LGBT equity in health and care

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As Pride month comes towards a close, we have examined LGBT people's experiences in healthcare and provide reflections for healthcare leaders to make purposeful, impactful and positive change for LGBT health inequalities. The significant issues faced by LGBT people in health and care highlight the importance of maintaining ongoing focus and action on these health inequalities, beyond Pride month.

In this article we explore the experiences of LGBT patients and staff, limitations on data collection and use, and key thoughts for leaders to consider.

LGBT people continue to face significant adversity

The significant challenges experienced by LGBT (lesbian, gay, bisexual and transgender) people – despite historic progress – continue to persevere, especially around the social determinants of health. Research by Stonewall in 2018 involving more than 5,000 LGBT people across the UK revealed some of the stark realities faced: 52% of LGBT people were suffering from or had recently experienced depression; 46% of trans people and 31% of LGB people had considered suicide in the last 12 months; and 13% of 18-24 year old LGBT people had taken drugs at least once per month.

Research from the LGBT Foundation published last year sheds further light into such adversities: 24% of homeless 16-24 year olds are LGBT, the majority of which due to parental rejection; more than double the number of LBT women had experienced sexual violence (42.8%) compared to all women in the UK; and attempted suicide rates are as high as 45% among transgender 11-19 year olds and 22% for cis-LGB young people.

Some determinants behind such adversities are laid bare in a report published this month by LGBT education charity Just Like Us, which surveyed 2,934 pupils aged 11-18 and 513 educators, highlighting what it is like to grow up LGBT in the UK today: twice as many LGBT pupils have been bullied in the last year (42%) compared to 21% of non-LGBT young people; 27% of LGBT young people feel close to their family and 25% face daily tensions at home, compared to 50% and 15% of non-LGBT pupils, respectively; and 31% of LGBT young people have self-harmed compared to 9% of non-LGBT pupils.

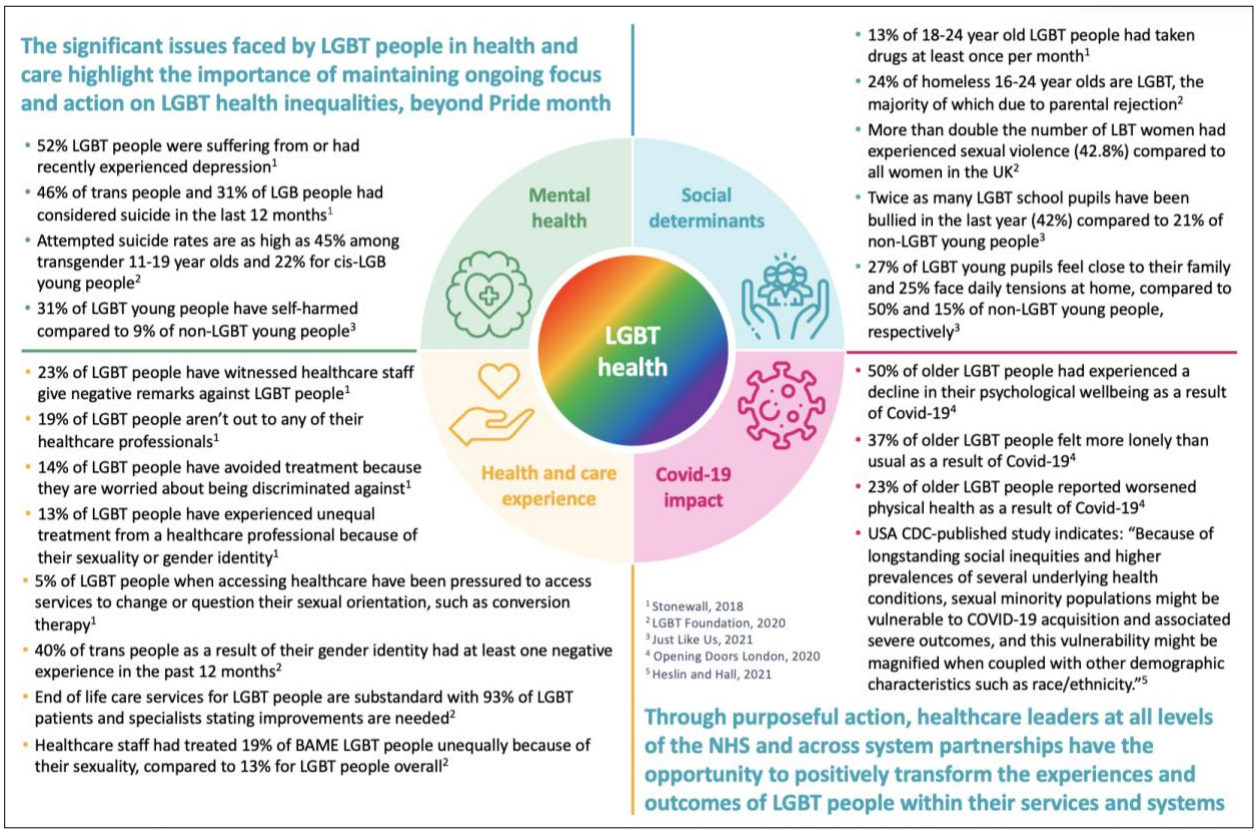
Within healthcare services specifically, Stonewall research also revealed that 23% of LGBT people have witnessed healthcare staff give negative remarks against LGBT people; 19% aren't out to any of their healthcare professionals; 14% have avoided treatment because they are worried about being discriminated against; 13% have experienced unequal treatment from a healthcare professional because of their sexuality or gender identity; and 5% when accessing healthcare have been pressured to access services to change or question their sexual orientation, such as conversion therapy. Moreover, LGBT Foundation research shows 40% of trans people as a result of their gender identity had at least one negative experience in the past 12

months, and end of life care services for LGBT people are substandard with 93% of LGBT patients and specialists stating improvements are needed.

The intersectionality of being LGBT and part of another marginalised group worsens healthcare experience and outcomes further. According to the LGBT Foundation, healthcare staff had treated 19% of BAME LGBT people unequally because of their sexuality, compared to 13% for LGBT people overall.

Data on the impact of Covid-19 on LGBT people and health inequalities is limited, however evidence is emerging. In the United States, the Centre for Disease Control and Prevention (CDC) have published a study by researchers highlighting the disproportionate vulnerability of LGBT people to Covid-19 at a population level, citing that: "Because of longstanding social inequities and higher prevalences of several underlying health conditions, sexual minority populations might be vulnerable to COVID-19 acquisition and associated severe outcomes, and this vulnerability might be magnified when coupled with other demographic characteristics such as race/ethnicity."

Closer to home, research by Opening Doors London exposes the significant impact of the pandemic on older LGBT people, many of whom have felt forgotten, overlooked, and experienced increased psychological stress: 50% of older LGBT people had experienced a decline in their psychological wellbeing; 37% felt more lonely than usual; and 23% reported worsened physical health. Of course, many older LGBT people also face the unique double-burden of having been affected directly or indirectly by two pandemics – initially the HIV/AIDs pandemic and now Covid-19 – and the unique psychological burden this entails.



Patient data could be collected and used differently to better understand LGBT people's experiences of healthcare in the NHS

The availability of healthcare determinants and outcome data split by sexuality from NHS, Public Health England and other health and social care sources is limited, with few data sets available through NHS Digital or PHE Fingertips which includes information specifically available by sexuality, gender identity beyond male and female, and other protected characteristics. This in itself is a challenge which shows the progress still to be made in addressing LGBT health inequalities, as if such metrics are not being measured across all protected characteristics then we cannot be fully aware of the extent of inequalities faced.

With focus often placed on health determinants and outcomes within health inequalities, marginalised people's lived experiences of healthcare can sometimes be overlooked.

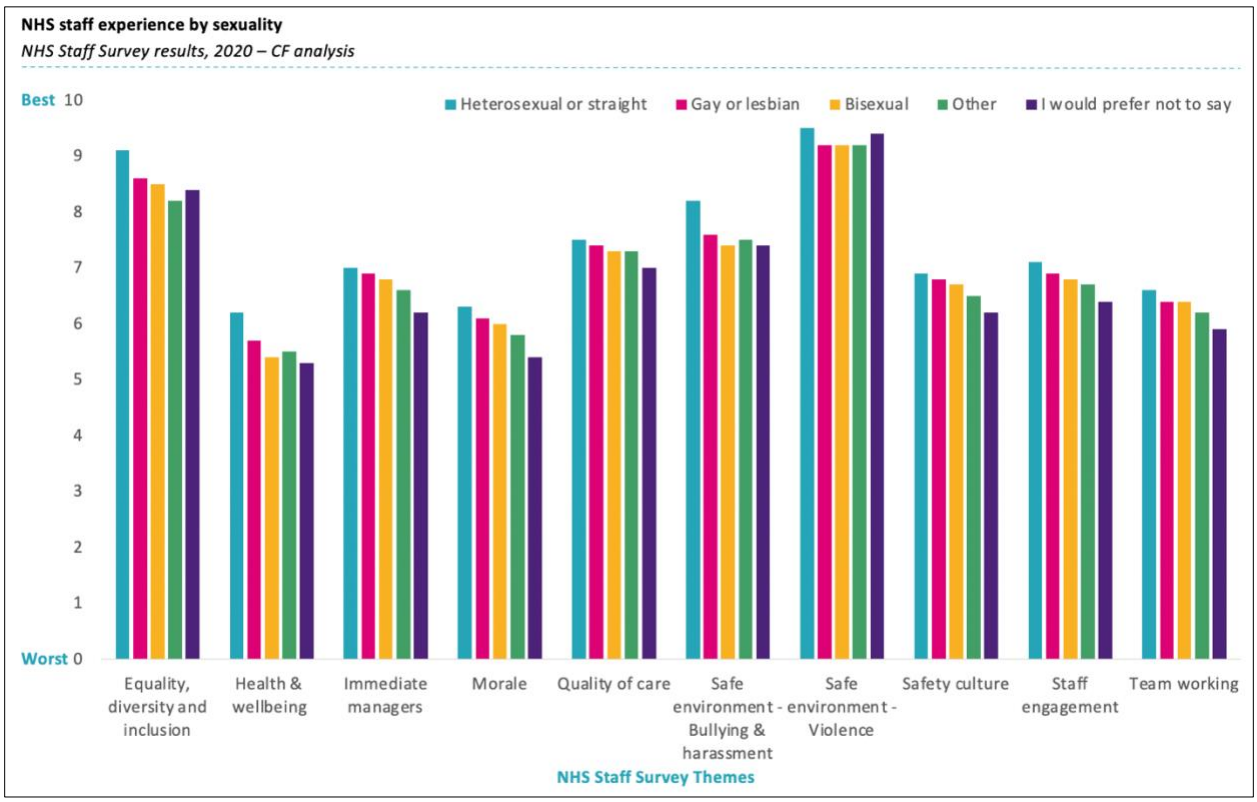
The annual CQC adult inpatient survey does however shed some light on the differing experiences of LGBT patients. Surveying 76,915 people, the most recent 2019 study looked across eight themes of patient experience: respect, hydration, information, support, confidence, coordination, dignity, food choice, and an overall aggregated score. Across all eight themes, gay, lesbian and bisexual people had a poorer experience of their inpatient care than their heterosexual counterparts. Moreover, those who did not wish to declare their sexuality – of whom some are likely to be LGBT people who are not currently comfortable to declare their sexuality – also had a poorer experience than heterosexual people. However, the survey only categorises gender by male and female, meaning that insights into transgender and non-binary patients' experiences cannot be drawn.

More can be done to improve working experiences of LGBT NHS staff

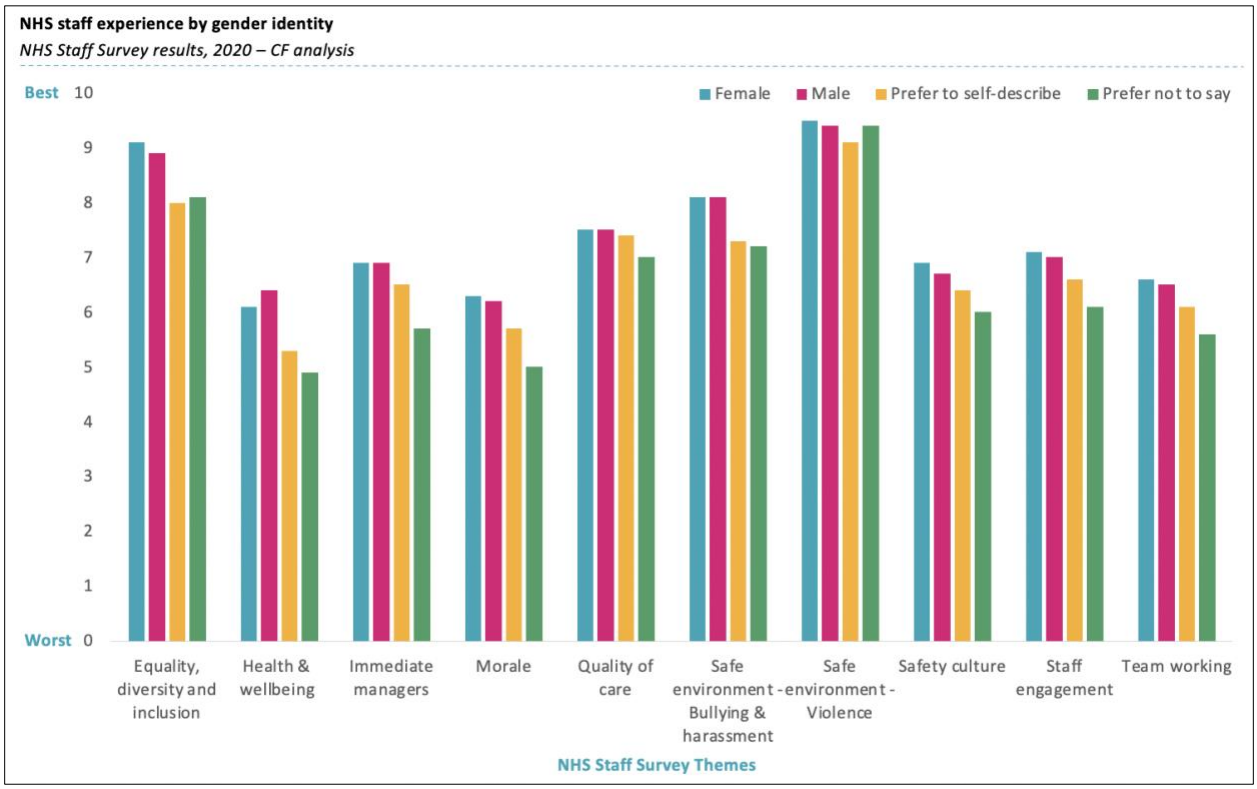
There is a substantial body of evidence demonstrating the general association between staff engagement and culture on patient outcomes. Drawing on this – and in the context of the determinants of health, experience and outcomes aforementioned – it is important to consider how staff experience may vary by sexuality and gender identity due to the resulting impact this may have on LGBT patients.

The 2020 NHS staff survey measures staff members' experiences of their workplace across ten themes: equality, diversity and inclusion; health and wellbeing; immediate managers; morale; quality of care; safe environment – bullying and harassment; safe environment – violence; safety culture; staff engagement; and team working.

Across sexuality groupings, our analysis has shown that people identifying as gay, lesbian, bisexual, other, or who chose not to disclose their sexuality, all reported a poorer experience of their workplace than their heterosexual counterparts, with bisexual people having a worse experience than gay and lesbian people. Most significantly, poorer experiences were mostly attributed to bullying and harassment, health and wellbeing, and their experiences of equality, diversity and inclusion (ED&I) in the workplace.



Considering gender identity, people who prefer to self-describe their identity – the group most likely to include transgender and non-binary individuals – also had a worse experience of the workplace than their cisgender male and female counterparts.



This highlights the importance of focussing on healthcare experience rather than solely outcomes when addressing LGBT health inequalities, thereby demonstrating the continued importance of healthcare leaders and role models championing inclusivity initiatives such as the NHS Rainbow Badge programme.

Healthcare leaders have an obligation to address adverse LGBT health inequalities

The improvement of LGBT health inequalities – and health inequalities more broadly – is not a nice-to-have, it is a central function of our healthcare system. The NHS Constitution begins "the NHS belongs to the people" – all people – and states that the healthcare service "has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population".

The long-term strategic direction of the NHS also places importance on addressing health inequalities. The NHS Long Term Plan centres "Stronger NHS action on health inequalities" as a priority. At a system level, the integration and innovation white paper published earlier this year places inequalities as a focus of the legislative proposals, specifically: "Enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities".

Healthcare leaders have a duty to create meaningful impact in this space.

Reflections for healthcare leaders at national, system and organisation levels

The current health inequalities faced by LGBT people demonstrate the need for further action by healthcare leaders to create purposeful and impactful change. Here, we outline our reflections for healthcare leaders seeking to create impact in this space.

Nationally, across the health and social care landscape, NHS England and national bodies play a central role in setting the strategic direction and overarching expectations of healthcare commissioners and providers:

- Existing items in the national agenda could be leveraged further to ensure improved and equitable outcomes for LGBT people, such as national requirements on Integrated Care Systems (ICS) development and data reporting of provider organisations.

- The current depth and availability of healthcare experience and outcome data for LGBT people within publicly available national NHS datasets is limited. Improving data collection, publication, and enabling data recording by sexuality and gender identity at the national level would allow a better informed approach to tackling health inequalities.

Regionally, with increasing focus on integrated and place-based care – both as core themes throughout the NHS Long Term Plan and outlined explicitly in the integration and innovation white paper – ICS and regional leaders have a clear opportunity to strengthen their efforts in ensuring equitable LGBT healthcare:

- Partnership working across the health and care landscape, including local authority and civil society partners, through ICS Partnership Boards represents an opportunity to systematically and consistently address inequalities faced by LGBT people within regional healthcare services in a unified manner.

- Covid-19 has accelerated collaboration between partners within and external to the NHS, notably voluntary and charitable organisations. ICS leaders should consider how these relationships can be maintained and strengthened into the future within the context of reducing health inequalities.

At an organisational level, leaders of healthcare providers have the opportunity to deliver measurable change through their relationships with local communities and frontline staff:

- LGBT staff consistently report poorer working experiences than their cisgender-heterosexual colleagues. The improvement of culture and working practices to better support LGBT staff may also improve care experiences for LGBT patients.

- NHS providers have developed unique relationships with community partners and local leaders through their Covid-19 response, both from the community supporting staff at the peak of the pandemic and through local engagement by NHS providers on Covid-19 vaccination uptake. Such relationships – for example, with spiritual, community and charity leaders – within the local area could be utilised to better understand the healthcare and Covid-19 experiences of local people from marginalised groups, and support future coproduction around health inequalities.

When creating change across all of these contexts, the focus should be on not only what needs to change but how. A 2020 report from University of York researchers demonstrated the additional work pressure that LGBT networks place on members, as staff are not often given time within their existing work for such activities, with chairs specifically citing an impact on their personal life due to having to work after hours and weekends to enable the networks to function effectively. Therefore, healthcare leaders must support individuals in creating capacity to build such networks, listen to and learn from the personal experiences of their staff. But crucially, the burden for action and change should lie with the organisation's leaders not the networks themselves.

Transforming adversity into opportunity

Over recent years, with the success of the NHS Rainbow Badge initiative and increasing focus on LGBT peoples' experiences – such as the GMC's new guidance for LGBT patients – the course of travel is set in the right direction. However, the level and severity of adversity faced by LGBT people within health and care remains significant. Through purposeful action though, and drawing on the energy currently focused on health inequalities and ED&I as a result of the disparities highlighted by Covid-19, healthcare leaders at all levels of the NHS and across system partnerships have the opportunity to positively transform the experiences and outcomes of LGBT people within their services and systems.