LGBTQ+ Leaders Network
NHS Confederation

Health and Care LGBTQ+ Inclusion Framework

September 2022

About the framework and the NHS Confederation

This practical framework provides health and care leaders with the tools to create inclusive environments for LGBTQ+ staff and service users, by using six core pillars of action.

It has been developed in conjunction with the NHS Confederation's Mental Health Network.

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

Our Health and Care LGBTQ+ Leaders Network, one of three leadership support networks, is committed to improving the experience of LGBTQ+ staff and outcomes for LGBTQ+ service users and carers. Key to this is developing inclusive cultures that are meaningfully supported by senior leadership, underpinned by co-production from those with lived experience.

NHS Confederation

Contents

Introduction

The LGBTQ+ population in the UK experiences significant physical and mental health inequalities compared to the general population.[1] These inequalities extend from increased risk factors for ill health and barriers to accessing healthcare and support, to discrimination against LGBTQ+ staff within the workplace. The COVID-19 pandemic has further exacerbated these inequalities and caused significant negative impact on the health and wellbeing of the LGBTQ+ population.[2] Recent NHS Staff Survey data shows that the LGBTQ+ workforce remains at heightened risk of physical violence from patients, and bullying, harassment or abuse from colleagues.[3]

The NHS, along with other health and care organisations, seeks to provide fair access to health and care for all, to improve the health of all parts of the population, and to be an inclusive employer. And yet, the sparse data that currently exists, along with feedback from members of the NHS Confederation's Health and Care LGBTQ+ Leaders Network, exposes that we are still on that journey.

Leaders of NHS organisations seek support on how to make progress and deliver on their role in creating genuine improvement for staff, patients and the population. The COVID-19 pandemic provided a catalyst for the Health and Care LGBTQ+ Leaders Network, in collaboration with the NHS Confederation's Mental Health Network, to develop this inclusion framework.

This framework comprises six key pillars of inclusivity that organisations should aim to build to create and maintain inclusive cultures.

1. LGBT Foundation (2020). Hidden Figures: LGBT Health Inequalities in the UK
2.LGBT Foundation. Hidden Figures: The Impact of the COVID-19 Pandemic on LGBT Communities in the UK. [Online]. Accessed August 2022.
3. NHS England. NHS Staff Survey 2022. [Online]. Accessed August 2022.

Background to the Health and Care LGBTQ+ Inclusion Framework

Identifying the pillars

In November 2020, after the first wave of COVID-19, the Health and Care LGBTQ+ Leaders Network convened a roundtable that brought together six healthcare leaders with interest and expertise in LGBTQ+ inclusion, to explore how health and care organisations could support the LGBTQ+ population once the pandemic had abated. From this roundtable emerged recommendations that health and care organisations could consider to make their services and working environments more inclusive for LGBTQ+ staff and service users. These recommendations were then tested and honed by the Health and Care LGBTQ+ Leaders Network's guiding group and by the wider membership of the network. The result was the development of six pillars that health and care organisations should build to support LGBTQ+ staff, patients and local populations.

1. We have **visible leadership and confident staff**
2. We have a **strong knowledge base**
3. We are **non-heteronormative and non-cisnormative in everything we do**
4. We take responsibility for **collecting and reporting data**
5. We **listen to our service users**
6. We proactively **seek out partners to co-deliver services**

These pillars were disseminated across the health and care system in 2021, and leaders were encouraged to adopt them.

Creating a practical framework for implementation

While the pillars were well received, health and care leaders had questions about how best to achieve them. They were particularly keen to learn from the good practice of their peers. To facilitate this, we developed a pilot project to create a practical framework based on peer learning.

The Health and Care LGBTQ+ Leaders Network issued a call for volunteer organisations to work towards building the pillars over a nine-month period. Thirteen pilot sites were selected, representing acute, mental health, clinical commissioning groups (CCGs) and independent sector organisations (see page 43 of the acknowledgements).

These organisations made a commitment to implement the pillars over the course of nine months. No specific guidelines were issued, to allow innovation to emerge. Between March and December 2021, we convened these pilot sites regularly to share their progress and key challenges.

At the end of the project, a representative from each pilot site was interviewed about their experience. These findings were summarised and recommendations extracted to form this implementation framework.

Using the framework

- Each pillar is built on a number of demonstrable elements, with recommendations on how they can be implemented and shared learning from pilot sites.
- Use the self-assessment traffic light checklist on page 8 to determine where your organisation is currently and in which pillars you might want to make progress.
- As you move through the recommendations, use the progress checklist on page 38 to track your progress and support evaluation. You might want to print this out and fill it in by hand or download our Excel version to create a collaborative document with colleagues.
- Where you might meet conflict or misunderstanding around why this is a vital area of development for the health and care sector, this framework aims to provide practical ideas for how you might overcome it.

A note on language

- **Heteronormative**: the assumption that heterosexuality is the only normal and natural expression of sexuality.
- **Cisnormative**: the assumption that all people have a gender identity that is the same as the sex the person was identified as having at birth.
- **Cisgender (or cis)**: of, relating to, or being a person whose gender identity corresponds with the sex the person was identified as having at birth.

Self-assessment checklist

Use this interactive traffic light self-assessment checklist to identify your organisation's current position. This will help you decide which pillars you want to focus your efforts on first. You can monitor your progress using our progress checklist on page 38.

Key

☐ Not in place ☐ Work in progress ☐ We have in place

1. We have visible leadership and confident staff

☐☐☐ LGBTQ+ leaders are visible and can bring their whole selves to work.

☐☐☐ LGBTQ+ staff network has been developed, is connected to decision-making and informs service delivery and training.

☐☐☐ LGBTQ+ staff are supported when faced with conflict arising from their sexual orientation and gender identity.

☐☐☐ Non-LGBTQ+ leaders model good allyship.

2. We have a strong knowledge base

☐☐☐ Staff understand the specific needs of LGBTQ+ people and the health inequalities they face.

☐☐☐ A safe space has been created for staff to learn and ask questions.

☐☐☐ The organisation is learning and using appropriate language.

3. We are non-heteronormative and non-cisnormative in everything we do

☐☐☐ Services are addressing the specific needs of LGBTQ+ people.

☐☐☐ Gender identity and sexual orientation are not assumed; heterosexuality and cisgender are not considered the default.

4. We take responsibility for collecting and reporting data

- ☐ Gender identity and sexual orientation information are being proactively sought from all staff and service users.
- ☐ Staff are confident and competent in collecting data.
- ☐ L, G, B, T, and Q data is reviewed separately and acted on accordingly.

5. We listen to our service users

- ☐ LGBTQ+ voices are included in co-production.
- ☐ The needs of LGBTQ+ children and young people are being considered.
- ☐ Action is being taken to create targeted interventions with the insight gathered.

6. We proactively seek out partners to co-deliver services

- ☐ The knowledge and reach of third sector and community organisations are being used to design or commission services.
- ☐ Lasting and meaningful relationships with local LGBTQ+ organisations are being fostered.

Pillars and recommendations

Each pillar is built on a number of demonstrable elements, with recommendations from pilot sites on how they can be achieved.

1. We have **visible leadership and confident staff**
2. We have a **strong knowledge base**
3. We are **non-heteronormative and non-cisnormative in everything we do**
4. We take responsibility for **collecting and reporting data**
5. We **listen to our service users**
6. We proactively **seek out partners to co-deliver services**

Pillar 1 We have visible leadership and confident staff

How this is demonstrated:

1.1 LGBTQ+ leaders are visible and can bring their whole selves to work.

1.2 LGBTQ+ staff network has been developed, is connected to decision-making and informs service delivery and training.

1.3 LGBTQ+ staff are supported when faced with conflict arising from their sexual orientation and gender identity.

1.4 Non-LGBTQ+ leaders model good allyship.

1.1 LGBTQ+ leaders are visible and can bring their whole selves to work.

Recommendation

LGBTQ+ leaders should aim to be visible, bringing their whole selves to work. This can be done with the support of the Health and Care LGBTQ+ Leaders Network.

Learning from pilot sites

LGBTQ+ visibility within senior leadership varied between pilot sites, but they were unanimous in their acknowledgement that diverse leadership is key in creating inclusive environments.

The action that pilot sites considered most impactful in making their LGBTQ+ leadership visible was to share personal stories with staff. This was done successfully through staff-wide meetings, blogs, videos and physical communication assets, such as posters.

To increase the impact of visible leaders and their stories, pilot sites leveraged specific days/months such as National Coming Out Day or LGBTQ+ History Month, which recognise the LGBTQ+ population.

Some leaders needed reassurance that sharing their stories was not a tokenistic action. This was done by highlighting the importance of staff seeing themselves, and their experiences, reflected in their leadership. Leaders found this context setting reassuring and feedback from staff indicated that sharing personal experience had meaningful impact on perceptions of LGBTQ+ people.

1.2 LGBTQ+ staff network has been developed, is connected to decision-making and informs service delivery and training

Recommendation

Encourage the development of LGBTQ+ staff networks, ensuring that they are part of and connected to decision-making across the organisation. Use the knowledge they generate to inform service delivery for training of non-LGBTQ+ staff.

Learning from pilot sites

In acknowledging the importance of staff experience and expertise, all pilot sites had or were in the process of creating staff networks by the end of the implementation period.

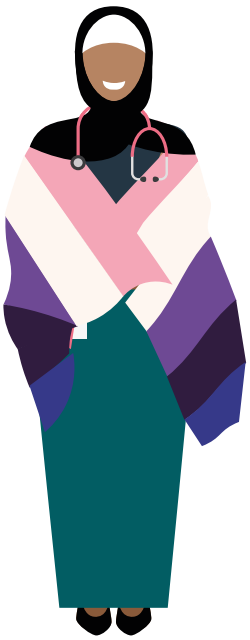
Most were led by non-executive staff and had executive sponsorship. This sponsorship facilitated network activity, secured funding and established a feedback channel directly to each organisation's board.

Designated staff network chairs were widely recognised as a vital resource for LGBTQ+ staff network success, as they often have access to senior leadership and equality, diversity and inclusion (EDI) leads, allowing them to create change far more effectively. However, the scale of their impact can be linked to the resources they are provided with to support their role. These resources can be broadly broken down to be either time or development based. For example, some chairs were given protected time to focus on their networks (on average two days a month), while others were offered training in leadership. One particularly advanced example saw an individual have their position as chair recognised in their job description and salaried accordingly.

Having observed that cisgender gay men tend to dominate LGBTQ+ staff network spaces, one pilot site's staff network established three chair positions: one for a cisgender man, one for a cisgender woman, and the third for a trans/non-binary person.

Underpinning the establishment of all the networks has been a need for financial support for operational costs. While this has only been possible for some networks, and on a small financial scale (budgets varied from around £1,000 to £7,000 per year), all networks have been able to use a variety of methods to secure funding, even providing unofficial budgets.

Recognising the importance of connecting the LGBTQ+ staff network to wider organisational decision-making, one pilot site established an allies' network that supports the activities of all other staff networks to ensure that the burden of progress does not fall solely to those with protected characteristics.



1.3 LGBTQ+ staff are supported when faced with conflict arising from their sexual orientation and gender identity

Recommendations

Ensure LGBTQ+ staff are supported to deal with distress, exclusion and conflict arising from patients and colleagues relating to their sexual orientation and/or gender identity.

Learning from pilot sites

Effectively communicating what support is available was a key action for pilot sites. Some of this was done through individuals, such as EDI leads making themselves visible, or ensuring staff knew they could contact HR or their union representatives if needed.

The Rainbow Badge Scheme was cited by several sites as a useful tool for signposting staff to support, if needed. More than one pilot site recommended only issuing rainbow lanyards to staff who understood the responsibility of wearing them, with one site requiring staff to make a meaningful pledge to support LGBTQ+ staff and service users.

Several sites had made use of Stonewall's UK Workplace Equality Index as a means to audit the robustness of its staff support.

Several pilot sites used their freedom to speak up guardians and equality champions as neutral contacts with whom staff could share any concerns or conflicts. One pilot site, which has a large geographical spread and struggled getting its freedom to speak up guardians to all sites, has created an easy-to-find button on its intranet that connects staff straight to their guardian.

Where non-LGBTQ+ staff would be present in meetings, most staff networks created protected space on their agenda to raise issues privately.

Pilot sites also recognised that much of the resolution to issues staff face was through 'corridor conversations' and was sometimes not officially escalated.

1.4 Non-LGBTQ+ leaders model good allyship

Recommendations

Non-LGBTQ+ leaders should model good allyship, ensuring that diversity in the workforce and the local population is reflected in diversity of leadership, and organisational policy reflects the experiences of LGBTQ+ staff.

Learning from pilot sites

Securing buy-in from non-LGBTQ+ leaders is vital. Pilot sites used informal conversations to bring senior leadership onside before key decisions were made in formal meetings.

Where there was already strong allyship within senior leadership, pilot sites saw leaders take an active and visible role in LGBTQ+ focused activities, including attending staff network meetings.

Leaders identified as good allies were open and receptive to training. This was sometimes delivered to them via one-to-one sessions with EDI leads.

One pilot site had undertaken targeted LGBTQ+ recruitment to its board to improve diversity.

Potential challenges to anticipate

- Some of this work might be seen as tokenistic, or even unnecessary where staff networks are concerned. It is important to point to research and work other NHS organisations are doing to secure senior buy-in, particularly those organisations rated as outstanding.

- Staff can often find it difficult to secure time to attend network meetings. Consider varying the times of your meetings, holding them outside of normal working hours, or securing back-fill funding for staff to attend meetings.

- Building staff networks within small organisations can be difficult. Consider reaching out to nearby organisations with a view to combining your networks if appropriate.

Summary

- Share the lived experience of LGBTQ+ leaders through platforms such as webinars, blogs and staff-wide meetings.

- Ensure staff networks have an executive sponsor to support activities and feedback to your organisation's board.

- Make staff support, such as freedom to speak up guardians or staff networks, highly visible so colleagues know where to turn for help.

- Encourage non-LGBTQ+ leadership to visibly engage in organisational activities that support LGBTQ+ staff.

Pillar 2 We have a strong knowledge base

How this is demonstrated:

2.1 Staff understand the specific needs of LGBTQ+ people and the health inequalities they face.

2.2 A safe space has been created for staff to learn and ask questions.

2.3 Our organisation is learning and using appropriate language.

2.1 Staff understand the specific needs of LGBTQ+ people and the health inequalities they face.

Recommendation

Ensure you and your staff understand the specific needs of LGBTQ+ people, the health inequalities they face, and the variance of experience between the L,G,B,T,Q and + identities, particularly that of transgender people.

Learning from pilot sites

Pilot sites were overwhelmingly in agreement that standard EDI training is not sufficient in articulating the needs of LGBTQ+ people and that tailored training for each organisation was needed, often through collaboration with LGBTQ+ charities. Most pilot sites had created online learning hubs that allowed staff to access training at a time that suited them. Sites had to consider the time constraints

of clinicians who often did not access training, and separate engagement work was often needed to encourage them to complete the training. Part of this was articulating the importance of LGBTQ+ education as part of their clinical competence.

A mixed-media approach was the most effective in engaging the widest range of staff. This included a mixture of in-person and online events; dedicated intranet spaces (with access to legal advice); lived-experience sharing sessions with service users; lunch-and-learn sessions; posters and podcasts.

One pilot site held an LGBTQ+ awareness event for staff with a trans service user from an inpatient, male-only forensic ward, who shared her experience in that service. Staff found this personal story impactful and eye-opening.

Another pilot site has developed manager toolkits to aid decision-making and improve understanding of the LGBTQ+ population. It also created a separate trans-focused toolkit that acknowledges the differing needs of trans people.

2.2 A safe space has been created for staff to learn and ask questions.

Recommendation

Create a safe space for staff to learn and encourage them to be curious about LGBTQ+ experiences, particularly where there is intersectionality between protected characteristics.

Learning from pilot sites

LGBTQ+ training across several pilot sites has been delivered complementary to anti-racism training, acknowledging that there is a significant intersection between these two populations.

One pilot site brought together its black and minority ethnic and LGBTQ+ networks to hold a webinar with a black trans woman who shared their transition journey with staff across the organisation.

Learning needs to be embedded into the culture of an organisation: a curious leadership will create curious staff who are more willing to expand their knowledge of LGBTQ+ issues. Some pilot sites have tied learning into their organisational values to foster a culture of development.

Pilot sites agreed that engaging non-LGBTQ+ staff in LGBTQ+ training was a vital step towards organisation-wide positive change. One site delivered virtual training on allyship and how to be a good ally, engaging all staff networks. The ethos of this organisation was to encourage staff to have a thirst for knowledge.

Some pilot sites noted that staff felt poorly educated on trans issues and were uncomfortable asking certain questions. These sites created groups and one-to-one spaces for staff to ask these questions. This enabled their people to be clear on the need to challenge antagonistic views if they arose. Some sites also created trans and non-binary training that was delivered separately to the LGB training packages.

There was not consensus on whether all learning should be mandatory. Pilot sites acknowledged the balance between the need for staff to be well-educated on LGBTQ+ issues, and the need for engagement with training to be meaningful and effective. Some pilot sites indicated ambitions to tie learning into conditions of employment, particularly in clinical settings.

Where engagement in training had been low, one pilot site is reviewing its current training and developing plans to improve and modify packages for staffing groups they have identified as disengaged.

2.3 Our organisation is learning and using appropriate language.

Recommendations

Take time to learn and use appropriate language. There can be a significantly negative impact on LGBTQ+ individuals when appropriate language is not used.

Learning from pilot sites

Where they could, pilot sites aimed to create training that was inclusive of all L, G, B, T, Q and + people, so that a wide range of appropriate language could be shared. The expertise in staff networks was used to guide the creation of learning programmes around language and pronouns.

Most pilot sites have moved to include pronouns in email signatures and on ID cards. Where organisations have not supported this with training or communications on why pronouns are important, there has been reluctance in uptake.

One pilot site had co-produced a package of LGBTQ+ training with children and young service users who were able to articulate a clear understanding around the gender spectrum and their lived experience of gender. This training is due to be delivered to the executive team.

Potential challenges to anticipate

- Engagement with patient-facing staff can be difficult due to time pressures. Consider specifically when and how you deliver training to these groups.

- Staff may be resistant to training if they do not think it affects their clinical work. Explaining the importance of understanding the implications of LGBTQ+ health inequalities can encourage staff to reconsider how this training has relevance to their practice.

- Some staff may be hesitant to engage with trans-specific training. Ensure you create a space in which they feel comfortable expressing their reservations, but ensure disrespectful behaviour is suitably challenged.

Summary

- Create an online learning hub for staff to access at a time that suits them.
- Include lived experience of LGBTQ+ patients and staff in your training materials or presentations.
- Deliver a mixed-media package of training to engage the widest range of staff.
- Work with your LGBTQ+ staff network and LGBTQ+ charities to create tailored training specific to your organisation and local population.

Pillar 3 We are non-heteronormative and non-cisnormative in everything we do

How this is demonstrated:

3.1 Services are addressing the specific needs of LGBTQ+ people.

3.2 Gender identity and sexual orientation are not assumed; heterosexuality and cisgender are not considered the default.

3.1 Services are addressing the specific needs of LGBTQ+ people.

Recommendation

When designing, commissioning and delivering services, consider whether they address the specific needs of LGBTQ+ people.

Learning from pilot sites

Equality impact assessments were identified as the key tool in ensuring services were inclusive of all LGBTQ+ people. One pilot site had the ability to reject policies or service developments that did not meet its standards, ensuring staff used the assessment as a development tool rather than a review tool once the policy had been drafted. The same pilot site had also commissioned an external audit of its equality impact assessments to ensure the process was even more robust.

Most pilot sites had conducted reviews of existing policy documents and service literature to ensure they were inclusive, by amending language to make it gender neutral.

Considering trans service users in particular, several pilot sites had reviewed their policy on admissions to single-sex services, allowing service users to be admitted on gender presentation.

One pilot site admitted a trans service user to an inpatient unit that hosted a patient community forum, which asked for more information on being transgender. Staff in the unit supported the trans service user with the resources to create a transgender information board. Both the service user and community forum shared positive feedback from this exercise.

Pilot sites ensured they were visibly supportive of LGBTQ+ service users, particularly within services for children and young people, by celebrating Pride events, hanging rainbow flags and creating spaces that did not feel gendered.

Two pilot sites noted that they had developed productive relationships with their estate management to open discussions around creating gender-neutral spaces. One site worked with its estate team to audit its facilities and identify where improvements could be made across all sites.

Where gender neutral toilets had been installed, no pilot sites reported a negative response from staff or service users to their presence.

Changes to make recruitment more inclusive were made across pilot sites. Some sites had specifically targeted LGBTQ+ people, where lack of representation in particular services had been identified. LGBTQ+ recruitment platforms were used, and inclusive language and specific calls for LGBTQ+ people were also included in advertisements.

One pilot site was implementing a recruitment process for senior positions whereby candidates would be placed on a ward and the recruiter would observe how they treated staff and patients and if this was done in an inclusive manner.

3.2 Gender identity and sexual orientation are not assumed; heterosexuality and cisgender are not considered the default.

Recommendation

Try not to assume a person's gender identity or sexual orientation. Heterosexuality and cisgender should be considered a possibility, not a default.

Learning from pilot sites

Developing non-assumptive policies was seen as key to being non-heteronormative and cisnormative. One pilot site had moved to using the term 'birthing person' alongside 'mother' in its perinatal service and was also in the process of updating its bereavement leave to include family members of LGBTQ+ staff who may not necessarily be blood relatives.

How pronouns are used was seen as equally important, making sure these are visible and used correctly, including in email footers and ID badges. This was largely done through induction paperwork, but exercises to engage current staff were also being undertaken.

To avoid assumption of gender, one pilot site reported a service that had stopped using pronouns altogether, and instead only used patients' names.

Bold communications are important in establishing a non-assumptive culture. This was done in pilot sites by creating inclusive posters, signage and literature. Some sites did report hesitation around being hyper-visible and subsequent backlash. Support from communications teams and executive support was needed in these cases.

Potential challenges to anticipate

- Adequate time to conduct checks and balances for policies and service development can be difficult to find. Be sure to create an agreed timeframe for this to be done that you measure success through and review resource need against.

- Inclusive policies can be met with contention, particularly around trans people. Consider motivating staff to drive progress through initiatives such as equality, diversity and inclusion awards.

- Understanding the concept of hetero and cisnormativity, and non-gendered language, can be difficult for some. Targeted training and sharing where other organisations have had success in this area can help counter this.

Summary

- Ensure equality impact assessments are being considered during the creation or review of policies and service development, not after.

- Take time to review policy documents, service literature and consent forms to ensure they are appropriate for gender non-conforming or trans service users.

- Make pronouns as visible as possible, encouraging staff to use them in email signatures and on name badges.

- Develop a positive and productive relationship with estate management. This is a helpful first step to creating inclusive spaces such as gender-neutral toilets.

Pillar 4 We take responsibility for collecting and reporting data

How this is demonstrated:

4.1 Gender identity and sexual orientation information are being proactively sought from all staff and service users.

4.2 Staff are confident and competent in collecting data.

4.3 L, G, B, T, and Q data is reviewed separately and acted on accordingly.

4.1 Gender identity and sexual orientation information are being proactively sought from all staff and service users.

Recommendation

Acknowledge that LGBTQ+ people are not one homogenous group, ensure you are proactively seeking specific gender identity and sexual orientation information from all service users and carers, and commit to reporting this to the NHS Data Set.

Learning from pilot sites

Collecting, reporting and making use of data was consistently highlighted as one of the most challenging areas for pilot sites to make progress with. Several shared that they are limited in their ability to collect data by the sophistication of their data collection systems, noting that their systems don't have an ability to record sexuality, and that gender is limited to 'he/she/other.'

All pilot sites were keen to make progress in the quantity and quality of the data they collect, and many had still been able to make progress in their use of data-driven decision-making despite these imperfections. There were differing opinions about the optimal amount of data that needs to be collected before it can be used to generate insights and contribute to decision-making within the organisation. Several pilot sites were able to begin undertaking data-driven work without a perfect data set, as they have been able to make use of the data they already have and supplemented this with the knowledge of their stakeholders and external organisations.

Where organisations want a more complete data set before they begin data-led decision-making, support from organisational leadership is vital in unlocking resources to gather greater granularity of data. To achieve this, some organisations began by understanding where weaknesses in their data collection lay and how they could go about making improvements.

When collecting data about employees within the organisation, several pilot sites highlighted that there have been low levels of self-reporting across many protected characteristics, which is attributed to low confidence among staff. To overcome this, pilot sites promoted why they collect this data and what the intended uses are, and how this will improve staff professional experiences.

Examples from one pilot site included consistently engaging with prominent members of staff about the importance of the staff survey so that they would support its completion. This subsequently encouraged all staff to update their records and share informative materials with new starters about how they can engage with the organisation's LGBTQ+ community.

4.2 Staff are confident and competent in collecting data.

Recommendation

Ensure staff are confident and competent in collecting data about a service user's gender identity or sexual orientation, creating a safe and inclusive environment in which to collect it.

Learning from pilot sites

Low staff confidence around asking service users about their sexual orientation or gender identity was identified as the key limiting factor to quality data collection across all pilot sites.

To mitigate staff hesitation, pilot sites clearly communicated the purposes behind collecting the data to staff so that they felt more confident explaining to service users why they are asking these questions.

Pilot sites noted the importance of training to build staff confidence in approaching and asking questions, providing coaching and establishing safe-space meetings where staff can ask questions without the fear of judgement.

One pilot site published blogs and legal summaries on its intranet that explain the legal basis for the collection of data on gender (among other topics), so that staff are able to quickly access information as and when they need it.

Pilot sites recognised that some staff were making a personal decision not to ask about sexuality and gender identity. To mitigate this, organisations tried to reach an understanding with health professionals that asking these questions is an expected part of their professional practice. Where staff continue to refuse to ask these questions, disciplinary action could be considered.

4.3 L, G, B, T, and Q data is reviewed separately and acted on accordingly.

Recommendation

Separate the data collected to better understand the issues specific to your local LGBTQ+ community, and design services accordingly.

Learning from pilot sites

Leaders need to be aware of the pitfalls of aggregating LGBTQ+ data and avoid the temptation to do so. The experiences of staff and services users will vary significantly depending upon an individual's sexuality and gender and could be influenced by their intersectionality. As such, taking a topline view of how services are working can mask challenges or failings for a particular group.

Leaders of organisations need to recognise the value in their ability to understand and critique LGBTQ+ data effectively and commit to upskilling themselves in this area.

Potential challenges to anticipate

- Staff might be resistant to asking personal questions of their service users, even after training, so make sure you are clear on why data collection is an expected part of their professional practice.

- Senior leaders might need to be sold on the importance of quality data, so try sharing best practice from other organisations that are doing this work well and have a strong Care Quality Commission rating.

- Recording accurate data on staff using the current Electronic Staff Record can be difficult, so ensure staff feel confident completing the staff survey so that you can use this data in the interim.

Summary

- Use training to build staff confidence to ask and share about being LGBTQ+ to collect better patient and workforce data.
- Use best practice learning from data collection of other protected characteristics.
- Take time to understand the quality of data needed to start making data-led decisions.
- Allow improving data collection and use to be an iterative process.

Pillar 5 We listen to our service users

How this is demonstrated:

5.1 LGBTQ+ voices are included in co-production.

5.2 The needs of LGBTQ+ children and young people are being considered.

5.3 Action is being taken to create targeted interventions with the insight gathered.

5.1 LGBTQ+ voices are included in co-production.

Recommendation

Organisations have a statutory duty to include service users and community groups in the design and commissioning of services. When co-producing and commissioning services, ensure LGBTQ+ voices are included.

Learning from pilot sites

Pilot sites reported a mix of initiatives that ranged from establishing patient councils and service user groups, through to supporting cafes that provide spaces to connect for those who are not necessarily a patient or service user.

One pilot site built trust with service users by remunerating them for their time and contribution towards co-developing services.

However, remuneration is not always recognised by leadership as an important or appropriate approach for trust building, and it will be the responsibility of those in the organisation to demonstrate why it is valuable to remunerate individuals for the time they commit to co-development with the organisation.

Organisations will also need to take the size of their organisation and its geographic distribution into account when developing an engagement strategy. The scale of spread across the organisation's geography will mean that it could be hard to coordinate all engagement from a central team. Instead, consider supporting individual teams to develop this for themselves and identify and share good practice.

To do this, individual teams will probably work with their patient engagement and communication colleagues. However, because of organisational separation, working together is not always the most straightforward process. Those leading EDI work should factor in time to build and maintain relationships with time-poor colleagues.

Whatever engagement is undertaken, consistency will play an important part in the success or failure of your activities. If a healthcare organisation doesn't engage consistently with its service users, it can give the impression that they are being exploited in an unequal partnership. This can foster distrust and disengagement.

5.2 The needs of LGBTQ+ children and young people are being considered.

Recommendation

Listen and respond to the needs of LGBTQ+ children and young people, particularly around mental health.

Learning from pilot sites

It was noted that organisations in the mental health sector, and more specifically within child and adolescent mental health services (CAMHS), had some of the more advanced practice for engaging their service users in co-production. Providers that are developing in this space may find it helpful to partner with local mental health organisations to share learning.

One pilot site developed LGBTQ+ training for its staff with the patients on a CAMHS ward. Through this co-development, patients were able to ensure that a clear understanding of the gender spectrum and their lived experience was included throughout.

The pilot site also placed an emphasis on the need to build trust with service users to generate an environment where meaningful engagement from service users was possible. They cited supporting the CAMHS patients to attend a Trans Pride event as an example of how they have approached developing this trust.

5.3 Action is being taken to create targeted interventions with the insight gathered.

Recommendation

Take action to create targeted interventions with measurable outcomes, using the insight you have gathered from LGBTQ+ service users.

Learning from pilot sites

Due to the timescale of the pilot period and compounded by the ongoing effects of the COVID-19 pandemic, pilot sites were unable to reflect on new services informed by service user engagement. They were instead able to offer insight into future ambitions.

These included regularly assessing who found engagement was working and who didn't. It is essential to acknowledge that the LGBTQ+ population is diverse and intersectional; a failure to recognise this will result in co-production that does not support sections of the community and could marginalise them further.

One pilot site was planning to use its staff network to engage with service users, using the lived experience and inherent trust of its LGBTQ+ staff.

Another pilot site has brought an LGBTQ+ service user onto its readers' panel for reviewing trust publications and policies.

Potential challenges to anticipate

- Successful engagement will require the support of disparate and time-poor internal colleagues, therefore time must be invested in developing relationships with these individuals and co-developing plans.

- The scale and ambition of service user engagement is a largely political choice. It should be expected that resistance will be met when larger-scale activities are advocated for.

- Trust is not the default position for many LGBTQ+ people when engaging with the health service, and organisations should be aware that they are likely to start from a position of active distrust when starting engagement activities.

Summary

- Approach engagement with service users with an open mind – there are numerous ways to engage meaningfully.
- Take time to develop meaningful relationships based on mutual trust.
- Consistently engage with your service users beyond the specific projects for which you are using their expertise.

Pillar 6 We proactively seek out partners to co-deliver services

How this is demonstrated:

6.1 The knowledge and reach of third sector and community organisations are being used to design or commission services.

6.2 Lasting and meaningful relationships with local LGBTQ+ organisations are being fostered.

6.1 The knowledge and reach of third sector and community organisations are being used to design or commission services.

Recommendation

Use the knowledge and reach of third sector and community organisations closely connected with the local LGBTQ+ population, to ensure the services you are designing or commissioning are appropriate for your locality.

Learning from pilot sites

Pilot sites agreed that partnerships at the national, regional/system and local levels should all be leveraged to co-deliver services and overcome shared challenges.

One pilot site encourages all its executives to maintain active relationships with their Royal College and are now in the position to co-produce a toolkit for mental health organisations.

Most organisations placed significant emphasis on engaging with the new integrated care system (ICS) infrastructure, organisations that work at the national level, such as the LGBT Foundation, and small community organisations.

ICSs, along with local authorities, offer an opportunity to engage with the renewed focus on population health and ensure that LGBTQ+ issues are meaningfully included in strategies, and allow LGBTQ+ initiatives to extend beyond service users and employees.

6.2 Lasting and meaningful relationships with local LGBTQ+ organisations are being fostered.

Recommendation

Nurture lasting relationships with local LGBTQ+ organisations and bring them into system-wide planning.

Learning from pilot sites

Community organisations provide a level of expertise and focus that may not readily exist within a provider or commissioner of healthcare. When seeking to understand and engage with the local population, these organisations are an invaluable source of insight. However, it was noted by several pilot sites that NHS organisations need to be aware of a practical or perceived resource and power imbalance between themselves and smaller organisations. Smaller organisations can report 'being used' by the NHS when needed and ignored when the organisation's focus is elsewhere.

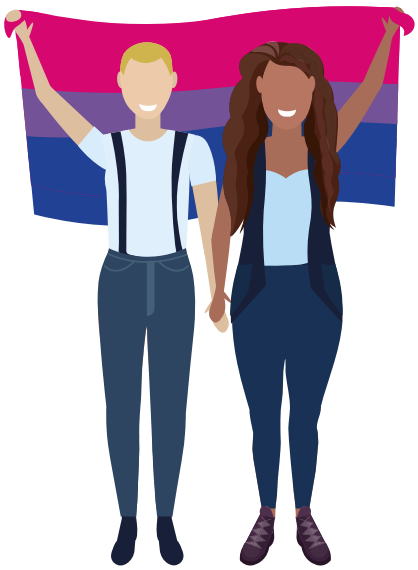
Overcoming this perception can be achieved by healthcare organisations investing time in building trust, with actions as simple as meeting regularly for coffee to maintain an open and informal dialogue. Where insight is sought from smaller organisations, healthcare organisations should consider how they will feed back to them about how their insight has or hasn't been used.

Potential challenges to anticipate

- There is a potential for the existence of actual or perceived power imbalances between healthcare organisations and their smaller partners, which if left unaddressed could undermine long-term engagement and co-development.
- There may be a lack of local LGBTQ+ organisations in your area, so consider establishing relationships with regional or national organisations instead.
- It might take a considerable amount of time to build and maintain your relationship with partner organisations, so be sure to build this into your planning.

Summary

- Consider partnership opportunities at the national, regional and local level.
- Invest time in building and maintaining trust with small community organisations.
- Use the integrated care system population health focus for engagement and co-development with partners outside the health service.



Progress checklist

Use this interactive and downloadable checklist to track and evaluate how you are progressing with each of the recommendations for achieving the pillars.

Progress key

☐ Significant progress ☐ Moderate progress ☐ No progress

Pillars and recommendations	Progress	Action to date
1. We have a visible leadership and confident staff		
1.1 LGBTQ+ leaders should aim to be visible, bringing their whole selves to work.	☐☐☐	
1.2 Encourage the development of LGBTQ+ staff networks, ensuring that they are part of and connected to decision-making across the organisation. Use the knowledge they generate to inform service delivery for training of non- LGBTQ+ staff.	☐☐☐	
1.3 Ensure LGBTQ+ staff are supported to deal with distress, exclusion and conflict arising from patients and colleagues, relating to their sexual orientation and gender identity.	☐☐☐	
1.4 Non-LGBTQ+ leaders should model good allyship, ensuring that diversity in the workforce and the local population is reflected in diversity of leadership, and organisational policy reflects the experiences of LGBTQ+ staff.	☐☐☐	

Pillars and recommendations	Progress	Action to date
2. We have a strong knowledge base		
2.1 Ensure you and your staff understand the specific needs of LGBTQ+ people, the health inequalities they face, and the variance of experience between the L,G,B,T,Q and + identities, particularly that of transgender people.		
2.2 Create a safe space for staff to learn and encourage them to be curious about LGBTQ+ experiences, particularly where there is intersectionality between protected characteristics.		
2.3 Take time to learn and use appropriate language. There can be a significantly negative impact on LGBTQ+ individuals when appropriate language is not used.		
3. We are non-hetero/cisnormative in everything we do		
3.1 When designing, commissioning and delivering services, consider whether they address the specific needs of LGBTQ+ people.		
3.2 Try not to assume a person's gender identity or sexual orientation. Heterosexuality and cisgender should be considered a possibility, not a default.		
4. We take responsibility for collecting and reporting data		
4.1 Acknowledge that LGBTQ+ people are not one homogenous group, ensure you are proactively seeking specific gender identity and sexual orientation information from all service users and carers, and commit to reporting this to the NHS Data Set.		

Pillars and recommendations	Progress	Action to date
4. We take responsibility for collecting and reporting data (continued)		
4.2 Ensure staff are confident and competent in collecting data about a service user's gender identity or sexual orientation, creating a safe and inclusive environment in which to collect it.		
4.3 Separate the data collected to better understand the issues specific to your local LGBTQ+ community, and design services accordingly.		
5. We listen to our service users		
5.1 When co-producing and commissioning services, ensure LGBTQ+ voices are included.		
5.2 Listen and respond to the needs of LGBTQ+ children and young people, particularly around mental health.		
5.3 Take action to create targeted interventions with measurable outcomes, using the insight you have gathered from LGBTQ+ service users.		
6. We proactively seek out partners to co-deliver services		
6.1 Use the knowledge and reach of third sector and community organisations closely connected with the local LGBTQ+ population, to ensure the services you are designing or commissioning are appropriate for your locality.		
6.2 Nurture lasting relationships with local LGBTQ+ organisations and bring them into system-wide planning.		

Resources

For context

- Supporting the LGBTQ+ Population Through COVID-19 and Beyond and the related information sheet
- Understanding LGBT+ Employee Networks and How to Support Them
- Webinar recording: Embedding and Empowering LGBTQ+ Staff Networks

Lived experiences

- Video: Responding to LGBTQ Inequalities During COVID-19 and Beyond
- Blog: Transforming the NHS into an Inclusive Environment for LGBTQ+ Staff and Patients
- Blog: In Conversation With Raffaela Goodby – Being an LGBTQ+ Ally
- Podcast: LGBTQ+ Workforce Visibility

Leadership

- Inclusive Leadership Survey Findings
- Working in partnership with people and communities
- Blog: The Time is Now
- Blog: Holding Organisations to Account for Equality in the Workplace
- Blog: Creating an LGBTQ+ Inclusive Service to Improve Data Collection

Language

- Blog: Why Pronouns Matter
- Blog: 'Hello, My Name Is... and My Pronouns Are...'

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Pilot sites

1. Cygnet Health Care
2. Devon Partnership NHS Trust
3. East London NHS Foundation
4. Greater Manchester Mental Health NHS Foundation Trust
5. Harrogate and District NHS Foundation Trust
6. NHS Surrey Heartlands Clinical Commissioning Group
7. North Middlesex University Hospital NHS Trust
8. Northern Care Alliance
9. Pennine Care NHS Foundation Trust
10. Sussex Partnership NHS Foundation Trust
11. The Christie NHS Foundation Trust
12. University Hospitals of Derby and Burton NHS Foundation Trust
13. West London NHS Trust

The Health and Care LGBTQ+ Leaders Network is a social movement comprising LGBTQ+ people and allies from a wide range of roles across health and care. Find out more about the network on the NHS Confederation website at nhsconfed.org/lgbtq-leaders or follow us on Twitter @NHSC_LGBTQ

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