

The National



LGB&T Partnership

# Out Loud

## LGBT Voices in Health & Social Care

A narrative account of  
LGBT Needs



May 2016

The report you are going to read reminds us how everyone wants to be treated: as an individual, with dignity, and with respect. This is how it should be for all people using health and care services, but we know that there are many ways in which LGB&T people are not afforded these rights, either through outright prejudice, lack of knowledge, or because heterosexuality and being cisgender (experiencing your gender as consistent with the sex you were assigned at birth) are unconsciously given privilege within our society by so many, including in the shaping of our health and social care systems.

LGB&T people still too often face hostility and are inappropriately treated because of their gender identity and/or sexual orientation. The aim and aspiration behind the production of this report and highlighting of these narratives is to change attitudes and ensure that LGB&T people can receive services as a whole person in their entirety. Too many people we spoke to either felt they should, or wished they could, hide their sexuality and/or gender identity from the people providing their care because of how they had been treated. This is something that should no longer be happening in 2016.

Whilst there have been many recent steps towards legislative equality for LGB&T people, it is important to remember that legislative change has not always resulted in LGB&T people receiving good experiences, particularly in relation to receiving health or social care support.

At a time of such change within health and social care, efficiency and efficacy are often at the forefront of the minds of decision-makers. The small changes required to make the statements within this report a reality will support LGB&T people to access support sooner and more appropriately, and will reduce both the emotional and financial cost that poor service delivery generates.

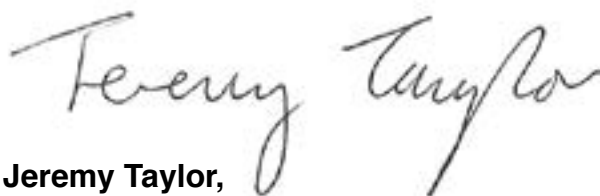
This document provides a much needed discussion of how to understand and implement the principles articulated through a number of 'I statements' which describe ideal standards of care and make explicit LGB&T people's particular needs when it comes to health and social care. The statements were determined through working with members of diverse LGB&T communities with different health and social care needs. These narrative statements complement existing statements produced by National Voices, adding another dimension by highlighting the key needs of a community often overlooked and invisible within existing structures.

These 'I statements' are one of many processes of raising the visibility of the needs of LGB&T people, and working to make them true will make substantial difference to the experience of LGB&T people in receipt of health and care services. I hope that heeding the recommendations made by these narratives will support all providers in knowing that they are enhancing the support for these communities.

Signed by



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Chief Executive of the LGBT Foundation and  
Chair of the National LGB&T Partnership.



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Chief Executive of National Voices and Chair  
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# Introduction



The set of narrative statements published in this document describe the way lesbian, gay, bisexual and trans people want high quality health and social care that takes account of their sexual orientation and/or gender identity. This document is intended to be used both by those who provide services and those who commission services to support them to work with LGB&T people. The aim is to provide a resource to assist in designing and providing care and support that will be successful in meeting LGB&T people's needs, and inclusive of their sexual orientation and/or gender identity, focusing outcomes on what matters most to LGB&T people as service users.

## Terminology

Throughout this document we have used the term LGB&T to refer to lesbian, gay, bisexual and trans people. The definition of lesbian and gay people refers to those that are sexually, romantically or emotionally orientated to having same gender relationships. The term bisexual refers to people that are sexually, romantically or emotionally orientated to have relationships with people of more than one gender. We utilise trans as an umbrella term to refer to all people who do not identify with their assigned gender at birth and/or the binary gender system. Some trans people feel they exist not within one of the two standard gender categories, but rather somewhere between, beyond, or outside of those two genders.

## Why LGBT people? Why now?

National Voices and its partners have previously produced five narratives to assist the planning of integrated care programmes (person centred coordinated care). One was generic and was adopted as the single national cross-system definition of the goals of integration. Subsequent narratives expressed the perspectives on coordinated care of older people; young people with complex lives; people using mental health services; and those using end of life care.

Inspired by that work, LGB&T communities decided there was a distinct need for similar 'I' statements to highlight their needs and preferences to commissioners and providers of all health and care services.

There are now many ways that LGB&T people have reached a greater level of legislative equality than ever before, and many, although not all, of the inequalities in law have been overcome. Often in health and care service provision, however, there is still a lack of knowledge about, invisibility of, and at times inappropriate delivery of service to, LGB&T people. In terms of legislative equality, these 'I statements' may support public bodies to review the needs of LGB&T communities when considering their duties under the Equality Act, Social Value Act and Care Act.

LGB&T people are still disproportionately affected by inequalities across a number of health and wellbeing areas. Research has shown for instance that compared with heterosexual people, LGB people are at higher risk of misusing substances, experiencing mental health problems and expressing suicidal thoughts and behaviours (Fay, 2016). Significantly higher levels of mental health difficulties and substance misuse have also been reported by trans people in health surveys (The National LGB&T Partnership, 2015). Research shows that LGB&T people often seek support at a later stage and many choose to use specialist LGB&T services where they can avoid some of the difficulties they may face in mainstream services (Mallon, 2000, Tai S et al., 2008)

There is growing research evidence that demonstrates the health inequalities faced by LGB&T people (The National LGB&T Partnership, 2013). LGB&T people often report having difficulty accessing services because they feel or fear their needs haven't been considered by the service provider (Stonewall 2013), including because the language used is exclusive of those who have an LGB and/or T identity (Stonewall 2012, National LGB&T Partnership, 2014).

Further evidence of the needs of LGB&T people can be found in publications such as the Adult Social Care Outcomes Framework LGB&T companion document (2015) and the Public Health Outcomes Framework LGB&T companion document (2014).

## **Why statements just for LGBT communities?**

LGB&T people face the same health and care issues as the general population, but may have additional needs to be considered. In order to meet the needs of LGB&T people it is important to know who we are and to consider our sexual orientation and or gender identity and the impact this may have on our health or social care needs. The 'I statements' and surrounding narrative gained from those taking part in this project emphasise the need for consideration of our identities as an important part of our health care.



These statements reflect the specific needs of the community, reflecting where being lesbian, gay, bisexual or trans impacts on the delivery of services. Generic approaches too often exclude the specific needs of LGB&T communities, based on the assumption that sexual orientation and gender identity are not relevant to health and care.

What is apparent through the gathering of these statements is that the attitudes and knowledge of health and social care staff in their interactions is paramount to the experience of LGB&T people. Whilst the statements could more generally be applied to the wider population, the specific relevance is explored in the narrative through the lens of being LGB&T, to make explicit the particular needs of LGB&T people.

There are specific needs that are relevant to all LGB&T people, but there are also some individualised needs related to each group under the umbrella of LGB&T. We have produced 'I statements' that relate to all, but the additional narrative alongside the statements provides some insight into these differences.

These statements have attempted to be inclusive as possible. We have ensured the voice of the 'I statements' has come from a diverse range of LGB&T people from many different parts of our communities, including those from a range of faith groups, with differing ethnic backgrounds, older and younger people, disabled people, and those who use social care and mental health services. We recognise that there are both similar needs within LGB&T communities as well as needs specific to different sections of our communities. We also recognise that within the LGB&T population there are differing needs as impact on, and experience of, health is affected by gender, sexual orientation, ethnicity and other intersecting identities. Whilst these 'I statements' do not differentiate, as we found there was there was much overlap in statements, in service provision it is necessary to understand the different needs.

LGB&T people in their responses had clear ideas as to what their expectations were, and we also received many examples of poor experiences. The statements clearly demonstrate that attitudes and knowledge are a key requirement of providing good health and social care to LGBT people. Wider research shows that there can be a general fear in LGB&T communities of how a person will be treated within services, and there is evidence of people having received discriminatory experiences for being LGB and/or T. This results in some people not disclosing their sexual orientation or gender identity, (Stonewall 2012, Fay 2016).

There is evidence that shows commissioners and service providers are not always aware of the demographics of the populations they serve, and therefore the needs of their constituencies. Thus, there is a need for routine gender identity and sexual orientation monitoring in all health settings (Fay 2016).

These new LGB&T narratives seek to articulate the concerns of LGB&T people and what makes for a successful relationship between providers and those seeking support. We urge providers, policy makers and commissioners to adopt these statements and to explore how it can be ensured that these needs are not overlooked in the commissioning and delivery of both specialist and generic services.



# Research Methods

In order to develop a specific narrative for LGB&T people, reflecting the different perspectives and needs of this population group, we needed to gather LGB&T people's views on how they wanted to be treated by health and social care providers. Having gathered input from a range of people across a number of methods, we spent time reflecting on the key themes that emerged, which became the 'I statements' you are about to read.

The research was carried out between November 2015 and January 2016 and included:

**A literature review.** A review was conducted of existing research and material to understand core themes and to provide a foundation for the research to build on. Both published and grey literature was included in the review.

**A survey.** The questions for the survey were drawn out from the literature review which highlighted some of the key concerns facing LGB&T people. They were structured to encourage respondents to describe what they wanted from the health and social care system, rather than simply describing the negative experiences that they might have had. The questions were drawn up and reviewed by a sub-group of the National LGB&T Partnership prior to further review by the whole National LGB&T Partnership, meaning that the questions were reviewed by 12 service providing organisations with expertise in supporting LGBT communities before the survey went live.

An online survey was conducted and LGB&T groups were asked to distribute the survey and support those who needed additional help to fill in online or hard copies of the survey. The survey was also taken to some specific existing LGB&T groups to ensure we had representation of LGB&T people with a range of identities and experiences, particularly young LGB&T people, trans people and BME LGB&T people, and LGB&T people who use mental health and fertility and maternity services.

Responses were received from over 200 participants. At the close of the survey demographic monitoring was reviewed, and additional views were sought from under-represented groups. Specifically, input from LGB&T people from Asian backgrounds was sought.

**Twitter conversations.** To diversify the input that we received, as well as to publicise the survey to a wide range of people, 3 Twitter conversations took place in December 2015. The 3 main prompts from the survey were used as questions to begin conversations with users on Twitter. These conversations were captured using Storify, and became part of the data analysed to develop and draw out the 'I statements'.

**Response analysis.** The online responses were analysed and grouped into repeated key ideas, themes or concepts. Through this, and through the use of responses to the question "The three most important things to me as an LGBT person using a health or social care service are" headings appeared, and answers were grouped under these themes.

It is apparent that some themes overlap and that the themes are not mutually exclusive. 'I statements' were formed from the repeated patterns of the key themes and the wording was taken from combined statements.

**Community review.** These statements were then reviewed by LGB&T people attending the LGBT consortium conference who made some amendments to the wording of some statements. Around a dozen people, each representing different LGB&T service provision organisations (and unique to the organisations involved in the initial survey design and review), were involved in reviewing the statements and there was general consensus that the statements were a good reflection of what people themselves wanted and would have chosen to say.



## Demographics

We endeavoured to ensure that the diversity of our communities was represented in the respondents to our survey. We asked for demographic information at the end of the survey, making it clear that this information would not be attached to respondent's answers, but would be used to assess the diversity of people completing the survey. Most respondents provided this information. We did not include an option to answer 'prefer not to disclose', as all questions were optional, and if this was a person's preference, they could choose not to answer. A breakdown of the information follows:

### Gender:

Man - 57, Woman - 96, In another way - 35, Chose not to answer - 12.

### Trans status:

119 respondents answered yes to the question 'Is your gender identity the same as that you were given at birth?'. 70 answered no, and 11 chose not to answer.

### Sexual orientation:

Participants were asked which of the following best describes how they thought of themselves: Lesbian - 54, Gay - 51, Bisexual - 26, Straight - 12, In another way 46. 11 respondents chose not to answer.

### Disability:

61 respondents stated that they were disabled, 13 respondents chose not to answer.

### Religion:

We asked 'what is your religion or belief, even if you are not currently practising?' 103 people stated a religion or belief, the majority, 54, described themselves as Christian. Respondents also defined themselves as: Buddhist, Humanist, Jewish, Muslim, Pagan, Sikh and Taoist.

### Race:

Participants were asked to choose which response best described how they thought of themselves. 37 respondents described themselves as BAME, from 10 different ethnic groups, 139 as white British, and 24 as other white background; 12 respondents chose not to answer.

### Age:

The youngest participant was 13 and the oldest 81. the number of respondents in each age category was as follows: <18 - 12, 18 to 30 - 40, 31 to 40 - 48, 41 to 50 - 34, 51 to 60 - 38, 61 to 70 - 11, 71 to 80 - 1, 80+ - 1. 15 respondents chose not to answer.

# Out Loud: A narrative for LGBT people in health and social care services

## The 'I Statements':

Confidentiality - My information about me belongs to me

*I am not outed to others without my consent.*

Support – See me for who I am

*Health care support is matched to my needs and takes account of my sexual orientation and/or gender identity where relevant.*

Equality - don't make judgements or assumptions

*Health care providers do not make assumptions or judgements about my body, identity or relationships.*

## Out Loud - I am who I am

...a narrative for LGBT people in health and social care services

Acceptance - show me that I am welcome

*I know that services are welcoming to and informed about LGBT people and communities*

Respect and Dignity - treat me well

*I am seen as a whole person with a wide collection of identities and needs*

Understanding - show me that you understand me

*Health and care staff providing my care are well informed and trained about gender identity and sexual orientation issues and do not expect me to educate them.*

Statements fell into six areas, with an example of each provided here. The full collection of statements follows.

# The 'I statements': What matters most to LGBT people by themes

The 'I statements' below are presented as if the ideal is already the case. The use of the present tense allows the reader to imagine a scenario in which the health and social care needs of the LGBT&T communities have been realised.

There were many overlapping concerns across each key theme and they need to be viewed collectively in order to understand the needs and wants of LGBT&T people in health and care settings.



## Equality - don't make judgements or assumptions

Not facing assumptions or judgements was described by the majority of people as one of the most important things to them. To be open as to who they are in order to receive the care they require is a key need for LGBT&T people. Experiences of assumed heterosexuality were common (and often resulted in respondents feeling forced to come out, particularly in relation to questions around birth control) and there is evidence that

"People providing my care act in a professional and non-discriminatory way"

inappropriate responses are made to those that have stated their sexual orientation. Negative responses, be these hostile, obstructive or invasive, whilst not everyone's experience are still too often occurring. Examples of professionals showing judgement and assumptions were seen in language used, questions asked, gestures and attitudes.

"Health care providers do not make assumptions or judgements about my body, identity or relationships"

The literature review showed that many health and social care professionals often do not think sexual orientation is relevant to any health care need, which reinforces the invisibility of people's identity and means that the specific needs of LGBT&T people are overlooked. Conversely to this, many examples were also given where people felt that their sexual orientation, or particularly their gender identity, was focused on inappropriately, for example when going to the GP with a common illness or unrelated issue such as a knee complaint or hearing problem.

"My sexual orientation and or gender identity is only taken into account when relevant to my care"

“I, and my partners or carers if I want this, am given all the information we need in an accessible way and we are encouraged to be part of the decision making about my care”

Whilst many LGB&T people wanted their identity to be recognised, this needed to be understood in the context of their specific health problem and not always as the first or most important aspect of their health care, unless this was what had caused them to seek support. This experience was significantly more common for trans people, but was also reported by cisgender LGB people (LGB people whose gender identity matches their sex as assigned at birth), particularly in the area of mental health.

Like most people, LGB&T people want to be able to make informed choices about their health care. There is a need for LGB&T patients themselves to be able to define who their partners and carers are, with a recognition from health and care professionals that, for some, birth family members may not be supportive of someone’s LGB and/or T identity. Often people stated that their partner was excluded from discussions even if they wanted their support to make decisions about their care, as they were not recognised as a partner. If someone wants a partner or carer involved, then this should be supported. This was particularly reported by women using fertility and maternity services, whose partners were often assumed to be friends or other relatives. Even when they were recognised as partners, they were not treated in the same way as the male partner of a woman in the same position would be.

“After outing myself to my CPN (Community Psychiatric Nurse) and Psychiatrist I feel they treated me as a stereotype, talking about Elton John. I felt this was a bit crass.”

## Respect and Dignity – treat me well

Being treated with respect and dignity is a key theme for all people who use health and care services. The additional needs for LGB&T people in this regard are in relation to their sexual orientation and gender identity. Respect needs to be actively shown through acceptance of individuals’ lifestyles, relationships and their definitions of who their family and carers are. For some LGB&T people ‘family’ are not necessarily people who are biologically related, both in terms of who their children are and also because for some, friends are seen as family. This is particularly important for those whose family of origin are not supportive of LGB&T people.

“I am seen as a whole person with a wide collection of identities and needs”

“My relationships are acknowledged and respected by health care providers”

There is also a need to recognise the range of identities beyond sexual orientation and gender identity that people have, and the interplay between these identities, so that people feel that their whole self is acknowledged and they do not have to choose which identity or identities they can be open about.

For LGB&T people with dementia, part of treating people with dignity is recognition of the person’s identity as LGB and/or T as part of their life and ensuring that conversations of the past include their relationships and identity where appropriate. One of the concerns of older LGB&T people is the fear of how they will be treated by care home staff or paid carers (Alzheimer’s Society, 2013).

“Providers respect my right to identify who are my family, and carers”



## Acceptance – show me that I am welcome

Acceptance was a frequently repeated theme, and many examples were given as to how LGB&T people would feel supported and know, or believe, that they were accepted within services. Many people look for visual clues in a service before they meet with a professional to identify if the service is going to be supportive of their identity

and therefore their whole self. Posters of LGB&T schemes supported by the service helped people to feel that there would be some knowledge among the staff, and that they could be offered

“Services use inclusive language and I see images of LGBT people in publicity”

“Health care providers ask me questions about my life in a way that makes me feel confident that I can give any answer”

alternative or additional support through specialist LGB&T provision if they wanted this.

The language used by staff was also crucial in supporting people to be open about being LGB&T. Open questions such as ‘are you in a relationship?’ (as opposed to ‘do you have a boyfriend or husband?’), directed to female service users, for example), and follow-up questions asking the gender of the partner or partners without judgement were seen as ways of being able to be open about being LGB. Asking for, and using, the appropriate name, title and pronoun for trans people was a key way of demonstrating acceptance.

“I know that services are welcoming to and informed about LGBT people and communities”

“I’ve experienced people pulling faces if I talk about LGBT issues”

“I need to see that the professional in front of me is relaxed and open and uses language that does not assume heterosexuality. Maybe they ask questions that help me to be open – as an older woman I still have some difficulties around initiating conversations about my sexuality, even when I know it is “safe” to do so.”

## Understanding - show me that you understand me

The research findings emphasised that whilst individuals were happy to answer relevant questions, overall there was a need for health and social care staff to have information about the specific needs of LGB&T communities, to prevent service users having to take on the role of educator. There were many examples of LGB&T people having to tell health professionals how to refer them to specific services such as fertility clinics

“Health and care staff know what to do if I want support about my gender identity”

or gender identity services, or explain why they need specific health care support. Reported responses from staff such as “I don’t know how to deal with people like you” portrayed LGB&T people as ‘other’ and were felt to be very stigmatising.

This lack of knowledge, potentially coupled with poor attitudes, will mean that LGB&T people continue to seek services after greater delay, not at all, or only when in crisis, and have less opportunity to take advantage of early interventions and preventative support.

As well as numerous reports from trans people that they found themselves having to educate their doctors both about trans people and about appropriate treatment pathways, there are some specific needs in relation to support for starting a family that were apparent from the responses. These were in relation to being given the relevant information about the options available and appropriate referrals, and also in relation to fertility for trans people. Trans people wanted to ensure that discussions about how they could

“Services confidentially, and separate from my care, ask the right questions to monitor whether they are serving my needs and the needs of LGBT community”

have a family, if this is what they wanted, were part of the overall discussion of their treatment plan. In general, health and social care need to be more person-centred.

an LGB&T person. Being questioned as if they could not know who they were was undermining and damaged people’s sense of self.

Monitoring of sexual orientation, gender and trans status appropriately was generally seen as something that gave a clear indication of understanding of needs, but must be done separately to providing services. Monitoring gave a clear indication that the needs of LGB&T communities as a whole were being explored, supporting people to develop trust in services.

Some LGB&T people, either because of their age, or because of a disability or mental health concern, are questioned about their identity and it is implied that they can not know who they are. It was expressed by respondents that having their right to self-identify affirmed was important to both being provided with relevant support and to know that they were understood as

“Health and care staff affirm my right to self-identify who I am irrespective of my age, disability, mental health needs or any other factor”

“Health and care staff providing my care are well informed and trained about gender identity and sexual orientation issues and do not expect me to educate them”

“Health and care staff know what to do I want support as an LGBT person starting a family”



## Confidentiality – my information about me belongs to me

Confidentiality is a key theme for many people but has additional relevance for LGB&T people, particularly in relation to physical safety for some LGB&T people who face violence, or would face violence, from people they know in relation to their sexual orientation and/or gender identity. Prejudicial attitudes are still prevalent

“I am not outed to others without my consent”

in society and therefore LGB&T people need to be able to trust that their identity is only revealed to those that they choose.

Too often, perhaps due to a lack of knowledge, health and social care providers do not know when it is relevant to ask about someone’s gender identity, trans status or sexual orientation, and too often people were asked about their story or experience where it had no bearing on their healthcare need. This is particularly true for trans people and intrusive questioning often takes place when it has no bearing on the current health care concern.

“I have confidence that health care providers understand my need for confidentiality”

“I only have to tell my story when it is relevant and I am not asked about it when it is not”

“I had changed my name and NHS number. At the local hospital, waiting for an outpatient appointment which had nothing to do with my transition, a nurse came out of one of the rooms, immediately followed by a voice from inside, shouting ‘is this next one male or female’.”



## Support - see me for who I am

Whilst not all services can be provided locally, there is a need, where possible, for local support to be available. There are particular concerns for trans people in relation to the long wait for gender identity services, with very limited local support during this waiting period. LGB&T people often want the option for some services, especially those relating to emotional support, sexual health and preventative health care, to be available via LGB&T organisations or delivered specifically to LGB&T communities, so that services can be tailored and delivered with a good understanding of LGB&T people’s needs and the specific nuances of being LGB&T.

“I can access the health care support I need quickly and locally”

Having support framed within a LGB&T perspective or provided by an LGBT person, ensures that LGB&T people can engage with this support more effectively and not be fearful of having their experiences devalued or not understood.

“I have access to services specifically for LGBT people”

status to the people assisting them. Not being able to access LGB&T spaces, magazines and books, or obtain gender appropriate clothing, for example, is likely to have a very negative effect on a person’s mental health.

“Health care support is matched to my needs and takes account of my sexual orientation and or gender identity where relevant”

Disabled people who use care support such as personal assistants may not be able to have all their support needs met if they are able to be not open about their sexual orientation, gender identity or trans

Many trans people wanted their GP’s to be able to be more involved in their gender-related treatment, and to be trained to be more knowledgeable about their needs around both gender-related and generic healthcare. This would in turn reduce the pressure on GIC’s, which could provide more specialist support.

“I can ask to be supported by someone from the LGBT community”

“I was told that I did not need to tell other mums that I was lesbian and then there would be no difficulties attending a mum and baby group - this ignored that my experience of parenting was entirely framed within a same sex relationship.”



# Case studies

We offered respondents the opportunity to let us know about both good and bad experiences of health and social care in relation to their identity or experience as an LGBT person.

## Good experiences

We received some examples of good practice, though what was striking was that these were overwhelmingly due to individual staff, rather than organisational policies or practices.

"I had an ASD (autism) assessment. The lady enquired carefully about my gender and I explained. She incorporated it beautifully in the final report; she clearly stated the facts as relevant but didn't make any insinuations that it is bad or anything, and just concentrated on the task at hand i.e whether I am autistic or not"

"My new GP accepted my registration as Ms without any fuss even though it had been so problematical at my previous GP. I then found she had never had a transgender patient before "you're my first" she said "so please be patient as I learn how this goes" – and she was wonderful, sensitive and supportive every step of the way. My previous practice when patients are called insisted on calling me Mister for everyone to hear/see though they know my preferred title is Ms. Even after I begged them to stop, they simply refused."

"On receiving a breast cancer diagnosis, my partner was totally included in my treatment and support, without question or judgement, it was just how it should be. our treatment was really wonderful and it removed a fear that we would be disrespected away so that we could just concentrate on getting me well."



## Bad experiences

Unfortunately, bad experiences were much more common.

"Both our midwives asked about the father which was quite hard and even did this in front of both of us (two women) together - we would have preferred 'Is there a father or is there a donor?'"

"I was asked "if I'd had the downstairs surgery" after someone discovering I was trans - I was there about seizures. This isn't the only time that question has been asked. Being asked "what it felt like to transition" by a well-meaning doctor - I was there about sleeplessness."

"I have been treated badly by a number of Drs who have refused blood tests to check hormone levels, and on one occasion by a Dr who said 'I have no time for you'."

"I recently gave up smoking and was getting support from a healthcare assistant at my GP practice. During a smoking cessation appointment, she once asked me what my old name was, and when I didn't tell her, she made up a girl's name to call me. She also said 'I am confused about your gender', even though my gender was correctly displayed right there on the screen of her computer, which I pointed out to her. I stopped accessing this service because her questions and comments made me too uncomfortable."

"An x-ray person made me come out to her because she didn't believe that because I was sexually active and not using contraception that I couldn't be pregnant. I had to come out as gay to a group of 2nd year medical students."



# Using the 'I statements': Recommendations

The aim of this Narrative project is to provide information about what LGB&T people want from services, and for health and social care providers to use this to improve their services at an organisational level, and to also inform their staff as to the needs and wants of LGB&T people.

The following recommendations respond to the key themes and concerns outlined in this report and exemplified by the 'I statements'.



## Nothing about us withOUT us

**LGB&T people need to be involved at all levels in the commissioning, design, delivery and monitoring of services as active participants in our health care.** Whilst there are opportunities for individuals to get involved (for example on Healthwatch boards or patient groups), it can be difficult for a single person to articulate the needs of LGB&T people generally, as there are a large breadth of different experiences, which also vary based on individuals' other identities. This means in many patient representative groups it can be difficult for the voice of LGB&T people as a whole to be present and even if present to some extent, to be heard. **Support for wider LGB&T representation is needed**, along with recognition that, as a community of identity, rather than of place, **information about LGB&T people can be gathered from wider sources beyond those in a small geographical location.** JSNA's and other planning documents for health and social care, for example, often do not include information about LGB&T people at a local level as this information is either unavailable or not collected, and therefore information needs to be sourced at a regional, national or international level, rather than allowing an absence of information.

## Training

**There is a need for all health and social care staff to receive both relevant knowledge and reflexive training that explores attitudes.** The aim should be to support staff to not make assumptions about people's sexual orientation or gender identity and to provide LGB&T people with the treatment, health advice and support they require. **Training should also support staff in the skills needed to monitor sexual orientation and gender identity.**

**There needs to be a commitment to this training being delivered in a way that includes and foregrounds the direct voice of LGB&T people.** Limited consideration is given in professionals' initial training courses to LGB&T issues, making the need for training while in practice even more necessary. This also allows training to be up-to-date, which is important when dealing with communities and people. Many LGB&T organisations will provide online resources, as well as in-person training.

**Training needs to be available for all staff who might have direct contact with LGB&T people, including those who are not delivering clinical services.** There are specific and different needs for different groups within the LGB&T communities which require tailored responses and consideration, and this needs to be incorporated into the training delivered. **Training also needs to consider the specific needs of black and minority ethnic LGB&T people, LGB&T people with disabilities and learning difficulties, and other intersecting identities.**

## Commissioning

**In commissioning, consideration needs to be given to the specific and distinct needs of LGB&T communities.** There will be times when specific LGB&T services will more thoroughly meet the needs of LGB&T people, and these should be supported to deliver the necessary services. Commissioners also need to assess mainstream services for their ability to meet the specific needs of LGB&T communities when reviewing tender applications. A co-production approach to service commissioning involving LGB&T organisations and/or LGB&T representatives would support the inclusion of LGB&T concerns in service delivery. Those commissioning and consulting on services should monitor levels of engagement with LGB&T populations, and work to improve engagement where necessary.

## Visibility

**It is important that LGB&T people are reflected in the surroundings in spaces in which services are delivered.** This means, for example, having posters and leaflets that reflect LGB&T communities and ensuring LGB&T people and their experiences are included and reflected in written materials. Again, there needs to be a recognition that LGB&T people also have other identities, for example, inclusion of images of and services for black and minority ethnic LGB&T people. Visual clues that LGB&T people are recognised and welcome, for example through the display of posters, service leaflets for LGB&T organisations, lanyards and rainbow stickers were suggested by respondents as examples of good practice.



## Changing Attitudes

Services need to consider the stigma and discrimination associated with LGB&T identities and experience, and ensure their service delivery actively redresses homophobic, biphobic, transphobic and heterosexist messages (along with considering the intersections of these oppressions with sexism, racism, ableism and ageism etc). **Resources need to be invested into actively combatting ongoing stigma and discrimination towards LGB&T people.**

## Monitoring

**Demographic monitoring that includes sexual orientation and trans status is needed to ensure that a clear picture of LGB&T needs is established at a service level and at a local area level.**

It appears that commissioners and service providers are not always aware of the demographics of the populations they serve, routine sexual orientation and trans status monitoring in all health settings and for health indicators would assist commissioners and service providers in making the appropriate interventions. Monitoring in the context of satisfaction surveys will help decision makers to explore the implications of the interventions they have made and services provided.

## Complaints

Responding to complaints where homophobic, biphobic or transphobic attitudes have been displayed is crucial both to improving services and to ensuring LGB&T people know that their concerns are being taken seriously. **Responding to complaints, and using learning from complaints, builds trust from LGB&T people.** Having clear statements available encouraging feedback and clearly advertising that homophobic, biphobic and transphobic attitudes will not be tolerated will build confidence and will encourage people to raise concerns where necessary, so issues can be addressed.

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# Partners



The National LGB&T Partnership is an England-wide group of LGB&T voluntary and community organisations who are committed to reducing the health inequalities of lesbian, gay, bisexual and trans communities and to challenging homophobia, biphobia and transphobia within public services.

Website: [www.nationallgbtpartnership.org](http://www.nationallgbtpartnership.org)  
Email: [nationallgbtpartnership@gmail.com](mailto:nationallgbtpartnership@gmail.com)  
Twitter: @LGBTPartnership



LGBT Consortium are a national membership organisation focusing on the development and support of LGBT groups, projects and organisations; so they can deliver direct services and campaign for individual rights.

Website: [www.lgbtconsortium.org.uk](http://www.lgbtconsortium.org.uk)  
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Twitter: @LGBTConsortium



ELOP's mission is to deliver service excellence in health and well-being the LGB&T community, and to promote equality and challenge inequality facing LGB&T communities.

Website: [www.elop.org](http://www.elop.org)  
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Twitter: @elop\_LGBT



National Voices is the national coalition of health and social care charities in England. We work for a strong patient and citizen voice and services built around people. We stand up for voluntary organisations and their vital work for people's health and care.

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The National  
  
LGB&T Partnership

**LGBT**  
foundation

  
stonewall  
housing

  
Embrace Difference

  
consortium  
of lesbian, gay, bisexual & transgendered  
voluntary and community organisations

  
gires

**GMFA**  
the gay men's health charity

**biUK**

**friend**<sup>LONDON</sup>  


**elop**  
promoting health and wellbeing

**GADD**



Birmingham LGBT

**Yorkshire  
MESMAC**  
GROUP OF SERVICES