NHS England

Guide to Consultation: Specialised Gender Identity Services for Adults

July 2017

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Guide to Consultation: Specialised Gender Identity Services for Adults

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Introduction

1. NHS England is holding a 12-week public consultation on proposals for new service specifications that, if adopted, describe how specialised gender identity services for adults will be commissioned and delivered in the future for the people of England. We want to hear from others including trans-people, patient groups, clinicians and professional bodies before making a final decision.

2. The final version of the service specifications will be used to inform a process of competitive procurement later in the 2017/18 year, and this will determine which organisations are best placed to provide specialist gender identity services for people in England in the future (the decisions on which organisations will provide specialist surgical services will also cover people living in Scotland. NHS Scotland will be undertaking a consultation process in August and September 2017 which will align with the NHS England consultation).

3. We have published two service specifications that should be read in conjunction with each other: a service specification that describes the proposals for how non-surgical interventions will be provided by Gender Identity Clinics; and a separate service specification that describes proposals for the service and interventions that will be delivered by designated surgical units.

4. An Equality and Inequalities Impact Assessment is attached as Appendix A.

5. The proposed service specifications have been developed by NHS England for the purpose of public consultation. In developing the documents for consultation we considered advice from a number of sources, including from trans people and campaign groups who have attended numerous engagement workshops; from the Clinical Reference Group for Gender Identity Services; from professional associations; and the findings and recommendations of the Women and Equality Select Committee inquiry on *Transgender Equality*.

6. The purpose of this consultation guide is to let you know how to respond to the consultation, and to raise particular issues for further discussion before final decisions are made; this includes considering elements of the proposed service specification where further work may be needed to explore the evidence which may (or may not) support the advice that has been offered to us, including advice from the Clinical Reference Group. The response form will also ask for your views on the content of sections of the service specifications generally. However, we do not wish to restrict your consideration of the proposals, and you are free to comment on any aspect of the proposed specifications.

Scope

7. During initial stakeholder engagement, some stakeholders requested that NHS England use the new service specifications to introduce to the NHS pathway of care certain surgical interventions that are not currently routinely commissioned by NHS England. These interventions include phonosurgery; augmentation

mammoplasty; facial feminisation surgery; lipoplasty; contouring, microdermabrasion and other cosmetic procedures. Also, NHS England does not currently routinely commission the reversal of previous gender reassignment surgical interventions that are requested by individuals who are satisfied with the surgical outcome at the time of discharge and become dissatisfied at having undergone the procedure at a later date.

8. However, the scope of the current exercise (i.e. consultation on a proposed service specification, and implementation of the eventual service specification for a prescribed specialised service) does not include the introduction of treatments or interventions that are not currently routinely commissioned by NHS England. Rather, a separate process exists for this purpose via the formation of a clinical commissioning policy proposition for each proposed intervention or treatment. It is for NHS England's Clinical Reference Group for Gender Identity Services to consider whether to submit proposals to NHS England for the routine commissioning of treatments or interventions that are not currently routinely commissioned.

9. Proposals to routinely commission new treatments or interventions must meet the requirements to be commissioned as a prescribed "specialised" service and therefore not appropriate for commissioning by Clinical Commissioning Groups. For proposals that meet those requirements, NHS England would consider whether to prioritise investment in the proposed intervention after taking advice from the Clinical Priorities Advisory Group. This group makes recommendations to NHS England on the relative prioritisation of all proposed interventions under consideration in each year's commissioning round based on a consideration of factors including patient benefit, the quality of the supporting evidence and the cost of adopting the proposal. Details of NHS England's process for forming proposals for clinical commissioning policies and the annual relative prioritisation process for specialised services (which was consulted upon in 2016) can be found here.

How to take part

10. Your response to consultation must be received by NHS England by **16 October 2017.** We encourage people to respond via the online survey. To request a hard copy of the consultation materials and feedback form please email england.scengagement@nhs.net or call 0113 824 9734.

11. Alternatively, you can send your response (whether on a response form, or as a letter) to:

    Jeremy Glyde
    NHS England
    Area 3A
    Skipton House
    80 London Road
    London
    SE1 6LH

    england.scengagement@nhs.net

12. Please let us know whether you are replying as an individual or whether your views represent those of an organisation. If you are replying on behalf of an organisation, please make it clear whom the organisation represents and, where appropriate, how the views of the members were canvassed.

13. Details of consultation events can be found on the NHS England website.

What happens after consultation?

14. All of the responses received will be analysed for the purpose of a summary report, and this report will be shared with stakeholders (we will not be responding to individual submissions). The Clinical Reference Group for Gender Identity Services will be asked to consider the report and to make final recommendations to NHS England on the proposed service specifications. NHS England's Specialised Commissioning Oversight Group will consider the recommendations of the Clinical Reference Group and, if appropriate, the Clinical Priorities Advisory Group, alongside the summary report and updated Equality Impact Assessment before making a final decision.

What do the proposals aim to improve?

15. We aim to establish a model of delivery that ensures that individuals who use specialised gender identity services receive high quality of care in terms of access, experience and outcomes; and a sustainable model for the future that has a focus on innovation and value in line with the ambitions of the NHS Five-Year Forward View. Moreover, we have heard from many trans-people that sometimes they feel that the NHS does not treat them with dignity and respect.

16. The Women and Equality Select Committee inquiry on *Transgender Equality* concluded that current service delivery is often characterised by inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery[1]. The outcome of our own engagement with stakeholders has affirmed those findings:

- There are no agreed quality and outcome measures; and there is only very limited long term outcome data; we have no accepted definition of 'quality
- Demand for services has increased significantly in recent years, far exceeding capacity; waiting times are excessively high and are routinely in breach of NHS Constitution requirements (in many cases over 52 weeks for a first appointment)
- There are workforce constraints that frustrate attempts to alleviate demand and capacity pressures
- Access to the range of available specialised interventions is inconsistent across current providers

[1] See also "Trans Research Review"; Equality and Human Rights Commission; 2009

- There is limited collaboration and sharing of best practice across the current providers
- There is significant variation in the frequency and number of appointments offered by the current providers
- The specialist service for gender variant young people and specialist adult services could be better aligned to ensure a patient centred approach to care
- Administrative processes in current providers are often poor, exacerbating long waiting times and missed appointments

Question: The proposed service specifications aim to address inconsistency in care quality, differing levels of access and out-dated service models. To what extent to you think the specifications achieve this?

Specific considerations and questions for respondents

Age of referral to Gender Identity Clinics

17. There is currently an inconsistent approach to the age of referral across the Gender Identity Clinics which leads to inequitable access arrangements and unnecessary delays in patient care. Some clinics accept a referral of a young person at 17 years and some accept referrals at 18 years (none of the clinics accept referrals below 17 years of age). We propose to adopt a consistent age threshold of 17 years for access to adult Gender Identity Clinics.

18. We also propose to bring greater clarity to the relationship between the Gender Identity Development Service for Children and Young People (GIDS)[2] and Adult Gender Identity Services. Currently, referrals may be made to the GIDS up to 18 years of age, which means that young people may be receiving very limited contact with the GIDS team before being transferred to Adult Gender Identity Services. With the support of the clinical team at GIDS we propose that in the future the GIDS would only accept new referrals of young people up to 16 years of age; this would mean that all young people of 17 years and above would be referred to Adult Gender Identity Services. This would help to prevent unnecessary delays in starting the adult pathway of care. However, we also propose that the GIDS team would be able to continue the care of young people up to 20 years of age in appropriate cases (such as those who have very complex or psychosocial issues that mean physical interventions are not yet appropriate, or where joint consultations with adult services may be appropriate as part of the process of transfer).

Question: It is proposed that in the future all young people who need to access a specialist gender identity service and who are aged 17 years and above will be referred to an adult Gender Identity Clinic. To what extent do you support or oppose this proposal?

[2] The GIDS is subject to a separate service specification that was agreed by NHS England in 2016 following public consultation.

Registration with a General Practice

19. The service specification for Non-Surgical Services proposes that the specialist Gender Identity Clinics for Adults will not accept referrals of individuals who are not registered with a General Practice, as the collaboration with a General Practitioner in providing healthcare support, prescribing drugs, monitoring of treatment and potential adverse effects is essential, particularly once the individual's contact with the specialist teams has reduced or has come to an end.

20. NHS England is minded to agree with the advice of the Clinical Reference Group for Gender Identity Services, which is that the requirement to be registered with a General Practice is appropriate as the collaboration with a General Practitioner in providing healthcare support, prescribing drugs, and the monitoring of treatment and potential adverse effects is essential, particularly once the individual's contact with the specialist teams has reduced or has come to an end.

Question: It is proposed that in the future the specialist Gender Identity Clinics for Adults will not accept referrals of individuals who are not registered with a General Practice. To what extent do you support or oppose this proposal?

Referrals for genital surgery

21. The service specifications propose that in the future an individual's referral for specialised genital reassignment surgery (for the purpose of alleviating gender dysphoria) must be made by one of the specialist Gender Identity Clinics for Adults that are designated by NHS England. This proposal reflects current commissioning arrangements, and has the support of the current designated surgical teams and the Clinical Reference Group for Gender Identity Services.

22. The proposal is based on advice that the expert multi-disciplinary teams in the designated specialist Gender Identity Clinics for Adults are best placed to consider an individual's suitability for surgery in the context of a consideration of the relevant medical, psychological, emotional and social issues in combination, and to assess and manage the likely range of risks in each case. The decision to refer an individual for specialised genital reassignment surgery should not be an isolated act. It should be the culmination of a process of assessment, diagnosis, review and evaluation of risks carefully designed around the needs of the individual. This proposal would mean that individuals could not be referred for specialised genital reassignment surgery by other NHS professionals, or by private clinics.

Question: It is proposed that only a designated specialist Gender Identity Clinic will be able to refer an individual for genital reassignment surgery. To what extent do you support or oppose this proposal?

Clinical opinions for genital reassignment interventions

23. NHS England's current commissioning protocol for gender identity services stipulates that a decision to offer genital reassignment surgery must involve two clinical opinions and that at least one of the opinions should be given by a Registered Medical Practitioner.

24. The proposed service specifications retain the requirement for at least one medical opinion to support a referral for genital surgery. This is because a decision about an individual's suitability for surgical interventions to alleviate gender dysphoria requires careful assessment and support from a specialist multi-disciplinary team, taking into account medical, psychological, emotional and social issues in combination. As such, and given the potential range of complexities that may be experienced by individuals on the NHS pathway of care and the potential treatments available, we propose that referrals to the specialist surgical team should be considered and endorsed by a team of experts that includes at least one medical opinion. This would be consistent with the proposed requirement elsewhere in the service specification that the referral letter for genital surgery must always include information from a Registered Medical Practitioner about past and current hormone therapy.

25. The Clinical Reference Group for Gender Identity Services has suggested an alternative proposal - that in the future, there should be no requirement for a Registered Medical Practitioner to give an opinion for genital surgery on the grounds that readiness for surgery can be appropriately assessed by the surgeon once the patient has been referred into the surgical unit. NHS England has asked the Clinical Reference Group to submit details of its alternative proposal as part of this consultation, with reference to the available evidence in support.

    Question: It is proposed that in the future a decision to refer an individual for specialist genital reassignment surgery must be supported by a Registered Medical Practitioner. To what extent do you support or oppose this proposal?

Equality and Inequalities Impact Assessment

26. NHS England wants to make sure we understand how different people will be affected by our proposals so that Gender Identity services are appropriate and accessible to everyone who needs them. In particular we have considered the following 'protected characteristics': age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; ethnicity; religion or belief; sex; and sexual orientation. Please see Appendix A for the Equality and Inequalities Impact Assessment.

    Question: We have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

    Question: Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

Prescribing arrangements

27. Currently, the specialist gender identity team assesses an individual's suitability for hormone treatment (with respect to appropriateness for treatment of gender dysphoria) and then makes a recommendation to the individual's General Practitioner, who is asked to accept responsibility for prescribing and administering the medicine (and to perform standard pre-treatment physical monitoring and laboratory investigations). The current arrangements are supported by guidance from the General Medical Council[3].

28. The British Medical Association's General Practitioners Committee has asked us to explore possible alternative models that fulfil the needs of patients, as it feels that the current common practice is not clearly defined and does not provide adequate support for prescribing practitioners.

29. In the table below we describe four options for prescribing arrangements with positive and negative factors for each:
    A. The patient's own general practice remains responsible for prescribing, on the recommendation of the specialist team (current arrangements)
    B. Specialist team is responsible for issuing the first prescription; the patient's own general practice will be responsible for issuing subsequent prescriptions
    C. Specialist team is responsible for issuing prescriptions for around one year (or until the patient's endocrine treatment is stabilised); the patient's own general practice will be responsible for continuing to issue prescriptions after this time
    D. A new role will be developed called "GPs with a Special Interest in Gender Dysphoria". The aim will be to establish a specialist GP in each local area (either at Clinical Commissioning Group level; or Sustainability and Transformation Partnership level; or equivalent). The specialist GP will issue prescriptions for all relevant patients in that area on the recommendation of the specialist team

Question: Which option for future prescribing arrangements do you most prefer?

Question: Can you suggest any alternative prescribing arrangements?

[3] "Advice for Doctors Treating Trans Patients"; General Medical Council; 2016

Options for prescribing arrangements

	Option	Summary of proposal	Arguments for	Arguments against
A	The patient's own GP remains responsible for prescribing, on the recommendation of the specialist team	The specialist team will ask GP to: • Perform pre-treatment physical monitoring and laboratory investigations • Initiate and prescribe medication(s) for the treatment of gender dysphoria; these will typically be estradiol and testosterone preparations and gonadotropin releasing hormone analogies • Ask GP to perform post-initiation physical monitoring and laboratory investigations, and give clear and detailed instructions regarding medication dose adjustment, to achieve and stabilise testosterone and estradiol levels within treatment target ranges; the specialist Gender Identity Service will retain responsibility for advising on medication use and dose adjustment until testosterone and estradiol levels are stable within treatment target ranges	• Similar to the current arrangements for the majority of patients • Convenient for the patient • Hormone treatment is managed by the GP alongside the patient's general healthcare needs (holistic approach to care) • GP is supported by the specialist team when this is needed • No additional resource needed to establish these arrangements • Supported by General Medical Council advice	• A small but significant and increasing proportion of GPs do not feel able to accept responsibility for prescribing; as such a small but significant and increasing proportion of patients are unable to get the services described in option A • This arrangement differs from prescribing practice in many other secondary and tertiary care services, particularly when prescribing for 'off label' indications • Additional primary care training and service development may be required

		• Provide long-term physical monitoring and laboratory investigations, and medication dose adjustment, to maintain testosterone and estradiol levels within treatment target ranges (following stabilisation after initiation and then continuing lifelong thereafter) The specialist team will be available to respond to enquiries and requests for advice from GPs in a timely manner		
B	Specialist team is responsible for issuing the first prescription; the patient's general practice will be responsible for issuing subsequent prescriptions	The specialist tem will: • Arrange pre-treatment physical monitoring and laboratory investigations • Initiate treatment by issuing the first prescription for medication(s) for the treatment of gender dysphoria; these will typically be estradiol and testosterone preparations and gonadotropin releasing hormone analogues • Ask GP to issue all subsequent prescriptions for medication(s) for the treatment of gender dysphoria, giving clear and detailed instructions regarding	• May be more convenient to patient than option A, as there is no delay in starting treatment (increases compliance with national waiting time standards) • GPs who are reluctant to issue the first prescription may be more content with this arrangement, as it is similar to "initiation" prescribing practice in many other secondary and tertiary care services, particularly when prescribing for 'off label' indications	• Some GPs may not feel able to take responsibility for providing further prescriptions, risking the abrupt cessation of endocrine treatment, which risks psychological harm to the patient • Requires changes to current clinical practice in the specialist teams; a prescribing clinician will need to be available at the specialist consultation when the decision to treat is made; specialist teams will need to

		preparations to be used • Be available to respond to enquiries and requests for advice from GPs in a timely manner • Ask GP to perform post-initiation physical monitoring and laboratory investigations, and give clear and detailed instructions regarding medication dose adjustment, to achieve and stabilise testosterone and estradiol levels within treatment target ranges; specialist Gender Identity Service will retain responsibility for advising on medication use and dose adjustment until testosterone and estradiol levels are stable within treatment target ranges • Ask GP to provide long-term physical monitoring and laboratory investigations, and medication dose adjustment, to maintain testosterone and estradiol levels within treatment target ranges (following stabilisation after initiation and then continuing lifelong thereafter)	• Hormone treatment is managed by the GP alongside the patient's general healthcare needs (holistic approach to care) • The specialist is responsible for and has access to the investigations required to safely recommend starting treatment • GP is supported by the specialist team when this is needed • Supported by General Medical Council advice	ensure that decisions are made and hormone treatment starts within 18 weeks of referral in line with national waiting time guidance • Will incur some additional costs to implement these arrangements in the specialist teams (cost associated with prescribing process, and of medications and their administration) • Additional primary care training and service development may be required • The current Gender Identity Clinics (that are hosted by mental health trusts) do not currently have the infrastructure to administer injections (pharmacy; sharps disposal; resources to manage serious drug reactions, including anaphylaxis)

C	Specialist team is responsible for issuing prescriptions for around one year (or until the patient's endocrine treatment is stabilised); the patient's own general practice will be responsible for continuing to issue prescriptions after this time	Specialist team will: • Arrange pre-treatment physical monitoring and laboratory investigations • Initiate treatment by issuing the first prescription for medication(s) for the treatment of gender dysphoria; these will typically be estradiol and testosterone preparations and gonadotropin releasing hormone analogues • Arrange post-initiation physical monitoring and laboratory investigations, and contact patient to recommend any dose adjustment; at the same time, communicate such recommendations to the patient's GP • Provide further prescriptions for medication(s) for the treatment of gender dysphoria for a fixed period of around 12 months or until the patient's endocrine treatment is stabilised (relevant hormone levels within treatment target ranges for two consecutive monitoring blood tests at an interval of at least one month), whichever is shorter	• Ensures that all patients receive hormone treatment for around the first year • Reduces the risk of delay in commencing hormone treatment • The specialist is responsible for and has access to the investigations required to safely recommend starting treatment • Physical monitoring is the responsibility of the specialist team for around the first year • GPs may be more content with this arrangement as it is similar to "initiation" prescribing practice in many other secondary and tertiary care services, particularly when prescribing for 'off label' indications • Supported by General Medical Council advice	• Will be less convenient for most patients as it involves more visits to a distant Gender Identity Clinic; may be more impact to certain groups (e.g. people with a disability; older people) • Some GPs may still not feel able to accept responsibility for providing prescriptions after around one year • Will require extensive new resource and risks increasing the capacity pressure in the Gender Identity Clinics; requires clinical staff to request, interpret and act upon blood test and physical monitoring results; requires prescribers; requires establishment of a safe and effective 'repeat prescribing system', with associated governance structures • Current Gender Identity Clinics do not have access to laboratory services local to patients' homes; some laboratory tests must be taken early morning and fasting, or at a specific time

		• Arrange subsequent physical monitoring and laboratory investigations, and contact patient to recommend any dose adjustment; at the same time, communicate such recommendations to the patient's GP • After this period, ask GP to issue all subsequent prescriptions for medication(s) for the treatment of gender dysphoria, giving clear and detailed instructions regarding preparations to be used • Be available to respond to enquiries and requests for advice from GPs in a timely manner • Specialist Gender Identity Service will retain responsibility for advising on medication use and dose adjustment until testosterone and estradiol levels are stable within treatment target ranges • Ask GP to provide long-term (following stabilisation after initiation and then continuing lifelong thereafter) physical monitoring and laboratory investigations, and medication		after medication administration • The current Gender Identity Clinics (that are hosted by mental health trusts) do not currently have the infrastructure to administer injections (pharmacy; sharps disposal; resources to manage serious drug reactions, including anaphylaxis) • Additional primary care training and service development may be required

		dose adjustment, to maintain testosterone and estradiol levels within treatment target ranges.		
D	A new role will be developed called "GPs with a Special Interest in Gender Dysphoria". The aim will be to establish a specialist GP at a local area level. The specialist GP will issue prescriptions for all relevant patients in that area on the recommendation of the specialist team	GPs with a special interest in Gender Identity Medicine will work in collaboration with specialist Gender Identity Services, as part of their clinical network, to provide the following services for patients of their own and of other GPs in their locality (responsibility for provision of other primary care services is retained by the patient's usual GP): • Arrange pre-treatment physical monitoring and laboratory investigations • Initiate and issue prescriptions for medication(s) for the treatment of gender dysphoria described in the treatment plan provided by the specialist Gender Identity Services clinician; these will typically be estradiol and testosterone preparations and gonadotropin releasing hormone analogies • Perform post-initiation physical monitoring and laboratory investigations, and give clear and detailed instructions	• Retains responsibility for prescribing in primary care and will be more convenient to more patients than option C as additional travel is limited to their local area • Enhanced governance arrangements for prescribing and administering medications • Develops local expertise; specialist GPs may, in the future and as they become more experienced, be able to take on more of the clinical services currently provided through the Gender Identity Clinics (if resourced to do so) • GPs in the area will experientially learn about trans health care and endocrine management; learning will be locally delivered and more relevant to local circumstances • The specialist GPs could provide a service for bridging prescriptions prior to	• Will be less convenient to more patients than options A and B; they will have to travel to a different GP practice for hormone treatments; may be more impact to certain groups (e.g. people with a disability; older people) • A less holistic model of care; it separates a consideration of the patient's general healthcare needs from the hormone treatment • Risks an inconsistent and inequitable approach to care if a GP willing to develop as a specialist cannot be found for every locality • Would require additional resource to implement in primary care (including training, payment and resource for the specialist GP) • May need more than one specialist GP in a particular locality in view of population size and case mix

		regarding medication dose adjustment, to achieve and stabilise testosterone and estradiol levels within treatment target ranges; specialist GPs will retain responsibility for advising on medication use and dose adjustment until testosterone and estradiol levels are stable within treatment target ranges or for twelve months are initiation, whichever is the longer • Specialist Gender Identity Service will be available to respond to enquiries and requests for advice from specialist GPs in a timely manner • Specialist GPs will inform specialist Gender Identity Service of patient's progress and eventual return of patient to their usual GP's care • The patient's usual GP will be asked to provide long-term prescribing of medication(s) for the treatment of gender dysphoria, physical monitoring and laboratory investigations, and medication dose adjustment to maintain testosterone and estradiol levels within treatment	specialist consultations where these are appropriate. • Supported by General Medical Council advice	• Succession planning would be an issue (i.e. plans for alternative arrangements if a specialist GP left the locality or stopped this work)

		target ranges; the specialist GP's direct involvement in patients care ceases at this point, although they remain available to offer advice to local GPs • Specialist GPs may act as a local 'champion' for trans healthcare and advise GPs and other clinicians in their locality on best practice in this field; assist other GPs in their locality to acquire appropriate knowledge, skills and cultural sensitivity in trans healthcare		

Appendix A - Equality and Inequalities Impact Assessment

1. There are legal duties on NHS England to have due regard to the promotion of equality and the reduction of health inequalities in the process for the formation of proposed service specifications for specialised services.

2. This Equality Impact Assessment (EIA) has been prepared in regard to the proposed service specifications for Gender Identity Services for Adults and has been informed by the views of stakeholders at various workshops and engagement events; and by the findings and recommendations of the Women and Equality Select Committee inquiry on *Transgender Equality* (2016). This EIA has been published alongside the proposed service specifications during a period of public consultation so that the views of respondents to the EIA can be considered when making a final decision on the content of the service specifications. The EIA should be read alongside the proposed service specifications and guide to consultation.

3. An EIA is not an end in itself. It exists to enable NHS England to discharge its public sector duty to have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by the Equality Act 2010; to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and to foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

4. The EIA should also assist NHS England in having regard to the need to reduce inequalities between individuals with respect to their ability to access health services, and to reduce inequalities between individuals with respect to the outcomes achieved for them.

5. The EIA will give careful consideration to who is at risk of suffering discrimination from NHS England's eventual decision, what form that discrimination could take and the impacts to people with relevant protected characteristics.

6. The fact that a service specification, if adopted, would benefit a specific group does not in itself provide evidence of eliminating unlawful discrimination, advancing equality of opportunity or fostering good relations. There should be no inference that a proposed service specification would promote equality solely on the grounds that, if adopted, it would benefit a specific cohort of people.

Summary of the duty to comply with the Equality Act ("the Act")

7. NHS England should understand the potential impact of adoption of a service specification on people with characteristics that have been given protection under the Act, especially in relation to their health outcomes. The duty applies to the "exercise of functions" by NHS England. This includes any decision made, and in the development of specification. Having "due regard" to the duty involves considering the aims of the duty in a way that is proportionate to the issue at hand reflecting on the potential impact that the proposed specification may have on

NHS England's to comply with the duty and identifying ways to mitigate or avoid any negative impacts.

8. This means that NHS England has legal obligations to have due regard to the need to:
    - Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
    - Advance equality of opportunity between people who share a protected characteristic and those who do not
    - Foster good relations between people who share a protected characteristic and those who do not.

9. These are often referred to as the three aims of the general equality duty and apply to the following protected characteristics:
    - Age
    - Disability
    - Sex
    - Gender reassignment
    - Pregnancy and maternity
    - Race
    - Religion or belief
    - Sexual Orientation
    - Marriage and Civil partnership (but only in regards to the first aim - eliminating discrimination and harassment)

10. In view of the nature and impact of adoption of a service specification this EIA will describe whether positive and negative impacts (for example, inclusion and exclusion criteria) can be justified with reference to the available clinical evidence where this exists.

Summary of the duty to comply with the NHS Act 2006 as amended by Health and Social Care Act 2012 ("the 2006 Act") - reducing health inequalities

11. NHS England must
    - Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s13G)
    - Exercise its functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where it considers that this would improve quality and reduce inequalities in access to those services or the outcomes achieved (s.13N)
    - The duty to “have regard to the need to reduce” means health inequalities must be properly and seriously taken into account when making decisions or exercising functions, including balancing that need against any countervailing factors.

12. The 2006 Act does not define a list of groups impacted by the duties. Any group experiencing health inequalities is covered. The duties in this regard therefore take a general population approach.

A consideration of the impact to people with the Protected Characteristics

13. The following paragraphs consider what impact (negative and positive) there may be to people with the protected characteristics should NHS England decide to adopt the proposed service specifications.

Gender reassignment (people with a non-binary gender identity)

14. To be protected from discrimination by virtue of gender reassignment, the individual does not need to have undergone any specific treatment or medical intervention, and does not need to identify with either a male or female identity.

15. The proposed service specifications respond to concerns expressed by some stakeholders during initial engagement that individuals who do not have a binary gender identity often have more difficulty in accessing specialist gender identity services. In recognition of the diversity of gender presentation (in that not everyone identifies as having either of the most common 'binary' gender identities) the service specifications make clear that all individuals referred to a gender identity service may exercise full personal autonomy in respect of their gender identity and presentation; and that they must have equitable access to the range of interventions described in this service specifications.

Gender reassignment (reparative therapy)

16. The proposed service specifications require Providers not to deliver, promote or refer individuals to any form of reparative therapy, reflecting the national *Memorandum of Understanding on Conversion Therapy in the UK*, of which NHS England is a joint signatory.

Gender reassignment (cultural awareness)

17. Initial engagement with stakeholders has highlighted a common concern, which is the need to address the lack of cultural awareness in the wider NHS that can often act as a barrier to access for trans people, and in some cases discrimination. This was also a recommendation of the Women and Equality Select Committee inquiry on *Transgender Equality* in 2016.

18. The problems can range from ignorance amongst front line staff about general issues (such as the correct use of pronouns) to more serious problems that can cause extreme distress to trans people and that raise concerns about safety and quality (such as hospitals placing trans people on wrong sex wards; and the exclusion of trans people from screening programmes).

19. Addressing these issues of concern would extend beyond NHS England's limited role as direct commissioner of prescribed specialised services, and thus beyond the

scope of the proposed service specifications. Nonetheless, NHS England will undertake an initial scoping and feasibility study (in partnership with other stakeholders) that will explore how these concerns can be most effectively addressed. This will, in the first instance, focus on certain non-specialised services that are described in NHS England's service specification as forming part of the NHS pathway of care (such as gynaecological services; and voice and communication services); and the outcome of the project will be used to inform consideration of wider application to NHS services generally.

Age (access to services)

20. Neither NHS England's current interim commissioning protocol for gender identity services nor the Good Practice *Guidelines* for the *Assessment and Treatment of Adults with Gender Dysphoria*[4] stipulate an age criterion for accessing Adult Gender Identity Services. This has led to inconsistent access criteria across Gender Identity Clinics; some clinics do not accept referrals until 18 years of age while other clinics accept referrals from 17 years of age. Both of the service specifications propose that in the future Gender Identity Clinics (and surgical units) for Adults will accept referrals of individuals from 17 years of age. A consistent age criterion across all designated clinics will benefit gender variant young people as it will bring equitable access arrangements, and will reduce unnecessary delays in offering first appointments.

21. The proposed age threshold of 17 years will not prejudice younger gender variant people, who are able to access a separate specialised service commissioned by NHS England – the Gender Identity Development Service for Children and Young People (delivered jointly by the Tavistock and Portman NHS Foundation Trust; Leeds Teaching Hospitals NHS Trust; and University College of London Hospitals NHS Foundation Trust). The proposed service specification for Non-Surgical Interventions emphasises the importance of collaboration between adult services and the young people' service to achieve a well-planned, timely transfer that has a focus on the particular needs of the individual.

Age (older people)

22. During initial engagement, some stakeholders spoke of a perception that Gender Identity Clinics had implemented a policy of denying access to older trans people. In response to these concerns both of the proposed service specifications stipulate that there is no upper age threshold for accessing either surgical or non-surgical interventions. Both of the proposed service specifications read that "equity of access and quality of care will be provided to all who need it regardless of age" (subject to the proposed age threshold described in paragraph 20).

Disability (individuals with significant medical or mental health concerns)

23. The service specification for Non-Surgical Services proposes that referrals will not be accepted of individuals with acute physical or mental health problems that may affect capacity or the individual's ability to engage in the assessment process.

[4] Royal College of Psychiatrists; 2013

24. Therefore, adoption of the proposed service specifications would delay or prevent access to specialised gender identity services for individuals with a significant physical or mental health concern which could be regarded as a "disability" under the provisions of the Act. NHS England is of the view that the proposed service specifications do not discriminate in this regard, and that the acceptance criteria are objectively justified on clinical grounds. NHS England agrees with the advice of the Clinical Reference Group for Gender Identity Services - that referrals should not be accepted of individuals with acute physical or mental health problems that may affect the individual's ability to engage in the assessment process; and that if significant medical or mental health concerns are present, they must be reasonably well controlled before surgery or other interventions are offered.

Disability (individuals with communication difficulties)

25. Some individuals may have a disability (as defined by the Act) that prevents or hinders the effective exchange of verbal communication between the individual and the clinician, and this could frustrate the process of assessment, diagnosis and treatments for gender dysphoria. This may include people with co-existing complex physical or mental health problems, communication difficulties or learning difficulties.

26. In recognition that some individuals may share a protected characteristic on this basis the proposed service specifications acknowledge that some individuals have complex or additional needs that may need to be met through an increased level of contact, such as additional assessment consultations and the provision of additional support services. Also, more generally, both of the proposed service specifications make clear that an assessment and resulting treatment plan must be tailored around the needs of the specific individual, which includes having regard to any disability or other health issue.

Disability (individuals who are overweight)

27. A person is considered overweight if they have a body mass index (BMI) between 25 and 29, and obese with a BMI of 30 and above. In England, 24.8% of adults are obese[5]. Case law has established that people with obesity may, in some circumstances, be considered to have a 'disability' under the Act.

28. The proposed service specification for surgical services describes a consensus opinion amongst surgeons who were consulted by the Clinical Reference Group for Gender Identity Services that patients who are obese and who have a BMI of 40 or more (masculinising chest surgery) or 30 or more (genital surgery) should lose weight before having genital surgery. Individualised discussions may take place with the surgeon, who may decide to proceed with surgery on an obese person once risk has been assessed, but the impact of this proposed provision will be that obese people may be less likely to access surgical interventions on the trans pathway of care until they lower their BMI.

29. NHS England has considered whether this provision discriminates against obese people, but agrees with the advice of the Clinical Reference Group that this is a clinically justified consideration because a patient being significantly overweight

[5] "Statistics on Obesity, Physical Activity and Diet"; Health and Social Care Information Centre; 2015

increases their risk of complications during the operation and may compromise the outcome of their surgery.

Disability (individuals with HIV)

30. People with HIV are considered to have a disability under the Act.

31. Literature[6] suggests that un-met trans-healthcare is a contributing factor to the increased disproportionate risk of acquiring HIV in the trans-population. Adoption of the proposed service specifications would therefore have a positive impact on trans people with HIV as it should ensure consistent access to the range of available interventions, and offer more timely assessment, diagnosis and treatment.

Disability (individuals who misuse substances)

32. The proposed service specifications describe that an individual's history of substance misuse is a relevant consideration in the process of assessment and diagnosis, and in assessing suitability for treatment interventions. Individuals with addiction to non–prescribed drugs or alcohol are not considered 'disabled' under the Act and do not share this protected characteristic. In any event, NHS England agrees with the advice of the Clinical Reference Group for Gender Identity Services that this is a clinically justified consideration.

Disability and / or Age (individuals who may have difficulty travelling)

33. Some individuals may have a disability that makes it more difficult for them to travel any distance; and some people may also have more difficulty travelling by virtue of their age. By their very nature, specialised gender identity services (like all specialised services) cannot be located in every locality as they need to be delivered by professional staff with the appropriate skills, experience and expertise. The proposed service specifications aim to achieve a balance between convenience for the individual where this is appropriate (for example, by proposing a limited number of two assessment appointments for most individuals; and the possibility of remote appointments such as video and web consultations) with the need for appropriately rigorous processes for clinical decision making and review at face-to-face appointments that ensures that the individual is provided with safe and effective treatment that is appropriate to their individual circumstances throughout the duration of their care on the NHS pathway.

34. For these reasons, NHS England has concluded that the proposed service specifications do not unfairly discriminate against people who may have more difficulty travelling distances (though the planned process of national procurement will explore the extent to which more equitable geographical access is possible in the future).

[6] Winter et al, Transgender People: Health at the Margins of Society; June 2016

35. Notwithstanding this, we have highlighted in the guide to consultation where options for future prescribing arrangements may have an impact to people who have more difficulty in travelling. The options are:
    - Option C, in which the prescription would be provided by the specialist gender identity clinics for around the first year of treatment, after which responsibility transfers to the individual's general practice; and
    - Option D, in which the prescription would be provided by a General Practitioner with a Specialist Interest in Gender Dysphoria, who (it is envisaged) would be located in relative proximity to the individual's home but who may be located further than the individual's own general practice.

Sex (surgical procedures that are not routinely commissioned)

36. During initial stakeholder engagement, some stakeholders raised a concern that the list of surgical interventions that are not currently routinely commissioned by NHS England is discriminatory against trans-women because they relate more to the male-to-female pathway of care.

37. The relevant surgical procedures include phonosurgery; augmentation mammoplasty; facial feminisation surgery (including thyroid chondroplasty and rhinoplasty); lipoplasty; contouring, microdermabrasion and other cosmetic procedures; and body hair removal (other than donor site for surgery).

38. Also, NHS England does not routinely commission the reversal of previous gender reassignment surgical interventions that are requested by individuals who are satisfied with the surgical outcome at the time of discharge and become dissatisfied at having undergone the procedure at a later date.

39. The scope of the current exercise (i.e. consultation on a proposed service specification, and implementation of the eventual service specification for a prescribed specialised service) does not include the introduction of treatments or interventions that are not currently routinely commissioned by NHS England. A separate process exists for this purpose via the formation of a clinical commissioning policy proposition for each proposed intervention or treatment. It is for NHS England's Clinical Reference Group for Gender Identity Services to consider whether to submit proposals to NHS England for the routine commissioning of treatments or interventions that are not currently routinely commissioned.

40. Proposals to routinely commission new treatments or interventions must meet the requirements to be commissioned as a prescribed "specialised" service and therefore not appropriate for local commissioning by an individual's Clinical Commissioning Group. For proposals that meet those requirements, NHS England would consider whether to prioritise investment in the proposed intervention after taking advice from the Clinical Priorities Advisory Group. This group makes recommendations to NHS England on the relative prioritisation of all proposed interventions under consideration in each year's commissioning round based on a consideration of factors including patient benefit, the quality of the supporting evidence and the cost of adopting the proposal. Details of NHS England's process for forming proposals for clinical commissioning policies and the annual relative prioritisation process for specialised services can be found here.

41. In June 2017 the National Institute for Health Research, having taken advice from the Clinical Reference for Gender Identity Services, published call for applications for research in the field of gender identity services. An improved evidence base will assist the NHS in making decisions about the commissioning and delivery of gender identity services in the future.

Marriage and civil partnership (family members)

42. In response to concerns expressed during initial stakeholder engagement, the proposed service specification for non-surgical interventions confirms that the Provider must not insist that the individual gives permission for spouses or civil partners (or other family members, or other people) to attend appointments jointly with the individual. If a clinician advises the individual that it would be beneficial for a family member or other person to jointly attend an appointment, the reasoning must be explained to the individual and reassurance given that a refusal to give permission will not prejudice the individual's assessment or ongoing treatment.

43. The proposed service specification for non-surgical interventions requires each Provider to make provision for therapeutic work with partners of the service user where this is clinically indicated.

Race

44. In 2016 NHS England analysed data collected from the current Gender Identity Clinics on the ethnicity of individuals accessing specialist gender identity services in England. The analysis suggested that there is an under representation of people from Black and Minority Ethnic (BAME) Groups accessing these services when compared to data from the Office of National Statistics on the ethnicity profile of the general population.

45. There is evidence[7] that transgender people from BAME groups are more likely to face discrimination on the basis of their race and gender and often within their religious community as well. This may be one of the barriers that prevents many BAME trans people from accessing healthcare and support for themselves, placing them in a vulnerable and isolated position. It also may encourage BAME trans people not to disclose their ethnicity or religious status when accessing health care services (as is their right).

46. The proposed service specifications make clear that arrangements must be in place to ensure that services deliver culturally appropriate care and support; and that 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.

[7] "Barriers to health faced by transgender and non-binary black and minority ethnic people"; Race Equality Foundation; 2016. "Inclusivity: Supporting BAME Trans People"; GIRES. "Sharing Experience of Being Black and Minority Ethnic and Trans – Report of Focus Group"; Race Equality Foundation, 2014

47. NHS England will take steps to improve data collection and reporting in the Gender Identity Clinics (currently and in the future) to ensure compliance with contractual and data collection requirements so that the ethnic and religious profile of the caseload can be monitored.

Religion or belief

48. There is limited available evidence on the religious attitudes of trans people in the United Kingdom, although The Trans Mental Health Study[8] found that most people who took part stated that they had no religious beliefs (62%). Of those who did, the majority were Christians (20%), with Pagans (6%) and Buddhists (3%) being the next highest groups represented. Jews, Muslims and Sikhs accounted for less than 1% of the sample each, whereas Hindus were not represented at all. The study concludes that this is not representative of the population as a whole and that religious inclusion is an on-going difficulty for trans people.

49. A data collection exercise undertaken by NHS England in 2016 reaffirmed the findings of this study. Data collected from the current Gender Identity Clinics suggests that the main reported religion and belief was “None” at 65%; the second largest religious group was “Christianity” at 21%; and the third largest group was “Other” at 6%. As data completeness for the field of “religion and belief” was 35% NHS England will take steps to improve data collection and reporting in the Gender Identity Clinics (currently and in the future) to ensure compliance with contractual and data collection requirements so that the profile of the caseload can be monitored.

50. The proposed service specifications make clear that arrangements must be in place to ensure that individuals must be able to access services in a way that ensures their spiritual needs do not prevent them from receiving the same quality of healthcare as others. This is reaffirmed by NHS England’s Chaplaincy Guidelines that recognise that ‘the need for chaplaincy departments to advise providers about equality and access has increased’. It is implicit that trans people will require pastoral or spiritual care within any of the specialities that chaplaincy services support as set out within the guideline. The guideline specifies that chaplains must abide by all requirements of NHS England and the National Institute for Health and Care Excellence (NICE), including the generic Quality Standard for patient experience in adult NHS services (NICE 2010) that includes the requirement that care ‘should be culturally appropriate’.

Pregnancy and maternity

51. NHS England is of the view that the proposed service specifications do not discriminate against individuals who share this protected characteristic as there are no impacts to this group of people.

[8] McNeil, Jay, et al. "Trans mental health study 2012; quoted in NHS England’s Equality Analysis of Chaplaincy Guidelines 2015

Sexual orientation

52. Research suggests that trans people have a diverse range of sexual orientations. The largest survey[9] of trans people in the United Kingdom reported the following:

Sexual Orientation	N	Percentage
Bisexual	145	27%
Queer	126	24%
Straight or heterosexual	104	20%
Pansexual	79	15%
BDSM/Kink	73	14%
Lesbian	69	13%
Not sure or questioning	64	12%
Other	59	11%
Don't define	55	10%
Gay	51	10%
Polyamorous	46	9%
Asexual	41	8%
Total	**912**	

53. NHS England recognises and respects the diversity in sexual orientation and its expression amongst trans people (as it also does for the general population). The proposed service specifications require providers of specialised gender identity services to observe and promote respect, dignity and equality for trans people, and this implicitly covers sexual orientation. NHS England has concluded that there are no elements of the proposed service specifications that may directly or indirectly discriminate against people based on their sexual orientation.

Inclusion Health

54. NHS England has also considered whether adoption of the proposed service specifications would discriminate against other groups of people who are not usually well provided for by healthcare services, and have poorer health outcomes (called "Inclusion Health"). Traditional definitions cover people who are homeless and rough sleepers, vulnerable migrants (refugees and asylum seekers), sex workers and those from the Traveller community (including Gypsies and Roma)[10].

55. The service specification for Non-Surgical Services proposes that the specialist Gender Identity Clinics will not accept referrals of individuals who are not registered with a General Practitioner. People who belong to the above groups may be less likely to be registered with a General Practitioner, and may therefore be more likely to be denied access to specialist gender identity services.

[9] McNail, J, et al. 'Trans Mental Health Study 2012', Scottish Transgender Alliance, 2012. http://www.scottishtrans.org/Uploads/Resources/trans_mh_study.pdf

[10] People from the Traveller community should also be considered under the protected characteristic of "Race"

56. For the purpose of consultation NHS England agrees with the advice of the Clinical Reference Group for Gender Identity Services, which is that the requirement to be registered with a General Practitioner is appropriate as the collaboration with a General Practitioner in providing healthcare support, prescribing drugs, monitoring of treatment and potential adverse effects is essential, particularly once the individual's contact with the specialist teams has reduced or has come to an end.

57. We are also mindful that individuals who belong to these groups and who want to register with a GP are not required to provide evidence of identity or address, or an NHS number, and there is no statutory or contractual requirement for General Practice staff to request this. Individuals who belong to the groups that are listed above should not be refused registration with a GP because they do not have a proof of address or personal identification at hand.

58. We have asked a specific question in the consultation guide as to the extent to which respondents to consultation agree with the proposal so that these views may be considered by NHS England before making a final decision.

Considerations under the 2006 Act s13G

59. NHS England must have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved. This duty requires a consideration of the impact to the general population rather than specific groups with protected characteristics. In this regard, it should be borne in mind that adoption of the proposed service specifications would exclude the general population from accessing specialised gender identity services, as access would be (appropriately) restricted to people who may have gender dysphoria as a consequence of gender incongruence.

60. NHS England will explore during consultation (and during the subsequent process of national procurement that will identify future providers of specialised gender identity services) whether there are any considerations under s13G of the 2006 Act (i.e. issues that may impact negatively on the population of people generally who use specialised gender identity services).

61. Potential considerations include:

- Inequity in geographical access, particularly in the North West of England (this will be explored further via the process of procurement)
- Long waiting times that are in breach of the requirements of the *NHS Constitution* (this is partly addressed via the provisions of the proposed service specifications generally, and will be addressed further via the process of procurement)
- Inconsistent and inequitable approaches to commissioning and delivery of these services
- Individuals in the criminal justice system and secure settings
- An increasing incidence of some general practitioners feeling unable to prescribe hormone treatments for trans people (this is addressed via the options for future service delivery in the consultation guide).