# Lesbian, Gay, Bisexual, and Trans (LGBT) People

## Introduction

The term LGBT stands for: lesbian, gay, bisexual, and transgender. Although we consider LGBT together, we need to remember that there are two minority groups covered by this term both of which are protected by law: LGB people who have a minority sexual orientation and trans people who have a minority gender identity (their assigned sex at birth conflicts with their psychological gender). Different legal frameworks apply to LGB people and trans people and there will be differences in how to promote equality within both groups.

**Terminology**

Bisexual: someone who is attracted to people or the same gender and/or opposite gender

Gay: a man or woman who is attracted to people of the same gender

Heterosexual/straight: someone who is attracted to people of the opposite gender

Lesbian: a woman who is attracted to other women

Trans: someone whose assigned sex at birth differs to their psychological gender

Sexual orientation: the general attraction a person feels towards one sex or another (or both)

Gender identity: whether an individual feels comfortable in the gender that they were assigned at birth

This section of the Joint Strategic Needs assessment (JSNA) aims to map the needs of LGBT people in Slough as part of a formal process for the first time. It is acknowledged that the quality of evidence used is variable. However, this is an important first step in recognising the needs of this group which include the need for further data collection, analysis and use.

When we consider the needs and experiences of healthcare of LGBT people, it is important not to view LGBT as a singular group but rather as a group of indivduals with individual differences. These are individuals who will identify with many different groups of which just two are based on sexual orientation and gender identity. The situations in which they choose to disclose these indentities may differ and this disclosure may be given in different forms.

In light of the fact that people identify with many different groups we also need to also consider that within the LGBT population there will be further minorities amongst this group. For, example LGBT people who are also disabled or also from a Black or Minority Ethnic Background. These minorities within minorities are discussed throughout.

### Why we need a specific focus on the people who are LGBT in our JSNA

It has been clearly demonstrated that commissioners and providers of health and social care services fail to recognise LGBT communities which serves as a barrier to service access (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013).

Many Joint Strategic Needs Assessments (JSNAs) currently do not address LGBT issues and experiences of healthcare and these remain a low priority for policy makers and commissioners. This is despite the fact that they have a statutory obligation to do so and that key public health issues disproportionately effect LGBT populations as will be described below (The Lesbian & Gay Foundation, 2012). If we are to address inequalities in our JSNA then we need to give attention to the LGBT population. There is need to ensure that there is information specific to the needs LGBT people and that evidence about the general population is linked to evidence about LGBT people. Therefore, readers are encouraged to read this section of the JSNA in the context of its whole. Links to topics felt to be of particular relevance are provided at the bottom of the page.

## What do we know?

There is no robust evidence that will tell us how many LGBT people there are in the population although we can use what evidence we have to make some estimates and these are described below. A key theme throughout this assessment is the lack of high quality, large scale research around the needs of LGBT people. However, what is included in the sections below is based on the evidence that we do have and clearly indicates numerous inequalities in the health and wellbeing of LGBT people compared to the general population as well as inequalities in health and social care service access and provision. Therefore, the main focus of the following section of this assessment will focus on the known and indicated inequalities experienced by LGBT people both as a group as a whole and separately for groups within the LGBT population.

## Facts, Figures and Trends

### Estimates of the number of LGBT people within the population

Sexual orientation is not asked on the National Census and is not monitored for consistently in employment or services. Research allowing us to make a reasonably reliable estimate indicates that 5-7% of people are LGB (LGBT Foundation). There will be variation between different areas with sexual minorities more likely to migrate to larger cities.

**The “I exist” survey respondent characteristics (sample = 2,580)**

41% had a religion or belief 6% of whom said they were Christian

68% were in employment (similar to general population)

1/10 identified as carers (similar to general population

42% said they had realised that they might be LGB between the ages of 13-15

Only 14% had come out by this age

By 25 years old ¼ had not come out

3% have never come out (The Lesbian and Gay Foundation, 2012a)

An estimated 1% of the population identify with a gender that is not the same as the sex that they were born with. 0.2% may seek gender reassignment intervention with the median age for presentation for reassignment being 42 years of age. There are now an increasing number of people presenting in adolescence (Varney, 2013).

### Key health issues and inequalities for all LGBT people

Qualitative evidence coming from the LGBT community and peer reviewed research both provide a wealth of evidence of the health inequalities faced by LGBT people. Key areas where inequalities are described are; lifestyle behaviours (e.g. smoking and drug use), sexual health, mental health, workplace health, and service access and quality. Lifestyle, sexual health, and mental health inequalities are discussed in more detail later in this assessment. The experiences reported by LGBT people in relation to workplace health and services access are outlined in the table below.

Table 1: Experiences of LGBT people relating to healthcare and workplace health

| **Topic** | **Experience** | **Source** |
| --- | --- | --- |
| Healthcare service quality (data relates to service using [Stonewall’s Healthcare Equality Index Tool](http://www.healthylives.stonewall.org.uk/for-organisations/healthcare-equality-index/) so are likely to represent the more positive experiences of care) | 38% felt the organisation was lesbian, gay and bisexual friendly | (Stonewall, 2015b) |
| 63% felt they were treated with dignity and respect at all time |
| 53% felt comfortable telling healthcare professionals their sexual orientation all of the time |
| 68% would recommend services to friends or family if they needed similar care or treatment |
| Workplace health and wellbeing | 33% of LGB people have not disclosed their orientation to any service user | (Stonewall, 2015c) |
| Bisexual men are the least likely to have told any colleagues about their sexual orientation (35% had not disclosed their orientation to any colleague) |
| Older LGB respondents were less likely to be out with anyone at work than younger respondents |
| Those who are out with colleagues are more satisfied with their sense of achievement (86% versus 54%) |
| Those who are out with colleagues are more satisfied with their job security (76% versus 50%) |
| Those who are out with colleagues are more satisfied with the support from their manager (86% versus 51%) |
| Those who are out with colleagues are more satisfied with the training that they receive (76% versus 46%) |
| 3/10 LGB people missed work in the last 12 months due to stress and 7% missed a month or more 1/10 had missed work due to their alcohol use and 4% had missed work due to their drug use | (The Lesbian and Gay Foundation, 2014a) |

Research shows that; patients want to talk to healthcare professionals about their sexual orientation; pateints want the healthcare professional to initiate these conversations; but clinicians feel uncomfortable discussing issues around sexual orientation (Rogers, 2014).

**Barriers to GPs and practice nurses discussing sexual orientation**

1) Embarrassment stemming from a mismatch in patient-doctor demographics

2) A lack of confidence in dealing with sexual health

3) A feeling that sexual health was not a part of the GP remit

4) Fear of offending the patient

5) A lack of understanding around the emergence of new sexual terminology

6) Workload and demand

(Rogers, 2014)

The Public Health Outcomes Framework Companion Document (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013)**;** describes the health inequalities experience by LGBT people across each Public Health Outcomes Framework (PHOF) indicator. These inequalities flow through all domains of the framework beginning with the wider factors which are know to lead to inequalities in health. These stem from discrimination which impact on housing provision, education, and experiences of crime and violence. There is much evidence that shows that LGBT people are more likely to engage in lifestyle behaviours that are damaging to health including smoking, alcohol misuse, and drug use. They are less likely to engage with health improvement services which support people to improve their own health as well as to engage with screening services such as cancer screening. LGBT people are more likely to experience inequality in relation to healthcare services and are more likely to die prematurely.

The Adult Social Care Outcomes Framework Companion Document (The National LGB&T Partnership, 2015) brings together existing evidence on the needs of LGBT people in a similar way to the Public Health Outcomes document but, this time, with a focus on care and support needs. Providers of social care services have commented that sexual orientation and gender identity were never mentioned in regards of the provision of services.

There is evidence that inequalities exist between LGBT people and the general population against the majority of the indicators within these two frameworks and these are included in the additional information provided along with this assessment.

### Key health issues and inequalities for lesbian women

It should not be assumed that all issues around the health of lesbian women are the same as those of heterosexual women with recent research suggesting some key differences. Research indicates that lesbian women do not seek intervention or support from the health sector and that they are less likley to respond to preventative healthcare messages (The Department of Health, 2009). The table below outlines some of the key health inequalities for these women.

Table 2: Key inequalities for lesbian women

| **Topic** | **Inequality** | **Source** |
| --- | --- | --- |
| Smoking | Young lesbian and bisexual women almost 10 times more likely to smoke at least weekly  | (The Department of Health, 2007c) |
| 25% of lesbian women are smokers compared with 15% of heterosexual women |
| Alcohol | Lesbian and bisexual women are at an increased risk of binge drinking and report higher alcohol consumption than heterosexual women |
| Lesbian and bisexual women are more likely to report alcohol-related social consequences and to have sought help for an alcohol problem |
| Weight problems | There is some evidence that lesbian women are more likely to have a higher BMI than heterosexual women |
| Drug use | 20.7% of lesbian/bisexual women reported using any drug in the past year (compared to 6.9% of heterosexual women) | (The Lesbian and Gay Foundation, 2014a) |
| 8.2% of lesbian/bisexual women reported using a stimulant drug in the past year (compared to 6.9% of heterosexual women) |
| 6.6% of lesbian/bisexual women reported using a class A drug in the past year (compared to 2.2% of heterosexual women) |
| Sexual health | A significant percentage of women who have sex with women (WSW) who attend GUM clinics receive a diagnosis. Almost all WSW engage in sexual practices which could transmit STIs yet most lesbian and bisexual women (6/10 women) report it difficult to find relevant sexual health information | (The Lesbian and Gay Foundation, 2014a) |
| Mental health | LGBT people are at an increased risk of self-harm with lesbian women and gay men at more risk than bisexual men and women | (The Department of Health, 2007g) |
| Higher risk of mental illness than the general population |
| 40% of lesbian women report negative or mixed reactions from mental health professionals when the disclosed their sexual orientation |
| 1/5 lesbian women report a mental health professional making as causal link between their sexual orientation and mental health problem |
| Cancer screening | Lesbian women are less likely to attend routine screening for breast and cervical cancer so may be less likely to benefit from early detection of these diseases | (The Department of Health, 2007e). |
| Lesbian women are less likely to be told that they are at risk of cervical cancer and some women have reported being refused a smear test |
| Lesbian women have a slightly increased risk of breast cancer due to the fact that they are less likely to have children; more likely to be overweight; and more likely to drink alcohol |
| Healthcare satisfaction | Lesbian women are less likely to report satisfaction with healthcare and a third of lesbian women have not told their healthcare provider their sexual orientation |
| 5/10 lesbian and bisexual women have had a negative experience of healthcare in the last year and 4/10 have experienced a healthcare provider assuming that they were heterosexual  | (The Lesbian and Gay Foundation, 2014a) |
| Lesbian women can experience discrimination during pregnancy and childbirth. For, example the non-biological birth mother may be excluded form discussions or decisions | (The Department of Health, 2009) |

With regards to the sexual health of lesbian women, there is a common assumption that lesbian women cannot contract STIs or are at a lower risk than heterosexual women. This is partly based on the underlying assumption that lesbian women have never had sex with men. However, one study showed that 85% of lesbian women had previously had sex with men. It is, therefore, important to note that a lesbian identity does not necessarily reflect a lifetime of same-sex relationships. Furthermore, some STIs have been diagnosed with women who have had no sexual history with men including genital herpes and warts (The Department of Health, 2007i).

### Key health issues and inequalities for gay men

Suicide and HIV infection are both key health concerns for gay men. However, we need to be mindful that gay men have other health needs other than those that relate to sexual activity and HIV prevention in order not to perpetuate the belief that gay men’s health needs relate to what the do rather than who they are (The Department of Health, 2009). Key health inequalities relating to gay men are outlined in the table below.

Table 3: Key inequalities for gay men

| **Topic** | **Inequality** | **Source** |
| --- | --- | --- |
| Smoking | 33% of gay men are smokers compared with 21% of heterosexual men | (The Department of Health, 2007c) |
| Weight problems | Gay men are more likely to engage in binge eating and purging. Eating disorders are likely linked to aspirations to the ideal gay male body shape which is both slim and muscular |
| Mental health | Young gay men are particularly vulnerable to suicide and suicide attempts. The concerns behind these suicides and suicide attempts are complex and include the presence of other factors such as anxiety disorder | (The Department of Health, 2007g) |
| Higher risk of mental illness than general population that has been linked to discrimination and intimidation |
| 1/3 of gay men report negative or mixed reactions from mental health professionals when the disclosed their sexual orientation |
| 1/5 gay men report a mental health professional making as causal link between their sexual orientation and mental health problem |
| Sexual health | 80% of all HIV infections acquired within the UK are transmitted through sex between men and the diagnosis rates of HIV amongst men who have sex with men (MSM) are increasing | (The Department of Health, 2007i)  |
| HIV affects the immune system leaving those with HIV at an increased risk of other infections |
| Despite their increased risk of infection, uptake of HIV testing amongst MSM is not high |
| GP consultations are an opportunity for health promotion that is missed as half of gay men report that their GP does not know their sexuality |
| There has recently been a particular rise in the rates of gonorrhoea among gay men in England |
| Cancer | Prostate cancer is potentially more common among gay men and anal cancer is more common amongst gay men (20 times more common) and is associated with genital warts, hepatitis b, human papilloma virus, herpes simplex virus and being a current smoker. It is also associated with HIV infection | (The Department of Health, 2007b) |
| Healthcare satisfaction | Surveys around gay men’s use of healthcare reveal dissatisfaction with primary care. They report that the literature in waiting rooms is often aimed a families and rarely addressed issues relevant to themselves | (The Department of Health, 2007i) |
| Gay men report “shopping around” to find a sexual health clinic that was empathetic to their needs and only attending a clinic regularly if it was “gay friendly” |

Gay men have been criticised for taking unnecessary sexual risk based on the data around HIV infection included in the box below. We need to remain mindful to the fact that some gay men are very responsive to safer sex promotion with condoms been widely and properly used. The high rate of infection that we see despite this relates to a complex relationship between a previous lack of information, patterns of sexual activity, and the risk of infection and existing prevalence of the virus amongst gay men (The Department of Health, 2009).

**HIV infection in gay and bisexual men**

80% of new domestic HIV infections are among MSM

59% of people living with AIDs are gay and bisexual men

66% of gay men do not discuss safer sex with their GP

Up to 50% of gay men have never been tested for HIV

1 in 10 MSM are living with HIV (The Lesbian & Gay Foundation, 2012)

### Key health issues and inequalities for bisexual men and women

Bisexual people’s health needs may differ from lesbian womens’, gay men’s, and heterosexual people’s health. The evidence that is available suggests that bisexual people are at a increased risk of eating disorder, mental ill health including anxiey and depression and suicide, and increased alcohol consumption. Bisexual women are more likely to be teasted for STIs than lesbian women. However, fewer bisexual men have ever been for an STI or HIV test than gay men (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013). There is evidence that bisexual men are less well educated about STIs, are much less likely to see materials aimed at gay men, are more likely to have trouble obtaining and using condoms, and have had unsafe sex with a greater number of men than exclusively gay men (The Department of Health, 2007m).

**Results of the Stonewall survey related to the bisexual cohort of responders are described below;**

Table 4: The health and wellbeing of bisexual men and women

| **Bisexual women** | **Bisexual men** |
| --- | --- |
| **25% currently smoke** | **27% currently smoke** |
| **77% had a drink in the last week and 37% drink three or more days a week** | **74% had a drink in the last week and 40% drink on three or more days per week** |
| **57% have been tested for STIs (compared to 44% of lesbian women who have been tested)** | **38% have never been tested for an STI (compared to 25% of gay men)** |
| **11% have never had a cervical screen (compared to 7% of women in general)** | **49% have never had a HIV test (compared to 29% of gay men)** |
| **7% attempted to take their own life in the last year** | **5% have attempted to take their own life in the past year (compared to 3% of gay men and just 0.4% of men in general)** |
| **29% have deliberately self-harmed in the last year (compared to 18% of lesbian and 0.4% of the general population)** | **11% have harmed themselves in the past year (compared to 6% of gay men and 3% of men in general)** |
| **3/10 have an eating disorder (compared to 2/10 lesbian women and 1/20 of the general population)** | **51% have had problems with their weight or eating in the past year (compared to 6% of gay men and 4% of men in general)** |
| **¼ experience domestic violence** | **51% have experienced at least one incident of domestic abuse since he age of 16 (compared to 17% of gay men)** |
| **¾ say that they are in good health** | **28% report being in fair or bad health (compared to 16% of men in general)** |
| **51% have had a negative experience of healthcare in the past year** | **1/3 who have accessed healthcare in the past year have had a negative experience relayed to their sexual orientation** |
| **66% are not out to their GP or other healthcare provider (compared to 46% of lesbian women)** | **60% are not out to their GP or other healthcare professions (compared to 30% of gay men)** |
|  | **50% have taken drugs in the last year (compared to 12% of men in general)** |

(Varney, 2013)

### Key health issues and inequalities for trans people

Amongst the LGBT population as a whole, the research into trans health is particulary limited (outside of the gender reassignement pathway of care). Research and other evidence that is available suggests that this is a group that are potentially particulary vulnerable to extremely poor mental and physical health outcomes and poor service provision.

**The largest study of Trans people in England found;**

20% identify as heterosexual

58% have a disability

8.5% were deaf

5% were visually impaired

18% were carers with 7% giving significant levels of care

(Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013).

Trans people (particulary male to female trans women) are often the victims of violence. More than 1/3 of trans people have attempted suicide. They are 25 times more likely to attempt suicide that then general population. Young trans people report poor housing, financial difficulties, access to healthcare, a lack of family support, higher rates of substance abuse, and high risk sexual behaviours as particular concerns (The Department of Health, 2007j).

The largest survey of Trans people’s mental health in Europe was conducted in 2012 (see (Varney, 2013)). The survey’s findings are shown in the figure below;

Figure 1: The mental health and wellbeing of trans people

Despite significant improvement in the clinical support offered to trans individuals, gender reassignement care pathways are inconsistent with 25% refused treatment because a pratitioner did not approve of gender re-assignment (The Lesbian & Gay Foundation, 2012). 29% of trans people reported that being trans adversely affected the way that they were treated by healthcare professionals (The Department of Health, 2007j).

There are many examples of inappropriate healthcare been provided to trans people including;

* Female to male trans men rarely including in breast screening
* Male to female trans women rarely offered prostate screening
* Placing trans women on male wards and trans men on female wards

More than 30% of trans people in one study experienced decimation when they were;

* Trying to get information from their GP
* Obtaining funding for gender reassignment surgeries
* Accessing ordinary non-trans healthcare

Trans people also report problems with healthcare professionals;

* Persisting in using male rather than female pronouns and vice versa
* Being critical about appearance
* Asking for their ‘real’ name (The Department of Health, 2007j)

### Key health issues and inequalities for young LGBT people

It is widely recognised that being a young person in itself presents many challenges particulary when transitioning from childhood to adulthood. Being a young person who is in a minority group can lead to extra vulnerabilities to negative experiences and resulting poor mental and physical wellbeing. One difficulty for people responsible for supporting children and young people is that not all young LGBT will be open about their sexuality and gender identity for many years after they become aware of it themselves. Many young people know their sexual orientation by the age of 11 or 12 but may not tell anyone until years later and just 13% of young people have disclosed their sexual orientation to a healthcare provider (The Department of Health, 2007l).

**Homophobic language in schools**

96% of gay young people say that they hear homophobic remarks made by other children in schools (17% say they have heard teachers make homophobic remarks)

84% of gay young people feel distressed when the word ‘gay’ is used as an insult (45% feel very distressed)

2/3 of secondary school and 2/5 primary school staff admit they do not always intervene when they hear derogatory language

½ of secondary and ¼ primary school teachers think homophobic language is ‘just harmless banter’

94% of teachers have not received specific training on how o deal with homophobic bullying and language

Homophobic bullying is higher is schools where teachers never challenge homophobic remarks compared to schools where homophobic remarks are always challenged (Stonewall, 2015a)

The table below summarises some of the key health inequalities between young LGBT people and their peers.

Table 5: Health inequalities for young LGBT people

| **Topic** | **Inequality** |
| --- | --- |
| Mental health | 4 times more likely to suffer major depression |
| 3 times more likely to be assessed with generalised anxiety disorder |
| Males are seven times more likely to have attempted suicide and three times more likely to have suicidal intent |
| Healthy lifestyles | Lesbian and bisexual girls are 10 times more likely to smoke than their heterosexual peers |
| Illicit drugs may be an increased risk for some young gay and bisexual young men |
| Lesbian and bisexual girls are twice as likely to have consumed alcohol in the past month |
| Lesbian and bisexual girls are one and a half times more likely to have engaged in binge drinking in the last year |
| Lesbian and bisexual girls are nearly three times as likely to have consumed a first alcoholic drink before age 12 |
| Young LGBT people are three times more likely to use MDMA/ecstasy |
| Young LGBT people are eight times more likely to use ketamine |
| Young LGBT people are 26 times more likely to use crystal methamphetamine |
| Violence and victimisation | 78% of LGBT people under the age of 18 had experienced verbal abuse |
| 23% of LGBT people under the age of 18 had been attacked by another pupil |
| Young LGBT people are more likely to suffer from bullying at school than their peers although rates have fall over the past 15 years with the number of schools explicity saying that homophobic bullying is wrong doubling. However, the use of homphobic language remains endemic (Stonewall, 2015a). |
| Sexual behaviour and the risk of HIV | Young gay men are becoming sexually active from the age of 14 and may not be aware of the risks from unprotected sex |

(The Department of Health, 2007l)

### Key health issues and inequalities for older LGBT people

**Although older LGBT people’s health and care needs are mostly likely to be similar to that of the wider older person population, the lack of recognition of this group when it comes to service commissioning and provision likely leads to overlooked needs specific to this group** (The Department of Health, 2007h)**.**

**LGBT older people are more likely to live alone and have fewer support networks than the general older person population (**The Lesbian & Gay Foundation, 2012)**. They are twice as likely to be single and four and a half times less likely to have children to call upon in times of need** (The Department of Health, 2007h)**.**

**Older LGBT people have extra concerns around entering residential accommodation due to isolation and discrimination and the need, therefore, the hide their sexual orientation.**

**Many health and social care providers report not having worked with older LGBT people. However, only 14% of LGBT people are open about their sexuality with providers of services. Just 25% of older LGBT people believe that health professionals were positive towards LGBT people and only 16% thought health professionals would be knowledgeable about LGBT lifestyles** (The Department of Health, 2007h)**.**

### Key health issues and inequalities for LGBT people with disabilities

There is numerous litereature which highlights the challenges for people with disabilities in being able to express their sexuality and being supported in developing a sexual identity (Varney, 2013).

Although the evidence with regards to disability in the LGBT community is limited, some evidence suggests that; disability in the trans community is higher than the general population; higher disability prevalence in the LGBT community in general (15-17%); 23% of older LGBT people have a disability which limits their daily activity in some way (Varney, 2013).

Compared to heterosexual disabled people, fewer LGBT disabled people are accessing the health and social care services that they feel they need. Smoking and drug use is higher amongst disabled gay and bisexual men than it is amongst non-disabled gay and bisexual men. Fewer LGBT disabled people have disclosed their sexual orientation/gender identify to their GP than non-disabled LGBT people (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013).

A number of small scale qualitative studies suggest the following as particular issues for disabled LGBT people;

* Difficulties in meeting other LGBT people
* Lack of validation for same-sex relationships
* Lack of acknowledgement of LGBT people
* Lack of acceptance in the non-disabled LGBT community
* Lack of privacy
* Few policies mean that staff do not feel supported to do proactive work

The table below looks at the key health inequalities between disabled LGBT people and their peers.

Table 6: Health inequalities for disabled LGBT people

| **LGBT group** | **Inequality** | **Comparison group** |
| --- | --- | --- |
| **Older LGBT people with a disability** | **37% did not access the health services they felt they needed in the past year** | **28% disabled heterosexual people** |
| **23% did not access the mental health services they felt they needed in the past year** | **6% of disabled heterosexual people** |
| **19% did not access social care services they felt they needed in the last year** | **10% of disabled heterosexual people** |
| **Gay and bisexual men with a disability** | **29% currently smoke** | **26% of gay and bisexual men in general** |
| **55% had used recreational drugs in the past year** | **51% of gay and bisexual men in general** |
| **7% had attempted suicide in the past year** | **Higher than gay and bisexual men in general** |
| **15% had self harmed in the past year** | **Higher than gay and bisexual men in general** |
| **63% had experienced domestic violence at least once since the age of 16** | **Higher than gay and bisexual men in general** |
| **27% had never had a HIV test** | **30% of gay and bisexual men in general** |
| **Lesbian and bisexual women with a disability** | **10% had attempted suicide in the past year** | **Higher than gay and bisexual women in general** |
| **31% had self harmed in the past year** | **Higher than gay and bisexual women in general** |
| **39% had experienced domestic violence at least once since the age of 16** | **Higher than gay and bisexual women in general** |
| **35% were not out to their GP or other healthcare professional** | **49% of gay and bisexual women in general** |
| **61% had had negative experiences of healthcare in the past year** | **52% of gay and bisexual women in general** |

(Varney, 2013)

### Key health issues and inequalities for BME LGBT people

There is variation between different ethnic groups of LGBT people in health risks and behviours. BME LGBT people have higher smoking reates than heterosexual BME individuals. BME lesbian and bisexual women have higher risk of cardiovascular diseas and cancer compared to bothe white lesbain and bisexual females and heterosexual BME women (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013).

BME LGBT health needs have almost been completely overlooked in research conducted in the UK. Gay African-Caribbean men in the UK are twice as likley to be living with HIV than White gay men. US research suggests that BME lesbain and bisexual women are more likely to be overweight compared to their heterosexual peers. BME LGBT communities are disporprotianatley affected by violence, abuse and harassment. African-Caribbean men in general are more likely to receive a diagnosis of schizophrenia and are three time more likely to be sectioned under the mental health act (The Department of Health, 2007f). There is some evidence that BME gay men who have a HIV diagnosis are more prone to psychological stress than their Caucasian counter parts. BME LGBT people are also more likely to experience physical abuse and harassment from stragers than White LGBT people (Varney, 2013).

UK research has highlighted that migrant gay men are particularly vulnerable and have a higher risk of poor mental health and sexual risk behaviours (Varney, 2013).

Table 7: Health inequalities for BME LGBT people

| **LGBT group** | **Inequality** | **Comparison group** |
| --- | --- | --- |
| Young BME LGBT people aged 11 to 19 | 76% BME gay and bisexual boys have thought about taking their own lives | 56% of White gay and bisexual boys |
| 83% BME lesbian and bisexual girls deliberately self harm | 56% of White lesbian and bisexual girls |
| BME lesbian and bisexual women | 33% currently smoke | 28.7% of all lesbian and bisexual women |
| 1/3 drink three or more days a week | 25% of women in general |
| 44% have taken drugs in the last year | 35% of all lesbian and bisexual women |
| 55% have been screened for STIs | 47% of all lesbian and bisexual women |
| 19% have never had a cervical screen | 16% of all lesbian and bisexual women |
| 7% have attempted to take their own life in the past year | 5% of all lesbian and bisexual women |
| 26% have deliberately harmed themselves in the past year | 20% of all lesbian and bisexual women |
| 21% have an eating disorder | Approx. 21% of all lesbian and bisexual women |
| 27% have experienced domestic violence | Approx. 27% of all lesbian and bisexual women |
| 54% have had a negative experience of healthcare in the past year | 52% of all lesbian and bisexual women |
| BME gay and bisexual men | 27% currently smoke | 26% of all gay and bisexual men |
| 53% have taken drugs in the last year | 52% of all gay and bisexual men |
| 5% have attempted to take their own life in the past year | 3% of all gay and bisexual men |
| 8% have harmed themselves in the last year | 6.5% of all gay and bisexual men |
| 15% have had problems with their weight or eating in the last year | 21% of all gay and bisexual men |
| 55% have experienced at least on incident of domestic abuse | 23% of all gay and bisexual men |
| 22% have never been tested for an STI | 22% of all gay and bisexual men |
| 24% had never had a HIV test | 29% of all gay and bisexual men |
| 37% have had a negative experience of healthcare in the past year | 35% of all gay and bisexual men |
| 36% are not out to their GP or other healthcare professional | 33% of all gay and bisexual men |

(Varney, 2013)

### Key health issues and inequalities for LGBT people from faith communities

Over a third of LGBT people identify with a faith or belief and different religions take different attitudes towards sexual orientation and gender identity. These can range from complete acceptance complete condemnation. Research had highlight both the tensions that can occur as a result of religious emphasis on traditional gender roles and the positive support coming from faith-based voluntary and community groups to enable people to explore their identity (Varney, 2013).

### Local facts and figures

Stonewall’s Top 100 employers (Stonewall, 2015c) is a guide to the best places to work for LGB staff. 15 of the top 100 employers in 2015 were local government organisations 10 were health and social care organisations. A number of the top employers have bases in Berkshire including Ernst and Young, Microsoft. Berkshire Healthcare NHS Foundation Trust is number 79 in the top 100.

Data from the Integrated Household Survey, (IHS), 2014[[1]](#footnote-1), showed that 1.7% of the national population identify as lesbian, gay or bisexual, (LGB). Younger people are more likely to identity as LGB with 2.7% of 16 to 24 year olds. This dropped to 0.5% for people aged over 65. Twice as many males (1.6%) as females (0.8%) in this survey were likely to state their sexual identity as gay or lesbian. The survey analysed responses along occupational lines showing that adults in Managerial and Professional Occupations were more likely to identify themselves as gay, lesbian or bisexual (2.2%) compared with those in either Intermediate Occupations or Routine and Manual Occupations (1.4% for both).

The figure from the Integrated Housing Survey is lower than the 5-7% estimated from other surveys. This may be due to differences between surveys with some measuring other aspects of sexual orientation such as behaviour and attraction or covering different age groups.

Using the figures for the South East from the Integrated Housing Survey to estimate the local LGB population gives the following figures for Slough. These are presented alongside the estimates for LGB people based on the higher 7% estimate reported in other surveys and the 1% estimate for the trans population;

**Table 1: Estimated number of LGBT people living in Slough**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Age Group** | **Population***(Mid-2013 estimates)* | **Estimated LGB population***(based on IHS 2013)* | **Estimated LGB population***(based on 7% of total population)* | **Estimated trans population***(based on 1% of total population)* |
| **16-24** | 15,287 | 391 |  |  |
| **25-34** | 26,641 | 594 |  |  |
| **35-49** | 32,144 | 545 |  |  |
| **50-64** | 20,266 | 280 |  |  |
| **65+** | 13,320 | 84 |  |  |
| **TOTAL**  | 107,658 | 1830 | 7,536 | 1,076 |
| *Source: Office for National Statistics* | *Source: LGBT Foundation* | *Source: Varney (2013)* |

The following table shows the trends in same-sex civil partnerships between 2008 and 2014. It should be noted that the drop in figures during 2014 is partly due to the fact that the first marriages of same sex couples took place on 29 March 2014. Couples have been able to convert their civil partnership into a marriage, if they so desired, from 10 December 2014.

**Table 1: Same-sex civil partnership formation in Slough**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Area of formation** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **TOTAL** |
| **ENGLAND** | 6,276 | 5,443 | 5,536 | 5,900 | 6,103 | 5,381 | 1,616 | 36,255 |
| **SOUTH EAST** | 1,147 | 1,004 | 989 | 1,017 | 1,067 | 891 | 284 | 6,399 |
| **Slough**  | 6 | 4 | 9 | 12 | 8 | 8 | 3 | 50 |

Source: Office for National Statistics

The 2011 Census gives us additional information on the characteristics of people who have entered into same-sex civil partnerships in Slough. There were 14 female and 46 male same-sex civil partnership couples on Census day in 2011. There were fewer same-sex civil partnership couples in Slough than there were across the South East and England as a whole. This is much more marked for females.

**Table 1: People registered in same-sex civil partnerships in Slough – gender**



|  |  |  |  |
| --- | --- | --- | --- |
|  | **Female** | **Male** | **% Same-sex civil partnership** |
|  | **Same-sex civil partnership** | **All** | **Same-sex civil partnership** | **All** | **Female** | **Male** |
| **Slough** | 14 | 19,699 | 46 | 31,067 | 0.07% | 0.15% |
| **England** | 19,252 | 8,823,627 | 30,654 | 13,239,741 | 0.22% | 0.23% |
| **South East** | 3,443 | 1,368,896 | 4,777 | 2,186,567 | 0.25% | 0.22% |

Source: Census 2011

Data broken down by age is based on very small numbers at a local level and interpretation of any differences should be done with caution. Couples aged between 35 and 49 are most likely to be in a registered same-sex civil partnership. Older age groups are much less likely to be in a registered same-sex civil partnership.

**Table 1: People registered in same-sex civil partnerships in Slough – age**



|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Area** | **All categories: Age** | **Age 24 and under** | **Age 25 to 34** | **Age 35 to 49** | **Age 50 to 64** | **Age 65 to 74** | **Age 75 to 84** | **Age 85 and over** |
| **Slough** | 60 | 1 | 24 | 22 | 10 | 1 | 1 | 1 |
| **England** | 49,906 | 1,327 | 7,960 | 22,064 | 13,584 | 2,827 | 1,683 | 461 |
| **South East** | 8,220 | 181 | 1,077 | 3,684 | 2,346 | 531 | 308 | 93 |
| **Slough** | 0.12% | 0.07% | 0.22% | 0.12% | 0.08% | 0.03% | 0.03% | 0.08% |
| **England** | 0.23% | 0.17% | 0.25% | 0.34% | 0.23% | 0.10% | 0.08% | 0.05% |
| **South East** | 0.23% | 0.17% | 0.24% | 0.35% | 0.24% | 0.12% | 0.09% | 0.06% |

Source: Census 2011

Data broken down by Ward is presented below. Again, this is based on very small numbers at a local level and interpretation of any differences should be done with caution.

**Table 1: People registered in same-sex civil partnerships in Slough – Wards**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **All persons** | **Same-sex civil partnership** | **Same-sex civil partnership %** |
| Baylis and Stoke | 3,334 | 0 | 0.00% |
| Britwell | 3,648 | 1 | 0.03% |
| Central | 3,880 | 13 | 0.34% |
| Chalvey | 4,241 | 5 | 0.12% |
| Cippenham Green | 3,641 | 2 | 0.05% |
| Cippenham Meadows | 4,589 | 5 | 0.11% |
| Colnbrook with Poyle | 2,533 | 2 | 0.08% |
| Farnham | 3,462 | 7 | 0.20% |
| Foxborough | 3,276 | 7 | 0.21% |
| Haymill | 4,198 | 2 | 0.05% |
| Kedermister | 3,445 | 5 | 0.15% |
| Langley St Mary's | 3,106 | 3 | 0.10% |
| Upton | 3,654 | 6 | 0.16% |
| Wexham Lea | 3,759 | 2 | 0.05% |
| Slough | 50,766 | 60 | 0.12% |
| England | 22,063,368 | 49,906 | 0.23% |
| South East | 3,555,463 | 8,220 | 0.23% |

Source: Census 2011

Hate crimes recorded by the police are broken down by the motivating factor behind the crime. Sexual orientation and Transgender are both included in the data as potential motivating factors. As there may be more than one motivating factor behind the crime, each factor is counted separately. The lowest area the data is available by is Police Force Area and the data for the local Thames Valley Police Force Area is presented below. It shows that Sexual Orientation is the second most common motivating factor for hate crime after race. There were 99 crimes where the motivating factor was sexual orientation and 17 crimes where gender was the motivating factor across the Thames Valley accounting for 8% and 1% of all hate crimes respectively. Sexual orientation as a motivating factor is less prevalent in the Thames Valley compared to England and the South East as a whole.

**Table 1: Hate crimes by motivating factor 2014/15**

|  |
| --- |
| *Numbers*  |
| **Police force area** | **Monitored hate crime strand** | **Total number of motivating factors** | **Total number of offences** |
| **Race3** | **Religion** | **Sexual orientation** | **Disability** | **Transgender** |
| Hampshire | 1,137 | 99 | 224 | 98 | 33 | 1,591 | 1,547 |
| Kent | 788 | 31 | 96 | 49 | 10 | 974 | 966 |
| Surrey | 536 | 48 | 77 | 47 | 1 | 709 | 684 |
| Sussex | 973 | 108 | 230 | 107 | 29 | 1,447 | 1,365 |
| Thames Valley | 1,074 | 26 | 99 | 45 | 17 | 1,261 | 1236 |
| **South East** | **4,508** | **312** | **726** | **346** | **90** | **5,982** | **5,798** |
| **England and Wales** | **42,930** | **3,254** | **5,597** | **2,508** | **605** | **54,894** | **52,528** |
| *Percentages of all hate crime motivating factors*  |
| **Police force area** | **Monitored hate crime strand** |  |  |
| **Race3** | **Religion** | **Sexual orientation** | **Disability** | **Transgender** |  |  |
| Hampshire | 71% | 6% | 14% | 6% | 2% |  |  |
| Kent | 81% | 3% | 10% | 5% | 1% |  |  |
| Surrey | 76% | 7% | 11% | 7% | 0% |  |  |
| Sussex | 67% | 7% | 16% | 7% | 2% |  |  |
| Thames Valley | 85% | 2% | 8% | 4% | 1% |  |  |
| **South East** | **75%** | **5%** | **12%** | **6%** | **2%** |  |  |
| **England and Wales** | **78%** | **6%** | **10%** | **5%** | **1%** |  |  |

Source: Home Office

### Collecting, analysing and using sexual orientation/gender identity data

There are significant gaps in the evidence of need of LGBT people particularly at a local population level. This is largely due to gaps in services sexual orientation data collection and a lack of health data specific to this population gathered in population studies and routine data sets including cancer registries, and the UK Census (The National LGB&T Partnership, 2015). LGBT people are under-represented in peer-reviewed journals despite the fact that where they are included there is strong evidence of health inequalities being experienced by LGBT people. There is also a gap in understanding around the positive protective factors that have developed in the LGBT communities to counter the inequalities in health and service provision that they face (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013).

Although the PHOF indicators are now evidencing the inequalities between the LGBT people and the general population they are not able to generate data on LGBT alone due to the lack of sexual orentation monitioring in service provision and at a population level (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013). There is a similar lack of routine monitoring of sexual orientation and gender identitiy within social care data. Where data is collected, few commissioners and providers are using it to understand or improve people’s use of services (The National LGB&T Partnership, 2015).

The Equality Act (2010) states that all public sector organisations must meet the requirements of the Equality Duty. They must ensure that the needs of people with protected characteristics (including gender reassignment and sexual orientation) are considered when services are designed and delivered.

**The benefits for the organisation of monitoring and using sexual orientation data**

Ability to highlight inequalities

Ability to identify issues affecting LGBT people

Understanding of barriers to services

Ability to provide appropriate services and to improve existing services

Ability to monitor and prevent discrimination

Ability to measure performance and manage changes

Maximising investment in the workforce

Higher levels of staff satisfaction, productivity and employee retention

The key requirements under the duty are to;

* Eliminate discrimination
* Tackle prejudice and promote understating
* Advance equality of opportunity
* Remove or minimise disadvantage due to a protected characteristic
* Take steps to meet the needs of people with a protected characteristic

It is therefore, necessary that organisations monitor sexual orientation and gender identity in order to meet the requirements of the Duty.

[The NHS Equality Delivery System](https://www.england.nhs.uk/about/gov/equality-hub/eds/) supports the routine data collection covering the protected characteristics included in the Equality Act (2010).

Many public sector bodies will already monitor protected characteristics as they need to consider them by law but there is wider variation in how well the data is been utilised to drive service improvement. It is not enough to know how many people with protected characteristics are using a service or are employed in a particular occupation.

**The benefits for individual service users and staff of monitoring and using sexual orientation data**

Equality of access and opportunity

Improved services

A culture or inclusivity and openness

Increased openness and recording elsewhere

(NHS North West, 2011)

There are numerous benefits to the local health and social care system in improving their monitoring and use of sexual orientation data. Understanding the population which you serve is essential for providing a targeted and effective service and as such makes good business sense in the context of budget pressures needing ever increasing efficiency savings to be made.

NHS North West (NHS North West, 2011) have produced a useful guide on collecting, analysing and using sexual orientation data which can be used across public sector organisations. There summary recommendations can be seen in the diagram below.

**Figure 2: Process for monitoring and using sexual orientation and gender identity data**

 (NHS North West, 2011).

## National & Local Strategies

### National strategies and recommendations

**LGBT Foundation Policy Briefing and Factsheets (LGBT Foundation, 2016):** Web page summarising key policy documents such as the Care Act and Equality Act and providing links to the original documents <http://lgbt.foundation/policy-research/policy-briefings/>.

**Sexual Orientation: A guide for the NHS (Stonewall, 2012):** A practical guide for NHS organisation on meeting the needs of LGBT people – as both employees and patients. It includes an action plan for improving services for LGBT patients and case studies of good practice. Suggestions for meeting the needs of LGBT patients include;

* Targeting services at LGBT people where appropriate
* Conducting surveys on LGBT patient experience
* Displaying LGBT-friendly policies
* Use images of same-sex couples and their families in promotional material
* Train staff on the organisation policies on discrimination, dignity, respect, and patient confidentiality
* Train staff on the health inequalities experienced by LGBT people
* Consult LGBT staff about the obstacles they encounter accessing healthcare
* Train staff to avoid making assumptions or asking inappropriate questions
* Assure patients that their data will be held in confidence and treated sensitively

Suggestions for meeting the needs of LGBT staff include;

* Have a clear policy for tackling homophobic bullying and harassment
* Enter the Stonewall Workplace Equality Index
* Tell staff what the organisation is doing to tackle anti-gay bullying
* Encourage LGBT senior staff to come out in the work place and take an active role in supporting other LGBT staff
* Provide specific training for managers so that they know how to support LGBT staff
* Monitor staff attitude surveys by sexual orientation
* Ask LGBT staff about collecting their data and how they think it should be done

**The Public Health Outcomes Framework Companion Document (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013);** describes the health inequalities experience by LGBT people across each Public Health Outcomes Framework (PHOF) indicator and makes recommended actions to reduce the gap in the health and service use between LGBT people and the general population. Universal recommendations fall under four domains; recognition, engagement, monitoring, and service provision.

**Similarly, The Adult Social Care Outcomes Framework Companion Document (The National LGB&T Partnership, 2015):** describes the health inequalities experience by LGBT people across each Adult Social Care Outcomes Framework (ASCOF) indicator and makes recommended actions to reduce the gap in the health and service use between LGBT people and the general population. The Universal recommendations reflect those outlined in the PHOF Companion Document. These are summarised below;

Figure 3: Public Health Outcomes Framework/Adult Social Care Outcomes Framework Companion Document Summary Recommendations

(Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013)/ (The National LGB&T Partnership, 2015)

**The Healthcare Equality Index (Stonewall, 2015b):** describes what a good LGBT-friendly healthcare organisation should look like and provides case stuides of good practice. A good healthcare organisation;

1. Has staff members who understand the needs of LGBT patients
2. Provides clear sexual orientation equality messages
3. Uses patient’s sexual orientation data to inform services
4. Provides a service tailored to the needs of LGBT patients
5. Works in partnerships with a range of partners in the public, private, and third sectors
6. Provides opportunities for LGBT patients to influence services
7. Is part of the Diversity Champions programme
8. Makes sure that LGBT people are treated fairly

**Sexual orientation: The Equality Act made simple (Stonewall, 2012a):** A brief guide to the Equality Act with regards to what organisations are required to do when it comes to LGBT staff and service users.

**Healthy lifestyles for LGBT people (The Department of Health, 2007c):** Commissioners and providers should consider how the services that they deliver are perceived by LGBT people. With regards to healthy lifestyle services;

* LGBT people should be represented in smoking surveillance
* Alcohol and smoking prevention and cessation services should be targeted at LGBT people
* Easting disorder services should not assume gay men’s needs are the same as heterosexual women and need to address their particular health concerns

**Disabled LGB people (The Department of Health, 2007a):** Social care staffs should be provided with clear guidelines to support LGB disabled people. This supports should include; sex education, support for their identities as LGB people, support to help them socialise in LGB spaces, inclusion of their identities in person-centered plans, and support for developing intimate same-sex relationships. Support should be considered that would allow disabled LGB people to use direct payments to emply a gay-firdly home care assistant.

**LGBT people from Black and minority ethnic communities (The Department of Health, 2007f):** Recommendations for improving healthcare for BME LGB people include:

* Increasing the number of ethnic and sexual minority providers
* Expanding definitions of cultural competency curricula at academic institutions
* Targeting future research efforts of BME LGBT people and improving structural and communication barriers
* HIV prevention should target specific population within ethnic minority groups
* HIV prevention should address the fact that migration had a major impact on health and wellbeing

**Sexual orientation: A practical guide for the NHS (The Department of Health, 2009):** Practical advice to NHS organisation to help them comply with legislation, and understand the role of sexual orientation in the context of healthcare. The guidance covers both LGB staff and patients. Key recommendations are summarised below for staff;

* Ensure fair recruitment
	+ Does the organisation’s staff reflect the communities it serves?
	+ Raise an organisation profiles through sponsorship of LGB community events
	+ Take advise from LGB staff to ensure policies and procedures are inclusive and effective
	+ Make the recruitment process transparent
	+ Ensure recruiters are no making unfounded assumptions based on stereotypes
	+ Set up a system so that staff know what to do if they think a recruiter has made a prejudiced remarks or decisions
* Tackle workplace bullying and harassment
	+ Adapt harassment policies to make them LGB inclusive
	+ Ensure that initiative for prevent LGB bullying and harassment are endorsed by senior staff
* Make sure conditions of employment are fair
	+ Communications should be inclusive: se same-sex couples in oral or written examples of staff benefits or reward packages
* Manage performance fairly
	+ Managers need to be able to identify any bias in the way they make judgements about people
	+ Training should include examples of how homophobia can be disguised and common misconceptions that are applied to LGB people
* Workforce monitoring and evaluation
* LGB staff as a resource
	+ Draw on the experience of LGB staff to add to the organisation awareness of the needs of LGB patients and service users
	+ LGB staff could be involved in developing policies which relate to employment issues

And for patients;

* Unique health needs
	+ Services should deliver targeted appropriate care to patients on the grounds of sexual orientation
	+ LGB services users may have particular concerns about the control of sensitive information which needs to be considered when sharing information within teams
	+ Smoking, alcohol, and drug interventions need to be tailored to the needs of LGB people

**26 ways to be young LGB people friendly (The Equity Partnership, 2011):** recommendations for creating a wlecoming environment for young LGB people under the headings of; language, policies, staff, involvement, information and visibility, and classroom activities.

**30 ways to be LGB friendly (The Equity Partnership, 2011a):** recommendations for working positively with LGB health issues under the headings of; language, policies, staff, involvement, information and visibility, and health.

**Beyond babies and breast cancer: expanding our understanding of women’s health needs (The Lesbian and Gay Foundation, 2014a):** Brings together relevant information about health needs and experiences of lesbian and bisexual women for use by all involve during the planning and delivery of healthcare services. Five overarching recommendations;

1. COMMUNICATE in a non-discriminatory way
2. MONITOR and us sexual orientation data to inform planning
3. INCLUDE lesbian and bisexual women’s need in health information, services, policies and strategy
4. TARGET lesbian and bisexual women with appropriate and specific health information and campaigns
5. DEVELOP specialist health and support services for lesbian and bisexual women and their families

**Building health partnerships case studies (The Lesbian and Gay Foundation, 2014b):** A series of case studies from the Manchester area around building partnerships with community and voluntary organisations.

**Tackling homophobic language (Stonewall, 2015a):** A guidance for teachers along with links to resources on practical ways to prevent and tackle homophobic language in schools. The top 10 tips are summarised below;

1. Get the basics right – have a policy which makes it clear that there is zero tolerance for homophobic language
2. Challenge consistently
3. Explain the impact (Department of Health, 2008)
4. Support staff
5. Communicate with parents
6. Measure progress
7. Engage young people
8. Let students lead the way
9. Celebrate difference
10. Don’t reinvent the wheel – learn from what other schools have done

**Using monitority data: making the most of sexual orientation data collection (Stonewall, 2015)**: A good practice guide aimed at employers for making the most of sexual orientation data collection outlines the benefits of data collection; advises when to monitor, how to get the most out of the monitoring process and what to do with with data. The top ten tips included in the guide are;

1. Establish clear aims and objectives
2. Communicate the purpose of sexual orientation monitoring
3. Maintain confidentiality
4. Gain the support of senior management
5. Consult with lesbian, gay and bisexual staff to establish the best way of introducing monitoring
6. Improve data collection by making it as easy as possible for people to provide their information
7. Analyse the data to identify problem areas and successes
8. Take action to address issues revealed by monitoring
9. Report findings to senior management
10. Set internal benchmarks and commit to repeat monitoring

## What is this telling us?

The term LGBT covers two minority groups protected by law: those protected under the characteristic of sexual orientation (lesbian women, gay men, and bisexual men and women) and those protected under the characteristic of gender identity (trans people). It is important to not view this group as a singular group but as a group of individuals with their own individual differences. There will also be other minority groups included within the LGBT community (e.g. LGBT people with disabilities). Their needs will differ to the general population of people with disabilities and to the needs of the general LGBT population.

Estimates suggest that 5-7% of the population are LGB and that 1% of people are trans with 0.2% of the population actively seeking gender reassignment. The tendency for sexual minorities to migrate to larger cities would suggest that there will be variation in the size of the local LGBT community depending on how urbanised an area is.

Despite their protected status and the evidence of inequalities in health status and access to health and social care, the needs of LGBT people are rarely addressed systematically and remain a low priority for commissioners and providers of services.

There is lack of high quality; large scale research around the needs of LGBT people but the information that is available for assessment suggests numerous health and wellbeing inequalities between the LGBT population and the wider population. This spans across all of the domains of both the Public Health Outcomes Framework and the Adult Social care Outcomes Framework. The level and distribution of inequalities across domains differs for different groups of people within the LGBT community. Some of the data around the health and care of trans people is particularly striking suggesting a group that is potentially very vulnerable and under-supported. Trans people are particularly vulnerable to violence and to suicide.

It is clear that the health and social care issues that affect these individuals are not the same as for their heterosexual counter parts. We also know that they are less likely to respond to the same health and wellbeing messages. There are also examples of where LGBT people are been treated differently to their heterosexual counterparts in ways that are inappropriate. For example, it is assumed that lesbian women are at a lower risk for STIs and are not always offered cervical screening as they are assumed to have never had sex with a man and are at a generally lower risk. Inappropriate healthcare being provided to trans people is a particular concern with screening programmes rarely including trans people based on their gender as assigned at birth.

There is a propensity to believe that gay men’s health needs centre on HIV and sexual activity. Whilst these are one of the key health issues amongst this group as a whole there are other key health needs prevalent amongst this group and some gay men are very responsive to safer sex promotion and condoms are widely and properly used.

There is a need to consider LGBT people across the life course with both younger and older LGBT people showing particular vulnerabilities. Younger LGBT people are often aware of the sexual orientation/gender identity years before they discuss it with anyone else. They are particularly vulnerable to the impact of bullying at school with the use of homophobic language within schools a real issue that has a high impact on individuals yet is not consistently addressed with schools. Older LGBT people are a lot more likely than the general population to be living alone and to not have the support from children and families. A real concern of this group can be the thought of going into residential care with many fearing having to hide their sexual orientation/gender identity once more.

Two other minority groups discussed are those with disabilities and those from BME communities. There is a clear need to support disabled LGBT people in expressing their sexuality and developing their sexual/gender identity. We have seen that BME LGBT people are particularly overlooked by research in the UK. What research that has been done in the UK suggests that migrant gay men are particularly vulnerable to poor mental health and high sexual risk behaviours.

We know that LGB patients often want to talk to their healthcare professional about their sexual orientation but that they want the professional to initiate this conversation. Unfortunately, many clinicians report feeling uncomfortable in doing this through a lack of confidence and fear of offending the patient.

There is a clear need to encourage the use of further local data collection within services both in terms of the staff employed and the users of these services. Although, data is been collected there is likely to be much variation with how this data is been used to understand and improve services for the LGBT population.

## What are the key inequalities?

A key theme of this assessment has been the identification of the inequalities experienced by LGBT people. These are summarised in the figure below;

Figure 3: Key inequalities for LGBT people

## Recommendations for consideration

### Recognition

* There is a need to undertake awareness raising of LGBT needs for both service providers and commissioners of services. This should include regular training for healthcare staff on how to work with trans patients on issues of dignity, particularly the right to be treated as a member of their new gender, and privacy needs.
* Regular and detailed local assessments of LGBT people should be undertaken and these should focus on the different groups within the LGBT population. There is a particular need for an individual assessment of the trans population needs and the needs of BME LGBT people.
* Images of LGBT people and their families should be included in promotional materials and LGBT-friendly polices should be clearly displayed
* Health and Wellbeing Board partners should ensure that single equality schemes explicitly consider sexual orientation and gender identity
* Local strategies and action plans should consider the needs of LGBT people. These include older people, drug and alcohol, mental wellbeing and crime and disorder strategies and action plans

### Engagement

* The commissioning and provision of services should be done in partnership with LGBT voluntary and community sector groups and service specifications should explicitly consider the needs of LGBT people. These specifications could refer to and relate to Stonewall’s Healthcare Equality Index
* Consult with LGBT staff about the obstacles that they come across in accessing health and social care services.
* Ask LGBT staff about collecting data and how they think it should be done
* Community Sport and Physical Activity Networks should explicitly consider the needs of LGBT groups in developing local engagement strategies
* Local government and NHSE should work together to promote chlamydia screening uptake amongst LGBT people and require service providers to monitor sexual orientation and gender identity

### Monitoring

* Steps should be taken to ensure representation of LGBT people in smoking surveillance to understand smoking rates in this group.
* Local government homelessness and housing strategies should consider the needs of LGBT service users and monitor sexual orientation and gender identity in service user datasets
* Coroners and medical examiners should monitor sexual orientation and gender identity and explore a potential link between suicide and sexual orientation and gender identity
* Commissioners should include a requirement in contracts for service providers to monitor sexual orientation and gender identity. This should be used to better understand and meet LGBT service users’ needs

### Service provision

* Health improvement services should deliver targeted messages to LGBT people which have been shown to be cost effective. In particular, drug and alcohol and smoking prevention and cessation interventions should be targeted at LGBT people.
* Services for gay men with eating disorders need to address their particular concerns: it should not be assumed that these are the same as heterosexual men or women.
* Physical examinations of trans people whould be offered to patients on the basis of the orgrans present rather than the perceived gender.
* Lesbian women should be offered STI and cervical cancer screening in a manner consistent with that of heterosexual women.
* Services should be encouraged to take part in the Stonewall Workplace Equality Index.
* Steps should be taken to ensure that schools are following Stonewall’s guidance on tackling homophobic language within schools.
* Schools should ensure that PHSE includes positive and supportive discussion about sexual orientation and safe sex
* School nurses should be trained to support LGBT youth and young people questioning their sexual orientation or gender identity
* Service commissioners and providers should ensure staff receive training on LGBT issues; have promotional materials using LGBT language and imagery; monitor service user sexual orientation and gender identity and data use to improve services
* Health and social care professionals should establish a local database of LGBT community groups for signposting
* CCGS should consider the needs of LGBT communities when commissioning secondary prevention such as cardiac rehabilitation
* LAs should provide care services with recourses and signposting information to enable carers to have knowledge and information about appropriate and specific community resources
* Social care providers should ensure that’s staff receive training on LGBT issues and are able to discuss an individual’s needs sensitively so the impact of person-centred and personalised care can be assessed and responded to

## See also

* JSNA sections on; drugs, alcohol, smoking, older people, developing well, sexual health
* LGBT Foundation. (2016). *Resources Directory.* Retrieved January 12, 2016, from LGBT Foundation: <http://lgbt.foundation/policy-research/the-lgbt-public-health-outcomes-framework-companion-document/>

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1. ONS Integrated Housing Survey 2014 *(experimental statistics)* [↑](#footnote-ref-1)