

TransActual response to stakeholder consultation on NHSE's gender dysphoria services non-surgical service specification

This consultation provides an important opportunity to improve transition-related care for trans people. For several sections of the service specification, there is more to say than 1200 characters would permit. We have completed the online form - some sections are more or less in bullet point form due to the word count and we've not been able to include any references.

It is important that organisations advocating for trans people are able to fully respond and it is important that NHSE fully engages with these responses. With that in mind, I attach our full response to the stakeholder consultation on the non-surgical service specification.

Please consider this document TransActual's response to the stakeholder consultation on the non-surgical service specification.

Throughout our consultation response we make reference to version 8 of the WPATH Standards of Care. These standards were created according to Delphi Principles by a large group of international experts. The standards are evidence based and have been published in a peer-reviewed journal. They represent international best practice and it is important that NHS England pays due regard to them.

Background (paragraphs 4 - 6)

TransActual think that NHS gender services should remain prescribed specialised services for now. It would, however, be good to see the scope of the service specification expanded to more clearly specify the role of GP practices, PCNs and ICBs in the provision of NHS gender care. Where the specification references the extension of the model to primary care settings and sexual health settings, and given the success of the pilot gender clinics, we hope that all future commissioning of new clinics will focus on primary care based provision.

There are some changes we would wish to see in relation to terminology. The service specification is correct to use the term Gender Incongruence rather than other outdated terminology. However, it would be sensible to replace the definition of transsexualism with the definition of Gender Incongruence. It is important to acknowledge that many trans people experience gender dysphoria but in most places within the service specification, 'gender dysphoria' ought to be replaced with 'gender incongruence' as not all trans people seeking care will necessarily experience gender dysphoria. We do, however, appreciate that the specification acknowledges that some trans people do not experience gender dysphoria.

Principles guiding the development of this service specification (paragraphs 7-11)

It is good that the service specification recognises that being trans isn't a mental health condition and it is important that this acknowledgement is retained. We are pleased that the service specification recognises that all individuals should have 'full personal autonomy' over their gender identity and presentation. We'd like the specification to expand on this, by recognising that an individual's ability to self-determine their identity is an essential feature of autonomy, and a universal human right, as noted in WPATH standard 2.5. We wish to see all gender clinicians moving away from outdated and fixed expectations around how a trans person will present in clinic.

In line with WPATH standard 2.5 we would like to see stronger clarity around equitable access - we recommend that the service specification names the things that could prevent equitable access (such as being non-binary, disability, neurodivergence, race, religion, age) and sets out recommendations and considerations in relation to addressing them. This is important because there is data to show that trans people do not currently experience this equity of access. Populations of trans people experiencing this inequity include Black people and People of Colour (Hord and Medcalf, 2021; TransActual, 2021; Holti et al 2024), non-binary people (Valentine, 2016; TransActual, 2021; Holti et al, 2024), disabled and chronically ill people (Valentine, 2016; TransActual, 2021; Holti et al 2024), people who are neurodivergent (Valentine, 2016; Hord and Medcalf, 2021; Holti et al, 2024) and older people (Valentine, 2016; Hord and Medcalf, 2021; Holti et al, 2024). Within these studies, barriers to equity of access to transition related care have been documented to manifest across settings including within GICs, GPs, other healthcare settings, and in relation to wider social factors. It is also important to recognise that these issues can be multiplied for individuals experiencing multiple factors affecting equitable access (Holti et al, 2024).

It is good that the service specification acknowledges the right to timely and appropriate care, however we changes in the service specification and in service delivery are needed to allow this to become a reality. Current waiting times are well documented, unacceptable and have a negative impact on trans people's mental and physical health as well as personal and work lives (TransActual, 2022).

It is important that you keep the wording: 'Providers will respect the right of an individual to self-refer. These individuals should not be disadvantaged by a Provider's insistence on obtaining a prescriptive set of data from the individual's GP as a pre-condition to assessment as this may, in practice, deny an individual the access to care.'

Designated Gender Dysphoria Clinics will...

(paragraphs 12-22)

We are of the view that much in this section of the service specification is positive, in particular the requirements to:

- Provide a high quality service
- Promote respect, dignity and equality for trans people
- Meet the needs of the population
- Incorporate the views of individuals
- Publicise national and local trans-focussed support organisations
- Collaborate on research and share best practice.

Unfortunately, trans people's reports indicate that some clinics do not currently meet all of these requirements.

We also welcome the requirement for clinics to work with Children and Young People's services to facilitate transfer of care. However, the service specification needs to detail what good practice is in this area.

It is currently a requirement for clinics to 'Employ consistent and equitable decision-making about the effective use of resources on the NHS pathway of care for trans people.' Again, the service specification needs to state what this would look like. We'd also like to see the addition of a requirement for transparency in decision making as it relates to service delivery.

Holti et al (2024), in their study 'Improving the integration of care for trans adults: ICTA a mixed-methods study', recommend that there ought to be access to peer support and mental health support for those on the waiting list for gender clinics. This need is evidenced by the findings of TransActual's Transition Access Survey 2022, which highlighted the mental health impact of waiting for care (Grassian, 2022). Waiting list support ought to be added to the service specification as a requirement until such a time as waiting times return to an acceptable and clinically safe length.

The service specification currently places few requirements for gender clinics in relation to support and information provision for trans people that have been discharged. We would wish to see these requirements extended. It is essential that gender clinics support GPs and other healthcare professionals to ensure that trans people have access to inclusive and appropriate healthcare throughout their lifespan. Adding this requirement will help to ensure that NHS provision meets WPATH standard 2.5.

In line with WPATH standard 5.7, we wish to see a requirement for gender clinics to offer support to people who wish to change the trajectory of their transition (for example detransition). Whilst this impacts relatively few people, provision should be available and could easily be integrated into the work of existing clinics.

Staffing, structure and governance (paragraphs 23-34)

It is good that the specification states that there should be 'Arrangements in place to ensure that the service delivers culturally appropriate care and support', however TransActual's 2021 Trans Lives Survey found that an unacceptable number of trans people experience ableism, racism and transphobia when accessing transition related care (TransActual, 2021).

The specification for the senior clinical lead is broadly appropriate, however we'd like to see the addition of a requirement for senior clinical leads to have a secure understanding of health inequalities, particularly in relation to multiple marginalisation. Training for staff should also be mandatory in relation to this. This will help NHS services meet WPATH standards 2.5 and 4.2.

We are glad that all staff are expected to be trained in the mental health needs of trans people. It is well documented that trans people experience mental health difficulties at a disproportionate level, often due to the experience of being a trans person living in our society.

In line with WPATH standard 4.2, the service spec recognises a need for 'ongoing training' 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'd like to see the service specification offer clarity around the regularity, essential content and target audiences of this training, ensuring that the NHS provision is able to meet WPATH standards 2.5 and 4.1 - 4.3.

In relation to the multi-disciplinary team, the current specification meets WPATH's recommendations on the matter (WPATH standards 5.1 and 14.2), however some amendments will be beneficial:

- Care navigators and/or peer supporters should be available at all clinics.
- There must be lived experience of social and/or medical transition within the multi-disciplinary team.
- A requirement for there to be expertise around sexual health within the team, supporting NHS services to meet WPATH standards 17.1 to 17.5.
- All staff (including admin staff) should have neurodiversity awareness training.
- Any training around cultural competence needs to include admin staff. Holti et al (2024) found that administrative and reception staff, play a significant role in creating positive experiences or facilitating transphobia in the healthcare experiences of trans people. These findings are supported by multiple other studies which similarly highlight administrative staff and processes as a source of difficulty and disruption to care (Evans et al, 2023; Healthwatch Liverpool, 2023).
- All staff should be trained in the needs of non-binary people and different transition pathways they may wish to take. Despite the current service specification stating that non-binary people should be supported in their transition goals, reports from non-binary people accessing gender clinics indicate that this is not always the case. TransActual (2021), in our 2021 Trans Lives Survey found that many non-binary

people experienced non-binary specific discrimination in trans-specific health services.

- In line with WPATH standard 10.2, it is essential that training delivered to professionals involved in the care of trans and non-binary people should include content on a non-pathologising approach to the care of intersex individuals.

Whilst the specification states that the clinics ought to have a robust system of governance, we would question whether all of the current clinics meet this – both in monitoring of productivity and in the management of allocated budgets.

The specification states that clinics should have ‘sufficient administrative and managerial support needed for efficient and timely delivery of services’. Some clinics can take several months to send a report to a GP or referral to a surgeon. It is very clear that clinics are lacking in administrative support. We’d wish to see the requirement specify that clinics should be looking to improve admin efficiency, for example identifying tech based solutions to streamline some of their processes. It would be useful to require clinics to have systems in place for the quick and easy sharing of reports and blood test results, for example by using System One to its full capabilities.

We welcome the requirement to use information and technology systems that enable remote contact with service users (such as video and web consultations), as this makes appointments more accessible and removes the financial, emotional and time burdens of travelling to in-person appointments. That being said, there should be as much choice as possible, with all appointment types, as to whether the appointment is online or in person. This is for important reasons of accessibility and was something that was highlighted in the evaluation report of the Indigo Clinic at the end of its pilot phase.

In line with WPATH standard 5.2, more could be done to emphasise the role of Primary Care in providing transition-related care - in particular GPs, practice nurses, and phlebotomists. It is important that primary care staff know and understand their role in the pathway, and that funding is provided to ensure that practices have the capacity for clinicians to fulfil their responsibilities.

Whilst the specification does refer to person centred care, care planning has not always been as service user-led as it ought to have been. With that in mind, we’d like to see more emphasis on care plans being service user-led, which will help to ensure equitable access to care. This will help NHS services to meet WPATH standards 2.5, 4.2 and 8.1.

It is already a requirement that clinics gather data and conduct audits in order to help them continue to improve their services, but it is clear that this does not always happen. This needs to change and the data needs to be made as publicly available as possible. Being transparent with data and with service improvement will help rebuild trans people’s trust in NHS services.

We recommend that gender clinics should be required make the following data public:

- Waiting time from referral to first appointment
- Waiting time between appointments
- The number of people on the waiting list

- Number of appointments given per month
- The number of FTE staff employed by the clinic
- An annual report on the clinic's budget

Additionally, it should be a requirement that all clinics gather and report service user reported outcomes and experiences (PROMs and PREMs), with an analysis that takes equality monitoring data into account to help identify any inequities of experience or outcome.

The statement 'Arrangements in place to ensure that service improvement is shaped by active service user involvement, and be able to demonstrate how this is achieved via means that are accessible, transparent and inclusive' could go further. Any reviews of gender services should, where possible, be led by trans people or have trans people in a central role within the process. This needs to be made a consistent dimension of service development and evaluation, in line with WPATH standard 2.5.

We welcome the a requirement for proper complaints procedures to be in place, however it must be made clear to service users that their care will not be prejudiced by them making a complaint. It should also be clear that a complainant can request a change of clinician as well as ensuring that they know how to escalate their complaint if they're not happy.

It is essential that NHS England commits to commissioning more services to provide transition related care for trans people. We would like to see the NHS moving away from locating services within mental health provisions and instead commissioning GP led services in trans people's local communities or in pre-existing sexual health services already offering trans-specific clinics and services. There is evidence from the success of the Welsh Gender Service and from the pilot clinic evaluation reports to support this change in approach.

Care Pathway (paragraphs 35-36 + Appendix A)

Many of our comments on Appendix A are relevant to other sections of this consultation, to prevent unnecessary repetition, these are detailed in the new referrals, transfers of care, assessment, shared decision making, interventions delivered directly by the provider, interventions that are delivered directly by the provider, interventions delivered by other providers, surgery and conclusion of contact sections of this consultation.

The Transition Access Survey 2022 (TransActual, 2022) demonstrated the mental health impact of waiting for transition related care. This data is backed up by a growing number of prevention of future deaths reports. Until such a time as waiting lists reach a clinically safe level, mental health support for those on the waiting lists must be commissioned. This must go beyond peer support groups and provide access to optional NHS funded psychological therapies delivered by culturally competent clinicians.

Care navigators and/or peer support workers have become successfully integrated within some gender clinics. They play an important role and should be a required part of a clinic's offer.

We'd like to see the reference to 'Assessment for gender dysphoria and diagnosis' changed to 'Assessment for gender incongruence and for the suitability of transition related care'. This is because the word 'diagnosis' implies that there is something wrong with trans people and something to diagnose.

It is good that the specification states that trans people will have access to care from a multi-disciplinary team, but it would be useful to emphasise that their involvement in a person's care will be based on an individual's care plan and not on any requirement or rigid pathway.

There is no mention in the service specification about the need for clinicians to discuss contraception, sexual health and sexual pleasure with their service users. This is important information for trans people to have, there are many myths and misconceptions around trans people's sexual health. Including this in the service specification will help NHS provisions meet WPATH standards 17.2 to 17.5 and standard 16.6.

TransActual's research suggests that quarter of trans people self-medicate for HRT at some point in their transition (Grassian, 2022). In line with WPATH standard 2.5, we'd like to see a commitment to a non-judgemental, harm reduction approach for those who self-medicate. The approach taken by The Welsh Gender Service is an example of good practice in this area.

We are aware that three common barriers to accessing transition related surgeries are weight, smoking and poor mental health. Whilst psychological therapies are available at gender clinics, appropriate trans-specific support needs to be available for those who wish to lose weight or stop smoking. Minority stress can impact eating, exercise and substance use, and many trans people have experienced eating disorders. It is essential that any health promotion service is delivered in a manner sensitive to that.

Access to NHS funded hair removal should remain in place, in line with WPATH standard 15.14. However the majority (79.7%) of people for whom it was relevant told TransActual's 2022 Transition Access Survey that the hair removal sessions funded by the NHS were insufficient to meet their needs (Grassian, 2022). Similarly, many participants in Holti et al (2024, p.27) found that NHS provision for hair removal was 'too minimal to be helpful'. The limit on the funding given to each person for facial hair removal should be removed and replaced with a new system. An initial 8 hours of laser hair removal (or equivalent of electrolysis) could be prescribed, with the option for clinicians to prescribe additional blocks if they are needed in order to meet the individual's treatment goals. It is not appropriate to have a one size fits all approach. Factors such as grey hair or darker skin can make some hair removal techniques less effective. To deny older trans people or Black and brown trans people these additional sessions could breach the Equality Act 2010. In Holti et al (2024), participants in these groups were more likely to pay privately for additional hair removal with significant associated financial burden.

The care pathway needs to specify more clearly that ongoing care from the GP, with support from the gender clinic, runs in tandem to other aspects of the care pathway. There should be a national shared care agreement, with funding provided to ICBs so that they may pay practices for enhanced services. This will help to address some of the barriers to GPs

prescribing – lack of local policy on the matter and a perception that they aren't funded to prescribe HRT to trans people are two of the most commonly given reasons for refusal reported to TransActual (TransActual, 2024). This suggestion is supported by the recommendations in Holti et al (2024), which recommend the introduction of standards for trans care within primary care, accompanied by training for GP practices.

Currently, reimbursement of the cost of travelling to in-person appointments and for surgery is only provided to trans people on a low income. This places trans people at financial disadvantage when being trans already comes with additional costs for prosthetics, new clothing and wigs (for example). As is the case in Scotland, we recommend that travel costs should be reimbursed for any trans person travelling over 30 miles for an appointment.

New referrals (paragraph 37 + Appendix B)

The current specification should be amended to specify that all clinics must accept self-referral. Incidents of GPs refusing to refer trans people to gender clinics because of their own prejudices are far too common. Additionally, whilst everybody is entitled to register with a GP, data from the BMA (2024) and the ONS (2024) suggests that 7% of people in the UK are not registered with a GP. The barriers to accessing healthcare for trans people are multiple and some people may need support with it. We suggest that self-referrals from individuals not registered with GPs ought to be accepted and that GDNRSS offer those individuals support to register with a GP whilst they are on the waiting list.

In the case of co-morbidities, it should be clear in the care pathway that any GP that has been asked to refer a trans person to a gender clinic does so in addition to referring to any other specialist services needed and that these referrals happen in parallel and without delaying referral to a gender clinic. It is, however, important to stress that nobody should be compelled to access care or assessments that they do not wish to access. For example, if a GP recommends that a trans person is assessed for autism, they should have the right to state they do not wish to seek an autism diagnosis without that preventing them from accessing transition-related care.

Until waiting times for NHS gender services are clinically safe, it is essential that services are commissioned to support those on the waiting list. Well-BN in Brighton and The Bridge in Southwark both offer support, including bridging prescriptions, for those waiting to be seen by an NHS gender service. Trans people in all areas of England should have access to similar levels of support, and as such the service specification ought to include such provisions as part of a harm reduction approach.

Mental health support is also vital for those on the waiting list. TransActual's Transition Access Survey 2022 (Grassian, 2022) and a number of prevention of future deaths reports have highlighted the mental health impact of waiting for transition related care. Psychological therapies should be available on the NHS for those on the waiting list for NHS gender services - these could include provision of NHS funding to existing LGBTQ+ charities offering counselling to trans people, as they are currently oversubscribed and underfunded.

Requests for transfers of care from specialised adult services (paragraph 38 + Appendix C)

The service specification on requests for transfers of care is broadly appropriate, however could be improved by stating that all clinics should honour the position on the waiting list for requests for transfer of care. It should also be a requirement that gender clinics publish their policy on transfers of care on their websites in an easily accessible location.

A flow chart within the appendix would be useful to ensure that expectations around roles and responsibilities are clear in relation to transfer of care.

Requests for transfers of care from the Gender Identity Development Service for Children and Young People (paragraph 39 + Appendix D)

The current service specification places an expectation of a 6 month crossover period between CYP and adult gender services. This is good but we suggest changing the wording on shared appointments with previous and new clinicians and the young people from 'may' to 'should'. The specification ought to place more emphasis on trans people being supported to take ownership of their care plan and being central in discussions about the transfer of their care. A flow chart within the appendix would be useful to ensure that expectations around roles and responsibilities are clear in relation to transfer of care.

We are aware that NHS England is considering developing a service specifically for 17 to 25 year olds. Improved service delivery and improved transfers of care ought to make such a service unnecessary. However, if such a service is developed, it should sit within adult gender services because people aged 18 and over are adults and not children. Given that transfer of care has proved an issue thus far, it would be illogical to commission a stand-alone 17 to 25s service because it would result in there being two transfers of care between services (CYP to young adult, then young adult to over 25s services). Furthermore, adults aged 18 to 25 should be able to access the aspects of transition related care that over 25s can. Age is a protected characteristic within the Equality Act 2010 and due regard should be paid to that.

Assessment process for newly-referred individuals (paragraph 40 + Appendix E)

Whilst the assessment process detailed in the service specification is broadly in line with WPATH's Standards of Care, there are some aspects that need to change. There is research to show that trans people find the current NHS assessment process stressful, adversarial and prolonged (Holti et al 2024). It needn't be this way and there are examples of good practice in Wales and elsewhere in the world that could be replicated in NHS England services.

There are a number of reasons to remove the requirement for two assessment appointments. Most trans people will not require a second assessment appointment, as many people will arrive at the clinic confident in knowing who they are. Jones et al (2017) found a high level of agreement between clinicians conducting first and second assessment appointments, demonstrating that second appointments are often unnecessary. Removing the requirement for a second assessment will also free up clinicians to see other service users. Moving to a single assessment model has been shown to effectively reduce waiting times in other services (Eade et al, 2018).

Second assessment appointments should be reserved for people who want or need more time to discuss their gender identity with a clinician or for people with particularly complex needs. There should, however, be clear guidance on what is classed as complex – for example, being clear that being neurodivergent does not automatically mean that a trans person's case is more complex.

We see the benefit of MDT discussions on more complex cases, but there must be clear expectations that judgements of complexity are based on material facts and not ableist assumptions.

For those people who are exploring their gender, NHS gender clinics should offer access to holistic services to enable them to do that. This care must be supportive, affirming and non-judgemental. It should also be open to people further on in the care pathway who wish to re-explore their gender. These services should, of course, be optional and not be a requirement for access to treatment for people who already know their gender and wish to proceed with transition.

There is data to suggest that there is a greater incidence of disability, neurodivergence and chronic illness in the trans population. With that in mind, the service specification should state that service users must always be asked in advance about any access needs they may have.

A quarter of trans people self-medicate for HRT and more than half access it privately (Grassian, 2022). This is largely due to NHS waiting times. The service specification should emphasise the need for a non-judgemental approach to people who are already taking HRT, including those who have self-medicated. At a minimum, clinicians should offer harm reduction advice and signposting where needed. However, where the service user is already

on HRT, and the clinician is satisfied that it's appropriate, gender service clinicians should offer an immediate recommendation for the GP to prescribe. This would be in line with WPATH standard 12.20 which states 'We recommend health care professionals initiate and continue gender-affirming hormone therapy for eligible* transgender and gender diverse people who require this treatment due to demonstrated improvement in psychosocial functioning and quality of life'.

Currently the service specification uses the terminology of diagnosis and treatment process. The WHO recognise that being trans is not a disorder, therefore it would be more appropriate to refer to care pathways instead of treatment processes and 'identification of gender incongruence' rather than 'diagnosis'. This approach would be in the spirit of the WHO stance on the matter, as well as WPATH standard 2.5.

The current service specification states that service users that do not experience gender dysphoria as a consequence of gender incongruence should be referred to alternative services and discharged. Some trans people who do not experience gender dysphoria may, nonetheless, experience gender euphoria as a result of access to transition related care. This is something that should be taken into consideration.

In line with WPATH standard 8.2, the service specification states that people shouldn't need to socially transition (eg name and appearance change) in order to access care. This is positive and this should be retained in the specification. However, in practice, there are often expectations from clinicians around social transition, indicating a need for greater emphasis on this point in the specification. In the past, lack of social transition was a frequently given reason for people not receiving access to hormone treatment after assessment (Jones et al, 2017).

It is important that the service specification retains the current wording around the attendance of family members at appointments and their role in the assessment process – involvement of family members should remain optional and decisions on family member involvement should sit with service users.

Physical examination (paragraph 41 + Appendix F)

The specification is very clear with regards to physical examination and we consider both the wording and content to be sufficient. This should be retained. It would be useful for Appendix F to give examples of cases where physical examination would be clinically necessary.

We would like an addition to this part of the service specification that states that anybody conducting a physical examination is trained in trauma informed approaches and that they are knowledgeable about the steps they can take to minimise a service user's experience of dysphoria in these instances. Emphasis needs to be given to this, so it ought to appear in the main body of the service specification in addition to Appendix F.

More information would also be beneficial on the right to refuse examination, how that is communicated to service users by clinicians, and how that would (or would not) impact

access to care. We emphasise that, as part of making informed consent to care, that trans people should be able to make decisions on their care and the level of risk to their health (for example by not having a physical examination) that it may carry.

Named professional's role in treatment process (paragraph 42 + Appendix G)

It is useful to have a named professional involved in each trans person's care, especially because it reduces the need for service users to repeat the things they'd already spoken about in previous appointments. It is important that any change in named professional is clearly communicated to both the trans person and their GP.

Lines of communication between the named clinician and trans people and their GPs should be clearer and make better use of emerging technology or technology that is well established in other areas of medicine. For example, both trans people and clinicians should be able to use a system such as e-consult to ask for information quickly. Clinical data should also be available via System One and on the NHS App. This will reduce some of the burden on the admin team and improve relationships between GPs and clinics.

Many gender clinicians send extensive reports to GPs after every appointment. Some GPs tell us that, apart from providing information assessment and discharge reports, the level of detail is given is unnecessary. Unnecessarily long reports add to GP workload. Instead, letters should be much more succinct, with information easy to access at a glance. More detailed reports could be added electronically to a service users' medical record should the GP wish to read them.

It would also be good to make it clear that trans people have the right to request a change of named clinician without prejudicing the care they receive.

Lead Clinician role in treatment process (paragraph 43 + Appendix H)

We agree that the lead clinician should be a registered medical professional or clinical psychologist. It is important to emphasise that they need not be a psychiatrist because being trans is not a mental health condition.

It is essential that the statement on the lead clinician not being the one offering talking therapy remains, to ensure that service users do not avoid being honest about their feelings in therapy sessions for fear of it prejudicing the care they have access to.

It is important to add that lead clinicians' CPD should include training on key topics such as non-traditional transitions, neurodivergence, anti-racist practice and disability-equity.

Of course we agree that lead clinicians should be experienced and knowledgeable, however the requirement for two years' experience will create challenges in opening any new services, which are desperately needed. Whilst the caveat that lead clinicians without two years' experience could do the role, the requirement for supervision from a colleague with 2+ years' experience will add to the workload of the already overstretched clinicians, impacting the capacity of the system to care for service users. Dropping the requirement to one year could help overcome this issue.

Shared decision making (paragraph 44)

The paragraph on shared decision making is generally quite good, although some aspects would benefit from additional emphasis. We would recommend a move away from the phrasing of 'treatment plan', instead referring to a person's 'care plan'. This will support efforts to destigmatise the existence of trans people.

When referring to the individualised care plan, it is essential to emphasise that care planning should be person-centred and service user-led. This will help NHS services to meet standard 2.5 and is in line with recommendations made by Holti et al (2024).

It's good that the specification highlights that interventions can take place in the order that suits the trans person best. However we would like additional emphasis to make it clear that clinics must offer or provide access to the interventions specified in the service specification, but that the interventions given to an individual are ones that they want access to. For example, it is important to retain all statements around psychological therapies being optional and based on an affirming model of care.

It may be useful, in this part of the service specification, to reiterate the role of the service user's GP in providing some of the care identified in the care plan (ie HRT prescribing and blood testing).

Capacity and informed consent (paragraphs 45 - 46)

We are glad that this section is broadly in line with WPATH standards, however it would be useful to specify or reiterate what best practice is around assessing capacity to consent and the making of best-interest decisions. A reference to a national Mental Capacity Act Policy may achieve this.

In particular, it is absolutely essential to recognise and respect the rights of adults to make decisions about their own care where they have the capacity to do so. This includes neurodivergent people and people with learning disabilities. In line with the Mental Capacity Act, best-interest decisions should not be made by family members unless they have lasting power of attorney.

In line with WPATH standard 18.1, it would be beneficial for the service specification to specify that those deemed too mentally unwell to consent should be offered mental health support in order to support them to become well enough to consent.

When talking about informed consent in the service specification, we would like to see an acknowledgement that the life changing effects of accessing transition related care tend to be positive. This can be done whilst still acknowledging risk, which is present in almost all medical interventions.

Loss of fertility (paragraphs 47 - 48)

We agree that it is important that fertility is discussed, in line with WPATH standard 16.1, although it would be useful to make it clear that discussions around the psychosocial implications of infertility should be part of those discussions. Trans people's bodily autonomy should be respected in regards to decisions around whether or not they wish to preserve their fertility.

Currently decisions to fund the referrals for fertility preservation are made at an ICB level and are at their discretion. This has resulted in a 'postcode lottery' for trans people seeking this. The service specification needs to set a clear expectation that ICBs will fund fertility preservation. This will ensure NHS provision is in line with WPATH standards 16.2 and 16.3.

The Provider's role in the treatment process (paragraphs 49 - 50)

We are glad that the service specification acknowledges that each trans person's journey through the care pathway is unique to them, and that it can be non-linear. However, some trans people still report finding the care pathway to be lacking in flexibility. With that in mind, additional emphasis on this may be needed. We feel that it is appropriate that service users returning after deferred treatment don't have to go through full reassessment, unless they indicate that it may be beneficial for them.

In the spirit of WPATH recommendation 2.6, we would like the specification to state that clinicians should take a non-judgemental approach.. They should offer wellbeing support but not to make assumptions about service user motivations for asking to change parts of their care plan. Care should be taken not to equate changing or stopping treatment to detransition and regret, as these do not necessarily occur together. Research indicates that individuals may change their treatment choices for a variety of reasons, some of which do not relate to detransition associated with a change in identity (MacKinnon et al, 2022). Detransition is not consistently associated with regret, with regret reported in only 22% of cases in MacKinnon et al (2022) and documented in 2 of the 12 cases of detransition identified by Hall et al. (2021) in their UK study.

It is important to reiterate that transition-related regret is rare. Regret after gender affirming surgery is less than 1%, whereas the regret rate following bariatric surgery is 19.5% (Thornton et al, 2024).

Interventions that are delivered directly by the Provider - Voice and Communication Therapy (paragraphs 51-52)

In line with the standards in section 14 of the WPATH standards of care, Speech and Language Therapy should continue to be offered to trans people by the NHS. This provision should be based on each service user's need and transition goals, rather than there being a fixed number of sessions.

It is good that the specification highlights the potential for the involvement of non-specialist local services, however it would be useful to clarify how this would be funded if the trans person would not normally meet the referral threshold for their local service.

An amendment is needed to the service specification in relation to people with pre-existing voice difficulties:

- For those people who have already had treatment for voice difficulties and have achieved the best outcome possible, Speech and Language Therapy should remain available if there may be some benefit for them. To not offer this may constitute disability discrimination in some cases.
- People who need to access local Speech and Language Therapy to address pre-existing voice difficulties should be referred to local services by staff at the gender clinic rather than placing the burden on them to self-refer or ask their GP to refer.

Interventions that are delivered directly by the Provider - Specialised psychological interventions (paragraph 53-54 + Appendix I)

It is important that psychological interventions remain optional and evidence based, in line with WPATH standard 18.9 which states that 'health care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment, while acknowledging psychotherapy may be helpful for some transgender and gender diverse people'.

Holti et al (2024) found that while service users who have experienced psychological interventions within the GIC system post-diagnosis to be helpful, service users are anxious about how information disclosed during psychological interventions may impact on their access to other elements of transition-related care, and as a result feel unsafe discussing

complex aspects of their identity in these circumstances. Holti et al (2024) recommend for this reason that the provision of psychological interventions needs to be separated from other elements of transition-related care in order for service users to be able to fully engage and benefit from these. Therefore, when they are offered psychological interventions, it should be made very clear to service users that they are interventions rather than assessment appointments. Similarly, when attending assessment appointments, clinicians should ensure that service users understand that they are not psychological interventions. To support this distinction, psychological interventions should not be provided by the clinician completing the assessment.

It would be good for all service users that access psychological interventions to be given the option of individual or group therapy, as well as couple and family therapy.

It would be useful to amend the specification to add that support will be made to people returning to the service after discharge if they would like to access interventions that will support them around any changed understanding of their gender.

We are pleased that the service specification recognises that conversion practices are not appropriate, in line with WPATH standards 2.5 and 18.10. It would be useful to add that if a trans person discloses experiences of conversion practices, that they should be offered appropriate support to deal with the trauma resulting from it, if that is something they wish to access.

Interventions that are delivered directly by the Provider - Assessment for endocrine and other pharmacological interventions (paragraph 55 + Appendix J)

There are a number of updates needed to the specification to reflect the most recent updates to the WPATH standards of care. In particular, WPATH standards 12.9, 12.10, 12.15, 12.20, 12.21, 15.11, 15.13 and 18.6.

It is essential that access to HRT for trans people remains, in line with the standards outlined in Section 12 of the WPATH Standards of Care. Access to HRT has been demonstrated to have a positive impact on the lives of trans people who access it. We value the ongoing provision of testosterone-lowering medications for people with testes seeking hormonal feminisation, in line with WPATH standard 12.16. It is essential that this provision continues, as recommended by the Endocrine Society. The positive impact is demonstrated across multiple research papers, and is highlighted by the qualitative data in the Transition Access Survey 2022 (Grassian, 2022).

It is important for the service specification to acknowledge that many service users will have started endocrine pathways before they present to the clinic. Emphasis should be given to taking a non-judgemental approach to this, with consideration given to harm reduction

approaches in relation to people who are self-medicating. The approach the Welsh Gender Service takes to harm reduction provides a workable example of how gender clinics in England could do this. In the majority of cases, it will be clear in that appointment if the treatment is appropriate. As such, the service specification should be amended to state that if the service user is already taking HRT when they arrive at the clinic and they are happy with the results so far, NHS gender clinicians should make an immediate recommendation for the GP to prescribe unless there is a medical contraindication. To not do so places unnecessary financial burden on trans people, many of whom make great sacrifices in order to afford to pay for private care whilst waiting for the NHS to provide the care they're entitled to.

BMI is not a reliable measure of obesity and it does not assess disease risk related to body fat. In addition to this, a number of factors influence the risk typically associated with BMI (including social determinants, race, ethnicity, and age) (National Academies of Sciences, Engineering, and Medicine, 2023). With that in mind, we suggest a move to using more reliable measures associated with the clinical risks around body fat and use of HRT.

Whilst the specification states that clinicians should discuss weight loss and smoking cessation with service users when relevant, it would be extremely beneficial to commission a trauma informed, non-judgemental trans specific service to support people with this. At the very least, the service specification needs to specify that clinicians signpost to smoking cessation and (healthy) support around weight loss, with consideration to history of eating disorders and the impact of minority stress and prior trauma.

For many trans people, regardless of gender, there are concerns about testosterone-related hair loss. It would be useful for the service specification to state that gender clinicians should offer advice around that to people accessing HRT.

We are glad that the specification is broadly in line with WPATH standard 12.14 in stating that people over 40 will be offered transdermal oestrogen due to the higher risk of developing venous thromboembolism. It is good that the specification advises clinicians not to prescribe ethinyl oestradiol in line with WPATH recommendation 12.13. We suggest also discouraging the prescribing conjugated oestrogens in line with WPATH standard 12.15.

Whilst it is implied, we suggest that the specification is more explicit in stating that professionals should evaluate and address medical conditions that can be exacerbated by lowered endogenous sex hormone concentrations and treatment with exogenous sex hormones, bringing the specification in line with WPATH standard 12.11.

In line with WPATH standard 12.17, the service specification highlights the need to monitor haematocrit (or haemoglobin) levels in people taking testosterone. However, due to issues with GPs refusing to share care, we worry that this (and other important testing) is not always accessible in practice. With that in mind, it's essential to add very clear expectations on GP responsibilities to prescribe HRT and to order blood tests. It could be useful to have a table or diagram showing which aspects of care ought to sit with the GP and which aspects ought to sit with the gender clinic. As discussed elsewhere, GP responsibilities should be reflected in ICB policies and in funding for GPs. Without this, the NHS will continue failing to meet WPATH standard 12.20. Access to care needs to be actual, not just theoretical.

Interventions delivered by other providers (paragraph 56)

The care pathway needs to specify more clearly that ongoing care from the GP, with support from the gender clinic, runs in tandem with other aspects of the pathway. There should be a national shared care agreement, with funding provided to ICBs so that they can pay practices to offer enhanced services. This will help to address some of the barriers to GPs prescribing – lack of local policy on the matter and a perception that GPs aren't funded to prescribe HRT to trans people are two of the most commonly given reasons for refusing to prescribe, as reported in TransActual's October 2024 report on GP refusal to prescribe HRT (TransActual, 2024). This suggestion is supported by the recommendations made by Holti et al (2024) in 'Improving the integration of care for trans adults :ICTA a mixed-methods study'.

Digital solutions could support GPs and gender clinics to work together more effectively. These improved working relationships could take the burden off the service users, who are often expected to chase up their own blood tests and results prior to appointments.

We are supportive of the statement 'The Provider may refer the individual for other interventions delivered by other providers should the intervention be routinely commissioned by the NHS' and it should remain in the specification.

Surgery for the treatment of gender dysphoria (paragraphs 57 - 64)

We agree that NHS England should continue to commission transition related surgeries, although will have more to say on the services commissioned when the surgical service specification is next updated.

Some changes are needed to the referral process for transition related surgeries. There should be a move to all types of transition related surgery being available based on 1 letter of referral. In addition to the consent for referral, trans people attend a surgical consultation, a pre-op appointment and then sign an informed consent agreement on the day of surgery. A second letter of referral is entirely unnecessary. Removal of the second referral requirement would bring NHS provision in line with WPATH standard 5.5. A second letter of referral is also inconsistent with surgeries for cisgender people that have similar irreversibility, effects on fertility and involvement of 'healthy tissue' (Bouman et al, 2014). Bouman et al (2014) suggest that any risks associated with single practitioner assessment for surgery that would be addressed by a second assessment can equally be addressed through good clinical governance procedures and an effective multidisciplinary team.

We suggest bringing the time-related requirement for HRT prior to surgery in line with WPATH standard 5.6. This recommends that trans people should be on HRT (if at all) for 6 months prior to lower surgery. It is good, however, that in line with WPATH standard 8.3,

that people don't have to have been on HRT to transition if it's not something they wish to/can do.

Having a GRC ought to be immaterial to a person being referred for surgery, so we would recommend removing this from the specification. References to 'gender role' and use of arbitrary time limits should also be removed. Whilst we value the acknowledgement that comments on 'this must not entail a requirement for the individual to conform to externally imposed or arbitrary preconceptions about gender identity and presentation', it nonetheless plays into gender stereotypes. The specification states that the references to 'gender role' relate to assessments of preparedness to cope with the personal and social consequences of surgery. Rather than referring to 'gender role', then, the specification ought to refer to discussions the clinician and service user have had around their hopes for surgery and any challenges that may arise as a consequence. Simply, the referral should state that the clinician is happy that the service user understands the implications of surgery and wishes to proceed. They would of course comment on capacity to consent and, if a best interests decision has been made, the process which was followed.

Currently the specification does not state that referral letters for surgery should say what outcomes matter to the trans person being referred. This is an oversight that ought to be addressed.

The Transition Access Survey (Grassian, 2022) highlighted the impact of waiting for surgery on trans people's lives, including on mental health and personal relationships. Waiting times for NHS transition-related surgeries are unacceptable, in particular the 5+ year wait for masculinising lower surgeries. Appropriate mental health support needs to be provided for those waiting for NHS transition related-surgeries and this support needs to be part of the care pathway until waiting times meet the 18 week duty.

Similarly, mental health support should be available to those who have experienced surgical complications and for those who have been refused surgery due to high clinical risk.

The service specification needs to set out pathways for surgical re-referral for complications that come to light after discharge from the gender clinic and for replacement of erectile devices when required. It may be that these referrals go via GDNRSS without the need for involvement from the gender clinics, however this needs making clear.

It would be helpful for the specification, either in its main body or in an appendix, to state what responsibilities sit with gender clinics and which sit with GDNRSS. Our view is that GDNRSS can support trans people by:

- Offering information to support service user choice, including information on complication rates, surgical outcomes and people's experiences.
- Providing information on waiting times for different surgical teams.
- Managing waiting lists and maintaining an appropriate level of communication with people on them - this could be in part, be managed by an app or online portal. For example, an app to indicate where on a waiting list a person's referral is sitting.
- Managing re-referrals for surgical complications arising after discharge from the gender clinic and for replacement erectile devices.

Conclusion of contact with the Provider (paragraphs 65 - 66)

Holti et al (2024) identified a number of issues around attendance policies at NHS gender clinics (Holti et al, 2024). The service specification should state what would and wouldn't be acceptable reasons for discharge. For example, it would not be appropriate to discharge someone for missing an appointment because of an episode of poor mental health on the day of the appointment.

It is appropriate that gender clinics are expected not to discharge service users until 6 months after the last intervention, unless it is at the request of the individual. However, some NHS gender clinics may need reminding of this - we are aware that some have been discharging service users who are still on the waiting list for surgery.

The service specification needs to very clearly state the GP's responsibilities for continuation of care in relation to prescribing and blood tests. This is an important aspect of ensuring that the NHS fully meets WPATH standards 12.6 and 12.20 and is actually providing access to HRT, including continuity of care. TransActual's October 2024 report into GP refusals to prescribe found that, of those with a letter from an NHS gender clinic recommending that their GP prescribes HRT, more than a third of those refused had already been discharged from their gender clinic (TransActual, 2024).

After the conclusion of contact, it is important to have clear routes of access back to gender services and easy ways for trans people who have been discharged to access information. Digital portals for discharged services users and for GPs may provide an efficient solution in this matter. This pathway should be clearly communicated to GPs and service users at the point of discharge, with a clear pathway for re-referral for anybody whose relationship with their gender identity changes or who experiences surgical complications years after the initial surgeries.

Holti et al (2024) found that older trans people can have particular difficulties accessing appropriate screening and with ongoing access to hormones, as well as to inclusive and appropriate healthcare more broadly. Currently access to screening, much of which occurs in later life and post-discharge from gender clinics, is variable and relies on trans people having awareness of which screening they need (Holti et al, 2024).

At discharge, trans people and their GPs should be given access to information about life-long care and how that may differ from care for cisgender people. This goes beyond HRT, but relates to cancer, different reference ranges for blood testing, and aging related psychological, medical and social concerns. To offer this would bring NHS provision in line with WPATH standard 15.5.

Interdependence with other Services (paragraph 67)

We value all of this paragraph and it should be retained, albeit with added content. Given the data on racism and ableism in the Trans Lives Survey 2021 (TransActual, 2021), it is important that MDTs within gender clinics have access to support from colleagues with expertise in Equality, Diversity and Inclusion.

It would be sensible, in this section or elsewhere in the specification, to specify what the responsibilities of GPs are and to more clearly state the responsibilities of gender clinics to communicate effectively and in a timely manner with GPs.

It is important for the service specification to recognise that some trans people have complex health needs. There should be an expectation that, with the service user's permission, clinics will collaborate closely with other clinicians and agencies involved in the person's care. We note, also, the importance of services such as The UK Cancer and Transition Service, which clinics should also be expected to work closely with when relevant to any of their service users.

Gender Identity Healthcare Credential (paragraph 68)

We support the concept of a Gender Identity Healthcare Credential, but wish to see the specification expand to cover other areas of medical education. It is our view that, in addition to supporting the delivery of the Gender Identity Healthcare Credential, NHS gender clinics should also support:

- GP training on reference ranges in blood testing. This includes hormone levels, but covers other tests that could be impacted by a person being trans. Offering this support to GPs will help ensure that NHS provision is in line with WPATH standard 15.3.
- Delivery of trans-specific teaching to undergraduate and postgraduate clinical trainees.

It is important that any increase in the demand on staff time and energy should be reflected in budget and staffing levels.

Population Covered By This Specification (paragraphs 69 - 72)

TransActual recommend retaining the following wording:

'This specification recognises and respects diversity in gender identity and its expression. It recognises that there are other identities than the traditional (binary) identities associated with 'man' and 'woman', and that gender diverse people with such identities (and who are known by a variety of other names, including non-binary, trans-feminine, trans-masculine, Genderqueer, non-gender and others) who meet the criteria for access to the NHS pathway of care 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 suggest replacing the statement 'Subsequent interventions will only be accessed by individuals who have been diagnosed with gender dysphoria' with 'Subsequent interventions will only be accessed by individuals experiencing gender incongruence'. This is because trans people are not ill and do not need diagnosing, and because some people who don't experience gender dysphoria may still benefit from the support of a gender clinic.

As stated elsewhere in our response, we suggest that referrals from individuals without a GP should be accepted and that GDNRSS should support them to register with a GP - either via an online provision or locally to them.

Population needs; and Expected Demographic Changes (paragraph 73)

This section needs to be updated with the 2021 Census data. Whilst there have been concerns raised about some people not understanding the trans-specific question, any inflation of figures in that respect is likely to be counterbalanced by some trans people being unwilling to answer the question.

There are estimated to be 262,000 trans people in England and Wales. Of those individuals in England:

- 18% are men
- 18% are women
- 11% are non-binary
- 7% identify in another way
- 45% did not specify their gender
- (ONS, 2023)

Younger people are more likely to be out as trans. We believe that this is likely to be a result of increased social acceptance amongst younger people, and that there may well be many older people who feel unable to come out as trans. Data for England shows the proportions of trans people in the population as:

- 1% of 16-24 year olds
 - 0.77% of 25-34 year olds
 - 0.65% of 35-44 year olds
 - 0.48% of 45-54 year olds
 - 0.34% of 55-64 year olds
 - 0.25% of 66-74 year olds
 - 0.22% of people aged 75 and over
- (ONS, 2023)

It is important to dispel the misconception that all trans men are attracted to women and that all trans women are attracted to women. Of the Census respondents in England that specified their gender identity and sexual orientation,

- 32% of trans men identify as LGB+ and 68% are heterosexual (attracted to women).
 - 34% of trans women identify as LGB+ and 66% are heterosexual (attracted to men).
 - 92% of people of other gender identities identify as LGB+ and 8% are heterosexual.
- (ONS, 2023)

28% of trans men are disabled, 29% of trans women are disabled, 55% of people of other gender identities are disabled (ONS, 2023). It is well documented that a high proportion of the trans population are neurodivergent. We suggest that whilst the service specification should acknowledge this, it is important to acknowledge the reason for this is ultimately unimportant. Because there is nothing 'wrong' with either neurodivergent or trans people, there is no need to identify a 'cause' - seeking a 'cause' indicates a desire to seek a 'cure'.

It is important to acknowledge that, of those that misunderstood the question about gender identity in the Census due to language barriers, many will not have been White British. However, the majority of non-White British respondents will have understood the question. For that reason, we include the figures in this response. Of the people in England who stated that their gender identity is not the same as the one assigned to them at birth:

- 16% are Asian, Asian British or Asian Welsh
 - 11% are Black, Black British, Black Welsh, Caribbean or African
 - 4% are of mixed heritage
 - 47% are White English, Welsh, Scottish, Northern Irish or British
 - 1% are White Irish
 - 13% are of Gypsy or Irish Traveller, Roma or Other White heritage
 - 7% are of another heritage
- (ONS, 2023)

Referral data for children and young people's gender services to draw conclusions about adult demographics should only be used with caution. Demographic data may differ for trans adults as there are a number of factors that could delay someone coming out as trans and some disproportionately impact people of different genders, social and cultural backgrounds, and faiths. These include:

- Society's punishment of femininity in people perceived to be male.

- Fear of family rejection and associated considerations around safety, funding for higher education, and housing.

Comments on other matters not included in the survey

Clinical outcomes indicators

In addition to the clinical outcomes indicators listed in the service specification, we suggest that the following indicators are added:

- Service user satisfaction
- Appointments per FTE clinical staff member per month
- Maximum wait between appointments
- Something around transfer of care from CYP service to adults
- Number of non-specialist professionals trained as part of clinical outreach
- Number of people accessing support for those on the waiting list
- Something about demographic monitoring, mapped across the different KPIs
- Number of complaints per year
- % of emails responded to within 1 week
- % of reports and referrals on sent within 1 month

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