NHS National Services Scotland

Scottish Pathway for Trans Healthcare

Sub-group considerations and recommendations

Contents Page

1. Introduction

1.1 Purpose of the Document

This document is intended to provide an overview to the Oversight Group of the key recommendations and decisions made by each working sub-group.

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

1.2 What informed the review

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

It took 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 was 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

The review documented the clinical needs of TGD people accessing pathways for gender identity healthcare, and did not consider service provision or funding. Other activity may take place regarding this after this process is completed, but it is independent of the review. Discussion of gender recognition was out with the scope of the review.

1.4 Key areas of the review

The review split into six major sections, and more details on each sub-groups work 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 was at the heart of this work. We engaged widely with people using or interested in accessing services and also professional organisations.

1.5 Rationale

Each Sub-group contained a group of experts with extensive knowledge of trans healthcare. This included service user and third sector input alongside NHS staff. In the case of the children and young people's group, there was parent support group representation. There were non-binary, trans feminine and trans masculine people represented across the other groups. Each group considered and assessed all the information to produce evidence based recommendations for Scotland. The summarised evidence and rationale for each sub-group is set out within each sub section.

2. Initial Assessment - Adults

2.1 Deliverables

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

Red	**R**	Deliverable not met
Amber	**A**	In progress
Green	**G**	Complete

2.2 Key recommendations

Deliverables

1. Evaluation and recommended models of care regarding appropriate approaches for initial assessment.

5. Appropriate support and information for people whilst they are waiting to be seen.

6. Recommendation on how people can be referred for gender identity healthcare and information that should be provided.

The Adult Assessment Sub-group produced a proposal based on the following:

Key principles of gender affirming healthcare:

- Holistic, person-centred and needs-led
- Works with the spectrum of gender diversity and identity
- Allows people to present authentically
- Access regardless of location, moves away from a postcode lottery of provision
- Access provided regardless of ethnicity, age, race, neurodiversity, ability, physical health status or other intersection

Gender affirming healthcare includes:

Medical interventions (provided within NHS or via private sector providers with NHS funding):

- Hormone therapy
- Surgeries
- SALT/voice therapy
- Facial hair reduction laser and electrolysis
- Wig Prescriptions

Psychosocial support (may be provided within NHS or via third-sector orgs with NHS funding):

- Group info sessions
- Short-term family/couple counselling
- Occupational therapy
- Individual counselling or psychological therapies
- Help to explore gender expression options and ‘coming out’
- Help to access identity document changes
- Help to understanding legal rights & equality
- Help to develop social connections & peer support

General information about Assessment approach:

Developing best practice, together with the changes within WPATH’s Standards of Care Version 8 draft and the change to Gender Incongruence in ICD-11, has moved away from psychiatric assessments that focus on evaluating how ‘gender dysphoric’ a person is, to person-centred assessments that focus on the person’s understanding and readiness for initiating particular aspects of gender affirming healthcare. Therefore, the generic terminology of ‘initial assessment’ is no longer most appropriate. Instead an assessment should be described in relation to the aspect of gender affirming healthcare it is considering initiating, for example, hormone readiness assessment, chest masculinisation surgery readiness assessment, genital surgery readiness assessment.

There is not a single linear route through the various possible aspects of gender affirming healthcare. Access should be person-centred and take account of the individual's goals and priorities. Some trans people may be assessed as ready for particular gender affirming surgeries without undergoing gender affirming hormone therapy.

People must not be expected to describe their childhood, sexuality, or current gender identity and gender expression in stereotypical ways in order to access gender affirming healthcare. Non-binary gender identities must not be discriminated against during assessments.

Some trans people may not know what gender affirming healthcare is available via the NHS or may be unsure which aspects they might want to undergo, so accessible information and psychosocial support to help them consider their options should be offered throughout their engagement with NHS gender identity services and via third sector community organisations.

Counselling or psychotherapy can be helpful when requested by a trans person, however counselling or psychotherapy for trans people specifically focused on their gender identity is not a prerequisite for any gender affirming healthcare.

The assessment approach recognises the lived experience and self-knowledge of the trans person and the clinical knowledge of the health professional. The decision to initiate an aspect of gender affirming healthcare is shared between the trans person and the assessing clinician, with both playing a key part in collaborative decision making.

It is not necessary for trans people to experience severe levels of distress regarding their gender incongruence to access gender affirming healthcare. In fact, access to hormones and surgeries can act as a prophylactic measure against distress. A trans person can have persistent gender incongruence without distress and can still benefit from gender affirming hormones or surgeries.

Access to gender affirming SALT/voice therapy, facial hair reduction laser and electrolysis, wig prescriptions and/or psychosocial support is extremely low risk. Therefore, all that is necessary in order to refer for provision of these is to:

- Briefly document that the person has ICD-11 Gender Incongruence of Adolescence or Adulthood (HA60) (if not already documented in their medical record);
- Collaboratively agree between the person and the health professional that the particular aspect of gender affirming healthcare is of potential benefit to the person.
- Record sufficient details of the referral to support later follow up.

Following referral, the actual providers of gender affirming SALT/voice therapy, facial hair reduction laser and electrolysis, wig prescriptions and/or psychosocial support should:

- Support the person to understand and have realistic expectations of possible positive and negative effects of the particular aspect of gender affirming healthcare;
- Seek guidance from a health professional with greater expertise if there are any concerns about the potential benefit to the person or the person's ability to give informed consent.

The group were in agreement that assessments of readiness for gender affirming

Deliverable
2. Content and structure of assessment, including number and type of appointments. Suggested outputs and distribution.

hormones or surgeries should:

- Collaboratively agree between the person and the health professional, the aspect of gender affirming healthcare for which readiness is being assessed;
- Determine and document that the person has persistent ICD-11 Gender Incongruence of Adolescence or Adulthood (HA60) (if not already well-documented);
- Identify any co-existing mental health or other psychosocial concerns and exclude other possible causes of apparent gender incongruence;
- Collaboratively discuss how the particular aspect of gender affirming healthcare fits within the person's goals for expression of their gender identity and their hopes or concerns;
- Support the person to understand and have realistic expectations of possible positive and negative effects of the particular aspect of gender affirming healthcare, including possible impact on reproductive and sexual function;
- Collaboratively explore fertility preservation options and agree referral, if appropriate, where the aspect of gender affirming healthcare has potential to reduce reproductive function;
- Identify any significant mental or physical health conditions which could negatively impact the outcome of gender affirming healthcare, discuss risks and benefits, and identify sources of additional support and assistance if relevant;
- Seek guidance from, or further assessment by, a health professional with greater expertise if the severity of mental or physical health conditions places the assessment beyond the current health professional's competency;
- Assess the person's ability to give informed consent for the particular aspect of gender affirming healthcare;

- Ensure the reasoning is clearly explained for any clinical opinion of unreadiness or inability to give informed consent at the time of assessment, identify additional psychosocial support or other interventions that could facilitate the person's readiness or ability to give informed consent, provide a mechanism for a second opinion if the person wishes, and provide a mechanism for reassessment at a later date;
- Record sufficient details of the assessment and resulting decisions and referrals to support later clinical review.

Deliverable

3. Example pathways including options for modified pathways for people who have started transitioning, have more complex needs, or are re-transitioning.

The group produced a series of example pathways including options for modified pathways for people who have started transitioning, have more complex needs, or are re-transitioning. Final edits of this document are being worked on, however a draft has been added to the meeting papers.

Assessment example journeys 19 May 202

Deliverable

4. Criteria for assessing competence of staff undertaking assessments.

The Sub-group were in agreement that the following competencies would be considered appropriate to carry out assessments:

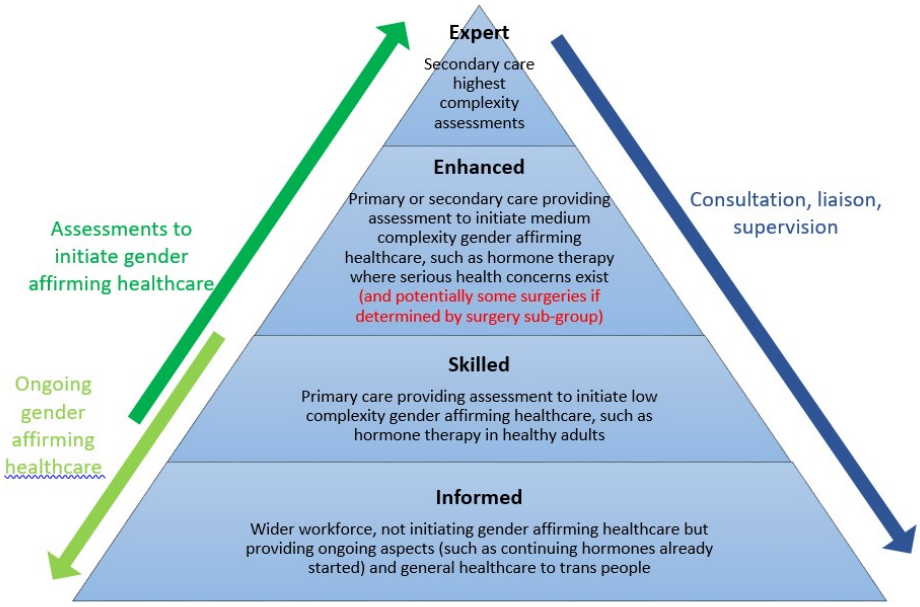
A wide variety of health professionals can develop competencies to carry out assessments of readiness for gender affirming healthcare, including doctors working in primary or secondary care (such as GPs with special interest, psychiatrists, sexual health specialists, and endocrinologists), nurse practitioners, psychologists, and allied health professionals (such as occupational therapists).

Assessments vary in complexity depending on the irreversibility and risks of an aspect of gender affirming healthcare and the trans person's health circumstances. Where possible, information about anticipated complexity should be used to allocate

the assessment appointment to an appropriately competent health professional. In situations where an assessment proves more complex than anticipated, a multidisciplinary team approach could enable additional expert guidance to be sought and a complex decision reached safely without necessarily requiring the trans person to have additional assessment appointments about the same aspect of gender affirming healthcare.

Health professionals carrying out assessments of readiness to initiate NHS gender affirming healthcare should engage in relevant continuing professional development and have clear supervision, MDT consultation and referral arrangements in place to ensure the complexity of their case load appropriately reflects their developing competencies.

The Assessment Sub-Group welcomes that NHS Education for Scotland will be developing a competency framework for gender affirming healthcare readiness assessments and routes of progression for different health professional backgrounds (doctors, nurse practitioners, psychologists, allied health professionals). We recommend a tiered approach:



Informed Practice Level

- Not expected to initiate hormones or surgeries but should provide ongoing related care;
- Informed about ongoing needs relating to gender affirming healthcare appropriate to their NHS role, e.g. GP prescribing long-term hormones and annual health check, practice nurse providing routine wound-care after gender affirming surgery, mental health services providing general mental healthcare to trans people;
- Informed about how to refer trans people for gender affirming healthcare such as hormone initiation, SALT, hairpieces/wigs, hair removal, and psychosocial support;
- Informed about how to uphold trans people's equality and human rights;
- Informed about how to update name, title and sex markers on NHS records;
- Informed about third-sector LGBT community support services;
- Seek guidance from Skilled/Enhanced practitioners where appropriate;
- Refer to Skilled/Enhanced practitioners where appropriate, e.g. initiating hormones or surgeries.

Skilled Practice Level (Likely to be primary care based):

- Determine and document that the person has persistent ICD-11 Gender Incongruence of Adolescence or Adulthood (HA60);
- Appropriately gather personal history and identify any additional health concerns;
- Ascertain presenting issues, hopes, expectations and support needs;
- Assess readiness for initiating gender affirming hormones for adults with realistic expectations who are able to provide informed consent and do not have additional health concerns or complex additional support needs (the actual prescription may be issued by another practitioner);
- Provide, or refer for, other gender affirming healthcare such as SALT, hairpieces/wigs, hair removal, and psychosocial support;
- Seek guidance from Enhanced/Expert practitioners where appropriate;
- Refer to Enhanced/Expert practitioners where appropriate, e.g. initiating surgeries or where high risk health concerns or complex additional support needs require more senior level initiation of hormones;

Examples of potential health professionals: GPs with Special Interest; Sexual health doctors; Psychiatry registrars; Specialist nurse practitioners; Assistant, trainee or qualified psychologists; Occupational therapists.

Must have supervision/consultation in place with Enhanced/Expert level practitioner.

Enhanced Practice Level (May be primary or secondary care based)

In addition to the tasks listed for Skilled Practice Level:

- Assess readiness for initiating gender affirming hormones for adults with realistic expectations who are able to provide informed consent and have additional health concerns or complex additional support needs (the actual prescription may be issued by another practitioner);
- Assess readiness for initiating referral for gender affirming surgeries

Examples of potential health professionals: GPs in primary care hubs; Sexual health doctors; Endocrinologists; Gynaecologists; Psychiatry registrars; Advanced nurse practitioners; Trainee or qualified psychologists.

May focus case load on a particular type of complexity or health concern.

Must have supervision/consultation in place with Expert level practitioner.

Expert Practice Level (Secondary care based)

In addition to the tasks listed for Skilled and Enhanced Practice Levels:

- Assessment of readiness for complex gender affirming surgical treatments
- Significant role in supervision, liaison, service design
- Significant role in consultation and MDT case reviews where additional health concerns or complex additional support needs require more senior level initiation of referral for surgeries (or occasionally hormones in exceptional cases)

Examples of potential health professionals: Endocrinologists; Gynaecologists; Consultant Sexual Health Doctors; Psychiatrists; Consultant Nurses; Consultant Clinical Psychologists and Clinical Psychologists under Consultant supervision.

May focus case load on a particular type of complexity or health concern.

Must have sufficient prior experience at Enhanced Practice Level in gender affirming healthcare assessments. Some health professional backgrounds may require additional evidence of further training to develop sufficient competencies.

Must have peer supervision/consultation in place with Expert level practitioner.

Deliverable

7. Arrangements for supporting people in institutional settings

The Sub-group endorsed the prison pathway model which had been produced with consultation from NHS GG&C Lead for Prison Healthcare in addition to Consultant Clinical Psychologists working within the Scottish Prison Service in order to ensure the proposal meets the needs of service users. Further details of this model is available below:


GS Prison Model Appendix 1 May 2022


GS Prison Model May 2022.doc

Deliverable

8. Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

The Adult Assessment Sub-group had service user and third sector input alongside NHS staff. Each member was invited to participate in an initial evidence gathering exercise to assist in progression of the Sub-groups project deliverables. Actions were agreed in an open forum and assigned to smaller groups of volunteers to progress offline ahead of the next scheduled meeting. Key actions were then tabled at subsequent meetings with individuals, or their representative presenting associated papers to the wider group to stimulate discussion and further action.

All members were provided ongoing opportunities to track any suggestions for change on working draft documents for their Sub-group via their teams channel stream, GRP mailbox or online at meetings. Any changes were then reviewed in a wider group format for agreement. Individuals were regularly invited to suggest any ideas for group recommendations. These were discussed and agreed at Sub-group final meetings by all members.

Multiple public consultations took place throughout the project wider in order for each group to gain the views of a larger cohort. The initial feedback survey had 76 responses which were collated and key themes were reviewed at each groups first meeting. A further consultation followed once the group agreed their deliverables. There were 12 responses submitted during this period. Responses were then circulated to the group for consideration during group discussions at meetings.

3. Endocrine and Fertility Preservation Sub-Group

3.1 Deliverables

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

Red	**R**	Deliverable not met
Amber	**A**	In progress
Green	**G**	Complete

3.2 Key recommendations

Deliverables

1. Updated clinical guidance for the initiation, titration and maintenance of hormone treatment that is inclusive of the needs of all trans, non-binary and gender diverse people.

2. Narrative for fertility preservation including pathways and advice for people already started hormone treatment.

5. Specific consideration for hormone treatment and monitoring across the lifetime (noting that this will be adjacent to work carried out by the CYP group)

This Sub-group have created the following clinical guidance. It updates and replaces the previous NGICNS guidance on 'Endocrine Management of Adult Transgender Patients', first published 11 August 2015 and revised 7 July 2016. The group have aimed to outline what is currently considered best practice for safe and effective care as applicable within NHS Scotland for endocrine management and fertility preservation in the provision of masculinising and feminising gender affirming hormone treatment for transgender, non binary and gender diverse (TGD) people. While previous versions of this and other guidelines as well as primary research were used in developing this document, it is recognised that the evidence base remains incomplete and that there is variation in acceptable practice, which will therefore evolve over time.

Endocrine and fertility preservation g

Deliverable

3. Clinical aspects suitable for a shared care agreement or similar application.

The group welcomed a shared care agreement recommendation between Primary and Secondary Care settings in relation to the ongoing monitoring of TGD people. Members of this sub-group were also present on the Primary Care Sub-group. Further details of this deliverable can be found within the Primary Care sub-section.

Deliverable

4. Options for interim support for people who may be self-sourcing hormone treatment until waiting times are normalised (this is a shared deliverable with the Primary Care group).

This deliverable was shared across multiple sub-groups. Each group explored options of interim support for people who may be self-sourcing hormone treatment until waiting times are normalised. Further details of this proposal is available within the meeting papers.

Deliverable

6. Recommendations for patient facing material that supports the exploration of hormone treatment, fertility preservation and appropriate consent.

7. A patient facing document that clearly describes NHS practice and methodology that may be useful for people deciding to source their hormone treatment elsewhere.

The sub-group created a patient information leaflet based on the updated guidance published. A final version of the leaflet will be circulated in due course.

The GRP project team have aimed to create a patient facing SPATH document, in line with other National initiatives. The formalised document will be circulated to the Oversight Group shortly.

Deliverable

8. Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

All six of the sub-groups have service user and third sector input alongside NHS staff. In the case of the children and young people's group, there is parent support group input. There are non-binary, trans feminine and trans masculine people represented across groups.

This sub-group utilised lived experience representation to not only shape the updated clinical guidelines, but also to develop a patient information leaflet. After an initial consultation that received 76 responses, the sub-group then received an additional 5 responses on their proposed deliverables. These responses were collated and themed for consideration at each meeting. Further responses were then circulated during the patient information leaflet drafting phase for consideration and update to the draft.

4. Gender Affirming Surgery Group

4.1 Deliverables

Project Deliverables		RAG status		
		R	A	G
1	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.			
2	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.			
3	Narrative based upon review of current evidence and WPATH SoC8 recommendations relating to gender affirming surgeries not currently commissioned nationally or locally			
4	A patient facing document that describes the above			
5	Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.			
6	Recommendations to improve access to locally commissioned surgeries for TGD people			

Red	**R**	Deliverable not met
Amber	**A**	In progress
Green	**G**	Complete

4.2 Key recommendations

Deliverable
1. 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.

The Surgical Sub-group examined all currently available evidence and best practice to inform their deliverables. Narrative for deliverable 1 was written in line with current arrangements in place that are managed by National Services Division (NSD) on behalf of all Scottish NHS Boards. These surgeries include surgeries include feminising and masculinising genital reassignment, and masculinising chest reconstruction.

The group supported the creation of a formal competency framework that was proposed by the Adult Assessment Sub-Group. This outlines that clinical staff supporting surgical decisions are placed at the Enhanced Level, and Specialist where there is uncertainty or complexity. In the absence of formal qualification in this field, the group recommends that referring health boards provide NSD with a list of clinicians approved to support surgical referral and that a process supported by NGICNS and NSD is established for maintenance of this list.

The Sub-group were in agreement that a **single opinion** is sufficient for referral for surgery where there is certainty and the circumstances relating to the decision are not complex. Where a further opinion is sought, providers are encouraged to facilitate this with minimal delay unless otherwise desired by the person seeking surgery. This decision is based on WPATH SOC8 consultation guidance.

In addition, the Sub-group encouraged the development of specialist surgical and nursing expertise within Scotland to deal with post-surgical issues, acknowledging the considerable potential distance between patients and providers in many situations.

Deliverable
2. 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.

The group outlined narrative on locally commissioned surgeries. There was concern raised across the group that there is variability in accessibility and assessment for other locally provided surgeries. The group endorsed the current NGICNS

recommendation that referral is made following discussion between the gender specialist and relevant surgical team, and the current position of being decoupled from the Adult Exceptional Aesthetic Referral Protocol (AEARP). Given the comparatively small number of procedures the group recommends a national MDT is established by NGICNS to support NHS Boards achieve fair and consistent assessment. This MDT should be comprised of a relevant surgeon and gender specialist, including the one (or their representative) who representing the patient.

In addition, the Sub-group recommends a Regional contact to be identified to assist fellow colleagues with patient enquiries, and appropriate support to their trans patients. Further details on the Sub-groups recommendations to improve access to locally commissioned surgeries can be found within deliverable 6 of this section.

Deliverable

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

The group recognised that there are a wide range of surgeries that may help align an individual's body with their gender identity, not all of which are included in this protocol. Though the evidence base doesn't support inclusion in this version of the protocol, some of these procedures may be carried out elsewhere in the world and we recognise that the evidence base is evolving. It is therefore recommended that the evidence is monitored for these surgeries on an ongoing basis to assess whether these surgeries should be included in future iterations and which individuals would benefit. This includes for a literature review to be conducted following publication of the SPATH to review relevant evidence of procedures suggested by WPATH that are not currently carried out in Scotland.

Deliverable

4. A patient facing document that describes above.

The GRP project team have aimed to create a patient facing SPATH document, in line with other National initiatives. Further details of this document will be available shortly.

Deliverable

5. Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

All members were provided ongoing opportunities to track any suggestions for change on working draft documents for their Sub-group via their teams channel stream, GRP mailbox or online at meetings. Any changes were then reviewed in a wider group format for agreement. Individuals were regularly invited to suggest any ideas for group recommendations. These were discussed and agreed at Sub-group final meetings by all members.

In addition, wider consultation took place for each group to gain the views of a larger cohort. The initial feedback survey had 76 responses which were collated and key themes were reviewed at each groups first meeting. Once the sub-group agreed their proposed project deliverables, the project team went back out for consultation to gain views from the wider community on each specific deliverable. There were 10 responses submitted during this period of consultation. Feedback was then circulated to the group for consideration in their discussion and agreements.

Deliverable
6. Recommendations to improve access to locally commissioned surgeries for TGD people

The Sub-group found that NGICNS service mapping from December 2019 showed a highly variable picture of availability for locally commissioned surgery in Scotland. It is the intention of the group that the additional support outlined in this pathway may support the removal of some of the barriers preventing people accessing these procedures.

The group recommended that further analysis is commissioned six months post publication of SPATH to understand the impact in relation to accessing locally commissioned surgeries and what, if any, further support would be required.

The review discussed the use of BMI as a criteria for eligibility for surgery, and had anecdotal evidence that this could be affecting some patients in Scotland negatively. The review recommends that this situation is discussed with commissioners to better understand the situation and take any appropriate action. Therefore, the group has asked the NSD commissioners to forward these considerations to specialised commissioning at NHS England, who manage the UK wide contracts for gender surgery for consideration and response.

5. Primary Care Sub-group

5.1 Project deliverables

Project Deliverables		RAG status		
		R	A	G
1	Recommendation and options for an improved formalised arrangement between local gender identity healthcare and gender specialists, including resourcing.			
2	Recommendations for understanding the competence of gender specialists, including those not based in the NHS.			
3	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).			
4	Consideration of the effectiveness of current screening arrangements and information provided.			
5	Provision of a framework with examples for communication between the TGD person, their GP and their gender specialist.			
6	Consideration of arrangements and strategy for long term monitoring of hormone treatment.			
7	Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.			
8	A patient facing document on all of above			

Red	**R**	Deliverable not met
Amber	**A**	In progress
Green	**G**	Complete

5.2 Key recommendations

Deliverable
1. Recommendation and options for an improved formalised arrangement between local gender identity healthcare and gender specialists, including resourcing.

The Primary Care sub-group were asked to consider a range of deliverables as part of the review. Group membership included representatives from the British Medical Association (BMA), Royal College of General Practitioners (RCGP), Primary care and pharmacy staff, GIC colleagues and people with lived experience, and/or their representatives.

The group considered the current interface between Primary Care and Gender Identity Clinics (GIC). It was noted that for many TGD people, all care relating to gender

transition is delivered by the Gender Identity Clinic (GIC), including monitoring and ongoing management of gender affirming hormonal therapies (GAHT). As the number of referrals to GIC services have increased, so too have the number of return appointments; this has resulted in significant service pressures. Consequently, individuals now experience long waiting times when accessing specialist GIC services.

In line with the National Clinical Strategy for Scotland that emphasises the importance of person centred care, it was recognised that some individuals wish to receive care closer to their home; this may facilitate access by reducing associated travel, time and financial costs. Additionally, following transition, some trans individuals no longer wish to attend the GIC for ongoing care due to this being perceived as stigmatising. The group were in agreement that this needs to be balanced against the need for specialist oversight or care, as not all this work can appropriately sit in general practice. However, the group recognised that the experience of care for people who are trans is highly variable. Differences exist throughout Scotland, particularly regarding the role and responsibilities of Primary Care and GIC services. Consequently, optimising the model of care between Primary Care and GIC services was noted to be a priority for the Primary Care subgroup.

The Sub-group were there in agreement with the following recommendations:

1. People who are trans that present to medical services with general health concerns and medical conditions should be reviewed and managed as per standard pathways in line with recommendations from the Royal College of General Practitioners (RCGP) and the General Medical Council (GMC).

2. There should be equitable access to GICs from Primary care across Scotland. Primary Care should refer individuals to local GICs. If the individual prefers, Primary Care will signpost to any available self-referral pathway(s) into GIC services. Each NHS board should work with their local GP subcommittee to ensure:
    i. there is clear guidance on referral pathways to local GICs
    ii. There is clear information for both professionals and service users regarding the assessment process and expectations from the GIC service (see additional documents for an example from NHS Greater Glasgow and Clyde GIC; although this is now out of date, the areas covered represent an appropriate level of information).

3. Information for individuals considering gender affirming hormone treatment (GAHT) and surgical interventions should be made available early in the referral process, prior to assessment. Any materials should include the risks and benefits of hormonal therapy. This should inform health improvement conversations around smoking, healthy weight and other health behaviours and modifiable factors early in the individual's journey, to optimise safety and outcomes of any later surgical or hormonal interventions.

4. The Primary Care subgroup endorse the Endocrine hormone monitoring protocol. This provides clear advice on the necessary monitoring and should be clearly signposted and easily available for those who need to access it.

5. Clear systems are required for the long term follow up of people who have accessed gender affirming treatments via GIC services. For most people, this is long term monitoring and management of GAHT. All NHS Boards should work with Primary Care, including GP subcommittees, and Endocrinology to agree clear processes for long term follow up; these may vary between NHS Board areas but should be based on the following principles:
    i. Equal access to long term follow up across Scotland
    ii. Care delivered close to home whenever possible
    iii. Recognition that some individuals do not wish to attend the GIC for long term follow up; consideration of this should inform service models where possible.
    iv. Processes should be equitable to other groups of patients who receive similar treatments for different indications, for example other groups prescribed testosterone and oestrogen.
    v. Clear governance structures with pathways to access specialist advice when required
    vi. Service models which reflect the Triple Aim, namely improving population health, providing high quality care and ensuring cost-effectiveness. Staff wellbeing in work should also be a key consideration to ensure sustainable services.

6. A range of specific options for delivering long term monitoring and management of GAHT were explored within the Primary Care subgroup. Whilst these are not exhaustive, the following options were recognised as possible service models and should be considered by all NHS Boards:

    i. **All phlebotomy and blood pressure measurements should be undertaken in the Community Treatment and Care Service (CTACS).** This should be resourced by the Gender Identity Service and will require new investment. This will provide care close to home in a standardised setting alongside other routine care. This should be facilitated through the HSCPs who both commission GICs and develop CTACS.

    Options for the recall and review of results and individuals are either:

    ii. **In GP practices with an enhanced service**. This model would be beneficial in providing ongoing care, particularly in more remote areas. In order to be delivered, this will require funding for initial and ongoing training. Notably, some GP practices will have very few eligible patients and therefore there will be a requirement to maintain knowledge and skills for small numbers. Whilst this option has not undergone formal economic appraisal, it is anticipated to be costly overall. Furthermore, GPs can opt out of an enhanced service and therefore the NHS Board

and GIC will require a mechanism to identify and provide a service for individuals affected by this. Opting out of this enhanced service may also worsen coverage and therefore exacerbate inequality of access.

iii. **In a Gender Identity Service**. Provision of ongoing monitoring and management of GAHT is a service which the GIC is not currently resourced to provide. If resourced, this function could be integrated into the current GIC model or be provided through a wider Gender Identity Service or network. Within either model, reviews of individuals and results could be performed virtually; individuals with abnormal results or who are at high risk of complications would be proactively reviewed, virtually in the first instance. Individuals with results within agreed parameters would be eligible for Patient-Initiated Review; they would be advised to continue current medications and to contact the clinic if they have anything they wish to discuss.

This system is anticipated to be cheaper that an enhanced service; we estimate that one clinician would manage larger numbers of patients. Clinicians may be from medical, nursing, pharmacy or other professional disciplines. This would standardise follow up, with patients having access to an equitable level of expertise. Furthermore, many patients would not need to attend a GIC in person, which some find stigmatising or traumatic.

iv. **The ongoing management of all complex and high risk patients** should be led by the Gender Identity Service, following discussion and agreement with primary care. CTACS should be used to obtain convenient monitoring close to an individual's home. The number of these patients is expected to increase over time (see section 11).

Prescribing

v. The GP/Primary Care team should prescribe as part of an enhanced service. Where a Gender Identity Service provides ongoing monitoring and management, the GP/Primary Care team should prescribe under a shared care agreement (SCA), with a letter being sent annually from the clinic to the patient, copied to the GP, following review. A draft SCA from NHS Lothian is available in Appendix 1a and b.


Masculinising Treatment FINAL ADD


Feminising Treatment FINAL ADD

The exception to this is where individuals are deemed complex or high risk and are managed by the Gender Identity Service. In this circumstance, the Gender Identity Service should prescribe as it needs to carry the risk and not transfer this to the GP/Primary Care.

7. Where individuals are identified as having complex medical or psychiatric needs, partnership working between the GICs, Primary Care and other specialists is expected to ensure appropriate support is available.

8. Determining appropriate service models will require contractual agreement. Negotiations should be overseen by the Scottish Government to deliver a solution that addresses all stakeholder needs and can be agreed at local NHS Board level. Any service model should undergo economic and service user appraisal as part of service design.

9. GPs with Extended Roles, who work within GICs, may help to improve capacity, bridge between primary and secondary care and educate within General Practice. In a very small number of instances, these practitioners could be practice based. This would be guided by local population need but would risk a ‘postcode lottery’ effect. The development of GPs with Extended Roles may build capacity within the GIC service to support the development of future service models, including specialist locality clinics as part of a hub-and-spoke model of care.

10. A robust educational offering should be available to Primary Care to ensure adequate knowledge and skills within the team. NES should be commissioned to develop a transgender problem based small group learning (PBSGL) module specifically on shared care agreements, CHI change counselling, screening, hormone monitoring and ongoing care. In addition to producing educational materials, resourcing should be made available to facilitate time for CPD across the primary care team.

11. As the population of older TGD people increases, it is anticipated that the burden of comorbidities in this population will also increase. Future service planning should consider this and include training for professionals across the health service, specifically those within Primary Care, GICs, Endocrinology and Elderly Medicine. Clear referral routes for re-engagement with specialist care as an individual ages should be determined based on the risk of therapies. Services should be adequately resourced to meet any projected increase in demand.

12. All endocrine and shared care protocols should be reviewed regularly and in line with national guidance as the evidence base evolves to ensure optimal care for individuals. Scotland should contribute to this longitudinal evidence base by developing data systems co-designed with service users.

Deliverable

3. 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).

The group had extensive discussions in relation to NHS management of private healthcare referrals. It was noted that a significant number of individuals have sought private trans and gender affirming healthcare in response to long NHS GIC waiting times. Following assessment, private healthcare providers may directly prescribe GAHT. Alternatively they may direct recommendations for commencing GAHT to the individual's GP. The impact of this is that GPs may have to make decisions about prescribing and/or the ongoing monitoring of therapies, whilst remaining within the limits of their clinical expertise. The group acknowledge that whilst waiting lists for NHS services remain lengthy, this issue may increase over time. The associated patient safety concerns mean that this was identified as a priority area of the Primary Care subgroup. Consequently, the Primary Care subgroup recommended:

1. Individuals commenced on GAHT by an NHS GIC should continue to receive therapy and monitoring in line with local monitoring protocols if they move NHS area. They should be referred to the local GIC if there are any concerns.

2. Where individuals have sought private healthcare assessment and GAHT is recommended, the GP should refer the individual to the local GIC, including relevant correspondence from the private provider. The GIC should have a timely process to quality assure private assessments and provide any treatment recommendations based on this. Medications prescribed should align with standard NHS practice and utilise existing agreed NHS Board mechanisms for ongoing prescribing and monitoring. GICs should be adequately resourced to undertake this assurance role, as should CTACS, Primary care and GICs for the ongoing prescribing and monitoring.

3. Healthcare Improvement Scotland (HIS) should support this by quality assuring private providers of gender identity assessments and prescribing through regulation and accreditation. This should be done at the level of the clinician and organisation. As part of this assurance, providers should have appropriate resilience and business continuity plans in place to ensure services are sustainable. HIS should liaise with the Care Commission to provide similar assurance for providers of these services within England and Wales. This will support GPs and GICs engagement with the private sector.

The group considered instances of self-sourcing of hormonal therapies that are prevalent in Scotland currently due to lengthy NHS GIC wait times. Self-sourcing of hormonal therapies is where hormonal therapies are purchased and used directly by an individual without any oversight from a health professional. It was recognised by the group that individuals often self-source hormonal therapies as an option of last resort. The literature estimates that between 0.5-25% of individuals on GIC waiting lists self-source. Self-sourcing is associated with a range of potential harms: the quality of the pharmaceutical product being sourced is often unknown and may come with risks, individuals may not have access to monitoring and administration of supratherapeutic doses may occur. Therefore, the Primary Care subgroup recommends:

1. For individuals who are self-sourcing, a harm reduction approach should be taken. This should include signposting to the Injection Equipment Provider (IEP) scheme within Community Pharmacy where relevant.
2. The National Gender Identity Clinical Network for Scotland (NGICNS) should work with 3rd Sector organisations to develop information sources that detail the risks of self-sourcing hormonal therapies and increase awareness about the necessary monitoring for GAHT. There resources should also cover the risks associated with having gender affirming surgery performed outside of the UK.
3. Patients who report self-sourcing of hormonal therapy should have monitoring in line with recommendations for those prescribed GAHT in the NHS, utilising the agreed protocols and systems within the NHS Board.
4. The Primary Care subgroup endorse pilot projects which aim to reduce harm from self-sourcing. For example, the rapid GIC assessment of individuals who are self-sourcing hormonal therapy (Appendix 2: Lothian proposal). Unintended consequences of any pilots should be fully explored and mitigated against prior to implementation, including the risk of incentivising self-sourcing as a method of shortening waiting time for assessment. Consequently, self-sourcing should not be the sole entry criterion for obtaining a rapid assessment in the GIC.
5. Within each NHS Board, there should be clear agreed pathways that allow Primary Care to access timely advice from GICs regarding individuals who are self-sourcing, including when the pharmaceutical product in use may pose specific risks. This should facilitate risk assessment and substitution to a safer alternative where necessary, thereby reducing associated harms.

Deliverable
4. Consideration of the effectiveness of current screening arrangements and information provided.

The group considered current screening protocols, alongside changes to CHI. The group were in agreement that people who are trans need to be able to access the relevant national screening programmes, as well as any further targeted screening recommended by their care provider. It was noted that the evidence base for trans specific recommendations within national screening programmes is limited. Furthermore, the trans population is heterogeneous in terms of duration and level of hormone exposure. The call-recall system for several national screening programmes is reliant on a gender marker; in Scotland, this is currently the CHI number. The impact of an individual changing their CHI number as part of transition has been mitigated against through appropriate mechanisms. These largely ensure that ongoing invitation to relevant national screening programmes occurs. The NHS inform website provides detailed patient facing information using appropriate language, although the complexity for individuals navigating this is recognised by the Primary Care subgroup. The group recommends the following:

1. Information on NHS inform continues to be available as a useful, patient facing resource.

2. The existing mechanism when a CHI number is changed largely ensure that individuals continue to be invited to participate in the relevant national screening programmes.

3. The decision to change an individual's CHI number requires a clear and personalised discussion of the potential impacts on healthcare, including screening. This requires clinicians in both the GIC and Primary Care to have sufficient knowledge to discuss these issues and deliver personalised care. This should inform the PBSGL module recommended earlier in this document. This should include opting out of any screening programmes.

4. In addition to screening, the implications of a CHI number or gender marker change should also be discussed in relation to other elements of care, including laboratory test reference ranges. It was recognised that an individual's trans status may be relevant when determining appropriate care for non-trans specific healthcare, and this should be explained to individuals. This may be important for the individual to disclose in order to ensure patient safety and delivering high quality, person centred care.

5. Disclosure of an individual's trans status may occur inadvertently through details contained within the medical notes, such as repeat prescriptions, and individuals should be counselled regarding this.

6. NGICNS and the trans community should co-produce resources which detail the information in points 4 and 5, with this being available for both staff and patients. This information should also be supplied with the letter an individual receives from the NHS following the change of their CHI number.

7. Screening programmes should be alerted to potential inequity of access experienced by trans individuals and take active steps to address these.

8. Ongoing research into the appropriate screening for trans individuals should continue to be supported.

9. Screening teams should have ongoing training and support to ensure inclusive, accessible services. Appropriate advice should be available and should be person centred.

10. Individualised screening recommendations should be provided by Gender Identity Service Providers following any operative procedures. Any additional screening outside of the national screening programmes should be coordinated by the GIC.

11. A clear process for consenting and administratively changing CHI and Name changes should be made available. The current documentation should be reviewed by NGICNS to ensure this is accessible and available to the relevant clinicians.

Deliverable
5. Provision of a framework with examples for communication between the TGD person, their GP and their gender specialist.

The Group considered communication between GICs and Primary Care, and highlighted that this is fragmented in some areas. It was acknowledged that Primary Care providers may not have expertise in the delivery of trans specific healthcare issues and require specialist support. It was agreed that good communication links between Primary Care and GICs are necessary. Furthermore, strong communication is also required as part of patient centred care, ensuring that communication is transparent and clear for service users. The Primary Care subgroup therefore recommends:

1. Clear written communication templates should be used for correspondence from the GIC to Primary Care, clearly detailing any actions required (Appendix 3). Patients should also be copied into this correspondence where appropriate.
2. The use of patient facing apps and online platforms should be explored as part of the wider NHS digital strategy. Digital inclusion and the risk of inequality should be considered as part of this work.
3. A clear method of seeking urgent advice from the GIC should be available within each NHS Board and agreed by the GP subcommittee. This may be a dedicated email address or phone line depending on the preference of local

services. This is particularly important to ensure that specialist advice is available if bridging prescriptions are being considered.

4. As previously stated, clear information materials should be made available for individuals referred to GICs at the point of referral.
5. A website should be developed which acts as a national information source for both clinicians and patients. This should be informed by the needs of stakeholders and should contain resources which could be printed to support those who are not digitally enabled. This could be achieved using the NGICNS website although alternative options should be explored.

Deliverable

6. Consideration of arrangements and strategy for long term monitoring of hormone treatment.

Narrative for this deliverable has been included within deliverable 1 of this section.

Deliverable

7. Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

Like the other sub-groups primary care had service user and third sector input alongside NHS staff. Each member was invited to participate in an initial evidence gathering exercise to assist in progression of the Sub-groups project deliverables. Actions were agreed in an open forum and assigned to smaller groups of volunteers to progress offline ahead of the next scheduled meeting. Key actions were then tabled at subsequent meetings with individuals, or their representative presenting associated papers to the wider group to stimulate discussion and further action.

All members were provided ongoing opportunities to track any suggestions for change on working draft documents for their Sub-group via their teams channel stream, GRP mailbox or online at meetings. Any changes were then reviewed in a wider group format for agreement. Individuals were regularly invited to suggest any ideas for group recommendations. These were discussed and agreed at Sub-group final meetings by all members.

Multiple public consultations took place throughout the project wider in order for each group to gain the views of a larger cohort. The initial feedback survey had 76 responses which were collated and key themes were reviewed at each groups first meeting. A further consultation followed once the group agreed their deliverables. There were 8 responses submitted during this period. Responses were then circulated to the group for consideration during group discussions at meetings.

Additional areas highlighted by Primary Care Sub-group

In addition to the agreed deliverables, other key areas were highlighted during this groups discussions. Consequently, the primary care group recommend:

1. The National Labs IT Programme should engage with the transgender community, GICs and Primary Care to ensure trans-specific issues are considered during the procurement of any new lab system. This should ensure that appropriate clinical information is made available to requestors and those who will interpret lab results. If clinically appropriate, laboratory reference ranges should be decoupled from gender markers and instead be relevant to the individual, with specific consideration of creatinine and troponin.

2. The governance around transgender surgeries should be strengthened to improve patient experience and safety and address unmet needs within this population.
    a. Post-operative care should include appropriate community services, with practice nursing, CTACS and district nursing services appropriately trained and resourced.
    b. Educational materials for staff and post-operative care support should be available from nationally commissioned Gender Reassignment Surgical Services to ensure post-operative care is of appropriate standard. National service specifications for transgender surgeries should include an advice service, and should make provision for advice where these procedures are undertaken by alternate providers overseas.
    c. The provision of a national advice line for post-operative care should be considered within Scotland, staffed by a specialist nursing team.
    d. Within each NHS Board there should be an agreed local surgical service who will support aftercare of transgender related surgeries and act as a liaison between primary care and the tertiary services. These arrangements must be pre-agreed.

3. Systems within NHS Scotland need to allow for increasing gender identities for patients, specifically including non-binary identities. This should be done as part of a general move away from gendered healthcare.

4. As workload within and referral routes to GICs increase, there should be a robust mechanism for triage and prioritisation of patients. With the development of new care pathways, such as those for harm reduction or managing private referrals, consideration should be given to the risk of these incentivising certain behaviours and creating inequities. It should be the ambition that services are equitable for all individuals accessing them and this principle should guide service activity. Inequalities should be proactively monitored and action taken should these become evident.

5. There needs to be a consistent approach in NHS Scotland to the management of requests from private healthcare beyond transgender care.

6. Awareness and information for health professionals should be available around inadvertent disclosure of an individual's trans status and the legal consequences under the Gender Recognition Act

The group were in agreement that this work should be reviewed on a bi-annual basis.

6. Non-Surgical Sub-group

6.1 Project deliverables

Project Deliverables		RAG status		
		R	A	G
1	Narrative for speech therapy including access to pathway			
2	Narrative including consideration of NGICNS clinical guidance for hair removal and wig provision			
3	Narrative regarding and recommendations to improve access to psychological and mental health support			
4	Recommendations to improve access to sexual and reproductive healthcare for TGD people			
5	A patient facing document that describes the above			
6	Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.			

Red	**R**	Deliverable not met
Amber	**A**	In progress
Green	**G**	Complete

6.2 Key recommendations

Deliverable
1. Narrative for speech therapy including access to pathway

The group considered current evidence and best practice across the UK in relation to speech and language therapy for TGD people. The following recommendations were agreed:

- Voice and communication specialists assess the current and desired vocal and communication function of transgender and gender diverse people and develop appropriate intervention to facilitate voice and communication.

- Voice and communication specialists working with transgender and gender diverse people should demonstrate the knowledge and skills to support this group effectively, promoting healthy vocal functioning, communication skills and wellbeing. This should include an awareness of how to address people appropriately. In addition, they should be aware of the short, longer term and sometimes changing support needs of this population. They should also develop skills for patient interaction and understanding of gender diversity using RCSLT trans voice and communication competencies framework and be part of the RCSLT clinical excellence network

- Healthcare professionals in trans health**,** working with transgender and gender diverse people who are dissatisfied with their voice or communication**,** refer them to voice and communication specialists (Speech and Language Therapist) for assessment and intervention. Referrals can be made before or after GIC assessment or by self-referring to a local Speech and Language Therapy service.

- Healthcare professionals in trans health refer transgender and gender diverse people undergoing voice surgery to a specialist in voice and communication behavioural training pre and post surgery. Voice feminisation surgery is not currently offered by NHS Scotland.
- Healthcare professionals in trans health inform transgender and gender diverse people commencing testosterone therapy**,** of the potential and variable effects of this treatment on voice and communication and refer to SLT as appropriate.
- Therapy should be specific to each patients individual needs and considered across a range of modalities including face to face, video consultation, group and individual. Access to therapy will vary across individuals and should always be at a time when the patient feels able to actively participate in the therapeutic process.

This group also produced a patient information leaflet on this topic. The leaflet can be found here.

trans voice & communication - leafl

Deliverable
2. Narrative including consideration of NGICNS clinical guidance for hair removal and wig provision

Hair removal

The Sub-group acknowledged that recent work had been undertaken by NGICNS in the production of hair removal guidance. It was agreed that some amendments accessed here

2022 Facial Hair Removal Guidelines fc

Wig provision

The Non-Surgical Group were in agreement that wig provision should continue to follow the current guidance outlined by the Scottish Government, whereby in order to reduce unnecessary referral and clinical time within dermatology and to ensure equity of access, we request that NHS Boards facilitate referral direct from the transgender service direct to the wigs service. The referring clinician will complete the wig referral form with all relevant information.

2018-05-29 Letter re Provision of Wigs.pdf

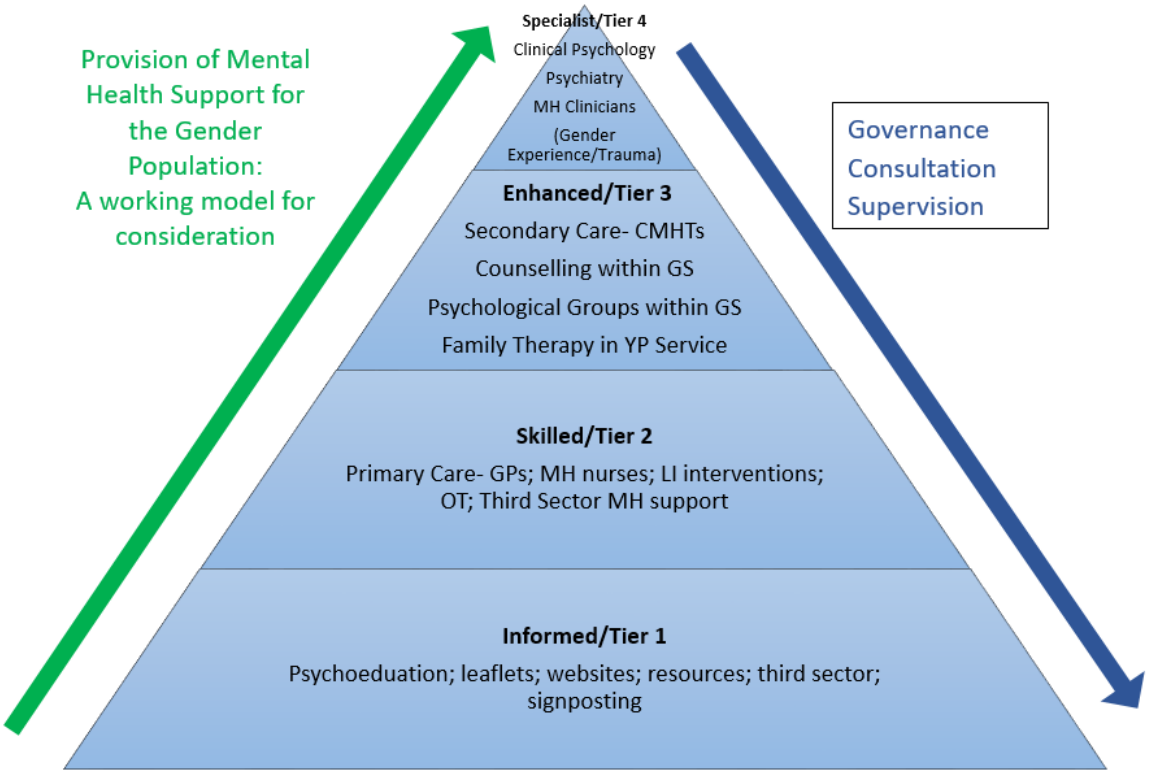
Letter re Provision of Wigs - 29 May 2018.c

Deliverable
3. Narrative regarding and recommendations to improve access to psychological and mental health support

The Non-Surgical Sub-group considered various models to assist in shaping narrative to support psychological support to TGD people. Firstly, The Psychological Matrix (2011) provides a guide to planning and delivering evidence based psychological therapies in Scotland. Since its inception, it has been adapted for use across a variety of clinical populations (e.g. Forensic, Child and Adolescent Mental Health) was a helpful basis from which to consider a match-stepped care approach to mental health support in the gender population. In addition to the psychological matrix, a second model to consider (as part of developing a model which improves access to mental health support for the gender population) is the “Transforming Psychological Trauma” model. This model was developed by NHS Education for Scotland (NES) as a knowledge and skills framework for the Scottish Workforce. The framework is designed to reflect the range of roles that workers may have in relation to providing services to people who have lived through traumatic experiences. These are not hierarchical and will not necessarily reflect someone’s seniority within their organisation or professional group but the nature of the role they hold in relation to

their responsibilities to and work with those affected by trauma. The implementation of the trauma framework led to the development of a trauma training plan for the Scottish Workforce. Therefore, it was acknowledged that the trauma framework and training models can be adapted and applied to the gender population as a way of conceptualising mental health support, and who should provide this, for the gender population.

The group were in agreement to propose a blended and adapted model of both the psychological matrix and the trauma and skills framework, The Gender Matrix. It is hoped that this model will improve access to a match-stepped care approach to mental health and social services for the gender population. It also considers who should be delivering which interventions and to whom, across each of the tiers, and what training and governance should therefore be in place to support effective delivery. The following matrix is proposed:



Informed Practice Level

- Awareness of resources, information available, can access these.
- Informed about how to uphold trans people's equality and human rights

- Informed about third-sector LGBT community support services and NHS Services for Gender Population
- Seek guidance from Skilled/Enhanced practitioners where appropriate
- Refer to Skilled/Enhanced practitioners where appropriate, e.g. signposting, mental health needs identified
- Signposting to other relevant services, awareness of referral processes, can support with these.

Skilled Practice Level (Likely to be primary care based):

- GP's referring to specialist MH Services and/or Third Sector (GP's may or may not be involved in prescribing hormones at this stage).
- Third Sector Mental Health and Social Support e.g. groups; 1:1 interventions.
- Low Intensity Psychological Interventions for e.g. depression, anxiety, sleep problems (either by MH Nurse within GS or Primary Care dependent on if related to GI or not and needs of service user).
- OT to provide psychosocial support (again could be primary care based and/or in in GS dependant on need).
- IPL and SALT may fit in this level given although not MH interventions, access to these services may positively impact on MH.

Must have supervision/consultation in place with Enhanced/Expert level practitioner.

Enhanced Practice Level (May be primary or secondary care based)

In addition to the tasks listed for Skilled Practice Level:

- High Intensity Psychology Interventions e.g. for more severe depression/anxiety (again could be primary/secondary based and/or in in GS, dependant on need)
- Access to Community Mental Health Team/CAMHS and MDT support therein, regardless of stage in gender pathway.
- Gender OT to provide psychosocial support
- Consider specialist service for neurodivergence e.g. local ASD input, input for intellectual disabilities (both NHS and third sector agencies)
- Counselling within Gender Service to support exploration of gender identity
- Psychological Groups within local Gender Service.

- Family Therapy in YP Service to help families support their young people in expressing their gender identity delivered by accredited therapist with governance structures in place.

Must have supervision/consultation in place with Expert level practitioner.

Expert Practice Level (Specialist Services)

In addition to the tasks listed for Skilled and Enhanced Practice Levels:

- Specialist input from a senior mental health clinician (likely but not exclusive to clinical psychology and/or psychiatry) for complex mental health problems such as trauma within the gender service. **Those who provide highly specialist intervention within the gender service must not be the clinician involved in assessment for gender pathway.**
- Access to highly specialist services out with the gender service e.g. local specialist trauma services, first episode psychosis services. Ensuring Tier 4 services are available to gender patients. The local gender service can provide consultancy to these cases.

Must have peer supervision/consultation in place with Expert level practitioner.

<u>Considerations that must be taken into account in implementation of the Gender Matrix Model:</u>

- Those who provide “highly specialist” intervention could not also be in assessment role.
- What modality of treatment has the largest evidence base for which presentations (e.g. Cognitive Behavioural Therapy, CBT; Compassion Focussed Therapy, CFT). A review of current evidence needs to be conducted.
- Consider if psychological intervention available in service, with limited resources, how would this impact on assessment for services users and fit into job plans for clinicians
- Measuring outcomes- ensuring data is collected across all tiers.
- Upskilling and training of workforce across all domains- NES colleagues are in the process of developing a workforce plan.
- Governance- across all tiers of matrix and consider how to ensure for third sector partners and that they feel supported by their local Gender Service.
- How to ensure appropriate mental health support is available at all stages of GRP and never a barrier to treatment

- Inequalities dependent on health board and what staff/services are available in each health board- how to overcome and move towards consistency of care.

The group recommend that in addition to mental health support, psychosocial support should also be available to the gender population. Psychosocial support (may be provided within NHS or via third-sector organisation with NHS funding) may include:

- Group info sessions
- Short-term family/couple counselling
- Occupational Therapy
- Individual counselling or psychological therapies
- Help to explore gender expression options and 'coming out'
- Help to access identity document changes
- Help to understanding legal rights & equality
- Help to develop social connections & peer support

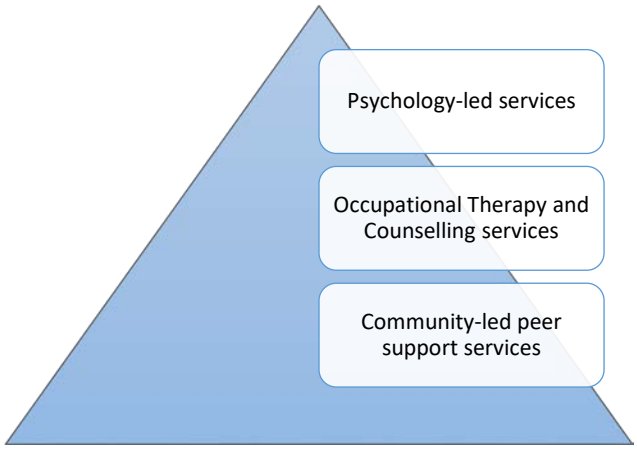
Counselling or psychotherapy can be helpful when requested by a gender non-conforming individual, however counselling or psychotherapy for people specifically focused on their gender identity is not, and should never be, a prerequisite for any gender affirming healthcare. Some of the populations mental health needs may be adequately met within local MH Services (e.g. Primary Care, Community Mental Health Teams) and these services should be able to fully support people who identify as gender non-forming. In addition to this, some gender non-confirming people may wish to access specialist mental health support when they feel their mental health needs at the time, are in relation to their gender identity. Therefore, there is also a requirement for mental health clinicians who are skilled in working with gender non-conformity in a therapeutic as well as assessment role. Any mental health support, intervention or therapy offered to gender non-conforming individuals should never be conflated with "conversion therapy" as supported by the 2017 Memorandum of Understanding.

Gender Specific Psychosocial Support (within the Gender Matrix)

Key principles:

- Should be accessible as an option throughout gender affirming healthcare
- Should take a tiered approach
- Should reflect individual goals, needs, requests:
    - Non-directive support to explore gender identity, role, and expression
    - Addressing the negative impact of gender dysphoria and stigma on mental health
    - Alleviating internalised transphobia

    - Enhancing social and peer support
    - Improving body image
    - Promoting resilience
- Should not impede access to other aspects of gender affirming healthcare
- Is never mandatory
- May include individual, couple, family, groups
- Never to be conflated with “conversion therapy”



The group welcomed the news that NES will be developing a knowledge and skills framework in addition to training plan for the gender population. It is recommended a specific model for mental health is also considered. The Gender Matrix (a proposed draft):

This section is intended as a draft model for consideration as a way of improving access to mental health support for gender non-conforming service users. It was drafted by a senior mental health clinician who is employed in a NHS Gender Service as part of the GRP review process for the non-surgical subgroup. When considering finalising the model and implementation, NES colleagues are in the process of advancing a formal model, and associated training framework, to improve mental health care for all gender non-conforming patients in Scotland. It is hoped the current draft will inform this work.

Deliverable

4. Recommendations to improve access to sexual and reproductive healthcare for TGD people

The group considered there was recently updates guidance on sexual and reproductive health services. It is recommended that all services providing SRH care to TGD people should follow the HIS Sexual Health Standards and may consider providing enhanced pathways for this patient group. Services should take into consideration other documents including the BASHH trans guideline, The Womens Health Plan and the There Needs to be Care Throughout document when planning or improving SRH services for TGD people.

The following considerations were agreed by the Sub-group:

Sexual health is more than just an absence of infection, it is about being able to have sexual experiences that are safe, pleasurable, consensual, and respectful. Sexual health is extremely important to the overall wellbeing of an individual. Whether someone achieves good sexual health will depend on their ability to access high quality and relevant information about sex and sexuality, understand the adverse consequences of unprotected sex, and access services that provide sexual health care (1). Attitudes towards sex and sexuality from within an individual's community may also positively or negatively impact on sexual health and well-being.

TGD people have poorer sexual health outcomes. Globally transwomen are estimated to be 49 times more likely than other adults to be living with HIV (2) and in England transwomen with HIV were more likely to be diagnosed late compared to other adults (3). There is also some evidence of higher rates of other STIs amongst TGD people (4) and in addition TGD people are more like to experience inter relationship violence. TGD generally have little visibility within mainstream sexual health services. A recent peer led research project sought the experiences of trans people accessing sexual health services in Scotland (5). It identified several barriers to accessing care including fear and anxiety, challenges in interpreting gendered sexual health information to understand levels of risk, misgendering from service providers, a lack of professional knowledge of trans people's sexual health needs, and limited access to accurate and reliable information. Transphobia within the press, politics, and public opinion were also barriers to accessing services.

There will be specific reproductive health care needs for TGD people that may change during the course of their gender identity care. Moreover, depending on the age when accessing gender identify clinics (GIC) or indeed what degree of gender transition an individual decides to proceed there may be different needs. Taking a life course approach from puberty to the menopause there will be there will be different

considerations in terms of fertility, pregnancy planning, cervical screening or menopause care for people accessing a GIC. In particular, the transition from paediatric to adult health care is a crucial phase and this may be made more challenging for young people with gender identify needs.

Disease prevention and promotion of health lifestyle should continue throughout adulthood and access to services based on needs. Screening (cervical, breast & bowel) will also pose specific challenges for transgender individuals in particular transmen depending on stage of transition. Disabled people face specific barriers to accessing a range of services and indeed may also face barriers to accessing GICs including face to face, remote and digital access. Transgender individuals may be uncomfortable seeking reproductive health care or contraception when the services' 'target audience' is advertised in a way that is incongruent to their gender identity (eg a transman may be really uncomfortable attending "women health clinic" for a coil or for a cervical smear). The procedures and investigations themselves may also provoke heightened feelings of dysphoria.

In an attempt to improve sexual health outcomes some services have introduced dedicated sexual health clinics for TGD people. Clinic Q in London is a well established sexual health and wellbeing service for TGD people. NHS Lothian introduced a dedicated sexual health clinic for TGD in xx but unfortunately this did not continue due to low demand. BASHH guidelines set out recommendations for how integrated sexual health services may overcome some of the barriers TGD people face to ensure their services are accessible to tgd people. These include consideration to service design issues including inclusive signage(?), registration forms, literature/leaflets and appropriate staff training. There needs to be care throughout noted some factors that were facilitative in accessing sexual health care. Some examples were peer encouragement and practical support to attend services, non-assuming approach to sexual history taking, varied access options ie F2F/virtual.

Sexual and reproductive health care is currently delivered in a variety of settings including GP, integrated sexual health services, 3rd sector organisations, pharmacy, secondary care ie infectious diseases, gynaecology. Dean Street in London piloting an integrated Gender, Sexual Health and HIV service called TransPlus which is receiving positive feedback. There are currently no examples of such integration in Scotland but it is recognised that most but not all GICs in Scotland are physically located within sexual health services which may in itself improve access for some people. If sexual and reproductive healthcare is unable to be delivered through the GIC due to expertise or other reasons then the GIC must ensure they establish pathways with local sexual health providers for the timely referral of tgd people and be able to signpost to reliable sources of information and condoms. This includes referral pathways to sexual problems services. It is expected that GIC clinicians at a minimum should be competent in taking a sexual history for the purposes of

counselling about expected effects prior to treatments and to establish contraceptive requirement for testosterone users.

Deliverable

5. A patient facing document that describes the above

The GRP project team have aimed to create a patient facing SPATH document, in line with other National initiatives. Further details of this document will be available shortly.

Deliverable

6. Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review.

The Non-surgical Sub-group had service user and third sector input alongside NHS staff. Each member was invited to participate in an initial evidence gathering exercise to assist in progression of the Sub-groups project deliverables. Actions were agreed in an open forum and assigned to smaller groups of volunteers to progress offline ahead of the next scheduled meeting. Key actions were then tabled at subsequent meetings with individuals, or their representative presenting associated papers to the wider group to stimulate discussion and further action.

The initial feedback survey had 76 responses which were collated and key themes were reviewed at each groups first meeting. A further consultation followed once the group agreed their deliverables. There were 9 responses submitted during this period. Responses were then circulated to the group for consideration during group discussions at meetings.

7. Children and Young People's Sub-group

7.1 Project deliverables

Project Deliverables		RAG status		
		R	A	G
1	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.			
2	Recommendations for updates to pathways including the cooperation between the Young People's Service and the endocrine service.			
3	Recommendations for pathways relating to the transition of young people from the Young People's Service to adult services			
4	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			
5	Identify mechanisms for providing community based support to YP under 12 and their families			
6	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.			
7	A patient facing document that describes the above			
8	Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review			

Red	**R**	Deliverable not met
Amber	**A**	In progress
Green	**G**	Complete

7.2 Key recommendations

Deliverable
1. 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.

The group produced a proposal in relation to narrative considering the recommendations from the relevant WPATH chapters for children and young people, as appropriate to the context within Scotland. The sub-group endorsed the Adult Assessment proposal on the staff competency matrix that had been produced, but have requested to broaden the informed level tier out to appropriately outline the needs of Children and Young People at this level. Work is underway for this to be finalised.

YP GENDER SERVICE ASSESSMENT PROFO

Deliverable
2. Recommendations for updates to pathways including the cooperation between the Young People's Service and the endocrine service.

The group have produced recommendations for updates to pathways including the cooperation between the Young People's Service and the endocrine service. An initial draft is currently being updated as per group decision.

GRP Childrens and YP age and stages for

Deliverable
3. Recommendations for pathways relating to the transition of young people from the Young People's Service to adult services

The group considered recommendations for pathways relating to the transition of young people from the Young People's Service to adult services. There was an

acknowledgement that as this group had a delayed start, there is an opportunity to really understand from children and young people what that pathway should look like. Therefore, the group were in agreement to recommend that NGICNS with assistance from the sub-group should undertake an extensive engagement period with stakeholders for this deliverable, in order to inform pathway ideas.

Deliverable
4. 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

Deliverable four was progressed by 3rd sector representatives on the group. The group were in agreement with the following proposal for support to people whilst on the waiting list:

Short term

- Fund partnership work with the third sector and the Sandyford/ young people's services to provide interim person-centred support.

- Triage young people into appropriate services including NHS mental health services and third sector. This could be done by nurses.

- Provide information for young people (and their parents & carers) on the needs/ expectations for treatment in advance of their first meeting via resources and triage

- Update existing resources (the Sandyford leaflet) and information for children, young people and their parents and carers and those that support them. This should include information on:
  - information on timescales
  - the services provided
  - the importance of gender affirming care
  - reassuring in tone rather than a focus on assessment
  - a flow chart/roadmap drawing of what the assessment process looks like and who carries it out
  - interim support available including 3rd sector and trained counsellors
  - support available for under 13s and their parents and carers
  - information and links to support children and young people's wellbeing more broadly

- Provide practical support for parents/ carers and professionals as they will be providing much of the support in the interim (particularly for children and young people 12 and under on the waiting list). This could include:
  - Online advice sessions for parents and carers

- Printed/ online resources targeted at parents and carers
- Be badged as from the NHS/ Sandyford to provide credibility

- Ensure regular updates are provided and provide one point of contact for all children, young people and their families. This could be provided through nurses or additional admin support for clinicians

- In general, ensure young people's needs are considered in the review of the Gender Reassignment protocol, particularly considering the needs of non-binary young people

Medium to Long-term

- Create a long-term approach to create a national service for children and young people building on an evidence-based approach, the Cass Review and a trans affirmative approach
- Consider the role of Primary Care to deal with treatment following assessment, reducing the need to specialist clinicians
- Improve joined-up thinking between CAMHS and mental health services with referrals across services
- Long term funding for partnership work between the third sector and Sandyford following evaluation
- Consider the development of localised Gender Identity services to include services for young people and reduce travel for children, young people and families
- Training for Primary Care staff and school counsellors
- Website information on a wide range of topics to support children, young people, parents and families

Recommendations for GRP YP Subgroup.

Deliverable
5. Identify mechanisms for providing community based support to YP under 12 and their families

The group were in agreement that further work should be completed to build on the support highlighted in deliverable 4. This work will help identify mechanisms for providing community based support to YP under 12 and their families. A small SLWG are currently drafting this item.

Deliverable

6. 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

The group acknowledged that parts of their review may be further informed by the Cass Review, but were in agreement that this should not delay progress. Therefore, the group agreed to the following iterative update period:

- Assessment model to be reviewed in 12-18 months post publication of SPATH
- Endocrine guidance proposal is well underway by the sub-group. There is an acknowledgement that this proposal could be further informed by the Cass review in relation to research into longer term outcomes. In light of this, the group suggest a review 12 months post publication.

- Transition to adult services between paediatric endocrine service and adult GIC's should be informed by results from the recommendation of immediate and broader stakeholder engagement events with children and young people.
- As items contained in the further support to people on the waiting list propose funding actions, the group recommends an evaluation piece would be appropriate to understand the effectiveness of this support once established.

Deliverable

7. A patient facing document that outlines all of above.

A patient facing SPATH document, in line with other National initiatives is in the course of being created. Further details of this document will be available shortly.

Deliverable

8. Summary describing the involvement of people with lived experience in the group's work and intersection with the principles of the Review

The Children and Young People's Sub-group had service user parent representation and third sector input alongside NHS staff. Each member was invited to participate in an initial evidence gathering exercise to assist in progression of the Sub-groups project deliverables. Actions were agreed in an open forum and assigned to smaller groups of volunteers to progress offline ahead of the next scheduled meeting. Key actions were then tabled at subsequent meetings with individuals, or their representative

presenting associated papers to the wider group to stimulate discussion and further action.

The initial feedback survey had 76 responses which were collated and key themes were reviewed at each groups first meeting. A further consultation followed once the group agreed their deliverables. There were 15 responses submitted during this period. Responses were then circulated to the group for consideration during group discussions at meetings.

8. Summary of involvement of people with lived experience in the group's work and feedback for the future

It was recognised that this project had a higher volume of lived experience representation across groups in line with the CMO request. Therefore, an evaluation report has been prepared that highlights the effectiveness of the project approach to date. There was an interest to understand what worked well, what didn't and lessons learned. Findings from this report will be used to shape future projects. The report can be accessed here (ADD REPORT)

9. Recommendations for further action

- In the absence of formal qualification in this field, the Surgical group recommends that referring health boards provide NSD with a list of clinicians approved to support surgical referral and that a process supported by NGICNS and NSD is established for maintenance of this list.
- The Surgical Sub-group encouraged the development of specialist surgical and nursing expertise within Scotland to deal with post-surgical issues, acknowledging the considerable potential distance between patients and providers in many situations.
- The Surgical group recommends a national MDT is established by NGICNS to support NHS Boards achieve fair and consistent assessment. This MDT should be comprised of a relevant surgeon and gender specialist, including the one (or their representative) who representing the patient.
- The Surgical group recommends an action to be taken forward for supplementary guidance to be created in the immediate post GRP publication period by NGICNS with instructions for clinicians on how to access locally commissioned surgery requests.
- A Regional contact to be identified to assist fellow colleagues with patient enquiries, and appropriate support to their trans patients.
- Though the evidence base doesn't support inclusion in this version of the protocol for surgeries that are not currently available in Scotland/UK, some of these procedures may be carried out elsewhere in the world and we recognise that the evidence base is evolving. It is therefore recommended that the evidence is monitored for these surgeries on an ongoing basis to assess whether these surgeries should be included in future iterations and

which individuals would benefit. This includes for a literature review to be conducted following publication of the SPATH to review relevant evidence of procedures suggested by WPATH that are not currently carried out in Scotland. The group suggested that this could be conducted by Scottish Health Technologies Group (SHTG), but would appreciate input from the Oversight Group.

- The group recommended that further analysis is commissioned six months post publication of SPATH to understand the impact in relation to accessing locally commissioned surgeries and what, if any, further support would be required. It was agreed this review should be broadened to include an attempt to understand the situation surrounding Body Mass Index (BMI). Any further work should include service user representation.
- It is recommended by the Primary Care Group that The GP/Primary Care team should prescribe as part of an enhanced service. Where a Gender Identity Service provides ongoing monitoring and management, the GP/Primary Care team should prescribe under a shared care agreement (SCA), with a letter being sent annually from the clinic to the patient, copied to the GP, following review. The group acknowledged further work would be required to assist with the production and implementation of SCA's in each area.

- The Primary Care Group acknowledges determining appropriate service models will require contractual agreement. Negotiations should be overseen by the Scottish Government to deliver a solution that addresses all stakeholder needs and can be agreed at local NHS Board level. Any service model should undergo economic and service user appraisal as part of service design.
- The PC group recommends that development of GPs with Extended Roles may build capacity within the GIC service to support the development of future service models, including specialist locality clinics as part of a hub-and-spoke model of care.
- The Primary Care Group recommends a robust educational offering should be available to Primary Care to ensure adequate knowledge and skills within the team. NES should be commissioned to develop a transgender problem based small group learning (PBSGL) module specifically on shared care agreements, CHI change counselling, screening, hormone monitoring and ongoing care. In addition to producing educational materials, resourcing should be made available to facilitate time for CPD across the primary care team.
- The Primary Care Group recommends future service planning should be considered and include training for professionals across the health service, specifically those within Primary Care, GICs, Endocrinology and Elderly Medicine. Clear referral routes for re-engagement with specialist care as an individual ages should be determined based on the risk of therapies. Services should be adequately resourced to meet any projected increase in demand.

- Healthcare Improvement Scotland (HIS) should support by quality assuring private providers of gender identity assessments and prescribing through regulation and accreditation. This should be done at the level of the clinician and organisation. As part of this assurance, providers should have appropriate resilience and business continuity plans in place to ensure services are sustainable. HIS should liaise with the Care Commission to provide similar assurance for providers of these services within England and Wales. This will support GPs and GICs engagement with the private sector.
- The National Gender Identity Clinical Network for Scotland (NGICNS) should work with 3rd Sector organisations to develop information sources that detail the risks of self-sourcing hormonal therapies and increase awareness about the necessary monitoring for GAHT. There resources should also cover the risks associated with having gender affirming surgery performed outside of the UK.
- NGICNS and the trans community should co-produce resources which detail the information in points 4 and 5, with this being available for both staff and patients. This information should also be supplied with the letter an individual receives from the NHS following the change of their CHI number.
- A clear process for consenting and administratively changing CHI and Name changes should be made available. The current documentation should be reviewed by NGICNS to ensure this is accessible and available to the relevant clinicians.
- A website should be developed which acts as a national information source for both clinicians and patients. This should be informed by the needs of stakeholders and should contain resources which could be printed to support those who are not digitally enabled. This could be achieved using the NGICNS website although alternative options should be explored.
- The National Labs IT Programme should engage with the transgender community, GICs and Primary Care to ensure trans-specific issues are considered during the procurement of any new lab system. This should ensure that appropriate clinical information is made available to requestors and those who will interpret lab results. If clinically appropriate, laboratory reference ranges should be decoupled from gender markers and instead be relevant to the individual, with specific consideration of creatinine and troponin.

- The governance around transgender surgeries should be strengthened to improve patient experience and safety and address unmet needs within this population.
    - Post-operative care should include appropriate community services, with practice nursing, CTACS and district nursing services appropriately trained and resourced.
    - Educational materials for staff and post-operative care support should be available from nationally commissioned Gender Reassignment Surgical Services to ensure post-operative care is of appropriate standard. National service specifications for transgender surgeries

should include an advice service, and should make provision for advice where these procedures are undertaken by alternate providers overseas.
    - The provision of a national advice line for post-operative care should be considered within Scotland, staffed by a specialist nursing team.
    - Within each NHS Board there should be an agreed local surgical service who will support aftercare of transgender related surgeries and act as a liaison between primary care and the tertiary services. These arrangements must be pre-agreed.

- Systems within NHS Scotland need to allow for increasing gender identities for patients, specifically including non-binary identities. This should be done as part of a general move away from gendered healthcare.

- As workload within and referral routes to GICs increase, there should be a robust mechanism for triage and prioritisation of patients. With the development of new care pathways, such as those for harm reduction or managing private referrals, consideration should be given to the risk of these incentivising certain behaviours and creating inequities. It should be the ambition that services are equitable for all individuals accessing them and this principle should guide service activity. Inequalities should be proactively monitored and action taken should these become evident.

- There needs to be a consistent approach in NHS Scotland to the management of requests from private healthcare beyond transgender care.

- Awareness and information for health professionals should be available around inadvertent disclosure of an individual's trans status and the legal consequences under the Gender Recognition Act
- The Children and Young People's Sub-Group recommends that NGICNS with assistance from the sub-group should undertake an extensive engagement period with stakeholders for this deliverable, in order to inform transition to adult service pathway ideas. This period should include focus sessions and/or a public event for C&YP, and their parents. A similar event was held in December 2020 for adults. Feedback from the event was used to inform the review.
- Update existing resources and information for children, young people and their parents and carers and those that support them.
- Website information to be produced on a wide range of topics to support children, young people, parents and families
- Iteration of Children and Young People's Endocrine guidance and assessment proposal 12 months post publication to scope the results from the Cass Review.
- The Children and Young People's group recommends that any items contained in the further support to people on the waiting list information that propose future funding actions, that an evaluation exercise should be undertaken to understand the effectiveness of this support once established.

- To provide a consistent approach to record keeping and distribution across Scotland, the group recommends that this work is to be undertaken by NGICNS
- National Education for Scotland (NES) to utilise the background outlined in the adult assessment and C&YP draft proposal to inform the knowledge and skills framework.

	Outstanding actions from Sub-groups				
				RAG status	
		Sub-group	R	A	G
1	Example pathways including options for modified pathways for people who have started transitioning, have more complex needs, or are re-transitioning.	Adult Assessment			
2	Updated clinical guidance for the initiation, titration and maintenance of hormone treatment that is inclusive of the needs of all trans, non-binary and gender diverse people.	Endocrine and FP			
3	Recommendations for patient facing material that supports the exploration of hormone treatment, fertility preservation and appropriate consent.	Endocrine and FP			
4	A patient facing document	All groups			
5	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.	C&YP			
6	Recommendations for updates to pathways including the cooperation between the Young People's Service and the endocrine service.	C&YP			
7	Recommendations for pathways relating to the transition of young people from the Young People's Service to adult services	C&YP			
8	Identify mechanisms for providing community based support to YP under 12 and their families	C&YP			