

Equalities, Human Rights and Civil Justice Committee

18th Meeting, 2022 (Session 6), Tuesday 14 June 2022

Gender Recognition Reform (Scotland) Bill

Note by the Clerk

Introduction

1. [The Gender Recognition Reform \(Scotland\) Bill](#) was introduced in the Parliament by the Cabinet Secretary for Social Justice, Housing and Local Government, Shona Robison MSP on 2 March 2022 and referred to the Equalities, Human Rights and Civil Justice Committee.
2. The Bill and accompanying documents can be accessed [here](#).
3. The Bill amends the [Gender Recognition Act 2004](#) to reform the grounds and procedure for obtaining legal gender recognition. The process under the GRA has been in place since 2005. Applicants must either have been born in Scotland or be ordinarily resident here.
4. The key differences between the current procedure and those provided in the Bill are:
 - The removal of the requirement for applicants to have a diagnosis of gender dysphoria and the removal of the requirement for medical reports;
 - A reduction in the period for which an applicant must live in their acquired gender before submitting an application from two years to three months;
 - The introduction of a mandatory three-month reflection period;
 - The removal of the Gender Recognition Panel (GRP). Applications will be made instead to the Registrar General for Scotland; and
 - A reduction in the minimum age for applicants from 18 to 16.
5. The Bill also creates a specific offence of knowingly making a false statutory declaration in an application for a GRC and creates an offence of knowingly including information which is false.
6. According to the Scottish Government's [policy memorandum](#), the Bill will simplify and improve the process in Scotland for those applying for legal gender recognition. It believes the current system can have an adverse impact on applicants due to the requirement for a medical diagnosis and supporting evidence.

Background

7. The Scottish Government undertook two separate consultations. The first ran from 9 November 2017 to 1 March 2018. It sought views on areas including reducing the minimum age of applicants and removing medical requirements.
8. The second consultation on the draft bill ran from 17 December 2019 to 17 March 2020. It sought views on areas including the requirement for applicants to live in their acquired gender for three months and on the three-month reflection period.

Approach to Stage 1 consideration

9. At its meeting on 15 March 2022, the Committee agreed its approach to Stage 1 scrutiny of the Bill. It began taking oral evidence on 17 May 2022 and will continue taking evidence throughout May and June.

Oral evidence

10. At its meeting on [Tuesday 17 May](#), the Committee heard from

- Vic Valentine, Scottish Trans Alliance & Equality Network, Dr Mhairi Crawford, LGBT Youth Scotland, Colin Macfarlane, Stonewall Scotland and then from Alasdair MacDonald and Melanie Field, Equality and Human Rights Commission (EHRC).

11. At its meeting on [Tuesday 24 May](#), the Committee heard from organisations representing children and young people and sports organisations.

- Bruce Adamson, Children and Young People's Commissioner Scotland, Ellie Gomersall, President-Elect of NUS Scotland and then from Hugh Torrance, LEAP Sports Scotland and Malcolm Dingwall-Smith, sportscotland.

12. At its meeting on [Tuesday 31 May](#), the Committee heard from

- Susan Smith, For Women Scotland, Lucy Hunter Blackburn, Murray Blackburn Mackenzie, Malcolm Clark, LGB Alliance, Dr Kate Coleman, Keep Prisons Single Sex and then from Catherine Murphy, Engender, Sandy Brindley, Rape Crisis Scotland, Naomi McAuliffe, Amnesty International UK and Jen Ang, Justright Scotland.

13. At its meeting on [Tuesday 7 June](#), the Committee heard evidence focussing on the Bill's roll out in practice and on faith and secular groups:

- Paul Lowe, Registrar General for Scotland, James Kerr, Deputy Chief Executive and Robert Strachan, Head of Strategy and Improvement, both of Scottish Prison Service, Dr Kevin Guyan, University of Glasgow and then from Anthony Horan, Director, Catholic Parliamentary Office of the Bishops' Conference Scotland, Rev Karen Hendry, Vice Convener of the Faith Impact Forum, Minister of Yoker Parish

Church, Church of Scotland, Chris Ringland, Public Policy Officer, Evangelical Alliance and Fraser Sutherland, Chief Executive Officer, the Humanist Society Scotland.

14. At today's meeting, the Committee will hear from academics and legal experts and then from health organisations.

- Professor Sharon Cowan, Professor of Feminist and Queer Legal Studies, University of Edinburgh School of Law, Naomi Cunningham, Barrister, Outer Temple Chambers and Chair, Sex Matters, Karon Monaghan QC, Barrister, Matrix Chambers, and then from David Parker, Lead Clinician, the National Gender Identity Clinical Network Scotland.

15. Written submissions received from relevant witnesses at today's evidence session are linked at [Annexe A](#).

16. The Royal College of General Practitioners was also invited but was unable to attend the session so has provided a written submission which is included at [Annexe B](#). This will be published on the Committee's webpage in due course.

17. The meeting will be held in hybrid form. Members of the public can watch the evidence session live on the Scottish Parliament TV website from 09.30am on Tuesday 14 June.

<https://www.scottishparliament.tv/>

18. Following this evidence session, the Committee will consider the evidence received as part of the Stage 1 scrutiny of the Bill.

Written evidence

19. The Committee issued two [call for views](#) on the Bill. The first in the form of a survey for individual respondents and the second, where individuals or organisations could provide a more detailed response. The Calls for Views closed on 16 May 2022. Written submissions are published on the Committee's [webpage](#).

20. A [SPICe briefing](#) setting out further detail on the Bill was published on 10 March 2022.

Next steps

21. The Committee is due to report to the Parliament on the general principles of the Bill later this year.

Clerks to the Committee
June 2022

The following documents are included for this meeting:-

- Annexe A: written submissions to our consultation from today's witnesses
- Annexe B: written evidence from The Royal College of General Practitioners

Annexe A

Gender Recognition Reform (Scotland) Bill

Written submissions received from:

Panel 1 witnesses

1. [Sharon Cowan, Professor of Feminist and Queer Legal Studies at the University of Edinburgh School of Law](#)

Annexe B

Gender Recognition Reform (Scotland) Bill

Written evidence and position statement on providing care to transgender patients from The Royal College of GPs.

7 June 2022

Dear Convenor

Royal College of General Practitioners Scotland - Gender Recognition Reform (Scotland) Bill

I am writing on behalf of the Royal College of General Practitioners (RCGP) Scotland to give evidence to the Equalities, Human Rights and Civil Justice Committee as part of its scrutiny of the Gender Recognition Reform (Scotland) Bill at Stage 1.

RCGP Scotland welcomes the opportunity to submit evidence to this Bill. General practice plays a vital role in ensuring that individuals questioning their gender receive the care they need. GPs are most often the first point of contact with the health care system for these patients, and are expected to approach their holistic care openly, respectfully, sensitively and without bias.

RCGP describes the overall role of the GP in providing care to patients with gender dysphoria as to:

- I. Holistically assess the patient's health needs, collaborating with other healthcare professionals and services as relevant. GPs should be mindful that approaching a healthcare professional to discuss their gender identity needs can be considerably distressing for patients.
- II. Promptly refer patients to a Gender Identity Clinic (GIC) or equivalent if there are indications of gender dysphoria and the person requests treatment or wishes to consult with a gender identity specialist for further advice. There are currently four GICs in Scotland, most of which accept regional referrals with one accepting referrals from across Scotland as well as self-referrals. In Scotland, under the Referral to Treatment Standard, there is a maximum waiting time of 18 weeks for diagnostic tests, assessments and treatment if required. Scotland's main GIC, the Sandyford clinic, has an average waiting time of 12 months for an initial appointment.
- III. Liaise and work with GICs and gender specialists to jointly provide effective and timely treatment for patients. This includes considering taking on the ongoing prescribing of medication for patients and the monitoring of any side effects, where that is resourced and joint prescribing arrangements between primary and specialist care are agreed.
- IV. Recognise that the family members of a patient experiencing gender dysphoria also face significant challenges and may need further support where appropriate.

- V. Provide holistic care for their other medical needs, as well as signposting to other sources of support.

The provision of detailed advice about gender identity issues and associated treatments does not fall within the remit of a GPs education and training. Our membership tells us that GPs often feel it is outside their area of competence to undertake assessment or treatment for patients with gender dysphoria.

GPs face significant challenges with accessing advice from specialists and there are limited Continued Professional Development (CPD) programmes available for gender identity and trans health issues. The UK lacks a nationally recognised training programme for gender identity healthcare. It is also important to note that GPs undertaking CPD in gender identity would not reduce the requirement for access to specialist advice and support. There is an urgent need to increase the capacity of gender identity specialists and clinics and expand the understanding of gender variance issues across the entire health system, including more definitive knowledge about the causes of rapidly increasing referrals and the outcomes of interventions or 'wait and see' policies.

Furthermore, a major issue facing this area of healthcare is the significant lack of robust, comprehensive evidence around the outcomes, side effects and long-term consequences of such treatments for people with gender dysphoria, particularly children and young people. GPs are also facing increasing difficulties addressing patient requests for "bridging" prescriptions, particularly for those patients who have self-started medication, including medication which they have procured over the internet.

RCGP Scotland is represented on the Scottish Government's Primary Care Subgroup of NSS's Gender Reassignment Protocol Review. The intention of the group is to, *"take into account the role of primary and community care in supporting gender identity services, recognising aspects of ongoing care of trans and non-binary individuals who have accessed specialist services that will be managed in such a setting"*. The group is multidisciplinary and includes members of the trans community. Discussions have been very constructive, and it is felt that the group will achieve an approach to care, and especially prescribing, which, if adequately resourced, would improve the care given to those seeking gender reassignment. The College is very pleased to be contributing to this important work.

I include the RCGP position statement on the role of the GP in caring for gender-questioning and transgender patients to give further evidence to the committee.

Yours sincerely

Dr Catriona Morton
Deputy Chair (Policy) RCGP Scotland

The role of the GP in caring for gender-questioning and transgender patients

RCGP Position Statement

June 2019

Executive summary

GPs are most often the first point of contact with the health care system for individuals questioning their gender. In some cases, GPs can be the first people they confide in about their gender identity or uncertainties about their gender identity. General practice plays a vital role in ensuring these patients receive the care they need. GPs are expected to approach the holistic care of gender-questioning and transgender patients as they do with every patient – openly, respectfully, sensitively and without bias.

The Royal College of GPs recognises that GPs are not experienced in treating and managing patients with gender dysphoria and trans health issues. Gender dysphoria and gender identity issues are not part of the GP curriculum or GP Specialty Training, and GPs are currently required to refer patients experiencing gender dysphoria to gender identity specialists for further assessment and treatment advice. GPs face difficulties in accessing gender identity specialists in a timely way which often has severe implications for the mental and physical health of their patients. As such, GPs are under increasing pressure to provide services which are usually provided in specialist clinics, as they lie outside the remit of a GPs generalist expertise, with limited access to specialist support.

There is an urgent need to increase the capacity of gender identity specialists and clinics and expand the understanding of gender variance issues across the entire health system, including more definitive knowledge about the causes of rapidly increasing referrals and the outcomes of interventions or 'wait and see' policies. The gaps in education, guidance and training for GPs around treating gender dysphoria for both adults and children, and managing broader trans health issues, also needs to be urgently addressed.

Introduction

This paper provides an overview of the key issues facing gender-questioning and transgender patients, general practice and the broader health system. It establishes the RCGP's position on the role of a GP in providing care to patients experiencing gender dysphoria, the policy principles underpinning this position and recommendations for ensuring these patients receive equal access to the highest standard of care.

The following are common definitions of terms in this document that are provided for clarification. They are provided for explanation and their use is not necessarily endorsed by the Royal College of General Practitioners.

Key definitions

Gender identity: A person's self-identification and expression as male, female or other gender (e.g. gender neutral, non-binary, gender fluid, gender queer).

Gender dysphoria: Distress or discomfort experienced due to a discrepancy between a person's gender identity and their biological sex observed at birth.

Gender questioning: A person who may be processing, questioning, or exploring how they want to express their gender identity.

Gender Identity Disorder (GID): The International Classification of Diseases (ICD) 10 states that gender identity disorder is a disorder characterized by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex, manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery.

Transgender/Trans: An umbrella term for people whose gender identity and/or gender expression differs from their biological sex observed at birth. Trans people may or may not decide to alter their bodies hormonally and/or surgically.

Transsexualism: The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to have treatment to make a person's physical appearance more consistent with their gender identity.

Current gender identity services

1. The General Medical Council (GMC) advises that doctors promptly refer patients requesting treatment for gender dysphoria to GICs or an experienced gender specialist (who has evidence of relevant training and at least two years' experience working in a specialised gender dysphoria practice such as an NHS GIC).
2. Current service provision in England is network-based, shaped around seven NHS Gender Identity Clinics (GICs) for adults, three providers of adult genital reconstruction surgery and only one designated provider of gender identity development services for children, adolescents and young people, the Tavistock and Portman NHS Foundation Trust, which also offers services to adults and to patients from Scotland and Wales.
3. There are currently four GICs in Scotland, most of which accept regional referrals with one accepting referrals from across Scotland as well as self-referrals.
4. Welsh GPs will soon be able to directly refer patients over the age of 17 to the Wales Gender Identity Clinic. The clinic will assess patients and establish treatment plans where appropriate, before discharging the patient back to the GP practice. Patients under the age of 17 are referred to the Child & Adolescent Mental Health Service (CAMHS). There is currently no gender identity service in Wales for people under the age of 17.
5. In Northern Ireland, there is a paediatric gender identity service which accepts referrals from the CAMHS. There is also the Brackenburn Clinic in Belfast which provides a Regional Gender Identity Service.

Key issues

A changing landscape, increasing demand and insufficient system capacity

6. In England, GICs have seen a 240% overall increase in referrals over five years. The Tavistock & Portman clinic alone received 283 referrals in March 2019, an 8.43% increase from March 2018. In Scotland referrals to GICs have also increased markedly with the largest increase between 2014 and 2015. In August 2017, the Welsh Health Secretary Vaughan Gething spoke publicly about the increasing demand for transgender health services in Wales, which led to the recent opening of the Wales Gender Identity Clinic. There is currently no official data available on the increase in referrals to the Brackenburn Clinic in Northern Ireland.
7. Under the NHS Constitution for England, the maximum waiting time for an initial specialist appointment following referral is 18 weeks. As of 2018, the average waiting time for an initial appointment at a GIC in England following a GP referral was 18 months, with around 7,500 adults waiting for a first appointment as of August 2018. In 2016, NHS England pledged to reduce waiting times to below 18 weeks by 2018.

8. In Scotland, under the Referral to Treatment Standard there is a maximum waiting time of 18 weeks for diagnostic tests, assessments and treatment if required. Scotland's main GIC, the Sandyford clinic, has an average waiting time of 12 months for an initial appointment.
9. If a person is registered with a Welsh GP they are subject to the NHS Wales waiting times and referral criteria which includes a waiting time target of 26 weeks or less from referral to treatment.
10. As of March 2018, the waiting time target for an initial specialist appointment in Northern Ireland is no longer than 9 weeks for at least 50% of patients, with no patient waiting longer than 52 weeks. The Brackenburn Clinic in Northern Ireland has a current waiting time of approximately 2 years for an initial appointment with the Regional Gender Service following referral.
11. A report on transgender equality published by the House of Commons Women and Equalities Committee in January 2016 found "serious deficiencies in the quality and capacity of NHS gender identity services" and expressed concern about "the apparent lack of any concrete plans to address the lack of specialist clinicians in this field." The Committee reports the uneven geographical distribution of GICs, meaning people need to travel long distances to access treatment.
12. Whilst the current GP curriculum broadly references the need for GPs to adapt their clinical approach for gay, lesbian and transgender people, it is unsurprising that the House of Commons Committee report also found that GPs often lack a deeper understanding of trans identities, gender dysphoria, referral pathways into gender identity services, and their own role in prescribing hormone treatment. It was asserted that in some cases this leads to appropriate care not being provided.
13. The UK lacks a nationally recognised training programme for gender identity healthcare. Although there are apprenticeship training models in several specialist GICs and guidelines are available from various organisations such as the British Association of Gender Identity Specialists (BAGIS), the European Professional Association for Transgender Health (EPATH) and the World Professional Association for Transgender Health (WPATH), the GIHP workforce needs to expand rapidly to meet service need therefore a comprehensive national training programme is needed.
14. Whilst in the past, many transgender patients sought a gender transition treatment, increasingly many people identify with a range of gender types (such as trans, fluid, non-binary and gender-queer). Not all these people seek interventions for their gender dysphoria. Gender identity services are also needed for people who are uncomfortable or distressed by their biological sex or gender roles and behaviours assigned to them by society, but do not wish to alter their sexual characteristics.
15. The significant lack of evidence for treatments and interventions which may be offered to people with dysphoria is a major issue facing this area of healthcare. There are also differences in the types and stages of treatment for patients with gender dysphoria depending on their age or stage of life. Gonadorelin (GnRH) analogues are one of the main types of treatment for young people with gender dysphoria. These have long been used to treat young children who start puberty too early, however less is known about their long-term safety in transgender adolescents. Children who have

been on GnRH for a certain period of time and are roughly 16 years of age can be offered cross-sex hormones by the NHS, the effects of which can be irreversible. There is a significant lack of robust, comprehensive evidence around the outcomes, side effects and unintended consequences of such treatments for people with gender dysphoria, particularly children and young people, which prevents GPs from helping patients and their families in making an informed decision.

Transgender patient and family experiences

16. Of the 108,100 respondents to the Government Equalities Office (GEO) National LGBT Survey, 13% of respondents were transgender. Of these respondents, 38% accessing general healthcare services reported a negative experience due to their gender identity. Some of the respondents specifically called for healthcare professionals to be trained in not making assumptions about their patients' gender identity.
17. Of the 2,900 respondents who elaborated on their experiences of gender transition and gender identity services, the emerging overall view was of hard-to-access services, and a lack of knowledge among GPs about what services are available and how to access them. Of all the trans respondents who had tried accessing gender identity services, 80% said that access had not been easy, with the majority of these (68%) reporting that waiting times had been too long. The survey also found that 16% of trans respondents had gone outside the UK to pay for healthcare or medical treatment, and a further 50% were considering it.
18. Informal feedback is that some new university students may not register with a new GP practice near to their campus due to fear of dropping off the waiting list for a GIC appointment, which is linked to referral from a GP in the surgery they were originally registered at.
19. NHS England's transgender communities listening exercise from 2013/14 found that most of the frustrations experienced by trans patients and their families with the NHS system related to a perceived poor cooperation between GPs and GICs.

Gender identity clinic perspectives

20. The significant increase in referrals to GICs and the lack of capacity in the system to meet this demand for specialist care, has placed immense pressure on GICs to meet the demand from both patients and other healthcare professionals including GPs.
21. The Tavistock and Portman NHS Trust website states that GICs do not endorse GPs prescribing hormone therapy or bridging prescriptions for self-started, internet-sourced hormones, until a GIC has made a full assessment of the patient.

GP perspectives

22. GPs are expert generalists. The provision of detailed advice about gender identity issues and associated treatments does not fall within the remit of a GPs education and training, therefore GPs often feel it its outside their area of competence to advise patients with gender dysphoria. However, GPs can contextualise a person's presentation of gender dysphoria with other conditions, particularly autism, and within their broader environment. GPs may also be able to contextualise the distress felt by the individual against that person's medical history and possibly relate it to the distress and discomfort often experienced by many young people during puberty and adolescence.
23. The GMC guidance suggests if GPs feel a lack of knowledge or experience about the healthcare needs of trans people, they ask for advice from an experienced gender specialist and address their training needs as part of continuing professional development. However, GPs face significant challenges with accessing advice from specialists and there are limited CPD programmes available for gender identity and trans health issues. It is also important to note that GPs undertaking CPD in gender identity would not reduce the requirement for access to specialist advice and support.
24. GPs are facing increasing difficulties addressing patient requests for "bridging" prescriptions, particularly for those patients who have self-started medication, including medication which they have procured over the internet.

GMC advice on 'bridging prescriptions' for trans and non-binary people recommends that GPs should only consider issuing bridging prescriptions in cases where all the following criteria are met:

- a. the patient is already self-prescribing from an unregulated source (over the internet or otherwise on the black market)
- b. the bridging prescription is intended to mitigate a risk of self-harm or suicide, *and*
- c. the doctor has sought the advice of an experienced gender specialist, and prescribes the lowest acceptable dose in the circumstances.

Additionally, GMC advice references a harm reduction approach, whereby GPs or other medical practitioners may prescriber bridging endocrine treatments as part of a holding or harm reduction strategy while the patient awaits assessment and advice from a specialist, if it is judged that this approach benefits the patient overall. However, this advice fails to address the ethical and safety issues around prescribing outside the limits of one's competence, the significant medicolegal implications this carries and the non-pharmacological needs of patients as they await access to a specialist.

Further, the GMC advice above conflicts with their *Good Medical Practice* ethical guidance which states that GPs must recognise and work within the limits of their competence. As such, GPs face conflicting messages about how to approach advising and prescribing for these patients, which poses a significant risk to GPs in their practice, and patient safety. GPs are ultimately responsible for their prescribing and should not be pressured into prescribing where they feel it is unsafe or involves unacceptable risks. The GMC advice needs review and clarification.

25. GPs face even greater challenges in addressing the needs of children and young people under the age of 16 who are experiencing gender dysphoria or are in the process of transitioning to another gender. These challenges include the vulnerabilities of young people at this time and the heightened risk of self-harm and attempted suicide, the concerns of parents who may not be accepting of what is happening to their child and the lack of a robust evidence base for interventions. Parental and carer involvement in the care of these patients is crucial and adds another layer complexity to the GPs role.
26. GPs also face difficulties with current IT systems which do not accommodate for transgender and non-binary patients in relation to referrals and screening. For example, a trans male cannot be referred for a cervical smear or to a gynaecology clinic if they are recorded as male in the practice database, despite still having female reproductive organs.

Policy principles

27. The policy principles underpinning the RCGP's position statement reflect the role of the GP in working with and alongside specialist colleagues, to care for any patient presenting with a relatively rare or infrequent physical and/or psychological experience, within a system of services which are adequately funded and delivered.
 - i. GPs and their teams are required to show the same level of support, dignity, respect, sensitivity and understanding, to patients with gender dysphoria or trans patients, as they would with any other patient.
 - ii. GPs should not be expected to fill the gaps in commissioned gender identity specialists and clinics. Patients who are experiencing gender dysphoria should not have to resort to self-medication without the advice of a gender identity specialist.
 - iii. Patients with possible or diagnosed gender dysphoria, or who self-define as trans, should receive prompt and timely access to the skills of relevant healthcare professionals across the healthcare system (GPs, gender identity specialists, mental health professionals, counsellors and so forth) and appropriate treatment when they need it. These patients should have access to high quality, joined-up,

person-centred healthcare based on robust evidence.

- iv. GPs should be trained and prepared to provide high-quality, *holistic* care to patients who identify as suffering from or are diagnosed as having gender dysphoria. The GP curriculum should be enhanced to develop GPs' knowledge of gender variance and trans health issues. There should also be comprehensive resources readily available to GPs to ensure they can keep their professional knowledge about these issues up to date, and provide the appropriate support, advice and referral information to patients with various types of gender identity needs. This does not remove the need for gender identity specialists and there should no expectation for GPs to advise patients outside the remit of their role as expert generalist, even if some GPs have more training than others in gender identity and trans health.

The role of the GP

28. Based on the above principles, and with consideration of current guidance from various organisations, we believe the overall role of the GP in providing care to patients with gender dysphoria is to:

- i. Holistically assess the patient's health needs, collaborating with other healthcare professionals and services as relevant.

GPs should be mindful that patients often find it very difficult to confide their feelings of gender incongruence and that approaching a healthcare professional to discuss their gender identity needs can be considerably distressing for them. GPs and their practice teams should approach these patients openly, respectfully and sensitively, with an awareness and understanding that a person's outward appearance may not necessarily correspond to their gender identity, particularly at early stages of the person's journey to exploring their gender identity.

- ii. Promptly refer patients to a GIC or equivalent if they exhibit signs of gender dysphoria and request treatment or wish to consult with a gender identity specialist for further advice.
- iii. Liaise and work with GICs and gender specialists in the same way as any other specialist, to jointly provide effective and timely treatment for patients. This includes considering taking on the ongoing prescribing of medication for patients and the monitoring of any side effects, with the appropriate funding, after a patient has been discharged from a GIC.

- It is common for GPs to work under Shared Care Agreements (SCAs) set up between GICs and practices to provide joint care for

patients. It is important that SCAs are agreed upon by all parties involved, ensuring the appropriate levels of resource, competence and expertise are established, as informed by the patient's level of medical risk. NHS bodies need to ensure that local shared care arrangements are adequately funded to support the ongoing care and treatment of patients.

- When responsibility for ongoing medical monitoring and prescribing is assumed by a GP, the limitations of this need to be recognised and mitigated. This is especially important for children and young people, where there is concern regarding the outcomes of some interventions. The GIC involved in the SCA should have access to the patient's GP records and be accessible to provide specialist consultation to GPs to ensure the patient is being monitored correctly and the appropriate dosages of medication are being prescribed based on the progress of the patient.
- iv. Recognise that the family members of a patient experiencing gender dysphoria also face significant challenges and refer these family members to further support services where appropriate.
- v. Provide appropriate treatment or signposting to patients presenting with gender dysphoria alongside other social or medical issues. This may include referring the patient to mental health services or engaging with social care, safeguarding or sexual health colleagues.

UK-wide policy recommendations

29. To ensure gender-questioning and trans patients are receiving the care and advice they need, when they need it, it is crucial that GPs, primary care teams and the wider health system are equipped with the adequate knowledge, skills and resources to address these needs.
30. The RCGP calls for the implementation of the following policy recommendations (outlined in the boxes below) as priority to enabling a high-quality service over the next five years. It is vital that frontline GPs, patients and the broader trans community are involved in the design and implementation of changes to the current system.

Expanding and improving services

31. NHS England is taking steps to address the insufficient clinical capacity and geographical inequality of gender identity services across England. A two-year pilot was agreed in January 2019 whereby the Greater Manchester Health & Social Care Partnership is jointly working with NHS England to build a new model of healthcare for transgender and non-binary people in Greater

Manchester, as there are currently no specialist clinics in the North West of England. NHS England is also developing a new model for gender identity services – we await the details around this new model and the evaluation of the Greater Manchester pilot, and highlight the need to ensure there is a sufficient specialist workforce to support the expansion of clinics.

32. The RCGP will work with the other Royal Colleges, the GMC and the NHS, to collectively improve gender identity services for patients, reduce barriers to accessing these services and ensure the appropriate **educational pathways and standards of accreditation** are in place to enable doctors to pursue professional development in this area.

- i. We strongly encourage the NHS to consider the **expansion of gender identity services in the Devolved Nations and for gender-questioning children** as well as adults.
- ii. The NHS should urgently address the extensive waiting lists for GICs across the country and ensure the **commissioning of gender identity services** is sufficient to support the level and spread demand for specialist advice from patients and GPs.
- iii. **Up-to-date IT systems** and associated IT training is needed to enable GPs and other healthcare professionals to treat trans patients and patients with gender dysphoria in a safe and respectful manner (for example, documenting generalist and specialist advice in writing as part of the patient record, maintaining safe access to screening programmes such as smears after a patient's gender has been changed on records). **NHS systems should record codes for biological sex** as well as gender identity, while ensuring all patients are afforded the right to express their preferences for how they wish to be named and referred to by their GP and other healthcare professionals.

Preparing GPs and their teams

33. The RCGP is currently developing an **e-Learning** module, which aims to expand the understanding of gender variance for primary care, covering patients who are transgender and non-binary. The module will cover a wide range of issues including the risks and benefits of prescribing, the ever-changing and expanding language in this area and the need to treat patients with respect, confronting reasons why some GPs may feel uncomfortable advising patients on gender identity issues.
34. The Royal College of Physicians with the support of NHS England, is developing an **interprofessional postgraduate certificate and diploma (PGCert/Dip) in GIHP** for GPs and other regulated healthcare professionals working within the NHS who wish to deepen their skills and expertise in gender identity and gender variance. The PGCert/Dip is planned to launch on

1 November 2019. The RCGP welcomes and support the development of this programme of study as a way of expanding the capacity of the wider system and ensuring specialist practitioners working in this field are appropriately trained and meeting threshold standards of competence.

- i. The **GP curriculum** should cover gender dysphoria and broader trans health issues to ensure GPs have an understanding of these issues for both adults and children, to inform the care and advice delivered to these patients.
- ii. Education and training bodies, commissioners and employers should provide **training programmes and materials** which help and support GPs and their teams with engaging with and advising trans patients. These materials should include comprehensive, consistently updated, evidence-based information about identifying gender dysphoria, interacting with patients in a respectful and unbiased manner, signposting patients to relevant support services, referring patients to specialist services when appropriate, and understanding their role as a GP in the prescription of various treatments. Such materials should also include information about the uncertainties in contemporary knowledge about gender dysphoria and associated interventions, and guidance for GPs when considering SCAs.

Research & regulation

- i. The promotion and funding of **independent research** into the effects of various forms of interventions (including 'wait and see' policies) for gender dysphoria is urgently needed, to ensure there is a robust evidence base which GPs and other healthcare professionals can rely upon when advising patients and their families. There are currently significant gaps in evidence for nearly all aspects of clinical management of gender dysphoria in youth. Urgent investment in research on the impacts of treatments for **children and young people** is needed.
- ii. The **fundamental standards of care** and principles of **oversight and regulation** applied by the Care Quality Commission (CQC) in England and equivalent bodies in the Devolved Nations, should be applied to **all providers** of gender identity services, through regular service reviews and publication of results.