CORE TRAINING STANDARDS FOR SEXUAL ORIENTATION

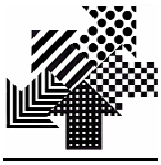
JUNE 2006

MAKING NATIONAL HEALTH SERVICES INCLUSIVE FOR LGB PEOPLE

By Wendy Cree and Simon O'Corra

"I want you to continue the determined drive to promote equality……. in all its dimensions".

Sir Ian Carruthers OBE, Acting Chief Executive of the NHS: April 2006



Diverse Identities

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Key Agencies: Alison Burnal, Oxleas NHS Trust: Paul Carswell, London Ambulance Service: Sarah Holmes-Smith, Heritage Care; Clive Taylor, Fylde Primary Care Trust;

Training Providers: Jan Bridget, GALYIC (Gay and lesbian Youth in Calderdale): Alan Cook, Edgecombe Consultancy; Paul Fairweather, Housing Diversity Network; Denise Frame, Stonewall Scotland; Debbie Gold, Stonewall Housing; Ruth Hunt, Stonewall; Joan Kendall and Camilla Tegg, TUKLO-Orenda Associated; Nick Laird, NHS Inclusion Project; Alyson Malach, Inclusive Learning; Gerard McGuiken, Terence Higgins Trust; Stephanie Morgan, Crosslight Management; Suzanne Motherwell, LGBT Youth Scotland; Lindsay River, Polari; Sue Sanders, Chrysalis; Antony Smith, Age Concern England; Rosemary Watts- Wyness, PACE; Christine Yates, Imperial College;

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Special thanks also go to Joan Kendall and Camilla Tegg of TUKLO-Orenda Associates for the significant contribution of their work on diversity.

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Executive Summary

'Core Training Standards for Sexual Orientation (June 2006): making National Health Services inclusive for Lesbian Gay and Bisexual (LGB) People'

Core training standards in sexual orientation to inform training and development are a crucial component of the NHS drive to promote equality.

'I want you to continue the determined drive to promote equality – an issue that Sir Nigel Crisp put so firmly on the agenda. Nigel did many great things for the NHS and this is but one. His race equality action plan needs to be expanded into a concerted drive to promote equality in all its dimensions. It is my aim to ensure his excellent work continues'.

Presentation by Sir Ian Carruthers OBE, Acting Chief Executive of the NHS: HR in the NHS Conference, 26 April 2006

These Core Training Standards For Sexual Orientation have been produced in consultation with stakeholders, training providers and participants and this report also draws together the best practice in sexual orientation training already in existence within the NHS.

Presented in a four tier format the standards are accessible and can be used by anyone to inform their learning and practice. Each standard is supported by elements that describe its application to practice and in total these standards provide a map for training and development, including personal development plans and appraisal systems, to make services inclusive of LGB people.

For LGB people the imperative for core training standards in sexual orientation is now reinforced by the Equalities Act 2006 which outlines regulations on the provision of goods and services and is due to be implemented in October of 2006. These regulations will make inclusion of LGB staff and service user/patients within health and social care a requirement.

The development of a supported and valued workforce and a climate of inclusion for all staff, including those from the LGB communities, is a major factor in providing a work environment that can be positively diverse in making its services inclusive for LGB people.

The inclusion in training of all staff from all levels and all disciplines, from porter to board room, is essential in the creation of a positively diverse organisational culture and the achievement of seamless and inclusive services for LGB people across the National Health Service.

In commissioning this project the Department of Health and Sexual Orientation and Gender Identity Equality Advisory Group (SOGIAG) have contributed to Carruther's vision of making NHS services inclusive for LGB people.

TRANSGENDER ISSUES

The needs of the transgender community extend beyond the remit of this project in that they relate to both gender and sexual orientation. This project encompasses the needs of those members of the transgender community in as much as they identify themselves to be lesbian, gay or bisexual.

It was the view of the DH that the wider needs of the transgender community warranted and would be best served by the transgender workstream.

PROJECT PARTNERS

DIVERSE IDENTITIES is experienced in undertaking work with both statutory and voluntary organisations on equality and diversity issues including LGBT issues, including research initiatives.
Diverse Identities supports both individual service users and statutory, voluntary and not for profit organisations to achieve inclusive and person centred services.
As members of the LGBT community the team brings an in depth understanding of the issues that affect members of the LGBT community. They have a working relationship with many of the agencies that are working with and on behalf of the LGBT community,

STRAD Consulting has worked on various aspects of the Race Equality Schemes including advising organisations across the public sector on the development and implementation of their schemes; and training staff and boards of NHS organisations in their responsibilities and opportunities.

As a member of the UK professional institute (IMC) STRAD Consulting is recognised as participating in an NGO with Special Consultative Status. This status is recognised by The United Nations Economic and Social Council (ECOSOC).

THE CONSULTANTS

Wendy Cree: BA Hons (Leeds) PSW Certificate (Manchester), Master Practitioner Certificate NLP, NLP Coaching Certificate

Wendy has extensive experience in teaching at tertiary level and training management within social services. She has developed training programmes in partnership with the NHS at both local and regional level. Early in her career she undertook research at the Institute of Psychiatry commissioned by the DHSS on long stay patients within psychiatric hospitals (White Paper 'Better Services for the Mentally Ill" 1974). She has worked as a freelance trainer for twenty years on diversity issues, including sexual orientation. She has recently worked with Schools OUT on an anti-homophobic bullying project in schools. Wendy has a private practice in coaching and mentoring for individuals and organisations.

Simon O'Corra:

Simon has extensive experience in the LGBT field both as researcher, policy developer and front line worker. He is embedded in the LGBT network and has sat on the management committees of Polari, PACE and The Affinity Trust. He is currently working on developing LGBT guidelines for Age Concern, England and researches LGBT issues, including social care. He facilitates Older LGBT support groups and individuals through advocacy. He manages a website devoted to Older LGBT people www.olgbtresources.com

Simon has twenty years experience of working as an advocate, group worker and trainer with people with learning difficulties. Much of this work has focused on sexual expression and personal relationships.

Research Assistant

Sara Barron: BA (hons), MSc (SOAS)

Sara has worked in education and community health in Nepal in partnership with international NGO's including UNICEF. Research work with Diverse Identities has included scoping for people with learning disabilities in long stay institutions and the evaluation of provision for the needs of Older Lesbian, Gay, Bisexual and Transgender (LGBT) people within Local Authorities and PCT. Since 2003 she has worked on the development of software systems and a website for Psynet Psychological Services Network and DPL software systems also acting as strategic coordinator between them and The Management Standards Institute.

'***Diversity is the most essential feature of life, and fear of difference and change is dread of life itself'***
Pauline Graham – Integrative Management: Creating Unity from Diversity

'The NHS must provide services that are fair to everyone and recognise the needs of each individual. Our population is diverse and needs to be dealt with equally. Our challenge is to make this happen.

We are striving to deliver a patient-led NHS, where services are the best that they can be. To do this we must be a model employer and recruit and retain a workforce from all sections of the community, and develop our services to meet the needs of all groups.

Lesbian, Gay, Bisexual and Transgender people need to be treated with respect as both service users and employees… Stories … of LGBT service users and staff in our health and social care system… say how they want services to be provided and tell us how they want to be treated as employees. Their stories highlight the need for specific intervention through staff training and development to ensure that they do not experience discrimination and prejudice in service delivery'.
Sir Ian Carruthers – Script from Real Stories – Real Lives DH DVD

'*Working with diversity is an engagement with the whole person and the richness of their diversity and identity….*
Working with diversity seeks to focus on the strengths and positives of difference, as well as the problems; engages with and understands the totality of people's identity and experience; and recognizes and confronts experiences of oppression and discrimination and their impact on the individual'.
Camilla Tegg – Tuklo-Orenda Associates

1.0. INTRODUCTION

1.0.1. Just over 6% of the UK population is lesbian or gay, according to the first official figures to be released by the government. This 6% figure represents approximately 3.6 million people from across the country.
Source: Department of Trade and Industry 2006

1.0.2. The National Health Service was founded on the principle of access for all and a commitment to improving the health of the whole nation and has as one of its strategic aims:

"To ensure that the NHS uses its influence and resources as an employer to make a difference to the life opportunities and the health of its local community especially those who are shut out or disadvantaged"
The Vital Connection: An Equalities framework for the NHS (DH 2000*)*

1.0.3. This ideal is echoed in the words of Sir Ian Carruthers, acting Chief Executive of the NHS in this statement made on 26th April 2006.

"I want you to continue the determined drive to promote equality – an issue that Sir Nigel Crisp put so firmly on the agenda. Nigel did many great things for the NHS and this is but one. His race equality action plan needs to be expanded into a concerted drive to promote equality in all its dimensions. It is my aim to ensure his excellent work continues".

1.0.4. Statistics[1] indicate that the NHS still has some way to go before inclusive services are achieved in relation to the LGB communities. Over a third out of 866 (approximately 300) respondents to the Beyond Barriers survey of LGBT people in Scotland had not disclosed their sexual orientation to their GP[2]. Wells[3] in1997 identified that within mental health services, mental health nurses' attitudes reflected those in wider society where 77% were either moderately or severely homophobic. In 2003, King and McKeown[4] found that a third of gay men, one quarter of bisexual men and over 40% of lesbians recounted negative or mixed reactions from mental health professionals when being open about their sexuality.

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[1] The Royal College of Nursing: 'Diversity Appraisal Resource Guide: Helping Employers, RCN Officers And Representatives Promote Diversity In The Workplace (London: 2002 RCN)

[2] First Out: Report of the findings of the Beyond Barriers National Survey of LGBT people - L Morgan and N Bell (2003, Beyond Barriers)

[3] Wells, A (1997) Homophobia and Nursing Care Nursing Standard 12 (6) Oct pp 41-42

[4] Mental Health and Social Well Being of Gay Men, Lesbians and Bisexuals in England and Wales: Joint project between University College London and MIND; King, Professsor Michael and McKeown, Dr. Eamonn (2003)

1.0.5. The Government will be outlawing sexual orientation discrimination in the provision of goods and services from October 2006. The implications of the new legislation are considerable and there is an imperative to ensure that all National Health Service and social care provision is inclusive for lesbian, gay, bisexual people.

1.0.6. Inclusive services requires health and social care staff, from hospital porter to board room executive, whether concerned with the delivery of frontline services or strategic and policy development, to be aware of the current discrimination experienced by lesbian, gay and bisexual people, to understand the impact of prejudice and discrimination on lesbian, gay and bisexual communities and to develop well informed attitudes and approaches to LGB people in all aspects of service delivery.

1.0.7. The belief of the LGB communities working within the NHS, represented by SOGIAG[5], is that without a specific intervention through the training and development of staff, LGB people will continue to experience discrimination and prejudice in service delivery.

1.0.8. Such standards would establish a baseline, making it easier to ensure a consistency of approach in the procurement, delivery and evaluation of training in relation to sexual orientation and could be instrumental in the establishment of more inclusive services on a national basis for LGB people. Standards will also help to ensure that poor training with negative and potentially damaging consequences is avoided.

1.0.9. The Department of Health commissioned Diverse Identities and STRAD Consulting to scope existing models of training related to sexual orientation; identify examples of good practice; map and develop core standards for training in sexual orientation. (See Appendix One: Contact list and examples of best practice).

1.0.10. It is important to emphasise that this particular project has been concerned with the development of inclusive services. It has not had a remit to look at the employment aspects of the service or the training standards that would relate to this. Sir Ian Carruthers statement taken from the Real Stories – Real Lives DVD, highlights that the distinction between the twin aspects of service inclusion and employment practice is an artificial one since confident delivery of an inclusive service is dependent on a confident and well supported workforce. Statistics support the need for change in employment practice before an LGB workforce is confident in being out in the workplace. A Royal College of Nursing report[6] states that:

[5] SOGIAG Sexual Orientation and Gender Identity Advisory Group – is a subgroup of the Equality and Human Rights Group (EHRG). SOGIAG has identified four work streams; inclusive services, better employment, reducing health inequalities and transgender health issues.
[6] Op Cit

i) 64% of people concealed their sexuality from some or all of the people they worked with.
ii) 4% of workers had lost their jobs because of their sexuality
iii) 8% of workers had been refused promotion because of their sexuality
iv) 21% of workers had been harassed at work because of their sexuality

There will therefore inevitably be inclusion of employment practice standards and many of the standards will apply both to developing an inclusive service and employment practice.

1.0.11. From the outset this has not been an audit exercise. The researchers have taken the view that it is better to work from a base of establishing and acknowledging the good practice that already exists and to engage relevant personnel in a debate about the development of standards, rather than import a set of standards generated by 'experts'.

1.0.12. This research project has provided an opportunity to talk with training providers and organizations which at local/regional level have been committed to and involved in the development of good practice in relation to service provision and training on sexual orientation. It has been an opportunity to draw these various threads together and to establish with those involved what they consider to be best practice and to identify what they would want to see forming core training standards in relation to sexual orientation.

1.0.13. The research has been primarily consultative in nature and much of
The role of the researchers has been to elicit and collate these achievements and maximize their effectiveness by turning them into a set of standards that can be shared by all parts of the service.

1.0.14. Fuller accounts of research methodology and the research findings are to be found in Appendix Two: Research Methodology and Appendix Three: Research Findings

1.0.15. In a report of this nature it is important that the terms used in relation to sexual orientation are defined both to:

- Avoid ambiguity in relation to subjects about which there is a degree of confusion
  and
- Support the reader in their understanding

1.0.16. These definitions may be open to debate but we have used terms in common parlance within the LGB communities and/or understood within the health service.

1.0.17. Where possible we have used definitions which comply with the terminology within the NHS Knowledge and Skills Framework (NHS KSF). Where this has not been possible definitions relate to the researchers' own perceptions supported by references to the Oxford Dictionary and the 'people's encyclopedia' Wikipedia.

1,0.18. A full glossary of terms is included as the first of the reference documents situated at the back of this report

2.0. REAL STORIES – How people experience services now.

2.0.1. Five individual stories[7] were collected for this research, focusing on personal experiences of the health service including the partner's or carer's experience where this is relevant.

2.0.2. The experiences that these and other similar stories[8] reveal, provide the initial rationale for undertaking this research, grounding it in the truth of lived experience. Placing these service user and partner issues at the front of this report serves both to provide a context for the report and as a reminder of who the services are for.

2.0.3. P's statement:
"There is still prejudice and areas where the service can improve".
echoes the sentiments of all those that told their stories.

Inclusiveness Of Services

2.0.4. Most story tellers felt that there had been some improvement in the inclusiveness of health services and their experience of them over the last decade[9].

2.0.5. LGB people have had variable and patchy experiences of health services ranging from bad to excellent. Services such as Genito-Urinary Medicine Clinics (GUM) dealing specifically with sexual health issues were more likely to be gay friendly than other services such as liver units or gynecological units. O's experience of a gynecological unit illustrates the heterocentric nature of institutions well. She was treated for polycystic fibrosis within an Assisted Conception Unit where the implication was that if she was not 'a potential baby making machine' then she should not be there. The experience made her feel 'abnormal' and added to feelings of anxiety and vulnerability. However, even in GUM clinics friendliness related more to the manner of the personnel than to how information was elicited or given.

2.0.6. At times storytellers said that it was hard for people to identify discrimination on grounds of sexual orientation - a case of "not quite being able to put your finger on it" (T *and K*).

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[7] The people who recounted their stories are:
E - Gay man aged – late thirties
N - Gay man aged – late forties
P - Bisexual man aged – early fifties
T&K - Lesbian T and partner K - late fifties
B&O – Lesbian O and partner B - mid thirties

[8] DVD Real Stories –Real Lives: Department of Health

[9] Whether this was the result of the proactive efforts of the NHS, general changes in society's attitudes towards LGB people or a combination of the two is open to debate.

"I believe that outside GUM clinics there is some form of (almost always) veiled and vague hostility usually expressed by a coldness in behaviour ….. Not overt but able to sense it by their body language" (N*)*

Accessing Health Services

2.0.7. These stories confirm, at an anecdotal level, that there is an inequality between the health services for gay men and health services for lesbians and bisexuals. P, T&K and B&O all said that there are far more access points into sexual health services for gay men than for bisexuals or lesbians. They acknowledged that many of these services were focused on HIV and AIDS and that gay men falling outside the remit of these services would also experience inequalities.

2.0.8. All storytellers and particularly lesbians said that they would like an access/contact point within the health service where they could discuss issues and get information in an environment where they knew that their sexuality would be a given. These services would need to recognise the different needs of the lesbian, gay and bisexual communities. Ideally, such a service should be a local resource but even a national contact point would be helpful. They would like to see such a resource backed by an accessible website giving clear information on lesbian, gay and bisexual health issues with indications as to where to get support that would not make assumptions about being straight, that would treat people as individuals and give them the opportunity to share vital information. Specialist services would be more likely to get people to the service that they need.

2.0.7. There was a recognition that such a service would and could not replace mainstream services; there needs to be a combination.

Staff Attitudes

2.0.8. Staff make assumptions about sexuality (even in GUM clinics) and see it in terms of clear divisions between lesbian, gay or straight, ignoring bisexuality and the fact that for many, sexual orientation is not fixed and sexual expression and practice may be fluid.

2.0.9. GP's, most often the first point of contact with health services, were identified as particularly important in accessing services and often unable to respond appropriately to issues of sexual orientation. E tells his story of the disgust demonstrated by his G.P. when he came out and as a consequence the G.P. was unable to see the depression that he was experiencing as a result of bereavement. T's G.P. forgot that she had already come out to him and that this was recorded on her notes. This led to inappropriate questioning which completely ignored her sexuality.

2.0.10. Even where staff (G.P's) had known a person to be lesbian, they continued to operate as though they did not, leaving the patient in the position of having to make the decision to 'come out' at every visit and increasing a sense of invisibility and being unvalued.(T&K, B&O).

2.0.8. People interviewed felt that there is a particular need to focus on GP's making their services inclusive both in terms of attitude and in terms of the literature within surgeries which needs to include specific information on gay and lesbian health issues.

2.0.12. Two of the six people who told their stories said that they had experienced more hostility around sexual orientation from black and ethnic minority staff.

Issues Of Visibility And Disclosure

2.0.13. T&K, B&O and P said that the invisibility of sexual orientation placed an additional pressure upon them to decide whether or not to come out when receiving a medical consultation. Already feeling vulnerable they had to make a decision as to whether 'coming out' would jeopardize their fair access to services and increase their sense of vulnerability. (T&K, B&O)

2.0.14. The lesbians interviewed for this report are out in many arenas of their lives; they are clear about their sexuality; two of them have jobs directly related to sexual orientation. These decisions were still difficult for them and came at an emotional cost. How much more so for a lesbian who is less clear about her identity, less rooted within her community and more wary of being out?

2.0.15. Internalised homophobia and childhood proscriptions around sexual expression may prevent some people from disclosing or mean that they only give partial information. (E)

2.0.16. P points out that there is a difference in the disclosure of sexual orientation and sexual practice. E.g. He had been able to disclose his sexual orientation in a GUM Clinic but not his sexual practice.

2.0.17. There are a number of people who lead secret lives, e.g. secret gay men and married bisexuals. It will always be hard to reach all populations. Many in these populations think that it is dangerous for them to disclose their sexual practices as disclosure may lead to referral from a general clinic to a specialist gay man's project, raising the possibility that a female partner may find out (P).

2.0.18. The impact of not disclosing may have serious impact on relationships both physically and psychologically (creating secrets in relationships) (P).

2.0.19. All storytellers emphasised that members of the LGB communities need to feel safe to disclose their sexual orientation and therefore services need to pay much more attention to the issue of making people feel safe.

2.0.20. There is a need for service users/patients to have time to think through what they will and will not disclose and without this they will be less open (P).

2.0.21. Services could offer people a variety of ways of answering questions ranging from the impersonal (forms and computer based questionnaires) through to the more personal (face-to-face interviews) (P).

2.1.22. All storytellers feel that agencies need to be much more proactive about being inclusive in their information on health issues. Information needs to be clearly inclusive and visible with any health implications for LGB communities clearly stated. P suggested that people need more detailed information from GUM clinics with information covering the range of risk involved in various sexual practices from the slight and less serious to the more serious – nuances were often ignored in literature.

Inclusiveness And Language

2.1.23. T&U and B&O felt that questions about sexual practice were clumsy and excluding and made the assumption that people were in heterosexual relationships. They said that much more thought needed to be given to language used to make questions inclusive[10].

Partnership Issues

2.1.24. The lesbians interviewed were both in long term relationships with partners present at the interviews who contributed to the discussion from the perspective of their experience as partners and carers.

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[10] The following example of how exclusion through questioning can work, was experienced by both T and O:

Dr: *'What contraception do you use?'* This question is exclusive of a lesbian life-style

O: *'None'* This response is most likely to make the doctor think that N is being irresponsible or wanting to become pregnant. This places N in a dilemma.

Either:

- She does not respond in which case the GP may continue to consider her an irresponsible heterosexual which could lead to a less than fair service or inappropriate lines of enquiry wasteful of resources

Or:

- She has to come out to a doctor who has demonstrated by his/her question that at best he/she is heterocentric in their thinking and at worst may be homophobic.

A simple reframing of the question 'Do you practice safe sex appropriate to your lifestyle?' is much more inclusive, does not imply a heterosexual relationship and actively demonstrates the possibility of either a lesbian or bisexual lifestyle. It creates an increased safety zone.

2.1.25. Both couples had mixed experiences of how they had been received. For T&K one of these experiences, which involved an emergency in-patient stay for T, K had met with considerable hostility in her requests to stay with T so much so that she had been forced to leave the hospital, which caused both of them considerable and unnecessary distress. A later experience was quite different with staff totally accepting and supportive of their relationship.

2.1.26. These experiences took place in the last five years. Hopefully with civil partnership legislation, a greater recognition of LGB lifestyles, partners with more clearly defined rights and a greater social acceptance of same sex relationships, members of LGB communities will experience these situations less.

2.1.27. These stories can only provide a snapshot of some of the very broadest issues that affect all LGB people within their communities. They cannot and do not claim to address the additional issues faced by particular groups.

2.1.28. All of these stories were from white and able bodied people; none of the complexities of the interplay of sexual orientation with the other diversity strands of disability, race or religion and culture was explored.

2.1.29. This leaves a serious gap in information as to the additional issues for those LGB people who form minorities within the minority of wider LGB communities, and a gap in the knowledge of how these issues impact on their health needs and experience of health services. For example issues of double jeopardy, racism in addition to homophobia; disablism and homophobia; ageism and homophobia; issues of triple jeopardy - racism, sexism and homophobia; or the issues that arise from the potential of being isolated from a religious and cultural community that is homophobic and also dealing with the hetero and 'WASP[11] normativity' that exist within wider society.

2.1.30. One of the two lesbian couples interviewed was an older couple but issues of age were not specifically discussed. The issues that emerged for both lesbian couples were remarkably similar.

2.1.30. Stories of younger people below the age of consent are also not included and it is important that the particular issues for younger people in LGB communities are not ignored; health issues arising from homophobic bullying within schools and below age sexual activity.

2.1.31. People of both genders were interviewed and although the interplay of gender with sexuality was not specifically explored differences in the nature of the content between the men's and the women's experiences were necessarily different.

[11] White Anglo Saxon Protestant

2.1.32. To do justice to all the elements of LGB communities would have been a study (or several) in its own right which time did not permit.

3.0. CONSIDERATIONS IN DEVELOPING CORE TRAINING STANDARDS FOR SEXUAL ORIENTATION

Is There An Ideal Model For Training?

3.0.1. It is hard to say that there is one model of training that should be applied in all agency contexts. Health and social care agencies have different structures and cultures, are different sizes, fulfill different functions and belong to both the voluntary/private and statutory sectors. A one size fits all would not be helpful. However, from the responses that we received from stakeholder, key agencies, training providers and participants, there are certain elements that seem to make training more or less effective depending on their presence or absence.

Diversity Strands Are Non Hierarchical

3.0.2 Responses in interviews indicate that a number of people within the health service feel that there is effectively a hierarchy between the diversity strands with sexual orientation holding a low ranking.

3.0.3. Why this should be the case can only be surmised. However, there is a strong correlation between belief in choice and disapproval of homosexuality. (See Appendix Four: Models of Sexual Orientation). The practical result of this correlation can be the denial of parity of sexual orientation between LGB people and other diversity strands and the people who identify with those strands. This belief and the disparity it can engender must be noted and addressed to make sure that there is no hierarchy of oppression in the six diversity strands in relation to employment and service delivery.

3.0.4. It is important to make it explicit that the development of these standards has as a starting point that there is no hierarchy between the strands of diversity and the discrimination that is associated with them.

3.0.5. This research assumes that no one strand of diversity is ideologically or theoretically more important than any other, although practically in the delivery of a service one aspect may be more important than another at a particular point in time[12]

Individual Diversity Is Multi Faceted

3.0.6 In a world where none of us is defined by any one single aspect of diversity, a non hierarchical approach allows each one of us to identify with a number of

[12] E.g. Offering a service to older people may mean that the needs of the elderly and an understanding of how ageism may limit or distort service delivery is a primary requirement. Alternatively, a sexual health service being offered to gay men will have as its essential requirement the need to make the environment safe and welcoming for gay men to approach the service and the need to ensure that the staff do not act in ways that are discriminatory towards this particular group of service users.

aspects of diversity[13] and to decide for ourselves which aspect of that identity is most important or prominent at any point of time.

3.0.7. The multi-faceted nature of diversity allows us all to acknowledge our own experiences of discrimination and to recognise that we all also have the potential to discriminate.

Standards And Good Practice

3.0.8. Some standards will have a general application that extends far beyond training and practice related to sexual orientation or general equality and diversity training. This is a reflection that the standards of practice and training relevant to equality and diversity and sexual orientation are very often about general good practice.

Mainstreaming

3.0.9. There was considerable reference throughout conversations with stakeholders, key agencies and training providers that part of the process of making services for LGB people inclusive is to mainstream both services and training on sexual orientation.

3.0.10. The term 'mainstreaming' is used in the context of countering the marginalisation that LGB people experience. However, it is apparent in these conversations that not all mainstreaming is seen as being effective and in some situations may be counter productive.

3.0.11. The Oxford Dictionary defines the verb 'to mainstream' as 'to bring in line with the majority, the usual, the normal.' In our view this has both benefits and disadvantages for LGB communities and there needs to be a distinction between 'positive mainstreaming' i.e. that which brings advantages to LGB communities and 'negative mainstreaming' that which continues to disadvantage.

3.0.12. An example of 'positive mainstreaming' would be to ensure that core funding for developments in services for these communities is available once special funding, which is often time limited, ceases. Another example is to include sexual orientation components, such as case studies, in non diversity training.

3.0.13. In contrast 'negative mainstreaming' with an emphasis on 'normalising' sexual orientation and LGB services may only lead to absorption/assimilation into an existing heteronormative culture in which the recognition of difference and increased visibility are lost. What is commonly referred to as 'tokenism' or 'lip service' frequently falls within this category as do gaps between policy and practice. For example a cervical screening clinic may encourage lesbian attendance but failing to ask inclusive questions on sexual practice will have the negative effects of forcing women into a position of coming out and reducing their

[13] A lesbian by definition is a woman or maybe transgender; she will also identify with a particular racial group, will come from a particular culture have a learning or a physical disability etc.

attendance at these clinics. The inclusion of sexual orientation training within a general diversity training may have the intention of making the training inclusive of all strands of diversity but have the effect of 'tokenism' in which passing reference only is made to sexual orientation and the issues remain unaddressed.

3.0.14. Those developing these services need to be mindful of the distinction and always use as their base-line questions:

i) How is this action decreasing the marginalisation of LGB communities and making services more inclusive?
ii) What else needs to happen to make this action effective?

The NHS Knowledge And Skills Framework (KSF)

3.0.15. A number of key stakeholders emphasised the importance of the KSF in the development of standards.

3.0.16. As one of the three key strands within Agenda for Change the KSF has been an important point of reference throughout this research. Two of the purposes of the KSF are to:

i) 'facilitate the development of services'.
ii) 'promote equality for and diversity of all staff'.

3.0.17. Therefore in developing training standards for sexual orientation and service inclusion, this research has referred to:

i) Core Dimensions 4: Service Improvement
ii) Core Dimension 6: Equality and Diversity

3.0.18. Elements of these core dimensions have been incorporated into the training standards where possible and appropriate.

4.0. ORGANISATIONAL ISSUES IN RELATION TO TRAINING IN SEXUAL ORIENTATION

4.0.1. The most critical factor in the achievement of effective service delivery has to be the organisational context.

4.0.2. Most large institutions almost inevitably have large elements which are heterocentric[14] and heteronormative. An example of this is the organisation that claims 'sexual orientation is not a problem for us'. A non heteronormative approach would question what problems the LGB community might experience within their organisation[15].

4.0.3. Our research has evidenced that there are individuals within the NHS who in their work and in delivering training, pose questions that challenge heterocentric and heteronormative thinking. However, they often do from a position of personal rather than organisational commitment. The consequence of this is that their work is effectively marginalized and vulnerable to changes in personnel and financial constraints. Those that drive this work, whether heterosexual and particularly if members of the LGB community, because they have to be out about their sexual orientation, are also vulnerable to for example, bullying, harassment, ostrasisation and limited career advancement.

4.0.4. There are some organisations who have appointed people to posts supporting the promotion of equality and diversity but often their thinking has not fully embraced sexual orientation and the need to address a heteronormative position.

4.0.5. The changes in thinking and values necessary to embrace LGB communities, develop effective and inclusive services, make this work secure and protect those that lead it, have yet to become fully embedded as an approach within the organisations' culture and ethos.

4.0.6. Changing heteronormative and heterocentric patterns and the behaviours that are associated with them is at best not easy and can be experienced as difficult, personally challenging and at times painful as old certainties have to be unlearned and new ways of doing things established. They can also be exciting and very rewarding.

4.0.7. NHS and social care organisations need to provide a supportive environment in which these changes can occur

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[14] For definitions of the terms 'heterocentric' and 'heteronormative' please see Appendix - Terminology

[15] Another mainstream organisation demonstrated their confluence with heteronormativity when they claimed that they "do not promote sexual orientation". The response from Sue Sanders of Chrysalis was "except heterosexuality".

4.0.8. Core organisational standards that allow and support this shift are essential if services to LGB people are to be inclusive and training in relation to sexual orientation effective.

4.0.9. Whilst the remit of this research has not included organisational standards this is such an important area that some suggested organisational standards are included within Appendix

Medical Staff And Training Standards

4.0.10. Peoples' stories within this research underline the enormous influence of medical staff in determining whether or not LGB people feel that services are inclusive. Seen by service users to be extremely powerful in terms of expertise, status and access to resources, it is vital that medical staff understand their power, are aware of the impact this has on service users and have the knowledge and skills that enable them to relate to LGB people.
(Appendix Five: Organisational Standards)

Knowledge And Skills Framework

4.0.11. It is an issue of concern that the Knowledge and Skills Framework only applies to non-medical staff. Given the direct contact that many medical staff have with service users, these standards are equally applicable to medical and non medical staff. For services to become inclusive all staff within the NHS will need to embrace and apply these standards.

The Location Of Training Within Organisations

4.0.12. This research seems to indicate that the location of training functions within an organisation may have an effect on the effectiveness of training in introducing change.

4.0.13. Many agencies have training functions located within Human Resources. Where this is the case it is sometimes harder for training to impact on service delivery and there is an emphasis on employment issues.

4.0.14. In some agencies training functions for equality and diversity including sexual orientation are located within operational or executive divisions.

"I am based in corporate services and I connect to all other departments. I provide professional supervision to the Equality Diversity Training Officer who is part of the Learning and Development Department"
Christine Trethowan- Lead for Involvement and Diversity Coventry Teaching PCT

4.0.15. Within the Oxleas Trust the officer with a specific responsibility for equality development which includes training is located within an operational nursing division.

4.0.16. The experience seems to be that where this is the case it is easier to work with operational staff and develop strategies in partnership with management. In addition the relevant post holder is more likely to have a voice and a place in strategic planning groups.

“I now sit on our Training and Planning Implementation group and we now feed into NHS Education Scotland”.
Nick Laird Training and Community Engagement officer – NHS Inclusion Project Scotland

5.0. DESIGNING CORE TRAINING STANDARDS

5.0.1. The view that the processes that are common to discrimination, and conversely inclusion, are the same for all diversity strands, informs a tri-partite model of training which is reflected in the one used by the Coventry Teaching Primary Care Trust:

i) Tier One - General Equality and Diversity – one day
ii) Tier Two – Separate days on each of the six areas of equality and diversity. Including sexual orientation[16] awareness.
iii) Tier Three – Training sessions arranged on request for specific equality and diversity issues.

5.0.2. Tiers one and two are mandatory to be completed over three years

5.0.3. In addition to these three tiers we strongly recommend an additional and complementary fourth tier of training standards relating specifically to managers. Managers working with frontline staff are critical in the translation of policy into effective practice. Therefore we have considered these standards to be core.

5.0.4. The effectiveness of training depends both on 'what' is taught and 'how' it is taught. The training standards therefore relate to the:

i) Content of training in each one of the three levels identified above
ii) Training processes
iii) Monitoring and evaluation

5.0.5. Each of the standards offered contains a number of elements. All these elements are important and collectively represent best practice but to some extent may be regarded as a menu from which each organisation needs to identify those elements which are of particular relevance to it and therefore prioritised within training programmes.

[16] Each of the six strands of diversity should have specific training related to it

6.0. TIER ONE: CORE TRAINING STANDARDS FOR GENERAL EQUALITY AND DIVERSITY

Introduction

8.1.1. The standards proposed here are those that underpin equality and diversity training in all strands. It establishes general principles that inform an understanding of how to make employment environments and services inclusive for both staff and service users/patients.

These have been identified in brief

6.1. Content - General Equality And Diversity Training Standards

Standard One: Legislation, Strategies And Policies

i) General Legislation on Discrimination.
ii) National agendas particularly those relating to health
iii) Organisational strategies and policies
iv) Implications for practice

Standard Two: Defining The Territory

i) Definition of Key Terms: Equality, Diversity, Discrimination; Identity
ii) Identifying key strands of diversity
iii) Non hierarchical nature of oppression
iv) The multi-dimensional nature of identity
v) History relating to each of the diversity strands
vi) Contributions of people to society from each of the diversity strands

Standard Three: Understanding The Nature And Process Of Discrimination

i) Prejudice
ii) Assumptions
iii) Stereotyping
iv) Wilful ignorance (I don't know and I don't want to know!)
v) Intentional and Unintentional discrimination
vi) Overt and Covert discrimination
vii) Concepts of Double and Triple Jeopardy

Standard Four: Individual Awareness And Discrimination

i) Identifying personal experiences of discrimination
ii) Identifying the ability to discriminate against as well as experience discrimination.
iii) Identifying personal responsibility in perpetuating discrimination
iv) The relationship between personal behaviour and political action
v) Developing anti-discriminatory practice in relation to LGB service users/patients

Standard Five: Using Power Responsibly

i) The power of the medical profession
ii) The nature of power; real and perceived; power and powerlessness
iii) Types of power
iv) Personal ownership of power and using power appropriately
v) Using power responsibly
vi) Power in the workplace; the power and influence of the medical profession
vii) Constructive challenging and the use of feedback
viii) Empowerment; overcoming experiences of exclusion and oppression.

Standard Six: Communication And Language

i) Language as signifier an cultural transmitter
ii) Power and impact of language
iii) Language as a tool for inclusion

Standard Seven: Creating A Positively Diverse Workplace

Creating a positively diverse workplace means having the ability to be responsive to staff and service users/patients who identify with any one of the diversity work strands and to make working environments and services more inclusive.

i) Presentation of up to date statistics and research data and other literature that informs the knowledge base of health inequalities and the development of equality and diversity strategies in the workplace
ii) Use of evidence based practice including examples of best practice to inform change.
iii) Developing strategies/action plans to improve employment conditions and service inclusion.
    a. Policies
    b. Procedures
    c. Publicity
    d. Management structures and practice
    e. Developing anti-discriminatory work practice
    f. User/patient involvement and empowerment e.g. expert patient programme
    g. Community Involvement to inform and provide expertise
    h. Partnership Working
    i. Carer Involvement
    j. Learning and Development issues including supervision, appraisal and training.
    k. Evaluation and Monitoring

7.0. TIER TWO: CORE TRAINING STANDARDS FOR SEXUAL ORIENTATION

Introduction

7.0.1. The specific standards for sexual orientation assume that participants have the general understanding that is covered by the general equality and diversity standards.

7.0.2. What differentiates one strand from another is the content of what is expressed and the specific evidence that will be needed to demonstrate that any one particular strand of diversity is being addressed.

7.0.3. The framework used for these standards echoes that of those for general equality and diversity but the content is much more specific.

7.0.4. Underpinning these standards are two key elements:

- The causes and effects of homophobia
- Developing services that are inclusive of LGB people[17].

Training Outcomes

7.0.4. Core training standards have been identified to elicit the following outcomes:

i) Increased understanding of the issues related to sexual orientation in the context of a social rather than clinical model. (Appendix 5)

ii) An increased understanding of the issues of silence and invisibility faced by LGB people.

iii) An increased awareness which gives participants a flavour of the lived experience of the discrimination experienced by LGB people. This adds another dimension to an intellectual (and at times intellectualized) understanding of the issues.

iv) Increased understanding and development of best practice.

v) Skills/toolkit to support organisations and individuals to be more gay friendly.

vi) Clearer criteria to be used in policies, procedures, appraisals and other training packages such as customer care.

[17] Training carried out by Jan Bridget of GAYLIC divides training on sexual orientation divides training into these two distinct elements with one day devoted to each.

7.1. Core Standards For Training In Sexual Orientation

Standard One: Knowledge Of Legislation, Strategies And Policies Relating To Sexual Orientation Equality And Implications For Practice

i) Specific legislation as it relates to sexual orientation (Appendix Six: Legislation Relating to Sexual Orientation)
ii) Current national agendas in relation to sexual orientation particularly in relation to health and social care services.
iii) Organisational agendas and strategies policies and procedures related to sexual orientation both within the workplace and in relation to service delivery. This applies to both:
    a) The place of sexual orientation within general strategies, policies and procedures for example bullying and harassment for both staff and service users/patients; complaints procedures; confidentiality.
    b) Specific strategies, polices and procedures that relate to sexual orientation.
    c) Implications for practice
    d) Introduction to issues of sexual orientation and policies on sexual orientation harassment in induction training.

Standard Two: Understanding Of Broad Issues Relating To LGB People And Their Communities.

i) Definition of key terms: particularly sexual orientation/sexual identity; gender, heterosexism; heteronormative and homophobia.
ii) Sexual orientation within the wider diversity context; hierarchies of oppression.
iii) Different models of sexual orientation. (Appendix Four)
iv) LGB histories and the contribution of LGB people to society
v) The diversity of LGB communities
vi) Recognition of separate health needs of lesbian, gay and bisexual people
vii) Person centred approaches as opposed to service led approaches
viii) Exploding myths in relation to LGB communities
(See reference section for further reading/viewing)

Standard Three: Understanding The Nature And Process Of Discrimination Towards LGB People

i) Understanding and identifying how heteronormativity operates within society.
ii) Understanding how heterocentrism
    a) Works in society
    b) Within the workplace
iii) Understanding how homophobia is expressed:
    a) In society
    b) In the workplace

iv) Understanding how heteronormativity, heterocentrism and homophobia in the workplace both as it affects employees and service users/patients:
a) Differences in experience and issues between gay, lesbian and bisexual communities.
b) Differences in experience of rural and urban communities
c) Patients' stories or journeys.

v) Exploding myths in relation to LGB people, their communities and sexual practices. e.g. gay men and sexual stereotyping and how to challenge

vi) Widening understanding of determinants on health for lesbians, gay men and bisexuals beyond medical issues e.g. psychological impact of heterosexism on LGB people.

Standard Four: Individual Awareness Of Discrimination Towards LGB People

i) Awareness of own attitudes, stereotypes, prejudices and assumptions in relation to LGB people and their communities

ii) Understanding of how attitudes, stereotypes, prejudices and assumptions may impact on others and on practice.

iii) Understanding own values

iv) Understanding the beliefs of others and being respectful of them in working practice.

v) Dissociating the personal from the professional; e.g. managing own feelings.

vi) Taking responsibility for own behaviour

vii) Taking responsibility for own development and learning in relation to understanding of LGB issues and sexual orientation

viii) Understanding and closing the gap between own and LGB service user/patient perceptions of barriers to services.

ix) Developing reflective practice; how does my practice promote inclusive services for LGB people? What action do I need to take to improve this?

x) Understanding the transferability of skills. e.g. how general knowledge of processes of discrimination may be transferred from one setting to another

xi) Taking decisions that are risky but informed by ethical critique in relation to LGB people and issues of sexual orientation. e.g. risk assessments

Standard Five: The Responsible Use Of Power In Making Services Inclusive For LGB People And Their Communities

i) The positive and negative uses of power to include or exclude LGB service users/patients

ii) Locating the personal power of the practitioner e.g. status, expertise, control of knowledge and resources etc.

iii) Using influence to promote service inclusion for LGB people

iv) Empowerment; overcoming experiences of exclusion and oppression for LGB community members

Standard Six: Effective Communication And Language In The Development Of Inclusive Services For LGB People And Communities

i) The relationship of language to homophobia; the capacity of language to injure/wound.
ii) The role of language in LGB communities; language as cultural transmitter
iii) Generational differences within LGB communities leading to variation in the language used to define their sexual orientation
iv) Non verbal communication; e.g. non verbal cues as a means of understanding a person's situation – not saying all of the things that impact on their situation.
v) Conflict resolution training.
vi) Communication through the physical environment.

Standard Seven: Creating A Positive/LGB Friendly Workplace

i) Identifying and addressing homophobic and heterosexist behaviour and practice, including common misconceptions, within the organisation in relation to:
   a) Service users/patients
   b) Colleagues within the same organisation
   c) Other professionals and workers
ii) Identifying and addressing covert homophobia is within the organisation
iii) Knowledge base of LGB resources both locally and nationally with regard to:
   a. Local communities
   b. Specific health needs
iv) Simple steps to inclusion
v) Creating a positive work environment in which LGB staff and service users/ / patients can be out and open about their sexuality.

Standard Eight: Working Effectively With LGB Service Users/Patients – General Issues.

i) Issues relating to intimate and personal care.
ii) Setting clear care plans with patients with set objectives taking full account of issues related to sexual orientation.
iii) Facilitating service user/patient autonomy and involvement in care
   a) Relating to the person as a whole and not only to their sexuality – integrating the sexual health dimensions of a person's life.
   b) Respect for people and their view of the world
   c) Respecting a service user/patient's unique perspective in a situation
   d) Promoting a person's dignity
   e) Ways of information sharing to enhance LGB peoples' problem solving and decision making.
   f) Connecting people to relevant LGB support networks.
   g) Expert patient programmes
   h) Monitoring health care of LGB communities

Standard Nine: Working Positively With Partners And Families

i) Working in collaboration with partners
ii) Responding to blood relatives of LGB patients
iii) Recognising and working with parenting relationships within the LGB communities.
iv) Dealing with bereavement as this affects LGB communities and their 'families'
v) Consent issues
vi) Broadening concepts of family to be inclusive

Standard Ten: Effective Management Of Information And Recording

i) Managing information as this relates to LGB service users/patients and their partners and carers; principle of need-to-know.
ii) Recording documentation around sexual orientation and permissions

Standard Eleven: Monitoring LGB People And Services Sensitively

i) Understanding of the issues for LGB service users related to monitoring
ii) Sensitive approaches to monitoring LGB service/users/patients and staff to include:
    a) The purposes of monitoring in improving services for LGB people,
    b) The need for sufficient flexibility for self definition e.g. lesbian mother
    c) The need for privacy
    d) Assistance in completing forms

Standard Twelve: Understanding Of Issues For LGB People As Service Users/Patients

i) Issues for LGB people in coming out
ii) Internalised homophobia
iii) Coming out including a recognition of psychological impact of being in the closet; Isolation issues from peers and LGB communities
iv) Hidden populations
v) Peoples' stories and journeys
vi) Accessing domiciliary care and other personal care
vii) Providing domiciliary and personal care sensitive to the needs of LGB people

Standard Thirteen: Understanding Of Issues For LGB People As Staff

Supporting LGB people within organisations is one expression an agency's commitment to its LGB employees. In addition LGB people within organisations are a valuable resource in making services more inclusive for LGB service users/patients their partners/carers.

i) Issues of visibility to LGB service users/patients.
ii) Isolation from peers
iii) LGB experience as a tool in developing inclusive services.
iv) Appropriate support; issues of sustainment and protection

v) Hidden populations; sensitivity in working teams and development of non heterocentric approaches.
vi) Acting as a role model to colleagues and students.

8.0. TIER THREE: CORE TRAINING STANDARDS FOR SPECIFIC SERVICE NEEDS IN RELATION TO SEXUAL ORIENTATION

Introduction

8.0.1. Tier Two Core training standards for sexual orientation develops a general awareness of the discrimination experienced by LGB communities and a general understanding of the issues for LGB communities.

8.0.2. Tier Three extends this awareness and understanding further. In addition to addressing the specialist health areas (Standard One) it covers broad and complex areas of mental health and social care issues (Standards Two and Three).

8.0.3. Standard Four signposts and begins to address the areas of health inequalities experienced by LGB people who identify with other diversity strands

Standard One: Specialist Subjects And Clinical Practice

i) Briefings/modules on specialist subjects and clinical practice relating to the health needs of LGB communities[18]
ii) Research base supporting treatment and practice; evidence issues
iii) Patient's journeys relating to their experience of specific health issues
iv) Language –specialist technical terms relating to specialist areas of health care affecting LGB communities
v) Assumptions made in relation to specific health issues
vi) Exploding myths associated with particular health issues affecting LGB populations.

Standard Two: Understanding Mental Health Issues For LGB People

A disproportionate number of LGB people suffer from mental ill health. Therefore the development of core training standards for sexual orientation needs to include standards that specifically relate to mental health issues for LGB people.

i) The differing perspectives of clinical and social models of mental health
ii) The history of treatment for LGB people including medical and legal status
iii) The impact of homophobia, biphobia and transphobia on mental health
iv) The impact of internalised homophobia on LGB people's health and wellbeing.
iv) Issues relating to LGB people choosing to access mental health services. e.g. mainstream or specialist LGB services.

[18] HIV/AIDS, Sexually transmitted diseases, health screening for lesbians, dealing with death, transplantations etc as this pertains to LGB people.(Human Tissue Act 1961), accurate and unbiased information about various sexual activities e.g. rimming, finger play etc.

v) Fears around physical and emotional safety and confidentiality for LGB people when accessing mental health services.
vi) Promoting mental health and creating a healing environment for all
vii) The integration of sexual orientation into general mental health training.

Standard Three: Housing And Social Care Issues

i) Housing Issues as they impact on social care and health issues e.g. moving from hospital into nursing home or supported living
ii) Accessing domiciliary care; the fears and concerns of LGB people
iii) Working with LGB people in long term residential care
iv) Same Sex Domestic Violence
v) Same sex partnerships e.g. social care issues.

Standard Four: Understanding Multi Diversity Issues:

This report does not attempt to establish comprehensive training standards in relation to multi diversity issues. What follows are a few suggested standards relating to multi-diversity issues which both provide a starting point for further development and an indication of how these complexities impact upon LGB people's access to services.

4a: Understanding How Age Impacts On LGB People.

Older People

i) Why older LGB people don't use generic services.
ii) Working with older peoples' sexuality across the board and specifically in relation to the needs of older LGB people.
iii) Recognising that older LGB people's definition of family may be different to heterosexuals and therefore they may have different support needs.
iv) Issues of consent for people with dementia
v) The impact of dementia on sexual expression and implications for LGB people.

Younger People

i) Providing active support working with younger people up to the age twenty-five.
    - Sexual health
    - Education
    - Prejudice
    - Personal self esteem
    - Bullying
    - Sexual identity crisis

4b: Understanding How Disability Impacts On LGB People

i) Understanding and working with sexuality and its impact on people with physical and learning disabilities.
ii) Understanding and working with sexuality as it impacts specifically on the needs of LGB people who may be physically disabled or and/or

have a learning disability[19].

4c: Understanding How Race Impacts On LGB People

i) Understanding the additional issues of LGB people who also identify as part of other diversity strands e.g. such women and members of the BME communities[20].

4d: Understanding How Religion And Culture Impacts On LGB People

i) Understanding the conflict in value bases that exist between Religion and culture and sexual orientation.
ii) Dealing with bigotry: what to do with information and understanding complaint procedures.

4e: Understanding How Gender Impacts On LGB People

i) Defining gender
ii) The relationship between gender and sexuality
iii) The differential impact of gender as it impacts on lesbians and gay men; both in relation to health inequalities and experience of health services.
iii) Transgender issues in relation to LGB identities

[19] For example people with learning disabilities are often not fully appraised and educated about sex and their right to a sexual relationship of whatever sexual orientation.

[20] For example evidence suggests that black gay and bisexual men are under served within the health sector, yet black gay and bisexual men remains amongst one of the highest 'at risk' groups of getting and passing on sexually transmitted infections, including HIV/AIDS (Stonewall 2006)

9.0. TIER FOUR: CORE TRAINING STANDARDS FOR SEXUAL ORIENTATION: MANAGERS

Introduction

9.0.1.

"If equality and diversity are shown to be top level priorities, the likelihood of them being translated into action is high".
The Vital Connection: An Equalities framework for the NHS: DH 2000

9.0.2. All managers will need to have undertaken basic awareness training in relation to general diversity and sexual orientation. In addition there are particular core training standards related to a management role. Management operates at different levels within an organisation and these standards may require particular adaptation.

9.0.3. For a variety of reasons it is vital that all managers at all levels undertake training and are seen to do so:
Managers need to be seen to be committed to the issues

i) Managers are not exempt from the potential to discriminate however 'aware' they may believe themselves to be.

ii) Working with the discriminatory actions of staff, developing services and a team approach inclusive of LGB colleagues and service users and creative in its approach to service delivery, requires a detailed understanding of how discrimination operates and specific skills to work sensitively with issues.

iii) Managers need to share the same understanding of discrimination and how it operates as their staff. In relation to sexual orientation this means an understanding of heterosexism and homophobia and how this may manifest itself in relation to both staff and service users. Staff who are members of LGB communities and staff who have increased their awareness through training can be frustrated by managers who have not.

9.1. Core Training Standards For Sexual Orientation: Managers

Standard One: Knowledge Of Sexual Orientation Equality Legislation[21]:

i) Knowledge of legislation related to sexual orientation including employment equality (2003), goods and services (2006), Human Rights legislation and other relevant legislation (Appendix):
ii) Managers use legislation to inform their own good practice
iii) Managers use legislation to inform good practice within their teams
iv) Skills to apply changes in legislation.

Standard Two: Knowledge Of Sexual Orientation Policies And Strategies And Skill In Applying These In The Workplace

i) National agendas and strategies:
Knowledge of national agendas and strategies in relation to sexual orientation and how these relate to specific and local responsibilities for service delivery.
ii) Organisational and agency policies:
a) Knowledge of organisational and agency policies on sexual orientation and in relation to LGB communities.
b) Knowledge of agency duties and responsibilities in relation to staff and service users in relation to sexual orientation equality and service inclusion.
c) Knowledge of agency strategy and policies in relation to inclusive services for LGB communities.
d) Knowledge of the specific roles and responsibilities of employees for whom they have management responsibility.
e) Managers use of legislation to inform their own good practice to promote sexual orientation equality and inclusive services.
f) Skills to apply changes in sexual orientation equality legislation to the workplace and service delivery

Standards Three: Knowledge And Skills To Work Effectively With LGB Communities:

i) Knowledge of a national picture of LGB communities and their needs.
ii) Local knowledge and understanding of LGB needs within specific geographical localities or regions.
iii) Particular understanding of LGB communities needs as they relate to specific areas of health provision e.g. within broad mental health provision a specific understanding of lesbian health needs.

[21] See Appendix: Legislation Relating to Sexual Orientation

iv) Knowledge of national and local agencies and other resources within the LGB communities.
v) Understanding of the diversity within LGB communities with regard to race, disability, age, gender status including transgender, religion and culture and the impact that these differences may have upon different members of the LGB communities.
vi) Skills to apply knowledge in work with staff and making services for LGB communities more inclusive.

Standard Four: Knowledge And Skills To Work With All Staff And Service Users/Patients To Promote Appropriate Behaviour In The Workplace In Relation To Sexual Orientation Equality:

i) Knowledge of the behaviour and practice expectations in relation to LGB staff and service users/patients e.g. harassment and bullying policies.
ii) Knowledge of procedures that will be employed if these expectations are violated or ignored:

a) Informal mechanisms
b) Formal mechanisms; disciplinary procedures and processes.

iii) Skills in engaging with employees about the consequences of not meeting agency expectations in relation to sexual orientation as it relates to:

a) Employment practice
b) Service delivery e.g. maintaining transparency, clarity in explaining procedures and rights, managing anger and denial.

Standard Five: Knowledge And Skill To Use Power To Promote Sexual Orientation Equality:

i) Knowledge of power and the role that this plays in relation to perpetuating and countering heterosexism and homophobia and discrimination.
ii) Skills to identify the different types of power that people have as managers and an understanding of how these may impact upon employees and service users/patients for whom they have responsibility.
iii) An understanding and skill in using power to facilitate practice that is:

a) anti-discriminatory
b) works positively with LGB communities

Standard Six: Supervisory And Appraisal Skills In Relation To Sexual Orientation Equality

i) Meeting learning and support needs and knowing how to recognise the different starting points of individual staff in their understanding and experience of issues related to sexual orientation and LGB communities.

ii) Skills to integrate sexual orientation equality issues into supervision

a) Reviewing and developing PDP's to incorporate individual learning needs on issues of equality and diversity including sexual orientation.
b) Making the criteria for the assessment of good practice clear in relation sexual orientation employment and service delivery.
c) Enabling employees to challenge and/or enquire into the appraisal process.
d) Facilitating the supervisee in the ability to critically evaluate their own practice particularly in relation to service delivery to LGB communities.
e) Supporting continuous professional development including continuous learning in relation to sexual orientation.

Standard Seven: Communicating And Facilitating Staff To Develop Their Understanding Of Equality And Diversity, Including How To Make Services Inclusive For LGB Communities.

i) Skills to communicate clearly and accessibly with staff and service users/patients in a variety of ways; verbally, electronically, in written forms including pictorially on issues related to sexual orientation equality and service delivery.
ii) Awareness of the communication needs of service users/patients, knowledge of a range of communication resources, how to access them and use them appropriately e.g. interpreting services including signers, Braille, talking tapes, communication boxes etc.
iii) Supporting and enable individuals to undertake their tasks effectively and efficiently by sharing information.
iv) Recognising non verbal communication and the creation of an inclusive environment for LGB people.

Standard Eight: Managing Difficult Situations Effectively:

i) Manage conflicts between team members and service users where sexual orientation is a possible issue.
ii) Manage overt and covert discrimination in relation to sexual orientation.
iii) Work positively with personal challenge around issues of sexual orientation.
iv) Challenge staff, peers, managers and service users/patients constructively in relation to discrimination on the basis of sexual orientation and LGB issues.
v) Encourage the giving and receiving of positive critical feedback.

Standard Nine: Working With Groups Effectively To Promote Sexual Orientation Equality And Inclusive Service For LGB Communities:

i) Facilitate the contribution of all team members in making plans that include clear objectives and targets about making services more inclusive for LGB communities.
ii) Manage meetings: own team's, partner agencies including those within the LGB community, and LGB service users to arrive at clear outcomes and action plans to improve service inclusion for LGB communities.
iii) Manage differences within groups, particularly those that arise from different aspects of diversity. e.g. how to prioritise the needs of different groups, how to challenge behaviours that are discriminatory across diversity strands, including sexual orientation.

Standard Ten: Develops Creative And Responsive Practice In Self And Others.

i) Understand the role of evidence based practice, research and reading in developing best practice.
ii) Manage expectations in self, colleagues, partner agencies, service users/patient and their partners.
iii) Skills to change work practices both at an individual and team level to be more responsive to the needs of LGB communities.
iv) Manage and assess risk, both real and perceived.
v) The skills to work sensitively and clearly with actual and perceived homophobic harassment.
vi) The knowledge to seek appropriate support from the LGB community and 'to know where to go when you don't know'
vii) The skills to be an agent and catalyst for change
    a) The skills to identify the full range of possibilities in responding to any situation – lateral (blue sky) thinking.
    b) Identifying the positive and possible developments to make services inclusive of LGB people.
    c) Skill to use influence to achieve inclusive services for LGB people.
    d) The skill to involve and support staff in shaping and introducing new systems and practices.
vii) Addressing the 'blame culture' where it exists.
viii) Skills to be a reflective practitioner.

Standard Eleven: Understanding Of Financial Processes Which Support Health Gains For LGBT People (where appropriate)

i) Effective management and targeting of budgets
ii) Knowledge of purchasing contracts
iii) Knowledge of organisational financial regulations
iv) Understanding of financial concepts such as best value and cost effectiveness

7.3. Indicators For Managers

If standards are met effectively then this will be evidenced in the following indicators:

Indicators

a) Managers are able to promote equality in relation to sexual orientation, value LGB communities and their diversity in relation to all their work from developing clinical governance to allocating resources.

b) A work environment where all staff and service users feel supported and equipped to challenge harassment, bullying, stereotyping and discriminatory practice and behaviour where this is directed towards LGB staff or service users and LGB communities.

c) Managers are able to identify and evaluate areas for potential service improvement for service users and the public.

10.0. STANDARDS FOR THE EVALUATION AND MONITORING OF TRAINING IN SEXUAL ORIENTATION

Introduction
Evaluation and monitoring are important mechanisms in integrating training with organisational change.

Standard One: Effective Design of Evaluation and Monitoring

i) Evidence of partnership in evaluation and monitoring between organisational management and training providers
ii) Evaluation forms appropriate to the training and agreed between training providers and commissioners on completion of training events and over time.
iii) Variety of methods for receiving qualitative feedback from participants e.g. written and verbal, individually or group based.
iv) Monitoring the impact of training on participants during training events through for example verbal check-ins, sitting in on training

Standard Two: Clear pathways of evaluation within organisation

i) Clear feedback pathways of evaluation results to management and strategic groups.
ii) Focus on short and long term benefits to changes in practice and service delivery. 'How has the training helped to make your service more inclusive?
iii) Follow-up to 'tailored' training to measure effectiveness in addressing specific issues.
iv) Equality impact assessment on the inclusivity of services for LGB communities e.g. customer satisfaction impact.
v) Cost effectiveness
vi) Evaluation at different points in time to identify long term learning impact of training for participants.

Standard Three: Involvement of Service Users/Patients In Evaluation And Monitoring

i) Service user/patient surveys, focus groups etc. to evaluate the inclusiveness of services and impact of change.
ii) 360 degree feedback from patients

Standard Four: Engagement of Staff in Evaluation and Monitoring

i) Action learning based evaluation (is dynamic and can sustain the continuing learning process).
ii) Integration of equality and diversity issues into Personal Development Plans and appraisal systems.

Standard Five: Effective Personal Evaluation

In line with basic principles of a learning organisation the idea of a personal evaluation tool emphasises the responsibility of the individual for their own learning and development and develops skills in relation to reflective practice.

This standard may be used in conjunction with the KSF Descriptors for Diversity in relation to Sexual Orientation. They may be used at any time for example as part of a phased qualitative assessment in relation to a particular piece of work, following training or as part of personal development plans and appraisal. The tool may be used by both LGB people and heterosexual people and by anyone at any level within the organisation.

Effective personal development in relation to sexual orientation can be measured against an individual's ability to be open to realistic and objective consideration of the following questions

Questions:

i) What do I consider to be my competencies/skills in working with LGB people and communities?

ii) How would I rate my self-confidence around issues of sexual orientation? How could I improve this?

iii) What are the gaps in my knowledge and understanding of LGB people and communities?

iv) What is the impact of my sexual orientation on me and my working practice?

v) What is the impact of my work environment on my working practice?

vi) What is the impact of my working practice on LGB people and communities?

vii) In what ways may I exclude and discriminate against LGB people and communities in my working practice? How will I address this?

viii) In what ways can I be innovative in my practice with LGB people and communities?

ix) How can I contribute to making services for LGB people and communities inclusive?

11.0. CORE TRAINING STANDARDS FOR SEXUAL ORIENTATION: PROCESSES

Introduction

11.0.1. When dealing with issues of equality and diversity, trainers are 'rubbing up against' the beliefs of the individual and asking people to think about their identity. As this is an important element in the training, it is critical that trainers are skilled in facilitation and are able to encourage people to think outside their 'comfort zone' without making them defensive and angry.

11.0.2. The implication of this is that commissioners need to be extremely rigorous in the recruitment of highly skilled, experienced and sensitive trainers.

Standard 1: Effective Tendering For Commissioners

i) Commissioners have clarity about the reasons and context for the tender.
ii) Commissioners are realistic in what can be achieved.
iii) Tenders leave open the possibility of consultation between training providers and commissioners about the detail of training and how it fits into a wider development context.
iv) Timing of tendering ensures response from as many agencies as possible and allow a considered tender.

Standard Two: Identifying Quality Tenders:

i) Clear objectives
ii) Well formed and achievable outcomes
iii) Clear value base and rationale for working; no training is neutral in its value base and these values need to be as explicit as possible.
iv) Knowledge and understanding of LGB communities
v) Variety of training methods
vi) Tailoring of courses to the needs of the organisation
vii) Involvement of the commissioning agency's staff in the content, design and key messages of planned training.
viii) Involvement of staff in training delivery where possible and appropriate
ix) Involvement of LGB community in delivery of training. To include LGB people from local communities where possible and appropriate (avoiding tokenistic 'specimen' representation).
x) Clear monitoring and evaluation procedures
xi) Follow up consultancy where appropriate.
xii) Qualifications of trainers both formal and informal
xiii) Quality assurance procedures – how is quality and development of trainers maintained.
xiv) CV of relevant experience.
xv) Testimonies/References/Recommendations

Standard Two: Effective Preparation Of Staff

i) Full explanation to staff of reasons and context for training. Why it is important to do the training; reasons why change is needed.
ii) Clear and well timed Marketing of courses: advertising, lead-in times, timing in relation to other courses.
iii) Status of training: mandatory, recommended (for whom) or voluntary.
iv) Environmental Issues: room, light, comfort, refreshments[22]

Standard Three: Effective Training Delivery

i) Facilitative
ii) Recognising peoples' different starting points.
   a) Working from the premise that training groups will include LGB people and issues may have personal resonance.
   b) Checking the current knowledge base of participants
   c) Noting peoples' attitudes and values
iii) Empathetic Listening skills
iv) Seeking to understand and be understood
v) Use of non-discriminatory language
vi) Use of best practice examples where possible.
vii) Relating training to practice
vii) Creating a safe learning environment

Standard Four: Effective Learning Methods

These may be applied within training courses or extend into the wider learning and development sphere

i) Action learning
ii) Structured reflection
iii) Mentoring - Critical companionship working alongside
iv) Coaching
v) Peer review
vi) Gathering quality evidence for developments and achievement in working with LGB people and sexual orientation issues. For:
   a) constructing continuing professional development portfolios
   b) evidencing portfolios for professional awards e.g. NVQ's
vii) 360 degree feedback from LGB service users/patients.
viii) Best practice examples

[22] (Relevant when training is external to agency environment or for learning and development units that have responsibility for booking training).

12.0. LINKING CORE TRAINING STANDARDS FOR SEXUAL ORIENTATION TO THE NHS KNOWLEDGE AND SKILLS FRAMEWORK

12.0.1. The training standards relating to sexual orientation and making services inclusive of LGB communities needs to relate to the wider learning and development environment of the NHS.

12.0.2. The Knowledge and Skills Framework is designed to form the basis of a development review process, (which includes appraisal) undertaken by an individual member of staff and a 'reviewer' (usually the individual's line manager).

12.0.3. Linking the standards to KSF levels, and thereby to posts, would provide an effective way of linking the standards to practice; the Personal Development Plan providing an effective vehicle through which an individual's ability to apply their knowledge and skills in relation to sexual orientation and making services more inclusive can both be measured and learning and development needs to improve these, identified, addressed and agreed.

12.0.4. Both remit and time constraints related to this research project have not made it possible to undertake the more detailed work of relating the training standards that have been identified to levels one to four of the KSF. However a suggested staged development approach that maps the broad components at each level has been suggested as a signpost for this work. The stages are based on original work by Tuklo-Orenda.

12.0.5. The table below represents a starting point for this process.

12.0.6. The term 'practitioner' is used to describe the stage of development that an individual has reached in their awareness and practice in relation to sexual orientation it does not refer in any way to the post which they hold within the health service.

12.0.7. This model can also be applied to any working context and is not limited to the NHS

Table One: Descriptors For Diversity Practice Development (Sexual Orientation) As Linked To The Knowledge And Skills Framework

KSF LEVELS	DESCRIPTION
Level 1 Act in ways that support equality and value diversity	Beginning Practitioner • Develop an understanding of the processes of discrimination work in relation to sexual orientation and their part in it • Seek to understand the perspectives and issues that relate to LGB people and communities. • Seeking historical perspectives and information about positive contributions to society of LGB people and communities. • Using increased awareness respond positively and effectively to LGB people and communities. • Begin to identify their existing good practice and become aware of the areas for personal development.
Level 2 Support equality and value diversity	Conscious Practitioner • Deepen awareness of interactions with others, colleagues and service users • Develop an awareness of why others and self do what they do • Articulate what they do and how they can improve it • Being proactive in engaging with LGB people and communities • Challenging constructively discriminatory practice in self and others
Level 3 Promote equality and value diversity	Established Practitioner • Continue the development of self awareness of others and self • Managing and developing the practice of others and self e.g. team plans, supervision • Initiating and developing services inclusive of LGB people and communities • Communicating ideas and examples of best practice to senior management and executives
Level 4 Develop a culture that promotes equality and values diversity	Strategic Practitioner • Develop awareness in role as an agent of change to develop inclusive services • Developing policies and strategies to embed existing best practice in relation to sexual orientation equality into the organisation. • Contribute to moving the organisation on, and deepening the organisational inclusive culture of positive diversity.

13.0. CONCLUSION AND RECOMMENDATIONS

Overview

13.0.1. The evidence detailed in this report emphasises the need for the provision of specific training in sexual orientation to **all** NHS staff in order to effect inclusive services for LGB people.

13.0.2. The evidence also emphasises the need for this training to be led at an organisational level and indicates a need for organisational cultural change in order for this to happen and be effective. This can only be achieved by embedding the standards within the organisational structures and systems.

13.0.3. The success of sexual orientation training can only be measured by the changes that result from it and the extent to which services become inclusive. For these changes to happen and be embedded within organisations requires the visible commitment of Boards of Management and Senior Executives.

13.0.4. The findings also point to the importance of staff and management at all levels and of all disciplines within the NHS participating in sexual orientation training.

13.0.5. The emphasis on the creation of a health service where the balance of power is shifted to frontline staff is also a reminder that practical innovation and the translation of policy into practice has at its root frontline staff and their managers.

13.0.6. There is some excellent practice and training in relation to sexual orientation within parts of the NHS.

13.0.7. A number of key organisations have/are identifying standards and providing guidance in relation to service delivery for LGB people and preempting the implementation of the Equalities Act 2006.

13.0.8. However, it is clear from these findings that there is a need to ‘join-up’ the work that has been achieved by creating core standards owned at departmental level and relevant to the whole of the NHS.

Recommendations

We therefore recommend the following:

1. these standards and the recommendations linked to them are adopted in their entirety by the Department of Health and promoted to all organisations within the NHS with clear statements as to their importance.

2. **Tiers One and Two:** are mandatory training for **all NHS staff at all levels** within first three years of employment.

3. **Tier Three:**
    - Additional work is undertaken to develop training standards for sexual orientation in relation to each of the six diversity strands.
    - The mental health and social care standards are refined and developed.

4. **Tier Four:** Standards for managers are adopted as required management training.

5. These standards are more clearly linked to the Knowledge and Skills Framework and thereby to posts and responsibilities.

6. The DH recommend that these standards also be adopted in training by other voluntary/private complementary health services outside of the NHS and become part of contractual requirements where appropriate.

7. In order to ensure that these standards are effectively promoted, identify an individual with responsibility for managing this process who is accountable to SOGIAG or an associated steering group.

8. Develop an Action Plan, clearly identifying target dates for rolling out these standards within a realistic time span (over the next three years).

9. The action plan is monitored.

10. Publication of the standards so that they are easily accessible to all? (hard and electronic copy)

11. Publicising and promoting standards as part of a wider campaign to make services inclusive of LGB people and communities in anticipation of imminent regulations relating to Equality Act 2006.

12. Offering people guidance and support in the operationalising of these standards e.g. website

The Value Of Core Training Standards in Sexual Orientation

These standards in conjunction with the recommendations will:

- Provide institutional support for those who are already doing this work.
- Develop consistency in training on sexual orientation within the NHS and Social Care Field
- Provide a benchmarking tool for training on sexual orientation within the NHS and Social Care field
- Minimise the possibility of commissioning ineffective and wasteful training on sexual orientation.

- Support the NHS in its commitment to develop service user/patient orientated focus with particular regard to LGB people.
- Increase communication between LGB communities and health agencies.
- Increase the accountability of health organisations to LGB communities.