HOUSE OF COMMONS

Women and Equalities Committee

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

Wednesday 16 June 2021

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Watch the meeting

Members present: Caroline Nokes (Chair); Elliot Colburn; Philip Davies; Kim Johnson; Anne McLaughlin; Kate Osborne; Bell Ribeiro-Addy; Nicola Richards.

Questions 258 - 287

Witnesses

I: Baroness Falkner of Margravine, Chair, Equality and Human Rights Commission; Melanie Field OBE, Executive Director for Policy, Strategy and Wales, Equality and Human Rights Commission.

II: Jo Churchill MP, Parliamentary Under Secretary, Department of Health and Social Care.

Examination of witness

Witness: Jo Churchill.

Chair: We now move on to the second session, with Minister Jo Churchill. Thank you very much for coming this afternoon.

Q258 **Anne McLaughlin:** Can I thank you, Chair, for allowing me to take a moment to mention the very sad and untimely death of Leeze Lawrence? She was a trans woman, trans ally, and trans activist, as well as being on the SNP's NEC and being convenor of Out for Independence. I did not know Leeze personally, but I know how relentlessly she campaigned to support others. I also know that she watched every single one of this Committee's GRA sessions. She died last week at the age of 39. I am very grateful for the opportunity to put her name and the contributions she made to trans rights on the record, particularly for her family and many friends.

Good afternoon, Minister. I wanted to talk a little bit about the Government's response to the GRA consultation. I wonder if I can start by asking you what discussions, if any, you had with the Government Equalities Office prior to the Government's announcement on Gender Recognition Act reform.

Jo Churchill: Thank you very much indeed, Anne. I would first like to say how sorry I am for Leeze's passing. My sympathies go out to not only colleagues and so on in the SNP but to her family and friends. It is a very young age.

If I may take your indulgence, I would just like to introduce myself. I am the Parliamentary Under Secretary for Prevention, Public Health and Primary Care. I have responsibility for the gender identity services and health inequalities within my portfolio. It is essentially trans healthcare that I will be focusing on.

Indeed, your question asked me specifically what conversations we had on GRA reform between the Departments. We were asked to advise on the potential changing of wording within the Gender Recognition Act, from "gender dysphoria" to "gender incongruence". We advised that, if they wished to keep the current medical process within the GRA, then they had to keep the wording as "dysphoria". It is a recognised medical term, and therefore there was not the scope to make that change.

The wording within the Act and the decision to have a medical process within that is a matter for the GEO. DH is neutral, I would argue, on whether there is a need for that medical diagnosis. The briefing papers on this are in the public domain, though, so people can pick this up.

Q259 **Anne McLaughlin:** There will be some questions on that later. You will have been aware of some of the criticism of the fact that it took two

years for the Government to respond to the consultation. I wonder if you have a view on why it took so long.

Jo Churchill: As I said, my focus is specifically on healthcare in this space. I am charged with making sure that services, which are not very good, improve. You have already heard from the Government's LGBT health adviser, Dr Brady, and also John Stewart, who leads for NHS England on this. My job is to really make sure that the system is improving because it certainly needed it. I am afraid your question lies within GEO. They have told me that they will be listening in and they are more than happy to write to you. I am sure they will do that.

Q260 **Anne McLaughlin:** My understanding is that we invited other Ministers who would have been more appropriate to answer some of these questions. They said that they would send you along and you would be able to answer them. You may not be able to, but I am just going to keep asking on this issue anyway.

One of the things that I really wanted to talk about was how the Government's proposed changes to the GRA make the process "kinder and more straightforward". I am quoting. How do they make them kinder and more straightforward?

Jo Churchill: The challenge has been that they are longwinded, so digitisation would be a primary one. If the past 18 months have taught us anything, it is that all healthcare does not have to be in person. Support can be given in a digital way. Certainly, elements of bureaucracy are made considerably easier if people can access them. Pushing on with digitisation would be the first thing.

The next thing would be that, as I alluded to, the need for medical reports is a GEO decision and something that I will not comment on. I will refer to the reduction in fees. If you like, in order of priority, people's main concern was their access to healthcare. That is why I was happy to come along. It is important that we look at those services and that I am asked to tell you what we are doing to improve them because they were not good enough.

It was also cost and access. They were dealt with by making the system digitised and reducing the cost from £140 down to £5. By way of explanation for the people who go, "You might as well have just made it nothing", that would require primary legislation. That would take much longer. This was, by way of a compromise, driving the cost down to £5, which is a very minimal cost. I would argue it would go some way to being a kinder system and making it much more affordable to have access.

Q261 **Anne McLaughlin:** I wanted to talk about the fact that it was coming online. Someone who gave evidence to this Committee—I have only just joined the Committee, but I have been reading over it—said that to try to pass that off as a reform was insulting, given that most Government services already are online. Stonewall said, "We have ended up with

some valuable but minor changes to the scope of gender recognition"—that is not to say that reducing the cost and putting things online is not valuable—"when we could have stepped back into the space of being among some of the leading nations internationally with simple, dignified processes of self-declaration. The Government had the mandate for doing that in the responses to their consultation. It is just unclear to us why they did not take the political leadership at the time".

Can you say why the Government did not make legislative changes, given that the majority supported that in the response to the consultation? What is the purpose of a consultation if the Government are not going to respond to what the majority of people say?

Jo Churchill: I would argue that we have responded. The focus is on delivering better healthcare and access. We ensured that, when the NHS took over in 2013, it drove forward from that point and ensured access to services. There was a challenge in the workforce. All those things needed addressing.

I will take from your commentary that there was a comment that most Government services are digitised anyway. This one was not. It is important to make sure that we drive forward, and it is digitised. You might consider that that is just something that should be there, if you like; maybe it should. That is our objective: that it is there, it is kinder, and people have access to it.

The other thing you said was that Stonewall commented that valuable advances had been made. It is important that this is a journey. The most important focus, and my primary focus, is ensuring access to healthcare services. When you read the report and read about some of the challenges that the LGBT community has in accessing healthcare, for a plethora of reasons, then that is the most important thing. That was the thing that came out time and time again as what was needed here.

Q262 **Anne McLaughlin:** I do not deny that that was important, but one of my other colleagues will speak about that. I just want to go back to taking everything online. You said it was a journey, and it is, but it just feels like an incredibly slow journey. This is a very painful journey for so many who have to wait so long. I wondered if you had had an update on the progress of getting things online and getting it all digitised. Do you know what that online process will look like? Will they ask the same questions and ask for the same evidence that people are asked for now?

Jo Churchill: We will write to you outlining the timescale, because I am not going to tell you that I know something I do not know. GEO will write to you as it has control over the speed that this is going at. It will inform the Committee as to how far down the process it is. It is my desire that this happens at pace, because it is a kinder part of the process. It is something that individuals can or should expect to be able to do. As you say, just about everything else is accessible online.

Q263 **Anne McLaughlin:** My final question is on the matter of kindness,

because we keep mentioning it, and rightly so. I do not know if you were listening earlier to the previous panel. One of my colleagues was talking about the former member of the LGBT advisory panel who said that the Government had created a hostile environment for LGBT people. I am not going to ask you to refute or agree. I am just going to ask if you will commit to ensuring that, where you see that happening, you will work to stop it. From the tone of what you have said today, I am sure you will, but there are people out there who would really like to hear that from a Government Minister.

Jo Churchill: Within my portfolio, within healthcare, my drive is to make sure that people are treated with kindness and dignity throughout every service that they access, making sure we have more services and a workforce to support them, and that that workforce is supported, which is a key thing here, in order to feel more enabled to deliver services.

Anne McLaughlin: Thank you. Chair, I am very sorry. I am now going to speak in a debate in Parliament but thank you very much for your time.

Jo Churchill: Thank you for your questions.

Q264 **Nicola Richards:** Minister, in response to the GRA consultation, the GEO announced the opening of three new gender identity clinics. Are these new clinics or are they a continuation of the clinics announced by NHS England?

Jo Churchill: The three clinics that you are talking about are the pilot clinics: Dean Street, Indigo in Manchester, and CMAGIC in Cheshire and Liverpool. We also have one now open in the east of England; it started to take patients yesterday. I know that, at the last session you had, John Stewart said that it was coming online but he could not give you any more details. That one is now open. Pushing forward, I can tell you that we will have another clinic in the Sussex area by June 2022. We are then looking at other regions in the country to make sure there is spread. These are pilot clinics.

In answer to your question, the clinics that were there had a lack of connectivity. There was a lack of service cohesion for people to access the service. You only need to read the respondents. We could not be sure at all that people were getting a good service. You need to make sure that people are not only getting a service but that service is good. We have just had the first evaluation back from Dean Street; that is very positive on people's experience of how they are working with and interfacing the service that they are trying to access and the support they are getting.

We know that waiting times have increased. We know that we have a very rapid demand curve for these services. We are making sure that the pilots deliver. We are evaluating them over the next two to three years. If you are asking me whether what we have is better than what we had, my answer to that is already yes. Is it our intention to grow that? Yes, it

is. Is it our intention to improve local access via general practice? Those conversations are ongoing with Dr Brady, making sure that we have the right training in place.

People need to be able to talk to someone and access services. That is my job: to make sure those services are accessible. I hope that answers your question with a degree of clarity.

Q265 **Nicola Richards:** Was the opening of the new clinics driven by the GEO?

Jo Churchill: No. They were provided by the NHS off and, I would argue, off the back of the surveys and the general recognition that services were not adequate. We have just been through one of the most challenging 18 months for healthcare. Still, John Stewart's team at NHS England and Dr Brady, who still works on the front line, and his team have really pushed on to make sure that we have got these clinics open and that we are challenging where services are not available. We are making sure that we tender and that, when tenders come in, they are robust, so that services are good. There is no point in providing services that are not coherent or linked together. Put the individual at the centre of them. Healthcare is about care rather than the identity of somebody.

Q266 **Nicola Richards:** You have already addressed this, but 80% of respondents to the National LGBT Survey said that access to gender identity clinics had not been easy. We have also heard that some GPs did not know where to refer somebody with gender identity issues. Alongside that, we have also heard that some GPs would not support trans people in accessing gender identity services. How would you respond to this? What steps are you taking to solve this issue across the country outside of these pilot projects?

Jo Churchill: Basically, Dr Brady is working on guidance with one of the executive team at the royal college. I also believe that he is working with the head of all the royal colleges in order to drive forward making sure that both the training and the guidance is in place for individuals to have those conversations with their general practitioner.

I have friends who have not wanted to see their family doctor for a conversation that has involved their sexuality and their choices, perhaps coming out or whatever, because they have been worried about reactions. We need guidance so that people understand how to have those conversations. There is then, within practices, the right for people or doctors to take a view. However, making sure that you have access is the key thing here. Those are part of the conversations and part of making sure that we can improve services for everybody.

Q267 **Nicola Richards:** We have also heard that there is a postcode lottery for accessing gender identity services and that it depends on where you live as to how long the waiting times are. Is this part of what you are looking at the moment to improve?

Jo Churchill: As the previous answer indicated, we now have clinics in London, Liverpool, Manchester, and the east of England around Cambridge. We are looking at Sussex. We are also looking at those areas that are not covered: the south-west and the north-east. Using general practice for local accessibility will also help in this access.

I would also argue that digitisation will help. Many services have gone remote. Very often, when people are talking, they believe that all the services might be surgical, but they are very often not. They involve speech, language, counselling, wellbeing therapy and psychological support. They may or may not take an individual on a journey to hormone treatment and/or surgical interventions. We are individuals and that individual choice needs to be there in what anybody chooses around their healthcare needs. It applies as much to you or me. This is about treating individuals with dignity.

Q268 **Nicola Richards:** I would also suggest that the West Midlands is perhaps a bit of a blind spot for this. It is physically quite difficult to get to the services that young people are pointed to in that area. Given that the demand for gender identity clinics is rising, how are you ensuring that there are going to be enough specialist staff to operate these new services across the country?

Jo Churchill: I have noted Birmingham. I took that as a little ticking off, so I will stick that in my book as well. On workforce, you are absolutely right. We had a lack of workforce. To increase the professional workforce, we have now established a postgraduate training credential in gender medicine. The course is delivered by the Royal College of Physicians and the University of London. There are 41 individuals currently going through that course. We are making sure that we are building the teams under that. I know this is something that Dr Brady is incredibly focused on, because you cannot give services if you do not have the workforce. Making sure that you have those within your workforce who have that specialist knowledge is really important.

The guidance for GPs, as I said, also covers not only supporting adults with gender dysphoria, but also bridging prescriptions, blood test monitoring and the shared care agreements. Often, it can be quite a long journey for an individual. It may also involve private providers in this space. It is about making sure that people are communicating and that the care of an individual is shared. They might be accessing healthcare services that are not for anything to do with their identity, but it may be relevant to what they are doing. Making sure that things are joined up is a key objective of what I want to do in this space.

Q269 **Nicola Richards:** We have also been told that the pandemic has caused many staff in the NHS to experience burnout and that many healthcare professionals are considering leaving their profession. How will this affect the drive to open more clinics and upskill current clinicians?

Jo Churchill: Questions on workforce are largely a matter for the Minister for Care as that sits in her portfolio. I do not see it affecting it as the NHSE is funding individual fellowships for surgeons who want to train in gender reassignment. The first fellowship has already started at Imperial College, and we are also training people in care navigator roles so that they act as support.

This is a new service. First, we should recognise that this has just been the most alarming year for staff across the NHS, because this has not gone away; there have been intense periods of acute pressure. Now we know we have the normal day-to-day things such as making sure that services are rebuilt, backlogs are addressed and so on. This is a new area. Making sure that those training courses support the delivery for people is really important.

I have been pleased by the fact that people are accessing the new training. That gives me a degree of assurance that we will be able to see the numbers of workforce rise. I would gently point out that we are working from a pretty low base in this area. To get a rise is not as challenging as in some areas, and it is needed.

Q270 **Chair:** Minister, can I just follow up on some of the comments you have made about cohesive, joined-up services? You have quite rightly made the point that many people would not choose to go down a surgical route, but some will. Can you give us any update on the services that were previously provided by St Peters Andrology Centre, which I understand has now had to retender its services for phalloplasty, and whether the knock-on effect of those services not being carried out at the moment is expected to have a long-term impact on those transgender men who are seeking that sort of surgery?

Jo Churchill: Essentially, the provider you named did not secure a deal with a third-party organisation to provide the facilities to perform procedures. There is a degree of commercial sensitivity around this area, so you would not expect me to divulge a large amount of information.

To your point, there are individuals who are partway on this journey who have needs. The contract for these services is currently out to tender with a view to rapidly award this contract in very short order. It is not acceptable that people cannot complete, and others cannot start, phalloplasty if they wish to go that route. I am optimistic about the contract being re-awarded, from my conversations. Because of the commercial sensitivity, that is about as far as I am willing to go.

Chair: Can I just thank you for that? I am conscious that it is causing significant concern that the services are not currently available. I am sure people will be reassured to hear that you are optimistic that this will be resolved in short order.

Q271 **Kate Osborne:** Good afternoon, Minister. Thanks for coming to the Committee today. According to the Government's analysis of the GRA,

nearly two-thirds of the respondents were in favour of removing the diagnosis of gender dysphoria from the gender recognition process. Can I ask why the Government did not address this in its proposed changes?

Jo Churchill: I am really sorry to sound like a stuck record, but that is GEO policy. As I have said, we have a neutral stance on whether it is required. The focus from this Department is on delivering healthcare. Making sure that we have more individuals—GEO holds the register of clinicians—and making sure that we have more clinicians on that register, so people have more choice and access, is the important thing from my position. As I say, you will have to refer that to GEO.

Q272 **Kate Osborne:** I feel already that that may be an answer as we move forward, but I will move forward regardless. We have received evidence arguing that the requirement for a diagnosis of gender dysphoria reinforces the false belief that being trans is a mental illness. Will your Department challenge that belief? If so, how will it do that? Does it have any plans to review the gender dysphoria diagnosis requirement?

Jo Churchill: As I said, the policy is held by GEO. I would gently say that that is not in scope of what we are here to discuss today. I am sorry. I do understand. Was it Dr Hutchinson who made those comments at your Committee? I read them and I understand why it hurts. That is the term I would use. However, that is GEO's policy at the moment. I am focused on making sure the healthcare provision is there so that people have as many choices as they can. These things are not a policy that DH has any control over. The requirement is one that is put in place by GEO.

Q273 **Kate Osborne:** We may be able to make some progress with this one, hopefully. In 2018, the World Health Organization formally moved gender identity disorder from mental and behavioural disorders to conditions related to sexual health, because classifying them as mental ill health can cause enormous stigma. Can you tell us how the DHSC, and possibly GEO, responded to this move?

Jo Churchill: I cannot tell you how GEO has responded to the move. Could I ask for a degree of clarification on your question? I am not quite sure what you are driving at. The definition of gender identity is a person's internal sense of their own gender. Sorry; what are you asking me to confirm or qualify? As I referred to earlier, I am focused on individual healthcare and making sure that that healthcare is accessible and is there in safety, with privacy and dignity. We provide healthcare, regardless of any characteristic, free at the point of delivery, for the entire population. I am a bit lost as to what needs clarification in that. The important thing is that, if you have a need, it can be seen to. In this area, we were not good enough. The waiting times are too long. We need to focus on it and drive them down. As was mentioned, people live with a great deal of angst while they are waiting for these services.

Q274 **Kate Osborne:** I understand that, but the term "mental and behavioural disorder" causes a certain amount of upset, and, as I said before, stigma,

as opposed to it being related to a sexual health issue.

Jo Churchill: I will commit to write to the Committee because I cannot find in my frame of reference that that is anything that I have ever come across in working policy out for individuals, if you see what I mean. I will investigate and write to you. I am not going to bluff an answer to you because someone's identity is who they are. We all have a right to live as who we wish. No one in the Department or the broader NHS sees this as a mental health condition or mental illness. Gender dysphoria is a recognised clinical definition, which is where we started this questioning. That is where I am just a little unsure of what you are trying to find there.

Q275 **Kate Osborne:** The World Health Organization moved gender identity disorder from being a mental and behavioural disorder.

Jo Churchill: That is positive.

Q276 **Kate Osborne:** If you could write to us once you have looked at this further, that would be welcome.

Jo Churchill: Next year is 50 years of Pride. Hopefully, if we are in an easier situation with regard to the pandemic and so on, we will lead an international conference. All I would say, as you have enlarged on your point, is that I would welcome very much everybody seeing this not as a mental health condition.

Kate Osborne: Thank you. I very much look forward to the conference. Hopefully, it will be able to go ahead without any problems.

Jo Churchill: Let us hope so.

Q277 **Kate Osborne:** 80.3% of the respondents to the GRA consultation were also in favour of removing the requirement for medical reports. If you can answer this, can you tell me why the Government did not address this in their proposed changes to the GRA?

Jo Churchill: With respect, that is an answer I have already given before, outlining that it is GEO policy. DH is neutral. While it is in law, it sits on the statute book. I would say that the way you help address those other concerns around that is that access is improved, cost is improved and so on, so that the environment is one that makes it much easier for an individual to pursue a path.

Q278 **Kate Osborne:** A large amount of evidence to the inquiry has expressed concern about the gender recognition panel, stating that there is no real transparency in what feels like a panel of strangers. Is the panel necessary? What steps could be taken to improve transparency?

Jo Churchill: I will refer that to GEO. The panel is theirs for selection and approval. I am sure GEO will write to you on how it was selected and how it feels it is transparent in what it is doing.

Q279 **Kate Osborne:** Some 78.6% of respondents to the Government's

consultation on the GRA argued for the removal of the requirement to live in the acquired gender for two years. We were told that this requirement inscribed sexism and sexist stereotypes into law. Why was this requirement not addressed in the Government's proposed changes?

Jo Churchill: Again, I am really sorry. That is GEO policy. I am a Department of Health Minister, not the Minister with responsibility for that policy. Again, I am sure that GEO will write to you on that matter.

Q280 **Kate Osborne:** Would it not be helpful if we had a Minister from GEO here?

Jo Churchill: All I can say is that I am here. I am happy to answer what questions I can in the area of healthcare and what we are doing to try to make sure that healthcare is more accessible. If you are pushing for a comment, there is a balance to be struck. These are massive decisions. We are making sure that someone has the right psychological support and time to reflect. People make different decisions on that journey. There is a definite balance to be struck as far as having some period for reflection built in as well.

Q281 **Kate Osborne:** I am going to ask you one last question. I strongly suspect that we may be in the same territory, but here goes. In oral evidence, we were told that some trans people have been criticised for not wearing lipstick or that they were not feminine enough in appointments at gender identity clinics. In your view, does wearing lipstick make you feminine or more feminine? How should staff in gender identity clinics check for this in practice? How should someone demonstrate that they are living in the acquired gender?

Jo Churchill: I would refer you back to the values of the NHS: dignity, safety and privacy, but particularly dignity. I would also gently say that one of the reasons that we are focusing on education and training among clinicians and care pathway navigators is so that there is a degree of sensitivity in conversations and conversations are appropriate at all times when people are accessing their healthcare. That is all I am willing to say on that.

Q282 **Elliot Colburn:** Hello, Minister. This section is about trans health outcomes, so it is hopefully more in your portfolio. Throughout this panel, we have spoken about the interaction between GEO and the Department of Health and what policy sits with which Department. Is it fair to say that the Department of Health and Social Care is restricted in how far it can go in terms of the health outcomes for trans people when it comes to their health based on what GEO sets as its priorities? Can the Department of Health and Social Care go beyond the ambitions set out by GEO in order to secure those outcomes?

If we use gender identity clinics as an example, the Secretary of State set out the ambition to have three new clinics. We have had the debate over whether they are new or existing; let us leave that to one side. Obviously, we have had the announcements of the new one in the east of

England and your proposals today for one in Sussex as well. That has obviously gone beyond what was set out by the Secretary of State, which is very welcome.

Are you limited in what you can do based on the priorities set by the GEO, or can the Department of Health and Social Care pursue its own ambitions in terms of outcomes for trans people, and indeed for every protected characteristic?

Jo Churchill: Very gently, I would say that GEO looks after the policies it is responsible for. My day job is working with the NHS to ensure that treatment is there and is accessible. When you look at some of the statistics on waiting times and some of the need to drive more capacity into the system determine, that is what determines how Dr Brady and his team advise my policy officials, the Secretary of State and I as to what is required. As you have said, it has already gone beyond three because we have seen the demand in the system. When you look at waiting times in this area, about 9,000 referrals were made in 2019-20. When you look at the ability to deliver we had in the system, it was not there. We needed to do more and do better.

There is no point in setting up a clinic without a workforce. One of the other questioners alluded to whether we have the right workforce. There is a question of building that, but around 13,500 people are waiting for their first appointment. What drives me is outcomes. This is about the outcomes for people in their healthcare needs, and I would include this area in that healthcare need. I do not differentiate. I suppose the short answer to whether they have any influence is no.

Q283 **Elliot Colburn:** Sticking with the theme of outcomes, the National LGBT Survey commissioned three years ago highlighted that health outcomes for LGBT people across the board were generally lower than those for the rest of the population. It is fair to say that you have already touched on the work that the Department is doing to try to reduce those inequalities. If you want to add anything in terms of the specific inequalities faced by trans people, please do.

I will also highlight the outcome of the survey that 38% of trans respondents accessing general NHS healthcare services reported having a negative experience because of their gender identity. I would be really interested to hear what steps the Department is taking to improve transgender people's experience of accessing healthcare services and addressing the inequalities in those outcomes.

Jo Churchill: If I may, I am going to start with the end of that question first. You need to know where the need is. I am sure that you have discovered—it was certainly the case when I was on the Committee and we were looking into this issue back in 2016—that there is a lack of real, good-quality data that can determine where the need for trans individuals is, whether on location, accessibility or whatever else.

First, we now have the GP Patient Survey. That is the biggest survey of its kind. It goes to about 2.2 million households. It will help to address the gaps in the evidence because, for the first time, it includes a new gender status—trans. We will have the ability to collect a better dataset by the use of the GP Patient Survey.

In the last census, we also had a question on gender. It was a non-mandatory one. I would argue this conversation is not always an easy conversation to have. I think I read, "If you do not count me, I do not count". You need to stick your hand up so that I can count you and so that we can drive services to where they are needed the most.

The first bit is knowing where people are and understanding where the need is. The next bit is making sure that we can provide those services on a local basis through primary care, and then through the specialist clinic network that I am really pleased to say is going ahead at pace. Looking back to the LGBT Action Plan, we promised a national health adviser. Dr Brady has given you evidence. His team and the team at NHS England have done the most phenomenal amount to drive service accessibility up in this area. He is also driving forward with the GP guidance that I have alluded to, the Royal College of Physicians, which I have mentioned, and so on. The care pathway navigators are making sure that the work that goes on is done in a sensitive and appropriate way with individuals so that they get the most out of the service that they can.

Standard operating procedures and service specifications were also wanted and are now in place within the pilot schemes. We are making sure that we evaluate those pilot schemes so that we know what works and what people feel. You can set up a service, but if you do not ask the people who use it whether it has been any good, it is probably not going to give you a great deal of information.

We are getting more information. We are only looking at post-18, but we have the Cass report. Dr Hilary Cass will report later this year. We are improving action for mental health frailties and care within the LGBT community per se because, like everyone, you have different healthcare needs. The susceptibility to other diseases like diabetes or mental health episodes is there. Arguably, when you look at the research, they are services that people often need to access more because of some of the challenges.

There was a piece of research—I think by the Terrence Higgins Trust, but I may have got that wrong—on the number of young gay and trans people who were sleeping rough; that was obviously before the pandemic. There were also a number of attacks. I remember visiting a centre up in Manchester when I was on the Committee. We can only make sure that those appropriate services are there if we have the data, so this is a two-way street.

Finally, enhancing fertility was another thing. From 2019 or 2020, we made sure that every area of the country would also take needs within social care into account. It is about improved monitoring and making sure the services are delivered.

Q284 **Elliot Colburn:** Thank you, Minister. It is great to hear you reference the recommendations in the LGBT Action Plan and your Department's progress against those. It is fair to say that we have been unclear as a Committee as to whether the LGBT Action Plan is still a live document with GEO and whether or not it still views that as Government policy. It is really reassuring to hear you say that. Is it fair to say that the LGBT Action Plan and the survey that was conducted are still very much a point of reference in the Department of Health and Social Care in terms of information about the needs of the LGBT community and things that the Department of Health and Social Care should do to address those needs?

Jo Churchill: I would argue that it is. It showed us where we needed to improve. I would also say that, like any action plan, you need to constantly ask yourself the difficult questions like, "Are we doing well enough? Are we delivering well enough?"

It is quite a challenging thing across my portfolio, which, as you heard from the title, is quite large. There are sometime things that are delivered in healthcare that are not optimal. We need to be brave enough when we evaluate things to see that we could do better or stop something in order to improve something. That is very much how I see the pilot.

I was asked the question of whether these were new. I would like to think that, yes, they are, because the old way was not joined up and did not deliver what we needed it to. It was not led by somebody who worked on the front line, understanding and having those conversations every day about how people would like to receive this service.

People will always bring a criticism that it is just your sister's bike that has been painted so that you can have it at Christmas. It is not new, if you see what I mean, but I would argue that the services that we are delivering now are of a substantially higher quality. We are seeing more people who need to access those services. We are on a journey. I have been quite frank about the size of these waiting lists and the level of demand that we are seeing. We need to keep pushing on the workforce and pushing on delivery.

Q285 **Elliot Colburn:** I am conscious of time, so I just have two very quick final questions for you. Do you have conversations with GEO, however intermittently, about the health outcomes for trans people, or in terms of health outcomes across the protected characteristics in general? Do you have that relationship with the Government Equalities Office?

Jo Churchill: I speak to the Equalities Minister regularly across the spectrum of health inequalities. It goes back to that point that we talk on

a regular basis. Obviously, she leads on the work on racial disparity as well; the Prime Minister asked her to lead that work. Many of these things are commonly shared objectives that we do better, but I have the delivery vehicle. We see the outcomes in health. I am certainly not the only Minister in a Department that can affect health inequalities, levelling up or whichever term you want to use around it. We talk regularly about the delivery of services, which is my remit into this.

Q286 **Elliot Colburn:** Thank you very much, Minister. That is very helpful. The British Medical Association has told us that more dedicated training for healthcare professionals on trans issues was needed. That was highlighted in the survey as well, and we have touched on this throughout the course of this panel. Is that a commitment from the Department of Health and Social Care to deliver that training? Is it a commitment to make sure that the ethos for the NHS and the staff who work for it is delivered in terms of making it a more positive experience by giving staff the training that they need to deal with trans healthcare?

Jo Churchill: I have already gone over the fact that we are writing this guidance and so on. Funnily enough, I am meeting with the GP lead for the BMA next week. I will commit to the Committee to raising this issue in particular and seeing if he as any concerns that we are not addressing. If he has, I will write to the Committee and let you know that we have discussed issues outstanding and what action may be taken.

Q287 **Chair:** Can I just ask one final question please, Minister? At various points in your evidence, you have made it clear that they were questions that GEO should have answered. Correct me if I am wrong, but you also said that GEO was planning to write to us with responses to those questions that you were not able to answer.

Jo Churchill: Yes, that is my understanding.

Chair: Thank you for confirming that. We will very much look forward to receiving that correspondence. Can I just thank you for taking the time to come and give us evidence this afternoon? It is very much appreciated. That concludes this afternoon's meeting. Thank you and goodbye.