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Women and Equalities
Committee

**Health and Social Care
and LGBT Communities**

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relating to the report*

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Women and Equalities Committee

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Summary

Good quality medical care is the foundation of our health and social care service. Treatment that is respectful and inclusive is a cornerstone of these services. LGBT people have the same health and social care needs as the rest of the population of England for the majority of the time: clinical and care expertise, a listening ear, understanding, and health and social care structures that enable them to lead healthy and cared-for lives. However, it is not always the case that LGBT people receive the same level of service as non-LGBT people. Research has shown that, although LGBT people are often less healthy than the wider population, they also tend to receive lower levels of care than non-LGBT people. Too often medical professionals focus on sexual health rather than broader health needs and differences when supporting LGBT people. The reasons for this have become clear to us through this inquiry.

LGBT people need to be treated equally, but not identically to, other groups. Access to the same services as others is ineffective if that service is structured for a heterosexual and cisgender default and has limited flexibility. There is not enough understanding from service-providers of the different needs that LGBT people might have.

We have found that too few health and social care providers are actively thinking about LGBT people when they plan their services and that senior leaders are not doing enough to ensure that LGBT-inclusion is hardwired into commissioning strategies. This problem filters all the way down to training, where medics of the future are not taught how to provide LGBT-inclusive treatment. While few people set out to discriminate, training currently sends the message that sexual orientation and gender identity are not relevant to providing “person-centred care”. We have heard that for many witnesses that it is, in fact, essential. At the moment, there seems to be neither the leadership necessary to ensure services are designed to be LGBT-inclusive nor swift enough improvements among staff on the ground.

We have, however, heard many good ideas and lots of examples of good practice. These are not as widespread as they should be and so this report should be a clarion call to the health and social care sectors to take up the work that some very dedicated and inventive individuals have already begun.

Introduction

Our inquiry

1. In July 2018 the Government published its National LGBT Survey and LGBT Action Plan, which committed to improving the lives of LGBT people in the UK. The same month, an event on LGBT and health inequalities was held by the Parliamentary Office for Science and Technology (POST).¹ Researchers noted that there is often an unhelpful conflation of LGBT health services with sexual health services and that the inequalities experienced by LGBT communities in health and social care were much broader. This is why we called for evidence on how well policy-makers and service-providers were taking into account the health and social care needs of the LGBT communities.

2. The inquiry was launched in August 2018 and received 100 written submissions from academics, community groups, local authorities and public service providers. We began taking oral evidence in May 2019, after holding an outreach event for LGBT people to tell us about their experiences of health and social care directly. Witnesses included experts in a variety of policy areas, LGBT people speaking about their own experiences, organisations conducting representative and advocacy work, service-providers, and the Secretary of State for Health and Social Care and Minister for Equalities. We thank all of our witnesses and those who submitted evidence for their valuable contributions.

3. One of the challenges raised by this inquiry was the potentially broad scope of the subject matter - there were many issues that were raised that we were not able to fully explore. We received a number of submissions about trans-specific issues, including several submissions from the parents of transgender children relating to gender identity services. These submissions were considered carefully and we appreciate the time that people took to write to us. However, we concluded that this report needed to focus on the discrimination that LGBT communities experience in their day-to-day interaction with health and social care services across the board rather than on problems that exist with specific services. There is much work still to do and we are certain that this report will help Government and health and social care services to improve their work with LGBT communities.

1 Parliamentary Office for Science and Technology, ['LGBT+ Health Inequalities'](#), accessed 24 September 2019

1 The disparities in health and social care experienced by LGBT people

4. Most of the time, outside of very specialist provision, LGBT people use health and social care services much like non-LGBT people do. They access GPs and other primary care providers, are referred to consultants, present at A&E when there is an emergency and apply for care home places. There are two ways in which it is possible to gauge whether these services are working effectively for LGBT people: data collected about the LGBT people's health outcomes and how LGBT people themselves feel about the service they are receiving. This Chapter focuses on the first of these: the data collected through clinical studies, surveys and administrative data - data collected during the course of an individual's treatment.

Data collection

5. While there has been a fair amount of academic research into health inequalities of LGBT people, especially in the fields of sexual health and among gay cisgender men, there has been little in the way of large-scale data collection and it is rare for data to be collected at a local level.² Many submissions to the inquiry have highlighted a lack of data (and data collection) as a cause of concern.³ Health and Social Care services are unable to understand the needs of their LGBT populations if they are not collecting data about them. LGBT needs are not routinely included in Joint Strategic Needs Assessments, public health strategies or other commissioning documents, in part, due to the lack of available data about LGBT health outcomes.⁴

6. It is only possible to take account of the needs of any group if policy-makers are aware of the existence of the group and of their needs. As Dr Justin Varney from Birmingham City Council told us, "If you are not counted, you don't count".⁵ Many of the problems that we heard about throughout the inquiry could be traced back to lack of data-collection being undertaken across the NHS and social care services. As part of the NHS Long Term Plan, Integrated Care Systems (ICSs) and Sustainability and Transformation Partnerships (STPs) will need to show how they are reducing inequalities.⁶ Secretary of State for Health and Social Care, Matthew Hancock told us that:

Local health systems will be required to take action and report on that through a series of equality impact assessments.⁷

In addition to this, Clinical Commissioning Groups, who have to bid for funding, can make a case for "unmet need and health inequalities" which would make them eligible

2 London Friend ([HSC0032](#))

3 Action on Smoking and Health (ASH) ([HSC0058](#)), Birmingham LGBT ([HSC0039](#)), Brighton & Sussex Medical School, University of Sussex ([HSC0027](#)), Dr JOANNA SEMLYEN ([HSC0046](#)), Dr Justin Varney ([HSC0013](#)), Dr Sue Westwood ([HSC0002](#)), Equality and Human Rights Commission ([HSC0055](#)), FPA ([HSC0061](#)), LGBT Foundation ([HSC0035](#)), London Friend ([HSC0032](#)), Macmillan Cancer Support ([HSC0057](#)), Opening Doors London ([HSC0025](#)), Professor Catherine Meads ([HSC0014](#)), Professor Kathryn Almack ([HSC0051](#)), Stonewall ([HSC0048](#)), Stonewall Housing ([HSC0021](#)), The National LGB&T Partnership ([HSC0033](#)), Trades Union Congress ([HSC0020](#))

4 London Friend ([HSC0032](#))

5 Q158

6 NHS England, [NHS Long Term Plan Implementation Framework](#) (June 2019), p 5

7 Q223

for funding on top of their standard funding from NHS England.⁸ This means that it is absolutely vital for all health and social care bodies to know how many LGBT people are using their services, how they are using them and what the unmet need might be.

7. Very few front-line services are collecting information about the sexual orientation and gender identity of their patients as part of registration. The Office for National Statistics conducted an audit of public datasets and found that, of 108 health datasets, only 23 included sexual orientation monitoring in datasets in England. Only four datasets included gender identity, and three of these were surveys specifically aimed at LGBT people.⁹ This lack of quantitative data is also reflected at a local level, with witnesses telling us that local services rarely collect this information. Prof Kathryn Almack of the University of Hertfordshire described the problem in care homes:

If we have an estimate that—we do not know, but let us say—6% of the population are LGBT, there are going to be LGBT people in care homes, yet they seem on the whole to be invisible. I go into care homes and they say, “We do not have any people like that here”.¹⁰

8. Lack of consistent data collection causes a dual problem. The first is that individuals may not have their needs as LGBT people taken into account when they should be. The second is that service commissioners are unable to plan for the needs of their LGBT population. The Government has acknowledged this issue within the LGBT Action Plan stating that:

The Government Equalities Office will develop best practice guidance for monitoring and make this openly available to the public sector, and the National Advisor will work to ensure healthcare professionals understand the benefits of asking patients about their sexual orientation and gender identity. The Care Quality Commission will look at how we can promote the NHS England voluntary sexual orientation monitoring standard for people using health and social care services.¹¹

This commitment has come after NHS England published a new Sexual Orientation Monitoring Information Standard (SOM) in 2017¹² and stated that it was voluntary to use by any health provider who wished to. NHS England had already begun encouraging take-up of the SOM by health and social care providers before the LGBT Action Plan was published.¹³

9. We found it strange that the new SOM had been developed by NHS England but its use was not being mandated. Brighton and Sussex Medical School suggested to us that the reason for the collection being optional was due to the discomfort that health and social care professionals felt in asking the questions. Brighton and Sussex Medical School’s submission states that:

8 NHS England, [Equality and Health Inequalities Analysis](#) (January 2019), p 6

9 Office for National Statistics, [‘Equalities Data Audit’](#), accessed 19 September 2019

10 Q112

11 Government Equalities Office, [LGBT Action Plan](#) (July 2018), p 10

12 NHS England, [‘Sexual Orientation Monitoring Standard’](#), accessed 19 September 2019

13 NHS England, [Sexual Orientation Monitoring: Full Specification](#) (October 2017)

Our research strongly suggests additional support is necessary to support health service staff on administering monitoring, and to support patients' confidence to disclose this stigmatised information.¹⁴

Their research also found that the discomfort was one-sided, in that that LGBT (and non-LGBT) people were willing to disclose their sexual orientation but the health staff worried that they would object, so worried about asking the relevant question. The submission states that:

Staff discomfort with explaining sexual orientation questions almost exactly mirrored their assumption of patient discomfort with answering such questions, suggesting that staff may be projecting their anxieties about monitoring onto patients.¹⁵

10. When we asked witnesses about whether SOM should be mandatory, they not only told us it should be¹⁶ but that they considered there to be a double standard at play. Dr Justin Varney told the Committee how ethnicity monitoring was rolled out in the NHS, saying:

When the NHS introduced ethnicity monitoring across the system, that was introduced with a mandation element, so if you did not achieve, I think, a 90% threshold of compliance, as a provider you were not paid. There was a financial penalty. Because of that, we know a huge amount, but we have also been able to systematically drive improvements in services for people from ethnic minorities.¹⁷

11. However, when we asked Dr Michael Brady, the National LGBT Health Advisor for the Government about the possibility of making monitoring compulsory, he was non-committal, saying:

Do we need to mandate it? I am not sure that I would say yes at this stage. What I would say is that my first approach to this is to let me understand where it is happening and how it is happening. From my initial discussions around this, it really seems that those places that have implemented it have implemented it on the basis of existing knowledge about health inequalities. That is why, for example, cancer services or mental health services are doing it perhaps more than other settings.¹⁸

12. Services that already monitor sexual orientation are clearly aware of the health disparities that are uncovered through data collection. If sexual orientation monitoring remains optional, health disparities will remain hidden across the services that choose not to implement it. *In line with ethnicity monitoring, sexual orientation monitoring should be made mandatory across all NHS and state social care providers within the next 12 months. Any service provider who does not implement it should face fines at a level equivalent to those imposed for not monitoring ethnicity.*

14 Brighton & Sussex Medical School, University of Sussex ([HSC0027](#))

15 British Journal of General Practice, February 2019

16 Dr Joanna Semlyen ([HSC0046](#)),

17 Q159

18 Q203

13. Development of monitoring of gender identity is far less advanced than that of sexual orientation. NHS England has not yet agreed a standard, although Dr Brady told us in July 2019 that it would be a priority for him to drive this forward in the next six to twelve months. He told us that he believed that, within five years there would be:

... across-the-board monitoring for sexual orientation and gender identity or trans status that is acceptable to those to whom the question is being asked and useful to those who need that data to inform their system plans or their service delivery.¹⁹

14. This seems optimistic, given what others have told us about existing monitoring. For instance, we were told by Dr Duncan Shrewsbury that it is currently impossible to list a patient's gender identity as a characteristic as opposed to a health problem in GPs' computer systems:

It is absolutely right to capture that data, but at the moment there is not a practical way of using it, because within the systems that we use to capture that data, it is coded as a problem—as part of the list of diseases that somebody may or may not have. It is not included—there is no physical space in the fields to record it as part of gender, address, date of birth or something as core as that.²⁰

When we asked the Secretary of State about timescales for rolling out monitoring, he was unable to give us a firm commitment beyond the general target of completing all the actions in the LGBT Action Plan “in this Parliament”.²¹

15. Monitoring both sexual orientation and gender identity is far too important to be an aspiration rather than a concrete goal with clear timelines for delivery. The NHS needs to understand where the disparities are in order to formulate strategies to tackle them. This is especially true for the transgender population, where the LGBT Survey found that some of the greatest health disparities exist.

16. *Gender Identity monitoring work should be accelerated with a view to creating a standard by the end of 2019. This should then be rolled out on a mandatory basis to all NHS and state social care providers before the end of 2020.*

Disparities in health outcomes

17. Despite a lack of consistent data collection, some disparities in health outcomes in the LGBT community are well-known and are reflected in health policy, such as higher rates of smoking²² and alcohol consumption.²³ But other disparities receive less attention from policy-makers, such as research that shows that gay and bisexual men are more than twice as likely to report having anal cancer and bisexual women are more than twice as likely to have cervical cancer²⁴ Part of the reason these disparities are not widely discussed is

19 Q195

20 Q5

21 Government Equalities Office, [LGBT Action Plan](#) (July 2018), p 5

22 Action on Smoking and Health (ASH) ([HSC0058](#))

23 Dr Sue Westwood ([HSC0002](#))

24 Macmillan Cancer Support ([HSC0057](#))

because research on health and social care outcomes for LGBT people has been slow in developing outside of ‘traditional’ areas such as sexual health. Nonetheless, many of our submissions explored other disparities, including:

- Three per cent of gay and bisexual men have attempted to take their life in 2013, compared to just 0.4 per cent of men in general.²⁵
- More than four in five trans young people have self-harmed at some point compared to one in ten young people in general.²⁶
- Gay and bisexual men are less likely to eat five portions of fruit and vegetables a day than the general population.²⁷
- Men who have sex with men (MSM) account for 8 out of 10 of new cases of syphilis.²⁸
- Lesbian and bisexual women have higher risks of obesity and cardiovascular disease than straight women.²⁹
- Bisexual women are four times as likely to have a long-term mental health problem as straight women.³⁰

The rest of this report explores some of the reasons why health disparities persist that what can be done to tackle them.

25 Dr Sue Westwood ([HSC0002](#))

26 Stonewall ([HSC0048](#))

27 Birmingham LGBT ([HSC0039](#))

28 FPA ([HSC0061](#))

29 Dr Justin Varney ([HSC0013](#))

30 [Q8](#)

2 Access to health and social care and discrimination

18. As well as analysis of data on health outcomes, another way of evaluating whether the health and social care system is working for LGBT people is through information on whether the services are being used and what attitudes towards these services among their users are. We received a lot of information about LGBT people's experiences of using the health system, both from submissions to the inquiry and from the national LGBT Survey. We also heard about the attitudes that health and social care professionals have towards LGBT service-users, some of which were concerning.

The National LGBT Survey

19. In July 2017, the Government conducted what it described as “the largest national survey of LGBT people in the world”.³¹ Over 108,000 LGBT people took part and the Government released the results of the Survey in July 2018. The health section of the survey found that 13 per cent of cisgender LGB people and 40 per cent of transgender people had had a negative experience with healthcare in the 12 months preceding the survey. These negative experiences included inappropriate curiosity, having their specific needs ignored and avoiding treatment for fear of having a negative reaction. While most LGBT people were happy to disclose their sexual orientation or gender identity with healthcare staff, 9 per cent said that it had a negative effect on their treatment, rising to 26 per cent among asexual people. Trans respondents were almost twice as likely to say that they had experienced negative treatment from coming out to their healthcare practitioner.³² As discussed above, respondents to the survey spoke of the overwhelming assumption by healthcare staff that they were heterosexual and cisgender.

20. The results of the LGBT Survey were analysed by the Government Equalities Office and resulted in the LGBT Action Plan, published in July 2018. The Government stated that:

With over 75 commitments, the cross-Government plan sets out how we will improve the lives of LGBT people over the course of this Parliament.³³

The Action Plan is discussed in Chapter 3.

Types of discrimination

21. Much of the evidence that we heard during this inquiry echoes the results of the National LGBT Survey and points to parts of the health and social care systems that are not catering effectively to LGBT communities, whether intentionally or not. This can lead to LGBT people opting out of services for fear of poor treatment.

22. Some discrimination is clear and direct and consists of one individual discriminating against another. A woman who attended our outreach event, for instance, was told by medical staff:

31 Government Equalities Office, [‘National LGBT Survey: Research report’](#), accessed 19 September 2019

32 Government Equalities Office, [National LGBT Survey](#) (July 2018), p162

33 Government Equalities Office, [LGBT Action Plan](#) (July 2018), p 2

They don't want to treat people like me, I was told how much money was spent on me and told that NHS money shouldn't be spent on me.

23. Some of this discrimination can take the form of signs and symbols that LGBT people may interpret as hostile. The fear that this instils in LGBT individuals seeking healthcare was encapsulated in a quote from a gay man, as reported by Healthwatch Suffolk:

My GP has bibles in the waiting room and a large sign in his consulting room inviting patients to 'Pray with me if it's bad news' As a gay man I feel very anxious my doctor is a practising Christian. I feel inhibited and frightened to discuss health issues concerned with my sexuality.³⁴

24. In many cases discrimination is less direct and relates to structures of health and social care systems that assume that everyone is heterosexual and cisgender. For instance, we heard that lesbian and bisexual women are much less likely to attend cervical screening than straight women. FPA, a sexual health organisation, told us that many women who have sex with women exclusively have been told by professionals that they do not need to be screened³⁵ despite clear advice from Public Health England that all women aged 25–49 should be screened.³⁶ In addition, trans men who still have a cervix are also advised by PHE to attend cervical screening,³⁷ but are removed from the screening invitation list automatically by the computer system if they are registered with their GP as men.³⁸ In this case, it is the design of the NHS system that is excluding people rather than any individual. Systemic institutional issues such as these are inherently discriminatory and may be the cause of unintended poorer health outcomes.

Underlying causes of discrimination

25. As discussed above, it is not acceptable for LGBT people to be forced to adapt to a health and social care structure that assumes them to be cisgender and straight. Both health and social systems and health and social care professionals must respect the gender identity and sexual orientation of their service-users. We were told again and again by witnesses that many mainstream services were not considering LGBT people and were discriminating against them, albeit unintentionally, by treating them as “the same” as their non-LGBT counterparts.³⁹ This attitude was expressed to us succinctly by Debbie Ivanova of the CQC, who quoted care homes that she had inspected:

“Person-centred care means everybody is treated the same or equally, and we meet everybody's needs because we treat everybody the same”. That does not address the issues when people maybe do not fall into a heteronormative

34 Healthwatch Suffolk CIC ([HSC0026](#))

35 FPA ([HSC0061](#)). FPA went into liquidation in May 2019, after its evidence was submitted.

36 NHS Cancer Screening Programmes, [NHS Cervical Screening Programme Cervical screening for lesbian and bisexual women](#) (September 2009), p 2

37 Public Health England, [Information for trans and non-binary people NHS Screening Programmes](#) (July 2017), pp 11–15

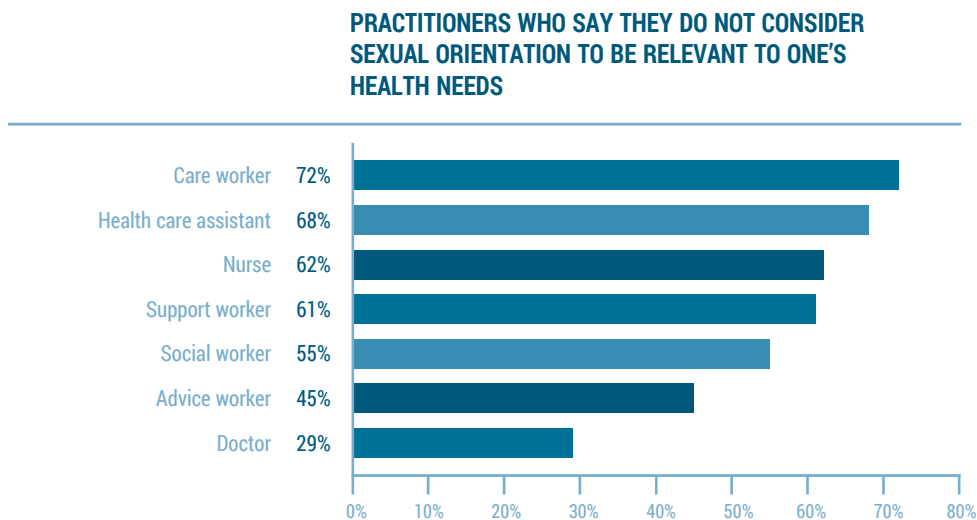
38 The National LGB&T Partnership ([HSC0033](#))

39 Q109, Q129

setting. We have to fight that assumption and get on to really making sure that people are confident with difference. That includes our staff too, in the way they inspect.⁴⁰

26. One problem is that frontline staff do not consider sexual orientation and gender identity to be relevant to an individual's care. This is especially true in social care; Stonewall has reported that 72 per cent of care workers did not consider sexual orientation to be relevant to one's health needs.⁴¹

Figure 1: Practitioners who say they do not consider sexual orientation to be relevant to one's health needs



Source: Stonewall

27. Dr Ju Gosling of Regard, an organisation of LGBT disabled people, agreed with this and added that:

My partner got a letter saying, “Home from hospital’ will be taking over your care on Monday; it will be delivering services regardless of your sexual and gender orientation”. We believe that practice should be stamped out. It is not appropriate to the Equality Act at all to say, “We will deliver a service regardless”. The Care Act states it has to be personalised, and so does the Equality Act.⁴²

28. The evidence we heard suggests that most health and social care professionals feel under-equipped to deal with LGBT people's needs rather than intentionally discriminating.⁴³ Staff may be struggling to communicate effectively with LGBT people or to understand how sexual orientation and gender identity are important to person-centred care. Some also simply do not feel confident with specialist needs, such as gender identity pathways.⁴⁴ Sophie Meagher from the LGBT Foundation remarked on this lack of confidence, saying:

40 Q109

41 Stonewall, [Unhealthy Attitudes](#) (2015), p 15

42 Q119

43 University of Bristol ([HSC0036](#)), Compassion in Dying ([HSC0011](#)), Dr Justin Varney ([HSC0013](#)), Encompass Network ([HSC0059](#)), NAT (National AIDS Trust) ([HSC0060](#)), Opening Doors London ([HSC0025](#)),

44 Stonewall ([HSC0048](#))

I think the main problem comes when healthcare professionals don't understand that LGBT people might have specific needs, and they don't understand that they might need different treatment. There is also a lack of evidence on the specific needs of LGBT people.⁴⁵

29. There are a number of reasons why health and social care providers may be under-equipped to support LGBT people. Much of this is to do with training, a topic which is explored further in Chapter 5. However, there is also a lack of understanding of the differences that exist between LGBT people and non-LGBT people (and between communities under the LGBT umbrella) and how best to tackle them. Birmingham LGBT, an LGBT charity, listed potential barriers:

Discrimination is caused by a number of factors, including unconscious bias; stereotypical and prejudicial attitudes of staff; lack of specialist, cultural competence skills-based training; religious beliefs; cultural homophobia; lack of inclusive policies and procedures. All of these issues need to be addressed in order to create LGBT affirmative services.⁴⁶

30. As Wendy Irwin from the Royal College of Nursing told us:

I genuinely don't believe that the vast majority of nurses and healthcare support workers get up and go to a shift with the intention of deliberately discriminating against LGBT communities. What they may well experience is the impact of unconscious bias—those heteronormative assumptions.⁴⁷

There are a number of ways in which these issues may be tackled, in order to provide the truly person-centred care that the NHS and social care sectors aspire to. These are explored in Chapter 4.

45 Q2

46 Birmingham LGBT ([HSC0039](#))

47 Q2

3 Leadership and creating policy that results in measurable improvement

31. Disparities in health and social care outcomes can be tackled, but this requires commitment from across the health and social care sectors. We saw no evidence that suggested service-providers and policy-makers are unwilling to provide an equal service to LGBT people and, indeed, we have heard numerous examples of individual health and social care providers delivering excellent, person-centred care to their LGBT communities. We have also heard that there are a number of barriers to full inclusion that relate to strategic leadership and accountability and that without improvements in this area the effectiveness work to tackle health and social care disparities will be limited.

The role of national and local leaders

32. LGBT-inclusion is rarely seen as a distinct issue to be considered and championed by senior leaders. This can manifest itself either in the outdated idea that “inclusion” means treating everyone the same regardless of specific needs⁴⁸ or in the loss of LGBT-specific interventions within the more general work on “equality, diversity and inclusion”.⁴⁹ We are hopeful that this issue will be addressed through the ongoing drive to provide “person-centred care”.

33. In an attempt to ensure that all staff take individual responsibility for equality issues, strategic leadership on LGBT inclusion within NHS services can be lost. As Wendy Irwin from the Royal College of Nursing told us:

What we often hear is that there is no clear leadership on this issue, so this desire that it is everybody’s business is fine, but in practice it becomes nobody’s business because there isn’t someone holding people to account over, “Well, we see that in this community those health inequalities are widening, sharpening, broadening, deepening.” Who is responsible for changing outcomes on that? It is not always at all clear who is responsible.⁵⁰

34. NHS England has an Equality and Diversity Council whose role is to:

Help shape the future of the healthcare system from an equality, diversity and inclusion perspective; focussing upon improving access, experience, and health outcomes for all patients, service users, carers and the NHS workforce. To achieve this, the EDC undertakes a strategic approach and through agreement initiates programmes to support and enhance quality performance across the healthcare system.⁵¹

It is unclear if, until now, the EDC has specifically dealt with LGBT issues or if it has considered the LGBT Action Plan, as its website has not been updated since 2017. However,

48 Q109

49 Q25

50 Q47

51 NHS England, [‘NHS Equality and Diversity Council’](#), accessed 19 September 2019

NHS England has told us that the National LGBT Health Advisor will be invited to sit on the EDC.⁵² This is a positive step, but only if the role of the Advisor is truly embedded in NHS England so that this role can be an effective part of the EDC.

35. In practice, most of the innovation in creating LGBT-inclusive services seems to come from individuals working on the ground, or from individual commissioners of services, rather than at a strategic level. There is a lack of clear strategic thought about providing LGBT-inclusive services in health organisations, whether these are care homes, local authorities or the NHS. We heard from witnesses that much of the policy and research work is being done by relatively junior members of staff who have no authority to create systemic change.⁵³ At the tops of these organisations are individuals, who, while well-intentioned, do not have the expertise to ensure that LGBT needs are embedded into all strategic thinking, whether due to an overly broad portfolio or simply through being overstretched. Dr Justin Varney of Birmingham City Council told us:

Much of the work that has been done in health, whether in Public Health England, NHS England or the Department of Health and Social Care, has been through committed individuals with personal passion, often at personal cost, in order to deliver what they fundamentally believe is important to shifting the lives of LGBT people.⁵⁴

36. This has led to a lack of strategic, organisation-wide drive that often results in initiatives getting stuck or not being effective. Harri Weeks of the National LGB&T Partnership told us:

There is a lack of investment and commitment behind these pieces of work. They happen, again, once and then there is little thought given to how to disseminate them or how to keep driving forward, keeping them updated, because often these pieces of work only really come about because of the passion and interest of one particular person who then may move on to a different role, and who was often doing it above and beyond their usual work.⁵⁵

37. Mx Weeks also explained the role of the National LGB&T Partnership in liaising between various parts of the NHS, many of whom are not working in a joined-up fashion. As members of the Health and Wellbeing Alliance, the role of the Partnership is to bring together examples of good practice and share them across the NHS.⁵⁶ Dr Varney spoke about good practice not being widely enough replicated across multiple health services, each of which is working independently:

What I would say [...] is that there are lots of gemstones, but there is not a coherent necklace in place. That is the gap for us; it is about how we take fantastic examples of good practice in individual hospitals, GP practices, partnerships with the voluntary and community sector, the NHS and local

52 [Letter from John Stewart, NHS England, 22 August 2019](#)

53 Q157

54 Q157

55 Q156

56 Q155

government, and go, “Here, this is how this connects from this part of the country to this part of the country and does it in a way that is not enforcing one-size-fits-all”.⁵⁷

38. While we welcome the fact that there are pockets of good practice, as Dr Varney also pointed out, it is not single projects or small-scale activities that are going to make the difference to the everyday experiences of the majority of LGBT people across health and social care settings.⁵⁸ If there is no clear commitment from the very top of health and social care organisations, it is difficult to see how good practice can be spread effectively or how a consistently good service can be provided to LGBT people.

The NHS Long Term Plan

39. Much of the Government’s overarching strategy for healthcare in England is contained in the recent NHS Long Term Plan, published in January 2019.⁵⁹ The Long Term Plan sets out the vision that the Government has for the NHS for the next decade. Part of the Long Term Plan focuses on the need to reduce health inequalities. The Plan states that:

For reasons both of fairness and of overall outcomes improvement, the NHS Long Term Plan therefore takes a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care.⁶⁰

Although the NHS Long Term Plan addresses the need to reduce inequalities generally, LGBT people are not one of the specific groups for whom the Plan specifically urges action to improve health outcomes and there are no references to LGBT service users as a targeted group beyond a single mention in the context of mental health provision in schools.⁶¹ This is surprising given the health inequalities for LGBT people already outlined in this report.

40. Part of the Long Term Plan involves restructuring local health providers into new and existing Integrated Care Systems (ICS). Each ICS:

... will agree system-wide objectives with the relevant NHS England/NHS Improvement regional director and be accountable for their performance against these objectives. This will be a combination of national and local priorities for care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance.⁶²

41. One of the requirements that the Long Term Plan introduces is that all ICSs set out how they are planning to reduce health inequalities within “System Plans” that will run until 2023/24. The Long Term Plan states that ICSs will need to identify health inequalities in their area and set out “evidence-based interventions” that would reduce these inequalities. ICSs would then be able to set these out in their System Plan, which would then be used

57 Q170

58 Q154

59 The Plan does not, for the most part, deal with social care provision as the majority of social care is provided by local authorities rather than the NHS.

60 NHS England, [The NHS Long Term Plan](#) (January 2019), p 41

61 NHS England, [The NHS Long Term Plan](#) (January 2019), p 41

62 NHS England, [The NHS Long Term Plan](#) (January 2019), p 31

to make the case for additional funding.⁶³ Support to identify these “evidence-based interventions” these are being developed by NHS England. While these interventions are welcome and will hopefully be able to deal with unequal outcomes that are considered to be part of public health, they are likely to be of limited help in eliminating structural discrimination affecting LGBT people within the NHS itself if the data identifying that group remains voluntary to collect and Systems Plans do not address problems in social care provision.

42. It is vital that all local health and social care organisations actively consider the needs of their LGBT communities, as required by the public sector equality duty. This should be mandated directly from the Department of Health and Social Care and from NHS England as a part of commissioning requirements and as a requisite for receiving funding.

43. *All commissioning outcome frameworks should include an explicit requirement to demonstrate how a service provider will meet equalities obligations and best practice and show that it has consulted on and considered the needs of LGBT service-users. This should include both NHS contracts and local authority contracts for social care provision.*

44. We also recognise that some NHS and social care providers will not have considered LGBT issues as part of their commissioning requirements before. We have seen plenty of good practice among individual CCGs but this practice needs to be promoted throughout the NHS and social care. DHSC and NHS England should work together to create an LGBT inclusion commissioning toolkit that health commissioners can use to spread best practice in commissioning LGBT-inclusive services.

45. *NHS England should review all new bids for funding from CCGs and Integrated Care Systems to ensure that not only are they having due regard for the need to eliminate discrimination but also that the needs of the LGBT populations of their areas have been specifically taken into account. Any bids that are found to be lacking should be passed on to the Equality and Human Rights Commission for enforcement action.*

Integrating the LGBT Action Plan into NHS Strategy

46. The NHS Long Term Plan contains the core policy for health care provision generally. It does not specifically set out requirements for improving LGBT health inequalities in the way that the LGBT Action Plan does (see below). The NHS Long Term Plan speaks in very general terms about public health problems, rarely going into detail on specific populations, even in the sections that are dedicated to eliminating inequalities. The assumption that the Government seems to be making is that interventions that benefit the population in general will equally benefit all parts of the population. The Secretary of State spoke to us about the goals of the NHS Long-Term Plan, including using the example of smoking cessation. He stated that:

First, by monitoring the gap, we know the level of inequality. Secondly, we have a whole series of measures aimed to tackle smoking across the board,

including interventions at what are called teachable moments. If you go into hospital—and this is true across the whole population—we will be intervening to give people smoking cessation support.⁶⁴

47. While we applaud the intention, such generalised measures overlook the specific barriers that LGBT people are facing, described in more detail in Chapter 2. For example, evidence from organisations such as Action on Smoking and Health (ASH) suggest that, while smoking rates are dropping, rates remain significantly higher in LGBT populations. It is impossible to tell, due to lack of consistent data collection, whether measures intended to improve the health outcomes of the entire population would have a similar impact on LGBT communities. **We do not consider such interventions to be specific enough to tackle the unique inequalities that LGBT people are experiencing. The Government, in the LGBT Action Plan, acknowledges that these problems need bespoke solutions, so it is disappointing that most of the measurement of success seems to be tied to the long-term plan and is therefore too general to be able to pinpoint whether LGBT service-users are benefiting.**

48. When it comes to policy to improve healthcare for LGBT people specifically, the flagship policies are contained in the LGBT Action Plan, published in July 2018 by the Government Equalities Office.⁶⁵ The Action Plan set out 75 commitments to improving the lives of LGBT people in the UK. Of these commitments, there were 12 that related specifically to health and social care, set out in the table below:

Table 1: Government Commitments to health and social care and responsible body

We will appoint a National Advisor to lead improvements to LGBT healthcare	Government Equalities Office
The National Advisor will work to improve healthcare professionals' awareness of LGBT issues so they can provide better patient care.	National Advisor
We will improve the way gender identity services work for transgender adults.	NHS England and Government Equalities Office
We will improve our understanding of the impacts on children and adolescents of changing their gender.	Government Equalities Office
We will take action to improve mental healthcare for LGBT people. The Department of Health and Social Care and the Government Equalities Office will jointly develop a plan focussed on reducing suicides amongst the LGBT population.	Department of Health and Social Care, Government Equalities Office and Health Education England
We will enhance fertility services for LGBT people. The Department for Health and Social Care will revise surrogacy legislation so single people (including LGBT individuals) can access legal parenthood after a surrogacy arrangement.	Department of Health and Social Care
We will ensure LGBT people's needs are taken into account in health and social care regulation. The Care Quality Commission will continue to improve how it inspects the experience of LGBT people in adult social care and mental health in-patient wards, and we will begin to inspect all gender identity clinics on a risk basis	Care Quality Commission

64 Q225

65 Government Equalities Office, [LGBT Action Plan](#) (July 2018)

We will support improved monitoring of sexual orientation and gender identity in healthcare services to enable better patient care.	Government Equalities Office, National Advisor and Care Quality Commission
We will work to tackle body image pressures that LGBT young people face.	Government Equalities Office
We will continue to review the blood donation deferral period for men who have sex with men.	NHS Blood and Transplant
We are committed to tackling HIV transmission, AIDS and HIV-related deaths. As part of this, we are currently funding a 3 year trial with 10,000 people to determine how best to deliver 'PrEP'. NHS England will consider the impact of increasing the PrEP trial further.	NHS England
We will take action to improve the support for LGBT people with learning disabilities. The Department of Health and Social Care will review, collate and disseminate existing best practice guidance and advice regarding LGBT issues and learning disability; and will also ensure that training requirements for support staff and advocates who work with people with learning disabilities includes advice regarding LGBT people	Department of Health and Social Care

Source: National LGBT Action Plan, Government Equalities Office

49. One of the commitments was that the Government Equalities Office would report back on progress on the Action Plan annually, which the Government did in July 2019.⁶⁶ The Government reported that it had progressed its health work through: the appointment of the National LGBT Health Advisor, Dr Michael Brady; funding of five organisations working to improve LGBT health; completing work on revising adoption legislation; expanding the PrEP trial to include an extra 26,000 places; and beginning a national procurement process to identify organisations best placed to deliver gender identity services in the future.⁶⁷

50. While these are positive steps, we are concerned that the Government seems to be taking a lot of action without being able to quantify whether it is having any measurable impact on the health outcomes of the LGBT communities. This was highlighted to us by Wendy Irwin of the Royal College of Nursing, who commented:

What are the metrics that matter? It is really easy within the current system to produce lots of statistics, but often I wonder whether those KPIs matter, in terms of the communities they are supposed to serve and the healthcare they are supposed to reflect?⁶⁸

51. Dr Brady, the National LGBT Health Advisor, agreed that he would only consider the Action Plan to have been successful if outcomes across a range of health and social care measures have improved, saying:

In five years' time, if my team, our partners and I have done what we have been asked to do, we will have seen a significant difference [...] in the health inequalities experienced by LGBT individuals, and also in the experience.

66 Government Equalities Office, LGBT Action Plan: Annual progress report 2018 to 2019, [CP 115](#), July 2019

67 Government Equalities Office, LGBT Action Plan: Annual progress report 2018 to 2019, [CP 115](#), July 2019, pp 5–6

68 Q48

We need to give equal focus to the clinical and mental health, physical and mental health, outcomes as to the experience; it is not just, “Are you going to smoke less, have less mental health or less chance of getting a sexually transmitted infection?” It is, “Will your experience of going to the GP or A&E, going for an operation or going to your cancer specialist be the same as those who are from the non-LGBT community?”⁶⁹

52. When we asked the Government about measuring success of the LGBT Action Plan, the Secretary of State for Health and Social Care cited the publication of the Action Plan itself as a mechanism for accountability, adding:

We are being held to account for delivering against that action plan, and this Select Committee is one example.⁷⁰

While we are heartened by this vote of confidence, a select committee cannot be responsible for the day-to-day accountability of establishing mechanisms for measuring the impact of Government policy. His response also did not deal with how he will know that the Action Plan has been effective in reducing the disparities in health outcomes.

53. We agree that, while the LGBT Action Plan is integral to achieving the intentions of Government, it cannot exist in a vacuum and not enough is being done to satisfy us that it is being integrated into the existing NHS structures. When we questioned the Secretary of State for Health and Social Care and the Minister for Equalities, we found that each spoke of their own strategies, the Long Term Plan and the LGBT Action Plan respectively, but that there was little read-across. We are concerned that currently the LGBT Action Plan does not require DHSC to take any responsibility for its implementation. This means that the health elements of the Action Plan are not embedded into NHS strategy in a systematic way but are seen as an adjunct to the work of the NHS, to be added on after strategies have already been devised. **We feel that the split between the LGBT Action plan, on which GEO has the lead, and the NHS Long Term Plan is extremely unhelpful and seems to imply that responsibility for LGBT-inclusive healthcare lies with GEO rather than within the health and social care institutions. In order to ensure that the LGBT Action Plan is integrated into NHS England strategy, the Chief Executive of NHS England should work with the GEO to produce the next LGBT Action Plan update and should be a signatory to it. The Government Equalities Office and Department of Health and Social Care should formulate and publish a list of key inequalities in LGBT health that the NHS need to be accountable for and include in the LGBT Action Plan and should report back to the Committee annually on progress in eliminating these.**

The role of the National LGBT Health Advisor

54. There has been a lot of optimism from stakeholders about the impact of the newly created role of the National LGBT Health Advisor.⁷¹ Dr Michael Brady was appointed in March 2019 under funding from the Government Equalities Office. He is working within NHS England and reports to the Director of Experience, Participation and Equalities. When we spoke to Dr Brady, he told us that his role was part-time (20 hours per week) and

69 Q195

70 Q222

71 Dr Justin Varney ([HSC0013](#)), Greater London Authority ([HSC0064](#)), LGBT Foundation ([HSC0035](#)), Mermaids ([HSC0068](#)), METRO Charity (The Metro Centre Ltd) ([HSC0034](#)), Terrence Higgins Trust ([HSC0015](#)), Trades Union Congress ([HSC0020](#))

that his contract was for 12 months only, as the post is subject to the Spending Review. We secured assurances from the Secretary of State for Health and Social Care, despite this, the post would be secure until at least 2022.

55. While this is a positive step, we are concerned about the National Advisor being able to effect long-lasting cultural change across the NHS. For as long as the role remains an advisory one, funded outside of NHS England and reporting to a director rather than being a director-level post, it will continue to feel as though the Health Service considers tackling the health inequalities faced by LGBT people to be an “add-on” rather than intrinsic to the work of the NHS. The Secretary of State told us that, in discussion with the Chief Executive of NHS England, he decided that it would be better for the post to remain advisory, as giving it to a director would risk “focus within that one area, as opposed to having the focus across the board.”⁷² **While we agree that it is important for the National Advisor to look across the piece of the NHS, we also believe that Dr Brady does not currently have the authority to make any of the structural changes that are needed for LGBT-inclusion. *The continued funding of the role of the National LGBT Health Advisor should be prioritised in the next Spending Review and should be confirmed for, at least, the next three years. The National Advisor should be embedded at a senior level and report directly to the Chief Executive of NHS England.***

4 Creating LGBT-inclusive services

56. As discussed in Chapter 2 there are barriers that currently prevent health and social care services from becoming LGBT-inclusive. These include staff not understanding that LGBT people can have significantly different health and social care needs, structures that are built on a model of service users being heterosexual and cisgender; and cultures that state everyone should be treated ‘the same’ without considering different needs. Creating LGBT-inclusive services requires proactive steps and strategic thought from providers, rather than waiting for practice to evolve in the hope that it becomes inclusive. Our evidence points to a much good intention and good will among some health and social care providers. This can translate into pockets of good practice and we have heard of health and social care organisations that are taking innovative steps to make their service LGBT-inclusive. But the evidence we received demonstrated this is the exception and not the rule and that there is a pressing need for the development of LGBT-inclusive services to be explicitly part of training and local strategy.

Materials and guidance to health and social care providers

57. We have received examples of good practice guides and materials that can be used to help health and social care services to make their practice LGBT-inclusive. For instance, we heard from Dr Justin Varney of Birmingham City Council that, during his time at Public Health England, PHE produced a variety of public health leaflets and guides, dating back more than 10 years, that helped professionals and the public to understand the needs of LGBT service-users.⁷³ However, we found little evidence of these materials being used widely or even that practitioners knew about them. When we asked Clare Perkins of Public Health England about this, she told us of various mechanisms that PHE use to disseminate their materials, from publishing them on the gov.uk website to sending out weekly emails to stakeholders.⁷⁴ She also highlighted the importance of working with community organisations when producing and disseminating good practice:

One of the key things we are moving to, which is critical [...] is that it is absolutely essential for these publications to be co-produced. If we involve our partners, stakeholders and community groups really early on in the process, there is much more ownership and help in disseminating that and working with us to make sure we have an impact.⁷⁵

58. **Publishing materials in isolation, with no guarantee that they will be taken up or even seen is a waste of time and resource. Public Health England need to step up their efforts in raising awareness of materials and disseminating them. Given that PHE is keen to work with stakeholders, the National LGB&T Partnership, a group made up of 10 LGBT organisations, is an ideal partner for this work.**

59. *Public Health England should work with the National LGB&T Partnership to prepare a five-year plan of LGBT-specific campaigns. The plan should include measurable performance indicators on disparities such as smoking and alcohol abuse and should be reviewed annually.*

73 Dr Justin Varney ([HSC0013](#))

74 Q184

75 Q184

LGBT-inclusive messaging

60. Another aspect of inclusive practice involves ensuring that materials for general health and social care use inclusive language and imaging. Sophie Meagher of LGBT Foundation gave us an example of a cervical screening campaign that was inclusive. . told us about a recent campaign that she felt did this well.⁷⁶

61. We also heard of the value of inclusive messaging in relation to social care, where individuals often have a lot more choice of provider. Jim Glennon of Opening Doors London, a charity for older LGBT people, said that he would personally look for signs of inclusion if he were choosing a care home:

People do not realise that, if we saw some marker and had confidence that this place, rather than that place, was doing the right things, with whatever, a sticker or a statement, we would choose to spend our money over there rather than over there. There is a business argument to be made.⁷⁷

62. The issue of having clear LGBT-inclusive policies was also raised as being an important marker of safety for some. Although not all LGBT people will look for these sorts of signs of “safety” in health and social care services, the absence of such explicit policies is noted by some and may deter them from using a service for fear of discrimination.⁷⁸

63. There are also initiatives for individual staff members, such as rainbow lanyards, in some NHS settings which are intended to indicate that the person wearing it is an “ally”. Stakeholders such as the Cicely Saunders Institute for Palliative Care point to such measures as clear markers of inclusion.⁷⁹ Macmillan Cancer Support was positive about this, saying:

Our research, ‘More than a Diagnosis’ was clear that some LGBT people felt substantially less anxious about discrimination when they could see signs in a hospital of a commitment to equality and—indeed—actively looked for them.⁸⁰

We were, however, concerned by the possibility that rainbow lanyards, or other markers of allyship could lead to unintended consequences. It is possible that, if a service-provider instigated such a scheme without training or appropriate practical support, individuals with no real understanding of LGBT issues might be signifying themselves as allies or that there would be organisational pressure on staff to take part while, at the same time, those individuals are unaware, unsympathetic or even hostile towards LGBT people. The TUC agreed, saying:

We also have concerns, as highlighted by union members, that many organisations providing such cues have not provided the prerequisite training to enable their staff to meet the needs of LGBT service users. So high quality training must accompany such approaches.⁸¹

76 Q21

77 Q129

78 Dr Michael Toze ([HSC0006](#)), The National LGB&T Partnership ([HSC0033](#)), University of Bristol ([HSC0036](#))

79 Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation ([HSC0012](#))

80 Macmillan Cancer Support ([HSC0057](#))

81 Trades Union Congress ([HSC0020](#))

64. *We agree with stakeholders who say that clear signs of LGBT-inclusion are to be welcomed. Markers of individual inclusivity are important, but this cannot be a replacement for service-wide commitment, which should also be clearly visible to all service users in an organisation's aims and strategy and communicated visibly through posters and other visible markers. It is vital that staff who want to be identified as allies are properly trained to take on this role. All NHS and social care providers should ensure that all staff understand their legal responsibility to deliver a service that is inclusive of LGBT people but that, until this is rolled out in the NHS and in social care provision, only staff that have had training should be allowed to identify themselves in this way.*

LGBT-specific services

65. The role of LGBT-specific services is subject to ongoing discussion, both within the LGBT communities and in health and social care policy. The importance of community organisations that provide support for different parts of the LGBT communities is well-documented and accepted by the Government as a vital part of health and wellbeing.⁸² Macmillan Cancer Support wrote that:

Macmillan's 2018 study—More than a Diagnosis—undertaken with De Montford University - showed the benefits that tailored LGBT support groups can bring. Their work showed clearly that LGBT support groups had proven popular and successful where they existed, and that there was demand for a greater range of LGBT support resources.⁸³

66. However, there was some disagreement among people we heard from about whether health and social care services that were exclusive to LGBT people were desirable. Some of these services, such as CliniQ⁸⁴ (a wellbeing clinic for trans people) and MindOut⁸⁵ (a mental health service for LGBT people), have been very successful and seem to be filling a gap in provision. When asked if these sorts of models should be more widespread, views varied. For social care, the School of Health Sciences at the University of Brighton said that:

One study showed that the preference of some older LGBT people was living independently in their own home, followed by shared accommodation with other LGBT people.⁸⁶

Similarly, the University of Bristol, undertaking research with older LGB people found that:

Half of the older LGB adults participating our study indicated their preference to live in LGB-specific care and nursing homes if needing these services in the future. These were imagined environments in which heterosexual norms and assumptions would not feature in the delivery of

82 Government Equalities Office, [LGBT Action Plan](#) (July 2018), p 6

83 Macmillan Cancer Support ([HSC0057](#))

84 CliniQ CIC ([HSC0072](#))

85 [MindOut](#), accessed 24 September 2019

86 School of Health Sciences, University of Brighton ([HSC0052](#))

care and participants could anticipate feeling safe and valued as LGB adults. This was more common among older lesbians who had established women-only networks for mutual support.⁸⁷

67. Jim Glennon of Opening Doors London, however, took a slightly different view. He felt that, when LGBT people asked for services that were just for them, it might stem from fear of discrimination in mainstream services. He said:

I have had this conversation several times, and I have heard different views from our group. Some say, “Yes, that would tick all my boxes; that would be perfect”. It is often to do with fear, fear about treatment. That seems to be an issue that I am picking up. I have also spoken to people [...] who have said, “The last thing I want to do is have my retirement completely surrounded with LGBT people”.⁸⁸

Dr Michael Brady, the National LGBT Health Advisor, felt that mainstream services should be catering to the needs of LGBT people rather than relying on specialist services to deal with the problems created by non-inclusive services:

Services in the broadest possible sense should be LGBT-inclusive and acceptable, full stop. Whatever kind of service you go to, it should be accessible and inclusive for you. That is the first thing. I do not see a case for LGBT cardiology services or LGBT physio services necessarily. All services need to have this on their agenda.⁸⁹

However, Dr Brady also recognised that, as stop-gap measures, LGBT-specific services were valuable:

For some areas, you could make a case for specific services that bridge from one place to the next. If it is going to take five years or even longer to make things truly inclusive, I do not want LGBT individuals to keep suffering for those five years until things get better.⁹⁰

68. We agree with Dr Brady that, while LGBT-specific services play a vital role in the health and social care landscape at the moment, these services often exist because mainstream services are not yet fully inclusive. These services should continue to be sustained and supported for as long as they are needed. In the meantime, the priority should be for mainstream services to become inclusive to the needs of the LGBT communities.

87 University of Bristol ([HSC0036](#))

88 Q119

89 Q216

90 Q216

5 Staff training and regulation

69. Every witness that we heard from in this inquiry emphasised the need for frontline staff to better understand the lives and needs of LGBT people under their care. Whether in mental health, cancer care or social care, the need for a “person-centred” approach was highlighted again and again. However, as outlined in the previous chapters, health and social care professionals do not always understand the needs that LGBT people have, and often do not consider these needs to be relevant to their care.⁹¹ While outright discrimination may be relatively rare, a single poor experience can undermine confidence in an LGBT person’s future interactions with other health and social care services. Niazy Hazeldine of METRO Charity told us, in relation to young people:

If you have experienced any of those kinds of things, or even if you have a doubt that you might experience those kinds of things, it is going to be very hard for you to access that service with trust. That makes it very difficult to create a feeling of trust where people can access services.⁹²

70. Witnesses told us that there were numerous reasons why healthcare professionals may not provide an inclusive service in practice. These include a lack of training leaving them to feel ill-equipped to deal with LGBT-specific issues, not feeling confident of the questions to ask an LGBT patient or simply working under the misapprehension that treating patients equally means treating them all the same.⁹³ Training for health and social care professionals, registration with professional bodies and ongoing inspection all need to be addressed in order to support better provision for LGBT service-users.

Training of health and social care professionals

71. Whether or not a health or social care professional receives formal occupational training largely depends on their role and whether or not there are mandatory requirements placed on them by professional bodies or inspectorates. This can be extremely prescriptive or light touch. For instance, while doctors and nurses coming from abroad need to pass a series of tests in order to register to practice as individuals,⁹⁴ social care workers do not need to register.⁹⁵ Instead, social care workers’ training is delivered by employers so that they can demonstrate that they are working effectively enough to pass inspections. We explored different parts of the training framework at different points in the inquiry, but the consistency with which witnesses raised training issues lead us to conclude that this is an area that needs comprehensive consideration.

Pre-qualification training

72. The bodies that are responsible for training and professional development of regulated health professions varies depending on the occupation. In many cases, a health professional will start their training at a university or college for pre-qualification training, where they will learn the basics of their field. The content of this training is mostly decided by the learning institution, although the parameters are set by bodies such as the General

91 Stonewall, [Unhealthy Attitudes](#) (2015), p 15

92 Q95

93 Q109, Q129

94 General Medical Council ([HSC0093](#)), Nursing and Midwifery Council ([HSC0097](#))

95 Health and Care Professions Council, [‘Regulating further professions’](#), accessed 24 September 2019

Medical Council (GMC) or Nursing and Midwifery Council (NMC). In this inquiry, we heard mostly about the training provided to doctors and nurses, so these are the examples we have used, although our conclusions are applicable across other disciplines.

73. The NMC told us that its involvement in curricula is light-touch but that it does regulate them, saying:

The NMC does not set detailed curricula for pre-registration programmes. Instead we set the proficiencies that all newly qualified nurses and midwives in the UK and nursing associates in England must be able to demonstrate to enter onto our register [...] We approve and monitor the pre-registration programmes designed by approved education providers across the UK against compliance with our standards.⁹⁶

The NMC within its guidelines, is clear that must staff on their register must:

Provide and promote non-discriminatory, person centred and sensitive care at all times, reflecting on people’s values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments.⁹⁷

However, it also states that “ It will be up to individual education providers to decide the content of their course based on our standards, and other sources”.⁹⁸

74. We have found that there seems to be a gap between what the registration bodies require from learning institutions and what these institutions are actually providing. Witnesses have told us that inclusion of LGBT health and social care needs in curricula vary greatly across institutions. Wendy Irwin of the Royal College of Nursing told us that:

The feedback that we continually get from students is that the practice within various universities is variable. A number of nursing students have spoken to me about feeling not quite prepared for dealing with the reality of meeting patients who are complete, complex, living and breathing human beings.⁹⁹

75. A related problem is that, when LGBT issues are touched upon, it tends to be within a much broader context of “inclusive healthcare” or “person-centred care” rather than dealing specifically with inequalities experienced by LGBT communities. Dr Duncan Shrewsbury told us that:

Curricula largely articulate LGBT health-related issues at quite a high level, in terms of how they orientate towards whole person care—a “no health without inclusive health” view.¹⁰⁰

He added that, when training on LGBT issues does exist, it tends to be within the context of particular medical issues, rather than being seen as a part of the equalities framework:

96 Nursing and Midwifery Council ([HSC0097](#))

97 Nursing and Midwifery Council, [Future nurse: Standards of proficiency for registered nurses](#) (March 2018), p 6

98 Nursing and Midwifery Council ([HSC0097](#))

99 Q26

100 Q24

You tend to find that they still feature in particular areas such as sexual and reproductive health, but increasingly also in other areas such as mental health.¹⁰¹

The GMC states that “equality, diversity and inclusion (ED&I) runs as a thread throughout our outcomes for education for medical students and doctors too”. However, it states that the “outcome” that newly qualified doctors must be able to demonstrate in ED&I is “clearly, sensitively and effectively with patients, their relatives, carers or other advocates, and colleagues from medical and other professions”.¹⁰² While this is relevant to working with LGBT patients, this “outcome” feels insufficient to deal with the barriers that LGBT people are facing in health and social care.

76. Understanding the real needs of LGBT people is necessary in order for health and social care professionals to truly deliver person-centred care. Those responsible for the education and training of health and social care professionals should treat training on LGBT needs with the same integral importance as other basic training. This must happen early in training and not be seen as a “specialism” to be delivered post-qualification.

77. *The GMC and NMC should review their guidance for medical schools with a view to ensuring that LGBT content exists in every medical school curriculum. This content should be spread across modules rather than being restricted to modules on, for instance, sexual health.*

Post-qualification training and continuing professional development

78. Training after initial qualification is equally inconsistent. Training in certain disciplines can be set by Royal Colleges, such as the Royal College of Nursing, although not exclusively. However, these bodies have more control than over curriculum design than registration bodies do over initial training. Royal Colleges and other bodies set curricula for a wide range of specialisms, from cardiology to social work. Some institutions are developing specific equality and LGBT health modules, however, these training programmes are mostly optional and are delivered at an advanced stage of health or care professional’s working life.¹⁰³ This approach runs the risk of not reaching the professionals who need the training the most. As Wendy Irwin of the Royal College of Nursing told us:

What we do know about post-registration CPD for nurses is that it can be quite hit and miss. Often people do not understand how complex people’s identities are. [...] What we do not often see is very clear, mandatory, high quality CPD that enables nurses to do the job that they want to do, which is a great one for all patients.¹⁰⁴

79. For GPs, who provide the most frequent frontline service for patients, Dr Shrewsbury told us that decisions on training tended to be set by CCGs, meaning that the provision is even more uneven:

101 Q24

102 General Medical Council ([HSC0093](#))

103 Qq25–26

104 Q10

There is no formal structured and delivered training programme that is rolled out for all people in their post-qualification training. It is very much set and determined by local needs that are identified and matched to local resources. It can be quite variable and it can be quite hit and miss, to a certain extent.¹⁰⁵

Dr Shrewsbury nevertheless emphasised the role of Royal Colleges in the training landscape, saying that the Royal College of GPs had e-learning available to GPs who wanted to use it.¹⁰⁶ The GMC also told us about the post-graduate curricula content that it is responsible for, but was unable to provide an accurate picture of which content covered LGBT needs.¹⁰⁷

80. We would urge the GMC to look again at its curricula to truly assess whether the mandatory training for these specialties includes LGBT content and, if they are found lacking, to revise them.

81. Witnesses were critical of e-learning in equalities , with Dr Shrewsbury telling us that:

You have to do your [equality and diversity] modules every year. It is all done online. It is not a particularly engaging means of teaching somebody about something that is really complicated, dynamic and ever-changing—a lot of these things have not been updated for a couple of years.¹⁰⁸

82. Even when training is delivered in person, our witnesses told us that the content left much to be desired. Sophie Meagher of the LGBT Foundation gave an example of where stereotypes were being used instead of an holistic approach:

We know that first-year students had one case study of a LGBT person—it was a gay man who caught HIV and his life spiralled and everything went terribly for him—and that was the only time in that whole year that they learned about LGBT people.¹⁰⁹

83. *Training can be the first exposure that students have to LGBT health needs. All registration bodies should ensure that case studies featuring LGBT people are included in courses in a way that does not play into stereotypes. Registration bodies should develop these case studies in cooperation with local LGBT organisations.*

Registration of individual professionals in health or social care

84. The registration requirements for health and social care vary from none at all for care workers to over a decade of training for consultant doctors. We were particularly concerned about the lack of any registration or qualification requirement in England to work as a care worker or to offer mental health services.

105 Q24

106 Q24

107 General Medical Council ([HSC0093](#))

108 Q24

109 Q28

85. In the care sector, care workers who work for agencies or in care homes are indirectly inspected by the CQC and are expected to be able to demonstrate inclusive behaviours.¹¹⁰ This covers scenarios where social care workers will have received their training and education in other countries. In all cases, it is the responsibility of the employer to ensure that, if inspected, staff can demonstrate understanding of the UK's equality law framework and practice.

86. In mental health and counselling services, while professionals may choose to register with trade organisations such as the British Association for Counselling and Psychotherapy (BACP), or the Health and Care Professions Council (HCPC) this is not mandatory. This means that, in effect, such workers may, at best, be ignorant of equality law and, at worse, be causing harm to their patients with practices such as conversion therapy. Dr Joanna Semlyen of the University of East Anglia told us that:

We have people offering lay interventions without any qualification. People can set themselves up, or people can describe what they are doing in a faith setting as mental health support.¹¹¹

87. If someone works outside of a formal organisational structure, for example as a personal assistant (PA) to a disabled person, they would not be subject to CQC inspection and any discrimination may go unchecked. As Dr Ju Gosling of Regard told us of their research with users of self-directed care, they found that:

More than half of those surveyed said that they never or only sometimes disclosed their sexual orientation or gender identity to their PAs, and less than a third said they were very comfortable with talking about their support needs in relation to being LGBTQI+. More than a third said they had experienced discrimination or received poor treatment from their PAs because of sexual orientation or gender identity. This went all the way to somebody being sexually assaulted, having told the PA that they were gay.¹¹²

88. In the regulated professions (e.g. doctors and nurses), on the other hand, there are rigorous registration processes for, for instance, doctors who have qualified outside of the UK (which accounts for over a third of doctors currently practicing). Both the Nursing and Midwifery Council and General Medical Council outlined the processes they have in place to ensure that medical professionals are trained up to UK standards, which include being tested on the Equality Act 2010.¹¹³

89. *The Government should consult on ways in which effective knowledge and understanding of unacceptable discriminatory practices and the Equality Act could be ensured amongst the widest range of health and social care providers. This should include staff feeling empowered to take action when they are aware of LGBT discrimination. All NHS and social care providers should ensure these expectations are embedded into their interactions with new patients or residents and provide staff with the relevant training so they feel confident in challenging discriminatory behaviour. The CQC might consider how to strengthen the monitoring of these issues as part of their existing inspection regime.*

110 Care Quality Commission, '[Regulation 10: Dignity and Respect](#)', accessed 24 September 2019

111 Q79

112 Q117

113 General Medical Council ([HSC0093](#)), Nursing and Midwifery Council ([HSC0097](#))

Identifying and dealing with poor practice

90. While many of the barriers for LGBT people accessing health and social care seem to stem from misunderstanding and ignorance, we did hear of specific incidences of outright discrimination and poor practice. Some instances of discrimination may seem minor to outsiders, but can and do cause considerable distress to the individual concerned. These low-level acts were described as “micro-aggressions” by witnesses,¹¹⁴ events that, over time, wear down an LGBT person and cause them to lose confidence in the institutions that are meant to provide their care. The Encompass Network, an LGBT charity, gave an example of this in their evidence:

Ignorance and awkwardness took the form of inappropriate terminology, describing heterosexual sex as “proper” sex, or inappropriate comments such as “nurse said she could never be a lesbian because she had seen so many disgusting vaginas”.¹¹⁵

91. In cases of direct discrimination, it is very difficult for LGBT people to know how to complain and whether their complaint will be taken seriously. In common with other groups, LGBT people may be at their most vulnerable when accessing health or social care, but they are also less likely to have family support during these times, thus increasing their vulnerability.¹¹⁶ One participant in our outreach session observed that

We are expected as patients to complain but don’t always have strength or time [...] lots of this is left to charities.¹¹⁷

92. Beyond this, it seems that some healthcare providers are ignoring the problem, for fear of negative exposure. For example, one trans man in our outreach session spoke about trying to access mental health services and A&E. He said that some NHS staff use transphobic and homophobic slurs, which he was able to hear on the ward. This made him feel unsafe as an LGBT person. He said that this was especially acute in one hospital:

I am talking about stuff like nurses talking about killing gay people ... the hospital was terrified to have this talked about, [to have it known] that it was happening in our city.¹¹⁸

93. Stonewall’s 2015 report *Unhealthy Attitudes* made a similar finding, stating that a quarter of patient-facing staff had heard negative remarks being made about LGB people in five years preceding the survey.¹¹⁹ The report also found that one in six (16 per cent) of health staff would not feel confident challenging such language.

Taking forward complaints

94. Complaints about the standard of care provided by health and social care professionals need to be taken through the relevant NHS or care processes, ultimately ending with one of the two ombudsmen that are responsible,¹²⁰ if the matter remains unresolved. But these

114 Q2, Q33

115 Encompass Network ([HSC0059](#))

116 Q112

117 See Appendix

118 See Appendix

119 Stonewall, [Unhealthy Attitudes](#) (2015), p 6

120 The Parliamentary and Health Service Ombudsman or Local Government and Social Care Ombudsman

processes take a long time and often individuals do not have the knowledge or confidence to take them forward.¹²¹ This may especially be the case with LGBT communities as making a complaint would involve “outing” themselves multiple times to different agencies. When we asked about this, Helen Jones of MindOut, an LGBT mental health charity told us that her solution would be increased support to make complaints:

We need more advocacy services. Independent advocacy is really vital for people to be able to complain. We run a lot of advocacy services in Brighton and Hove, and even where people do not want to take the issue forward themselves—for all sorts of reasons they may not—we can take issues forward as collective concerns. That can be really useful.¹²²

95. We agree that advocacy services can be a way to increase access for LGBT people who have concerns about their care. We also feel that more and clearer information is required to help LGBT people to take a complaint forward. The Government should help fund more capacity in national health advocacy services as part of the LGBT Action Plan. The GMC and NMC should, in addition to this, produce information specifically for LGBT patients that clearly explain what level of service they can expect from their doctor, nurse or midwife and how to complain if they encounter discrimination.

Inspection

96. One of the ways of more efficiently identifying and dealing with non-inclusive practice is through the existing inspection regimes, the majority of which falls to the Care Quality Commission (CQC). The LGBT Action Plan specifically includes the CQC within its commitments, saying that:

The Care Quality Commission will continue to improve how it inspects the experience of LGBT people in adult social care and mental health in-patient wards, and we will begin to inspect all gender identity clinics on a risk basis. The Care Quality Commission will develop guidance for care quality inspectors on the healthcare pathway for people who are transitioning their gender, and embed LGBT equality issues into the methodology used by inspectors.¹²³

97. Debbie Ivanova of CQC told us that much of this framework is already in place through the CQC’s “key lines of inquiry”:

Within our key lines of inquiry, we have very specific prompts and questions about equality. Under our questions on “safe”, we will make sure that people are not discriminated against. If people felt they were discriminated against because of their faith, religion or sexual orientation, we would follow that through and make sure they had access to complaints and were able to do that.¹²⁴

121 Dr Michael Toze ([HSC0006](#))

122 Q81

123 Government Equalities Office, [LGBT Action Plan](#) (July 2018), p 10

124 Q109

Ms Ivanova told us that there is work still to be done with health and social care providers to move them away from a view that “person-centred” means that everyone is treated the same and to a better understanding of the individual needs of LGBT people.¹²⁵

98. While the steps that the CQC have been taking to ensure that inspections are looking for evidence of LGBT-inclusive practice, inspection cannot always be the solution as it cannot uncover every incident of poor practice.

99. *The CQC should conduct a thematic review of social care services for LGBT people which should include examples of best practice and guidance to social care providers around how to create LGBT-inclusive care services.*

100. *CQC and NHS England should work together to produce a guide to making complaints along with an online form that can be used to ensure that complaints are received by the appropriate body to address them.*

Conclusions and recommendations

The disparities in health and social care experienced by LGBT people

1. Services that already monitor sexual orientation are clearly aware of the health disparities that are uncovered through data collection. If sexual orientation monitoring remains optional, health disparities will remain hidden across the services that choose not to implement it. *In line with ethnicity monitoring, sexual orientation monitoring should be made mandatory across all NHS and state social care providers within the next 12 months. Any service provider who does not implement it should face fines at a level equivalent to those imposed for not monitoring ethnicity.* (Paragraph 12)
2. Monitoring both sexual orientation and gender identity is far too important to be an aspiration rather than a concrete goal with clear timelines for delivery. The NHS needs to understand where the disparities are in order to formulate strategies to tackle them. This is especially true for the transgender population, where the LGBT Survey found that some of the greatest health disparities exist. (Paragraph 15)
3. *Gender Identity monitoring work should be accelerated with a view to creating a standard by the end of 2019. This should then be rolled out on a mandatory basis to all NHS and state social care providers before the end of 2020.* (Paragraph 16)

Leadership and creating policy that results in measurable improvement

4. It is vital that all local health and social care organisations actively consider the needs of their LGBT communities, as required by the public sector equality duty. This should be mandated directly from the Department of Health and Social Care and from NHS England as a part of commissioning requirements and as a requisite for receiving funding. (Paragraph 42)
5. *All commissioning outcome frameworks should include an explicit requirement to demonstrate how a service provider will meet equalities obligations and best practice and show that it has consulted on and considered the needs of LGBT service-users. This should include both NHS contracts and local authority contracts for social care provision.* (Paragraph 43)
6. We also recognise that some NHS and social care providers will not have considered LGBT issues as part of their commissioning requirements before. We have seen plenty of good practice among individual CCGs but this practice needs to be promoted throughout the NHS and social care. *DHSC and NHS England should work together to create an LGBT inclusion commissioning toolkit that health commissioners can use to spread best practice in commissioning LGBT-inclusive services.* (Paragraph 44)
7. *NHS England should review all new bids for funding from CCGs and Integrated Care Systems to ensure that not only are they having due regard for the need to eliminate discrimination but also that the needs of the LGBT populations of their areas have*

been specifically taken into account. Any bids that are found to be lacking should be passed on to the Equality and Human Rights Commission for enforcement action. (Paragraph 45)

8. We do not consider such interventions to be specific enough to tackle the unique inequalities that LGBT people are experiencing. The Government, in the LGBT Action Plan, acknowledges that these problems need bespoke solutions, so it is disappointing that most of the measurement of success seems to be tied to the long-term plan and is therefore too general to be able to pinpoint whether LGBT service-users are benefiting. (Paragraph 47)
9. We feel that the split between the LGBT Action plan, on which GEO has the lead, and the NHS Long Term Plan is extremely unhelpful and seems to imply that responsibility for LGBT-inclusive healthcare lies with GEO rather than within the health and social care institutions. *In order to ensure that the LGBT Action Plan is integrated into NHS England strategy, the Chief Executive of NHS England should work with the GEO to produce the next LGBT Action Plan update and should be a signatory to it. The Government Equalities Office and Department of Health and Social Care should formulate and publish a list of key inequalities in LGBT health that the NHS need to be accountable for and include in the LGBT Action Plan and should report back to the Committee annually on progress in eliminating these. (Paragraph 53)*
10. While we agree that it is important for the National Advisor to look across the piece of the NHS, we also believe that Dr Brady does not currently have the authority to make any of the structural changes that are needed for LGBT-inclusion. *The continued funding of the role of the National LGBT Health Advisor should be prioritised in the next Spending Review and should be confirmed for, at least, the next three years. The National Advisor should be embedded at a senior level and report directly to the Chief Executive of NHS England. (Paragraph 55)*

Creating LGBT-inclusive services

11. Publishing materials in isolation, with no guarantee that they will be taken up or even seen is a waste of time and resource. Public Health England need to step up their efforts in raising awareness of materials and disseminating them. Given that PHE is keen to work with stakeholders, the National LGB&T Partnership, a group made up of 10 LGBT organisations, is an ideal partner for this work. (Paragraph 58)
12. *Public Health England should work with the National LGB&T Partnership to prepare a five-year plan of LGBT-specific campaigns. The plan should include measurable performance indicators on disparities such as smoking and alcohol abuse and should be reviewed annually. (Paragraph 59)*
13. *We agree with stakeholders who say that clear signs of LGBT-inclusion are to be welcomed. Markers of individual inclusivity are important, but this cannot be a replacement for service-wide commitment, which should also be clearly visible to all service users in an organisation's aims and strategy and communicated visibly through posters and other visible markers. It is vital that staff who want to be identified as allies are properly trained to take on this role. All NHS and social care providers should*

ensure that all staff understand their legal responsibility to deliver a service that is inclusive of LGBT people but that, until this is rolled out in the NHS and in social care provision, only staff that have had training should be allowed to identify themselves in this way. (Paragraph 64)

14. We agree with Dr Brady that, while LGBT-specific services play a vital role in the health and social care landscape at the moment, these services often exist because mainstream services are not yet fully inclusive. These services should continue to be sustained and supported for as long as they are needed. In the meantime, the priority should be for mainstream services to become inclusive to the needs of the LGBT communities. (Paragraph 68)

Staff training and regulation

15. Understanding the real needs of LGBT people is necessary in order for health and social care professionals to truly deliver person-centred care. Those responsible for the education and training of health and social care professionals should treat training on LGBT needs with the same integral importance as other basic training. This must happen early in training and not be seen as a “specialism” to be delivered post-qualification. (Paragraph 76)
16. *The GMC and NMC should review their guidance for medical schools with a view to ensuring that LGBT content exists in every medical school curriculum. This content should be spread across modules rather than being restricted to modules on, for instance, sexual health. (Paragraph 77)*
17. We would urge the GMC to look again at its curricula to truly assess whether the mandatory training for these specialties includes LGBT content and, if they are found lacking, to revise them. (Paragraph 80)
18. *Training can be the first exposure that students have to LGBT health needs. All registration bodies should ensure that case studies featuring LGBT people are included in courses in a way that does not play into stereotypes. Registration bodies should develop these case studies in cooperation with local LGBT organisations. (Paragraph 83)*
19. *The Government should consult on ways in which effective knowledge and understanding of unacceptable discriminatory practices and the Equality Act could be ensured amongst the widest range of health and social care providers. This should include staff feeling empowered to take action when they are aware of LGBT discrimination. All NHS and social care providers should ensure these expectations are embedded into their interactions with new patients or residents and provide staff with the relevant training so they feel confident in challenging discriminatory behaviour. The CQC might consider how to strengthen the monitoring of these issues as part of their existing inspection regime. (Paragraph 89)*
20. We agree that advocacy services can be a way to increase access for LGBT people who have concerns about their care. We also feel that more and clearer information is required to help LGBT people to take a complaint forward. The Government should help fund more capacity in national health advocacy services as part of the LGBT

Action Plan. The GMC and NMC should, in addition to this, produce information specifically for LGBT patients that clearly explain what level of service they can expect from their doctor, nurse or midwife and how to complain if they encounter discrimination. (Paragraph 95)

21. While the steps that the CQC have been taking to ensure that inspections are looking for evidence of LGBT-inclusive practice, inspection cannot always be the solution as it cannot uncover every incident of poor practice. (Paragraph 98)
22. *The CQC should conduct a thematic review of social care services for LGBT people which should include examples of best practice and guidance to social care providers around how to create LGBT-inclusive care services. (Paragraph 99)*
23. *CQC and NHS England should work together to produce a guide to making complaints along with an online form that can be used to ensure that complaints are received by the appropriate body to address them. (Paragraph 100)*

Appendix 1: informal note from outreach event for LGBT people held on 30 April 2019

The Committee held an outreach event to hear from LGBT people and their experiences in health and social care. Participants included people with a range of sexual orientations and gender identities, and were recruited through open recruitment, with anyone able to sign up. The discussion was facilitated by the Committee Chair and Jess Phillips and anonymised notes were taken of the discussion.

What has your experience of accessing NHS services been like as an LGBT person?

A trans bisexual man living in London commented that he had arrived from the US 12 years ago and has accessed healthcare in multiple ways. He said: “The ‘B’ [bisexual] has made no difference.” But he said he was still on waiting list to be assessed or the gender identity clinic. He said: “My primary care provider is fantastic. They have other trans patients, but I may be the first trans man. They have been incredibly supportive but I understand from, for example, online forums that that is the exception rather than the rule.”

A gay cisgender man talked about his experience with HIV services. He said that best practice could be found in London, but that outside London, the situation was “appalling”. He attributed this to the high numbers of gay men living in London, leading to more experience in the NHS and the existence of specialist charities. He also spoke of the stigma, which he believed was increasing, saying that doctors ask: “why have you got this, are you not smart enough, are you engaging in risky behaviour?”

A trans man compared the treatment he received for a broken ankle, where he had a great experience, to his treatment for lower surgery. For the latter, he was placed in a women’s ward by the nurse, only to have this questioned by the doctor. He said “People feel a right to treat you differently as the rules don’t apply to us.” He also commented that he had been spoken to in a discriminatory and offensive way, with phrases such as being told he would go to hell and that he would be prayed for. He commented “training alone isn’t going to deal with that—it’s their core belief”.

A trans woman spoke about the fact that she has a rare genetic condition. She said that when she goes to a new GP and speaks to them about this, she is always given the prescription she requires. However, she said that when she tells the GP that she is trans and needs a hormone prescription (which she has been taking for a long time) the GPs get confused and are unwilling to prescribe. She considered this to be a double standard.

Another trans man, based in Yorkshire, spoke of the frustration he felt at having to wait for his referral to the gender identity clinic. He said he felt “left” trying to deal with his business, his marriage and his three step-children. He said: “I made a drastic decision to create my own pathway—I ordered testosterone off the internet. I spoke to GP and was honest—the GP didn’t condone but said it [the testosterone] appears to be real, did my blood tests so I had a baseline. The decision was mine. It was a very positive experience.”

He also paid to see a private psychiatrist, but could not afford this long-term. He said that, while his GP was doing their best, “The GPs are terrified because they have no experience. They were not trained in medical school though this starting to change. A good experience with a GP is them saying—look I don’t really know what I’m doing, but come and see me in a week.”

A trans woman from the south west also had a difficult experience with GPs and hormone treatments, having come out of an abusive relationship where her partner had prevented her from taking hormones. Her GP tried to get advice from the gender clinic, but they refused to advise without seeing the patient themselves. The GP decided that this was unnecessary, as the trans woman had transitioned years earlier. The GP prescribed the hormones without support, despite his reservations.

A gay cisgender woman from a local charity commented that suicide rates for trans people are very high. As an organisation, they started to provide workshops to try to support people during their long wait for a referral.

Another trans man from north London spoke of his experience trying to register at a new GP surgery. He thought he had registered successfully, but later found out that they were waiting for a deedpoll to confirm his name change. Even after he provided it, they stated that this was not a legal document and would not accept it.

A trans woman said that she had had a similar issue, with her former name being put next to her current name on her records. She felt she had to change surgeries. She also spoke of discriminatory treatment, saying: “Another professional said they don’t want to treat people like me, was told how much money spent on me and told that NHS money shouldn’t be spent on me”

Another trans man, from Yorkshire, had to have emergency surgery and spoke of an experience where a nurse asked him questions that, on reflection, he thought were inappropriate regarding his medical transition. He commented: “She asked professionally and I was vulnerable so I answered - later I felt violated”.

Another trans man spoke about trying to access mental health services and A&E. He said that some NHS staff use transphobic and homophobic slurs, which he was able to hear on the ward. This made him feel unsafe as an LGBT person. He said that this was especially acute in one hospital: “I am talking about stuff like nurses talking about killing gay people ... the hospital was terrified to have this talked about, [to have it known] that it was happening in our city”.

A gay cisgender woman stated that she had a good relationship with her GP, who she found respectful and supportive. But she also found that there were assumptions made by medical staff around her sexual practices. She stated: “I went for smear test and when I mentioned sexuality the nurse basically stopped the test and said, ‘you don’t need it’. It wasn’t expressly homophobic and a few follow up questions but was clear I didn’t need it. Then got a follow up saying I need it—so I went back and receptionist told me the same thing!”

A straight trans man spoke about how he was misidentified by NHS staff. He was referred to as a virgin, as he has never had penetrative sex with a man and was also told that he did not require a cervical smear.

A cisgender lesbian woman spoke about how it was unclear whether a lesbian partner would be welcomed on a hospital ward and whether affection would be acceptable. She said that this depended on the ward and who the chief nurse was. Another lesbian concurred with this assessment, saying that she was questioned: ‘why are you here, we don’t do that, we don’t have your kind here’.

Have you come across any healthcare practices that are particularly good for LGBT people?

There was general consensus that the group had not come across any practices that were especially good for LGBT people. A straight trans man commented that some sexual health services in Yorkshire were good because they were commissioned out to a local charity. A cisgender gay man commented that there was a similar service in London, but that people “order things off the internet”. He commented that: “we have seen hands off referral from GPs”.

A straight trans man commented that, because his GP is LGBT, he felt comfortable with him. This was echoed by other participants. Another participant commented that they had had good experiences where the medical staff concerned were specialist in a particular area.

The group stated that they use networks to identify good GPs, from lists that are circulated online between the communities. One participant said that: “If I meet an LGBT person from my area I recommend my surgery”.

What can the NHS do to make health services more appropriate and inclusive to you as an LGBT people?

A trans woman stated that having satellite clinics rather than single gender clinics would take the pressure off them and would give patients a “bridge” as they are waiting for their appointments with gender clinics.

There was disagreement among participants over whether specialist services were needed for LGBT people or whether mainstream services needed to be more inclusive. One participant commented: “I don’t prescribe to ghettoization. [All staff] need to be given mandatory training [in LGBT issues].”

It was generally agreed that perceptions of LGBT people (especially trans people) among medical professionals need to change. One participant suggested that there should be “LGBT champions” in medical settings.

Another participant spoke about how difficult it was to challenge problems when they arise, saying “we are expected as patients to complain but don’t always have strength or time ... lots of this is left to charities”.

What has been your experience of accessing social care services as an LGBT person?

Two of the participants in this session opened by performing a poem entitled “Lesbian Loneliness” that dealt with a woman living in a care home. The participants commented that the message of the poem was that people “go through life as if they have something they didn’t want others to know. it is particularly the older people.”

When the poem was concluded, the participants stated that they were taking these sorts of performances into care homes. One cisgender woman who presented stated: “Care homes must fall over backwards to show they are LGBT friendly. They must do this so we can know our end of life care is in safe hands. At the moment it isn’t. CQC are masking this; they must find out how many LBGT people there are in care homes.”

One of the participants runs a home care services for LGBT people. He spoke about how his service tries to match the user with LGBT and non-LGBT staff, as appropriate. He spoke about he wants his service-users to feel: “People are safe and they know no one is going to judge them”.

One participant spoke of the problems that LGBT people can have in later life, focusing in on trans people. She said: “especially late in life trans people who get dementia, their memories of themselves are not necessarily the same and they don’t necessarily remember they have transitioned—the care system doesn’t know how to cope.”

What can social care providers do to make health services more appropriate and inclusive to you as an LGBT people?

One participant spoke of a local care home that was very explicit in its inclusion of LGBT people, using rainbow symbols and t-shirts with slogans that make it clear that LGBT people were welcomed and respected. The participant said that this was due to one person who had “sold the idea” to the care home. In addition, she said: “in brochures they have pictures of people in same sex relationships and they have an LGBT champion”.

One participant felt that there should be LGBT-specific care homes, stating, “need and demand is high”.

One participant, a trans gay man, spoke of his fear of having to go into a care home, seeming to prefer death over going into care. He said: “my biggest champion is my husband and there’s a history of early onset dementia in my family. All my family are back in US. If my husband goes first, and the choice is a care home here or returning to US, I’m not sure I want to be around.”

Some participants raised the issue of “next of kin” in care settings. One participant stated that “England, Wales and Northern Ireland you have to live with a partner for 5years before you can be considered next of kin—biological family takes precedence. In Scotland you can nominate someone—that is so important to our community”.

Another participant stated that, near the end of life, some trans people find that their families are so unsupportive of their gender identity that they “transition people back”. Another participant mentioned that in California, legislation has been introduced that,

if a trans person has a living will, families are unable to de-transition them. There was general discussion that there should be a legal mechanism available to help people to set out their wishes around their sexuality and gender identity as they age.

Formal minutes

The following declarations of interest relating to the inquiry were made:

23 April 2019

Sarah Champion declared the following interest:

Paid National Counselling Society Ambassador .

Wednesday 16 October 2019

Members present:

Mrs Maria Miller, in the Chair

Sarah Champion	Vicky Ford
Angela Crawley	Tulip Siddiq

Draft Report (*Health and Social Care and LGBT communities*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 100 read and agreed to.

Summary agreed to.

A Paper was appended to the Report as Appendix 1.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

[Adjourned till Wednesday 23 October 2019 at 9.30 a.m.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Wednesday 1 May 2019

Professor Carrie Llewellyn, Professor of Applied Behavioural Medicine, Brighton and Sussex Medical School, **Wendy Irwin**, Diversity and Equalities Coordinator, Royal College of Nursing, **Dr Duncan Shrewsbury**, Local medical director, Practice Plus Brighton, **Sophie Meagher**, Policy Officer, LGBT Foundation

[Q1–49](#)

Wednesday 15 May 2019

Dr Joanna Semlyen, Senior Lecturer in Psychology/Medical Education, University of East Anglia, **Dr Igi Moon**, Researcher/Practitioner, CliniQ, **Helen Jones**, Director, MindOut

[Q50–83](#)

Rosie Stamp, Research lead on Children & Young People, Healthwatch Suffolk, **Cecily Ward**, Service User, METRO, **Niazy Hazeldine**, Youth Manager, METRO

[Q84–106](#)

Wednesday 19 June 2019

Prof Kathryn Almack, School of Health and Social Work, University of Hertfordshire, **Debbie Ivanova**, Deputy Chief Inspector of Adult Social Care, Care Quality Commission, **Jim Glennon**, Training and Policy Manager, Opening Doors London, **Dr Ju Gosling**, Chair, Regard

[Q107–135](#)

Prof Catherine Meads, Cambridge Institute of Public Health, Anglia Ruskin University, **Peter Thompson**, Chief Executive, Human Fertilisation and Embryology Authority, **Joanne Anton**, Policy Manager, Human Fertilisation and Embryology Authority

[Q136–151](#)

Wednesday 3 July 2019

Dr Justin Varney, Director of Public Health, Birmingham City Council, **Harri Weeks**, Stakeholder Engagement Manager, LGB&T Partnership

[Q152–178](#)

Clare Perkins, Deputy Director Priorities and Programmes, Public Health England, **Dr Michael Brady**, National LGBT Advisor for Health, NHS England, **John Stewart**, Director of Specialised Commissioning, NHS England

[Q179–221](#)

Wednesday 17 July 2019

Rt Hon Matthew Hancock MP, Secretary of State for Health and Social Care, **Baroness Williams of Trafford**, Minister for Equalities

[Q222–285](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

HSC numbers are generated by the evidence processing system and so may not be complete.

- 1 A member of the public ([HSC0019](#))
- 2 A member of the public ([HSC0001](#))
- 3 A member of the public ([HSC0016](#))
- 4 A member of the public ([HSC0017](#))
- 5 A member of the public ([HSC0018](#))
- 6 A member of the public ([HSC0028](#))
- 7 A member of the public ([HSC0029](#))
- 8 A member of the public ([HSC0037](#))
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