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This is a phase 2 redraft of the specification and has no official status at this time.

**NHS STANDARD CONTRACT
 FOR GENDER IDENTITY DEVELOPMENT SERVICE
 FOR CHILDREN AND ADOLSCENTS**

**SCHEDULE 2 – THE SERVICES
 A. SERVICE SPECIFICATION**

Service Specification No.	E13/S(HSS)/e
Service	Gender Identity Development Service (GIDS)for Children and Adolescents
Commissioner Lead	NHS England
Provider Lead	
Period	1.4.2016 to 1.4.2018
Date of Review	30.12.2017

1. Population Needs

1.1 National/local context and evidence base

National context

This specification sets out the deliverables for a highly specialised service for Gender Identity Development (GID) children and adolescents, who have or are suspected to have Gender Dysphoria (GD) or need support to explore their gender identity up until their 18th birthday. Once accepted into the service, these young people are referred to as 'clients'.

The service is commissioned to provide specialist assessment, consultation and care. The service will also provide support to the family or carers of clients. The psychological elements of the service are a Tier 4 mental health service,

The service will be delivered through a specialist multidisciplinary team (MDT) with contribution from specialist social workers family therapists, psychiatrists, psychologists, psychotherapists and paediatric and adolescent endocrinologists and clinical nurse practitioners and other NHS healthcare professionals such as gynaecologists and licenced fertility experts. Children with differences of sex

development or intersex conditions and other endocrine conditions may be referred if there are associated concerns with gender identity development.

Gender identity is an individual's personal experience of their own gender.

Gender Dysphoria (GD) is where a person feels that they identify emotionally and psychologically as a different gender to the biological sex they were assigned at birth based on physical sex characteristics. The dysphoria relates to the distress and unease experienced, which can be significant.

Gender identification is diversifying. A person may identify as the opposite gender to their biological (natal) gender or may identify by another descriptor such as non-binary or gender queer. Binary implies that an individual identifies exclusively as a man or a woman. However there is a growing recognition that many people do not regard themselves as conforming to the binary male/female classification.

GD is a potentially distressing experience, particularly in adolescence. Adolescents are at high risk of self-harm and suicidal thoughts, and their sense of despair frequently leads to them being vulnerable to relationship difficulties, social isolation, stigma, and educational disadvantage.

Various studies show that transgender young people may present with psychosocial difficulties. Yet it is also true that many youngsters who present to gender services are not acutely distressed. This may be particularly true for adolescents who live in a supportive environment, are aware of the possibility of gender transition and have access to appropriate psychosocial and physical care (Drescher et al. 2012).

Prevalence

Epidemiology

Formal epidemiological studies on GD among adolescents of 15 years or older and adults are usually based on the number of people who have been treated at gender identity clinics. The numbers vary widely across studies, probably reflecting differences in methodology and differences between countries in treatment availability and the criteria for treatment eligibility. Estimates of the prevalence of GD range from a lower estimate of 1:2000 (or about 0.05%) in the Netherlands and Belgium (Conway 2008) to 1.2% in New Zealand (Clark et al 2014). These numbers are based on those who identify as transgender.

The number of adolescents referred to specialised gender identity clinics for GD appears to be increasing. There also appears to be a corresponding shift in the sex ratio, from predominantly favouring natal males to one favouring natal females. In a study at clinics in Toronto and Amsterdam, there was a significant change in the sex ratio of referred adolescents between two cohort periods: between 2006 and 2013, more natal females were referred, but in the prior years there were more natal males. (In Toronto there was no corresponding change in the sex ratio of 6,592 adolescents referred for other clinical problems). Sociological and sociocultural explanations are offered to account for this recent inversion in the sex ratio of adolescents with GD (Aitken et al 2015).

There seems to be a higher prevalence of autistic spectrum conditions in clinically referred, gender dysphoric adolescents than in the general adolescent population. For example Holt, Skagerberg & Dunsford (2014) found that 13.3% of referrals to GIDS in 2012 mentioned comorbid ASD (although this is likely to be an underestimate). This compares with 9.4% in the Dutch service; in the Finland service 26% of adolescents were diagnosed to be on the autism spectrum (Kaltiala-Heino et al. 2015).

Evidence base

Gender Dysphoria (GD) is a potentially distressing experience, particularly in adolescence. There is no established psychological causation for GD and it does not yield to change through psychotherapy; evidence for a biomedical causal model also remains limited (Drescher & Byne, 2012; Bao and Swaab 2011).

The service will be delivered in line with:

- Emerging evidence for best practice
- Relevant National and international guidelines for the care of Children and Adolescents with gender dysphoria such as the World Professional Association for Transgender Health Standards Of Care For the Health of Transsexual, Transgender, and Gender Nonconforming people, (Version 7) 2011) and the Endocrine Society's Clinical Guidelines (2009);
- NICE guidelines specific to the treatment of mental and emotional health and wellbeing including for psychosis, anxiety and depression.

Published guidelines for the treatment of adolescents with gender dysphoria (GD) have been produced by:

The Endocrine Society (2009) and the World Professional Association for Transgender Health (2012). A proportion of adolescents experiencing GD choose to have physical interventions and can do so provided they fulfil eligibility and readiness criteria. The guidelines recommend the use of gonadotropin-releasing hormone agonists in adolescence to suppress puberty, later followed by cross-sex hormone treatment from age 16 (sex steroids of the experienced sex). If they fulfil additional criteria, they may have various types of gender affirming surgery from the age of 18.

There has been some debate about the minimum age at which puberty suppression and cross-sex hormone treatment could start. At first, an age of 12 years was recommended for puberty suppression. However, boys and girls enter puberty at different stages; also psychological maturity, competence and decision making authority differs between adolescents. Therefore, not age but the stage of onset of puberty is now mentioned in the Standards of Care. The international recommendation remains that cross-sex hormone treatment should not commence before the age of 16, although in some clinics in the US there are reports of physical treatments being offered at younger ages (Spack et al 2012; Rosenthal 2014). Thus far these are descriptions of clinical practice rather than reports of outcomes.

1.2 Persistence / Desistence

There are various papers and debates around gender identity development which set out how an individual's gender identity may or may not change over time. One such debate concerns the developmental path of gender identity using the theories of persistence and desistence, although these theories have been criticised as presenting a narrow and binary view of trans identities.

Many children experience incongruence between their experienced and their assigned gender early in life. They may not identify with the assigned gender, show behaviours and preferences not stereotypical for the gender they were assigned to at birth, and sometimes strongly dislike their physical sex characteristics.

If the distress resulting from this incongruence reaches clinical levels, the diagnosis of GD according to the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM 5) is applicable. The WPATH Standards of Care (version 7) note that not all gender variant people experience Gender Dysphoria and those that do may not experience it persistently throughout their lives.

In most children, GD will disappear before, or early in, puberty. However, in some children these feelings intensify and body aversion may develop or increase as they become adolescents and their secondary sex characteristics develop. The period of adolescence, with its changing social environment and the onset of physical puberty, seems to be an important factor in the way gender identity develops and decisions about how gender identification is expressed.

A service review of cases that were closed between April 2013 and December 2014 indicates that of 262 closed cases, 17% never attended the service, 17.8% had attended but dropped out, 5.9% had declined further treatment and 51.4% were referred to adult services. A further 2.8% had been referred to another agency and 2% chose to opt for private therapy. In about 20% of cases, the clinician noted that GD had decreased and in 20% GD was noted to have desisted.

Across all studies, the persistence rate of GD has been approximately 16% (Steensma & Cohen-Kettenis, 2015). It should be emphasised that most studies did not use the fairly strict criteria of DSM-5, and children might previously have received a diagnosis based only on gender-variant behaviour. Gender questioning children who do not persist may be more likely to later identify as gay or lesbian than non-gender-questioning children (Drescher, 2013; Wallien & Cohen Kettenis, 2008).

Although both 'persisters' and 'desisters' can be quite similar in their gender atypical interests, preferences and behaviours, there is also a noticeable difference.

Steensma et al. (2013) followed up in adolescence 127 adolescents who were referred for GD in childhood (<12 years of age). 'Persisters' attributed their GD primarily to the discrepancy between body and gender identity and a true longing for having a different body. The 'desisters', however, indicated that their desire to have the body of the other sex or the desire to be the other sex, which was considered to be more related to the opportunity to fulfil the preferred gender role, than to a true aversion against their bodies per se. Nevertheless, it remains the case that 'predicting individual persistence at a young age will always remain difficult' (De Vries et al 2015).

There is some evidence that 'persistence' versus 'desistence' of childhood GD may be related to three factors, looking at the period between 10-13 years of age: 1) changing social environment: between 10-13 years as the social distance between boys and girls was considered to gradually increase; 2) the change in feelings to the anticipation of, and experience of actual body changes during puberty: for the persisters the aversion towards their bodies intensified immensely created severe distress and concerns about the future; 3) the experience of falling in love and sexual attraction: the 'persisters', who were all attracted to same- (natal) sex partners in this study, indicated that this functioned as a confirmation of their cross-gender identification, as they viewed this as typically heterosexual (Steensma et. al., 2011).

1.3 Social transition

The age at which adolescents transition socially has decreased in the last decade. Many young people choose to socially transition before any treatment has started, although some more anxious youngsters often prefer to wait until cross-sex hormone treatment actually commences. (Kaltiala-Heino et al. 2015).

Steensma & Cohen-Kettenis (2011) report that between 2000 and 2004, out of 121 pre-pubertal children, 3.3% had completely transitioned (clothing, hairstyle, change of name, and use of pronouns) when they were referred, and 19% were living in the preferred gender role in clothing style and hairstyle, but did not announce that they wanted a change in name and pronoun. Between 2005 and 2009, these percentages increased to 8.9% and 33.3% respectively. This study strongly suggests that early social transition does not equate to an adult transgender identity. In a qualitative follow up study, it was reported that two girls who had transitioned when they were in elementary school, had been struggling with the desire to return to their original gender role. Fear of teasing and shame to admit this wish resulted in a prolonged period of distress (Steensma, 2011).

In their writings the Dutch team do not encourage early social transition and explicitly advise parents to proceed with great caution, to seek to keep a balance between the acceptance of cross-gender play and preferences and encouraging activities that are associated with the child's natal gender (Steensma & Cohen-Kettenis 2011). In the Amsterdam clinic, pre-pubertal children may be assessed, but generally will not be seen again until they enter puberty.

It is notable that the literature looking at social transition is frequently based in a binary model of gender. Young people self-identify in an increasingly diverse way and some question the assumptions about stereotypical gender expression associated with gender identities.

1.4 Associated difficulties:

Various studies show that transgender young people may present with psychosocial difficulties. Yet it is also true that many youngsters who present to gender services are not acutely distressed. This may be particularly true for adolescents who are aware of the possibility of gender transition, who live in an accepting environment, and who can have access to puberty suppressing treatments until they are able to take a decision to transition physiologically (Drescher et. al. 2012).

Some empirical studies of the mental health of gender variant young people, mostly from the US, show that adolescents are at high risk of self-harm and suicidal ideation (e.g. Grossman & D'Augelli, 2006). However, it is not helpful to generalise across the whole international population of gender variant young people: data from the Netherlands (de Vries 2015) show that there is a group of well-supported, mentally stable young people who cope well with their significant gender incongruence.

In the UK the experience of GD can correlate with severe distress (Holt, Skagerberg & Dunsford 2014). The service identified that the three most common associated difficulties which patients encountered in their daily lives were bullying (47%), low mood/depression (42%) and self-harming (39%), (Holt et al, 2014). In their service, the Dutch team found that 67% of referred young people had no additional psychiatric disorders (de Vries et al 2010). For Dutch adolescents with GD, it was more common to have coexisting internalising disorders such as anxiety and depression, than an externalising disorder such as oppositional defiant disorder (de Vries et al., 2010).

Self-harming thoughts or behaviours are common in adolescents referred to the service. In an early study, the incidence of suicide attempts e.g. overdoses, was seen in 23% of cases prior to referral to the service; contact with the service reduced this risk to between 1% and 2% (Di Ceglie et al 2002).

In a more recent study, 24% of the young people being referred self-harmed, 14% of the young people had thoughts of self-harming, and suicide attempts were indicated in 10% of the young people prior to attending the service (Skagerberg et. al., 2013).

Looking separately at the data for the natal females and natal males, it was found that thoughts of self-harm were more common in the natal males than in the natal females prior to attendance at the service, whereas actual self-harm was more common in the natal females. These figures for associated difficulties appear to be increasing in line with the rise in the general population; self-harm rates in the general population tripled between 2002 and 2012 (HBSC Report, 2014).

In Finland, more than three quarters of adolescent sex reassignment applicants had needed/or currently needed specialist level child and adolescent psychiatric services due to psychiatric problems other than GD (Kaltiala-Heino et al. 2015).

Kaltiala-Heino et al. (2015) identified five distinctive groups of young people and adolescents amongst 49 adolescents presenting at their service: Group A: Early onset with no significant psychopathology; Group B: Early onset with considerable psychopathological difficulties; Group C: Adolescent onset with no, or very few psychopathological or developmental difficulties; Group D: Adolescent onset with severe psychopathological and developmental difficulties; and Group E: Adolescent onset with identity confused development. This last group was the largest, consisting of young people who were bullied, isolated with few friends, not attending school or not leaving the house, and frequently self-harming; they had a strong conviction that gender reassignment would solve their psychosocial difficulties.

In some settings, it appears that social exclusion may be a key causal pathway for

the relationship between gender identity and disadvantageous health outcomes (Hendricks & Testa 2012). This can take the form of prejudice; stigma; transphobia; individual, institutional, and societal discrimination and violence.

1.5 Autistic spectrum conditions (ASD):

There seems to be a higher prevalence of autistic spectrum conditions in clinically referred, gender dysphoric adolescents than in the general adolescent population. For example Holt, Skagerberg & Dunsford (2014) found that 13.3% of referrals to the service in 2012 mentioned comorbid ASD (although this is likely to be an underestimate). This compares with 9.4% in the Dutch service; whereas in the Finnish service, 26% of adolescents were diagnosed to be on the autism spectrum (Kaltiala-Heino et al. 2015).

1.6 Physical Treatments:

Not all young people will decide to access physical treatments. But for those who do, it should be noted that the research evidence for the effectiveness of any particular treatment offered is still limited. In adolescents with GD, psychological support and puberty suppression have both been shown to be associated with an improved global psychosocial functioning. Both interventions may be considered effective in the clinical care of psychosocial functioning difficulties in adolescents with GD (Costa et al: in press).

Engagement in social interaction with other transgender people has been shown to help build resilience: Testa, Jimenez & Rankin (2014) demonstrated this effect empirically.

In the Dutch long-term evaluation study, it has been found that the psychological functioning of selected transgender adolescents tends to improve after a staged programme of puberty suppression, cross-sex hormones and gender reassignment surgery (de Vries et al, 2014). In this series of studies, 55 adolescents with GD have been followed up three times: at intake, before the start of puberty suppression (mean age 13.6); when cross-sex hormones were introduced (mean age 16.7); and at least one year after gender reassignment surgery (mean age 20.7). No adolescent withdrew from puberty suppression, and all started cross-sex hormone treatment. Their psychological functioning improved steadily over time, resulting in rates of clinical problems that were indistinguishable from general population samples (e.g. numbers in the 'clinical' range dropped from 30% to 7% on some Child Behaviour Checklist (CBCL) measures. Quality of life, satisfaction with life, and subjective happiness were comparable to same-age peers. Transwomen showed more improvement in body image satisfaction and in psychological functioning than transmen, who showed continuing high rates of anger and anxiety. The researchers note that in the Netherlands, transgender youth tend not to experience the gender-related abuse and victimisation that young trans people in other setting may undergo.

This Dutch research programme indicates that a treatment protocol including puberty suppression followed by cross-sex hormones and gender reassignment surgery, leads to improved psychological functioning of a comprehensively evaluated and selected group of transgender adolescents. The authors conclude: 'Clinicians should

realize that it is not only early medical intervention that determines this success, but also a comprehensive multidisciplinary approach that attends to the adolescents' GD as well as their further well-being and a supportive environment' (de Vries et al 2014).

It is important to underline that in this Dutch follow-up cohort study young people were only eligible for the puberty suppression if they (a) had persistent GD from childhood, (b) lived in a supportive environment and (c) had no serious co-morbidities. These were called the 'immediately eligible' group (de Vries et al 2011). (This is not the profile of a high proportion of the service's clients). In other words, those young people who achieve good outcomes are more likely to be those who have experienced lifelong gender non-conformity and who start off with significant social advantages: chiefly, the absence of any serious psychological difficulties and the presence of strong family support. Young people were started on puberty suppression only after a 'comprehensive psychosocial evaluation with many sessions over a longer period of time' (de Vries et al 2014). For the 'immediately eligible' group, the time from starting assessment to starting on the blocker was up to 18 months, with a mean of 9 months.

If the young people did not show persistent GD from childhood, live in a supportive environment or if they had serious co-morbidities, assessment was prolonged to up to almost 2 years (1.86 months). Such young people were in the 'delayed eligible' group. This delay in starting the blocker was to ensure they had adequate mental health treatment prior to medical intervention.

It is worth noting that in Spack, Edwards-Leeper and Feldman (2012), all the young people who were seen in the Boston service were reported to be in counselling, and the authors reference studies to show that 'those who do not receive counselling have a higher risk of behavioural and emotional problems and psychiatric diagnoses'.

Safety concerns remain regarding the impact of physical interventions. Although puberty suppression, cross-sex hormones and gender reassignment are generally considered safe treatments in the short term, the long-term effects regarding bone health and cardiovascular risks are still unknown (Cohen-Kettenis & Klink, 2015). Therefore, vigilance is warranted during and long after completion of the last gender affirming surgeries. Tragically, we have recently been reminded (de Vries, 2014) that the risks of surgery remain very real: one young person from the original Dutch treatment cohort died after her vaginoplasty owing to a postsurgical infection.

The Dutch team and the WPATH Standards of Care both emphasise the importance of informed consent at each stage of treatment. This means being informed about the possibilities and limitations of gender reassignment and other types of treatment, including psychological interventions. As GD may exist in many forms and intensities, gender reassignment is not the only treatment option to help resolve GD. The broader impact of gender reassignment on many aspects of their lives has to be discussed, including fertility.

The research base for the effectiveness of any particular treatment offered is small.

Therefore, the evidence for making treatment recommendations is very limited. This is a rapidly evolving field with emerging diversity of gender expression including for those who fulfil the criteria for gender dysphoria. Similarly what young people request of health care varies according to their developing identification on a case by case basis. Currently responses to treatment and treatment outcomes are being more widely evaluated.

2.0 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	✓

The service will rectify differences identified in England across Domains 1 to 5 as follows:

Domain 1: Preventing people from dying prematurely

Gender dysphoria can be associated with acute distress. The service aims to reduce premature mortality by providing high quality psychological and medical support as required on an individual basis.

Domain 2: Enhancing Quality of Life for people with long-term health conditions

The impacts of GD can be experienced for many years until the dysphoria is resolved. GD can be associated with significant social and emotional difficulties. The service aims to ameliorate negative effects on client's general development and build their resilience across a range of domains, including family and peer relationships, self-esteem, self-image and education, thereby improving quality of life.

Domain 3: Helping people to recover from episodes of ill-health or following injury

The service aims to reduce morbidity by providing high quality psychological and medical support through standard health care pathways.

Domain 4: Ensuring that people have a positive experience of care

Overarching indicator: patient/client experience:

To ensure that the client and their family or carer is well-supported during their time they are in contact with the service, each client will be assigned a named Lead Worker at the first assessment who will support them in their time with the service. This professional will be the primary source of contact for any issues arising between appointments and will be the lead provider of psychological care, supported by other consultant staff as appropriate. Referrals will be made to the endocrine liaison service when indicated. Endocrine Consultants are the lead professionals for physical care and interventions. Care decisions related to the commencement of hormone blockers and cross sex hormones are made jointly with Tavistock and endocrine professionals in consultation with adolescents and their families.

As a result of interaction with the service, clients will:

- feel safe, supported and listened to by the service during their personal gender identity development experience
- experience a reduction in level of distress and conflict around their gender dysphoria
- have an increased ability to function well in daily life in relation to their gender identification
- feel supported as a consequence of clear pathways, availability of support materials and routes of access for local professionals to gain information and support
- be able to access care locally as far as possible, including accessing prescribed hormone treatments by their local GP, with oversight from the service's Paediatric and Adolescent Endocrine Liaison Team
- know what the service can and cannot provide, know how to access help and support from the service between appointments, including telephone enquiries from clients and their families or carers which are staffed on a rota basis, online literature and other support from national and local voluntary networks and community groups
- have clarity about how to access other health care services for example, speech and language and sexual health
- have initial information provided on fertility options, be signposted to other specialists such as gynaecologists and fertility experts for gamete retrieval via their GP
- be offered support when transferring to adult gender services if this is their chosen path
- feel that their parents or carers are supported by the service, and that the parents in turn are better able to support their child
- feel that those supporting them (e.g. professionals from schools, health and social care) are appropriately included and consulted with for the benefit of the young person's health and wellbeing.

The service will also provide peer support via therapeutic groups focusing on providing information sharing, reducing harm and promoting coping and resilience. Family days will bring together clients, families and carers who are facing similar issues, with health professionals to facilitate peer support and a safe environment to explore options and concerns.

Service users will be involved in service developments in a variety of ways which may include:

- regular feedback from clients and their families about their experience of the service;
- participation in a Young Person's Stakeholder Group which will empower clients through a partnership approach, with those attending setting the agenda in areas where they would like to influence the service based on their personal experience;
- being part of interview panels for new staff;
- attending wider trust meetings to represent the views of service-users;
- requests to comment on specific issues;
- being involved in events and communications aimed at increasing awareness of needs of transgendered young people and their families and what services, professionals and communities can do to best support them.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

The service will ensure that local systems are in place to track and manage client safety performance including taking action when agreed standards are not met. Robust reporting of incidents through local procedures and NHS England. Overarching indicator: Risks will be identified and incidents reported. Evidence of lessons learnt and subsequent improved patient safety.

3. Scope

3.1 Aim and objectives of service

The aim is to provide a highly specialised service for children and adolescents up until their 18th birthday. who are experiencing features of GD or need support to explore their gender identity

It will do this by fostering recognition and non-judgemental acceptance of diversity in gender identities and gender expressions ; providing support, advice and treatment to assist in reducing behavioural, emotional and relationship difficulties and their effects; offering options for physical interventions as appropriate, and working to prevent further mental health problems such as anxiety, low mood, self-harming and suicidal thoughts. The service will consider difficulties associated with gender identity development in the context of general developmental processes.

Objectives

The service will be provided in a timely way and will deliver the aim by working in a tiered way with other services so that the client can be supported as close to home as possible, accessing the service only when specialist expertise and input is required. This will include joint-working, consultation and liaison with local Child and

Adolescent Mental Health Service (CAMHS) services, schools and others as required.

The service will provide specialist input and consultation for GD experienced by a client but is not commissioned to provide care for psychiatric emergencies, as the local clinical professionals remain accountable for this care: this care will be specific to the individual, and may include CAMHS, GPs and/or secondary care consultants.

The service is commissioned to improve a client's state of psychological health and social inclusion by delivering tailored treatment packages in a safe environment. The service will hold in mind individual and diverse trajectories.

For those clients who decide to undertake physical intervention, the service will follow a staged approach including ongoing monitoring and therapeutic exploration of gender identity. This approach will ensure that clients have adequate time to fully assimilate the effects of each stage of physical intervention, together with the different options for gender expression, recognising that the needs of each individual will be different.

The objectives of the service are to provide:

Objective Area	Aim	Deliverables – this will include:
Expert advice	To be the lead clinical service and a source of expert advice for the diagnosis and care of children and adolescents with GD within the NHS, social care and educational system;	Raised awareness and increased understanding across health, social care and educational agencies of the issues associated with GD, thereby enabling those organisations to provide improved support locally to the individual and their family/carers and a more informed, timely and effective response in referral, assessment and treatment.
Pre-referral advice	Provide consultation advice to healthcare professionals prior to referral and pre-referral support where there is a complex presentation or when the young person,	Advice and view by telephone/email.

	parents or carers are not yet ready for direct contact with the service.	
Provide support to local services	Ensure excellent working interfaces with other NHS, education and care providers so that there is effective monitoring of the ability of clients with GD to have optimal daily functioning and to feel socially included	Good communication, liaison and support available to local schools, Child and Adolescent Mental Health (CAMHs) services, health and social care providers to support young people with GD, whenever it is clinically appropriate and safe to do so; and to support this via appropriate literature and web-based resources
Improved access	Promote equity of access and choice through the development of satellite clinics where there is a high volume of clients, following consultation and agreement with commissioners.	Ongoing review of need
Objective Area	Aim	Deliverables – this will include:
High Quality Care	<p>To provide expert opinion, therapeutic support and care for clients who have GD to maximise the client's experience of care, improving their long-term quality of life, social inclusion, mental and emotional health and reducing self-harm and suicidal thoughts.</p> <p>Do this through:</p> <ul style="list-style-type: none"> • providing therapeutic support and care, with a client and family-centred focus • the use of the most up-to-date clinical protocols for prescribing, therapeutic interventions, control of symptoms and treatment; • support for on-going exploration of gender identity and expression, • enable the client and their parents or carers to make an informed choice of the treatment options having been given the 	<p>An assessment report and care plan after three to six meetings to include a history of gender development and gender identification, and a description of associated mental health issues.</p> <p>High quality information for clients, families or carers, schools, colleges and healthcare professionals in</p>

	<p>best possible advice on life changing decisions;</p> <ul style="list-style-type: none"> the provision of an integrated service which encourages exploration of the mind-body relationship by promoting close collaboration among professionals in different specialties, including paediatric and adolescent endocrinology for consideration of physical treatment with the hormone blocker when the young person is in established puberty, (not before Tanner Stage 2) and with NHS specialists such as gynaecologists and fertility experts for gamete retrieval advice and support; provide a prompt, staged approach to reducing the risk of self-harming behaviour and encourage a positive self-image. 	appropriate and accessible formats and media;
Improved functioning of clients in their daily life	<p>Maximise the client's function in daily life by working within the client's relationships with parents and family or carers, school and other social agencies.</p> <p>Help the client and their parents or carers to:</p> <ul style="list-style-type: none"> understand the nature of obstacles or adverse factors in the development of gender identity and try to minimise their negative influence, support the client and their parents or carers to tolerate uncertainty in gender identity development; combat the stigma which is often associated with the experience of atypical gender identity and is at times internalised by the individual experiencing GD; to alleviate the feeling of shame that some clients and their parents and families or carers' experience and enable them to develop skills in handling social interactions and dealing with possible hostility; to promote the development of autonomy 	The client has an improved ability to effectively communicate and make informed choices about their life
Transfer	<p>To facilitate a secure and seamless transfer to adult services for those requiring ongoing care.</p> <p>Establish effective working relationships with providers of the adult services and maintain</p>	Supported transfer

	supportive contact with the clients referred to those services until they are securely placed.	
Audit	Undertake a rolling programme of clinical audit to test current practice and inform the evolution of care and therapeutic intervention for GD;	Audits and publications of findings
Engagement	Collaborate and provide relevant engagement with community groups who deliver services to transgendered young people and their families for the benefit of young people with GD, their families and communities.	Annual programme of engagement activities.
Service improvement and innovation	Continually develop the specialist experience, knowledge and skills of the service's multi-disciplinary team (MDT) to ensure high quality, sustainable provision. Continually develop clinical methods, new aspects of the service and new ways of delivering care, while increasing the evidence base, in the area of GD.	Annual training and development programme.

3.2 Service description/care pathway

Service description

3.2.1 The service will be provided through a highly specialist multidisciplinary approach to the assessment and care of GD in children and adolescents, and will work in collaboration with local CAMHS, GP's, secondary care paediatricians and gynaecological consultants as required on an individual basis.

The service will be delivered through a network model with the local specialists including secondary care clinicians, GP and CAMHS teams to ensure that a holistic approach is offered to clients and their family or carers that meets their complex needs. The service will provide direct therapeutic work with clients and their family or carers and provide an outreach service to related support services in other parts of the UK as agreed with commissioners.

Figure 1: Schematic illustration of GIDS service pathway

Following assessment, clients follow different and individualised pathways, which may or may not include physical assessment and treatment. Clients can move between and back and forth from the various aspects of the pathway at any stage

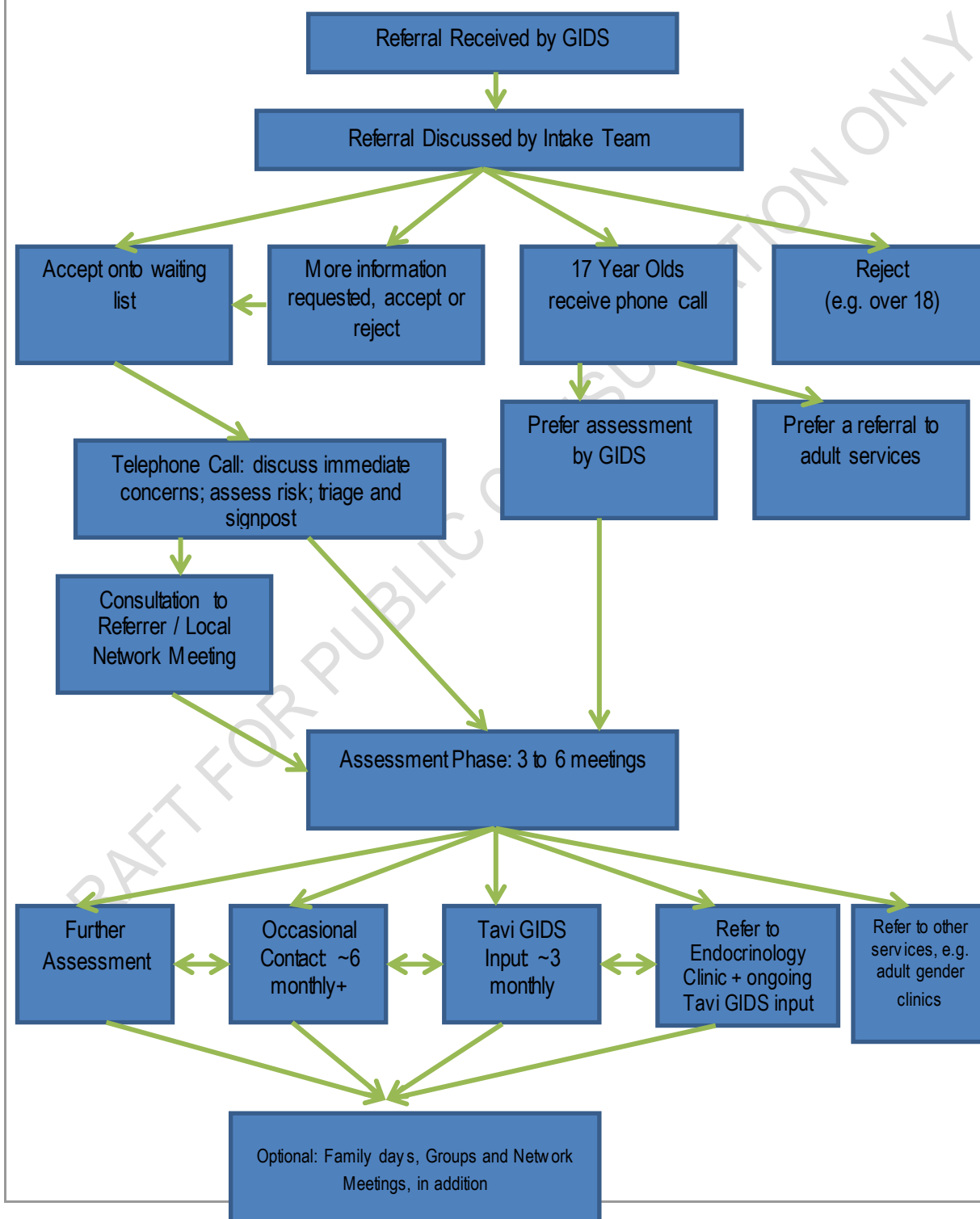
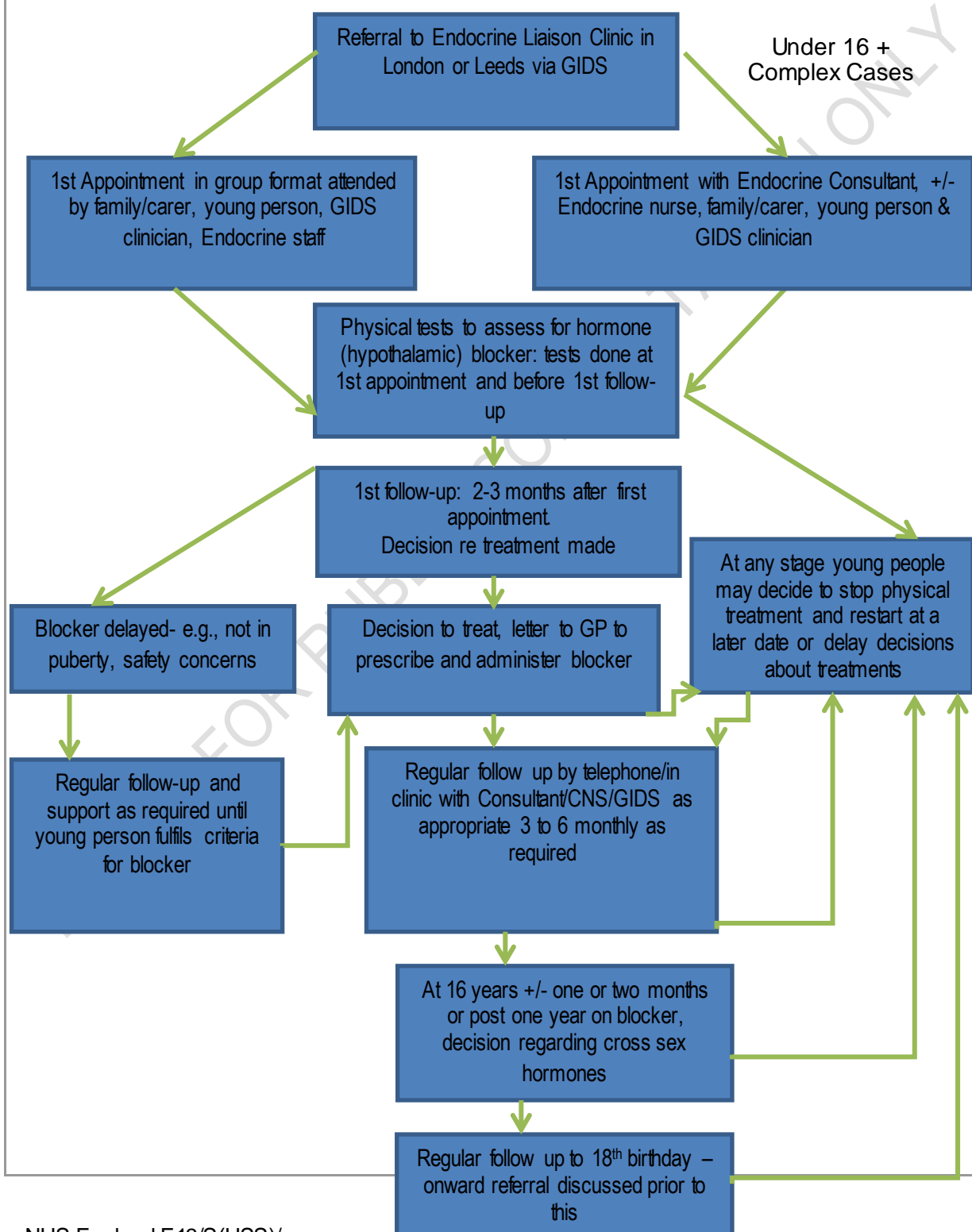


Figure 2: Indicative schematic diagram of pathways through the Paediatric Endocrine Liaison Clinic (in practice pathways may be adjusted to meet individual circumstances) - For clients who decide to undertake physical assessment and treatment



Referrals

Referring professionals should be encouraged to discuss the referral with the family or carer and seek their agreement. The service will only accept referrals for young people with features of gender dysphoria consistent with current diagnostic criteria as defined in DSM 5.

3.2.2 Service inputs:

- psychosocial support aimed at increasing the wellbeing and resilience of the client;
- therapeutic exploration of gender identity development and gender expression, including in relation to the client's familial, social and cultural situation;
- referral, when appropriate to the needs of the client, to the Paediatric Endocrine Liaison Team for physical assessment and to provide advice to clients and their parents or carers when key decisions need to be made, such as when being offered hormone blockers or cross-sex hormones;
- access to other medical specialists such as local secondary care gynaecologists and licenced fertility specialists to provide advice to clients and their parents or carers when key decisions need to be made with regard to gamete retrieval and egg storage.

The service will also provide:

- consultation and teaching;
- research;
- a service to children of transsexual parents
- a service to children with DSD (Disorder of Sex Development – also known as intersex conditions) experiencing GD and to professionals and families/carers making decisions about sex assignment and associated care;
- court reports;
- clinical placements.

3.2.3 Tiered model of care

The service model is based on four tiers of care, with the service managing care at Tier 4 and supporting the provision of care at the other tiers.

This will ensure that:

- appropriate care is provided as close to home as possible and,
- local professionals caring for children and adolescents can access appropriate information and support between the appointments with the service.

Table 1: Tiers of Care

Tier	Description	Detail of support and toolkits/documentation that the service will make available to this Tier
Tier 1	Local meetings with professionals involved in the care of young people with a diagnosis of GD including: teachers, social workers, school staff, secondary care consultants, GPs and others as appropriate, which are used to identify roles and facilitate the recognition and support of the young person in their local community.	<p>The service will support the following staff with advice in local service network meetings and advise on any issues that arise:</p> <ul style="list-style-type: none"> • School nurses, teachers • College lecturers • Social workers • GP's • CAMH's professionals
Tiers 2 and 3	Young people will access local generic CAMHS and GPs for general mental health needs. However, staff in these services will be able to access consultation and liaison from the service, and access specialist assessment and care for GD at Tier 4.	<p>The service will support staff as follows:</p> <p>CAMHS – establish communication protocols and close working arrangements to enable local services to better support clients and their family or carers.</p> <p>The service to report regularly to NHS England on risk management and other interactions with GP's, local CAMHS teams and secondary care clinicians to provide an understanding of how/whether the issues have been addressed.</p>
Tier 4	The service will see children and adolescents with GD for specialist assessment and care. The service will also support generic CAMHS (Tiers 2 and 3) and other professionals (Tier 1), working with children for emergency and urgent care and treatment for mental illness. This will be done through liaison and consultation, and where appropriate joint assessment and co-working in relation to GD	<p>The service will:</p> <p>Share care on a case by case basis</p> <ul style="list-style-type: none"> • Work with those who support clients locally by giving them information and providing education and advice • The service will promote a wider understanding of GD through: <ul style="list-style-type: none"> ○ Creating education materials ○ Undertaking and disseminating research ○ Creating and taking part in Continuing Professional Development opportunities

The service is commissioned to provide assessment/consultation and the following treatments:

- continuing therapeutic exploration
- intermittent reviews to monitor gender identity development
- family therapy, work with parents/carers and support for siblings
- group work and family days for parents, carers and clients
- consultation to the network with or without further direct involvement with the client and their family/carers
- network meetings in the client's locality
- when opted for, referral to the Paediatric Endocrine Liaison Clinic for physical assessment and endocrine treatment;
- referral, via the client's GP, to other NHS healthcare professionals such as gynaecologists and licensed fertility experts for discussions around gamete retrieval;
- referral to adult gender services

a combination of the above.

Therapeutic input will be agreed on a case by case basis dependent on each client's needs, with component parts being described, including focus and frequency of contact. The service follows an integrated model of care involving both psychosocial support, occasional contact and monitoring of GD, and physical interventions, as appropriate on a case by case basis. Where clients need more support between appointments and that support is within the expertise of local healthcare teams such as local CAMHS, the client's GP or the local acute or community paediatrician, the service will make contact with the relevant organisation and request this.

It is recognised that a client's needs may change during their time with the service and these may impact on the frequency and type of support needed. The service will discuss the level of support needed with clients and their family or carers during clinic visits and other forms of contact.

Assessment, consultation and treatment at Tier 4 :

The service for pre-pubertal children will include initial assessment together with the family or carers to ascertain the features of GD and the nature of associated difficulties. The service will facilitate communication in the family about the client's perceptions and behaviour regarding their gender identity to support their ongoing relationships. In this initial assessment/consultation phase, clients and carers will be seen every two to three months, although this may be more or less frequent as needed. The service will also provide therapeutic support and liaise with local services where appropriate to help clients and their family or carers manage any relationship difficulties. The service may meet with parents/carers separately.

The service will organise and host Family Days to be attended by clients and their parents or carers, and young peoples' support groups. The aim of these will be to encourage peer support and discussion of shared experiences.

The service for children approaching puberty, in puberty and post-pubertal clients will

include the input described above, as well as individual sessions for clients.

For clients opting for physical assessment and treatment and their families or carers, there will be a discussion on the different kinds of physical intervention as appropriate. The service will, when indicated, make a referral to the Paediatric Endocrine Liaison Clinic for assessment for suitability for the hormone blocker, which is not offered before Tanner Stage 2.

The initial assessment/consultation phase will take between two and six sessions. The time intervals between the sessions will be adjusted on a case by case basis, to enable those approaching puberty or in puberty to move promptly, where appropriate, on to referral to the Paediatric Endocrine Liaison Team for assessment for physical intervention and associated care plan to be set out.

There will be a multi-factorial assessment to enable the Lead Worker to gain a broad picture of the client's previous and current gender identification, as well as their development across a number of domains (education, family relationships, peer relationships), with a particular focus on any associated psychological difficulties that may impact on future development and response to treatment.

The work will facilitate the curiosity and thoughtfulness of clients and their family or carers about the complex interactions between gender identity, gender expression, gender roles and other aspects of identity. Such conversations might also touch on the impact of living in a social world where negative attitudes towards gender variance are widespread and how these forces may be contested.

The exact content and manner of delivery will be dependent on the developmental stage and age of the client.

Where the client's situation is complex, that is, there is a number of health conditions or psychosocial adversities in addition to the GD presentation, the service will undertake joint 'network' meetings with the client, their family or carers, their GP, CAMHS provider, school, secondary care paediatrician and others to ensure the appropriate care.

The service will use a range of questionnaires as part of the assessment process to gather information on the client's gender identification and general functioning and contribute to the evidence base.

The diagnostic criteria for GD (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition), will also inform the assessment regarding the child's gender identity development. The American Psychiatric Association (2013) provides further clarity on defining GD in children.

The assessment/consultation phase will involve clients and their family or carers

being seen together for at least some of the time, to facilitate communication about the young person's perceptions of their gender identity.

The specialist assessment will take into account:

- the subjective sense of the young person's identity over time;
- their expression of gender identity across different contexts over time;
- the client's and their family or carers' wishes, hopes and expectations, and their stance towards the client's gender identification;
- the capacity of the client, and their understanding of gender, puberty and fertility;
- any actual or potential risks (related to the young person's physical and mental health) and how these are managed. If the risk of harm is felt to be significant, the necessary steps must be taken (i.e. immediate liaison with, or referral to, relevant agencies).
- the degree to which the young person is engaged in school or work, and their experience of bullying or harassment;
- the young person's psychosexual development and any sexual experiences
- the quality of relationships within the family and wider community, and the level of support;
- the family or carers and young person's spiritual, cultural, or religious beliefs;

Factors that could influence the complexity and length of the assessment include:

- the intensity of any associated difficulties;
- on-going risk issues, including self-harm and suicidality, and safeguarding issues;
- concerns with regard to a young person's capacity to understand and consent;
- family conflict (especially in a younger child) about how to proceed;
- inadequate support from the network (where there are any concerns regarding mental health or social functioning);

The service may liaise with CAMHS, social care and education at the assessment/consultation stage in order to set out specific needs which local services may respond to, now or in the future, with further psychiatric, educational and inter-disciplinary input.

The clinical work that supports identity exploration involves conversations which are focused on increasing understanding and insight. These conversations can be engaged in during the assessment period and continued subsequently when the relationship with the clinicians in the service may become more trusting. Exploratory work recognises the right of young people to self-define their gender identity and to make decisions about their own life and treatment, taking their developmental stage and competence into account.

Issues to do with body dissatisfaction may be broached, and hopes (which may be more or less realistic) for achieving a more settled relationship with the body. The opportunities provided by medical intervention, and the limitations of intervention, will be discussed.

It may also be relevant to promote a sense of the range of possibilities of varied trans identities in order to encourage thinking about notions of masculinity and femininity and to tolerate uncertainty – although for other young people a very questioning approach might not be helpful. Understanding the unique experience and point of view of each young person will be a priority.

All aspects of the care pathways are offered to clients who present with other gender identifications, including non-binary, who will follow a care pathway as appropriate for their needs.

The service will take particular care in assessing clients who may have social and communication difficulties or other difficulties in learning, with attention paid to the client's understanding of gender and sex development and physical treatments for gender dysphoria and any issues regarding informed consent to treatment.

Liaison with CAMHS, social care, schools and colleges may be conducted at the assessment/consultation stage, identifying specific needs to which local services may respond, now or in the future, with further psychiatric and inter-disciplinary input. If there are concerns about a client's mental health, then local services will be asked to provide further psychiatric and multi-disciplinary input.

The service will take appropriate action if harm, or the risk of harm, is felt to be significant (i.e. immediate liaison with or referral to relevant agencies).

The responsibility for the care programme approach will be held by local services.

It is noted that not all clients decide or wish to undertake physical assessment and treatment. On an individual basis therefore, clients may prefer to access on-going support and therapeutic exploration of gender identification and/or social gender expression and not opt for physical treatment. At any time whilst in contact with the service, clients can move between different elements of the pathway (see Figure 1).

3.2.3 Informed consent

The service recognises a wide diversity in sexual and gender identities. It affirms the importance of young people's developing autonomy in relation to treatment decisions, as well as their need for care and support from their family and the professional team.

The service will facilitate the careful consideration by clients and their family or carers of the meaning of informed consent, as it is an important aspect of ethical assessment and intervention, including the emotional, social and factual issues, so as to enable them to make informed decisions about the treatment options, benefits, risks, and the alternatives to the treatments proposed (including the option of no treatment). The consequences of treatment decisions can be significant and life-changing.

The service will support the client and their family or carers to jointly understand the

factual information which will enable them to make informed decisions about treatment options, including hormone treatments if appropriate; will provide initial advice about fertility options and, make a recommendation to the client's GP that a referral to a licenced fertility specialist is required.

Age does not determine capacity to give consent. If it is concluded that a young person has sufficient autonomy and understanding of what is to be offered, they can consent to treatment.

The service will assess a client's capacity or competence to consent to physical interventions. The term 'competence' means that a person fully understands what is proposed; can retain an understanding of the implications; appreciate the importance of the information and see how it applies to themselves, and can assess the benefits and dis-benefits of their decision. The level of understanding that is sufficient will vary with the complexity and gravity of the decision.

The evaluation of competence of a client for whom physical intervention is recommended within the scope of the specifications will be undertaken with special care for those under the age of 16 (see the Tavistock and Portman NHS Foundation Trust policy on 'Consent to Treatment').

<http://tavistockandportman.uk/sites/default/files/files/consent-policy-and-procedure-Apr-15.pdf>

All efforts will be made to ensure that clients under 16 years of age are aware of the longer term consequences of the endocrine treatments, including implications for fertility, and the decision of the competence of the client will be jointly made by the endocrine and psychological members of the service's integrated team.

The current context of treatment decisions about cross sex hormones in adolescence is that there is limited scientific evidence for the long-term benefits versus disadvantages of this intervention, and great uncertainty about both the causes of significant GD and the early identification of those young people who will persist in their trans identity and feel content in the long term with the early treatment choices they made. Please see Appendix 6 for further information.

3.2.4 Referral to the service's Paediatric Endocrine Liaison Team

Following a detailed psychosocial assessment and consultation, a client may wish to be considered for referral to the Paediatric Endocrinology Liaison Team.

Physical intervention in the early stages of puberty is available via the Paediatric Endocrine Liaison Team's 'Early Intervention' Clinic for carefully selected clients who are at least in Tanner Stage 2 of puberty and are up to age 15.

The Early Intervention Clinic will continue to follow the research protocol, with the exception that the age of 12 years for the hormone blocker no longer applies and the hormone blockers will be considered for children under the age of 12 if they are in established puberty.

'Standard' clinics are for adolescents aged 15 to 18 years.

The client will be booked into the clinic for discussion between the team and the family or carers about available physical interventions. The Paediatric Endocrine Liaison Team includes Consultant Adolescent Endocrinologists and Clinical Nurse Specialists. Physical intervention is one part of the overall treatment offered and is not offered in isolation from other aspects of the treatment provided by the MDT.

Paediatric Endocrine Liaison Team assessment appointments:

In standard Paediatric Endocrine Liaison clinics, the client and their parents or carers will first attend an educational group session or a joint appointment with a member or members of the endocrine and GIDS teams. Joint clinic appointments and the educational group will both include an introduction and information about the work of the clinic and issues relating to informed consent.

In the first or second Paediatric Endocrine Liaison clinic appointment, there will be a standard physical examination to ensure good physical health and determine whether self-neglect or self-harm are present. There will also be a very short, largely visual, examination to provide the clinician with a baseline assessment of the stage of pubertal development and (genital stage/testicular volume in natal males and breast stage in natal females).

Following appropriate tests and physical assessments the client, their family or carers and clinicians will discuss further plans and reach a joint decision about whether to start the use of the hormone blocker.

The Paediatric Endocrine Liaison team will advise natal males on the pathway that can be followed once adult for gender reassignment surgery, if this is an option that the client may wish to take up at a later date, Hormone blockers stop pubertal development that has not already taken place and hence for clients who commence hormone blockers in the early stages of puberty this may affect future surgical interventions.

There are two separate categories of hormone treatments available:

- gonadotropin-releasing hormone analogue (GnRH) (referred to in this document as the hormone blocker): which is used for a period prior to the next stage of hormone treatment. The service will liaise with the client's GP and make the referral to the GP to prescribe these, which will be an injection given in primary care according to recommended dosage schedules.
- cross-sex hormones: a client who has been assessed as having persistent gender dysphoria may be considered as being appropriate for cross-sex hormones which will be prescribed in addition to hormone blockers. The service will make the referral for the GP to prescribe cross sex hormones in addition to the hormone blockers.

It is expected that all treatments will be prescribed and administered in primary care services.

The Paediatric Endocrine Liaison Team will consider with clients and their family or carers the prescribing cross-sex hormone therapy to adolescents in whom the gender identity is settled inconsistently with the sex assigned at birth, but only to clients who are at least aged 16, plus or minus one or two months depending on the timing of endocrine clinic appointments and have been receiving the hormone blocker for at least one year.

When ethically approved, the service will undertake a research study to assess the physical and psychosocial impact and outcomes of offering cross sex hormones from the age of 15 years for a carefully selected group of clients who have been receiving the blocker for a minimum of two years.

It is understood that some young people may wish to privately access hormone treatments earlier than is considered appropriate in this specification. In such cases, where the young person is a client, the service will provide educational information on the risks of taking products sourced off the internet as they may not be safe. In such cases, the Paediatric Endocrine Liaison Team will be unable to provide ongoing clinical supervision and the client will be discharged from the endocrine team until such time as they fulfil the criteria in the service specification, although psychosocial support will be provided to support the client with any other issues.

Fertility

All clients attending the Paediatric Endocrine Liaison clinic will receive general fertility advice including the possible effects of taking hormones for future fertility.

The Paediatric Endocrine Liaison Team will provide initial information on fertility options and signpost the client and their family or carers back to their GP who can make an onward referral to licensed NHS fertility specialists for expert advice on fertility options including gamete retrieval.

See Appendix 5 for Referral Processes to other Related Services.

3.2.5 Staffing

The specialist MDT team will include:

- family therapists,
- consultant child and adolescent psychiatrists,
- consultant clinical psychologists
- consultant and principal social workers
- principal child and adolescent psychotherapists,
- consultant and clinical nurse specialists in endocrinology
- consultant adolescent endocrinologists

3.2.6 Service hours:

The service will operate Monday to Friday 9.30-5.30pm
If an appointment is cancelled by the service, a replacement appointment will be booked within a week for an appointment within six weeks. There should be a record kept of the number of times that a clinic appointment is cancelled before it takes place.

3.2.7 Discharge planning and possible transfer to adult services:

Adult gender services will accept referrals from the age of 17 years. There are two outcomes for older service users from the age of 17 years following being a client with the service:

- referral back to local clinicians including the GP and local CAMHS for those clients who do not wish to proceed to the adult service for whatever reason
- referral to the adult gender service for those adolescents who have persistent GD

The service will ensure effective, safe, smooth and timely discharge to local services, other NHS professionals or the adult gender service as appropriate to the client. To facilitate this, the service will put in place a discharge plan to ensure that the client's needs are considered from the earliest point of contact. Discharge planning will include the needs and wishes of the client and their parents or carers. The final discharge plan will be agreed with the client and their family or carers. Discharge planning should commence from the 17th birthday or as close to this as appropriate, depending on the age at which a client is referred.

A copy of the discharge plan will be given to the client and their family or carers, the referrer, their GP and, with the permission of the family, to any other involved professionals.

The discharge documentation will include a copy of the healthcare discharge plan, an 'About Me' hand-held booklet, co-designed with clients to include sections which are important to them and inform other health and social care professionals about key issues, GD experiences and intentions of the person so that they do not have to unnecessarily repeat their personal story. This should be updatable. For example: identity, pronouns, experiences with dysphoria, any experiences with self-harm or suicide attempts - if the client wishes, as these can often be very difficult to talk about.

Clients will transfer to other services where this is appropriate. This may include care from:

- the adult gender service;
- adult mental health services
- other appropriate services.

See Appendix 2 for NHS England Transfer guidelines

At the point of discharge, the service will collect data on outcomes of GD and their reason for leaving the service including transfer to adult service. This will be shared

with the commissioners on an annual basis to influence future service development activities.

3.3 Population covered

The service is for clients who are registered with an English General Practitioner (GP), or who are resident in Scotland or the European Union and eligible for treatment in the NHS under reciprocal arrangements. Clients from Wales and Northern Ireland are not part of this commissioned service and the service provider will have separate arrangements in place for these clients.

The service will provide consultation on a discretionary basis to Wales and Northern Ireland, and will only carry out direct clinical work with children or families in Wales or Northern Ireland if the child is either resident or in school in England. The service will support the development of new services in other countries.

3.4 Any acceptance and exclusion criteria

3.4.1 Referral management

New clients will be seen within 18 weeks from the date the service receives the referral.

As a young person may or may not be experiencing distress relating to the social or physiological aspects of their GD, referrals will be assessed to ascertain the level of distress and any associated risk. If the referral is received from a health professional other than the local CAMHS service or from a voluntary organisation, a letter will be sent to the client's GP and the local CAMHS team to advise them of the referral and the perceived level of risk with the client. Where the service identifies that the client is at significant risk, the communication from the service to the GP and local CAMHS will request that the young person is reviewed locally as soon as possible and an appropriate risk management plan put in place. Referrals will not be accepted in cases when the identified risk is not being managed locally.

Criteria for acceptance into the service are as follows:

- Referrals will be accepted from a range of professionals including CAMHS professionals, GPs, secondary care clinicians including paediatricians and gynaecologists, schools and colleges of further education plus voluntary organisations.
- Referrals will be accepted if there is evidence of features consistent with a diagnosis of GD and identified risk is being managed locally;
- If, after assessment, it is apparent that the young person does not fulfil the criteria for a diagnosis of GD, or it is concluded that there are no issues with gender identity development, the case will be closed and the young person referred back to their GP or other referring healthcare professional, with advice regarding appropriate support.

3.4.2 Age of access

The service will offer a service in England to children and young people aged up to their 18th birthday and accept referrals from a wide range of professionals in health, social services and education departments and voluntary organisations who may have concerns about a young person's gender identity development and associated difficulties.

If a new referral is received for a client who is already 17 years of age, the service will contact the young person by telephone to discuss referral options, given that the 18 week timeline to be seen as a new patient and then the appropriate duration of assessment means that they are likely to have already reached or nearly reached the exclusion criteria for the service (their 18th birthday) before they can commence hormone treatment, if this is indicated.

In such cases,

- If the young person's objective is for hormone treatment and they would prefer a direct referral to adult services the referrer will be contacted and asked to do this.
- If the young person would like the opportunity to explore their gender identification and options, on their own or with their parents or carers, the service will offer to assess the young person over two to three appointments, complete the assessment and agree an appropriate onward referral if appropriate and the young person wishes this.

In all cases, referrers will be informed of the client's decision so that local health professionals can put in place support as required whilst the young person waits to access the adult gender identity clinic.

Hormone blockers will be considered as an appropriate treatment alongside psychological intervention, and will not necessarily be viewed as the pre-cursor to the prescribing of cross-sex hormones. The next stage of treatment, if any, should be left open for further exploration with the client.

The paediatric endocrinologist's assessment of the biological environment and the client's physical development will precede the prescribing of hormone blockers. The decision to start hormone blockers is reached after an in-depth discussion involving the MDT, following which the final responsibility for prescribing the hormone blocker and the physical monitoring of this treatment remains with the paediatric endocrinologists, subject to periodic review by the MDT.

3.4.3 Criteria for referral to the Paediatric Endocrine Liaison Team for hormone blockers in the early stages of puberty and/or under the age of fifteen.

The criteria for considering a referral to the Paediatric Endocrinology Liaison Team are as follows:

- The adolescent has been presenting with long term and persistent GD and the intensity and distress has increased with puberty;
- The adolescent presents as relatively stable psychologically as evaluated through clinical observation and questionnaires,
- There is support from the family or carers,
- In some cases, the referral to the paediatric clinic is made for the purpose of

physical assessment e.g. to exclude a disorder of sex development or other endocrine conditions,

- To provide information about physical development in order to allay some anxieties in the adolescent patient and the family.
- Young people under 16 should be assessed able to give informed consent and have the appropriate autonomy to make decisions

3.4.4 The criteria for considering administering hormone blockers to post-pubertal adolescents over the age of 15 years with GD:

- there is a significant level of distress associated with secondary sex characteristics
- there is a serious level of conviction about gender identification both in statements and the desire of living in another gender, often together with some experience of living in the preferred gender role;
- therapeutic engagement and exploration has already taken place and is ongoing between the client and the service and the client has committed to maintaining this throughout treatment
- the client is in established puberty

3.4.5 Exclusion criteria:

- the client has not met all the criteria described above.
- the client presents with a psychotic or other significant mental health disorder that is not adequately controlled as this may reduce their ability to manage the emotional issues that may arise from the changes in hormone levels from the hormone treatments and may impact on their capacity to consent..
- abnormalities in status or timing of pubertal development or other physical contraindications that require further investigation.

3.4.6 The criteria for prescribing cross-sex hormones

Please see Appendix 7 for the diagnostic template used to assess readiness for intervention with cross-sex hormones, which has been agreed in conjunction with the NHS England adult gender identity service teams and includes:

- diagnosis of GD
- the client is aged 16 years plus or minus one or two months depending on the date of the endocrine clinic follow up appointment
- the client is able to give informed consent
- impact on fertility has been discussed and the implications are understood
- some evidence of presentation coherent with gender identity, for example deed poll name change
- the client is engaged in or taking steps to secure, meaningful activity such as education or employment, accepting that societal limitations may affect this
- there is support for the client from the family or carers or social support if the client is a 'Looked After Child', and the Local Authority been consulted
- the client is in good physical health
- associated difficulties such as self-harm are not escalating or are being actively

monitored and managed by local healthcare professionals. This will be assessed on a case by case basis

- the client has not smoked for a minimum of three months
- the client is therapeutically engaged with the service
- at least two clinicians agree on the suitability of the client receiving cross-sex hormones

3.5 Exclusion criteria

The service is not commissioned to respond to emergencies or offer treatment to associated psychological and psychiatric problems (e.g. school refusal and compulsive symptoms). The service is required, in complex cases, to ensure that the client's GP and CAMHS provider are engaging with the client and are aware of any escalation in risk.

When a client who does not meet the age requirements of this specification seeks physical interventions privately via alternative medical providers, the care they will receive from the service will only be within the scope of this service specification until the age requirements contained within it are met and a subsequent MDT assessment has been completed.

This means that :

- where a client accesses hormone treatments including hormone blockers or cross-sex hormones privately but does so at an earlier stage of puberty or age than set out in this specification, the service will not be required to supply or monitor the use of these until the client either:
 - in the case of hormone blockers, meets the stage of puberty set out in this specification and has been assessed by the service's MDT as having reached the right stage. Psychosocial support will be provided to support the client with any other issues.
 - in the case of cross-sex hormones, the client meets the age set out in this specification and has been assessed by the service's MDT as meeting the criteria for cross-sex hormones. Psychosocial support will be provided to support the client with any other issues.
 - in the case of clients who are already accessing hormone blockers through the service, who then choose privately to access cross sex hormones at an earlier age than set out in this specification, the service will no longer provide hormone blockers and both should be sourced via the private provider, including any ongoing assessment and maintenance of the impacts of this medication. The service will not be liable for the impacts of hormone treatments that are sourced privately.

Once the client has reached the age set out in this specification, they will be assessed by the MDT and if appropriate, hormones will be prescribed. If required for this assessment, the service will, with the consent of the client and their parents or carers, review and evaluate the records of any prior mental health assessments or treatments, and liaise as necessary with any previous provider, to obtain the results of baseline examinations and laboratory tests.

Where a client is understood to be accessing hormone treatments privately, the service will share safety concerns with the client and their family or carers. Appropriate plans for the future will be discussed, but this may mean the client will need to cease the self-administration of hormone medication until a full assessment has been completed. The service will work with the client to substitute an appropriate treatment.

Neither NHS England nor its contracted providers will be liable for any adverse effects where a client sources medication or treatments outside of the NHS.

The service offers a holistic interdisciplinary service with input from mental health professionals and adolescent endocrinology and does not offer shared care with private clinicians.

The service's Paediatric Endocrine Liaison Team cannot take on responsibility for monitoring treatment obtained over the internet or prescribed elsewhere where no shared care protocols are in place.

3.6 Stopping criteria

Endocrine treatment will be suspended, following discussion with the client and their family or carers where:

- 1 there are any concerns about the client's physical health such as low bone density
- 2 the client and family do not attend regular follow ups at the Paediatric Endocrine Liaison Clinic and/or the GIDS general clinic as agreed in their care plan.
3. the client is having a significant psychotic or other significant mental health disorder that is not adequately controlled as this may reduce their ability to manage the emotional issues that may arise from the changes in hormone levels from the hormone treatments and may impact on their capacity to consent.
- 4 there are physical contraindications that require further investigation.
- 5 the client decides to cease treatment for any reason

3.7 Response time and prioritisation

The service is required to see clients for the first time and begin the assessment process within eighteen weeks of referral.

The service will provide equitable services for any child or young person up to their 18th birthday from any cultural background, with any protected characteristic and with any illness or disability. Every reasonable effort is to be made to make services accessible. The service will provide accessible toilets and access for wheelchair users. When required, the service will use interpreters and translate printed documents

The service will co-operate with the commissioner in undertaking Equality Impact Assessments with regard to all protected characteristics as a requirement of equality legislation and promoting equality and addressing health inequalities.

The service will:

- give due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- give regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

3.8 Interdependencies with other services

The service provider is to be the leader in the NHS in England for the assessment and care of children and adolescents with GD even though the tiered model of care means that interaction with the service will only be part of the client's experience.

The service will provide advice and support to referrers and will provide education on GD within the NHS and across the education, social care and voluntary sectors to raise awareness of gender identity development in child and adolescents.

The service will form supportive relationships with local education, health, social care providers and the voluntary sector to support optimal care for clients with GD. This will include liaison with healthcare professionals such as secondary care paediatric and gynaecological consultants; GPs; community nurses; school nurses and health staff in colleges of Further Education; academies; staff in Local Education Authorities that have pupils attending the service in any of its locations; CAMHS staff; social workers; adult gender service providers; adult endocrine services; adult surgical providers; local Clinical Commissioning Groups; helpline providers; and charities.

The service will engage in two way communication with and seek to have robust working relationships with local CAMH services, GP's and secondary care healthcare professionals and provide routine feedback to them of client progress, subject to appropriate information governance.

This will include:

- direct consultations;
- co-working for complex cases;
- good liaison and individual client care planning;
- support for transfer of clients to adult services.

In line with the tiered model of care, responsibility for managing the risk associated with gender dysphoria for all clients will reside with local services.

The service will work in collaboration with another gender identity clinic in the Netherlands, and others in Europe, Canada and America to share and implement standardised assessments for research and evidence base practice purposes.

The service will:

- undertake effective two-way communication with adult gender services prior to the transfer of clients to the adult service. This needs to take place with the client and their family or carers.
- provide transfer support to the adolescent in their move to the adult service

Discussions about any substantive potential change to the service model or clinical approach must take place with NHS England commissioners in order that clinical approval can be given and any changes to commissioning policies taken through the clinical governance and approvals processes.

A report to commissioners will be submitted annually on innovation and improvements in the service.

3.9 Audit and Research

The service will conduct high quality research and undertake audit projects as part of ongoing service improvement and development. This will build knowledge about the profiles of the young people who are referred, their experiences at different stages in their development and at different stages of treatment, and their outcomes.

The service will collaborate with adult services in the UK to follow up young people in a way that respects their privacy.

International collaboration will also be undertaken. The data collected will be used by the service to gain an improved understanding of the most effective treatment pathways for different groups of young people.

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE, Royal College

The service will be fully integrated into their Trust's corporate and clinical governance arrangements. There is an expectation that practitioners will participate in continuous professional development and networking.

Staff from the service will meet on an annual basis and interface with local CAMHS Services, Paediatric Endocrinology Liaison clinics and other NHS Specialists to review the clinical governance and outcomes of the service including:

- clinical outcomes;
- service issues;
- notable events;
- treatment guidelines
- evidence based practice;
- review of learning from the year
- safety
- client, family and carer involvement and engagement and with other

- stakeholders including voluntary sector support groups
- sustainability
- transfer to adult services
- review of international evidence and benchmarks to inform changes in delivery
- audit activities, service evaluation and research, including future audit programme
- potential new developments and service innovations
- potential Improving Value schemes

The service will develop standardised evidence base tools and training programmes, including:

- common risk assessment, care approaches and systems;
- training for gender identity development, clinical skills and specific training related to mental health;
- clinical information systems, reports to commissioners;
- child protection procedures;
- client consultation and advocacy.

Education and training

The service will undertake a training and education role including:

- training of professionals working within the service
- education (including educational materials) for professionals at Tiers 1,2,3
- education for other agencies such as schools, and colleges of further education, CAMHS and social services

Documentation and Information Technology

Following each multidisciplinary clinic, the staff will produce a single clinic letter which will integrate the reports from each clinician. This will be sent out to the client and their family or carer; the client's GP and CAMHS and other secondary care paediatric specialists.

Clinic notes and correspondence will be stored at each centre (computerised) and included in the hospital-wide computerised client records of the client. The provider local administrator will have responsibility for ensuring safe storage and adherence to the Data Protection Act (1998) for computerised data. Offsite backup storage will also be arranged.

Facilities

Each centre used by the service for provision of care will have clinic space that is appropriate for children and adolescents and suitable for attendance by a number of multi-professional staff at one time.

Equity of access to services

Service access is paramount to success.

The service will be tiered so that care can be provided as close to home as possible, with appropriate geographic access related to demand, agreed in conjunction with commissioners.

Managing Risk

The service provider must meet the standards set out in this specification. It is the provider Trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the standards. Where there are any breaches, any consequences will be deemed as being the Trust's responsibility.

5. Applicable quality requirements and CQUIN Goals (see Schedule 4 Parts A-D)

There is a requirement to hold national audit meetings on an annual basis.

All parts of the service must assure that:

- all practitioners participate in continuous professional development and networking
- client outcome data is recorded and audited across the service
- all centres must participate in the national audit commissioned by NHS England.

Audit meetings will address:

- clinical performance and outcomes
- process-related indicators e.g. efficiency of the assessment process, prescribing policy, outpatient follow-up etc.
- stakeholder satisfaction, including feedback

Measures for monitoring the clinical benefit of the service are:

- diagnosis rate including time from referral to diagnosis.
- participation in a research study.
- a minimum defined data set will be collected on all client when available.
- networks will develop a plan to improve partnership working.

6. Location of Provider Premises

The service is provided by the Tavistock and Portman NHS Foundation Trust in London and Leeds with associated integrated Paediatric Endocrine Liaison clinics in both cities.

The community outreach service is delivered through a hub and spoke model in London and agreed outreach centres in England to ensure equity of access.

The location of outreach clinics will be determined by the commissioner and will be based on referrals and following agreement with commissioners. These are currently Barnstaple, Exeter, Bristol, Brighton and Bath.

Sub-contractors

The Paediatric Endocrinology Liaison Clinic which is based at the University College London Hospital NHS Foundation Trust and the Leeds Teaching Hospitals NHS Trust: Leeds General Infirmary (LGI) site, is sub-contracted although these staff are part of the service's MDT and there is a single, integrated protocol.

7. Individual Service User Placement

Not applicable.

DRAFT FOR PUBLIC CONSULTATION ONLY

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Glossary of Terms

	Term	Initials	Description
1	Analogue		See GnRH below
2	Autonomy		Term used to describe a person's ability to give informed consent.
3	Child and Adolescent Mental Health Services	CAMHS	CAMHS are specialist NHS children and young people's mental health services See http://www.youngminds.org.uk/for_parents/services_children_young_people/camhs
4	Child Behaviour Checklist	CBCL	The Child Behaviour Checklist (CBCL) is a parent-report questionnaire on which the child is rated on various behavioural and emotional problems.
5	Cross Sex Hormone (therapy)	CSH	Hormone replacement therapy for gender variant individuals, where sex hormones (androgens for trans male) and oestrogens for trans female) are administered for the purpose of synchronising a person's gender with their identified gender. This is the second stage of physical intervention which induces masculinising or feminising characteristics. The treatment is considered to be partially reversible. (Delemarre-van de Waal and Chohen-Kettenis 2006; Meyer et al, 2006).
6	Diagnostic and Statistical Manual of Mental Disorders		Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, http://journals.lww.com/co-psychiatry/Abstract/2007/01000/Dimensional_models_of_personality_disorder_.11.aspx
7	Gamete		Reproductive or sex cells. Female gametes are called ova or egg cells and male gametes are called sperm.
8	Gender Dysphoria	GD	Where a person experiences discomfort or distress due to a mismatch between their biological sex and the gender as which they identify. Biological sex is assigned at birth, depending on the appearance of the genitals. www.nhs.uk/conditions/Gender-dysphoria/Pages/Introduction.aspx
9	Gender Identity PER GRES		The psychological identification of oneself, typically, as a boy/man or as a girl/woman, known as the 'binary' model. There is a presumption that this sense of identity will be consistent with the, respectively, male or female sex appearance. However, some people experience a gender identity that is somewhat, or completely, inconsistent with their sex appearance; or they

			may regard themselves as gender neutral, or non-gender, or as embracing aspects of both man and woman and, possibly, falling on a spectrum between the two. People have the right to self-identify, many reject the idea of binary tick-boxes, and describe themselves in non-binary, more wide-ranging, open terms such as pan-gender, poly-gender, third gender, gender queer, neutrois and so on. Pronouns he/she, his/hers, may be replaced with more neutral pronouns such as: they, per, zie or fey; and the title Mx may be preferred to Mr, Mrs, Miss or Ms.
10	Gender Identity Development		The emotional and intellectual experiences of a child or young person in seeking to understand their gender identity
11	Gender Identity Development Service	GIDS	The NHS England service commissioned for children and adolescents with GD.
12	Gender role (PER GIRES)		The gender role is the social role – the interaction with others that both gives expression to the inner gender identity and reinforces it. Despite the greater gender equality in modern Western culture in terms of the subjects studied in school and at university; the choice of friends; work and domestic arrangements; dress and leisure pursuits, there is still a presumption of conformity with society's 'rules' about what is appropriate for a man or a woman, a boy or a girl, especially in terms of appearance. A significant departure from stereotypical gender expression often causes anxiety and discomfort in those who witness it. Their own discomfort may be reflected back on gender nonconforming individuals, causing a continuous source of stress in social situations. © GIRES 2015
13	Gillick/Fraser competence		A term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Based on the names of cases. https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/ 'Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-

			<p>year-olds without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions’.</p> <p>‘...whether or not a child is capable of giving the necessary consent will depend on the child’s maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.” (Gillick v West Norfolk, 1984).</p> <p>See also line 17 below</p>
14	Gonadotropin - releasing hormone (also known as the hormone blocker/s)	GnRH	<p>A gonadotropin-releasing hormone analogue (GnRH analogue), also known as a luteinizing hormone releasing hormone agonist (LHRH agonist) or LHRH analogue is a synthetic peptide drug modelled after the human hypothalamic gonadotropin-releasing hormone (GnRH). This is designed to ‘competitively block’ the GnRH receptor and prevent the release of pituitary gonadotropins FSH and LH for therapeutic purposes.</p> <p>It is used by the service to halt puberty in order that the client can further explore their GD without the fear of puberty progressing.</p>
15	General Practitioner	GP	<p>http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx</p> <p>GPs deal with a whole range of health problems and manage the care of their patients, referring onto specialists as appropriate.</p>
16	Multi-Disciplinary Team	MDT	The identified group of professional staff who provide the service
17	Natal gender		The biological gender that a person is born with which is either male - ‘natal male’ or female - ‘natal female’ and in GD, is different to the gender a person identifies as, which may be for example, the opposite gender or non-binary.

18	Non-binary, genderqueer (GQ) or gender fluid	GQ	<p>An umbrella term for any gender identity that does not fit into the traditional gender binary of male and female, including agender, bigender and genderfluid, among others.</p> <p>Can also be a discrete gender identity. Sometimes the term “genderqueer” is used.</p> <p>Also:</p> <p>Agender: a gender identity characterised by having no feeling of gender, or a specific identity of no gender.</p> <p>Bigender: experiencing two genders simultaneously. These two genders are often, but not always, male and female, and are not necessarily split evenly.</p> <p>Genderfluid: an experience of gender that is not fixed, but changes between two or more identities. For example, someone may feel female some days and non-binary on others.</p>
19	Tanner Stage		<p>Specialist classification of puberty by stage at which adolescents experience maturation. Used by specialists only. The complex series of biologic transitions are known as puberty, and these changes may impact psychosocial factors. See http://www.childgrowthfoundation.org/CMS/FILES/Puberty_and_the_Tanner_Stages.pdf</p> <p>For a simpler classification of pubertal development – puberty phases, see http://www.rcpch.ac.uk/child-health/research-projects/uk-who-growth-charts/uk-growth-chart-resources-2-18-years/school-age#cpcm</p>
20	US	USA	United States of America
21	World Professional Association for Transgender Health (2012)	WPATH	World Professional Association for Transgender Health (2012)

Appendices

- Appendix 1: Children's Insert to NHS England specifications
- Appendix 2: Transfer Insert to NHS England GIDS Specification (draft)
- Appendix 3: Definitions of Tanner Stages
- Appendix 4: Description of partnership working with local CAMHS
- Appendix 5: Referral processes and funding arrangements to access associated treatments for children and adolescents with Gender Dysphoria
- Appendix 6: Informed consent in the context of GIDS
- Appendix 7: Guidance for Discussions relating to Young People Wishing to Commence on Cross Sex Hormones

Appendix 1: Children's Insert – Provision of services to children

n.b this is a generic NHS England insert, no changes can be made other than by the editor to remove any unnecessary requirements not related to the service (BS)

Aims and objectives of service

This specification annex applies to all children's services and outlines generic standards and outcomes that would be fundamental to all services.

The generic aspects of care:

The Care of Children in Hospital (Health Service Circular 1998/238) requires that:

- Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities.
- Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child.

Service description/care pathway

All paediatric specialised services have a component of primary, secondary, tertiary and even quaternary elements.

The efficient and effective delivery of services requires children to receive their care as close to home as possible dependent on the phase of their disease/condition.

Services should therefore be organised and delivered through "integrated pathways of care" (National Service Framework for children, young people and maternity services (Department of Health & Department for Education and Skills, London 2004)

Interdependencies with other services

All services will comply with Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies – Department of Health (DH)

References

Continuing Professional Development (CPD) matrix level 3

Taking account of the differences in client profiles the principles and standards set out in this specification apply with modifications to the recommendations regarding the following:

- Facilities and environment – essential Quality Network for In-patient CAMHS (QNIC) standards should apply (<http://www.rcpsych.ac.uk/quality/quality/accreditationaudit/qnic1.aspx>)
- Staffing profiles and training - essential QNIC standards should apply.
- Parents/carers are involved in the child/young person's care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Applicable national standards e.g. NICE, Royal College

Children and young people must receive care, treatment and support by staff registered by the Nursing and Midwifery Council on the parts of their register that permit a nurse to work with children (Outcome 14h Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

- There must be at least two Registered Children's Nurses (RCNs) on duty 24 hours a day in all hospital children's departments and wards.
- There must be an Registered Children's Nurse available 24 hours a day to advise on the nursing of children in other departments (this post is included in the staff establishment of 2RCNs in total).

Accommodation, facilities and staffing must be appropriate to the needs of children and separate from those provided for adults. All facilities for children and young people must comply with the Hospital Build Notes HBN 23 Hospital Accommodation for Children and Young People NHS Estates, The Stationary Office 2004.

All staff who work with children and young people must be appropriately trained to provide care, treatment and support for children, including Children's Workforce Development Council Induction standards (Outcome 14b Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

Staff must carry out sufficient levels of activity to maintain their competence in caring for children and young people, taking account of guidance from relevant expert or professional bodies (Outcome 14g Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

Providers must have systems in place to gain and review consent from people who use services, and act on them (Outcome 2a Essential Standards of Quality and Safety, Care Quality Commission, London 2010). These must include specific arrangements for seeking valid consent from children while respecting their human rights and confidentiality and ensure that where the person using the service lacks capacity, best interest meetings are held with people who know and understand the person using the service. Staff should be able to show that they know how to take appropriate consent from children, young people and those with learning disabilities (Outcome 2b) (Seeking Consent: working with children Department of Health, London 2001).

Children and young people must only receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur (Outcome 7 Essential Standards of Quality and Safety, Care Quality Commission, London 2010 defines the standards and evidence required from providers in this regard). Providers minimise the risk and likelihood of abuse occurring by:

- Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them
- Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
- Ensuring that people who use services are aware of how to raise concerns of abuse.
- Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.

- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:
 - a. Having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse
 - b. Separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider
 - c. Reporting the alleged abuse to the appropriate authority
 - d. Reviewing the person's plan of care to ensure that they are properly supported following the alleged abuse incident.
- Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.
- Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010

All children and young people who use services must be:

- Fully informed of their care, treatment and support.
- Able to take part in decision making to the fullest extent that is possible.
- Asked if they agree for their parents or carers to be involved in decisions they need to make.

(Outcome 4I Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

Key Service Outcomes

Evidence is increasing that implementation of the national Quality Criteria for Young People Friendly Services (Department of Health, London 2011) have the potential to greatly improve client experience, leading to better health outcomes for young people and increasing socially responsible life-long use of the NHS.

Implementation is also expected to contribute to improvements in health inequalities and public health outcomes e.g. reduced teenage pregnancy and STIs, and increased smoking cessation. All providers delivering services to young people

should be implementing the good practice guidance which delivers compliance with the quality criteria.

Poorly planned transfer from young people's to adult-oriented health services can be associated with increased risk of non-adherence to treatment and loss to follow-up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes. When children and young people who use paediatric services are moving to access adult services (for example, during transfer for those with long term conditions), these should be organised so that:

- All those involved in the care, treatment and support cooperate with the planning and provision to ensure that the services provided continue to be appropriate to the age and needs of the person who uses services.

The National Minimum Standards for Providers of Independent Healthcare, (Department of Health, London 2002) require the following standards:

- A16.1 Children are seen in a separate out-patient area, or where the hospital does not have a separate outpatient area for children, they are seen promptly.
- A16.3 Toys and/or books suitable to the child's age are provided.
- A16.8 There are segregated areas for the reception of children and adolescents into theatre and for recovery, to screen the children and adolescents from adult patients; the segregated areas contain all necessary equipment for the care of children.
- A16.9 A parent is to be actively encouraged to stay at all times, with accommodation made available for the adult in the child's room or close by.
- A16.10 The child's family is allowed to visit him/her at any time of the day, except where safeguarding procedures do not allow this (?does not apply)
- A18.10 There are written procedures for the assessment of pain in children and the provision of appropriate control.

There should be age specific arrangements for meeting Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These require: (we will need to delete those that do not apply)

- A choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs
- Food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background
- Support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs
- For the purposes of this regulation, "food and hydration" includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed
- Providers must have access to facilities for infant feeding, including facilities to support breastfeeding (Outcome 5E, of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

All paediatric clients should have access to appropriately trained paediatric trained dietitians, physiotherapists, occupational therapists, speech and language therapy, psychology, social work and CAMHS services within nationally defined access

standards.

All children and young people should have access to a professional who can undertake an assessment using the Common Assessment Framework and access support from social care, housing, education and other agencies as appropriate.

All registered providers must ensure safe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines (Outcome 9 Essential Standards of Quality and Safety, Care Quality Commission, London 2010). For children, these should include specific arrangements that:

- They are supported to have a health action plan
- Facilities meet the appropriate requirements of the Disability Discrimination Act 1995

They meet the standards set out in Transfer: getting it right for young people.

Improving the transfer of young people with long-term conditions from children's to adult health services. Department of Health, 2006.

Appendix 2: Transfer Insert to NHS England GIDS Specification (draft as at 19 08 15)) Transfer from the Gender Identity Development service (GIDS) for children and adolescents to the adult gender clinic

GUIDELINES (not yet accepted – pending review by Adult Gender CRG March 2016)

I. AIM OF THE GUIDELINES

These guidelines have been written at the request of the Clinical Reference Group (CRG) for Adult Gender Dysphoria (GD) and the NHS England Gender Identity Development Service (GIDS) for Children and Adolescents in order to facilitate a successful transfer of young people with GD between child/adolescent and adult gender identity services. The following professionals have been involved in the development of these guidelines: Dr Leighton Seal, Dr Walter Bouman, Dr Polly Carmichael, Prof. Gary Butler, Dr Sarah Davidson, Dr Victoria Holt, Keyur Joshi, Sheela Upadhyaya, and Prof. Jon Arcelus (J.A) (Chair).

II. BACKGROUND

Transfer

Transfer has been defined as the purposeful, planned movement of adolescents and young adults with chronic physical, medical, psychological and psychiatric conditions from a child centred to an adult-orientated healthcare system (American Academy of Pediatrics, 2002). It also refers to a broad set of physical and psychosocial changes, arbitrarily defined as starting in late puberty and ending with full adult maturation (Clayton et al, 2005). Although it is acknowledged that the transfer process can be a very difficult time (Growth Hormone Research Society, 2000) if handled correctly, can be a guided, educational and therapeutic process (Royal College of Nursing, 2004).

There have been a number of documents that refer to the importance of transfer care arrangements for adolescents, particularly related to medical conditions (Royal College of Paediatrics and Child Health, 2003; National Institute for Clinical Excellence (NICE), 2004; DoH, 2005). These documents have highlighted that as they get older, children need to be increasingly involved in decisions about matters that affect them, so that by the time they are young adults they have learned to take responsibility for their own health. That task is more complicated for those with GD as they may be required to make complicated decisions at a difficult time and the price of getting it wrong can be very high.

For these young people, a well-planned transfer between child and adult gender identity clinic services must provide co-ordinated, uninterrupted healthcare to avoid negative consequences. For a successful transfer, many young people will also benefit from help in developing skills in communication, decision making, assertiveness and self-care, helping them to manage social, educational and employment opportunities and challenges and develop the independent living skills which underpin fulfilment and well-being. Their parent(s) or guardian(s) may also

value support, information and guidance in advocacy.

Although transfer can be a stressful experience, it could be argued that the stress of coping with the adult world is just part of the growing-up process and must be accepted as such. However, the evidence shows that getting transfer right does matter as many young people may not be able to cope with the difficulties and frustrations involved - which could result in the deterioration of their mental health with serious consequences for their health and well-being.

III. SERVICE INVOLVED IN THESE GUIDELINES

Gender Identity Development Service (GIDS) for Children and Adolescents: This is a nationally commissioned highly specialist service for children and young people (up to the 18th birthday) and their families who are experiencing difficulties in the development of their gender identity. This includes children whose sex and gender identity are not aligned and who may want treatment to halt puberty. This specialist service is unique to the NHS. The service has a multidisciplinary team, with experts in child and adolescent psychiatry, clinical psychology, social work, psychotherapy and adolescent endocrinology. The service is based in London and is part of the Tavistock and Portman NHS Foundation Trust (www.tavistockandportman.nhs.uk) and provides a Paediatric Endocrine Liaison clinic in association with University College London Hospital (UCLH) NHS Foundation Trust and Leeds Teaching Hospital NHS Foundation Trust. There is a well-established second centre in Leeds with an associated Paediatric Endocrine Liaison Clinic and regular outreach clinics offered in the southwest of England.)

Services for Adults with Gender Dysphoria-Gender Clinics (GIC): There are several Gender Identity Clinics for Adults in the UK. They provide a secondary and tertiary service for people aged 17 years and over with GD and/or other issues related to gender and sexuality. These services are located in Exeter, London, Leeds, Newcastle, Nottingham, Northampton, and Sheffield.

As with the GIDS, these services are also nationally commissioned NHS multidisciplinary gender identity clinics which provide clinical services to people from a wide geographical area. Most clinics incorporate, as necessary, psychiatric and psychological assessment, endocrine assessment and treatment, and, if required, supportive psychotherapy. The clinics work according to their clinic protocol, which is largely based on the Good Practice Guidelines for the Assessment & Treatment of GD from the Royal College of Psychiatrists Intercollegiate Committee (Wylie et al., 2014) and the NHS Guide for GPs and Professionals (Ahmad et al, 2013).

IV. CURRENT DIFFICULTIES WITH TRANSFER

The lack of an agreed and consistent seamless transfer care pathway for young people with GD as well as long waiting lists in all NHS gender identity clinic services highlight the need for clear and transparent guidelines regarding transfer from GIDS to adult gender identity clinic services.

The lack of current transfer guidelines and capacity in adult services means that if a

young person with GD is referred at the age of 18 years old, it can take up to one year for the young person to be assessed and treated in an adult gender identity clinic service. This is a substantial period during a particularly difficult time of the young person's life. A second difficulty relates to the view by some clients or clients that the assessment process is repetitive, as they feel the young person has already been assessed and diagnosed by child and adolescent services. Another major difficulty is the fact that many of the clients transferred from the service are getting their hormone blockers and cross-sex hormones from the Paediatric Endocrine Liaison clinic at UCL secondary care and not from their GP.

There is an expectation that the transfer between services will not take longer than 120 days, however the main difficulty is the lack of allocated resources or budget for the work with young people transferred to adult services, which means that it makes it difficult for them to be assessed by adult services as a priority and before other people who have been on the waiting list of adult services.

With this in mind these guidelines recommend the following:

TRANSFER PROCESS RECOMMENDATIONS

Referral process

1. For the GIDS to refer the young person up to six months before they reach the age of 17, depending on the circumstances of the referral. As most adult services have a waiting list of more than 6 months, it is likely that the young person will be over 17 years by the time they are seen.
2. Clients who have commenced or completed the assessment by the service should be prioritised above routine referrals to the adult service but resources (including extra funding) needs to be in place
3. A letter of acknowledgement of the referral including the assessment date to be sent to the GIDS for information and planning.
4. For clients who are already on hormone blockers or cross-sex hormones: Following the receipt of all the information in table 1, it would be possible for the adult service to take responsibility for advising with regard to the young person's ongoing hormone treatment at the first assessment appointment. This may mean advising the GP to continue to prescribe the same hormone treatment unless recent blood results are available previous to the first appointment.

The service will establish that all clients are on GP prescribing before they are transferred to the adult service. Failing that, to make it clear very early on to the GP that once the client gets to an adult clinic that there is an expectation of GP prescribing and have the discussion with the GP about primary care prescribing at a time when the patient is receiving treatment. If this doesn't happen there is the risk that the patient will experience a cessation of all endocrine treatment, at least for a while, as soon as they join the adult service.

It feels important for the clinicians working with the client to know them as this will be required for future advice regarding surgery. In view of this the service will arrange appointments, as per usual practice, not with the aim of making a diagnosis but in order to know the client. Following the initial meetings the clinicians may discuss medication options and even surgery.

A new booklet has been developed by adult services to give information to and prepare the client regarding the adult service. This booklet is to be given to the

young person previous to referral to adult services, in order for the expectations to be clear.

There will be a summary of the endocrine treatments and pre-hormone physical assessments made available to the adult service. There will be a clear indication of whether the client is at regarding their hormonal therapy, where adult hormone doses can be used or whether further dose titration of cross-sex hormones is needed. Patients who are being titrated on sex hormones to be seen or supervised by an endocrinologist with experience in titrating sex steroids in this situation at the adult team.

If they have completed puberty and are at a stage where standard adult hormone dose can be used then the young person could be seen by a clinician at the GIDS without necessarily involving an endocrinologist.

5. For clients on/not on hormone blockers or cross-sex hormones:

Following the receipt of the information in table 1 (if appropriate), it would be possible for the adult service to take the responsibility for the client's hormone blockers (if previously prescribed) at the first assessment appointment. This may mean advising the GP to continue to prescribe the same hormone blockers.

Appointments will be planned in the context of the previous diagnosis being made (if this had already been made) but in order to build a collaborative therapeutic relationship with the young person. Following the initial meetings, the clinicians may discuss sex hormones options if appropriate.

It is routine to aim to conclude the assessment process in between 6-12 months but the adult service may try to speed up this process in order to end it in a shorter period of time, however due to the lack of extra available resources, at the current time, this may not always be possible.

A new booklet has been developed by adult services to explain to the young person about the adult service and prepare the young person to it. This booklet is to be given to the young person previous to referral to adult services, in order for the expectation to be clear.

6. The adult gender identity service will write a letter to the service accepting responsibility for advising the GP on the continuation of cross sex hormones and blockers following the first assessment so that the young person can be discharged from the service and paediatric endocrinology. Please see comments above.

Assessment process

7. In view of the fact that there will be a need for two clinical recommendations for surgery in the future, the client will still meet with two clinicians from the adult gender identity clinic service on two separate appointments.

8. In some adult clinics (Nottingham), a third appointment will be organised where a significant other of the young person will be invited to conclude the assessment process and plan future care.

9. This process currently takes between 6-12 months but the adult service may try to do this process quicker, however this will not be a guaranteed.

Table 1:

- Comprehensive information about gender history
- A clear diagnosis as per the International Classification of Disease -10 (ICD-10, WHO, 1992) or ICD-11 in the future.

- Formulation
- Letter of confirmation that the GP is prescribing the hormone blockers or cross-sex hormones or that they have agreed to do so (if appropriate).
- A clear list of co morbid conditions and comments on their stability and impact on the gender identity issues
- Comment on the degree of social integration in desired gender role, including evidence of being involved in social activities, work or voluntary work (outside home) or education
- Comment on degree of psychological maturity with regards to consent for treatments
- Confirmation that fertility impact has been discussed
- Copy of Deed poll or statutory declaration showing name change
- Copy of 3 official documents showing change of name such as bank account, college letter, driving license, passport, etc.
- Copy of the consent form for the initiation of sex hormones
- Information of the sex hormone pathway
- Tanner stage before initiation of hormone treatment
- Protocol being used (standard versus early intervention)
- Statement of stage of dose titration of hormones/indicating that standard adult dose can be used
- Statement that the young person is not (or is) not smoking

10. If there has been no change of name and no gender role transition by the time the young person is assessed at the gender identity clinic service, the young person will follow the same assessment procedure as other patients referred to the clinic.

11. In cases where ambivalence is clear, or when the assessment is complex, clinicians may decide to extend the assessment process as per usual practice at the clinic.

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Initial of Main author: J.Arcelus

Wording revised 19 08 15 and 23 11 15 BStocks

Appendix 3: Definitions of Tanner Stages

Adolescents experience several types of maturation, including cognitive (the development of formal operational thought), psychosocial (the stages of adolescence), and biologic. The complex series of biologic transitions are known as puberty, and these changes may impact psychosocial factors.

The most visible changes during puberty are growth in stature and development of secondary sexual characteristics. Equally profound are changes in body composition; the achievement of fertility; and changes in most body systems, such as the neuroendocrine axis, bone size, and mineralization; and the cardiovascular system. As an example, normal cardiovascular changes, including greater aerobic power reserve, electrocardiographic changes, and blood pressure changes, occur during puberty.

The normal sequence of pubertal events and perils of puberty are reviewed here. This is within the normal ranges and does not take into account Precocious Puberty or Delayed Puberty. See http://www.childgrowthfoundation.org/CMS/FILES/Puberty_and_the_Tanner_Stages.pdf
See <http://www.rcpch.ac.uk/child-health/research-projects/uk-who-growth-charts/uk-growth-chart-resources-2-18-years/school-age#cpcm> for a simpler classification and explanation of puberty development.

Appendix 4: Description of partnership working with local CAMHS

The service will work with local CAMHS to promote clarity about respective responsibilities and good communication on both sides.

When referrals are accepted by the service, it will ensure that the local CAMHS team to where the client lives, are made aware that they retain responsibility for monitoring and managing risk and associated difficulties. Any change in risk will be communicated to CAMHS by telephone and/or letter as appropriate.

In complex cases, the service will convene local network meetings with CAMHS teams to review and discuss the needs of the client and agree roles.

If risk is identified with a client at any stage in their time with the service and there is no local CAMHS involvement, the service will facilitate an appropriate referral in order that the risk is understood locally and so that the CAMHS can provide support to the young person.

The service will respond promptly to enquiries and concerns raised by CAMHS teams.

CAMHS teams will be asked to keep the service informed of their contact with clients by letter and/or telephone as appropriate.

With the permission of the client, the service will copy CAMHS into correspondence including the assessment report.

Appendix 5: Referral processes and funding arrangements to access associated treatments for children and adolescents with GD

There are a range of other services which children and adolescents with GD may require access to, but are funded outside of this specification, commissioned by NHS England Clinical Commissioning Groups rather than the Highly Specialised Commissioning Team.

For clarity, the means of accessing these is as follows:

		Funded by	Requirement
1	Speech and language therapy (SaLT)	CCGs	GIDS to write to GP proposing that a referral is made to local team.
2	Occupational therapy	CCGs	GIDS to write to GP proposing that a referral is made to local team.
3	Physiotherapy	CCGs	GIDS to write to GP proposing that a referral is made to local teams.
4	Gynaecological advice	CCGs	GIDS to clarify access routes to other medical specialists, i.e. gynaecologists to assist clients and their family or carers in making key decisions. GIDS to write to GP proposing that a referral is made to local clinician.
5	Gamete retrieval/fertility	CCGs	GIDS to signpost, via GP, to other Medical specialists such as gynaecologists, and licensed fertility experts who will be able to assist clients in making key decisions regarding gamete retrieval. This will include being made aware of the full facts of the implications of extracting or not extracting the eggs or sperm and what happens, before, during, and after the procedure. Also discussion on subsidiary issues such as storage of gametes, how long they can be kept for, what happens if you want to use these at a future date if you want to use them, and the additional future consequences and treatments required if gametes haven't been extracted before hormone therapy is started.

Appendix 6: Informed consent in the context of GIDS

Thinking carefully about informed consent is an important aspect of assessing and intervening ethically. The aim is to enhance the young person's and the family or carer's grasp of the available factual information about the interventions they are offered, including hormone treatments, and the emotional and social issues involved in undertaking treatment, so as to enable them to make informed decisions about the options.

Children's competence relies on them having access to good information tailored to their comprehension level: they need to understand fully what is proposed, retain an understanding of the implications, appreciate the importance of the information and see how it applies to them. Therefore young people and their parents/carers are offered a thorough discussion of the treatments offered, the benefits and risks, and alternatives to the treatment proposed (including the option of no treatment). Information sheets are provided prior to attending the service's endocrinology clinics explaining available physical treatments, and Consent Forms need to be signed prior to medical intervention.

Age does not determine capacity to give consent: there is no international consensus on the age limit for presuming competence. For young people of 16 and under, consent to treatment should usually be sought from the child and from one or both parents, except under exceptional circumstances. For adolescents over 16, if it is concluded that they have sufficient understanding of what is to be offered (this is known as 'Gillick' or 'Fraser' competence), they may give their own consent to treatment, although under most circumstances, it is good practice to seek parental or carer assent too. The Tavistock and Portman NHS Foundation Trust's policy on consent and confidentiality ('Consent to treatment policy and procedure' Dec 2011) applies.

A clinician should assess a young person's capacity to give consent. While we may think of a young person expressing their 'autonomy' by deciding on their own, with good understanding and without undue constraint, in reality a number of contextual factors are likely to influence a child or young person's decision-making competence.

These will include their developmental stage, the quality of information provided (as discussed above, the influence of peers and parents and their life experience. For instance, young children face cognitive limitations: they may view the world in concrete terms and struggle to reason about abstract or hypothetical problems. In adolescence, new cognitive and social skills are acquired which lead to increased maturity in reasoning about complex issues. Yet adolescents may still find it difficult to restrain impulsiveness and to see a given decision in a larger temporal context.

Competence in children and young people may also be related to life experience: children who have personal experiences with particular kinds of challenge may show greater insight and understanding than children of comparable age who lack this experience. Finally, children and young people are still dependant on their parents or carers (and their clinicians) to define the meaning of the situation they are in, and so

the quality of those relationships may also influence the young person's capacity for autonomous decision-making. (See Heim et al 2015).

Reference: Hein I.M., De Vries M.C., Troost P.W., Meynen G., Van Goudoever J.B. and Lindauer R.J.L (2015) Why is it hard to make progress in assessing children's decision-making competence? BMC Medical Ethics 16:1

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Appendix 7: Guidance for Discussions relating to Young People Wishing to Commence on Cross Sex Hormones – (to be filed in notes)

Name:.....

Clinicians:.....
.....

Preferred Gender.....

Date of discussion:.....
.....

	Yes	No	Unclear	Comments/Specify details
Gender Dysphoria				
Aged at least 16 years				
Able to give informed consent				
Impact on fertility discussed				
Some evidence of presenting coherently with gender identity eg deed poll name change				
Engaged in some meaningful activity (employment/education)				
Family and /or social support (if a Looked after child has Local Authority been consulted?)				
In good physical health				
Relatively stable mental health				
Self- harm not escalating and local management plan in place				
Not smoking for a minimum of 3 months				
Therapeutically engaged with GIDS				
At least 2 clinicians agree				Names of those agreeing:
Please note any other comments or concerns:				

Please note the following criteria that may indicate the need to postpone commencement of cross-sex hormones

Summary of possible criteria for postponing going ahead

- Actively psychotic or any other severe mental health problem, including eating disorders, which raises queries about capacity to make informed decisions, impact on capacity to be stable and thriving in role, and the impact on physical health.
- Presence of significant risk issues, e.g. on-going/escalating suicidal acts, being homeless or at risk of homelessness if family are rejecting, severe self-harm and other risk-taking behaviours, e.g. offending, being sexually exploited/sexually exploiting, substance abuse or homelessness. As above, likely to make it difficult to reasonably conclude that they are happier since role transition and that they are thriving in role.
- Smoking – majority of adult services not keen on going ahead if smoking. Nottingham requires being smoke-free for 3 months before prescribing.

Diagnostic criteria for Gender Dysphoria (DSM 5)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following indicators:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability**

Subtypes

- With a disorder of sex development
- Without a disorder of sex development

Specifier - Post-transition, i.e., the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is undergoing) at least one cross-sex medical procedure or treatment regimen, namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g. penectomy, vaginoplasty in a natal male, mastectomy, phalloplasty in a natal female).

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