Clinical Commissioning Policy: The Provision Of Gender Dysphoria Services

December 2012
Reference : NHSCB/C4
Clinical Commissioning Policy: The Provision Of Gender Dysphoria Services

First published: December 2012

Prepared by the NHS Commissioning Board Clinical Reference Group for Gender Identity Dysphoria

© Crown copyright 2012
First published December 2012
Published by the NHS Commissioning Board, in electronic format only.
Contents

Policy Statement .............................................................................................................................................. 4
Equality Statement ........................................................................................................................................... 4
1. Introduction .................................................................................................................................................. 5
2. Definitions .................................................................................................................................................. 5
3. Aim and Objectives ................................................................................................................................. 6
4. Criteria for commissioning ..................................................................................................................... 6
5. Patient pathway ......................................................................................................................................... 9
6. Governance arrangements ....................................................................................................................... 12
7. Epidemiology and needs assessment .................................................................................................... 12
8. Evidence Base ........................................................................................................................................... 13
9. Rationale behind the policy statement ................................................................................................... 16
10. Mechanism for funding .......................................................................................................................... 16
11. Audit Requirements ............................................................................................................................... 16
12. Documents which have informed this policy ....................................................................................... 16
13. Links to other policies ............................................................................................................................ 17
14. Date of Review ........................................................................................................................................ 17
15. Glossary .................................................................................................................................................. 17
References ...................................................................................................................................................... 18
Appendix A: Commissioned procedures ..................................................................................................... 20
Policy Statement

The NHS Commissioning Board (NHS CB) will commission gender dysphoria services in accordance with the criteria outlined in this document.

In creating this policy the NHS CB has reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population in England.

Equality Statement

The NHS Commissioning Board (NHS CB) is committed to ensuring equality of access and non-discrimination, irrespective of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

In carrying out its functions, the NHS CB will have due regard to the different needs of different protected equality groups. This applies to all the activities for which they are responsible, including policy development, review and implementation.
1. Introduction

Gender Dysphoria
The sense of belonging to a particular sex, not only biologically but also psychologically and socially, is called gender identity.

Gender Dysphoria (GD) is a rare condition in which there is a psychological experience of oneself as male or female, which is incongruent with the external sexual characteristics of the body.

An individual with profound and persistent GD may need clinical intervention to facilitate a transition of status, to live in accordance with his or her core gender identity rather than with the phenotype.\(^1\)

This degree of GD is termed transsexualism (ICD10 F64). The ICD-10 diagnosis of transsexualism (F64.0) in an adult requires three criteria to be met.\(^2\)

- The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment.
- The transsexual identity has been present persistently for at least two years.
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Gender Dysphoria, if not treated 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.\(^3\) Transsexualism cannot be ‘cured’. Instead interventions may be required to optimise mental health and facilitate transition of status where appropriate.

2. Definitions

Gender Dysphoria (GD): A condition in which the psychological experience of oneself as male or female is incongruent with the external sexual characteristics of one’s body.

Gender Identity: The sense of belonging to a particular sex

Gender Identity Clinic (GIC): The staff providing specialist clinical care for patients with Gender Dysphoria. The service meets and discusses the progress of all clients receiving care, especially those initiating, receiving hormone therapies and/or those approaching readiness for surgery.

Gender Reassignment Surgery (GRS): Also known as Gender Confirmation Surgery, GRS aims to alleviate the psychological discomfort of patients with profound GD through changes to the body in line with the individual’s gender identity.

Real Life Experience (RLE): is a period of time, usually one to two years, living in
the gender role with which the individual identifies, with the aim of assisting the patient to fully appraise the practical and social implications of a permanent gender change and to assure themselves that it feels right for them and that they can cope with any negative implications.

**Transsexualism:** The desire to live and be accepted as a member of the opposite gender, usually accompanied by the wish to make one’s body as congruent as possible with the preferred sex through surgery and hormone treatment.

**Trans man:** An individual who was born with a female phenotype, who is seeking to undergo, in the process of undergoing or having already undergone 'transition' from female to male.

**Trans woman:** A individual who was born with a male phenotype, who is seeking to undergo, in the process of undergoing or having already undergone 'transition' from male to female.

3. **Aim and Objectives**

This policy represents the NHS Commissioning Board position on Gender Dysphoria services for adults eligible for NHS funded services in England, including gender reassignment surgery (GRS). The goal of the policy is to assist the service user to find a personal accommodation with their sense of gender identity, including the provision of clinical interventions to facilitate a transition of social gender role where necessary.

The policy aims to ensure that those most in need and able to benefit are given equitable access to the service across England.

People under 17 years should be referred to the Gender Identity Development Service at the Tavistock and Portman NHS Trust.

People between 17 and 17 years 6 months will be referred to the most appropriate service to meet their needs; this will be agreed in discussion with the young person and their carers and the receiving preferred service.

People over 17 years 6 months will be referred into the adult service.

4. **Criteria for commissioning**

4.1 **Criteria for treatment**

The following statements set out the position of the NHS Commissioning Board with respect to all current patients (in treatment and on the waiting list) and future referrals for Gender Dysphoria (GD) services for patients in England.

- General Practitioners are able to make direct referrals provided they are familiar
with the ICD-10 criteria for referral. Otherwise they should in the first instance refer to a local psychiatry service.

- If the GP has reason to believe that there are co existing conditions that may need prior, or parallel treatment, those conditions may require a referral to a relevant local health professional. Treatment for GD should not be delayed unless for strictly clinical reasons.\(^9\)

- Criteria for referral to a NHS Gender Identity Clinic (GIC) service are that the patient should meet the ICD-10 criteria for transsexualism.

- Patients should be offered a choice of GD service provider wherever possible.

- Progression through the stages of treatment will be based on joint decisions between the patient and the multidisciplinary team, via the GD service.

Criteria for referral to the specialist GIC service will be further explored following the publication of the standards of care currently being developed by the Inter Collegiate Working Party for Standards of Care for People with Gender Dysphoria.

### 4.2 Patient Eligibility Criteria for Gender Reassignment Surgery

- Not all patients will either choose or be eligible to undergo gender reassignment surgery (GRS). However, as a point of principle GRS is an integral part of the treatment of GD and should not be considered separately. Prior approval for GRS should not be required for patients who are accepted by the specialised GIC and who then meet the criteria detailed below. Gender reassignment surgery will not be offered to individuals outside of the care pathway.

- However, there is the option of applying to an Individual Funding Request (IFR) panel if a patient feels they are exceptional in terms of their ability to be eligible for GRS without meeting all/some of the criteria listed below. Please contact local commissioning organisations for more details on their IFR policy.

- The patient eligibility criteria for GRS are adapted from the Harry Benjamin criteria.\(^8\) Eligibility criteria for all 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 a medical contraindication).
  - A sustained period of at least 12 months continuous full-time real life experience (RLE).
  - Although some patients may not require it, regular participation in some form of psychological input during RLE will be made available. (This criterion only applies if the patient requires this).
  - Demonstrable knowledge of the length of hospitalisation, possible complications, limitations and post-surgical requirements of the various surgical procedures.
• Gender recognition certificates may be taken into account where appropriate.

4.3 Patient Readiness Criteria
In addition to fulfilling the eligibility criteria, the GIC service must be satisfied that the patient meets the readiness criteria:

- Demonstrable progress in consolidating one's gender identity role.
- Demonstrable progress in dealing with external social, family and interpersonal issues resulting in an improved state of mental health.

4.4 Service and Service Engagement Criteria
- The process of identifying patients as eligible and ready for GRS must involve all members of the multidisciplinary team (MDT) and the patient.
- The decision to refer a patient to a surgical team must follow extant professionally recognised best practice, as recognised by relevant UK clinicians. At present, this includes two letters of recommendation from suitably qualified clinicians.
- The surgeon should be appropriately qualified and operating within a designated service. S/he should personally communicate with the referring GIC specialist, to verify the referral.
- Patients should be offered a choice of surgeon, wherever possible.
- The patient must be medically fit for surgery and have all medical conditions appropriately monitored by their GP.
- The patient and surgeon must complete appropriate informed consent documents, which may follow those produced by GIRES.

4.5. Gender Reassignment Surgery Procedures
Appendix A details those surgical procedures that will be routinely commissioned for patients meeting the criteria detailed in paragraphs 4.2 and 4.3 where the procedures are deemed appropriate for the individual.

Any other procedures recommended by a clinician would be considered via PCT Individual Funding Requests (IFR).

4.6 Revision Surgery
Patients should be advised that revision surgery is not routinely commissioned by the NHS unless clinically required.
4.7 Reversal Surgery
Patients should be advised that reversal surgery is not routinely commissioned by the NHS.

4.8 Discharge Criteria
Patients will be discharged from the service when:
- They are no longer receiving benefit
  OR
- Following surgery they are medically stable and their care can be transferred to their GP
  OR
- They request discharge.

5. Patient pathway

5.1 The Patient pathway
Although there is no single model for treatment, the care pathway for individuals with Gender Dysphoria usually includes diagnostic assessment, appropriate psychological intervention, the ‘real life experience’, hormone therapy and surgical interventions in a patient appropriate pathway but not predefined order. It is noted that it may be possible to miss a stage, if it is appropriate, for the patient and reasonably acceptable. Any clinical support for changing from one gender to another, regardless of biological or current gender, must follow extant professional best practice as recognized by relevant UK clinicians.

There are two groups of individuals with GD; biological males and biological females. This policy recognises specific differences in the care of these two groups.

5.2 The Initial Assessment Period
Referrals for initial assessment should be placed on a single waiting list. Once accepted for treatment, prior approval should not be required for core procedures (see Appendix A) deemed appropriate to any individual wishing to undergo them and who meets the criteria detailed in section 4 of this policy.

An initial assessment period of usually three to six months involves diagnostic assessment of the patient (including the patient’s history of and current experience of GD), psychological assessment, general medical examination and physiological measurements, including blood tests. It will be expected that all patients who wish to proceed beyond initial assessment will have been through this initial assessment period in order to discount any differential diagnosis of the patient.
5.3 Psychological input
All patients will be reviewed at regular intervals in line with best practice guidelines. Patients may, in some cases, be offered psychological support as part of their individualised package of care.
In some cases, formal psychiatric intervention may be required, particularly for patients with psychiatric comorbidities. Shared care may be appropriate in these cases.

5.4 The Real Life Experience
The Real Life Experience (RLE) is a period of time, usually one to two years, living in the gender role with which the individual identifies, with the aim of assisting the patient to fully appraise the practical and social implications of a permanent gender change and to assure themselves that it feels right for them and that they can cope with any negative implications.
During this time the role of the clinician is to advise on coping strategies and (where necessary) challenge the patient to ensure they derive the full benefit of the experience.
Discretion rests with the clinicians involved as to whether it is reasonably practicable to proceed with the RLE prior to administration of hormones (endocrine therapy). If it is not practicable, then endocrine therapy should be considered prior to commencing with the RLE.
The Real Life Experience is an integral part of any individualised treatment plan where gender reassignment surgery is being considered. The quality of the real life experience is assessed through the patient’s ability to thrive in their acquired gender. Gender Recognition Certificates may be taken into account at this stage.

5.5 Endocrine Therapy
Endocrine therapy is an important component of treatment for properly selected individuals with persistent GD. Endocrine therapy usually consists of a combination of hormone blocking medication (reversible) and the administration of cross sex hormones.
The administration of cross sex hormones is only commenced if the patient fulfils the following criteria:
- Competent to consent to receive treatment consistent with safe clinical practice and relevant legislation.
- Demonstrable knowledge of what hormones medically can and cannot do, and their social benefits and risks.
Having had a reasonable period between initial decision between clinician and

The assessment period of patients who are further down the care pathway or transfer with a complete history from another clinician may be shorter.
patient to proceed with hormone therapy and the actual administration of hormones, allowing time for relevant tests to be carried out where necessary or a cooling off period where appropriate.

5.6 Gender Reassignment Surgery (GRS)

Patients may only be referred for NHS-commissioned GRS when the GIC service is satisfied that all criteria are met (Section 4). The specialist GIC will be responsible for informing commissioners of patients referred for GRS, in line with the service specification.

Gender reassignment surgery (GRS) aims to alleviate the psychological discomfort of patients with profound GD through changes to the body in line with the individual’s gender identity. The criteria for GRS are summarised in section 4.2. Please see Appendix A for further details of core commissioned procedures.

Surgery for male-to-female patients includes genital surgery. Surgery which, if appropriate for the individual should be routinely commissioned includes penectomy, orchidectomy, vaginoplasty, clitoroplasty and labiaplasty. Other surgery to assist feminisation includes breast augmentation.

Core genital surgery for female-to-male patients may involve hysterectomy, vaginectomy, salpingo-oophorectomy, metoidoplasty, scrotoplasty, urethroplasty, placement of testicular prostheses and phalloplasty including glans sculpting and placement of testicular and penile prosthesis.

5.7 Other Interventions

Other interventions to assist feminisation and masculinisation during transition, and to preserve reproductive potential, include:

- Speech and language therapy (core procedure).
- Support and advice on style (core procedure).
- Hair removal techniques (non-core procedure).
- Storage of gametes (non core procedure).

5.8 Service Provision and delivery

The availability of services across the country is limited.23

NHS Specialist Gender Identity Clinic services, are based in

- Exeter
- Leeds
- London
- Newcastle
There are a limited number of surgical units performing GRS procedures. Services for people with GD need to offer a flexible approach to meet the needs of individuals at different stages of gender transition. Services will be commissioned from designated contracted providers that meet the requirements of the national service specification.

6. Governance arrangements

Gender Identity Clinic services and Gender Reassignment Surgery should only be offered in experienced specialist centres willing to publish their results and use established clinically relevant patient outcomes.

7. Epidemiology and needs assessment

The data available to estimate the prevalence of transsexualism and GD is limited due to research and data quality issues, a wide spectrum of diagnosis, stigma and discrimination. There are variations in the estimated prevalence of GD. The NHS report ‘Trans: a practical guide for the NHS’ contains population estimates based on published research, and states a prevalence of 1 in 11,500 people as being transsexual. A Scottish primary care based survey was conducted in 19986 (8.70/100,000 population). The prevalence of Gender Dysphoria among patients aged over 15 years was calculated as 8.18 per 100,000, with an approximate sex ratio of 4:1 in favour of male-to-female patients. The number of people presenting for treatment is increasing. The current growth rate in the number of people who are presenting is 15% per annum, doubling every 5 years, with a GIRES publication suggesting prevalence may be 20 per 100,000 of the population and the annual incidence to be 2.6 per 100,000.

The Women and Equality Unit estimated in 2005 that there are currently 5,000 transsexual people in the UK (including those who are predicted to seek help in the future, those undergoing treatment, and those who have completed treatment for their gender issues).

The Charing Cross clinic received 775 new referrals in the year to mid 2008 and is reported to have 2,000 patients on its books at any one time. It is thought that this service receives the majority of UK patients. Referrals to other centres for this time includes 30 at Nottingham, 78 at Sheffield and 41 in Edinburgh. In total, the figures...
for adult treatment in 2008 for NHS centres is approximately 1,3647 (i.e. approximately 2 per 100,000). Ninety-nine NHS funded gender reassignment surgical procedures were reported to Ministers as being carried out in 2006, notably all of which were male to female transformations.

The Gender Recognition Panel reports over 2,350 requests since April 2005 of which 97% were successful, but many of these reflect a backlog relating to a change in legislation. An average of 25 new applications is currently received every month, equating to 300 per year.

From this data, estimating the conversion rate from the general population to referral to specialised services to full gender reassignment is problematic but using the above data it is estimated as approximately 18-51%. It should be noted that these are gross estimates.

Research-based prevalence estimates have previously been inconsistent with actual numbers of residents in one region (East Midlands) being referred to GIC services. The reasons for this are unknown but possible reasons are discussed in this document. It would therefore be unreliable to solely use these estimates to determine the level of service to be commissioned.

Of the current estimated trans population some may have received treatment already, some may never wish or seek assessment for treatment, and there will be a steady stream of new referrals (incident cases) presenting for treatment as young people reach adulthood. It is likely that the majority of the trans population will require specialised assessment at some stage in their life, especially as services become better established and as surgical procedures become more advanced. Following assessment, many will progress along the care pathway and it can be expected that a percentage of patients will progress to surgical intervention.

It is likely that demand may increase as the service becomes better established as described above, therefore it is recommended that these figures should be revised as more information becomes available and that services are commissioned at a level of 2.6/100,000. It should be noted that the majority of patients requesting specialised interventions are likely to be for male to female transitions, and that not all patients proceed to have a full package of care.

8. Evidence Base

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 reviewed journals.

This policy is based on a searches of key resources at two time-points:

- 2003. Using the terms ‘transsexualism’ and ‘sex reassignment’ in the following sources: Cochrane Library (2003, issue 2), MEDLINE, CINAHL, PsycInfo, EMBASE, BNI. This search was restricted to reviews and studies in English relating to the clinical and cost-effectiveness of sex reassignment in adults.
Studies primarily considering surgical techniques were excluded.

- 2009. Using search terms ‘transsexual/ism’; ‘gender dysphoria’; and ‘gender identity disorder’ in Bandolier, Evidence Based Reviews, NHS Evidence Specialist Collections, National Library of Guidelines, NICE Guidance, and Clinical Knowledge Summaries. The Cochrane database was searched using the above terms and this found an additional study from Spain which was discarded as it was not translated into English. Another new study was not readily obtainable (required a subscription). A decision was made that it was unlikely to change the commissioning policy therefore it was not pursued further.

8.1 Clinical effectiveness

Five reviews of effectiveness of sex reassignment surgery were identified in 2003, of which three reviewed evidence in male-to-female patients, two reviewed evidence in female-to-male patients, and one considered results overall. The findings of these reviews are summarised briefly below.

A technical brief in New Zealand aimed to identify subgroups of transsexual people for whom evidence of effectiveness of GRS exists. It identified one systematic review, one prospective controlled study, one retrospective cohort study and seven quasi-experimental studies. The review concluded:

- There is insufficient evidence to prove the efficacy of GRS for specific subgroups.
- The study designs of the included studies had methodological weaknesses.
- There is limited evidence that early rather than delayed GRS may be of greater benefit to carefully selected individuals.
- GRS may be of benefit to carefully assessed and selected transsexual people.

A report by the Wessex Institute, published in 1998 reviewed one prospective controlled study, numerous case studies and one cross-sectional study on GRS in male-to-female patients. It concluded that:

- A small number of people may experience important benefits from this technology.
- The evidence base is limited in that most studies are non-controlled and have not collected data prospectively. The overall conclusion of the DEC is that the intervention is ‘not proven’.
- Evidence on the incidence of adverse outcomes of GRS is limited due to high rates of losses to follow-up.
- Sex reassignment surgery should be available for carefully selected transsexual people, and standardised selection criteria should be used.
- There is no comparable alternative to surgery in those eligible for surgery.

A Canadian rapid review on vaginoplasty in male-to-female transsexuals in 1997 aimed to identify criteria for this type of surgery, and concluded that the Harry Benjamin standards of care set an appropriate framework for Canada. The review
includes a brief summary of evidence of effectiveness of vaginoplasty, and concludes that despite lack of standardised outcome measures, a high proportion of patients benefit from surgery.

A Canadian rapid review of phalloplasty in female-to-male transsexuals\textsuperscript{13} concluded that this remains a highly specialised procedure, requiring high levels of surgical expertise, and careful patient selection and follow-up. Limited data on outcome measures including patient satisfaction, physiological function and social integration, indicate that centres specialising in GRS achieve successful outcomes in a majority of patients.

A published literature review\textsuperscript{15} on gender reassignment surgery in 2005 concluded: “In the majority of studies a large number of transsexual people experience a successful outcome in terms of subjective well-being, cosmesis and sexual function. Like the conclusions made in previous reviews the magnitude of benefit and harm cannot be reliably estimated accurately using the current available evidence”.

A narrative review of the literature in an article by Gijs and Breuweys\textsuperscript{16} similarly concluded that ‘despite methodological shortcomings, GRS is an effective treatment for transsexualism and the only treatment that has been empirically evaluated’.

Two publications have reported the results of GRS (or sex confirmation surgery). For male to female surgery at Leicester, the satisfaction rate was 89\% at 8 weeks\textsuperscript{17}. For female to male surgery at London, the cosmetic appearance of the phallus was considered good in 68\% of patients\textsuperscript{18}.

A commissioned review of psychological and quality of life outcomes for GRS patients reviewed the literature and similarly found that ‘overall, it does seem that some people do benefit from GRS, but that some do have adverse outcomes’. However, because of the poor quality of the evidence base, it is difficult to reliably quantify these benefits and risks compared to other treatments\textsuperscript{19}.

8.2 Cost Effectiveness

The 2003 search strategy failed to find any published data on the cost-effectiveness of GRS. One of the reviews of effectiveness\textsuperscript{11} assesses the costs associated with GRS for male-to-female transsexuals, but lacks sufficient outcome data to summarise the results in terms of QALYs. The review concludes that psychiatric and pharmacological cost savings of up to £950 per patient per year may result from successful GRS. This calculation is based on a comparison with patients attending Gender Dysphoria Clinic four times a year and receiving anti-androgen and oestrogen therapy. Post-GRS costs are based on yearly attendance at GD clinic, with reduced oestrogen prescription.

The 2005 literature review\textsuperscript{15} considers cost effectiveness and notes the lack of available evidence. However, the study considers that such surgery is relatively cheap, provides successful outcomes for the majority of patients and is likely to reduce the need for psychiatric and hormonal treatments.

No comparison is made with costs for patients on the waiting list for GD services, but local experience indicates that some patients require intensive contact with community mental health services during their waiting time.
An audit carried out by the NHS Audit, Information and Analysis Unit in 2008 found that 98% of patients who had undergone gender reassignment surgery (647 responses) felt it was a positive or mainly positive experience and were happy with their outcomes. 49% felt that treatment for trans people at Gender Identity Clinics could be improved.

9. Rationale behind the policy statement

This policy sets out clear criteria for access to services to support patients with Gender Dysphoria, including the provision of gender reassignment surgery as directed by the Department of Health and legislation. It establishes an equitable framework for commissioning across England.

The policy complies with the Gender Recognition Act, 2004.

10. Mechanism for funding

To be confirmed

11. Audit Requirements

Service providers are required to provide data and information as part of their contractual obligations. The GIC and GRG services will evaluate their service at least annually and make the results of the evaluation available to commissioners.

12. Documents which have informed this policy


- This policy has been adapted from the Yorkshire & Humber and East Midlands Specialised Commissioning Group (SCG) policies.

13. Links to other policies

The mechanism operated by the NHS CB for funding requests outside of the clinical criteria in this policy is yet to be finalised

14. Date of Review

The review of this policy (date to be confirmed) will take into account the findings of the service evaluation and / or when further significant information becomes available, either from clinical trials, NICE or the Inter Collegiate Working Party for Standards of Care for People with Gender Dysphoria.

15. Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>GD</td>
<td>Gender Dysphoria</td>
</tr>
<tr>
<td>GD</td>
<td>Gender Identity Dysphoria</td>
</tr>
<tr>
<td>GRS</td>
<td>Gender Reassignment Surgery (also known as Gender Confirmation Surgery)</td>
</tr>
<tr>
<td>RLE</td>
<td>Real Life Experience</td>
</tr>
<tr>
<td>GIRES</td>
<td>Gender Identify Research and Education Society</td>
</tr>
</tbody>
</table>
References


Appendix A: Commissioned procedures

Gender reassignment involves a variety of therapeutic options, including surgical procedures and other clinical interventions summarised in Section 5. The following procedures, if appropriate for the individual undergoing gender reassignment, should be routinely commissioned.

Non-surgical interventions include:
- Diagnostic assessment
- Psychotherapy during all stages of active progression, including RLE
- Hormone therapy, including endocrinology assessment
- Speech and language therapy
- Support and advice on style
- Pre and post operative wound management support from a District Nurse with a specialist knowledge of gender reassignment.
- Routinely funded surgical interventions are different for trans-men and trans-women, as follows:

Surgical procedures for gender reassignment in trans-women are:
- Penectomy
- Orchiectomy
- Breast augmentation. 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
- Clitoroplasty
- Labiaplasty
- Donor site hair removal on surgeon’s recommendation

Surgical procedures for gender reassignment in trans-men are:
- Mastectomy
- Hysterectomy
- Vaginectomy
- Salpingo-oophorectomy
- Metoidoplasty or phalloplasty (metoidoplasty may be done in conjunction
with phalloplasty. NB. Phalloplasty is a multi-stage procedure and can include glans sculpting and placement of testicular and penile prosthesis.

- Urethroplasty
- Scrotoplasty.
- Implantation of penile prosthesis
- Donor site hair removal on surgeon’s recommendation.