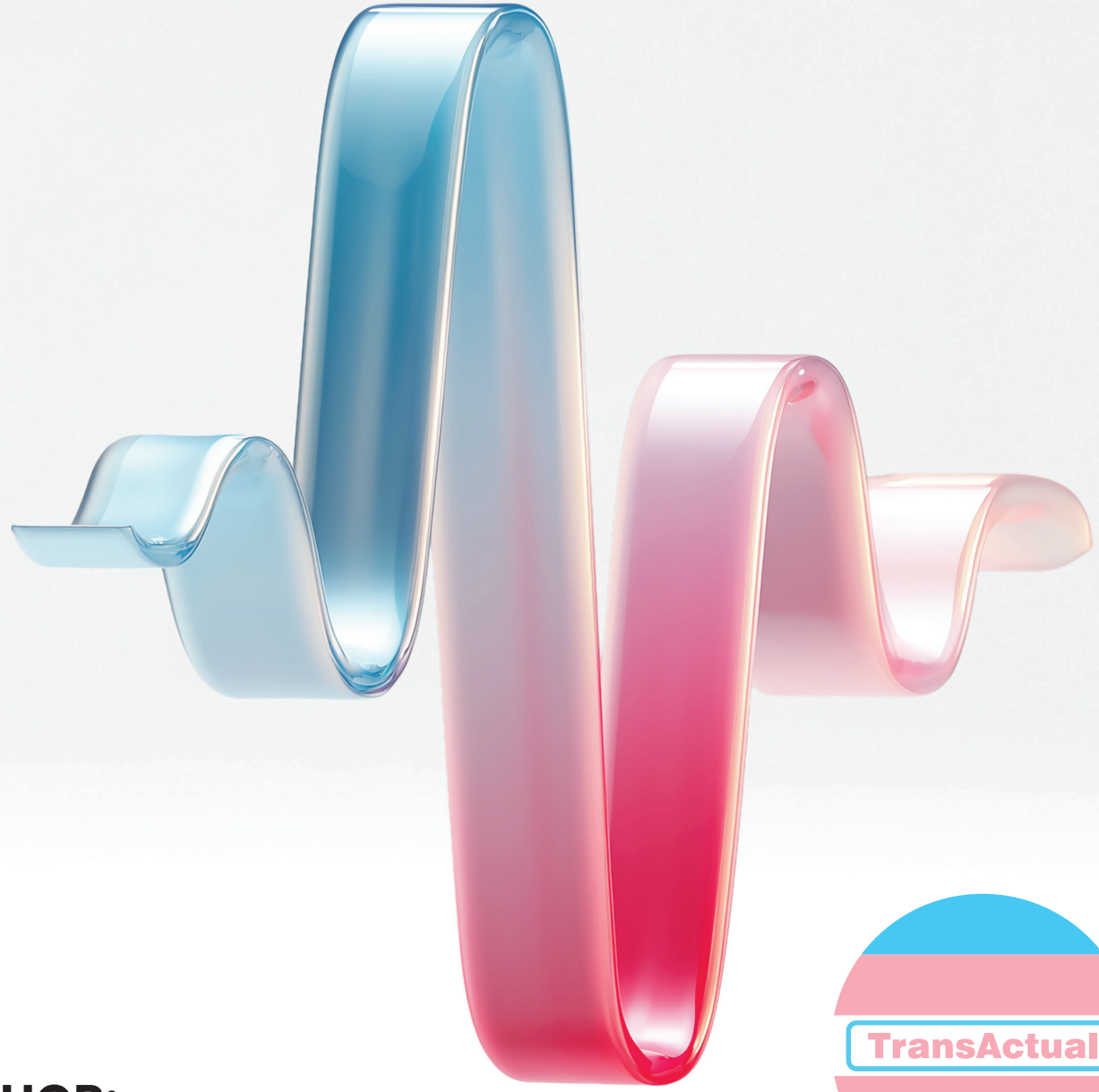
HEALTHCARE PROFESSIONALS REPORT 2025

UK Healthcare Workers' Experiences, Confidence and Comfort Supporting Trans Patients



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TransActual

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FOREWORD

TransActual regularly hear from trans community members about issues they encounter when accessing (or trying to access) healthcare. This includes general healthcare, as well as transition related care. We've done a lot of work to understand what's happening for trans people, and our research shows that trans people aren't experiencing the standards of care they should be able to expect. However, to advocate for the changes that will bring about improvements to trans people's healthcare experiences we need to understand what's preventing healthcare professionals from offering trans people the standards of care they ought to be able to expect. So, we commissioned a survey of healthcare professionals.

We'd like to thank everyone that completed our Healthcare Professionals Survey. We know the pressures that you're working under and appreciate the time you took to answer our questions. As you might expect, many (but not all) of our survey respondents were motivated to take part in our survey because they are supportive of trans people and want to help us. Professionals who are less confident in supporting trans patients or are less motivated to proactively work in a trans inclusive way were also less likely to respond to the survey. It doesn't mean they don't exist and, with high workloads and busy lives, answering our survey may just not have been a priority for them. As a result, the data in this report is likely to paint a more positive picture than is representative of healthcare professionals in the UK.

What is very clear from our data, however, is the need for high-quality training for healthcare professionals on trans inclusive care. Trans patients shouldn't be a healthcare professional's only source of CPD on trans inclusion, nor should professionals have to pay from their own pocket to access it. It is essential that all healthcare professionals, during initial training and throughout their careers, are trained to understand trans people's healthcare needs and to offer high quality trans inclusive care. Training for GPs, in particular, is important – they need to feel confident and competent to prescribe hormone replacement therapy to their trans patients.

But training on its own will not be enough. Policies and guidance must clearly set out professionals' roles and responsibilities in relation to the care of trans people, and IT systems must support them to follow good practice.

It is possible for the NHS, Royal Colleges, and training providers to make the changes that will result in trans people receiving care of the highest standard. There are things healthcare professionals can be doing now.

So, I urge you – be part of bringing about change for good.

Chay Brown (he/him)
Director for Healthcare, TransActual

EXECUTIVE SUMMARY

Research consistently shows that trans people encounter significant barriers in accessing healthcare—both in relation to gender-affirming care and in receiving general medical treatment. Yet, there is a significant gap in the literature regarding the experiences of medical practitioners in this area, including their levels of knowledge and experience in supporting trans patients and how comfortable and confident they feel in doing so.

Our survey of 646 medical practitioners – including GPs, nurses, pharmacists, Allied Health Practitioners, and others – may well be the largest study to date into this important topic.

Our sample was heavily skewed toward those who are most likely to be knowledgeable and supportive of trans experiences and medical needs. We found that practitioners were likely to describe themselves as confident and comfortable in a range of areas, including that they:

- Felt competent assessing a trans person in a therapeutic setting (67%, 436);
- Were very or extremely comfortable using trans-inclusive language (53%, 345) and patients' chosen names and pronouns (65%, 421);
- Knowingly had experience working with trans patients (60%, 389);
- Felt prepared to speak with trans patients about issues related to gender identity (60%, 386);
- Were very or extremely comfortable working with other medical professionals to support trans patients (57%, 370); and
- Were aware of institutional barriers that may inhibit trans people from using healthcare services (73%, 473).

Yet, we also found that this confidence and comfort was unlikely to reflect relevant medical training or supervision, with just 31% (202) of respondents stating that they had received sufficient medical training or supervision to work with trans patients.

Where practitioners reported having received adequate training, they often described having proactively sought it out, with some even paying out of their own pocket. In a general population of medical practitioners, the proportion who had accessed adequate levels of training would likely be even lower.

However, it is also of note that, within this sample, while most people indicated they held some confidence and/or competence, these sentiments were less likely to be strongly expressed. For instance, while 67% (436) agreed with the statement that they felt competent assessing a trans person in a therapeutic setting, only a fifth (20%, 129) stated that they strongly agreed with this.

These findings reflect the high likelihood of an overrepresentation of those most interested in and/or experienced in supporting trans patients, particularly as these findings are in stark contrast to our **2025 Trans Lives Report**.

Out of 4,008 trans respondents, 52% (1,830) indicated that they had experienced transphobia in a medical setting, including 60% (129) of People of Colour. Specifically, 33% (1,175) reported having experienced transphobia from a GP, 15% (548) from a nurse, and 12% (429) from a pharmacist. Where experiences with transphobia were reported, 97% stated that this had been (at least in part) due to a lack of knowledge around trans issues.

Combined, these two data sources – our **2025 Trans Lives Report** and this research into medical practitioners – could suggest that moderate to low levels of confidence and comfort are insufficient to provide appropriate medical care and treatment to trans individuals, with further steps needed to raise knowledge and skill sets.

Without access to training and/or relevant supervision, appointments with trans patients may instead become learning opportunities for medical practitioners, as expressed by one NHS social worker in the mental health field:

> "I feel that there has been little training in supporting transgender patients and therefore, it is difficult to understand how best to meet the needs of transgender patients. Much of my knowledge stems from direct work with transgender patients and their discussions on their lived experiences".

Where practitioners maintain a patient-led approach, this can be a positive experience for trans people.[1,2] However, this can also place a large burden on patients, who may then need high levels of knowledge and the ability to self-advocate to ensure they receive appropriate care.

Other respondents described not feeling that they needed specific training and that their general skills and training were sufficient, as one NHS medical doctor stated: "*It [is] part of my job as a doctor to support patients regardless of their gender identification*". Some described respect and empathy as the key skills in being able to support any patient.

One of the areas where a lack of knowledge appears to create the most challenges is in prescribing Gender Affirming Hormone Therapy (GAHT). The primary route for accessing GAHT in the UK is through NHS-funded Gender Identity Clinics (GICs). However, at present, waiting lists for even initial appointments are many years long.

In England, there are 12 GICs for adults, with those now receiving an initial appointment having waited at least two years for just this first step.[3] Some clinics are currently seeing patients who have been waiting more than eight years. From there, waiting times to receive GAHT can average a year or more. Without systemic change, those joining waiting lists today will wait even longer.

Our **2022 Transition Access** research found that, after initial appointments, NHS patients had waited an average of 325 days before receiving a GAHT prescription.[4] Waiting times can, however, be shortened through the use of a bridging prescription, where a GP prescribes GAHT until the person can see someone from a private clinic or NHS GIC. Bridging prescription waiting times were nearly 50% shorter than those through a GIC, averaging 170 days after initial appointment (and without the multi-year wait for that appointment). The use of a bridging prescription could therefore reduce waiting times by up to 95%.

Waiting times are even shorter for those able and willing to pay for private medical care. Average waiting times for a first appointment through private clinics was just 67 days, nearly ten times less than the GIC with the shortest current waiting time (two years) and more than 40 times shorter than the GIC with the longest current waiting time (eight years).

Waiting times from first appointment to accessing a GAHT prescription were 113 days for those with a private prescription, less than half of the NHS average.

Even after receiving a GAHT prescription through a GIC, patients will need their GP to enter into a shared care agreement to support ongoing treatment. Those accessing hormones privately will also need a shared care agreement or must pay to see a private clinician.

Despite the many challenges in accessing NHS GICs, in this piece of research we found that shared care agreements with a GIC remained the most common source of GAHT prescriptions (80%, 40). Shared care with a private provider had been utilised by 52% (26) of clinicians prescribing GAHT. Overall, most (62%, 31) of those who had provided GAHT prescriptions had used more than one mechanism.

Despite the ability to dramatically reduce waiting times, bridging prescriptions were the least frequently used (30%, 15). Respondents commonly described not feeling qualified to provide prescriptions, as with one NHS GP working in general practice:

> "Prescribing of hormones is still challenging as we feel we do not have the expertise as GPs, yet we are under huge pressures to prescribe as patients do not have other viable options. Technology [and] IT systems – EMIS specifically – don't help with gender/ pronouns well". [5]

Prescribers commonly described being reluctant to work with private clinics and frustrations with

challenges accessing specialists for support and shared care. In open responses, 24% (9) specifically mentioned difficulties acquiring specialist input or a specialist to work with as a reason they had not prescribed GAHT. Our research found that GPs working for the NHS held a range of views about the current pathways and their roles in them:

> "[GAHT is] not under NHS specialist care and therefore [there is] no shared care in place. NHS shared care is essential before [providing] any prescription for specialist medication".
>
> "No shared care agreement with GID clinic and an abject disinterest from Specialists in appropriately supporting General Practice in providing this – a badly commissioned pathway".
>
> "My ability to support transgender patients is limited by the difficulties accessing specialist transgender care".

The overwhelming majority of those who were asked for and provided GAHT prescriptions were GPs working in general practice (84%, 66). This creates a key opportunity to target a specific group of individuals who play a significant gatekeeping role in trans people's access to transition-related care.

Expanding on existing research,[6,7,8,9] many other systemic challenges were raised. Many described how services and service pathways to support trans individuals are routinely not or under-funded and can frequently change, causing confusion and difficulties in accessing appropriate pathways.

Some also described challenges with IT systems that would not allow updating of chosen names or pronouns or once updated, would not then ensure patients were offered correct medical care (e.g., smear tests).

> "I feel like my ability [to support trans patients] is hindered by the structure and policies of the NHS".

NHS NURSE

> "I don't feel confident in my knowledge of local and national services, as it changes often and can be labyrinthine!"

ALLIED HEALTH PROFESSIONAL WORKING IN MENTAL HEALTH FOR THE NHS AND PRIVATE SECTOR

> "I don't think EMIS is well set up for transgender patients. … We are supposed to counsel about not being invited for cervical screening for example … I think there should be the ability to invite anyone for any screening and not put back to them to ask".

NHS GP WORKING IN GENERAL PRACTICE

It is clear from our research that, even amongst those most likely to seek out training and/or supervision related to supporting trans patients, significant gaps in knowledge and experience are likely to exist. In a complex, continuously changing landscape, without clear pathways and policies, requests for GAHT prescriptions may be rejected without access to NHS-funded GICs, as one NHS GP working in general practice stated: "*It is not funded or resourced in General Practice, not part of the curriculum and not GMS,*[10] *so [there] is no capacity to offer this care*".

The group that is largely absent from our study is those who believe that being trans is a mental disorder, who represent just 4% (23) of our respondents, with a further 8% (53) being unsure. One NHS GP working in general practice stated: "*Forcing this down the neck of old GP's doesn't work. We think it's nuts. We are bewildered and think this is woke*".

For these individuals, providing training and/or changing policies may not be sufficient and additional measures would likely be required, as with one NHS Allied Health Professional working in neurological rehabilitation who stated: "*Don't necessarily agree with some of the ideology*".

Overall, there are many positive elements to our findings. Despite our recognition that those most supportive of and knowledgeable about trans identities and experiences are likely to be overrepresented in this study, it remains promising to see that there are practitioners who are proactively seeking out relevant training and/or supervision, even if paying out of pocket.

The wide range of mechanisms used to provide GAHT also demonstrates that the NHS can and does have functioning routes for trans people to access transition-related care, where this is desired. However, further work is needed to ensure equitable access to these pathways and to necessary transition-related care across the NHS.

The many mentions of different systemic barriers within existing healthcare systems, while a negative in themselves, represent practitioners who are willing to think critically on behalf of their trans patients about the systems they work in. Overall, this study highlights areas where urgent reform is needed to ensure that trans patients have access to appropriate medical care, both that which is related to their trans identity and that which is not.

RECOMMENDATIONS

FOR POLICYMAKERS

1. All medical practitioners should be required to complete training in best practice in caring for trans people. This should be embedded within the relevant pre-qualification curricula, as well as within required CPD post-qualification.
2. There is an urgent need to provide clear policies and guidance relating to the provision of trans-inclusive medical care. There should be consistency in this across the UK to prevent a 'postcode lottery'.
3. GP contracts and NHS Service Specifications should make GPs' responsibilities for prescribing GAHT clear, and national and local policies should be in place to support GPs to fulfil their responsibilities in relation to them.
4. IT systems need to be updated to enable flexibility in patient biology to account for intersex and trans individuals, whilst retaining the ability for intersex and trans individuals to update the sex marker on their medical records.

FOR HEALTHCARE PROFESSIONALS

1. Recognise that trans patients have some needs that require specific understanding and training. Be proactive in developing your trans-inclusive practice by attending training, reading about trans people's lived experiences and learning from examples of good practice.
2. Remember that whilst your trans patients are often experts in their own care, they shouldn't have to be. Avoid placing the burden on them as your sole source of information on their healthcare needs.

FOR PRESCRIBERS

1. Do what you can to support trans patients to access GAHT. If you currently feel unable to prescribe, reflect on what could make you feel differently and take steps to make that change – for example by accessing training or seeking advice from a more experienced colleague.

INTRODUCTION

The ability of trans people[11] to access medical treatment and support related to their gender identity has been a topic of significant debate in the UK, increasingly so in recent years. Research has consistently found that trans people routinely must wait many years before accessing services related to medical transition,[12] with waiting times of up to 8 years (or more) for initial appointments with Gender Identity Clinics (GICs) in the UK.[13] A 2016 Inquiry on Transgender Equity by the House of Commons' Women and Equalities Committee Select found:

> *"The NHS is letting down trans people: it is failing in its legal duty under the Equality Act. Trans people encounter significant problems in using general NHS services, due to the attitude of some clinicians and other staff who lack knowledge and understanding—and in some cases are prejudiced. The NHS is failing to ensure zero tolerance of transphobic behaviour. GPs too often lack understanding and in some cases this leads to appropriate care not being provided."*[14]

Trans people may have negative experiences in a medical setting due to a lack of knowledge and understanding by practitioners, not only about potential medical options available to trans individuals but also about the identities, experiences and needs of trans people. While medical care for trans people is currently housed in gender clinics, GPs routinely serve as 'gatekeepers' to access these services and, with multi-year waitlists, many individuals receive care from other medical practitioners and/or private clinics.

Our 2024 report, **Trans Inclusive Healthcare?**, found that the quality of this care and the willingness of GPs to do research can vary widely.[15] Some trans respondents reported positive experiences where practitioners were less knowledgeable but adopted a patient-led approach. However, it was also acknowledged that this can create a large burden for trans people, who then need to be extremely knowledgeable themselves to ensure appropriate care.

Practitioners having limited knowledge can also lead to overconfidence in their own knowledge and abilities, which may inhibit patients' abilities to self-advocate and lead to over-generalisations from limited interactions with trans patients. In an examination of the responses of over 96,000 people to public science surveys over the previous 30 years, Lackner and colleagues found that, while those with no knowledge were likely to respond with 'I don't know', those with a little knowledge were likely to be over-confident (i.e., provide an incorrect answer).[16] This phenomenon, commonly referred to as the Dunning-Kruger effect,[17] has been replicated in a wide range of research over the past three decades.[18] This raises concerns that practitioners with limited knowledge about trans patients may make incorrect assumptions or decisions related to patients' needs and care.

A recent survey by Healthwatch of 1,393 trans, non-binary, and gender-diverse individuals in the UK also found that many respondents did not feel confident in their GPs' ability to provide support.[19] Just 53% of respondents rated their GP as good or very good, with even fewer (32%) rating the gender-affirming care by their GP as good or very good. Two in five respondents (39%) stated that they were not at all confident with their GP's ability to meet their healthcare needs. Where care was reported as being good, respondents often spoke of GPs who took the time to learn more about providing gender-affirming care.

A qualitative study of a diverse group of 20 UK health professionals carried out in 2019-2020 identified four key barriers to supporting trans patients: structural, educational, cultural and social, and technical (see Table 1:1, below).[20]

These findings have been supported by additional research, including those focused on trans individuals, rather than medical practitioners. This includes a study of 22 older trans individuals in Wales who commonly reported GPs lacking relevant knowledge and

Table 1.1 Mikulak et al.'s categorisation of medical professionals' barriers to supporting trans patients

CATEGORY	BARRIERS
STRUCTURAL	- Shortage of gender clinics - Lengthy waiting times - Inadequate / no guidance from local commissioning groups - Lack of support in managing shared care agreements when working with private clinics (used increasingly due to long waiting times)
EDUCATIONAL	- Insubstantial / no training about trans health - Lack of knowledge of local resources for signposting
CULTURAL AND SOCIAL	- Individuals' negative attitudes and/or prejudice toward trans people and identities, including denying the legitimacy of trans identities - Insufficient awareness of non-binary identities - Communication challenges, including not being familiar with trans and gender-diverse identities, pronouns, and titles
TECHNICAL	- Inflexible data management systems inhibit recording a person's gender identity in addition to their assigned sex at birth - Systems not correctly assessing appropriate care for patients (e.g., smear tests) - Physical spaces, including waiting areas and single sex toilets that are not set up for trans individuals

that, while some GPs were supportive, others were *"failing to educate themselves about trans peoples' needs in the way they would for other health problems"*.[21] Medical professionals' own views again emerged as a key barrier, with some reporting having had GPs tell them that they were against providing GAHT through the NHS. Long waiting lists and delays, particularly in accessing GICs, were also commonly reported.

The current NHS England service specification places the responsibility for prescribing Gender-Affirming Hormone Therapy (GAHT) with the patient's GP. This can be done through a shared care agreement with a GIC or private clinic. GPs can also provide a bridging prescription until a patient can see a GIC or private clinic.[22,23]

Incorrect and outdated assumptions may hinder patient's ability to access GAHT. While there is a need for more high-quality longitudinal studies with large, diverse cohorts into the benefits and risks of GAHT, existing data is extremely promising and GAHT has been used in the care of trans people for decades. A 2023 meta-analysis examined the findings from 38 studies that included a mix of longitudinal cohort studies, cross-sectional studies, and mixed studies that included both cross-sectional and longitudinal data.[24] van Leederman and colleagues found that most studies found improvements to psychological well-being and quality of life (QoL), including reducing gender dysphoria, uneasiness, and body dissatisfaction. Similarly, a 2021 meta-analysis of 20 studies across 22 publications found associations between the administration of GAHT and reductions in depression and anxiety, along with increased QoL.[25]

While earlier studies had suggested potential risks associated with GAHT (e.g., an increase in cardiovascular episodes in those receiving testosterone and metabolic changes in those receiving oestrogen), more recent data has found that risks are generally linked to incorrect dosing (particularly where it is too high) and/or a lack of appropriate monitoring.[26] Over or incorrect dosing and a paucity of monitoring may more commonly occur where medical professionals are lacking in relevant training and knowledge.[27]

Issues with dosing can also occur where patients are self-medicating (buying and using unprescribed hormone medication from unregulated sources). This may be increasingly common as NHS waiting lists grow longer and longer, and waiting times approach a decade or more. Our 2022 Transition Access Survey found that 25% (179) of those on GAHT had self-medicated at some point.

Despite the wealth of evidence not only into the benefits of GAHT but the low associated risks, research has found that medical providers may still hold incorrect beliefs about GAHT's risks.[28] For instance, a study of medical practitioners in San Diego, California (n=220) found that 42% had not received any training on trans health.[29] A lack of training was also described as the most common barrier (74%) to prescribing GAHT.

Healthwatch's research found that GPs may be unwilling to provide bridging prescriptions or to use a shared-care agreement, with some refusing to refer patients to a GIC and/or stopping ongoing gender-affirming care.[30] Given the many barriers to accessing GAHT, it is not surprising that 70% of those who had requested GAHT from their GP stated that they had experienced delays, interruptions, or terminations of their ability to access this essential treatment.

Prior experience and/or training related to gender identity can be key to whether experiences are positive or negative for patients,[31] as can medical practitioners' own personal views about trans identities and people. Research has repeatedly demonstrated that relevant training can lead to increases in practitioners' skills and confidence.[32,33]

Other studies have also found a wide range of experiences, with many finding that GPs lack knowledge and/or can be openly biased against the existence of trans identities, though some GPs may take steps to increase their own awareness and knowledge.[34] Stereotypical assumptions about gender presentation and expression can also be a challenge.[35] Lack of medical professionals' awareness may be particularly challenging for older trans individuals who may struggle to access information on the internet to advocate for themselves and stay informed.[36]

The 'gatekeeping' nature of referrals to GICs also leads to varied experiences in accessing these pathways,[37] with waiting times a prominent barrier across studies.[38,39] Lack of privacy can also be a challenge (e.g., being told to tell a GP receptionist to change their recorded name/gender in a very public setting).[40]

Taking steps toward being more inclusive can have a positive impact for trans individuals accessing medical care. This can include practices having information about LGBTQ+ organisations publicly displayed in waiting rooms, the use of appropriate language and pronouns, providing relevant high-quality professional development for staff members, offering safe spaces with trained staff, and working to link with local support groups.[41,42]

While many barriers have been identified, little is known about medical practitioners' likelihood of having worked with trans individuals and, where this does occur, how confident and comfortable they feel in supporting these patients. In addition, research with medical practitioners in this topic has generally had very small sample sizes, creating challenges in identifying generalised trends across the UK health sector.

This research project seeks to help fill this gap by assessing the experiences, comfort, and confidence of medical practitioners in working with trans individuals. The findings within this report can help those across the sector, policymakers, and relevant advocates assess where additional policies, resources, training, and/or work may be needed to ensure access to appropriate, affirming care for trans people and others with diverse gender identities.

METHODOLOGY

STUDY DESIGN

The study included a short online survey of UK-based medical staff hosted on Typeform. The survey was available to all individuals who were 18 or over and currently working in clinical roles in the health sector in the United Kingdom, including those in the private, non profit, and/or public sectors. This included nurses, doctors, pharmacists, physiotherapists, occupational therapists, and others with health-related qualifications. This also included anyone who may have been on leave, but not individuals who were retired/no longer working in the medical field.

The survey was designed to be as concise and easy to complete as possible, with few open-ended questions, all of which were optional. To incentivise participation, all participants were entered into a prize draw to win a £150 Love2Shop voucher. Participants were not asked for any identifying information, aside from their email address if they wished to enter the prize draw or to receive the report once it has been published. Email addresses were stored separately from other responses in a password-protected folder in a password-protected device and will be destroyed following the report's publication.

Questions focused on competence and comfort in terms of:

- Assessing a trans person in a therapeutic setting;
- Using pronouns and names chosen by a trans patient;
- Using trans-inclusive language with patients;
- Talking to a trans client/patient about issues related to their gender identity;
- Working with other medical professionals to support trans patients;
- Identifying ways to learn more about supporting trans patients;
- Adapting one's practice to meet trans patients' needs where they differ from other patients; and
- Supporting trans patients, in general.

Participants were also asked whether they had received adequate clinical training and supervision to work with trans patients, if they had experience working with trans clients/patients, and if they were aware of institutional barriers that can deter trans people from using health services.

Two additional questions focused on respondents' views towards trans people, including whether they thought being trans is a mental disorder and whether they would be morally uncomfortable working with a trans client/patient.

These questions were derived from Bidell's (2017) validated scale – The Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS),[43] with slight adaptions to account for their inclusion of lesbian, gay, and bisexual clients and patients, while this research focused exclusively on trans individuals.

An additional set of questions asked participants if they were prescribers and, if so, if they had ever been asked to prescribe GAHT. If they had, they were then asked if they had issued a GAHT prescription when asked, with the ability to select multiple options (i.e., where they had provided a prescription or prescriptions for some patients but had not provided one for other(s)).

Those who had issued a GAHT prescription were also asked what basis they had used: a bridging prescription, shared care with a private provider, shared care with an NHS gender clinic, continuation of NHS care, or another mechanism.

Those who indicated they had rejected a request for a GAHT prescription were asked why, with options including: not feeling competent to prescribe, funding constraints, potential medical impact / individual's medical needs, personal views about trans people / identities, policy constraints / lack of policy (either at practice, PCN, or ICS level), concerns about career implications, non-medical patient / client factors (e.g., immigration or relationship status), or another reason.

Some questions were also included for comparative purposes, to assess differences in experience, comfort, and knowledge based on different characteristics and backgrounds. Some of these aims were successfully met, including comparisons based on:

- Individual's professional role (e.g., as a nurse, GP, etc.);
- the area individuals work in (e.g., in general practice, the mental health field, etc.);
- when individuals received their qualifications;
- whether participants identify as LGBTQIA+; and
- whether they have trans friends / family.

Comparisons based on country and whether practitioners worked in the NHS were not possible, as most respondents worked in England for the NHS.

Analysis was conducted using a mixture of quantitative and thematic analysis, including the use of STATAC 15 for quantitative analysis.

The full text of the survey can be found in the Appendix.

SAMPLE AND RECRUITMENT

All individuals with a qualification in the field of health who were 18 or over and currently working in this area in the UK were able to participate in this study. This includes those working in the private, non-profit, and/or public sector, including those whose work focuses on mental health. This also includes those currently on leave (e.g., for medical reasons, parental leave, sabbatical, etc.). This does not include individuals who are retired / no longer working in the field, non-clinical staff (e.g., administrators), or those currently working exclusively outside of the UK.

A snowball sampling approach was used to disseminate the survey, which included emails to the following groups, with a specific request for it to be shared widely, particularly including beyond LGBTQIA+ network members:

- NHS Trusts, including Equity, Diversity and Inclusivity (EDI) leads within Trusts;
- Integrated Care Boards;
- LGBTQIA+ Staff Networks;
- Individual clinicians that TransActual has interacted with previously (including those who have previously signed up for TransActual's training and/or attended webinars);
- Royal Colleges;
- The General Medical Council (who also shared the survey on their social media channels);
- Trade unions and professional bodies with health members; and
- The NHS confederation.

Recipients who did not open the survey email also received a follow-up reminder.

In total, 646 people completed the survey between 11 November 2024 and 17 February 2025. The sample had the following characteristics:

COUNTRY

Nearly all participants (98%, 631) worked in England, with 4% (27) working in Scotland, 2% (15) in Wales, and 2% (12) in Northern Ireland. Of these, 1% (8) worked in all four countries, <1% (4) in three countries, and 2% (12) in two countries.

SECTOR

Most respondents (91%, 587) also indicated that they work for the NHS, with just over one in ten (11%, 72) working in the private sector, and 5% (30) in the non-profit/charity sector.

The most common combination of sectors was NHS and private (5%, 35), followed by non-profit/charity and NHS (2%, 12), private and non-profit/charity (1%, 6), and those working in all three sectors (<1%, 3). In total, 9% (56) of respondents worked in two or more sectors.

The most common medical sector for respondents to work in was general practice (39%, 253), followed by mental health (20%, 127). Just 5% (33) of respondents worked in gender-affirming care, while 41% (266) worked in an additional sector.

ROLES

Respondents represented a wide range of roles, most commonly being nurses (35%, 226), Allied Health Professionals (25%, 160) – a category that includes fourteen types of medical professionals,[44] General Practitioners / GPs (13%, 82), other medical doctors (13%, 82), and those who were in other medical roles (13%, 86). Pharmacists comprised just 2% (10) of respondents.

PRESCRIBERS

Just over one in three respondents (35%, 226) were prescribers, the majority of whom worked for the NHS (97%, 219). Most prescribers worked in general practice (60%, 13%) and the most common roles were GPs (35%, 79), nurses (33%, 75), and other medical doctors (27%, 61).

YEAR OF QUALIFICATION

Half of respondents received their primary (non-clinical) qualification before 2010 (50%, 326), with an average qualifying year of 2007 across all respondents (646). A further 31% (197) had received their qualification in the 2010's, and 19% (123) in the 2020's. Most had received their qualification in 1990 or later, with 1% (9) receiving their primary qualification before 1980, 10% (62) in the 1980's, and 19% (121) in the 1990's.

TRANS FRIENDS / FAMILY

Just under half of respondents had trans friends and/or family members (49%, 313), with 48% (309) stating that they do not and 3% (21) being unsure. This high proportion is likely due to this group being more interested and motivated to respond, in addition to our having reached out directly to LGTQIA+ networks to share the survey.

LGBTQIA+

Just under one in three respondents (30%, 194) stated that they identified as LGBTQIA+, with a further 2% (15) stating that they were unsure. This is higher than the national average, with the 2023 Annual Population Survey estimating that 4% of people identified as lesbian, gay, or bisexual[45] and the 2021 Census finding that 0.5% of respondents indicated that their gender identity and sex registered at birth were different.[46]

This indicates a skew in the sample. As with those with trans friends or family, this group was likely more interested and motivated to respond and more likely to have been aware of the survey through our direct communications with LGTQIA+ networks

Respondents who indicated that they identified as LGBTQIA+ also tended to have received their primary (non-clinical) qualification more recently, with an average qualification date of 2013 (n=194), compared to 2004 (n=437) for those who did not identify as LGBTQIA+.

This may reflect the fact that younger individuals tend to be more likely to identify as LGBTQIA+. For instance, the latest findings from the Office for National Statistics estimated that 10% of

those aged 16 to 24 identified as lesbian, gay, or bisexual, compared to 1% of those aged 65 or over.[47]

VIEWS ON TRANS IDENTITIES

Within our sample, just 4% (23) of respondents stated that they believe that being trans is a mental disorder, and 3% (18) stated that they would feel uncomfortable treating a trans client or patient. While this is encouraging, it is highly likely that these responses reflect our selection bias. Comparative statistics are not available within the UK population, but existing research suggests that within the general population these proportions are likely to be much higher.

In recent years, research has repeatedly found that support for trans people has been going down in the UK. For instance, 49% of respondents to a 2024 YouGov survey stated that people should be able to identify as a different gender to the one recorded at birth.[48] This figure is down six points from 2022, while those who disagree has risen from 25% to 35%. Most Britons now say that gender affirming surgery and GAHT should not be available through the NHS (57% and 51%, respectively).

A 2023 study by the National Centre for Social Research (NatCEN) also found that Britons' attitudes towards moral issues had generally become more liberal, with views towards trans people being the primary exception.[49] While YouGov found that a majority still support trans people changing their recorded sex on their birth certificate, NatCEN found the opposite, with just 3 in 10 people agreeing with this, while 4 in 10 disagreed.

These findings support our belief that this sample is more supportive of trans people than the general healthcare sector in the UK. However, the discrepancy between these findings and that within our research sample could also, at least in part, reflect that clinicians are more informed about trans people's identities and needs than the general public.

LIMITATIONS

Within our snowball sampling strategy and with this being a voluntary survey, in addition to there being a clear overrepresentation of LGBTQIA+ respondents, NHS staff, and people working in England, it is also highly likely that our sample has a disproportionate number of: (a) those who are most likely to be interested in and supportive of trans individuals; (b) those who have trans friends and/or family; (c) those who may have the most experience working with trans clients/patients; and (d) those who may be most likely to have engaged in training and/or be knowledgeable about the medical needs of trans individuals.

We are therefore cautious in our interpretation of our findings, as these likely sample biases inhibit the ability to generalise across the entire UK medical sector. However, TransActual also disseminated a survey to trans individuals across the UK during a similar period – **The 2025 Trans Lives Report**, with 4,013 responses. This and secondary data from external research have been used to help contextualise and triangulate our findings.

Comfort and Confidence Supporting Trans Patients

INTRODUCTION

In the majority of assessed areas, most respondents indicated that they felt comfortable and/or confident in supporting trans patients. This finding, on its own, could be a promising sign that health professionals are suitably trained and experienced to provide appropriate medical care and treatment for trans people. However, as will be discussed in subsequent chapters, measures of competence and confidence do not, in most instances, reflect levels of training or experience.

These figures are also at odds with our findings from our **2025 Trans Lives Report** and are likely to be inflated due to the general selection bias across our sample (see previous chapter).

MODERATE LEVELS OF COMFORT AND CONFIDENCE

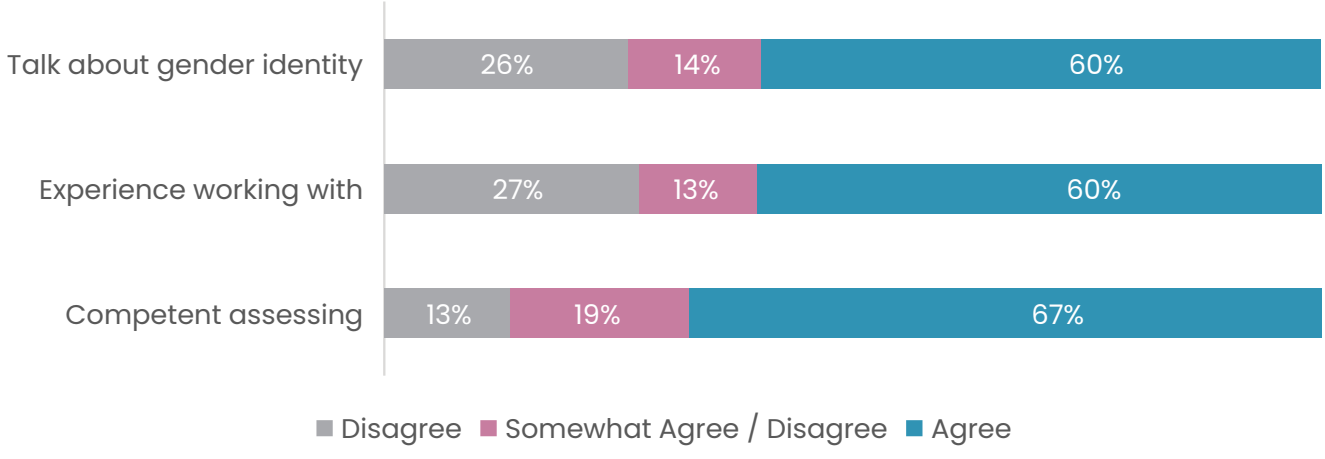
Across nearly all assessed areas (see Figure 2.1, below), most respondents indicated that they:

- Felt competent assessing a trans person in a therapeutic setting (67%; 436);
- Were very or extremely comfortable using trans-inclusive language (53%, 345) and patients' or clients' chosen names and pronouns (65%, 421);
- Knowingly had experience working with trans clients or patients (60%, 389);
- Felt prepared to speak with trans clients or patients about issues related to gender identity (60%, 386);
- Were very or extremely comfortable working with other medical professionals to support trans clients/patients (57%, 370); and
- Were aware of institutional barriers that may inhibit trans people from using healthcare services (73%, 473).

On their own, these findings could be promising, suggesting that most medical practitioners are prepared and comfortable when it comes to encountering trans clients or patients. However, these findings are at odds with our **2025 Trans Lives Report** and likely reflect a general bias across our sample, as discussed in the Methodology section. Nonetheless, even with this likely slant in our sample, 26% (168) of respondents still stated that they did not feel comfortable talking to patients about their gender identity.

2025 Trans Lives Report reports on a survey of 4,008 trans respondents. 52% (1,830) of respondents to that survey stated that they had experienced transphobia in a medical setting, including 60% (129) of People of Colour. Specifically, 33% (1,175) reported having experienced transphobia from a GP, 15% (548) from a nurse, and 12% (429) from a pharmacist.

Figure 2.1. *Participants' reported agreement with statements about confidence and comfort supporting trans patients*



IMPLICATIONS

These findings suggest two potential ramifications. First, it is likely that comfort and confidence do not often or always reflect holding necessary knowledge sets, such as would be obtained through receiving relevant training and/or supervision (as is discussed in the following chapter). Secondly, as has been previously explained, it is likely that those who are less comfortable and/or confident are significantly under-represented in this survey.

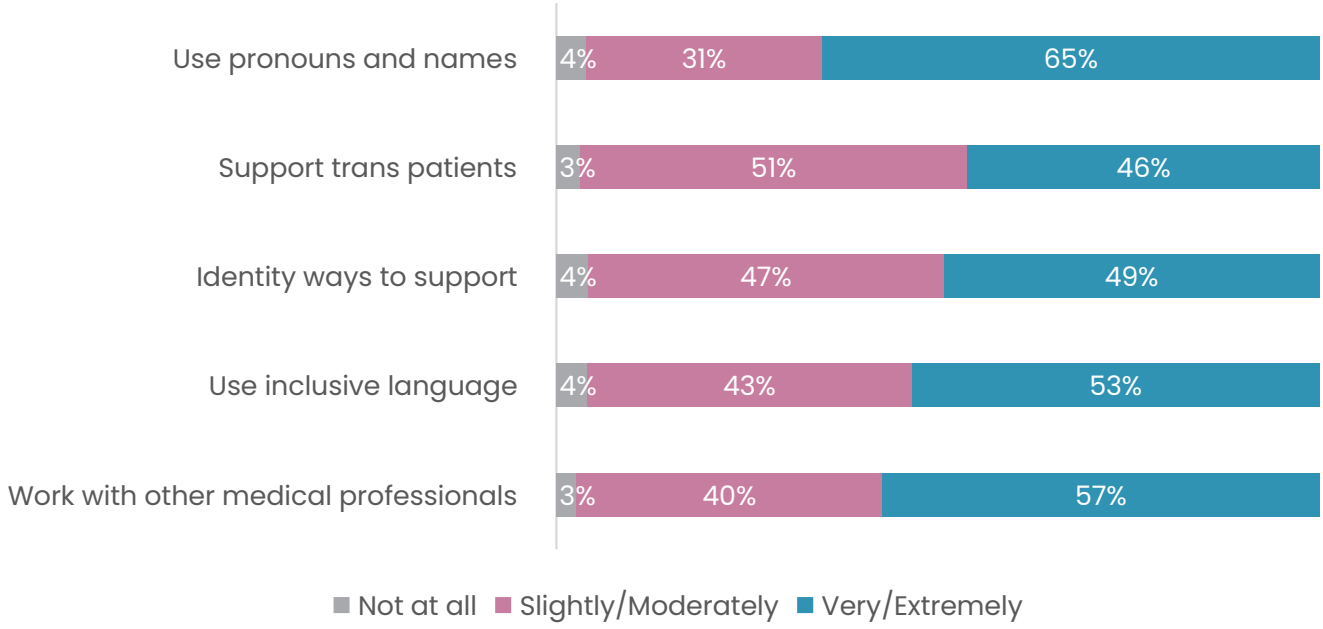
However, it is also of note that, within this sample, while most people indicated they held some confidence and/or competence, these sentiments were less likely to be strongly expressed. For instance, while 67% (436) responded affirmatively when asked if they agreed that they felt competent assessing a trans person in a therapeutic setting, only a fifth (20%, 129) stated that they strongly agreed with this.

This was particularly noticeable when asking about participants' experiences of knowingly working with trans patients. While most respondents (60%, 389) agreed that they did have this experience, they were unlikely to strongly agree with the statement (23%, 151). This suggests that interactions with trans patients were in some way limited, perhaps due to having only been brief, relatively superficial, and/or only with one or a limited number of trans people.

Respondents may also have been unsure if the individual(s) identified as trans, though just 13% (81) of respondents provided a neutral answer to this statement, which might indicate uncertainty. Just over one in four respondents (27%, 176) disagreed that they had experience working with trans patients.

Respondents were the least likely to respond in a strong affirmative to the question about their abilities to support trans patients. Nonetheless, 46% (298) still said they were very or extremely comfortable in their ability to provide support, with just over half (51%, 328) stating that they were slightly or moderately comfortable (see Figure 2.2, below).

Figure 2.2. *Participants' reported comfort and confidence in supporting trans patients*



CONCLUSION

As these findings show, most respondents indicated confidence and comfort in most questions about supporting trans patients. While these numbers may appear promising, they represent a sample where people interested and/or experienced in supporting trans patients are very likely to be over-represented. In a general sample of medical practitioners across the UK, it is likely that findings would demonstrate a far higher proportion of participants who would not feel comfortable or confident in, for instance, using correct pronouns and names or supporting trans patients.

In addition, levels of confidence and comfort were often more likely to be moderate to low than they were to be high. These findings reflect the high likelihood of an overrepresentation of those most interested in and/or experienced in supporting trans patients, particularly as these findings are in stark contrast to our recent **2025 Trans Lives Report**. These findings indicate that limited confidence and comfort may undermine the provision of appropriate care for trans individuals, underscoring the importance of targeted education and skills development.

Access to training and relevant experience

INTRODUCTION

While most respondents indicated that they felt prepared to talk to trans patients about their gender identity and felt competent assessing trans patients in a therapeutic setting, most did not think they had received adequate training and/or supervision about trans people's identities and the issues they might encounter. Several respondents said their knowledge was based entirely on experiences with trans patients, while others stated that they had no experience at all.

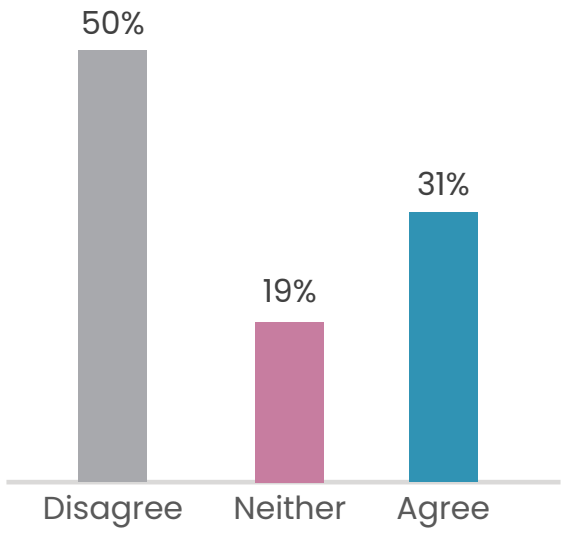
A LACK OF RELEVANT TRAINING

In comparing this survey's findings with our **2025 Trans Lives Report**, this suggests that, in addition to the likely overrepresentation of those most interested and experienced in supporting trans patients, confidence and comfort may not reflect experience or knowledge of appropriately supporting trans individuals in a medical setting.

Specifically, less than one in three respondents (31%, 202) agreed they had received enough training and supervision, including just 7% (45) who strongly agreed. Half (50%, 324) disagreed. Respondents were more than twice as likely to strongly disagree (18%, 119) than to strongly agree with this statement.

In our **2025 Trans Lives Report**, of the trans people who reported experiencing transphobia from a GP, 97% stated that this was (at least in part) due to a lack of their GP's knowledge around trans issues. A further 89% (879) reported that they had been misgendered by a medical professional (i.e., referred to by a gendered term that did not reflect their gender identity).

Figure 3.1. *Agreement that they have received adequate training/supervision to support trans patients*



CONNECTING ACCESS TO TRAINING WITH COMFORT AND CONFIDENCE

In line with previous research,[50,51] this survey found that professionals who reported having received adequate levels of training were more likely to report higher levels of confidence and comfort across all areas. While 94% (190) of those who reported adequate levels of training stated that they felt competent assessing a trans person in a medical setting, the same was true for just 36% (259) of those who had not received adequate training (see Figure 3.1, above).

Some respondents who indicated that they had not received adequate levels of training or supervision to support trans patients still indicated high levels of confidence and comfort in doing so. However, those who had received training remained much more likely to report confidence and comfort in all areas.

For instance, of those who stated they had not received sufficient training, 49% (159) agreed that they were competent at assessing a trans person in a medical setting, compared to 94% (190) of those who reported having received

enough training (see Figure 3.2, below). Just over half of those who reported not having received enough training or supervision also felt prepared to talk to trans patients about their gender identity (52%, 170), compared to 73% (148) of those who reported having received enough training.

Figure 3.2. *Levels of confidence and comfort based on receipt of adequate training*

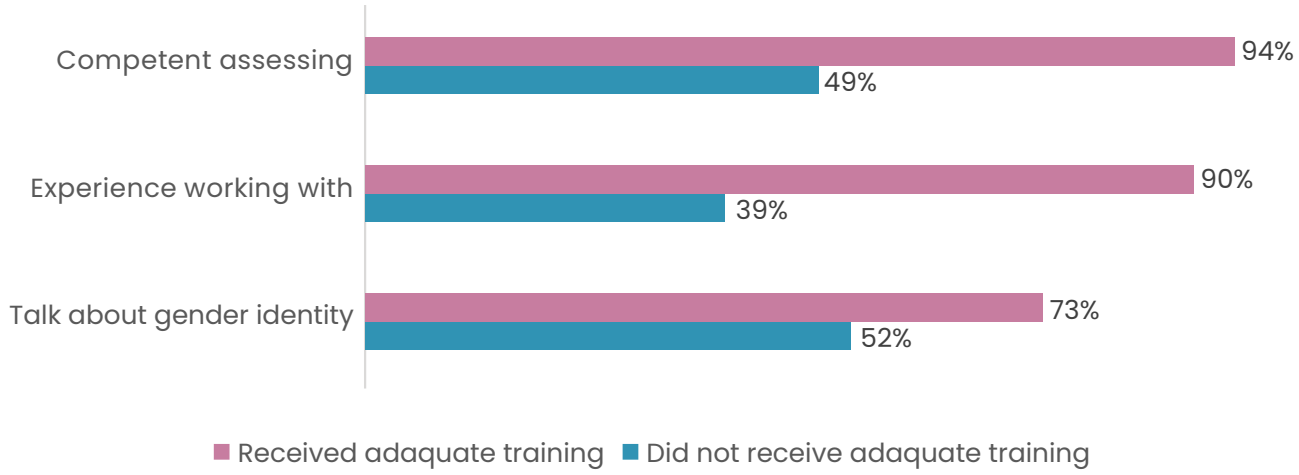
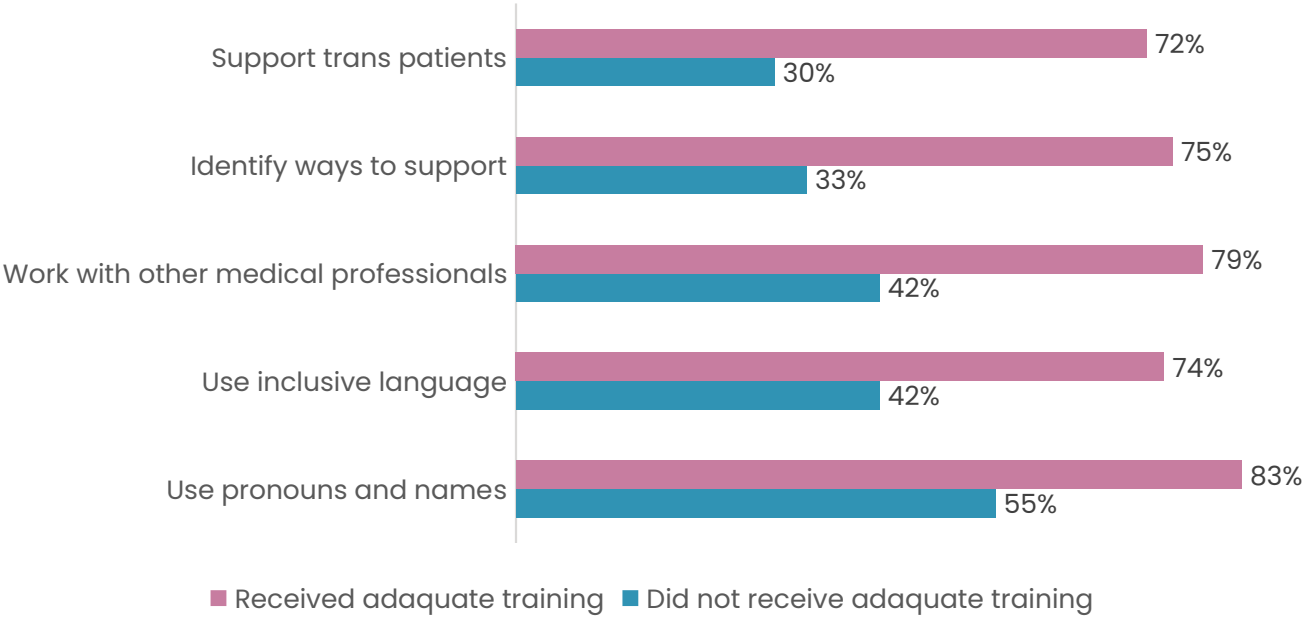


Figure 3.3*. Additional measures of comfort and confidence based on reported receipt of adequate training*



BARRIERS TO ACCESSING RELEVANT TRAINING AND KNOWLEDGE

Within this survey of healthcare professionals, when respondents were asked why they had indicated their specified level of confidence in supporting trans patients, a lack of knowledge and/or training (34%, 120) emerged as the most common response. Many made statements indicating that there were no opportunities to receive training or guidance around supporting trans people.

> "I have not received any formal training or information from our Trust on this".

NHS ANAESTHETIST

> "I have only met a very small number of individuals who have described themselves as transgender and I have not received training in this important area".

NURSE WORKING IN PUBLIC HEALTH

This lack of formal training and supervision could lead to practitioners feeling out of their depth when it came to working with trans people, including not knowing where to refer on, as one respondent working for the NHS in general practice explained: *"I'm not aware of any organisations to refer to for further support".* In the context of multi-year waiting lists and challenges in accessing transition-related services, this can be particularly difficult for an already overstretched NHS.

> "I think there is little training for an increasingly common consultation. The use of hormones are out of my comfort zone and when asked to request monitoring bloods I often feel unable to interpret them prior to sending them back to secondary service. The services are overstretched and the process is long for patients involved".

NHS GP WORKING IN GENERAL PRACTICE

Some expressed ambivalence in their ability to raise concerns about the lack of training in this area, citing a climate where showing support for trans people in a professional setting can be seen as contentious.

> "I don't think there is enough mandatory training/support from my Trust but I also think there is such a negative perception about trans people from everyday people that even raising this is seen as controversial for some".

NHS ALLIED HEALTH PROFESSIONAL WORKING IN THE COMMUNITY

In some instances where training or supervision had not been provided, respondents felt that they had been able to obtain necessary skills and knowledge through experience. Comments related to experience working with trans folks were common (27%, 94), with 16% (57) of respondents describing experience as the reason they felt confident in their ability to support trans people in a medical setting. For these respondents, the act of working with a trans patient could be their main (or only) opportunity to learn about how to support this population, using interactions to gain skills and knowledge through experience.

> "I feel that there has been little training in supporting transgender patients and therefore, it is difficult to understand how best to meet the needs of transgender patients. Much of my knowledge stems from direct work with transgender patients and their discussions on their lived experiences".

NHS SOCIAL WORKER IN MENTAL HEALTH

> "[I] have come across few transgender patients and learned with exposure".

NHS NURSE WORKING IN GENERAL PRACTICE

> "I have never had any training in this area. I have some transgender patients so I have some hands on experience through them and learnt on the job".

NHS GP WORKING IN GENERAL PRACTICE

> "I've used each experience I've had with transgender clients as [a] learning experience".

NHS NURSE WORKING IN MENTAL HEALTH

Learning how to support trans patients through the act of supporting individual trans people can put these patients in the difficult position of needing to self-advocate, despite being unlikely to be knowledgeable about systems

and medical options themselves. Whilst it is a key way to develop skills and knowledge, relying solely on direct experience places an undue burden on patients. It also leads to inequities in services, where providers in areas with a higher trans population (e.g., London, Brighton, or Manchester) may be more likely to be better equipped to provide appropriate care. As discussed in the previous chapter, 27% (143) of respondents reported not having experience working with trans patients, with a further 13% (81) being unsure. In open responses, 11% (37) indicated that a lack of experience was the reason they did not feel confident or felt less confident supporting trans patients in a medical setting.

> "Lack of experience makes me nervous. I wouldn't want to cause harm".

PRIVATE PSYCHOTHERAPIST

> "I have some experience working with transgender patients, but this was quite a few years ago and to my knowledge, I haven't worked with any transgender patients in my current role".

NHS ASSISTANT PSYCHOLOGIST

While less common than responses relating to clinical experience, some described accessing training as the primary reason they felt competent in caring for trans patients. However, some of the professionals who had found other avenues for training and learning described having accessed these themselves, by being proactive and/or by paying out of pocket rather than the content being available through standard training routes or as part of their workplace's routine training offer.

DISPARITIES IN WHO IS ACCESSING TRAINING

It is likely that those who are most likely to seek out learning opportunities proactively may be those who are already most interested in and knowledgeable about trans needs and identities. For instance, of the 4% (15) of respondents who explicitly stated that they had paid for or sought out additional training, 67% (9) identified as LGBTQIA+, 73% (11) had LGBTQIA+ friends or family, and none thought that being trans is a mental disorder.

> "I have done further training paid for myself on gender identity healthcare".

NHS GP WORKING IN GENERAL PRACTICE

> "It's an area of work I feel quite strongly about and I try to educate myself outside of work".

NHS SOCIAL WORKER WORKING IN MENTAL HEALTH

Personal investment in trans issues was a key reason that many had chosen to further educate themselves, with nearly one in six respondents (14%, 51) discussing how their own experience and/or identity had contributed to their ability to support trans patients. These comments generally referred to individuals identifying within the LGBTQIA+ umbrella and/or having trans friends or relatives.

> "I have a trans nephew. My son (aged 24) has friends who are trans and some who are non-binary. I am an ally of trans people".

NHS ALLIED HEALTH PROFESSIONAL WORKING IN GENERAL PRACTICE

> "I have trans/non-binary friends. However, [I] don't know what resources are out there to further support medical patients".

NHS ALLIED HEALTH PROFESSIONAL WORKING IN GENERAL PRACTICE

> "I grew up with trans friends and teachers at school – I try to keep up with trans related news and such to stay informed with current trans struggles to see how I can support".

NHS ALLIED HEALTH PROFESSIONAL WORKING IN MORTUARY / BEREAVEMENT

These findings indicate that it may be extremely difficult for many in the UK health sector to access the training necessary to adequately support trans patients, leaving it up to those most interested to proactively seek out this information and/or pay out of pocket to access training.

With services and GPs already overstretched and filling in a wide range of service gaps,[52,53,54] learning how to support trans individuals can be seen as an additional burden that practitioners do not feel able to take on. This is particularly true where clinicians perceive that trans-specific healthcare (such as monitoring and prescribing GAH) is not part of the general GP contract.

> "It is not funded or resourced in General Practice, not part of the curriculum and not GMS [General Medical Services], so there is no capacity to offer this care".[55]

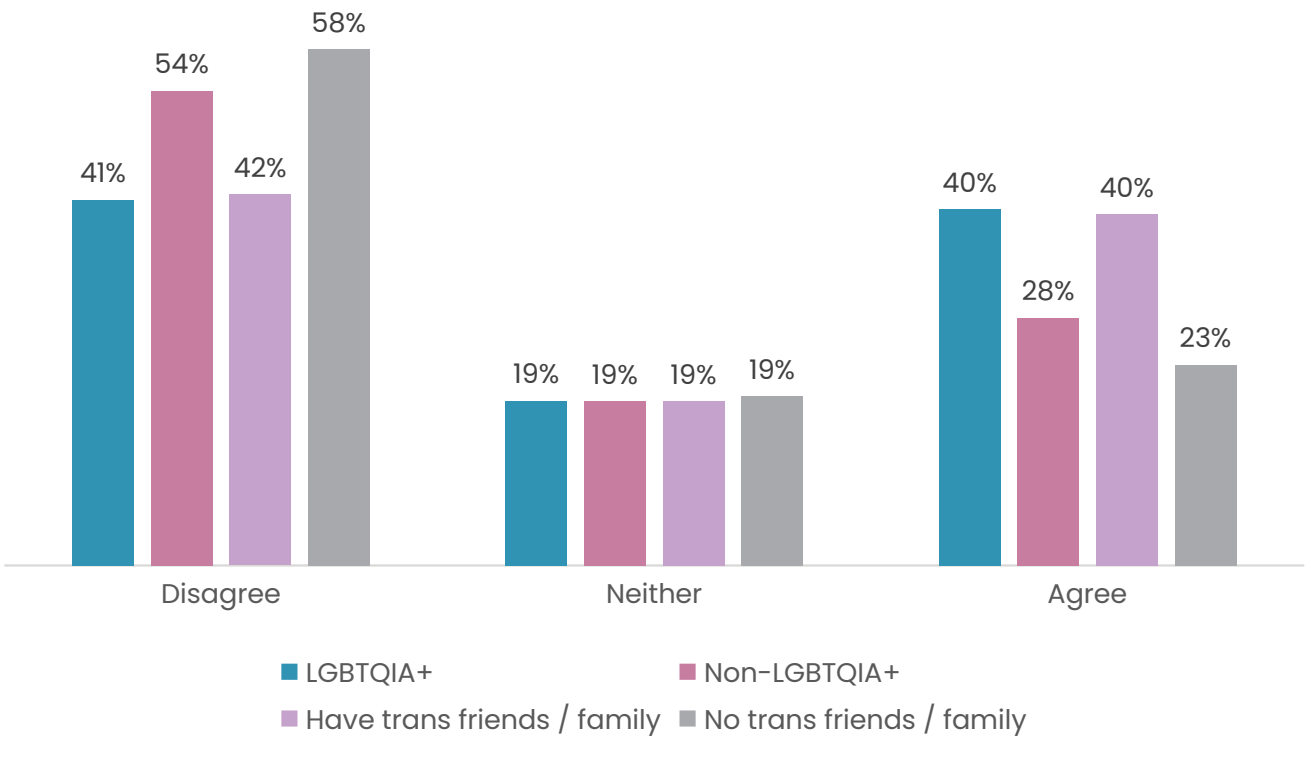
NHS GP WORKING IN GENERAL PRACTICE

This also means that those less interested in supporting trans patients, particularly professionals with prejudicial views about trans identities, may be the least likely to receive adequate training and/or knowledge.

In our survey, LGBTQIA+ respondents were more likely to indicate that they had received adequate training and/or supervision, including 40% (78) of LGBTQIA+ respondents and 28% (122) of non-LGBTQIA+ respondents. Similar findings emerged for those with trans friends or family, where 40% (124) stated that they had received enough training or supervision, compared to 23% (70) of those without trans friends or family.

However, some of the professionals who had found other avenues for training and learning described having accessed these by being proactive and/or by paying out of pocket rather

Figure 3.4 *Participants' perceptions of having received adequate training*



than the content being available through standard training routes or as part of their workplace's usual training offer.

Discrepancies in who is accessing relevant training are furthered by the reality that many need to be proactive (potentially even paying out of pocket). This trend persisted when analysing respondents by their beliefs and opinions about trans people. Of those who stated that they believe being trans is a mental disorder (though a much smaller group than those who do not hold this belief), 22% (5) stated that they had received adequate training/ supervision, compared to 34% (192) of those who did not. Similarly, 11% (2) of those who felt morally uncomfortable treating a trans person felt they had received enough training, compared to 33% (200) who stated that they would not feel morally uncomfortable.

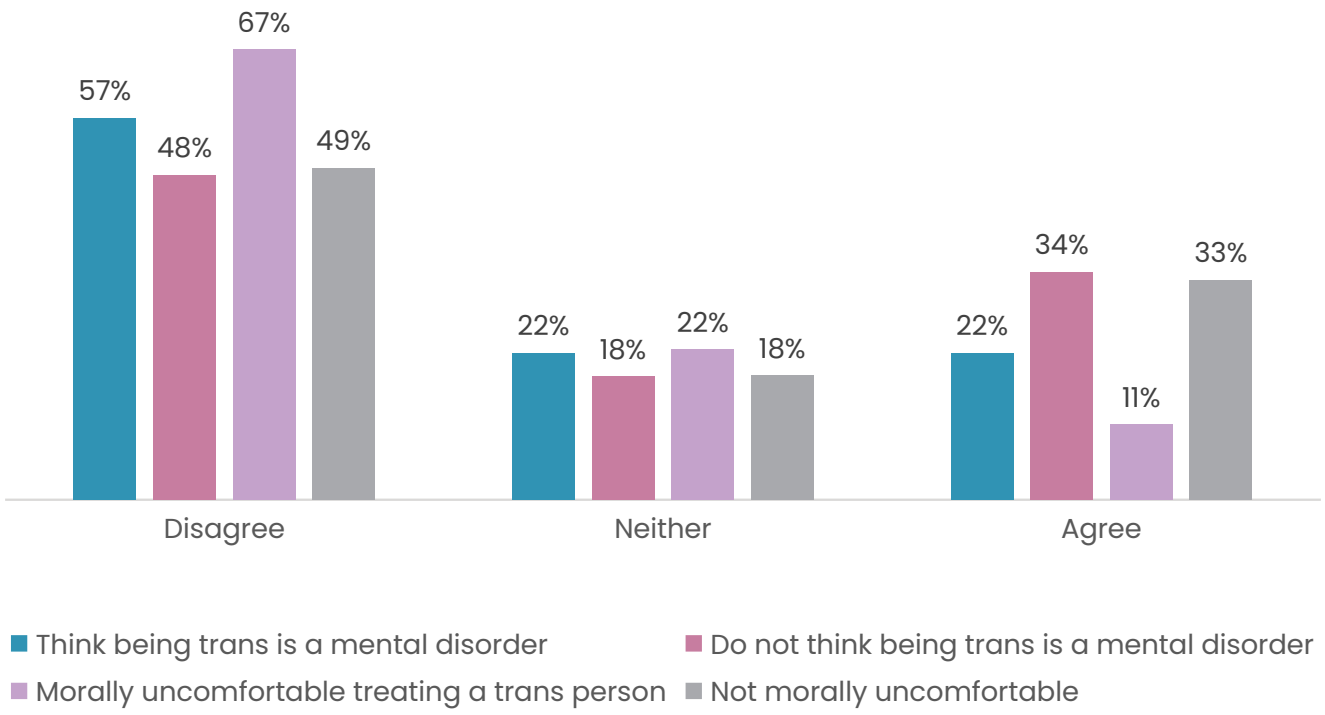
OBTAINING ADDITIONAL INFORMATION

The ability of practitioners to obtain essential knowledge is reliant not only on their access to training but their ability to know where to look to find relevant information when they need it. Worryingly, less than one half of respondents indicated that they were very or extremely comfortable in their ability to identify ways to learn more about supporting trans patients (49%, 318), with a further 47% (301) feeling slightly or moderately comfortable. This means that just over half of respondents do not feel fully confident in their ability to access the information necessary to support trans patients.

> "I would like to receive more training but do not know where to access this".
>
> **ALLIED HEALTH PROFESSIONAL WORKING IN MENTAL HEALTH FOR THE NHS AND PRIVATE SECTOR**

This is most concerning where individuals may have views that do not support trans identities and may therefore be least likely to proactively seek out training and/or supervision in this area. As an NHS Allied Health Professional working in mental health explained: *"I also have experienced colleagues in this team who are anti-trans people who I would be worried about how they work with transgender patients".*

***Figure 3.5**. Whether participants had received adequate training based on their beliefs and feelings about trans people*



CONCLUSION

The low proportion of respondents who reported receiving adequate training and/or supervision about supporting trans patients, especially amongst those who do not identify as LGBTQIA+ and/or have trans friends or family, is a particularly concerning finding. Whilst it is good that respondents still felt confident and/or comfortable supporting trans people in a medical setting, they were still unlikely to be fully confident in their ability to access additional information. The fact that many people are learning by experience without access to specific training is likely to put many trans people in the uncomfortable position of being both an educator and a patient, needing to self-advocate about systems and treatments due to their clinician's lack of knowledge.

In summary, professionals who identify as LGBTQIA+ and/or have trans friends or family were the most likely to report accessing training and the most likely to proactively seek out training. Those who believed that being trans is a mental disorder and/or reported that they would be morally uncomfortable treating a trans person were the least likely. It is not clear if it is the lack of training that causes these individuals to have these views or if it is because of these views that these individuals would avoid attending/accessing training related to trans identities (or a combination of both). Further research is likely to be needed in this area to understand how to best work with medical practitioners who hold these views.

Experiences and views on Prescribing Gender-Affirming Hormone Therapy (GAHT)

INTRODUCTION

While not all trans people choose to access Gender-Affirming Hormone Therapy (GAHT), many do. In our **2022 Transition Access Survey**, we found that 88% (1,046) of respondents had either accessed GAHT or planned to do so in the future.[56] Prescriptions for GAHT are traditionally provided through a shared care agreement, usually between a patient's primary GP and a private or NHS-funded Gender Identity Clinic (GIC).

NHS GICs are currently seeing patients for an initial appointment who have been on a waiting list for up to eight years. Those joining waiting lists now are likely to wait many years more if urgent action is not taken. This leaves many trans people without access to GAHT through the NHS. Even after lengthy waits for initial appointments, patients commonly wait another year or longer to access GAHT through the NHS.

Our 2022 research found that NHS patients waited an average of 325 days between their first appointment and receiving a GAHT prescription.[57] Waiting times can, however, be shortened by a bridging prescription, where a GP prescribes GAHT until the person can see someone from a private clinic or NHS GIC. Bridging prescription waiting times were nearly 50% shorter than those through a GIC, averaging 170 days after initial appointment (and without the multi-year wait for an initial appointment). However, in this study, we found that, of all mechanisms for providing GAHT, bridging prescriptions were the least commonly used. This reflects the reality that NHS GPs are becoming increasingly reluctant to provide bridging prescriptions, while being more likely to refuse shared care with NHS GICs.[58]

The 2022 Transition Access Survey found that, where people can afford to, more are turning to private clinics for GAHT, where waiting times are exponentially shorter.[59] Patients are also likely to self-medicate, where the risk of taking incorrect doses, taking counterfeit medicines, or having adverse side effects can be high. Average waiting times for a first appointment through private clinics was just 67 days, nearly ten times less than the GIC with the shortest current waiting time (two years) and more than 40 times shorter than the GIC with the longest current waiting time (eight years). Waiting times from first appointment to accessing a GAHT prescription were 113 days for those with a private prescription, less than one-half of the NHS average.

In this research we found that, despite the many barriers and long delays in accessing NHS gender clinics and the infrequent use of bridging prescriptions, providers may still be reluctant to work with private providers. This reflects the increasing number of people reaching out to TransActual who are unable to obtain a bridging prescription or find an NHS GP willing to have a shared care agreement with a private provider.

With our findings that most practitioners will not have received training specific to transition-related medical care (see previous chapter), it is not surprising that many practitioners prefer to work alongside a specialist through a shared care agreement. Respondents described the pathways to accessing specialist support as complex, constantly changing, and difficult to navigate.

It was common for practitioners to have used a range of different mechanisms to prescribe GAHT. Just over one in three prescribers who had provided GAHT (38%, 19) had used only one mechanism, with 14% (7) having used all four, 30% (15) having used three of four, and 18% (9) having used two. The most common responses were: shared care with a private clinic, shared care within the NHS, and a continuation prescription (20%, 10); shared care with the NHS only (18%, 9); and those who had utilised all four mechanisms (14%, 7).

Over one-third of those who had been asked had never approved a GAHT prescription request (36%, 31), with a further 6% (5) being unsure if they had ever approved a prescription.

PRESCRIBERS

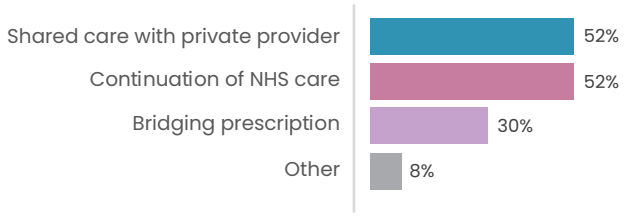


Figure 4.1. *Prescribers Administering GAHT Prescriptions When Asked*

Most prescribers (62%, 139) indicated that they had not had a patient ask them to prescribe GAHT. Only one person was unsure about this.

Unlike the entire sample of prescribers, those who had been asked to prescribe GAHT were more likely to work in general practice (87%, 75) and be a GP (77%, 66). Few nurses (10%, 9) or other types of medical doctors (10%, 9) had been asked to prescribe GAHT. None were from the non-profit or charity sector, and all worked in England.

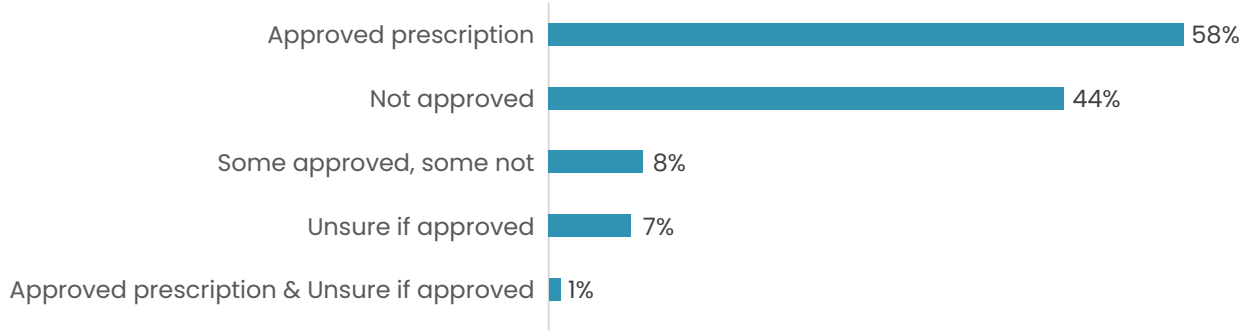
Across all prescribing GPs (96% of all GPs, with three newly qualified GPs indicating they were not prescribers), the majority (80%, 75) stated that they had been asked to prescribe GAHT, while the reverse was true for all other professions. For instance, of the 26% (21) of doctors who aren't GPs but are prescribers, just 15% (9) stated that they had been asked to prescribe GAHT. This was also the case for 12% (9) of prescribing nurses and 33% (2) of prescribing pharmacists.

PROVIDING GAHT PRESCRIPTIONS

Of those who had been asked, just over one-half (58%, 50) had provided at least one prescription for GAHT, while 44% indicated that they had not (44%, 38), and 7% (6) were unsure (see Figure 4.1, left). Respondents were able to select multiple options to specify if they had, for instance, approved a prescription for one patient but not authorised a prescription for another. Of those who selected multiple responses, 8% (7) indicated that, while at least one of their patients had received a prescription, at least one had not. One respondent who had provided a prescription (or prescriptions) was unsure if they had not authorised a prescription for other patient(s).

Most respondents (62%, 31) had provided a GAHT prescription within more than one context (see Figure 4.2, below). Prescriptions were most commonly provided through shared care agreements with an NHS GIC, which 80% (40) of those who had approved a prescription had used. Prescribers were also somewhat likely to have provided GAHT through shared care with a private provider or continuation of NHS care (52%, 26 for each), while being least likely to have used a bridging prescription (30%, 15).

Figure 4.2*. Prescribers Administering of GAHT Prescriptions When Asked*



NOT PROVIDING GAHT PRESCRIPTIONS

The most common reasons given for not providing a GAHT prescription were due to either the prescriber not feeling competent to authorise the prescription (58%, 22) or policy constraints (see Figure 4.3, below), including where there was a lack of policy (either at practice, Primary Care Network, or Integrated Care System level) (55%, 21).

> "Prescribing of hormones is still challenging as we feel we do not have the expertise as GPs, yet we are under huge pressures to prescribe as patients do not have other viable options. Technology [and] IT systems – EMIS specifically – don't help with gender/ pronouns well".[60]
>
> **NHS GP WORKING IN GENERAL PRACTICE**

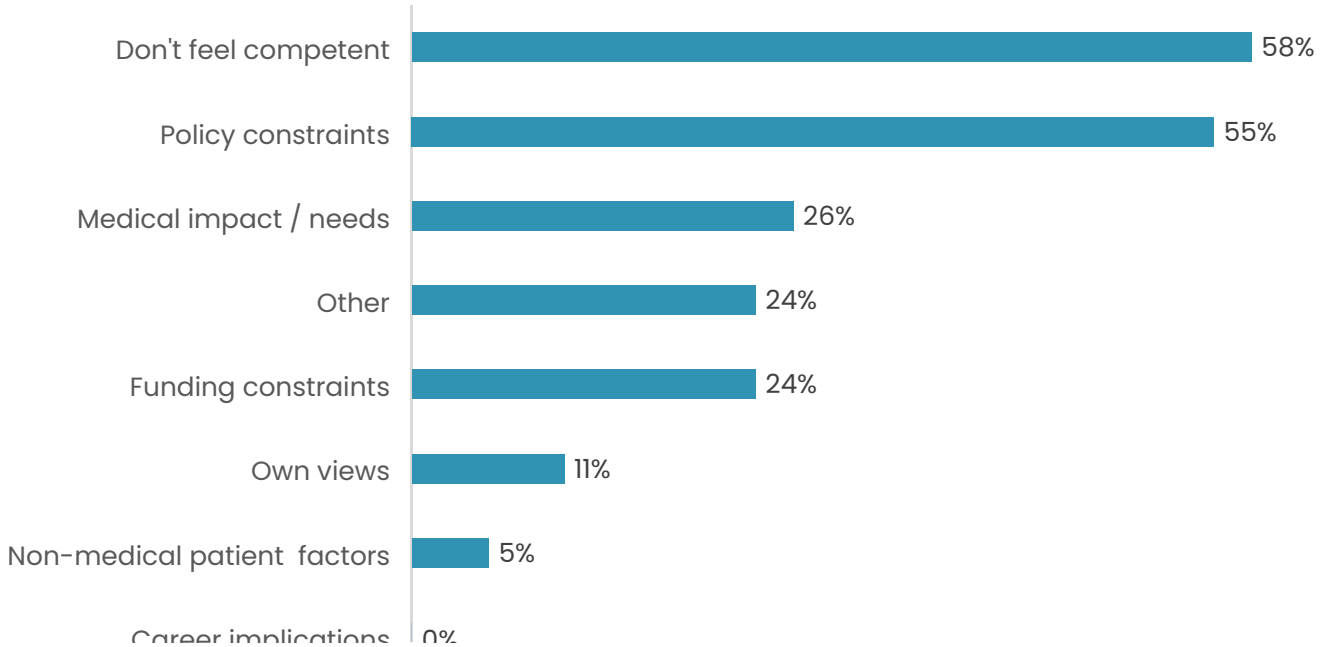
Those who provided additional reasons for not prescribing GAHT when they had been asked to (24%, 9) commonly discussed issues related to not having specialist input or a specialist to work with, including rejecting patients who had received support privately. The lack of infrastructure to create and maintain shared care agreements with NHS GIC's and/or private clinics was also mentioned by multiple responses, such as one GP who stated, *"Private patient not under shared care prescribing"*.

It is of note that most respondents gave more than one reason for not prescribing, with the average respondent providing two reasons and 33% (14) providing three or four reasons. This could be because they had rejected one individual's request for several reasons or because they had denied multiple people for different, possibly overlapping reasons.

This finding suggests that eliminating one barrier (e.g., training individuals so that they feel more competent to write prescriptions for GAHT) may not in itself be sufficient to enable prescriptions to be written, where it is appropriate to provide them.

Where individuals' own views about trans people are inhibiting them from writing prescriptions, which was the case for 11% (4) of those who had not provided a prescription, further work may be needed to ensure robust policies and procedures prevent personal bias from affecting medical practice.

Figure 4.3 *Reasons for not providing GAHT*



This need for policies was particularly apparent for those who had been asked to prescribe GAHT but had never done so, all of whom had provided only one reason for this, and all under the 'other' category. Responses included:

> "No shared care agreement with GID clinic and an abject disinterest from Specialists in appropriately supporting General Practice in providing this – a badly commissioned pathway".

GP WORKING IN NHS GENERAL PRACTICE

> "[GAHT is] not under NHS specialist care and therefore [there is] no shared care in place. NHS shared care is essential before [providing] any prescription for specialist medication".

GP WORKING IN NHS GENERAL PRACTICE

> "No specialist input".

NHS NURSE

One medical doctor working in sexual health who had never provided a GAHT prescription stated that this was because they were *"not commissioned to supply hormones"*. Similarly, a dermatologist working for the NHS stated that this was *"beyond [the] scope of [their] current clinical practice as [a] dermatologist"*.

While these responses correctly reflect that these practitioners' specialisms are not related to the provision of GAHT, that they were asked may reflect increasingly common situations where patients are struggling and/or unable to access GAHT through the usual NHS channels (i.e., their GP and/or an NHS GIC).

Other responses demonstrated where practitioners are unlikely to ever provide a GAHT bridging prescription. This included one NHS GP working in general practice who stated that they *"waited until [a] gender clinic recommended [the] prescription"*. Another NHS GP working in general practice demonstrated a lack of understanding of GAHT and the research supporting its provision, incorrectly described it as an *"unlicensed medication with unknown long-term safety profile"*.

CONCLUSION

Responses demonstrate the complex environment patients must navigate to access GAHT, including many potential barriers. In this environment, patients may not only need to be knowledgeable enough to advocate for specific medical needs but are likely to face uncertainty as to whether their GPs will be willing to work with a private provider, provide a bridging prescription, and/or be supportive of a request for GAHT.

These issues around prescribing are also likely to contribute to situations where trans people may avoid seeking necessary medical care. In our **Trans Lives Report 2025,** 22% (812) of respondents reported having been denied non-transition related healthcare due to their trans identity. A further 64% (2,456) stated that they had avoided going to the GP, even if unwell, because of concerns about discriminatory treatment. These figures were even higher for disabled people (67%, 1,598) and people of colour (70%, 153).

Our findings suggest that GPs working in general practice are the group most likely to receive requests for GAHT, with 84% (66) of all prescribing GPs having been asked to prescribe GAHT. This finding was, of course, to be expected but highlights just one of many reasons that staff working in GP practices should be given more support to provide adequate care for their trans patients.

Additional Systemic Barriers

The systemic challenges described regarding providing GAHT prescriptions reflected some of the systemic barriers raised by respondents in relation to supporting trans patients. One NHS nurse working in general practice stated: "*I feel like my ability [to support trans patients] is hindered by the structure and policies of the NHS*".

Others discussed how the NHS, specifically, was not structured appropriately for trans patients.

> "I support as best I can, but the systems are limited and transphobic".

ALLIED HEALTH PROFESSIONAL WORKING IN MENTAL HEALTH FOR THE NHS AND PRIVATE SECTOR

Many described structural barriers, including how services and service pathways to support trans individuals are routinely under-funded, if they're funded at all, and can frequently change, causing confusion and difficulties in accessing appropriate pathways.

> "I don't feel confident in my knowledge of local and national services, as it changes often and can be labyrinthine!"

ALLIED HEALTH PROFESSIONAL WORKING IN MENTAL HEALTH FOR THE NHS AND PRIVATE SECTOR

> "It is not funded or resourced in General Practice, not part of the curriculum and not GMS, so [there] is no capacity to offer this care".

NHS GP WORKING IN GENERAL PRACTICE

The complexity and evolving nature of these pathways, coupled with medical practitioners' limited understanding, places an undue burden on patients to be sufficiently informed and to know exactly what to request to secure appropriate care. When it is difficult to find this information through the NHS, this can require tapping into local networks of trans people.

Some respondents described technical barriers, including how IT systems can inhibit the use of appropriate pronouns or the flagging of necessary medical tests. This included how, while patients can change their sex on their NHS record, systems do not adequately support this change in practice. This can mean that, for instance, trans men over 50 are not automatically offered a breast cancer screening, while others may not automatically receive reminders for cervical screening or prostate exams, depending on their GP's knowledge about caring for trans patients and the opt-in system for the cervical cancer screening programme.

> "Technology [and] IT systems – EMIS specifically – don't help with gender/ pronouns well".

NHS GP WORKING IN GENERAL PRACTICE

> "I don't think EMIS is well set up for transgender patients. … We are supposed to counsel about not being invited for cervical screening for example … I think there should be the ability to invite anyone for any screening and not put back to them to ask".

NHS GP WORKING IN GENERAL PRACTICE

The result is that, as with instances where trans patients serve as the main source of 'training' for medical practitioners, individuals need to proactively obtain necessary knowledge and seek out essential procedures independently, potentially facing additional barriers when doing so. This challenge is furthered by issues with accessing specialist support, as discussed in the previous chapter.

> "My ability to support transgender patients is limited by the difficulties accessing specialist transgender care".

NHS GP WORKING IN GENERAL PRACTICE

> "I only know some support services".

– NHS GP WORKING IN GENERAL PRACTICE

Building on previous research, a range of barriers to supporting trans patients in a medical setting have emerged from this study.[61] Findings suggest that patients need to be heavily reliant on their own knowledge base and ability to proactively access appropriate medical treatment and care, while the care they receive remains reliant on practitioners' personal views and willingness to seek out further knowledge.

There were examples where communities, practices, and/or hospitals were taking active steps to appropriately support trans patients.

Some responses also highlighted the benefits of having easy access to support from specialist colleagues.

> "I have sought out to learn from the trans community and try and be the best ally I can. In Greater Manchester, we have the Indigo Clinic, so our patients are better supported and I have more guidance regarding prescribing their hormones as I have clinic letters and personalised plans in place".[62]

NHS PHARMACIST

While this study's main aim was not the identification of systemic barriers trans people may face in a medical setting in the UK, these findings can help expand on earlier work, particularly Mikulak *et al.* (2021)'s barrier classification. Table 5.1 provides an updated version of their classification, with the addition of information obtained from this study. A broader understanding of the barriers faced by trans people in a medical setting can help ensure targeted support, training, and resources are used as efficiently and effectively as possible.

Table 5.1. *Medical professionals' barriers to supporting trans patients*

CATEGORY	BARRIERS
STRUCTURAL	– Shortage of gender clinics – Lengthy waiting times – Inadequate / no guidance from local commissioning groups – Lack of policies and support in managing shared agreements when working with private (used increasingly due to long waiting times) or NHS clinics – Clinicians and patients struggling to access appropriate specialist support – Lack of policies and/or protocols for offering bridging prescriptions – Over-burdened medical professionals taking on increasing level of specialist care due to lengthy waiting times – Not routinely requesting preferred names and pronouns – Lack of policies leading to high level of discretion on part of medical practitioners
EDUCATIONAL	– Insubstantial / no training about trans health / identities – Lack of knowledge of local resources for signposting – Lack of awareness of appropriate local specialists – Learning from experience of working with trans patients rather than from training or supervision, placing undue burden on patients – Relying on a small number of trans people's stories for essential knowledge, obscuring how gender identity intersects with other marginalised identities/experiences (e.g. race, disability, care leavers) and perpetuating a narrow understanding of trans people's experiences and needs
CULTURAL AND SOCIAL	– Individuals' negative attitudes and/or prejudice toward trans people and identities, including denying the legitimacy of trans identities – Misconceptions that GAHT is unsafe and/or an unwillingness to prescribe GAHT – Insufficient awareness of non-binary identities – Communication challenges, including not being familiar with trans and gender-diverse identities, pronouns, and titles – Fear of "getting it wrong" (e.g., not being confident in correct language to use) leading to inaction – Beliefs that specialist knowledge is not needed to appropriately treat trans patients – Environment where discussing or raising issues related to supporting trans patients is seen as combative/controversial
TECHNICAL	– Inflexible data management systems inhibit recording a person's trans status in addition to their sex (e.g., whilst a trans man can change the sex marker on his medical record to male, data fields aren't available to note that he is trans). – Systems not correctly assessing appropriate care for patients (e.g., breast cancer screening) – Physical spaces, including waiting areas and single sex toilets that are traditionally gendered (e.g., a gynaecology department) and a lack of gender-neutral toilets – Lack of opportunities to select preferred GPs and/or medical practitioners who are more knowledgeable and supportive of trans issues

Views about Trans Patients

INTRODUCTION

Our findings indicate the presence of a complex landscape where confidence and comfort in supporting trans patients is not necessarily related to levels of experience or the possession of relevant knowledge. Practitioners may need to proactively seek out training, potentially even funding it themselves, while experiences with trans individuals may be used as crucial learning opportunities. Medical practitioners may not be aware of how to obtain additional, necessary information, including struggling to access appropriate specialists.

DE-PRIORITISATION OF TRANS ISSUES

In the context of reported confidence and comfort levels that are higher than might have been expected (coupled with low levels of experience and/or training), many healthcare professionals perhaps do not pursue or support a prioritisation of the needs of trans patients. For some, there may not be enough of an understanding to recognise why relevant training and/or resources are needed, with several respondents questioning the need for specified knowledge or training related to treating trans patients.

> "Never come across a patient who is transgender and feel more support and training should go towards more common conditions, including diabetes, heart failure and Dementia and [I am] a firm believer that all people should be treated the same".

NHS NURSE WORKING IN GENERAL PRACTICE

Some respondents indicated that they did not see why there was any need for differentiation for this group (5%, 16), often emphasising their ability to empathise and/or show respect (8%, 28) as the primary reason that they felt confident in their ability to support trans patients and/or any patient.

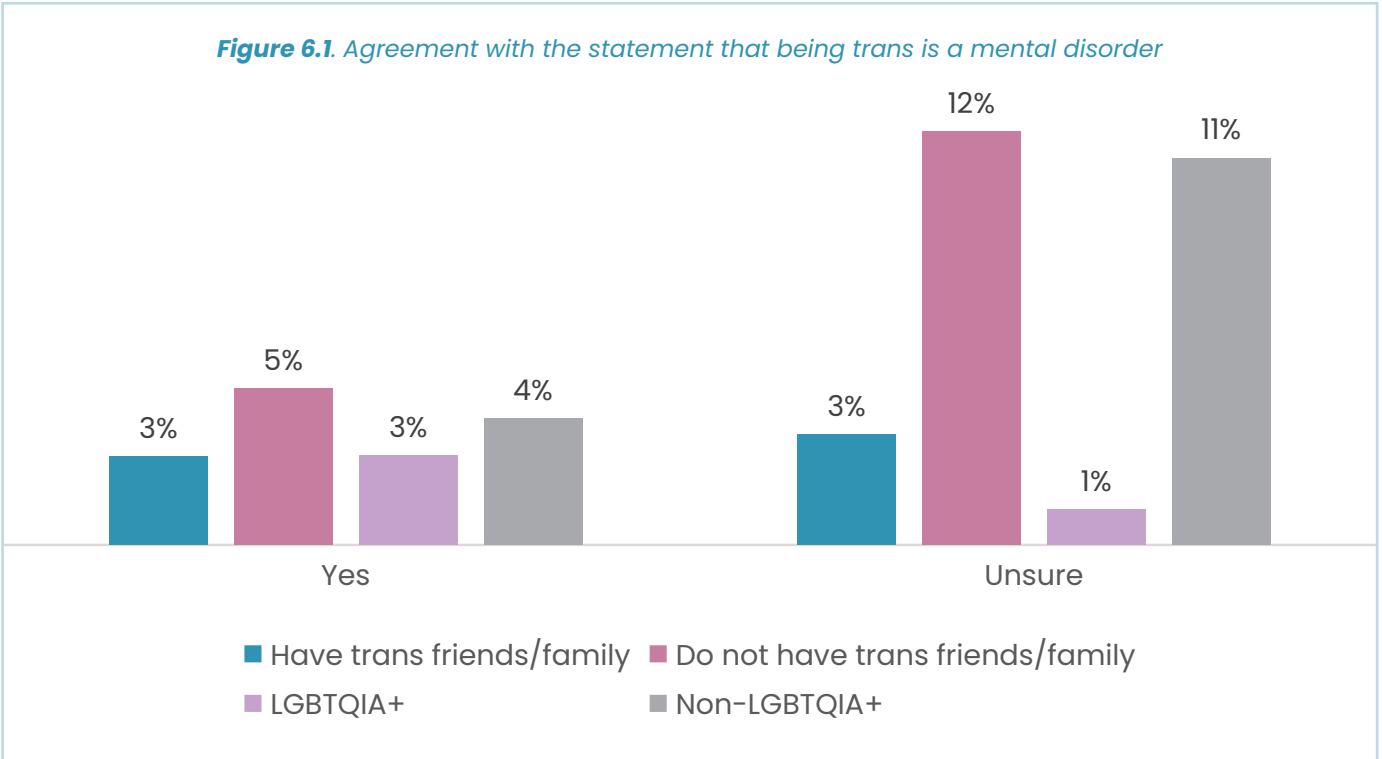
> "I'm supportive of all my patients. Trans identifying people are no different. Pronouns aren't important when talking direct[ly] to someone."

NHS GP WORKING IN GENERAL PRACTICE

> "My focus is on treating a patient and the medical condition, not necessarily their identity concerns".

NHS MEDICAL DOCTOR WORKING IN A HOSPITAL

Figure 6.1. *Agreement with the statement that being trans is a mental disorder*



> "It is not a common occurrence and language and what is ok to say changes constantly, so it feels like a minefield. However, genuine respect should be present in all interactions, so it wouldn't feel difficult to communicate in a way that respects diversity".

NHS NURSE WORKING IN MENTAL HEALTH

> "They are human beings with discomfort. They don't need special medicalisation most of the time. I don't agree that they need special treatment. Treat them as we treat other individuals in distress. However, I do not believe in just acquiescing to their identity or demand ... but holding it softly and giving it time".

NHS ALLIED HEALTH PROFESSIONAL WORKING IN RADIOGRAPHY

While it is positive that many practitioners are expressing the desire to be patient-led and/or empathetic, it is important to recognise that there are specific knowledge sets required to provide medical care to trans individuals.

This includes, for instance, an understanding of different potential medical interventions to support transition, as relevant to the care the practitioner is providing, and awareness of and an ability to use preferred pronouns (including gender-neutral pronouns).

Individuals who feel that they can provide appropriate care without specified knowledge or training may be reflecting the Dunning-Kruger effect, such that those with limited knowledge about trans identities and needs may overestimate their ability to provide appropriate, individualised care (see the Introduction for more information on this theory).

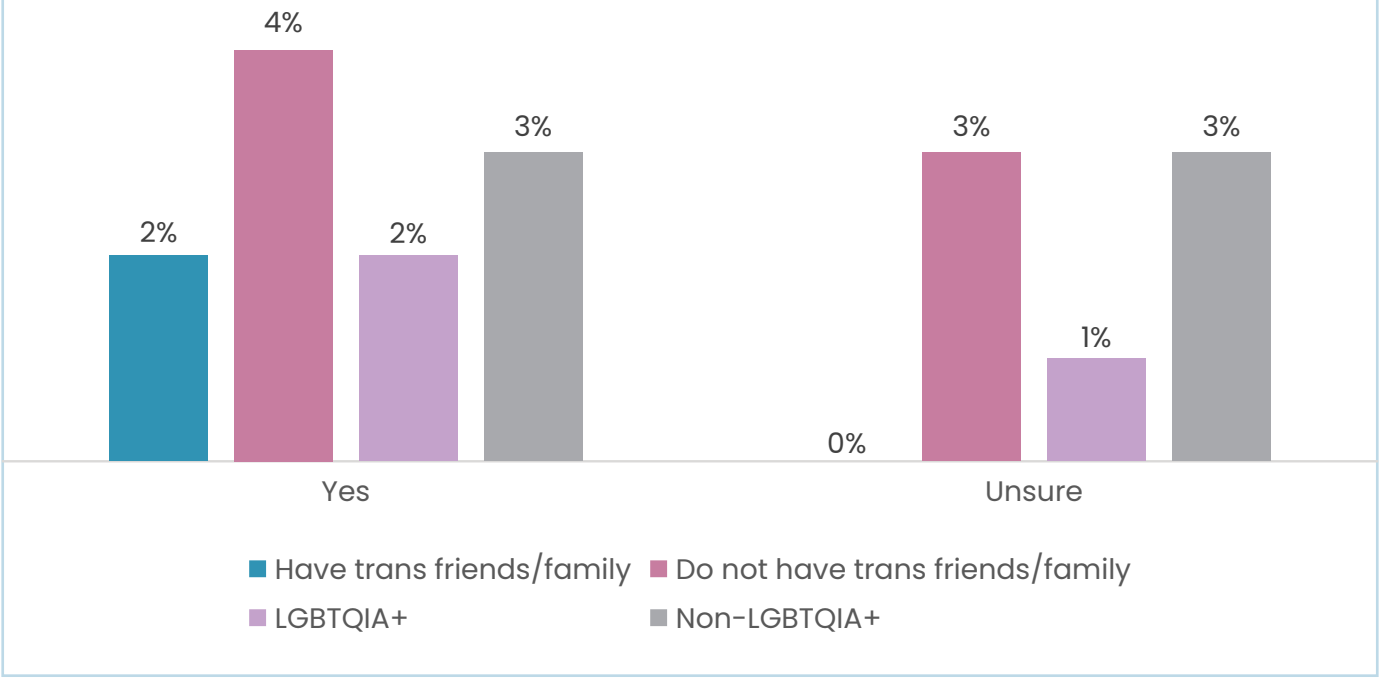
The potential for overconfidence can be particularly dangerous in a context where accessing training and/or additional resources may be largely led by a practitioner's own initiative.

LACK OF UNDERSTANDING TO ASSESS OWN KNOWLEDGE BASE AND SKILLSET

Where specific knowledge and training has not occurred, medical practitioners may not be aware of what they do not know. This includes not being aware of why an understanding of the needs and identities of trans individuals is essential to providing appropriate treatment and care. Rather than expressing a desire to better understand trans identities and needs, some instead implied that trans identities are a barrier to being able to provide appropriate care, such as one NHS medical doctor working in mental health: "*It [is] part of my job as a doctor to support patients regardless of their gender identification*".

This lack of understanding can lead to confusion, an inability to provide individualised care, and challenges respecting individuals' chosen names and/or pronouns. One NHS trainee nurse associate working in general practice, describing why they do not need specialist knowledge to support trans individuals, confused gender identity with sexuality: *"Transgender patients should receive [the] same care and support [as] if the person was heterosexual".*

***Figure 6.2**. Agreement that they would be morally uncomfortable treating a trans patient*



HIGH LEVEL OF DISCRETION

Our findings demonstrate a troubling over-reliance on practitioners proactively seeking training and information related to their trans patients' needs. This is especially concerning when access to GAHT or other support depends heavily on individual discretion.

> "Still little formal training/information to be able to support this group of patients – guidance tends to be very much 'sit on the fence' or 'it's up to you if you prescribe/support'".

NHS GP WORKING IN GENERAL PRACTICE

This is most worrying in relation to practitioners who do not recognise trans people's identities as valid and/or believe that being trans is a mental disorder. This group is likely to be underrepresented in our sample – 4% (23) of respondents stated that they believe being trans is a mental disorder, with a further 8% (53) being unsure. Though less common, 3% (18) of respondents also indicated that they would feel morally uncomfortable treating a trans person, with a further 2% (13) being unsure.

> "Don't necessarily agree with some of the ideology".

NHS ALLIED HEALTH PROFESSIONAL WORKING IN NEUROLOGICAL REHABILITATION

> "Forcing this down the neck of old GP's doesn't work. We think it's nuts. We are bewildered and think this is woke".

NHS GP WORKING IN GENERAL PRACTICE

LGBTQIA+ respondents were less likely to believe that being trans is a mental disorder, with 3% (5) stating that they held this belief and 1% (2) being unsure, compared to 4% (16) of non-LGBTQIA+ respondents who held this belief and 11% (49) who were unsure. Similarly, 2% (4) of LGBTQIA+ respondents indicated that they would feel morally uncomfortable treating a trans patient, with 1% (1) being unsure, compared to 3% (13) of non-LGBTQIA+ patients who would feel this way and 3% (11) who were unsure.

Similarly, having trans friends/family made respondents less likely to state that they believe being trans is a mental disorder (3%, 8 people who said yes and 3%, 10 who were unsure) than those who stated that they did not have trans friends/family (5%, 14 people who said yes and 12%, 37 who were unsure) (see Figure 6.1, on page 38). The same was true for feeling morally uncomfortable treating a trans person (see

Figure 6.2, on the previous page), with 2% (5) agreeing with this statement and less than 1% (1) being unsure, compared to 4% (12) of those who did not have trans friends/family and 3% (10) who were unsure.

It is important to note here that being LGBTQIA+ and/or having trans friends/family did not preclude these beliefs and feelings, as (though a smaller proportion) there were still respondents in both groups who believed that being trans is a mental disorder and/or stated that they would be morally uncomfortable treating a trans patient.

When these beliefs impact clinical practice, they will inevitably create barriers to accessing care for trans people. As discussed in the previous chapter, our **Trans Lives Report 2025**, found that more than one in five respondents (22%, 812) reported having been denied non-transition related healthcare due to their trans identity. A further 64% (2,456) stated that they had avoided going to the GP, even if unwell, because of concerns about discriminatory treatment. These figures were even higher for disabled people (67%, 1,598) and People of Colour (70%, 153).

CONCLUSION

Understanding medical practitioners' views of trans people is essential to identifying the best approaches to creating safe and accommodating medical institutions in the UK for trans people. Though less pronounced in online than written surveys,[63] the impact of social desirability bias means that those who are least supportive of trans identities and people are probably less likely to respond to a survey from a trans advocacy organisation. Thus, while most respondents to this survey expressed views that were generally supportive of trans identities and needs, it is very likely that those who do not support medical transition and/or believe that being trans is a mental disorder would represent a larger proportion across a general sample of medical practitioners.

Particularly with the high prevalence of discriminatory treatment reported in our **2025 Trans Lives Report**, this group needs to be strongly considered in any policy and/or planning decisions. It is likely that multiple steps would be needed to prevent discriminatory treatment that not only create learning opportunities but ensure that policies are stringent enough to reduce the impact of anti-trans bias. However, while these issues are prevalent in medical settings, we know that negative views toward trans people are common in the UK,[64] and it is likely that these issues need to be addressed at a societal level to reduce discrimination within the medical sector.

We would nonetheless like to express our immense gratitude to all respondents and to those who were willing to express biased views, as it would not be possible for us to understand the climate of the UK health sector for trans people if we did not hear from a wide range of people.

Conclusion and Recommendations

The findings within this report are important in helping us understand the medical landscape for trans people in the UK. While it is highly likely that our sampling methods led to an overrepresentation of those most interested in and supportive of trans individuals, the responses of those who are aware of barriers and taking proactive measures to support trans patients are promising.

We see that there are practitioners across the country who are willing to take time from their increasingly busy schedules to understand and address the needs and experiences of trans people. This includes those who went so far as to pay out of pocket to access training and those who are willing to learn from the trans people they seek to support.

However, these promising findings are tempered by several key factors. First, the findings within our **2025 Trans Lives Report** suggest that negative experiences with medical practitioners may be far more prevalent than this study would suggest, with 52% (1,830) of respondents indicating that they had experienced transphobia in a medical setting, including 60% (129) of People of Colour.

Second, the higher levels of confidence and comfort in supporting trans people do not reflect levels of training accessed, knowledge of appropriate pathways (where these exist and in a context where they may change regularly), or familiarity with sources of additional information. This may be due to overconfidence amongst those with limited knowledge, the so-called Dunning-Kruger effect.

Third, it is well-evidenced that the NHS is extremely overburdened and under-resourced to provide essential care to the diverse range of people across the UK. In this environment, trans medical care and support may be deprioritised. This is particularly concerning when research suggests that most trans people have a mental health condition.[65] Where it is desired, transition-related care has been found to significantly reduce and/or alleviate mental distress.[66]

Fourth, our findings suggest that knowledge about how to appropriately support trans individuals is rarely a part of standard training or supervision. Knowledge may instead be most likely to be obtained through proactive steps to access training, including funding it individually, and/or by learning through experience(s) with trans patients.

Finally, systems within the medical sector and within the NHS were not initially established with trans patients in mind. Respondents demonstrated a range of ways in which systems continue to create challenges when it comes to supporting trans individuals.

This research found that those most likely to overcome these challenges (e.g., by taking the time to understand pathways to prescribe GAHT or by proactively identifying training opportunities) are those who are already most supportive of trans people.

They are likely to identify as LGBTQIA+, have trans friends and/or family, not believe that trans identities are mental health issues, and not feel morally uncomfortable working with trans people. However, even within this group, confidence and comfort levels were generally more likely to be moderate or low than to be very or extremely high.

Our findings suggest that there are likely to be many professionals who feel moderately comfortable and confident supporting trans people, but who do not have the relevant training or experience to enable them to feel very comfortable and confident. Coupled with insights from our **2025 Trans Lives Report**, it is likely that these levels of knowledge are not sufficient to prevent transphobia in a medical setting and that these responses may instead demonstrate overconfidence where limited knowledge is held (i.e., the Dunning-Kruger effect).

Overly busy practitioners may not be aware of what information they may be lacking, while finding it difficult to navigate complicated, regularly changing pathways, particularly when

waiting lists to access GICs are years long.

With frequently reported challenges for professionals in accessing necessary resources and specialist support and advice, many trans people are likely to be put in the difficult and uncomfortable position of having their medical needs used as learning opportunities for medical practitioners.

Whilst learning in a clinical context does play a vital role in supporting healthcare professionals to develop their confidence and competence, the burden should not be placed solely on patients to provide development opportunities.

Despite trans people making up a small percentage of the UK population, with approximately 1 in 200 people in the UK identifying as trans or non-binary,[67] any medical practitioner will likely treat trans people at some point during their career.

For GPs working in the NHS, who have an average of 2,257 patients at any one time,[68] this is particularly relevant. It is essential that these individuals have adequate training to understand how to refer to and support trans people, while practice policies need to reflect the current challenges in trans healthcare, including around access to GAHT.

Recommendations

FOR POLICYMAKERS

1. All medical practitioners should be required to complete training in best practice in caring for trans people. This should be embedded within the relevant pre-qualification curricula, as well as within required CPD post-qualification.

With approximately 1 in 200 people in the UK identifying as trans or non-binary, it is very likely that medical practitioners will support trans patients at multiple points during their careers. There is a growing evidence base to indicate the presence of multiple barriers to accessing appropriate care faced by trans people. Training can help reduce the likelihood of discriminatory treatment and language, while enabling appropriate medical care for all patients, including trans patients. Training of GPs should be the priority, as the primary providers of GAHT outside of gender specialists and those who may be most likely to provide support to trans individuals.

2. There is an urgent need to provide clear policies and guidance relating to the provision of trans-inclusive medical care. There should be consistency in this across the UK to prevent a 'postcode lottery'.

The quality and level of care patients receive should not be determined by where they live. This can put trans people in the difficult position of being concerned about moving to a new area, where they are not sure if their shared care agreement will continue to be upheld. It is essential that national policy establishes a standard set of expectations mandating the right to a shared care agreement and (whilst waiting times remain unreasonably long) bridging prescriptions. Clear guidance can help reduce confusion, but any guidance must be created in consultation with trans advocacy organisations and trans people.

3. GP contracts and NHS Service Specifications should make GPs' responsibilities for prescribing GAHT clear, and national and local policies should be in place to support GPs to fulfil their responsibilities in relation to them.

With many medical practitioners lacking knowledge and understanding about trans issues and some holding anti-trans views, standard practices and policies are necessary to ensure adequate care. This should include: the use of preferred names and pronouns, the issuing and maintaining of shared care agreements, prescribing GAHT, working with specialists, and invitations to routine, biologically based medical procedures (e.g., breast cancer screenings or prostate exams).

4. IT systems need to be updated to enable flexibility in patient biology to account for intersex and trans individuals, whilst retaining the ability for intersex and trans individuals to update the sex marker on their medical records.

Systems need to be more flexible in their understanding of sex and gender. While it is imperative that the ability to change sex marker remains, an anatomical inventory (e.g., presence of a uterus) could ensure appropriate diagnoses and testing. It is also essential that all individuals are automatically invited to necessary tests based on the body parts that they have rather than assumptions based on their sex markers. This access should come without requiring proactive effort on the part of trans and intersex patients. Medication and other treatment (e.g., antibiotics for a urinary tract infection) also need to reflect individual need. Systems should also be flexible about holding legal and preferred names and pronouns.

FOR HEALTHCARE PROFESSIONALS

1. Recognise that trans patients have some needs that require specific understanding and training. Be proactive in developing your trans-inclusive practice by attending training, reading about trans people's lived experiences and learning from examples of good practice.

There are a wealth of freely-available practical resources about supporting trans patients that can be used. TransActual's website hosts a regularly-updated comprehensive list of links to guidance on trans inclusive healthcare from the NHS, regulatory bodies and professional associations, available at: **transactual.org.uk/healthcare**. Some key guides and resources from TransActual include:

- **Supporting trans patients: A brief guide for GPs**
- **Supporting trans patients: A brief guide for staff at the GP surgery**
- **Trans Inclusive Hospital Care**
- **Nobody teaches you how to be a patient: The lived experiences of neurodivergent, disabled and chronically ill trans people**

Other resources include:

- **The General Medical Council's Trans healthcare guide**
- The Royal College of General Practitioners' policy paper, 'The role of GPs in transgender care'
- Dr. Kamilla Kamaruddin's article in the peer-reviewed journal, Nature: **Access to quality healthcare for trans people**

However, please note that these resources cannot take the place of a comprehensive training and education programme on supporting trans patients and we urge all medical professionals to seek out relevant training.

2. Remember that whilst your trans patients are often experts in their own care, they shouldn't have to be. Avoid placing the burden on them as your sole source of information on their healthcare needs.

While respect and empathy are crucial components for any medical practitioner to provide appropriate, supportive care, more is needed to ensure a sufficient understanding of and ability to support trans patients and to understand their needs. This includes understanding how trans people's experiences and needs may differ depending on their gender, ethnicity, and/or disability.

FOR PRESCRIBERS

1. Do what you can to support trans patients in accessing GAHT. If you currently feel unable to prescribe, reflect on what could make you feel differently and take steps to make that change – for example by accessing training or seeking advice from a more experienced colleague.

In the current climate, where waiting times to access NHS-funded gender clinics are many years long, more patients are likely to seek out bridging prescriptions and others will be self-medicating, while those who can afford to do so may choose to access GAHT privately.

The inability to access GAHT through the regular pathways in the NHS places a significant financial burden on patients, while putting many at risk. Mental health implications can be incredibly dangerous, as can self-medicating. Meanwhile, private clinics are unaffordable for many. It is essential that those seeking GAHT have the support and guidance of a trained professional through the NHS. In many cases, the only person that can fill this role is a GP.

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10. GMS refers to General Medical Services, the 'core' medical services under the national standard GP contract.

11. The term 'trans' is used as an umbrella term throughout this report to include those "whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth". This includes those who identify outside of the gender binary. For more information, see: http://transactual.org.uk/glossary/.

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Appendix 1: Survey questions

1. Can you confirm that you are over 18 and have freely agreed to participate in this research project?
   - Yes
   - No

Respondents that answered no were directed to an end screen. Respondents that answered yes were taken to the survey questions.

2. I feel competent to assess a person who is transgender in a therapeutic setting.
   1 to 7 Likert scale, where 1 = Strongly disagree and 7 = Strongly agree.

3. I have received adequate clinical training and supervision to work with transgender clients / patients.
   1 to 7 Likert scale, where 1 = Strongly disagree and 7 = Strongly agree.

4. I have experience working with transgender clients / patients.
   1 to 7 Likert scale, where 1 = Strongly disagree and 7 = Strongly agree.

5. I would feel unprepared talking with a transgender client / patient about issues related to their gender identity.
   1 to 7 Likert scale, where 1 = Strongly disagree and 7 = Strongly agree.

6. How comfortable do you feel in terms of your ability to use pronouns and names chosen by transgender clients / patients?
   - Extremely
   - Very
   - Moderately
   - Slightly
   - Not at All

7. How comfortable do you feel in terms of your ability to use transgender-inclusive language with clients / patients?
   - Extremely
   - Very
   - Moderately
   - Slightly
   - Not at All

8. How comfortable do you feel in terms of your ability to work with other medical professionals to support transgender clients / patients?
   - Extremely
   - Very
   - Moderately
   - Slightly
   - Not at All

9. How comfortable do you feel in terms of your ability to identify ways to learn more about supporting transgender clients / patients?
   - Extremely
   - Very
   - Moderately
   - Slightly
   - Not at All

10. Why did you give this answer (optional)?
    Free text box.

11. I am aware of institutional barriers that may inhibit transgender people from using healthcare services.
    - Yes
    - No
    - Unsure

12. I think being transgender is a mental disorder.
    - Yes
    - No
    - Unsure

13. I would be morally uncomfortable working with a transgender client / patient.
    - Yes
    - No
    - Unsure

14. What country/countries do you work in (select all that apply)?
    - England
    - Scotland
    - Northern Ireland
    - Wales

15. What sector(s) do you work in (select all that apply)?
    - NHS
    - Private Sector
    - Non-profit or charity
    - Other

16. What is your professional role in the health sector?
    - Allied Health Professional
    - General Practitioner/GP
    - Medical Doctor (not GP)
    - Nurse
    - Pharmacist
    - Other

17. What medical sector(s) do you work in (select all that apply)?
    - Gender-affirming care
    - General practice
    - Mental health
    - Other

18. Are you a prescriber?
    - Yes
    - No

Asked only to those that answered yes to Q18:

19. Has a patient ever asked you to prescribe gender-affirming hormone therapy?
    - Yes
    - No
    - Unsure

20. Were the client(s)/patient(s) given a prescription (select all that apply)?
    - Yes
    - No
    - Unsure

21. On what basis were they given a prescription for gender-affirming hormone therapy (select all that apply)?
    - A bridging prescription
    - Shared care with a private provider
    - Shared care with an NHS gender clinic
    - Continuation of NHS care
    - Other

Asked only to those that answered no to Q20:

22. Why were the client(s) / patient(s) not given a prescription?
    - Don't feel competent to prescribe Funding constraints
    - Potential medical impact / individual's medical needs
    - Own views about transgender people / identities
    - Policy constraints / lack of policy (either at practice, PCN, or ICS level)
    - Concerns about career implications
    - Non-medical patient / client factors (e.g., immigration or relationship status)
    - Other

Asked to all participants:

23. When did you receive your primary qualification (omit clinical)?
    Choice from a dropdown of years starting 1955.

24. Do you have any transgender friends / family?
    - Yes
    - No
    - Unsure

25. Do you identify as LGBTQIA+?
    - Yes
    - No
    - Unsure

26. I would like to (select all that apply):
    a. Enter the prize draw to win a £150 Love2Shop voucher
    b. Receive the final report

27. If so, please provide your email address below (this will be stored separately from your other answers):
    Text box – email address format required

28. Is there anything else you'd like to add?
    Free text box

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