

# Delivering same-sex accommodation

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# Foreword

All providers of NHS-funded care are expected to prioritise the safety, privacy and dignity of all patients. Adherence to this guidance is an essential part of this.

In April 2011, reporting of breaches to same-sex accommodation guidance became mandatory. Since then, trusts have continued to report on a monthly basis and there have been huge improvements in privacy and dignity. Over the last decade practice has developed, particularly the way emergency assessments and patient admissions are managed, therefore the guidance has been reviewed and some changes made to reflect current patient pathways.

There are some clinical circumstances where mixed sex accommodation can be justified. These are few, and mainly confined to patients who need highly specialised care, such as that delivered in critical care units. A small number of patients will actively choose to share with others of the same age or clinical condition, rather than sex. Further detail on the circumstances in which mixing is justified (and therefore does not constitute a breach) is provided in Annex A.

Because of the huge variation in ward designs, it is impossible to monitor all aspects of mixing centrally; this is why central reporting concentrates on admitted patients in sleeping accommodation. All providers of NHS-funded care should regularly monitor their estate, and the way they use it, to make sure the highest possible standards are maintained. In mental health inpatient units, women-only day rooms must be provided.

We are aware that there are some local agreements between providers and their commissioners for reporting breaches nationally, which mean some trusts report breaches where others would not. Providers must agree with their commissioners, every month, the number of justified and unjustified breaches using the revised national guidance.

Where breaches do occur, providers and their commissioners should agree action plans to avoid further breaches.

This revised guidance gives further clarity regarding definitions of what does and does not constitute a mixed-sex accommodation breach and ensures alignment with any corresponding guidance published since the original version in 2009.

We ask all commissioners and providers of NHS funded care to read this guidance carefully and work together to ensure it is routinely adhered to and the safety, privacy and dignity of patients prioritised.



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# 1. Guidance

## 1.1 Overview

Every patient has the right to receive high quality care that is safe and effective and respects their privacy and dignity. This is one of the guiding principles of the NHS Constitution and is at the core of local NHS visions. This *Delivering Same-Sex Accommodation* guidance updates and replaces previous guidance (PL/CNO/2009/2 and PL/CNO/2010/3) on requirements around recognising, reporting and eliminating breaches.

## 1.2 Guidance statement

Providers of NHS-funded care are expected to have a zero-tolerance approach to mixed-sex accommodation, except where it is in the overall best interest of all patients affected.

## 1.3 What is a mixed-sex accommodation breach?

This description of a mixed-sex accommodation breach refers to all patients in sleeping accommodation who have been admitted to hospital.

- A breach occurs at the point a patient is admitted to mixed-sex accommodation outside the guidance.
- Patients should not normally have to share sleeping accommodation with members of the opposite sex.
- Patients should not have to share toilet or bathroom facilities with members of the opposite sex.
- Patients should not have to walk through an area occupied by patients of the opposite sex to reach toilets or bathrooms; this excludes corridors.
- Women-only day rooms should be provided in mental health inpatient units.

Note:

- *Sleeping accommodation includes all areas where patients are admitted and cared for on beds or trolleys, even when they do not stay overnight.*
- *An admitted patient is one who undergoes a hospital's admission process to receive treatment and/or care.*

On the rare occasion that mixing does occur, every effort should be made to put the situation right as soon as possible. Until that time, staff must take extra care to safeguard privacy, particularly where patients are cared for on beds or trolleys, even where they do not stay overnight. This description does not include areas where patients have not been admitted.

In every instance, the patient, their relatives and their carers should be informed of the reasons mixing has occurred, what is being done to address it and some indication as to when it may be resolved.

Non-permanent structure changes to the estate can support the delivery of same-sex accommodation where the partition is solid, opaque and floor to ceiling, and protects the privacy and dignity of the individual patient.

## 1.4 Guidance principles

- All providers are responsible for ensuring that all patients and relatives/carers as appropriate are aware of the guidance and are informed of any decisions that may lead to the patient being placed in, or remaining in, mixed-sex accommodation.
- Decisions to mix should be based on the patient's clinical condition and not on constraints of the environment or convenience of staff.
- The risks of clinical deterioration associated with moving patients to facilitate segregation must be assessed.
- All providers are responsible for ensuring all staff are aware of the guidance and how they manage requirements around recognising, reporting and eliminating mixed-sex breaches.
- There are situations where it is clearly in the patient's best interest to receive rapid or specialist treatment, and same-sex accommodation is not

the immediate priority. In these cases, privacy and dignity must still be protected.

- Patient choice for mixing must be considered and may be justified. In all cases, privacy and dignity should be assured for all patients.
- There are no exemptions from the need to provide high standards of privacy and dignity at all times.
- Identifying the right patient for the right bed first time improves patient outcomes by improving patient experience.

## Out of scope

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- All units (see Annex A for definitions of unit) where a patient may be referred directly for assessment, treatment or observation are not included pending a final decision to admit to another area. In all cases, breaches should be recorded from when the decision to admit is made or when the patient arrives in the unit and a decision to admit has already been made.
- Accident and emergency departments are not included.

## 1.5 Background

Monitoring of mixed-sex accommodation (MSA) breaches began in December 2010. This followed a programme of investment to support reductions in the number of patients sharing sleeping accommodation with members of the opposite sex.

In March 2012 the NHS Constitution introduced a pledge that if admitted to hospital, patients will not have to share sleeping accommodation with members of the opposite sex, except where appropriate.

In March 2013 MSA monthly reporting was included in the NHS Standard Contract as an Operational Standard.

In 2014 MSA was included in Care Quality Commission (CQC) Regulations 2014: *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10: Paragraph 10(2)(a)*.

Since the first pledge to deliver same-sex accommodation the models of care delivery have changed significantly and continue to do so. This guidance reflects the changes to service delivery but keeps the patient central to the guidance.

**The decision matrix at Annex A provides a framework to help determine the nature of a breach, whether it is clinically justified or not.**

**The information in Annex B regarding trans patients and gender variant children has been considered and updated as required with support from colleagues in the Government Equalities Office.**

**Annex C provides questions and answers (Q&A) and scenarios to help with recognition of breaches.**

## 1.6 Reporting breaches

### Justified breaches

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There are times when the need to urgently admit and treat a patient can override the need for complete segregation of sexes. In these cases, all reasonable steps should be taken to maintain the privacy and dignity of all patients affected.

There are some clinical circumstances where mixing can be justified. These are few, and mainly confined to patients who need highly specialised care, such as that delivered in critical care units. Further detail on the circumstances in which mixing is justified (and therefore does not constitute a breach) is provided in Annex A.

### Unjustified breaches

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This is where mixing occurs that cannot be clinically justified.

### National reporting

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All occurrences of unjustified breaches of sleeping accommodation must be reported via the Strategic Data Collection System (SDCS). Each occurrence should be counted once for national reporting purposes, regardless of duration. Please see link to [reporting guidance](#).



## Local reporting

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Local reporting should cover:

- all toilet and bathroom breaches
- an additional requirement for mental health inpatient units in relation to the availability of same-sex day space for women who use services and
- all cases of justified and unjustified breaches of sleeping accommodation in each 24-hour period, regardless of whether it is the same occurrence of mixing.

## 1.7 Roles and responsibilities

### Providers' responsibilities

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All providers should identify an executive board lead to:

- ensure national MSA reporting guidance is applied and submitted appropriately
- ensure local reporting guidance is applied, monitored and actioned
- establish a culture of open reporting of MSA breaches, ensuring staff are encouraged to raise concerns where delivery of same-sex accommodation is compromised
- review at executive board level the numbers of justified and unjustified breaches
- seek a feedback mechanism for all patients affected by MSA.

### Commissioners' responsibilities

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Commissioners need to:

- work with providers to ensure that pathways and resources are sufficiently secured to aid patients to be placed in the right place at the right time first time for their care needs (eg high numbers of delayed transfers of care and long length of stay can lead to flow issues, which in turn could lead to unjustified breaches)
- ensure that accountability is clear within the senior team

- monitor, review and work with providers to ensure that appropriate action is taken to prevent breaches and learn from them.

## 1.8 Financial sanctions

Under the terms of the NHS Standard Contract, where breaches occur, the commissioner whose patient is affected should levy the financial sanction specified by the Contract. It is for commissioners to determine how they use any funding withheld through the levying of a sanction. NHS England's guidance on the NHS Standard Contract strongly recommends that commissioners consider investing it in a way which will help to rectify (or avoid recurrence of) the breach in question.

For the purposes of applying financial sanctions, all breaches should be reported locally for every 24-hour period and not per occurrence as is the requirement for the nationally reported breaches.

# Annex A: Decision matrix

Decision matrix	Justified breaches	Notes
Critical care levels 2 and 3: eg intensive care unit/ coronary care units/high dependency units/hyper acute stroke units	Green Almost always	<p>When a clinical decision is made for a patient to be stepped down from level 2 or 3 care, they should be transferred within four hours of being ready to be moved. An unjustified breach should be recorded if a patient does not transfer within the four-hour period.</p> <p>For the comfort and safety of patients, transfers should not take place between the hours of 10.00pm and 7.00am. Breaches should not be counted within this period, they should start/restart from 7.00am.</p>
End-of-life care	Green Almost always	A patient receiving end-of-life care should not be moved solely to achieve segregation – in this case a breach would be justified, there is no time limit.
Assessment/ observation units, eg medical/ surgical assessment units/clinical decision making units/ observation wards	Green Almost always	A patient should be moved from an assessment / observation unit within four hours of a decision to admit or from when the patient arrives in the unit and a decision to admit has already been made. If mixing occurs after the four hour period, breaches should be recorded as unjustified.
Areas where treatment is delivered, eg chemotherapy units/ ambulatory day care/ radiotherapy/ renal dialysis/ medical day units	Green Almost always	Mixing should not be recorded as an unjustified breach wherever regular treatment is required, especially where patients may derive comfort from the presence of other patients with similar conditions. A very high degree of privacy and dignity should be maintained during all clinical or personal care procedures.

Children / young people's units (including neonates)	Amber Sometime s	Children (or their parents in the case of very young children) and young people should have the choice of whether care is segregated according to age or gender. There are no exemptions from the need to provide high standards of privacy and dignity.
Area where a procedure is taking place and the patient will require a period of recovery, eg day surgery/ endoscopy units/recovery units attached to theatres/ procedure rooms	Red Almost never	Segregation should be provided where patients' modesty may be compromised, eg when wearing hospital gowns/ nightwear, or where the body (other than the extremities) is exposed.  Where high observation bays are used for patients in the first stage of recovery or when they require a period of close observation but not level 2 or 3 care, any breaches that occur will be classed as justified.
Mental health	Red Never	All episodes of mixing in mental health inpatient units and in women-only areas should be reported.
Inpatient wards	Red Never	All episodes of mixing in inpatient wards should be reported.

# Annex B: Delivering same-sex accommodation for trans people and gender variant children

Transgender, or trans, is a broad, inclusive term referring to anyone whose personal experience of gender extends beyond the typical experiences of their assigned sex at birth. It includes those who identify as non-binary.

Under the Equality Act 2010, individuals who have proposed, begun or completed reassignment of gender enjoy legal protection against discrimination. A trans person does not need to have had, or be planning, any medical gender reassignment treatment to be protected under the Equality Act: it is enough if they are undergoing a personal process of changing gender. In addition, good practice requires that clinical responses be patient-centred, respectful and flexible towards all transgender people whether they live *continuously or temporarily* in a gender role that does not conform to their natal sex. General key points are that:

- Trans people should be accommodated according to their presentation: the way they dress, and the name and pronouns they currently use.
- This may not always accord with the physical sex appearance of the chest or genitalia.
- It does not depend on their having a gender recognition certificate (GRC) or legal name change.
- It applies to toilet and bathing facilities (except, for instance, that pre-operative trans people should not share open shower facilities).
- Views of family members may not accord with the trans person's wishes, in which case, the trans person's view takes priority.

Those who have undergone transition should be accommodated according to their gender presentation. Different genital or breast sex appearance is **not** a bar to this,

since sufficient privacy can usually be ensured through the use of curtains or by accommodation in a single side room adjacent to a gender appropriate ward. This approach may be varied under special circumstances where, for instance, the treatment is sex-specific and necessitates a trans person being placed in an otherwise opposite gender ward. Such departures should be proportionate to achieving a 'legitimate aim', for instance, a safe nursing environment.

This may arise, for instance, when a trans man is having a hysterectomy in a hospital, or hospital ward that is designated specifically for women, and no side room is available. The situation should be discussed with the individual concerned and a joint decision made as to how to resolve it. In addition to these safeguards, where admission/triage staff are unsure of a person's gender, they should, where possible, ask **discreetly** where the person would be most comfortably accommodated. They should then comply with the patient's preference immediately, or as soon as practicable. If patients are transferred to a ward, this should also be in accordance with their *continuous* gender presentation (unless the patient requests otherwise).

If, on admission, it is impossible to ask the view of the person because he or she is unconscious or incapacitated then, in the first instance, inferences should be drawn from presentation and mode of dress. No investigation as to the genital sex of the person should be undertaken unless this is specifically necessary to carry out treatment.

In addition to the usual safeguards outlined in relation to all other patients, it is important to take into account that immediately post-operatively, or while unconscious for any reason, those trans women who usually wear wigs, are unlikely to wear them in these circumstances, and may be 'read' incorrectly as men. Extra care is therefore required so that their privacy and dignity as women are appropriately ensured.

Trans men whose facial appearance is clearly male, may still have female genital appearance, so extra care is needed to ensure their dignity and privacy as men.

Non-binary individuals, who do not identify as being male or female, should also be asked discreetly about their preferences, and allocated to the male or female ward according to their choice.

Trans men and non-binary individuals can become pregnant and should be treated with dignity while using maternity services.

Further advice on providing services to trans people can be found in [Providing services for transgender customers](#) on GOV.UK.

## **Particular considerations for children and young people**

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Gender variant children and young people should be accorded the same respect for their self-defined gender as are trans adults, regardless of their genital sex.

Where there is no segregation, as is often the case with children, there may be no requirement to treat a young gender variant person any differently from other children and young people. Where segregation is deemed necessary, it should be in accordance with the dress, preferred name and/or stated gender identity of the child or young person.

In some instances, parents or those with parental responsibility may have a view that is not consistent with the child's view. If possible, the child's preference should prevail even if the child is not Gillick competent.

More in-depth discussion and greater sensitivity may need to be extended to adolescents whose secondary sex characteristics have developed and whose view of their gender identity may have consolidated in contradiction to their sex appearance. It should be borne in mind that many trans adolescents will continue, as adults, to experience a gender identity that is inconsistent with their natal sex appearance, so their current gender identity should be fully supported in terms of their accommodation and use of toilet and bathing facilities.

It should also be noted that, although rare, children may have conditions where genital appearance is not clearly male or female and therefore personal privacy may be a priority.

# Annex C: Frequently asked questions

## **1. Is it acceptable to set a time limit before recording mixing as a breach of the standard, eg two hours, four hours, twelve hours?**

A) In a ward, this is not acceptable. The breach occurs the moment the patient is placed in mixed-sex accommodation. However, in a high acuity area (as described in Annex A), a patient who is 'fit' to be stepped down from level 2 and 3 care, should be transferred within four hours of being ready to be moved. Transfers should not take place between the hours of 10.00pm and 7:00am. Annex A also confirms that when a patient is in an assessment unit and a decision to admit is made the transfer should occur within four hours of that decision being made.

## **2. Are assessment units exempt?**

A) Patients in assessment units are excluded until a decision to admit is made, after which they will be counted as a breach if not admitted within four hours.

## **3. Are critical care units exempt?**

A). Within critical care, some patients may have a clinical need to be in that environment, and therefore should be recorded and monitored locally as a justified breach. Annex A outlines the procedure for managing critical care breaches. For example, in an eight-bedded critical care unit there are four male patients and four female patients. This is to be recorded locally as eight patients in justified mixing. One of the male patients becomes ready to be transferred to a level 1 unit, but there is no available bed for his transfer: this would then become an unjustified breach four hours after he is ready to be moved. As only this patient is classed as an unjustified breach, this would be counted as one breach only.

## **4. If a patient in critical care becomes an unjustified breach at 9.00pm and is not transferred before 10pm, does that count as a separate breach at 7.00am?**

A) Breaches are not counted between the hours of 10.00pm and 7.00am. In this case, the four-hour period from the patient being ready to transfer would start again



from 7.00am, any previous count before 10.00pm would be disregarded. Given this is the same occurrence the breach would only be reported nationally once.

**5. If a patient needs to be admitted to a bed on a ward in the middle of the night, and the only option is to put them in a mixed-sex bay, would this be a breach?**

A) Yes, this is still a breach and should be reported. However, you must admit patients, including transfers, even if you can't provide the right gender bed.

**6. Does the MSA policy apply to children? Is there an age limit at which a breach can occur?**

A) It is recognised that for many children and young people, clinical need and age take precedence over gender considerations. Children and young people should therefore have the choice whether their care is segregated according to age or gender – hence, mixing may be acceptable. If the child's preference cannot be met and there is no clinical justification to support the patient being placed in mixed-sex accommodation, this should be recorded as a breach. If the child's request is to be with others of a similar age and this results in a mixed bay, then all patients in that bay must choose to be in mixed-sex accommodation otherwise the mixing of all patients should be recorded as breaches. There is no specific age limit – for very young children, the wishes of the parent may be sought.

**7. How do I record breaches if a patient has been moved several times?**

A) All occurrences of mixing should be recorded and reported. During a stay in hospital, if a patient experiences mixing on multiple wards, each occurrence of mixing should be recorded.

**8. How do I determine and record patient choice?**

A) On the rare occasion where, for example, a husband and wife choose to be placed together, this should be recorded in both their notes. The breach should still be recorded locally but as justified due to the patient choice. Where a patient has specifically indicated that they wish to be cared for in mixed-sex accommodation, only that patient should not be recorded as a breach, (but all other patients would be in breach if this is not their personal choice). Where patient choice occurs, the privacy and dignity of all patients should be protected.

**9. Mixing has occurred in a multi-bedded bay. Do I record all patients as breaches or just the one patient that ‘triggered’ the mixing?**

A) All patients in the bay are experiencing mixed-sex accommodation and therefore they should all be recorded. Where the bay is within a critical care area the rules about recording breaches in that area should be applied, so breaches are only counted for those patients who have waited for over four hours from being assessed as well enough to stepdown from level 2 and 3 care and ready to be transferred.

**10. In an independent sector treatment centre, how do I record my NHS-funded patients that are in breach?**

A) Using an example of a four-bedded bay which is mixed-sex accommodation: three patients are privately funded and one patient is NHS-funded. Only the NHS-funded patient is reportable. Private patients can trigger a breach if they are sharing with NHS patients, but only the NHS-funded patients should be reported as breaches nationally.

**11. It is not possible for patients to be placed in mixed-sex accommodation at our organisation, do we still need to submit a data return?**

A) Yes, all providers with the facilities to admit 10 or more patients at any one time are included in the data return - simply submit a ‘nil’ each month. Please see the [reporting guidance](#)

**12. In a six-bedded bay, there are four male patients and one female patient. I count this as five breaches. Then an extra female patient is added into the same bay as the four male and one female patient who have already been counted as a breach in that bay. Do I count everyone again or just the extra female patient?**

A) Regardless of whether an extra male or female patient is admitted it is counted as one additional breach. This means there are now six breaches.

**13. After initial mixing in a four-bedded bay, same-sex accommodation is achieved in the bay. However, later the same day a new spell of mixing occurs which involves two of the patients from the original scenario – how is this counted?**

A) In the above situation, the first set of (four) breaches is 'cancelled' when the bay becomes same-sex although they would have already attracted a fine. However, when the later mixing occurs, we still have two of the original patients having their privacy and dignity breached (for the second time that day), hence a further four breaches would be reported nationally. A fine would however only be applicable to the two new patients – as the two involved in the original mixing would already have attracted a fine.

**14. Can we turn patients away if same-sex accommodation is not available?**

A) No, the priority will always be to admit patients and treat them promptly. If you fully understand your capacity and demand this should not happen except in extreme circumstances, in which case you should ensure they are placed in same-sex accommodation as soon as possible.

**15. Can visitors cause a breach?**

A) No, visitors cannot trigger a breach of the mixed-sex accommodation standard as they are not admitted patients. More pertinently, though, they cannot cause an admitted patient to breach the standard.

**16. How can an organisation cope with fluctuations in the proportion of male and female patients admitted?**

A) Most fluctuations in flow can be predicted and accommodated. It is important to understand the anticipated flow of unscheduled patients into your unit so you can manage it appropriately. Reviewing previous admissions patterns for the number of male and female patients will help.

**17. How do we position eliminating mixed-sex accommodation in the long list of clinical and organisational priorities?**

A) Protecting patients' privacy and dignity is integral to good quality patient care and should be part of an organisation's overall ethos and approach.

**18. How can I ensure that the wishes of all patients in an area or on a ward/bay are considered when accommodating the wishes of a small number of those patients?**

A) Staff should remember that, under the Equalities Act and the Public Sector Equality Duty, it is a legal requirement to ensure that trans people are not discriminated against. This guidance clearly states that trans and non-binary people should be accommodated in line with their stated gender identity. In all cases staff should communicate to all patients and or their carers the situation that arises, ensuring sensitivity to all views and acting accordingly to protect the privacy and dignity of all patients. Where the situation, for example, relates to trans patients, staff should do everything they can to respond to the wishes of all patients, while still protecting the dignity and legal rights of the trans person. There may be some circumstances where it is lawful to provide a different service or exclude a trans person from a single sex ward of their preferred gender but only if this is a **proportionate means** of achieving a **legitimate aim**. Any decision to do this must therefore be made on a case-by-case basis, and based on:

- an objective and evidence-based assessment of the circumstances and relevant information
- respecting the rights and needs of the trans person and the detriment to them if they are denied access and balancing that against the needs of other service users and any detriment to them if the trans person is admitted.

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