Voice of LGBTQIA+ Luton Residents

Healthwatch Luton's report for the Denny Review

January 2023

Contents pg

1. Glossary Term (Stonewall) 2
2. Methodology of Engagement and Feedback 3
3. Report Limitations 5
4. Overall Summary Findings – Thematic Statements in Common 7
5. Findings for Denny Questions; What works well, what doesn't and what could be improved? 9
6. Recommendations for Denny Steering Group to take forward 12

Further Report Details **14**

7. Case Study 1 15
8. Demographics from Collaborators and Engagement 17
9. Case Study 2 19
10. Thematic Findings from Initial Statements 21
11. Case Study 3 25
12. Thematic Findings from HWL survey 27
13. Case Study 4 30
14. Next Steps 32

Appendix 33

a) Biography of partner organisations 33
b) Data Collation Thematic Tables from Surveys / Forum 34
c) Thematic responses to the Forum / Interview / Case Study: 36
d) Thematic Summary Findings from Survey: Collaborators Denny Survey (Only) 38
e) Interview Questions for Case Studies 39

END : Contact Details for HWL 40

1. Glossary - Stonewall

LGBT stands for Lesbian, Gay, Bisexual or Transgender and the plus sign stands for a range of other descriptions people may choose to use. HWL have opted to use the term LGBTQIA+
The charity Stonewalls definition of these terms is below:
Lesbian Refers to a woman who has an emotional, romantic and/or sexual orientation towards women.
Gay Refers to a man who has an emotional, romantic and/or sexual orientation towards men. Also a generic term for lesbian and gay sexuality - some women define themselves as gay rather than lesbian.
Bi is an umbrella term used to describe an emotional, romantic and/or sexual orientation towards more than one gender. Bi people may describe themselves using one or more of a wide variety of terms, including, but not limited to, bisexual, pan, bi-curious, queer, and other non-monosexual identities.
Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) transgender, transsexual, gender-queer (GQ), gender-fluid, non-binary, gender-variant, crossdresser, genderless, agender, nongender, third gender, two-spirit, bi-gender, trans man, trans woman, trans masculine, trans feminine and neutrois. TGD – Trans Gender / Gender Diverse
Q is Questioning or Queer – intermittently used
I relates to Intersex
A is Asexual
+ Stands for other terms, such as but not limited to 'non-binary': An umbrella term for people whose gender identity doesn't sit comfortably with 'man' or 'woman'. Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely.
MOM – Man on Man (Sexual encounters)
Cisgender or Cis Someone whose gender identity is the same as the sex they were assigned at birth. Non-trans is also used by some people.
Transitioning The steps a trans person may take to live in the gender with which they identify. Each person's transition will involve different things. For some this involves medical intervention, such as hormone therapy and surgeries, but not all trans people want or are able to have this. Transitioning also might involve things such as telling friends and family, dressing differently and changing official documents.
Other terms: (https://www.stonewall.org.uk/help-advice/ glossary-terms)
SMW – Sexual Minority Women
HWL – Healthwatch Luton
VCSE – Voluntary and Community Sector

'If there truly was no stigma in 2022 – you would not be seeking my views. I don't represent everyone, but can only ask you just see this as my view – a human, a person, who is struggling because I don't know where to go for support. That, - that is the part I hope you can help with.'

2. Methodology of Engagement and Feedback

This report was commissioned by the BLMK Integrate Care Board.

The Denny Engagement Project was commissioned by the BLMK ICS after the Denny Literature Review was completed, to look at those disproportionately affected by COVID-19 across Bedford, Luton and Milton Keynes.

The Denny Literature Review had three distinct stages:

Stage one - A literature review to assess the existing information about health inequalities and their impact on BLMK Communities. This review pulled together the common themes and identified the gaps and understanding of good practice relevant locally – and used this to inform strategy and service change
Stage two - An engagement exercise listening to individuals and communities about their experiences of health inequalities and working together to think about how to address them effectively
Stage three – the development of co-produced practical recommendations for action by the whole health system; its partners and communities, supporting the achievement of the ICS Strategic Priorities and targeted resources to making positive difference collectively.

This report outlines the Stage Two section organised by Healthwatch Luton, within Luton, with their Collaborating Partners:

Healthwatch Luton had already begun a project to gather views from those within the LGBTQIA+ community in Luton, which from prior year's feedback had been shown to be lacking. With this project already underway, Healthwatch Luton were commissioned to support the Denny Steering group, with questions from the steering group to determine how to analyse thematic responses to feed into Stage 3.
Healthwatch Luton began this work in July 2022 – and did not find a suitable and collaborative partner until September / October 2022. These partners are now:

- Penrose (x 5 LGBTQIA+ Ambassadors and connections)
- Pride in Luton (Committee and Contact connections)
- Individual Collaborators (x 4 individuals)

Healthwatch Luton, after doing an initial findings survey, realised we could not 'partner' with one individual group / community led support service in Luton. Many people within Luton provided feedback that they were not attributed nor represented by just one partner, and so we opted to partner with two community organisations and individuals we called 'Collaborators' who provided personal insights.

Healthwatch Luton used the following methods to gather the feedback:

- Individualised Interviews to create supporting Case Studies for the report
- Healthwatch Luton's own survey – for initial findings
- Initial Statements reviewed by Partners for discussion
- Denny Engagement Survey – using questions confirmed by the Denny Steering Group
- Healthwatch Luton's Listening Events – online forums on a arrange of topics
- Individual phone-call discussions; interview style
- Feedback centre – generalised feedback Healthwatch Luton had gathered
- Healthwatch network events and discussions with other Healthwatch and their feedback

Healthwatch Luton also did a review of the Healthwatch networks' reports to determine other leading themes which co-existed in Luton, and those which the feedback from the Denny Partners would be solely regarding Luton residents.

In total, Healthwatch Luton, in 2 months gathered feedback in some form from just over 50 (52) Luton residents and people who were happy to respond to our engagement, either via survey, interview, email or phone call. Some residents no longer resided in Luton, some reflected views outside of Luton, but all had heard of our work through the Collaborators we worked with on this project about Luton and BLMK.

All views are anonymised and not associated with any individuals, and cannot be attributed to any person. All likeness in Case Studies have been removed for anonymity and where people have disclosed their data, we have sectioned them out. Where a name has been attributed to a quote this has been done with full consent and all who took part have fully consented for their views to be used by the ICB Denny Steering group and engagement and Healthwatch Luton for ongoing use.

All images used are from Healthwatch England's stock images (BrandStencil) and not attributed to the views relayed to Healthwatch Luton – but have been used to reflect the reporting in a more stylistic approach.

3. Report Statement – Limitations

Report limitations within our engagement

- Healthwatch Luton worked with two organisations for this project. Due to timescales, the deep relationship management usually considered in our engagement was unable to be completed, but we hope to carry on working with individuals from those community groups in to 2023 to gain further views
- Individual collaborators and people who contacted us 'offline' outside of our usual routes were quite enlightening to our findings; including terminology discussions, non-aggressive training and outlining of 'stereotypes' and general support in continuing the conversation with the health and care system
- The term 'community' was one of the most common themes, particularly during interviews and case study discussions during the course of this work. People felt very much there was a difference in the 'community' which tended to be 'out and proud' and those who identified as LGBTQIA+ and not associated with an organisation or group; this terminology is used within this report for those who found the terminology important.
- There was an over-riding review of support being held or led by 'gate-keepers' – who tended to want to lead in supporting people with similar views; but also resulted in other LGBTQIA+ residents not associating or being able to engage with community 'support' organisations; particularly from non-white non-British collaborators
- The timescales for this work has, for Healthwatch Luton, outlined that further work is needed regarding understanding more from how we can support people who identify as LGBTQIA+. **This report should be the starting of a conversation that can help change and improve service delivery.**
- HWL worked with two partner VCSE groups – Penrose, and Pride in Luton. Due to timescales, these organisations have provided a wide range of input into this work – but both have stated those contributing views do not reflect all the voices needed to be gathered in order to make this a BLMK overview; further work is needed.
- It has been made clear from those we have spoken to that each individual's journey and experiences only represent their own; and should not be taken as a reflection of all those who identify as LGBTQIA+ across a regional area; and more in-depth work would be needed at each Place area
- Most willing to 'speak' to Healthwatch were mostly white and British. Views captured of Asian, Black and Ethnic minorities were harder to receive in the timescales provided. Through developing our approach, and with longer timescales, we believe we could collate more views to represent the ethnically diverse population better.

'You keep referring me as part of a 'Community' – which I am not. I am just me, trying to figure out what I am and how to navigate my life. The less the system tries to pocket us into groups would be a start to understanding half our needs.'

"The approach is always – ask 'them' about this one topic– so we know how to deal with them. Why doesn't the system recognise, if they changed *their* approach, we wouldn't be a 'them'.

'Most of the support groups I am aware of – or are signposted too – are run by middle-aged white men, who may or may not be gay. That doesn't reflect me, my life, my history and who I need to connect with. It's another mis-hap, and I don't know what to do to change that.'

"I don't know if they even realise half of us are also just trying to figure it out. It's great to be asked my opinion, but I am willing to give you my views. It's those I know who won't step up that need to be heard, and I am not sure, unless the world changes to support them entirely, whether they ever will be.'

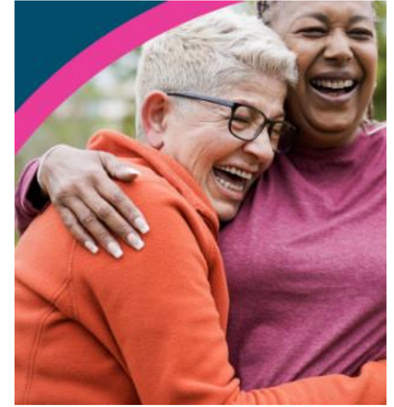
'For those of us who do refer to the 'community', it is entirely invaluable; without having what I class as my community; which are virtually my family now; I am unsure of what I would do. I know not everyone feels the same – but for me – it has been all the support I needed.'

4. Overall Summary Findings

From the people who identified as being Lesbian, Gay, Bisexual, Trans, Queer/ Questioning, Intersex, Asexual or Other + - these are the overall summary statements taken from the responses we have been provided.

- Older and younger people (throughout the feedback) reflected on their **feelings of anxiety and isolation** which had been exacerbated through the COVID lockdowns; but is also driven by micro-aggressions and experiences throughout their lives
- **Anxiety was outlined as a 'baseline' feeling** for many young LGBTQIA+ people, stating that 'as they start the day they probably worry more about how that day will be' than their straight peers; within this – many knew of the offering of self-referral mild / moderate mental health support, but none had engaged with the service due to not feeling it would be supportive; reflective; knowledgeable
- There was a **distinct lack of culturally appropriate support** for varying ethnicities and identities; generally health services and community support services that were most funded / most awareness, were not culturally reflective of many of those we spoke to
- There was a common theme of **diagnostic overshadowing** – a term used by a few people we spoke to, referring to feeling dismissed or there experiences being 'downplayed' or dismissed
- **Cis-normative communications** in health and care was a large theme discussed throughout the project, and that a change in terminology in data gathering would be beneficial and supportive, and even lead to discussions that may support health and care needs
- **First contact care** affects lifetime of health and care interactions; and people discussed if their first interaction (at any age) with a health or care provider was negative, cis-normative, or un-engaging to allowing them to express (or not) their identity, it had a lifetime effect on how they continued to engage / trust the health and care system.
- Some medical professionals still made some people feel like **'medical curiosities'** and this will have a profound effect on how they engage with health and care ongoing. This approach needs addressing particularly for the trans / transitioning community
- **Medical identity** needed to remove the 'tick boxing' element in continuing care or referrals. Some residents expressed seeing sight of their medical notes which referred 'Lesbian / Gay' at the top – regardless of the health condition, which would not be consistent for 'straight' patients.
- It was discussed on a few occasions, and highlighted in a few survey respondents that the '**gate-keepers' to community** support could sometimes also create division and cultural disparity – leading to particular some younger (black) residents not associating with statutory or community support.

- '**Concealment' factors** were particularly raised in the Black (British) and Black (Caribbean) feedback, highlighting stigmatisation within their own community (cultural stigmatisation) led to some not being able to raise their views due to fear of community rejection.
- Many from non-white ethnicities (mainly Pakistani / Bangladeshi / Hindu feedback but also noted in Black Caribbean) discussed **cultural disparity in seeking health and care support** – where when unable to see culturally ethnically reflective health and care staff, could cause dis-engagement and lack of trust
- Many young people outlined the **lack of age -appropriate support for young people** 'questioning' their identity. Some felt the 'appropriateness' of the information was set by those outside of their age range without discussion – leading to some young people not feeling guided
- Some **young people reported 'self-education' and 'educating down'** was happening among young people (particular in the White / and South Asian young feedback). Because of a lack of appropriate support, young people were researching and teaching young people, and felt this could be improved
- One family discussed the lack of support they perceived whilst transitioning from male to female – for their children. The reflection was provided anonymously, **asking for more support for trans children, or children from Trans parents.**
- For those who had positive experiences, they thought that **general staff / workforce attitudes were improved** than from historical experiences when younger; they found stigmatisation to be limited, and for those with positive experiences – found the **health and care system supportive and empathetic**
- **Access to services –** was generally deemed as needing more up to date and appropriate timescales – for most health and social care settings
- **Understanding different cultural perceptions and backgrounds –** key to addressing cultural competency and awareness; many different ethnic minorities displayed concern for general mis-understanding of their general cultural differences; which affected accessing health and care
- **Terminology understanding –** use of the correct terminology goes a long way in providing assurance and trust for people experiencing different gender affirming /dysphoria expressions. Understanding terminology supports people's interactions with the health and care services (binding, packing etc) and training would be recommend to update health and care workers on this terminology



- **Sexual Minority Women (SMW)** – already feel displaced and 'invisible' as minority women in white towns, feel dis-engaged when discuss 'women's health' due to feeling unsupported. Combined wider determinants (being ethnic minority and gay/lesbian) increases lack of feeling heard, empowered or supported in health and care journey through their life.

Luton Sexual Health services was mentioned by over half of all those we spoke to, and nearly all rated the service positively / had positive interactions with the provision. I-CASH was another sexual health provider that was rated highly.

Of those who did not rate the service highly – the theme was around needing more funding / more outreach in younger audiences / more cultural groups / sessions held / more extended hours in availability.

5. Findings from the Denny Project:

The main topics of the Denny Engagement for the ICB were situated around the following themes and questions:

- What worked well?
- What didn't?
- What and how could it be improved?
- Communications and being understood
- Tools and messages for self care
- Support around self care
- Trustworthy messaging and advice
- Health prevention

Healthwatch Luton used these questions as agreed by the Steering Group from the ICB outlined in the project proposal. We also however, adapted some of our interviews and forum questions to understand information further from the Denny Collaborators and participants.

We included questions around

- Communications general and inclusive messaging
- Training and staff competencies; beyond cultural competency
- Access to services and awareness of services
- Stigmatisation in health and care

Outside of the two Voluntary organisations who supported this work (Penrose and Pride in Luton), and aside from the individual Collaborators, toward December 2022 we began to receive individual anonymised phone calls relaying experiences to us. We amalgamated these views with our Denny respondents and thematically analysed along with our formal partners.

Allowing individuals to feed into this project alongside our partners ensures we capture as many diverse views as possible; and seemingly black and Asian responders mainly preferred the interview and phone call route to providing input.

What works well?

- Generally feedback highlighted **staff and staffing attitudes** more favourable (in over half of those who responded) – words used were, 'caring, respectful, empathetic, responsive'
- Therapist using **inclusive language** and being supportive opened up more honest dialogue between health and care clinicians and patients; resulting in more trusting relationships for ongoing care
- **Luton Sexual Health services/ I-CASH** – many mentioned this provider and service favourably in support; for content provided, knowledge and educational information
- **Hospital support was 'great'** from a few respondents; 'non discriminatory' and 'empathetic' when sexual health was affected
- For those who are engaged with health and care services, many had similar issues to general population concerns (like GP access, dental access etc) and few found their orientation was involved in this
- **Health prevention messages** (on general health) were clear – but could be advertised more in more appropriate places; digital forums, apps etc
- **Digital access to clinicians where available –** worked best for a lot of responders, to support anonymity (for those where this was important) and choice of appointment

What wasn't working well?

- **Waiting for gender identity psychoanalysis** before turning 18 – or receiving under 18 information lacking; more general information on this would be helpful
- **GPs** – many felt not enough time to discuss issues available, being seen face to face, continuity of care lacking by never seeing same GP – made it harder to have honest open conversation; online and phone were generally working well, but needed longer time to open more
- **CAMHS** – no follow up after referrals, – resulting in admissions; more than a few respondents outlined waiting times for support being an issue for young people

- **Staff shortages** – resulting in long waiting times, lack of resources, and no time to provide good health or care;
- **Referrals / Hospital Discharges** – not much support
- **Feeling misgendered** – or dismissed '2nd class citizen' or 'ignored'; some outlined challenges in correcting gender representation on more than one occasion; resulting in fatigue and irritation
- **Lack of awareness of support service** – or lack of culturally or age appropriate groups; with culturally appropriate staff and workforce
- Those who were not engaging in health and care had psychological **and deep routed traumatic experiences which dis-engaged** them and would most likely never recover to engage with HSC
- **Advice outlet** for young people / older people / people from different cultures to have sexual health information and guidance; more than just in sexual health clinics
- **Diagnosis and symptom management information** – available at outlets such as Sexual Health services but if not engaged with these services, feel limited communications (e.g. HIV diagnosis)

What could be improved?

- **Access to sexual health services** – to be more appropriate for the working person; sometimes staff shift / opening hours are not appropriate for people in various age/ cultures
- **GP or General Health support access** – to be more available, time allowing for more person centric and honest discussions
- **Health Literacy** – for younger people to be more available in more accessible places (such as schools) and for older to be more available for aging members who identify as LGBT+
- **More education on Gender services** – these are well known by those who use the sexual health services but those who do not know, need to be promoted further, and more outreach options available
- **Inclusive language** – to be used more in general health and care paperwork/ data collation –
- **Cultural competency** – felt generally competency was there, but actually more in depth signposting and training on behaviours, relationships and ongoing health support
- **Comprehensive assessments** – to be more widely available for all with regards time of assessments, length of assessments and where assessments take place
- **Gate Keepers within the community** – should not be used as always representative and the term 'community' to not always be used as a tick

box summary of those who are LGBT+; understanding language usage important for engagement

- **General Communications on Sexual Health** – to be more apparent in general society – not just allocated to sexual health service provisions
- **Extending opening times** – for information outlets and providers – to ensure working well are able to use as well as within day / 7 day service
- **Local people refer to local services** – whilst have opportunity to attend town wide / regional wide support – for those who cannot access, need online / digital versions available more

6. Recommendations for the Denny Steering Group

The recommendations below on the next page reflects the overall recommendations suggested by collaborators, either individually or thematically analysed as part of this engagement; as well as overview from Healthwatch Luton.

These recommendations are based on the work completed through September – December 2022 and ongoing engagement with these collaborators, but the main recommendation for the Denny Engagement Steering Group would be to **develop further engagement more sustainably** to ensure co production can be achieved in the future.

Many collaborators felt this engagement was 'a good start' to understanding some issues faced by some people; but that overall the general health and care system needed to continue to develop engagement in this process in order for residents to trust sharing their views made a difference.

Many praised the overall staffing and staffing attitudes in health and care; and many acknowledged general issues in health and care unaffected by someone's sexual orientation or gender identity (such as GP access) However, the reasons for being affected by GP access outlined some specific issues for people who are LGBTQIA+, such as how they build trust to explore and discuss sexual or orientation health and care concerns.

The recommendations are outlined – but are brief due to the nature of this short-timed programme of work. **Healthwatch Luton would recommend**

- The Denny Steering group review this report in full and review the thematic **changes which can be made at Scale**
- Healthwatch Luton would like to share this report at Luton Place and Health and Wellbeing – **to review what can be supported at Place**
- We would also recommend this report be taken as a '**start' of a process;** and that these recommendations are not a representation of everyone in BLMK who is or identifies as LGBTQIA+

- SCALE – ICB
  - Healthwatch Luton would recommend that the ICB review the approach to engaging with the Luton community regarding seeking experiences of a 'set piece' work – and start to adapt their communications and engagement to be more inclusive and less cis-normative generally;
  - Digital support to be progressed; for anonymity and time – many supported a digital strategy of progression allowing more people to access health and care; for anonymity
  - ICB to review approach to engagement at both scale and place; one Luton resident review does not reflect those across BLMK – and need to ensure steps for planning engagement going forward at scale
  - ADVICE LINE – for all health, before 111 or after GP access tried – for general concerns but also for health related to gender / YP / Isolation / - for advice and info – not for diagnosis or referral (could be non clinical)
  - Training and development in LGBTQIA and approaches to languages when used in diagnosis / coding etc / not being seen as medical curiosities or dismissed – leads to dis-trust in honest health conversations – cis normative languages
  - Challenge the view of systemic racism and homophobia within the health and care institutions –many viewed this to be a priority
  - Provide funding / support for different ethnic minority led awareness / support groups – need to be racially / ethnically appropriate or supported
  - Just over half of responders felt stigmatised when accessing health and care – needs to be addressed; and deeper work undertaken to review why this is
- PLACE – Luton
  - More funding to be allocated to support services that are currently working well and engaging with communities (Luton Sexual Health / iCash – Dunstable etc)
  - Extending hours of clinical assessments to be more appropriate for 2022-23 needs; extended clinics; available workforce for sexual health needs outside of 9-5
  - Culturally targeted support for different cultures / ethnicities – relevant to language used, workforce appropriate representation; support groups to be supported with funding in Asian and black communities
  - Luton Place Board to review findings and discuss potential local action plans; to feed into wider ICB plans for support. Luton JSNA outline HIV diagnosis concerns, and Engagement outlines access to diagnosis lacking from those we spoke to
  - Trans community small but apparent in Luton – research wider network shows more who won't come forward.
- Healthwatch Luton and Collaborators recommendations to provider / commissioners:
  - Training to staff / workforce around informing health and care staff on how to advise and support 'behaviours' and 'relationships' – not just general awareness
  - Trans people felt much more work was needed in general awareness of individual needs; as much as for culturally competent language and acceptance; stigma was noted most within / from these responders
  - Cultural competencies to be reviewed; most competent but need further work in workforce on signposting for behaviour / relationship information
  - Reviewing all generalised areas of working well and not working well to be constructed into action plan to review at SCALE< but also, at PLACE
  - Mental health Services known of generally – being appropriate for gender / sexuality not found so much

Further Report Details

7. Case Study 1

Profile: 24, Female, Pakistani, Queer/Questioning

We spoke to one lady who outlined various barriers she had faced in her own community regarding her own identity. She was very articulate and welcoming of having the opportunity to speak about her experiences, but highlighted the need to spend more time developing trust from any members of Luton residents to ensure more views could be captured.

All our case studies have been summarised, edited and stylised to produce an outline of the hour interview conducted.

Young female, Questioning, Asian (Pakistani)

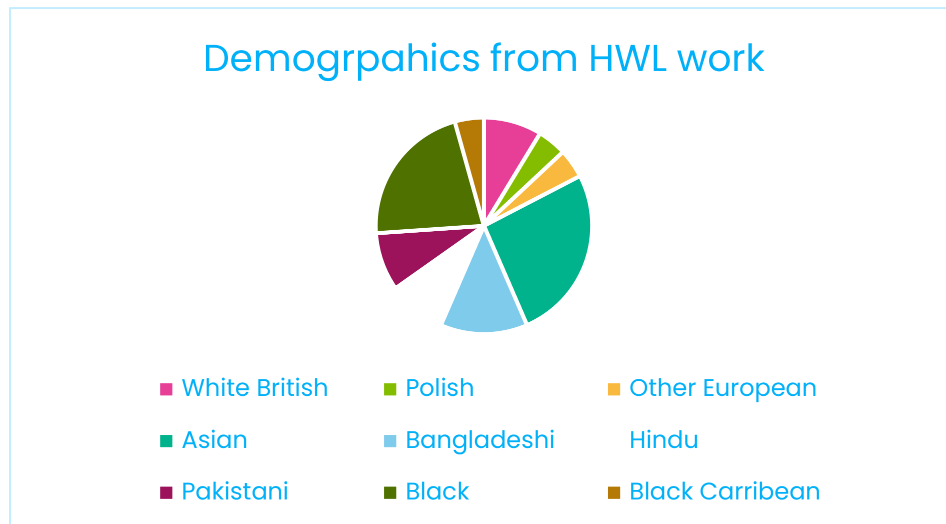
"Being an Asian woman in a white British town creates, for some, a particular sense of invisibility when it comes to health and care anyway.

If you grow up seeing white women who don't reflect your family or self, in every image, text book or media image, you learn to dis-engage very early on. Having said that, I have to admit more cultural appropriate images have been seen on health messages more recently – but I wouldn't say it's the norm.

With this early dis-engagement and invisibility, layered with being queer, or questioning your sexual orientation or identity, just adds so much aloneness to feeding into anything that you think may change. We are constantly told Luton has more Asian people than other towns, and yet everything I still encounter is white – white messaging, hetro-normative messaging – nothing that ever speaks to me as a young questioning Pakistani.

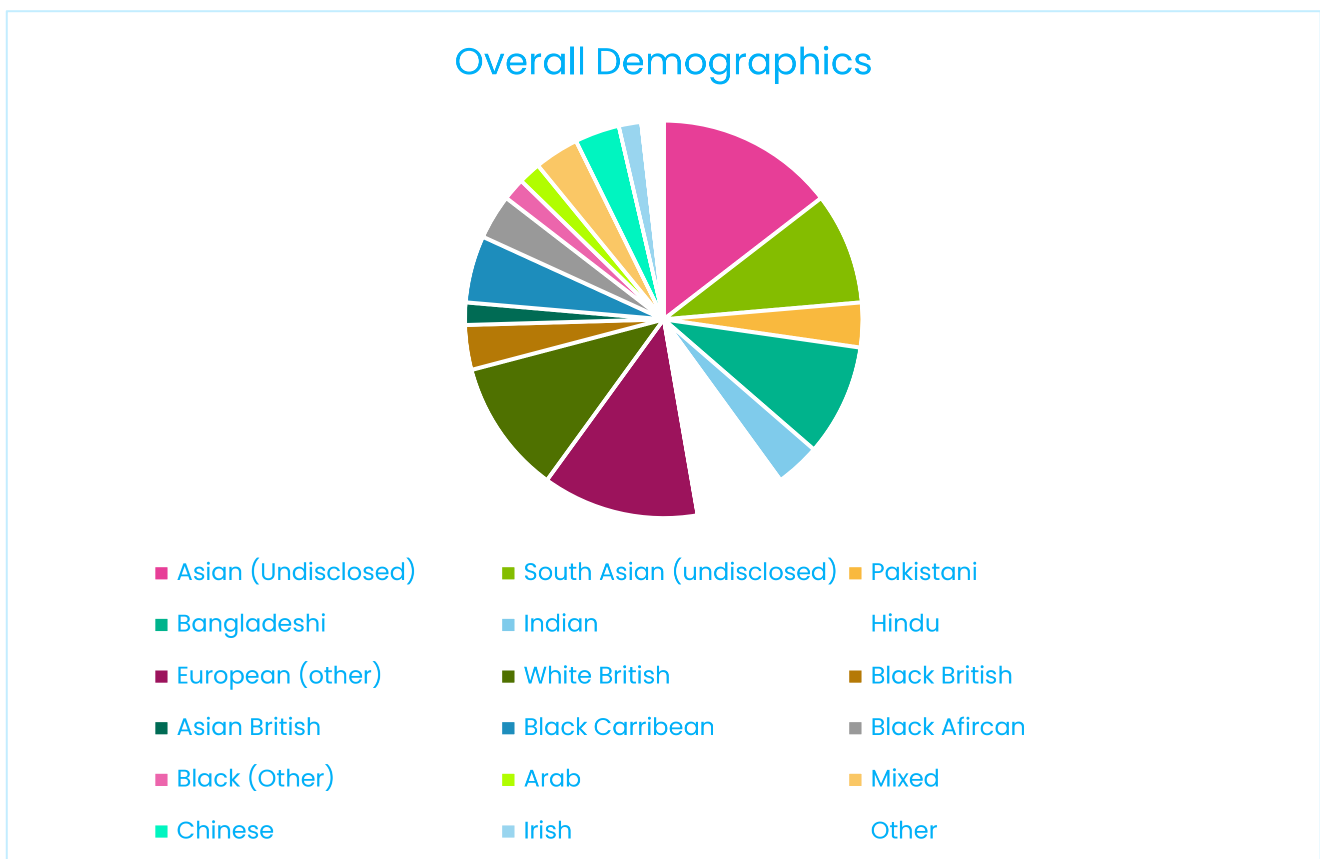
I think white people also can't or won't grasp deeply held cultural and religious and societal views which we hold in our families, and in our sense of selves. To be honest, you could change everything to be culturally appropriate and it would still take a generation before I would even feel comfortable being 'out and proud' as so many seem to be. There is a lot about cultural understanding which seems fixed in a competency workshop but if you talk to young people, like me and my friends, we could share a world of understanding, or lack of, which infiltrates all parts of my life. You can't fix things by changing the hours of service to be more appropriate – you need to really address the wider deeper issue of how health is delivered to everyone in this country.
I have felt stigmatisation in my own community for being female, I could never have the 'out and proud' motto others profess. Just to be able to access information online, discreetly and anonymously would be so beneficial. And to have in my language would make it so much easier. But I know there isn't resource for that.
I think the approach of asking us how things are for us is a great start and appreciated, but I hope as I grow up there will be less need to ask us – as we will be catered for as just other humans are catered for, no matter the identity.

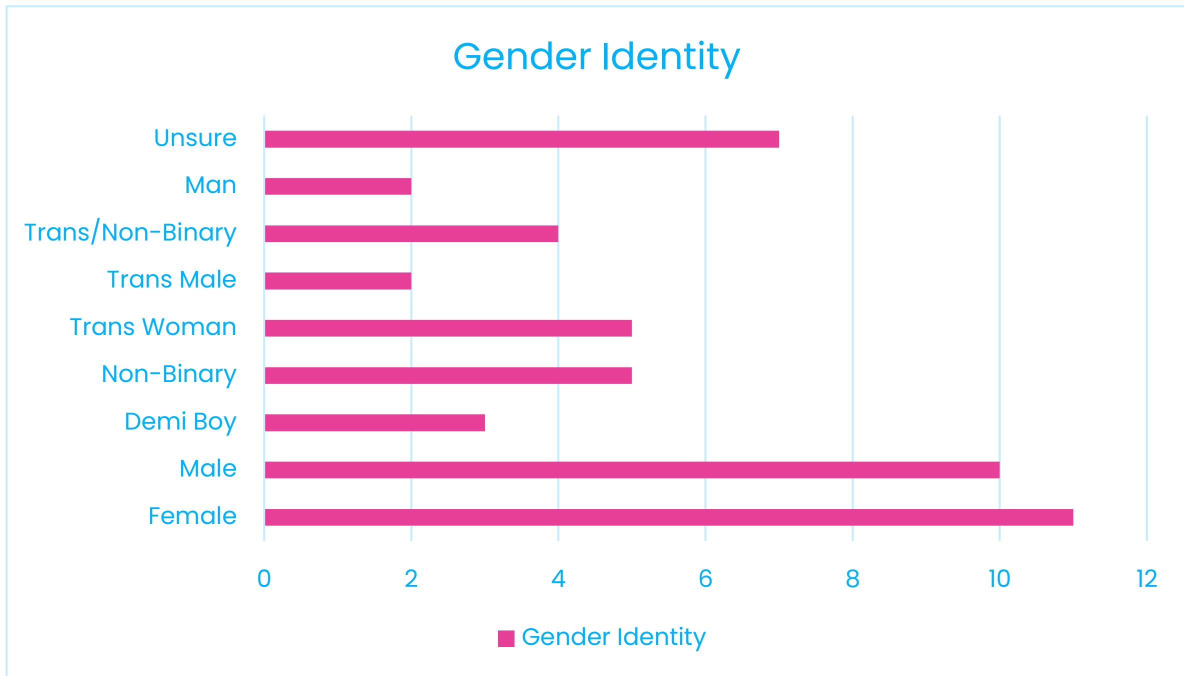
8. Demographics from Collaborators



The above demographics are from the Collaborators who took part in our survey for the Denny Engagement. Due to one of the partners main demographics being white/male – Healthwatch Luton used other approaches such as inviting individual collaborators for anonymous interviews and case study pen portraits (allowing people to send their views in anonymously) to ensure we had full representation reflective of the Luton community. Most participants affiliated themselves with their ethnicity and we added those factors to our data.

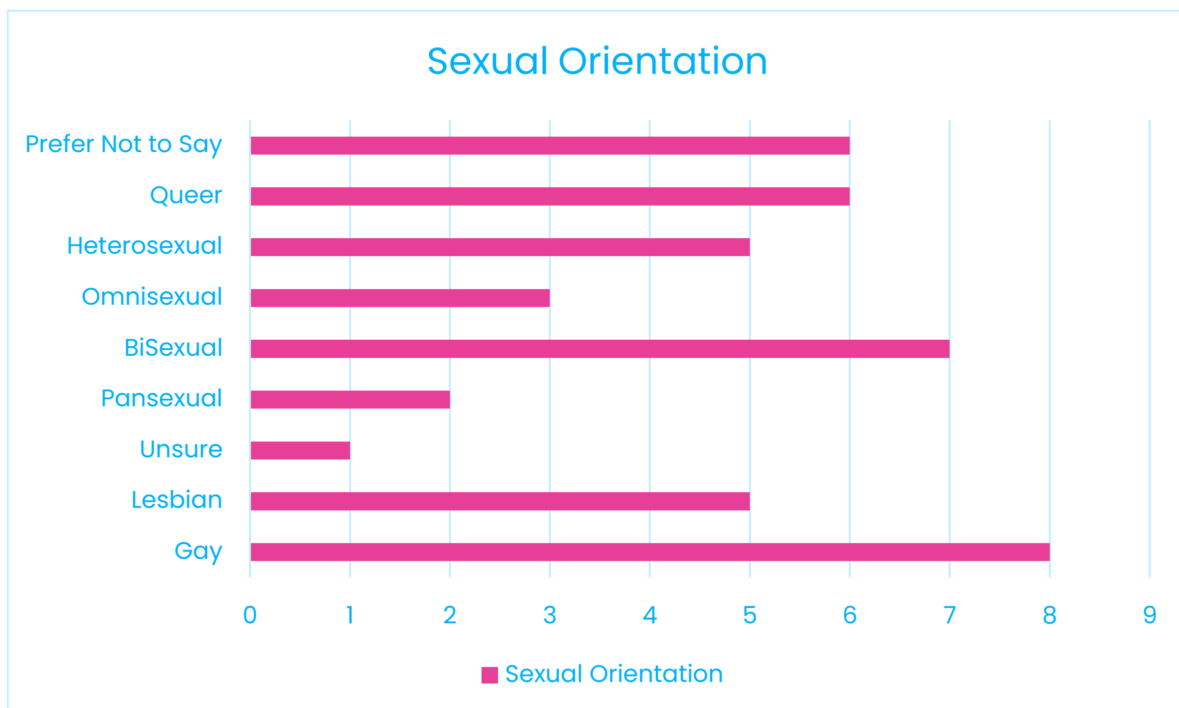
Demographics from all Collaborators / Survey / Forums / Interviews / Individuals





Most of the responders (particularly on survey) were female. The majority of our overall feedback was from females, but our interviews options for partners and collaborators were more male.

We felt a succinct lack of Trans/ Transitioning individual feedback, although the ones we received were massively informative. We also lacked Asexual, Intersexual and many other orientations / identities and with more time feel we could capture and hear more views.



9. Case Study 2

Profile: Male, White, British, Gay

We spoke to one gentleman who was adamant his view was not representative of others within Luton. And whilst he provided an insightful overview of his experience wanted us to outline the difficulty in generational views of white British people within those he knew to be LGBT+

The gentleman agreed to meet post interview to continue conversations on supporting the health system develop care for people who were LGBT+

All our case studies have been summarised, edited and stylised to produce an outline of the hour interview conducted.

Male, British, White, Gay

"My experience will in no way reflect all those I know who are also Gay in Luton. It can't. I have my experience and history and suspect it won't be the same for all.

I have had many positive experiences of health and care over the years and have to say I have felt limited stigmatisation in general health settings. There have been more issues in my wider life, such as socially and with my colleagues at work, but for health, it hasn't generally been an issue.

If I have had to declare my sexuality it tends to still come with some shame, or awkwardness, but mainly on my part. Most I have encountered have accepted and not perceptibly judged or changed their level of care, from what I can tell. The only reason I wouldn't openly declare my sexuality

would be for insurance and record purposes which they could expose me in a different environment.

It is hard to discuss openly with my GP – so I tend to revert to the Sexual Health clinic for all manner of support, as I trust them.

Communications these days should be better but actually a long time ago a leaflet / flyer in the right pub or place went a long way to bringing together the community. If it wasn't for my work I wouldn't know half of the events going on for people in the LGBT community.

Calling the community a 'community' is paramount to me because essentially they became my family when I moved away when younger. You can't say it is so for everyone though and do feel the younger generation have their own way to interact and explore with each other.

Training on sensitivities of language would be good – if you get the language right or try, you're half way there – some people just show disrespect with not even attempting to find the right words. It can make interactions quite closed if you don't have that respect in health and care

I worry about the Trans community now more – more like how I felt about the gay / bisexuals in the 80s. It seems they lack a lot more support, so that would be beneficial.

The most important part of all of this is making everything inclusive – the moment you divide it up and target it is the moment people withdraw. Just make everything accessible to all and most will find that the most helpful thing.

10. Thematic Findings from Initial Statements

These statements were thematically collated from Healthwatch Luton's initial survey sent from April – September 2022. HWL wanted to discuss these thematic statements with the collaborators of the Denny engagement – and gave options to review or amend these statements. Most responders agreed with all initial statements made from our initial survey – with amends in the final column to be added to for evidence.

Statement	Agree / Disagree	Amend / Own Experiences
1.**Training and information** for GP Surgery staff and frontline health care workers was suggested to challenge their approach and knowledge of health concerns around different aspects of LGBTQIA+ and how that affects health – e.g. MOM sexual encounters can be stigmatised	Agree	None directly but most sectors are still coming to terms of the evolving LGBTQIA+ facets.
2 **Wider social determinants affect general health and care, such as older LGBTQIA** community and housing support – screening at health access areas for wider special determinants such as stress, housing etc	Agree	Empirical research suggests that LGBTQIA+ Community have accumulated numerous unresolved trauma incidents which often impact on ability to trust and be fully transparent about presenting social needs.
3.**Cis-normative approaches to communications** and language immediately makes young people find it hard to be honest about health and care ongoing for their life; cis-normative language can be confusing for young people and general LGBTQIA+ community	Agree	Cis-normative language can create a sense of isolation across the age spectrum and often trigger passive or overt aggressive reactions.

4. Dismissal of acknowledging the LGBTQIA focus on health and care leaves a blockage ongoing through life support and se**eking honest overviews of someone's health** – however, being ticked at LGBTQIA was not well received or wanted	Agree	Being labelled by a group who have minimal lived experience can cause additional engagement obstacles regardless of how well intended the gesture was.
5 Mainly, people only used 1 or 2 outside statutory services available to support life and care ongoing; and had **limited knowledge of other services available to them in the local area**	Agree	It's a common trend in most Boroughs'.
6 **Gender diversity should not be pathologized**, and gender diversity is not synonymous with a clinical diagnosis of gender dysphoria	Agree	The use of language often is a key indicator of if a relationship based on trust and respect can be built/sustained.
7 **Gender identity** evolves and develops across the lifespan of all individuals, and this developmental process may not follow a linear progression along any set gender affirmation or expression pathway; continuous dialogue should be encouraged with health professionals and members of the community	Agree	Gender identity like most other life perspective is fundamentally driven by emotions and opinions which are by nature fluid.
8 **Distinct lack of support for young children /paediatric**	Agree	This is just one of many examples of groups who have been adversely affected by the last 12 Years of sector under investment.

support of TGD families – and the stigmatisation		
9 **Social** isolation for older community more explicit – more likely to not share identity or sexual orientation even in private lives	Agree	Elder Community Members have been forced to accept marginalised positions in society and may never fully be trusting in this new age of comparative transparency to present authentically.
10 **Younger mental health – particularly in some cultures (raised in Bangladeshi / Pakistani/)** serious psychological distress in non-acceptance (1 in 7 people in ELFT feedback[1] identified as non-straight in ELFT in-patient ward work)	Agree	The highlighted statistic is influenced by having the additional psychological hurdle of religious definitions around lifestyle choices to address.
11 **Intersex community still viewed as medical curiosities** – and the inappropriate expectation for investigation with students and many professionals causes distress	Agree	This comment underlines many of the emerging themes around statutory subject knowledge gaps that really needs to be meaningfully addressed.
12 **Black and Ethnic Minority communities – concealment factors,** cultural disaffirmation, homophobia contribute to health disparities; support networks led and managed by white British not representative of selves	Agree	As with a number of protected characteristics' the absence of support facilitators with lived experience can adversely impact on the level of support accepted.
13 **Black and Ethnic Minority Communities – heightened**	Agree	Despite the high profile of GDPR legislation, accountability approaches

[1] Taken from MH Perspective report demographic collation

concerns to confidentiality within the health system; leading to avoidance; stories of shared information with family members causing stigma		in regard to confidentiality breaches are not generating appropriate professional responses.
14 **Cervical screening for lesbian and bisexual women** – just as likely to get cervical cancer as heterosexuals, but less likely to be screened or attend screening; cis-normative approach to screening; wider social issues affecting need to screen	Agree	Health providers need to look at existing information sharing strategy and consider the merits of tapping into platforms such as Terrestrial Tv Channels, YouTube & Radio Stations to get the correct information into key communities.

Collaborators and partners were asked to add any further comments and those we received, outside of these initial statements above in the table, but to be added were:

- Access to health provision such as Monkey Pox Vaccinations etc has been difficult for many with people having to travel to London to receive the vaccine
- Point 13 on trust in the health system is prevalent in the Trans community particularly as well as the black community.

11. Case Study 3

Profile: Male, Black, Bisexual

We met anonymously with a gentleman who provided some insight into his experiences (outside of case study / collaborator interaction)

All our case studies have been summarised, edited and stylised to produce an outline of the hour interview conducted.

Male, Black Caribbean, Bisexual

"The largest thing I can say is how much being different affects your general mental health from the moment you wake up – to how you interact with every element of your life.

Accessing culturally appropriate services cannot be under-rated. Watching particularly young people I know trying to navigate their own identity journey in a world where all we see is white – cis normative people, it is more highly damaging than I can express.

Being from the culture I am, being how I am is viewed so differently to how British people view it. But if you want to really understand how it makes us feel, then change some how you present the world to us.

My mental health has not ever been in crisis state but I could have appreciated some more culturally relevant support – having British white women or men sympathise with me, has not been conducive. Not everyone who is Black and Bisexual will feel the way I do – I hope this review and report highlights that – I can only speak for me. And for me, I don't trust many things, because you always start everything on defence, in case you are attacked.

It is better these days, but in Luton – with all its multi-culturalisms, you don't even know how that affects trying to access and be honest with services. Telling my Doctor from a different culture to mine, who has his own views on what I am and what I do – just makes for a very un-honest approach. I would never go to him for health advice and would only use online.

You're asking us to outline what could improve – but until I feel that society itself improves I feel limited in what I can offer to suggest change. I do feel society is still racist and bigoted, so its hard to suggest one thing that could help that feeling of insecurity in all interactions I have. When discussing my health I feel the UK has one of the best systems in the world, but that's for if I had a crisis need that needed fixing. Like everything else, the nuances of wanting to 'be better' comes with probably more resource and funding the health system has. I just need to feel heard and unguarded.

I think reaching the younger generation is the key to real change now – it feels with covid they have been left in isolation, and trying to figure the world out without direct contact and face to face interactions. Using online is amazing, and helped so many, but we have to support people talking and listening to people. We have to get the young people out in the community again, we need their fresh thinking and innovative minds to help change the world.

12. Thematic Findings from Healthwatch Luton's Survey (April – December)

- Digital
  - People generally felt more digital access was needed; for anonymity and time and access to services and information
- Inequality
  - Most felt there was an inequality to someone being heterosexual to homo / other – and this inequality was found in all walks of life, not just health and care
- Communication
  - Communication for those with different identities and sexualities did need to be reviewed; when medically needed people generally agreed better to disclose, but didn't understand why system 'generally' needed to know what sexuality / identity they were
  - Communications needed to be accessible more online with online options
  - Communications needed to be reflective of culture / sexuality etc
- Access
  - Most people worked / were students – and found access to all general health and care difficult in working hours – and thought extended hours for most services, including sexual health knowledge and information would be beneficial
- Competency
  - Most found most staff competencies fine, but mentioned cultural and sexual competency and sensitivity training could be improved
  - Knowledge training wasn't a requirement, but how to support beyond knowledge, such as behavioural support / mental health support etc would be beneficial
- Awareness
  - Most are aware of sexual health services locally, but not regionally or nationally (some are aware nationally but not locally)
  - People generally felt more awareness of needs of people who are LGBTQIA+ would be beneficial in helping them access services
- Accessible Language
  - Most felt most health and care language was accessible – but the term cis-normative was commonly mentioned throughout the project in communications and language
  - Clinicians tended to assume people were heterosexual in first approach – and many found this in-accessible

- Stigmatisation
    - Older people we spoke with found stigmatisation less with more gay / bisexual orientations and health and care
    - Younger people (YP) felt this was more apparent with 'transitioning' or 'trans' community
    - YP stated more national guidance affected way YP approached health and care settings with queries or questions
- Cultural Disparity
    - Majority of black and Asian respondents found cultural disparity in health messaging – usual use of one black / Asian person in comms publications
        - Suggestion of usage of more targeted messaging or co designing of messaging
- Trust / Confidentiality
    - How people's first interactions with health and care are experienced tended to affect their outlook to ongoing health and care experiences (for life)
    - Transitioning / identity questioning was life-long transformation and adaption – needing more flexibility in health and care recording and stigmatisation
- Co-Morbidity Care
    - Some mentioned having co morbidity health needs affected whether they disclosed further sexual information which may affect their health and care – the more consultants / departments and people they were reviewed by – the less likely they felt comfortable continuously sharing private information
- Isolation and Anxiety- knowledge of services, but being appropriate to needs of micro-aggressions and psychological trauma
    - Many expressed micro-aggression experiences throughout their life / and health and care journey -which did result in quite a few respondents having anxiety issues on the health and care interactions
- Self care
    - Many liked the digital route for self care and wanted to access sexual health necessities to practice safe sex and have information provided for them. Some were unsure what self care meant and how young people accessed information and advice on this area
- Advice Line – Potential suggestion
    - Some suggested having a formal / clinical and updated advice line / website where information could be provided which was local,

supportive and non-judgemental on health and care for different ages. Some suggested adapting a page on the 111.nhs.uk page (January 2023 input)

- Health prevention
  - Many were involved and engaged about health and care prevention but with self care / found accessing updated and correct information on prevention limited
- Digital Support progress
  - Many referenced digital support to support working people being able to access prevention, self care and ongoing updated messaging on sexual and general health
  - Many referenced digital for young people to access broader range of information and care without having to attend a sexual health clinic
  - Discussions around different platforms being invested in – many responders mentioned websites, apps, and forums etc to be used on online functions. Young responders mentioned further digital support such as mobile, applications designed and provided for YP to be separate from other platforms.
  - Digital approaches allowed for anonymity and time for people to access / review / and use health and care information and advice.

13. Case Study 4

Profile: Teenager, White, Female, Questioning, Catholic

We met anonymously with a teenager who provided her insights into her experiences

All our case studies have been summarised, edited and stylised to produce an outline of the hour interview conducted.

Female, Teenager, Questioning, Catholic

"There is apparently less stigmatisation for young people these days – but that is mostly the view of older people about us.

I think that there is more information out there possibly than before – and that is great – but it is like it is all written by people who don't really know or understand what it is like to be LGBTQIA+

There is a lot even in the NHS guidelines that refer to all questioning or queer young people as 'transient' as though its not for all of us something sustainable, or real. It is something we may even 'grow out of' and some may. But you can't have guidelines stating that and then expect young Questioning people to come forward to share their experiences and feel like they are being heard. They can't have local support offering something and national guidance pertaining something else.

As a young person from my background, it has been hard to even be honest to family. Sometimes if that part is hard – it is hard to know who you are and what you should be. The support for young people with their mental wellbeing is so old-school and face to face – we need the online anonymous digital support to really support us in navigating our way through who and what we are feeling.

Have you heard the term 'binding'? I am in a position now where I am teaching younger people than me what they should and shouldn't be doing – because there is no access to this information elsewhere. An 18yo shouldn't be explaining what she knows to a 14yo. It should be more readily available. But a lot of the guidance is written by straight forty-somethings who want us to just not feel mental strain. If you have kids teaching kids – it is a strain. I worry all the time what I am saying is it right or wrong? I should be able to signpost them to a website where this real information can be discussed.
I think most of my experiences are okay – there is a lot that could be changed, but I think just understanding we are not all a 'group' goes a long way. The groups that I am part of come from being built a certain way to want to help others – if you're not built that way it really is a dark lonely path to be questioning yourself and not know where to turn.

I think this is great to be asked my opinion but it can't be reflective of all the young people in this area. Again, I think it is great the 'health people' are asking for our opinion – but they must know a few case studies and surveys can't make the difference. It will take time and more talking and understanding and real change for us to feel there is a health system built on knowledge, care, sensitivity and support for us all.

14. Next Steps

The next steps of this programme of work are for the four Healthwatch (Bedford, Luton, Central Bedfordshire and Milton Keynes) to submit their Denny reports to the ICB. Once this has been done (by end of January 2023) the next steps are:

- Denny Steering Group to review reports (Jan-March 2023)
- An amalgamated report to be completed by Lloyd Denny for the Steering group and the ICB to review (tbc)
- The LGBTQIA+ Luton Collaborators to reconvene, discuss elements of project with Healthwatch Luton for 2023 workplan (Feb – March 2023)
- Stage III (3) of the Denny Review: Co production support for ICS on working toward implementation plan on service delivery

Healthwatch Luton have made recommendations within this report which relate to both system-wide Integrated Care System approach (Scale), as well as some aspects which may need to be reviewed regionally within Bedfordshire (Care Alliance) as well as more service-provision and commissioning reviews to take place at Place level (Luton Health and Wellbeing, Scrutiny and Luton Place Board).

The collaborators who invested time and energy and shared experiences to produce this report would expect to receive

- Response to the thematic findings from the ICB / ICP – and action plans on what could / can't be amended / altered/ improved
- Introduction to further co production and discussion on community and people involvement in service delivery for this cohort of people (LGBT+)

Other steps to be reviewed would involve:

- Training of staff on behaviours / cultural competency / mental health around LGBTQIA+ people (assumptions / judgement / stigmatisation / young people's views etc)
- Diversity and cultural appropriate communications / engagement – if real understanding is to be met from this community; understanding language, tone, wording and diverse/cultural references and language support should be reviewed.

- ICB = Integrated Care Board
- ICP = Integrated Care Partnership
- ICS = Integrated Care System

Home - Bedfordshire, Luton and Milton Keynes (BLMK) Health (blmkhealthandcarepartnership.org)

Appendix

a) Biography of partner organisations

Penrose

Penrose Housing Association was set up as an Industrial & Provident Society, an exempt charity, in 1969 by two ex-offenders and several volunteers to provide housing for ex-offenders. It became a company limited by guarantee, registered with the Charity Commission and changed its name to Penrose Options on the 28th of March 2013.
It traded as Penrose and joined the Group on the 1st of October 2014. Penrose strives to address inequality of access to health, employment, training, and social care support for people with complex needs. People that struggle with daily living, mental illness, personality disorders, trauma, substance and alcohol issues, homelessness, offending backgrounds, facing everyday challenges or needing support to overcome difficulties because of their complex, chaotic life.
We specialises in working with people excluded from other services as they present personal or public safety risks. It provides practical social support and health care solutions, supported housing in residential accommodation, resource centres, floating support and Housing First services. Penrose also provides specialist rehabilitation and technical and therapeutic support that aids recovery, reduces reoffending and changes behaviour. Penrose currently operates across London, Bedfordshire and Luton and has the ambition to grow.
Penrose services are as far-reaching as our resident and participant profiles. We strive to address inequality of access to health, employment, training, and social care support for people with complex social and health care needs. People who struggle with daily living, mental illness, personality disorders, trauma, substance and alcohol issues, offending backgrounds and experiencing homelessness face everyday challenges or need support to overcome difficulties because of their complex, chaotic life.
We provide practical social support and health care solutions, supported housing in residential accommodation, resource centres, floating support and Housing First services. We specialise in working with people excluded from other services as they present personal or public safety risks.
We offer specialist rehabilitation and technical and therapeutic support that aids recovery, reduces offending and changes behaviour. Penrose operates across London, Bedfordshire and Luton and is ambitious to grow.

Pride in Luton

Pride in Luton formed in November 2022 out of focus group conversations with the LGBTQ+ community in Luton. Their aim is to support the LGBTQ+ community in Luton and the surrounding area by providing events, social activities, advice and guidance and a support network for the community. Pride in Luton are supporting the development of the LGBTQ+ community as they evolve, based on lived-experience and shared beliefs.

a) Data Collation Thematic Tables from Surveys / Forums

Culture and Religion	Communication Barriers	Understanding / Knowledge of Health services	Cultural Competencies of NHS Staff	Accessible Language about health prevention
Social isolation; particularly in Asian community; but noted in black British community / elderly and young people both mention isolation being exacerbated by COVID – 19; where progress was being made publicly, no more	Cis-normative language creates ongoing lifetime dis-honesty in approach to health and care	On average, individuals only knew of 1-2 outside statutory services available to support their needs; once engaged with one service tended to stick with (Luton Sexual Health services for example)	Training and Information to front line health and social care staff – challenge approach and knowledge of health concerns – and how it affects health outcomes	Cis-normative approach leads to dis-engagement about all aspects of health and care – including prevention
Younger Mental Health – particularly in Pakistani YP mentioned more psychological distress in non-acceptance (1 in 7 on ELFT MH Inpatient Wards were from Ethnic Minorities and under age of 25)	Assumptions from clinicians and system wide engagement / communications leads to dis-engagement with services	Distinct lack of support for TGD families and stigmatisation – including lack of paediatric support for children of TGD families and awareness groups	Cis-normative approaches to languages when engaging associated with dishonesty ongoing through life cycle of engagement with health services	MOM individuals fear disclosing information regarding lifestyle choices in relation to health and care' affecting preventative measure of illness / disease – underlying

				cause around stigma
Concealment factors particularly in the Black (other) communities and South Asian communities led to cultural disaffirmation, and homophobia	Engaging with community views on aspects of health needed to become continuous conversations with community – and not a one off sound bite piece	Support networks and most health services run by white British / not representative of own community; result in dis-engagement	Gender diversity tended to be pathologized – not synonymous with clinical diagnosis of gender dysphoria	Cervical screening for lesbian and bisexual women – just as likely to get cervical cancer, but less like to attend screening *wider social issues affecting need for screening
Heightened concerns from Ethnic minority (Asian – Other) regarding confidentiality and distrust – leading to avoidance of interaction with services			Gender identity evolves over lifetime; development doesn't fit the linear health and care structure of support; continuous dialogue needed	
Inability to relate to support services due to ethnic disparity – need more ethnic appropriate support groups (most WB led)			Intersex community mentioned being medical curiosities and still reviewed as such; leading to distress and exclusion from	

			service provision	

b) Thematic responses to the Forum / Interview / Case Study reviews:

Communication	Training / Competencies	Access to HSC services	Stigmatization / Focalised Issues in LGBTQIA community	Other
Approach to develop targeted or non-Cis-normative language when engaging and communication to general public	Information support and awareness around gender affirming hormone therapies available – policy funding and information to be more widely available to staff and public	Most respondents found accessing both primary care and secondary care as hard / easy as non-community members – outline not effective in their community – however – they did feel once accessed they could not disclose their gender identity inline with their care, as not always appropriate but could be ongoing	Trans community reported more isolation within COVID-19 and transcending into post – COVID	Division within the LGBTQIA community was felt during the course of this project and mentioned by few collaborators and contributors to the survey. This division within the community leads to more difficulty in approaching trying to help change or collaborate moving forward.

		effective to their health outcomes		
Request for more fluid apps / websites regarding availability of services and information to be provided. NHS trusted – but limited in appeal and lacks local source and knowledge	Co-morbidities are not dealt with holistically or joined up with national data – those with HIV outline more support is needed co-progressing illness, such as diabetes or Hep C – more support on assessment and linkage	GP / 111 / Hospital access rated as much as general population (in line with HWL feedback) and in fact this community rated access slightly higher than 2022 feedback from general community	Elderly / Young and Black LGBTQIA collaborators reported isolation	HSC can be alienating – but so can sections of the LGBTQIA community
Targeted advertisements to be used for different sections of communities – don't want to be targeted / but at same time cis-normative approaches lead to lack of interest	SOGI – Sexual orientation and gender identity data – not standardised on NHS – cis-normative, and allows gaps to form over patients lifetime	Access to support services needed development – most didn't know what was available – and most were never signposted by HSC staff to other community organisations to provide support	Just over half of Collaborators felt they had be stigmatised in their health; or unheard due to their disclosure of sexual orientation when with HSC staff	
	Trans Health for general HSC as well as ongoing		YP felt asking for advice from HSC regarding	

	community / social and general public to be provided to support community		sexual experiences was dismissed as 'and 'would grow out of'	
			Sexual minority women (SMW) find there is a shortage of culturally affirming care	
			SMW also state more invisibility even within own communities / white British support services	

d) Thematic Summary Findings from Survey: Collaborators Denny Survey (Only)

- Awareness needed of affirming hormone therapy information for young people
- 'Binding' education needed for young people
- Division within those who were LGBTQIA+ - if you are part of the community it is invaluable and almost a replacement to the family; if you were not, you felt they did not represent you at all
- More needed space for anonymised feedback on health and care – digital app progression
- SOGI (Sexual Orientation Identity Information) data gathering to be reviewed
- Sexual Minority Women (SMW)felt an invisibility in general population, for healthcare exacerbated as no routes to have voice heard
- Gender identity to be seen as 'evolving' and not fixed, as per medical date (some forms related to being seen as 'bi-sexual; which was stated when younger, but now changed')
- Assumptions from health and care staff made when gender orientation disclosed

- Young people (Pakistani lady) outlined mental health services being cultural disparity in representation
- Support for Trans Gender families particularly young family members needed to increase
- Male on Male sex individuals had a larger fear of disclosing health concerns for stigmatisation
- Black (Other and British) disclosed concealment factors affecting support or accessing support

e)Interview Questions for Case Studies

DENNY ENGAGEMENT – Interview Questions and overview

- Introduction Notes Outline
- Outline of Project
    - HWL gathering feedback from 2022
    - ICB Project for Denny Review in Health Inequalities
    - HWL LGBTQIA+ - Survey specific Q's
    - Forums
    - Interviews
    - Case Studies
- Project end in December/January
- Progression work – continue into 2023
- Now going to ask questions

Questions? (Refer to internal Case Study Interview Guide for reference)

Use Interview style to ask more questions – happy to be case study? Will be thematically reported – but individualised:
Name: Or Anonymous?
CONSENT TO SHARING CONTENTS
How do you identify:
Demographics:
Age:

Overview of ICB themes (agreed by steering group and Healthwatch proposal documentation) to give context for questions:

Culture and Religion	Communication Barriers	Understanding / Knowledge of	Cultural Competencies of NHS Staff	Accessible Language about

		Health services		health prevention

Other finding from Denny Survey and Interviews

Communication	Training / Competencies	Access to HSC services	Stigmatization / Focalised Issues in LGBTQIA community	Other
Approach to develop	Information support and	Most respondents found	Trans community reported	Division within the

Question 1: Could you provide an overview of your experience in the health and care system: *Prompt to enquire:
- Affected by your sexual orientation / gender / sexuality / which you are happy to share:

Question 2: How did this make you feel?
Question 3: Can you outline what you think could have been improved / how it could be improved?
Question 4: Themes from ICB –

- Culture and religion aspects
- Communications
- Understanding or knowledge of health and social care services available to support you
- Staffing cultural competencies
- Accessible language
-

Question 5: Other themes to highlight

- Inclusive Language used in health and care messaging
- Staff attitudes to your sexuality / orientation / questioning / identity
- Service usage for sexual care / sexual health care
- Awareness of services for sexual health / general health
- Stigmatisation with health and care experiences
- Advice provision for newly questioning / young people support
- Digital support and interest in health and care
- Community terminology
- Anxiety and mental health
- Micro-aggressions
- Diagnostic overshadowing

- End Case Study Interview
- Round up any further queries or questions may have
  - Report to Denny
  - Ongoing work;
- Hand back to XX for further info ongoing

END REPORT

Healthwatch Luton
Marsh Farm, Futures House
Luton
LU3 3QB

www.healthwatchluton.co.uk
t: 01582 817 060
e: info@healthwatchluton.co.uk

healthwatch Luton