CQC’s Strategy 2016-2021: Shaping the Future – National LGB&T Partnership

Introduction

This document provides feedback from the National LGB&T (lesbian, gay, bisexual and trans) Partnership, a member of the Department of Health, NHS England, and Public Health England’s Health and Care Voluntary Sector Strategic Partner Programme. The National LGB&T Partnership is an England-wide group of LGB&T voluntary and community service delivery organisations (see below for members of the Partnership) that are committed to reducing health inequalities and challenging homophobia, biphobia and transphobia within public services

The National LGB&T Partnership members intend to positively influence the policy, practice and actions of Government and statutory bodies, in particular the Department of Health, for the benefit of all LGB&T people and communities across England. The member organisations of the National LGB&T Partnership are:

- LGBT Foundation
- East London Out Project (ELOP)
- Gay Advice Darlington and Durham (GADD)
- Gender Identity Research and Education Society (GIRES)
- Health Equality and Rights Organisation also known as GMFA
- Consortium of LGB&T Voluntary and Community Organisations
- London Friend
- PACE
- Stonewall Housing
- Yorkshire MESMAC
- METRO
- Birmingham LGB&T
- BiUK

The National LGB&T Partnership will ensure that health inequalities experienced by LGB&T people are kept high on the Government’s agenda and that best use is made of the experience and expertise found within the LGB&T voluntary and community sector. The National LGB&T Partnership has also established a National LGB&T Stakeholder Group which is open to interested groups, organisations, service providers and individuals, giving a direct voice to the LGB&T sector. For more information, see http://nationallgbtpartnership.org.

Consultation Response

The National LGB&T Partnership wants to initially highlight the importance of monitoring sexual orientation and trans status and doing research into lesbian, gay,
bisexual and trans (LGBT) health inequalities as distinct identities and experiences and their particular experiences of accessing health and social care services. This is especially important in order to ensure ‘relevant data and information’ is available about all people, especially those who are most marginalised and thus vulnerable such as LGBT people. When collecting data and information about LGBT people it is also important to recognise the impact of intersectional identities, such as being BAME and LGBT, and consider the specific barriers to accessing services and contributing to CQC’s work for these people.

This latter point is key when considering how you ask and thus who you ask for feedback on CQC’s work, normally through the process of consultation. It remains a reality that the most vulnerable and isolated people may not be in contact with services through which consultations are distributed and insight is gained. In order to ensure feedback is truly representative of all people, efforts must be made to reach people with protected characteristics in their localities. This could exist as an opportunity to expand the cohort of ‘Experts by Experience’ to include people with important experiences of accessing healthcare but who may require additional access needs due to their marginality.

The National LGB&T Partnership’s concern with the concept of a ‘single shared view of quality’, whilst it may help standardise the quality of care given, is that it may also overlook the different experiences and demonstrations of care. For instance, a trans person may be seen by a health practitioner that is deemed caring and safe by all their other patients, but then this practitioner may unintentionally misgender and de-value their trans patient’s identity due to a lack of cultural competency. In many cases, practitioners do not intentionally provide an uncaring or unsafe service, but through a lack of up-to-date and consistent awareness training around LGBT issues and cultural competency, they can cause offence and distress. For this reason, it is important to have a nuanced understanding of quality so that it takes into account gaps in quality assurance measures, such as deeming how ‘caring’ a service is for all its users, so not to exclude more marginal perspectives.

The National LGB&T Partnership is very pleased that our suggestions have been taken on board and CQC have acknowledged the importance of practitioners monitoring all protected characteristics, including sexual orientation and trans status, in the Equality and Human Rights Assessment. As mentioned before, sexual orientation monitoring (SOM) and trans status monitoring (TSM) are essential to ensure ‘relevant data and information’ is available about all people and that the health and care system as a whole can recognise the health inequalities and particular experiences of LGB and T people. For more information on best practice for monitoring sexual orientation (SOM) and trans status (TSM) please see: http://lgbt.foundation/som. As this indicates, The National LGB&T Partnership is at the forefront of decision making around best practise for SOM and TSM so encourages CQC to contact them for further guidance on this issue.
On this topic, it is extremely important that monitoring is done in a respectful and confidential manner and thus when CQC are encouraging providers to ‘strengthen their data collection around protected characteristics’ this should include up-to-date definitions and terminology that reflect best practice and how LGBT identify themselves. This should include details such as not capitalising ‘trans’ and acknowledging ‘trans*’ and transgender, as umbrella and inclusive terms used to describe people whose gender identity is incongruent, partially or completely with the sex assigned at birth; these terms therefore include non-binary and non-gender people, as well as those who cross dress on an intermittent basis. Details such as these demonstrate cultural competency and enable statutory bodies to have more genuine engagements with LGBT people based upon understanding and awareness rather than assumption.

Similarly with regards to the reference to monitoring protected characteristics in the Equality and Human Rights Assessment, CQC might consider listing the protected characteristics to ensure that those whose identities are included under this term are aware that they are included. The concept of having a ‘protected characteristic’ is not necessarily a wording that minority groups identify with. Equally however, it is important to recognise that the ‘protected characteristics’ are not a homogenous group and the identities within it differ greatly in their experiences and many overlap to make intersectional identities. In light of this, CQC should ensure their final Equality and Human Rights Assessment is more specific as to which protected characteristics are impacted by which action and to what extent. This specificity may require further consultation with the VCS, service users and the wider community, but it would be greatly preferred over the current vagueness of the assessment. Specific considerations would fundamentally indicate that CQC had considered in detail the impact on equalities groups and thus make the members of these groups more comfortable with CQC’s proposed strategy.

Additionally, further detail is needed in section 1b. when statements such as this are made: ‘Put in place specific methods for ensuring that we capture the views and experiences of regulated services from those equality groups who might be more at risk of breaches of human rights’. Members of equalities groups are unlikely to be reassured that their needs are being taken into account if detailed consideration is not given as to what these specific methods will be. CQC should acknowledge the added resources and time that is needed to ‘capture the views and experiences of regulated services’ from the most marginalised members of equalities groups. For instance, CQC could consider a combined approach of targeted outreach in localities and coproduction with the VCS in an attempt to genuinely engage with all members of equalities groups.

In section 6b, the statement that CQC will ‘Maintain awareness of which equality groups are omitted from a populations approach’ refers specifically to looking at quality of care for equality groups within population groups such as ‘Black and
minority ethnic or lesbian, gay and bisexual older people’. There is no reason that The National LGB&T Partnership can see as to why trans older people have been excluded from this reference so advise that CQC amend this.

Finally, within CQC’s document ‘Our human rights approach’, it states that ‘through the KLOEs [key lines of enquiry] we will also be able look at GP services for equality groups not covered by the six population groups, for example Black and minority ethnic people, lesbian, gay and bisexual people and transgender people, though we will not provide a separate rating for how a GP practice meets the needs of these groups.’\(^1\) (emphasis added) The decision not to provide a separate rating for these two groups when CQC is aiming to provide a rating for the other six population groups is not explained. If the specific treatment of BME and LGBT people is not being deemed a priority in determining whether a provider is delivering sufficient levels of care to all patients, then this needs to be explicitly justified.

Whilst we acknowledge that the ‘equality groups’ CQC is providing separate ratings for are social and health determinants rather than protected characteristics, if the part-inclusion of BME and LGBT cannot be explicitly justified without comprising compliance with the Equality Act 2010, CQC should strongly consider working towards providing ratings for how GP's meet the needs of BME and LGBT people. This especially considering we are aware that a significant proportion of LGBT people in Greater Manchester, for instance, are not having their needs met by their GP practice and other public services in relation to their sexual orientation and/or trans status.\(^2\) This is particularly problematic right now as some GPs are refusing to refer trans people to appropriate specialist providers, whilst some groups of GPs are refusing to provide hormone treatment within primary care.

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