Lesbian, Gay, Bisexual and Trans People in Stockport
Needs Assessment

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1. Executive Summary

1.1. Summary of Key Findings

It is estimated that 5-7% of the UK population is LGB, with a further 1% estimated to be gender variant. There are a number of areas in which LGBT people experience greater inequality of outcome and therefore have needs that differ from the general population.

Local research demonstrates that those in younger age groups are more likely to identify as LGBT, probably due to the increase in social acceptability of 'coming out' within this age group . This may account for the higher percentage of LGB people in work and lower percentage retired than for the heterosexual population of Stockport. This is likely to change over time, as these individuals age, leading to an overall increase in the percentage of the population.

Stockport's highest concentration of LGBT people appears to be in the North West of the city. This is likely to continue to be the case due to expected changes in housing.

In Stockport, STI prevalence continues to be greatest in young people, men who have sex with men, and black communities. Evidence suggests the sexual health needs of LGBT people in Stockport are not being met.

LGBT people in Stockport experience increased lifestyle risk factors, including higher rates of smoking, drug and alcohol use, are less likely to exercise, and are more likely to eat a poor diet.

Disabled LGBT people and those with long-term conditions may be less likely to get their needs met. Data suggests a higher prevalence of disability within trans communities.

BAME LGBT people experience compounded health inequalities due to increased marginalisation and are likely to not have their needs met by mainstream services, or by services targeted at either the BAME community or the LGBT community.

Bisexual people have worse health outcomes, particularly regarding long-term mental health conditions.

Trans people experience some of the most significant health inequalities and frequently experience abuse, harassment and violence.

Older LGBT people are more likely to live alone than heterosexual and cisgender people and less likely to have informal support from families and social networks, but often do not get their needs met by adult social care services.

Those in same sex relationships are as likely to experience domestic violence as those who are not. Trans people are more likely to experience domestic violence and face specific forms of abuse related to transphobia. Mainstream services are often unaware of the needs of LGBT people who experience domestic abuse.

There is a lack of system-wide monitoring of sexual orientation, gender identity, and trans status across Stockport which results in a lack of data. Where this data is collected, it is inconsistently recorded and used.

Data from public sector services suggests that LGBT staff are not comfortable being out at work or disclosing their sexual orientation in anonymous staff surveys.

Information on LGBT status within Black, Asian and minority ethnic (BAME) groups is also poor. Individuals who are members of more than one minority group experience compounded disadvantage, so better understanding is important to improve understanding and identify specific commissioning needs. Some research has found higher incidence of bisexual identification among BAME LGB people.

Recognition of the needs of this population in Stockport has led to initiatives such as the adoption of ***Pride in Practice*** throughout Stockport, a quality service funded by Greater Manchester Health and Social Care Partnership and NHS England to improve LGBT people's access to primary care services, and a Stockport CCG Masterclass on the specific health needs of trans people.

1.2 Summary of Recommendations

Monitor sexual orientation, gender identity, and trans status

Services should monitor the sexual orientation, gender identity, and trans status of service users.

Health, social care and other staff should understand the rationale for monitoring as well as the benefits in general and to their specific service.

This data should be used to enhance our knowledge of the health of LGBT communities and to inform and improve service delivery.

Monitoring data should be used to identify sub-groups within LGBT communities with the highest support needs in Stockport.

Public sector organisations should monitor the sexual orientation, gender identity, and trans status of their staff, and provide support to enable staff to feel comfortable to be out at work by engaging in cultural competency training and establishing LGBT staff networks.

Data on the percentage of LGBT staff should be publicised.

Improve access to sexual health services

It is recommended that sexual health clinics in Stockport increase the number of people tested for HIV.

The needs of trans people and women who have sex with women should be included within mainstream sexual health services.

Specialist sexual health services or walk-in clinics for LGBT people in Stockport should be considered.

Include drug awareness and practical actions such as needle provision in contact with men likely to engage in Chemsex practices in sexual health settings, as well as giving out STI prevention messages through drug and alcohol services.

Increase LGBT cultural competency in Stockport

Staff working in health and social care services should receive training to develop cultural competence in support LGBT people.

Mental health services in Stockport should consider the specific needs and experiences of this population group.

Drug and alcohol services in Stockport should consider the specific needs and experiences of this population group.

Domestic violence services in Stockport should consider the specific needs and experiences of this population group.

Smoking cessation services in Stockport should consider the specific needs and experiences of this population group.

Continue to increase the number of pharmacies and GP, dental and optometry practices involved in Pride in Practice.

Cervical and breast cancer services should include clear information on risks for LGBT people and monitor uptake of screens by this community.

All services should work to reduce the consistently reported concern LGBT people express about poorer experiences of care due to their sexual orientation or gender identity.

Work in partnership with VCS organisations to improve wellbeing of LGBT people in Stockport

LGBT events hosted and delivered by community groups are popular and well attended throughout the city, with community members noting a link between LGBT visibility and their own wellbeing. SFT, SCC and the CCG should support these events and community organisers.

Swimming pools, leisure centres and sporting facilities should consider working with voluntary and community sector organisations and offering LGBT sessions to enable wider access to these community facilities.

Future needs assessment work

Future needs assessments conducted for Stockport should consider the needs of LGBT people.

A separate needs assessment focusing on young LGBT people should be developed. The needs assessment should be developed with staff working in schools and colleges as well as those working in youth services and sexual health services for young people and involve a steering group of young LGBT people.

2. Setting the Scene

2.1 Introduction

This needs assessment for the lesbian, gay, bisexual and trans (LGBT) people of Stockport arrives at a key time for LGBT rights in the UK. 2016 saw the launch of the largest inquiry into trans equality in UK history, led by the Government Women and Equalities Select Committee. The report made recommendations on a number of issues, including the provision of NHS services and care pathways; hate crime prevalence, stigma and transphobia within society; and care for trans children and young people. In February of 2017, LGBT History Month celebrated the 50th anniversary of the decriminalisation of homosexuality in England and Wales.

The Equality Act 2010 protects individuals from unfair treatment and promotes a fair and more equal society. It also enshrines the rights of individuals with specific protected characteristics to equitable and fair access and use of public sector services.

This needs assessment aims to identify the needs of a segment of the local population in order to understand their distinct needs and where their wellbeing and health outcomes may differ from those of the general population. We intend this document to be used to inform future commissioning of services, aiming to ensure that the identified group does not suffer inequalities of poorer health and other outcomes or in access to services. This report will also be of use to policymakers and researchers, as well as LGBT people in Stockport themselves.

The needs of LGBT people in Stockport have not previously been mapped in a formal process. Although the needs of LGBT people are often considered together, it is important to remember that within this acronym are two protected minorities: LGB people, who have one of the minority sexual orientations and trans people, whose gender identity is different from the gender they were assigned at birth. It is also worth noting that these categories are not mutually exclusive, meaning that some people will belong to both minority groups simultaneously.

2.2 Aim and Scope

This needs assessment will cover the needs of adult LGBT people in Stockport, with sections on the specific health needs of segments of this population, including BAME LGBT people, older LGBT people, and disabled LGBT people.

This needs assessment aims to gather evidence to determine the health and wellbeing needs of the LGBT population in Stockport.

3. Methodology

3.1. Community insight

At the start of this needs assessment, a meeting between Stockport NHS Foundation Trust and LGBT Foundation in Manchester was held. This provided some initial insight on the areas in which inequalities for LGBT people are evidenced and perceived.

Staff from Stockport NHS Foundation Trust and LGBT Foundation co-delivered a focus group with People Like Us Stockport (PLUS), a social group for the LGBT community of Stockport, on their experiences of health and social care services in Stockport.

During the course of the needs assessment, there were two relevant events held at the LGBT Foundation; Pride in Our Health, a community voice event focusing on the health and social care experiences of LGBT people in Greater Manchester, and the launch of Transforming Outcomes (LGBT Foundation, 2017) a needs assessment of trans communities in the North West of England. These were attended by the authors.

3.2. Literature review

National and local literature was examined to identify areas where the incidence of specific conditions or health needs might be different for LGBT people than the general population and where inequalities in health outcomes or access to health and social care were identified. Local data was sought to inform this picture for Stockport and used where available.

3.3. Local data

Following the initial review of literature and identification of areas in which it appeared LGBT people might experience inequalities in rates and outcomes from the heterosexual and cisgender population, very little data was identified at a service level where sexual orientation or trans status had been consistently recorded so that outcomes could be analysed.

Sources identified which do include this data for Stockport are:

- GP Patient Survey
- Stonewall national surveys: local level data available
- Contact with specialist commissioners or managers in specific instances
- Stockport Public Health

Local data on the LGBT population of Greater Manchester has also been included where relevant and available, and where no Stockport-specific data is currently exists.

3.4. Synthesis

Three strands; LGBT community insight, literature review, and local data were brought together in an iterative process to identify areas which are consistently highlighted as areas of health and wellbeing inequality for this community of identity.

3.5. Limitations

The information contained within this report is a summary of relevant research articles, papers, NHS data and statistics, and community insight. As such, the quality of evidence used in this assessment is variable. We have compiled the information using broad quality assessment criteria to ensure that the information in this document is largely representative and unbiased. The LGBT community is diverse and encompasses a very wide range of experiences, thus the information presented here may not reflect the profile or experiences of every individual within the categories presented.

Though the evidence base is growing, still there is little of the highest quality evidence, such as meta-analyses or randomised controlled trials, available on the specific health needs of the LGBT community. Where these are available, they tend to focus on specific areas rather than population health e.g. treatment and prevalence of HIV/AIDS in trans women[1]; mental disorders and low wellbeing[2].

[1] Baral, S.D. et al. 2013. *Worldwide burden of HIV in transgender women: a systematic review and meta-analysis in The Lancet Infectious Diseases, Vol 13 (3),* pp. 214-222. [Electronic version]

Systematic reviews similarly exist where focusing on particular areas e.g. smoking cessation[3]; psychosocial factors and ageing in older LGB populations[4]; GB men and domestic violence and abuse[5].

There is a large body of survey data for LGBT groups. Some of this is extracted from national surveys such as The National Survey of Sexual Attitudes and Lifestyles (NATSAL) and the GP Satisfaction Survey, which collect data on sexual orientation, though not on trans status. Gender identity data is collected but not in a way that includes non-binary gender identities, i.e. the options 'male' and 'female' are given. An example of how this data on sexual orientation can be analysed is provided by Elliott et al. (2014), who present comparative rates of mental wellbeing and drug use[6]. One systematic review discovered assessed national and international literature and compared it with surveys conducted in the West Midlands. The authors of the systematic review note that there is a lack of quality peer-reviewed studies into the health of LGBT populations in the UK[7].

Two large surveys (some of the largest internationally) have been conducted in the UK by an advocacy group (Stonewall) each with over 6,000 respondents. These provide information on a wide range of health topics, including rates of experience of domestic violence. However, the lack of a matched control group of either the general UK population or of the heterosexual and cisgender populations limits the comparative aspect of the findings.

Local research by LGBT specialist organisations across the UK often rely on promoting surveys through their contacts and service users, meaning that there is a possibility that data on minority groups within LGBT communities and the experiences of those not engaging with those services may be excluded from local LGBT datasets.

All surveys are limited by the willingness of those surveyed to identify as LGBT and the lack of system-wide effective monitoring of sexual orientation, gender identity and trans status. Because of the history of the legal status of LGB sexual orientation,

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[2] Semylen et al. 2015. *Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys in BMC Psychiatry, BMC Series – Open, Inclusive and Trusted*. [Accessed 24/4/17]

[3] Blosnich, J. et al. 2011. *A systematic review of the aetiology of tobacco disparities for sexual minorities in BMJ Journals: Tobacco Control, Vol 22 (2)*. [Accessed 5/5/2017]

[4] McParland, J. & Camic, P. M. 2016. *Psychosocial factors and ageing in older lesbian, gay and bisexual people: a systematic review of the literature in Journal of Clinical Nursing, Vol 25 (23-24).* [Electronic version]

[5] Buller, A. M. et al. 2014. *Associations between Intimate Partner Violence and Health among Men Who Have Sex with Men: A Systematic Review and Meta-Analysis in PLoS Med, Vol 11 (3).* [Electronic version]

[6] Elliott, M. N. et al. 2015. *Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey in J Gen Internal Med, Vol 30 (1)*, pp. 9-16. [Electronic version]

[7] Meads, C. et al. 2009. *A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research.* Unit of Public Health, Epidemiology and Biostatistics, University of Birmingham: Report number 71 [Accessed online 24/4/17]

and the history of discrimination and stigma towards LGBT people, older LGBT people may still not be comfortable identifying and participating in such a survey[8].

LGBT individuals from many Black, Asian, and Minority Ethnic (BAME) groups may also be reluctant to self-identify and to participate for a variety of reasons, including racism within the LGBT community and stigma within BAME communities, and may not describe their sexual orientations or gender identities in the same ways as white LGBT people[9], meaning that surveys disseminated and collected by majority-white LGBT organisations may not always account for the needs of this segment of the population.

3.6. Identified needs

Comparing outcomes for LGBT people with the heterosexual and cisgender populations or the population in general is limited by poor sexual orientation, gender identity and trans status monitoring within services, nationally and locally. However there is consistency in identifying the following areas in which there are health inequalities for LGBT people:

- Higher incidence of poor mental health, including suicide, suicide ideation, depression, and self-harm
- Higher rates of smoking, alcohol, and drug use
- Higher incidence of STIs
- Increased cancer risk factors
- Lower satisfaction with the quality of care of health and social care services.
- Experience of stigma, discrimination and hate crime as a result of prejudice towards LGBT people
- Lack of acknowledgement of specific health and social care needs based on sexual orientation, gender identity, and trans status

Two themes are also evident. One is the impact of discovering a minority sexual identity and/or discovering a gender variant identity, and the impact on the life course of individuals. The effects on health and wellbeing outcomes will vary depending on

[8] Guasp, A. 2011. *Lesbian, Gay and Bisexual People in Later Life*. Stonewall

[9] LGBT Foundation and Manchester City Council. 2016. *The State of the City for Manchester's Black and Ethnic Minority Lesbian, Gay and Bisexual People*. Available: http://lgbt.foundation/assets/_files/documents/dec_16/FENT__1481273610_State_of_the_City_Report_2016_.pdf

the level of support and acceptance given to each individual during this formative process[1011].

It is generally assumed that the development of a minority sexual identity and/or a gender variant identity in an environment hostile to LGBT identities has an impact on later lifestyle choices, such as smoking, alcohol, and drug use, and on mental health[12]. This may be due in part to coping mechanisms which manifest as risk-taking behaviours such as substance misuse [13] and to minority stress; a phenomenon whereby the daily stressors that members of a minority group are exposed to has a negative impact on their long term health and wellbeing. Thus it should be noted that adolescence is a crucial period in this regard.

The other theme which appears to impact all LGBT groups is the ongoing experience of discrimination, social exclusion, homophobia, biphobia, transphobia and hate crime due to social attitudes about LGBT people. The links between discrimination and poorer mental health have been documented[14], and it has been suggested that the increased use of tobacco, drugs and alcohol in LGBT people may partly be a response to such exclusion [15] . Where LGBT people have experienced misunderstanding or outright homophobia, biphobia and transphobia from health and social care services, this may act as a barrier preventing this community from accessing care.

'The doctor said to me "you're very peculiar!" and I thought "why don't you just ask me if I'm gay?" That's obviously what he meant.'

[10] Public Health England. 2014. *Promoting the health and wellbeing of gay, bisexual and other men who have sex with men: initial findings*. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339041/MSM_Initial_Findings__GW2014194.pdf

[11] Public Health England. 2014. *Draft Strategic Framework to promote the health and wellbeing of gay, bisexual and other men who have sex with men*. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/313692/Strategic_Framework_to_promote_the_health_and_wellbeing_of_MSM_FINAL_DRAFT_For_comment.pdf

[12] Ward. R, Pugh. S & Price. E. 2011. Don't look back? *Improving health and social care service delivery for older LGB users.* Equality and Human Rights Commission. Available: https://www.equalityhumanrights.com/en/publication-download/dont-look-back-improving-health-and-social-care-service-delivery-older-lgb

[13] Levahot, K. & Simoni, J. M. 2011. *The impact of minority stress on mental health and substance use among sexual minority women in Journal of Consulting and Clinical Psychology, Vol 29 (2),* pp. 159-170 [Electronic version]

[14] Balsam, K. F. 2011. *Measuring multiple minority stress: The LGBT People of Color Microaggressions Scale. Cultural Diversity and Ethnic Minority Psychology, Vol 17(2)*, pp. 163-174 [Electronic version]

[15] Meyer. Ilan H. 2003. *Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence, Psychological Bulletin, Vol 129(5)*, pp. 674-697

4. Characteristics of the population

4.1. Percentage of the population which identifies as LGBT in the UK

No robust UK survey data exists to allow an uncontested agreement of the percentage of the adult population which identifies as LGBT. The 2010 census did not include a question on sexual orientation, trans status, nor an inclusive gender identity question that would account for non-binary people. The Government's 2004 impact assessment of the Civil Partnership Act prior to its implementation [16] concluded that between 5-7% of the UK population were likely to be lesbian, gay and bisexual, based on data from the 2000 National Survey of Sexual Attitudes and Lifestyles (NATSAL), which asked respondents about sexual attitudes and behaviours, and on research from Europe and America.

At present, there is no official estimate of the UK trans population and the Office for National Statistics did not include a question about trans status in the 2011 census. In 2000, after informal consultations with the Passport Section of the Home Office, Press for Change estimated there were around 5,000 people in the UK who had changed their passports due to transitioning [17]. In 2011, the Gender Identity Research and Education Society (GIRES) estimated around 1% of the UK population to be gender variant based on referrals to and diagnoses of people at gender identity clinics (GICs), and noted that there was increasing evidence to suggest that there were equitable numbers of trans people assigned male and assigned female at birth[18].

Between August and October 2015, 14674 people were on the waiting list or currently under the care of a UK GIC, indicating increasing prevalence of people seeking treatment related to gender dysphoria. The Tavistock Clinic, the only child and adolescent gender identity service in the UK, reported that in 2015 they had seen an unprecedented 100% increase in referrals to their service within a 12 month period[19].

2013 NATSAL data indicates that for men over the age of 16, 8% had had sexual experience or contact with another man, 5.5% with genital contact. For women the figures were 11.5% and 8.1%. In the same survey, it was reported that 97.3% of

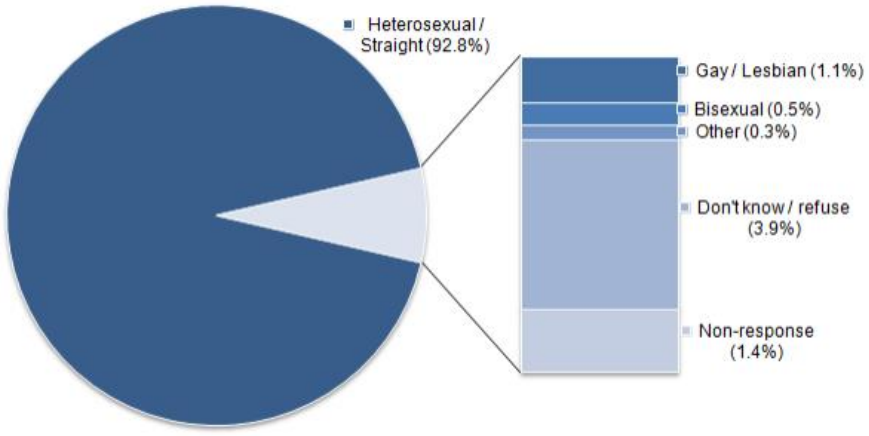
[16] Final Regulatory Impact Assessment: Civil Partnership Act 2004, available from http://webarchive.nationalarchives.gov.uk/+/http:/www.berr.gov.uk/files/file23829.pdf [Accessed 24/4/17]
[17] Al-Alami, M., Turner, L. & Whittle, S. Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination, Press for Change, 2007
[18] The Number of Gender Variant People in the UK – Update 2011, GIRES, 2011, available from https://www.gires.org.uk/assets/Research-Assets/Prevalence2011.pdf [Accessed 24/4/17]
[19] Current waiting times and patient populations for gender identity services in the UK, UKTransInfo, 2016, available from https://uktrans.info/attachments/article/341/patientpopulation-oct15.pdf [Accessed 26/4/17]

respondents considered themselves to be heterosexual/straight, 1% G/L, 1.4% B and 0.3% other. No percentage was given for those who declined to answer.[20]

The national Integrated Household Survey (IHS) contains information from approximately 325,000 individual respondents. In 2014, responses to the question on sexual identity showed about 1.6% identified as LGB, this figure has remained the same since 2013 (1.6%) and has experienced a small increase since 2010 (from 1.5%), although this increase was not statistically significant. A high percentage made no response or declined to state. A further 0.3% of the population identified their sexual identity as "other". We can extrapolate that these were adults who did not consider themselves to fall into heterosexual/straight, gay/lesbian, or bisexual categories but who may be affected by homophobic, biphobic and transphobic discrimination.

The Office for National Statistics, discussing the level of response, notes that indicative analysis indicates that the characteristics of responders and non-responders to the sexual identity question are similar. The introduction of ethnicity monitoring encountered similar issues and the historical record of how information on individuals' sexual orientation has been used means that it is necessary to give good information about the benefits of monitoring and to repeat monitoring exercises over time in order to improve coverage of responses and secure more representative datasets in future. It is likely that, as it is relatively recent for surveys to request data on sexual orientation and trans status, there remains a lack of understanding of the benefits of a more accurate knowledge of the percentage of the population which is LGBT which may act as a disincentive preventing LGBT people from answering.

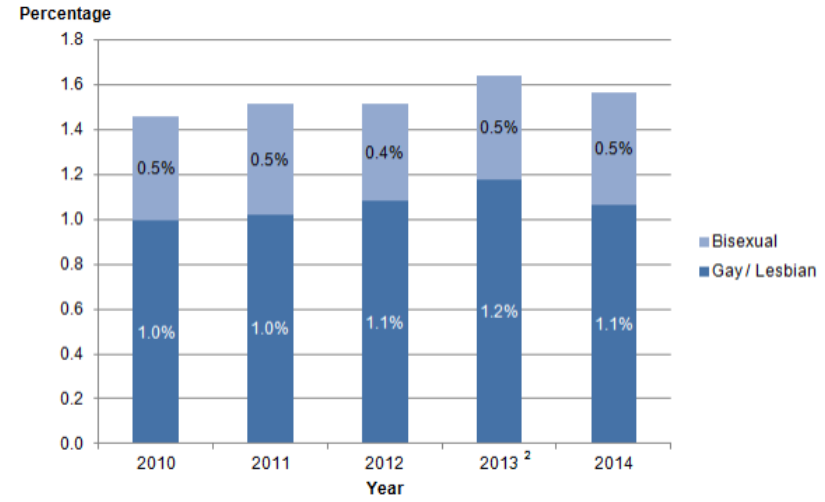
Figure 1: Sexual identity, UK, 2014



Source: Integrated Household Survey - Office for National Statistics

[20] Mercer, C. et al. Sexual Function in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles, 2013, available from http://www.sciencedirect.com/science/article/pii/S0140673613623661 [Accessed 26/4/17]

Figure 2: Sexual identity, lesbian, gay and bisexual population, UK, 2010 to 2014

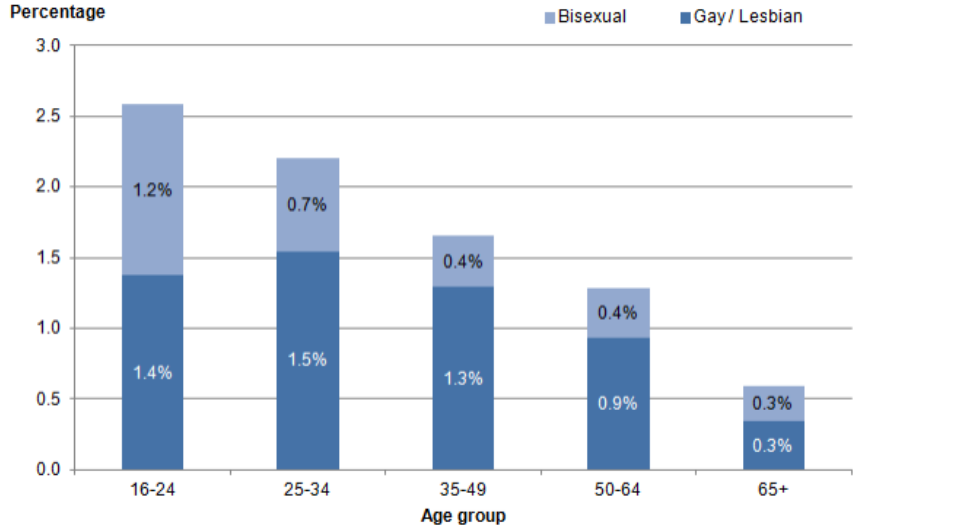


Source: Integrated Household Survey - Office for National Statistics

4.2. Sexual orientation by age group

The IHS found the likelihood of an adult declaring an LGB identity decreased with age. In 2014, 2.6% of adults aged 16 to 24 identified as LGB, decreasing to 0.6% of adults aged 65 and over. A YouGov poll in 2015 found that 49% of young people did not identify as exclusively heterosexual[21], which may indicate higher prevalence of LGB identities within the under-18 age group, or a higher prevalence of willingness to be open about having an LGB identity within this age group.

Figure 3: Sexual identity, lesbian, gay and bisexual population by age group, UK, 2014



Source: Integrated Household Survey - Office for National Statistics

[21] YouGov Poll, August 2015. Available: https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/7zv13z8mfn/YG-Archive-150813-%20Sexuality.pdf

The GP Patient Survey 2016 allows cross tabulation of sexual orientation by age band. For England as a whole, it is clear that within younger age groups (18-34) there are more likely to be individuals who identify openly as LGBT. This is likely to reflect the history of social attitudes, as many older LGBT people will have lived as adults in a time when having an LGBT identity was against the law and when anti-discrimination legislation for LGBT people was non-existent. People who left school before 2003 will have been in education while Section 28 was still in effect, preventing education about LGBT equality and LGBT rights from taking place in schools until its repeal in September of that year[22].

GP Satisfaction Survey 2016 All England

	18 to 24		25 to 34		35 to 44		45 to 54		55 to 64		65 to 74		75 to 84		85 or over	
Heterosexual or Straight	90%	69,172	90%	125,552	91%	125,005	93%	138,584	94%	112,574	95%	93,578	94%	51,253	94%	19,856
Gay or Lesbian	2%	1,759	2%	3,316	2%	2,925	2%	2,507	1%	1,165	0%	461	0%	150	0%	34
Bisexual	2%	1,738	1%	1,819	1%	1,133	1%	772	0%	391	0%	220	0%	97	0%	52
Other	1%	692	1%	1,135	1%	1,112	1%	831	0%	575	0%	412	1%	344	1%	220
Prefer not to say	4%	3,399	5%	7,057	5%	7,120	4%	6,576	4%	5,123	4%	3,751	4%	2,435	5%	1,065

This pattern appears to be reflected in the Stockport responses to the survey, although the low numbers (responses of fewer than 10 people are shown by the asterisk) makes this harder to establish.

GP Satisfaction Survey 2016 Stockport

	18 to 24		25 to 34		35 to 44		45 to 54		55 to 64		65 to 74		75 to 84		85 or over	
Heterosexual or Straight	91%	372	94%	621	92%	684	94%	800	96%	657	97%	546	97%	320	92%	113
Gay or Lesbian	3%	12	2%	12	2%	17	2%	20	*	*	*	*	*	*	*	*
Bisexual	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Other	*	*	*	*	1%	10	*	*	*	*	*	*	*	*	*	*
Prefer not to say	*	*	3%	19	4%	26	3%	26	2%	14	3%	14	*	*	*	*

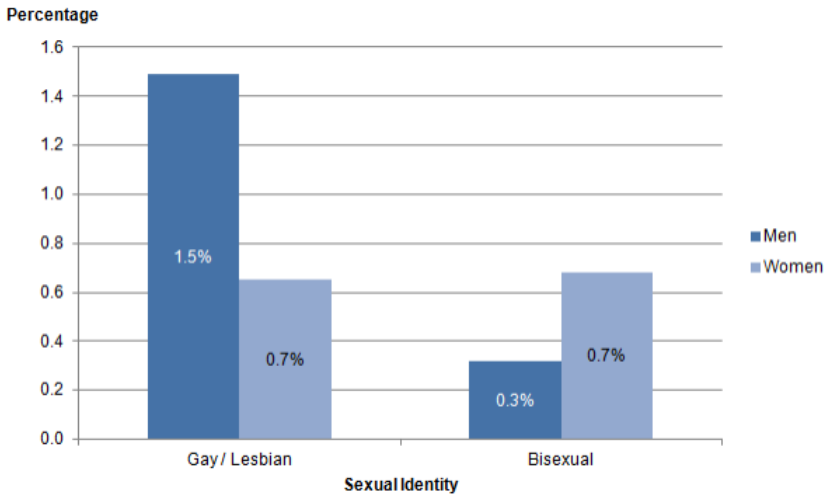
4.3. Sexual orientation by gender

In 2014, twice as many men responding to the IHS identified themselves as gay (1.5%) when compared with women who identified themselves as gay or lesbian (0.7%). By contrast, women were more than twice as likely to identify themselves as bisexual (0.7%) compared to men (0.3%). These statistics are closely matched with the 2013 IHS. As no question about trans status was asked, we can assume that

[22] Local Government Act 1988, Section 28. Available: http://www.legislation.gov.uk/ukpga/1988/9/section/28

trans women are subsumed into the category women and trans men subsumed into the category men. There is no national survey data available on the sexual orientations of non-binary people. Surveys reporting on sexual orientation of trans respondents indicate that trans people are more likely to identify as bisexual or queer than gay, lesbian, or straight, and a large proportion identify their sexual orientation in other ways, including asexual[23].

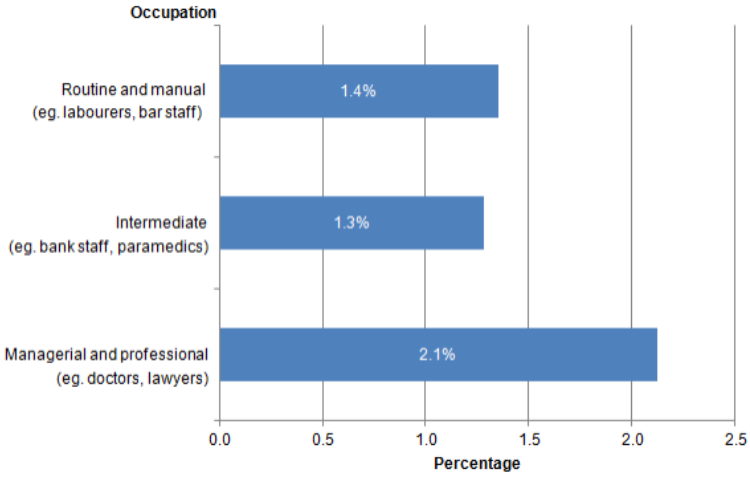
Figure 4: Sexual identity, lesbian, gay and bisexual population by gender, UK, 2014



4.4. Sexual orientation by occupation

The IHS analysed responses along occupational lines, demonstrating that adults in managerial and professional occupations, such as lawyers and doctors, were more likely to disclose a gay, lesbian or bisexual identity (2.1%) compared with those in either intermediate occupations such as bank staff and paramedics, (1.3%) or routine and manual occupations such as labourers and bar staff (1.4%).

Figure 6: Sexual identity, lesbian, gay and bisexual population by occupation, UK, 2014



Source: Integrated Household Survey - Office for National Statistics

[23] Stafford, L. 2017. *Transforming Outcomes: A review of the needs and assets of the trans community*. Available: https://lgbt.foundation/transformingoutcomes/

4.5. Percentage of the population who identify as LGBT in Stockport

The GP patient survey is conducted across England every 6 months and has a response rate of over 900,000. It is sent to a random selection of adult patients registered with a GP in England every six months, numbering approximately 2 million patients per year. The GP patient survey collects sexual orientation monitoring information and this information can be cross-tabulated with other responses. The percentage of respondents captured by the survey identifying as LGB is shown below. The high percentage of those who prefer not to say makes it difficult to establish the true percentage of LGB respondents. It is at present impossible to capture the percentage of trans respondents to the GP patient survey, nor the percentage of respondents with non-binary gender identities as this information is not currently collected.

The responses to the GP patient survey for Stockport total 4,500 and demonstrate similar findings to the national picture in terms of sexual orientation.

Stockport GP Patient Survey, 2016	**Male**	**Female**
Heterosexual / straight	93%	95%
Gay / Lesbian	2%	1%
Bisexual	1%	1%
Other	1%	1%
I would prefer not to say	3%	3%

All England GP Patient Survey, 2016	Male	Female
Heterosexual / straight	92%	93%
Gay / Lesbian	2%	1%
Bisexual	1%	1%
Other	1%	1%
I would prefer not to say	5%	5%

The percentage of LGB men and women in Stockport are similar to the national averages. There is a slight decrease in the number of "I would not prefer to say" replies though this is not statistically significant. It is unknown whether this similarity to the national picture will continue.

4.6. LGBT population estimate for Stockport

	Persons	Men	Women
Total Population aged 18 Plus (2014 JSNA)	225,000	110,250	114,750
Minimum estimated LGBT population (Using 1% of population)	2250	1102	1147
Maximum estimated LGBT population (3% males and 2% females)	11,250	5512	5737

Taking into consideration the evidence presented above, a calculation of the estimated number of LGBT people over the age of 18 in Stockport is between 2,250 (1%) and 11,250 (5%). These figures were calculated excluding the 3% who "prefer not to say" and from datasets which use wording that may prevent trans and non-binary people from responding. This means that it is possible that the Stockport

LGBT population could be larger than the upper limit in this estimated range due to aforementioned difficulties in gathering accurate sexual orientation data.

4.7. Stockport Adult Lifestyle Survey 2012

The Stockport Adult Lifestyle Survey used the question 'What is your sexual orientation?' and gave the options, 'Bisexual, Gay Man, Straight/Heterosexual, Lesbian/Gay Woman, Prefer not to say'. The response rate for this question was 98.0% (including the 2.4% who actively answered the question but indicated they preferred not to state their sexual orientation). In response to the sexual orientation question, 0.4% described themselves as lesbian, 0.7% described themselves as gay, 1.5% described themselves as bisexual, 95% described themselves as heterosexual/straight, and 2.4% chose the 'prefer not to say' option.

Overall, respondents who indicated they were straight were more likely to be middle aged, and those who indicated that they were LGB had a younger age profile. The respondents who did not answer or preferred not to indicate their sexual orientation had an older age profile.

Of those who responded to say they were LGB, 89.4% white, though there was an increased prevalence of BAME individuals who identified as bisexual compared to those who identified as gay or lesbian.

LGB respondents surveyed indicated a broadly similar range of religions to those indicated by all respondents.

Stockport respondents who identified themselves as LGB were significantly more likely to report below average levels of mental wellbeing, were less likely be active 5 or more times a week, and had higher levels of underweight BMI than those who identified themselves as straight.

There is no robust UK survey data that exists to allow an uncontested agreement of the percentage of LGBT adults. The estimated number of LGBT over-18's in Stockport is between 2,250 and 11,250, and likely to be at the higher end of the range or even higher. This is similar to the national average for England. There is a higher proportion of people who identify as LGBT in younger age groups.

5. Location of the LGBT population in Stockport

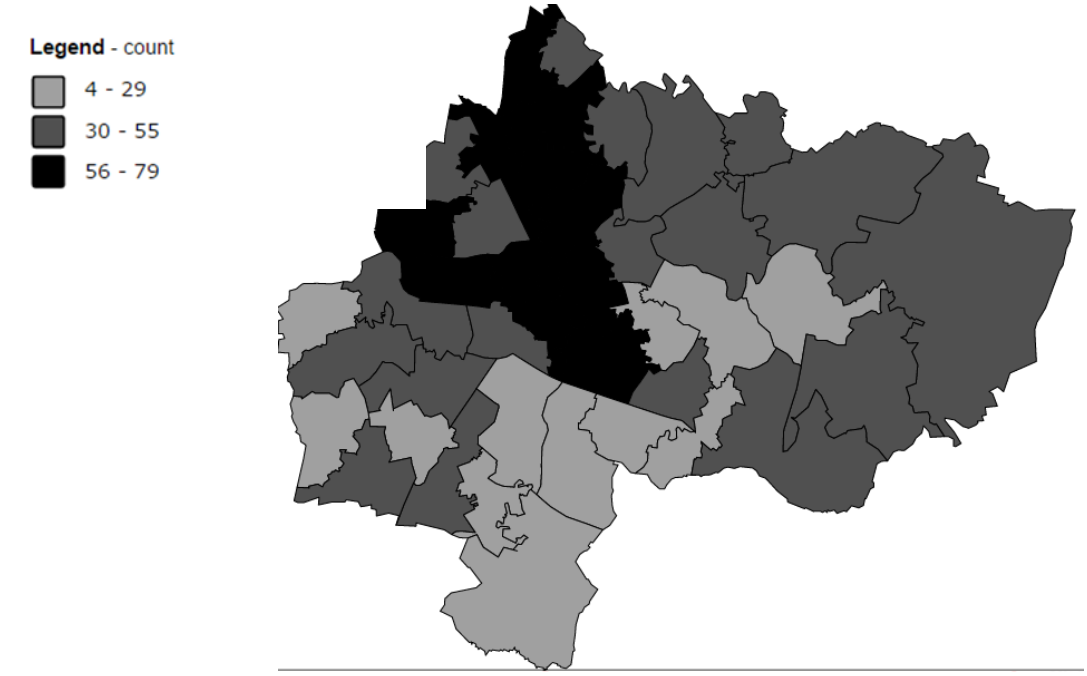
5.1. 2011 Census

The 2011 ONS Census did not include a question on sexual orientation, but a question regarding marital status included the possible answer 'living in a same-sex

partnership'. Mapping of the replies (1,639) for Stockport residents shows the distribution of civil and same-sex cohabiting partnerships across the city.

The map below shows the highest concentrations for same-sex cohabiting and civil partnerships are found in the North West of Stockport. This area is made up of Reddish North/South, Heatons North/South and Brinnington & Central. The concentration of same-sex partnerships in the North West of the city may be a result of being closer to Manchester; these areas also contain a lower percentage of 65+ year olds and a higher percentage of the younger generation (E.g. Brinnington & Central contains 21.5% aged 0-15 and only 12.9% aged 65+). There is no current data regarding the concentration of the trans population of Stockport.

Living in a Couple; In a Registered Same-Sex Civil Partnership or Cohabiting (Same-Sex) (Count, Persons, Mar11)



Stockport's highest concentration of same-sex couples in civil partnerships or co-habiting is in the North West of Stockport.

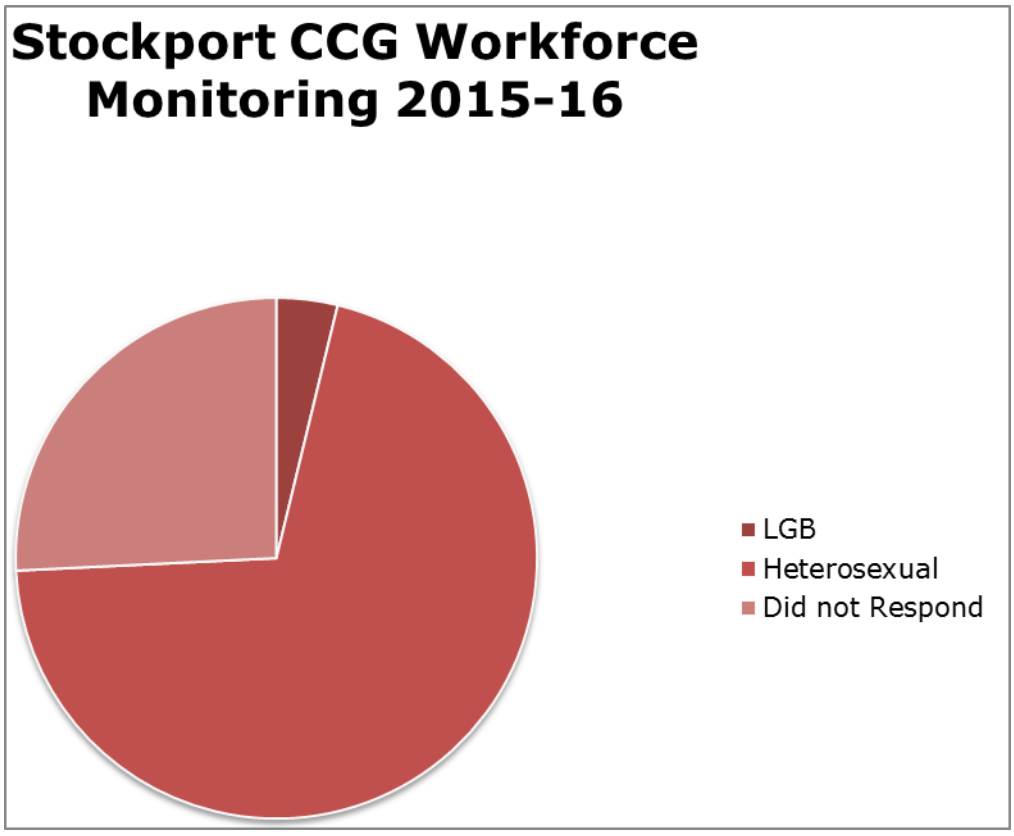
6. Working Status and Out at Work

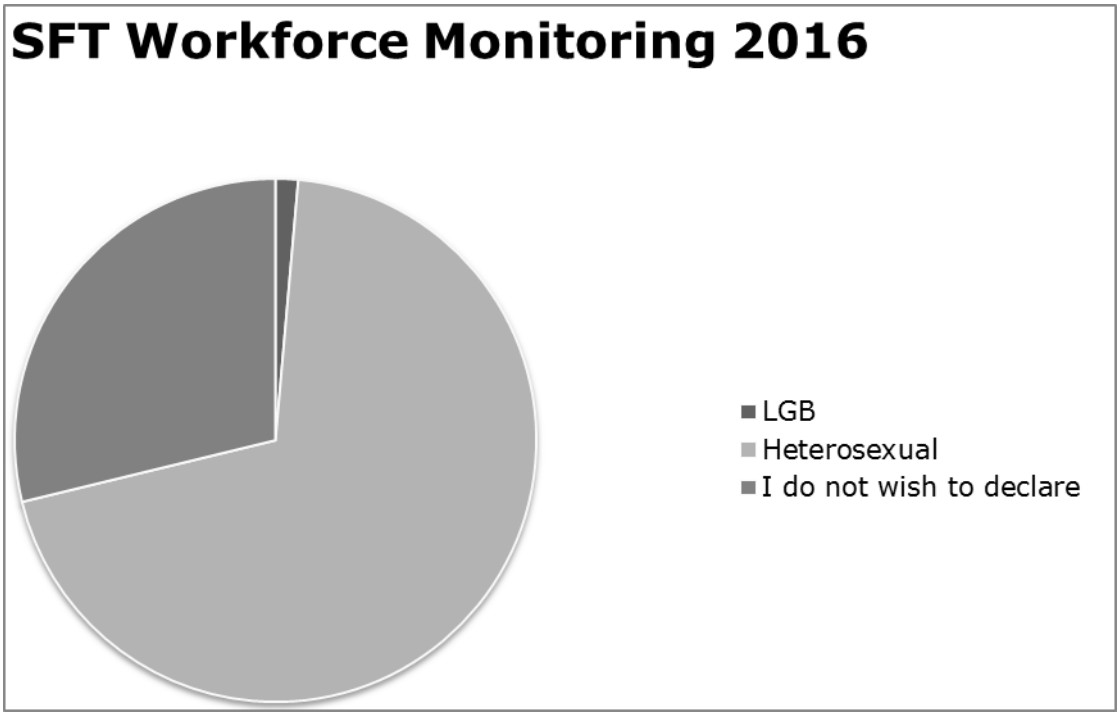
6.1. Staff monitoring in the Local Authority and Stockport Foundation Trust

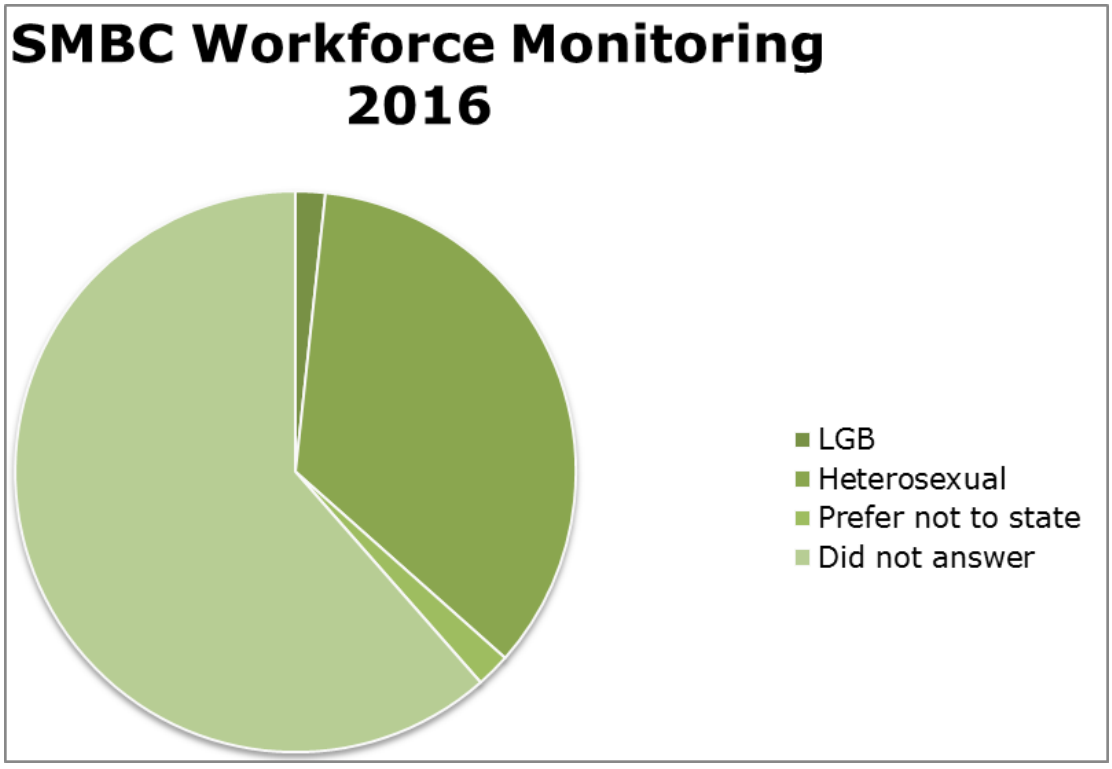
Establishing the percentage of the population that is LGBT is important in ensuring that public services are appropriately commissioned and meet the needs of LGBT groups. It is also helpful to establish the percentage of Stockport's LGBT population in employment. It would be useful to determine whether the large public sector employers in the city reflect the local population. This is important in terms of ensuring that the local services are welcoming places to work and also for the public to feel that their services reflect the whole community.

Data from Stockport CCG, Stockport NHS Foundation Trust (SFT) and Stockport Metropolitan Borough Council (SMBC) indicate that internal sexual orientation, gender identity and trans status monitoring within these workforces elicited a large rate of data withheld. This indicates that there is a need to explain to staff why this information is requested and how it may be to the benefit of all staff to answer, so that HR policies can reflect the needs of a diverse workforce, or the recruitment policy can be examined in relation to the local population, and so that equality of opportunity within the workplace can be established and evidenced. This information should be given alongside supporting and empowering LGBT staff to have the choice to be open about their sexual orientation, gender identity and trans status without concerns of negative repercussions, including through structures like LGBT staff networks.

Work to inform staff of the reasons for sexual orientation, gender identity and trans status monitoring within SFT and SMBC. As the largest public service employers in Stockport, work should be undertaken to improve the understanding of the percentage of the workforce who are lesbian, gay, bisexual and trans. The percentage of LGBT staff should then be publicised.




SFT Workforce Monitoring 2016
LGB
Heterosexual
I do not wish to declare


SMBC Workforce Monitoring 2016
LGB
Heterosexual
Prefer not to state
Did not answer

In workforce surveys for SFT, Stockport CCG and SMBC Council there is a high rate of non-response to SOM; particularly at SMBC. Public sector employers should improve the sexual orientation monitoring of their staff.

7. Sexual orientation, gender identity and trans status monitoring

7.1. Rationale for monitoring

As evidenced by the discussion above, it is difficult to establish the size of the national or local population which identifies as LGBT. This difficulty impacts on the understanding of the extent of health inequalities, and whether there are inequalities between the LGBT sub-groups. Routine collection of data about patient / service user sexual orientation, gender identity and trans status would give health care commissioners and providers data they need to more accurately evaluate the quality of health care that LGBT people receive, and help tailor services and devise interventions to reduce inequalities in outcomes.

Public sector organisations have a duty under the Equality Act 2010 to take into account the needs of people with protected characteristics when designing and delivering services. Sexual orientation and gender reassignment are two of the nine protected characteristics, and monitoring them provides a way to evidence taking into account and subsequently meeting the specific needs of this population group. For the purposes of the Act, the term gender reassignment encompasses anyone who has transitioned, come out as trans, or expressed an intention to transition, thus including anyone who has gone through a process of legal or medical transition such as deed poll, hormone replacement therapy, or Gender Recognition Certificate; non-binary people, who have expressed that their gender identity differs from the sex they were assigned at birth; and anyone who has undergone any aspect of a social transition, including using a different name and changing gender presentation.

7.2. Benefits of Monitoring

Benefits of ensuring sexual orientation, gender identity, and trans status monitoring is carried out are expected to be for service users, staff, and public sector organisations. Routine collection of data about patient sexual orientation, gender identity, and trans status would give health and social care providers, commissioners and researchers the data they need to more accurately evaluate the quality of service provision that LGBT people receive, and help them devise population-wide strategies to reduce health inequalities. Collecting data about sexual orientation, gender identity and trans status can also help foster discussion between patients and clinicians or service users and care providers that will result in more accurate

health promotion messages, assessments of health risks, and care tailored to the patient.

7.3. Best Practice on Monitoring

Information on sexual orientation, gender identity and trans status should be collected along with other population characteristics, such as ethnicity. As with ethnicity, sexual orientation, gender identity, and trans status is a matter of self-definition.

Barriers to good monitoring reported from the view point of service users include fears about the use data could be put to, concerns about confidentiality and also about how the disclosure will affect the attitudes of staff and the level of service which will be received, meaning that the introduction of monitoring should take place alongside training for staff to help them understand the rationale for monitoring, and cultural competency and awareness training. LGBT Foundation have published a guide to sexual orientation monitoring, a briefing sheet on gender identity and trans status monitoring, and a clinical rationale for monitoring within health and social care services[24].

National LGBT organisations have published information for LGBT people to increase the understanding of the benefits of monitoring within the LGBT community. Examples include Stonewall's *What's it got to do with you?* (2009) and LGBT Foundation's *Why you need to tick the box* (2013b).

Monitoring of staff is also important for organisations as it helps to recognise the diversity within the workforce and helps to support staff appropriately. This should help to maximise satisfaction and employee retention and ensure equality of opportunity.

'I went to Specsavers and they asked me about sexuality but the girl apologised for asking and seemed really shocked when I said lesbian.'

Sexual orientation monitoring should be undertaken by all services. Staff will need training so that they understand the monitoring is important to enable provision to address the needs of the LGBT population and ensure that the service is addressing health inequalities. As long as LGBT people continue to be invisible, they are at continued risk of poorer outcomes.

[24] Available: http://lgbt.foundation/policy-research/sexual-orientation-monitoring/

8. Sexual Health

The majority of adults in the UK are sexually active, and good sexual health is an important component of overall health. Individuals need age-appropriate education, information and support to help them make informed and responsible decisions to maintain their sexual health[25]. Together, STIs and HIV represent a burden on health services and on individuals. In Stockport, the burden of STIs continues to be greatest in young people, men who have sex with men (MSM), and black communities[26]. The highest STI diagnosis rates in England are in young people aged 15-24 years.

Responses should include improving early detection, treatment and prevention through promotion of safer sex initiatives and reducing the barriers to comprehensive sexual healthcare. As well as the absence of disease, good sexual health includes forming and maintaining emotionally healthy sexual relationships. This should be remembered as the context for services.

8.1. Stockport Sexual and Reproductive Health Profile 2016

The 2016 Stockport Sexual and Reproductive Health Profile[27] noted that over the past decade, diagnoses of gonorrhoea, syphilis, and genital herpes have increased considerably in England, most notably in men, while diagnoses of genital warts have decreased in women. Since the full scale implementation of the National Chlamydia Screening Programme (NCSP) in 2008, diagnosis rates of chlamydia have also increased in men and women. More STI testing in sexual health clinics (SHCs) and through the NCSP with routine use of more sensitive diagnostic tests, such as nucleic acid amplification tests (NAATs), will partly explain these increases in the early part of the decade, although access to comprehensive sex education, provision of safer sex supplies such as condoms and dental dams, and sexual risk-taking will also have played a role.

The number of STI diagnoses in MSM has risen sharply in England in recent years. Gonorrhoea is the most commonly diagnosed STI among MSM. High levels of gonorrhoea transmission are of particular concern given the emergence of gonococcal resistance. The outbreak of high-level azithromycin resistant gonorrhoea persists (Azithromycin is one of the antimicrobials used for treatment) and as of August 2016, there were a total

[25] Department of Health. 2013. A Framework for Sexual Health Improvement in England. Available: https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
[26] Public Health England. 2015. *Stockport Local Authority HIV, sexual and reproductive health epidemiology report (LASER).* Prepared by Field Epidemiology Services, National Infection Service and the PHE LASER Working Group
[27] Ibid

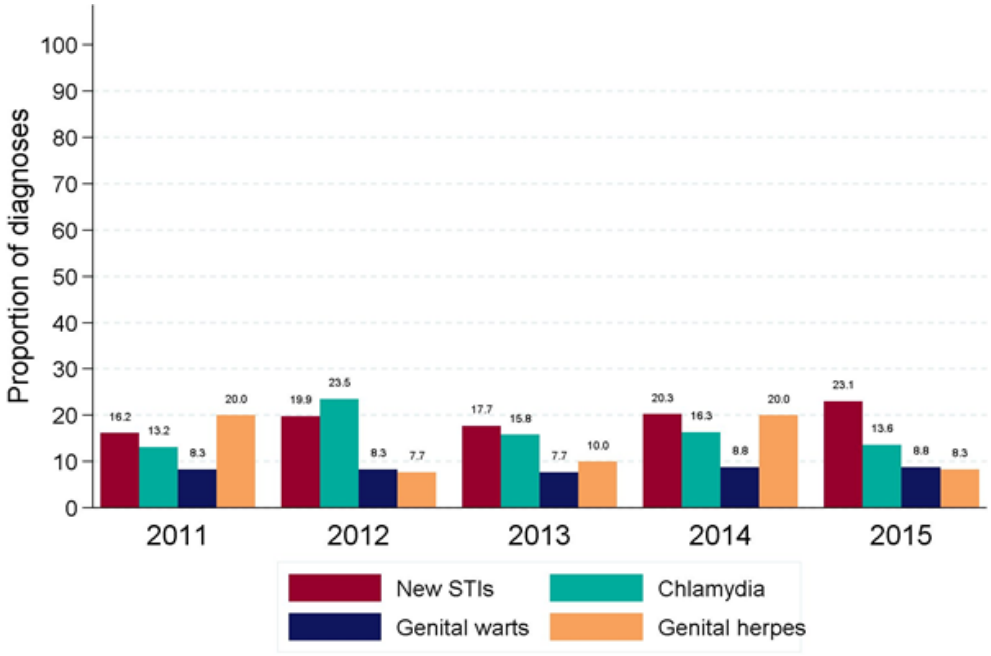
of 48 confirmed cases. Cases have been geographically dispersed throughout England and found in all sexual networks, including MSM, women who have sex with women (WSW) and heterosexuals. The first documented global case of treatment failure with first-line dual therapy was reported recently in the UK.

Several factors may have contributed to the sharp rise in diagnoses among MSM including condomless sex and Chemsex; the use of recreational drugs during sex. Increased screening of extra-genital (rectal and pharyngeal) sites in MSM using NAATs will also have improved detection of gonococcal and chlamydial infections, although this will have had less impact in recent years as these developments have become more established.

As STIs are often asymptomatic, frequent testing of high risk groups is important. Early detection and treatment can reduce important long-term consequences, such as infertility and ectopic pregnancy.

While vaccination is a measure that can be used to control genital warts and hepatitis B, control of other STIs relies on consistent and correct condom use, ensuring good access to testing and treatment, ensuring that sexual risk is reduced by increasing access to safer sex provisions and ensuring partners of cases are notified and tested.

8.2. Men who have Sex with Men



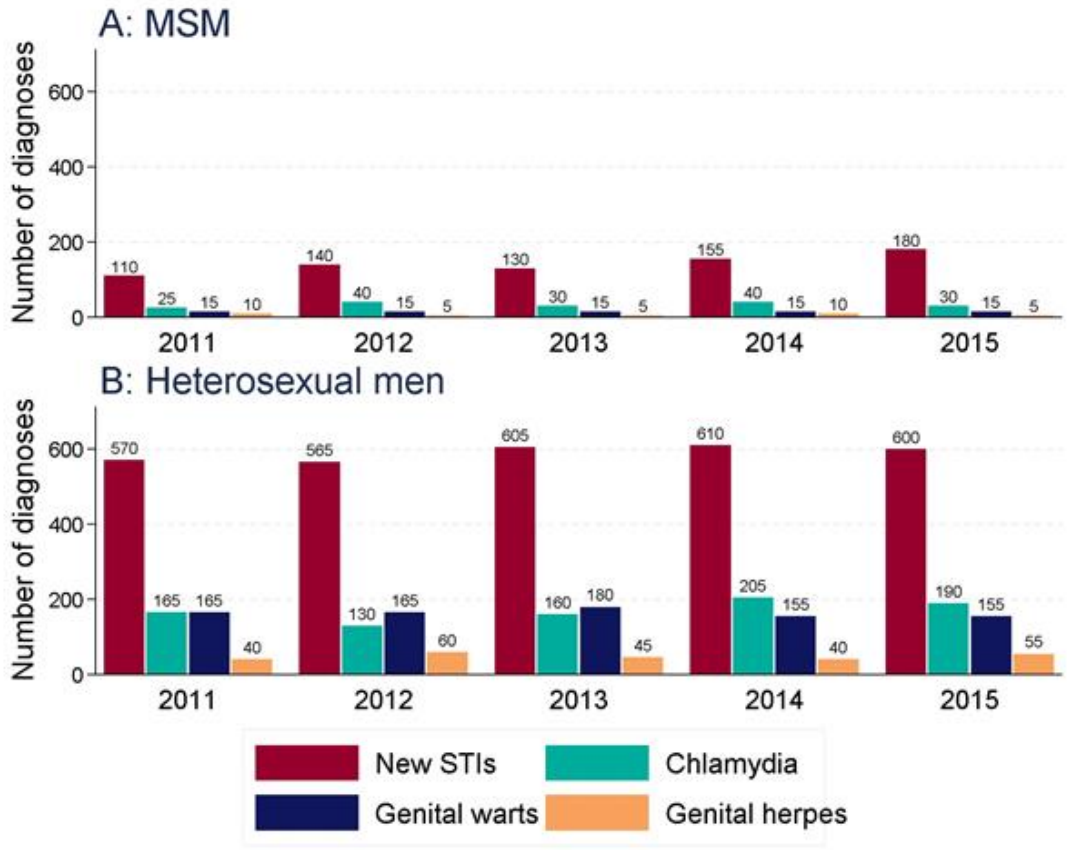
Source: Data from specialist sexual health clinics
Excludes chlamydia diagnoses made outside specialist SHCs
For cases in men with known information on sexual orientation
See Figure 5 for denominator
*Please note that to prevent deductive disclosure the number of STI diagnoses in this figure has been rounded up to the nearest 5

Figure 5: Number* of new STI diagnoses in MSM and heterosexual men in Stockport 2011-2015

In Stockport in 2015, for cases in men where sexual orientation was known, 23.1% (n=180 – number rounded up to the nearest five) of new STIs were among MSM. In 2011, the proportion of new STIs among MSM was 16.2% (n=110 – number rounded up to the nearest five).

Unfortunately the data for prevalence of cases of syphilis and gonorrhoea among LGB people in Stockport is unavailable, potentially due to small numbers of infections but likely due to inconsistent monitoring of sexual orientation within sexual health services. In England, 70% of gonorrhoea cases and 84% of syphilis cases were in MSM in 2016.

The needs of trans men who are gay, bisexual, or have sex with men are rarely incorporated within programmes or services targeted towards gay, bisexual, and other MSM, despite evidence to suggest significant risk of HIV infection and high rates of unprotected receptive genital sex within this group.[28]



Source: Data from specialist sexual health clinics
Excludes chlamydia diagnoses made outside specialist SHCs
*Please note that to prevent deductive disclosure the number of STI diagnoses in this figure has been rounded up to the nearest 5

[28] Stafford, L. 2017. *Transforming Outcomes: a review of the needs and assets of the trans community. LGBT Foundation*. Available: http://lgbt.foundation/assets/_files/documents/may_17/FENT__1493978351_TransformingOutcomesLGBTFdn.pdf

8.3. Women who have Sex with Women

A 2011 study in the North West of England found that 37% of Women who have sex with women (WSW) had been told they did not need a cervical screening due to their sexual orientation.[29] Research undertaken by the LGB&T Partnership in 2016 reported 57% of WSW had a negative experience at a sexual health clinic in the previous six months. Many respondents anecdotally expressed a lack of knowledge among sexual health professionals in terms of the specific health needs of WSW and a lack of representation in literature.

A common theme surrounding the negative experiences of WSW is the assumption of heterosexuality. One UK survey found that two in five lesbian and bisexual women reported that healthcare practitioners had assumed that they were heterosexual and this had resulted in their specific needs not being met[30]. A study published in 2010 reported that heteronormative assumptions most routinely occur in relation to sexual history taking, contraception, and cervical screening.[31]

The Beyond Babies and Breast Cancer report identified that despite the fact that the majority of WSW engage in sexual practices which place them at risk of STI transmission, very few use barrier protection (such as dental dams) and that 40% of women who exclusively had female partners who attended GUM clinics were diagnosed with an STI, compared to 18.5% of women who had sex with men.[32]

8.4. Trans people

There are severe limitations on available evidence regarding the prevalence of HIV and STIs in trans communities. This is due to a combination of factors, including a lack of comprehensive data on HIV prevalence in the UK, mostly composed of small samples of convenience that rarely use actual test results; and a lack of monitoring of trans status within sexual health services in England. As a result, most of the data regarding sexual health in trans communities is small in sample sizes or not UK-based.

Research into sexual practices of trans people suggests that STI prevalence would be greater than the general population[33] and estimates based on US research

[29] Light, B. & Ormandy, P. 2011. *Lesbian, Gay & Bisexual Women in the North West: A Multi-Method Study of Cervical Screening Attitudes, Experiences and Uptake.* University of Salford & The Lesbian and Gay Foundation. Available: http://lgbt.foundation/policy-research/cervical-screening-the-north-west-research/

[30] Hunt, R. and Fish, J. 2008. Prescription for Change. Stonewall. Available: https://www.stonewall.org.uk/sites/default/files/Prescription_for_Change__2008_.pdf

[31] Fish, J. and Bewley, S. 2010. *Using human rights-based approaches to conceptualise lesbian and bisexual women's health inequalities* in Health and Social care in the Community 18 (4) pp. 355 - 362

[32] LGBT Foundation. 2016. *Beyond Babies and Breast Cancer: expanding our understanding of women's health needs*. Available: http://lgbt.foundation/womenshealth?fp

[33] Stafford, L. 2017. *Transforming Outcomes: a review of the needs and assets of the trans community*. LGBT Foundation. Available:

indicate that trans people may be up to four times more likely to be living with HIV than the general population[34]. A Canadian study found that just under 70% of trans men are at low/moderate risk of HIV infection, while only 30% of trans women are at low/moderate risk.[35]

Anecdotal evidence suggests that sex work is likely to be more prevalent within this population group, although there is a lack of evidence into the size of the trans population engaging in sex work in the UK. It is thought that barriers to other forms of employment coupled with costs associated with private healthcare could lead to some individuals finding alternative employment through sex work.[36] This is significant because evidence suggests that trans women sex workers face a prevalence of HIV that is up to 9 times higher than cis women sex workers, and at least 34 times higher risk than that faced by the general population in the USA.[37]

Trans people face specific barriers to accessing sexual health services; a survey by the Scottish Transgender Alliance unearthed a prevalent belief within trans communities that mainstream sexual health services will struggle to accommodate trans people due to these services being delivered in very gendered ways, for example having separate male and female waiting and clinic areas[38]. However, the same survey noted a dissonance between perceptions of NHS services and actual experiences, with many participants praising the non-judgemental nature of services whilst simultaneously recognising that their specific needs were not always accounted for.

8.5. HIV

In their 2016 HIV in the UK report, Public Health England note that an estimated 101,200 people across the UK were living with HIV in 2015. MSM and black African communities are the population groups most affected by HIV infection. A large proportion of infections are acquired sexually, while the number of infections acquired through injecting drug use and mother-to-child transmission remains low.

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http://lgbt.foundation/assets/_files/documents/may_17/FENT__1493978351_TransformingOutcomesLGBTFdn.pdf

[34] Grant, J. 2010. *National Transgender Discrimination Survey Report on Health and Health Care*. Available: http://www.thetaskforce.org/static_html/downloads/resources_and_tools/ntds_report_on_health.pdf

[35] Bauer, G.R., Travers, R., Scanlon, K. & Coleman, T. 2012. H*igh heterogeneity of HIV-related sexual risk among transgender people in Ontario, Canada: a province-wide respondent-driven sampling survey* in BMC Public Health, 12(1). Available: http://transpulseproject.ca/research/ high-heterogeneity-of-hiv-related-sexual-risk-among-transgender-people-in-ontario-canada-a- province-wide-respondent-driven-sampling-survey/

[36] Action for Trans Health. 2016. *Sex Work*. Available: http://actionfortranshealth.org.uk/ resources/for-trans-people/sex-work/

[37] UNAIDS. 2014. *The Gap Report*. Available: http://les.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

[38] Morton, J. 2008. *Transgender Experiences in Scotland.* Scottish Transgender Alliance. Available: http://www.scottishtrans.org/wp-content/uploads/2013/03/staexperiencessummary03082.pdf

It is estimated that 13% of people living with HIV are unaware of their infection. The number of people living with diagnosed HIV infection has continued to increase in England, while the number of new HIV diagnoses remains stable at around 6,000 per year in recent years. People diagnosed with HIV late have a ten-fold increased risk of death in the year following diagnosis compared to those diagnosed promptly.[39]

Those living with HIV appear to be at elevated risk of diseases of the cardiovascular system, kidneys, and liver; cognitive function; malignancies; and metabolic bone disease. Certain infections continue to be a significant cause of co-morbidities for people living with HIV, including viral hepatitis and HPV.[40] In late-stage HIV infection, the weakened immune system means the body is more vulnerable to life-threatening conditions such as pneumonia and cancer. For many individuals, having HIV means living with a long-term condition which requires management and medical support. For services, HIV represents a significant cost burden

People living with HIV can expect a near normal life span if they are diagnosed promptly and receive treatment. People diagnosed with HIV late continue to have a tenfold increased risk of death in the year following diagnosis compared to those diagnosed promptly[41].

In 2015, the diagnosed HIV prevalence rate in Stockport was 1.3 per 1,000 population aged 15-59 years, compared to 2.3 per 1,000 in England. 20% of the middle super output areas (MSOAs) in this local authority had a prevalence rate higher than 2 per 1,000 (Figure 9).

In 2015, 248 residents in Stockport received HIV-related care: 200 (number rounded up to nearest 5) males and 55 (number rounded up to nearest 5) females. This represents a 29.2% change from 2011 to 2015. Among these, 75.0% were white, 17.3% black African and 1.9% black Caribbean. With regards to exposure, it is estimated that 62.7% acquired their infection through sex between men and 29.4% through sex between men and women (Table 7).

[39] Public Health England. 2016. *HIV in the UK Report*. Available: http://www.judahtrust.org/HIV_in_the_UK_2016.pdf

[40] Friis-Moller, N. et al. 2003. *Cardiovascular disease risk factors in HIV patients association with antiretroviral therapy: results from the DAD study* in AIDS Vol17 (8) pp. 1179-1193

[41] Harris, J. et al. 2015. *HIV & AIDS in Cumbria and Lancashire 2014.* Centre for Public Health, Liverpool John Moores University. Available: http://www.cph.org.uk/wp-content/uploads/2015/12/Full-report_CL_final_cover.pdf

		2011	% 2011	2015	% 2015
Ethnicity	White	140	68.3	195	75.0
	Black African	45	22.0	45	17.3
	Black Caribbean	5	2.4	5	1.9
	Other	15	7.3	15	5.8
	Not known	0	0.0	0	0.0
Probable route of infection	Sex between men	120	60.0	160	62.7
	Sex between men and women	65	32.5	75	29.4
	Injecting drug use	5	2.5	5	2.0
	Other/Not known	10	5.0	15	5.9
Total	Actual total	192		248	

Source: HIV and AIDS Reporting System (HARS)

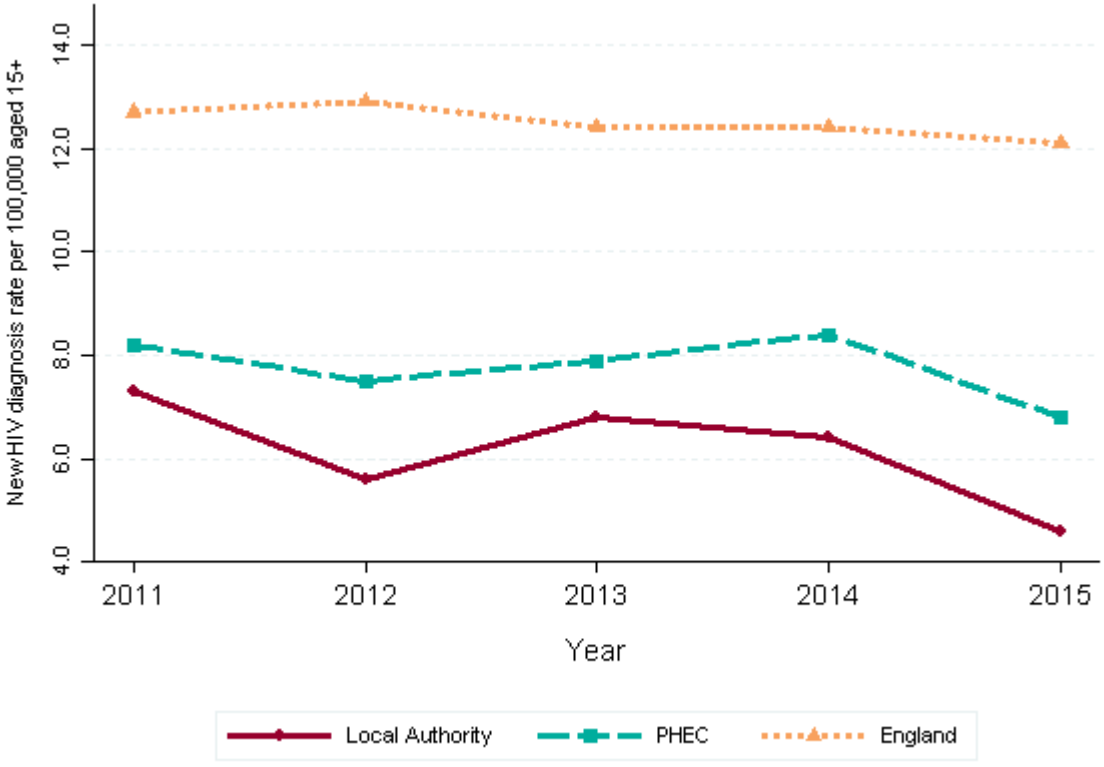
* Please note to prevent deductive disclosure the number of people living with diagnosed HIV has been rounded up. Numbers from 0-4 are rounded to 5 and thereafter rounded up to the nearest 5. Therefore, the totals, as they have not been rounded, may not equal the sum of their parts.

Please note the rounding of the underlying numbers will distort the percentages especially for those local authorities with small numbers of cases. As a result this table will only be meaningful for local authorities with large numbers of cases.

Table 7. Number* of people living with diagnosed HIV by ethnicity and exposure group in Stockport: 2011 and 2015

In England, of those diagnosed with HIV infection in 2015, 79% had residence information available. Where residence information was available in 2015, 11 adult residents of Stockport were newly diagnosed with HIV. The rate of new HIV diagnosis per 100,000 population among people aged 15 or above in Stockport was 4.6, compared to 12.1 in England.

Unfortunately due to limitations of data collection it is not possible to present a break-down of new HIV diagnoses by route of transmission within Stockport in this report. In England in 2015, 48% of new HIV diagnoses were in MSM, 15% in male heterosexuals, 19% in female heterosexuals; 53% of new HIV diagnoses were in white and 20% in black African populations.



Source: The new HIV and AIDS reporting system (HARS)

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a critical component of the Public Health Outcomes Framework and monitoring is essential to evaluate the success of local HIV testing efforts.

In Stockport, between 2013 and 2015, 37.1% (95% CI 21.5-55.1) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm^3 within 3 months of diagnosis) compared to 40% (95% CI 39-41) in England. 32.0% (95% CI 14.9-53.5) of MSM and 50.0% (95% CI 18.7-81.3) of heterosexuals were diagnosed late.

In 2015, HIV tests were offered at 63.1% of eligible attendances at specialist sexual health clinics among residents of Stockport and, where offered HIV tests were accepted at 72.0% of these attendances.

Nationally, an HIV test was offered at 80.4% of eligible attendances at specialist SHC and, where offered, an HIV test was done in 76.2% of these attendances. Among MSM an HIV test was offered at 86.2% of specialist sexual health clinic attendances, of which 93.4% had an HIV test.

In 2015, among specialist sexual health clinic patients from Stockport who were eligible to be tested for HIV, around half (51.1%) were tested. Nationally, 67.3% of specialist sexual health clinic patients who were eligible to be tested for HIV were tested.

Reductions in undiagnosed infections can be achieved through increasing testing coverage in STI clinics, and through the introduction and consolidation of HIV testing in a variety of different medical settings such as GP practices, in addition to further development of community testing, including self-sampling/self-testing, and testing and targeted interventions delivered from community resource centres.

'Manchester's [sexual health services] are really good, and the LGBT Foundation's, but Stockport's are really bad now there is no longer a walk in centre'.

In Stockport, STI prevalence continues to be greatest in young people, men who have sex with men, and black communities. As STIs are often asymptomatic, frequent testing of high risk groups is important.

Access to sexual health services should be improved for LGBT people in Stockport.

It is recommended that sexual health clinics in Stockport increase the number of people tested for HIV.

There is a lack of robust information regarding the sexual health of women who have sex with women and trans people within Stockport.

9. Lifestyle risk factors

9.1. Smoking

A significant body of evidence suggests that LGBT people are likely to experience a range of health inequalities. A notable contributing factor is the higher prevalence of smoking amongst this population group. Smoking is a significant risk factor for many different cancer types and two in three smokers will die from smoking related diseases[42]. The latest data from the IHS shows that 25.3% of people who describe themselves as gay or lesbian are smokers, compared to 18.4% of individuals who describe themselves as straight. While the evidence base is slightly weaker around the smoking habits of bisexual and trans people, existing data suggests that these communities are also more likely to smoke than the straight and cisgender populations.

Despite this, a lack of sufficient sexual orientation, gender identity and trans status monitoring results in an incomplete picture when trying to identify the rates of LGBT people using existing smoking cessation services. Similarly, many cancer services are routinely failing to ask patients about their sexual orientation or trans status as they would record other protected characteristics. With better monitoring in place it would be easier to research smoking behaviours for this population, as well as the impact on health and interactions with other determinants. At the moment the consequences of increased rates of smoking and the effectiveness of treatments and therapies for this community remain largely hidden and unrecognised.

Anecdotal evidence in research conducted as part of the LGBT Cancer Support Alliance's Proud 2B Smokefree report suggests that the LGBT community continues to be the subject of targeted marketing by tobacco companies through events such as Prides. With a few exceptions (e.g. the Smoking Cessation Service at UHSM), the local picture in Greater Manchester is one of traditional smoking cessation services being curtailed or cut.[43]

The report predominately associates sustained smoking behaviours with socialising and holding significant relationships with other smokers, as well as finding a less pronounced association with flirting, cruising and sex, and identifying social context and stress as specific triggers for smoking for LGBT people.

The 2012 Stockport Adult Lifestyle Survey found that 14.9% of respondents currently smoke. This finding falls below other estimates for smoking rates in Stockport which suggest a current smoking rate of around 19%. This may be explained due to self-reported smoking rates being lower than those reported through other measures.

[42] Banks, E. et al. 2015. *Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence* in BMC Medicine Vol 13 (38)
[43] Heyworth, B. et al. 2017. P*roud 2B Smokefree*. LGBT Cancer Support Alliance. Available: https://issuu.com/lgbtcancersupportalliance/docs/proud2bsmokefree_final_pdf_for_onli

The survey also found that women are less likely to be smokers or ex-smokers than men and that the smoking rate for men in Stockport is almost 50% higher than that for women, though this does not differentiate between the experiences of GBT men, LBT women, and non-binary people who for the purposes of survey data collected about men and women may be subsumed into one of those categories or prevented from taking part altogether.

Rates of smoking decline with age and are lowest for those over 70. However there is significant prevalence of non smokers in the 18-24 age group. Young adults in Stockport who are in not good health are significantly more likely to smoke than average; the smoking rate rises to over 30% in this group. A literature review with a particular focus on the needs of young LGBT people revealed that LGBT young people are more susceptible than their heterosexual peers to cancers and poor physical health outcomes partly owing to negative health behaviours such as smoking, drug use, inadequate dietary intake and alcohol misuse[44]. Given the health inequalities and society-wide discrimination faced by LGBT young people and the correlations between discrimination and poorer self-reporting of good health, we can expect many LGBT young people in Stockport to fall within this 30%.

There is a strong deprivation profile, with smoking rates significantly higher in the two most deprived quintiles and significantly lower in the two least deprived quintiles. Though Stockport has one of the lower smoking rates in Greater Manchester, the deprivation profile is steeper than in other boroughs. Smoking rates in the most deprived areas again are likely to be higher than 30%. Correlations between unemployment, underemployment, and depravation in LGBT communities mean they are more likely to be represented within this profile[45], with 37% of trans people in receipt of out of work benefits[46].

Just over half (55%) of Stockport's smokers report than no-one regularly smokes in their home, for non smokers the rate is even higher at 95%. Smokers who live with children are less likely to smoke in their own home than those living without children.

[44] *ManchesterJoint Strategic Needs Assessment for LGBT Young People*. Available: https://www.theproudtrust.org/resources/research-and-guidance/manchester-joint-strategic-needs-assessment-lgbt-young-people/

[45] European Union Agency for Fundamental Rights. 2013. *European Union Lesbian, Gay, Bisexual and Transgender Survey: results at a glance*

[46] Stafford, L. 2017. *Transforming Outcomes: a review of the needs and assets of the trans community.* LGBT Foundation.

Smoking and Sexual Orientation

Sexual Orientation	Sample size	Current smokers	Ex smokers	Non smokers
Heterosexual	6185	14.8%	17.9%	67.3%
Not heterosexual	170	20.6%	14.7%	64.7%
Prefer not to say	159	13.2%	16.4%	70.4%

	Never smoked		Former smoker		Occasional smoker		Regular smoker	
Heterosexual or Straight	92%	411,046	94%	208,514	91%	52,610	91%	67,726
Gay or Lesbian	1%	5,881	1%	3,143	2%	1,414	3%	1,941
Bisexual	1%	3,166	1%	1,305	2%	921	1%	876
Other	1%	3,489	0%	948	1%	424	1%	540
Prefer not to say	5%	24,088	3%	7,057	4%	2,575	4%	3,089

GP Patient Survey 2016 All England

Women in Stockport are less likely to be smokers or ex-smokers than men with the smoking rate for men in Stockport being almost 50% higher than that for women.

Young adults in Stockport who are in not good health are significantly more likely to smoke than average; the smoking rate rises to over 30% in this group.

Local targets should be set for reducing smoking for youths and GBM. Services will need to improve their understanding of smoking triggers and motivations to quit within these groups.

9.2. Drugs and Alcohol

The Stockport Adult Lifestyle Survey 2012 found that a fifth of respondents reported that they do not drink alcohol at all, a level slightly lower than that reported in 2009. 29.8% of respondents disclosed that they drank within the daily guidelines over the last week though 18.9% disclosed binge drinking on the day they drank most in the previous week.

2.9% of respondents consumed a high risk amount of alcohol over the previous week, a level below that reported in 2009; a further 16.9% drank at increasing risk levels, slightly below the level in the previous survey. There is a degree of overlap between the daily and weekly alcohol categories. Most of the respondents who were high or increasing risk drinkers also binge drank or drank over the daily guideline. However 8.7% of the respondents who drank, binge drank on the day they drank most but did not exceed the weekly guideline. A study into LGB people's drug and

alcohol use in England between 2009-2014 found that LGB people were approximately twice as likely to binge drink compared to the general population[47]. A national survey found that 62% of trans people may be drinking harmful amounts[48].

Links between drinking and deprivation in Stockport are not clear and demonstrate trends that appear to different to those seen for other lifestyle behaviours and in other geographical locations; the 2012 Stockport Adult Lifestyle Survey revealed more non-drinkers in the most deprived areas and levels of unhealthy drinking that were not significantly higher than wealthy areas. This contrasts with other national research indicating higher rates of binge drinking in deprived communities, as well as local data indicating significantly higher rates of alcohol related hospital admissions in deprived areas.

Those who were drinking unhealthy amounts of alcohol and were classed as both binge drinkers and high risk drinkers only identified their drinking as harmful to their health in 35% of cases, and a further 41.1% identified that their drinking was probably harmful.

This survey found LGB people were slightly more likely to binge drink than heterosexual people. Those who preferred not to state their sexual orientation are more likely to be non-drinkers which may relate to their older age profile.

Binge Drinking and Sexual Orientation

Sexual Orientation	Sample size	Binged	Over daily guideline	Drank within daily guideline	Didn't drink last week	Non drinker
Heterosexual	6188	19.3%	23.6%	30.0%	7.0%	20.2%
Not heterosexual	168	22.6%	22.0%	29.2%	1.8% L	24.4%
Prefer not to say	158	9.5% L	15.8%	27.8%	4.4%	42.4% H

The Stockport Adult Lifestyle Survey 2012 found that LGB people were more likely to binge drink than heterosexuals, though due to small numbers the findings are not statistically significant.

The Part of the Picture report found that across all age groups, LGB people are much more likely to have used drugs in the last month compared to the general population[49]. Over a fifth of the survey sample scored as dependent on a substance,

[47] UCLan & LGF. 2014. *Part of the Picture: lesbian, gay, and bisexual people's alcohol and drug use in England: Briefing Sheet for Researchers.* Available: http://lgbt.foundation/policy-research/part-of-the-picture/

[48] McNeil, J. et al. 2012. *Trans Mental Health Study*

[49] UCLan & LGF. 2014.

with a further quarter demonstrating at least one indicator of substance dependency on the Diagnostic and Statistical Manual of Health Disorders (DSM) and the International Classification of Diseases (ICD- 10) compatible screening questionnaire for harmful substance use and dependence.

Trans people also appear to be more likely to partake in use of illegal drugs, although the current picture is unclear; a Northern Ireland study in 2012 found that 53% of trans people had used an illegal drug in the last year compared to 37% of LGBT people in general and 7% of the population as a whole[50], while a national survey found that 24% of trans people had used drugs in the past year compared to 8.9% of the population of England and Wales. The difference between these figures cannot be explained by geographical focus alone, and indicates that more research needs to be undertaken to clarify exact figures. However, despite discrepancies in figures, a clear picture of higher rates of drug use within LGBT, and particularly trans, communities emerges. Research indicates not only that men and women have different patterns of drug use, but also that non-binary and agender people exhibit distinct patterns of drug use, with higher rates of cocaine use than men or women alongside higher rates of ecstasy and poppers use than women[51].

"I drink to make myself feel better and cope with anxiety; stuff happening in my life is stressful right now. I have no support from my family and I am in a lot of debt and I could get chucked out of my accommodation at any moment. I am really worried about my drinking because I am on the waiting list to see a doctor at the Gender Identity Clinic, if I tell my GP that I am drinking so much they might not let me access the treatment I need."

LGB people have higher rates of alcohol dependency and binge drinking than the general population, and, unlike heterosexual people, there are high rates of problematic drinking in middle age.

Stockport data however, contrasts against these findings and shows no significant differences between LGB and heterosexual populations. The data also revealed more nondrinkers in the most deprived areas of Stockport which contrasts local data indicating significantly higher rates of alcohol related hospital admissions in deprived areas.

[50] Rooney, E. 2012. *All Partied Out? Substance Use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community*. The Rainbow Project.
[51] Ibid

9.3. Obesity

The 2012 Stockport Adult Lifestyle Survey found no significant differences in obesity, overweight or normal weight between non heterosexual groups and the overall Stockport figure, either considered separately or together. LGB people were found to be significantly more likely to be underweight than the Stockport average. Although the numbers of LGB respondents are low, it would appear that this propensity towards low weight is driven by gay men and bisexual people. It is not known if there are differences in behaviour between bisexual men, woman and non-binary people in Stockport from this data.

Obesity and Sexual Orientation

Sexual Orientation	Sample size	Obese	Over-weight	Normal weight	Under-weight
Heterosexual	6019	16.3%	35.3%	46.5%	1.8%
Not heterosexual	156	10.9%	36.5%	45.5%	7.1%H
Prefer not to say	148	16.2%	33.8%	47.3%	2.7%

This correlates to the national picture; 44% of gay and bisexual men are overweight or obese compared to 70% of men in general. National LGBT research has found higher prevalence of eating disorders within LGBT communities, with 1 in 5 LB women self-reporting an eating disorder compared with 1 in 20 straight women, 20% of GB men being diagnosed with anorexia, 11% with bulimia and 40% with binge eating, and evidence that eating disorders are more prevalent among bisexual people of all genders[52].

Those who identified themselves as LGB were significantly less likely to be active five times a week or more.

Physical Activity and Sexual Orientation

Sexual Orientation	Sample size	Less than once a week	1-2 times a week	3-4 times a week	5 times a week or more
Heterosexual	6164	16.9%	24.5%	31.8%	26.8%

[52] Williams, H. et al. 2016. *The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Document*. National LGB&T Partnership. Available: http://lgbt.foundation/assets/_files/documents/jul_16/FENT__1469789610_PHOF_LGB&T_Companion_2016_FINA.pdf

Not heterosexual	167	20.4%	28.7%	32.3%	18.6%L
Prefer not to say	159	23.3%	25.8%	28.3%	22.6%

The Survey of Exercise & Physical Activity in LGB&T Lives in England found that 55% of LGBT men were not active enough to maintain good health compared with 33% of men in the general population, that 56% of LGBT women were not active enough to maintain good health compared with 45% of women in the general population, and that 64% of non-binary people were not active enough to maintain good health[53]. The survey also found that though LGBT people are less likely than the general population to meet PHE's physical activity guidelines, they are also less likely than the general population to be completely inactive.

The Stockport Adult Lifestyle 2012 survey found those who self-identify as LGB or prefer not to say are slightly more likely to eat zero portions of fruit or vegetables per day and that LGB people are less likely to eat 5+ portions of fruit or vegetables per day, though this finding is not statistically significant.

Portions of Fruit/Vegetables and Sexual Orientation

Sexual Orientation	**Sample size**	**0**	**1**	**2**	**3**	**4**	**5+**
Heterosexual	6202	1.7%	9.1%	20.5%	29.4%	21.2%	18.1%
Not heterosexual	170	4.1%	9.4%	20.0%	30.0%	21.2%	15.3%
Prefer not to say	160	4.4%	7.5%	25.6%	28.8%	15.6%	18.1%

Nationally in 2012, 13% of LGB people said they eat the recommended five or more portions of fruit and vegetables daily. This compares to 25% of men and 27% of women in the general population who meet the '5-a-day' recommendation according to the 2010 Health Survey for England.[54]

[53]LGB&T Partnership. 2012. *The Survey of Exercise & Physical Activity in LGB&T Lives in England.* Available: https://nationallgbtpartnershipdotorg.files.wordpress.com/2016/02/lgbt-people-and-physical-activity-what-you-need-to-know.pdf

[54] The Lesbian & Gay Foundation. 2012. *I Exist: UK Findings.* Available: http://lgbt.foundation/policy-research/i-exist-survey-research-into-LGB-needs-and-experiences/

Gay and bisexual men are more likely to be underweight than the Stockport average.

36.5% of LGB people within Stockport are overweight; this mirrors the national average of 44% gay and bisexual men being overweight.

LGBT people have reduced access to exercise and are more likely to eat zero portions of fruits and vegetables per day.

10. Long-term conditions and disability

10.1 Disability and LGBT people

There is a lack of data on the health inequalities experienced by disabled LGBT people and less still that is peer reviewed. However, there exists a range of literature detailing the additional barriers faced by LGBT disabled people to expressing their sexual orientation and gender identity within health and social care services, and the challenges of having their LGBT identity supported and validated by carers.

Indications from national reports suggest disabled LGBT people experience dual and compounded health inequalities, including discrimination from within LGBT communities due to negative attitudes towards disabled people that exist across wider society also being prevalent in these. Such discrimination may impact negatively on disabled LGBT people's mental health.[55]

Stonewall reports that disabled LGB people are more likely to have experienced domestic abuse and attempted suicide and self-harmed in the last year than LGB people in general[56].

A YouGov survey of older people found that 23% of LGB people had an impairment or long-term condition that limited their daily activities in some way. These individuals showed less likelihood of accessing services they needed than heterosexual over 55s:

- 37% LGB disabled people vs 28% heterosexual disabled people did not access health services they needed
- 23% LGB disabled people vs 6% heterosexual disabled people did not access mental health services they needed

[55] 23 Blyth C. 2010. *Coming out of the shadows* in Learning Disability Today pp. 14-16
[56] Guasp, A. & Taylor, J. 2012. *Stonewall Disability Health Briefing*. Available: http://www.stonewall.org.uk/sites/default/files/Disability_Stonewall_Health_Briefing__2012_.pdf

- 19% LGB disabled people vs 10% heterosexual disabled people did not access social care service[57]

The Stonewall Disability Health Briefing found that LGB people were more likely to live alone without support from wider family, so would be more reliant on services. This cohort had less confidence that their needs would be understood by services due to lack of awareness about their sexual orientation and impairment/s. Consequently, disabled LGB people are less likely to access the services they need than disabled heterosexual people.

There are indications that there are higher numbers of trans disabled people compared to the national average. One large survey found that 58% of the 848 respondents were disabled[58], though another found the figure only slightly higher than the national average[59]. Many smaller surveys find higher numbers of disabled trans people than the national average[60] [61], indicating that there is likely a higher prevalence within this population group.

Anecdotal evidence suggests higher prevalence of autism within the trans community, particularly among non-binary individuals[62]. A 2015 report found that disabled non-binary people's needs were particularly not well met by specialist gender identity services, and recommended these services undertook an impact assessment to understand how to better meet the needs of this population group[63].

10.2. Disability and long-term conditions in Stockport

In Stockport there is very little data on outcomes and disease prevalence among the LGBT population. This means no robust conclusions can be made. However, the inequalities in lifestyle risk factors reported in this needs assessment indicate that there are likely to be increased incidence of long-term conditions for this population.

The GP Patient survey for 2016 shows data on sexual orientation and long-term health conditions. This shows that in Stockport, lesbian women and men describing their sexual orientations as 'other' have a higher prevalence of long term conditions. Though a lot of data is lacking due to low numbers of respondents, this indicates that approximately 2% of people with long-term health conditions in Stockport are LGB;

[57] Varney, J. 2013. *Minorities within Minorities: the evidence base relating to minority groups within the LGB&T community.* Available: http://lgbt.foundation/policy-research/PHOF/
[58] McNeil, J. et al. 2012. Trans Mental Health Study.
[59] Ibid
[60] Hill, A. & Condon, R. 2015. *Brighton & Hove Trans Needs Assessment 2015*. Brighton & Hove City Council
[61] Morton, J. 2008. *Transgender Experiences in Scotland*. Scottish Transgender Alliance.
[62] Rudacille, D. 2016. *Living Between Genders* in Spectrum News. Available: https://spectrumnews.org/features/deep-dive/living-between-genders/
[63] Bradley, J. et al. 2015. *Falling Through the Cracks: Non-binary people's experiences of transition related healthcare.* Action for Trans Health. Available: http://actionfortranshealth.org.uk/wp-content/uploads/2015/11/Falling-through-the-cracks-final-with-cover.pdf

with this number most likely being higher due to the 3% who did not declare their sexual orientation. As this survey does not monitor trans status, we cannot extrapolate the approximate number of disabled trans Stockport residents.

'Do you have a long-term health condition?'

	Heterosexual or Straight				Gay or Lesbian				Bisexual				Other				Prefer not to say			
	Male		Female		Male		Female		Male		Female		Male		Female		Male		Female	
	-		-		-		-		-		-		-		-		-		-	
Yes	53%	1,038	52%	1,093	36%	16	60%	14	*	*	*	*	92%	17	*	*	56%	37	57%	32
No	45%	876	46%	952	64%	28	*	*	*	*	*	*	*	*	*	*	35%	23	38%	21
Don't know / can't say	2%	47	2%	42	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*

There is a lack of robust information on the incidence of disability or most long-term conditions for LGBT people in Stockport.

Evidence suggests that trans people may be more likely to be disabled compared to the general population.

People who are disabled or have long-term conditions may be LGBT and their needs should be considered holistically.

11. Black, Asian, and Minority Ethnic (BAME) LGBT People

11.1. BAME People in Stockport

Stockport is overall less ethnically diverse than the general population, with 92% of the population identifying themselves as white in the 2011 census compared to 86% nationally. However, Stockport is diversifying over time, with the number of BAME residents almost doubling between the 2001 and 2011 census. Currently the largest BAME group within Stockport is the Asian Pakistani community.

The majority of BAME people in Stockport live in Heald Green, Cheadle & Gatley, and Heatons South. In each of these areas there are particularly high numbers of people who self-identify as Asian Pakistani or Indian, and the total BAME population in these wards is almost 20%. These areas are also those with higher than average rates of people whose religion is Muslim; 50% of Muslims in Stockport live in one of these three wards. Gatley also has a community of Jewish residents.

The age patterns of Stockport's BAME populations are also different, with a far younger profile than average. 20% of babies born in Stockport in 2013-14 were BAME, as were almost 50% in Heald Green and Cheadle & Gatley. The population is therefore likely to continue to become more diverse, which should be reflected in the forthcoming 2021 census.

11.2. The BAME LGBT population

A review of the UK Longitudinal Lifestyle Survey found that ethnic minorities are more likely to self-identify their sexual orientation as 'other' or select a 'prefer not to say' option compared to general population[64].

Research conducted within Manchester found that within BAME communities overall there was a higher prevalence of people who self-identified as bisexual compared to those who identified as gay or lesbian; 23% of Asian women described themselves as bisexual compared to 16% of white women and 8% of black women, while 13% black men, 10% of Asian men and 10% of mixed and other ethnicity men described themselves as bisexual compared to 7% of white men[65].

The two largest surveys that monitored the ethnicity of trans people in the UK had strikingly similar results when identifying underrepresentation of BAME trans people; 13% of people in the UK overall identify themselves as non-white British compared to 6% and 2.5% of trans people[66]. It is unlikely that BAME people are less likely to be trans and more likely, given the limitations on capturing the size of the trans population UK-wide, that BAME trans people are being underrepresented in research at present.

11.3. Intersectionality

Research indicates that the disproportionate health inequalities experienced by LGB people are likely to be exacerbated for BAME LGB people, who experience stigma and discrimination in relation to both sexual orientation and ethnicity. The Manchester research found that while services do often consider the needs of BAME groups and LGB groups, the intersectionality of identities is not always considered in service provision, meaning that the specific needs of those who are both BAME and LGB can remain hidden and thus unmet[67], as targeted interventions or services focused at one of these communities can end up overlooking those who stand at the intersection of both.

The Longitudinal Lifestyle Survey research found that BAME LGBT respondents were very likely to experience material disadvantage such as poverty, being behind on bill payments, and being in receipt of benefits[68].

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[64] Uhrig, SCN. 2014. *An Examination of Poverty and Sexual Orientation in the UK*. University of Essex. Available: https://www.iser.essex.ac.uk/publications/working-papers/iser/2014-02.pdf

[65] LGBT Foundation and Manchester City Council. 2016. *The State of the City for Manchester's Black and Ethnic Minority Lesbian, Gay and Bisexual People*. Available: http://lgbt.foundation/bmelgb/

[66] Whittle, S. et al. 2007. *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*. Press for Change. Available: http://www.pfc.org.uk/pdf/EngenderedPenalties.pdf

[67] LGBT Foundation and Manchester City Council. 2016. *The State of the City for Manchester's Black and Ethnic Minority Lesbian, Gay and Bisexual People*.

[68] Uhrig, SCN. 2014. *An Examination of Poverty and Sexual Orientation in the UK*. University of Essex.

While data on the specific experiences of BAME LGBT people is limited, available evidence indicates that those who experience stigma and discrimination in relation to both sexual orientation and ethnicity demonstrate higher prevalence of poor mental health; higher incidence of HIV among MSM; higher prevalence of substance use; and are at higher risk of violence and hate crime. Research shows that 26% of BAME lesbian and bisexual women deliberately harmed themselves in the last year compared to 1 in 5 lesbian and bisexual women in general and compared to 0.4 per cent of the general population, one third of BAME lesbian and bisexual women currently smoke compared to a quarter of lesbian and bisexual women in general, and 55% of BAME 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 50% of gay and bisexual men and 17% of men in general.[69]

A focus group held in Manchester with Rainbow Noir, a support and social group for queer people of colour, found that some participants had experienced positive reactions to coming out as LGB in the BAME community, and felt that there often were assumptions made that these communities would be homophobic. Other participants were selectively not out to some family members because they held homophobic or strongly religious beliefs; it was felt that religion plays a role in the acceptability of LGB identities[70].

11.4. Refugees and Asylum Seekers

Stockport has a low population of refugees and asylum seekers compared with other areas of Greater Manchester. However, LGBT refugees and asylum seekers often experience specific marginalisation due to a combination of their minority sexual orientation and/or gender identity, ethnicity and immigration status. Research by UK Lesbian and Gay Immigration Group and Stonewall found that LGBT asylum seekers face discrimination in detention centres both from other detainees and staff, and that detention centres have serious negative effects on the mental health of those detained, including exacerbating or triggering depression, self-harm and suicide attempts. Trans detainees report being placed in detention centres of the wrong gender and being placed at additional risk by having to use communal showers and bedrooms. Many LGBT asylum seekers find it very difficult to settle back into society after detention and feel excluded from both LGBT and diaspora communities[71]. Thus, due attention must be paid to the specific health needs of LGBT asylum seekers and refugees.

[69] LGBT Foundation and Manchester City Council. 2016. *The State of the City for Manchester's Black and Ethnic Minority Lesbian, Gay and Bisexual People*.
[70] Ibid
[71] Bachmann, C. L. 2016. *No Safe Refuge: Experiences of LGBT Asylum Seekers in Detention*. UKLGIG and Stonewall. Available: https://www.stonewall.org.uk/sites/default/files/no_safe_refuge.pdf

"As a gay woman of colour, it was a double jeopardy to identify openly because being a homosexual was seen as a taboo where I was born and grew up. I know it was difficult to come out, but it was important for my psychological well-being and integrating my sexual orientation into my life.

I have had difficulties even in the UK when I have decided to come out. I have been identified as a lesbian in various African communities and had homophobic comments made at me by my own people. A few years ago I was a victim of hate crime when I was physically assaulted by a woman who I believe was of the same country of origin as me."

Members of BAME groups can also be LGBT. There is minimal local data for Stockport on this.

Staff and services need to be aware of this and appropriately conduct ethnicity, sexual orientation, gender identity and trans status monitoring in tandem and use this data to inform and improve services. Services should improve their knowledge of local communities and the needs of BAME LGBT individuals.

A future needs assessment for Stockport's BAME population should include consideration of LGBT people.

12. Trans People

There exists a lack of local and national research into trans communities, with a lack of comprehensive and system wide trans status monitoring meaning that the specific needs of this community, on a national and local level, are often not well evidenced.

A 2017 assessment of the needs and experiences of trans people in the UK identified several key areas where trans people experience significant inequalities and substantial barriers, including reduced access to mainstream health and social care services; inequality within specialist gender identity services; poorer mental health; poorer social wellbeing, increased drug and alcohol use; and poorer overall health[72].

In 2016 Manchester City Council embarked on a series of consultations and engagement activities with local trans people and their organisations in order to improve its own data and to explore the prevailing issues and opportunities

[72] Stafford, L. 2017. *Transforming Outcomes: a review of the needs and assets of the trans community*. LGBT Foundation.

experienced by Manchester's trans population. Through this consultation, a number of thematic areas emerged which have a significant impact on the lives of trans people. These are: Young People and Education, Health, Housing, and Domestic Violence[73]. A significant proportion of trans people had experienced transphobic bullying or discrimination, with participants also acknowledging high rates of homelessness, low levels of good health, and high prevalence of domestic abuse.

It is likely that the themes and findings unearthed in national and local research will correspond to the experiences of Stockport's trans population.

'I've been trying to get my GP to refer me to the gender identity clinic for 10 years. She finally referred me a few months ago to Leeds. I don't know why Leeds, I asked to be referred to London as their waiting list is shorter.'

There is currently a lack of data regarding the trans population of Stockport.

Trans people appear to experience some of the poorest health outcomes and encounter the greatest stigma, including frequent harassment and violence.

Many trans people cannot avoid healthcare services as much of this population require medical intervention, and GP practices, drug and alcohol services and domestic violence services especially should increase their knowledge of this segment of the LGBT community.

13. Bisexual People

Although bisexual people are part of the LGBT community, they may experience suspicion and biphobia from gay and lesbian people as much as from heterosexual people. A 2014 briefing by a Bi support group estimates that two thirds of bisexual people do not interact with LGBT organisations[74]. This may mean that surveys commissioned by LGBT organisations capture only a section of bisexual people with unknown consequences for the results. This has been described as the 'silent B in LGBT' with few specific recommendations for practitioners, or unique identified needs for this group being shared publicly by LGBT advocacy and support organisations.

[73] Manchester City Council. 2016. *Research Study into the Trans Population of Manchester*. Available: http://www.manchester.gov.uk/downloads/download/6603/research_study_into_the_trans_population_of_manchester

[74] BiPhoria. 2014. *Getting Bi in a Gay/Straight World*. Available: https://issuu.com/biphoria/docs/getting_bi_web_2014_a6

There are likely to be needs shared by bisexual people of all genders while there may be other needs that are best identified in gender-specific groups of bisexual men, bisexual women, (which may or may not be suitable to be grouped with gay and lesbian men and woman respectively) and non-binary bisexual people.

In much of the literature cited in this review, analysis does not separate gay from bisexual men or lesbian from bisexual women, thus dimensions of difference in needs and outcomes may be lost.

The poorer mental health evident for LGB people compared to heterosexual people appears to be distinctly worse for bisexual people. A systematic review found that self-report of a long-standing psychological or emotional problem in the 2009-10 GP Patient Survey showed that self-reported presence of a longstanding psychological or emotional condition varied markedly between LGB people and heterosexual people, with bisexual people having distinctly poorer outcomes than heterosexual people or gay or lesbian men and women[75].

Findings from the GP Patient Survey for July 2012-March 2013 show the different incidence of long-term mental illness between women with differing sexual orientations, finding a higher rate for bisexual women than either lesbian or heterosexual women[76]. Mental health services in particular should pay due regard to the needs of this population group.

The data presented here suggests bisexual people have some of the poorest mental health outcomes within the LGBT population.

Mental health services should ensure all staff receive cultural competency training and are confident to work with bisexual service users.

The difference in outcomes for bisexual people compared to gay and lesbian people is not well explored and should be considered within service delivery in Stockport.

[75] Elliott, M. N. et al. 2014. *Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey*. Available: http://www.ilga-europe.org/sites/default/files/sexual_minorities_in_england_have_poorer_health_and_worse_health_care_experiences_a_national_survey.pdf

[76] The Lesbian & Gay Foundation. 2014. *Community Safety: The State of the City for Manchester's Lesbian, Gay and Bisexual Communities*.

14. Older LGBT People

Older LGBT people will have had life experience of different social and legal conditions and will have come of age in a time when their sexual orientation was more socially marginalised and stigmatised, and potentially criminalised.

A YouGov poll commissioned by Stonewall sampled more than a thousand LGB people aged 55 plus, along with a similar sized sample of heterosexual people, providing a comparison group[77]. LGB people were more likely to ever have had a diagnosis of depression, with 40% LGB people being diagnosed compared to 33% heterosexual people, or to have had a diagnosis of anxiety, with 33% of LB women being diagnosed compared to 26% heterosexual women. Depression differences were most marked between GB men (34%) and heterosexual men (17%). The findings noted increased concern about future mental health for older LGB people.

Older LGB people in this survey were more likely to be single and live alone than older heterosexual people. The difference was greatest for men, with 40% of GB men living alone compared to 15% of heterosexual men. 30% of LB women lived alone compared to 26% of heterosexual women. Overall, 41% of LGB people over 55 live alone compared to 20% of heterosexual over 55s. LGB people over 55 were identified as having less family support and were almost twice as likely to expect to rely on health and social care services, GPs, and paid help as they aged compared to the heterosexual control group. However, LGB people voiced concern about how these services were likely to react to their sexual orientation and expressed discomfort at disclosing this.

Research in Manchester revealed that very few trans people had made plans for their care in times of serious illness or old age, yet there were common concerns about not being able to access appropriate care that would be trans-friendly[78].

Focus groups held with older LGBT people in Manchester in 2014 found that many respondents were experiencing daily struggles with isolation, loneliness, and complex health problems[79], and these struggles are likely to be true of older LGBT people across Greater Manchester, including in Stockport.

A Marie Curie report into the experiences of end of life care for LGBT people identified significant research gaps, particularly around the needs of LGBT people

[77] Guasp, A. 2011. *Lesbian, Gay and Bisexual People in Later Life*. Stonewall.
[78] Manchester City Council. 2016. *Research Study into the Trans Population of Manchester*.
[79] LGBT Foundation. 2015. *The State of the City for Manchester's Lesbian, Gay, and Bisexual Communities.*

living with and dying from diseases other than cancer, the issues faced by bisexual people, and the issues faced by trans people[80].

'I discuss my partner at the GP and they are fine, very non-judgemental. My partner is out there too, we're two old ladies but they've never been surprised at all!'

Nationally, LGB people over 55 have poorer mental health, are more likely to live alone and have greater reliance on services than heterosexual counterparts. They also have concern that services do not account for their sexual orientation.

As younger people are more likely to identify as LGBT age, in the future we will see increased numbers of LGBT people needing LGBT-affirmative adult social care.

There is a lack of data regarding older bisexual and trans people particularly.

Trans communities are fearful of adult social care and end of life care.

15. Domestic Abuse

Domestic abuse or intimate partner violence (IPV) is recognised as having a negative impact on health, physical and mental. This effect may be long-standing. Often framed as violence by men against women, it is increasingly recognised that IPV can be perpetrated by women against men and within same-sex relationships of either gender.

A systematic review and meta analysis of studies, while acknowledging weaknesses in the research findings, identified that MSM who experienced IPV had increased odds of substance use, living with HIV, reporting symptoms of depression, and engagement in unprotected anal sex. Perpetrators of IPV had increased odds of substance misuse[81].

The Prescription for Change survey found that one in four LB women experienced domestic abuse - a similar rate to heterosexual women. In the qualitative comments from respondents it was noted that services are set up with the presumption that

[80] Marie Curie. 2016. *Hiding Who I Am: the reality of end of life care for LGBT people*. Available: https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2016/reality-end-of-life-care-lgbt-people.pdf

[81] Buller, A. M. et al. 2014. *Associations between intimate partner violence and health among men who have sex with men: a systematic review and meta-analysis* in PLOS medicine Vol. 11(3)

those experiencing domestic violence are heterosexual women. Comments identified that women could sometimes be interviewed by police in the presence of the female perpetrator, under the assumption that she was a friend or there for support. Women-only refuges may not appear as places of safety if the perpetrator of violence is a woman.[82] Broken Rainbow, a former charity dedicated to supporting the LGBT victims of domestic violence and abuse called for services to recognise that LB women also experience domestic abuse.

The threat of being 'outed', for example unwillingly having one's LGBT identity disclosed to family members or work colleagues, is a form of psychological abuse that is specific to LGBT people.

Research into domestic abuse within trans communities has found that trans people are more likely to experience domestic abuse compared to the general population, and that trans people often have unique experiences of domestic violence intertwined with both their trans status and transphobia from others. Trans people are at greatest risk of domestic abuse after coming out to a partner, and telling a partner of their intent to transition. Transphobia, transmisogyny (the cultural violence and discrimination towards trans women and trans and gender non-conforming people on the feminine end of the gender spectrum), services not being equipped to support trans people, small social support networks, fear and distrust of police, fear of being 'outed', and barriers to accessing services (for example, the gendered nature of refuges and support services), all act as compounding difficulties for trans people experiencing domestic abuse[83].

It has been noted that across Greater Manchester, the sexual orientation and trans status of victims or perpetrators of crime is not consistently monitored, limiting the development of preventative interventions around hate crime or LGBT domestic violence[84].

Those in same sex relationships are as likely to experience domestic violence as those who are not.

Trans people are more likely to experience domestic violence and face specific forms of abuse related to transphobia.

Mainstream services are often unaware of the needs of LGBT people who experience domestic abuse.

82

Hunt, R. & Fish, J. 2008. *Prescription for Change: Lesbian and bisexual women's health check*. Stonewall.

83 83 Stafford, L. 2017. *Transforming Outcomes: a review of the needs and assets of the trans community*. LGBT Foundation.

84 The Lesbian & Gay Foundation. 2014. *Community Safety: The State of the City for Manchester's Lesbian, Gay and Bisexual Communities*.

17. Focus Group

Stockport PLUS is a vibrant and diverse social group for the LGBT population of Stockport that meets monthly in the Arden Arms Pub. Staff from Stockport Foundation Trust and LGBT Foundation attended a monthly meeting and held a focus group with attendees about their experiences of health and social care in Stockport.

17.1 Demographics of participants

23 people attended the session and took part in the focus group. Of those, 5 identified as women and 18 identified as men. 2 participants identified as having a gender that was different to the one they were given at birth; these participants will be referred to as trans. 4 participants identified as lesbian, 16 identified as gay, and 3 identified as bisexual. The age range of participants was between 19 and 68. The mean age of participants was 36 and the median age was 32. 10 participants were Asian Pakistani, 1 was Asian Bangladeshi, 9 participants were White British, and 1 was White Irish.

Although the group is aimed at LGBT people in Stockport, some participants travelled from other parts of Greater Manchester, and in one case from Burnley, to attend. Some of these individuals worked and/or used other services in Stockport and some did not. 7 participants lived in Stockport, 6 lived in Manchester, 4 in Rochdale, 3 in Bolton, 1 in Oldham, 1 in Salford and 1 in Burnley. Participants who identified as gay men from Asian Pakistani backgrounds were most likely to live outside Stockport and use services within Stockport, and those who identified as gay men and lesbians from White British and Irish backgrounds were most likely to reside in Stockport.

17.2 Health and wellbeing

Participants were told that one side of the room represented the statement ‘I feel completely in control of my own health and wellbeing’ and the other side represented the statement ‘I do not feel at all in control of my own health and wellbeing’. They were then asked to place themselves somewhere in a line between those points while considering the question ‘How in control do you feel of your own health and wellbeing?’

Participants spread themselves across the spectrum between the ‘not at all in control’ and the top third. No-one stood at the very end of the spectrum that represented the statement ‘I feel completely in control of my own health and wellbeing’.

People related their feelings of being in control to good self-management and knowledge about their own long term-conditions, and self-education about their own health through the internet. Those towards the middle of the spectrum noted that they don't always feel GPs give them the right information and advice, and disclosed using alternatives to mainstream services to have their health and social care needs met, such as using services provided by voluntary sector organisations like Mind, using services out of area, and using the internet and self-education to help them feel more in control.

Participants highlighted good sexual health services out of area, with specific mention of both mainstream and LGBT-specific sexual health services in Manchester, but felt that Stockport's sexual health services are not currently meeting their needs, especially with the reduced walk-in access; 'Manchester's are really good, and the LGBT Foundation's, but Stockport's are really bad now there is no longer a walk in centre'.

Those towards the 'not at all in control' end highlighted issues with constant changes of GPs due to high numbers of locums, and explained that this meant having to 'come out' about being LGBT to a different GP every time, which they felt increased their anxiety and reduced their continuity of care. Some participants disclosed that they would like to be more open and honest about their lives but feel there are barriers to opening up to GPs.

Those who placed themselves at the furthest point of the spectrum representing 'not at all in control' raised issues around misgendering and staff refusing to use the right name and pronouns for them despite them having deed polls and documentation in that name, lack of co-ordination between health and social care services, and lack of knowledge of staff in terms of how to meet their needs as an LGBT person.

Participants felt that staff and services having more knowledge about the specific health needs of LGBT people would help them feel more in control of their health and wellbeing.

17.3 Satisfaction with services

People were asked when they had used specific services, for example sexual health or mental health services, if those services had met their needs as an LGBT person. Where services had met their needs, they were asked the follow up question: what was done well? Where services did not meet their needs they were asked: what could be done better?

Participants shared positive experiences of mental health services in Stockport and reflected that it made them feel happy to be able to be honest and open about their lives and identities. Attendees repeatedly made mention of LGBT-specific services

and community and voluntary sector services meeting their needs where mainstream services did not, feeling very positive about being referred to LGBT specific counselling services where one participant described their experiences as ‘being made to feel like a family member’.

People felt that they had benefitted from LGBT History Month events in Stockport, noting these had raised visibility for LGBT people in the area and improved their sense of overall wellbeing as a result.

Participants overwhelmingly felt that sexual health services in Stockport were not currently meeting their needs, citing reduced access, no walk-in, lack of evening clinics, inconvenient opening times, poor signposting, and a lack of up to date information online.

One disabled LGBT participant shared very poor experiences of health and social care within Stockport, including a delayed assessment of need which left them without appropriate disability support for several months. This individual found that Disability Stockport had been supportive in helping them resolve the matter.

Participants often felt that their GPs offered ‘generic’ treatment that did not work for them as LGBT people, and instead felt that they wanted their differences to be acknowledged and accounted for. The group recommended that GPs have more education on working with LGBT patients. They also noted a lack of recognition of mental health problems by GPs, which they felt were not taken seriously compared to when they presented with physical symptoms.

Good experiences of friendly and welcoming staff in GP practices were shared, which participants characterised as positive experiences. However, it was felt that even when staff were friendly, health professionals needed to listen to patients better to fully understand their needs. Participants felt that health professionals had a lack of knowledge about how to meet the needs of trans patients particularly, and noted that there were pockets of good practice but this was often patchy; one participant reflected that their GP had been very supportive of them coming out as trans but the hospital had been very unsupportive.

Some participants raised that they had a preference for seeing clinicians of a particular gender but found this was not always made possible. In one instance, a gay male patient had been seeing a female GP that he felt very comfortable with but was then told by reception staff that she no longer felt comfortable seeing him due to his sexual orientation and discussion of sexual health needs and that he had to see a male doctor in the practice instead. Multiple participants of different genders expressed that they felt more comfortable and supported by female doctors than male doctors.

Many participants felt there should be more LGBT specific services, groups, and events in Stockport. Several had started attending the PLUS group following the closure of an LGBT youth group and expressed concern that other LGBT young people may no longer have their needs met in the area following the group's discontinuation. Many members of the former LGBT youth group had been encouraged to join mainstream youth groups after its closure, and they did not feel the mainstream groups met their needs.

17.4 Coming out

Participants were asked if they had come out to healthcare professionals, and whether they felt that had been received positively or negatively.

Many people shared positive experiences of coming out to health professionals and being accepted, with one participant noting 'I discuss my partner at the GP and they are fine, very non-judgemental. My partner is out there too, we're two old ladies but they've never been surprised at all!' People felt that it was very positive to be able to discuss being LGBT with their health professionals and have it be treated as a normal conversation.

Some participants shared experiences of being asked about sexual orientation where the health professional was obviously embarrassed to ask the question, 'I went to Specsavers and they asked me about sexuality but the girl apologised for asking and seemed really shocked when I said lesbian.'

Other participants had negative experiences of coming out to a health professional, including being asked invasive and irrelevant follow-up questions, or their disclosure being ignored altogether. One participant had come out to his GP only to have his GP tell him that he no longer wanted to see him at the practice, leaving the individual, who has a history of complex mental health issues, without access to any care or support.

Many participants did not feel confident or comfortable to come out to a health professional although they would like to. Some noted this was linked to bad demographic monitoring within services, explaining that seeing the term 'homosexual' on a form made them feel their sexual orientation was being seen as a mental illness. Others said they would feel more comfortable to be able to come out if they could see a poster in the waiting area. Participants felt that GP practices were more open to diversity than other primary or secondary care services in Stockport.

17.5 Challenging discrimination

Participants were asked if they had ever experienced homophobia, biphobia, transphobia, or discrimination from health and social care services. This was explored as a group discussion and many participants noted that they had negative experiences accessing health care that were linked to their sexual orientation or trans status but were unsure what constituted discrimination.

One participant shared that he had seen ‘homosexuality’ listed as a medical condition on his patient history while looking at the computer screen during a consultation with his GP but said that he had not felt able to challenge this though he found it upsetting. He disclosed that he was not sure whether this ‘counted’ as homophobia or not.

Participants were then asked when they felt confident to challenge discrimination, homophobia, biphobia or transphobia, or unfair treatment and what would make them feel more confident to do so.

Overwhelmingly, participants felt that they were not always able to challenge discrimination. Most participants shared negative experiences of incorrect assumptions being made about their sexual orientation or gender identity, noting that they did not always feel confident to challenge this when it happened.

The group felt that often it was difficult to complain or challenge assumptions as there was a feeling that the health professional was in control or an authority figure, which made them feel too anxious to speak up. Some people felt that it was easier to challenge stereotypes now than it had been for them in the past.

Those who had complained said that it was difficult for them to remember the correct policies and what their rights when they were experiencing discrimination, so found that it was much easier to make a complaint in writing rather than challenging a negative experience at the time.

Participants noted that the circumstances often did not empower them to be able to complain; for example it is difficult to complain if you have just had surgery and are dependent on healthcare professionals for support. One participant shared a story in which she and her partner were visiting a dying relative in hospital, noting that nurses refused to acknowledge their relationship and were very rude to them due to their sexual orientations. She explained that challenging it or making a complaint did not seem an option as it was such an upsetting and stressful time and they were both emotionally exhausted.

17.6 Quotes

'I've been trying to get my GP to refer me to the gender identity clinic for 10 years. She finally referred me a few months ago to Leeds. I don't know why Leeds, I asked to be referred to London as their waiting list is shorter.'

'I discuss my partner at the GP and they are fine, very non-judgemental. My partner is out there too, we're two old ladies but they've never been surprised at all!'

'My GP was very supportive, she listened and was very good. I said "Can I share a personal thing?" and she replied "Yes, you should trust your doctor the most!" She was great.'

'I went to Specsavers and they asked me about sexuality but the girl apologised for asking and seemed really shocked when I said lesbian.'

'Manchester's [sexual health services] are really good, and the LGBT Foundation's, but Stockport's are really bad now there is no longer a walk in centre'.
'I prefer to see female doctors as they are much more understanding than male doctors'

'The doctor said to me "you're very peculiar!" and I thought "why don't you just ask me if I'm gay?" That's obviously what he meant.'

Many LGBT people in Stockport do not feel in control of their own health and wellbeing.

LGBT people expressed that health care services would benefit from increased knowledge of their needs. People want to be open with healthcare professionals about sexual orientation and gender identity, and need services to understand why this is important to their care.

People felt that GP practices were more welcoming of diversity than hospitals.

18. LGBT Community Assets

The LGBT community of Stockport benefits from its proximity to Manchester and access to Canal Street and the Gay Village. In the focus group, many residents made mention of the LGBT specific services available in the Manchester such as sexual health services and mental health and wellbeing services, noting that they travel out of area to access services that understand their needs as LGBT people.

Stockport has its own LGBT support group, People Like Us Stockport (PLUS) and a group for the trans community of Stockport, Trans Stockport, is launching on 17th May 2017. There is also a weekly LGBT youth group. These groups run a vibrant programme of regular events, are supported by larger voluntary sector organisations and annually engage with LGBT History Month.

The engagement of LGBT people in volunteering and in groups that support their communities is a significant asset and these groups should be routinely engaged in supporting the actions of this needs assessment. At the same time, it is important to remember that there are likely to be members of LGBT groups dispersed across the city, who may not engage primarily through identity groups.

There are a number of community groups and resources in Stockport. These should be regarded as allies in working to improve the inequalities identified in this needs assessment.

Community members expressed a preference for both LGBT specific and LGBT friendly services.

Stockport should consider establishing more LGBT specific services and improving mainstream services' offer to this community of identity.

19. Conclusion

This needs assessment examines the evidence of inequalities in the health and wellbeing of LGBT people in Stockport. In order to understand the possible origins of some of these inequalities, it is helpful to understand the complexities and intersectional nature of LGBT people's lives, recognising that the health of communities is reflective of the accumulation of risks and protective factors throughout their lives. This is significantly influenced by the experiences of early life, but also by exposure to traumatic events in middle and later life such as hate crime, domestic violence, and family rejection, as well as by exposure to long-term stressors as outlined in the minority stress model.

For young LGBT people, acceptance and support from an early age and during the transition to adulthood is key to strengthening wellbeing and preventing poorer health outcomes in the long term. However, the experience of discrimination, stigma, homophobia, biphobia and transphobia, and marginalisation appear to be underlying factors in the development of later lifestyle behaviours such as smoking, alcohol and drug use, and sexual risk-taking. Negative experiences in early, middle, or later life are also likely to partially account for increased rates of poor mental wellbeing and ill health in this population group.

In recognition of the inequalities and needs identified, the following recommendations have been formulated. These should be considered by commissioners and providers of services in Stockport with the aim of improving the wellbeing and health outcomes of the LGBT people of Stockport.

18. Recommendations

Monitor sexual orientation, gender identity, and trans status

Services should monitor the sexual orientation, gender identity, and trans status of service users.

Health, social care and other staff should understand the rationale for monitoring as well as the benefits in general and to their specific service.

This data should be used to enhance our knowledge of the health of LGBT communities and to inform and improve service delivery.

Monitoring data should be used to identify sub-groups within LGBT communities with the highest support needs in Stockport.

Public sector organisations should monitor the sexual orientation, gender identity, and trans status of their staff, and provide support to enable staff to feel comfortable to be out at work by engaging in cultural competency training and establishing LGBT staff networks.

Data on the percentage of LGBT staff should be publicised.

Improve access to sexual health services

It is recommended that sexual health clinics in Stockport increase the number of people tested for HIV.

The needs of trans people and women who have sex with women should be included within mainstream sexual health services.

Specialist sexual health services or walk-in clinics for LGBT people in Stockport should be considered.

Include drug awareness and practical actions such as needle provision in contact with men likely to engage in Chemsex practices in sexual health settings, as well as giving out STI prevention messages through drug and alcohol services.

Increase LGBT cultural competency in services across Stockport

Ensure staff working in mental health services develop cultural competence to support LGBT people.

Ensure staff in alcohol and drug services develop cultural competence when working with LGBT people.

Ensure staff in domestic violence services develop cultural competence when working with LGBT people.

Continue to increase the number of pharmacies and GP, dental and optometry practices involved in Pride in Practice.

Cervical and breast cancer services should include clear information on risks for LGBT people and monitor uptake of screens by this community.

All services should work to reduce the consistently reported concern LGBT people express about poorer experiences of care due to their sexual orientation or gender identity.

Partner with voluntary and community sector organisations to improve wellbeing of LGBT people in Stockport

Evidence shows that this community of identity has less access to exercise than heterosexual and cisgender people. However, LGBT events hosted and delivered by community groups are popular and well attended throughout the city, with community members noting a link between LGBT visibility and their own wellbeing.

Swimming pools, leisure centres and sporting facilities should consider introducing LGBT sessions to enable wider access to these community facilities.

Smoking cessation and drug and alcohol services in Stockport should consider the specific needs and experiences of this population group.

Future needs assessment work

Future needs assessments conducted for Stockport should consider the needs of LGBT people.

A separate needs assessment focusing on young LGBT people should be developed. The needs assessment should be developed with staff working in schools and colleges as well as those working in youth services and sexual

health services for young people and involve a steering group of young LGBT people.