Initial Clinical Contact Protocol for Clinicians

Assessments will be undertaken in a clinic format. Clinicians will be allocated to the clinic as per their job plan and in line with service requirements. Clinicians carrying out initial clinical contacts will follow the protocol below.

1) **Preparation**

Clinicians carrying out initial assessments will allow 15 minutes prior to the initial assessment appointment to review the patient's referral documentation (including the referral form or letter and any additional documentation attached).

2) **Introduction**

- Introduce self and role
- Double check name and pronouns and whether legal name change has been made (request documentation if this has been done)
- Check whether there are any communication needs
- Describe the assessment:

  Purpose: To establish the patient's needs, expectations and goals in relation to their gender concern and to what extent treatment at the GIC may meet those needs and assist the patient in achieving their goals.

  Content: An exploration of the patient's experience of gender diversity and incongruence and its impact on psychological wellbeing and social functioning, their hopes and expectations regarding the outcome of treatment and the presence of the necessary physical, psychological and social resources required to enable them to engage with and potentially benefit from treatment.

  Process: Assessment is carried out in two parts beginning with this initial clinical contact where referral information is checked and more information gathered relating to the patient's needs, expectations and goals and their physical health, psychological wellbeing and social functioning. Explain that this will enable the team to formulate how best to meet their needs and make a pathway decision with the outcome being either a) discharge back to GP with recommendations or b) further assessment in the clinic with a particular clinician. Once the second part of the assessment is completed a final decision is made regarding next steps; a) discharge back to GP with recommendations or b) treatment in the clinic based on an individualised plan.
- Explain that assessments are completed in between two and four sessions depending upon individual need and circumstances.
- Explain that any recommendations for formal psycho-social support, medical and/or psychological interventions and any referrals for external interventions are only made following completion of the second part of the assessment and discussion with the multi-disciplinary team.
- Explain that peer support is available via contact with our volunteers during the process of assessment and provide details of how to access.
- Stress the need for openness, willingness to engage and co-operate fully in the assessment in order that we can formulate how best to meet individual needs.
- Briefly summarise the Trust's confidentiality policy.
- Briefly summarise attendance policy.

3) Information to be gathered during initial clinical contact

Gender identity

- Description of gender identity and diversity/incongruity from sex assigned at birth
- Duration of experience of diversity/incongruity from sex assigned at birth
- Consistency/reliability of gender identity: e.g. length of time felt this way, any fluidity of identity
- Description of social role and length of time inhabited this role (if different from that assigned at birth)
- Exclusivity of social role or specific contexts where this is inhabited or not

Thoughts about transition and desired interventions

- Knowledge and understanding of process of transition: e.g. friends or others having experienced this, personal research
- Desired service interventions: e.g. hormone treatment, surgical interventions, hair removal, speech and language therapy, psycho-social support (including legal advocacy, employment or identifying document changes), counselling and/or psychological interventions
- Treatment goals and expectations: e.g. physical changes, improved mood and social functioning, improved sense of satisfaction/comfort in relation to body, improved confidence and self-esteem, consideration of how others will perceive and relate to them differently
- Doubts or anticipated difficulties/obstacles (related to process of transition or how life might be post transition): e.g. financial cost of travel, difficulties at work, likelihood of passing, possible transphobia, impact upon family and or/other relationships, sexual relationships, - practice/function, lack of support or poor coping strategies

Family relationships (Complete Family Form on CARENOTES)

- Quality of relationships with and between parents, with children and siblings and significant extended family
- Family members awareness of, and perspectives upon, gender concern and request for treatment

Social circumstances

- Current accommodation and financial situation
- Summary of employment history
- Experience of education, highest educational attainment and any special educational needs
- Current leisure pursuits, activities and interests
- Current peer/social relationships
- Current romantic/sexual relationships
- Faith, spiritual beliefs and practice
- Current specific sources of social support and their quality

Mental health and wellbeing (current and historical)

- Current sense of wellbeing and any current or relevant history of identified mental health issues and current and historical diagnoses
- Experience of trauma (physical, emotional, sexual abuse/assault and/or neglect)
- Psychiatric or learning disability service use: note dates and services provided (obtain consent to access records including risk assessment and management plan if not already provided)

Risk (Complete Brief Risk Assessment Form and Full Form on CARENOTES as necessary)

- Harm to self and/or others
- Harm from others
- Safeguarding children/adults
- Forensic history

Physical Health (confirm accuracy and completeness of medical printout)

- Height, weight and blood pressure measured and BMI calculated
- Allergies & sensitivities
- Immunisations
- Current prescribed/ over the counter/unregulated/self –prescribed medicines, including herbal supplements
- Current/historical alcohol use
- Current/historical illicit substance use
- Current/historical tobacco use

- Current contact with other health providers: note dates and services provided (obtain consent to access records if not already provided)

Gender related health care use • Current or previous use of any gender health care provider (obtain consent to access records if not already provided)
Reproductive considerations • Discuss patients thoughts and feelings about this and review information provided in pack sent with initial appointment letter

4) Information to be provided and conclusion of assessment

- Explain that the information gathered will be recorded and discussed with the team in order that appropriate decisions can be made regarding next steps
- Provide some information regarding the likely wait for part two and reiterate that support can be accessed via our volunteer service and signpost to external sources of information and support, e.g. Intercom, Transwiki
- Provide information sheets regarding the desired treatments available at the GIC and relevant consent forms
- Encourage the patient to consult www.hfea.gov.uk for more information regarding fertility preservation
- Where hormone therapy is desired explain the increase risk of serious harm where BMI is >35 – advise to lose weight, with support from GP
- Where surgery is desired explain that this may not be possible or that outcome may be poor if their BMI is >30 and advise to lose weight, with support from GP
- Encourage the patient to provide feedback and raise any questions or concerns
- Provide the Patient Satisfaction Questionnaire and encourage the patient to return the completed form to reception before they leave

5) Recording the information gathered during the initial assessment

- Complete the Specialist GIC Assessment Form on CARENOTES
- Complete the Brief (and Full if indicated) Risk Assessment form on CARENOTES
- Complete the Family Form on CARENOTES

6) Follow up and liaison (variable)

Prior to presentation at triage meeting there may be times when it is necessary to consult with a senior colleague, the MDT and/or with the patient's GP, e.g. when there are any physical or mental health needs and or any risk identified that may need immediate attention. The clinician will enter a clinical note on CARENOTES to record the details of these consultations and their outcome. It may also be necessary to write to the GP and/or referrer (if different). In these cases additional time should be made available in order that this work can be completed promptly.

7) Triage

Attend and present case at triage meeting for RAG rating to be applied and pathway decision to be made. Send letter to patient and copy GP (and referrer) if different with outcome of meeting and next step