PSA response to Equality and Human Rights Commission (EHRC) consultation on updates to services Code of Practice

June 2025

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1. Introduction

1.1. The Professional Standards Authority for Health and Social Care (PSA) is the UK's oversight body for the regulation of people working in health and social care. Our statutory remit, independence and expertise underpin our commitment to the safety of patients and service-users, and to the protection of the public.

1.2. There are 10 organisations that regulate health professionals in the UK and social workers in England by law. We audit their performance and review their decisions on practitioners' fitness to practise. We also accredit and set standards for organisations holding registers of health and care practitioners not regulated by law.

1.3. We collaborate with all of these organisations to improve standards. We share good practice, knowledge and our right-touch regulation expertise. We also conduct and promote research on regulation. We monitor policy developments in the UK and internationally, providing guidance to governments and stakeholders. Through our UK and international consultancy, we share our expertise and broaden our regulatory insights.

1.4. Our core values of integrity, transparency, respect, fairness, and teamwork, guide our work. We are accountable to the UK Parliament. More information about our activities and approach is available at www.professionalstandards.org.uk.

2. Answers to questions posed in the consultation

Would you like to provide feedback on the updated legal definition of sex throughout the code of practice?

- Yes

To what extent do you agree or disagree with the following statement:

The explanation of the updated legal definition of sex is clear.

- Agree

Is there anything you would change to make the explanation of the legal rights and responsibilities in this update clearer?

2.1. We do think that the updated legal definition of sex is clear, insofar as it applies for the purposes of the Equality Act. We do however suggest that it could be improved by adding a reference to the commonly used terms ‘birth sex’ and ‘biological sex’ (e.g. changing the definition to: ‘Legal sex is the sex that was recorded at your birth. This may be referred to as your birth sex or biological sex’). Adding references to birth sex and biological sex would also align with the terminology used in the Code of Practice, which frequently uses both terms.

Would you like to provide feedback on the new content on asking about sex at birth?

- Yes

To what extent do you agree or disagree with the following statement:

The explanation of the legal rights and responsibilities set out in the new content on asking about sex at birth is clear.

- Disagree

Is there anything you would change to make the explanation of the legal rights and responsibilities in this update clearer?

2.2. The updated content sets out that public authorities should take care when requesting information about birth sex, and cautions that requesting this information where it is not necessary or proportionate may breach Article 8 of the European Convention on Human Rights (ECHR). The example given in the guidance relates to the provision of single sex support groups.

2.3. The regulators and Accredited Registers we oversee collect and publish data about the professionals on their registers to understand the diversity of their registrants and ensure that their processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics. They may also collect data from other groups, such as members of the public who respond to their consultations, or people wishing to make a complaint. The collection and analysis of diversity data enables regulators to demonstrate that they are meeting their obligations under the Public Sector Equality Duty (PSED)[1]. It is also an important element of our assessments of regulators against Standard three of the PSA’s Standards of Good Regulation.[2]

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[1] Note that the Public Sector Equality Duty applies to all the regulators that we oversee with the exception of the Pharmaceutical Society Northern Ireland (PSNI)

[2] Standards of Good Regulation | PSA

2.4. There is variation in terms of the Equality, Diversity and Inclusion (EDI) data collected by the organisations that we oversee. While some collect information about the sex of their registrants, others do not, or do not clearly distinguish between sex and gender. Some regulators publish the sex or gender of registrants on their public registers.

2.5. The Supreme Court judgment appears to point to a need for public bodies to collect data that distinguishes between legal gender and birth sex. The judgment notes that including trans women in data relating to women is confusing because it *"cuts across and fragments both biological sex and gender reassignment into heterogenous groupings which may have little in common. Any data collection exercise will be distorted by the heterogenous nature of such a group."*[3]

2.6. The judgment further suggests that the requirements of the PSED cannot be fulfilled by categorising women and trans women together*: "the distinct discrimination and disadvantage faced by women as a group (or trans people) would simply not be capable of being addressed by the PSED because the group being considered would not be a group that, because of the shared protected characteristic of sex, has experienced discrimination or disadvantage flowing from shared biology, societal norms or prejudice."*[4]

2.7. Our expectation following the Supreme Court judgment is, therefore, that in future, to fulfil their obligations under the PSED the organisations we oversee will need to ensure that the EDI data they collect includes birth sex. This would also align with the recommendations of the Independent Review of data, statistics and research on sex and gender conducted by Professor Alice Sullivan.[5] We note that the Government's response to the Sullivan review remains outstanding, and that public bodies can expect more clarity about data collection requirements when this is published.

2.8. In our view, the EHRC's updated Code of Practice does not adequately explain how public bodies such as professional regulators and accredited registers (who are not traditional 'service providers') should apply the ruling in relation to asking about birth sex. The PSA and the organisations we oversee will need absolute clarity about how to ask about birth sex as part of EDI data collection and in what circumstances (if any) requesting evidential proof is likely to be necessary or justifiable. Regulators will also require guidance on whether mandating registrants provide sex information (for example, as a condition of registration) would be considered proportionate. Further clarity is also required on whether, having collected this information, regulators and registers would be able to publish it.

The draft guidance states that disclosure of biological sex without consent in the case of someone with a Gender Recognition Certificate (GRC) may be a criminal offence, as provided for in the Gender Recognition Act (GRA) 2004. More clarity is urgently required on how the Supreme Court ruling intersects with the provisions contained within the GRA. If the provisions of the GRA relating to the illegality of publishing the birth sex of someone

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[3] For Women Scotland Ltd (Appellant) v The Scottish Ministers (Respondent)

[4] For Women Scotland Ltd (Appellant) v The Scottish Ministers (Respondent)

[5] https://www.gov.uk/government/publications/independent-review-of-data-statistics-and-research-on-sex-and-gender/review-of-data-statistics-and-research-on-sex-and-gender-executive-summary

with a GRC still apply, regulators will be prohibited from publishing the birth sex of registrants on their registers. This means that for regulators that publish the sex/gender of registrants, the information published will be certified sex, not birth sex. While this may be entirely appropriate, it may create confusion for patients where they expect this information to relate to birth sex.

2.9. Finally, health and care professionals themselves would benefit from further guidance about how to ask about birth sex in a way that would be considered proportionate and justified without causing harassment or discrimination under the Equality Act. Professionals will look to their regulators for guidance on how to achieve this in practice. The example set out in paragraph 2.2.7 highlights a range of issues not addressed by the guidance. For example, it refers to 'reasonably' thinking a trans woman is biologically male which suggests a trans person is easily identifiable; this may not be the case. Further, asking about the birth sex of a patient or service user may be experienced as compromising their dignity, which could contradict guidance issued to registrants by professional regulators. It is also unclear whether patients and members of the public would be bound to answer, and what health and care professionals should do in a scenario where someone did not want to disclose their birth sex.

Will your organisation make any changes as a result of this update to the code of practice?

For example, any changes to your policies, procedures or practices.

- Yes

What changes might your organisation make as a result of this update to the code of practice?

2.10. We are considering the need to update the Equality, Diversity and Inclusion requirements of the regulators and registers that we oversee. The main areas of our oversight likely to be affected are how we determine whether the regulators are collecting the correct data, and how regulators are supporting professionals to deliver health and care that meets the new legal definition.

2.11. However, we do not believe that the EHRC guidance provides sufficient detail in relation to complex service providers such as regulators and accredited registers to enable us to confidently update our requirements on either of these areas at this time. We do not think the guidance is sufficiently clear or detailed enough to enable the PSA, or the regulatory bodies we oversee, to make changes that would support health and care professionals to handle examples such as that detailed at paragraph 2.2.7 in a way that is both in line with the law, and maintains the dignity and privacy of patients and the public in relation to disclosing their birth sex. In our view, there needs to be significant further engagement and consultation on how health and care professionals should navigate situations such as this in which there is a risk of conflict of rights and loss of dignity for patients and the public.

Would you like to provide feedback on the updated section on separate and single-sex services for men and women?

- Yes

To what extent do you agree or disagree with the following statement:

The explanation of the legal rights and responsibilities set out in the updated section on separate and single-sex services for men and women is clear.

- Disagree

Is there anything you would change to make the explanation of the legal rights and responsibilities in this update clearer?

2.12. The consultation sets out the circumstances in which services may be single sex. This includes where the service *"is likely to involve physical contact between the service user and another person and that other person might reasonably object if the service user is of the opposite sex."* The guidance also gives examples of circumstances in which services may reasonably be single sex, including hospital wards and intimate personal care.

2.13. We believe that paragraph 13.2.20 could be clearer in explaining the types of physical contact that may justify single-sex provision. The guidance states that *"limited non-intimate physical contact"* is unlikely to be a justification. However, it does not explain either i) what might be considered 'intimate,' or ii) whether single-sex provision may be justified in the case of extensive but non-intimate physical contact.

2.14. Many of the health and care professionals registered with the regulators that we oversee are involved in the provision of intimate care. While there has to date been no automatic right to same-sex care (i.e. where the practitioner is the same sex as the patient), patients, and in particular women, may request same-sex care for a variety of reasons, including religious or cultural factors, a history of abuse, where they are particularly vulnerable (either due to their situation or personal factors), or simply because they feel more comfortable with a healthcare provider of the same sex, particularly in the case of intimate examinations.

2.15. In light of the Supreme Court judgment and the EHRC draft guidance, it seems clear that where healthcare services are legitimately single-sex, this should mean 'birth sex'. It would therefore logically follow that the same would apply in relation to requests for same-sex care. However, the practical implications of this within healthcare settings remains unclear.

2.16. We would welcome more clarity, including specific examples, relating to how requests for same-sex care should be handled. Areas which require further clarification include:

- Whether the effect of the EHRC guidance is to introduce a legal right for patients to be treated by a healthcare professional of the same birth sex in the case of intimate care?

- Whether the ruling creates an obligation for healthcare professionals to inform either their employer or their regulator of their birth sex, and a corresponding right for the employer, regulator or patient/service user to ask?
- How and whether information about birth sex could or should be provided in the case of sole practitioners, operating outwith an organisational structure or providing services on behalf of the NHS?
- Whether patients have a legitimate right to know the sex of the professional caring for them, even where that professional holds a Gender Recognition Certificate (GRC) and the potential legal consequences of this?
- Whether any of the above suggests a need for health and care regulators to publish the sex of registrants on their registers? (see our response to asking about birth sex for further details).

Will your organisation make any changes as a result of this update to the code of practice?

For example, any changes to your policies, procedures or practices.

- Yes

What changes might your organisation make as a result of this update to the code of practice?

2.17. We are considering the need to update the requirements of the regulators and registers we oversee in relation to the Equality, Diversity and Inclusion data they collect and publish. We may also consider updating our position on the information that should be published on registers.

Do you have any other feedback about the content of the code of practice that you have not already mentioned?

Include references to specific changes where relevant

2.18. We would like to see the guidance do more to explain how the changes apply to a diverse range of organisations, including those that are not traditional ‘service providers’ and bodies that provide a public benefit but are not subject to the Public Sector Equality Duty (PSED). For example, we accredit registers of health and care practitioners that are not regulated by law under our Accredited Registers programme. These registers help to ensure that practitioners meet high standards of practice and deliver safe and effective care. They perform a similar function to the statutory regulators of health and care professionals but they are not subject to the PSED. The guidance should do more to help organisations like these navigate the expectations on them flowing from the Supreme Court judgment.

2.19. On a separate matter, while we appreciate the external pressure that the Equality and Human Rights Commission (EHRC) has been under to produce the guidance, we feel that a six-week consultation period may be too short for all affected groups to contribute meaningfully. We have highlighted elsewhere that the guidance as it stands is not sufficient to allow us or the regulators we oversee to develop meaningful guidance. Greater consultation with those affected could assist EHRC to develop guidance that supports regulators and professionals to ensure care is delivered in a way that meets the new legal definition and protects dignity and privacy. A longer consultation period would have allowed for a more comprehensive and inclusive response from all stakeholders, including, for example, patients and patient representative organisations.

3. Further information

3.1. Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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