

Trans

A practical guide for the NHS



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Foreword



There are a number of people in the United Kingdom whose gender identity (their sense of being a man or a woman) does not match their appearance and/or anatomy.

This guide is designed to equip NHS managers at all levels – as employers and as planners, commissioners and providers of services – to understand the needs of trans people so that they can ensure we care for them equally, alongside everyone else who works for the NHS or has need of our care.

Other existing public sector equality duties, ongoing reform towards personalised services and the commissioning agenda present a real opportunity for NHS organisations to reconsider the design of services to take full account of the equalities agenda. By developing expertise and implementing the lessons learnt, we can embed equality at the heart of all functions and structures and contribute to a better understanding of our staff and more informed, personalised patient care.

As an employer and a provider of healthcare services, the NHS should not only comply with the law, but should also aspire to be an exemplar of good practice and seek to ensure that its services reflect the needs of the whole of our society. This means that it is essential that we strive to involve and take account of trans people's needs in the design and delivery of all our services. This doesn't just apply at the time in their lives when they need support and care to undertake the immense challenge of changing their gender identity, but throughout life.

It is also right that we should strive to retain valuable skills when a colleague needs to 'transition' from one gender role to the other. It is essential that we are seen as an inclusive employer – enabling us to find and recruit people with the best skills and aptitude to make careers in the NHS.

A handwritten signature in black ink that reads "Surinder Sharma". The signature is fluid and cursive, with the first name being the most prominent.

Surinder Sharma

National Director for Equality and Human Rights, Department of Health

1. Executive summary

People who cross contemporary cultural gender boundaries for any reason – collectively referred to as ‘trans people’ – are an often ignored group in society, yet all research undertaken in the areas of employment, health provision, social exclusion and hate crime indicates that they experience disproportionate levels of discrimination, harassment and violence. Transsexual people, those who identify as transgender and people who periodically cross-dress in private have distinctly separate social experiences and needs; nevertheless they all experience similar kinds of unwarranted social disapproval.

Trans people are more likely than others to experience difficulty in finding work or retaining it if their background becomes known to others. High numbers report feeling obliged to change jobs because of workplace harassment and abuse. Upon revealing their gender issues people are at high risk of being shunned by family and friends. Many experience violent intimidation on the streets or outside their homes. Consequently trans people are also susceptible to depression and at risk of suicide. A 2007 report, *Engendered Penalties* (Whittle S, Turner L and Al-Alami M, The Equalities Review, February 2007; see www.pfc.org.uk/files/EngenderedPenalties.pdf), highlighted that 34% of respondents in a survey of 872 trans people had considered suicide one or more times before receiving professional assessment and support. This is considerably higher than the risk in many other groups and should serve to underline that trans people would not subject themselves to such experiences unless, for them, there was no better option. As explained in this guide, there is nothing trivial

or capricious about permanently changing gender role.

Creating better services

There is evidence to indicate that, for some trans people, the National Health Service (NHS) has at times unfortunately contributed towards anguish and distress. Research published in February 2007 (see above) showed that almost 20% of trans people surveyed for the Equalities Review reported that their healthcare was either affected or refused altogether by GPs who knew they were trans. Whilst there are notable examples of excellent care and good practice, 60% of trans people who thought their GPs and other medical professionals would like to be more helpful and supportive reported that the practitioners felt unable to do so through lack of training and information.

The kinds of specific issues that arise are explained in part 5 of this booklet. Best practice is readily achievable by combining the advice contained here with the kinds of training that accompany wider diversity initiatives.

Once staff are more conversant with trans people’s needs and concerns, much of the solution simply involves everyone applying the core principles set out in the NHS operating framework for 2007/8.

Annex 1 in this guide shows the wealth of information available to support staff and service users alike. Consultation with service users is a legal requirement for developing gender equality schemes and we explain how

to do that with trans people. Consultation is also an important factor in our drive towards World Class Commissioning. Again, this guide explains how it's possible to be innovative when addressing service user needs whilst also achieving better value for money at the same time. Best practice care frequently involves better use of existing local resources, rather than long distance referrals, for instance.

Becoming a better employer

The NHS is the nation's largest employer and trans people are as equipped as anyone else to play valuable roles at all levels. Research indicates that although education is sometimes disrupted by the bullying experienced by trans people in their school years, a greater than average proportion of trans people subsequently attend college and university courses and obtain higher level qualifications, especially after being enabled to address their gender issues and settle down in their newly acquired gender role.

Discrimination against transsexual people in employment, pay and vocational education has been unlawful since the enactment of the Sex Discrimination (Gender Reassignment) Regulations in 1999. Since that time employers have been obliged to support existing staff through the period of gender transition at work and ensure they remain protected from discrimination, bullying and harassment like all other staff. The evidence shows that with good consultation, planning and professional guidance, the outcomes are very successful. There is therefore no reason why skilled and experienced NHS staff should be lost as the result of needing to transition. This guide contains practical guidance to help managers handle such circumstances as a project in conjunction with the employee concerned.

It is vital that NHS organisations are seen as inclusive and therefore are able to recruit the best staff and skills from across the whole of society; this includes signalling that trans people are welcome and respected, and that policies in recruitment, retention and day-to-day employment do not unintentionally operate in ways that act as an institutional barrier.

Beyond the law's requirements: good practice

Considerable legislation already provides explicit protection and rights for transsexual people in the areas of employment, goods, facilities and services (including health) and for their legal recognition as ordinary men and women in their acquired gender. The Gender Equality Duty builds upon this and means that NHS organisations must factor in the needs of transsexual people in the development of gender equality schemes and be proactive in promoting their equality. This includes equality in employment, in the development of public health policy and across the board in terms of commissioning and healthcare provision.

The Government is also evaluating calls in response to the Discrimination Law Review for a wider view of the need for inclusion and protection. Discrimination is arguably just as unacceptable whether someone fits the medical definition of a transsexual person, or whether they fall outside the definition but are simply perceived that way. It is not always possible to tell by looking whether someone would be categorised (or identify themselves) as transsexual, transgender, or something else. What matters is that the NHS is designed to be a service for all citizens, available without prejudice, at the point of need.

For these reasons, the law's requirements should be considered as the absolute bottom line in planning and training for equality throughout NHS organisations. Wherever possible, the advice and examples in this guide assist in ensuring all people benefit, whether the law requires that or not.

Beyond single strands: multi-dimensional people

Although the idea of distinct 'strands' (gender, race, disability, sexual orientation, religion or belief, age and transgender status, etc.) has been a helpful aide-memoire for thinking about different grounds leading to discrimination, the Equalities Review, published in February 2007, highlighted the dangers of thinking about people and their individual experiences in the same narrow single-dimensional terms.

Most people experience factors in their lives related to more than one strand. Everyone has a gender – man or woman. There are specific health experiences associated with both. Everyone also has an ethnicity – not always indicated by their skin colour – but their experiences are coloured positively or negatively by skin tone and their ethnic and religious background in complex ways. Some of those same people may be born with a disability or acquire one as the result of illness, accident or their age. Ageing affects everyone too; each life stage brings fresh potential for health and employment advantage or disadvantage. The sexual orientation of the individual further embellishes their experience, whether straight, gay/lesbian or bisexual. Finally, on top of all those factors, a colleague or service user may also have a trans background – with implications that intersect with all of those other six dimensions.

The Equalities Review highlighted that the combination of specific factors can exacerbate the problems that an individual may experience. Being a trans, middle-aged, lesbian Asian woman may lead to experiences of discrimination that are greater than the average in any of those categories individually. This guide provides a method for capturing knowledge about these complex interrelationships, using a matrix-based approach. Equally, managers are strongly urged to remember to include the potential additional barriers or problems encountered by trans people when considering initiatives connected with broader aspects of gender, race, disability, sexual orientation, religion or belief, and age. The needs of young and older trans people are particularly good areas to start.

The layout of this guide

This is intended to be a practical guide, recognising that trans people's needs are especially likely to be unfamiliar to most managers. Plenty of background is provided in recognition that people need to know where to begin and how to bring about change.

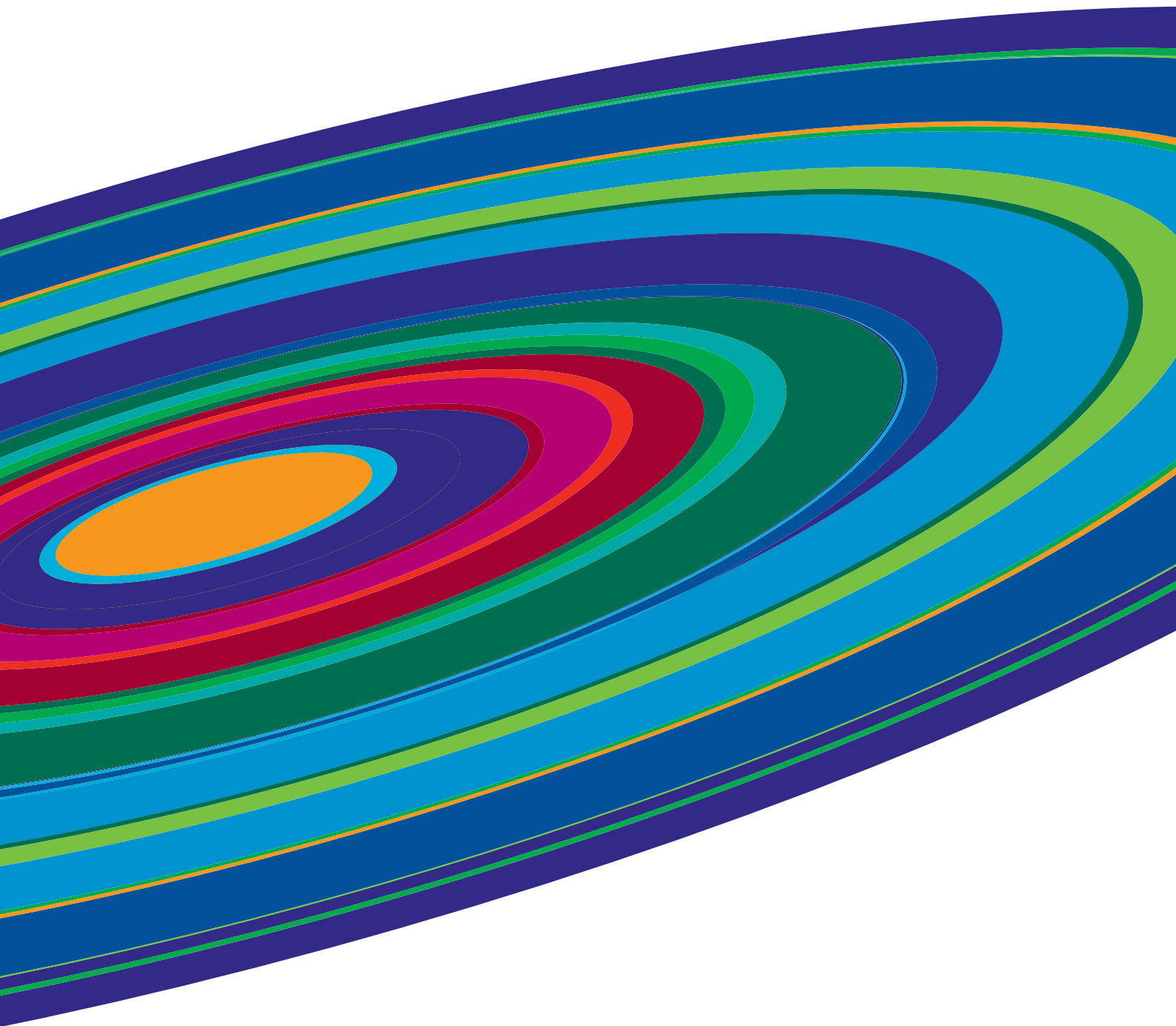
Section One is about principles and background understanding. Part 2 explains unfamiliar labels, terminology and some relevant aspects of trans people's lives and medical needs as a foundation for planning and policy making. Part 3 develops the case for aspiring to good practice above and beyond legal compliance. Part 4 sets out the law's requirements and the basics for good practice.

The following sections then deal in detail with practical considerations in relation to employment and healthcare, plus the overarching need for education, training and the provision of information. Annexes also provide a thorough reading list and details of resources for training and providing information to both staff and service users. A considerable volume of material has been made available through new publications designed for both professionals and patients, and this is readily available to order through Prolog or online from the Department of Health website.

Other practical guides for the NHS

This guidance is part of a suite of equality guides produced by the Department of Health for the NHS. Others in the series cover disability, gender, sexual orientation, age, and religion or belief. The Race for Health programme provides extensive guidance and support for the NHS on issues of ethnicity.

Section One: Background knowledge and advice



2. Labels, terminology and lives

What is meant by 'trans' or 'transgender'?

According to the Department of Health publication *An introduction to working with Transgender people*:¹

- *"About 1 in every 11,500 people in the world are transsexual. Transsexual people feel they belong to the gender opposite to the one assigned to them at birth."*
- *"Some other people simply cross-dress for pleasure or relaxation and do not identify themselves as belonging to the opposite gender. An older term for this is 'transvestism'."*
- *"Transgender has different meanings. In the UK it is usually an umbrella term for all people who cross gender boundaries, permanently or not. Many prefer the adjective 'trans' for the same thing. Americans use 'transgender' differently. That is why 'trans' is better."*

The original American usage of the term 'transgender' referred to people who adopt the opposite gender role to the one assigned to them at birth, but without the formal clinical diagnosis connected with the term 'transsexual'. Some transgender people nevertheless take hormones (clinically prescribed or otherwise obtained from the Internet) to help maintain an appearance closer to that of the gender they have adopted. Traditionally such transgender

people eschewed genital reassignment surgeries but nowadays the distinctions have become blurred as it has become possible for people to largely manage their own clinical gender transition if they have the funds to do so privately.

The simplest distinction is therefore that 'trans' or 'transgender' are terms of choice often adopted by people to describe themselves, whereas 'transsexual' remains a medically defined term, appearing in diagnostic guides, and ascribed to people by doctors.

Why can 'transsexual' be a sensitive term?

Much of the sensitivity about terms and who is applying them is rooted in past tensions between trans people and previous generations of clinicians. In the UK, clinical involvement for people expressing gender identities at variance from their physical sex has been led for more than 40 years by psychiatrists, with approaches that were originally grounded in theories about sexual deviancy and mental disorder. In other countries clinical involvement has been led from different disciplines such as endocrinology or by gynaecologists and urologists.

Nowadays even psychiatrists are at pains to stress that the inclusion of transsexual terminology in mental health categories reflects the historical demand for a formal diagnosis on which to base treatment, and the widely appreciated need for talking therapies to support people through taking an immense step in their lives, often in the face of disapproval among those they know. It cannot be overemphasised that being trans is not a mental illness.

¹ *An introduction to working with Transgender people*; Department of Health 2007; Prolog reference 278143-B.

Why are the different terms important?

People with different racial or ethnic origins or religious traditions may often appear superficially similar but health and social care professionals will know that an African Caribbean man may have different specific health needs from an Asian man, or that a Muslim woman may have care needs that are not the same as a Christian woman. This kind of nuanced understanding is the essential first stage of fully appreciating service users' needs and treating colleagues with respect.

In the case of trans people, not everyone will be seeking or have undergone gender reassignment. People who live in the opposite gender role without seeking hormonal or surgical treatment may still need support with regard to their gender feelings and the social disapproval they encounter. A transsexual person's reassignment may dominate their care needs for a short while but, afterwards, they will need to rely on their GP to deal with general ailments and check-ups just like anyone else. The parents, children, brothers and sisters of trans people who 'come out' may have many similarities no matter whether their relative is changing gender role permanently or simply cross-dresses once in a while; yet there will also be differences to understand too. People also differ in how they label *themselves*.

People who are simply androgynous or don't appear conventionally masculine or feminine enough for their birth assigned sex may also be *perceived* to be trans. The same can be true of people whose sex characteristics from birth fall into one of the many clinically recognised conditions collectively referred to as 'intersex'.

A broad understanding of trans people is therefore an essential part of ensuring that

services reflect people's needs and that colleagues treat one another with respect and consideration.

As far as possible, this guide endeavours to use the more encompassing term 'trans', which is replacing 'transgender' in common usage. However, it is necessary to refer to 'transsexual' people specifically where the law uses narrower definitions to ensure there is clarity in relation to legal duties – and to 'transgender' people when referring to older publications.

Annex 2 provides a concise description of terms in a form that can be used within policy documents, training handouts and other literature. It is based on a form of words developed by the Department of Health Sexual Orientation and Gender Identity Advisory Group (SOGIAG) with the involvement of trans stakeholders. Terms to avoid are also explained.

Getting pronouns and gender terms right

Of all the things that could offend a trans person or lead them to feel misunderstood, excluded and distrustful, mistakes involving forms of gender-related speech are perhaps the most upsetting. Potentially they are also easiest to pay attention to getting right.

People alter their gender presentation and ask to be regarded as the gender in which they present because of a profoundly felt conviction about their identity.

A trans woman – someone who was registered as a male child and later undertakes the 'transition' to presenting as a woman – embarks on that difficult and arduous journey because she wants to be

regarded and treated as the woman she feels inside.

Similarly, someone who was born with female anatomy and undertakes the transition to present to the world as a man – a trans man – makes that one-way journey in the face of family and social disapproval because, after maybe years of soul-searching, he has concluded that that is the only way in which he can live a happy and productive life, being true to himself and others.

Understanding the challenges faced

The opposition and barriers that trans people still encounter to the present day are well documented. According to survey research published as part of the Equalities Review:²

- 73% of trans people surveyed experienced some form of harassment in public (ranging from comments and verbal abuse to physical violence)
- 21% stated that they avoided going out because of fear of harassment
- 46% stated that they had experienced harassment in their neighbourhoods
- 64% of young trans men and 44% of young trans women experienced harassment or bullying at school, not just from their fellow pupils but also from school staff including teachers
- 28% stated that they had moved to a different neighbourhood because of their transition.

Not a trivial or capricious 'choice'

Gender transition is not embarked upon lightly; it can involve heartbreaking decisions anticipating the potential loss of friends and family. There is substantial evidence that many trans people also have to encounter extreme violence and discrimination if their background becomes known within their community. The campaign organisation Press for Change³ stated in a submission to the Commons Public Bills Committee considering possible hate crime provisions:⁴

"Every trans person in the UK today has to undertake a risk analysis that weighs up home imprisonment on welfare benefits, suicide or the risk of physical harm, possibly even rape or murder as the price to be paid for living their lives in their preferred gender role. Research [published by the Equalities Review] showed that the suicide attempt rate for trans people is very high, far higher than the rate for one of the most mentally vulnerable groups; people with ongoing mental health problems as a result of childhood abuse or trauma."

In these circumstances referring (no matter how innocently) to a trans woman as 'he or him', 'Mister or Sir' is inevitably going to be construed by that person as a body blow to everything she is sacrificing to achieve. The same applies in reverse when referring to a trans man according to his female birth gender.

Not only is the choice of the wrong terms a display of bad manners and poor caring skills, such behaviour and errors (intended or accidental) can destroy the trust that is essential between colleagues in the

2 Whittle S, Turner L and Al-Alami M, *Engendered Penalties*, The Equalities Review, Feb 2007. See www.pfc.org.uk/files/EngenderedPenalties.pdf

3 See www.pfc.org.uk

4 Memorandum submitted in regard to the committee stage on the Criminal Justice and Immigration Bill (CJ&I 391); November 2007. www.publications.parliament.uk/pa/cm200607/cmpublic/criminal/memos/ucm39102.htm

workplace or between NHS professionals and their service users.

Sometimes the error may be someone else's (for example, a computer record that has not been updated properly) or a member of staff may be genuinely unsure of which gender a service user wishes to be addressed as. In those circumstances staff must be trained to act with intelligent sensitivity. Possible errors should be explored discreetly with the individual concerned. Where there is uncertainty about how to address someone, then the correct procedure is to ask. If it is not possible to ask, then staff should endeavour to draw reasonable conclusions based on what they can see. If someone is wearing predominantly female attire, for instance, then in all likelihood they will wish to be referred to in female terms, regardless of their anatomy.

Trans people's families and partners

It is important to keep in mind that trans people have families and significant relationships like everyone else. This needs to be appreciated from every angle.

Trans people have parents and extended families of uncles and aunts, so it follows that there are many thousands of service users who may also need support at the time when someone in their family is undergoing a gender transition. All of these people need to be able to rely on professionals to give them accurate and impartial advice. It should not be forgotten that trans people can also be stakeholders in the care or death of elder relatives. The Department of Health has produced a specific publication giving advice on the care issues that arise when

a trans person or someone close to them is bereaved.⁵

In the past, trans people have delayed addressing their gender issues through fear of being ostracised by society. In attempts to fit in, such people have often followed well-meant advice to marry, and many consequently have children as a result. Research underlines the fact that it is preferable for families to stay together where possible and for trans people to continue having normal contact and relationships with their children.⁶ However, this underlines the need for NHS professionals in all capacities to be equipped to support families in which there is a trans person either undergoing or who has undergone a change of gender role.

Trans people also have partners and it is essential not to make assumptions about a trans person's sexual orientation. Trans people can be heterosexual (attracted to people opposite to their acquired gender), homosexual or bisexual like everyone else. In many cases trans people may find that they are not fully able to be sure about their orientation until they have settled down in their acquired gender role. Respect and the need for professionalism also apply to the partners of trans people as well. A heterosexual man does not cease being heterosexual when the woman he dates just happens to have a trans background.

Trans children and teenagers

Last, but certainly not least, it is important for NHS staff to be professionally aware and attuned to the fact that young people can express gender issues too – and need professional support and care as a result. This is not a new phenomenon; indeed, most adult trans people report having had

⁵ *Bereavement: A Guide for Transsexual, Transgender People and their Loved Ones*; Prolog reference 281087.

⁶ Green R, *Transsexuals' Children*. IJT 2,4. www.symposion.com/ijt/ijtc0601.htm

an awareness of their feelings about their gender from early childhood (typically four–five years of age). What has changed is that it is nowadays possible for young voices to be heard and for professional guidance to be given to families, teachers and social workers in order to evaluate the best way to support such children.

According to the research and educational charity GIRES:⁷

“Despite the pressure to conform, some children feel such acute discomfort with the gender roles assigned to them that they try to express their core gender identities in their behaviour and dress. Usually other family members discourage this, often strongly. Expressing gender variance at school frequently leads to bullying. Too often, when families seek medical help ... the professionals respond unhelpfully.”⁸

The importance of services to support and care for young people and their families is expected to grow with increasing awareness of the need in this area (and the danger of suicide and self-harm where needs are not appropriately addressed). Some examples are as follows:

- There is a specialist centre at the Portman and Tavistock Clinic.⁹ The clinic is reported to receive around 60 cases each year from

across the UK – a figure that has grown sixfold in the last decade.

- Additionally, Mermaids is a well-established charity,¹⁰ set up by parents to support families in which there are young trans people.
- The Department of Health has also published a booklet designed and written by young trans people themselves, providing advice and guidance.¹¹ A companion guide to provide advice for parents¹² has also been published and a guide with practical guidance for teachers and social workers is planned.

Moving from disease and disorder to wellbeing

Medical treatment of the significant distress felt by people in the ‘wrong’ gender role is nowadays increasingly viewed in terms of actions necessary to promote the wellbeing of the individual rather than an imperative to classify people’s difference as a sickness or disorder.

It is more widely understood that people’s innate sense of gender extends beyond a simple two-extremes concept of man and woman. Throughout the world there are cultures in which genders have always been more flexibly defined.¹³

7 The Gender Identity Research and Education Society; Registered Charity no. 1068137. www.gires.org.uk

8 *Early Medical Treatment for Transsexual People*; GIRES.

9 Contact Dr Domenico Di Ceglie, Consultant Child and Adolescent Psychiatrist, Tavistock and Portman NHS Foundation Trust (part of the Children and Adolescent Mental Health Service (CAMHS)).

10 Mermaids – Family Support Group for Children and Teenagers with Gender Identity Issues; Registered Charity no. 1073991. www.mermaids.freeuk.com/

11 *A Guide for Young Trans People in the UK*; Prolog reference 281091.

12 *Medical care for gender variant children and young people: answering families’ questions*; Prolog reference 285384.

13 Professor Stephen Whittle OBE writes: “Waldemar Bogoras (in *The Spirit and the Flesh; Sexual Diversity in American Indian Culture* by WL Williams, Boston, Beacon Press, 1988) lived amongst the Chukchi of Siberia from 1890 to 1908. He describes seven gender categories in addition to the categories woman and man – used by the Chukchi. Similar categories were recognised in other groupings such as the Koryak and Kamchadel in Siberia. The practice was also found by Langsdorff (as mentioned in *Voyages and Travels*, 1814) to be common across the Bering Straits in Alaska amongst, among others, the Aleuts and the Kodiak Island Eskimos (Ellis, 1948). A number of North American tribal Indian groups have recorded examples of cross-gender living, amongst which the institution of the Bedarche has been well documented. The North American concept of the Bedarche includes many different types of gender that existed in these native societies, but it is difficult for those of us who live in a world of binary gender roles to fully grasp their meaning. However in Western European modernist terms it could be said that the Bedarches did include some transgendered individuals.” Extracted from *The Transgender Debate*, Garnet Publishing, 2000. ISBN 1 902932 16 1.

In many of these societies people whom we would nowadays identify as trans have long been respected and even revered. This wider historical, anthropological and cultural appreciation has gradually led to a clinical acceptance that people who don't fit society's assumption of 'either/or', 'man/woman' deserve sympathetic and practical assistance from medicine to find the best way to accommodate themselves within our own society's contemporary assumptions.

Clinicians and trans people themselves are approaching a mutual consensus that is not dependent on classification in terms that inevitably produce stigma. The role of health and social care professionals goes beyond diagnosing and treating pathological illnesses and should be concerned with promoting health, wellbeing and successful social functioning.

For those who are familiar with the Social Model of Disability,¹⁴ there are strong parallels. Being trans is not inherently problematic for the individual – the problems mostly arise out of the reaction of others and the consequent experience of stigma, with all the effects that that has for the health of the individual. Much of the support needed by trans people is about developing coping strategies to be themselves in a hostile world. NHS organisations can strive to be the first place in society where such coping strategies become unnecessary.

The World Professional Association for Transgender Health (WPATH)¹⁵ in the current version of its *Standards of Care*¹⁶ says:

"The designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients' civil rights. The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments."

Government policy is also very clear, as stated in a policy document introducing steps towards the creation of the Gender Recognition Act:¹⁷

"Transsexual people do not choose their gender identity. Transsexualism is an overpowering sense of different gender identity rather than any sexual orientation: transsexual people may be heterosexual, gay/lesbian or celibate ... It is not a mental illness. It is a condition considered in itself to be free of other pathology (though transsexual people can suffer depression or illnesses like anyone else)."

Population levels and service demand

Population estimates for transsexual people are based on published research in The Netherlands¹⁸ and Scotland¹⁹ over the last decade, combined with available data from

14 The 'Social Model of Disability' is credited to the disabled academic Professor Mike Oliver, who coined the term in 1983, although the roots go back to the mid 1960s. See www.daa.org.uk/social_model.html. Also see *Pride Against Prejudice* by Jenny Morris; ISBN 0 7043 4286 3.

15 Formerly the Harry Benjamin International Gender Dysphoria Association. www.wpath.org

16 *Standards of Care For Gender Identity Disorders – Sixth Version*. www.wpath.org/Documents2/socv6.pdf

17 Government Policy Concerning Transsexual People; Department for Constitutional Affairs (now the Ministry of Justice); Dec 2002. See www.dca.gov.uk/constitution/transsex/policy.htm

18 Van Kesteren PJ, Gooren LJ, Megans JA, *An epidemiological and demographic study of transsexuals in The Netherlands*, *Arc Sex Behav.* 1996 Dec; 25(6): 589–600. This research provides the longstanding statistic that gender identity disorder affects 1 in 11,900 of the adult population (rounded in some accounts to 1 in 11,500).

19 Wilson P, Sharp C, Carr S, *The prevalence of gender dysphoria in Scotland: a primary care study*, *Br J Gen Pract.* 1999 Dec; 49(449): 991–2. This broadly supports the Dutch figure with a population estimate of 1 in 12,500 of the adult population.

government agencies that deal with changes of name and gender (e.g. DWP, Identity and Passport Service, DVLA). There are no corresponding reliable estimates for the number of people who consider themselves transgender, since their existence as a group has only recently begun to be appreciated.

In 2005 the Women and Equality Unit indicated that there are an estimated 5,000 transsexual people in the UK²⁰ – although it should be noted that this includes those who (statistically) are predicted to seek help in the future, those who are already undergoing treatment and those who have completed treatment for their gender issues.

In other words, this should not be confused as either the number who have already undergone reassignment or the number who are going to present for treatment. It is merely an estimate of the total population.

The Charing Cross Gender Identity Clinic reports that it receives around 500 new referrals every year and has 2,000 patients on its books at any point in time. Ministers have also confirmed to Parliament that 99 NHS gender reassignment surgical procedures were carried out in the last year for which statistics are available.²¹

The Gender Recognition Panel (GRP), which administers applications for legal recognition under the Gender Recognition Act, reports that over 2,350 requests had been received since the enabling legislation came into force in April 2005.²² Of these, 97% of applications are successful, including many

from people who, at the time, are still waiting for NHS surgery.²³ The GRP also reports that an average of 25 fresh applications are received every month, now that the initial backlog has been dealt with.

These statistics need to be interpreted according to the appropriate circumstances:

- The prevalence ratio of around 1 in 11,500 of the general population provides a crude means of estimating the likely numbers of pre- and post-operative transsexual people within the working population of NHS organisations. Estimates made in this way need to be used with care, however, since there is anecdotal evidence to suggest that a disproportionate number of people are attracted towards certain professions – health and social care being one of these.
- The population estimate of 5,000 people is relevant when considering the level of the trans community's need for health and social care services. The number also provides an indication of the numbers of people likely to have a transsexual relative. In other words, the number of parents, aunts, uncles, sisters, brothers and children with a trans person in their life is likely to run into tens of thousands.

20 *Gender Reassignment – A Guide for Employers*; Women and Equality Unit (DTI); January 2005; page 5.

21 Hansard 27 Feb 2006 Col 446W. "Jane Kennedy: In 2004–05, there were 99 combined operations for transformation from male to female and zero combined operations for transformation from female to male."

22 The figure from the GRP as at 18 Mar 2008 was 2,366 applications. Only 72 of these had been refused (3%).

23 Genital reassignment surgery is not an absolute pre-requisite for legal recognition, although it is generally expected that most applicants will have undergone such treatment unless medically contraindicated. The Gender Recognition Panel has accepted several applications where surgery has been agreed but delayed for funding reasons. It is reasoned that NHS delays are beyond the applicant's control and that they do not constitute a reason for delaying access to the important rights conferred to transsexual people by legal recognition.

- The 500 per annum figure for gender clinic referrals and the level of 25 gender recognition applications per month are both indicative of the numbers who are likely to present for and complete NHS care in England and Wales each year. In practice it means that the average PCT is likely to see few new cases annually. In turn this means that timely and clinically appropriate provision for the needs of such patients is never going to have a significant impact on budgeting. Savings are far more likely to be found through creative approaches to commissioning – especially with a view to making greater use of local resources to cover care needs. Remember that innovation of this kind is positively encouraged as part of World Class Commissioning (using strategies to deal with the market and meet demand).

3. Policy considerations

Why this guide?

This practical guide forms part of a family of publications designed to help NHS managers implement all their public sector equality duties in an informed and professional manner. Similar booklets in this series deal with issues associated with gender, disability, age, religion or belief, and sexual orientation.

No matter which characteristics mark individual NHS employees and service users as being 'different' from others, the responsibility of senior managers of NHS organisations is made clear in the Department of Health publication *Equality and Human Rights in the NHS*:²⁴

"Chairs, Chief Executives, Board Directors and Non-Executive Directors all have a responsibility for ensuring that the NHS organisation that they lead is compliant with equality and human rights legislation.

"Equality and human rights is as applicable to service users as it is to employment, and as such is the responsibility of all parts of the organisation and of all board members."

Statutory requirements

In recent years the law has been extended in various ways to clarify the rights of people who are planning to undergo, who are undergoing or who have undergone the gender reassignment process. These provisions are explained in detail in part 4 and the terms in Annex 2.

In summary, it is unlawful to discriminate against or harass such people in employment or vocational training,²⁵ or in the provision of goods, facilities and services.²⁶ Specific responsibilities attach to the conduct of staff and organisations in the case of transsexual people who have gone on to apply for and have received legal recognition of their acquired gender.²⁷ A criminal offence can be committed by staff who disclose the gender history of a legally recognised transsexual person without explicit consent.²⁸ Case law has established that it is unlawful for commissioning policies to operate what amounts to a blanket ban on assessment or treatment of gender identity issues.²⁹ The Public Sector Gender Equality Duty also makes clear that all references to duties to promote the equality of men and women include transsexual men and transsexual women.³⁰

24 *Equality and Human Rights in the NHS: A Guide for NHS Boards*, 2006; Prolog reference 278711. Details of this and other publications recommended for reference are provided in Annex 1.

25 The Sex Discrimination (Gender Reassignment) Regulations 1999.

26 The Sex Discrimination (Amendment to Legislation) Regulations 2008.

27 The Gender Recognition Act 2004.

28 The Gender Recognition Act 2004, Section 22.

29 *AD & G v North West Lancashire Health Authority*, Court of Appeal (1999).

30 The Equality Act 2006.

Illustrative example

A woman may have noticeable facial hair because:

- she has a condition such as Polycystic Ovarian Syndrome (PCOS) leading to an excess of the male hormone testosterone in her system, or
- she may have been born with one of several intersex³¹ conditions and been assigned to the female sex from birth, or
- she may simply have inherited a tendency to dark facial hair growth, or
- she may be a transsexual woman undergoing male-to-female reassignment and receiving treatment to remove her former beard growth.

All such women in this example may feel intense insecurity about their hair growth and staff may never know what lies behind the appearance of the person they see in a waiting room or applying for a job. Although the law only specifically mentions the last category, it would be inappropriate to ask the individual before deciding how to behave towards them, and doubly inappropriate to treat someone differently depending on the answer.

Good practice

The Acts of Parliament and Regulations which organisations *must* comply with (outlined in Section One, part 4) are written in terms of a series of definitions that apply to people experiencing a clinical condition referred to as 'gender dysphoria' and involved with a process known as 'gender reassignment'. The definitions do not cover everyone who might encounter the kinds of negative reaction which non-conventional gender presentation or behaviour can attract. This is why good practice needs to extend to ensure that NHS personnel at all levels, and in every discipline, behave in an inclusive and respectful manner that goes beyond the strict letter of compliance.

The NHS exists to serve the wellbeing of everyone in our society, regardless of how they appear or express themselves. This applies to gender presentation in the same way that it applies to superficial judgements about a person's skin colour and assumed ethnic origins.

Is this all just 'political correctness'?

Gender variation is nothing new. Trans people are recognisable throughout history and appear in every culture. In some societies such people are even revered for the special way in which they appear to transcend the conventional division between masculine and feminine. Individual care and respect begins with appreciating that all people are individuals. The NHS is there for everyone, no matter in what way they are different.

31 There are many ways in which development in humans and other species may depart from a pattern in which all physical characteristics are mutually consistent with the general expectation of one sex or the other. Examples include a range of varied chromosomal patterns, mixed development of sex-specific organs and differences in the way sex hormones are either produced or metabolised. Historically these have often been grouped by the term 'intersex'.

There's a practical side too: the Department of Health guide *Human Rights in Healthcare*, published in conjunction with the British Institute of Human Rights, says:³²

"Neglecting people's human rights is bad for their health. In contrast, the protection and the promotion of their human rights is not only good for individuals' health, it also makes for better services for everyone."

The same goes for employment. The overview to *A Framework for Fairness*, the consultative Green Paper resulting from the Discrimination Law Review, says:³³

"... there is also a clear business case for equality. In a rapidly changing world we cannot as a nation afford to waste potential talent and skills of all individuals in our increasingly diverse society."

In NHS terms, the need to recruit the most talented staff for the job, and to retain skills and knowledge developed through training and practical experience, means that organisations simply cannot afford the luxury of turning people away or allowing them to be forced from existing jobs on the basis of ignorance, prejudice or poor attention to people's needs and concerns. Not only is discrimination towards transsexual people unlawful, it wastes talents and lives and must be considered unacceptable by everyone who subscribes to the principles on which the NHS was founded.

An holistic view in health and social care

Throughout any thinking about the inclusion of trans people within NHS policy making it is important to promote and maintain an holistic view of people as unique individuals.

Trans people are not simply the recipients of medical, surgical and mental health services connected with the assessment of gender issues and the reassignment of gender. This would be as wrong-headed as to think of women exclusively in terms of gynaecology and paediatrics, or to think of disabled people only in terms of their specific impairment.

Gender treatment is no more than a specific intervention in the course of a lifelong need for health and social care in an individual's life. Like everyone else in the community, trans people will go on to need treatment for a full range of sickness and injuries over the course of their lives. They will need dental care; they may experience mental illness; they are as likely as everyone else to need support as they experience the onset of age-related impairments. They are also stakeholders in the care of family members and partners.

This means that there is an imperative (underpinned by the general duty to promote gender equality proactively) for NHS organisations to factor the circumstances and needs of trans men and women into all service planning and policy making and public consultation.

32 *Human Rights in Healthcare – A Framework for Local Action*; Department of Health and British Institute of Human Rights, October 2008; Prolog reference 289869.

33 *Discrimination Law Review – A Framework for Fairness: Proposals for a Single Equality Bill for Great Britain*; Department for Communities and Local Government, June 2007; DCLG Product code 07EL04410/a.

Part 5 of this guide deals with the issues to be considered in developing local public health policy, commissioning services, training staff, and generally ensuring that services are inclusive and respectful towards *all* trans people and able to meet their specific needs.

There are strong reasons for taking the need for this inclusive thinking seriously. Research undertaken with trans people in the UK for the Equalities Review and published in February 2007 showed that in a sample based on 872 survey responses and analysis of over 80,000 support service communications by Press for Change:³⁴

- 6.3% of respondents said they had been refused medical treatment because of their trans background
- a further 13.2% felt their treatment had been adversely affected because of health staff knowing about that background (sometimes through inappropriate disclosure)
- the other 80% said they thought their GP would like to be more helpful, but
- 60% of those 80% reported that their GPs had a lack of appropriate information.

These statistics not only illustrate a clear problem but they also helpfully suggest that a major element of the solution lies with effective education and training.

The Department of Health has recognised the gap that previously existed in terms of good resources and guidance to address training and information needs in this area. Annex 1 of this guide contains comprehensive details of a range of authoritative publications and

teaching resources aimed at providing both NHS staff and the public with the information they need. Part 7 also suggests topics to include in the training or development of staff at various levels.

Inclusive employment policy

Trans people are not just service *users*: it is equally essential to consider trans people in recruitment, retention and day-to-day employment policies.

Part 6 deals with specific guidance in this area but it is important above all to stress that trans people are as qualified as any other members of society to work at all levels within the health service. This doesn't just mean the employment of trans people in low- or non-skilled occupations, or away from frontline public-facing roles.

As the examples opposite illustrate, trans employees can continue to work in the most high profile of roles. There is no justification for NHS organisations to lose valuable skills as a result of an employee's transition, no matter what position they work in.

³⁴ Whittle S, Turner L and Al-Alami M, *Engendered Penalties*, The Equalities Review, Feb 2007. See www.pfc.org.uk/files/EngenderedPenalties.pdf for the full report.

Employment examples

The following are two authentic examples of trans people working successfully in professional and frontline roles within the NHS:

- Sarah Muirhead-Allwood MBBS, BSc, FRCS, an orthopaedic surgeon who assisted at the hip replacement operation for the Queen Mother, continued to practise with the public support of the British Medical Association (BMA) and the two NHS hospitals where she worked when her transition from male to female was widely publicised by the press in April 1996 – three years before her employment rights were formally enshrined by law. In 2003 the BBC featured Ms Muirhead-Allwood talking about her pioneering involvement with the introduction of short-stay keyhole hip surgery, an indication of the enduring value of her skills.
- In January 2006 media coverage revealed that Colin Bone, a consultant gynaecologist and the medical director at the Queen Elizabeth Hospital in King's Lynn, was to go on extended leave and return to work the following

autumn as a woman. In a statement to the press, the hospital said the transition was being made with the full knowledge of the hospital trust and chief executive. A spokesperson said: "The Board and professional colleagues, along with his wife and family, will continue to give Colin/Celia support as necessary during what is certain to be a challenging time in both his professional and personal life." Patients were sent letters explaining the situation and a helpline was set up to answer any questions.³⁵

These examples are in the public domain because the NHS employers concerned made a judgement, in conjunction with the individuals concerned, that a proactive media approach was the best strategy in their circumstances. There was a time when there was no alternative because of the routine intensity of press interest in such cases. It is important to stress that nowadays the majority of cases can and should be addressed in a more private manner, as with any event concerning the health treatment of a member of staff. Sometimes the circumstances may still warrant a proactive media strategy but this should not be considered the norm. Decisions must involve the employee concerned.

Factoring with other equality needs

Much of this guide deals specifically with practical approaches to including trans people in the vision of a fully rounded approach to staffing, policy making, service commissioning, and all-round planning and public health strategy. However, it is

important to understand, plan and train staff for the fact that people are not single dimensional.

When looking at equality for (say) black and minority ethnic people, it is important to see this in terms of the influence that such an aspect has on people in conjunction with their gender, age, religion or belief, sexual orientation and disability status.

³⁵ BBC News report.

Likewise it must not be forgotten that the same applies for trans people as well. Some factors may have elevated importance when taken in conjunction with others.

Mapping needs and consulting with communities

Part 8 of this guide provides detailed guidance on how to integrate the needs of trans people into a gender equality scheme, through the stages of gathering information, conducting impact assessments, creating an action plan and monitoring it. Annex 4 also provides suggested tools for consultation

Multi-dimensional considerations

Transsexual women are at risk of breast cancer like other women. This means they must be considered for inclusion in the same public health campaigns, with proactive consideration of whether any special training or approach may be necessary for staff. There are differences to consider as well though. Trans women do not need to be summoned for smear tests as they have no womb or cervix. Conversely, transsexual women also continue to have a prostate gland so it is necessary to screen for the risk of cancer there (although oestrogen therapy renders this a lower risk than in men). Similar arguments apply in reverse for transsexual men. The best approach is to screen people according to their anatomical needs as opposed to considering their pre- or post-operative gender alone. Treating a trans woman or man differently from non-trans people is not discriminatory towards either group if the policy is developed in this way on reasoned clinical need. However, there is a danger of the implementation being discriminatory if the planning is not thought through. For instance, if a trans woman is summoned to a men's health clinic for prostate examination, or if a trans man is sent to a gynaecological unit for a smear test,

then the individual would have grounds for complaints of discrimination and/or violation of their right to privacy.

- Disability is not a reason in itself to deny assessment and gender reassignment treatment to an individual, although travel and accessibility issues with established services may require alternative planning. The concerns of others may need to be anticipated and handled where an individual has learning difficulties. Conversely, a trans person who becomes disabled in their acquired gender may need nursing staff, occupational therapists and physiotherapists to understand their special needs. For instance, how do you sensitively toilet a trans man who has a vagina and no penis?
- Trans people grow older and may need extra support and social care services like everyone else. Research by Age Concern England and by transsexual support groups shows that the fear of what will happen when they age is a significant concern for many trans people. Indications are that the needs of ageing populations of both lesbian, gay and bisexual people and transsexual people will grow in importance in the next few years.

across the board, and for identifying issues that are of particular geographic or community interest.

Sometimes NHS organisations may already be aware of dissatisfaction from individuals or groups of patients. In some areas service users may have used the complaint or advice services such as the Patient Advice and Liaison Service (PALS), or even approached their local authority health scrutiny committee. However, organisations should not wait for matters to progress this far. The Gender Equality Duty requires that organisations must be proactive in seeking to promote equality for all women and men *including* transsexual women and transsexual men.

As the example below illustrates, it may be helpful to utilise local or national patient organisations to develop a well-informed action plan, or to contact local service users for consultation. An alternative way of contacting service users for consultation may be via GPs. However, the latter should be approached with care, as some trans people may be living in circumstances where the people around them are not aware of their trans background. GPs may also be unaware of some patients who could benefit from NHS care. Any approach through GP lists should therefore be organised by inviting the service user to attend the surgery or a local clinic, where these matters can be explained without the risk of compromising the service user's privacy or raising concerns.

Good practice example from a West Yorkshire Primary Care Trust (PCT)

A West Yorkshire PCT faced criticism from individual trans people and its local authority scrutiny committee over excessive waiting times for referrals to a single clinic, with little flexibility for accommodating different patient needs, and no recourse in the event of a breakdown in relationships between service users and the provider. Other aspects of provision had also been criticised in the press.

Senior managers responded by initiating talks with local patient representatives and bringing in advice and expertise from the national organisation Press for Change (see Annex 5), to advise upon best practice and the options they could consider for updating policies and services. The external advisor was also

able to ensure that the PCT understood the options open to them and had the means to access the whole local community when required. Much of the work revolved around the principles of World Class Commissioning – notably working collaboratively with third sector organisations and having meaningful public engagement to shape and improve health.

Having made substantial changes to the commissioning policy, including the introduction of measures to clear the waiting list and provide a choice of providers, the PCT used the trans community's own publicity channels to ensure the changes were widely known and understood. A special telephone line was also set up so that all local service users could get in touch and ensure that their needs were factored into the reform programme.

4. Legal and good practice considerations

What the law requires

There is a significant body of law that nowadays protects the rights of transsexual people in all areas of society:

- The Sex Discrimination (Gender Reassignment) Regulations 1999 extended Parts I and II of the Sex Discrimination Act 1975 to prohibit discrimination in employment and the provision of vocational training for transsexual people in all stages of their transition from the gender recorded at birth to the opposite role.
- The Court of Appeal ruled in 1999 that it is unlawful for NHS organisations to operate anything amounting to a blanket ban on the funding of gender treatment.
- The Human Rights Act 1998 protects and upholds the rights of trans people in the same way as for all citizens.
- The Gender Recognition Act 2004 provides a formal method for the legal recognition of the acquired gender of a person who can meet the Act's requirements. The granting of a Gender Recognition Certificate (GRC) recognises the individual's acquired gender for all purposes in law from that moment forward (the law is not retrospective). Legal recognition also provides formal protection for the privacy of individuals in a way that has significant implications for NHS staff. NHS organisations have a consequent responsibility to ensure their staff are properly informed, so as to avoid criminal proceedings being brought against them personally for unauthorised disclosure.
- The Equality Act 2006, which sets out the Gender Equality Duty, makes clear that all requirements relating to the promotion of equality for men and women include transsexual men and transsexual women.
- The Sex Discrimination (Amendment of Legislation) Regulations 2008 extended Part III of the Sex Discrimination Act 1975 to render discrimination against transsexual people in the provision of goods, facilities, services and housing unlawful.

These specific provisions are in addition to the overall body of law that applies to the rights and responsibilities of all people living and working in the UK.³⁶

³⁶ For instance, under the Data Protection Act 1998, transsexualism and gender reassignment would constitute "sensitive data" for the purposes of the legislation. The data can only be processed for certain specified reasons set out in the Act.

Each of the above provisions has acted in its own way to level up the rights of transsexual people to the same level expected by everyone else.

Advances have not given trans people any *extra* rights over other people; the adjustments have merely ensured they have the *same* rights.

What the law doesn't mean

The way in which specific legislation has been introduced to provide equality for transsexual people emphasises an important point. In order to achieve equality of outcomes for some people who are likely to otherwise experience discrimination, it is sometimes necessary to take specific or extra steps. Requirements such as the Gender Equality Duty are not to be interpreted in ways that preclude this.

This means that it is quite appropriate to provide services or support in a different way than for other people if that is necessary in order to offer people the same levels of dignity, quality of care and respect. An example might be arranging specific provisions for trans men to receive smear tests or undergo hysterectomy operations in a way that is separate from the facilities provided for women. Trans women likewise require some provision that is different to trans men and which may be different from other men and women on the basis of physiological needs.

It is also permissible in some instances to take *extra* steps for a particular group, in circumstances where these are necessary to overcome and reverse the effects of previous exclusion or marginalisation. Clearly this applies to trans people's health and

social care, and their representation in the NHS workforce.

The underlying objective was highlighted when the Government's policy for the legal recognition of transsexual people was announced by the responsible Minister, Rosie Winterton MP, in December 2002:³⁷

"The Government has explicitly made a commitment to providing opportunity for all. This commitment underpins the many initiatives being taken forward to tackle poverty and social exclusion.

"It remains a sad fact that there continue to be identifiable groups who are at a disadvantage and are discriminated against simply by virtue of their disability, gender, race, sexual orientation or some other characteristic. We believe that this is wrong. We are taking steps to remove unfair discrimination and to promote equality of opportunity."

The remainder of this section deals with each area of the law as it applies particularly to NHS organisations as employers and as providers or procurers of care services. It is important to note that at the time of writing the Government is reviewing the entire framework of discrimination law with the intention of bringing forward an Equality Bill. Although the proposed legislation is yet to be debated in Parliament, this underlines the reason why the good practice, discussed later in this section, is just as important as the letter of the law.

Employment law

The requirements of the law for employers are covered in detail by a guide published by

³⁷ Government Policy Concerning Transsexual People, Dec 2002. www.dca.gov.uk/constitution/transsex/policy.htm

the Women and Equality Unit: *Gender Reassignment – A Guide for Employers*.³⁸

The guide explains how the Gender Reassignment Regulations which amended the Sex Discrimination Act 1975 from April 1999 apply. The guide also provides information about the implications of the subsequent Gender Recognition Act 2004 in the context of employment and training.

The relevance of the Gender Recognition Act in this context is that it disapplies certain very limited exceptions, known as Genuine Occupational Qualifications (GOQs), created by the aforementioned regulations when an individual obtains legal recognition.

Following legal recognition of an individual, the entire body of employment law must be interpreted on the basis that they are regarded, for all purposes, as a full member of the acquired gender. This means that a male-to-female transsexual person (a transsexual woman) could only be lawfully discriminated against in a situation where it would be lawful to discriminate against any other woman.

The Sex Discrimination Act 1975, as amended, says that it is unlawful for an employer to discriminate against an employee, job applicant or contractor on the grounds of that person's sex, or gender reassignment, or because they are married or in a civil partnership. It applies equally to men and women. The law also covers harassment and victimisation.

The employment provisions of the Act cover recruitment, transfer, training and promotion, access to work-related benefits, facilities and services, dismissal, and any other detriment.

It is also unlawful for an employer to instruct someone else to do something discriminatory – for instance, telling an employment agency not to hire a transsexual person. Pressure to discriminate is also unlawful – for example employees threatening not to work unless their employer dismisses a colleague who has decided to undergo gender reassignment.

The introduction of the Gender Reassignment Regulations in 1999 means that it is unlawful to discriminate against someone if he or she:

- intends to undergo gender reassignment,³⁹ or
- is undergoing gender reassignment, or
- has at some time in the past undergone gender reassignment.

This ensures that the initial stage is covered by the legislation, when an individual indicates an intention to commence gender reassignment. It is not necessary for all three circumstances to apply. Discrimination in this context means treating a transsexual person less favourably than you treat (or would treat) another employee who is not undergoing gender reassignment (or contemplating it, etc.).

Employers can be held responsible for discriminatory acts by their employees, unless the employer can show that he or she had taken such steps as were reasonably practical, to stop the employee from doing the particular act or acts of that kind. For example, an employer might be able to show that he or she provided equal opportunities training to all employees and

³⁸ Available online at www.equalities.gov.uk/publications/gender_reassignment_guide05.pdf

³⁹ Gender reassignment is defined in the Regulations as "a process which is undertaken under medical supervision for the purpose of reassigning a person's sex by changing physiological or other characteristics of sex, and includes any part of such a process".

deals thoroughly with any discrimination complaints.

Employees remain individually liable for their own discriminatory acts, even where the organisation is also potentially liable.

During the process of gender reassignment there are some very limited exceptions to the principle of non-discrimination when individuals have to share accommodation, and it is not reasonable on privacy or decency grounds to do so while in the process of undergoing gender reassignment (this might apply in single-sex communal sleeping accommodation, for instance).

In that case, the employer has to show that it would not be reasonable to provide alternative accommodation for the individual. If someone already has a job requiring him or her to share accommodation, the employer should take all reasonable steps short of dismissal to sort out an alternative – for example, redeploy them, or replace them temporarily while they are undergoing gender reassignment.

There is also a limited exception if a post requires the holder to provide vulnerable individuals with personal services, and the employer reasonably believes those services cannot be effectively provided by someone undergoing gender reassignment. This exception will apply only in very rare circumstances.

None of this applies to someone with a full Gender Recognition Certificate.

Gender recognition

The Gender Recognition Act 2004 gives legal recognition in their acquired gender to transsexual people who satisfy the Gender Recognition Panel (a judicial body of lawyers and doctors) that they:

- have or have had gender dysphoria, and
- have lived in the acquired gender for two years prior to the application, and
- intend to live permanently in the acquired gender.

The Panel or the Secretary of State can also apply for medical evidence, marital status and other information, which must be given for an application to be successful.⁴⁰

Following a successful application, a transsexual person will acquire the rights and responsibilities of their acquired gender from the date of recognition. The gender recognition process ensures that transsexual people are afforded all the rights and responsibilities appropriate to that gender.

Since the Gender Recognition Panel began processing applications in April 2005, over 2,350 transsexual people have applied for legal recognition under the Act and 97% of these applications have been granted.

Applications have now settled down from an initial peak to a level averaging around 25 per month.

If a transsexual person is successful in applying for gender recognition, and they are unmarried, they will get a full Gender

⁴⁰ Note that the law does not explicitly require an applicant to have undergone specific surgical or medical procedures normally expected. This recognises realities such as medical contraindications and delays.

Recognition Certificate (GRC),⁴¹ and, if their birth was registered in the UK, they will be automatically entered on the Gender Recognition Register held by the Registrar General. Their original birth register entry will be marked, confidentially, to indicate that they have become recognised in their acquired gender. They will then be able to marry a person of the opposite gender and be eligible for the state retirement pension and other benefits at the age appropriate to their new gender. If their birth has been registered in the UK, they will receive a new birth certificate, in their acquired name and gender. Birth certificates issued in this way contain nothing to indicate that the individual's gender has changed. Certificates have the same appearance as for anyone else obtaining a fresh copy of their birth register entry.

Individuals who are married or have a civil partnership in their previous gender role cannot receive a full GRC because marriage is not permitted between two members of the same sex (and civil partnership is not available between people of different sexes). Such persons may, however, apply to a Gender Recognition Panel for an interim GRC. This enables the transsexual partner to obtain a full GRC after their relationship is annulled, and provides a new ground for annulment to ease the process. The detailed provisions for these circumstances also mean that couples in this position can enter a legally appropriate relationship again, within a few hours of annulling the previous one.

It is important to understand, however, that some couples who entered legal relationships prior to the gender reassignment of one of them may have strong feelings that prevent them from being able to countenance

annulling that relationship in order to obtain legal recognition. At present this means that there are people who qualify in every other respect for legal recognition but make the difficult choice not to pursue this under the law as it stands. This does not mean that such persons are any less certain about their gender change, or any less of a woman or a man. It simply means that they are just as seriously committed to the relationship they entered as a couple. It is essential that such people are not treated differently or unfairly by the NHS in these circumstances, to the extent that the law permits.

Privacy

One aspect of the Gender Recognition Act is so important for NHS staff to understand that it merits attention in its own right. This concerns the criminal offence that is created in respect of disclosing a successful applicant's gender history to somebody else.

Section 22 of the Gender Recognition Act says that:

"It is an offence for a person who has acquired protected information in an official capacity to disclose the information to any other person."

"Protected information" means information which relates to a person who has made an application under the Gender Recognition Act. This covers both the fact of the application itself and, if the application was successful, the fact that the individual was previously of the opposite gender to the one in which they are now legally recognised.

⁴¹ Note that the purpose of a GRC is merely to facilitate the creation of a new entry in the register of births, from which a new birth certificate can be issued. The GRC as a document has no other legal standing. It is not appropriate to operate a policy of requiring sight of a GRC in order to change an individual's name in patient or employee records. A statutory declaration or deed poll is the most that should be required for changes of name and title, just as for anyone else, and regardless of the individual's state of transition.

A person acquires information in an “official capacity” if they are acting:

- in connection with their functions as a member of the civil service, a constable or the holder of any other public office or in connection with the functions of a local or public authority or of a voluntary organisation
- as an employer, or prospective employer, of the person to whom the information relates or as a person employed by such an employer or prospective employer, or
- in the course of, or otherwise in connection with, the conduct of business or the supply of professional services.

It is not an offence to disclose information obtained in these circumstances if:

- the information does not enable the person to be identified, or
- that person has agreed to the disclosure of the information, or
- the person making the disclosure genuinely does not know or believe that a full Gender Recognition Certificate has been issued, or
- the disclosure is in accordance with an order of a court or tribunal, or
- the disclosure is for the purpose of instituting proceedings before a court or tribunal, or
- the disclosure is for the purpose of preventing or investigating crime, or
- the disclosure is made to the Registrar General for England and Wales, the Registrar General for Scotland or the Registrar General for Northern Ireland, or

- the disclosure is made for the purposes of the social security system or a pension scheme, or
- the disclosure is in accordance with provisions made through regulations which the Secretary of State is permitted to make under the Act.

What all this means, however, is that NHS employees at all levels, who could learn about an individual's gender reassignment history in the course of their work, need to be very clear about the handling of this information. This could apply to:

- the information that can be entered into Human Resources files to which other staff might have access
- discussion about an applicant's job interview
- the contents of occupational health reports
- information that can be passed from one medical professional to another in the course of referral or when discussing a case
- information stored in medical records where that data could be accessed by others.

It is therefore imperative that all staff receive appropriate guidance. Ignorance of the law is not a valid defence. A conviction obviously involves a criminal record for the individual. At the time of publication, a fine of up to £5,000 could also be imposed.

Staff also need to understand how to seek permission to disclose protected information if this is considered important to need to do, and how to deal with the circumstances that can arise if the individual makes an informed

choice to withhold permission even after the implications have been explained to them.

Training requirements are covered in detail in part 7 and should be seen in context of a wider emphasis upon appropriate and inappropriate reference to employee and patient data. The handling of protected information relating to staff is also covered in part 6.

Funding policy

In 1999 the Court of Appeal⁴² made a favourable ruling in the case of three male-to-female transsexual women who were challenging a policy by their health authority, which had refused funding for treatment connected with their gender dysphoria. This followed an appeal by the authority against a similar earlier judgment in favour of the plaintiffs.

The ruling recognised that gender reassignment is the appropriate medical response to gender identity disorder and that it would be unlawful for health authorities (now PCTs) to operate anything that amounts to a blanket ban on funding in such cases.

The ruling does not just apply to explicit policy statements that exclude assessment or treatments; it also applies where the impact of policies may amount to the same outcome. For instance, this would apply if a policy made funding for referral applications subject to consideration by an Exceptional Cases panel, but the panel was unable to indicate the criteria that would be considered exceptional, or was unable to demonstrate that a reasonable proportion of applications had been accepted.

Services

In addition to the specific case law referred to above, Parliament has recently brought into force new legislation which prohibits discrimination in the provision of goods, facilities, services and housing for transsexual people on the grounds of their gender reassignment. ('gender reassignment' has the same meaning as explained in connection with employment and vocational education).

The Sex Discrimination (Amendment of Legislation) Regulations 2008 make it unlawful, in general, to treat a transsexual person any less favourably on the grounds of their gender reassignment than any other person who is not intending to undergo, is not undergoing or has not undergone gender reassignment when providing goods, facilities, services or housing. The Regulations also make it unlawful to subject a transsexual person to harassment on the grounds of their gender reassignment.

There are limited exceptions which can be relevant in a health and social care context.

For example, in hospitals and establishments for persons requiring special care and attention it may be permissible to take a possibly less favourable approach towards transsexual people in the provision of goods, facilities or services provided that to do so is a proportionate means of achieving a legitimate aim. Similar limited exemptions are applicable to charities and the use of communal accommodation.

It is important to be clear about what the concept of a "proportionate and legitimate aim" means in practice. It is generally held that in order to constitute a legitimate aim an objective must be something fundamental

42 R v North West Lancashire Health Authority ex p A, D and G [2000] 1 WLR 977.

to the purpose of the organisation. So it would not be appropriate for a local hospital manager to declare that all transsexual people must be assigned to wards of their birth assigned gender. However, it might be arguable that, in some few circumstances where vulnerable individuals might need to be exposed to a state of undress within a ward, that a pre-operative transsexual person may need to be placed in a side ward. The “legitimate aim” would be the protection of a vulnerable transsexual person.

The word “proportionate” means that an action must be both appropriate *and* necessary in order to meet a specified aim. That specified aim must not be to discriminate against the trans person, because that could never be a legitimate aim, since the intention of the law is to prevent discrimination against trans people.

The public sector Gender Equality Duty

From April 2007 amendments made to the Sex Discrimination Act 1975 (SDA) by the Equality Act 2006 have required public authorities, including NHS organisations, to comply with a general duty to proactively promote gender equality. To support authorities in meeting the general duty, there are a series of specific duties applicable to key public bodies, one of which is to produce a gender equality scheme.

Detailed guidance for NHS organisations is provided by the booklet, *Creating a Gender Equality Scheme: A Practical Guide for the NHS*.⁴³ This guide belongs to a family of additional documents dealing with specific aspects of *all* of the various equality duties.

The Equality Act 2006 places a statutory duty on all public authorities (including NHS organisations), when carrying out their functions, to have due regard to the need to:

- eliminate unlawful discrimination and harassment that is unlawful under the SDA
- eliminate discrimination that is unlawful under the Equal Pay Act 1970
- promote equality of opportunity between men and women.

The ‘general duty’ came into effect on 6 April 2007 and, at that time, the legislation specifically included transsexual people in relation to the parts of the SDA which relate to discrimination and harassment in employment and vocational training. The Sex Discrimination (Amendment of Legislation) Regulations 2008, which took effect from 6 April 2008, further extended the SDA and the general duty so as to protect transsexual people in the provision of goods, facilities, services and housing.

It should be noted that the protection for transsexual people under anti-discrimination legislation protects people who are intending to undergo, are undergoing or have undergone the process of gender reassignment. Gender reassignment is defined in the SDA as:

“a process which is undertaken under medical supervision for the purpose of reassigning a person’s sex by changing physiological or other characteristics of sex, and includes any part of such a process”.

⁴³ *Creating a Gender Equality Scheme: A Practical Guide for the NHS* is available online at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_066068

There is no legal requirement for public authorities to take action to eliminate discrimination against transsexual people who do not fall under the definition of the “grounds of gender reassignment” in the SDA, even though they may define themselves as transgender or encounter the same discrimination on the basis of being perceived that way.

However, since persons who may be minded to discriminate on the grounds of perceptions about a person’s physiognomy, dress or behaviour may not be in the position to know whether the person meets the gender reassignment definition or not, good sense suggests that it is always best to err on the inclusive side.

The Equality and Human Rights Commission particularly recommends that public bodies, such as NHS organisations, should take action, wherever possible, to include trans people in the widest sense. This reinforces earlier statements by the Equal Opportunities Commission (EOC):

“EOC recommends that public authorities should ensure that their policies and procedures cover transgender people as well as those who are transsexual.”⁴⁴

The Government’s Discrimination Law Review has also consulted for views on the possibility of extending protection through a wider definition. Information will continue to be updated on the website of the Equality and Human Rights Commission⁴⁵ and through the *Equality and Human Rights Bulletin* launched in 2007 by the Department of Health’s Equality and Human Rights Group.

Going further – best practice

As stressed throughout this guide, the strict letter of the law in relation to equality and human rights is intended to be the baseline for policies and conduct within NHS organisations. The fact that the law does not strictly require a particular action to promote equality, dignity and respect for staff and service users does not preclude managers from aiming high and seeking to level up the way in which everyone is treated and regarded. Similarly, the existence of limited exceptions should never be seen as an invitation to seek to exploit them unless all other possible avenues for inclusion have been tried and exhausted.

⁴⁴ *Meeting the Gender Duty for Transsexual Staff*, EOC; Feb 2007.

⁴⁵ www.equalityhumanrights.com

These principles apply particularly in the case of trans people, where the definitions employed in framing the law can mean that, between two superficially similar or identical people, one person can be legally protected and the other may not. To split hairs over equality in these circumstances is to miss the point about the social aim to be achieved.

NHS organisations should aim to set an exemplary example, both as an employer and as a provider and procurer of services, by acting (and encouraging others to act) in accordance with the principle that the NHS is a service provided for all members of society, without prejudice.

Good practice example from the Home Office

A policy decision was made by the Home Office to accord all staff who live in the opposite gender to the one assigned at birth the same level of privacy for personal files, whether they have a Gender Recognition Certificate or not. Action plans were devised to check historical personnel records for information which could unintentionally reveal their previous gender. For instance, sickness absence records might reveal that a transsexual man had, in the past, taken maternity leave. The department also trained strategically selected liaison officers in Human Resources to be especially well-versed in these issues, so that staff could have someone they could approach to handle all their record change needs.



Section Two: Practical guidance on service quality, employment and training

5. Service commissioning and delivery

Context

The authors of the Equalities Review report on trans people's experiences of exclusion and discrimination had this to say in summarising their findings about Britain's health and social care services:

"When they are seeking treatment to transition, [trans people] will start a medical process which reduces every aspect of their life and, in particular, their health down to the most minimal of issues, their trans mental health. Practitioners, at every level of medicine, ignore the trans person's abilities to cope with ongoing crises that would destroy other people, their educational standing and the nature of the actual illness they are presenting with. The fact that some qualified nursing staff will insist on calling a person who has been transitioned for over 30 years in their former gender, is indicative of the level of ignorance that exists within our health services. But are they 'our' health services?"

"Increasingly, despite the Court of Appeal ruling in R v North West Lancashire Health Authority ex p A, D and G, trans people are being refused gender reassignment services or are being made to wait for years before they can obtain assessment and diagnosis, never mind surgical procedures. The NHS is not a welcoming place for many trans people, much of their medical treatment they will pay for themselves, and if any treatment

*is actually obtained it is often as a result of a Herculean struggle past recalcitrant GPs, rude nursing staff, arrogant and demanding psychiatrists, finally to be met with the news that there are very few surgeons and the waiting list is several years long. Is it surprising then that many sell their homes in order to be able to self finance their own way through the private route ways to surgery in Thailand."*⁴⁶

The same report cited some quotes by service users:

"I had to change GP because he just could not accept gender dysphoria as being real."

"My endocrinologist refuses to treat, recommend or monitor trans people."

"I was put in a side room on the women's surgical ward. I was told that before I had even arrived on the ward the word had gone out that a man was being put on the ward. My stay was made a living hell by one staff nurse who all the others seemed to follow." (Male-to-female trans woman describing her experience of non-trans-related hospital treatment)

The Gender Equality Duty, which now embraces the provision of services for transsexual people in the same way as for all men and women should not need to be viewed as the only compelling reason to consider those statements as the mandate for careful attention to trans people's needs and rights.

46 Whittle S, Turner L and Al-Alami M, *Engendered Penalties – Transgender and Transsexual People's Experiences of Inequality and Discrimination*, The Equalities Review, Feb 2007 (p77). www.pfc.org.uk/files/EngenderedPenalties.pdf

The principles of the NHS were clearly set out in the Operating Framework for 2007/8:⁴⁷

“(1) The NHS will provide a universal and comprehensive service with equal access for all, free at the point of use, based on clinical need, not ability to pay.”

“(2) We will help keep people healthy and work to reduce health inequalities...”

“(5) We will treat every patient with dignity and respect.”

“(6) We will shape our services around the needs and preferences of individual patients, their families and their carers.”

“(7) We are committed to equality and non-discrimination.”

The need for change and improvement is therefore beyond question or debate. However, where managers encounter the beliefs that give rise to the kinds of discrimination and neglect that are evidently present in many services, it is important to be clear about how this point in understanding has been reached.

Gender reassignment is a legitimate medical response for some people with a dissonance between their gender identity (their sense of being a man and a woman) and their anatomy. Professor Richard Green, a leading specialist who has practised and conducted research in the field for over 40 years states:

“Severe gender dysphoria cannot be alleviated by any conventional psychiatric treatment, whether it be psychoanalytic therapy, eclectic psychiatric treatment, aversion treatment, or by any standard psychiatric drugs.”

(Cited in Bellinger, 2001, para 32)⁴⁸

The 1999 Court of Appeal ruling in the case of R v North West Lancashire Health Authority ex p A, D and G recognised that gender reassignment is the appropriate medical response to gender dysphoria, and that it would be unlawful for health authorities (now PCTs) to operate anything that amounts to a blanket ban on funding in such cases.

Managers should therefore be clear that the time is long gone for debate about the legitimacy of trans people’s existence, or the approaches taken to treating them. That debate has taken place; trans people’s legitimacy is accepted; it is time to move on.

Part 2 explains why it is also best practice to see beyond this to a broader understanding of gender diversity in a historical and anthropological sense, and to appreciate that the same values apply to accepting and respecting people, no matter which route they take to accommodate and express their sense of self. The same section also underlines that health professionals need to think beyond gender reassignment, and also consider how to support families, partners and children.

47 *The NHS in England: the operating framework for 2007/08*, Prolog reference 278247 and online at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063267

48 *Bellinger v Bellinger* [2003] 2 All England Law Reports 593.

Where does change need to occur?

The examples and quotes provided in this guide make it plain that problems may be experienced by trans people within every part of the health service.

- **General practice** – not just the behaviour and knowledge of GPs but in the attitudes and conduct of receptionists and practice nurses. This is not limited to teaching people about policies and how to behave; they need information and tools to do a professional job too. The Department of Health has produced a range of literature to support this. See Annex 1 for details. Professional guidance is now also available for health specialists involved in the care of trans people. This is included in recommended education and training.
- **Hospitals** – again, not just in the attitudes and knowledge of consultants but across the board among nurses, ancillary staff and managers. It must be remembered that trans people do not just come into contact with health services for gender transition. They can be injured, become ill and succumb to the effects of ageing like everyone else. Good care in those circumstances relies on staff knowing when a trans history is relevant and (more to the point) when it is not.
- **The design and implementation of policy** – especially in regard to rationing and waiting times, absence of choice, and distances that patients need to travel for care related to assessment and treatment of gender dysphoria. However, other commissioning, professional and operational policies may also need to be assessed in terms of the impact they might have for people with a trans background.

Other NHS organisations are not exempt either:

- **Ambulance and A&E staff** may need practical advice on how to attend to trans people's needs in crisis situations. How do you catheterise a trans person, for instance?
- **Specialist clinics** may need to look at the way their organisation operates and how this could impact on the dignity and privacy needs of trans people. For instance, how should a genito-urinary clinic provide check-ups for trans women and men – especially trans men, who are more than likely to have a vagina rather than a penis, but who should clearly not be forced to attend the women's clinic?
- **Local mental health trust** psychiatrists involved in initial assessment of transsexual people's needs must be clear about what is expected, and how this fits within the local care path for this.

This is not an exhaustive list. These examples merely underline the extent of impacts.

What trans people think, expect and fear

Good practice undoubtedly exists in all areas; however, even in the most enlightened and professional of services the negative expectation of trans people – formed throughout their lives by hearing or reading of bad experiences in the press and from contemporaries – leads to poor expectation, anxiety about the simplest of contacts with services, and an overall need to build trust.

Continued overleaf

These are some of the beliefs and fears that health professionals are likely to encounter:

- **My GP will refuse to treat me, will be rude and dismissive, or will blame any illness I have on my gender reassignment.** In particular, people fear that their GP will decline to prescribe hormones as part of a shared care protocol during gender treatment, or as normal following reassignment surgery. Continued hormone therapy is a medical necessity following gender reassignment to maintain physical and mental health and especially to avoid osteoporosis. Regular (annual) health checks are advised too.
- **My trans background will not be private and will be seen by everyone having access to my records.** Trans people especially fear that any referral to a consultant will routinely disclose their transsexual background, whether this is relevant or not. Part 4 in this guide explains the circumstances in which such disclosure would be a criminal offence.
- **People in the NHS will use inappropriate pronouns and will fail to consider my need for privacy and dignity.** Most trans people have experienced extreme social disapproval and rejection at some point in their lives. The fact that people undertake transition whilst knowing and expecting this underlines how important their identity is to them. Any disregard for the expression of that identity is experienced as total rejection of who they are. Careful thought therefore needs to be given to the way in which staff are trained and prepared to accommodate

trans patients, especially in clinics and on hospital wards. Unlawful disclosure can also occur through negligent action as well as direct word of mouth, and could therefore result in the criminal prosecution of staff who fail to respect trans people's legally recognised identity.

- **If I need to see a gender specialist, then I will not be allowed a choice of where to go. I may have to wait years for my first appointment, if I'm allowed one at all. I will have to travel hundreds of miles for every appointment, and I will be treated without respect for my intelligence and preferences when I finally get there.** These are still the harsh realities of healthcare policy for trans people in many parts of the UK, even in 2008. These are also one of the first and most enduring experiences that trans people will have with the NHS. As a result, no matter what actions are taken to improve services elsewhere, trans people will be likely to carry a negative expectation with them throughout their lives – making it harder for the NHS as a whole to include and care for them following transition.

It is therefore not sufficient to review services and conclude that all is well. Consultation with trans service users is essential to build bridges and learn what people (rightly or wrongly) think about their services. There can be few communities with less general trust and belief in the NHS.

Annex 4 in this guide provides two tools for initiating a process of review and reform by consultation. One tool is designed to capture knowledge of multiple discrimination in a wider sense.

This emphasises that consultation with trans people can be undertaken within the wider context of consultation with all communities. The second tool allows consultation to be taken to a further stage, by determining where people's priorities lie, and what they would regard as the evidence of successful inclusion.

When conducting consultation, reviewing policy and undertaking impact assessments on services, it is also helpful to see things from the mindset encouraged by the Social Model of Disability.⁴⁹ This is not to say that being a trans is a disability. The point is that many of the experiences that people have do not arise inherently from their condition; instead they are a result of the way society

has been organised without taking account of their existence.

Changing gender role is a positive thing for trans people. It involves moving from a state that feels wrong or unnatural to a place where the individual is able to express their true self. Any anxiety therefore does not arise from that transition in itself, but from the reaction of others and the obstacles they place in the trans person's path. If service managers find that providing services to trans people requires a rethink or special arrangements, that is not the 'fault' of the trans person for being different; the problem is that the service was not designed with them in mind.

Applying World Class Commissioning principles

The principles embodied in World Class Commissioning (WCC) provide an ideal approach to addressing the issues raised:

- The achievement of wellbeing for the individual is the central goal.
- Service users specifically identify local provision, choice and personalisation of services as being critically important to good outcomes. These are WCC goals too. Annex 3 explains how innovation in care pathways can be approached.
- There is plenty of opportunity to look at best practice from outside the UK, where gender treatment has often been conducted very differently.
- Private sector providers can have a significant role to play, and are already aware of the ways that innovation can be used to improve patient experiences and provide better public value for money. WCC encourages looking at private sector methods.
- WCC encourages a clear understanding of the part that local prevalence has to play in utilising local resources to best effect.

Healthcare policy good practice

There is no existing published good practice guidance for including trans people within general everyday healthcare, so NHS organisations need to develop and share this among themselves, in conjunction with the national organisations which support trans people.

⁴⁹ The concept of the 'Social Model of Disability' is credited to the disabled academic Professor Mike Oliver, who coined the term in 1983, although the roots go back to the mid 1960s. See www.daa.org.uk/social_model.html. See also *Pride Against Prejudice*, Jenny Moore, ISBN 0 7043 4286 3 and *The Politics of Disablement (Critical Texts in Social Work & the Welfare State)*, Mike Oliver, ISBN 0 3334 3293 2.

Here are some pointers though:

- Trans people should be included in consultation concerning the way that every aspect of their identity affects their healthcare. Trans women need to use breast clinics, for example, and they may have personal safety concerns accessing surgeries and clinics like other women. Trans men may have needs relating to retained female aspects of their anatomy, *and* have a view on services targeting their health as men. Being trans and disabled may add extra issues to the experience of using services. Trans people may also have caring responsibilities; they have specific concerns about ageing, and so on. The consultation methodology explained in Annex 4 provides a way of teasing out these multi-dimensional facets for everyone, as the basis for impact assessment.
- Those running public health campaigns need to consider the factors that influence smoking, alcohol, diet and exercise for trans people – otherwise campaigns aimed at changing behaviours may miss the mark. As with the previous point, this is good practice overall. Without this there is a danger that initiatives may simply fail to appreciate the driving forces in the lives of a large proportion of the population and will therefore fail.
- Statistically it is highly likely that the average GP practice will encounter one or more trans people – or their relatives. The same applies to hospitals and clinics. This means that awareness of trans needs is not to be considered something that *'isn't needed here'*. Preparedness includes training staff to address people appropriately, understand their sensitivities and fears, and handle their records accordingly.
- Ambulance and A&E staff need trans awareness in their training – for instance how to handle a pre-operative trans person with dignity, and how to catheterise someone with reconstructed genitals.
- GPs need *support* too. There is no specific training in this field, and GPs may have difficulty locating authoritative clinical and procedural advice to brief themselves in the way they would do for any other patient presenting with needs they are unfamiliar with. This means that PCTs need to consider the best way to address this need.
- Privacy is a vitally important topic, especially in view of the possibility of criminal actions against staff for unauthorised disclosure of “protected information” under Section 22 of the Gender Recognition Act.
- In the light of research evidence showing that more than 6% of trans people have been refused treatment by doctors, there is clearly also a need for NHS organisations to provide clear and unequivocal policy guidance relating to this (or indeed the refusal to treat any patient).

Specific policy issues regarding the assessment and treatment of gender issues are covered under ‘Specifics concerning gender treatment’ on page 44.

Equality impact assessments

NHS organisations are obliged to perform equality impact assessments as part of fulfilling the Gender Equality Duty. As explained in part 4, this now includes considering impacts upon transsexual men and women in the provision of services. People who are not trans, and have not

grown up with the fears and experiences which accompany that, are unlikely to anticipate the things service users might experience or imagine. A rigorous equality impact assessment should therefore include consultation with trans people themselves.

Remembering that the health policy areas listed above are only examples and not an exhaustive list, the following are some areas in which existing policies and service provision may require impact assessment from a trans perspective:

Training

All the research indicators suggest that most of the problems encountered by trans people in healthcare relate to the need for staff training and the reinforcement of core NHS principles. Most NHS organisations therefore need to embed trans awareness into existing training curricula and, where necessary, plan specific action. In some cases, given the relatively rare incidence of trans cases, it may be a good idea to make some training available in ways that can be accessed at short notice when needed. The suggested training topics covered in part 7 advocate this approach for what managers may need to know when an employee of theirs commences transition. Online self-study is an option.

Medical records

Trans people's medical records will contain details of any gender reassignment treatment and changes of name. Even without the legal protection afforded by the Gender Recognition Act it is good practice to take positive steps to ensure that the gender reassignment is not casually visible or communicated without the informed consent of the service user. This may require the review of relevant policies and specific instructions to staff.

Routine health screening

Trans people need to be screened for risks such as cervical, breast or prostate cancer on the basis of physiological need, not their birth or acquired gender. Systems and procedures may need to be reviewed with this and the need for patient privacy in mind.

Clinic organisation

Some clinics provide gender-specific or gender-segregated services. An example of the former may be a clinic performing prostate examinations. Similarly clinics dealing in genito-urinary infections may have sessions for men and sessions for women, or separate entrances. It would be unacceptable to require a trans woman to use a waiting room for men in the former case, or for a trans man to share a female clinic waiting area in the latter case.

Hospital wards

As with clinics, some consideration is necessary to consider the impact of accommodation policies on trans people (both pre- and post-operative, with and without legal recognition). Consider, for instance, the scenario of a trans man requiring a hysterectomy.

Health advice

The way that health advice is given to the public (for example through leaflet racks in GP waiting rooms) may also warrant attention. Trans people and their families need discreet access to good advice. The Department of Health has commissioned a set of leaflets covering a range of topics that service users and their families need to know about – for instance, information about hormones, what they do and how to use hormone treatment safely. In some instances

this can compensate for the absence of appropriate patient information with the drugs themselves. See Annex 1 for details. Policy on how this information is made available may need consideration.

Specifics concerning gender treatment

Of all the issues reported nationwide by trans people in surveys, the biggest topic concerns the provision of services for assessing and addressing gender issues. Analysis of these documented cases indicates that the problems boil down to issues concerning:

- **Contract/clinic capacity and consequent waiting times.** Most PCTs will see only a handful of new cases per year, with maybe less than a dozen patients at different stages of a two- to three-year treatment episode. However, patients appear to frequently experience disproportionately long delays between presenting for help and obtaining an initial referral appointment. In some cases waits of up to 24 or 30 months have been reported. During this period, having taken significant personal steps, service users can be especially vulnerable. One service user was told they would need to wait up to ten years for reassignment surgery – remaining, for that period, on medication and requiring additional therapy for the stresses endured. Prioritisation arguments do not stand up to scrutiny in these circumstances.

As explained in part 4, policies that amount to a blanket ban on referral funding are unlawful.

The Department of Health emphasises that the waiting list targets apply for these services in the same way as for any other.

- **Absence of choice.** At the present time many PCTs still have procurement contracts with only one NHS gender identity clinic. This policy, replicated widely, accounts for many of the waiting list problems which then occur. Close examination of single-supplier policies often reveals that they exhibit the typical problems that can occur in a health market with no contestability. It is probable that this may have arisen in the past through a lack of other clinics to choose from; however, that is no longer the case. Quite apart from the question of public value for money, this is a service area where the *style and nature* of the care provided by different clinics and practitioners are important to the patients concerned, undertaking the biggest possible change in their lives. Therefore it is essential that trans service users should be offered a meaningful range of choice. This does not simply mean a choice of gender clinics following the same protocols, but a choice of approaches too.

It is now unlawful to provide services to transsexual people on a less favourable basis than for non-transsexual patients.

- **Travelling distance.** Single source purchasing arrangements result in the need for patients in many areas to travel long distances for appointments. Clinics may also fail to take adequate account of this in the allocation of appointments, resulting in severe difficulties in attending and in arranging the necessary time off with employers. Some parts of the country have no local gender provision at all and commissioners may fail to appreciate that many of the components in the services they are commissioning (for example speech therapy, endocrinology, counselling) could be provided from local sources with little or no professional development. Indeed it is possible to conceive of the majority of all but very specialist elements of gender services being provided locally (or regionally), if coordinated by an appropriate local professional such as a GP with Special Interest (GPwSI). New guidelines which are to be published by an interdisciplinary group under the auspices of the Royal College of Psychiatrists are designed to enable this kind of flexibility of approach in commissioning.

Excessive travelling requirements may render existing arrangements non-compliant with the Disability Discrimination Act 2005 if the services are inaccessible to disabled service users as a result.

- **Inflexibility.** Some of the remaining problems that are reported relate to inflexibility – either within the services which are procured, or in terms of funding rules. Two common scenarios are that the service may fail to accommodate the life circumstances of a service user (for example someone needing to abandon private care and continue their advanced reassignment with an NHS provider) or the realities forced upon them (for example needing to move to a different area in mid treatment). Trans service users need services which can cater for different entry or handover situations without requiring the service user to start treatment again from scratch, and commissioners need to reassess policies which may refuse funding for a period after moving into their catchment. The former is medically unethical. The latter is unlawful.

For many PCTs it is therefore necessary to review policies in terms of the way in which past procurement decisions may now conflict with the imperative to embody equality and human rights principles into commissioning practice.

Treatment for what is referred to as gender identity disorder is listed under the Mental Health category of the Specialised Services National Definition Set.⁵⁰ This means that commissioning will normally be undertaken on a regional basis by specialised commissioning groups.

This does not alter the accountability of individual PCTs in terms of local health scrutiny and their equality and human rights obligations under the law. Nor does it rule out individual PCTs making local

⁵⁰ *Specialised Services National Definition Set: 22 Specialised mental health (adult).*
See www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Specialisedservicesdefinition/DH_4001697

commissioning arrangements in the interests of better patient care and flexibility. However, it *does* encourage strategic commissioning groups to consider a regional-level reappraisal of how they commission, and whether they are achieving the correct balance between compliance with the law and the achievement of good public value for money. This is a good application of World Class Commissioning practice.

Experience indicates that there is significant opportunity to satisfy both objectives at once – to provide faster, more flexible, more diverse patient-centred services and to reduce their per capita cost.

The following are some suggested target outcomes from review:

- To ensure that the national target for referral from primary care to a relevant gender identity professional is achieved or bettered for members of the public presenting with concerns relating to their gender and gender identity.
- To enable trans service users to select from a meaningful choice of services for the assessment and treatment of their gender issues, having regard to information about comparative waiting times, differences in clinical approach, and the travelling distances involved.
- To ensure that services are accessible without the need for excessive travel.
- To offer a choice of one or more existing gender identity clinics but also consider ways to maximise the use of local services – either by encouraging existing clinics to collaborate in a coordinated multi-disciplinary approach with local specialists, or by constructing a regional/local service and externally commissioning for only the services that cannot be sourced locally.

- To achieve cost savings whilst improving the levels of service as above.
- To establish a local consultative review forum for service improvement, comprised of commissioners, service users and practitioners, in order to oversee the transformation of services.

For more detailed information about commissioning of services for trans people, see Annex 3.

Not just trans

Finally, as noted on page 23, it is important to remember that trans people are not just trans. Their experience as service users is also influenced by other factors listed below. Sometimes these combinations can add to the barriers that people face.

A methodology for eliciting more examples of so-called multiple discrimination like this is explained in Annex 4.

Gender

At the most basic level, trans people are also men and women. This means that trans people are as likely as any other man or woman to be affected by the issues relating to their acquired gender. They should therefore not be forgotten in broader consultation on gender equality.

Ethnicity

Little is known about the way racial and ethnic background interacts with being trans in the UK. Knowledge of the way that cultural background influences other health issues suggests that it is important for NHS organisations to make the effort, through consultation and encouragement of research, to find out.

Disability

Research carried out for the Equalities Review indicated that trans people are just as likely as the general population to have a physical or learning disability. In particular, it is important to be aware that a learning disability does not preclude gender reassignment treatment. The new care guidelines specifically address this need. Likewise it is important to assess the accessibility of services for trans service users – especially for being able to get to clinics.

Religion or belief

Some clinical staff may voice objections towards treating trans service users on the grounds of their religion or beliefs. Managers must be prepared to deal with this in the same manner as for any other similar objection (for example on grounds of sexual orientation). It is helpful to be aware that a fatwa issued by the Ayatollah Khomeini in 1976⁵¹ sanctioned gender reassignment treatment under Islamic law and, although some evangelical Christian groups have opposed or sought exemptions from the employment, service provision and legal recognition legislation described in this guide, other Christians are generally sympathetic and welcoming. There are at least two cases of Church of England clergy having undergone gender reassignment.

Sexual orientation

Being trans is not a sexual orientation; it is about identity as a man or woman. Being trans doesn't predict sexual orientation – trans women can be attracted to men or women or both. The same applies to trans men. Whatever the case, however, transsexual people have a sexual orientation and have relationships in accordance with

that. Trans people who identify as lesbian, gay or bisexual (LGB) are as susceptible as non-trans LGB people in terms of the issues that can affect them. This means that their needs should be considered in public health policy making on sexual health. Trans people can also have specific risks. For instance there can be increased risk of infection through vaginal sex for trans women owing to the lack of natural lubrication and the lack of elasticity and thickness in vaginal walls.

Age

Age affects everyone, but some aspects can affect trans people disproportionately. Trans people have particular health concerns and social care concerns with regard to ageing. A fact sheet on this has been produced by Age Concern England.⁵²

Employers and employees both share negative assumptions about age. It is anticipated that, by 2021, 40% of the population will be over fifty. The proportion is already over 30%. Many people over fifty expect to encounter difficulties in even getting interviews for jobs. This also affects the fear of losing a job. Trans people feel this fear acutely. People who transition later in life also have elevated difficulties in 'passing' well and they may need longer to heal from surgeries.

51 See 'A Fatwa for Freedom', *The Guardian* (G2), 27 July 2005.

52 *Planning for later life: transgender people – Information sheet 30*, Age Concern England. www.ageconcern.org.uk/

6. Employing and retaining trans people

Context

As explained in part 2, transsexual people are comparatively rare – perhaps as few as 1 in 11,500 of the adult population. Yet the NHS is large enough to make even this small population density significant for managers.

A report on NHS staff numbers published by the NHS Information Centre in April 2007 indicates that 1.3 million people were directly employed by the NHS and contracted GP practices in 2006.⁵³ Of these:

- over 80% (1.13 million) are frontline staff. Of these, 60% (675,000) are professionally qualified clinical staff, for example 126,000 doctors and 398,000 qualified nurses. They are supported by 454,000 staff in trusts and GP practices
- the remainder (209,000) are NHS infrastructure support staff, with nearly a half (102,000) of them in central functions, just over a third (71,000) in hotel, property and estates and just under a fifth (37,000) being managers.

Research published for the Equalities Review⁵⁴ indicated that, within the significant number of trans people surveyed, the respondents were three times more likely to work in professional occupations (33% against a

national level of 10.8%) and more than typically likely to work in management roles (26.4% compared with 22.0%).

The same research also indicates significantly higher than normal educational attainment among trans people when they have transitioned. Results showed that 34% have A levels compared with 19.8% of the general population; 29.2% have a first degree (compared with 21.1% average); and 14.8% have obtained higher degrees (compared with 5.8% in the rest of the population). These are educationally motivated people too. The report authors noted:

“A large number of respondents stated that they returned to continue their education as adults, which may explain the high numbers of respondents educated to degree level and higher, compared with the national average.”

These figures therefore indicate that trans people are not only likely to be well qualified and motivated recruits, but they are also likely to be statistically over-represented in the existing workforce.

The other side of the coin is sobering, however. Separate research, published in 2002⁵⁵ (three years after the introduction of employment protection) showed that 16% of transsexual people reported feeling obliged to move to another employer following their transition from one gender to the other – although the author noted that this was an improvement on the 62% who had felt that way obliged prior to the change in the law. However, many were also still working one or two levels below their capability.

53 NHS Staff 1996–2006, The Information Centre.

54 Whittle S, Turner L and Al-Alami M, *Engendered Penalties*, The Equalities Review, Feb 2007, Figure 4.10.

55 Whittle S, *Employment Discrimination and Transsexual People*, 2002.

www.pfc.org.uk/files/Employment_Discrimination_and_Transsexual_People.pdf

As explained in part 4, the Sex Discrimination (Gender Reassignment) Regulations 1999 mean that it is unlawful to treat someone unfavourably in employment and vocational education if that person:

- intends to undergo gender reassignment,⁵⁶ or
- is undergoing gender reassignment, or
- has at some time in the past undergone gender reassignment.

The Gender Equality Duty takes that a step further and requires that NHS organisations (as public bodies) have a duty to proactively promote the equality of transsexual people in the same way as for other men and women. The net effect of the Gender Equality Duty is that NHS organisations have a duty to prevent:

- direct and indirect discrimination against women and men (*including transsexual women and men*) in employment and education, in goods, facilities and services, and in the exercise of public functions
- harassment, sexual harassment and discrimination on the grounds of pregnancy and maternity leave
- direct and indirect discrimination in the employment field on the grounds that a person is married or a civil partner (this may include someone who remains married to someone they married prior to gender change)
- victimisation
- harassment and sexual harassment.

Beyond the law – NHS principles and exemplar practice

Among the restatement of principles for the NHS, set out in Appendix C of the NHS Operating Framework for 2007/8,⁵⁷ number eight asserted that “*We will support and value our staff.*” It states:

“The strength of our organisation lies in our staff, whose skills, expertise and dedication underpin all that we do. They have the right to be treated with respect and dignity. We will continue to support, recognise, reward and invest in individuals, providing opportunities for staff to progress in their careers and encouraging education, training and personal development. Professionals and organisations will have opportunities and responsibilities to exercise their judgement within the context of nationally agreed policies and standards.”

The business imperative for inclusion is regularly stressed at the highest levels too. The publication *Equality and Human Rights in the NHS – A guide for NHS Boards*⁵⁸ says that:

“The business case for demonstrating and exceeding compliance equality requirements range from the most basic – that is, avoidance of the cost and negative publicity of Employment Tribunals (Stonewall, for example, estimate general Tribunal costs at £35,000 and employee replacement costs of up to £50,000) – to more strategic matters ...”

Also...

56 Gender reassignment is defined in the Regulations as “a process which is undertaken under medical supervision for the purpose of reassigning a person’s sex by changing physiological or other characteristics of sex, and includes any part of such a process”.

57 *The NHS in England: the operating framework for 2007/08*, Prolog reference 278247 and online at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063267

58 *Equality and Human Rights in the NHS – A Guide for NHS Boards*, Prolog reference 278711 and online at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062906

“Demonstrating best practice standards will enhance the prospect of NHS organisations being able to engage meaningfully with all sections of the community/potential workforce.”

Statistics produced and explained in part 2 suggest that, even at the modest rate of a few hundred new transsexual cases per year, UK employers in general will have encountered several thousand people commencing gender reassignment treatment and “transitioning” in the workplace since the law protecting transsexual people from employment discrimination came into effect in 1999.

The practical experience of these cases is that employers and their transsexual staff are clearly able to cope with the challenge, although the 16% statistic for people still feeling pressured to leave shows that there is space for NHS managers to better the general trend and eliminate the causes for people wanting to go elsewhere. Therein lies the potential for the NHS to show the way, by exemplary commitment and practice.

Recruitment, retention and business as usual

The case for why it is imperative for NHS organisations to be inclusive employers, and to include trans people within that vision, has been set out earlier in this section. In addition to the reasons for doing this as an employer, there is the additional benefit that staff trained to be tolerant towards trans colleagues have a head start on understanding how to respect and care for trans service users too.

The key to planning how to achieve and maintain trans inclusion requires an understanding of the settings in which barriers and problems can present themselves – whether intentionally, or unwittingly. It can be helpful to think of these in terms of the particular “trigger points” where issues might arise. The two obvious trigger points are:

- recruitment of someone who is already undergoing or has undergone gender reassignment
- the time when an existing member of staff discloses that they are planning to undergo gender reassignment.

This does not mean there might not be other triggers as well. For instance:

- the previously undisclosed gender history of a trans employee becomes known to their patients or colleagues (or becomes the subject of speculation) – perhaps as the result of being ‘outed’ by the press or an individual
- a new employee joins a team in which a member of staff is undergoing the ‘Real Life Experience’ (RLE) stage of treatment and takes exception to that person’s use of gendered facilities such as toilets or locker rooms.⁵⁹

These scenarios underline that transformational activities cannot be approached piecemeal, or as a one-off event. It is not sufficient to deal with recruitment barriers and leave workplace attitudes unaddressed. Likewise training to promote cultural change must be embedded so that it is instilled into all staff – now and in the future. Trans awareness and policy reinforcement need to become a routine

⁵⁹ The ‘Real Life Experience’ stage in gender reassignment is described on page 57.

part of induction, development and refresher training, in conjunction with wider diversity awareness. Some training suggestions are provided in part 7.

Employment policy good practice

The Women and Equality Unit publication *Gender Reassignment – A Guide for Employers* (see Annex 1) sets out the policy good practice:

- Equal opportunities policies should refer to discrimination on grounds of gender reassignment, as well as grounds of sex.
- Employers who have policies and procedures on sexual orientation, culture and religion, age and HIV status as well as race, sex and disability should add gender identity to the list.

Note that sexual orientation (who you are sexually attracted towards) is distinct from gender identity (whether you feel yourself to be a man or a woman). Assumptions should not be made about the sexual orientation of a trans person. Trans people can be heterosexual (for example a trans woman attracted to men) or homosexual (for example a trans woman attracted to other women, who both identify as lesbian), bisexual or indeed asexual. Policies covering sexual orientation alone are not sufficient to signal the commitment to eliminate or deal with discrimination on the grounds of being (or being perceived to be) trans.

Policies can also go further and articulate a positive approach towards trans people. The starting point for a list might include:

- Stating the organisation's commitment to ensure vacancies are open and accessible to trans people. This may necessitate an equality impact assessment of all the elements involved in recruitment, for example ensuring that application forms do not request information in a way that might unintentionally deter trans people from applying, with particular attention to previous names, employers' references and certificates. Advertising should stress the organisation's inclusion policies. Monitoring policy should follow the advice published by Press for Change at www.pfc.org.uk/files/trans_monitoring.pdf
- Stating clearly that the organisation has a zero tolerance approach to discrimination, victimisation or harassment of staff who are trans or are perceived to be trans.
- Embodying a commitment to the privacy of trans people and underlining that disclosure of "protected information" (as defined by Section 22 of the Gender Recognition Act) is a criminal offence. This is particularly important within policies relating to the handling of personal data; however, it is important enough to be added to staff conduct policies explicitly, so that the effect is carried through to all forms of day-to-day execution of duties.
- Developing a specific operating procedure/ policy for transition in the workplace. This could be based upon the detailed good practice advice contained in *Gender Reassignment – A Guide for Employers* (see Annex 1). A checklist is provided on page 59. This may also require liaison with Occupational Health to determine how to integrate the need for absences during treatment into the normal sickness and absence policy.

Equality impact assessments

NHS organisations are obliged to perform equality impact assessments (EqIAs) as part of fulfilling the Gender Equality Duty (as well as the race and disability duties). As explained in part 4, this includes considering impacts upon transsexual men and women. However, EqIAs can only be effective as a tool if the people performing the assessment process are able to envision the barriers, fears and pitfalls that could be encountered by someone undertaking gender reassignment, or now living in their acquired gender role.

A rigorous assessment should include consultation with trans people themselves. Only someone who has walked that particular path will have the experience of real and perceived obstacles that can arise. Remember that a barrier doesn't have to be 'real' in order to get in the way. Preconceptions about the NHS, based on community anecdotes or more general experience of discrimination in the past, can be just as much of an obstacle as the real thing. People who are not trans, and have not grown up with the fears and experiences that accompany that, are unlikely to anticipate the things that job applicants might imagine.

Here are some particular impacts to be aware of, however:

Previous names. Application forms should avoid asking for previous names of applicants. The implication for trans people is obvious. However, this is also good practice in a wider sense too. The requirement for previous names could deter someone who has taken a new identity following domestic violence, for instance. Data protection principles require that information should not be gathered without a purpose. Previous names are in any case covered

by the Criminal Records Bureau disclosure application process (which has a special provision for trans people – see page 54).

Proof of identity. Although people who have applied for and received legal recognition can obtain a fresh birth certificate that avoids 'outing' their previously registered sex, there are several categories of applicant who may be unable to benefit from this. People who wish to remain in a marriage made before their transition are one category (they cannot obtain legal recognition without annulling that marriage). Trans people from some countries abroad are another category. Generally such people will be able to present alternatives such as a passport and driving licence in their acquired gender. Therefore rules about what can be presented need to be flexible. Trans people may also not have a long paper trail of utility bills and bank statements in their new identity. This should be borne in mind too.

Certificates. Some examining authorities are uncooperative about correcting the names of people who have changed gender role after obtaining their qualifications.

References. References from anything other than a current employer may present problems or anxieties for trans people. If all applicants are made aware of positive employment policies before references are requested and taken up, this should help a great deal.

Medical history and current medications. Questions relating to medical history and medications can also be a source of anxiety or act as a deterrent to trans people. People who have undergone gender reassignment surgeries may be anxious about whether they need to declare these. Trans people all take hormone therapy for life, even after gender reassignment surgery. They are inevitably

likely to fear the effect which this information may have on whether they are even invited to interview.

Questions in employee pension, life assurance and other staff benefits packages.

People who don't expect to be interviewed don't apply for jobs. Again, a good practice approach to this obstacle is to avoid asking questions about private medical details outside of a confidential occupational health setting. An organisation may already take this best practice approach; however, it is important to realise that a trans applicant may fear being asked. Therefore it is good practice to spell out to applicants the confidential way in which all this kind of personal information is assessed only when a provisional job offer is to be made (and that it won't be seen by their prospective manager or colleagues).

Role models. What kinds of role models are depicted in your organisation's literature? If pictures are used, do they depict a diverse workforce in every sense? The NHS image library includes photos of trans people to utilise.

Advertising. Consider where you advertise jobs. In addition to conventional placements such as the *Health Service Journal* and the national press, advertising in the magazines and newsletters of trans support groups and lesbian, gay, bisexual and trans (LGBT) community organisations can be used to explicitly signal that trans applicants are welcome. Ensure this covers posts at all levels. Many trans people have the experience and qualification to be board chairs, chief executives, consultants and managers.

Equality monitoring. LGB groups largely welcome questions about sexual orientation in equal opportunities monitoring; it is increasingly seen as an indication of a positive attitude towards LGB people. The reverse is true for trans people, however, and employers are recommended to either avoid monitoring in this area, or at least to do it very carefully, according to the recommendations set out by Press for Change⁶⁰ or a:gender (see Annex 5). The pitfalls are that trans people are so rare that disaggregating numbers at anything other than the organisation-wide level is likely to create the threat of outing people or starting a witch hunt. The language of inclusion is important too. Trans should not be presented as a third choice to male/female. Also, because people quite legitimately consider themselves to be just women or men after reassignment, many people may decline to tick a box asking them to identify as something else; the results are therefore unlikely to be statistically useful.

Recruitment interviews

Even the most secure and integrated of trans people can have an above-average level of anxiety about face-to-face job interviews. As for any applicant, they are going into an unknown situation to meet strangers from an unfamiliar organisational culture, where aspects of their background and working/life history are liable to be probed, along with their qualifications and references. This is stressful enough for most of us.

Many trans people's backgrounds may not be apparent from seeing or talking to them – either naturally so, or because of specialist surgery. Being undetectable in this way is referred to as 'passing'. When people pass well and don't wish their background to be

60 The 'Real Life Experience' stage in gender reassignment is described on page 57.

known or discussed, this is known as 'living in stealth'. The preference for stealth is not an attempt to deceive you – it is a defence that has evolved in response to the overt stigma and disrespect that generations of trans people have known.

Trans people also fear that even when people are not discriminatory, they can still treat them differently when knowing what is, in effect, an intimate detail of their medical history. Most people would balk at such an intrusion into their own privacy. Trans people are the same as everyone else in that respect, and their privacy rights are underpinned by the protection from unauthorised disclosure provided in the Gender Recognition Act.

There are other trans people for whom the transformation is less complete – especially during transition or in the first few years afterwards. Some trans people may know or fear that their gender background may be perceived by the interviewers. This is referred to as being 'read' and is often very distressing. There is likely to be an inbuilt expectation that being read will prejudice the interview process. This is why it is important for literature seen by applicants before interview to include equal opportunities reassurance.

Don't ask – anticipate! Even if you think that an applicant may be trans, you should never ask. Think of this in the same category as asking someone if they plan to have a family. Although you may perceive someone to be trans, you could also be wrong. Maybe they have an intersex condition, or they're simply a feminine man or a masculine woman. However, if one of the limited exceptions to the Sex Discrimination Act applies (and remember that this can only happen in the case of someone who has

not obtained legal recognition), then an individual would be expected to disclose their transsexual status and an interviewer would be able to ask an appropriate question.

Rather than place an interviewer in this position, however, it is best practice to impact assess the job requirement *before* the post is advertised, so that any requirement for trans people without legal recognition to self-disclose can be made clear in advance. The requirement is likely to be very rare in practice, making it easy to filter the job descriptions where an impact assessment is necessary. However, any statement about the need for disclosure should be accompanied by the explicit reassurance that such information will be treated in absolute confidence, and that disclosure may not preclude eligibility for the post.

The flip side to not asking about someone's gender history is behaving professionally when an applicant discloses it. This is something that should therefore be covered as part of the routine training for staff who are going to interview applicants.

Criminal Records Bureau disclosure applications

Any NHS member of staff having contact with patients is likely to have to apply for a Criminal Records Bureau (CRB) disclosure. Part of this process involves a strict requirement for applicants to state all previous names and aliases. The last page of the form then has to be completed by the 'Registered Person' who checks and verifies the contents and the evidence supplied. This means there can be some anxiety about the implications of this for trans applicants and existing staff.

CRB applications need not be a problem for trans people, however. There is a special process which they can follow in order to sidestep the problems they would otherwise face in complying with the requirement to make truthful statements. It should be stressed that this process does not weaken the effectiveness of the process in any way.

The detailed steps are explained on the CRB website.⁶¹

Applicants may telephone the CRB on 0151 676 1509 or 0151 676 1570 to discuss this matter in confidence. Briefly, however, the process operates as follows:

- Trans applicants for a CRB disclosure should first ring one of the above numbers to clarify anything they are not sure about and ensure that the CRB know they will be using the special provisions.
- They should then complete the form presented by their employer in the normal way, except that they need not complete details (or supply forms of evidence) that would expose their gender history to their employer.
- If they wish to leave out details that could 'out' them, then they should photocopy the form, ensuring they have a clear record of the application serial number.
- The applicant should then immediately contact the CRB on one of the numbers above and notify them of the application number.

- The special security section of the CRB in Liverpool then have the means to intercept the application forwarded by the employer. They will ask the applicant to supply the information needed to replace that which was omitted. This is then married up so that a rigorous criminal records check can be carried out in the same way as for any other applicant.
- Disclosures sent to the employee and their employer will not reveal the applicant's former identity *unless* they have an offence or caution that has been recorded in that name in police records. In this case there is no way of avoiding the disclosure of that former identity to the employer. However, the organisation's policy for dealing with CRB applications and data should instruct staff on how to deal with this eventuality in a responsible manner if it occurs. This should include reassurances that will need to be given to the applicant/member of staff in the event that the offence itself is not serious enough to preclude employment.

Record keeping

The Gender Recognition Act makes it a criminal offence to disclose protected information about a transsexual person without permission if it was obtained in an official capacity. This applies to indirect as well as direct (word of mouth) disclosure and therefore means that paper and computer records should be considered with great care. The Data Protection Act (DPA) 1998 also means that information about an employee's gender history or treatment should be regarded as sensitive information. The DPA applies whether they have obtained

61 See www.crb.gov.uk/default.aspx?page=2319

legal recognition or not. This means that it is good practice to treat such details with equal care whether an individual has a Gender Recognition Certificate or not, and whether they are transsexual or identify as transgender.

- Employers should ensure that all documents, public references (such as telephone directories, prospectuses, web biographies) and employment details reflect the acquired gender of the individual. This will prevent any breach of confidentiality. Note that organisations will probably have a process for this already for the circumstances when people change their name for marriage or civil partnership.
- When documents have been seen and copies taken at the point of starting employment (such as a birth certificate), then every effort should be made to replace those with equivalent documents in the new name and gender. The DPA limits the purposes for which information may be kept. When that information is no longer useful, it must be destroyed.
- In some instances it is necessary to retain records relating to an individual's identity at birth, for example for pension or insurance purposes prior to obtaining gender recognition. However, once a person has obtained a Gender Recognition Certificate these *must* be replaced with new details.

- Access to records showing the change of name and any other details associated with the individual's transsexual status (such as records of absence for medical treatment) must be restricted to staff who need the information to do their work. Such people could include those directly involved in the administration of a process, for example the examining medical officer, or the person who authorises payments into a pension scheme. They do not include colleagues, line managers or third parties.
- Once a person has obtained a Gender Recognition Certificate, there must be no disclosure of this information. Breaches of confidentiality should be treated in the same serious manner as disclosure of personal details of any other member of staff.

Understanding the transition process

There are many factors relating to gender transition under medical supervision which are outside the control of the employee concerned. Understanding how the process usually unfolds, and the requirements this imposes on an employee transitioning in the workplace, is essential to achieving a successful outcome.

As explained in more detail in Annex 3, medically supervised gender transition involves a number of stages, starting at the point where a person first starts to acknowledge the desire to seek help and support for the feelings they experience. The process was developed through consensus between consultants in both America and the UK in the mid 1970s, giving

birth to an international professional association⁶² whose guidelines, although deliberately flexible, are followed to a greater or lesser extent throughout the world.

From an employer's point of view the important points to note are as follows:

- Gender reassignment is a process that takes several years in many cases.
- Assessment and exploration of the individual's feelings and needs can take several months and a number of consultations before a path is decided. On the other hand, some individuals can be far more certain and can begin living in their new role immediately. An employee may decide that they will only disclose their intentions to their employer when they have decided to begin living in the opposite gender role.
- Most UK clinicians wish to see people live successfully in their desired gender role for an extended period of time – being able to maintain their employment and have successful social relationships in and out of work. This includes doing all the things that a member of that gender would normally do.
- Some clinicians go as far as to demand evidence of this from employers even before they will begin prescribing cross-sex hormones and the 'blockers' that will halt the effects of the sex hormones the patient's body normally produces.
- The period of cross-gender living is referred to as a 'Real Life Experience' (RLE) and is supposed to be for the benefit of the individual to be able to determine that a permanent change of role is going to be right for them. However, some clinicians also regard the experience as a 'test' to determine whether they feel comfortable about referring the individual for irreversible surgeries. This means that any failure by managers and colleagues to accept the individual during this phase of treatment can have a damaging effect on the progress of their treatment. This is why it is important that people undergoing medically supervised transition should be enabled to work normally, socialise and use workplace facilities in the same way as others of the intended gender.
- It is not a foregone conclusion that someone will undergo any particular surgeries. People seeking gender change are generally more concerned with being able to function in the role where they are comfortable. A lot of the pressure for genital conformity comes from others. Some surgeries may be clinically contraindicated for certain individuals too – perhaps through age, family medical history or factors such as obesity which add to the risks of lengthy anaesthesia. It is for these reasons that genital surgery is not an absolute pre-requisite for legal recognition – the emphasis is instead placed upon medical diagnosis of the need for transition. Most transsexual people do seek surgery of some kind though, particularly to aid in 'passing'.
- Both assessment and surgeries will require the employee to have time off from work.

62 The Harry Benjamin International Gender Dysphoria Association (HBIGDA) renamed itself the World Professional Association for Transgender Health (WPATH) in 2007. The guidelines which WPATH publish are now in their sixth edition. See www.wpath.org for details.

- For assessments it should be borne in mind that many PCTs currently only offer a single option for referral – often to the UK’s largest gender identity clinic, at Hammersmith in London. This means that employees may often have far to travel – increasing the amount of time off required.
- The recovery time from surgeries will depend on the procedure, the individual and any complications that may arise. Trans people *generally* make comparatively rapid recoveries because they are physically healthy and also because the surgery is a positive event for them. Nevertheless, major surgeries like genital reassignment can require several weeks. Male-to-female genital surgery is usually accomplished in a single step. Female-to-male surgery (to create a phallus) is more complex; it usually involves four to five separate surgeries and each will require a period of recovery before returning to work. Time off may also depend on the kind of work the individual does. Someone doing physically strenuous work may need a longer absence, for instance.

Any *reasonable* absence because of the effects of treatment for gender reassignment should not normally be taken into account for the purposes of formal action for unsatisfactory attendance. Careful account should be taken of the requirements imposed by the clinicians treating the individual, the distances travelled to appointments, plus the differences that can occur between different people recovering from surgery.

Occupational health

Gender reassignment treatment has no specific occupational health implications other than the need for time off for appointments and recovery time from surgeries.

Occupational health staff may encounter transsexual people for checks following the provisional offer of employment or as a matter of routine. In these circumstances it is possible that the individual will volunteer details of their history, or it may become apparent from examination of the individual or their medical records.

The guidance elsewhere in this section with regard to record keeping and disclosure still applies. In other words, reports should be confined to addressing the question of whether a member of staff is medically fit to perform their duties. In the rare eventuality that the patient has a condition connected in some way with their gender treatment, care should be taken to avoid disclosing the trans aspect. For instance, if a trans woman has a prolapsed vagina, then that can be described and assessed in the same way that any other woman’s prolapse would be approached.

Planning for transition at work

The line manager should discuss with their employee what help and support is needed. A positive and constructive approach would be to approach the process as a joint project. It is helpful to remember that the person with the greatest commitment to a successful outcome will be the individual themselves. Their personal expertise should also be valued. Most transsexual people are experts on the details of what is going to happen, and what the implications are going to be.

Depending on seniority, managers may know who else to involve or may need support from the Human Resources department. Either way, it is best to have covered the 'what if...' scenario in managerial training before the day when a member of staff presents the challenge.

Here is a suggested checklist of what to cover in planning and documenting a programme:

- Consider the overall timescales. Include the anticipated order of milestones and the likely time between them. Remember that these are outside the employee's control in many cases though.
- Consider which other departmental managers may need to be involved in the plan.
- Discuss how any kind of announcement to colleagues is going to be made, what kinds of training or support will be necessary, and at what point and by whom this will be carried out. Some employees may prefer to tell people themselves, in their own words. Others may prefer a manager to handle the announcement. If gender reassignment has already been covered within broader routine diversity training, then the need for any special action can be minimised.
- Discuss and agree whether the employee would like to stay in their current post or be redeployed. A move cannot be forced on the employee but some may prefer it.
- Discuss whether some kind of advice or support to service users is necessary, and how this will be approached. In some cases, involving GPs or consultants operating outpatient clinics, employers have opted to send letters of explanation to service users and even set up a helpline or contact point. In other cases this may be completely unnecessary. Also agree how hostile reactions will be handled.
- Agree whether a media plan is necessary. The media is nowadays far less interested in gender changes than even just a few years ago. Generally there will be no interest from the press and, even if there is, the organisation's press office should be able to field it. However, in cases where it is considered necessary to write to members of the public, it is advisable to have a media response plan, with a press release and supportive senior management statements prepared for the possibility of a reaction.
- Consider the expected point or phase of change of name, personal details and social gender and how this will affect, for example, the use of male or female toilets, changing rooms, dress codes, etc. New uniforms should be provided when required.
- Although the employee may not know the precise details in advance, discuss what time off they are likely to require for medical treatment, bearing in mind that appointments will often involve long-distance travel.

Toilets and locker rooms

The use of toilets and other gendered facilities can occasionally be an issue in the workplace, particularly during the early stages of transition if colleagues were familiar with the employee in their former role.

The usual point for starting to use opposite gender facilities will be the day the employee starts coming to work in that role.

- Provided any anxieties are approached intelligently, the usual experience is that concerns can soon be overcome – at worst by agreeing, as a temporary compromise measure, to reserve one set of facilities for colleagues who may have strong objections to sharing facilities used by the transsexual employee.
- Where locker or shower facilities are open plan, then it is good practice to review this and, at the least, provide some provision (for example curtained spaces) where staff need not be in a state of undress in the presence of others. Remember that this may be important to other staff too. For instance, a member of staff with a stoma bag would not wish to get undressed in the presence of other people.
- If it is genuinely impossible to adapt locker or shower facilities in order to accommodate a pre-operative member of staff in a state of undress, then this is one very limited example of an instance where the law permits an employer to make separate arrangements. It is highly unlikely that the employee concerned would object to this pre-operatively.

- However, it is not good practice to require a trans person to use disabled toilet facilities (unless they have a disability requiring this), nor is it permissible to expect disabled staff to accept such arrangements.
- Any special arrangements must be time limited.
- Above all, following gender reassignment surgery or legal recognition, transsexual people must be supported to use all facilities designated for other members of their acquired gender.

It must be borne in mind that successful routine use of the appropriately gendered facilities is a part of what clinicians involved in supervising an employee's gender reassignment are expecting to see. This is considered a mark of the individual's social acceptance.

It is also important to appreciate that if anyone is likely to feel vulnerable in the toilet, then it will most likely be the transsexual person – being acutely aware of the incongruity in their anatomy and certainly not wishing to draw any attention to this. The individual is aiming to move away from their former gender role; they are therefore not going to behave in any way that reminds them or anyone else of that background.

Finally, it is never acceptable to require someone undergoing gender reassignment to use toilets or other facilities designated for members of their birth gender. Under those circumstances employers would not be able to guarantee the employee's safety.

Public-facing roles

A health professional's gender transition may be unavoidably visible to the public, especially in the early stages of gender transition. Although many people cease being visibly different as transition progresses, there are others for whom it will continue to be a reality.

Some staff may elect to move to another role during transition; however, they cannot be required to do so. Similarly, the way someone looks and the negative reactions this might be expected to elicit from certain members of the public must not be a barrier to recruitment for a public-facing role. Quite apart from the law's requirements, NHS organisations have a responsibility to set an example for how employers (and the public) should behave.

In these circumstances it is important that managers support the member of staff in a positive manner and constantly listen to how they feel about things and how they feel they are coping. Co-workers may benefit from advice on how to contribute too.

Not just trans

Finally, as explained in the previous section, it is important to remember that people are not just trans. Their experience as employees is also influenced by other factors. Sometimes these combinations can add to the barriers that people face. See the list of points to consider on pages 46–47. Methods of building upon this concept of so-called multiple disadvantage through stakeholder consultation are also provided in Annex 4.

Good practice pointers

a:gender, the support network for trans civil servants, have developed best practice recommendations for employment and monitoring, following consultation across a number of government departments. They have produced two reports, which are available on request (see Annex 5 for contact details). One report, *Perspectives*, contains the results of the group's survey of stakeholder views on monitoring. The second report, *Recommendations*, contains monitoring guidance which is now already in use in some departments.

a:gender have also developed a model 'Transgender Action Plan' for employment, which is already in use and being championed by the chief executive of one government department. The Plan covers various human resource functions,

including transfer, secondment and security clearance, and may be a helpful adjunct to the guidance given in part 8 of this guide.

Several government departments, including the Home Office, have also developed policies relating to what they refer to as 'Gender Transition Related Workplace Absence', which they have specifically excluded from normal attendance disciplinary warning triggers (recognising that the overall process of transition may require an above-average level of absences for appointments and treatments for a period of time). It is also good practice to review policies for reduction of sick pay in the rare event that complications require a longer than average recovery time from gender surgeries.

7. Education, training and information

Throughout this guide there are examples which emphasise that one of the main tools for making NHS organisations more ‘trans-friendly’ is the provision of appropriate education and training for staff, backed up by information they need to do the job well.

Training needs will vary according to the job function. In most cases curriculum developers will find that it is only necessary to make minor adjustments and additions to existing courses.

The Department of Health has produced a range of specific resources, including DVDs and resources to train trainers. These are listed in Annex 1. The contents of this guide are also written in order that sections can be copied for use in handouts or as a script for creating presentations.

The following are some suggestions for the kind of training that needs to be covered for various distinct job functions. Training can either be developed in-house or resourced from consultants who have demonstrable skill and experience in the field.

| Training Category | Topics to be Covered |
|---|---|
| <p>General awareness</p> <p>Target time: 10 mins</p> <p>E.g. three slides within general equality and diversity training</p> | <p>This needs to cover who trans people are and their needs, plus an outline of the law and an appreciation that issues relate to both service provision and employment. Content relating to who trans people are can be derived from part 2 of this guide. The outline of the law and the overview of issues can be drawn from part 4.</p> <p>Developers and trainers can utilise the Department of Health publication <i>An introduction to working with Transgender people</i> plus the DVD <i>Real Stories, Real Lives</i>. Annex 2 of this guide provides a photocopiable handout and Annex 1 provides a further reading list.</p> |
| <p>Trans for recruiters</p> <p>Target time: 10 mins</p> | <p>This should be designed to build on the general awareness module, utilising the content provided in part 6 relating to recruitment. Ideally this should simply be incorporated into more general training given to line managers who will be involved in recruitment to fill vacancies.</p> |

| Training Category | Topics to be Covered |
|---|---|
| <p>Trans for managers</p> <p>Target time (lite version): 10 mins</p> | <p>This should be designed to build on the general awareness module with details of the law drawn from part 4 and details of employment practice drawn from part 6. It may be desirable to produce a summary course for general line manager awareness, coupled with a detailed self-study unit for managers to use for personal development and for immediate support when presented with an employee transitioning.</p> <p><i>Gender Reassignment – A Guide for Employers</i> provides the basis for handouts. Annex 1 of this guide provides further policy reading.</p> |
| <p>Trans for policymakers</p> <p>Target time: half a day</p> | <p>This should be designed to build upon the general awareness module and utilise detail from parts 2, 4 and 6 to fully familiarise policy-makers and commissioners in order that they are properly equipped to perform trans-inclusive equality impact assessments on the policies they produce and the services they commission.</p> |
| <p>Trans for GPs, consultants and nursing staff</p> <p>Target time: 1 hour</p> | <p>Medical staff are in the front line of dealing with trans people and therefore adequate knowledge of guidelines for care, their PCT's referral policy and commissioning arrangements, and where to obtain specific data and resources for supporting patients, is essential. Clinical training should include details about management of hormone therapy before and after reassignment, plus long-term health issues.</p> <p>The Department of Health has produced a range of booklets and leaflets which supplement the guidelines published by a group led by the Royal College of Psychiatrists. These are listed in Annex 1. The booklets include information for GPs and for their patients.</p> |

The table below provides a suggested syllabus for key categories of staff.

| | Equal opps and HR staff | General practitioners | Nursing staff | Hospital consultants | Policymakers and commissioners | Administrative and ancillary workers | Line managers |
|---|-------------------------|-----------------------|---------------|----------------------|--------------------------------|--------------------------------------|---------------|
| General awareness | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Trans for recruiters | ✓ | | | | | | ✓ |
| Trans for managers | ✓ | | | | | | ✓ |
| Trans for policymakers | ✓ | | | | ✓ | | |
| Trans for GPs, consultants and nursing staff | | ✓ | ✓ | ✓ | | | |

8. Consolidation into a gender equality scheme

Putting it all together

This guide forms part of a family of Department of Health guidelines designed to enable NHS managers to fulfil their responsibilities under equality and human rights law and to produce equality schemes. In particular, this guide is intended to help NHS organisations to ensure that trans people are fully included within the design of a gender equality scheme (or a single equality scheme if your organisation is working in this way).

The guide *Creating a Gender Equality Scheme: A Practical Guide for the NHS* deals with the overall requirements and processes involved in addressing this aspect of the Public Sector Gender Equality Duty. This part is provided to assist in relating the topics covered here to that wider process.

Gathering information

Once the governance and accountability details have been established for a gender equality scheme, the first step is to gather information.

From reading this guide it will be clear that information in relation to trans people involves three key areas:

- employment within the organisation, including being able to recruit, retain and ensure the equality and protection of people who are trans

- trans people as stakeholders in the delivery of healthcare and the maintenance of wellbeing in the full sense of what the organisation does (i.e. as men and women who just happen to have a trans background)
- trans people as the recipients of gender reassignment treatment.

It is appreciated that managers need particular help in knowing how to even begin collecting information for this group. For that reason this guide provides background to get you started, including specific details of the applicable law in part 4, and points to some key resources from which raw statistical data can be obtained. Parts 5 and 6 also explain how parts of your core business can impact upon trans women and men.

It is possible to set up *some* systems in order to support the collection of quantitative data about trans people, although monitoring in employment, service delivery and on a local public health scale can be difficult to do reliably for the reasons set out earlier in this guide. Data collection is most likely to be useful in terms of establishing local levels of annual service demand for gender-related treatments.

Qualitative research is more likely to be useful, coupled with stakeholder consultation involving local service users and representatives from the national organisations listed in Annex 5. The typical problem areas outlined in this guide can be used to prepare the way in which input is sought.

A mix of quantitative and qualitative data is also available from a Department of Health funded nationwide survey into service user experiences connected to gender treatment, led by the Audit, Information and Analysis Unit (AIAU)⁶³ of the London Specialised Commissioning Group and carried out in the second half of 2007.

Core information or data that can be collected or estimated includes:

- estimated local population of transsexual people (all organisations)
- numbers of new cases each financial year, as far back as records permit (PCTs; mental health and hospital trusts; gender clinics)
- waiting list statistics (PCTs; mental health and hospital trusts; gender clinics)
- details of current commissioning arrangements, where relevant to the organisation, including review dates and policy ownership (PCTs)
- details of complaints (PCTs; mental health and hospital trusts; gender clinics)
- local trans support groups or LGBT/other organisations advocating for trans people
- details of cases where staff have transitioned in the organisation (subject to confidentiality precautions).

Further qualitative data can be collected through consultation, using the methods outlined in Annex 4 and with the cooperation of national organisations which may be able to assist with finding local volunteers to approach. Remember to ensure that consultation includes representation from

trans people of both genders, with different ethnic/religious backgrounds, with disabilities, and at different stages of life and gender transition, plus trans people who identify as lesbian, gay or bisexual.

Equality impact assessment

Parts 5 and 6 highlight a number of service and policy areas where an equality impact assessment may need to be performed in the light of the needs of trans people explained in this guide.

Key areas include:

- **commissioning policies** – not just directly trans-related, but those where gender-specific or gender-segregated services are involved. Service level agreements may need to be reviewed and updated in some cases for the organisation to be assured that its policy intentions are carried through by service providers – especially private or voluntary sector organisations which are not themselves subject to the Gender Equality Duty but are contracted to provide services as agents
- **recruitment policies** – including aspects related to determining whether person specifications may need to be reviewed; advertising policy; design of application forms and processes; training of interviewers and privacy guidance
- **record-keeping policies** relating to staff/contractor files and service user/medical records
- **equal opportunities and diversity policies** with particular reference to the inclusion of gender identity

⁶³ See www.london specialised commissioning.nhs.uk/londonarrangements/content.asp?id=66. For details contact Carrie Gardner, AIAU Project Coordinator, Bexley Care Trust, 221 Erith Rd, Bexleyheath, Kent DA7 6BR.

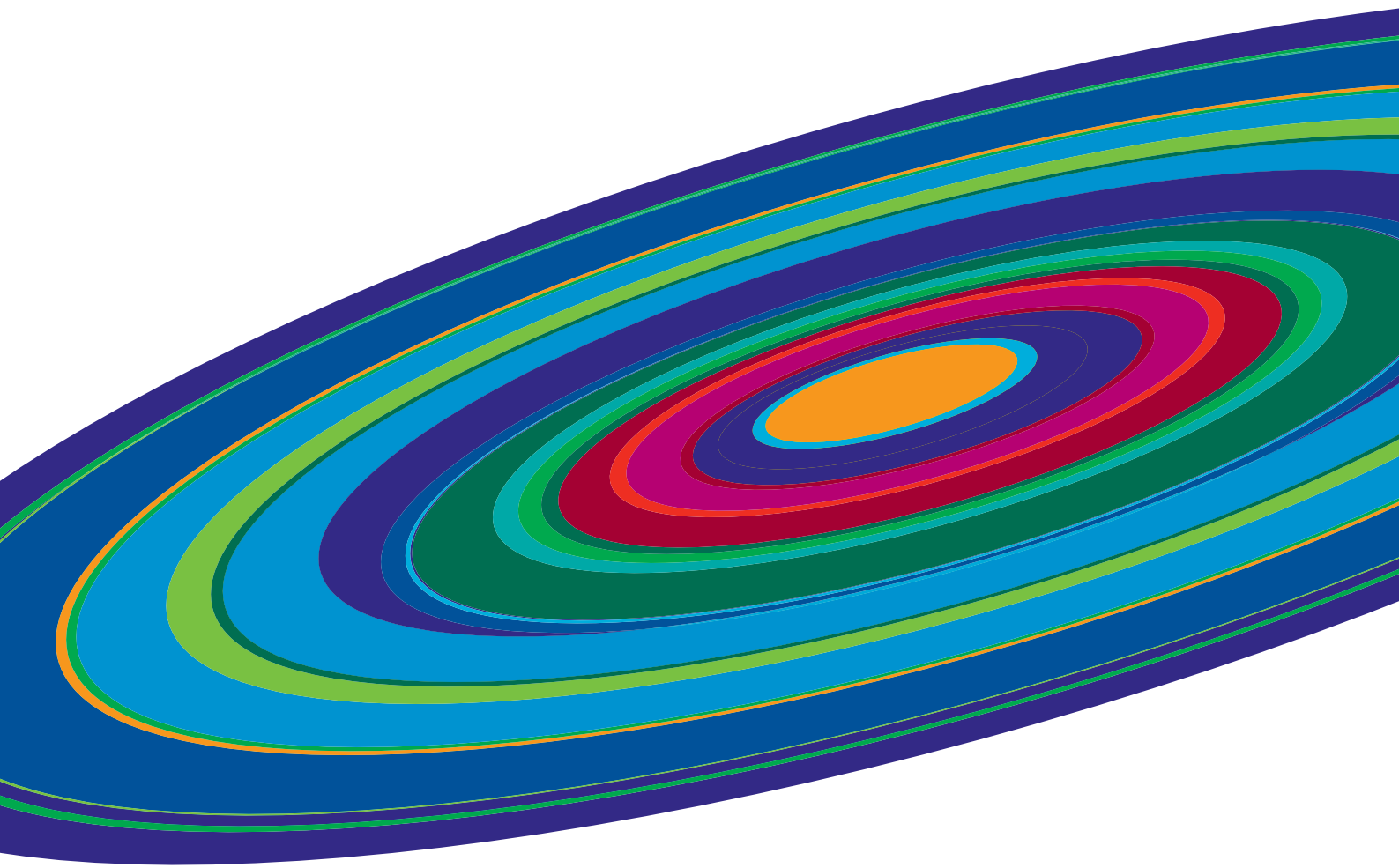
- **disciplinary and grievance policies** with reference to dealing with harassment and discrimination, unlawful disclosure of “protected information” and the handling of absences relating to gender treatment
- **training** to include trans awareness alongside teaching about other diversity characteristics, and to ensure that continuing professional development plans for all staff roles incorporate the appropriate level of training into the development of all staff within the organisation.

The action plan/monitoring

Organisations may need to factor actions arising from information gathering, consultation and equality impact assessment alongside the actions arising from the rest of the development of the gender equality scheme. In this process there is a risk that trans-related actions may be pushed down the list by the relative population impact of initiatives addressing the needs of women or men as a whole. To permit this to occur would itself be discriminatory, since the assessment of whether an action is proportionate enough is not determined by numbers alone.

One way to ensure that catch-up and remedial actions for trans people receive appropriate attention is to create a separate sub-programme within the scheme, with a board member taking accountability and a senior manager having overall delivery responsibility for the specified outcomes. In this way, overall learning and progress relating to this aspect of the scheme will be assured sufficient prominence for the scheme’s lifetime.

Section Three: Annexes and resources to assist managers



Annex 1 – Publications and resources

General Department of Health and NHS publications

Equality and Human Rights in the NHS – A Guide for NHS Boards

This guide is designed to help NHS Board members understand and comply with their obligations under equality and human rights legislation. Every NHS organisation, as a public body, needs to assure itself of legal compliance.

Prolog reference 278711 and online at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062906

Human Rights in Healthcare – A Framework for Local Action

Human Rights in Healthcare – A Framework for Local Action (second edition) was developed in conjunction with the British Institute of Human Rights (BIHR) and five NHS trusts to assist organisations across the NHS to use a human rights based approach to help improve the way services are delivered.

Prolog reference 289869 and online at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088970

The NHS in England: the operating framework for 2007/08

This document was designed to help local NHS staff shape services around the needs of their local communities. It explains why there is a need to continue embedding reform, and stresses the need for PCTs to work with local authorities to improve health and wellbeing, reduce inequalities and achieve a shift towards prevention.

Prolog reference 278247 and online at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063267

A dialogue of equals: The Pacesetters programme Community Engagement Guide

The Pacesetters programme is a partnership between local communities who experience health inequalities arising from discrimination, the NHS and the Department of Health. Working with strategic health authorities and trusts, the programme's overall aim is to deliver equality and diversity improvements and innovations.

This guidance offers a framework for effective community engagement, particularly with communities and groups who are seldom heard.

Prolog reference 285436 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082382

Ten Steps to Your SES

This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the Race, Disability and Gender Public Sector Duties; and in anticipation of new duties in relation to age, religion or belief and sexual orientation. Whilst NHS organisations may develop different approaches to a single equality scheme, these easy-to-follow steps set out the necessary stages required to develop a generic approach to the common activities associated with the various duties.

Online only from:

www.dh.gov.uk/en/Policyandguidance/Equalityandhumanrights/Browsable/DH_066006

Creating a Gender Equality Scheme: A Practical Guide for the NHS

This document gives practical guidance on how NHS organisations might produce a gender equality scheme that sets out how they will meet their statutory duty to promote gender equality.

Prolog reference 280260 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_066068

Creating a Disability Equality Scheme: A Practical Guide for the NHS

This document gives best practice advice on how NHS organisations might produce a disability equality scheme that sets out how they will meet their statutory duty to promote disability equality, which came into effect on 4 December 2006.

The practical techniques for consultation and systematically developing an equality scheme make a good model that also applies to trans people.

Prolog reference 277550 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139666

Care and resource utilisation: ensuring appropriateness of care

This document sets out for commissioners using practice-based commissioning and PCTs some techniques to help identify areas where services can be redesigned, thereby freeing up resources to focus on clinically needy patients. Care and resource utilisation is all about giving the patient the right treatment in the right place at the right time.

Online only from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063265

Trans-related Department of Health and NHS publications

Trans people's health

Fact sheet number 11 within a pack of briefings entitled *Reducing health inequalities for lesbian, gay, bisexual and trans people*.

These briefings are intended to show that LGBT people can be younger, older, bisexual, lesbians, gay men, trans, from black and minority ethnic communities and disabled, and to dispel assumptions that they form a homogeneous group.

The briefings provide easy-to-read guidance for health and social care commissioners, service planners and frontline staff. They aim to inform the delivery of appropriate services and to support health and social care professionals in their everyday work with LGBT people, by providing fundamental awareness and evidence of LGBT needs in relation to health.

Prolog reference for complete pack 283255.

Individual briefings can be downloaded from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078347

An introduction to working with Transgender people

This leaflet is intended to support staff to ensure that transgender people do not experience discrimination and prejudice in service delivery. It is part of a more detailed package of resources to help staff to improve the quality and uptake of health and social care services for LGBT people.

Prolog reference 278143-B and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074257

An introduction to working with lesbian, gay and bisexual people

This is a companion to the above leaflet, enabling staff to appreciate and draw similarities and contrasts between the experiences of LGB and trans people.

Available online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074255

A guide for young trans people in the UK

This booklet was produced by a group of young trans people aged between 15 and 22 in conjunction with Gendered Intelligence. It aims to offer information to young people who know they are trans or are confused about or questioning their gender in any way, so as to help clarify some of their questions and offer them language to express themselves.

Prolog reference 281091 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074258

Bereavement: A guide for Transsexual, Transgender people and their loved ones

This booklet has been produced to assist bereaved trans people or friends, or the family of a trans person who has died. It will also inform professionals such as coroners, pathologists, mortuary staff and undertakers to understand the particular needs of trans people in the circumstances of death.

Prolog reference 281087 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074259

A guide to hormone therapy for trans people

This publication gives trans men and trans women straightforward information about the benefits of hormone therapy and the risks and side effects.

Prolog reference 284892 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081580

Transgender experiences – Information and support

This leaflet has been produced to help trans people and their families understand about the experiences of trans people, their rights and their choices. It also helps healthcare staff to understand about their role when caring for trans people.

Prolog reference 284887 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081579

Medical care for gender variant children and young people: answering families' questions

This publication provides answers to the questions typically asked by parents of gender-variant children and young people (up to the age of 17). It helps families to understand about gender variance and gives some suggestions about how to respond.

Prolog reference 285384 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082976

NHS funding processes and waiting times for adult service-users

This publication is intended to help trans people understand the processes involved in obtaining funding for treatment within the context where not all of the help they need may be routinely provided. It answers the questions that service users typically ask, and it provides guidance on how to navigate a complex system with minimum delay.

Prolog reference 285383 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082956

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

This publication aims to provide wide-ranging information to help medical professionals respond confidently and appropriately when they are approached by trans service users. Several topics relating to initial assessment, psychological support and hormone treatment are covered in a series of detailed annexes.

Prolog reference 286109 and online from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084919

Other official publications

Gender Reassignment – A Guide for Employers

Women and Equality Unit, Jan 2005

An invaluable guide to both the Gender Recognition Act 2004 and the Sex Discrimination (Gender Reassignment) Regulations 1999, seen from an employer's perspective.

Available online at:

www.womenandequalityunit.gov.uk/research/index.htm

Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination

Stephen Whittle, Lewis Turner and Maryam Al-Alami, The Equalities Review, February 2007

Based on a survey of 872 trans people (17.5% of the UK trans population), coupled with analysis of thousands of items from case files, this report provides a stark portrait of the experiences of trans people in contemporary society, including health and social care.

Available online at:

www.pfc.org.uk/files/EngenderedPenalties.pdf

Fairness and Freedom: The Final Report of the Equalities Review

Trevor Phillips (Chair), Cabinet Office,
February 2007

This independent review, commissioned by the Prime Minister, was asked to provide an understanding of the long-term and underlying causes of disadvantage that need to be addressed by public policy; to make practical recommendations for key policy priorities; and to inform the modernisation of equality legislation towards a Single Equality Act and the development of the Commission for Equality and Human Rights.

Available online at:

http://archive.cabinetoffice.gov.uk/equalitiesreview/upload/assets/www.theequalitiesreview.org.uk/equality_review.pdf

Gender Equality Duty: Code of Practice for England and Wales

This Code of Practice was produced by the Equal Opportunities Commission (EOC) and gives practical guidance to public authorities on how to meet the Gender Equality Duty. The EOC prepared and issued the Code under the Sex Discrimination Act, as amended by the Equality Act 2006. It applies to England and Wales and non-devolved authorities in Scotland. A similar but separate Code applies to Scotland.

The Code of Practice is a 'statutory' code. This means that it has been approved by Parliament. It also means that the code is admissible in evidence in any legal action under the Sex Discrimination Act 1975, the Equal Pay Act 1970 or Equality Act 2006 in criminal or civil proceedings before any court or tribunal. A court or tribunal must take into account any part of the Code that appears

to the court to be relevant to any question arising in the proceedings. On its own, the Code does not impose any legal obligations on public authorities. If a public authority has failed to follow recommendations in the Code, however, a tribunal or court may draw an adverse inference from such a failure.

Available in PDF and Word format from the Equality and Human Rights Commission website, within a larger index to Gender Equality resources at:

www.equalityhumanrights.com/en/forbusinessesandorganisation/publicauthorities/Gender_equality_duty/Pages/Genderequalitydutydocuments.aspx

Legislation

Gender Recognition Act 2004

The purpose of the Gender Recognition Act is to provide transsexual people with legal recognition in their acquired gender. Legal recognition follows from the issue of a full Gender Recognition Certificate by a Gender Recognition Panel.

Available from TSO and online from:

www.opsi.gov.uk/acts/acts2004/20040007.htm

Explanatory Notes to Gender Recognition Act

Available online at:

www.england-legislation.hmsso.gov.uk/acts/en2004/2004en07.htm

The Sex Discrimination (Gender Reassignment) Regulations 1999

(Statutory Instrument 1999 No. 1102)

Regulations that extended the Sex Discrimination Act (Parts I and II) to afford protection in employment and the provision of vocational training for those who are planning to undergo, are undergoing or have undergone gender reassignment.

These provisions are explained in the Women and Equality Unit publication *Gender Reassignment – A Guide for Employers*.

The statutory instrument can be inspected online at:

www.opsi.gov.uk/si/si1999/19991102.htm

The Sex Discrimination (Amendment of Legislation) Regulations 2008

(Statutory Instrument 2008 No. 963)

Regulations that extended Part III of the Sex Discrimination Act to afford protection against discrimination, harassment or sexual harassment in the provision of goods, facilities, services and premises for those who are planning to undergo, are undergoing or have undergone gender reassignment.

The regulations (which also add similar protections relating to pregnancy/maternity) cover indirect forms of discrimination, using the definition adopted in the EC Goods and Services Equal Treatment Directive (Council Directive 2004/113 EC of 13 December 2004).

The statutory instrument can be inspected online at:

www.opsi.gov.uk/si/si2008/uksi_20080963_en_1

Clinical guidance

Guidelines for the treatment of Gender Dysphoria

Royal College of Psychiatrists 2008

These guidelines have been produced by an interdisciplinary committee chaired by Dr Kevan Wylie (Clinical Head of the Sheffield Gender Identity Clinic) under the auspices of the Royal College of Psychiatrists.

At the time of producing this guide the guidelines were undergoing final revision following a wide-ranging stakeholder consultation. See the RCPsych website for details: <http://rcpsych.ac.uk/>

Standards of Care for Gender Identity Disorders (Version 6)

The World Professional Association for Transgender Health's (WPATH's) Standards of Care for Gender Identity Disorders articulate the organisation's professional consensus about the psychiatric, psychological, medical and surgical management of gender identity disorders. According to WPATH:

“Professionals may use this document to understand the parameters within which they may offer assistance to those with these problems.”

Available as a download from:

www.wpath.org/publications_standards.cfm

Books

True Selves – Understanding Transsexualism for families, friends, co-workers, and helping professionals

Mildred L Brown and Chloe Ann Rounsley, Jossey-Bass 1996; ISBN 0 7879 0271 3

An informative and sensitive text providing an insight into the experience of being transsexual, and what the decision to transition involves, written by a specialist who worked for many years with transsexual people in San Francisco. Well regarded as a book which trans people will often choose to lend to their families, friends and colleagues when they transition.

The Transgender Debate: The Crisis Surrounding Gender Identity

Dr Stephen Whittle
South Street Press 2000; ISBN 1 9029 3216 1

This short but well-researched pocket-sized book is written by an academic professor who is also a transsexual man. It is an ideal quick read for people who wish to get a simple grasp on contemporary trans issues from the perspective of trans people themselves. It addresses the historical, social, legal and medical issues surrounding trans people, throwing light onto what are complex issues and clarifying them in a way that challenges those who have always simply taken gender for granted.

Training DVDs

Real Stories, Real Lives

DH Equality and Human Rights Group
(June 2006)

Produced as part of the work of the Sexual Orientation and Gender Identity Advisory Group, this 24-minute DVD is made up of several short segments that can be used individually or as a set in LGBT awareness training. The segment '88 Kilograms' provides insights into the experiences of a transsexual man undergoing treatment in Sheffield.

Also online at: www.dh.gov.uk/en/Policyandguidance/Equalityandhumanrights/Sexualorientationandgenderidentity/DH_065333

Annex 2 – A concise guide to terms

Transsexual people experience a condition in which they have a strong and ongoing cross-gender identification, i.e. a desire to live and be accepted as a member of the opposite sex. The individual typically feels a sense of inappropriateness in the gender role to which they were assigned at birth and consequently often a persistent and significant discomfort with their anatomical sex.

Within contemporary medicine this syndrome is generally described as '**gender identity disorder**' (GID) or '**gender dysphoria**' (GD).

At some time in their life, depending upon their personal and social circumstances, their family support, and their own determination, such people will seek medical advice and support to resolve the feelings they experience. Depending on the severity of their experiences, some may wish to undertake hormonal treatment and surgery to make their body as congruent as possible with their gendered sense of self.

Those who change from being female to male are referred to as **trans men**, i.e. they are now men with a transsexual history. Similarly those who change from male to female are referred to as **trans women**.

In Britain, **care pathways** generally commence through primary care, beginning with an approach by the individual to their general practitioner. A significant number of individuals may alternatively approach one of a small number of private practitioners, who will inform the patient's GP of any diagnosis

and may seek a shared care protocol for the prescription of medications, subject to the consent of the patient. NHS care pathways may involve an initial referral to general psychiatry to confirm no mental illness is present and to facilitate a tertiary referral to a specialist centre for assessment and support. In other areas GPs may refer direct to a gender specialist or clinic or could themselves adopt the lead role in coordinating therapies to assist the patient.

Whatever forms the care path may take, patients will start hormone therapies and begin living permanently in their preferred gender role. Most will proceed to have some, if not all, gender reassignment surgeries.

Hormone therapy consists of a programme of administration of prescription formulations equating to the physiological sex hormones of the desired target sex. In male-to-female individuals the administration of female sex hormones is usually accompanied by prescription drugs designed to inhibit the body's production or metabolism of testosterone. Cross-sex hormone administration usually continues for life, even following genital surgeries. Testosterone blocking is not necessary following surgery that removes the patient's testes.

Gender reassignment is a collective expression describing a range of hormonal, surgical and therapeutic treatments and interventions which can support an individual's transition to a social role and physical presentation that is congruent with their gender identity. Although there is some debate about which combination and order

of interventions provides the most positive health outcomes in specific cases, it is widely accepted that intervention of some form is usually needed to support an individual's transition and provide a positive and satisfactory outcome for the patient.

The 1999 Court of Appeal ruling in the case of North West Lancashire Health Authority v A, D & G confirmed that gender reassignment is the appropriate medical response to GID and that it is unlawful for health authorities (now PCTs) to operate anything that amounts to a blanket ban on funding in such cases.

Having discussed the path followed by transsexual people, it is important to be aware that there are other kinds of gender-variant experience and expression which, although not leading to the kind of therapeutic care pathway described above, can still result in the need for awareness and support on the part of primary care and social care professionals. The need for support may arise from the individual themselves seeking a comfortable accommodation with their nature, but it may also originate from parents, partners, siblings or associates experiencing difficulty with coming to terms with what is going on around them.

Transvestite people (TVs) enjoy wearing the clothing of the 'opposite' sex for short periods of time. They are generally men who started cross-dressing as they entered puberty. Their sense of female identification can range from being very strong and indeed, their 'real' selves, to being only a part of their identity – they may identify for example as 'bi-gendered'. Transvestite people (now also referred to as '**cross-dressers**') do not seek gender reassignment; however, they and their families may present to GPs with stress and anxiety-related problems including depression or suicidal feelings, or simply

needing support and advice. At present there is no means of estimating this potentially unmet need.

As they get older, some transvestite people may decide that they are in fact transsexual and will proceed to living permanently in their new gender role. Others are happy to continue 'dressing' part-time for the rest of their lives. Some transsexual people may also seek to accommodate their feelings by experimenting with whether occasional cross-dressing is sufficient to avoid the upheaval of permanent gender transition. An understanding of how boundaries may be blurred in these ways is important in order to understand the variations in personal expression and the paths individuals may have followed.

Transgender people: Transgender is used as a very broad term to include all sorts of trans people. It includes cross-dressers, people who wear a mix of clothing, people with a dual or no gender identity, and transsexual people. It is also used to define a political and social community which is inclusive of transsexual people, transgender people, cross-dressers (transvestites), and other groups of 'gender-variant' people such as drag queens and kings, butch lesbians, and 'mannish' or 'passing' women. 'Transgender' has also been used to refer to all persons who express gender in ways not traditionally associated with their sex. Similarly it has also been used to refer to people who express gender in non-traditional ways, but continue to identify as the sex of birth. Nowadays, many people who present their gender in a variety of ways which are at odds with the norm will consider themselves to be transgender. Equally, some may just describe themselves as men or women.

Trans person/people/man/woman are inclusive terms adopted in the late 1990s by the UK government and now commonly also used by members of the UK cross-dressing, transgender and transsexual population to refer to themselves. Note, however, that some earlier medical texts used to refer to people in terms of their genital sex at birth. A declining number of medical practitioners may therefore still employ this outdated nomenclature, often perceived by trans

people themselves as offensive. Note, above all, that people may have different words to describe *themselves*. It is always wise to ask individuals.

Commonly used abbreviations and terms

| | |
|------------------------------------|--|
| FtM/F2M | Female to male |
| Gender | An individual's personal sense of maleness or femaleness. It is also a social construction that allocates certain behaviours into male or female roles. These will not always be the same across history, across societies, across classes, hence we know that gender is not an entirely biological matter, rather it is influenced through society's expectations. |
| Gender dysphoria | Used by clinicians to describe the condition that transsexual people present with – that is not feeling well or happy with their gender as assigned at birth, in terms of both their social role and their body. Gender dysphoria is not characterised by denial; for instance, female-to-male transsexual people (trans men) acknowledge that their (pre-transitional) bodies are female. The fact that their anatomy does not correspond with their sense of being a man (psychological sex) leads them to seek to bring the two (body and mind) into harmony. Specifically, the diagnosis required by the Gender Recognition Panel states that gender identity disorder is " <i>characterised by a strong and persistent cross-gender identification</i> " which " <i>does not arise from a desire to obtain the cultural advantages of being the other sex,</i> " and that it should not be confused with " <i>simple nonconformity to stereotypical sex role behaviour.</i> " |
| Gender reassignment surgery | Medical term for what transsexual people often call gender-confirmation surgery: surgery to bring the primary and secondary sex characteristics of a transsexual person's body into alignment with his or her internal self-perception. |
| Gender Recognition | A process whereby a transsexual person's preferred gender is recognised in law, or the achievement of the process. |

| | |
|---|--|
| Gender Recognition Act 2004 (GRA) | The UK law which allows transsexual people to obtain gender recognition. |
| Gender Recognition Certificate (GRC) | A certificate which is provided to those who have been successful in their application for gender recognition. The document has no standing other than as a means to enable the register of births and Department for Work and Pensions systems to be updated in line with the decision. |
| Gender Recognition Panel (GRP) | A group of lawyers and doctors appointed to consider applications for gender recognition, and to approve them if the transsexual person has met the relevant criteria. See www.grp.gov.uk |
| MtF/M2F | Male to female |
| Non-op | A person who does not desire surgery, or does not need surgery to feel comfortable with his or her body. |
| Passing | When a trans person is not visible as a trans person. Those who do not 'pass' have some residual features of their birth gender – which often means that other people regard them still as their birth gender. |
| Pre-op/ Post-op | Pre-operative and post-operative; having had or not had gender-confirmation surgeries. 'Pre-operative' implies that the person desires gender reassignment surgery; if this is not the case, 'non-op' is the correct term. |
| Stealth | Living in a way where nobody knows your previous gender history. |
| Trans man | Someone who has transitioned from female to male. Caveats as per trans woman. |
| Trans woman | Someone who has transitioned from male to female. Note that some people, following treatment, strongly prefer to be thought of as simply a woman (or perhaps a woman with a transsexual background). |
| Transition | The process of social change in presentation between genders. |

Expressions that should be avoided

Some expressions or forms of speech are perceived to be offensive and should be avoided.

| | |
|--|--|
| A transsexual/transsexuals | Terms like 'transsexual' should not be used as a noun; they are best used only as adjectives to qualify other descriptive characteristics. This is similar to not referring to someone as 'a black' or to 'the disabled'. The example set by this guide should be followed, i.e. 'transsexual people'; 'trans people'; 'transsexual woman'; 'trans woman', etc. Note also the caveat in the previous table that some people simply prefer to be described as women or men. |
| Chosen gender | Trans people are very sensitive about the suggestion that they have 'chosen' their gender, given the overwhelming nature of the feelings that lead someone to face the social disapproval that accompanies transition. Professionals are recommended to talk about 'acquired gender' or 'true gender' (for the role they have transitioned to). The latter term respectfully acknowledges how the individual feels about themselves. |
| Sex change, tranny, gender bender, 'the chop', etc. | These terms that sometimes still appear in the media are regarded as offensive and inaccurate. Note that some trans people are beginning to 'reclaim' the word 'tranny' in the same way that some lesbian and gay people have reclaimed 'queer'. This is not recommended for anyone who is not a member of those communities. |

Annex 3 – Care pathways for gender issues

Approaches to trans people's needs

Formal services dealing with gender issues in the adult population began to be established under the NHS in the late 1960s. These early developments grew into what is now the main gender identity clinic, originally within Charing Cross Hospital.⁶⁴ Prior to this time, transsexual people had been generally obliged to obtain hormones from black-market sources and to travel abroad for surgery. Famous transsexual autobiographies from the early 1970s document this well.⁶⁵

Other NHS-run gender identity clinics (GICs) have been established over the course of time, although they are all far smaller than the Charing Cross centre, with consequent capacity and waiting problems. In England there are small centres elsewhere, such as in Sheffield. Coverage of the country is uneven though, with entire regions (for example the North West) having no clinic at all. This leads to the risk of over-dependence upon a sole provider (Charing Cross), with consequent lack of choice, inevitable bottlenecks awaiting referral and the requirement for long-distance travel by service users for appointments.

The emergence of private practice to meet patient demand for an alternative has served to create a dual market for provision; albeit accessible only to the few who can afford the consultation fees. There is one main private

clinic,⁶⁶ which is now also taking an increased number of NHS referrals from PCTs already responding to a demand for choice.

The Internet has created a third market, with serious implications for public health. Trans people who have difficulty accessing the NHS, and who cannot afford to attend a reputable private clinic, are nowadays increasingly liable to purchase hormones online. Similarly, service users who cannot wait for NHS surgical treatment, and who cannot afford private surgery by the same consultants in Britain, are increasingly likely to go abroad to well-advertised centres in Thailand or the United States. These centres have a high reputation among trans people – some of whom assert that techniques and the quality of results are superior to those in the UK. However, the emergence of gender reassignment tourism is a phenomenon which raises concerns about aftercare and the funding of any post-operative complications. Similarly, there are public health concerns associated with patients self-prescribing cross-gender hormones without local monitoring.

These factors mean NHS organisations have a serious responsibility to consider how to win back the trust of trans patients in order to ensure their proper care.

64 Whilst still referred to as 'Charing Cross', the service now operates as part of West London Mental Health Trust. For details see www.wlmht.nhs.uk/services/g/gender_identity.html

65 The 1974 classic *Conundrum* by Jan Morris has been republished by Faber and Faber; ISBN 0571209467.

66 The London Gender Clinic – www.transhealth.co.uk/

Care pathways

NHS care pathways generally begin with an approach by an individual to their GP. Some referral policies enable GPs to refer direct to a gender identity clinic (or consultant by name). In the majority of cases, patients are generally referred first to a local psychiatrist, whose principal role should be to eliminate the possibility of an underlying psychiatric condition.

A provisional diagnosis of gender dysphoria relies on eliminating other known reasons for a patient to exhibit concerns about their gender role. If a psychiatric illness has been eliminated in this way, then – although the established approach has been to refer patients to a psychiatrist-led gender identity clinic – modern thinking allows for alternative approaches. These can be designed in order to provide patient-centred local treatment, whilst remaining faithful to good clinical governance. There are significant advantages to reappraising the approach to care in this way – for patients, clinicians and commissioners.

This means that it should not be assumed that the options for commissioners are limited to a narrow choice between one traditional external referral to an NHS gender identity clinic, and another of the same kind. Some PCTs have found that there are benefits in offering referral to a suitably accredited and inspected private clinic as one of the options for patients.

Where a suitably interested local General Practitioner with Special Interest (GPwSI) exists, it may also be possible to create a fresh approach to service provision by centring local care on that practice and utilising the skills of other local specialists.

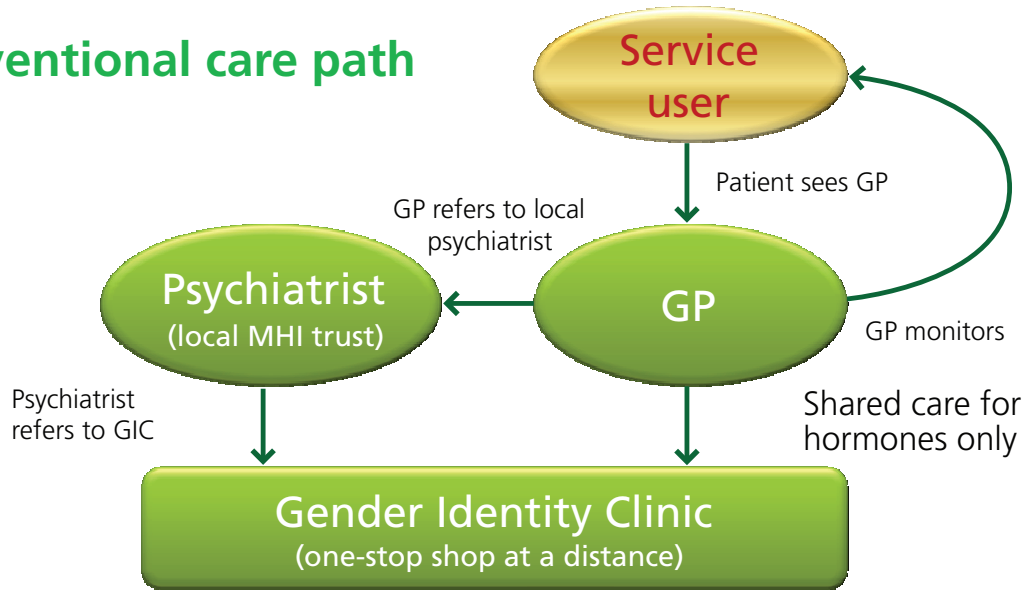
With suitable professional development it is possible for many of the component parts in the overall care of a trans person to be delivered locally, in addition to managing the patient's overall access to services through a GPwSI – prime examples would be endocrinology, speech therapy and counselling services. Very little additional training is required to equip local specialists to care for trans service users and many, having overcome initial trepidation, find it engaging and rewarding work.

New guidelines for the care of transsexual people, produced by a committee set up by the Royal College of Psychiatrists,⁶⁷ acknowledge that whilst the care of trans people benefits from a multidisciplinary team approach, there is no need in this day and age for the team to operate under one roof. The important factor is that practitioners should communicate – and this can be achieved through a GPwSI just as effectively as through a psychiatrist in the traditional model of a single-centre gender identity clinic. Indeed it can be argued that GPs have better experience of coordinating care and are in a better position to monitor the patient's whole health.

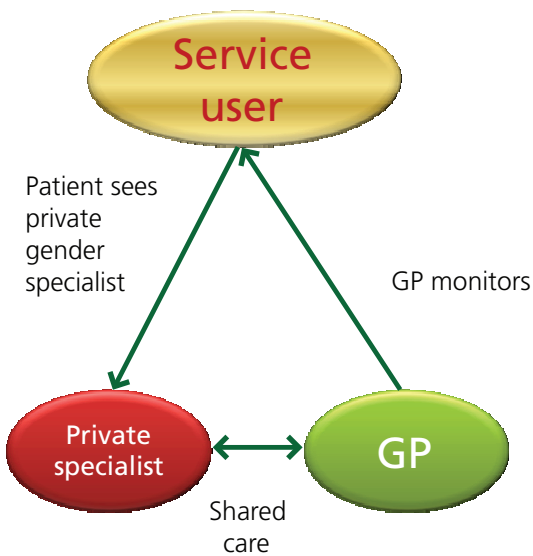
67 See the RCPsych website (<http://rcpsych.ac.uk>) for details of when these will be available.

Diagram showing different ways of organising care

Conventional care path

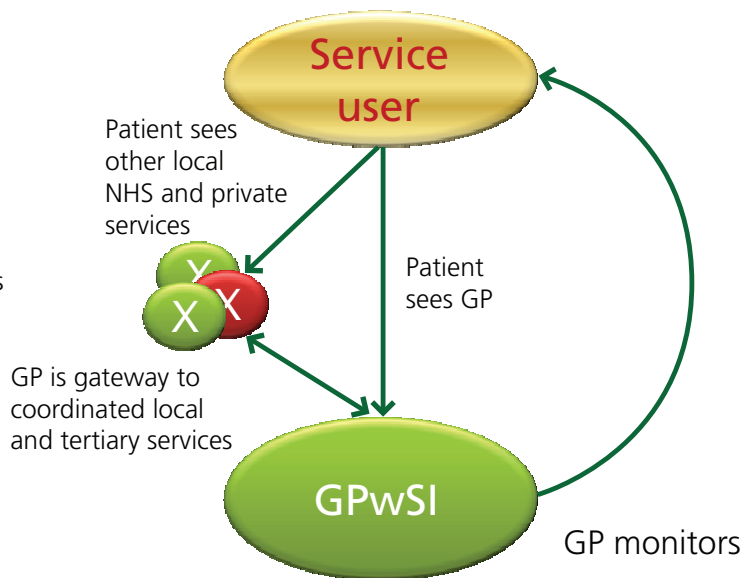


Private care



Unless the specialist provides a range of services in a clinic setting, the range of additional services such as speech therapy may be limited and will probably not be coordinated in a multidisciplinary approach

GP-centred local care



GP acts as a gateway to all the services which the patient needs and is in the position to monitor overall progress

Mixed use of psychiatry, clinical psychology and counselling

In part 2 it was stressed that being trans is not considered to be a mental illness, and that the existence of classification within mental health diagnostic categories is to help and not to pathologise or stigmatise people.

There is a very valid role for psychiatrists, clinical psychologists and counsellors in therapeutic relationships with trans people, but it is concerned with diagnosis by elimination of other possible explanations for an individual's gender discord and then with helping the patient with self-insight, understanding options, and the development of coping strategies for the changes to be undertaken. There is no 'cure' in the sense of simply making the individual's sense of self come into line with their body.

The goal is to find the best way in which the individual can achieve "*lasting personal comfort with the gendered self in order to maximize overall psychological wellbeing and self-fulfilment*".⁶⁸

The first role is one of clinical responsibility and necessity. Although being trans or expressing the desire to transition is not an indication of psychopathology, there are mental illnesses which can result in people expressing very similar convictions or desires. An important starting point in any clinical pathway must therefore be to determine whether the individual's desire to transition is the product of being innately trans, or the result of some other condition which, if addressed, may result in the desire for transition abating.

This preliminary process of eliminating (or at least identifying) mental illness as a factor

can be performed by any competent local psychiatrist or clinical psychologist in the course of one or two local consultations. Although such practitioners need not be trained to expert level in dealing with gender issues (and the average PCT may only see a handful of cases every year), it is important that consultants used for this initial referral process should be familiar with an outline of how the overall treatment pathway operates in that PCT, and the limits of what is expected of them within that model.

The existence of some psychiatric conditions does not preclude that someone can be trans as well. For instance, the process of coming out to oneself and seeking help may often be cathartic and, if denial has not already led to depression, the effects of how others react to the news about someone's gender identity could well provide the circumstances in which depression comes about. Some chronic mental health conditions or a patient's learning disability should also not be assumed to be a barrier to treatment. The aim is to know and understand the factors that need to be taken into account in assessment and for the support of a transition (if that turns out to be the right course).

Having eliminated the existence of psychiatric illness in a patient expressing gender issues, it is then important to confirm a diagnosis of gender dysphoria and to work with the patient to determine how they are going to accommodate that into their life.

If the possibility of a mental illness has been eliminated already, then confirmation of the formal diagnosis of gender dysphoria can be performed by any clinician familiar with the diagnostic category. The principal private sector clinic currently operating in this field is headed by a General Practitioner with Special Interest working in conjunction

68 WPATH Standards of Care Version 6, www.wpath.org

with specialists in other disciplines. Other small services have been provided by clinical psychologists.

One practical consideration is that clinicians carrying out this function need to be acceptable to the Gender Recognition Panel in order that the diagnosis they make is considered satisfactory evidence for the purposes of a legal recognition application by the patient.

Apart from this, the requirement is to work with the patient in accordance with the guidelines to achieve an outcome that is right for that individual. This means that some of the work could be carried out by a suitably accredited counsellor.

A large portion of the time involved in helping trans people involves support through one-to-one contact with someone who can encourage the individual to explore their feelings, motivation and assumptions. It involves teaching coping strategies and monitoring progress in individual or group therapy. Therefore there is considerable scope for optimising the way in which valuable clinical skills are utilised in a coherent overall approach to care. The result of such consideration in design of a local care pathway can result in both improved patient experience, and better public value for money.

Focusing on outcomes

A common historical problem for service users undergoing gender reassignment with the NHS has been a tendency to think in narrow terms about the treatment necessary to achieve a long-term successful outcome for the individual. It is understandable that there may be a tendency to focus on the obvious requirements for assessment and counselling and genital reassignment

surgery, but there is far more to successfully functioning as a man or woman.

Nobody is going to see the genitals of a transsexual person walking down the street, or attending a job interview. What they will see is any facial hair on a transsexual woman's face, or the breasts on a transsexual man's chest. What they may hear is a voice that may need training in order to 'pass' without comment for a woman or man's voice on the telephone or at the bus stop. In turn, the patient's concerns about these or other features may come to replace the original gender discomfort as a cause for enduring anxiety.

For these reasons a degree of flexibility is required to determine which interventions should be funded so as to not lose sight of the actual therapeutic goal – which, as quoted earlier from the WPATH standards of care, is to help the individual achieve "*lasting personal comfort with the gendered self in order to maximize overall psychological wellbeing and self-fulfilment*".

Within this context some interventions, which might be considered purely elective cosmetic treatments in another patient, may need to be viewed as essential determinants of overall success in the treatment of someone being treated for gender issues. This is not to suggest that commissioners should have a blank chequebook approach; however, careful regard must be given to the advice of clinicians dealing with the individual patient. A helpful list of treatments that may fall into this category is provided in the guidelines which will be published by the Royal College of Psychiatrists.

The need for flexible entry points

Nowadays a significant proportion of the population may need to move house from time to time – either because of work, education or family responsibilities. In the case of people who are transitioning, the need for this may be exacerbated.

People also do not need ‘permission’ to transition. Sometimes trans people will approach a GP before taking any steps to transition; sometimes they may have socially transitioned for a while and might only approach a GP because they have reached the point where they need medical assistance to progress further. Recently a third category has begun to emerge – people who have managed their entire social, hormonal and surgical transition themselves, using the Internet, but then require help or support for their ongoing health or because their money has run out.

For these reasons care paths cannot be too prescriptive in terms of the ways in which people enter the process, or in terms of assumptions concerning the point they have reached. In the past some PCTs have made rigid stipulations about funding for gender reassignment treatment when people move into their catchment from elsewhere. This is bad practice and must be avoided, especially if the effect is to interrupt a process of care that is already underway. Regardless of local purchasing arrangements it may be necessary to negotiate a spot purchase agreement with an existing care provider in order to ensure continuity of a therapeutic arrangement that has been in place. An alternative is to agree the continuation of the existing referral with the patient’s previous PCT until treatment is completed.

Commissioners should also ensure that their service providers have a protocol that can

deal with the situation where a service user has already socially transitioned (and may have been taking hormones for extended periods) prior to referral. It is not reasonable or ethical to require such patients to resume living in their former gender role and cease taking hormones in order to be accepted into a treatment programme – though some providers have insisted upon this in the past.

Where does treatment stop?

Another common error is to assume that treatment in these cases simply ends following genital reassignment surgery. Again this would be to miss the overarching goal of all therapy in this area, which is concerned with long-term wellbeing.

It is therefore better to see genital surgery as an intervention that forms part of an overall planned therapy, which ends when the patient is happy and functioning confidently in their acquired gender role. Usually the end will be fairly soon after surgeries have been completed; however, it is important not to rush this and to be sure that any issues that arise out of the surgeries themselves have been fully resolved too.

Follow-up and long-term healthcare

Following gender reassignment a trans person will need periodic follow-up by their GP in order to ensure their long-term health. People who have undergone surgery to remove testes or ovaries will require a maintenance level dose of the appropriate sex hormones in order to maintain their psychological and physical wellbeing. In turn this also means that, in addition to providing those hormones under prescription, the patient’s GP will also need to schedule appropriate health checks, as recommended

by guidelines for care. In principle this is no different to the kind of follow-up and general health monitoring that GPs provide for all their patients; however, training is necessary to ensure that general practitioners know where to find the appropriate guidance. The Department of Health has published a detailed guide containing the necessary information. This is available in printed form or online.⁶⁹

Trans people get colds too

Finally, as regularly emphasised throughout this guide, trans people must never come to be seen exclusively in terms of their gender reassignment history. Like other members of the public, trans people get illnesses requiring treatment; they can have chronic conditions; they can be injured; they can develop problems through ageing; and they can become depressed or mentally ill for all the normal reasons. The NHS is there to treat these needs for trans people in just the same way as for everyone else.

⁶⁹ *Guidance for GPs, other clinicians and health professionals on the care of gender variant people* – see Annex 1.

Annex 4 – Consultation methodologies

A matrix approach to multiple needs

A simple way to ensure that planning and policymaking is fully inclusive and cognisant of the intersecting experiences contributing to disadvantage is to work in matrix terms.

The matrix should be completed one row at a time with representatives from that particular group. The objective for each row is to focus through consultation with service users, public health specialists, clinicians and managers, and with the aid of specialists and published research, on the factors that are likely to lead to health or employment disadvantage at each intersection.

Taking trans people as an example (row 7): the exercise would probably lead to the identification (in column 1) that trans women’s and trans men’s preventative health needs are different. Moving right, discussion with black and minority ethnic trans stakeholders about column 2 encourages consideration of the effects that racial and ethnic background may have on being trans. This may lead to the conclusion that services need to take those factors into account. Next the exercise moves on to trans with disability, trans with sexual orientation and so forth.

The exercise should be similarly repeated for each of the other strands. Note that in each instance, the intersection with being trans has the opportunity to be debated from the reverse perspective, i.e. a workshop looking

| | Gender | Race | Disability | Sexual Orientation | Religion or Belief | Age | Trans Status |
|--------------------|--------|------|------------|--------------------|--------------------|-----|--------------|
| Gender | | | | | | | |
| Race | | | | | | | |
| Disability | | | | | | | |
| Sexual Orientation | | | | | | | |
| Religion or Belief | | | | | | | |
| Age | | | | | | | |
| Trans Status | | | | | | | |

at equality needs from the perspective of a group whose main speciality and focus is upon (say) race may elicit a different set of perspectives about trans issues than a group looking at racial and ethnic considerations from a trans viewpoint.

At the end of the exercise a complete 360 degree perspective can therefore be derived by taking all the concepts captured in one row and the corresponding column.

Some themes will be recurrent and some groups may be seen to have higher risk of combined intersectional disadvantages or health risks than others. Detailed analysis of the matrix therefore enables coherent planning to take place. Above all, the opportunity to maximise the impact of policy interventions will often present itself.

Envisioning what trans inclusion looks like

Another technique that is especially valuable in consultation with stakeholders is to develop a map of what a comprehensive and successful set of outcomes would look like.

It is recommended that this task should be approached through facilitated workshops with stakeholders collaborating together from all viewpoints. For example:

- service users (pre- and post-operative, transsexual and transgender in this case)
- public health directors
- clinicians (GPs, nursing specialists and consultants)
- social workers
- commissioners

- human resource managers
- team managers (as employers)
- equality leads.

The goal is similar to the process of actualisation sometimes used in counselling and personal development – except that it is the organisation and its stakeholders who are being asked to envision the place they would like to be, as opposed to any individual.

To encourage joined-up thinking between agencies and the promotion of all round wellbeing and social cohesion, it may also be valuable to include stakeholders from agencies concerned with crisis support, housing, hate crime and anti-social behaviour as well. The health and wellbeing of trans people can depend as much on these environmental and support considerations as conventional medicine. Socially integrated, secure, employed and happy people present less call on health and social care services. Joined-up thinking pays dividends across the public spectrum. In short it is better to avoid crises than to spend health funding patching up the consequences.

The first step is to facilitate an agreed top level topic list with the agreement of all concerned. This is likely to reflect the interests of each of the participants and so the facilitator's aim is to ensure that the list covers high level subjects such as Employment, Services, Preventative Medicine and Consultation – especially if some stakeholders are not present to advance these top level headings themselves.

The next step under each category is to draw out a list of the factors which, if satisfied, would be indicative of a positive and inclusive approach towards trans people. If you have previously performed a matrix evaluation of

issues and needs, then the outputs from that can help in building the picture.

For instance, under 'Employment' the stakeholders might identify job opportunities (recruitment), job security (retention) and job satisfaction as indicators of a successfully inclusive policy outcome.

Note that indicators need not all relate to health and social care settings. In a multi-agency approach, different stakeholders may each take away objectives that relate to their own specialist area.

A part-completed inclusion portrait may look like this:

As a final step, stakeholders should be invited to produce one or more words, phrases or sentences that define success for each marker.

The completed portrait, taken in conjunction with the needs matrix contains all the essential information needed to begin planning a goal-driven approach to transformational activities.

| | | |
|--------------------------------|-------------------|------------------------------|
| Employment | Job Opportunities | Feel OK to apply |
| | | Can see role models |
| | | Respect privacy |
| | | Career opportunities |
| | Job Security | NHS will support me |
| | | Staff will respect me |
| | Job Satisfaction | Able to support my patients |
| | | Colleagues don't harass me |
| | Services | GPs |
| Can supply information | | |
| Helpful, not obstructive | | |
| Look after my long-term health | | |
| Protect my privacy | | |
| Gender Treatment | | Local |
| | | Provides choice |
| | | Reasonable waiting times |
| | | Patient-centred approach |
| | | Covers the treatments I need |
| | | Seems fair, not prejudiced |
| Preventative Medicine | Etc. | Etc. |

High on the list of ways and means to achieve many of the goals will be training. Indeed that may be all that is required in order to achieve many of the identified objectives.

Part 7 provides practical guidance on who needs to be trained and how.

Slicing the cake – an exercise in multi-dimensional thinking

Sometimes it may be helpful to use a warm-up exercise designed to help consultation participants think about people as multi-faceted individuals rather than labelled by single categories such as their gender, race, disability, sexual orientation, religion or belief, age or trans status. It's important to bear in mind that even the two-dimensional matrix approach, described earlier, only considers pairs of attributes together – it's not capable of picturing the unique health and social care needs that may be experienced by someone who is (say) a retired, lesbian, Christian, black transsexual woman with a hearing impairment. This may be considered an extreme example, and maybe there might only be one such person in the whole country; however, that is the point about thinking about people as individuals with specific background experiences, rather than grouped vaguely under labels for administrative convenience.

The slicing the cake exercise requires a round cake and a knife (or several sets if you opt to do this with people working in groups).

The first step is to invite participants to consider how they might slice the cake fairly to include a suitable-sized slice for everyone in the local community. This encourages discussion of what kinds of groups there are and their relative sizes. Answers might

include just dividing the cake into roughly two pieces (49% men and 51% women), or a slice for each age group, or maybe slices for black and minority ethnic people, disabled people, gay and lesbian people, etc.

It doesn't matter which approach the audience decide to take, as the facilitator's role is to lead the group into successive layers of complexity. If the cake has been divided into male and female halves, for instance, the group can then be asked to decide how to slice both those halves into different race and ethnic portions.

However, it is at the third stage that the exercise starts to become truly instructive. If, for instance, the cake has been divided as above, the facilitator should then ask the group to decide how to provide fair slices for the one in seven of the population who have a disability of some form. With the cake already in many pieces, the challenge is to divide out one-seventh of every single slice – underlining that there are many permutations to sex, race and disability.

At the next step, carving out the 6–8% of each piece that may be gay, lesbian or bisexual, the cake will probably have been reduced to a mass of crumbs – which is probably a reasonable enough place to stop – drawing the analogy that the crumbs are like the individuals in our society (the whole cake).

Annex 5 – Specialist organisations

Help and advice

| Name and address | Telephone | Email and website | Information |
|--|---|---|---|
| a:gender 1st Floor Seacole Building 2 Marsham Street London SW1P 4DF | 020 7035 4253 0114 207 4318 | Email: agender@homeoffice.gsi.gov.uk www.agender.org.uk | The support network for staff in government departments/agencies who have changed or need to change permanently their perceived gender, or who identify as intersex; a:gender is now recognised as a valuable source of expert advice and has generated much best practice and good case study material |
| Depend BM Depend London WC1N 3XX | | Email: info@depend.org.uk www.depend.org.uk | Depend is a support network linking friends and families of transsexual people |
| Equality and Human Rights Commission | 0845 604 6610 Textphone 0845 604 6620 | www.equalityhumanrights.com | The commission works to eliminate discrimination, reduce inequality, protect human rights and to build good relations, ensuring that everyone has a fair chance to participate in society |

| Name and address | Telephone | Email and website | Information |
|---|--|---|--|
| <p>Gender Identity Research and Education Society (GIRES) Milverley The Warren Ashtead Surrey KT21 2SP</p> | 01372 801554 | <p>Email: admin@gires.org.uk</p> <p>www.gires.org.uk</p> | <p>GIRES provides information, training, literature, website material and policy advice to organisations in the public and private sectors, including health and social care, as well as support for the families of transsexual people</p> <p>Registered Charity Number 1068137</p> |
| <p>Mermaids BM Mermaids London WC1N 3XX</p> | <p>07020 935066</p> <p>Mon to Sat 3pm until 7pm only</p> | <p>Email: mermaids@freeuk.com</p> <p>www.mermaids.freeuk.com</p> | <p>Family support group for children and teenagers with gender identity issues</p> <p>Registered Charity Number 1073991</p> |
| <p>The Gender Trust PO Box 3192 Brighton BN1 3WR</p> | 0845 231 0505 | <p>Email: info@gendertrust.org.uk</p> <p>www.gendertrust.com</p> | <p>The Gender Trust offers help and support to adults who are transsexual, gender dysphoric or identify as transgender</p> <p>Registered Charity Number 1088150</p> |

Training and consultancy specialists

| Name and Address | Telephone | Email and website | Information |
|--|------------------|--|---|
| ACAS Brandon House 180 Borough High Street London SE1 1LW | 020 7210 3613 | See website for regional contact and helpline details www.acas.org.uk | ACAS aims to improve organisations and working life through better employment relations. They provide up-to-date information, independent advice, high quality training and work with employers and employees to solve problems and improve performance |
| Gender Identity Research and Education Society (GIRES) Melverley The Warren Ashtead Surrey KT21 2SP | 01372 801554 | Email: admin@gires.org.uk www.gires.org.uk | GIRES has provided training, literature, website content and policy advice for government agencies and private employers in the health, criminal justice, education and other fields. It has also conducted research surveys and scientific symposia funded by major charitable trusts Registered Charity Number 1068137 |
| Health First Mary Sheridan House 15 St Thomas Street London SE1 9RY | 020 7188 2837 | Email: reception.msh@lewishampct.nhs.uk www.healthfirst.org.uk | Health First is the specialist NHS health promotion agency for Lambeth, Southwark and Lewisham in South East London. It is hosted by Lewisham PCT. They include trans-awareness training |

| Name and Address | Telephone | Email and website | Information |
|---|---|---|--|
| Plain Sense Ltd | 07836 344334 Fax: 0161 861 7149 | Email: c_burns@btinternet. com | Plain Sense is headed by Christine Burns, an equality and diversity specialist with many years' experience as a government advisor, public speaker, consultant and training provider in this field |
| Press for Change BM Network London WC1N 3XX | | letters@pfc.org.uk www.pfc.org.uk | Press for Change is one of the leading organisations involved with the development of legislation and best practice in all areas connected with the equal rights and liberties of all trans people in the UK PFC consultants carry out research, undertake business and document auditing, and provide training and consultancy |
| TG F.A.C.T. | | Email: tina@tgfact.co.uk www.tgfact.co.uk | TGFact works with employers in the proactive management of transition in the workplace, enabling people who have a clinical requirement to change gender role to effect successful transition |

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|---|---|
| ACAS www.acas.org.uk | ACAS aims to improve organisations and working life through better employment relations. They provide up-to-date information, independent advice, high quality training and work with employers and employees to solve problems and improve performance. |
| a:gender www.agender.org.uk | The support network for staff in government departments/agencies who have changed or need to change permanently their perceived gender, or who identify as intersex. a:gender is now recognised as a valuable source of expert advice and has generated much best practice and good case study material. |
| Equality and Human Rights Commission www.equalityhumanrights.com | The Equality and Human Rights Commission champions equality and human rights for all, working to eliminate discrimination, reduce inequality, protect human rights and build good relations, ensuring that everyone has a fair chance to participate in society. |
| NHS Employers www.nhsemployers.org/ | NHS Employers represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work. NHS Employers is part of the NHS Confederation. |
| Dr Kevan Wylie Clinical Lead Porterbrook clinic, Sheffield www.porterbrookclinic.org.uk/ | The NHS Porterbrook clinic provides a wide range of programmes for people with problems in their sexual lives. The clinic includes a regional-level gender dysphoria service which has operated for ten years and is one of the largest outside London. The clinical lead, Dr Wylie, also chairs an inter-collegiate committee headed by the Royal College of Psychiatrists which has been responsible for developing the first set of guidelines specifically aimed at clinicians working in this field in the UK. |



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