

Women and Equalities Committee

Oral evidence: [Health and social care and LGBT communities](#), HC 1492

Wednesday 1 May 2019

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Members present: Mrs Maria Miller (Chair); Tonia Antoniazzi; Philip Davies; Jess Phillips.

Questions 1–49

Witnesses

I: Wendy Irwin, Diversity and Equalities Co-ordinator, Royal College of Nursing, Professor Carrie Llewellyn, Professor of Applied Behavioural Medicine, Brighton and Sussex Medical School, Dr Duncan Shrewsbury, Local Medical Director, Practice Plus Brighton, and Sophie Meagher, Policy Officer, LGBT Foundation.

Written evidence from witnesses:

- [Brighton and Sussex Medical School](#)
- [LGBT Foundation](#)

Examination of witnesses

Witnesses: Wendy Irwin, Professor Carrie Llewellyn, Dr Duncan Shrewsbury and Sophie Meagher.

Q1 Chair: Good morning. I welcome our witnesses and those watching online or in the Public Gallery. This is the first evidence session of our inquiry into health and social care and LGBT communities. We have had a huge amount of written evidence that suggests that frontline services are not always treating LGBT people appropriately and that that may be causing people to have a worse experience, particularly with the NHS, than other groups.

We hope to explore many of those issues today with our witnesses, all of whom have tremendous expertise in this area. We thank you for coming along. We have a series of questions and colleagues will be coming and going. Apologies for that, but it is one of those days. Can you start off by saying your name and the organisation you come from?

Professor Llewellyn: I am Carrie Llewellyn. I am a professor of applied behavioural medicine and a chartered psychologist. I work within the academic department of primary care and public health within Brighton and Sussex Medical School.

Sophie Meagher: I am Sophie Meagher. I am from the LGBT Foundation, which is a Manchester-based charity.

Wendy Irwin: I am Wendy Irwin. I am head of equalities for the Royal College of Nursing, which is both a professional organisation and a trade union for nurses.

Dr Shrewsbury: I am Duncan Shrewsbury. I am the local medical director for Practice Plus in Brighton.

Chair: Brilliant. I think I am right in saying that none of you has ever given evidence to a Select Committee before, so we are really grateful. Sometimes we get worried that it is the same people who come round every time. That is not to disparage anyone who gives evidence on a regular basis, but it is great to have people who have not done this before, and I hope we make it such a positive experience that you want to do it again. That is our objective, anyway.

Q2 Philip Davies: Can I ask each of you to set out how big a problem you feel discrimination against LGBT people is in primary and social care, and what form it tends to take? Carrie, do you want to start?

Professor Llewellyn: I would probably start by saying that we do not know what proportion of the population is LGBT. Starting with that in mind is helpful for these kinds of discussions. We do not have any reliable estimates, which is part of the problem. Public Health England estimates



that between 1.2 and 3.6 million people in the English population over 16 are possibly LGBT, but that is often seen as an underestimate. That contextualises the fact that we do not have much data about this.

In my opinion, there are significant health disparities between sexual minorities—lesbian, gay, bisexual and transgender populations—and heterosexuals. I think disclosure of sexual orientation can be challenging due to organisational barriers, and also personal barriers. I think there are a lot of heteronormative assumptions within the NHS and within healthcare settings. I think there is a lack of monitoring; there are limited opportunities for personal disclosure, and most of this is driven by thoughts about fears of stigma and discrimination—whether or not these are perceived or real doesn't really matter.

Disclosure levels have historically remained quite low in health settings outside of traditional sexual health settings, and we can talk a bit about the differences later on. Unpublished data that we have at the moment also indicates that there are huge long-term health conditions and mental health disparities between these populations.

Sophie Meagher: I have some evidence on discrimination that LGBT people face from a survey we did in 2017. We found that 21% of LGBT people had experienced discrimination or unfair treatment based on their sexual orientation or trans status from a primary care service, and we found that trans patients were 30% more likely to experience discrimination. Some 33% of people said their GP did not meet their needs as an LGBT person, and 72% thought that GP practices could improve services they offer to their LGBT patients.

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.

Wendy Irwin: I think I need to say that 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 that my colleague speaks of. That possibly is a factor in shaping people's experience.

What we see, or what I certainly believe, is that there is—as Carrie said—very little data that enables us to accurately predict or forecast the actual size of this issue, but when we do speak to people and we learn about their anecdotal experience, that suggests the experience of discrimination and the perception of harm and stigma is severe and persistent. We have seen a number of cases of fear around disclosure, and issues around some of the assumptions. Particularly for people moving into end of life or care homes in the social care sector, those issues become quite exacerbated, and certainly cause for concern.



Dr Shrewsbury: I absolutely agree with what Wendy has said, but I would carry that across to other clinicians in general practice. I can't improve on the data that you have already reported in your action plan, which I think speaks for itself and suggests that discrimination is perceived, and perceived at an extent that is worrisome. Part of the problem is that there are lots of different layers and levels to discrimination that are pervasive throughout society, but also the healthcare system, with some aggressions and micro-aggressions being enacted through interactions with professionals in the clinical sphere, which may be due to ignorance or clumsiness, but rarely due to malice—or at least I would hope.

I think there are larger-scale, system-wide prejudices that influence some of the pressures and choices that are made around service design, availability and commissioning, and that both influences the interactions that patients will have with clinicians—which may have an impact on the dynamics of a consultation, leading to a sense of prejudice or discrimination—and also has a systematic impact on how an individual might be able to access the help that they need.

Q3 Philip Davies: When LGBT people are first using health services, what is the most important thing for healthcare professionals to do to ensure they get a good experience?

Dr Shrewsbury: My initial reaction to that is that every health professional should be looking to provide compassionate whole-person care. That is one of the values that underpins general practice, general practice training and, indeed, the practice of many clinicians from different disciplines in primary care. I am aware that there are incidences where that does not appear to be happening, and that can be due to a number of different reasons. Certainly, it is about being open and being whole-person and compassionate in your approach.

There are examples where that is particularly highlighted. You might be aware that there are certain organisations within the NHS now that promote championing particular individuals as being open and approachable, to help support issues either around disclosure or the full exploration of health issues related to sexuality, such as the rainbow lanyards, rainbow pin badges and things like that. Those are a wonderful example of a real enthusiasm towards addressing those issues.

There are potential issues related to how that might be exploited to a certain extent, but I think I will stop there before I swallow up too much time.

Q4 Philip Davies: Is there anything anyone else would like to add on the most important thing for healthcare professionals to do when an LGBT person is first using a service, to make them feel comfortable?

Wendy Irwin: As my colleague said, it is actually to see the person, but that takes time to do. We do know that currently, certainly for nurses and healthcare support workers, they are not often given that time because of

the systemic pressure. We know that currently there are around 40,000 nursing vacancies.

There is a lot of evidence about the link between safe staffing and better patient outcomes. Systemically, there are obviously things that nurses and healthcare support workers can do, but structurally they may be prevented from doing so, because of the shortage—and growing shortage—of nursing numbers currently in the workforce.

Sophie Meagher: I would say monitoring. When a new patient registers, it is really important that they ask those questions on sexual orientation and trans status, and then their GP or healthcare professional can know about that person. It might not be relevant in a consultation, but it might be, so if they know it they can start to have an open and honest conversation with that patient and provide person-centred care.

They might need to be signposted to an LGBT organisation that can give them specialist counselling. If those questions are not asked in the first place, that is never going to happen. I would say that monitoring is the most important thing and then, definitely, visibility as well. It is proved that if there is LGBT visibility in, say, the reception of a GP, someone is much more likely to disclose their LGBT status. I would agree with Duncan there.

Q5 **Chair:** I'd like to ask Duncan a supplementary. Sophie just talked about the importance of visibility. Isn't that better than having an individual who is approachable, because you might end up with ghettoisation if it is just that person you go to because they are a gay nurse or doctor? Surely, it has got to be across the board. It has got to be visibility across the board, rather than just an individual that people want to go to.

Dr Shrewsbury: I do agree to a certain extent. I'm smiling because I am that doctor in most surgeries that I've worked in. There is a difference between visibility and an intention to be open and compassionate and whole-person orientated in as inclusive a way as possible, and a skill set that allows that to happen authentically within the constraints of a very time-pressured interaction.

That is something that you probably can't enforce on a workforce-wide basis. You can certainly instil the values and the intention. I think we will all have experienced examples where we have the best intention to do things in a particularly sensitive way—and, goodness knows, I get things wrong all the time—but in the particular dynamics of that consultation it does not always happen.

There does need to be an organisation-wide visibility and intention, but I also believe in allowing people the flexibility to play to their strengths—though they should not necessarily shy away from weaknesses. I would not necessarily advocate avoiding having to address certain issues of ignorance. Certainly, allowing some people to play to their strengths does have a role.

I am sorry to shoehorn this in, but I want to pick up on the fact that I absolutely support what Wendy said as being relevant to general practice as well. You mention the importance of monitoring in your action plan. I see it as important—

Chair: We have not got an action plan. We are not the Government.

Jess Phillips: I am definitely not.

Dr Shrewsbury: Sorry—I beg your pardon. Well, the document from last year around the action plan mentions the importance of monitoring. I want to highlight a practical issue with that information. 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. If you want to try to record it in a useful way, you are forced to code it in that particular way at the moment. That is something that I know the Royal College of General Practitioners is working on with the software companies that develop those things, but it is important to make sure that those sorts of things are joined up.

Q6 **Philip Davies:** What are the biggest barriers—Wendy mentioned time and people—to LGBT people getting a consistently good experience in primary and social care, aside from the time issue that Wendy has mentioned and the fact that maybe in some places there are not enough people?

Dr Shrewsbury: That is a very big question to answer, aside from the fact that interactions are very influenced not just by time pressures, but by what resources are available to draw upon, which has a huge amount of variation across the country.

I believe that a role is played by service availability and waiting times. That influences these sorts of consultations, because patients with certain needs will keep on presenting to general practice—primary care is the only source of help that they have. Once an attempt has been made to access the right support, however, clinicians can often feel that there is not much more that can be done, but that person still presents with a need. That can potentially influence the dynamics of a consultation in an unfavourable way, I suspect. It is important to acknowledge system pressures in that.

There will also be individual traits that make those sorts of consultations go better or worse though, I am sure, including simple things such as whether somebody is having a good or bad day. There will be some wider levels around awareness, education and things like that, which could be addressed.

Q7 **Philip Davies:** Sophie, what does your organisation tend to find are the biggest barriers that people face?

Sophie Meagher: A lot of it is lack of awareness. We get a lot of healthcare professionals who say, “Well, we treat everyone the same. It’s



fine,” but people are not aware that LGBT people face specific barriers. They are more likely to misuse alcohol and drugs, they are more likely to smoke, they are more likely to have poor mental health, and they are more likely to be reluctant to access healthcare. People do not realise that and they will associate being LGBT only with sex, STIs and HIV and that is it. People do not see beyond that and do not think that they might need to refer someone to an LGBT-specific service or that someone might need a different level of support. For us, a lot of the training that we do is going into services and explaining why they even need the training, because a lot of services are reluctant and do not think that there is an issue when, clearly, there is evidence that there is.

Professor Llewellyn: I absolutely agree with what Sophie and Duncan are saying. There are clear training needs around this issue for the whole of our workforce, and indeed our future doctors as well from a medical training point of view.

As Sophie was saying, it is to understand the experiences of LGBT people and the cumulative effect of minority stresses on that—so, the question about intersectionality, which is basically the multiple deprivations or categories that people fall within. LGBT is a huge catchment; it is not just one homogeneous group. It’s a large group of people that fall into different ethnicities and different classes, and there are the effects of stress and all sorts of different deprivations. There is a need to understand that and then perhaps people will understand the value and the purpose of the monitoring. It goes hand in glove.

Q8 **Philip Davies:** Following on from that, are there any groups that experience discrimination more frequently? Older or younger LGBT people? Ethnic minority? Trans, lesbian and bi? Is there a particular group or groups that suffer more?

Professor Llewellyn: I would not say there is a particular group, but, from the academic research that I have seen, bisexual women tend to come out quite poorly in terms of long-term health conditions and mental health issues. Our recent general practice data shows that they are four times more likely than their heterosexual counterparts to have long-term mental health problems. I think women in particular—gay and bisexual women—get more marginalised. They are less visible. A lot of our academic research is focused on gay men’s experiences because of the legacy of HIV and sexual health and the prevalence of STIs. So I think women are underserved. Their voices tend not to be heard in these forums.

Q9 **Philip Davies:** Sophie, what’s your experience?

Sophie Meagher: I would agree with what Carrie said. Also, from our own research, we found that black, Asian or minority ethnic LGBT people and also disabled people have worse experiences. We found that 22% of BAME LGBT people had experienced homophobia, biphobia or transphobia from their GP compared with 13% of white people. Disabled people were 19% less likely to feel their GP practice met their needs compared with



non-disabled respondents, and we found that LGBT people with multiple intersecting identities might feel forced to choose between their identities, feel discriminated against for multiple different identities or don't know which identity is being discriminated against.

- Q10 **Philip Davies:** Is there any reason why those figures vary or why those people suffer more discrimination than other LGBT people? Is there any reason they feel that happens?

Sophie Meagher: I guess those groups that are outside the LGBT umbrella face more discrimination than people within the LGBT umbrella.

Wendy Irwin: To amplify that point, there is often a multiplier impact, so when we think about people and their identities we don't simply just add to the LGBT maybe disability, black and minority ethnic and possibly a religious identity. These things have a multiplier effect. If you are experiencing racism and you are an older person and perhaps moving into homecare or into a care home, you may feel a number of pressures that are cultural around certain heteronormative assumptions that are made about you. What we see often is that the monitoring that takes place often silences. We do not see the impact on these different groups. Across the system we actually don't know what people's experiences are more generally. It is really difficult to say what the impact is without proper monitoring.

I want to add a little point about CPD, which can potentially be very powerful in overcoming barriers. 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. People are always more than one thing. People are many things. That is how identities are. That is how life is. 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.

- Q11 **Philip Davies:** Duncan, do you recognise all those things?

Dr Shrewsbury: I do. In practice I think there are probably some systematic issues that affect women disproportionately and people from the trans community disproportionately: for example, the criteria that are required for referral and acceptance to reproductive assistance services. That disproportionately affects women who identify as belonging to the lesbian or bisexual community. Also, although I do not have data to support this, both older and younger people who identify as belonging to the community, as in towards the extremes, are probably affected. I think there is probably greater isolation for people who are older and for the young. There is probably a greater extreme of prejudice—"haven't quite got through that phase yet" or "don't quite understand". That might very well result in a delay in their gaining access to the right level of support for them, which is more reflective of ignorance, I think.

- Q12 **Chair:** Before we move on, we are talking about barriers—I suppose this question is to Wendy and Duncan—but are there barriers to people who are LGBT becoming nurses and doctors? Wendy, do you want to go first?



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Wendy Irwin: I would say no. I think nursing is a profession that really does welcome absolutely everybody. I think the issues that people face are when they get into the workplace and work with other colleagues. Actually, there are lots of issues around culture in organisations that make lots of assumptions about people and their choices that could be perceived as less than welcoming.

Q13 **Chair:** So could people be less than welcoming to gay nurses or transgender nurses?

Wendy Irwin: Possibly in some organisations. I think that nursing as a profession welcomes everybody, because for us there is a very clear understanding that people with lived experience can offer some really powerful insights and help shape better outcomes for patients who identify in that way as well.

Q14 **Chair:** As the head of diversity and inclusion at the Royal College, do you provide specific support for LGBT nurses?

Wendy Irwin: Yes. We have an LGBT network that meets at our annual congress. We take part in a whole range of Pride events. So we do a lot to support our members who identify as LGBT. What those members may sometimes tell us is that they may well experience homophobia, biphobia and transphobia inside their larger organisations.

Q15 **Chair:** Do you think that is less or more than they would see if they were working outside the NHS?

Wendy Irwin: It is hard to say; I would have to get back to you on that, with data.

Q16 **Chair:** And when there are disciplinary cases of homophobia, transphobia or whatever it might be, do your members think that it is dealt with fairly by the NHS?

Wendy Irwin: We would support members who were taking cases on discrimination of that kind. I would have to get back to you with that data, because I am not entirely sure.

Q17 **Chair:** That would be really helpful; that is great. How about you, Duncan? Do you think your Royal College is really welcoming of people of whatever sexuality and from whatever background?

Dr Shrewsbury: The medical profession in general is, in intention, inclusive. I think the healthcare profession as it operationalises in certain organisations, through naturally including diverse individuals within that, potentially exposes individuals to prejudicial environments.

In the past, I have done quite a lot of work around supporting an LGBT mentoring network for healthcare professionals. The majority of examples were not from other healthcare professionals; they were from other sectors in society. Medical students were exposed to parents telling them, "You can't be a doctor and be gay", and things like that.



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I also think that there are relationships between certain specialties or certain areas of work within healthcare that naturally—no, not naturally, sorry; that is completely the wrong word to use—that more commonly expose people to difficulties, having had trainees talk about some attitudes and comments made specifically in paediatrics, “People like you need to be careful around children”, and things like that, speaks—

Q18 **Chair:** Presumably that is in hospitals?

Dr Shrewsbury: Yes.

Q19 **Chair:** So they are large organisations; they are not GPs’ surgeries, which might be relatively small.

Dr Shrewsbury: No. I certainly have not got any data to reflect on the experience of it in general practice; I am not aware of there being a particularly widespread issue as reported. But I think part of the problem is that the culture within medicine is to get your head down and get on with it, which is especially instilled through training, whereby people do not tend to raise concerns about these particular things, because of the reliance on maintaining sensitive relationships in that working environment on your progression in training.

Chair: Don’t rock the boat.

Dr Shrewsbury: Yes, exactly.

Q20 **Jess Phillips:** You have described how the problem is not necessarily systemic, but is part of the culture and part of working in big organisations. How do you think some of the health messaging, and specifically the public health messaging, needs to be improved for the LGBT community? Imagine your doctor’s surgery waiting room—well, you probably don’t need to imagine.

Dr Shrewsbury: I cannot help but be critical and think that the majority of public health messaging still centres around sexual health. I think we have come a long way from the days of the tombstone that said “AIDS” on it, when it was all associated with men doing things that society disapproved of, but I still think that the public health messaging is probably more extensively orientated towards sexual health.

Q21 **Jess Phillips:** Has there been any effort—this has been a live case in education recently—to make generic public health messaging around diabetes, for example, inclusive of the LGBT community, with things like examples in children’s school books?

Sophie Meagher: There is a recent Public Health England campaign, Cervical Screening Saves Lives, with really good wording around who needs cervical screening: it says “Everyone with a cervix, which is most women and many trans people”. It is not that hard to do, and it shows that it can be really simple to include trans people. It might mean a lot to a trans man who does not want to go and get a cervical screening—they might see it and then go and get one. So that is a good example.



Q22 Jess Phillips: Do you think that generally the messaging in the health service is LGBT-inclusive?

Professor Llewellyn: I would say that there needs to be some kind of social campaign. I think there are some really good similarities with the stigma campaigns for mental health problems that we have seen recently, although they have not focused on LGBT. I think a similar approach could be taken as in stigma campaigns like Time to Change—that would be useful. Obviously we need more information about who to target and where, but that could be done with an LGBT national advisory group.

Q23 Jess Phillips: On your specific example of the messaging around smear tests—cervical screening—I think that there have been some complaints around the dropping of the term “woman” in some of those campaigns, so it gets confusing who exactly you are appealing to. I have certainly seen complaints made about that. Do you think that some of those issues mean that people will shy away from having LGBT-inclusive messaging?

Sophie Meagher: I am sure that people are scared, because there will always be a backlash, especially with that: people just see the word “trans” and there is always a backlash. So I think it will stop people, but it shouldn’t because it is not excluding anyone. No woman is going to see that and think, “Oh, so I don’t need to get a cervical screening test”—it is not excluding anyone. I think it will stop people, but it shouldn’t.

Jess Phillips: I think that including the word “women” is fine, but including everybody is fine.

Sophie Meagher: You can say “women and trans people”—exactly.

Q24 Jess Phillips: How much are LGBT health needs covered in professional training? Let’s start with doctors.

Dr Shrewsbury: After medical school, doctors go through their foundation years and then further training. In general practice, for example, you go through post-qualification training in general practice, which takes about three years full time. That is guided by a curriculum set by the Royal College; the foundation programme curriculum is set by the UK Foundation Programme Office. It is all approved by the General Medical Council, which is the regulatory organisation that regulates our practice and qualifications.

At the moment, those 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—rather than being disease specific. 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.

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. There are opportunities to support the haphazard

professional development approach, and the Royal College supports that through the provision of e-learning resources.

I personally have a particular issue with the way that e-learning resources are over-relied on in these sorts of settings, and I think that is exemplified beautifully in the equality, diversity and inclusion training that is mandated as part of working in healthcare services. You have to do your E&D 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.

On top of that, I do not think there is a more effective way of devaluing something than making it mandatory and telling you to do it in the limited personal time you have left after you have finished your 14-hour shift. I think that sends completely the wrong message. It is quite well known that people will do what they can to achieve the certificates from these things to prove that they are keeping up and doing everything they have to do to maintain registration or regulation—

Q25 Chair: Who runs those sorts of teaching modules? Is it the Royal College?

Dr Shrewsbury: There is e-Learning for Healthcare. I am not quite sure about the organisation that runs it, but that is a nationally provided platform—

Jess Phillips: Through the NHS?

Dr Shrewsbury: Yes, it is through the NHS. The Royal College provides specific modules around LGBT health issues. It is not the same as the equality and diversity; I take particular issue with that. There will be other sorts of organisations that support those activities in other ways, such as Sophie's organisation among others. Making things mandatory, making things online and that sort of practice utterly devalues it.

Q26 Jess Phillips: Wendy—nursing?

Wendy Irwin: In nursing, you can divide learning and development into pre and post-registration. Pre-registration there is a curriculum, or a set of learning outcomes, that are linked to standards that are set by the Nursing and Midwifery Council, which is welcome but 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.

Post-registration, the picture looks fairly spotty again. We have spoken to a number of nurses who have spoken about doing the mandatory e-learning module. While I am in favour of it being mandatory—I absolutely think that no one should be putting their hands on patients without the requisite skill—there is also an awful lot of evidence about the fact that CPD must be done often within nurses' own time, when they are so busy, tired and overstretched.



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We know that there is actually very little money, or not sufficient money, going in to protect, support and enhance CPD post-registration for nurses. That is a huge healthcare gap and one that does not help us to close any of the health inequalities that we see across the population as a whole. Thinking in terms of that, that needs to be something that is done, because we have seen that those budgets have been cut. Often, it is the equalities bit that is cut and delivered in a really robotic way.

- Q27 **Jess Phillips:** Just out of interest, from both your perspectives, what we are talking about very much here is healthcare—you are a doctor and nurse, healthcare professionals—but do you see any evidence of similar training going on wholesale with staff in social care?

Wendy Irwin: I don't know, I'd have to get—

Dr Shrewsbury: I am not in a position where I could comment, I am afraid.

- Q28 **Jess Phillips:** Fair enough. I will come on to my training experts now. What level of training do all healthcare professionals currently get? You can include social care in that—it strikes me that people working in social care are not getting a lot of training—and all healthcare professionals, not just doctors and nurses.

Sophie Meagher: I don't know too much about the training of all healthcare professionals, but I do know we have been working with the medical school at the University of Manchester, and have been looking at the case studies that it uses. 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. So we worked with them to update that case study and to talk about U=U, undetectable is untransmittable. If you have HIV and you are on the right medications, you can't pass that on and you can still have a good quality of life. We have been working with them to try to update case studies—you might have a gay man who is not out and he has anxiety because of that, and that means that he smokes, or you might have a trans person with dementia who doesn't remember that they've transitioned or aren't having their gender identity respected, and things like that—and making sure that these case studies are constantly being reviewed and updated to include the wide range of health inequalities that LGBT people face. That goes back to what I mentioned before about awareness and people understanding that being LGBT and health goes beyond sexual health and HIV.

Professor Llewellyn: I think that's absolutely right. There is huge variation in how this is delivered. There are pockets of good practice. Birmingham and UCL have been doing some really good training. There is no national programme that addresses the issues in our medical schools as yet, but I do think that there are new drivers for change in medical education at the moment, so there are really good opportunities for starting to embed these things into the curriculum.



Q29 Jess Phillips: In one of the sessions for this inquiry, issues about the different cultures of those working in the NHS were raised with us. We hear a lot about that at the moment. A huge amount of the NHS workforce comes from migrant communities, so they will not necessarily have been trained here in this country. Do you know of any efforts to ensure that LGBT education is especially addressed for those migrating from countries that may have much more draconian laws relating to LGBT issues?

Professor Llewellyn: In the existing workforce.

Jess Phillips: Yes, in the existing workforce.

Professor Llewellyn: There is nothing that I know of. I think the evidence is lacking in that area. You don't necessarily need to change people's attitudes, but you do need to set a behavioural expectation of what they are doing in certain work environments, and set an expectation for what colleagues are doing and try to change the norms around that. But I don't think there is any evidence on educating the existing workforce.

Dr Shrewsbury: There are patchy examples. Different organisations collaborate to provide some form of cultural induction for the people who come to work in our healthcare system from overseas. That is on top of whatever inductive processes those organisations use for everybody else. Having one-off things—your annual equality and diversity training, whether online or not, and those sorts of things—is probably not as effective as having a culture in which the whole organisation supports people in working towards trying to provide the best practice they can.

Wendy Irwin: We hear feedback from nurses who are recruited from overseas, and they speak of a really quite poor experience, particularly in some sectors, in relation to the support they get to transition from one cultural context to another. So it is poor anyway. If you add to that really variable practice in terms of CPD, the picture then just looks really bleak. There is very little work done to have very clear behavioural expectations beyond very vague organisational goals around "fair" and "personal" and so on. What they mean in terms of everyday practice often isn't made very clear or explicit to clinicians.

Q30 Jess Phillips: So, the "You can never say this to a person" and that sort of thing would never be said? Like, "It is totally unacceptable to"—think of an example—"to say that God's not happy about this" or whatever. There are no "Definitely don't say this" pointed out to people?

Wendy Irwin: I would say that there is very little evidence. I have not come across nurses who have told me, particularly when they have been educated overseas and are working in a—

Jess Phillips: I mean this for everyone as well.

Wendy Irwin: They have been told about, you know, even understanding accents, and that "Going to spend a penny" means something. Those



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nurses have very little support in understanding some of the social norms and cultural things that are constantly changing, and it goes back to the point about the need for proper investment in ongoing CPD.

- Q31 **Chair:** Wendy, presumably when a nurse who has been trained in another country comes to the UK, they have to learn what is legal and not legal here—for instance, FGM. What training do they get to understand what is lawful and unlawful—for instance, “Discrimination is unlawful”?

Wendy Irwin: In order to register, they have to sign and agree that they are competent, according to a code of conduct, but often some of the things that people experience—

- Q32 **Chair:** If they come from overseas, do they have to go through registration here?

Wendy Irwin: Yes, they go through a registration process with the Nursing and Midwifery Council.

- Q33 **Chair:** And the code of conduct would say what, when it comes to the issues we are discussing today?

Wendy Irwin: The code of conduct would make some specific demands about treating people fairly and putting people at the centre of practice, and speaking about human rights. It sets out some very broad behavioural expectations, but often what people experience might not be a direct discriminatory comment. There might well be things that sit beneath that but are equally as damaging and feel hostile to the person who receives it, whether intentionally or not. My colleague spoke about micro-aggressions. There could be a whole range of things that are quite culturally determined, quite culturally sensitive.

Jess Phillips: Things like talking about God.

- Q34 **Chair:** We know that the vast majority of people in the medical profession want to do the right thing, but we have had direct evidence of people who are working within the NHS saying things that are absolutely unlawful to individuals who have given evidence to us. To what extent will it be obvious to people coming to practice in the UK that that would be unlawful; not just culturally not very nice, but actually unlawful?

Wendy Irwin: Could you give me an example about what you mean, from some of the evidence you have received?

Chair: I will make up something that is similar: “God will act against people who are gay.” I mean, to say that to somebody in a hospital environment—

- Q35 **Jess Phillips:** The issue comes down, I think, quite specifically in the examples that we have been given—which we won’t reveal at the moment, because they were given in a private session—to the intersection of BME and LGBT communities. While LGBT communities seem much less of a taboo in mainstream society, actually within some BME communities it is still much more of a taboo. The idea is that medical



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staff from the same culture as—in this example—a person who presents as a trans person feels more at liberty to speak to that person in a way that they wouldn't speak to somebody who wasn't from their culture, and say things like, "We don't do this sort of thing. It's not normal." It's that sort of thing.

Wendy Irwin: Excuse me while I gather myself, because of the shock.

Q36 **Chair:** We realise that we are putting you on the spot. It goes to the broader issue of when you are training—

Jess Phillips: Of training all of the different facets.

Chair: But it is also when you are registering somebody coming to the UK. What support are we giving people to know what the law is?

Wendy Irwin: Most organisations will have some really clear behavioural standards. There will be some there, but clearly there are examples of where that is not there. Could I get back to you, once I have had an opportunity to think about that in a bit more detail?

Q37 **Jess Phillips:** I am sure we could get access to this, but a copy of exactly what those registration documents and that code of conduct are would be helpful.

Chair: Because that might be the prompt.

Jess Phillips: That is not just for people coming from overseas; that is for everyone, isn't it?

Dr Shrewsbury: From a medical point of view, overseas doctors coming to work in this country are subjected to an assessment, but that is largely of linguistic and professional clinical skills. Beyond that, and beyond the individual examples where trusts or organisations put on a specific induction, there isn't an ongoing orientation towards the legal and cultural expectations of this country, beyond those articulated in the equality and diversity online learning training, called "e-learning for health".

Chair: Which we hold in such high esteem.

Dr Shrewsbury: I appreciate how these things come about, but it is clearly not an effective way of delivering it, because we are still talking about very significant issues. If it were effective, then there should be fewer issues than there are.

Q38 **Tonia Antoniazzi:** We have received a lot of evidence about really disrespectful and uninformed attitudes from medical staff towards LGBT patients. Is the training really going to resolve this—you have spoken about how patchy and inconsistent it is—or is there other action that can be identified that needs to be taken?

Professor Llewellyn: I disagree a little with what Duncan said earlier—I will answer your question at the same time—about the mandatory nature of the training. I would recommend that the training should be mandatory, but maybe it is a question of the value of how we are doing this and the



creativity behind how we are educating our workforce, our students or whoever. That is the nub of it.

People have to have the sense that this is the right thing we are doing and there is legislation to back it up. There are structural things. Some of these things are unlawful and people need to be reminded of that. They also need to be reminded of the value of understanding these issues. I think that is one thing that is perhaps not capitalised on enough.

On one hand, I think education is important—it absolutely is—in spelling out the value of why LGBT issues are important to healthcare and to start normalising some of the conversations we are having within the NHS, such as normalising what your peers are doing or the culture around the ways things are said and articulated. If that is not enough, we can pick up on the fact that there is legislation to support it and perhaps come down more firmly.

Sophie Meagher: I agree with what Carrie has said. It is really important that each individual practice commits to that zero-tolerance policy on discrimination. If it keeps happening, then it is down to the regulatory bodies and the Government to come down on the people who are doing that, because ultimately they are breaking the law.

Q39 **Tonia Antoniazzi:** I got the impression from what Duncan was saying it was more the case that times have changed and the online stuff is not up to date, that the conversation needs to be live and that the teaching needs to be more inclusive and more current.

Dr Shrewsbury: It is not just that it is not up to date. I would hate for that to lead to somebody quickly updating some references, clicking refresh and then getting everybody to do it again. As a caveat to my comment about mandatory training, I think that part of problem is that it is often lumped together with completing your manual handling and fire extinguishing training. It is so much more important than that, which is what I meant to articulate.

I absolutely agree with the importance of setting a cultural organisational tone by placing that prominently, but I don't think that having something shifted off into the darkness of the online sphere is effective. On top of that, I don't think that having just one punt-take, even if it is every year, to tick that box is particularly effective either. You need something that is not punitive but is supportive and developmental on the shop floor. That could be delivered through a network of inclusivity champions who are able to express to a colleague in a nurturing way, "There are other ways of doing what you have just done; that could be interpreted in a way that could be unlawful in this context; shall we have an opportunity to reflect on alternatives together?" In my opinion, those sorts of things are far more likely to support more positive, intention-orientated behaviour.

Tonia Antoniazzi: And better relationships between patients and staff.

Professor Llewellyn: There are some training packages currently under development that are more evidence based and more engaging for



healthcare professionals. They involve more active components, such as role playing and having respectful conversations. One of the barriers for healthcare professionals is that sometimes they don't know what to say, and they would almost rather say nothing than say, "I need some help with this. Can you help me? What are your pronouns and how do you want to be addressed?" Those are the kinds of issues. I think that it is about instilling some of the self-confidence and behavioural skills to uplift people into having those conversations, and ways of doing that could be implemented.

Sophie Meagher: To add to that, in the training that we do, GPs will do a training session and we then deliver an assessment and ensure that they have filled out certain criteria. Beyond that, we build up a relationship with GPs and with primary care practices, so if they have an issue or are unsure of how to deal with a situation, they can get in touch with us and we can help them with that. Equally, if a patient experiences problems with a certain GP, they can speak to us and we can then get in touch with the GP to try to resolve the situation, or advise the patient to move to a different GP that might be better suited to their needs. It is really important to have those live links with other organisations that can provide ongoing expertise, and that the training is not done just once every few years.

Wendy Irwin: I think that training is part of a multi-point approach. Evidence-based training allows people some cognitive rehearsal when they meet those difficult situations. A lot of evidence proves that that is a really successful way of supporting people. On culture, there are currently very few measures around culture in the NHS, yet when you look at lots of the things that do not work well, often culture is somewhere at the bottom of that list.

We can think about how we can strengthen the public sector equality duty, because that is already there, and it often feels that for organisations it is not strong enough. There is much better data showing that this work is everybody's business. It is about closing the really shocking and astonishingly bad healthcare inequalities for communities that deserve better.

When we start to look at that holistically, I do not think that training is the silver bullet—I do not think there are any—but a natural way to go is taking a much more holistic and systemic approach that looks at what the evidence shows works well.

- Q40 **Tonia Antoniazzi:** Much of the focus on LGBT needs seems to be on sexual health, but the evidence that we have received varies hugely, from mental health to end-of-life care, which you have touched on. What can be done to sever the link made in many minds between LGBT health and sex?

Dr Shrewsbury: That is complex; it involves societal, cultural and individual levels of awareness, or lack thereof. That is reinforced by some of the system-wide structures that we have in healthcare and the fact that



public health is completely separate from the NHS, where we deal with sexual health. All the other stuff about LGBT issues can happen in a haphazard way elsewhere. It needs to be a lot more joined up. That division is perhaps quite unhelpful. Some decisions that are made on a commissioning basis potentially reinforce some of those attitudes, partly because some things are easier to count and see results for—"Yes, we can see the productivity there, so we will support that." Elsewhere it is slightly less clear, specifically with some of the issues to do with mental health needs, I feel.

Q41 Tonia Antoniazzi: Thank you. Do you want to add anything, Carrie?

Professor Llewellyn: One issue is that it is in the public consciousness, and public awareness campaigns may try to overturn some of that. Another is that in the teaching forum, you might not need to completely uncouple it from sexual health teaching—teaching medical undergraduates, for example—because obviously some of the issues are still pertinent. I think having discussions about LGBT health solely within sexual health is problematic and would need addressing, which could easily be done. That is a quicker fix.

Wendy Irwin: I think that there is a lot of evidence showing that you need a really strong drip, drip, drip effect of information that helps to show the complexity and diversity of the health needs of those communities. I think of other equality movements, and the truth is that you cannot over-communicate that often enough. There is a huge piece of work there around narrative, around what is being shared and why, and how often, and whether we are using absolutely every opportunity we have to show that LGBT communities will have health needs, such as dental care and all of those sorts of things. Are we doing that enough? I sometimes feel as though that is not thought through enough but is just seen as niche. We can't communicate enough in this area, as far as I am concerned.

Q42 Chair: The NHS has a duty in law to ensure that it delivers the same healthcare to everybody. That is not new; the public sector equality duty has been in place for a decade. Who is actually responsible for ensuring that the NHS is meeting its public sector equality duty?

Dr Shrewsbury: I think that part of the problem is that demonstrating how it is being met might be quite variable, according to different organisations.

Chair: But who is responsible, rather than whether it is difficult to do?

Dr Shrewsbury: Impact assessments should be conducted by CCGs for everything that they are trying to implement. That should demonstrate how it is complying with the PSED. The problem is how some things can get buried or lost, or even innocently or honestly forgotten, in that process. There are very clear examples where there is enormous variation between footprints of healthcare across the country in how that is operationalised. I hate to conflate these issues—



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- Q43 Chair:** So CCGs have got a key role and, as we know from the stats, not all of them are doing this. Why not? As MPs we deal with our clinical commissioning groups on a regular basis and they are all full of people trying to do the right thing. It is a systemic thing, isn't it, achieving your public sector equality duties? As a Minister, you just have to have "due regard to." It is not actually that difficult to meet the public sector equality duty. Why do you, as a clinician on the ground, think so many CCGs are just not taking account of all these things?

Dr Shrewsbury: As a clinician on the ground who sometimes gets a little bit exasperated at some of these things, I think that there is an element of stuff being so awfully disconnected. You think that the right hand doesn't have a clue what the left hand is doing here. There is a bit of that. Sometimes it is de-prioritised through other things being shouted about louder, and therefore being drowned out, rather than consciously being dropped as a priority area.

- Q44 Chair:** But would it not be covered through a strategic needs assessment, on a very systemic basis? Because a strategic needs assessment is painting by numbers, isn't it? It is the things you need to think about within your area.

Dr Shrewsbury: Yes, but part of the problem with those is that they are driven by very condition-specific or population-specific needs. In the area where I work now—Brighton—the needs of the local LGBT community are going to be a lot more consciously raised as a matter for consideration. In other communities that may be less so, either because of representation and voice from the community itself, or because of what that organisation is sensitive to.

- Q45 Chair:** So, in fact, strategic needs assessments need to be more sensitive to people who are not as good at shouting about what they need as those who are.

Dr Shrewsbury: Absolutely.

- Q46 Chair:** Is there anything else anybody wants to add? Wendy, hospitals have a public sector equality duty, which is where many of your members will work. Are they responsible for delivering it?

Wendy Irwin: In this scenario, there is a tension between skill and will. There is the ability to do an impact assessment and pay due regard. I don't think it is particularly difficult, but for lots of organisations, particularly those in the NHS, that equalities function has often been stripped out. Some organisations will be left without somebody who is suitably supported or able to do this well. So there is a distinct lack of skill within the system. The other thing we also see, just generally when we are thinking about workforce, is that there is just a systemic lack of accountability. It is disconnected and seems very discordant. It is really hard, if you were taking this at a system level, to say who does it, because I would say it is designed to be unclear.

- Q47 Chair:** It is designed to be everybody's responsibility, isn't it, and not just somebody who has a job title?



Wendy Irwin: We often say that, but when we say it is somebody's responsibility often it turns out to be no one's responsibility. If I were to talk to some nurses and organisations and ask, "Well, have you done an equalities impact assessment?" they might well do one, but they might not do one well. They might not know who to ask. They might not know how to do one, or when to do one. They might not have sufficient engagement with different communities to understand—to hear voice. They might not have sufficient information in order to understand narrative and framework. I think that issues around accountability are loose within our system. There are issues with metrics—what we measure. Often we measure what is easy to measure, as my colleague said, rather than what is important.

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.

- Q48 **Chair:** So what should the national LGBT health advisor be prioritising to make sure that all LGBT people have a good experience, particularly of primary care but also of the NHS more generally? Obviously this is a relatively new role—it was set up in March. It sounds like a jolly good idea. Maybe it can cover a lot of the things you have just been talking about, Wendy. What do you think they should be prioritising, to make sure that it actually goes from being a jolly good idea to something that actually affects people's experience of the NHS?

Wendy Irwin: I think there are five broad areas, and I might have covered them already. One is absolutely getting clarity about leadership: who is actually responsible? Whose job is it to make this decision or to sign off something, or to say that something needs to go back for further scrutiny? The second thing I think they need to be looking at is: 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?

Alongside the leadership piece is the very clear accountability piece, but also thinking about how we ensure that the voices of LGBT communities in their full diversity—so we are speaking about LGBT communities from black and minority ethnic backgrounds, migrant backgrounds; from a whole range of backgrounds—are heard, understood and responded to intelligently both at a national level and at a regional level, and at the level of local commissioning.

Finally, there is a big piece of work to be done—I think we have covered this in relation to narrative—on how the adviser can ensure that all the arm's length bodies are really pushing those messages out there about the fact that this isn't niche; this is everybody's business. Action across each



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of those five areas is important, along with a much deeper dialogue with the Royal College of Nursing, which I hope we are starting.

Q49 Chair: That sounds like starting in the foothills, really. It doesn't sound like we are coming in to fix a little problem. It is like capturing quite a significant issue.

Wendy Irwin: It is interesting. I had a conversation with a colleague recently, and we were just talking about this whole business around equality and inclusion. She asked whether there was a silver bullet, and I had to tell her to holster her weapon, because there are none. This is really hard work. We are speaking about systems and processes that are deeply embedded—things that often seem resistant to evidence and logical argument. We have to be in this for the long haul. We have to ensure that there is proper investment to support that role and a really clear mandate to understand that. I don't think that is a quick fix. I think this is a long-term thing.

Chair: My final comment would be that many people—most people in this country—hold the NHS in high regard, and we feel that it is an organisation that does good. I think they might be quite shocked at some of the evidence that we have had about the way LGBT people are treated within it, and the way the issues they face are treated. The NHS has a really important task to do here, so that it doesn't suffer reputational damage from this. It feels to me that it has got quite a long way to go on this. As constituency Members of Parliament, it is certainly something that we should be raising more vigorously with our own CCGs, because it is also at a local level, not just at a national level. Certainly within our report we will be encouraging Members of Parliament to be aware of these issues in their own communities.

Brilliant. Thank you very much for your time today. I really appreciate it. Is there anything else that anybody wants to add at this stage? I hope that we can welcome you all back again, now that you have given evidence to a Committee.

Jess Phillips: I was tempted to ask you medical questions.

Chair: Thank you all very much for your time today. That ends today's session. Wendy, we look forward to receiving that extra information. The Clerks will get in contact with you for what particular issues would be most helpful.