November 2010

Dear Colleague

Eliminating Mixed Sex Accommodation

The revised Operating Framework for 2010-2011 made it clear that NHS organisations are expected to *eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice.* This letter updates you on requirements with regard to recognising, reporting and eliminating breaches of this policy.

Recognising breaches of policy

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

Reporting breaches of policy

National monitoring and reporting
(ROCR approval applied for)
All breaches of sleeping accommodation[1] must be reported, for each patient affected, via the Unify2 system. Reporting systems should be established immediately, and data will be made public from January 2011 (reporting data from December 2010).

[1] "Sleeping accommodation" includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight. It therefore includes all admissions and assessment units (including clinical decision units), plus day surgery and endoscopy units. It does not include areas where patients have not been admitted, such as accident and emergency cubicles.

From the Chief Nursing Officer and Deputy NHS Chief Executive

Dame Christine Beasley DBE RN

David Flory CBE

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PL/CNO/2010/3

For action

- Directors of Finance
- Directors of Operations
- Directors of Performance
- 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. 15024

Organisations providing NHS-funded care must agree with their commissioners how they will determine whether or not a particular episode of mixed sleeping accommodation is justified (and therefore not in breach of the guidance). The agreements must be sufficiently detailed to cover the majority of predictable situations, and are intended to ensure that episodes of mixing are not wrongly classified as "justified" for non-clinical reasons. Annex B provides a matrix that may be used to frame such agreements. It is important that patients have confidence that mixing is restricted to those circumstances where it is genuinely in the patient's best interests. We will consider whether additional audit mechanisms are necessary.

Local monitoring and reporting

Because of the huge variation in ward designs, it is impossible to monitor all aspects of mixing centrally, and this is why central reporting concentrates on sleeping accommodation. But mixing in bathrooms or WCs is still unacceptable, as is requiring patients to pass through opposite-sex areas to reach their own facilities. All providers of NHS-funded care should regularly monitor their estate, and the way they use it, to make sure that the highest possible standards are maintained.

Breaches of bathroom accommodation, including situations where patients must pass through opposite-sex areas to reach their own facilities, must be monitored at organisational level, and plans put in place to deal with the problem. In mental health units, the provision of women-only day rooms must also be included in these plans. The plans should be agreed with commissioners, who will hold them to account for delivery.

Trust declarations of compliance

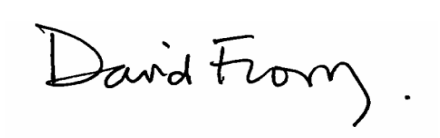
In addition to the new reporting regime, trusts must declare, by 1 April 2011, whether or not they comply with the new policy statement (set out at the head of this letter, in italics). Failure to declare compliance will trigger immediate financial sanctions in the new contract year.

Details on the declaration exercise will be issued in due course.

Eliminating breaches of policy

Where breaches occur, commissioners should consider imposing financial sanctions. These range from a fine of a minimum of 10% of the cost of the procedure/service of all patients affected (for individual patient breaches), to withholding, and ultimately retaining funds for an organisational level breach. There is some local discretion to prevent disproportionate fines, or perverse behaviours, but by and large, commissioners are expected to impose financial sanctions as directed by the contract. Annex D gives detail.

Yours sincerely



Dame Christine Beasley
Chief Nursing Officer

David Flory CBE
Deputy NHS Chief Executive

Further information
The actions in this letter are mandatory for NHS trusts, with immediate effect. NHS Foundation Trusts are encouraged to participate, prior to the establishment of the new contract in April 2011.

Support and advice is available until the end of the calendar year whilst the new reporting system beds in. Please contact any of the following:

Data collection and reporting
Caroline Angel
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This letter is also available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefnursingofficerletters/index.htm

Annex A

What is a breach of the guidance?

Guidance for providers, commissioners, SHAs and regulators

Policy statement
Mixed-sex accommodation will be eliminated, except where it is in the overall best interest of the patient, or reflects their personal choice.

Definition
A breach occurs at the point a patient is admitted to mixed-sex accommodation outside the terms of the policy.

What constitutes a breach?
Mixing may be justified (ie NOT a breach) if it is *in the overall best interest* of the patient, or *reflects their personal choice*. These are separated out below for convenience, although in reality there will often be some overlap.

In the best overall interests of the patient
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 be protected – eg by the enhanced staffing provided in critical care facilities. The patient should be provided with same-sex accommodation immediately the acceptable justification ceases to apply.

There is no justification for placing a patient in mixed-sex accommodation where this is not in the best overall interests of the patient and better management, better facilities, or the removal of organisational constraints could have averted the situation.

Acceptable justification – ie **NOT a breach**
- In the event of a life-threatening emergency, either on admission or due to a sudden deterioration in a patient's condition
- Where a critically ill patient requires constant one-to-one nursing care, e.g. in ICU
- Where a nurse must be physically present in the room/bay at all times (the nurse may have responsibility for more than one patient, e.g. level 2 care). This would be unacceptable if staff shortages or skill mix were the rationale
- Where a short period of close patient observation is needed e.g. immediate post-anaesthetic recovery, or where there is a high risk of adverse drug reactions
- On the joint admission of couples or family groups

Unacceptable justification – ie a **breach**
- Placing a patient in mixed-sex accommodation for the convenience of medical, nursing or other staff, or from a desire to group patients within a clinical specialty
- Placing a patient in mixed-sex accommodation because of a shortage of staff or poor skill mix
- Placing a patient in mixed-sex accommodation because of restrictions imposed by old or difficult estate
- Placing a patient in mixed-sex accommodation because of a shortage of beds
- Placing a patient in mixed-sex accommodation because of predictable fluctuations in activity or seasonal pressures
- Placing a patient in mixed-sex accommodation because of a predictable non-clinical incident e.g. a ward closure
- Placing or leaving a patient in mixed-sex accommodation whilst waiting for assessment, treatment or a clinical decision
- Placing a patient in mixed-sex accommodation for regular but not constant observation

It is not acceptable to mix sexes purely on the basis of clinical specialism. For instance, in a stroke unit, it may be acceptable to mix patients immediately following admission (life-threatening emergency, and in need of one-to-one nursing), but not to maintain mixing throughout the rehabilitation phase, simply on the basis that it is easier for staff, or because there are not enough people with the necessary skills.

Reflects patient choice
There are some instances when sharing accommodation with the opposite gender reflects personal choice and may therefore be justified. In all cases, privacy and dignity should be assured. Group decisions should be reconsidered for each new admission to the group, as consent cannot be presumed.

Acceptable justification – ie **NOT a breach**
- If an entire patient group has expressed an active preference for sharing (eg renal dialysis etc)

- If individual patients have specifically asked to share and other patients are not adversely affected (eg children/young people who have expressed an active preference for sharing with people of their own age group, rather than gender).

Unacceptable justification – ie a **breach**

- "Take it or leave it" – ie the patient is asked to choose between accepting mixed-sex accommodation, or going elsewhere
- "No-win situation" – ie the patient is asked to prioritise same-sex accommodation over another aspect of care (eg speed of admission, specialist staff etc)
- Custom and practice – eg routine mixing of young people without establishing preferences
- If the patient said they didn't mind (there should always be a presumption of segregation unless patients specifically ask to share)
- If the patient did not express a preference

It is important to note that the norm is always to aim for segregation – the circumstances in which patients choose to share are expected to be very much in the minority.

Footnote

Notwithstanding the above, there will be a very small set of circumstances where mixing is acceptable as an emergency response to extreme operational emergencies. This is limited to unpredictable events such as major clinical incidents e.g. a multiple road traffic accident or natural disaster, and major non-clinical incidents such as fire or flood requiring immediate evacuation of buildings.

Annex B

Decisions matrix for providers and commissioners

This matrix offers a framework to make sure that local decisions on mixing in sleeping accommodation reflect the national guidance. Providers and commissioners will need to agree their own version, listing each clinical area by name, and identifying the expectations for patients in that area. *No areas are exempt, and every decision to mix must be justified by reference to the patient's clinical needs, not organisational convenience or custom and practice.*

The decision to mix (and to record whether or not the mixing constitutes a breach) is made by the provider. These decisions are then validated at the contract review meeting. As a general rule, all episodes of mixing in red or amber areas should be discussed. A local system of validation and assurance should be agreed to monitor mixing in green areas, and ensure that unjustified mixing is not being overlooked.

Category	Acceptable?	Notes
Critical care, levels 2&3 eg: • ICU/coronary care units • High dependency units • Hyperacute stroke units • Recovery units attached to theatres/procedure rooms	Almost always G	• *Not* acceptable when patient no longer needs level 2 or 3 care, but cannot be placed in an appropriate ward • *Not* acceptable in recovery units where patients remain until discharge (eg some day surgery/endoscopy units)
Acute wards, eg: • Medical/surgical (general and specialist) • elderly care • orthopaedic	Never R	• *All* episodes of mixing in acute wards should be discussed individually with commissioners.
Intermediate and continuing care wards	Never R	• *All* episodes of mixing in intermediate and continuing care wards should be discussed individually with commissioners
Admissions units, eg: • Medical/surgical admissions • Observation wards • Clinical decision units	Almost never R	• *Not acceptable* for organisational convenience (eg to "park" patients whilst awaiting admission) • *Not acceptable* as a routine occurrence
Day surgery	Rarely R	• Acceptable for very minor procedures (eg operations on hands/feet that do not require patients to undress)
Endoscopy units	Rarely R	• *May be* acceptable for pre/post-procedure waiting areas as long as high standards of privacy can be assured. • *Not* acceptable where dignity is likely to be compromised, eg if bowel prep is needed
Patients with long-term conditions admitted frequently as part of a cohesive group (eg renal dialysis)	Sometimes A	• Patients may choose to be cared for together, as long as this is the decision of the whole group and does not adversely affect the care of others. • *Not* acceptable where the only justification is frequent admission, and there is no recognisable group identity
Children/young people's units (including Neonates)	Sometimes A	• Children and young people should have the choice of whether care is segregated according to age or gender.
Mental health and LD	Never R	• There is no acceptable justification for admitting a mental health patient to mixed-sex accommodation. • *May be* acceptable, in a clinical emergency, to admit a patient temporarily to a single, ensuite room in the opposite-gender area of a ward. In such cases, a full risk-assessment must be carried out and complete safety, privacy and dignity maintained.

Annex C
Guidance on data collection (ROCR approval applied for)

1. National reporting of **unjustified mixing** in relation to **sleeping accommodation** commences on 1 December 2010 with the first provider submission due by 12 January 2011. Monthly collection will continue with returns due on the 7th working day of each month.

2. The data is to be published by DH as official statistics and made available through the DH website, data.gov.uk, NHS Choices website and NHS Information Centre. At the time of publication, data from the previous two months will be refreshed, following contract/performance review meetings.

3. The data to be submitted is total occurrences of unjustified mixing in relation to sleeping accommodation only, by site, by commissioning PCO.

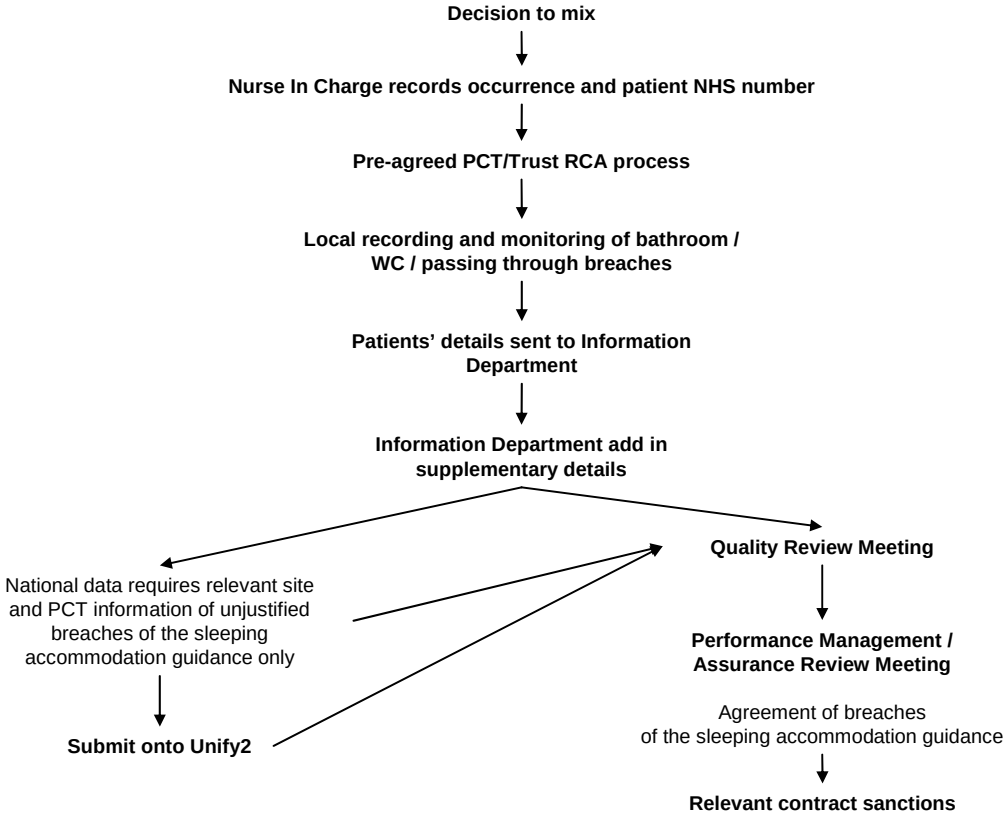
4. If a patient is placed in mixed-sex accommodation more than once during their stay, each occurrence is to be counted separately.

5. There are no blanket specialty exclusions from the return. There is no set time to define "sleeping accommodation".

6. "Sleeping accommodation" includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight. It therefore includes all admissions and assessment units (including clinical decision units), plus day surgery and endoscopy units. It does not include areas where patients have not been admitted, such as accident and emergency cubicles.

7. Justified mixing of sleeping accommodation, bathroom and WC mixing and women-only lounges for mental health are to be collected and monitored locally.

8. The flow chart demonstrates the process for reporting and local assurance.



Annex D

Contracting and sanctions

1. Under the NHS Standard Contract 2010/11 (or Standard Variations issued to bring the pre-2010/11 standard contracts in line with the requirements of the Operating Framework), Commissioners have an absolute requirement placed upon them to make a deduction equivalent to the total cost of the service or treatment for all patients affected by a breach of the same sex accommodation requirements as set out under *Nationally Specified Events* and Clause 7.23.

2. From January 2011 commissioners have discretion on the level of the financial sanction to be applied to breaches of sleeping accommodation up to and including the total cost of the service or treatment episode. Commissioners will be able to offer a variation to the existing contracts to Providers, which will allow commissioners to exercise discretion on the level of sanction for a sleeping accommodation breach, which is between 10% to 100% of the total cost of the procedure/service of patients affected by a breach.

3. Commissioners should vary their NHS Standard Contracts in accordance with clause 38 by sharing a locally raised contract variation using a model format which will be available on the DH Standard Contract web page. The variation would be along the lines of the following.

Nationally Specified Event	**Threshold**	**Method of Measurement**	**Consequence per breach**
Breach of the Same Sex Accommodation Requirements	> 0	Review of Monthly Clinical Quality Performance Report	Recovery of the cost of the procedure or service received by the Patient

With

Nationally Specified Event	**Threshold**	**Method of Measurement**	**Consequence per breach**
Breach of the Same Sex Accommodation Requirements	> 0	Review of Monthly Clinical Quality Performance Report	Recovery of the cost of the procedure or service received by the Patient **the level of sums recovered at the Commissioner's discretion and shall be not less than 10% nor greater than the total cost of the procedure or service received by all the Patients affected by the breach**

Breaches of sleeping accommodation

4. As part of the routine contract performance monitoring meetings the Commissioners and Providers should discuss the MSA Breaches reported by the provider.

5. The parties will confirm the provider's reported level of breaches and will agree any adjustment to the figures published by providers.

6. As part of the discussion, the commissioner will identify the level of financial consequence that will be deducted from the next payment to the provider.

7. The level of deduction will not be less than 10% of the total cost of the procedures or services received by the patients affected, nor exceed the total cost of the treatments or services of all patients affected

8. Where appropriate, the commissioner will notify any associate commissioners of the level of deduction to be made in accordance with Clause 7 (Payments and Pricing)

Breaches of bathroom accommodation

9. As part of the routine contract performance monitoring meetings the Commissioners and Providers should discuss the MSA Breaches reported by the provider.

10. As part of the discussion, the provider will identify to the commissioner any 'bathroom breaches' (as set out in the Guidance).

11. The Provider will put forward a Remedial Action Plan with a timescale for the resolution of the breach (clause 32.16.1)

12. The parties shall agree a level of consequence that will be levied should the Remedial Action Plan be in breach (clause 32.16.2)

13. The Commissioner and the Provider shall review the bathroom breach Remedial Action Plan at subsequent contract monitoring meetings until complete.

14. Failure by the provider to draw up the action plan may result a withholding of 10% of all the monthly sums payable to the provider (clause 32.21)

Breaches that involve the passing through or alongside sleeping accommodation en route to bathroom accommodation

15. As part of the routine contract performance monitoring meetings the Commissioners and Providers should discuss the MSA Breaches reported by the provider.

16. As part of the discussion, the provider will identify to the commissioner the any breaches involved with 'passing through or along side sleeping accommodation en route to bathroom accommodation' (as set out in the Guidance).

17. The Provider will put forward a Remedial Action Plan with a timescale for the resolution of the breach (clause 32.16.1)

18. The parties shall agree a level of consequence that will be levied should the Remedial Action Plan be in breach (clause 32.16.2)

19. The Commissioner and the Provider shall review the passing through or along side sleeping accommodation en route to bathroom accommodation breach Remedial Action Plan at future contract monitoring meetings until complete.

20. Failure by the provider to draw up the action plan may result a withholding of 10% of all the monthly sums payable to the provider (clause 32.21)

Breaches that involve women-only dayrooms in Mental Health hospitals

21. As part of the routine contract performance monitoring meetings the Commissioners and Providers should discuss the MSA Breaches reported by the provider.

22. As part of the discussion, the provider will identify to the commissioner any breaches involved with 'women-only dayrooms in mental health hospitals' (as set out in the Guidance).

23. The Provider will put forward a Remedial Action Plan with a timescale for the resolution of the breach (clause 32.16.1)

24. The parties shall agree a level of consequence that will be levied should the Remedial Action Plan be in breach (clause 32.16.2)

25. The Commissioner and the Provider shall review the ‘women-only dayrooms in mental health hospitals’ breach Remedial Action Plan at future contract monitoring meetings until complete.

26. Failure by the provider to draw up the action plan may result a withholding of 10% of all the monthly sums payable to the provider (clause 32.21)