Please find below the responses from The National LGB&T Partnership to the NHS England Consultation on Adult Gender Identity Services.

3	The proposed service specifications aim to address inconsistency in care quality, differing levels of access, and out-dated service models. To what extent to you think these sections of the specification for Non-Surgical services achieve this?
	Principles (section 2.2) To some extent Duties on providers (section 2.3) To some extent Staffing, structure and governance (section 2.4) To some extent New referrals and transfers of care (sections 2.6 – 2.8) To some extent Assessment process (sections 2.9 – 2.10) Fully Role of named professional and lead clinician (sections 2.11 – 2.12) Fully Interventions that are delivered by the Gender Identity Clinic (section 2.17) To some extent Interventions that are delivered by other providers (section 2.18) To some extent Population covered and population needs (sections 3.1 – 3.2) To some extent Outcomes (section 4) To some extent
	Principles (section 2.2) We are concerned about the section "**Equity of access and quality of care will be provided to all who need it regardless of age, gender expression or ethnicity unless there is evidence that these factors affect the appropriateness or effectiveness of the intervention/treatment."** We believe it raises the question of what is considered 'evidence', and could result in discrimination against non-binary people and people with a BMI above an arbitrary threshold. The opinions of an undisclosed number of surgeons on what weight they feel provides 'effective results' do not appear to be backed up by any medical research (on the effectiveness of gender-related surgeries for people with higher BMIs), and there is some evidence to support the idea that there is no additional risk during surgery to those with higher BMIs (e.g.. Dindo, D. et al. (2003) 'Obesity in general elective surgery'. The Lancet, 361, 2032–35). We would also question whether 'effective' is a concept viewed through a lens of cisnormativity and based on an assumption of the trans person wishing to 'pass' as cisgender. If the service is to be truly person centred, and **"Assessments and interventions will be personalised and based on shared decision making"** then 'appropriateness or effectiveness' should not be pre-decided, nor should it be down to clinicians to decide, but rather the patient. *Duties on providers (section 2.3)* While we understand that the service specification is not designed to be exhaustive and overly directive, we would like to see further attention given to the ways in which gender identity services are expected to **"Achieve an integrated approach to care with primary care providers"**, as the integration of care and effective communication between the Gender Identity Service and the service user's primary care providers is both a key area to ensure good and effective care, and an area which has been raised as a particular concern and an area to be addressed by the new service specifications. We would expect to see some guidelines on the ways in which GICs and GPs/Primary care are expected to work together, which require GPs to provide appropriate and timely care, and for these to be supported by the GP Advisory Committee of the BMA. We have a concern that the directive that gender identity service providers "**Increase awareness of best practice in the diagnosis and management of gender dysphoria through active engagement with health professionals; and educate healthcare professionals in the health and support needs of trans people."** could go some way to continue the status quo in terms of best practice, rather than moving practice forward through the inclusion of external individuals and bodies (such as researchers, charities, and trans people themselves). We would like to see the suggestion that staff working in Gender Identity Services continue to seek out opportunities for

professional development, particularly through working with affected communities (trans people and the people who represent and support them), and specialist researchers.

Relatedly, we feel that it is insufficient that Gender Identity Services **"Publicise national and local patient organisations, which can provide invaluable additional information and ongoing support for trans people and their families."** and would recommend active collaboration by services with local and national organisations, both to provide much-needed support (for example particularly during waiting times) but also so that the services can receive organised feedback from users and can be supported in developing and growing their understanding of individual and community need.

Staffing, structure and governance (section 2.4)
It is our view that, regardless of the outcome of the consultation with regards to prescribing options, the minimum requirements of the multi-specialist team should additionally include a hormone-prescribing physician. The requirement that **"A Provider without a Consultant Endocrinologist must demonstrate arrangements in place for obtaining timely advice from an endocrinology team when this is needed"** is welcomed. Health Education England have recently developed a competency framework for staff working in Specialist Gender Identity Services which should form the basis of the plans to ensure that **"all clinical staff are trained in meeting the health needs of trans people"**.

We would like to see greater detail of what is expected of services in terms of having **"Arrangements in place to ensure the service is delivered culturally appropriate care and support."** Particularly in relation to the underrepresentation of BAME people in the current data on GIC users, and evidence that trans people are more likely to identify as having a disability than is average in the population.

We welcome the requirement that each provider will have **"Information and technology systems to enable patient contact remotely."** and would like to see the development of the relevant skills, and the procurement of the appropriate technology, prioritised, so as to reduce the burden of travel on service users.

New referrals and transfers of care (sections 2.6 – 2.8)
It appears unclear from the service specification exactly who is able to make a referral to a GIC, and we would expect to see this clarified, and that any health or social care professional, including counsellors and youth/case workers, be able to make a referral, as well as individuals being able to self-refer. We do not believe that an individual should have to be registered with a GP to be referred to a GIC for treatment, see question 6.

Assessment process (sections 2.9 – 2.10)
No comments

Role of named professional and lead clinician (sections 2.11 – 2.12)
No comments

Interventions that are delivered by the Gender Identity Clinic (section 2.17)
We are concerned that the requirement that treatment for a 'pre-existing voice difficulty' must be completed 'before specialist voice modification proceeds' may constitute an unnecessary delay in receiving appropriate care, leading to unnecessary continuation of gender dysphoria. In the case of those undertaking hormone therapy, withholding 'specialist voice modification' within a certain

timeframe may result in an outcome which is less satisfactory to the service user than it might otherwise have been.

Interventions that are delivered by other providers (section 2.18)
The information in appendix K is lacking in guidance for clinicians referring people with dark skin.

The requirement that a second letter of referral for genital surgery must come from a **"similarly-qualified and experienced professional not directly involved in the individual's care"** might be difficult or complicated in small practices. Further to this, we believe that the referral should not have to come from an NHS Gender Identity Clinic.

This requirement does not appear to be in line with the following principles: (from the BMA guide: The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland, 2009)

- Patients who are entitled to NHS-funded treatment may opt into or out of NHS care at any stage.
- Patients may pay for additional private health care while continuing to receive care from the NHS.
- Patients who have had a private consultation for investigations and diagnosis may transfer to the NHS for any subsequent treatment. They should be placed directly onto the NHS waiting list at the same position as if their original consultation had been within the NHS.

Additionally, on the NHS site (http://www.nhs.uk/chq/Pages/2572.aspx?CategoryID=96) it states: "You shouldn't need to have any of the same tests twice – for example, to diagnose or monitor your condition." Requiring a referral from an NHS GIC would require a person who already had a diagnosis going through the diagnostic process a second time.

However, we are pleased to see the requirement for a medical as well as a psychological opinion has been removed and that, in line with WPATH SoC v7, two psychologists (for genital surgery) or one psychologist (for chest surgery) may now make recommendation. We additionally welcome that hormone therapy is not a pre-requisite for mastectomy and masculinising chest surgery.

It should be made clear whether all individuals, seeking all types of genital surgery, will be subject to the requirement of 12 continuous months of hormone therapy as the current specifications does not make it sufficiently clear under what circumstances individuals will and won't be expected to have taken hormones. The phrase 'as appropriate to the individual's gender goals' appears contradicted by the latter part of the same paragraph, which states **"the aim of hormone therapy prior to orchidectomy is primarily to introduce a period of reversible oestrogen or testosterone suppression, before the individual undergoes irreversible surgical intervention"**. this stipulation would be imposed for all individuals seeking one of the aforementioned genital surgeries (metoidioplasty, phalloplasty, feminising genital reconstruction with or without vaginoplasty), however, this is confused by the use of the term orchidectomy, which to our knowledge is used only to refer to removal of the testicles. A note later in the section also implies that bilateral salpingo-oophorectomy (removal of the ovaries) will not always take place as part of the genital surgical intervention.

The statement **"this requirement is not about qualifying for surgery"** is disingenuous as the requirement must be fulfilled in order that the individual is then referred for surgery.

The assertion that **"Where individuals can demonstrate that they have been living in their gender role before the referral to the Provider, this will be taken into account."** raises questions about what will be accepted as 'proof', and the impact this may have on individuals' ability to access the interventions they need. For example, there are significant issues with those born abroad legally changing their names, and many people may feel it unnecessary to change their name. For many

people, there may not be an obvious or identifiable 'start date' for them living in their gender role, as the change in identification and presentation they have been gradual, and some individuals may have been able to live in a congruent gender role for only some parts of their daily life and not others.

Population covered and population needs (sections 3.1 – 3.2)
The specification appears to exclude people who are both resident in and registered with a GP in Wales. The National LGB&T Partnership are aware that there is one proposed gender identity service in Wales and are concerned that this leaves those resident and registered in Wales with a single option to access specialised gender identity services, which is not in line with the legal right to choice of first outpatient appointment laid out in the NHS Choice Framework published in April 2016 (https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs)

We welcome that the specification states that people with non-binary identities **"must have access to treatment and the interventions described in this document that is equitable to the access available to people with binary identities."**
We once again raise our concerns around the necessity of registration with the GP and the inability of individuals to self-refer.

Outcomes (section 4)
No comments.

Additional points not covered by the areas above include:

Procedures which we believe should be commissioned as part of the service specification:
We note that, despite fairly widespread dissatisfaction with available options for genital reconstruction, many trans people who were assigned female at birth may choose not to undergo genital reconstruction. Nevertheless, significant dysphoria is experienced by many as a result of the ongoing existence of, at times functioning of, and necessary attention to (eg. cervical screening), the internal reproductive organs. As a result, we believe that independent removal of the internal reproductive organs should constitute an option on the service pathway as it is an intervention which specifically reduces gender dysphoria.

Independently to this suggestion, we also seek clarification as to whether the different stages of a 'step-by-step' process which included hysterectomy, oophorectomy and genital reconstruction but where all parts of the procedure were not carried out during one procedure would be covered by the specification or would need to be separately commissioned, potentially resulting in delays, unnecessary admissions (where the procedures are broken down into more steps than necessary due to funding) and a greater strain on the NHS.

While we welcome that (under 2.15) providers will be expected to discuss the options for fertility preservation with service users, we would argue that provision of fertility preservation should be included in the service specifications, and that NHS Specialised Commissioning and the Clinical Reference Group should have acted to include these before publishing the specification for consultation, and should now rectify this error during the review process and before publishing the final specification. Gamete storage at the point of surgery is demonstrably part of the surgery itself. Gamete storage prior to surgery is contingent to it – in the same way as hair removal prior to phalloplasty or vaginoplasty is – and should be funded accordingly. Further to this, when interventions take place during cancer treatment which will affect a person's fertility, fertility preservation is routinely commissioned. The EHRC have made "caps and restrictions in relation to

	independent living and health services for trans people (including the taking and storage of gametes for those transitioning).” one of their legal priorities for 2017-18, as they view the current situation as a contravention of trans people’s human rights. There should additionally be provision for breast augmentation surgery as a core procedure, just as there is provision for bilateral mastectomy and associated chest reconstruction. To do otherwise creates a material difference between how men and women are treated, which is discrimination based on sex. There should be provision for facial feminisation and facial masculinisation surgeries. These surgeries have great positive effect on trans and non-binary people’s psychosocial wellbeing through allowing people to accurately present themselves though the key element of social interaction – the face. No specific question is asked in relation to point 2.19, where some commentary on re-referral would be welcomed. For example, it seems appropriate that an individual discharged from (any) GI service should be able to re-refer themselves to receive further support and/or other interventions. There is no discussion of the structure of the links/interdependences mentioned under section 2.20, particularly not the links with gynaecological and sexual health services. While we recognise the need for flexibility, we would expect to see some comment on the expected relationships between the services and some consideration given to how it will be ensured that these external services and providers have the necessary knowledge and competencies to effectively and appropriately address the needs of trans people.
4	The proposed service specifications aim to address inconsistency in care quality, differing levels of access, and out-dated service models. To what extent to you think these sections of the specification for surgical services achieve this?
	Principles (section 2.2) To some extent Duties on providers (section 2.3) To some extent Staffing, structure and governance (section 2.4 & 2.8) To some extent Referral for surgical intervention (section 2.6) To some extent Role of the specialist surgeon and surgical team (section 2.7) Totally Assessment process (sections 2.9 – 2.10) To some extent Patient dissatisfaction with technical outcome of surgery; and discharge arrangements (section 2.17 & 2.19) To some extent Population covered and population needs (sections 3.1 – 3.2) To some extent Outcomes (section 4) Totally
	Principles (section 2.2) We are concerned about the section “**Equity of access and quality of care will be provided to all who need it regardless of age, gender expression or ethnicity unless there is evidence that these factors affect the appropriateness or effectiveness of the intervention/treatment.”** We believe it raises the question of what is considered ‘evidence’, and could result in discrimination against non-binary people and people with a BMI above an arbitrary threshold. The opinions of an undisclosed number of surgeons on what weight they feel provides ‘effective results’ do not appear to be backed up by any medical research (on the effectiveness of gender-related surgeries for people with higher BMIs), and there is some evidence to support the idea that there is no additional risk during surgery to those with higher BMIs (e.g.. Dindo, D. et al. (2003) ‘Obesity in general elective surgery’. The Lancet, 361, 2032–35). We would also question whether ‘effective’ is a concept viewed through a lens of cisnormativity and based on an assumption of the trans person wishing to ‘pass’ as cisgender. If the service is to be truly person centred, and **“Assessments and**

interventions will be personalised and based on shared decision making" then 'appropriateness or effectiveness' should not be pre-decided, nor should it be down to clinicians to decide, but rather the patient.

Duties on providers (section 2.3)
While we understand that the service specification is not designed to be exhaustive and overly directive, we would like to see further attention given to the ways in which gender identity services are expected to **"Achieve an integrated approach to care with primary care providers"**, as the integration of care and effective communication between the Gender Identity Service and the service user's primary care providers is both a key area to ensure good and effective care, and an area which has been raised as a particular concern and an area to be addressed by the new service specifications. We would expect to see some guidelines on the ways in which GICs and GPs/Primary care are expected to work together, which require GPs to provide appropriate and timely care, and for these to be supported by the GP Advisory Committee of the BMA.

We have a concern that the directive that gender identity service providers "**Increase awareness of best practice in the diagnosis and management of gender dysphoria through active engagement with health professionals; and educate healthcare professionals in the health and support needs of trans people."** could go some way to continue the status quo in terms of best practice, rather than moving practice forward through the inclusion of external individuals and bodies (such as researchers, charities, and trans people themselves). We would like to see the suggestion that staff working in Gender Identity Services continue to seek out opportunities for professional development, particularly through working with affected communities (trans people and the people who represent and support them), and specialist researchers.

Relatedly, we feel that it is insufficient that Gender Identity Services **"Publicise national and local patient organisations, which can provide invaluable additional information and ongoing support for trans people and their families."** and would recommend active collaboration by services with local and national organisations, both to provide much-needed support (for example particularly during waiting times) but also so that the services can receive organised feedback from users and can be supported in developing and growing their understanding of individual and community need.

Staffing, structure and governance (section 2.4 & 2.8)
We would like to see greater detail of what is expected of services in terms of having **"Arrangements in place to ensure the service is delivered culturally appropriate care and support."** Particularly in relation to the underrepresentation of BAME people in the current data on GIC users, and evidence that trans people are more likely to identify as having a disability than is average in the population.
Health Education England have recently developed a competency framework for staff working in Specialist Gender Identity Services which should form the basis of the plans to ensure that **"all staff in public-facing roles have cultural sensitivity towards trans and gender diverse people's health and social care needs."**.

We commend the inclusion of the requirement that **"A health professional member of the surgical team will be available during daytime working hours to provide non-urgent advice to patients, and other practitioners providing care to patients who are not currently in-patients of the specialist surgery provider unit, such as urgent and emergency care services, General Practitioners and Gender Identity Clinics."**

Referral for surgical intervention (section 2.6)

This requirement does not appear to be in line with the following principles: (from the BMA guide: The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland, 2009)

- Patients who are entitled to NHS-funded treatment may opt into or out of NHS care at any stage.
- Patients may pay for additional private health care while continuing to receive care from the NHS.
- Patients who have had a private consultation for investigations and diagnosis may transfer to the NHS for any subsequent treatment. They should be placed directly onto the NHS waiting list at the same position as if their original consultation had been within the NHS.

Additionally, on the NHS site (http://www.nhs.uk/chq/Pages/2572.aspx?CategoryID=96) it states: "You shouldn't need to have any of the same tests twice – for example, to diagnose or monitor your condition." Requiring a referral from an NHS GIC would require a person who already had a diagnosis going through the diagnostic process a second time.

Role of the specialist surgeon and surgical team (section 2.7)
No Comments

Assessment process (sections 2.9 – 2.10)
The detail outlined in point 2.9 is welcomed, as numerous service users report having been told that there is only one available option for surgery, and not having any input into deciding on the expected results.

Shared decision making (2.10) must not unnecessarily lengthen the process, for example through the patient being given information at the end of an appointment and only being able to convey their decision at the next appointment, weeks/months later.

Patient dissatisfaction with technical outcome of surgery; and discharge arrangements (section 2.17 & 2.19 [actually 2.15])
We welcome that: **"Patients may be discharged from routine surgical follow up when this is clinically appropriate but Providers will provide open access review at the request of the patient, referrer or the patient's GP for at least one year after surgery."**
Under section 2.15, we note that in the case of chest reconstruction, there is no non-specialist provider to be referred to after 18 months. We also query that any subsequent procedures **"are not interventions performed for the alleviation of gender dysphoria related to gender incongruence."** as, particularly for non-binary people or perhaps where later physical changes (weight change or the impacts of hormone use) impact on the results of surgery, gender dysphoria could arise from the surgical results.

The lack of provision for those who have had surgery and chose to have another surgery to 'reverse' this might be seen to amount to discrimination on the basis of gender reassignment, is it results in a situation where only people who have not previously undergone gender reassignment are eligible for surgery.

Population covered and population needs (sections 3.1 – 3.2)
The specification appears to exclude people who are both resident in and registered with a GP in Wales. The National LGB&T Partnership are aware that there is one proposed gender identity service in Wales and are concerned that this leaves those resident and registered in Wales with a single option to access specialised gender identity services, which is not in line with the legal right to choice of first outpatient appointment laid out in the NHS Choice Framework published in April 2016 (https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs)

	We welcome that the specification states that people with non-binary identities **"must have access to treatment and the interventions described in this document that is equitable to the access available to people with binary identities."** We once again raise our concerns around the necessity of registration with the GP and the inability of individuals to self-refer. *Outcomes (section 4)* No comments.
5	Question: It is proposed that in the future all young people who need to access a specialist gender identity service and who are aged 17 years and above will be referred to an adult Gender Identity Clinic. To what extent do you support or oppose this proposal?
	4 - Tend to support.
6	*Question: It is proposed that in the future the specialist Gender Identity Clinics for Adults will not accept referrals of individuals who are not registered with a General Practice. To what extent do you support or oppose this proposal?*
	2 – Tend to oppose.
7	Please provide comment in support of your answers.
	We tend to support the proposal outlined in question 5. However, this is with the caveat that those who wish to receive the specific (more family focussed, and also anecdotally more suitable for those without a support system) support of the Gender Identity Development Service (GIDS) for children and young people can remain there until 20, as outlined in the draft specification, and could be referred there should they wish. Transition arrangements between the services also need to be addressed more fully, and shouldn't be assumed solved by a change in age banding. We tend to oppose the proposal outlined in question 6. While we recognise that ongoing care should be provided and/or co-ordinated by a person's GP, we see this service specification as an opportunity for NHSE Specialised Commissioning to consider alternative ways of working, for example, under some conditions, ongoing care and relevant referrals being co-ordinated by the GIC and a multi-disciplinary team of professionals. Many GPs appear to not be supportive of transition (often citing ethical or religious objections), so even when the instruction comes from the GIC, the GP's duties may not be fulfilled, effectively 'vetoing' a person's medical transition. This requirement might lead to an assumption that all patients at the GIS have a GP who will be supportive of their shared care, and a lack of flexibility to treatment and referral pathways which is in fact at odds with some of the recommendations made by this draft service specification (for example the suggestion of having a GPSI who would prescribe, and perhaps provide other support, for all patients in a given area). As noted in the EIA, many groups find it hard to register with GPs, particularly including people who are homeless/precariously homed, gypsies and travellers, recent immigrants & those who speak little or no English, and asylum seekers. As many GP practices request photographic ID as well as proof of address, registration with a GP can prove difficult for trans people. Trans people are more likely than the general population to experience homelessness and will often need to move areas due to their transition or as a result of homelessness, leading to periods of time without a GP, in addition to the previously described difficulty registering. It is also important to ensure that that this requirement, should it be implemented, is not interpreted by Gender Identity Services that the referral must come from a GP, as a person might

	seek referral (through whatever means are decided upon) before seeking a new GP who will then support their healthcare needs during transition. We recommend that NHSE works with the BMA and Royal College of GPs to develop guidelines on the ways in which GICs and GPs/Primary care are expected to work together, and GPs to support trans patients, requiring GPs to provide appropriate and timely care. It appears unclear from the service specification exactly who is able to make a referral to a GIC, and we would expect to see this clarified, and that any health or social care professional, including counsellors and youth/case workers, be able to make a referral, as well as individuals being able to self-refer.
8	Question: It is proposed that only a designated specialist Gender Identity Clinic will be able to refer an individual for genital reassignment surgery. To what extent do you support or oppose this proposal?
	Strongly oppose.
9	Question: It is proposed that in the future a decision to refer an individual for specialist genital reassignment surgery must be supported by a Registered Medical Practitioner. To what extent do you support or oppose this proposal?
	Tend to oppose.
10	Please provide comment in support of your answers
	The requirement outlined in question 8 does not appear to be in line with the following principles: (from the BMA guide: The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland, 2009) • Patients who are entitled to NHS-funded treatment may opt into or out of NHS care at any stage. • Patients may pay for additional private health care while continuing to receive care from the NHS. • Patients who have had a private consultation for investigations and diagnosis may transfer to the NHS for any subsequent treatment. They should be placed directly onto the NHS waiting list at the same position as if their original consultation had been within the NHS. Additionally, on the NHS site (http://www.nhs.uk/chq/Pages/2572.aspx?CategoryID=96) it states: "You shouldn't need to have any of the same tests twice – for example, to diagnose or monitor your condition." Requiring a referral from an NHS GIC would require a person who already had a diagnosis going through the diagnostic process a second time. It is unclear how question 9 relates to the previous question, nor which part of the service specification it relates to. We reiterate our statement that the requirement that a second letter of referral for genital surgery must come from a **"similarly-qualified and experienced professional not directly involved in the individual's care"** might be difficult or complicated in small practices, we also question the need for a referral to come from a medical practitioner when the surgeon will be able, and required, to make the appropriate assessments. Further to this, we believe that the referral should not have to come from an NHS Gender Identity Clinic, as this is not in line with the NHS policies on the interface between private and NHS treatment, as noted above.
11	We want to make sure we understand how different people will be affected by our proposals so that Gender Identity Services are appropriate and accessible to all and meet different people's needs. We have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?
	No
12	Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?
	Disability (individuals who are overweight)

	We disagree that this is a clinically justified consideration because a patient being significantly overweight increases their risk of complications during the operation and may compromise the outcome of their surgery. The opinions of an undisclosed number of surgeons on what weight they feel provides 'effective results' do not appear to be backed up by any medical research (on the effectiveness of gender-related surgeries for people with higher BMIs), and there is some evidence to support the idea that there is no additional risk during surgery to those with higher BMIs (e.g.. Dindo, D. et al. (2003) 'Obesity in general elective surgery'. The Lancet, 361, 2032–35). We would also question whether the concept of weight 'compromising the outcome of the surgery' is viewed through a lens of cisnormativity and based on an assumption of the trans person wishing to 'pass' as cisgender. If the service is to be truly person centred, and **"Assessments and interventions will be personalised and based on shared decision making"** then 'appropriateness or effectiveness' should not be pre-decided, nor should it be down to clinicians to decide, but rather the patient. *Pregnancy and Maternity* No justification is given for the assertion that the service specifications do not discriminate against anyone on the basis of pregnancy, we feel it would be prudent to seek reassurance on this issue. Sex (surgical procedures which are not routinely commissioned) This section does not address the initially stated argument that sex discrimination is apparent in the distribution of available surgical interventions, instead only making and repeating the point that adding new treatments to the pathway is outside the scope. While we do not currently have a comprehensive proposal as to how a fair distribution would be identified, this should be an area to consider in greater detail, including the outcomes and well as provision of treatment. For example, hormone therapy is likely to result in the development of facial hair for people undertaking a standard female to male pathway, but does not result in the loss of facial hair for those undertaking a male to female pathway, so the provision of facial epilation should be commissioned to produce equality in results. As noted above, there should be provision for breast augmentation surgery as a core procedure, just as there is provision for bilateral mastectomy and associated chest reconstruction. To do otherwise creates a material difference between how men and women are treated, which is discrimination based on sex. While name change is not explicitly mentioned in the service specifications, it is a routinely used marker of both serious intent to transition and 'start point' for real-life experience. As well as the fact that name change may be seen as unnecessary by many trans people (particularly those from some ethnic backgrounds), name change may not be legally possible for many who were born outside of the UK.
13	We have identified four potential options for prescribing arrangements for hormone treatment and described the positive and negative factors for each. Which of these options for future prescribing arrangements do you prefer?
	[no option chosen]
14	Please describe any other options for prescribing arrangements for hormone treatment that should be considered?
	We believe that all the above options should be available as required by individuals with different circumstances and needs. We also believe that the options should be explicitly available that the GP prescribes hormones before or without intervention from the GIC, allowing for local and decentralised treatment where expertise allows. We additionally suggest that individuals could receive their hormone prescriptions and monitoring from the local endocrinology department at the request of either the GP or GIC, or that the local endocrinology department or GPSI could support a GP to prescribe, again without any involvement with a GIC.

	If necessary, however, it should also be possible for an individual to have all their hormone prescription and monitoring undertaken and/or overseen by a GIC, for an indefinite period and without the involvement of a GP. This will be particularly important in the case of those with obstructive GPs or who are not currently registered with a GP due to homelessness or other factors. We would like to see hormone treatment for trans people added to the list of treatments routinely exempted from NHS prescription charges (alongside diabetes, epilepsy and cancer, for example: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx), and medical exemption certificates are issued routinely to people prescribed hormones (and/or hormone blockers).
15	Do you have any other comments about the proposals?
	We wish to reiterate that provision of fertility preservation should be included in the service specifications, and that NHS Specialised Commissioning and the Clinical Reference Group should have acted to include these before publishing the specification for consultation, and should now rectify this error during the review process and before publishing the final specification. We do not feel that the new service specifications go far enough towards addressing inconsistency in care quality, differing levels of access, and out-dated service models, particularly in the area of fertility. Gamete storage at the point of surgery is demonstrably part of the surgery itself. Gamete storage prior to surgery is contingent to it – in the same way as hair removal prior to phalloplasty or vaginoplasty is – and should be funded accordingly. Further to this, when interventions take place during cancer treatment which will affect a person's fertility, fertility preservation is routinely commissioned. The EHRC have made "caps and restrictions in relation to independent living and health services for trans people (including the taking and storage of gametes for those transitioning)." one of their legal priorities for 2017-18, as they view the current situation as a contravention of trans people's human rights.