal chaperones although if a patient would like a friend or family member also to be present during the procedure this is acceptable and should be documented.

5.4 Role of chaperone

a. Be sensitive and respect the patient's dignity and confidentiality
b. Reassure the patient if they show signs of distress or discomfort
c. Be familiar with the procedures involved in a routine intimate examination, best practice would be that the chaperone clarify in advance what the examiner proposes to do.
d. Stay for the whole examination and be able to see what health care practitioner is doing, if practical
e. Be prepared to raise concerns if they are concerned about the health care practitioner's behaviour or actions
f. Ensure the environment supports privacy and dignity

g. Be prepared to ask the examiner to abandon the procedure if the patient expresses a wish for the examination to end
h. Ensure their presence at the examination is documented in the patient's record/electronic record by the examining practitioner and the chaperone must record their name and designation and sign to confirm that they have chaperoned the consultation, naming all staff involved.
i. If the patient requires assistance due to mobility problems, then the chaperone should have moving and handling training but independence should be encouraged. Always document if assistance was required and given.
j. Beware of any communication needs. If the person has a Learning Disability or a diagnosis of Autism please ensure you read their Hospital Passport if it is available.

5.5 Environment

Adequate facilities should be provided to ensure the privacy of the patient, without interruption whilst undressing and dressing during the examination, either in a dedicated examination room or behind a screen. Sheets or gowns should be available to use during the examination to minimise the extent of nudity.

Where a healthcare professional is working in a situation away from other colleagues e.g. a home visit, in a Children's Centre, GP surgery, the same principles for offering and the use of chaperones must apply.
Where it is appropriate family members or friends may take on the role of informal chaperone.

In cases where a formal chaperone is appropriate, i.e. intimate examinations, it is best practice for the healthcare professional to reschedule the examination to a more convenient location.

However, in cases where this is not an option, for example due to the urgency of the situation, because the practitioner is community based, or because the patient is unable to travel, then procedures must be in place to ensure that communication and record keeping are treated as paramount. Where advice on the best way to proceed is required, then decisions as to what should be done are to be made with the patient and the advice of a senior colleague sought if available.
Where the patient lacks mental capacity then all decisions are made in the patient's best interests. Decisions must be communicated to relevant parties and fully documented evidence of capacity assessment, appropriate consent form, Best Interest meeting or IMCA.

5.6 Process

5.6.1 As previously covered, It is good practice to offer all patients a chaperone for any consultation, examination or procedure where a patient or practitioner feels one is required.

If a patient prefers to undergo an examination/procedure without the presence of a chaperone and they are not one of the patients for who it is mandatory to have a chaperone such as a person who lacks capacity, this should be respected and their decision documented in their clinical record if the practitioner is willing to proceed without a chaperone.

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 should be given to the patient. This should be followed by a check to ensure that the patient has understood the information and gives consent.

Information on consent can be found in the:
Consent to Treatment, Examination and Care Policy and Procedure

Facilities should be 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.

Examinations should take place in a closed room or well screened bay that cannot be entered without consent while the examination is in progress. 'Do not enter' or 'Examination in progress' signs must be used when possible, and the chaperone must be present.
During the examination the examiner should:

- Be courteous at all times
- Offer reassurance
- Keep all discussion relevant to the examination and avoid personal comments
- Remain alert to any verbal and non-verbal signs of distress from the patient
- Respect any requests for the examination to be discontinued
- Document in the name and presence of the chaperone in the patient's notes or electronic record and ensure that the chaperone documents their presence and signs the record
- Interpreters can be used as required to explain why a chaperone is required

5.6.2 Where a suitable chaperone is not available
Every effort should be made to provide a chaperone. 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.

5.7 Chaperoning intervention
The chaperone should identify unusual or unacceptable behaviour on part of the practitioner or patient, for example lack of dignity/privacy, violence/aggression, consent issues, safety etc.

If the chaperone feels they need to intervene they should:

- Suspend treatment and explain to the patient what is happening Practitioner and chaperone leave the patient and discuss reason for suspension
- Reach a decision to either continue with changes agreed or obtain advice from senior staff
- Document decision and rationale in the notes
- Raise concern to the appropriate more senior clinician

5.8 Documentation
The importance of robust documentation has already been described. The chaperone must record their name and designation in the patient record and sign to confirm that they have chaperoned the consultation, naming all staff involved within the patient's notes or examination/procedural report. This must be done by the chaperone at the end of the patient's consultation. If the patient is offered a chaperone and declines the offer, this must also be documented.

5.9 Patients with individual needs

5.9.1 Staff must be aware of the implications of the Mental Capacity Act (2005) 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. This should be fully documented in the patient's notes or electronic record, along with a rationale for the decision.

Family or friends who understand their communication needs and are able to minimise any distress caused by the procedure, could also be invited to be present throughout any examination.

5.9.2 Children and young people

- It is good practice for **all** children and young people under the age of consent (16 Years) to be examined in the presence of another adult. If the child is deemed to be Gillick competent and declines this should be recorded in the notes.

This may be a parent/carer, or someone already known and trusted by the child, acting as an informal chaperone, for example, during a new-born baby check or physical examination of a pre-pubertal child. The practitioner should clearly explain what is involved.

- Any **intimate** examinations of young children who are nervous or post-pubertal children **must** be carried out in the presence of a formal chaperone
- The young person who is assessed as Gillick competent, or deemed to have mental capacity aged over 16 or the person with parental responsibility must receive an appropriate explanation of the procedure in order to obtain their informed consent to examination.

Information on consent can be found in the Trusts:
Consent to Treatment, Examination and Care Policy and Procedure

- A parent or carer or someone already known and trusted by the child may also be present for the child's reassurance
- For young people, who are deemed to have mental capacity, the guidance that relates to adults will apply if they are Fraser Competent.
- Children and young people transitioning to adult services (from 12 years) can request to see the practitioner on their own with parental consent. However, if a child requested to see a clinician alone and the parent declined this may require further exploration to exclude safeguarding concerns.
- All physical examinations require a chaperone either informal or formal. If the young person specifically requests not to have a chaperone present, this must be discussed with them and the person with parental responsibility and documented in the records by the clinician.
- An intimate physical examination should not proceed without a chaperone.
- Fraser guidelines should be used to assess the ability of children and young adults to understand and their ability to consent.

5.9.3 Learning Disability, Autism, Dementia and Mental ill health

Adult patients with learning disabilities, autism, dementia or mental ill health may require 'reasonable adjustments' to support their understanding and ability to consent.
Provision of health care in the patient's best interest needs may need to be considered depending on a capacity assessment outcome to be considered with other key health or social care professionals or Next of Kin & IMCA: Mental Capacity Act 2007.

It is strongly recommended that a chaperone is always used in the intimate examination of all of these groups.

5.9.4 Ethnic minority groups/language difficulties

Intimate examinations must not be carried out on non-English speaking patients without an interpreter/advocate being available. All attempts should be made to ensure understanding, through an interpreter if necessary. If appropriate 2 individual members of staff should assess the understanding of the patient before the examination is carried out.

The ethnic, religious and cultural background of some patients can make intimate examinations particularly difficult. Requests for examination by a practitioner of the same gender must be accommodated where possible when requested, but in an emergency this may not be possible. This aspect must be discussed with the patient.

Interpreting services should be provided for patients where spoken English is not understood by the patient. This can be provided through the use of telephone, audio, video or face to face interpreters. British Sign Language interpreters must be provided using video or face to face interpreters.

5.9.5 Examination of patients who have experienced violence, including rape/sexually abused (trauma informed approach)
A chaperone must always be present for the examination of patients who have been raped/sexually abused, particularly if a police investigation is in progress or likely to be

According to the Crime Survey for England and Wales (CSEW) approximately 20% of women and 4% of men over 16 years of age have “experienced some type of sexual assault”.25 Many of these cases (83%) are not reported. This would suggest that many patients attending for intimate examinations may be survivors of sexual violence.

A ‘trauma informed approach’ to sensitive practice will enable survivors of sexual violence to get the appropriate care they require, without divulging information that they may wish to keep private.

Patients should be given a sense of control by ‘informing before performing’, to ensure that during each step of the process and throughout the examination the patient understands what will happen and can ask questions.

It is important to be aware of other aspects that might affect a patient’s comfort within an examination or treatment room, for example concern about anything touching the face or neck area. This could include the wearing of face coverings. Non-judgemental, individualised and open communication is required to assist patients in receiving the care they need
#CheckWithMeFirst Animation - YouTube

Healthcare staff should be particularly mindful of the potential for past trauma or discrimination experienced by LGBTQIA+ patients when offering a chaperone and further that LGBTQIA+ individuals may be particularly vulnerable and require trauma-informed care due to higher rates of past violence and discrimination.

5.10 Maternity
Midwifery practice, by definition, involves intimate contact with women throughout pregnancy, in labour and during the postnatal period. The Nursing and Midwifery Council (NMC) (2015) as part of the professional code of conduct states, “Your nurse or midwife listens to you and takes note of concerns. They respect your right to dignity, privacy and confidentiality. They share information about your health, care and treatment with you in a way you can understand.”

- Consent should be obtained, and documented, for all intimate examinations on pregnant or post-partum women by midwives (e.g. vaginal examinations, induction of labour, examinations of the perineum, perineal suturing, assisting with breastfeeding). In gaining consent there should be acknowledgement of the intimate nature of the procedure and the choice for women to request a chaperone. In most cases an informal chaperone (e.g. partner) is present. Equally, some women may not want their partner present for such an examination and this request should also be respected. Respect for cultural preference should be acknowledged and facilitated wherever possible.

- Where women request a formal chaperone for an examination by a midwife, this should be provided, with an explanation that the need to provide appropriate clinical care in an emergency may require intimate procedures to be performed in the absence of a chaperone and may conflict with cultural preference. However, midwives should not proceed with an intimate examination if consent is withheld (but see Emergency care, below)

5.11. Emergency Care
It is acceptable for practitioners to perform intimate examinations without a chaperone if the situation is an emergency or life threatening and speed is essential in the care of treatment of the patient, and the patient's condition means they are unable to be consulted for consent. This should be recorded in the patient's notes or electronic record.

5.12. Radiology
There are potentially risks associated with radiological investigations. Further information can be found within the following specific publications,
Intimate-Examinations-and-Chaperone-Policy.pdf
All our publications | The Royal College of Radiologists (rcr.ac.uk)

5.13. Intimate personal care
'Intimate personal care' is defined as the care associated with bodily functions and personal hygiene, which require direct or indirect contact with, or exposure of, the sexual parts of the body. It is recognised that much medical and nursing day-to-day care is delivered without a chaperone as part of the unique and trusting relationship between patients and practitioners.

However, staff must consider the need for a chaperone on a case-by-case basis, mindful of the special circumstances outlined in this policy, and patients should always be offered the opportunity to have a chaperone if they wish. Staff must be aware that patients of diverse cultures may interpret other parts of the body as intimate.

It is not necessary to request a chaperone for assisting infants and young children with care, such as nappy changing, unless there are special circumstances as outlined in this policy.

5.14 Medical Photography
Patients requiring Medical Photography should be chaperoned and written consent obtained from the patient or those acting on their behalf prior to clinical photographs being taken. The Trust requires that Consent level 1 (I consent to photographs being taken for my personal medical case notes) is obtained.

The needs of all patients need to be met in relation to chaperoning (as previously detailed) and this applies to medical photography. If a young person who is deemed to have mental capacity age over 16 refuses to be photographed this must be documented in the patient record and their wishes must be followed irrespective of the person with parental responsibility.

If a patient has been assessed as not having capacity to give consent for images to be take, the patients official guardian or court appointed trustee can give consent on behalf of the patient. If no guardian or trustee exists, the patient's Consultant will be responsible for the decision to take photographs or videography for the purpose of patient care only. This should be documented on the consent form.

It must be documented in the patient's record that a chaperone has been offered and if accepted or declined. The identity of the chaperone must also be documented.

The chaperone is required to observe the whole session and should be in view of the patient and the photographer.

6. Equality and Human Rights Statement

The Trust is committed to providing non-discriminatory care to all patients, regardless of sexual orientation, gender identity, or gender expression. Relevant adjustments have been made throughout this document in line with EHRA document.

7. Training

The Trust provides safeguarding training on Induction and level 2/3 in accordance with the Intercollegiate Document's where an awareness of this procedure will be brought to staff's attention.

It is expected that it will be the line manager's responsibility to ensure that any staff acting as a formal chaperone are fully aware of their responsibilities as outlined in this procedure, the chaperone will have completed a set of competencies.

8. Monitoring Compliance with the Document

Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Compliance with this guideline	Safeguarding Team	Audit	Every 3 years or 6-9 months after a practice change	Safeguarding Team	Head of Safeguarding Clinical Service Managers Ward Matrons OPD lead nurses	Safeguarding Team

9. References

- Bibby, B., Boyd. N., Redman, C.W.E. and D.M. Luesley. 1988. Consent for vaginal examinations by students on anesthetised patients (letter). *Lancet*. Ii: 1150 Guidelines for the Use of a Chaperone and the Conduct of Intimate Examinations and Procedures within Obstetrics and Gynaecology
- Care Quality Commission 2010 Essential Standards of Quality and Safety
- Clinical Governance Support Team (NHS). 2005. *Guidance on the Role and Effective Use of Chaperones in Primary and Community Care settings.* London: DOH
- Falconer, C. 2007. Mental Capacity Act 2005: Code of Practice. London: The Stationary Office.
- General Medical Council. 2013. Guidance on Good Medical Practice. [On-Line] Intimate examinations and chaperones - professional standards - GMC (gmc-uk.org)
- Nursing and Midwifery Council (NMC). 2008. *The Code: Standards of conduct, performance and ethics for nurses and midwives. London: NMC*
- Nursing and Midwifery Council (NMC). 2003. Guidelines for Record Keeping. London: NMC
- Nursing and Midwifery Council (NMC). 2003. Guidelines for Professional Practice. London: NMC
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- Royal College of Obstetricians and Gynaecologists .2002. Gynaecological Examinations: Guidelines for Specialist Practice, Report of the Working Party on Intimate Examinations. London:
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- Royal College of Nursing (RCN).2006. Vaginal and Pelvic examination. Guidance for Nurses and Midwives. London: RCN Publication
- Royal College of Nursing (RCN). 2002 (reprinted August 2006). Chaperoning. The Role of the Nurse and the rights of the patients: Guidance for nursing staff. London: RCN Publication
- Department of Health. Clinical Governance Support Team NHS. Guidance on the Role and effective Use of Chaperones in Primary and Community Care Settings (2005)
- Royal College of Nursing 2001(reprinted December 2003) Protection of nurses working with children and young people. Guidance for nursing staff. London: RCN. Publication code 001741
- Intimate Examinations and Chaperone policy, 2023, The Society of Radiographers

Appendix A: EHRA Form

Equality and Health Inequalities Impact Assessment (EHIA) template

SECTION A ADMINISTRATIVE INFORMATION

This form is a central part of how the Trust makes sure and can demonstrate to others that we are meeting our legal duties; and how we can assure ourselves that all patients will get the best outcome for them from our services.

A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal. **Function/policy/service name and number:**	Policy for the Use of Chaperones		
Main aims and intended outcomes of the function/policy/service and summary of the changes you are making (if existing policy/service):	To update intended aims and function of this policy, to update the correct EHIA form.		
How will the function/policy/service change be put into practice?	The updated version will be added to the Extranet		
Who will be affected/benefit from the policy?	All members of the service mentioned in the policy and all service users that are mentioned in the policy,		
State type of policy/service	Policy X	Service ☐	
	Business Case ☐	Function ☐	Existing
Is an EHIA required? NB :Most policies/functions will require an EA with few exceptions such as routine procedures	Yes X		
	No ☐ (If no state reasons)		
Accountable Director: (Job Title)	Deputy Chief Nurse		
Assessment Carried out by:	Name: [redacted]		
Contact Details:	PA for Gail Gowland, Head of Safeguarding		
Date Completed:	16/09/2024		

SECTION B ANALYSIS AND EVIDENCE

Analysis of the potential impact – Equality and Health Inequalities Duties
For this section you will need to think about all the different groups of people who are more likely to experience poorer access or have poorer outcomes from health and care services. For each group please describe in the first column the potential impact you have identified, in the second column explain how you have arrived at this conclusion and what information you used to identify the potential impact, and in the third column say what you are going to do to prevent it from happening, or which elements of a service or policy specifically address the potential impact. Key things to remember.

- Everyone has protected characteristics but some groups who share one or more protected characteristics may be more likely to have poorer outcomes or access compared with others – and it is this potential that the EHIA process seeks to identify and address.
- The information included here should be proportionate to the type and size of the policy/service/change.
- An update to a policy should demonstrate that you have considered the potential for the policy to impact differently on different groups and taken steps to address that.
- A minor policy update is likely to need to be much less comprehensive than an EHIA for a major service change.
- You will need to know information about who uses or could use your service/policy will apply to (the population). You can use information about current patients or staff, and about the general population the Trust serves.

3. PROTECTED CHARACTERISTICS - Main potential positive or negative impact of the proposal for protected characteristic groups summarised
Please write in the box below a brief summary of the main potential impact (positive or negative) Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below, but make sure you include information on how you know there will be no impact.**

This policy is designed to support patients in all aspects of their medical needs. It is designed to give staff support when dealing with patients.

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Age: older people; middle years; early years; children and young people.	Potential positive impact on all age groups.	The aspects of negative impact are the NICA guidance and local data. The support of the patients and improved medical support.	Any physical support will be in accordance with the documentation.
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered	Any personal support will be in accordance with the documentation.
Gender Reassignment and/or people who identify as Transgender	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered.	Any personal support will be in accordance with the documentation.
Marriage & Civil Partnership: people married or in a civil partnership.	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered.	Any personal support will be in accordance with the documentation.
Pregnancy and Maternity: before and after childbirth and who are breastfeeding.	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered.	Any personal support will be in accordance with the documentation.
Race:	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered.	Any personal support will be in accordance with the documentation.
Religion and belief: people with different religions/faiths or beliefs, or none.	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered.	Any personal support will be in accordance with the documentation.

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Sex:	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered.	Any personal support will be in accordance with the documentation.
Sexual orientation	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered.	Any personal support will be in accordance with the documentation.
Veterans/Armed Forces Communities	Potential improvement of the patient's personal support when being treated in all areas.	Stakeholder and patient feedback will be considered.	Any personal support will be in accordance with the documentation.

4. HEALTH INEQUALITIES -Potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). **If the policy/procedure is unrelated to patients, this sections does not require completion.**

Please state none if you have assessed that there is not an impact, but please make sure you complete the 'how do you know this' column to demonstrate that you have considered the potential for impact**. If you identify the potential for impact for one or more of these groups please complete the full assessment in Appendix A**

Groups who face health inequalities[1]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
This includes all groups of people who may have poorer access to or outcomes from healthcare services. It includes: People who have experienced the care system; carers; homeless people; people involved in the criminal justice system; people who experience substance misuse or addiction; people who experience income or other deprivation; people with poor health literacy; people living in rural areas with limited access to services; refugees or asylum seekers; people in or who have been in the armed force; other groups who you identify as potentially having poorer access and outcomes.	Potential positive outcomes are expected from this policy	All appointments for these stakeholders are made to improve their medical needs and this policy is designed to support the practitioners.	Patients will be supported as detailed in the policy.

SECTION C ENGAGEMENT

5. Engagement and consultation

a. Talking to patients, families and local communities can be a rich source of information to inform health care services. If you are making substantial changes it's likely that you'll have to undertake specific engagement with patients. For smaller changes and policies your may have undertaken some engagement with patient groups, gained insight from routine sources e.g. patient surveys, PALS or Complaints information or information from Healthwatch, you may also have looked at relevant engagement that others have undertaken in the Trust, or locally
Have any engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes X	**No**

b. If yes, please ensure all stakeholders are listed in the consultation table at the beginning of the policy.

SECTION D SUMMARY OF FINDINGS

Reflecting on all of the information included in your review-

6. EQUALITY DUTIES: Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please **add an x** to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			
The proposal may support?	X	X	X
Uncertain whether the proposal will support?			

7. HEALTH INEQUALITIES: Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		
The proposal may support?	*X*	X
Uncertain if the proposal will support?		

8. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1	N/A	
2	N/A	
3	N/A	

9. EHIA sign-off: (this section must be signed)

Person completing the EHIA:	[redacted]	**Date:16/09/2024**
Line Manager of person completing:	[redacted]	**Date:16/09/2024**

Appendix

Breakdown of Groups who are more likely to experience health inequalities:

Groups who face health inequalities[2]	**Summary explanation of the potential positive or adverse impact of your proposal**	**How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback**	**Action that will be taken to address the potential for negative impact.**
Looked after children and young people	It should improve attendance once the patients are more settled.		
Carers of patients			

Groups who face health inequalities[2]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
	This should give carers more support when bringing patients to health appointments		
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	This policy should give more support to the patients under difficult circumstances		
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	This policy should give more support to the patients under difficult circumstances		
People with addictions and/or substance misuse issues	This policy should give more support to the patients under difficult circumstances		
People or families on a low income	This policy should give more support to the patients under difficult circumstances		
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).	This policy should give more support to the patients under difficult circumstances		
People living in deprived areas	This policy should give more support to the patients under difficult circumstances		
People living in remote, rural and island locations	This policy should give more support to the patients under difficult circumstances		

Groups who face health inequalities[2]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Refugees, asylum seekers or those experiencing modern slavery	This policy should give more support to the patients under difficult circumstances		
People who have served in the Armed Forces	N/A		
Other groups experiencing health inequalities (please describe)	N/A		

Appendix – EHIA Resources
Sources of Information on the East Sussex population and sources of community or patient insight.

Population Data
State of the County 2021 Focus on East Sussex

East Sussex JSNA

Community Insight

Further Reading on Equality and Health Inequalities

Training