East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST WIDE DOCUMENT

	Policy
DOCUMENT TITLE:	**Eliminating Mixed Sex Accommodation (EMSA) Policy**
DOCUMENT NUMBER:	**ELHT/C107 Version 1.8**
DOCUMENT REPLACES	**Version 1.7**
LEAD EXECUTIVE DIRECTOR DGM	**Executive Director of Nursing**
AUTHOR(S):	**Head of Patient Flow**

TARGET AUDIENCE:	All Trust Personnel
DOCUMENT PURPOSE:	To identify the organisation's policy on Mixed Sex Accommodation and the process to be followed in the event of a breach of the policy
To be read in conjunction with	

SUPPORTING REFERENCES	**DH (2007)** *Privacy & Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals* DH, London **DH (2009a)** *CNO letter – Eliminating Mixed-Sex accommodation* DH, London **DH (2009b)** *Delivering same-sex accommodation – principles* DH. London **DH (2009c)** *Delivering Same-Sex Accommodation in Mental Health and Learning Disabilities* DH, London **DH (2009d)** *The Operating Framework for the NHS in England 2010/2011* DH, London **DH (2009e)** *The Story So Far: Delivering Same-Sex Accommodation – A Progress Report December 2009* DH, London **DH (2010a)** *Guidance on the NHS standard contract for Acute Hospital Services 2010/2011* DH, London **DH (2010b)** *The NHS Standard Contract for Acute Hospital Services 2010/11* DH, London **DH (2010c)** *Letter – Delivering Same-Sex Accommodation – Self-Declaration* Gateway ref: 13530, DH, London **DH / NPSA (2009)** *Action on mixed-sex accommodation root cause analysis tool* Gateway ref: 11872 Department of Health, London **Ipsos MORI for DH (2008)** *Public Perceptions of Privacy & Dignity in Hospitals* DH, London **NHS for England (2009)** *The NHS Constitution* DH, London **Picker Institute Europe (2003)** *Improving Patient's Experience Issue 4 Feb 2003* Picker Institute Europe, Oxford **Supporting Information** DH "Dignity in Care" Network: http://www.dhcarenetworks.org.uk/dignityinc are/ DH Same-sex accommodation webpage: http://www.dh.gov.uk/en/Healthcare/Samesexaccommodation/index.htm NHS Institute for Innovation and Improvement Eliminating Mixed Sex accommodation Good practice guidance and checklist: http://www.institute.nhs.uk/quality_and_value/introduction/privacy_and_dignity.html RCN Dignity campaign homepage: http://www.rcn.org.uk/newsevents/campaigns/dignity **CQC Standards Guidance - Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 http://www.cqc.org.uk/content/regulation-10-dignity-and-respect#guidance** **NHS England and Improvement; Delivering same-sex accommodation. September 2019**

CONSULTATION		
	Committee/Group	**Date**
Consultation	Chief Nurse Head of Patient Safety Corporate Head of Nursing Head of Patient Flow	March 2021
Approval Committee	Senior Leadership Group Nursing & Midwifery Forum	March 2021
Document ratification date:	21/06/2024	
NEXT REVIEW DATE:	May 2026	
AMENDMENTS:	New title - Eliminating Mixed Sex Accommodation (EMSA) policy. Amendments December 2019 to align with updated NHS England and Improvement guidance.	

	Appendix 1 is now incorporated into a Datix and therefore supersedes the need for a paper form to be sent June 2021

Contents

1 Introduction

In line with the NHS Operating Framework 2010/11 and updated guidance in Delivering Same Sex Accommodation, September 2019 (NHS England and Improvement), our organisation (East Lancashire Hospital NHS Trust, ELHT) and NHS East Lancashire/NHS Blackburn with Darwen are committed to improving the quality of patient experience.

We have a zero-tolerance approach to mixed-sex accommodation. This policy and procedure aim to enable us to monitor when mixing occurs and continue to improve our delivery of clean, safe care with privacy and dignity.

We have the necessary facilities, resources, and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in the Intensive Care Unit), or when patients actively choose to share, or when it is in the overall best interest of all the patients affected.

Our ESSA self-declaration (Appendix 10) as required under the NHS contract, indicates that we are compliant. The declaration can be found on the Trust website (http://www.elht.nhs.uk/index.php/aboutus/203/)

2 Definition of mixed sex occurrence

The placement of a patient within a clinical setting following admission, where one or more of the following criteria apply:

a. The patient occupies a bed space that is either next to or directly opposite a member of the opposite gender.

b. The patient occupies a bed space that does not have access to single-sex washing and toileting facilities.

c. The patient must pass through an area designated for occupation by members of the opposite sex to gain access to washing and toileting facilities.

3 Scope

The definition of mixed-sex occurrences will apply:

a. Following admission.
b. At all points on a patient's in-patient pathway
c. Day case units, including endoscopy.
d. Areas where a person is required to disrobe, such as x-ray departments.
e. In all clinical areas where patients are admitted. This includes:

- Accident & Emergency
- Clinical Decision Units
- Medical Assessment Units
- Surgical Assessment Units
- High Dependency Units
- Intensive Treatment Units

4 Clinical Justification

There are times when the need to treat and admit can override the need for complete segregation. This might apply, for instance, with:

- A patient needing high-tech care with one-to-one nursing, e.g., ICU, HDU. (See Appendix 7: Critical Care settings key principles)
- A patient needing very specialised care, where one nurse might be caring for a small number of patients (see also Appendix 8 regarding children's unit's key principles)
- A patient needing very urgent care, e.g., rapid admission following heart attack. (See Appendix 4 Emergency admissions key principles)

Where mixing 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.

In circumstances where there is clinical justification, the mixed-sex occurrence reporting procedure must still be followed.

5 Mixed-sex occurrence procedure

In the event of a mixed-sex occurrence, including those with clinical justification, the following procedure will be followed. In all cases, for each patient affected, staff must:

- Explain the reasons for mixing with the patient and / or their relatives, carers or loved ones.
- Record the discussion in the medical record.
- Review the impact on all patients involved.
- Use the recording and reporting process.
- Move the person to same-sex accommodation as soon as possible.

5.1 Recording & reporting

Clinical Flow Team Lead to complete an incident form and breach report (appendix 1) must be completed, 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)

A Datix incident form should be completed see Appendix 1 for screenshot.
Escalation of breach in hours and out of hours (Appendix 2)

5.2 Root Cause Analysis

To aid the investigation and analysis of mixed-sex occurrences, the DH / NPSA Root Cause Analysis tool (DH / NPSA 2009, NHS E&I, 2019) will be used on every confirmed breach.

5.3 Board reporting

The Quality Committee Patient Safety Report will include an exception report of any confirmed breaches to be received at Trust wide Quality Governance Meeting with other data sources (e.g., Customer Care complaints, capacity & flow, patient survey) will be a routine part of the analysis and subsequent action planning for patient experience monitoring.

5.4 Contract monitoring and assurance process.

Single Sex Accommodation data, including all breach reports, will be captured, and reported to the coordinating commissioner via the Clinical Quality Performance monitoring process. This will be reviewed as part of the contract monitoring process.

Under the contract the Trust is also required to have:

1. A EMSA Self-declaration, which is published on the website.
2. A DSSA plan (completed)
3. A Remedial Action Plan if Quality Requirement is breached or Nationally Specified Event occurs.

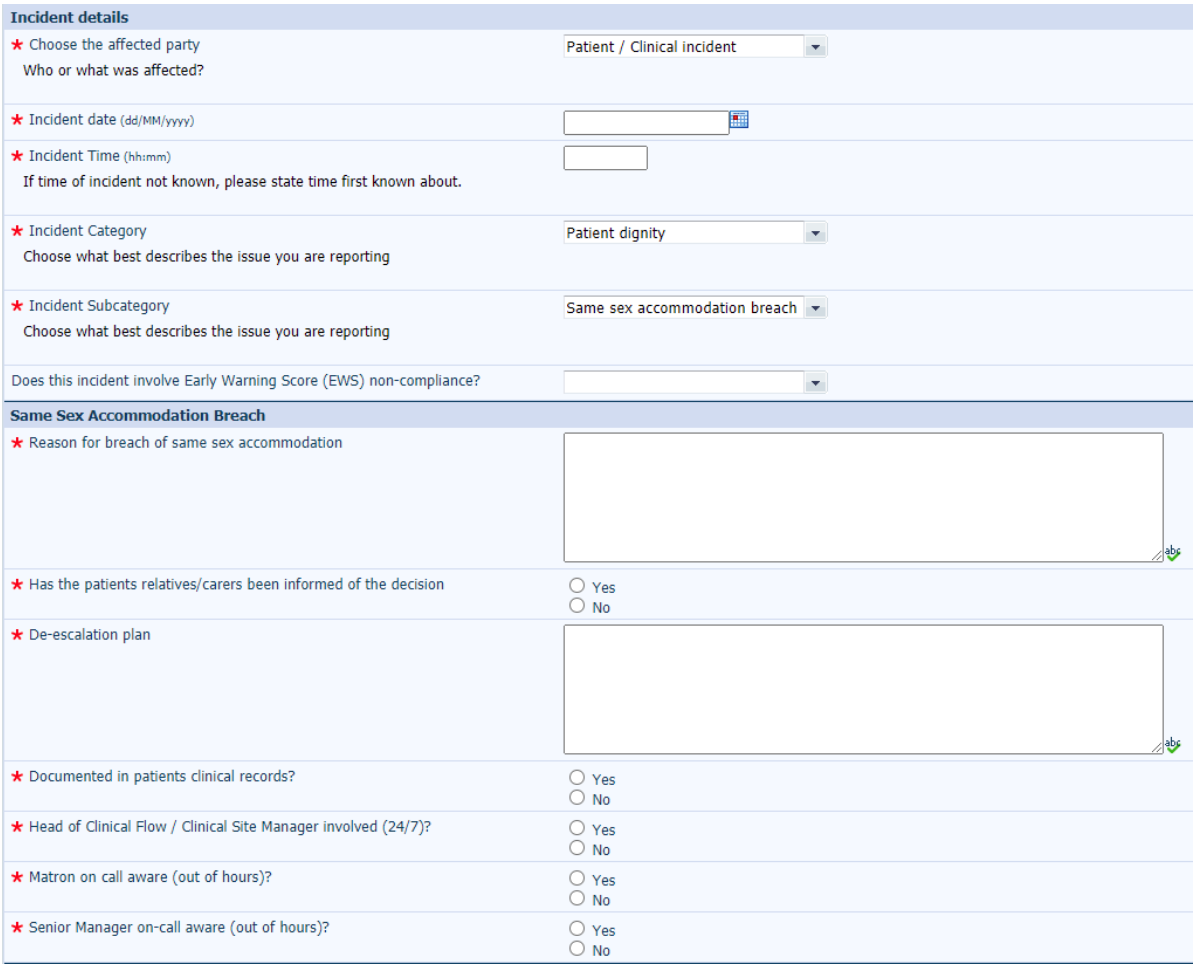
6 Measuring and Monitoring Compliance

Measuring and monitoring compliance with the effective implementation of this procedural document is best practice and a key strand of its successful delivery. Hence, the author(s) of this procedural document has/have clearly set out how compliance with its appropriate implementation will be measured or monitored. This also includes the timescale, tool(s)/methodology and frequency as well as the responsible committee/group for monitoring its compliance and gaining assurance.

Aspect of compliance being measured or monitored.	Individual responsible for the monitoring	Tool and method of monitoring	Frequency of monitoring	Responsible Group or Committee for monitoring
Mixed sex breaches	Head of Patient Flow	Breach reports	Monthly	ICU Network

Appendix 1

Datix Record



Incident details

* Choose the affected party
  Who or what was affected? — Patient / Clinical incident

* Incident date (dd/MM/yyyy)

* Incident Time (hh:mm)
  If time of incident not known, please state time first known about.

* Incident Category
  Choose what best describes the issue you are reporting — Patient dignity

* Incident Subcategory
  Choose what best describes the issue you are reporting — Same sex accommodation breach

Does this incident involve Early Warning Score (EWS) non-compliance?

Same Sex Accommodation Breach

* Reason for breach of same sex accommodation

* Has the patients relatives/carers been informed of the decision — Yes / No

* De-escalation plan

* Documented in patients clinical records? — Yes / No

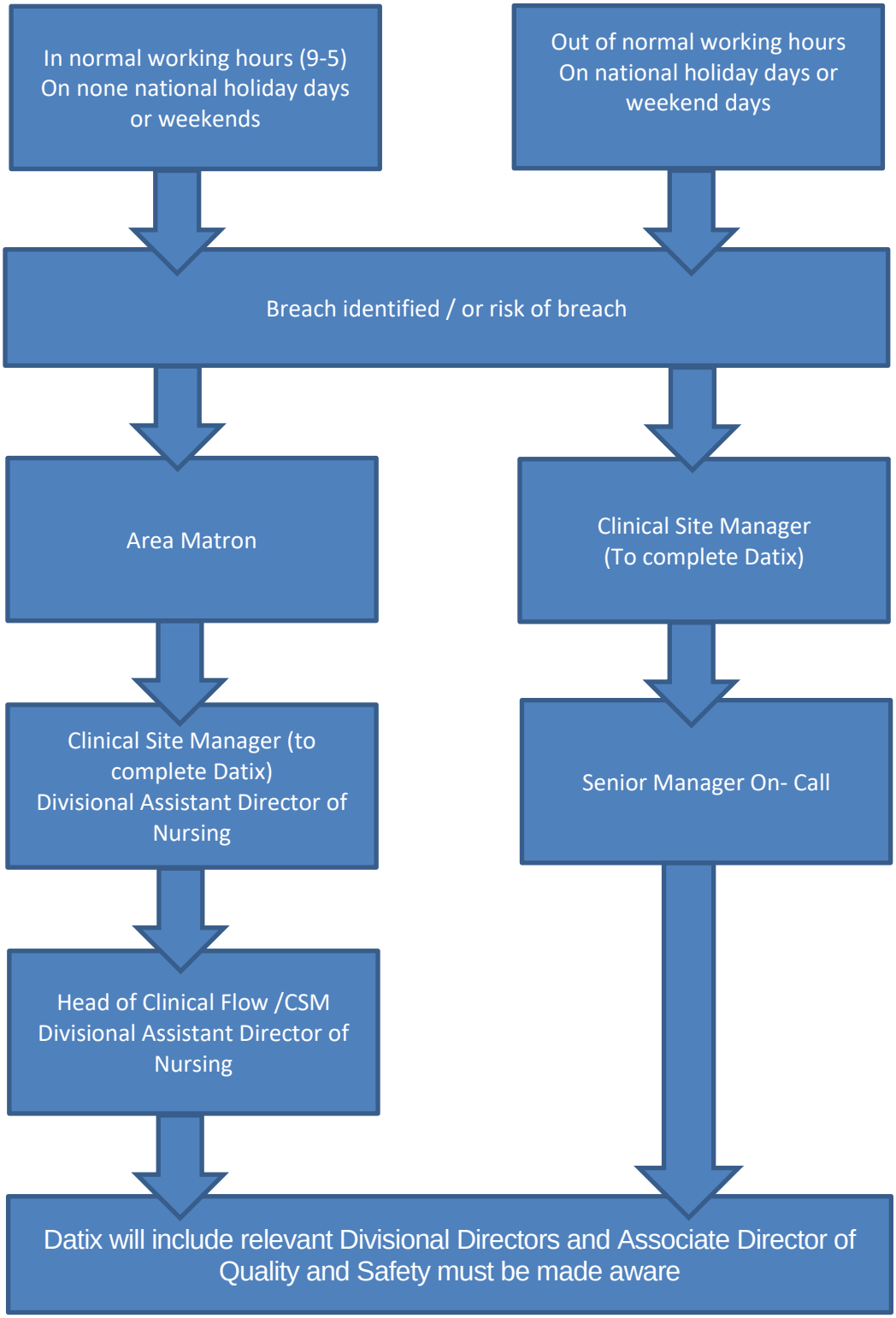
* Head of Clinical Flow / Clinical Site Manager involved (24/7)? — Yes / No

* Matron on call aware (out of hours)? — Yes / No

* Senior Manager on-call aware (out of hours)? — Yes / No

Appendix 2

In and out of hours escalation of a mixed breach



Appendix 3

Decision matrix

(NHS E&I, 2019 Annex A)

Decision matrix	Justified breaches	Notes
Critical care levels 2 and 3: eg intensive care unit/ coronary care units/high dependency units/hyper acute stroke units	Green Almost always	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 10.00pm 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, eg medical/ surgical assessment units/clinical decision making units/ observation wards	Green Almost always	A patient should be moved from an assessment / observation unit within four hours of a decision to admit or from when the patient arrives in the unit and a decision to admit has already been made. If mixing occurs after the four hour period, breaches should be recorded as unjustified.
Areas where treatment is delivered, eg chemotherapy units/ ambulatory day care/ radiotherapy/ renal dialysis/ medical day units	Green Almost always	Mixing should not be recorded as an unjustified breach wherever regular treatment is required, especially where patients may derive comfort from the presence of other patients with similar conditions. A very high degree of privacy and dignity should be maintained during all clinical or personal care procedures.

Children / young people's units (including neonates)	Amber 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, eg day surgery/ endoscopy units/recovery units attached to theatres/ procedure rooms	Red Almost never	Segregation should be provided where patients' modesty may be compromised, eg when wearing hospital gowns/ nightwear, or where the body (other than the extremities) is exposed. Where high observation bays are used for patients in the first stage of recovery or when they require a period of close observation but not level 2 or 3 care, any breaches that occur will be classed as justified.
Mental health	Red Never	All episodes of mixing in mental health inpatient units and in women-only areas should be reported.
Inpatient wards	Red Never	All episodes of mixing in inpatient wards should be reported.

Appendix 4

Emergency Admissions

DH, 2009

Clinical need 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 one.

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.

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, or if the person is vulnerable or lacks capacity).
- Where mixing is unavoidable, transfer to same-sex accommodation should be as soon as possible. Only in the most exceptional circumstances should this exceed 24 hours.

Appendix 5

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

(NHS E&I, 2019, Annex B)

Transsexual people (that is, individuals who have proposed, commenced, or completed reassignment of gender) enjoy legal protection against discrimination. In addition, good practice requires that clinical responses be patient-centered, respectful, and flexible towards all transgender people who do not meet these criteria but who live continuously or temporarily in the gender role that is opposite to their natal sex.

General key points are that:

- trans people should be accommodated according to their presentation (the way they dress, and the name and pronouns that they currently use)
- this presentation may not always accord with the physical sex appearance of the chest or genitalia.
- it does not depend upon their having a gender recognition certificate (GRC) or legal name change.
- it applies to toilet and bathing facilities (except, for instance, that pre-operative trans people should not share open shower facilities)
- The views of the trans person should take precedence over those of family members where these are not the same.

Those who have undergone full-time transition should always be accommodated according to their gender presentation. Different genital or breast sex appearance is not a bar to this since sufficient privacy can usually be ensured through the use of curtains or by accommodation in a single side room adjacent to a sex-appropriate ward. This approach may only be varied under special circumstances where, for instance, the treatment is sex-specific and necessitates a trans person being placed in an otherwise opposite sex ward. Such departures should be proportionate to achieving a 'legitimate aim', for instance, a safe nursing environment.

This may arise, for instance, when a trans man is having a hysterectomy in a hospital, or hospital ward that is designated specifically for women, and no side room is available. The situation should be discussed with the individual concerned and a joint decision made as to how to resolve it. At all times this should be done according to the wishes of the patient, rather than the convenience of the staff.

In addition to these safeguards, where admission/triage staff are unsure of a person's gender, they should, where possible, ask discreetly where the person would be most comfortably accommodated. They should then comply with the patient's preference immediately, or as soon as practicable. If patients are transferred to a ward, this should also be in accordance with their continuous gender presentation (unless the patient requests otherwise).

If upon admission it is impossible to ask the view of the person because he or she

is unconscious or incapacitated then, in the first instance, inferences.

should be drawn from presentation and mode of dress. No investigation as to the genital sex of the person should be undertaken unless this is specifically necessary in order to carry out treatment.

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

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

Considerations for gender variant children and young people

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

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

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

More in-depth discussion and greater sensitivity may need to be extended to adolescents whose secondary sex characteristics have developed and whose view of their gender identity may have consolidated in contradiction to their sex appearance. It should be borne in mind that they are extremely likely to continue 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.

Appendix 6

Day treatment areas include:

- renal dialysis units
- day surgery units
- endoscopy units
- elderly care day hospitals
- chemotherapy 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.

Appendix 7

Critical Care Settings

(Refer to appendix 8 for COVID guidance Jan 2021 to end of March 2021)

(DH, 2009a)

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.

Appendix 8:

Children's Units

(DH, 2009a)

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 based on 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 to 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, or if the person is vulnerable or lacks capacity).
- 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.

Appendix 9: Mental Health and Learning Disabilities

(DH, 2009c)

Consideration will be given to how each mental health and learning disability area can adhere to the DSSA agenda. This would ideally be evidenced through an options appraisal, acted upon, and communicated to all staff.

A significant number of service users will be detained under The Mental Health Act 1983 (2007 Amendments) and will require a protective approach to their care and the environment that care is delivered in.

Where clinically appropriate, service users will be encouraged to mix with members of the opposite sex, for the delivery of therapeutic and social programmes. Safety and respect will be central to the delivery if those programmes and the environment in which the programmes are delivered.

Single rooms with en-suite facilities will be the standard that Trusts should aspire to.

A female-only lounge should be made available and separate dining areas should be considered.

Staff carrying out physical examinations should either be of the same sex or there should be a same-sex chaperone present.

Planning & Commissioning

- In planning new facilities or the refurbishment of existing facilities, design will support segregation of accommodation, toilets, and bathrooms.
- All business cases for proposed new build mental health units must provide separate day rooms, to which women only have access.
- There will be a review of bed stock to ensure it delivers against the capacity demands of commissioned services whilst delivering same- sex accommodation.
- Commissioning of female/male-only treatment facilities out of area may need to be considered where same-sex wards are not available.
- Commissioning arrangements should be in place for young people requiring specialist inpatient treatment and who require single sex treatment facilities, due to past abuse or vulnerability issues.

Governance

- Leadership and governance structures will ensure risk assessment processes to clearly identify vulnerability, sexually disinhibited and predatory behaviors, and risks.
- Reporting to CQC (formerly Mental Health Act Commission) is mandatory for a lone woman detained in Psychiatric Intensive Care Units.
- Ideally patient/service user views on Privacy and Dignity will be sought with actions taken within a specific time frame and shortfalls addressed.

- DSSA and Privacy and Dignity policies will be explained to all patients.
- DSSA guidance and escalation procedure will be included in mandatory and induction training.
- Bed management processes will adhere to DSSA guidelines, and an escalation process will be in place for when mixed-sex occurrences take place.

Information for Service Users

- All newly admitted service users and or their relatives, carers or loved ones must be given information about the configuration of the unit/ layout of the ward and its same sex facilities and have the opportunity to ask questions.
- Service users are offered a choice in allocation of a key worker, where possible offering choice of sex of key worker but also considering ethnicity, age, and professional issues.
- Except in an emergency, patients should be informed, prior to admission, if any parts of the clinical area are shared between men and women. Relatives and carers views should be sought in relation to privacy and dignity. However, the Mental Capacity Act 2005 provides the legal framework for making decisions on behalf of individuals who do not have capacity to make particular decisions for themselves.

Considerations for Female Service users

- Female service users should have the opportunity to associate together in women-only lounge areas, if they wish, and to take part in women only therapy groups and social activities. This should apply particularly in units where female service users are in the minority, for example, in some secure settings.
- Female service users should have access to a female member of staff at all times, and an escort of the same gender should always be available (particularly in secure psychiatric facilities when a patient poses a risk of escaping).
- Female service users should have access, where possible, to a female doctor for physical health care.

Appendix 10 – Current Declaration of Compliance

same-sex accommodation:

your privacy, our responsibility

Declaration of Compliance

East Lancashire Hospitals NHS Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in the Intensive Care Unit), or when patients actively choose to share.

If our care should fall short of the required standard, we will report it. We will also set up an audit mechanism to make sure that we do not misclassify any of our reports. We will publish the results of that audit as part of the Annual Quality Account

Appendix 11

Equality Impact Assessment Screening Form

Department/Function	Clinical Flow			
Lead Assessor	Sharon Reid			
What is being assessed?	Eliminating Mixed Sex Accommodation (EMSA) Policy			
Date of assessment	April 2024			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Staff Inclusion Network/s	☒	Staff Side Colleagues	☐
	Service Users	☒	Other (Inc. external orgs)	☐
	Please give details:			

1) What is the impact on the following equality groups?		
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	Negative: ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	Neutral: ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	Impact (Positive / Negative / Neutral)	Comments ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Positive	Patient choice
Gender reassignment	Positive	Recognised and patient's wishes catered for.
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	

Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Positive	Patient right and choice to be nursed in area supportive of gender identity.
2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?		

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised. ➢ This should include where it has been identified that further work will be undertaken to further explore ➢ the impact on equality groups ➢ This should be reviewed annually.
Action Plan Summary

Action	Lead	Timescale