

Summary Report of the Public Panel Discussion of Gender Reassignment Services in London.

Tuesday 1st May 2007

Hosted by the Greater London Authority

Supported by the Department of Health and the Gay & Lesbian Association of Doctors and Dentists

Panel members:

Dr Justin Varney – Gay & Lesbian Association of Doctors and Dentists (Chair)
Frances Mapstone – Head of Social Inclusion and Health, Greater London Authority
Dr Susan Schonfield – Consultant in Public Health, Hillingdon Primary Care Trust, NW London Specialised Commissioning Group
Dr Stuart Lorimer – Consultant Psychiatrist, Charing Cross Gender Identity Clinic
Tracy Dean – Press for Change
Persia West – Brighton and Hove Trans Focus Group
Ben Thom – FTM London

The panel was attended by over fifty members of the public, some travelling from outside London to join this public discussion of gender reassignment services in the Capital.

The discussion opened with an introduction from Dr Varney acknowledging that although there were historical tensions, the panel marked the first step in developing a stronger dialogue between commissioners, the gender identity clinicians and the Trans community. The panel was the second of two public discussion panels supported by the Department of Health and the Greater London Authority (GLA) to mark LGBT History Month.

Frances Mapstone, Head of Social Inclusion and Health for the GLA, started by welcoming the panel and the audience on behalf of the Mayor and recognising the value of this type of public engagement between services and communities. She highlighted that individuals and communities should be engaging with the GLA around the emerging Health Inequalities Strategy and that she was keen to see the voice and experiences of LGB and T communities powerfully visible in the evidence, the engagement and the strategy as it develops.

Frances reflected on the role that the Mayor and the GLA have taken in supporting London's diverse Lesbian, Gay, Bisexual and Transgender (LGBT) community for example through funding the annual LGBT Pride celebrations, commissioning the Spell It Out training DVD to tackle homophobia in schools, supporting the young LGBT film makers programme through the LGBT film festival and working with statutory partners like the Metropolitan Police to challenge and tackle hate crime in London. The Mayor holds a unique position of leadership in London and is keen to ensure that Londoners experience equity of access to healthcare, consistency of standards and a health service that is responsive to the needs of the current and future population.

Frances finished by acknowledged the role that Dr Sheila Adam, the previous director of public health for London, had played in enabling recognition of the Trans voice following the first panel discussion on LGBT health.

Dr Susan Schonfield, Consultant in Public Health from Hillingdon Primary Care Trust, then spoke from the perspective of working as part of the North West London specialised commissioning team, pivotal to the commissioning relationships in London that determine gender reassignment services for London residents.

Susan re-iterated Frances's closing comments about Dr Adam and followed on by stating that the interim Director of Public Health, Dr Anne Mackie was similarly committed and keen to ensure that the voice of London's LGBT population continues to be heard and engaged with.

Susan started by outlining some of the structures involved in specialised commissioning. Following a ministerial review (Carter Review) of specialised services commissioning in 2006 the structures involved in commissioning are shifting to:

- a national specialised services commissioning group (NSSCG) from April 2007 which will look at all commissioning of specialised services.
- A sub-group of that committee, the National Commissioning Group (NCG) will look at very, very rare or very, very expensive services e.g. fewer than 1000 cases nationally or only 2-6 centres providing the service.
- 10 specialised commissioning groups (SCGs) to be established nationally (England) to cover populations of 3 to 8 million
- National screening programmes will move to be integrated with the NSSCG
- There will be a pooled budget for all SCG groups

Specialised services are for rare disorders with low numbers of cases, services are provided in a small number of centres, usually at high cost and they need to be commissioned over a large population base (between 1.5-10million). The Department of Health has defined 37 specialist services (www.dh.gov.uk/PolicyandGuidance/Healthandsocialcaretopics/specialisedservicesdefinition). Gender reassignment services is commissioned under these arrangements as part of the Specialised Mental Health services label. The NSSCG have started a project to revise the national specialised services definitions set over the next two years (DR Saroj Auplish is leading on this) and there are opportunities to comment on the process via the London SCG website (see below).

London will have one SCG which will oversee the existing five specialised commissioning teams (www.londonspecialisedcommissioning.nhs.uk). Currently London has five 'local' SCG's which each lead on several different specialised services. Some services, such as haemophilia and genetics are commissioned for the whole of South East of England (London, Kent, Surrey, Sussex, Essex, Herts and Beds = Pop 14 million). Susan reflected that at a recent talk given by Christine Burns there had been a quoted 5,000 trans people with gender reassignment service needs, this was equivalent to the number of people affected by Haemophilia A.

North West London has been leading on the commissioning of gender reassignment services, along with 11 other services. Gender reassignment services are known to

commissioners as Gender Dysphoria (GD) or Gender Identity Disorder (GID) and are commissioned from the West London Mental Health Trust (Claybook/Charing Cross Gender Identity Clinic). There is a defined patient and referral pathway which is adhered to across London. Susan presented the numbers of London residents treated under these arrangements, in 2003/04 – 30 MtF and 27 FtM funded transitions and in 2006/07 there were 20 MtF and 32 FtM funded transitions. There had been a backlog of FtM transitions and this was being addressed but there was no real pattern in the numbers over the past four years. Although she recognised that the Charing Cross GIC did provide services for residents from other areas these could not be addressed by the London SCG, but she recommended that individuals contact their local strategic health authority to find out how to provide input to their local SCG – all of which have a patient involvement forum of some form.

It has been quite difficult to get an understanding of the prevalence of Gender Dysphoria which means that services are difficult to commission as demand is hard to judge and there is also work needed to improve the measuring of patient outcomes as well as quality of services. Based on some of the research Susan suggested that there are approximately 188 MtF and 46 FtM Trans people in London. Work in Scotland has estimated an approximate ratio in adults of 4 MtF individuals to 1 FtM individual. Further information from GIRES after the meeting has indicated a much higher prevalence. She acknowledged that there is very limited data on children and adolescents' gender dysphoria.

The current activity is approximately 22 MtF and 8 FtM transitions a year through the commissioned arrangements. Surgery costs approximately £8,687 for MtF, and £54,000 for FtM but the costing of different procedures varied and Susan was keen to hear of anyone who has specific costs for different approaches and procedures that could be fed into a commissioning policy paper that is in draft for the London SCG. The budget for the surgical interventions is around £0.5 million per year and has been doubled in the last two financial years to try and sort out the FtM backlog but this is unlikely to continue beyond this financial year. Funding for the GIC is through a block contract of £160,000 and this means that there is not a cap on the number of patients that can be seen within the clinics capacity. Susan commented that for commissioners this represented incredibly good value in terms of the numbers of patients seen.

Susan then moved on to talk about the work that has been going since she became involved in 2004. This included:

- work to look at the prevalence of gender dysphoria in London
- quality monitoring of the independent providers
- reviewing quality management data with service providers
- seminar on gender dysphoria with medical managers in April 2006
- development of a draft surgical policy – currently being developed to define what are core and non-core procedures

- audit of patients' experiences – this is now a national piece of work to help provide a voice for the patient experience in the quality management framework
- looking at options for treatment abroad – it is recognised that Belgium may be a viable option for FtM surgery but that Thailand is not viable for MtF. Susan also expressed thanks for the support and help that she had received from the many trans individuals who had provided information and details of overseas services.

Susan then talked briefly about the patient experience audit that she has been developing with support from the Department of Health SOGIAG Transgender work stream. The audit is using patient questionnaires developed by patient group representatives – one general, one each FtM and MtF, these are due for completion in May this year. The patient group representatives have been supported by the London SCG audit facilitators and funding was provided by the SOGIAG. The audit will be available for people to respond nationally and will be accessible via a website which when established will be promoted through the Trans community networks. The results of the audit will be instrumental in developing services in London. She reiterated several times that the audit is independent of the clinics and in no way will patient's responding be traced back to their clinics.

There was also a brief mention of the expert patient programme, where individuals are trained to support others going through similar experiences with conditions. There may be an opportunity for some trans individuals to join the expert patient programme.

Susan concluded by making some brief comments on the NW Lancs (1999) judgement: she was clear that the judgement did not apply to London in that London was already commissioning and providing services for gender reassignment. Outside of London the decisions were being made at individual PCT exceptions committees and there were challenges in getting this recognised against political imperatives such as Herceptin. She reflected that there may be opportunities to influence the National Specialised Services Commissioning Group for a national approach which would reduce the post-code approach outside of London.

Dr Stuart Lorimer from the Charing Cross Gender Identity Clinic (CX GIC) then gave an overview of the clinic and its work. Stuart started by saying how pleased he was to take part in the panel and acknowledged that the clinic had historically been seen as being quite aloof and distant from patients and he hoped that this panel was the start of breaking down some of the myths and building a better level of engagement. He had been attached to the clinic through some of his specialist registrar training and had been appointed as a full time consultant just over a year ago.

The CX GIC is the largest and oldest consultant-led gender identity clinic in the UK. The clinic has a small core team of three full-time consultants and then a wider team including a consultant endocrinologist and speech and language therapist. The clinic sees an estimated 95% of all NHS patients going through gender reassignment, with

about 500 new patients every year and about 2000 under the care of the clinic at any one time. This represents an incredibly busy service with each clinician seeing between eight and ten patients a day, including usually at least two new patients for extended initial consultations. The case load also has substantial paperwork and hence there is a lot of additional work around the direct patient contact. Stuart stressed that the clinic had a very low non-attendance rate, which was unusual for the NHS, and hence does not have as much flexibility as would be liked by both staff and patients. He was clear that this was not about creating sympathy for the clinic but hoped that by understanding how stretched the service was, participants will understand some of its inflexibility and challenges.

Approximately 80% of patients undergo full transition to their desired social gender role; the remaining 20% tend to remain in an androgynous, dual or 'other' identified role. Similar to other GICs, the CX GIC follows a modified version of the Harry Benjamin Standards of Care, the main difference being that there is a requirement for 2yrs of real life experience rather than 1 year, however he made it clear that this was judged on a case by case basis. The clinic followed an ethos of 'reversible before irreversible', this meant that social adjustment preceded hormone/endocrine treatment which in turn preceded surgical intervention.

Stuart showed a graph of an audit of patient satisfaction which was undertaken in October 2004. The audit had 22 questions and about 100 patients completed the audit form over the month. The forms covered all aspects of the service and were returned anonymously to the audit department – not to the consultants who only saw the final report.

Stuart focused on the questions where there were higher levels of dissatisfaction and low satisfaction. This was illustrated in the question about length of wait for the first appointment, the average wait at the GIC is between 5-6 months for a first appointment, however the wait is often a lot longer for patients because of securing local funding outside of London and getting the initial psychiatric referral to the GIC. He moved on to talk about the dissatisfaction with support for family, friends and relatives. Although there are currently no resources for this it is something that the clinic has recognised and he also acknowledged that the clinic needed to be better at signposting patients and their close ones to voluntary and community sector groups.

The question which looked at local psychiatric support may reflect the lack of expertise and sensitivity of local community mental health teams. The recent survey on Doctors.net illustrated that many doctors don't think that gender reassignment should be funded by the NHS and he was personally aware of resistant general practitioners, surgeons and psychiatrists. Although the clinic does its best to raise awareness and understanding he acknowledged that there is a long way to go.

Dissatisfaction around employment issues he felt reflected wider societal discrimination but once again illustrated the clinics role in signposting to other organisations and groups that could support individuals around this area.

The questions which had the highest level of dissatisfaction in the audit was around post-operative hormone advice both from the GIC and local general practice. The

clinic had recognised this and had expanded its endocrine support to try and improve this in the future.

Admin support was a significant factor in the audit and reflected some of the more generic challenges in medical administration across London. The clinic had unique challenges in finding and retaining good administration staff and it was hoped that this might improve when the clinic moves to new premises later this month.

Stuart talked about the move to the new premises in Greyhound Road which represented a more concrete split from General Adult Psychiatry. The new premises will have more room, more staff and hopefully therefore substantially improved waiting times. Bringing all of the staff onto one site also means that there will be a single patient set of notes so this will reduce communication errors and the new premises also have more space so there may be opportunities to build on the existing support groups, potentially to start a relative/family support group. The clinic will also be returning to the 'old appointment system' where patients are given their next appointment date before leaving the clinic, it is hoped that this will also reduce confusion and lost appointment letters.

Stuart concluded by saying that personally he hoped that the new premises, new staff and events such as this panel starts a new era of engagement between the gender identity services and the transgender community.

Tracy Dean followed Stuart to talk about the Sexual Orientation and Gender Identity Advisory Group (SOGIAG) at the Department of Health. Tracy gave a perspective as someone who is outside of the SOGIAG structures but has given input and support to those directly involved in the Transgender work stream through Press for Change.

The SOGIAG was established around two years ago and have four work-streams covering employment, services, reducing health inequalities and transgender issues, although there is transgender representation across the groups and lots of cross stream working.

Tracy set out some of the findings from the report by Stephen Whittle and others for the Equalities Review team (Box 1). This represented findings from the largest ever survey of transgender individuals with over 870 respondents. The report highlighted that the NHS appears to be failing to serve Trans people.

Box 1: In a sample of 870 trans people in September 2006(1):

- 6.3% said they had been refused medical treatment
- Overall, 19.5% felt their treatment had been adversely affected because of health staff knowing their trans background
- 60% said their GP would like to help but lacks sufficient knowledge to do so
- Only 20% felt they encountered no problems
- 34.4% said they had thought about or attempted suicide or self harm one or more times prior to treatment

(1) Engendered Penalties –Whittle, Turner and Al-Alami –The Equalities Review, Feb 2007

Tracy highlighted that there was evidence of a strong need to educate healthcare professionals and raise awareness and understanding of both gender reassignment and of transgender individuals experiences. She then moved on to talk about some of the work that had been supported by the transgender work stream:

1 - Audit of treatment experiences and outcomes – this was the piece of work that Susan Schonfield had spoken about previously.

2 - Mapping of existing services and models – being undertaken by Stephen Whittle's team. This would provide a snapshot of the provision of gender reassignment services across the UK

3 - Booklet for Transgender Youth – developed in partnership with Sci:identity and GAYLIC. This was launched last week by the Department of Health. Tracy highlighted how important it was that this excellent resource was badged with both Department of Health and NHS logos. The booklet can be downloaded at www.dh.gov.uk/EqualityAndHumanRights

4 - Resource booklets - Creation of a collection of DH/NHS endorsed/branded educational and advice leaflets (or booklets) for both trans people and health professionals. These are being developed by GIRES and should be launched in May/June 2007. They will cover topics such as safe hormone use, appropriate preventative medicine, good practice on patient privacy and dignity, patient rights etc.

5 – Top Ten Tips – There are now two simple two sided "top ten tips" card for all NHS workers, explaining the key things they need to know about the background and needs of LGB people and Trans people. They were launched last week and can be downloaded at www.dh.gov.uk/EqualityAndHumanRights

6 – Bereavement: A guide for transsexual, transgender individuals and their loved ones - A comprehensive guide for all health practitioners, mortuary staff, undertakers, etc. for sensitively dealing with bereavement situations involving trans people (either as the bereaved, next of kin or the deceased). This was launched last week and can be downloaded at www.dh.gov.uk/EqualityAndHumanRights

7 – Training DVDs - A training package development to take forward the NHS DVD "Real Stories, Real Lives" and the "Trans Matters" DVD which was previously commissioned by the National LGBT Health Summit and completed by Jason Barker of Transfabulous in June 2006. The training package will enable trainers within the NHS to utilise the DVD resources to develop better awareness of the needs of LGB and T patients, and how to treat LGBT colleagues with respect.

Tracy closed by plugging the Press for Change project website which has been developed to help everyone keep up to speed with what is going on across the country on transgender work. The website can be reached at <http://projects.pfc.org.uk/>

Persia West from the Brighton and Hove Trans Focus Group followed Tracy and spoke about some of the experiences in Brighton and Hove where they have highlighted the need for varied and flexible models of service provision.

Persia started by reflecting on her own experiences as a trustee of both the Gender Trust, Spectrum and The Clare Project. She transitioned personally outside the NHS but has spent a lot of time working with patients who feel they have been damaged by the system.

In 2004 she wrote a report for Spectrum - A Report into the Medical and Related Needs of Transgender People in Brighton and Hove: The Case for a Local Integrated Service (www.pfc.org.uk/node/630) – which looked at how patients from Brighton and Hove were treated within the NHS, consulting with both service users and providers, both locally and throughout the UK. Clients and local GP's were united in their criticisms of the expensive service provided by Charing Cross. The report notes that there were significant challenges in enabling the patient voice in the way that services are provided and delivered. Persia reflected that at a recent Spectrum Community Health Forum a speaker from Mind Out (The LGBT section of Mind, the national mental health charity) had described the current system of providing care for gender reassignment as regularly damaging to patients over years of experience.

In researching and writing up the work she met with local and national NHS specialists to discuss different ways that the gender transition process could be managed.

She reflected that the need for psychiatric assessment every step of the way was an unnecessary expense, with reference to the fact that transgender individuals are not mentally ill, and that this approach in itself is the cause of unnecessary distress.

In taking apart the current policies and processes they had identified that the current approach in Brighton was not patient led and only allowed a single point of entry which didn't allow for flexibility or client individuality. She acknowledged the support of healthcare professionals within the NHS in supporting the creation of a different model of care pathway.

Persia re-iterated the need for transgender patients to be treated as individuals, and talked about a need for non-linear care pathways and using a care co-ordinator model based on client need, rather than a psychiatrist-led structure, which would both save money and create a more relevant, caring, and therefore efficient service.

Persia acknowledged that for some patients the CX GIC provided a good service but called for there to be some alternative models and choice factored into gender reassignment services.

Persia concluded by reflecting that there is an opportunity now through the choice and patient involvement agenda to influence and challenge the status quo. The treatment outcome is not surgery; it is the well being of an individual.

Ben Thom from FTM London was the final panellist to speak, he started by reflecting that the challenge in coming last is that all the best lines have been taken.

He set out the NHS principles of choice and autonomy and challenged the audience to claim these freedoms as their own. Research had shown that trans people are still being denied treatment or experiencing discrimination and that had to end.

FTM London has over 100 members and many have experienced transition through the Gender Identity clinics in both London and elsewhere, experiences varied widely but informed the following reflections.

The domination of the psychiatric label stigmatises Trans people and sets out a prescriptive care pathway in which the 'real life experience' is seen as a test rather than a supported therapeutic intervention. The insistence on a second opinion creates additional hurdles and challenges for patients.

There appears to be a lack of choice for trans individuals, particularly for trans men. Currently the GICs appear to be exempt from the waiting time targets and many patients fund private treatment rather than wait. In some areas there is a cap on patient referrals from PCTs and there are challenges in surgical expertise and surgical options provided by the NHS. This was particularly true around genital construction where there were more surgical options across Europe with better functional outcomes. In one case an individual had had surgery but had not been provided with the specialist dressing required for post-operative care. Lack of surgical expertise and poor surgical techniques offered through the NHS have resulted in Trans men seeking private surgery in the UK or abroad but then are penalised on return if further intervention or care is needed. This despite guidance by the BMA in 2006 (interface between NHS and private treatment) that reflects the BMA position that – "Patients who are entitled to NHS funded treatment may opt into or out of NHS care at any stage".

The principles of choice and autonomy fundamental to the NHS should not be negated when it come to Trans health care. It is unethical to part treat someone and then withdraw or withhold funding for the remaining treatment. This leaves some trans men extremely vulnerable, in a distressed limbo unable to form relationships and function in working life.

Ben re-iterated Tracy's and Stuart's previous comments and concerns about the doctors.net survey and Stephen Whittle's work which suggested that GPs have become the de facto arbiters of society's morals and are blocking access to services for trans people. However he highlighted that the impending goods, services and facilities anti-discrimination legislation and the existing gender equality schemes

should help improve understanding and awareness of transgender individuals and also allow legal redress.

Ben concluded by highlighting the contribution the GLA had made to starting to raise some of these issues through supporting the first National LGBT Health Summit in 2006 and the panel debate. His final comment reflected that the high level of suicide amongst Trans people prior to transition illustrated that this vulnerable and neglected community could and should not be ignored any longer.

The panel then moved on to a short session of questions and answers from attendees, these are summarised here in an anonymised form:

- a question was asked about hair removal and whether it is or isn't funded in London as there appears to be some variation in this across the country and post-operative removal is expensive and can lead to complications.

Susan responded that she would be grateful if anyone had any information on the costing of hair removal and they could be sent through the chair via LGBTHealthUK@aol.com to feed into the current review of core and non-core procedures in London. She was currently drafting a commissioning policy for the London SCG that would include of both hair removal on surgical sites and bilateral mastectomy as core procedures in funding pathways.

Stuart supported Susan's statements and reflected that the CX GIC had pressed for funding for hair removal, arguing that it is not a cosmetic procedure for most patients and they have had it funded for a couple of patients.

Susan concluded by mentioning that if the draft policy is agreed by the necessary processes of the London SCG then all London PCT's will fund the two procedures mentioned above.

- a question was raised about the emotional costs that two of the speakers had commented on and whether the mental health diagnosis is compounding this.

Susan started by saying that the ICD codes were negotiated at a national level but the first step might be to lobby the Royal College of Psychiatrists. She certainly acknowledged the stigma associated with mental health diagnoses.

Stuart started by recognising that there was a historical aspect to this and that there was not a clear consensus across the Trans community about tackling the mental health label. He also highlighted that as a liaison psychiatrist he was used to working with patients who aren't mentally ill but are covered by a psychiatric diagnosis. There are lots of tensions and stigma in this area, but in practical terms there are often other conditions present (co-morbidities) and the psychiatrists role can be to try and recognise and disentangle these.

Ben added that he felt that the psychiatric input was important and that this assessment of co-morbidities was important but questioned if once the initial assessment had been completed whether ongoing psychiatric input was needed.

- a secondary question about the role of psychiatrist as gate keep was being handled and how the CX GIC perceives this role in the future

Stuart spoke from a personal perspective reflecting that he is aware of being seen as a holder of hoops and although he acknowledges the need for some gate keeping as the situations and people are often complex, however acknowledged that the system is geared towards protecting the very complex. He also reflected that the more complex patients are often the ones who do not have the financial means to secure private treatment and this skews the patient case mix.

Susan added that her understanding of European services, particularly in Belgium, was that there were similar roles and functions for psychiatrists and similar hoops.

- this question focused on the challenges in the real life experience for FtM individuals, especially for those with big breasts and whether there is flexibility in the system.

Stuart said that there was flexibility and that the clinic generally enables mastectomy after 1yr of RLE. He felt that views may be changing on this and that a new time period may evolve in the future but this will take time.

- a question was asked specifically of Stuart relating to why individuals who have had private surgical intervention but require some post-operative surgical or endocrine intervention require another psychiatric assessment.

Stuart reflected that this was usually at the request of the endocrinologist or surgeon, not the psychiatrist. The waiting times for the endocrinologist are substantially longer than that to see the psychiatrist and as he had outlined earlier those at Charing Cross are liaison psychiatrists so may be able to help with hormone issues for example, his feeling was that such a consultation would not be driven by a psychiatric assessment.

- A question was asked about Susan's comments on the core and non-core procedures, if the specialist commissioning group in London agrees something can the PCT then choose not to follow it.

Susan answered that the PCTs in London have to belong to the specialised commissioning group and cannot opt out of its decisions, nor can a trust opt out. If a patient is referred and fulfils the GICs criteria then the PCT must fund the full patient pathway.

- There was a question asked about how the current services provide for variant gender identities in individuals going through transition.

Susan felt that if there was agreement by two psychiatrists as required in the pathway then that would be enough to fund, it was up to the patient how far through transition they progressed. Stuart supported this and pointed out the clinic's emphasis on social readjustment rather than a specific surgical outcome.

- The panel was asked for an opinion on whether presenting as gender queer would be a barrier for services.

The panel reflected that the language of queer is something quite specific to the LGBT community and hence it would probably be best to avoid this as the more general NHS and commissioners would not understand gender queer in this context.

- A question was asked specifically about the need for more therapeutic support for services, this was particularly important for individuals who may not fully disclose to psychiatrist because of the gate keeping perceptions, e.g. sex workers.

Susan reflected that this should be fed into the lobby groups and perhaps into the transgender work stream as may be something that they could work on. Stuart added that different clinics have different protocols and is very aware that the GIC is not offering therapy because of lack of resources, but would actively support patients to get counselling and therapeutic support.

- A question was asked about how the service caters for deaf service users

Stuart stated that the CX GIC does have deaf patients and do use a regular interpreter to help support patients and try and support the interpreter being comfortable with the language being used. They also provide longer appointment slots for deaf patients to help enable the interpretation.

The Chair reflected that this sounded incredibly positive and was ahead of many other services in London in providing accessible services for disabled patients.

- A question/comment was made about whether there was a need for a psychiatry led service, the Dutch service was led by an endocrinologist and there are models with GP specialist.

The participant and Stuart agreed that there was a valid reason for psychiatric involvement in identifying co-morbidities and that all clinics followed different modified versions of the Harry Benjamin criteria. Ben reflected that he felt that there was still a challenge in expressing choice in the current model of service.

- The final question raised the issue of sex and the lack of advice, support and discussion with patients about how the different surgical procedures affect sexual activity and functionality post-operatively.

Stuart reflected that he had personally had some of these conversations with patients but agreed that it was an area where there were huge gaps in terms of frank discussion. The Chair suggested that the point was fed into the SOGIAG as it sounded like something where a simple resource would help enable the conversation for a lot of patients and break down some of the mystique and myths.

Following the question and answers the Chair formally thanked the panellists, the sign language interpreters and the audience.

