HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Health and social care and LGBT communities, HC 1492

Wednesday 3 July 2019

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Watch the meeting

Members present: Mrs Maria Miller (Chair); Tonia Antoniazzi; Angela Crawley.

Questions 152–221

Witnesses

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

II: Clare Perkins, Director of the Knowledge and Intelligence Team (North West), Public Health England; Dr Michael Brady, National LGBT Adviser for Health, NHS England; John Stewart, Director of Specialised Commissioning, NHS England.

Written evidence from witnesses:

– Department of Health & Social Care, Public Health England & NHS England

– Dr Justin Varney

– The National LGB&T Partnership

Examination of witnesses

Witnesses: Dr Justin Varney and Harri Weeks.

Q152 **Chair:** Good morning. Can I welcome our witnesses and those watching online or in the Public Gallery? This is the fourth session of our inquiry into health and social care in LGBT communities. Today we are hearing from two panels of witnesses about the responsibilities the NHS bodies have for ensuring inclusive healthcare for LGBT people. Our first panel is made up of those who are not currently working for the NHS but have a great deal of experience of working with it. The second panel is made up of representatives from NHS England and Public Health England. Before we start our session, could I just ask our witnesses to introduce themselves?

Harri Weeks: I am Harri Weeks. I am the stakeholder engagement manager for the national LGB&T Partnership.

Dr Varney: I am Dr Justin Varney. I am director of public health at Birmingham City Council.

Q153 **Tonia Antoniazzi:** Welcome to you both. The Government have pledged £1 million until 2020 to tackle health inequalities in LGBT communities. Is this enough?

Dr Varney: It is a nice, easy question to start with; thank you for that. It is important to think about how we tackle health inequalities in the breadth of what is driving them. It is not just about health services. It is about education, it is about employment and it is about tackling discrimination in society. A single funding pot is not going to solve anything when it comes to health inequalities.

It is a useful thing to bring people together around action, but it needs to be framed in the context of everyone working together, and it is really important for the Committee to reflect that many of the inequalities that LGBT people experience in terms of their health are the responsibility of local government. Sexual health services, drug and alcohol support and support around smoking cessation sit with me, as a director of public health, working closely with my NHS colleagues. It is that whole-system approach that is really important. The money is always helpful—we will always take more money from Government—but the challenge is about how we truly change the system in a sustainable way.

Q154 **Tonia Antoniazzi:** The challenge is how it gets out to the right services. Is it being spent in the right places now?

Dr Varney: From what I have seen, this is still evolving in terms of how the money is being used as part of the Innovation Fund. The challenge for us is to see the narrative move beyond money and go from, “This is a special pot and that is how you solve this problem”, into real system reform in terms of training, data collection, performance management and setting of standards, so that five or 10 years down the line—and I have been in this game 20 years—we are not sat here again having the same conversation about a single pot of money, which, in the grand scheme of things, will only ever be a drop in the ocean. It is the fundamental reform of the way we practise and the way we commission that will change the experience for LGBT people.

Harri Weeks: I do not have a lot to add to what Justin has said, really. I suppose the one thing to mention is that this pot allows us to set up a number of projects, to start a number of pieces of work, but it does not really seem to consider the need for those to become sustainable, the need for them to continue after that initial year of being set up or the need for us to consider whether they have worked, how they have worked and why, as well as how to scale them up or move them to other areas.

Q155 **Tonia Antoniazzi:** It is very important to make sure that the good practice that you are using with this pot of money is shared as well.

Harri Weeks: Absolutely, yes, and in particular this pot of money maybe only just begins to think about how we share the work that is being done. There is also other good practice happening, and there are a number of different ways that we could be looking at how we share that good practice. The Health and Wellbeing Alliance that I am part of is one of the opportunities to do that. A number of the pieces of work we do are about gathering good practice together. Often, unfortunately, which good practice we are gathering, and in what areas, is not set by us, as communities who know what is happening on the ground, but is set by policy leads and comes down to us.

Q156 **Chair:** We are going to go into good practice a lot more in a moment, so we might just press pause on that at the moment.

I just wanted to move on to the role of Public Health England, because they have written and published many guides, reports, factsheets and goodness knows what over the last nine years, which are really relevant and important for LGBT health. Many of these deal with the barriers that LGBT people are still facing today, but the evidence would suggest that things are not really changing. Why are things not improving, and what should Public Health England be doing to get its message across more effectively than it might have done in the past?

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

Q157 **Chair:** So they are more individually driven than systemic?

Harri Weeks: That has been my experience, yes. We see some examples where working with PHE has felt a bit more embedded, where we have been asked to be involved much earlier in the process, and so LGBT issues have clearly been considered key to that piece of work. This is not unique to PHE but, with all the system partners we work with, the LGBT input comes as a bit more of an afterthought, so structurally, sometimes, the piece of work is not actually designed for LGBT people.

Dr Varney: I have to confess that I wrote, co-authored or was involved in many of those reports, so I perhaps have a slightly biased perspective for the Committee on this. Harri is right that much of the work that has been done in health, whether in Public Health England, NHS England or the Department of Health and Social Care, has been through committed individuals with personal passion, often at personal cost, in order to deliver what they fundamentally believe is important to shifting the lives of LGBT people. It is important to pay tribute to them, because often they do it behind closed doors and are not acknowledged in the way perhaps they might be.

In terms of the question about what would change, in 1995, *Diagnosis: Homophobic* described horrendous experiences of LGBT people in mental health services; in 2015 *Unhealthy Attitudes*, by Stonewall, reiterated virtually identical findings. We have not moved yet to a systemic approach in which this is routine. Equality impact assessments are not a mandatory requirement in terms of policy formation or in terms of pieces of work in PHE or in other areas of the health service.

Q158 **Chair:** But why is it not? You spent many hours, probably months and years, writing reports based on evidence; sensible people agree with it. Why has that then not been translated? What is the fundamental problem there?

Dr Varney: The fundamental problem can be described as, "If you do not count me, I do not count." Because there is a lack of routine data collection on LGBT people within the health system, irrespective of whether you can prove it, with international evidence and national surveys saying that this is an issue, when it comes down to delivery, because you are unable to routinely report on whether you are achieving change, the system does not know how to respond.

Q159 **Chair:** You have the theory there, but when it comes to putting it into practice, because it is not obvious where these populations might sit and how we would then measure the impact on those populations, it is difficult to embed that change. Some of this is data-collection driven and objectives driven.

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

If at the moment we looked at a service and went, "How many LGBT people walk in the door?", taking cardiovascular disease as an example, despite the evidence—we know the evidence says LGBT people smoke more, drink more alcohol, are more likely, for some of those groups, to be overweight, and therefore logic would say they will have more coronary heart disease—we have no data from cardiac units. We just do not know whether they are coming or not. Therefore to say, "Is the service improving its support for LGBT people?" is impossible, because the data does not exist.

Q160 **Chair:** So count people and then make some targets, and that is how the NHS works.

Dr Varney: "Four-hour wait" is the simplest way of putting it.

Q161 **Chair:** Justin, your role as LGBT leader, Public Health England, has been vacant since you left.

Dr Varney: I moved in transition, in April 2018, into an external secondment while I was being restructured, and I moved into my present role in February 2019, so for about 18 months now.

Q162 **Chair:** It has been more than a year. Why do you think it has been left vacant?

Dr Varney: I know you are taking evidence from Clare from PHE later, and she will talk about some of what PHE has done. The reality is that, as Harri alluded to, I came to PHE with significant experience in LGBT health inequalities. I was able and supported to have that written into my role and my objectives, and there was huge support from Duncan Selbie, the chief exec, to see that, and from Kevin Fenton, the then director of health improvement. I was supported to keep it in my job, perhaps more than it being a role that was additionally created.

Since I have left, there is not necessarily the same individual in the space, but PHE is having to review how it does that, and not just for LGBT. There are not necessarily identified leads for disability or technical expert leads for different ethnicity groups in the organisation. It has been reliant to some extent on the expertise that it inherited.

Q163 **Chair:** Do you think that lack of specialist leads is a policy change by the NHS, or is it simply that the people are not there?

Dr Varney: The people are there in the system.

Q164 **Chair:** But has there been a policy change?

Dr Varney: We have not had named LGBT leads since the sexual orientation gender identity advisory group, which was back between 2005 and 2009, when there was actually a job description that was recruited to and appointed to in that way. We have the opportunity, with the national

LGBT adviser role that has been appointed, to re-explore that, but ultimately there has been a policy shift from perhaps 10 years ago, when every NHS organisation or public sector body would have an executive champion for different diversity strands. We have moved back into a world where there is usually a champion for diversity and inclusion, rather than strand-specific, so the dedicated capacity has changed, and that has been a policy shift on diversity.

Harri Weeks: I just wanted to mention that we very recently discovered that there are apparently director-level leads at DHSC for each of the protected characteristics, but the partnership has been around since 2010 and we have not met either of the leads for sexual orientation or for gender reassignment in that capacity. When my colleagues have met one of them in another capacity, it was never actually brought up that they were the lead for that area of work, so where those leads sometimes do exist, it might be in name only, unfortunately.

Q165 **Chair:** So in practice it is not really coming through to people who are at the coalface.

Harri Weeks: Yes. As a Health and Wellbeing Alliance member, we are a sector strategic partner of DHSC, NHS England and Public Health England, and yet we only met with the inequality and vulnerable groups team for the first time very recently, and it was they who mentioned these names that we had not met before.

Q166 **Chair:** Why do you think that is?

Harri Weeks: Sometimes there is a consideration that the voluntary and community sector is seen as quite separate and outside of the system and maybe not given the value that it deserves. We are working with individuals every day, and we, in many cases, are actually providing the services that the NHS is not, but perhaps that is not always recognised from within the system bubble.

Q167 **Chair:** We have heard how the NHS has more successfully taken on BAME health issues. Why would it not have equally spent the time taking on LGBT health issues?

Harri Weeks: In 2016 the Equality and Diversity Council made commitments to work on LGBT health. In that particular context, it was around workforce, but of course working on workforce support provides better support to patients as well. Of course, we are a member of the Health and Wellbeing Alliance, so some consideration is given to the need to include LGBT people. Unfortunately, the restructuring of the EDC removed the representatives of LGBT communities, and the work plan has been lost to the mists of time.

Chair: It has not been central.

Q168 **Angela Crawley:** My question was going to be about how you felt NHS England and Public Health England were engaging with LGBT people, but

I will move on from that, because you have answered quite a lot of that already. What are the top three improvements that you would like to see in this relationship, and how do you think that change could be brought about?

Harri Weeks: There is to some extent, as I was saying, more of a consideration of us as experts, both in terms of the individuals who work in the sector, being the people who work on the ground with often the most marginalised people from our communities, but also recognising that a lot of research and evidence is coming out of our sector that often does not fulfil the double-blind scientific requirements that are placed upon a lot of research before it can be viewed as feeding into influencing change.

One of the difficulties that we as the LGB&T Partnership are dealing with at the moment is that the Health and Wellbeing Alliance has not received any funding this year. It is due to, but it has not been released as yet. I essentially have not been paid since April, which we feel points to, again, a lack of recognition of how the sector works: that individual knowledge, experience and relationships are built and developed and will be lost if what might feel like a very small amount of funding to the system, but is a much larger amount of funding to the organisations involved, is lost. Those are definitely two issues. How we want things to change is quite a big question.

Q169 **Angela Crawley:** I appreciate that. It is a great shame that you have not been paid since April, and I hope that will be resolved soon as well, but you are right that what seems quite a small amount of funding to your organisation could actually be a salaried position that you cannot necessarily fulfil. The responsibilities for LGBT-related issues are split in a highly complex way sometimes, and some of the services are commissioned by NHS England, some fall to Public Health England and many of the rest remain in the hands of CCGs. Is this structure serving the LGBT community well? Justin, you look like you have a lot to say on this.

Dr Varney: Obviously, I have gone through that journey from national to local, so I am now deeply embedded in England’s largest city and largest unitary authority. I wrestle daily with how to best support 1.2 million citizens and do that at scale, with a complex landscape of five NHS trusts, two CCGs and NHS England, which has a much larger regional footprint. When you look at a service like sexual health, Umbrella, which is our local provider, is a fantastic example of partnership between our hospital and 14 voluntary sector organisations working together to deliver an integrated accessible service that includes specific components for LGBT people, not just in terms of sexual health services but also in terms of supplementing the NHS England commissioning of sexual assault and rape clinics by providing LGBT-specific independent advisers and support workers.

At a place level, local government is working phenomenally hard to make that system work. The challenge at the moment is that, in most cases, there are competing different directions and priorities that play out. We have opportunities, with the new primary care networks, with the clustering of GPs in place. That could be a game changer, provided that we use the Equality Act and the equality duty, which should apply to them as a public sector provider, to ensure that they are delivering services and are able to demonstrate that they are delivering services. You asked about what would be the game changer, and it is the requirement to demonstrate accessible and inclusive services, which I feel is in the spirit of the Act but has not necessarily played through in delivery.

We as a local authority put significant emphasis on whether we can consider who is walking in the door and using the service and who is missing. The NHS has at periods done that, but it comes back to the point that if you do not count someone, you cannot see whether they are coming or not, and they do not count to the system.

The system in place is trying really hard to make that work for citizens, whether that is LGBT citizens or BAME LGBT citizens, because it is the overlapping and the intersectionalities of identities where this gets really complicated. I am conscious of the evidence you took from my colleagues from Regard, which is a fantastic example. If we cannot get services to work effectively for young LGBT people with complex needs and disabilities, we are failing them as a society. How we think about that kind of opportunity makes the service better for everyone, and it is about using that equality narrative to level up for all, rather than just a particular strand that is the changing space.

Q170 **Angela Crawley:** You mentioned that there are organisations that are doing this very well. Are there any examples of best practice or places where you think we should highlight the way service delivery is done well within the NHS and promote that in the wider sense?

Dr Varney: We can provide further evidence to the Committee afterwards, but there are a huge number of pockets of gemstones across the country. What I would say—and it is a phrase I often use in Birmingham—is that there are lots of gemstones, but there is not a coherent necklace in place. That is the gap for us; it is about how we take fantastic examples of good practice in individual hospitals, GP practices, partnerships with the voluntary and community sector, the NHS and local government, and go, "Here, this is how this connects from this part of the country to this part of the country and does it in a way that is not enforcing one-size-fits-all." How you deliver and support LGBT people in Devon and Cornwall will be very different from how you deliver in Birmingham, London or Manchester, but there may be common elements that could be translated and shared.

Harri is quite right that the challenge with the innovation funding is that scaling, and how we really understand which are gems that can be shared and which are gems that are truly just place-based, with the infrastructure and the environment around them meaning that they would not translate or be able to be moved.

Q171 **Angela Crawley:** Harri, your role within the LGB&T Partnership is quite a unique position, in the first instance, and obviously if the NHS was doing its job properly then there would essentially be no role for you to play in that conversation. How do you get the NHS in a position, not to put yourself out of a job, to make sure it is working for LGBT people in the way it should, essentially?

Harri Weeks: First, I would say that even if the NHS was working the way it should, I probably would not necessarily be out of a job, because the NHS needs to be working with the voluntary and community sector, and that relationship needs to be there.

We are obviously really excited about Michael Brady's post and Michael coming into that post. When he came in, we thought about how his role and the work that he would be doing and my role and the work I am doing would overlap and contribute to each other's work plans. If you think about it, he is constrained by certain things. He is constrained by working within the system in particular ways, and I am constrained by not having access to the system in particular ways. We have agreed to work very closely together on that. I would argue that there is always going to be a place for a relationship with the voluntary and community sector.

Because I was focusing on that, if you could repeat the rest of the question, that would be great.

Q172 **Angela Crawley:** I am absolutely not advocating to put yourself out of a job. If the NHS were to work in an ideal way, what would you like to see happen? What would be your asks? I know it is a really big question and there is a lot to encapsulate, but what would you do to make sure the NHS simply worked better?

Harri Weeks: One of the things that we were discussing outside was leadership, and one of the things that led to that conversation was that we were talking about how LGBT health inequalities are still largely considered as just being about mental health and sexual health, and then only really being about depression, suicide and HIV. We are beginning to have data that can support what we already know, which is that health inequalities affect LGBT people across the whole of health and social care.

What is needed is a greater push from those people will listen to, to encourage them to think about what are the LGBT health inequalities in the areas where they work. The work that we do often is with, again, interested individuals in policy teams. The work I do is almost always at a policy team level; I am working with groups on pieces of work that usually are almost finished already, and we are trying to shoehorn some LGBT considerations into them.

If something was coming down to every different part of the system, and to teams that maybe do not realise what they do not know—that they should be, essentially, paying attention to the public sector equality duty, thinking about due regard, and maybe going a little bit beyond what people usually do when they think about giving due regard—hopefully we would then be ready, if not with the evidence, where that is not available because we are not counting, then at least with the justification for why we think there might be an issue, like the explanation that you gave about cardiovascular disease, and the offer to support the system in working out what to do next. We are not getting that routinely across the piece.

Q173 **Angela Crawley:** You make a valid point about essentially almost trying to shoehorn in that consultation, rather than being a part of the process from inception to delivery, and that is perhaps—

Harri Weeks: It is not unique to LGBT health. It is an experience shared by probably all of my partners across the Health and Wellbeing Alliance. Often things are brought to us when people realise that the voluntary sector should have been involved but they did not do it earlier in the process. That could mean that the structure of the piece does not allow for that kind of engagement.

Dr Varney: You asked about solutions in this space. GLADD, the gay and lesbian association of doctors and dentists, for probably 15 years has been trying to get mandatory inclusion in medical education of LGBT awareness, and it has not been achieved. There is no single e-learning module on LGBT awareness on the e-learning for health platform that all NHS trusts can access for free. Although there is within the civil service, for other bits of policymaking that is not there and it is not mandatory. On Harri's point of, "You do not know what you do not know", we cannot blame, to some extent, the individuals involved because it may not be within their realm of reality. It is not part of our standardised training approach. If it were, we would be in a quantum different place from where we are now.

Q174 **Angela Crawley:** When you say there are not free materials, there are materials available but the onus is perhaps on the trust to invest in that material if it wants to lead from that direction. It is not freely available in a consistent way across all the—

Dr Varney: Yes. I would not necessarily encourage a one-size-fits-all—every trust should be able to make a choice—but just having that universal baseline of training. If we had a single training module for the entire NHS on gender identity and on "What is sexual orientation?" we would be a step further. The sexual orientation gender identity advisory group tried; in 2005 it commissioned and published an NHS leaflet. It was not quite called, "What is LGB?" but it was pretty much along those lines, and it was a two-sider, written in a language that hospital porters could understand. This was designed for the entire NHS. We had about three or four years where that was there and was available, and now it is only available as an archive. We do not have that systematic approach, and it is very dependent on an individual organisation, whether that is a GP practice or hospital, finding the money and the training time to commission it independently, rather than this being, "This is how we practise medicine in Britain."

Harri Weeks: That was why the potential commitment to do workforce work around LGBT people was so important. In another role I worked as a trust equality and diversity lead, and my experience there was that everything was so driven by the need to submit data to the workforce race equality scheme, and now I imagine also the workforce disability equality scheme, that all resource just had to be funnelled in that direction. Similarly, at a system level, if work were to be done on an LGBT topic or subject, it was because either there was particular passion within the team or because an issue came up and there was a complaint. Even when that did happen, there was no consideration or thought about taking it beyond the department in which there had been a complaint.

Q175 **Chair:** It has been fascinating to hear you talk about the barriers that are there to doing all the things on which there has been a great deal of work to do. Just to tie that up, it seems to me that there are three potential barriers, and I would be interested in your reflections. One is the barrier around professional training and understanding. I suppose the people who we are going to speak to next, who are from the NHS, will say, "That is not really our bag; that is down to the medical professional bodies, the training bodies, the universities and continuous professional development".

The second thing we have been hearing is that it is the prioritisation of resources. Is it that, for some reason that is unclear, LGBT health issues are not seen as a priority? This is possibly linked to the former issue. They are not part of training and therefore they cannot be, let us say, important.

Then there is the final issue, which you have not said, but is it down to prejudice? Is there prejudice, within both the NHS and also the professional organisations, which would default to marginalise this as an issue just because of ingrained prejudice? Do you think those are the barriers that you have articulated or not articulated, or do you think I have it wrong?

Dr Varney: You have summarised them well. I would expand them a little bit. On the training front, the leadership for training of healthcare professionals now sits with local workforce action boards, the LWABs, which are led by local NHS providers and system leaders. The NHS absolutely has a way of influencing and requiring elements of training and has always done, whether that is through its leadership of medical professionals or working with the trade unions and the Royal Colleges. It is perfectly capable. Health Education England is an NHS special authority, so it is part of a family.

The prioritisation one is interesting. When we were writing the report on women who have sex with women, I remember very vividly a series of conversations about why it is that lesbian and bisexual women's health, particularly lesbian health, is so invisible. That report is the first in the world, from any Government, on lesbian and bisexual women's health. It is a fundamentally groundbreaking piece of work.

Q176 **Chair:** When was that published?

Dr Varney: That was 2018. It is my personal swansong.

Chair: Last year.

Dr Varney: That is exactly the point. When you look at why, it is because the societal perception is that lesbian women do not have children and they do not support men at work. When you try to find what the cost of lesbian women being unwell is, given that statistically they have been shown to be lower-income earners and not in necessarily the same positions of power or authority, the cost to the system is relatively low compared with the cost of women who support children and men. That goes back to the original basis of the NHS Act and some of the commissioning of health services. It is hard to prioritise people when they are invisible in terms of the cost that they are creating for the system; that goes back to the data bit.

Finally, on prejudice—I say this having been probably one of the most visible out gay men in healthcare over the last 20 years—it is definitely career-limiting to be visible and articulate in this space. There are many colleagues who have not been as fortunate as me.

Q177 **Chair:** But also there is the point you have just made about the misconceptions of the role of LGBT people in society; that is prejudiced.

Dr Varney: Yes, absolutely. There is still a significant challenge within the system. Unfortunately, as Harri has alluded to, if you are the LGBT person who has an ability within their role to move this agenda forward, you are often pigeon-holed: "You would do that, because you are LGBT." We have moved beyond that in terms of ethnicity, but I would say in some cases that is still the case for some of my black and minority ethnic colleagues. We still have some way to go for this to truly be an inclusive service, as set out in the NHS charter.

Chair: A lot of people listening to this will be quite shocked by that.

Harri Weeks: I would agree. You have summarised very well what some of those issues are. To add to the discussion around training, I would say that we are at a point now where a lot of training is being developed by some of those bodies that have responsibility, some of the Royal Colleges, for example. The issue that we are coming up against as we discover more about those trainings, or as we get involved or are asked to input into those trainings occasionally, is that they seem to be happening in silos and in isolation, which will no doubt lead to them being presented and used in silos and in isolation, rather than in the more general way that was outlined as being required.

Also, there seems to be little consideration given to the need to actually work with the communities who are affected. It is all written by doctors or psychiatrists or whoever is the expert at that point in time, and no consideration is given to the expertise of communities. Inasmuch as communities are asked to engage, they are not given credit for that expertise and they are asked to do so out of the goodness of their own hearts rather than being paid for it.

On prejudice, everything that Justin said was correct, but I would also add that the fear of prejudice is probably one of the barriers that we come up against. I have two examples of that. One is around the sexual orientation monitoring data standard. When that was announced and released, the NHS did not come out ahead of that. It did not make any kind of commitment at a senior level to speak to it, which resulted in my colleagues who had been working on it taking the full brunt of having to explain it. No work was done by the NHS either with the media or with the doctors who were going to have to implement it, or might have to implement it, to talk about what that would mean. I think that was because there was this fear of people not wanting to ask the questions or not knowing how to ask the questions, but instead of getting out ahead of that, it was stepped back from.

Another example is that I am on the NHS England specialised commissioning gender identity programme board, and we are having a lot of difficulty at the moment getting any comms out, because there is a big fear that if any comms about the work that is being done go out into the press, or even somewhere the press could pick it up, there will be some kind of backlash.

Q178 **Chair:** Fear from whom?

Harri Weeks: Fear within NHS England’s comms teams that, if information is put out about the work that is being done, the growing anti-trans sentiment in the country will mean that there will be a pushback against the work that is being done within the system.

Chair: That is really helpful. It is really useful to get that insight from you; it is a really helpful basis for our next panel of witnesses. Thank you for your frankness; it really is helpful.

Examination of Witnesses

Witnesses: Clare Perkins, Dr Michael Brady and John Stewart.

Q179 **Chair:** Thank you very much. We will have a series of questions for panel members, as we had for the previous panel. Perhaps before we start I could ask each individual to introduce themselves and say which organisation they are from.

Clare Perkins: My name is Clare Perkins, and I am from Public Health England.

Dr Brady: My name is Michael Brady, and I am the national adviser for LGBT health at NHS England.

John Stewart: I am John Stewart, director of specialised commissioning at NHS England.

Q180 **Chair:** Dr Brady, just before we start, as an adviser on these issues, you are employed by the NHS.

Dr Brady: I am employed by the NHS. I am employed by NHS England. My role is funded by the Government Equalities Office, though.

Q181 **Chair:** Is it a full-time job?

Dr Brady: It is a part-time job. I do the role two and a bit days a week, just over 20 hours a week, so I am part-time, but I have a team—a full-time programme manager for the role and a full-time business manager and personal assistant.

Q182 **Chair:** But you advise into Government. You are not responsible for policies being implemented.

Dr Brady: That is right.

Q183 **Tonia Antoniazzi:** The LGBT Action Plan has made explicit commitments to NHS England but none for Public Health England. Is Public Health England irrelevant in reducing health inequalities in LGBT communities?

John Stewart: No, clearly not. The whole NHS system, all arm's-length bodies, Clinical Commissioning Groups and NHS providers have a vitally important role to play in addressing these issues. Public Health England clearly has a vital role in supporting work around helping to understand, through data, the health inequalities that exist, particularly in this area. I am sure Clare will be able to confirm the commitment that Public Health England has to this agenda.

Dr Brady: I agree with that, and I my role, as an advisory one, is very much externally looking as well as internally looking. It is not just advising on NHS policies. To get any real traction on the priorities for my role, it will be essential to work very closely with bodies like PHE and other external stakeholders to fulfil the brief. PHE has a very important role, too.

Clare Perkins: I understand there was lots of discussion as the action plan was being developed, between GEO and Public Health England, as to which aspects PHE might be responsible for. As the final focus was on healthcare services, it was felt more appropriate that the 12 healthcare commitments were assigned to the Department of Health and Social Care. Saying that, though, as an agency of the Department of Health and

Social Care, we continue to actively support delivery of those commitments, specifically in relation to mental health and all the work we are doing on suicide prevention, which I can talk about today, if that is helpful, and around sexual health, reproductive health and HIV. In those two particular areas, we are really actively supporting the work.

Q184 **Tonia Antoniazzi:** Clare, Public Health England has published many reports and guides that then just gather dust. What are you doing to make sure that best practice on LGBT inclusion is disseminated effectively?

Clare Perkins: It is a tricky issue, in terms of how you get your publications to the right people and make sure that you have an impact. I am absolutely committed, for anything that comes out from my team, that we have an impact on decision-making and, ultimately, on outcomes. We have some standard processes we use for communicating and disseminating our publications. We have a publication standards process in PHE that has some principles around this. There are lots of routes to publication. We are restricted in publishing our outputs on Gov.uk, although we do publish them on the knowledge hub for local government as well.

There are various mechanisms: weekly emails to local government, to our PHE centres; we do webinars; we do all sorts of things around communicating and disseminating. One of the key things we are moving to, which is critical and something that I know Harri raised earlier, is that it is absolutely essential for these publications to be co-produced. If we involve our partners, stakeholders and community groups really early on in the process, there is much more ownership and help in disseminating that and working with us to make sure we have an impact.

Q185 **Tonia Antoniazzi:** Do you think there is anything more specifically that you could be doing or working towards? If you are working with the other agencies, what specifically could you be doing to move forward?

Clare Perkins: There are always things we could be doing more on, and we would certainly welcome your advice if you think there are areas we could be doing more on. I will give you an example I am really proud of. We are going to be producing, very shortly, a reproductive health action plan. From the very beginning that plan has been developed and co-produced through the Health and Wellbeing Alliance, the LGB&T Partnership and others. That is where we are going to focus, actually: on that co-production, and really making sure that all the stakeholders and partners that are relevant for that particular publication come together and we do it together.

Q186 **Tonia Antoniazzi:** What are the most important improvements for healthcare for LGBT communities that have come about as a result of your work?

Clare Perkins: Probably I would highlight the work we have done on sexual health, reproductive health and HIV. We have been really active in reducing HIV transmissions, and partly because of our work we now have this ambition to get to zero transmissions by 2030. Currently we fund an HIV prevention programme. We fund an HIV innovation fund. We have a whole range of things that we are doing in order to particularly focus on the inequalities around sexual and reproductive health and HIV.

We know that for some sexually transmitted infections, there is a really good news story. We still have a lot to do, particularly on gonorrhoea and syphilis, but we have just produced a syphilis action plan. Yes, we are proud of the work and the improvements we have made around HIV.

Q187 **Chair:** We have had quite a lot of evidence given to us that, too often, the healthcare profession pigeonholes LGBT health issues into mental health or sexual health, and possibly by giving that example of the work that you have done you have reinforced that perception. We have also heard a great deal of evidence to suggest that people who are LGBT are also more likely to have other health conditions that are possibly even more serious than that, because of potential alcohol consumption or other health-related issues. On what evidence do you base your work? Is there evidence of prevalence of a particular condition? Why would you choose sexual health, when we have heard there are many other health conditions that affect LGBT people more profoundly?

Clare Perkins: That is just one issue.

Q188 **Chair:** It is the one you chose to share.

Clare Perkins: It is the one I chose to share, and one that we have done a lot of work on, but it is not to say we are not doing a lot of work on lots of other areas as well.

Q189 **Chair:** What other things are you doing work on?

Clare Perkins: We base our work on evidence. Primarily we use the public health outcomes framework; it is our main measurement tool around understanding the health inequalities and the needs of the population. We go through a process internally of defining our priorities, based on where we think, in Public Health England, we can make the most impact. Another example might be smoking. We know that the prevalence of smoking, particularly among lesbian and bisexual women, is much higher than the England average, so we have been doing work to focus smoking cessation services particularly on those groups.

Q190 **Chair:** How does that work in practice? How do you make sure you focus on those groups?

Clare Perkins: For the services that local government commission—that is around alcohol, drugs, and tobacco, as well as sexual health services and others—we work with local government to produce commissioning guidance, where we specifically include the needs of all people with protected characteristics.

Another example I could give is around suicide prevention. It is fantastic that every local authority in the country now has a suicide action plan. The national strategy specifically mentions the needs of LGBT people. We have commissioned the University of Exeter, together with the Samaritans, to do an external quality assurance of those plans, and there is mention of prioritising LGBT health within some of the plans, though not as much as we would like; we will be working with local government, through their sector-led improvement programmes, to challenge and encourage more to be done in that area.

Q191 **Tonia Antoniazzi:** I would like to extend the question. I will ask it again to Michael and John. What are the most important improvements to healthcare for LGBT communities that have come about as a result of your work?

Dr Brady: I probably need to acknowledge that I have only been in this post for three months, and my team have only been in post for two months, so I would probably answer that by saying that I have not yet had the opportunity, personally, in this new role to give you evidence of positive change.

Tonia Antoniazzi: What are you working on?

Dr Brady: Our work is very much built around the health commitments in the LGBT Action Plan. In that sense, it is a good example of how NHS England and the Government Equalities Office are working very closely together. Our plan for the year, for the first year hopefully, is focused around those commitments, with four key priorities, which will link into topics that have already come up this morning and in your previous inquiries. Internally, within NHS England, a key focus of our work is aligning the LGBT health inequalities to the health inequalities work that is happening as part of the long-term plan, particularly with the recently published implementation framework for the long-term plan. It feels very timely that this role has started now, when all the work is going on in local systems to ensure that health inequalities, in the broadest sense, and now LGBT health inequalities specifically, are built into those local plans.

There is also a lot of work going on that we are engaging with internally around specific specialist areas. For example: mental health, as we have mentioned; children and young people; the work going on around personalised care; the work going on around ageing; and the work going on around primary care. We have a real opportunity, with my role, to plug the LGBT-specific needs into the broader work of NHS England. That is one key priority.

My second key priority is around education and training. This has been talked about a lot, so I will not go into too much detail or repeat, because I agree with everything, pretty much, that the previous speakers have said. We need to describe what is good in terms of education, and we need to embed it in every level of training, from undergraduate medical students, nursing students and other allied healthcare provider professionals in training to postgraduates, so that we have enough resources for induction, for mandatory training, that can be either generic or relatively easy access, such as e-learning, or more bespoke and more detailed face-to-face training. Training is the second key priority. The third one is about data collection.

Q192 **Tonia Antoniazzi:** Sorry. Just to go back to training, you talked about e-learning. How are you going to get that out to people?

Dr Brady: The first thing is that we need to create it. As Dr Varney said, it does not exist on e-learning for health. A key focus for me will be to engage with Health Education England and those that run e-learning for health to get some standard, simple LGBT health and equality modules on e-learning for health that everybody in the NHS can access for free, albeit that it is relatively basic foundation training.

Q193 **Tonia Antoniazzi:** How long does it take to turn around something like that?

Dr Brady: I do not know.

Tonia Antoniazzi: Having been a teacher, I know how complicated systems are, in terms of putting things in place.

Dr Brady: The honest answer is that I do not know. I can try to find out and answer that for you later. I have not been involved in creating an e-learning for health module, but it is a priority, because it is a well-respected and great resource. There is some e-learning for health around sexual orientation monitoring, but we need a module that addresses the broader issues of health inequalities.

The other thing is that my team are involved in work, along with the Government Equalities Office and the RCGP, to develop what I hope will be really useful e-learning, specifically for general practitioners. That will be open access, so there will be modules that other healthcare professionals can use. There are many components to the training; there is a lot that we can do on that. A lot of that will require partnership working. I have started to build those relationships already.

Q194 **Chair:** You were going on to data. I was interested.

Dr Brady: Data is so important. If you do not count people, they do not count. If we do not measure inequalities, we do not know either if they are there—we are pretty sure that they are there—or to what extent they are there, and we also cannot measure the impact of the interventions that we use to make a difference. Data monitoring is really key, as we have said. We have the sexual orientation monitoring information standard, and I have committed to a key priority, in the next six to 12 months, to work to embed that and roll it out to settings where it has not currently been rolled out, and to start the work to develop and define what gender identity or trans-status monitoring would look like as well.

That exists and is actually happening in some places, but we need to have an agreed standard, similar to sexual orientation, for gender identity and trans-status monitoring. I have been reasonably pleased, in the digging around I have done in my first few months in role, to find that sexual orientation monitoring is happening in more places than I thought it was. We have it in many national surveys and data sets; we have it in a number of clinical settings, through the really great work that the LGBT Foundation is doing with their Pride in Practice in Manchester, and now in other parts of the country. There are many GP surgeries that are doing it.

We can learn from those, and from the pilots that NHS England did, and pull together the quick and easy "how to": first, on why it is important—for me, there is an element around hearts and minds, making the case for why it is needed—and secondly, on supporting any of those practical things around implementation. How have those that have implemented it done it relatively easily? What leadership was required? What were the technical adjustments to their IT systems? It feels like we are getting closer and closer to making that much more sustained and widespread, and that will make a really big difference in terms of understanding inequalities around sexual orientation, but then we need to do the work around gender identity and trans status.

Q195 **Angela Crawley:** I appreciate you have been in the job for three months so, fast-forwarding a wee bit, in five years' time what improvements in LGBT health and social care should we expect to see as a result of your work? No pressure.

Dr Brady: It would be great to be here in five years' time. I am currently funded until the end of March 2020, and I hope that will continue. In five years' time, if my team, our partners and I have done what we have been asked to do, we will have seen a significant difference—it may be too ambitious to say an eradication, but a significant difference—in the health inequalities experienced by LGBT individuals, and also in the experience. We need to give equal focus to the clinical and mental health, physical and mental health, outcomes as to the experience; it is not just, "Are you going to smoke less, have less mental health or less chance of getting a sexually transmitted infection?" It is, "Will your experience of going to the GP or A&E, going for an operation or going to your cancer specialist be the same as those who are from the non-LGBT community?"

Experience will feel very different, and we have systems, processes and surveys in place already to monitor that. It will also need to be a key priority of those who are responsible for developing and agreeing their local system plans to have service user-related outcomes built into their key performance indicators, so that we can measure experience. Experience will be better, and outcomes will be better. We will have across-the-board monitoring for sexual orientation and gender identity or trans status that is acceptable to those to whom the question is being asked and useful to those who need that data to inform their system plans or their service delivery.

One of the things that struck me, which I am keen to focus on, is that even where we are collecting data in quite a systematic way or in a large-scale way, we are not quite as good at sharing and disseminating that and making it maximally accessible in a way that is really meaningful, perhaps, at a local level. That does not feel like a massive thing to do: to make the data sets that we have into something that is a little bit more usable. That will be really important.

In five years we will have established really useful, meaningful and impactful training programmes at every level. The other thing that is really important, which is the fourth priority for me in my first year, is about pulling together and developing the evidence base. There is a lot that we know about LGBT health inequalities, but there is also a lot that we do not know. There is a lot of data that is sitting in different places. I completely agree with what Harri Weeks said in the previous session. We need to look at evidence in its broadest sense; it does not have to be huge randomised controlled trials that are published in important peer-reviewed journals to tell us something and to inform a change in our service delivery. Surveys are important, and more grey literature is important. The data that comes from the LGBT community and community organisations who are right at the frontline in dealing with the affected communities is really powerful as well.

It is going to be really important for us to understand what data we have now, to use that to inform the gaps, and to encourage whoever it might be—whether they are academics or academic funders—to support the community or the NHS to fill those gaps. For me, it feels like we need to, first, pull together what we have now so we can use that to inform commissioning, service delivery and educational training plans, and then have a clear direction of travel for where we are going to go in terms of meeting the evidence base gaps.

Q196 **Angela Crawley:** It sound like you are quite confident, then, that your measures and the advice you provide will be taken seriously and that long-term improvements will be achieved. John, let me ask you: NHS England assesses funding levels for CCGs based on the joint strategic needs assessment and the existing data, but very few of the CCGs specifically address LGBT issues in their commissioning, and LGBT people are rarely mentioned in the joint strategic needs assessment. How will this be resolved?

John Stewart: The joint strategic needs assessment is absolutely the place at local level where health systems and local authorities really need to understand the needs of their local communities, whether that is the needs of LGBT communities or other groups with protected characteristics. The data piece is really important to helping them understand that, and the work we are doing, which Michael is going to be supporting us on, will make a difference. Getting that right at that level is critical.

Above that level, we are now, as part of the long-term plan implementation framework, asking whole systems to develop five-year strategic plans. We have been absolutely explicit with them that those plans need to detail how they are going to really tackle health inequalities and issues facing communities like LGBT groups. That is a real focus, both at a local CCG level and at the system level, of the plans people are developing. That has been a very explicit focus in the LTP framework.

The other thing I would say, though, is that Michael and I have a real opportunity to work very closely together now. One of the things about NHS England is that we are a direct commissioner of a significant number of services. I look after specialised commissioning. It is about 150 services. They range in nature from really quite common areas through to ultra-rare conditions. I am also responsible for overseeing health services within the criminal justice system. What that gives us is a slightly more direct and immediate route into trying to tackle these issues, in terms of the formulation of our national clinical policies and the development of our service specifications.

What I am trying to say is that we have a real opportunity in NHS England to lead the way and show the system how this can be done well. We have made some really important progress in areas of work around gender identity where we are looking to improve both access to those services and the quality. I am delighted that Harri has been involved in our gender programme board, helping to oversee the development of our new service specifications.

There is an opportunity to go much further in the services we commission. Only last year we were developing new guidance for adult secure service providers.

Chair: Can we keep the answers a bit shorter? Sorry. We have quite a lot to get through.

John Stewart: Of course.

Chair: It sounds a bit bossy. Could we move on to the next question?

Q197 **Angela Crawley:** This is the last question from me. Are health and wellbeing boards that are not including LGBT needs in their joint strategic needs assessments in breach of the Equality Act?

John Stewart: It is clear that all public bodies have a duty under the public sector equality duty to have due regard and to consider the health needs of all groups with protected characteristics. It is difficult to answer that question specifically without seeing individual health and wellbeing board plans. What is absolutely clear is there is a legal requirement on public bodies to consider those so we would expect that to be factored into all these plans.

Q198 **Chair:** You said "expect." The question was, "Would it be in breach of the Equality Act?" That is not giving us an answer. Sorry. Saying that you would expect it to be incorporated is not the same as, "Is it a breach of the Equality Act if it is not incorporated?" Sorry to be pointed on this. Is it a breach of the Equality Act—yes or no?

John Stewart: Without seeing specific cases, it is difficult for me.

Q199 **Chair:** It is not. If we are not including LGBT needs in a joint strategic needs assessment, would that be in breach of the Equality Act?

John Stewart: It is absolutely clear that they need to be incorporating and assessing the needs of all groups with protected characteristics.

Q200 **Chair:** So it would be a breach of the Equality Act?

John Stewart: Potentially it could be, but we need to see examples.

Q201 **Chair:** Of course; it is a case-by-case basis.

John Stewart: Absolutely.

Q202 **Chair:** Sexual orientation monitoring was agreed by NHS England in 2017 but very few health services actually did anything about that. Should the new monitoring standard that we have been talking about be made compulsory? If it is not, why not?

Dr Brady: Without being repetitive, it has been brought in in more places than certainly I thought. I will not go through a list, but I can send that to you afterwards. It is being asked in many more places than I thought, in clinical settings, primary care and secondary care, and as part of national surveys.

Q203 **Chair:** We have already heard that the inconsistencies mean that it is potentially a breach of the Equality Act because people would not then be able to provide services based on the actual needs.

Dr Brady: Absolutely. I have stated that it is essential that we are asking these questions in every setting to understand the experience and the inequalities. I am at the stage where I am working out what the best levers are. Do we need to mandate it? I am not sure that I would say yes at this stage. What I would say is that my first approach to this is to let me understand where it is happening and how it is happening. From my initial discussions around this, it really seems that those places that have implemented it have implemented it on the basis of existing knowledge about health inequalities. That is why, for example, cancer services or mental health services are doing it perhaps more than other settings.

The argument I would add to that is about the public sector equality duty and the requirements to have due regard to protected characteristics and to ensure that inequalities do not exist. My argument would be that, first, if you know that there might be or that there are health inequalities, you need to ask that question; secondly, how can you meet your duties under the public sector equality duty without asking that question? My sense is that that approach is how those services or those data sets have implemented it relatively easily. There have not been any catastrophes in any of the places I have seen that have started asking the question.

Q204 **Chair:** Can I move my question to John? If this is not made compulsory, going back to the question about the public sector equality duty, do you not, as the director of specialised commissioning, worry that you might not have the data available to ensure that you are working and operating within the law?

John Stewart: Absolutely. This is a really important development in making sure that both policy makers and commissioners can better understand the needs of communities in developing those services. We want to see this rolled out widely, used and embraced. I am particularly interested in Michael's view, when he has had a chance to get his feet a bit more under the table, around what the next steps in the implementation of that might be, and whether there is a strong case for making it mandatory or not.

Q205 **Chair:** Are you not worried that your service will not be within the law because you do not have the data? Going back to our earlier evidence, you are not counting.

John Stewart: Counting is absolutely clear. Yes, it is vitally important to make sure that we can fully discharge our public sector equality duties and that we have the best available data to do that.

Q206 **Chair:** Michael said a few moments ago something that I was not aware of: your contract is only until March 2020, which in my estimation is nine months. I know you can have a baby in nine months but what you are outlining was probably more than even that. It was quite a considerable body of work. John, how are you going to make sure that enthusiasm, energy and commitment is taken forward if Michael only has a nine-month contract?

John Stewart: We are all hoping that Michael will be able to stay beyond that. Michael, I think I am right in saying that your post is currently funded by the Government Equalities Office, but you are obviously sitting within NHS England. Michael's work is obviously not just nine months of work and then we leave it there. I am very hopeful that Michael will continue in this role beyond that and will be working right across teams in NHS England and the system to embed the thinking that is needed in this area.

Dr Brady: Yes, the funding arrangement, as John has said, means that my funding is part of the current Spending Review, which is why it finishes at the end of March 2020, because it is Government funding. It is not that somebody has thought that this is a job just for one year. We will be making a case, or I will be doing everything I can to support a case, to get funding as part of the next Spending Review. That is why it is a year; it is not that anybody thought that this was only a year.

The other thing that is worth pointing out is that because of that, whilst I hope and expect that this job and role will continue much longer, not just for me personally but because the need is so great and there are years' worth of work in this, we are working as if, worst-case scenario, we only exist until March 2020, which is why I have picked priorities that I am confident we can deliver in the first year.

We are also focusing on embedding and sustaining. You have heard from Justin Varney that there are lots of tombstones—maybe "tombstones" is a bit unfair—or lots of things that are still gathering dust that have not become sustainable in the system. Alongside the things that I intend to achieve in the first year, I want to build the foundation for sustainability. A good example is what I mentioned before about the implementation framework, which is a really important lever within the NHS so that, should my team and I disappear at the end of March, hopefully some things will continue or there is more for other people to pick up.

Q207 **Chair:** How long do you think it will take to roll out the sexual orientation monitoring standard?

Dr Brady: I would like to see that maximally rolled out by the end of my first year.

Q208 **Chair:** Which is when?

Dr Brady: March 2020, so by April 2020 or very close to that. That is one of my "quick fixes".

Q209 **Angela Crawley:** Part of your work is about co-ordinating across the LGBT community and making sure they are represented within this body of work. Rather than reinventing the wheel, part of that is about ensuring that the methods of communication are sustainable. What is the current status of the NHS England Equality and Diversity Council in that regard? As far as I understand it, that website has not been updated for two years. How do you bring them back into that conversation?

Dr Brady: I am going to have to claim "new boy" on that. I have a very long list of things, people, groups and organisations to meet with. I have not put any major focus on to that. I am happy to submit a written answer to that question having had an opportunity to give it a little bit more thought, to be honest with you.

Q210 **Angela Crawley:** I will leave you to look into that, then. How are you working with CCGs and the foundation trusts to ensure that they are all equally LGBT-inclusive and that no health service falls through the cracks?

Dr Brady: Some of that will be related to previous discussions around data. We have monitoring rolled out. That is the first start. The main way initially that we have the opportunity to influence what happens in local CCGs and local foundation trusts is through the implementation framework, through the work that is going on in terms of the local systems plans and through the really strong focus on health inequalities and LGBT health inequalities. I will not go back on that because we have covered that, but I do believe that the work that is going to go on over the next six months before those plans are agreed is a real opportunity to make that influence. The other thing that I want to focus on—

Q211 **Angela Crawley:** I will stop you there because we have lots to get through, and I know you might want to say lots more on it because you are very enthusiastic, which is not a bad thing. How are NHS England and Public Health England working with the third sector to understand what is going on in those communities? I appreciate the point you have just made, so we will try to move on from that to how that understanding is being translated into improvements in health services beyond the framework we have just discussed.

Dr Brady: It is through an absolute commitment from myself—I have worked in the voluntary sector, as well as in the NHS—to make the voluntary and community sector absolutely equal partners and front and centre in the work that we do. Engaging with, communicating with and co-producing with the sector is absolutely essential and will be a real priority of what we do. How are we doing it so far? We are already working closely with Harri and the LGB&T Partnership. Harri and my team meet regularly. That is something that we will continue. We are hoping to work on some specific projects.

Q212 **Chair:** You are an adviser. John is the commissioner. How is it affecting commissioning today? It is very good that it is affecting you as an adviser in your role, but I think we are really interested in how it is affecting the commissioning of the services, not just Michael's role as an adviser.

John Stewart: Building on the point I was making earlier, this is where NHS England really does have an opportunity through the direct commissioning responsibilities that we have. Specialised commissioning in areas of personal health—

Q213 **Chair:** How is it improving the work you are doing already with third-sector organisations? How is that actually improving commissioning today? Give us some examples.

John Stewart: The work we are doing around developing our gender identity services has absolutely been informed by really extensive engagement with people with lived experience, as I mentioned earlier. Harri sits on our gender programme board alongside four other members with lived experience. We are working with voluntary sector groups as we develop our service specifications and as we develop clinical policies. We need to look at how we build that in across the full range of specialised services that I look after. As I said, there are 150. In the areas of mental health and in health and justice services, we have done a lot of work with groups to try to make sure that the needs of LGBT communities are factored in. I would be very happy to write to the Committee to set out a full range of areas where that has made a really demonstrable impact.

Q214 **Chair:** I think, John, that we need to know how that filters down to all NHS services. Throughout this discussion we keep coming back to sexual health as being the default, or trans services, but what we have heard in all of our evidence is that this is important for all aspects of LGBT health, not simply those that are perhaps the default mental health services.

John Stewart: I absolutely agree with that.

Q215 **Chair:** But you are not giving me examples.

John Stewart: It is difficult for me to give you precise examples of where, at a local level, health communities have built those needs into their plans. What we have asked, and Michael has made it very clear, is that now we have our systems developed, in terms of their long-term implementation plans and their strategies, there is an explicit requirement for those plans to demonstrate how they are going to tackle issues around health inequalities and LGBT issues.

To quote from that, it says, "System plans should demonstrate the key areas of inequality they will tackle and how additional funding is targeted, for example actions that will address the health inequalities experienced by disadvantaged or vulnerable groups, such as people with disabilities, LGBT+, BME communities". We are expecting, in those system-wide plans, to begin to see evidence of how that is being taken forward. We are due to get first cuts of those plans back at the end of September, and we will be reviewing them before those plans are finalised towards the end of this year.

Q216 **Angela Crawley:** You mentioned earlier the importance of the voluntary sector in your work for NHS. LGBT-specific services are currently offered by some volunteer organisations, although this tends to be in areas where there are many LGBT people. Specifically what I am asking is whether there should there be LGBT-specific services. If so, should they be funded, and how should they be funded?

Dr Brady: Do you mean services in the broadest possible sense?

Angela Crawley: Yes.

Dr Brady: Services in the broadest possible sense should be LGBT-inclusive and acceptable, full stop. Whatever kind of service you go to, it should be accessible and inclusive for you. That is the first thing. I do not see a case for LGBT cardiology services or LGBT physio services necessarily. All services need to have this on their agenda. You can see some areas where LGBT-specific services do have value. There is this balance between the place we are at the moment, where expectation of experience is poor for LGBT individuals and experience is poor for LGBT individuals, and the situation we want to get to. For some areas, you could make a case for specific services that bridge from one place to the next. If it is going to take five years or even longer to make things truly inclusive, I do not want LGBT individuals to keep suffering for those five years until things get better.

You could look at things like mental health services, for example, particularly maybe around children and young people. In terms of sexual health services, we have talked before about the relative invisibility of lesbian and gay women in sexual health services, yet bisexual women particularly—women who have sex with both women and men—have much higher rates of unplanned pregnancy or chlamydia. That is something that people do not really shout about. You could make a case, in the short term, for a bisexual or lesbian and gay women-specific approach to unplanned pregnancy, teenage pregnancy or chlamydia screening. There are pockets where we could see specificity of service.

When you look at the services that are provided, talking in the broadest sense, by the third sector in the community, they clearly have real value in that they are right at the front-face, connecting to the communities they serve and should be focused on those communities; they are therefore specific to those. You think of some things like counselling support services, advice services and maybe drug and alcohol services. If we talk about the range, we should think about services provided by the NHS, social care and the third sector as the same. There are some areas where there is a real value and we have real evidence of real benefits of LGBT-specific services. Generally, we need to be fighting to make sure that everything is inclusive for LGBT individuals.

Q217 **Tonia Antoniazzi:** The NHS long-term plan implementation framework has recently been published. What part of the framework do you feel would most benefit LGBT people, and why?

Clare Perkins: I would hope the equality impact assessments that are going to be required on all the ICS full plans, which are due out in November, will highlight inequalities and address those as part of the implementation of the NHS plan. That is certainly a key part of the implementation, which will benefit LGBT people.

John Stewart: It is worth saying that the long-term plan implementation framework is absolutely clear that we expect to see measurable reductions in health inequalities experienced by different populations, whether that is in terms of access, experience or outcomes.

As a condition of receiving long-term plan funding, all our major national programmes and every local area across England will be required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five years. That is a really important systemic requirement across both national planning and system-wide planning at a regional level.

Dr Brady: I do not have much to add to that. John has gone into real detail about what the real levers and the importance of the implementation framework is.

I would add two things. I think it is the right approach that this is a centrally co-ordinated and centrally supported service that gives real power to local areas, with that importance of really understanding the needs of your local population. How things are implemented should ultimately be locally determined with the right data and so on and so forth, as we have touched on before.

The other thing that is a key part of certainly the first phase of that implementation plan is NHS England's ability to support the development of those plans through the production of evidence-based interventions, which is a piece of work that is happening at the moment. We have certainly already been able to feed in some LGBT specific evidence-based interventions that local systems can use. It is the beginning of that sharing good practice thing. There is support for local systems and strategic plan development over the next few months.

John Stewart: To add on that, my understanding is that systems will be able to draw on Public Health England's place-based approaches to reducing health inequalities. The menu of evidence-based interventions that Michael was talking about for reducing health inequalities is due to be published in the summer. That will help local systems develop those plans.

Q218 **Tonia Antoniazzi:** We have heard a lot of evidence that one of the major challenges that LGBT people face is a fear of discrimination from NHS services. Do you genuinely think that this implementation framework will address the issue, and how?

Dr Brady: That fear is real, as I said before. That experience is real. It is not just the perception; it is the experience of many LGBT individuals as well. I am not suggesting that the framework is the only answer to that. The system approach to reducing inequalities has to be the infrastructure within which we all work and has to be the top-down or certainly the regional top-down approach to addressing those.

There are other things that are very much part of what I see as my work, or my work with others, that will plug into improving that experience. The training thing is absolutely key. The other thing that is really important, and which we have started to have some initial discussions around, is that a lot of my thinking has been internal; it has been about healthcare professionals, the system, primary care, NHS England and the Royal Colleges or whatever. That is key but I would like also to keep a focus on the individuals. It is not just about ensuring that the voice of the community and the community organisations is central to this.

I would really like to work with the communities to develop something that empowers the individuals to get the best service that they want. It is not their responsibility to deliver it, but I am not quite sure that everybody yet knows what they should be able to expect, in terms of what good care looks like and how you complain effectively about it when it does not happen. I am keen to start some discussions. We had a brief discussion about this last week with Harri. Something that starts from the service user's point of view, which complements what we are doing from the service provider’s point of view, would be really powerful.

Q219 **Chair:** Can I ask one final question? This is really for Clare and John. A lot of people will be shocked to have heard what we were told in our previous session by Dr Varney, that we have a long way to go for the NHS to be an inclusive service. For many people, they will feel quite shocked at hearing that, because people feel that our NHS is an inclusive service. How are you going to address that, Clare?

Clare Perkins: Obviously we do not directly provide services, although we do work with local government, which does provide services. Let me give you an example around screening. We have done a lot of work with lesbian and bisexual women and with the trans community on making it a really inclusive service that has really good access. We have gone through all our leaflets and booklets to remove any gender-specific references. We have produced leaflets, particularly around cervical screening, breast screening and bowel screening for particular communities. Our cancer screening campaign, Saving Lives, which was earlier this year, had a focus on LGBT and features same-sex couples. We really are trying, through our screening services, to make them really inclusive.

Q220 **Chair:** John, you commission specialist services, so you must be particularly stung by the comment that says that the NHS is not inclusive, given that you are director of specialised commissioning.

John Stewart: I have absolutely no doubt that there are groups of patients who do not feel like the NHS is providing an inclusive service. There is clearly more work we need to do. This is about changing the culture, among both professionals and commissioners, right up to the top level. Absolutely, the situation is not perfect. It is incredibly welcome that we now have Michael to advise NHS England, myself and other parts of the system on what more we can do.

One of the other things that is worth highlighting, and perhaps we can send more detail to the Committee on this, is that we have recently published an interim NHS people plan that is really emphasising the importance of how we create, across a workforce that is over a million strong, the right culture and a culture that is inclusive for all different groups and communities that we are serving. I am very happy to send more detail on that.

Q221 **Chair:** Michael, it sounds like it is a jolly good thing that the GEO funded your position.

Dr Brady: It is a jolly good thing, and that the NHS has welcomed my position as well. That is the final thing I would like to say. I will not talk too much. I do feel that the time is right. The challenges are really great but what has been fantastic in the first two or three months is that I have been pushing at open doors. I have arrived in a situation where there is a lot to do but I have arrived in a situation where lots of people are already starting to do things. Those partnerships are working and hopefully we can get some movement.

Chair: Wonderful. Thank you very much for your time today. We are really appreciative of it. We know you are very busy people, so thank you for taking the time to speak to us. It is incredibly helpful.