QUALITY SPECIFICATION	**Eliminating Mixed Sex Accommodation (EMSA)**

1. STATEMENT

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

1.2 The Clinical Commissioning Group (CCG) requires providers to have published a declaration that they have eliminated mixed sex accommodation. Providers should have robust plans in place for continued delivery of this commitment.

1.3 The CCG acknowledges its responsibility to take all reasonable steps to promote and facilitate compliance. This specification applies to all our commissioned patient episodes and beds, and applies to all provider staff.

2. DEFINITION

2.1 A *breach* is defined as the point that a patient is admitted to mixed-sex accommodation outside the terms of the policy.

2.2 A mixed-sex occurrence is defined as the placement of a patient within a clinical setting where one or more of the following criteria applies:

- The patient occupies a bed in a bay or room that is occupied by a patient of the opposite gender.
- The patient occupies a bed that does not have access to co-located same-sex toilet and washing facilities.
- The patient must pass through an area designated for occupation by members of the opposite sex to gain access to toilet and washing facilities.
- The patient occupies a bed in a bay or room that is occupied by a patient of the opposite gender where a clinical justification previously applied is no longer applicable.

2.3 No areas are exempt and every decision to mix must be justified by reference to the patient's clinical needs, not organisational convenience or custom and practice.

2.4 There may be circumstances where patient interest may take precedence or when a patient's survival and recovery depends on rapid admission; the requirement for full segregation clearly takes a lower priority (see sections 12-22). But this does not imply a blanket exemption for all emergency admissions nor for all admissions units.

2.5 The matrix (section 23) offers a framework to make sure that local decisions on mixing in sleeping accommodation reflect the national guidance.

3. BREACHING

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

4. BEST OVERALL INTERESTS OF THE PATIENT

4.1 There are situations where it is clearly in the patient's best interest to receive rapid or specialist treatment, and same-sex accommodation is not the immediate priority. In these cases, privacy and

4. BEST OVERALL INTERESTS OF THE PATIENT

dignity must be protected – e.g. by the enhanced staffing provided in critical care facilities. The patients should be provided with same-sex accommodation immediately the acceptable justification ceases to apply.

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

5. IN THE BEST INTEREST OVERALL INTERESTS OF THE PATIENT - ACCEPTABLE JUSTIFICATION – NOT A BREACH

5.1 In the event of a life-threatening emergency, either on admission or due to a sudden deterioration in a patient's condition.

5.2 Where a critically ill patient requires constant one-to-one nursing care, e.g. in ITU.

5.3 Where a nurse must be physically present in the room/bay at all times (the nurse may have responsibility for more than one patient, e.g. level 2 care). This would be unacceptable if staff shortages or skill mix were the rationale.

5.4 Where a short period of close patient observation is needed e.g. immediate post-anaesthetic recovery, or where there is a high risk of adverse drug reactions.

5.5 On the joint admission of couples or family groups.

6. IN THE BEST INTEREST OVERALL INTERESTS OF THE PATIENT UNACCEPTABLE JUSTITIFACTION – A BREACH

6.1 Placing a patient in mixed-sex accommodation for the convenience of medical, nursing or other staff, or from a desire to group patients within a clinical specialty.

6.2 Placing a patient in mixed-sex accommodation because of a shortage of staff or poor skill mix.

6.3 Placing a patient in mixed-sex accommodation because of restrictions imposed by old or difficult estate.

6.4 Placing a patient in mixed-sex accommodation because of a shortage of beds.

6.5 Placing a patient in mixed-sex accommodation because of predictable fluctuations in activity or seasonal pressures.

6.6 Placing a patient in mixed-sex accommodation because of a predictable non-clinical incident e.g. ward closure.

6.7 Placing or leaving a patient in mixed-sex accommodation whilst waiting for assessment, treatment or a clinical decision.

6.8 Placing a patient in mixed-sex accommodation for regular but not constant observation.

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

7. TRANSFERS FROM CRITICAL CARE (ACUTE SERVICES)

7.1 A breach will be counted as defined by the *East of England Critical Network criteria*, in addition to this, local amendments will be applied. Sign off of any Critical Care EMSA breaches beyond these criteria should be taken by the CEO of the provider organisation.

7.2. Information and analysis regarding the number and reasons for the patients who are identified as not breaching due to the local amendments, but who would be a breach under the East of England Critical Care Network criteria must be shared with the CCG on a monthly basis and action plans developed with the aim reducing these incidents to zero by March 2015.

Best practice as defined by NICE CG50 *Acutely Ill Patients in Hospital* (2007) regarding admission to critical care can be found within the attached link http://www.nice.org.uk/nicemedia/live/11810/35949/35949.pdf.

7.3 The local amendment may be changed based on the outcomes of the analysis as defined in 7.2

7.4 Transfers to general wards from critical care should be as early in the day as possible.

7.5 Transfers to general wards from critical care should be avoided between 22.00 and 07.00 wherever possible. To enable this guidance to be adhered to the time a patient is breaching for will not be counted between 22:00 and 07:00.

7.6 Transfers to general wards out of hours must be documented as an adverse incident if they occur.
7.7 A Root Cause Analysis must be completed for all EMSA Breaches. RCA's must be completed using a recognised patient safety framework.

8. REFLECTS PATIENT CHOICE

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

9. REFLECTS PATIENT CHOICE - ACCEPTABLE JUSTIFICATION – NOT A BREACH

9.1 If an entire patient group has expressed an active preference for sharing (e.g. renal dialysis etc.).

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

10. REFLECTS PATIENT CHOICE – UNACCEPTABLE JUSTIFICATION – A BREACH

10.1 "Take it or leave it" – i.e. the patient is asked to choose between accepting mixed-sex accommodation or going elsewhere.

10.2 "No-win situation" – i.e. the patient is asked to prioritise same-sex accommodation over another aspect of care (e.g. speed of admission, specialist staff etc.).

10. REFLECTS PATIENT CHOICE – UNACCEPTABLE JUSTIFICATION – A BREACH

10.3 Custom and practice – e.g. routine mixing of young people without establishing preferences.

10.4 If the patient said they didn't mind (there should always be a presumption of segregation unless patients specifically ask to share).

10.5 If the patient did not express a preference.

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

11. UNPREDICTABLE EVENTS

11.1 Notwithstanding the above, there will be a very small set of circumstances where mixing is acceptable as an emergency response to extreme operational emergencies. This is limited to unpredictable events such as major clinical incidents e.g. a multiple road traffic accident or natural disaster, major non-clinical incidents such as fire or flood requiring immediate evacuation of buildings, a CBRN event (Chemical, Biological, Radiological, Nuclear) with mass casualties.

12. GUIDANCE FOR SPECIFIC AREAS

12.1 Sections 13 to 22 below look at various circumstances where patient's interests may take precedence or when a patient's survival and recovery depends on rapid admission; the requirement for full segregation clearly takes a lower priority.

13. EMERGENCY ADMISSIONS

13.1 Clinical need must be judged for each individual patient. If a patient is admitted into a bay, 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.

13.2 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.

13.3 There must not be an implied blanket exemption for all emergency admissions, nor for all admission units.

14. EMERGENCY ADMISSION KEY PRINCIPLES

14.1 Decisions should be based on the needs of each individual patient, not the constraints of the environment or the convenience of staff.

14.2 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. If a patient does not have the capacity to understand and/or agree the decision to mix must be discussed and agreed with the next of kin/carer. Staff should make clear to the patient that the trust considers mixing to be the exception, never the norm.

14.3 Greater protection should be provided where patients are unable to preserve their own modesty (for example when semi-conscious or sedated).

15. DAY TREATMENT AREAS

15.1 Day treatment areas include renal dialysis units, elderly care day hospitals, chemotherapy units, and other units where minor operation procedures are conducted. 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.

15.2 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 and personal care procedures.

16. DAY TREATMENT AREAS KEY PRINCIPLES

16.1 Decisions should be based on the needs of each individual patient, not the constraint of the environment, or the convenience of staff.

16.2 Greater segregation should be provided where patients' modesty may be compromised (e.g. when wearing hospital gown/nightwear, or where the body other than the extremities is exposed).

16.3 Staff should make clear to the patient that the trust considers mixing to be the exception, never the norm.

16.4 Greater protection should be provided where patients are unable to preserve their own modesty (e.g. following recovery from a general anaesthetic or when sedated).

17. ITU/HDU/CCU AND THEATRE RECOVERY UNITS

17.1 When a patient's survival and recovery depends 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.

17.2 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. Staff training should be available to support this.

18. ITU/HDU/CCU AND THEATRE RECOVERY UNITS KEY PRINCIPLES

18.1 Decisions should be based on the needs of the individual patient while in critical care environments, and their clinical needs will take priority.

18.2 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.

18.3 The risks of clinical deterioration associated with moving patients within clinical care environments to facilitate segregation must be assessed.

18.4 Where mixing does occur, there should be high enough levels of staffing that each patient can

18. ITU/HDU/CCU AND THEATRE RECOVERY UNITS KEY PRINCIPLES

have their modesty constantly maintained by nursing staff. This will usually mean one-to-one nursing, or at the least, constant nurse presence within the room or bay.

Where possible (for instance planned post-operative care) patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives or loved ones.

18.5 The absence of full separation by gender does not preclude careful attention to patient privacy and dignity.

18.6 Each unit should have in place a clearly defined policy covering privacy and dignity issues for patients in that unit. The policy should be taught as part of the induction process for all new staff. Its implementation should be consistently reinforced and supported in daily practice.

18.7 A 'decision to mix' form should be prepared and reviewed on each occasion that a breach in the policy occurs.

18.8 Each unit should include information about its gender separation policies and procedures in its patient/relative information pack.

18.10 If a patient is ready to leave the unit but this cannot be implemented there should be clear documentation and a record of actions to be taken to ensure transfer of the patient to appropriate same sex accommodation.

19. CHILDREN'S UNIT

19.1 For many children and young people, clinical need, 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 sharing with others of their own age and that 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).

19.2 Staff must make sensible decisions for each patient. This may mean segregating on the basis of age rather than gender, but decisions must be demonstrably in the best interests of the 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.

20. PARENTS

20.1 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.

21. CHILDREN'S UNIT KEY PRINCIPLES

21.1 Privacy and dignity is an important aspect of care for children and young people.

21.2 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 inconvenience of staff.

21. CHILDREN'S UNIT KEY PRINCIPLES

21.3 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 extremities) is exposed, or they are unable to preserve their own modesty (for example following recovery from a general anaesthetic or when sedated).

21.4 The child or young person's preference should be sought, recorded and where possible respected.

21.5 Where appropriate the wishes of the parents should be considered, but in the cases of young people their preference should prevail.

22. TRANSGENDER PEOPLE

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

22.2 General key points are that:

- Transgender 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 them 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 family members where these are not the same

22.3 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 transgender 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.

22.4 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).

22.5 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.

22. TRANSGENDER PEOPLE

22.6 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.

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

22.8 Particular considerations for children and young people

- Gender variant children and young people should be accorded the same respect for their self-defined gender as are trans adults, regardless of their genital sex.
- Where there is no segregation, as is often the case with children, there may be no requirement to treat a young gender variant person any differently from other children and young people. Where segregation is deemed necessary, then it should be in accordance with the dress, preferred name and/or stated gender identity of the child or young person.
- In some instances, parents or those with parental responsibility may have a view that is not consistent with the child's view. If possible, the child's preference should prevail even if the child is not Gillick competent.
- More in depth discussion and greater sensitivity may need to be extended to adolescents whose secondary sex characteristics have developed and whose view of their gender identity may have consolidated in contradiction to their sex appearance. It should be borne in mind that they are extremely likely to 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.

23. DECISION MATRIX FOR PROVIDERS AND COMMISSIONERS

23.1 The decision matrix (see below) offers a framework to make sure that local decisions on mixing in sleeping accommodation reflect the national guidance. Providers and commissioners will need to agree their own version, listing each clinical area by name, and identifying the expectations for patients in that area.

23.2 No areas are exempt, and every decision to mix must be justified by reference to the patient's clinical needs, not organisational convenience or custom and practice.

23.3 The decision to mix (and to record whether or not the mixing constitutes a breach) is made by the provider. These decisions are then validated at the contract review meeting.

23.4 As a general rule, all episodes of mixing in red or amber areas should be discussed. A local system of validation and assurance should be agreed to monitor mixing in green areas, and ensure that unjustified mixing is not being overlooked.

DECISION MATRIX FOR PROVIDERS AND COMMISSIONERS

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

24. DATA COLLECTION

24.1 All providers will submit monthly reporting to the Luton CCG Quality Team via the Service Quality and Performance Report for all justified and unjustified breaches.

24.2 Unjustified breaches need to be reported via the national reporting system (Unify2) on the 07th working day of each month.

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

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

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

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

25. PERFORMANCE MANAGEMENT FRAMEWORK

25.1 This Guidance forms part of the agreed LCCG Quality and Performance Framework and as such commissioners and providers have a duty to comply with the agreed process for notification of changes and amendments to local policy.

25.2 The Department of Heath Sanctions Matrix will also be adhered to.

26. EMSA PROCESSES AND SYSTEMS

26.1 Procedures and systems provide clear step-by-step guidance on what to do in different circumstances and clarify roles and responsibilities. Systems for recording information and dealing with complaints EMSA are necessary to ensure implementation and compliance. Impact on capacity and demand issues must be considered and processes to understand gender specific demand on elective and emergency admissions must be in place.

26.2 The procedures and systems should include:

- Board awareness of EMSA position and approved policies and procedures in place with regular reports to the Board
- All organisations will have in place written procedures for handling complaints relating to EMSA
- All planning for new services and buildings will be assessed for compliance
- Patient satisfaction strategy to include process for meeting EMSA expectations
- Patient and carers have a process to report breaches
- Process to report EMSA status as per specification and all breaches and near misses within 24 hours
- RCA to be provided within 1 week – failure to do so will result in following contracting process section 32 of the contract
- RCA will be used to investigate any issues addressed to prevent reoccurrence

26. EMSA PROCESSES AND SYSTEMS
▪ Publicly available declaration on EMSA status with action plan to ensure on-going compliance and process to ensure capacity issues do not effect EMSA

27. ASSURANCE PROCEDURES
27.1 Providers to submit full root cause analysis on all unjustified breaches to the commissioner. 27.2 Any action plans from root cause analysis will be monitored via the quality monitoring process. 27.3 Announced and unannounced visits will be made to provider organisations by the CCG to look at specific areas of action plans and to audit compliance on a sample of wards, units and departments.

28. SANCTIONS
28.1 The CCG have a requirement placed upon them to make a deduction equivalent up to the total cost of the service or treatment for all patients affected by a breach of the same sex accommodation requirements as set out under *Nationally Specified Events and Schedule 4 part a*

Provider Performance Indicators

Quality and Performance Indicators	Process Measures	Threshold	Method of Measurement	Consequence of Breach
Maintaining compliance	EMSA Plan		Updated plan submitted quarterly to commissioners	
Patient /service users expectations are met in relation to EMSA	Patient satisfaction surveys including privacy and submitted quarterly with any appropriate action plans	One month after quarter end	Quality Monitoring Process	As per GC9
	Patient satisfaction survey to include DH metrics submitted to the Quality Team	In accordance with agreed schedule		
Breach of same sex accommodation requirements	Clinically unjustified breaches of sleeping accommodation	>0	Review of monthly data and Unify2 submissions	Retention of £250 per day per patient affected as may be varied pursuant to Guidance
	All other breaches (bathroom; passing through) and decisions to mix must be reported to the Quality Team on the specified form within 24hrs of the start of the incident	Next working day	Quality Monitoring Process	As per GC9
	All actions plans will be updated monthly until fully implemented	One month after the breach or decision to mix report and then monthly until all actions implemented	Quality Monitoring Process and announced/unannounced visits.	

References:

Operating Framework (2012/13):
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216304/dh_123660.pdf

Eliminating Mixed Sex Accommodation (2010), Professional Letter CNO/2010/3, Department of Health Gateway No. 15024
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215932/dh_121860.pdf

Delivering Same Sex Accommodation
http://www.institute.nhs.uk/delivering_same_sex_accommodation/what_is_same_sex_accommodation/policy_and_guidance.html