

<b>Service No.</b>	<b>Specification</b>	<i>Enter CRG document code</i>
<b>Service</b>	<b>Gender Identity Services</b>	
<b>Commissioner Lead</b>	<b>Steve Hamer</b>	
<b>Provider Lead</b>	<i>The name of the individual leading on the service for the provider</i>	
<b>Period</b>	<i>12 months</i>	
<b>Date of Review</b>		

## 1. Population Needs

### 1.1 National/local context and evidence base

#### 1.1.1 Context

Specialist Gender Identity Services (SGIS) provide assessment, care and treatment for people affected by concerns regarding gender identity, role and/or expression that differs from the cultural norms for their birth-assigned sex. SGIS offer advice and assessment for people affected by such concerns, and will advise them as to the options that might be pursued to address them. These options include, but are not limited to, treatments facilitated by SGIS. SGIS providers shall offer or facilitate a variety of therapeutic practical, physical, medical and surgical interventions for people affected by gender dysphoria. The services and interventions that SGIS providers are required to provide are described in section 3 of this service specification; some SGIS providers may provide additional services. The range and type of interventions and the order in which these are provided will differ from person to person. Individuals may not need, or desire, some of these interventions. SGIS providers provide service users with the opportunity to prepare for their future in their acquired gender role. This will include preparation for relationships, exploration of sexuality, and the promotion and maintenance of optimal physical and mental health.

The need of individuals for SGIS varies considerably. This Service Specification addresses the

needs of persons aged 17 and older in England. Gender identity development service for children and adolescents the needs of children, adolescents and younger adults are addressed in the Service Specification for the Gender identity development service for children and adolescents [<http://www.england.nhs.uk/wp-content/uploads/2013/06/e13-gender-identity-dev.pdf>], developed by the Multi-system Disorder Clinical Reference Group (E13).

### **1.1.2 Gender Identity**

Gender Identity is the individual's personal sense of their own gender. It includes both binary and non-binary experiences of gender. Binary experience implies that an individual identifies either exclusively as a man or exclusively as a woman. However, there is growing recognition that many people do not regard themselves as conforming to the binary man/woman divide and that this will impact on their treatment. Self-descriptions include: *pan-gender*, *poly-gender*, *neutrois* and *gender queer*. A few people who reject the gender concept altogether, and see themselves as non-gendered (*agendered*), may require gender neutralising treatments from appropriate clinical services.

UK Intercollegiate Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria (UKGPG) recognise that there are gradations of gender experience between the binary 'man' or 'woman', some of which cause discomfort and may need some medical intervention; others may need little or none.

### **1.1.3 Gender Dysphoria**

Gender dysphoria refers to psychological distress that is caused by a discrepancy between a person's gender identity, their sex assigned at birth (e.g. male or female) and their primary/secondary sex characteristics; it also includes the impact of that discrepancy on their gender role (the discrepancy between how they wish to live their lives and how society expects them to live their lives) and the perceptions of others. Untreated, gender dysphoria can severely affect the individual's well-being and quality of life, and may lead to mental ill-health. For the purposes of this document, the term gender dysphoria refers to both those who currently have gender dysphoria or who have had it in the past.

### **1.1.4 Epidemiology**

A primary care population study of transsexual people conducted in Scotland reported of an incidence of 1:12,225 (0.00818%), and a prevalence of 1:7,500 in birth-assigned males and 1:31,000 in birth-assigned females. The trend in epidemiological research appears to be towards higher prevalence rates in the more recent studies.

In 2011, the Gender Identity Research and Education Society published a report<sup>1</sup> that suggested the gender balance of gender variant people was changing, as more people assigned as female at birth sought medical help. It also suggested that as much as 1% of the population may experience some degree of gender variance. Personal communications from Clinical Directors of GICs in England suggest that referral rates to their services have been increasing by around 20% per year for the past several years; in 2012/13, the referral rate to specialist gender clinics in England was around

2500 people a year. Not all of these people will be transsexual persons, nor will all be seeking to transition.

### 1.1.5 Health inequalities

In response to public consultation on a proposed 2013/14 service specification for gender identity services, several areas of health inequality were identified:

- a) Inequity of access to the Gender Identity pathway across England
- b) Differences in provision of services by different service providers
- c) Differences in interpretation of standards of care resulting in differences in treatment provision by different service providers,

On 28<sup>th</sup> October 2013, NHS England published the *Interim Gender Dysphoria Protocol and Service Guideline 2013/14* [<http://www.england.nhs.uk/resources/spec-comm-resources/npc-crg/group-c/c05/>], broadly based upon the NHS Scotland Protocol and specification, and UKGPG. There was divergence from NHS Scotland Protocol and specification to allow for organisational, clinical and funding differences between the NHS structures. Since its publication, it became apparent that some aspects of the Interim Protocol conflict with other, more recently published NHS England policy documents. This resulted in a range of difficulties for commissioners, and frustration for clinicians and service users.

NHS England is aware that transgender people have, in the past, often received inequitable access to other health services. Throughout the production of this document, due regard has been given to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to relevant equality and human rights legislation.

### 1.1.6 Scale and pattern of existing service provision.

In England, on 1st June 2014, there are seven Gender Identity Clinics (henceforth referred to as SGIS providers) commissioned by NHS England to provide SGIS.

- **West London Mental Health NHS Trust Gender Identity Clinic**, 179-183 Fulham Palace Road, London W6 8QZ; Telephone: 020 8483 2801
- **Sheffield Health and Social Care NHS Foundation Trust Sexual and Relationship, Sexual Medicine and Transgender Services**, Porterbrook Clinic, Michael Carlisle Centre, Nether Edge Hospital, 75 Osborne Road, Sheffield S11 9BF; Telephone: 0114 271 6671
- **Leeds Gender Identity Clinic**, Management Suite, 1st floor, Newsam Centre, Seacroft Hospital, York Road, Leeds LS14 6WB; Telephone: 0113 305 6346
- **Northern Region Gender Dysphoria Service**, Benfield House, Walkergate Park, Benfield Road, Newcastle upon Tyne NE6 4QD. Telephone number: 0191 287 6130
- **Northamptonshire Healthcare Foundation Trust Specialist Gender Clinic**. Northamptonshire Healthcare NHS Foundation Trust, Danetre Hospital, London Road, Daventry, Northants NN11 4DY
- **Nottingham Gender Clinic**, Mandala Centre, Gregory Boulevard, Nottingham NG7 6LB;

Telephone: 0115 960 2820

- **The Laurels Gender Identity and Sexual Medicine Service (Devon Partnership NHS Trust)**, The Laurels, 11-15 Dix's Field, Exeter EX1 1QA; Telephone: 01392 677077

These SGIS providers will:

- Accept referrals for service users registered with GPs anywhere in England
- Follow operational policies consistent with UK Intercollegiate Good Practice Guidelines for the Assessment & Treatment of Adults with Gender Dysphoria (UKGPG).
- Comply with UKGPG in the delivery of care for their service users; departures in clinical practice from UKGPG, which may occur as a consequence of the exercise of clinical judgment, must be justifiable and their rationale must be explained to the service user.

## 1.2 Evidence base

1. *World Professional Association for Transgender Health Standards of Care (WPATH SoC) for the Health of Transsexual, Transgender and Gender Nonconforming People*, 7th version, 2011 (retrieved from [www.wpath.org/documents/IJT%20SOC.%20V7.pdf](http://www.wpath.org/documents/IJT%20SOC.%20V7.pdf) on 23/08/2013)
2. *Good Practice Guidelines for the Assessment & Treatment of Adults with Gender Dysphoria* (Royal College of Psychiatrists CR181; October 2013).

There is no NICE guidance with specific relevance to this service.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

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

- 2.1.1 The over-arching outcome intended for those engaging with SGIS is to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfilment.

- 2.1.2 SGIS will be tested against measureable, service-wide, outcomes. These will include high levels of service user satisfaction, and minimised levels of adverse incidents and complaints.
- 2.1.3 SGIS will be expected to report separately to organisations concerned with the quality and safety of services.
- 2.1.4 Providers of the services comprising SGIS should comply with generic service standards expected for that service in other populations.

**Process indicators and outcome measures will include:**

**Patient – Global Impression of Change (P-GIC) in Psychological and Emotional Well-being (NHS outcome framework domain 2)**

*Outcome sought:* Improvement in service users self-perceived psychological and emotional Well-being at completion of care for gender dysphoria or time of discharge from the service,

*Process indicators:* Standard P-GIC question posed to service users at completion of care or time of discharge from service. This question will be posed to service users by the lead provider service. Responses and the response rate will be recorded

*Outcome measures:* Service users will be asked to answer the question,

“Compared with a time six months before you first received care for gender dysphoria from this service, how would you rate your sense of psychological and emotional well-being?  
(please tick one box only)

- Much better (score +3)
- Moderately better (score +2)
- A little better (score +1)
- Neither better nor worse (score 0)
- A little worse (score -1)
- Moderately worse (score -2)
- Much worse (score -3)”

**Patient – Global Impression of Change (P-GIC) in Social Well-being, and Personal Comfort Living in a Gender Identity-Congruent Social Role in Wider Society (NHS outcome framework domain 2)**

*Outcome sought:* Improvement in service users self-perceived social well-being, and personal comfort living in a gender identity-congruent social role in wider society, at completion of care for gender dysphoria or time of discharge from the service,

*Process indicators:* Standard P-GIC question posed to service users at completion of care or time of discharge from service. This question will be posed to service users by the lead provider service. Responses and the response rate will be recorded.

*Outcome measures:* Service users will be asked to answer the question,

“Compared with a time six months before you first received care for gender dysphoria from this service, how would you rate your sense of social well-being, and personal comfort living in a gender identity-congruent social role in wider society? (please tick one box only)

- Much better (score +3)
- Moderately better (score +2)
- A little better (score +1)
- Neither better nor worse (score 0)

- A little worse (score -1)
- Moderately worse (score -2)
- Much worse (score -3)

**Patient – Global Impression of Change (P-GIC) in Physical Health (NHS outcome framework domain 2)**

*Outcome sought:* Improvement in service users self-perceived physical health, at completion of care for gender dysphoria or time of discharge from the service,

*Process indicators:* Standard P-GIC question posed to service users at completion of care or time of discharge from service. This question will be posed to service users by the lead provider service. Responses and the response rate will be recorded.

*Outcome measures:* Service users will be asked to answer the question,

“Compared with a time six months before you first received care for gender dysphoria from this service, how would you rate your physical health? (please tick one box only)

- Much better (score +3)
- Moderately better (score +2)
- A little better (score +1)
- Neither better nor worse (score 0)
- A little worse (score -1)
- Moderately worse (score -2)
- Much worse (score -3)

**Patient – Global Impression of Change (P-GIC) in Mental Health (NHS outcome framework domain 2)**

*Outcome sought:* Improvement in service users self-perceived mental health, at completion of care for gender dysphoria or time of discharge from the service,

*Process indicators:* Standard P-GIC question posed to service users at completion of care or time of discharge from service. This question will be posed to service users by the lead provider service. Responses and the response rate will be recorded.

*Outcome measures:* Service users will be asked to answer the question,

“Compared with a time six months before you first received care for gender dysphoria from this service, how would you rate your mental health? (please tick one box only)

- Much better (score +3)
- Moderately better (score +2)
- A little better (score +1)
- Neither better nor worse (score 0)
- A little worse (score -1)
- Moderately worse (score -2)
- Much worse (score -3)

**Friends and family test (NHS outcome framework domain 4)**

*Outcome sought:* Improving the number of positive recommendations to friends and family by people receiving care for gender dysphoria for the place where they received this care.

*Process indicators:* Standard question posed to service users at completion of care or time of discharge from service. This question will be posed to service users by all providers within a

clinical network, not just by the lead provider. Responses and the response rate will be recorded  
*Outcome measures:* Service users will be asked to answer the question, “Would you recommend this service for the care of gender dysphoria to your friends and family?” Yes/No

### 3. Scope

#### 3.1 Aims and objectives of service

- 3.1.1 SGIS provide assessment and therapeutic services for transsexual, transgender and gender non-conforming people, who experience gender dysphoria and who are seeking therapeutic interventions to reduce or resolve this.
- 3.1.2 The core objectives for SGIS are to assist people with gender dysphoria to explore their gender identity, find a gender role that is comfortable for them and provide therapeutic interventions. The process of treatment aims to achieve an improved quality of life. As such, all interventions described in this service specification, including surgery, should be viewed as possible components of a personalised package of care specific to the needs of each service user. Personalised treatment programmes may or may not involve a change in gender expression or body modifications.
- 3.1.3 Each SGIS provider (GICs and others) will deliver services in compliance with contemporary, generic service standards for their discipline, in addition to additional, specific standards that respect the specific needs, values and dignity of transsexual, transgender and gender non-conforming people. SGIS providers will deliver services in compliance with UKGPG.
- Persons granted a Gender Recognition Certificate under the Gender Recognition Act 2004*
- 3.1.4 All services provided within this service specification are provided irrespective of possession of a GRC.

#### 3.2 Service description/care pathway

- 3.2.1 SGIS may be delivered by single provider or by a clinical network of providers. At the time of publication, all SGIS are delivered through clinical networks.
- 3.2.2 SGIS will be established on a multi-disciplinary, multi-professional basis and may include general practitioners, psychology, psychiatry, psychotherapy, nursing, voice and communication therapy, endocrinology, dermatology, surgery, social work and other related professions, all of whom should have a special expertise in gender identity and its issues.
- 3.2.3 *Clinical Networks:* A typical clinical network would consist of one of the seven Gender Identity Clinics (GIC) in England working with other providers of surgery, epilation, voice and communication and other services. The GIC provides overall clinical leadership for personalised treatment programmes for individual service users, and refers for, and co-ordinates, the interventions delivered by other providers within the clinical network. Other models of service delivery may be commissioned in the future.

- 3.2.4 *Lead Providers:* Each clinical network shall have a lead provider. The Lead Provider will:
- a) Maintain a Clinical Network with other SGIS providers, so as to be able to arrange delivery of all the interventions for service users described in Section 3.3.1, below.
  - b) Provide clinical leadership in delivery of personalised care agreements
  - c) Be responsible for referring service users to other Clinical Network providers for delivery of interventions set out in the personalised care agreements
  - d) In collaboration with other Clinical Network providers and the service user's GP, monitor the safety, tolerability and efficacy of interventions delivered by other Clinical Network providers
- 3.2.5 SGIS providers should provide service users and referrers with details about clinic services and protocols. This will include information about service provider operational policies.
- 3.2.6 All SGIS providers will provide information about assistance available to partners and families.
- 3.2.7 Providers and clinical networks of providers will engage in peer review and supervision networks, local audit and governance processes; this will include engagement with service-users.
- 3.2.8 Clinical networks of providers will identify and publish a point of access where referrals to that network may be received.
- 3.2.9 The operational process of a SGIS will include:
- a) Receipt and triage of referrals
  - b) Assessment and explanation to service user of options for care and treatment of gender dysphoria
  - c) Timely and effective communication with the service user's GP
  - d) In collaboration with the service user, development of a personalised care agreement with the service user
  - e) In collaboration with the service user, delivery of interventions described in the care agreement by the SGIS clinical network
  - f) Agreement with the service users when the care pathway has been completed
  - g) Discharge and provision of information regarding ongoing healthcare needs to the service user and their GP

### 3.3 Services that will provided by SGIS providers and clinical networks

#### 3.3.1 The following services will be provided by SGIS.

- i. Assessment of gender identity development and its physical, psychological and social consequences for service users
- ii. In collaboration with service users' GPs, assessment of physical and mental health, as relevant to service users' engagement in SGIS care pathway
- iii. Information for service users, and their significant others, about: gender identity development; its consequences and related issue; options for achieving improved personal comfort with



gender and the relief of gender dysphoria

- iv. Support for service users, in decision-making related to gender identity expression and interventions for the relief of gender dysphoria
- v. Agreement with individual service users to a personalised care agreement, a written copy of which will be provided to the service user and their GP; in collaboration with the service user, the care agreement will be updated from time to time, with provision of updated copies to the service user and their GP
- vi. In collaboration with the service user and their GP, monitoring of physical and mental health throughout the period of care with SGIS
- vii. In collaboration with the service user and their GP, monitoring of response to SGIS interventions throughout the period of care with SGIS
- viii. In consultation with the service user and their GP, agreement as to when care with SGIS is complete and provision to the service user and their GP of written guidance on future healthcare need, including long-term provision of endocrine and other pharmacotherapies, and recommendations for ongoing monitoring and screening

The lead provider will:

- ix. Provide service users, their GP and the referring clinician with any formal diagnosis made following assessment; if this is a tentative, working diagnosis, this should be specified. If, once engaged in the care pathway, a new or modified diagnosis is made, this should also be communicated to service users, their GP and the referring clinician.
- x. Assess service users' capacity where indicated and ensure that they are in a position to give meaningful informed consent to interventions offered by the lead provider service
- xi. Explain to service users:
  - a) The potential risks, benefits and limitations of interventions recommended as a part of the SGIS care pathway
  - b) Which, if any, recommended pharmacotherapies are not approved for the specific indication of gender dysphoria, and the implications thereof
  - c) Obtain and document consent for treatments directly provided by the lead provider, or before making a recommendation to a GP to prescribe pharmacotherapy for a service user;
- xii. Supervise and co-ordinate service users' care, in collaboration with service users' GPs;
- xiii. Provide service users' GPs with clear written guidance on prescribing and monitoring, be available to provide additional information on request, and answer GP questions regarding treatment and monitoring at reasonable notice;

The lead provider will arrange, through direct provision or referral to another specialised provider within their clinical network, for service users to receive the following interventions, according to individual service user need and as described in their personalised care agreement:

- xiv. Specialised psychological therapies (psychotherapy, specialised counselling, specialised education and behavioural advice: see Section 3.4.1)
- xv. Provision of recommendations for endocrine and other pharmacological interventions to relieve gender dysphoria and facilitate changes in sex-specific characteristics, to include:
  - a) Feminising and virilising hormone therapy (sex steroids, GnRH analogues, modifiers of sex steroid receptor function); SGIS providers are not commissioned to prescribe

hormonal or any other pharmacotherapy

b) Depilatory and hair growth-inhibiting agents

- xvi. Provision of interventions to enhance desirable changes in voice and communication (Specialised Voice and Communication Therapy, including specialised voice and communication therapy provided by a Speech and Language Therapist and/or voice coaching: see Section 3.4.2)
- xvii. Provision of interventions to reduce facial hair growth (see Section 3.4.3)
  - a) Photoepilation
  - b) Electrolysis
- xviii. Provision of virilising (bilateral partial mastectomy and male chest reconstruction, female-to-male chest surgery) chest surgery (see Section 3.4.4)
- xix. Provision of feminising or virilising genital reconstruction surgery; this may require provision of interventions to remove hair from genital reconstruction skin donor sites (see Section 3.4.5)
- xx. Provision of gonadectomy (hysterectomy and bilateral salpingo-oophorectomy or bilateral orchidectomy) when feminising or virilising genital reconstruction surgery is not included in the personalised care agreement (see Section 3.4.6)
- xxi. Gamete storage (see Section 3.4.7)
- xxii. Thyroid chondroplasty (see Section 3.4.8)
- xxiii. In specific circumstances defined elsewhere in this service specification, provision of:
  - a) Feminising chest surgery (breast augmentation; augmentation mammoplasty: see Section 3.4.4)
  - b) Phonosurgery (see Section 3.4.9)

3.3.2 The following are not provided by SGIS:

- i. Prescribing of any medication, and associated laboratory monitoring tests, for the treatment of gender dysphoria recommended by SGIS providers, or the cost of such prescription medication and monitoring tests. Arrangements for prescribing and monitoring are described in a Specialised Services Circular, "*SSC1417 Primary Care responsibilities in relation to the prescribing and monitoring of hormone therapy for patients undergoing or having undergone gender dysphoria treatments*"
- ii. Facial feminising and masculinising surgery
- iii. Lipoplasty
- iv. Hair transplant
- v. Body hair removal (other than donor site)
- vi. Body contouring

This list is not exhaustive

3.3.3

SGIS providers are only required to provide the interventions for the management of gender dysphoria and sex characteristic modification described within this service specification. Where service users require interventions for other health problems, such as psychosis, depression, anxiety, chemical dependency, personality disorder, learning difficulties, urological, gynaecological and other health problems not specifically related to gender dysphoria and sex characteristic modification, they should be referred to a local, non-specialised service provider or, where necessary, another specialised service provider. Such interventions will not be funded by NHS England as part of Specialised Gender Identity Services. SGIS providers will respond to requests for information and advice from other service providers where gender dysphoria may affect the clinical management of other health problems.

### 3.4 Description of Services and Service Standards

#### 3.4.1 Specialised psychological therapies

##### a) Description of Service

- i. SGIS providers and Clinical Networks will provide psychological therapies for service users on the basis of clinical need and service user choice.
- ii. Not every person using Gender Identity Clinics (GICs) will require psychological therapies; however, they must be provided if clinical need is identified. If it is identified that psychological therapies would be of value, then a personal plan of care will be negotiated identifying the goals and intended outcomes. Psychological therapies can be accessed at any point during treatment.
- iii. Psychological therapies will be provided for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support, improving body image; or promoting resilience.
- iv. Typically, it will be between two people and will be a cycle of interactive exchanges between a therapist who is knowledgeable about how people suffer emotionally with the impact of their gender issue and how this may be alleviated, and a service user who is experiencing distress.
- v. Typically, psychotherapy consists of regularly-held sessions of around 50-minutes duration, the number of which will be determined by need.
- vi. Most work will be undertaken face to face but it may, by mutual agreement between the service user and therapist, be undertaken through video link or telephone consultations
- vii. Post-operatively, some people may require further psychotherapy or emotional support as a consequence of gender issues. By mutual agreement between the service user and therapist, this may be provided within SGIS.
- viii. Regular reviews will determine the length of treatment, taking into account the clients wishes.

##### b) Service Standards

- i. All counsellors and psychotherapists are required to have regular and on-going formal

supervision/consultative support for their work in accordance with professional requirements.

- ii. Practitioners have a responsibility to monitor and maintain their fitness to practise at a level that enables them to provide an effective service. They must belong to and be accredited/registered with one or more of BACP, BABCP, UKCP, BPS, COSRT, and HCPC, which would mean that practitioners are bound to an accepted code of practice.

### 3.4.2 Specialised Voice and Communication Therapy

#### a) Description of Service

- i. SGIS providers and Clinical Networks will provide Specialised Voice and Communication Therapy for service users on the basis of clinical need and service user choice.
- ii. Voice and Communication Therapy, as defined in this document, is aimed at adults with gender dysphoria and under the care of a SGIS provider commissioned by NHS England. Regular therapy will usually commence when the individual is living in a social gender role congruent with their identity or plans to do so imminently, in order to maximise voice and communication changes. Assessment may commence prior to this. All eligible service users should be offered assessment with a speech and language therapist.
- iii. Whilst all eligible service users in England will have access to Voice and Communication Therapy, the location of services and the route of access varies according to local protocols. Some Gender Identity Clinics have Speech and Language Therapists (SLT) embedded in the team, while others either refer to local services or ask the service users GP to do so.
- iv. The overall purpose of Voice and Communication Therapy is to help trans people adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self.
- v. Voice and communication therapy enables trans people to work towards communication skills that are more appropriate for their gender. SLTs working with trans people aim to develop voice and communication skills that are congruent with age, physical appearance and consistent with the expectation of both the individual and society for that person's gender identity. SLTs may be involved in the care of transsexual, transgender and gender non-conforming people, be they trans masculine or trans feminine.
- vi. On the rare occasions that voice and communication therapy proves to be unsuccessful, phonosurgery may be considered. All referrals for phonosurgery must be accompanied by a recommendation from a SLT that phonosurgery is appropriate for the service user. Individuals undergoing voice feminisation surgery will receive voice and communication therapy after surgery to maximise the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Provision of voice surgery procedures must include follow-up sessions with a SLT.
- vii. Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable role in developing the communication skills of people with gender dysphoria, although they cannot provide voice and communication therapy. Their services may be included within the provision of SGIS provider, such as a GIC, but will not be separately commissioned. Their activities must be included within and be compliant with the

host provider's governance arrangements. Such professionals will ideally have experience working with, or be actively collaborating with, SLTs. Delivering communication skills training in this novel way appears to be highly valued by service users and can support service users in achieving their goals.

#### b) Service Standards

- i. Voice and communication therapy will be provided by qualified SLTs, working in specialist adult voice services (serving voice specific caseloads) or SGIS clinics. Relevant qualifications and membership of accountable bodies include a degree certificate in Speech & Language Therapy or Masters Qualification; membership of the Royal College of Speech and Language Therapists (RCSLT) and membership of Health and Care Professions Council (HCPC).
- ii. SLTs should only accept the referral if the therapist is clinically competent in this specialised area and has access to specialist colleagues and national support networks.
- iii. SLTs undertaking voice and communication therapy for trans people will participate in clinical supervision and clinical networks.
- iv. SLTs providing voice and communication therapy will work as part of recognised SGIS multidisciplinary teams, with links to other members, especially psychotherapist colleagues. However, their location may constrain their capacity to attend meetings. Where this is not possible, therapists should contribute to the MDT process through two-way, written communication with the SGIS clinic.

### 3.4.3 Facial Hair Removal and Donor Site Epilation

#### a) Description of Service

- i. SGIS providers and Clinical Networks will provide Facial Hair Removal and Donor Site Epilation for service users on the basis of clinical need and service user choice.
- ii. The two modalities provided for long-term hair removal are electrolysis and photoepilation; both modalities will be available as part of SGIS. Electrolysis (more properly electroepilation) is the permanent removal of hair by the insertion of a needle into the hair follicle, the application of an electric current at the base of the hair shaft to destroy the cells and removal of the hair from the treated follicle. Photoepilation devices fall into two categories, lasers using coherent light and Intense Pulsed Light (IPL) devices that use filtered non-coherent light.
- iii. The suitability of the technique, service user choice and provider performance will be taken into consideration and referral for treatment should be made to a suitably qualified provider that is recognised by NHS England. Selection of treatment modalities will depend upon hair and skin colours. Electrolysis is suitable for all hair colours and skin types, whereas the ideal for photoepilation is pale skin and coarse dark hair and it is less or not effective with lighter hair colours or darker skin types.
- iv. The provision of hair removal will be delivered in blocks of treatment, since it is recognised that the time required to achieve the above objectives varies considerably between individuals. Each block will be either 8 sessions of photoepilation or, for electrolysis, 80 hours for facial epilation or 40 hours for donor site epilation. The need for further treatment

after a particular block shall be determined on the basis of a visual assessment by the service provider and service user. Further confirmation, if required, will be provided by the referring SGIS.

- v. On completion of each block of treatment, assessment should be made of the effectiveness of the treatment. Further blocks for the same modality should only be funded if persistent epilation is demonstrated and the maximum number of treatment blocks has not been reached.

*Facial hair reduction*

- vi. Service users will be referred for facial hair removal following a confirmed diagnosis of gender dysphoria by the Lead Provider of SGIS. The referral should be made as soon as possible after diagnosis, since hair removal is usually essential to a successful transition for trans women.
- vii. Facial hair removal is intended to reduce the amount of facial hair to that congruent with a service user's gender identity. This is achieved by a sustained long-term hair reduction determined by the permanent reduction of facial hair growth to a few scattered terminal (as opposed to vellus) hairs together with a number of terminal hairs that may surround the outer lip area; although not enough to form a moustache. This reduction of growth must be persistent. The ideal would be complete permanent hair removal, however given the current paucity of outcome data, the target of permanent hair reduction is both realistic and achievable.
- viii. Treatment provision for facial hair reduction will be one of the following, (a) to (c):
  - a) Up to 2 blocks of photoepilation, or
  - b) Up to 3 blocks of electrolysis, or
  - c) One block of photoepilation and one of electrolysis.
- ix. Treatment will end for any of the following reasons:
  - a) the treatment objective has been fulfilled
  - b) the agreed block of sessions has been completed and further treatment is deemed neither necessary nor useful following discussion between the provider, SGIS and service user
  - c) the service user and service provider agree to cease treatment
  - d) the treatment is demonstrably ineffective
  - e) no further funding for hair removal is available
- x. A final report on facial hair reduction will be written by the hair reduction service provider, and made available to the service user and the SGIS. This report will describe the treatment outcome and provide an assessment of the course of treatment, whether completed or not. If the treatment did not achieve the objectives the reason will be fully explained and include, where applicable, the required actions for fulfilment of the objectives.

*Donor site hair removal*

- xi. Service users who require donor site hair removal prior to surgery will be referred for this by the SGIS, in accordance with guidelines agreed with the surgery provider. Epilation treatment

may commence prior to referral for surgery, in accordance with guidelines agreed with the surgery provider.

- xii. Donor site epilation is intended to achieve the permanent removal of hair from the donor site. It is required by both trans women and trans men prior to certain gender surgery and intended to prevent post-operative complications that result from the presence of hair in areas that are inaccessible or cannot be treated effectively following surgery. An assessment whether the hair removal treatment has either met the target of persistent hair removal or reached a point where further treatment is ineffective should be initially made by the service provider. The final determination of any further need for donor-site hair removal should be made by the surgical team.
- xiii. Donor site epilation is not limited by funding and will continue until a clinically acceptable outcome is achieved

#### b) Service Standards

- i. Hair removal by either laser or electrolysis is provided in both clinical and non-clinical environments. For example, many laser clinics that provide hair removal are private concerns, but based within NHS hospitals, while electrolysis is mainly provided within beauty salons.
- ii. Electrolysis should be provided within a clinical environment or by a beautician who is either a member of a professional association recognised as a provider of epilation for trans people or who can demonstrate both two years' experience since obtaining a level 3 qualification in electro-epilation (e.g VTCT, NVQ etc) and has treated successfully at least five trans clients in the previous 12 months or engage in regular supervision with an experienced provider. Providers of donor site epilation will ideally have evidence of practical training or experience in that area.
- iii. Providers of electrolysis in a non-clinical environment, where bye-laws exist, will be required to register with the appropriate local authority. An example of such regulation is provided by North Devon Council [[http://www.northdevon.gov.uk/index/lqcl\\_business/lqcl\\_business\\_and\\_street\\_trading\\_licence/lqcl\\_personal\\_treatment\\_licences/nonlqcl\\_electrolysis.htm](http://www.northdevon.gov.uk/index/lqcl_business/lqcl_business_and_street_trading_licence/lqcl_personal_treatment_licences/nonlqcl_electrolysis.htm)]. This must be followed as a minimum standard of care by all providers unless contradicted by this sub-specification.
- iv. The provision of photoepilation is not currently regulated, but providers will be required to follow the MHRA guidance "Guidance on the safe use of lasers, IPL systems and LEDs - DB 2008(03)".
- v. Photoepilation should be provided within a clinical environment or by a trained beautician, technician or nurse who can demonstrate training [ideally a level 4 VTCT Certificate in Laser and Intense Pulsed Light Treatments (IPL)], at least one years' experience and the successful treatment of at least five trans clients in the previous 12 months.
- vi. All service providers will hold appropriate indemnity insurance and public liability insurance.
- vii. Certain medical conditions, medical devices and medication are contra-indicated for photoepilation or electrolysis and the service provider is expected to liaise with the service user's GP or the SGIS when required.
- viii. All service providers should provide evidence of CPD for personnel

### 3.4.4 Chest Reconstruction Surgery for Gender Dysphoria

#### a) Description of Service

- i. SGIS providers and Clinical Networks will provide Chest Reconstruction Surgery for Gender Dysphoria for service users on the basis of clinical need and service user choice.
- ii. Referrals of service users for chest surgery for gender dysphoria as part of SGIS will only be accepted from a clinician working as part of the MDT of the Lead Provider service of a Clinical Network. Before surgery is performed, service users must fulfil the eligibility criteria for chest surgery set out in UKGPG.
- iii. The referral process should comply with the requirements of UKGPG.
- iv. Teams providing chest surgery for gender reassignment will work in close collaboration with the providers from whom they receive referrals, and be able to confirm the referral and eligibility criteria, and readiness for chest surgery of the service user. They will comprise specialist surgeon(s) and appropriately trained Clinical Nurse Specialists (CNS) working in close collaboration as an MDT.
- v. Chest surgery may be combined with other surgical procedures, such as genital reconstructive surgery, if the eligibility criteria for each procedure are fulfilled, if it is appropriate in the clinical judgment of the surgeon, and if this is the service user's preference.
- vi. Service users will be treated in a clinically-appropriate area. In out-patients, this will include giving the option of attending a separate clinic for transitioning patients or in a clinic separated in time from service users of a different group. As an in-patient, service users must be offered the option of use of side rooms/personal rooms.
- vii. Consent will be obtained at a specific pre-op appointment, so as to allow an informed process and give the service user adequate time to consider any relevant options/alternatives in the less formal setting of out-patient service users rather than on the morning of surgery. Each service user should receive detailed oral, written and pictorial information on available surgical interventions, including likely outcomes and possible limitations and complications of surgery, and appropriate aftercare. Service users who have been offered surgery will be assessed by a member of the surgical team to confirm their physical suitability and fitness for surgery.
- viii. Service users should undergo the relevant pre-op laboratory tests according to local protocol. The service user's GP will normally be asked to arrange these tests locally.
- ix. The time of gender transition surgery is a vulnerable point and service users undergoing this should be cared for in an appropriate environment. As an in-patient, service users must be offered the option of use of side rooms/personal rooms. Nursing staff should be experienced in the care of such service users.
- x. It is important to note that the surgical procedure is only a part of the overall surgical management and it would be expected that the service user would be seen both pre- and post-operatively for surgical assessment and on more than one occasion if clinically indicated.
- xi. Communication with the referring specialist and GP should occur by letter at the time of



discharge from hospital and at all subsequent post-operative out-patient consultations. If ongoing surgical follow-up is indicated, this should be communicated to the referring specialist and GP.

- xii. A member of the surgical team will be available to answer queries from other practitioners to whom the service users might go in the event of complications, such as A&E units, GP's and other non-gender surgical units.

*Chest surgery for trans men (female-to-male transsexual people; see also section 3.1.4)*

- xiii. Chest surgery will be provided for trans men who fulfil the eligibility criteria set out in UKGPG. The choice of technique will be made on the basis of the surgeon's clinical judgement, informed by discussion and service user preference.

- xiv. There are essentially two techniques, the Double Incision Technique & Peri-Areolar Technique. Surgeons should be familiar with both techniques and should be prepared to compare and contrast both. A specific consent form is suggested. Other techniques, such as liposuction, may also be provided in appropriate cases.

*Chest surgery for trans women (male-to-female transsexual people; see also section 3.1.4)*

- xv. Chest surgery will be provided for trans women who fulfil the eligibility criteria set out in UKGPG and who have received at least 24 months of adequate feminising hormone therapy (to include adequate suppression of testosterone). The choice of technique will be made on the basis of the surgeon's clinical judgement, informed by discussion and service user preference.

- xvi. Augmentation mammoplasty should be performed by surgeons with appropriate experience of subglandular and submuscular implant positions with specific reference to transgender service users.

*Chest surgery for non-binary and non-gendered people (male-to-female transsexual people; see also section 1.1.2)*

- xvii. Chest surgery may be provided for non-binary and non-gendered people as part of SGIS. The decision to recommend surgery for these groups is a complex clinical judgment, and should only be made after discussion between the service user and all SGIS clinicians involved in their care (including the MDTs of the referring service and the surgery provider).

*Revision Procedures*

- xviii. In cases where revision procedures are appropriate, this is usually apparent within the first year after surgery, and arrangements for such procedures should normally be made within that timescale and provided as a part of SGIS. Service users should be made aware, however, that there are inevitably limitations to the quality of the cosmetic result which can be achieved. If a service user feels that further revisions might improve the cosmetic appearance, which the surgeon does not consider practical or appropriate, it would be open to the service user to seek a second opinion, either from a different surgeon in the same unit, or from another unit.

- xix. Service users seeking revision surgery more than a year after their primary surgery would normally be expected to be referred to a unit de novo. Revision surgery for purely cosmetic reasons will not be funded through this care pathway. Service users should be advised of any facilities that are available to manage the problem that has occurred within their local

area and a referral organised where appropriate.

b) Service Standards

- i. A unit offering chest surgery for gender reassignment will be expected to perform a minimum of 10 cases (at least five trans woman or at least five trans man) in a calendar year, so that the skills of the entire unit are maintained. New units should be able to demonstrate that they will receive sufficient referrals to maintain a satisfactory volume of cases.
- ii. *Surgeons:* A chest reconstructive surgeon is likely to be either from a breast onco-plastic or plastic surgical background and as such will be on the appropriate specialist register and have received the relevant training in mastectomy and related reconstructive techniques such as breast augmentation and breast liposuction.
- iii. *Specialist nurses:* The specialist nurse is able to support the service user through the surgical pathway and is ideally involved from the outset i.e. pre-operatively as well as being available for advice/support whilst an in-patient and out-patient.
- iv. The most common complications are those of haematoma and infection. Both rates should be less than 5%. Revision surgery should be required in less than 5% of service users. Venous thromboembolism and its prophylaxis must be considered and provision will depend on local protocol and procedure.

3.4.5 Genital Reconstructive Surgery for Gender Dysphoria

a) Description of Service

- i. SGIS providers and Clinical Networks will provide Genital Reconstructive Surgery for Gender Dysphoria for service users on the basis of clinical need and service user choice.
- ii. The aims of genital reconstructive surgery (GRS) are to achieve one or more of the following goals
  - Remove superfluous anatomy
  - Enable sexual function
  - Permit acceptable urinary function (which in the case of trans man service users may include use of a urinal)
  - Provide visually acceptable external genitalia
  - Minimise donor site scarring
- iii. The surgery provided as part of SGIS consists of one or more of the following procedures;
  - Trans woman Service users
    - Penectomy
    - Orchidectomy
    - Vaginoplasty
    - Clitoroplasty
    - Labioplasty

#### Trans man Service users

- Hysterectomy
  - Salpingo-oophorectomy
  - Vaginectomy
  - Metatoidioplasty
  - Phalloplasty
  - Urethroplasty
  - Scrotoplasty
  - Implantation of testicular prostheses
  - Implantation of penile prosthesis
- iv. Not all service users have all procedures and whilst most trans woman people require the full range of procedures some do not; for example some choose not to have a vaginoplasty, or choose orchidectomy alone. Likewise, some trans man people will not require phalloplasty and some of those who do will not require urinary or sexual function and thus will not require urethroplasty or penile prostheses.
- v. Some procedures, particularly phalloplasty, require multiple stages. Individual components of the pathway should be combined when appropriate to minimise the number of admissions. Service users' surgical pathways will be tailored to fulfil individual requirements, so as to maximise outcomes within the optimum number of admissions.
- vi. Teams providing GRS will work in close collaboration with the GIC's from whom they receive referrals, and be able to confirm the referral and eligibility criteria, and readiness for GRS of the service user. They will comprise specialist surgeon(s) and appropriately trained Clinical Nurse Specialists (CNS) working in close collaboration as an MDT.
- vii. Each service user will be assisted to understand and make appropriate informed decisions regarding the types and variations of surgical intervention, as appropriate, to ensure confidence about these decisions.
- viii. Each service user will receive detailed verbal, written and pictorial information on available surgical interventions, including likely outcomes and possible limitations and complications of surgery, and appropriate aftercare.
- ix. Service users who are offered surgery will be assessed by a member of the surgical team to confirm their physical suitability and fitness for surgery.
- x. During admission to hospital for surgery, service users should be admitted to a ward where there are nurses experienced in caring for this group, or where care can be supervised by a clinical nurse specialist. Nurses working in these units should undergo training in pack removal, recatheterisation and other skills needed in this group, and only trained nurses, or the surgeons, should undertake these procedures. As an in-patient, service users must be offered the option of use of side rooms/personal rooms.
- xi. On discharge from the hospital, service users will be given contact details for a CNS or other team member, who may be contacted in case of problems. A member of the surgical team will be available to answer queries from other practitioners to whom the service user might go

in the event of complications, such as A&E units, GP's and other non-gender surgical units.

- xii. Service users undergoing GRS will be offered follow up appointments in the unit providing the primary surgery, or by a surgeon from that unit who may visit a clinic geographically closer to the service user. Further follow up continues until the surgeon is confident that complete healing has taken place.

#### *Revision surgery*

- xiii. In cases where revision procedures are appropriate, this is usually apparent within the first year after surgery, and arrangements for such procedures should normally be made within that timescale and provided as a part of SGIS. Service users should be made aware, however, that there are inevitably limitations to the quality of the cosmetic and functional result which can be achieved. If a service user feels that further revisions might improve the cosmetic appearance, which the surgeon does not consider practical or appropriate, it would be open to the service user to seek a second opinion, either from a different surgeon in the same unit, or from another unit.
- xiv. Longer term problems may arise that require further surgery. These are normally related either to malfunction of a prosthesis or stricture formation within a neourethra.
- xv. Service users seeking revision surgery more than a year after their primary surgery would normally be expected to be referred to a unit de novo. Such referrals might either originate with the GP or a GIC clinician. Service users should be advised of any facilities that are available to manage the problem that has occurred within their local area and a referral organised where appropriate.

#### b) Service Standards

- i. A unit offering GRS will be expected to perform a minimum of 25 cases in a calendar year, so that the skills of the entire unit are maintained. New units should be able to demonstrate that they will receive sufficient referrals to maintain a satisfactory volume of cases.
- ii. Surgeons performing genital surgeries should be urologists, gynaecologists, plastic surgeons, or general surgeons, and certified as such by one of the Royal Colleges. They should have specialised competence in genital reconstructive techniques as indicated by documented further training with an experienced genital reconstructive surgeon. Surgeons should regularly attend professional meetings where new techniques are presented and visit other units to see other techniques and exchange ideas.
- iii. Surgeons should be knowledgeable about the full range of surgical techniques for genital reconstruction so that they, in consultation with service users, can choose the most appropriate technique for each individual. They should ideally offer a range of techniques but if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a service user, the surgeon should inform the service user about other procedures and offer referral to another appropriately skilled surgeon, possibly by another provider.

### 3.4.6 Gonadectomy (Hysterectomy and Bilateral Salpingo-oophorectomy and Bilateral Orchidectomy) for Gender Dysphoria

#### a) Description of Service

- i. SGIS providers and Clinical Networks will provide Gonadectomy (hysterectomy and bilateral

salpingo-oophorectomy or bilateral orchidectomy, without genital reconstruction surgery) for the treatment of Gender Dysphoria for service users on the basis of clinical need and service user choice.

- ii. The choice of technique will be discussed by the service user and surgeon; the surgeon will exercise clinical judgement in deciding which technique to offer and will give due consideration to the wishes of the service user. Laparoscopic gonadectomy is the preferred technique for gonadectomy for trans men, to minimise abdominal scarring that might limit options for phalloplasty, should this be necessary in the future.
- iii. Referrals of service users for gonadectomy for gender dysphoria as part of SGIS will only be accepted from a clinician working as part of the MDT of the Lead Provider service of a Clinical Network. Before surgery is performed, service users must fulfil the eligibility criteria for gonadectomy set out in UKGPG.
- iv. The referral process should comply with the requirements of UKGPG.
- v. Teams providing gonadectomy for gender dysphoria will work in close collaboration with the providers from whom they receive referrals, and be able to confirm the referral and eligibility criteria, and readiness for gonadectomy of the service user. They will comprise specialist surgeon(s) and appropriately trained Clinical Nurse Specialists working in close collaboration as an MDT.
- vi. Gonadectomy will usually be combined with genital reconstructive surgery. It may be offered as a separate procedure if it is deemed appropriate in the clinical judgment of the surgeon, and if this is the service user's preference.
- vii. Service users will be treated in a clinically-appropriate area. In out-patients, this will include being given the option of attending a separate clinic for transitioning service users or clinics that are separated in time from those for non-service users. As an in-patient, service users must be offered the option of use of side rooms/personal rooms.
- viii. Consent will be obtained at a specific pre-op appointment, so as to allow an informed process and give the service user adequate time to consider any relevant options/alternatives in the less formal setting of out-patients rather than on the morning of surgery. Each service user should receive detailed oral, written information on available surgical interventions, including likely outcomes and possible limitations and complications of surgery, and appropriate aftercare. Service users who have been offered surgery will be assessed by a member of the surgical team to confirm their physical suitability and fitness for surgery.
- ix. Service users should undergo the relevant pre-op laboratory tests swabs according to local protocol. The service user's GP will normally be asked to arrange these tests locally.
- x. The time of gender transition surgery is a vulnerable point and service users undergoing this should be cared for in an appropriate environment. Nursing staff should be experienced in the care of such service users. As an in-patient, service users must be offered the option of use of side rooms/personal rooms.
- xi. It is important to note that the surgical procedure is only a part of the overall surgical management and it would be expected that the service user would be seen both pre- and post-operatively for surgical assessment and on more than one occasion if clinically indicated.
- xii. Communication with the referring specialist and GP should occur by letter at the time of

discharge from hospital and at all subsequent post-operative out-patient consultations. If ongoing surgical follow-up is indicated, this should be communicated to the referring specialist and GP.

- xiii. A member of the surgical team will be available to answer queries from other practitioners to whom the service users might go in the event of complications, such as A&E units, GP's and other non-gender surgical units.

b) Service Standards

- i. A unit offering gonadectomy for gender dysphoria will have published policies on provision of care for trans, non-binary and non-gendered people, specifying arrangements for out-patient consultations, in-patient accommodation and training of all staff, clinical and non-clinical in caring for their needs, and respecting their dignity.
- ii. Surgeons performing gonadectomy should be urologists, gynaecologists, plastic surgeons, or general surgeons, and certified as such by one of the Royal Colleges.

### 3.4.7 Gamete Storage

a) Description of Service

- i. Cryopreservation is a technique that freezes an individual's eggs or sperm for use in future fertility treatment. Cryopreservation of sperm is a well-established technique used to maintain an individual's fertility. Cryopreservation of eggs is a newer technology, though has been widely used in relation to cancer treatment for a number of years.
- ii. Gamete cryopreservation will be commissioned in individuals undergoing medical or surgical treatments for gender dysphoria who may be at risk of permanent infertility as a result of their treatment. Gamete cryopreservation will not be commissioned for social reasons, or if gametes are being frozen for use by individuals other than the patient receiving treatment.
- iii. Before referral for gamete storage, the referring clinician should explain to patients:
  - The process of gamete capture and storage
  - The risks, benefits and limitations of gamete capture and storage
  - How stored gamete may be used in the future

In particular, patients should be made aware that only collection and storage of gamete is commissioned as part of SGIS. NHS funding for the future use of frozen gamete is not commissioned. Provision of gamete freezing and storage under the terms of this policy is made without prejudice to the future determination of funding of any subsequent fertility treatment.

- iv. Patients eligible for NHS-funded gamete cryopreservation should be about to commence a treatment that may cause permanent infertility as a result of that treatment. Treatments considered appropriate for commissioning of prior gamete cryopreservation are:
  - Feminising endocrine therapy
  - Virilising endocrine therapy
  - Gonadectomy, either as a part of genital reconstructive surgery or as a separate procedure

Some patients already receiving feminising or virilising hormone therapy, or receiving a gonadotrophin releasing hormone analogue, but who have not undergone gonadectomy, may

elect, in consultation with the SGIS provider supervising their endocrine therapy, to temporarily stop their hormone therapy to assess whether or not their reproductive capacity recovers. If their reproductive capacity recovers the gamete storage will be commissioned for them under this policy.

- v. Oocyte cryopreservation should only be offered if patients meet all of the following criteria:
    - They are well enough to undergo ovarian stimulation and egg collection; and
    - They are willing to delay or interrupt initiation of fertility-affecting treatment interventions in order to allow sufficient time available to harvest eggs
  - vi. Individuals should also meet the following criteria:
    - Registered with a GP in England
    - Receiving care for gender dysphoria through NHS England-commissioned SGIS
    - People with ovaries of reproductive age up to 42 years old (stimulation treatment to take place prior to individual's 43rd birthday)
    - People with testes of reproductive age up to 55 years old (sperm retrieval to take place prior to individual's 56<sup>th</sup> birthday)
    - Written consent to treatment and gamete storage is required
  - vii. Individuals will not be eligible for NHS-funded gamete cryopreservation if:
    - Gametes are being frozen for non-medical or non-surgical reasons, such as for social reasons
    - They have previously been sterilised
    - Their infertility is as a result of a congenital disorder
  - viii. Future use of frozen gametes will be in line with all relevant policies in place at the time.
  - ix. Cryopreservation of ovarian or testicular tissue is still considered to be an experimental procedure and therefore funding of this is not included under this policy.
  - x. Meeting the criteria for NHS-funded gamete cryopreservation as part of SGIS does not automatically entitle individuals to subsequently receive NHS-funded assisted conception treatment. In order to receive subsequent NHS funding, an individual will be required to meet the eligibility criteria outlined in policies in place at the time relating to assisted conception and IVF/ICSI, or the prevailing relevant policy of a successor organisation at that time
  - xi. The NHS will fund the storage of egg for a maximum period of 10 years, or until the carrying female reaches their 43rd birthday, or until the person from whom the eggs have been harvested reaches their 50<sup>th</sup> birthday, whichever is sooner.
  - xii. On the death of the patient NHS funding for gamete storage will cease. However, if it is lawful to do so and there is a legally-binding document signed by the patient allowing the use of frozen sperm after death, NHS funding of gamete cryopreservation will continue for up to a total of 10 years.
- b) Service Standards
- i. A unit offering gamete collection and storage for service users will have published policies on provision of care for trans, non-binary and non-gendered people, specifying arrangements for out-patient consultations, in-patient accommodation and training of all staff, clinical and non-clinical in caring for their needs, and respecting their dignity.
  - ii. Gamete storage will only be funded at centres licensed by the Human Fertilisation and Embryology Authority. Access into services for gamete cryopreservation will be by referral by a clinician at the lead provider of SGIS.

### 3.4.8 Thyroid Chondroplasty (Tracheal Shave Surgery) for Gender Dysphoria

#### a) Description of Service

- i. SGIS providers and Clinical Networks will provide thyroid chondroplasty for Gender Dysphoria for service users on the basis of clinical need and service user choice.
- ii. Referrals of service users for thyroid chondroplasty for gender dysphoria as part of SGIS will only be accepted from a clinician working as part of the MDT of the Lead Provider service of a Clinical Network. Before surgery is performed, service users must fulfil the eligibility criteria for thyroid chondroplasty set out in UKGPG.
- iii. The referral process should comply with the requirements of UKGPG.
- iv. Teams providing thyroid chondroplasty for gender dysphoria will work in close collaboration with the providers from whom they receive referrals, and be able to confirm the referral and eligibility criteria, and readiness for thyroid chondroplasty of the service user.
- v. Thyroid chondroplasty may be combined with other surgical procedures, such as phonosurgery, if the eligibility criteria for each procedure are fulfilled, if it is appropriate in the clinical judgment of the surgeon, and if this is the service user's preference.
- vi. Service users will be treated in a clinically-appropriate area. In out-patients, this will include giving the option of attending a separate clinic for transitioning patients or in a clinic separated in time from service users of a different group. As an in-patient, service users must be offered the option of use of side rooms/personal rooms.
- vii. Consent will be obtained at a specific pre-op appointment, so as to allow an informed process and give the service user adequate time to consider any relevant options/alternatives in the less formal setting of out-patient service users rather than on the morning of surgery. Each service user should receive detailed oral, written and pictorial information on available surgical interventions, including likely outcomes and possible limitations and complications of surgery, and appropriate aftercare. Service users who have been offered surgery will be assessed by a member of the surgical team to confirm their physical suitability and fitness for surgery.
- viii. Service users should undergo the relevant pre-op laboratory tests according to local protocol. The service user's GP will normally be asked to arrange these tests locally.
- ix. The time of gender transition surgery is a vulnerable point and service users undergoing this should be cared for in an appropriate environment. As an in-patient, service users must be offered the option of use of side rooms/personal rooms. Nursing staff should be experienced in the care of such service users.
- x. It is important to note that the surgical procedure is only a part of the overall surgical management and it would be expected that the service user would be seen both pre- and post-operatively for surgical assessment and on more than one occasion if clinically indicated.
- xi. Communication with the referring specialist and GP should occur by letter at the time of discharge from hospital and at all subsequent post-operative out-patient consultations. If on-going surgical follow-up is indicated, this should be communicated to the referring specialist and GP.



- xii. A member of the surgical team will be available to answer queries from other practitioners to whom the service users might go in the event of complications, such as A&E units, GP's and other non-gender surgical units.

*Thyroid chondroplasty for non-binary and non-gendered people (male-to-female transsexual people; see also section 1.1.2)*

- xiii. Thyroid chondroplasty may be provided for non-binary and non-gendered people as part of SGIS. The decision to recommend surgery for these groups is a complex clinical judgment, and should only be made after discussion between the service user and all SGIS clinicians involved in their care (including the MDTs of the referring service and the surgery provider).

#### b) Service Standards

- i. A unit offering thyroid chondroplasty for gender dysphoria will have published policies on provision of care for trans, non-binary and non-gendered people, specifying arrangements for out-patient consultations, in-patient accommodation and training of all staff, clinical and non-clinical in caring for their needs, and respecting their dignity. As an in-patient, service users must be offered the option of use of side rooms/personal rooms.
- ii. Surgeons offering thyroid chondroplasty as part of SGIS should perform at least five procedures per year per unit, and be certified by one of the Royal Colleges.

### 3.4.9 Phonosurgery for Gender Dysphoria

#### a) Description of Service

- i. Phonosurgery (voice-modifying) may be offered as a part of SGIS to service users who engage in speech and language therapy but do not achieve treatment goals, and who are assessed by a Speech and Language Therapist (SLT) and surgeon as being likely to benefit from such surgery. To be eligible for referral, service users must agree to engage in further speech and language therapy, which is essential to voice and communication development, after phonosurgery.
- ii. Before referral for phonosurgery, service users must have completed a course of therapy supervised by a qualified SLT. If voice and communication training has been provided by a practitioner who is not a qualified SLT, the service user must be referred to a qualified SLT for assessment and further treatment.
- iii. Only a qualified SLT may recommend referral for phonosurgery; the Therapist should submit recommendations for referral to the Lead Provider service of a Clinical Network. Referral to a phonosurgery provider will only be accepted from a clinician working as part of the MDT of the Lead Provider service of a Clinical Network, who will include the written recommendation of the SLT with their referral.
- iv. Provision of voice surgery procedures will include follow-up sessions with a SLT.
- v. The surgical technique provided as part of SGIS is cricothyroid approximation, sometimes with thyroid chondroplasty, if this is considered necessary in the surgeon's clinical judgment.

#### c) Service Standards

- iii. A unit offering phonosurgery for gender dysphoria will have published policies on provision of care for trans, non-binary and non-gendered people, specifying arrangements for out-patient

consultations, in-patient accommodation and training of all staff, clinical and non-clinical in caring for their needs, and respecting their dignity. As an in-patient, service users must be offered the option of use of side rooms/personal rooms.

- iv. Surgeons offering phonosurgery as part of SGIS should perform at least five procedures per year per unit, and be certified by one of the Royal Colleges.

### 3.5 Population covered

The services outlined in this specification are for individuals who are ordinarily resident in England\*, or who are the commissioning responsibility of the NHS in England (as defined in "Who Pays? Establishing the responsible commissioner" and other Department of Health guidance relating to individuals entitled to NHS care or exempt from charges).

The services outlined in this specification are for people aged 17 and over with gender dysphoria that, in the opinion of the referring GP and the SGIS, requires care and treatment with or through a SGIS.

\* Note: for the purposes of commissioning health services, this EXCLUDES individuals who, whilst resident in England, are registered with a GP Practice in Wales, but includes individuals resident in Wales who are registered with a GP Practice in England.

### 3.6 Any acceptance and exclusion criteria and thresholds

This specification relates specifically to SGIS provided for people aged 17 and older with gender dysphoria.

#### *Acceptance Criteria:*

Presence of a gender dysphoria, or confusion and/or distress related to gender identity, gender-specific social role and physical development that, in the judgement of the referring GP, is clinically relevant and requiring of care and/or treatment through SGIS.

#### *Exclusion criteria*

None

### 3.7 Interdependencies with other services/providers

3.7.1 SGIS are part of a spectrum of services whose function is to best meet the needs of those with gender dysphoria who will benefit from specialist care and treatment. In support of the care pathway, SGIS will provide advice to referrers or other healthcare providers on the care of individuals as appropriate. SGIS will establish close working relationships with other services which form part of the individual's care pathway.

3.7.2 Key partnerships include:

- i. NHS England

- ii. General Practitioners
  - iii. Gender Identity Development Service, The Tavistock and Portman NHS Foundation Trust (specialist child and adolescent gender identity service)
  - iv. NHS / Independent / Third Sector providers
  - v. Local mental health services
  - vi. Advocacy Services
  - vii. Transgender Support Services
  - viii. Department of Health
  - ix. Gender Recognition Panel
  - x. Social Care Agencies
  - xi. Care Quality Commission
  - xii. Professional Regulatory Bodies
- 3.7.3 SGIS are expected to have protocols in place to enable it to share clinical information with other agencies when appropriate which are underpinned by Caldicott principles and information governance structures.
- 3.7.4 SGIS will comply with the requirements of the Gender Recognition Act 2004, particularly with regard to information sharing.
- 3.7.5 There will be a well-managed interface with the GP of service users receiving care through SGIS. An effective clinical partnership with the service user's GP is essential to achieve the service aims and objectives.
- 3.7.6 There will be a well-managed interface with child and adolescent gender identity services, to ensure smooth transition in provision for high-risk young people to adult services
- 3.7.7 Providers of adult SGIS will give priority to allocating initial appointments for patients transferred from child and adolescent gender identity services to adult gender identity services, ahead of other, non-transfer patients on clinic waiting lists for first appointments. Transfers of young persons aged 17 years and older should be accepted when clinically appropriate, and when this has been agreed between child and adolescent gender identity services, the receiving adult service and the transferring patient. Prior to transfer, the patient must have completed their assessment and have a treatment plan with the child and adolescent gender identity services. Transferred patients should be seen by adult services at an interval agreed between the child and adolescent service, the adult service, and the service user. NHS England should ensure that funding of transfer patient care is in place for adult services at the time of transfer

#### 4. Applicable Service Standards

#### 4.1 Applicable national standards e.g. NICE

There are no NICE national standards with specific relevance to this service.

#### 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Good Practice Guidelines for the Assessment & Treatment of Adults with Gender Dysphoria (2013, in press). UK Intercollegiate publication.

World Professional Association for Transgender Health Standards of Care (WPATH SoC) for the Health of Transsexual, Transgender and Gender Nonconforming People, 7th version, 2011 (retrieved from [www.wpath.org/documents/IJT%20SOC,%20V7.pdf](http://www.wpath.org/documents/IJT%20SOC,%20V7.pdf) on 23/08/2013)

### 5. Applicable quality requirements and CQUIN goals

#### 5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

#### 5.2 Applicable CQUIN goals (See Schedule 4 Part E)

*The reference numbers for quality requirements and the CQUIN goals which apply to the service should be listed here. This allows clarity about the requirements relating to specific services.*

*Please note any contractual levers relating to quality, KPIs, CQUINs will need to be included in the relevant schedules of the contracts.*

### 6. Location of Provider Premises

The Provider's Premises are located at:

*ONLY LIST PROVIDERS IF THERE HAS BEEN A FORMAL DESIGNATION PROCESS.*

### 7. Individual Service User Placement

*Insert details including price where appropriate of any individual service user placement e.g. mental health. This is likely to be relevant where the service provides tailored specialist placements. It may*

*also be used to record any specialist equipment that is provided as part of an individual care pathway.*

## Appendix Two

Quality standards specific to the service using the following template:

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
<b>Domain 1: Preventing people dying prematurely</b>			
Insert text			
<b>Domain 2: Enhancing the quality of life of people with long-term conditions</b>			
Insert text			
<b>Domain 3: Helping people to recover from episodes of ill-health or following injury</b>			
Insert text			
<b>Domain 4: Ensuring that people have a positive experience of care</b>			
Insert text			
<b>Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm</b>			
Insert text			

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