Evidence submitted by Rainbow Hospitality with respect to the proposed Health Bill

My name is Dr Rachel Saunders. I am the Director of Rainbow Hospitality, a trans and queer inclusive pressure group based in the UK. I have 26 years of LGBTQI+ advocacy. I hold a law and computer science doctorate from the University of Nottingham and have previous conducted research into LGBTQI+ data in the UK over the last seven years.

Summary

This evidence focuses on s. 47 of the draft bill, specifically the centralising and sharing of LGBTQI+ patient data. Our overarching concern is that a single patient record may end up causing longitudinal harm to LGBTQI+ patients, and transgender patients in particular, due to how NHS data has thus far been collected, collated, and stored in multiple silos which may reflect different identities due to when a patient interacted with specific clinical or social care provision.

We lay out our concerns and propose changes which could ameliorate the potential harms which the Bill could cause to the LGBTQI+ community.

Evidence

The focus of this evidence is the potential impact of disclosure of data into a combined single patient record on LGBTQI+ people living in the UK, who that information will be shared with, and how their identities will be both dignified and protected in a singular record. Therefore, we address s. 47 specifically in this evidence.

In principle Rainbow Hospitality welcomes a unified data point for all patients because this could ensure that LGBTQI+ patients are treated with dignity and respect if the data is captured in such a way to dignify their identities and ensure their affirmed identities are used throughout any clinical pathway. Indeed, a central data point could overcome the issues faced by LGBTQI+ patients and social care clients whereby certain clinicians and social workers refuse to dignify or change data to reflect an LGBTQI+ person's affirmed identity. However, we do have concerns which *ought* to be addressed to prevent harms being inflicted on the LGBTQI+ community.

We recognise that conversations about sex, gender, and sexuality-based data are complex and divisive due to the UK Supreme Court's *For Women Scotland* ruling, along with broader conversations about how "biological sex" *ought* to shape patient clinical pathways. Our contention is that healthcare is a personal issue between clinician and patient, and while the principles of equity and access have been discussed elsewhere, in practice the sharing of patient data is a personal matter of the utmost important to all LGBTQI+ patients irrespective of the philosophical and religious beliefs of their clinicians or social workers.

In light of the European Cout of Human Rights decision in *T.H. v Czech Republic*[1] transgender patients have Article 3 protections from not being continually misgendered by the State. This ruling was passed down in September 2025 after the UK Supreme Court's *For Women Scotland* ruling in April 2025, and imposes a duty on the UK government not to expose transgender and other LGBTQI+ people to repeated misgendering and denial of their gender identity or sexuality. Our principle concern is that s. 47 opens up another avenue through which LGBTQI+ people are exposed to systemic and systematic misgendering, either inadvertently through the incorrect synthesising of their data or through direct imposition of a rigid sex-based approach to sex in any centralised dataset.

S. 47.2(b) of the draft bill means that if two competing datasets, such as GP records and hospital in-patient records, are combined there is no mechanism for synthesising those records in such a way that a trans person's identity would be dignified in the process.

The bill makes no provision for the synthesising of patient data, which impacts a broad swathe of patients including married women, adopted children, intersex and transgender people, anyone who has legally changed their name, foreign born residents who changed their birth certificate in their home country, indeed anyone who has amended a name, sex, gender, sexuality, or other maker across their life time. This could also expose the victims of domestic violence who have changed their name and other crime victims and witnesses whose medical records may reflect their prior name.

With respect to LGBTQI+ patients:

Example 1: A trans woman has been registered with her GP from birth, recorded as *male*, then has her records changed to *female* when she transitioned. Prior to transitioning she broke her leg and spent a week in hospital where her data was recorded as *male*. She has not needed any in- or out-patient care since. When her medical records are centralised which version of her data is synthesised as the correct sex/gender markers.

Example 2: Ms Collins emigrates to the UK from Ireland for work in 2023. Prior to emigrating her birth certificate was changed to reflect her female gender. She joined a local GP practice where her gender was accepted without question. Under the EHRC framing she is "biologically male", yet as per her Irish citizenship and medical data she is legally female without any ability of the UK healthcare system questioning this. Thus, when her single patient record is synthesised does this capture her female gender, or would it seek to enforce a sex which is not recognised by the Irish State?

This raises questions over s. 47.2(c)(ii)'s provision over the whole of the British Islands. If Irish citizens are able to cross the border, live in Northern Ireland and utilise healthcare provided by the NHS how *ought* their data be centralised, especially if they have received or still receive healthcare provision in the Republic of Ireland. The same goes for any citizen of the European Union. Northern Ireland is not covered by the ECHR guidance, conceptually using the same framing of gender as the Irish Republic. From a data centralisation perspective due to the Windsor Framework the question then needs to be asked as whether any centralised single patient record would impose "sex" through a "biological sex" lens, or use gender *and* sex in a UK wide dataset.

While the May 2026 Equality and Human Rights Commission (EHRC) Guidance delineate patients based on "biological sex", patient data is more complex and nuanced:

- Foreign born residents in the UK from countries such as Germany and Austria may have apostilled medical documents which reflect a gender or sex not recognised within the UK's current data framework, while other foreign-born residents may their medical records reflect their gender change as if they were that gender from birth.
    - Any centralised single patient record ought to be set up to allow such patients their legally recognised identity as per their apostilled records.
- While the EHRC guidance reflects the UKSC conception of sex, in reality sex and gender are used synonymously across legislation since 2010[2], and British society reflects this in the expansion of LGBTQI+ identities which encompass a person's conception of self. Other jurisdictions such as Ireland only use *gender* on birth certificates, and Germany

allows for a third sex option[3], meaning that foreign born residents potentially face a centralised data system which is not compatible with their medical and legal history.
    - As per *T.H.* this could mean that foreign born UK residents will be required to out themselves at every touch point in their medical journey
- Intersex patients potentially have complex medical histories which step beyond those of transgender patients. They have different legal options to amending their birth certificates, and there is a risk that any centralised patient record may present conflicting sex and gender markers which the system may not be set up to resolve.
- Sex markers on medical records are not a blunt edged dataset; they are complex and require personalised considerations due to each patient's medical history. A centralised data point cannot impose a blanket framing of sex because this will erase the texture and nuance of individualised healthcare provision. Indeed, if such an approach is taken it could cause longitudinal patient harm as well as an erosion of truth between the NHS and the LGBTQI+ community.
    - Transgender patients already face complications from their GPs with respect to name and sex marker changes, so any centralised data point *ought* to enable frictionless and dignified changes.

If a single data source is created for all patients our concerns are:

1. Transgender people's gender, sex, name change, and other protected data may be:
    a. Mis-recorded across all their medical records
    b. Edited without their consent by clinicians who may chose to impose their own philosophical and religious beliefs onto transgender patients
        i. The *Forstater EAT* ruling makes clear that manifested religious and philosophical belief *ought* not be used to harass, demean, or dehumanise trans people as they receive service provision.
    c. Data is shared with family or next of kin who are transphobic or homophobic and seek to erase a patient's transgender identity without the patient's consent
    d. Sharing of sensitive data about sex, sexuality, and gender identity with third party organisations could impact a transgender patient's European Convention of Human Rights Article 8 right to a private life because that information may be recorded in such a way as to misgender, mis-sex, or deny their transgender identity.
    e. Shared with gender critical clinicians, statisticians, and other healthcare professionals without a transgender patient's consent
        i. Our suggestion is that only GPs and registrars or above ought to be able to access trans people's medical history prior to transitioning without explicit informed consent of the transgender patient.
        ii. The caveat to this is in a clinical emergency, at which point the transgender patient *ought* to be informed at the earliest opportunity that their medical history was inspected.

We propose that the following amendments and/or explanatory notes be added to the Bill to ameliorate the potential harms which a central synthesised single patient record poses to LGBTQI+ patients:

1. UK law currently provides no legal mechanism through which transgender patients can have their patient data reflect their gender change holistically from birth[4]. The UK courts have ruled that it is up to Parliament to create legislation to enable transgender patients to have their identity reflected from birth, and as such we ask that the Health Bill's data provisions include:
    a. A provision allowing transgender people who have obtained a Gender Recognition Certificate under the Gender Recognition Act 2004 to amend their centralised medial record to reflect the change in their birth certificate across their entire medical history, not just from the moment of obtaining a GRC.
    b. Place the same restrictions on prior health history for all transgender patients as are currently in place for the DWP, which restricts access to transgender people to management and above.
2. Set in place an informed consent approach to sharing sensitive sex, gender, and sexuality data whereby this information can only be shared with the explicit approval of the patients involved.
    a. This is especially important for LGBTQI+ patients whose sensitive data may be shared against their wishes or in such a format that could breach their Article 8 protections.
3. Amend 47.2.(2)(C)(ii) to address concerns about Irish citizens living in Northern Ireland and how this impacts their rights with respect to amended birth certificates.
4. Factor in *T.H. v Czech Republic*'s ruling that the British State *ought* not set in place legislation and civil procedures through which the *de jure* legal principle is to force transgender people to out themselves every time their data is shared in a clinical or social care setting.
5. Establish in the explanatory notes to the Bill that *sex* and *gender* are synonymous in a healthcare setting and that all LGBTQI+ patients have the right to data dignity with respect to their sex and gender in a health care and social care setting.

In summation, our intent with this evidence is to draw attention to the potential harms which could arise should LGBTQI+ patient data be centralised and homogenised in any synthesising process. LGBTQI+ patients will have no control over this process, and there is significant risk that longitudinal harm will befall transgender, gender non-binary, and intersex patients should a single patient record incorrectly record their data or their data is shared with parties which do not recognise, respect, or dignify their identities.

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[1] https://hudoc.echr.coe.int/eng?i=001-243567
[2] *Succession to the Crown Act 2013* and *Ministerial and other Maternity Allowances Act 2021,* as well as the use of *gender* in the asylum process due to the nature of international refugee law.
[3] https://www.bmj.com/content/347/bmj.f5249
[4] R (on the application of C) (Appellant) v Secretary of State for Work and Pensions (Respondent)