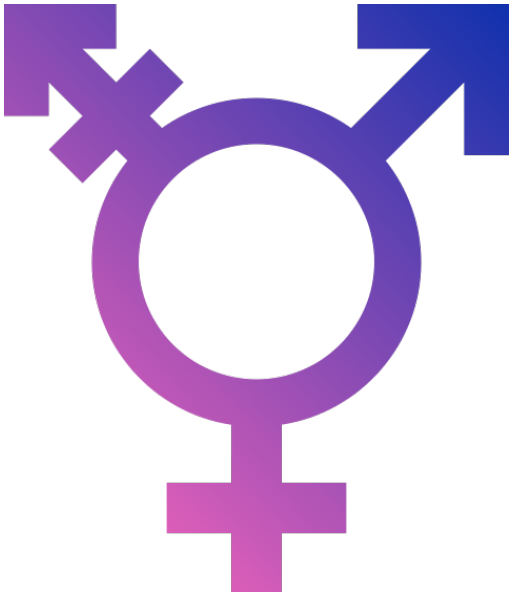
Exploring the reality: How do the various health and social care agencies provide services appropriate to individuals who identify as trans? An initial exploration.



2016 - 2018

"Trans people encounter significant problems in using general NHS services, due to the attitude of some clinicians and other staff who lack knowledge and understanding — and in some cases are prejudiced. The NHS is failing to ensure zero tolerance of transphobic behaviour.[1]"

healthwatch Shropshire

sand Safe Ageing No Discrimination LESBIAN, GAY, BISEXUAL, TRANS

[1] Fair Care for Trans Patients: An RCN guide for nursing and health care professionals, 2016.

A note about language

Trans

The word trans[2] is an umbrella term to describe people whose appearance, personal characteristics or behaviours differ from socially accepted stereotypes about how men and women are 'supposed' to be.

Trans includes, amongst many others, transsexual people, gender queers, cross dressers, androgynous and bi-gendered people, as well as people with a transsexual history who simply identify as the men and women they know themselves to be.

The language people use to describe themselves changes over time.

Shining the Light[3] has produced a glossary of current terms (see overleaf) and how they relate to each other while reminding that:

• There is no such thing as a 'standard' trans person – the words people use to describe themselves are many and various – as are their experiences.

• It's important not to label people as 'trans' based on our perceptions of their identity – instead use the words they use to describe themselves.

Being trans can also involve a variety of life choices including:

- Living permanently with a different gender identity.
- Living part-time with a different gender identity.
- Changing your appearance to reflect another identity through choice of clothes and other methods of presenting as your true self.
- Partly or permanently changing the appearance of your body through hormone therapy and/or surgery.
- Not conforming to any gender stereotypes – for example, a trans person who was born male who has facial feminising surgery and breast implants but does not want to have any lower body surgery.
- Not transitioning but occasionally wearing clothes usually associated with the 'opposite' gender.
- Being gender neutral and not wishing to present as either male or female. It is important to acknowledge that not all trans people are able to or choose to have genital corrective (or reassignment) surgery. For others, however, this is an incredibly important stage in correcting the gender they were assigned with at birth and in living the life they want to live. How you decide to live your life as a trans person is really up to you.

[2] Also with an asterisk [trans*]

[3] Shining the Light: 10 keys to becoming a trans positive organisation: Benjamin Gooch Galop.org.uk

Terminology

There are many different glossaries of terminology. The one below is taken from Shining the Light – 10 Keys to Becoming a Trans Positive Organisation by Benjamin Gooch. www.galop.org.uk

Androgyne	Someone whose gender is neither male nor female.
Bi-gender	Someone whose gender identity is both masculine and feminine.
Cisgender	A synonym for non-trans people. It comes from the Latin 'cis' which means 'on the same side' and is used to describe someone who is comfortable in the gender they were assigned with at birth.
Cross dresser	Someone who wears clothes that are traditionally or stereotypically worn by the other sex, but who usually does not intend to live full time in another gender to the one they were assigned with at birth.
FTM	Female to male transsexual or transgender person.
Gender dysphoria	A medical term for the persistent discomfort and/or inability to live as a member of the gender a person was assigned with at birth.
Gender identity	Whether a person feels like a man, woman, combination of these or neither.
Gender non conforming	Someone who does not subscribe to the dominant ideas of male and female behaviour.
Gender queer	Someone who uses their gender variance to challenge dominant social categories of male and female.
Gender reassignment surgery	Surgery to reconstruct secondary sex characteristics. The aim of these procedures is to make a person's gender identity and physical body congruent with each other, thereby reducing gender dysphoria. Surgeries differ between FTM and MTF individuals and involve a number of procedures. Not all trans people undergo surgery for a variety of social, medical and personal reasons.
Gender stereotype	Powerful socially sanctioned (yet repressive) ideas about what men and women should look like, who they are and how they should behave. E.g. that gender is binary, sex is determined birth and cannot be changed, or that all doctors are male.
Gender variant	A synonym for 'trans'. It describes behaviour, expression or identity that does not conform to dominant gender norms of male and female.
MTF	Male to female transsexual or transgender person.
Pass	The act of being seen as the gender(s) you know yourself to be.
People with a transsexual history	when a transsexual person who wants to live fully and permanently in the gender opposite to the gender they were assigned with at birth completes their transition they may not see themselves as being under the trans umbrella. They may see their transsexual history as a medical issue which has now been resolved and so is no longer relevant to their lives. As

	such, it is disrespectful to insist on calling them trans, or transsexual. They should be treated as the men or women they know themselves to be.
Sex	Male, female, intersex: it's about your hormones, chromosomes, genitalia etc.
Sexual orientation	Who you are attracted to.
Stealth	The act of passing in your 'target gender' without disclosing one's transsexual history, usually because it is irrelevant e.g. living in the stealth mode
Trans	Distinguished from transsexual: a person who experiences gender dysphoria but does not undergo medical intervention. It is also used by some as a 'longhand' for 'trans'
Transition	The process of becoming the gendered person you know yourself to be.
	The diagnostic category for people with gender dysphoria. The ICD-10 (International Classification of Diseases 10th Ed.)describes transsexualism as "*[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex*". Some people with transsexual diagnoses self-identify simply as the men and women they know themselves to be, whilst others have less binary gender identities
Trans Man	See 'ftm'.
Trans Woman	See 'mtf'.
Visibility	Describes issues arising from the paradox that whilst current language and social structures are lacking in their ability to describe and therefore make visible some people's gender identities – and that these people remain unwillingly invisible, for others the goal is to move towards being able to be accepted within currently recognised definitions.

Contents

Executive Summary

This research was the result of one recommendation drawn from our previous Healthwatch funded research (March 2015) into the issues facing older and old lesbian, gay, bisexual and trans people accessing health & social care services in Shropshire[4]. We wanted to explore the levels of understanding about specific issues facing trans people.

This is a complex area of research and our starting point was far too ambitious. We quickly discovered that service providers are rarely able to disaggregate specific experiences of trans people from those more broadly being flagged up for LGB people – and that they are keen to increase their knowledge in this broader area.

The conflation of trans issues with those of lesbian, gay and/or bisexual people reportedly leaves this marginalised group more vulnerable, and yet this research finds that the benefit of conflation is that trans experiences are included in conversations, and this outweighs the dangers of further marginalisation by starting the discussions with a focus on more generic LGB issues.

Our methodology changed as we became more understanding of where people were starting from in these conversations, and also as we became aware of other research in progress. In favour of individual meetings with service providers, we delivered facilitated awareness raising sessions with an introduction about the research process and opportunities to raise questions. We also waited for the outcomes of a bigger piece of research which coincidentally had begun at Swansea University (this has not yet been concluded).

All of this serves to illustrate the complexity of or challenge to doing this research.

Our findings suggest that there is some way to go to make the experience of trans people accessing health and social care equitable to that of the cis-gender population and, with growing numbers of young people presenting as gender non-binary or gender questioning, this is an area for some urgent focus – on different fronts:

- around actual transition
- around health conditions associated with having transitioned
- around historic poor experiences which lead people to wait longer before accessing the services they need
- around approaches adopted by service providers

Having said this, there is a case to be made for all of this fitting well into health and social care values of privacy, dignity, personalised care, adult safeguarding, compassion and good communication. This last cannot be over-stated and SAND recognises our own need to continue conversations and develop relationships in the County. This is about laying the foundations before introducing some of the bigger, more specific challenges to policy and practice when considering the main focus of our own trans work: older and old trans people accessing health & social care, such as research into the impact of taking gender changing hormones for decades, gender surgery and any particular implications of dementia.

[4] https://lgbtsandresources.files.wordpress.com/2015/04/sand_research_report_final.pdf

To take this forward, we have identified 9 recommendations:

1. SAND continues to develop relationships with service providers to build reputation and trust, capitalising on the presentations and events delivered throughout 2017.

2. SAND continues to raise issues for trans people throughout its work, including when delivering awareness and training sessions.

3. SAND waits for the publication of findings from the Swansea research and NHS England Consultation and uses them as a springboard to open up wider conversations.

4 CHT Everyone Counts equality and diversity strategy develop clear policies and build in processes to feedback, implement and monitor changes to healthcare provision, following site visits.

5 Health & social care providers work with SAND to embed good practice in training [including to students] and raise awareness and understanding about issues impacting on older and old LGBT people.

6 End of Life teams work with SAND to identify key changes to practice which would improve experiences for older and old LGBT people.

7 Domiciliary Care providers review their current staff training programmes and build in elements to ensure that carers feel confident to provide environments which feel safe to LGBT clients.

8 Care Home Providers work with SAND to develop a replicable approach to raise awareness and understanding of issues impacting on older and old LGBT people in Shropshire amongst staff.

9 SAND ensures that its own work to develop some form of accreditation framework for health & social care providers is inclusive of trans people.

ADDENDUM: Recent Update

Since embarking on this work there have been some key initiatives that aim to provide better support to trans people in terms of health and social care and in particular removing the need for a medical diagnosis of gender dysphoria before being able to apply for gender recognition.

In July 2017 the Minister for Women and Equalities announced proposals to streamline and de-medicalise the process for changing gender as part of plans to reform the Gender Recognition Act, alongside the launch of a survey canvassing the views of LGBT people on ways to improve public services.

This government is committed to building an inclusive society that works for everyone, no matter what their gender or sexuality and today we're taking the next step forward.

We will build on the significant progress we have made over the past 50 years, tackling some of the historic prejudices that still persist in our laws and giving LGBT people a real say on the issues affecting them.

In terms of trans people the intention is to

- *Removing the need for a medical diagnosis of gender dysphoria before being able to apply for gender recognition. The current need to be assessed and diagnosed by clinicians is seen as an intrusive requirement by the trans community; and*
- *Proposing options for reducing the length and intrusiveness of the gender recognition system.*

It will aim to relieve the bureaucratic and medical burdens for those who choose to change their gender.

Alongside this NHS England launched a 12-week consultation [until Oct 2017] on specialised gender identity services for adults as part of the national review of specialised services for trans and non-binary people

Through consultation we want to hear people's views on two proposed service specifications: one for how Gender Identity Clinics will deliver specialised outpatient services; and another for how surgical units will deliver surgical interventions. The service specifications have been developed taking into account the outcome of engagement with the trans community and clinical experts and describe new proposals for how specialised gender identity services will be delivered in the future.

Trans lives have been more prevalent in television dramas and documentaries; more young people have been identifying as non-binary and – locally – Shrewsbury's own LGBT youth group has had wide trans representation at schools events to launch the new (2018) Trans Guidance for schools.

As mentioned, Swansea University has still to conclude its in-depth research and publish any detailed findings.

Why this research?

Just 13% of nurses feel prepared to meet the needs of their transgender patients (RCN Survey, 2016)

The original research question in full was :

How do the various health and social care services provide services appropriate to individuals who are transgender, transsexual, cross dressers, intersex or gender fluid?
Is there a lack of awareness, a need for training or change in policy?

Recognising very early on the complexity of the question and the paucity of possible responses for reasons that will be explained later, we simplified it to read:

How do the various health and social care agencies provide services appropriate to individuals who identify as trans?

A glance at national research[5] illustrates that trans people can experience specific issues when accessing health and social care, for example:

- Trans people often delay seeking care due to a general distrust of the medical establishment and a perception of the institutional environment as being transphobic
- Few care providers have the necessary training to be able to cater to trans specific needs in a non-discriminatory environment
- Trans people have an increased likelihood of experiencing particular health complaints depending on what medical interventions they have had
- Trans people often have less robust support networks, higher instances of mental and physical health problems, and may experience loneliness

SAND's own (Healthwatch Shropshire funded) research[6] around the health and social care needs of older and old LGBT (Lesbian, Gay, Bisexual and Trans) people and discussions with older and old trans people locally told us that service providers do not take steps to improve their experience:

- Professionals are often confused as to how to treat / deliver care to patients whose gender is not how they would identify it to be. Often patients who have gender identification issues are placed in the wrong hospital bays.
- There are issues with data storage; when an individual transitions gender they are given a new NHS Number and yet still old files get brought through – as these carry a complete medical history. However this then serves the additional purpose of 'outing' the person, again in an open and public space.
- Transgender individuals post-op still require physical checks for the pre-op body, for instance a transgender woman will still need a prostate check and a transgender

[5] http://actionfortranshealth.org.uk

[6] https://lgbtsandresources.wordpress.com/2015/03/01/researching-the-hopes-fears-experiences-expectations-of-health-social-care-by-older-and-old-lesbian-gay-bisexual-and-trans-people-in-shropshire/

man will still need a mammogram and may require a cervical smear. These examinations are embarrassing enough without turning up to an all male clinic as a woman. The clinic staff may be confused and ask questions – in an open, public space.

Trans population in Shropshire

It is – and always will be – impossible to know how many trans people there are in Shropshire, for all sorts of complicated reasons: many people who transition do not identify as trans once they are living confidently in their gender; others may not accept the term 'trans', or 'non-binary' or whatever language the researcher has chosen to use; the Census, so often a statistical source, does not collect the data, and many more.

We do know that the 2011 Census showed Shropshire has a population of 306,129. Research related to calculating numbers of trans people would conclude that:

- 380 people in Shropshire are trans - one in every 250 people defines as 'non-binary' and 31% of these identify as trans[7]
  OR
- 3,979 people in Shropshire are trans[8]
  OR
- 3,061 people in Shropshire are trans[9]

Anecdotally, geographical locations with established support groups for trans people attract more people to live close by through the period of their transition, and these people may of course choose to stay. The (now closed) presence of Gender Matters in Wolverhampton, formerly known as 'Trans Shropshire' may mean there is a disproportionately high number of trans people living in the County.

SAND's own research also identifies that trans issues are often conflated with LGB (Lesbian, Gay and Bisexual) issues and thus not specifically addressed. As we identified in our first research report, this potentially leaves this vulnerable group even more marginalised than older and old LGB people.

Background

Our initial research suggested that there are many issues that trans people face regarding health and social care – some similar to LGB people and many related specifically to them as trans people. As a result, SAND undertook to look specifically at some of the issues facing trans people.

A key issue is the distinction between sexual identity and gender identity – one which may be unclear in the minds of many of those who consider themselves cis-gender.

[7] http://practicalandrogyny.com/2014/12/16/how-many-people-in-the-uk-are-nonbinary/)

[8] ttp://www.equalityhumanrights.com/sites/default/files/documents/research/rr75_final.pdf EHRC research suggests that 1.3% of the population is in some way transgender or gender variant

[9] GIRES the national charity uses a 1% estimate http://www.gires.org.uk/assets/Workplace/Monitoring.pdf

As a starting point we wanted to find out what actually happens in terms of service delivery and what the issues are facing trans people as potential and actual recipients of services.

We are all too aware that people often give their views of their experiences without feeling that it makes much difference. The experiences of trans people are fairly well documented and it is doubtful that Shropshire experiences are that different from elsewhere, including those areas that have LGBT centres and trans campaigning and support groups. Indeed, a conversation with a trans activist confirmed that even if you have the ear of national equality and diversity specialists it doesn't necessarily lead to the change that is needed.

Methodology

Trans *gender people experience severe disadvantage in accessing healthcare in a timely way (EHRC 2016)*

During the research, we were careful not to set ourselves up as experts – the idea was to raise questions to get a picture of the level of knowledge and understanding of the issues and experiences of trans people accessing health & social care, with a particular emphasis on older and old people - the core of SAND's work.

Desk Research
We undertook extensive desk research to extract themes and issues arising for trans people. From this we compiled a brief summary of findings to illustrate the variety of existing resources.

Specialist input
It was never the remit of this research to have an advisory panel or to undertake formal consultation, but it was important to have some input from trans people to help shape the questions and to identify the people we should be talking to. To this end, we met and maintained contact with two trans Women.

Interviews
The original plan was to conduct 12 interviews with health & social care professionals. This was adapted to 'meetings' with individuals or small groups rather than interviews, using a loose framework of questions.

The initial tranche of meetings were conducted May – August 2016 and included professionals working with:
Shropshire Community Health NHS Trust [CHT]: One senior Manager and 5 Patient Experience Leads
Shropshire Clinical Commissioning Group [CCG] - one Commissioner and one GP [retired]
Shrewsbury & Telford Hospital NHS Trust [SaTH] – Director of Nursing

At this point, we recognised that the research was taking much longer than anticipated
Our original intention to talk to 'policy makers and providers about trans-specific issues had not proved as easy as anticipated for a whole variety of reasons:

- the complexities of the healthcare system and 'finding the right people' to talk to
- the fact that this is not a priority item on most people's busy agendas
- it became clear early on that those we spoke to didn't have much to say about the issues and/or wanted us to give them information about what they could do to improve their services – asking us for information rather than the other way around!
- most hadn't even begun to think about the issues for lesbian, gay and/or bisexual people, let alone trans people

We met with Healthwatch Shropshire towards the end of July 2016 to explain that we were making some progress in highlighting the need to address LGBT issues in a broad sense,

and – at that stage - we proposed that we piggy-back on that to encourage conversations about 'trans specific' issues at the same time.

The whole 'research' process has inevitably been 'iterative' – one contact leading to another, and the building of trusting and constructive relationships. Some of these led to opportunities to work with providers in the future, building relationships, developing awareness sessions and continuing conversations. It is at these sessions that we hoped to test out knowledge about both LGB and T issues and work out what they need to know to provide the best services possible.

Interviews, contacts and meetings continued in this way from Aug 2016 – Jan 2017[10] including those with:

- CHT – specifically sessions relevant to End of Life care delivered to a total of 40 staff over 3 sessions in different locations across the County, as well as conversations with 6 members of the Everyone Counts Equality Group and a presentation to an audience of 100 CHT staff and stakeholders, raising awareness of the issues for LGBT people. And a visit to a local community hospital, as part of a patient engagement group visit and conversation
- Robert Jones Agnes Hunt [RJAH], Orthopaedic Hospital, where SAND delivered an exploratory awareness raising / information gathering session to 16 Ward Managers
- One County-wide Residential care provider, engaging a team of 5 staff in an exploratory conversation and engaging the Director in ongoing dialogue
- One domiciliary care provider, where we had conversations with 5 senior staff and then conducted a facilitated discussion with 2 of the team
- Shropshire Partners in Care who engaged with SAND in conversation and the development & delivery of training to a total of 45 people over 4 separate sessions in different locations across the County to identify what will work best for increasing understanding and ensuring a trans aware and inclusive service
- 2 Social Work professionals about developing appropriate training

During these conversations it became clear that service providers knew very little about the health and social care needs of LGB people, and even less about Trans people. On the whole our experiences of working with people in the sector suggested that it was less about outright prejudice and deliberate discrimination and more about lack of thought and knowledge. These were not issue that most professionals in the sector had considered.

At this stage, SAND also made contact with a trans activist connected with the Swansea Centre for Innovative Ageing. They were conducting a large scale 2 year well-funded piece of research on trans people's health and social care needs in later life in Wales. A key piece of their research focussed on exploring professional knowledge, experience and perspective, with a view to develop good practice. They intended that the evidence from the research would help to raise awareness of what the issues are and the work that needs

[10] Later, in Dec 2017 we also ran an awareness raising session with 20 GPs where we were able to ask them about their own examples of practice

to be done. Two members of SAND went to visit the researcher who was more than happy to keep in touch and share findings when they become available.

At various stages SAND had considered using a survey as a way of capturing information from service providers. However, following the meeting at Swansea we realised that this wouldn't be appropriate.

Trans* Ageing & Care Project

This project[11] is funded by a 2-year programme grant from Dunhill Medical Trust to December 2017. Sponsored by Swansea University, the project is based at the Centre for Innovative Ageing in the College of Human and Health Sciences.

Very little is known about trans* people's health and social care needs in later life. This mixed-methods research project will seek to address this gap by investigating the current provision of health and social care services to older trans* people in Wales. The research will include the professional perspectives and experiences of health and social care professionals to develop good practice guidelines for improving services. This encompasses health and social care teams that deliver services to older adults in Wales including: GP clinics, mental health teams, disability teams, adult community and social care teams, and nursing and residential care staff.

Findings from the research will provide new evidence to raise awareness about gender identity and ageing for health and social care professionals across Wales. In accordance with the priorities of the Welsh Strategy for Older People (Welsh Government, 2013) the findings will help ensure that older trans* adults 'do not experience multiple discrimination' (p. 9) by identifying barriers, assumptions and actions in health and social care services which reinforce transphobic attitudes and service environments, and prevent older trans* people from receiving equal, dignified and person-centred care.

The aims of the research are:

1. To identify what support services older trans* people currently access and receive and how effective trans* people perceive these services to be in meeting their needs;
2. To examine attitudes and perceptions of health and social care professionals working with older people towards older trans* people;
3. To identify the a) health and social care needs of trans* people aged 50 and over residing in Wales across the life course, and b) the hopes, expectations and concerns of older trans* people about service provision in older age; and,
4. To produce digital stories and guidelines for health and social care practitioners on supporting older trans* people in later life and for ensuring receipt of person-centred services. Research methods include an all-Wales survey of health and social care professionals and life-history interviews with trans*-identifying adults

[11] http://trans-ageing.swan.ac.uk/

over 50 years of age.

The project will use three research methods:

1. Life-history interviews with older trans* people (50+ years of age) currently living in Wales
2. An online questionnaire of health and social professionals currently providing services to older people across Wales
3. Workshops in North and South Wales to bring professionals and community members together to develop good practice guidelines for supporting older trans* people through health and social care services.

We will use the findings to develop web-based materials for professionals to inform them about how they can provide better, more inclusive care. There will be a final conference for service providers and trans* community members in 2017 to share the findings and outcomes of the project.

The project is proudly delivered in collaboration with Unique Transgender Network and the Older LGBT Network for Wales, Age Cymru. The research will be guided by a critical reference group of which half the group will be trans* community members.

As a thorough piece of investigative research with a similar intended sectoral audience, it was sensible to revisit our approach. It made sense for SAND to wait and utilise the findings from Swansea as a way of raising awareness and testing out the issues in Shropshire.

In October 2016, SAND met again with Healthwatch Shropshire to agree an extension to the research as we awaited those results, due towards mid-2017 (this was later delayed to a projected end time of December 2017).

By January 2018, delays and illness affecting the Swansea research team led to the decision to complete and submit SAND's own research report without the Swansea findings. Having said that, we are acutely aware that the information never stops coming – that as we write, the Government is planning changes to legislation[12].

[12] https://www.theguardian.com/society/2017/oct/18/theresa-may-plans-to-let-people-change-gender-without-medical-checks

Research Findings

One of the key issues emerging from Network discussions was the treatment of transgender and non-binary people in the wider NHS system, outside of specific gender identity services[13]

Desk research illustrates the complex issues that need to be addressed and the further research that needs to be undertaken to better understand the experience of trans people accessing health and social care. The extracts below are not exhaustive but they do serve to illustrate the range of both issues and of resources currently available to providers.

Findings from Desk Research

In 2006, a team of researchers undertook a mixed quantitative/qualitative approach to collecting and analysing information on transgender and transsexual people's experiences of inequality and discrimination in the UK. The resultant report: **Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination**[14] Found that *29% of respondents felt that being trans adversely affected the way they were treated by health care professionals.*

General practitioners

Around 21% of trans people start the process by seeking help from a knowledgeable GP to begin the process of obtaining Gender Reassignment Surgery [GRS], or other relevant services. However this [2006] research also found, that another 21% of respondents' GPs either did not want to help, or in 6% of cases actually refused to help[15].

This is 12 years ago and there has been no equivalent research since to comprehensively assess any changes, but 2013 research found that,

... At best the majority of GPs are ignorant of how to treat and refer Trans patients to the gender identity services and at worst are obstructive and discriminatory. As in past surveys many respondents felt that much more work on the training of GPs and their practice staff was the principal key to improving service provision to Trans* people[16].

And, in a 2015 report, Dame Barbara Hakin is quoted as saying:

[13] Treatment and support of transgender and non binary people across the health and care sector: Symposium report Treatment and support of transgender and non-binary people across the health and care sector: NHSE Symposium report First published: September 2015

[14] Authors: Stephen Whittle, Lewis Turner and Maryam Al-Alami; Contributors: Em Rundall and Ben Thom . Press for Change and Manchester Metropolitan University

[15] http://www.pfc.org.uk/pdf/EngenderedPenalties.pdf

[16] Trans* Patients' Experiences of their GP Surgery - Annual Survey 2013
Jenny-Anne Bishop, TransForum, supported by The Lesbian & Gay Foundation local

There is an issue with GPs not knowing enough to even start the conversation, or not wanting to have the conversation in the first place. This is a very significant cultural issue and long-term change is needed to get the right approach and attitude.[17]

In 2016, Healthwatch Devon identified a lack of understanding about the **rights and status** of trans people at all levels of service delivery, and across general and specialist services[18].

- Long waiting times
- Out of date or incorrect information provided by the NHS
- Bullying and discrimination

Nurses

Just 13% of nurses feel prepared to meet the needs of their transgender patients according to a UK wide survey by the RCN, involving more than 2000 staff[19].

This research suggested that this 'could be due to lack of training, despite over three quarters encountering transgender patients in their work, and 56% caring for them directly.' Following this the Royal College of Nursing produced a guide for nursing and health care professionals, in 2016 (see resources section).

The themes outlined below are summarised from a variety of desk research sources, including a report from the House of Commons Women and Equalities Committee - **Transgender Equality, First Report of Session 2015–16.** [See Appendix 1 for their detailed recommendations].

Broader themes

- There are a huge variety of different identities under the generic term Trans and a danger of conflating gender identity with sexual orientation.

- In spite of some progress in terms of recognising LGBT rights Trans people still experience high levels of transphobia leading to high suicide rates

- Trans people encounter significant problems in using general NHS services, due to the attitude of some clinicians and other staff who lack knowledge and understanding—and in some cases are prejudiced.

- Trans people face discrimination across all areas of life, often have less robust support networks, higher instances of mental and physical health problems, and may experience loneliness

- NHS figures suggest that 1.7% of live births have some form of gender anomaly – over 1m in the UK – these are not necessarily obvious until people try for a family

[17] Treatment and support of transgender and non binary people across the health and care sector

[18] https://www.healthwatchdevon.co.uk/wp-content/uploads/2016/07/Gender-Identity-Report-FINAL-29.04.16.pdf

[19] https://rcni.com/nursing-standard/newsroom/analysis/training-and-knowledge-transgender-issues-being-left-chance-68061

- There are potentially lots of people self prescribing hormones, issues around substance abuse and self harming which potentially mean a high cost to the NHS

- Not all transgender people want to have genital surgery

- While trans people want to be able to access services just like anyone else, there are times when it is important that the provider is aware that they are trans and therefore may have particular and sometimes complex needs/health issues

They also made reference to specific issues around:

Transitioning and Gender Identity Clinics (see Appendix 2)

- Referrals
- Waiting times
- How 'trans' identity is perceived
- Treatment protocols regarding 'real life' experience

Generic Health and social care issues facing trans people (see Appendix 3)

- General mistrust of the medical establishment
- Less financial access to private treatment due to employment discrimination
- Lack of training and awareness
- Trans people themselves having to 'educate' providers
- Delays potentially causing mental health issues

What can be done to improve things

The literature[20] identifies:

- *better health policy on trans issues*
- *improved training on trans issues for practitioners*
- *assessment procedures and processes that include trans awareness*
- *treatment of trans people as 'not sick but different'*
- *funding for trans health services.*

And[21]:

- acknowledge the systemic inequality experienced by trans and non binary people
- more research into the issues they face

In 2015/16 NHS England pledged to invest an extra £4.4million in providers of gender identity services[22], with more to follow in 16/17[23] to address the unacceptable waiting times being experienced by people seeking gender surgery.

[20] https://www.equalityhumanrights.com/sites/default/files/research_report_27_trans_research_review.pdf

[21] Treatment and support of transgender and non binary people across the health and care sector: NHSE Symposium report First published: September 2015

Providers can usefully ask key organisational questions:

- What are the responsibilities of those organisations with a statutory and/or professional role in the regulation and monitoring of how health and care services are delivered to trans and non-binary people
- What does professional leadership in this field look like?
- Who is setting the standards?
- Where could organisations make a difference to the experience of trans and non-binary people?
- Where are the examples of organisations taking action to improve practice?

GPs can really make the difference in supporting their patients through the process.

- Recognition of how important the patient voice is to improving services
- Sharing information to help to understand the problems from a user-perspective and to find more creative solutions (including accessing the skills and expertise of the voluntary sector)

Nurses too can make a difference[24]

- As well as understanding more about gender dysphoria and the health issues transgender people may face, a key change that nurses can make is to stop mis-gendering patients
- Avoiding disclosing a patient's trans status to anyone who doesn't explicitly need to know
- Always discuss issues with sensitivity and in private

Hints

- Make sure you are aware of local support services, support groups and referral pathways
- Make sure that you use the name and title that the trans person wants to be called. If you are unsure – ask.
- Do not comment on someone's appearance unless asked
- Do not confuse being trans with sexual orientation
- Under the Gender Recognition Act it is illegal to disclose someone's trans status without prior consent or to anyone who does not explicitly need this information
- Make sure that your service is 'welcoming' – display trans-positive information in your workplace

- Establish an effective workplace policy for addressing discrimination, including comments about and behaviour towards trans people 'Living My Life'[25]

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[22] There are 7 Gender identity Clinics in England: London, Leeds, Daventry, Newcastle (NE), Nottingham, Sheffield and Exeter

[23] Will Huxter, Regional Director of Specialised Commissioning (London) at NHS England https://www.england.nhs.uk/2015/09/will-huxter/

[24] Fair Care for Trans Patients

[25] http://www.sexualhealthsheffield.nhs.uk/?s=Living+My+Life and Living My Life

Some resources:

It's Just Good Care, Guidance for GPs and other clinicians on the treatment of gender variant people. GIRES, 10 March 2008

Listening to the Transgender Community (15 mins) - film aimed at raising awareness of the transgender pathway amongst general practitioners. Produced by Healthwatch Hampshire & Chrysalis, a charity supporting trans-people (2015)

Recommended Questions for Monitoring purposes [p128]. In response to employers and service providers seeking guidance and information on monitoring for gender reassignment/transgender status protected characteristic, extensive research by the Equality & Human Rights Commission concluded in 2011 with recommended question sets.

Standards of Care – developed by The World Professional Association for Transgender Health (7th edition produced in 2011 – currently being updated). Provide clinical guidance for health professionals to assist transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfilment. This assistance may include primary care, gynaecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counselling, psychotherapy), and hormonal and surgical treatments.

Living My Life: information booklet and display kit **– i**ncludes a section on 'Providing the Best Possible Services for Trans People'

Shining the Light: 10 Keys to Becoming a Trans Positive Organisation – written for LGBT organisations with some transferability. Provides information and guidance about all aspects, including stories from trans people about their experiences.

A guide to trans service users' rights : Transgender wellbeing and healthcare: Produced by GIRES, funded by Department of Health - Legal aspects, NHS funding processes and waiting times, pursuing appeals and complaints, service user involvement in the NHS

Fair Care for Trans Patients**:** An RCN guide for nursing and health care professionals, 2016.

Cervical screening for transgender men (video)

Gender Identity Clinics

Findings on the Subject

Trans people don't want to receive special treatment, they just want to be treated with dignity[26].

As reported in the methodology, this has been complex research which has necessarily taken different turns.

Refreshing honesty

As part of our generic work for SAND, and reinforced by this research, we have recognised that – before we can have any discussion about what needs to happen to improve experiences – we first need to reach a point where people are prepared to **listen** to the issues and **agree** that they exist. This is a hurdle which we commonly refer to *'getting people to get that there is something to get'.*

Our experience tells us that issues for Lesbian, Gay and Bisexual people have not yet been adequately considered, let alone issues for Trans people, whose experience is traditionally less-well understood.

Anecdotally, those who have been supportive within the sector during these research conversations, admit that they know very little, haven't really considered the issues and don't think that the majority of providers, either institutions or individuals, have considered them either.

This refreshingly honest approach has led to SAND being invited to work with certain sectors to explore what would need to be delivered in terms of awareness raising and training so that the needs of LGB and T people could be better met.

A growing issue

As part of our own learning, we now understand that, over the past few years there has been an increase in the number of younger people coming forward, questioning their gender identity and challenging the notions of binary gender. This means that there is likely to be an increase in the number seeking to transition or seeking to live as their chosen gender, or to continue to challenge notions of binary gender. Clearly there are implications for the health and social care sector generally, including services for older and old people.

Lack of forethought

One conversation with a senior nursing manager stated that 'we have a 3 minute video which all staff should be able to access' for training purposes and, what staff really need is how to decide in which bay to place a trans person. Another conversation suggested that they had had a trans woman in their ward and, as far as they were aware, no-one had noticed and they were very respectful. There was no specific policy regarding trans people and to some extent care was reliant on the compassion and kindness of individuals.

[26] Shining the Light:10 keys to becoming a trans positive organisation: Benjamin Gooch Galop.org.uk

Findings on the Process

Wheels move slowly and things change all the time
Identifying and accessing 'the right people' to talk to is a long and complex business and is vulnerable to key people leaving or being moved to a different part of the health service.

Not ready
Policy makers, decision takers and service providers in Shropshire are not yet in a position to engage in strategic conversations about trans people's experiences of health & social care, or the issues that may specifically impact on them. Rather than organisational policy and procedure, there are examples of humanitarian actions of individual staff members.

Very complex
We can talk about issues impacting on trans people:

- around actual transition
- health conditions associated with having transitioned
- historic poor experiences which lead people to wait longer before accessing the treatment they need
- approaches adopted by people they come into contact with – because they are trans

Not a single issue
Whilst a key issue is the distinction between sexual identity and gender identity – one which we suggest may be unclear in the minds of many of those who consider themselves cis-gender[27] - it is difficult to extract 'Trans' from the broader 'Lesbian, Gay, Bisexual & Trans' parlance.

How we could do things differently
Some of the obstacles we have encountered have been very frustrating, others have been illuminating. Our learning from the Swansea research includes incorporating True/False and more/less confident questions or statements into a survey for professionals to illustrate the relevance of the subject to them in their own work and which may raise questions for them e.g." I feel confident in providing a health or social care service to older transgender adults".

The CHT convened 'Protected characteristic' equalities group which visited a local community hospital provided an opportunity to ask about LGBT issues. Staff who attended a brief meeting acknowledged that they need to do more thinking re issues for trans patients although they are aware that they have had some and 'treat them with respect'. They would be good contacts to go back to and develop further ideas.

[27] someone whose self-identity conforms with the gender that corresponds to their biological sex

Conclusions

It has been nigh on impossible to distinguish generic SAND work from the trans work – for example, at several meetings, it has been impossible to engage people in a dialogue about the trans research because they have been keen to pick our brains about generic LGBT issues and how they might be able to take them forward or how we might be able to help them do that.

And, of course, one of the issues has been how on earth to get busy people in an incredibly complex system, to talk to us. While we haven't been funded to make contact with service providers to talk about 'training' and change, we wouldn't be in a position to have the conversations that will include trans issues, without doing this work. Truly a piece of action research.

We are ahead of ourselves
Our original ideas about where the research may lead were far too adventurous. When we started the research, we thought we might end by considering:

- Could Shropshire provide specific clinics for trans patients?
- Should there be a special identification marker put on files or at the reception desk to identify awareness?
- What ideas might service providers have to address some of the issues facing older and old trans people in the County?

Start where people are at
This research has taught us things we did not expect to reveal. We thought we could focus on the experiences of trans people without the 'distraction' of including sexual orientation, but the service providing sectors are not ready for this. With a softly, softly approach they are willing to think about LGBT issues in a generic way and it is our job then to hone this down.

In fact, it is unhelpful for SAND to disaggregate its trans work from its LGBT work as one message leads into another and opens doors that might otherwise remain shut.

Stumbling block
There is plenty of evidence of the issues, drawn from research and reported real-life experiences, and clear ideas about how things might be improved and more specific information will become available when the Swansea research is complete [now due later in 2018]. Like everything else, the big question continues to be how to implement those changes at service delivery level.

No rocket science here
To be honest, most of it isn't rocket science and should fit perfectly into health and social care values of privacy, dignity, personalised care, adult safeguarding, compassion, good communication etc.

It's all about relationships

As a direct result of this research, SAND is now developing positive working relationships with sections of the health and social care sector and looking at collaborative ways of developing awareness and training. At the moment we are regarding these opportunities as ongoing Action Research as we will be exploring participants' knowledge/lack of knowledge of LGBT issues and what needs to happen to improve service delivery. As part of this we will input on the issues for trans people and find out what they know/need to know.

As part of the SAND work we have also got involved in CHT site visits with others representing the 9 protected characteristics. The first one of these took place mid-December 2016 and will continue into 2018. During these, we will be in a position to pose the question – what do you know about, how do you work with, what do you think the issues might be etc.

We re-looked at our original questions to assess how useful they are, who to address them to, when and what level of detail we need to go into.

- Are we, as a service and as individual service providers, aware of the issues, needs and fears that the trans community face when they need to access care or treatment?
- How do we/can we respond to these issues so that Trans people in Shropshire receive the best possible services?
- What do we need to put into place?
- Do we need more information and training?
- Do we have the right policies and procedures in place?
- Could services be delivered differently?

We concluded that these questions may provide openers for conversations but that they are still quite ambitious and we need to do much more background work to increase health and social care providers' very basic understanding of why there is a need for change.

There is so much more to know

Because the ears of the change-makers are not yet receptive to the experiences of trans people in the County, the messages that we are trying to convey remain fairly straight-forward, around treating people with respect, courtesy, asking them how they prefer to be addressed etc. This means we are not yet investing in the research with trans people which would reveal the bigger challenges to policy and practice, things like:

- the impact of taking gender changing hormones for decades
- implications of gender surgery on presenting for mammograms, cervical smears, testes scans
- the impact of dementia on retention of gender identity

Recommendations

1. SAND continues to develop relationships with service providers to build reputation and trust, capitalising on the presentations and events delivered throughout 2017.

2. SAND continues to raise issues for trans people throughout its work, including when delivering awareness and training sessions.

3. SAND waits for the publication of findings from the Swansea research and NHS England Consultation and uses them as a springboard to open up wider conversations.

4. CHT Everyone Counts equality and diversity strategy develop clear policies and build in processes to feedback, implement and monitor changes to healthcare provision, following site visits.

5. Health & social care providers work with SAND to embed good practice in training [including to students] and raise awareness and understanding about issues impacting on older and old LGBT people.

6. End of Life teams work with SAND to identify key changes to practice which would improve experiences for older and old LGBT people.

7. Domiciliary Care providers review their current staff training programmes and build in elements to ensure that carers feel confident to provide environments which feel safe to LGBT clients.

8. Care Home Providers work with SAND to develop a replicable approach to raise awareness and understanding of issues impacting on older and old LGBT people in Shropshire amongst staff.

9. SAND ensures that its own work to develop some form of accreditation framework for health & social care providers is inclusive of trans people.

Appendix 1:

Women's Equality Committee Recommendations re NHS Services

Following the last election the Women's Committee decided to initiate an enquiry looking at how far, and in what ways, trans people still have to achieve full equality; and how the outstanding issues can most effectively be addressed.

Before commencing the inquiry, they consulted informally with representatives of two key stakeholder organisations, Press for Change and Stonewall.

Their inquiry covered a wide range of policy areas, which are affected in different ways by the current devolution arrangements, including health services

In general they concluded that the Government must make a clear commitment to abide by the Yogyakarta Principles and Resolution 2048 of the Parliamentary Assembly of the Council of Europe. This would provide trans equality policy with a clear set of overall guiding principles which are in keeping with current international best practice.

Their recommendations relating to health care include:

PRINCIPLE 17. THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity. Sexual and reproductive health is a fundamental aspect of this right.

PRINCIPLE 18. PROTECTION FROM MEDICAL ABUSES

No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed.

Below are comments from the Committee hearings that relate most directly to the provision of healthcare.

Gender Recognition Act and the medicalised approach

While we recognise the importance of the Gender Recognition Act as pioneering legislation when it was passed, it is clear that the Act is now dated. The medicalised approach regarding mental-health diagnosis pathologises trans identities; as such, it runs contrary to the dignity and personal autonomy of applicants. (Paragraph 44)

Within the current Parliament, the Government must bring forward proposals to update the Gender Recognition Act, in line with the principles of gender self declaration that have been developed in other jurisdictions. In place of the present medicalised, quasi-judicial application process, an administrative process must be developed, centred on the wishes of the individual applicant, rather than on intensive analysis by doctors and lawyers. (Paragraph 45)

We have found that the NHS is letting down trans people, with too much evidence of an approach that can be said to be discriminatory and in breach of the Equality Act. (Paragraph 144)

Professional regulation of doctors

26. We welcome the evidence we received from the Parliamentary Under-Secretary of State for Public Health regarding the importance of understanding and addressing the needs of transgender patients. And the creation for this purpose by NHS England of the Transgender and Non-Binary Network is a commendable step. (Paragraph 181)

27. However, it is clear from our inquiry that trans people encounter significant problems in using general NHS services due to the attitude of some clinicians and other staff when providing care for trans patients. This is attributable to lack of knowledge and understanding—and even in some cases to out-and-out prejudice. (Paragraph 182)

28. GPs in particular too often lack an understanding of: trans identities; the diagnosis of gender dysphoria; referral pathways into Gender Identity Services; and their own role in prescribing hormone treatment. And it is asserted that in some cases this leads to appropriate care not being provided. (Paragraph 183)

29. The NHS is failing in its legal duty under the Equality Act in this regard. There is a lack of Continuing Professional Development and training in this area amongst GPs. There is also a lack of clarity about referral pathways for Gender Identity Services. And the NHS as an employer and commissioner is failing to ensure zero tolerance of transphobic behaviour amongst staff and contractors. (Paragraph 184)

30. A root-and-branch review of this matter must be conducted, completed and published within the next six months. (Paragraph 184)

31. The General Medical Council must provide clear reassurance that it takes allegations of transphobia every bit as seriously as those concerning other forms of professional misconduct. (Paragraph 185)

Treatment protocols

32. Part of the NHS's duty regarding equality for trans people is its obligation to provide appropriate Gender Identity Services to meet the needs of the trans community. (Paragraph 207)

33. We strongly welcome the long overdue trend towards the depathologisation of trans identities (decades after the same happened in respect of lesbian, gay and bisexual identities) and the explicit acknowledgement within Gender Identity Clinics that the treatable condition of gender dysphoria is not synonymous with trans identity as such. This approach must be reflected in all areas of Government policy on trans issues, not least in relation to gender recognition. (Paragraph 208)

34. We are concerned that Gender Identity Services continue to be provided as part of mental-health services. This is a relic of the days when trans identity in itself was regarded as a disease or disorder of the mind and contributes to the misleading impression that this continues to be the case. (Paragraph 209)

35. Consideration must be given to the transfer of these services to some other relevant area of clinical specialism, such as endocrinology (which deals with hormone related conditions), or their establishment as a distinct specialism in their own right. (Paragraph 209)

36. We heard that there are serious concerns within the trans community regarding the treatment protocols that are applied by Gender Identity Services, particularly in respect of clinical assessment prior to treatment and the requirement to undergo a period of "Real-Life Experience" prior to genital (reassignment / reconstructive) surgery. This requirement is seen as reflecting outdated, stereotyped attitudes to male and female gender identity. (Paragraph 210)

37. Many people now favour the adoption instead of a model involving only the granting of informed consent, which is said to be used by some providers of private care in the USA. (Paragraph 211)

38. However, we are unconvinced of the merits of the proposed informed consent only model. While there is a clear case for the granting of legal gender recognition on request, with the minimum of formalities, this approach is less appropriate for a medical intervention as profound and permanent as genital (reassignment / reconstructive) surgery. Clinicians do have a responsibility to observe ethical and professional standards, including their duty of care towards patients. In this particular area of medicine, appropriate practice also entails paying due regard to the internationally recognised guidelines of the World Professional Association for Transgender Health. In addition, clinicians practising in the NHS have a duty to ensure that the service's finite resources are spent appropriately and effectively. All of the foregoing obligations are incompatible with simply granting on demand whatever treatment patients request. (Paragraph 212)

39. The issues that exist around clinical protocols must instead be addressed through the consistent application of clear and appropriate standards across the Gender Identity Clinics. The situation described to us by Dr John Dean, Chair of the NHS National Clinical Reference Group for Gender Identity Services, whereby "there is not a standard approach or a standard training in how the guidelines are interpreted", is clearly unacceptable and must change. (Paragraph 213)

40. The Protocol and Service Guideline must make explicit the right of patients to be fully involved in their treatment and to exercise full personal autonomy in respect of their gender identity and presentation. It must be stipulated that treatment criteria are to be exercised flexibly case-by-case on that basis. (Paragraph 214)

41. Assessment prior to treatment must be undertaken in order to meet clinically necessary criteria regarding the patient's diagnosis, ability to consent to treatment and (physical and mental) fitness for treatment. The requirement to undergo "Real- Life Experience" prior to genital (reassignment / reconstructive) surgery must not entail conforming to externally imposed and arbitrary (binary) preconceptions about gender identity and presentation. It must be clear that this requirement is not about qualifying for surgery, but rather preparing the patient to cope with the profound consequences of surgery. (Paragraph 215)

Capacity and quality of services

42. The evidence is overwhelming that there are serious deficiencies in the quality and capacity of NHS Gender Identity Services. In particular, the waiting times that many patients experience prior to their first appointment (in clear breach of the legal obligation under the NHS Constitution to provide treatment within 18 weeks) and before surgery are completely unacceptable. (Paragraph 229)

43. We are also concerned at the apparent lack of any concrete plans to address the lack of specialist clinicians in this field. This will be a serious obstacle to addressing the lack of capacity, which growing demand for the service is sure to exacerbate, and cannot be ignored. (Paragraph 230)

44. The Department of Health must say in its response to us how it will work with Health Education England and other stakeholders to ensure that this is addressed. (Paragraph 230)

The Tavistock Clinic (children and adolescents)

45. We acknowledge the hugely important and pioneering work of the Tavistock Clinic in providing help and support for gender-variant children and adolescents, and their families. (Paragraph 249)

46. We recognise that there are legitimate concerns among service-users and their families about the clinical protocols which the clinic operates regarding access to puberty-blockers and cross-sex hormones. Failing to intervene in this way, or unnecessarily delaying such intervention, clearly has the potential to lead to seriously damaging consequences for very vulnerable young people, including the risk of selfharm and attempted suicide. (Paragraph 250)

47. We also recognise that the clinic has a difficult balance to strike. As with adult Gender Identity Services, clinicians have ethical and professional obligations to ensure that treatment is appropriate; and they must pay due regard to the internationally recognised guidelines of the World Professional Association for Transgender Health. In addition, care must be taken that NHS resources are spent effectively and appropriately. (Paragraph 251)

48. There is a clear and strong case that delaying treatment risks more harm than providing it. The treatment involved is primarily reversible, and the seriously dangerous consequences of not giving this treatment, including self-harming and suicide, are clearly well attested. (Paragraph 252)

49. Accordingly, we recommend that, in the current review of the service specification and protocol for the Gender Identity Development Service, consideration be given to reducing the amount of time required for the assessment that service-users must undergo before puberty-blockers and cross-sex hormones can be prescribed.

Recording names and gender identities

54. There is a need for greater awareness of trans people's legal right in most contexts to have their name and gender recorded as they wish without precondition. It is commonly assumed that there is such a thing in UK law as a "legal name", when there is not; and that legal gender must be proved in many situations when this is in fact neither required nor appropriate. (Paragraph 296)

55. The Government must take the lead by ensuring public services have clear and appropriate policies regarding the recording of individuals' names and genders. The requirement for trans people to produce a doctor's letter in order to change the gender shown in their passport inappropriately medicalises what should be simply an administrative matter. This requirement must be dropped. (Paragraph 297)

56. The UK must follow Australia's lead in introducing an option to record gender as "X" on a passport. If Australia is able to implement such a policy there is no reason why the UK cannot do the same. In the longer term, consideration should be given to the removal of gender from passports. (Paragraph 298)

57. The Government should be moving towards "non-gendering" official records as a general principle and only recording gender where it is a relevant piece of information. Where information on gender is required for monitoring purposes, it should be recorded separately from individuals' personal records and only subject to the consent of those concerned. (Paragraph 299)

Appendix 2:
Gender Identity Clinics: from Women's Equality Committee report

Referrals
There are currently about 4,500 referrals to gender identity clinics in England per year and the House of Commons Women and Equalities Committee report said the demand for the clinics is growing at 25-30% each year.

Waiting Times
One of the largest clinics, based in London, has admitted that waiting times are "between 12 and 18 months" for an initial consultation. At the current rate, it is forecasting waiting times for physical surgery to be at three-and-a-half years, by 2017. Under NHS guidelines, an initial appointment for hormone therapy and surgery should be within 18 weeks. Transgender people in the north west of England, where no clinics exists, are travelling to Leeds, Sheffield, the Midlands or London for treatment.

In addition

- Gender Identity Services continue to be provided as part of mental-health services, giving the impression that trans identity is a disease or disorder of the mind. It is argued that GPs should decide if it is a Mental health issue, as for other people who attend their clinics
- There are serious concerns about treatment protocols in Gender Identity Services, particularly regarding "Real-Life Experience" prior to genital surgery – not everyone sees the need for the system to be so inflexible and there is an argument that primary care can do more of the work
- Transgender people are usually required to undergo hormone therapy for a year, before further consultations at a gender identity clinic.
- If surgery is deemed appropriate, they are given a consultation with a surgeon - all of whom have their own individual waiting lists.
- Before having any surgery to fully transition, patients must be seen by two psychiatrists - something some believes adds to the stress of the situation unnecessarily.

Appendix 3:
Accessing care in general: from Women's Equality Committee report

- Trans people often delay seeking care due to **a general distrust of the medical establishment** and a perception of the institutional environment as being transphobic.
- Trans people in general have less financial access to high-quality care due to **discrimination in employment and the costs of transition related care** (when not NHS funded).
- Delaying accessing care can have a **negative impact** on mental and physical health as well as a strain on social relations.
- Few care providers have the necessary **training** to be able to cater to trans specific needs in a non-discriminatory environment.
- Trans people are often forced to educate care providers or clinicians themselves on basic trans etiquette such as not asking intrusive/irrelevant questions, not getting flustered when peoples' bodies don't necessarily match with gendered assumptions, and keeping patients confidentiality.
- Trans people face higher **level of domestic and personal abuse** than their cis peers. This abuse can come from family, friends, or from staff in a care / clinical environment. Care workers may need to navigate very complex social situations where abusive situations may appear.

Healthcare in later life:

- It is now possible for trans people to change their gender markers on their NHS records when they get legal recognition of their gender. However, this means that trans people are **often not automatically invited to attend some screenings** (e.g. prostate, cervical, and breast cancer screens) in later life which may be medically relevant to them.
- Very little is known about the **long term effect of hormone therapy** on trans patients. Particular areas of concern include how hormone therapy might alter bone density or may result in blood problems later in life.
- Very **little research** has been done into how hormone doses should change as patients get older, and how hormone treatments interact with various other drugs (which may be increasingly important as a person ages as they are likely to take more medications).
- Trans people have an **increased likelihood of experiencing particular health complaints** depending on what medical interventions they have had. A trans-feminine person who has had bottom surgery is at increased risk of rectovaginal fistula and urinary tract infections, and a trans-masculine person on hormone therapy has increased risk of liver problems and diabetes.

Transitioning in later life

- Many trans people may choose to wait until later in life, after family and work commitments are less pressing, to undergo any transition related healthcare. However, older people often have more entrenched social roles and so making these changes can sometimes be more complex at this time.
- Older people may have increased health issues, i.e. heart disease or high blood pressure, which can make transition related medical interventions riskier