Provision of Same-Sex Accommodation Policy

Version No: 2

Document Summary:

- Same-sex accommodation will be provided, except where it is in the best interests of the patient or reflects their personal preference
- A breach occurs at the point a patient is admitted to mixed sex accommodation outside of the terms of this policy
- An Inphase incident report must be completed for all same-sex breaches including clinically justified mixing
- Non-compliance or breaches are mandated to be reported nationally via the Strategic Data Collection System (SDCS)

Document status	Approved	
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Review date	***3 years from approval date** **06/05/2029**	
Accountable Director	Chief Nurse	
Policy Author	Deputy Director of Governance -Quality and Patient Experience	
Target audience	All staff	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments

Document Control

[Author to complete all sections apart from Section 4 & 5]

Section 1 – Document Information		
Title	Provision of Same-sex Accommodation Policy	
Directorate	Quality & Risk	
Brief Description of amendments		
Reviewed with EDI team and PEC members and transferred into MWL template		
Does the document follow the Trust agreed format?		Yes
Are all mandatory headings complete?		Yes
Does the document outline clearly the monitoring compliance and performance management?		Yes
Equality Analysis completed?		Yes
Data Protection Impact Analysis completed?		Yes

Section 2 – Consultation Information* *Please remember to consult with all services provided by the Trust, including Community & Primary Care			
Consultation Completed	☒ Trust wide ☐ Local ☐ Specific staff group		
Consultation start date	Click here to enter a date.	**Consultation end date**	Click here to enter a date.

Section 3 – Version Control		
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1	05/04/2023	
2	06/05/2026	Reviewed against National guidance-copy of breach reporting tool removed.
	Click here to enter a date.	
	Click here to enter a date.	

Section 4 – Approval – *To be completed by Document Control*			
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Assurance provided by author & Chair	☐ Minutes of meeting ☐ E-mail with Chair's approval		
Date approved	06/05/2026	**Review date**	06/05/2029

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1. Scope

This policy applies to all staff working for or on behalf of the Trust. It relates to all ward areas and departments accommodating inpatients with the requirement to promote the privacy and dignity of all patients, including working towards the principles of same-sex accommodation in specialised and urgent care areas, where possible.

Breaches will be declared in a timely way as soon as a patient is admitted into a bay of other sex patients and will include all affected patients, i.e. those within the bay.

Note: In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff must take advice from their manager and take all possible actions to maintain ongoing patient and staff safety, including same-sex accommodation as far as is reasonably practicable.

2. Introduction

Patient safety and patient experience are of primary importance in delivering high-quality care. Every patient has the right to receive high quality care that is safe, effective and respects his or her privacy and dignity. The Trust is committed to providing every patient with same-sex accommodation, to safeguard their privacy and dignity when they may be at their most vulnerable. The development of this policy is supported by guidance derived from national best practice. The primary guidance includes the following:

- Delivering same-sex accommodation (September 2019) NHS England and NHS Improvement, noting: Following the ruling from the Supreme Court in the For Women Scotland Ltd (Appellant) v The Scottish Ministers (Respondent) case published 16 April 2025, **our Delivering same-sex accommodation guidance, published in 2019, is currently being reviewed**.
- The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital and contains a pledge that if admitted to hospital patients will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution.
- The Chief Nursing Officer's report on privacy and dignity (2007) identifies same-sex accommodation as a 'visible affirmation' of the NHS's commitment to privacy and dignity.
- High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organise care around the individual, 'not just clinically but in terms of dignity and respect'.

The Trust's current declaration is displayed on the Trust website (patients and Visitors/Information for Patients section)

3. Statement of intent

The Trust is committed to providing same-sex accommodation wherever clinically appropriate and to maintaining patients', carers' and family's privacy and dignity in line with the standards identified in this policy.

4. Definitions

Term/Abbreviation	Definition/meaning
Breach	A breach occurs at the point a patient is admitted to mixed-sex accommodation outside of the terms of this policy.
Classification of breaches	• The Operating Framework for 2012-2013 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. Prior to any possible mixing occurring, patients must be informed and given an alternative • The collection of monthly breaches to same-sex accommodation guidance was introduced from 1 December 2010 and reporting became mandatory in April 2011. NHS organisations submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation. The collection enables the analysis and publication of consistently defined data to allow patients and members of public to understand the extent to which breaches are occurring in individual organisations • From 1 April 2011, if the patient occupies a bed space that does not have access to same sex washing and toileting facilities, this also classifies as a breach, which must be reported locally, via our commissioners • Organisations providing NHS-funded care must agree with their commissioners how they will determine whether a particular episode of mixed sleeping accommodation is justified (and therefore not in breach of guidance) • A small number of patients may actively choose to share with others of the same age or clinical condition, rather than gender. Particular groups include children and those patients' receiving haemodialysis. This is explained in detail later in this policy There are some circumstances where mixing can be clinically justified and therefore do not need to be reported nationally. These are few and mainly relate to patients who require specialised care, for example, critical care units.

Failure to deliver same sex accommodation	• 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. **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.
Strategic Data Collection System (SDCS)	SCDS is an online collection system used for collating, sharing and reporting NHS and social care data.

5. Duties, Accountabilities and Responsibilities

5.1 Chief Executive

The Chief Executive has overall responsibility for the strategic and operational management of the Trust including and ensuring that this Trust policy complies with all legal, statutory and good practice guidance requirements.

5.2 Chief Nursing Officer

The Chief Nursing Officer has delegated responsibility for ensuring this policy is implemented effectively across the Trust. Moreover, they are responsible and accountable for providing the Board of Directors with assurance reports of compliance and exception reports where instances of non-compliance occur.

5.3 Divisional Director of Operations (DDO) and Divisional Medical Director (DMD)/Associate Medical Directors (AMD)

The DDO and DMD/AMD have operational accountability for ensuring the effective implementation and for monitoring compliance of this policy.

5.4 Divisional Directors of Nursing/Midwifery/Allied Health Professionals and Scientists

The Divisional Directors of Nursing/Midwifery/Allied Health Professionals and Scientists will monitor compliance with this policy. Where there are areas of concern, direction will be given for remedial action including root cause analysis to ensure delivery of same-sex accommodation.

5.5 Senior Management Team (Directorate Managers/Heads of Department) & Clinical Directors

It is the responsibility of the Senior Management Teams and Clinical Directors to ensure that all staff within their areas of responsibility understand the importance of this policy and implement it accordingly as part of the appraisal process. Also, they are responsible for ensuring all incidents are reported including root cause analysis where required.

5.6 Operational Site Managers/Clinical Co-ordinator

The Operational Site Managers/Clinical Co-Ordinator's are responsible for the coordination of same-sex accommodation for patients.

The team must ensure that patient administration system is accurately kept up to date, ensuring each patient is always allocated to his or her bed and bay, in real time, on the computer system.

5.6 Matrons

Matrons are responsible for advising and instructing staff on the policy requirements via local induction arrangements and ongoing communication mechanisms, such as staff meetings, supervision etc. In addition, they are responsible for monitoring and acting on completed incidents reported in line with the processes described in this policy.

5.7 Corporate Information Team/Business Intelligence Team

The Corporate Information Team/Business Intelligence team will collate and analyse all incidents of breaches of same-sex accommodation as described in this policy document. Moreover, the Team is responsible for reporting breaches via national reporting system, Strategic Data Collection System (SDCS) on behalf of the Trust.

5.8 All staff

All Trust employees will comply with the processes described in this policy. In instances where there is non-compliance an incident report will be completed in line with the Trust incident reporting policy inclusive of serious incident management.

5.9 Trust Board

The Board of Directors are responsible for monitoring compliance with this policy. The Directors will receive a monthly report by exception. In addition, the Board of Directors will receive an annual report on compliance and approve the annual self-certification. The Board will ensure the approved certificate is submitted to the commissioners annually.

5.10 Divisional Business Unit Governance Groups

The Divisional Business Units governance processes will monitor monthly exception reports including associated root cause analysis reports and action plans where relevant. The report will be cascaded to specialty meetings to ensure lessons are learned.

5.11 Estates staff are responsible for:

- Ensuring the delivery of same-sex accommodation is integral to building design
- Any re-design or refurbishment of patient areas must include the involvement and sign-off of the Trust lead.
- Supporting clinical staff in the management of facilities and signage to promote same- sex accommodation.

6. Same sex breaches process

6.1 Areas out of scope

The requirement to provide same-sex accommodation does not apply to:

- All units where a patient is referred directly for assessment, treatment or observation 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
- Emergency departments.

6.2 Clinical justification for mixed sex accommodation

There are times when the need to treat and admit can override the need for complete segregation, however privacy and dignity must be maintained wherever the patient is receiving care. The risks of clinical deterioration associated with moving patients to same-sex accommodation must be taken into consideration. This might apply, for instance, with:

- A patient needing high-tech care with one-to-one nursing, e.g. Critical Care Units (CCU) (See Appendix 1: Critical Care settings key principles)
- A patient needing very specialised care, where one nurse might be caring for small number of patients
- Due to patient choice (see also Appendix 2 regarding children's units key principles, Appendix 3 regarding day treatment areas and Appendix 4 regarding transgender patients)
- A patient needing very urgent care, e.g. rapid admission following heart attack (see Appendix 5 emergency admissions key principles)

Where mixed sex accommodation does occur, it must be justifiable for ***all*** the patients affected. There are no blanket exemptions for particular specialties and no exemptions at all from the need to provide high standards of privacy and dignity at all times.

Once a patient is deemed to no longer require CCU Level 2/3 care or other justified mixed-sex care the Trust will ensure the patient is **transferred within 4 hours**. In circumstances where there is clinical justification, the mixed-sex occurrence reporting procedure will still be followed. Please note that for the comfort and safety of patients, transfers should not take place between the hours of 10 pm and 7 am and, therefore, breaches should not be counted within this time period, for the purposes of transferring within 4 hours.

Please refer to Appendix 6 for the list of justified breaches and a decision matrix.

6.3 Unacceptable justification for mixed sex accommodation

- Placing a patient in mixed sex accommodation for the convenience of medical and/or nursing staff or from a desire to group patients in a clinical specialty. It is not acceptable to mix sexes purely on a basis of clinical specialism, 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 predictable non-clinical incident e.g. ward closure
- Placing a patient in mixed sex accommodation for regular but not constant observation

6.4 Mixed sex occurrence procedure

Appendix 7 contains the staff decision tree for ensuring patients are allocated same-sex accommodation wherever possible. In the event of a mixed-sex occurrence, including those with clinical justifications the following procedure will be followed. In all cases staff will escalate the breach in accordance with the procedure contained in Appendix 8 and follow the steps below:

- Explain and apologise to all patients and carers affected for every episode of mixing, explaining the reason for the breach and an indication of when it will be resolved
- Record the discussion in the patient's health records
- Review the impact on all patients involved and any potential ongoing risks remain identified on the Trusts InPhase risk register.
- Not enter enclosed curtains unannounced
- Ask patients how they wish to be addressed including the name and pronouns they currently use.
- Give extra personal nursing support to patients in mixed bays, for example: use a separate quiet room for personal conversations

- Avoid giving personal care (e.g. toileting) in the bay where possible – dependent upon clinical condition
- Allocate extra nursing time to patients who may require it based on assessment for enhanced care needs.
- Move beds around in a bay to ensure that the new patient (attributable to the breach) is closest to the bay exit and therefore the bathroom and toilet facilities.
- Keep the bedside curtains partially drawn at all times if clinically safe to do so.

Whenever a patient is admitted to a mixed sex area, it should be on the understanding that this will be temporary, with every effort made to move to same-sex accommodation as soon as possible. As soon as an appropriate bed is available in a same-sex bay or side room the patient should be offered the opportunity to move.

6.5 Incident recording & reporting & escalation

- An incident report via InPhase must be completed for all same-sex breaches including clinically justified mixing.
- If a decision to mix is taken and not clinically justified, this will be identified as a breach and subject to financial penalty.
- At ward-level a mixed-sex occurrence breach report must be completed (refer to Appendix 9), to include:
- Identification of the clinical area.
- The number of patients affected.
- The type of mixed-sex occurrence (bed location, location of bathrooms or toilets).
- Reason for the occurrence (e.g. clinical justification, patient choice, capacity).
- The completed form must be sent to Submissions@merseywestlancs.nhs.uk who will collate and analyse the incidences.

- If a patient has been a clinically justified breach but their clinical condition no longer requires that level of increased clinical support and the patient remains in a mixed area, then they become a non-clinically justified breach. This must be urgently escalated to the relevant Operational Site Manager/Clinical Coordinator and every effort made to move the patient to same-sex accommodation within 4 hours.
- To aid the investigation and analysis of mixed-sex occurrences, the Trust Root Cause Analysis Tool will be used where clusters of mixing occur and/or where further investigations and action is needed and/or as requested by the commissioner.
- The incident report upload via InPhase will automatically generate an alert email to the CEO and Executive Team. In addition, senior managers in the Trust will receive an email alert to ensure timely action is instigated.
- SDCS: Non-compliance or breaches are required to be reported nationally via SDCS, to the Commissioners and to provide assurance with PLACE (Patient Led Assessment of the Care Environment) and the Care Quality Commissions requirements.

7. Training

There is no specific training attached to this policy. However, staff are expected to be familiar with the policy content and discuss through line management responsibilities.

What aspect/s of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Statutory & Mandatory Training Policy?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
Sections 5 & 6	All staff involved in the provision of direct patient care and their line managers	No	Local induction	Line manager	On induction	Line manager
Sections 5 & 6	Corporate information /Business Intelligence	No	Local induction	Line manager	On induction	Line manager

8. Monitoring Compliance

8.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1.	Incidents of same sex breaches
2.	Root cause analysis completed on non-justifiable breaches
3.	Published annual declaration

8.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Mixing will only occur by exception for reasons of clinical justification or patient choice	Chief Nursing Officer, Divisional Directors/Deputy Divisional Directors of Nursing/Midwifery/Allied Health Professionals and Health Care Scientists.	Exception reports	Monthly	Divisional Governance Groups	Chief Nursing Officer, Divisional Directors/Deputy Divisional Directors of Nursing/Midwifery/Allied Health Professionals and Health Care Scientists.
When breaches occur, the reporting process to investigate the reason, take prompt action and take remedial steps as required to prevent future occurrence are followed as described in this policy (Section 6)	Assistant Director of Patient Safety	Incident Report including RCA reports and associated action plan	Monthly	Patient Safety Council	Chief Nursing Officer, Divisional Directors/Deputy Divisional Directors of Nursing/Midwifery/Allied Health Professionals and Health Care Scientists.
Published annual declaration	Chief Nursing Officer	Completed declaration	Annual	Board of Directors	Chief Nursing Officer

9. References/Bibliography/Relevant Legislation/National Guidelines

No	Reference
1.	Department of Health (2009) NHS Single Sex standards DH, London
2.	Department of Health (2009) Eliminating Mixed Sex Accommodation. DH, London
3.	Department of Health (2009) Delivering same-sex accommodation in day treatment areas, Annex B. DH, London
4	Department of Health (2009) Delivering same-sex accommodation for trans people and gender variant children, Annex E. DH, London
5	Mixed Sex Accommodation Guidelines under HSC 1998/143, 2007
6	Department of Health (2010) Delivering same-sex accommodation: self-declaration DH, London
7	Department of Health (2007) Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals DH, London
8	Department of Health (2008) High quality care for all: NHS Next Stage Review final report DH, London
9	Department of Health (2009) The NHS Constitution: securing the NHS today for generations to come DH, London.
10	DH / NPSA (2009) Action on mixed-sex accommodation root cause analysis tool Gateway ref: 11872 Department of Health, London
11	Eliminating Mixed-Sex Accommodation. From the Chief Nursing Officer and Deputy NHS Chief Executive. (10 February 2011).
12	CQC Brief guide: Assessment of same-sex accommodation (May 2015)
13	NHS England and NHS Improvement: Delivering same-sex accommodation (September 2019)-Updated April 2025 to advise remains under review.
14	Government Equalities Office (2015) Providing services for transgender customers

10. Related Trust Documents

[List any procedural documents which are referenced within the text.]

No	Related Document
1	Risk Management Framework -PD2125
2	Incident Reporting and Management Policy -PD2694
3.	Caring for transgender patients policy-PD0593

11. Equality Impact Assessment (EIA) Screening Tool

The EIA screening must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the beginning of the planning stage of any change process. Where the screening identifies that a full EIA needs to be completed, please use the full EIA template.

The completed EIA screening form must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to PatientEDI@ merseywestlancs.nhs.uk for monitoring purpose for EIAs carried out on patient related functions.
If the assessment is related to workforce a copy should be sent to workforceedi@ merseywestlancs.nhs.uk

If this screening assessment indicates that discrimination could potentially be introduced, then seek advice from the Head of Patient Experience and Inclusion via cheryl.farmer@ merseywestlancs.nhs.uk for patient related functions or Head of Workforce Equality Diversity and Inclusion via darren.mooney@ merseywestlancs.nhs.uk for workforce related functions.

A full equality impact assessment must be considered on any cost improvement schemes, organisational changes or service changes that could have an impact on patients or staff.

Title of function	Same sex accommodation policy
Brief description of function to be assessed	This policy applies to all staff working for or on behalf of the Trust. It relates to all ward areas and departments accommodating inpatients with the requirement to promote the privacy and dignity of all patients, including working towards the principles of same-sex accommodation in specialised and urgent care areas, where possible.
Date of assessment	12/03/26
Lead Executive Director	Chief Nursing Officer
Name of assessor	Cheryl Farmer
Job title of assessor	Head of Patient EDI and experience

1. Equality, Diversity & Inclusion

Does the policy/proposal:
1) Have the potential to discriminate against equality groups or people in inclusion health groups
2) Promote equality of opportunity, or foster good relations between those who share a protected characteristic and those who don't?
3 Where there is potential unlawful discrimination, is this justifiable?

Please tick the relevant box

	Positive impact	Negative impact	No impact	Justification/ evidence
Age			x	See appendix 2 for guidance
Disability			x	
Gender reassignment			x	See appendix 4 for guidance
Pregnancy or maternity			x	
Race			x	Religious and cultural needs of patients will always be taken into consideration wherever clinically appropriate
Religion or belief			x	Religious and cultural needs of patients will always be taken into consideration wherever clinically appropriate
Sex			x	Aim is to provide same sex accommodation wherever clinically appropriate
Sexual orientation			x	Aim is to provide same sex accommodation wherever clinically appropriate

2. Human Rights

Does the policy/proposal breach the Human Rights of individuals or groups?

	Yes	No	Justification/ evidence
Right to life		x	
Inhumane treatment		x	
Liberty		x	
Privacy/family life, home and correspondence		x	
Thought/conscience		x	
Freedom of expression		x	
Right to a fair trial		x	

3. Health Inequalities

Is there potential that the policy/proposal could have a negative impact on inclusion health groups? Is the policy/proposal addressing health inequalities? Where there are potential unlawful impacts are they justifiable.

	Positive Impact	Negative Impact	No impact	Justification/ evidence and data source
Deprived Populations			x	
Inclusion health groups			x	

4. Sign off

Name of approving manager	Carol Fowler
Job title of approving manager	Deputy Director of Governance
Date approved	12/03/26

5. EIA Action Plan

Recommendations	Actions Required	Resources required /costs	Timeframe	Lead officer responsible

Please forward an electronic copy of this action plan with the completed assessment to Cheryl.farmer@ merseywestlancs.nhs.uk for patient related assessments or equality&diversity@merseywestlancs.nhs.uk for workforce related assessments for monitoring purposes.

12. Data Protection Impact Assessment Screening Tool

If you answer **YES or UNSURE** to any of the questions below a full Data Protection Impact Assessment will need to be completed in line with Trust policy.

	Yes	No	Unsure	**Comments -** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
Is the information about individuals likely to raise privacy concerns or expectations e.g. health records, criminal records or other information people would consider particularly private?		No		
Will the procedural document lead to the collection of new information about individuals?		No		
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No		
Will the implementation of the procedural document require you to contact individuals in ways which they may find intrusive?		No		
Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		No		
Does the procedural document involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		No		
Will the procedural document result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		No		
Will the implementation of the procedural document compel individuals to provide information about themselves?		No		

Sign off if no requirement to continue with Data Protection Impact Assessment:
Confirmation that the responses to the above questions are all NO and therefore there is no requirement to continue with the Data Protection Impact Assessment

Policy author **Cheryl Farmer/Carol Fowler** **Date 12/03/26**

Appendix 1 – Critical Care Units

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. However, this does not mean that no attempt at segregation should be made. At the very least, staff should consider whether it is possible to improve segregation. In new units, 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 being transferred to a ward. While 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.

Key principles

- Decisions should be based on the needs of the individual patient while 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, carers or loved ones.
- For critical care only when a patient is:
    - Declared ready for discharge
    - AND is downgraded to Level 1 (patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team).
    - AND is in a mixed gender area they will be considered at risk of breaching.
    - If they are not in mixed gender area this is not breaching.

In the event that a patient who is fit for transfer to a base ward, is in a critical care or theatre recovery area without clinical justification, this is defined as a same-sex accommodation breach and must be reported under the breach process

Adapted from DH 2009a Annex C

Appendix 2 - Children's Units

For many children and young people, clinical need and age and stage of development may take precedence over gender considerations. Mixing of the sexes may be wholly reasonable and even preferred. There is evidence that many young people find great comfort from sharing with others of their own age and that this often outweighs their concerns about mixed sex rooms. Washing and toilet 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).

Staff must 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 interests of each patient. It is not acceptable to apply a blanket approach that assumes mixing is always excusable. 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.

Parents

Parents are often 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 for patients.

Key principles

- Privacy and dignity are an important aspect of care for children 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 and dignity should be maintained whenever children and young people's modesty may be compromised (e.g. 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.

Taken from DH, 2009a Annex D

Appendix 3 – Day treatment areas

Day treatment areas include:

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

Staff in these areas will need to make decisions on a day-to-day basis. 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. For example, 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.

The presumption of same-sex accommodation will apply in day surgery units, especially those where patients may remain overnight. The exception might be where very minor procedures are being undertaken. 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.

Key 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 (e.g. 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 if the person is vulnerable or lacks capacity).
- Patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives, carers or loved ones.

Taken from DH, 2009a Annex B

Appendix 4 – Transgender equality

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-centered, 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

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.

Taken from Delivering same-sex accommodation (September 2019) NHS England and NHS Improvement.

Following the ruling from the Supreme Court in the *For Women Scotland Ltd (Appellant) v The Scottish Ministers (Respondent)* case published 16 April 2025, our Delivering same-sex accommodation guidance, published in 2019, is currently being reviewed.

All providers of NHS-funded care continue to be expected to provide high quality care that meets all patients' clinical needs, safeguards them from the risk of harm and ensures their privacy and dignity when they are admitted to hospital.

Providers should continue to measure and report breaches of the NHS Constitution pledge on same sex accommodation.

Revised guidance which supports privacy, dignity and safety for all patients in hospital accommodation will be published as soon as possible.

Appendix 5 – Emergency admissions

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

Where patients cannot be immediately admitted to the 'right bed' (i.e. 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, and this must be documented in each patient's record.

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.

Key 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 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 their 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 (e.g. 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 as soon as possible. Only in the most exceptional circumstances should this exceed 24 hours.

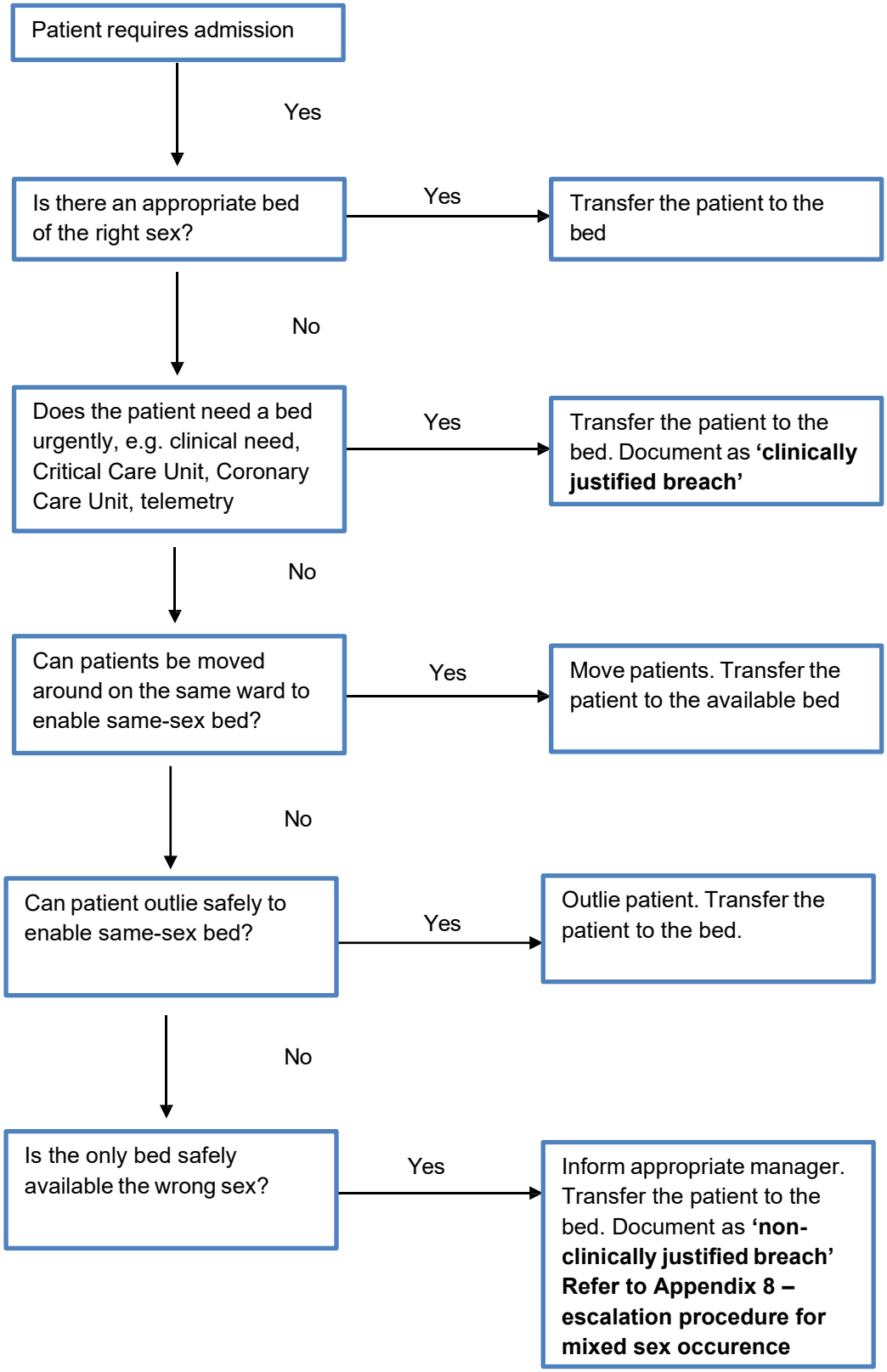
Taken from DH, 2009a Annex A

Appendix 6 - Decision matrix

Area	Justified breach	Notes
Critical care levels 2 and 3: e.g. intensive care unit/coronary care units/high dependency units/hyper acute stroke units	Green - almost always	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. For the comfort and safety of patients, transfers should not take place between the hours of 10 pm and 7.00am. Breaches should not be counted within this period, they should start/restart from 7.00am.
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, e.g. medical/ surgical assessment units/clinical decision-making units/observation wards	Green - almost always	A patient should be moved from an assessment or 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, e.g. 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 in young people's units (including neonates)	Amber - sometimes	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, e.g. day surgery/ endoscopy units/recovery units	Red – almost never	Segregation should be provided where patients' modesty may be compromised, e.g. 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

attached to theatres/ procedure rooms		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.

Appendix 7 – Staff decision tree for patient same-sex accommodation



Appendix 8– Escalation procedure for mixed sex occurrence

