Healthwatch Portsmouth

Understanding Trans and Non-Binary People's Experiences of GP Services in Portsmouth

Early Insight Report: Community and Staff Perspectives on Primary Care Access and Experience

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Executive Summary

This Early Insight Report presents initial findings from Healthwatch Portsmouth on trans and non-binary people’s experiences of accessing GP services in Portsmouth, bringing together perspectives from community focus groups and a staff survey of 59 primary care staff. The report provides an overview of current challenges and opportunities associated with inclusion in primary care, based on both lived experience and staff perspectives.

The findings suggest that barriers are not limited to individual interactions but are embedded across administrative systems, workforce capability, referral pathways, and wider organisational processes. Focus group participants described repeated difficulties in relation to names, titles, gender markers, privacy, and first contact with

services. These experiences were often described as frustrating, emotionally burdensome, and at times discouraging enough to reduce trust, openness, or willingness to re-engage with care.

Staff responses suggest that trans and non-binary patients are a routine part of primary care practice, but confidence and knowledge are variable. While many respondents reported feeling somewhat confident, significant gaps were identified in administrative processes, referral pathways, prescribing, and shared care. A majority of respondents reported receiving no formal training, and concerns about making mistakes were common.

The report also identifies a disconnect between patient experience and organisational awareness. While participants described barriers to raising concerns and low confidence that feedback would lead to change, most staff reported no awareness of complaints. This suggests that existing feedback systems may not be consistently capturing lived experience or supporting organisational learning.

Overall, the findings indicate that inclusion is not yet consistently embedded within primary care and remains affected by variation in practice, interpretation of guidance, and limited system-level coordination. The report recommends a more structured and practical approach to implementation, including clearer local guidance, stronger administrative consistency, role-specific training, improved referral clarity, strengthened first-contact processes, better use of feedback, and greater system-level coordination across practices, PCNs, and the ICB.

This report provides early insight rather than final conclusions. Further work in the wider programme will explore these issues in more depth, including additional policy and organisational analysis.

1. Introduction

Access to primary care is a fundamental component of an equitable health system. However, for trans and non-binary people, access to GP services is shaped by a complex interaction of administrative systems, workforce capability, and wider policy environments. These factors influence not only how care is delivered but also whether individuals feel able to access services at all.

National evidence has highlighted that trans, and non-binary individuals may experience barriers in healthcare settings, including challenges related to communication, administrative systems, and access to appropriate clinical pathways (Holland et al., 2024). These barriers can contribute to delays in care, reduced trust in services, and wider health inequalities.

Recent legal developments, including the UK Supreme Court judgment in *For Women Scotland Ltd v Scottish Government*, have added further complexity to how sex and gender are interpreted within public services (Beury et al., 2025). While the judgment provides legal clarification in specific contexts, its implications for healthcare delivery are not always clearly translated into operational guidance. In primary care settings, this can create uncertainty around how patient records are managed, how screening pathways are applied, and how staff interpret their responsibilities in delivering inclusive care. The British Medical Association (BMA, 2025) stated that "since the announcement of this decision many of our members have shared their feelings of uncertainty, distress and concern for the future."

Within this evolving context, this report presents early insight into the experiences of trans and non-binary people accessing GP services in Portsmouth. It draws on focus group discussions and a staff survey conducted by Healthwatch Portsmouth, informed by earlier engagement at Portsmouth Pride 2025, which helped shape the initial areas of enquiry. By bringing together community and staff perspectives, the report aims to provide a balanced understanding of current challenges and opportunities for improvement, while situating these within a wider organisational and policy landscape.

2. Context: Policy Landscape and Existing Initiatives

The inclusion of trans and non-binary people within primary care is influenced by a wide range of national policies, contractual frameworks, and professional guidance. These include the General Medical Services (GMS) Contract and the Network Contract Directed Enhanced Service (DES), which define expectations for GP practices but provide limited operational detail on trans and non-binary inclusion.

While evidence from Stonewall identifies key barriers and outlines system-level recommendations, it does not translate into detailed, operational guidance for implementation in routine primary care practice (Stonewall, 2018).

Current operational processes, as outlined by Primary Care Support England, involve issuing a new NHS number and creating a new patient record following gender reassignment, with acknowledged risks to record continuity, screening, and access to care (Primary Care Support England, 2023). In contrast, the UK Government's independent review of data, statistics and research on sex and gender raises concerns about these practices, particularly in relation to data integrity, clinical care, and safeguarding (UK Government, 2025). This reflects a policy tension between existing system processes and emerging policy critique.

Guidance from organisations such as TransActual provides detailed recommendations on specific clinical processes, such as cervical screening pathways for trans men and non-binary people. However, as these resources sit outside formal NHS structures, their implementation is not standardised and depends on individual practice awareness and uptake (TransActual, 2025). Existing initiatives such as the LGBTQ+ Foundation's Pride in Practice programme demonstrate a structured approach to supporting LGBTQ+ inclusion in primary care through training, resources, and accreditation (LGBT Foundation, n.d.). However, such approaches are not yet embedded consistently across all practices or systems.

Overall, the policy landscape can be characterised as complex and fragmented, with limited alignment between policy intent and practical implementation. This creates variability in how inclusion is understood and delivered across GP practices.

3. Methodology and Engagement

This report presents findings from the initial phase of a wider programme of work exploring trans and non-binary people's experiences of accessing GP services in Portsmouth.

The current analysis draws on two primary data sources: focus group discussions with trans and non-binary participants, and a staff survey capturing perspectives from primary care staff.

Focus group discussions were conducted in collaboration with trusted community organisations, including Beyond Reflections and engagement linked to Portsmouth City Council's Early Help and Prevention (0–19) services. These partnerships supported inclusive participation and enabled individuals to share their experiences in safe and familiar environments.

The staff survey generated responses from 59 participants across a range of GP practice roles, including both clinical and non-clinical staff. The survey was delivered using a mixed approach to maximise accessibility and participation. It was promoted through the Hampshire and Isle of Wight Primary Care Place extranet site; however, response via this route was limited.

To increase engagement, the survey was also conducted in person during a GP Target Day attended by Healthwatch Portsmouth. Paper copies of the survey were made available, alongside QR codes which participants could scan to complete the survey on their own devices. Android tablets were also provided to enable on-site completion. This approach allowed staff to participate during breaks and contributed to the majority of responses collected.

In addition, early community engagement was undertaken at Portsmouth Pride 2025, where a small number of individuals shared their experiences. While limited in scale, this input helped inform the development of focus group discussions and survey questions.

Participation in both focus groups and the staff survey was voluntary. Participants were provided with information about the purpose of the work, and responses were treated confidentially. No identifiable information, including individual names or GP practice details, is included in this report.

4. Findings and Interpretation

4.1 Administrative Systems and Structural Barriers

Across focus group discussions, participants consistently described challenges in navigating GP administrative systems, particularly in relation to names, titles, and gender markers. These issues often required individuals to repeatedly explain their identity, creating discomfort and, in some cases, leading to avoidance of services.

These experiences are reflected in staff responses, where 22 out of 59 respondents (37%) reported uncertainty in managing administrative processes, including updating patient records and recording gender identity. This suggests that while procedural guidance exists, it is not consistently understood or implemented.

Participants described instances where changes to gender markers resulted in the creation of new patient records, which were later merged but led to fragmentation of medical histories.

According to a study by Healthwatch England (2025), 28% of trans and non-binary respondents who changed their gender marker said they had lost access to their previous NHS record**.** Administrative systems therefore act as a structural barrier, placing responsibility on patients to navigate limitations rather than enabling inclusive access.

These repeated administrative challenges were described as frustrating and emotionally burdensome, with some participants indicating that they would avoid or delay contacting services to prevent having to repeat explanations.

4.2 Workforce Confidence, Training and Role-Based Variation

The staff survey indicates that trans and non-binary patients are a regular part of primary care practice. Of the 59 respondents, 16 (27%) reported frequent contact and 25 (42%) reported occasional contact, demonstrating that inclusion is part of routine service delivery.

Despite this, confidence levels vary. While 35 respondents (59%) described themselves as somewhat confident and 13 (22%) as very confident, 7 (12%) reported lacking confidence. This suggests a baseline level of comfort that is not consistently supported by deeper knowledge.

This becomes more evident in specific areas of practice. Thirty-two respondents (54%) reported needing additional knowledge on prescribing and shared care, while 28 (47%) identified gaps in understanding referral pathways, and 22 (37%) reported uncertainty in administrative processes. These findings indicate that confidence is often limited to general communication, with uncertainty increasing in more complex clinical and system-related areas.

Training appears to strengthen these gaps. A majority of respondents, 35 (59%), reported receiving no formal training. Among those who had received training, only 10 (17%) found it very useful, suggesting that training is both inconsistent and not always sufficiently practical.

Differences between staff roles are also evident. Non-clinical staff, particularly those in reception and administrative roles, more frequently described challenges at the point of patient access, including communication, confidentiality, and record management. Clinical staff, including GPs and nurses, more commonly identified uncertainty around referral pathways, prescribing, and shared care arrangements.

4.3 Access, Gatekeeping and First Contact

Focus group participants highlighted the importance of first contact, particularly interactions with reception and administrative staff. Experiences of being misunderstood or questioned, and of having to discuss sensitive information at the reception desk in an open environment, were described as barriers to accessing care. Participants reported that they were often unable to access a clinician without first explaining their issue in this setting, which limited privacy and created discomfort.

These experiences align with staff findings, where uncertainty and lack of guidance may contribute to unintentional gatekeeping. While staff expressed willingness to support patients, the absence of clear processes can affect how access is facilitated.

This demonstrates that barriers to inclusion are not limited to clinical care but are embedded across the entire access pathway.

These experiences were described as discouraging, with some participants reporting that negative or uncomfortable first interactions reduced their willingness to access care or disclose their needs fully.

4.4 Referral Pathways and System Navigation

Participants described challenges in navigating referral pathways, including confusion, delays, and the need to self-advocate. These experiences were mirrored in the staff survey, where 28 out of 59 respondents (47%) reported uncertainty around referral pathways, and 32 (54%) identified gaps in knowledge related to shared care and prescribing.

These findings suggest that while pathways exist, they are not consistently understood or applied. This creates variability in patient experience and places additional burden on individuals to navigate the system.

4.5 Trust, Safety, Feedback and Engagement

Trust emerged as a central theme across both data sources. Participants described how repeated administrative challenges, inconsistent experiences, and lack of clarity reduced their confidence in services.

From a staff perspective, this is compounded by uncertainty and system pressures. Thirty-one respondents (53%) identified fear of making mistakes, alongside time pressures (44%) and lack of training (36%).

Awareness of patient dissatisfaction appears limited, with 36 respondents (61%) reporting no awareness of complaints. However, findings from focus group discussions suggest that this may reflect under-recognition rather than absence of issues.

Focus group participants described a lack of confidence that concerns would lead to meaningful change. While some participants felt they understood how to raise a complaint, there was uncertainty about whether complaints would be taken seriously. Others highlighted that raising concerns could feel emotionally burdensome, with one participant noting that it may be “more traumatic than just letting it go.”

There was also evidence of negative experiences when concerns were raised. One participant described submitting a complaint about inappropriate clinical communication but reported that, despite raising the complaint, the issues they highlighted were not consistently addressed in subsequent interactions, which reduced trust in the process.

Participants further reflected that complaints processes are not always clearly accessible or framed as supportive. Feedback suggested that GP practice systems may appear restrictive, with communication focusing on formal complaint routes rather than encouraging open feedback. The language of “complaints” itself was perceived as a barrier.

Importantly, participants highlighted that opportunities to provide feedback may be inconsistent, with positive interactions more likely to trigger feedback requests than negative experiences. This may contribute to a gap between lived experiences and formally recorded concerns.

More broadly, these findings suggest that staff may not always have visibility of how patients feel about the care they receive. In the absence of clear and effective feedback loops, patient experiences particularly negative ones, may not be consistently recognised, understood, or reflected within day-to-day practice.

Together, these findings suggest that concerns may be underreported, not because issues are absent, but because patients may feel uncertain, unsupported, or reluctant to engage with existing feedback mechanisms.

Some participants described becoming less likely to raise concerns or engage with services over time, indicating that experiences within primary care can directly influence future health-seeking behaviour.

5. Discussion: Implications for Health, Inequalities and System Responsibility

Health inequalities are shaped by a range of interconnected determinants, including access to services, trust, health seeking behaviour, and the ability to navigate healthcare systems. The findings presented in this section highlight how factors within primary care systems, such as administrative systems, workforce capability, communication, and service processes, shape patient experience, access, and engagement, with implications for equity and variation in health outcomes. These factors act as determinants that create barriers, contributing to patterns of delayed access, reduced trust, and unmet need, ultimately reinforcing health inequalities.

5.1 Structural Barriers and Patient Safety

Instances where changes to gender markers result in the creation of new patient records, and the subsequent merging of records, carry risks of data loss or fragmented medical histories. This may affect clinical decision-making, particularly where important historical information is not readily available. While patients reported being informed of these risks, they often had limited choice but to proceed.

Patients may not always be in a position to repeatedly explain their medical history, increasing the risk of missed information, duplication, or inappropriate care. This has potential implications for both patient safety and equitable access to care. Burnett et al. (2011) argue that whenever critical clinical information is absent, there is a significant risk of delays in care and potential patient harm.

These structural challenges highlight how administrative systems act as a determinant of both patient safety and equitable access, with potential implications for health inequalities.

5.2 Workforce Confidence as a System Issue

Variation in staff confidence reflects broader system-level challenges rather than individual capability or willingness. The concern about making mistakes expressed by staff appears to stem from limited training and a lack of clear guidance.

This worry may also reflect a lack of trust in the system’s ability to manage errors appropriately or provide constructive support when mistakes occur. As a result, fear of making mistakes may lead to more cautious communication and reduced openness in interactions. This has implications for patient safety and may contribute to unintentional discrimination.

Overall, inclusion is not reliably embedded but varies depending on individual knowledge and confidence, with potential impacts on the effectiveness and safety of patient care. which may contribute to variation in care quality and consistency across patient groups.

Some Focus group participants described that reduced openness during consultations could lead to hesitation in accessing services and in some cases avoidance of care, particularly where repeated negative interactions had occurred.

Variation in workforce confidence therefore acts as a determinant of care quality and consistency, influencing how equitably services are delivered across different patient groups.

5.3 Privacy, Referral Pathways, Shared Care and Continuity of Care

Lack of privacy when interacting with reception or administrative staff may lead to discomfort or embarrassment, particularly where individuals are required to disclose sensitive information in open or public spaces.

This may result in hesitation to access services or reluctance to engage fully with primary care. For trans and non-binary individuals, who may already experience stigma or vulnerability, such barriers can disproportionately affect access. Over time, this contributes to reduced help-seeking, delayed care, and widening health inequalities.

Referral pathways and shared care arrangements are central to effective and safe healthcare delivery. Where pathways are unclear or inconsistently applied, patients may experience delays in accessing specialist services and increased reliance on self-advocacy.

Shared care arrangements are particularly important in relation to ongoing prescribing and monitoring. Treatments may require regular blood tests and monitoring of parameters such as kidney or liver function. Without clear protocols, there is a risk of gaps in monitoring, uncertainty around clinical responsibility, and disruption to continuity of care. These issues have direct implications for patient safety and long-term health outcomes.

These factors position privacy, referral clarity, and continuity of care as key determinants of health, influencing access, engagement, and longer-term health outcomes, particularly for individuals already experiencing vulnerability or stigma.

5.4 Feedback, Complaints and System Learning

While staff report limited awareness of complaints and focus group participants described barriers to raising concerns and a lack of confidence that feedback would lead to meaningful change, this highlights a disconnect between patient experience and organisational awareness.

Where complaints are not raised, or where they are collected but not actively reviewed, shared with staff, or linked to service improvement, opportunities for organisational learning may be missed. This can result in allowing patterns of poor experience to persist without visibility or action.

Without clear processes to identify themes, implement changes, and communicate outcomes, feedback risks becoming procedural rather than a meaningful driver of quality improvement. As reflected in focus group discussions, this can reduce trust in the system, with some individuals becoming less likely to raise concerns or engage with services over time.

Feedback and complaints processes therefore act as a determinant of organisational learning and responsiveness, with implications for whether inequalities are identified, addressed, or allowed to persist.

6. Policy Context and System Responsibility

The findings suggest a gap between national policy expectations and local implementation. The Equality Act 2010 requires services to ensure that individuals are not disadvantaged on the basis of protected characteristics. However, variability in administrative processes, staff confidence, and access pathways indicates that this is not consistently realised in practice.

Similarly, NHS priorities, including those set out in the NHS Long Term Plan, emphasise prevention, personalised care, and reducing health inequalities. The barriers identified in this report risk undermining these ambitions, particularly where access to primary care is affected.

The findings also highlight inclusion as a system-level issue rather than an individual or practice-level responsibility. Variability in processes, training, and interpretation of guidance suggests that inclusion is not yet consistently embedded within core systems and structures. This has implications for how policies are translated into practice, with gaps in implementation potentially leading to variation in patient experience and access.

Addressing these challenges requires a more coordinated and system-level approach to inclusion, supported by clearer guidance, consistent training, and alignment across policy, commissioning, and practice. Further analysis of these issues from a policy and organisational perspective will be explored in the next phase of this work.

7. Strategic Recommendations for Improvement

The findings indicate that challenges in trans and non-binary inclusion are driven by variability in practice, uncertainty among staff, and limited system-level coordination. Addressing these issues requires a structured approach that moves beyond policy awareness towards consistent implementation across primary care.

A key priority is improving how existing policies and guidance are translated into day-to-day practice. While national frameworks are in place, staff reported uncertainty in accessing and applying them, highlighting the need for clearer, practical, and locally relevant guidance supported at system level by the Integrated Care Board (ICB) and Primary Care Networks (PCNs).

Administrative processes represent a significant structural barrier, particularly in relation to patient records, names, and gender identity. Inconsistencies in these processes place additional burden on patients and affect access, indicating a need for greater standardisation and alignment with existing guidance.

Workforce capability is another critical area. While staff report general confidence, gaps remain in more complex areas such as referral pathways, prescribing, and shared care. This highlights the need for consistent, role-specific training that supports both clinical and non-clinical staff in applying knowledge in practice.

Clarity and consistency in referral pathways and shared care arrangements are also required. Variability in understanding and application contributes to delays, increased reliance on self-advocacy, and inconsistency in patient experience.

The findings further highlight the importance of first contact, with reception and administrative processes playing a key role in enabling or restricting access. Strengthening support for non-clinical staff is therefore essential.

In addition, there is a disconnect between patient experience and organisational awareness. Feedback mechanisms are not always capturing lived experience effectively, limiting opportunities for learning and improvement. Strengthening feedback systems is necessary to ensure that concerns are recognised, acted upon, and translated into service improvement.

Overall, the variation observed across practices indicates a need for stronger system-level coordination. Inclusion is not yet consistently embedded and remains dependent on individual practice approaches. A coordinated approach is required to support consistency, accountability, and sustained improvement across the system.

8. Key Action Points

The following actions are designed to support implementation at practice, PCN, and system level, recognising that while delivery sits within GP practices, coordination and support are required across the wider system.

1. ICB to develop and issue a concise primary care guidance pack on trans and non-binary inclusion, translating existing national policies into clear, practical steps for GP practices, including administrative processes, referral pathways, and shared care expectations, to reduce variation and uncertainty in day-to-day practice.

2. ICB, in collaboration with GP IT leads, to standardise IT administrative processes across systems, including clear protocols for updating names, titles, and gender identity, aligned with PCSE guidance, to reduce patient burden and improve safety and consistency of records.

3. PCNs to coordinate and deliver role-specific training across member practices, focusing on practical, scenario-based learning for both clinical and non-clinical staff, to improve confidence and enable consistent application in routine practice.

4. ICB and PCNs to develop and circulate clear local service referral pathway guidance, including simple pathway maps and clarification of roles between primary and specialist care, to reduce delays and minimise reliance on patient self-advocacy.

5. GP practices, supported by PCNs, to review and develop initial contact processes, ensuring confidential communication options and clear guidance for reception staff, to improve access and reduce barriers at the point of entry.

6. GP practices, supported by ICB quality teams, to strengthen feedback and learning systems in supporting trans and non-binary patients, ensuring that patient experiences are actively captured, reviewed, and translated into service improvement, to improve visibility of issues and support continuous quality improvement.

7. ICB to embed inclusion within existing quality and performance frameworks, aligning expectations across commissioning, policy, and practice, to ensure inclusion is consistently implemented rather than dependent on individual practice approaches.

9. Limitations

This report is based on a limited sample of focus group participants and 59 staff survey responses. As such, findings should be considered as early insight rather than definitive conclusions.

Further work, including wider community survey data, system-level interviews, and policy analysis, will provide a more comprehensive understanding of organisational, commissioning, and implementation factors.

10. Conclusion

This report highlights that challenges in accessing GP services for trans and non-binary people are shaped by interconnected system-level factors, including administrative processes, workforce capability, and policy interpretation. The alignment between community experiences and staff perspectives indicates that these issues are systemic rather than isolated, reflecting broader challenges in how inclusion is operationalised within primary care.

The findings demonstrate that while there is willingness among staff to provide inclusive care, this is not consistently supported by clear guidance, structured training, or coordinated system-level approaches. As a result, inclusion remains variable and dependent on individual practice rather than embedded within consistent systems and processes.

Importantly, this report represents an early stage in a wider programme of work. The next phase will include a broader community survey, enabling a more comprehensive understanding of lived experience across a wider population. In addition, semi-structured interviews with system leaders, including representatives from the Integrated Care Board, Primary Care Networks, GP practices, and public health teams, will provide insight into how policies are interpreted, implemented, and monitored at an organisational level.

A detailed policy and document analysis will further examine key national and local frameworks, including GP contracts, PCSE guidance, NHS England policies, and professional standards. This will explore how policy intent is translated into operational practice, and where gaps or inconsistencies may exist.

Together, these components will provide a more complete picture of how structural, organisational, and policy factors shape access to GP services. This will enable the development of more targeted, evidence-informed recommendations that move beyond early insight towards practical system-level change.

Ultimately, this work aims to support the development of a more coordinated, consistent, and inclusive primary care system, where trans and non-binary individuals can access services with confidence, dignity, and equitable outcomes, recognising the system’s responsibility to support their health and wellbeing.

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