WHRC Research Paper
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"Availability and Clarity of Information on Patient Single-Sex Accommodation provided by the NHS
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About the WHRC

The Women's Human Rights Campaign (WHRC) campaigns to reaffirm in their entirety the sex-based rights of women and girls and to oppose infringements of those rights which result from the replacement of the category of sex with that of 'gender identity'.[1]

Research

The present research aims to explore the current status of single sex accommodation (SSA) for inpatients in general hospital wards, with brief reference to mental health services and maternity provision, by assessing the visibility and accessibility of SSA policies to the general public, and the ways in which the 2019 review of NHS had affected the content of patient information, with specific reference to Annex B.

A random exploration of 52 NHS England trust websites, including 150 hospitals was undertaken covering each of the regions in order to answer the following:

- Are inpatients informed of their right to same sex accomodation and same sex health practictioner?
- Where is information about SSA found?
- Are the protected characteristics of sex and gender reassignment used used correctly in information to patients?

Background (From single-sex to mixed-sex-to single-sex to 'gender identity')

It took from early 1990 to 2009/10 to introduce the mandatory abolition of mixed sex accommodation in the NHS and the introduction of a national reporting system for breaches of SSA and their justification.

At its inception the NHS (1946) segregated accommodation and bathing/toilet facilities by sex in all inpatient services. Within mental health asylums patients of the opposite sex mixed for social/ recreational purposes always under supervision by designated staff.

In the 1960s psychiatry moved to implement mixed sex accommodation (MSA) and units, under the guise of

[1] Women's Human Rights Campaign https://www.womensdeclaration.com

what was termed the 'greater enlightenment of psychiatry'[2]. It was argued that patients (males) benefitted from sharing living arrangements (not sleeping accommodation) with women. Learning disabled facilities were based on a mixed-sex model that was intended to create a pseudo family set-up.

Around this time general hospitals were seeking models that cut costs. Intensive care units began to move to mixed-sex wards, to treat unwell patients needeeding complex and costly equipment in order to save their lives. Concentrating such equipment in one unit, with few beds and individual care made economic sense and women and men housed side by side, too ill to notice, was considered appropriate to save lives.

Then the cash-strapped NHS identified a surfeit of beds in single-sex wards. Mixed-sex units spread rapidly across the NHS general hospital estate during the 1970/80s, creating much debate amongst patients and NHS professionals. Many doctors opposed the reintroduction of single-sex wards, but representatives of those with the closest experiences of patient care such the Royal College of Nursing, Women's Institute and work by feminists Broverman[3], brought strong arguments for a return to safe single-sex services. Psychiatry was particularly under fire as it used stereotypical presentations of women to assess their level of recovery and how they behaved around the opposite sex on the ward.

The public were lodging objections to MSA via their MPs, citing embarassment, loss of privacy and anxieties from women (and men) about sharing space with strange men/women.

Evidence emerged that mixed arrangements benefitted men but placed women at greater risk from coercive sexual exploitation by both fellow patients and staff. At no point[4] were women consulted about such arrangements. Subsequent research has revealed a litany of sexual exploitation of women by both

[2] Broverman I. (1970) Sex Role Stereotypes and Clinical Judgements of Mental Health. Journal of Consulting and clinical Psychology (43) 1-7

[3] Broverman I. (1970) Sex Role Stereotypes and Clinical Judgements of Mental Health. Journal of Consulting and clinical Psychology (43) 1-7; Chesler P. (1972), Women and Madness. Avon Books New York (updated 2018)

[4] Namdarkhan L. (1995) 'Women with Learning Difficulties: Mixed Sex Living: who Benefits?' MA Thesis (Middlesex University)

male staff and patients[5] identified four coping strategies for women confined in prison: withdrawal, retaliation, incorporation and self-mutilation evidenced for short or long periods of time. Namdarkhan[6] discovered that women's coping strategies in mixed wards in mental health provision echoed those of women in prison, with confinement stress exacerbated by the presence of the opposite sex.

It was not until 1997 that the Minister of State for Health (MOH) pledged the removal of MSA by 1999. However there was no committment to SSA (single-sex accommodation) until 2002 (in Scotland) following which SSA implementation stalled. A report from the Patients' Association, a voluntary group which represents patients interests (2008), claimed their membership was 'frustrated by the slow pace of change in achieving SSA'.

The government invested £100 million, ringfenced, to speed up the process of abolishing mixed sex wards. In 2011 NHS UK instructed all general hospitals to complete a declaration confirming commitment to SSA, which, once adopted, should be available as part of inpatient information with exceptions for A&E and intensive care units.

In 2012 NHS UK included SSA as a patient right within the Constitution of the NHS, making SSA mandatory, further strengthened in 2013 when SSA pledge breach reporting was now required monthly as part of standard operational commissioner monitoring, with financial sanctions where contracts are failing. Belatedly, in 2014 the Care Quality Commission (CQC) began monitoring SSA.

2010 equalities legislation[7] outlined nine protected characteristics one of which is sex. There are six significant areas that recognise the need for 'women only spaces, services, roles and activities', where exclusions of the opposite sex, 'must be a proportionate means to achieve a legitimate aim',

[5] Hide L (2018) In Plain Site: Open Doors, Mixed-sex Wards and Sexual Abuse in English Psychiatric Hospitals, 1950s—Early 1990s *Social History of Medicine*, Volume 31, Issue 4, November 2018, Pages 732–753; Eaton M. (1993) Women After Prison. Open University Press

[6] Namdarkhan L. (1995) 'Women with Learning Difficulties: Mixed Sex Living: who Benefits?' MA Thesis (Middlesex University)

[7] Equality Act 2010 https://www.legislation.gov.uk/ukpga/2010/15/contents

A short review (2019) updated and replaced the 2011 guidance, which appears to privilege gender over biological sex so that EA10 understandings of biological sex are replaced with a belief system known as 'gender identity'. In doing so the NHS seems to have created a massive contradiction within its own mandatory SSA guidance. These contradictions are found within Annex B. EA10 is never quoted in the SSA guidelines that specifically relate to the protected characteristic 'sex', that affords women/girls sex-based protections, particularly relevant to the NHS which by its very nature provides intimate inpatient services. SSA forms part of the measures that seek to provide women with safety and privacy.

In Annex B, under the heading "Delivering same-sex accommodation for trans people and gender variant children 2019", we find EA10 becomes the rationale for introducing choices of single-sex wards based on 'gender presentation' even though the EA10 would /should equally uphold the rights of women/girls/men/boys to access SSA without the opposite sex occupying designated single-sex spaces.

An enquiry to the Patients' Association (January 2021) about whether there have been any updates on their view of SSA since 2018 was answered with a confirmation that their position on SSA had not changed, although the focus of their work was currently elsewhere.

Results

The information from each trust website was classified according to the level of clarity of information for patients about their mandated right to SSA and choice of same-sex practitioner. The NHS trust websites varied as did the standard presentation of local hospital web pages. There appears to be no corporate unified approach throughout the nation's NHS websites that give accurate, consistent up-to-date information to the public.

The information was grouped according to the following categories

Category 1 (26)

No SSA declaration was accessible. The right to single-sex accommodation and same-sex medical

practitioner was not found. Reference to EA (2010) removed 'sex' as a protected characteristic and replaced the protected category 'gender reassignment' with 'gender identity'.

Staff are advised to allocate patients to the single-sex accommodation of their choice and 'gender presentation'.

Category 2 (13)

No declaration on SSA was accessible. The right to single-sex accommodation was in information to patients coming into hospital. The right to a same-sex practitioner was absent from the information.

Reference to EA (2010) replaced the protected category of sex with 'gender' / 'gender identity' or omitted it altogether.

Category 3 (7)

Although the declaration on SSA was inaccessible, information on SSA was available to patients coming into hospital. The right to a same-sex practitioner was absent from the information.

Correct depiction of the nine protected characteristics of EA (2010), with no language changes or presumptious additions.

Category 4 (6)

Declaration on website. All breaches reported on a monthly basis. The right to single-sex accommodation and the right to a same-sex practitioner was in the information to patients.

Advice about having a chaperone if requested was made available.

Correct depiction of the nine protected characteristics of EA (2010), with no language changes or presumptuous additions.

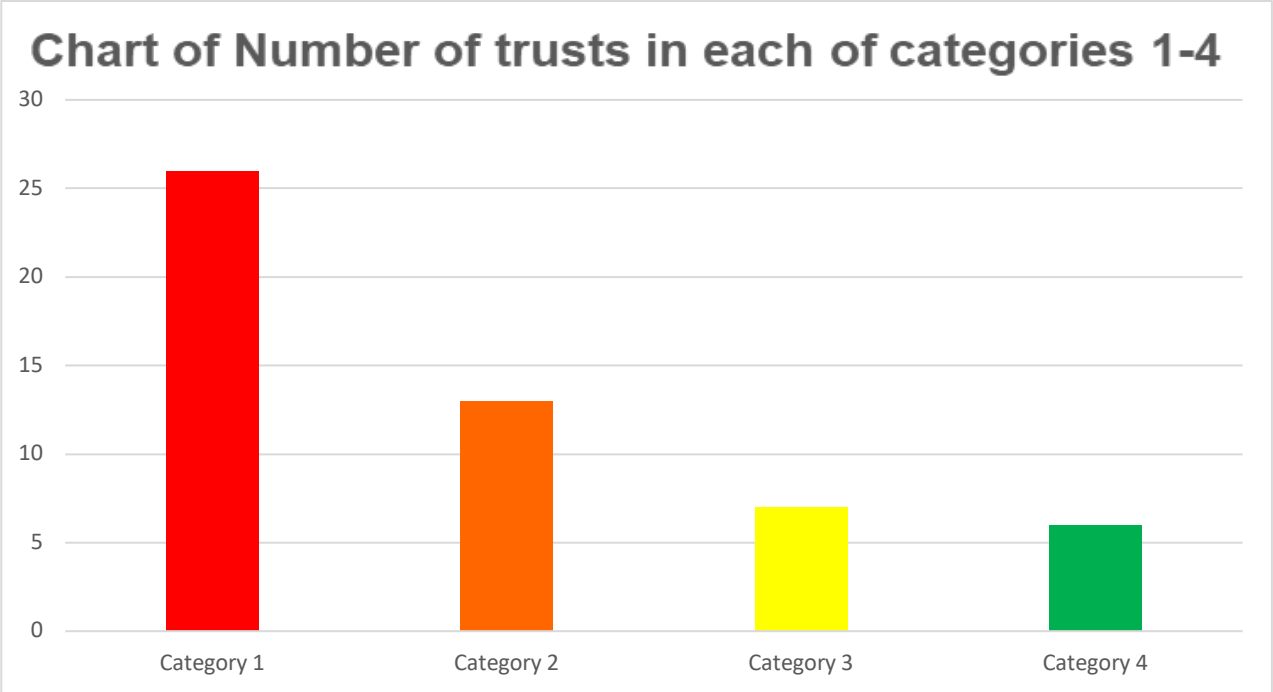

Chart depicts the number of trusts in each of categories 1-4

NB: WHRC investigated 52 (24%) of the 217 NHS trusts in England and Wales

Conclusions

The data highlights some of the contradictions that have crept into NHS trust policy on SSA over the last few years about the provisions of SSA, since it first became a public concern in the early 1990s.

The confusion about the rights of patients to single-sex accommodation results in various levels of adherence among trusts to the declaration of SSA and the right to choose a same-sex medical practitioner. The duty to inform patients correctly of their constitutional rights, based on the Equality Act (2010), in which sex is a protected characteristic, depends on interpretation by those responsible for ensuring the dignity and privacy of inpatients. Furthermore, some trusts' reinterpretation goes against the spirit of SSA by interpreting Annex B into policy and rolling back NHS inpatient services to the much discredited era of mixed-sex wards.

When SSA guidance is breached there are contractual sanctions, which can involve financial penalties. For

example, those which were applied in 2018 to Oxford University Hospitals NHS Foundation Trust. Nevertheless, loopholes remain, embedded in Annex B, which some trusts have interpreted as overriding SSA and allowing an inpatient to choose whichever ward they feel most comfortable in. On the basis of choice, a patient could be in the opposite-sex ward, even when such a person is not on a pathway to gender reassignment but based on 'self identification' (SID).

The guidance in Annex B privileges 'gender identity' over two protected characteristics of EA (2010) namely 'religion' and 'sex' and ignoring the rights and sensibilities of other inpatients. It is difficult to see how declarations to respect patients' privacy and dignity are implemented without referencing 'sex' as a protected characteristic.

Recommendations

The NHS must ensure that information for patients follows the law by unambiguous policy wording so that SSA respects the protected characteristic of 'sex' and should not refer to personal choice in the matter of inpatient ward accommodation. The NHS should direct trusts that SSA within EA (10) falls within 'proportionate means', given the past 30 years of establishing SSA.

Trusts should correctly state the protected characteristic of 'gender reassignment' and not use terms such as 'gender identity' or 'transgender', neither of which has any basis in law.

NHS trusts in the UK, funded by the public, should not delegate equality, diversity and inclusion policies to outside organisations like Stonewall, without checking constitutional compliance with mandated policies.

The 2019 SSA guidance, should be re-examined on the basis that it contradicts both the NHS's local declarations 2011 and the NHS national constitutional commitment in 2012 to ensure mandatory SSA provision. The 2019 NHS review of SSA, by introducing Annex B, breaches its own guidance and the Government's announcement towards the end of 2020 that SID would not form part of the Gender Recognition Act review.

Reports should maintain a focus on SSA in mental health settings. The recent CQC inspection report (2018) of the Tavistock clinic 'Sexual Safety on Mental Health Wards' found that women patients received overwhelmingly the highest incidents of all forms of abuse from men, mostly committed in communal areas of the ward. Nevertheless the report's focus seems to be on making sure people are addressed appropriately and their 'gender' needs are met by caring staff teams. There was no evidence that LGBT+community on these wards were a 'high-risk' group. Yet there was no reference in remedy to respond to legitimate evidence and fears of women, only the prioritisation of the needs of LGBT+ community.

WHRC are concerned that the NHS trusts are covertly misusing their mandated commitment to SSA by changing the language of the Equality Act (2010) so that 'gender identity' replaces 'sex' as the determiner for single-sex accommodation, thereby giving access to a ward designated for the opposite sex. All patients using NHS inpatient facilities must be treated with dignity and respect. Allowing people to self-identify into wards intended for the opposite sex does not facilitate this. WHRC asks that NHS trusts interpret the law correctly and provide single-sex accommodation as its own constitution demands.

References

- Broverman I. (1970) Sex Role Stereotypes and Clinical Judgements of Mental Health. Journal of Consulting and clinical Psychology (43) 1-7
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