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Interim service specification:

Specialist service for children and young people with gender dysphoria (phase 1 providers)

20 October 2022

1. Service name	INTERIM SERVICE SPECIFICATION Specialist Service for Children and Young People with Gender Dysphoria (Phase 1 Providers)
2. Service specification number	GROUP EDITING
3. Date published	TBN
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5.	**Summary**
	This is an interim service specification for 'Phase 1' services pending the establishment of new regional services working to a new national service specification. The Service will provide multidisciplinary assessment and care to children and young people and their families who will benefit from clinical support around the development of their gender identity, and interventions in response to a diagnosis of gender dysphoria, and consultation and support to local professionals. The Service will adopt an integrated approach to assessing and responding to an individual's needs in view of the range of co-presentations that may typically present in this patient cohort and the range of complexity relating to gender identity

development. The most appropriate clinical pathway for the child or young person will be determined through an integrated multidisciplinary team (MDT) approach.

Providers delivering The Service must be an established specialist tertiary paediatric unit with a strong partnership with mental health services; be an established academic centre with a strong track record of research in children and young people; and have robust safeguarding frameworks in place.

The clinical management approach should be open to exploring all developmentally appropriate options for children and young people who are experiencing gender incongruence, being mindful that this may be a transient phase, particularly for pre-pubertal children, and that there will be a range of pathways to support these children and young people and a range of outcomes.

Children and young people, their families/carers and the local services supporting them will engage with a care pathway which offers brief guidance and referral advice to professionals, initial consultation, ongoing consultation advice and liaison, and collaborative care with local services as well as specialist direct assessment and intervention.

Not all children and young people who present with issues of gender incongruence will require direct interaction with The Service; in many cases appropriate care can be provided locally with support and consultation by The Service. A significant proportion of children and young people who are concerned about or distressed by issues of gender incongruence, experience co-existing mental health, neuro-developmental and/or family or social complexities in their lives.

The relationship between these aspects and gender incongruence may not be readily apparent and will often require careful exploration.

The primary intervention for children and young people who are assessed as suitable for The Service is psychosocial (including psychoeducation) and psychological support and intervention; the main objective is to alleviate distress associated with gender dysphoria and promote the individual’s global functioning and wellbeing.

Where children and young people present with co-existing disorders or presentations, these will normally be addressed by the appropriate local service alongside this Service.

6. Population and/or geography to be served

6.1 Population Covered

The defined patient cohort is children and young people up to their 18th birthday who are:

- Registered with a General Practitioner in England or who are otherwise the commissioning responsibility of NHS England; AND
- Who were under the care of the Gender Identity Development Service at the Tavistock and Portman NHS Foundation Trust; OR
- Who were on the NHS waiting list for the Gender Identity Development Service managed by the Tavistock and Portman NHS Foundation Trust; OR
- Who are referred to The Service because gender dysphoria may be present

Terminology

This service specification will refer to **gender incongruence** and **gender dysphoria**. The terms are not interchangeable. Gender incongruence is where the individual's experience of their gender identity does not align with their biological sex. Gender dysphoria is present when the gender incongruence causes clinically significant levels of distress to the individual. Not all individuals with gender incongruence will experience dysphoria.

6.2 Minimum population size

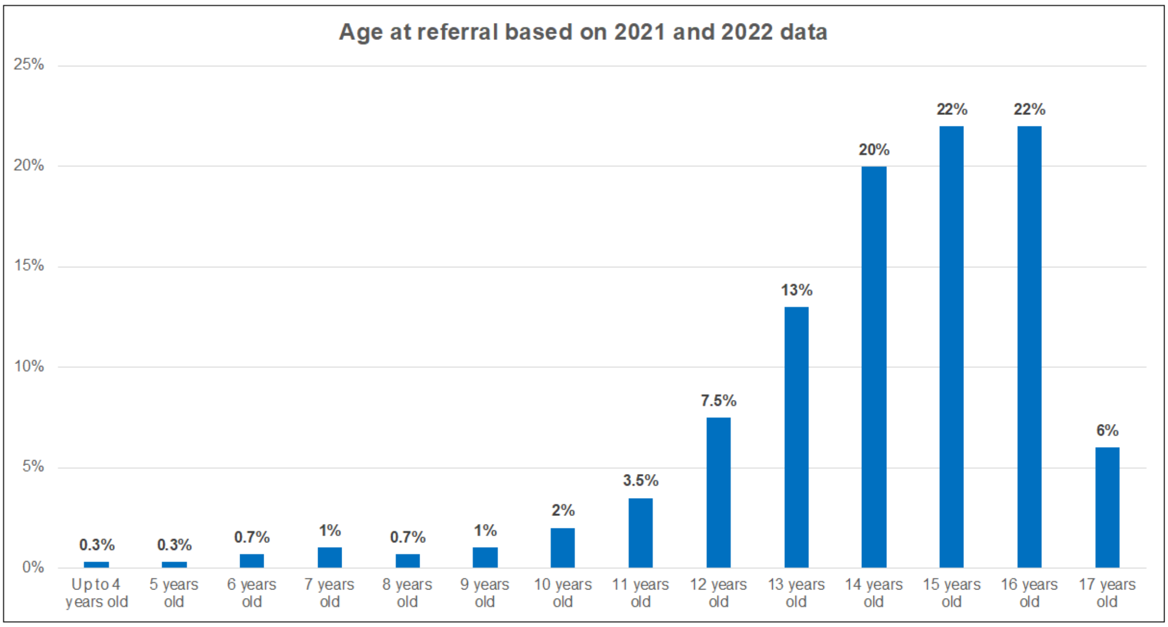
There is no official data on the number of people in England and Wales who present with a degree of gender variance. There is considerable variation in reported prevalence due to factors such as: variable data reporting by providers; differences in diagnostic thresholds applied and inconsistent terminology; the methodology and diagnostic classification used; and the year and country in which the studies took place.

The number of referrals is currently at 8.7 per 100,000 population per year in 2021/22 compared to 4 per 100,000 in 2020/21 and 4.5 per 100,000 in 2019/20.

The minimum population size for planning a service is estimated to be 5 million based upon current referral rates.

The current referral profile suggests that the majority of referrals will be of children and adolescents following the onset of puberty, and this will be reflected in the composition of the MDT and the clinic environment.

Table: Age at referral; percentage of eligible referrals; based on 2021 and 2022 data



Age at referral based on 2021 and 2022 data

Eligible Patient Cohort

The Service will assume a share of the responsibility for: the existing open caseload; and existing national waiting list of children and young people who are waiting to access a specialist gender dysphoria service. Although new referrals will be made to the Service it is recognised that it is unlikely that the interim Service will be able to offer direct assessment and / or intervention for patients who are new referrals, or to a large proportion of the existing waiting list, before these individuals are transferred to one of the new regional services as they become operational. Before that point, new referrals will be made to the Service as follows, allowing for a degree of individual flexibility, and a collaborative approach across commissioner and providers to ensure an appropriate and equitable distribution:

- Service provider/s in [North] will accept referrals from the following NHS regions: North East and Yorkshire; North West; Midlands

- Service provider/s in [London] will accept referrals from the following NHS regions: East of England; London; South West; South East

7. Service aims and outcomes

7.1 Service aims

Pending the establishment of a new national service specification that will describe the new regional service, this interim service specification describes an interim model for delivery that will:

- Provide initial guidance and referral advice to healthcare professionals
- Provide consultation, liaison and advice to referrers and the professional networks supporting children and young people
- Tailor an individual care plan following a standardised approach to assessment and diagnosis
- Provide psychoeducation and clinical interventions for children and young people with gender incongruence, including support for the family
- Provide advice in respect of and, referral to endocrine (hormone) intervention services
- Work with commissioners to regularly validate the waiting list confirming that individuals wish to be seen and that referral information is adequate to initiate care
- Screen and triage those on the waiting list and all new referrals to determine the most suitable clinical pathway
- Support local services in meeting the gender incongruence needs of children and young people where appropriate through professional liaison and collaboration,
- Through professional liaison and collaboration support local services meet the wider needs of children and young people (including mental health, neuro-developmental and safeguarding) and in risk mitigation
- Build and document the history and nature of gender incongruence

7.2 Outcomes

NHS Outcomes Framework Domains & Indicators

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

Service defined outcomes/outputs

- To deliver a plan defining demand split by regions and capacity and deliverable timeframes for first assessment within 3 months of service initiation.
- To provide continuing high-quality data:
  - A monthly SPC Chart on referrals by region, age, biological sex and aggregated
  - A monthly waiting list summary by region, age, biological sex and aggregated
  - Workforce plan including vacancy status
  - A monthly SPC Chart on first consultations by region, age, biological sex and aggregated
  - A monthly SPC Chart on work in progress (WIP) by region, age, biological sex and aggregated
  - A monthly SPC Chart on discharges by region, and aggregated
- Evidence of engagement with children, young people and families in design and review of service delivery
- Collection and reporting of children and young people’s experience of the service

7.3 Audit and evaluation

The Service will take part in continuous data collection, reporting and audit to support the NHS in developing a better understanding of the relevant patient cohorts and for the purpose of evaluating and enhancing the benefits and value of the service model.

NHS England will commission a third party to support a Learning Healthcare System working with designated providers to build standardised workflows, apply continuous improvement and to create a standard data set for service evaluation through audit and research.

8. Service description

8.1 Future Service model

The future service model will be developed while this interim service specification is used to initiate the service development. Providers are encouraged to adopt a range of service provision strategies within a structured framework to determine which approaches should be standardised into the workflow.

As a developing area of clinical practice, commissioned providers must actively participate in an ongoing programme of quality improvement to enable continued refinement of models of patient access, assessment, treatment delivery and follow up. This will include:

- Proactive and visible clinical leadership within each service
- Strong links with primary and community care services
- Enhanced data collection, reporting and audit
- Sharing of data and learning between commissioned providers and with national commissioners
- Identification, sharing and rapid adoption of good practice
- Contributing to the prioritisation and focus of national service and quality improvement programmes and initiatives
- Active participation in and delivery of quality improvement initiatives, both at provider level and through a co-ordinated national network approach
- Regular review of service level data at each stage of the pathway and service user feedback, with prompt delivery of any resulting actions for

improvement, including where inequalities in access or outcomes are identified

It is important that the opportunity is taken to gather further evidence on the safety, potential benefits and harms of Gonadotropin-Releasing Hormone Analogues in children and young people with gender dysphoria.

In addition, well-structured research programmes will be developed by the National Institute for Health Research and academic partners to include for example: epidemiology; prediction; the course of gender querying; and outcomes of psychological treatments to reduce distress. Commissioned centres must:

- Contribute to the identification of study and treatment evaluation priorities through participation in a national steering group
- Deliver research and evaluation programmes within the service and in partnership with other commissioned service providers
- Ensure an enhanced data set is collected from assessment through to follow up to facilitate research and evaluation, including for those whom, following assessment, it is determined would not benefit from intervention by the Service

Providers will build clear relationships with the range of services and skills across all Integrated Care Systems within the regional catchment.

8.2 Current Pathways

The provider will deliver The Service through an integrated MDT. An individual’s route will be determined by, among other things, the clarity, persistence and consistency of gender incongruence, the presence and impact of other clinical needs, and family and social context. A care plan should be tailored to the specific needs of the individual following careful therapeutic exploration; this plan may require a focus on supporting other clinical needs and risks with networked local services.

Screening, triage, and professional consultation & advice

The Service will screen individuals who are on the waiting list and new referrals. It will be important for The Service to identify individuals or sub-groups of individuals who are higher risk and this will necessitate consultations with the referrer and local professional network. The purpose of screening and triage is to:

Identify children and young people who are likely to meet the access criteria for The Service as defined by DSM-V (Appendix A)

- Identify children and young people who can be or need to be supported by local services including further support through professional consultation and advice from The Service, including those who meet the access criteria for The Service
- Identify additional mental health needs / neurodevelopmental needs / safeguarding risks that require local professional care planning and support
- Support clinical prioritisation for further specialist assessment and treatment

There are a range of different outcomes following the screening process including discharge with psychoeducation / signposting for family and professionals; professional consultation / advice or care navigation (with or without discharge); and direct assessment by The Service.

Overall clinical responsibility for a patient on the waiting list will remain with the referrer and the local professional network; recommendations are provided as general clinical management principles. A course of action will be agreed between The Service and the local professional network, which may include initial development of risk and care plan.

Referral pathway

A referral can be made by a healthcare professional, who must first make an initial enquiry of The Service prior to a request for professional consultation with The Service. Outcomes from the enquiry will include signposting or links to psycho-educational material, guidance on local referral and/or assessment options and/or a professional consultation meeting, (and who should attend this).

Referral to The Service for direct assessment and/or intervention will require a consultation meeting which is requested and attended by the relevant local secondary healthcare team and / or the GP. Following the professional consultation and agreement to accept a referral for assessment, The Service may advise or require the involvement of appropriate secondary healthcare as an element of the collaborative care plan with local services.

If, after professional consultation between a referrer and The Service, a child or young person is considered suitable for assessment by The Service, the referrer will be advised to proceed with the referral via a standardised referral form. The Service will agree with the referrer an initial formulation of the young person’s needs and risks and a local care plan to support the child or young person. The type and level of ongoing support to the local professional network from the Service while the child or young person is on the waiting list for assessment will be commensurate with the needs of the child or young person.

Where the outcome of the initial professional consultation between the Service and the referrer is that the patient does not meet the access criteria for The Service at this time, the patient will not be added to the waiting list – but the family and professional network will have been assisted to develop their formulation of the child or young person’s needs and a local care plan and will be advised of other resources for support that are appropriate for individual needs.

In some cases, a further consultation for referral may be appropriate following further local assessment and intervention and/or a process of watchful waiting.

Support to Local Professional Networks

Not all children and young people who meet the access criteria will need to be seen directly by The Service. A key intervention that will be delivered by The Service is the provision of consultation and active support to local professionals, including support in formulation of needs and risks and individualised care planning. The level and type of consultation offered to the professional network will be determined according to the individual needs of each case and through a process of clinical prioritisation.

In summary, the Service will:

- Offer referrers the opportunity for rapid access to make an initial enquiry to address gender incongruence concerns. This may include or lead to more substantive consultation, support and advice.
- Offer specialist support to the professional network in the development and formulation of individual care plans and risk management; this may include local health, social care and education professionals. In more complex cases this is likely to involve regular case consultation meetings and may involve joint consultation appointments with the family and referrer if that is necessary; in some cases this will involve alerting the local network to potential risks and unmet needs that had hitherto not been identified or addressed.
- Identify co-existing mental health, neuro-developmental or other conditions. The Service will formulate a collaborative care plan, co-produced with the local service/s identifying respective roles including local assessment and/or intervention support for co-existing conditions. The Service will not normally

undertake assessments or intervention for co-existing conditions which would be part of the local service's ordinary remit.
- Initiate agreed local protocols where child protection or safeguarding concerns are identified.
- Identify patients who require further specialist assessment and treatment by The Service and/or those who would benefit from further local monitoring and support. This will usually entail the agreeing of specific collaborative care arrangements between the local and the specialist Service clarifying their respective roles and responsibilities.

Standardised Assessment

All children and young people who are accepted for assessment and/or intervention by The Service will do so in the context of a collaborative care agreement with local secondary healthcare services who will identify a lead professional to co-ordinate local care and communication with The Service and the patient and their parents/carers.

All children and young people who are seen by The Service will receive a standardised comprehensive assessment that will identify and formulate a child or young person's needs including developmental history, history of gender incongruence and associated needs and risks. Assessments should be respectful of the experience of the child or young person and be developmentally informed.

Clinicians should remain open and explore the child or young person's experience and the range of support or treatment options and their implications that may best address their needs, including any specific needs of neurodiverse children and young people.

There is an increased prevalence of mental health needs in children and young people who present to gender identity services (such as depression; anxiety; risk-taking behaviours). There is also an increased prevalence of neurodevelopmental disorders including autistic spectrum disorder and ADHD though the cause of the relationship with gender identity is unclear.

A small but significant number of children and young people with very complex needs may also be looked after or may not live with their birth family and may require the active involvement from children's social care and/or expert social work advice. Assessment appointments will aim to identify coexisting needs and their impact on the child or young person, including gender incongruence.

A child or young person with mental health or neurodevelopmental needs and / or risk-taking behaviours that require additional assessment, intervention and support will be supported to access this through professional liaison and care navigation with local services including health, social care and education. The Service should confirm collaborative care arrangements for further assessment and treatment with local services through professional liaison.

Identification of coexisting conditions or needs will lead to an exploration of the relationship between the presentation and gender incongruence through an integrated approach by MDT members.

Assessments will focus on:

- Subjective sense of the child / young person's identity over time
- Their expression of gender identity across different contexts over time and different settings
- Their hopes and expectations and that of their family members/carers and their stance towards the child / young person's gender identification
- Developmental needs including cognitive functioning and capacity of the child / young person, and their understanding of gender
- Associated physical mental health and neurodevelopmental needs and their relationship with gender incongruence
- Risk including mental health, safeguarding including risk of vulnerability and exploitation and impact of any unregulated medications
- Psychosocial functioning and impact of the gender incongruence (eg on educational attendance and progress, or experience of bullying or harassment)
- With adolescents - psychosexual development and any sexual experiences
- Assessment of family functioning and quality of relationships within the family, including children and young people in care (or kinship care or who have been adopted) and the wider community
- Exploration of parent/carer and family views on the child or young person's gender identity journey and family support
- Peer relationships and wider social support
- Family's spiritual, cultural, or religious beliefs

The outcome of the initial assessment including formulation of needs and risks will be confirmed in writing with the GP and referrer and shared with the family. The outcome of assessment may either be discharge to local services, with support or consultation offered to the professional network as appropriate; and / or a referral to local services; or direct work with the child or young person.

Psychoeducation

Provision of or, signposting to psycho-education resources may be key outcomes of both an initial enquiry and a professional consultation meeting. Psycho-education material for children and young people, parents/carers and local professionals alike will include information on gender identity development including research evidence and how to support an exploratory approach that allows their child or young person time and opportunity to consider different options in a flexible and non-judgemental context.

Children, young people accepted for direct assessment and/or intervention, and their parents/carers, will receive further psycho-educational information, including the implications of medical treatment (and non-treatment). Parents, carers and families, (including siblings) will have the opportunity to access additional resources including facilitated group discussions with peers on a similar journey.

Direct work with pre-pubertal children, and their families

The clinical approach in regard to pre-pubertal children will reflect evidence that suggests that, while young people who are gender querying or who express gender incongruence may have started their journey as younger children, in most pre-pubertal children, gender incongruence does not persist into adolescence[1].

Generally, the approach will focus on a careful observation of how gender dysphoria develops as puberty approaches and is reached. The therapeutic approach for younger and pre-pubertal children is not directed at gender dysphoria itself but instead focused on other clinical presentations and needs, or familial/social circumstances that may impact on the child's psychological health and gender dysphoria.

The level of intervention will be commensurate to the individual's needs and may range from advice by The Service to the family and professional network where there are no concomitant issues, to more intensive clinical interventions that seek to address other clinical diagnoses delivered by local secondary services with support, advice and consultation by The Service.

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[1] This is the conclusion of the Endocrine Society's Clinical Practice Guidelines[1] that state "*combining all outcome studies to date, the gender dysphoria / gender incongruence of a minority of prepubertal children appears to persist in adolescence*"[1].

Psychological support and interventions provided directly by The Service will focus on children whose presentations are persistent and who have impaired functioning, with the aims of alleviating or preventing the onset of emotional problems, behavioural problems and social relationship problems, improving psychosocial health and global functioning. Support will be offered as part of the collaborative care agreement with local services and may be provided by the local and/or specialist service and, could be offered through individual / family work or group work.

In cases where a pre-pubertal child has effected, or is effecting, a social transition (or expresses a wish to effect a social transition) the clinical approach has to be mindful of the risks of an inappropriate gender transition and the difficulties that the child may experience in returning to the original gender role upon entering puberty if the gender incongruence does not persist into adolescence.

However, some children state that they want to make a social transition to their preferred gender role long before puberty, which means that increasing numbers of children may have made a partial or full social transition prior to the first attendance with The Service.

In summary, for pre-pubertal children the clinical approach and advice applied by The Service will be supportive and non-judgemental, balancing on a case-by-case basis a watchful approach overall with a more individualised approach in cases where the child’s level of global functioning may be maintained or improved through a carefully observed process of exploration of social transition. Medical interventions will not be considered at least until puberty has been reached (Tanner Stage 2).

Direct work with adolescents, and their families

Psychological support and interventions provided directly by The Service, including family therapy/work, will focus on alleviating or preventing the onset of emotional problems, behavioural problems and social relationship problems, improving psychosocial health and global functioning, while responding to co-existing needs and conditions.

Clinicians should remain open and explore the young person’s experience and the range of support or treatment options and their implications that may best address their needs, including any specific needs of neurodiverse children and young people. The overall aim is to reduce distress in the individual; support the development of positive self-image and self-esteem; promote the individual’s global functioning; facilitate understanding and acceptance within the family unit.

Co-existing mental/physical health, neurodevelopmental and/or wider needs will be addressed through an overall treatment plan and in partnership with local professional services.

Interventions with adolescents should be at a level commensurate with the needs of the individual. More intensive clinical interventions may be needed that seek to address other clinical diagnoses and will be delivered by local secondary services with support, advice and consultation by The Service.

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

- unstable or escalating mental health problems
- ongoing risk issues, and safeguarding issues
- concerns with regard to capacity to understand and consent
- family conflict about how to proceed
- inadequate support from the local network of agencies and services involved with the young person (where there are any concerns regarding mental health or social functioning).

Not all adolescents will want or benefit from social transition. The provision of approaches to support social transition may be considered in cases where:

- Gender dysphoria has been diagnosed, is consistent and persistent; AND
- Associated needs and risks have been considered and are being addressed or supported; AND
- The young person expresses a clear wish to affirm their gender transition and fully understands the implications of affirming a social transition (informed consent); AND
- The proposed clinical approach is necessary for the alleviation, or prevention of, clinically significant distress or impairment in social functioning in the individual.

In these cases the clinical approach will involve a focus on exploring or supporting (as appropriate to the individual) social transition through psychological support and interventions, family work/therapy and guidance for the local professional network.

Young people and their families will be supported in making difficult decisions regarding the expression of a gender role that is consistent with their gender identity, including the timing of changes to gender role and possible social transition.

The Service will aim to maintain a therapeutic relationship with young people and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a young person has already socially changed gender role prior to being seen by The Service.

Gonadotropin-Releasing Hormone Analogues (GnRHa) (puberty suppressants) and masculinising / feminising hormone drugs

Consistent with advice from the Cass Review highlighting the uncertainties surrounding the use of hormone treatments, NHS England is in the process of forming proposals for prospectively enrolling children and young people being considered for hormone treatment into a formal research programme with adequate follow up into adulthood, with a more immediate focus on the questions regarding GnRHa. On this basis NHS England will only commission GnRHa in the context of a formal research protocol. The research protocol will set out eligibility criteria for participation.

Prescribing from unregulated sources and unregulated providers

Children, young people and their families are strongly discouraged from sourcing GnRHa and masculinising / feminising hormone drugs from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies. In such cases The Service will make the child or young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of the drugs and will advise the GP to initiate local safeguarding protocols.

Should a child or young person access GnRHa from unregulated sources or unregulated providers The Service will not assume responsibility for prescribing recommendations nor will it enter into shared cared arrangements in these circumstances.

Where a child or young person has obtained masculinising / feminising hormones from an unregulated source (such as the internet) The Service will not accept clinical responsibility for management of the endocrine intervention.

Where a child or young person has been prescribed masculinising / feminising hormones by an unregulated provider outside of the eligibility and readiness criteria described in the current NHS clinical commissioning policy The Service will not accept clinical responsibility for management of the endocrine intervention.

Transition to adult services and discharge

The Service will provide support to young people up to their 18th birthday.

The Service will review the needs and progress of the young person in relation to their gender dysphoria and the goals of treatment and will step down or discharge their care to local primary care or secondary care services as appropriate.

For young people who have been seen by The Service and who are approaching their 18th birthday the Service will co-ordinate a transition and support plan with the professional network specific to the young person's needs. A referral may be made to an NHS-commissioned Gender Dysphoria Clinic from 17 years of age where the young person meets the access criteria.

Young people who are approaching 18 years and who, it is determined are unlikely to be seen by the Service before their 18th birthday, may continue to benefit from consultation and liaison support with their local healthcare services where appropriate and will be screened to identify the most appropriate treatment pathway for their needs.

A co-ordinated transfer to appropriate local adult services will be needed where complex presentations continue.

8.3 Essential Staff Groups

The key clinical leadership role will be through a medical consultant with significant experience in the developmental needs of children and adolescents.

The MDT will have (or have access to) the following competencies and experience (see also Appendix B). Practitioners will need access to clinical supervision across a range of clinical areas (eg, psychological, mental and physical health, safeguarding and gender identity development) to support their roles.

- Multi-agency working including provision of consultation, liaison and advice for complex cases, and care navigation
- Expertise in child safeguarding and assessment and management of risk-taking behaviours
- Childhood and adolescent development, including cognitive, social and sexual development; gender identity development and gender expression
- Paediatric medicine, including psychological health

- Child and adolescent mental health, including expertise in assessment and formulation, delivery of evidence based therapeutic interventions, trauma informed approaches; and family work/family therapy
- Neurodevelopment disorders including learning disability and autism spectrum conditions
- Gender incongruence; and gender dysphoria
- Expertise in sex development, and endocrine intervention
- Children and young people who may be Looked After or in Special Guardianship or who may be adopted.

8.4 Essential equipment and/or facilities

The provider must have in place premises that are appropriate to ensure effective delivery of the services described in this service specification; and in an age-appropriate environment that children and young people regard as safe and welcoming. Providers will be mindful that the majority of patients are likely to be of an age following the onset of puberty.

8.5 Interdependent Service Components – Links with other NHS services

The Service must be expert in working with a wide variety of agencies. It is expected that close working will be needed in particular with Children and Young People’s Mental Health Services, child health and neurodevelopment services, voluntary community services, education professionals, children’s social care and with general practitioners.

The Service should also be competent in their understanding of and close working with children and young people with social care needs – including adopted children and young people, and children in care, and in working with schools and colleges to facilitate wellbeing and full access for their education.

Collaborative care arrangements

Referrers, together with local healthcare services, will agree with The Service collaborative care arrangements particularly in relation to the young person’s mental health, neurodevelopmental needs and / or risk-taking behaviours. Local services including children and young people’s mental health services, paediatric healthcare services and local authorities will continue to provide the care that they would routinely offer young people and families as part of local or national commissioning arrangements across relevant care pathways. It is not the expectation that The Service will address these broader needs.

Collaborative care arrangements should be clarified through professional liaison and confirmed in writing with all stakeholders including the young person and parents/carers.

8.6 Additional requirements

The provider must have in place:

- A robust system of clinical governance that ensures, *inter alia*, all clinical staff are trained in assessing and meeting the health needs of children and young people including those on the waiting list, have access to clinical supervision, and are deemed competent to deliver the interventions as per their role; this will include a documented approach to safeguarding that is consistent with NICE guideline NG76[2].
- A robust system of corporate governance, including a nominated senior manager, that demonstrates effective management, guidance, oversight and accountability by the host organisation; and supported by experienced communications and engagement teams.
- Arrangements in place to ensure that the service delivers culturally appropriate and trauma informed care and support; individuals must be able to access services in a way that ensures their cultural, language and communication needs do not prevent them receiving the same quality of healthcare as others.
- Sufficient administrative and managerial support needed for efficient and timely delivery of services.
- Arrangements in place (including ongoing training) to ensure that all staff in public-facing roles have cultural sensitivity towards children and young people who may be gender diverse.
- Arrangements in place to ensure that service design and improvement is co-produced with experts by experience and promotes equality, diversity and

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[2] https://www.nice.org.uk/guidance/ng76/chapter/Recommendations#principles-for-working-with-children-young-people-parents-and-carers

	inclusion., This should include routine outcomes and experience monitoring and be able to demonstrate how improvement is achieved via means that are accessible, transparent and inclusive. • Arrangements in place to ensure that feedback, comments and complaints by individuals and their families are acknowledged investigated and responded to promptly; and that the means to complain are publicised and accessible.
8.7	**Commissioned providers** Providers delivering The Service must be an established specialist tertiary paediatric unit with strong links to mental health services and have established academic links. NHS England will establish a framework for a co-ordinated and collegiate approach across all of the new regional services - focusing initially on development of the model and then moving to issues of operational delivery, service development, improvement and audit. This approach will help to ensure continuity of provision for children and young people if they move across sub / regional boundaries. Providers will co-operate as part of a clinical network with other designated providers to support sharing of best practice, quality improvement and research processes and consistency against the service specification and model of care.
8.9	**Links to other key documents** This interim service specification supersedes service specification E13/S(HSS)/e Gender Identity Development Service for Children and Adolescents (2016) Other key documents: NHS England Service Specification: Gender Identity Services for Adults (Non-Surgical Interventions); 2019 as amended; 1719 NHS England Clinical Commissioning Policy Prescribing of Cross Sex Hormones as part of the Gender Identity Development Service; 2016 The Cass Review Interim Report, February 2022

	NHS England Statement: “Implementing the Recommendations of the Cass Review”, July 2022