

Women and Equalities Committee

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

Wednesday 17 July 2019

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

Questions 222–285

Witnesses

I: Rt Hon Matthew Hancock MP, Secretary of State for Health and Social Care; Baroness Williams of Trafford, Minister for Equalities, Government Equalities Office.

Written evidence from witnesses:

- [Department of Health and Social Care, Public Health England and NHS England](#)

Examination of witnesses

Witnesses: Rt Hon Matthew Hancock MP and Baroness Williams of Trafford.

Chair: Welcome to our witnesses and to those who are watching online or in the public gallery today. This is a final session of our inquiry into the health and social care in LGBT communities. Today we are hearing from our Ministers, Matt Hancock and Baroness Williams. Thank you, on behalf of the whole Committee, for taking the time to be with us. We know you have extremely busy diaries, but this has been an incredibly interesting inquiry for us, and we would welcome your feedback on some of the issues that have been raised.

We have the usual format. Colleagues are going to be asking questions on a number of issues. I know you have very tight diaries today, so we will try to keep to time as much as we are able to.

Q222 **Jess Phillips:** The action plan states, “We will ensure that LGBT people’s needs are at the heart of the National Health Service”. How are you measuring the success of this commitment?

Matthew Hancock: It is very important to me personally and to the NHS leadership that we tackle inequalities in access to healthcare. That includes inequalities that exist with the LGBT community. It is worth thinking about this in terms of the specific needs of the LGBT community, but also the broader health inequalities that there are between the community and the population as a whole. Specifically, we will be monitoring progress in two ways. The first is that we have published the action plan, and we are being held to account for delivering against that action plan, and this Select Committee is one example. The second is that, within the implementation of the long-term plan for the NHS, there is a specific set of goals for tackling health inequalities, including LGBT health inequalities.

Baroness Williams of Trafford: Should I make some broader points?

Jess Phillips: Yes, go for it.

Baroness Williams of Trafford: Delivering on the action plan is not purely a job for health in the round. It is cross-Government. We published an update on the action plan a few weeks ago—I think it was in Pride week—which I think you have a copy of.

Q223 **Jess Phillips:** In five years’ time, how will you know if the measures you have put in place will have made any difference to the health and wellbeing of LGBT people?

Matthew Hancock: There are a couple of examples. The implementation framework for the long-term plan is designed to hold the NHS to account for delivering against the goals within it. One of the goals within it is to



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reduce health inequalities, including for LGBT+ people. At the moment, we are doing the work to make sure that those goals are cascaded down from the national level to local health systems. Local health systems will be required to take action and report on that through a series of equality impact assessments.

Q224 Jess Phillips: They will be expected to report upwards through the chain, so that will be monitored centrally and then published.

Matthew Hancock: And then published. There are other ways, in terms of published data as well, that we can look. For instance, smoking rates are much higher amongst the LGBT+ population than the population as a whole. The latest figures are that for bisexual people, 26% of people smoke, and, for gay and lesbians, 23.9% of people smoke, compared to just over 14% for the population as a whole. That is one example. The point I am making is that there is broader population data.

Q225 Jess Phillips: In that example, what would you be doing about it, so that, in five years' time, it is 14%?

Matthew Hancock: I hope it is below 14% for all groups. First, by monitoring the gap, we know the level of inequality. Secondly, we have a whole series of measures aimed to tackle smoking across the board, including interventions at what are called teachable moments. If you go into hospital—and this is true across the whole population—we will be intervening to give people smoking cessation support. I call it support slightly euphemistically, because sometimes it is quite firm support.

Jess Phillips: I am an ex-smoker. I remember it.

Matthew Hancock: That is aimed at bringing down smoking rates across the board, and then we can monitor the additional impact. Also, we are working with ASH to have a national brief specifically on LGBT smoking.

Q226 Jess Phillips: There will be specialist—

Matthew Hancock: Yes, there is both general and specific.

Q227 Jess Phillips: Using that example, there will be specialist services targeted specifically at pinch-point groups, equality groups, that are not currently accessing the services, for whatever reason.

Matthew Hancock: Yes.

Q228 Jess Phillips: You will monitor that with data cascaded down and then up.

Matthew Hancock: And published, yes.

Baroness Williams of Trafford: Could I come in at this point? I mentioned that we had done an update to the action plan, which WEC has received. You will see there a third of the commitments have already been delivered, which I think is very good progress in quite a short time.



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Q229 **Jess Phillips:** Or that people put things into action plans that are low-hanging fruit, depending on which way you look at it.

Matthew Hancock: It is still progress.

Baroness Williams of Trafford: Suffice it to say that the Office for Tackling Injustices will gather and publish data. Also, the advisory board will have a real part to play in this, in holding the Government to account as to whether they are delivering in the timeframe we have set out for ourselves.

Q230 **Chair:** Matt, you mentioned smoking. Are there other examples of other performance indicators that you think are important?

Matthew Hancock: Yes. There is also a very big area of work that is needed around mental health inequalities. The prevalence of mental ill health is higher in the LGBT population. Around 17% of the general population met the criteria for common mental health disorders, and the 2018 national LGBT survey reported 24% of respondents had accessed mental health services in the preceding 12 months. Those two data points are not exactly comparable, because one is that they met the criteria. For the general population, that data point is meeting the criteria to have a common mental disorder. They will not all have accessed mental health services. 24% of LGBT people, according to the survey, actually accessed mental health services.

We are increasing the access to and funding of mental health services, which we are doing faster than increasing funding of the NHS overall. The improvement of access to mental health services will disproportionately help LGBT people on average, because there is a higher rate of access amongst the community, so that is another example.

Baroness Williams of Trafford: One of the groups that we are funding currently is Mind in the City.

Q231 **Jess Phillips:** The upgrade to the action plan does not mention any improvements to data collection on LGBT people in health services. Many of the witnesses who we have met have told us multiple times that robust data is crucial to improving the health of LGBT people. What are you doing to ensure that LGBT people are counted and can therefore have their needs taken into account?

Baroness Williams of Trafford: In terms of monitoring, as I have said before, the GEO is a Government-wide body. We will be expecting individual Departments to play their part in monitoring. I have talked about the Office for Tackling Injustices as well. The advisory panel will be doing its own monitoring, as the GEO will be doing itself.

Q232 **Jess Phillips:** I have no doubt that the GEO understands the importance of data-gathering in the equalities field. The gap always occurs with other Departments, so I would ask Mr Hancock what plans you have to properly, robustly monitor it in this area.



Matthew Hancock: I totally agree with you that you can only manage what you measure. NHS England is piloting a sexual orientation monitoring information standard, which is all about collecting the data in a way that is consistent across the NHS, so that we can collect the data better and publish more. The development of that standard is in progress at the moment, precisely to address some of the concerns that have been raised.

Q233 **Jess Phillips:** You are expecting that, potentially, once the pilot is done, to be rolled out, so that across the board in NHS England services, there is better monitoring of both sexuality and gender identity.

Matthew Hancock: Yes. There is probably more monitoring and published data in the NHS than in any other public service. The way it is done is that NHS Digital requires what data must be returned by all the different NHS institutions, hospitals, GP practices, et cetera. It does this by setting out a set of information standards to require the data to be collected in ways that are consistent, so that you can compare it. This new sexual orientation monitoring information standard will then allow us to have properly publishable datasets on these issues.

Jess Phillips: Specific health issues, yes.

Q234 **Chair:** Can I ask a supplementary on that? That is really welcome, but the research that we had and the submission that we had from the Brighton and Sussex Medical School set out very clearly that medical staff often do not recognise the importance of gathering this information, in terms of its importance for helping support LGBT groups. We can attempt to try to have better data-gathering, but, if we have not changed the attitudes of those who are gathering the data, you could still run into the problem of the data not being accurate.

Matthew Hancock: Yes. That is why we are bringing in these standards and piloting them at the moment to make sure that the standards are done right. Standards for consistent measurement of data are the basis on which people collect and report this data within the NHS. I am not surprised to hear local reporting of that, because it is not seen as vital unless there is a standard. That is why we are bringing in a standard. At the moment, some of this data is collected through five different data services, but standardising them all and bringing them all together in this new information standard will help.

Q235 **Sarah Champion:** I am troubled by this, Secretary of State. You have identified that mental health needs are often higher in the LGBT population. You have identified smoking. I would add into that self-harm and suicide attempts. They are all higher in the LGBT population. My concern is about whether you in the NHS and associated organisations are recognising the underlying holistic issues that the community face. I would say that these are all symptoms of not dealing with the societal, psychological and traumatic pressures on people. If you do not have the data, it seems you are just dealing with the outlying, rather than



addressing the underlying issues with people.

Matthew Hancock: I totally agree with the premise of your question. Having the data in a standardised format is incredibly important and that is good progress. It is in the very embodiment of the NHS that everybody is treated equally according to need. The ability to improve services where there is a higher prevalence among the LGBT population will inevitably be the main way we improve these inequalities. Clearly, access to mental health services is not good enough now, which is why we have put the increase in funding. There is a higher prevalence of mental ill health among the LGBT population, so it will disproportionately help them, but that is because it is there to support anybody who has a mental health problem. Does that make sense?

Sarah Champion: It does.

Matthew Hancock: Of course we have to get to the underlying social problems. Some of them are something that the NHS is responsible for. Other parts of it are much broader. Society's support for people to be who they are and love who they want to love is something the NHS, broadly, strongly supports, but it is not its first responsibility to deal with. They deal with the ill health of the person in front of them. Having said that, I do not want to play down the preventative measures that can be taken to get to the root of problems earlier. Where the NHS has a role to play, it must. The better we can measure that, the better we can deliver.

I wanted to bring one other thing in here as well. We now have a specific national adviser on LGBT.

Chair: We have met him.

Matthew Hancock: Yes. Part of his job will be to educate frontline staff and also focus on ensuring this information standard lands properly.

Q236 **Sarah Champion:** If my mum had died from breast cancer and my grandma had died from breast cancer, the NHS, at a very early stage, would start me on a regular programme of checks and just be calling me in because it is an indicator that there may well be an issue. Would it not be better, in terms of prevention, if people were actually asked at an early point about their sexual orientation? Then the support is automatically there, rather than waiting until they are presenting with a symptom. For some people, they could have been waiting years before that is identified.

Matthew Hancock: Yes. The move of the NHS away from focusing—not “only”; “only” is too strong—on a responsive approach to a preventative approach is at the core of the long-term plan and critical in this area, as right across the board. You mentioned breast cancer. That approach is what should happen, but also does not happen too often.

Q237 **Jess Phillips:** Specifically going back to the point you made about the adviser, who, as the Chair identified, we have met, currently the contract



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for the LGBT health adviser is only for a single year. What are your plans to ensure this post is funded in the longer term?

Matthew Hancock: I very much hope that the post will be funded in the long term. We are hoping to publish the MOU today.

Q238 **Jess Phillips:** You are the Secretary of State. You do not have to just hope. You are in charge of such hopes.

Matthew Hancock: Technically, it is subject to the spending review, which is why I cannot.

Jess Phillips: The spending review of the Treasury, yes.

Matthew Hancock: Obviously, within a £125 billion budget—

Jess Phillips: You have some flex.

Matthew Hancock: There is some flexibility. I fully expect this to be a permanent post.

Q239 **Jess Phillips:** Similarly, how will you ensure that the funding for the action plan is secured to the planned completion date of 2022?

Matthew Hancock: That funding will come from within the NHS settlement, which is agreed for the next five years.

Jess Phillips: So you are—

Matthew Hancock: Done.

Jess Phillips: Okay. I like it.

Matthew Hancock: The funding is available.

Jess Phillips: That was better than the “hope”. I like the “done”.

Q240 **Chair:** For clarity, will the adviser then become an employee of the NHS rather than not? At the moment, it is funded by the GEO.

Matthew Hancock: It is subject to the spending review because it is coming out of a different budget, as opposed to the NHS budget, which is settled.

Q241 **Chair:** What will happen in the future?

Matthew Hancock: Whether we settle it by having the employment through the NHS or through the spending review is of the second order. What matters is that the post stays.

Q242 **Jess Phillips:** Do you feel that specific post would be better integrated within the NHS? There is often a worry that the GEO—

Matthew Hancock: No, he is fully integrated.

Q243 **Jess Phillips:** The abortion fund is funded through the GEO, not through the NHS budget, and then it is not integrated within in the whole system.



Matthew Hancock: No, he is very much integrated with the NHS. I have talked to Simon Stevens about this. We think this is the most effective way for that post to operate. You could give responsibility to an individual—say, a director within the NHS—but then you would get a focus within that one area, whichever director it was, as opposed to having the focus across the board. I want to give you the reassurance that Michael Brady will be able to do his job for as long as is necessary. We will make it happen.

Q244 **Jess Phillips:** Good. We liked him. The LGBT action plan contains no current recommendations about social care. In the evidence from users, the issue of social care was the most heartbreaking, in terms of the discrimination, especially considering generational issues around LGBT people. What actions are you taking to improve social care provision for LGBT people?

Matthew Hancock: This is something where more needs to be done. Social care is clearly delivered in a different way, because it is delivered through local authorities. They have the primary contractual and quality responsibilities, so we have a different relationship with the social care system. Having said that, the CQC inspect social care settings. We have sent the CQC in to review the worst performers.

Q245 **Jess Phillips:** Is that specifically in this area?

Matthew Hancock: The specific areas where councils and providers can improve. I want to see much more focus on this area, and I think there is more to do.

Q246 **Jess Phillips:** The discrimination in social care that is happening is having a serious impact on people. In that sector, it turns out that there are no standard training or qualification schemes for anything, and certainly not for this. How can we ensure that care workers are providing appropriate care to LGBT people?

Matthew Hancock: The CQC has equality objectives that it inspects against. This is an important part of their equality objectives. That is the first thing. The second thing is, on the broader question of qualifications within social care, we have to make sure that the workforce is skilled up as much as possible. We are working with the Department for Education to look at how we can improve the qualifications that are available. Again, because we do not directly employ people in social care, it is not something where I can pull a lever directly.

Q247 **Jess Phillips:** It is unfortunately in your job title, though.

Matthew Hancock: That is not unfortunate. It is incredibly important.

Q248 **Jess Phillips:** No, of course, but it is unfortunate when it starts to go wrong. Unfortunately, in this area, like I say, we have heard upsetting evidence from users of the service that the buck does not seem to stop anywhere because of the commissioning frameworks and what seems like



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a lack of standards for receiving taxpayers' money to fund services that are simply currently not for everyone.

Matthew Hancock: I have seen some of that testimony, and I absolutely understand the problem. This is an area where more needs to be done. In terms of quality at a national level, the assurance we have on quality of social care provision is through the CQC, because we do not have the direct contractual relationship. You would have to get the LGA or local authorities individually, who are responsible for delivery of social care, to take this into account through the contractual relationship.

Q249 **Chair:** Can I just ask a supplementary on that? It is really heartening to hear that you feel more needs to be done in this area. Do you not share our concerns that, given the evidence we have seen, this should have already been picked up by those that have the responsibility for delivering the services? That is not least because LGBT communities are more likely to be dependent on the state for social care services, because they are more likely to be alienated from their families, to not have that support, less likely to have children who can provide that support and more likely to be socially isolated, for reasons of all the discrimination this group experiences.

Sitting here as somebody involved in the democratic process, I am really concerned that the NHS and local authorities have been so insensitive on this issue. I mean corporately insensitive on this issue. Do you not think that shows an underlying problem with the NHS and with local authorities, in terms of being able to pick up on equality issues? Do you not think that there is a much more fundamental problem here about their sensitivity to the needs of the people who they are trying to provide services to?

Matthew Hancock: Let me take the NHS first. In any organisation that employs 1.3 million people, there are always going to be examples of insensitivity, and I do not excuse any of them. However, corporately the NHS takes this very seriously. The fact that tackling health inequalities, including for LGBT people, is such a central part of delivering the long-term plan and the implementation framework means we have direct oversight of the need not only to tackle the health issues we have been discussing hitherto, but to make sure that there is a sensitive and fair system in place, so that people are treated with the dignity that they deserve. That is on the NHS side. There is always more to do, and in any large organisation, things are never perfect, but the NHS's heart is in the right place, and there are systems and processes in place to deal with problems. There is more to do on the NHS staff side as well, which we might come on to, if you look at the bullying and harassment figures.

Chair: We will come on to that shortly.

Matthew Hancock: Yes. Having said all that, social care is commissioned as a local authority service. The national responsibility we have is to ensure that it is inspected, including against equality



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standards. Without changing the entire 1948 settlement that social care is provided locally and the health service provided nationally, we cannot change that contractual obligation. We can ensure that the CQC does its job in its inspections. That is the area that falls to my responsibility.

Q250 Chair: Yes, but you can hold local authorities to account through the public sector equality duty. The evidence we have seen on this has been quite harrowing in its nature; it has been really, really concerning. You can hold local authorities to account through the public sector equality duty. Why are you not doing that?

Matthew Hancock: We do hold local authorities to account through the public sector equality duty. However, in this whole area on social care, there is much more to do. Some of the testimony in front of this Committee has demonstrated that.

Q251 Sarah Champion: I want to expand it beyond social care. Health provision is provided by local authorities in sexual health services and addiction services. How do you hold those to account? You are putting a lot of weight on CQC inspections. Also, how do you hold CQC to account?

Matthew Hancock: CQC is independent, of course, but I hold it to account by meeting its senior leadership regularly. It publishes a huge amount on what it does. The nature of its inspections is that it publishes. That is part of the impact it has.

More broadly, on sexual health services, they are increasingly co-commissioned between local authorities and the NHS. Although the formal responsibility for the provision of sexual health services was moved to local authorities alongside the responsibilities for provision of other public health services, as you know, five or so years ago, we have recently reviewed how that has been operating and found the places it operates best is where there is a co-commissioning between the local authority and the NHS. Therefore we do have a direct line.

Q252 Sarah Champion: A lot of them have actually gone to private providers, so how do you make sure they are spending your money with a view to LGBT?

Matthew Hancock: We have an outcomes framework that measures the—

Q253 Sarah Champion: It is actually a question to their data-capturing, to make sure they are equally offering services to everybody.

Matthew Hancock: Yes, absolutely. We have an outcomes framework and we publish against those outcomes. Whether the provider itself is an NHS provider or is an external provider, they are held to the same standards of accountability, absolutely.

Q254 Jess Phillips: As somebody who was part of one of the commissioning processes, as a commissioner, for the largest local authority in both substance misuse and sexual health, I have to say I did not feel ever that



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the framework of the contracts had equalities at its heart. I believe Birmingham is the only sexual health service, for example, that has specialisms for children who have been sexually exploited who come into the service. It has provisions for independent sexual violence advisers. That was only because I was one of the commissioners. What do we have in the commissioning framework that we pass down in public health and social care where there is any weighting where money matters less than making sure that the service is for everybody? As somebody who has sat through thousands of hours of commissioning meetings in public health contracting, it—

Matthew Hancock: When was that?

Q255 **Jess Phillips:** It was 2014. It went to a health service provider. The specific issue is that it is only because I happened to be in the room of the commissioning that domestic and sexual violence got to be included, for example. That is one of the major issues that leads women to substance misuse, and one of the major issues that would lead to young women going to sexual health services over and over again, with nobody ever asking them, “Why are you coming here, and do you need specialist support for sexual violence?”, for example. Only because I was in that room did that contract reflect that.

What is the NHS doing through this co-commissioning, whether it is of social care or of public health services that are much more likely to directly affect those with mental health issues and vulnerabilities, as we have discussed, to make sure that the weighting of the contract is not 50% or even, in most cases, 80% price over value and equality in the service? Had I not been in that room, women would have been forgotten from the substance misuse commissioning, for example.

Matthew Hancock: The ability of the system to learn from best practice like that is—

Jess Phillips: It is lovely when Birmingham local authority is considered to be best practice. That will be a first.

Matthew Hancock: I have not looked into that specific example, Jess, of the outcomes of the commissioning that you were involved in. Knowing you, I am sure it was brilliant.

Q256 **Jess Phillips:** Thanks, Matt. That is kind, but the point is I am not on every single council.

Matthew Hancock: No, but in a way that is what I was trying to say. You find good practice in council commissioning in lots of different areas. Part of the national role is to spread that best practice, both through Public Health England and through the outcomes framework against which people commission. It is always a challenge to work out at what level of detail you want to require the outcomes framework to be set. If you set an outcomes framework that is incredibly detailed, you do not leave local discretion to do exactly the sort of thing you were talking



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about. If you have it at too high a level, you end up with a postcode lottery. There is a challenge there. It is broadly in the right place, but there is currently a review of the outcomes framework to make sure we get it exactly right.

Q257 Jess Phillips: Are there specific equality standards in the outcomes framework?

Matthew Hancock: There are, but they do not go down to the level of detail that you just described.

Q258 Jess Phillips: No, I would not expect them to go down to the level of detail. In any outcomes framework for commissioning of social care or any other service, would you expect a weighting in a contract for ensuring that the service was for all of the equalities and their characteristics?

Matthew Hancock: Yes. You were specifically asking about sexual health services, where we have co-commissioning. For social care, by law that is a matter for local authorities, not a matter for me.

Q259 Jess Phillips: Talking about other localities, not one that I am from, of the five community organisations that have been funded by the GEO, none work within rural communities. We have heard that support is most needed in places where there is little infrastructure for improving LGBT health and social care. How is the GEO, and I suppose the NHS, with a broader remit, planning on dealing with that?

Baroness Williams of Trafford: You are absolutely right, Jess, that there are a number of areas in which there are gaps. Training for sensitivity for LGBT services is one. Broader delivery of services is another. That is why, in the next five years, we need to ensure that LGBT needs are not just an adjunct to everything else, but are integrated within health and social care generally. I am sure our national health adviser will be pushing that ahead.

Q260 Chair: We are going to move on to the next section, but I have to say that it feels that we have a lot of great ambition coming from the strategy but, when it comes to the actual practice on the ground, there is a big disconnect. It is heartening to hear that you have an understanding and appreciation of that, but my concern, and I think the concern of the Committee, would be about how we could have such an enormous organisation as the NHS, or indeed local government, with all the pressures on them from the CQC and all the pressures on them in terms of the public sector equality duty, and yet this is something that is still so sadly lacking in the way that services are being delivered on the ground. It is quite concerning, given the legal framework within which these organisations are operating.

Matthew Hancock: I would say that the road to equality is long and much of it is still to be travelled. The work you are doing in highlighting some of these problems helps. For instance, if you want speed of action, I



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have just been informed that the MOU for the LGBT adviser has now been published, since I promised it half an hour ago. More broadly, your point is right that we should be seeking to ensure that public services are delivered fairly and equally to all citizens according to need. That is the constitution of the NHS and it is the expectation within social care. There is still a long way to go.

Chair: Many people would find the evidence we have been given quite shocking, particularly when we move on to the next set of questions around the treatment of LGBT people within the NHS. That is in terms of being patients within hospitals and the discrimination they have suffered, really quite overtly in some cases. Let us move on to those questions from Tonia.

Q261 **Tonia Antoniazzi:** We have heard from witnesses that health providers say they treat everyone the same and see this as inclusive practice for LGBT people. What are the Government doing to tackle this misconception?

Matthew Hancock: Do you mean the misconception that it is not a good place to work?

Tonia Antoniazzi: Yes, and whether they are being treated the same.

Matthew Hancock: They ought to, and the practice is not yet good enough. I became Health Secretary just over a year ago. To tell you the honest truth, I was shocked at the outcomes of the NHS people survey, and in particular the bullying and harassment scores, and, within the bullying and harassment scores, the higher bullying and harassment reports among people who also reported being LGBT+. Given that the whole point of the NHS is to treat everybody equally, I thought this was shocking.

NHS England is ranked 113th out of 445 organisations in Stonewall's 2019 UK Workplace Equality Index. That is a rise of 61 places, just on a year previously, so the NHS is on that road but has a lot further to go. I have tried to change the way we approach workforce management within the NHS. Here, Baroness Dido Harding has done absolutely brilliant work. She is the chair of NHS Improvement and has recently published the NHS's first ever people plan.

In the past, the culture of the NHS was that—this is a broad generalisation but I think it is fair—you needed numbers of people. All workforce planning was about predicting how many people you would need in a few years' time and getting the training budgets lined up to deliver on that. Changing the mindset and attitude to match the best institutions within the NHS, and the best are absolutely brilliant, to treat the workforce, the people who work in the NHS, as its most important asset and value each one of them and have an attitude of respect, rather than hierarchy, is a huge culture change that is underway in the NHS, but there is a long way to go.



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The reason I describe all of that is that, for me, one of the bellwethers of success is treatment of people who are minorities, whether they are ethnic minority or LGBT+. If you have an organisation that values all of its staff, it will value all of the differences between its staff as well.

Q262 **Chair:** Can I just interject here? The idea of treating everybody the same and seeing that as being inclusive is actually not correct. We have to treat people in accordance with their needs, and different groups of people have different needs.

Matthew Hancock: Yes.

Q263 **Chair:** To be told that healthcare providers treat everybody the same and that that is their version of inclusivity completely misunderstands the fact that different groups of people will want to have the support tailored to their needs. That was the quite shocking evidence we had from witnesses. People who are coming into a hospital setting who are LGBT will want to have that recognised and supported, or if they are transgender, but to just say you treat everybody the same—

Matthew Hancock: Who said that?

Chair: Witnesses that we had before us.

Matthew Hancock: In the broader culture change I was describing, there was an attitude in too many places in the NHS. These are all generalisations. The NHS is thousands of organisations. Some are brilliant at this and others are not. I have been trying to move the general culture—and Simon Stevens and Dido Harding are brilliant on this as well—from being one of what I think of as a tractor production attitude, which is, “We need to get our numbers. These are the numbers”. I arrived and asked about workforce planning and was given these projections of numbers. I said, “What are we doing to motivate people? What are we doing to improve morale? What are we doing to tackle bullying and harassment?” Those are the areas we need to get on to. Getting the most out of each and every employee involves not treating them the same but giving them the support they need to succeed. It is a huge culture shift in management that is underway.

Q264 **Tonia Antoniazzi:** You were just talking about moving culture. The problem is that there is no consistent standard of training of healthcare professionals on LGBT issues. What are you going to do to ensure that the current and future health workforce is equipped to deal with LGBT people?

Matthew Hancock: The interim people plan touches on this, but there needs to be more in the final people plan that will be published after the spending review.

Q265 **Tonia Antoniazzi:** Do you have any plans to make training on LGBT issues mandatory for all health workers?



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Matthew Hancock: That is not something we have looked at, but I am very happy to take it away and consider it.

Q266 **Tonia Antoniazzi:** At the moment, mental health practitioners do not need to be licensed or regulated in any way. Is this not counterproductive to the aim of eliminating discrimination against LGBT people?

Matthew Hancock: Sorry, mental health practitioners?

Q267 **Tonia Antoniazzi:** Yes, mental health practitioners—psychotherapists. You have pledged to ban conversion therapy. Is it not counterproductive to eliminating the discrimination?

Matthew Hancock: I am happy to take away that specific point for those where qualifications are not needed. Of course, there are huge areas of the NHS where obviously qualifications are needed in clinical roles. There is an enormous amount of rigour put into what those qualifications are for doctors, nurses and what-have-you.

Chair: We were particularly talking here about mental health practitioners.

Q268 **Sarah Champion:** Secretary of State, first I need to declare an interest, because I am an ambassador for the National Counselling Society. This is something that vexes me, because my degree was psychology and I then trained to become a counsellor. It is encouraged that you register with an accredited body or a regulated body. However, if Stephanie went back to her office, she could do a one-hour online course and call herself a counsellor. By being in the counselling or psychotherapy profession, by your very nature you are dealing with vulnerable people. In the private sector you are taking cash off them. Does the Department of Health have any intention to look at regulating, either through legislation or through voluntary regulation, the sector of people who call themselves counsellors and psychotherapists, so a person going to them knows they are getting a well-vetted individual?

Chair: In our inquiry, we are particularly interested in this, because of the issues around conversion therapy, which we had a lot of evidence about.

Matthew Hancock: I am very happy to take that suggestion away and look at it. Within the NHS there are areas where a particular qualification is needed statutorily. There are areas where it is voluntary, as you say. There are also areas of non-statutory regulation through the royal colleges and what-have-you. I am very happy to take that point away.

Of course, conversion therapy is wrong and we have a programme of action on the way to stop it from being applied. It is a complex set of issues, especially because of the interaction of some cultural settings, but clearly this is something we are working to stop.

Q269 **Tonia Antoniazzi:** We have heard from witnesses that LGBT people fear



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discrimination from health services. This discrimination is still occurring across the health and social care sectors, but no one seems to be taking any responsibility for eliminating it. What responsibility should you be taking, and who else should be taking responsibility?

Matthew Hancock: My responsibility is to ensure that the NHS is there for everybody, so reports like that worry me. Of course, the NHS leadership takes this very seriously. Michael Brady's job is to make sure, at a senior level, that the whole NHS gets this agenda and is driving it.

Q270 **Tonia Antoniazzi:** On a more general issue, if we are talking about changing culture and moving people's perceptions, are you having any conversations with the Department for Education to ensure schools and teachers are receiving training and guidance? They need to be teaching inclusive LGBT subjects to a higher level on HIV and sexual health. Are you having those conversations so that it is happening in schools as well?

Matthew Hancock: Yes. We had those conversations around the publication of the new PSHE curriculum. Obviously, this has also recently come to light with some Birmingham examples where DfE took action.

Q271 **Chair:** Before we move on to the questions on data, you mentioned again Michael Brady, the national health adviser, being responsible for training frontline staff on these sorts of things to make sure frontline staff are not acting in a discriminatory way. Just to reiterate, we heard harrowing evidence about people in hospitals, as well as people in GP surgeries, being discriminated against in quite an overt way. Michael Brady is only one person and we were unclear as to how he would, as an adviser as opposed to a line manager, be able to effect the sort of change you are implying he would be able to create.

Matthew Hancock: I did not mean he would personally go and train over a million people. What I said, or certainly what I mean, is that he will ensure that, across the range of areas of the NHS, these issues are taken seriously and embedded in policy. The reason that he is not a line manager is that the only line manager who has the full range of responsibilities that are affected is the chief executive, Simon Stevens, because LGBT issues touch all different areas.

Q272 **Chair:** Dr Brady came to see us with the specialist clinical commissioner for within the NHS, who, certainly to the Committee, appeared to rely very heavily on Dr Brady for his knowledge on LGBT issues. That was quite concerning, given the other individual, John Stewart, was responsible for commissioning specialist services, so one would have hoped that his input to the Committee's questions would have been a little more full than it was.

Matthew Hancock: Okay. I will take that away. The other thing I can say is that it is not all about the NHS; the Royal College of GPs is funding to improve training in primary care to make sure that, across primary care, we have the same fair access.



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Chair: Brilliant. We are going to move on to talking about data collection. We touched on it a little earlier.

Q273 **Stephanie Peacock:** I have a question on data but, as the Chair says, it has been touched on briefly before. Why is sexual orientation monitoring in the NHS not compulsory in the same way that ethnicity monitoring is?

Matthew Hancock: We are piloting exactly how to do it. Once the pilot is complete, we will consider how to make it work right across the board.

Q274 **Stephanie Peacock:** What is the timescale on that? When are you planning to introduce it?

Matthew Hancock: I do not have an exact timescale. I am happy to come back to you with precision over the timescale.

Baroness Williams of Trafford: Could I make a point on this? In the census 2022, there will now be a question on sexual orientation. We can all guess at some of the figures, but actually, through the census, there will be a very good foundation for the data we use in order to inform our activity, but it will not be for some time yet.

Q275 **Chair:** Are you going to be introducing gender identity monitoring as well in the NHS?

Matthew Hancock: We will look at the results of the pilot of the sexual orientation monitoring and see how that works. I am very happy to take away the point about gender identity monitoring as well.

Q276 **Sarah Champion:** Many people in the NHS are passionate about LGBT rights and providing the best service for LGBT people, but we are finding they are often at junior levels. There are two parts to the question. How do you make sure that their good ideas filter up and get embedded? Also, how do you make sure that the senior people in the organisation are as passionate and committed to providing the best service for LGBT people?

Matthew Hancock: There is a top-down and a bottom-up answer to this question. We can effect top down by policy, by requiring more data to be collected, which then helps to identify where there are problems, for instance through the national adviser. Bottom up, it is all about the culture change that we were talking about earlier in the answers to the questions from Tonia. Historically, the NHS has been an incredibly hierarchical institution, where people are essentially directed as much as managed in terms of what to do. Anybody who has been involved in the NHS will recognise this. This affects a whole swathe of life in the NHS, down to inflexible rotas, where you are told, "I am terribly sorry; you cannot attend your child's birthday party because the rota says no". In that example, we even gave all hospitals the technology to have flexible rotas. 80% of them installed it, but only 20% of them used it.

This is a cultural issue within the NHS: hierarchical, very top down. The best way to solve the problem of spreading the sort of enthusiasm that you talk about, which is absolutely there in large parts of the NHS, is the



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same answer as breaking down the overly hierarchical nature of large parts of the NHS. There are examples where this is working brilliantly. Birmingham Children's Hospital is a brilliantly led organisation where staff feel more able to express themselves and to improve the way their area works than many other places in the NHS. Guy's and Tommy's is a similar example of an incredibly well-run NHS hospital, so much so that we just hired the chief executive to run NHS Improvement and to be essentially the number two executive in the whole NHS. I have absolutely no doubt that Amanda Pritchard will make a big impact on this agenda and on others.

Q277 **Sarah Champion:** Will she be focusing on LGBT issues?

Matthew Hancock: She will be focusing on this sort of culture change, of which the positive impact on LGBT issues will be one part and one consequence.

Q278 **Sarah Champion:** We have heard that the Department of Health and Social Care has leads for each protected characteristic. I wonder if you could tell us what the roles are for the leads for sexual orientation and gender reassignment.

Matthew Hancock: How do you mean what the roles are?

Sarah Champion: What is their brief? What are the leads on these two areas meant to do?

Matthew Hancock: Their role is, first, to make sure that the collection of data and monitoring is properly done and, secondly, to make sure that these issues are taken seriously. I will get exact terms of reference if I can.

Sarah Champion: That would be great.

Matthew Hancock: I will do that if I can. Also, can I give you a better answer to the question about gender identity monitoring? There is development of a uniform information standard for protected characteristics being looked at, including gender identity and how that data can be collected.

Q279 **Sarah Champion:** We are very heartened that lots of things are being looked at and reviewed.

Matthew Hancock: And done. The data collection is not a review. It is being done.

Q280 **Sarah Champion:** Okay, so it is going to be implemented.

Matthew Hancock: Yes.

Q281 **Sarah Champion:** Great. One of my concerns is that you have these two leads. You have the national LGBT health adviser. In other organisations, I have seen when you appoint someone with the title, everyone says,



"They are dealing with it. They are looking at it". What are you doing to give grist to their mill, to make sure that their recommendations are actually embedded?

Matthew Hancock: This comes back to the very first answer about the long-term plan implementation framework. That is the document through which we are holding the NHS to account for its delivery of its commitments, including its explicit commitments in this area. It is not just an adviser. He is impressive, as I am glad you thought.

Sarah Champion: Yes, we agree.

Matthew Hancock: Also, there is the drive to improve standards for LGBT people, especially given the health inequalities that we discussed at the start, and the specific needs. There are two parts to this. One is there are health inequalities on needs that all of us have, and then the specific needs. That is in there in the implementation framework for the long-term plan, which is the device through which we are driving the improvements in the NHS that it has committed to.

Q282 **Sarah Champion:** Do you have regular meetings, or in your weekly or monthly briefings do you ask for specific report-backs? I ask that because I find, if organisations know the boss is looking closely at these matters, things tend to change, whereas if it is just an adviser, they can ignore them.

Matthew Hancock: Yes, we have regular meetings, and we have regular meetings with the GEO, which holds our feet to the fire as well.

Q283 **Sarah Champion:** Great. I want to pick you up—and I am sorry, Chair; I am like a Labrador puppy with a bone here—on the "equally" statement you made.

Matthew Hancock: What do you mean?

Q284 **Sarah Champion:** I will come back to it. In refuges commissioning, there is a misperception that you have to commission equal services for everyone, but of course some people have greater needs than others. Within your answers, you have been saying the NHS treats everyone equitably. I know what you mean, but my concern is that gets diluted down to, "We treat everyone the same and we do not treat particular people with particular issues differently".

One example that has led me to want to do this inquiry is lesbian friends who are going for IVF and have to pay for it privately—I cannot remember if it is three or five times—before they are entitled to it on the NHS. That is not fair, because as a straight woman, I could go straight into NHS paid-for support. I am concerned that this "Treat everybody the same" does not recognise the specific issues that specific groups have.

Matthew Hancock: Where I use "equally", of course I mean equally according to need.



Sarah Champion: I know you mean that, but I am concerned that the NHS as a whole could be using that as a sop for not recognising specific needs from specific people.

Q285 **Chair:** Just to reiterate the point, it is certainly a very considerable issue with local authority commissioning. It is something we have been looking at carefully as part of the Domestic Abuse Bill. It is something the Government need to be more aware of more generally: that equality is not the same as treating everybody the same.

Matthew Hancock: Absolutely, yes.

Baroness Williams of Trafford: If I could come in there, you mentioned refugees and they are a very clear area, particularly when we are talking about the Domestic Abuse Bill, where to have single-sex services is entirely justifiable within the Equality Act.

Matthew Hancock: Of course I mean equal according to need. I really think this is less of an issue in the NHS, because the whole principle is that you treat people according to need. If you work in the NHS, that happens every single day, by its nature.

Sarah Champion: Unfortunately our inquiry is not finding that.

Matthew Hancock: On the IVF issue specifically, I have instituted a review of that sort of provision to make sure it is fair according to people's different needs.

Chair: Thank you very much. Thank you to both Ministers for coming in front of us today. I think there can be few who doubt your own commitment to this agenda. I would urge you, perhaps when we publish our report, to look at it further and particularly to look at the evidence of what is happening on the ground and the way in which policy is interpreted, and look at how we can lessen the gap between policy intention and the actual practice. Thank you very much both of you for your time today. We are incredibly grateful.