

Women and Equalities Committee

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

Wednesday 19 June 2019

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Members present: Mrs Maria Miller (Chair); Sarah Champion; Angela Crawley.

Questions 107 to 151

Witnesses

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

II: Professor Catherine Meads, Cambridge Institute of Public Health, Anglia Ruskin University; Peter Thompson, Chief Executive, Human Fertilisation and Embryology Authority; Joanne Anton, Policy Manager, Human Fertilisation and Embryology Authority.

Written evidence from witnesses:

- [Professor Kathryn Almack](#)
- [Care Quality Commission](#)
- [Professor Catherine Meads](#)
- [Opening Doors London](#)
- [University of Bristol and Regard](#)

Examination of Witnesses

Witnesses: Debbie Ivanova, Jim Glennon, Professor Kathryn Almack and Dr Ju Gosling.

Q107 **Chair:** Good morning, everybody, and sorry to keep you waiting. It is the vagaries of Parliament at the moment. It is a fast-moving place, but thank you very much for bearing with us. We are very grateful for you coming in to give evidence in our inquiry into health and social care and LGBT communities. We are really grateful for your time. We are going to follow the usual format, which is to ask questions from various members, and please, before we start, give your name and the organisation that you are representing.

Debbie Ivanova: I am Debbie Ivanova, and I am from the Care Quality Commission.

Jim Glennon: I am Jim Glennon, Opening Doors London, providing groups and services for older LGBT people in London.

Professor Almack: I am Professor Kathryn Almack. I am from the University of Hertfordshire.

Dr Gosling: I am Dr Ju Gosling. I am a co-chair of Regard, the national LGBTQI+ disabled people's organisation.

Chair: To be really clear, because there was a question as to whether we would be having a private session or a public session, this is a public session, and we are being broadcast, just so we are clear about that.

Q108 **Sarah Champion:** Thank you all for coming today. I wonder if we can start looking at care of older people and social care in general. I will start with you, Debbie, and then ask the panel for their comments as well. What are the biggest challenges in providing inclusive healthcare to older LGBT people, but also social care to LGBT people of all ages?

Debbie Ivanova: There are probably two areas that we focus on when we are looking at our work. One is about how the service itself is inclusive and how, therefore, it creates an environment where people feel confident to be themselves within that service. That will be about how the service is set up right from the beginning: what kind of image it has, what kind of welcoming culture it has, but also about the very questions people are asked during their assessment processes, and the way their care plans are devised so that they are very much about meeting individual people's needs.

Alongside that, then, are the issues about staffing, and making sure that staff are properly trained and understanding of the importance of asking questions that take people into a type of care that really meets their needs. In our inspections, we have had to really focus on how we do that, and how we make sure we ask the right questions to get the answers to how well people's care is delivered.



Q109 **Sarah Champion:** When you do inspections, it is one of your tick-box areas?

Debbie Ivanova: Our regulations, which are laid down by Parliament, are focused on issues that are about human rights. We have a human rights approach to the way we regulate. Within our key lines of inquiry, we have very specific prompts and questions about equality. Under our questions on “safe”, we will make sure that people are not discriminated against. If people felt they were discriminated against because of their faith, religion or sexual orientation, we would follow that through and make sure they had access to complaints and were able to do that. Under “effective”, “caring” and “responsive”, we also look at care planning, people’s likes and dislikes, and the way that people are able to have care that meets all of them so that it is holistic in that way.

It is difficult, because a lot of providers are not confident or comfortable with doing that. We have used our equality objectives over the last couple of years to direct our staff much more to ask the right questions, and our new equality objectives, which are coming out shortly, are very much about being confident with difference. There has been a little element of going away from saying, “Person-centred care means everybody is treated the same or equally, and we meet everybody’s needs because we treat everybody the same”. That does not address the issues when people maybe do not fall into a heteronormative setting. We have to fight that assumption and get on to really making sure that people are confident with difference. That includes our staff too, in the way they inspect.

Q110 **Chair:** Jim, you were nodding. What are the challenges, and are they being met? Is it possible to provide an inclusive service?

Jim Glennon: In a word, the challenge, if I can say it, is heteronormativity. It is seeing everything from the view that this is a heterosexual environment, a heterosexual culture; we are dealing with heterosexual people. To echo Debbie’s point, it is about confidence with things that are different. I still go back—it is four years old—to *Unhealthy Attitudes* from Stonewall, which looked at 3,001 professionals working in health and care, and there was some prejudice, but the biggest thing that came out was a lack of confidence about working and, linked to that, a lack of training.

I did a webinar, with some of our team, for BMA recently. Towards the end of the session, I did a call out. There were 400 people tuned in, and I asked how many of them had had any kind of training on the issues we were talking about on that webinar, and 7% came back. Generally, the research is that the manager training is quite poor in this area. Long term, that is the big one, because if we are able to ensure that any social worker, any nurse, any doctor, has to do some good element of training on the issues we are talking about in this session, that would go a long way.



Q111 **Sarah Champion:** Is that the mandatory training that they would be getting from their organisation, or when they trained to be a nurse or professional?

Jim Glennon: The ideal would be that, if they want to get that important position in society of engaging and providing personalised care, they need to have an element that picks up some of the issues of LGBT, health inequalities and how to engage with that. Training online is important, but training experientially with people in the room, especially people who are LGBT themselves, gets the most impact, we would suggest.

Broadly, the quality standard we use when we are working with care services starts at the top: absolute leadership commitment, and we cannot always be certain of that. Then, in terms of recruitment, who are the staff we are recruiting? Are they properly inducted? Do they have training that meets their needs? Then there are the communications of an organisation. If you looked at any care organisation's website, would you see a glimmer of opening doors to LGBT people? Most of the care organisations that we are working with at the moment do not have that.

Now, these are mostly low-cost solutions. This is about management, decision-making and leadership. Most of the organisations can change the content of the website if they want to. There is more than that; there is a lot about security and safety, which we might come on to. But I share, pretty much, what you have said.

Q112 **Sarah Champion:** Kathryn, what is your experience of the challenges?

Professor Almack: There are significant barriers to services for individual older LGBT people. We must not forget that, within the LGBT community, there is a lot of intersectionality, so there will be additional layers on top of their sexual orientation or gender identity. Those are at system and individual levels. At system level, as has been mentioned, the heterosexual assumption, the heteronormativity of society, leads to an LGBT population feeling marginalised and quite often invisible. I have been into many care homes. LGBT people are more likely to need formal care for a number of reasons: lack of family around them; fewer possibilities for the older generations to have children, so they do not have adult children in their lives; more likelihood of having single generation networks around them. There is an increased need for formal care, but we are not seeing them in formal care.

If we have an estimate that—we do not know, but let us say—6% of the population are LGBT, there are going to be LGBT people in care homes, yet they seem on the whole to be invisible. I go into care homes and they say, "We do not have any people like that here". I hear that so many times, but when you start working with care homes, and they start thinking about the issues, they think, "Well, maybe. Do you remember so-and-so?" Beginning to raise that awareness is really important, as has been mentioned.



Q113 Sarah Champion: I am interested that you were saying there is likely to be more of a need from the LGBT community. Do you have any data that backs that up?

Professor Almack: I do not have that at my fingertips, but I could send it to you. There are a number of research reports that will demonstrate that evidence, the different factors that would lead to the need for formal care. Then there are also barriers at an individual level: lack of understanding, lack of awareness, potential discrimination from health and social care providers. That is either perceived or real, but it does not matter if it is perceived or real; it is still a barrier.

As Jim was saying, it is not necessarily intentional homophobia or discrimination, but it is a lack of confidence and a lack of awareness. I use the example of a porter wheeling a gay man on to a ward in one of my studies, and the porter is saying, "They are lovely nurses; you will like the nurses". Then the man is thinking, "Now, do I say I am gay?" He did, and then the rest of the walk was very awkward and silent, and it made him feel deeply uncomfortable.

Those kinds of instances can accumulate and lead to barriers to entering into and accessing services, as well as a long and cumulative history of the past and having to hide sexual identity or gender identity. If you were brought up to feel, in earlier years, that you are abnormal and different, if you had to lead double lives, if you maybe had psychiatric interventions to try to cure you, all that accumulative history is also going to make LGBT people hesitant to access services.

Q114 Sarah Champion: Can I pause you there, because I would like to come back on discrimination? If I could bring Ju in, from your members, is it possible to get good, inclusive healthcare? What are the challenges that they face?

Dr Gosling: We would certainly like to think so, as an aspiration. I would just like to say I am 57, and I have been using social care for 20 years—

Q115 Sarah Champion: And clearly a good moisturiser as well.

Dr Gosling: I just want, before I move on, to pick up on the point about incidence. We believe that as many as one in three of our community would be defined as disabled under the Equality Act, because of the long-term impact on physical and mental health of discrimination, plus, but only to a minor extent, the higher incidence of HIV among men who have sex with men.

In terms of social care use, we are much more likely to move away from where we grew up, so we do not have lifetime friends. Our contact with our biological families is at best polite, is very seldom close, and is often non-existent. We are much less likely to have children. Over three-quarters of LGBT people, over three-quarters of disabled people, do not have children, and they are the primary support in terms of social care.



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Many of us are in relationships where, when we met our partners, there was no formal recognition, so our housing choices have had to be made as single people. Even if we have partners, it does not mean we are living with them or have any possibility of living with them.

That instantly means that we are much more likely to use social care. When we do, we are part of networks that are not recognised, because people expect these gaps to be filled. Right at the beginning, when it comes to advocacy for social care, most people depend on their children. We have nobody. In fact, we do not have access to the friends straight people have, because more often than not we still meet in social venues. It is not safe for people to come round to our homes on a regular basis. That is the first problem with recruiting at home: that people do not want to be identified as going to a gay person's home, because then—and there are many cases of this—the social care worker starts being harassed as well.

It is not just about regulation. For all of us who use self-directed support, who is there to regulate it? It is very difficult, for all sorts of reasons, to recruit social care. People leave without giving notice; that is a very common experience. If anybody feels uncomfortable, or gets challenged, they leave. I would like to come on later to Regard members' experiences of what happens in self-directed care, which should be where we are most comfortable and completely in control, but it is not the case at all.

Q116 Sarah Champion: My first question was about the barriers and the isolation. Do you think that is going to be a generational thing? I am thinking, as society becomes, hopefully, more tolerant, as you are getting equal marriage, as you are getting more people having children in the LGBT community, do you think the existing barriers and obstacles that create the isolation are going to start diminishing?

Dr Gosling: I do not see that direction of travel. I know in previous evidence sessions people were assuming that it is much easier for young people. I was certainly called gay when I was eight years old at school, but there was nothing like the bullying. We see it over and over again: the mental health difficulties young people face are setting them up for a lifetime of disability, and that discrimination is far worse than it used to be. Hate crime, we know, is worse than 10 years ago. Right now, I do not see that direction of travel.

Q117 Sarah Champion: So there will be different challenges that they are facing. Could we talk about discrimination? One of the things we were hearing is that the LGBT community might not be accessing or feel able to access older care or social care because of the perceived discrimination. Do you think it is perceived, or do you think it is real?

Dr Gosling: Stonewall has done a lot of research that shows it is real. Stonewall's research shows that something like 10% to 15% of LGBTQI+ people approaching adult services departments report discrimination, but it almost doubles if you are disabled. That in itself becomes a problem,



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because you are much more likely to be self-advocating; the level of discrimination you are facing is much higher. Sorry, I have a low brain injury that affects my ability to access facts; I will just have to keep consulting my notes.

We did research with the University of Bristol that was published in 2017 into self-directed social care. More than half of those surveyed said that they never or only sometimes disclosed their sexual orientation or gender identity to their PAs, and less than a third said they were very comfortable with talking about their support needs in relation to being LGBTQI+. More than a third said they had experienced discrimination or received poor treatment from their PAs because of sexual orientation or gender identity. This went all the way to somebody being sexually assaulted, having told the PA that they were gay.

When they were asked about getting support to do LGBTQI+ things—we gave examples of things like going to an event or a bar, through to setting up to receive a lover—over 22% said their PA did not help them with any of those activities. When asked why not, 40% said they were not out to their PAs; 40% said their PAs were such that they were not comfortable having them anywhere around anything LGBTQI+; and 20% said their PAs had outright refused to help.

Now, these are the people who in theory are giving the personalised care that the Care Act promises us, and the appropriate service that the Equality Act promises us. If they are working for agencies, they are supposedly getting the training that the CQC regulations already mandate and, I would argue, the Equality Act already mandates. The legislation is not the issue. It is how it is being implemented.

Q118 Sarah Champion: I am thinking about money. Is there a business model for specialist services?

Dr Gosling: There are all sorts of things that we would say were not a business model, but I want to make the point that, if you do not have your needs met, your needs increase, and you exponentially become more expensive. If you do not have the funding for a PA, or like many of us you have the funding but you cannot recruit, you do not go out; you self-medicate; you eat badly. All those things increase your social care needs. If your department says, "We will not pay for cleaning", if you have a dirty home covered in things that cannot be put away and heaps of ironing everywhere, you do not invite friends round. You self-medicate. You do not eat properly. Your social care needs to go up. You cannot access the LGBT community. You cannot access your friends. You do not have any self-advocacy support or informal care support. Your social care needs go up.

Not meeting needs is vastly more expensive than meeting them. The idea that somebody can just take £20,000 or £30,000 of my house value away does not really seem to me, as somebody who has already been using services for 20 years, like a business model. Regard, of course,



would just say that social care should be free at the point of use, like healthcare. As for the disputes that are going on, does the local authority pay? Does the NHS pay? Is a bath continuing care? Is a bath social care? Does it really matter? Surely, we should just be giving the person the dignity and respect of being able to have a bath.

Q119 Sarah Champion: I completely agree. Sorry, I have led you slightly astray. Is there a business model to meet the specific needs of the LGBT community? Should there be LGBT care homes? Should there be LGBT PA services? That is what I meant.

Dr Gosling: Those that have tried have not been very successful. We would really like to see them as beacons of best practice, because it is much better to have an appropriate service, local to you, that delivers the services that are appropriate whoever you are and takes account of all facets of your identity.

Sarah Champion: I agree.

Dr Gosling: In terms of beacons of good practice, yes, absolutely. Again, it is that direction of travel. There were very good services set up in response to AIDS, because nobody else would work with people with HIV. As councils moved into a market model, they cancelled all the contracts for LGBT people who had chosen those agencies. My partner got a letter saying, "Home from hospital" will be taking over your care on Monday; it will be delivering services regardless of your sexual and gender orientation". We believe that practice should be stamped out. It is not appropriate to the Equality Act at all to say, "We will deliver a service regardless". The Care Act states it has to be personalised, and so does the Equality Act.

Professor Almack: I did research looking at LGBT old age and end-of-life care. Within that, we did a survey and then 60 qualitative interviews. We asked about LGBT-specific services. Would people like LGBT-specific services or for them to be run by LGBT staff? Two-thirds of our respondents in the survey said, yes, they would like that.

Then, when we looked at that in more depth in the interviews, it was more nuanced. Some people were afraid of creating new ghettos, where they might feel vulnerable. A number of lesbians did not necessarily want to live in a home with men or male carers. Bisexual people are quite often discriminated against by lesbians and gay men, as well as wider society. There are a number of different issues going on that complicate the idea of LGBT care homes.

Stonewall Housing and Tonic Housing are looking into business models to develop LGBT-specific services, and I have visited services in Berlin and San Francisco, which have been very successful. It needs investment, but it also needs time to build up. In San Francisco, they cannot advertise their accommodation for LGBT only, but they have made it a very LGBT-friendly environment, insisting on residents being likeminded, so there is



a zero-tolerance policy. There, they have older heterosexual people living very happily alongside older LGBT people and creating a community where people can feel safe. That is a nice model.

Jim Glennon: I support the difference of views. We work with 2,000 older LGBT people in London. I regularly meet with a group of about 50 or 60 people. We are pretty mixed, LGB and T people, who attend that. I have had this conversation several times, and I have heard different views from our group. Some say, "Yes, that would tick all my boxes; that would be perfect". It is often to do with fear, fear about treatment. That seems to be an issue that I am picking up. I have also spoken to people—I can think of one person I spoke to only about a month ago—who have said, "The last thing I want to do is have my retirement completely surrounded with LGBT people". That is just her view. It is not automatic that all LGBT people think that is the solution. It would depend on people's personalities, their fears and their issues, I suppose.

Q120 **Sarah Champion:** Debbie, some evidence suggests that cultural or religious attitudes among care staff may contribute to a feeling in the LGBT community that they would not be safe and respected in social care services. Does that accord with your experiences? If I could ask the panel, is that a reality that you are aware of?

Debbie Ivanova: Certainly, we will hear stories about situations like that, but I do not think we can say it is a general finding. It is very much about not making assumptions about certain groups of people who may be prejudiced, just as much as the people who are in the care service. If you have a care home that is operating good, values-based recruitment, and making sure right from the start that it is taking people into the service who can and will understand the way the service should be run, that the service is truly inclusive in itself and that it is inclusive both for staff and for the people who are in the service, this should not be an issue.

Q121 **Sarah Champion:** How do you make sure that that happens?

Debbie Ivanova: Part of our regulation will be about looking at staff recruitment and how staff are recruited to those services. It is really important to say at this point that we are only part of the solution. The way that local authorities both commission and contract services has to play a really important part in how they are set up and monitored properly too. One of the things—I know Jim has talked about this before—is to have some really good, clear quality standards that apply, so services can audit and monitor themselves.

Our standards are great. They have a lot of parts of them that are on equalities issues. But to have some really specific standards for LGBT people's care would help that to be embedded in good practice.

Jim Glennon: Can I pick up the religious aspect? It is real. When we do training of health and social care professionals, we usually have a



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scenario about this. I had this conversation with a care home manager only about six weeks ago. We encounter management thinking they should take a balanced approach, recognising that religion is one of the protected characteristics under the Equality Act 2010, but sexual orientation is as well. Some managers think, "Well, what I have to do is keep the peace in my home. If I am very positive about LGBT, that is going to cause a problem for a number of our workers whose religious beliefs are so strong".

Q122 Sarah Champion: So they just discriminate across the board.

Jim Glennon: They often do not realise. I had it quoted to me recently: "Well, the Act protects people's religious beliefs". I was given an example of a care worker who had refused to work with somebody—I think it was an older lesbian—and they said it was because of their religious beliefs. The manager said, "But that is protected, is it not?" I had to explain to the manager that, yes, the religious belief is protected, but it does not enable you to discriminate by not giving care, giving poorer care or being homophobic, in this case. There is an education about the Act, because religion is protected within it.

In the care sector at the moment, we rely on a lot of people who have strong religious beliefs. There is also a lot of churn, so the issue of training, which is very close to our heart, is an extra difficulty, because the churn of staff moving all the time makes that a genuine problem for managers trying to ensure that their staff are aware.

Q123 Sarah Champion: Ju, you were nodding.

Dr Gosling: I was reminded of some research Pink Paper published last year, which showed that something like three-quarters, certainly over two-thirds, of people of colour and over two-thirds of people of faith believe that same-sex relationships are "always wrong". Now, depending on where you live, they may be the vast majority of people coming forward in social care. I have had great social care support from people of faith and people of colour who were straight, but I have also had a great deal of problems in terms of agencies, for example, that simply cannot recruit.

That is another thing we do not look at. Agencies will take up contracts to recruit, and then they hand the contracts back because they cannot recruit, because people are simply not willing to work with them. That is why people make these compromises and employ staff they cannot even be out to, to the extent that they cannot even look at Regard's website in their own home. They might be out at work, and they go home, they take off the suit and they have to go back into the closet. They cannot even connect online with the rest of the community.

Sarah Champion: I am shocked and appalled at what I am hearing, but thank you for sharing it all.



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Q124 **Chair:** Moving on a little, some of the evidence we have had from CQC suggests that many care providers are not seeing a person's sexuality and gender identity as relevant to their care and emphasising that need to treat everybody the same. If we want a truly inclusive service for LGBT people, what needs to happen for that to be achieved, and who should be responsible for making that change?

Debbie Ivanova: The change has to happen in individual services, and therefore providers have the responsibility for the care they provide in those services. But all of us working together, in a way, have to put the support around that service, to make sure we are explicit, in the way we contract and commission with them, and in the way we regulate, on what is needed and what we expect in terms of the standards provided. Of course, yes, we have the Equality Act, which can be used to make sure that services are meeting their requirements under the legislation, but also under our regulation to make sure that services are changing the way they operate and becoming more inclusive.

We have some great examples of that, where we have gone in and seen services that are not offering truly person-centred care, and we have talked about equalities issues. We referred them to our website and Equally Outstanding. In one particular case I can think of, we issued a notice of a proposal to cancel the registration of that service. But they listened, they saw and understood what we had said to them, and they improved the service enough for us to stop that action.

Q125 **Chair:** You were going to cancel the registration of a service because of the way it approached LGBT issues.

Debbie Ivanova: It was part of it. It would not be the only aspect, but it was part of the whole picture and a focus of the inspection.

Q126 **Chair:** You talked about the need to be explicit in contracting. Is that actually required? There is an obligation on anybody who is applying to supply a service like that to have regard to public sector equality duties.

Debbie Ivanova: It is back to the bit about how people make sure these things are followed through and enforced, rather than the actual legislation that is behind it. The powers are there. Are we making sure we are using them in the most effective way?

Q127 **Chair:** Actually, thinking about it, which bit of law would cover private care home providers? Where would the obligation come from, the requirement to provide services for LGBT people, because they are not public bodies?

Debbie Ivanova: They are not public bodies, but because they are providing a public service it still falls under the—

Q128 **Chair:** They are providing a public service, so therefore they would still be covered by the Equality Act, but not necessarily the public sector



equality duty.

Jim Glennon: It is a legitimate question to ask when commissioners are contracting services: what is this particular organisation going to do to engage with or provide good service to older LGBT people, for example? It is possible to write that into certain kinds of contracts, if you want to do that.

Q129 **Chair:** I have been reminded that, if care home providers are providing a public service, the public sector equality duty does apply, just for the sake of clarity for me. Jim, you were coming in there. You talked earlier about a lack of confidence in organisations when they are providing services. Going on to this question with you, if we want to see really inclusive services, who do you see as being responsible for making sure that change actually happens? We can talk about very warm words, and we can all be there and support, but, when it comes down to changing things, who is going to trigger that change, from your experience?

Jim Glennon: Can I come to that in a second? Just to amplify what I was saying before, this is a recent report from a care home, which will be nameless, but which we surveyed. We surveyed all the staff in the care home; this is about six weeks ago. There were 136 staff in the care home. My summary report to their managers is that most felt confident or very confident in responding to LGBT people's care and support needs, but 45 staff said they did not think that knowing a person was lesbian, gay, bisexual or transgender was at all relevant to providing personalised care or support. Eight staff said they did not feel personally responsible for providing care and support to lesbian, gay, bisexual and transgender people. We might wonder what that means, but it might relate to strong beliefs and things like that. Fifteen staff in this home—this is this year—had heard people make direct negative or hostile remarks about lesbian, gay, bisexual or trans people in the care home. Three people had concerns a person might be getting poor care because they were LGBT.

Somewhere in the report—I do not have it to hand—a small number, but about 8% or 9%, of people said they did not know what to do if they came across something. They probably did know what to do about the normal complaints procedures, but somehow they were seeing LGBT as something over there. Somebody said in a written response to one of these surveys, "I think this is something for HR to deal with". That is just a very recent indication. When we try to put an equality framework in place, one of the things we start with is the attitudes and values of staff. It is totally confidential, so the staff know it is not going to go back to management; there is no linkage, but you get quite a powerful argument to go back with.

To the main question you asked, I do think it is working in partnership with CQC. I do think there is a business argument here. There is a business argument that care homes do not realise. I will be looking to choose a place at some stage, probably. I and my partner are getting old.



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We fit the statistics. We are of the generation where we do not have children. That means we do not have grandchildren. We are both estranged from our families, because of the shame that was involved when we are growing up, so we are pretty much on our tod. At some stage, one of us will become the other's prime carer, obviously, and sadly, when one of us dies, the other will be left alone, and we are contemplating care. We are faced with that situation of going in there.

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

The other side of that—I am losing my track a little—is linkage to CQC, because it is the stick as well as the carrot. If you are clear that you will get, let us say, a good rather than a very good mark, or possibly even fail your inspection, that will address the interest of your management team. If they do not have the learning, somebody will say, "We need to get learning about this, because, if we are losing our business, that is serious".

It is working together. For example, I am doing a course in dementia; it is quite a long course. I was a bit early one morning, two months ago, and I got speaking to a woman who is a care home manager. We were making conversation: "What do you do?" "What do you do?" I said, "I work with older LGBT people". She had just been inspected, and she said, "For the first time, I was asked a question: what are you doing to engage with the older LGBT people? I said what I always say. I think it is right, is it not? We treat everybody the same". That was a good entry, because we had time to wait, and I started to explain some of the differences between particularly the older generation of LGBT people and their heterosexual peers, and why it is important to be aware of that, to have a better and more meaningful conversation, apart from anything else, about people's lives and the issues around that.

That person, in that particular situation, had had the inspection, but they had not had, it seemed to me, any linkage to get a little more knowledge. If we were able to look at the inspection as a really important tool that has business arguments behind it, we could link that to saying, "You might want to contact this organisation". There are a number of organisations that provide awareness raising on these issues in the voluntary sector, which could be linked into that process, with some follow-up on it. This person just still had not got it, when she spoke to me, and she thought she had given the right answer.

Q130 **Chair:** I would just like to point out that not everybody who uses care services is old.

Jim Glennon: Sure.



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Chair: We have not really talked about that. Many care homes provide services simultaneously to people who are old and people who are young. I will pose that there, in case people think of a response to that.

Professor Almack: I will try to come back to that. Picking up on issues of care homes—and we must not forget domiciliary care as an element—I have done a number of pieces of work, and produced research reports and papers looking at knowledge, attitudes and practices of care home staff to LGBT residents and LGBT staff. I can send those on if that is useful evidence.

We also produced an assessment and development tool for care homes to use to do an audit on their LGBT practices. That includes things like looking at their policies and procedures, access and admissions, consultation. It goes beyond just having a rainbow flag or sticker; there has to be much more meaningful, engaged work behind that, from the top down and the bottom up.

We make a number of recommendations as to how they can do that: for example, appointing LGBT champions, who do not necessarily have to be LGBT staff, to make connections into the community; preparing in advance for the possibility of having LGBT residents, before they might actually have any or be aware of any; just talking about lesbian, gay, bisexual, trans lives and making it part of ordinary, everyday conversation. It is a real problem that we are just seen as a little niche, extraordinary group. It is just incorporating that—it is not remarkable, and it should not be remarkable in this day and age—and bringing it into team meetings, having it on the agenda, having conversations. What is happening in LGBT History Month? What could we do? What could we bring into the care home? There are these small acts, as well as the big, top-down issues.

Chair: That is really helpful.

Dr Gosling: We do not provide care for older people anyway; we provide care for disabled people, and two-thirds of disabled people are over retirement age. It is really important to make that distinction, because Disability History Month is equally important. The UN Convention on the Rights of Persons with Disabilities is equally important.

I want to pick up on the last three questions you asked and look at the role of local authorities. It is almost like we have skipped up to CQC, past the other people doing any kind of inspection, monitoring or anything else. They are supposed to train social workers to include questions about sexual and gender orientation in care assessments and reviews, and train them how to meet those needs in care packages. That is required under the Care Act and the Equality Act. More than 90% of the people we surveyed with the University of Bristol said their needs as an LGBTQI+ disabled person were either not considered at all or only given some consideration. Less than a third said they were comfortable when they were talking about them, and a third said they felt they had been



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discriminated against at assessment and review stage on grounds of sexual or gender orientation.

When they are commissioning—and, of course, many people in care homes have been commissioned by local authorities—they should be making the Care Act and Equality Act obligations explicit, whether that is day opportunities, day care providers, home care providers, residential care providers. They should be monitoring the delivery of services, including assessment and reviews, and using a range of methods to ensure service users are able to reflect their experiences accurately and fully. They should be ensuring that co-production groups include LGBTQI+ disabled people and they are empowered to be effective, whereas, if they are there at all, too often it is token, tick-box or people feel they will be victimised if they speak up.

They should be supporting co-carer networks, because many of us in couples are both disabled, or we have friends who are disabled, so the caring aspect as opposed to the paid care aspect needs to come from that. They should be providing centres for independent living. They should be empowering groups of direct payments users to come together to commission care. They should be promoting rights and inclusion in the community more widely by things like supporting history months. These things are not happening. Regard feels, as with so many things, the frameworks are there; it is just that they are not being implemented.

I would add, as disabled people, we do not believe institutions should exist more than they absolutely have to. This assumption that we need to reform care homes, as opposed to get much more home care, is really wrong. If you look at the way all the chains are collapsing, it is just not a sustainable model. We put more and more money in, trying to make them more equal and diverse, as opposed to saying, “Well, care in the home is always the ideal”. What needs to happen, including things like disabled facilities grants, to make the home accessible? So many people move just because their housing is inappropriate.

Professor Almack: On top of all those recommendations, I feel passionately that we should embed education on LGBT populations and wider diversity into our university curriculums, which are training teachers, social workers, nurses and medics. I do a lot of teaching in universities, drawing on my research on LGBT, but it is very ad hoc; it depends on where I am situated or where I am invited. It is not embedded and meaningful in our curriculums, and that could be a really important change, right from the start, putting it in there.

Chair: That is a very important point.

Q131 **Angela Crawley:** We have covered fairly expansively—or perhaps we have not—how effective inspectorates and regulators are at ensuring care providers are being inclusive of LGBT people’s needs, and we have discussed briefly the difference in oversight between private social care providers, and the NHS and local authority-run services. But what



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oversight is there if a care worker is working alone and not through an agency or registered care provider? In that example of someone remaining in their own home and having a care provider coming in, how much oversight would you say that there is?

Debbie Ivanova: If an agency is not registered with us, so if it is a private arrangement between two individuals, we have no ability to regulate those kinds of service. Where personal care is bought through a budget, an individual personal budget, that is not something we are able to regulate unless there is an agency bringing those people together and organising those people. Then they would be registered with us as a domiciliary care agency. We regulate the work of domiciliary care agencies where they are an organisation working together to provide care to people rather than through individual contracts.

Q132 **Angela Crawley:** Who should be responsible, then, for regulating the provision of services?

Dr Gosling: It is not possible to regulate it. The issue, again, comes back to local authorities. Everybody is supposed to have an annual review. The difficulty at the moment is that social workers turn up on the doorstep saying, "I am here to cut your hours", and that is the conversation. The conversation is not as it should be: "What issues are you having with your support, and how can we tackle them together?" We would very strongly argue for the return of the policy that asked for a centre for independent living, led by disabled people, in every local authority area, because peer support is not only the cheapest but also the most effective way to provide monitoring.

Generally speaking, if you are isolated at home, you have nobody to tell. If you have peer support meetings once a month for direct payments users, you have someone to tell. You have staff; you have workers. The difficulty is that so many of these services have been closed or been put out to generic support agencies that are not run by disabled people. They are not run by social care users. They do not really know what the issues are, and of course they do not know how to tackle them. As we say, unless your social worker—and none of us have named social worker any more—is monitoring the right things at review rather than trying to cost cut, there is literally nobody. You do not have to have any qualifications to work in social care.

Q133 **Angela Crawley:** The Government have stated that they will ensure LGBT people's needs are taken into account in health and social care regulation. What role does the CQC have in ensuring that this is the case?

Debbie Ivanova: In terms of our regulation, it is the things I was talking about already: that when we inspect, this is a focus of our inspections. Our whole approach is based on a human rights approach, and our inspectors should be consistently asking questions about how the provider and the service itself, whether it be a domiciliary care agency or a care home, make sure they are running a service that is both inclusive



and meets the needs of all the people who are at that service.

Now, I acknowledge that we know we have to continue to focus on that. While the information gathered through our provider information returns shows us that an increasing number of people are paying more attention and introducing new initiatives on LGBT work in their services, it is still not enough. We also acknowledge that the way our staff are confident in inspecting on this issue needs to continue to be a subject of the way that we improve regulation.

Q134 Angela Crawley: We have heard already from other members of the panel that this is not actually happening in practice, that it seems to be a bit of a tick-box exercise, but it has not been delivered on the ground. What action has the CQC actually taken in this regard to make this more in line with the framework that has been provided? It is not being adhered to, by all accounts.

Debbie Ivanova: I would disagree that there is any tick-boxing here. We have had equality objectives over the last two years that have focused on, first, person-centred care, and particularly on LGBT people in adult social care, and we are now moving to a new one about being confident with difference. As part of those, all our staff have had additional training and we have prepared sets of slides and questions. We have also spent time coming up with what good looks like in a care home or domiciliary agency that is providing the right kind of care for all the people within the service. On top of our normal policy and procedure, we have these additional helps and prompts.

Q135 Angela Crawley: How are you measuring the outcome of that work, then?

Debbie Ivanova: We have just done a piece of auditing of our reports. We know we are still not there. We have more to do. With this new objective that we have just set up, we are now taking another baseline, to look at how confident our staff are. Then we will, at the end of that period, measure that again, but alongside that we will look at what we put in the reports, because our reports should also reflect that we are asking those questions and moving things onwards.

There is that internal bit, but then there is the bit where we work with other organisations and co-produce the way we move forward, in terms of improving our methodology and making sure we address and focus on things in the right way. We know we do not have it completely right yet, but it is part of our objectives, and that is what we are working on.

Chair: I am afraid we are going to have to move on to our next panel.

Professor Almack: I commend the work that has been done but, from a CQC report, 23% of adult care providers have had any training or work on grounds of sexual orientation, compared to other levels of inequality. There is a huge amount of work still to do. Also, residents or people living



in a home can feel very vulnerable and not complain about instances that happened to them. Sometimes, if it is indirect discrimination, it is very hard to evidence, so there is a lot of work to do, through a multi-faceted approach, to improve the inspections and make sure they move beyond what a lot of people still perceive as a tick-box exercise.

Dr Gosling: The four-stage process for social services complaints was abolished, I think, in 2010. That allowed for four different stages; it did not stop until the disabled person said "stop". You had external support, external advocacy and external panel chairs. Now they just investigate themselves. You can complain and complain and complain. I support Regard members who complain every day, and they get nowhere, because it is literally a tick-box. We think the CQC needs more resources, but we do not feel that is where the main problem lies.

Chair: We have obviously opened up somewhat of an interesting issue here. I hope our report will help to throw a real spotlight on the issues you have raised today. I am so sorry; we are running massively over. If anybody wants to write to us on anything else, please feel free to do that.

Examination of Witnesses

Witnesses: Professor Catherine Meads, Peter Thompson and Joanne Anton.

Q136 **Chair:** Thank you very much to our second panel for joining us, and sorry for keeping you waiting. Time is a little skewed at the moment. We are going to swiftly move on to our next set of questions. Before we do that, perhaps I could ask you to say your name and where you are from.

Joanne Anton: I am Joanne Anton. I am policy manager at the Human Fertilisation and Embryology Authority; that is a UK regulator of assisted reproduction. I have worked at the HFEA for over 10 years now in the policy team, so I have a range of policy knowledge across assisted reproduction.

Peter Thompson: I am Peter Thompson. I am the chief executive of the HFEA.

Professor Meads: I am Professor Catherine Meads. I am from Anglia Ruskin University. I am also on the GEO advisory panel on LGBT issues, and I need to say that what I am saying here is my own view and not from the panel.

Chair: That is thoroughly understood.

Q137 **Angela Crawley:** As part of our work, we have looked into issues with LGBT services. One of the main issues identified has been the provision of services for couples who want to have children. We have been sent evidence that suggests that LGBT people are not always given the appropriate advice or treatment and that, when they approach fertility services, they do not necessarily have the best experience. Perhaps we could start with either Peter or Joanne, and you could indicate your



thoughts.

Peter Thompson: I would not wish to pretend that everybody who has fertility services has an experience that they always find entirely satisfactory, but from the evidence we have there is nothing systematic to suggest that LGBT patients who undergo licensed fertility services feel more dissatisfied than heterosexual couples. So what sort of evidence do we have? We have undertaken things like a national patient survey; people can write to us and rate their clinic, effectively. People can make complaints, and so on. We hold no evidence to suggest that, at a systematic level, LGBT patients feel they are getting a poorer service once they are inside a licensed fertility clinic.

Q138 **Angela Crawley:** So you are saying there is no data to suggest this. We are basing this on first-hand experience of individuals who have submitted to this inquiry and said, anecdotally, they feel their experience has not been positive. What steps can be taken to ensure LGBT people are getting equal and respectful treatment in fertility services?

Peter Thompson: First, in order to provide fertility services in this country, you need a licence from us. You have to then meet a series of conditions that we impose upon clinics, some of which is set out in law, in the Human Fertilisation and Embryology Acts of 1990 and then 2008, and various bits of equality legislation, but crucially in a code of practice that we require all licensed clinics to meet and we inspect against. In 2009, we included a new section in that code of practice entitled "treating people fairly". That sets out a whole series of requirements in this area, which, as I say, we inspect against. Joanne might be able to give you a little sense of the spread of responsibilities that we put on clinics in this area.

Joanne Anton: In addition to the Equality Act requirements that every service provider needs to meet, we also require centre staff to ensure that there are policy structures and procedures in place to evidence that they are meeting the relevant equality legislation, that centre staff have up-to-date training on equality issues, that they are sensitive to varying attitudes and that they ensure that staff must not harass or victimise anyone due to their own personal beliefs.

Adding to what Peter said, a couple of years ago we did a focused piece of work looking at the guidance we provide to clinics for treating transgender patients, because that was something we had heard about. As the regulator, we were getting more questions from transgender patients and from fertility clinics on how to treat these types of patients. We worked with a stakeholder group that we set up to develop some more guidance to clinics on treating transgender patients, ensuring that they are aware that someone's anatomical sex may be different from their gender identity, that they need to be sensitive and aware to that, and understand that people have individual needs that will need to be listened to and respected.



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Following that work, we produced a lot of patient information on our website to transgender patients setting out some of the issues that they had questions about, in terms of what types of fertility treatment were available to them. We try to listen to what clinics and patients are telling us through the various means Peter has set out. We are able through our code of practice to be flexible, and to change and update our guidance when needed.

Q139 **Chair:** Would it be possible for us to get a copy of that code of practice and guidance?

Peter Thompson: It is available online as a link. It is a publicly available document.

Chair: Brilliant, thank you very much.

Q140 **Angela Crawley:** It is interesting to hear that you have a code of practice and you referred to “these types of patients” when you were referring to individuals who presented as transgender, but this is not the experience that individuals have. To bring in Professor Meads in this case, she has outlined that in her study lesbians were being encouraged to undergo in vitro fertilisation, whereas other types of intrauterine services were also available, and that the advice they were given was perhaps not appropriate or tailored to their specific needs. I might want to bring Catherine in at this point.

Professor Meads: My understanding is that lesbian couples are being offering IVF, so that they could have the egg from one partner implanted into the uterus of the other. At the same time, eggs are harvested, they are sold on and they can fund their fertility treatment through that. They might be fertile or they might be sub-fertile. My understanding is that IVF is for people who are sub-fertile and donor insemination is appropriate for women who are fertile.

Would it be appropriate for someone to be offered IVF when they are fertile? Some clarification of that would be extremely useful, if that is going on. I do not have any data on exactly how many lesbian couples are being offered this service. From a social perspective between the couple, you can see why they might wish to go in that direction, but IVF has side effects. There are multiple pregnancies. There are hormone issues. Some people can be off work for quite a while, and so forth. It is not really appropriate, even though it is being offered.

Peter Thompson: I am trying to give a short answer to what is a very complicated question.

Chair: It is a very interesting point.

Peter Thompson: It is a very fair point. NICE guidelines seem to me to be a sensible starting place on this. The presumption with NICE guidelines is that, in theory, for a heterosexual couple, you gain access to NHS services having tried unprotected sex for up to two years, and the



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presumption for lesbian couples is that they should try a number of rounds of IUI before moving on to IVF.

The fact that NICE guidelines suggest that suggests that there may well be cases where it would be appropriate for lesbian couples to undertake IVF, and generally IVF is more successful than IUI. It is more of a medical intervention and all the things you said, Catherine, are right, involving drugs and the like. As a generality, 2017 is the last time we have figures for the success rates for IUI and they are something like 14%. The preferred one we use is a different measure for IVF, but it is closer to an average of 22% or, indeed, a more comparable measure would get you up to 26% or 27%.

There are clinical reasons why, for particular women, even women who do not have fertility problems, IVF might be the appropriate treatment. The danger as a regulatory body is trying to put an entirely rigid framework over a set of clinical decisions that rely enormously on the judgment of the doctor, the wider clinical guidelines and, indeed, the particular prognosis of individual patients.

Chair: I feel Catherine wants to come back in there.

Professor Meads: Although the success rate with donor insemination is about 14%, the success rate in lesbian women is higher, as they are approaching it because they need the semen and not because they have infertility issues, so 14% is a bit of a misleading statistic. You need the success rate in the lesbian parents compared to the heterosexual parents.

Peter Thompson: I agree that general statistics can hide as much as they reveal, but equally what is also crucial in this is the age of patients, because women's fertility in all circumstances declines quite significantly from 35, 36 or 37 onwards, so you then get into an issue of subdividing those statistics by age. You then also start to get pretty small cohort numbers and the like.

Chair: It sounds like there is quite a debate here.

Peter Thompson: What I am trying to say is that these statistics require some unpacking. The more you unpack them, the smaller the numbers get and frankly the less reliable they are.

Professor Meads: On average, lesbians tend to be older when they get as far as infertility treatment or treatment with the services here. That is another reason why the statistics might be slightly misleading, because the women are older.

Joanne Anton: If the Committee would like to see our latest fertility trends report, that might be useful. We can send it on to you. We released it just a couple of months ago, showing data on success rates, and it is broken down more into age groups. You might also be interested



to know that, from our last report, in general we have seen a decline in donor insemination until about 2009, where we saw a bit of an uptick in donor insemination taking place at clinics. One of the reasons for that is that we are seeing more same-sex couples coming to fertility clinics for treatment.

Q141 Angela Crawley: A key point is that same-sex couples who choose to start a family will generally start a family at a later stage and, particularly and predominantly for a female, age is a significant factor. I accept the point you have made and it is easy to interpret statistics in a number of ways, but, primarily speaking, most couples who go for treatment will tend to go privately. If they do go through the NHS system, their experience will be sporadic at best, because they might get different advice from different practitioners. You cannot be wholly accountable for that, but ultimately a couple who are electing to go privately and pay for the service have an expectation and a demand of that service.

One of the key things about having this inquiry was that it was highlighted to us that couples felt they were being adversely discriminated. Where discrimination is uncovered within the fertility services provided, what steps are open to a couple who want to take forward a complaint? Is that open to either individuals or regulators to ensure that discrimination is tackled where it does occur?

Peter Thompson: Individuals should first complain to the clinic that treated them. If they are not satisfied by the response of the clinic, they can complain to us. We will then investigate. Depending on the nature of that complaint and what we find, that will determine the kinds of actions we might take. Typically, if, for example, we get a complaint, particularly in the run-up to preparing for an inspection for a clinic, that provides us an opportunity to have a conversation with the person responsible at the clinic and so on.

It very much depends on the nature of the complaint as to the kind of action we might take. Under the law, we then have a range of enforcement sanctions that we can decide to use, as long as we act proportionately, depending on the kinds of discrimination that might be found. That is something we inspect when we go to a clinic, because the "treating fairly" section is in our code of practice. The Act says that we have to inspect at an interval not exceeding two years, so in other words we go fairly regularly.

Q142 Angela Crawley: Going back to the previous point about statistics, though, I would imagine that percentage-wise the number of same sex couples who come forward for treatment is still a lower percentage than the average number of couples from heteronormative relationships who come forward for fertility. Would I be correct?

Peter Thompson: That is right. In 2017, about 90% of couples who had treatment in a licensed fertility clinic were heterosexual. Of the remaining just under 9%, just under 6% were lesbian couples. Most of the



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remainder effectively were single women and a very small percentage of women were involved in a surrogate arrangement. All those figures, again, are available in our report.

Q143 Angela Crawley: I am a lesbian with my partner who wants to go and receive fertility treatment. I am adversely discriminated and I want to take up a complaint. However, I am in the process of going through this procedure and the ongoing treatment that is required. It has been identified within the evidence we have received that there is generally a fear around making a complaint. Given the small numbers of individuals and how easily identifiable those individuals could be, can you understand why there would be fear about making a complaint through that process, and why there is a bit of concern about individuals who do receive discrimination being able to raise that in an anonymous way when the numbers are so small?

Peter Thompson: Yes, I entirely accept that in any medical setting deciding to make a complaint against the people who are treating you is not a remotely straightforward matter.

Q144 Angela Crawley: How do you change that culture, then? Is there a way to promote a way for couples to engage with services, to understand their rights and to understand, if they are being adversely discriminated, the process by which they can receive better care and services, and feel that they can elect to make those choices in a system where they are still in the minority of individuals who receive treatment? I think you said 6% are lesbians and 9% are LGBT.

Peter Thompson: This is not straightforward, in the sense that, to be honest, as a regulator you can set a framework and a set of expectations; you can produce patient information; there is a whole bundle of things you can do, but those steps in and of themselves do not always provide the circumstances that allow people to confidently make those kinds of decisions.

Similarly, quite a few people who undertake fertility treatment do not know that we exist as a regulatory body. In one sense, why should they? Their engagement is with the clinic or hospital that they go to. Plenty of people who have medical treatment do not know that the CQC exists. There is always quite a tricky job in making people aware of the avenues to follow.

Quite a bit of what Joanne set out in that part of our code of practice is about clinics getting better at making patients aware of these things. More generally, a big part of our code of practice is about the nature of informed consent. It has to become part of those conversations.

There is also an issue here that a lot of the approach on discrimination that one gets through the Equality Act does not neatly fit on to the kinds of clinical judgments that somebody might make about whether donor



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insemination or IVF is for a particular woman in a particular place the most appropriate treatment choice.

Chair: Catherine, you wanted to come in very briefly.

Professor Meads: I have been looking at the education resources for NHS service provision and it has become apparent that there have been loads and loads of efforts to train NHS and social care staff on LGBT issues; they just have not come up. There are also patient information leaflets specifically for sexual minority people that could be provided, but are not.

There is some evidence about how clinic staff may not appreciate that, despite more tolerant attitudes in society, many lesbians still expect to be judged for their sexuality. They have to come out and that is difficult. There is an expectation generally that often lesbian and bisexual women are not going to get as good care, so they might not even get as far as complaining, because they might not even know that it is worth it. They might have complained in the past and nothing has happened. The whole environment is set up heteronormatively and there just is not the space for the sexual minority women to be there.

Q145 **Sarah Champion:** I have a quick question. Peter, you talked about the NICE guidance. For lesbian women it advises up to six sessions of fertility treatment privately before the CCGs could consider funding on the NHS. Here are some quick-fire questions from me. Is IUI cheaper than IVF?

Peter Thompson: Yes.

Q146 **Sarah Champion:** Could that be one of the reasons that lesbians are actively encouraged to have IVF treatment rather than IUI treatment?

Peter Thompson: I do not think so. The NICE guidelines are produced through a pretty rigorous process, as you know. Echoing one of the points that Catherine made, IUI is not just cheap; it is not a very intrusive medical process. As a matter of good ethical practice, ideally you should be searching for a medical intervention that gets you the outcome with the least risk. IVF is a bigger step than that.

Q147 **Sarah Champion:** Let me pause you there, just because of time, I am afraid. If lesbians are having to spend five grand on average, whereas straight women would not have to, is that fair?

Professor Meads: No, it is not fair.

Peter Thompson: To be clear, we do not regulate access to IVF services. These are decisions in England taken on the basis of CCGs. We do not write the NICE guidelines. We set standards for the licensed services themselves.

Q148 **Sarah Champion:** Catherine, do you see it as discrimination?

Professor Meads: Yes.



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Q149 **Chair:** Can I ask one slightly tangential question? The Law Commission has just launched a consultation on the laws on surrogacy and I thought you guys might have a view on this. What are your views on the state of current law and do you feel as though your statutory powers are currently sufficient to regulate surrogacy services in the way that they should be? Does anybody have any views on that?

Professor Meads: Surrogacy tends to be much more with gay men and they can adopt now, so there are two main routes to having children if you are a gay male couple. The current rules are such that it is quite tricky to find a surrogate mother in the UK, so often they have to go abroad to do it and then there are all sorts of legal ramifications.

Q150 **Chair:** Do you think the laws need a look at in this area?

Professor Meads: Given that adoption is now an available option, that is another route through, but it means that you have no genetic link to the child you are getting, whereas with surrogacy you can.

Peter Thompson: There are a couple of things from me. We do not regulate surrogacy per se and, indeed, that is part of the criticism of the surrogacy laws. The bit we regulate is if you need the IVF service in the middle of that. There are an awful lot of interested stakeholders out there who think that the Law Commission's report is long overdue, and that is not a criticism of the Law Commission, in the sense that, if you look at a lot of what family judges are saying, the surrogacy laws feel out of date.

I am going to sound a bit civil servant-ish at this point. The Law Commission report puts a number of recommendations that would increase the regulatory responsibilities of the HFEA if the report was ever taken up by Government. My board is going to be considering that over the summer and we will do a formal report then. Really it would not be appropriate for me to say much more at this stage.

Q151 **Chair:** There is a consideration in your organisation.

Peter Thompson: There are a number of recommendations addressed squarely at us and we need to come back to the Law Commission and say whether we think these are practical propositions. We will do that over the summer.

Chair: Perfect. Thank you very much. We could have gone on a lot longer. I am sorry. Time has beaten us, but thank you very much for attending today. We are really appreciative of that.