

## C4a

### 2012/13 NHS STANDARD CONTRACT FOR ACUTE, AMBULANCE, COMMUNITY AND MENTAL HEALTH AND LEARNING DISABILITY SERVICES (MULTILATERAL)

#### SECTION B PART 1 - SERVICE SPECIFICATIONS

<b>Service Specification No.</b>	<b>C4a</b> (22(4))
<b>Service</b>	Gender Identity Services – Chest and Genital Reconstructive Surgery (GRS)
<b>Commissioner Lead</b>	Jo Scott
<b>Provider Lead</b>	
<b>Period</b>	12 months
<b>Date of Review</b>	

#### 1. Population Needs

##### 1.1 National/local context and evidence base

- Chest and genital reconstructive surgery (GRS) is the surgical modification of an individual's physical sex characteristics to establish greater congruence with their gender identity. Genital surgery is, for many, the final stage in the treatment pathway for gender dysphoria.
- Gender Dysphoria is a condition in which there is a psychological experience of oneself as a man or woman, which is incongruent with the phenotype. The individual's physical sex is not aligned with their gender identity.
- If not treated, gender dysphoria can lead to mental ill health and severely affect the person's quality of life. The aetiology of the condition is not yet fully understood; however there is current evidence that suggests that transsexualism is not a mental illness, but rather a neuro-developmental condition. Transsexualism cannot be 'cured'. Instead interventions may be required to optimise mental health and facilitate transition of status where appropriate.
- Individuals, who need help to optimise mental health and to make the social gender role transition, will need intervention from professionals with knowledge, training and experience in the treatment of gender dysphoria. In many cases,

chest and genital reconstructive surgery will also be appropriate. This document seeks to specify commissioners' requirements of Gender Identity Services – Chest and Genital Reconstructive Surgery (GRS). The requirements for Gender Identity Services – Gender Identity Clinic Services (GIC) are addressed in a separate service specification.

- Not all patients with gender dysphoria symptoms wish for surgery and the numbers related to need are largely unknown. National demand for these services is currently at a level of approximately 1,500 new cases per year in England. Anecdotally, it is believed that approximately 1 in 5 patients, referred to gender identity clinics (GIC), proceed to surgery, although robust data is lacking. The impact of moving to a national access policy for surgery on demand cannot be accurately predicted.
- Legislation now enables trans people to obtain legal recognition of their new gender status, after they have undergone transition which does not necessarily include hormone treatment or reconstructive surgery (Gender Recognition Act, 2004).
- This is a field in which there are known limitations to the evidence base, owing to a history of restricted funding for detailed research, general stigma surrounding the subject matter and evidence of difficulties in getting research published in peer review journals
- Terminology can vary widely, and individual preferences must be respected; people with Gender Dysphoria might identify as male or female, and / or gender variant, transgender, transsexual, transvestite, genderqueer, gender neutral, androgyne, neutrois, or other.

## **2. Scope**

### **2.1 Aims and objectives of service**

- The aim of surgery is to make the individual's body as congruent as possible with their gender identity, following referral and recommendation by the gender identity clinic services.
- Surgical treatments for gender dysphoria are not merely another set of elective procedures. Chest and genital surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in the Gender identity services – gender identity clinic service specification. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for specific surgical treatment. By following this procedure, mental health professionals, surgeons, and the patient share responsibility for the decision to make irreversible changes to the body

- The overarching treatment goal is lasting personal comfort with the gendered self in order to maximise overall psychological well being and self-fulfilment and there by improving the individuals quality of life.
- The aim is to improve quality of life for those diagnosed with gender dysphoria by:
  - Maintaining close working relationships with the referring gender identity clinical multidisciplinary team (MDT) (working in the GICs), including both the referring clinicians and the endocrinology specialist.
  - Having gained insight into each patient's history and the rationale that led to the referral for surgery.
  - Being knowledgeable about more than one surgical technique for genital / chest reconstruction so that, in consultation with patients, the optimum technique for each individual can be selected.
  - Ensuring that patients have a realistic expectation of outcomes, gaining informed consent.
  - Surgeons will be experts in the field of providing surgery for individuals with gender dysphoria.
  - Surgeons will personally communicate with the referring GIC regarding the referral, eligibility and GRS readiness criteria.
  - Providing the expert surgical interventions required for the individual to take on the physical form of their gender identity.
  - Providing good quality postoperative care and follow-up after surgical treatments.
  - Taking all precautions to limit complications and infections.

## **2.2 Service description/care pathway**

### **• Service Description**

- There is no single model for the surgical treatment; the care pathway for individuals with gender dysphoria varies as appropriate for the patient, and birth phenotype.
- For trans women (MtF) genital reconstructive surgery is in most cases the final stage in the treatment pathway, and the only surgery performed. Whichever surgical procedure selected (with or without vagina) the surgery is performed in one procedure. Breast augmentation is only considered after a sufficient period of exposure to adequate hormone treatment if the GIC MDT (including endocrinology specialist) and the surgeon agree there is a clinical need.
- For trans men (FtM) the surgical pathway is longer and more complicated. Chest surgery, a mastectomy procedure with reconstruction, is usually the first surgery performed for success in gender presentation, and for some patients it is the only surgery undertaken; a hysterectomy maybe performed at any stage in the patient pathway dependent on individual preference, it is clinically recommended, however, either prior to or during genital surgery. Genital surgery is performed in up to four stages with a minimum of 3 months between each operation.

- Patients will be discharged back to the referring GIC who will (as a minimum) follow up at 12 months post surgery to review and record the outcome (see the GIC service specification).

- **Referral**

Referrals for surgery will be made by the gender identity clinic (GIC), as stated in 2.1 the referring clinicians share the responsibility for the decision to proceed to irreversible surgery with the surgeon who undertakes the treatment.

- **Chest and Genital Reconstructive Surgery (GRS)**

- Surgeons, who perform surgical treatments for Gender Dysphoria (GD) should be urologists, gynaecologists, surgeons, or general surgeons, and board-certified as such by the one of the Royal Colleges or National Associations. Surgeons performing genital surgery should have specialised competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Surgeons performing chest surgery/breast augmentation should have specialised competence in chest reconstructive/breast augmentation techniques for patients with gender dysphoria as indicated by documented supervised training with a more experienced surgeon.
- The multidisciplinary team will consist as a minimum of: Surgeon; Clinical Nurse Specialist; Anaesthetist; the referring GIC team including the endocrinology specialist will also be considered as part of the MDT.
- Ideally, surgeons should be knowledgeable about more than one surgical technique for genital/chest reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon, possibly at another provider.
- The role of the surgeon in the treatment of GD is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other professionals, who have been actively involved in their clinical care.
- Consultation is readily accomplished when the surgeon practices as part of a multidisciplinary health care team (MDT). The MDT and the surgeon must be confident that the referring GICs clinicians, and if applicable, the physician who prescribes hormones\*, are competent in the assessment and treatment of GD, because the team, including the surgeon, is relying heavily on their expertise.

- Nobody should undergo genital surgery unless their hormone levels will remain the same before and after surgery.
- Once a surgeon is satisfied that the criteria for specific surgeries have been met, surgical treatment should be considered and a preoperative consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatment for GD:
  - The different surgical techniques available (with referral to colleagues, who provide alternative options);
  - The advantages and disadvantages of each technique;
  - The limitations of a procedure to achieve optimal results;
  - The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure
- These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their Gender Dysphoria. As part of these discussions, patients will be informed that unless clinically required revision surgery is not routinely funded by the NHS; reversal surgery is not routinely commissioned by the NHS.
- All this information should be provided to patients in writing, in a language in which they are fluent and in graphic illustrations. Patients should receive information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because reversal procedures are very complex, with poor outcomes and are currently not NHS funded, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide consent. A minimum of 24 hours is required.
- Surgeons should provide immediate aftercare and consultation with other physicians (both GIC and primary care) serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.
- The procedures listed below are considered to be the main elements of surgical treatment of gender dysphoria. Not all patients have the same care pathway nor do they necessarily have all the procedures listed.
- Trans women (MtF):
  - penectomy (removal of penis)
  - orchidectomy (removal of testes)
  - Breast augmentation only available on a clinical need basis (joint agreement between MDT GIC & SRS). Breast augmentation can

only be considered after a sufficient period of exposure to adequate hormone treatment has taken place. The expected maximum effect of feminising hormone treatment is usually three years.

- vaginoplasty (creation of a vagina)
  - clitoroplasty and labiaplasty (creation of clitoris and labia)
  - Donor site hair removal on surgeon's recommendation
- Trans men (FtM):
    - chest reconstruction / bilateral mastectomy (carried out by surgeons with experience in performing surgery for trans men or gynaecomastia surgery)
    - hysterectomy (removal of uterus)
    - vaginectomy (removal of vagina)
    - salpingo-oophorectomy (removal of ovaries and fallopian tubes)
    - metoidioplasty (creation of micropenis)
    - phalloplasty (creation of phallus)
    - urethroplasty (creation of urethra)
    - Scrotoplasty
    - Implantation of penile prosthesis
    - Donor site hair removal on surgeon's recommendation
  - For patients who require surgical repair following gender reconstructive surgery (GRS) the service will provide this in accordance with the criteria set out in the commissioning policy – patients should be advised that revision surgery is not routinely commissioned by the NHS unless clinically required.
  - The MDT and GRS provider must take all precautions to prevent complications and infections.
- **Postoperative Care and Follow-up**
    - Long-term postoperative care and follow-up after surgical treatments for Gender Dysphoria are associated with good surgical and psychosocial outcomes. Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region. The MDT, surgeon and provider must take all precautions to limit complications and infections.
    - Postoperative patients might sometimes consider excluding themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognising that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. Health professionals should stress the importance of postoperative follow-

up care with their patients and offer continuity of care.

- Postoperative patients should undergo regular medical screening according to recommended guidelines for their age.
- All patients should be referred back to and followed up by their Gender Identity Clinic service up to 12 months following surgery, to review and record the outcome. The patient and the GIC clinician may decide that it is both appropriate and necessary for patients to attend the GICs following GRS for ongoing support, and/or hormone monitoring.
- Patients will be discharged from Gender Identity Clinics following surgery when they are medically stable and their care can be transferred to their GP.

### **2.3 Population covered**

- The service outlined in the specification is for patients ordinarily resident in England\*; or otherwise the commissioning responsibility of the NHS in England<sup>1</sup> (as defined in *Who Pays?: Establishing the responsible commissioner* and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).
- Specifically, this service is for adults referred from GICs with a confirmed diagnosis of Gender Dysphoria that fulfil the eligibility and GRS readiness criteria (see section 2.4).

### **2.4 Any acceptance and exclusion criteria**

- Referral must be from an NHS commissioned GIC.
- Only those patients that fulfil the eligibility and GRS readiness criteria should be referred to GRS.
- The GIC MDT will refer patients when they are satisfied that the individual has met the eligibility and readiness criteria for surgery; the recommendation for an individual to proceed to surgery will be confirmed in writing:
  - One letter of recommendation is required for referring FtM patients for either chest surgery or hysterectomy (if performed as a separate procedure to genital reconstruction surgery).
  - Two letters of recommendation are required for genital reconstruction surgery (or one letter with two supporting signatures).

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<sup>1</sup> Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

- The GIC letter of referral recommending surgery will specify:
  - The patient's general identifying characteristics;
  - The individual's birth phenotype and their gender identity, plus other psychiatric diagnoses if present;
  - The duration of the professional relationship including the type of psychotherapy or evaluation that the patient underwent;
  - The eligibility criteria that have been met (including the social gender role transition period) and the mental health professional's rationale for recommending surgery.
  
- MtF patients can only be referred for breast augmentation on a clinical need basis; this will be a joint agreement between the MDT at the GIC and the surgical centre. Breast augmentation can only be considered after a sufficient period of exposure to adequate hormone treatment has taken place. The expected maximum effect of feminising hormone treatment is usually three years.
  
- The **patient eligibility criteria** for GRS are adopted from the WPATH criteria. Eligibility criteria for patients, regardless of biological or current gender status, seeking genital surgery are the same:
  - Competent to consent to receive treatment consistent with safe clinical practice and relevant legislation;
  - Usually 12 months of continuous endocrine therapy (for those without medical contraindication);
  - A continuous full-time social gender role transition period;
  - Regular participation, where required, in some form of psychological input during the social gender role transition period;
  - Demonstrable knowledge of the length of hospitalisation, possible complications, limitations and post-surgical requirements of the various surgical procedures.
  
- **Patient Readiness Criteria** in addition to fulfilling the eligibility criteria, the Gender Identity Clinic service must be satisfied that the patient meets the readiness criteria:
  - Demonstrable progress in consolidation of one's gender identity role;
  - Demonstrable progress in dealing with external social, family and interpersonal issues in an improved state of mental health.
  
- The patient must be medically and mentally fit for surgery and have all medical conditions appropriately monitored by their GP. The patient and surgeon must complete informed consent documents in line with national guidance.
  
- All referrals received will be placed onto a single waiting list for the gender identity surgical service
  
- **Exclusion criteria**
  - People under 18 years of age
  - Any referral from a source other than an NHS commissioned GIC.

- **Revision Surgery** is not routinely commissioned by the NHS unless clinically required.
- **Reversal Surgery** is not routinely commissioned by the NHS.

## 2.5 Interdependencies with other services

- Co-located services (genital reconstructive surgery MtF)
  - Urological Surgery
  - Plastic Surgery
- Co-located services (genital reconstructive surgery FtM)
  - Gynaecological Surgery
  - Urological Surgery
  - Plastic Surgery
- **Interdependent services**
  - **Gender Identity Clinic Services (GIC):**  
In England there are 7 Gender Identity Clinic services (GICs) providing NHS funded assessment and treatment for people with Gender Dysphoria, including providing endocrinology expertise to support hormone therapy prescribing. These providers, especially their clinicians, are essential for people, who wish to progress to NHS-funded surgery. Patients will be referred from and discharged back to their GIC.
  - **Local hair removal services**
  - **Surgical Interdependent Services:**
    - Adult intensive care (does not need to be on a co located)
    - Breast Surgery
    - General Surgery
- **Related Services**
  - **General Practitioners (GP):**  
The care pathway for individuals with gender identity Dysphoria starts with a referral from a patient's GP. The GP is responsible for ongoing prescribing of hormone therapy and organising blood and other diagnostic tests as recommended by the GICs clinician. GPs are also responsible for assuring that the patient's life-long wellbeing is assured by conducting periodic diagnostic tests and medication reviews as recommended initially by the discharging specialist and thereafter according to extant best practice.
  - Emerging Clinical commissioning Groups (CCGs) may choose to agree local care pathway / referral routes should consortia wish to develop one Primary Care practice or GP as their expert, including using them to prescribe the hormone therapy in partnership with the Gender Identity Clinic service (GICs).

- **Gender Identity Development Service at the Tavistock and Portman NHS Trust**  
Highly specialised GIC service for young people (18 and under).

### 3. Applicable Service Standards

#### 3.1 Applicable national standards e.g.: NICE, Royal College

- Any clinical support for changing from one gender to another regardless of biological or current gender must follow extant professionally recognised best practice, as recognised by relevant UK clinicians.
- Intercollegiate Committee (2006). 'The Draft Good Practice Guidelines for the Assessment and Treatment of Gender Dysphoria'.  
<http://www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf>
- \*World Professional Association for Transgender Health (WPATH) (2001)<sup>2</sup>. 'The Harry Benjamin International Gender Dysphoria Association's Standards Of Care For Gender Identity Disorders, Sixth Version'.  
<http://www.wpath.org/documents2/socv6.pdf>
- National Offender Management Service (2011). 'The care and management of transsexual prisoners', Reference PSI 07/2011, London, Ministry of Justice.

### 4. Key Service Outcomes

Prior to the surgical intervention, the patient received good verbal and written information on possible interventions, limitations of surgery and aftercare. The patient was offered choice about the kind of surgical intervention. Patients leaving this service will have received high quality surgery by a competent surgeon, who is part of a highly trained multi-disciplinary team (MDT). The MDT must take all precautions to limit complications and infections. Patients satisfied with sex reassignment surgery will have a stable gender identity; accepting and confident of the decisions they have been supported to make with regards to their care pathway and transition.

**2012/13 NHS STANDARD CONTRACT- (MULTILATERAL)  
SECTION B – THE SERVICES  
GATEWAY REFERENCE: 16953**

<sup>2</sup> Note: Replaced by WPATH Standards of care version 7 published July 2012 not considered in the writing of this service specification, this will need to be reviewed by the NHS CB at the earliest opportunity  
<http://www.wpath.org/documents/SOC%20V7%2003-17-12.pdf>