Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Governing Body Meeting

Date: 1st December 2020
Time: 1.30pm
Location: Virtual meeting to be held via MS Teams

Agenda Number :	6.1
Title:	Equality Impact Assessment for *Supporting Trans People: best practice guidance for health and care practitioners*
Purpose: Decision	
Key Points for Discussion:	

To share with Governing Body the Equality Impact Assessment (EIA) undertaken in relation to the 'Supporting Trans People: best practice guidance' toolkit, originally tabled in November 2019.

The toolkit was commissioned by Bristol CCG and a range of partner organisations in 2018. Its original purpose was to support health and care practitioners to better understand issues around gender identity and what it means to be trans – in order to provide more compassionate care and an improved experience of health and care services for transgender people. BNSSG CCG remains committed to this aim, and to ensuring the best possible health and care for our whole population.

The EIA has been carried out following representations from the public and local groups, to assess the potential impact of the toolkit as currently written, on people with one or more protected characteristics. Alongside desk research and legal advice; engagement with clinicians, local women's organisations and members of the public has helped to inform the EIA. It highlights potential negative impacts on the basis of sex, age, disability and faith/religion. The potential impact on all other characteristics was identified as 'neutral', apart from gender reassignment where a positive impact was noted.

A series of edits are recommended to mitigate against identified risks, which include:

- Amending the 'Treatment works' section; including removing references to the use of hormone blockers in young people pending the outcome of the nationally commissioned Hilary Cass review.
- Amending the treatment pathways section; being clear that this section is intended to illustrate a typical patient journey rather than define a single pathway.
- Acknowledging sex as a protected characteristic under law in the crisis management section, and making stronger reference to national guidance in this area.
- Removing reference to suicidality in young people and improving the use of statistics throughout the document; contextualising with sample sizes.
- Including more case studies to bring people's experiences of accessing local health and care

services to life.

As well as mitigating the risks identified through the EIA process, the proposed edits bring the focus of the toolkit back to its original intent and purpose: to provide a clear guide for practitioners that will improve understanding, awareness ultimately the care and experience of transgender people in BNSSG.

Should Governing Body approve the recommendations, the CCG will seek to progress these further with the toolkit writing group, as well as our partners in the system (including NBT and AWP) in order to reach a final draft that we can collectively endorse.

We also recommend keeping the EIA process open for a further two weeks for any additional contributions following the publication of this document.

Recommendations:	Governing Body is asked to: • Note the contents of the EIA and subsequent recommendations. • Approve the recommendations made. • Keep the EIA process open for a further two weeks to incorporate any additional views following publication of this document.
Previously Considered By and feedback :	The Transgender Toolkit and progression of the EIA has been considered by the Governing Body on a regular basis since November 2019.
Management of Declared Interest:	None
Risk and Assurance:	N/A
Financial / Resource Implications:	No specific financial implications relevant to this report.
Legal, Policy and Regulatory Requirements:	As set out in the EIA.
How does this reduce Health Inequalities:	The toolkit was designed to improve the experience of transgender people when accessing healthcare. Improved access and experience is proven to have a positive impact on equity and outcomes.
How does this impact on Equality & diversity	Both the Toolkit and the EIA relate directly to equality and diversity.
Patient and Public Involvement:	The public involvement undertaken is outlined in the Equality Impact Assessment.

Communications and Engagement:	N/A
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Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Equality Impact Assessment

Supporting Trans People: best practice guidance for health and care practitioners

Version: V1.2
24.11.2020

Equality Impact Assessment Form

1. What are the main aims, purpose and outcomes of the proposal?

Purpose of the Toolkit

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) takes its responsibilities with regard to equality, diversity and inclusion extremely seriously. We are committed to engaging with our whole population and designing and buying services that are informed by their needs and experiences. This Equality Impact Assessment (EIA) demonstrates our compliance with the Public Sector Equality Duty and our commitment to be transparent by publishing equality information.

The *Supporting Trans People Toolkit* (the toolkit) was commissioned in 2018, by Bristol CCG, Bristol Independent Mental Health Network (BIHMN), Devon Partnership NHS Trust and Avon & Wiltshire Mental Health Partnership NHS Trust (AWP). The purpose of the toolkit was to help health and care professionals to understand their needs and issues enabling them to provide better care for transgender people. A working group was responsible for authoring, reviewing and providing feedback on the toolkit, this included representation from North Bristol Trust, Priory Group and University Hospital Bristol. A list of participating organisations is included in the appendix.

This Equality Impact Assessment (EIA) reviews the toolkit as currently drafted to ascertain any potential impacts on the 9 protected characteristics. It also considers its legal basis, and identifies potential areas of risk, as well as offering mitigations and recommendations for next steps.

This EIA includes the following:

- Outline of engagement undertaken
- Equality analysis of the toolkit against the 9 protected characteristics
- Legal and safeguarding advice
- Summary and recommendations
- List of participating organisations

In compiling this EIA, we have reviewed the toolkit, the NHS Delivering Same-sex Accommodation Guide, the EHRC Code of Practice (for services, public functions and associations), legal advice from Bevan Brittan and documents submitted by members of the public for review. We have also conducted engagement with members of the public who made representations to the CCG in response to the toolkit's draft publication in November 2019.

Engagement

The organisation Stand Against Racism and Inequality (SARI) was commissioned to produce the toolkit, working in close partnership with a range of transgender people, clinicians and stakeholders from across the South West who comprise the document's working group.

The group have reported that in producing the toolkit, multiple organisations including mental health, learning and disability hospitals, acute hospital trusts, voluntary organisation, LGBT+ organisation and support groups, equalities specialists and a housing support organisation had either been consulted, written a section of the document or reviewed the draft.

The CCG has undertaken the following additional engagement in support of its EIA process:

26.03.20	External legal advice; Bevan Brittan
29.06.20	Local women's group representatives
02.07.20	Members of the public
14.08.20	Meeting with writing group
07.07.20	Governing Body Ethnical Decision Making Framework session
24.09.20	South West clinicians group
27.10.20	Additional meeting with writing group to review pathway section of toolkit

Desk research

Desk research was also undertaken looking at a range of evidence, reports and guidance. Hyperlinks are included throughout this document to referenced information. Several submissions of evidence were discounted from the analysis on the basis of relevance and/or source credibility.

In July, the CCG Governing Body considered the toolkit through the lens of its ethical decision making framework. This session considered terminology including definitions of sex and gender; the shifting national policy context (e.g. Gender Recognition Act reform) and the legal context (including current legal cases).

2. Does this Proposal relate to a new or existing programme, project, policy or service?

The '***Supporting Trans People***' guide is a new toolkit.

3. If existing, please provide more detail

N/A

4. Outline the key decision that will be informed by this EIA

The purpose of the EIA is to determine any potential impacts of the toolkit on protected characteristic groups, and to support the CCG'S Governing Body in its decision-making.

5. Does this proposal affect service users, employees and/or the wider community?

Provide more information on: Potential number of people affected, potential severity of impact, equality issues from previous audits and complaints. The key decision that will be informed by this EIA

The Supporting Trans People: best practice guidance for health and care practitioners has been designed to support transgender people's access to and experience of health and care services. There is limited data available on the UK transgender population, but various sources, including the Gender Identity Research and Education Service (GIRES) estimate that the UK transgender population is between 0.6%-1% of the total population.[1]

Within the report from GIRES, it is estimated that in 2007 the prevalence of people who had sought medical care for gender variance was 20 per 100,000 (i.e. 10,000 people in total). Of this total, it was estimated that 6,000 had undergone transition; 80% were assigned as boys at birth and 20% as girls. GIRES also references more recent data from the individual Gender Identity Clinics to anticipate that the gender balance may eventually become more equal.

Following publication of the draft toolkit in November 2019, the CCG received a number of representations from women's groups and members of the public to suggest that the toolkit as currently written could have an adverse impact on women and girls. Further detail is included within the Equality Analysis section below.

[1] Various sources reviewed:
- The Gender Identity Research and Education Service (GIRES) estimated the trans population (people who experience some degree of gender variance) at between 0.6%-1% of the UK adult population within a 2011 report funded by the Home Office. This report references that no robust data are available for the UK, therefore the report draws on overseas estimates of prevalence of transgenderism, including data from the American Psychological Association and from the Netherlands
- A factsheet produced by the Government Equalities office also estimates the size of the total trans population as between 200,000 and 500,000 (no source quoted)
- A reference on the Stonewall website estimates the total trans population at 1% of the total UK population (no source quoted)

6. Could the proposal impact differently in relation to different characteristics protected by the Equality Act 2010?

Assess whether the Service/Policy has a positive, negative or neutral impact in relation to the Protected Characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief and sex.

- ***Positive** impact means reducing inequality, promoting equal opportunities or improving relations between people who share a protected characteristic and those who do not*
- ***Negative** impact means that individuals could be disadvantaged or discriminated against in relation to a particular protected characteristic*
- ***Neutral** impact means that there is no differential effect in relation to any particular protected characteristic*

Equality Analysis

The following section provides detailed analysis of the toolkit's potential impact on people who hold one or more of the 9 protected characteristics. In summary:

Protected Characteristic	RAG	Impact
Age		Neutral/Negative
Disability		Neutral/Negative
Gender reassignment		Positive
Race		Neutral
Religion and Belief		Neutral/Negative
Sex		Neutral/Negative
Sexual Orientation		Neutral
Pregnancy and Maternity		Neutral
Marriage and Civil Partnership		Neutral

For the characteristics of Age, Disability (particularly those living with mental health conditions or who have learning difficulties), Religion and belief and Sex, some sections of the toolkit, as it is currently written, could create a neutral or negative impact. To be clear, there is no evidence that individuals with gender dysphoria pose a threat to other groups. Our analysis raises concerns that some sections of the toolkit, as it is currently written, are not sufficiently clear and could be misinterpreted.

The toolkit is likely to have a positive impact for those with the characteristic of gender reassignment.

Please refer to table below for a breakdown by protected characteristic.

** Under-18s are only protected against age discrimination in relation to work, not in access to services, housing, etc. Children's rights are protected by several other laws and treaties, such as: The Children Act; the Human Rights Act 1998; the UN Convention on the Rights of the Child; the European Convention on Human Rights; the UN Convention on the Rights of Persons with Disabilities; and the UN Convention on the Elimination of Discrimination against Women.*

Protected Group	RAG	Impact	PSED	Risk/ Mitigation
Age		Neutral/ Negative	The toolkit references the treatment of young transgender people. According to the University of Cambridge/Stonewall School study 2017 young transgender people report that they have experienced high rates of poor mental health as a result of being bullied, being stigmatised, experiencing isolation and gender dysphoria. According to the study 1 in 4 have self-harmed and 2 in 5 have attempted to take their own life. Of the 3,713 respondents, 16% said they were transgender and 8% were questioning their gender identity. A British Medical Journal article stated that some health care professionals can feel pressured to initiate physical intervention without consultation with psychological colleagues. The toolkit can help to educate health and care staff about the specific challenges this group faces; without undermining the need to respect, safeguard and care for all children. A U.S. study identified that socially transitioned transgender children (children presented and raised as their preferred gender) have better mental health outcomes therefore appropriate support is vital for their overall wellbeing and health. The toolkit currently states that 'doing nothing' (in terms of treatment for young people) 'causes harm'. Conversely, a group of South West clinicians who made representations to the CCG during the EIA process positioned that a policy of 'watch and wait' is preferable in the short to medium term for many children and young people presenting with gender confusion.	**Risk: Potentially to young or older women who are likely to feel/be more vulnerable in a hospital setting.** **Mitigation:** The toolkit should expressly state that the intended audience are mental health care professionals and GPs. The toolkit should align with the Code of Practice. Where policy calls for a risk assessment, EHRC Code of Practice states the provider should apply this policy on a case-by-case basis. The Code goes on to say service providers will need to balance the need of the transgender person for the service and the detriment to them if they are denied access, against the needs of other service users and any detriment that may affect them if the transgender person has access to the service. This was supported by legal advice received "reliance on the exemptions under the Equality Act 2010 (EqA) will only be done in exceptional circumstances and does create a status quo going forward". The safeguarding section is currently very brief, and in line with the CCG's own policy, should state clearly that practitioners need to consider and specifically ask or screen for safeguarding and risks to a young person's wellbeing. In line with the CCG safeguarding policy we recommend that "the practitioner should be fully aware of a holistic approach for young people,

			The toolkit references gender identity development service (GIDS) for children and the use of hormone blockers and sex hormones. The NHS stance is that "little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria…" These clinics are commissioned by NHS England & Improvement. NHS England & Improvement is currently undertaking a review of gender identity services for children and young people, the review will include examining the issues surrounding prescribing puberty blocking and cross sex hormone drugs to children and young people, the review will be overseen by Dr Hillary Cass OBE. A 23 year old woman has taken legal action against the Tavistock and Portman NHS Trust Gender Identity Development Services (GIDS) as the claimant believes she was too young to make an informed decision about medical transition. She began taking puberty blockers at the age of 16. Research evidence: The Delivering Same-sex Accommodation Guide identifies a number of justifiable breaches where mixed sex may be permitted e.g. critical care settings, end of life care, and should be read in conjunction with the toolkit. The Equality & Human Rights Commission (EHRC) Equality Act 2010 (EqA2010) Statutory Code of Practice provides guidance to support interpretation of the EqA2010, the Act states a service provider may provide a different service or exclude a person from the service who is proposing to undergo, is undergoing or who has undergone gender reassignment. This will only be lawful where the exclusion is a proportionate means of achieving a legitimate. Further points are included to help the reader apply the law - see appendix for more detail	promote typical wellbeing advice, and apply professional curiosity to ensure they ask the right questions to enable them to deliver the right help." This might also require them to refer to their safeguarding team or safeguarding policy for guidance (see appendix). Remove reference to hormone blockers and cross-sex hormones pending the outcome of the nationally commissioned Hilary Cass review. The statement "doing nothing or delaying treatment CAUSES HARM" should be removed. Legal advice: Legal advice must be shared with the authors of the toolkit.

			on EHRC guidelines.	
Disability		Neutral/ Negative	A recent article in the HSJ highlighted that there are hundreds of sexual assaults each year on mental health mixed-sex wards. Mental health inpatients are an extremely vulnerable group. Provision of same-sex accommodation has therefore been considered particularly important for male and female service users in a mental health setting. Women and young people are notably vulnerable during a period of inpatient care. Some service users may have a history of sexual abuse, disinhibition or offending that can exacerbate risk. There is some evidence of a relationship between autistic spectrum disorder and gender dysphoria, and issues around capacity and consent (as referenced in this study from Oxfordshire around gender reassignment). Young people who are referred to a GIDS may go through a rigorous process before any medical intervention takes place, but there is a small percentage (less than 1%) of people who de-transition mostly as a result of unsatisfactory surgical procedures or social difficulties. Research evidence: The Delivering Same-sex Accommodation Guide identifies a number of justifiable breaches where mixed sex might be permitted, e.g. critical care settings, end of life care and should be read in conjunction with the toolkit. Mental health and inpatient wards should never be mixed. Mental Health Network Briefing: Delivering same-sex accommodation in mental health and learning disability	**Risk: Potentially to vulnerable adults and children with mental health issues and learning difficulties** **Mitigation:** The section on crisis management is not sufficiently clear, the document does not stipulate that it is intended for readers in a mental health setting and therefore reference to being admitted in a crisis and the use of risk assessment is not interpreted in its intended context. Prioritising the needs of anyone in crisis would be appropriate in those circumstances. The intended audience should therefore be stated. Where policy calls for a risk assessment EHRC Code of Practice states, the provider should apply this policy on a case-by-case basis, balancing the needs of either patient/s, as noted in the above section (Age). The toolkit should make reference to the fact that some - albeit a very small percentage of people - de-transition; and highlight that there are risks to certain medical interventions. The toolkit currently states that “providing education to other service users in a ward to prevent ignorant or transphobic comments is, if successful, a better solution than having to protect or isolate the trans service user” – this reference should be removed. The toolkit should direct the reader to the relevant national guidance; NHS England’s Delivering Same-sex Accommodation. Legal advice:

			services, The NHS Confederation, January 2010 The Equality & Human Rights Commission (EHRC) Equality Act 2010 (EqA2010) Statutory Code of Practice - see appendix for more detail on EHRC guidelines.	Legal advice must be shared with the authors of the toolkit.
Gender Reassignment		Positive	The toolkit is in line with the section of the NHS 'Delivering Same-sex accommodation' guide published by NHS England, which states that transgender people should be treated according to the gender in which they present (Annex B). It is also in line with GMC guidance. The GMC Ethical guidance for transgender care states "Transgender and non-binary people experience the same health problems as everyone else and have very few differing needs. If a health problem is unrelated to gender dysphoria or its treatment, you must assess, provide treatment for and refer transgender patients the same as your other patients"; and highlights the duty of doctors including the need to treat all patients fairly. Under the Equality Act 2010 a person is protected under the characteristic of gender reassignment if they propose to transition; are in the process of transitioning; have transitioned, or started the journey but stopped. The EHRC states "In UK law, 'sex' is understood as binary, with a person's legal sex being determined by what is recorded on their birth certificate. A transgender person can change their legal gender by obtaining a GRC. A transgender person who does not have a GRC retains the sex recorded and is protected under the Equality Act as per their legal sex or under the protected characteristic 'Disabled' in some circumstances (impaired or limited ability to engage in certain tasks or actions, or to participate in typical daily activities).	**Risk: No risk** **Mitigation:** N/A

			On 22.09.20, the Government issued a response to the consultation on the 2004 Gender Recognition Act (GRA). The proposal to move to a process of gender self-identification was not adopted; the process will not be de-medicalised. The Equality Act 2010 does permit service providers to provide a different service or exclude a person from the service who is proposing to undergo, who is undergoing or who has undergone gender reassignment. This will only be lawful where the exclusion is a proportionate means of achieving a legitimate aim (Code of conduct 13.57). The intention is to ensure that the transgender person is treated in a way that best meets their needs and to best meet the needs of any other patients. The Code of Practice states any policy should be on a case-by-case basis and balance the needs of the transgender person and any other. The Code of Conduct also states the right to privacy must be maintained for patients recognised under the Gender Recognition Act. Therefore, clinicians must carefully manage any conversations. The legal advice received by the CCG recommends training for clinicians must include current changes to policy to avoid breaches. Research evidence: Sheffield Hallam University Study - the Scottish Transgender mental health study; GMC Disclosing patients' personal information: a framework; GMC Ethical Guidance for transgender healthcare; Stonewall School Report 2017; Mental health of Transgender Children who are supported in their identities.	

			The Equality Act 2010 Schedule 3 Part 7 (paragraph 27 and 28) addresses provision of separate and single services (separate services for the sexes), under S3 part 7 exceptions to the general prohibition of sex discrimination which allow the provision of separate services for men and women. See appendix.	
Race		Neutral	There is no evidence to show that any elements of the toolkit would have an impact on race. The toolkit should be read in conjunction with the Delivering Same-sex Accommodation Guide.	**Risk: No risk** **Mitigation:** N/A Legal advice: Legal advice must be shared with the authors of the toolkit.
Religion & Belief		Neutral/ Negative	The relationship between transgender people and people who practice a religion varies widely. For some religions, modesty is strongly correlated with faith and this will include the need for segregation on the basis of sex. Because of this, where mixed wards are concerned there is potential negative impact. If this is the case the clinical team must take this into account, but this should be balanced against clinical priorities and the rights of the transgender person, as both characteristics are equally protected under the law. EHRC Code of Practice states, the provider should apply this policy on a case-by-case basis. Service providers will need to balance the need of the transgender person for the service and the detriment to them if they are denied access, against the needs of other service users and any detriment that may affect them if the transgender person has access to the service. NHS England is to update the Same-sex Accommodation	**Risk: Potentially to women on grounds religion** **Mitigation:** The toolkit should direct the reader to the Delivering Same-sex Accommodation Guide. Remove the sentence with the wording 'education' from the crisis section. Amend the sentence around risk assessment. Where policy calls for a risk assessment EHRC Code of Practice states, the provider should apply this policy on a case-by-case basis, balancing the needs of either patient/s, as noted in the above section (Age). Legal advice: Legal advice must be shared with the authors of the toolkit.

			Guide and the CCG is hopeful of further clarification on its application in this context. Research: The Delivering Same-sex Accommodation Guide	
Sex		Neutral/ Negative	The toolkit as it is currently written does not recognise sex as a protected characteristic under law. Members of the public who have engaged with the CCG in this process were concerned about the section on same-sex wards. Those who engaged with the CCG expressed concerns that women who have experienced trauma and abuse could effectively be placed on mixed-sex wards without knowing it and that this compromises dignity, safety and for some women, religious custom. Research: The public perceptions survey "Eight in ten men agree they would feel safe in an NHS hospital if very ill compared with seven in ten women (80% agree compared with 70%)" (pages 46/47, Dec 2011). Seventy percent of all women surveyed felt safe in a hospital setting; their sense of safety was also dependent on age. 83% of the 16 to 24 year old group felt safe, and 78% of those over 65 would feel safe in an NHS hospital if very ill; 35 to 54 year olds felt the least safe (70% agree). Links shared by members of the public including 'grey' literature (produced by organisations outside of traditional academic or known distribution channels) have been reviewed and has highlighted the specific needs and concerns of very vulnerable women. The Delivering Same-sex Accommodation Guide published by NHS England states that "there are no exceptions to the need to provide high standards of	**Risk: Potentially to vulnerable women on grounds of history of trauma or religion** . **Mitigation:** The toolkit should acknowledge sex as a protected characteristic in the section that references same sex accommodation. The toolkit should direct the reader to the Delivering Same-sex Accommodation Guide. Previous references to risk assessment apply. The toolkit references 'educating' patients, this paragraph should be deleted as stated above. Legal advice: Legal advice must be shared with the authors of the toolkit. .

			privacy and dignity at all times." Same-sex wards were established to achieve this aim. However, the guide states a number of exceptional circumstances where there is a clinical need when a breach might be justifiable (e.g. critical care settings, end of life care). Annex B of the guide states that transgender people are to be treated as the sex in which they present. A transgender person can be discriminated against if justifiable "provided that it is a proportionate means of achieving a legitimate aim". NHS England is to update the Same-sex Accommodation Guide and the CCG is hopeful of further clarification on its application in this context. EA2010 Statutory Code of Practice.	
Sexual Orientation		Neutral	There is no evidence to show that any elements of the toolkit would have an impact on sexual orientation. The toolkit should be read in conjunction with other materials e.g. Delivering Same-sex Accommodation Guide.	**Risk: No risk** **Mitigation:** N/A
Pregnancy & Maternity		Neutral	There is no evidence to show that any elements of the toolkit would have an impact on marriage and civil partnership. The toolkit should be read in conjunction with the Delivering Same-sex Accommodation Guide.	**Risk: No risk** **Mitigation:** N/A
Marriage & Civil Partners		Neutral	There is no evidence to show that any elements of the toolkit would have an impact on marriage and civil partnership. The toolkit should be read in conjunction with the Delivering Same-sex Accommodation Guide.	**Risk: No risk** **Mitigation:** N/A

Relevance to the Public Sector Equality Duty - Please select which of the three points are relevant to your proposal. There is a general duty which requires the system to have due regard to the need to:

7. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010?

Does this proposal address risk in relation to any particular characteristics?

The toolkit has the potential to reduce or eliminate unlawful discrimination, harassment and victimisation if applied as a tool that will help health and care staff to understand the needs of transgender people.

With reference to mixed-sex accommodation, there is potential negative impact for some groups, in particular vulnerable women and people who practice a faith or belief based on religious observance as outlined in the equality analysis section.

The toolkit has been reviewed by legal advisors Bevan Brittan. The endorsement of the toolkit does not appear to be in contravention of the legal framework or Public Sector Equality Duty (PSED).

8. Advance equality of opportunity between people who share a protected characteristic and those who do not?

Will this proposal facilitate equality of opportunity in relation to particular characteristics?

Yes – for its intended beneficiaries transgender children and adults. The toolkit proposes that the provider trains its staff and widely disseminates the toolkit to improve the service experience of a group that are disproportionately impacted by inequality. The toolkit highlights the need for risk assessment for each admission and provides references to further material to support education of staff.

9. Foster good relationships between those who have protected characteristics and those who do not?

Will this proposal foster good relationships between people of one group and another?

Yes – any opportunity to improve service for all patients will foster good relationships between the public and the provider; including the education of staff.

Summary & Recommendations

The toolkit has the potential to provide useful information for healthcare staff who need to improve their everyday interactions with transgender people. The toolkit has moved beyond its original intent which was to support GPs and staff in a mental health setting; the document does not clearly state that it does not supplement or replace treatment guidelines or present a treatment pathway.

Research and engagement during this process has highlighted a number of ways that the toolkit could be improved:

- The legal section of the document could be developed to help the reader better understand the rights afforded by the Equality Act, including referencing the Public Sector Equality Duty. Also, references to the Gender Recognition Act (GRA) 2004 could be developed to include differences between those who hold a Gender Recognition Certificate and those who do not and the legal protection this affords e.g. data protection implications. Extract of the legal advice is included in the appendix.

- It is good practice to include sample sizes when quoting statistics to enable the reader to contextualize the level of risk. Statistics quoted should be updated to reflect this and the reference to suicide removed.

- Research would be well supported with the inclusion of case studies.

- Staff training is integral to delivery patient-centred care. The section of staff training should recommend providers must commission robust training including relevant risk assessment processes, policy and legislation (see legal advice).

This exercise has identified a number of risks to the protected groups (age, sex, disability, religion and belief); and recommends a number of actions that mitigate those risks. In order for the CCG to endorse the toolkits the following changes should be made, the above improvements have been included:

1. The following changes should be made to the toolkit:

    a. Revised introduction – There should be a clear statement about the intended audience and the purpose of the toolkit; i.e. a clear statement that the toolkit is not a treatment guide.
    b. The section on ‘what it means to be trans’ should made simpler and clearer.
    c. The document should recognise sex as a protected characteristic in the section that refers to same-sex accommodation (crisis section).
    d. Update references to statistics in the document ensuring the total population size is included to provide context and remove references to suicidality in young people (treatment works section).

e. Rename the Treatment Pathway section making clear that this is not a defined / single treatment pathway; the heading should instead reflect that it is a typical journey someone might take.
f. Remove reference to hormone blockers and cross-sex hormones pending the outcome of the nationally commissioned Hilary Cass review.
g. Make reference to the fact that some - albeit a very small percentage of people - de-transition; and highlight that there are risks to medical interventions. Remove the sentence: 'doing nothing causes harm'.
h. Strengthen the sections on lived experience through the use of case studies.
i. Update the legal section.
j. Remove sentence relating to 'education' of patients in the crisis management section.
k. The reader should be encouraged to ensure training is robust and includes changes in transgender policy.
l. The section on crisis should align with the Delivering Same-sex Accommodation Guide. References to risk assessment should be in line with EHRC code of practice section on policy (weighing up the needs of both the transgender patient and any other patient); and signpost readers to the 'Delivering Same-sex Accommodation Guide.
m. The toolkit should direct the reader to review their safeguarding policy and the reader should be encouraged to assess the person holistically and with professional curiosity and always step back and ask themselves objectives questions about their assessment and treatment plan. (see appendix: safeguarding advice).

2. Resubmit the revised toolkit for Governing Body approval.

Appendix

Legal Advice

The legal basis of the EIA had been challenged and in response the CCG sought legal advice. The following recommendations (extract) were received from our legal team:

The wording of any adopted policy, whether that is the Toolkit itself or some other format of guidance, should include wording to the effect of the below:

- an understanding of the distinction between those with or without a GRC, as well as the legal protections that this affords (or doesn't, if applicable) in relation to healthcare service;
- explicitly stating that any allocation to single sex services would be made following a thorough case by case analysis and would seek to achieve a reasonable balance between competing legal rights - perhaps with reference to guidance…..; and
- including provisions outlining that reliance on the exemptions under the EqA will only be done in exceptional circumstances and does create a status quo going forward, again reiterating the CCG's duty to protect all individuals' rights as far as possible.
- Amend the wording of the toolkit in line with legal recommendations leaving no room for misinterpretation. Strengthen recommendation for training to include best practice in compliance and legal framework.
- If formal guidance or policy is planned for implementation, arrange for substantial internal training and communications for all staff so that they can be assured of best practice in compliance with the legal framework. This would need to include accepted protocol for deciding, or not, to separate any patients by relying on an EqA exemption and an appropriate route for patients to seek redress.
- Proceed with the EIA including engagement to open dialogue around transgender issues and share the CCG line on the toolkit and the importance of this work.

CCG's Safeguarding Policy

Hyperlink to policy.

National policy context

A number of contextual factors that were considered during the undertaking of this EIA remain live issues;

NHS England (NHSE) launched an independent review into the Gender Identity Development Service (GIDS), which was announced in September 2020. The review will focus on how and when children are referred, how care can be improved and clinical practice. The review will also examine the recent rise in children seeking treatment and issues around the use of puberty blockers and cross-sex hormones in this cohort.

The CCG has asked NHS England to confirm if there are plans to update the national NHS Delivering Same-sex Accommodation Guide. The EIA will be shared with the team. The 'Delivering Same-sex Accommodation Guide states that it is not a requirement to hold a GRC, however Matt Hancock Secretary of State for Health & Social Care is quoted in a Telegraph article (March 2019) stating that was the case, this view was also taken by other articles in the research. The health secretary also stated both NHS rules and the law needed serious consideration. The guide does not currently express that admitting a patient who does not hold a GRC should be reported as a breach.

NHS Greater Glasgow & Clyde Trust produced a transgender toolkit to support its staff, which was also challenged. This toolkit is currently under review following consultation with the Equality Human Rights Commission (EHRC). A statement will be issued to the CCG following the conclusion of their review and due process.

A paragraph will be added to this EIA at a later date when an update is available.

Guidelines: EA2010 Statutory Code of Practice (EHRC)

The above guideline was used as an evidence based for the usage of same sex accommodation. This document is a Statutory Code of Practice. This is the authoritative, comprehensive and technical guide to the detail of law.

13.54: Single sex only services
The Act provides that it is not unlawful sex discrimination to provide separate services for each sex if: b) the limited provision is a proportionate means of achieving a legitimate aim. And at least one of the condition applies, in NHS case
d) The service is provided at a hospital or other place where users need special care, supervision or attention.

13:57 Gender reassignment discrimination and separate and single-sex services
If a service provider provides single- or separate sex services for women and men, or provides services differently to women and men, they should treat transgender people according to the gender role in which they present. However, the Act does permit the service provider to provide a different service or exclude a person from the service who is proposing to undergo, is undergoing or who has undergone gender reassignment. This will only be lawful where the exclusion is a proportionate means of achieving a legitimate.

13.59
Service providers should be aware that where a transgender person is visually and for all practical purposes indistinguishable from a non-transgender person of that gender, they should normally be treated according to their acquired gender, unless there are strong reasons to the contrary.

13.60
As stated at the beginning of this chapter, any exception to the prohibition of discrimination must be applied as restrictively as possible and the denial of a service to a transgender person should only occur in exceptional circumstances. A service provider can have a policy on provision of the service to transgender users but should apply this policy on a case-by-case basis in order to determine whether the exclusion of a transgender person is proportionate in the individual circumstances. Service providers will need to balance the need of the transgender person for the service and the detriment to them if they are denied access, against the needs of other service users and any detriment that may affect them if the transgender person has access to the service. To do this will often require discussion with service users (maintaining confidentiality for the transgender service user). Care should be taken in each case to avoid a decision based on ignorance or prejudice. Also, the provider will need to show that a less discriminatory way to achieve the objective was not available.

2.27
States “Transgender people should not be routinely asked to produce their Gender Recognition Certificate as evidence of their legal gender. Such a request would compromise a transgender person’s right to privacy. If a service provider requires proof of a person’s legal gender, their (new) birth certificate should be sufficient confirmation.”

The Equality Act 2010 Schedule 3 Part 7

Paragraph 27 and 28 addresses provision of separate and single services (separate services for the sexes), under S3 part 7 exceptions to the general prohibition of sex discrimination which allow the provision of separate services for men and women. Paragraph 27 states single sex services are permitted where:

- Only people of that sex require it;
- There is joint provision for both sexes but that is not sufficient on its own;
- If the service were provided for men and women jointly, it would not be as effective and it is not reasonably practicable to provide separate services for each sex;
- They are provided in a hospital or other place where users need special attention (or in parts of such an establishment);
- They may be used by more than one person and a woman might object to the presence of a man (or vice versa); or
- They may involve physical contact between a user and someone else and that other person may reasonably object if the user is of the opposite sex.

In each case, the separate provision has to be objectively justified. Included in the examples on the Equality Act webpage (www.legislation.gov.uk) of allowable exceptions is “separate male and female wards to be provided in a hospital”.

Paragraph 28 of part 7, contains an exception to the general prohibition of gender reassignment discrimination in relation to the provision of separate and single-sex services; discrimination by the provider has to be objectively justified.

Engagement meeting notes and draft toolkit

Meeting notes provided under separate cover. The meeting with representatives from a number of women’s organisations was held in confidence at their request, therefore there are no meeting notes from this engagement.

A list of partners who have been involved/ consulted*/ inputted into the draft has been provided by SARI:

- Avon and Wiltshire Partnership NHS Trust (AWP)
- Priory Group
- Diversity Trust
- LGBT Bristol
- Devon Partnership NHS Trust
- NHS Bristol, North Somerset & South Gloucestershire CCG
- OTR Bristol
- University of Bristol
- Crossroad (support agency for trans people)
- North Bristol NHS Trust
- Bristol Mind
- St Mungo's
- Independent Mental Health Network
- University Hospitals Bristol & Weston NHS Foundation Trust
- SARI

*consultation includes obtaining support in principle.

Contact us:

Healthier Together PMO Office, Level 4, South Plaza, Marlborough Street, Bristol, BS1 3NX

bnssg.htpmo@nhs.net

SUPPORTING TRANS PEOPLE

Best practice guidance for health and wellbeing practitioners

"Healthcare professionals who have taken the time to sit with me, find out answers together, and support me with everything from referrals, hormones, surgery, and the everyday realities of transitioning gender have been, and continue to be, the most fundamental cornerstone of why my NHS experience has been life-changing, but crucially, not faultless. The NHS still has many areas to improve, but driven with support from clinicians who take responsibility and ownership for ensuring trans, non-binary and gender diverse people get the care they need, are ones who give me huge hope for an even stronger, more inclusive NHS in the future. I hope this guide will encourage all services and practitioners to strive for best-practice." – Trans man, aged 31, Bristol

Introduction

Thank you for taking the time to read this booklet!

The purpose of this booklet is to provide you and other health professionals with a toolkit to help you when working with trans people, their families and carers.

The trans community has received a lot of attention in the media in recent times. More and more trans people are reaching out and are comfortable in expressing themselves. They represent a significant proportion of our community (recent studies suggest up to 1% although this is well-accepted as being significantly under-reported). You are likely to encounter gender diversity in all aspects of your life.

You may feel less confident or even uncomfortable with this due to the lack of information and training available on this subject. This booklet is here to help you deliver the best care and support for trans people. It contains background information on trans people and the types of treatment they receive in England. In addition there are pointers to relevant and useful medical information that has a strong research evidence-base with recent guidelines and recommendations.

After reading this booklet I am confident that you will feel much better equipped to relate to trans people in your day-to-day work, both as patients and as work colleagues. There is a wealth of other resources available and there are suggestions for further reading within this toolkit.

Dr. Daniel Hodgson,
Consultant Psychiatrist
Senior Medical Lead for Bristol Services
Bristol Mental Health (AWP)

What Does It Mean to be Trans?

When a baby is born, or these days when we get the first clear ultrasound picture, we assign a sex to that child based on the appearance of their genitals. Much follows from that, including our expectations of the child's future behaviour and life. However, anatomy is not always a good guide to what gender a child will be, or even what sex they are.

When Western science first considered sex and gender it was assumed that there were only two types of humans: men, who were masculine and attracted to women; and women, who were feminine and attracted to men. Anyone outside of that simple binary was assumed to be ill; and needed to be cured. We now know, as other cultures always have done, that humans are much more complicated than that.

These days we understand that love may have nothing to do with what sex or gender you are. We are also much more relaxed about people's clothing choices. We understand that some people are born *intersex*. And we know that some people are *transgender*.

Someone is transgender, or trans, if they identify as a gender other than that which they were assigned at birth. Some undergo lengthy medical treatment to make changes to their bodies with hormones and surgery. Others only have limited medical treatment, or none at all. We say that these people have a *gender identity* that is different to that they were assigned at birth.

Sex: Assigned by medical practitioners at birth based on physical characteristics. Sex-based physical characteristics include hormones, chromosomes, genitalia, internal sex organs and secondary sex characteristics (breasts, facial hair, etc., mostly acquired at puberty).

Gender: A social system for coding the behaviour of people as either masculine, feminine, or something else.

Intersex: An umbrella term for people who are born with a diversity of sex-based physical characteristics. Many different variations exist.

Glossary of Terms

The language used to describe trans people has been evolving rapidly. The terms defined here represent the current most popular definitions, but please be aware that terms may change, and that not everyone uses them in the same way. In addition, while many people are happy to be included under umbrella terms such as "trans" or "non-binary", others may prefer to use a term that describes them more precisely. Some people who have undergone gender transition say that they are no longer trans, they are simply men and women. Some people from non-Western backgrounds prefer to use terms that are common in their culture rather than Western terms such as trans which may have subtly different meanings.

Gender Identity: a person's individual understanding of whether they are male, female or something different. Most people have a gender identity that aligns with the sex they were assigned at birth.

Cisgender: a person whose gender identity aligns with the sex that they were assigned at birth.

Gender Expression: how people express their gender through clothing, hairstyles, accessories, mannerisms and so on.

Trans/Transgender: an umbrella term for people whose gender identity and/or gender expression diverges in some way from the sex they were assigned at birth.

Non-Binary: an umbrella term for people whose gender identity and/or expression is neither male nor female.

Gender Non-Conforming: an umbrella term for people whose gender identity is the same as the sex they were assigned at birth, but whose gender expression does not conform to social expectations for someone of that sex. Such people may call themselves cross-dressers, or occasionally transvestites.

Trans Man: a person who has transitioned, or is in the process of transitioning, from female to male. The abbreviation FTM is sometimes used for "female to male".

Trans Woman: a person who has transitioned, or is in the process of transitioning, from male to female. The abbreviation MTF is sometimes used for "male to female".

Genderqueer, Genderfluid, Agender: terms used by non-binary people to indicate the particular way in which they express their gender.

Questioning: a person who is currently unsure what gender and/or sexuality suits them best.

Please note that these definitions are not always understood and/or accepted. For example, a non-binary person may not identify as trans because, in their view, being trans is strongly associated with a medical transition process that they have no interest in. Some gender non-conforming people strongly identify as not trans, while some may be on a journey towards transition.

Terminology does change with time, and some trans people, particularly older ones, may have attachments to, or concerns about, these changes. The term "transsexual" has now fallen out of favour, but some older trans people may still prefer it as it was what they called themselves when they came out. Some people still use it to distinguish those transgender people who have had/want medical intervention from those who have/do not.

Some trans people associate being trans with gender dysphoria and hold that after transition they are no longer trans. Such people may describe themselves as someone with trans history.

Reasons Why People May Need Support

"being trans is not an illness" – Theresa May[1]

- **66% of respondents** reported that they had used mental health services for reasons other than access to gender reassignment medical assistance – Sheffield Hallam University study
- **Over half of the respondents** felt that they had been so distressed at some point that they had needed to seek help or support urgently. When asked for more information about their experiences, 35% of those individuals had avoided seeking urgent help due to being trans or having a trans history. – Sheffield Hallam University study

In the past people were deemed to be "mentally ill" for all sorts of social transgressions, from being gay to becoming pregnant outside marriage. We no longer stigmatise people in this way, from July 2018 the World Health Organisation officially stated that trans people are not mentally ill.

Nevertheless, trans people may need the help of medical professionals. In some cases that is to access hormones and surgery, but sometimes they need help with their mental health.

For those trans people who experience an extreme disconnect between their idea of self and their physical bodies, life prior to transition is very stressful. This is described as gender dysphoria. The good news is that the treatments provided by gender clinics are highly successful in making trans people happier in themselves.

Other trans people have fewer issues with their bodies, but may still experience extreme stress due to lack of acceptance by family, friends and wider society. Those who identify outside of the gender binary are less likely to find such acceptance.

Trans people worry about losing friends, family and jobs. They worry about whether they will be accepted as themselves. The slowness of the process, which may take many years, can also be economically, emotionally and spiritually challenging.

Wider society is not always understanding of trans people and their lives. A 2012 Study by Sheffield Hallam University

found that trans people had many mental health issues, and that these were often brought on by discrimination.[2]

Issue	Prevalence
Diagnosed with depression	55%
Have self-harmed	53%
Had considered suicide	84%
Had attempted suicide	48%
Had experienced problems at work due to being trans	52%
Believed they had a problem with drug use	18%
Had been homeless at some point	19%
Described parents as "not at all supportive"	17%

> "Been in and out of therapy since I started coming out as a teenager. As you can imagine there was little in way of pro-trans help back in the nineties."
> – Trans woman, aged 36-40, Bristol

Finally, some trans people do have poor mental health, just like everyone else in society. It is important not to assume that if someone has a recognised condition, this is somehow a symptom of, or caused by, their being trans.

Sadly many trans people avoid seeking help for mental health issues because they fear being discriminated against.

1 From a speech at the Pink News Awards in London, October 2017; https://www.independent.co.uk/news/uk/politics/theresa-may-transgender-not-illness-gender-recognition-act-lgbt-rights-sex-edution-homophobia-pink-a8008486.html

2 Available from: https://www.scottishtrans.org/trans_mh_study/

The Trans Pathway

> "If your patient requests treatment for gender dysphoria, referring them to a Gender Identity Clinic (GIC) or gender specialist without delay will likely be the best option." – GMC website[3]

> "The whole process took over 10 years!" – Trans woman, aged 61–65, Devon

There are a number of Gender Identity Clinics or Gender Dysphoria Centres in the UK, which specialise in the treatment of trans people. The nearest to Bristol is The Laurels in Exeter. Some local people may be using clinics elsewhere in the country.

The clinic will undertake a holistic assessment of the patient to see if they are someone who will benefit from being provided with medical help with transition. While such checks are a standard part of the process, the most significant indicator of suitability is that the patient has asked for a referral. Given the level of discrimination they see others facing, trans people tend not to come out until they are very determined to proceed.

Because of the lengthy waiting lists, many trans people will begin the transition process independently, either through a private provider, or by self-medicating.

Having accepted someone onto their programme, the clinic will require the patient to undergo a process by which they come to be recognised as the person they know themselves to be in all aspects of their day-to-day life. In addition the hormonal changes in their bodies can have psychological effects similar to those experienced during puberty.

Many trans people will undergo more than one surgical process. In particular trans men may undergo several different operations. However, some patients have no surgery at all. Patients may need support while going through the process of deciding what surgery to have, and dealing with questions of what treatments are available through the NHS versus what they can afford privately.

3 https://www.gmc-uk.org/ethical-guidance/ethical-hub/trans-healthcare

The Pathway for Young People

Young people are exploring, identifying and recognising their gender in many different ways. Some young people identify broadly as trans or transgender; with a strong sense of a male or female identity. Others may feel a disconnect or ambivalence to their gender, sex and sense of self. There is no textbook answer. Regardless of how they identity, or their age at the time, they should be treated with dignity and respect.

For people under the age of 18, referral must be through the Gender Identity Development Service (GIDS) who are a separate service from adult clinics. Young people will be transferred to adult services when they turn 18.

For young people who are struggling to maintain their mental health and wellbeing a practitioner should consider a referral to Child & Adolescent Mental Health Services (CAHMS). Some young people work with CAHMS before attending the GIDS service if risk or safeguarding issues are present, whereas others do not. Each case should be considered individually.

> "F wanted to cut off their genitals when they were little, that is how distressed they were" - a parent talking about their child aged 4 at the time.

Presently in the UK, cross-sex hormones are not normally prescribed to children under 16 years of age. Gender-related surgery is not normally permitted until the person is 18 or over.

GIDS may prescribe puberty blockers to delay the effects of puberty in the patient. These drugs have been in regular use for many years for treatment of precocious puberty in very young children. The primary reasons using blockers are to alleviate the distress caused by body changes during puberty, and potentially to avoid surgery to reverse those effects.

Delaying puberty also allows the patient extra time to think through their situation before undergoing any irreversible treatment.

Some young people do go on to transition permanently to a gender different to their assigned birth sex. Other young people may explore their gender but not go on to transition. Both groups need access to information, advice and support.

Adult Pathway Flowchart

Visit to GP age 18+

NHS Pathway

GIC: Gender Identity Clinics - regional adult clinics for those aged 17.5 and upwards.
May also be known as GDS - Gender Dysphoria Services.

Referral from GP to Specialist Gender Identity Clinic Service (GIC / GDS). Waiting times vary considerably - often upwards of 24 months until first appointment. GP to advise individual on waiting times.

GP is always asked to support ongoing care of individual e.g. GP instigating commencement of hormones on recommendation from GIC, or referral for locally provided treatments, ongoing post-surgery care, and ongoing hormone dose monitoring via bloodtests.

Appointments provided. Several assessment appointments for hormonal / surgical intervention before provision of recommendations (Often upwards 24-48 months.)

GP to continue to provide care and commencement of hormones / surgical aftercare. Advice provided by GIC/GDS

The following may be provided to support those in your care:
- Voice therapy
- Hair removal
- Fertility preservation treatment
- Hysterectomy

GP ensures regular monitoring of hormone levels in blood and ongoing physical health tests - eg. prostate and cervical cancer checks

Supporting those discharged from services?
Those no longer engaged in NHS or private specialist services due to no longer needing ongoing engagement with the Gender Identity service will have their ongoing healthcare managed by their GP. If a person is no longer engaged with any Gender Identity service (or has not been), and requires further input in relation to, for example, hormone support, then referral local services should be considered.

Private Pathway

Individual pays to undertake hormones / surgery via private providers. A person may engage with this route to reduce time the process takes. It is costly and requires several appointments of assessment and surgical costs.

A shared care agreement may be put into place with GP prescribing under supervision from private provider.

Individual may continue to engage with private care, or wish to be referred to an NHS provider for surgical options.

All surgery may involve local primary care support - eg. removal of staples, stitches, drains, catheters.

Not all trans / non-binary people follow a binary pathway of surgical intervention and hormonal interventions. Options may involve low dose hormones, or surgery without hormones.

Support options - Ensuring a person has local support from community groups, encouraging engagement with friends/ family where possible, and ensuring access to mental health and wellbeing services where appropriate.
Create a care pathway for your surgery for trans and non-binary people is a good way to demonstrate positive practice.

Self-medicating cross-gender hormones
Clinicians may encounter someone self-medicating oestrogen or testosterone obtained online / elsewhere and undertake harm reduction measures - eg. taking over prescribing, monitoring blood levels and engaging person in local services. Ensure access to safe injecting equipment and explore motivations for self-medication and referral to a gender identity service.

Issues for Young People

Young trans people have decisions to make about fertility, which could be compromised if hormonal and surgical treatments are undertaken. Fertility preservation services may be sought. Other people may opt to forego certain treatments in order to preserve their fertility.

Social, information and community spaces are often crucially important to trans, non-binary and gender diverse young people. These may be within their youth groups or schools. Spaces and places to meet others in a safe, supportive and social environment can provide opportunities for young people to access friendship, information and advice, and additionally, in some services, for parents/carers to meet.

Young people who have not yet started with GIDS, or do not wish to, may seek support with worries around development and puberty: menstruation, hair growth, etc., alongside other everyday health issues. Young people may also flatten their chest tissue or tuck genitalia. Issues around body image and eating disorders are higher among trans young people. These issues need to be dealt with, and supportive information provided, so as to reduce potential harm, regardless of whether referral to GIDS is forseen in the future.

Young trans and non-binary people still need support with health, relationships, wellbeing, exercise etc. This should be tailored to their bodies and experiences.

For young people, parental consent is normally required before a GIDS referral, and also for issues such as changes of name.

Nearly 1 in 10 trans pupils (nine per cent) are subjected to death threats at school.

More than 4 in 5 trans young people (84 per cent) have self-harmed.

More than 2 in 5 trans young people (45 per cent) have attempted to take their own life.

– Stonewall School Report, 2017]

Parents & Carers

Young people and their parents and carers can be confused or worried if they are unsure of support options available if their gender identity is causing them distress, worry or concern. Often young people may face stigma from those around them or a lack of understanding of how they feel or recognise themselves to be. Parents and carers may feel lacking in knowledge, have their own worries, and turn to health, education and social care agencies for support.

Research shows supportive environments improve young people's reported wellbeing and mental health outcomes considerably. Good mental health support is critical for trans youth, and may also be necessary for parents, carers and siblings.

Practitioners can use Fraser Guidelines to make a referral without parental consent if they consider that young person is at risk of harm to themselves or someone else. Also, if the parent/carer behaviour is non-supportive, the practitioner should consider whether the young person needs assistance to feel supported and safe.

"Socially transitioned transgender children who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety, suggesting that psychopathology is not inevitable within this group." – Olson et al

"My Mum not supporting me and my gender – she ignores it most of the time- makes me feel like she just doesn't understand. I go to my local sexual health clinic and talk to the nurses there about how I feel as it helps me. They also suggested I go to my LGBTQ+ youth group where I have met lots of friends and heard other people's stories."

["Mental Health of Transgender Children Who Are Supported in Their Identities", Kristina R. Olson, Lily Durwood, Madeleine DeMeules, Katie A. McLaughlin. Pediatrics 2016 ;137(3):e2015322

"Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes", Murad MH1, Elamin MB, Garcia MZ, Mullan RJ, Murad A, Erwin PJ, Montori VM. Clin Endocrinol (Oxf). 2010 Feb;72(2):214-31]

Young People's Pathway Flowchart

Young person (0-18) is experiencing distress / discomfort related to their gender identity. Young person may first discuss this with peers, parent/carers or professionals.

→ Signposting to local voluntar here for young person and f LGBTQ+ groups and 1:1 talkin for ongoing support and in r

Signposting to GP. GP should provide ongoing support and referral to specialised services in conjunction with young person and parent/s carer/s.

Referral to Gender Identity Development
Service GIDS service by GP which has a satellite base in Bristol. Waiting times for appointments can be lengthy before a young person reaches the service.

→ A referral to specialised gend without a referral to CAMHS relevant, a referral to CAMH within a referral to GIDS serv young people may require lo others may not. This should r being made. Contact GIDS fo

Engagement with GIDS offers the young person and their family multidisciplinary support , talking therapies, psychology and psychotherapy and endocrinology. A young person may be able to access puberty delaying medication which put secondary sex development on hold.

→ Aged 17 or above, a young pe referred to an Adult GIC serv protocol.

Not all young people wish to pursue hormonal or surgical treatment but may wish for social transition of how they are known and seen and managing gender related distress/discomfort.

→ Cross gender hormones may from the minimum age of 16 i has been successfully comple and they wish to undertake h Surgical intervention is not ur person reaches 18. Often this amount of time. Individuals ar to access private treatment fr medication. Have a robust an related to managing shared c

On reaching 18, young people engaged with GIDS are referred onwards to an Adult GIC service if they wish to be. There is often a period of delay between referrals.

y and community services
amilies. Peer support
g therapies may be useful
educing isolation.

Involvement with Local targeted support provision such as youth groups and helplines, and support for parents, carers and schools. See support pages.

der service can take place
. If GP feels clinically
5 or inclusion of the team
vice may be useful. Some
cal CAHMS support, but
ot delay a GIDS referral
r advice.

erson may be directly
vice. Check individual clinic

be prescribed on the NHS
f the period of assessment
ted by the young person
ormonal intervention.
dertaken until a young
process takes a considerable
nd their families may opt
om overseas, or self-
d thoughtful policy in place
are.

KEY:
CAMHS: Child & Adolescent Mental Health Services.
GIDS: Gender Identity Development Service (GIDS) Tavistock and Portman http://gids.nhs.uk/
GIC: Gender Identity Clinics - regional adult clinics for those aged 17 and upwards. Increasingly known as GDC - Gender Dysphoria Centres.

SAFEGUARDING:
Lack of support from parents/carers may result in safeguarding concerns (eg. loss of accommodation, young person feeling unsafe or threatened). Manage this as per organisational Safeguarding protocol for Children and Young people.

The Treatment Works

> The participants were also asked if hormones had changed how satisfied they were with their overall lives. Of 398 people, 82% reported greater levels of life satisfaction than pre-hormones. As before, only 2% were less satisfied. – Sheffield Hallam University Mental Health Study]

Given the high level of discrimination that trans people face, you may wonder why anyone would undergo gender transition. The answer is that trans people are mostly happier in themselves after transition, despite exposing themselves to that discrimination. Many trans people say that they only opted to transition when their lives became so unhappy that suicide seemed the only other option.

Studies that have been done on trans people post-transition show significant levels of satisfaction, both with surgical outcomes and with quality of life.

Newspaper articles on trans issues often focus on people who have undergone transition and later regretted it. However, the number of cases of genuine regret is very low, and will hopefully continue to fall as treatment protocols improve. Recent studies at two UK clinics put the de-transition rate at around 1%. Those who leave the programme often do so for practical reasons and resume transition once they are able.

The acceptance of non-binary genders, rather than forcing all patients to undergo full binary transition if they wanted any treatment at all, as has been the case in the past, should make a big difference.

Outcomes are also improved, particularly in the case of young people, if family support can be secured. Support for families during the transition process is thus very important.

Doing nothing or delaying treatment **CAUSES HARM**.

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https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/

"Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment", Annelou L.C. de Vries, Jenifer K. McGuire, Thomas D. Steensma, Eva C.F. Wagenaar, Theo A.H. Doreleijers and Peggy T. Cohen-Kettenis. Pediatrics 2014;134;696

"Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada", Bauer GR, Scheim AI, Pyne J, Travers R, Hammond R. BMC Public Health; 15:525; Jun 2 2015]

Hate Crime

Transgender hate crime is any incident perceived by the recipient (or a 3rd party) to be motivated by prejudice towards an individual because of transgender identity. It can happen to people perceived to be trans or who are associated with trans people.

Hate crime takes many forms including: verbal abuse, physical violence, teasing, intimidation, bullying, online abuse, and damage to property. The impact can be catastrophic with serious mental health repercussions including self-harm (including substance abuse) and at worst suicide.

SARI collaborates with several agencies to deliver hate crime services across Avon & Somerset including **LGBT Bristol** and the **Diversity Trust.** In Bristol their collaboration is **Called Bristol Hate Crime & Discrimination Services (BHCDS)**. They encourage anyone who suffers hate crime in Avon & Somerset area to report it. They offer free, **confidential advice** and can open a case to support victims further. For more info, call 0800 171 2272 or visit www.sariweb.org.uk.

If the victim or anyone else thinks an act was hate motivated, it should be recorded as a hate crime or incident by the agency you report to. In an emergency call the police on 999 or contact them on 101 or online for less serious incidents.

"I was verbally assaulted, called a 'tranny', 'shim', he/she, 'pussyboy', groped and had someone try to yank my binder outside a nightclub and this was all on the same night."
– Sean, 23 (South West), Stonewall 2017 Report]

41%
of trans people suffered a hate crime or incident in the past 12 months

12%
of trans employees were physically attacked by a colleague or customer in the last year

- Stonewall 2017 Report

Legal Issues

The two pieces of UK legislation that deal specifically with trans people are the Gender Recognition Act (GRA, 2004) and the Equality Act (EA, 2010). The EA is by far the most important as it deals with day-to-day issues and gave rise to the Public Sector Equality Duty (PSED, 2011).

Gender Reassignment is one of the nine Protected Characteristics in the EA. Anyone with that characteristic is entitled to equality in the provision of goods & services, including healthcare. Under the PSED, health services have a duty to eliminate discrimination, advance equality of opportunity, and foster good community relations.

A person acquires the Protected Characteristics of Gender Reassignment from the moment that they propose to undergo such treatment. They do not need to have started treatment, nor do they need to have changed any legal documentation.

A person is also protected if they are discriminated against because they are assumed to have a Protected Characteristic.

For specific issues regarding admission to single-sex facilities, see the section on Crisis Management.

Many issues that trans people face when accessing the NHS are a result of interacting with other patients rather than direct discrimination by NHS staff. See the section on the Service Environment for suggestions.

The GRA is currently undergoing reform. However, it deals only with matters of legal gender. In almost all cases trans people's protections under the EA apply regardless of whether they have changed their legal gender or not.

- For advice on changing trans people's records within the NHS, see: https://www.gp.brightonandhoveccg.nhs.uk/changing-nhs-records]
- For specific issues regarding data protection and trans people, see: "CPS Transgender Equality Management Guidance", Crown Prosecution Service
- For the impact of the GRA on NHS records see Section 7 of the PDS NHAIS Interaction Procedure Guide

> "The NHS is letting down trans people: it is failing in its legal duty under the Equality Act."
> – House of Commons Women & Equalities Committee Report on Transgender Equality, 2016

Tips for Interacting with Trans People

- The most important thing to remember when interacting with trans people is to accept them as who they are. Use the name and pronouns that they ask you to use. This simple act of acceptance will go a long way towards earning their confidence.

- Terminology can be a minefield, even for trans people. Try to worry less about the precise meanings or words, and more about what individual patients mean by them.

- Everyone makes mistakes. However, if you are genuinely sorry, and make that clear in your apology, most trans people will be happy with that. Don't get defensive or try to blame someone else. Don't make a big show of apologising as this will only embarrass the person you have upset.

- Many trans people have to put up with a constant stream of belittling comments from others. Your mistake might be small, but it might be the last straw in a day of humiliations.

- Try to use inclusive language, especially when people's genders are unknown to you. Use "partner" instead of "husband" or "wife". Use "person" instead of "man" or "woman".

- Do not ask trans people for details of their treatment unless it is relevant to the work you are doing with them.

- Don't assume that you know what the needs and preferences of a trans person are. Even if someone is presenting very obviously as one binary gender, they may be afraid to be placed in a single-sex facility.

- Try to make sure that patients have some means of support outside of the health services. Trans people can be very lonely and isolated. Offer support to friends and family if that will help.

- Involve trans people in your process design and feedback systems. Also involve them in recruitment and service development.

More tips are available in the following sections.

Service Environment

The environment that trans people are presented with when they seek treatment has a major influence on how much they trust the practitioners that they meet. If that environment feels unduly hostile they may fail to disclose important details relating to their care, or even just leave.

Avoid requiring anyone to state their gender in public. For example, do not have separate registration lines for men and women, or use sign-in machines that ask for gender in a very visible way.

Talk to patients about how best to announce and/or display their name when they are being called to be seen.

Have posters or leaflets on display showing that your service is trans inclusive. While a rainbow flag is a good means of indicating LGB inclusion, it may not speak to trans people. It is better to use the trans flag and/or symbol.

The increasing number of people identifying as non-binary poses a particular issue in a service that traditionally has catered only to two genders. Providing ways to cater for these people is therefore an urgent priority. Such provision may also help some binary-identified trans people, particularly when they are just starting transition and may be very nervous of how they will be received by others.

Ensure that discriminatory behaviour by other patients towards trans people is dealt with firmly.

Care Planning

The Care Programme Approach[4] provides a framework for managing the care of service users. Service users are entitled to a care coordinator, key nurse and a care plan for a continuity of care and prevent the loss of contact with mental health services.

The care plans should be followed by all the nurses and worked on in collaboration with service users. The key nurse should also review them regularly for any changes and if they are still working for the service user. Care plans could include how to manage risks around gender on mental health units; personal care, one-to-one's, de-escalation, pronouns, preferred names and so on. The plan can also include guidance on how to deal with family who may be unaware of or hostile to the service user's gender identity. Additional support and resources are available, including from the care coordinator and gender champions within both BMH and AWP.

The main aim is to provide patient-centred and compassionate care led by the individual with the support of the health professionals. To establish this, it is good to have a frank and honest discussion early in the relationship. Don't be afraid to say you are learning and have limited knowledge. Ask politely and privately. Listen to what the patient says, and respect their understanding of their identity.

In particular, ask what name, pronoun and identity description a trans person prefers to use in written and verbal communication. Do this politely and in private.

Staff should seek feedback from trans service users about the quality of their care. This can form the basis for further improvements to the service.

4 https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

Crisis Management

"I had to go to casualty once and when the doctor discovered I was trans she asked to see my genitals and show them to another colleague." – Trans man, aged 36–40, North Somerset

Trans people may present in acute emotional crisis that may be brought on by gender dysphoria, or another reason. Trans people can have mental health difficulties completely unrelated to their gender identity. Do not assume that these are related, as they may not be!

If a person is in crisis it is even more important to make sure you acknowledge that person correctly and respectfully. Failure to do so will deepen the crisis that the person is suffering.

If a trans person is to be admitted to hospital you should carry out a risk assessment, taking into consideration known higher risks such as deliberate self-harm, harassment and transphobia.

Forcing a trans person to use a single-sex ward that does not conform to their gender identity is likely to have a catastrophic effect on their emotional wellbeing. The needs of the patient need to be given priority. Trans people may feel unsafe in any ward with other patients. Where to place a trans patient should always be a case by case decision. Ask and involve the patient rather than making decisions for them.

Providing education to other service users in a ward to prevent ignorant or transphobic comments is, if successful, a better solution than having to protect or isolate the trans service user.

There may be no ideal solution. Weigh up risks and benefits of each possibility. Make sure any decisions are made

after consulting the patient fully. Ask for help from senior managers if difficult decisions need to be made.

There may be some circumstances where it is lawful under the Equality Act to provide a different service or exclude a trans person from their preferred treatment or inpatient facility. This is justifiable provided that it is a proportionate means of achieving a legitimate aim. You need to balance the needs of the trans person and the detriment to them if they are denied access etc. versus managing risk safely.

Don't place a trans patient in isolation simply because there is no clear option. Patients should not be punished for being trans. If a sub-optimal decision has to be made, explain the reason to the patient. Make sure that they understand that the decision is unavoidable in the circumstances and not a result of discrimination. Offer advocacy and support for the patient.

In situations where a patient lacks capacity, be very careful who you involve in decision making. Family members are sometimes deeply hostile to trans people.

> "What prevents me from accessing services is not knowing how staff members will react, and how much knowledge about trans issues they will have."

Monitoring

Good quality data is essential for making a business case to provide better services to a particular community and can mean people feel heard. However, trans people may be very reluctant to share information about themselves, especially if the questions seem inappropriate.

Often questions are not asked at all so this leaves Trans people and their needs invisible.

Do's	Don'ts
Do give people the opportunity to identify as non-binary.	Do not ask people if they are lesbian, gay, straight or trans. Being trans is not a sexuality.
Do give the option to use Mx as a title as well as adding non-binary to the gender question.	Do not ask people if they are female, male or trans. Being trans is not a gender.
Do include a free text box for "other". It isn't easy to analyse, but it does make people feel wanted.	Don't try to include every gender you have heard of. There will always be more. The more options you have, the more likely it is that people whose identities are not listed will be upset.
Always give the option to decline to answer.	Don't ask for "legal gender." This has a specific meaning and is not relevant to providing health care.
Ask about intersex people separately.	Most intersex people don't identify as trans. Don't assume they are trans.
Ask separately about trans status.	Some trans people will cease to identify as trans after their treatment is completed. Don't assume or guess.

Suggested questions

Gender:

- Male
- Female
- Non-Binary
- Other [text box]
- Decline to answer

Do you identify as intersex:

- Yes
- No
- Decline to answer

Is your gender different from the sex you were assigned at birth:

- Yes
- No
- Decline to answer

Staff Issues

Policies, Training and Continuous Personal Development (CPD)

Your organisation will have equalities, LGBT+ or trans-specific policies. Staff are expected to read, understand and comply with them. These policies can help staff to understand in more detail the diversity of trans healthcare and terminology. Staff should also be aware of other associated policies, including:

- Acceptable Behaviour
- Concerns and complaints
- Whistleblowing

Your organisation should have mandatory equalities training including face-to-face training at induction with e-Learning refresher courses either annually or every other year.

Each service should have an equality, diversity and inclusion champion(s) and it is recommended that champions attend face-to-face trans awareness training to support their role.

Practitioners are encouraged to discuss equalities issues in relation to clinical practice during clinical supervision and to access the support of equality leads for guidance and advice.

Interacting with trans employees

Staff should act fairly and compassionately, treating trans colleagues with the same dignity and respect as any other colleague. The guidance above for interacting with trans patients applies equally to trans colleagues.

Services should offer a person who identifies that they are, or wish to transition a workplace support plan which could include transition timeframes, how the staff member wishes to be supported, and how they wish to manage communication to colleagues.

Any repeated or deliberate misgendering/use of previous names ('deadnaming') undermines trans people's identity, constitutes harassment and should be reported to a line manager or alternative person. Staff should never inappropriately disclose a colleagues' personal history relating to their gender identity as this is a criminal offence under the Data Protection Act 1998.

Training

> "Sometimes a bad attitude can undermine what little self-confidence a person has. Everyone here and in the NHS needs trans inclusivity training."

Research suggests that most problems that staff have when interacting with trans patients is a result of ignorance rather than malice. With increasing visibility of trans people in the media, more people have an opportunity to educate themselves. Unfortunately this visibility has given rise to anti-trans campaigns in certain parts of the media that spread misinformation.

Good quality trans awareness training for staff is invaluable, especially if it involves actual trans people who are able to tell their own stories. Training should be given at all levels. There is no point in clinical staff being well trained if trans patients are put off by interactions with receptionists, and vice versa.

Training Resources

E-Learning courses on trans issues are available from GIRES: https://www.gires.org.uk/e-learning/.

Opportunities for training on trans issues that can be part of Continuous Professional Development schemes include:

- AWP Champions
- Shadowing or advice from gender specialists.
- Royal College CPD modules.
- GMC CPD modules.

External organisations providing in-depth, face-to-face training on trans issues include:

- Gendered Intelligence: http://genderedintelligence.co.uk/
- The Diversity Trust: https://www.diversitytrust.org.uk/
- Off the Record: https://www.otrbristol.org.uk/
- SARI: https://www.sariweb.org.uk/

The SARI training is available through Bristol Mental Health and regular courses are scheduled.

Other Non-NHS Resources

Mental health support

Priory Hospital Bristol – A team of psychiatrists and therapists, trained on supporting the trans community to tackle a wide range of mental health challenges. www.priorygroup.com

Books

Transgender Health: A Practitioner's Guide to Binary and Non-Binary Trans Patient Care, Ben Vincent PhD, Jessica Kingsley Publishers, 2018 (short, accessible and practical)

Understanding Trans Health, Ruth Pearce, Policy Press, 2018 (more academic)

Guides

Guidance for GPs, other clinicians and health professionals on the care of gender variant people, NHS, 2008

Transgender Guide for NHS Acute Hospital Trusts, Royal Free Hampstead NHS Trust, 2010

Good practice guidelines for the assessment and treatment of adults with gender dysphoria (CR181), Royal College of Psychiatrists, 2013

Fair care for trans patients, Royal College of Nursing, 2017

Supporting & Caring for Transgender Children – American College of Osteopathic Pediatricians, American Academy of Pediatrics, Human Rights Campaign (2016)

Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents – The Royal Children's Hospital, Melbourne (2018):

Supporting transgender and gender-diverse people – The Royal College of Psychiatrists (2018)

Trans Equality At Work –Unite the Union https://unitetheunion.org/media/2511/trans-equality-at-work-guide.pdf

Studies

Trans Health, Care and Wellbeing, The Diversity Trust (April 2018)

Experiences of health care in Sheffield's trans community, Healthwatch Sheffield (March 2019)

Trans Inclusion Policies

Morecambe Bay NHS Trust

https://www.uhmb.nhs.uk/files/3115/1067/2200/UHMB_Transgender_Care_Policy_V1.1.pdf

South London & Maudsley NHS Trust

https://www.slam.nhs.uk/media/409809/trans%20guidance.pdf

Support Groups

Mermaids – A national support group for trans young people and their families: https://www.mermaidsuk.org.uk/.

Freedom Youth – social information, advice and support offering 1:1 and group work for young people across Bristol and South Glos. Working with those 11-25, and supporting their schools and communities. http://www.otrbristol.org.uk/ and http://www.freedomyouth.co.uk

FFLAG – a national organisation for the friend and families of LGBT+ people. Useful for families were the trans person is no longer a child: https://www.fflag.org.uk/.

MindLine Trans+ is a UK wide service offering a confidential, non-judgemental listening space for people who identify as Trans+, non-binary and their friends and families to talk. www.bristolmind.org.uk/mindlinetransplus

Bristol Crossroads provides a supportive, safe, secure social space for all TG people, their partners and family. www.bristol-crossroads.org.uk

The development of this toolkit was coordinated by SARI in partnership with:

STAND AGAINST
RACISM & INEQUALITY

Designed by frankduffy.co.uk

3rd February 2020

Deborah El-Sayed
Bristol, North Somerset
and South Gloucestershire
Clinical Commissioning Group

Dear Ms El-Sayed

RE- Formal Complaint regarding SARI Toolkit

We are a group of concerned clinicians and are contacting you to formally complain about the trans toolkit for which you are the Sponsoring Director. From information available on the internet, we note the toolkit was produced by SARI and endorsed at the BNSSG CCG Governing Body Meeting on 5th November 2019.

We have a number of concerns about this guidance which we wish to raise directly with the CCG. We believe that if the recommendations contained within the toolkit were to be adopted, a number of groups will be at risk of significant harm, particularly young gender non-conforming people, and girls and women.

In December, Dr Griffin asked that a copy of the Equality Impact Assessment (EIA) be forwarded through a Freedom of Information request (1). The response she received from the CCG was that an EIA has not yet been completed (2). Confusingly, she was also informed that the toolkit has not been endorsed by the CCG, although this is contradicted by the minutes of the Governing Body Meeting dated 5th November 2019 stating that "the Governing Body endorsed the toolkit and its dissemination to relevant practitioners" (Page 10 of the minutes). It is also clearly documented on the Governing Body Agenda, dated 5th November 2019, under Risk and Assurance that there are 'No specific risk implications'.

We have itemised individual concerns as follows:

1. **Terminology (Page 3-5)**

   The toolkit describes sex as being 'assigned by medical practitioners at birth'. This is scientifically incorrect and misleading. Sex is determined at the point of fertilisation and revealed at, or often before, birth. It is simply not true that anatomy is not a good guide to the sex of a child. The presence of rare disorders of sexual differentiation (DSD) does not negate the fact that sex is both binary, and necessary for human reproduction. People born

with DSD's have requested that their unique situation is not used to further trans-activist agendas.

Throughout the pages on definitions, sex, gender and sexual orientation are confusingly conflated. Gender is a socially constructed mechanism through which human behaviour deemed acceptable for either sex is rigidly enforced. Many people reject the notion of an inherent gender identity. The notion of 'cis-gender' (meaning simply 'not trans') is therefore increasingly contested as many people, particularly women, regard it as offensive to suggest they naturally identify with second class status.

2. Relationship with mental illness (Page 6)

The toolkit emphasises that being transgender is not a mental illness but cites research suggesting that 66% trans people have been users of mental health services. This number would seem very high, and the lack of curiosity as to why is troubling. If being trans is not an illness, why the urgent need for invasive medical intervention on an otherwise healthy body?

The same section also asserts that treatments provided by gender clinics 'are highly successful'. This is untrue. There is very little evidence of any kind with regard trans healthcare outcomes, and the little data available on long term outcomes suggests that high rates of mental illness and suicide remain post-transition (3).

3. Young people (Page 9 & 12)

The document references the use of puberty blocking drugs, but fails to report the controversy surrounding the adopting of this prescribing policy by the UK's primary gender service for children at the Tavistock Clinic. The toolkit suggests that GnRH analogues, or puberty blockers, are entirely reversible and alleviate distress. There is no evidence to support this assertion. The Tavistock has been criticised for not publishing the results of its own study on these drugs which showed, among other things, a rise in suicidal thoughts amongst young people on blockers (4). Despite these findings, the study was deemed a success and this treatment was rolled out to pubertal dysphoric children (5). Data suggests almost all children prescribed blockers go on to receive cross-sex (or 'gender-affirming') hormones, suggesting children are being put on a one-way medical pathway (6). The claim of reversibility would therefore seem disingenuous. A recent BMJ review of the evidence undertaken by independent academics from the Oxford Centre of Evidence-based Medicine is critical of hormonal intervention in young people, stating "the current evidence base does not support informed decision making and safe practice" (7).

The toolkit also refers to breast binding but fails to provide any of the potentially serious consequences of this practice. Is the CCG satisfied that it is promoting a practice without mentioning that it may results in fractured ribs, respiratory problems and permanent damage to breast tissue in young females (8)?

4. Safeguarding (Page 13 & 15)

It seems doubtful that the CCG should be advocating for practitioners to refer children and young people for life changing medical intervention without parental consent. There is evidence that up to 85% transgender children 'desist' if left alone (9). In addition, there are a growing number of detransitioners who are speaking out about the harm they believe trans healthcare has caused them. It is therefore unsurprising that many parents are reluctant to automatically affirm their child's trans status. At present, a case is being brought against the Tavistock gender service, by an ex-patient who halted her own transition, and a mother of a trans child, who believe medical intervention has proved harmful (10).

The only mention of safeguarding in this document is in relation to dealing with parents who are perceived as 'unsupportive'. It might be more pertinent to consider the wisdom of allowing adults, with adult agendas, access to gender confused children and young people under the guise of 'support provision' in youth groups, schools and social and community spaces, as is promoted throughout the document.

5. Medical Care (Page 16)

The CCG appears to be endorsing an uncritical affirmation of trans healthcare despite lack of available evidence as to its efficacy and safety. There is limited data concerning long term outcomes, and most of the earlier research and clinical guidelines concern older male-to-female subjects. We are witnessing an exponential increase in numbers of younger people seeking interventions, primarily natal females. It is unclear if existing clinical guidelines are suitable for this group. Whilst the toolkit cites the debunked 1% detransition rate, clinical experience would suggest that more of the younger patient group are coming to regret early medical and surgical intervention (11). It is worrying that the CCG appears to be endorsing rapid and unquestioning intervention when the consequence of this intervention is permanent bodily modification, including infertility, loss of breasts and serious medical conditions stemming from hormonal treatment. The statement: '"Doing nothing or delaying treatment **CAUSES HARM**" is debatable.

6. Single sex spaces (Page 19)

Under the Equality Act 2010, when there is a conflict between the needs of various groups with protected characteristics, it is still permissible to discriminate on the grounds of sex if it is a proportionate means in achieving a legitimate aim (12). A good example of this would be the necessity of a female-only psychiatric ward for seriously ill women. It is surprising that the CCG sees fit to endorse a document that recommends the 'needs of the [trans] patient be given priority' when considering which ward to admit to. In the context of the document as a whole, which gives only the vaguest definition of 'trans', including such terms as 'divergent gender expression', 'genderqueer', 'questioning' and those 'who have not yet started treatment', it would seem impossible to differentiate between a trans patient, and a male patient who wishes to access a women's ward for other reasons. Given the high rate of

sexual trauma that female psychiatric patients have experienced, it seems callous to give so little regard to the safety, privacy and dignity of this group. Where trans prison policies have been similarly implemented without any regard for the safety of women, some egregious abuses are known to have occurred (13).

7. **Changing sex marker on medical records (Page 18)**

   It would be important to understand the consideration that the CCG has given to the clinical consequences of responding to requests for change of sex recording on medical records. For a detailed discussion on why this might be unsafe for patients, as well as the resultant confusion in data collection, please see the case study from NHS Scotland (14).

In conclusion, we believe the CCG needs to urgently review its endorsement of this toolkit. It uses selective poor quality evidence to back up claims that are underpinned by ideology, rather than empirical research. In view of the ongoing debate around what constitutes best practice in this area, coupled with the growing evidence that poorly thought-out guidance is causing harm, it might be more appropriate for the commissioners to hold a neutral perspective. It is worrying that the CCG does not appear to be familiar with the legal requirement to assess the impact on groups with protected characteristics when implementing a new policy, especially when there is a high risk of significant harm on vulnerable groups.

We look forward to your response.

Yours sincerely

Lucy Griffin, Consultant Psychiatrist, Bristol

Responding on behalf of:

Richard Byng, GP and Professor in Primary Care Research, University of Plymouth
Damian Clifford, Consultant Psychiatrist, Cornwall
Katie Clyde, Consultant Psychiatrist, Hampshire
xx xxxxx xxxxx, Consultant Psychiatrist, Hampshire
Tessa Katz, GP, London
Julie Maxwell, Associate Specialist Community Paediatrician, Hampshire
David Pilgrim, Professor of Clinical Psychology, University of Southampton
Ellen Wright, GP, London
Pamela Yerassimou, Consultant Psychiatrist, Cardiff

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NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Supporting Trans People Toolkit Listening Event for Clinicians
25 September 2020 @ 5:15-6:30pm

Attending:

Dr Peter Brindle – Medical Director
Sharon Woma, Inclusion Coordinator
Louise Townsend - Customer Service Support Manager
Dr Katie Clyde – Consultant Psychiatrist
Dr Lucy Griffin – Consultant Psychiatrist
Dr Julie Maxwell – Community Paediatrician
Dr Richard Byng – General Practitioner - had to leave at 6pm

Apologies:

Michelle Smith – Associate Director of Communications and Engagement
Alex Ward-Booth – Head of Insights & Engagement

Introduction

It was agreed by all that the notes for this meeting would be in summary form and not formal verbatim minutes.

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG) have arranged listening events with members of the public, women's groups and clinicians to hear the concerns they have about the Supporting Trans People Toolkit.

Dr Peter Brindle, Medical Director for BNSSG began by thanking his clinical colleagues for the joint letter they had previously submitted and for taking the time to meet today. Peter also acknowledged that the Toolkit is a sensitive issue.

Sharon Woma, Inclusion Co-ordinator assured the group that BNSSG is committed to reviewing and taking into account all the documentation that has been submitted by members of the public and clinicians as part of the Equality Impact Assessment (EIA) process, which we plan to present at Governing Body in November 2020.

Peter opened the session to the clinicians for their feedback and input.

Themes from the clinicians – what we heard

- It was noted that concerns raised in the letter dated 3.2.2020 were still relevant and that the comments below are to be interpreted noting the contents of the letter.

- Tone of the Toolkit – it was felt that the Toolkit promotes medical intervention as the only option. The Toolkit should clarify all options that are available and include the risks of medical intervention. Such as the effects of puberty blockers, currently there is not enough evidence to show the impact these drugs can have.
- Lack of good quality evidence in the Toolkit. There is insufficient good quality research available, particularly looking at long-term outcomes. Existing research, such that it is, is largely centred on natal males however there has been a surge in referrals for young natal females – poor evidence is being applied to a new group.
- Concerns raised about the current references to suicidality in the toolkit as irresponsible; suicide rates in young people (trans and non-trans) are low – suggestion that the Samaritans guidance on suicide and self-harm should be used.
- Confusing language within the Toolkit conflating sex and gender.
- Concerns raised about the section on same-sex wards. Concerns were raised that women could effectively be placed on mixed-sex wards if males that self-identify as females were permitted to join the ward.
- Neutrality and shared decision-making principles - Clinicians should be able to work with patients by communicating, listening and making shared and evidence informed decisions, rather than being pressurised into following a pathway that may not be appropriate.
- De-transition rates are likely to be higher than the reported 1%. A long-term review is needed.
- There is a need for more neutral organisations for patients to be signposted to for advice and information, rather than just those with an affirmative approach.
- It was felt that children need time to grow up and explore. Commissioning of therapeutic groups which allow children to do this is really important.
- More neutral guidance needs to be available to schools and parents.
- Gender dysphoria should be treated as any other condition; medically taking the least invasive approach to treatment, with supportive care, normalising and watchful waiting being better clinical practice.
- Medical interventions cause irreversible changes, eg, young females on testosterone grow beards, their voices break and these effects don't go away following cessation of the drugs
- The toolkit mentions surgery specifically for trans men and specifies mastectomy and hysterectomy. Should these interventions be being offered as part of a standard care pathway?
- We believe the CCG should have a view on the ethics of being able to obtain these medications online and GPs should not be coerced into prescribing.

In Summary the key points from the clinicians are:

- Affirmation overstated within the Toolkit.

- Some of the evidence cited in the toolkit is poor and its validity overstated.
- The language/tone of the Toolkit is confused and often not appropriate.
- Risks of irreversible medical intervention are not recognised within the Toolkit.

Next Steps:

Sharon confirmed the next steps.

- Within the coming weeks CCG Clinicians will be meeting with the writing group to discuss the pathways section of the document.
- The feedback from today's meeting with the external clinicians and the other engagement will inform the EIA and this will be shared with the writing group. The CCG hopes that the writing group will consider and reflect on the recommendations.
- EIA to go to Governing Body in November 2020.
- The EIA will be published on the CCG website and all groups that have engaged with the CCG will be notified.

Peter thanked everyone for their time and assured the group that the submissions received and the views given at this event will be considered during the drafting of the EIA, which will then be discussed with the Governing Body to ensure that BNSSG are able to develop services and respond to the needs of all of the population.

Peter confirmed that BNSSG are committed to maintaining communication with members of the public and clinicians about this subject.

Further written representations can continue to be made by email: bnssg.customerservice@nhs.net

Supporting Trans People Toolkit Listening Event
2 July 2020 @ 5:15pm

Attending:

Sarah Talbot-Williams, Independent Lay Member for Public Involvement
Julia Ross – Chief Executive
Michelle Smith – Associate Director of Communications and Engagement
Dr Rachael Kenyon, GP in Woodspring and member of Governing Body
Sharon Woma, Inclusion Coordinator
Vicky Daniell – Customer Service Manager
Louise Townsend - Customer Service Support Manager
2 Members of the Public

1. **Introduction**

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG) arranged a listening event with members of the public to hear the concerns they have about the Supporting Trans People Toolkit.

Julia Ross, Chief Executive for BNSSG began by thanking members of the public for the information they had provided prior to this event and for taking the time to meet today. Julia apologised that wider input was not obtained in the development of this Toolkit and acknowledged that this is a sensitive issue.

Julia assured the group that BNSSG is committed to reviewing and taking into account all the documentation that has been submitted by members of the public as part of the Equality Impact Assessment process. Julia updated on progress to date and then opened the session to public feedback and input.

2. **Themes from the public – what we heard**

- A concern was expressed about the need for transgender support guidance specifically and members of the pubic questioned the broader approach to guidance for other protected groups.
- Concerns were raised about the original authorship of the Toolkit and who will be involved going forward.
- Members of the public stated that a conflict exists between the legal position (sex as protected characteristic) and the toolkit contents which imply gender identity as a protected area.
- Members of the public further raised concerns that biological sex and gender identity have been unhelpfully conflated in the document, and expressed that this would ultimately be harmful to women and girls.
- Members of the public were concerned about the section on same-sex wards. Concerns were raised that women could effectively be placed on mixed-sex wards without knowing it and that this compromises dignity and safety.
- It was stated that women have the right to know if they are on a mixed-ward without having to disclose discomfort or that they have been victims of abuse. It was also raised that women may be scared to speak up, and the onus should not be on women to protect their dignity in single-sex spaces.

- Concerns were raised that NHS staff are being 'forced to accept that men are women' and concede to gender identity as a belief. A comparison was made here with religious belief and freedom of expression.
- Members of the public raised the potential disproportionate impact on young lesbians, and referenced a 4, 400% increase in young women seeking help for dysphoria over the last decade.
- Members of the public raised concerns that Bristol does not have a Lesbian Alliance Group and that schools are referring young people to LGBT+ organisations if they are gender dysphoric.
- Members of the public raised concerns about the current references to suicidality in the toolkit as irresponsible.
- Members of the public raised BNSSG's status as Stonewall Diversity Champions as potentially problematic given the organisation's recent stance on gender issues. Members of the public also questioned female staff within the CCG would feel comfortable with this position.

3. Conclusion

Julia thanked everyone for their time and assured the group that the submissions received and the views given at this event will be built into the EIA, which will then be discussed with the Governing Body to ensure that BNSSG are able to develop services and respond to the needs of all of the population. This is going to be challenging and this is a constantly moving issue and we have to adhere to any legal guidance.

Julia confirmed that BNSSG are committed to maintaining communication with members of the public about this subject.

Further written representations can continue to be made by email: bnssg.customerservice@nhs.net