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Gender Reassignment Protocol Review
Lead Clinician's Initial Briefing Paper

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1. Introduction

1.1. Project Summary

The Chief Medical Officer for Scotland (CMO) requested the National Gender Identity Clinical Network for Scotland (NGICNS) to undertake a review of the Gender Reassignment Protocol (GRP) on 08/07/2021. This is a protocol for care provided to transgender, non binary and gender diverse (TGD) people in relation to gender transition.

NGICNS is a managed clinical network hosted by National Services Scotland (NSS), National Services Division (NSD). A Project Initiation Document (PID) was agreed with the NSD senior management team and funding for resources to undertake the review has been identified. NGICNS forwarded a project update to the CMO at the end of October 2021.

An independent chair, [redacted], has been recruited and agreed to support the project. Project oversight for NSD is provided by Senior Programme Manager, [redacted]. A project oversight group is being recruited and will meet for the first time in January 2022.

Six short life working groups will be established as necessary to support the review. These groups will report to the oversight group. The board will aim to complete its work by 01/09/2022 and deliver an updated GRP to the CMO for consideration and publication.

We expect the GRP will then be regularly updated as needed, and at least annually.

1.2. What we will do

We will undertake a review and deliver an updated GRP that is fit for purpose and fully inclusive of all TGD people.

1.3. What will inform the review

The review will be based on principles of human rights and person centred care.

It will take into account in relation to gender identity healthcare:

- Best practice and developments from across and outwith NHS Scotland
- Different models of care
- Advances in evidence including World Professional Association of Transgender Health (WPATH) Standards of Care
- Updates to the World Health Organisation's International Classification of Diseases and Health Problems (ICD-11)
- Extensive and detailed engagement with those with lived experience of using gender identity services in Scotland and across NHS Scotland
- Principles of Realistic Medicine

The review will be informed by key documents including:

- The Scottish Public Health Network Healthcare Needs Assessment of Gender Identity Services
- Planning with People
- The National Health and Wellbeing Outcomes Framework

Discussion of gender recognition is outwith the scope of the review.

It may be helpful to be clear that this review is about the clinical needs of TGD people accessing pathways for gender identity healthcare, and does not consider service provision or funding. Other activity may take place regarding this at the same time or after this process is completed, but it is independent of the review.

1.4. How the review will work

An oversight group has been formed based upon the recommendations from the CMO letter and including people with lived experience (and their families if appropriate), clinical specialisms providing gender identity healthcare, organisations representing TGD people, representatives from primary care and from NHS Scotland.

Subject matter experts supported by the project team will review the available evidence. A Delphi approach may be used to develop consensus. Once the evidence has been collected the project team will compile the draft protocol and accompanying explanation document for approval by the oversight board.

1.5. Key areas of the review

It is proposed the review will be split into five major sections, and more details on each of these work areas can be found in later sections of this document:

- **Initial assessment**, including support and therapeutic approaches
- The role of **primary care** in gender identity healthcare
- Gender affirming **non surgical care**, including hormone therapy, facial hair removal, sexual and reproductive health, speech therapy and fertility preservation)
- **Gender affirming surgery**
- Pathways for **children and young people**

The individual needs of people accessing gender identity healthcare is at the heart of this work. We will engage widely with people using or interested in accessing services and also professional organisations. There will be a consultation period prior to the completion of the review. A public engagement questionnaire has been available since 24/12/2021 and will continue throughout the review.

We know that there are different clinical perspectives related to the delivery of gender identity healthcare and we will listen respectfully to all voices. Where there are differences we will reflect on this and find ways to reach a consensus.

1.6. What the review will produce

A progress report to the CMO in October 2021; this has been completed.

An updated GRP in September 2022 for the consideration of and publishing by the CMO.

An accessible explanation document for TGD people to understand and set expectations when accessing NHS gender identity healthcare.

1.7. About this briefing paper

This paper provides a starting narrative on each of the key areas identified above.

It is not intended to provide a definitive position, simply an introduction to the subject areas and some of the key questions that the review may wish to cover. The precise direction of work and activity will be determined by the oversight group. Output from the public engagement will also be made available to the oversight and working groups. Links to relevant resources and to some reference articles are provided.

We are not setting out official policy or position of NGICNS, NHS Scotland, Scottish Government or any organisation. Nothing here assures that any suggestion or idea will be explored further and shouldn't be read as a possible outcome or working area of the review.

If you have any questions or comments about this paper please contact NSS.grp@nhs.scot

1.8. Listening to people with lived experience

The review will be driven and informed by the voices and needs of people with lived experience. We intend this to be meaningful and effective collaboration. This process will develop as needed throughout the review. The ways we intend to collaborate include but are not limited to:

- Inviting people with lived experience to be involved in our oversight and working groups, and having a meaningful representation and influence on decision making
- Maintaining an online consultation for people to share their views about gender identity healthcare throughout the review
- Inviting people with lived experience to individual or small group focus sessions to discuss some of the key issues and to feed this back into the relevant working groups

In addition, we will ask group chairs to consider the involvement of people with lived experience with the group work:

- Results from the consultation will be provided at each of the group meetings
- At the first group and second meetings we will ask the group to consider at least three areas where feedback from people with lived experience can be used to further inform and guide the work of the group
- People with lived experience who have expressed an interest in the group will be invited to share detailed feedback, which may be via a proxy or in person; the questions will also be made available on the NGICNS website for others with lived experience to share feedback
- Should there be more people wishing to attend a meeting to share feedback than time permits, the group chair may ask support from the oversight group to apply a strategy that is as inclusive and representative as possible

An accompanying paper to the final protocol submission will provide a narrative of the actions undertaken with regard to listening to people with lived experience.

1.9. About our approach

We are acutely aware that this work is long anticipated and of the need to work efficiently to provide guidance and pathways that will support transformation of gender identity healthcare in Scotland.

Following the first meeting of the Oversight Group, we wanted to be very clear about some of our principles and approach.

- We recognise that some of the challenging messaging and debate about trans topics has an impact on those accessing gender identity healthcare
- As a result of this and TGD people's experience of factors such as societal stigma, discrimination and transphobia that there may be a greater vulnerability to mental health for some people. We recommend an approach that is holistic and that may include support from community-based, medical or psychological sources to the extent that this is desired by the person and relevant to their individual needs
- We recommend moving away from traditional binary categorisations of gender to appreciate the spectrum of gender diversity and identity and to help people to feel comfortable engaging as their authentic selves in all aspects of their gender identity healthcare
- We ask that pathways are fully inclusive and needs-led, regardless of gender identity, ethnicity, age, race, neurodiversity, ability, physical health status or other intersections

- Equitable care for all is a key foundation of NHS care in Scotland, and we wish for there to be support for TGD people across the pathways, no matter at what stage they enter or exit, and irrespective of their location within Scotland.

2. Initial Assessment - Adults

2.1. What is initial assessment?

WPATH Standards of Care v8 (SoC8) describe assessment as a process which identifies gender incongruence, any co-existing mental health concerns and capacity. The person is supported to consider the risks, effects and benefits of any proposed treatment. Collaborative decision making between the person and their clinician is encouraged.

Current practice in Scotland is a biopsychosocial assessment with a particular focus on gender identity development, experience and narrative.

In England a two-stage assessment is preferred with the first being an exploratory discussion, followed by diagnosis and care planning at the second.[1] Traditionally, GICs have been specially commissioned and linked to mental health Trusts. Newer pilots are up and running within primary care, sexual health and nurse-led services. It is an increasingly diverse landscape.

In Scotland three of the four clinics are established within sexual and reproductive health services, with the other sited within mental health.

Worldwide there are various models. Some are referred to as "informed consent" models[2] where the self determination of the person is prioritised with the clinician acting to identify significant contraindications or concerns; much of this activity is related to hormone prescribing. Settings vary with many services provided in community and primary care.

Above all, initial assessment should be a meaningful and supportive endeavour for the TGD person bringing together their personal expertise with an experienced clinician or team. We need to find ways to provide "just the right amount" of assessment in individual situations, and inevitably this will require some flexibility in service design and delivery.

2.2. Is a diagnosis required?

The current practice in NHS Scotland is that a formal diagnosis is required to access gender identity related treatments.

It is vitally important to recognise and respect the personal knowledge and lived experience of the person, however, access to specialised healthcare generally requires a degree of clinical collaboration. The current UK prescribing framework requires a diagnosis for

[1] NHS England. Gender Identity Services for Adults (Non-SurgicalInterventions). Published Online First: June 2019.https://www.england.nhs.uk/wp-content/uploads/2019/07/service-specification-gender-dysphoria-services-non-surgical-june-2019.pdf (accessed 10 Jan2022).
[2] Morenz AM, Goldhammer H, Lambert CA, et al. A blueprint for planning and implementing a transgender health program. Ann Fam Med 2020;18:73–9. doi:10.1370/afm.2473

medications used as part of hormone treatment. Gender affirming surgical specifications likewise require a diagnosis as part of the access route to surgery.

Access to interventions would be complicated without a formal diagnostic process, and for that reason alone should probably be retained, however, delivered in ways that avoid unnecessary pathologisation of the person.

There needs to be consideration as to how triage can work effectively, and direct meaningful support to those who are waiting. Could it be possible to start some treatments post triage but before initial assessment – for example speech therapy, access to peer or third sector support and fertility preservation?

2.3. Who can undertake assessments?

In the 2012 GRP it was recommended that this assessment was undertaken by a mental health professional, usually a psychiatrist or psychologist. Over the past few years in the UK there has been a broader range of specialisms and professionals involved in assessment including medical and nursing professionals from critical care, emergency care, general practice and sexual and reproductive health. Greater diversity is reflected worldwide.

Historically in the UK assessment has been the domain of psychiatry and psychology, and there are excellent professionals from these fields working within NHS Scotland. The key issue however is that the TGD person is able to meet with someone sufficiently experienced to offer appropriate support. It would seem essential to ensure that mental health expertise is available within teams to offer support in the right situations, however, it would be beneficial to must encourage greater diversity within our workforce, and encourage more staff to work in this field.

NGICNS has previously worked on developing competencies for gender identity healthcare clinicians and this may be able to be taken further forward to a framework that offers support to individuals as they gain experience in this field. It would seem reasonable that any clinician involved in assessment is a regulated and registered professional and part of an appropriate multidisciplinary team, and that otherwise their suitability is based upon experience with more junior staff being supervised as they gain proficiency in this field.

It would be helpful therefore for the review to consider the types of people who could work effectively in this field alongside the competence and training that would be required; with a focus to facilitating broader interest and involvement.

2.4. Some key considerations

We know from feedback that there can be a lot of anxiety surrounding initial appointment. This is further exacerbated by very long waiting times and the desire to progress once this becomes possible.

We hear repeated concerns about being believed and the impact of mental health concerns. Gender incongruence is not, and should not be considered a mental health condition. Nor is there any mental health condition that would automatically contraindicate receiving medical intervention for gender incongruence.

We want people to have an experience that is needs-led, clearly person centred and human rights' based. This Review is an opportunity to consider the context of assessment and promote an experience that reflects effective shared collaborative decision making between the person and their clinician.

In many cases assessment may result in a diagnosis then relevant treatment planning (personal plan). This is an individualised process and may involve referrals to other services or clinicians within the same service, or the clinician may be able to provide some of the treatment directly. We will ask the working group to consider an appropriate end point of initial assessment.

2.5. Crossover with other workstreams

We have separated initial assessment from that related to gender affirming surgery and children and young people workstreams and we will ask these groups to share some representation.

2.6. Proposed deliverables

These include, but are not limited to:

- Evaluation and recommended models of care regarding appropriate approaches for initial assessment.
- Content and structure of assessment, including number and type of appointments. Suggested outputs and distribution.
- Example pathways including options for modified pathways for people who have started transitioning, have more complex needs, or are re-transitioning.
- Criteria for assessing competence of staff undertaking assessments.
- Appropriate support and information for people whilst they are waiting to be seen.
- Recommendation on how people can be referred for gender identity healthcare and information that should be provided.
- Arrangements for supporting people in institutional settings.
- Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

3. The role of primary care in gender identity healthcare

3.1. Current situation

Most TGD people on hormone treatment receive excellent care from their GP including prescribing medication and arranging necessary tests. This situation has developed considerably in the past few years and is on a quasi-formal basis being supported by endocrine guidance published by NGICNS. There is no formal shared care agreement in Scotland although work has been undertaken at Lothian to bring proposed agreements to draft (these will be made available to the working group).

Information about screening for TGD people is provided by NHS Inform. Since 14 June 2015, CHI number changes have retained people in the relevant screening programme. Prior to this a manual intervention is required. Anecdotally there remains some confusion around screening and concerns regarding uptake.

3.2. Generalist v specialist care

There are many issues which can raise questions. GPs are experts in generalist care and many of the drugs used in gender identity healthcare are familiar albeit not necessarily with a TGD population. There are differing views as to the boundary between generalist and specialist care, and consequently variation in practice and TGD people's experience. This may arise when treatment is initiated, varied or when the person moves practice. It may relate to the prescribing of medication, the monitoring of efficacy, risk or side effects, or the competence of the specialist advice.

A formal agreement would be helpful as it could describe the boundaries in detail and the specialist and GP responsibilities. Any arrangements should include ready access to specialist advice as needed. A "Once for Scotland" approach would support consistency.

3.3. Prescriptions prior to GIC assessment

This refers to requests to GPs to prescribe for people who have not been assessed and do not have a diagnosis from a GIC. This includes people who may be considering self sourcing medication, accessing it via an alternative provider, or who have moved to Scotland already established on treatment.

We ask that pathways provide continuing endocrine care without disruption for people moving to Scotland already established on treatment.

In some other cases the GMC offers advice and describes a harm reduction approach for those who are, or are considering, self sourcing hormone treatment. It is intended to mitigate a risk of self harm or suicide. Some may consider that this is a high threshold that may not recognise cumulative distress experienced by someone who doesn't meet it.

The risks of self sourcing medication are well documented and in this instance are often exacerbated by it being unreported and therefore unmonitored. Supplying hormone treatment in this situation removes the benefit to the person accessing specialist advice to support their treatment decision.

There are a number of possible approaches that may facilitate safer and supportive hormone treatment. There are risks too, especially that some who might have waited for expert discussion will proceed without it, however this would be balanced against the additional distress that is otherwise experienced through long waiting times. In essence any pathway developed would become redundant once waiting times are at a reasonable level.

We will ask the primary care and endocrine and fertility preservation groups to consider options that may involve bringing forward elements of endocrine care for people in specific situations, and including suggestions as to how any proposal might be delivered.

3.4. Crossover with other workstreams

The outputs of the Endocrine working group will be made available to the Primary Care working group.

3.5. Proposed deliverables

- Recommendation and options for an improved formalised arrangement between gender identity healthcare and gender specialists, including resourcing.
- Recommendations for understanding the competence of gender specialists, including those not based in the NHS.
- Options for improved arrangements for TGD people who are or are considering self sourcing hormone treatment until waiting times are normalised (this is a shared deliverable with the Endocrine and Fertility Preservation group).
- Consideration of the effectiveness of current screening arrangements and information provided.
- Provision of a framework with examples for communication between the TGD person, their GP and their gender specialist.
- Consideration of arrangements and strategy for long term monitoring of hormone treatment.
- Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

4. Gender affirming non surgical care, (including hormone therapy, facial hair removal, sexual and reproductive health, speech therapy and fertility preservation)

This is a cohort of different interventions, many of which may be accessed by people at different times in their care. None are accessed solely by TGD people, however, all of these services requires to be sensitive to and meet the needs of TGD people.

4.1. Hormone Therapy (Adults)

SoC8 notes that TGD people may wish to access hormones to achieve changes consistent with their gender identity. They note that it is safe when provided under medical supervision, however, careful monitoring and screening is required, and a discussion about fertility preservation should take place prior to initiating hormones. Discussions about lifestyle choices to help manage risk should take place once a regime is in place.

Feminising interventions may involve oestrogen and an androgen lowering medication. Testosterone is used as a masculinising hormone.

SoC8 recommends a series of steps to health professionals, with the aim of ensuring adequate information is shared with TGD people about benefits of hormone treatments, the risks and interdependencies with other areas of healthcare. It notes that hormones should be provided to adults if they fulfil the criteria as set out in the assessment chapter.

NGICNS has developed and updated guidelines for hormone prescribing, and a further update of these will form part of the work of the endocrine subgroup. Of key importance will be the requirement for adequate monitoring of risk. It is envisaged that there will be primary care input to the endocrine subgroup.

The group will be asked to consider the types of clinician who can support people to access hormone treatment and appropriate competence. Further we will request a review of long term monitoring to include current evidence and the principles of Realistic Medicine.

There will be a crossover with the primary care group and we will arrange appropriate representation.

4.2. Hormone Therapy (Young People)

A large number of the recommendations in SoC8 chapter on hormone therapy relate to young people.

Services in the UK await the findings of the Cass review and it is not yet known whether an appeal to the Supreme Court will be made in the Bell v Tavistock case. There is currently no lead for the national C&YP gender service in Scotland. In light of these uncertainties, the GRP

Project Team appreciate that the C&YP workstream may not be completed after the Cass review reports. Some aspects of care are unlikely to be significantly affected.

NGICNS has supported the development of pathways for young people in collaboration with the C&YP gender service and the relevant paediatric endocrine teams.

This workstream will be subsumed into the Children & Young People's workstream.

4.3. Fertility Preservation

We will ask the endocrine subgroup to include fertility preservation within its work. There is an ongoing workstream with the Scottish Government Fertility Preservation Subgroup and a national Fertility network and we will ask the groups to liaise accordingly.

4.4. Proposed deliverables for the endocrine and fertility preservation group

- Updated clinical guidance for the initiation, titration and maintenance of hormone treatment including all trans, non binary and gender diverse people.
- Narrative for fertility preservation including pathways and advice for people already started hormone treatment.
- Clinical aspects suitable for a shared care agreement or similar application.
- Options for interim support for people who may be or may be considering self sourcing hormone treatment until waiting times are normalised (this is a shared deliverable with the Primary Care group).
- Specific consideration for hormone treatment and monitoring across the lifetime
- Recommendations for patient facing material that supports the exploration of hormone treatment, fertility preservation and appropriate consent.
- A patient facing document that clearly describes NHS practice and methodology that may be useful for people deciding to source their hormone treatment elsewhere.
- Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

4.5. Sexual and reproductive health

TGD people are less likely to access sexual health services than non TGD people however evidence suggests that TGD people may be at higher risk of HIV and the uptake of PrEP amongst TGD people has been low.

Recent work in Scotland by Scottish Trans and Waverley Care[3] identifies a number of steps that can be considered to improve access to sexual and reproductive healthcare for TGD people and their report, "There Needs to be Care Throughout" has been distributed to the

[3] Maund O, McKenna R, Wain O. "There needs to be care throughout" : Exploring the access of non-binary people, trans men and trans women to sexual health services in Scotland. 2020.https://www.waverleycare.org/application/files/2716/0992/0912/There_needs_to_be_care_throughout_DIGITAL_Dec20.pdf (accessed 17 Jan2022).

network alongside direct engagement with sexual health clinics. TGD in Scotland have also expressed uncertainty as to the services they should access.[4]

There have been pilots for trans sexual health services in Edinburgh and Glasgow, and there are established services in London.

4.6. Speech therapy

Speech and language therapy (SLT) in Scotland is typically a non-delegated activity and provided by local SLT teams. Currently most therapy is provided on an individual basis, although some services are interested in piloting group therapy. Individualised goals of therapy can vary considerably with access open to anyone attending a GIC who would like to make changes to their voice.

We will ask the group to consider the models elsewhere in the UK where SLT is provided as part of the GIC on both an individual and group basis, and to explore updates to the protocol in this area based upon engagement with people with lived experience and those providing services.

4.7. Facial hair removal

Facial hair removal is essential for many service users. Services remain the responsibility of the NHS Board in which the service user lives. NGICNS provided guidelines in 2020 to assist NHS Boards in this provision. We will ask the group to consider these guidelines, alongside other information available.

4.8. Mental Health & Psychological Support

As noted in earlier sections, gender incongruence is not, and should not be considered a mental health condition, nor is there any mental health condition that would automatically contraindicate receiving medical intervention for gender incongruence.

However, it is important to ensure that mental health expertise is available within teams to offer support to service users who may require this.

There needs to be consideration of adequate support for service users. This might be from others with lived experience, from the GIC, or via third sector organisations with specialist knowledge of gender issues. Signposting to and contracting with these external support networks could be developed.

[4] Leven T. Health needs assessmentof lesbian, gay, bisexual,transgender and nonbinary people. 2020.https://www.stor.scot.nhs.uk/bitstream/handle/11289/580258/Health%20Needs%20Assessment%20LGBTQ.pdf?sequence=1&isAllowed=y (accessed 17 Jan2022).

4.9. Proposed deliverables for the non surgical interventions group

- Narrative for speech therapy including access to pathway
- Narrative including consideration of NGICNS clinical guidance for hair removal
- Narrative regarding and recommendations to improve access to psychological and mental health support Recommendations to improve access to sexual and reproductive healthcare for TGD people
- A patient facing document that describes the above
- Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

5. Gender affirming surgery

Gender affirming surgery for TGD people falls into two categories dependent upon whether it is commissioned under specialist national arrangements (nationally commissioned procedures) or by the person's health board (locally commissioned procedures).

5.1. Nationally commissioned procedures

Nationally commissioned procedures include masculinising chest reconstruction, and masculinising and feminising genital reassignment surgeries. These are managed under a four nations' contract for whom NSD are the Scottish commissioners. A detailed specification describes the current arrangements.

5.2. Locally commissioned procedures

Locally commissioned procedures include standalone orchidectomy, hysterectomy and oophorectomy, breast augmentation and facial feminising procedures.

For breast augmentation and facial feminising procedures NGICNS service mapping suggests some uncertainty regarding provision and there have been recent calls for a 'Once for Scotland' approach. Removing these surgeries from the aesthetics protocol was intended to lead to greater consistency of access and we suggest the working group considers how well this may be working.

Standalone orchidectomy, hysterectomy and oophorectomy are provided by local board acute services.

5.3. Assessment

The assessment process for nationally commissioned surgeries is described in the service specification. The group will be asked to review recent evidence relating to these and standalone orchidectomy, hysterectomy and oophorectomy, including that from WPATH SoC8 to consider any recommendations relevant to Scotland. This should include the criteria for staff undertaking assessments as well as the support provided to people to explore and consider their options.

Furthermore, the group will require to consider the recommendation in WPATH SoC8 that one recommendation is required for surgery.

For other locally commissioned surgeries, the group will be asked to consider changes in evidence relating to these procedures as well as recommendations for assessment and referral. We suggest that commissioning arrangements for these procedures are out of scope for the Review.

5.4. Proposed deliverables

- Narrative for nationally commissioned surgeries based upon review of current evidence and WPATH SoC8 recommendations. This should include, but is not limited to, criteria for assessment, criteria for staff undertaking assessments, support for people to explore their options, review post-surgery and pathways for revision.

- Narrative for locally commissioned surgeries based upon review of current evidence and WPATH SoC8 recommendations. This should include, but is not limited to, criteria for assessment, criteria for staff undertaking assessments, support for people to explore their options, review post-surgery and pathways for revision.

- Narrative based upon review of current evidence and WPATH SoC8 recommendations relating to gender affirming surgeries not currently commissioned nationally or locally

- A patient facing document that describes the above
- Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

6. Pathways for children and young people

In Scotland the NHS gender service for Children and Young People is a multi-disciplinary team based at Sandyford in Glasgow who specialise in working with young people up to the age of 18, who are experiencing uncertainty or distress about their gender. The Service provides clinical input for young people and their families from across Scotland, as well as consultation and training to professionals and other agencies.

At the time of writing the 2012 protocol, specialist gender identity development services for children and young people under 16 were not available in Scotland. Since that time the Sandyford service has developed and there are now considerable waiting lists. Annual referral numbers have increased year on year.[5]

GIC staff and endocrinologists across Scotland have been working on a national endocrinology pathway for young people, which is nearing completion, and which will also be considered by the endocrinology and fertility working group. This pathway development is part of an ongoing process to formally establish a national service for young people. This work is being led by NHS staff in Glasgow, and funding is available from Scottish Government.

It is anticipated that this workstream may be further informed by the Cass Review.

We intend to include pathways for children and young people within the GRP Review. As noted above some recent work has been or is near to completion. The GRP Review will be informed by developments including the evidence considered as part of the revision of the WPATH Standards of Care.

We will ask the working group to identify the work that can reasonably be achieved during the GRP Review and to consider how it will continue its work as the national process progresses and evidence becomes available.

6.1. Proposed deliverables

- Narrative considering the recommendations from the relevant WPATH chapters for children and young people, as appropriate to the context within Scotland. This should include ensuring an appropriately skilled and supervised workforce, the provision of a suitable assessment, processes supporting consent, support and information and be fully inclusive of all trans, non-binary and gender diverse children and young people.
- Recommendations for updates to pathways including the cooperation between the Young People's Service and the endocrine service.
- Recommendations for pathways relating to the transition of young people from the Young People's Service to adult services
- Investigate ways of providing support to children and YP on the waiting list for services– this should include identifying formal (e.g. mental health support/counselling) and informal (e.g. 121 and group work/befriending/peer support) methods
- Identify mechanisms for providing community based support to YP under 12 and their families

[5] Scottish Public Health Network (ScotPHN) Health Care Needs Assessment of Gender Identity Services, May 2018, Thomson R, Baker J, Arnot J, pp 44 [last accessed 12/08/2021 - (scotphn.net)]

- Plan identifying those parts of the Review that may be further informed by the Cass Review and progression towards a national service. Proposals for an iterative update of the Review.
- A patient facing document that describes the above.
- Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.