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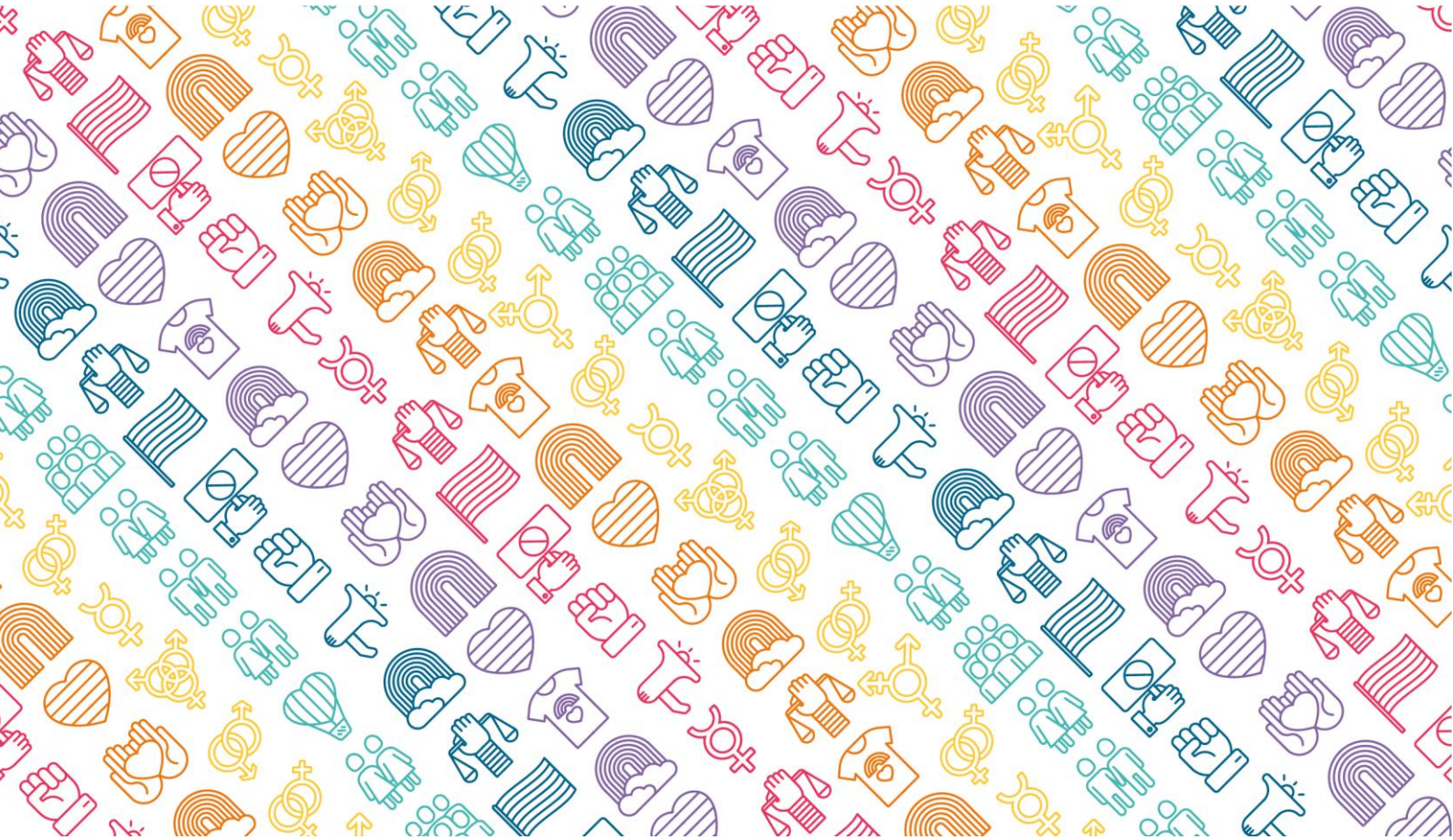
East Sussex County Council

East Sussex Lesbian Gay Bisexual Trans Queer + (LGBTQ+)

Comprehensive Needs Assessment 2021



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List of abbreviations

Abbreviation	Meaning
ASC	Adult Social Care
ASCOF	Adult Social Care Outcomes Framework
BIPoC	Black Indigenous People of Colour
BPOC	black and/or People of Colour
CAMHS	Children & Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CI	Confidence Interval
CQC	Care Quality Commission
EOLC	End of Life Care
ESCC	East Sussex County Council
ESHT	East Sussex Healthcare Trust
GIC	Gender identity clinic/s
GPPS	General Practice Patient Survey
HBT	Homophobic, Biphobic, Transphobic
HCP	Health care professions
IAPT	Improving Access to Psychological Therapies
ICP	Integrated Care Partnership
ICS	Integrated Care System
LCS	Locally Commissioned Service
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer, and any other sexual or gender minority or person who is intersex. At times just aspects of this acronym are referred to (e.g., LGB women or lesbian/gay/bisexual women)

LTC	Long term condition
LTS	Long term support
MHMS	My Health My School Survey
MSM	Men who have sex with men
NBGV	Non-binary/gender variant
PHE	Public Health England
PoC	Person/People of Colour
PrEP	Pre-exposure Prophylaxis
SHCP	Sussex Health and Care Partnership
SPFT	Sussex Partnership Foundation Trust
SPSS	The software package used to analyse statistical data
STI	Sexually Transmitted Infection
TGD	Trans and gender diverse
TNBI	Trans, non-binary and intersex

Glossary

Term	Meaning
Binary or trans binary	This refers to the gender binary of men and women. Trans binary refers to someone who identifies with a binary gender that differs or does not align to their sex assigned at birth.
Biphobia	The dislike or fear of a person because they are, or are perceived to be, bi.
Chosen family	A group of individuals, not biologically or legally related, who deliberately choose one another to play significant roles in each other's lives. In the LGBTQ+ population, who may be at greater risk of familial rejection, chosen families can be an important source of practical and emotional support.
Cisgender/cis	A person whose gender identity matches their sex assigned at birth, someone who is not transgender
Cisnormative assumption	The assumption that all individuals are cisgender (i.e., a person whose gender identity matches their sex assigned at birth)
Deadnaming	Calling someone by their birth name after they have changed their name. This term is often associated with trans people who have changed their name as part of their transition.
Gender dysphoria	The discomfort or distress a person may experience because their sex assigned at birth doesn't match their gender identity. This is also a clinical diagnosis.
Gender identity	A person's innate sense of their own gender, whether that be man, woman, non-binary or another gender identity. This may or may not align with the sex a person was assigned at birth. This is different to biological sex and different to sexual orientation.
Gender incongruence	The mismatch an individual feels as a result of the discrepancy experienced between their gender identity and their sex assigned at birth.

Gender variant	A term to describe where a person's gender identity or expression does not align to societal binary gender roles (i.e., outside the binary of man and woman).
Heteronormative assumption	The assumption that an individual is heterosexual or straight.
Homophobia	The dislike or fear of a person because they are, or are perceived to be, gay or lesbian.
Intersex	People with intersex characteristics are born with physical sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that do not fit typical definitions for male or female bodies. Intersex is not a gender identity or sexual orientation.
Misgendering	Misgendering occurs when you intentionally or unintentionally refer to a person, relate to a person, or use language to describe a person that doesn't align with their gender identity.
Non-binary	An umbrella term used to describe gender identities that fall outside the binary of man/woman. Often but not always included under the trans umbrella, people may or may not transition or consider themselves transgender.
Sexual orientation	Sexual orientation is an umbrella term that encompasses sexual identity, attraction and behaviour. Examples of sexual orientations are lesbian, gay, bi, pansexual or asexual. This is different to gender identity.
Transgender/trans	An umbrella term for people whose gender differs and/or does not fully align with the sex assigned at birth
Transition	The steps that a trans person may take to live in the gender with which they identify. The steps taken will vary by individual but may include hormone medication, surgery, dressing differently and telling family or friends.
Transphobia	The dislike or fear of a person because they are, or are perceived to be, trans.

Chapter one- Executive Summary

Whilst much progress has been made nationally regarding the rights of LGBTQ+ individuals, there are still significant inequalities that exist and gaps in the rights and support of some groups. A national programme of work is underway to implement the commitments of the LGBT Action Plan (1) to address some of these gaps and persisting inequalities for LGBTQ+ people. In East Sussex, there is not currently a systematic approach to addressing the needs and experiences of LGBTQ+ people. Although, there are areas of good work underway, such as the Sussex wide Trans healthcare programme. This needs assessment will contribute to systematically addressing inequalities in these groups within East Sussex.

Currently, consistent and robust data to enable the estimation of the number of LGBTQ+ people locally is lacking. This needs assessment estimates that there may be between 17,273 and 39,004 LGB+ people living in East Sussex (between 3.1% and 7% of the population) and 5,572 Trans and Gender Diverse (TGD) people (1% of the population). Although, there will be some overlap between these groups. Additionally, it appears that at a national level the proportion of people who identify as LGB+ may be increasing, and the proportion of those who identify as heterosexual are decreasing. Census 2021 data on sexual orientation (SO) and gender identity (GI) will be available from Spring 2022 which will include indicative population estimates of the number of LGBTQ+ people living in East Sussex. There is currently an even bigger data gap regarding estimating the number of people who have an intersex variation, with studies suggesting a range of between 0.05%-1.7% of the global population (2).

An overview of the health needs and experiences of LGBTQ+ people across the life course are outlined in the following section:

Young people

Wider determinants of health

The national and local data indicate that young LGBTQ+ people report feeling unsafe in and around school and levels of bullying are high, with local data suggesting that almost half (46%) of LGB+ pupils and 61% of TGD pupils surveyed have been bullied in the past year. This is significantly higher than for non-LGBTQ+ pupils. The literature review found that bullying has significant impacts on LGBTQ+ young people, including affecting future plans for education, mental health and wellbeing, suicidal thoughts or suicide attempts and lower life satisfaction in adulthood.

The literature review highlighted that young LGBTQ+ people are at high risk of experiencing hate crime, especially trans people, and our community survey indicated that half of LGBTQ+ young people had experienced homo/bi/transphobic abuse in the past 18 months. Only 3% of young people reported hate crime to the police or setting it occurred in. Additionally, young LGBTQ+ people often lack social support, with the majority not having an adult at home they can talk to about their identity, especially in people from diverse ethnic groups. Indeed, our community survey found that for young people still living with parents/carers or family, over one quarter had experienced bi/homo/transphobia at home during the COVID-19 pandemic, increasing to 37% of TGD people.

The prevalence of loneliness is extremely high in LGBTQ+ young people, with two thirds of community survey respondents reporting they had felt lonely or isolated during the pandemic, increasing to 79% of trans binary people. Local school survey data indicated that LGBTQ+ pupils are more likely to report feeling lonely every day or most days, with 44% of TGD pupils reporting this, compared to 19% of cis pupils and 38% of LGB+ pupils reporting this compared to 19% of heterosexual pupils. LGBTQ+ pupils also reported coping less well with feeling lonely compared to heterosexual/cis pupils.

Health behaviours

Mixed evidence was found regarding smoking in young LGBTQ+ people. The literature review suggested a higher prevalence of smoking in LGBTQ+ young people and a tendency to start at a younger age. Local data in secondary school pupils suggested a higher rate of having tried a cigarette in TGD pupils, but the frequency of smoking was similar across groups. Our community survey found that young gay men had the highest rate of occasional or regular smoking across any group (59%).

Problematic alcohol use also appears to be high in young LGBTQ+ people, with almost one quarter (23%) of young people who responded to our community survey reported drinking five or more alcoholic drinks in a typical drinking session, increasing to 67% in gay men.

Young LGBTQ+ people, especially those who are TGD, often feel excluded from organised physical activity and team sports, and the benefits they can confer. Our community survey found low levels of physical activity across LGBTQ+ young people, with only 23% achieving sufficient weekly activity (defined as at least 30 minutes of moderate physical activity at least 5 days per week), with even lower rates in TGD groups. The local school pupil survey also found significantly lower levels of physical activity in LGBTQ+ pupils compared to non-LGBTQ+ pupils.

Health status and disability

LGBTQ+ young people may be more likely to report a disability. The local school survey found that TGD pupils were over twice as likely to report being disabled compared to cis pupils (41% compared to 15%). A higher proportion of LGB+ pupils report being disabled compared to heterosexual pupils (22% compared to 13%).

Further to this, the prevalence of mental health conditions and the need to access mental health support is disproportionately high in young LGBTQ+ people, especially in TGD people. Of young respondents to the community survey, almost half (48%) reported an anxiety disorder, increasing to 70% of gay women/lesbians and 75% in non-binary/gender variant people. One in four young people reported having depression, increasing to 52% in people from other sexual minorities and 67% in non-binary/gender variant people. Young LGBTQ+ people also have a higher risk of self-harm, with three quarters of TGD respondents to the school survey reporting a history of self-harm and one third of those who have self-harmed reporting self-harming weekly or daily. The literature review also outlined a higher risk of suicide in young LGBTQ+ people. In our community survey, over half (55%) of young respondents reported that they had thought about suicide during the pandemic, increasing to 67% for non-binary/gender variant young people.

Experience and use of services

According to the community survey, experiencing heteronormative assumptions from staff was common for young LGB+ people, especially in GP practices, mental health services and in hospital settings. This was particularly common for gay women/lesbians and bi people. Cisgender assumptions were also commonly experienced by young people, with 57% of young trans binary people reporting this in GP settings. This was also commonly reported in mental health and hospital settings.

One in five (20%) young respondents reported that they access health and care services outside of East Sussex, with this increasing to 43% of trans binary people, especially in relation to trans health services.

COVID-19

COVID-19 has been a challenging time for all but may have been particularly challenging for young LGBTQ+ people. LGBTQ+ young people may be more likely to be concealing their identity from who they are living with or have been living in an unsafe or unaccepting environment during the pandemic, with anecdotal evidence suggesting this may especially be the case for TGD people. Our community survey highlighted that three quarters of young respondents reported that a previous mental health condition had worsened during COVID-19, increasing to 83% in non-

binary/gender variant groups and 86% in gay women/lesbians. Of those who stated they required support for their mental health during this time, 17% were unable to access this. Additionally, over half (57%) of trans binary young people reported a delay in transitioning during the pandemic, as did 17% of non-binary/gender variant respondents.

Working age people

Wider determinants of health

Mixed evidence exists about levels of unemployment in LGBTQ+ adults, and there is limited robust data available, but the data available suggests that there may be a disproportionately high rate of unemployment in some LGBTQ+ groups. One local survey found a threefold increase in unemployment of LGB+ people compared to heterosexual people. The same survey found LGB+ people had almost double the rate of permanent sickness/disability compared to heterosexual people. Additionally, our community survey found a much higher rate of being unable to work due to sickness/disability in trans binary people, bi and pansexual people and the literature review findings also supported this.

Further to this, LGBTQ+ people report high levels of discrimination, bullying and sexual harassment in the workplace, especially for TGD people and people from diverse ethnic groups. Our community survey found that for those in full or part-time employment, over one in ten (12%) of respondents reported experiencing bi/homo/transphobic abuse in the workplace, increasing to over one in four (44%) trans binary people.

It is likely that homelessness disproportionately impacts LGBTQ+ people with one UK based study noting 18% of LGBTQ+ people surveyed had experienced homelessness at some point in their lives. A recent study of TGD people found that 27% of those surveyed had experienced homelessness at some point in their lives, increasing further for those who report being disabled or those from diverse ethnic groups.

The incidence of anti-LGBTQ+ hate crime is increasing nationally. In the last 18 months, 53% of trans binary respondents to the community survey reported experiencing an anti-LGBTQ+ hate crime, compared to 29% of cis LGB+ people. Such incidents occurred most commonly in public places or leisure settings, online or in a workplace. Based on evidence from the literature review and the community survey, most anti-LGBTQ+ hate crime goes unreported.

The literature review outlined that LGBTQ+ people are often excluded from community spaces, such as sports clubs and in communities of faith. Some groups, such as people from diverse ethnic groups, may feel excluded and experience discrimination from LGBTQ+ spaces. Additionally, trans people, LGBTQ+ Muslim

people and LGBTQ+ people from diverse ethnic groups are disproportionately being offered or subjected to harmful conversion therapy practices.

The prevalence of loneliness is high amongst LGBTQ+ working age people. Our community survey found that 43% of working age, LGBTQ+ people reported feeling isolated or lonely during the pandemic, increasing to 77% in non-binary/gender variant people. One third (32%) of LGB+ respondents of the GP Patient survey reported feeling isolated in the last 12 months, over twice the rate of heterosexual people (14%).

Health behaviours

The literature review outlined that drug use appears to be substantially higher in LGBTQ+ people compared to non-LGBTQ+ people, especially in gay/bi (GB) men. Sexualised drug use may be higher in LGBTQ+ people, especially sexual minority men, although the evidence on this is limited. In adults who had accessed and were discharged from the local substance misuse provider in 2020/21, it appeared that there may be some differences in the types of substances that bi people were seeking support for, but the sample was too small to draw firm conclusions on this.

National and local evidence indicates that smoking prevalence is disproportionately high in LGBTQ+ people, with the local GP patient survey finding that LGB+ people were more likely to be occasional (13%) or regular smokers (14%), compared to heterosexual people (6% and 7% respectively). Our community survey found that four in ten respondents were former smokers, increasing to 53% of trans binary people. Further to this, the literature review found that alcohol use appears higher in LGBTQ+ people compared to non-LGBTQ+ people, especially in Gay, Bi or trans (GBT) men. In the community survey, one quarter (25%) of respondents drank alcohol every day or most days, increasing to 31% in gay men.

Keeping physically active is highly beneficial for both physical and mental health. However, the literature review outlined that LGBTQ+ people, especially TGD people, are less likely to be sufficiently physically active compared to non-LGBTQ+ people. Indeed, only one quarter (26%) of community survey respondents achieved 30 minutes of moderate physical activity per day for five or more days per week.

PrEP is an effective form of HIV prevention for people who may be at increased risk of HIV. In working age respondents of the community survey, knowledge of PrEP was high in gay men (86%) but lower in bi men (67%) and trans binary people (67%). The literature review outlined some evidence suggesting there remains a stigma in the use of PrEP in gay and bi men, which may impact uptake.

Health status and disability

Over two thirds (68%) of LGB+ respondents to the GP Patient survey had a long-standing health condition or disability, compared to 58% of heterosexual people and LGBTQ+ people also appeared to have greater mobility issues than cis/heterosexual people.

In adults, the GP patient survey found that mental health condition prevalence was significantly higher in LGB+ people (41%), compared to heterosexual people (11%), especially in bi people (56%). Additionally, TGD people were much more likely to report a mental health condition than cis people (27% compared to 12%). These findings align with the results of the community survey and the literature review in terms of a higher prevalence of mental health conditions in LGBTQ+ groups. Of those who accessed IAPT services locally, recovery appears to be somewhat lower in bi people, compared to both lesbian/gay (LG) people and heterosexual people (43% compared to 52%). This is a pattern also seen nationally.

Additionally, evidence from the literature review suggests that long waiting times for GICs, currently at around four years for a first appointment, negatively impact the mental health of TGD people, increase the risk of suicide and self-medication. Focus group and community survey respondents also outlined this as a key issue locally.

The literature review also outlined an increased risk of self-harm and suicide in LGBTQ+ people, especially TGD groups. In respondents of the community survey, the prevalence of self-harm during the pandemic was 13% overall, but this increased to 20% in trans binary and 35% in non-binary/gender variant people. Additionally, over one in five (22%) respondents to the community survey reported thinking about suicide during the pandemic, increasing to over 40% in TGD groups.

Additionally, the literature review outlined mixed evidence regarding the incidence of cancer in LGBTQ+ people, although some cancers appear to be more common in sexual minority men and women. Further to this, evidence suggests that uptake of screening may be lower in LGB+ women and TGD people. The community survey outlined that whilst 90% of working age LGBTQ+ people reported they would be likely/very likely to take up screening if invited, this decreased to 53% in trans binary people.

Experience and use of services

Responses from the community survey and focus groups indicate that heteronormative assumptions by health and care staff were common, especially in GP settings, hospitals and mental health settings. Gay women/lesbians were the most likely to report this, with 58% reporting experiencing this in their GP practice in the past 18 months. Cisnormative assumptions were common in a range of

settings, including in primary care, hospital, perinatal and mental health settings, especially for non-binary/gender variant people. Trans binary working age people were more likely to report experiencing unfair treatment and inappropriate questions in health and care services than cis and non-binary/gender variant people. A very small number of respondents reported experiencing homo/bi/transphobic abuse in health and care settings. The focus groups highlighted that for some respondents there was a heightened fear of discrimination, due to other protected characteristics, such as race.

In working age people, 18% reported accessing health and care services outside of East Sussex, increasing to 23% of non-binary/gender variant people, 24% of gay men and 33% of trans binary people. Services accessed were mainly trans healthcare or HIV care. Further to this, a bespoke survey suggested that up to 20% of activity in key LGBTQ+ organisations based in Brighton is from East Sussex residents. This suggests there may be significant unmet need locally.

COVID-19

Whilst COVID-19 has been challenging for all, LGBTQ+ people may have particularly struggled during lockdown if they weren't living in a safe or supportive environment and due to reduced access to community spaces to connect with other LGBTQ+ people. The literature review suggests that rates of abuse or violence during lockdown were high amongst LGBTQ+ adults, especially those from South Asian backgrounds and TGD people.

Over one in four (43%) of working age respondents of the community survey reported a previous mental health condition had worsened, increasing to 71% in non-binary/gender variant people. Disruption in access to medical care impacted many people during the pandemic but may have significant impacts on TGD people awaiting a GIC appointment, where waiting times were already extremely lengthy (four or more years). Our community survey indicated that COVID-19 had delayed transition for 27% of TGD people. Additionally, 31% of respondents reported using substances to support their mental health. Of those that reported they required support for their mental health, 14% stated they were not able to access appropriate support, and this increased to 25% of trans binary people.

Due to a lack of routine monitoring of SO and GI in health services, we will never know whether the virus itself (as opposed to the restrictions) disproportionately impacted LGBTQ+ groups. However, based on the known risk factors (such as smoking) for serious illness and death from COVID-19, it may be that some LGBTQ+ groups were impacted to a greater degree than non-LGBTQ+ people.

Older people

Wider determinants of health

There is limited robust evidence of differences in home ownership between older LGBTQ+ people and non-LGBTQ+ people. Although, our community survey highlighted that TGD respondents were more likely to be renting their home compared with cis respondents, who were more likely to own their home outright or be buying their home with a mortgage.

The literature review highlighted that older LGBTQ+ people may be more likely to be single, live alone and may be less likely to have traditional family structures to rely on for support than non-LGBTQ+ people. This may increase the risk of loneliness and isolation. One third (34%) of older people who responded to our community survey reported feeling isolated or lonely during the pandemic, increasing to 64% of TGD people.

Further to this, the literature review outlined that poor treatment or discrimination due to age within LGBTQ+ communities is commonly reported by older LGBTQ+ people, with one survey finding that 28% of respondents reported this. This was also highlighted by some of the older focus group participants.

Just over one in ten (11%) of older respondents to the community survey reported experiencing bi/homo/transphobia in any setting in the past 18 months but this increased to 27% in TGD older people.

Finally, the literature review highlighted that one in ten older cis LGB people reported being offered or having been subjected to conversion therapy and one in five older trans people reported this.

Health behaviours

The literature review found that older LGBTQ+ people may be less likely to smoke than younger LGBTQ+ people. Our community survey found that one in ten (10%) older respondents smoked regularly. Gay men were most likely to be regular or occasional smokers (31%) compared to all other SO groups. The literature review found that daily alcohol consumption was disproportionately high in older LGBTQ+ people, and the community survey findings supported this, with 39% of older respondents reporting drinking alcohol almost every day or every day. Although, of all the age groups, older people were least likely to drink excessively in one sitting according to the community survey.

Compared to older heterosexual people, older LGB people appear to be more likely to exercise regularly based on the literature review findings. However, there may be some inequalities within LGBTQ+ groups, with our community survey

highlighting that older cis LGB+ people were three times more likely to be sufficiently physically active than TGD people (33% compared to 9%).

In older people, the community survey outlined that a high proportion of gay men were aware of PrEP (86%) as a form of HIV prevention but this reduced to 40% in TGD people.

Health status and disability

The evidence suggests that LGBTQ+ older people may be more likely to report poor health, with the literature review outlining that GB+ men were more likely to report long term conditions (LTC) and limitations related to health, and LGB+ women had lower self-reported health. In our community survey, 79% of older respondents reported at least one LTC or disability, increasing to 82% in trans binary people and 83% in gay women/lesbians. Older respondents to the community survey were most likely to report arthritis or other issues with back/joints (32%), high blood pressure (31%) or a respiratory condition (19%). One quarter (24%) of older gay men had HIV.

Additionally, the literature review highlighted that older LGB+ people have a higher prevalence of poor mental health, especially in bi people. Lifetime suicide attempts appear to be higher in GB+ men compared to heterosexual men. The community survey found that 10% of cis older respondents reported thinking about suicide during the pandemic. In older trans women, the literature review found that self-harm rates seem to be three times as high as in the general population. Although, no self-harm was reported in the older TGD respondents to the community survey.

Experience and use of services

The practical and emotional reliance on chosen families (who may be of a similar age) for many older LGBTQ+ people may result in needing to access formal care sooner or more frequently than non-LGBTQ+ older people. The literature review highlighted that many LGBTQ+ people anticipated discrimination, cis and heteronormative assumptions in care settings and also had heightened concerns that the quality of care they received would be poor if they were to disclose their LGBTQ+ identity or identities to care workers. This was also a theme that arose in our focus groups. Further to this, the literature review outlines how anxieties may be heightened in TGD people in relation to personal care for tasks with potential exposure to gendered body parts. Whilst many care homes appear to have good intentions with regards to LGBTQ+ inclusion, evidence suggests many lack the knowledge and awareness to support LGBTQ+ in care settings.

Additionally, older LGBTQ+ people fear discrimination from palliative and End of Life Care (EOLC) services, with the literature review finding that some

professionals make cis and heteronormative assumptions about patients and at times treat same-gender partners differently. In some cases, partners and/or chosen family members may not be recognised in the way the person wants them to be and they may be overlooked in decision making. Concern regarding the use of palliative and EOLC services also arose as a theme within the focus groups.

The community survey found that heteronormative assumptions occurred most in GP practices, hospital and pharmacy/dentist/optician settings for older LGBTQ+ people, especially for gay women/lesbians. In both hospital and GP settings, 27% of TGD older people reported experiencing cisnormative assumptions. The focus groups highlighted that for some older LGBTQ+ people there was a heightened concern about discrimination from services due to other protected characteristics such as age or race, as well as their LGBTQ+ identity or identities.

Almost one in five (18%) of older respondents to the community survey reported accessing health and care services outside of East Sussex, especially with regards to HIV services.

COVID-19

During the pandemic, older LGBTQ+ people may have been cut off from less traditional networks such as their chosen family, and the practical and emotional support that these provide. Additionally, many older LGBTQ+ people may be reliant on organised LGBTQ+ support, and much of this went online during the pandemic, with some older LGBTQ+ lacking the necessary IT skills to utilise these.

The literature review outlined that older LGBTQ+ people experienced a substantial decline in their mental health during the pandemic. The community survey found that over half (51%) of respondents reported feeling stressed and anxious and 29% reported that a previous mental health condition had worsened. Additionally, 18% of respondents reported using substances to support their mental health, increasing to 24% of gay men.

Inequalities between different ethnic groups

There was limited analysis conducted by age group and ethnicity due to small sample sizes or a lack of available data. However, some inequalities were highlighted by broad ethnic groups, across all age groups, based on the community survey:

- Respondents from a Black, Asian and other minority ethnic background were less likely to be employed full time (32%) compared to 43% of ‘other white’ groups and 48% of white British groups.
- Black, Asian and other minority ethnic respondents were almost twice as likely to encounter homo/bi/transphobia in the workplace as white British respondents (20% vs 11%)

- People from ‘other white’ backgrounds reported slightly more experiences of anti-LGBTQ+ hate crime (38%) than white British (32%) and Black, Asian and other minority ethnic (32%) respondents.
- 58% of respondents from Black, Asian and other minority ethnic backgrounds felt isolated/lonely during the pandemic, compared to 54% from ‘other white’ groups and 45% of white British groups.
- Regular smoking rates in Black, Asian and other minority ethnic respondents were almost double that of white respondents (16% compared to 8%).
- ‘Other white’ respondents were more likely to drink five or more alcoholic drinks in one sitting (19%) than people from White British groups (15%) and people from Black, Asian and other minority ethnic groups (6%).
- People from Black, Asian and other minority ethnic backgrounds were more likely to report that they felt depressed and that a previous mental health condition has worsened during the pandemic than white groups.
- Almost half (47%) of people from a Black, Asian and other minority ethnic group reported that they had thought about suicide during the pandemic, compared to 26% of white British respondents and 16% of ‘other white’ respondents.

It is recognised that analysis of ethnicity by very broad groups such as this is problematic and fails to capture the differences in experiences of different ethnic groups. It was however the only suitable form of analysis due to a small sample of ethnic minority respondents to the survey (n=19) who were from a wide range of backgrounds. More data is required to consider the impact of additional protected characteristics, such as ethnicity, on health and wellbeing in LGBTQ+ groups. The Census 2021 data released in Spring 2022 will support in enabling some analysis as would the routine monitoring of SO and GI across all health and care services, which is highlighted as a key recommendation.

Best Practice

A wide range of guidance exists to support organisations and services to deliver high-quality support to LGBTQ+ people. Whilst there are some particular considerations in specific settings, there are several commonalities in best practice in supporting LGBTQ+ people across all settings and determinants for health: the need for consistent and systematic data collection, monitoring and analysis; staff training in LGBQT+ needs, both general and service specific; the need for inclusive and ‘safe’ service provision, including clear confidentiality policies; and the need for robust preventative policies and proactive approaches to tackling discrimination.

Recommendations

The recommendations alongside a summary of the evidence base for each are shown in full in appendix one.

Recommendations from this needs assessment are outlined below:

Strategic

1.1 The response to the challenges and recommendations set out in this report require a whole system approach. A multi-agency group to be convened to implement the recommendations. The group should be embedded within the Integrated Care Partnership (ICP) and should include schools and colleges.

Communication and engagement

2.1 Increase awareness of the benefits of PrEP for the prevention of HIV for LGBTQ+ groups and how to access this

2.2 Work with trusted LGBTQ+ organisations to promote the benefits of screening to LGBTQ+ people, including clear risk communication.

2.3 Given that IAPT services were one of the few local services with excellent SO data, we were able to note a pattern whereby outcomes appear poorer for bi people, which aligns with national research on this. We recommend that engagement is undertaken with LGBTQ+ IAPT service users to understand their experiences of using the service.

2.4 Actively seek out insight as to the experiences of LGBTQ+ people accessing a wide range of health and care services, ideally led by LGBTQ+ organisations.

Inclusion and awareness in mainstream settings

3.01 Health and care settings should conduct reviews, with full engagement of staff and users, to consider providing gender-neutral and accessible toilet facilities for staff and service users.

3.02 Health and Care services should ensure their public facing materials (e.g., leaflets, webpages etc) include representation of LGBTQ+ people (including those with intersectional identities, such as a disability) and use inclusive language, such as encouraging staff to identify their pronouns.

3.03 Swimming pools, leisure centres and sporting facilities should consider how they could become more LGBTQ+ friendly and inclusive, including the introduction of LGBTQ+ sessions.

3.04 Health and Care settings should display LGBTQ+ signifiers and visible policies which communicate a zero-tolerance approach to homo/bi/transphobic discrimination within services, alongside LGBTQ+ champions in services.

3.05 Support visible, positive LGBTQ+ role models within public sector organisations through forming/developing LGBTQ+ staff networks, LGBTQ+ champions, taking part in Pride events and LGBT History Month, Black LGBT history month, International Day Against Homophobia, Biphobia and Transphobia, Trans Day of Remembrance.

3.06 Develop an anti-LGBTQ+ bullying strategy across East Sussex, working closely with schools, colleges and specialised local organisations already supporting LGBTQ+ young people.

3.07 Provide schools, colleges and youth-focused services and organisations with the guidance needed to promote inclusion of LGBTQ+ young people and to support those who are victims of hate crime or online harassment, linking in with local LGBTQ+ organisations.

3.08-3.13 Work with local LGBTQ+ organisations to provide LGBTQ+ awareness and inclusion training for staff and volunteers in:

- End of life care services;
- Care Homes;
- Perinatal services;
- Specialist community public health nurses;
- Primary Care.
- Mental health services (Adult and Children & Young People).

3.14 Awareness sessions to be delivered to health and wellbeing decision makers/leaders and elected members on health inequalities amongst LGBTQ+ groups.

3.15 Explicit consideration should be given to the needs of LGBTQ+ people in the delivery of health behaviour initiatives (e.g., smoking cessation, alcohol harm reduction, substance misuse).

3.16 Ensure specific and inclusive support is in place from a range of partners to ensure young people feel supported to manage their sexual health and safety.

3.17 Develop a scheme to identify and promote LGBTQ+ friendly businesses and wellbeing spaces.

3.18 Health and Care organisations (including LGBTQ+ CVS organisations) need to have an understanding of the impact of intersectionality in the planning, delivery and evaluation of services.

3.19 Homelessness commissioners and service providers should explicitly consider the needs of LGBTQ+ people accessing support

3.20 Implement any learning from SPFT as a pilot site of the NHS Confederation LGBTQ+ recommendations across other Health and Care settings.

3.21 Consider specific needs of LGBTQ+ young people Not in Education, Employment or Training (NEET) and provide relevant support.

3.22 Consider specific needs of LGBTQ+ people accessing domestic abuse services and support.

LGBTQ+ specific services and support

4.1 Support the development of LGBTQ+ (and especially TNBI specific) organisations in East Sussex to provide services and groups to support wellbeing (e.g., peer-led support groups, opportunities for socialising, exercise/sports sessions etc).

4.2 Consider commissioning specific suicide prevention for LGBTQ+ people, especially for TGD people, as part of a suicide prevention programme.

4.3 Support the development of the provision of LGBTQ+ inclusive and specialist spaces/organisations in the county, ensuring inclusive provision for TGD youth.

4.4 Consider commissioning specific mental health support for LGBTQ+ people, especially ensuring adequate and appropriate provision for young people that addresses their specific needs and experiences.

4.5 Work with community safety partners to establish liaison person for LGBTQ+ hate crime to encourage reporting, closely linked to local LGBTQ+ support groups.

LGBTQ+ specific services are encouraged to be community led with staff and volunteers who are LGBTQ+, as far as possible.

Trans healthcare

5.1 Ensure that the TGD community are proactively involved and consulted in the development of trans healthcare services in Sussex (including the services outlined below), from the planning, monitoring and evaluation of them. This should harness the expertise that this community has regarding their own health needs.

5.2 Promote and ensure the success and quality of the planned trans healthcare Locally Commissioned Service (LCS) in General practice (to be commissioned by the CCG in 2022) to ensure equal access to TGD people across East Sussex. This includes training on trans health needs and an annual health check, which will include hormone blood test monitoring and check screening status.

5.3 Support the ongoing development of the local Gender Identity Clinic model at the Sussex level.

5.4 As per recommendation 5.3 (development of a Sussex GIC), the excessive waits for a first appointment at a GIC must be addressed as a priority. As this will not be an immediate solution, a range of options to support TGD people awaiting a GIC appointment should be available. This may include access to a specialist gender therapist or peer support via local TNBI organisations, and this menu of options should be co-designed with TGD community members.

Data and information

6.1 Health and Care services should collect SO and GI data. Ideally, this should be using the question-and-answer categories outlined in LGBT foundation and NHSE/I 'if we're not counted…' guidance to enable consistent monitoring to understand access to services and outcomes, but it is recognised that not all digital systems facilitate this currently.

6.2 Raise awareness and offer training to health and care services regarding the importance of SO/GI monitoring and how to ask monitoring questions.

6.3 Future population wide JSNAs, Health and Wellbeing Strategies and DPH reports should explicitly consider the needs of LGBTQ+ people.

6.4 Analyse local Census data when available in Spring 2022 to supplement the findings of this Needs Assessment. This will give better insight regarding inequalities in the wider determinants of health especially and a robust estimate of the number of LGBTQ+ people locally. An almost complete population sample will also enable intersectional analysis to understand inequalities within groups within groups.

6.5 Actively promote regular national LGBT+ surveys (e.g., LGBT foundation primary care survey) to residents. Sufficient sample sizes locally will enable analysis at a local level and provide useful insight into the experiences of LGBTQ+ people in East Sussex.

Other

7.1 Conduct specific research on the experiences of people with intersex variation locally to inform appropriate service provision.

7.2 Ensure sexual health provision is accessible for LGBTQ+ people locally, including specialist HIV support.

7.3 Improve access to GPs and mental health services (generally).

7.4 Improve cycling infrastructure locally to enable active travel.

Chapter two- Introduction

Context

Lesbian, Gay, Bisexual, Trans, Queer people and other sexual and gender identity minorities and people with intersex variation (LGBTQ+) experience significant inequalities across many aspects of health and wellbeing. These inequalities are well documented in both international and national literature, from increased rates of substance misuse to higher rates of some cancers, to poorer experiences of end-of-life care provision. Despite this evidence base, which continues to grow, sexual orientation (SO) and gender identity (GI) are often overlooked as significant factors of health outcomes. Very few health and care services routinely monitor SO and GI to enable commissioners, providers and researchers to monitor differences in the experiences and outcomes of LGBTQ+ people, and ultimately make the changes required to improve the health and wellbeing of LGBTQ+ groups. This is problematic, with Dr Michael Brady, LGBT+ health advisor for NHS England/Improvement (NHSEI), noting:

"Wherever you meaningfully look for LGBTQ+ health inequalities, you find them. And yet we're still not properly looking."

Dr Michael Brady, LGBT+ health advisor for NHSE/I

This needs assessment was launched in response to these longstanding inequalities, which had not yet been considered comprehensively in the county of East Sussex. It was also launched in the knowledge that many of these inequalities in health also increase the risk of adverse outcomes from COVID-19 as well as in response to an emerging evidence base that suggested that LGBTQ+ communities had been disproportionately impacted by the pandemic restrictions. This Joint Strategic Needs Assessment (JSNA) will bring together various forms of evidence to create a more comprehensive picture of local needs and to make evidence-based recommendations to improve the health and wellbeing of these groups.

Aims and scope of needs assessment

This JSNA aims to:

- Describe the current health needs of LGBTQ+ people in East Sussex.
- Assess the provision of, access to and utilisation of health and care services by these groups, including barriers to access and areas for improvement.
- Make recommendations to improve the health and wellbeing of LGBTQ+ people in East Sussex.

The JSNA will focus on individuals living in East Sussex who identify as LGBTQ+ which includes:

- Any sexual minority (lesbian, gay, bisexual, asexual, pansexual, queer and any other sexual minority);
  and/or
- Any gender minority (trans, non-binary, agender, gender fluid, gender non-conforming or any other gender minority);
  and/or
- People with an intersex variation.

It is not within the scope to consider the needs of cisgender, self-identifying heterosexual people that behave bisexually.

Methodology

This needs assessment aims to offer a strategic overview of needs and current service provision supporting our LGBTQ+ population in East Sussex. This will be used to improve the health and wellbeing of the population by informing commissioning decisions and ensuring high quality and effective service delivery that meets the specific needs of LGBTQ+ people.

The needs assessment considers national statistics and the wider evidence base, alongside local intelligence on prevalence, trends, and provision. Information from several agencies and organisations has helped to build this picture by providing evidence to identify current and future levels of need. Need will be defined quantitatively in terms of service use, demand, and broader comparison, and qualitatively in terms of thematic analysis of LGBTQ+ community engagement.

A life course approach will be taken, recognising the very different experiences of LGBTQ+ people at different stages of life in terms of their formative years and societal acceptance of their identities. Older LGBTQ+ people grew up during a period when coming out was very likely to have serious adverse impacts on their lives including criminalisation, psychiatric interventions, family rejection, job discrimination and other forms of prejudice (3), and the impact of this on health and wellbeing today is an area of interest.

Therefore, where possible, the evidence is analysed and presented by life course. Whilst the data does not always align completely, these are generally grouped as follows:

- Young people (aged up to 24 years old[1])
- Working age people (25-59 years old)
- Older people (aged 60 years and over).

It was recognised that many people may still be working in their 60s and beyond, however, this age band was selected as it most closely aligns with much of the literature base on older LGBTQ+ people.

Within the scope of this project, we have aimed to include all sexual minority groups, gender minority groups and people with intersex variation. However, the project team recognises that LGBTQ+ communities are by no means a homogenous group, and the issues and experiences of different groups within the LGBTQ+ population will vary greatly. Where the data allows, differences between SO and GI are outlined, as well as differences between SO groups (e.g., between gay/lesbian women and bi women) and GI groups (e.g. trans binary and non-binary/gender variant people). It should also be noted that much of the local data, such as the community survey, has overlapping groups within the analysis. For instance, when analysing one of the community survey questions by SO, each SO group will also include people who are TGD if they also identify as a sexual minority.

Analysis by other protected characteristics, such as ethnicity and LGBTQ+ identities, have been drawn out where possible. This is key to understanding the breadth of different experiences within LGBTQ+ communities. It should be noted that in the literature review section, the terms related to ethnicity used by the source material have been referenced. In most cases, the term 'Black, Asian and other minority ethnic group' has been used or less frequently, 'Black people and people of colour,' because this is how the research has been analysed. In the focus group section analysis, the terms that respondents have used to describe their ethnicity have been used. When analysing the community survey, due to sample sizes, we unfortunately had to group a wide range of ethnicities together and have used the term 'Black, Asian and other minority ethnic' group. A slightly more detailed analysis has been done by ethnicity and LGB+ young people via the secondary school survey dataset, but only for questions with sufficient sample sizes, and the sample for some groups remains very small.

The author recognises that terms that group a wide range of people from different ethnicities together are problematic in that they disguise the wide range of

[1] For the literature review and local data sets there was no lower age limit set for inclusion. However, for bespoke engagement via the survey and focus groups the minimum age set was 16 years old. This was due to time pressures on the project which meant there was not the time to go through the required ethics process to engage with under 16s.

experiences of people from different ethnic groups and hide differences between groups. More detailed analysis by Census 2021 ethnic groups was planned for the community survey, however, due to sample sizes within these groups, it was not possible to draw meaningful conclusions from the data.

It should also be noted that throughout this report terms such as LGBTQ+, LGBT and LGBTQI+ have been used interchangeably and are based on the acronym used in the source material. Additionally, the term Trans and Gender Diverse (TGD) has been used in local data analysis, and this has been further broken down into trans binary and non-binary/gender diverse groups where possible. However, different terms for these groups have been used in the literature review and best practice sections, utilising the terms used by the source documents.

The needs and experiences of LGBTQ+ people will be considered across several domains including the wider determinants of health; health behaviours; health status and disability; use and experience of services; social care and end of life care; and the impacts of COVID-19.

This report will enable a better understanding of current arrangements for these groups, current and future needs and any gaps or challenges in provision by: collating new research, policy, and standards; reviewing the evidence base on inequalities in these groups; comprehensive analysis of available service data; engaging with members of LGBTQ+ communities to understand their experiences of health, wellbeing and local provision; and making recommendations where there is evidence of service assets, gaps and improvements for delivery.

The first five chapters outline the context and the broader evidence base, before looking in more detail at local need from chapter six onwards. The needs assessment has the following structure:

Chapter 1: EXECUTIVE SUMMARY: summarising the main findings of the needs assessment.

Chapter 2: INTRODUCTION: Introducing the needs assessment, inclusions and exclusions, and the methodologies being used.

Chapter 3: POLICY AND GUIDANCE: An overview of the national and local policy context and best practice in LGBTQ+ health and care provision.

Chapter 4: ESTIMATES OF THE NUMBER OF LGBTQ+ PEOPLE: A summary of the best available estimates of LGBTQ+ people at a national and local level.

Chapter 5: LITERATURE REVIEW OF INEQUALITIES IN THE LGBTQ+ POPULATION: A review of the evidence base on the prevalence or incidence of a particular issue, health behaviour or condition, differences in these estimates between the LGBTQ+ communities and heterosexual/cisgender communities and any differences

between within the LGBTQ+ communities and the use/experience of related services.

Chapter 6: LOCAL SERVICE PROVISION AND PREVALENCE DATA: Local data available by sexual orientation and/or gender identity outlining health, prevalence and service use for LGBTQ+ people.

Chapter 7: COMMUNITY SURVEY: The analysis of the views and experiences of health, wellbeing and services in East Sussex from a community survey of LGBTQ+ people.

Chapter 8: FOCUS GROUPS: Thematic analysis of the views and experiences of health, wellbeing and services in East Sussex from community focus groups.

Chapter 9: FUTURE NEED: Population trends indicating future needs.

Chapter 10: CONCLUSIONS: Key findings of the needs assessment from which the recommendations of the needs assessment have been drawn.

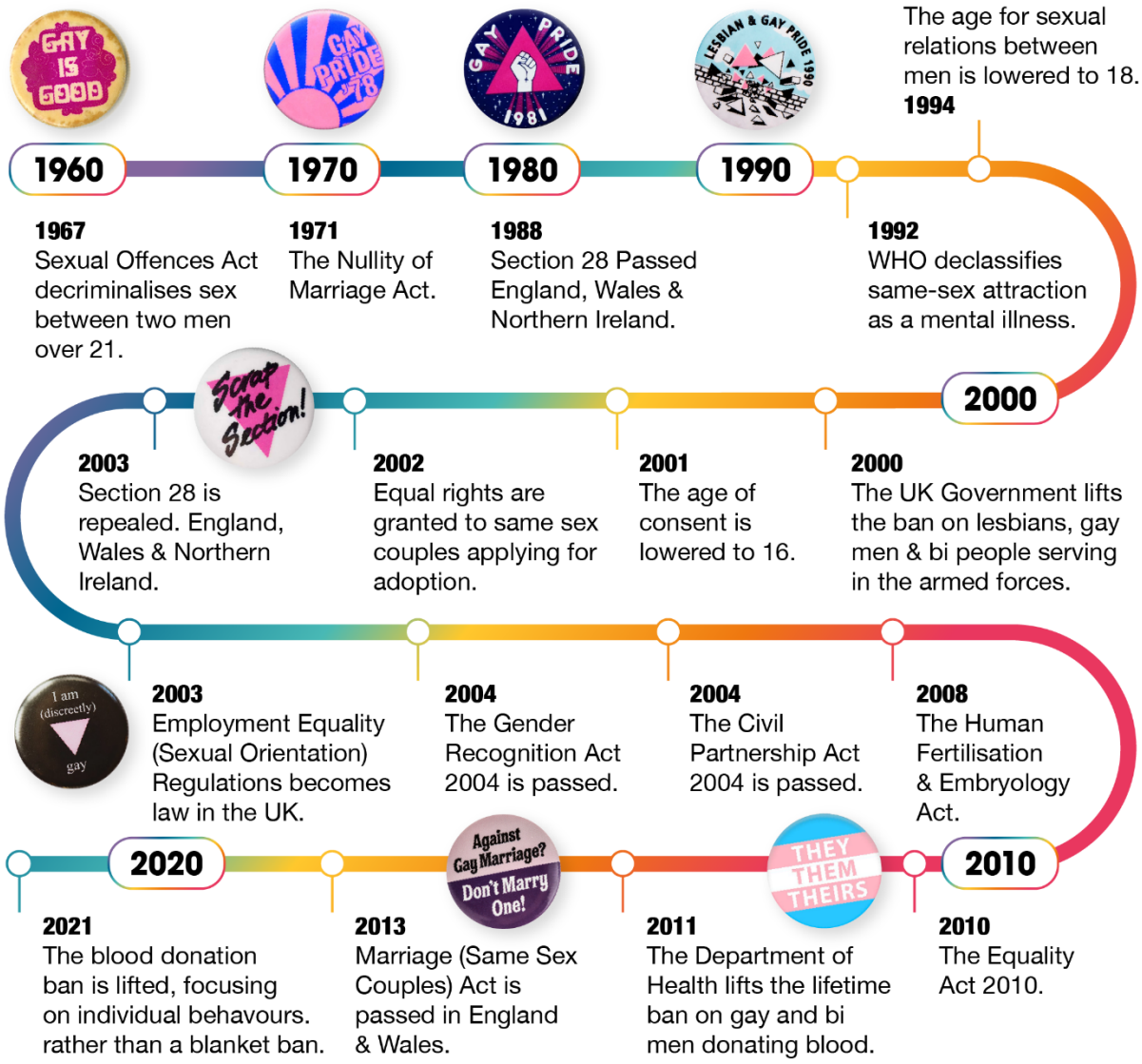
Chapter 11: RECOMMENDATIONS: The recommendations of the needs assessment.

Chapter three- Policy and Guidance

National policy context

The last 60 years have seen significant changes in the rights of LGBTQ+ people living in the UK, with many discriminatory laws revoked. Some of the key legislative changes affecting LGBTQ+ people are outlined in the diagram below:

Figure 1: Key legislative and policy changes regarding LGBTQ+ rights



The Equality Act 2010 was a key legislative change and consolidated previous discrimination legislation and aims to offer legal guarantees of equal treatment for people with certain protected characteristics (4). These include sexual orientation and 'gender reassignment'. Under this law, public authorities have a duty to

proactively remove discrimination against and advance equal opportunity for LGBTQ+ people (4).

Despite improvements in legal protections, significant inequalities in health and wellbeing persist for these groups, and some LGBTQ+ identities, such as non-binary, is not currently a recognised gender identity in UK law.

In July 2017, the Government launched a national survey of LGBT people. The survey was open to anyone who identified as having a minority sexual orientation, gender identity or had an intersex variation. The survey received more than 108,000 responses, making it the largest national survey of its kind anywhere in the world. The results informed the 2018 Government Equalities Office LGBT Action Plan containing over 75 commitments to advance the rights of LGBT people and improve the way public services work for them (1). These commitments are broad, including actions to improve SO/GI monitoring in services, improving safety and support for victims of hate crime, ensuring that the education system supports young LGBT people, increasing inclusion in mainstream health and care services and reviewing the Gender Identity Clinic model of care. As per one of the commitments, the UK's first National LGBT advisor for health was appointed and work has begun on realising other health commitments within the plan.

Local policies and guidance

Currently, there is no strategic approach to tackling inequalities in LGBTQ+ people in East Sussex. There are limited local strategic documents that address the needs of LGBTQ+ people.

The Sussex Health and Care Partnership (SHCP) (the local Integrated Care System) notes in their strategic delivery plan that LGBTQ+ people may require more intensive support or additional help to access services (5). However, no specific strategies are outlined regarding improving the health and wellbeing of these groups (5). The desire to reduce inequalities in certain groups, including LGBTQ+ people, is stated again in the SHCP vision for the future document and this will be measured with the healthy life expectancy at birth metric (6). However, measuring this for LGBTQ+ groups will be challenging due to a lack of routine monitoring of SO and GI currently. Within East Sussex, the Integrated Care Partnership (ICP) place-based plan commits to reducing health inequalities, although no specific groups of focus are mentioned (7). One of the reasons for this lack of a focus on LGBTQ+ groups with well-known health inequalities is the lack of data available routinely.

However, at a Sussex level, there is a specific commitment to improve the health and wellbeing of trans people locally, with the Sussex Trans Healthcare Programme

launched in 2021 to tackle inequalities for trans and non-binary people and to oversee the development of a new Gender Identity Clinic (GIC) in Sussex (8). Additionally, there are specific service areas where the needs of LGBTQ+ groups are being actively considered, for example, trans inclusion in schools and within sexual health commissioning.

This Needs Assessment aims to support the local system to take a more systematic approach to tackle health inequalities within LGBTQ+ groups.

Best Practice

This section of the needs assessment provides an overview of best practice for supporting and providing services for people who are LGBTQ+. This is not an exhaustive list but draws on key best practice documents at the time of writing. Where best practice or guidance uses slightly different definitions (e.g., LGBT or LGBTQ) this is reflected in the particular sections. Policy and practice in this area generally considers LGB and/or LGBTQ+ issues together. While there are many shared experiences and needs across the LGBTQ+ spectrum, there are also significant differences, so where there is information, guidance for specific groups have been summarised throughout.

There are several commonalities in best practice in supporting LGBTQ+ people across all settings and determinants for health: the need for robust data collection and monitoring; staff training in LGBTQ+ needs, both general and service specific; the need for inclusive and 'safe' service provision, including clear confidentiality policies; and the need for robust preventative policies and proactive approaches to tackling discrimination.

Monitoring and data

"Services that already monitor sexual orientation are clearly aware of the health disparities that are uncovered through data collection. If sexual orientation monitoring remains optional, health disparities will remain hidden across the services that choose not to implement it".

House of Commons Women and Equalities Committee, 2019

In 2017, the LGBT Foundation launched a good practice guide to monitoring SO which provided advice on implementing the Sexual Orientation Monitoring (SOM) Information - the mechanism for recording the SO of patients and service users across all health services and Local Authority social care providers in England Standard (9). However, the Standard can be used as good practice in organisations from all sectors and for all age groups. Monitoring of SO will ensure that all health and social care organisations are able to demonstrate the provision of equitable access for LGB individuals; care providers have an improved understanding of the

impact of inequalities on health and care outcomes for LGB populations in England; and policymakers, service commissioners and providers can better identify health risks at a population level to support targeted preventative and early intervention work to address health inequalities for LGB populations, thus reducing future treatment costs.

In 2021, LGBT Foundation and NHS England produced an updated summary of good practice for monitoring SO and trans status (10). The document outlines the value of monitoring to improve services and address health inequalities:

- Improving patient care – awareness of a person's LGBT identity facilitates conversations about issues services know may be more likely to affect that person and allows for opportunities to carry out targeted signposting and social prescribing. LGBT patients may feel their identity is being recognised and so feel more able to speak about related issues.
- Business case – awareness of a person's LGBT identity enables better identification of health risks at a population level which informs the more efficient allocation of services where there is greatest need. This also means health and social care interventions and strategies can be better targeted.
- Policy context - it is a legal requirement for public organisations to consider how they treat all people fairly and equally. Monitoring can help organisations demonstrate that they are complying with the public sector Equality Duty: to eliminate discrimination, harassment and victimisation; tackle prejudice and promote understanding; advance equality of opportunity; remove or minimise disadvantages connected to a particular characteristic; and take steps to meet the needs of people who share a protected characteristic, based on evidence of need.
- Improving the evidence base – there are still gaps in the evidence on the experiences of LGBT communities, particularly on intersectional inequalities groups within LGBT communities, such as LGBT People in minority ethnic groups and older LGBT people. Lack of evidence means that some LGBT health inequalities may not be properly recognised so it's harder to create a strong case for commissioned work to address inequalities, and harder to measure the impact of work.

The report makes several recommendations to facilitate and utilise monitoring:

- **Asking about sexual orientation** – this should align with the wording in the SOM information standard, giving options for how a person would best describe themselves: heterosexual or straight, gay or lesbian, bisexual or other sexual orientation not listed.

- **Asking about gender identity and trans status** – this should be asked in two questions: how a person would describe their gender identity, and if this is aligned to their sex assigned at birth. This information should protect a persons' confidentiality regarding obtaining a Gender Recognition Certificate and inform the care provided, for example, anyone with a cervix, including trans men and non-binary people assigned female at birth, should be invited for cervical screening. There is currently no national trans status monitoring information standard, although there is work to develop this and to update IT systems so trans status can be properly recorded.
- **Understand and communicate the importance and purpose of monitoring** sexual orientation and trans status and use this information to improve and personalise care.
- **Have a confidentiality policy that is easily accessible** and well understood by all involved.
- **Open/judgement-free communication,** so people are comfortable sharing personal information.
- **Do not make assumptions** - sexual orientation and trans status should be asked routinely, just as questions of age and ethnicity are routinely asked.
- **Improve visibility** to show an inclusive environment.
- **LGBT inclusion and awareness training** is instrumental to help services carry out these steps.
- **Use the data collated as evidence to commission and plan services and interventions.**
- **Assess the impact on equality of all proposed work programmes.**
- **Share headline data with staff and services where appropriate,** publishing the results of monitoring and any actions planned against these.
- **Share learning** from the monitoring process and organisational actions.
- **Track monitoring** over time and learning from issues arising.

Wider determinants of health

Employment

Research commissioned by Stonewall looked at the experiences of over 3,200 LGB people's experience of discrimination in the workplace and found that despite some employers in the UK making progress towards inclusion in their workplaces, LGBT people still face discrimination, exclusion and barriers at work (11). Based on

this evidence, the report provides several recommendations for developing a more inclusive workplace:

- Develop clear equality policies and zero-tolerance policies on harassment and discrimination.
- Support staff through diversity and inclusion training, and ensure managers have appropriate training and support to take a zero-tolerance approach to discrimination.
- Improve trans inclusion by raising awareness for all employers and developing a policy to support trans employees who are transitioning.
- Recruit diverse candidates and develop clear policies around recruitment and promotion.
- Monitor staff diversity and collect diversity data.
- Support visible LGBT role models, for example by supporting the formation of LGBT networks and taking part in events such as Pride and LGBT History Month.

Not in Education, employment and training (NEET)

Research commissioned by Stonewall in 2020 identifies core factors leading to LGBT young people becoming disengaged from education, training or work (12). Key measures were identified for local areas to better support young people to stay in, or re-enter education, training or work, including:

- Improve data and monitoring. Local Authorities should ensure all employment, education and training (EET) staff have received training on the needs of LGB young people, should conduct voluntary monitoring of the sexual orientation and trans status of people supported by EET teams, and should include young people (including LGBT young people) in service development decisions. More should also be done nationally to monitor SO and trans status in nationwide surveys such as the Labour Force Survey, and to facilitate future studies on the national prevalence of poor mental health among young people to include analysis of SO and trans status.
- Improving mental health support for LGBT young people through good-quality mental health support as part of inclusive, wider mental health support for all young people. This should be accessible through multiple channels, with all services being LGBT inclusive and delivered by practitioners who have training in how to support LGBT young people. Mental health support, specifically for LGBT young people, should be explicit in Local Authority health and wellbeing strategies which should encourage joint working across services and settings.

- Delivering inclusive careers support for LGBT young people, focusing on entry-level positions, and including advice on finding an LGBT-inclusive employer (particularly in sectors not widely considered inclusive), guidance on worker's rights, and interview preparation.
- Enabling peer support from other LGBT young people, not only as a key source of information but also for motivation and inspiration when pursuing education and employment opportunities with clear support and supervision from school leaders. This should be enabled nationally by inclusive guidance on youth services, and locally through practical support and resources, delivery of training for all youth workers on meeting the specific needs of LGBT young people, and proactive advertising of peer support available.
- Creating LGBT-inclusive education environments, with the Local Authority supporting sixth form/final year and further education colleges to deliver LGBT-inclusive teaching, for example by embedding LGBT people and relationships in wider teaching, such as in textbooks. Colleges should also have strong policies to tackle homophobia, biphobic and transphobic (HBT) bullying, clear complaints procedures, and inclusive facilities. Local Authorities should also offer guidance and share best practice with education settings to make sure they are aware of the importance of tackling anti-LGBT bullying and language and delivering LGBT-inclusive teaching. Universities should ensure their access and participation plans explicitly include LGBT students (and have been developed in consultation with students), should have clear and widely promoted policies with a zero-tolerance approach to discrimination, bullying and harassment, and should ensure that data collection systems and facilities are trans-inclusive and develop a policy to support students who are transitioning.
- Delivering inclusive employment opportunities for LGBT young people, supporting employers to develop clear and widely promoted zero-tolerance policies on HBT discrimination and harassment, include equality and inclusion commitments on websites, implement all-staff LGBT-inclusive diversity and inclusion training and collect diversity data on the workforce.

Housing

Stonewall Housing has been the specialist LGBT housing advice and support provider in England for the last 30 years, providing housing support for LGBT people in their own homes, supported housing for young LGBT people, and confidential housing advice for LGBT people of all ages. Their 2016 report into housing for older LGBT people outlines that housing, support and care providers need to take positive action to ensure that they are taking on the needs and wishes of LGBT people, and to ensure policies and attitudes are embedded in their

organisation, through training, involvement with local LGBT groups and activities (13). Recommended actions include:

- To support and encourage specialist older LGBT housing schemes across all tenures.
- To encourage housing and care providers to develop good practice and greater understanding in their provision of services to the older LGBT community.
- To develop a resource collating research, learning and experiences of older LGBT housing.
- To work with housing providers and others on the development of a range of housing options to maximise the choice of housing available to older LGBT.
- To provide advice and support to individuals and groups who want to work together to create their own housing and support solutions.
- To build links and shared understanding of different housing options between providers and customers.

Homelessness

Service providers are not always aware of the SO or GI of the people they support, and a lack of awareness of their needs can mean LGBTIQ+ individuals struggle to get the right support when experiencing homelessness which can increase the risk of further disadvantage or exclusion. In 2020 The Outside Project updated their guidance for good practice to support people who identify as LGBTIQ+ in homelessness services (14). Key recommendations for homeless services are:

- **Asking people about their sexuality and gender identity in a respectful and direct way**. This includes being aware that some people in the LGBTIQ+ community don't feel safe discussing their sexuality or gender identity when rough sleeping, and, for example, may not share who their next of kin is at a first meeting if they've experienced trauma. When introducing themselves, services should also include local LGBTIQ+ specific support services they work with. A lack of awareness by the service may mean the person doesn't receive the support they need and then disengage from the service.
- **Maintaining confidentiality** and being aware that people who are trans have no obligation to share their trans history, and if they do, it's against the law for services to share this information.

- **Creating an inclusive service culture**. Best practice for this includes building relationships with LGBTIQ+ specialist services (specifically transgender services as transgender service users often face exclusion from multiple services and are more likely to be subject to abuse and harassment than others in the LGBTIQ+ community), enabling staff to feel confident tackling homophobia, biphobia and transphobia, regularly discussing LGBTIQ+ inclusion in team meetings, providing opportunities for staff to develop their knowledge and understanding, avoiding language assuming someone's gender, where possible provide gender-neutral toilets with sanitary provisions in all, target the LGBTIQ+ community in recruitment and volunteer opportunities, include and normalise same-gender relationships when talking about partnerships, ensure there are visible signs of inclusion, and create LGBTIQ+ staff and client forums and groups. This helps develop a safe space where clients can discuss their sexuality and gender identity with services openly and be guided to LGBTIQ+ services to better support their needs.

The report also identified a need for **awareness of the particular impacts of homelessness on trans people**. For example, women may present as males for their safety on the street, where they are at higher risk of sexual assault towards women, as well as sexual and violent assault targeted towards transwomen and hate crime towards the trans community. There may also be no access to toiletries and clothing enabling them to present as female if sleeping rough.

Additionally, Stonewall provide additional advice to services providing support for young LGBTQ+ people faced with issues of homelessness (12). Key recommendations for local authorities include:

- Working with other local authorities or relevant agencies to consistently commission LGBT-specific homelessness support services, and to engage with local LGBT organisations and communities when planning homelessness and care services provision.
- Include equality and diversity considerations in commissioning and procurement processes for all homelessness and care services.
- Train all frontline staff in homelessness support services and residential children's homes to meet the specific needs of LGBT young people.
- Monitor, and support local services to monitor, the sexual orientation and trans status of young people and adults accessing homelessness support services.

Crime

Hate crime related to SO and GI is increasing nationally, and there is evidence to suggest such crimes are significantly underreported. Galop provided several recommendations in their recent report on LGBTQ+ hate crime (15):

- Dedicated funding should be available to enable the delivery of specialist hate crime services to those in need, providing support, advice and advocacy.
- Increased referral of LGBT+ victims to specialist support services by police and other agencies.
- A national campaign to increase awareness of available specialist support.
- Quality improvements to the frontline and investigative police responses toward anti-LGBT+ hate crime.
- Efforts by authorities to work with LGBT+ communities to understand and address the barriers faced by those facing hate crime in accessing assistance and support.

Bisexuality

The bisexuality report provides specific recommendations for crimes experienced by bisexual people (16). Key recommendations include:

- Tackling biphobic hate crime by separating out experiences of bisexual people in national surveys, examining bisexual-specific experiences, and particularly addressing sexual assault.
- Addressing bisexual-specific experiences of domestic violence given evidence that bisexual people in same-gender relationships are more at risk than other groups.

Health behaviours

Substance and alcohol misuse

Stonewall recommend several actions for local government to address substance and alcohol misuse among LGBT populations (17):

- Ensure LGBT inclusion is mainstreamed throughout commissioned services.
- Commission specific services for LGBT people based on needs and issues identified.
- Implement mandatory equality and diversity training for staff, which covers their duties to LGBT people under the Equality Act 2010 and meeting the needs of LGBT service users.

- Develop and prominently display bullying and harassment policies that communicate a zero-tolerance approach to HBT discrimination.
- Provide specific resources and signposting for LGBT service users.
- Consistently monitor service users' sexual orientation and gender identity, supported by training for staff. Use this to identify inequalities in service user experience and outcomes and develop targeted interventions.

Key settings

Education settings

Schools, colleges, and settings play a vital role in supporting LGBTQ+ young people, not least by creating an inclusive environment where all young people feel safe and valued. In 2020, Stonewall produced a guide to supporting LGBT young people in schools, colleges, and settings, including looking at what education settings are required to do, creating an inclusive environment, individual support, support during the transition to other educational settings, supporting LGBT young people with special educational needs and disabilities (SEND), and working with parents, carers and the wider community (18). The guide made ten general recommendations to effectively support LGBT young people in education settings:

1. Keep an open mind
2. Listen and be positive
3. Work with parents and carers
4. Tackle bullying and challenge gender stereotypes
5. Support young people to find an LGBT youth group
6. Provide access to resources and information
7. Help LGBT+ children and young people to stay safe
8. Increase the visibility of LGBT+ young people in the curriculum
9. Equip staff to support LGBT+ students
10. Work collaboratively with local authorities, schools, settings, youth services and the wider community to support LGBT+ young people.

Sex and relationships education

New government guidance (19) on Relationships Education, Relationships and Sex Education (RSE) and Health Education, published in 2021, outlines that RSE teaching should ensure:

- That the needs of all pupils are appropriately met, and all pupils understand the importance of equality and respect, in compliance with the relevant provisions of the Equality Act 2010.
- That all of their teaching is sensitive and age-appropriate in approach and content. At the point at which schools consider it appropriate to teach their pupils about LGBT, they should ensure that this content is fully integrated into their programmes of study for this area of the curriculum rather than delivered as a standalone unit or lesson.
- That teaching about families includes the many forms they can take, including single-parent families, LGBT parents, families headed by grandparents, adoptive parents, foster parents/carers amongst others.

Bullying

Research commissioned by the Government Equalities Office in 2014 looked at what works in tackling anti-LGBT bullying in school-aged children and young people (20). The study involved establishing the types of bullying that were happening, mapping the types of initiatives being used to tackle this, in-depth interviews with teachers and providers, and working with staff and pupils in four schools around bullying and anti-bullying initiatives. Four main approaches to tackling HBT bullying were found to be most effective:

1. Preventative or proactive approaches, including evidence-based policies that give school staff confidence to tackle HBT bullying. These should be part of a whole-school, integrated approach, and an inclusive and equality-driven ethos.
2. Interactive, discursive, and reflexive teaching, based on staff training on sexual orientation, gender identity and good teaching practice in tackling bullying. This should include involving pupils in the design and delivery of anti-bullying learning, encouraging engagement in discussion, identifying different issues related to HBT bullying, and specifically addressing cyber-bullying.
3. Playground or school life approaches. Regular assessment of bullying at school would inform how the physical and social environment of the school could make it less susceptible to bullying. For example, through a visibly LGBT+ friendly environment, positive role models, consistent challenging of HBT bullying by staff and pupils, peer support, and inclusion of issues related to sexual orientation and gender identity in wider school initiatives.
4. Reactive and supportive approaches. Reactive approaches include reporting, recording and punishment of HB bullying, which is most effective when based on clear definitions, clear policies for reporting and recording bullying, and consistent action against bullying. Alongside this would be

supporting pupils who have been bullied to take the lead in which of a range of options would meet their needs and not exacerbate bullying, and signposting pupils to available local support around sexual orientation or gender identity.

In 2015, Stonewall produced a 5-step toolkit (21) for tackling HBT bullying in secondary schools by embedding work on LGBT issues across the curriculum and celebrating diversity across the whole school community. Each step includes a set of tools, templates and checklists and ways to measure the impact of wider anti-bullying initiatives in the school:

- **STEP 1: Set the ground rules** by ensuring the school's policies refer to HBT bullying.
- **STEP 2: Communicate the school's approach** to parents and carers.
- **STEP 3: Keep track of incidents** by recording and monitoring HBT bullying and language.
- **STEP 4: Find out what's going on in school** by running surveys on HBT bullying and language.
- **STEP 5: Support LGBT young people** by providing information and resources on LGBT issues.

Beyond these five steps the toolkit looks at how schools can develop school scripts to challenge HBT language, can celebrate diversity and LGBT people in school and can include LGBT people and issues across the curriculum.

A follow-up report by Stonewall in 2017 (22) reflect the recommendations above, identifying a clear need for schools to have:

- Clear and widely promoted policies and procedures on preventing and tackling HBT bullying and language, including online abuse. These should be developed with LGBT pupils and informed by their experiences.
- Clear leadership of an inclusive learning environment and curriculum which reflects LGBT people and experiences, promotes diversity and celebrates difference.
- All teaching and non-teaching staff trained on tackling HBT bullying and language, on online safety, supporting LGBT pupils and young people's mental health and wellbeing (including mental health first aid).
- Provision of information on LGBT topics and signposting to online resources, counselling, pastoral support and LGBT organisations, including local LGBT youth groups, to all pupils. Schools should also talk to parents and carers about their work to tackle bullying and support LGBT pupils and should

work collaboratively with local organisations and services to share best practice and support this.

- Specific support for and with trans pupils and explicit references to supporting trans pupils in all relevant policies and training.

Both the Stonewall and Government Equalities Office reports also cite the role of local and national organisations. For example:

- National government in providing effective statutory guidance and best practice, training CAMHS practitioners in the needs of LGBT young people, ensure good quality monitoring data and collaborative working.
- Local government in providing guidance, training, resources, identifying good practice and prioritising mental health support, specifically for young LGBT people.
- Social media and online platforms to ensure safety, to moderate, and monitor and review HBT incidents and information.
- Ofsted to ensure schools are effective in supporting LGBT pupils, in delivery of inclusive learning, in the training of teachers to support LGBT pupils, and in tackling HBT bullying.

Bisexual equality in education settings

The Bisexuality Report, published by the Open University (16), looks at bisexual inclusion in LGBT equality and diversity and provides recommendations aiming to improve UK policy and practice in relation to bisexual people as part of the wider LGBT equalities agenda. While there are many shared experiences and needs across the LGBT spectrum, there are also significant differences, and bisexual people can face discrimination and prejudice from within heterosexual, lesbian and gay communities which can be obscured by LGBT amalgamation. Specific recommendations for the education sector for supporting bisexual students include:

- Tackling biphobia in schools through further research focusing on bisexual youth specifically.
- Ensuring that teacher training and antibullying campaigns include bisexual specific issues.
- Ensuring that Personal, Social, Health and Economic Education includes bisexuality.

Transgender equality in education settings

Guidance on promoting transgender equality in further education (23) outlines actions for further education institutions and organisations to develop a greater understanding of transgender issues, understand and implement the law, and good practice so all in further education are supported. The guidance recommends that providers:

- Embed a transgender specific anti-discrimination, anti-bullying Code of Practice into an equality scheme that is subject to an Equality Impact Assessment. This should be prominently displayed in all buildings, staff rooms and student union rooms.
- Appoint a trans champion to work with the Teachers/Student Unions, liaise with support groups, arrange regular social meetings and celebrations, and support a person e.g., through transition, or a complaint.
- Ensure that premises, facilities and services can accommodate trans people appropriately.
- Consider agreements on gender identity and sexual orientation equality policies and procedures, such as those between education unions and the Association of Colleges.
- Update training for existing staff and familiarise new staff with trans issues and ensure that staff know how to respond if a learner or member of staff discloses their transgender status and/or intention to transition.
- Raise trans awareness with students at the start of each year, or more often if necessary.
- Explain what constitutes bullying, harassment, discrimination and victimisation, and that religious views do not give grounds for discriminating against transgender people.
- Respond robustly, through well-publicised protocols, when direct discrimination or harassment of a trans person occurs. Monitor incidents and collect data on these.
- Embed trans issues across the curriculum.

Health Services

General Practice provision

A 2017 primary care patient experience survey conducted by LGBT Foundation found that LGBT people who shared their sexual orientation with their GP were

21% more likely to feel their GP met their health needs than those who did not (24). Trans people who shared their trans status with their GP were 62% more likely to feel their GP met their health needs than those who did not. This research was undertaken in Greater Manchester as part of Pride in Practice, a quality assurance and social prescribing programme for primary care services and LGBT communities. Primary care providers need to both be aware of the specific health issues and needs of LGBT patients in order to treat these needs and need to know a patient's sexual orientation and trans status to know when there is a need to offer LGBT specific advice or treatment. Key recommendations from the survey include:

- **Inclusion** – services undertaking LGBT training to understand specific health needs, and sexual orientation and trans status monitoring implemented to identify differences in treatment outcome and ensure LGBT people are included in health promotion.
- **Expansion** – Pride of Practice awards to celebrate primary care services that provide a high standard of care to LGBT communities and engagement with local communities, for example for Lesbian, Bisexual and Trans Women's Health Week, Men's Health Week, and Pride.
- **Voice** – Increase the visibility of LGBT communities to enable LGBT people to access services, be open about their sexual orientation and trans status, and receive appropriate care. Respond positively when information is disclosed to empower patients to proactively look after their health and wellbeing, and visually represent LGBT communities in local initiatives.

Of the services that Pride in Practice have worked with, 87% have implemented sexual orientation monitoring and 60% trans monitoring (25). Amongst these services, there has been an 11% increase in LGBT people accessing primary care services (including a 35% increase in community pharmacy), LGB patients are 24% more likely to disclose their sexual orientation, and trans patients were 21% more likely, and 100% of participating health professionals could evidence changes made within their practice to better support the needs of LGBT people.

Mental health service provision

The 2017 Mental Welfare Commission for Scotland report (26) on LGBT inclusive mental health services makes recommendations to raise awareness of LGBT rights, and help services provide high-quality care and support to everyone with a mental illness, particularly LGBT people:

Mental health practitioners

- Avoid assumptions – about a person's sexuality or gender identity based on the way they look. Use gender-neutral language in initial questions. Don't

assume that an LGBT patient is out to their family or has had a positive previous experience of mental health services. Treat information on sexuality or gender identity as confidential unless given permission to share.

- Avoid inappropriate questions – including questions about more intimate topics than would be asked to someone who is not LGBT. If unsure, ask the individual which pronouns to use.
- Acknowledge LGBT partners and carers - acknowledge the importance, for some LGBT people, of a group of friends (their family of choice) who may be a crucial source of care and support. Be aware that there may be tensions between the role of biological family, family of choice and a same-gender partner.
- Stand up against HBT language or behaviour from patients or staff.

Mental health services

- Ensure information materials are inclusive of LGBT people and those with other protected characteristics.
- Make LGBT awareness part of induction training for all new staff and have regular refresher training for existing staff at all levels.
- Implement a clear and accessible complaints procedure explicitly including discrimination.
- Monitor gender identity and sexual orientation across the service.

Perinatal and gynaecological services

CQC recently released guidance for perinatal and gynaecological services in inclusive support of trans and non-binary people, based on joint work with the LGBT Foundation (27). They outline several expectations of providers:

- Staff are aware of and understand issues relating to trans and non-binary people, and do not make assumptions about people's bodies.
- Staff understand the funding and storage issues for gamete samples for trans and non-binary people who want to have children at a later date.
- Staff respond positively to enable trans and non-binary people to feel confident when using services and address people by their preferred name, title and pronoun.
- Staff are aware that a person's voice on the phone may not match their preconceptions about their gender.
- The service places trans or non-binary people on an appropriate ward, using side rooms and offering flexible options where appropriate.

- The design of a hospital has considered trans and non-binary people, for example having gender-neutral toilets.
- The service discusses and makes arrangements for trans men and non-binary people who want to give birth and supports them with antenatal and postnatal care

Bisexual inclusion in health services

The Bisexuality Report, published by the Open University (16) looks at bisexual inclusion in LGBT equality and diversity and provides recommendations aiming to improve UK policy and practice in relation to bisexual people as part of the wider lesbian, gay, bisexual and transgender (LGBT) equalities agenda. The report recommends that the health sector:

- Address the mental health experiences of bisexual people in research, policy and practice. This includes increased awareness among practitioners of specific issues faced by bisexual people, putting initiatives in place to address bisexual mental health, and offering separate services if desired by the person.
- Conduct further research into the specific physical health needs of bisexual people, particularly in relation to substance use and cancer screening.
- Make sexual health promotion literature more inclusive of a range of sexual practices and specifically target bisexual youth in sexual health campaigns, rather than subsuming them in lesbian and gay categories.

Social Care, palliative and end of life care settings

When people receive personal care and support, they are likely to lose some privacy, and some may feel restricted or judged by those providing their care. All individuals have the right to expect that when health and social care is required, it is compassionate and safe. This section outlines best practice around sexuality and gender identity considerations and impacts for social care provision.

The Adult Social Care Outcomes Framework (ASCOF) is a means of measuring how well councils are providing support to the people that need it most (28). The ASCOF Lesbian, Gay, Bisexual & Trans Companion Document by the National LGB&T Partnership (29) sets out the evidence on LGBT communities in relation to the indicators under the four domains of the ASCOF and makes recommendations for actions to address inequalities in outcomes for LGBT people and communities:

Universal recommendations for partners delivering support

- Recognition – Joint Strategic Needs Assessments should explicitly consider LGBT care and support needs, and health and wellbeing strategy implementation should explicitly consider actions to reduce inequalities affecting LGBT communities. Commissioners should use equality impact assessment frameworks for population strategies and action plans, and social care should implement published guidance on becoming LGBT-friendly providers.
- Engagement – Commissioning and contracting should monitor engagement with LGBT communities. CCG communication strategies should specifically include LGBT communities.
- Monitoring – Social care contracts should require monitoring of sexual orientation and gender identity for those age 16+ and should consider younger age groups if appropriate.
- Service provision – Health and social care services should be integrated and recognise the particular needs of LGBT people, using the data available to assess whether mainstream services are accessible and appropriate and providing specialist services to address specific LGBT health care needs where appropriate.

The report also makes recommendations for each of the four domains of the Adult Social Care Framework: ensuring quality of life for people with care and support needs; delaying and reducing the need for care and support; ensuring people have a positive experience of care and support, and safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

Further to this, the CQC provides guidance for CQC inspection staff and registered providers on caring for people who need support to express their sexuality and to have their needs met (30). Providers need to understand the importance of enabling people to manage their sexuality, including making sure people have access to education and information to help them develop and maintain relationships and express their sexuality. Providers also need to understand the risks associated with people's sexual needs and have a duty to promote equality, diversity and human rights in their service, including for their staff.

Identified actions facilitating this include:

- Promoting LGBT+ inclusive practices and proactive support.
- Asking about sexuality and gender identity needs when during the assessment of needs.

- Helping people access support around relationships if they're unable to access it themselves.
- Training for staff to support people with their personal relationship needs - Induction and ongoing training on sexuality and relationships, and on equality, diversity and human rights (EDHR) issues will help staff to respond to situations in a considered way.

Residential care

A Community Advisors' Assessment and Development Tool was developed for use in residential care settings by academic partners at Middlesex, Nottingham, Bristol and Edge Hill University, UK (31). The tool was developed with the support and guidance of the providers lesbian, gay, bisexual, transgender and intersex (LGB T&I) national advisory group to help establish a more inclusive environment for LGB T&I older people, their families and support networks. A successful pilot of the tool involved training voluntary community advisors from the LGB T&I community and supporters who supported care homes to develop, pilot and embed an improved infrastructure.

Based on the best available evidence, the tool aims to:

- Support staff in being confident to provide a person-centred and quality service to older people by ensuring every individual is respected and enabled to discuss their support needs.
- Develop a holistic commitment to equality to support LGB T&I older people who come from a range of diverse backgrounds.
- Enable care home residents to benefit through the knowledge and experience of their opportunities for increased contact with members of the LGB T&I community.
- Comprise topics for exploration in several different areas of policy and practice to promote constructive conversations and consideration about everyday systems that could be re-examined and unpicked to ensure inclusivity for LGB T&I communities.

Dementia Care

Sexuality and the expression of that sexuality is an integral part of a person's daily living experience, and this is no less true for people with dementia. The feeling of being loved and being able to express sexuality in a safe and rewarding way contributes to an individual's overall sense of self-worth and wellbeing.

Operational guidance (32) on relationships, sexuality and dementia looks at the needs of LGBT people with dementia and outlines key learnings for practitioners:

Gay, Lesbian and Bisexual people with dementia

- Training and awareness programmes need to address issues around same-gender relationships, rights, equality and identity. Staff need knowledge and awareness to support the needs of LGB people accessing dementia services –a person's sexual or gender identity can have a big impact on their needs e.g., reminiscence activities may focus on people's biological family and children, not realising that some LGB people may not be in touch with biological family or may have had traumatic experiences linked to their gender or sexual identity.
- Staff need to acknowledge and be sensitive to the views of relatives but must also promote and safeguard the rights of the individual with dementia.
- Most types of dementia cause people to experience memory problems. LGB people may be affected by these in different ways e.g., an LGB person may forget who they've told about their sexual orientation or forget that they have gone through the process of sharing their sexual identity (coming out) at all which can be distressing.
- Care Plans must include reference to sexual orientation.

Transgender people with dementia

Although transgender issues are frequently considered with LGB issues, people who are transgender have different needs from cis LGB people. While all the learnings for LGB people outlined above are also relevant for transgender people with dementia, to proactively support and adequately balance risks and responsibility towards people with dementia who are transgender, staff need to have an awareness of the issues and needs of this specific group. The guidance (32) outlines some specific considerations for this group, including:

- Physical examinations may be distressing - some people who are transgender may or may not have undergone a physical transition process but express their identity through their style of dress. If an individual has not had gender-affirming surgery and is receiving personal care, staff may become aware of the person's gender identity even if they haven't chosen to disclose it. This can make the individual uncomfortable if they feel intimate care or physical examination "outs" their biological sex.
- People may not remember they've had/are having gender-affirming surgery which can be distressing and confusing.

- People may be taking hormones or undergoing long term hormone therapy - it is important for those supporting the person to be aware of the treatment the person is having and to support them to take the right medications because of the health implications of forgetting to take the hormones or stopping suddenly.
- It is also important that the individual feels respected, and this can be done by building relationships early with the person. If someone chooses to tell a care worker they are transgender, this is confidential and can't be shared without the person's consent.

Palliative care and End of Life Care

In 2012, the NHS National End of Life Care Programme produced a practical guide (33) for improving the quality of end of life care in relation to LGBT people. The guide provides considerations and recommendations for good practice for each of the six steps of the End of Life Care Pathway, reflecting the need to work collaboratively across health and social

care and other care sectors:

1. **STEP 1: Discussions as end of life approaches** - Be open to different relationships, identify important people in the person's network, recognise barriers that may have prevented access to services, consider living arrangements (LGBT people may be more likely to live alone and talking about the end of life for the first time), be sensitive talking about personal life history, use inclusive language, and support colleagues to have open conversations.
2. **STEP 2: Assessment care planning and review** - Holistic assessment of needs to address physical, psychological, social, spiritual, cultural and, where appropriate, environmental needs and wishes of each person. Honesty and sensitivity are key: establish the support needs of the carer(s) and avoid assumptions about their relationship to the person, consider any body image needs such as physical appearance within the care plan, plan care and preferences in advance of deterioration, be aware that if a person has a gender recognition certificate it is a criminal offence to share this information without (written) permission, reassure that key people will be included in care decisions when they can't communicate this for themselves, understand specific health needs of transgender people.
3. **STEP 3: Coordination of care** – all services needed to meet the care plan need to be effectively coordinated, and individuals should be asked permission to share (agreed) appropriate information with those services. This requires the identification of a key worker to ensure effective linking of

services, identifying key personal contacts to notify of changes in circumstance, awareness of discrimination people may have faced and the difficulties of speaking about their identity, and supporting the person to live their life as they choose.

4. **STEP 4: Delivery of high-quality care in different settings** - Ensure environments and literature portray a variety of relationships, ensure organisations core values are inclusive, positively challenge poor practice and share good practice, be aware that multiple providers can be involved in end of life care, promote open and honest conversation, engage LGBT people and organisations in the process of continuous service improvement.
5. **STEP 5: Care in the last days of life** – continue open communication, identify the level of information wanted at this stage, identify if preferences have changed and ensure care is still tailored to needs, recognise support needs of friends/carers/family, support those working with the individual and their family, identify any spiritual/religious needs, identify who the person wants present at the bedside and ensure that care is inclusive and offers support to all involved, regardless of tensions.
6. **STEP 6: Care after death** - Ensure key people closest to the deceased are involved in care immediately after death if they wish to be, consider everyone's support needs and recognise the strength of 'friend' relationships to ensure grief is not overlooked, maintain continuity and be aware of who has a relationship with different family members.

Across all of this, services should ensure all staff have undertaken training in equality and diversity, confidentiality and the Mental Capacity Act, should raise awareness of the unique issues faced by LGBT people and their families and carers during end of life, promote inclusive language and openness to all relationships, recognise that many LGBT people still face inequality and discrimination, promote a positive learning culture, ensure services are LGBT friendly, work with LGBT people to review services, and have clear policies on confidentiality.

In 2018, Hospice UK, along with several partners including NHS England, co-produced a guide to delivering high quality, personalised palliative and end of life care (34). Five key principles were recommended across several in-depth case studies from organisations delivering end of life care:

1. **Good communication** which includes engaging with people in a way that is meaningful for the individual and so enables people to make informed decisions about their care.
2. **An approach founded on dignity and respect** and investing in a relationship of trust.
3. The provision of **workforce training and support**.

4. Enabling **partnership working** at a strategic level.
5. **Recognising that people are all different** so inclusive, equitable care is not about treating everybody the same way.

Wider observations were also highlighted for the system, services and knowledge base, including: Improving the evidence base; more priority at local levels, including needs assessments looking at the end of life needs of vulnerable groups and actions to tackle health inequalities in health and wellbeing strategies; stronger data; and facilitating opportunities to share learning and experiences about what works in practice.

In 2021, this work was updated with a Hospice UK report on equality in End of Life Care, involving consultation with over 100 hospices about their ongoing work to provide services to all parts of their community, including people who are LGBT (35). The report developed five recommendations for delivering end of life care, which compliment findings in the 2018 report outlined above:

- **Develop an evidence base** to capture experience, wishes and needs of palliative, end of life and bereavement care for LGBT people, especially for trans people.
- **Commission actively and inclusively** – to ensure that LGBT people are treated equally, but not necessarily identically, to other groups. There is not enough understanding from service-providers of the different needs that LGBT people might have.
- **Collect data robustly** both locally and nationally, as effective service planning from both providers and commissioners depends on better knowledge and understanding of communities, key issues affecting them, specific needs, use of services and unmet needs.
- **Invest in workforce development** – not everyone's needs or experiences are the same which can be a real barrier to service access and could exacerbate inequality.
- **Apply evidence-based research recommendations to practice**.

COVID-19

The NHS Confederation has produced several recommendations in light of the health challenges of COVID-19 to ensure services and workplaces meet the needs of the LGBTQ+ population, both in short term delivery and long term planning (36):

Figure 2: Diagram of NHS Confederation recommendations to support LGBTQ+ people

A number of pilot sites have been identified to implement these recommendations in 2022, including Sussex Partnership NHS Foundation Trust.

Chapter Summary

Whilst much progress has been made nationally regarding the rights of LGBTQ+ individuals, there are still significant inequalities that exist and gaps for some groups. A national programme of work is underway to implement the commitments of the LGBT Action Plan to address some of these gaps and persisting inequalities for LGBTQ+ people. Locally, there is not currently a systematic approach to addressing the needs and experiences of LGBTQ+ people across health and social care. Although, there have been recent positive developments, such as the Sussex wide Trans healthcare programme. This needs assessment will contribute to systematically addressing inequalities locally.

A wide range of guidance exists to support organisations and services to deliver high-quality support to LGBTQ+ people. Whilst there are some particular considerations in specific settings, there are several commonalities in best practice in supporting LGBTQ+ people across all settings and determinants for health: the need for robust data collection and monitoring; staff training in LGBQT+ needs,

both general and service specific; the need for inclusive and 'safe' service provision, including clear confidentiality policies; and the need for robust preventative policies and proactive approaches to tackling discrimination.

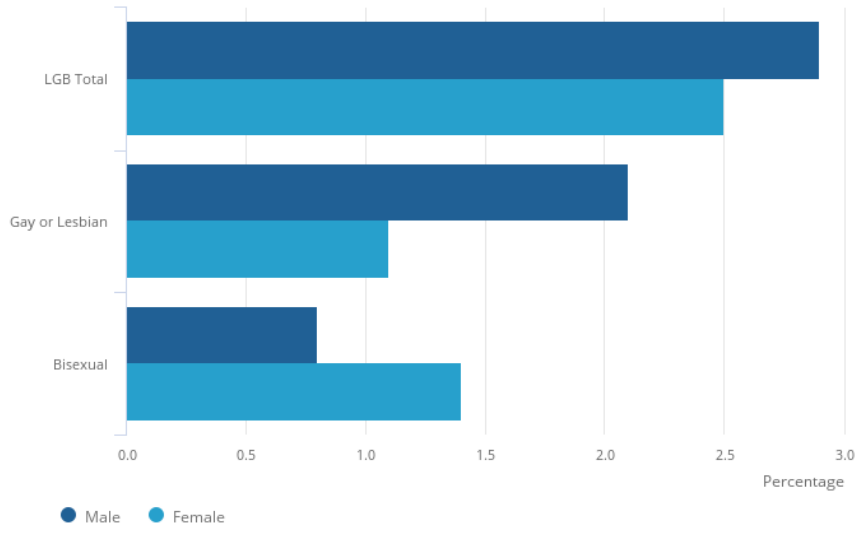
Chapter four- Population estimates of LGBTQ+ people

Sexual Orientation

Based on a national probability sample survey, in 2019, 3.4% of the UK population aged 16 years and over identified as LGB or another sexual identity minority (37). A further 3% did not know or refused to answer (37).

Men were almost twice as likely as women to identify as gay or lesbian, but women were more likely than men to identify as bisexual, as shown in below (37):

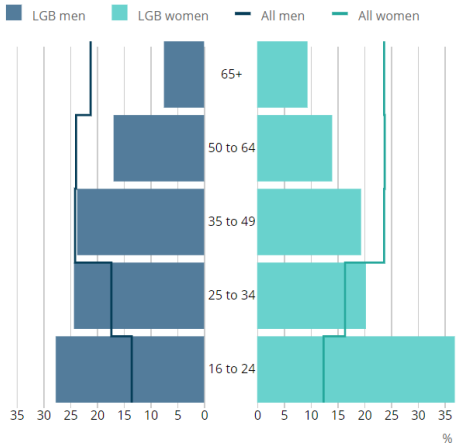
Figure 3: LGB identification by gender, UK (2019)



Source: Annual Population Survey, Office for National Statistics, 2019

Young people (aged 16-24 years) were most likely to identify as LGB compared to other age bands, as shown below.

Figure 4: LGB population by age and sex, UK (2019)



Source: Annual Population Survey, Office for National Statistics, 2019

This data, based on the annual population survey, is currently only available at a national, country and regional level but there were no statistically significant differences between the proportion of the LGB population in the South East (2.9%, CI 2.4-3.4%) and the proportion in England (2.7%, CI 2.6-2.9%) or the UK (2.7%, CI 2.5-2.8%) (37).

Within the county of East Sussex, experimental statistics produced by the ONS in 2018 suggested that:

- 93.5% of the population identify as heterosexual or straight
- 1.9% identified as gay or lesbian
- 0.7% identified as bisexual
- 0.5% identified as another sexual minority
- 3.3% didn't know or refused to answer the question.

(Note - figures may not add up to 100% due to rounding.)

These experimental statistics are not as robust as the annual population statistics above as they have not been through a formal assessment process for national statistics status nor are they standard published experimental statistics. However, based on these estimates, with 3.1% of the population identifying as LGB+, and current population size of 557,200, there would be 17,273 LGB+ people living in East Sussex.

A probability-based survey undertaken in 2019 in East Sussex, however, suggests this figure may be higher, finding that of those who responded:

- 93% of respondents identified as heterosexual
- 1.7% identified as a gay man
- 0.8% identified as a gay woman/lesbian
- 1% identified as bisexual

- 3.5% identified as none of those options

(Note - figures may not add up to 100% due to rounding. The figures above excluded those who 'preferred not to say'.)

Based on this, approximately 7% of the East Sussex population may identify as LGB+. A crude extrapolation of the above figures suggests that 19,502 people may identify as LGB, and a further 19,502 may identify with an alternative sexual identity (for example pansexual, queer or asexual). This would equate to a total of 39,004 LGB+ people living in East Sussex. This is only a crude extrapolation and should be treated with caution as the people who chose to respond to the survey may not be representative of the wider population.

National data collection on sexual identity has improved recently and the 2021 census included an individual question on sexual orientation which will allow a more accurate estimate of this within a local area, although there is likely to be some under-representation. This data will be available from Spring 2022.

Gender identity

Currently, there isn't an accurate figure for the number of TGD people in the UK. However, a figure commonly used to estimate the number of people that might be trans or non-binary is 1% (38).

Locally, there is insufficient data to robustly estimate the number of TGD people living in the area. However, a crude extrapolation of the 1% figure would mean that there may be approximately 5,572 people living in East Sussex who identify as TGD. There would likely be some overlap between people who are TGD and people who identify as a sexual minority group.

National data collection on gender identity has improved recently and the 2021 census included an individual question on gender identity which will allow a more accurate estimate of this within a local area, although there is likely to be some under-representation. This data will be available from Spring 2022.

People with intersex variations

Currently, there isn't an accurate figure for the number of people who have intersex variation, but experts suggest it may range between 0.05%-1.7% of the population globally (2). There is no consistent agreement on what does and does not constitute a variation in sex characteristic, with some arguing that Polycystic Ovary Syndrome should be included, which would greatly increase the prevalence (39). One UK based estimate is that there may be 358,105 people with intersex variations living in the UK (40).

Chapter summary

There are limited robust data available to provide an estimate of the number of LGBTQ+ people living in East Sussex. The proportion of people locally who identify as LGB+ may range from 3.1% (ONS experimental statistics for East Sussex) to 7% (the ESCC community survey estimate). Approximately 1% of the population may be TGD and 0.05-1.7% of the population may have an intersex variation. This section outlines some crude estimates, largely based on nationally collected data. The Census 2021 data, available from Spring 2022, will enable more accurate estimates of the number of people from a sexual minority and/or are TGD locally.

Chapter five- Literature review of inequalities in the LGBTQ+ population

Wider determinants of health

Young people

Education

Evidence suggests that only 18% of LGBTQ+ young people report that school provided any useful preparation for happy and healthy sex and relationships (41). Further to this, a study found that more than half (53%) of LGBTQ+ pupils report there is not an adult at school they can talk to about their identity and only 33% LGBTQ+ pupils say their school provides information on LGBTQ+ topics and relevant signposting to LGBTQ+ resources and organisations (42).

National surveys indicate that many schools do not feel a safe environment for LGBTQ+ pupils or those with LGBTQ+ families, with one survey indicating that only 27% of secondary school students believe it would be safe to come out as LGBTQ+ (43). Further to this, over half of respondents reported that HBT language is common at their school (43). Indeed, one survey reported that 7 in 10 primary school teachers surveyed reported hearing children saying phrases like “that’s so gay”, yet 42% of primary school teachers report they don’t challenge such language every time they hear it (44). Bullying is not experienced equally across LGBTQ+ groups. One study found that 67% of young gay men, 60% of bisexual men, 53% of lesbians/gay women and 43% of bisexual women had encountered bullying (45). Additionally, bullying rates are higher in TGD groups than cis LGB+ groups. For instance, one study outlined that 45% of LGBTQ+ pupils reported being bullied at school, increasing to 64% of trans pupils (44). A recent study that focused on TGD youth attending a transgender health service demonstrated an even higher rate of bullying in these groups, with 86.5% of survey respondents reporting being bullied, mainly in school (46). Bullying was more prevalent in people assigned female at birth and in people who were out (46). Another large study found that LGBT students who received free school meals were more likely to be bullied than those who did not (57% compared to 44%) (42).

Unsurprisingly, bullying has a significant impact on LGBTQ+ pupils, with 52% of respondents in one survey feeling that this has had a negative impact on their plans for future education (44). One survey investigating the effects of bullying in school found that 41% of those who were subjected to homophobic bullying at

school reported that it had led them to either attempt suicide or think about doing so (45). In TGD groups that were bullied, there were higher levels of self-reported anxiety, depression and low self-esteem than in those who weren't bullied (46). Additionally, the effects of bullying can have a lasting impact with one large international study demonstrating that exposure to homophobic/biphobic school bullying was associated with lower life satisfaction in adulthood in LGB+ people (47).

There is evidence that the frequency of anti-LGBT bullying varies between different types of institutions, with bullying more common in secondary schools than sixth form colleges and further education colleges (45). Although, anti-LGBT bullying is still prevalent in university settings. One study found that 36% of trans students and 7% of cis LGB+ students faced negative comments or conduct from university staff in the last year because they are LGBTQ+ (48). The same study found that 60% of trans students and 22% of cis LGB+ students were the target of negative comments or conduct from other students (48). Disabled LGBTQ+ students are also particularly likely to be the target of such remarks from other students, with 47% reporting to have experienced this (48). This study also revealed that 7% of trans students were physically attacked by another student or a member of university staff in the last year because of their gender identity (48). For Black, Asian and other minority ethnic LGBTQ+ students, 24% have experienced negative comments or conduct from a member of university staff in the last year because they are LGBTQ+ (48). Further to this, 28% of LGBTQ+ students reported that they were excluded by other university students in the last year for being LGBTQ+, and this increased to 55% of trans students (48). Black, Asian and ethnic minority LGBTQ+ students of faith were also more likely to feel excluded (37%) (48).

Housing

Robust data does not exist to determine the true prevalence of homelessness amongst young LGBTQ+ people but one study estimated that 24% of homeless young people are LGBTQ+, with the main reasons cited including parental rejection, abuse within the family or aggression/violence in the family (44). Another large-scale survey also found that nearly 1 in 10 (8%) LGBTQ+ young people have had to leave home for reasons relating to their sexuality or gender identity, suggesting a greater risk of homelessness in this group (41). A recent survey of LGBTQ+ young people who had experienced any sort of homelessness found low levels of familial support, with 61% of LGBTQ+ young people feeling frightened or threatened by their family members before they became homeless, with this rising to 66% of disabled people and 71% of trans people (49). Reports of abuse from romantic partners were also common amongst respondents, especially in trans people compared to cis LGB people (26% vs 15%) and in those who report

being disabled compared to those who aren't disabled (25% vs 15%). Additionally, 59% of respondents faced discrimination and harassment whilst accessing services (49).

Hate Crime

Evidence suggests that young LGBTQ+ people are at a particularly greater risk of experiencing hate crime (50). One survey outlined that 33% of young LGB+ people had experienced an anti-LGBT hate crime in the last 12 months (51). This rose to 56% of young trans people (51). Cyberbullying remains an issue for young people with 59% LGBTQ+ young people being bullied online by someone they know (42).

Community

There remain particular areas of social activity where LGBTQ young people face exclusion. A large scale survey found that 59% of LGBTQ young people that would be interested in joining a religious organisation have stopped or reduced their involvement due to their sexuality or gender identity (41). Further to this, 34% of LGBTQ young people are not able to be open about their sexuality or gender identity at a sports club they are involved in (41).

Isolation, loneliness and social support

Only 40% of LGBT young people have an adult at home they can talk to at home about being LGBT but this falls to 28% for Black, Asian, and ethnic minority LGBT young people. Bi pupils are also less likely than LG pupils to have an adult at home they can talk to about being LGBT (37% compared to 46%) (42).

For young people with an intersex variation, evidence suggests that relationships with peers, romantic or sexual partners were challenging, and led to high levels of sexual anxiety (52).

Conversion therapy

Conversion therapy is an unethical and damaging practice that refers to any treatment or psychotherapy that aims to change a person's gender or sexual identity (53). A large national survey found that 7% of young cis LGB+ people had been offered conversion therapy, rising to 14% of young trans people (54).

Working age adults

Employment

There is mixed evidence around whether LGBTQ+ people are more likely to be unemployed than non-LGBTQ+ people. The National LGBT survey found that 80% of respondents had been in paid employment in the previous 12 months which was

largely similar to the general population at the time (44). However, there were clear differences between groups, with cis LG people most likely to be employed and asexual people least likely to be employed, (87.6% compared to 62.6%) (44). Additionally, trans respondents were less likely to be employed (63%) than cis respondents (83%), with the lowest rate in trans men (57%) (44). This is despite the fact that a greater proportion of trans people are educated to university degree level than the general population (35% vs 27%) (44).

A 2016 review reported evidence of discrimination in recruitment practices, deployment, and promotion within particular occupations, with many workplaces remaining unfriendly to LGBTQ+ people, especially for trans people (50). A more recent survey found that 63% of TGD respondents had experienced transphobia while seeking employment, increasing to 69% of TGD disabled people 73% of TGD black people and people of colour (BPOC) (55). Evidence suggests that the perception of the treatment of LGBTQ+ people in some jobs led to restricted job choice with 39% of gay men and 33% of lesbians/gay women reporting there were some jobs they would not consider due to their sexual orientation (45). A further study found that 12% of Black, Asian and ethnic minority LGBT employees have lost a job in the last year because of being LGBT compared to 4% of white LGBT people (11).

LGBT employees felt that they missed out on promotion due to their identity, with one study highlighting that 1 in 10 LGBT employees did not get a promotion they were up for at work in the past year because they are LGBT (11). This rises to 24% of trans people, 19% of Black, Asian and other minority ethnic LGBT people and 16% of LGBT disabled people (11).

One study highlighted a 16% wage gap between LGBTQ+ and non-LGBTQ+ employees, equating to an average of £6,703 less per year (56). The recent Trans Lives survey also demonstrated an income disparity within TGD groups, with BPOC who are TGD reporting lower earnings than non-BPOC TGD respondents (55). A similar finding was also noted between disabled and non-disabled TGD people (55).

Bullying and hate crime in the workplace

LGBTQ+ people are more likely to experience bullying and harassment at work than heterosexual cis people, with some studies suggesting that LGBTQ+ people are four times more likely to experience bullying and harassment (57). One study found that 12% of trans employees have been physically attacked by colleagues or customers in the last year (58). Hate crime in the workplace was also higher for Black, Asian and ethnic minority LGBTQ+ people, with 10% experiencing being physically attacked because of their sexual orientation and/or gender identity compared to 3% of white LGBT staff (11).

Evidence suggests levels of sexual harassment at work are high for LGBTQ+ people, with one study finding that 68% of LGBT people had been sexually harassed at work, with many incidents appearing to be linked to their LGBT identity or identities (59). LGBT women appear to be more likely to experience unwelcome behaviours and harassment whilst at work. Over half (53%) of LGBT women have experienced unwelcome jokes of a sexual nature compared to 44% of GBT men (59). The rate was higher in Black, Asian and other minority ethnic women (54%) compared to white women (31%). Black, Asian and other minority ethnic men reported similar rates of sexual harassment as white men (59). The same report notes that over one in ten (12%) of LGBT women have been seriously sexually assaulted or raped at work compared to 7% of men (59). Additionally, this report highlighted that trans women were even more likely than other women to experience sexual assault (32%) and serious sexual assault or rape (22%) at work (59).

Social Attitudes

Despite significant progress in public attitudes towards LGBTQ+ people, HBT attitudes remain prevalent, with one in five people in a recent survey stating that being LGBTQ+ was immoral or against their beliefs (60). One in ten people surveyed said they thought LGBTQ+ people were 'dangerous' to others and one in ten people thought LGBTQ+ people could be 'cured' (60). This study found that generally, attitudes towards trans people were more negative than towards LGB+ people (60). Further to this, evidence suggests that people with intersex variation experience higher levels of discrimination and stigmatisation compared to the general population (52).

Housing

There is a lack of robust data on the prevalence of homelessness in LGBTQ+ groups, however, it is likely that homelessness disproportionately impacts LGBTQ+ people, with one report noting 18% of LGBTQ+ people surveyed have been homeless at some point in their lives (44). A recent national survey of TGD individuals found that 27% of all respondents had experienced homelessness at some point in their lives, with a greater proportion of BPOC experiencing this compared to non-BPOC (36% compared to 26%) (55). Similarly, a greater proportion of disabled people had experienced homelessness than non-disabled people (36% compared to 21%) (55). Trans men had the highest rate (30%) compared to trans women (28%) and non-binary people (23%) (55).

Further to this, evidence suggests that LGBTQ+ people experiencing homelessness both experienced and expected discrimination from housing services and did not feel their needs were addressed adequately (50).

Additionally, 10 % of LGBT people reported they were discriminated against when looking for a house or flat to rent or buy in the last year (51). This rose to 20% of non-binary people, 25% of trans people and 24% of Black, Asian and other minority ethnic LGBT people (51).

Deprivation

Although there is a paucity of robust evidence, the literature suggests that gay men and bisexual men and women may be more likely to experience poverty than their heterosexual counterparts (61). On the other hand, lesbians/gay women are about as likely to experience poverty as their heterosexual counterparts (61). There is limited evidence related to TGD groups, but one large US-based study found that one third of trans respondents reported living in poverty, which is about double the rate of the general population (62).

Hate Crime

Between 2015/16 and 2019/20, the incidence of anti-LGBT hate crimes that were reported increased year on year in England and Wales (63). Between 2018/19 and 2019/20, there was a 19% increase in reported hate crime associated with a person's perceived or actual SO and a 16% increase in reported hate crimes associated with a person's perceived or actual transgender identity (63). The government has suggested that this increase in hate crimes is largely due to improvements in recording by the police (63). It is well documented that the proportion of people who experience hate crime that actually report this to the police is low. Estimates vary between studies, but it appears that this is lower than 20% (51), (15). Therefore, the true problem of anti-LGBT hate crime is much larger than official statistics suggest. One study found that of the small minority that have reported anti-LGBT hate crimes to the police, only 46% felt satisfied with the response they got (15). The main reasons that respondents were dissatisfied with the police were that no action was taken, they felt the incident was not taken seriously or they had to repeat their story several times (15).

A recent survey outlined that 64% of LGBT+ people have experienced anti-LGBT+ violence or abuse (15). Over one third (36%) of respondents said they experienced anti-LGBT+ violence or abuse on a daily or weekly basis (15). The most common forms of abuse experienced were verbal (92%), online abuse (60%), harassment (59%) and physical violence (29%) (15). Over one fifth (21%) of LGBTQ+ people report having experienced an anti-LGBT+ hate crime in the past 12 months (51).

Some groups with LGBTQ+ communities are at greater risk of experiencing hate crime. One study outlined that 41% of trans people experienced a hate crime incident in the previous 12 months due to their gender identity, and 18% of trans people experienced a hate crime due to their perceived or actual sexual identity

(51). Non-binary people also report greater rates of anti-LGBTQ+ hate crime, with 39% of survey respondents experiencing this in the previous year (51). Black, Asian and other minority ethnic LGBT people are also at greater risk compared to white LGBT people (34% compared to 20%). LGBT people of a non-Christian faith are also more likely than other LGBTQ+ people to have experienced a hate crime of this nature, with 30% reporting this (51). Finally, the rate of anti-LGBT hate crime is also higher in disabled people compared to non-disabled people (27% compared to 17%) (51).

Hate crime can have a significant effect on LGBTQ+ people, with 37% of respondents of a recent survey outlining that their most recent experience of anti-LGBT hate crime had a moderate or significant impact on them (15). The impacts varied, including physical health impact, mental health impact and financial impacts through having to quit their job or pay for treatment (15). There is also evidence that the fear of hate crime can lead to significant anxiety in LGB+ people which can result in hyper-vigilance, poor mental health, stress, self-harm and suicide (45). Direct and indirect experiences of hate crime may increase feelings of vulnerability or threat amongst LGBTQ+ people and may result in changes in behaviour to avoid perceived risk (64).

Domestic abuse

Evidence suggests that domestic abuse is disproportionately high in LGBTQ+ groups, with one study outlining that 11% of LGBT people had experienced this from a partner in the previous year, increasing to 17% in LGBT people from minority ethnic groups and 19% in trans and non-binary people (65). Additionally, 15% of LGBT disabled people surveyed have experienced domestic abuse in the last year (65). ONS estimates for the same period indicate that 6% of women and 3% of men from the general population have experienced domestic abuse in the previous year (65). Little research has specifically separated experiences of domestic violence in bi people but that which has found that bisexual people were more likely than lesbian or gay people to experience physically and emotionally abusive behaviour from 'same gender' partners (16). One survey found that 13% of bi women, 12% of bi men and 17% of bi non-binary people experienced intimate partner abuse in the year before being surveyed (66). LGBTQ+ people are also at risk of different types of abuse. For example, half of transgender people who have experienced domestic abuse have experienced abuse from a partner directly related to their gender identity (67) this may include withholding medication or treatment relating to their transition and using incorrect pronouns (68). There may be particular challenges in LGBTQ+ people seeking support for domestic abuse, including not wanting to disclose their identity, perpetrators threatening to 'out' the person and mainstream services perhaps not being equipped to deal with the needs of LGBTQ+ people (44).

Community

LGBTQ+ people are often excluded from community spaces. Evidence suggests that TGD people are being excluded from the physical health, mental health and social benefits of participating in non-competitive sport due to anti-LGBTQ+ discrimination, and gendered changing facilities/toilets a specific barrier to participation for TGD people (44). Further to this, many LGBT people do not feel they can express their identity in communities of faith. One study reported that 32% of LGB+ people of faith are not open about their sexual orientation with anyone in their faith community, and 25% of trans people of faith are not open about their gender identity in their faith community (65). This is compounded in the report with the finding that only 39% of LGBT people of faith (39%) think their faith community is welcoming of LGB people and just 25% report they think their faith community is welcoming of trans people (65).

Some people within LGBTQ+ groups also find they are excluded from LGBTQ+ spaces. Whilst many people who come out, find support in the LGBTQ+ community, many minority groups face discrimination from within the LGBTQ+ community itself. A Stonewall Survey notes that 51% of LGBTQ+ people from minority ethnic backgrounds and 26% of disabled LGBTQ+ people report discrimination or prejudice in the community (44). Additionally, bi people also experienced this, with 27% of bi women and 18% of bi men reporting discrimination or poor treatment, compared to 9% of lesbians and 4% of gay men (44). Further to this 12% of LGBTQ+ people of faith have experienced discrimination and poor treatment from other LGBTQ+ people in their local community because of their faith (65).

Isolation, loneliness and social support

Evidence suggests that being out about your sexual identity can confer positive benefits on wellbeing, in supportive contexts (69). A large-scale study of 5,000 LGBTQ+ people in Britain found that only 46% of LGB+ and 47% of trans people feel able to be open about their sexual identity or gender identity to everyone in their family. The same study found that 30% of bi men and 8% of bi women reported they cannot be open about their identity with any of their friends, compared to 2% of gay men and 1% of lesbians/gay women (65). Almost one quarter (24%) of trans non-binary people couldn't be open about their gender identity to anyone in their family, compared to 12% of trans men and 5% of trans women (65).

Further to this, rates of loneliness appear to be higher in LGBTQ+ communities. Even before lockdown, one study found that 21% of LGBTQ+ respondents felt lonely very often or every day (70). Nearly half of LGBTQ+ people living in social housing report that don't feel a sense of belonging in the community they live in, and over one quarter report feeling lonely (44). Finally, one study found that LGB people living in small towns or cities are more likely not to be open about their sexual

orientation to anyone in their family (20%), compared to LGB people living in large towns and cities (14%) (65).

One systematic review reported that people with intersex variation may be more at risk of social isolation and loneliness due to high levels of discrimination, stigmatisation and a lack of understanding of their lives (52). One study found that 25% of people with intersex variation had never had a romantic or intimate relationship (52).

Conversion therapy

A national survey found that 2% of LGBT people in the UK had been subjected to conversion therapy with a further 5% being offered this (54). Trans people were almost twice as likely to have been offered or subjected to conversion therapy than cis LGB people (13% compared to 7%) (54). Over four in ten (43%) Muslim trans respondents had undergone or been offered conversion therapy and 19% of cis LGB Muslim respondents also reported this (54). The rate was also significantly higher in Black and Asian LGBT people compared to white LGBT people (54).

Conversion therapy practices can have serious and long-lasting impacts with one study finding that of those who had undergone such practices to change their sexual orientation, over two thirds (68.7%) had experienced suicidal thoughts, 40.2% had self-harmed and 59.8% experienced anxiety and depression requiring medication (71).

Of significant concern, is news of a recent vote amongst British Medical Association (BMA) members on the BMA's stance on conversion therapy, with over one quarter (26%) of doctors unsupportive of the BMA lobbying to ban LGBTQ+ conversion therapy (72).

Older adults

Housing

Some evidence suggests that older LGB+ adults are less likely to be homeowners, although there was little evidence found regarding exclusion from decent housing (73). When applying for social housing, one survey found that 25% of gay respondents aged over 65 expected to be treated worse than heterosexual people during the application process (45).

The experiences of residential settings for older LGBTQ+ people are covered in the social care section of this chapter.

Isolation, loneliness and social support

Evidence suggests that older LGB+ people are more likely to be single, live alone and less likely to have children and see their biological family regularly than heterosexual people (74). Whilst by no means universal, for older LGBTQ+ people, the risk of social isolation increased where resources that enable meeting and socialising with others in the community were not available or accessible (75). For some older GB men, the HIV/AIDS epidemic may have had an acute impact on their friendship networks and left substantial gaps in social support (76). Additional evidence also suggests that some older LGBTQ+ people that may not have developed strong friendship networks are in a more precarious position in terms of future care and isolation as a result of an absence of children and/or estranged family members (76). Those LGBTQ+ people who may have formed networks (biological and social) could potentially maintain their independence for longer (76).

Feelings of isolation are prevalent in older LGBTQ+ people, with one survey finding that just under half of the respondents had experienced this (44). A review of loneliness in older LGB+ people demonstrated that concealment of identity may increase the risk of loneliness in older LGB people (77). The evidence from this review also indicated that the social networks of LGB people may not be as immediately accessible as non-LGB people as typically geography doesn't define LGB communities (77).

Community

Older LGBTQ+ people have reported experiencing discrimination or poor treatment because of their age in their local LGBTQ+ community with 28% of people aged over 65 reporting experience of this (65). Further to this, one study found that over a third of LGBTQ+ people living in social housing did not feel safe in their neighbourhood, and this increased to two thirds of trans people (44).

Conversion therapy

In a large-scale national survey, one in ten older cis LGB people reported being offered or having been subjected to conversion therapy and one in five older trans people reported this (54).

Health behaviours

Young People

Drug Use

One study found that 13% of young LGBTQ+ people took drugs at least once per month (17). Evidence suggests that cannabis use is higher in sexual identity minority men compared to heterosexual cis men, with some studies suggesting triple the rate of cannabis use in the past year (78). Further to this, one study outlined that LGB women who are undergraduates have greater likelihood of using various illegal drugs compared to heterosexual women, with bisexual women having a higher risk of using amphetamines compared to LG women (79).

Smoking

Compared with young heterosexual people, evidence suggests that young LGB+ people are more likely to be smokers and data indicates that there is a tendency to start at younger ages, as well as have a higher smoking frequency (80). One study on college students found a greater risk of tobacco use in LGB women, with bisexual women having the highest risk level (79).

Alcohol Use

Problematic alcohol use has been shown to be higher in sexual minorities compared to heterosexual people (81). The same study demonstrated that 21% of the association between SO and problematic alcohol use was explained by an increased risk of depressed mood (81). Further to this, some evidence suggests that these disparities appear to be higher in female sexual minority groups, especially bisexual women (82), (79).

Physical Activity

There are differences in participation in team sports between LGBTQ+ communities. In the youth population, one study found that whilst many gay or lesbian people play team sports 73% believe that it is not safe for gay/lesbian people and most are completely or partially in the closet (83). TGD young people face even more barriers in participation in sport, including gendered facilities, body dissatisfaction and fears of not being accepted by others (84), as well as feeling excluded due to typically binary gender divisions and sport governing body policies that are explicitly exclusionary (85).

Working age adults

Drug Use

National data outlines that gay and bisexual people are more likely to have taken any illicit drug in the last year, with the rate in GB men around three times higher than among heterosexual men (86). Evidence suggests that the types of drugs taken may differ between gay and bisexual men compared to heterosexual men, with more problematic use of amphetamines, GBL and a higher tendency to inject non-opiate drugs (e.g., mephedrone or crystal methamphetamine) (87). Poly-drug use also seems to be more prominent (88).

In LGB+ women, one large survey reported that 39% of respondents reported taking a drug in the last 12 months (89). For this group, the most common drug taken was cannabis (89).

In TGD groups, one survey found that 15.4% of respondents reported using recreational drugs around the time of being surveyed and a further 46.2% reported using recreational drugs previously (90).

Sexualised drug use (often known as chemsex)

The prevalence of sexualised drug use in the UK is difficult to assess due to variations in the definitions used in studies, as well as variations in the populations assessed (91). One report highlights that 6.6% of men who have sex with men in England have used any one of the three common chemsex drugs (crystal methamphetamine, GHB and mephedrone) in the last four weeks (44). In men who have sex with men living with HIV, this increases to 21.9% (44). There is less evidence relating to chemsex prevalence in trans women. However, the LGBT Foundation notes that there has been a recent increase in the number of trans people, especially trans women, accessing their chemsex support service (44).

Evidence is also limited regarding sexualised drug use in LGB+ women. One large survey identified that 17% of LGB+ women had engaged in sexualised drug use in the previous 12 months (89). Women reporting sexualised drug use were significantly more likely to report engaging in sex with both men and women, compared to just women (89). The most common drugs taken by LGB+ women just before/during sex were cocaine and ecstasy (89).

Smoking

Differences in smoking prevalence between sexual minorities and heterosexual people have narrowed, although surveys suggest that prevalence among LGB people is still higher than among heterosexual people (92). The Annual Population Survey 2018 found that prevalence was around 23% for LGB people and around 16%

for heterosexual people (93). Although a more recent smaller study found that LG people had roughly the same prevalence of cigarette smoking as heterosexual people (92). Bi people appear to be more likely to smoke than LG people, with the highest risk in bi women (94). A further study found that whilst bi people were more likely to smoke than heterosexual people, they were less addicted (92). For TGD populations, there is limited data but one study from Northern Island suggests that smoking prevalence may be higher in these groups (95).

This higher prevalence of smoking among LGBT people is thought to be related to prejudice, discrimination, and poor mental health (96). Additionally, LGBTQ+ people may be more likely to belong to other groups with high smoking prevalence, such as being single, homeless or having mental health conditions (96).

Alcohol use

Alcohol use is disproportionately high in LGBT communities, with one study outlining 16% of LGBT people drank alcohol almost every day (17). This compares to around 10% of people in the general population that drink every day (17). One fifth (20%) of GBT men reported drinking alcohol almost every day over the past year, compared to 13% of LGBT women and 11% of non-binary people (17). Another study suggests that bi women have a higher risk of binge drinking compared to LG women (99).

Physical Activity

Evidence suggests that participation in sport and physical activity is lower in LGBTQ+ people than heterosexual cis people (100). One report outlines a greater proportion of LGBTQ+ men were not active enough to maintain good health compared to men in the general population (55% compared to 33%) (100). Similarly, 55% of LGBTQ+ women were not active enough to maintain good health as opposed to 45% of women in the general population (100). Further to this, 64% of LGBTQ+ people who identified as outside of a gender binary were not active enough to maintain good health (100). One study found that transgender people seeking treatment from a transgender health service engaged in significantly lower levels of physical activity than matched cisgender people, although both groups had insufficient physical activity levels (101).

Many TGD people have a negative experience when engaging in physical activity, which may be explained by a range of factors, such as changing facilities, sport-related clothing, and discrimination (101). Transphobia may be especially high when playing a sport, with one study finding that 57% of TGD people had experienced this, increasing to 77% in trans women (55).

Diet

There is limited robust evidence related to differences in diet quality between LGBTQ+ people and non-LGBTQ+ people. One American study found that LGB women reported a higher quality of diet compared to heterosexual women (102).

Older adults

Drug Use

There is mixed evidence regarding drug use in older LGBTQ+ people. One study demonstrated that just 1% of LGBTQ+ respondents over the age of 65 reported taking drugs at least once a month, which is lower than for younger LGBTQ+ people (17). However, one older study with a more representative sample, found that 9% of older LGB people reported taking drugs in the previous year compared to 2% of non-LGB people (74).

Smoking

Evidence suggests that older LGBTQ+ people are less likely to smoke than younger LGBTQ+ people, with 9% smoking almost every day, compared to 15% of all LGBTQ+ people (17).

Alcohol use

Alcohol use is disproportionately high in LGBTQ+ communities, with one study outlining that 33% of LGBTQ+ people over 65 drank alcohol almost every day (17). Almost daily alcohol consumption appears to be higher in gay men compared to LGB women (74).

Physical activity

Compared to older heterosexual people, older LGB people appear to be more likely to exercise regularly (35% compared to 28%) (74).

Health, disability and use of services

When reading this section please note that a comprehensive needs assessment of sexual health in East Sussex took place in 2019 (103). This included a literature review, which considered the needs and experiences of different groups including LGBTQ+ people. Therefore, sexual health inequalities are not summarised here in detail, to avoid duplication of work. The sexual health section that follows focuses on PrEP use, which has been a key development in sexual health care relevant to LGBTQ+ groups since its publication in 2019.

Young people

General health, LTCs and disability

There was limited evidence found around the general health and LTCs in young LGBTQ people. However, one survey of LGBTQ+ young people found that transgender people were more likely to report a disability than their cisgender peers (104). Further to this, a recent report of UK students found that trans students were the most likely group to declare multiple disabilities (105).

Mental health

There is an abundance of evidence demonstrating that LGBTQ+ young people have an increased risk of poor mental health compared to their heterosexual/cis peers. However, it should be noted that mental ill-health is not inherent to being a gender or sexual minority, rather this higher prevalence could be considered to be socially induced, through stigma, societal prejudice and discrimination, which can lead to minority stress (106). Minority stress may increase the risk of people from a sexual and gender minority developing a mental health condition (106).

A recent study found that 30% of LGBTQ+ students declared a mental health condition, compared to 12% of non-LGBTQ+ students (105). The rate was highest in trans people, followed by bisexual people, gay women/lesbians, other LGBT groups and gay men (105). Sexual minority adolescents are more likely to report depressed mood than heterosexual adolescents (81), with some estimates suggesting that LGB young people have rates of depression and anxiety up to three times higher than heterosexual young people (107). Similarly, a 2016 survey of 16-25 year olds found that LGBTQ+ respondents were significantly more likely to have received medical input for depression or anxiety than heterosexual respondents (108). For TGD young people, a UK based study found that non-binary young people may have worse self-esteem and higher rates of anxiety and depression than binary trans young people (109). A further study on students found that TGD people had over twice the likelihood of experiencing a current mental health problem, compared to cis LGB+ people (107).

The role of community appears to influence the mental health of young LGBTQ+ people. A North American study found that bisexual young people are more likely to experience cyberbullying than their heterosexual counterparts, which has been found amongst LGB young people to directly correlate to depression, psychological distress, physical fighting, and suicidal intent (110). However, the same systematic review acknowledged the protective factors associated with strong social support that LGB young people may receive in an online community (110).

Correspondingly a separate systematic review found that belonging to a religious community demonstrating acceptance may act as a protective factor for the

mental health of LG adolescents and that young people who are members of a non-LGBTQ+ affirming denomination may experience negative consequences in their mental wellbeing (111). A 2017 scoping review found evidence that for trans young people, negative behaviours and attitudes from others may increase susceptibility to mental health problems including anxiety, depression and suicidal behaviour, however, there is also evidence to suggest trans young people also develop resilient coping mechanisms, and when supported appropriately become less distressed (112).

Use of mental health services

LGBTQ+ young people are more likely to report a perceived need for mental health support, more likely to access mental health professionals and more likely to report feeling that their mental health needs have not been met (107). Despite the increased use of mental health services, there is evidence to suggest that young people may struggle to seek support for mental health difficulties due to the dual stigma of LGBTQ+ identities and poor mental health (104). There appear to be gender differences amongst sexual minority students' use of mental health services, with sexual minority female students having higher use of services than sexual minority male students, as well as TGD students having higher use of such services compared to cis LGB students (107).

Suicide and self-harm

There is significant evidence about the occurrence of suicide and self-injurious behaviour in LGBTQ+ young people. LGB young people have a higher risk of self-injurious behaviour (107), and Public Health England estimates from 2015 suggest one in two LGBTQ+ young people in the UK reported self-harming at some point in their life, with 44% thinking about suicide (113).

There is some evidence about what puts young people at risk of suicide or self-harm behaviour. Young people who come out or have thoughts that they are lesbian, gay, or bisexual at a younger age may be at increased risk of suicide attempts (114). There is a correlation between experiencing victimisation and self-harm and suicide in LGBTQ+ young people (115). Future suicide risk, past suicide attempts and suicidal ideation in young LGB people may be associated with stigma and discrimination, including school stigma, negative reactions from family and friends, and exposure to LGB related crime (114).

For TGD young people in the UK over the age of 12, evidence suggests there is an increased occurrence of self-injurious thoughts and behaviour when compared to the whole adolescent population, likely a result of a complex psychosocial environment (116). Risk factors for TGD young people experiencing non-suicidal self-injury include experiencing greater levels of transphobia, parental abuse, and low body esteem (112). One study amongst students reported that suicide risk

appears to be three times as high in TGD people compared to cis LGB+ people (107). The same study found that the prevalence of self-harm was over twice as high in TGD people as cis LGB+ people (107). Although, a 2021 meta-analysis found insufficient statistical power to infer differences between LGB and TGD young people in the prevalence of self-harm and suicide intent (115).

Weight

Evidence suggests that sexual minority adolescents have an increased likelihood of both overweight and obesity compared to heterosexual adolescents, and although not more likely to increase exercise to lose weight, this group had increased likelihood of eating less to lose weight (117), which may in turn increase the risk of disordered eating. Sexual minority adolescents are more likely to perceive themselves to be overweight or very overweight, regardless of whether this is the case (117).

Learning disabilities and neurodiversity

Limited evidence was identified regarding the prevalence of neurodiversity and learning disabilities in LGBTQ+ young people. However, a report from Mind identified that young people with autism are more likely to report being bisexual (118). A further study outlined that trans students were the most likely LGBTQ+ group to have autism (105).

Working age people

General health, LTCs and disability

Evidence on the prevalence of chronic disease in LGBTQ+ people is lacking, however, the English GPPS study found that a higher proportion of LGB women self-reported their health status to be “fair or poor” compared with heterosexual women suggesting poorer perceived health (119). Without specific UK based data, there is some research undertaken internationally which suggests that LGB women may be at higher risk of developing type 2 diabetes (44), and sexual minority women have a greater prevalence of prediabetes than heterosexual women (120). Bisexual men may have an increased risk of diabetes than heterosexual men, with few differences found between gay men and heterosexual men (120). There is evidence across multiple studies that suggests LGB women have higher rates of asthma compared to heterosexual women, however, there is no research to indicate why this is the case (119).

There are significant gaps in the literature regarding chronic physical health disease in TGD groups (121). One US study of privately insured TGD people found

that TGD people had a higher risk than cisgender people across most chronic conditions (122). From largely US-based studies there is evidence that transgender people experience poorer physical health than cis people. Further to this, transgender women are more likely to experience risk factors for cardiovascular disease and cardiovascular mortality than cisgender adults (121). Changes in blood lipid profiles for transgender people may be linked to gender-affirming hormones (120). The American Heart Association's position is that psychosocial factors may impair cardiovascular health for LGBTQ+ people (120). However, they note that health record data indicates that transgender women taking gender-affirming hormones have a higher incidence than their cisgender counterparts of myocardial infarction, venous thromboembolism, ischemic stroke, and cardiovascular mortality, but findings for transgender men are varying (120).

There is a lack of evidence relating to general health, including chronic disease prevalence, amongst people with intersex variation (52). One recent American study reported that 43% of people with intersex variation rated their physical health as fair/poor and arthritis and hypertension was prevalent (123).

Cancer

There is a complex picture regarding sexual and gender minority people and cancer diagnosis. With regards to overall cancer incidence, data from the English GP Patient Survey found that after adjustment for age, there was no evidence to suggest LGB women had differing rates of diagnosis of cancer in the last five years than heterosexual women. The same data found that GB men were more likely to report a diagnosis of cancer in the last five years than heterosexual men (124).

The English Cancer Patient Experience Survey suggests that, after adjusting for age, LGB women represent a higher proportion of women with oropharyngeal cancer, mesothelioma, stomach, and endometrial cancers and are less frequently represented amongst those with anal, vulval/vaginal, liver, and oesophageal cancers (124). The same data, when adjusted for age, suggests that GB men are more likely than heterosexual men to have a diagnosis of Kaposi's sarcoma, melanoma, Hodgkin lymphoma, anal, penile, oral and thyroid cancers. They have lower representation amongst those with liver and stomach cancers, leukaemia, and mesothelioma. However, the small number of people from sexual minorities diagnosed with some types of cancers in this study means that it is difficult to draw firm conclusions (124).

There is limited evidence related to cancer incidence in TGD groups. However, one Dutch study in trans people receiving hormone treatment found that for trans women there is 46 times the risk of breast cancer compared to cis men and a lower risk in trans men compared to cis women (125).

There is a lack of evidence relating to cancer incidence amongst people with intersex variation (52).

Screening

Women from sexual minorities in the UK appear to be less likely to partake in breast or cervical cancer screening, with 15% of LGB women over 25 reporting never having had a cervical screening test compared to 7% of heterosexual women (119). A further study found that 51% of LGB women had either never had a test or not had one within the recommended timeframes and 28% had been told a screening test wasn't necessary for them (126).

Additionally, there are specific issues in TGD people accessing screening appropriately. In the UK, the call and recall system for screening is not currently able to account for those who registered with their gender identity but require screening based on their sex assigned at birth (127). This puts the onus on the individual to be aware of what screening they need and when and proactively seek out an appointment. A mixed-methods study on cervical screening in trans men and non-binary people assigned female at birth found that 65% of those eligible for cervical screening had delayed testing at least once and 13% of participants had never received an invitation for screening (127). Respondents noted a range of barriers including a male gender marker on their patient record, experienced or expected discrimination, poor provider understanding of trans health needs, female-centred screening information materials and dysphoria related to the screening procedure, information or correspondence (127). One study found that 27% of TGD people said they always or often avoided GP visits for this type of care (55).

Mental health

There are persistently higher rates of poor mental health amongst people from sexual minorities (128). It should be noted that mental ill-health is not inherent to being a gender or sexual minority, rather one key driver of this higher prevalence could be considered to be socially induced, through stigma, societal prejudice and discrimination, which can lead to minority stress (106). Minority stress may increase the risk of people from a sexual and gender minority developing a mental health condition (106).

Amongst LB women there is an increased prevalence of stress, anxiety, depression, eating disorders and self-harm (128). Gay and bisexual men have twice the likelihood of being anxious or depressed (129) and may be more likely to experience disordered eating than heterosexual men (130).

One study reported that bi people are more likely than gay and lesbian people to develop mental health conditions including depression, anxiety, bipolar disorder

and obsessive-compulsive disorder (118). These are higher still amongst people who are bi and from a minority ethnic group (118).

In contrast to Thorne et al.'s study which found that non-binary young people had worse mental health outcomes than transgender young people (109), a 2019 study of adults found that non-binary participants had better mental health than trans binary participants, but worse than cis people (131).

It is acknowledged that long waiting times to access GICs negatively impact the mental health of trans people. Transgender people may experience a more negative body image than cis people, particularly before gender affirmative treatments (130), and discrimination is associated with poorer body image in transgender people (132).

There is less evidence related to mental health condition prevalence in people with an intersex variation. An Italian study reported an increased risk of depression and anxiety in women with intersex variation compared to the general population (133). A systematic review reported higher rates of psychological distress in people with intersex variation but also found that psychological support and counselling went some way in addressing this (52). A further American study found that there was a lifetime prevalence of 61% for a depressive disorder, 62% lifetime prevalence of an anxiety disorder and 41% for PTSD in people with intersex variation (123).

The risk of mental ill-health for LGBTQ+ people can be compounded by intersectionality. For example, LGBTQ+ people from lower-income households are more likely to experience depression, as are LGBTQ+ people who are from black and minority ethnic backgrounds (134). There are few available studies on religion and transgender, although, some studies suggest that transgender Muslim people experience greater risk of poor mental health due to their intersectionality, however strong faith may be a protective factor (135).

Use of mental health services

Of those who have accessed England's Improving Access to Psychological Therapies (IAPT) services, bisexual people and LG women have been found to have higher baseline depression, anxiety and functional impairment than heterosexual people (136). Bisexual people were 43% more likely not to have recovered from depression or anxiety at their final session (136). Treatment outcomes were also poorer for LG women compared to heterosexual women (136). There were no differences in treatment outcomes between gay men and heterosexual men (136).

The 2018 National LGBT Survey indicated that 24% of LGBTQ+ people had accessed and 8% had unsuccessfully tried to access mental health services in the preceding 12 months (54). Trans respondents were more likely to have accessed and unsuccessfully tried to access mental health services than cis respondents. Of

those who did access or try to access mental health services, 51% of respondents felt they had difficulty accessing the service as they had to wait too long (54).

Suicide and self-harm

Population surveys and international studies indicate increased ideation of suicide and self-harm behaviour in sexual minority groups (128). One study reported that over one in four (42%) of LGBTQ+ people felt that life was not worth living in the last year, increasing to 60% in trans people and 64% in non-binary people (17). This study also found that a greater proportion of disabled LGBTQ+ people felt that life was not worth living compared to non-disabled LGBTQ+ people (59% compared to 31%) (17).

Further to this, 12% of GBT men reported deliberately harming themselves in the last year, 20% of LGBT women and 41% of non-binary people (17). Over a quarter (28%) of trans people reported self-harming in the past year compared to 14% of non-trans LGB people (17). It is estimated that that about 6% of the general population self-harms in England (17). The same study found that 12% of trans people said they had attempted suicide in the last year, compared to 2% of LGB people who aren't trans (17).

There is more limited evidence related to suicide and self-harm in people with an intersex variation. However, one Australian study found that 26% of people with intersex variations engaged in self-harm (137). The same study reported that 19% had attempted suicide and 60% had considered suicide (137).

Weight

There is a lack of good quality data on weight in LGBTQ+ people. American data suggests sexual minority women have higher rates of obesity than heterosexual sexual women, whereas gay men have broadly similar or lower rates of obesity than heterosexual men. Bisexual men appear, from American nutrition surveys, to have increased rates of obesity than heterosexual men (120).

Eating disorders

A 2018 study reported that 12% of LGBTQ+ people had experienced an eating disorder in the past year, rising to 22% in Black, Asian and other minority ethnic LGBTQ+ people and 24% in non-binary people (17).

Use of PrEP

PrEP (pre-exposure prophylaxis) is a medication taken by HIV negative people to reduce the risk of HIV. PrEP is available free at the point of access in the UK, as part of the aim to eliminate transmission of HIV in the country by 2030 (138). Little evidence has been found on the uptake of PrEP since it became more freely

accessible in England in October 2020. In 2019, almost 30% of men who have sex with men reported that they would be very likely to take PrEP if it were available to them (139). Despite high demand, a 2019 qualitative study of gay and bisexual men suggested that there is a degree of stigma associated with taking PrEP, with the perception that those who do take it are more likely to engage in risky behaviours (140).

For trans people receiving gender-affirming hormone therapy, an on-demand dosing regimen may be less effective at preventing HIV than it is for people not receiving hormone therapy, however, daily dosing appears to be as effective (141). Given the seemingly higher incidence of HIV in transgender women, this has important implications. However, one drug monitoring study found trans people may have worse compliance with the medication than gay and bisexual men (141).

Learning disabilities and neurodiversity

In TGD people, a large cross-sectional data study found increased rates of autism and neurodevelopmental diagnoses, with TGD people between 3 and 6 times as likely to be autistic compared to cis people (142).

Access to and experience of healthcare services

Some LGBTQ+ people report feeling that healthcare services do not meet their requirements as sexual or gender minorities. A third of respondents to the LGBT Foundation Primary Care survey felt that their GP did not meet their needs as an LGBT person (143) and 13% of LGBTQ+ people have reported unequal treatment from healthcare staff because they are LGBTQ+ (17). A further study found that 45% of TGD respondents felt that their GP did not have a good understanding of their needs, increasing to 55% in non-binary people (55). This can lead to TGD individuals avoiding contacting their GP when unwell (55). Further to this, 70% of TGD individuals reported being impacted by transphobia in general health services to some extent (55). The same report found that almost 7 in 10 (69%) of BPOC respondents had been impacted by racism and 74% of disabled TGD people had been impacted by ableism in general health services (55).

A large national survey found that around half of LGB people disclosed their SO to a healthcare professional in the previous 12 months, with fewer bisexual people doing so than LG people (54). A systematic review identified barriers to disclosure including the use of heteronormative language, negative perceived outcomes, and the perception that a healthcare professional would not be accepting (144). Concerningly, 14% of LGBTQ+ people have avoided treatment out of concerns they may face discrimination (17). Gay men are less likely to reveal their sexual orientation in healthcare settings if they feel they may experience homophobia, discrimination or heteronormative attitudes (145)

The national LGBT survey published in 2018 revealed that 40% of trans respondents who had tried to access healthcare had experienced at least one negative experience because of their gender identity whilst trying to access healthcare in the preceding 12 months (54). Around 7% of trans respondents to the same survey felt they had to change their GP due to negative experiences, in comparison to 1% of cis respondents (54).

Regarding health service usage, the English GPPS study data indicates that women from minority sexual orientation groups, use family practitioners less than heterosexual women (128). Conversely, gay men use family practitioners more than heterosexual men (146).

The results of the 2018 National LGBT survey found respondents reported better experience of and access to sexual health services than mental health services (54). However, trans respondents were more likely to report being worried, anxious, or embarrassed about going. Amongst cis respondents, bisexual and asexual respondents were more likely to report feeling worried, anxious, or embarrassed about accessing sexual health services (54).

Trans affirming healthcare

Trans affirming healthcare is any care related to gender-affirming pathways, including social, psychological medical and surgical (147). Many, but not all, TGD people seek trans-affirming healthcare via the NHS or private providers.

There has been a vast increase in the number of referrals to GICs nationally, with a 240% increase in referrals in the five years up until 2018 (148). The current wait time for a first appointment with the London GIC is four years, with people who were first referred in October 2017 currently (as of 28th October 2021) being offered their first appointment, with similar waiting times for other GICs nationally (149). These long waits have resulted in an increased rate of self-medicating and mental health crises (148). Evidence demonstrates improved mental health outcomes, including reduced suicidal ideation, for TGD people who receive gender-affirming surgery (150). With the societal cost of a suicide estimated to be over £1.7m (151), there is a clear economic case for increasing access to GIC and providing support during the wait for treatment.

A recent survey of TGD individuals found that 98% of respondents reported that NHS transition-related healthcare is not completely adequate (55). Trans women and non-binary people were more likely to report that NHS transition-related healthcare was not at all adequate (55). Whilst the reasons for this need further exploration this may be due to the lack of NHS provision of procedures such as facial feminisation surgery and hair transplant, which are often sought by trans women and some non-binary people (55). One third of TGD respondents sought

private healthcare for trans specific healthcare needs, with a greater proportion of trans women and men accessing this compared to non-binary people (55).

Even when accessing trans-specific services, evidence suggests that transphobia still occurs, with one study finding that 7% of respondents had experienced this within such services, increasing to 13% of BPOC individuals (55). Whilst not all non-binary people access trans-specific healthcare, of those who did, the same survey found that 83% had experienced discrimination (55). Further to this, over half (53%) of BPOC who had accessed trans-specific healthcare reported experiencing racism and 60% of disabled people had experienced ableism (55).

Healthcare issues for people with an intersex variation

For people with an intersex variation, there are significant healthcare-associated concerns. Non-emergency surgery in infancy and childhood that may have been undertaken to normalise the bodies of people with intersex variation to binary sex categories cause significant harm (52). Where these happen in infancy, the individual is unable to consent, and so parental consent is required. A European study found that almost half (47%) of study participants were unhappy with their surgical outcomes (52). These procedures can cause pain, incontinence, loss of sexual sensation, infertility and long-term psychological distress (2). Additionally, many people with intersex variation do not identify with the bodies that they have been forced into (52). Whilst such non-emergency surgeries are now categorised as an abuse of human rights by the UN (2), there is currently no law in the UK that prevents unnecessary normalising surgeries.

Further to this, evidence suggests that people with intersex variation feel clinicians fail to consider their views and choices regarding treatment and poor communication between HCPs and parents of and children/young people with intersex variation increases stigma and contributes to psychological distress (52). HCPs lack sufficient knowledge and training to meet the needs of people with intersex variation (52). All of these factors can lead to fear of accessing healthcare services.

Older people

General health, LTCs and disability

Few studies were found that looked specifically at the health of older LGBTQ+ people, with much of the evidence base related to sexual health and use of drugs and alcohol (76). However, there is evidence that older LGBTQ+ people aged 50+ are more likely to rate their health as “poor” than heterosexual people (75). A systematic review in 2020 found that sexual minority men aged 50+ were more

likely to report LTCs and limitations related to health (76). In the same systematic review, sexual minority women aged 50+ had lower self-reported health (76).

Mental health disorders

Few studies were found that looked specifically at the mental health of older sexual and gender minority people. A meta-analysis of almost 95,000 people in the UK found that older LGB adults, aged 55+, have a higher prevalence of poor mental health than heterosexual people, and this was particularly apparent for bisexual people (152). The study hypothesises that this may be attributed to minority stress theory or internalised stigmatisation (152). Research from the LGBT Foundation found that of LGB people aged over 50 in Manchester, just 12% reported never having experienced a mental health issue (44).

Suicide and self-harm

Limited research was found considering the suicide and self-harm risks of older LGBTQ+ adults. Compared to heterosexual men, GB men over the age of 50 have a greater likelihood of having attempted suicide in their life (75). Further to this, in older trans women attending a GIC, one study found non-suicidal self-injury rates were around three times higher than among the general population (76). In bi women, the risk of suicidal ideation has been found to increase with age (76).

Dementia

There is limited available evidence on the experience of being LGBTQ+ with dementia. However, a qualitative study found themes of duality in that LG people with dementia reported feeling similar stigma associated with their diagnosis and their sexuality (153).

Social care, palliative care, end of life care and bereavement

Young people

Experiences of children's services

There is limited evidence of LGBTQ+ people's experience of children's social care and family services. A recent review suggests that gender variance in children is not well understood by social workers (154). A barrier between social care professionals and families often arises because families find themselves educating the professionals about gender variance (154). Further to this, some evidence

suggests that transgender people report experiencing social workers as being actively prejudiced, labelling parental support of a gender diverse child as abuse, and making uninformed judgements around the acceptance of gender variance (154). On the other hand, some trans people report positive relationships with social workers in promoting the best interests of children and young people where gender variance is better understood (154).

Working age adults

Help in the home

As outlined in the 'health, disability and use of services' section of this literature review, LGBTQ+ people may be at greater risk of poorer general health and of some LTCs and as such, these groups may be more likely to require social care at home. There is limited research about the experience of LGBTQ+ people accessing such support. One small study indicated that over half of those surveyed never or only sometimes would disclose their sexual or gender identity to a personal assistant (PA) who supported them in their home (155). Further to this, over a third of respondents reported they had been discriminated against or received poor treatment from a PA because of their sexual or gender identity (155). Additionally, 90% of the respondents reported that their needs as an LGBTQ+ person were not considered or only given limited consideration when their needs were assessed (155). Due to the small sample, it was not possible to consider differences in the experiences of different LGBTQ+ groups.

Older adults

The social networks of some older LGBTQ+ people may be structured quite differently to those of non-LGBTQ+ people, instead perhaps relying on chosen family for practical support, many of whom may also be ageing. This may increase the risk of needing to access formal care, rather than informal care via children for example (76).

Help in the home

A recent review of studies exploring social care support in the home for older LGBTQ+ people outlined that many LGBTQ+ people are afraid of accessing home care for fear of discrimination, often based on past negative experiences with care providers (156). Fear of discrimination often led to concerns about receiving poor quality care (156). As a result, many older LGBTQ+ people do not disclose their sexual identity to care workers, with some going to great efforts to hide anything in their household that may reveal this, leading to anxiety (156).

Whilst this review aimed to include a range of sexual and gender minority identities, the majority of the sample included were LG people, and so there is little evidence related to the experiences of other sexual minorities or TGD people. However, one small international study reported that older trans people expressed anxiety related to personal care assistance for tasks that come with the potential exposure of gendered body parts, such as bathing and dressing (157). Participants also noted the wide range of gender identities and experiences that exist in TGD groups, and that the experience and needs of those who had or hadn't pursued surgery would be quite different, and care staff need to be comfortable with that (157). Some respondents outlined that even providers who were LGB+ affirmative were not necessarily aware or respectful of TGD identities (157).

Residential and nursing home settings

Of respondents to the 2018 National LGBT survey aged 65 or over, 7% of trans people had been in residential, nursing or care facility, compared to less than 1% of cis respondents in the same age group (54). Overall, 72% of respondents aged over 65 who had been in a care home in this period reported being open about being LGBTQ+ with other residents and staff, but this fell to 44% of bi people (54).

Evidence suggests that concerns regarding accessing care later in life, such as fear of loss of autonomy and fear of dying alone, are similar for LGBTQ+ and non-LGBTQ+ people (76). However, these fears may be exacerbated in older LGBTQ+ people due to anticipated or experienced discrimination (158), heteronormative cultures, invisibility and enforced undertaking of new roles and identities (76). The manifestation of these concerns varies- from staff refusal to acknowledge same-gender relationships or differential treatment of partners, concern that entering a care setting will lead to reversal of one's identity (76) or fear of rejection (159). Evidence suggests that almost half of older LGBTQ+ people may feel the need to conceal their identity in care home settings (76). The concerns of older LGBTQ+ people in accessing social care services may lead to these groups being less likely to plan care transitions which may increase the risk of a more stressful and disorganised transition to a formal social care setting later on (76).

Perhaps as a result of these concerns, some studies suggest that the majority of older LGBTQ+ people want specific LGBTQ+ housing provision (76), (160). Although there may be some differences between groups- one study indicated that gay men typically wanted LGBTQ+ specific or affirmative settings and lesbians/gay women tended to opt for more gender-specific settings (161). For those who feel specific provision is important, there are very few LGBTQ+ settings to support these groups as they age and may require residential or nursing care (158).

There is limited specific evidence for bi people in this area, although one small study indicated that some of the concerns about receiving care for bisexual people

are similar to that of lesbians/gay people (162). However, some respondents raised additional concerns about being assumed to be straight if being seen with an opposite-gender partner, or gay if being seen with a same-gender partner, and a greater need to explicitly disclose because of this (162). There were also additional concerns that even in a gay/lesbian affirmative setting, they may experience biphobia (162). The evidence base is similarly limited for TGD groups in this area in the UK. However, one American study reported that 14% of trans people accessing long term support services experienced unequal treatment, verbal or physical abuse from staff due to their gender identity (163). A further small international study of older trans people indicated that some respondents may prefer (or feel it necessary) to access trans specific residential care (157).

Evidence suggests that whilst many care home staff have good intentions, they have inadequate awareness about how to support LGBTQ+ people in care homes (161). In one relatively large study of care home staff in the UK, over 80% of staff reported they would not be embarrassed to talk about LGBTQ+ issues and rejected the notion that same-gender relationships 'are wrong' (164). Almost two thirds of staff surveyed felt that staff should receive training on the needs of LGBTQ+ people, with most respondents noting that no such training was provided in their workplace currently (164). Over half (59%) of respondents stated they were unaware of any LGBTQ+ residents in their workplace (164). Sufficient knowledge of LGBTQ+ issues was a concern for a substantial number of staff with only 70% and 61% of staff feeling they had sufficient knowledge about LGB issues and trans issues respectively (164). A common statement from open-ended survey questions included phrases such as 'we treat them all the same' (164). Whilst such statements may be well-meaning, they reinforce heteronormativity, cisgenderism, which can deny LGBTQ+ residents' identities (164).

Palliative and End of Life Care (EOLC)

Fear of discrimination for some older LGBTQ+ people may lead to a delay or unwillingness to access palliative and EOLC services (165). This can result in increased pressure on informal carers and potentially reduce a person's quality and length of life (165). Actual or expected discrimination in palliative or EOLC settings can come in many forms- with partners not being treated in the same way as heterosexual partners, for example being asked to leave during a consultation (166), inappropriate questioning or forced outing of trans patients (165), or to advanced care planning forms not being distributed by healthcare professionals when caring for LGBTQ+ people (167).

Further to this, as with other types of health and care services, evidence suggests that healthcare professionals often make assumptions about gender or sexual identity and this can have a significant impact on an LGBTQ+ person's experience

of palliative or EOLC (165). LGB+ people are often assumed to be straight and trans people are often referred to by the pronouns associated with the sex they were assigned to at birth, rather than their gender identity (165). These assumptions lead LGBTQ+ people to regularly make decisions about whether to disclose their identity and the level of risk that entails, at a time when they are potentially at their most vulnerable (165). Whilst not disclosing might reduce the risk of discrimination this could lead to a lack of recognition for the most important people in their lives (165). Partners and/or chosen family members may not be recognised in the way the person wants them to be and they may be overlooked in EOLC decision making (159).

The evidence base suggests that LGBTQ+ people have limited knowledge around legal decisions to ensure EOLC decision making is respected (167), (159). Further to this, one study found that only 18.5% of older LGBTQ+ people had written down their preferences for future care. Whilst this is broadly in line with the general population rate, heteronormative and cisnormative conventions may lead to healthcare professionals seeking out people related by blood or heterosexual marriage in the absence of a formally nominated next of kin (3). For some LGBTQ+ people, this may be entirely inappropriate and there may even be an explicit desire for families of origin to not be involved in care and decision making (3). Some evidence suggests that gay men are more likely to have thought about advance care planning than bi men and lesbians/gay women were more likely to have thought about this compared to bi women (168). There are limited subgroup analyses or specific research available in this area focussing on TGD groups. However, one Canadian study found that trans people were 50-70% less likely than LGB+ people to have made formal EOLC preparations, such as in nominating a power of attorney for health and welfare (169).

Additionally, many people with spiritual or religious beliefs wish to access this support towards the end of their lives. There may be additional concerns for religious or spiritual LGBTQ+ people who may find it difficult to access LGBTQ+ affirmative religious or spiritual support (3). Additionally, some LGBTQ+ people may be concerned about accessing hospices affiliated with a particular religion for fear of being treated with hostility (165).

Further to this, for some groups, concerns went beyond EOLC but extended to include anxieties about what would happen to them after death. Evidence suggests that some trans people are concerned about being buried by blood relatives under the gender associated with the sex they were assigned at birth, rather than their gender identity, despite legal protection (3). Further, one study outlines that LGB+ people have concerns that blood relatives may exclude partners or chosen family members from their funerals (3).

Evidence points to a lack of awareness from some mainstream EOLC providers for LGBTQ+ people (76) and that some care providers fail to create LGBTQ+ friendly environments (167). Indeed, research into EOLC for LGBTQ+ people by CQC found a lack of awareness and proactive engagement with LGBTQ+ people by both commissioners and providers (166). Organisations often defended this by stating there were a very low number of LGBTQ+ people in their area, but it is unclear how this was established, due to little formal monitoring of sexual and gender identity (166). Providers need to be aware that previous poor experiences of LGBTQ+ people in accessing health and care may cause a lack of trust in health and social care providers, and this can translate into a suspicion that providers won't carry out their EOLC wishes (159). Good EOLC requires open communication between patient and provider, and this is challenging when LGBTQ+ people expect or experience discrimination, heteronormative or cisnormative assumptions (35).

Bereavement

Bereavement can be particularly difficult for LGBTQ+ people. Where LGBTQ+ relationships aren't acknowledged, the grief associated with the tragic loss of a partner may not be recognised in the usual way or supported (165). This is sometimes known as disenfranchised grief which is defined as 'a mourning process marked by stigma and a lack of social recognition and validation that the bereaved person has suffered a significant loss, and subsequent lack of support' (170). This may heighten or prolong grief and contribute to legal, financial and other stressors (35). Additionally, chosen family members who may be particularly important to an LGBTQ+ person may also experience this additional layer of complexity on top of grief where their close relationships may not be recognised or respected by biological family members or healthcare professionals (167).

It should be noted that most of the evidence base is built on predominantly lesbian or gay samples, with limited subgroup analyses. However, one review revealed an additional vulnerability in gay or bi men who had lost a partner to HIV or AIDS, finding that this group faced an increased risk of depression, suicidal ideation and inadequate support following bereavement (171). Qualitative data drawn from the same review outlined feelings of stigma associated with losing a partner to HIV or AIDS (171). There is a lack of robust evidence into bereavement in other sexual identity minority groups and gender identity minority groups, for whom the issues may be quite different (35).

The impact of COVID-19

COVID-19 and the subsequent restrictions to control the disease may disproportionately adversely impact marginalised groups, including people who

identify as LGBTQ+. As this evidence base is still emerging there is limited research or sub-analysis by age group.

Young people

Home and access to the community

LGBTQ+ youth may be more likely to be hiding their identities from people they are living with or living in an unsafe/unaccepting environment during the pandemic (172). LGB young people who experience high levels of parental rejection are more likely to report high levels of depression and attempt suicide and trans and non-binary young people may experience heightened dysphoria (172). One study found that LGBTQ+ young people report a greater level of tension in the place they are living (25%) compared with non-LGBTQ+ people (15%) (173). This was substantially higher for trans people (29%) (173).

Mental health and wellbeing

One study outlined that loneliness was felt acutely by young LGBTQ+ people during the lockdown, with 67% of under 18s feeling lonely very often or every day, compared to 56% for all LGBTQ+ people (70). Whilst the rate of under 18s rating their mental health as poor or extremely poor before the lockdown was worryingly high, at 43%, this increased to 69% during lockdown (70). In a follow-up survey, 14% of LGBTQ+ people under 18 reported a suicide attempt in the previous 12 months, the highest rate of any age group (174). One study that gathered the experiences of LGBTQ+ people and non-LGBTQ+ people, demonstrated that young LGBTQ+ are twice as likely to worry about their mental health daily and feel lonely compared to non-LGBTQ+ people (173).

Working age adults

Home and access to the community

Stay at home orders and quarantine requirements may be especially challenging for LGBTQ+ people who are not out to their family or whose family have rejected their sexual or gender identity (175). In a national survey, 8% of respondents reported that they did not feel safe where they were staying. This increased substantially for disabled LGBTQ+ people (15%), trans people (17%) and non-binary people (17%) (176). A second survey reported that 15% of respondents reported experiencing abuse or violence during lockdown, with Black and South Asian LGBTQ+ people more than twice as likely to experience this compared to white LGBTQ+ people (70). Additionally, TGD people were almost twice as likely as cis people to experience violence and abuse during lockdown (70). Indeed, the LGBT Foundation's Domestic abuse programme reported an unprecedented increase in

people accessing support from their service and online resources over lockdown (176). LGBTQ+ people experiencing domestic abuse may be further disadvantaged due to a lack of male refuges and refuges that accept trans women (176). Additionally, many LGBTQ+ people living with LGBT-phobic people who have wanted to access confidential support may have struggled to access this from services delivering care solely online or via the phone (176).

Support systems for LGBTQ+ people often differ from heterosexual and cis people, with many people relying on their chosen family, who they may not live with, for practical and emotional support. Requirements restricting access to people from outside their household, along with long periods of non-essential business closure, restricted many LGBTQ+ people from meeting up and accessing community spaces, potential reducing connections to their communities (177). A recent survey outlined that 14% of LGBTQ+ people had not spoken with another LGBTQ+ person in over a month, with this increasing to 25% in asexual people (174). Connection with others in the LGBTQ+ community has been shown to be a mitigating factor for some psychological distress associated with minority stress (177), and some studies suggest these connections may be more effective than traditional mental health support, such as cognitive behavioural therapy (178). The loss of opportunities to connect with other LGBTQ+ people is likely to have adversely impacted mental health and wellbeing.

Further to this, medical quarantine and surveillance can be traumatising to intersex people who may have been subjected to medical testing or procedures without their consent (175).

Mental health and wellbeing

A national survey found that 27% of respondents felt that increased isolation was one of their main worries during the pandemic (176). One survey found that before lockdown 21% of LGBTQ+ respondents felt lonely very often or every day, increasing to 56% during lockdown (70). TGD people reported a bigger increase in loneliness than cis people, and South Asian people reported an almost threefold increase in loneliness (70).

A survey undertaken during the first lockdown found that 79% of LGBTQ+ people reported their mental health had worsened during the lockdown and this disproportionately affected TGD people, as well as black and south Asian LGBTQ+ people (70). A follow-up survey undertaken in March 2021 demonstrated that mental health remains fragile, with rates of depression, anxiety and loneliness worsening slightly (174). One in three respondents reported feeling suicidal and 6% reported a suicide attempt, with TGD people three times as likely to attempt suicide in the previous year than cis people (174). In asexual people, 14% reported

a suicide attempt in the past 12 months, which was the highest for any sexual identity (174). A further study that also demonstrated high levels of poor mental health in LGBTQ+ people during the pandemic found that perceived stress and depressive symptomology was heightened in those who had experienced discrimination compared to those who had not (179).

As outlined in the 'health behaviours' section of this literature review, LGBTQ+ people may be more likely to misuse alcohol or recreational drugs. During the pandemic, 18% of respondents to a national survey were worried that the pandemic would lead to substance or alcohol misuse or trigger a relapse (176). This figure was higher for trans people (22%) and non-binary people (24%).

Disruption to medical care

Access to medical care was disrupted for much of the UK population throughout the pandemic, especially during the first lockdown. One national survey of LGBTQ+ people found that 16% of respondents reported being unable to access healthcare for non-covid related issues, increasing to 22% in people from minority ethnic groups and 26% in disabled people (176). For trans and non-binary people, 27% reported being unable to access healthcare for a non-covid related issue, and 38% of trans and 37% of non-binary respondents had a medical appointment cancelled (176). Even before lockdown waiting times averaged 18 months for a first appointment with a GIC and during the pandemic access has only worsened (176). There was also significant worry in trans people of being unable to access medication (45%) compared to all LGBT respondents (23%), especially with regards to hormone medication (176). Delays to gender-affirming care have the potential to cause significant harm including infection, chronic pain, hormone imbalances, de-transition, as well as depression, anxiety, self-harm, increased dysphoria, suicidal ideation and suicide attempts (175).

Whilst sexual health services continued to run throughout the pandemic, at times this was at a significantly reduced capacity and access varied across the country (176). For the duration of the first lockdown, PEP (post-exposure prophylaxis) was obtainable via A&E and from GUM clinics but only 79% of respondents to a recent sexual health survey were aware this could be obtained from A&E (143). Qualitative feedback suggested that those who did attempt to access this essential medication from A&E felt afraid and ashamed to do so (143). Further to this, PrEP use changed amongst survey respondents during the lockdown, with both daily and event-based use reducing, although most respondents outlined that this was because they weren't having sex (143). However, qualitative feedback suggested that for a small number of respondents still having sex they weren't able to get a refill or had been misinformed that taking this might make COVID-19 worse if they were to contract the virus (143). For the small number of respondents that

continued to take PrEP throughout the first lockdown 100% of these had to pay for these themselves via online providers in between prescriptions (143).

Impact of the virus

GI and SO aren't routinely monitored in the UK and so we will never know whether the virus itself (as opposed to the restrictions) disproportionately impacted LGBTQ+ groups. However, based on the known risk factors for serious illness and death from COVID-19, it may be that LGBTQ+ people were impacted to a greater degree than non-LGBTQ+ people. Some of the LTCs that LGBTQ+ people are more likely to experience may increase the risk of becoming seriously unwell with COVID-19 (180). Further to this, a higher proportion of LGBTQ+ people smoke, which may also increase the risk of adverse outcomes following COVID-19 infection (180). LGBTQ+ people are also more likely to be homeless, and experience poor health associated with homelessness, as well as barriers in accessing care and difficulties in socially distancing or self-isolating effectively (180). Previous surveys have demonstrated that LGBTQ+ people, especially trans and non-binary people, may be more reluctant to access healthcare due to concerns of being discriminated against (180). Due to this, it is possible that LGBTQ+ people experiencing severe COVID-19 symptoms may have delayed or avoided seeking treatment, potentially leading to poorer outcomes (180).

Older people

Home and access to the community

Older LGBTQ+ people are more likely to live alone, and even before the pandemic were at greater risk of experiencing isolation than non-LGBTQ+ people (176). They may also be less likely to access informal intergenerational support, for example, if they do not have children, and may have experienced family rejection (181). During the lockdowns, older LGBTQ+ people may have been cut off from less traditional networks such as their chosen family, and the practical and emotional support that these provide (178). This may be especially problematic for LGBTQ+ people whose support networks are all of a similar age and so may have been subject to the same advice regarding shielding (176). An older LGBTQ+ person survey found that 10% of respondents did not have someone they could call on in an emergency, and this was higher in older people living alone (181).

Further to this, many older LGBTQ+ people, especially single cis gay men, are reliant on organised LGBTQ+ support, and much of this went online during the pandemic (181). Older LGBTQ+ people surveyed outlined the necessity of having or

acquiring IT skills to access online support to help mitigate loneliness and isolation (181).

Mental health and wellbeing

Older LGBTQ+ people experienced a decline in their mental health during the pandemic, with one survey finding that 49% of people reported their mental health was slightly or a lot worse than before the pandemic (181). A second survey outlined that 37% of older LGBTQ+ people felt more lonely than usual and 27% hardly ever or never had someone to talk to (182).

Disruption to medical care

18% of LGBT+ people aged over 50 reported they had been unable to access healthcare for non-COVID-19 related issues during the first lockdown (176).

Impact of the virus

As discussed above, a lack of routine data on SO and GI has resulted in an inability to assess whether LGBTQ+ people have suffered more adverse outcomes as a result of contracting COVID-19. However, older LGBTQ+ people are more likely to have poor self-rated health and LTCs that may increase the risk of adverse outcomes from contracting COVID-19 (176).

Chapter Summary

The literature review outlined a wide range of specific health issues and inequalities in LGBTQ+ people across the life course.

LGBTQ+ young people:

- Experience higher rates of bullying at school than non-LGBTQ+ pupils, with higher rates in GB men and TGD groups.
- Are at increased risk of homelessness.
- Are at high risk of experiencing anti-LGBTQ+ hate crime, compared to other LGBTQ+ age groups, especially young TGD people.
- Have higher rates of smoking, drug and alcohol use compared to non-LGBTQ people. This risk appears to be higher in young bi women.
- Have lower levels of physical activity than non-LGBTQ+ people with TGD groups facing additional barriers to sport and exercise.
- Have poorer mental wellbeing and higher rates of mental health conditions than non-LGBTQ+ people.
- Have a higher prevalence of self-harm risk of suicide, especially in TGD groups.

- May have been disproportionately impacted by the lockdown restrictions due to being more likely to live in an unsafe/unaccepting environment. This may especially be the case for TGD people
- Have experienced high levels of loneliness and mental health deterioration, including increased suicide attempt rates, during the pandemic.

Working age LGBTQ+ people:

- Report high levels of discrimination, bullying and sexual harassment in the workplace and certain groups, such as asexual or TGD people, may be more likely to be unemployed than non-LGBTQ+ people.
- May experience high levels of homelessness, particularly in TGD people who are disabled or from diverse ethnic groups.
- Experience high levels of anti-LGBTQ+ hate crime, especially TGD people, disabled people and those from diverse ethnic groups.
- Some groups, such as those from diverse ethnic groups often feel excluded and experience discrimination from LGBTQ+ spaces.
- Are being offered or subjected to harmful conversion therapy with trans people, Muslims and those from diverse ethnic groups disproportionately affected.
- Are at higher risk of using drugs than non-LGBTQ+ people, especially GB men.
- Have disproportionately high rates of smoking, although the difference between LGB+ smoking rates and heterosexual smoking rates appears to be narrowing.
- Are more likely to drink alcohol excessively than non-LGBTQ+ people, especially GBT men and bi women.
- Are less likely to be sufficiently physically active for good health, compared to non-LGBTQ+ people.
- Have high rates of loneliness and mental health condition prevalence.
- Experience a higher risk of self-harm and suicide, especially amongst TGD people.
- Are more likely to experience some cancers and less likely to attend screening, but the overall cancer incidence rate appears similar between LGBTQ+ and non-LGBTQ+ groups.
- Regularly experience heteronormative and cisnormative assumptions in health and care settings.
- Have experienced high rates of abuse or violence during lockdown, especially those from South Asian backgrounds and TGD people.

Older LGBTQ+ people:

- May be more likely than non-LGBTQ+ people to be single, live alone and less likely to have traditional family structures to rely on for support

- Report poor treatment or discrimination due to age within LGBTQ+ communities.
- Are more likely to drink alcohol daily/almost daily, compared to other LGBTQ+ groups, especially older gay men.
- May be more likely to report being in poor health than non-LGBTQ+ people
- Have a higher prevalence of poor mental health, especially in bi people.
- Experience anxiety in accessing formal care due to anticipated discrimination, cis and heteronormative assumptions. Anxieties may be heightened in TGD people in relation to personal care for tasks with potential exposure to gendered body parts.
- May have been disproportionately impacted during the pandemic restrictions if cut off from less traditional networks such as their chosen family, and the practical and emotional support that these provide.
- Experienced a substantial decline in their mental health during the pandemic and high levels of loneliness.

Chapter six- Local service use and prevalence data

Due to a lack of routine collection of SO and GI data, limited local data sources were available to enable understanding of the prevalence of risk factors and ill health, as well as the use of services by LGBTQ+ people locally. This section is not summarised by life course due to the limited data that could be analysed by age group, as well as small numbers for whom SO or GI were recorded. Where sample size is sufficient and the data obtained allows, some age group analysis has been presented.

Much of the data provided here is descriptive, rather than analytical, due to the lack of a denominator in order to understand if service usage in minority SO/GI groups is greater or lower than we would expect. Further analysis has been conducted where sample size permits. Statistical analysis was conducted on statistical software SPSS and consisted of chi-square tests with z test between proportions and Bonferroni correction where multiple comparisons were being made.

Summary of data sources

The data sources utilised throughout this section are summarised below.

My Health, My School dataset, School Health Service, 2021

Raw data was provided for schools in the county that completed the My Health, My School Survey (MHMS) in the 2020/21 school year. The data was filtered to mainstream secondary schools (which comprised, year 7, year 9 and year 11). Whilst only a small number of schools completed this survey with at least one year group, the total pupils in the sample represent approximately 13% of year 7s, 8s and 9s in East Sussex on the pupil census. The questions asked varied depending on the year group of the child.

Analysis by GI was conducted across all three year groups. There were a very small number of pupils in primary schools who identified as TGD, but these were too small to include whilst enabling fair comparison across the questions.

Table 1: My Health, My School Survey GI breakdown

	Number of pupils	% of pupils
Female	894	45.22%

Male	957	48.41%
Trans	24	1.21%
I would describe my gender in some other way	63	3.19%
I would prefer not to say	39	1.97%
Total	**1977**	**100%**

Pupils that described their gender as other than male or female or prefer not to say were categorised as TGD, whereas those that described their gender as male or female were categorised as cis. 4.4% of pupils were TGD according to this method. However, it should be noted that trans binary pupils may have described themselves as either female or male rather than trans and there wasn't an additional question related to whether gender identity was the same as or aligned to sex assigned at birth to unpick this. The TGD proportion therefore could be an under-representation.

For analysis by SO, only the data for year 9 and year 11 pupils were included, as year 7s weren't asked a question on their sexual identity. SO is outlined below:

Table 2: My Health, My School Survey SO breakdown

	Number of pupils	**% of pupils**
Heterosexual	828	75.20%
Bi	134	12.17%
Gay/Lesbian	39	3.54%
I would describe my sexual identity in some other way	100	9.08%
Grand Total	**1101**	**100%**

To enable more robust analysis within most questions, any pupil who described their SO as a minority (gay/lesbian, bi, describe in some other way), was coded as

LGB+. One quarter of pupils in years 9 and 11 identified as LGB+. It should be noted that 93% (n=39) of TGD pupils in years 9 and 11 also identified as LGB+.

The sample size of LGB+ pupils from Black, Asian and other minority ethnic groups was fairly small, at 42. Some questions have been analysed at this broad grouping level and for questions where more data is available, this has been analysed by the ethnic groups provided in the dataset (Black, Asian, Mixed, Other, White), noting where the numbers are very small.

As with most surveys where response rates are low, there is a risk of volunteer bias, whereby those that take part are not representative of the wider population. In this case, it may be that the schools that took part are not representative of most schools in East Sussex. There is also a risk of recall bias, for example, for questions asking about frequency of physical activity. Additionally, there may be some reluctance by pupils to answer some questions honestly, for example around sexual activity. Finally, the surveys were administered at different times of the year, with most surveys being administered in terms five or six and a smaller proportion being administered in terms one or two. This is important to note as responses given at the start of the year for some questions may have been very different to responses given at the end when children/young people will have had additional time in school following the introduction of statutory Relationships, Sex and Health education. These limitations should be kept in mind when reading the analysis.

East Sussex County Council community survey, Public health department, (2019)

East Sussex County Council commissioned Ipsos MORI to conduct its 2019/20 Community Survey, to gain insights into residents' perceptions across a range of measures, such as views of the local area, mental wellbeing and attitudes towards public services. A random sample of residents was selected, stratified by Lower Super Output Area (LSOA). This method aimed to ensure a representative geographic spread. The response rate was 30.5%, a higher rate than for many similar surveys but there is still a risk of volunteer bias, with those completing the survey potentially differing systematically from those who received it but did not complete it. Survey data were therefore weighted by factors such as age, gender and working status. Statistical summaries of differences between different population groups were provided from the 2019 survey.

LGB people comprised 3.5% of the sample for the SO question (n=422), with a further 3.5% (n=420) identifying as a sexual minority other than LGB.

GP Patient Survey, Ipsos MORI, 2021

The GP Patient Survey (GPPS) is an annual, nationally run survey that asks patients about their experience of General Practice.

The programme utilises a probability sampling method, with patients being randomly selected from GP registers. This enables a more robust comparison of LGBTQ+ people compared to non-LGBTQ+ people who completed the survey. Although, it should be noted that as with any survey there is a risk of selection bias, whereby those that are invited that choose to respond may differ systematically from those who do not respond. Raw data for the questions and variables of interest were provided by Ipsos MORI, who are commissioned to run the survey. The data were weighted using their standard methods.

The sample by SO and GI are outlined in the table below:

Table 3: GPPS sample by SO and GI

	Cis number (%)	**TGD** number (%)	**Prefer not to say/unknown** number (%)	**Total**
Heterosexual	6800 (99.5%)	20 (0.3%)	16 (0.2%)	6836
Gay or lesbian	126 (96.9%)	4 (3.1%)	0 (0%)	130
Bisexual	96 (88.9%)	9 (8.3%)	3 (2.8%)	108
Other	38 (92.7%)	2 (4.9%)	1 (2.4%)	41
Prefer not to say	176 (84.6%)	6 (2.9%)	26 (12.5%)	208
Total	**7236 (98.8%)**	**41 (0.6%)**	**46 (0.6%)**	**7323**

For some analysis, lesbian/gay, bisexual and other groups were combined to create an LGB+ group. This group (n=279) comprised approximately 3.8% of the sample.

A TGD group was created based on those who described themselves as non-binary (n=7) or preferred to self-describe (n=3) or those who had noted that their gender identity differed from the sex they were assigned at birth (n=31). This group (n=41) comprised approximately 0.6% of the sample.

LGB+ respondents were more likely to be between 16 and 35 years of age. Heterosexual respondents were more likely to be 55-84, with similar numbers of LGB+ and heterosexual respondents aged between 45 and 54 or over 85. TGD respondents were more likely to be 25-34 years of age, but there was a more even spread across other age groups between cis and TGD respondents.

Homelessness applications and duties, UK government website, 2020/21

Lower tier local authority housing departments are required to submit data to the government on the number of applications and duties relating to homelessness and this includes some protected characteristics data. The summary tables of the applications/duties are available on the UK government website and were extracted for analysis. There were some reporting gaps in the SO data provided by some of the local departments and the data available suggests possible recording issues. The data provided may not, therefore, be an accurate reflection of the SO of those interacting with the housing departments.

Hate Crimes motivated by GI or SO (2017-2021), Sussex Police

Sussex Police provided data related to the number of hate crimes (relating to SO and GI) reported to them between 2017 and 2021, as well as some additional analysis of the types of crimes, victim demographics and location of crimes between 2019 and 2021. It should be noted that, as outlined in the literature review, many hate crimes of this nature go unreported, and so this only provides information about the number, trend and types of crimes that have been reported to the Police.

Substance misuse treatment and outcomes, CGL, 2021

Data was provided by CGL, the local substance misuse provider, via the ESCC commissioning team. This data included activity for 2020/21 by SO for service users discharged during this financial year. The dataset also included the type of substance the service user was seeking treatment for and the outcome of treatment. However, the number of those who identified as LGB+ were very small (n=31), which means we cannot draw firm conclusions about the meaning of the data.

Mental health services dataset, SPFT, 2019-2021

Sussex Partnership Foundation Trust (SPFT) provide a range of mental health services to residents of East Sussex. Data provided by SPFT outlines the activity for a range of services and activity attributed by SO. Of services (excluding IAPT)

provided to East Sussex residents in 2019/20, 32% of contacts (rather than unique individuals) had an SO recorded, with 63% not having an SO recorded and the remaining (5%) unsure, asked but declined to respond or preferred not to say.

IAPT services dataset, SPFT, 2017-2021

Improving Access to Psychological Therapies (IAPT) services are provided by SPFT in East Sussex and use evidence-based psychological therapies with people with anxiety disorders and depression. Between 2017/18 and 2021/22 to date, 62% of IAPT referrals had an SO recorded, 33% did not have an SO recorded, with a further 4% who were asked but declined to answer and 1% who were unsure. There are therefore reasonably high numbers of people from LGB+ groups to enable analysis of differences in referral rates and outcomes.

ESHT sexual health service activity, ESHT, 2017-2021

East Sussex Healthcare Trust (ESHT) provide a wide range of sexual health services locally including family planning, GUM clinics, HIV and psychosexual services. Activity data (based on attendances rather than unique individuals) was provided to outline service usage by SO group. Over five years, approximately 99% of activity had an SO recorded, enabling robust analysis.

Online STI testing activity and positivity, Preventx, 2017-2021

Preventx provides online sexual health testing in East Sussex, including by SO and GI. Activity data was provided from 01 April 2017- 30th September 2021. It should be noted that the SO groups were comprised almost entirely (99.9%) of cis service users as very few of the TGD service users had an SO recorded. This is because up until May 2021 SO was determined internally by service user gender and the gender of their sexual partner(s). Since May 2021 this question has been specifically asked of service users. This limitation means that SO is based on behaviour reported to the service rather than self-reported identity. Activity was coded as belonging to a TGD service user if the sex category had been assigned as non-binary or trans or other, to enable a sufficient sample size for analysis. The number of TGD services users was small across this period (n=100). It is unclear if this is due to this data not always being captured or potential under use of services by TGD groups.

Bespoke survey to Brighton LGBTQ+ and TNBI organisations, LGBT Switchboard, 2021

A short survey was designed and disseminated by LGBT Switchboard to other LGBTQ+ and TNBI organisations based in Brighton. This survey aimed to determine

the proportion of service use by East Sussex residents and some of the reasons behind this.

Long term support service use equalities report, ESCC Adult Social Care, 2020/21

This data source provides detail as to the proportion of people receiving a form of long-term support (LTS) with an SO recorded and the details of this. The report also pulls together findings of the proportion of people who completed an about you form with regards to SO and GI.

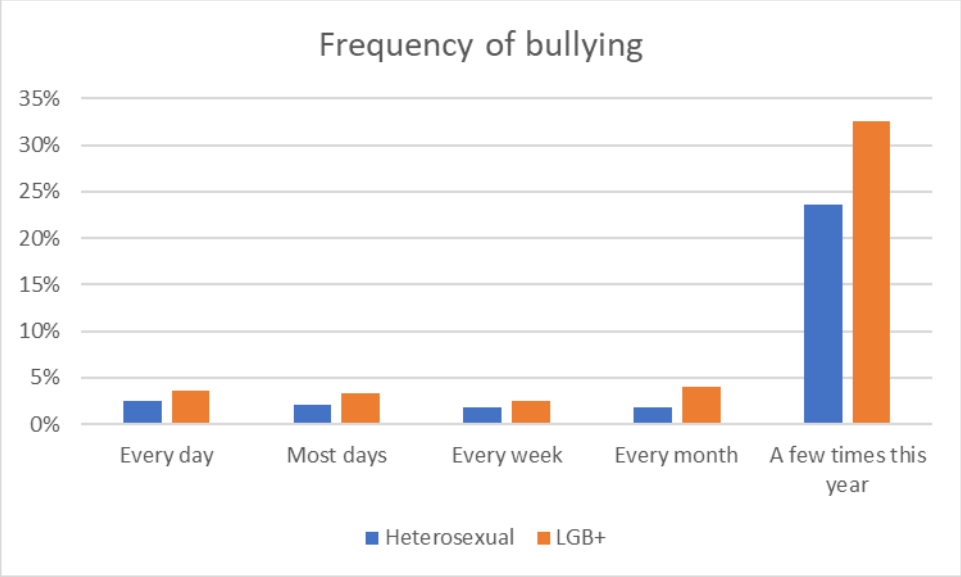
Wider determinants of health

Education

Bullying

According to the MHMS survey, almost half of LGB+ pupils (46%) reported experiencing some bullying in the past 12 months compared to heterosexual pupils (32%) and this was a significant difference ($p<.05$). The frequency of bullying by SO group is outlined below:

Figure 5: Frequency of bullying by SO group



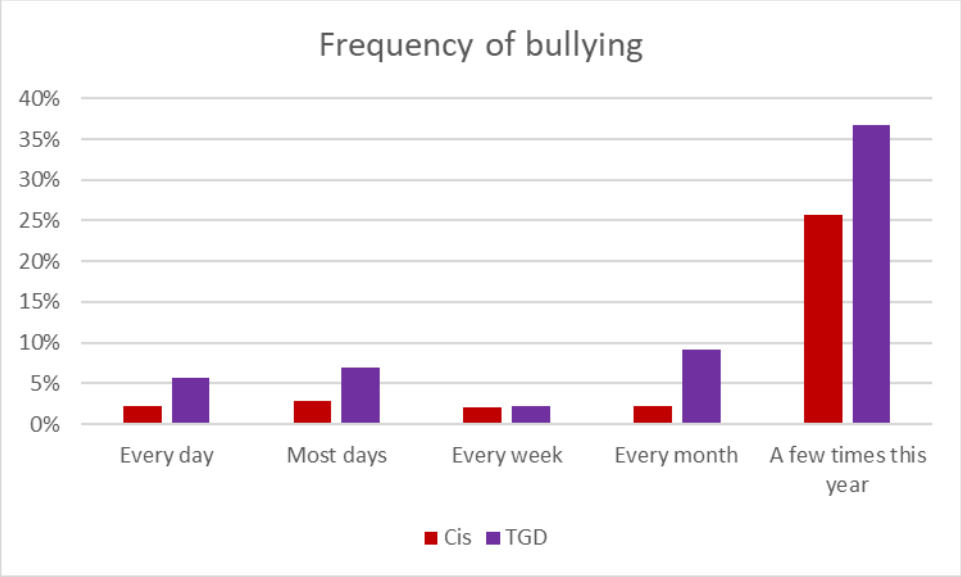
Source: MHMS survey, 2021

Further to this, LGB+ pupils who are disabled were more likely to report experiencing some bullying in the past 12 months compared to LGB+ pupils who weren't disabled (58% compared to 43%, $p<.05$). Whilst no significant differences were found between groups, likely due to small numbers, 80% (n=4) of Black LGB+ pupils and 60% of mixed race LGB+ pupils reported experiencing some bullying in the past 12 months, compared to 47% of White pupils and 33% of Asian LGB+ pupils.

Of those LGB+ pupils that reported being bullied, 46% stated this was HBT bullying. Unsurprisingly, a greater proportion of LGB+ pupils reported worrying about being bullied compared to heterosexual pupils (21% compared to 12%). When asked how good their school was at dealing with homophobic bullying, 50% of LGB+ students stated this was poor or very poor.

The rate of bullying was even higher in TGD pupils with 61% reporting experiencing some frequency of bullying in the past 12 months, compared to 35% of cis pupils ($p<.05$). The frequency of bullying for these pupils is outlined below:

Figure 6:Frequency of bullying by GI group



Source: MHMS survey, 2021

A greater proportion of disabled TGD pupils reported experiencing some bullying (72%) compared to TGD pupils without a disability (53%), but this was not found to be statistically significant (p>.05). A greater proportion of TGD pupils from Black, Asian and other minority ethnic backgrounds also reported experiencing some bullying in the past 12 months compared to White TGD pupils (69% compared to 60%) but this was not found to be statistically significant (p>.05).

Of TGD pupils who reported being bullied, 64% reported this was HBT bullying. Over one third of TGD pupils (36%) reported worrying about being bullied compared to cis pupils (15%).

Learning

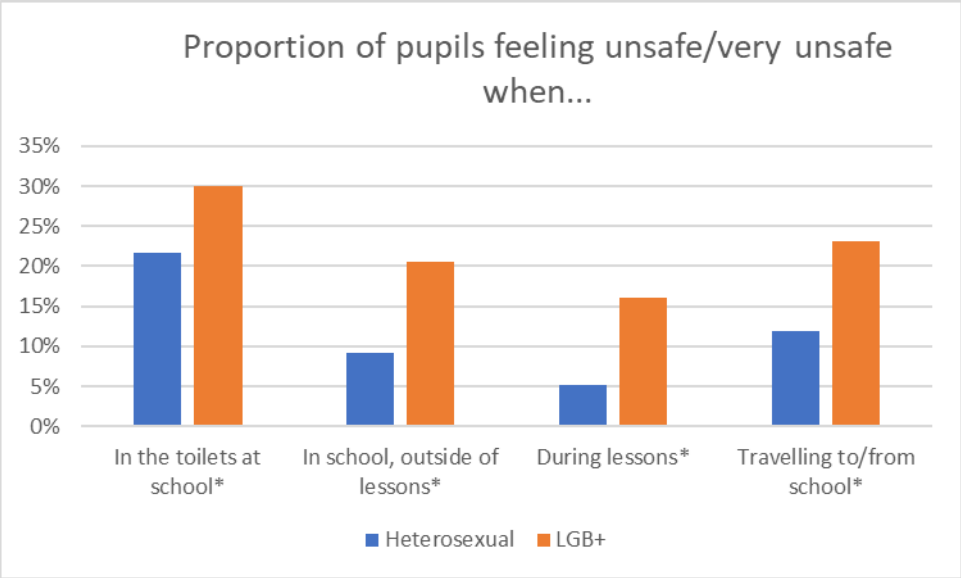
Over one third of TGD pupils (37%) felt they needed better information from schools about different types of families, compared to 28% of cis pupils (although this difference wasn't statistically significant). Similarly, 37% of LGB+ pupils felt they needed better information of this topic, compared to 28% of heterosexual pupils (p<.05).

However, there was less of a difference in whether LGB+ pupils felt they had sufficient information about sex and relationships, with 25% of LGB+ pupils stating they needed better information, compared to 22% of heterosexual pupils.

Safety at school

LGB+ pupils consistently felt less safe than their heterosexual counterparts in and around school, as outlined below:

Figure 7: Pupils feeling unsafe/very unsafe in and around school by SO group

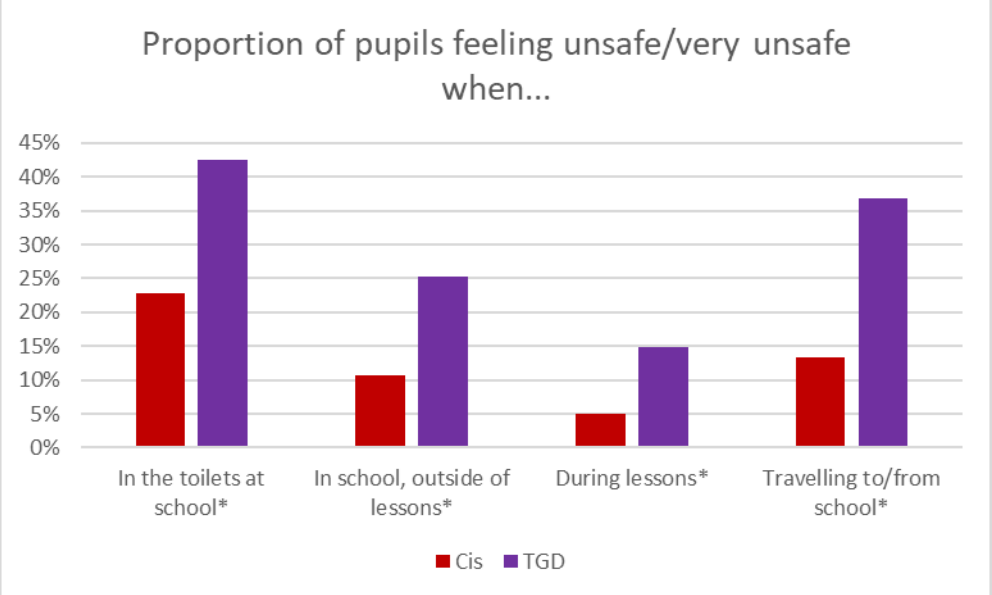


*Source: MHMS survey, 2021. *= Difference is significant at the p<.05 level.*

Further to this, although the numbers were small, 80% (n=4) of Black LGB+ pupils felt unsafe or very unsafe when travelling to/from school compared to 21% of White LGB+ pupils (p<.05) and 80% (n=4) of Black LGB+ pupils reported feeling unsafe/very unsafe in school toilets, compared to 30% of White LGB+ pupils (p<.05).

These differences in feelings of safety were even more pronounced when comparing TGD and cis pupils, as shown below:

Figure 8: Pupils feeling unsafe/very unsafe in and around school by GI group



*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level.*

Qualifications

The ESCC Public Health commissioned community survey from 2019, indicates that LGB+ residents were more likely to have a bachelor's degree or higher degree than the average East Sussex resident (45% compared to 34%).

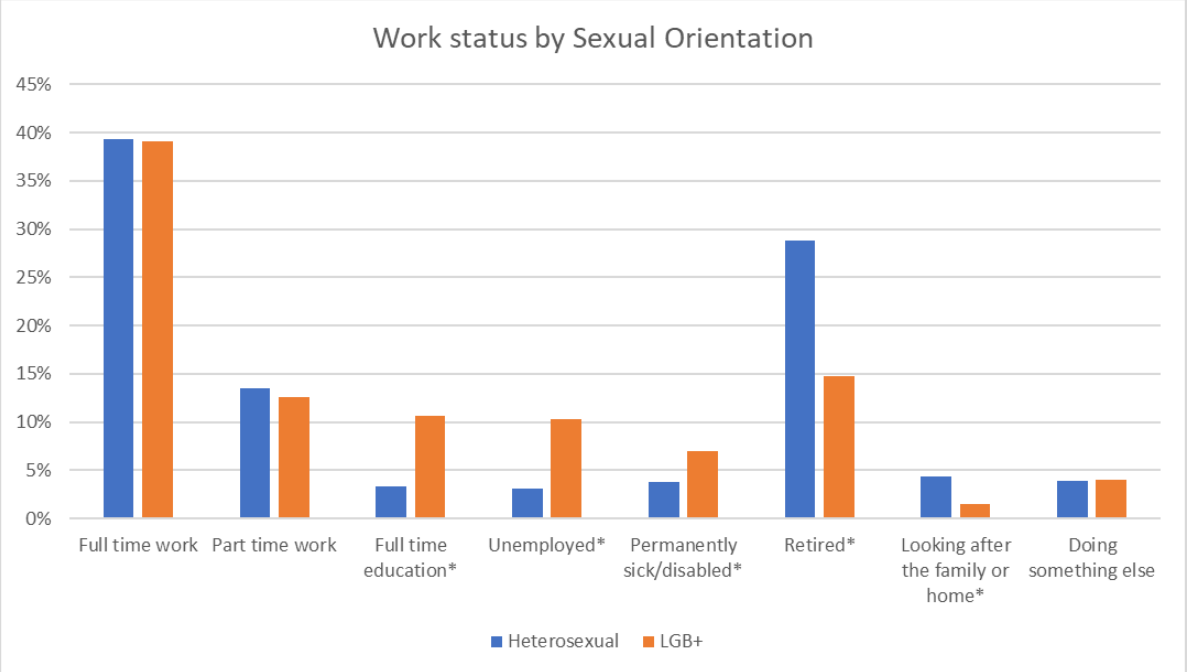
From Spring 2022, Census 2021 data should be available to enable an analysis of qualifications held by SO and GI groups in East Sussex.

Employment

The 2019 community survey found that a greater proportion of LGB+ people were working (67%) compared with heterosexual people (55%), however over three times the proportion of LGB+ people were unemployed and available for work (7%) compared to heterosexual people (2%).

The GP Patient Survey 2021 (GPPS) provides some insight into the employment status of LGBTQ+ people locally. The work status of LGB+ respondents compared to heterosexual respondents is outlined in the figure below:

Figure 9: Work status by SO



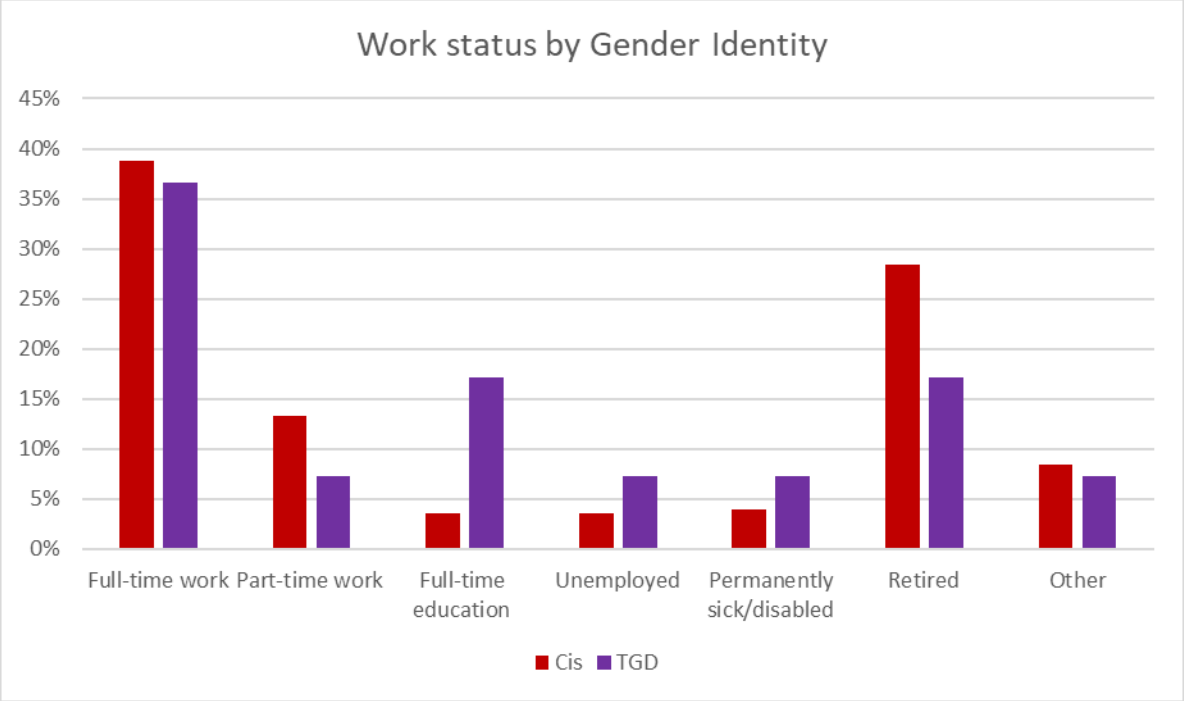
*Source: GPPS 2021 data, IPSOS MORI. *= Difference is significant at the p<.05 level.*

This data hasn't been adjusted for age differences amongst groups, which may explain some of the differences in work status. However, it is interesting to note the greater proportion of LGB+ people who are unemployed or permanently

sick/disabled and these differences were found to be statistically significant in both cases ($p<.05$).

With regards to TGD groups, a similar pattern can be seen:

Figure 10: Work status by GI- GPPS 2021



Source: GPPS 2021 data, IPSOS MORI

Due to small sample sizes within some of the categories for TGD groups, this data was not tested for significance. Caution must be taken in interpreting this data due to this, and the fact that this hasn't been adjusted for age. However, it is noteworthy that a greater proportion of TGD people are unemployed or permanently sick/disabled, as this is in keeping with the community survey findings and the literature review.

From Spring 2022, Census 2021 data should be available to enable an analysis of employment status by SO and GI groups in East Sussex.

Housing

Limited data are available to indicate any inequalities in housing status between LGBTQ+ groups and cis and heterosexual groups. Some data exists and is routinely collected about the lead applicant of households owed a homelessness duty by the council. Table four outlines 2020/21 data for the five localities in East Sussex:

Table 4: Applicants owed a homelessness duty by the council by SO, 2020/21

	Straight	Gay/ Lesbian	Other	Prefer not to say	Not known
Wealden	85.7%	3.4%	3.6%	7.4%	0.0%

Rother*	90.3%	1.7%	2.7%	5.4%	0.0%
Hastings	48.7%	1.5%	30.0%	19.8%	0.0%
Eastbourne*	34.0%	2.1%	0.8%	55.9%	7.2%
Lewes*	33.7%	1.2%	2.4%	41.0%	21.7%
East Sussex total	**59.3%**	**2.0%**	**14.2%**	**22.4%**	**2.1%**
South East	**69.9%**	**1.4%**	**3.3%**	**24.5%**	**0.9%**
England	**69.0%**	**1.5%**	**2.7%**	**23.0%**	**3.8%**

Source: Live tables on homelessness - GOV.UK (www.gov.uk),

** Please note Eastbourne and Rother percentages are based on the data for quarters 1-3, as quarter 4 data was unavailable and Lewes only includes quarter 1 data as no further SO data was submitted in 2020/21*

Compared to both the South East and England, East Sussex had a slightly greater proportion of applicants recorded as gay/lesbian (2% compared to 1.4% for the South East and 1.5% for England). The highest rate locally was Wealden, with 3.4% of applicants recorded as gay or lesbian. Additionally, East Sussex had a much larger proportion of applicants coded as 'other' sexual orientation, at 14.2%, compared to 3.3% in the South East and 2.7% in England. This also varied substantially between local areas, with 30% of applicants in Hastings recorded as 'other' sexual orientation compared to 0.8% in Eastbourne. Over one fifth of applicants are recorded as 'prefer not to say' in East Sussex, similar levels to the South East and England average. However, given the substantial variation in the proportion of people who are assigned 'prefer not to say' between local areas (5% in Rother to 56% in Eastbourne), it may be that this question isn't routinely being asked in all areas, but applicants are being coded in this way.

With regards to GI, limited data were available for most areas in this period. Hastings reported that three applicants were coded as 'other gender/gender not known' (0.3%) and Wealden reported that two applicants were coded as 'other gender/gender not known' (0.4%).

From Spring 2022, Census 2021 data should be available to enable an analysis of housing tenure, housing type, overcrowding and home ownership by SO and GI groups in East Sussex.

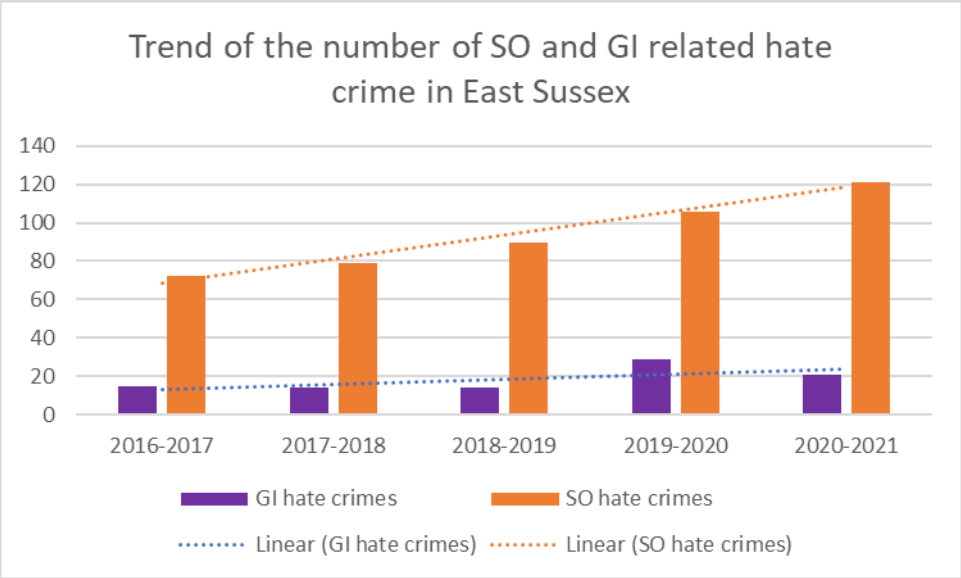
Deprivation

From Spring 2022, Census 2021 data should be available to enable an analysis of deprivation by SO and GI groups in East Sussex.

Hate crime

Hate crime that is motivated by GI or SO appears to be on the rise, with an increase of 40% in GI motivated hate crime in East Sussex over the last five years, and a 68% increase in hate crimes motivated by SO, based on crude figures. This is outlined below:

Figure 11: Hate crimes related to SO and GI reported to the Police in East Sussex over five years



Source: Hate Crimes motivated by GI or SO, Sussex Police database

This apparent increase is in keeping with national data which suggests that hate crimes related to SO and GI reported to the Police are increasing.

Tables five and six provide a breakdown of the crude number of hate crimes by GI and SO within each area of East Sussex.

Table 5: Hate crimes motivated by GI reported to Sussex Police

	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	Total
Eastbourne	7	8	3	13	7	38
Hastings	3	4	6	7	2	22
Lewes	1	1	2	1	4	9
Rother	1	0	0	2	6	9
Wealden	3	1	3	6	2	15
Total	**15**	**14**	**14**	**29**	**21**	**93**

Source: Hate Crimes motivated by GI or SO, Sussex Police database

Table 6: Hate crimes motivated by SO reported to Sussex Police

	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	Total
Eastbourne	22	28	27	36	31	144
Hastings	13	15	26	25	32	111
Lewes	17	21	16	16	16	86
Rother	5	7	5	14	22	53
Wealden	15	8	16	15	20	74
Total	72	79	90	106	121	**468**

Source: Hate Crimes motivated by GI or SO, Sussex Police database

Please note that some of the same crimes may be included in both tables, for crimes related to both GI and SO. The highest crude number of hate crimes related to GI and SO occurred in Eastbourne. Although it should be noted that the population sizes of these areas vary, and these figures have not been converted to a rate due to the unknown denominator of LGBTQ+ people living in these areas.

Sussex Police also provided some more detailed analysis on these hate crimes during the period 01 April 2019 to 31 August 2021.

During this period, there were 62 GI motivated hate crimes. Key findings of the analysis are as follows:

- The most common victim age group were people aged 25-59s (46%), followed by people under 25 years old (43%) and people over 60 (11%).
- The most common offender/victim relationship was acquaintance (48%), followed by a stranger (44%), ex-partner (4%) and family (4%)
- The most common location of these hate crimes was on a street/road, followed by a house.
- The most common hate crime types were public fear, alarm or distress (31%), followed by malicious communications (18%), harassment (15%), assault without injury (13%), and actual bodily harm and another injury (13%).

Further to this, there were 309 hate crimes motivated by SO recorded during the same period. Key findings of the analysis are as follows:

- The most common victim age group was people aged 25-59 years old (70%), young people aged under 25 (20%), and people aged over 60 (10%).
- The most common victim/offender relationship was stranger (52%), followed by an acquaintance (39%), family member (2%), workmate (2%), ex-partner

(1%), intimate (1%), friend (1%) and other (1%). (These figures don't add up to 100% due to rounding.)
- The most common location of these hate crimes was on a street/road, followed by a house, flat, pavement, or park or garden.
- The most common hate crime types were public fear, alarm or distress (37%), malicious communications (15%), assault without injury (11%), and harassment (8%).

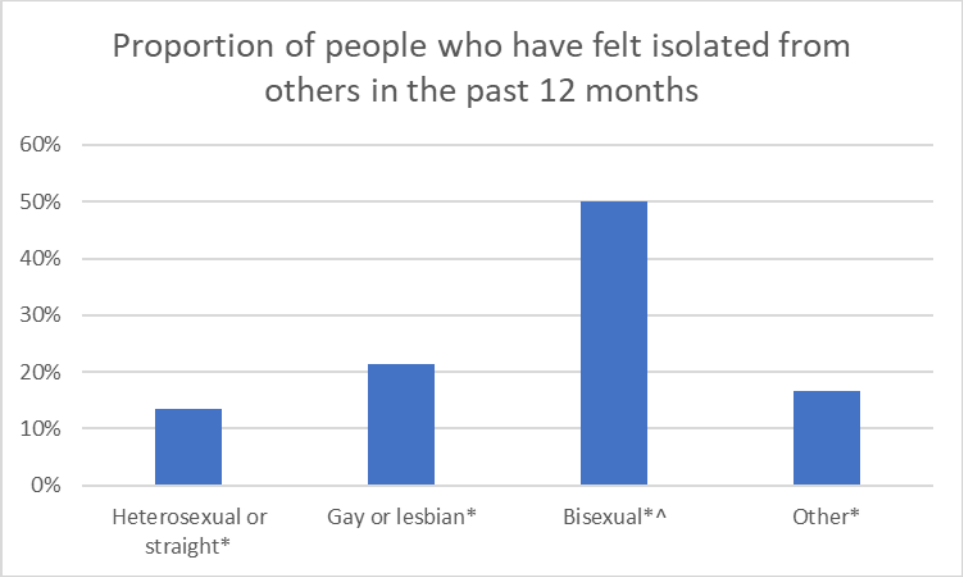
As discussed in the literature review section of this report and the survey findings, only a small proportion of hate crimes are reported to the Police, and so the issue is likely much larger than this data suggests. It does however provide some useful insight as to the overall trends of such incidents and the types of crimes committed.

Isolation, loneliness and social support

The East Sussex community survey from 2019 highlighted that almost half of LGB+ people (48%) felt disconnected from their immediate neighbourhoods, with only 31% of heterosexual people reporting this. Further to this, LGB+ people were also more likely to report struggling to see their friends and family as much as they would like to (38% compared to 31% of heterosexual people). Finally, the same report found that 10% of LGB+ people felt lonely often, compared to 4% of heterosexual people.

The GPPS collects data on whether a person has felt isolated from other people over the past 12 months. Almost one third (32%) of LGB+ respondents reported feeling isolated from others compared to 14% of heterosexual people and this was statistically significant ($p<.05$). Differences were also noted between SO groups with bisexual people more likely to report this than any other SO group ($p<.05$):

Figure 12: Proportion of people who have felt isolated from others in the past 12 months by SO group

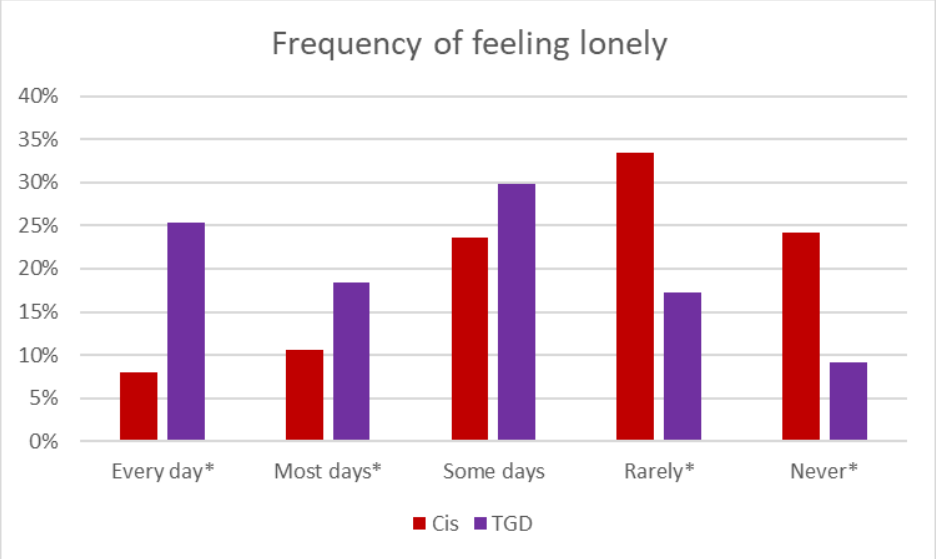


*Source: GPPS 2021 data, IPSOS MORI. *= Difference is significant at the p<.05 level. ^=difference between bisexual group and all other SO groups at the p<.05 level.*

Additionally, the same survey found that 24% of TGD respondents reported feeling isolated from others compared to 14% of cis respondents, although this wasn't found to be statistically significant, but this may be due to a far smaller sample size in the TGD group (p>.05).

In school pupils, feeling lonely every day or most days was much more prevalent in TGD pupils compared to cis pupils, as outlined below:

Figure 13: Frequency of feeling lonely by GI group

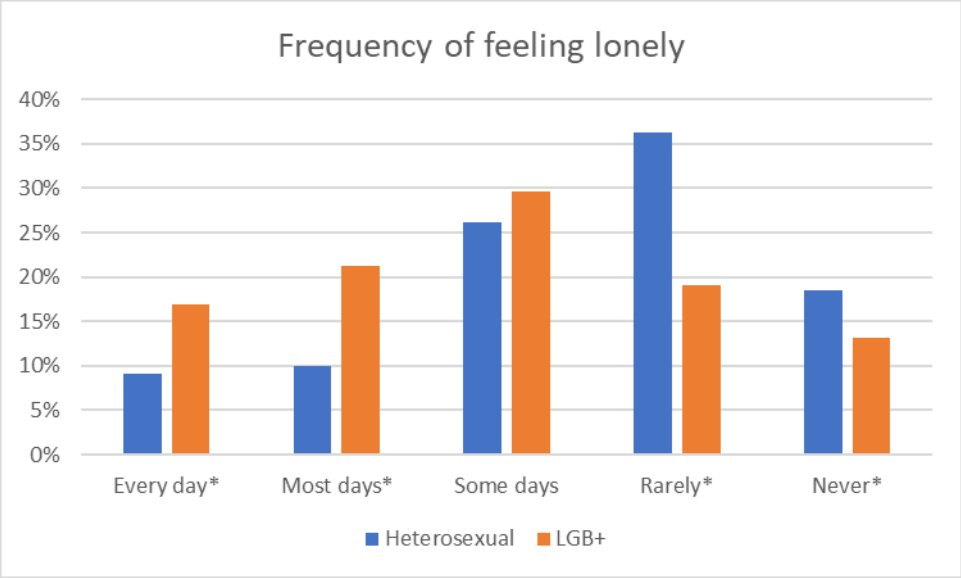


*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level*

Additionally, TGD pupils were more likely to report not coping well with loneliness (47%) compared to cis pupils (21%).

A similar, although less pronounced, pattern was seen in LGB+ pupils compared to heterosexual pupils:

Figure 14: Frequency of feeling lonely by SO group



*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level*

When considering the proportion of pupils feeling lonely every or most days mixed race students were significantly more likely to report this than White pupils (67% compared to 38%, p<.05). LGB+ pupils were also more likely to report not coping well with their loneliness (32%) compared to heterosexual pupils (19%).

A greater proportion of LGB+ pupils felt they couldn't talk to a parent or family member if they were worried about something compared to heterosexual pupils (32% compared to 17%, p<.05). Although no statistical significance was found, a greater proportion of Asian LGB+ pupils (47%) and Black LGB+ pupils (60%, n=3) felt they couldn't talk to a parent or family member if they were worried about something compared to 32% of White LGB+ pupils (p>.05).

For TGD pupils, 27% felt they couldn't talk to parent or family member if they were worried about something compared to 17% of cis pupils (p<.05). Additionally, LGB+ pupils were less likely to feel they could talk to other adults than heterosexual pupils (62% compared to 47%, p<.05). There was no difference for TGD pupils. The proportion of pupils who felt they could talk to adults at their school if they were worried about something was low across all SO and GI groups.

Health behaviours

Substance misuse

The MHMS survey provides data on the use of alcohol and drugs amongst school pupils. Over one third (36%) of pupils in years 9 and 11 reported that they had been drunk at least once, and this was similar across LGB+ and heterosexual groups, and cis and TGD groups. Additionally, 14% of year 9/year 11 pupils reported having used drugs at least once, increasing to 16.5% in LGB+ pupils, although this was not statistically significant (p>.05). Whilst overall use of psychoactive substances was small across the sample, a significantly greater proportion of LGB+ pupils had used these compared to heterosexual pupils (8.6%, compared to 4.5%, p<.05). There were no differences between year 9/year 11 cis and TGD pupils reported drug use.

During 2020/21, 75% of service users of the local substance misuse service who were discharged during this period had an SO recorded. Of those with an SO recorded, 96% (n=689) were heterosexual, 2.4% gay or lesbian (n=17), 1.8% bisexual (n=13), and 0.1% recorded as another sexual orientation (n=1).

The type of drug these groups were receiving treatment for varied, as outlined below:

Table 7: Type of drug by SO group for service users discharged during 2020/21

Type of drug	Heterosexual	Lesbian/gay	Bisexual
Alcohol unspecified	56%	88%	31%
Heroin illicit	17%	0%	46%

Cocaine	11%	0%	8%
Cannabis	8%	0%	8%
Cocaine Freebase (crack)	4%	0%	0%
Methamphetamine	0%	6%	0%
Amphetamine Sulphate	0%	0%	8%
Other opiates	2%	0%	0%
Others	1%	6%	0%

Source: Substance misuse service activity data, CGL

Lesbian/gay people were most likely to be being treated for alcohol addiction, with bi people most likely to be treated for heroin use. However, the numbers in these groups are very small, and so should be interpreted cautiously.

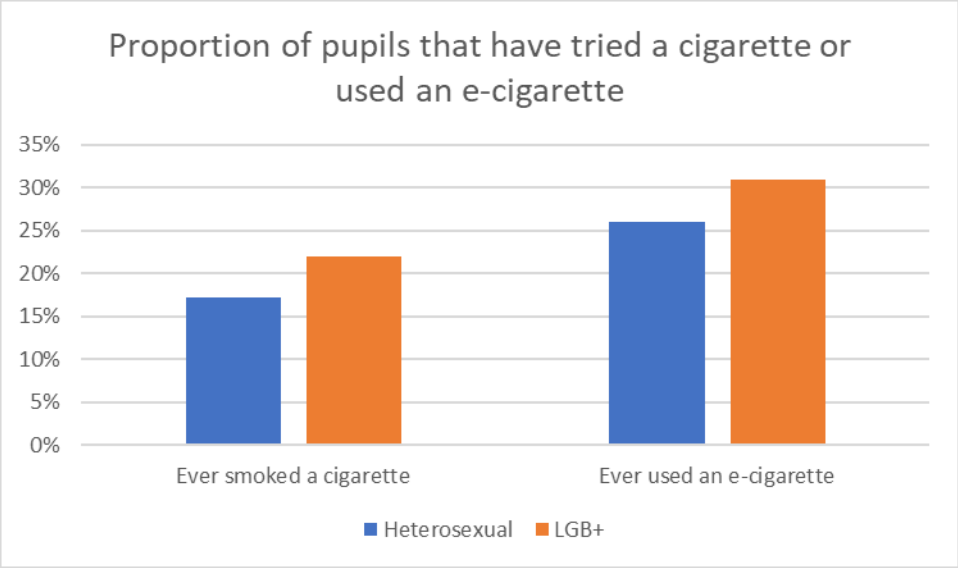
In terms of treatment outcomes, bisexual people were the least likely group to complete treatment (31%) compared to heterosexuals (37%) and gay or lesbian people (41%). However, it is likely that the type of drugs that the different SO groups were seeking treatment for would confound that finding, and due to small numbers, it is not possible to analyse treatment outcomes by drug for each SO group.

The number of those from a sexual minority in this dataset were very small, and so drawing conclusions about differences in types of drugs used and outcomes in treatment are difficult. Seemingly notable differences may well be due to chance, but the data available suggests that routine monitoring going forwards may be useful to ascertain whether there are any meaningful differences in substances people are seeking help for and outcomes.

Smoking

With regards to smoking in younger people, a slightly greater proportion of LGB+ pupils reported smoking a cigarette and e-cigarette compared with heterosexual pupils. However, there were no statistically significant differences between groups ($p>.05$).

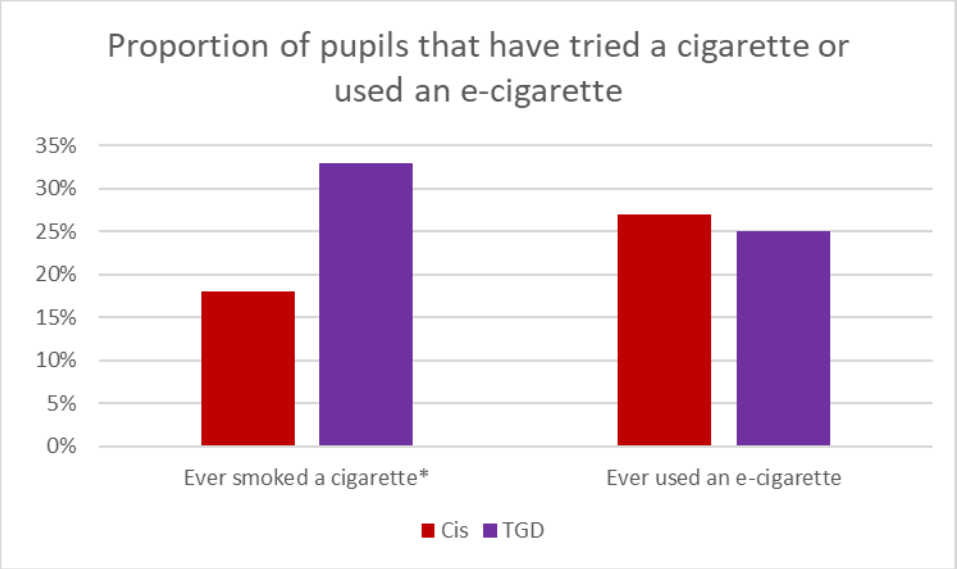
Figure 15: Proportion of people that have tried a cigarette or used an e-cigarette by SO group



*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level.*

One third (33%) of TGD pupils in year 9 and 11 reported having tried a cigarette, compared to 18% of cis pupils and this was a significant finding (p<.05). There was no significant difference between the proportion of cis and TGD pupils who had used an e-cigarette:

Figure 16: Proportion of people that have tried a cigarette or used an e-cigarette by GI group

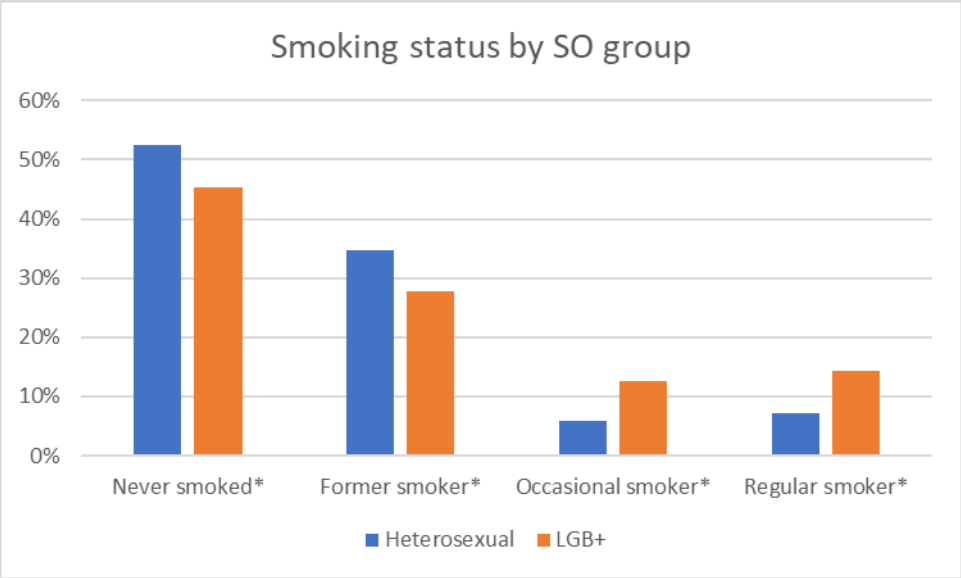


*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level.*

Most people who reported trying a cigarette used to smoke, smoke irregularly or have just tried a cigarette once, rather than being regular smokers, and there were no discernible differences between groups.

With regards to adults, smoking rates between SO groups varied, as outlined below:

Figure 17: Smoking status by SO group



*Source: GPPS 2021 data, IPSOS MORI. *= Difference is significant at the p<.05 level*

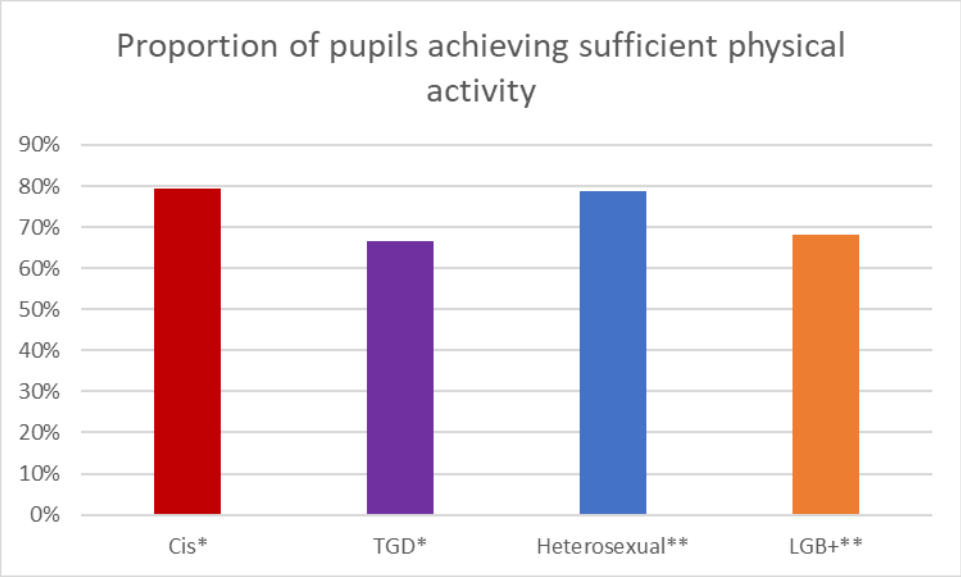
LGB+ people were more likely to be occasional or regular smokers, compared to heterosexual people (p<.05). Additionally, gay/lesbian people were the least likely to have never smoked compared to all other SO groups (p<.05).

Further to this, there was a greater proportion of cis people who were former smokers compared to TGD respondents (34% compared to 14%, p<.05) and a greater proportion of TGD people who were occasional smokers compared to cis respondents (33% compared to 6%, p<.05). There were no differences found in regular smoking rates or those never having smoked (p>.05).

Physical activity

The proportion of pupils responding to the MHMS survey that reported sufficient weekly physical activity (defined as five days or more where they are physically active for at least 30 minutes) was high overall. However, there were significant differences between groups, as outlined below:

Figure 18: Proportion of pupils achieving sufficient physical activity



*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level comparing cis/TGD. **= Difference is significant at the p<.05 level comparing heterosexual/LGB+.*

TGD pupils were less likely to be sufficiently physically active compared to cis pupils (67% compared to 79%, p<.05) and LGB+ pupils were less likely to be sufficiently active compared to heterosexual pupils (68% compared to 79%, p<.05).

No significant differences were found between White LGB+ pupils and pupils from Black, Asian or mixed ethnic groups. No significant differences were found between LGB+ pupils who were disabled and those who were not.

One of the barriers noted by survey respondents around what stopped them from taking part in physical activity was confidence. Almost four in ten LGB+ pupils (39%) noted this as a key reason they didn't do physical activity, compared to 21% of heterosexual pupils (p<.05). Over four in ten (44%) of TGD pupils noted this as a barrier, compared to 20% of cis pupils (p<.05).

There was no local data available on physical activity in LGBTQ+ adults.

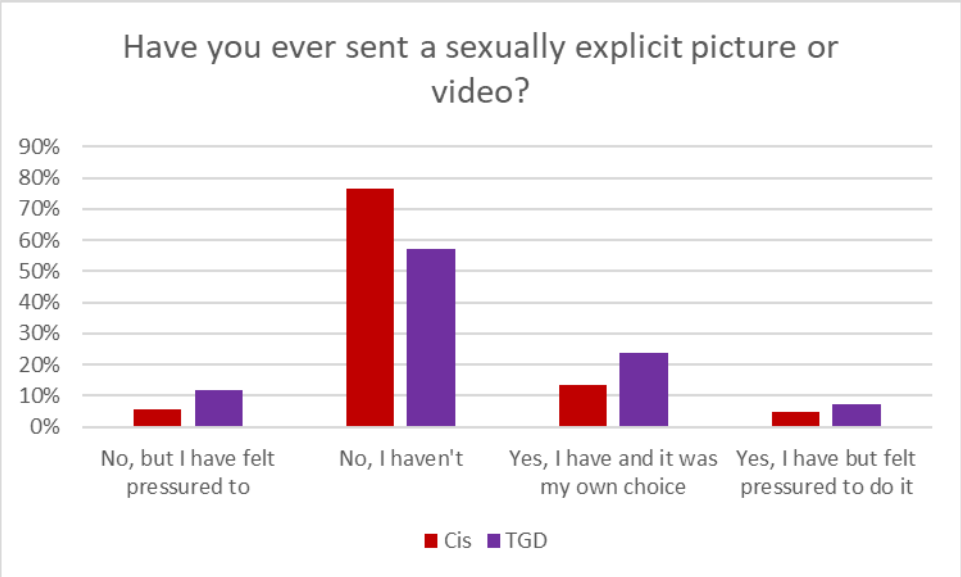
Diet

Limited data were available regarding diet. The MHHS survey provides some data on this related to school pupils. Less than one fifth of pupils reported consuming five or more portions of fruit or vegetables per day, with no substantial differences between cis/TGD or heterosexual/LGB+ groups. However, a greater proportion of TGD pupils reported drinking at least one high energy drink per day (32%) compared to cis pupils (18%) and this was statistically significant (p<.05). There was a smaller but still significant difference in the high energy drink consumption between LGB+ pupils (25%) compared to heterosexual pupils (17%) (p<.05).

Behaviours and attitudes towards sex

Almost one third of TGD pupils in year 9 or year 11 reported having sent a sexually explicit picture or video compared to 18% of cis pupils ($p<.05$). A slightly greater proportion of TGD pupils reported they had felt pressured to do so, compared to cis pupils (7% compared to 5%, numbers too small to test for statistical significance):

Figure 19: Experience of sending a sexually explicit picture or video by GI group



Source: MHMS 2021 survey

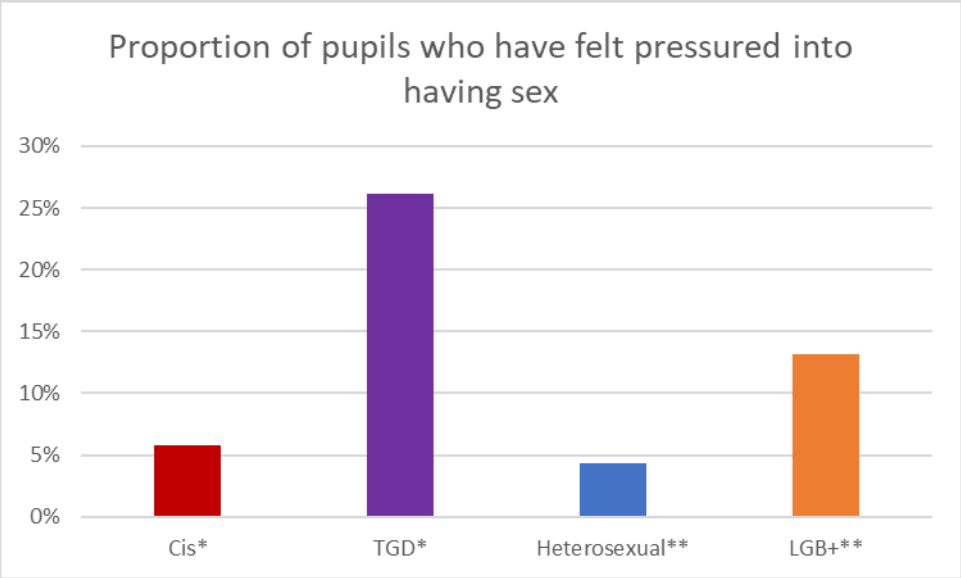
Similarly, LGB+ pupils were more likely to report sending a sexually explicit picture or video compared to heterosexual pupils, as well as feeling pressured to do so, as shown below:

Figure 20: Experience of sending a sexually explicit picture or video by SO group

*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level.*

Further to this, there were disparities in the proportion of year 9 and year 11 pupils who reported feeling pressured into having sex. TGD pupils were over four times as likely to report this compared to cis pupils (26% compared to 6%, p<.05) and LGB+ pupils were over three times as likely to report this as heterosexual pupils (13% compared to 4%, p<.05).

Figure 21: Proportion of pupils who have felt pressured into having sex by GI and SO



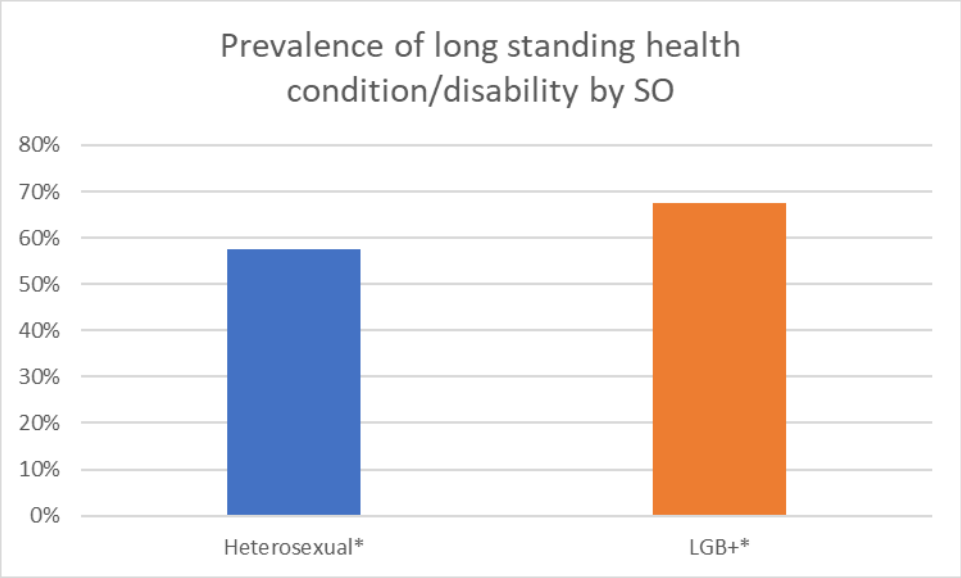
*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level comparing cis/TGD. **= Difference is significant at the p<.05 level comparing heterosexual and LGB+.*

Health, disability and use of services

General health, long term conditions and disability

According to the GPPS data, the prevalence of long-standing health conditions/disabilities was significantly higher in LGB+ compared to heterosexual respondents (68% compared to 58%, p<.05):

Figure 22: Prevalence of long-standing health condition or disability by SO



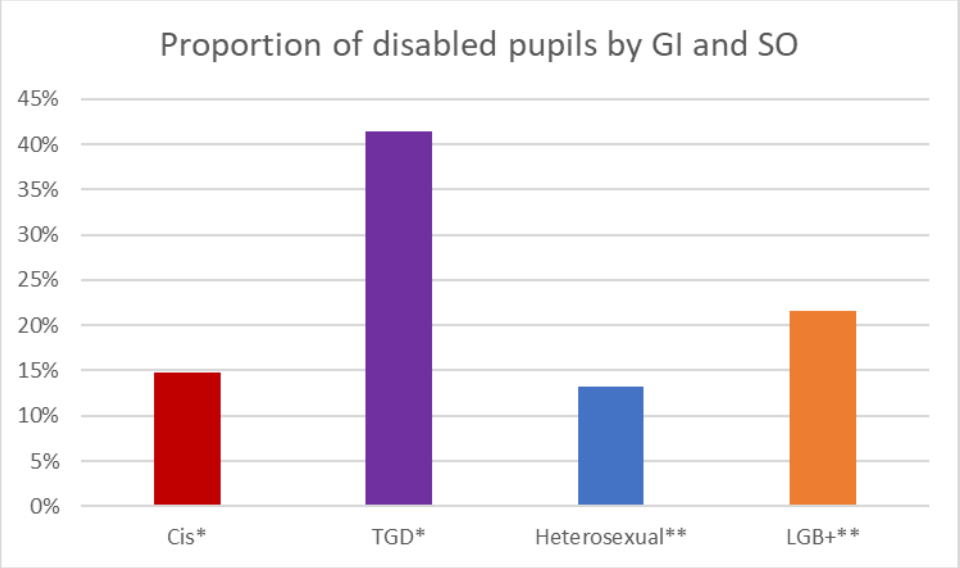
*Source: GPPS 2021 data, IPSOS MORI. *= Difference is significant at the p<.05 level.*

There was no difference between the prevalence of long-standing conditions or disabilities between cis and TGD respondents (58% and 59% respectively.)

Further to this, the GPPS found a greater prevalence of physical mobility issues in LGB+ respondents compared to heterosexual respondents (20% compared to 13%, p<.05). One fifth of TGD respondents (20%) reported physical mobility issues compared to 13% of cis respondents, but no statistical difference was found, potentially due to the small sample size of TGD respondents. It should be noted, however, that these findings have not been adjusted for age.

In young people, the MHMS survey found a greater proportion of LGB+ and TGD pupils reported a disability, compared to cis and non-LGB+ pupils, as outlined below:

Figure 23: Proportion of disabled pupils by GI and SO



*Source: MHMS survey, 2021. *= Difference is significant at the p<.05 level comparing cis/TGD. **= Difference is significant at the p<.05 level comparing heterosexual and LGB+.*

Cancer

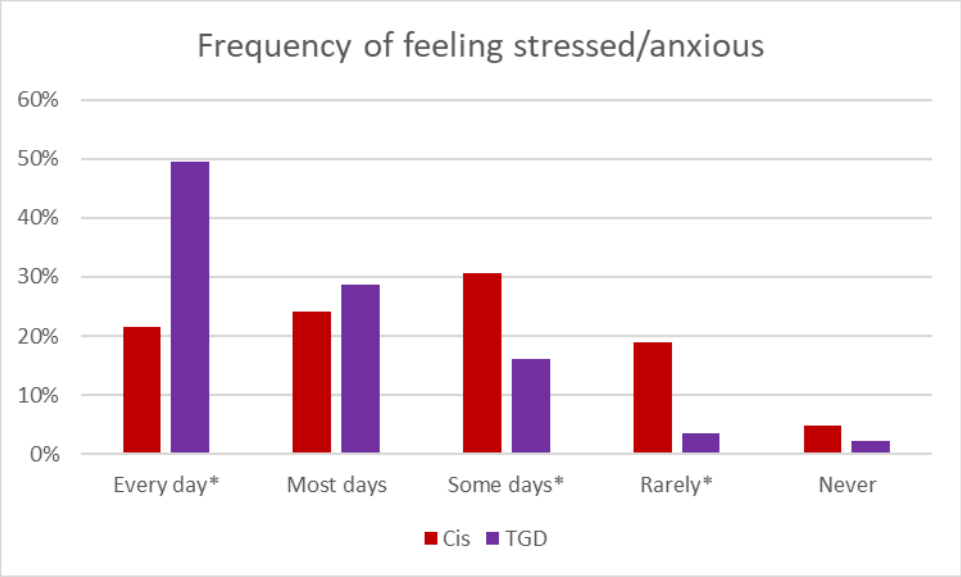
Whilst GPPS 2019 collects data on cancer prevalence, and a similar proportion of LGB+ and heterosexual people reported a cancer diagnosis in the past five years (4%). The number of cancer cases were too small to assess by GI.

Mental wellbeing

The MHMS survey gives good insight as to the mental wellbeing of pupils that took part.

Clear differences were seen in the proportion of pupils who felt stressed/anxious frequently by GI group, with almost half of TGD pupils (49%) reporting feeling this every day, compared to 22% of cis pupils:

Figure 24: Frequency of feeling stressed/anxious by GI group

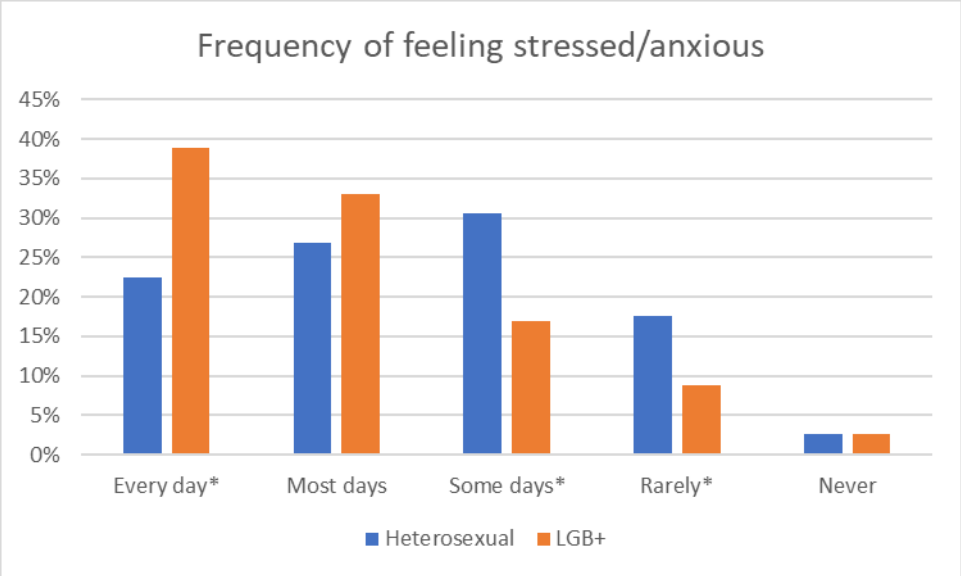


*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level*

Over two thirds of TGD pupils (68%) reported that they did not cope well with feeling stressed/anxious, compared to 42% of cis pupils (p<.05).

LGB+ pupils were also more likely to report feeling stressed/anxious every day compared to their heterosexual counterparts (39% compared to 22%). This is outlined below:

Figure 25: Frequency of feeling stressed/anxious by SO group



*Source: MHMS 2021 survey. *= Difference is significant at the p<.05 level*

Whilst no significant difference was found, it is notable that 100% (n=5) of Black LGB+ pupils reported feeling stressed or anxious every or most days, compared to 74% of White LGB+ pupils (p>.05).

LGB+ pupils were more likely to report not coping well with feeling stressed/anxious compared to heterosexual pupils (59% compared to 41%, $p<.05$).

Further to this, over two thirds of TGD pupils (68%) reported feeling sad/upset every day or most days, compared to 30% of cis pupils ($p<.05$). Over half (57%) of LGB+ pupils felt sad/upset every day or most days, compared to 28% of heterosexual pupils ($p<.05$). Whilst no significant difference was found, 100% (n=5) of Black LGB+ pupils reported feeling sad/upset every day or most days compared to 58% of White LGB+ pupils ($p>.05$).

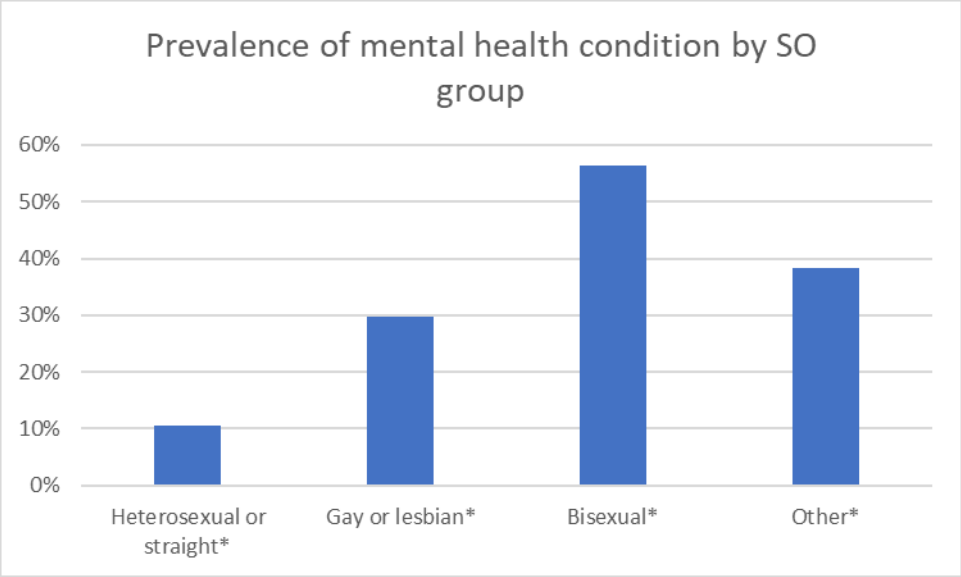
Additionally, over half of TGD pupils (53%) reported feeling angry or bad-tempered every day or most days compared to 28% of cis pupils ($p<.05$). Almost half of LGB+ pupils (45%) reported feeling angry or bad-tempered every or most days, compared to 30% of heterosexual pupils ($p<.05$). Black LGB+ pupils reported higher rates of feeling angry or bad-tempered every or most days (80%, n=4), as did mixed race pupils (60%), compared to White LGB+ pupils (42%) but this was not a significant finding ($p>.05$).

Finally, concern about their appearance was common across all pupils. However, this was significantly higher in TGD pupils (80%) compared to cis pupils (62%) ($p<.05$). Concern about appearance was also greater in LGB+ pupils (81%) compared to heterosexual pupils (68%) ($p<.05$). The SO group that this was highest in was bi pupils (87%).

Mental health condition prevalence

Local GPPS data outlines a clear discrepancy in the prevalence of mental health conditions across SO groups. The prevalence across LGB+ groups differed significantly from heterosexual groups (41% compared to 11%, $p<.05$), with every SO group significantly higher than heterosexual people ($p<.05$):

Figure 26: Mental health condition prevalence by SO

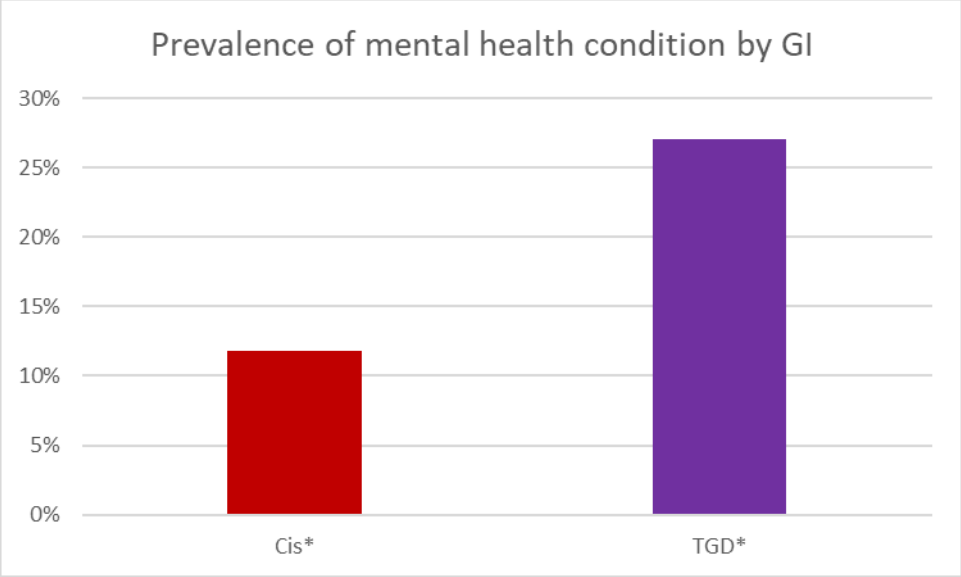


*Source: GPPS 2021 data, IPSOS MORI. *= Difference between LG, bisexual, and other group compared to heterosexual group at the p<.05 level.*

Additionally, there were some differences seen between minority SO groups with bi people reporting a significantly higher prevalence of mental health conditions compared to LG and heterosexual people (p<.05).

There was also a significant difference in mental health condition prevalence between TGD and cis groups (p<.05), as outlined below:

Figure 27: Mental health condition prevalence by GI



*Source: GPPS 2021 data, IPSOS MORI. *= Difference is significant at the p<.05 level*

Use of mental health services

SPFT activity for larger services have been analysed between heterosexual, gay/lesbian, bisexual and other sexual minority groups, for 2019/20. This date range has been utilised to avoid the confounding effects during the pandemic restrictions in 2020/21. Services are listed in order of most contacts to least, and the services have been included where there were more than 300 contacts across the SO groups listed:

Table 8: Proportion of contacts with medium-large mental health services by SO group (where known)

Service name	Heterosexual	Gay/ Lesbian	Bisexual	Other sexual orientation	Total contacts
Assessment & Treatment Service	91%	4%	4%	1%	57133
Crisis/Home Treatment	90%	5%	5%	0%	18617

Community Teams	91%	3%	5%	1%	15077
Dementia Treatment	99%	1%	0%	0%	14605
Assertive Outreach	98%	1%	0%	0%	7094
Liaison	92%	4%	3%	0%	5147
Specialist Services	91%	4%	5%	0%	4827
Early Intervention Service	94%	2%	4%	1%	4437
Perinatal Services	94%	1%	5%	0%	3618
Community Forensic Team	90%	3%	8%	0%	3308
Mental health Liaison Practitioner	95%	3%	2%	1%	3110
Inpatient Acute	94%	4%	2%	0%	2877
Rehabilitation Team	99%	0%	1%	0%	2579
Day Services/Centres	77%	14%	9%	1%	1690
Medium secure inpatients	99%	0%	1%	0%	1408
Specialist Eating Disorder Service	88%	2%	7%	3%	1308
Community Learning Disability Teams	93%	4%	3%	1%	1168

Primary Care Wellbeing	85%	10%	4%	1%	1093
Low secure inpatients	99%	1%	0%	0%	817
Specialist outreach	90%	1%	7%	2%	716
Inpatient Functional	100%	0%	0%	0%	705
Community Eating Disorder Service	96%	0%	4%	0%	442
A&E/Hospital Liaison	99%	1%	0%	0%	375
Individual Placement and Support Service	91%	4%	5%	0%	363
Inpatient Psychiatric Intensive-Care Unit	99%	0%	1%	0%	329

Source: Mental health services dataset, SPFT. Note- numbers may not add up to 100% due to rounding.

This data relates to contacts rather than unique individuals and excludes contacts where SO was not recorded which varied substantially between services.

It is difficult to draw conclusions from this service usage data, due to a lack of a robust denominator in terms of the number of LGB+ people in the wider population in East Sussex, as well as the large proportion of contacts where no SO is recorded. Based on a crude estimate of 7% LGB+ people living in East Sussex (Community Survey, 2019) and the table above (which excludes contacts where SO is not recorded) there are some services where LGB+ groups make up a greater proportion of some service's contact data than we might expect:

- Day services/centres-24% of contacts were from LGB+ groups
- Primary care wellbeing- 15% of contacts were from LGB+ groups
- Specialist eating disorder service- 12% of contacts were from LGB+ groups

- Community Forensic team-12% of contacts were from LGB+ groups
- Crisis/home treatment- 10% of contacts were from LGB+ groups
- Specialist outreach- 10% of contacts were from LGB+ groups

For many of these services mentioned, these figures appear to be disproportionately high in bisexual people. For instance, 7% of specialist eating disorder service contacts were in bisexual people.

This is a crude analysis, due to the limitations of the data, and of course also doesn't take into account that this data relates to contacts rather than unique individuals, which potentially could show a different picture. It is however potentially in keeping with the evidence base that demonstrates a higher prevalence of mental health issues amongst LGB+ people.

IAPT services data, also provided by SPFT, are captured elsewhere. Between 2017/18 and 2021/22 to date, 62% of IAPT referrals had an SO recorded, 33% did not have an SO recorded, with a further 4% who were asked but declined to answer and 1% who were unsure. The following analysis includes only those with an SO recorded and relates to referrals (rather than unique individuals who may have received more than one referral over this period).

In terms of referrals to IAPT, the proportion of referrals of LGB+ people have been increasing over the past five years, as outlined below:

Table 9: Proportion of referrals by SO group

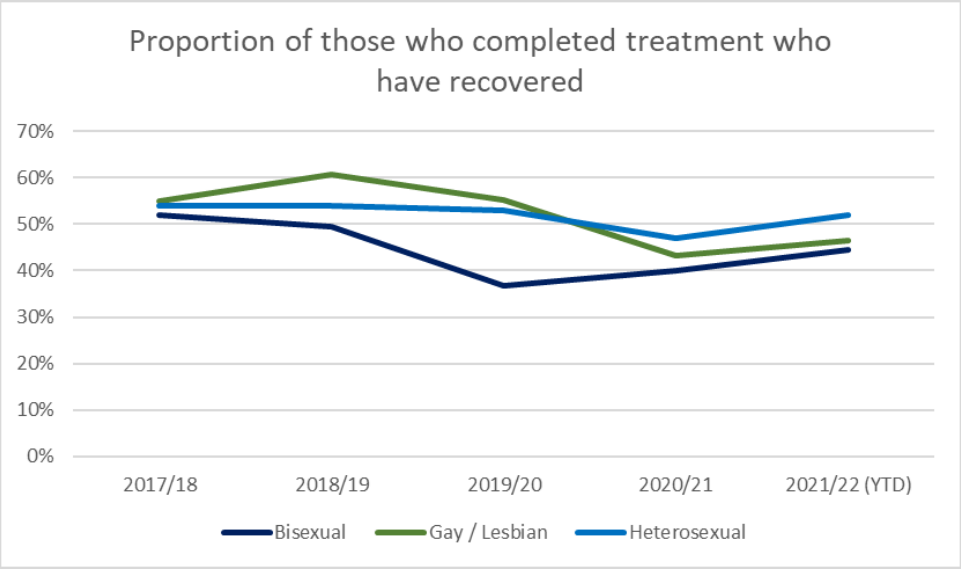
	2017/18	2018/19	2019/20	2020/21	2021/22 (YTD)
Heterosexual	94.6%	94.4%	93.4%	92.1%	91.7%
LGB+ total	5.4%	5.6%	6.6%	7.9%	8.3%
Bisexual	2.3%	2.5%	3.3%	3.9%	4.0%
Gay / Lesbian	3.0%	3.0%	3.1%	3.5%	3.6%
Other	0.1%	0.1%	0.1%	0.4%	0.7%

Source: IAPT services dataset, SPFT

There were very minor differences in the proportion of people completing IAPT treatment by SO group, ranging from 68% for bi people to 71% for heterosexual people in the period 2017/18-2021/22 to date. However, in the most recent full financial year, 2020/21, bi people had the highest completion rate at 73%, followed by heterosexual people (71%) and lesbian/gay people (70%).

There appear to be, however, some disparities in the proportion of people that are assessed as having recovered on completion of treatment by SO group, with bisexual people with consistently lower recovery rates than both lesbian/gay and heterosexual people, as outlined below:

Figure 28: Proportion of those who completed IAPT treatment who have recovered by SO group



Source: IAPT services dataset, SPFT. Due to small numbers, people who identified as any other sexual orientation have been excluded from this analysis.

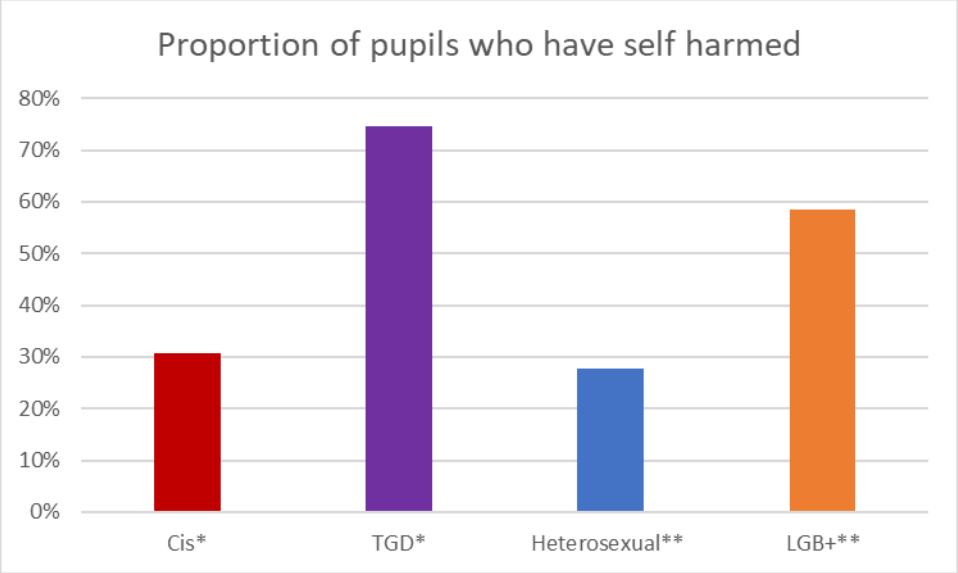
As shown, over these 4.5 years, the recovery rate of bisexual people was consistently lower than for LG people or heterosexuals. The difference between the recovery of bisexuals compared to heterosexuals and lesbian/gay people was statistically significant (43% compared to 52%, $p<.05$). There was no significant difference in recovery rates between lesbian/gay people and heterosexual people. Based on more recent data (2020/21 and 2021/22 to date), a statistically significant difference remained in the recovery rate between bisexual people and heterosexual people (42% compared to 49%, $p<.05$) but there was no difference between lesbian/gay people and bisexual people (45% compared to 42%, $p>.05$) or lesbian/gay and heterosexual people (45% compared to 49%, $p>.05$).

GI is not currently recorded systematically in local mental health services.

Suicide and self-harm

As outlined in the graph below, a far greater proportion of LGBTQ+ pupils report having ever deliberately harmed themselves, compared to non-LGBTQ+ pupils. Three quarters of TGD pupils report having self-harmed compared to 31% of cis respondents. Whereas 59% of LGB+ pupils reported this compared to 28% of heterosexual pupils.

Figure 29: Proportion of pupils who report having self-harmed

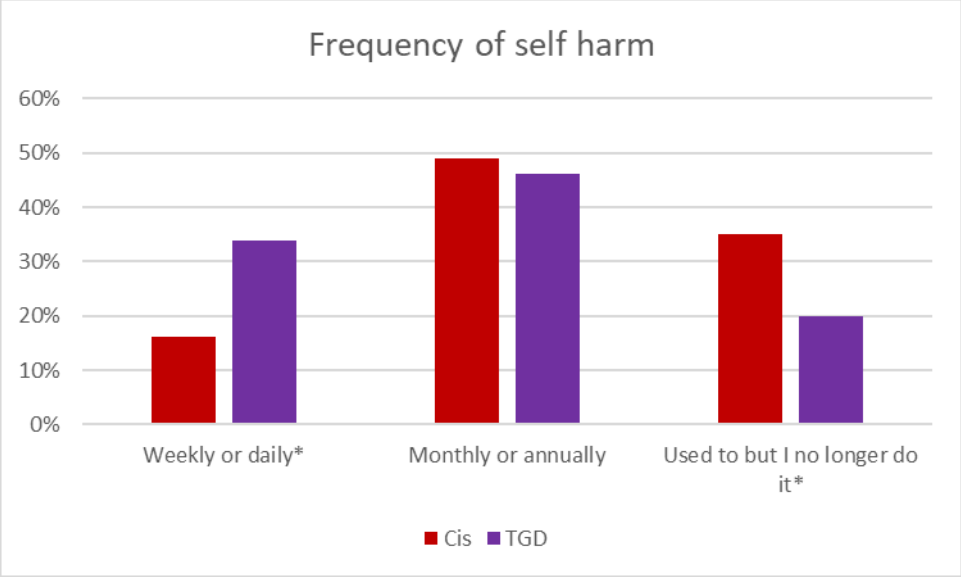


*Source: MHMS survey, 2021. *= Difference is significant at the p<.05 level comparing cis/TGD. **= Difference is significant at the p<.05 level comparing heterosexual and LGB+.*

The SO group that reported the highest prevalence of self-harm was in bi people (66%), although this wasn't a statistically significant increase compared to gay/lesbian people (59%) and other sexual minority groups (49%.) Mixed race LGB+ pupils had the highest rates of having ever self-harmed compared to other ethnic groups (67% compared to 57% in White LGB+ pupils and 47% in Asian LGB+ pupils). However, there was no significant difference in these findings, potentially due to the small sample size of mixed race and Asian pupils. There were no significant differences found in the prevalence of self-harm between disabled and non-disabled LGB+ pupils.

Of those who reported a history of self-harming, there were also differences in the frequency of this behaviour by GI group, with TGD groups more likely to do this daily or weekly and cis pupils more likely to no longer self-harm:

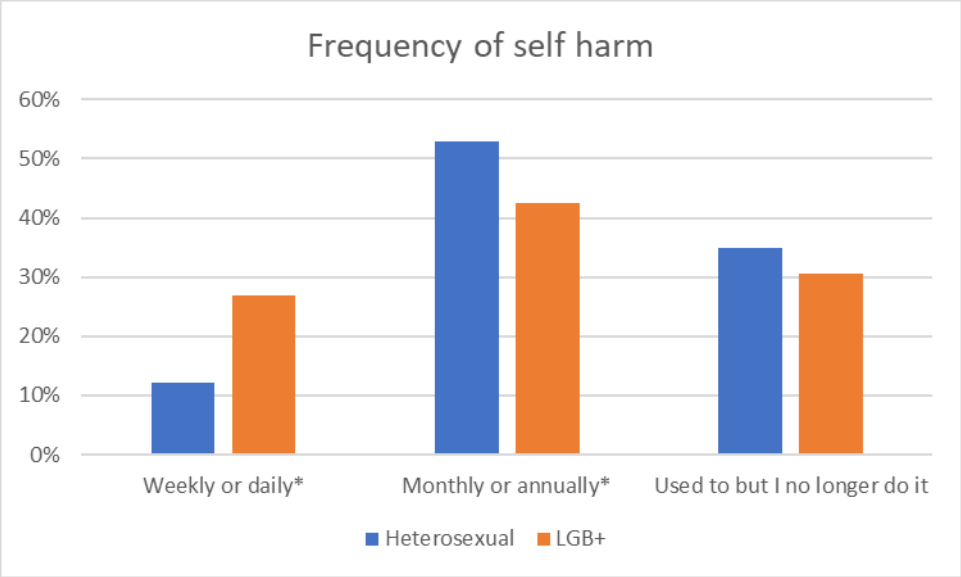
Figure 30: Frequency of self-harming by GI group



*Source: MHMS survey, 2021. *= Difference is significant at the p<.05 level.*

Similarly, LGB+ groups were more likely to report self-harming weekly or daily and heterosexual groups were more likely to report doing this monthly/annually.

Figure 31: Frequency of self-harming by SO group



*Source: MHMS survey, 2021. *= Difference is significant at the p<.05 level.*

Weight

No data was available on weight by GI and SO.

Sexual health

East Sussex Healthcare Trust (ESHT) provide a wide range of sexual health services locally including family planning, GUM clinics, HIV, and psychosexual services. Activity data (based on attendances rather than unique individuals) was provided to outline service usage by SO group.

Of activity with an SO recorded (over 99% of the dataset), the activity over the past five years is outlined below:

Table 10: ESHT sexual health service use by SO

	Heterosexual man	Heterosexual woman	Bi man	Bi woman	Gay man	Gay woman/ lesbian
2017-18	15.2%	74.5%	1.3%	2.7%	5.9%	0.3%
2018-19	15.5%	73.1%	1.3%	3.3%	6.5%	0.3%
2019-20	15.2%	71.2%	1.5%	3.7%	8.1%	0.3%
2020-21	14.4%	72.8%	1.4%	3.0%	8.1%	0.3%
2021-22 (Q1&2)	15.6%	68.8%	2.2%	3.2%	9.8%	0.3%

Source: Sexual health service activity, ESHT

Over time, there have been slight increases in the proportion of activity by gay men. Bi men appear to have an increased proportion of activity in 2021/22 to date, although the numbers are small in this group so this may be due to random variation.

This service started collecting gender identity data from April 2021, however, there was little data to analyse at the point of data extraction in October 2021 due to small numbers of activity recorded as TGD.

ESHT are also providers of PrEP. Between October 2020 and June 2021, the service had 218 appointments with people related to PrEP use, which included first appointments and follow-ups. This activity involved 149 individuals. Most of this activity (90%) was with service users who identified as gay, with a further 8% identifying as bisexual and 2% as heterosexual.

Further to this, online sexual health testing provided by Preventx also enabled some data analysis of service use and STI test positivity rates by SO group and GI group. It should be noted that the SO groups were comprised almost entirely (99.9%) of cis service users as very few of the TGD service users had an SO recorded. This is because up until May 2021 SO was determined internally by service user gender and the gender of their sexual partner(s). Since May 2021 this question has been specifically asked of service users. This limitation means that SO is based on behaviour reported to the service rather than sexual identity and that the SO data summarised that follows is for cis respondents only (due to the number of TGD service users with an SO recorded being too small for analysis).

The proportion of activity by SO group varied by age group, as outlined in the tables below:

Table 11: Online sexual health testing activity by SO group- Young people

Year (Jan-Dec)	Hetero man	Hetero woman	Bi man	Bi woman	Gay man	Gay woman / lesbian	Unknown	Total number
2018	26.33%	64.05%	0.82%	3.53%	2.71%	2.35%	0.21%	4250
2019	26.62%	63.45%	1.34%	3.03%	3.32%	1.99%	0.25%	5217
2020	24.09%	63.39%	1.27%	4.30%	4.57%	2.18%	0.19%	6280
2021 (YTD)	22.12%	63.80%	1.31%	5.30%	4.31%	2.14%	0.95%	4431
Grand Total	**24.78%**	**63.63%**	**1.20%**	**4.03%**	**3.80%**	**2.16%**	**0.38%**	**20178**

Source: Online sexual health testing activity, Preventx

Table 12: Online sexual health testing activity by SO group- Working age people

Year (Jan-Dec)	Hetero man	Hetero woman	Bi man	Bi woman	Gay man	Gay woman / lesbian	Unknown	Total number
2018	33.82%	58.75%	1.95%	3.72%	6.56%	2.35%	0.13%	4727

2019	38.27%	58.28%	3.20%	3.63%	6.99%	2.34%	1.11%	6196
2020	29.52%	57.68%	2.48%	4.02%	8.13%	2.53%	0.17%	9262
2021 (YTD)	32.32%	58.89%	2.35%	3.97%	8.25%	1.65%	0.84%	7866
Grand Total	**32.57 %**	**58.33 %**	**2.51 %**	**3.87%**	**7.65 %**	**2.21%**	**0.34%**	**28051**

Source: Online sexual health testing activity, Preventx

Table 13: Online sexual health testing activity by SO group- Older people

Year (Jan-Dec)	Hetero man	Hetero woman	Bi man	Bi woman	Gay man	Gay woman / lesbian	Unknown	Total number
2018	56.25%	25.00%	14.06%	0.00%	29.69%	0.00%	0%	68
2019	58.23%	20.99%	10.13%	1.27%	27.85%	1.27%	1.23%	81
2020	53.70%	22.89%	11.73%	1.23%	30.25%	1.23%	1.81%	166
2021 (YTD)	47.71%	17.07%	9.15%	0.00%	39.22%	0.65%	3.05%	164
Grand Total	**52.84 %**	**20.88 %**	**10.92 %**	**0.66%**	**32.75 %**	**0.87%**	**1.88%**	**479**

Source: Online sexual health testing activity, Preventx

Please note- %s may not add up due to rounding.

In young service users, bi women were the highest utilisers of the service, followed by gay men, gay women/lesbians, and bi men. In working age people, gay men were the group with the highest activity, followed by bi women, bi men, and gay women/lesbians. In older people, gay men made up the highest activity in this age group, followed by bi men, gay women/lesbians, and bi women.

The proportion of people who were recorded as TGD was very low. It is difficult to discern, but it may be that this is due to a lack of accurate recording rather than a disproportionately low use of the service by TGD people. The proportion of online

service users by GI group over the last 3.5 years is outlined below and shows an increase in the proportion of TGD service users over time:

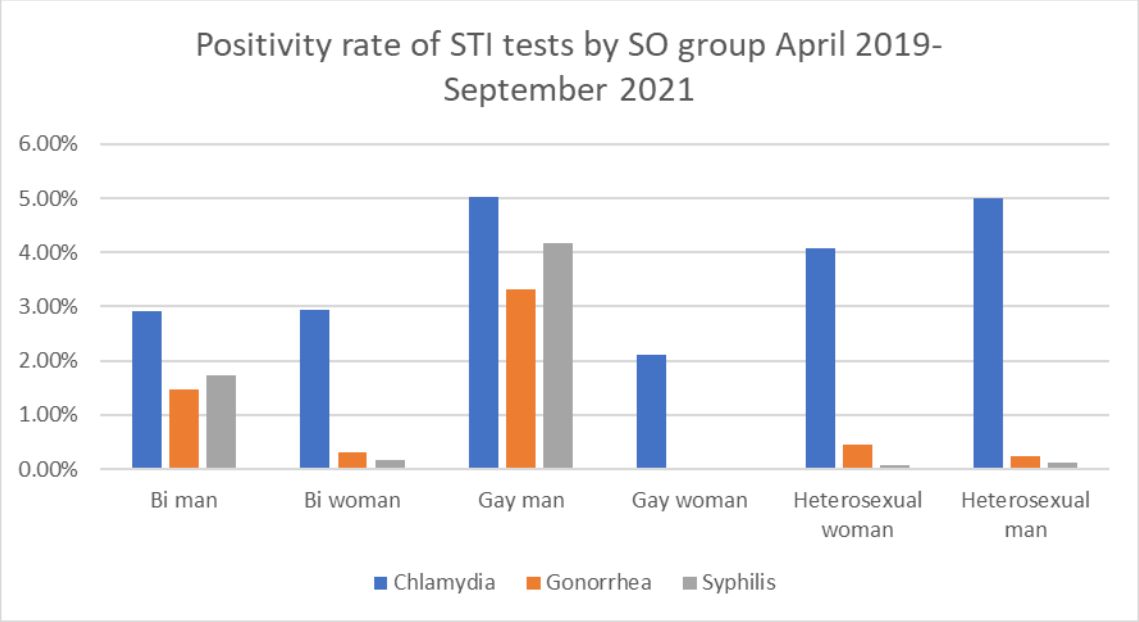
Table 14: Online sexual health testing activity by GI group- all age groups

	Cis		TGD	
	Number	**%**	**Number**	**%**
2018	9031	99.83%	15	0.17%
2019	11473	99.81%	22	0.19%
2020	15678	99.80%	31	0.20%
2021 (Q1&2)	12379	99.32%	85	0.68%
Grand Total	**48561**	**99.69%**	**153**	**0.31%**

Source: Online sexual health testing activity, Preventx

An average positivity rate was taken between April 2019 and September 2021 to even out any behavioural changes that might have impacted sexual activity during the lockdowns. Positivity rates across the most common STIs varied by SO group, as outlined below:

Figure 32: Positivity rate of STIs by SO group- all age groups



Source: Online sexual health testing activity, Preventx

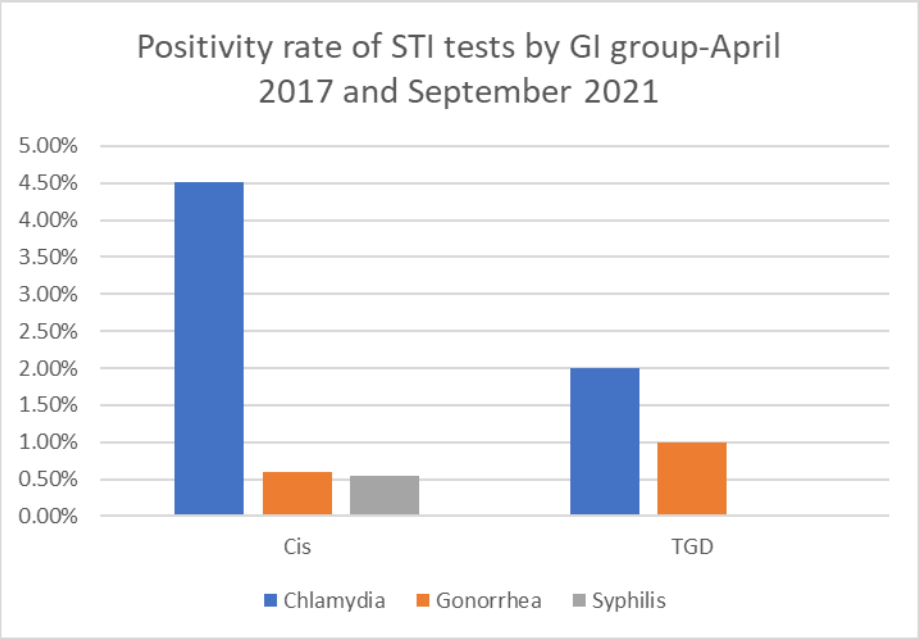
Gay men had the highest positivity rate for all STIs. Heterosexual men had the second highest positivity rate for chlamydia, followed by heterosexual women, bi

women, and bi men. Bi men had the second highest positivity rate of gonorrhoea and syphilis.

HIV positivity rates are not available, as further testing is required before a diagnosis can be confirmed. However, during this period, the reactivity rate of HIV tests was highest in gay men (1.66%), followed by bi men (0.98%), heterosexual men (0.68%) and heterosexual women (0.47%). Whilst the numbers are small, and therefore more likely to be impacted by random variation, this pattern aligns with the evidence base that men who have sex with men are at increased risk of HIV.

STI positivity by GI groups was analysed over a longer period due to the small numbers of people recorded as TGD. Chlamydia and syphilis rates were highest in cis service users, with a slightly increased rate of gonorrhoea in TGD service users. This is shown below:

Figure 33: STI positivity rare by GI- all age groups



Source: Online sexual health testing activity, Preventx

HIV reactivity from online testing was 0.5% in cis service users and 0% in TGD service users over the same period. However, the numbers for TGD users were very small so it is difficult to draw any conclusions from this data.

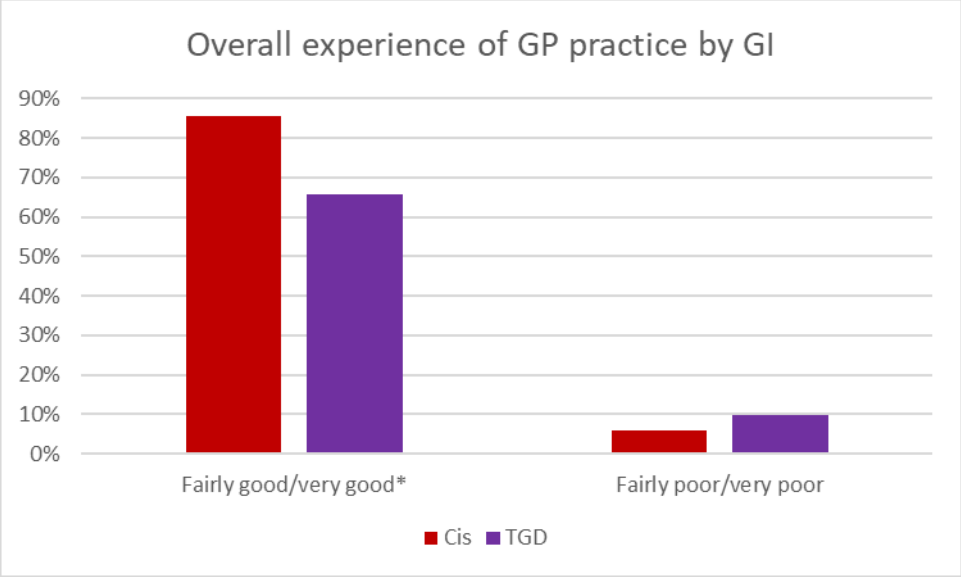
Access to and experience of health, care and support services

Experience of GP services

There were some small differences in the overall experience of GP practice by GI, with 86% of cis people reporting their last GP appointment experience as fairly or

very good, compared to 66% of TGD respondents ($p<.05$). A slightly greater proportion of TGD respondents reported their experience as fairly or very poor compared to cis respondents but this was not statistically significant (10% compared to 6%, $p>.05$). This is outlined below:

Figure 34: Overall experience of GP practice by GI



*Source: GPPS 2021 data, IPSOS MORI. *= Difference is significant at the p<.05 level.*

Similarly, LGB+ respondents were less likely to report a fairly or very good experience at their GP and this was statistically significant (80% compared to 86%, p<.05). However, there was no significant difference in reporting their overall experience as fairly or very poor (7% compared to 6%, p>.05)

LGBTQ+ and TNBI specific services

A short survey was undertaken by LGBT Switchboard of other LGBTQ+ specific organisations based in Brighton regarding service use by East Sussex residents. Six LGBTQ+ or TNBI specific organisations responded to the survey and found that:

- Between those six services, approximately 1375 East Sussex residents were seen in Brighton each year.
- On average, this represented 20% of their total service user population.

This suggests that significant numbers of LGBTQ+ residents are travelling to Brighton to access specific services. This may be for several reasons, including confidentiality, convenience (if a person was working in the Brighton area, for example), or due to an unmet need within the East Sussex area. The majority of organisations surveyed felt that the latter may be the most common explanation.

Social care, palliative care, end of life care and bereavement

Children's services

Sexual orientation is rarely recorded within children's services in ESCC, with approximately 2% of cases having an answer recorded. Most of these cases are within the care leavers service, early help and the family support teams. The department is currently undertaking some work to establish which teams should be recording SO. Currently, GI is not recorded within children's services.

Adult Social Care

Long term support (LTS) provided to adults in East Sussex consists of nursing or residential care (permanent or short term but excluding respite), direct payment, home care, day case, transport, meals, adult placement, support in the community or other professional support (such as mental health support.) Information gathered on those receiving LTS only includes clients receiving LTS either provided or commissioned by ESCC or the NHS under section 75 agreements. Self-funders or 100% health funded clients are excluded from this dataset.

Table 15 shows a breakdown of sexual orientation for clients receiving LTS in 2020/21.

Table 15: SO of people receiving LTS (2020/21)

2020/21	Number of people receiving LTS	Percentage of total receiving LTS
Heterosexual	2,078	22.38%
Bi	3	0.03%
Gay / Lesbian	23	0.25%
Other	27	0.29%
Prefer not to say	204	2.20%
Unsure	31	0.33%
Not recorded	6,920	74.52%
Total	**9,286**	

Source: Long term support service use equalities report, ASC

Although the percentage of clients without an SO recorded has improved from 79.01% in 2018/19 to 74.52% in 2020/21, the majority of clients still do not have a SO recorded in the system. Therefore, it is difficult to draw any conclusions about this data regarding the proportion of service use by sexual minorities.

A higher proportion of sexual minorities completed an about you form as part of the 'Listening To You' surveys carried out between March and November 2020. Of the 436 "About You" forms received, 376 people answered the question about sexuality, with the following results:

- 89.1% said they were Heterosexual
- 1.3% said they were Bisexual
- 1.3% said they were a Gay man
- 1.1% said they were a Gay woman/lesbian
- 2.4% stated their sexuality was "other"
- 4.8% preferred not to say

Whilst this is not representative of service users, it suggests that the proportion of sexual minority groups in receipt of LTS services may be higher than the recorded data suggests.

In the same data set, 352 of 436 people answered the question "Do you identify as a transgender or trans person", with the following results:

- 98.3% said no
- 0.6% said yes
- 1.1% preferred not to say.

There is no data available to explore outcomes or satisfaction with services by SO or GI.

Gaps in the local data

There are significant gaps in the data. The census 2021 data, available in Spring 2022, will fill some of these gaps, especially with regards to the wider determinants of health. There are also gaps on physical activity, diet and weight in adults, common chronic condition prevalence, and the experience of services generally.

Chapter summary

Almost half of LGB+ pupils (46%) reported experiencing some bullying in the past 12 months, significantly higher than heterosexual pupils. This increased to 58% for disabled LGB+ pupils, and 61% for TGD pupils. Half of the LGB+ pupils reported that their school's response to homophobic bullying was poor. LGBTQ+ pupils

consistently reported feeling less safe than their heterosexual/cis counterparts in and around school

With regards to employment, there is limited robust data available, but the data available suggests that there may be a higher rate of unemployment and permanent disability/sickness in LGBTQ+ groups. In addition to this, over the past five years hate crime reported to the police has increased by 68% for crimes motivated by SO and 40% for crimes motivated by GI.

Almost one third of LGB+ adults (32%) reported feeling isolated in the last 12 months, compared to 14% of heterosexual people. This increased to 50% of bi people. In young people, 44% of TGD pupils reported feeling lonely every or most days, compared to 19% of cis pupils. Over one third of LGB+ pupils (38%) reported feeling lonely every day or most days, compared to 19% of heterosexual pupils.

In school pupils, alcohol and most drug use appeared to be similar across LGBTQ+ and non-LGBTQ+ pupils, although a slightly greater proportion of LGB+ pupils reported using psychoactive substances (8.6%) compared to heterosexual pupils (4.5%). In adults who had accessed and were discharged from the local substance misuse provider in 2020/21, it appeared that there may be some differences in the types of substances that sexual minorities were seeking support for, but the sample was too small to draw conclusions on this.

Smoking rates in young people were similar across LGB+ and heterosexual groups, but TGD pupils were more likely to report having tried a cigarette compared to cis pupils. In adults, LGB+ people were more likely to be occasional (13%) or regular smokers (14%), compared to heterosexual people (6% and 7% respectively). TGD people were more likely to be occasional smokers (33%) compared to cis respondents (6%).

LGBTQ+ pupils were less likely to be sufficiently physically active compared to non-LGBTQ+ pupils. Around four in ten LGBTQ+ pupils noted confidence as a barrier to physical activity compared to approximately two in ten cis/heterosexual pupils.

Whilst the overall numbers were small, LGBTQ+ pupils were more likely to have sent a sexually explicit picture or video and to report feeling pressured into having sex compared to non-LGBTQ+ groups.

Over two thirds of LGB+ people (68%) reported a long-standing health condition or disability, compared to 58% of heterosexual people. LGBTQ+ people also appeared to have greater mobility issues than cis/heterosexual people. In young people, TGD pupils had over double the rate of disabilities as cis pupils, with LGB+ people also having an elevated rate compared to heterosexual pupils.

In terms of mental wellbeing, almost half of TGD pupils (49%) reported feeling stressed or anxious every day, compared to 22% of cis pupils. LGB+ pupils were also

more likely to report feeling this every day compared to heterosexual pupils. LGBTQ+ pupils were also more likely to report feeling sad/upset every day or most days and angry or bad-tempered every day or most days compared to non-LGBTQ+ pupils. The prevalence and frequency of self-harm was higher in LGBTQ+ pupils than non-LGBTQ+ pupils, with the highest rate in TGD pupils, with three quarters of pupils reporting doing this at some point and over one third of those who have self-harmed reporting doing this daily or weekly.

In adults, mental health condition prevalence was significantly higher in LGB+ people (41%), compared to heterosexual people (11%), especially in bi people (56%). TGD people were also more likely to report a mental health condition than cis people. Of those who access IAPT services, recovery appears to be somewhat lower in bi people, compared to both lesbian/gay people and heterosexual people (43% compared to 52%).

Based on the online STI testing service, gay men were the most likely SO to test positive for chlamydia, gonorrhoea and syphilis. In TGD groups, there was a slightly increased positivity rate of gonorrhoea compared to cis groups, but a lower rate in the other common STIs.

There is a lack of data on the experience of services by SO and GI. Some data available suggests that LGBTQ+ people were less likely to find their overall experience of their GP practice as fairly or very good, compare to cis/heterosexual people. Further to this, a bespoke survey suggests that up to 20% of activity in key LGBTQ+ organisations based in Brighton is from East Sussex based residents. This suggests there may be an unmet need locally.

There are significant gaps in the data currently. The census 2021 data, available in Spring 2022, will fill some of these gaps, especially with regards to the wider determinants of health. There are also gaps on physical activity, diet and weight in adults, common chronic condition prevalence, cancer prevalence, palliative care, end of life care and the experience of services generally.

Chapter seven- Community survey

This section outlines the findings from a community survey to understand the needs and experiences of LGBTQ+ people in East Sussex. The survey was designed with steering group members and included some questions from the Brighton & Hove LGBT Switchboard report on the "*Impact of Covid on LGBTQ Communities in Brighton and Hove*.

This was available online and a telephone option was available for people who did not have access to the internet. It was widely advertised online, through social

media, through local LGBTQ+ events and organisations, wider health, care and community partner organisations and via posters and promotional cards in LGBTQ+ and other community venues. The survey ran from 14th August to 26th September 2021 and received 452 responses. However, 28 responses were excluded from analysis because they didn't meet the inclusion criteria (aged 16 years or over, living in the East Sussex County Council area and identifying as a sexual or gender minority or a person with an intersex variation.) Therefore, 424 responses remained for analysis.

Survey demographics overview

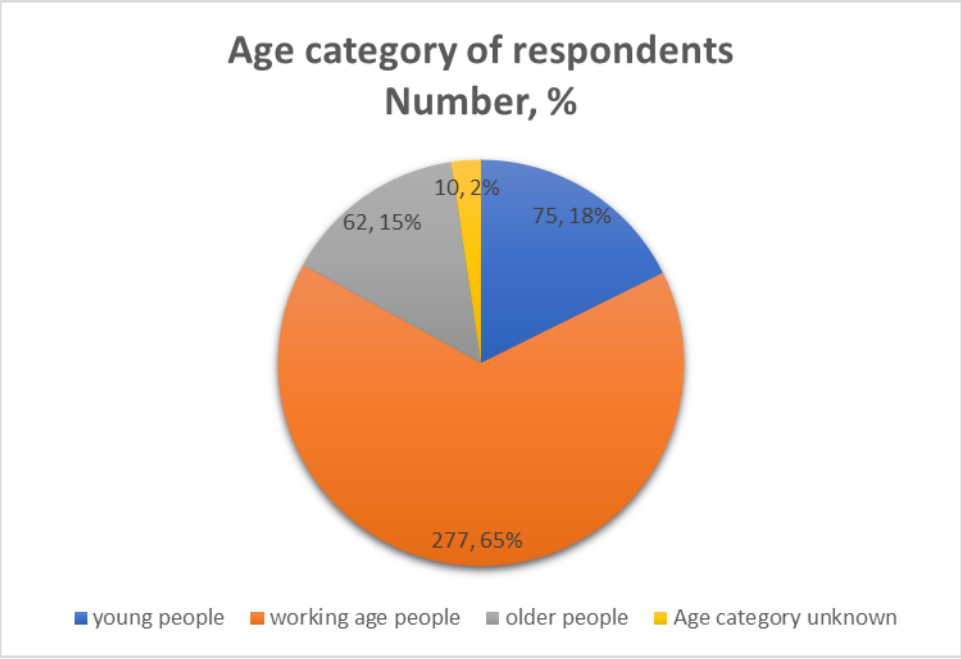
Age

The youngest respondents were 16, whilst the oldest was 82. Following the life course methodology outlined in earlier sections, much of the analysis has been done in three age groups:

- Young people (aged 16-24 years);
- Working age people (aged 25-59 years);
- Older people (aged 60 years and over).

Most respondents were in the working age category, as outlined below:

Figure 35: Pie chart depicting age categories of survey respondents



Where the age category was unknown, these responses have only been included in broader analysis groups, such as by ethnic group, where the sample was too small to conduct this analysis within the age groups.

Gender identity

Respondents described their gender identity in a wide range of ways, with many selecting more than one answer to describe their gender identity or choosing to self-describe. To analyse responses in a meaningful way by gender identity, responses have been coded as either cisgender or trans or gender diverse (TGD). Any respondent who selected or self-described using any non-binary or gender variant term or selected that their gender identity differed from the sex they were assigned at birth, was coded as TGD. An additional layer of coding was then added to enable subgroup analysis for TGD respondents that described their gender in either a binary or non-binary/gender variant way. This is summarised below:

Table 16: Gender identity of survey respondents for all age groups

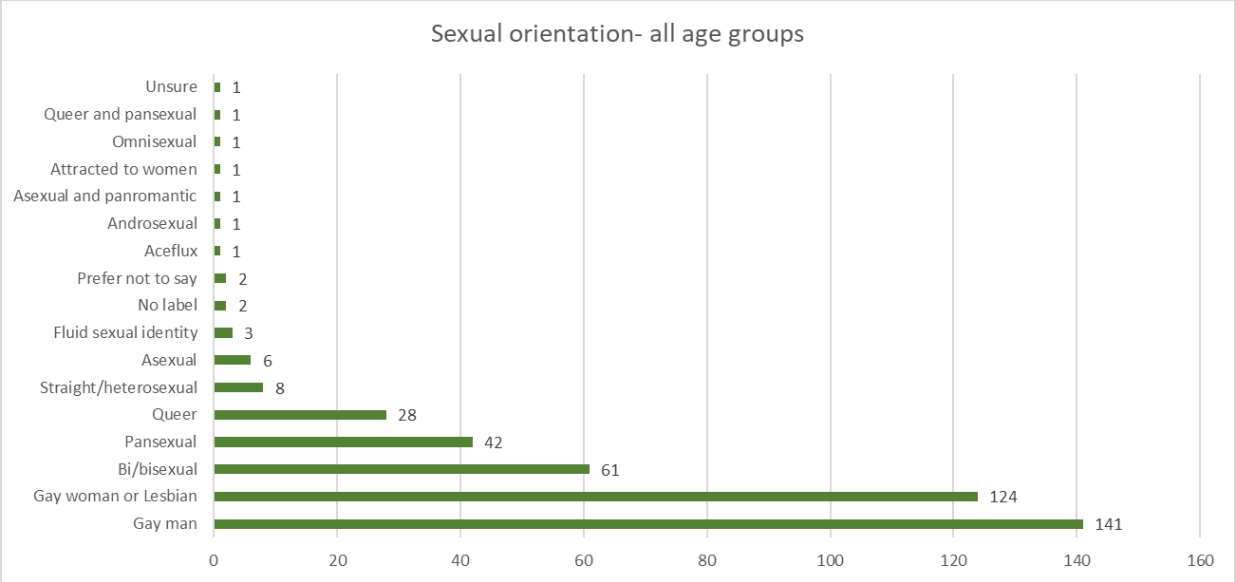
	Cis	TGD	Unknown	Total
Binary	**307**	**36**	**2**	**345**
Man	147	17		164
Woman	160	19	2	181
Non-binary/gender variant		**61**	**5**	**66**
Unknown		**4**	**9**	**13**
Total	**307**	**101**	**16**	**424**

Overall then, there were 307 cis respondents (73%), and 101 TGD respondents (24%) of whom 36 identified as trans binary and 61 identified as non-binary/gender variant. For 16 respondents, their gender identity was not stated.

Sexual Orientation

Respondents identified with a wide range of sexual orientations as outlined below:

Figure 36: Sexual orientation in all age groups



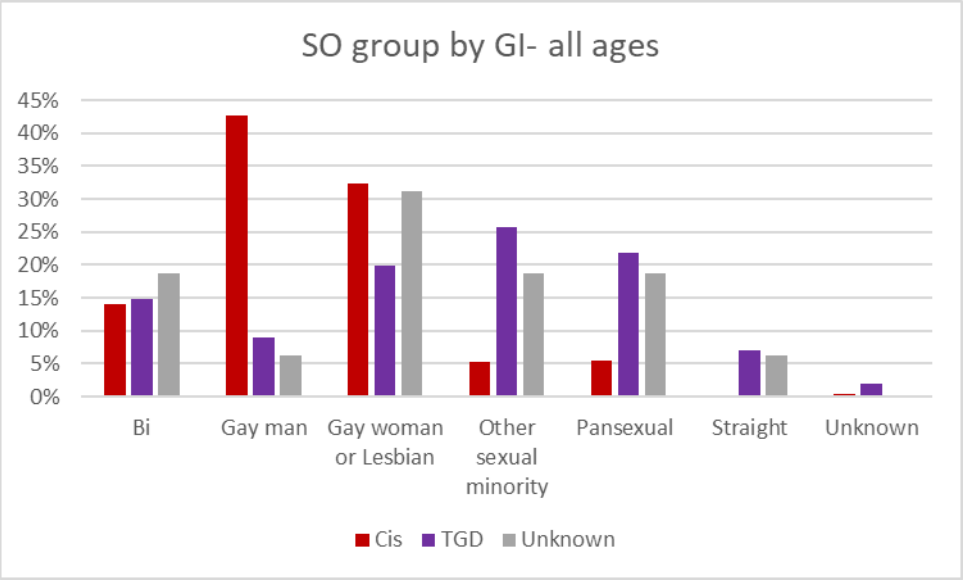
To ensure sufficient sample sizes for subgroup analysis, sexual orientations were categorised as either lesbian/gay woman, gay man, bisexual, pansexual, any other sexual minority and unknown (for those who preferred not to say or who were unsure.)

SO varied by GI, with cis people more likely to identify as gay and TGD people more likely to identify as pansexual or with another sexual minority identity. This is shown for all age groups in table 17 and figure 37 below:

Table 17: SO group by GI group

	Cis	TGD	Unknown	Grand Total
Bi	43	15	3	61
Gay man	131	9	1	141
Gay woman or Lesbian	99	20	5	124
Other sexual minority	16	26	3	45
Pansexual	17	22	3	42
Straight		7	1	8
Unknown	1	2		3
Grand Total	**307**	**101**	**16**	**424**

Figure 37: SO group by GI- all ages



It should be noted, therefore, that analysis by SO also includes TGD people who identify as a sexual minority.

Young people

Half of the young people (52%) identified as either trans binary or non-binary/gender variant and 43% of young respondents identified as cis. This is shown below:

Table 18: GI of Young people

	No.	%
Cis	**32**	**43%**
Trans and Gender Diverse	**39**	**52%**
Binary	14	19%
Non-binary/gender variant	24	32%
Unknown	1	1%
Unknown	**4**	**5%**
Grand Total	**75**	**100.00%**

Young people were most likely to identify as bi, followed by an other sexual minority, pansexual, gay man, and gay women/lesbian. 4% of the sample identified as straight and these were all people who identified as TGD. This is shown below:

Table 19: SO of Young people

	No.	%
Bi	23	31%
Gay man	12	16%
Gay woman or Lesbian	7	9%
Other sexual minority	17	23%
Pansexual	12	16%
Straight	3	4%
Unknown	1	1%
Grand Total	**75**	**100%**

Working age people

The majority of working age people identified as cis (80%), with a further 17% identifying as TGD. This is outlined below:

Table 20: GI of Working age people

	No.	%
Cis	**221**	**80%**
Trans and Gender Diverse	**48**	**17%**
Binary	15	5%
Non-binary/gender variant	31	11%
Unknown	2	1%

Unknown	**8**	**3%**
Grand Total	**277**	**100%**

In contrast to young people, working age people were more likely to identify as a gay man or gay woman, with far fewer identifying as bi, pansexual, or as an other sexual minority. All four respondents who identified as straight were TGD. This is outlined in the table below:

Table 21: SO of working age people

	No.	%
Bi	33	12%
Gay man	97	35%
Gay woman or Lesbian	92	33%
Other sexual minority	24	9%
Pansexual	26	9%
Straight	4	1%
Unknown	1	0%
Grand Total	**277**	**100%**

Older people

As shown in the table below, the number of older people who identified as non-binary/gender variant and trans binary was very small, and so the analysis was conducted at a TGD level.

Table 22: GI of older people

	No.	%
Cis	**49**	**79%**
Trans and Gender Diverse	**11**	**18%**

Binary	6	10%
Non-binary/gender variant	4	6%
Unknown	1	2%
Unknown	**2**	**3%**
Grand Total	**62**	**100%**

As shown in the table below, the number of older people identifying as an other sexual minority or pansexual was very low, and so analysis at the SO level has been conducted for LGB people.

Table 23: SO of older people

	No.	%
Bi	5	8%
Gay man	29	47%
Gay woman or Lesbian	24	39%
Other sexual minority	1	2%
Pansexual	2	3%
Straight	1	2%
Grand Total	**62**	**100%**

The number of bi people within the older people sample was smaller than ideal for analysis, and so the findings for this sub-group should be interpreted with caution.

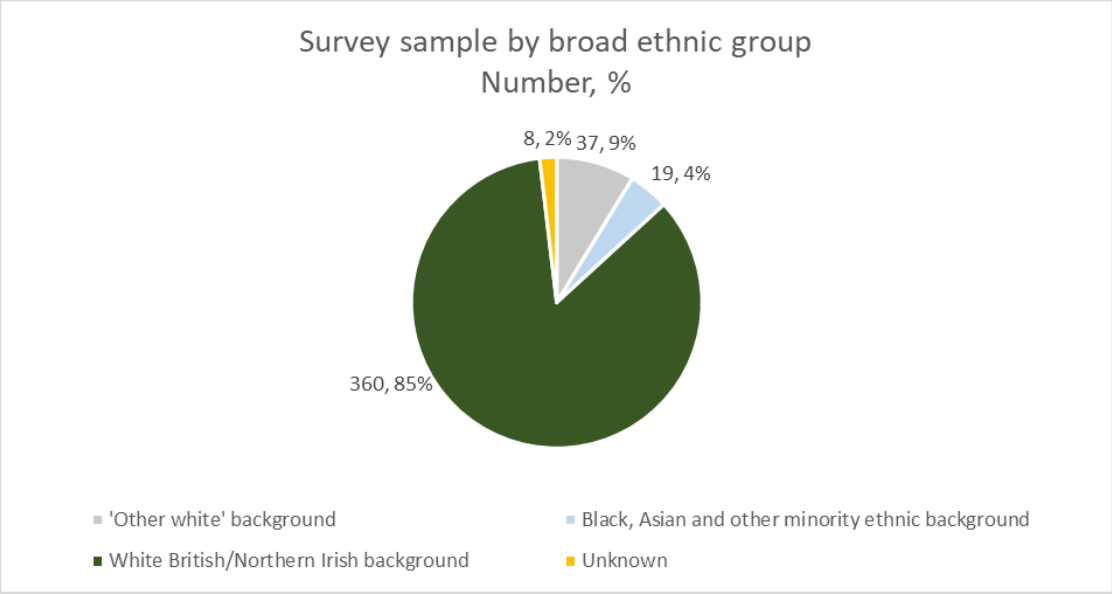
Ethnicity

Due to small sample sizes, it has not been possible to review differences in responses by ethnic groups within age groups. Instead, this has been highlighted at the end of each section using the following categories: White British, 'other white' backgrounds and Black, Asian and other minority ethnic backgrounds. The project team acknowledge the limitations of grouping different ethnicities together in this way and appreciate it may not give an accurate picture of the differences of

experience between LGBTQ+ people of different ethnic groups. Unfortunately, it was not possible to analyse this in more detail, based on the sample size of specific ethnic groups.

85% of the sample identified as White British/Northern Irish. 9% of the sample identified with another white background and 4% of the sample identified as being from a Black, Asian and other minority ethnic background, across a wide range of ethnic groups. A further 2% of the sample did not state their ethnicity. This is shown below:

Figure 38: Broad ethnic groups of the whole sample



People with an intersex variation

Five respondents (1.18% of the sample) stated they had an intersex variation. All five intersex respondents also identified as a sexual minority group and as TGD. Due to the small sample size, it was not possible to analyse differences between people with intersex variation and people without intersex variation.

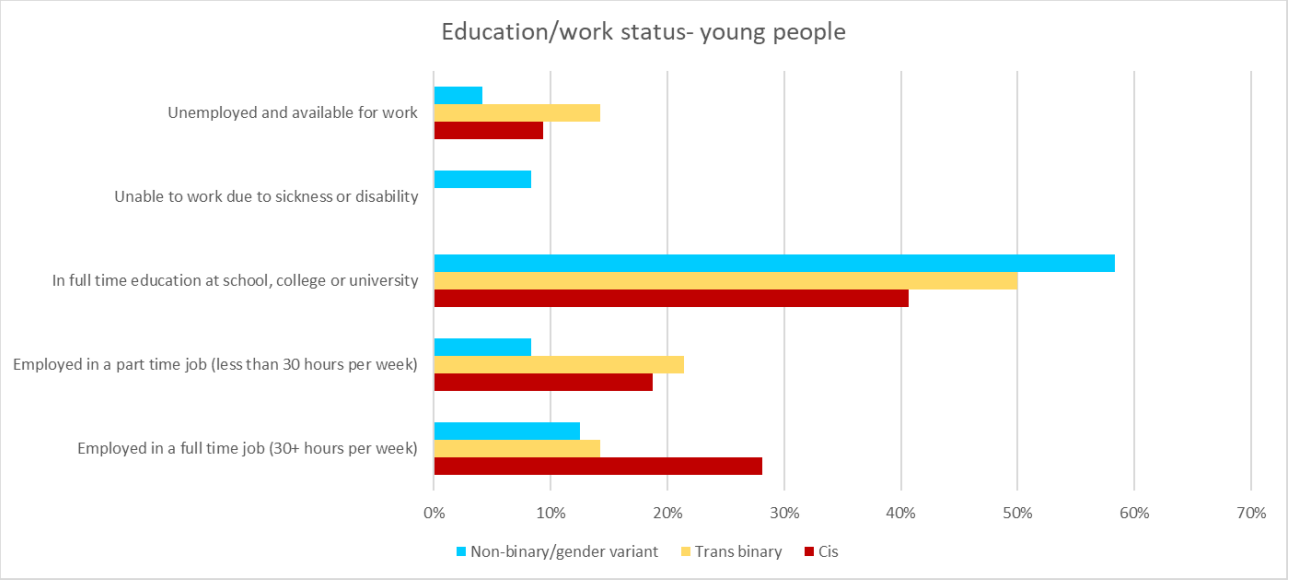
Wider determinants of health

Young people

Education and employment

Almost half of the young respondents (47%) were in full-time education, 20% of respondents were employed full time and 17% of young respondents were employed part-time. The remainder of responses regarding work status varied widely. Differences in education/work status could be seen between cis, trans binary and non-binary/gender variant people:

Figure 39: Graph depicting differences in education or work status in young people by gender group



A greater proportion of non-binary/gender variant people (58%) and trans binary people (50%) compared to cis people (41%) were in full-time education, with a greater proportion of cis people employed full time.

There were also some differences in education/employment status between SO groups, with gay women/lesbians the most likely to be employed full time (43%), and other sexual minorities the least likely to be employed full time (6%). Bi people were most likely to be in full-time education (57%), with gay women/lesbians the least likely to be in education full time (29%). The SO group most likely to be unable to work due to sickness/disability were pansexual people (8%).

Housing

The majority of young respondents (72%) still lived with parents/carers or family. Of those, one quarter (26%) had experienced bi/homo/transphobia at home during the pandemic, with the prevalence of this three times higher in TGD people (37%) compared to cis people (12%.) Across all housing arrangements, 23% of young people reported experiencing bi/homo/transphobic abuse during the pandemic at home.

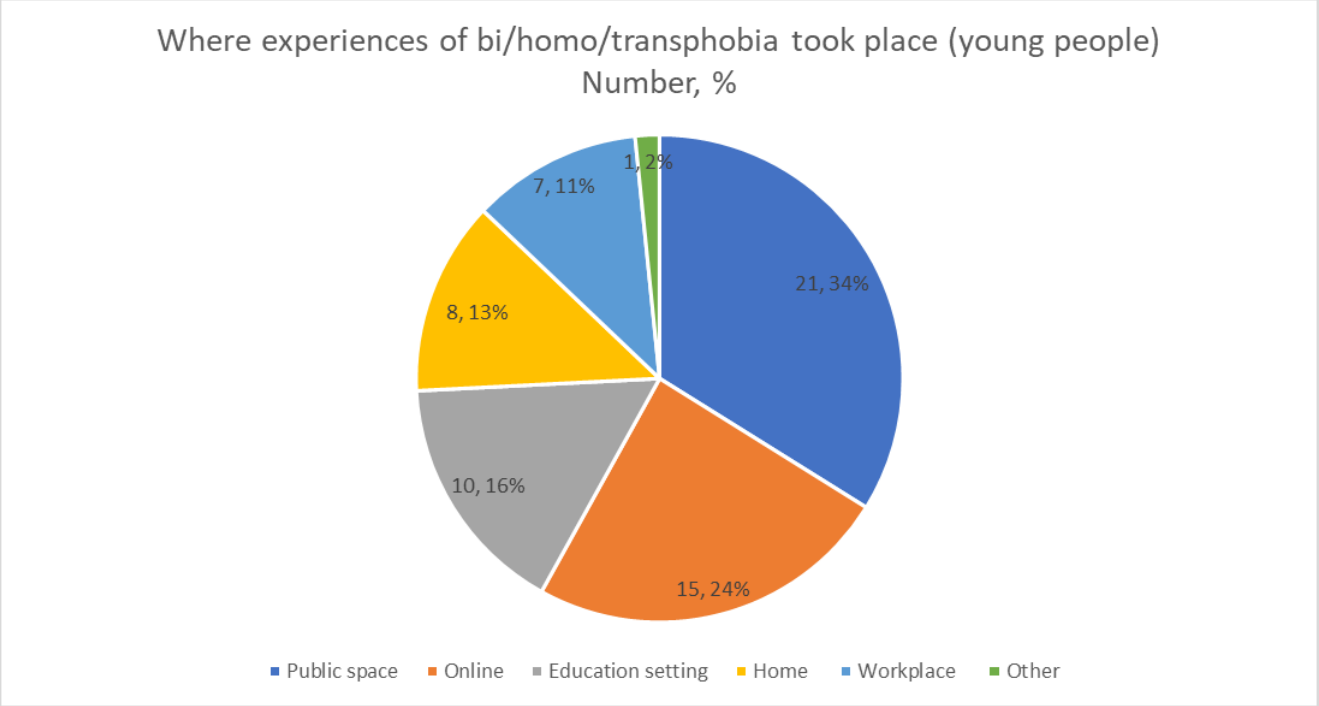
A further 5 % of young people stated they had returned to live with family and, 3% of respondents lived in precarious settings, including temporarily with friends or family, sofa surfing and living in their car. The remaining respondents chose from a wide range of responses relating to their current living circumstances.

Hate crime

Over half of young respondents (51%) reported experiencing bi/homo/transphobia in any setting over the past 18 months, increasing slightly to 57% for trans binary young people.

For young people, the settings where most LGBTQ+ hate crimes took place were within the workplace, online or in an education setting, as outlined below:

Figure 40: Location of bi/homo/transphobia instances in the past 18 months



Only 3% of young people stated that they reported such an incident to the police or the setting it occurred in. A further 29% of respondents noted they didn't feel comfortable reporting this and 63% didn't feel the need to report this.

Isolation, loneliness and social support

One form of social support is that of a relationship(s). In young respondents, 39% were in a relationship. There were no large differences between people of different sexual orientations nor between cis and TGD people.

Being out about your sexuality may be an important facilitator of social support (69). For young respondents from a sexual minority, just over a third (35%) of respondents were out to all or almost all of the people they know, with only 4 % not out to anyone they know. The SO group that were most likely to be out to everyone or almost everyone they knew were gay men (67%), followed by gay women/lesbians (57%), bi people (30%), other sexual minorities (24%) and pansexual people (17%).

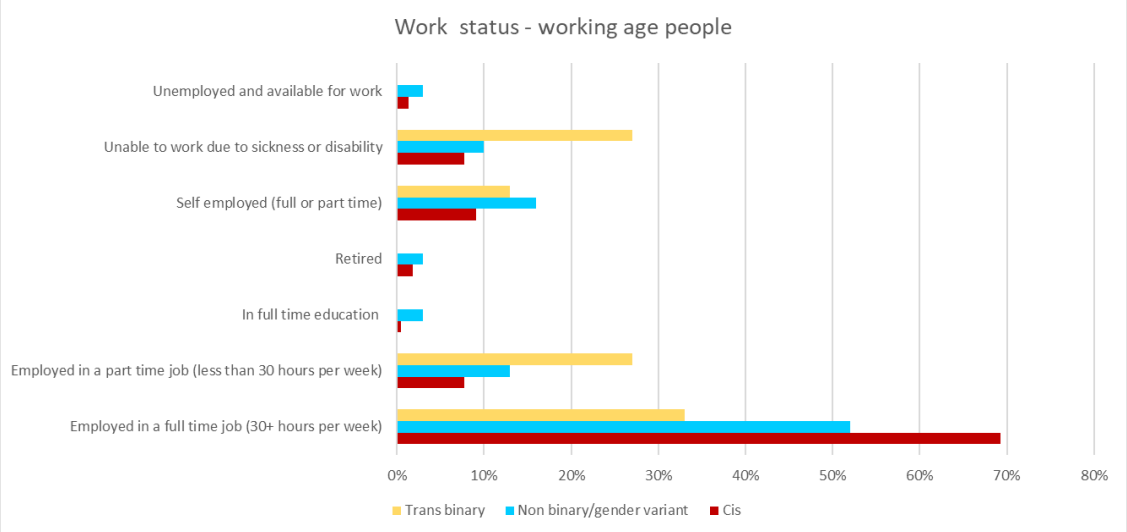
When asked whether they had experienced loneliness/isolation during the pandemic, two thirds (67%) of young people agreed that they had. This was the highest of any age group. This increased to 79% of trans binary young people. Contrary to what might be expected, 75% of young people living with a partner reported feeling lonely or isolated during the pandemic, compared to 58% of single people.

Working age people

Employment

The majority of working age respondents were employed full time (65%). A further 10% were self-employed and 9% were unable to work due to disability or sickness. The remaining responses were varied. Differences arose by gender group, as outlined below:

Figure 41: Work status by GI for working age people

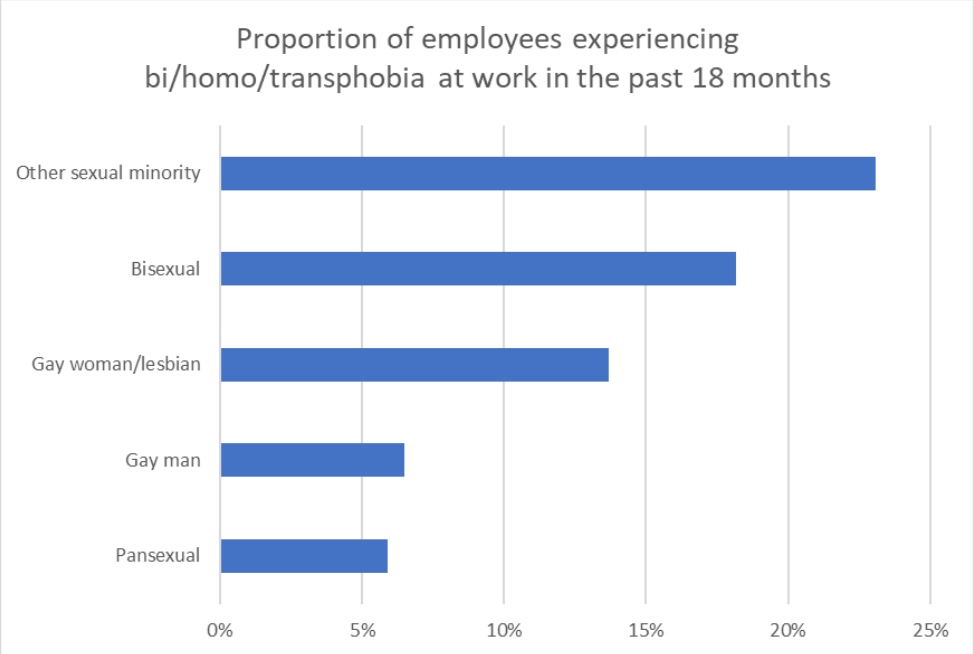


Cis people were most likely to be employed full time, compared to TGD groups. Whereas trans binary people were most likely to be employed in a part-time job or unable to work due to sickness or disability. Non-binary/gender variant people were more likely to be self-employed than the other groups.

Gay men were most likely to be employed full time (73%), followed by lesbian/gay women (64%), bi people (58%), pansexual people (58%) and other sexual minorities (50%). Pansexual people and bi people were over twice as likely to be unable to work due to sickness or disability than gay/lesbian or other sexual minorities with 19% (pansexual people) and 18% (bi people) unable to work for this reason.

Of those in full or part-time work, the prevalence of experiencing bi/homo/transphobic abuse in the workplace was high, with 12% of respondents reporting this. This increased to over one in four (44%) trans binary people. The prevalence of such abuse within the workplace also varied significantly by sexual orientation as outlined below:

Figure 42: Proportion of employees experiencing bi/homo/transphobia at work in the last 18 months

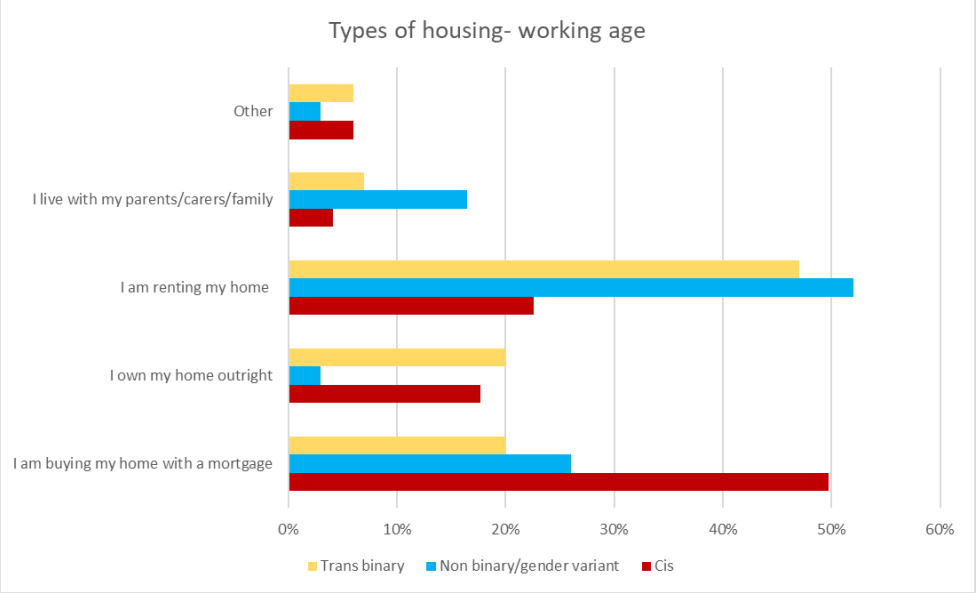


Housing

Almost half (45%) of working age people stated that they were buying their home with a mortgage. 16% of respondents stated they owned their home outright. Almost one quarter of respondents (23%) were renting privately and a further 6% lived with family or friends. The remaining respondents chose from a wide range of responses relating to their current living circumstances.

Amongst the sample, there were some clear disparities in housing arrangements between cis, trans binary people and non-binary/gender variant people, as outlined in the graph below:

Figure 43: Types of housing by gender group in working age respondents



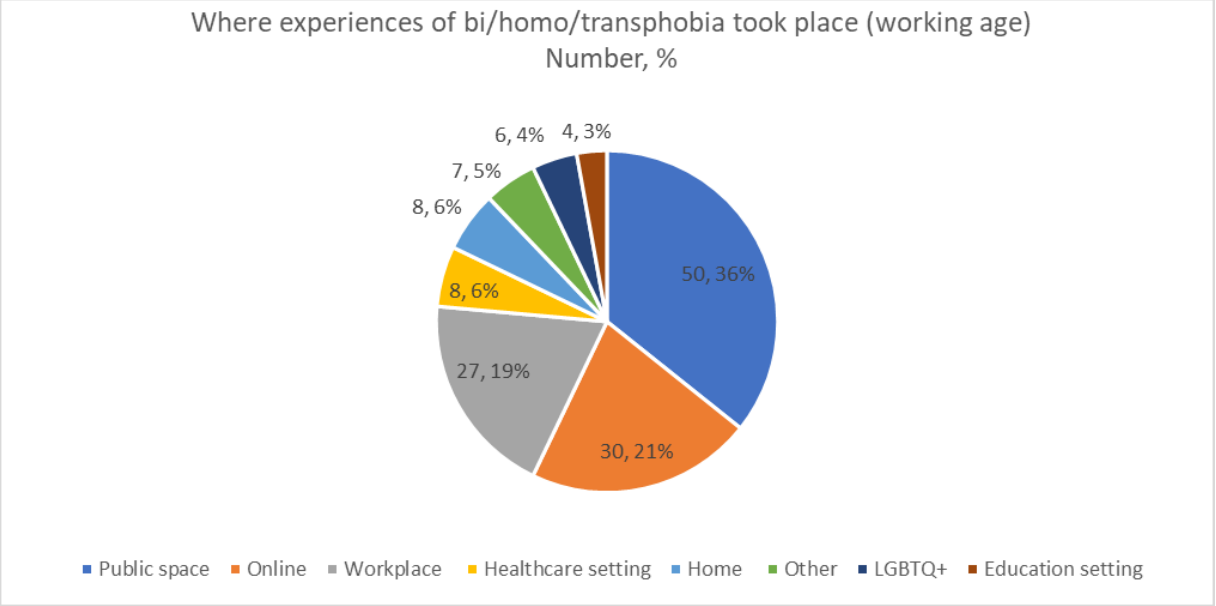
As demonstrated, cis people were more likely to be buying their home with a mortgage, compared to trans binary and non-binary/gender variant people. A greater proportion of cis people and trans binary people owned their home compared to non-binary/gender variant people. Both trans binary and non-binary/gender variant people were more likely to be renting (from the council, privately or a housing association) and to be living parents or family. Additionally, there were some differences in housing status by sexual orientation with gay men the most likely to be buying their home with a mortgage (53%), compared to gay women/lesbians (47%), bi people (42%), other sexual minorities (42%), and pansexual people (23%). Compared to young people, a much smaller proportion of working age respondents reported experiencing bi/homo/transphobic abuse in the home during the pandemic (3%.)

Hate crime

Compared to young people, a lower proportion of working age respondents experienced bi/homo/transphobia in any setting in the past 18 months. Trans binary people were most likely to experience this (53%), compared to non-binary/gender variant people (35%) or cis people (29%.) When considering the incidence of hate crime by SO group, 27% of pansexual people, 28% of gay men, 32% of lesbian/gay women, 33% of bi people and 50% of other sexual minorities reported experiencing this.

The top three settings that such abuse took place were public places/leisure settings, online or in a workplace, as highlighted below:

Figure 44: Location of bi/homo/transphobia instances in the past 18 months



Only 17% of working age people that experienced a hate crime reported this, either to the police or to the setting it occurred in, such as HR at their workplace. Cis people were almost twice as likely to report the incident(s) than TGD people. Of the 36% of respondents that didn't feel comfortable reporting their experience(s), several noted that they no longer report such incidents because their experience is that no meaningful action is taken. A further 44% of people explained that they did not feel the need to report this.

Isolation, loneliness and social support

For working age respondents from a sexual minority, almost three quarters (73%) were out to all or almost all of the people they know, with only 1% not out to anyone they know. The SO group that were most likely to be out to everyone or almost everyone they knew were gay women/lesbians and gay men (both 87%), followed by other sexual minorities (54%), pansexual (50%) and bi people (36%).

In working age respondents, 72% were in a relationship, with cis people more likely to be in a relationship than TGD people (76% compared to 50%.) Lesbian/gay women were the SO group most likely to be in a relationship (78%) and bi people were the least likely group to be in a relationship (58%).

For working age people, 43% of respondents reported feeling lonely/isolated during the pandemic, increasing to 77% in non-binary/gender variant people. Other sexual minorities were the most likely to feel isolated and lonely (63%), followed by bi people (55%), pansexual people (50%), gay women/lesbians (39%) and gay men (36%.) Single people (64%) or people in a relationship but not living with their partner (59.26%) were more likely to feel lonely compared with people living with a partner (31%).

Older people

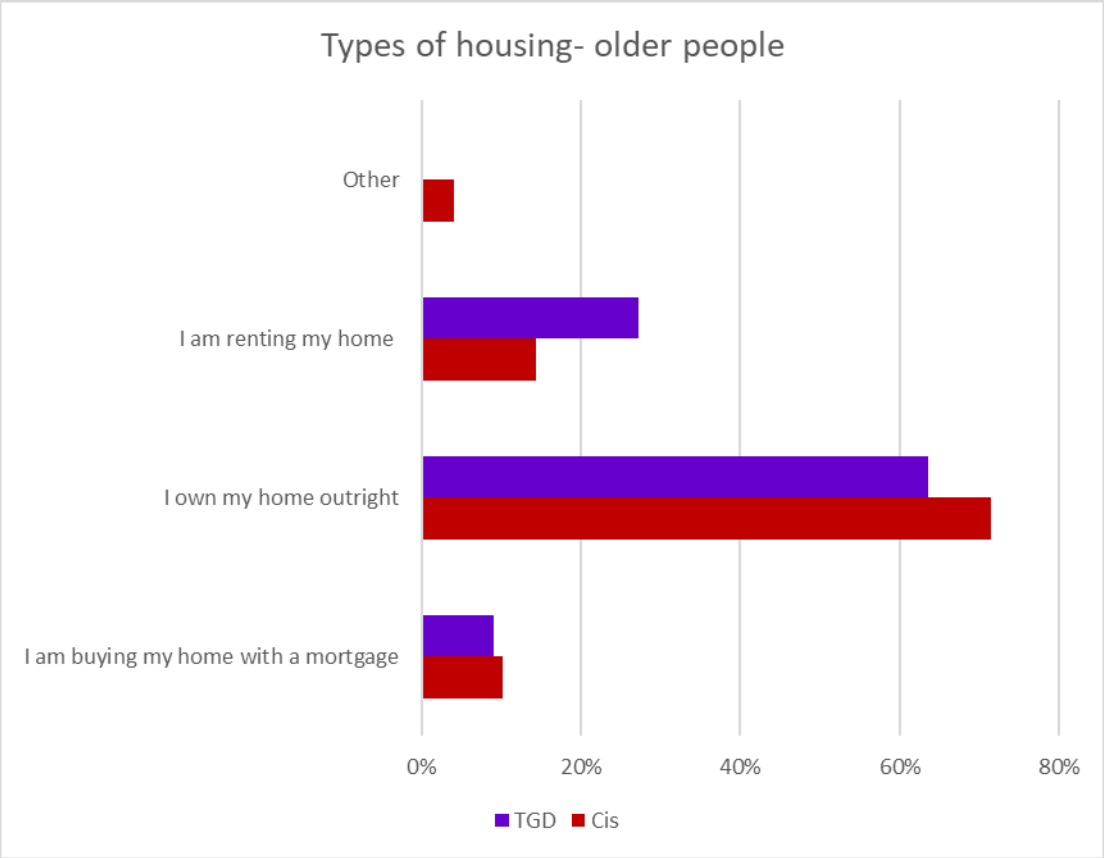
Employment

Most older respondents (63%) were retired, and 18% reported working either full or part-time. A greater proportion of cis older people were retired than TGD people (67% compared to 55%).

Housing

The majority (69%) of older respondents stated that they owned their home outright, with a further 10% buying their home with a mortgage and 11% renting privately. Compared to cis people, TGD people were slightly less likely to own their home outright and more likely to be renting. This is outlined below:

Figure 45: Types of housing in older respondents



6% of respondents reported they were not out where they were living and 2% of respondents reported experiencing bi/homo/transphobic abuse in the home.

Hate crime

Older people reported the lowest incidence of bi/homo/transphobia in any setting in the past 18 months compared to the other age groups with 11% of people experiencing this. However, TGD people were over three times more likely to experience this (n=3, 27%) than cis people (8%.) For older LGBTQ+ respondents, 50% of such incidents occurred in a public space or leisure setting. Of all age groups, older respondents were more likely to report these incidents, with 29% reporting this to the police or setting it occurred in.

Isolation, loneliness and social support

In older respondents, 56% of respondents were in a relationship. For older respondents from a sexual minority, 80% were out to all or almost all of the people they know, with only 2% not out to anyone they know. Most lesbian and gay older people were out to all or almost all of the people they know (87%), with only 40% (n=2) of older bi people out to almost all or all the people they know.

Just over a third (34%) of older respondents reported feeling isolated or lonely during the pandemic. This was much higher in TGD people (64%) than cis people (29%). Single older people were also much more likely to report experiencing loneliness/isolation during the pandemic than people in a relationship cohabiting (54% compared to 17%).

Other groups

Analysis by ethnic group

Respondents from Black, Asian and other minority ethnic backgrounds were less likely to be employed full time (32%) compared to 43% of 'other white' groups and 48% of white British groups. Respondents from Black, Asian and other minority ethnic backgrounds were almost twice as likely to encounter bi/homo/transphobia in the workplace as white British respondents (20% vs 11%). There were no large differences in housing status between ethnic groups. People from 'other white' backgrounds reported slightly more experiences of anti-LGBTQ+ hate crime in general (38%) than white British (32%) and Black, Asian and other minority ethnic (32%) respondents.

In terms of social support, less than half (47%) of respondents from a Black, Asian and other minority ethnic background reported that all or almost all of the people they knew were aware of their SO, compared to 69% of respondents from white British backgrounds. When asked whether the pandemic had led them to feel isolated or lonely, 58% of respondents from Black, Asian and other minority ethnic

backgrounds felt that it had, compared to 54% from 'other white' respondents and 45% of white British respondents.

Trans women

Across all age groups, trans women (n=19) had the highest rate of being unable to work due to sickness or disability (21%). Additionally, trans women were the GI group across all age groups most likely to experience hate crime with 68% experiencing this in the past 18 months, compared to 28% of LGB+ cis women. Only 11% of trans women reported these incidents. Further, 53% of trans women reported feeling isolated or lonely during the pandemic, compared to 43% of cis women.

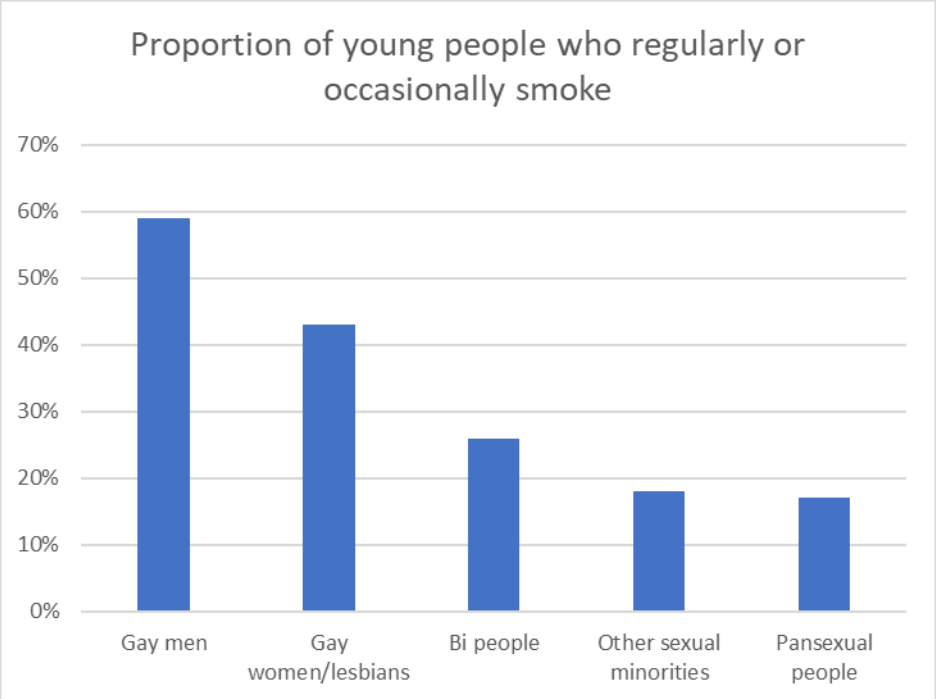
Health behaviours

Young People

Smoking

8% of young LGBTQ+ respondents reported smoking regularly, with similar rates between gender groups. Trans binary people reported a higher rate of occasional smoking (36%) compared to cis people (19%) and non-binary/gender variant people (17%). Over half (59%) of young gay men reported regularly or occasionally smoking, compared to 43% of gay women/lesbians, 26% of bi respondents, 18% of other sexual minorities and 17% of pansexual people. This is summarised below:

Figure 46: Proportion of young people who regularly or occasionally smoke by SO

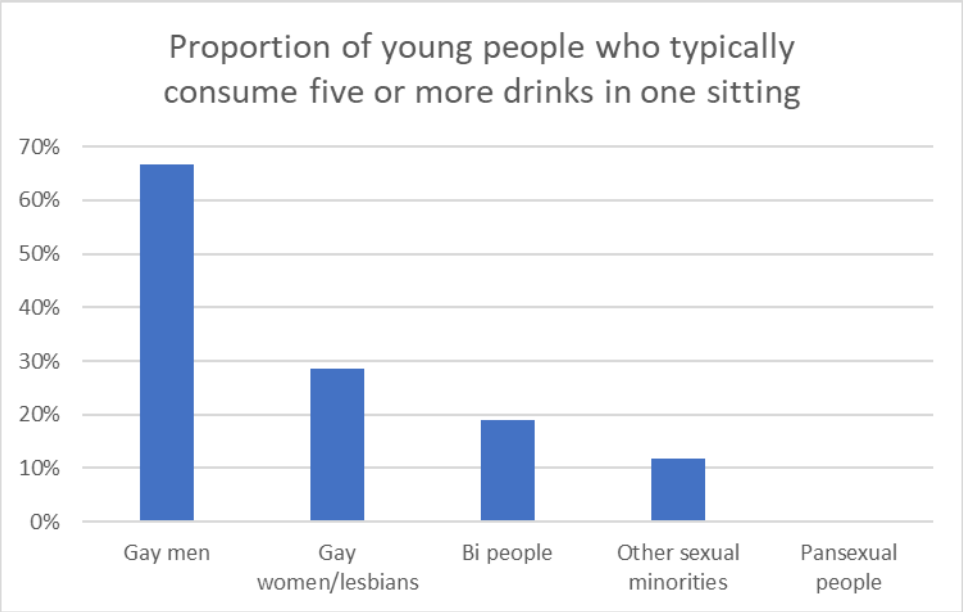


Additionally, most young people have never vaped (75%) with 3% of cis people vaping regularly, increasing to 13% in non-binary/gender variant people and 14% in trans binary people.

Alcohol Use

A small minority of young respondents reported drinking alcohol every day or most days (7%). However, almost one quarter (23%) of young people reported drinking five or more alcoholic drinks in one sitting when they typically drink. This was highest in trans binary people (36%) and cis people (31%) compared to non-binary/gender variant people (4%). There were also significant differences by SO group, with gay men the most likely to drink excessively in one sitting:

Figure 47: Proportion of young people who typically drink five or more drinks in one sitting by SO group



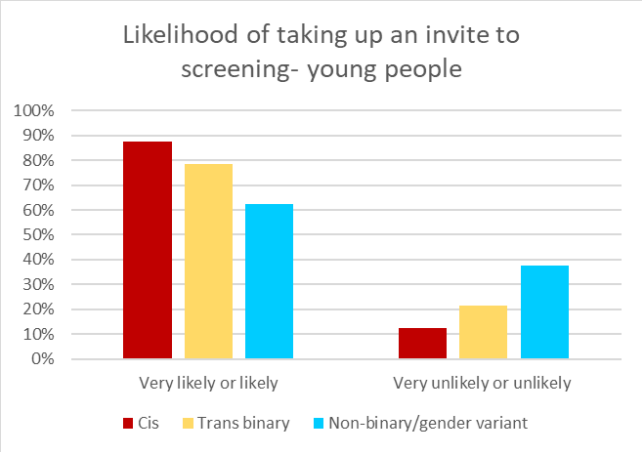
Physical Activity

The majority of young respondents reported insufficient levels of physical activity (categorised as less than 30 minutes of moderate physical activity per day at least five days per week.) Less than one quarter (23%) of young people were sufficiently physically active, and there were significant disparities between gender groups. 38% of cis people achieved sufficient levels of physical activity compared to 17% of non-binary/gender variant people and 0% of trans binary people. Bi people and gay men were the most likely to achieve this sufficient physical activity (35% and 33% respectively), with gay women/lesbians and other sexual minority groups as least likely to achieve this (14% and 12% respectively.)

Attending screening

Willingness to take up a screening offer was relatively high in cis young people, but lower in trans binary and non-binary/gender variant people, as shown below:

Figure 48: Likelihood of taking up an invite to screening - young people



As outlined in the literature review section of this report, there are many issues beyond willingness to attend screening for TGD people, including being invited in the first instance. This question only reflects willingness to take up the offer of screening once invited.

When considering the likelihood to take up screening by SO, 100% of gay women/lesbians reported they would be very likely or likely to take up the offer of screening, compared to 92% of gay men, 76% of other sexual minority groups, 74% of bi people and 58% of pansexual people.

Knowledge of PrEP

Just over one third (39%) of young respondents were aware of PrEP as a form of HIV prevention and that it is available for free from NHS sexual health clinics. 92% of gay men were aware of PrEP, and less than half of respondents in all other SO groups were aware of this. Amongst trans binary people, 43% were aware of this, and just 29% of non-binary gender variant young people were aware of this.

Working age people

Smoking

Less than one in ten (8%) of respondents regularly smoked, increasing to 13% in trans binary people. Whilst this is below the UK average, 40% of respondents were former smokers, increasing to 53% in trans binary people. The data collected give no indication of previous smoking frequency or time elapsed since quitting.

There were small differences in smoking rates between SO groups. Pansexual people had the highest rate of regular smoking (12%), followed by gay men (10%), other sexual minorities (8%), gay women/lesbians (7%) and bisexuals had the lowest rate (6%). Further to this, 9% of the working age respondents vaped regularly, increasing to 27% of trans binary people. Gay men were the most likely group to vape regularly (13%), compared to all other SO groups.

Alcohol Use

One quarter (25%) of working age respondents drank alcohol every day or most days, reducing to 16% in non-binary/gender variant people. Gay men were the group most likely to drink every day or almost every day (31%), followed by gay women (23%), bi people (21%), other sexual minorities (21%) and pansexual people (15%), as shown below:

Figure 49: Proportion of working age adults drinking alcohol every day or most days

The proportion of working age people drinking five or more alcoholic drinks in one sitting was lower than for younger people, at 14%. This increased to 19% in pansexual people, and 18% in bi people and gay men. There were no clear differences between gender groups.

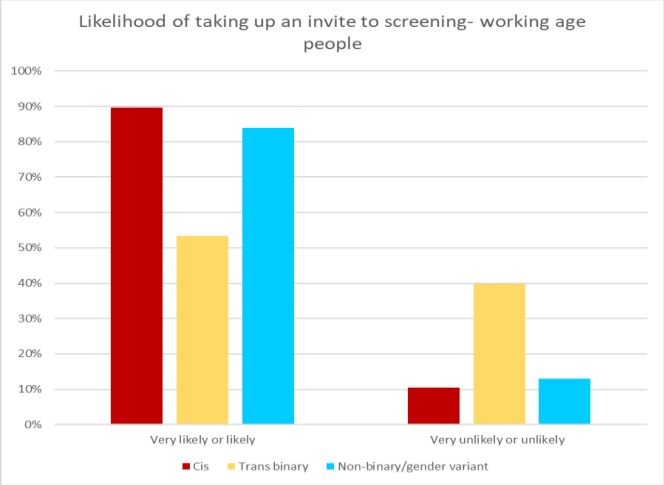
Physical Activity

Just over one quarter (26%) of working age respondents achieved 30 minutes of moderate physical activity per day for five or more days per week. This increased to 33% of non-binary/gender variant people. In terms of SO groups, other sexual minority groups were the most likely to achieve sufficient physical activity (38%), compared to gay men (30%), gay women (22%), bi people (21%) and pansexual people (15%).

Attending screening

Intention to take up screening when offered was high in cis people (90%) and non-binary/gender variant people (84%) but very low in trans binary people at just 53%. This is shown in the graph below:

Figure 50: Likelihood of taking up an invite to screening - working age people



As outlined in the literature review of this report, there are issues beyond willingness to attend screening for TGD people, including being invited in the first instance. This question only reflects willingness to take up the offer of screening once invited.

When considering the likelihood to take up screening by SO, 94% of gay men reported they were very likely or likely to take up a screening offer, compared to 88% of bi people, 88% of other sexual minority groups, 84% of gay women/lesbians and 81% of pansexual people.

Knowledge of PrEP

A greater proportion of working age respondents were aware of PrEP, with 61% aware of this as a form of HIV prevention. Knowledge was highest in gay men (86%), pansexual people (65%), other sexual minorities (79%), bi men (67%), bi women (48%), bi people who identify as non-binary or gender variant (40%) and lowest in gay women/lesbians (35%).

Over two thirds of non-binary/gender variant people (68%) and trans binary (67%) people were aware of PrEP compared to 61% of cis people.

Older people

Smoking

Almost four in ten (39%) older people were former smokers, with similar rates across cis and TGD groups. One in ten (10%) older respondents smoked regularly, with the same rate across TGD and cisgender groups. Gay men were most likely to be regular or occasional smokers (31%) compared to all other SO groups. Vaping rates were 4% in cis people and 0% in TGD groups.

Alcohol Use

Older people were the age group most likely to drink alcohol almost every day or every day, with 39% of respondents reporting this. However, this group was least likely to drink excessively in one sitting, with only 6% of respondents drinking five or more alcoholic drinks in one sitting typically, with cis people more likely to report this than TGD people. One in ten (10%) of gay men reported drinking five or more drinks in a typical sitting, compared to 0% in all other SO groups.

Physical Activity

Older respondents were slightly more likely to be sufficiently physically active than younger and working age people, with 31% undertaking moderate exercise for at least 30 minutes per day for five or more days per week. However, cis people were over three times more likely to be sufficiently physically active than TGD people (33% compared to 9%).

Attending screening

The vast majority of older respondents (97%) reported they would be very likely or likely to take up an offer of screening when invited, with similar rates for cis and TGD people and across SO groups.

Knowledge of PrEP

Slightly fewer older respondents were aware of PrEP compared to working age people, with 56% of older adults being aware of this. The majority of gay men were aware of this (86%) with gay women/lesbians the least aware of this (25%). In cis people, 61% reported being aware of PrEP compared to 40% of TGD people.

Other groups

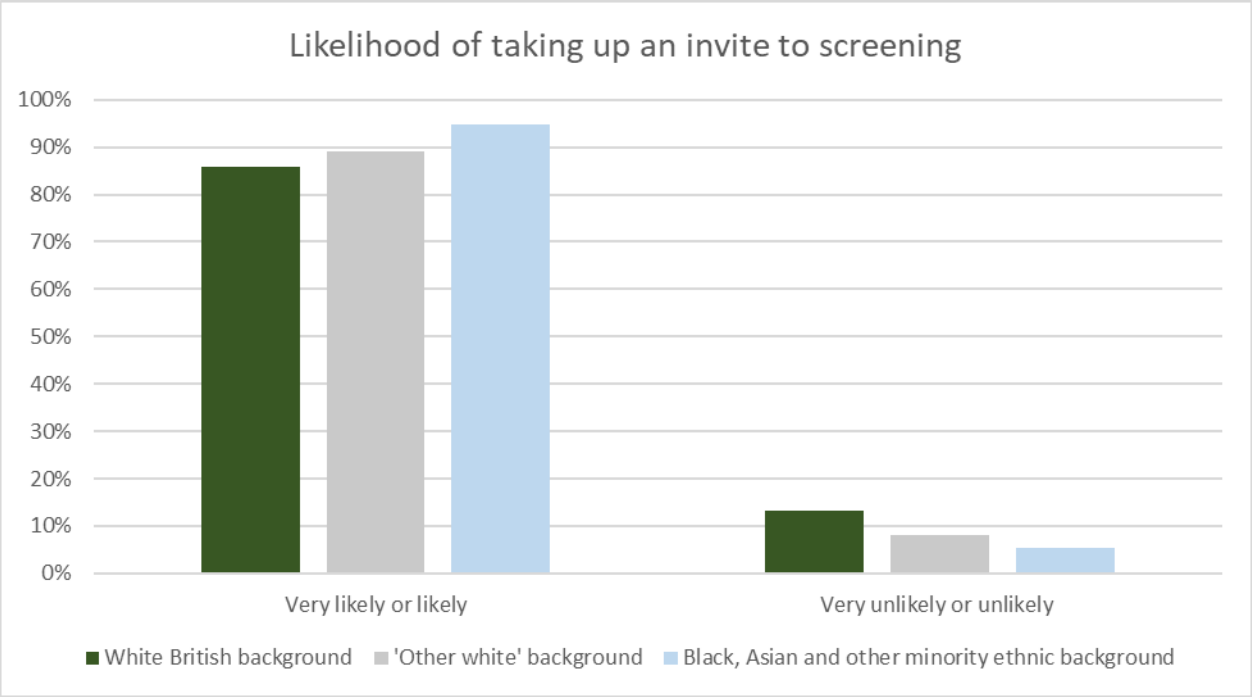
Analysis by ethnic group

Regular smoking rates in Black, Asian and other minority ethnic respondents were almost double that of white respondents (16% compared to 8%). The proportion of respondents who drank alcohol almost every day or every day was similar across ethnic groups, although Black, Asian and other minority ethnic groups were more likely to not have drunk any alcohol in the last 12 months compared to white British respondents (26% compared to 18%). People from 'other white' backgrounds were more likely to drink five or more alcoholic drinks in one sitting (19%) than white British groups (15%) and people from Black, Asian and other minority ethnic groups (6%). Respondents from 'other white' backgrounds had the

highest levels of sufficient physical activity (32%), compared to 26% of Black, Asian and other minority ethnic respondents and 25% of white British respondents.

Screening uptake rates were highest in Black, Asian and other minority ethnic respondents compared to white respondents, as outlined below:

Figure 51: Likelihood of taking up an invite to screening by ethnic group



Trans women

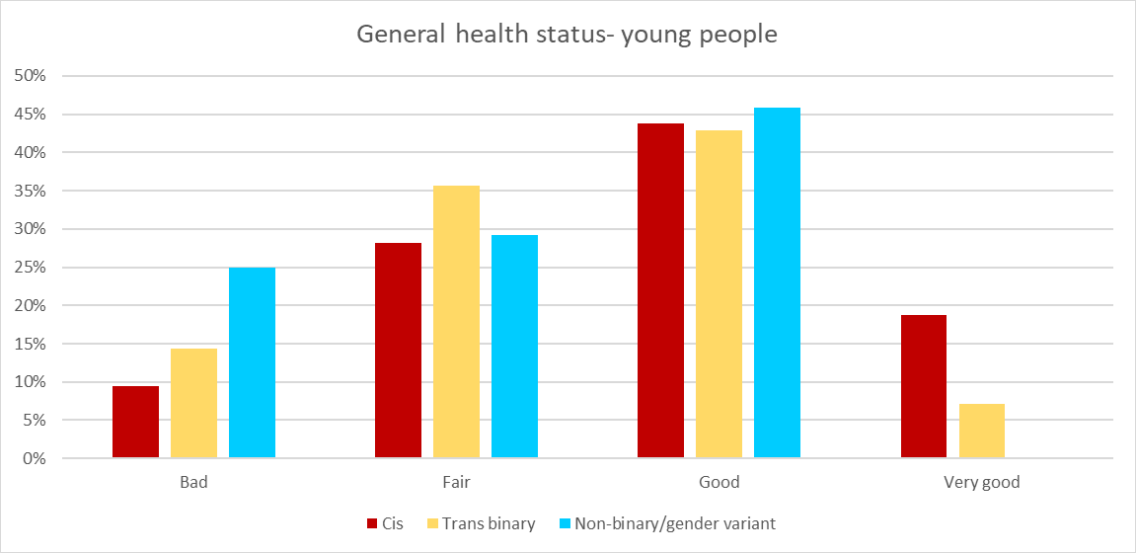
A greater proportion of trans women were aware of PrEP than cis women (53% compared to 36%), but this was low compared to gay men across all age groups (87%). With regards to intention to take up screening, 68% of trans women reported they would be likely or very likely to attend a screening appointment, with 26% unlikely or very unlikely to do so.

Health status and disability

Young people

Overall, 11% of young respondents reported they were in bad health, compared to 15% of respondents who reported they were in very good health. However, this varied substantially between gender groups, as shown below:

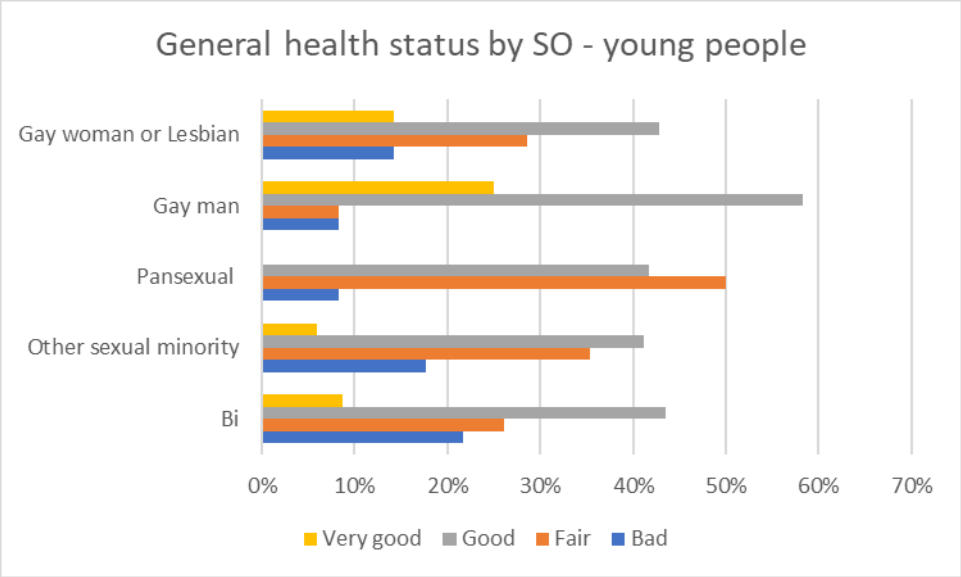
Figure 52: General self-reported health status by gender group- young people



Cis people were more likely to report either good or very good health compared to trans binary and non-binary/gender variant people. One quarter of non-binary/gender variant young people reported they were in bad health, and none of this group reported very good health.

Differences in self-reported health could also be seen between SO groups, as shown below:

Figure 53: General self-reported health status by SO- young people



Pansexual people, other sexual minorities, and bi people were the least likely to report very good health, with gay men most likely to report very good health.

Over eight in ten (83%) of young people reported one or more LTC or disability, with 100% of TGD people reporting this. For those from other sexual minorities, 94% reported one or more LTC or disability.

Almost half (48%) of young respondents reported an anxiety disorder, with the rate increasing to 75% of non-binary/gender variant young people. Rates of depression were also high, at 40%, with the rate in non-binary/gender variant people over three times that of cis people (67% compared to 19%). Rates of diagnosed gender dysphoria were high for trans binary people (86%), with a lower proportion reporting undiagnosed gender dysphoria (14%). Non-binary/gender variant people reported higher rates of undiagnosed gender dysphoria (33%) and 17% reported diagnosed gender dysphoria.

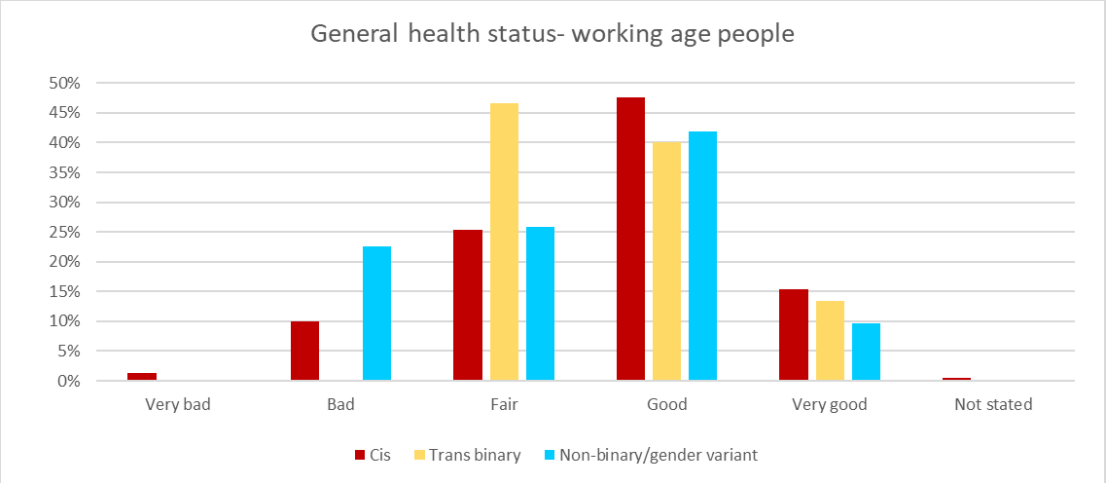
Gay women/lesbians reported the highest rate of anxiety disorders (71%) across SO groups. Young people from other sexual minorities had the highest rate of depression (52%) and autism (24%). Bi people had relatively high rates of anxiety (61%) and depression (43%).

A breakdown of the most common conditions young people reported by GI group and SO group are outlined in tables in appendix two.

Working age people

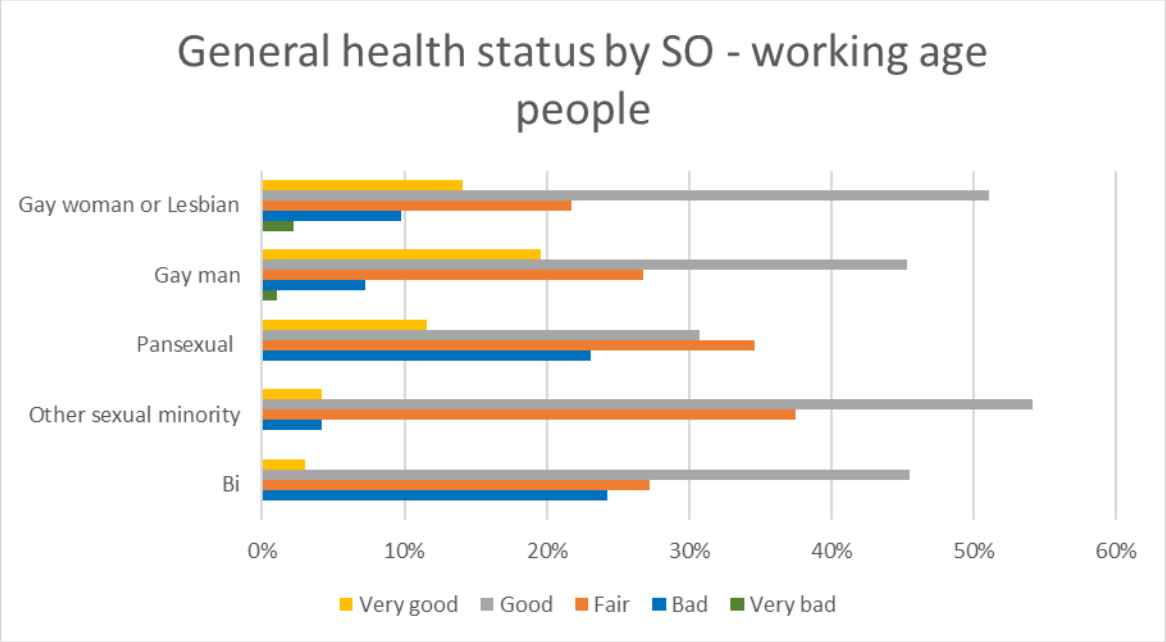
Overall, 1% of working age respondents considered themselves to be in very bad health, 11% felt their health was bad and 14% of respondents felt their health was very good. Self-reported health status however varied by gender groups, with almost one quarter of non-binary/gender variant people reporting bad health, compared to 9% of cis people and 0% of trans binary people.

Figure 54: General self-reported health status by gender group- working age people



Differences in self-reported health also exist between SO groups, with gay men and gay women/lesbians the most likely to report very good or good health, and pansexual people the least likely to report very good or good health, as shown below:

Figure 55: General self-reported health status by SO- working age people



Over two third (69%) of working age people reported at least one LTC or disability, increasing to 81% in non-binary/gender variant people, 93% in trans binary people.

For working age people, anxiety disorder was reported by 29% of respondents, increasing to 33% of binary people and 42% of non-binary/gender variant people. The SO groups with the highest anxiety disorder rates were in other sexual minority groups (50%) and pansexual people (46%). Depression was reported by 29% of respondents overall, increasing to 53% of trans binary people and 58% of non-binary/gender variant people. Over one in six (63%) of respondents from other sexual minorities reported depression and half (50%) of pansexual people reported this. A greater proportion of trans binary people reported a diagnosis of gender dysphoria (53%) compared to non-binary/gender variant people (16%). Rates of undiagnosed gender dysphoria were higher in non-binary/gender variant people (23%) compared to trans binary people (13%).

Almost one in five (18%) of respondents reported arthritis or chronic back/joint pain, with this highest in other sexual minority groups (29%) and non-binary/gender variant people (23%). High blood pressure was reported by 13% of respondents, with the highest prevalence in gay men (22%) and trans binary people (20%). Autism or autism spectrum disorder was reported by 7% of respondents, increasing to 23% in non-binary/gender variant people. HIV rates were 6% overall, increasing to 16% of gay men. Finally, PTSD was reported by 5% of the respondents, increasing to 13% in trans binary people and 12% of bi people.

Appendix two provides more detail on the prevalence of common conditions within survey respondents by gender group and SO group.

Older people

Overall, 68% of older respondents reported they were in good or very good health, with slightly more cis respondents reporting this (69%) compared to TGD respondents (64%). 79% of older respondents reported at least one LTC or disability, increasing to 82% in TGD people and 83% in gay women/lesbians.

Almost one third (32%) of respondents reported arthritis or ongoing back/joint issues, with TGD people slightly less likely to report this (27%). Of all SO groups, gay women/lesbians were most likely to report this (42%). High blood pressure was also common in this age group (31%), with a higher rate in cis people (35%) than TGD people (9%). The rate of high blood pressure was highest in gay men (40%) compared to other SO groups. Deafness/hearing loss affected 16% of respondents, increasing to 27% of TGD people and 40% of gay men. 15% of respondents had depression, increasing to 21% of gay women/lesbians. Additionally, 13% of the respondents have HIV, increasing to 24% in gay men. Over one in ten (11%) respondents reported having diabetes, increasing to 17% of gay women/lesbians. A further 11% report having a heart condition.

Appendix two provides a full breakdown of the prevalence of common conditions within survey respondents by gender group and SO group.

Other groups

Analysis by ethnic group

Self-reported health varied across ethnic groups, with the proportion of respondents rating their health as very good or good lowest in the white British group (59%), compared to the Black, Asian and other minority ethnic groups (68%) and 'other white' group (70%.)

'Other white' groups had lower levels of anxiety disorder (14%), compared to Black, Asian and other minority ethnic groups (32%) and white British groups (33%). Similarly, depression prevalence was lowest in 'other white' groups (19%) compared to white British (30%) and Black, Asian and other minority ethnic groups (32%). People from a Black, Asian and other minority ethnic background had the highest rate of high blood pressure (21%), compared to those of an 'other white' background (14%) and white British groups (13%). The rate of heart conditions was also higher in people of a Black, Asian and other minority ethnic background (16%, n=3), compared to 'other white' groups (5%, n=2) and white British groups (2%). It should be noted, however, that this hasn't been adjusted for age which could explain some of the disparities in these conditions.

Trans women

Almost nine in ten (89%) of trans women reported one or more LTC or disability, although 0% of trans women rated their health as very bad or bad. Almost one third (32%) of trans women had depression, compared to 23% of cis women. Although a higher proportion of cis women reported an anxiety disorder (31% compared to 15%).

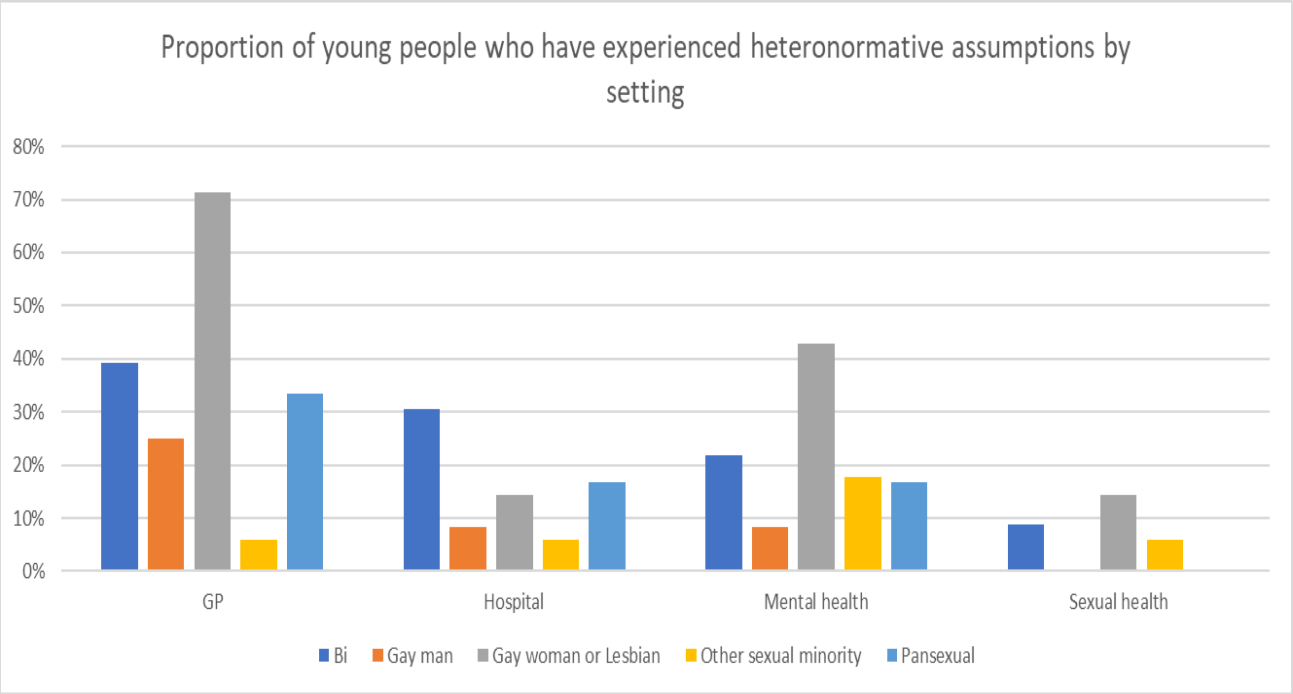
Health and Care Services

Young people

Experience and use of health and care services

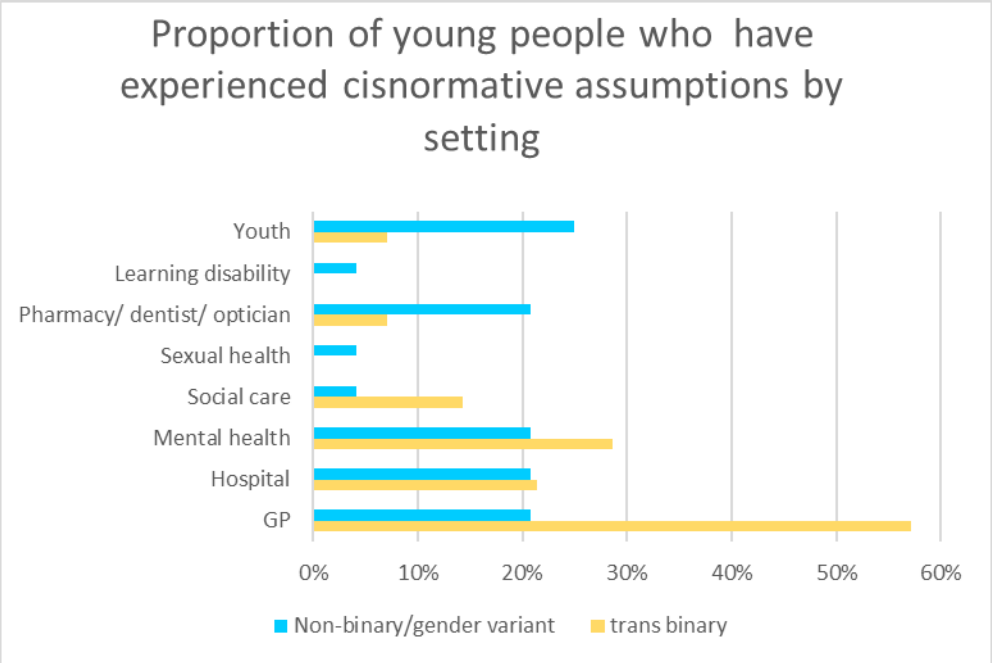
In GP settings, 71% of young gay women/lesbians reported GP staff making assumptions that they were straight, followed by 39% of bi people and 33% of pansexual people. Within hospital settings, bi people were most likely to report assumptions being made by staff that they were straight, with 30% reporting this. In mental health settings, 43% (n=3) of gay women/lesbians reported these assumptions. The breakdown for types of health and care services and the experience of heteronormative assumptions within the last 18 months can be seen below:

Figure 56: Proportion of young people who have experienced heteronormative assumptions by setting



Cisnormative assumptions in services were also commonly experienced by young people within the last 18 months. Over half (57%) of young trans binary people reported experiencing this in GP settings and 21% of non-binary/gender variant people reported this in the same setting. Over a fifth (21%) of trans binary people reported this in hospital settings and mental health settings (29%) and one fifth (21%) of non-binary/gender variant young people reported this in pharmacy/dentist/optician settings and a quarter (25%) reported this in youth settings. This is outlined below:

Figure 57: Proportion of young people who have experienced cisnormative assumptions by setting



Three young people (4%) reported being asked inappropriate questions around their LGBTQ identity/identities in GP practices, and two young people (3%) reported this in learning disability services. Eight people (11%) reported this in youth settings, with over one in five (n=5, 21%) non-binary gender variant people reporting this.

It should be noted that the question related to assumptions within youth services was intended to relate to youth groups and youth social worker teams. However, given the high rate of responses and a potential lack of clarity in the question, it may be that some respondents also answered in relation to education settings.

Only two young people (3%) reported being treated unfairly within any healthcare setting as a result of being LGBTQ+.

There were no reports of transphobic abuse across most health and care services, although one trans binary young person reported experiencing transphobic abuse in mental health services. Three young people (4%) reported biphobic abuse within youth settings, one person reported this regarding mental health services, and one person reported this from interactions with social care. One young gay man reported experiencing homophobic abuse in a pharmacy/dentist/optician setting. Further to this, two young respondents reported homophobic abuse occurring in a youth setting.

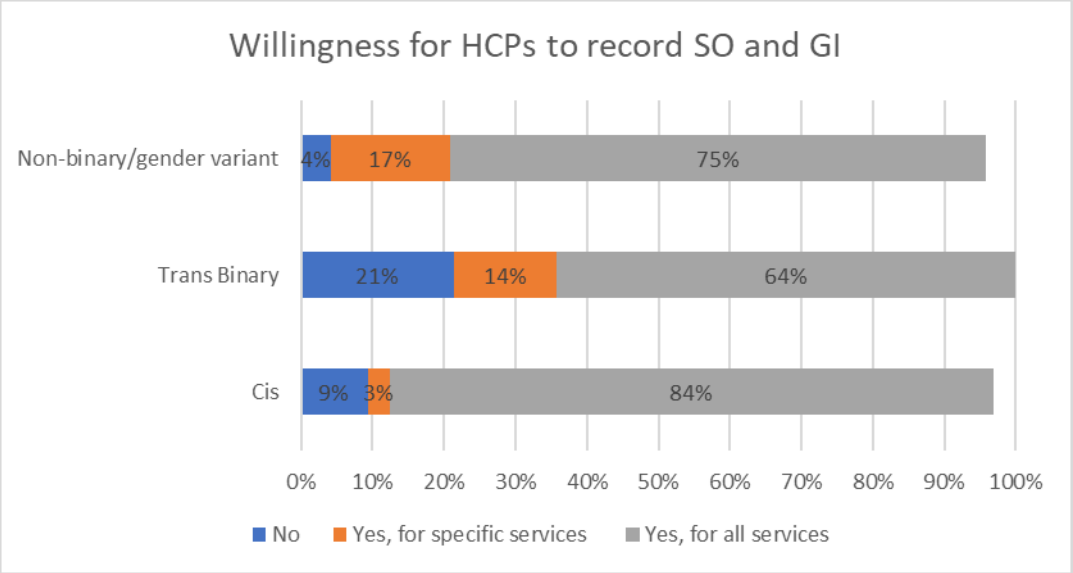
One in five (20%) young respondents reported that they access health and care services outside of East Sussex, with this increasing to 43% of trans binary people.

Of respondents who provided more detail on services accessed outside of East Sussex, most related to London based GICs or private trans healthcare services, such as gender GP. One respondent noted that prior to accessing a private trans healthcare service they were suicidal and could not manage the very long waiting times for NHS GIC provision.

Future health and care provision in East Sussex

Overall, 87% of young people reported that they would be happy for health care professionals (HCPs) to ask about and record their SO and GI for all services (77%) or specific health and care services (9%). However, this varied between groups with 84% of cis people agreeing that they would be happy for all health and care services to do this, with a further 3% happy for specific services to do this. Three quarters (75%) of non-binary/gender variant people were happy for all services to do this and a further 17% would be happy for specific services to do this. Almost two thirds (64%) of trans binary people stated they were happy for all services to do this, and a further 14% felt that just specific services should do this. The respondents who provided detail about which specific services they would feel comfortable this being asked within included a range of services such as sexual health, GP practices and mental health services. The differences by gender group are outlined below:

Figure 58: Recording SO and GI in health and care services- young people



Some differences also arose between SO groups, with gay men the most likely to be happy for HCPs to ask about and record their SO and GI for all services (100%), with bi people the least likely to agree with this (70%).

Almost half of young respondents (47%) responded to a free text question regarding what could be done to improve care and support for LGBTQ+ people in East Sussex.

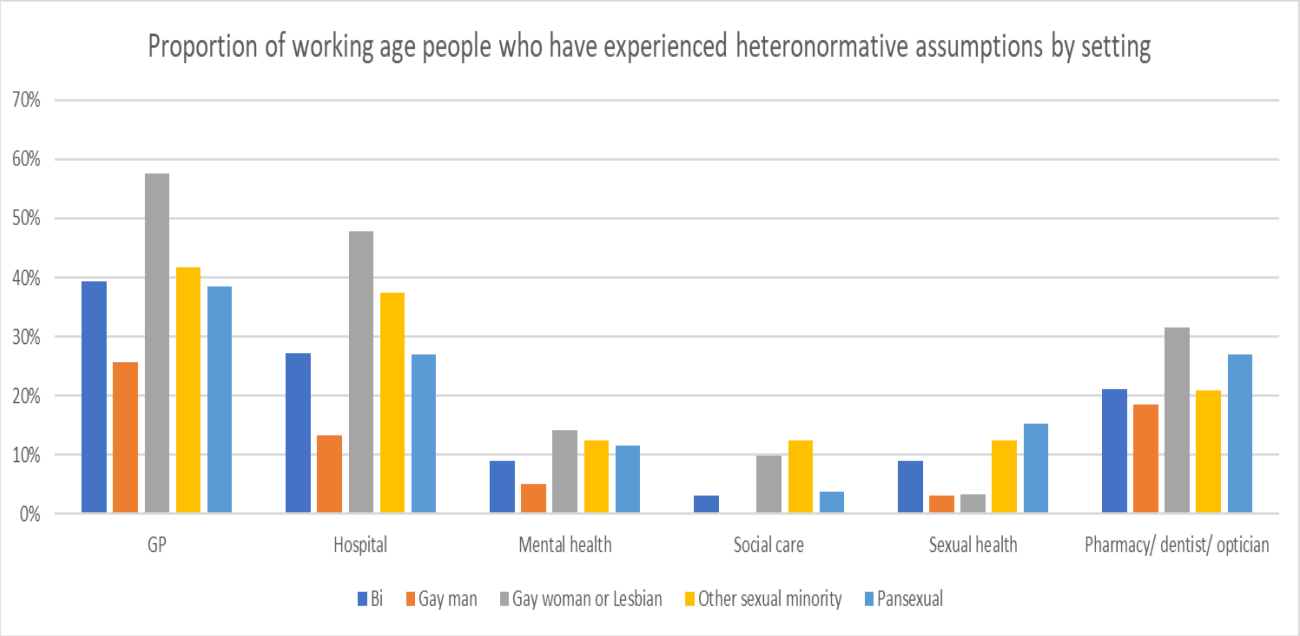
24 respondents made suggestions related to the improved provision of a range of services, especially mental health services, sexual health services and trans health services. This largely related to addressing long waiting times for mental health and GIC appointments, and for sexual health largely related to the timing and locations of clinics. Six respondents noted the need for more inclusive health and care environments, through active promotion of an organisation's support of LGBTQ+ people and normalising the use of pronouns. Four respondents suggested that there was a need for more LGBTQ+ training for HCPs, and two of these respondents outlined that this should be led by members of LGBTQ+ communities.

Working age people

Experience of health and care services

Over half (58%) of gay women/lesbian respondents reported heteronormative assumptions within GP services in the last 18 months and almost half (48%) of this group reported experiencing this within hospital services. Around four in ten people identifying as bi (39%), pansexual (38%) or other sexual minorities (42%) also reported such assumptions within GP practices. This compares to one quarter of gay men (26%) who reported these assumptions. This can be seen below:

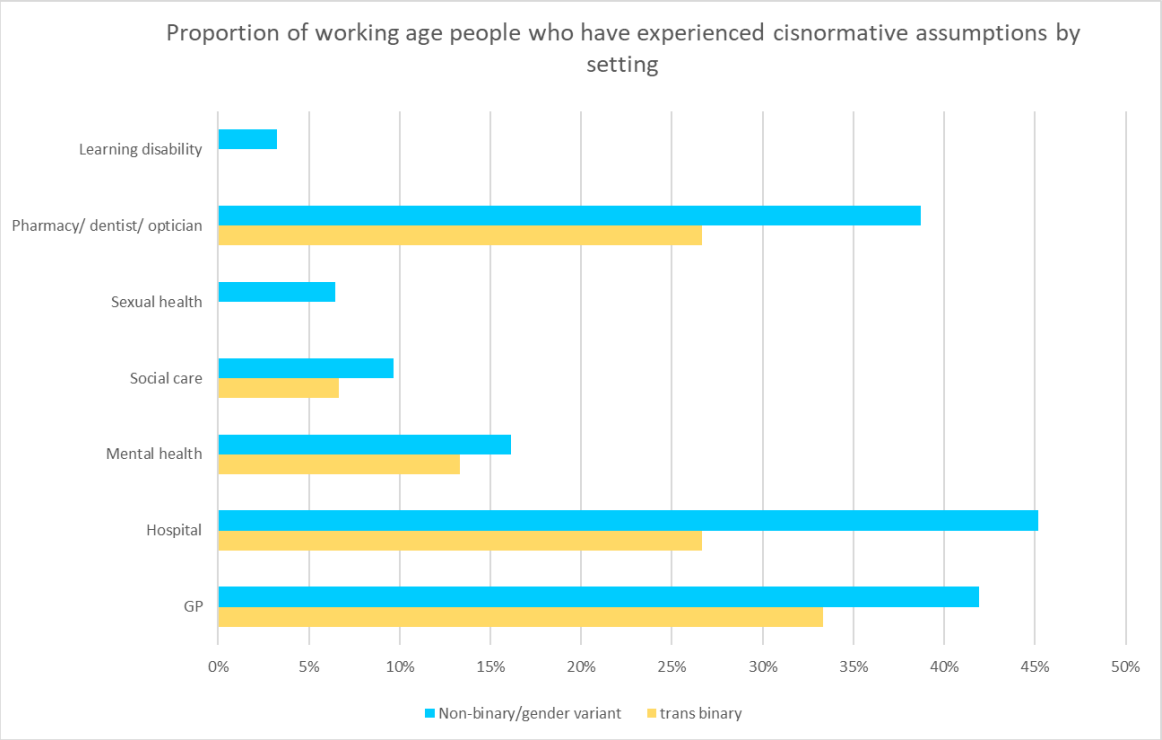
Figure 59: Proportion of working age people who have experienced heteronormative assumptions by setting



Experiences of cis gender assumptions within health and care services were common amongst TGD working age people. Non-binary/gender variant people were more likely to report this than trans binary people in every setting, with this most commonly being reported in hospital and GP settings.

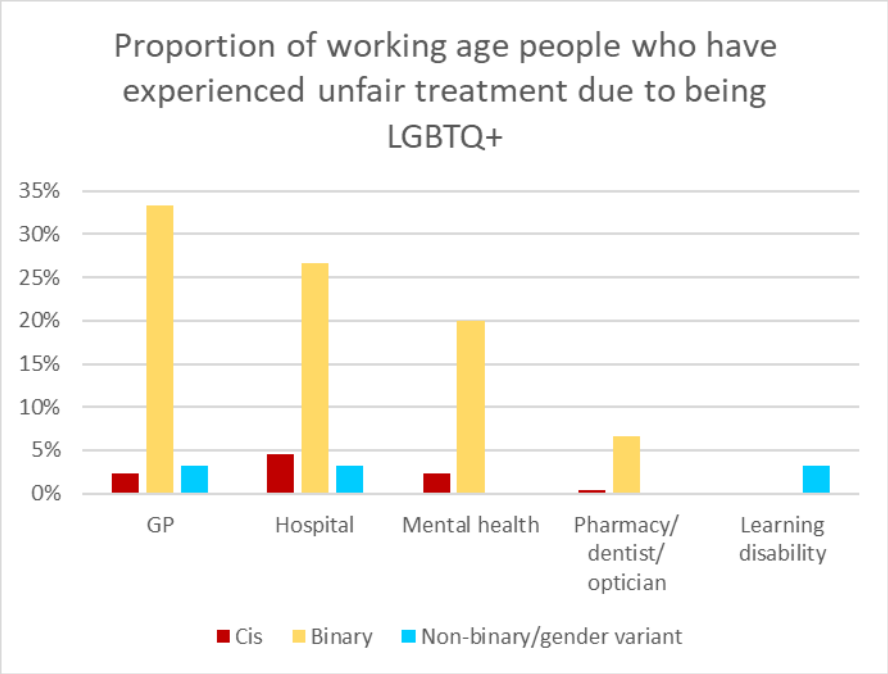
This is outlined in below:

Figure 60: Proportion of working age people who have experienced cisnormative assumptions by setting



Trans binary working age people were more likely to report experiencing unfair treatment in health and care services in the last 18 months than cis and non-binary/gender variant people, across almost every setting. This is outlined below:

Figure 61: Experience of unfair treatment due to being LGBTQ+ in working age people



When considering SO, gay women/lesbians were the most likely to report unfair treatment within hospital settings (11%) and within mental health services (7%).

In hospital settings, 27% of trans binary people reported staff asking inappropriate questions as a result of their identity, compared to 10% of non-binary/gender variant people and 5% of cis people. Over one in ten (11%) of gay women/lesbians reported inappropriate questions in this setting. Three trans binary people (20%) reported inappropriate questions by mental health service staff. Additionally, trans binary people were twice as likely to report experiencing inappropriate questions in GP settings (n=2, 13%), compared to cis (n=13, 6%) and non-binary/gender variant people (n=2, 6%). However, the numbers were small and so the findings should be interpreted with caution.

It should be noted that this data hasn't been adjusted for levels of interactions with such services. For example, it may be that the trans binary people within this sample were more likely to use such services regularly, compared to cis people.

The number of people reporting transphobic abuse was small with three people reporting transphobic abuse in a hospital setting, one person reporting transphobic abuse in a GP setting, one person reported this in another primary care setting and one person reporting this in a mental health setting in the last 18 months.

Reports of bi-phobic abuse weren't experienced across most health and care settings. However, one person reported experiencing this within pharmacy/dentist or optician settings. Further to this two people reported experiencing this in youth settings.

Within GP settings, one gay man and one gay woman/lesbian reported experiencing homophobic abuse. Two gay women/lesbians reported this in hospital settings and two reported this in mental health settings. Additionally, five working age people (2%) reported experiencing homophobic abuse within youth settings.

Within this age group, it is unclear what the respondents' interactions with the youth settings were as this group is not likely to be a service user based on their age, it may be that they are parents of youth service users. It also may be that due to the wording of the question there was some ambiguity about what constituted a youth service and that some respondents considered schools a youth service, which wasn't what was originally intended. Therefore, these findings should be interpreted with caution.

Several respondents provided more detail of their experience as LGBTQ+ people interacting with health and care services. Two TGD people highlighted issues with the treatment they have received from a GP. One respondent reported that their GP refused to refer them to a GIC because the GP did not believe in non-binary identities. A second TGD person reported that their GP stopped prescribing their hormone medication because the person had rescheduled appointments and they

felt this was ‘a form of punishment’. Further to this, one trans person noted that because their medical record shows their sex assigned at birth rather than gender identity, they are often outed as trans every time they seek assistance. The person noted that this has impacted negatively on their mental health and has led them to avoid seeking help when required.

Several comments related to perinatal services. One respondent noted that throughout their perinatal care they were regularly asked where their husband or boyfriend was, as well as reporting that information leaflets and posters were heteronormative, failing to show the diverse range of families that exist. A second respondent highlighted the same issue regarding being constantly asked about a husband/boyfriend. Respondents noted that this led them to feel lonely, isolated and tired of constantly correcting staff. Two further respondents who had been pregnant reported that their wife/partner was regularly referred to as a friend or sister throughout their perinatal care. Further to this, one respondent noted that staff assumed their fertility history incorrectly due to an assumption that they were a cis couple.

One respondent noted that despite having a note on their medical record that they are a gay woman, they have received unwanted advice regarding contraception. A further respondent noted the frustration of using sexual health services and clearly stating they were bisexual on the paperwork, and yet staff still making assumptions that they were straight. A further respondent noted that whilst they understood the need for the mandatory question ‘could you be pregnant’ when accessing some services, that when they answered ‘no’ this led to intrusive follow up questions that forced them to come out. A third respondent who identifies as a lesbian reported that they have told their GP practice their SO numerous times, but when attending the GP for gynaecological reasons, they are asked the same heteronormative questions every time. Two other respondents experienced similar issues with regards to gynaecological areas of health.

Two respondents noted discrimination during the adoption process, with social workers preferring a heterosexual couple.

Several respondents noted that in general, when an assumption was made regarding their gender or sexuality and they corrected the professional, the rest of the interaction felt rushed or awkward.

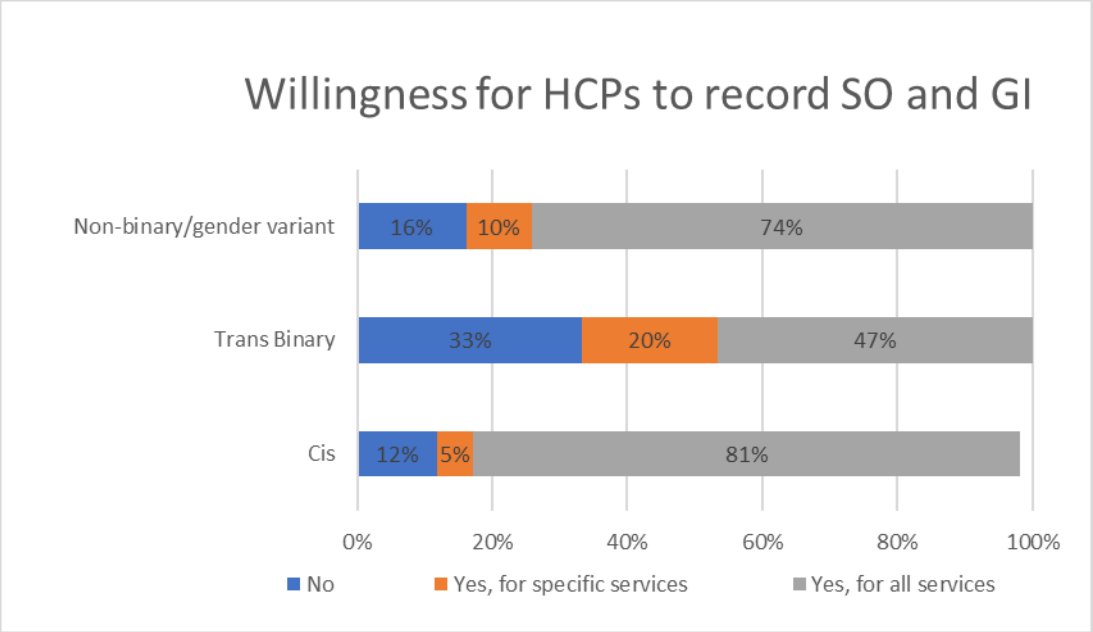
In working age people, 18% reported accessing health and care services outside of East Sussex, increasing to 23% of non-binary/gender variant people and 33% of trans binary people. The rate was also higher (24%) in gay men. In TGD respondents that provided further information on the reasons for this, several respondents noted they were accessing NHS GIC outside of East Sussex due to a lack of local provision with some respondents advising they were accessing private GIC care, with two people outlining that they could not have waited for NHS services due to

the severe impact on their mental health and risk of suicide during the wait. In cis respondents, the main services accessed outside East Sussex were HIV services, either because of existing relationships with staff elsewhere or due to a lack of provision locally. Respondents also highlighted the use of Brighton based sexual health services due to a lack of local provision or perceived greater quality in Brighton services.

Improving health and care services

The majority of working age adults reported that they would be happy for HCPs to ask about their SO and GI for all services (79%) or specific services (7%). However, this varied significantly by gender group, as outlined below:

Figure 62: Recording SO and GI in health and care services- working age people



Different responses were also seen across SO groups, with bi people the most likely to be happy for HCPs to ask about SO/GI across all services (85%) and those of other sexual minorities the least likely to respond in this way (63%).

Several respondents provided more detail as to what specific services they would be happy for this data to be collected in. The services noted included: sexual health services, screening services, mental health services or other services the respondents felt SO/GI was relevant in their circumstances.

Almost half of working age respondents (49%) responded to a free text question regarding what one thing could be improved in health and care services in East Sussex. Improving access to services was the most common comment, especially with regards to general practice, mental health services, GICs, and fertility services. In addition, several TGD respondents specifically noted the need for improved support for trans people within General Practice. Respondents noted

that many GPs have inadequate training and knowledge around trans issues, and in some cases, their treatment within General Practice has had a negative impact on their mental health.

The second most common suggestion related to improved training for HCPs on supporting LGBTQ+ people and to improve awareness and challenge assumptions/biases. Similarly, respondents highlighted building a more inclusive culture as a key improvement for East Sussex, including eradicating heteronormative and cisnormative assumptions (especially in perinatal services), improving staff attitudes to LGBTQ+ people and active promotion of LGBTQ+ inclusion (e.g., via posters, leaflets). Finally, several respondents noted the need for more specific LGBTQ+ support and spaces in East Sussex.

Older people

Experience of health and care services

In older people, one third of gay women/lesbians reported that GP staff assumed they were straight and 28% of gay men reported this. Similar levels of this were reported within hospital settings, with 34% of gay men reporting this and 29% of gay women/lesbians reporting this.

In both hospital and GP settings, 27% of TGD people reported experiencing cisnormative assumptions.

Only one older person reported unfair treatment due to being LGBTQ+ in any healthcare setting. Further to this, one person reported inappropriate questions in a hospital setting and two people reported inappropriate questions when interacting with social care.

There were no reports of HBT abuse across any of the health and care services included in the survey amongst older people.

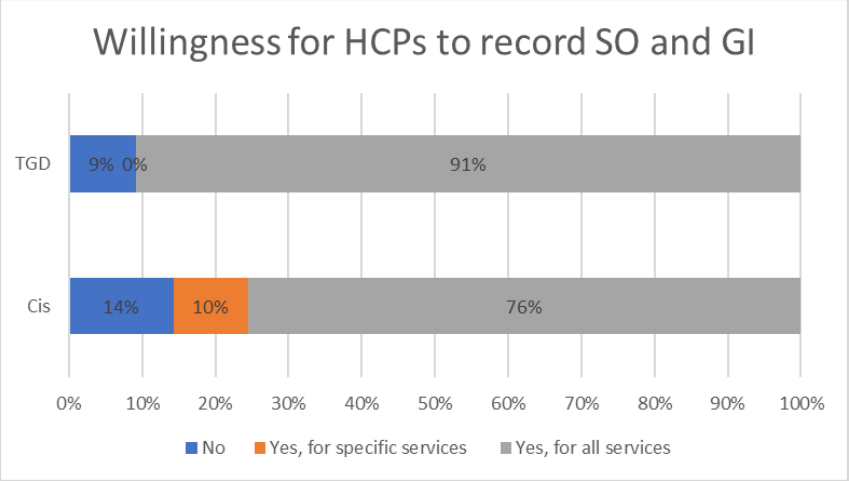
Almost one in five (18%) of older respondents reported accessing health and care services outside of East Sussex. Of respondents who provided more detail on why this is, four noted that they use HIV services in London or Brighton. Two of these respondents specifically note that this is due to inadequate support within East Sussex for people with HIV.

Improving health and care services

The majority of older respondents were happy with HCPs asking about and recording their SO and GI for all services (76%) or for specific services (8%). Some respondents who provided more detail about specific services asking this, noted a range of services such as sexual health services, mental health services or generally services where this was considered relevant to diagnosis or treatment.

TGD groups were more likely to feel comfortable with this being asked about and recorded than cis people, as outlined in the graph below:

Figure 63: Recording SO and GI in health and care services-Older people



Half of the older respondents responded to a free text question regarding improvements that could be made within health and care services locally. The main improvements suggested related to service provision, especially improving access to GPs, and healthcare generally. Ensuring health and care organisations are inclusive environments was also a common suggestion, especially in terms of eradicating heteronormative and cisgender assumptions and actively ensuring the inclusion of LGBTQ+ people, for instance using notices that are gender-neutral and visible signifiers that LGBTQ+ people are welcome within a setting.

Other groups

Analysis by ethnic group

People from 'other white' backgrounds or white British backgrounds were more likely to report cis assumptions in health and care services than people from a Black, Asian and other minority ethnic background, especially in GP and hospital services. White British people were the most likely to report assumptions that they were straight by health and care professionals, especially with regards to GP services (39%) and hospital services (28%). One person (5%) from a Black, Asian and other minority ethnic background reported unfair treatment in social care and sexual health services due to being LGBTQ+ compared to none in both white groups. People from a Black, Asian and other minority ethnic background were over twice as likely (n=2, 11%) to report inappropriate questions from GPs about their identity compared to white British people (5%) and 'other white' groups (3%). Due to the small numbers involved here, the interpretation of this data is limited.

People from a Black, Asian and other minority ethnic background were the most likely to report being happy for all health and care services to ask about and record their SO and gender identity (84%), compared to white British people (77%) and 'other white' groups (73%).

The impact of COVID-19

Young people

Vaccination

The majority (83%) of young respondents reported that they had received at least one dose of the COVID-19 vaccine. Of those who had not, 42% explained that they had not received this yet as it had only just become available for their age group. The remaining explanations for why they had not yet received this were varied, including vaccine centres being too tricky to get to, severe medical phobia and not wanting the vaccine.

Positive impacts of COVID-19

Overall, 84% of young respondents reported one or more positive benefits from COVID-19. Almost four in ten (39%) young respondents reported they had saved money during the pandemic, one third said they had learnt a new skill and one third said they had enjoyed not being in spaces where they felt uncomfortable. Cis people were more likely (53%) to report saving money than trans binary (21%) and non-binary/gender variant people (33%). Cis people were also more likely to report learning a new skill (44%) compared to trans binary (14%) and non-binary/gender variant people (33%). The converse was true for enjoying not being in spaces respondents felt uncomfortable in, with 43% of trans binary and 59% of non-binary/gender variant people reporting this, compared to 9% of cis respondents.

Some differences in reported benefits were shown by SO group too. Over one in four gay women/lesbians (43%, n=3) and pansexual people (42%) reported enjoying not being in spaces they feel uncomfortable in, with gay men the least likely to report this as a benefit at 17%. Gay women/lesbians also reported the highest benefit in terms of increased physical activity (43%, n=3), compared to one third of gay men (33%), 30% of bi people, one quarter (25%) of pansexual people and 18% of other sexual minorities. Similarly, gay women/lesbians were more likely to report a positive impact on their mental health (43%, n=3) compared to all other SO groups.

All reported benefits are outlined by gender group and SO group in appendix two.

Negative impacts of COVID-19

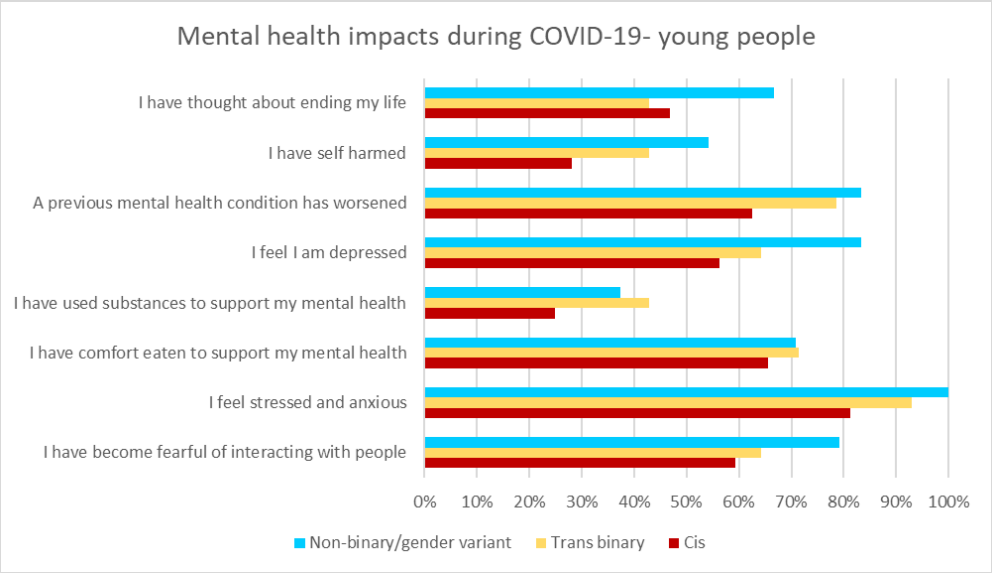
Two thirds of young people reported feeling lonely or isolated during the pandemic, with a higher rate in trans binary people (79%), compared to non-binary/gender variant people (67%) and cis people (63%). Half (50%) of young people reported challenges with home schooling/study, with slightly higher rates

in bi people (57%) and people from other sexual minorities (59%). Over a quarter (27%) of young people reported difficulties in getting shopping or medication, with a greater proportion of trans binary people reporting this (43%). Over a quarter (27%) of respondents reported their alcohol consumption had increased over the pandemic, with higher rates in trans binary people (36%), compared to cis people (22%) and non-binary/gender variant people (13%). Increased alcohol consumption was also more likely in gay women/lesbians (43%) and bi people (39%). Over half (57%) of trans binary respondents reported a delay in transitioning, as did 17% of non-binary/gender variant respondents. A full breakdown of the negative outcomes of COVID-19 by GI and SO group can be found in appendix two.

Mental health impacts of COVID-19

Young people reported a wide range of mental health impacts of the pandemic, with clear differences between gender groups, as outlined below:

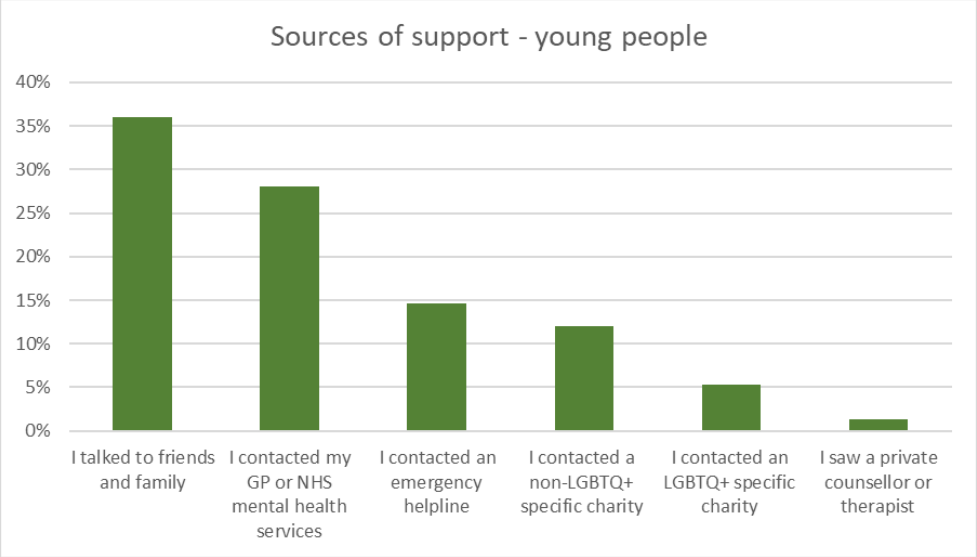
Figure 64: Mental health impacts of the pandemic by gender group- young people



Three quarters of young respondents reported that a previous mental health condition had worsened, with a higher rate in non-binary/gender variant groups (83%) and trans binary people (79%), compared to cis people 63%. Gay women/lesbians were the most likely of any SO group to report a worsening previous mental health condition, with 86% reporting this. More than two thirds (68%) of respondents reported feeling depressed, increasing to 83% in non-binary/gender variant people. Over half (55%) of young respondents had thought about suicide, increasing to 67% in non-binary/gender variant people. Of all SO groups, bi people were the most likely to report having thought suicide, with 65% reporting this. Additionally, 44% of respondents had self-harmed, increasing to 54% in non-binary/gender variant respondents. The rate of self-harm in gay women/lesbians was the highest of any SO group, at 71%.

Over half of young respondents (56%) reported that they required support for their mental health during the pandemic, this increased to 64% of young trans binary people. Respondents sought support from a variety of sources, as outlined below:

Figure 65: Sources of support- young people



One third of respondents talked to friends and family to support their mental health and over one quarter contacted their GP or NHS mental health service. 15% of respondents contacted an emergency helpline, increasing to 25% of non-binary/gender variant people.

Of those who stated they required support, 17% outlined they were not able to access appropriate support. Respondents who provided a further explanation on this explained that some of the reasons they couldn't access support was due to no appointments being available, knowing there are very long wait times for NHS services and that their family didn't believe they needed support.

Working age people

Vaccination

Vaccination rates in working age people were high, with 94% reporting having received at least one dose of the COVID-19 vaccine. Rates differed however between gender groups, with lower uptake in trans binary people (87%) and non-binary/gender variant people (90%), compared to cis people (95%). Vaccination rates were similar across SO groups but lowest in gay women/lesbians, with 10% reporting not receiving at least one dose of the vaccine. Half of those who had not received at least one dose of the vaccine did not provide a reason for this, and the remaining reasons were varied, from recently testing positive for COVID-19, medical reasons and personal preference.

Positive impacts of COVID-19

Overall, 84% of working age respondents reported one or more positive benefits from COVID-19. Over four in ten (44%) of working age people reported spending

more quality time with their household during the pandemic, although this was more strongly reported by cis people (48%) compared to trans binary people (27%) and non-binary/gender variant people (32%). Additionally, 42% of respondents reported saving money as one of the benefits of the pandemic, with similar rates seen across gender groups. Not having to commute was noted as a benefit by 42% of respondents with cis people more likely to report this (44%) than trans binary (27%) and non-binary gender variant people (35%). TGD groups were more than twice as likely to report enjoying not being in spaces where they felt uncomfortable, with 27% of trans binary and 26% of non-binary gender variant people stating this, compared to 10% of cis people.

Some differences in reported benefits were seen by SO group too. One in four gay men (26%) and gay women/lesbians (25%) were most likely to report an increase in physical activity, compared to just 12% of bi people. One in four pansexual people (25%) and one in five bi people (21%) reported enjoying not being in spaces where they felt uncomfortable due to their identity, compared to one in ten gay men and gay women/lesbians (10%). The reported rate of positive impact on mental health was similar across all SO groups.

A full breakdown of reported benefits is outlined by GI group and SO group in appendix two.

Negative impacts of COVID-19

Similarly to young people, the most frequently reported negative outcome from COVID-19 was feeling lonely/isolated, with 43% of respondents reporting this. Non-binary/gender variant people were more likely to report this than cis people (77% compared to 38%). Almost one in four (39%) of respondents reported increased stress in the workplace with similar rates across groups. Over 45% of TGD people reported difficulty in getting shopping or medication, compared to cis people (27%). Further to this, 27% of trans binary and 26% of non-binary/gender variant respondents reported a delay in transitioning.

Other sexual minorities were the most likely to report feeling lonely/isolated during the pandemic (63%), with gay men the least likely to report this (36%). Other sexual minorities and gay men had high rates of increased alcohol consumption (33% and 28% respectively). One fifth of respondents reported a loss of earnings, with the highest rate in other sexual minorities (46%) and pansexual people (27%).

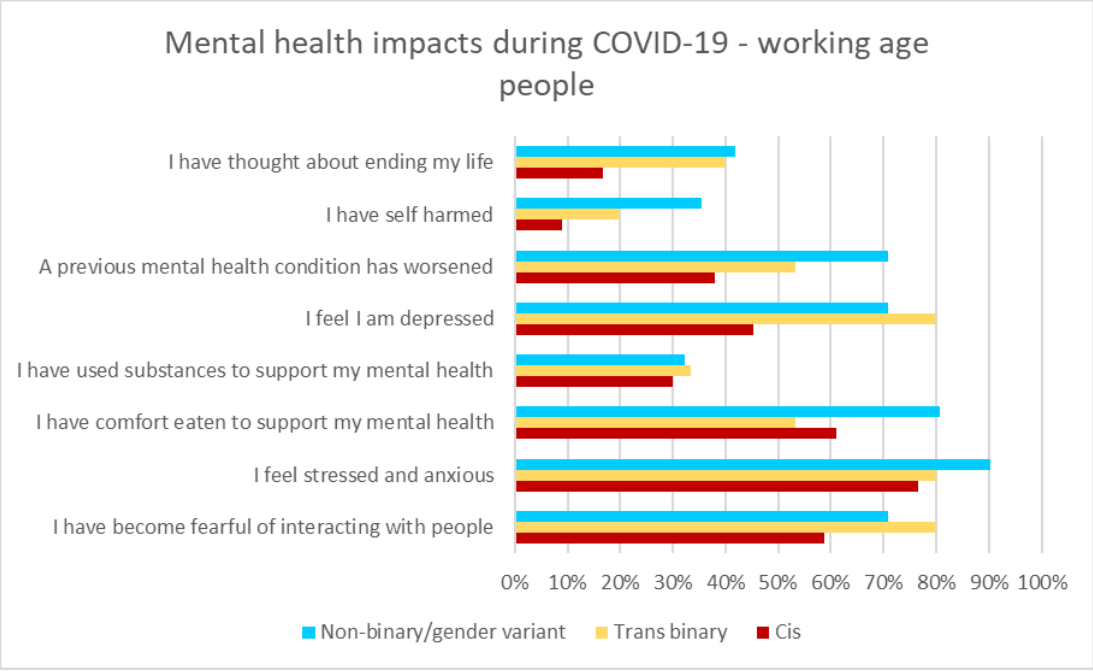
A full breakdown of the negative impacts of COVID-19 are outlined in appendix two.

Mental health impacts of COVID-19

Relatively fewer working age adults reported mental health impacts of COVID-19 compared to young respondents. Half of the respondents reported feeling depressed, with this increasing to 71% in non-binary/gender variant people and 80% of trans binary people. Three quarters of people who identified as other sexual minorities reported feeling depressed, the highest of any SO group. Over one in five (22%) respondents reported thoughts of suicide, with trans binary and non-binary gender variant groups being more than twice as likely to report this than cis people. The SO group that was most likely to report thoughts of suicide was those from other sexual minorities (33%). The prevalence of self-harm over the pandemic was 13% overall, but this increased to 20% in trans binary and 35% in non-binary/gender variant people. One quarter of those from other sexual minorities reported self-harm over the pandemic, the highest of any SO group.

The mental health impacts during the pandemic in this age group are highlighted below by GI group:

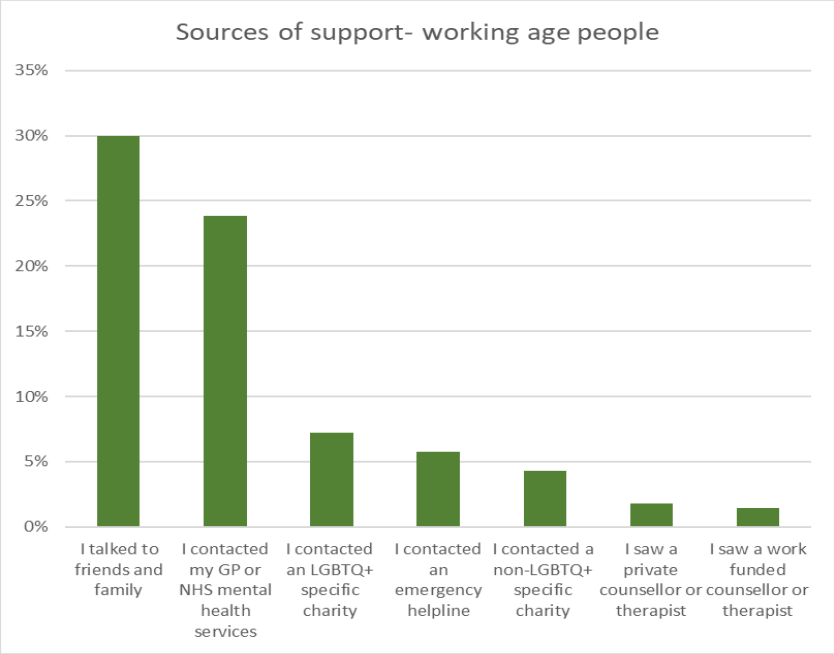
Figure 66: Mental health impacts of the pandemic by gender group- working age people



Almost half of working age respondents (45%) reported that they required support for their mental health during the pandemic, this increased to 68% of non-binary/gender variant people and 80% of trans binary people.

Respondents sought support from a variety of sources, as outlined below:

Figure 67: Sources of support- working age people



The sources of support working age people reported turning to were talking to friends and family (30%) and contacting their GP or NHS mental health service (24%). Compared to younger respondents, working age respondents were less likely to contact an emergency helpline (6% compared to 15% in young people), but this increased to 20% in working age trans binary people.

Of those that reported they required support, 14% stated they were not able to access appropriate support, and this increased to 25% of trans binary people. Of those who elaborated on why they had not been able to access support the main reasons related to being too embarrassed to seek help or not seeking help due to past experiences within healthcare services, seeking help from a GP but without success and waiting list length.

Older people

Vaccination

Vaccination rates in older people were extremely high with 98% of respondents reporting at least one dose of the vaccine, with no substantial difference between cis and TGD people.

Positive impacts of COVID-19

Overall, 73% of older respondents reported one or more positive benefits from COVID-19, lower than for both other age groups. Half of the respondents reported saving money as a benefit, although cis people were more likely to report this (53%) than TGD people (36%). A smaller proportion of older respondents reported a positive impact on their mental health with just 5% noting this, compared to 9% of

young people and 14% of working age people. TGD people were more likely to report increased physical activity (27%) compared to cis people (14%.)

Some differences in reported benefits were shown by SO group also. Bi people were more likely to report saving money (n=3, 60%) compared to gay men (48%) and gay women/lesbians (46%). Bi people were also more than twice as likely to state they felt more connected to their local community (n=1, 20%) compared to gay men (7%) and gay women/lesbians (8%). One in five gay women/lesbians (21%) reported an increase in physical activity compared to gay men (10%) and bi people (0%).

A full breakdown of the positive impacts of COVID-19 are outlined by GI group and SO group in appendix two.

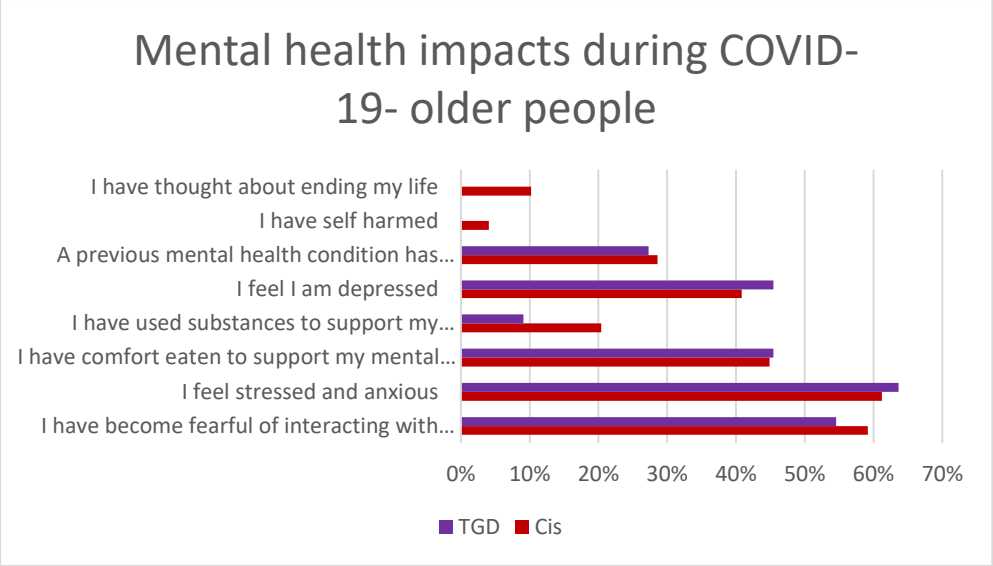
Negative impacts of COVID-19

Older people also reported feeling lonely/isolated as the most common negative outcome of COVID-19, although they reported this at a lower rate than working age and younger people, with one third (34%) of older people reporting this. However, TGD groups were over twice as likely (64%) than cis people (29%) to report this. Gay women/lesbians were more likely to report this (42%) than gay men (24%) and bi people (n=1, 20%). Almost one in five (18%) older people reported difficulty in getting shopping or medication, with a greater proportion of TGD groups reporting this (27%) than cis people (14%). The third most common negative outcome was being unable to access safe peer-led LGBTQ+ social spaces, with 18% of cis and TGD people reporting this. Gay women/lesbians were more likely to report this (25%) than gay men (14%).

Mental health impacts of COVID-19

Overall, it appears that the mental health impacts during COVID-19 have been somewhat less severe on older respondents, compared to younger and working age respondents. There also appears to be less disparity between TGD groups and cis people for many indicators. This is outlined below:

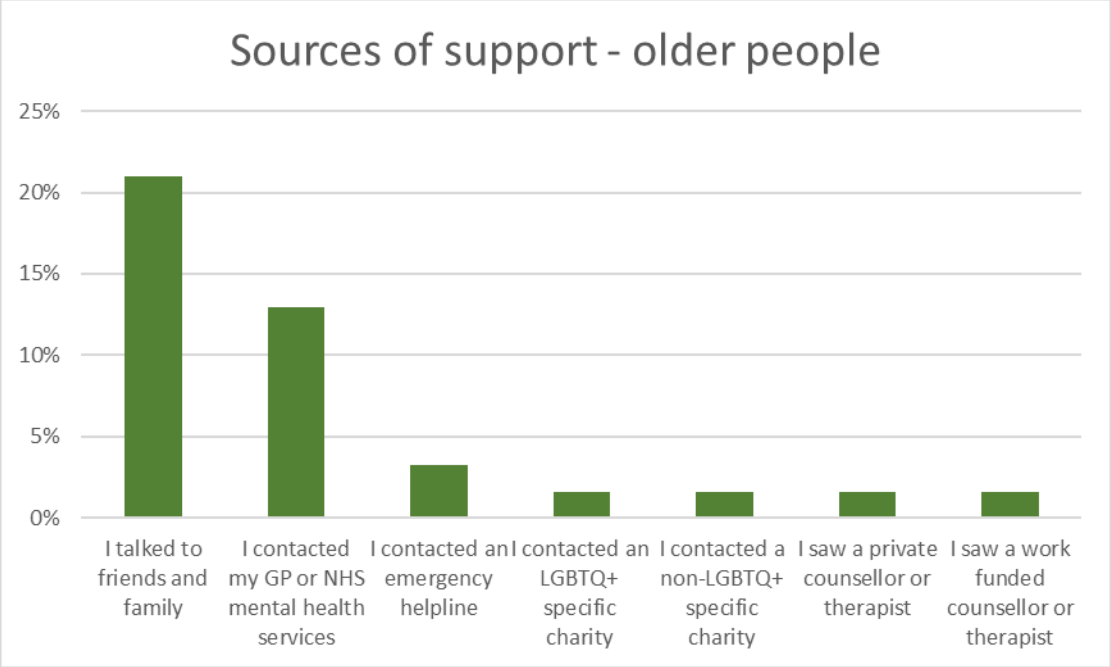
Figure 68: Mental health impacts of the pandemic by gender group- older people



Some differences could be seen, however, by SO group. Bi people were more likely to report a previous mental health condition worsening (n=2, 40%) compared to 29% in gay women/lesbians and 24% in gay men. Bi people were also more likely to report feeling depressed (n=3, 60%), compared to 45% of gay women/lesbians and 34% of gay men. Whereas gay men were more likely to report using substances to support their mental health (24%), compared to 17% of gay women/lesbians and 0% of bi people.

One quarter of older respondents (26%) reported that they required support for their mental health during the pandemic, increasing to 36% of TGD groups. Respondents sought support from a variety of sources, as outlined below:

Figure 69: Sources of support- older people



One in five (21%) of respondents reported talking to friends and family for support, and 13% reported contacting their GP or NHS mental health service. Of respondents that reported they required support, none indicated they weren't able to access this.

Other groups

Analysis by ethnic group

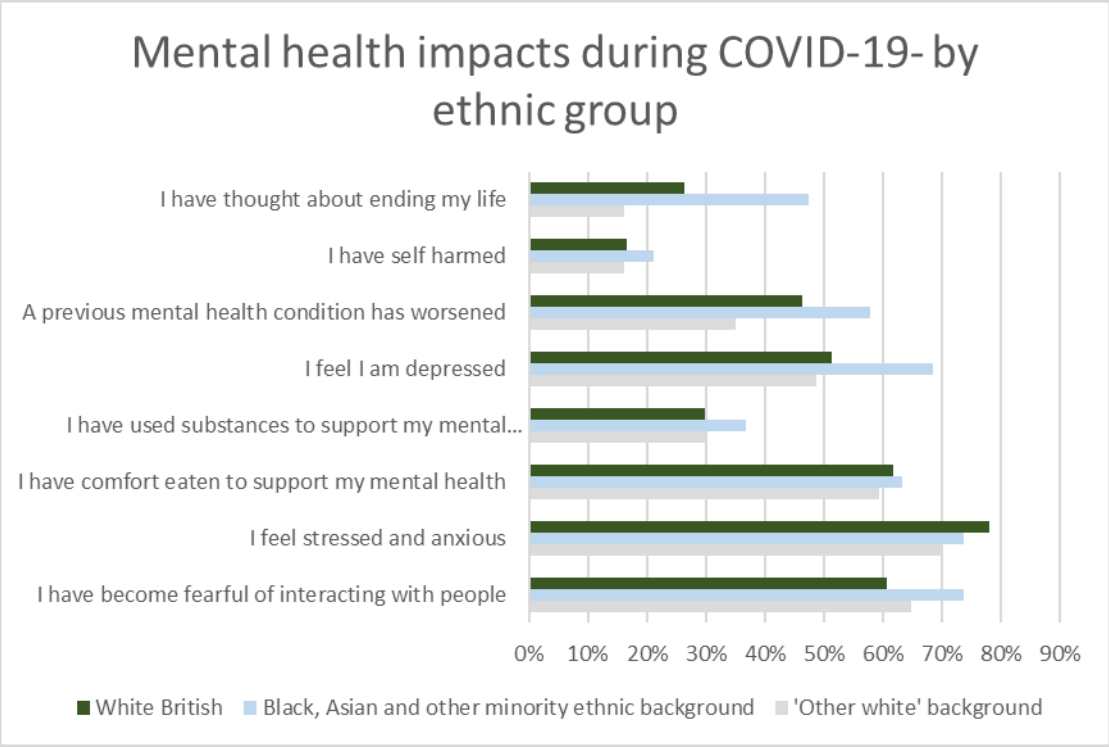
Vaccination rates were highest in white British people and 'other white' groups (both 92%) and slightly lower in people from a Black, Asian and other minority ethnic background (89%.)

78% of 'other white' groups reported experiencing at least one positive outcome from COVID-19, compared to 81% of white British people and 89% of people from a Black, Asian and other minority ethnic background. Almost one quarter of people from 'other white' backgrounds (24%) reported a loss of earnings during the pandemic, compared to 16% of people from a Black, Asian and other minority ethnic background and 13% of those from a white British background. Similarly, those from 'other white' backgrounds were more likely to report losing their job (11%), compared to 8% of white British respondents and 5% (n=1) of Black, Asian and other minority ethnic respondents. People from a Black, Asian and other minority ethnic background needs were more likely to report living in an unsafe situation (n=2, 11%) than white British people and people from 'other white' backgrounds (n=1, 3%). Additionally, those from a Black, Asian and other minority

ethnic background were more likely to report loneliness/isolation (58%), compared to those from 'other white' backgrounds (54%) and white British groups (45%).

When considering the mental health impacts of the pandemic, some disparities are seen by ethnic groups, as outlined below:

Figure 70: Mental health impacts of the pandemic by ethnic group



People from Black, Asian and other minority ethnic backgrounds were more likely to report becoming fearful of interacting with people, that they feel depressed and that a previous mental health condition has worsened. Additionally, almost half (47%) of Black, Asian and other minority ethnic respondents reported that they had thoughts of suicide during the pandemic, compared to 26% of white British respondents and 16% of 'other white' groups.

Chapter summary

An online community survey was undertaken and analysis was based on the responses of LGBTQ+ people in East Sussex (n=424).

This outlined a wide range of need and inequalities between LGBTQ+ groups across the life course.

LGBTQ+ young people:

- Experienced a high rate of bi/homo/transphobia in any setting over the past 18 months, with over half experiencing this.
- Reported high levels of loneliness/isolation, with two thirds of young people reporting this, increasing to 79% of trans binary people.
- Had fairly low levels of regular smoking generally but high levels of occasional or regular smoking in some groups, such as in gay men.
- Had high rates of excessive alcohol consumption in some groups, such as in gay men.
- Reported low levels of physical activity, especially in TGD groups.
- Commonly reported one or more LTC or disability (83%), especially depression and anxiety disorders.
- Often experienced hetero and cisnormative assumptions in health and care settings.
- Reported high levels of existing mental health condition deterioration during the pandemic, especially in non-binary/gender variant groups (83%) and in gay women/lesbians (86%).
- Reported high rates of self-harm (44%), and thoughts of suicide (55%), with an increased risk in non-binary/gender variant people.

Working age LGBTQ+ people:

- Had varied employment status across groups, with trans binary people, bi and pansexual people most likely to be unable to work due to sickness or disability.
- Reported high levels (12%) of bi/homo/transphobic abuse in the workplace, increasing to over one in four (44%) trans binary people.
- Were more likely to be renting their home if they were TGD, compared to cis people.
- Were more likely to experience bi/homo/transphobia in any setting over the last 18 months if trans binary, with over half of respondents reporting this.
- Experienced high levels of loneliness/isolation during the pandemic, with 43% reporting this, increasing to 77% in non-binary/gender variant people.
- Reported high rates of being a former smoker, especially in trans binary people.

- Were less likely than younger people to drink excessively in one sitting, but a quarter of respondents drank every or most days.
- Reported high intention to take up screening when offered (90%) in cis people but this decreased to 53% in trans binary people.
- Were more likely to report being in bad or very bad health if they were non-binary/gender variant (23%) or bi (24%).
- Often experienced hetero and cisnormative assumptions in health and care settings.
- Over one in five (22%) respondents reported having thoughts of suicide during the pandemic, with trans binary and non-binary gender variant groups being more than twice as likely to report this than cis people.

Older LGBTQ+ people:

- Were largely retired, but over twice as many TGD older people were unable to work due to sickness or disability compared to cis people.
- Were less likely to own their home outright or be renting if they were TGD.
- Reported fewer experiences of hate crime than other age groups, but a greater proportion of TGD respondents experienced this than cis respondents (27% compared to 11%).
- Experienced lower levels of isolation/loneliness during the pandemic than other age groups with 34% reporting this, but this increased to 64% in TGD people.
- Had a high rate of regularly or occasionally smoking in gay men.
- Had high levels of drinking every or most days (39%) but tended not to drink excessively in one sitting (6%).
- Reported high levels of LTCs/disabilities (79%), increasing to 83% in gay women/lesbians.
- Reported somewhat less severe mental health during COVID-19 compared to younger and working age.

Across all age groups, some differences emerged between broad ethnic groups. People from Black, Asian and other minority ethnic groups were more likely to encounter bi/homo/transphobia in the workplace compared to white British groups. Regular smoking rates were twice as high in people from Black, Asian and other minority ethnic groups compared to white British groups (16% compared to 8%). Additionally, those from Black, Asian and other minority ethnic groups were more likely to report feeling lonely or isolated during the pandemic. Almost half (47%) of people from a Black, Asian or minority ethnic group reported that they have thought about suicide during the pandemic, compared to 26% of white British respondents and 16% of 'other white' respondents.

Across all age groups, the majority would be happy for HCPs to ask about their SO and GI for all services (77%) or specific services (8%). Key suggestions to improve health and care delivery to LGBTQ+ people locally were to improve access to mental health services, gender identity clinics and fertility treatment for LGBTQ+ people. Improving support for TGD people in GP practices was outlined as an area for improvement. The need for more inclusive health and care environments and for improved LGBTQ+ training for HCPs were also key suggestions. The need for East Sussex based specific LGBTQ+ health and care services was also highlighted.

Chapter eight- Focus Groups

Alongside the survey which provided mainly quantitative data, seven focus groups were conducted to gather qualitative data. These were held between September and October 2021. This included one focus group with young people (aged 16-24), two with working age people (aged 25-59), two with older people (aged over 60) and two with members of the TNBI community. Whilst we did have some TNBI representation across the LGBTQ+ life course focus groups, it was important to ensure there was a safe space and time to explore specific issues faced by TNBI people locally. The TNBI groups were facilitated by The Clare Project, and the other focus groups were facilitated by staff members from the ESCC public health team.

During the sessions, the aims of the needs assessment were explained, and verbal consent was obtained from participants before commencing each focus group.

The topic guide included the following questions:

1. What is health and wellbeing to you personally?
2. Is this different to heterosexual and cisgender people?
3. What is your perception of the health and wellbeing of the LGBTQ+ community?
4. What supports or enables your health and wellbeing?
5. How has the COVID-19 pandemic been for you?
6. What barriers have you experienced in accessing health, care and wellbeing services?
7. How are things locally where you live?
8. What examples have you got of good and bad health and care services?
9. What would make things better?
10. What do you think LGBTQ+ communities need in East Sussex?
11. What one thing would you want to improve LGBTQ+ health and well-being in East Sussex?

The focus groups were recorded, and then independently transcribed. All recordings and transcripts were processed in accordance with ESCC's Information Governance processes. The groups lasted for up to 90 minutes. Participants were offered a £15 love to shop voucher for giving up their time to take part in the focus group. Participants were also offered a debrief or to contact a supportive member of the facilitation team after the session if needed. This was re-emphasised as needed throughout the session.

Following this, the transcripts were coded and subsequently themes and sub-themes were drawn out from the data. Sub-theme counts may not add up to the total theme counts, as any coded response that only had one count was removed

as a sub-theme. Where quotes are provided to illustrate a theme, these have been anonymised to ensure participant confidentiality.

This section outlines the themes and sub-themes that arose for each group, with a summary of all themes and sub-themes found in appendix three.

Young people

There were seven participants in the young person focus group. Although due to technical issues, not every participant was as active in their involvement. There was therefore less in-depth data compared to the other groups.

Experience of health & care services

The main theme that arose related to the experience of health and care services. Respondents expressed both positive and negative experiences of services, but there was a lack of depth in most responses regarding the reasons for these. However, more detail was provided regarding some of the key sub-themes, as outlined below.

The most common sub-theme that arose here was the **inadequate support & expertise in GP practices for trans people**. Respondents that sought support from their GP regarding their gender identity, were generally met with a lack of expertise and support. Participants felt that some professionals weren't qualified to support their needs as trans people, that they were dismissed due to their age or that the GP did not follow the processes needed to start them on the pathway to assessment at a GIC:

> *"…they said to me that they were going to put a referral in and I waited four years before I chased it up, because obviously being London I just thought it was normal to be waiting that long, but when I phoned a couple of months ago I was told that the one that was going to put the referral in four years ago for me to start hormone treatment didn't even put it through and didn't even put it on my record that he was going to."*

This contrasted sharply with another strong sub-theme that arose regarding **positive experiences of Allsorts Youth** service (despite being Brighton based). Participants who had used Allsorts reported that the service provided a safe space, helped signpost them to other services and groups and provided a listening ear, which was important for their wellbeing.

Respondents typically experienced **HCP attitudes** as unhelpful, especially in relation to mental health concerns, gender dysphoria and previous experience of trauma:

"…when I went to the doctors… about how I felt and I felt like I was trapped in the wrong body and I explained to them everything that was inside my head they told me I was too young to know what I was going on about."

Other sub-themes that arose related to **negative experiences of CAMHS**, **positive experiences of youth services**, **inadequate access to GICs** and **barriers to trans affirmative surgeries**.

Negative impacts on health and wellbeing

The top sub-theme that arose here was the experience of **bullying** within school environments and the impact that this had on self-esteem and mental health:

"I was being bullied from primary school all the way up to year 9 in secondary school, just because of either the way that I look… what I am – because of obviously me being gender fluid and pansexual …it kept pushing my self-esteem and my mental health to the lowest point and that was when I need some help in school, because I became the lone wolf and I had nobody to talk to."

Lack of **financial resources** also arose as having a negative impact on health, for differing reasons. This was outlined as a barrier due to not being able to afford to get public transport to more specialist services in Brighton as well as the inability to purchase specific items to support transition, such as chest binders.

Social rejection, both from wider society and from within LGBTQ+ groups, was also highlighted as having a strong negative impact on wellbeing. **Lack of private transport** to reach specialist services and **lack of local specialist services** were also noted as having negative impacts on health and wellbeing.

COVID-19

The most common sub-theme arising was **mental health deterioration**. Several respondents noted that their mental health had worsened throughout the pandemic, in some cases reaching crisis point:

"During the first lockdown everything got way too much and it got to the point where I was actually going to end everything but because I thought of family members and other people that it might affect more than me, I didn't."

Respondents also noted a great deal of **concern for relatives** who were more vulnerable to the virus, which drove fear and worry throughout the pandemic:

"Well my nan is living with me and she's a shielded person... so every day I kept going to bed thinking what if I go out tomorrow and I catch something and then I pass it to my nan and I am the one that kills my nan?"

However, a positive sub-theme that arose relating to COVID-19 experiences was the benefits of spending more **quality time with family**.

School & college

The experience of trying to/accessing **mental health support in schools** was a major sub-theme for young people. Respondents felt this was important and school counsellors/therapists should have an awareness and knowledge of LGBTQ+ issues and identities, but some respondents reported this was not always the case which can result in harm:

> *"(In) year 9 they managed to get me a counsellor but the only major issue there was she wasn't talking about the LGBTQ side of things. She was more digging deep for traumas and other things in my life that may have gone wrong, which didn't help at all, because that is not what I wanted to talk about... she sort of forced me to talk about things that I really wasn't ready to talk about, which really lowered my mental health and really sent me down a dark path again."*

For some respondents, **bullying** was a constant feature of their time in school, with a lack of supportive teachers who intervened.

A further sub-theme was the need for greater **LGBTQ+ awareness within schools**, with respondents feeling this should be talked about from an earlier age to drive greater social acceptance.

Where respondents experienced a **supportive and accepting environment** within school/college, this was noted as hugely beneficial to respondents being able to be themselves.

Positive impacts on health & wellbeing

Whilst there was quite a wide range of activities and tools noted as positive drivers on health and wellbeing, there was significant variation, resulting in only minor sub-themes in this theme. The acceptance of their **LGBTQ+ identity/identities by others** was noted as a sub-theme. Some respondents noted that one of the main things they do to improve their own health was taking part in **physical activity**. The activities noted tended to be solitary activities such as running or cycling. Additionally, respondents who had encountered a lack of acceptance for their identities noted the importance of **removing unsupportive people from their lives** to maintain their mental health and wellbeing. Finally, **a strong support network**, including close friends and teachers, was noted as a positive influence on health.

Future hopes for society

When asked what improvements were needed to improve the health of LGBTQ+ people, the main suggestion from respondents related to **greater LGBTQ+ awareness and acceptance** across society:

"For me it would just be getting more people to understand about our community and to understand that we are just like them. Because we are human and we do have the same feelings."

Improvements

The main suggestion respondents noted for future health and care delivery was the need for LGBTQ+ awareness **training for HCPs**, especially regarding trans issues and identities.

Working age people

Seven working age people took part in one of two focus groups.

Experience of health and care services

The most common theme arising from the working age focus groups was that of the experience of health and care services.

The most prevalent sub-theme was in relation to **HCP attitudes**, with many respondents noting encountering inappropriate attitudes from HCPs when seeking or receiving care:

"…when you go to a health professional or any other – as I say, you have to come out every time and often it can be quite embarrassing, and depending on the situation in which it's done, and in some areas, there are times where you almost feel you are being looked down at because of it."

In relation to this, an equally common subtheme was **self-disclosure**. Respondents highlighted a number of different approaches to the disclosure of their LGBTQ+ identities, some chose not to disclose their identity, even when relevant to their care:

"When I went to therapy and all that stuff, it took ages before I talked about my sexuality and my views on my identity and that was part of the problem… in the end she just had to ask me, because I wasn't telling them, and that was a massive barrier to my care."

On the other hand, other respondents chose to immediately disclose their identity on meeting a new HCP, to avoid assumptions:

"So we have kind of got to the point where we immediately go into these meetings going 'This is my wife, before you put your foot in your mouth this is my wife' and in some cases, or in most cases it is absolutely fine."

The cis LGB women who took part in the focus groups in particular noted the frustrations of feeling as though they were constantly coming out when interacting with health and care professionals.

Respondents expressed that often when seeking care, SO or GI was relevant and HCPs needed to know this to meet all of their needs, but due to the barriers, SO/GI was not always expressed. This resulted in **hidden needs** that can't be adequately addressed:

"[The view from some professionals is] *it's a private matter, you don't have to tell us about your sexuality. But of course… we do actually, because it makes up the whole of us and if you don't know the whole of us then you don't know us, and you can't help us and we're holding back.*"

Linked to some of the other sub-themes such as self-disclosure and HCP attitudes, was that of the **assumptions** made by HCPs that patients are straight and cis. Respondents noted that these assumptions caused discomfort and feeling the need to justify themselves and their identities:

"You come to midwife appointments and several times people looked at my wife and said 'Oh, is your mum coming in with you?'"

Inadequate access to services, especially to GICs, arose as a key sub-theme. This was in terms of getting a GP to refer to the GIC in the first place, as well as the extremely long waiting times once referred and the long distances required to travel to the nearest London based clinic:

"Speaking from somebody who is non-binary who has requested a referral to the gender identity clinic and who has waited well over 2 years just to get my very first appointment, and that was before the pandemic, it's longer now. The waiting list is years and years and years and years."

Other less common sub-themes that arose included **HCP knowledge** regarding LGBTQ+ identities/issues, feelings of **exclusion** from mainstream services, **mistrust** of HCPs and issues with NHS **systems and processes**.

Positive impacts on health and wellbeing

The most common sub-theme here was the importance of **safe spaces** -either LGBTQ+ specific spaces or LGBTQ+ friendly spaces, for health and wellbeing. Although it was noted that there was a lack of safe spaces for LGBTQ+ people locally, compared to Brighton, for example, and that many (but not all) of these spaces revolved around alcohol. These spaces enabled participants to freely be themselves, and to **connect to other LGBTQ+ people**, the second most common sub-theme raised:

"I think that one thing that I'm not sure other people look for as much as I do for my wellbeing and for what I consider to be important in nourishing my children's wellbeing is that I am looking for my tribe. I often feel like I'm looking for my tribe."

All respondents had a **holistic understanding of health and wellbeing**, rather than understanding this as merely the absence of disease. This holistic understanding perhaps helped these participants in proactively supporting their health and wellbeing, through forms of self-care such as **physical activity**, **participating in creativity and consuming culture**, **enjoying outside space** and maintaining **self-awareness** regarding triggers for previous mental health issues.

Another key positive impact on health and wellbeing was having a **supportive employer**, including emotional and practical support. Finally, the importance of **representation** and role models across the media and in workplaces was raised in terms of LGBTQ+ identities but also minority ethnic identities:

"I remember when I first moved to the UK and the first time I ever saw an advert of a biracial couple I was blown away, like I had never seen that before I came here, ten years ago. So seeing more representation, seeing more queer people, more gay people, more lesbians, more trans diverse people, that would be essential – especially in this area. Feeling like I'm being represented. That is a big deal."

Although, respondents also noted the need to ensure that representation is not tokenistic.

Differing needs of LGBTQ+ people

Largely, respondents felt that there were different needs between LGBTQ+ and non-LGBTQ+ people. The strongest sub-theme that arose here was that **mental health** needs may be both greater (i.e., more prevalent) and that mental health support required may specifically need to consider LGBTQ+ identities and issues:

"I think your mental health can definitely be affected if you consider yourself as part of the LGBTQ+ community and it can be for varying reasons; how you're shaped within society and what's expected of you and all those things."

Respondents also noted that **concerns for their safety** as LGBTQ+ people also drove differing health and wellbeing needs:

"We have to monitor, we have to be vigilant of where we are around our safety, about our coming out, about staying out, about being safe. I think that all of that absolutely impacts on both our mental health and our physical health so I would say quite certainly yes, we have different needs."

The areas of fertility and perinatal services were also noted as areas of differing need:

"[I went]….to the GP and said I'm a gay woman, I want a child, can you help me. She just looked at me like I was an alien, sent me off and then said she would call me later. So that was a little bit of a kick really. I thought she would be educated around what services were available."

Gender identity services were also noted as a clear area of specialist need for some TGD people.

Negative impacts on health & wellbeing

Locally, it was noted that there were **few opportunities to make connections with other LGBTQ+ people**, and this could lead to feelings of isolation:

"I have recently moved to [the area]…and I don't really know the area or the people and so there is a huge level of isolation on my part, especially when it comes to finding support, finding a community, finding activities that just really support my wellbeing. I am really lacking in that area right now."

This was noted even more acutely in terms of a **lack of safe spaces for groups within LGBTQ+ groups**, such as for people of colour:

"…the access to networks, but specifically around queer people of colour, like if you think about the bubble of queer people in Sussex, that is a very small bubble, but then like what happens if you're born brown or black, like it is even more complex and even more difficult to access spaces that you need to thrive."

Societal perceptions and attitudes, in terms of being dismissive of LGBTQ+ identities or the different needs of LGBTQ+ people were raised as a barrier to good health and wellbeing.

Other sub-themes that arose included feeling the need to **conceal sexual or gender identity**, the ongoing practice of **conversion therapy** in parts of the country and **memories of bad experiences of school** that impact feeling safe in some spaces that support wellbeing, such as gyms.

COVID-19

Almost all working age respondents noted a **negative impact on their mental health** during the pandemic, especially in terms of feeling isolated, stressed or triggering of a previous mental health condition. Going through points of transition, such as starting a new job or having a new baby, during this period were highlighted as particularly challenging:

"It was the worst experience of my life. I literally can't think of anything positive about it. For me I regressed in every way. No work routine… everything was up in

the air …I started a new job before lockdown, really horrible as I say, it triggered all my stress and trauma to come out."

Some respondents did note some **benefits of COVID-19**, largely where they were in a position of privilege, where they had a large house and garden, or in finding that working from home suited them.

Further to this, several respondents noted **concerns for the future**, especially with regards to returning to increased interactions with people and returning to work face to face:

"I am actually kind of feeling apprehensive about normal day-to-day office work because travelling, like commuting and being around more than myself, more people than just myself sounds really overwhelming for me at the moment…I really struggle to think of a time when that would actually feel okay again, being around people on a daily basis."

Education

The impact of supportive or non-supportive education settings for LGBTQ+ young people in their formative years, and the need for wider societal education regarding LGBTQ+ issues and identities arose as a theme.

Respondents noted progress in terms of the **inclusion of teaching about LGBTQ+ issues** within the school curriculum and this was celebrated by respondents, although it was noted that there was more work to do to ensure this reaches every child.

The second most common sub-theme was the power of **storytelling with and for young people** to discuss LGBTQ+ history and empower young people to be themselves.

Other sub-themes that arose included the need for **education of the wider public**, given the current lack of understanding in the wider public around equality for LGBTQ+ people, the positive impact and ongoing need for **LGBTQ+ groups in schools.** Finally, some respondents spoke of **memories of bad experiences at school**, due to their LGBTQ+ identity, which remain with them to this day.

Improvements

Working age respondents had a wide range of suggestions for improvements of health and care delivery for LGBTQ+ people. Firstly, respondents noted the need to provide good quality **training for HCPs and decision-makers** in public services to raise awareness/knowledge of LGBTQ+ issues and needs, challenge heteronormative and cisnormative assumptions and improve the care delivered to LGBTQ+ people.

The need for health and care spaces to be actively **inclusive** was also highlighted. Suggestions included NHS and council spaces to offer gender-neutral toilets and facilities, for information and materials to have greater LGBTQ+ representation in and for visible signifiers in health and care spaces:

"And the GPs surgeries, in hospital etc, even [if] *they just put some visual representation to show that this is acceptable here, we are an inclusive environment. It's so simple to put some stickers on the door so long as they mean it. For me it really helped me and made me feel more comfortable."*

A further sub-theme here related to **representation** and the powerful impact that LGBTQ+ staff working within health and care services could have when supporting LGBTQ+ service users:

"And without that disclosure [of HCP's own sexual identity] *I just must say I wouldn't have felt listened to and I was really, really at a low point."*

Other sub-themes that arose included the provision of **specific LGBTQ+ support**, **decision-makers explicitly considering the needs of LGBTQ+ people**, increased access to services, especially GIC and mental health services and the potential role of **LGBTQ+ champions** in East Sussex.

Older people

Five older LGBTQ+ people took part in one of two focus groups.

Negative impacts on health & wellbeing

The most common sub-theme arising here was **memories of discrimination and abuse**. Some respondents vividly recalled abusive treatment or witnessing the abusive treatment of sexual minority groups, especially during the HIV/AIDS epidemic during the 1980s. Respondents reflected that these experiences have affected them throughout their lives:

"You've got people openly laughing as gay men are dying and [they were] saying 'Hope you die' and they're laughing about it and they thought it was a joke… the things that you have been subjected to in youth, you know, they can't be erased because that determines how you proceed in your life... that is going to just affect how you are now because it's all there. Nothing can erase your memories."

A **lack of financial resources** was noted as having a negative impact on health. Respondents noted that in parts of the county accessing leisure facilities and other sources of wellbeing support were expensive, which excludes some people from opportunities to look after their own health:

"I understand that they can't all be [free], *but just the idea that things get more expensive to access and that accessing leisure facilities shouldn't be – you shouldn't feel excluded because you can't pay and that just feels awful."*

Further to this, respondents reflected on their experience of having to **conceal their identities** over many years, in public, in workspaces and how in some settings the feeling of needing to self-censor persists today:

"You still have to censor your behaviour. You do occasionally see two women hand in hand walking, but that's it. I mean if two men were walking hand in hand down a high street I think that would cause a little bit of adverse reaction."

Further to this, one general negative impact on health that arose was the **lack of cycling infrastructure** and facilities (e.g., places to store a bike, showers and changing facilities in workplaces) to support active transport locally.

Further to this, **societal discrimination** in the local area was noted, with respondents feeling that parts of East Sussex were closed minded, especially in more rural areas.

Ageism within the LGBTQ+ community was highlighted as an issue, constraining access to some LGBTQ+ spaces:

"…as older, senior gay members of the community, we could be – I was going to say that we could be seen as, but you could sometimes feel slightly invisible because the gay scene is slightly youth-oriented. Yes, you've got to be young, beautiful and…gorgeous. Well, we're still gorgeous but you see we're not young."

Discrimination in leisure spaces was also noted as a deterrence to accessing some of these spaces, which have the potential to greatly benefit health and wellbeing. Homophobia and transphobia were noted in some leisure space settings, including within allotments and gyms:

"I mean when we were at the allotments there was quite a lot of homophobia there. Well they just hated gay people. They wanted to get rid of us."

Similarly, leisure spaces often excluded participation for TGD people, due to a lack of due to lack of private changing spaces or gender-neutral spaces.

Another sub-theme that arose was the impact of **social isolation**, with respondents noting that opportunities for social interaction reduce with age, and this can lead to isolation, which can impact wellbeing.

Other less prominent negative impacts on health and wellbeing raised included **demand exceeding supply in adult learning courses and leisure settings**, **inability to self-identify**, **memories of invisibility**, **risk-taking behaviours** and **work stress**.

Experience of health & care services

Anticipated discrimination from health and care services due to their LGBTQ+ identities was the most prevalent sub-theme that arose. However, it was clear that this became heightened for some respondents with the added anticipation of ageism and racism. In fact, in some cases, respondents believed ageism or racism within services to be worse:

"…I'm probably on the lookout for it, but because [my wife is] *a woman of colour I sometimes think that it's racism as well… and I sometimes think the racism dominates even more."*

The second most common sub-theme was **inadequate support for TGD people from GP practices.** This was especially in terms of support in obtaining a referral to GIC and in the issuing of prescriptions and blood hormone level monitoring:

"It just doesn't seem good [hormone prescription]. *The GP seems to almost be making it up and then there is nowhere else you can go. You can't double-check it, and I mean that seems very poor health practice."*

Further to this, respondents described a range of **attitudes from HCPs** in relation to their sexual or gender identity, from being accepting of SO/GI to awkwardness or withdrawal following disclosure to trans/homophobia:

"…I did experience a little bit of a homophobic response from the dentist when I introduced my wife as a potential… patient… And that felt uncomfortable. I haven't left the practice but it did feel uncomfortable."

Frustrations with some **NHS systems and processes** were raised by respondents. This included NHS patient systems inflexibility regarding gender markers, resulting in regular misgendering of people, including in public waiting areas. This also included other processes resulting in potentially unnecessary face to face appointments and the need for patients to regularly chase up blood test results for hormone level monitoring.

Respondents noted a **lack of knowledge in HCPs** in trans specific care (such as the health impacts of hormone use) as well as more generally in supporting people going through menopause. Respondents felt that some of this lack of knowledge may be due to a lack of research in these areas.

Self-disclosure of SO or GI was something respondents reported having to think about often when accessing H&C services, alongside the anticipated discomfort of doing so:

"You have to come out like hundreds of times over and over again to the service providers."

The **lack of mental health support** was noted by respondents, especially in terms of communicating a mental health need to a GP in a 10 minute appointment but also in a structural sense in terms of the reduction of NHS mental health services/resources over several years.

Further to this, respondents noted that they felt **additional barriers** within Health and Care services beyond being LGBTQ+, especially in terms of being older or as people of colour.

Other sub-themes noted were the **outdated GIC model** of care in this country, prevailing heteronormative and cisnormative **assumptions from HCPs** and **acceptance of discrimination** (in that, when they experience discrimination, they feel this no longer impacts them).

Positive impacts on health & wellbeing

Older respondents really emphasised the assets of East Sussex to support good health and wellbeing. The top sub-theme noted was the benefits of accessing **green space**. **Physical activity**, especially outdoors, was also noted as having a positive impact on health and wellbeing. Further to this, respondents noted the importance of **blue space** on their health and wellbeing.

Creativity and culture was another sub-theme arising here, with respondents noting taking part in a wide range of creativity and culture, from photography, drawing and attending museums, as a way of maintaining their wellbeing.

Further to this, whilst respondents recognised the importance of **connections to other LGBTQ+ people** for wellbeing, there was also the desire for **wider societal acceptance**, and for differences amongst LGBTQ+ people to be celebrated:

"… it's nice to be felt that you're wanted within the gay community, but it is also nice to feel that you're wanted within the wider community and not sort of looked at as different."

Connecting to others, in general, was highlighted as key to maintaining good health and wellbeing. Additionally, the importance of being able to access **safe spaces** was highlighted.

Further to this, respondents noted that they try to **proactively take care of their mental health**, for example through mindfulness and self-awareness. The importance of being able to access charitable **24/7 mental health phone lines** during a mental health crisis was also noted:

"It's a phone line, it's there, you might be in your own home, it's confidential, it's private, and you can speak, you know someone is there. A great thing, an amazing thing with the Samaritans all day and all night, you know, so someone will be there at 2 o'clock in the morning, which is amazing."

Being **connected to local amenities** and **learning a new skill** were also highlighted as important in keeping healthy and well.

COVID-19

The most common sub-theme that arose was the experience of **loss** during the pandemic, and the restrictions in place as impacting the ability to deal with this:

"Just before we went into lockdown we lost a… member of our family to cancer and so there was a certain amount of grieving, which is still happening. We have only just had a memorial actually… because it all got delayed, delayed and delayed. So that grief and grieving during COVID was quite tough I must admit, because while there is stuff online it's not quite the same."

An increase in **work stress** was an issue for some respondents during the pandemic. Further to this, the **impact of restrictions of leisure activities** had put some respondents off doing the things they used to derive much pleasure in, such as trips to the theatre. Respondents discussed constant **assessments of risk** and changing of behaviour to avoid contracting the virus when living day to day. It was noted that some people had found unhealthy **coping mechanisms**, such as increased alcohol consumption, to cope with the stress of the pandemic. Finally, one of the benefits of COVID-19 for respondents was the **enjoyment of outside space**:

"And being able to go outside, because obviously we could still go to the sea and still go to the park and the allotments, so that was very good for the mental health side."

Fears about future health & care

A key sub-theme that arose regarding future health and care was the **anticipation of use of services for older people**. Respondents highlighted worry, or even fear, of accessing services, such as EOLC or residential care homes, later in life, due to hetero and cisnormative cultures and practices, and possible lack of acceptance within these services:

"You're thinking to be a gay man in a care home... it would be horrendous wouldn't it."

More broadly, respondents were concerned about their future health and care where they had a **less traditional family structure** around them. Some respondents were instead surrounded by other members of the community of a similar age, and were aware of the concern that this posed regarding who might provide support to them informally when they were older if it was required:

"…if we were two 70-year-old straight, heterosexual men, most likely we might be married, we might have had children, we might have grandchildren, so there is a larger framework that could feed into us and maybe help…. So there is that issue of we're all getting on a bit, and how do we cope?"

Progress

Some respondents reflected that significant progress had been made in terms of the rights of LGBTQ+ people. Respondents **recognised the significant progress** in the UK of the rights of LGBTQ+ people but that there is a need to not become complacent. Further to this, respondents noted the value of **intergenerational conversations** with young people in building respect for LGBTQ+ history and in recognising progress towards equality.

Improvements

Respondents noted it would be useful to have more **specialist support for LGBTQ+ groups** (especially for TGD people) available within the county, even if this was just online:

"it would be brilliant if there was some sort of countrywide service like an online or a phone thing but you could at least double check with the person even if you put a query forward, they are linked up with your GP and that they came up with an answer."

Further to this, a key change when accessing health and care services was the need for **equality across all protected characteristic groups**, rather than specifically just for LGBTQ+ people. Respondents were aware of issues across various protected characteristic groups, including ethnicity, age and disability, when accessing services and felt that energy should be put into ensuring equality for all protected groups.

TNBI

Eight people who identify as TNBI took part in one of two focus groups.

Experience of health & care services

The most common sub-theme arising was **inadequate support & expertise in GP practices for TNBI people**. Respondents spoke of a lack of support from some GPs when seeking help, for instance dismissing gender dysphoria as a fad, a lack of knowledge in HCPs regarding TNBI identities and issues and a lack of understanding about the transition process:

"…there are so many things in the path of transition that they just don't know. They just don't know what you're talking about."

This often resulted in respondents having to spend much of their limited appointment time with a professional educating them:

"…obviously the lack of knowledge amongst healthcare professionals in terms of terminology, what being trans is, non-binary identities, means that when you go and access these services you're kind of playing a game of 'Do I spend half my appointment explaining gender 101?'"

The second most common sub-theme was **access and waiting times for GIC**. This was both in terms of the several year wait for a first appointment but also the difficulty in travelling to these clinics, especially for those with disabilities:

"it's very difficult for me to get to these clinics, you know. Can I get assisted transport to go to these appointments should I eventually get one."

Further to this, some individuals noted they had reluctantly sought private care due to the unacceptably long wait times.

Some respondents reported a **positive experience of trans affirmative care**, with examples of GPs being responsive to needs and supportive in their attitudes. However, respondents noted that despite positive attitudes in some cases there was still a need to educate the GPs about the process that needed to be followed:

"Our GP was really good with applying for a gender recognition certificate … the GP admitted they didn't know much, they didn't know exactly what they needed, but they were very open to being kind of guided with 'Okay, this is what the statement needs to say' or this is the information that needs to be in it for the letters and things that he needed. So that was kind of a positive experience from that respect."

A significant issue raised by respondents was **misgendering and deadnaming** that took place in services, with some respondents noting this was a regular occurrence and contributed to their fear of accessing services:

"The secretary misgendered me 5 times on the phone and so I slammed the phone down, and I was like 'Now you've ruined my help, now you've made me feel uncomfortable, just talking on the phone, let alone going to the [appointment]'"

This was noted as occurring often when continuity of care was lost, with a new GP providing a consultation or when accessing a new service.

Anticipated discrimination from health and care services and wellbeing facilities were noted as a key barrier to attending health and care settings:

"…this is the kind of eclectic issue you take every time you meet another professional… you don't know what their particular brand of discrimination is…"

Anticipated discrimination was particularly heightened when individuals were considering interacting with a new service or new HCP, due to their past

experiences. This was outlined as one of the key contributors to the **avoidance of interaction with health and care services**:

"I only go if really desperate to be honest. Even outside of Covid, I hate going to those spaces. I haven't been to the dentist in about 6 years and haven't had my HRT levels checked in about 3 years. I get misgendered at the door, they never give me straight answers about my transition, and I can get most answers I need on the internet. I don't want to waste my time or get stressed out going…"

For many respondents attending a health and care setting induced significant fear, due to previous experiences of **actual discrimination**, misgendering and other factors, resulting in them not receiving the care they need, instead relying on the internet for medical advice.

Further to this, **lack of continuity of care** in General Practice was highlighted as an issue for respondents, especially due to the general lack of knowledge regarding TNBI health amongst professionals.

Respondents also noted **barriers to screening** they have experienced due to inflexible clinical systems with binary record-keeping, meaning that someone registered under their gender identity but requiring screening associated with their sex assigned at birth would miss out on an automatic invite to screening. This, alongside the avoidance of interacting with health and care services, may result in a high proportion of TNBI people missing out on potentially life-saving screening.

Finally, **inadequate support & expertise for TNBI people from mental health services** was also noted as an issue:

"They have very little understanding of how being trans affects your mental health and they would be more than happy for you to talk about your anxiety or your depression or what have you, but completely unable to relate to the reason for that is because of the social context of where we live."

Negative impacts on health and wellbeing

Respondents noted **specific drivers of poor health in TNBI people**, compared to cis and heterosexual people. These included the impact of waiting for GIC, managing the stress of these waiting times, minority stress and body image issues.

Further to this, respondents reported **avoiding leisure/wellbeing spaces** due to fears for their safety and anxiety regarding the lack of gender-neutral toilets in spaces:

"I can't use my local gym, or boxing club, it's not safe for me."

Due to these concerns about accessing health and wellbeing related spaces, respondents reported avoiding this unless it was entirely necessary.

Respondents highlighted the impact of housing on health and specific **housing issues** in relation to finding a suitable house and experiencing discrimination from neighbours, with little support from the council housing team to address this.

Respondents noted the impact **attitudes and behaviours of the public** could have on them, often causing embarrassment due to unwarranted comments or people laughing at them for being visibly trans or transitioning. Perhaps given this, unsurprisingly some respondents talked of the need to **conceal their identity,** leading to increased isolation:

"…my partner and I are very isolated here, purely because like my wife does the park run, for example, but I won't go with her because they see us together."

The issue of the current **lack of legal recognition of non-binary identities** was raised and the binary societal assumptions that this enables was noted as a stressor on some respondents.

Additionally, respondents noted the **lack of local TNBI specific or inclusive services** to support their health and wellbeing, with those in more **rural areas** facing additional challenges in accessing the services that do exist in parts of the county or further afield.

Finally, respondents noted that the **unaffordable cost of transport** made it difficult to access employment opportunities and trans-inclusive spaces, leading to greater isolation.

COVID-19

The most common sub-theme was that of the **mental health impacts** of the pandemic, noting highs and lows throughout. Some respondents found they became increasingly isolated and others found this time to be a relief due to the reduced anxiety from going out less. Respondents also noted the use of **remote appointments** throughout the pandemic, with some advantages of these such as not having to travel so far to make a GIC appointment, especially for disabled people, and disadvantages, such as greater communication challenges:

"Not having to travel to the middle of London. I think that's a bonus. Obviously slightly less stressful but you've got to worry about your internet breaking down rather than the train being on strike, or missing the train, finding somewhere to park at the train station."

Some respondents felt COVID-19 was beneficial in the sense that it gave them the space and **time to transition** in a more comfortable way:

"It meant I could transition! I came back after Covid with a new me, it gave me room and time to think."

Finally, some respondents noted that **fewer opportunities for wellbeing**, such as volunteering roles or attending gyms, were available to them during the lockdown.

Positive impacts on health and wellbeing

Respondents noted the importance of **peer support**, especially early on in the transition process:

"…it wasn't until I spoke to a counsellor, which I found through an internet search, and they signposted me to the Clare Project. It wasn't actually until I came along to the Clare Project that I really started to think 'Yes, this all starts to make sense now." And I was able to talk to other trans people and that has been really useful for me. And just getting the information [from] people [who] are a little bit further along in the whole process."

Further to this, **the role of LGBTQ+ or TNBI organisations in supporting wellbeing** via facilitating peer support, wellbeing activities and providing safe spaces was highlighted by respondents:

"That initial process of taking that next step, of being very sort of in-the-closet about it, and the shame, the guilt and all that stuff that I guess many of us have experienced to actually stepping out thinking how the hell do I do this, do I want to do this? Getting that help at that stage [via TNBI organisations and peer support] I think is pretty important."

Improvements

The most common suggestion to help improve the health and wellbeing of TNBI people living in East Sussex was the provision of **TNBI specific spaces and groups**, from trans health services to local CVS organisations supporting wellbeing, to TNBI sports groups:

"We shouldn't have to travel 50 miles to enjoy ourselves or be healthy. I've not been registered with a sports team in years, or seen a dentist in years, out of fear."

Further to this, respondents noted the need to provide **TNBI training to HCPs** to raise awareness of TNBI identities, issues such as minority stress and why there is significant anxiety in accessing services and to better understand the transition pathway:

"I mean the biggest difference it could make to most of our lives is just having someone to talk to who actually knows what they're bloody talking about."

Respondents also reported that a named **LGBTQ+ liaison person within services**, such as the housing department in the council, would be beneficial for supporting with issues such as discrimination from other service users.

Finally, general spaces, such as pools, gyms or health/care settings, should be made more **inclusive** for TNBI people, for instance through offering gender-neutral toilets and changing facilities. Respondents also noted that improving the **affordability of gyms** would help to encourage people to attend.

Chapter Summary

Seven focus groups were held to understand the experiences and concerns of LGBTQ+ people in East Sussex in relation to health and wellbeing. One group was held for young people, two for working age people, two for older people and two specific groups for TNBI people. This summary draws together the most prominent shared themes that arose across groups, as well as highlighting differences.

Due to highly prevalent cis and heteronormative assumptions across health and care settings, self-disclosure of SO or GI was something respondents reported having to think about often when accessing H&C services, alongside the anticipated discomfort of doing so. Cis LGB+ women especially noted the feeling of constantly coming out and the frustration of that. Respondents described a range of attitudes from HCPs, from being accepting of SO/GI to awkwardness or withdrawal following disclosure to trans/homophobia.

Respondents recognised a lack of training currently for many HCPs on LGBTQ+ and TNBI specific issues and noted the need to provide good quality training for HCPs and decision-makers in public services to raise awareness/knowledge of needs, challenge heteronormative and cisgender assumptions and improve the care delivered to LGBTQ+ people. The lack of representation of LGBTQ+ people in service literature was highlighted as a practice that made people feel excluded.

Inadequate support & expertise in GP practices for trans people was a theme that arose to greater or lesser extents across all groups, with respondents feeling GPs often (but not always) lacked expertise and provided insufficient support for trans people. The difficulty in getting a referral to a GIC was noted by many TGD people across the different groups. The waiting list for the GIC, as well as the lack of local provision, was also noted as a key issue.

The role of education was raised across all age groups, especially the impact of bullying on the wellbeing of young people, but also the recognition that these experiences are carried with a person throughout life and can still impact older LGBTQ+ people. The need for good quality and LGBTQ+ affirming mental health support in schools was also highlighted. The importance of raising awareness of LGBTQ+ issues and identities in schools and the provision of LGBTQ+ groups for young people was highlighted. Working age and older respondents noted that significant progress had been made on this point in recent years.

Several of the focus groups noted additional barriers to health and healthcare due to other protected characteristics, such as age and ethnicity. Further to this, financial resources and lack of transport were noted as a barrier to health and access to health and care services, especially where there was a need to travel to LGBTQ+ specific services out of the county.

Whilst the experiences of COVID-19 varied significantly between groups, respondents in most groups noted a negative impact on their mental health during the pandemic, especially in terms of feeling isolated, stressed or triggering of a previous mental health condition.

Respondents noted local assets which were positive drivers on their health, such as blue and green spaces, although the lack of infrastructure (e.g., safe cycle paths) meant that these were not always being fully utilised for health.

The importance of safe LGBTQ+ spaces was raised across most groups, especially where these enable connection to other LGBTQ+ people which was noted as a positive driver for health and wellbeing. Respondents noted the importance of peer support in helping to make sense of the transition process as well as TNBI specific groups for facilitating peer support and in providing a safe space and TNBI specific services.

For older people particularly, there was a heightened sense of anticipated discrimination in services due to their LGBTQ+ identities, but this expectation could be heightened with the added anticipation of ageism, and racism for some respondents. Some of this may be driven by vivid memories of discrimination and abuse towards LGBTQ+ people over the years.

The lack of a traditional family structure for many (but not all) LGBTQ+ older people was also highlighted, with people instead often surrounded by other members of the community of a similar age, and the concern that this posed regarding who might provide support informally if it was required. Further to this. respondents highlighted worry, or even fear, of accessing services, such as EOLC or residential care homes, later in life, due to hetero and cisnormative cultures and practices, and possible lack of acceptance within these services.

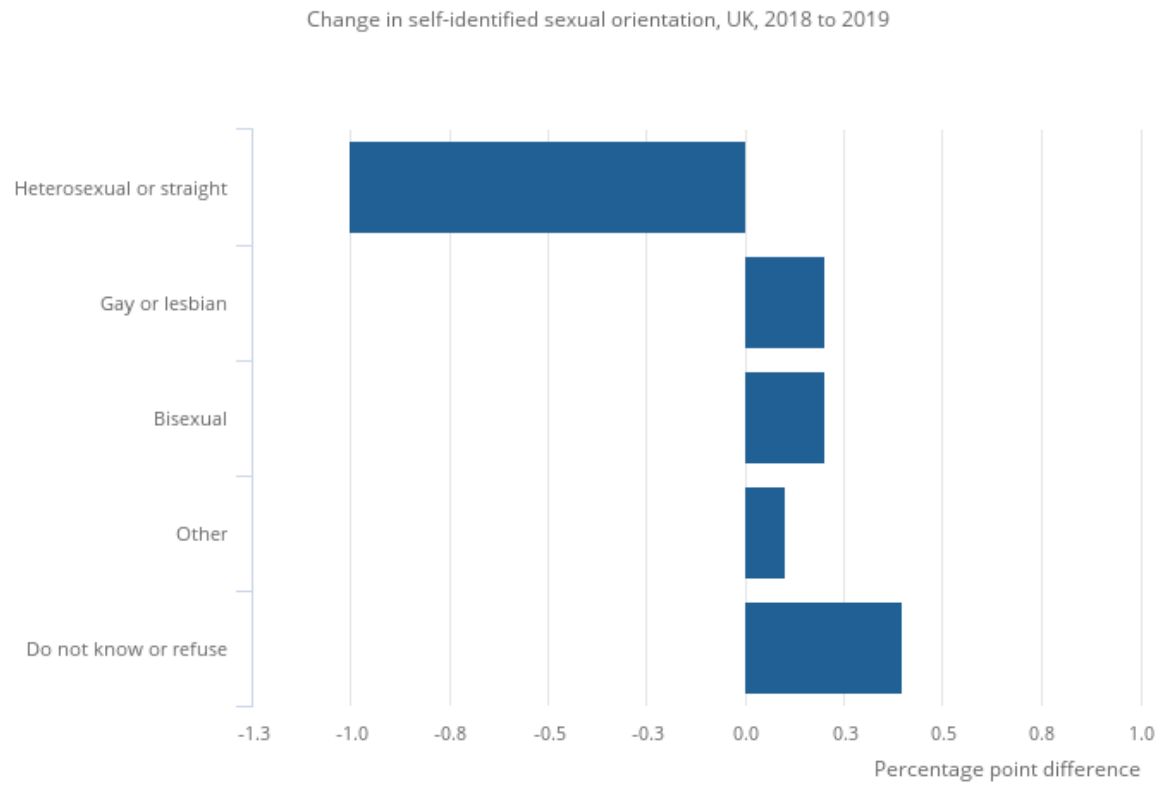
For the TNBI groups, misgendering and deadnaming was a common occurrence within health and care services. Anticipated and prior experience of discrimination from health and care services was also highlighted. These factors contributed to the avoidance of health and care spaces, due to the fear and stress this causes. Leisure and wellbeing spaces were also highlighted as spaces to avoid due to being potentially unsafe and exclusive.

Several specific drivers of poor health in TNBI people locally were noted, including the impact of waiting for a GIC appointment, managing the stress of these waiting times, minority stress and body image issues.

Chapter nine- Future need

It is challenging to assess the future need of LGBTQ+ people, given the lack of robust population estimates currently. However, it does appear that at a national level the proportion of people who identify as LGB+ may be increasing, compared to those people identified as heterosexual, as highlighted below:

Figure 71: Percentage change in SO identification nationally between 2018 and 2019



Source: Annual Population Survey, ONS

As shown, there has been a reduction in the proportion of people who identify as heterosexual, and an increase in the minority SO groups between 2018 and 2019, and this continues a trend since 2015 (37).

The ONS data also demonstrates a greater proportion of young people identifying as LGB+ at a national level. Locally, one quarter of respondents to the MHMS survey in East Sussex reported their SO as LGB+, although not all schools took part in this survey so this may not be representative. However, it does appear that a greater proportion of younger people tend to identify as LGB+ than older people, suggesting the proportion of LGB+ people may grow over time. Although, as the proportion of LGB+ people grow, it may also be that health needs change, if, for

example, societal acceptance grows, discrimination reduces and therefore minority stress may reduce.

As noted in earlier sections, there are currently no robust data on the number of TGD and people with intersex variations at a national level to enable an understanding of changing trends in these population groups.

More robust data locally is required to better understand what future need might look like for LGBTQ+ people in East Sussex. The Census 2021 will provide a useful baseline for this, but efforts will be needed on an ongoing basis to capture this data at a more regular frequency.

Chapter Summary

There is a lack of robust data in order to predict future need for LGBTQ+ people locally. Whilst estimates of the proportion of people who identify as LGB+ are increasing, there is a current lack of data regarding TGD people and people with intersex variations, even at a national level. More robust data locally is required to better understand what future need might look like for LGBTQ+ people in East Sussex. The Census 2021 will provide a useful baseline for this, but efforts will be needed on an ongoing basis to capture this data at a more regular frequency.

Chapter ten- Conclusions

This needs assessment has been the first comprehensive review in East Sussex of the needs and experiences of LGBTQ+ people. Although local data was not universally available across health and care services due to limited routine monitoring of SO and GI, the literature review, bespoke engagement and local data that was available has enabled us to build a much better understanding of our LGBTQ+ communities locally. A clear finding is that although many outcomes are worse generally in LGBTQ+ groups, compared to non-LGBTQ+ groups, there are significant disparities within LGBTQ+ groups, for example between cis-LGB+ and TGD groups. This needs assessment has aimed to draw out these differences, where possible.

This section of the report provides an overview of the main findings of the needs assessment and what the evidence is suggesting. From this evidence, recommendations have been produced to inform how inequalities in and within LGBTQ+ groups can be addressed and how provision can be more inclusive going forwards.

LGBTQ+ population in East Sussex

Currently, we are unable to accurately estimate the number of LGBTQ+ people living in East Sussex, although more robust data will be available on this from Spring 2022 with regards to minority gender identity and minority sexual identity groups.

The best estimates available of the number of LGB+ people living locally may be somewhere between 3.1% (ONS experimental statistics for East Sussex)- 7% (East Sussex 2019 community survey estimate). This would equate to between 17,273 and 39,004 LGB+ people living in East Sussex. Some of these people may also be TGD.

With regards to GI, there currently isn't an accurate figure of the number of TGD people living in the UK or at a local level. A figure of 1% is commonly used to estimate the number of people who may be trans or non-binary, which would equate to approximately 5,572 people living in East Sussex who identify as TGD. Some of these people may also be LGB+.

Currently, there isn't an accurate figure for the number of people born with intersex variations, but experts suggest it may range between 0.05%-1.7% of the population.

Due to the lack of population data on these groups, and therefore limited data on trends over time, it is difficult to predict how this population is changing and

therefore how future needs may change. However, it does appear that at a national level the proportion of people who identify as LGB+ may be increasing, and the proportion of those who identify as heterosexual are decreasing. There are currently no robust data on the number of TGD and people with intersex variations at a national level to enable an understanding of changing trends in these population groups.

Health issues and inequalities

Key health and wellbeing issues and inequalities that the evidence from this report contains are outlined below:

Young LGBTQ+ people:

- Experience higher rates of bullying at school than non-LGBTQ+ pupils and feel unsafe in and around school.
- Have poorer mental wellbeing than non-LGBTQ+ people.
- Experience high levels of hate crime related to GI and SO and are less likely to report this than other age groups.
- Have a high prevalence of self-harm and higher frequency of this compared to non-LGBTQ+ people and increased risk of suicidal ideation.
- Have a high risk of smoking, drug use and problematic alcohol use amongst some groups.
- Have lower levels of physical activity than non-LGBTQ+ people.
- Are more likely to be disabled, compared to non-LGBTQ+ people.
- Regularly experience cis and heteronormative assumptions when interacting with services.

Generally, TGD groups were more at risk of these issues, with higher rates of bullying, feeling unsafe at school, poorer mental wellbeing, and increased risk of self-harm. Young TGD people appear to be less likely to take up screening, alongside the structural issues regarding being invited correctly in the first place. Young non-binary/gender variant people also have lower awareness of PrEP. Further to this, TGD people experience inadequate support from GP practices regarding trans health needs and face extremely long waits for a first appointment at a GIC.

Working age LGBTQ+ adults:

- May experience higher rates of unemployment and inability to work due to sickness/disability compared to non-LGBTQ+ people.
- Experience high levels of GI or SO motivated hate crimes, with low levels of reporting.
- Are more likely to feel isolated than non-LGBTQ+ people.

- Have high rates of mental health conditions prevalence compared to non-LGBTQ+ people.
- Have higher rates of self-harm, suicidal ideation and suicide attempts.
- Have a higher risk of smoking, drug use and problematic alcohol use amongst some groups.
- Have lower levels of physical activity.
- Regularly experience cis and heteronormative assumptions when interacting with services.

On the whole, the evidence suggests greater inequalities for TGD people compared to LGB+ people, with lower mental wellbeing, lower rates of physical activity, higher rates of self-harm, and suicide risk. Trans binary people also appear less likely to take up screening when offered, alongside the structural issues of being invited in the first place.

Additionally, LGBTQ+ people from Black, Asian and other minority ethnic groups appear to be more likely to experience hate crime, feel lonely and to have thought about suicide during COVID-19. Further to this, bi people appear to have higher rates of loneliness, a higher prevalence of mental health conditions and appear less likely to recover following treatment via IAPT services.

Older LGBTQ+ adults:

- Experience high rates of loneliness or isolation and many have less traditional networks of support to rely on than non-LGBTQ+ people.
- Often feel excluded from LGBTQ+ spaces, due to ageism.
- Had high levels of drinking every or most days
- Had a high rate of regularly or occasionally smoking in gay men.
- Have high rates of having at LTCs and disability.
- Report concerns about discrimination when accessing health and care services due to their LGBTQ+ identities, but also face additional barriers regarding ageism and racism for some.

TGD older people were much more likely than cis LGB+ people to experience a hate crime. These groups also reported higher rates of loneliness during the pandemic and were less likely to be sufficiently active than LGB+ people. Additionally, TGD older people were much less likely to be aware of PrEP than LGB+ cis people.

Access and experience of services

Whilst some positive experiences were reported in mainstream services, we received substantial feedback regarding issues of access and experience for LGBTQ+ people. This was reported most acutely for TGD groups attempting to

access trans healthcare, finding that GPs, generally, lacked basic knowledge about TGD identities and information about the transition pathway. Once through the initial hurdle of obtaining a referral to a GIC, the waiting times for a first appointment, approximately four years at the time of writing, were unacceptably long and clinics inaccessible due to their London location when an appointment was available.

LGBTQ+ people reported cis and heteronormative assumptions were common across a wide range of settings, leading to regular decisions about self-disclosure and the safety of doing so, often followed by the rest of the encounter with the HCP feeling uncomfortable. Some people also reported being asked inappropriate questions due to their identity/identities and unfair treatment in health and care services. A very small number of people had experienced homo/bi/transphobic abuse in a health or care setting over the past 18 months.

The data available suggests many LGBTQ+ East Sussex residents are travelling outside of the county to access care and wellbeing support due to a lack of provision locally.

Best practice

A wide range of guidance exists to support organisations and services to deliver high-quality support to LGBTQ+ people. Whilst there are some particular considerations in specific settings, there are several commonalities in best practice in supporting LGBTQ+ people across all settings and determinants for health: the need for robust data collection and monitoring; staff training in LGBQT+ needs, both general and service specific; the need for inclusive and ‘safe’ service provision, including clear confidentiality policies; and the need for robust preventative policies and proactive approaches to tackling discrimination.

Chapter eleven- Recommendations

The response to the challenges outlined in this report requires a multi-agency and multi-faceted response, alongside working much more closely with members of our LGBTQ+ communities, especially in service design and delivery.

The recommendations alongside a summary of the evidence base for each are shown in full in appendix one.

Recommendations from this needs assessment are as follows:

Strategic

1.1 The response to the challenges and recommendations set out in this report require a whole system approach. A multi-agency group to be convened to implement the recommendations. The group should be embedded within the Integrated Care Partnership (ICP) and should include schools and colleges.

Communication and engagement

2.1 Increase awareness of the benefits of PrEP for the prevention of HIV for LGBTQ+ groups and how to access this

2.2 Work with trusted LGBTQ+ organisations to promote the benefits of screening to LGBTQ+ people, including clear risk communication.

2.3 Given that IAPT services were one of the few local services with excellent SO data, we were able to note a pattern whereby outcomes appear poorer for bi people, which aligns with national research on this. We recommend that engagement is undertaken with LGBTQ+ IAPT service users to understand their experiences of using the service.

2.4 Actively seek out insight as to the experiences of LGBTQ+ people accessing a wide range of health and care services, ideally led by LGBTQ+ organisations.

Inclusion and awareness in mainstream settings

3.01 Health and care settings should conduct reviews, with full engagement of staff and users, to consider providing gender-neutral and accessible toilet facilities for staff and service users.

3.02 Health and Care services should ensure their public facing materials (e.g., leaflets, webpages etc) include representation of LGBTQ+ people (including those with intersectional identities, such as a disability) and use inclusive language, such as encouraging staff to identify their pronouns.

3.03 Swimming pools, leisure centres and sporting facilities should consider how they could become more LGBTQ+ friendly and inclusive, including the introduction of LGBTQ+ sessions.

3.04 Health and Care settings should display LGBTQ+ signifiers and visible policies which communicate a zero-tolerance approach to homo/bi/transphobic discrimination within services, alongside LGBTQ+ champions in services.

3.05 Support visible, positive LGBTQ+ role models within public sector organisations through forming/developing LGBTQ+ staff networks, LGBTQ+ champions, taking part in Pride events and LGBT History Month, Black LGBT history month, International Day Against Homophobia, Biphobia and Transphobia, Trans Day of Remembrance.

3.06 Develop an anti-LGBTQ+ bullying strategy across East Sussex, working closely with schools, colleges and specialised local organisations already supporting LGBTQ+ young people.

3.07 Provide schools, colleges and youth-focused services and organisations with the guidance needed to promote inclusion of LGBTQ+ young people and to support those who are victims of hate crime or online harassment, linking in with local LGBTQ+ organisations.

3.08-3.13 Work with local LGBTQ+ organisations to provide LGBTQ+ awareness and inclusion training for staff and volunteers in:

- End of life care services;
- Care Homes;
- Perinatal services;
- Specialist community public health nurses;
- Primary Care.
- Mental health services (Adult and Children & Young People).

3.14 Awareness sessions to be delivered to health and wellbeing decision makers/leaders and elected members on health inequalities amongst LGBTQ+ groups.

3.15 Explicit consideration should be given to the needs of LGBTQ+ people in the delivery of health behaviour initiatives (e.g., smoking cessation, alcohol harm reduction, substance misuse).

3.16 Ensure specific and inclusive support is in place from a range of partners to ensure young people feel supported to manage their sexual health and safety.

3.17 Develop a scheme to identify and promote LGBTQ+ friendly businesses and wellbeing spaces.

3.18 Health and Care organisations (including LGBTQ+ CVS organisations) need to have an understanding of the impact of intersectionality in the planning, delivery and evaluation of services.

3.19 Homelessness commissioners and service providers should explicitly consider the needs of LGBTQ+ people accessing support

3.20 Implement any learning from SPFT as a pilot site of the NHS Confederation LGBTQ+ recommendations across other Health and Care settings.

3.21 Consider specific needs of LGBTQ+ young people Not in Education, Employment or Training (NEET) and provide relevant support.

3.22 Consider specific needs of LGBTQ+ people accessing domestic abuse services and support.

LGBTQ+ specific services and support

4.1 Support the development of LGBTQ+ (and especially TNBI specific) organisations in East Sussex to provide services and groups to support wellbeing (e.g., peer-led support groups, opportunities for socialising, exercise/sports sessions etc).

4.2 Consider commissioning specific suicide prevention for LGBTQ+ people, especially for TGD people, as part of a suicide prevention programme.

4.3 Support the development of the provision of LGBTQ+ inclusive and specialist spaces/organisations in the county, ensuring inclusive provision for TGD youth.

4.4 Consider commissioning specific mental health support for LGBTQ+ people, especially ensuring adequate and appropriate provision for young people that addresses their specific needs and experiences.

4.5 Work with community safety partners to establish liaison person for LGBTQ+ hate crime to encourage reporting, closely linked to local LGBTQ+ support groups.

LGBTQ+ specific services are encouraged to be community led with staff and volunteers who are LGBTQ+, as far as possible.

Trans healthcare

5.1 Ensure that the TGD community are proactively involved and consulted in the development of trans healthcare services in Sussex (including the services outlined below), from the planning, monitoring and evaluation of them. This should harness the expertise that this community has regarding their own health needs.

5.2 Promote and ensure the success and quality of the planned trans healthcare Locally Commissioned Service (LCS) in General practice (to be commissioned by the CCG in 2022) to ensure equal access to TGD people across East Sussex. This includes training on trans health needs and an annual health check, which will include hormone blood test monitoring and check screening status.

5.3 Support the ongoing development of the local Gender Identity Clinic model at the Sussex level.

5.4 As per recommendation 5.3 (development of a Sussex GIC), the excessive waits for a first appointment at a GIC must be addressed as a priority. As this will not be an immediate solution, a range of options to support TGD people awaiting a GIC appointment should be available. This may include access to a specialist gender therapist or peer support via local TNBI organisations, and this menu of options should be co-designed with TGD community members.

Data and information

6.1 Health and Care services should collect SO and GI data. Ideally, this should be using the question-and-answer categories outlined in LGBT foundation and NHSE/I 'if we're not counted…' guidance to enable consistent monitoring to understand access to services and outcomes, but it is recognised that not all digital systems facilitate this currently.

6.2 Raise awareness and offer training to health and care services regarding the importance of SO/GI monitoring and how to ask monitoring questions.

6.3 Future population wide JSNAs, Health and Wellbeing Strategies and DPH reports should explicitly consider the needs of LGBTQ+ people.

6.4 Analyse local Census data when available in Spring 2022 to supplement the findings of this Needs Assessment. This will give better insight regarding inequalities in the wider determinants of health especially and a robust estimate of the number of LGBTQ+ people locally. An almost complete population sample will also enable intersectional analysis to understand inequalities within groups within groups.

6.5 Actively promote regular national LGBT+ surveys (e.g., LGBT foundation primary care survey) to residents. Sufficient sample sizes locally will enable analysis at a local level and provide useful insight into the experiences of LGBTQ+ people in East Sussex.

Other

7.1 Conduct specific research on the experiences of people with intersex variation locally to inform appropriate service provision.

7.2 Ensure sexual health provision is accessible for LGBTQ+ people locally, including specialist HIV support.

7.3 Improve access to GPs and mental health services (generally).

7.4 Improve cycling infrastructure locally to enable active travel.

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