Gender Reassignment Protocol Audit
Community Engagement Focus Groups
Report of Findings

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Disclaimer

Contents

Abbreviations

AEARP	Adult Exceptional Aesthetic Referral Protocol
A&E	Accident and Emergency
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Services
FTM	Female To Male (direction of gender reassignment)
GIC	Gender Identity Clinic
GP	General Practitioner
GRP	Gender Reassignment Protocol
IPL	Intense Pulsed Light (hair removal method)
LGBT	Lesbian, Gay, Bisexual and Transgender
MTF	Male To Female (direction of gender reassignment)
NMCN	National Managed Clinical Network
STA	Scottish Transgender Alliance

Glossary

Asexual	A sexual orientation term signifying that a person does not experience sexual attraction.
Gender Dysphoria	A recognised medical condition where a person experiences distress, unhappiness and/or discomfort about their biological sex and/or social gender not corresponding with their gender identity.
Gender Expression	A person's external gender-related appearance (including clothing), speech and mannerisms.
Gender Identity	A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body.
Gender Reassignment	The process of reassigning social gender role, biological sex characteristics and/or legal gender to correspond with the existing gender identity. A person's individual process may or may not include any of the following: hormone treatment, speech therapy, hair removal and various genital and/or non-genital surgeries.
Intersex People	People who have biological variations within their chromosomes, genitals and/or reproductive organs which are in-between what science has traditionally regarded as clearly male or clearly female.
Non-binary People	People who do not self-identify as simply either men or women and therefore are positioned out-with the traditional man/woman gender binary. Such people may instead self-identify as having complex or fluid gender identities or as having no gender.
Pansexual	A sexual orientation term signifying that a person can experience sexual attraction towards other people regardless of gender identity, gender expression or biological sex. It includes potential sexual attraction to non-binary people.
Trans Men	People assigned female at birth who self-identify as men and are undergoing, or have undergone, gender reassignment from female to male in order to live as men for the rest of their lives.
Trans Women	People assigned male at birth who self-identify as women and are undergoing, or have undergone, gender reassignment from male to female in order to live as women for the rest of their lives.
Transgender People	A diverse range of people whose gender identity and/or gender expression do not correspond with the sex they were assigned at birth. This includes, but is not limited to: trans men, trans women, transsexual people and non-binary people.
Transsexual People	People who intend to undergo, are undergoing or have undergone any part of a process of gender reassignment from male to female or from female to male.

Executive summary

Rationale and aim

In July 2012 the Scottish Government approved the NHS Scotland Gender Reassignment Protocol (GRP) and it was cascaded to health boards. NHS Health Scotland has undertaken an audit of the implementation of the GRP on behalf of the Scottish Government. To support that audit process, the Scottish Transgender Alliance (STA) conducted community engagement in October and November 2013. The aim of the community engagement was to explore patient experiences of barriers and facilitators to accessing NHS Scotland gender reassignment services since July 2012 and their views on the degree to which these services meet the four GRP ambitions of equitable, effective, patient-focused and timely provision.

Method

The authors of this report acknowledged their subjectivity, particularly due to being equality professionals and having personal experience of accessing NHS gender reassignment services. These aspects of the authors' backgrounds helped ease community engagement. The authors utilised these methods to maximise objectivity:

- They worked collaboratively with, and incorporated feedback from, the Scottish Government Equality Unit and NHS Health Scotland on project design and delivery
- They adhered to the scope limitations of the GRP audit
- They used carefully phrased questions in a semi-structured facilitation format
- One-third of the focus groups were observed by NHS staff
- The accuracy of the scribed notes were checked against audio recordings (due to time and budget constraints full audio transcription was not feasible)
- They ensured confidentiality was upheld for all participants
- They avoided use of charged language within this report
- A review of the findings for consistency with the data was carried out by two STA staff not involved in the analysis.

In order to reach the maximum number of potential participants, including those not actively engaged with transgender organisations, 500 posters and 6000 flyers were distributed and displayed in a range of NHS and voluntary sector health services, student unions, citizens advice bureaus, transgender support groups and LGBT organisations and venues. Social media and email promotion were also used.

The community engagement balanced geographical accessibility for participants with the need for effective scale focus groups of between 3 and 10 participants each. To aid in the shared development of meaning as well as to aid comfort and confidence in participants, youth specific (under 26 years old), trans women specific and trans men and non-binary specific focus groups were offered in Edinburgh and Glasgow.

In all, 50 people aged 16 and over who had requested or received NHS gender reassignment services since July 2012 participated in the community engagement (48 via nine focus groups and 2 via one-to-one interviews conducted using the same questions as the focus groups).

Scribes recorded the points made by the participants which were then compared to the audio recordings to ensure all points were captured accurately. Each point captured was entered as a line in an excel spreadsheet for analysis. The data were cleaned to exclude instances where participants speculated about others' experiences, discussed services accessed prior to July 2012 or spoke about services to which they had yet to request access. The data were analysed to identify barriers and facilitators to uptake of services in the context of the four GRP service ambitions of equity, effectiveness, patient-focus and timeliness. Central themes were identified within specific parts of the GRP services and ambitions and also across them. The data from participants resident in different areas of Scotland were also compared in an effort to identify similarities and differences between participants' experiences of various Health Boards and Gender Identity Clinics.

The data were stored securely at all times and will be retained by NHS Health Scotland for review at three years post project completion. Once no longer needed, NHS Health Scotland will securely destroy the data.

Findings

The following findings emerged from the community engagement data regarding the extent to which participants considered the GRP four ambitions of equity, effectiveness, patient-focus and timeliness to have been achieved since the publication of the GRP in July 2012. The findings are listed for each type of NHS gender reassignment services.

In regard to Gender Identity Clinic (GIC) services

- Equity:
  - Participants expressed concern that GICs not providing patients with sufficient information was causing inequity in access to services. Nearly all participants were of the view that GICs were not providing patients with adequate clarification of treatments, procedures, access criteria, associated risks and expectations.
  - Long travel distances were highlighted as creating inequity in access to GIC appointments. Participants who were disabled, on low incomes or living in very rural areas experienced this as particularly problematic. Participants wanted local outreach services from GICs, such as satellite appointments at rotating locations beyond the four permanent GIC locations, telephone and webcam appointments and shared-care agreements with local practitioners.
- Effectiveness:
  - Participants felt ill-prepared to use their GIC appointments effectively due to GICs not providing information in advance about NHS gender reassignment. To overcome this barrier, participants suggested that the GICs should provide all those joining their waiting lists with written information including realistic information regarding waiting times, access criteria, GIC expectations of patients and broad discussion of the variety of paths open to transgender patients with an accurate listing of the services and approximate current timelines attached to each path.
  - Self-referral to GICs was praised as more effective and easier than via GPs.
  - Some participants attending the Glasgow Sandyford GIC were concerned that their ongoing GIC appointments were too short in length to be able to

effectively discuss their needs. Appointment length was not raised as a concern in regard to the other three GICs.

- Patient-focus:
  - None of the participants felt that they had been given any co-production opportunities by their GIC doctors to discuss and agree clear treatment plans. Participants said they were not provided with sufficient opportunity within their GIC appointments to discuss the pros and cons of different treatments and expressed concern about lack of transparent GIC communication regarding treatment possibilities and approval criteria.
  - Several participants were concerned that GIC assessment processes were simplistic box-ticking rather than being used to understand patients' needs.
  - Due to fear of being excluded from GRP services, several participants had hidden from GICs their true experiences of childhood, mental health problems, non-binary gender identity and/or genital surgery preferences.
- Timeliness:
  - Young participants stated they had waited between 8 to 16 weeks from referral to their first GIC appointment with the specialist child and adolescent psychiatrist and generally considered this an acceptable waiting period.
  - The participants who accessed GICs as adults over 18 stated strongly that the current adult waiting times from referral to first GIC appointment were too long. They reported waiting an average of around 44 weeks from referral to first appointment and expressed concern that there was inadequate GIC appointment capacity, particularly within the Edinburgh GIC and the Glasgow Sandyford GIC.

In regard to counselling/psychotherapy services

- Equity:
  - Almost two-thirds of the participants who had requested counselling in regard to their gender reassignment had not been able to access any specialist or non-specialist counselling.
  - Only participants attending the Glasgow Sandyford GIC reported any access to specialist counselling from a therapist experienced in working with people undergoing gender reassignment. Participants attending the other three GICs stated that those GICs did not have any specialist gender reassignment counselling capacity.
  - Participants attending the Glasgow Sandyford GIC expressed frustration that information about the specialist counselling service was not routinely provided and this created an uptake barrier. As the other three GICs did not have any specialist counselling capacity, this information provision issue was not relevant to them.
  - Participants also expressed concerns about inequity in availability of support for their children, partners and parents. Only a few participants had been able to access any GIC information signposting them to voluntary sector sources of family support (such as the groups Parents Enquiry Scotland, Me&T Scotland and Mermaids).
- Effectiveness:
  - Participants who had accessed counselling from a specialist therapist all spoke positively about the effectiveness of the counselling they received.
  - Participants who had received more general counselling were concerned that lack of specialist knowledge about gender issues reduced effectiveness.

- Patient-focus:
  - No participants raised concerns about the patient-focus of counsellors. The participants who had accessed the Glasgow Sandyford GIC counselling service were very positive about its empathetic and responsive patient-focus.
- Timeliness:
  - The participants who had been able to access specialist gender reassignment counselling found the waiting time satisfactory.

In regard to hormone treatment services

- Equity:
  - Participants expressed concern about variation in the degree of involvement by endocrinologists and gynaecologists across the four GICs. Participants felt that the GRP lacks clarity about when patients should be referred to see an endocrinologist for specialist hormone treatment decisions and some reported difficulty obtaining referral when they had concurrent health issues.
  - Participants attending Aberdeen GIC were very unhappy that they had to undergo assessment by a gynaecologist prior to approval for hormones and highlighted that they were not given adequate explanations for intrusive questioning and medical investigations (such as ultrasound examination).
- Effectiveness:
  - The majority of participants who had been receiving hormone treatment for several months or more were concerned that their GPs lacked sufficient information to provide effective hormone monitoring.
  - Some of the participants stated that they felt their GICs had not provided them with adequate information about the risks of hormone treatment.
  - A few participants highlighted difficulties in accessing information and referrals regarding fertility preservation options.
- Patient-focus:
  - Participants were satisfied with the patient-focus of endocrinologists.
  - Two trans men and one non-binary person spoke positively about patient-focus in terms of their GIC supporting their hormone preferences and not requiring them to conform to gender stereotypes.
  - However, two participants expressed concerns about mental health difficulties being a barrier to uptake of hormone treatment and felt insufficient patient-focus was being shown by GICs in this regard.
- Timeliness:
  - The young participants who had been given hormone blockers to delay their puberty were satisfied that this took place in a timely manner.
  - Most participants were satisfied with the time they waited for hormone treatment. However, the participants attending the Aberdeen GIC expressed dissatisfaction that having to see a gynaecologist before starting hormone treatment had added an extra 12 weeks to 32 weeks onto their wait.
  - A few participants felt frustrated that an extra 4 to 8 weeks was added to their wait by GIC administrative delays in sending the written approval letter to their GP following GIC assessment as ready to start hormones.

In regard to speech therapy services

- Equity:
  - Although the GRP shows speech therapy as being available to both trans men and trans women, only one of the trans men participating had been

offered any access to speech therapy. However, the trans men themselves were uncertain about whether or not access to speech therapy would be of any benefit to them.

- Effectiveness:
  - Nearly all of the trans women receiving speech therapy were fully satisfied with the effectiveness of the treatment.
- Patient-focus:
  - None of the trans women participants expressed any concerns about the level of patient-focus shown by their speech therapists.
  - The only trans man who had accessed speech therapy expressed dissatisfaction that he felt he was pressurised by the speech therapist to conform to gender stereotypes about masculine body language.
- Timeliness:
  - Nearly all participants who accessed speech therapy regarded it as timely.

In regard to hair removal services

- Equity:
  - None of the participants who were trans men had needed to access any hair removal services.
  - Participants who were trans women reported that access to pre-surgical genital hair removal was generally equitable across their various local health boards.
  - Participants who had requested facial hair removal were extremely concerned about the inequity of access which existed between different local health boards. They reported very wide variation in provision of NHS funded facial hair removal, with some reporting that their local health boards funded all facial hair removal required by participants and others reporting that their local health boards refused to fund any at all.
  - Some health boards provided only laser/IPL sessions and not electrolysis. Participants strongly criticised this as causing inequity for older trans women and those of ethnicities with skin and hair colours unsuitable for laser/IPL.
  - Participants within NHS Greater Glasgow and Clyde all reported a refusal by that health board to fund ongoing facial hair removal after genital surgery had taken place. Participants were strongly critical about this restriction and viewed it as inequitable. No other local health boards were reported to have such a restriction in place.
- Effectiveness key findings:
  - Participants highlighted that while the GRP outlines that trans women may need up to 15 laser/IPL sessions for facial hair removal to be effective, a number of local health boards were restricting the maximum number of laser/IPL session to substantially below 15.
  - Participants highlighted that while the GRP outlines that trans women may need 200 to 400 hours of electrolysis for effective facial hair removal and that laser treatment is not effective for some hair colours and ethnicities, a number of local health boards were not providing any electrolysis and others were providing less than 10 hours of facial electrolysis.
- Patient-focus key findings:
  - Participants in NHS Grampian and NHS Tayside spoke positively about their boards providing open patient choice of hair removal methods and providers.

    - Participants in NHS Grampian proposed that direct payment to hair removal salons would be more patient-focussed than upfront payment by patients.
    - Participants strongly expressed that they felt restrictions on facial hair removal funding ignored the individual needs of patients.
- Timeliness key findings:
    - Several participants reported delays in receiving facial hair removal access.
    - Participants living within health board areas which expected them to pay upfront and claim back a refund, expressed concern about delays of 4 to 16 weeks between applying for and receiving the refund.

In regard to surgical services

- Equity:
    - Nearly all the participants who had requested any surgery expressed concern that lack of provision by GICs of clear information about surgery options, processes and access criteria created inequity.
    - Participants from across Scotland were strongly of the view that the retention of MTF breast augmentation and facial feminisation surgeries under the AEARP was extremely unfair and inequitable.
    - Participants living in NHS Greater Glasgow and Clyde expressed strong concerns that their health board's attempt to implement the GRP had created new AEARP related barriers to uptake that reduced their access to breast augmentation. These barriers included extra non-GIC psychological assessments and long delays without any decision from the plastic surgery team about whether or not they would provide surgery.
    - Participants in NHS Highland and NHS Grampian stated they had access to MTF breast augmentation and facial feminisation surgeries without extra psychological assessments external to a GIC. This was compatible with the GRP guidance on access to surgeries which remain under the AEARP.
    - Trans men resident in NHS Grampian expressed concern that they were still being sent to a local surgeon for FTM chest reconstruction surgery rather than to the NHS National Services Scotland contracted provider.
    - A few trans men were unhappy that FTM chest reconstruction surgery was still subject to BMI restrictions despite its GRP reclassification as a medically necessary core treatment rather than a non-essential aesthetic procedure.
    - Participants expressed concern about inequity between health boards in the provision of travel expenses for out-of-area surgery.
- Effectiveness key findings:
    - Nearly all participants who had received genital surgery expressed serious concerns about the effectiveness of their GPs in dealing with post-operative wound care and complications. They stated they felt that GPs did not have access to sufficient information about FTM and MTF genital surgeries to be able to provide effective care.
    - A view was expressed that making trans women undergo additional non-GIC psychology assessments to access breast augmentation and facial feminisation surgeries would not provide any benefit or risk reduction and that the additional assessments were not an effective use of NHS resources.
- Patient-focus key findings:
    - Most surgery consultations and hospital experiences were rated extremely positively for patient-focus. However, there were a few isolated accounts of local surgeons being rude, arrogant and/or dismissive.

    - Dissatisfaction was expressed in regard to NHS Greater Glasgow and Clyde breast augmentation surgery consultations due to their AEARP procedures.
- Timeliness key findings:
    - The two participants in NHS Lothian who had waited several years for genital surgery funding were hopeful that GRP implementation by NHS Lothian would lead to them receiving surgery soon.
    - The one participant who had interacted directly with NHS National Services Scotland regarding a surgery funding request praised their quick response.

Discussion

Three particularly important themes which emerged from the findings were barriers to uptake of services due to perceived lack of GIC capacity, lack of information provision and lack of service provision for trans women.

Adult participants attending the Glasgow Sandyford GIC and the Edinburgh GIC reported that they experienced long waiting times for first GIC appointments and once attending GICs participants experienced difficulties which they viewed as the result from overstretched service capacity. In regard to GIC provision of counselling, participants expressed concern that only one of the four GICs had any current capacity to provide specialist gender reassignment counselling. Participants also perceived a need for GICs to develop the capacity to provide outreach appointments and shared-care arrangements to reduce the distance and frequency of travel to GIC appointments required of patients in rural areas, on low incomes and who are disabled.

Participants faced barriers to service uptake due to lack of a range of information. Participants identified a need for more information about treatment options, procedures, access criteria, associated risks, likely waiting times and GIC expectations to be provided to them by GICs. Participants did not feel they had access to patient-focussed co-production of their treatment plans with GIC clinicians. They also felt their GPs needed information about effective long-term hormone monitoring and about genital surgery post-operative wound care and management of complications.

The findings showed that many trans women participants were experiencing particularly severe barriers to uptake of facial hair removal and MTF breast augmentation surgery. These services were regarded by many trans women to be as important as genital surgery and integral to successful gender reassignment. Participants were very concerned about the wide variance of provision between different local health boards and also that the amounts and types of facial hair removal being funded by many local health boards remained below what participants regarded as effective. Also of great concern to participants was the barrier to uptake of MTF breast augmentation surgery due to such surgery remaining part of the AEARP. Rather than improving access in this area, the findings highlighted that GRP implementation had a detrimental impact on trans women's access to MTF breast augmentation surgery in NHS Greater Glasgow and Clyde at least. Insufficient participants had requested facial feminisation surgery to identify whether or not there had been any similar detrimental impact on access to facial feminisation surgery due to its retention within the AEARP.

Conclusions

The data suggest that from a patient perspective, nearly all aspects of GRP implementation have started to improved the equity, effectiveness, patient-focus and timeliness of gender reassignment service provision. The key exception to this was the detrimental impact of GRP implementation in regard to access to MTF breast augmentation due to its retention within the AEARP.

The data indicate that the four GRP ambitions are currently being achieved by most health boards in regard to provision of speech therapy and genital surgeries.

However, the data identified that despite improvements resulting from GRP implementation progress, there still remained significant deficits in equity, effectiveness, patient-focus and timeliness within some parts of NHS gender reassignment services. The key deficits highlighted by participants related to GIC capacity, information provision and service provision for trans women.

Recommendations

The STA welcomes the creation of a NHS Gender Identity Services National Managed Clinical Network (NMCN). The STA is keen for the NHS Gender Identity Services NMCN to utilise the whole GRP Audit to develop a national action plan to improve gender reassignment services. The STA offers for consideration the following nine possible improvement activities:

To improve GIC capacity to increase equity and timeliness of appointments and access to specialist counselling:

1. Review GIC capacity relative to demand, invest necessary resources and introduce ongoing monitoring of GIC waiting times.
2. Create a transgender training package to increase the number of NHS counsellors with sufficient knowledge to provide specialist counselling.
3. Develop outreach appointments and shared-care arrangements to reduce the distance and frequency of travel to GIC appointments required of patients in rural areas, on low incomes and who are disabled.

To improve information provision to increase equity, effectiveness and patient-focus of treatment planning and effectiveness of GP role in gender reassignment provision:

4. Develop comprehensive GIC patient information about treatment options, procedures, access criteria, associated risks, likely waiting times and GIC expectations.
5. Develop a national gender reassignment treatment planning co-production toolkit for GIC clinicians to use with patients.
6. Provide GPs with specialist information about ongoing hormone monitoring.
7. Develop information for GPs on post-operative genital surgery wound care and handling of complications.

To improve equity, effectiveness and patient-focus of service provision for trans women:

8. Identify health board best practice in MTF facial hair removal service provision and cascade to local health boards.
9. Remove MTF breast augmentation and facial feminisation surgeries from the AEARP.

1. Introduction

1.1 Background

In July 2012 the Scottish Government approved the NHS Scotland Gender Reassignment Protocol (GRP) and cascaded it to health boards. The GRP applies to primary and secondary care services, and its purpose is to provide a clear and consistent treatment pathway that is equitable, effective, patient-focussed and timely.

From August 2012 to March 2014, NHS Health Scotland has undertaken, on behalf of the Scottish Government, an audit of the implementation of the GRP in regard to its four ambitions of equitable, effective, patient-focused and timely provision of NHS Scotland gender reassignment services. To support the audit, the STA was funded by the Scottish Government Equality Unit to conduct community engagement to gather information about patient experiences of accessing NHS gender reassignment services since the publication of the GRP.

The community engagement was carried out by the STA in October and November 2013 to allow time for health boards to embed the GRP into local services, implement any necessary changes or improvements, and for patients to have had experience of the same. This report details the findings.

1.2 Aims and objectives

The aim of the STA community engagement process was to support the NHS Health Scotland GRP Audit by exploring patient experiences of barriers and facilitators to accessing NHS Scotland gender reassignment services since July 2012 and their views on the degree to which these services meet the four GRP ambitions of equitable, effective, patient-focused and timely provision.

The community engagement had the following specific detailed objectives:

- To gather views of participants about their experiences of whether access to non-surgical services, including Gender Identity Clinics (GICs), counselling/psychotherapy, hormones, hair removal and speech therapy, since July 2012 has been equitable, effective, patient-focused and timely.
- To gather views of participants about their experiences of whether access to surgical services since July 2012, including genital and non-genital surgeries which are core to the GRP and also non-genital surgeries still overlapping with the Adult Exceptional Aesthetic Referral Protocol (AEARP), has been equitable, effective, patient-focused and timely.
- To gather views of participants about their experiences of barriers and facilitators to uptake of gender reassignment services since July 2012.

2. Methodology

2.1 Subjectivity and efforts to maximise objectivity

Traditionally it has been regarded as undesirable to be in any way emotionally connected to, or part of, the community being engaged, due to concern that this could minimise the supposed objectivity of the findings. However, a close and equal insider relationship to the community engagement participants can enable more fruitful and significant data to be gathered. Outsiders to a minority community are not inherently more objective than insiders, rather the subjectivity of those who are out-with the community being engaged is more commonly left unexamined. An advantage of identifying subjectivity is to reflect on the role it plays in helping or obstructing the objective comprehension of the community engagement and how best to ensure quality. When reflexively examined and techniques adopted to maintain objectivity, the subjectivity of those conducting a community engagement process need not result in bias or preclude objectively understanding the data gathered. (Davies[1])

The authors of this report acknowledge their subjectivity, particularly due to being equality professionals and having personal experience of accessing NHS gender reassignment services. These aspects of the authors' backgrounds helped ease community engagement. The authors utilised the following methods to maximise objectivity:

- They worked collaboratively with, and incorporated feedback from, the Scottish Government Equality Unit, NHS Health Scotland and sociology academics throughout all stages of the design, implementation, analysis and reporting of the community engagement.
- They used the GRP as the foundation for the community engagement data collection and avoided the inclusion of any transgender equality issues out-with the scope of the audit.
- They used a semi-structured framework for the community engagement discussions and took great care in phrasing the community engagement questions and facilitating the focus groups to avoid bias.
- They invited NHS Health Scotland and local health board equalities staff to observe as many of the focus groups as they wished. One-third of the focus groups were observed in this way.
- They used the audio recordings of the focus group discussions to check the accuracy of the scribed notes and ensured all relevant points made by participants were captured accurately. (Due to time and budget constraints full audio transcription was not feasible.)
- They ensured that confidentiality was upheld for all the community engagement participants while still maintaining sufficient data files for others to check the findings.
- They avoided using charged language within the report.
- A review of the findings for consistency with the data was carried out by two STA staff not involved in the analysis.

2.2 Advantages of community engagement focus groups

The collection of information about service provision through community engagement has a number of advantages. Engaging the end users of a service can

introduce elements of perception regarding the equity, effectiveness, patient-focus and timeliness of the service provision that are otherwise unavailable to either the designers or the providers of the services. Community engagement can also expose unintended and unforeseen consequences of chosen service delivery methods while also identifying gaps in the coverage of the intended target population.

Focus groups have a long history as a method of data collecting for community engagement. By bringing together participants who feel that they have a common interest, both in sharing their experiences and in presenting their wishes for change, focus groups can help to break down communication barriers put up by real and/or perceived imbalances of power between service users and service providers (Morgan & Krueger[2]). Interaction within a focus group can also help participants to form meaning around the subject of discussion. Where participants may struggle individually to find words with which to express their experiences, the interaction of the group often helps to crystallise vague thoughts into concrete points (McNaghten & Myers[3]).

2.3 Community engagement design and operation

In order to reach the maximum number of potential participants, including those not actively engaged with transgender organisations, 500 posters and 6000 flyers were distributed and displayed in a range of NHS and voluntary sector health services, student unions, citizens advice bureaus, transgender support groups and LGBT organisations and venues. Social media and email promotion were also used.

The community engagement focus group locations balanced geographical accessibility for participants with the need for effective scale focus groups of between 3 and 10 participants each. To maximise accessibility, participants' travel expenses were reimbursed.

A total of nine focus groups and two one-to-one interviews were conducted across Scotland. Focus groups were held in Aberdeen, Dumfries, Dundee, Edinburgh (x2), Glasgow (x3) and Inverness. The first one-to-one interview was conducted for a participant in a very rural area for whom travel to a focus group was not feasible and the second was conducted as a result of having to cancel a tenth focus group due to low turnout. In so doing, it was ensured that no eligible participant was denied the opportunity to participate. It should be noted that the one-to-one interviews were conducted using the same structure of questions as the focus groups. To m

Recognising that homogeneity of participants can aid in the shared development of meaning as well as building a level of comfort and confidence in participants who might otherwise be too intimidated to contribute (Morgan & Krueger[2]), two of the focus groups (one in Edinburgh and one in Glasgow) were made specific to young people aged 16 to 26 years old. Likewise two focus groups were made specific to trans women (Edinburgh and Glasgow) and one in Glasgow was made specific to trans men and non-binary people. This allowed for conversations to develop among people who shared experiences and thus held a common language for their gender reassignment journeys.

In total 50 people aged 16 and over who had requested or received NHS gender reassignment services since July 2012 participated in the community engagement

(48 via nine focus groups and 2 via one-to-one interviews conducted using the same questions as the focus groups). The participants were resident across 11 of the 14 local NHS Health Boards. Unavoidably, participants were self-selecting and due to the qualitative nature of the work, their views cannot be regarded as representative of the population of NHS gender reassignment patients in Scotland.

All nine focus groups were moderated by the same person. This provided for consistency in the style and dynamic of interaction within the groups. The scribes did not participate in the focus group discussions and were located in the room as much as possible out of the view and the attention of the participants.

Three of the focus groups included non-participating observers from the NHS. The two youth events were observed by youth workers from LGBT Youth Scotland.

Information and consent forms were circulated to participants a minimum of 24 hours in advance. After completion of the consent forms, the participants were advised of the ground rules for the focus groups (see Appendix 1). The moderator used nine questions to prompt participants to move through discussing the range of non-surgical and surgical gender reassignment services (see Appendix 2). Discussion was allowed to free flow with the moderator only engaging to ask clarifying questions, prompt the participants to move to the next discussion topic or to encourage engagement of any participants who appeared hesitant to contribute.

In order to be considered as eligible to comment on specific gender reassignment services, participants must have requested or received the relevant service between July 2012 and October 2013 inclusive.

All participants were asked to complete an anonymous diversity monitoring form (see Appendix 3). The questions on the diversity monitoring form were all optional.

2.4 Data collection and analysis

During the focus groups, the scribes recorded handwritten notes of the points made by the participants. In addition, the focus group discussions were digitally audio recorded. The handwritten notes were typed up within 24 hours of each focus group and then compared to the audio recording to ensure all points were captured accurately. Due to the short time period and low budget available for carrying out the community engagement, full transcription of the audio recordings was not feasible.

Each point captured was entered as a line in an excel spreadsheet for thematic coding and analysis. The data were cleaned to exclude instances where participants speculated about others' experiences, discussed services accessed prior to July 2012 or spoke about services to which they had yet to request access. The data were analysed to identify barriers and facilitators to uptake of services in the context of the four GRP service ambitions of equity, effectiveness, patient-focus and timeliness. All points in the data were sorted and categorised to the appropriate GRP ambitions and service types. Central themes were identified and coded both within specific parts of the GRP services and ambitions and also across them. The data from participants resident in different areas of Scotland were also compared in an effort to identify similarities and differences between participants' experiences of various Health Boards and Gender Identity Clinics.

NHS Health Scotland was the data controller and the STA was the data processor. All paper documents and data relating to the community engagement were stored securely and converted to password protected electronic files then the paper documents were cross-cut shredded and disposed of as confidential waste. Once the analysis and report writing was completed, the electronic data files were transferred to NHS Health Scotland for secure password protected retention and review three years post project completion. Once no longer needed, NHS Health Scotland will securely destroy the data.

3. Findings

3.1 Participant demographics

The 50 participants were resident across 11 of the 14 local NHS boards in Scotland. In terms of age, they were reasonably evenly spread across the ages of 16 to 65. Over three-fifths were trans women, a quarter were trans men and 10% were non-binary trans people. Almost all were white British, Scottish, English or Northern Irish. The participants had a wide diversity of sexual orientations. One-third of the participants identified as disabled. (See Appendix 4 for detailed diversity statistics.)

3.2 Participant gender reassignment services access since July 2012

All of the 50 participants had attempted to access at least one type of NHS gender reassignment service between July 2012 and October 2013 inclusive. To help protect anonymity the exact numbers have been obscured where less than five.

It is important to note that five participants had finished their direct contact with their Gender Identity Clinic before July 2012 but were still receiving other types of NHS gender reassignment services such as hair removal and surgeries between July 2012 and October 2013 inclusive.

Types of NHS Gender reassignment services	Number of participants who requested or received service since July 2012 (n)	Number of participants who actually received service since July 2012 (n)
Gender Identity Clinic	45	42
Counselling/psychotherapy	27	10
Hormones	41	38
Speech therapy	16	13
Hair removal	27	18
MTF genital surgery	12	*(<5)
MTF breast augmentation surgery	7	*(<5)
Facial feminisation surgery	*(<5)	*(<5)
FTM chest surgery	9	*(<5)
FTM hysterectomy surgery	*(<5)	*(<5)
FTM genital surgery	*(<5)	*(<5)
Non-Binary genital surgery	*(<5)	*(<5)

Table 1: Participant gender reassignment services access (n)

3.3 Findings regarding Gender Identity Clinic services

3.3.1 Relevant GRP implementation expectations

The flowchart on the first page of the GRP highlights that once the GIC has made a provisional diagnosis of gender dysphoria in regard to a patient then the next stage should be to 'discuss treatment possibilities and agree preoperative 12 month experience and/or other treatment start dates with patient'. (NHS Scotland, 1[4])

The GRP also states:

> 'At the beginning of the preoperative 12 month experience the GIC and patient should discuss the practicalities and requirements of the experience and details of patient and family support mechanisms as well as the possible treatments available.' (NHS Scotland, 2[4])

The GRP makes clear that:

> 'Throughout the process of gender reassignment all treatments, procedures, access criteria, associated risks and expectations should be clarified with the patient. An individualised programme of information provision, services, treatment, and surgery as appropriate to the person's individual needs and situation should be discussed and agreed as the patient progresses through the preoperative 12 month experience. Treatment can be reviewed and modified by agreement of those involved.' (NHS Scotland, 2[4])

3.3.2 Equity

Concerns about time and expense barriers faced in travelling to GIC appointments emerged from the data. Most of the participants who were resident in local health board areas other than NHS Lothian and NHS Greater Glasgow and Clyde expressed dissatisfaction that their access to gender reassignment services was inequitable because they had to travel long distances for GIC appointments. Particular concerns were raised by participants who were disabled or who lived in extremely rural areas or on the islands rather than the mainland. Even where travel expenses could later be claimed back, several participants stated that they had low incomes and therefore they struggled to pay upfront for petrol or bus/rail tickets to get to their GIC appointments. To keep upfront costs as low as possible, some participants stated they had to pre-purchase non-refundable travel tickets and then felt financially penalised if their GIC appointment date was changed at short notice. A common solution proposed by participants was that GICs should utilise local outreach methods, such as satellite appointments at rotating locations beyond the four current GIC permanent locations, telephone and webcam appointments and shared-care agreements with local NHS practitioners.

Another concern raised by the majority of participants was that GICs had not provided them with information about what NHS gender reassignment treatments and services were available. Participants were strongly of the view that the GRP had not been fully implemented by the four GICs in terms of providing patients with clarification of treatments, procedures, access criteria, associated risks and expectations. Participants highlighted that inequity was created by this lack of clarity because it meant that if they failed to manage to find out from the internet or other transgender people about their options then they were unable to make informed choices about whether or not to request access to various treatments and services.

Participants expressed repeatedly that they felt the GICs expect patients not only to inform themselves about their options, but also to independently determine in advance of attending the GIC what treatments they needed and to be able to self-determine the right time to request different things. This was perceived by the majority of the participants as being a test by the GICs of a patient's determination and seriousness about pursuing gender reassignment.

3.3.3 Effectiveness

Participants highlighted that a barrier to GIC service effectiveness was the lack of information from GICs for patients regarding the general nature of the NHS gender reassignment assessment process and available services. There was consensus across the focus groups that, in the absence of any clarifying information from GICs, participants felt they were ill-prepared to use appointments effectively and also assumed that GICs would expect them to present very stereotypical transsexual narratives and immediate certainty about wanting hormones and surgeries, which created a barrier to honestly describing their own experiences and effective consideration of different treatment options. Participants were particularly concerned about the impact on effectiveness of a lack of advance information about their first GIC appointment when they were most nervous and unsure of what to expect.

To overcome this barrier, participants suggested that the GICs should provide those joining their waiting lists with written materials to help to clarify options and GIC expectations so that they could be ready to utilise their appointments as effectively as possible. Participants felt that this should ideally include realistic information regarding waiting times, access criteria, GIC expectations of patients and broad discussion of the variety of paths open to transgender patients with an accurate listing of the services and approximate current timelines attached to each path.

Several participants highlighted that being able to self-refer to a GIC rather than relying on a GP referral was a particularly good facilitator to uptake. Self-referral was considered to be significantly easier and indeed one participant, who had not realised they could self-refer, gave an account of experiencing delay due to their GP insisting that referral to a GIC needed to be from their Community Mental Health Team while their Community Mental Health Team insisted the referral needed to be from their GP.

Several participants receiving Glasgow Sandyford GIC appointments expressed concerns that their appointments were too short to be able to effectively discuss their gender reassignment needs. They felt that 50 minute appointments would be more appropriate than appointments of between 10 minutes and 30 minutes duration. Their frustration with the short appointment duration was increased by the long distances they had travelled to get to their appointments. The length of appointments was not raised as a concern by participants attending other GICs.

A barrier to effective uptake of services was identified by participants as a lack of NHS communication about the progress of referrals by GICs to surgical services. Several participants recounted being told verbally at GIC appointments that they would be referred for surgery only to then find themselves waiting months without any confirmation from the GIC or the surgical service which caused them

considerable uncertainty and anxiety about whether their referrals had been processed. Participants felt that a solution would be for the GICs to provide patients with copies of their referral letters and information about likely timescales for first contact by the relevant surgical service together with details of what to do if the surgical service did not contact them within the expected timescale.

3.3.4 Patient-focus

Participants identified serious concerns in regard to the level of patient-focus by GICs. Most notably, none of the participants felt they had been given the opportunity to discuss and agree a clear treatment plan by their GICs. Participants said they were not provided with space to discuss the pros and cons of different treatment options within their GIC appointments. Nearly all of the participants expressed concerns in regard to what they regarded as a lack of transparency from GICs about possibilities for treatment and approval criteria despite the GRP specifically stating that this information should be given to patients (NHS Scotland, 2[4]).

Several participants expressed particular concern that the process of assessment was simplistic box-ticking rather than being used by the GICs as an opportunity to improve their understanding of the patient's individual needs, 'It's not very person-centred. You feel like you're on a conveyor belt' (Participant 3.3). One participant stated, 'I was unsure about my options, but the appointment was just a chat about me and then straight onto the second opinion' (Participant 4.5) while another said, 'It's like talking to a robot' (Participant 1.8).

Several participants across the four GICs stated that they had hidden from GIC doctors their true experiences of childhood, mental health problems, non-binary gender identity, or decisions that they would not undergo genital surgery. They stated that they hid this information out of fear that if they discussed these issues openly the doctors would exclude them from any gender reassignment services: 'You're scared to put a foot wrong for fear they will pull all treatment from you. They control the game without telling you the rules.' (Participant 4.4). These fears may often be unfounded and indeed one participant was particularly pleased that their GIC doctor turned out to actually be 'very open-minded' about non-binary gender presentations (Participant 7.3). However, there were a few participants who recounted that their honesty in these areas had caused problems for them in terms of accessing services. For example, one participant's perception was that upon telling their GIC doctor that they did not want genital surgery the doctor no longer regarded them as being serious about gender reassignment.

3.3.5 Timeliness

Participants who were young enough to have received their first GIC appointment with the Child and Adolescent Psychiatrist at the Glasgow Sandyford GIC reported that their first appointment was within 8 to 16 weeks of self-referral and that this was an acceptable waiting period. They were relieved that they did not have to wait as long for their first appointment as older participants did. The adolescent participants stressed that timeliness of GIC access was very important to them as a facilitator to uptake of services because they were in the process of going through very upsetting unwanted pubertal changes and felt that early intervention with hormone blockers would reduce their distress and improve the physical effectiveness of their subsequent gender reassignment.

The participants who accessed GICs as adults over 18 stated strongly that the current adult waiting times for a first GIC appointment were too long. They reported waiting on average around 44 weeks from referral to first appointment. They expressed concern that there was inadequate GIC appointment capacity, particularly within the Edinburgh GIC and the Glasgow Sandyford GIC. A few participants additionally recounted that due to appointments being double-booked by GIC administrators and lack of appointment availability, they had ended up with gaps of nine months to 18 months between some of their GIC appointments which had caused delays to their gender reassignment access to hormones and surgeries.

3.4 Findings regarding counselling/psychotherapy services

3.4.1 Relevant GRP implementation expectations

The GRP states that:

> 'Regular psychotherapy and counselling should be available throughout the process. Patients require counselling from those with specialist knowledge of gender issues. GPs and Gender Clinicians should also signpost patients to external support networks. Sessions should be made available to help the patient, their families, partners and carers.' (NHS Scotland, 5[4])

3.4.2 Equity

Inequity in service provision was identified by participants as a barrier to uptake of gender reassignment counselling. Almost two-thirds of the participants who had requested counselling in regard to their gender reassignment had not been able to access any specialist or non-specialist counselling. Only participants attending the Glasgow Sandyford GIC reported any access to specialist counselling from a therapist experienced in working with people undergoing gender reassignment. Participants attending the other three GICs stated that those GICs did not have any specialist gender reassignment counselling services.

Participants attending the Glasgow Sandyford GIC expressed frustration that information about the specialist counselling service was not routinely provided and that this created an uptake barrier. It emerged that the participants who did know about the specialist counselling available at the Glasgow Sandyford GIC had found out in an ad-hoc manner from other transgender people or from happening to access information about Sandyford services which had not been given to them at their GIC appointments. They had then self-referred to the Sandyford specialist counselling service. As the other three GICs did not have any specialist counselling services, this information provision issue was not relevant to them.

Participants also expressed concerns about inequity in availability of support for their children, partners and parents. Several participants recounted that they had requested support for their families but had not received any GIC information or sign-posting. Only a few participants had been given any information about sources of support for their families. The support those few participants had been sign-posted to were the small voluntary family support groups Mermaids (www.mermaidsuk.org.uk), Parent's Enquiry Scotland (www.parentsenquiryscotland.org) and Me&T Scotland (www.meandtscotland.wordpress.com).

3.4.3 Effectiveness
The participants at the Glasgow Sandyford GIC who had been able to access specialist gender reassignment person-centred counselling all spoke positively about the effectiveness of the counselling they received. None of the participants who attended other GICs had been able to access counselling from a therapist with specialist knowledge of gender issues.

The participants who had received support from general NHS mental health services without any knowledge of gender reassignment issues expressed concern that this lack of specialist knowledge had reduced the effectiveness of the support. For example, one stated that his local psychologist's lack of understanding of transgender issues meant that the appointments made him feel worse rather than better but there was nothing else available to him. Another participant was upset that the effectiveness of their general NHS mental health service counselling was reduced due to their GIC apparently never responding to the counsellor's requests for collaborative working.

3.4.4 Patient-focus
No concerns were raised by any participants about the patient-focus of counsellors. Participants who had been able to access the Glasgow Sandyford GIC specialist gender reassignment counselling service all spoke very positively about its patient-focus, commenting in particular that the counsellor is empathetic and that patient-focussed flexibility is shown regarding fitting in urgent appointments during crisis as well as the number of appointments a person can receive.

3.4.5 Timeliness
The participants who had been able to access specialist gender reassignment counselling stated that they found the waiting time satisfactory and two particularly commented that they were able to access the service quickly within a few weeks of self-referral.

3.5 Findings regarding hormone treatment services
3.5.1 Relevant GRP implementation expectations
The GRP states that:

> 'The criteria for hormone therapy are as follows:
> 1. Persistent, well-documented gender dysphoria
> 2. Capacity to make a fully informed decision and to consent for treatment
> 3. Aged at least 16 (see page XX for protocol details for children and adolescents aged under 16)
> 4. If significant medical or mental health concerns are present, they must be reasonably well controlled.' (NHS Scotland, 7[4])

The GRP states:

> 'The appropriate clinician is required to prescribe and monitor hormone treatment via blood tests (with support from the GIC). This includes the referral to endocrinologists and gynaecologists. This should be monitored at least every 6 months in the first 3 years by the GP / gynaecologist / endocrinologist depending on local availability and yearly thereafter dependant on clinical need.' (NHS Scotland, 5[4])

The GRP also states that '…patients should be made aware of the risks and the importance of long term monitoring.' (NHS Scotland, 8[4]) and that:

> 'Hormone therapy can provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so. Hormones can be given to patients who do not want surgery following diagnosis with a qualified mental health professional following minimal standards listed above. In some patients hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery.' (NHS Scotland, 8[4])

3.5.2 Equity

The key hormone treatment equity issue which arose from the data was variation in the degree of involvement by endocrinologists and gynaecologists in the approval and monitoring of hormone treatment across the four GICs. Participants were concerned that the GRP lacks clarity about when patients should be referred to see an endocrinologist for specialist decisions on their gender reassignment hormone treatment.

A few participants, from different local health boards, stated that they had access to regular appointments with an endocrinologist because they had intersex variations in addition to undergoing gender reassignment. Those participants were satisfied with the hormone monitoring this provided. However, most participants without underlying intersex variations, from a variety of local health boards, reported finding it difficult to get referred to an endocrinologist even when they had concurrent health issues which complicated their hormone treatment.

Participants attending the Edinburgh, Inverness and Glasgow Sandyford GICs stated that they were not routinely assessed by an endocrinologist or gynaecologist prior to starting hormone treatment. Instead they described the GIC doctors arranging blood tests and only involving an endocrinologist if the blood test results came back abnormal. However, the participants attending the Aberdeen GIC reported that to access hormone treatment they had to attend an appointment with a fertility clinic doctor. They stated that they initially believed the fertility doctor to be an endocrinologist but the doctor subsequently turned out to be a gynaecologist. These participants were all unhappy that the doctor was a gynaecologist rather than an endocrinologist as no explanation why had been given to them. The trans men also stated that they found it humiliating to have to attend an appointment with a gynaecologist at a fertility clinic.

The participants attending the Aberdeen GIC were also concerned that they were being required to undergo more investigation before starting hormones than those attending other GICs. They stated that they felt insulted that, rather than the gynaecology appointment being focussed solely on their physical suitability for hormones, they were asked about their gender dysphoria and gender reassignment plans when they viewed such questions as not relevant to the purpose of the appointment. One participant also found it particularly distressing that in order to access hormone treatment he was told he had to undergo a vaginal or abdominal ultrasound examination without being informed of the reason it was needed or the results.

3.5.3 Effectiveness

The majority of the participants who had been receiving hormone treatment for several months or more stated that they were concerned about lack of monitoring of their ongoing hormone use. They reported that their GICs had not provided either them or their GPs with information about how frequently they should have their health checked while receiving long-term hormone treatment or what types of health checks should be carried out.

Some of the participants stated that they felt their GICs had not provided them with adequate information about the risks of hormone treatment. They reported that they felt their GICs had instead expected them to research the risks themselves via the internet and from speaking to other transgender people. Additionally, a small number of participants highlighted that possible ways to preserve fertility prior to starting hormones were not discussed unless the participant specifically asked and even then the necessary information and referrals were rarely provided.

3.5.4 Patient-focus

There were very few concerns raised about patient-focus in regard to hormone treatment. Those who had been referred to see endocrinologists expressed no concerns about the patient-focus of their endocrinologists. Additionally two trans men and one non-binary person spoke positively about patient-focus in terms of their GIC supporting their preferences about hormone treatment and not being asked to conform to gender stereotypes for access to hormones.

However, two participants expressed concerns about mental health difficulties being a barrier to uptake of hormone treatment and felt insufficient patient-focus was being shown in this regard. One believed that a single incident of self-harm within the previous two years was preventing them getting access to hormones while the other stated that they had their readiness for hormones questioned due to experiencing panic attacks. These two participants felt this was unfair and not patient-focussed because, in the participants' opinions, their mental health issues were due to their gender dysphoria and could have been helped by starting hormone treatment sooner rather than later.

3.5.5 Timeliness

The young participants aged 16 and 17 who had been given hormone blockers to delay their puberty while under the age of 16 were satisfied that this took place in a timely manner. For example, one participant waited 12 weeks for their first GIC appointment and was delighted to be able to receive hormone blockers 12 weeks after their first appointment.

Most participants were satisfied with the time they waited for hormone treatment. However, the participants attending the Aberdeen GIC expressed dissatisfaction that waiting to see a gynaecologist before starting hormone treatment had added between 12 weeks to 32 weeks onto the length of time they had to wait for hormone treatment to begin.

A few participants felt frustrated that their access to hormones were delayed between 4 to 8 weeks by GIC administrative delay sending the written approval letter to their GP following GIC assessment as ready to start hormones.

3.6 Findings regarding speech therapy services

3.6.1 Relevant GRP implementation expectations

Within the GRP, speech therapy is listed as a service available regardless of the direction of gender reassignment being undergone (NHS Scotland, 1^4) and is described as enabling patients 'to work towards a voice which is more appropriate for their chosen gender' (NHS Scotland, 5^4).

3.6.2 Equity

Although the GRP shows speech therapy as being available to both trans men and trans women, only one of the trans men participating had been offered any access to speech therapy. However, the trans men themselves were uncertain about whether or not access to speech therapy would be of any benefit to them.

3.6.3 Effectiveness

Nearly all of the trans women receiving speech therapy were fully satisfied with the effectiveness of the speech therapy services they were receiving. Two felt that the effectiveness of their speech therapy was limited by their starting vocal range. Two other trans women highlighted that they were pleased their speech therapist provides not only assistance with voice but also with gendered body language and felt this further increased the effectiveness of the therapy they received.

3.6.4 Patient-focus

None of the trans women participants expressed any concerns about the level of patient-focus shown by their speech therapists. However, the only trans man who had accessed speech therapy expressed dissatisfaction that his pre-testosterone vocal needs were not addressed and that he felt he was pressurised by the speech therapist to conform to gender stereotypes about masculine body language.

3.6.5 Timeliness

Nearly all the participants that used speech therapy services said that access was quick and easy. Two expressed dissatisfaction that they had experienced a wait of over 18 weeks.

3.7 Findings regarding hair removal services

3.7.1 Relevant GRP implementation expectations

The GRP states in regard to facial hair removal:

> 'The removal of facial hair is seen as an essential part of gender reassignment for a transsexual woman to facilitate the preoperative 12 month experience…
>
> It is recommended that facial hair removal should commence prior to the preoperative 12 month experience as the beard must grow to visible lengths to be removed.
>
> Electrolysis is the most safe, effective way of removing facial hair. Hair removal should be funded by the patient's Health Board and should only be carried out by a skilled operator. Electrolysis may require between 200 – 400 hours of treatment.

> Laser and Intense Pulse Light (IPL) treatment for facial hair removal may require up to 15 sessions. It is most effective on those with dark hair and fair skin and is unsuitable for treating non-pigmented hairs such as grey, white, blonde and red. Some modern lasers are able to effectively treat racially pigmented skin.' (NHS Scotland, 15[4])

In regard to hair removal from surgical donor sites, the GRP states:

> 'FTM patients require hair removal prior to radial artery phalloplasty or radial artery urethroplasty; otherwise the patient would have hair-bearing skin on the inside of the neourethra. MTF patients require [genital] hair removal prior to vaginoplasty and labiaplasty.
> Electrolysis may require 32 sessions over a period of 6 months (ensuring no re-growth). An alternative and more cost effective approach is for hair follicles to be removed during surgery, this would have to be discussed and agreed with the surgeon performing the procedure.
> Hair removal from the donor site can be performed with a surgeon's recommendation prior to completion of the preoperative 12 month experience in order to reduce delays in surgery.' (NHS Scotland, 15[4])

3.7.2 Equity

None of the trans men participating in the focus groups had needed to access hair removal so nothing could be determined from the data regarding hair removal service provision for trans men.

For trans women, experiences of access to pre-surgical genital hair removal was relatively equitable across the participants' various local health boards. However, the data highlighted inequity in regard to trans women's access to facial hair removal services. Large variations in both the type and quantity of facial hair removal funding provided by the different local health boards were reported. Some participants expressed great distress about difficulties accessing facial hair removal and regarded facial hair removal as integral to successful gender reassignment.

Participants living in NHS Tayside and in NHS Grampian stated that they were able to get all the facial hair removal funding they felt they needed and that they could access any individual mix of both NHS funded laser/IPL services and NHS funded electrolysis services as they preferred and needed. However, participants in NHS Grampian expressed concerns that they were expected to pay upfront and then claim back the cost and that they experienced delays in being refunded. Participants on low incomes experienced this as a barrier to uptake.

At the other end of the spectrum, the participants living in NHS Ayrshire and Arran and in NHS Dumfries and Galloway reported that they had not been able to access any hair removal funding at all.

Other specific experiences within local board areas of residence included:

- NHS Greater Glasgow and Clyde: Participants reported being provided with a maximum of 15 sessions of laser/IPL but not having access to any NHS funded electrolysis. All reported a health board refusal to fund ongoing facial hair removal after genital surgery had taken place.

- NHS Highland: Participants reported that initially after the GRP publication all costs incurred for any individual mix of both laser/IPL and electrolysis within the private sector were refunded (the patient had to be able to afford to pay upfront). However participants stated that more recently they were only provided with laser facial hair removal using an NHS facility in Dundee and not electrolysis. Some participants stated that officially they were told they could only receive 6 sessions of laser but in fact they had been able to keep going beyond this number of sessions. They also reported that they experienced no problem with continuing to access facial hair removal funding after genital surgery.
- NHS Lothian: Participants reported being provided with a maximum of 6 sessions of laser/IPL or 6 sessions of electrolysis. (In contrast participants stated that NHS Lothian offered them up to 32 sessions of electrolysis for genital hair removal.) Some participants were dissatisfied that they were not allowed to access a mixture of laser/IPL and electrolysis even though their hair removal specialist had advised that mixed treatment was needed.

Restrictions on access to electrolysis were very strongly criticised by participants. They emphasised that such restrictions cause inequity for older trans women who have white facial hair and also cause inequity for a variety of ethnicities with skin and hair colour combinations unsuitable for laser hair removal treatment.

3.7.3 Effectiveness

Participants highlighted that while the GRP outlines that trans women may need up to 15 laser/IPL sessions for facial hair removal to be effective, a number of local health boards are restricting the maximum number of laser/IPL session to substantially below 15.

Participants highlighted that while the GRP outlines that trans women may need 200 to 400 hours of electrolysis for effective facial hair removal and that laser treatment is not effective for some hair colours and ethnicities, a number of local health boards were not providing any electrolysis and others were providing less than 10 hours of facial electrolysis.

3.7.4 Patient-focus

Participants from NHS Grampian and NHS Tayside liked the patient-focussed flexibility provided by those health boards being willing to let each patient select their type of hair removal sessions and private sector provider. However, participants in NHS Grampian recounted difficulties they had experienced in regard to paying upfront and then waiting months for a refund. They proposed that direct payments by the health board to the selected hair removal service provider would be a more patient-focussed payment system.

Participants resident in local health boards which placed restrictions on facial hair removal funding strongly expressed that they felt such restrictions ignored the individual needs of patients.

3.7.5 Timeliness

Several participants across a range of local health boards expressed concerns about delays in the process of receiving funding approval for facial hair removal. In addition the participants living within health board areas which expected them to pay upfront

and claim back a refund, expressed concern about time periods of 4 to 16 weeks between applying for and receiving the refund.

3.8 Findings regarding surgical services

3.8.1 Relevant GRP implementation expectations

The GRP states in regard to FTM chest reconstruction surgery:

> 'The procedure can take place during the preoperative 12 month experience provided it has been agreed in their treatment plan with their GIC and referral is accompanied by one assessment from an appropriately qualified professional.
> Testosterone can make the binding of breasts more uncomfortable, whereby some patients experience breast growth and increased sensitivity, thereby raising the issue of having this treatment prior to hormone treatment.
> This is an irreversible procedure and timescales for when the surgery should take place should be agreed by the GIC in discussion with the patient.
> Criteria for mastectomy and creation of a male chest in FTM patients:
> 1. Persistent, well-documented gender dysphoria
> 2. Capacity to make a fully informed decision and to consent for treatment
> 3. Aged at least 16 (see page XX for protocol details for children and adolescents aged under 16)
> 4. If significant medical or mental health concerns are present, they must be reasonably well controlled.' (NHS Scotland, 13[4])

In regard to FTM and MTF genital surgeries, the GRP states:

> 'Patients should only be referred for genital surgery once they have completed the preoperative 12 month experience as agreed in their treatment plan with their GIC and two separate assessments and diagnoses of transsexualism have been provided from appropriately qualified professionals.
> Criteria for genital surgery in FTM patients and MTF patients:
> 1. Persistent, well documented gender dysphoria
> 2. Capacity to make a fully informed decision and to consent for treatment
> 3. Aged at least 16 (see page XX for protocol details for children and adolescents aged under 16)
> 4. If significant medical or mental health concerns are present, they must be well controlled
> 5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones)
> 6. 12 continuous months of living in a gender role that is congruent with their gender identity.' (NHS Scotland, 13[4])

As part of the implementation of the GRP, all FTM genital surgeries and MTF genital surgeries where the patient's second assessment occurred from 1st October 2013 onwards should be arranged and funded by NHS National Services Scotland with the relevant England-based private surgical teams. All FTM chest reconstruction

surgeries, regardless of the date that the patient's second assessment occurred, should be arranged and funded by NHS National Services Scotland with the relevant England-based NHS surgical team. (Evans[5])

In regard to MTF breast augmentation surgery and MTF facial feminisation surgery which remain governed by the Adult Exceptional Aesthetic Referral Protocol (AEARP), the GRP states:

> 'Aesthetic surgery is not routinely offered by the NHS and can only be provided on an exceptional case basis. Patients will only be referred for this surgery following a clinical assessment by their GIC and where there is a symptomatic or functional requirement for surgery. All cases will be referred to a panel for consideration and assessment against agreed criteria on an individual basis.
> Access criteria will consider age, body mass index (BMI), impairment of function, and psychological distress. Referral for consideration does not necessarily mean that surgery will be offered. This must be communicated to the patient.' (NHS Scotland, 6[4])

3.8.2 Equity

The data revealed four areas of inequitable access to gender reassignment surgeries.

Nearly all the participants who had requested any type of gender reassignment surgery expressed concern that lack of provision by GICs of clear information about surgery options, processes and access criteria created inequity in access. This inequity was very similar to that created more generally by the GICs not properly discussing treatment options, processes and access criteria with patients, which was highlighted in Section 3.3.2 of this report.

Participants from across Scotland were strongly of the view that the retention of breast augmentation and facial feminisation surgeries under the AEARP was extremely unfair and inequitable. Many of the trans women participating regarded these surgeries as being just as integral to successful gender reassignment as genital surgery. Some questioned how NHS Scotland could justify sending people to England for FTM non-genital surgery but not also for MTF non-genital surgeries. Some also questioned how NHS Scotland could justify treating trans women who had already undergone extensive specialist GIC assessment to determine their surgical needs as though their situation were the same as a non-trans woman seeking aesthetic breast augmentation with no prior specialist assessment of need.

In terms of access to MTF breast augmentation, participants living in NHS Greater Glasgow and Clyde expressed strong concerns that their health board's attempt to implement the GRP had created new barriers to uptake that reduced their access to breast augmentation. The participants reported that these new barriers included multiple extra non-GIC psychological assessments and long delays without any decision from the plastic surgery team about whether or not they would provide surgery. This was illustrated powerfully by the contrasting experiences of two of the participants. One recounted that, shortly after July 2012, NHS Greater Glasgow and Clyde funded her MTF breast augmentation in Brighton at the same time as her genital surgery. She did not have to prove psychological distress or undergo any

additional AEARP psychological assessment and she was not required to have minimal breast growth to qualify. However another participant also resident in NHS Greater Glasgow and Clyde who requested breast augmentation only one month later than the first participant was not permitted funding to receive breast augmentation surgery at the same time as genital surgery. Instead she found herself subject to a newly implemented AEARP process which involved two extra psychological assessments via NHS Greater Glasgow and Clyde's plastic surgery service and was still not concluded at the time of her focus group participation over a year later. She stated that the stress this had caused her had harmed her health such that she had to be prescribed beta-blockers.

To compound the inequity of provision of facial feminisation surgery and breast augmentation surgery, participants in NHS Highland and NHS Grampian stated they had smooth access to these surgeries without being put through any extra psychological assessment appointments with non-GIC psychologists. They described a process which was still compatible with the GRP statement that following GIC assessment that there is a symptomatic or functional requirement for breast augmentation or facial feminising surgeries under the AEARP, patients should be 'referred to a panel for consideration and assessment against agreed criteria on an individual basis.' (NHS Scotland, 6[4])

Inequity in terms of access to FTM chest reconstruction surgery was also revealed. NHS National Service Scotland advises that all FTM chest surgery referrals from July 2012 onwards should be sent to them so that there is equity of access Scotland-wide to their contracted NHS provider in Manchester (Evans[5]). However, trans men living in NHS Grampian stated that NHS Grampian was continuing to send them to a surgeon in Aberdeen. Participants also expressed concern that FTM chest surgery was still subject to BMI restrictions despite the GRP designating it a surgery required as part of a medically necessary treatment pathway rather than a non-essential aesthetic procedure.

Inequity was also identified in terms of provision of expenses for patients travelling outside of their local health board area for surgery. Participants in NHS Greater Glasgow and Clyde stated that they were able to get their surgery related travel and accommodation booked for them if they could not afford to pay those costs upfront. However, participants living in other health board areas stated they were being told that if they could not find the money upfront for their travel and accommodation then they would not be able to go for surgery.

Additionally, some of the participants said it was left to them to realise themselves that they might be able to try to claim surgery related travel and accommodation from their health board rather than anyone at their GIC or local health board advising them of this possibility.

3.8.3 Effectiveness

Nearly all the participants who had undergone any genital surgery expressed serious concerns about the effectiveness of their GPs in dealing with post-op wound care and complications. They stated they felt that GPs did not have access to sufficient information about FTM and MTF genital surgeries to be able to provide effective care.

A view was expressed that making trans women undergo additional non-GIC psychology assessments in order to access breast augmentation and facial feminisation surgeries would not provide any benefit or risk reduction for trans women and that therefore the additional assessments were not an effective use of NHS resources.

3.8.4 Patient-focus

The data revealed extremely positive patient-focus findings in regard to most of the surgery consultations and hospital experiences recounted. For example, one participant described the surgeon in Aberdeen providing facial feminisation surgery as ‘brilliant’ (Participant 2.3) and was very positive about the surgeon’s patient-focus. The surgeon carrying out MTF genital surgery was described as ‘very good and professional’ (Participant 3.4) and participants who had undergone MTF genital surgery praised the responsiveness of that surgeon to post-op questions.

However, there were a few isolated accounts of local surgeons being rude, arrogant and/or dismissive. There was also patient-focus dissatisfaction expressed in regard to MTF breast augmentation surgery consultations due to the AEARP procedures within NHS Greater Glasgow and Clyde as described in Section 3.8.2.

3.8.5 Timeliness

In addition to participants who had experienced long delays in accessing breast augmentation as described in Section 3.8.2, two participants (one a trans man and the other a trans woman) living in NHS Lothian had experienced extremely long delays of several years (one over a decade) waiting for funding approval for their genital surgeries. Both were hopeful that the GRP implementation by NHS Lothian would lead to them receiving genital surgery through the new contracts arranged by NHS National Services Scotland.

Only one participant had interacted directly with NHS National Services Scotland regarding a surgery funding request. They praised the quick processing of the request by NHS National Services Scotland, contrasting its two week processing of the request with the 24 weeks that the request had remained unprocessed within the local health board.

4. Discussion

4.1 GIC capacity

From the findings, an important theme which emerged was that lack of GIC capacity was strongly perceived by participants as a barrier to uptake of services. Participants perceived inequity across Scotland and lack of timeliness in access to GIC appointments and specialist counselling.

In terms of GIC services for adults in Scotland, the findings indicated that the Glasgow Sandyford GIC and the Edinburgh GIC both lack capacity to provide timely access to GIC appointments. Among participants the average length of adult waiting time for a first GIC appointment reported was 44 weeks which is greatly over the maximum 18 week waiting time promised across NHS Scotland services by the Scottish Government's Referral To Treatment Standard (Scottish Government[6])

Participants also reported that once they were attending GIC appointments, they experienced further service provision timeliness issues which they felt indicated overstretched GIC services. For example, participants reported GIC administrative delays and some reported being unable to secure next appointments for several months due to lack of available appointments.

Access to counselling was identified as not being equitable across Scotland because participants reported that only the Glasgow Sandyford GIC currently has any capacity to provide specialist gender reassignment counselling.

A need for increased gender reassignment services capacity is likely due to the fact that the number of people seeking NHS gender reassignment each year has been increasing substantially over the last decade and this expected to continue:

> 'The only safe assumption for commissioners and providers is that the present growth rate in the incident of new people requiring [gender reassignment] medical and other care is likely to continue...At a growth rate of 15% per annum compound, the number of new cases will approximately double every 5 years.' (Reed, Rhodes, Schofield & Wylie, 15[7])

Participants also identified the need for GICs to improve equity of access by developing the capacity to provide outreach appointments and shared care arrangements to reduce the distance and frequency of travel to GIC appointments required of patients in rural areas, on low incomes and who are disabled.

4.2 Information provision

From the findings, an important theme which emerged was that lack of information formed a barrier to uptake of services. Participants perceived it as necessary to improve information provision in order to increase the equity, effectiveness and patient-focus of treatment planning and also the effectiveness of GP role in gender reassignment provision. Participants identified a need for more information about treatment options, procedures, access criteria, associated risks, likely waiting times and GIC expectations to be provided to them by GICs. They also identified that their GPs needed information about effective hormone monitoring and about genital surgery post-operative wound care and management of complications.

In regard to achieving the GRP's equity, effectiveness and patient-focus ambitions, the STA views it as essential that patients receive all the information they need to understand their gender reassignment options and make informed treatment decisions. Otherwise, even if the same level of hormone treatment, hair removal and surgical services were all available evenly across Scotland, patients would still not have equitable ability to access them or receive equitable and effective healthcare.

The community engagement findings identified that participants frequently perceived any lack of information provision by GICs as a gatekeeping test of their commitment to gender reassignment through self-research of their options. This undermined the effectiveness of GIC assessments because some participants stated that, in the absence of information about the expectations of GICs, they presented what they assumed GICs might want to hear rather than feeling empowered to openly discuss their histories, stressors and treatment decision uncertainties.

4.3 Service provision for trans women

The community engagement findings highlighted that many trans women participants were experiencing particularly severe barriers to uptake of facial hair removal and MTF breast augmentation surgery. These services were regarded by many trans women to be as important as genital surgery and integral to successful gender reassignment. Therefore, it was of great concern to participants that they perceived the GRP ambitions of equity, effectiveness and patient-focus as not being achieved across provision of services for trans women.

Of greatest concern to many participants who were trans women was the very limited access to facial hair removal that many experienced. The level of access to facial hair removal reported by the participants was somewhat better than that reported during similar STA community engagement focus groups during 2011 (Morton & Joester[8]). However, substantial inequity was still reported in 2013 and many participants were very concerned about the wide variance of provision between different local health boards and also that the amounts and types of facial hair removal being funded by many local health boards remained below what participants regarded as effective.

Also of great concern to participants was the barrier to uptake of MTF breast augmentation surgery due to such surgery remaining part of the AEARP. Rather than improving access in this area, the community engagement findings highlighted that GRP implementation had a detrimental impact on trans women's access to breast augmentation surgery for participants resident in NHS Greater Glasgow and Clyde at least. Continued inclusion within the AEARP was particularly perceived as not recognising trans women's particular needs and therefore not being patient-focussed or equitable. Participants regarded it as inequitable to require trans women who have already undergone extensive specialist GIC assessment to determine their surgical needs to undergo reassessment as though their situation were the same as a non-trans woman seeking aesthetic breast augmentation with no prior specialist assessment of clinical need.

Insufficient participants had requested facial feminisation surgery to identify whether or not there had been any similar detrimental impact on access to facial feminisation surgery due to its retention within the AEARP.

The STA strongly believes that it is confusing and problematic to overlap the GRP and AEARP by placing MTF breast augmentation surgery and facial feminisation surgery under the AEARP. In the view of the STA sufficient flexibility in determining clinical need could be provided by moving MTF non-genital surgeries out of the AEAPR and fully into the GRP.

The STA believes that such a move would not cause inequity between trans women and non-trans women because equity does not mean providing exactly the same service to two groups with different circumstances. The situation of a non-trans woman requesting aesthetic breast or facial surgery who has always been regarded by others as being a woman is different from that of a trans woman who has undergone lengthy specialist assessment via a GIC to determine the surgeries she requires to not only to relieve acute gender dysphoria but also to successfully integrate in society as a woman. The assessment of a trans woman's psychological and functional need for breast augmentation and/or facial feminisation surgery is most appropriately done by a highly specialist GIC service rather than by a plastic surgery psychologist unspecialised in the clinical needs of trans women undergoing gender reassignment. Therefore, it would be more equitable to separate out the surgery referral pathway for trans women's non-genital gender reassignment surgeries from the AEARP pathway for solely aesthetic surgeries which are not part of a larger specialist approved treatment process.

5. Conclusions

The findings of the community engagement revealed that all of the participants' health boards and GICs were perceived to have undertaken some good work in the implementation of aspects of the four GRP ambitions of equitable, effective, patient-focussed and timely NHS gender reassignment service provision. It also revealed that all of the participants' health boards and all four GICs were perceived to still have more to do in order to fully achieve these four GRP ambitions.

From the perspective of participants in the community engagement, nearly all aspects of GRP implementation had resulted in more equitable, effective, patient-focussed and timely service provision. The key exception to this was the detrimental impact of GRP implementation in regard to access to MTF breast augmentation due to its retention within the AEARP. The STA strongly believes that this unintended effect of the GRP implementation should be addressed as a priority.

The community engagement findings indicate that the four GRP ambitions are currently being achieved by most health boards in regard to speech therapy and genital surgeries.

However, the data identified that despite improvements resulting from GRP implementation progress, there still remained significant deficits in equity, effectiveness, patient-focus and timeliness within some parts of NHS gender reassignment services. The key deficits highlighted by participants related to three areas: GIC capacity, information provision and service provision for trans women.

6. Recommendations

The STA welcomes the creation of a NHS Gender Identity Services National Managed Clinical Network (NMCN). The STA is keen for the NHS Gender Identity Services NMCN to utilise the whole GRP Audit to develop a national action plan to improve gender reassignment services. The STA offers for consideration the following nine possible improvement activities:

Possible activities to improve GIC capacity to increase equity and timeliness of appointments and access to specialist counselling:

1. Review GIC capacity relative to demand, invest necessary resources and introduce ongoing monitoring of GIC waiting times.
    - In the view of the STA, this should ideally include undertaking a comprehensive review of GIC capacity levels relative to service demand for both clinical and administrative functions. If GIC capacity is determined to be over-stretched, appropriate additional resources should be invested and also consideration given to utilising nursing and allied healthcare professions such as occupational therapists for simple patient cases with senior GIC clinicians assessing more complex patient cases. In common with other NHS services, the waiting time between referral and first appointment treatment should be monitored and reduced to comply with the Scottish Government's referral to treatment 18 week standard (Scottish Government[7]).
2. Create a transgender training package to increase the number of NHS counsellors with sufficient knowledge to provide specialist counselling.
    - In the view of the STA, the equity and timeliness of access to specialist counselling could be efficiently improved through the creation of a transgender training package for NHS counsellors. Such a training package could increase the number of counsellors across Scotland with specialist knowledge of gender reassignment counselling issues.
3. Develop outreach appointments and shared-care arrangements to reduce the distance and frequency of travel to GIC appointments required of patients in rural areas, on low incomes and who are disabled.
    - In the view of the STA, methods of GIC outreach to patients should ideally include utilising teleconferencing facilities, telephone appointments and online contact methods such as email and Skype/webcam software. The introduction of rotating temporary clinics locations across a range of Scottish cities could also be considered.

Possible activities to improve information provision to increase equity, effectiveness and patient-focus of treatment planning and effectiveness of GP role in gender reassignment provision:

4. Develop comprehensive GIC patient information about treatment options, procedures, access criteria, associated risks, likely waiting times and GIC expectations.
    - In the view of the STA, the development of patient information could be most efficiently done at a national level via the new NMCN, which would avoid duplicating efforts across the four GICs,. Ideally, the information materials developed should highlight the diversity of gender reassignment needs, flexibility of service provision and assist patients

to reflect on their gender reassignment needs and treatment options. Such information could reassuringly communicate what patients can expect from GIC appointments and encourage patient honesty and openness in discussions with GICs.

5. Develop a national gender reassignment treatment planning co-production toolkit for GIC clinicians to use with patients.
    - In the view of the STA, the creation of a treatment planning co-production toolkit would aid implementation of collaborative treatment planning between clinicians and patients and provide a standardised method for recording the resulting treatment plans.
6. Provide GPs with specialist information about ongoing hormone monitoring.
    - In the view of the STA, this ideally should include information from an experienced endocrinologist detailing hormone risks, recommended dosages, recommended health monitoring, and indicators for referral to specialist endocrinology services.
7. Develop information for GPs on post-operative genital surgery wound care and handling of complications.
    - In the view of the STA, ideally post-operative genital surgery information and contact details for specialists for GPs should be developed nationally in cooperation with the NHS National Services Scotland contracted surgeons and the resulting information should be made available via NHS online information sources used by GPs. Ideally the information should also be provided directly to patients in the form of a pack they can directly give to any healthcare professionals providing them with local post-operative care.

Possible activities to improve equity, effectiveness and patient-focus of service provision for trans women:

8. Identify health board best practice in MTF facial hair removal service provision and cascade to local health boards.
    - In the view of the STA, ideally local health boards with poor current provision of MTF facial hair removal services should be supported to learn from the best practice of boards which are successfully providing equitable, effective, patient-focussed and timely access to MTF facial hair removal services.
9. Remove MTF breast augmentation and facial feminisation surgeries from the AEARP.
    - In the view of the STA, MTF breast augmentation and facial feminisation surgeries should be urgently removed from the AEARP by the Scottish Government and instead incorporated fully into the GRP in the same manner as FTM chest reconstruction surgery and MTF and FTM genital surgeries already are.

7. References

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Appendix 1: Focus group ground rules

Mobile phones need to be turned off or switched to silent mode.

Participation is voluntary and there are no consequences for refusing to take part in the focus groups and no requirement to answer specific questions.

We want to keep the focus group confidential so we need you to keep the identities of the other participants in the focus group and their comments confidential and not discuss them out-with the focus group.

In the unlikely event that a participant reveals a clear intention to harm themselves or others, or gives information which makes us concerned that a child is at risk, then we may need to break confidentiality to inform relevant third-parties such as the police or social work services.

The facilitator might move you along in conversation. Since we have limited time, we ask that questions or comments off the topic be answered after the focus group session.

We'd like to make sure everyone gets the opportunity to speak so the facilitator might ask people who have not spoken up to comment. If you don't wish to make a comment on that point, that will be respected.

Please respect each other's opinions and experiences. There's no right or wrong answer to the questions. We want to hear what each of you think and it's okay to have different opinions. You don't need to agree, but you must listen respectfully.

Please use "I statements" and contribute information about your first-hand experiences only. Please do not try to describe the possible experiences of others who are not present.

Our focus is on hearing about your experiences and views of service use since the implementation of the GRP in July 2012, so please do not contribute experiences prior to July 2012 unless they are needed as background to your more recent service use. If you do need to mention pre-July 2012 experiences, then please make sure you say clearly that you are referring to prior to July 2012.

This focus group is not a space to debate terminology or to make judgements about other people's gender identities or gender reassignment decisions. Please talk only about your own experiences and needs rather than speculating about other people's experiences and needs.

If you have any experiences or comments which you do not feel comfortable sharing in front of the other participants, then you are welcome to write any such comments or experiences down and pass them to us at the end of the focus group for inclusion.

Appendix 2: Focus group discussion questions

Non-surgical gender reassignment services discussion questions:

- What has made accessing a NHS Gender Identity Clinic easy or difficult for you?
- How responsive to your preferences, values and needs around non-surgical services (such as hormones, counselling, hair removal and speech therapy) have your NHS Gender Identity Clinic doctors been?
- How well has NHS counselling support during gender reassignment been offered and provided to you and your family?
- What has made the process of accessing NHS hormone treatment easy or difficult for you?
- What has made accessing NHS speech therapy easy or difficult for you?
- What has accessing NHS funding for hair removal easy or difficult for you?

Surgical gender reassignment services discussion questions:

- What has made the process of gaining NHS Gender Identity Clinic approval for various surgeries easy or difficult for you?
- What has made accessing NHS funded surgeries easy or difficult for you?
- How responsive to your preferences, values and needs around surgery have your NHS Gender Identity Clinic doctors and your surgeons been?

Appendix 3: Focus group diversity monitoring form

The Scottish Transgender Alliance and NHS Health Scotland would find it useful if you would agree to complete this anonymous diversity monitoring form. We use the collected data to report on how well we have managed to reach out to diverse people. All the questions are optional.

What is your age?

- ☐ Under 18 years old
- ☐ 18-24 years old
- ☐ 25-34 years old
- ☐ 35-44 years old
- ☐ 45-54 years old
- ☐ 55-64 years old
- ☐ 65 years old or over

What is the direction of your gender reassignment?

- ☐ Male-to-Female (MTF)
- ☐ Female-to-Male (FTM)
- ☐ Other (please specify): _____

How do you describe your ethnicity and nationality? _____

How do you describe your sexual orientation? _____

Do you consider yourself to be disabled or to have a limiting or long term health condition?

- ☐ Yes
- ☐ No

Which NHS Board area do you live in?

- ☐ NHS Ayrshire and Arran
- ☐ NHS Borders
- ☐ NHS Dumfries and Galloway
- ☐ NHS Fife
- ☐ NHS Forth Valley
- ☐ NHS Grampian
- ☐ NHS Greater Glasgow & Clyde
- ☐ NHS Highland
- ☐ NHS Lanarkshire
- ☐ NHS Lothian
- ☐ NHS Orkney
- ☐ NHS Shetland
- ☐ NHS Tayside
- ☐ NHS Western Isles

Appendix 4: Participant diversity statistics

To help protect anonymity the exact numbers have been obscured where less than five. The total respondents to each question are not always equal to 50 because not all participants completed each optional question.

Age	Number of participants (n)
16-17	6
18-24	10
25-34	6
35-44	8
45-54	9
55-64	6
65 and over	*(<5)

Table 2: Ages of participants (n)

Gender reassignment direction	Number of participants (n)
MTF	31
FTM	12
Other	5

Table 3: Gender reassignment directions of participants (n)

Ethnicity/Nationality	Number of participants (n)
White British/Scottish/English/N.Irish	44
Other	*(<5)

Table 4: Ethnicities/nationalities of participants (n)

Sexual Orientation	Number of participants (n)
Lesbian	5
Gay	*(<5)
Bisexual	10
Heterosexual/Straight	5
Pansexual	9
Asexual	*(<5)
Unsure/Complicated/Don’t Define	*(<5)

Table 5: Sexual orientations of participants (n)

Disability	Number of participants (n)
Yes	16
No	22

Table 6: Disability status of participants (n)

NHS board area of residence	Number of participants (n)
Ayrshire and Arran	*(<5)
Borders	*(<5)
Dumfries and Galloway	*(<5)
Fife	*(<5)
Forth Valley	*(<5)
Grampian	7
Greater Glasgow and Clyde	9
Highland	6
Lanarkshire	*(<5)
Lothian	14
Orkney	*(<5)
Shetland	*(<5)
Tayside	*(<5)
Western Isles	*(<5)

Table 7: NHS board areas of residence of participants (n)