HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Reform of the Gender Recognition Act, HC 129

Wednesday 12 May 2021

Ordered by the House of Commons to be published on 12 May 2021.

Watch the meeting

Members present: Caroline Nokes (Chair); Theo Clarke; Elliot Colburn; Kim Johnson; Kate Osborne; Bell Ribeiro-Addy; Nicola Richards.

Questions 186 - 217

Witnesses

I: Dr Harriet Hutchinson, Community Organiser, Action for Trans Health Durham; Dr John Chisholm CBE, Chair of the Medical Ethics Committee, British Medical Association.

II: Dr Michael Brady, National Adviser for LGBT Health, NHS England; John Stewart, National Director of Specialised Commissioning, NHS England; Leigh Chislett, Clinical Manager, 56 Dean Street.

Written evidence from witnesses:

Examination of Witnesses

Witnesses: Dr Michael Brady, John Stewart and Leigh Chislett.

Chair: Our next panel this afternoon is Dr Michael Brady, the national adviser for LGBT health at NHS England; John Stewart, the national director of specialised commissioning at NHS England; and Leigh Chislett, who is the clinic manager at 56 Dean Street. Can I welcome our second set of witnesses this afternoon?

Q186 **Elliot Colburn:** Welcome, panel. My set of questions are all going to be directed towards John Stewart. Michael and Leigh, if you want to jump in on any of them, please wave at me and I will try to notice you. John, could I begin by asking you to explain briefly the role and the purpose of the gender dysphoria clinical programme and how it came to exist in the first place?

John Stewart: I would be very happy to. The first thing to explain is that NHS England first took on provisioning responsibility for gender dysphoria services for adults and children back in 2013, when it was first formed. Our first task back then was to try to make sure that we address some of the inconsistencies that there have been across the country through different commissioning arrangements being in place. It is one of the real benefits of NHS England taking on sole commissioning responsibility.

Our gender dysphoria programme board was formally established at the end of 2017 to provide even more enhanced focus, advice, challenge and leadership to NHS England's direct commissioning responsibilities around this area. It took over from a dedicated task and finish group that we had established almost at the start, when NHS England was formed. Membership of our board includes people with lived experience, clinical experts and representations from the devolved Administrations, as well as national and regional commissioners.

There are a few things to say about what the board has done since it was set up. It has developed two new service specifications for the adult service, following the outcome of extensive stakeholder engagement and public consultation. It has overseen the process of awarding contracts for the provision of both surgical and non-surgical specialised services to adults. It has developed a framework for the establishment of the new gender dysphoria pilot clinics in primary care, which I am sure you will want to hear more about in due course. It has established a national referral support service to assist individuals in choosing surgical providers that can best meet their objectives. It is a quite extensive and ongoing programme of work.

Q187 **Elliot Colburn:** Thank you, John. You have touched on some of my later questions, but feel free to add to them when I come to them. How often does the board meet, and how does it conduct its reviews of specialised gender identity services?

John Stewart: The board meets on a monthly basis. It is chaired by Dr James Palmer, the medical director for specialised services within NHS England, who works with me. I gave a bit of an overview in my previous answer of the work programme that it has established. It has been focused, up until recent years, on the development of new service specifications around surgical and non-surgical services, working very closely with our clinical reference group on some of the clinical advice that we need to inform those. Following the extensive consultation that we have done, it has played a critical role in helping to shape the design and development of the new pilot clinics that we have launched.

Q188 **Elliot Colburn:** What assessment has the board made of the current role played by specialist gender identity clinics for adults?

John Stewart: The current gender dysphoria clinics have a really vital role. We have seven clinics across the country. One of the things that is worth saying is that, when we went out to re-tender the service in 2019, we were very conscious of the constraints and waiting-list challenges facing people wanting to access the service. It was very disappointing that, during that tender process, we did not manage to attract any new bidders willing to provide new and additional services to support these patients.

That is precisely why, having listened very carefully to some of the feedback that came through the extensive engagement and consultation process that we ran in developing the specifications, we really began to understand the important role that primary care could potentially play going forward. That is what led us to developing and designing these three new pilot clinics that you will be aware of. They are up and running in London’s Dean Street, which Leigh will be able to say more about, in Greater Manchester and in Merseyside. I am also really pleased to be able to let the Committee formally know today that there is a fourth pilot in the east of England that will be going live this summer.

Combined, we are expecting these pilots to see, over the next two to three years, about 3,500 patients. We are deliberately targeting those patients who have already been waiting for access to one of our seven gender dysphoria clinics. There are some really exciting developments there, particularly recognising the potentially really important role that primary care can play, and, as you will probably hear from Leigh, particularly around how we can also integrate with other services such as sexual health.

Q189 **Elliot Colburn:** Just picking up on that point, it is quite a big announcement that you have gone for a fourth pilot. That is news to this Committee, I think it is fair to say, so that is exciting. Could you tell us a little more about how that decision was made? Have you been awarded new funding to do this fourth pilot? Is it an NHS decision? Has this been pushed from the GEO or DH? Where did this fourth pilot come from?

John Stewart: The fourth pilot will have come out of the discussions and deliberations of our programme board. I forgot to mention that Michael Brady sits on that programme board as well. It is very much an NHS England-led initiative, as were the three original pilots. It is worth saying that we are open-minded about whether additional pilots might be something that we should be considering, particularly given the challenges that we recognise around some of the long waiting times.

Q190 **Elliot Colburn:** That is brilliant. This has not been a central Government push. You have not been given specific new funding to try to do this. This is a board decision and an NHS decision.

John Stewart: Yes, this is an NHS England decision. We are the direct commissioners of these services. Funding for the four pilots is additional funding that NHS England has made available from its specialised commissioning budgets. It is absolutely not money that has been taken away from existing services.

Q191 **Elliot Colburn:** Thanks, John; that is incredibly helpful. I was going to move on to ask you to outline the specific pieces of work that the board has undertaken since 2018, but it is fair to say that you touched on quite a lot of that. Just before I move on to my next question, I wanted to give you the opportunity to add anything that you feel you have missed so far.

John Stewart: No, that is fine. Please move on to your next question.

Q192 **Elliot Colburn:** Would you mind explaining the changes that you have made to the 2018 service specifications for adult gender dysphoria services?

John Stewart: As I said, we have two service specifications that are relevant here, the first being around non-surgical services, which are principally being delivered by our seven gender dysphoria clinics. There is also the surgical service. The key objective in developing these services specifications was to make sure that, across all these services, we are providing patients with consistent, high-quality care, particularly given the context that I explained at the start, whereby, before NHS England existed, the arrangements were taken forward by 10 specialised commissioning groups that all had to respond to their constituent PCTs. That led to significant variations across the country.

We worked up those specifications very extensively through stakeholder engagement. We held a 15-week public consultation in 2017. We published a report of that consultation afterwards. Overall, it would be fair to say that respondents have been supportive of the changed service specifications.

Just to summarise, the benefits include: a consistent, defined approach to how services should be delivered; a consistent approach to assessment and diagnosis, including an expectation that assessments will usually comprise two appointments; an emphasis on shared decision-making with the patient; and a real focus on preventing unnecessary intrusive physical examinations.

The other thing that I would say, picking up on some of the comments made during the previous session, is that the service specifications for the non-surgical service do allow for patients to self-refer to those services. That is absolutely a response to some of the concerns that were raised with us about GPs sometimes being reluctant to make referrals. We have also been very clear in those service specifications that clinicians should not expect, from a patient self-referring, an inappropriate, unnecessary amount of detail. That is an important step.

The final thing I would say is that all seven of our gender dysphoria clinics are signed up to those service specifications and, in fact, delivery against those specifications is a contractual requirement.

Q193 **Theo Clarke:** What impact will the opening of the three new gender identity clinics have? I am particularly interested in waiting times.

John Stewart: These pilot clinics are important for two reasons. First, we recognise the potentially important role that primary care can play, as well as the potential role of sitting these services alongside other areas, such as sexual health. This is absolutely about testing a quite new, exciting and modernised service.

In terms of waiting times, we are planning on the assumption that the four clinics combined are going to see at least 3,500 patients over the next two to three years, which is the lifetime of the pilots. That represents about a quarter of the current total national waiting list. It will have a really important impact. It is not going to solve everything, but our aim is to try to evaluate these pilots as quickly as possible—we have already appointed an organisation to conduct that evaluation—and then to make sure that we can fairly seamlessly move in to the commissioning of a new routine service going forward.

Dr Brady: John has covered the waiting lists. I would like to focus on something that is really important about these new models of care. It is the beginning of a paradigm shift in how we think about the service model of gender identity services, and a shift that reflects the approach that we are making in other clinical areas across the NHS of a more integrated, community-based model, with some degree of specialist, hospital-based input, and delivery by a newer workforce in a newer model.

I am very optimistic about these pilots and these new models—I am sure we will hear more from Leigh presently—because they will move us from where we have been until now, with seven very focused specialist services, into a completely different model, predominantly primary care-based, although it is also really important to assess this in other settings such as sexual health services. This will not only improve the capacity and the ability to meet the needs within those services, but will, as we will probably hear from Leigh later, have a knock-on effect particularly into the wider primary care community of upskilling colleagues who are working alongside but perhaps not directly within those services.

Leigh Chislett: I have quite a lot to say. I do not know if you want to come back to me, because I would like to describe the service as a whole. Would you like me to do that now or would you like to come back?

Q194 **Theo Clarke:** I have a few more questions, so maybe I will come back to you. John, it has also been argued that these gender clinics are not new but, in fact, were already established by the gender dysphoria clinical programme. I would be interested to know your thoughts on that.

John Stewart: The development and design of these clinics was absolutely overseen by our gender dysphoria programme board. They are new. The three clinics went live over the course of 2020-21 and, as I said, the fourth clinic is going live later this summer.

Q195 **Theo Clarke:** What progress has been made by each of the clinics since they opened? Have waiting times for these services now been reduced?

John Stewart: I might bring Leigh in here, but I know that, because we are very deliberately making sure that the new pilots are seeing patients who have already been on the waiting list for one of our gender dysphoria clinics, it is having a huge impact for them, which is fantastic. As soon as those patients are referred to the new pilots, we are talking about waiting times of potentially weeks or months, but certainly not years. Maybe I could ask Leigh to say a bit more about the impact that he is seeing at the Dean Street clinic.

Q196 **Theo Clarke:** I would love to hear about that, Leigh, but also about any progress that the Dean Street clinic has made, particularly since it has opened, and any issues that it is facing.

Leigh Chislett: We have come up with an extremely lean model that has hugely positive patient satisfaction. We are slightly thwarted by Covid but we have seen 177 people for a first assessment and 163 for a second. We have referred 37 people for gender-affirming surgery and 78 for epilation, which is a service we have set up from Dean Street as well. Thirty people are currently having psychological input that they have chosen, and 76 are having speech and language therapy. I will go on a little more when it comes to my turn, but I have heard a lot of similar things and experiences to Dr Hutchinson. We are getting extremely positive feedback from the service users at Dean Street with this pilot, and it could potentially be transformative.

Q197 **Theo Clarke:** Just to clarify, the Dean Street clinic appears to focus more on LGBT sexual health than on gender dysphoria. Could you explain to the Committee what services it is providing to trans people?

Leigh Chislett: The client will be seen by a nurse or a social worker. We have to go with the current guidelines, of course. They will get a psychosocial appointment and get relevant tests done, and they will get a named nurse at that appointment who will see them through their care package. Two to three weeks later, should they wish to proceed, which most do, they will see our medical doctor or one of our psychologists, and that is where they can get their gender dysphoria confirmed. Sometimes people want further appointments or want to discuss it, so we are very keen that clients come absolutely as their authentic selves, to a point made by Dr Hutchinson. We make that very clear from the upshot.

At Dean Street, if the gender dysphoria is confirmed between the client and the doctor, they get their hormones on that day. They get the prescription and are not referred back to the GP. They go to the pharmacist, who will go through the treatments with them, and the nurse will also teach people to inject. It is a very quick, lean service, and the feedback that we are getting, which is the most important thing, is extremely positive. At the moment, we have only two clinicians who do the second assessment, but my job is to get public money and to prove that this is an efficient model that will work and has good, positive outcomes for clients.

John Stewart: Perhaps I could just clarify that all of our pilots are providing and able to offer exactly the same services as our traditional seven gender dysphoria clinics. Following assessment and diagnosis, it includes psychological support and hormone treatment, referral on to surgery if required, voice and communication therapy and facial epilation. The full range of services is being provided by these pilot clinics.

Leigh Chislett: Just to add to that, as you were saying, we have a psychosexual therapist and a psychologist, so it is one to one, and we have some groups. Some of our most recent groups that we have been running are on how to manage stress or body dysphoria, and they are very well attended. We did one recently on how to get the sex you want, so we are very engaged with the community. Dean Street is known for its innovation. Before Covid, we saw about 12,000 patients a month, and 70% are from the LGBT community. We have an established relationship with the trans community, because we have been running transsexual health services for over 10 years.

Q198 **Theo Clarke:** Dr Brady, I am interested to know what discussions you had with the Government Equalities Office regarding the three gender identity clinics before they were opened.

Dr Brady: I have a regular meeting with officials from the Government Equalities Office. In the first couple of years, when the GEO was funding my post and my team, we met fortnightly. Now that funding has stopped and has moved over to NHS England, we have a monthly meeting, which is broad in its breadth. It is a catch-up on progress in terms of our workplan. It is an opportunity for both of us to raise any particular issues that are current. It would have been during those meetings that there would have been discussions around the development of the pilots. As John said, I also sit on the gender identity programme board, so was involved in the discussions as that model was being developed.

Q199 **Theo Clarke:** One of the commitments made in the LGBT action plan is to improve the way gender identity services work for transgender adults. Has that commitment been met?

Dr Brady: I would say that is one of the commitments in the action plan that is partially met and a work in progress. John has gone through a lot of the things that NHS England has been doing over the last couple of years that will contribute to meeting that particular commitment. I would put that in the partially met, work in progress category.

Q200 **Theo Clarke:** John, the NHS website states that NHS England will assess how useful these pilot services are. When will that be, and how does the NHS plan to make this assessment?

John Stewart: We are evaluating these pilots. We have already appointed an evaluation partner, Rocket Science, which is already onboard and working with the initial pilot sites. That will be an ongoing evaluation over the lifetime of the pilots, which is over the next two to three years, depending on when they started. What I would say is that we are really keen to extract the learning as quickly as possible, so that we can make quick progress in rolling out the successful pilots right across the country. We are committed to evaluating as fast as we can.

Q201 **Theo Clarke:** Just finally, the NHS website also states that those gender dysphoria clinics will initially be available to people who are already on the waiting list, but when will they also be available to those not on a waiting list?

John Stewart: We have been clear that the priority for the pilots is to focus on those patients who have already been waiting a long time, but we are absolutely clear that, if and when they clear that group of patients, they can open up to accept new referrals in line with their referral criteria. The first step is to try to make sure that we can support those patients who have been waiting a long time.

Q202 **Kate Osborne:** Good afternoon to everyone on the panel. First of all, John, this fourth clinic that has been mentioned is really interesting. It would be really useful to know where you are planning on opening it. Could you share any of that with us?

John Stewart: I might need to write back with precise timescales, but I am confident that we are going to be opening it this summer. I am hopeful that it will be in the next couple of months, so a summer timetable.

Q203 **Kate Osborne:** Can you share the location?

John Stewart: It covers the east of England. It will cover patients registered with a GP in Cambridge, Norfolk, Suffolk and Essex. As I said, it plans to see patients from summer 2021. It is going to be led by the Nottingham gender clinic in partnership with the Cambridgeshire and Peterborough NHS Foundation Trust. It is going to work on a specialist hub-and-spoke basis, with GPs and clinical nurse specialists working in local settings and linking in with the specialist hub in Nottingham. Given the interest from the Committee, it sounds like it would be helpful if I wrote and provided a bit more detail about the nature of that pilot and when it will go fully live.

Q204 **Kate Osborne:** That would be great. I very much appreciate, as do all the Committee, your giving what information you have given there. If you could write, that would be fantastic. I have one more point regarding this. A point was made by the previous panel that there are not enough staff with specialist knowledge. Can you tell us how you might ensure that there are enough specialist staff to work in these new clinics?

John Stewart: Alongside the significant growth in demand for and referrals to the service, the other challenge that we have is absolutely around workforce capacity. Although workforce issues are principally the responsibility of Health Education England, it is important to say that this is such an important issue for NHS England to tackle that we have taken direct action to increase the clinical workforce in this respect.

We have funded the Royal College of Physicians to develop a credential programme in gender dysphoria medicine, delivered by the University of London. This is the UK's first accredited training programme in gender medicine for clinicians who wish to specialise in this field. It will provide greater reassurance about the quality of the national service and, it is hoped, will encourage new recruits. We currently have 43 clinicians taking the course, who are all due to graduate this year. We hope that number will grow, but to put it in context, there are currently only around 90 clinical whole-time equivalents working across our established gender dysphoria clinics, so already, in the first year, there has been important progress. All of the clinicians and other staff involved in the pilot sites will be going through this new accredited training programme.

Leigh Chislett: At the moment, we are doing an online platform and portal for training GPs. With this platform, we have people from the trans and non-binary community contributing, so they have been really involved in the content of the curriculum. That has been incredibly empowering for us as staff and for the clients, so there is a real investment in their care.

Q205 **Kate Osborne:** The rest of my questions are directed at Dr Michael Brady. What work have you done to implement the health commitments made in the LGBT action plan?

Dr Brady: It is important to recognise that, in the health section and the 12 health commitments in the LGBT action plan, there is probably not one commitment that could be delivered by one organisation, and certainly not one individual working part-time with no budget. It has been a partnership working. I have been very involved in a number of the commitments, and less, it is probably fair to say, in some of the others.

If we look more broadly at where we are at with the action plan, which is still an important document, as I alluded to before, there are a number that have been achieved and a number that are works in progress. The other thing to keep in mind is that there is a lot of work that I and my team do to address LGBT health inequalities and to address the health inequalities of trans and non-binary people specifically, which are not even reflected in the action plan, so it is not all-encompassing.

If we think about the things that have been done, the first commitment is to appoint the national adviser. That was done quite quickly and we have been in post since 2019. On work to change rules around surrogacy, legislative changes were made quite early on in the action plan.

I have been very involved in and sat on the committee that made recommendations regarding the deferral period for blood donations from men who have sex with men, and it was really pleasing to see the announcement yesterday or the day before that those changes to a more individual risk-based approach to blood donation are coming in on 14 June. That is something I have been particularly involved in.

One of my other hats is as a sexual health and HIV clinician. That is what I do with the rest of my time, so I have also been very involved in the PrEP rollout. That is the fourth commitment that we have achieved in the action plan, which is around achieving NHS-commissioned pre-exposure prophylaxis for the prevention of HIV.

That leaves us with eight that are works in progress. Some have had some work done. On action around improving mental health, there has been work published by Government and a considerable amount by NHS England particularly in terms of meeting their commitments under the long-term plan around improving mental health across all areas. We have already talked about gender identity services and we can see the progress that is being made there, but it is, as I have said, another work in progress.

One of the areas where I spend a lot of time and that is a really important commitment, which still remains a work in progress, is around sexual orientation and gender identity monitoring. It is one of the key areas of my work and probably the thing that I spend the most amount of time on.

We are still too far behind, across the system—I would include Government and healthcare in this—in terms of not systematically collecting information on sexual orientation, gender identity and trans status. To me, it is the fundamental starting point in addressing health inequalities. The often used but really powerful message of, “If you do not count us, we do not count,” says it all. Too often, we talk about health inequalities but we do not have the data to back it up. We need to do a lot more to put sexual orientation, gender identity and trans status at the same level that we have around monitoring disability or ethnicity, or around postcode when we are thinking about deprivation-driven inequalities.

Data collection and monitoring is an important work in progress. We have made quite a lot of progress in the NHS. We have the sexual orientation monitoring information standard, which members of the Committee may well be aware of. I would say that we are not fully rolled out with that, but it does exist in all NHS experience surveys and in some datasets. We are about to get it in a few other datasets, so we are making progress on sexual orientation monitoring, and I and my team will be having a relaunch. We have commissioned the LGBT Foundation to refresh and relaunch their supporting and advisory documents around sexual orientation.

The main area of focus, though, because it is so much further behind, is the monitoring of gender identity and trans status. A lot of momentum has been put behind this by the really important changes in terms of including those questions, as well as those on sexual orientation, in the national census, but we do not have a nationally agreed information standard about how to ask those questions, so that is further behind.

We have made progress. This is an area on which I and my team have been working with colleagues in the insight and feedback team at NHS England. We are very pleased to say we have got an inclusive gender identity and trans-status question into the national GP patient experience survey, which is one of our patient experience surveys and a very important one, not least because it is the largest, usually with around 750,000 responses. We are soon to get the same question into the cancer patient experience survey, into the mental health services dataset and, next year, into the NHS staff survey. There is progress, but it is not completed.

Q206 **Kate Osborne:** My second question is around what you have done to improve the provision of healthcare for transgender people since your appointment, and you have covered a large amount, but is there anything you want to add?

Dr Brady: I would add a couple of things. Some of them are "watch this space." Like everyone, there has been a degree of delay in terms of Covid and most of us getting redeployed to do other things, but there are a couple of things that I would like to highlight. We have already mentioned my seat on the gender identity programme board, focusing specifically on specialist gender services. As witnesses in the previous session highlighted, trans and non-binary people face considerable inequalities in every area of healthcare, to a varying degree.

We have been doing specific work in primary care. I will not labour the point, because this has been mentioned before, but there is a need to provide better guidance, support and training more generally for general practitioners around trans health—not just gender identity but trans health in general—to make the workforce more comfortable managing trans and non-binary people, and more comfortable using correct pronouns, to understand what is and should be a relatively simple process of changing names on systems and so on and so forth. That is a piece of work that we will be publishing in the next few months.

The other thing that I would like to mention is the ITEMS project. We are working with the LGBT Foundation on a piece of work that will publish some guidance and recommendations around improving trans and non-binary people's experience of maternity services.

We have some broader things that are not just trans-specific but are across all areas of addressing LGBT health inequalities. We have commissioned phase two of the rainbow badge project, which is going to work with NHS trusts to improve their approach to addressing health inequalities. We have commissioned Anglia Ruskin University to do a piece of mapping work that is going to focus specifically on education and training, which is something that has come up a number of times. It will give us some examples of best practice, as well as making recommendations about what good looks like. We will be working with other organisations like Health Education England, the royal colleges and the medical schools on that.

Q207 **Kate Osborne:** You are doing extremely well at guessing my questions and answering them before I ask them, so well done for that. There is one thing I want to ask you, Dr Brady, that you have not covered. How often do you engage with transgender groups to assess their healthcare requirements?

Dr Brady: Frequently. I strongly believe that robust and meaningful engagement and co-production is the way forward. It is absolutely essential that those of us who make decisions or set policies or legislation that has an impact on other people's lives involve those people over whom we have influence in that decision-making process. We never make decisions, plan things, develop or deliver projects without robust engagement with trans or non-binary individuals, trans-led organisations or trans-inclusive organisations.

In fact, we commission quite a lot of our work to those organisations to deliver on our behalf, because they know the communities that we are trying to support better than we do. They connect better with them and have a better level of trust. You can imagine, for obvious reasons that you have heard, that sometimes having NHS on your badge does not necessarily encourage people to be trusting of your approach, and I can understand why that is, so working with those organisations is really important.

We do that all the time, and we also have ongoing ways in which we communicate with the sector. We have a regular newsletter. Something that we set up to support organisations during Covid but have kept going is a monthly videocall with sector leaders, so pretty much all the LGBT and trans organisations in the voluntary and community sector join that call.

Q208 **Kate Osborne:** That is great to hear. As a final question from me, you talked earlier about the importance of capturing information. One of the concerns that we have heard from trans stakeholders is around data protection. Can you tell us what, if anything, you are doing to mitigate those fears?

Dr Brady: There are multiple stages to the data collection journey. The first part is agreeing the question and deciding exactly how we are going to ask. We have done that, and we are testing it in some settings, but it is not a perfect question.

In the broader data protection sphere, with my national adviser hat on, but probably more so with my clinician hat on, there are wider provisions that should be protecting everybody, not just trans and non-binary people. These are our responsibilities under UK GDPR and the Data Protection Act, and really very strict information governance policies and procedures that we should all be following in the NHS. It is worrying and troubling to hear those examples of data breaches. It must be said that they are not unique to gender identity services. They happen too frequently across the board. My personal view is that that is most important, and less so anything that is particularly trans-specific.

The only other thing that I would add on this, and it reflects back to a discussion that I know you had at a previous hearing around section 22 of the Gender Recognition Act, is perhaps the unintended consequences of that. You were hearing evidence about the impact on HR. There is an unintended consequence in healthcare as well, but the presence of that legislation is misunderstood by most people in healthcare. They think that showing any information about any trans person is illegal, which is not the case. It is also seen as a real barrier. Quite often when I am going to organisations to support them or encourage them to collect information on their trans service users and patients, they use section 22 as a reason why they have not done it; they say it is illegal to collect that information.

There is an unintended consequence in healthcare, as well as in other settings, about the misinterpretation of section 22 of the Gender Recognition Act, which is very easy to address but quite time-consuming. It is all about consent. If you explain to people why you are collecting the information, that you are collecting only the information that you need and is relevant, who you share it with and how it will be used, there are no concerns under the legislation in terms of data protection or the GRA.

Q209 **Chair:** Dr Brady, can I stick with the issue of data collection? We know that the Government Equalities Office is very keen on improving the quality and amount of data that it holds across a whole range of issues. Could you give us some indication of how much engagement you have with GEO?

Dr Brady: On that issue specifically or generally?

Chair: On that specifically and more widely.

Dr Brady: More widely, as I said earlier, I and my team have regular meetings with GEO officials. They are now monthly; in the first two years of our jobs, they were fortnightly. We dropped them down at the point that GEO stopped funding us and we moved into NHS. It was felt that that frequency was not needed. It was not about being spiteful or anything. We have really good relationships with the officials at GEO.

Data collection and monitoring is, as I have alluded to, the single biggest thing that we talk about and work on, so it will have taken up quite a bit of those meetings on quite a few of those occasions. It is partly around the work we were doing to improve monitoring of sexual orientation and gender identity in the NHS, and partly around other pieces of work that were going on, like the unified information standard for protected characteristics. Apologies for throwing that in just now, but I know it has been discussed at previous hearings. Essentially, it is a piece of work across healthcare, and potentially Government, looking at how we collect data on protected characteristics.

There was a particular period, just because there was a lot going on, probably in the run-up to the census, when we worked closely not just with GEO but with other Government Department officials and with the ONS on data harmonisation. It is an important step forward that we have questions on sexual orientation and gender identity in the census, but in order to make that data the most useful it can be, we have to be able to cross-reference it across other datasets. Probably the bulk of the time was the six or eight months leading up to the signing-off of the census and that being passed through Parliament, because there was a lot of work to do to make sure that the work that we were doing in healthcare settings was aligned with the work that the ONS and other Government Departments were doing around those questions.

Q210 **Chair:** How much contact have you had from Ministers?

Dr Brady: I have had a couple of meetings with Liz Truss over the last year and with other MPs who were interested to get together and talk particularly about a lot of the things that we are talking about now in terms of trans healthcare particularly.

Q211 **Chair:** What about with other Ministers such as Kemi Badenoch and Baroness Berridge?

Dr Brady: I have been in one meeting with Kemi Badenoch, but not with Baroness Berridge.

Q212 **Chair:** You have highlighted to us that your role is still part-time. I get the sense that you are jamming a full-time job into 20 hours a week. Would you say it is an asset that you are continuing your clinical work?

Dr Brady: It is absolutely an asset that I continue my clinical work. I do juggle quite a lot, but it is worth it and it is really enjoyable. The reason it is important is that I bring things to the national adviser role by still having a clinical job. For many of the things that I work on, my clinical job is extremely relevant. I work in sexual health and HIV, and I have set up and run a specific sexual health service for trans and non-binary people, so I am really alive to the issues on the frontline. I understand how the NHS works from that side as well as how it works from the NHS England side, so it is definitely of value, even if it is sometimes a little stretching of my time.

Q213 **Chair:** Do you get any sense that your role is going to be extended beyond 2022?

Dr Brady: My role has been made permanent now, I am pleased to say. It was clear from early 2019-20 that the funding from the Government Equalities Office was going to end. They had a pump-priming model, and NHS England has taken up my funding. I and my team now have permanent roles at NHS England.

Q214 **Chair:** You will be conscious that three members of the LGBT advisory panel recently resigned, one saying that the Government had created a hostile environment for LGBT people. Has that been your experience?

Dr Brady: If we look back two or three years, over the time that I have been working on this, there was a lot of energy, optimism and activity around this area on the back of the LGBT survey, the publication of the action plan and the appointments of the national adviser and the advisory panel. There was a lot of energy and optimism around at the time, which I would say is not there to the same degree now.

Going back to what I said before about how I like to work in terms of engagement, it is really important that, whether we are Government, policymakers or service providers, we have a way of engaging with the communities that we are impacting. The advisory panel was one way but not the only way of engaging and communicating with them, so there is a gap now.

Q215 **Chair:** Is it your expectation that a new panel will eventually be formed?

Dr Brady: I do not know if there are any future plans.

Q216 **Chair:** Would it be an asset for a new panel to be formed? Is it necessary?

Dr Brady: Engaging with the community, listening to their voices and putting them at the centre of what we do is essential. There are many ways that you could do that. An advisory panel or similar group is one of them, because you can get a broad range that covers all of the communities and does that in a manageable way. A way to keep that dialogue going and to put the people who we are here to serve at the heart of what we do should be the way forward.

Q217 **Chair:** You will have heard yesterday, as the rest of us did, the inclusion in the Queen's Speech of legislative plans to ban conversion therapy. Has enough been done to date around conversion therapy and the concerns that have been raised for trans people? Has enough been done by healthcare professionals to support trans people who might have experienced conversion therapy?

Dr Brady: The announcement the other day in the Queen's Speech is very welcome. Many people have been calling for a ban on conversion therapy for a long time and, indeed, it was about three years since it was announced as a direction of travel by Theresa May. To get to this point is very welcome. We need to continue that pace and move further and faster towards that point. It is important that we are robust in ensuring that we ban conversion therapy in all its forms for all individuals who it is attempted upon or offered to, and in all settings.

In terms of the healthcare approach, you cannot overestimate the harm and damage that is done to people by so-called conversion therapy; I hate to use the words "conversion therapy" because it is not a therapy. There is definitely more that could be done to support them. We have generic services, but I suspect it takes a particular level of knowledge, skill and insight, and it is good to see that there is some commitment to deliver that kind of service. Banning it is essential, but it is only one part of the picture. We need to be sure that we are fully supporting those who have gone through it.

From the medical point of view, NHS England has been a signatory to the memorandum of understanding on conversion therapy since its first iteration in 2015 and re-signed it in 2017, when it was broadened to take into account gender identity as well as sexual orientation. That is important and welcome. It is a public commitment from the organisation, alongside many others, that this awful practice needs to be ended.

Chair: I was a little worried when you said you wanted to see the pace continue because, as you said, it has been three years.

Dr Brady: I meant accelerated.

Chair: Thank you to the witnesses for coming to give evidence this afternoon. It has been hugely appreciated and very useful. I would just like to conclude the meeting, so thank you very much.