The National LGBT Partnership

VCSE health & wellbeing alliance

Working with LGBTQ+ Groups: A guide for Health Organisations

March 2025

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Foreword

The recommendations in this guidance are based on the real-world experiences of our sector, and the vitally important relationships we have developed within healthcare systems. They are intended to aid healthcare leaders in their awareness of the needs of LGBTQ+ groups who work tirelessly to support patients, deliver life-changing services, and ensure the most marginalised people in our communities receive high quality, culturally sensitive care.

The LGBTQ+ voluntary, community and social enterprise sector has faced incredible challenges over the last few years, with unprecedented need for services met by reduced funding, and increased hostility aimed at inclusion initiatives. The relationships we have forged with healthcare leaders during this time have been invaluable, and the advocacy of these professionals has allowed the vital work of our sector to continue. This guide is a blueprint for building new relationships across the LGBTQ+ sector, and strengthening those that already exist.

This guidance would have been impossible without the trust and collaboration of the LGBT Partnership's steering group members, who have dedicated time and effort to co-produce this project, and have, time and again, provided invaluable resources to the Partnership over the previous decade.

We hope that readers will use this guidance as a tool to create stronger relationships, and use its recommendations to facilitate good communication and mutual understanding across sectors, for the benefit of those most in need of our services.

Dr Paul Martin OBE
Chief Executive at LGBT Foundation

Foreword

Accessible, fair and equitable healthcare is one of the highest priorities for people across our diverse and intersectional LGBT+ communities. This guide has been designed to support LGBT+ groups and health organisations to identify ways of working together which are equitable, and which nurture mutual understanding, trust and confidence.

There is a wealth of knowledge, expertise and lived experience across our communities. We must never forget the immense value this expertise brings in the work we do to improve healthcare systems. I am incredibly proud of the work of the National LGBT Partnership, as well as people and organisations from across the LGBT+ spectrum, from our dedicated staff to our Steering Group members.

I hope organisations will embrace this guide and its recommendations as a tool to support them on the journey to reducing LGBT+ health inequalities, with a focus on those most in need of vital and life-saving services.

Paul Roberts OBE
Chief Executive at LGBT Consortium

Introduction

The LGBT Partnership is a group of LGBTQ+ organisations working to address health inequalities, led by LGBT Consortium and LGBT Foundation. We're members of the Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance, a partnership between the health and care system and the voluntary sector, jointly managed by the Department of health and Social Care, the UK Health Security Agency, and NHS England. We work to highlight LGBTQ+ health inequalities and convey LGBTQ+ voices within the wider Alliance and system partners.

Members of the LGBT Partnership deliver a wide variety of services, and work with LGBTQ+ people locally and nationally. See a list of our members on our website: https://www.consortium.lgbt/nationallgbtpartnership/about-the-partners/

This guide is intended to help health organisations understand the needs of the LGBTQ+ Voluntary, Community and Social Enterprise (VCSE) sector in relation to commissioning of specialist work, cultural competency, and effective collaboration.

How to use this guide

This guide will dissect the key barriers to engagement with health organisations facing the LGBTQ+ VCSE sector, based on interviews with 5 organisations and a survey of LGBT Consortium partners which collected 41 responses from LGBTQ+ groups. These range from grassroots to England-wide in size and scope. It has also been produced using feedback from the LGBT Partnership Steering Group, consisting of 10 organisations who bring intersectional perspectives into our work.

If you're part of a health organisation, this guide will provide practical tips for developing your relationships with LGBTQ+ groups.

Health organisation in this context includes any organisation or body that directly commissions or works with VCSE sector partners to deliver healthcare services. This includes the Department of Health and Social Care, Integrated Care Boards, Local Authorities, Hospitals and Primary Care Network members, amongst others.

- **If you have 5 minutes**: read the 'Tips for working with LGBTQ+ groups' section, and think about how you can apply its recommendations to your work.
- **If you have 15 minutes**: read the executive summary and 'tips for working with LGBTQ+ groups' and consider how working with LGBTQ+ organisations might help reduce LGBTQ+ inequalities in your work.
- **If you have 30 minutes**: read the entire guide and consider how you can change your practice to reduce health inequalities and be an advocate for the LGBTQ+ VCSE sector, and the communities they represent, in your organisation.

Executive Summary

What is the value of working with LGBTQ+ groups?

The LGBTQ+ VCSE sector has the skills, expertise and community buy-in to help tackle some of the biggest issues facing the NHS.

Stark healthcare disparities prevent many of the 1.5 million LGBTQ+ people living in England and Wales from living independent, prosperous and healthy lives. The LGBTQ+ VCSE sector has a proven track record of well evidenced solutions to these, such as NHS Rainbow Badges and Pride in Practice.

LGBTQ+ people continue to face unequal access across the NHS, in services such as IVF and cancer screening services. LGBTQ+ communities are excluded from NHS England's Core20PLUS5 strategy despite known healthcare inequalities across clinical priority areas. Record waiting lists and lack of commissioned services leave trans and non-binary people facing a dearth of appropriate and high-quality care.

The solutions to these issues will be best navigated by LGBTQ+ groups themselves, who can already evidence effective solutions and effective community buy-in.

To foster respectful, collaborative, and mutually beneficial working relationships, health organisations need to understand LGBTQ+ groups and communities, and the challenges we can face when working collaboratively with health organisations.

There are several ways for LGBTQ+ groups to add value to the work of health organisations. This can include:

Promoting engagement

- The VCSE sector is trusted by and embedded within communities. This level of trust enables deeper and more significant engagement, can provide insight into inequalities and their sources, and be a mechanism to hear the voices of patients. VCSE organisations are closer to evidence bases and can enable systems to hear from communities that are heard less often. Particularly for LGBTQ+ communities, trust towards health organisations has been damaged by experiences and expectations of discrimination. However, the LGBTQ+ sector can contribute so much more than just patient voice and insight.

Specialist expertise

- The LGBTQ+ VCSE sector has unique expertise that isn't held anywhere else, due to the nature of our varied work. As a sector, we're well placed to support complex and multiple needs, providing specialist services that are tailored to the experiences of specific groups within our communities. Working with LGBTQ+ groups can help NHS organisations develop their cultural competancy on LGBTQ+ issues.

Fresh perspectives

- Working with VCSE can provide fresh perspectives and new solutions to old problems. LGBTQ+ groups can think outside the box to apply creative and innovative approaches, but we also know what works for our communities through lived and worked experience and can evidence the effectiveness of tried and tested solutions.

Able to be trauma informed

- LGBTQ+ sector groups will especially be able to recognise sources and expressions of trauma that are specific to LGBTQ+ people. When delivering services, LGBTQ+ groups can work in a trauma sensitive way that's most appropriate to our communities. When partnering with or training health organisations, we can share our unique understanding of how trauma affects LGBTQ+ people and their health needs.

Social value

- The VCSE sector has a high social value- it addresses specific social problems and invests in community wellbeing, to strengthen society. Although social value isn't always measurable in the same terms as financial value, working with the LGBTQ+ groups provides value for money because we know what works for our communities, and because of the social, preventative and community-based benefits we can provide.

Working flexibly

- Partnering with VCSEs allows for unique flexibility; smaller organisations that exist outside of more embedded NHS structures can respond to new information and issues. With the dynamic nature of challenges and crises facing our communities, the LGBTQ+ sector is particularly agile and responsive, able to take risks and respond to needs on the ground. This also means LGBTQ+ groups can take more holistic approaches, designed to prevent rather than treat ill health rather than to treat symptoms.

Types of engagement

There are many ways that health organisations can engage with LGBTQ+ groups and projects. The organisations surveyed for this project provided several examples of work they'd been involved in, to reduce LGBTQ+ health inequalities:

- Direct delivery of services, such as sexual health testing, talking therapies and substance misuse recovery.
- Delivery of broader services, such as wellbeing groups for trans and non-binary people, movement and physical activity classes, self-care and resilience workshops, and more. These services may not be directly funded by health organisations, but contribute huge social value, supporting people before they are in crisis and taking a preventative role, reducing the use of health services. Some organisations are referred to and provide services within social prescribing initiatives.
- Provision of 1:1, peer led LGBTQ+ advocacy, with the goal of tackling barriers to participation in mainstream health organisations. For some, this has included facilitating primary care peer support groups, to allow GPs to work with more experienced peers in delivering trans affirmative care etc.
- Community outreach, such as providing targeted messaging around Covid-19
- Community research, such as examining the impact of loneliness and isolation on LGBTQ+ people.
- Providing consultancy and expertise through membership of various committees, including public health strategy working groups.
- Working with ICBs and ICPs, local authority public health teams and other bodies to inform strategy and ensure LGBTQ+ inclusion.
- Awareness and training programmes across primary, secondary and specialist care, aimed at developing culturally competent health organisations.

- Providing accreditation to services based on their development of LGBTQ+ inclusion policies, use of correct terminology, demographic monitoring, ability to provide affirmative healthcare for trans people and inclusive patient communications.
- Working with social care organisations to ensure housing services meet the needs of older LGBTQ+ people.
- Forming coalitions with other LGBTQ+ groups to jointly deliver health services.

Despite this work, some groups felt that little progress had been made on tackling LGBTQ+ inequalities in the health organisations. One organisation shared that:

> *"Over the last 10-15 years (there has been) … no forward movement… (we have more) outreach workers but the system itself (never addresses the underlying issues)."*

Tips for working with LGBTQ+ groups

Based on the themes discussed in interviews with LGBTQ+ groups, and insights from the LGBT Partnership steering group, we've compiled the following top tips to help health organisations better understand and utilise the LGBTQ+ VCSE sector.

All of the organisations surveyed for this project identified significant barriers to participation in health and social care infrastructure, which prevented their ability to tackle inequalities, and deliver the work they had been funded to provide. These issues are examined in greater detail below.

Based on this feedback, when working with LGBTQ+ groups, the following best practice tips were identified:

1. Commission inclusion training from LGBTQ+ groups, to develop staff cultural competency and understanding of LGB+ and specifically trans and non-binary issues and challenges.

   This may help organisations to understand some of the intersectional challenges and pressures facing staff in LGBTQ+ VCSE groups, which may include histories of trauma, disability, neurodiversity, working class status and discrimination based on sexuality and/or gender identity.

2. Carefully consider the type of LGBTQ+ groups you wish to commission for particular types of work. This can help ensure that LGBTQ+ groups are treated as equal partners when delivering work within health organisations and help avoid tokenism.

   For example, a group that focuses on supporting LGBTQ+ parents may not be best placed to facilitate focus groups on the experiences of trans and non-binary people living with HIV, compared to an organisation that focuses on supporting this cohort directly.

3. When writing business cases, consider how LGBTQ+ groups, particularly grassroots organisations might be impacted by the way in which the NHS provides funding. It is helpful for LGBTQ+ groups to have clear expectations about when and how payments will be made across the course of the programme, as they may face significant funding shortfalls if payments are not made when expected, or may not have the internal structure to handle the way that NHS payments are routinely made.

4. To ensure groups can deliver their work effectively, at project commencement, it may be beneficial to discuss deadlines, how communication is preferred to be received and the frequency at which this suits all parties. It is also good practice to provide up to date contact details for the named project lead on both sides, and an indication of regular availability.

5. To foster a collaborative environment, and mitigate disagreements, it may be helpful for a robust decision-making process to be agreed between organisations, allowing for necessary edits to programme materials, while ensuring that both parties are able to effectively contribute to key decisions.

6. While anti-LGBTQ+ backlash becomes more common, it is vitally important that health organisation partners continue to work with LGBTQ+ groups. Where pre-existing projects are at risk of closure due to this pressure, it is beneficial to be honest with LGBTQ+ groups about this, as the organisation may be able to provide more support around navigating these issues. This may include safety planning with project staff, upskilling on identifying discriminatory rhetoric, or developing comms plans that do not accidentally exacerbate any public backlash.

7. Newly commissioned LGBTQ+ groups may not have worked with health organisations before and may be unfamiliar with the language or cultural expectations within NHS systems. It may be beneficial to provide a named project lead who can both spearhead the project itself but also provide contextual information to mentor the group delivering work, if this is needed.

Key Themes from our Engagement

Funding

Many of the organisations surveyed for this project told us about difficulty they had experienced receiving funding from health organisations.

One of these organisations expressed frustration that payments had not been received on time, forcing them to fund essential work such as a counselling service for LGBTQ+ people out of financial reserves. They discussed a lack of understanding of the nature of charity sector funding versus longer-term public-sector funding that enjoys greater stability, and extended time scales. This imposition of public sector time frames on LGBTQ+ VCSE groups, and a general lack of timeliness in terms of payment, can have a tangible effect on the ability of essential work to be delivered.

Another organisation discussed a beneficial arrangement with a local provider, stating that:

> *“(Our) partnership with (the local NHS) Trust works well because they pay monthly in advance.”*

with another agreeing that:

> *“Monthly payments make a real difference, (but) most contracts are paid every 3 months in arrears.”*

This is also reflected in the short-term nature of funding that is provided. Organisations surveyed expressed that a smaller number of lengthened, high-quality contracts would allow more stability than the near-constant funding scramble for short-term projects, which in turn necessitate increased staff turnover, loss of resources and an inability to build expertise or partnership working across the length of a long-term project.

This model requires a large number of small LGBTQ+ charities to compete for the same resources. This is particularly acute for training contracts, as these have the potential to bring unrestricted income for longer periods of time.

It was also highlighted that short term funding requires an emphasis on innovation and short-term solutions to systemic issues, rather than supporting the long term work that would most benefit communities. Organisations expressed frustration that it was so difficult to have their mainstream, day to day work sufficiently funded:

> *“The NHS is very metrics driven… frameworks which have set KPIs … are more likely to be taken forward. Often people in commissioning don’t understand the needs of the people experiencing health inequalities.”*

The ability to influence the funding cycle and emphasise the barriers it poses for identity-based work was felt to be difficult, with one organisation stating:

> *“Influencing the commissioning cycle is the big challenge … (funders) will say ‘there’s no evidence’ and not take (us) seriously… KPIs and metrics get prioritised, and areas that don’t have that can fall to the wayside.”*

A key issue expressed by all interviewees was the hesitancy to fund specialist demographic services. The example of the NHS Rainbow Badges scheme was cited by many as a key example of fundamentally important work having funding pulled due to, what seemed to be, a politically motivated hesitancy to fund LGBTQ+ projects.

A lack of specialist demographic services emphasises a ‘one size fits all’ approach in health organisations, which can contribute to known health inequalities.

Some organisations expressed concern that economic hardship can translate into scarcity within health organisations, which leaves specialist services, such as LGBTQ+ Talking Therapies for example, as easy targets for budget cuts, as these are seen as frivolous.

A few participants cited the importance of embedding their strategies into health and wellbeing strategic priorities, as this made funding easier to acquire. However, in order to do so, groups are reliant on pre-existing relationships and allies to get them ‘a seat at the table’.

Securing buy-in and engagement from health organisations

Where work is funded, maintaining good relationships with health organisations can be challenging. Many organisations raised issues communicating and delivering work to primary care services, particularly where training was concerned.

As detailed above, funding for training contracts is highly sought. This often allows organisations to deliver training to primary care providers at negligible cost to the provider. This is important, as cost was cited by all participants as the biggest barrier to primary care buy-in. However, low cost is often not sufficient incentive, and many organisations discussed how difficult they had found working with primary care:

> *“Being ignored when reaching out to ICBs and local health care authorities happens regularly… (you get) stonewalled (because you’re) not medical professionals.”*
>
> *“There’s a) tension between medical professionals and the third sector, and a scepticism about peer experience.”*
>
> *“I would usually ask for changes around policy, and often GP practices would just stop responding.”*

This included challenges communicating via email, telephone and post with GP surgeries, and retention rate between signing up for training and turnout. One organisation reported contacting over 100 primary care providers, for only 20 individual GPs to attend training, while other spoke of resorting to Freedom of Information Act requests:

> *“(We had to) access information through FOIA requests, as previous response rates to enquiries were poor (with only) a third of contacted practices responding… (I) felt like I needed to be a ‘professional nuisance’ to acquire the necessary data.”*

Very little support is given by funders commissioning this training, to ensure that primary care providers utilise it.

Aside from issues getting LGBTQ+ (and particularly trans and non-binary specific) identity-based work funded, engagement in these initiatives across primary and secondary care was given as a huge barrier to VCSE sector involvement.

One organisation explained that:

> *“Engagement is always an issue with trans-related work, even if an event is free.”*

With another stating that:

> *“Services often won’t do policy work … (or) LGBTQ+ training (as this is) seen as ‘having a side’ or ‘taking a (political) position’, making them liable to attack in the media.”*

Others discussed having their work ‘co-opted’, with most of their expertise and recommendations removed, but their name retained to make the outcomes seem as if they had been coproduced:

> *“The offer was to help them devise a trans inclusion policy; they made their own policy with no consultation or oversight, and removed 90% of the content of the template they were given but kept (our) name on the work.”*

Others discussed navigating public backlash, and the hesitancy of NHS organisations to weather these sorts of attacks, stating:

> *“It’s scary … lots of creativity is stunted by fear of organised anger and anti-trans backlash. It creates a culture in the NHS where people are very skittish and afraid.”*

Another gave an example of work being deliberately hidden due to this fear:

> *“It doesn’t exist anymore because there was a hit piece … from one of the newspapers, which meant (pulling our) resources (from) from the website to keep (ourselves) safe as individuals.”*

This hesitancy to engage is work that may be seen as political was expressed by many of the organisations interviewed.

When asked how this might be mitigated, organisations spoke about seeking out work with those who are already invested in LGBTQ+ policy, stating that:

> *“It’s better to work with those who want to engage… and can see the value (LGBTQ+ specific work) can add to healthcare policy… rather than those who are sceptical (or) perceive bias.”*

Many spoke of the importance of allies in building support and momentum for a project:

> *“Our local NHS Trust) has a very engaged and competent EDI department and EDI manager, who really cares and is invested in the work. (We have) mutual respect for each other’s time, and they’re willing to do research and legwork to advocate for change.”*
>
> *“When you meet someone who is really keen and a committed ally… having someone like this at every level can’t be understated – it is so helpful.”*

Many expressed that those most invested in the implementation of LGBTQ+ policy and training in health organisations were often community members themselves, and emphasised that, while this fostered positive relationships, it often meant that work would cease if this person left their role:

> *“(LGBTQ+ work) needs to be embedded as a priority, rather than dependent on an individual with a passion for the work… Experiences really depend on who is in the Equality Diversity and Inclusion management position. (These relationships) can fall off when there isn’t that person anymore.”*

Examples included both loss of individuals, but also loss of helpful ways of working with sector organisations due to large scale restructuring:

> *“(In the transition from) clinical commissioning groups to integrated care systems, all former strategy documents that were committed to addressing LGBTQ+ health inequalities were thrown away. It’s frustrating to have to re-do this work or lose past efforts.”*

Organisations were also weary of their work being used as a ‘tick box exercise’:

> *“If (a health organisation) views working with LGBTQ+ organisations as a box tick so they can use our name, it’s very tokenistic, (and doesn’t) feel like meaningful collaboration.”*
>
> *“You can tell when you’ve been invited to engage due to ‘damage repair’ or lip service, or if they actually are interested in hearing what you have to say. There needs to be transparency around whether our engagement with them will actually be part of enacting change.”*

Organisational culture clashes

Working practices between VCSE organisations and health organisations were felt to contribute to a ‘culture clash’ between the two. This was highlighted in a number of ways, from differences in expected project timelines between NHS and VCSE colleagues, meeting fatigue, and ‘death by consultation’.

The latter of these was felt to be particularly dispiriting, with some emphasising that public consultation, particularly on politically contentious issues.

> *“(Can cause the) overriding of best practice, in ways that (can be) hostile, unhelpful … or impractical.”*

This was felt most acutely where the results of this consultation were not shared with VCSE sector partners, or contradicted advice provided by them.

It was also noted that often the burden of tackling anti-inclusion backlash fell to organisations staffed in large part by community members facing attack, with one organisation stating:

> *“Trans organisations get asked so often to challenge discriminatory bills that may be passed against us. There’s currently so much fatigue around this in the sector… this should be known by NHS orgs before seeking to engage.”*

Additionally, it was felt that inter-department working presented significant barriers, with departments ‘not talking to each other’, and no mechanism for centralised policy, training or information. In many cases, this had led to duplication of work and wasted resources, further damaging VCSE sector relationships.

Some groups discussed feeling that, as grassroots organisations, they faced significant difficulty breaking into the health ecosystem to become recognised providers. This was particularly evident for those organisations that did not yet have registered charity status, or felt that such a status would be a barrier to their work with marginalised groups:

> *“(It’s a) barrier for new people and smaller organisations who want to make a difference, unless they have the chance to build connections.”*
>
> *“The NHS is a beast in itself; it has its own language and way of thinking about things. Because it’s so big, it’s really hard to break into that structure and do anything differently if you aren’t already speaking that language.”*

Some spoke of how this may be exacerbated by monetary issues:

> *“Funding restraints for NHS organisations mean that they don’t have time for people who aren’t already speaking their language. (This makes) interactions easier for established charities.”*

Interviewees expressed a wish for more support from the NHS to be given to grassroots organisations, to allow them to meaningfully contribute to important LGBTQ+ policy work.

While overarching organisational structures were often felt to be ‘a riddle to navigate’, organisations did express that opportunities to speak to local, borough specific NHS organisations allowed them to develop better relationships and understanding, than if they had relied on building relationships at a national or regional level.

Lack of appropriate relationship building and collaboration

Organisations of different sizes and status equally expressed concerns that LGBTQ+ groups (and particularly trans specific groups) were not treated as equal partners when working with the NHS at all locality levels, compared to other types of non-identity based VCSE organisations.

This was felt to be due in part to an inadequate understanding of the nuances of LGBTQ+ sector organisations:

> *“We are often seen as either a service user (with lived experience), or a professional (with expertise), rather than being recognised as both.”*

and scepticism of professional experience borne of the politicisation of LGBTQ+ identities:

> *“(Our) credentials were questioned – (these challenges) were openly discriminatory… (we had to) justify why we deserved to be listened to.”*
>
> *“As a trans person working for a trans organisation some professionals view(ed me) as implicitly biased.”*

The latter of these issues was given as a reason for a more guarded approach to working with potential partners.

> *“We had to cut losses and work with those who were (respectful)... (we) previously engaged with anyone … due to scarcity and forced engagement with terrible working partners. Now (we) try to work with people (we) think will be mutually beneficial.”*

However, when organisations were treated as equal partners, and trusted to give expertise, this led to beneficial results, with one interviewee stating,

> *“During (our work), we were able to provide feedback, and the local council team were receptive, amending (their scheme) as a result. (We) were then listed as contributors, and the council’s … team brought community engagement on earlier next time.”*

Sexual health services were noted to be an exception to these experiences, with many local sexual health services performing well with LGBTQ+ sector colleagues:

> *“Sexual health services are already familiar working with LGBTQ+ communities… (they) listen to the (LGBTQ+) VCSE sector, which helps the tender process.”*

Some felt that the differences between lived experience and peer support organisations, versus those organisations that deliver services and campaign on particular issues was fundamentally misunderstood, with inappropriate groups being consulted on issues to which they could not speak.

For example, one organisation discussed being asked for legal advice, despite not being qualified to provide this. Others felt that they were being pressured into providing services that they could not appropriately manage due to lack of resources and overwhelming community need.

> *“(Patients) are moved from NHS waiting lists to (ours, but we) don’t have the capacity to see them in a clinically appropriate time. Often, people trying to access mainstream mental health services are referred instead to (us), simply because of their sexuality.”*
>
> *“There is a worry that people are so desperate for specialist support that (our) unregistered community group is being asked (to provide it), despite no safeguarding structure, governance or resources in place to provide this level of support.”*

This inevitably causes missed deadlines and lack of return on investment, effectively ensuring that those services will never be recommissioned in the future, and creating a reluctance to work with the LGBTQ+ sector in general.

> *“(The pressure on) emerging specialist initiatives is really concerning because it means that people get exploited. Organisations are often under-resourced, underfunded and cut off from support, and do not have what they need in place to take referral loads. (We’re concerned) that this might result in health and care services no longer being willing to work with small organisations (like ours).”*

Some expressed concern that lived experience and peer support groups were being inappropriately utilised by health organisations, to the detriment of LGBTQ+ individuals:

> *“Private and confidential anecdotal experience ... shouldn’t be exchanged for nothing… especially where it’s not going to contribute to systems change.”*

Appropriate conduct when utilising lived experience

It was raised that, where organisations need to facilitate lived experience perspectives from LGBTQ+ people, there should be a trauma informed approach to collecting this data.

> *“There should always be a trauma informed approach to engaging with marginalised populations… this ensures a good level of trust, transparency and safety for everyone involved.”*
>
> *“The fact is that our lived experience can mean that our work within health care spaces is triggering and harmful. Both queer organisations and NHS systems need to acknowledge this.”*

Specific concerns were raised regarding the institutional bias experienced by trans and non-binary colleagues, stating that:

> *“Trans (and non-binary) people are seen as visually younger in many ways, and it’s common (for us) to be talked down to within work environments.”*
>
> *“Colleagues who are middle and upper class and not neurodivergent often don’t understand the experiences of trans (and non-binary people) who haven’t been given opportunities to develop ‘professional’ or academic language (skills).”*

Trans specific organisations expressed a desire for greater respect from healthcare professionals, stating that:

> *“With clinical disciplines, there can be a tension when a relatively ‘unqualified’ trans person is there to educate them. It’s about having your experience respected, not just for who you are, but what it allows you to have an authority on, which it doesn’t allow others to have.”*

The need for greater cultural competency

Many felt that a majority of the issues raised would be solved by greater LGBTQ+ cultural competency prior to the point of engaging with the LGBTQ+ sector. Recommendations included:

Training content

Having staff undergo LGBTQ+ awareness training before working with LGBTQ+ organisations, particularly regarding appropriate language.

It was also recognised that this training should be updated and completed regularly to avoid complacency, and that actionable steps with accountability mechanisms should be taken as a result of its completion.

For example, ‘In this training we learnt about the importance of using pronouns correctly. As a result of this, we will ask patients their pronouns when meeting them and note this information securely. To ensure this is being consistently done, we will ask patients if they were asked for their pronouns on our patient experience surveys and follow up with staff who are not consistently asking for this information.

Onward accountability

When commissioning work on a specific topic (such as sexual health testing for trans people, or LGBTQ+ experiences of cervical screening), doing a minimum level of research and upskilling prior to meeting with lived experience groups.

Commissioning

An openness and willingness to accept challenges and corrections, including honesty about past mistakes.

Need for structural change

When reflecting on experiences they had faced with NHS and other healthcare providers, all of the organisations interviewed expressed similar wishes for a system in which flexibility and experimentation was valued to a greater degree.

It was recognised that LGBTQ+ groups can react more quickly and with more creativity to emerging need, and that this should be utilised more effectively by health organisations:

> *“The best resources have been co-produced with community members, or just generated from a need…. (but) systems are often stuck in their ways, and people can’t always see out of the particular paradigm in which they’re working.”*

There was a keen desire for greater flexibility within NHS systems, and a recognition that the system itself posed a barrier for innovative solutions to LGBTQ+ health inequalities:

> *“Systems create systems… (and the) one thing they can’t do is be flexible… Community organisations are so good at being reactive to community needs because we directly respond to them, pivoting and learning along the way.”*
>
> *“Healthcare systems often don’t acknowledge failure … (instead they) often try and do the wrong thing better.”*

Glossary

Clinical Commissioning Group: CCGs were responsible for commissioning local services based on population health needs. They were replaced by ICSs in 2022.

Core20+5: This is an NHS strategy aimed at reducing key health inequalities for marginalised populations. It targets the 20% most deprived as defined by the Index of Multiple Deprivation, plus communities at a local level who may face worse health outcomes or be part of an inclusion health group. The strategy aims to reduce health inequalities in 5 key areas: maternity, severe mental illness, chronic respiratory disease, cancer diagnosis and hypertension.

Health inequality: A recognised disparity in healthcare outcomes. This often refers to the differences in outcomes between marginalised and historically privileged groups.

Integrated Care Board (ICB): An ICB is a board of members responsible for commissioning regional NHS services allocating budgets and planning the delivery of health projects and services. Members of the Board might include representatives from local NHS trusts, local government, and people representing Primary Care Networks.

Integrated Care Partnerships (ICP): Integrated care partnerships form part of a wider integrated care system (alongside integrated care boards), and are responsible for designing an integrated care strategy for the ICS to implement.

Integrated Care System (ICS): ICS's aim to better understand and meet the complex and long-term health of populations across England. They are not individual organisations, rather a grouping of parties across a geographical area. ICS's include integrated care boards and Integrated Care Partnerships. For more information on the relationship between Integrated care systems, boards and partnerships, see this explainer from the King's Fund.

Key Performance Indicator: A metric by which success or progress towards a certain goal might be measured.

Voluntary, Community and Social Enterprise (VCSE): VCSE organisations are charities, Community Interest Companies, Community Benefit Societies or otherwise unregulated or unincorporated organisations with a clear social mission, run not-for-profit.

Further Reading and Resources

The Clare Project- Resource for GPs

KCL- The ABCs of LGBT inclusive communication

Transactual- Trans inclusive healthcare survey report

Transactual- Trans Hospital Care guide for professionals

LGBT Partnership- LBT women's sexual health

LGBT Partnership- Bi+ health inequalities

Stonewall- LGBT in Britain Health Report

LGBT Foundation- Trans status and sexuality identity data monitoring standard (?)

LGBT Foundation- LGBT migrant inclusion in healthcare guide

LGBT Foundation- Understanding LGBT people's experiences of severe and multiple disadvantage

LGBT Foundation- Hidden Figures: LGBT+ Health inequalities in the UK

LGBT Foundation- Trans and Nonbinary experiences of maternity services

TONIC- Precarious Lives, Financial and Material Hardship among Older LGBTQ+ People

Integrated Care Systems Explained – The Kings Fund

Building relationships between the VCSE sector and integrated care systems – NHS

Guidance on how health organisations should work with VCSE organisations - The Kings Fund

Common barriers to working in partnership with VCSE organisations – The Kings Fund

A systems approach to tackling health inequalities – LGBT Partnership

Embedding LGBTQ+ priorities in health systems – LGBT Partnership

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