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

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January 2015
Executive Summary

Introduction
This needs assessment for the lesbian, gay, bisexual and trans people of Salford is timely. Public Health England issued strategic guidance on addressing the health inequalities of men who have sex with men in summer 2014, and the House of Lords held the first ever debate on the health of lesbian, bisexual and transgender women in December 2014.

The Equality Act 2010 protects individuals from unfair treatment and promotes a fair and more equal society. Two of the protected characteristics are sexual orientation (protecting lesbian, gay and bisexual people) and gender reassignment (protecting trans people).

A 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. This is then expected 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 because of their membership of the group.

This needs assessment considers two protected minorities: LGB people who have one of the minority sexual orientations and trans people who are individuals whose assigned sex at birth conflicts with their psychological gender.

The needs of lesbian, gay, bisexual and trans (LGBT) people in Salford have not previously been mapped in a formal process.

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

Methods
A literature review was conducted and drew together policy documents and national survey data. Local data was obtained where available. Stakeholder insight was obtained through Salford LGBT Multi-Agency Forum. The synthesis of this evidence is presented in the findings.

Findings

Population
There is no definitive national or local data on the proportion of the population which is LGBT. Using a number of sources, the estimated number of LGBT over-18’s in Salford is between 1,855 and 8,146 (although it may be higher). This is a higher proportion of the population than estimated for England as a whole, which is likely to be made up of a similar percentage of lesbian and bisexual women and a higher proportion of gay and bisexual men than nationally.

In younger age groups more individuals identify as LGBT, probably due to the increase in social acceptability of minority sexual orientation. This may account for the higher percentage of LGB people in work and lower percentage retired than for the heterosexual population of Salford. This is likely to change over time, as these individuals age, leading to an overall increase in the percentage of the population.
Salford’s highest concentration of LGBT population appears to be in the east of the city. This is likely to continue due to expected changes in housing.

Currently there is little information on the incidence of disability or most long-term conditions for LGBT people in Salford. Information on LGBT status within BME groups is also poor. Individuals who are members of more than one minority may experience compounded disadvantage, so better understanding is important to improve understanding and identify specific commissioning needs.

**Evidence of need**

There are a number of areas in which LGBT people experience greater inequality of outcome and therefore have higher needs than the general population. Some of the data is weak at a local level. However, the assumption has been made that findings at a national level are likely to hold for Salford.

Crucial to understanding both the extent of inequalities and tracking progress in addressing these is accurate monitoring of sexual orientation so that outcomes in the LGBT population can be analysed. Currently sexual orientation monitoring is not conducted routinely across services. As long as LGBT people continue to be invisible, they are at continued risk of poorer outcomes.

- LGBT people experience higher rates of poor mental health, including suicide, suicide ideation, self-harm, depression and anxiety, than for the general population nationally. Bisexual people, especially women, and trans people appear to have the poorest outcomes. The generally higher rates appear to be replicated in Salford. Addressing this will require a combination of prevention, through work addressing stigma, and culturally sensitive services which can support those with poor mental health.
- Sexually transmitted infections (STIs), including HIV, in gay and bisexual men (men who have sex with men) present a significant burden to Salford services. Gonorrhoea and Chlamydia rates are higher than the England average in this group. Rates of anal warts are higher and a national recommendation for HPV vaccination is under consideration. Uptake of STI testing is lower than nationally.
- The transmission route for two thirds of Salford’s high prevalence (nearly 5 per 1,000) of HIV is through men who have sex with men, and one third of cases were diagnosed late. There is a need for improvements in the offer and uptake of testing. People living with HIV are likely to have high support needs from services. As HIV+ individuals are living longer with HIV as a chronic condition, the integration of care will be increasingly important. A trial of PrEP (pre-exposure prophylaxis) may result in national recommendations.
- The emerging trend of sexualised drug use ‘chemsex’, is likely to be practiced by Salford men who have sex with men. This presents the possibility of increased STI and HIV transmission and drug harm.
- Uptake of sexual health screening by lesbian and bisexual women nationally has been hampered by myths that they are not at risk and is likely to affect Salford.
- LGBT people have higher rates of current smoking, problematic alcohol use and drug use. Data for Salford suggests that this is the case locally with indications that the rate for current smoking is 4% above the rate for the general population. There are some specific triggers for these behaviours within LGBT groups. Some campaigns are reported not to feel inclusive of LGBT people.
- Due to the differences in lifestyle factors, it is likely that LGB people have higher rates of cancers and may need specific risk information. There is national evidence that LBW may have mistakenly been advised that they do not need cervical or breast screening and this may affect Salford. Trans individuals also need to be included appropriately.
- There is some evidence that bisexual people have worse health outcomes in some areas than lesbian women or gay men. Trans individuals experience some of the highest inequalities in health.
outcomes. As individuals who have undergone gender reassignment age, a better understanding of their needs should emerge, although it is likely these will be varied.

- LGBT people are disproportionately affected by hate crime. The higher use of social housing, and decreased access to family support are also issues, the latter especially for older people. Domestic violence occurs in same-sex relationships, although support is rarely tailored for this.

Recognition of the needs of this population in Salford has led to initiatives such as the adoption of Pride in Practice by Salford GP practices, a Council for Voluntary Services project to monitor local surgeries, and a Greater Manchester West pilot for dedicated mental health services.

**Recommendations**

The literature and data gathered in this needs assessment underpin the following recommendations. The needs of the LGBT population should be embedded in commissioning across Salford through consideration of specific services, inclusion in all contracts and, where appropriate, through specific Key Performance Indicators. They should also be considered by provider organisations for service improvement.

The recommendations should be used to inform the development of Salford’s Equalities Strategy.

**Sexual Orientation Monitoring and report recording**

- Work towards routine sexual orientation monitoring (SOM). This will inform future commissioning and underpin reporting on uptake of services and outcomes.
  - Services working in the areas outlined in this needs assessment should be the first to adopt SOM (see full report).
  - Social care, health and other staff need training to understand the rationale for SOM and the benefits in general and to their specific service, for wellbeing and health outcomes and for service users.
  - The training should include understanding that BME and disabled individuals may also have an LGB sexual orientation or be trans.
  - Use SOM to improve the outcomes and experience of LGBT service users and clients.
  - Use SOM to identify sub-groups within LGBT with highest support needs in Salford.
  - Inform staff of the reasons for SOM within Salford City Council and SRFT and monitor staff. The overall percentage of LGBT staff should be publicised.
- Take measures to encourage the reporting of hate crime due to sexual orientation and gender identity.

**Workforce issues**

- Ensure staff working in mental health services develop cultural competence to support wellbeing in LGBT people.
- Ensure staff in alcohol and drug services develop cultural competence in working with LGBT people.
- Develop Making Every Contact Count (MECC) messages to signpost any LGBT individual to specific local LGBT support / groups as part of the referral process.
- Continue to increase the number of GP practices involved in Pride in Practice.
- Information regarding needs of trans people should be given in Pride in Practice or through a similar mechanism.
- All services should work to reduce the consistently reported concern LGBT people express about poorer experience of care due to their sexual orientation or gender identity.

**Reduction of stigma**

- Acknowledge the probable role of stigma in poorer mental health for LGBT people and ensure the issues faced by LGBT people is included with city-wide work on mental health and stigma.
Specific service recommendations

- Work to improve uptake of STI preventions and testing both for GBM and LBW.
- Consider the feasibility of implementing the recommendations of PHE ‘Halve It’, to increase HIV testing and reduce the number of people with undiagnosed HIV infection.
- Act promptly if PHE issue guidance on HPV vaccination.
- Set a local target for the gap between general rate of smoking in Salford and for Salford LGBT groups and make quit campaigns inclusive.
- 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 in drug services.
- Cervical and breast cancer services should include clear information on risks for lesbian women and monitor uptake of screens by LBW.

Future needs assessment work

- Future needs assessments conducted for Salford should consider the needs of LGBT people. In particular, the forthcoming housing needs assessment should do this.
- Conduct a separate needs assessment for LGBT youth. The needs assessment should include staff working in schools and colleges as well as youth services and sexual health services for young people on the steering group.

Abbreviations used in this document

SOM = sexual orientation monitoring
GI = Gender identity
LWHIV = living with HIV
MSM = men who have sex with men
WSW = women who have sex with women
LW= lesbian women
BW = bisexual women
LBW = lesbian and bisexual women
GM = gay men
BM = bisexual men
GBM = gay and bisexual men
MSM = men who have sex with men
T = trans people
PHE = Public Health England
DH = Department of Health
LGF = Lesbian & Gay Foundation
HCPs = Health Care Professionals
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Needs Assessment: introduction

A 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. This is then expected 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 because of their membership of the group.

The needs of lesbian, gay, bisexual and trans (LGBT) people in Salford have not previously been mapped in a formal process. As part of the work programme of the Salford Joint Strategic Needs Assessment, it was identified that a needs assessment should be conducted for these population groups. The Equalities Act 2010 has given public service providers the responsibility of ensuring that anyone who has one of the nine protected characteristics, which includes people who have a LGB sexual orientation, and people who are transgender is protected from discrimination (HM Government, 2013).

Although LGBT are often considered together, it is important to remember that there are two protected minorities included: LGB people who have one of the minority sexual orientations and trans people who are individuals whose assigned sex at birth conflicts with their psychological gender.

Scope

This needs assessment will cover the adult population, and includes LGBT people in Salford.

The initial scope for the needs assessment included the LGBT adult population 18+, and also young people, under the age of 18. In the initial stages of gathering evidence the importance of the early part of the lifecourse in the development of sexual identity was identified. This is a formative time for lifestyle patterns. The evidence suggests the potential for disruption of mental wellbeing through what appears to be the established homo (and bi/trans) phobic culture prevalent in Britain’s schools. Development of sexual identity in an atmosphere which encourages the internalisation of stigma appears to have a huge impact on LGBT individuals (PHE, 2014a,b,c). While it therefore may seem counterintuitive to suggest excluding under 18s from this needs assessment, it is recommended that a separate needs assessment be conducted for LGBT youth. Such an assessment would be strengthened by the inclusion of staff working in schools and colleges. This would be both because of their knowledge and insight about what issues could be explored, and also to create the momentum for actions resulting from a youth LGBT needs assessment. An emphasis on preventative interventions around smoking, alcohol and drugs would also be an important part of such a needs assessment.

Aim

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

Methods

1. Stakeholder input and insight

At the start of this needs assessment a meeting with officers of the Lesbian and Gay Foundation (LGF) in Manchester was held. This provided some initial thoughts on the areas in which inequalities for LGBT people are evidenced and perceived. Salford’s LGBT Multi-agency Forum (MAF) was attended. A presentation on needs assessments led to a discussion of issues which were felt to be of interest. Attendance at subsequent meetings helped keep these issues in focus through comment from representatives of Salford’s LGB groups. One session was devoted to a discussion on the needs assessment, although this was limited as there were few attendees.
During the course of the needs assessment, there were 2 relevant events held at the LGF; the launch of *Beyond Babies and Breast Cancer* (LGF, 2014a). A briefing for staff was held at Salford Royal Foundation Trust by Stonewall, with particular focus on alcohol. These were attended by the author.

2. Literature review

A search was conducted for national and local literature and for data sources. National 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 there is evidence of inequalities in health outcomes. Local data, where available, was sought to inform this picture for Salford.

In most cases, primary literature on specific conditions was not examined. Search terms on pubmed included ‘gay health’, ‘lesbian health’, ‘bisexual health’, and ‘trans health’. References were followed up in a number of instances to access more detailed information. Identification of consistent themes and repetition in conclusions and findings was sought, in order to provide a method of triangulation.

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 population, service data was requested from the Commissioning Support Unit. No data was identified at a service level where sexual orientation had been consistently recorded, so that outcomes could be analysed.

Sources identified which do include data for Salford are:

- GP Patient Survey.
- Stonewall national surveys: local level data available.
- Farsite, a database linked to all Salford GP practices which captures patient information.
- Contact with specialist commissioners or managers in specific instances.

4. Synthesis

The three strands, stakeholder insight, literature review and local data, were brought together in an iterative process to identify areas which are consistently highlighted as areas of inequalities in wellbeing and health.
Findings

Limitations
The quality of evidence used in this assessment is variable. There is little of the highest quality evidence available, such as meta-analyses or randomised controlled trials, other than in very limited areas (e.g. treatment of HIV/AIDS). A few systematic reviews exist in particular areas (e.g. King et al, 2008; Buller et al, 2014), including Mead et al (2009).

Survey data exists 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 sexual orientation data. An example of how this can be analysed is provided by Elliott et al (2014), who present comparative rates of mental wellbeing and drug use. One systematic review was discovered, which assessed national and international literature and compared it with surveys conducted in the West Midlands. As described by the authors (Mead et al, 2009), there is a lack of quality peer-reviewed studies.

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 population limits the comparative aspect of the findings.

All surveys are limited by the willingness of those surveyed to identify as LGBT. Because of the history of the legal status of same-sex/bisexual sexual orientation, older LGBT people may still not be comfortable identifying and participating in such a survey (Guasp, 2011b). LGBT individuals from many black and minority ethnic groups may also be reluctant to self-identify and to participate.

Identified needs
Comparing outcomes for LGBT people with the heterosexual population or the population in general is bedevilled by poor sexual orientation monitoring within services, nationally and locally. However there is consistency in identifying the following areas in which there are wellbeing and health inequalities for LGBT people:

- Increased rates of poor mental health, including suicide, suicide ideation, depression and self-harm.
- Higher rates of smoking, alcohol and drug use.
- Poorer sexual health.
- Increased risk of cancer, due to lifestyle behaviours and poorer uptake of screening.
- Lower satisfaction with the communication and quality of care of health care services.
- Experience of hate crime due to LGBT identity.
- Need to have sexual orientation and gender identity acknowledged in social care.

Two unifying themes are also evident. One is the impact developing a minority sexual identity or discovering a gender variant identity, and the impact on the lifecourse of individuals. The effects on health (particularly mental health) and other outcomes will vary depending on the level of support and acceptance that each individual finds during this process (PHE, 2014b, PHE, 2014c). Adolescence is a crucial period in this regard.

It is generally assumed that the development of a minority sexual identity or experiencing gender dysphoria in an environment hostile to LGBT identities has an impact on lifestyle choices, such as smoking, alcohol and drug use and on mental health (Ward et al, 2010). In part this may be due to developed sub-cultures of risky behaviour, and in part, coping mechanisms.

The other theme which appears to impact all LGBT groups is the on-going experience of discrimination, social exclusion, homophobia and hate crime due to sexual orientation or gender identification. This may impact mental health, 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. In so far as LGBT people have experienced
misunderstanding or outright homophobia from health and other services, this may act as a barrier to accessing support to improve wellbeing or health.

**Summary boxes**
Throughout this needs assessment, there are summary boxes at the end of each section. These present the most important findings within the section and indicate where evidence is the strongest.

1. **Characteristics of the population**

**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 LGB or T. The 2010 census did not include a question on sexual orientation. A generally quoted statistic is ‘between 5 and 7%’, which may derive from the Government’s 2004 impact assessment of the forthcoming Civil Partnership Act. This concluded that between 5-7% of the UK population were likely to be lesbian, gay and bisexual, based on the 2000 National Survey of Sexual Attitudes and Lifestyles (NATSAL), which asked respondents about sexual attitudes and behaviours, but not orientation, and on research from Europe and America.

More recent NATSAL data (Mercer et al, 2013) 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 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).

The national Integrated Household Survey contains information from approximately 340,000 individual respondents. In 2013, responses to the question on sexual identity, showed about 1.7% identified as GL or B, slightly increased from 2012. There was a high percentage who made no response or declined to state. Adults aged 16 to 24 were more likely to identify themselves as LGB (2.7 per cent) compared with adults aged 65 and over (0.5 per cent). It is likely that, as it is relatively recent for surveys to request sexual orientation data, there remains a level of unease with disclosure or a lack of understanding of the potential benefits of a more accurate understanding of the percentage of the population which is LGB or T. The Office of National Statistics, discussing the level of response, note that indicative analysis indicates that the characteristics of responders and non-responders to the sexual identity question are similar. The introduction of ethnic 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.
Twice as many males (1.6%) as females (0.8%) in this survey were likely to state their sexual identity as gay or lesbian.

The survey analysed responses along occupational lines showing that adults in Managerial and Professional Occupations were more likely to identify themselves as gay, lesbian or bisexual (2.2%) compared with those in either Intermediate Occupations or Routine and Manual Occupations (1.4% for both).

It is unknown how this difference may affect the information reported in Salford.

Estimations of the proportion of the population in the UK identifying as LGB T vary. The surveys noted here used differing questions and methodologies, accounting for some of the variance. The evidence suggests that the LGBT proportion of the population lies between just over 1% and 6%.

**Percentage of the population who identify as LGBT in Salford**

The Salford Health and Wellbeing Survey (2011), conducted by Ipsos Mori for Salford PCT, was constructed to capture a structured sample of Salford’s population over the age of 18. It included a sexual orientation question (none on gender identity). 2.8% percent of respondents identified as LG or B; however, the combined percentage of people who did not complete the question and those who ‘preferred not to say’ was 8%.
Farsite is a database which is linked to all Salford GP practices and captures patient information. It is searchable by read code for a number of items. Searching for sexual orientation found that 1.2% of patient records had information on sexual orientation entered (93% these were individuals recorded as heterosexual).

Reports run 25/09/14

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
<th>Percentage where orientation recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farsite population</td>
<td>251024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding of Sexual orientation record</td>
<td>3008</td>
<td>1.20</td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>2703</td>
<td>1.08</td>
<td>93</td>
</tr>
<tr>
<td>Homosexual</td>
<td>186</td>
<td>0.07</td>
<td>6</td>
</tr>
<tr>
<td>Bisexual</td>
<td>23</td>
<td>0.01</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>104</td>
<td>0.04</td>
<td></td>
</tr>
</tbody>
</table>

Mapping of the GP practices where sexual orientation was recorded is shown below.
In general, there is a higher rate of monitoring in the east of Salford. There is a wide variation between practices.

The GP patient survey is conducted across England every 6 months and has a response rate of over 900,000. It is sent to adult patients registered with a GP in England. This collects sexual orientation monitoring information as one of the characteristics and this information can be cross-tabulated with other replies. The percentage of the population of England 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 percentage of the population of LGB.

### All England GP Patient Survey, 2014

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual / straight</td>
<td>92%</td>
<td>94%</td>
</tr>
<tr>
<td>Gay / Lesbian</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>I would prefer not to say</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The results for Salford, which are a subset of this survey, show some differences from the national picture.

### Salford, GP Patient Survey, 2014

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual / straight</td>
<td>88%</td>
<td>93%</td>
</tr>
</tbody>
</table>
The percentage of LBW in Salford may be similar to the national averages, but the population of GM appears to be higher, even significantly higher. This is in line with anecdotal suggestions that the relative proximity to the centre of the city of Manchester, combined with relatively less expensive property in Salford compared to Manchester has proved attractive to gay men. It is unknown whether this apparent difference from the national picture is likely to continue.

**Population of LGBT people estimate for Salford**

Taking into consideration the evidence presented above, a calculation of the estimated number of LGBT people over the age of 18 in Salford is between 1,855 and 8,146 with the likelihood that it is at the higher end of the range. These figures were calculated excluding those who ‘prefer not to say’. This means that it is possible that the Salford LGBT population is larger than the upper limit in this estimated range.

- **Gay / Lesbian**: 6% 1%
- **Bisexual**: 1% 1%
- **Other**: *
- **I would prefer not to say**: 5% 4%

There is no definitive data on the proportion of the population which is LGBT. The estimated number of LGBT over-18’s in Salford is between 1,855 and 8,146, and likely to be at the higher end of the range or even higher. This is a higher proportion than the average for England. Within this population, there appears to be a higher proportion of GBM than nationally.

<table>
<thead>
<tr>
<th>Total population aged 18 plus (Mid year 2012 population estimate, ONS)</th>
<th>Persons</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum estimated LGBT population (using 1% of population)</td>
<td>1855</td>
<td>922</td>
<td>933</td>
</tr>
<tr>
<td>Maximum estimated LGBT population (6% of males and 2.8% females)</td>
<td>8146</td>
<td>5534</td>
<td>2612</td>
</tr>
</tbody>
</table>

2. Location of the LGBT population in Salford

People who identify as LGBT are unlikely to reside in an even distribution across the city of Salford. Data from the Salford Health and Wellbeing Survey 2011 allows the density of the population who identify as LGB to be mapped. The highest density is in Ordsall and Langworthy.
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 for Salford residents shows the distribution of civil partnerships across the city.

This map shows a more complex picture, but the highest concentrations for same-sex civil partnership are found in the east of Salford. These two maps appear to suggest similar areas where the LGB population of Salford may be concentrated.
3. Age distribution

The GP Patient Survey 2014 allows cross tabulation of sexual orientation by age band. For England as a whole, it is clear that within younger age groups there are more likely to be individuals who identify as LGBT. This is likely to reflect the history of social attitudes. Many older individuals will have lived as adults in a time when homosexuality was against the law, and also when there was greater stigma.

GP Satisfaction Survey 2014. All England

<table>
<thead>
<tr>
<th>Age Band</th>
<th>18 to 24</th>
<th>25 to 34</th>
<th>35 to 44</th>
<th>45 to 54</th>
<th>55 to 64</th>
<th>65 to 74</th>
<th>75 to 84</th>
<th>85 or over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual / straight</td>
<td>91%</td>
<td>91%</td>
<td>92%</td>
<td>93%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Gay / Lesbian</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>I would prefer not to say</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
</tr>
</tbody>
</table>

This pattern appears to be reflected in the Salford 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 2014 Salford

<table>
<thead>
<tr>
<th>Age Band</th>
<th>18 to 24</th>
<th>25 to 34</th>
<th>35 to 44</th>
<th>45 to 54</th>
<th>55 to 64</th>
<th>65 to 74</th>
<th>75 to 84</th>
<th>85 or over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual / straight</td>
<td>90%</td>
<td>87%</td>
<td>87%</td>
<td>91%</td>
<td>93%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Gay / Lesbian</td>
<td>*</td>
<td>6%</td>
<td>6%</td>
<td>4%</td>
<td>2%</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Bisexual</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>I would prefer not to say</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

Salford Health and Wellbeing Survey respondents can be analysed by age and sexual orientation. This indicates a higher number of those not stating and preferring not to say increasing at older ages. A higher percentage of respondents identify as LGB in the under 35 and 35-45 age band. This chimes with the suggestion (e.g. Guasp, 2011b) that older LGB people are wary of revealing their sexual identity. It also suggests that the identified LGB population of Salford is likely to grow over time, as individuals who are willing to identify age.

Percentage of respondents by age band and sexual orientation
(Weighted results)

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Under 35</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight (heterosexual)</td>
<td>87.0%</td>
<td>91.0%</td>
<td>91.0%</td>
<td>92.0%</td>
<td>91.0%</td>
<td>79.0%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>1.0%</td>
<td>1.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay/Lesbian</td>
<td>4.0%</td>
<td>4.0%</td>
<td>2.0%</td>
<td>1.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>3.0%</td>
<td>2.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Not stated</td>
<td>5.0%</td>
<td>2.0%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>6.0%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>
There is a higher proportion of people who identify as LGBT in younger age groups. Due to increasing social acceptance of identifying as LGBT, this is likely to change over time, as these individuals age.

4. Working status and out at work

The workplace has a significant impact on people’s health and well-being. Mental health issues are the biggest cause of work-related ill health and sickness absence. Bullying is a major contributor to work-related stress. Employers as well as individuals benefit when a workplace is supportive of mental and physical wellbeing (Equalities and Human Rights Commission, 2010). A national survey of LGBT employees’ workplace experiences found LGB people reported higher rates of being bullied and discrimination than heterosexual employees, with bisexuals reporting highest levels. (Manchester Business School, 2014).

The Salford Health and Wellbeing and Wellbeing Survey (2011) includes information on both sexual orientation and working status. This shows differences in working, retired and non-working status between the heterosexual population and LG and B respondents.

The data on working status in the survey shows a much lower level of retired people identifying as LGB. It is likely that the changing social attitudes which mean that younger people are more likely to acknowledge their LGB sexual orientation than many individuals in older age groups accounts for
some of the observed difference. It is possible that, as well as this, there may also be an effect of advice given to men in the early stages of the incidence of HIV in the UK. As they were not expected to survive, they may have been advised not to contribute to pensions and may therefore be working longer (Power et al, 2010).

**Staff monitoring in the Local Authority and Salford Royal Foundation Trust**

Establishing the percentage of the population is important to help in ensuring that public services are appropriately commissioned and meet the needs of LGBT groups. One of the areas in which this may be helpful is 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 Salford City Council and Salford Royal Foundation Trust (SRFT) indicate that internal monitoring within both these workforces elicited an extremely 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, whatever their sexual orientation, to answer, so that, for example, HR policies can reflect the needs of a diverse workforce, or the recruitment policy can be examined in relation to the local population.

![Salford City Council workforce monitoring 2013/14](image)
Work to inform staff of the reasons for Sexual Orientation monitoring within Salford City Council and SRFT as the largest public service employers in Salford should be undertaken to improve the understanding of the percentage of the workforce who give information on their sexual orientation. The percentage of LGBT staff should then be publicised.

SRFT are one of the selected NHS organisations participating in the Stonewall Health Champions for 2014/15 (http://www.healthylives.stonewall.org.uk/for-organisations/health-champions/default.aspx). This programme, funded by the Department of Health, works with 20 organisations each year and supports them with:

- Consultancy support
- A free initial needs assessment based on Stonewall health research
- Support to establish a lesbian, gay and bisexual network group for staff
- Access to NHS specific training on sexual orientation equality
- Support on an entry to the Stonewall health champions index to benchmark progress year on year
- A benchmarking meeting to identify next steps at the end of the programme

This initiative will benefit staff as well as patients. Further information will be available nearer the end in 2015.

Salford City Council LGBT staff group works to support staff within the organisation and to strengthen policies, practices and procedures. The forum was highlighted on the staff intranet in November, 2014, with a statement of support from the City Director. SCC also supports a Salford-wide multi-agency forum.
Population in the future

Where it is possible to break down data from surveys (in general) by age, this consistently shows a higher proportion of people in younger age bands identifying as LGBT.

It is likely that the proportion of the population who identify as LGBT in Salford will grow with time.

5. Sexual Orientation 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 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 Equalities Act, 2010 to take into account the needs of people with protected characteristics when designing and delivering services. Included in the 9 protected characteristics are LGB people and those who have undergone gender reassignment. Benefits of ensuring sexual orientation monitoring is carried out are expected to be for service users, staff and public sector organisations (NHS Northwest & LGF, 2011). Routine collection of data about patient sexual orientation and gender identity would give health and social care providers, commissioners and (ultimately) researchers the data they need to more accurately evaluate the quality of provision that LGBT people receive, and help them devise population-wide strategies to reduce inequalities. Collecting data about sexual orientation and gender identity 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 tailored care.

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

Barriers to good monitoring reported from the viewpoint 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. LGB groups publish information for LGB people to put monitoring in a positive context as something which can benefit people in these groups. Examples include Stonewall’s What’s it got to do with you? (2009) and LGF’s Why you need to tick the box (2013b).

Rogers (2013) considers the barriers from the point of view of clinicians, noting issues of embarrassment, lack of confidence in what they would then do with the information, and lack of time in consultations. Staff from South Manchester CCG were surveyed for their views, indicating that they would support SOM, “as long as it is clear to both patients and practitioners what the data is for and how it will be used whilst respecting patients’ privacy” (Rogers, 2013, p 17).
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.

The LGF (2014b) note that SOM of victims or perpetrators of crime is not consistent, limiting the development of preventative interventions around hate crime or LGB domestic violence.

6 Mental health and wellbeing

Mental wellbeing and good mental health is important for physical health and for generally functioning well personally and in connection with others. Its absence can mean worse outcomes for individuals in terms of health, successful work, and social functioning. It can impact on employment and therefore on income, which can have further negative effects on wellbeing and health.

The theme of poorer mental health outcomes for LGBT groups is a strong and consistent thread in the literature with a high level of evidence to support increased levels of suicide attempts and ideation and depression. A number of factors which may contribute to this have been proposed, such as homophobic bullying (current or in the past), family rejection due to sexual orientation of gender identity, harassment at work and poor responses from healthcare professionals (PHE, 2014c). An individual usually becomes aware of their sexual orientation as a young person and the attitudes of peers in school are an important influence in their experience. The stigmatised atmosphere of prevalent homophobia in schools is a large factor in the developing sense of sexual self. (PHE, 2014c) consider that these effects of stigma on MSM are ‘clear and include; internalised homophobia, leading to increased risk of depression and substance misuse’ (p16). This is likely to be evident for LBW and T as well. LGBT people who are older will have lived through a time of higher levels of homophobia and may therefore have greater effects of a lifetime of stigma on their mental wellbeing.

Mental health issues and substance misuse (including tobacco) are likely to be linked in several ways. Chemical means may be sought as alleviation for mental health difficulties. The focus of many LGBT social support networks, which may be part of what supports an individual’s wellbeing, centre around pub and club type venues which may foster substance use behaviours (Hunt & Minsky, 2006). However, alcohol and drug misuse can result in mental health problems.

A meta-analysis (King et al, 2008) revealed that the risk for depression and anxiety disorders was at least 1.5 times higher for LGB, with a two-fold excess in suicide attempts and increase in suicide ideation. Lifetime prevalence of suicide attempt was especially high in G&B&M. The authors conclude that, despite heterogeneity in the studies included and other limitations, “the consistent direction of ... findings suggests that mental health is poorer in LGB people”. Results from an analysis by sexual orientation of the 2007 Adult Psychiatric Survey, which aimed to be representative of the UK adult population living in private households, found that there were elevated levels of unhappiness, neurotic disorders overall, depressive episodes, generalised anxiety disorder, obsessive–compulsive disorder, phobic disorder, probable psychosis,
suicidal thoughts and acts, self-harm and alcohol and drug dependence for those who identified as LGBT (Chackraborty et al, 2011).

These analyses provide high-level evidence for the difference in mental health outcomes for the LGBT population. In her 2013 report on mental health, the Chief Medical Officer included in groups at risk of developing mental health problems are young LGBT people and LBGT adults (Davies, 2012).

The ‘I Exist’ surveys conducted by the LGF showed that 59% of the LGBT people surveyed in the UK had 3 or more mental health problems (56% in Greater Manchester – no percentage available for Salford due to low numbers). For older LGB people, a YouGov poll commissioned by Stonewall (Guasp, 2011b) documented the mental health issues for over 55’s, comparing LGB people with heterosexual peers. LGB people were more likely to have a history of mental ill health and concern for future mental health. 49% of over 55 LGB people worry about their mental health, compared to 37% of heterosexual over 55’s. With regard to the cumulative effect of poorer mental health over the lifecourse, 40% of LBW compared to 33% of heterosexual people had ever been diagnosed with depression. The contrast was particularly strong for men, with 34% of GBM compared to 17% of heterosexual men having been diagnosed. Similarly, for diagnoses of anxiety, 33% of LBW people compared to 26% heterosexual over 55’s had ever had a diagnosis. For men, the contrast was 29% of G&BM compared to 13% of heterosexual men. This may be due to their greater lifetime exposure to stigma associated with their sexuality. PHE (2014c) cite an estimate of 36% or older men having hidden their sexual identity throughout their lives, with resulting effects of internalised homophobia.

Guasp and Taylor (2012c) collated evidence from Stonewall surveys, noting increased levels of symptoms of depression and anxiety in GBM compared to men in general, with BM more likely to experience these. There were very high levels of depression and anxiety in LW, with higher levels for BW. These increased for black and minority ethnic LBW. The findings were echoed in Stonewall’s School Report (Guasp, 2012) which found that 46% of pupils who experience homophobic bullying have symptoms consistent with depression, while 35% of those who aren’t bullied also have these symptoms. This points to the formative life experience of stigma and peer acceptance (or lack thereof) in the development of later mental health. Stonewall further document higher levels of suicide attempts, ideation and self-harm. Their findings are based on large surveys, however these may not be representative and comparisons have been made to the whole population from other studies, which may not be strictly comparable.

The annual suicide audit relies on the notes held by the Coroner. Sexual orientation is not consistently recorded and there are sensitivities in requesting the data from bereaved families. It is therefore not possible to estimate the percentage of the people in Salford who have committed suicide who identified as LGBT and not appropriate to suggest that SOM is attempted after the event.

Stonewall data is available in regional reports and at PCT level. The following tables compare the responses of Salford women on some of the questions included in the survey with the Northwest and England responses. Due to the low number of Salford women (38) caution must be used in interpreting this, however, these results appear to indicate that LBW in Salford share the same issues with mental health given in the national report and may even have higher needs.
In an evidence overview, the LGF (2014a) depict findings from the GP Patient Survey for July 2012-March 2013, showing the different incidence of long-term mental illness between women with differing sexual orientations.
This shows stark differences, particularly for BW.

Stonewall’s survey of GBM shows lower incidence of suicide attempts and self-harm compared to national and regional GBM.
These surveys include low numbers of Salford residents, but the indication that LBW in Salford may have higher rates of suicide and self-harm than for national and regional populations of LBW, while GBM may show the opposite trend is intriguing and deserves follow up to establish whether this simply reflects the sample in these studies or results from actual differences in Salford.

The Department of Health (2012) identified that, alongside measures to improve the mental health of the population as a whole, LGBT people require a tailored approach to their mental health. (Among other groups identified as requiring tailored approaches were black, Asian and minority ethnic groups and asylum seekers; survivors of abuse or violence; people living with long-term physical health conditions; people with untreated depression; people who misuse drugs or alcohol; veterans. This highlights the impact of belonging to a ‘minority within the minority’ (Varney, 2013).)

An analysis of the GP Satisfaction Survey for England 2009/10 focused on measures of self-rated health and presence of a long-standing psychological condition, along with measure of patient experiences. LGBT people were two to three times more likely to report having a longstanding psychological or emotional problem than heterosexual counterparts (aged adjusted). Importantly, the study assessed the possibility that the results were skewed by being more likely to be registered with a low-performing practice, and this was excluded as a likely source of bias. (Elliot et al, 2014). Enquiries were made about obtaining the Salford data for this year of the survey, however this would have resulted in accessing patient-identifiable data which would not be able to be included in this document due to confidentiality rules.
A clear pattern can be seen here in terms of a gradient of self-reported psychological or emotional issues, with heterosexual people reporting fewer and bisexual people the highest. Within the LGBT community, while LW report fewer than GM, BW have the highest reported incidence of such issues. B people in general had the highest rates of psychological or emotional problems. The diversity of experience within sub-groups of the LGB community (likely to increase in complexity when the trans community is included), has received very little systematic attention, as noted in a report of a prospective research study (Pinknews, 2014).

As noted in the section on ethnic minorities, BME LGBT people have higher rates of mental ill health. A report of a seminar held by PHE notes that is important for services to develop understanding of the life histories for BME individuals and to work with them appropriately (PHE, 2014f).

A survey of trans people in the UK (McNeil et al, 2012) found that 66% of respondents reported that they had used mental health services for reasons other than access to gender reassignment medical assistance.

For Salford residents there are no services specifically commissioned for the LGBT population. In the current year, the CCG has made a contribution to a Greater Manchester service. The outcomes will be monitored to consider the effectiveness of this (personal communication, CCG Mental Health Commissioner).

A protocol has been developed for individuals experiencing gender dysphoria (NHS England, 2013b). The person’s GP would do a referral directly to one of the gender identity clinics for assessment, without the initial referral to psychiatrist which was previously standard. The gender identity clinic will assess the individual and make a diagnosis of gender dysphoria and discuss options for treatment and support. There is no collated record of the number of such referrals for Salford residents (CCG Mental Health Commissioner, personal communication).

PHE (2014c) progress indicators on the improvement of the health and wellbeing of MSM includes the goal of halving the proportion of MSM with poor mental health, as measured through self-reports feeling recently unhappy or depressed from 21% in 2011 to 17% in 2020.
The increased rates and risk of poor mental health for LGBT people should be addressed and a local target set to reflect PHE’s goal (and including LBW). Addressing this will require a combination of prevention, through addressing stigma and work with young people, and culturally sensitive services which can support those identifying poor mental health. Staff will benefit from training and should develop culturally competent practice.

7 Sexual Health

The Salford JSNA programme includes a Sexual Health Needs Assessment, which is due to be completed in 2015. This section should be considered in tandem with this.

Most 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 (Department of Health, 2013). Together, STIs and HIV represent a burden on health services and on individuals. Responses should include improving early detection, treatment and prevention through promotion of safer sexual and healthcare seeking behaviour (PHE, 2013). As well as the absence of disease, good sexual health includes forming and maintaining satisfying emotional sexual relationships. This should be remembered as the context for services, including information given in educational settings.

Men who have sex with men / Gay and Bisexual men

Many (although it should be remembered, not all) GBM report high numbers of partners, both regular and casual, compared to heterosexual men. This, combined with the risks associated with anal sex without condoms, results in high prevalence and incidence of HIV and sexually transmitted infections (STIs) in this group (PHE, 2014c).

Sexually Transmitted Infections (STIs)

Regular testing is important for early identification and treatment of STIs. The Stonewall survey suggests that GBM in Salford appear to access testing at a higher rate than in the national GBM survey (Guasp, 2011a).

<table>
<thead>
<tr>
<th>Testing for STIs</th>
<th>Never tested</th>
<th>Ever tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford</td>
<td>15.9%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Northwest</td>
<td>26.9%</td>
<td>73.1%</td>
</tr>
<tr>
<td>England</td>
<td>23.9%</td>
<td>76.1%</td>
</tr>
</tbody>
</table>

There are differences in the rates of diagnosed STIs by sexual orientation. There is a high percentage of diagnosed infectious syphilis and gonorrhoea cases for GBM nationally. High rates of these are held to reflect high levels of risky sexual behaviour (PHE, 2013). Salford ranks 21st for syphilis and 30th for gonorrhoea prevalence in local authority area in England (out of a total of 326).

In 2013, 31.3% of new STIs in Salford (where sexual orientation was known) were in MSM, indicating the disproportionate contribution this group makes to STI rates. The chart shows the percentage of men for each STI who are MSM or heterosexual.
Selected STIs by sexual orientation - Males
GUMCADv2 2012-2013 (pooled data)

<table>
<thead>
<tr>
<th>STI</th>
<th>England</th>
<th>Salford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
<td>81</td>
<td>76.9</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>63</td>
<td>81.9</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>17</td>
<td>30.1</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>11</td>
<td>17.2</td>
</tr>
<tr>
<td>Genital warts</td>
<td>8</td>
<td>10.8</td>
</tr>
</tbody>
</table>

(PHE, 2014d and PHE, 2014e)

Comparison of the percentage of diagnoses for MSM between England and Salford in 2013 shows differences. The higher proportion in Salford compared of male diagnoses of gonorrhoea and Chlamydia in MSM, in particular, should be noted.

Notes –
• 'Not specified' has been removed from the total following the dataset guidance from PHE
• Sexual orientation split is only available for Chlamydia in Salford, not for England or Greater Manchester
PHE has identified gaps in understanding issues which impact on BME GBM which influence uptake of testing (PHE, 2014f). Analysis by ethnicity shows varying patterns for different infections, with diagnosed syphilis cases in Salford wholly in white GM but higher incidence of other STIs in BME individuals. These figures demonstrate that it is important for services to acknowledge that all ethnic groups will have LGB individuals and to work with community groups to promote sexual health within overall health services.

Number of selected STI diagnoses
GUMCAD 2013
Patients from Salford attending any clinic, Male

<table>
<thead>
<tr>
<th></th>
<th>Infectious Syphilis</th>
<th>Gonorrhoea</th>
<th>Chlamydia</th>
<th>Anogenital Herpes</th>
<th>Anogenital Warts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male Heterosexual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>84.6%</td>
<td>73.9%</td>
<td>80.0%</td>
<td>81.0%</td>
<td></td>
</tr>
<tr>
<td>Black or Black British</td>
<td>0.0%</td>
<td>10.1%</td>
<td></td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>0.0%</td>
<td>5.3%</td>
<td></td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>Other ethnic groups</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td>0.0%</td>
<td>6.9%</td>
<td></td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td><strong>Male Homosexual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>100.0%</td>
<td>92.7%</td>
<td>89.7%</td>
<td>90.0%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>0.0%</td>
<td>4.5%</td>
<td></td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Male Bisexual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black or Black British</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male Not specified</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Blue fields indicate low numbers, which have been suppressed.

**Human Immunodeficiency Virus (HIV)**

HIV is a virus which attacks and weakens the immune system and is most commonly caught by unprotected sex, or sharing injecting equipment. When HIV emerged in the 1980’s, a diagnosis was often perceived as a death sentence, but newer advances in treatments have enabled most HIV+ people to live lives of relatively normal longevity and health. Early diagnosis and treatment maximises the impact of medications and minimises long term damage from the virus. Prevention, testing and early diagnosis, and good management of HIV to ensure a suppressed viral load and good screening and management of co-morbidities are important components of care. Late diagnosis (CD4 count<350 cells/mm3 within 3 months of diagnosis) is an important predictor of HIV-related morbidity and short-term mortality (PHE, 2014e).

One in 20 MSM in England are living with HIV in the UK and the number of MSM living with HIV doubled between 2003 and 2013 (PHE, 2013c). The number of new diagnoses among MSM is accounting for an increasing proportion of all diagnoses, with the number of new infections nationally attributed to MSM
greater than the number of heterosexual infections for the first time in 2011, and the trend continuing (Harris et al, 2013). This indicates a need to continue health promotion targeting high-risk practices with casual partners (see section on chemsex).

Diseases of the cardiovascular system, kidneys, and liver; cognitive function; malignancies; and metabolic bone disease appear to be more common among HIV-infected patients. Certain infections continue to be a significant cause of comorbidities for HIV+ people, including viral hepatitis and HPV. In late-stage HIV infection, (AIDS), 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 (PHE, 2014g).

Salford has a high prevalence of HIV with nearly 5 in every 1,000 residents HIV+. In 2013, there were 488 MSM living with HIV in Salford. 34 new cases the same year, where the infection route was MSM, were reported for Salford (PHE, 2014e). These are cases where the test was conducted in Salford. Data for Salford residents indicates a lower number.

<table>
<thead>
<tr>
<th>New Diagnosis in Salford resident by Infection Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route of infection</td>
</tr>
<tr>
<td>Sex between men</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Data received from HIV & STI Department, National Centre for Infectious Disease Surveillance and Control (CIDSC)

66.7% of Salford people living with HIV are MSM, compared to 52% for the Northwest as a whole (Harris et al, 2013). In 2013, 33% of MSM were diagnosed late (PHE, 2014e). National estimations are that approximately 200 people were living with undiagnosed HIV in Salford in 2013. Of HIV+ MSM, 16% are estimated to be undiagnosed, meaning an estimated 86 MSM in Salford who are HIV+ and undiagnosed (NAT, 2014a).

People living with diagnosed HIV are concentrated in the east of Salford.
NICE (2011) recommends testing annually for MSM who change sexual partners, but more recently PHE (2014g) has suggested MSM should have an HIV and STI screen at least annually, and every three months if having unprotected sex with new or casual partners. This is important to increase early diagnosis leading to effective treatment for the individual, and also to reduce onward transmission.

Data requested from Public Health England (*HIV & STI Department, National Centre for Infectious Disease Surveillance and Control (CIDSC)*) shows the percentage of MSM in Salford, and in England, attending clinics who were offered HIV tests.
Of those offered a test, the percentage who took it up is shown below.

![HIV coverage - uptake, MSM 2009-2013](image)

It should be noted:

- There was improved data reporting from 2012 so increases in numbers of patients and increases in sexual risk may be due to this rather than any other factors.
- MSM includes men who reported being homosexual or bisexual
- MSM reflect the sexual risk reported over a patient’s entire attendance history.
- HIV test uptake data represent the number of HIV tests reported & not the number of people tested for HIV.
- HIV test coverage data represent the number of persons tested for HIV & not the number of tests reported.
- Data is for calendar not financial years.

It appears that there continues to be room for improvement in increasing the coverage of offering HIV tests and acceptance of the offer.

NICE (2011) issued guidance aimed to increase the uptake of testing among MSM through normalising HIV testing in all healthcare settings. A national campaign, ‘Halve It’, supported by PHE (PHE, 2014c) aims to halve the proportion of people diagnosed late with HIV and halve the proportion of people living with undiagnosed HIV. In Salford sexual health clinics, 45.8% of those eligible (of the whole population) were offered an HIV test compared to 79.4% nationally (PHE, 2014e). Analysis of HIV testing in Salford will form part of the forthcoming Salford Sexual Health Needs Assessment, and actions to increase testing in GBM should be included.

Prevention messages are also important and need to be included alongside messages normalising testing. This should be done not only in healthcare settings but in venues which encourage or facilitate sex between men (e.g. saunas) (NICE, 2011). Personal, social and health education (PHSE) in schools could be vital in promoting the normality of HIV (and STI testing) for GBM with multiple partners, as well as for other groups.
PHE (2014g) notes the emerging evidence for the role of pre-exposure prophylaxis (PrEP) in the prevention of HIV. The UK PROUD trial for MSM at risk of HIV infection to be given PrEP is underway and will inform policy decisions which should be considered locally.

In Salford, alongside clinical services, the Lesbian & Gay Foundation is commissioned to provide HIV testing and advocacy, and the George House Trust provides support for those living with HIV.

**Living with HIV**

More than half of people accessing HIV care in the UK are aged between 35 and 49. At the same time, a combination of ongoing transmission and increased survival has led to a large increase in the numbers of people over 50 who are accessing HIV care. In 2013, nationally, 1 in 4 adults accessing care was aged over 50, compared to 1 in 8 in 2003 (NAT, 2014b)

Individuals living with HIV should be encouraged to eat a healthy diet, reduce or stop tobacco use and remain active, to aid immune functioning and guard against opportunistic infections.

BHIVA has produced Standards of Care for People Living with HIV (2013), which cover the range of care needed by people:

- HIV testing and diagnosis
- Access to, and retention in, HIV treatment and care
- Provision of outpatient treatment and care for HIV, and access to care for complex comorbidity
- Safe ARV prescribing: Effective medicines management
- Inpatient care for people living with HIV
- Psychological care
- Sexual health and identification of contacts at risk of infection
- Reproductive health
- Self-management
- Participation of people with HIV in their care
- Competencies
- Information for public health surveillance, commissioning, audit and research

These standards should be considered when services are commissioned and also by service providers.

A survey of people over 50 living with HIV found that a number of ways in which support could be improved, including the issue of homophobia or lack of knowledge about HIV within social housing, sheltered housing, care homes as well as health services more generally (Power et al, 2010. The respondents were more likely to be living in social housing than their peers.

Respondents were asked if they had any concerns about growing older with HIV.
Comments from the qualitative interviews conducted alongside the survey indicated that the self-care issue was linked to the perception of homophobia in current care services.

Salford’s social services team do not collect sexual identification/orientation. When referrals are taken and triaged at the Contact Team, a discussion with the person about their social care needs takes place and where an individual identifies they are HIV+, there is a referral to the HIV specialist worker. (Personal communication, Social Care Manager, March 2014.)

**Chemsex**

An emerging trend of sexualised drug use has been identified, particularly in London. ‘Chemsex’ occurs under the influence of (most commonly) stimulant drugs (Bourne et al, 2014). It is reported to be changing the way some GBM socialise, including the arrangement of private parties online or via smartphone apps and sourcing sexual partners with the explicit intention to use drugs together (Substance Misuse Skills Consortium, 2013). In a survey conducted in three London boroughs, Bourne et al (2014) discovered four differing types of sexual risk taking:

- About one quarter of respondents engaged in chemsex but remained in control and had limited chance of HIV/STI transmission.
- More than a quarter (all HIV positive) made pre-determined decisions to engage in unprotected anal intercourse, with men they believed to be sero-concordant. Drugs did not appear to be the main driver of sexual risk taking.
- Nearly a third found it difficult to control their behaviour while under the influence of drugs and engaged in behaviour that increased HIV/STI transmission risk. They subsequently regretted this behaviour. These men often had underlying self esteem or similar issues.
- A small proportion sought out risky sex and used drugs to push sexual boundaries.

Anecdotal evidence suggests that men who are HIV+ may not adhere to medication routines when under the influence of drugs, and this will lead to higher risk of transmission during unprotected sex.

Chemsex behaviour is likely to be evident in the Manchester/Salford GM community, although it is not formally documented. It is speculative whether the findings on types of risk behaviour from London pertain. GBM often have good relationships, developed over time, with sexual health services (Stuart, 2014). Providers need to be aware of differing patterns of chemsex, and provide appropriate information on drug

<table>
<thead>
<tr>
<th>Gay/Bisexual men</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulties with self-care</td>
<td>83.3</td>
</tr>
<tr>
<td>Mental health/depression</td>
<td>79.4</td>
</tr>
<tr>
<td>Financial difficulties</td>
<td>78.0</td>
</tr>
<tr>
<td>Inability to get healthcare</td>
<td>76.0</td>
</tr>
<tr>
<td>Social stigma/discrimination</td>
<td>67.9</td>
</tr>
<tr>
<td>Loneliness</td>
<td>61.7</td>
</tr>
<tr>
<td>Employment</td>
<td>56.1</td>
</tr>
<tr>
<td>Finding a partner</td>
<td>44.9</td>
</tr>
</tbody>
</table>

Lesbian, Gay, Bisexual and Trans People in Salford Needs Assessment
harm reduction, including needle exchange. Staff should be competent to open discussions on the psychosocial aspects of health and any harms arising from chemsex.

**Human Papilloma Virus (HPV)**

Genital warts are the result of a viral skin infection caused by HPV. HPV is also a causative agent for a number of cancers (penile and anal). There is a programme of universal vaccination for girls at the age of 12 or 13, to reduce cervical cancer. A recent recommendation from the Joint Committee on Vaccination and Immunisation has recommended HPV vaccination for MSM aged 16-40, as a preventative measure against anogenital warts (JCVI, 2014). This has yet to become a recommendation from PHE, although they have committed to reviewing this area (PHE, 2014c).

**Women who have sex with women / LBW**

LBW engage in a range of sexual practices which mean that they, too, are at risk of STIs, but clear information on this is not always available or included in sexual health campaigns (Bailey, 2003; Hunt & Fish, 2008; LGF, 2014a). Hunt & Fish (2008) gathered qualitative evidence of women being turned away from screening by health professionals who did not think they were at risk. LGF (2013) report that few LBW use barrier protection, and may not be aware of the need to use protection with sex toys.

The ‘I Exist’ survey asked LBW how often they had a sexual health screen and responses for Salford can be compared with the Northwest and England, showing little difference and less than 50% uptake.

**Ever tested for STI conditions**

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
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<td>Salford</td>
<td>52.6%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Northwest</td>
<td>54.9%</td>
<td>45.1%</td>
</tr>
<tr>
<td>England</td>
<td>53.4%</td>
<td>46.6%</td>
</tr>
</tbody>
</table>

LGF 2012a,b,c
However, data from Stonewall (Hunt & Fish, 2008) (with 52 LBW from Salford) suggests that there is a lower coverage of sexual health screening for LBW in Salford than in the rest of the UK or the rest of Greater Manchester.

<table>
<thead>
<tr>
<th></th>
<th>Never had a cervical smear</th>
<th>Had a smear test in last 3 years</th>
<th>Had a smear test in last 3 - 5 years</th>
<th>More than 5 years ago</th>
</tr>
</thead>
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<tr>
<td>Salford</td>
<td>20.0%</td>
<td>76.7%</td>
<td>3.3%</td>
<td></td>
</tr>
<tr>
<td>Northwest</td>
<td>14.3%</td>
<td>62.1%</td>
<td>13.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td>England</td>
<td>15.6%</td>
<td>57.7%</td>
<td>16.4%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

Hunt & Fish (2008)

LGF (2014a) cite Health Protection England statistics that of women who have sex with women attending GUM clinics in 2012, 40% had an STI diagnosis, compared to 18.5% of women who have sex with men.

In addition to a lack of clarity about the need for screening for STIs for LBW and the paucity of information about what is safe sexual practice, the sources cited here note the barriers for women in disclosing their sexual orientation in order to have a frank and useful discussion with caregivers.
Sexually transmitted infections, including HIV, in MSM in Salford represent a significant burden to local services. Salford has higher than national proportion of some STIs attributable to GBM than nationally.

The profile for diagnosed STIs for BME men differs from that of white GBM. This area is little researched.

Salford has a high prevalence of HIV and in two thirds of cases the transmission route is MSM (higher than the Northwest). One third of these cases were diagnosed late. MSM living with HIV are concentrated in the east of the city.

There is room for improvement in the offer and uptake of HIV testing in this population. Interventions around prevention as well as ensuring services are suitably meeting local need should be considered in Salford’s Sexual Health Needs Assessment.

As people living with HIV are living longer, there are more likely to be more HIV+ individuals in Salford. Those living with HIV are likely to have high support needs which they are concerned care and health services will meet.

An emerging trend of chemsex should be noted, with sexual health services and drug services working together to provide information and appropriate interventions.

Services should give clear information on the prevention of STIs and screening recommendations to LBW.

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8 Lifestyle risk factors

Smoking

Smoking increases the risk of lung and other cancers and other diseases such as coronary heart disease, heart attack and stroke. It speeds up the onset of AIDS among people with HIV (NHS Choices). Smoking rates are reported as higher for LGBT people than for the heterosexual population in a number of surveys. A Stonewall (Guasp, 2011a) survey of GBM found two thirds have smoked at some time in their life, and a quarter currently smoke. In the Stonewall survey of LBW (Hunt & Fish, 2008), two thirds have smoked, just over a quarter currently smoke. Within these surveys, separate analysis of Black and Minority Ethnic respondents indicate higher rates, with 27% of BME GBM 27% currently smoking, and 33% of BME LBW currently smoking. Reliable national or Salford rates of smoking among transgender people are not available; however due to complex medical histories, such as an increased risk of thrombosis due to oestrogen use by trans women (male to female transition) smoking cessation support may be of high value for health (Age UK, 2010).

Analysis of Farsite records from Salford GPs conducted on 2/01/2015 shows that, for the 2679 people whose sexual orientation was recorded, there were 192 LGB people, of whom 38% were current smokers. This rate is well above the Salford general rate.
The national GP Satisfaction survey asks demographic information, smoking status and sexual orientation questions. Comparisons of smoking prevalence show that, for England, Greater Manchester and Salford, smoking prevalence is higher for LGB people than for heterosexual people.

The Salford Health and Wellbeing survey (2011) collected smoking status and sexual orientation data. (As the numbers were small, the data for LGB men and women have been combined in this chart).
PHE (2014a,b,c) cite national findings that LGB people are more likely to be current smokers, less likely to have never smoked and less likely to have given up smoking compared to the general population.

LGF, 2012a,b,c

This data indicates that the national picture of higher rates of smoking within the LGB community is mirrored in Salford. The rates shown are similar for LGB people in Salford in the I Exist and the Salford Health and Wellbeing Survey.

Stonewall’s national surveys of GBM and LBW have data available at a local and regional level so that it is possible to compare the smoking rates of Salford LGB people with national rates of smoking for LGB people. These rates are lower than for LGB people in the Northwest, and England, and also in the other surveys. The number of people in the Salford section of these surveys was low.

Current smoker (cigarettes) GBM

<table>
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<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford</td>
<td>77.3%</td>
<td>22.7%</td>
</tr>
<tr>
<td>North west</td>
<td>72.5%</td>
<td>27.5%</td>
</tr>
<tr>
<td>England</td>
<td>74.4%</td>
<td>25.5%</td>
</tr>
</tbody>
</table>

Guasp, 2011
Current smoker (cigarettes) LBW

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford</td>
<td>84.2%</td>
<td>15.8%</td>
</tr>
<tr>
<td>North west</td>
<td>67.9%</td>
<td>32.1%</td>
</tr>
<tr>
<td>England</td>
<td>71.3%</td>
<td>28.7%</td>
</tr>
</tbody>
</table>

Hunt & Fish, 2008.

This data shows a lower proportion of Salford LBW women who are current smokers than for GBM.

Currently, smoking cessation services do not collect sexual orientation information. Collection of this data would allow confirmation of the rates within these groups, analysis of uptake of services and any difference in quit rate between LGBT and heterosexual people. Importantly, as these are all snapshots in time, it is impossible to say whether the rates for LGBT people are coming down in line with the reduction in the overall rate of smoking in Salford over the last 10 years.

Interestingly, a national YouGov survey, commissioned by Stonewall (Guasp, 2011b) found that smoking rates for over 55’s were the same (12% current daily smokers) for both LGB and heterosexual people. For those over the age of 70, a slight difference was evident: 6% of LGB people were daily smokers, compared to 4% of heterosexual people. For LGB people there was a marked social gradient in smoking prevalence, with no significant difference for heterosexual people in this sample.

Salford’s Health Improvement Service (HIS) runs community groups and activities. Although sexual orientation data is available for individuals accessing programmes (e.g. stop smoking groups) this is aggregated and it is not currently possible to state how many attend each type of activity.

A recent qualitative project conducted by the Lesbian & Gay Foundation in Manchester aimed to gain insight into attitudes toward smoking within the LGB community (2014c). This work is intended to inform PHE policy in this area. Findings include confirmation that smoking is seen as more permissible within the LGB community. LGB socialisation often centres on bars/clubs which includes smoking (and drinking); a cool image remains for smoking and it may play a role informing and expressing LGB identities. As well as this, it was noted that smoking cessation is not a priority in terms of health promotion messages targeted to the LGB community, and participants commented that general smoking campaigns could be made to feel more relevant to LGB people as they are currently often underpinned by heteronormative assumptions. Some LGB people receive support from services to quit, but there was an expressed view in favour of specific, targeted support in LGB-friendly spaces. Work to understand how LGBT people perceive local smoking cessation services could be undertaken, in order to inform how services meet the needs of Salford’s LGBT population (LGF, 2014c).

PHE propose to include a progress outcome in their strategic framework to reduce the proportion of MSM who smoke to be no more than 10% higher than the rest of the male population. It is not possible from looking at the Salford data above to establish where Salford currently sits with regard to this ambition, because of the aggregation of male and female data due to small numbers. A local target should be set. Should we already be within the 10% difference, a local target might be set to reduce the gap. PHE suggest that targeted smoking cessation groups should be considered in mental health and prison/offending populations, which may be salient for Salford.

General smoking campaigns could be made to feel more relevant to Salford LGBT people and venues for smoking cessation groups and activities should be LGBT friendly (along the lines of Pride in Practice). Stop smoking service staff should receive training around the particular issues in LGBT groups that may contribute to the higher rates of smoking.
Alcohol

People who regularly drink more than recommended levels may experience liver problems, reduced fertility, high blood pressure, and be at increased risk of various cancers and heart attacks. Drinking affects coordination and balance and can lead to accidents. Binge drinking can lead to anti-social behaviour, and in the long term, to serious mental health problems.

King et al (2008), in a meta-analysis, found that LGB people had a 1.5 higher rate of alcohol dependency over the previous 12 months than heterosexual people, with rates higher for LBW.

In a survey of 4206 LGB people recruited across England via LGB organisations, at Pride events and on the LGF website, Buffin et al (2012) note that 30% reported binge drinking (for males, this is 8 or more units of alcohol in a single session, for females, more than 6 units in a single session) at least once or twice a week. This divides by gender as 34% of GBM and 29% LBW, showing that this is not just an issue for men. Binge drinking was distributed across all age groups, with highest incidence for 16-24 year olds and 41-45 year olds. For the 41-45 group, the incidence of binge drinking at least 4-5 times a week is higher than at 16-24 (14% compared to 9%). This is a different drinking pattern across age groups than in the general population.

Data from the General Lifestyle Opinions and Lifestyle Survey (2013), report binge drinking (more than 8 units for men, more than 6 units for women) is highest amongst younger people in the general population. Each successive age group sees a drop in the percentage binge drinking within the previous week from 43% (men) and 36% (women) in the 16-24 year age group down to 10% (men) and 6% (women) for the 65+ age group. A survey conducted of over 55s found that 45% LGB drink alcohol on at least 3 or 4 days a week, compared to 31% of heterosexual people over 55 in the same survey (Guasp, 2011b). 16% of the LGB sample reported three signs of alcohol dependency. For dependency on any substance (alcohol and drugs), GB men had a higher level (25% dependent) than LBW (19%), however, BW showed a higher rate (23%) than LW (18%). This survey also looked at substance misuse and reported ‘poly-substance use’, where more than one substance is used during a particular occasion. For 81% of people, alcohol was one of the substances used, alongside a drug.

For those seeking help, informal sources were preferred, with individuals citing fears around confidentiality and feelings of shame and embarrassment. In a study scoping drug and alcohol services in London for LGBT people, consultation resulted in a strong preference for specialist LGBT services. These were felt to offer safer emotional and physical environments, and to better understand the patterns and pressures for LGBT respondents (Buffin et al, 2012).

A Stonewall survey (Hunt & Fish, 2008) found that nine in ten LBW drink and 40% drink three times a week. A comparison of Salford LBW respondents to this survey with national and regional shows a generally similar picture.
Hunt & Fish, 2008

For GBM comparison of Salford with Northwest and England data shows Salford GBM drinking at a lower than national GBM level.

<table>
<thead>
<tr>
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<th>Yes</th>
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</thead>
<tbody>
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<td>30.2%</td>
<td>69.8%</td>
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<tr>
<td>Northwest</td>
<td>24.6%</td>
<td>75.4%</td>
</tr>
<tr>
<td>England</td>
<td>22.2%</td>
<td>77.8%</td>
</tr>
</tbody>
</table>

Drank alcohol in the last week, Guasp 2011a

Drank alcohol on 3 or more days in the last week

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford</td>
<td>65.1%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Northwest</td>
<td>61.7%</td>
<td>38.3%</td>
</tr>
<tr>
<td>England</td>
<td>57.7%</td>
<td>42.3%</td>
</tr>
</tbody>
</table>

Guasp, 2011a

In the Salford Health and Wellbeing Survey, people were asked: ‘On average, how often do you drink alcoholic drinks? (eg beer, lager, cider, wine, sherry, vermouth or spirits)?’, with possible responses of – never, less than once per month, a couple of times a month, one to three times a week, four to six times a week, every day of the week. It is only possible, due to the number of people surveyed, to categorise this as ‘never’ or no drinking and all other frequencies combined. This does not identify more problematic levels of
drinking alcohol, but does indicate the proportion of LGB people who never drink is lower than for heterosexual people.

The evidence for Salford suggests that the pattern of higher rates of alcohol misuse for LGB people than for heterosexual people is replicated in the city. Service data would be useful to confirm this.

PHE strategic recommendations (2014c) include the reduction of the proportion of MSM with damaging use of alcohol, using the target of those who are concerned about their alcohol use reducing by a fifth, from 21% to 17% in 2020.

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. Salford data suggests these differences pertain to the local LGBT population.

PHE suggest targets for reduction of harmful use of alcohol: to mirror this in Salford SOM would be required, with local targets set.

Staff training to support their work with LGBT groups should ensure that the service provided is culturally competent. In particular, understanding the different pattern of drinking across the lifecourse is of importance in targeting services.

Drug use

Drug use – whether illegal drugs or ‘legal highs’ – can have a number of impacts on health and wellbeing. Cannabis, the most commonly used illegal drug, has been linked to mental health problems. Drugs foster addiction, and dependency affects all areas of a person’s life. In addition, they are not produced in controlled conditions, with potential unintended effects.
The Crime Survey for England (Home Office, 2014), which investigates drug use, includes a question on sexual orientation. Nationally, LGB adults are more likely to have taken any illicit drug in the last year than heterosexual adults. In particular, GBM men were the group most likely to have taken any illicit drug in the last year (33.0%), with higher levels of illicit drug use than lesbian or bisexual women (22.9%) and heterosexual men (11.1%). LBW were more likely than heterosexual people overall to have taken illicit drugs.

A breakdown of the use of different drugs shows that the pattern of higher usage for LGB people is consistent for all drugs. It can be seen that there is a substantially greater increased level of use of amyl nitrite.
The LGF and UCLan (Buffin et al, 2012) conducted a study across three years (2009-11) of alcohol and drug use by LGB people. 4206 people completed surveys, being recruited via LGB organisations at Pride events and through the LGF website. 35% had used a drug in the last month, with younger people more likely to report this, although drug use was common for people into their forties.

**Reported use of drugs in the last year, 2011/12 to 2012/13 combined**

- Tranquilisers
- Hallucinogens
- Ketamine
- Amyl nitrite
- Amphetamines
- Ecstasy
- Cocaine powder
- Cannabis

**Drug use in the last month by age group, Lesbian, Gay and Bisexual people’s drug use in England (2009-11)**

- Sample average

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

Due to the size of the sample, it was possible to analyse use by gender and sexual orientation, showing a marked difference between LW and BW usage (both lower than for men).

Buffin et al, 2012

Guasp (2011b) in a YouGov poll of over 55s found that

- Nine per cent LGB have taken drugs within the last year compared with two per cent of heterosexual people.
- 14 per cent LGB in social category C2DE have taken drugs in the last year; eight percent use drugs at least ‘once or twice’ a week.
- Seven per cent in social category ABC1 have taken drugs in the last year; two per cent use drugs at least ‘once or twice’ a week.
- There is no difference according to social category for heterosexual people; just two per cent of heterosexual people use drugs at least ‘once or twice’ a week.

The continuation of drug use patterns into older ages will impact on health, and should be noted by services, who may need to ensure that they are sensitive not only to LGB issues but to a different age group in their provision.

Guasp notes that although the use of GHB, crystal meth, crack cocaine and heroin was low in this sample, it was higher than comparable figures for the Crime Survey for the general population, and due to the harmful effects of these drugs, this increase is noteworthy (2011b).

Buffin et al (2012) note findings of the British Crime Survey of the clear relationship between nightclub and pub visits and illicit drug use, and also the increase in usage in urban areas. This, with the age profile, accounts for some of the elevation in drug taking behaviour in LGBT groups. In the survey, gay bars and venues these remain important social spaces, especially for GM and point out that “It is unclear whether gay and bisexual males’ greater use of the bar/club scene is driving their drug use, or vice versa.” (p19)
This survey showed a high rate of ‘poly-substance’ use, with 20% of the sample reported using more than one substance together in a single session. The use of drugs and alcohol together was common, with implications in terms of increased danger to users during their drug and alcohol sessions, but also in the longer term due to health risks from specific combinations. Buffin et al (2012) state that “when cocaine and alcohol are taken together they combine to form cocaethylene, which has been linked to a significantly increased risk of heart attack, other possible health effects and other social harms such as an increased propensity to violence amongst users” (p24).

An emerging trend of concern is ‘chemsex’ for MSM. Sessions are arranged, often online or through social media, which combine drug use (often use of several drugs in a session) with sex, usually with multiple partners. This appears to increase behaviour which increases the risk of HIV/STI transmission either by choice or due to difficulty in controlling behaviour while under the influence of drugs, particularly crystal methamphetamine, mephedrone and GHB/GBL (Bourne, et al 2014; Stuart, 2013; Kirby & Thornber-Dunwell, 2013). Injecting equipment is often shared and condoms are not used. This chemsex trend has been investigated and reported in London, where it is said to be overstretching services (Kirby & Thornber-Dunwell, 2013). It has, as yet, not been documented as an established part of the Manchester gay scene, but anecdotally is occurring with likely involvement of Salford MSM. This behaviour results in increases of STIs/HIV transmission and drug-related hospital admissions and will have an impact on services and budgets. Men using drugs in this way may not perceive their use as problematic, and anecdotal evidence from London indicates that they are more likely to present to sexual health services than to drug services.

PHE (2014f) note that there is no good data on drug taking behaviour for BME LGBT people and therefore services do not have information to help plan their services for these groups.

Estimations the incidence of drug use for Salford LGBT can be made from Stonewall data from their two large surveys includes data at Salford, Northwest and national level from LBW (Hunt & Fish, 2008) and GBM (Guasp, 2011a) respondents.

Use of any drugs in last year, Stonewall LBW survey, 2008

<table>
<thead>
<tr>
<th></th>
<th>Salford</th>
<th>Northwest</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not last year</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Yes last year</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>
Although these surveys include small numbers in the Salford sample, they indicate that Salford GBM may have a higher rate of use while LBW have a lower rate than the national LGB population. However, it is important to note that the lower rate for LBW in Salford is still higher than the national rate for heterosexual people in the Crime Survey. The difference in national rates between LW and BW suggest that a better understanding of the rates in Salford LBW should be sought and they should be included in any information and support sessions targeted to the LGBT communities.

PHE (2014c), in its strategic recommendations, includes the reduction of the proportion of MSM reporting the use of a range of illicit substances associated with harm, including those associated with ‘chemsex’, by 2020. This ambition includes the commitment to work with the Home Office to establish baseline rates. Interventions around chemsex should involve both drug and sexual health services working together to ameliorate the harms of this practice in the provision of information around the harms of polydrug use in sessions.

LGB people have a higher use of drugs nationally. Bisexual men and women are more likely to use drugs than gay men or lesbian women. Drug use continues into older age groups than for the heterosexual population. There is a high rate of poly-substance use.

The pattern of drug use appears to hold in Salford, although it is possible that Salford GBM have higher drug use than national GBM, with LBW lower.

The chemsex trend of sexualised drug use is likely to involve Salford GBM.

**Smoking, alcohol and drug use – interventions**

Buffin et al (2012) note that LGB people are deterred from seeking help with their substance dependence by shame and embarrassment and concern at lack of confidentiality, however they do not discuss how this may...
be different to barriers for the heterosexual population in seeking support. Consultation with drug and alcohol service users in London found a strong preference for specialist LGBT service, as these were felt to offer an environment which felt safer, particularly to discuss topics such as sexualised using. The Manchester Lesbian & Gay Foundation and Greater Manchester West Mental Health NHS Foundation Trust are developing a pilot drop-in for LGBT people worried about their drug use. This will provide an assessment with a Drugs Worker and up to three sessions of support with a specialist. (http://www.lgf.org.uk/get-support/talk-about-drugs/ accessed 13 November, 2014). On alternate weeks, the project provides sexual health screening at the same time. At the end of this project, evaluation should be considered for any insights and successes.

PHE(2014b) note that ‘making every contact count’ approaches to offering brief intervention and referral is evidence based and could be used in sexual health care settings where MSM may feel able to speak about their drug and alcohol use in the context of sexual identity and behaviour. Referrals made need to be met by culturally competent alcohol and drug services, with good links to the health services most frequently used by MSM. This should be extended to women, particularly bisexual women who appear to have higher drug use. In order to monitor the success of these approaches, services should collect sexual orientation data and gender identity on their clients and track outcomes for these groups compared to the outcomes for other service users.

Making Every Contact Count (MECC) should be used by sexual health services.
Prevention programmes should tackle the particular issue of alcohol, drugs and tobacco within the formation of LGBT identity for young people.
Treating chemsex holistically could include drug services providing condoms and lube, and sexual health services providing needles, with each referring to the other to provide holistic support.

Weight, overweight / BMI

Being overweight or obese can be a factor in poorer health, such as cardiovascular disease (mainly heart disease and stroke), type 2 diabetes, musculoskeletal disorders like osteoarthritis, and some cancers (endometrial, breast and colon). These conditions cause premature death and substantial disability. It has been suggested that LBW are more likely to be overweight or obese than heterosexual women (Hunt & Fish, 2008) but studies have not given clear confirmation of this. The Stonewall survey indicates some difference between the incidence of overweight for LGB women, however caution should be used, as this is not age-adjusted. The data gathered in this survey for LGB women showed the Salford respondents to have a higher percentage of overweight compared to the national profile for LGB women. This survey included small numbers in the Salford sample.
Hunt & Fish, 2008

The identification of overweight during consultations in primary care (e.g. NHS Health Check) might result in referral to community-based groups designed to improve physical activity and foster healthy eating. The Health Improvement Service (HIS) runs community groups and activities. Although sexual orientation data is available for individuals accessing programmes (e.g. for physical activity) this is aggregated and it is not currently possible to state how many attend each type of activity.

There have been suggestions that for GBM the focus on physical attractiveness within the community may lead men to underweight. Data for GBM was collected by Stonewall in 2011, and shows GBM in Salford being similar to the national GBM weight profile.
Guasp, 2011a

The Salford Health and Wellbeing survey shows some differences for the LGB population in comparison with the heterosexual population of Salford.
Disaggregating this by gender shows that LW show slight differences from the heterosexual female population, with the pattern for GM indicating a higher percentage with underweight (bisexual individuals have been excluded from this analysis). There may be some skewing in the findings due to the age profile of the respondents in this survey who self-identified as LGB.
Cancer

Cancer is common in the UK: more than one in three people will develop some form of cancer during their life. There are over 200 types of cancer, with different effects and which are of different treatability. Lifestyle patterns, such as smoking, are important contributors to risks for certain cancers. The increased rates of smoking, drinking alcohol and STIs within LGBT groups are likely to impact on cancer rates with an assumption that rates will be higher within these groups than in the general population. As services do not routinely monitor sexual orientation, rates of cancers in LGBT people are not available.

Some cancers are more common in people living with HIV, including anal cancer, which is linked to human papilloma virus (HPV). As people living with HIV are living longer, due to improvements in ARTs, they are at more risk of developing cancers which are more common in older people.

Anal cancer

Men who have anal intercourse are more likely to develop anal cancer. Anal cancer is linked to higher human papillomavirus (HPV) in 80-90% of cases (Grulich et al, 2012) with increasing evidence of higher rates of HVP in MSM compared to heterosexual men (PHE strategy). Other risk factors include immunodeficiency (anal cancer is the commonest cancer for HIV positive MSM), and tobacco exposure. HVP is also linked to a proportion of oral, throat and penile cancers. PHE (2014c) note that The Joint Committee for Vaccination and Immunisation recognise that the current HPV immunisation programme, which targets girls aged 12-13, will provide relatively little benefit to MSM and a review of the likely cost-effectiveness of HPV vaccination provided to MSM is underway. Commissioners and cancer screening services in Salford should be prepared to act promptly once PHE advise.

Prostate cancer

Prostate cancer is the most common cancer in males in the UK. Treatments can vary and may have side effects which may affect a man’s sex life. The ability to discuss the implications for GBM may not be easily available in cancer services. A support group for GBM2 with prostate cancer exists in Manchester, and could be included in information given to Salford men.

Trans women should be included in prostate screening invitations and information literature.

Breast cancer

Breast cancer is the most common cancer in women. Some evidence suggests lesbians are at higher risk of adopting lifestyle behaviours that increase the risk of developing breast cancer, such as consuming alcohol,
having higher rates of obesity and a reduced likelihood of having children and breastfeeding (Breast Cancer Care, no date). National and local rates by sexual orientation are not available and a recent systematic review (Meads and Moore, 2013) was unable to establish robust evidence of differential rates of breast cancer between LBW and heterosexual women.

For breast, cervical and ovarian cancer, there is no data to compare rates for FBW and heterosexual women.

Issues have been noted with misinformation about screening, which might lead to later detection and poorer outcomes.

Some evidence on dissatisfaction with services around the presumption that women are heterosexual is noted in literature and surveys (Fish, 2010). For women who have been diagnosed, and had treatment, support which presumes that they are in heterosexual relationships, such as discussions as to how the cancer has affected husbands / male partners is unhelpful (Fish, 2010; LGF, 2014a). Post- treatment support services should provide information which is inclusive of WSW.

**Cervical screening / cancer**

Uptake of screening for lesbian women is thought to have been reduced by the persistence of a myth that LW are not at risk of cervical cancer. As many LW have had sex with men at some point in their lives, sex between women is also able to transmit HPV, this is a myth and screening should be for all women who have ever had sex with a man or a woman (NHS Cancer screening programme, 2009). The Stonewall survey (Hunt & Fish, 2008) included the finding that one in five who have not had a test have been told they are not at risk, while one in fifty were refused a test.

Trans men who still have a cervix should be included in cervical screening.

Stonewall survey data (Hunt & Fish, 2008) on cervical screening (aged 25-64, not including trans) shows an interesting pattern comparing Salford LBW with Northwest and national LBW.

<table>
<thead>
<tr>
<th></th>
<th>Never had a cervical smear</th>
<th>Had a smear test in last 3 years</th>
<th>Had a smear test in last 3 - 5 years</th>
<th>More than 5 years ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford</td>
<td>20.0%</td>
<td>76.7%</td>
<td>3.3%</td>
<td></td>
</tr>
<tr>
<td>Northwest</td>
<td>14.3%</td>
<td>62.1%</td>
<td>13.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td>England</td>
<td>15.6%</td>
<td>57.7%</td>
<td>16.4%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

Due to small numbers (for Salford), this is only indicative, but it appears that while there is a higher rate of Salford LBW who have never had a cervical smear test than nationally, there was a higher take up in the three years prior to the survey. This contradictory finding could be investigated. National coverage for all women (regardless of sexual orientation) was reported as at 31st March 2013. The percentage of eligible women (aged 25 to 64) who were recorded as screened adequately at least once in the previous five years (coverage) was 78.3 per cent. Comparison of the ‘ever’ figure from Stonewall and the ‘within the last five years’ is not easy. In the absence of sexual orientation monitoring, it is not possible to comment further on uptake of screening or incidence of cancer or outcomes of treatment for LGB women in Salford compared with heterosexual women.

Evaluation of a campaign targeted at LBW showed a higher understanding of the need for screening and confidence to take up screening following the campaign (Light & Ormandy, 2011). Recommendations from this work include the inclusion of LBW in campaigns, and ensuring providers build the confidence of LBW in attending screening. This is suggested to involve specific provision, but, most importantly, training for professionals conducting screening so that they avoid making assumptions about sexual orientation. A further recommendation is for work to be conducted to understand the issues specific to the trans community with regard to breast screening.

Lesbian, Gay, Bisexual and Trans People in Salford Needs Assessment
Patient experience

The Cancer Patient Experience Survey for 2013 (NHS England, 2013a) included a question on sexual orientation. Due to low numbers (with a high number not answering / decline to state) analysis was for all LGB compared to heterosexual people. This showed 16 items with significant differences of opinion, in 15 of which the experience for LGB was more negative. 10 of these related to communication and, broadly, to the respect and dignity with which the patient was treated.

Nationally, LGBT people are likely to have higher rates of cancer due to lifestyle factors. It is unclear if, in Salford this is the case, due to generally higher rates of cancer in Salford than nationally.

Certain cancers are more likely for people living with HIV. Anal cancer rates are higher for MSM.

LBW may have higher rates of breast cancer due to lifestyle factors. There have been persistent myths reported in national literature which have resulted in LW missing cervical screening.

Trans people need to be appropriately included in screening, e.g. trans women with a prostate for prostate screening, trans men with a cervix in cervical screening.

Disability

There is little literature on the health inequalities experienced by LGBT people with disabilities, but indications from national reports suggest they experience dual and compounded health inequalities (Stonewall, 2012; Varney, 2013). 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 in general (Stonewall, 2012). 16% of the LBW survey (Hunt & Fish, 2008) and 14% of GBM respondents (Guasp, 2011a) stated they had a disability.

Guasp (2011b) found that, for people over 55, 23% of LGB had a disability 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 vs 28% heterosexual disabled did not access health services they needed
- 23% LGB disabled vs 6% heterosexual disabled did not access mental health services they needed
- 19% LGB disabled vs 10% heterosexual disabled did not access social care service.

The survey found that LGB people were more likely to live alone without support from wider family, so would be more reliant on services. As described in the section on older people, they had less confidence that their needs would be understood by services, due to their sexual orientation. The finding that disabled LGB people are less likely to access the services they feel they need is a particular aspect of this picture.

Disability and long-term conditions in Salford

In Salford there is very little data on outcomes and disease prevalence. 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 Salford Health and Wellbeing Survey (2011) provided some data on the incidence of disability (LGB have been combined due to low numbers). This appears to indicate little difference in Salford LGB and heterosexual respondents of incidence of disability.
Do you have a disability?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight (heterosexual)</td>
<td>25.0</td>
<td>73.7</td>
</tr>
<tr>
<td>Bisexual, Gay/Lesbian</td>
<td>24.8</td>
<td>74.3</td>
</tr>
</tbody>
</table>

The ‘I Exist’ survey (LGF 2012a,b,c), shows the percentage of respondents who have a disability, including long-term conditions.

This shows a lower overall rate of disability for Salford LGB people, and this is likely to due to the different methodology in recruiting the samples.

The GP Patient survey for 2014 included questions about sexual orientation and whether respondents have a long-standing condition. This shows a generally high percentage of individuals with a long-standing condition.

**GP Satisfaction survey (Salford CCG) - Do you have a long standing health condition**

<table>
<thead>
<tr>
<th></th>
<th>Heterosexual / straight</th>
<th>Gay / Lesbian</th>
<th>Bisexual</th>
<th>Other</th>
<th>I would prefer not to say</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>57%</td>
<td>53%</td>
<td>66%</td>
<td>*</td>
<td>61%</td>
<td>55%</td>
</tr>
<tr>
<td>No</td>
<td>41%</td>
<td>44%</td>
<td>*</td>
<td>*</td>
<td>35%</td>
<td>43%</td>
</tr>
<tr>
<td>Don't know / can't say</td>
<td>2%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>2%</td>
</tr>
</tbody>
</table>

* indicates low numbers
Older LGBT people will have had lifecourse experience of different social conditions and will have come of age in a time when their sexual identity was more socially marginal and stigmatised. An estimated 36% of older GBM may have hidden their sexual identity all their life (Heaphy cited in PHE, 2014c). This may mean a greater sense of internalised homophobia with impacts on mental health over the lifecourse. GBM are more likely to have been bereaved during the early decades of HIV/AIDS, with concomitant impacts on mental health (PHE 2014c).

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 (Guasp, 2011b). LGB people were more likely to ever have had a diagnosis of depression (40% LGB people vs 33% heterosexual people) or anxiety (LBW 33% vs heterosexual women 26% and GBM 20% vs heterosexual men 13%). Depression differences were most marked between GBM (34%) and heterosexual men (17%). There was also a higher concern about future mental health for LGB people.

Older LGB people in this survey were more likely to be single and live alone. The difference was greatest for men, with 40% of G&B living alone, compared to 15% of heterosexual men. 30% of L&BW lived alone, compared to 26% of heterosexual women. Overall, 41% LGB over 55 people live alone, compared to 20% heterosexual people over 55. They had less family support and were almost twice as likely to expect to rely on health and social care services, GPs and paid help as heterosexual people aged 55 plus. The LGB people, however, voiced concern with how these services were likely to react to their sexual orientation and expressed discomfort at disclosing this.
The theme of concern about services giving holistic support accounting for sexual orientation is echoed by Ward et al (2010). They note that there is an absence of a coherent policy approach to the needs of this group, e.g. LGB people are not considered in National Dementia Strategy. As sexual orientation monitoring is not routine in most services, and there is an assumption of heterosexuality, there are difficulties in establishing differences in needs of LGB from the heterosexual population. Specific areas such as mental health needs and the complex issues of aging for individuals with HIV or trans individuals who have undergone any form of gender reassignment are not well understood. Indeed, in these two cases, we are now seeing the first generations of individuals who have had this life history. There is also little specific information on dementia care for LGBT people, end of life care or the needs of LGBT carers.

Little is known about the health of trans people in later life. In part this is due to a paucity of research, but currently the first generation of people who have undergone gender reassignment (using earlier techniques) and who have experienced three or more decades of hormone therapy (Age UK, 2010) are aging.

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 who are more likely to identify as LGBT age, this population will increase.

The issues of aging for trans people are likely to become better known as people who have undergone transition age.

11 Black / Minority Ethnic LGBT people

For individuals whose identity includes more than one minority – ‘minorities with the minority’ (Stonewall, 2012; PHE 2014f) such as LGBT individuals who are BME, it is likely that this compounds health inequalities, through the experience of double sources of discrimination. Attitudes towards homosexuality and bisexuality will be different within each cultural group, and may create different and difficult pressures on individuals. This area is not well explored in the literature (Varney, 2013, PHE 2014f).

Stonewall’s surveys have been analysed by ethnicity (Stonewall, 2012) and note poorer outcomes in a number of areas from BME respondents to their surveys (Hunt & Fish, 2008; Guasp, 2011a). For example:

- 43% black GBM, and 32% Asian GBM, 34% mixed and other ethnicity GBM have experienced at least one incident of domestic abuse from a family member since the age of 16, compared to 22% white GBM.
- BME LBW had a higher rate of suicide attempts in the last year (7%) than LBW as a whole (5%). 26% had self-harmed.
- 5% of BME GBM had attempted suicide in the previous year, compared to 3% of GBM in the survey.
- 30% of Asian GBM compared to 26% white GBM, 7% black GBM and 24% mixed and other ethnicity GBM have never been tested for HIV
- 13% of black men, 10% Asian and mixed and other ethnicity GBM describe themselves as bisexual compared to 7% of white men
- 23% Asian LBW describe themselves as bisexual compared to 16% white and 8% black LBW
- 12% black LBW said their healthcare professional acknowledged their sexual identity after they had come out, compare to 26% of white LBW.
• 28% LBW of mixed or other identity deliberately harmed themselves in the last year compare to 21% black, 20% white and 17% Asian LBW.

These examples indicate that BME LGBT people are at risk of increased double stigma and health inequalities. A survey of 50 BME LGB individuals (Stonewall & Runnymede, 2012) found respondents reported that healthcare professionals may assume that BME individuals are heterosexual and culturally appropriate services often do not take account of different sexual orientations.

This survey also found that BME LGB people are unlikely to report homophobic hate crime.

One important aspect of developing cultural competence for services and staff in interactions with LGBT people is to include the understanding that people of all ethnicities may identify as LGBT. They should also be aware that within some communities, there may be very negative attitudes to homosexuality (Stonewall & Runnymede, 2012).

Members of BME groups may also have LGB sexual orientations. There is minimal local data for Salford on this.

Provider staff need to be aware of this and appropriately conduct ethnic and SO monitoring in tandem. Services should develop local knowledge of communities and the needs of BME LGB individuals. A future needs assessment for Salford’s BME population should include consideration of LGBT people.

12 Bisexual people

The population estimates discussed above indicate that the proportion of people willing to identify themselves as bisexual ranges from 0.4 in the general Household survey to 1.5 in the NATSAL, with 1% identifying in the Salford Health and Wellbeing Survey and 1% of both men and women identifying as bisexual in the Salford data in the GP Satisfaction Survey. 214

Bisexual individuals may ‘blend in’ at times when they are in a heterosexual relationship. Although they are included as ‘part of the rainbow’, they may experience suspicion and biphobia from gay and lesbian people as much as from heterosexual people. A briefing by a Bi support group (BIPhoria 2014) estimates that two-thirds of bisexual people do not interact with LGB organisations. This may mean that surveys commissioned by LGB organisations capture only a section of bisexual people with unknown consequences for the results. Ward et al (2010) describe this as the ‘silent B in LGB’ (page 26) with few specific recommendations for practitioners, or unique identified needs for this group. Indeed, there are likely to be needs shared by bisexual people and other needs that are best identified in gender-specific groups of BM and BW (which may or may not be suitable to be grouped with GM or LW) as many health conditions are mediated by gender.

In much of the literature cited in this review, analysis does not separate gay from bisexual men or lesbian from bisexual women 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. Elliott et al (2014) 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 BM and BW having distinctly poorer outcomes than heterosexual people or GM / LW.

In an evidence overview, the LGF (2014a) depict findings from the GP Patient Survey for July 2012–March 2013, showing the different incidence of long-term mental illness between women with differing sexual orientations, finding a higher rate for BW than either LW or heterosexual women.
The differences for bisexual women compared to heterosexual and lesbian women (although this may be influenced by age distribution of women within this sample) are stark, and indicate that issues for bisexual people may be masked if they are included with LG people in classification, although low numbers may mean this is done.

These authors suggest that the limited social understanding of bisexuality and biphobia from the LG community as well as wider society, may mean that B people experience additional social stress.

In the national Stonewall surveys (Hunt & Fish, 2008; Guasp, 2011a), similar differences were evident between L and BW and G and BM. 29% BW had deliberately harmed themselves in the previous year, compared to 18% LW. 3 in 10 BW had an eating disorder, compared to 2 in 10 LW. 5% BM attempted to take their own life in the last year, compared to 3% GM. 11% BM harmed themselves in the last year compared to 6% GM.

Stonewall also found that more BW had higher rates of having an eating disorder; 3 in 10, compared to 2 in ten LW. 57% BW had been tested for STIs, compared to 44% of LW. 66% were not out to their health care professionals, compared to 46% of LW. For BM, 38% have never been tested for an STI compared to 25% of GM, and 49% had never had an HIV test, compared to 29% of GM. 60% were not out to health care professionals, compared to 30% of GM.

The data presented here are suggestive of worse mental health outcomes for bisexual people, within the LGB population.

The difference in outcomes for bisexual people compared to gay and lesbian people is not well explored.

13 Trans people

Trans is an umbrella term covering many individuals who cross conventional cultural boundaries of gender, permanently or not, in their lifestyle or who have undergone a variety of levels of gender reassignment. Trans individuals may have a sexual orientation as heterosexual (in their adopted gender) or as L/G or B. Trans people have lifestyles and medical histories which are likely to influence their health and social care needs but which are not easily grouped together. In terms of issues to do with transition, each individual will require individual care. This is not the focus of this needs assessment.

Trans people will also access usual health care, unrelated to transition, where the issue of their Trans status does not need to be raised (Bishop, 2013). The LGF notes (Williams et al, 2013) notes that there is limited published research into trans health issues outside of gender reassignment pathways of care. As can be seen in the evidence sources cited throughout this needs assessment, surveys (national and local) often do not include trans people, and where they are included, low numbers make it difficult to establish robust comparisons.

According to research carried out by the Gender Identity and Education Research Society (GIRES) the prevalence of people who had sought medical care for gender variance in 2007 was 20 per 100,000, i.e. 10,000 people nationally, of whom 6,000 had undergone transition. 80% were assigned as boys at birth (now trans women) and 20% as girls (now trans men). Applying this to Salford, gives an estimated figure of 47 individuals, with 60% (28 individuals) having undergone transition. (This estimate rests on the assumption that the trans population is spread equally across England, which is unlikely to be the case.) GIRES update (2011) notes an upward trend of people seeking treatment, which represents a doubling every 6.5 years. They recommend that organisations should assume that 1% of employees and service users may be experiencing some degree of gender variance, and about 0.2% may undergo transition at some stage.
Most of these individuals are likely to wish to be undetected, with those who have undergone transition unable to escape detection.

Gender dysphoria is where someone feels they have been assigned the wrong gender at birth. Individuals who identify this way may seek a referral for counselling, and this might explore whether they wish to undertake gender reassignment. If someone decides that they do wish to undertake gender reassignment, there is no specialist local service within Salford and they need to be referred by their GP directly to one of the seven specialist gender identity clinics in England (NHS England 2013b).

Gender reassignment is commissioned by specialist commissioners, rather than local Clinical Commissioning Groups. Salford CCG advised that they do not have any record of numbers for current or previous years of individuals who have applied for this.

Procedures such as surgery, hair removal and on-going hormone therapy, as well as counselling for people seeking gender reassignment procedures and their families represent a cumulative expense (GIRES, 2009). Farsite, the Salford GP database which records treatments, was searched for a variety of hormone therapies, in an attempt to provide data on the number being accessed by trans people in Salford. However, each of the therapies is also used for other purposes (e.g. oestrogen for menopausal women, testosterone for acne) meaning identification of the level of therapy provided impossible to estimate.

In 2012 NHS Northwest commissioned the Trans Resource and Empowerment Centre on a project which included the aims of establishing the number of trans people in the Northwest and the co-morbidities for this population. Through lack of engagement from GP practices no robust estimates were obtainable (Bailey & McNeil, 2013). The project highlighted the need for better understanding of trans issues, perhaps in a project similar to Pride in Practice for LGB people. Gender Identity is one of the nine protected characteristics in the Equality Act, 2010.

In general, Trans people are at high risk of discrimination, including at work, despite the protections of the Equalities Act, 2010. They may face rejection from family and friends. Many will have experienced high levels of transphobia. All of this is likely to have impacts on mental health. According to an Equality Review conducted in 2007(Whittle et al, 2007, cited in NHS, 2008)

- 73% of trans people experienced some form of harassment in public
- 21% stated they feared going out due to fear of harassment
- 46% stated they had experienced harassment in their neighbourhoods
- 64% young trans men and 44% young trans women experienced harassment of bullying at school
- 28% stated they had moved to a different neighbourhood because of their transition

A survey of 889 trans people in the UK found that 58% had a disability or chronic condition. 36% had mental health issues and 66% had used mental health services. Just half of these were satisfied with the services and 29% reported that their trans identity was treated as a symptom of mental illness rather than their true identity (McNeil et al, 2012). Bishop (2013) noted survey respondents reported a “Catch-22” as they may not be able to transition if mental health issues are present, but delay in transition may lead to mental health issues.

Many trans people report poor experiences of care which they related to their trans identity. When opening a discussion with their GP about their trans identity with the aim of referral for gender reassignment, this may be the first such patient the GP has needed to consider trans issues. The Equality Review (Whittle et al, 2007, cited in NHS 2008) showed that 20% of trans people reported that their healthcare was affected or refused by GPs. 60% reported that where their GPs wanted to be helpful and supportive, they felt unable to do this through lack of training and information. A 2013 survey of trans people’s experiences of GP surgery (Bishop, 2013) garnered 70 respondents national (37% in the Northwest). Findings included that 62% of the

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3 Head of Service Improvement, Salford CCG, personal communication, 23 June 2014.

Lesbian, Gay, Bisexual and Trans People in Salford Needs Assessment
90% who had disclosed their trans identity to their GP received a positive response, meaning a high level of poor responses and 10% who did not disclose. Fewer than 50% of the GPs gave good advice on transition issues, even where their response had been positive and 80% did not refer to specialist services for trans people (either NHS or support networks). A major recommendation of this survey was to improve GP training (trans issues are not included in Pride in Practice), along with the importance of according trans people dignity and respect. A strong strand of need identified was mental health support. A positive finding from this survey was that 75% of trans people were prepared to disclose their gender identity on practice monitoring forms (eg upon registration), which rose to 90% if assured of confidentiality.

There is limited research into the long term impact of hormonal treatment and other issues for trans individuals as they age (Williams et al, 2013; Age UK 2010).

The DH has recommended that people need to be screened according to their anatomical needs, requiring inclusion in information and services. For example, trans women are at risk of breast cancer so need to be included in screening and screening campaigns. They would not require cervical screening but should be included in prostate campaigns.

In Salford there are an estimated 47 trans individuals, with 60% (28 individuals) having undergone transition. Trans people appear to experience some of the poorest health outcomes and encounter greatest stigma. Trans people require ongoing input from services.

**14 Satisfaction with services**

Surveys conducted nationally (Hunt & Fish, 2008, Guasp, 2011a; Guasp, 2012b, LGF, 2012a; LGF, 2014a) consistently report qualitative findings from LGBT people describing their experiences of health and social care services where the individual felt that they received a poorer level of care or service due to their sexual orientation or gender identity.

Reading anecdotal instances it can be difficult to separate out reports of poor experience due to a general level of poor service (which happens to manifest itself as discriminatory) from genuinely discriminatory delivery of service. However, quantitative estimates of satisfaction tend to back up the perception that a poorer service is received by LGBT people from health and social care services.

Elliott et al (2014) analysed the 2009/10 GP Patient Survey for England results and found that LGB people were about one and a half times more likely than heterosexual people to report unfavourable experiences with four aspects of primary care (no trust or confidence in doctor, poor/very poor doctor communication, poor/very poor nurse communication, fairly/very dissatisfied with care overall). The differences were generally largest for nurse communication. In this survey, different practices were divergent, with LGB patients in some giving a similar evaluation as heterosexual patients. This suggests that differential satisfaction levels are something that can be addressed and ameliorated.

Importantly, the authors conducted analysis which showed that the source of complaints was not preponderantly in poorly performing practices. This suggests that practices can address elements of practice culture to ensure inclusive care for LGBT patients is provided. The Pride in Practice initiative was created to support this change. Salford CCG has commissioned elements of this programme for the GP practices in Salford.

The Stonewall survey of LBW (Hunt & Fish, 2008) found that half of the respondents had had negative experiences in the health sector related to their sexual orientation in the previous year. Half were not out to their GP. One in ten stated that a healthcare worker ignored them when they did come out, while seven in
en said that health care workers made inappropriate comments when they came out. The survey of GBM (Guasp, 2011a) found that 34% (who accessed health care) had had negative experiences of health care in the previous year, and 34% were not out to their GP. Reasons given for not being out to GPs or other health care providers included the lack of visual clues in posters or statements on notice boards in health care settings of commitment to LGBT equality, and concern about confidentiality. The wariness of LGBT individuals in coming out to their health care providers needs to be addressed (Stonewall, 2009; LGF, 2013b).

For Salford, the Stonewall data indicate that LBW experience a similar or worse experience than LBW nationally, while men have a markedly better experience.

![Any negative experiences of health care, Stonewall LBW survey, 2008](image)

Hunt & Fish, 2008

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In the survey of over 55’s, Stonewall (2011b) found that 17% LBW have experienced discrimination, hostility or poor treatment because of their sexual orientation when using GP services – 40% of these incidents occurred within the last five years. 11% GBM experienced similar treatment from GP services and 36% of these incidents occurred within the last five years.

In the 2014 GP Patient Survey, the percentage reporting highest levels of satisfaction with the service (due to low numbers, the percentage reporting the lowest levels of satisfaction is not calculable) show lower levels for LGB people.
In an analysis of the GP Patient survey for 2012, Life in Salford and the Pride in Practice Survey, LGB respondents in Salford were likely to rate their experience with the nurse at the GP surgery more negatively than heterosexual Salfordians, while their experience with the GP was similar (LGF, 2013).

The general theme of lower levels of satisfaction with and trust in care could, in itself, lead to inequalities in health. Coupled with the higher rates of smoking, problematic drinking, drug taking, sexual risk taking and poorer mental health, this issue is important to address.

In combination with improving LGBT people’s experiences with all services, there is the potential to improve health in concrete ways by giving preventative health messages with greater acceptance. Accompanied by actions identified for young LGBT and with all young people, there is also the potential to create a more tolerant atmosphere with the likely increase in personal resilience and wellbeing.

**Pride in Practice**

Within Greater Manchester, the LGF can be commissioned to deliver a training initiative ‘Pride in Practice’. A GP practice which signs up receives resources and practical support to deliver an inclusive service for their lesbian gay and bisexual patients. Salford CCG has commissioned this for all 55 Salford practices, with progress reported as of the end of September, 2014:

| Completed the self-assessment | 7 | 13% |
| Policies reviewed             | 6 | 11% |
| Received training (not funded)| 4 | 7%  |
| Introducing/ introduced SOM   | 5 | 9%  |
Met in person onsite to discuss *Pride in Practice*  9  16%
Receiving regular CLDS (condom and lube distribution service)  30  55%

LGF, via Salford CCG, Equality, Diversity and Human Rights Consultant, personal communication

Five practices had begun sexual orientation monitoring of patients as of late November, 2014.

Salford Council for Voluntary Service (CVS) is launching (late 2014) a Pride in Practice volunteer team to support the initiative with ‘mystery shopping’ to visit practices and assess visibility of LGBT material, acting to promote the initiative, and gathering patient feedback ([https://www.salfordcvs.co.uk/news/salford-cvs-launches-its-new-pride-practice-volunteer-team](https://www.salfordcvs.co.uk/news/salford-cvs-launches-its-new-pride-practice-volunteer-team)). This should be a valuable resource in terms of making sure Pride in Practice is embedded within primary care and also in assurance for the LGBT community.

Within a guidance document for nursing staff, the Royal College of Nursing (2012) includes an action plan for improving services for LGB patients, with one of the action areas on using monitoring information to “improve access, outcomes and experience” (p20).

<table>
<thead>
<tr>
<th>Surveys consistently report lower levels of satisfaction with services for LGBT people. Many anecdotal reports suggest that this is related to their LGBT identity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford GP practices currently have the opportunity to benefit from the LGF Pride in Practice programme, addressing access and satisfaction for LGBT patients.</td>
</tr>
</tbody>
</table>

15 Hate Crime

Developing and maintaining a sense of wellbeing is an important part of an individual’s health throughout the life course. A sense of wellbeing can enhance resilience and be preventative against mental ill health. It is also suggested that individuals with poorer levels of wellbeing may be more likely to rely on tobacco, alcohol or drugs.

A feeling of safety within communities and at home contributes to a sense of wellbeing, and the incidence or fear of hate crime or hate incidents is likely to undermine wellbeing. Hatzenbuehler et al (2014) investigated US data to establish that LGBT people living in communities with high levels of antigay prejudice experienced a higher risk of mortality than those living in lower-prejudice environments. They estimated a lower life expectancy of 12 years, due to higher rates of suicide, homicide/violence and cardiovascular disease. A similar effect has not been established for the UK, however, it is likely that there are impacts of living with high levels of prejudice and overt hate crime.

Hate crime is defined as ‘any criminal offence which is perceived, by the victim or any other person, to be motivated by a hostility or prejudice towards someone based on a personal characteristic.’ This impact of hate crime can be great; 68% of victims of hate crime are ‘very much’ or quite a lot’ affected emotionally by the incident, compared to 37% of victims of overall crime (Home Office et al, 2013). The effects include feeling fear, difficulty sleeping and anxiety or panic attacks. As the nature of the crime is an attack on a person because of their identity, it is unsurprising that the effects are greater than for crimes motivated by gain, for example.

Two of the monitored strands of hate crime are sexual orientation and gender identity. National statistics show that in 2012/13, 10% of recorded hate crimes were sexual orientation hate crimes, although there was variation between police forces. 42% of these involved violence against the person (higher than for

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incidents motivates by race or religion), of which 52% resulted in injury. Numbers for gender-identity hate crime are low, with 1% of all police recorded hate crime in this category. 32% of gender identity hate crimes were violence against the person offences.

Within official statistics there is likely to be a high level of under-reporting. This is likely to be because many victims do not perceive that the police are likely to do anything in response (Home Office, 2013). While this is a feature of crime in general, this may be a substantial factor in sexual orientation and gender identity hate crime incidents Home Office, et al 2013). A survey in London suggested that there were higher levels of dissatisfaction in how the police handle homophobic hate crime than in how other types of crime were handled (Antjoule, 2013).

Stonewall and YouGov conducted a survey (2013) of LGB people nationally and report that 17% had suffered a hate crime within the last three years. They divided this by gender and sexual orientation, showing that 24% of GM, 19% LW and 10% BM and 9% BW had experienced a hate crime. BME and disabled LGB people were more likely to report feeling that hate crime was a problem where they lived. 5% of LGB people reported being the target of homophobic abuse or behaviour online in the last year, including 7% of those aged 18 to 24.

Locally, the Salford Crime and Disorder Reduction Partnership reports on hate crime. For the years 2012/11 to 2012/13 there were hotspots for hate crime overall in Salford. These were in the east of the city, with Kersal and Broughton consistently in the top three wards. In 2013, Kersal, Broughton, Langworthy and Ordsall were the wards which made the greatest contribution to reported hate crimes in Salford. The majority of these were racial or religious: however this also corresponds to the areas with the highest density of LG population.

In 2012/13, 46 hate crimes motivated by sexual orientation were reported in Salford with 19 of these in the four hotspot wards. Across Greater Manchester, there are more reported hate crimes due to sexual orientation in Salford than any other part of the conurbation besides Manchester itself (LGF, 2014b).

In terms of the impact on lives of Salford LGB people, the LGF I Exist survey (2011) found that, of 139 Salford respondents, 53% had ever experienced hate crime (59% of these were in the last 3 years), and of those who did experience it, 70% did not report it. For all of Greater Manchester, nearly half had ever experienced hate crime, and 62% who experienced it reported it. (LGF, 2012b; LGF, 2012c).

Centrally, the Government has committed to improve the recording of hate crimes and to develop a better understanding of the issue by strengthening the evidence base – to give a more robust picture of the types of hate crimes that are happening, the victims who are affected and offenders’ motivations. (Home Office, 2013). Within Salford, the Community Safety Partnership has sought to establish and publicise a number of third-party (independent of the police) hate crime reporting centres.

The Lesbian & Gay Foundation is a third party reporting centre and may be a preferred port of call for Salford LGBT residents. Greater Manchester police maintain a presence in Manchester’s gay village in order to help encourage trust and confidence from LGBT people.

Currently, the community organisation, Out in Salford, includes in its action plan, agreed through the Salford City Council Multi-agency Forum, a number of actions in order to make local residents more aware of how to report a hate crime:

- Build capacity by identifying and training individuals to support people to report hate crime
- Out in Salford to become a recognised third party reporting centre
- Arrange hate crime awareness sessions for Salford’s LGBT community
- Distribute information at all visibility events on how to report a hate crime

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4 These numbers vary slightly from the totals for Salford reported by LGF (2014).
• Explore the possibility of coordinating an anti hate crime tour across Salford
• Included and update information on how to report a hate crime on Out in Salford website and social media

These actions should be understood as contributing to wider goals of reducing stigma within the community and normalising acceptance of different sexual orientations and of individuals with gender dysphoria. Improved acceptance and reduction of stigma has the potential to create more salutogenic environment for LGBT people in Salford, with benefits for mental and physical wellbeing and health outcomes.

Hate crime has a negative impact on wellbeing and reinforces feelings of stigma for LGBT people.

In 2012/13, 46 hate crimes motivated by sexual orientation were reported in Salford, with the majority in the east of the city.

Improving reporting is important as part of a general approach that hate incidents are not to be tolerated, and also providing information which may aid the development of interventions.

16 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, being HIV positive, reporting depressive symptoms and engagement in unprotected anal sex. Perpetrators of IPV had increased odds of substance misuse (Buller et al, 2013). Broken Rainbow, a charity dedicated to supporting the LGBT victims of domestic violence and abuse has called for services to recognise that LBW are also victims.

Stonewall (Hunt & Fish, 2008) found that LBW in their national survey that one in four had suffered domestic abuse – a similar rate as the general female population. 80% of these had not reported it. In the qualitative comments from respondents of the survey, it was noted that services are set up with the presumption that those experiencing domestic violence are heterosexual women. Comments noted that women could sometimes be interviewed by police in the presence of the female perpetrator, under the assumption that she was a friend or support. Women-only refuges may not appear as places of safety if the perpetrator of violence is a woman.

In the survey of GBM, half had experienced at least one incident of domestic abuse from a family member or partner since the age of 16. More than a third GBM had experienced at least one incident of domestic abuse in a relationship with a man. This highlights a high level of intimate partner violence and also the violence within the family that may be experienced as part of revealing a GB sexual identity.

For both GBM and LGW abuse may include the threat of ‘outing’ the person to people who are unaware of their sexual orientation, e.g. work colleagues. This particular form of psychological abuse is specific to LGBT people.
Stonewall analysed the results of their surveys and note that disabled LBW and GBM are more likely to suffer domestic abuse than LBW and GBM in general. 39% of LBW with a disability had experienced domestic abuse in a relationship compared to 24% of LBW without a disability. For men, 63% GBM with a disability experienced domestic abuse from a family member or partner since the age of 16, compared to 47 per cent of gay and bisexual men who don’t have a disability (Guasp & Taylor, 2012).

Comparison of Stonewall data shows these issues exist locally.

**LBW, Hunt& Fish (2008)**

<table>
<thead>
<tr>
<th></th>
<th>No never</th>
<th>Yes, from a male</th>
<th>Yes, from a female</th>
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<tbody>
<tr>
<td>Salford</td>
<td>73.7%</td>
<td>10.5%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Northwest</td>
<td>70.2%</td>
<td>9.9%</td>
<td>19.2%</td>
</tr>
<tr>
<td>England</td>
<td>73.6%</td>
<td>9.4%</td>
<td>16.6%</td>
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**GBM, Guasp (2011a)**

<table>
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<tr>
<th></th>
<th>No</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Salford</td>
<td>52.3%</td>
<td>47.7%</td>
</tr>
<tr>
<td>Northwest</td>
<td>47.9%</td>
<td>52.1%</td>
</tr>
<tr>
<td>England</td>
<td>50.5%</td>
<td>49.5%</td>
</tr>
</tbody>
</table>

The national charity Broken Rainbow provides telephone counselling services, which are advertised within Manchester by the LGF.

Recognition of domestic abuse and violence within same-sex relationships on the part of services is patchy nationally and this is likely also to be the case in Salford. It should be strengthened. Services providing support should be encouraged to improve sexual orientation monitoring to improve understanding of needs in Salford.

**17 Housing**

LGBT people may be more likely than their heterosexual contemporaries to live in rented accommodation. The LGF and Manchester City Council (2014) suggest that the patterns of housing for LGBT people mean they have a higher exposure to crime, and this is confirmed by the quoted accounts in Guasp et al (2013).

Stonewall has produced a housing guide for older LGBT people (Stonewall Housing & Manchester Older LGBT Housing Group, 2014). This includes much generic information for older tenants, but also includes information on the death of a civil partner, domestic violence and a section on hate crime. City West Housing Trust in Salford is one of the supporters of the guide. Having this available and visible will be an important part of providing reassurance to LGBT tenants that their needs are understood and taken into account.

Young LGBT people appear to be more likely to become homeless, often through family rejection, with an estimated that one in 10 (8%) LGBT youth experiencing this (Metro Youth Chances, 2014). They are then vulnerable to crime, exploitation and violence (Roche, 2005) and poses risks to their mental and sexual health (Cull et al 2006). In Salford, the local authority works with the Albert Kennedy Trust. AKT is able to support LGBT people up to the age of 25 with the offer of emergency safe houses through the ‘purple door’
project and longer term support into education, employment and training, and skills needed for independent living through a structured tenancy training program.

Work done for Salford’s State of the City plan investigated trends in housing development. Projections based on the previous five years suggest that the trend of major development in the east of the city will continue. These will mainly be one or two bed flats or apartments which are likely to attract inward movement of people to the city. The mapping of the proportion of LGB people in Salford in the first section of this document indicates that this part of the city shows higher concentrations of the LGBT population; this appears likely to be strengthened by the housing trend. A future housing needs assessment for Salford should include specific consideration of the needs of LGBT groups.

LGBT people make more use of social housing and community safety issues make this an important determinant of wellbeing. Future housing plans make it likely this will continue in the east of the city.

LGBT young people have high rates of homelessness nationally and local need has been identified.

18 LGBT Community Groups and Assets

Salford benefits from proximity to Manchester with the locus of community activity around Canal Street. The Lesbian Gay Foundation actively provides support on many aspects of health and wellbeing. Salford also has its own group, Out in Salford, which receive some support from Salford City Council, as noted above. They are currently updating a local information leaflet which lists support available to Salford’s LGBT residents.

Both Salix Homes and City West have LGBT groups for residents of social housing in the city. This should help with issues of community cohesion and prevention of escalation to hate crime incidents.

The LGF’s ‘I Exist’ data for Salford (LGF, 2012c) shows that 40% of respondents felt that they could influence decisions affecting their local area. This was contrasted to Findings by the Department for Communities and Local Government (2011) findings that 29% of the general population say they can influence decisions in their local area. 34% volunteered for an organisation or voluntary group at least once a month, contrasted to 23% of the general population.

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.

A 2009 report for the Salford Carers’ Strategy board noted the result of consultation with LGBT groups and carers’ groups in the city. The finding was that ‘there was a clear demand for LGBT friendly services rather than LGBT specific services, which people felt can further segregate them from mainstream services.’ The report concluded that if carers’ services are actively promoted as LGBT friendly then this would encourage LGBT carers to access breaks and support services.
Conclusion
This needs assessment examines the evidence of inequalities in the health and wellbeing of LGBT people in Salford. In order to understand the possible origins of some of these inequalities, it is helpful to adopt a life course approach, which recognises that people’s health partly reflects the accumulation of risks and protective factors through different life stages, and is significantly influenced by the experiences in early life. For individuals whose developing sexual identity is LGB or who experience gender dysphoria, acceptance and support from an early age and during the transition to adulthood is key to strengthening wellbeing and preventing poorer outcomes. The flip side of this is that the experience of discrimination, stigma, homo/bi/trans phobia and marginalisation appear to be underlying factors development of lifestyle behaviours such as smoking, high alcohol use, drug-taking, sexual risk-taking. These experiences are also likely to help account for increased rates of poor mental wellbeing and ill health.

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 Salford with the aim of improving the wellbeing and health outcomes of the LGBT people of the city.

There are a number of community groups and resources in Salford. These should be regarded as allies in working to improve the inequalities identified in this needs assessment. Referrals made through Making every Contact Count could include information on LGBT groups as relevant to individuals who are signposted to services.

LGBT friendly services may be important in avoiding a sense of segregation.
Recommendations:

The literature and data gathered in this needs assessment underpin the following recommendations. The needs of the LGBT population should be embedded in commissioning across Salford through consideration of specific services, inclusion in all contracts and, where appropriate, through specific Key Performance Indicators. They should also be considered by provider organisations for service improvement.

The recommendations should be used to inform the development of Salford’s Equalities Strategy.

Sexual Orientation Monitoring and report recording

- Work towards routine sexual orientation monitoring (SOM). This will inform future commissioning and underpin reporting on uptake of services and outcomes.
  - Services working in the areas outlined in this needs assessment should be the first to adopt SOM (see full report).
  - Social care, health and other staff need training to understand the rationale for SOM and the benefits in general and to their specific service, for wellbeing and health outcomes and for service users.
  - The training should include understanding that BME and disabled individuals may also have an LGB sexual orientation or be trans.
  - Use SOM to improve the outcomes and experience of LGBT service users and clients.
  - Use SOM to identify sub-groups within LGBT with highest support needs in Salford.
  - Inform staff of the reasons for SOM within Salford City Council and SRFT and monitor staff. The overall percentage of LGBT staff should be publicised.
- Take measures to encourage the reporting of hate crime due to sexual orientation and gender identity.

Workforce issues

- Ensure staff working in mental health services develop cultural competence to support wellbeing in LGBT people.
- Ensure staff in alcohol and drug services develop cultural competence in working with LGBT people.
- Develop Making Every Contact Count (MECC) messages to signpost any LGBT individual to specific local LGBT support / groups as part of the referral process.
- Continue to increase the number of GP practices involved in Pride in Practice.
- Information regarding needs of trans people should be given in Pride in Practice or through a similar mechanism.
- All services should work to reduce the consistently reported concern LGBT people express about poorer experience of care due to their sexual orientation or gender identity.

Reduction of stigma

- Acknowledge the probable role of stigma in poorer mental health for LGBT people and ensure the issues faced by LGBT people is included with city-wide work on mental health and stigma.

Specific service recommendations

- Work to improve uptake of STI preventions and testing both for GBM and LBW.
- Consider the feasibility of implementing the recommendations of PHE ‘Halve It’, to increase HIV testing and reduce the number of people with undiagnosed HIV infection.
- Act promptly if PHE issue guidance on HPV vaccination.
- Set a local target for the gap between general rate of smoking in Salford and for Salford LGBT groups and make quit campaigns inclusive.
• 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 in drug services.

• Cervical and breast cancer services should include clear information on risks for lesbian women and monitor uptake of screens by LBW.

Future needs assessment work

• Future needs assessments conducted for Salford should consider the needs of LGBT people. In particular, the forthcoming housing needs assessment should do this.

• Conduct a separate needs assessment for LGBT youth. The needs assessment should include staff working in schools and colleges as well as youth services and sexual health services for young people on the steering group.
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