Trust-wide Policy
CHAPERONE POLICY

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Lead author(s) job title:	Head of Patient Experience and Engagement
Document summary:	All patients have a right, if they wish, to have a chaperone present during an examination or procedure or any care irrespective of organisational constraints or settings in which they are conducted – this document defines how staff should enable and provide that service.
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Version control history	
Version	**Brief summary of changes**
5.0	Updated to expand to trust wide policy and in line with new national guidance

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Instant Information

Key Messages of the Policy

- Patients have the right to a chaperone
- Inform patients of the Chaperone Policy
- Offer a formal chaperone for all intimate examinations
- The following must be offered a chaperone
  - Children,
  - Adult at risk
- Use Gillick Competence for < 16 years
- If emergency care is clinically necessary, this will take priority, and treatment may proceed without a chaperone if delaying care would increase risk to the patient
- The Chaperone must have received chaperone training
- Students must not undertake a formal chaperone role

Employee Checklist for Intimate Examinations

- Confirm identity
- Ensure the examination is clinically necessary
- Discuss examination, explain
  - Purpose
  - what it involves,
  - allow time for questions.
- Always maintain patient privacy and dignity, including during undressing and redressing
- Offer a chaperone, explaining their role clearly.
- If the patient requests a chaperone and none is available—or they decline the available option—provide an explanation and rearrange the appointment if needed.
- If the clinician requires a chaperone but the patient refuses, discuss alternatives and rearrange if necessary. Document the decision and rationale.
- Obtain and document patient consent, following capacity policies where relevant.
- Stop the examination immediately if the patient requests this and record the reason
- Children may have parents present. If a child declines a nurse chaperone, parents may act as chaperones if appropriate, with consent documented
- Explain each stage of the examination, the findings, and next steps
- Keep communication professional and relevant
- Document the presence and identity of any chaperone
- Record any concerns or relevant issues and escalate promptly

Key Standards for monitoring and Audit

The purpose of monitoring and audit is to determine patient awareness that they can ask for a chaperone, employee compliance with documentation standards against the policy and employee knowledge of the Chaperone Policy.

- Employees demonstrate a thorough knowledge of chaperoning policy and practice (100%).
- A formal chaperone is always present when performing intimate examinations unless documented otherwise as patient preference (100%).
- Is there a poster or patient information leaflet available on request or on display (100%)
- All children, young adults or adults who cannot consent to examination are seen or examined with a chaperone present (100%).
- The indication for not having a chaperone present is documented (e.g., emergency care, patient preference) (100%).

1) Purpose

Great Western Hospitals NHS Foundation Trust (the Trust) is committed to ensuring a culture which values patient privacy and dignity.

This policy sets out guidance on the use of chaperones within the Trust and is based on recommendations from the:

- General Medical Council Guidance (GMC) Intimate examinations and chaperones (Ref 1)
- Nursing and Midwifery Council (2015) The Code: Professional standards of practice and behaviour for nurses and midwives, London (Ref 2)
- Allied Health Professions Federation (AHPF) (Ref 3)
- Improving chaperoning practices in the NHS – NHS England 2025 (Ref 4)
- Safeguarding patients: the Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam inquiries (2007) (Ref 5)

2) Rationale:

All patient and staff have a right, if they wish, to have a chaperone present during an examination or procedure or any care irrespective of organisational constraints or settings in which they are carried out.

Patients can find some consultations, examinations or procedures distressing and may prefer to have a chaperone to support them. It is best practice to offer all patients a chaperone for any consultation, examination or procedure where the patient feels one is required.

Any consultations 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.

The intimate nature of many nursing, midwifery and medical interventions, if not practiced in a sensitive and respectful manner, can lead to misinterpretation and occasionally allegations of inappropriate examinations or sexual assault.

In these circumstances a chaperone can act as a safeguard for both patient and clinician.

3) Definitions

The following terms and acronyms are used within this document:

GWH	Great Western Hospital
IP&C	Infection Prevention and Control
%	Per cent
ANTT	Aseptic Non-Touch Technique
Datix	Electronic incident reporting form
GMC	General Medical Council
GP	General Practitioner
HCSW	Health Care Support Worker
HCP	Health Care Professionals
IP&C	Infection Prevention and Control
MCA	Mental Capacity Act
MSW	Maternity Support Worker
NHS	National Health Service

A Chaperone: - There is no clear definition of a chaperone since this role varies considerably depending on the needs of the patient, the healthcare professional and the examination or procedure being carried out. The designation of the chaperone will depend on the role expected and the wishes of the patient.
An NHS chaperone is an appropriately trained, as a chaperone, member of staff who is present during an examination or treatment of a patient. The primary role of the chaperone is to assist the clinician undertaking the procedure in supporting the patient and to act as the patient's advocate, being sensitive to their needs and respecting and maintaining their privacy and dignity.

Informal Chaperone may be referred to as a person who would not be expected to take an active part in the examination or witness the procedure directly. An example is a family member or friend, legal guardian, non-clinical employee, healthcare student i.e., a familiar person who may be able to give reassurance and emotional comfort to the patient leading up to and during the intimate procedure.

Formal Chaperone may be referred to as an employee who acts as a witness for the patient and the Clinician, (i.e., Doctor/nurse/therapist) during an intimate medical examination or procedure being undertaken and may also in some circumstances assist the Clinician to undertake the relevant procedure. Any member of staff undertaking the role must have a current Disclosure and Barring Service (DBS) check in place and have undertaken appropriate training. Healthcare students should not be used as formal chaperones (please see informal and medical student exceptions on page 16).

Intimate examinations: these 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. Cultural and diversity influences may affect what is deemed 'intimate' to a patient.

4) Duties & Process

This policy recognises the following principles to be considered:

4.1 Role of the Chaperone

This implies a health professional such as a qualified Nurse, or a specifically skilled unregistered employee e.g., Health Care Assistant (HCSW), Therapy Assistant, or Maternity Support Worker (MSW).

Where appropriate the chaperone may also assist in the procedure or examination being carried out and/or hand instruments to the examiner during the procedure where they have completed any required training to enable them to do so.

The chaperone's main responsibility is to provide a safeguard for all parties (patients and practitioners), as a witness to continuing consent to the procedure/ examination.

The role of the formal chaperone is also to identify any unusual or unacceptable behaviour on the part of the Clinician undertaking the intimate procedure. Should this occur, the chaperone should remove themselves and the patient from the treatment area and immediately report any incident of inappropriate behaviour, which also includes inappropriate sexual behaviour/ intervention, to their line manager or another senior manager.

A chaperone will also provide protection and evidence for the clinician against unfounded allegations of improper behaviour which may be made by a patient.

In all cases the presence of the formal chaperone is required during the actual physical examination element of the consultation or procedure unless the patient requests otherwise. If the patient declines a chaperone, then the clinician must assess the situation and record if this is appropriate in the patient's medical notes.

It is the responsibility of the clinician to ensure that accurate records are kept of the clinical contact, which also includes records regarding the acceptance or refusal of a Chaperone.

4.2 Key Functions of a Formal Chaperone

This will be determined by the requirements of each unique situation.

The main functions may include the following:

- Providing the patient with physical and emotional support and reassurance during sensitive and intimate examinations or treatment.
- Ensuring the environment supports privacy and dignity.
- Providing practical assistance with the examination.
- Safeguarding patients against unacceptable acts of humiliation, pain or distress or abuse.
- Identifying unusual or unacceptable behaviour on the part of the healthcare professional
- Providing protection for the Clinician from potentially abusive patients.

Chaperones should:

- Receive appropriate and necessary training.
- Stay for the whole examination and be able to see what the clinician is doing, if practical
- Ensure their presence at the examination is documented by the examining professional in the patient's notes or electronic record.
- Be prepared to ask the examiner to abandon the procedure if the patient expresses a wish for the examination to end or if the chaperone has concerns.
- Be prepared to raise concerns if misconduct occurs and report this via the Incident Management System (electronic incident reporting form) risk management process and/or Freedom to Speak Up Guardian.
- Be sensitive to the patient's needs, respecting and maintaining their privacy and dignity.
- Provide emotional comfort and reassurance.
- Encourage patients to ask questions and seek clarification.
- Be alert to signs of patient distress – both verbal and non-verbal.
- Understand the clinical context and be able to appropriately observe the examination or procedure.
- Act as the patient's advocate when required.
- Assist with undressing or dressing if requested by the patient.
- Help the patient understand what is being communicated to them.
- While chaperones may support clinicians, this is not their primary role.
- Chaperones are not required to be registered clinicians. It is outside their remit to challenge the clinical decision to perform an examination or procedure. However, they have a duty of care to raise concerns about unsafe practices, in line with wider NHS policies.

Supporting chaperones :

In all cases where a chaperone is used, the chaperone should be provided with sufficient information on the reason for the examination and background to the patient to allow them to provide sufficient support. In cases of intimate examinations, they should be provided with a clear rationale for this being required.

Local chaperone policies should consider how the organisation supports chaperones to:

- ensure that the patient understands why they are in attendance and has consented to this
- act as a witness as to the continuing consent of the procedure
- ensure time is provided for chaperones and patients to ask questions
- confirm the clinician has clearly communicated the role of the chaperone where the presence of one has been agreed promote awareness of chaperoning policies to staff and patients

Records Management:

In all cases the offer and presence of a chaperone (including name and role) must be documented including:

- explanation of the need for the examination or procedure clearly documented by the professional undertaking the examination. This should include confirmation of the patient's capacity and best interest.
- confirmation that an active offer of a chaperone was made.
- document the patient's decision regarding the examination and the offer of a chaperone in the clinical record.
- any decision to proceed, postpone or cancel the examination or procedure, along with any alternative arrangements made, including the name and title of alternative chaperones.
- any incidents or complaints related to the examination, procedure or use of chaperones, recorded in accordance with local policies and procedures.
- consent to the procedure and a chaperone including details of the discussion between the practitioner and the patient regarding the offer of a chaperone and the name and title of the chaperone offered and any additional persons present.
- if no chaperone present, explain why this was declined.
- where possible the chaperone should confirm their presence within the record to allow for identification and audit the recording of chaperoning should be sufficient to support an auditable process where required, including the monitoring of trends and exemptions.

4.3 Chaperone training

All patient facing staff must have an understanding of the role of the chaperone. Staff must understand procedures for raising concerns.

Staff who undertake a formal chaperone role must have been educated sufficiently so that they acquire the knowledge and confidence to undertake the role required.

Anyone undertaking the role of the chaperone must have an in-date Disclosure and Barring Service (DBS) record. This must be at least a standard DBS check, but eligibility should be assessed individually based on the specific context of the ask.

At GWH role education will be provided via:
Reference to the Chaperone policy, roles and responsibilities as part of the Trust induction process

Additional training via local departmental induction for relevant clinical areas

Mandatory Safeguarding of Adults and/or Children training Level 2
All staff undertaking chaperoning with children - Safeguarding Children Level 3 training
Consent, Mental Capacity Act 2005, and Deprivation of Liberties Safeguards training

Education will include:

- what is meant by the term ‘chaperone’
- what is an 'intimate examination'
- why the chaperone role is important
- Patient rights
- Core role and responsibilities.
- The importance of chaperones having line of sight observation at all times during chaperone duties
- Knowledge of the chaperone policy and mechanism for raising concerns.
- Records management procedures related to chaperoning including all documentation and recording processes
- Relevant safeguarding policies and national guidance

4.4 Chaperone Process

Examinations where a formal chaperone ***must be available***. This includes:

- Breast examinations or procedures
- Genitalia examinations or procedures
- Rectal examinations or procedures
- Vaginal examinations in women
- Examinations requiring dimmed lights
- Examinations where patients need to be undressed
- Nursing and clinical care interventions e.g. insertion of urinary catheter
- Any staff concerns regarding examining a patient without a chaperone

Other situations where a formal chaperone ***should be considered***

- Where a patient is semiconscious or unconscious.
- Where a patient is intoxicated with alcohol or who has taken drugs particularly those with a hallucinogenic effect
- Where English is not the patients first language. A professional interpreter should always be used for patients who do not speak English, to ensure they understand the procedure and are able to consent.
- For patients with a history of difficult or unpredictable behaviour, this may or may not be attributable to mental health illness.
- For adults who lack capacity including those with a learning disability
- Where there is a history of the patient being a victim of abuse.
- For unaccompanied children. (Please refer to Children’s Chaperone Policy for specific guidance)

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 pain or discomfort, if this differs from what you have told the patient before, explain why and seek the patient’s permission.

- Stop the examination if the patient asks you to.
- Get the patient's permission before the examination and record that the patient has given permission.
- Patients who resist any intimate examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned.
- Keep discussion relevant and don't make unnecessary personal comments
- A care partner (friend/relative) should be allowed to accompany the patient if the clinical situation allows (Ref 11).
- If dealing with a child or young person, you must assess their capacity to consent to the examination. If they lack the capacity to consent, you should seek their parent's consent.
- Where there are concerns regarding an adults capacity to consent, you must assess their capacity to consent to the examination. If they lack capacity, you act in their best interests in consultation with an appropriate interested party.
- Give the patient privacy to undress and dress and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.

During the examination, you must follow the guidance in consent (Ref 8).

4.5 Where a Chaperone is needed but is not Available or is Refused

Where a suitable formal chaperone cannot be provided for a specific intimate procedure, all reasonable attempts must be made to locate one before a decision to continue or otherwise is made. This decision should be jointly reached with the patient and recorded in the patient's notes. The patient must be given the opportunity to reschedule their appointment within a reasonable timeframe if the patient wishes.

If the seriousness of the condition would dictate that a delay would have a negative impact, then this should be explained to the patient and any discussion recorded in their notes.

It is the Clinician's own discretion following discussion with the patient about their preference to proceed without a formal chaperone present. Any discussions with the patient and the rationale to proceed without a chaperone must be documented in the patient's medical notes.

The Trust accepts that patients may decline the offer of a chaperone for a number of reasons which should be respected. This may be because the patient feels relatively assured and is trusting of the professional relationship and feels comfortable for the Clinician to undertake the procedure without chaperone and/or it may be that they do not think it necessary for, or in some cases patients may feel embarrassed or uncomfortable to have additional employees present.

If the patient is offered and does not want a formal chaperone it is important to record that the offer was made and declined. If a chaperone is refused the Clinician must make a decision about the suitability of the procedure continuing in the absence of a formal chaperone. As above, any discussions with the patient and the rationale to proceed without a chaperone must be documented in the patient's medical notes.

4.6 Special Considerations

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 nursing and medical day-to-day care is delivered without a chaperone, as part of the unique and trusting relationship between patients and practitioners. However, employees must consider the need for a chaperone on a case-by-case basis, mindful of the special circumstances outlined in this policy and below .

In situations where previous abuse is suspected, great care and sensitivity must be used to allay fears of repeat abuse. Individual and sensitive discussion should be held with the patient to understand specific triggers and ensure appropriate adjustments are made.

Some patients may request a chaperone to be of a particular gender and where possible this request should be supported.

4.7 Patients requiring additional consideration (Ethnic, Religious, Trans and Cultural Groups)

The ethnic, religious and cultural background of patients can make intimate examinations particularly difficult, for example, some patients may have strong cultural or religious beliefs that restrict being touched by others. 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. In these circumstances, a same sex healthcare practitioner should perform the procedure wherever possible. A personalised plan of care must be developed which will consider any specific ethnic, religious or cultural needs. Trans patients should be offered an appropriate chaperone, they should be asked if there is a gender preference, and this should be accommodated where possible however may not always be feasible and the examination should only continue if the patients consent to this.

4.8 Communication Barriers

It would be unwise to proceed with any examination if the healthcare professional is unsure that the patient understands due to a communication barrier. In life saving situations every effort should be made to communicate with the patient by whatever means available before proceeding with the examination. Interpreting services should be accessed to support any communication barriers.

4.9 Patients with additional needs related to Learning Disability or patients with cognitive impairment

Patients with communications needs or learning disabilities must have formal chaperone support from healthcare professionals.

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 agreed by the patient.

For patients with cognitive impairment or learning disabilities that affect capacity, a familiar individual such as a named family member or professional carer may be the best informal chaperone. This must be agreed and documented with the individual and the family member/carer as part of the overall best interest decision making process.

A personalised explanation of the planned procedure or investigation is needed i.e.. Simple language, pictures and additional time. Difficulties in understanding and processing information may increase anxiety, distress and engagement. Previous poor experience/ trauma may also impact behaviour and engagement. A familiar carer/ family member maybe the best informal chaperone. They will likely understand the patients' needs best and bring reassurance. This needs to be agreed/ documented etc.

Employees must be aware of the implications of the Mental Capacity Act *(2005)* ('MCA') and any 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 the rationale for the decision. In all circumstances the Adult Safeguarding team should be contacted wherever possible in advance to provide advice and specialist input regarding the personalised care plan and the additional support an individual may require.

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

In life threatening situations the healthcare professional should use professional judgment and where possible always discuss and engage with members of the relevant specialist teams within mental health and learning disabilities.

4.10 Children and Young People (Under 18 years)

The care of Paediatric patients often needs to be managed on an individual case basis, due to the complexities and range of issues which apply to the safe chaperoning of children and young people.

All children and young people under the legal age of consent (16 years) must be seen in the presence of another adult. This may be a parent, acting as an informal chaperone.

A parent or formal or informal chaperone must be present for any physical examination; the child should not be examined unaccompanied.

Any intimate examination must be carried out in the presence of a formal chaperone. If a chaperone is declined and the clinician feels it is in the child's best interest to proceed clear documentation should be provided.

Parents or guardians must receive an appropriate explanation of the procedure in order to obtain their informed consent to examination. A parent or carer or someone already known and trusted by the child may also be present for reassurance.

For young adults, who are deemed to have mental capacity, the guidance that relates to adults is applicable.

If it is ever necessary to see or examine a child or young person without a chaperone, written and signed consent must be obtained from the parent or guardian, on each occasion unless otherwise specified, and the young person and the reasons recorded in the notes.

Children and young adults being prepared for transition may be seen without their parent/carer at their request but should be examined in the presence of a chaperone. Gillick competence/Fraser Guidance can be used to assess the circumstances in which a child under 16 will be allowed to make their own decisions on medical matters (Ref 5).

As part of the newborn and infant physical examination it is routine to examine the genitalia, in this circumstance it would not be necessary to provide a chaperone, however clear explanation to the parents should be provided. 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.

In relation to any photography, if a competent child refuses to be photographed their wishes must be followed irrespective of parental wishes.

Remember:

- Before carrying out a procedure/examination on a child under 16 years of age, verbal consent must be obtained from the child and from the parent/person with parental responsibility.
- After obtaining verbal consent, the parent/person with parental responsibility should be encouraged to remain with their child throughout the procedure/examination, to give support and reassurance. The presence of a formal chaperone may be required.
- A child who is assessed as being Gillick competent (Ref 6) and therefore has '***sufficient understanding and intelligence to enable him or her to understand fully what is proposed'*** can accept an examination/procedure/parental presence. A minor the age of 18 or under does not have the legal capacity to refuse and so consent from one person with parental authority can override refusal by a minor. The health care professional then needs to assess whether the overriding of the child's refusal is in the child's best interests.
- Where a Gillick competent child (Ref 6) refuses parental presence during a procedure/ examination a formal chaperone **must** be present.
- Where minors elect to or need to be examined without a parent present the healthcare professional should be guided by an assessment of Gillick Competence (Ref 5). Even when permission is gained on behalf of a minor the consent of the patient her/himself should be obtained whenever practicable and possible.
- Adolescent patients generally have a lower embarrassment threshold, and the healthcare professional may feel it appropriate to use a chaperone in situations where one would not normally be used.
- The age of consent is 16 years, but young people have the right to confidential advice on contraception, pregnancy and abortion. The law is not intended to prosecute mutually agreed sexual activity between young people of a similar age, unless it involves abuse or exploitation. However, the younger the individual, the greater the concern about abuse or exploitation. Children under 13 years old are considered of insufficient age to consent to sexual activity, and the Sexual Offences Act 2003, (Ref 18) makes it clear that sexual activity with a child under 13 is always an offence.
- In situations where abuse is suspected great care and sensitivity must be used to allay fears of repeat abuse. In this instance Healthcare Professionals should refer to the Safeguarding Children and Young People Policy (Ref 6) and seek support from the Safeguarding Children's Leads before undertaking any examination or procedure.

As the law relating to capacity and children is complex, if there is any uncertainty the healthcare professional should seek advice from the Named Professional or the Trust Legal team.

4.11 Pregnancy in Under Sixteen Year Olds

In the case of under sixteen-year-olds pregnancies health professionals are advised that they should always consider being accompanied by a chaperone in the following circumstances:

- Pregnancy under 16 years and requires perineal or vaginal examination in the assessment of sexual, genitor-urinary and/or elimination disorders or in assessment of pregnancy.
- Pregnancy under 16 years and is not accompanied by an individual with parental responsibility.

Please read the section on Children and Young People *(Under 18 years)* for additional information

4.12 Maternity

Midwifery practice, by definition, involves intimate contact with women throughout pregnancy, in labour and postnatally. Whilst the Nursing and Midwifery Council (NMC) (2013), in its position statement, acknowledges the right of patients in the care of nurses and midwives to request a chaperone, it is often neither practical nor feasible for a formal chaperone to be present for all vaginal examinations, or at all births.

Consent should be obtained, and documented, for all intimate examinations on pregnant or post-partum women by the midwife, patients (with learning disabilities 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. (e.g., vaginal examinations, examination of the perineum, perineal suturing, assisting with breastfeeding). In gaining consent there should be acknowledgment of the intimate nature of the procedure and the potential for women to request a chaperone. In most cases an informal chaperone (e.g., partner) is present. (Ref 11)

Equally, some women may not want their partner present for such an examination, and this request should also be respected.

Where women request a formal chaperone for an examination by a midwife, this should be provided, where feasible, 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. However, midwives should not proceed with an intimate examination if consent is withheld.

4.13 Anaesthetised/Sedated Patients

For patients who have been anaesthetised or sedated, consent must be carefully assessed. Implied consent may apply only to essential, non-intimate and immediate care, such as monitoring vital signs or administering oxygen. As anaesthetic agents can impair judgement and capacity, staff must not rely on implied consent for intimate or non-urgent procedures, which require explicit informed consent once the patient is fully alert and orientated. Where capacity is reduced, procedures/examinations should be deferred if clinically safe. A chaperone must be offered for all intimate examinations or procedures and is considered mandatory practice in this context. Clear documentation is required, including assessment of capacity and whether a chaperone was offered, accepted or declined, with the chaperones details recorded where applicable.

Written consent must be obtained prior to anaesthesia, if the patient has capacity, for any intimate examination/photography under anaesthetic. Where this is not possible, e.g., as a result of unplanned or emergency surgery, every effort should be made to ensure that a chaperone is present during examination.

Please refer to the following policies for further guidance: Consent for Medical Treatment for all Patients at the Great Western Hospital Policy (Ref 8).

4.14 Virtual/Community Consultations

The policy applies to all areas of the Trust including acute, community and remote consultations.

Many intimate examinations will not be suitable for a video consultation. Should a clinician feel an examination during a remote consultation is essential, best practice would be to arrange a face-to-face consultation to facilitate this with an appropriate chaperone at the earliest convenience. If

delaying the examination could potentially cause further harm to the patient or delay further investigation, following discussion with the patient a remote examination may be appropriate.

As with non-remote consultations, for an intimate examination a patient should be offered a chaperone. The clinician should again ensure and document that the patient is fully aware of the limitations of continuing with an examination during the remote consultation. Check that the patient is comfortable with their surroundings/privacy and that there is no other unwanted third-party presence or likely to overhear/interrupt the call. A chaperone involved in a remote consultation must be able to fulfil their role in reassuring the patient and raising any concerns about potential inappropriate behaviour by the clinician.

There should be no requirement to video record or image capture and store a remote intimate examination. If the clinical care requires capture of such images this must be arranged as a face-to-face consultation and written consent obtained. Systems are not currently in place that can protect the patient or the practitioner in the use of recorded, virtual, intimate images and so this should not be undertaken.

In view of the practical difficulties in arranging for an effective chaperone for remote intimate examinations, the recommendation is that clinicians consider a face-to-face consultation instead. Remote intimate examinations should be only undertaken in very exceptional circumstances.

4.15 Additional Support

For any complex or challenging case support can be provided by the trust clinical ethics advisory group. Further information can be found via the Clinical Ethics Advisory Group.

5) Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

5.1 Ward Managers, Matrons and Managers for Non-Clinical Services

All Ward Managers, Matrons and Managers for Non-Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

5.2 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

5.3 Target Audience – As indicated on the cover page of this document.

The target audience has the responsibility to ensure their compliance with this document by:

- Understanding the requirements laid out in this policy
- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.
- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

5.4 Line Managers

The Line Manager has a responsibility for ensuring formal chaperones are available within their respective areas, and that chaperones work within their scope of practice and are fully aware of this and associated policies. They also have responsibility for informing the senior management if no suitable formal chaperone is available when required. They also have responsibility for ensuring all formal chaperones are aware of their responsibilities at a local level and that appropriate use of formal recording processes are in place within their areas of responsibility.

Managers are also responsible for ensuring that where necessary, local processes are developed, and training given to planning employee rosters and skill mix to support the full implementation of this policy. Managers should review the effectiveness of the implementation and take appropriate remedial action when they become aware of any acts or omissions that contravene it.

5.5 Health Care Professional (HCP)

The health care professional is responsible for ensuring that patients are offered a chaperone as outlined in this policy, and for respecting the individual's choice to either request or decline formal and informal chaperone. This should be applicable within both an outpatient and inpatient setting. The HCP is responsible for maintaining the accurate documentation including the consent given to proceed without a chaperone. They are also responsible for the appropriate escalation of concerns should these emerge during this process.

5.6 Nursing/Midwifery/AHP Students

Students can undertake the role of an informal Chaperone if the activity is deemed appropriate with their level of competence, commensurate with their stage of training, and where there is a specific learning and development opportunity associated with the task. An assessment would be undertaken by their mentor / practice educator in discussion with the student to determine this. The student has the right to engage or refuse to undertake the role as an informal Chaperone in accordance with their code of professional conduct.

5.7 Medical Students

In line with best GMC guidance, (Ref 1) Medical students should only:

- Act as a chaperone for patients examined by the relevant clinical supervisor.
- Conduct non-intimate examinations on patients with their clinical partner (other medical student) present or on their own during year five placements.

Medical student should not:

- Conduct intimate examinations on a patient without a clinically qualified chaperone being present (i.e., doctor or nurse)
- Act as chaperone to their clinical partner for intimate examinations.
- Conduct any intimate examination unsupervised even if the patient is happy for them to proceed with the examination.

5.8 The Divisional Governance Committee

The Divisional Governance Committees will be responsible for monitoring compliance.

6) Consultation

Below is a list of consultees who supported the formulating of this document.

Job title and department	Date approved
Deputy Chief Nurse	28 January 2026
Associate Director of Safeguarding	15 January 2026
Deputy Associate Director of Safeguarding & Mental Capacity Lead	26 January 2026
People Promise Manager	15 January 2026
Head of Maternity and Neonatal Services	10 March 2026
Divisional Director of Nursing Division of Medicine	24 February 2026
Divisional Director of Nursing Family, and Specialist Services	25 February 2026
Divisional Director of Nursing Surgery and Planned Care	18 March 2026
Consultant Cardiologist	26 January 2026
Associate Medical Director Family, and Specialist Services	2 February 2026
Lead Sonographer	28 January 2026
Learning Disability Nurse	2 February 2026
Clinical Audit, Effectiveness & Mortality Manager	2 February 2026
Paediatric Consultant and Named Doctor for Safeguarding Children	24 March 2026

7) Monitoring, compliance, and effectiveness of implementation

The arrangements for monitoring compliance are outlined in the table below:

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
Compliance with the Chaperone Policy	Trust wide Chaperone Audit	Policy Author, supported by the Clinical Audit & Effectiveness Team	Annually (or where action plans permit)	Patient Safety & Quality and Sub-Group Committee for Governance Oversight	Results shared with Divisional Leads for local review and implementation of actions. Identified risks to be managed by the Division.

8) Supporting documents

The following is a list of other policies, procedural documents, or guidance documents (internal or external) which employees should refer to for further details:

Ref No.	Document title	Link to document location
1.	General Medical Council Intimate Examinations and Chaperones Policy, 2024	Intimate examinations and chaperones - professional standards - GMC
2.	Nursing and Midwifery Council (2015) The Code: Professional standards of practice and behaviour for nurses and midwives, London	The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council

3.	Allied Health Professions Federation (AHPF)	Allied Health Professions Federation
4.	NHS England: Improving chaperoning practice 2025	NHS England » Improving chaperoning practice in the NHS: key principles and guidance
5.	Safeguarding patients: the Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam inquiries (2007)	Safeguarding Patients The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries CM 7015
6.	GWH Safeguarding Children & Young people Policy	Eolas Medical
7.	GWH Safeguarding Adults at Risk Policy	Eolas Medical
8.	GWH Consent for Medical Treatment for All Patients at the Great Western Hospital Policy	Eolas Medical
9.	GWH Mental Capacity Act 2005 Policy and Procedures	Eolas Medical
10.	GWH Aseptic Non-Touch Technique (ANTT) Procedure for any Invasive Clinical Practice	Eolas Medical
11.	Regulation 9A: Visiting and accompanying in care homes, hospitals and hospices	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
12.	GWH Standard Infection Control Precautions Policy	Eolas Medical
13.	GWH Conduct Management Policy	Eolas Medical
14.	Mental Health Act 2025	Mental Health Act 2025
15.	Mental Capacity Act 2005	Mental Capacity Act 2005
16.	GWH Perinatal Mental Health Guidelines	Eolas Medical
17.	Good practice service delivery standards for the management of children referred for child protection medical assessments (2020)	Child-Protection-service-delivery-standards-2020.pdf (rcpch.ac.uk)
18.	Sexual Offenses Act 2003	Sexual Offences Act 2003
19.	Management of Allegations under Safeguarding 'Persons in Positions of Trust' (PiPoT) Guidance	Eolas Medical

Appendix A – Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? **Chaperone Policy**		
2.	Briefly describe the aim of the policy, strategy, project. What needs or duty is it designed to meet? **The policy defines how staff should enable and provide a chaperone service to ensure patient and staff safety, protect privacy and dignity, and ensure individualised personal care.**		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e., there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Tania Currie
Date completed	3 February 2026
Job Title	Head of Patient Experience and Engagement

On completion of Stage 1: A full impact assessment will normally be required if you have answered YES to one or more of questions 3, 4 and 5 above.