healthwatch
Norfolk

2025 Pride Report

Exploring LGBTQIA+ people's experiences of healthcare in Norfolk

April 2026

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Registered office: Suite 6, The Old Dairy, Elm Farm, Norwich Common, Wymondham, Norfolk NR18 0SW

Registered company limited by guarantee: 8366440 | Registered charity: 1153506

Email: enquiries@healthwatchnorfolk.co.uk | Telephone: 0808 168 9669

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Who we are and what we do

Healthwatch Norfolk is the independent voice for patients and service users in the county. We gather people's views of health and social care services in the county and make sure they are heard by the people in charge.
The people who fund and provide services have to listen to you, through us. So, whether you share a good or bad experience with us, your views can help make changes to how services are designed and delivered in Norfolk.
Our work covers all areas of health and social care. This includes GP surgeries, hospitals, dentists, care homes, pharmacies, opticians and more.
We also give out information about the health and care services available in Norfolk and direct people to someone who can help.

At Healthwatch Norfolk we have five main objectives:

1. Gather your views and experiences (good and bad)
2. Pay particular attention to underrepresented groups
3. Show how we contribute to making services better
4. Contribute to better signposting of services
5. Work with national organisations to help create better services

We make sure we have lots of ways to collect feedback from people who use Norfolk's health and social care services. This means that everyone has the same chance to be heard.

Glossary

We understand that this is a topic that not everyone will be familiar with, and therefore this report may contain words and phrases you have not come across before. We have put this glossary together to aid with people's understanding.

LGBTQIA+ - This term stands for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Plus. The plus leaves the term open ended to include all identities that exist within the community, such as Non-Binary and Genderqueer.

Homosexual - a person who is sexually attracted to people of the same sex.

Heterosexual – a person who is sexually attracted to people of the opposite sex. Often referred to as straight.

Sex - Sex is biological (male or female). It's based on our genes and how our external and internal sex and reproductive organs work and respond to hormones.

Gender – This is a social construct that refers to our internal sense of who we are and how we see and describe ourselves.

Gay – This refers to men (including trans men) who are attracted to other men.

Lesbian – This refers to women (including trans women) who are attracted to other women.

Bisexual – This means being attracted to two or more genders, this does not exclusively mean to just men and women.

Cisgender – this describes someone whose gender identity matches the body they were born with

Transgender – Transgender or trans is a term that describes people whose gender is different from the sex they were assigned at birth.

Intersex – this refers to people born with innate sex characteristics that do not fit typical definitions of male or female. This differs from being transgender, as intersex people are usually assigned a sex at birth based on physical traits, even when those traits do not align neatly with standard categories.

Summary

This report explores the experiences of LGBTQIA+ people accessing healthcare services in Norfolk, with a focus on identifying barriers, inequalities and areas for improvement. LGBTQIA+ people are known to experience poorer health outcomes and less positive health care experiences compared to the general population. This is often linked to people assuming everyone is heterosexual, limited staff understanding and experiences of stigma or discrimination. Given that this group is underrepresented in general engagement activity, Healthwatch Norfolk identified a need for targeted engagement to better understand local experiences and to ensure these voices are heard.

Building on findings from previous Pride engagement, Healthwatch Norfolk attended Norwich Pride and King's Lynn and West Norfolk Pride in the summer of 2025, as well as social media engagement to gather responses to a survey to explore key themes in more depth. The survey focused on assumptions, pronoun use, screening, contraception and mental health. A total of 87 responses were received, with 77 included in the final analysis following data cleaning.

Findings show that incorrect assumptions about sexual orientation or gender identity remain common in healthcare settings, with non-heterosexual respondents being significantly more affected by this than heterosexual respondents. Free-text responses within the surgery highlighted that assumptions often persisted even when accurate information was recorded in medical notes, suggesting that existing systems and information are not always used effectively in practice.

Pronoun use also varied by gender identity. While most respondents identifying as male or female reported appropriate pronoun use,

those identifying as non-binary, genderfluid or transgender were less likely to have their preferred pronouns respected, with some reporting that this never happened. Repeated misgendering was described as distressing and undermining trust in healthcare services.

Experiences of screening and testing were mixed. Just over half of respondents reported being offered appropriate screening sometimes or always, with similar patterns across gender identities. This suggests that barriers may relate to wider issues, such as lack of invitations and appointment access, rather than identity alone. Contraception discussions were more likely to be reported as appropriate by heterosexual respondents than by LGBTQIA+ respondents. Free-text comments revealed assumptions by healthcare providers about heterosexuality and pregnancy prevention, a lack of recognition that contraception may be used for other medical reasons, and, in some cases, dismissive or judgemental attitudes.

Mental health support emerged as an area of particular concern. Transgender respondents were the most likely to report that their gender identity or sexual orientation affected their access to mental health care, while heterosexual respondents were least likely to report this. Experiences ranged from supportive and understanding care to feeling judged which discouraged engagement with services.

Overall, the findings highlight persistent inequalities in healthcare experiences for LGBTQIA+ people in Norfolk. While some challenges reflect broader pressures on healthcare services, assumptions that everyone is heterosexual, inconsistent use of recorded information and variable staff understanding continue to shape experiences of care. Addressing these issues through inclusive, person-centred approaches, improved training and consistent respect for individuals' identities is essential to reducing inequalities and improving healthcare experiences for LGBTQIA+ communities.

Why we looked at this

For the purposes of this report, the term LGBTQIA+ is used as an inclusive umbrella term to reflect a wide range of identities and experiences. Language in this area continues to evolve, and while we recognise this terminology may change over time, it is currently considered appropriate. The inclusion of the "+" is intended to acknowledge and respect identities not explicitly listed, and to support a sense of inclusion and representation for all.

In July and August, Healthwatch Norfolk attended both Norwich Pride and King's Lynn and West Norfolk Pride to engage with members of the LGBTQIA+ community about their experience of health care. This targeted engagement aimed to ensure voices of the LGBTQIA+ community in Norfolk were heard, to help identify what is working well, as well as areas where improvements to healthcare services in the county may be needed.

In 2023, approximately 3.8% of the UK population aged 16 and over, identified as lesbian, gay or bisexual, rising to around 10% among those aged 16 to 24 (Office for National Statistics, 2025). In addition, the 2021 Census found that 0.5% of the population in England and Wales (approximately 262,000 people) reported that their gender identity was different from their sex registered at birth (Office for National Statistics, 2023). Given these statistics, Healthwatch Norfolk identified a need for targeted engagement with the LGBTQIA+ community, as this group is often underrepresented in our general engagement and other project work.

Evidence suggests that in healthcare settings, some staff may have limited knowledge of LGBTQIA+ individuals' health needs, may make assumptions about sexual orientation, or may hold negative attitudes towards these individuals (Phatcharaphon & Noppawan, 2025). These factors can create barriers for LGBTQIA+ people when accessing healthcare (McNeill, McAteer, & Jepson, 2021). In addition, UK medical students have reported that current education on LGBTQIA+ specific healthcare is insufficient, which may impact their confidence and ability to provide appropriate care to these patients (Barber, Flach, & Pattinson, 2022). This is further supported by research which indicates that LGBTQIA+ people in the UK report poorer health outcomes and less positive

experiences of healthcare compared with the general population (Griffin, et al., 2023).

In addition to the wider issues experienced by LGBTQIA+ people, evidence shows that some groups face specific challenges when accessing healthcare, particularly transgender, non-binary and intersex individuals. The 2021 Trans Lives Survey found that 70% of respondents reported being affected by transphobia when accessing general healthcare services (TransActual, 2021). The survey also found that 45% of respondents felt their GP did not have a good understanding of their needs as a transgender person, rising to 55% among non-binary respondents. These findings suggest that transgender, non-binary and intersex people may experience poorer healthcare, or feel unable to access services at all, due to a combination of limited clinician understanding and the experiences of transphobia.

Another commonly reported issue for LGBTQIA+ people, particularly transgender, non-binary and intersex individuals, is difficulty in accessing sex-specific screening such as cervical screening. GP records currently use a gender marker, offering only male and female options, and there is no separate marker for sex. Changing this gender marker requires a new GP record and new NHS number to be created, which can lead to issues with record transfer, such as loss of medical records. Research by Healthwatch England found that over a quarter of people who changed their gender marker lost access to parts of their GP record, causing disruption to prescriptions and treatment (Healthwatch England, 2025). Additionally, changing a gender marker can affect access to sex-specific screening, as individuals may no longer be automatically identified as eligible, and therefore not invited. This then places all the responsibility on the individual to seek out this screening themselves. Research into cervical screening found that only 58% of eligible transgender and nonbinary individuals had attended cervical screening (Berner, et al., 2021). These challenges highlight gaps in healthcare records and processes which can create significant barriers to essential preventative care for LGBTQIA+ communities, and not having access to these screening tests can cause significant harm.

For transgender and non-binary people who are invited to, or arrange sex-specific screening, there can be additional barriers beyond just booking an appointment. Research has linked non-attendance to experiences of gender dysphoria and found that around half of transgender and non-binary respondents would be open to self-testing options (Berner, et al., 2021). This study also highlighted a need for improved staff training, particularly around inclusive

and appropriate language, as well as information resources that better reflect and include transgender people, including transgender-specific information resources.

Evidence shows that people who identify as LGBTQIA+ are at higher risk of experiencing poor mental health compared to the wider population (Mental Health Foundation, n.d.). For example, rates of suicidal behaviour and self-harm are significantly higher among LGBTQIA+ people and those who identify as LGBTQIA+ are around 1.5 times more likely to experience depression and anxiety than the rest of the population (Mental Health UK, n.d.). Additionally, research also indicates that outcomes from Improving Access to Psychological Therapies (IAPT) are poorer for individuals who identify as lesbian, gay or bisexual compared to heterosexual service users (Foy, Morris, Fernandes, & Rimes, 2019). This suggests that mental health services are not consistently meeting the needs of LGBTQIA+ people. Contributing factors may include assumptions within healthcare that everyone is heterosexual, as well as the experiences of stigma, discrimination and/or a lack of understanding from staff, which may influence both engagement with services and the effectiveness of treatment.

Another issue affecting LGBTQIA+ people is access to appropriate contraception and reproductive healthcare. Evidence suggests that LGBTQIA+ people with uteruses experience poorer quality sexual and reproductive healthcare compared to cisgender heterosexual individuals (Patel, Woods, & Singh, 2024). A key barrier identified in research, is the assumption of heterosexuality by healthcare professionals, which can make people uncomfortable when discussing their needs, and may require them to repeatedly disclose or explain their sexual orientation or gender identity in order to receive appropriate advice and care (Westwood, 2024). In addition, much of the available information and education about contraception is designed for people in heterosexual relationships, meaning that guidance may not feel relevant or accessible to LGBTQIA+ people (We Can't Go Backwards, 2025). This can limit people’s understanding of the full range of contraceptive options available to them and reduce confidence in the advice provided. Furthermore, experiences of homophobia or transphobia, alongside gaps in staff training and knowledge, can further discourage LGBTQIA+ people from accessing contraception services, contributing to ongoing inequalities in reproductive and sexual healthcare.

In July and August 2024, the Healthwatch Norfolk Engagement Team attended Norwich Pride and Kings Lynn and West Norfolk Pride to gather feedback from

LGBTQIA+ people about their experiences of healthcare. People were asked whether they felt being part of the LGBTQIA+ community affected their healthcare and were able to respond using coloured counters, with the option to provide further details. A total of 164 responses were received. Of these, 58% (94) felt that being LGBTQIA+ affected their healthcare, while 42% (68) did not (Healthwatch Norfolk, 2024). In addition, 36 people shared more detailed experiences, which highlighted several recurring themes. The most common theme was a lack of understanding or consideration of a person's sexuality or gender identity in healthcare settings. This included incorrect use of pronouns or titles, perceived lack of staff training on transgender issues, difficulties accessing appropriate sex-specific screening and assumptions about contraception or partners. Other concerns raised include long waiting times for gender-affirming care and mental health needs not being taken seriously or being attributed to a person's sexual orientation or gender identity. While most feedback described negative experiences, a small number of positive examples were also shared, such as services adapting care appropriately based on individual needs, including making a note in someone's record to not keep offering certain forms of contraception as these were not needed.

Based on the results of last year's Pride report and the literature discussed above, we felt it was important to revisit this topic, and to have a particular focus on certain areas identified as being potential issues. These were assumptions, pronouns, testing & screening, contraception and mental health.

How we did this

Using the responses from the 2024 engagement as a guide, Healthwatch Norfolk developed a new survey for 2025 using SmartSurvey to explore key themes in more detail. The survey included 13 questions, five of which focused on LGBTQIA+ experiences, with the remaining questions collecting demographic data. The questions on LGBTQIA+ experiences were multiple choice, with optional free-text boxes to allow respondents to share additional detail where relevant. The fill survey can be found in the appendices at the end of this report. Targeted engagement for the survey took place at Norwich Pride 26 July 2025 and King's Lynn and West Norfolk Pride 16 August 2025. The survey was also promoted through the Healthwatch Norfolk website and our newsletter. It was also shared on our social media channels, including Instagram, Facebook and Linkedin to reach a wider audience. There were multiple posts shared regarding the survey, each with a different graphic or photo, to improve engagement with the posts. An example of a social media post can be seen below.

Figure 1 - An example of a social media post used to advertise the Pride survey

Participants' involvement and consent In line with General Data Protection:

Informed consent was obtained from all participants. Clear information was provided about the purpose of the research, how data would be used, how long it would be retained, and participants' right to withdraw consent at any time prior to publication of the final report. All survey questions were optional, allowing participants to skip any they did not wish to answer. Participants were assured that responses would be anonymised, with any identifiable information removed before inclusion in the report. Digital data were stored securely on password-protected hard drives, and paper responses were kept in a locked drawer at the Healthwatch Norfolk office. All data will be securely deleted at the end of the project in line with data protection regulations and Healthwatch Norfolk's data retention policy.

Limitations

There are several limitations to this project that should be noted. Analysis of the geographical distribution of responses showed that some areas of the county were underrepresented. This is likely due to engagement taking place primarily at two Pride events, which are more likely to attract people from the local areas. If further targeted engagement is undertaken around the 2026 Pride events, wider coverage across the county could be achieved by increasing online promotion of the survey, and engaging with people in underrepresented areas, such as local community groups and GP surgeries.

A further limitation refers to the wording of some survey questions, which may have affected the strength of the conclusions that could be drawn. For example, one question asked whether respondents had experienced incorrect assumptions about their sexual orientation or gender identity, combining two distinct aspects into a single question. A persons' sexual orientation and gender identity are separate, and asking about these individually would have allowed for more detailed analysis.

In addition, the gender options used in the demographic questions did not include specific options for transgender male and transgender females, it was limited to "male" and "female". As a result, unless individuals opted to self-describe as transgender, we were unable to distinguish between cisgender and transgender respondents, meaning we may have been unable to draw as accurate conclusions about people's experiences of healthcare based on their gender identity.

What we found out

We received 87 responses to the Pride survey. After data cleaning to remove 10 responses we were left with 77 responses. While this is a relatively small number of responses, this data is still meaningful and was able to capture the thoughts and experiences of a usually under-represented group. Responses were removed if participants did not live in Norfolk or who did not answer the questions provided. A map below shows the postcodes covered by participants in the survey.

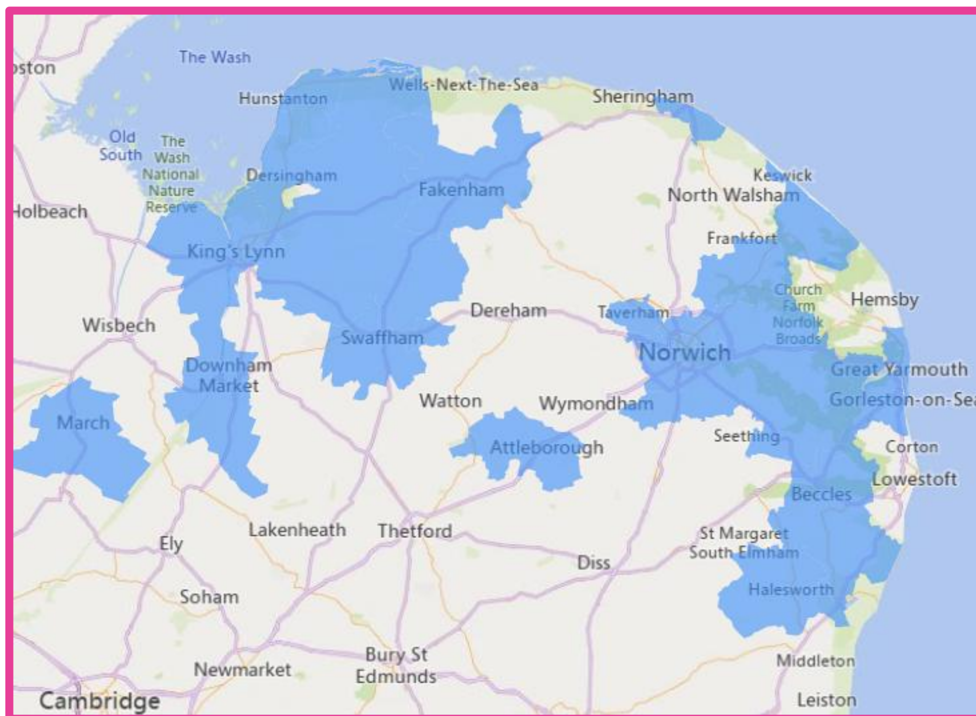

Figure 2 - A map showing the distribution of postcodes of respondents for the Pride survey

Based on answers to each individual demography question, respondents informed us that:

- The majority of respondents, 36 (48%) were aged between 25-49.
- While most respondents identified as female or male, we did hear from people who identified as genderfluid, non-binary and transgender.
- 30 (40%) of participants identified as homosexual (Gay or Lesbian) followed by 23% identifying as heterosexual.

- The majority of respondents identified as White British/English/Northen Irish/Scottish/Welsh (65, 87%)

Below can be found a series of graphs and charts that depict the demographic data, outlined on the previous page, in further detail.

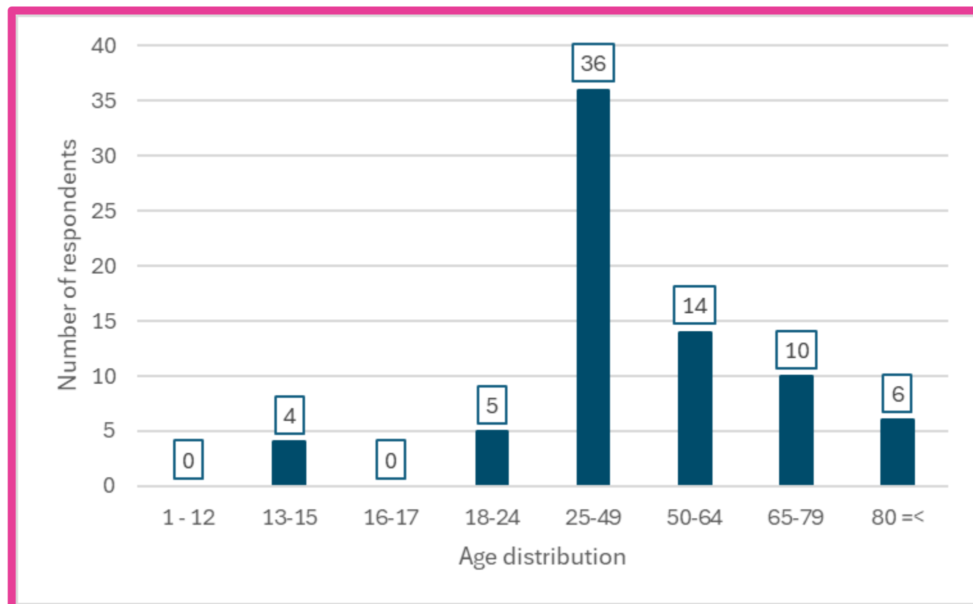

Figure 4 - A graph to show the age distribution of respondents.

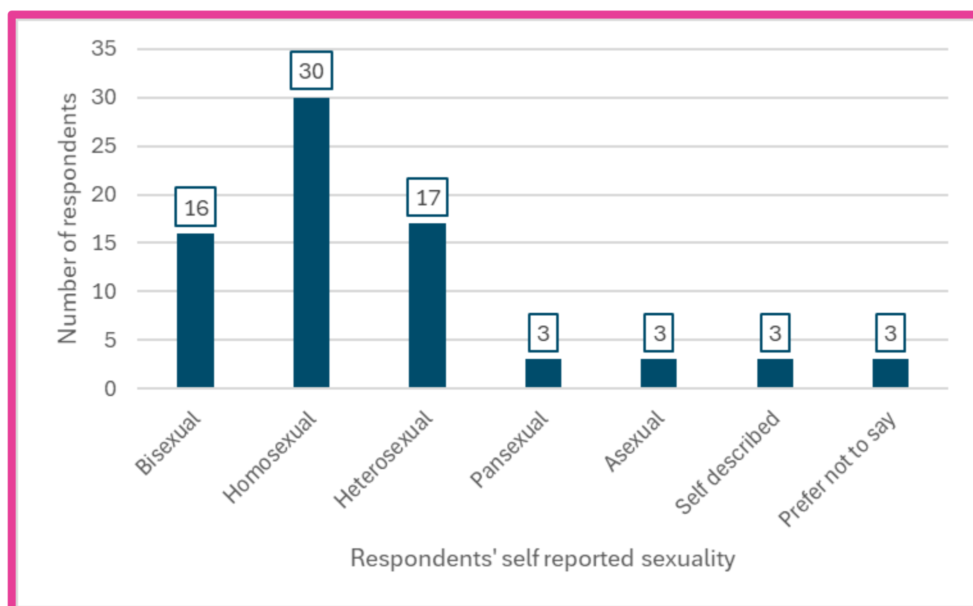

Figure 3 - A graph to show the self-reported sexual identity of respondents

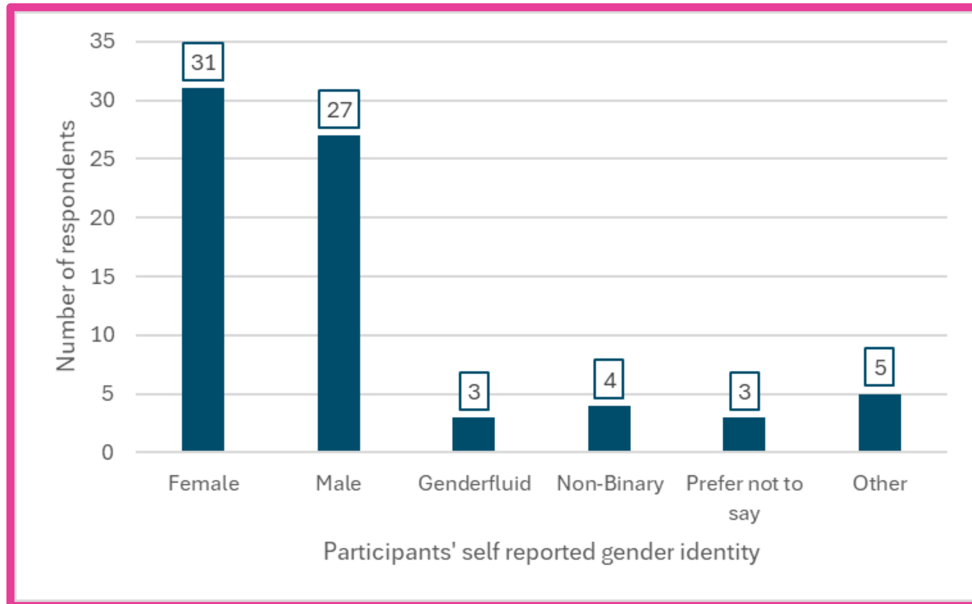

Figure 5 – A graph to show the self-reported gender identity of respondents

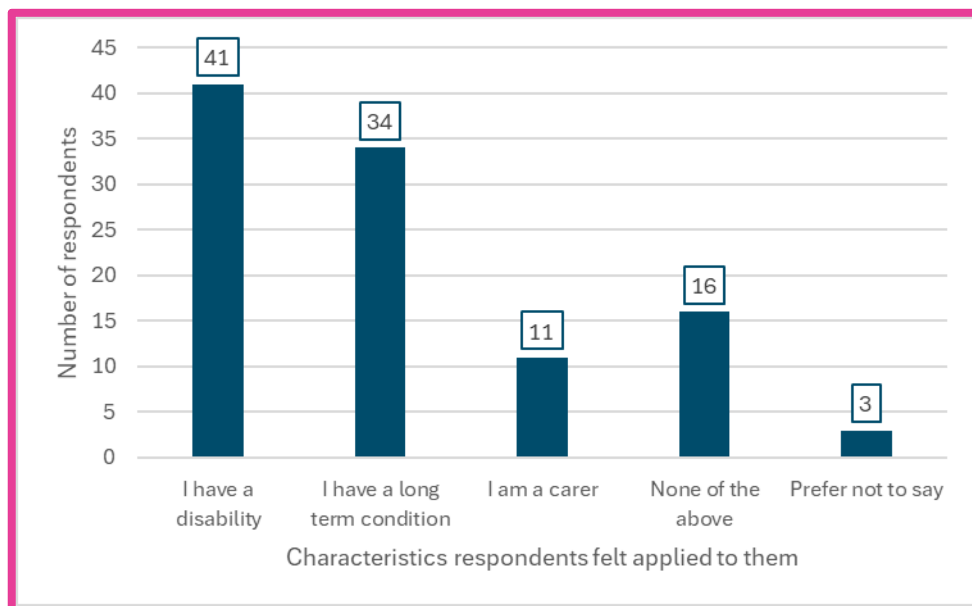

Figure 6 – A graph to show the number of respondents who identified as having a disability, a long-term condition and/or is a carer.

Figure 7 - A graph to show the ethnicity of respondents

Survey findings:

Of the 75 people who responded to the question "Have people ever made incorrect assumptions about your sexual orientation/ gender identity", 16 (21%) reported that incorrect assumptions about their sexual orientation or gender identity were always made, while 39 (52%) said this happened sometimes. Only 16 respondents (21%) said this had never happened. Among non-heterosexual respondents (for example, gay, lesbian or bisexual people), 88% reported that incorrect assumptions were made either always or sometimes, compared with 19% of heterosexual respondents. In the free-text responses, many participants described clinical staff assuming they were heterosexual and cisgender. Respondents also reported that, even when this information was corrected or recorded in their medical notes, it was not always acknowledged or acted upon.

> "Was misgendered multiple times despite mentioning I was trans, and wearing he/him pronoun pins"

> "Assumptions are sometimes made about my sexuality, as it is often presumed that I have a girlfriend and therefore that I am not gay. While these assumptions do not offend me, I do feel it is important to correct them, particularly now that I am in a relationship, although I would still correct them regardless. For me, this is about ensuring that people

understand and respect my identity, rather than allowing incorrect assumptions to go unchallenged."

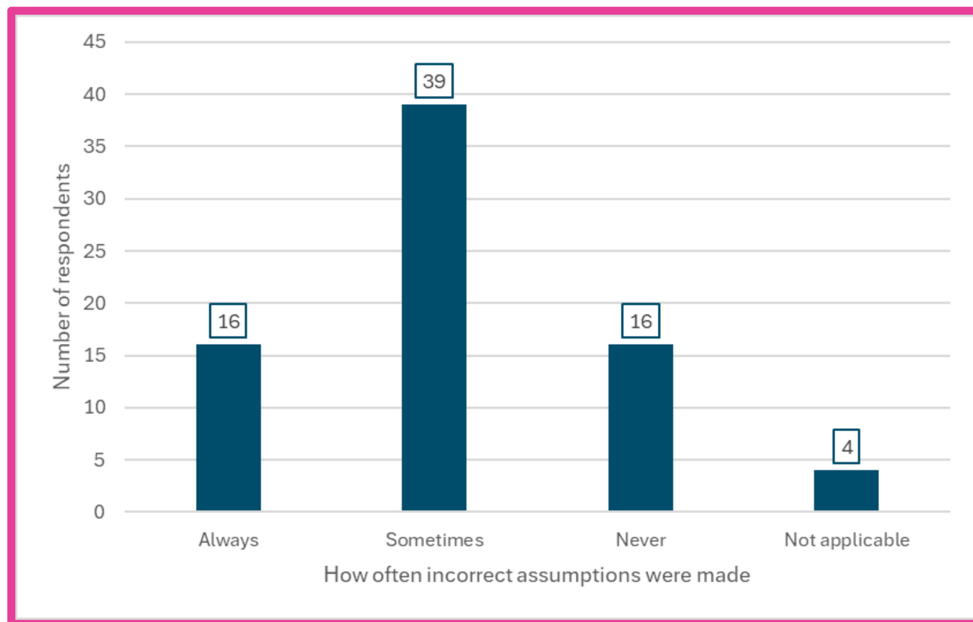

Figure 8 - respondents answers to the question "Have people ever made incorrect assumptions about your sexual orientation/ gender identity"

When asked whether staff used their preferred pronouns, 36 respondents (48%) said this always happened, while 18 (24%) said it happened sometimes. Nine respondents (12%) reported that staff never used their preferred pronouns. When respondents were broken down by self-reported gender identity, over three-quarters of respondents who identified as male or female (43 people) said their preferred pronouns were always or sometimes used. This compared with seven people (64%) of those who identified as non-binary, genderfluid or transgender, with four people (36%) saying staff never used their preferred pronouns. In the free text comments, many respondents reported that pronoun use was not an issue for them, however, a large proportion of respondents were cisgender and used pronouns typically associated with their sex. However, among those who had reported preferred pronoun use was an issue, experiences varied. Some described staff being respectful and using correct pronouns, while others reported staff repeatedly using incorrect pronouns despite being corrected. Several respondents also noted that staff often did not ask about preferred pronouns and instead made assumptions about these based off people's appearance.

"I've been routinely misgendered ever since I became pregnant with my daughter last year when accessing prenatal and postnatal care, despite there being sections filled out at the front of my notes with my preferred pronouns."

"In my experience, healthcare professionals have always used my pronouns (he/they), which is something I value deeply. It helps me feel respected, seen, and supported in healthcare settings, where trust and understanding are so important. On the rare occasion that someone might misgender me, I would address it in a positive and constructive way. My aim would not be to make them feel bad, but rather to gently correct the mistake so that it does not continue. The only circumstance in which I would respond differently is if the misgendering was deliberate, as intentional disregard for identity is harmful. Overall, I find that when healthcare professionals take care to use my pronouns correctly, it makes a meaningful difference to my comfort and confidence in their care."

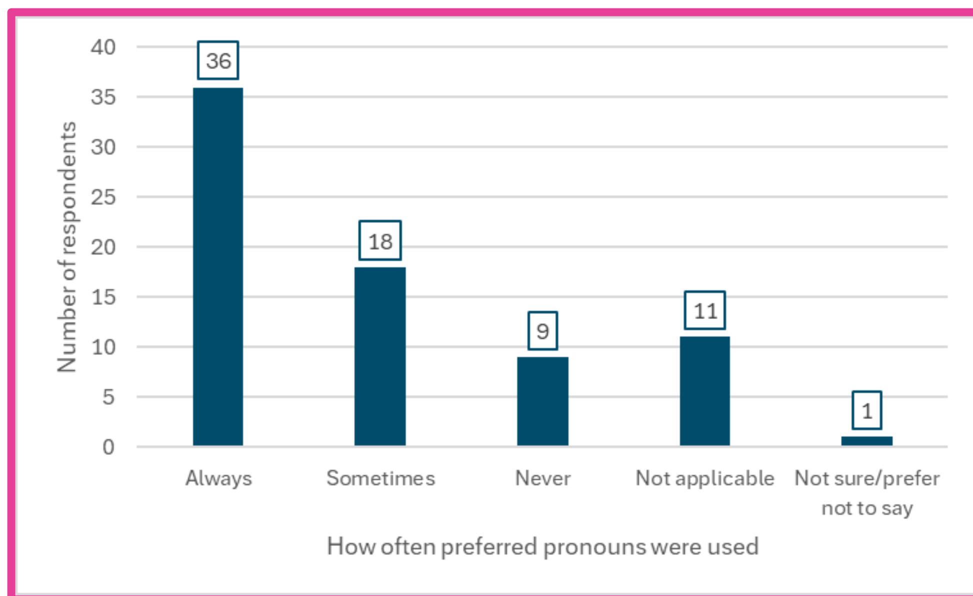

Figure 9 - A graph to show respondents answers when asked if staff used their preferred pronouns.

Respondents were asked whether they had been offered screening or testing appropriate to their needs, such as cervical screening, pregnancy tests or

prostate examinations. Overall, 33 respondents (44%) said they were always offered appropriate screening or testing. However, 13 respondents (17%) said this was offered sometimes, and 10 respondents (13%) said it was never offered. There was little difference in responses between those who identified as male or female and those who identified as another gender, such as non-binary. This suggests that, for those not offered screening, the issue may be linked to wider system processes—such as not receiving automatic invitations—rather than gender identity or sexuality alone. In free-text comments, respondents shared mixed experiences. One person noted that because their medical records still had their gender marker recorded as female, they continued to receive screening invitations appropriate to their anatomy. Others highlighted positive practice, such as the Norfolk and Norwich University Hospital (NNUH) Emergency Department offering HIV testing.

> "As I am still female on my medical records, I have been invited for appropriate screening for my anatomy."

> "They keep asking me if I'm pregnant which makes me feel worse because I'm trans and I know I can't have children."

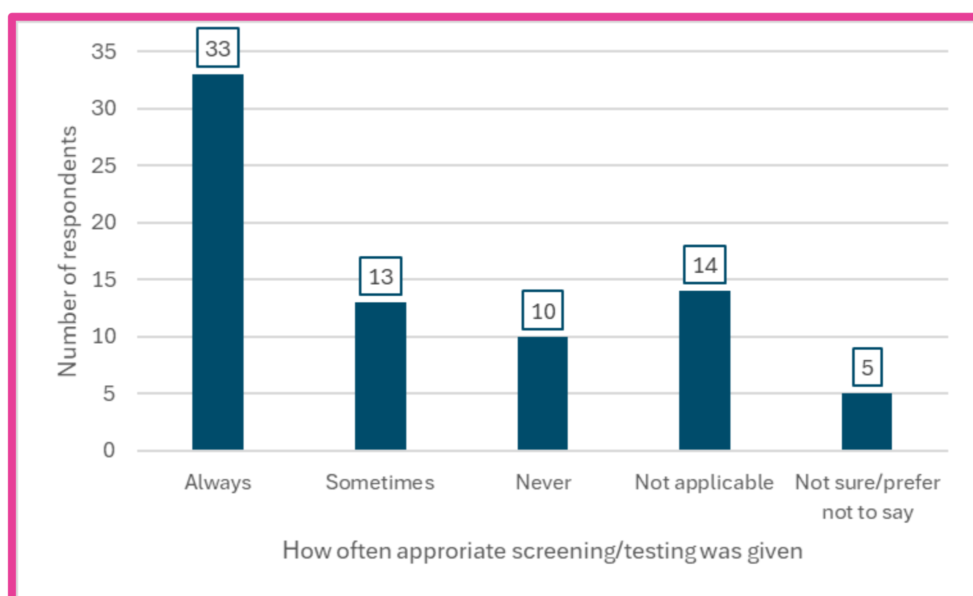

Figure 10 - A graph to show respondents answers to the question "Have you been offered appropriate screening/testing relevant to your needs"

When asked "When you have discussed contraception with healthcare professionals, have they been appropriate for you", 24 (32%) felt that this was always appropriate and 18 (24%) felt that this was only sometimes appropriate. Three (17%) respondents who identified as heterosexual felt that contraception conversations were only sometimes appropriate to them, compared to 14 (26%) of respondents who identified as another sexuality (e.g. homosexual or bisexual). From the additional comments, respondents raised issues such as having to continuously explain themselves and that clinicians automatically assume that if someone is on contraception this will be for pregnancy prevention, when there are multiple other reasons, someone may be using certain forms of contraception, such as to help with heavy periods. One respondent also reported clinicians urging them to go on contraception in case they "*change their mind*" regarding their sexuality.

"When I have had issues with my periods and the contraceptive pills I've been put on to stop this, doctors will always assume that I'm taking it because I'm sexually active. I often feel dismissed and judged when stating that I am asexual and am not on the pill to not get pregnant. I've had one doctor ask how this works with me being engaged (whilst looking at my engagement ring) which was not relevant to my medical issue at all."

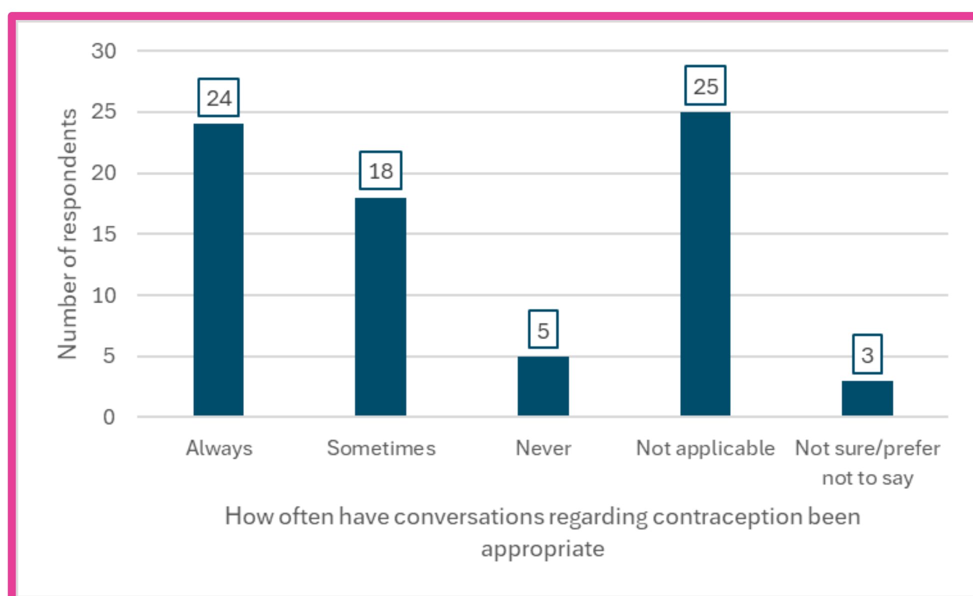

Figure 11 - A graph to show respondents answers to the question "When you have discussed contraception with healthcare professionals, have they been appropriate for you"

We asked respondents if they felt that their gender identity and/or sexual orientation had affected their access to mental health support. Overall, nine respondents (12%) felt their gender identity/sexual orientation always affected their access to mental health support, and a further 18 people (24%) felt that this was sometimes affected. Additionally, there were 30 people (40%) who felt their gender identity and/or sexual orientation had never affected their access to mental health support. When this is broken down by respondents' sexuality, 62.5% (10) of heterosexual respondents said that their gender identity or sexual orientation had never affected their access to mental health support, compared to just 25% (4) of bisexual respondents, and 43% (13) of homosexual respondents. Additionally, of the three respondents who identified as transgender, two (67%) felt their gender identity and/or sexual orientation always affected their access to mental health support, and one (33%) felt that sometimes it affected their access to this support. Based on the additional comments, respondents have had very mixed experiences with mental health care and how this has been affected by their sexual orientation or gender identity. For example, some found that people have been understanding and accepting, but many others felt judged and felt that services are more limited/difficult to access for them.

It seems so much more limited since I've come out as trans. I was getting a lot more help before. Now they're blaming it all on me being trans when it's not that, it's the same problems as before.

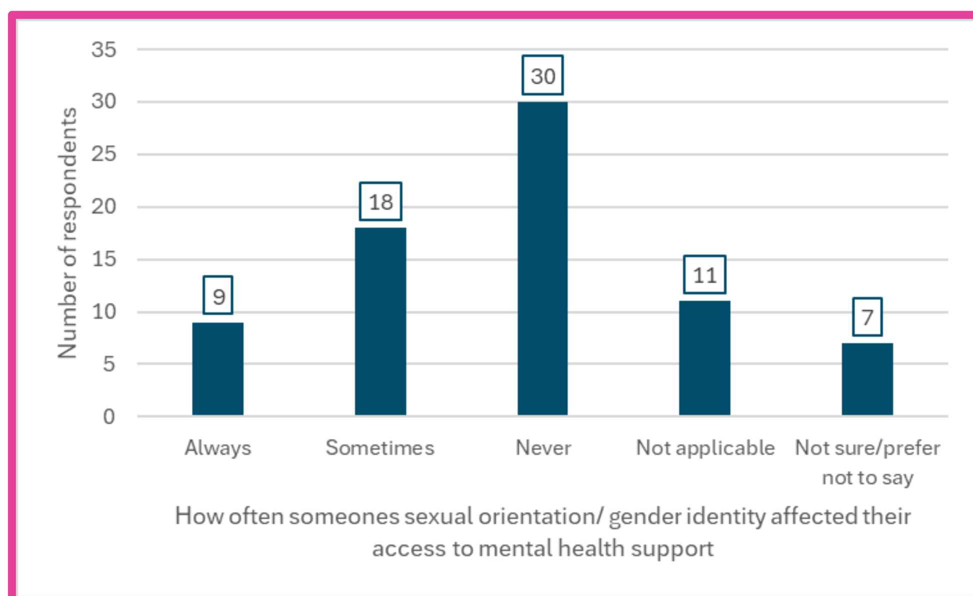

Figure 12 - A graph to show respondents answers to the question "Do you feel that your gender identity or sexual orientation has affected your access to mental health support"

What this means

The findings show that assumptions of everyone being heterosexual remain embedded within healthcare. LGBTQIA+ respondents were more likely to experience incorrect assumptions about their sexual orientation or gender identity, even when accurate information was recorded in medical notes. This suggests not only gaps in awareness but also inconsistent use of available patient information. Such experiences can be distressing and may undermine trust in healthcare professionals. Where people do not feel able or comfortable to challenge assumptions, there is a risk that care does not fully reflect their needs, increasing the likelihood of inappropriate advice or treatment and missed or delayed diagnoses.

Pronoun use emerged as a clear indicator or inclusion and respect. While most respondents identifying as male or female reported that their preferred pronouns were used appropriately, non-binary, genderfluid and transgender respondents were less likely to report this. Repeated misgendering, particularly when correct pronouns are known and recorded, signals a lack respect and may contribute to feelings of exclusion. Over time this may undermine confidence in services and discourage people from seeking care. These experiences align with wider evidence of transphobia in healthcare and highlight the impact of everyday interactions on trust and engagement.

Access to appropriate screening and testing appears to be shaped by broader system pressures as well as individual identity. Just over half of respondents reported being offered relevant screening or testing consistently, with little variation across gender identities. This suggests that while identity related barriers may not be the sole factor there remains a need for services to ensure that discussions about screening and testing are appropriate, inclusive and responsive to individual needs.

Contraceptive discussions revealed how assumptions about sexuality can directly affect the relevance and quality of care. LGBTQIA+ respondents were less likely to feel that contraception advice was consistently appropriate for them. Free-text responses indicate that this is often driven by assumptions that patients are heterosexual or that contraception is only relevant for pregnancy prevention. One respondent also reported being told by a clinician that they may

“change their mind” regarding their sexuality. Such experiences reflect potential internalised biases within healthcare settings and highlight how attitudes and assumptions can limit meaningful, person centred conversations about reproductive health.

Mental health support was an area where identity related barriers were most clearly felt. Transgender respondents were more likely to perceive their gender identity as affecting their access to mental health services. Inconsistent staff attitudes, ranging from supportive to judgemental, create uncertainty and anxiety for patients and may deter people from seeking help or fully engaging with mental health support. This variability reinforces existing inequalities and places additional emotional burden on those already at higher risk of poor mental health outcomes.

Overall, these findings highlight persistent inequalities in how LGBTQIA+ people experience and access healthcare services. Across identity recognition, contraception and mental health support, experiences were frequently shaped by assumptions, inconsistent practice and variable levels of understanding. While some challenges reflect wider pressures on services, the findings suggest that there is an ongoing need to address practices based on the assumption all people are heterosexual and improve staff confidence and competence. **Consistent use of recorded information, inclusive communication and a culture that actively challenges assumptions are essential to delivering person centred care and reducing health inequalities for LGBTQIA+ communities.**

Recommendations

- Our most important recommendation would be for the IT system that contains GP patient records to be improved, so that sex and gender are both recorded separately and that patients are able to change the gender marker in their record without an entirely new record having to be created.
- We recommend that all local clinical staff are given training on both overall LGBTQIA+ awareness, but also relevant training for LGBTQIA+ specific healthcare such as relevant contraception.
- We recommend that local GP surgeries, and other healthcare settings focus on accurately recording patients' preferred pronouns and ensure these are used in all conversations.
- The issues raised have highlighted some widespread difficulties faced by LGBTQIA+ people in Norfolk and we recognise it is important that this is reviewed. Therefore, Healthwatch Norfolk have set a recommendation for ourselves, in that we will aim to review this work in 2027, allowing time for positive change to take place.

Acknowledgement

- The Healthwatch Norfolk team would like to thank all the people who completed the survey which allowed us to write this report. Additionally, we would like to thank the organisers of both Norwich Pride and Kings Lynn and West Norfolk Pride for allowing us to attend these events and speak to attendees.

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Appendix

Appendix A – the full Pride 2025 survey

Pride 2025

1.

Who is Healthwatch Norfolk?

Healthwatch Norfolk is the independent voice for patients and service users in the county. We gather your views of health and social care services to ensure they are heard by the people in charge.

What is this survey about?

Last year we asked " Do you feel that being part of the LGBTQIA+ community affects your healthcare?" We received lots of responses and this year we are focusing on 5 key themes that emerged from the report to find out more. When you answer the questions, think about your experiences in the last 5 years.

How the survey results will be used

Survey responses are being collected and analysed by Healthwatch Norfolk. You can read our full privacy policy at:
http://www.healthwatchnorfolk.co.uk/about-us/privacy-statement.

All responses will be anonymous and will be used to make recommendations to health and social care providers. The report will also be publicly available on our website and may be used in other Healthwatch Norfolk communications.

Want to keep in touch?

To stay up to date with what we are doing at Healthwatch, you can sign up to our newsletter via our website: http://www.healthwatchnorfolk.co.uk

If you do not use email, you can call Healthwatch Norfolk on 01953 856029 to ask to receive our newsletter via post.

Survey closing date: 30th September 2025

If you would prefer to do this survey with us over the phone, please call Healthwatch Norfolk on 01953 856029 and we will arrange a time to ring you back to complete the survey.

Alternatively, please email: enquiries@healthwatchnorfolk.co.uk for further support. You can use the same email address if you would prefer to submit your feedback in a video format.

Please note: questions marked with an asterisk (*) require a response.

1. Healthwatch Norfolk produce quarterly newsletters about health and social care in Norfolk. If you'd like to receive this newsletter please leave your email here:

2. Have people ever made incorrect assumptions about your sexual orientation/ gender identity

- ☐ Always
- ☐ Sometimes
- ☐ Never
- ☐ Not sure/prefer not to say
- ☐ Not applicable

Tell us more

3. Do healthcare professionals use your preferred pronouns?

- ☐ Always
- ☐ Sometimes
- ☐ Never
- ☐ Not sure/prefer not to say
- ☐ Not applicable

Tell us more

4. Have you been offered appropriate screening/testing relevant to your needs? (e.g. smear/prostate/ pregnancy)

- [ ] Always
- [ ] Sometimes
- [ ] Never
- [ ] Not sure/prefer not to say
- [ ] Not applicable

Tell us more

5. When you have discussed contraception with healthcare professionals, have they been appropriate for you?.

- [ ] Always
- [ ] Sometimes
- [ ] Never
- [ ] Not sure/prefer not to say
- [ ] Not applicable

Tell us more

6. Do you feel that your gender identity or sexual orientation has affected your access to mental health support?

- [ ] Always
- [ ] Sometimes
- [ ] Never
- [ ] Not sure/prefer not to say
- [ ] Not applicable

Tell us more

2. Demographics

About you

In this next section we will be asking you some questions about yourself and your life. All these questions are optional. Your answers help us make sure that we hear from people from different backgrounds and that we understand the needs of different groups in our community. Remember: all your answers are strictly confidential and the survey is anonymous.

7. What is the first half of your postcode? (e.g. NR3)

8. How old are you?

9. What is your gender?

- [ ] Male
- [ ] Female
- [ ] Non-binary
- [ ] Genderfluid
- [ ] Genderqueer
- [ ] Intersex
- [ ] Prefer not to say
- [ ] Prefer to self-describe:

10. What is your sexuality?

- [ ] Bisexual
- [ ] Gay or Lesbian
- [ ] Heterosexual (Straight)
- [ ] Pansexual
- [ ] Prefer not to say
- [ ] If you feel the choices do not provide a suitable option, please write how you would describe your sexual orientation:

11. What is your ethnic group?

- [ ] Arab

Asian/ Asian British:

- [ ] Bangladeshi
- [ ] Chinese
- [ ] Indian
- [ ] Pakistani
- [ ] Any other Asian/Asian British background

Black/ Black British:

- [ ] African
- [ ] Caribbean
- [ ] Any other Black/ Black British background

Mixed/ Multiple ethnic groups:

- [ ] Asian and White
- [ ] Black African and White
- [ ] Black Caribbean and White
- [ ] Any other Mixed / Multiple ethnic groups background

White:

- [ ] British / English / Northern Irish / Scottish / Welsh
- [ ] Irish
- [ ] Gypsy, Traveller or Irish Traveller
- [ ] Roma
- [ ] Any other White background

Other:

- [ ] Any other Ethnic Group
- [ ] Prefer not to say
- [ ] If other, please specify:

12. Please select any of the following that apply to you:

- [ ] I have a disability
- [ ] I have a long term condition
- [ ] I am a carer
- [ ] None of the above
- [ ] I prefer not to say

13. Where did you hear about this survey?

- [ ] GP website
- [ ] Healthwatch Norfolk Event
- [ ] Healthwatch Norfolk Newsletter
- [ ] Healthwatch Norfolk Website
- [ ] News (website / radio / local newspaper)
- [ ] Podcast
- [ ] Search Engine (e.g. Google)
- [ ] Social Media (e.g. Facebook / Instagram / Twitter)
- [ ] Through a friend or co-worker
- [ ] YouTube
- [ ] Other (please specify):

3.

For this particular survey, we are keen to hear the feedback from LGBTQIA+ people. If that does not apply to you, you can still leave feedback about the health or social care you receive. Find out more on our website at www.healthwatchnorfolk.co.uk

Healthwatch Norfolk
Suite 6 The Old Dairy Elm Farm
Norwich Common
Wymondham
Norfolk
NR18 0SW

www.healthwatchnorfolk.co.uk
t: 0808 168 9669
e: enquiries@healthwatchnorfolk.co.uk
@HWNorfolk
Facebook.com/healthwatch.norfolk