

Chaperone Policy

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| Name of originator/author: | Peterborough Community Services have kindly given permission for the Community Health Newham Directorate of ELFT to use their policy.  Professional Development Lead Nurse |
| Executive Director lead : | Chief Nurse |
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| Next Review date: | December 2026 |

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| --- | --- |
| Services | Applicable |
| Trust wide | X |
| Mental Health and LD |  |
| Community Health Services |  |



Version Control Summary

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| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Author** | **Status** | **Comment** |
| 1.0 | September 2011 | Peterborough Community Services have kindly given permission for the Community Health Newham Directorate of ELFT to use their policy / Pamela Njawe | Final | Initial Policy |
| 2.0 | 11/03/2016 | Cynthia Tomu, Millicent Safo and Michele Olphonce | Final | Reviewed and updated with local and national policies including ELFT Policies and Procedures |
| 3.0 | 30/5/19 | Contributions from community services (Sickle Cell & Thalassaemia Service Newham, Bedfordshire Community Health Services, Safeguarding Team, GP practice for homeless people) co-ordinated by Caroline Ogunsola, Professional Development Nurse for Community Services, Richard Simmonds, Clinical Team Lead, and Ian McKay, service manager – Newham CAMHS, Community CAMHS |  |  |
| 4.0 | November 2023 | Caroline Ogunsola Professional Development Lead Nurse |  | Reviewed and updated with local and national policies including ELFT Policies and Procedures  Training of Chaperone included.  Use of Chaperone during video consultations. |

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**1. Introduction**

1.1 This policy applies to all clinicians working under the auspices of East London NHS Foundation Trust, and gives guidance on the use of chaperones for intimate examinations in primary and community care settings.

**2. Scope and Objectives of this Policy**

2.1 This policy applies to all clinicians directly employed by East London NHS Foundation Trust (ELFT) and contractors whose contract specifies adherence to this policy. It is offered as guidance to good practice for all other clinical contractors.

2.2 This policy specifically applies to intimate examinations. These are defined as any examination or procedure involving the rectum, genitalia or breasts. It also includes examinations involving the complete removal of outer clothing down to underwear or less. Other examinations could also be deemed intimate by some patients and clinicians need to be aware of cultural differences and what may constitute an intimate examination. See *Frequently* *Asked Questions* at *Appendix 2*.

2.3 The objectives of this policy are to:

* ensure that patients’ safety, privacy and dignity is protected during intimate examinations
* minimise the risk of clinicians’ actions being misinterpreted
* Ensure the clinician’s safety whilst carrying out intimate clinical examinations.
* protect both patients and staff from abuse or allegations of abuse
* Assist patients to make an informed choice about their examinations and consultations.

**3. Background**

3.1 **Why is a chaperone needed?**

All medical/ intimate consultations, examinations and investigations are potentially distressing. Patients can find examinations, investigations or photography involving the breasts, genitalia or rectum particularly intrusive. These examinations are called 'intimate examinations'.

Cultural factors should be considered. This is important when examinations are performed by members of the opposite sex. Also, any consultations where patients may feel vulnerable.

For most patients and procedures, respect, explanation, consent and privacy are all they need. They take precedence over the need for a chaperone. A chaperone does not remove the need for adequate explanation and courtesy. Neither can it provide full assurance that the procedure or examination is conducted appropriately.

It is important that children and young people are provided with chaperones.

The GMC guidance states that a relative or friend of the patient is not an impartial observer. They would not usually be a suitable chaperone. There may be circumstances when a young person does not wish to have a chaperone. The reasons for this should be clear and recorded.

All staff must be aware that chaperones are to protect both patients and staff. The following must be considered before any examination takes place:

* Explain the nature of the examination and obtain consent for the examination (refer to Primary Care Consent Policy). This may include:
* Establishing that there is a genuine need for an intimate examination and discussing this with the patient.
* Explaining exactly what the purpose of the examination is and what it will entail.
* Stating that a chaperone will be offered, and if a suitable chaperone is not available that it may be necessary for the patient to return at another time. The patient may elect to specify which gender the chaperone should be and this wish should be respected.
* The issue of consent is all-important. Before any examination takes place, informed consent must be obtained from the patient and documented on their records.
* Clarification should be sought in the associated policies.
* Young people of 16 years or over can give their own consent.
* Young people and children under 16 yrs can also give their own consent to examination or treatment if they are considered to be ‘Gillick competent’ (Gillick vs West Norfolk and Wisbech, 1986). ‘If the child is Gillick competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. It is, however, good practice to involve the child’s family in the decision-making process, if the child consents to their information being shared. (Department of Health, 2009). Services providing contraception and sexual health advice should also adhere to Fraser Guidelines (1985)
* Children and Young people also have the same rights to confidentiality as adults (0–18 years, Guidance for all Doctors, GMC) and so should be seen without their family members in the first instance. This is essential to build trust between young people seeking healthcare and their doctor or other healthcare professional, without confidentiality young people may not seek healthcare or may not provide complete information.
* Where a patient has a learning disability, mental illness or who does not speak English, the clinician must accurately document how consent was given, and by whom
* For clinicians, the two main considerations are informed consent and an

assessment of risk. The presence of a chaperone is helpful not only in

reassuring the patient, but also in minimising the risk of the clinician’s actions

being misinterpreted by the patient. It is vitally important that the clinician has

obtained informed consent from the patient and that this is documented in their records.

* There may be exceptional circumstances when a chaperone is not available to be present during an examination, or when it is totally impractical. This

guidance will help clinicians determine when and how chaperones should be

used.

The policy outlines that:

* Chaperones are there to support patients and staff.
* Chaperones should routinely be offered before intimate examinations.
* Patients can refuse a chaperone
* Documentation must be clear in the patient's clinical record of acceptance or refusal

The COVID-19 pandemic has accelerated the use of online and video consultations as part of core clinical practice. An online, video or telephone consultation does not negate the need to offer a chaperone. The same principles would apply.

NHS England have produced some key principles for intimate clinical assessments undertaken remotely in response to COVID-19. They include how to conduct intimate examinations by video and the use of chaperones.

The GMC has published guidance on intimate examinations and chaperones. It provides a framework for all health care professionals. This sets out when and why a patient may need a chaperone and considerations that should be given. It is guidance only and not a mandate. If a GP wishes not to follow this guidance they should risk-assess the situation. They should record their logic or discussion clearly. Even by doing this rather than following the guidance, they will put themselves at risk.

**4. The Policy**

***4.1. Patient information***

4.1.1 Adequate publicity of the chaperone policy/ information on chaperones availability should be made accessible to patients. Examples of this would be incorporation into patient information leaflets or letters and notices displayed in waiting rooms/ examination areas. (See *Appendix 1* for sample wording).

***4.2. Explanation and obtaining consent for the examination***

4.2.1 The nature of the examination and the reasons for conducting it should be

explained to the patient. This may include:

* Establishing that there is a genuine need for an intimate examination

and discussing it with the patient

* Explaining exactly what the purpose of the examination is and what it

will entail

* Stating that a chaperone will be offered, and if a suitable chaperone is

not available that it may be necessary for the patient to return at

another time. The patient may elect to specify which gender the

chaperone should be and this wish should be respected.

4.2.2 The issue of consent is all-important. Before any examination takes place,

informed consent must be obtained from the patient and documented on their

records. Clarification should be sought from the Trust’s Consent to Treatment

Policy.

4.2.3 Young people of 16 years or over can give their own consent.

4.2.4 Young people and children under 16 yrs can also give their own consent to

examination or treatment if they are considered to be ‘Gillick competent’

(Gillick vs West Norfolk and Wisbech, 1986). ‘If the child is Gillick competent

and is able to give voluntary consent after receiving appropriate information,

that consent will be valid and additional consent by a person with parental

responsibility will not be required. It is, however, good practice to involve the

child’s family in the decision-making process, if the child consents to their

information being shared. (Department of Health, 2009). Services providing

contraception and sexual health advice should also adhere to Fraser

Guidelines (1985) see appendix. Children and young people also have the

same rights to confidentiality as adults (0–18 years, Guidance for all Doctors,

GMC) and so should be seen without their family members in the first

instance. This is essential to build trust between young people seeking

healthcare and their doctor or other healthcare professional, without

confidentiality young people may not seek healthcare or may not provide

complete information (see guidelines in *Appendix 5*)

4.2.4 See *Frequently Asked Questions* at *Appendix 2* for guidance on examinations

of people with a learning disability, mental illness or if the patient does not

speak English.

The clinician must accurately document how consent was given, and by

whom, if the patient is unable to give consent due to physical or mental

disabilities (i.e. deaf/blind).

See also DoH Mental Capacity Act 2005.

***4.3. Offer of a chaperone***

4.3.1 A verbal offer of a chaperone to be present during the examination should be

made and this should be documented in patient’s record. Patients can also request chaperones as and when required.

4.3.2 Chaperones should be suitably qualified, e.g. fellow clinicians, student nurses, apprentices or staff who have undergone special training for this role. They must also be acceptable to the patient. Healthcare support workers and Nursing Associates can suitably fulfil the role of chaperones.

4.3.3 It is not recommended that family members or friends undertake a

chaperoning role. However there may be situations where this is unavoidable.

This also applies for children and young people but a parent/ guardian may be

present in addition to a chaperone in some instances.

4.3.4 If an acceptable chaperone is not available, the patient should be offered a

separate appointment to attend when a chaperone is available. A patient may

not wish a chaperone to be present and their wishes should be respected.

4.3.5 The Chaperone should not necessarily know the procedure they are observing inside out, but need to ensure that patient’s dignity is protected and safeguarding ensured.

Overall, it is the duty of the clinician to explain the procedure to the patient and chaperone prior to commencement.

***4.4. Premises***

4.4.1 Adequate facilities should be provided to ensure the privacy of the patient

without interruption whilst undressing and 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.

4.4.2 Intimate examinations in patients’ homes are to be discouraged and should

ideally take place at premises where adequate arrangements for the

examination can be made along with the chaperone requirements. See

*Frequently Asked Questions* at *Appendix 2* for more guidance on home visits.

***4.5. Conducting the examination – Roles & Responsibilities***

***The Clinician:***

* Ensure that a suitable sign is clearly on display in each consulting or treatment room offering the chaperone service if required. This should remove the potential for misunderstanding.
* However, there will still be times when either the clinician, or the patient, feels uncomfortable, and it would be appropriate to consider using a chaperone.
* Patients who request a chaperone should never be examined without a chaperone being present.
* If necessary, where a chaperone is not available, the consultation / examination should be rearranged for a mutually convenient time when a chaperone can be present.
* Clinicians (male and female) should consider whether an intimate or personal examination of the patient (either male or female) is justified, or whether the nature of the consultation poses a risk of misunderstanding.
* The clinician should give the patient a clear explanation of what the examination will involve.
* Always adopt a professional and considerate manner - be careful with humour as a way of relaxing a nervous situation as it can easily be misinterpreted.
* Always ensure that the patient is provided with adequate privacy to undress and dress.
* Complaints and claims have not been limited to male doctors with female patients - there are many examples of alleged homosexual assault by female and male doctors. Consideration should also be given to the possibility of a malicious accusation by a patient.

**4.6 Home visits**

* There may be occasions when a chaperone is needed for a home visit. The following procedure should still be followed. If there are no clinical staff, administrative staff can fulfil this obligation.

**5.0 Who Can Act As A Chaperone?**

* A variety of people can act as a chaperone in clinical settings. Where possible, it is recommended that chaperones should be clinical staff familiar with procedural aspects of personal examination.
* Where suitable clinical staff members are not available the examination could either be deferred or non-clinical staff will act in this capacity.
* The patient must agree to the presence of a non-clinician in the examination, and be at ease with this.
* The staff member should be trained in the procedural aspects of personal examinations, comfortable in acting in the role of chaperone, and be confident in the scope and extent of their role.
* They will have received instruction on where to stand and what to watch and instructions to that effect will be laid down in writing by the practice.
* Wherever possible, you should offer the patient the security of having an impartial observer (a ‘chaperone') present during an intimate examination. This applies whether or not you are the same gender as the patient.

A chaperone does not have to be medically qualified but will ideally be:

* sensitive, and respectful of the patient's dignity and confidentiality
* prepared to reassure the patient if they show signs of distress or discomfort
* familiar with the procedures involved in a routine intimate examination by listening carefully when the clinician is explaining what he/she will do.
* prepared to raise concerns about a clinician if misconduct occurs.
* If either the clinician or patient does not wish the examination to proceed without a chaperone present , or uncomfortable with the choice of chaperone, the clinician may offer to delay the examination to a later date when a chaperone (or an alternative chaperone) will be available, if this is in the patients best interests.
* You should record any discussion about chaperones and its outcome on EMIS/SYSTMONE/RIO.
* If a chaperone is present, you should record that fact and make a note of their identity.
* If the patient does not want a chaperone, you should record that the offer was made and declined.

**Training of a Chaperone:**

Training should include:

• 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 responsibilities. It is important chaperones should place themselves inside the screened-off area rather than outside of the curtains/screen (as they are then not technically chaperoning).

• policy and mechanism for raising concerns.

Clinical staff who undertake a chaperone role will already have a Disclosure and Barring Service (DBS) check. Non-clinical staff who carry out chaperone duties may need a DBS check. This is due to the nature of chaperoning duties and the level of patient contact. If a service / practice decides not to carry out a DBS check for any non-clinical staff, they need to provide a clear rationale for the decision. This should include an appropriate risk assessment.

## 5.1 Intimate examinations

Before conducting an intimate examination the clinician should:

* explain to the patient why an examination is necessary and give the patient an opportunity to ask questions;
* explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any potential pain or discomfort;
* obtain the patient's permission before the examination and record that consent has been obtained;
* Give the patient privacy to undress and dress and keep the patient covered as much as possible to maintain their dignity.
* Do not assist the patient in removing clothing unless he/she requested that your assistance is required.

**5.2 The process**

* The clinician will arrange a chaperone as soon as patient requests or the procedure is required.
* The clinician will record in the EMIS / SYSTMONE / RIO notes that the chaperone is present, and identifies the chaperone by name and designation.
* Where no chaperone is available the examination will not take place, the patient will be offered another appointment to see another clinician if possible (especially if it is gender related).
* The patient should not normally be allowed to dismiss the chaperone once a desire to have one present has been expressed.

During the examination the clinician should:

* explain what he/she is doing and, if this differs from what you have already outlined to the patient, explain why and seek further patient's consent;
* be prepared to discontinue the examination if the patient asks you to;
* keep discussion relevant and do not make unnecessary personal comments.
* Be courteous and offer reassurance.
* Explain to the patient what is happening at each stage of the examination and explain what will happen next
* Keep the amount of the patient’s body exposed to a minimum
* Remain alert to verbal and non-verbal signs of distress
* Respect requests that the examination should stop
* Gloves should be worn for all examinations of rectum and genitalia
* By highlighting some of the issues associated with intimate examinations, this guidance does not intend to deter you from carrying them out when necessary.
* Following this guidance and making detailed and accurate records at the time of examination, or shortly afterwards, will help you to justify your decisions and actions.

**5.3 Confidentiality**

## Patient’s confidentiality must be maintained throughout this process.

**5.4 The Chaperone**

* The chaperone will enter the room discreetly before the explanation of the procedure and remain in room until the clinician has finished the examination.
* The chaperone will normally attend inside the curtain at the head of the examination couch and watch the procedure.
* To prevent embarrassment, the chaperone should not enter into conversation with the patient or clinician unless requested to do so, or make any mention of the consultation afterwards.
* The chaperone should make a record in the patient’s EMIS / SYSTMONE/ RIO clinical notes after examination.
* The record will state that there were no problems, or give details of any concerns or incidents that occurred / observed.
* The Chaperone may be required to give a statement or be interviewed as part of investigation process if there is an allegation from the patient or clinician.
* The patient reserves the right to refuse a chaperone, and if so this must be recorded in the patient’s record – EMIS / SYSTMONE/RIO.

### Intimate examinations of anaesthetised patients

* The clinician must obtain consent prior to anaesthetisation, usually in writing, for the intimate examination of anaesthetised patients.
* If supervising a student the clinician should ensure that valid consent has been obtained before carrying out any intimate examination under anaesthesia.

5.4.1. After the examination

5.4.2 Allow patient to dress in private before continuing the consultation. Do not assist with dressing/ undressing unless the patient needs help and requests it.

Chaperone can leave after the examination to allow the consultation to continue.

**5.5 Documentation**

5.5.1 The patient’s clinical record on EMIS / SYSTMONE/ RIO should clearly note that informed consent was received for the examination.

5.5.2 Patients’ records should indicate that a chaperone was offered and if accepted or declined. For example, if a chaperone was present during the examination the name of the chaperone must be recorded on EMIS as follows:

9NP1- Chaperone present + (name of chaperone)

9NP2- Chaperone refused

In community services where clinical codes are gradually being used, entry should be written clearly in the patient’s clinical record on EMIS / SYSTMONE with chaperone’s name and designation.

**5.6 Use of chaperones during video consultations**

Many intimate examinations will not be suitable for a video consultation. Where online, video or telephone consultations take place, the Online and Video Consultation Policy for Primary Care explains how to protect patients when images are needed to support clinical decision making. This includes appropriate use of photographs and video consultations as part of patient care. Where intimate examinations are performed it is important that a chaperone is offered. Documentation should clearly reflect this. It is important to document who provided the chaperoning. It should also say what part of the consultation they were present for.

**5.7 Exceptions to this policy**

5.7.1 There are circumstances when strict adherence to this policy may not be

appropriate:

5.7.2 Examinations under sedation - a chaperone should be present during all

examinations in these circumstances.

5.7.3 Emergencies - it may be appropriate to conduct an examination without a

chaperone in circumstances when the clinician feels that a delay in the

examination may be detrimental to the patient’s well-being but this needs to be well documented and rationale stated.

**6. Monitoring of the implementation of this policy**

Describe how the implementation of this policy will be monitored. Will there be

audits – to which committee will the monitoring be reported?

**7. References**

RCN (2007) Chaperoning – the role of the nurse and the rights of patients:

guidance for nurses. London: Royal College of Nursing.

GMC (2006) Maintaining Boundaries. www.gmc-uk.org

DOH (2005) Mental Capacity Act. London: Dept of Health.

DOH (2009) Reference Guide to consent for examination or treatment. (2nd

edition.)

http://www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassets/documents/di

gitalasset/dh\_103653.pdf

NHS Clinical Governance Support Team (2005) Guidance on the Role and

Effective Use of Chaperones in Primary and Community Care Settings: Model

Chaperone Framework. London: Dept of Health.

East London NHS Foundation Trust (2016) Consent to Treatment Policy

**7. Appendices***Appendix 1*

**Sample wording for posters / leaflets**

**Intimate Examinations**

During your care, a (*clinician)* may need to examine you. Occasionally this may involve an examination of intimate areas. We understand that this can be stressful and embarrassing.

If this sort of examination is necessary:

* We will explain to you why the examination is necessary and give you the

opportunity to ask questions

* We will explain what the examination will involve
* We will obtain your permission before we carry out the examination
* You will be offered a chaperone to be present during the examination
* At all times we will respect your privacy during the examination and while

dressing and undressing

Your *(clinician)* will be happy to discuss any concerns you have about this

This information can be produced in different formats and different languages.

Please contact the Equality and Diversity Manager at East London NHS Foundation Trust for further information.

*Appendix 2*

**Frequently Asked Questions**

**What if a relative or friend offers to act as a chaperone?**

Patients may be accompanied by relatives or friends. In the event of an intimate examination being necessary, the clinician should consider the appropriateness or otherwise of having a relative or friend act as a chaperone as distinct from a member of staff. The clinician should still offer a practice chaperone and if declined this should be recorded in the notes.

Clinicians’ should exercise extreme caution when either patient or their chaperone has a history of violent or unpredictable behaviour, or are apt to make unjustifiable complaints. In such circumstances it would be advisable for a member of the practice team to be present in addition.

**What if you need to examine a patient on a home visit?**

If the visit or course of visits are pre-planned and are likely to involve an intimate

examination, it is advisable to ask the patient in advance if a chaperone would be

needed and if so, to arrange for one to be present.

If the examination is not planned, it may be acceptable to proceed if a family member is present, but bear in mind any concerns about past behaviour of family members. However, unless the clinical circumstances dictate an examination is immediately necessary, it would be better to advise the patient to attend the surgery for the purposes of the examination.

Clinicians should be aware they are at increased risk of their actions being misinterpreted if they conduct an intimate examination in the patients’ home where no other person is present.

**What if the patient does not speak English, or has poor understanding of it?**

It would be unwise to proceed with any examination unless the clinician is satisfied that the patient understands and can give informed consent.

If an interpreter is available, they may be willing to act as a chaperone together with a member of the practice team. However it would be unacceptable not to have explained to the interpreter the situation and to ascertain that they have understood what is being asked of them before suggesting such to a patient.

If the examination is urgent, every effort should be made to communicate with the patient, by whatever means are available, before proceeding with the examination.

**What if the patient has specific cultural or religious issues?**

What constitutes an ‘intimate examination’ will be different for people of different

cultures. Advice can be obtained from the Equality and Diversity Manager at

East London NHS Foundation Trust.

**What if the patient has a learning disability or dementia?**

A patient with a severe disability is unlikely to attend surgery unaccompanied. As with the previous heading, the clinician should endeavour to communicate with the patient with the assistance of the carer. Particular care should be made to ensure that the patient’s views and wishes are respected: refer to the Dept of Health *Mental Capacity Act* (2005) for further information.

For patients with a learning disability or a mental illness, a familiar individual such as a family member or carer may be the most appropriate chaperone. A careful, simple and sensitive explanation of the technique is vital. Adult patients with learning difficulties or mental illness who cannot give consent and consequently resist any intimate examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned.

**What if the clinician has doubts about the patients’ motives in requesting an**

**examination?**

Clinicians should be on the lookout for danger signs in such situations, for example,

evidence suggesting an infatuation with the clinician, irregular behaviour or a history of mental illness should encourage clinicians to be wary of putting themselves in a position where their actions may be misinterpreted.

*Appendix 3*

**Impact Assessment Tool**

**Incorporating: Equality and Diversity; Human Rights and Environmental Issues**

To be completed and attached to any procedural document when submitted to the

appropriate committee for consideration and approval.

|  |  |  | **Comments** |
| --- | --- | --- | --- |
| **1** | **Briefly describe the procedure/decision?** |  | Guidance on the use of chaperones for clinicians |
| 1.1 | **Briefly describe the purpose or objective of the procedure/decision?** |  | The protection of patients and clinicians during intimate clinical examinations |
| 1.2  1.3 | **Does the procedure/decision have a legitimate aim?**  **Is the procedure/decision necessary, proportionate and lawful?** | **Yes**  **Yes** | The protection of patients and clinicians during intimate clinical examinations |
| **2** | **Will the procedure/decision affect one group or a combination of groups less or more favourably than others on the basis of:**  Race, Colour, Nationality, Gender, Age, Sexual orientation, Disability, Religion, Language  (Disability includes: learning disabilities, physical disability, sensory impairment and mental illness) | **No** | The policy strives to eliminate this discrimination by advising clinicians to offer chaperones in every case, regardless of any of the factors listed opposite. |
| 2.1 | **List or describe the evidence that some groups will be affected differently?** |  | Not applicable |
| **3** | **Will the procedure/decision affect or restrict anyone’s human rights? (see attached list)** | **No** |  |
| 3.1 | **If the answer to Q3 is yes, which rights will be affected or restricted?**  **a) absolute right**  e.g. the right to protection from inhuman & degrading treatment  **b) limited right**  e.g. the right to liberty  **c) qualified right**  e.g. the right to respect for private and family life; freedom of expression; peaceful enjoyment of property etc; | **Yes/No**  **Yes/No**  **Yes/No** | Not applicable |
| 3.2 | **Can the procedure/decision be achieved without the infringement of human rights?** | **Yes** |  |
| **4** | **Will this procedure/decision:**  **Reduce or increase waste**  **reduce or increase use of energy**  **Have an impact on the use of transport**  **Create community employment opportunities** | **No**  **No**  **No**  **No** | None of these apply |
| **5** | **What action is to be taken to minimise the impact that the procedure/decision will have on equality and diversity and human rights.** |  | Not applicable |
| 5.1 | **What action is to be taken to minimise the impact that the procedure/decision will have on the environment** |  | Not applicable |
| **6** | **Have you consulted with relevant groups around this procedure/decision?**  **Staff members**  **Service Users**  **Carers**  **Other agencies** | **Yes**  **No**  **No**  **No** | This policy has been reviewed and ratified by the ELFT Nurse Development Steering Group |
| 6.1 | **Do you have further plans to consult with the relevant groups** | **No** |  |
| **7** | **Will the procedure/decision be monitored?** | **Yes** | Explain your answer |
| 7.1 | **Will the procedure/decision be reviewed?**  **If yes, when? 31.03.2019** | **Yes** | Explain your answer |
| 7.2 | **Will this procedure/decision and this Impact assessment be published?**  **If yes, list when and where this information will be available.** | **Yes** | On ELFT Trust’s Intranet  (electronic) |

This Impact Assessment Form must accompany the procedure to the relevant committee and copied to: Clementine Femiola, Associate Director of Equality and Diversity, 9 Alie Street, London E1 8DE

**HUMAN RIGHTS ACT 1998**

**Convention Rights**

Right to life

Right not to be tortured or treated in a inhuman or degrading treatment

Right to be free from slavery or forced labour

Right to no punishment without law

Right to Liberty

Right to fair trial

Right to respect for private and family life, home and correspondence

Right to freedom of thought, conscience and religion

Right to freedom of expression

Right to freedom of assembly and association

Right to marry and found a family

Right not to be discriminated against

Right to peaceful enjoyment of possessions

Right to education

Right to free elections

**Types of rights**

**Absolute rights** such as the right to protection from torture, inhuman and degrading

treatment and punishment, the prohibition of slavery and enforced labour and protection from

retrospective criminal penalties **– can never be interfered with.**

**Limited rights** such as the right to liberty which are limited under explicit and finite

circumstances set out European Commission for Human Rights (ECHR) itself, which

provides exceptions to the general right – can be restricted in some tightly defined

circumstances.

**Qualified rights** which include the right to respect for private and family life, religion and

belief, freedom of expression, assembly and association, the right to peaceful enjoyment of

property and to some extent the right to education. Interference with them is permissible only if what is done:

has its basis in law, and

Is done to secure a permissible aim set out in the relevant Article, for example for the

prevention of crime, or for the protection of public order or health, and

Is necessary in a democratic society, which means it must fulfil a pressing social need, pursue a legitimate aim and be proportionate to the aims being pursued.

Appendix 4 – **Policy owner**

**Implementation Plan Template**

**Who is this targeted at and who's responsibility is it to complete?**

**Procedure title: Lead Director:**

**Procedure lead: Sponsor Group:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Objective** | **Action** | **Lead** | **Timescale** | **Progress/Outcome** | **Evaluation/Evidence** |
| 1. The procedure is properly disseminated throughout the Trust. |  |  |  |  |  |
| 2. Appropriate training is provided to staff. |  |  |  |  |  |

**Appendix 5**

**Fraser Guidelines**

This refers to the provision of contraception to young people under the age of 16

years.

This means that the doctor or health care professional may carry out the treatment

or examination provided that:

1. that the young person understands the advice, the possible alternatives and the consequences or accepting or not accepting that advice.
2. that the health care professional cannot persuade him/her to inform his/her legal guardian or to allow him to inform them that she is seeking contraceptive advice;
3. that he or she is very likely to continue having sexual intercourse with or without contraceptive treatment;
4. that unless he or she receives contraceptive advice or treatment his/her physical or mental health or both are likely to suffer;
5. that it is in the best interests of the young person to receive the advice or treatment without parental (legal guardian) consent.

Gillick Competency and Fraser Guidelines NSPCC Fact sheet. December 2009.

http://www.nspcc.org.uk/inform/research/questions/gillick\_wda61289.html

Reference Guide to consent for examination or treatment. (2nd edition.) Department

of Health (July 2009)

<http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103653.pdf>