May 2009

From the Chief Nursing Officer and Director General NHS Finance, Performance and Operations

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For action

- Directors of Finance
- Directors of Operations
- Directors of Nursing
- Directors of Estates and Facilities
- Chief Executives

of all NHS Trusts and PCTs, including Acute, General and Mental Health Trusts.

For information

- Chief Executives of Strategic Health Authorities
- Strategic Health Authority Performance Leads
- Strategic Health Authority Nursing Leads
- Strategic Health Authority Estates and Facilities Leads
- Chief Executives of NHS Foundation Trusts

Authorised by the Department of Health:
Gateway no.

Dear Colleague

Eliminating Mixed Sex Accommodation

This letter updates you on progress in respect of delivering same-sex accommodation and confirms further action required in the coming months, for completion by **30th June 2009**.

Operating Framework 2009/10

The Operating Framework required PCTs to work with provider units to publish, by the end of March 2009, plans to deliver substantial and meaningful reductions in the number of patients who report that they share sleeping or sanitary accommodation with members of the opposite sex. This supports the NHS commitment to providing every patient with same-sex accommodation, helping to safeguard their privacy and dignity when they are often at their most vulnerable. This means providing a same-sex sleeping area, bathroom and toilet facilities.

Plans should by now be easily available on all PCT and provider unit websites. We will ask SHAs for assurance from PCTs that plans have been published. Where there is no evidence that plans are available, the PCT will utilise the standard contract performance levers available to them in publishing those plans.

£100m Privacy and Dignity Challenge Fund

All plans submitted from SHAs have been approved and SHAs have had allocations from the Privacy and Dignity Fund confirmed. Actions should by now be well underway to deliver these plans and to monitor their progress. Funds will be held by SHAs pending confirmation that work has taken place. Any queries about funding

should be directed to SHA Directors of Finance in the first instance.

Measuring Improvement

Delivery against the Privacy and Dignity Fund plans is being monitored fortnightly. However, any slippage should be reported immediately. Work is underway to establish mechanisms for gathering patient experience data at national level, but in the meantime, you should continue to develop local monitoring systems relevant to your particular patch. This may include near real-time monitoring or other mechanisms. Each trust/PCT will be required to demonstrate the action it has taken and the benefits that have been secured for patients through the Privacy and Dignity Fund and other investment programmes.

We are also looking at ways to gather national-level information about the changes in the physical environment as a result of this programme. We will provide further details via SHAs.

Withholding payment from poorly-performing trusts

In January 2009, Health Secretary Alan Johnson announced that we will be putting rigorous and transparent performance measures in place via the standard contract from April 2010, to ensure same-sex accommodation is provided for every NHS patient.

Work is under way to develop robust mechanisms for contract managing providers of NHS funded care not achieving the agreed levels of performance. Further detail will be available over the coming months.

Target support and development of improvement teams

We have established a process for offering targeted support to trusts who are struggling to deliver improvements. This support will be tailored to the individual trust and we are in the process of packaging target support. It is being tested with the trusts and will consequently define what the support package will look like.

Other Initiatives

A stakeholder engagement plan is now in place to ensure we draw on our key stakeholders' insight and encourage their support for the programme. We are also in dialogue with the Design Council in order to identify and develop ways that good design practice can be used to support the programme.

What constitutes "mixed-sex accommodation"

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. This is one of the guiding principles of the NHS constitution and at the core of local NHS visions.

Our policy remains the same as in previous years – ie patients should not normally have to share sleeping accommodation or sanitary facilities with members of the opposite sex. This applies to all areas of hospital care. However, we recognise that there are some exceptional circumstances (such as where the patient needs very specialised or urgent care), where providing fast effective care for the patient may take priority over ensuring same-sex accommodation. Where mixing does occur, it must be in the interest of all the patients affected.

For clarity, we have produced further detailed definitions, and these are appended. They cover patients admitted in an emergency, those undergoing day treatment, and those in critical care environments. Separate definitions are also appended for children, young people and transgender people.

The definitions set out what we expect in terms of ward accommodation (including emergency wards and critical care) and focus mainly on inpatients and those receiving treatment. However, good

standards of privacy and dignity apply across the NHS, and many of the principles of definitions can be used in other areas, including when patients are moving around the hospital.

Any further queries please contact Dr Liz Jones at the Patient Environment Team.

Yours sincerely

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For further information, please contact:

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PO Box 777, London SE1 6XH

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Link to be included

Annex A

Delivering same-sex accommodation when patients are admitted in an emergency

Introduction

There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including when admission is unplanned.

High standards usually involve a presumption that men and women do not have sleep in the same room, nor use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including casual overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

However, we recognise that in some emergencies, mixing of the sexes can be justified. Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff. This means that mixing must be justifiable for all patients in the room.

Further detail and background

This note explains our expectations in relation to patient perceptions in emergency and unplanned admissions, whether direct to a ward, or via an admissions unit[1]. Separate guidance is available for children's services, intensive care units, and day treatment areas

Principles

- Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff
- Admissions units should be capable of delivering segregation for most of patients for most of the time
- Patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives, carers or loved ones.
- The reasons for mixing, and the steps being taken to put things right should be explained fully to the patient and her/his family and friends.
- Staff should make clear to the patient that the trust considers mixing to be the exception, never the norm
- Greater 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
- Greater protection should be provided where patients are unable to preserve their own modesty (for example when semi-conscious or sedated)
- Where mixing is unavoidable, transfer to same-sex accommodation should be effected as soon as possible. Only in the most exceptional circumstances should this exceed 24 hours

[1] "Admission unit" includes all units where a patient may be admitted for assessment, treatment or observation, pending a final decision on treatment. This covers clinical decision units, emergency admission wards, observation wards, medical assessment units and so on.

Implications and examples
When a patient's survival and recovery depend on rapid admission, the requirement for full segregation clearly takes a lower priority. But this does not imply a blanket exemption for all emergency admissions. Nor does it imply a blanket exemption for admissions units.

Clinical need must be judged for each individual patient. If a patient is admitted into a multi-bed room, then either all patients must be same gender, or mixing must be clinically justified for *all* patients in the room, not just the newly-admitted one.

Where patients cannot be immediately admitted to the "right bed" (ie one in the right specialty, with same-sex accommodation) then the final placement decision should weigh the benefits and disadvantages of each available option. Wherever possible, the patient or their family should be consulted.

Clearly, patient safety is paramount, but the requirement for segregation should not be ignored. It should be demonstrably possible for the large majority of emergency patients to have their clinical needs met within segregated accommodation.

Annex B

Delivering same-sex accommodation in day treatment areas

Introduction
There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including day treatment areas.

High standards usually involve a presumption that men and women do not have to be cared for in the same room, nor use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

However, we recognise that in some day treatment areas, mixing of the sexes can be appropriate, or even desirable. Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff.

Further detail and background
This note explains our expectations in relation to patient perceptions in day treatment areas. Separate guidance is available for children's services and for intensive/high-dependency care and emergencies.

What is a "day treatment area" in this context?
Examples of "day treatment areas" include, amongst others:

- Renal dialysis units
- Day surgery units
- Endoscopy units
- Elderly care day hospitals
- Chemotherapy units

Principles

- Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff
- Greater 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)
- Staff should make clear to the patient that the trust considers mixing to be the exception, never the norm
- Greater protection should be provided where patients are unable to preserve their own modesty (e.g. following recovery from a general anaesthetic or when sedated)
- Patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives, carers or loved ones.

Implications and examples
Using these principles allows staff to make sensible decisions that may vary from day to day. For instance, in a renal dialysis unit, if all patients are well-established on treatment, wear their own clothes and have formed personal friendships, mixing may be a good thing. By contrast, a

new dialysis patient, with a femoral catheter, and wearing a hospital gown, should be able to expect a much higher degree of privacy.

Similar considerations apply wherever treatment is repeated, especially where patients may derive comfort from the presence of other patients with similar conditions. Thus, for instance, it may be appropriate to nurse a mixed group of patients together as they receive regular blood transfusions. Likewise, it is clearly reasonable for both men and women to attend an elderly care day hospital together – as long as toilet and bathroom facilities are separate, and very high degrees of privacy and segregation are maintained during all clinical or personal care procedures.

Day surgery and endoscopy units

The presumption of same-sex accommodation applies in day surgery units, especially those where patients may remain overnight. The exception might be where very minor procedures are being undertaken – eg “lumps and bumps” on the hand or foot. As a starting point, if the patient is in a hospital gown, and may have difficulty preserving their own modesty due to sedation or anaesthesia, then segregation should be the norm.

Annex C

Delivering same-sex accommodation in critical care environments

Introduction
There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including critical care environments.

High standards usually involve a presumption that men and women do not have to sleep in the same room, nor use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including casual overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

On occasion, however, a minority of patients may have a clinical condition which requires immediate access to potentially life-saving treatments which can only be delivered within critical care environments. At these points in a patient's journey, access to and treatment within appropriate locations is paramount. In these situations, mixing of the sexes can be justified.

Further detail and background
This note explains our expectations in relation to patient perceptions in critical care environments. Separate guidance is available for children's services, emergencies, and day treatment areas.

Principles
- Decisions should be based on the needs of the individual patient whilst in critical care environments, and their clinical needs will take priority.
- Decisions should be reviewed as the patient's clinical condition improves and should not be based on constraints of the environment, or convenience of staff.
- The risks of clinical deterioration associated with moving patients within critical care environments to facilitate segregation must be assessed
- Where mixing does occur, there should be high enough levels of staffing that each patient can have their modesty constantly maintained by nursing staff. This will usually mean one-to-one nursing, or at the least, a constant nurse presence within the room or bay
- Where possible (for instance for planned post-operative care) patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives or loved ones.

Implications and examples
When a patient's survival and recovery depend on the presence of high-tech equipment and very specialist care, the requirement for full segregation clearly takes a lower priority. But this does not mean that no attempt at segregation is necessary. At the very least, staff should consider whether it is possible to improve segregation. In new units, the design should support segregation as far as possible.

The same principles apply to theatre recovery units where patients are cared for immediately following surgery, before transfer to the ward. Whilst separate male and female recovery units are not required, some degree of segregation remains the ideal. High levels of observation and nursing attendance should mean that all patients can have their modesty preserved whilst unconscious.

Annex D

Delivering same-sex accommodation in children's units

Introduction
There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including children's and young people's units.

High standards in relation to adult care usually involve a presumption that men and women do not have to be cared for in the same room, nor use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

However, we recognise that for many children and young people, clinical need and age and stage of development may take precedence over gender considerations and mixing of the sexes is reasonable, or may even be preferred. There is evidence that many young people find great comfort from sharing with others of their own age and often, this outweighs their concerns about mixed sex rooms. Young people should be given the choice.

Washing & WC facilities need not be designated as same-sex as long as they accommodate only one patient at a time, and can be locked by the patient (with an external override for emergency use only).

Further detail and background
This note explains our expectations in relation to patient perceptions in children's areas. Separate guidance is available for day treatment areas and for intensive/high-dependency care and emergencies.

Decisions should be based on the clinical, psychological and social needs of the child. This approach should be conveyed to the child (where they are old enough to understand), and their parents. If they would prefer to be nursed in proximity to members of their own sex then this preference should be accommodated.

Principles
- Privacy and dignity is an important aspect of care for children of all ages and young people
- Decisions should be based on the clinical, psychological and social needs of the child or young person, not the constraints of the environment, or the convenience of staff
- Privacy & dignity should be maintained whenever children and young people's modesty may be compromised (eg when wearing hospital gowns/nightwear, or where the body (other than the extremities) is exposed, or they are unable to preserve their own modesty (for example following recovery from a general anaesthetic or when sedated)
- The child or young person's preference should be sought, recorded and where possible respected
- Where appropriate the wishes of the parents should be considered, but in the case of young people their preference should prevail

Implications and examples
Using these principles allows staff to make sensible decisions for each patient. This may mean segregating on the basis of age rather than gender, but such decisions must be demonstrably in the best interest of each patient. Flexibility may be required – for instance patients might prefer to spend most of their time in mixed areas, but to have access to single gender spaces for specific treatment needs or to undertake personal care. Such flexibility is encouraged. It is not acceptable to apply a blanket approach that assumes mixing is always excusable.

In children's units parents are encouraged to visit freely and stay overnight. This may mean that adults of the opposite sex share sleeping accommodation with children. Care should be taken to ensure this does not cause embarrassment or discomfort to patients.

Annex E

Delivering same-sex accommodation for trans people and gender variant children

Transsexual people, that is, individuals who have proposed, commenced or completed reassignment of gender, enjoy legal protection against discrimination. In addition, good practice requires that clinical responses be patient-centred, respectful and flexible towards all transgender people who do not meet these criteria but who live *continuously or temporarily* in the gender role that is opposite 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 that they currently use.
- This may not always accord with the physical sex appearance of the chest or genitalia;
- It does *not* depend upon 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 full-time transition should **always** 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 only 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. At all times this should be done according to the wishes of the patient, rather than the convenience of the staff (see http://www.gires.org.uk/assets/trans-rights.pdf section 1.4, pp9,10).

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 upon 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 in order 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 is 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.

Particular considerations for children and young people
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, then 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 they are extremely likely to 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.