Areas/questions of interest to the Committee:

1. An overview of the support that NHSGGC currently provide to trans people in Scotland.

The Gender service in NHSGGC has been in existence for approximately 30 years. It was initially part of the Family Planning Service at Claremont Terrace that had approximately 10 adult patients, who attended the service for support and advice with issues around Gender Dysphoria, and this grew slowly over time to around 30 patients. When the Sandyford Initiative opened in 2000, the service began to expand with more people becoming aware of the service, and by 2012 the service also began to see a small number of young people.

The current adult service is one of four in Scotland and sees patients from NHS Lanarkshire, NHS Ayrshire and Arran, NHS Forth Valley, NHS Dumfries and Galloway and NHS Tayside. The adult service also offers further assessment for complex presentations and second opinions for surgery for patients who are seen at gender services in NHS Grampian, NHS Highland and NHS Lothian. This may include prescribing medication or reviewing current prescriptions. Income is received via an agreed financial framework that covers clinical and administration time. No costs are built in for operational management time.

The Gender service for children and young people (<18 years), hosted at Sandyford, is the only one in Scotland and sees patients from all over the country for all aspects of their gender care. Income is also received for this via an agreed financial framework.

Both services are managed as part of Integrated Sexual Health Service and are well connected through Glasgow City HSCP and NHSGGC Board structures. It has an established Governance Framework and strong links through the National Gender Identity Clinical Network in Scotland (NGCINS). The service is also well connected to other services such as mental health, acute services such, as ENT and endocrinology, and works well with the surgical providers, commissioned by NSS for Gender Affirmation Surgery.

The service is staffed by a multi-disciplinary team consisting of psychiatry, psychology, sexual health doctors and specialist occupational therapy, all of whom are part-time. The service has a Clinical Lead with overarching responsibility for the whole service with delegated support from a lead for the Young People's Service.

Over recent years, the service has found it hard to recruit to vacancies which has contributed to the increasing waiting list and times. This is a relatively recent and specialist area of practice and therefore there are few clinicians with either the interest or experience who would be keen to join either team.

With regard to current waiting times to first assessment, the position as at May 2022 is as follows:

Service	**No. of patients**	**Waiting Time**
Young People	1086	3 years
Adult	2101	4 years

Glasgow HSCP through mental health and ADP funds, contributes some funding towards provision of Trans support to three third sector organisations. This includes some Trans specific support services but also broader LGBT+ related support work which is inclusive for Trans people. These services are able to provide some support to those on the waiting list.

2. **The interim Cass review has reported an increase in the number of young people seeking appointments at Gender Identity Clinics. Do you recognise the concerns raised in the Cass review in terms of what you are seeing in Scotland?**

   NHSGGC recognises and shares a number the concerns raised in the Cass Review. Taking into account the initial impact of the pandemic in 2020, the table below shows the annual recurring increase in referral numbers for the young people's service since 2019.

	2019	2020	2021	2022 (Mar)
GP Referral	141	111	198	45
Other Health/Social Care Referral	13	16	10	7
Self Referral	119	80	245	60
Other	44	74	68	3
Total	**317**	**281**	**521**	**112**

3. **More needs to be known about the population who are referred and what the outcomes are, and a lack of routine data collection makes this difficult.**

   Given that the majority of referrals are self-referrals, NHSGGC agrees that there is an issue with lack of information about individuals on the waiting list and more resources are required to interrogate this and appropriately triage.

   We have started to address this, the young people's and adult services' electronic record system (NaSH) has been upgraded to include a gender identity summary which enables recording of age of onset of gender incongruence and whether before or after puberty, direction of transition, key conditions e.g. ASD, outcome of assessment, psychological, medical, non-surgical and surgical treatments, and de-transition.

4. **There is a lack of consensus and open discussion about the nature of gender dysphoria and therefore about the appropriate clinical response**

   Within the service there is consensus about gender incongruence as a diagnosis and subsequent treatments. Balanced clinical judgments and decisions are taken through multi-disciplinary team discussions involving psychology, psychiatry, sexual health doctors, occupational therapy and endocrinology as appropriate. There is also regular patient specific communication with general practice.

5. **Because the specialist service has evolved rapidly and organically, the clinical approach and service design has not been subjected to some of the normal quality controls.**

   We stress that good clinical and governance structures exists to support clinical decision making and maintain patient safety and all clinicians are working within local, national and professional best practice guidelines.

   NHSGGC acknowledges that there is a lack of quality standards and performance indicators in place within the Scottish health system but that this will be addressed via the Scottish Government's Strategic Action Framework. This also applies to strategy and planning, which until recently, had been left to individual Boards with responsibility for gender services. This lack of national direction and strategic planning over recent years, coupled with the significant increase in demand has left the service vulnerable.

6. **That a different a different service model is needed that is more in line with paediatric provision.**

   NHSGGC believes that a properly funded and resourced new service model is required to ensure improved connectivity with other young peoples' services, in particular Child and Adolescent Mental Health Services (CAMHS). This is currently being considered as part of the review of the Gender Reassignment Protocol.

   It is evident that demand for the service exceeds current capacity, and recruitment challenges notwithstanding, the service requires significant additional resource to be able to respond to this.

7. **The Gender Reassignment Protocol is under review. Can you explain the purpose of the Protocol, what the review seeks to achieve, and what role NHSGGC has in it?**

   The current Protocol was developed in 2012 when it was recognised that this was required to support clinical guidance and service standardisation for Health Boards with gender services. Given the changing demography and increasing demand on services, it is essential that this is reviewed and brought up-to-date. The protocol is being reviewed in line with the draft w-PATH standards of Care Version 8 and should address improvements to service access and inequalities of service provision. NHSGGC is represented by clinicians and service managers from the gender service on all aspects of this review.

8. **One of the Scottish Government's arguments for reforming the GRC process is that the World Health Organisation has redefined gender identity-related health, replacing diagnostic categories like "transsexualism" and "gender identity disorder of children" with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood", respectively. It was removed from a list of 'mental and behavioural disorders' and moved into conditions relating to sexual health. What is NHSGGC's view of WHO's reclassification?**

   NHSGGC agrees that Gender Incongruence should not be classified as a mental disorder. However, the reclassification under conditions relating to sexual health only sits comfortably within this category in the broadest sense of gender incongruence meaning distress associated with sexual characteristics and is not within what are existing sexual health services for STI and reproductive health treatment and management. For example, the recent review of the national framework for sexual health services in Scotland does not include gender services and generally sexual health services in Scotland do not deliver gender services. Sexual health clinicians in the main do not have the care and treatment of gender patients within their competency range, other than for sexual health specific presentations. The very nature of clinical gender work requires to have input from mental health specialists, reemphasising the need for a multi-disciplinary approach.

   Within NHSGGC both services currently are managed within the sexual health service and this change does not in itself present operational challenges.

9. **What is NHSGGC's view of the Bill's approach, which effectively separates the process of legal and medical transition?**

   Not all patients who want to transition wish medical care and treatment and therefore this proposed separation would enable people to make this change without having to wait on an NHS assessment. Theoretically this may mean that the demand for clinical services would reduce. However, NHSGGC is concerned that there is the potential for the reverse effect of increasing expectation where people who have legally transitioned may expect the immediate right to clinical services with the purpose of affirming their transition. This would likely cause problems if the clinical judgement is contrary to what the patient expects.

Separation of the two processes would cease the need for specialist medical staff to endorse Gender Recognition Certificates. Currently, there are only a limited amount of clinicians who are approved to do this work which causes additional time delays for patients and resource away from the waiting list.

10. Some witnesses, opposed to the Bill, have raised concerns that without medical oversight in the GRC process, there is a chance that other mental health issues may be overlooked. What is NHSGGC's view of that suggestion?

There is a possibility that this could happen. There is a value in being able to assess mental and emotional health while individuals access gender services. Service users have disclosed to us that they may conceal other mental health issues while accessing gender identity services as they are concerned that doing so may impact on their ability to access transition care. What is important is that transition and care are provided in ways that are reassuring and that open up the possibilities for individuals to seek emotional and mental health support

However, if a patient in this position were to be referred into the specialist gender service, their mental health would be assessed, as it current standard practice, before any treatment were to commence.

11. How does the GRC process currently impact on the work that NHSGGC does in supporting trans people, and what do you think is likely to change as a result of the Bill?

As per response to question 5. There is the potential that patient expectations change in relation to what the service is there to do. This is potentially the case also for primary care services. Additionally there would be no requirement for a specialist clinician to endorse Gender Recognition Certificates which would free up clinical resource and reduce waiting list pressures

12. From your experience, do trans people seeking medical treatment seek to obtain a GRC as part of their overall transition and can you give an indication of the proportion that do seek to obtain a GRC?

Yes, this is the experience of the service. A minority of patients request GRC:

2019: 22
2020: 21
2021: 13

13. Do you think that fewer trans people might seek medical treatment if they are able to obtain a GRC by self-declaration, or do you think a system of self-declaration might encourage more trans people to seek medical treatment?

As per response to question 5.

14. Has NHSGGC supported people with the medical evidence required to obtain a GRC, and if so, what can you tell the committee about the process?

Yes, the adult gender service provides this service. This involves an additional assessment appointment with a registered member of the Gender Recognition Certificate Specialist Panel. Particular paperwork is required to be completed, with the overall process taking around three hours for each patient.

15. It has been suggested, that in Denmark, which has a system of self-declaration, there is now a desire to make access to the medical treatment pathways self-declared as well. Is this something you are aware of and what can you tell the Committee about international practice relating to medical treatment, where systems of self-declaration have been introduced?

NHSGGC is not aware of any international practice in this respect and all patients receive a mental health assessment prior to commencing treatment. NHSGG&C Gender Service has linked in with the Dutch, English, Welsh and Australian services and so is aware of the importance of keeping up to date with international best practice.

16. What is your view on other key provisions in the Bill, such as:

Removing the Gender Recognition Panel from the process

NHSGGC holds the view that removal of this stage would simplify the process for patients and that a confirmation of diagnosis would suffice.

Lowering the age limit from 18 to 16 to obtain a GRC

This would be in keeping with the aims and spirit of the UN Convention of The Rights on the Child and therefore consistent with maintaining personal agency, autonomy and legal decision making.

The requirement to live in your acquired gender for three months, instead of two years and the introduction of a three-month reflection period before a GRC is granted

NHSGGC is of the view that whilst two years may be considered to be too long a cumulative period, six months may be too short a period to fully consider all aspects of a social transition.