

Summary: Intervention & Options

Department /Agency:

Title:

Impact Assessment of Delivering Same Sex Accommodation

Stage: Final

Version: FINAL

Date: 25th September 2009

Related Publications:

Available to view or download at:

[http://www. Tbc](http://www.Tbc)

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What is the problem under consideration? Why is government intervention necessary?

Evidence from patient surveys and other studies indicates that patients often find themselves sharing sleeping accommodation or toilet and bathroom facilities with members of the opposite sex. For some this will be distressing and/or embarrassing. It is also inconsistent with established commitments to privacy and dignity. Whilst the NHS has made progress, there would appear to be scope to do more to ensure delivery. There is a need to consider a broader range of high intensity activities to support the NHS in moving rapidly towards the elimination of mixed sex accommodation.

What are the policy objectives and the intended effects?

The policy objective is to establish a programme of work that supports the NHS in all but eliminating mixed sex accommodation - except where it is clinically justifiable. By bringing the associated work together into a programme that is co-ordinated and funded centrally, then working with health communities, (especially in improvement activities), it is anticipated more rapid progress can be made, including improvements to the physical infrastructure. Upon conclusion of such activity, local health communities must be able to maintain the momentum of improvement.

What policy options have been considered? Please justify any preferred option.

1. DO NOTHING: No indication from past results that rapid improvements can be delivered on this basis.
2. Further use of existing mechanisms via GUIDANCE AND FINANCIAL LEVERS: Evidence is that two substantial pieces of guidance published in 2007 have not had the required level of impact.
3. Broad based Improvement Team approach. PREFERRED OPTION. A broad based programme of work, including substantial capital investment, co-ordinated local activity via SHAs and central support using an 'improvement team' model.


When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

A progress review will be completed in late 2009. A formal post implementation review will take place in 2012.

Ministerial Sign-off For final proposal/ implementation Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:



Date:

12.10.09

Summary: Analysis & Evidence

Policy Option: 2	Description: Use existing levers, via guidance etc to drive change
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COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' Assumed that to drive the guidance we use the opportunity to pursue Design Council work (£1m) and develop further guidance using additional resource (240k). In addition, the NHS funds one fifth of the required capital investment from existing local funds		
	One-off (Transition)	Yrs			
	£ 21.2m				
	Average Annual Cost (excluding one-off)				
	£ nil			Total Cost (PV)	£ 21.2m
Other key non-monetised costs by 'main affected groups'					

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' Benefits in reduced distress to patients valued in QALYs, increase quality of life by 0.05 for those who 'minded' sharing, for an average period of 5.7days in hospital, leads to a saving of 74 QALYs a year.		
	One-off	Yrs			
	£ nil				
	Average Annual Benefit (excluding one-off)				
	£ 3.7m cash	15		Total Benefit (PV)	£ 50.2m
Other key non-monetised benefits by 'main affected groups'					

Key Assumptions/Sensitivities/Risks Key sensitivity is that progress is less than expected. This is accounted for in the calculation of benefit range.

Price Base Year 2009	Time Period Years 15	Net Benefit Range (NPV) £12.2m – 45.7m	NET BENEFIT (NPV Best estimate) £ 28.9m
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What is the geographic coverage of the policy/option?				national (England)		
On what date will the policy be implemented?				end Sept. 2009		
Which organisation(s) will enforce the policy?				DH/local NHS		
What is the total annual cost of enforcement for these organisations?				£ nil		
Does enforcement comply with Hampton principles?				Yes		
Will implementation go beyond minimum EU requirements?				No		
What is the value of the proposed offsetting measure per year?				£ nil		
What is the value of changes in greenhouse gas emissions?				£ nil		
Will the proposal have a significant impact on competition?				NO		
Annual cost (£-£) per organisation (excluding one-off)			Micro	Small	Medium	Large
Are any of these organisations exempt?			NO	NO	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)				(Increase - Decrease)	
Increase of	£	Decrease of	£	Net Impact	£

Key: Annual costs and benefits: (Net) Present

Summary: Analysis & Evidence

Policy Option: 3

Description: Broad based central programme

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' £100m of capital investment, £1m for design council work to identify design solutions, £1m for new surveys to focus on patient reported measures, remainder for administration of improvement team methodology.	
	One-off (Transition)	Yrs		
	£ 105.9 million			
	Average Annual Cost (excluding one-off)			
	£ Nil		Total Cost (PV)	£ 105.9m
Other key non-monetised costs by 'main affected groups'				

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' Benefits in reduced distress to patients valued in QALYs, increase quality of life by 0.05 for those who 'minded' sharing, for an average period of 5.7days in hospital, leads to a saving of 346 QALYs a year.	
	One-off	Yrs		
	£ nil			
	Average Annual Benefit (excluding one-off)			
	£ 17.3m cash	15	Total Benefit (PV)	£ 234.2m
Other key non-monetised benefits by 'main affected groups'				

Key Assumptions/Sensitivities/Risks Key sensitivity is that progress is less than expected. This is accounted for in the calculation of benefit range.

Price Base Year 2009	Time Period Years 15	Net Benefit Range (NPV) £ 27.9m – 161.7m	NET BENEFIT (NPV Best estimate) £ 128.2m
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What is the geographic coverage of the policy/option?		national (England)		
On what date will the policy be implemented?		end Sept. 2009		
Which organisation(s) will enforce the policy?		DH/local NHS		
What is the total annual cost of enforcement for these organisations?		£ nil		
Does enforcement comply with Hampton principles?		Yes		
Will implementation go beyond minimum EU requirements?		No		
What is the value of the proposed offsetting measure per year?		£ nil		
What is the value of changes in greenhouse gas emissions?		£ 200k		
Will the proposal have a significant impact on competition?		No		
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	NO	NO	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)	
Increase of £	Decrease of £	Net Impact	£

Key: **Annual costs and benefits:** (Net) Present

Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

What is the problem we are trying to solve?

One of the Department of Health's objectives is to deliver "**Better care for all**". The aim is to provide the best possible health and social care, and within that it is clear that the NHS should treat patients with respect and dignity. Indicators of, and feedback from, patient experience surveys play a central role in determining the extent to which the Department delivers on this objective.

The modernisation of NHS buildings is one of many developments of the last 12 years that have been universally welcomed by patients. Public expectation however, does not diminish as things improve and a number of key publications have established the basis for momentum around privacy and dignity;

- Lord Darzi's "High Quality Care for All" ¹, was the final report of the NHS Next Stage Review, co-produced with the NHS during a year-long process involving more than 2,000 clinicians and 60,000 NHS staff, patients, stakeholders and members of the public. It sets out guiding principles that support delivery of high quality care by frontline staff, focusing on care that is clinically effective, personal and safe. It also emphasises the importance of patient's entire experience of the NHS, including treatment which is dignified, compassionate and respectful.

- the RCN's campaign on dignity is testament to how strongly this is understood in the nursing profession²

- the NHS Constitution (published Jan. 2009) is expected to focus on patients' entitlement – to be treated with dignity and respect.³

Whilst the NHS has made considerable progress on these fronts, Evidence from patient surveys and other studies indicates that patients often find themselves sharing sleeping accommodation or toilet and bathroom facilities with members of the opposite sex. For some this will be distressing and embarrassing and it is not consistent with the aim of providing respect and dignity. It is not unreasonable in the 21st century for patients to expect to be treated in single sex accommodation, and not to have to share bathrooms and toilets with the opposite sex. Being cared for in mixed sex accommodation can be deeply distressing for many patients – it compromises their dignity and contravenes their right to privacy. The national survey results for 2008 show that 23% of patients reported sharing accommodation when first admitted to hospital, and of these 33% reported that they minded sharing, indicating that around 7.6% of patients are in situations where they share with a member of the opposite sex and it causes them some concern or distress. In some settings, particularly mental health, there are patient safety issues associated with mixed sex accommodation.

What is the case for Government intervention?

In this section of the impact assessment, we make the case for the Government to intervene on this issue, rather than leaving the NHS to devise local solutions. This case rests on the evidence of past progress in delivering same sex accommodation. Whilst some progress has been made, the pace of change has been slow. This indicates that there are barriers to providing local solutions to the problem, either in terms of understanding the problem and finding ways to address it, or in having the financial or managerial resource to tackle the problem. There is a need for Government to inform and to drive change in this area.

Previous management mechanisms – Inclusion in the Operating Framework

Progress on reducing mixed sex accommodation was required as a 'local priority issue' within the 2008/09 Operating Framework (O.F) for the NHS⁴. As indicated by patient survey outcomes, the extent to which health communities have delivered progress varies and the national rate of progress has been slow. Between 2006 and 2007, the national survey results showed a one-percentage point improvement

(fall) in the proportion of patients reporting experience of shared accommodation (mixing) when first admitted to hospital, i.e. (25% to 24%).

Further evidence that the problem remains

Figures published later, for 2008, show a similar rate of improvement (less than 1% improvement between 2007 and 2008). There is a consistent pattern that Mixed Sex Accommodation data have not shown any substantial improvement over time. Whilst the percentage scores across all the relevant areas are improving, the pace of change is slow.

In addition, the *Independent* newspaper published figures⁶ in January 2009, following an enquiry under the auspices of the Freedom of Information Act, this stated:

"More than one in four (28 per cent) hospital trusts and 29 per cent of mental health trusts are also failing to provide segregated washing facilities for patients in some areas. One in three (33 per cent) hospital trusts and 24 per cent of mental health trusts did not provide segregated toilet facilities while 23 per cent of hospital trusts and 11 per cent of mental health trusts used partitions instead of solid walls to segregate patients in some areas.

The data also showed that between October 2007 and September 2008 there were 6,485 recorded breaches of procedures for segregating patients by sex in hospital trusts and 30 in mental health trusts.

However, not all trusts recorded this information, suggesting the figure could be higher. In the same period, there were 997 complaints about privacy and dignity in hospital trusts and 135 complaints in mental health trusts".

Mixed sex accommodation and 'market drivers'

Data on the level of mixed sex accommodation (MSA) at a specific Trust, (as reported by the inpatient survey), can be accessed via the Care Quality Commission's website. The extent to which such information is used by patients to help influence their choice about the organisation at which they are treated is not known. As such, it is not possible to determine whether Trusts' rates of MSA, are significant 'market drivers', but the evidence above suggests it is not having a large impact.

It is possible that the local NHS is able to use locally available data on MSA-specific complaints. The Department does not systematically collect these data, but there is no evidence that they serve as a substantive driver for improvement at local level either.

Clinical staff's support

Most nurses surveyed by the RCN (Defending Dignity 2008 survey²) in terms of providing same-sex accommodation considered that the physical environment had considerable impact on their ability to deliver dignified care. The report did not provide numerical data on this aspect of nursing views as the relevant survey questions were qualitative in nature. Whilst some nurses appreciated that their care setting assisted them to promote patients' dignity, for many others the physical environment hindered them in providing dignified care. For example, the staff summary for the Dignity and Physical Environment section of the RCN Defending Dignity report stated that they, "are faced with working in cramped surroundings, with inadequate means to provide privacy for patients, and basic aspects, such as adequate bathrooms, toilets and equipment are lacking, all of which poses barriers to dignified care."

Scoping the possible solutions, and developing the options:

The arguments outlined above make it clear that addressing the problem of mixed sex accommodation is likely to require a degree of capital investment. This investment would be needed to alter and add to the estates infrastructure to address the facilities problems described by nurses in the RCN survey, but it might also include investment in additional screens or curtains, or in training of staff. The options considered in this IA focus on different means to ensure that this investment takes place. We also consider the most appropriate scale of investment and the most appropriate means to apply the investment to deliver results.

Option 1: Do nothing

It is standard practice to include a 'do nothing' option in an impact assessment. This allows us to compare costs and benefits with a baseline measure, to allow fair comparison between different options. We have given consideration to the 'do nothing' option. Broadly speaking, this option would mean no initiation of any specific measures over and above the 'status quo'. The NHS would be left to pursue local level improvement in the context of the Operating Framework's requirements and through any organisational-level follow-up of MSA-related survey outcomes. In this scenario, there would be no central monies to act as a catalyst for improvement.

As described above, the do nothing option would not deliver the step-change approach required to develop heightened momentum toward improving privacy and dignity in general and eliminating MSA in particular. This option would mean that approximately one third of patients would continue to express a degree of dissatisfaction with this aspect of care and could leave central leadership on the issue out-of-synch with commitments in the NHS Constitution.

Option 2: Expand use of existing mechanisms, including more rounded guidance

An alternative option to 'do nothing' would be to make greater use of existing flexibilities by issuing more rounded guidance.

This approach does offer some potential advantages:

- It offers scope to provide practical 'backcloth' guidance resources to all stakeholders. These can be adapted for local use as appropriate
- It allows the local NHS to assess and consider MSA issues relating to their local organisations, and to identify what levers are most suited to resolve local issues
- It is low cost, relative to the preferred option described below.
- It is likely that NHS organisations would find means to address some of the required capital investment from within existing funds.

The *disadvantages* are that;

- Two substantial pieces of guidance were published in 2007 [see below]. These have been available to support local improvements for more than a year now. The extent to which this guidance, in conjunction with the Operating Framework, have driven progress at the 'required' pace is questionable. If we accept the premise that the pace of MSA-related improvement must be enhanced, then there is unclear how a guidance-based approach could be relied upon to instigate adequate change.
- Momentum around the Department's '*World Class Commissioning*' initiative has provided a base for improvement, though this key generic initiative is still gaining momentum in terms of it being a conduit for a specific 'push' on MSA-related improvement. It is open to us to use this mechanism to introduce financial levers/penalties, but these would have a long lead-time. In reality, these could not become an established part of the commissioning toolkit until April 2010, and without *additional* measures alongside their development, there is the risk of losing momentum around this area.
- Crucially, this approach would not offer *additional* financial resource to the NHS to address the barriers and 'inadequate means' identified locally.

Guidance documents published in 2007

- "*Privacy and Dignity – A report by the Chief Nursing Officer into Mixed Sex Accommodations in Hospitals*"⁷ (May 2007), published by DH.

- "*Privacy and Dignity: The Elimination of Mixed Sex Accommodation*", published by the NHS Institute for Innovation and Improvement.⁸

Option 3: Broad-based (central) programme approach:

The alternative to do nothing, or issuing of further guidance, is to pursue a broader strategy that actively tackles the problem of mixed sex accommodation. This is approached most easily by using the 'improvement team' approach used in other areas, such as healthcare associated infections (HCAI). There are nuances around the structure of any such programme, and these are explored below, but broadly speaking this option creates a programme of targeted work including allocation of additional funding to the NHS to tackle the problem locally.

The *advantages* of this approach are;

- It would build on the model of the successful Healthcare Associated Infection (HCAI) improvement team, to set strong central direction and support for improvement. It has the advantage of demonstrating clear leadership and high central ambition, and by building on an established team, it can be introduced quickly. The Department's experience in other areas is that this approach is likely to deliver rapid, measurable progress.
- the programme would deliver funding to improve Trusts' infrastructure, hence tackling the obstacles to progress inherent in existing, inadequate facilities.
- The improvement team approach sets out mechanisms for handing over responsibility to local structures as soon as possible. Working in conjunction with the key governance mechanisms, especially the operational steering group and external reference group, (the latter capturing support of SHA Chairs/local 'champions'), which alongside the communications programme will help embed the broad-based programme in the local NHS.
- Since Trusts are at differing baseline points in pursuing improvements, the improvement activity associated with this approach would be *tailored* so as to deliver meaningful support in the context of progress to date and in the face of specific challenges.

There are some disadvantages to this approach, the most obvious being that it has a large cost associated with it. The approach could be seen as being out of line with a devolved NHS that can take forward these objectives without a central 'driver'. It might give an implicit message to NHS managers of a lack of confidence in the NHS's ability to deliver change. Also, it is important that the approach avoids a 'one size fits all' solution.

Variants of option 3

Consideration of the possible disadvantages of option 3 leads us to consider variants, as follows:

Option 3a: A local, SHA centred approach: this approach would require DH to ask each SHA to set up an improvement team, setting them a range of tasks such as inspecting and assessing poorly-performing trusts, advising on refurbishment etc. It would also require them to establish local toolkits, web support and so on. Whilst this tackles the issues around devolved decision making it has substantial drawbacks. It would rely on untested local expertise, and would lead to wide variability in approach. It would be difficult for local team to access national expertise in a co-ordinated way and to spread the learning. This model probably harbours the greatest potential for duplication, as key delivery elements of the approach would inadvertently be duplicated across different SHAs.

Option 3b: A 'hybrid' approach: here, local inspection and improvement teams would be backed up by some central support, including a dedicated website, national toolkits, education and training etc. This however carries some of the drawbacks of (i) above, in that it assumes a high level of local commitment, and we cannot be sure that this exists equally in all areas.

These variants on option 3 are rejected because the costs would be very similar to option 3, but they are simply a less effective means of delivering this option, so the benefits would be reduced. There would be duplication and lack of co-ordination, and the benefits would be lower because the improvement would not be delivered in the most efficient manner. It is clear, even without considering the detailed costs and benefits, that these variants are less cost-effective than the core option 3.

Investment in infrastructure – a key element of cost

The arguments set out above highlight one of the key constraints to delivery of same sex accommodation. The RCN report 'Defending Dignity' describes inadequate means to provide privacy, including basic aspects such as adequate bathrooms, toilets and equipment. There may be other constraints too, for example in the level of training given to staff so they understand how to ensure sex accommodation or management capacity to put in place the appropriate logistics to deliver same sex accommodation.

As this impact assessment is a retrospective analysis of the decision process in this policy area, it is acceptable to draw on evidence that emerged from the implementation process (as long as we do not assume that the preferred policy was the right one).

In designing this programme in late 2008, the Department sought views from NHS experts on how much investment would be required to address the infrastructure challenges. Informal estimates from a range of contacts indicated a figure of around £10m per SHA. This was corroborated later when the Privacy & Dignity fund sought bids from Strategic Health Authorities (SHAs) for funding to address the local challenges and obstacles they faced in delivering privacy and dignity (with a particular emphasis on mixed sex accommodation).

Compilation of these bids involved a careful process of assessment between Trusts and SHAs, together with a formal process of approval of SHA level plans by Department of Health leads. SHA bids initially totalled £118m, for investment between April and June 2009. This amount was reduced to £100m when bids were assessed to remove any unnecessary funding, or areas where it was possible to deliver change within existing funding. This supports the general conclusion that there is a need for around £100m of investment.

From the Privacy and Dignity Fund bids it is possible to estimate where SHA expected Trusts to spend this money, as shown in Table 1, below.

The total figure of £100m provides a good estimate of costs. This is not because the figure was derived from a particular policy approach, but because the figure was derived independently from two separate sources in assessing the scale of investment required.

Table 1: Estimated requirement for investment to deliver privacy and dignity

	Estimated spend (£m) on different aspects of Privacy & Dignity funding
Bathrooms & Washrooms	44.9
Other Building Works	38.4
Partition/Screen	6.6
Staffing	1.8
Comms & Awareness	1.5
Curtains	1.4
Management Processes	1.0
Signs	0.4
Curtains	0.1
Other Equipment	0.9
Other / Support	2.9
Total	100.0

Costs of each option

With this reliable measure of infrastructure and other costs, it is now possible to list all the costs implicit in option 3, the preferred option:

Mobilisation

- Consultancy, admin support and hypothesis testing to define the work: £130k

Raising awareness

- Raising awareness, communications materials: £240k
- Raising awareness, staffing resource for communications: £60k

Identify, develop and spread good practice

- Design council work to apply the methodology used in 'design bugs out' for HCAI improvement teams. The aim is to 'design MSA out' using re-shaping of the physical environment: estimated cost £1m.
- Additional patient surveys to monitor and steer progress: £1m
- Developing tools, spreading best practice, and gathering data and intelligence: £150k
- Additional staffing resource in DH (six months support from 2 staff, plus 2 analysts at £50k for up to 9 months): £400k

Targeted support

- Targeted support for improvement teams, programme management and work stream development: £2,950,000

Investment to improve facilities

- Investment to improve local facilities: £100m, as described above.

Total anticipated cost of option 3: £105.93 million

Costs for the 'variant' options, 3a and 3b, are broadly similar for each option, although the extent to which different organisations (e.g. the Department as opposed to individual SHAs) would bear the costs would vary across the approaches. It is not possible to distinguish the differences in cost between options 3, 3a and 3b, but we do expect that the level of benefit delivered would differ.

The do nothing option would have zero cost, since for comparison purposes we compare it with itself.

Option 2 would incur much lower costs. Some of the items outlined above would also arise under option 2:

- Design council work to apply the methodology used in 'design bugs out' for HCAI improvement teams. The aim is to 'design MSA out' using re-shaping of the physical environment: estimated cost £1m.
- Raising awareness, communications materials: £240k
- We assume that the increased policy focus on same sex accommodation, together with additional guidance and support, would lead the NHS to fund some of the required investment from existing funding. We assume that £20m, or 20%, of the required investment would take place.

Total anticipated cost of option 2: £21.24m

Defining the benefits

The key benefit here is that patients feel that they are treated with respect and dignity, and as part of that do not share mixed sex accommodation unnecessarily. It is difficult to assign an economic value to this benefit, but it is possible to evaluate it by considering the 'quality of life' that a patient has whilst in hospital and translating the impact into quality added life years (QALYs). Assigning a numerical value to QALYs is a complex topic, which has been considered in some detail within Department of Health and elsewhere. A figure of £50k per QALY is typically assumed in impact assessments.

We do not have precise data on the value that patients place on single sex accommodation. We assume that a patient's quality of life is on a scale of 0 to 1, where 0 is equivalent to death and 1 is equivalent to

being in full health and being fully happy and content. We need some way of evaluating on this scale the distress or concern caused by inappropriate sharing of mixed sex accommodation. The EQ-5D quality of life instrument is a questionnaire completed by patients to assess their current state of well being on a scale of 0 to 100. The questionnaire also asks patients a series of questions about pain, mobility, level of anxiety etc. Research by the TOMBOLA group, published in November 2008, examined the relationship between these underlying factors and the overall well being score. It showed that patients recording an anxiety level of 'moderately anxious or depressed' typically had a well being score 5 points lower than those with a level of 'not anxious or depressed'. A score of 'extremely anxious or depressed' impacts by 20 points.

We make the modest assumption that sharing accommodation inappropriately during a stay in hospital would have a similar effect on well being to being 'moderately anxious or depressed' during their stay. This is equivalent to 0.05 on the quality of life score. We assume that this effect only has an impact on those who shared accommodation, and who also 'minded' sharing. This applies to 7.6% of all patients. Further, we make the assumption that any distress or upset caused would have no impact after they leave hospital.

We know, for Hospital Episode Statistics (HES) data that the average length of stay for an inpatient is 5.7 days and there are around 9.6 million admissions per year involving an overnight stay. Figures from the National Patient Survey Programme suggest that 7.6% of patients share accommodation when they are first admitted and minded doing so (and a higher percentage report sharing bathroom or toilet facilities).

This indicates that current mixed sex accommodation 'costs' patients around 570 QALYs per year, a value of around £28.5m per year. Values calculated in QALYs are discounted at a rate of 1.5% per year in an impact assessment. The 'cost' to patients of mixed sex accommodation is therefore calculated at £385.2m over 15 years.

Cost benefit analysis for each option

The costs and benefits of the do nothing option are, by definition, zero, because we evaluate all costs and benefits by comparing them to the do nothing option. However, this option has implicit costs in that it does nothing to address the effects of leaving up to a third of patients dissatisfied with this important aspect of service delivery. It also has potential costs arising from detriment to the health of individual patients who choose not to access healthcare because of anxieties about this issue. We do not attempt to place a monetary value on this issue.

The cost of option 2 is shown above to be £21.24m. We might assume that this has some impact on the degree of sharing. Progress arising from the operating framework commitments suggests there is some scope for modest improvement and this might accelerate given additional guidance and information from the design council, together with additional capital spending from existing NHS resources. The proportion of patients sharing accommodation on first admission might reduce to 20% within a year (and of these, 33% 'mind' sharing). This would mean a gross benefit of around £3.7m per year over the do nothing option – a total benefit of £50.2m NPV over 15 years, and a net benefit of £28.9m NPV over 15 years.

There is no reason to suppose that this benefit would be quickly lost over time, and future patients might also expect to receive a marginally improved service. We therefore assume a benefit of £3.7m each year for a total of fifteen years, discounting this amount at 1.5% per year because it represents the value of benefits defined in QALYs. This produces the total NPV benefit of £50.2m and net benefit of around £28.9m.

Option 2 is therefore strongly preferred to option 1. It has a net benefit of around £28.9m NPV over 10 years. We note also that the ratio of benefits to costs for this option exceeds 2:1.

Option 3, the preferred option, is expected to have a more substantial impact on the proportion of people sharing mixed sex accommodation. The plans submitted by Trusts via their SHAs are aimed at addressing the obstacles and challenges that have existed locally. The level of investment is substantial and involves capital building projects to address fundamental obstacles to delivery of same sex accommodation.

It is sensible to assume, therefore, that this investment will allow an average Trust to progress to the level of the current 10th percentile. For trusts in this category, around 9% of patients share accommodation on first admission. This would imply a benefit to patients of £17.3m per year over the do nothing option. Modelling the benefit over 15 years, as in option 2, gives a total benefit of £234.2m NPV, a net benefit over 'do nothing' of £128.2m NPV.

The preferred approach - establishing a central broad-based programme approach for delivering same-sex accommodation, is of course more expensive than the 'do nothing option', which would not incur any central financial cost.

The centrally- led approach may be the most expensive in pure cost terms, but it delivers sound leadership and drive, built on robust foundation of a proven 'central' programme-based approach. The calculations above show that it also delivers the largest net benefit, with a total net benefit of around £128.2m over 15 years. We note, again, that the ratio of benefits to costs for this options exceeds 2:1.

In addition, a broad-based central approach is likely to facilitate a number of desirable activities (some are informal 'spin-offs') that deliver continued improvement in future, including;

- strategic overview/monitoring of investment in local facilities
- shifting health communities' emphasis to existing mechanisms (e.g. local PALS feedback, complaints monitoring etc), that will assist them in better focusing on the eliminating mixed sex accommodation
- potential for the levering-in of new performance delivery indicators against programme objectives – such as in-year surveys around MSA that build on the annual survey's output
- consider introduction of key elements of a 'board to ward' approach
- potential for liaison with the *Design Council* about developing a programme of work that will identify and develop ways that good design practice can be used to help support its strategy for improving patient privacy and dignity.
- provide basis for 'board to ward' programmes that will to assist in maintaining local emphasis and to pave the way for follow-on arrangements, once the initial period of centrally-led activity concludes.

Conclusion :

In order to provide a platform for all trusts to deliver the established commitment for same-sex accommodation a centrally-led broad-based programme approach is calculated as being the most effective approach because;

- it builds on the model of the successful HCAI improvement team, to set strong central direction and support for improvement. It has the advantage of demonstrating clear leadership and high ambition, and can be introduced quickly. Our experience in other areas (eg HCAI) is that this approach is likely to deliver rapid, measurable progress.
- it sets out mechanisms for handing over responsibility to local structures as soon as possible. Working in conjunction with the key governance mechanisms likely to focus on operational aspects, internal governance and on key operational issues, plus benefits from a strategic communications approach that will establish the programme's objectives with the NHS.
- Whilst costs are high, relative to other options, the benefits outweigh the costs. It is the most cost-effective option.

Delivery via a broad-based central programme that would gain and maintain national momentum, would use an approach similar to the one adopted by DH to tackle Healthcare Associated Infections Improvement. This will support the local NHS in better focusing upon and making significant improvements to levels of MSA, meeting patient expectations and those likely to be found in the (forthcoming NHS Constitution).

Risks

The key risk is that the programme fails to deliver improvement in mixed sex accommodation from the point of view of the patient, and hence fails to deliver the measurable benefits described. This risk is mitigated by focussing measurement and management of the programme on patient-reported measures of success. The benefits themselves are defined in terms of the percentage of patients who report

sharing on first admission. We make modest assumptions about the extent to which this percentage might change.

Sensitivities

This analysis is underpinned by some implicit assumptions, as follows:

- The programme is able to demonstrate significant improvement in reducing MSA
- the NHS will adopt and maintain a heightened level of focus on this area beyond the conclusion of the initial period of intensive activities.
- the programme will be able to overcome the beliefs that occasionally come forward from some quarters that mixed sex accommodation MSA stems from busy hospital environments and is virtually inevitable
- ultimately, determination as to what constitutes any clinically acceptable instance of MSA will stem from local interpretation/decision-making, (in the context of national-level guidance).

The key sensitivity in the calculations is the extent to which capital investment in infrastructure can impact on patient perceptions of whether or not they share mixed sex accommodation. We start from a position in which 23% of patients report sharing on first admission. Previous figures suggest that progress in reducing this figure has been very slow, no more than 1% reduction per year. Under option 2 we assume this figure falls to 20% within a year. It is reasonable to assume a range of 19%-21%. For option 3, we assume that the average falls to the current 10th percentile value of 9%. If infrastructure is the main obstacle, it is possible that the percentage could fall further, to say 7%, but it is more likely that progress could fall short of this and, perhaps delivering only 15%.

These figures allow us to calculate a benefit range for options 2 and 3 as follows:

Option 2: central estimate of net benefit: £28.9m NPV Range: £12.2m to £45.7m

Option 3: Central estimate: £128.2m Range: £27.9m to £161.7m

Environmental impact

For this IA it is important to consider greenhouse gas emissions, given the substantial programme of building work proposed under option 3. Estimating levels of carbon emissions arising from building work is not easy, but a paper by Seongwon Seo entitled 'Estimation of CO₂ emissions in life cycle of residential buildings' estimates the CO₂ cost of building processes to be in the range 38-62 Kg-CO₂/ m² for different types of building.

The preferred option includes up to £100m of building work. Typical building costs for small scale domestic projects such as extensions average around £1000 per m². This implies that the building work is equivalent to that required to produce 100,000m² of space. This suggests 3800 to 6200 tonnes of CO₂ and we typically assume a value of £50 per tonne. This gives a total carbon cost of £190k - £310k. This is small, relative to the scale of costs and benefits in this programme.

Equality impact assessment

A full equality impact assessment is attached at annex 3

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	No	Yes
Small Firms Impact Test	No	Yes
Legal Aid	No	Yes
Sustainable Development	Yes	No
Carbon Assessment	Yes	No
Other Environment	Yes	No
Health Impact Assessment	No	Yes
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	No	Yes
Rural Proofing	No	Yes