

The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document

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Foreword



Duncan Selbie, Chief Executive of Public Health England

Given as a health system we are serious about our mission to address inequalities, one group that must demand our attention is the lesbian, gay, bisexual and trans community.

The LGB&T companion to the Public Health Outcomes Framework sets out a broad span of research that shows that LGB&T people experience significant health inequalities compared to the wider population from high rates of physical and emotional bullying, and risk of parental rejection and running away in childhood, through significantly higher rates of suicide and self-harm, drug and alcohol use and smoking in adulthood, and social isolation and extreme vulnerability in old age.

The companion sets out the evidence base related to each public health indicator, and makes clear recommendations for action at local, regional and national levels. The companion also highlights best practice and signposts a wide range of resources available to help everyone reduce the inequality gap for their LGB&T communities. I have tasked the Health and Wellbeing Directorate of Public Health England, with its responsibility to lead on health inequalities, to seek ways to support the implementation of these recommendations.

This is my commitment and I encourage others to do likewise.

A handwritten signature in black ink that reads "Duncan Selbie". The signature is written in a cursive, flowing style.

Executive Summary

The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document is a resource for all those commissioning and delivering healthcare services in order to support the delivery of an equitable public health system.

There is a substantial body of evidence demonstrating that lesbian, gay, bisexual and trans (LGB&T) people experience significant health inequalities, which impact both on their health outcomes and their experiences of the healthcare system. The relationship between sexual orientation and gender identity and health has often been overlooked by the healthcare system, and a lack of sexual orientation and gender identity monitoring in service provision and population level research means that the Public Health Outcomes Framework (PHOF) indicators alone will not generate data on LGB&T people.

The LGB&T Public Health Outcomes Framework Companion Document is intended for Health and Wellbeing Boards, Local Authorities, NHS England, Specialist Public Health Teams, Clinical Commissioning Groups, Commissioning Support Services, NHS and Social Care providers, and voluntary and community organisations working with LGB&T people. It is a resource to improve the commissioning and provision of services to meet the needs of the diverse LGB&T community.

The document follows the structure of the PHOF, the set of indicators to improve and protect the nation's health, providing data and evidence on LGB&T communities for each indicator and domain. It makes recommendations for actions to address inequalities in outcomes for LGB&T people and communities, and highlights best practice case studies and resources to support organisations in implementing these recommendations. Following these recommendations will help organisations to ensure that they are paying due regard to LGB&T people, as required by Section 149 of the Equality Act 2010, the Public Sector Equality Duty. It is important to note that the protected characteristic of gender reassignment covers only those who are proposing to undergo, are undergoing, or have undergone, the process of changing their gender. It is best practice to consider all trans people as though they are equally protected in the provision of appropriate healthcare services.

The LGB&T Public Health Outcomes Framework Companion Document has been developed by a group of volunteer experts from across the LGB&T community working with the Department of Health, to increase understanding of LGB&T health and make sure that the public health system tackles inequality related to sexual orientation and gender identity and promotes equality for everybody.

Domain One: Improving the wider determinants of Health

LGB&T individuals often experience discrimination and marginalisation that impacts on wider factors such as education, housing and perceptions and experiences of crime and violence, meaning that these groups experience specific health inequalities as a result.

Domain Two: Health Improvement

Local and national research and needs assessments of LGB&T communities have repeatedly demonstrated higher levels of health risk behaviours, such as smoking and drug and alcohol use, as well as higher levels of self-harm. LGB&T people are less likely to engage with health interventions and screening programmes, and gender-specific screening can present particular challenges for trans and non-gendered individuals. LGB&T communities therefore have higher levels of need for intervention and targeted support related to these indicators.

Domain Three: Health Protection

These indicators focus on protecting the population's health from major incidents, and other threats, while reducing health inequalities there are some areas which particularly affect LGB&T people. There is a lack of evidence on LGB&T communities in relation to many of the indicators in this domain, yet the available evidence indicates that LGB&T people may be experiencing health inequalities in relation to health protection.

Domain Four: Healthcare public health preventing premature mortality

Evidence indicates that LGB&T communities are more likely to be experiencing health inequalities in relation to public health areas and preventing premature mortality. The higher prevalence of smoking, alcohol use and drug use, and lower uptake of screening programmes, are likely to contribute to increased risk of preventable ill health. There is also a significant body of evidence demonstrating high rates of suicide attempts.



Universal Recommendations

The LGB&T Public Health Outcomes Framework Companion Document makes a number of overarching recommendations for Public Health England, Health and Wellbeing Boards, public health teams, local authorities, the NHS and other partners to support the delivery of improved health and wellbeing outcomes for LGB&T people.

Recognition:

- Health and Wellbeing Boards and Directors of Public Health should ensure that the Joint Strategic Needs Assessment explicitly considers the needs of the local LGB&T community.
- Health and Wellbeing Board Chairs must ensure that Health and Wellbeing Strategy implementation plans and supporting strategies explicitly consider the actions to reduce inequalities affecting LGB&T communities.
- All health and social care commissioners should continue to use equality impact assessment frameworks, which include sexual orientation and gender identity, for population strategy documents and action plans.
- All health and social care providers should implement the published guidance, as referenced in the supporting *Resources* document, on becoming LGB&T-friendly providers.

Engagement:

- Healthwatch commissioning and contracting processes should monitor levels of engagement with LGB&T populations.
- Clinical Commissioning Group public and patient involvement initiatives should ensure that LGB&T communities are specifically included in CCG communication and engagement strategies.

Monitoring:

- Commissioners should include a requirement in contracts for service providers to monitor sexual orientation and gender identity in service users over 16yrs, and consider monitoring younger age groups where appropriate.
- National cohort studies and disease registers should include sexual orientation monitoring and gender identity in routine data collection.

Service Provision:

- Commissioners should use the data available to them to assess whether mainstream services they have commissioned are accessible to and appropriate for LGB&T people.
- Commissioners should ensure provision of specialist services, where appropriate, to address specific LGB&T health care needs available in their local area.

Introduction

The Public Health Outcomes Framework (PHOF) was published in January 2012 and set out the desired national public health outcomes for England, with indicators to measure year on year progress.

The PHOF has two overarching high level outcomes:

- Increased healthy life expectancy;
- Reduced differences in life expectancy and healthy life expectancy between communities.

The PHOF measurement of progress is through a set of public health indicators which cover a wide range of areas and are grouped under four 'domains':

- Improving the wider determinants of health.
- Health improvement.
- Health protection.
- Healthcare public health and preventing premature mortality.

As the PHOF is a national document, part of the equality impact assessment in its development identified the lack of national data on sexual orientation and gender identity among other gaps in national equality data, and established a key action for Public Health England to address these gaps.

The [NHS Equality Delivery System](#) was established to support routine data collection across all equality strands and will hopefully reduce these gaps over time. It is intended to help organisations to start the analysis that is required by section 149 of the Equality Act 2010 ("the public sector Equality Duty") in a way that promotes localism and also helps to deliver on the NHS Outcomes Framework and the NHS Constitution. There is substantial guidance to support NHS and local government organisations now to monitor the of sexual orientation of service users and a growing body of resources to support monitoring of gender identity in ways that are acceptable to the broader trans community.

In comparison to other demographic groups, there is a lack of data relating to the health of LGB&T communities derived from population-based studies and statistical datasets.¹ LGB&T people are under-represented in peer reviewed journals on which epidemiologists and commissioners of health services base their decision-making. Moreover, LGB&T populations have not been included in international cancer registries or national Department of Health datasets, the UK Census, or the majority of Office for National Statistics surveys.² However, there is a significant evidence base on the health inequalities experienced by LGB&T communities from peer-reviewed research, grey literature published by the LGB&T community, and indicative evidence. This document brings together the existing evidence including grey literature, on the health needs of LGB&T people, recognising that the picture it paints is necessarily incomplete and consequently unbalanced. As is highlighted throughout there are significant gaps in data and knowledge in this area - in large part due to the lack of routine monitoring of sexual orientation and gender identity that it consistently recommends. What the evidence points to is the significant impact of discrimination on health and wellbeing outcomes for LGB&T people. What is not known is the role of resilience in determining better outcomes, nor the more positive protective factors that LGB&T communities have developed over time.

The LGB&T Public Health Outcomes Framework Companion Document is aimed at strategic commissioners and service providers. The document sets out the evidence on LGB&T communities in relation to each of the indicators under the four domains of the PHOF. It makes recommendations for actions to address inequalities in outcomes for LGB&T people and communities. The Case Studies and list of Resources presented in the supporting documents provide further best practice examples and toolkits to support organisations in implementing the recommendations in this document. Following these recommendations will help organisations to ensure that they are paying due regard to LGB&T people, as required by Section 149 of the Equality Act 2010, the Public Sector Equality Duty. It is important to note that the protected characteristic of gender reassignment covers only those who are proposing to undergo, are undergoing or have undergone the process of changing their gender. It is best practice to consider all trans people as though they are equally protected in the provision of appropriate healthcare services.

The document has been developed by a group of volunteer experts from across the LGB&T community working with the Department of Health. It draws on the legacy of the [Sexual Orientation and Gender Identity Advisory Group](#) that commissioned the 2007 LGB&T health briefing papers. These formed part of a suite of publications which demonstrated the Department of Health's commitment to addressing the needs of LGB&T communities in the UK, and established a series of international landmark health documents which has inspired and supported changes and improvements for LGB&T communities across the world.

Minorities within Minorities

The evidence base relating to minority groups within the LGB&T community



It is important to acknowledge that LGB&T is not an homogenous group but consists of individuals who identify across several demographic groups, of which their sexual orientation and gender identity are only two. Individuals have multiple identities which they experience in an integrated and holistic way, although they may choose to emphasise and disclose these identities in different settings and in different ways.

While there is a published evidence base relating to LGB&T communities, there is limited evidence that explores differences within this community based on other aspects of identity, for example African gay men's behaviours compared to white British gay men's behaviours.

A diversity of identities is represented under the trans umbrella, including people whose identities can be described as other than male or female. For instance, some people identify as neither male nor female while others identify as both male and female or somewhere in between. While this might present a new challenge for providers of healthcare, it is an issue that does require consideration. There is a lack of evidence as to the number of people who would identify themselves within these sections and their experiences of healthcare, but healthcare providers should be sensitive to these patients' needs and aware that gendered classification is not always appropriate.

The supporting *Minorities within LGB&T* document provides links to the evidence relevant to the PHOF for LGB&T minorities. In general the evidence shows clear and significant health inequalities amongst LGB&T minorities and supports a need for further work to understand and address these inequalities.

The evidence includes findings of:

- Significantly higher rates of attempted suicide, self-harm and mental ill health across all minority groups compared to the general LGB&T population.³
- Domestic violence are rates higher among minority LGB&T groups than in the general LGB&T population.⁴
- Variation between different ethnic groups of LGB people in their health risks and health behaviours.^{5,6}
- New migrant gay men are at particularly high risk of mental ill health and sexually transmitted diseases, including HIV.⁷
- Black and minority ethnic (BME) LGB individuals have higher smoking rates than their heterosexual equivalents and higher rates of hookah and cigar smoking than their white LGB counterparts.⁸
- BME lesbian and bisexual women appear to have higher risk of cardiac disease, diabetes and cancer as well as different patterns of risk behaviours compared to their white LB and heterosexual counterparts.⁹
- Surveys suggest a slightly higher proportion of the LGB&T population are living with a disability than the general population.^{10,11}
- Fewer LGB disabled people are accessing the health, mental health and social care services they feel they need than heterosexual disabled people.¹²
- Smoking and drug use amongst disabled gay and bisexual men is higher than non-disabled gay and bisexual men.¹³

- Fewer LGB disabled people are out to their GP or healthcare professionals than non-disabled LGB people.¹⁴
- Very little research has been conducted into the relationship between faith and sexual orientation or gender identity, although there is some evidence of specific networks linked to church spaces and further work is needed in this area.¹⁵
- There is limited published research into trans health issues outside of gender reassignment pathways of care. There is also limited research into the long term impact of hormonal treatment, although there is evidence of increased incidence of metabolic syndrome in male to female trans individuals using hormones.¹⁶
- The largest survey of trans people in England found that 20% of trans people identify as heterosexual, 58% have a disability or chronic health condition including 8.5% who were deaf and 5% who were visually impaired, 18% were carers with 7% giving significant levels of care.¹⁷
- There is limited research into bisexuality. However, there is evidence for bisexual men and women of increased risk of eating disorders, mental ill health and increased alcohol consumption compared to lesbians and their heterosexual peers. Although bisexual women are more likely to have tested for sexually transmitted diseases than lesbian women, significantly fewer bisexual men have ever been for an STD or HIV test than gay men.¹⁸

The lack of inclusion of sexual orientation and gender identity in routine data collection means that few studies have a large enough group of participants to be able to analyse differences between sub-groups within the LGB&T population. This therefore limits the ability to understand and compare the impact of multiple identities on health outcomes.



Key Recommendation:

- ➔ **Public Health England and the Department of Health should establish a research and development national work-programme to explore the impact of multiple identities on health inequalities in minority populations.**

Universal Recommendations

These recommendations are based on the evidence presented throughout the document and provide a foundation for engaging with and addressing the health needs of LGB&T people. Following these recommendations will support action to reduce health inequality in England.



RECOGNITION

National and international studies demonstrate that commissioners and service providers fail to recognise LGB&T communities as users of health services. This lack of attention to assessing need and providing appropriate services serves as a significant barrier to accessing services in general. The unintended consequence of this lack of recognition is the further marginalisation of an already excluded community.

At a strategic level organisations should include the needs of LGB&T communities explicitly in key strategic documents such as Joint Strategic Needs Assessments and Health and Wellbeing Strategies, and explicitly consider this population group's needs in action and delivery plans.

There is a wealth of best practice guidance available for NHS and health and social care organisations, outlining simple steps to improve recognition and promote acceptability in a wide range of settings; for example, public statements of non-discrimination, or including non-assumptive language in questionnaires (e.g. name of partner, rather than name of husband/wife). Links to these resources are given in the supporting Resources document.

Use of LGB&T inclusive imagery in publications is also very important. Substantial work has been done over the last ten years to provide LGB&T photographs to the NHS image bank and to promote inclusive imagery and language in public documents.

Recommendations:

- Health and Wellbeing Boards and Directors of Public Health should ensure that the Joint Strategic Needs Assessment explicitly considers the needs of the local LGB&T community.
- Health and Wellbeing Board Chairs must ensure that Health and Wellbeing Strategy implementation plans and supporting strategies explicitly consider the actions to reduce inequalities affecting LGB&T communities.
- All health and social care commissioners should ensure that they are paying due regard to the needs of LGB&T people, as required under Section 149 of the Equality Act 2010, the Public Sector Equality Duty. The use of equality impact assessment frameworks for population strategy documents and action plans can help to meet this requirement.
- All health and social care providers should implement the published guidance, as referenced in the supporting Resources document, on becoming LGB&T-friendly providers.

ENGAGEMENT

Public and patient engagement is at the core of the NHS Constitution and it is crucial that commissioners and providers undertake direct engagement with the LGB&T communities to include their voice in commissioning and service development decisions.

Where local government is commissioning Healthwatch, there should be explicit consideration of how the provider organisation will work with LGB&T residents to create safe and supportive spaces for these individuals and communities to engage in a valued and resourced way. Public fora can be an effective way for LGB&T community representatives to ensure that needs of LGB&T people are met, but consideration needs to be given to the challenges of public engagement forums for LGB&T people (for example, facing discrimination and harassment as a result of 'outing' themselves to the local community).

The LGB&T voluntary and community sector comprises a range of organisations and community groups, the majority of which are very small and run on low incomes: 28% of LGBT Consortium members have an income of less than £1000.¹⁹ In line with the [Compact](#) between the voluntary sector and government, it is crucial that time to contribute to engagement should be recognised and resourced.

Recommendations:

- Healthwatch commissioning and contracting should monitor levels of engagement with LGB&T populations.
- Clinical Commissioning Group public and patient involvement initiatives should ensure that LGB&T communities are specifically included in CCG communication and engagement strategies.

MONITORING

Sexual orientation and gender identity are absent from the key national data sets that underpin the PHOF, as this data is not routinely collected. This absence furthers the inequalities divide by making the LGB&T community invisible in routine data reporting.

NHS England is due to publish guidance on monitoring the protected characteristics in June 2013, providing an update on guidance published since 2006. Monitoring of the protected characteristics also forms part of the Equality Delivery System, which has been adopted by the majority of NHS trusts across England.

Recommendations:

- Commissioners should include a requirement in contracts for service providers to monitor sexual orientation and gender identity in service users over 16yrs, and consider monitoring younger age groups where appropriate.
- National cohort studies and disease registers should include sexual orientation monitoring and gender identity in routine data collection.

SERVICE PROVISION

Integrated care which is centred around the whole person and co-ordinated around their needs as a patient is at the heart of the Health and Social Care Act 2012. This must include addressing the specific needs of patients related to their sexual orientation and gender identity. However, evidence shows that LGB&T people experience barriers to accessing mainstream health and social care services due to a lack of understanding of their specific needs and a lack of targeted service promotion. Some health inequalities related to sexual orientation and gender identity require specialist service provision.

Recognition of LGB&T health inequalities and health care needs in strategic documents, in Equality Impact Assessments, and through community engagement, will highlight the need for inclusive mainstream services and provision of specialist services where appropriate.

Recommendations:

- Commissioners should include service user sexual orientation and gender identity monitoring as requirements in all contracts with service providers, and use the data available to them to assess whether mainstream services they have commissioned are accessible to, and appropriate for, LGB&T people.
- Commissioners should ensure provision of specialist services, where appropriate, to address specific LGB&T health care needs in their local area.

Indicators corresponding to the overarching outcomes

Healthy Life Expectancy

Healthy life expectancy is an estimate of the expected years of life spent in self-reported good health. This is different from life expectancy which is simply an estimate of the average remaining length of life at a certain point, normally at birth or at 65yrs.

The LGB&T Perspective

LGB&T Life Expectancy

Life expectancy in the LGB&T population has not been modelled in the UK. International studies have found the life expectancy of gay men to be up to 20 years less than their heterosexual counterparts, but most of this was attributable to HIV and subsequent work has suggested that the gap in life expectancy due to HIV is reduced substantially by treatment. However, more recent work in Denmark found that, despite the positive impact of same-sex marriage, individuals in same-sex relationships had a significantly higher mortality rate than the general population.²⁰

It is reasonable to extrapolate from the evidence of significantly higher levels of smoking, drug and alcohol misuse, and mental ill health, that LGB&T populations will have a shorter life expectancy than their heterosexual and non-trans peers due to their increased risk of cancer, coronary heart disease and suicide.

Healthy Life Expectancy

Healthy life expectancy is calculated through an equation based on a series of indicators. A proxy measurement of 'healthiness' is currently calculated through self-reported health status in the national surveys conducted by the Office for National Statistics, which do not include sexual orientation or gender identity.

The national Integrated Household Survey²¹ included sexual orientation as a dimension in 2010. This found that self-reported health was slightly better among lesbians and gay men than heterosexuals, but much worse among bisexuals and those identifying with another non-heterosexual identity.

Sexual Orientation	% in good health	% not in good health
Heterosexual	78.8	21.2
LGB (combined G/L&B)	78.1	21.9
Gay/Lesbian	80.4	19.6
Bisexual	73.6	26.4
Other	72.8	27.2

The grey literature has found lower rates of good health amongst gay and bisexual men (75.8%)²² but higher rates amongst lesbians (80.3%)²³ than in the general population in England population based surveys.

There are no national trans surveys of health that describe self-reported health status, although almost all population based surveys of trans communities report high levels of depression which would suggest that self-reported health will be lower.

The available evidence suggests that the indicators relating to the overarching outcomes of the PHOF are likely to have worse outcomes among LGB&T populations in terms of life expectancy, and varied rates of self-reported wellbeing. Without additional focus on LGB&T public health, this potential inequality gap may widen. Monitoring of sexual orientation and gender identity in relation to health, as recommended across this document, will provide the evidence about LGB&T life expectancy that is needed.

Domain One:

Improving the wider determinants of health

These indicators focus on improvements in wider factors that affect health and wellbeing and health inequalities. The wider factors identified in the [Marmot Review](#) that influence health and wellbeing include the quality of early years' experiences, of education, economic status, employment and quality of work, of housing and environment and the effectiveness of systems for preventing ill health. In addition, social inequalities exist across a range of domains: age (children and older people), gender, race and ethnicity, religion, disability, sexual orientation and gender identity.

LGB&T individuals often experience discrimination and marginalisation that impacts on wider factors such as education, housing stability and perceptions and experiences of crime and violence, meaning that these groups experience specific health inequalities as a result. This may be particularly true for individuals who describe their identity as other than male or female, and therefore may find it difficult to access gender-restricted or targeted services appropriately.



1.1 Children in Poverty

INDICATOR DEFINITION

Percentage of children in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs).

Sexual orientation is rarely measured in employment or economic indicators, meaning it is hard to estimate the impact of poverty on children raised in LGB&T households, or the experiences of poverty of children and young people who identify as LGB&T.

It is important to remember the increasing number of LGB&T identifying parents: an estimated 8% of lesbian and gay people and 30% of bisexuals live in a household with one or more dependant children.²⁴

International research²⁵ on large national surveys found that LGB couple families were significantly more likely to be poor than heterosexual married couples, with lesbian couple families experiencing most poverty. The research also found that children in gay and lesbian couple households have poverty rates twice those of children in heterosexual married couple households.

Recommendations:

- **Local government should explicitly consider LGB&T families in child poverty action plans by ensuring service providers have inclusive policies, staff training and actively monitor service user sexual orientation, and gender identity where appropriate, in data collection.**
- **Local Strategic Partnerships should include LGB&T families explicitly in child poverty needs assessments and mapping.**

1.2 School Readiness (Placeholder)

The definition for this indicator is being developed.

There is no evidence that LGB&T parenting has different developmental or health outcomes from those raised in heterosexual households and therefore we would not expect variation in school readiness outcomes related to parental sexual orientation or gender identity.²⁶ However, it is important that schools, health and early years interventions and services such as health visiting, parenting programmes, nurseries and children's centres are engaging with, accessible and welcoming of same-sex parents, and use language and imagery which does not assume heterosexual parenting. This is supported by the Ofsted inspection framework and the Early Years Foundation Stage Framework.

1.3 Pupil Absence

INDICATOR DEFINITION

Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence).

There is a body of evidence that LGB&T identification occurs in many people in childhood, and many children experience bullying and harassment in schools which can be a significant cause of persistent absenteeism.

- More than 2 in 5 LGB pupils who experience homophobic bullying skip school because of it.²⁷
- Nearly 3 in 4 LGB&T youth have feigned illness or played truant to avoid homophobic bullying and the majority of these left school at 16.²⁸
- Over half of secondary school pupils are victims of homophobic bullying in schools. 46% of lesbian and gay pupils don't feel able to be themselves at school, and 21% do not feel safe or accepted at school.²⁹
- 9 in 10 secondary school teachers and more than 2 in 5 primary school teachers (44%) say children and young people, regardless of their sexual orientation, currently experience homophobic bullying, name calling or harassment in schools.³⁰
- 1 in 4 trans young people experienced physical abuse at school.³¹

Recommendations:

- **Local and National Government should support schools to implement existing national guidance from the Department for Education and Ofsted and put anti-homophobia, biphobia and transphobia policies in place.^{32 33}**
- **Health and social care providers ensure that youth service provision includes explicit support pathways for LGB&T youth.**
- **Local government, as lead commissioners of the 5-19yr Healthy Child Programme, ensure school nurses are trained to support LGB&T youth and young people questioning their sexual or gender identity.**

1.4 First-time entrants to youth justice system

INDICATOR DEFINITION

Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population.

International research suggests that non-heterosexual youth are disproportionately represented in educational and criminal-justice punishments that are not explained by greater engagement in illegal or transgressive behaviours.³⁴ Further work is needed in the UK to look at sexual orientation and gender identity among young offenders to understand patterns of behaviour and punishment in a British context.

Recommendations:

- Local government Youth Offending Service Commissioners, and providers, should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services, including signposting to targeted support.
- Police and probation services should consider the needs of LGB&T young offenders and ensure staff are trained to support this group's specific needs.

1.5 16 - 18yrs olds not in education, employment or training

INDICATOR DEFINITION

Percentage of 16-18 year olds not in education, employment or training (NEET).

As evidenced under indicator 1.3, many LGB&T young people experience bullying and harassment in schools, which can lead to disengagement from further education, employment and training opportunities.

These young people may not benefit from the support offered by secondary education settings and therefore would be potentially more vulnerable and distanced from services, unless specific effort is made to engage LGB&T youth.

Recommendations:

- Local government should ensure that NEET interventions consider the needs of LGB&T youth and provide signposting to targeted support.
- Health and Social Care providers should ensure that youth service provision includes explicit support pathways for LGB&T youth.
- NEET support providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.



1.6 Adults with a learning disability /in contact with secondary mental health services who live in stable and appropriate accommodation

INDICATOR DEFINITION

- i. Percentage of all adults with a learning disability who are known to the Council, who are recorded as living in their own home or with their family.
- ii. Percentage of adults receiving secondary mental health services living independently at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting.

Although there is very limited information available relating to the experiences of LGB&T people with learning disabilities, recent research found that 63% of gay and bisexual men³⁵ and 39% of lesbian and bisexual women³⁶ living with a disability had experienced domestic violence from a family member, partner or ex-partner since the age of 16yrs. This would suggest that there may be more risks associated with remaining at home for LGB&T individuals with a learning disability if they express their sexual or gender identity at home. Commissioners and service providers should consider these when focusing on this indicator.

The relationship between the LGB&T community and psychiatry has been historically challenging. Being LGB was removed from the Diagnostic and Statistical Manual (DSM)II of mental disorders in 1974; ³⁷ it was not removed from the International Classification of Diseases of the World Health Organisation until 1993.

For trans people, the term Gender Identity Disorder was included in the most recent DSM-IV. There is current discussion about retaining a category of gender incongruence or gender dysphoria.³⁸ The new classification for the DSM is due to be published in May 2013.

Mental ill health is more prevalent among LGB&T people than in the wider population, although due to a lack of sexual orientation and gender identity monitoring, there is little data on LGB&T people's access of secondary mental health services.^{39 40} There is evidence to suggest that LGB&T people experience poor care in mental health services:

- Diagnosis Homophobic described very negative and, in some cases, abusive experiences of LGB mental health patients in secondary care and there is little research evidence that this situation has improved.⁴¹
- 2 in 5 lesbian women, 1 in 3 gay men and 1 in 4 bisexual men have experienced negative or mixed reactions from mental health professionals.⁴²
- Nearly a third (29%) of transgender people who accessed mental health services felt that their trans status was regarded as a symptom of mental illness.⁴³

The 2010 Mental Health Census (Count Me In)⁴⁴ included monitoring of sexual orientation of mental health in-patients across NHS and independent organisations in England and Wales. Analysis was not reported for the patients who identified as LGB and therefore it is hard to draw any further conclusions from this Census other than the population exists within the in-patient service user group.

Recommendations:

- **Local government should ensure social workers and care providers have training to support LGB&T identified adults with learning difficulties and provide opportunities for them to safely express their sexual and gender identities.**
- **Mental health service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**



1.7 People in prison who have a mental illness or significant mental illness (Placeholder)

This indicator is still being developed.

It is difficult to estimate the proportion of people in prison who identify as LGB&T. There is evidence that individuals in same-sex institutions such as prisons may engage in same-sex sexual activity but not identify as LGB and this difference makes analysis of the population difficult unless demographic monitoring includes opportunities for self-identification.

The general evidence base shows that LGB&T people are at higher risk of mental disorder, suicidal ideation, drug and alcohol use, and deliberate self-harm,^{45 46} and therefore it is reasonable to assume that LGB&T people in prison will have a higher risk of mental illness.

Further work is needed to look at the trans identified population in prison, where there is potential for even greater isolation and discrimination in a same-sex gendered environment.

Recommendations:

- NHS England and Public Health England offender health leads should explicitly consider how to meet the needs of LGB&T prisoners and their mental health needs in commissioning of service pathways and monitoring of service utilisation.
- The Prison Health Services should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.

1.8 Employment for those with a long-term health condition including those with a learning difficulty / disability or mental illness.

INDICATOR DEFINITION

i. Percentage of respondents in the Labour Force Survey (LFS) who have a long-term condition who are classed as employed using the International Labour Organisation (ILO) definition of employment, compared to the percentage of all respondents classed as employed care planning meeting.

Two further indicators are being developed.

There is no national evidence to baseline the level of learning difficulty/disability or mental illness amongst LGB&T individuals with long-term health conditions.

Peer-review published evidence suggests a prevalence of disability in the LGB&T community, between 15-17%, and this is supported by the national LGB&T survey grey literature which found rates around 23%.⁴⁷

It is important to note that advances in HIV treatment and care mean that although people living with HIV are protected under the Equality Act, and included in the context of this indicator, they may not self-identify in surveys as living with a disability or long term condition which limits their daily activities. In 2011 there were approximately 40,000⁴⁸ men who have sex with men living with HIV in the UK.

Nearly 1 in 5 lesbian and gay people, almost 350,000 employees in Britain, have experienced bullying from their colleagues because of their sexual orientation.⁴⁹ Six per cent of the UK population has witnessed verbal homophobic bullying in the workplace and 2% has witnessed homophobic physical violence.⁵⁰ This would suggest that LGB&T people living with disabilities, learning disability, mental health and long-term health conditions may face a compounded series of barriers in accessing employment.

Recommendations:

- Local government, Jobcentre Plus and Local Chambers of Commerce should work together to ensure suitable support is available for LGB&T adults with long term conditions and/or disabilities to enter, and continue in, the workforce.
- The Department for Work and Pensions in collaboration with Jobcentre Plus should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.

1.9 Sickness absence rate

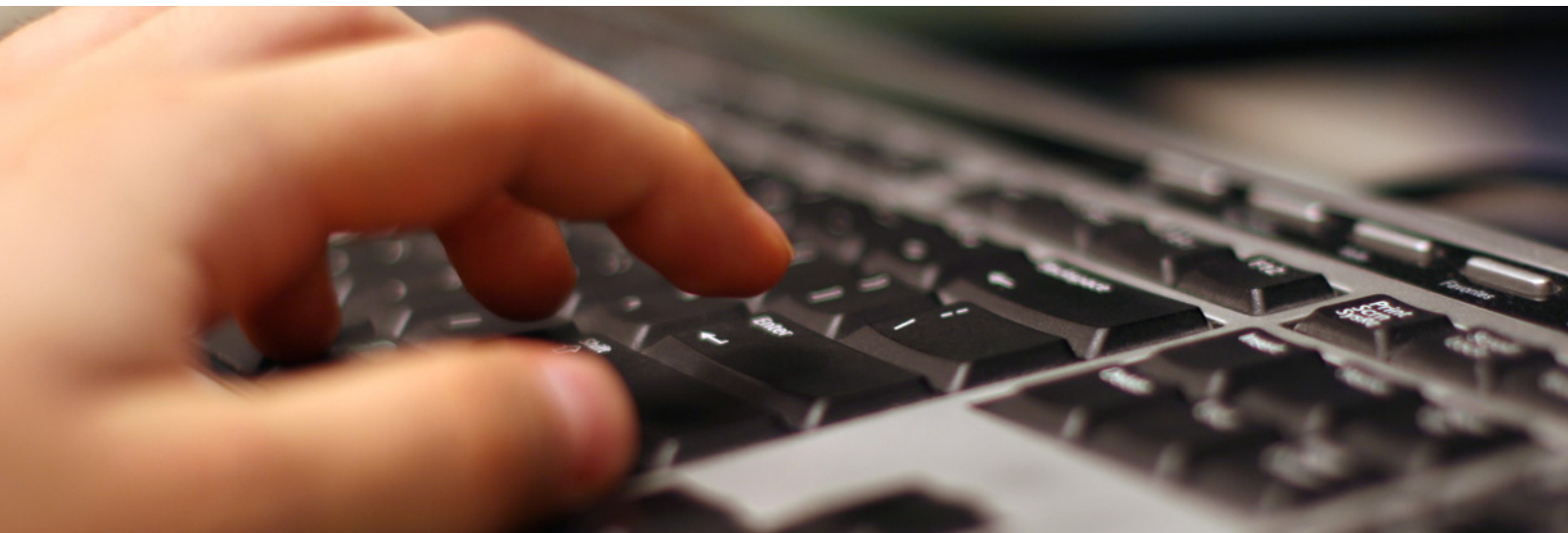
This indicator is still being developed.

Discrimination and harassment in the workplace can be a significant factor in workplace stress, anxiety and depression.

- Nearly 1 in 5 lesbian and gay people have experienced homophobic bullying in the workplace during the last five years.⁵¹
- 3 in 10 LGB people have missed work in the last 12 months due to stress and 7% have missed a month or more; 12% of respondents missed work due to their alcohol use, and 4% missed work due to their drug use.⁵²

Recommendations:

- Health and Wellbeing Board partners, including Chambers of Commerce, should ensure that single equality schemes explicitly consider sexual orientation and gender identity.
- Employers should consider LGB&T staff by ensuring that: all staff receive training on LGB&T issues; published materials use LGB&T language and imagery; and that employee sexual orientation and gender identity is monitored and this data is used to improve LGB&T access to, and experience of, the workplace. All reports of homophobic, biphobic and transphobic bullying and harassment must be recorded, anonymously where appropriate, and action taken in response.
- Occupational health departments should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services, including consideration of pathways for referral to specialist support for LGB&T service users.



1.10 Killed or seriously injured casualties on England's roads

INDICATOR DEFINITION

Number of people reported killed or seriously injured on the roads, all ages, per 100,000 resident population.

There is no evidence of differential road related injuries affecting LGB&T communities.

However, there is evidence of increased drug and alcohol misuse, which is associated with road traffic accidents.

Recommendations:

- National government should explicitly consider LGB&T audiences in its drink driving social marketing campaigns.
- Coroners and medical examiners should monitor the sexual orientation and gender identity of deceased persons where possible, and use this data to identify trends related to sexual orientation and gender identity.

1.11 Domestic abuse

This indicator needs further development.

There is a significant peer-review published and grey evidence base relating to increased levels of domestic violence and abuse experienced by LGB&T individuals.

- 38% of respondents to one survey reported experiencing domestic abuse in a same sex relationship (40% of women and 35% of men),⁵³ which is a slightly lower rate for women compared to national studies but a 9% higher than national rates for men.⁵⁴
- For gay and bisexual men:⁵⁵
 - Half of gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16 compared to 17 per cent of men in general.
 - More than a third of gay and bisexual men have experienced at least one incident of domestic abuse in a relationship with a man.
 - 4 in 5 gay and bisexual men who have experienced domestic abuse have never reported incidents to the police. Of those who did report, more than half were not happy with how the police dealt with the situation.
- For lesbian and bisexual women:⁵⁶
 - 1 in 4 lesbian and bisexual women have experienced domestic violence in a relationship. Two thirds of those say the perpetrator was a woman, a third a man. This is comparable to the 1 in 4 of the general population of women who have experienced domestic violence.⁵⁷
 - 4 in 5 lesbians and bisexual women who have experienced domestic abuse have never reported incidents to the police. Of those who did report, 49% were happy with how the police dealt with the situation.
- For trans people:⁵⁸
 - 80% have experienced emotional, physical or sexual abuse from a current or former partner based on a rejection of their trans identity.
 - 7% contacted specialist domestic abuse services and 25% did not tell anyone about. They expected that service providers would not treat them with respect.
 - 64% of trans people have experienced domestic violence and abuse, compared to 29% of non-trans respondents.⁵⁹

Recommendations:

- Health and Wellbeing Boards and local Crime and Disorder Partnerships should explicitly consider provision of appropriate sheltered accommodation and other services explicitly for LGB&T people affected by domestic abuse.
- Domestic violence and abuse support service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services, including working with partners to provide specific services to support LGB&T people experiencing same-sex violence and abuse.
- Local government should ensure that domestic abuse strategic and operational leads understand the evidence on LGB&T domestic abuse and receive training on addressing LGB&T needs.



1.12 Violent Crime (including sexual violence)

This indicator needs further development.

There is an emerging evidence base relating to LGB&T individuals' experience of violence, including, but not restricted to, homophobic, biphobic and transphobic hate crime. As well as the immediate trauma caused by the incident itself, hate crimes have a serious effect on the quality of life of victims. The majority of these hate crime are not reported, and research has shown that awareness of what constitutes a hate crime and confidence in reporting it is low among LGB&T communities.

- 1 in 5 LGB people have experienced a homophobic hate crime or incident in the last three years, and one in eight have been a victim in the last year.⁶⁰
- 3 in 4 victims of homophobic hate crime did not report the incident to the police.⁶¹
- Gay men are two and a half times more likely to be the victim of a hate incident involving a physical assault than lesbians.⁶²
- Black and minority ethnic LGB people are twice as likely to experience a physical assault when compared with the general LGB population.⁶³
- 19% of trans people have been physically attacked and 38% experienced physical intimidation and threats because of their gender identity.⁶⁴
- 97% of transphobic crime goes unreported.⁶⁵
- Over 1 in 20 lesbians have reported sexual assault related to sexual orientation.⁶⁶
- Half of all hate incidents reported to the police resulted in no action being taken other than it being recorded.⁶⁷

The Crown Prosecution Service's 2012 statistics for homophobic and transphobic hate crimes (biphobic hate crimes are not recorded separately) show that in the previous year, 1,281 cases were prosecuted nationally with a homophobic or transphobic element.

- 58% of the victims were men, 29% were women and 13% gender unknown.
- 3.2% of the cases concerned victims who were trans.
- 53% of the victims were aged 25-59.
- 48% of the cases were offences against the person, and 37% were public order offences.⁶⁸

There is no official data regarding sexual assault committed against LGB&T people, as sexual orientation and gender identity are not routinely monitored in police services or included in the British Crime Survey. Available evidence from the United States suggests that rates of sexual assault against lesbian and bisexual women are similar or higher than among women in general, and that gay and bisexual men experience rates at least five times that of men in general.⁶⁹

Recommendations:

- **Police services should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services. This includes monitoring of sexual orientation and gender identity in the standard demographic dataset for victims and perpetrators of crimes.**
- **Health and Wellbeing Boards and Crime and Disorder Partnerships should ensure consideration of LGB&T victims' needs.**
- **Sexual assault referrals centres (SARCs) should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services, including developing pathways of care for LGB&T victims of sexual assault and promoting access to these communities.**

1.13 Re-offending levels

INDICATOR DEFINITION

- i. The percentage of offenders who re-offend from a rolling 12 month cohort.
- ii. The average number of re-offences committed per offender from a rolling 12 month cohort.

The information on offending in LGB&T communities is presented in section [1.4](#).

Recommendations:

- Local government, the National Offender Management Service and offending service commissioners, and providers, should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services, including signposting to targeted support.
- Police and Probation Services should consider the needs of LGB&T offenders and ensure staff are trained to support this group's specific needs.



1.14 Percentage of the population affected by noise

INDICATOR DEFINITION

- i. Number of complaints per year per local authority about noise per thousand population.
- ii. The proportion of the population exposed to road and rail transport noise of 65 dB(A) or more, LAeq,16h per local authority (16h is the period 0700 – 2300).
- iii. The proportion of the population exposed to road and rail transport noise of 55 dB(A) or more, Lnight (LAeq,8h) per local authority (8h is the period 2300 – 0700).

Noise can be used as a form of abuse and intimidation and therefore although it is not possible to extract the LGB&T cohort affected by noise from traditional data sets, it is reasonable to suspect that this population may be disproportionately affected by noise as a weapon of abuse.

Recommendations:

- Local government Environmental Health Departments should include sexual orientation and gender identity in routine demographic data collection of noise related incidents.

1.15 Statutory Homelessness

INDICATOR DEFINITION

- i. Homelessness acceptances (per thousand households).
- ii. Households in temporary accommodation (per thousand households).

As many as 1 in 3 homeless youth are LGB&T,⁷⁰ and local LGB&T surveys have found that 22% of LGB&T people have been homeless at some point in their lives.⁷¹ LGB homeless youth may experience additional challenges because of their sexual orientation, and there is evidence that some young people become homeless because they, or their families, are unable to deal with them being LGB.⁷² While there is no similar research in relation to trans youth homelessness specifically, we would expect similar challenges in relation to non-acceptance of their gender identity.

- 1 in 5 lesbian and gay people still expect to receive worse treatment when applying for social housing, this proportion rises to 1 in 4 among young (18-24) and older (over 55) gay people.⁷³
- Trans individuals may be particularly badly affected by homelessness (due to separation from families and loss of employment) and temporary shelters are often single sex.

Recommendations:

- **Local government homelessness and housing strategies should explicitly consider the needs of LGB&T service users and monitor sexual orientation and gender identity in service user data sets.**
- **Service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services. Mainstream providers should build links with LGB&T housing and homelessness organisations.**
- **Local Government Homeless Person Unit staff should receive explicit training on sexual orientation and gender identity, addressing LGB&T needs, and creating supportive and safe spaces for disclosure.**

1.16 Utilisation of outdoor space for exercise /health reasons

INDICATOR DEFINITION

Percentage of people using outdoor space for exercise/health reasons.

The data for this indicator is collected from the national Monitor of Engagement with the Natural Environment Survey (MENE), led by Natural England. The survey does not monitor sexual orientation or gender identity alongside other protected characteristics.

There is evidence that fear of crime may be a restriction in outdoor activities, including walking and cycling and leading to increased car use.⁷⁴ Previous evidence quoted in this document has established that the LGB&T community may have a higher fear of crime and violence linked to experiences, and perceptions, of homophobic, biphobic and transphobic hate crime and discrimination. There have been several high profile murders of LGB&T people in public spaces, including the murder of Ian Baynham in Trafalgar Square in September 2009, demonstrating the justification for perceptions of fear for personal safety in public spaces. Fear of hate crime may be an important factor for LGB&T people in using outdoor space for any reason, including exercise and health.

Consultation with LGB&T people carried out by the Commission for Architecture and the Built Environment found that outdoor spaces which had been designed and managed for non-LGB&T users can lead to feelings of exclusion and separation.⁷⁵

Recommendations:

- **Further work is needed to explore whether the LGB&T community uses outdoor space differently from the general population, through the inclusion of sexual orientation and gender identity monitoring in the MENE survey.**
- **Providers of outdoor spaces should include LGB&T communities when consulting on the designing, developing and managing of these spaces.**

1.17 Fuel Poverty (Placeholder)

This indicator needs further development, including the definition of fuel poverty.

A household is said to be fuel poor if it needs to spend more than 10% of its income on fuel to maintain an adequate level of warmth. Historically, fuel poverty has been modelled from national surveys, and the English Household Survey in England does not monitor sexual orientation or gender identity alongside other protected characteristics.

Fuel poverty has long been associated with households including older occupants or someone with a disability or long-term illness. Single person households have also consistently had a higher rate of fuel poverty compared with other sizes of households.⁷⁶ Older LGB people are significantly more likely to live alone than their heterosexual peers, and four and a half times less likely to have children to call upon in times of need.⁷⁷ While there is no evidence in relation to trans people, we would expect a similar experience. This suggests that older LGB&T people may be particularly vulnerable to fuel poverty and this inequality may be compounded by perceptions and fear of discrimination related to historical relationships between sexual orientation and the state.

Recommendations:

- **National campaigns to reduce fuel poverty should include imagery and language to engage LGB&T communities and individuals.**
- **Service providers working to reduce fuel poverty should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**

1.18 Social isolation (Placeholder)

This indicator needs further development. In the short term it will be based on a question from the Adult Social Care Survey and Carers Survey, and in the longer term a new measure based on a population level approach will be developed.

Evidence presented under indicator [1.7](#) shows that LGB&T older people are likely to experience more social isolation than their heterosexual contemporaries.

The national standards on treatment and care to support trans people states that 'trans people suffer enormous social isolation as one of the most marginalised groups in society', acknowledging the extreme potential for social isolation. This statement is supported by a growing body of evidence which demonstrates that social isolation of trans individuals is a significant barrier to seeking health and medical support until crises occur and contributes to serious mental ill health and suicidal intent.⁷⁸

This evidence strongly suggests that LGB&T individuals, especially trans individuals, will experience significantly higher social isolation than the general population.

- 54% of LGB people have experienced feelings of isolation.⁷⁹
- 1 in 5 older LGB people have no one to contact in times of crisis (as much as ten times the number in the general population).⁸⁰
- In one study, when asked to rate how often they felt isolated due to being trans or having a trans history on a scale of one representing never feeling isolated and 7 representing constant isolation, the average score for trans people was 3.9.⁸¹

Recommendations:

- **The interim Adult Social Care Survey and Carers Survey should include standardised questions on sexual orientation and gender identity. The future population-based indicator should include monitoring of sexual orientation and gender identity from the baseline initiation.**
- **Local government should include specific reference to LGB&T people's needs in action plans to reduce isolation and improve mental wellbeing in local communities.**
- **Health and Wellbeing Boards should review local community development and infrastructure funding and support for targeted LGB&T community development.**
- **Health and social care professionals should establish a local database of LGB&T community groups to sign-post individuals to for socialisation and support.**

1.19 Older people's perception of community safety (Placeholder)

This indicator needs further development.

Older LGB people remain more likely than both their heterosexual peers and younger generations of LGB people to be single and live alone, and are less likely to have children, so they are more likely to be socially isolated and therefore have a greater potential to be vulnerable.⁸² While there is no evidence in relation to older trans people, we would expect similar experience of increased isolation and vulnerability. The experiences of many older LGB&T people before the decriminalisation of homosexuality will likely have a negative impact on their perception of community safety, as well as their perception of the police and the criminal justice system.

- 25% of gay and bisexual men and 16% of lesbian and bisexual women aged over 55 have experienced hostility or poor treatment from the police because of their sexual orientation.
- LGB people over 55 are more likely to live alone compared to heterosexual people of the same age (41% compared to 28%). Gay and bisexual men over 55 are three times more likely to be single than heterosexual men in the same age group.
- LGB people over 55 are significantly less likely to have children: just over a quarter of gay and bisexual men and half of lesbian and bisexual women have children compared to 9 in 10 heterosexual people.

More work is needed to develop the evidence base around community safety and minority LGB&T groups, including older LGB&T people.

Recommendations:

- **Local government's strategies and action plans to meet the needs of older people should explicitly consider the needs of older LGB&T people as well.**
- **Commissioners and providers of older people's services should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**
- **Police and community safety services should work with LGB&T organisations to consider how best to engage with older LGB&T networks to provide support and inspire confidence.**

Domain Two:

Health Improvement

These indicators focus on supporting people to live healthy lifestyles and make healthy choices, whilst also reducing health inequalities.

Local and national research and needs assessments of LGB&T communities have repeatedly demonstrated higher levels of health risk behaviours, such as smoking and drug and alcohol use, as well as higher levels of self-harm.

Research has also demonstrated that LGB&T people are less likely to engage with health interventions and screening programmes if they are not explicitly recognised by the service. Gender specific screening can present particular challenges for trans individuals, and non-gendered individuals, where screening risk may be linked to their birth gender rather than the gender they identify with.

LGB&T communities therefore have higher levels of need for intervention and targeted support related to these indicators.



2.1 Low birth weight of term babies

INDICATOR DEFINITION

Percentage of all live births at term with low birth weight.

There is no evidence on the birth weight of babies born to lesbian or bisexual women. However some lesbian mothers will have conceived via IVF which is associated with lower birth weight babies.⁸³ Further work is needed to review if this assumption is correct.

2.2 Breastfeeding

INDICATOR DEFINITION

- i. Breastfeeding initiation.
- ii. Breastfeeding prevalence at 6-8 weeks after birth.

There is no evidence about breastfeeding prevalence for lesbian or bisexual mothers. However, breastfeeding information for partners, and breastfeeding support services should not assume heterosexual partnerships and should explicitly welcome same-sex parents. Further work is needed to explore if there are different breastfeeding outcomes for lesbian and bisexual mothers compared to heterosexual mothers.

2.3 Smoking status at time of delivery

INDICATOR DEFINITION

Rate of smoking at time of delivery per 100 maternities.

There is no evidence about smoking status at time of delivery and the sexual orientation of the mother. Population based evidence shows significantly higher rates of smoking amongst lesbian and bisexual women than in the general population, however, because lesbian and bisexual women often require assistance to conceive there may be higher motivation to not smoke during pregnancy. Further work is needed to understand health risk behaviour in pregnancy amongst lesbian and bisexual women.

2.4 Under 18 conceptions

INDICATOR DEFINITION

Under 18 conception rate per 1,000 population.

Several US large-scale youth health risk surveys⁸⁴ have found that LGB youth were at least twice as likely as their peers to have conceived, although the proportion varied from 24% to 7%. There have been no population-based surveys of adolescents in the UK that include sexual orientation, however, small scale studies⁸⁵ have found that 61% of young lesbian and bisexual identified women had their first sexual experience with the opposite sex.⁸⁶

Recommendations:

- Health and Wellbeing Boards should ensure that sexual health and teenage pregnancy strategies explicitly consider the needs of LGB&T youth.
- Contraceptive service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services, including clear referral pathways to support for young LGB&T people.
- Schools should ensure that sex and relationship education includes positive and supportive discussion of sexual orientation, same-sex relationships and safe sex.

2.5 Child development at 2-2½ years (Placeholder)

This indicator is being developed.

There is no evidence that lesbian or gay parenting results in different developmental or health outcomes in the child than those raised in heterosexual households and therefore we would not expect variation in child development outcomes at 2-2.5yrs related to parental sexual orientation. A number of small-scale research studies support the assertion that there are no differential outcomes for children of LGB&T people and one recent study looking at children's experiences found that very young children do not see their families as different at all.⁸⁷ However, it is important that health and early years interventions and services such as health visiting, parenting programmes, nurseries and children's centres are engaging with, accessible to and welcoming of same-sex parents and use language and imagery which does not assume heterosexual parenting. This is supported by the Ofsted inspection framework and the Early Years Foundation Stage Framework.

2.6 Excess weight in 4-5 and 10-11 year olds

INDICATOR DEFINITION

- i. Percentage of children aged 4-5yrs classified as overweight or obese.
- ii. Percentage of children aged 10-11yrs classified as overweight or obese.

There is no evidence of different rates of excess weight in LGB&T identified children in these age groups or amongst children with LGB&T parents.

2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18 years

INDICATOR DEFINITION

Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 0-17years, per 10,000 resident population.

A lack of sexual orientation and gender identity monitoring in Accident and Emergency services means there is no data on emergency admissions caused by unintentional and deliberate injuries among young LGB&T people. However, research has consistently shown high levels of self-harming among LGB&T people, particularly young people. Self-harm is a component of this indicator, and the evidence on prevalence among young LGB&T people should be considered.

- Over half (56%) of LGB young people have deliberately harmed themselves. Self-harm is directly linked with experience of homophobic bullying.⁸⁸
- Half of lesbian and bisexual women under the age of 20 have self-harmed, compared to 1 in 15 teenagers generally.⁸⁹
- 1 in 6 (15%)⁹⁰ gay and bisexual men aged 16 to 24 have harmed themselves in the last year compared to seven per cent of men in general aged 16 to 24 who have ever deliberately harmed themselves
- Three quarters of trans young people have self-harmed, and over a quarter (27%) are currently purposely self-harming.⁹¹

Recommendations:

- **Accident and Emergency Departments and paediatric services should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services, including identified referral pathways for LGB&T people presenting with self-harm.**
- **Health and Wellbeing Boards should ensure that mental resilience and wellbeing strategies and interventions explicitly consider LGB&T individuals and populations.**
- **Schools should implement Ofsted guidance on tackling homophobic and trans-phobic bullying and have identified clear pathways of support for young people questioning their sexual orientation or gender identity.**

2.8 Emotional wellbeing of looked-after children

INDICATOR DEFINITION

Total difficulties score for all looked after children aged between 4 and 16yrs (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on the 31st March.

Evidence presented under indicator [1.15](#) shows that LGB&T youth are more likely to run away from home than their heterosexual counterparts, often linked to homophobic, biphobic and transphobic violence and abuse from family members. It is reasonable to expect that LGB&T identifying youth will be over-represented amongst older looked-after children populations.⁹² Evidence presented under indicator [2.7](#) demonstrates that LGB&T youth will be more likely to experience poor emotional wellbeing.

Some young LGB&T people may have less access to forms of social capital, including their social environment and sense of connectedness to their families, schools and communities, which are important in fostering resilience and in reducing the likelihood of risky behaviours such as suicidal ideation, drug and alcohol use, unprotected sexual behaviour and eating disorders. This may have implications for their mental health and resilience.⁹³

NICE guidance⁹⁴ on looked-after children makes explicit reference to the need to increase the evidence base around LGB&T looked-after children. Further work is needed to explore patterns of sexual and gender identity among looked-after young people.

Recommendation:

- **Looked-after children's service providers consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services. Services should consider working with specialist LGB&T services for LGB&T youth and specialist foster carers.**



2.9 Smoking prevalence – adults (over 18 years) (Placeholder)

INDICATOR DEFINITION

Prevalence of smoking among 15yr olds.

The data source for this indicator is under development to enable collection of local data. Indicator [2.14](#) presents the evidence on higher rates of smoking among LGB&T populations compared to the wider population.

There is a lack of data on smoking amongst LGB&T people aged 15 in the UK, although US research found that bisexual young people are twice as likely to smoke regularly as their heterosexual and homosexual peers.⁹⁵

Recommendations:

- **Smoking cessation interventions should consider the evidence on LGB&T smoking prevalence and target LGB&T identifying youth as a high risk group.**
- **Smoking cessation service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**

2.10 Self-harm (Placeholder)

This indicator is being developed.

Research had consistently shown higher prevalence of self-harm among LGB&T people.

- 1 in 5 lesbian and bisexual women have deliberately harmed themselves in some way in the last year compared to 0.4 per cent of women in general.⁹⁶
- 1 in 14 gay and bisexual men deliberately harmed themselves in the last year compared to just 1 in 33 men in general who have ever harmed themselves.⁹⁷
- 53% of trans people have self-harmed at some point, with 11% currently self-harming.⁹⁸

Recommendations:

- **Health and Wellbeing Boards should ensure that mental wellbeing strategies and interventions explicitly consider LGB&T individuals and communities.**
- **Mental health service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**
- **Specific attention should be paid to how trans individuals presenting with self-harm are supported in the context of their transition.**

2.11 Diet

PROPOSED INDICATOR DEFINITION

- i. Proportion of the population meeting the recommended '5-A-Day' on a "usual day".
- ii. Average number of portions of fruit consumed.
- iii. Average number of portions of vegetables consumed.

Precise definitions will depend on the exact wording of questions used in the data source, which are yet to be finalised.

Evidence suggests that LGB people are less likely to meet the recommended guidelines around fruit and vegetable consumption.

- 13% of LGB people said they eat the recommended five or more portions of fruit and vegetables daily⁹⁹ compared to findings from the 2010 Health Survey for England which found that 25% of men and 27% of women meet the '5-a-day' recommendation.

Eating disorders are prevalent among LGB&T communities:

- 1 in 5 lesbian and bisexual women say they have an eating disorder compared to 1 in 20 of the general female population.¹⁰⁰
- 21% of gay and bisexual men have been told they have problems with weight or eating at some point. This broke down into:
 - 20% anorexia, 11% bulimia, 40% binge eating.
- 45% of gay and bisexual men worry about the way they look and feel about their body.¹⁰¹
- 19% of trans people say they have had an undiagnosed eating disorder, with 5% saying they have had an eating disorder diagnosed.¹⁰²

Recommendations:

- **Local government strategic partnerships formed to address nutrition and obesity should engage with LGB&T community groups to deliver appropriate and targeted messages to the LGB&T community.**
- **National healthy eating campaigns should include diverse imagery and language that is inclusive of the LGB&T community.**
- **Eating disorder service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**

2.12 Excess weight in adults

INDICATOR DEFINITION

Proportion of adults classified as overweight or obese.

Research suggests that gay and bisexual men are less likely to be overweight than heterosexual men, and that lesbian and bisexual women may be more likely to be overweight than heterosexual women. Further research is needed, particularly in relation to lesbian and bisexual women, and trans people.

- 44% of gay and bisexual men are overweight or obese compared to 70% of men in general.¹⁰³
- International research suggests lesbian and bisexual women¹⁰⁴ are more likely to be overweight and obese than heterosexual women.¹⁰⁵ However, UK research has found similar BMI levels for lesbian and bisexual women and heterosexual women.¹⁰⁶

It is important to understand that particular physical characteristics are associated with sub-cultures of the LGB&T community, for example, the bear community (where physical size is desirable and individuals moving to a normal weight may be associated with a loss in social networks and support)¹⁰⁷ and that addressing excess weight needs to be sensitive to socio-emotional factors.

Recommendations:

- **Local government strategic partnerships formed to address nutrition and obesity should engage with LGB&T community groups to deliver appropriate and targeted messages to the LGB&T community.**
- **Further research should be conducted to explore issues of weight and body image among LGB&T people.**

2.13 Proportion of physically active and inactive adults

INDICATOR DEFINITION

i. Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity.

ii. Proportion of adults classified as 'inactive'.

Research suggests that gay and bisexual men are less likely to achieve physical activity recommendations than men in general, but that lesbian and bisexual women are more likely to compared with women in general.

- 37% of gay and bisexual men said they exercised daily or most days, which compares to findings from the Health Survey for England that 40% of men achieve physical activity recommendations.
- 39% of lesbian and bisexual women said they exercised daily or most days which compares to findings from the Health Survey for England that 28% of women achieve physical activity recommendations.¹⁰⁸
- However, the international evidence base suggests that LGB&T individuals are more likely to report activity limitation.¹⁰⁹
- Half of lesbians and bisexual women said they exercised at least three times a week.¹¹⁰
- A quarter of gay and bisexual men meet recommendations for 30 minutes or more exercise five times or more per week compared to 39% of men in general.¹¹¹

Trans and non-gendered individuals may face particular barriers to participation in facilitated or venue-based physical activity because of open changing rooms and gendered facilities.

Recommendations:

- **Community Sport and Physical Activity Networks should explicitly consider the needs of LGB&T populations in developing local physical activity and sport engagement strategies.**
- **National Sports Governing Bodies should work with LGB&T organisations to publish inclusive guidance for local and national clubs regarding inclusive practice to support LGB&T participation.**

2.14 Smoking prevalence – adult (over 18 years)

INDICATOR DEFINITION

Prevalence of smoking among persons aged 18yrs and over.

A body of research has shown greater prevalence of smoking among LGB&T communities compared to the wider population.

- Two thirds of lesbian and bisexual women have smoked compared to half of women in general, and just over a quarter are active smokers.¹¹²
- A quarter of gay and bisexual men currently smoke compared to half of men in general, and two thirds have smoked at some time in their life compared to half of men in general.¹¹³
- LGB people over 16yrs are more likely to be current smokers, less likely to have never smoked, and less likely to have given up smoking than the general population.¹¹⁴
- 32% of trans people smoke cigarettes regularly compared to LGB&T people in general.¹¹⁵

Recommendations:

- **Smoking cessation providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**
- **National smoking cessation campaigns developed by Public Health England should target LGB&T communities as a high-risk group.**



2.15 Successful completion of drug treatment

INDICATOR DEFINITION

- i. Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number of opiate users in treatment.
- ii Number of users of non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number of non-opiate users in treatment.

Successive studies have shown that LGB&T people are more likely to use drugs than the general population. However, due to a lack of sexual orientation and gender identity monitoring in drug services, there is no data on successful completion of drug treatment by sexual orientation or gender identity.¹¹⁶

- Across all age groups LGB people are much more likely to use drugs, with 35% of LGB people having taken a drug (excluding alcohol) in the last month.¹¹⁷
- Comparable data suggests LGB people are 7 times more likely to be using a recreational drug than the general population. Among LGB people aged 16-24, this likely to be 2.5 times higher than the general population of the same age.¹¹⁸
- Use of all drugs by LGB people is much higher than the general population and current use of all drugs, apart from cannabis, is significantly higher amongst LGB males than females.
- LGB people demonstrate a higher likelihood of being substance dependent, with between 4 and 13% of drug users scoring as dependent. Dependence is highest amongst gay men and bisexual men and women.¹¹⁹
- 24% of trans people have used drugs within the last 12 months, the most common being cannabis, poppers and ecstasy.
- 10% of trans people indicated signs of severe drug abuse using the Drug Abuse Screening Test.¹²⁰
- The British Crime Survey shows LGB people are three times more likely to have taken illicit drugs than heterosexual respondents. LGB people are more likely take a Class A drug and five times more likely than the general population to use stimulant drugs such as cocaine, ecstasy, amphetamines and amyl nitrate.¹²¹

There is also some evidence to suggest that LGB&T people may have different patterns of substance use, such as using drugs in a club environment or combination drug taking.^{122 123} Poly-drug use increases the possibility of mental or physical health problems and many drug fatalities result from poly-drug use. In addition, LGB&T substance users may use a wider range of illicit drugs or use club drugs such as GHB (Gamma- hydroxybutrate) that are not recorded in the British Crime Survey.¹²⁴

There is evidence that trans people who are unable to obtain hormone therapy through the NHS may procure them through other means, such as the internet or the black market. This can have serious implications for their health and wellbeing as the treatment is unregulated and unmonitored.¹²⁵

Evidence suggests that LGB&T people experience barriers to accessing drug services, both in relation to recognising they may have a substance problem which needs attention, and in accessing services where they feel comfortable and confident in the services provided.¹²⁶ In addition, there is a lack of evidence about good practice in drug treatment and prevention for LGB&T service users; no studies have measured outcomes or evaluated service use by sexual orientation or gender identity.¹²⁷

Recommendations:

- **Supported by Public Health England, drug service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**
- **Drug services commissioners should include a requirement to meet specific LGB&T needs in drug and alcohol commissioning strategies and procurement plans, and mandate that commissioned service providers monitor the sexual orientation of their service users, in order to better understand LGB&T people's need.**
- **Health and Wellbeing Boards should explicitly include LGB&T people in their health and wellbeing strategies and drug and alcohol strategies.**

2.16 People entering prison with substance dependence issues who are previously not known to community treatment

INDICATOR DEFINITION

Proportion of people assessed for substance dependence issues when entering prison who then required structured treatment and have not already received it in the community.

The evidence of inequalities in drug misuse amongst LGB&T communities is presented under indicator [2.15](#) and it is reasonable to expect that this pattern would be similarly high in LGB&T prisoners. NHS England leads for offender health should ensure that there is consideration of the needs of LGB&T prisoners as a high risk group.

2.17 Recorded diabetes

INDICATOR DEFINITION

Number of QOF-recorded cases of diabetes per 100 patients registered with GP practices (17yrs and over).

Research indicates that gay and bisexual men are less likely than men in general to have diabetes, which is consistent with a population that is less likely to be overweight or obese. 11 per cent of gay and bisexual men have ever discussed diabetes with a healthcare professional.¹²⁸ There is no evidence in relation to lesbian and bisexual women, or trans individuals. However, the evidence presented under indicator [2.17](#) which suggests that lesbian and bisexual women may be more likely to be overweight or obese than heterosexual women would indicate that they may be at greater risk of diabetes.

Recommendation

- **GP practices and national diabetes registers should monitor sexual orientation and gender identity of patients, and analyse this data in relation to diabetes.**

2.18 Alcohol-related admissions to hospital (Placeholder)

The exact definition for this indicator is being developed further but will be drawn from Hospital Episode Statistics which do not currently record sexual orientation or gender identity. Research shows a higher prevalence of alcohol use among LGB&T communities, including higher levels of binge drinking. It is reasonable to estimate that there will be a similar higher level of alcohol-related admissions to hospital among LGB&T people.

- Binge drinking is high across all genders, sexual orientations and age groups in the LGB community, with 34% of males and 29% of females reporting binge drinking at least once or twice a week. Available comparable data (from the ONS General Lifestyle Survey 2010) suggests that binge drinking is around twice as common in gay and bisexual males, and almost twice as common in lesbian, gay and bisexual females, when compared to males and females in the wider population.¹²⁹
- 41% of lesbian and bisexual women drink on three or more days in a week compared to 36% of women in general.¹³⁰
- 42% of gay and bisexual men drink alcohol on three or more days a week compared to 35% of men in general.¹³¹
- 62% of trans people may be dependent on alcohol or engaging in alcohol abuse.¹³²

Recommendations:

- **Health and Wellbeing Boards should ensure that local alcohol strategies include explicit pathways for treatment and care for LGB&T people and that health improvement campaigns use inclusive imagery and language.**
- **Public Health England should explicitly consider LGB&T populations in the development of the work-plan for alcohol.**
- **Alcohol service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**

2.19 Cancer diagnosed at stage 1 and 2

INDICATOR DEFINITION

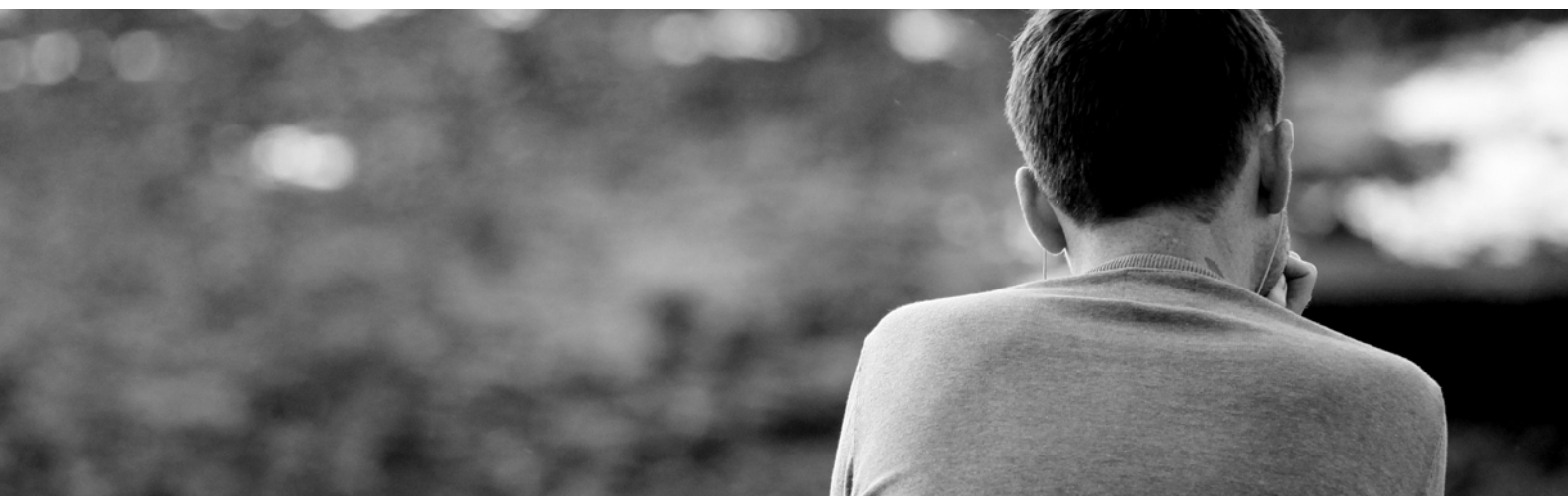
Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed.

The evidence base relating to the incidence of cancer in the LGB&T community is sparse, and the majority of research to date has focused on cervical and breast cancer. However, the high levels of health risk factors such as smoking, alcohol and drug use and poor dietary intake in the LGB&T community (see indicators [2.11](#), [2.14](#), [2.15](#), [2.18](#)) suggests that this group may well present with higher levels of other cancers. The lack of monitoring of sexual orientation and gender identity in the national cancer registry and cancer cohort studies is a significant barrier to understanding patterns of cancer inequalities.

- Cervical abnormalities seem to be more common in lesbian and bisexual women who have been sexually active with men than among 'exclusively' lesbian women.¹³³ Estimates of sexual activity with men amongst lesbians vary, but in a clinic sample 85% of lesbians had previously had heterosexual sex.¹³⁴
- US research found the prevalence of HPV was 13% among lesbian and bisexual women (74% of whom had oncogenic types of HPV) demonstrating that lesbian and bisexual women are still at risk of cervical cancer.¹³⁵
- Lesbian and bisexual women aged 50-79 are more at risk of breast cancer because of a lack of early diagnosis: 1 in 12 have been diagnosed with breast cancer compared to 1 in 20 of all women.¹³⁶
- Danish research looking at women in same-sex partnerships found that the cancer incidence was the same as Danish women in general.¹³⁷
- One study shows that men in same sex civil partnered relationships are at higher cancer risk than other men, mainly due to HIV positive status.¹³⁸ A similar pattern of cancer risk associated with HIV is found in non-partnered gay and bisexual men.
- The National Cancer Patient Experience Survey has shown significant differences in the experiences of cancer services between LGB and heterosexual patients, where LGB patients reported less positive views in relation to the respect and dignity with which they were treated.

Recommendations:

- **Public Health England should encourage sexual orientation and gender identity monitoring in the national cancer registry and national cohort studies relating to cancer.**
- **Supported by Clinical Commissioning Groups and NHS England, cancer service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**



2.20 Cancer screening coverage

INDICATOR DEFINITION

- i. The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period.
- ii. The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period.

The lack of monitoring of sexual orientation and gender identity in the national cancer screening programme is a significant barrier to understanding patterns of cancer inequalities. Research suggests that lesbian and bisexual women experience barriers to accessing cancer screening, but as mentioned in [2.19](#), may be at higher risk of both breast and cervical cancers. Screening may be particularly challenging for trans and non-gendered individuals as the service is by nature gendered and literature and imagery often assumes a heterosexual biological female status of the patient. Screening services should work with trans organisations to develop appropriate engagement with trans and non-gendered individuals.

- National and international research shows that lesbian and bisexual women are significantly less likely to attend routine screening for cervical cancer.¹³⁹
- Only 48% of lesbian and bisexual women aged between 25-49 years, accessed a screen test within the last three years, as recommended by the national screening programme, and only 73% of 50-64 year olds had accessed screening within the last five years as recommended.
- Overall 51% of lesbian and bisexual women had either never had a test, or not had one within the recommended timescales.
- 50% of lesbian and bisexual women eligible for screening had at some point failed to respond to a routine invitation for a cervical screening test, and of these 35% considered themselves less at risk of cervical cancer than a heterosexual woman.
- 37% of lesbian and bisexual women had at some point been told that lesbian and bisexual women did not require a cervical screening test. 14% of lesbian and bisexual women had been actively refused or discouraged from having a cervical screening test by a health professional as a direct result of their sexual orientation.¹⁴⁰

Lesbian and bisexual women who have never had sex with men are less likely to attend cervical screening, and more likely to have longer intervals between tests.^{141 142} International research suggests that this inequality does not exist in the same way for breast cancer screening in post-menopausal women.¹⁴³

Recommendations:

- NHS England and Public Health England should build on the historic partnership work of the National Screening Programme and continue explicit targeted approach for lesbian and bisexual women to promote uptake of screening and ensure that health professionals are supportive of their inclusion in national cancer screening programmes. NHS England should also work with trans organisations to develop appropriate engagement with trans and non-gendered individuals.
- Supported by Clinical Commissioning Groups and NHS England cancer service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.

2.21 Access to non-cancer screening programmes

INDICATOR DEFINITION

- i. HIV coverage: The percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result.
 - ii. Syphilis, hepatitis B and susceptibility to rubella uptake: The percentage of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella leading to a conclusive result.
 - iii. The percentage of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report.
 - iv. The percentage of babies registered with the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe.
 - v. The percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes – well babies, all programmes – NICU babies) or 5 weeks corrected age (community programmes – well babies).
 - vi. The percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth.
 - vii. The percentage of those offered screening for diabetic eye screening who attend a digital screening event.
- A further indicator will be added for the Abdominal Aortic Aneurysm (AAA) screening programme with a likely baseline of 2014/15.

The majority of indicators relate to women in pregnancy and new born babies where there is no evidence of different uptake amongst same-sex or trans parents.

Similarly, there is no evidence relating to the uptake of adult diabetic related screening programmes, however further work is needed to understand diabetes amongst LGB&T communities and the related screening uptake.



2.22 Take up of the NHS Health check programme by those eligible

INDICATOR DEFINITION

- i. Percentage of eligible population aged 40-74 offered an NHS Health Check in the financial year.
- ii. Percentage of eligible population aged 40-74 offered an NHS Health Check who receive an NHS Health Check in the financial year.

As with the previous indicator there is no evidence about uptake of NHS health checks by sexual orientation or gender identity communities because of a lack of monitoring. Local government should consider how to work with NHS England to ensure robust demographic monitoring in primary care to allow an understanding of inequalities in uptake of this national programme.

2.23 Self-reported wellbeing

INDICATOR DEFINITION

- i. The percentage of respondents scoring 0-6 to the question 'Overall, how satisfied are you with your life nowadays?'
- ii. The percentage of respondents scoring 0-6 to the question 'Overall, to what extent do you feel the things you do in your life are worthwhile?'
- iii. The percentage of respondents who answered 0-6 to the question 'Overall, how happy did you feel yesterday?'
- iv. The percentage of respondents scoring 4-10 to the question 'Overall, how anxious did you feel yesterday?'

Average Warwick-Edinburgh Mental Well-being Scale for adults (>16yrs).

The data source on which this indicator is based does not include sexual orientation or gender identity, and there is a lack of evidence on LGB&T self-reported health. The Healthy Life Expectancy section on page 11 includes data on self-reported health, which suggests that self-reported health is slightly better among lesbians and gay men than heterosexual people but much worse among bisexuals and those identifying with another non-heterosexual identity.

The published evidence suggests that for younger trans people the experience of gender non-conformity is negatively related to well-being.¹⁴⁵ It is important that this negative impact is interpreted in relation to a social model of well-being where the outcome is related to the social context and experience of an individual, not to their individual identity or belief pattern.

The data source for this indicator is the Annual Population Survey and the Health Survey for England. Both studies are understood to be including sexual orientation monitoring in future and hence will allow disaggregation of the results by sexual orientation.

Recommendations:

- Health and Wellbeing Boards should consider how best to improve wellbeing amongst LGB&T communities, and include LGB&T need in local health and wellbeing strategies.



2.24 Injuries due to falls in people aged 65 years and over

INDICATOR DEFINITION

- i. Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population.
- ii. Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 to 79 per 100,000 population.
- iii. Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 80 and over per 100,000 population.

This indicator is drawn from Hospital Episode Statistics, which do not currently collect data on sexual orientation or gender identity.

Falls in the elderly are associated with social isolation and infirmity. Individuals who live alone are more at risk of falls and more likely to remain in hospital for longer because of a lack of family support networks. Evidence shows that older LGB people are more likely to be socially isolated, suggesting that they will experience worse outcomes related to falls.¹⁴⁴

- Older LGB people are more likely than both their heterosexual peers and younger generations of LGB people to be single and live alone, and are less likely to have children. They are therefore likely to have a greater need for formal care and support.¹⁴⁶
- 1 in 5 older LGB people have no one to contact in times of crisis (as much as ten times the number in the general population).¹⁴⁷

Recommendations:

- Health and Wellbeing Boards should consider the needs of older LGB&T people in health and wellbeing strategies and specific older people strategies.
- Public Health England should explicitly consider LGB&T populations in the development of the work-plan for violence and unintentional injuries.
- LGB&T organisations should explicitly consider the needs of older LGB&T people, and promote intergenerational understanding.
- Accident and Emergency service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.

Domain Three:

Health Protection

These indicators focus on protecting the population's health from major incidents, and other threats, while reducing health inequalities.

There is a lack of evidence on LGB&T communities in relation to many of the indicators in this domain, yet the available evidence indicates that LGB&T people may be experiencing health inequalities in relation to health protection.



3.1 Fraction of mortality attributable to particulate air pollution

INDICATOR DEFINITION

Fraction of annual all-cause adult mortality attributable to long-term exposure to current levels of anthropogenic particulate air pollution.

There is no specific evidence relevant to this indicator for LGB&T communities.

3.2 Chlamydia diagnoses (15-24 year olds)

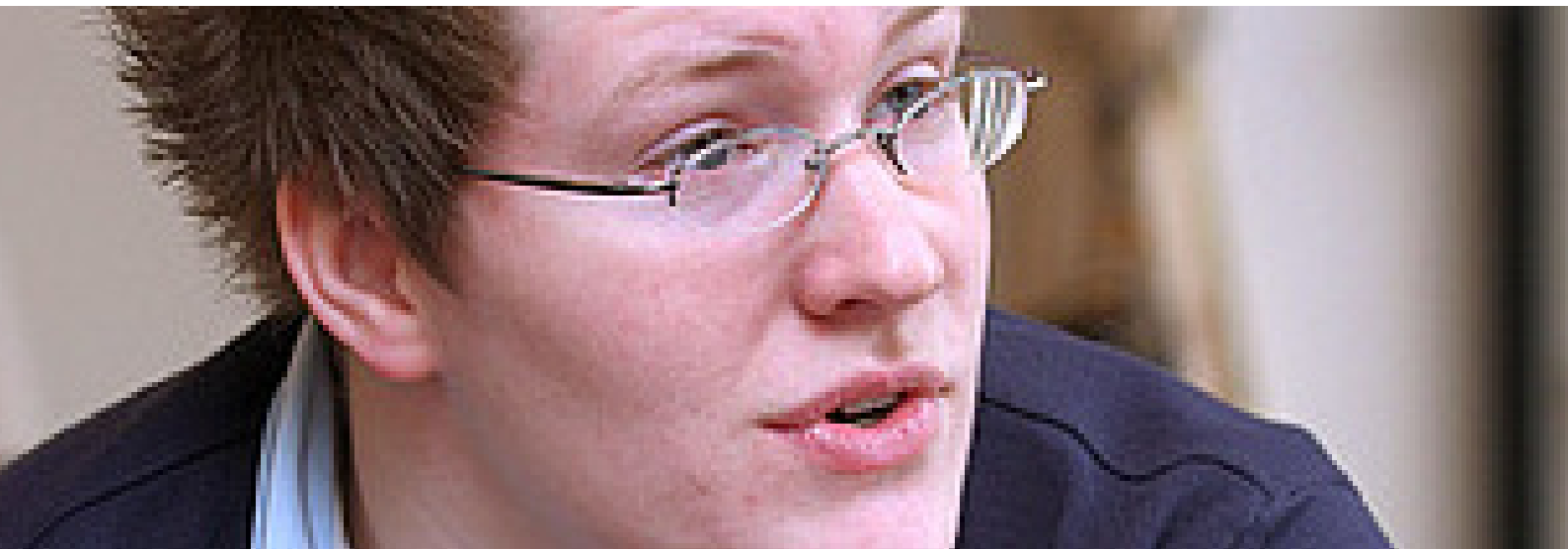
INDICATOR DEFINITION

Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24.

There is no data on chlamydia diagnoses among LGB&T people aged 15-24. However, men who have sex with men are 11 times more likely to have chlamydia than their heterosexual peers,¹⁴⁸ which suggests that chlamydia rates may be higher among young gay and bisexual men. Around half of lesbian and bisexual women have never had a sexual health screening,^{149,150} which again suggests that they may be at higher risk of late diagnosis of chlamydia.

Recommendations:

- Local government and NHS England should work together to promote chlamydia screening uptake amongst LGB&T young people and require service providers to monitor sexual orientation and gender identity to better assess levels of need.
- Sexual health service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.



3.3 Population vaccination coverage

INDICATOR DEFINITION

Hepatitis B vaccination coverage (1 and 2yr olds).

BCG vaccination coverage (aged under 1 year).

DTaP/IPV/HiB vaccination coverage (1,2 and 5yr olds).

MenC vaccination coverage (1 year olds).

PCV vaccination coverage (1 year olds).

Hib/Men C booster vaccination coverage (2 and 5yr olds).

PCV booster vaccination coverage (2yr olds).

MMR vaccination coverage for one dose (2yr olds).

MMR vaccination coverage for one dose (5yr olds).

MMR vaccination coverage for two doses (5yr olds).

Td/IPV booster vaccination coverage (13-18yr olds).

HPV vaccination coverage (females 12-13yr olds).

PPV vaccination coverage (aged 65yrs and over).

Flu vaccination coverage (aged 65yrs and over).

Flu vaccination coverage (at risk individuals from age six months to under 65yrs, excluding pregnant women).

This indicator focuses primarily on national immunisation programmes.

It does not include the uptake of hepatitis vaccination by men who have sex with men (MSM), despite this being national policy.^{151 152}

Previous evidence presented under indicator [2.24](#) demonstrates that older LGB&T people are more likely to be vulnerable and live alone, and this could potentially present a barrier to uptake for the annual flu and PPV vaccinations.

The Joint Committee on Vaccination and Immunisation is currently reviewing evidence to support extension of the HPV immunisation programme to MSM.¹⁵³

Recommendation:

- NHS England and Public Health England should work with LGB&T organisations in strategic partnerships designed to increase seasonal flu immunisation uptake.
- This indicator definition should be amended to include the uptake of hepatitis vaccination by men who have sex with men (MSM).



3.4 People presenting with HIV at a late stage of infection

Indicator Definition

Proportion of persons presenting with HIV at a late stage of infection.

HIV treatment and care has developed significantly in the last few years, yet it still remains a key issue for gay and bisexual men, particularly presentation at a late stage of infection.

- 1 in 10 men who have sex with men (MSM) is living with HIV, and 1 in 3 HIV positive men (in major UK cities) have undiagnosed HIV infection.¹⁵⁴
- 3 in 10 gay and bisexual men have never had an HIV test in spite of early diagnosis now being a public health priority.¹⁵⁵
- Community-based approaches to HIV testing have been shown to be acceptable and effective for gay and bisexual men.¹⁵⁶

There is no evidence about HIV testing among lesbian and bisexual women or trans individuals, although there is some evidence of increased prevalence in trans populations internationally.¹⁵⁷

Safer sex programmes promoting condom use and HIV testing remain a priority for both MSM and black African and Caribbean communities to reduce ongoing transmission and undiagnosed infection.¹⁵⁸

Recommendations:

- NHS England and Public Health England, in partnership with service providers from the LGB&T sector, should explore new ways of engaging with gay and bisexual men, and other men who have sex with men (MSM), to promote uptake of HIV testing.
- Health and Wellbeing Boards should commission HIV testing services in LGB&T community settings to ensure targeted outreach to promote testing to LGB&T community venues.
- LGB&T organisations should continue to promote uptake of testing across the community, and promote debate around HIV prevention. Specific consideration should be given to strategies for reaching and testing gay and bisexual men from black and other minority ethnic populations.
- Local government should commission HIV testing services in LGB&T community settings and ensure targeted outreach to promote testing to LGB&T community venues. This should include working collaboratively in high prevalence regions (e.g. pan-metropolitan) to commission HIV testing interventions that achieve significant economies of scale and have the greatest reach.



3.5 Treatment completion for tuberculosis

Indicator Definition

The percentage of people completing treatment for tuberculosis (TB) within 12 months prior to 31st December, of all those whose case was notified in the previous year.

TB incidence per 100,000 population.

Internationally, TB is a major cause of death among people living with HIV.¹⁵⁹ There is evidence of TB and HIV co-diagnosis becoming more common in the UK but there has not been focused work on how this affects gay and bisexual men living with HIV.¹⁶⁰

Further work is needed through the extension of TB data collection to understand patterns of TB in the LGB&T community, particularly among those who are HIV positive.

3.6 Public sector organisations with board-approved sustainable development management plan

Indicator Definition

Percentage of NHS organisations with a board approved sustainable development management plan.

There is no evidence relevant to this indicator for LGB&T communities.

3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)

The indicator definition needs further development.

In formulating local inter-agency plans local partners should consider how they engage with local LGB&T communities alongside other targeted plans for engagement with minority communities.

Domain Four:

Healthcare public health and preventing premature mortality

These indicators focus on reducing the numbers of people living with preventable ill health and people dying prematurely while reducing the gap between communities.

Evidence presented in much of this document indicates that LGB&T communities are more likely to be experiencing health inequalities in relation to public health areas and preventing premature mortality.



4.1 Infant mortality

INDICATOR DEFINITION

Crude rate of infant deaths (persons aged less than 1yr) per 1,000 live births.

There is no evidence relevant to this indicator for LGB&T communities.

4.2 Tooth decay in children aged 5

INDICATOR DEFINITION

Rate of tooth decay in children aged 5yrs based on the mean number of teeth per child sampled which either actively decayed or had been filled or extracted – decayed/missing/filled teeth.

There is no evidence relevant to this indicator for LGB&T communities.



4.3 Mortality rate from causes considered preventable

INDICATOR DEFINITION

Age-standardised rate of mortality from causes considered preventable per 100,000 population.

This is defined as causes of death that are considered to be preventable through individual behaviour or public health measures limiting individual exposure to harmful substances or conditions. Examples include lung cancer, illicit drug use disorders, land transport accidents and certain infectious diseases.

The evidence presented under a range of previous indicators ([2.9](#), [2.14](#), [2.15](#), [2.18](#), [2.20](#) and [2.21](#)) demonstrates that LGB&T populations exhibit higher levels of risk behaviours associated with preventable mortality, for example, higher rates of smoking and drug and alcohol use, and lower uptake of screening programmes. Therefore it is reasonable to assume that there will be inequalities in this indicator affecting the LGB&T community.

Recommendations:

- Health and Wellbeing Boards should ensure that their health and wellbeing strategies include a focus on preventable-mortality in LGB&T communities.
- Public Health England should develop national modelling of the impact of the enhanced risk factor prevalence in LGB&T communities on mortality outcomes.
- Public Health England should work with the Office for National Statistics and the Registry of Births and Deaths to explore inclusion of sexual orientation and gender identity in the death certification process to allow better understanding of mortality inequalities.

4.4 Under 75yrs mortality rate from all cardiovascular diseases (including heart disease and stroke)

Indicator Definition

- i. Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75rs of age per 100,000 population.
- ii. Age-standardised rate of mortality that is considered preventable from all cardiovascular diseases (including heart disease and stroke) in persons less than 75yrs of age per 100,000 population.

Evidence presented elsewhere in this document shows that LGB&T people are more likely to smoke, drink alcohol and use drugs (see indicators [2.14](#), [2.15](#) and [2.18](#)) and that lesbian and bisexual women may be more likely to be overweight. These are all factors which would increase risk of cardiovascular disease and so contribute to premature mortality related to cardiovascular disease.

Recommendations:

- **Health and Wellbeing Boards should ensure that their health and wellbeing strategies consider cardio-vascular disease risk factor amongst LGB&T communities.**
- **Clinical Commissioning Groups should consider the needs of LGB&T communities when commissioning secondary prevention such as cardiac rehabilitation.**

4.5 Under 75yrs mortality rate from cancer

INDICATOR DEFINITION

- i. Age-standardised rate of mortality from all cancers in persons less than 75yrs of age per 100,000 population.
- ii. Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75yrs of age per 100,000 population.

The UK cancer registry does not collect data on sexual orientation or gender identity. There are no data on cancer incidence, diagnosis, treatment, survival, morbidity and mortality among LGB&T populations.

Indicators [2.19](#) and [2.20](#) present the available evidence on both experiences of cancer and access to screening programmes among LGB&T communities. The evidence presented in relation to higher prevalence of smoking, alcohol, drug use and poor dietary intake among LGB&T people (see indicators [2.11](#), [2.14](#), [2.15](#), and [2.18](#)) suggests that LGB&T people are at higher risk of cancer in general. Evidence presented under indicators [2.19](#) and [2.20](#) shows that LGB&T people are less likely to go for routine health screenings, including for cancer. This could lead to increased risk of late diagnosis.

Recommendations:

- **Public Health England should work across cancer prevention and screening programmes to ensure recognition of the LGB&T community and engagement with these communities to promote early identification.**
- **The UK cancer registry should monitor sexual orientation and gender identity, and use this data to explore cancer incidence and experience among LGB&T people.**
- **NHS England should work with Public Health England to develop social marketing materials for HIV positive people to raise awareness of cancer risks and preventable aspects.**

4.6 Under 75 mortality rate from liver disease

INDICATOR DEFINITION

- i. Age-standardised rate of mortality from liver disease in persons less than 75yrs of age per 100,000 population.
- ii. Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75yrs of age per 100,000 population.

Liver disease is primarily associated with alcoholic liver disease or hepatitis liver disease, although a growing proportion is related to non-alcoholic fatty liver disease linked to obesity. Evidence presented under indicator [2.18](#) shows the higher prevalence of alcohol use and binge drinking among LGB&T communities compared to the wider population. There is no evidence on hepatitis prevalence among LGB&T communities.

Recommendations:

- **The National Liver Disease Strategy Implementation group should consider how to address the potential inequalities relating to LGB&T communities.**
- **Public Health England should consider a national social marketing campaign focusing on alcohol consumption in the LGB&T community.**
- **NHS England should monitor implementation of Hepatitis B vaccination amongst gay and bisexual men in sexual health settings.**

4.7 Under 75 mortality rate from respiratory diseases

INDICATOR DEFINITION

- i. Age-standardised rate of mortality from respiratory diseases in persons less than 75yrs of age per 100,000 population
- ii. Age-standardised rate of mortality that is considered preventable from respiratory diseases in persons less than 75yrs of age per 100,000 population.

Evidence presented under indicator [2.14](#) shows that LGB&T people are more likely to smoke, which would lead to increased risk of respiratory disease. The recommendations relating to this indicator focus on prevention aspects linked to smoking and have been made under indicator [2.14](#).

4.8 Age-standardised mortality rate from communicable diseases per 100,000 population

INDICATOR DEFINITION

Age-standardised rate of mortality from certain infectious and parasitic diseases per 100,000 population.

There is no specific evidence linked to the definition of this indicator at the moment, further work will be needed when the exact pathogens being monitored are defined to understand the evidence base linked to the indicator.

4.9 Excess under 75 mortality rate in adults with serious mental illness

INDICATOR DEFINITION

Excess mortality rate in adults with serious mental illness, ages under 75yrs, per 100,000 population.

There is substantial evidence of increased prevalence of suicide and self-harm and worse mental health outcomes among LGB&T people, described under indicator [4.10](#).

Deaths linked to serious mental illness are often due to suicide and the evidence relating to this is set out under indicator [4.10](#).

Further work will be needed to establish the relevant evidence once the indicator is more clearly defined. Hospital services and coroners should monitor sexual orientation and gender identity to explore a potential link between mortality in adults with serious mental illness and sexual orientation and gender identity.

4.10 Suicide rate

INDICATOR DEFINITION

Age-standardised rate of mortality from suicide and injury of undetermined intent per 100,000 population.

Research shows that LGB&T people are more likely to attempt suicide compared to the wider population, and the Department of Health's Suicide Prevention Strategy (2012) identified LGB&T people as a high-risk group. A systematic literature review¹⁶¹ commissioned with the support of the Department of Health in 2008 found:

- Two-fold increase in suicide attempts in LGB people.
- Lifetime prevalence of suicide attempt especially high in gay and bisexual men.

Further evidence since then has reinforced these findings:

- LGB people are twice as likely as heterosexual people to have suicidal thoughts or to make suicide attempts.¹⁶²
- 5% of lesbian and bisexual women say they have attempted to take their life in the last year and 16% of those under the age of 20 have attempted to take their life.¹⁶³
- 3% of gay men and 5% of bisexual men have attempted suicide in the last year. 6% of those aged 16-24 have attempted suicide in the last year.¹⁶⁴
- 84% of transgender people have considered suicide and half of transgender people have attempted suicide.¹⁶⁵
- Bisexual and queer identified people are more likely than lesbians or gay men to have thought about and attempted suicide in the past five years.¹⁶⁶

There is substantial evidence that the LGB&T community experiences inequalities relating to this indicator and it is an area where sustained and co-ordinated action is needed at a national level to address this inequality.

Recommendations:

- **Public Health England should establish a work-stream within the mental health programme to focus on LGB&T mental wellbeing in a whole system approach across Government.**
- **Health and Wellbeing Boards should establish suicide prevention plans that take into account the higher risk of suicide amongst LGB&T populations.**
- **Coroners and Medical Examiners should monitor sexual orientation and gender identity and explore a potential link between mortality from suicide and sexual orientation and gender identity.**

4.11 Emergency readmissions within 30 days of discharge from hospital

INDICATOR DEFINITION

Indirectly standardised percentage of emergency admissions to any hospital in England occurring within 30 days of the last previous discharge from hospital after admission.

There is evidence that older LGB people are more likely to live alone without solid social support networks and this is a significant risk factor for re-admission to hospital, presented under indicators [1.17](#), [1.18](#) and [1.19](#).

Furthermore, the evidence that LGB&T people may be reluctant to express their sexual and/or gender identity to health professionals and fear discrimination from home care support, would further enhance their risk of readmission through the potential to not accept or engage fully with support services.

Further work is needed to understand the inequalities linked to sexual orientation and gender identity and patterns of readmission to hospital. Hospital services should monitor the sexual orientation and gender identity of patients.

4.12 Preventable sight loss

INDICATOR DEFINITION

- i. Crude rate of sight loss due to Age Related Macular Degeneration (AMD) in persons aged 65yrs and over per 100,000 population.
- ii. Crude rate of sight loss due to glaucoma in persons aged 40yrs and over per 100,000 population.
- iii. Crude rate of sight loss due to Diabetic Eye Disease in persons aged 12yrs and over per 100,000 population.
- iv. Crude rate of sight loss certifications per 100,000 population.

There is some evidence of a link between the use of amyl nitrate, a drug commonly used in the LGB&T community, and fluctuating vision.^{167 168} Further work is needed at a population level to explore how significant this association is and whether it has an impact for this indicator.

4.13 Health-related quality of life for older people (Placeholder)

The indicator definition is being developed.

The health related quality of life for older LGB&T people needs to be understood within the social context of their lives. Many LGB&T older people will have come of age before the decriminalisation of homosexuality in 1967, and have lived in fear of the discovery of their sexual orientation, or censure of their gender identity expression. The implications of expressing one's sexual orientation and/or gender identity included: imprisonment; experimental treatments, including electric shock therapy and hormone injections; losing homes and jobs; and losing relationships with friends and family. The AIDS epidemic starting in the 1980s had a devastating impact on gay and bisexual men, and the LGB&T community in general. There are also shared experiences of resistance and rebellion with the birth of the gay liberation movement and gay pride marches. This history should be acknowledge by services working with older LGB&T people, and opportunities to share and express it encouraged.

The evidence shows that:

- LGB older people are lonelier and less socially embedded than heterosexual older people. 19% of older gay men and 14% of older lesbians are seriously lonely compared to 2% of older heterosexual men and 5% of older heterosexual women. Increased loneliness is only partly explained by weaker social connectedness; older LGB people felt lonelier because they 'miss depth, intimacy, recognition and understanding in their existing relationships'.¹⁶⁹
- Older LGB people are significantly more likely to live alone than their heterosexual peers, and four and a half times less likely to have children to call upon in times of need.¹⁷⁰
- There is increased risk of psychiatric morbidity in lesbian and bisexual older women, and in gay and bisexual men this risk was associated with concurrent HIV infection.¹⁷¹
- Some older LGB people fear a return to life in the closet if they need to be cared for in a residential home towards the later years of their lives.¹⁷²
- Gay and bisexual men are almost three times more likely to be single than heterosexual men. 41% of LGB people over 55 live alone compared to 28% of heterosexual people over 55. Just over a quarter of gay and bisexual men and half of lesbian and bisexual women have children compared to almost 9 in 10 heterosexual men and women over 55.¹⁷³

There is a lack of data on quality of life among older trans people, however, evidence quoted elsewhere in this document shows trans people experience high levels of isolation and poor mental health. It is likely that older LGB&T people will experience poorer quality of life than the wider population.

Recommendation:

- **Sexual orientation and gender identity must be considered in the development of this indicator.**
- **Service providers working with older people should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.**

4.14 Hip fractures in people aged 65yrs and over

INDICATOR DEFINITION

- i. Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65yrs and over per 100,000 population.
- ii. Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 to 79yrs per 100,000 population.
- iii. Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 80yrs and over per 100,000 population.

Evidence presented under indicators [1.17](#), [1.18](#), [1.19](#) and [4.13](#) demonstrate the higher levels of social isolation and potential vulnerability among older LGB&T individuals which may lead to increased risk of falls and hence increased risk of hip fractures.

Recommendation:

- Accident and Emergency services should monitor sexual orientation and gender identity of service users and use this data to ensure they are addressing LGB&T need.
- Service providers should consider LGB&T service users by ensuring that: staff receive training on LGB&T issues; promotional materials use LGB&T language and imagery; and that service user sexual orientation and gender identity is monitored and this data is used to improve services.

4.15 Excess winter deaths

INDICATOR DEFINITION

Excess winter deaths index: The ratio of extra deaths from all causes that occur in the winter months compared to the expected number of deaths, based on the average of the number of non-winter deaths.

Evidence presented under indicators [1.17](#), [1.18](#), [1.19](#) and [4.13](#) highlights the vulnerability of older LGB&T people. Evidence has also been presented under indicator [1.15](#) showing that LGB&T people may be more likely to be represented in the homeless population, who are also vulnerable to climate related deaths.

Therefore, although the current data collection does not allow measurement of the inequalities relating to sexual orientation and gender identity, it is reasonable to extrapolate that this community will be potentially more at risk of excess winter deaths.

The recommendations to address this are in line with those previously made in the document relating to addressing the needs of older LGB&T people.

4.16 Estimated diagnosis rate for people with dementia

The indicator needs further development but will be based on the gap between the number of people diagnosed with dementia as a percentage of the estimated dementia prevalence.

There is some published evidence on the experiences of care and support for LGB people with Alzheimer's that demonstrates the needs for service providers to be aware of this population and consider their specific needs.¹⁷⁴

Development of the new indicator should consider how inequalities in diagnosis will be identified through the data capture and reporting mechanisms.

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