

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	
Service	Gender Identity Services for Adults (Non-Surgical Interventions)
Commissioner Lead	<i>For local completion</i>
Provider Lead	<i>For local completion</i>

1.0 Scope

1.1 Prescribed Specialised Service

This service specification covers the provision of non-surgical Gender Identity Services for adults. This document should be read in conjunction with NHS England’s service specification for Gender Identity Services for Adults (Surgical Interventions).

1.2 Description

Gender identity services will include specialist assessment, non-surgical care packages and associated after care provided by designated Gender Identity Clinics.

1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners

NHS England commissions gender identity services from Specialist Gender Identity Clinics. This includes specialist assessment, non-surgical care packages and associated aftercare. Clinical Commissioning Groups (CCGs) are responsible for commissioning non-specialist elements of the NHS pathway of care.

2. Care Pathway and Clinical Dependencies

2.1 Background

The term currently used to describe a discrepancy between birth-assigned sex

and gender identity is **gender incongruence**; this term is preferable to the formerly-used terms of gender identity disorder and transsexualism. Gender incongruence is frequently, but not universally, accompanied by the symptom of **gender dysphoria**. Gender dysphoria is a cognitive symptom characterised by persistent concerns, uncertainties, and questions about gender identity, which become so intense as to seem to be the most important aspect of the affected individual's life. Affected individuals experience varying degrees of personal distress and dissatisfaction associated with gender that constitute the symptom, gender dysphoria. Since 2002 in the United Kingdom "transsexualism" has not been regarded as a mental health problem. Its trajectory is similar to the 'de-pathologisation' of homosexuality, which was removed as a mental health diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) in 1974. DSM-V, published in 2013, states that gender dysphoria, in itself, "is not a mental health problem".

The current version of the International Statistical Classification of Diseases and Related Health Problems identifies 'transsexualism' (ICD 10 code F64) as "*a disorder characterized by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex (manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery)*".

2.2 Principles guiding the development of this service specification

Gender dysphoria is not, in itself, a mental health condition, reflecting contemporary professional opinion.

All individuals referred to a Gender Identity Clinic may exercise full personal autonomy in respect of their gender identity and presentation; and must have equitable access to the range of interventions described in this service specification.

Equity of access and quality of care will be provided to all who need it regardless of age, gender expression or ethnicity unless there is evidence that these factors affect the appropriateness or effectiveness of the intervention / treatment.

Each individual will receive timely and appropriate treatment, as a minimum in accordance with national waiting time requirements.

Assessments and interventions will be personalised and based on shared decision making, with service flexibility to match the individual's needs.

2.3 Providers of specialised services for individuals with gender dysphoria will:

Provide a high quality service for adults who may have gender dysphoria; and will observe and promote respect, dignity and equality for trans people.

Provide a timely and sustainable service for adults with gender dysphoria that meets the needs of the population, and incorporates the views of individuals.

Work with specialised services for gender variant adolescents and young people to ensure a timely and effective transfer to adult services.

Achieve an integrated approach to care with primary care providers and ensure close links with other expert centres at national and international levels.

Ensure timely and appropriate communications with services who are expected to provide other parts of the individual's pathway.

Increase awareness of best practice in the diagnosis and management of gender dysphoria through active engagement with health professionals; and educate healthcare professionals in the health and support needs of trans people.

Collaborate in national and international research projects to increase the evidence base for the commissioning and delivery of specialised services for trans people.

Provide support, advice, expertise and training for the local, regional and national network.

Collaborate in sharing best practice, peer review, benchmarking, and in the development of research and innovation.

Employ consistent and equitable decision-making about the effective use of resources on the NHS pathway of care for trans people.

Publicise national and local patient organisations, which can provide invaluable additional information and ongoing support for trans people and their families.

2.4 Staffing, structure and governance

Each Provider will have:

A nominated Senior Clinical Lead, who has the key leadership role for the service overall. The Senior Clinical Lead must demonstrate evidence of appropriate experience and expertise in specialised gender dysphoria practice (as a minimum this will be at least three years' full time or equivalent experience in specialised gender dysphoria practice; significant management experience; and significant evidence of continued professional development).

A specialist multi-disciplinary team of professionals, with a mix of skills, experience and expertise that is appropriate to ensure the delivery of effective and high quality services in accordance with the requirements of this service specification. The multi-disciplinary team will include, as a minimum, an individual's Named Professional and Lead Clinician, and a specialist Speech and Language Therapist in Voice and Communication. It may also include a hormone-prescribing physician, endocrinologist, clinical or counselling psychologist, other provider of specialist psychological therapy, occupational therapist, and specialist nurse. A Provider without a Consultant Endocrinologist in the multi-disciplinary team must demonstrate arrangements in place for obtaining timely advice from an endocrinology team when this is needed.

A robust system of clinical governance in place that ensures, *inter alia*, all clinical staff are trained in meeting the health needs of trans people, and deemed competent to deliver the interventions as per their role.

A robust system of corporate governance, including a nominated senior manager, that demonstrates effective management, guidance, oversight and accountability by the host organisation (Board level or equivalent).

Arrangements in place to ensure that services deliver culturally appropriate care and support; individuals must be able to access services in a way that ensures their cultural, spiritual, language and communication needs do not prevent them receiving the same quality of healthcare as others.

Sufficient administrative and managerial support that facilitates efficient and timely delivery of services.

Information and technology systems that enable patient contact remotely (such as video and web consultations) where this is appropriate to the individual's circumstances; and the effective submission of data, including the reporting requirements of the national Referral to Treatment waiting time standards.

Premises that are appropriate to ensure effective delivery of the services described in this service specification; and in an environment that service users regard as safe and welcoming.

Arrangements in place (including ongoing training) to ensure that all staff in public-facing roles have cultural sensitivity towards trans and gender diverse people's health and social care needs.

Arrangements in place to ensure that service improvement is shaped by active service user involvement, and be able to demonstrate how this is achieved via means that are accessible, transparent and inclusive.

Arrangements in place to ensure that complaints by service users are acknowledged, investigated and responded to promptly; and that the means to complain are publicised and accessible.

Systems that demonstrate how Providers use audit, data management and analysis, service reviews (including peer reviews) and other intelligence to evaluate effectiveness and drive ongoing service improvement

2.5 Care Pathway

Care pathways for the assessment, diagnosis and treatment of individuals with gender dysphoria related to gender incongruence are described in the *Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria*¹. The model relies on access via primary care, and the principle of multidisciplinary and interdisciplinary teams and networks who work and collaborate in the provision of care. Gender Identity Clinics assess and diagnose individuals; directly provide some interventions and arrange for referrals to other services, including for medical and surgical treatments. Access to surgical intervention is only by referral from the specialist Gender Identity Clinic. Some elements of the NHS care pathway are delivered by non-specialised services. A diagram of the pathway is at [Appendix A](#).

The NHS pathway of care may be summarised as:

- Referral to a specialist Gender Identity Clinic from primary, secondary

¹ Royal College of Psychiatrists; 2013

or tertiary care

- Assessment for gender dysphoria, and diagnosis
- Individuals who meet the criteria for gender dysphoria related to gender incongruence are accepted on to the NHS care pathway and an individualised treatment plan is agreed
- Therapeutic interventions delivered by the specialist Gender Identity Clinic; and / or referral for interventions with other providers; which may include recommendations for prescribing hormone treatments, and surgical interventions
- Ongoing review and monitoring during and after interventions
- Conclusion of contact: discharge to primary care

2.6 New referrals

Referrals may be made by General Practitioners (GP), other medically qualified professionals, and other professionals regulated by the *Health and Care Professions Council*.

The Provider will not accept self-referrals, as the collaboration with a GP in providing healthcare support, prescribing and monitoring of both treatment and potential adverse effects is essential. See [Appendix B](#)

2.7 Requests for transfers of care from specialised adult services

Transfers of care may be requested by other specialised providers of gender dysphoria care that are commissioned by this service specification. See [Appendix C](#).

2.8 Requests for transfers of care from the Gender Identity Development Service for Children and Young People

A request for transfer of care may be made by the young person's service to the adult service before the young person's 17th birthday. This may be appropriate where joint working between the two services, including joint consultations with the young person, within a "lead-in" period is beneficial to ensure a timely and effective eventual transfer once the young person has reached 17 years. See [Appendix D](#).

2.9 Assessment process for newly-referred individuals

The Provider will undertake a specialised assessment for people who may have gender dysphoria; agree with them the most appropriate diagnostic coding; and agree a treatment plan. If the diagnosis is that the individual does not have gender dysphoria as a consequence of gender incongruence, the Provider will advise the individual and referrer on alternative services that might meet the individual's health and well-being needs. See [Appendix E](#).

2.10 Physical examination

Physical examination, other than the measurement of height, weight and blood pressure, must not be performed routinely during the assessment process. See [Appendix F](#).

2.11 Named Professional's role in treatment process

Individuals who progress to a treatment process, and individuals accepted for direct transfer of care between specialised services, will be allocated a 'Named Professional' for the duration of the episode of care. This will be a regulated health professional who will act as the individual's primary 'point of contact' with the service, provide basic information about interventions and the care process, and oversee and facilitate timely progress through the individual's treatment plan, including those elements of the care pathway that are delivered by other providers. See [Appendix G](#).

2.12 Lead Clinician role in treatment process

A medical practitioner or clinical or counselling psychologist will be appointed as 'Lead Clinician' for individuals who progress to a planned intervention on the NHS care pathway. See [Appendix H](#).

2.13 Shared decision making

Shared Decision Making is a process in which individuals, when they reach a decision point in their health care, can review all the treatment options available to them and participate actively with their healthcare professional in making that decision. The Named Professional and Lead Clinician will provide individuals with the necessary information about all of the options available to them so that they may ask questions, explore the options available, and take an active role in determining a treatment route which best suits their needs and preferences, and is clinically appropriate.

2.14 Capacity and informed consent

The Named Professional and Lead Clinician must make all efforts to ensure that individuals are aware of the longer-term consequences of the interventions offered to them. The consequences of treatment decisions can be significant and life-changing.

The process of obtaining informed consent is an important aspect of ethical assessment and intervention, including the emotional, social and factual issues, so as to enable the individual to make informed decisions about the treatment options, benefits, material risks, and the alternatives to the treatments proposed (including the option of having no treatment). Individuals must be given sufficient time to reflect on the clinical advice and the potential treatment options before deciding what is best for them.

2.15 Loss of Fertility

The individual must be provided with early advice about the likely impact of medical interventions to physical health. Where loss of fertility is likely the Provider will provide a general description of the options for conservation of reproductive potential, and, where appropriate and with the individual's consent, make a recommendation to the GP that they pursue a referral to a fertility service for cryopreservation of eggs or sperm for possible use in future fertility treatment (gamete storage). Responsibility for commissioning gamete storage rests with the individual's Clinical Commissioning Group.

2.16 The Provider's role in the treatment process

Individuals on the gender dysphoria pathway will have different needs, and the pathway will not always be linear or sequential. Not all individuals will require

all available interventions, and they may need to access them at times and in circumstances appropriate to their individual bio-psycho-social state. Personal goals for treatment may evolve as the individual gains more information and new experiences. Their needs will also be influenced by the varying severity of their gender dysphoria, the degree of incongruence between their identity and their body and social role, their social circumstances and networks of support, their current psychological adjustment, age and their health. These factors are largely patient-defined, and the Provider will be flexible and adaptable in matching the type, timing and order of interventions, and the duration of the entire treatment episode.

Individuals may elect to defer some interventions until a later date and will, by mutual agreement, be discharged by the specialist service, pending re-referral when they are ready to continue treatment. The timing of such treatment may be dependent upon their health or social circumstances; this may be an indeterminate number of years in the future. Individuals returning for treatment after a planned deferral will have a single 're-engagement' consultation with the Lead Clinician but will not be fully re-assessed unless there are compelling clinical reasons to do this (these must be carefully explained to the patient).

2.17 Interventions that are delivered directly by the Provider

a. *Voice and Communication Therapy*

Each Provider must ensure access to an appropriate level of provision of specialist voice and communication therapy on the basis of clinical need and individual choice. The objective of therapy is to facilitate changes in the individual's voice and communicative profile thereby improving quality of life and alleviating distress related to gender dysphoria. Only after a confirmed diagnosis of gender dysphoria will an individual be referred for an assessment of suitability of specialist voice and communication therapy.

The Provider's Multi-Disciplinary Team will include a specialist Speech and Language Therapist in Voice and Communication in order to provide direct assessment, to coordinate referrals to local speech and language therapy services and to provide direct intervention, particularly in complex cases. A Specialist Speech and Language Therapist in Voice and Communication working with transgender people must hold relevant qualifications and membership of accountable professional bodies, and have appropriate training and skills as Gender Specialists as per the guidelines of the Royal College of Speech and Language Therapists (2017)².

The number and frequency of sessions will be variable depending on the individual's needs, and is likely to comprise a combination of individual and group therapy sessions.

It may be necessary for some voice and communication interventions to be provided by appropriately-supported, non-specialist, local speech and language services (commissioned by Clinical Commissioning Groups) following a referral by the specialist Speech and Language Therapist in Voice and Communication.

Any pre-existing voice difficulty will be treated by local speech and

² Publication pending

language therapy services before specialist voice modification proceeds (for which commissioning responsibility rests with Clinical Commissioning Groups).

NHS England does not have a policy for the routine commissioning of Phonosurgery.

b. *Specialised, specific psychological interventions*

The Provider will make available specific psychological interventions that are adapted to the needs of the individual based on psychological assessment and collaborative formulation. Psychological interventions will not be offered routinely or considered mandatory, but instead with the consent of the individual and focussed on specific psychological needs.

Providers will ensure access to individual psychological therapies, including at least two of the approaches below:

- Systemic and Narrative Therapy approaches
- Cognitive and Behavioural approaches
- Humanistic or Existential Counselling approaches

In addition to the list above, the following are desirable:

- Psychosexual Therapy
- Group Psychotherapy
- Family Therapy
- Couples/Relationship Therapy

See [Appendix I](#) for a further description of specific psychological interventions.

Conversion therapy

Providers will not deliver, promote or refer individuals to any form of conversion therapy. The practice of conversion therapy is unethical and potentially harmful. For the purposes of this document 'conversion therapy' is an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any gender identity is inherently preferable to any other, and which attempts to bring about a change of gender identity, or seeks to suppress an individual's expression of gender identity on that basis.

c. *Assessment for endocrine and other pharmacological interventions*

Note: Currently, the specialist gender identity team assesses an individual's suitability for hormone treatment (with respect to appropriateness for treatment of gender dysphoria) and makes a recommendation to the individual's GP, 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 Council³.

The British Medical Association's General Practitioners Committee has asked NHS England 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.

Please see the supporting consultation guide for options for consultation.

[Appendix J](#) of this document describes current arrangements for prescribing.

2.18 Interventions that are delivered by other providers

a. *Prescribing of endocrine and other pharmacological interventions*

Note: Please see the supporting consultation guide for options for consultation.

b. *Facial Hair Reduction*

The aim of facial hair reduction (epilation) interventions is to bring psychological benefit to the individual through the reduction of hair growth on the face. The Lead Clinician may refer the individual for a time-limited hair reduction intervention once an individual has completed their assessment and it has been agreed as an intervention in the treatment plan. Prior treatment with an antiandrogen must not be made a precondition for treatment.

Individuals may not self-refer for a hair reduction intervention.

The Lead Clinician should consider the information in [Appendix K](#) when referring an individual for facial hair reduction.

c. *Surgery for the treatment of gender dysphoria*

This section should be read in conjunction with NHS England's service specification for Gender Identity Services (Surgical Interventions) which describes the specialist surgical procedures that are commissioned by NHS England for the treatment of gender dysphoria (masculinising chest surgery; masculinising and feminising genital reconstructive surgery; orchidectomy).

The criteria for initiation of surgical treatments are listed below. A common criterion for all surgical interventions is documentation of persistent gender dysphoria.

Before a referral for surgery is made, the Lead Clinician will meet with the individual to review current treatment interventions, and to assess the individual's needs and readiness for the surgical intervention, both as described in the criteria below and as an assessment of the individual's physical health generally. The processes of shared decision making and of obtaining consent (as described earlier in this document) will provide the patient with necessary information, and will allow the individual sufficient

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

time to ask questions, and to reflect on the advice of the Lead Clinician to enable an informed decision on the treatment options, risks and benefits. The possibility of the need for donor site skin epilation for some patients, and the likely implications for the timing of surgery, should be explained to the individual at this stage.

Criteria for mastectomy and creation of a male chest (requires one letter of referral from a Lead Clinician):

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- Aged 17 years or older
- If significant medical or mental health concerns are present, they must be reasonably well controlled
 - Hormone therapy is not a pre-requisite.

Criteria for genital surgery - metoidioplasty or phalloplasty, and for feminising genital reconstruction, with or without vaginoplasty

(requires two letters of referral: one from a Lead Clinician, the other from a similarly-qualified and experienced professional not directly involved in the individual's care and able to form an independent opinion; at least one letter of referral must be from a medical practitioner):

- Persistent, well documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- Age 17 years or older
- If significant medical or mental health concerns are present, they must be well controlled;
- 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless the individual has a medical contraindication or is otherwise unable or unwilling to take hormones); the aim of hormone therapy prior to orchidectomy is primarily to introduce a period of reversible oestrogen or testosterone suppression, before the individual undergoes irreversible surgical intervention;
- 12 continuous months of living in a gender role that is congruent with their gender identity; this must not entail a requirement for the individual to conform to externally imposed or arbitrary preconceptions about gender identity and presentation; this requirement is not about qualifying for surgery, but rather preparing and supporting the individual to cope with the profound consequences of surgery; where individuals can demonstrate that they have been living in their gender role before the referral to the Provider, this will be taken into account.

Hysterectomy (removal of uterus) and bilateral salpingo-oophorectomy (removal of ovaries and fallopian tubes) are interventions commissioned under this service specification when they are performed by a specialist Gender Identity surgical unit simultaneously with the genital surgical

interventions for the purpose of alleviation of gender dysphoria (described above). They are not commissioned by NHS England when they are performed as “stand alone” procedures; in such cases commissioning responsibility rests with the individual’s Clinical Commissioning Group.

2.19 Conclusion of contact with the Provider

Individuals will be discharged from the care of the Provider:

- At an individual’s request
- When the individual and Lead Clinician agree that treatment for gender dysphoria is complete, and not less than six months after completion of the last planned intervention (the purpose of such follow-up is to assess the longer-term impact of interventions)
- In accordance with the Provider’s access policy

At discharge the Lead Clinician will provide advice to the individual’s GP on long-term health maintenance and screening.

2.20 Interdependence with other Services

Links with other services include:

- The national Gender Identity Development Service for Children and Young People
- Primary care services
- Providers of surgical interventions for individuals with gender dysphoria
- Endocrinology services
- Speech and Language Therapy services
- Epilation providers
- Gynaecological services
- Sexual health services

3.0 Population Covered and Population Needs

3.1 Population Covered By This Specification

The service outlined in this specification is for patients ordinarily resident in England; or otherwise the commissioning responsibility of the NHS in England (as defined in guidance for “Establishing the Responsible Commissioner” and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges). For the purposes of commissioning health services, this excludes patients who, whilst resident in England, are registered with a GP practice in Wales, but includes patients resident in Wales who are registered with a GP practice in England.

The Provider will receive referrals (from a health professional) of individuals from 17 years of age who have gender dysphoria that is a consequence of their gender identity being incongruent with their visible sex characteristics

and/or the social role typically associated with those characteristics (gender incongruence).

This specification recognises and respects diversity in gender identity and its expression. It recognises that there are other identities than the traditional (binary) identities associated with 'man' and 'woman', and that gender diverse people with such identities (and who are known by a variety of other names, including non-binary, trans-feminine, trans-masculine, Genderqueer, non-gender and others) must have access to treatment and the interventions described in this document that is equitable to the access available to people with binary identities.

Exclusions

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; the Provider is not commissioned to provide immediate and urgent advice or to provide any form of emergency care
- Who self-refer, or who are not registered with a GP as the collaboration with a GP in providing healthcare support, prescribing and monitoring of treatment and potential adverse effects is essential
- Whose presentation relates primarily to intersex conditions

3.2 Population needs; and Expected Demographic Changes

There is no official data on the number of people in England who present with a degree of gender variance. Difficulties in assessing prevalence are exacerbated by the limited evidence base. 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.

A literature review by Public Health England in 2016⁴ provides a prevalence estimate of gender dysphoria in the United Kingdom of between 4.6 and 1200 per 100,000 people; it acknowledges that the lower prevalence estimate must be interpreted with caution as it considers historical data of over fifty years. A Home Office funded study in 2009 suggests prevalence for England of around 20 per 100,000 population⁵.

Thus there is considerable variation in estimates, and the absence of reliable prevalence data exacerbates the challenges in planning and commissioning gender identity services. What is consistent across the literature is a recognition that the number of people pursuing treatment options – the incidence of expressed need - is rising significantly. The number of referrals to adult gender identity services in England increased by 178% between 2011/12 and 2016/17⁶. The reasons for the increased numbers are unclear, though often surmised that it is attributable to: increased availability of treatment

⁴ Unpublished

⁵ *Gender Variance in the UK*; Gender Identity Research and Education Society; 2009

⁶ NHS England; April 2017

interventions; changing societal attitudes; a new cohort of non-binary people accessing services; and greater awareness.

4. Outcomes and Applicable Quality Standards

NHS Outcomes Framework Domains

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	

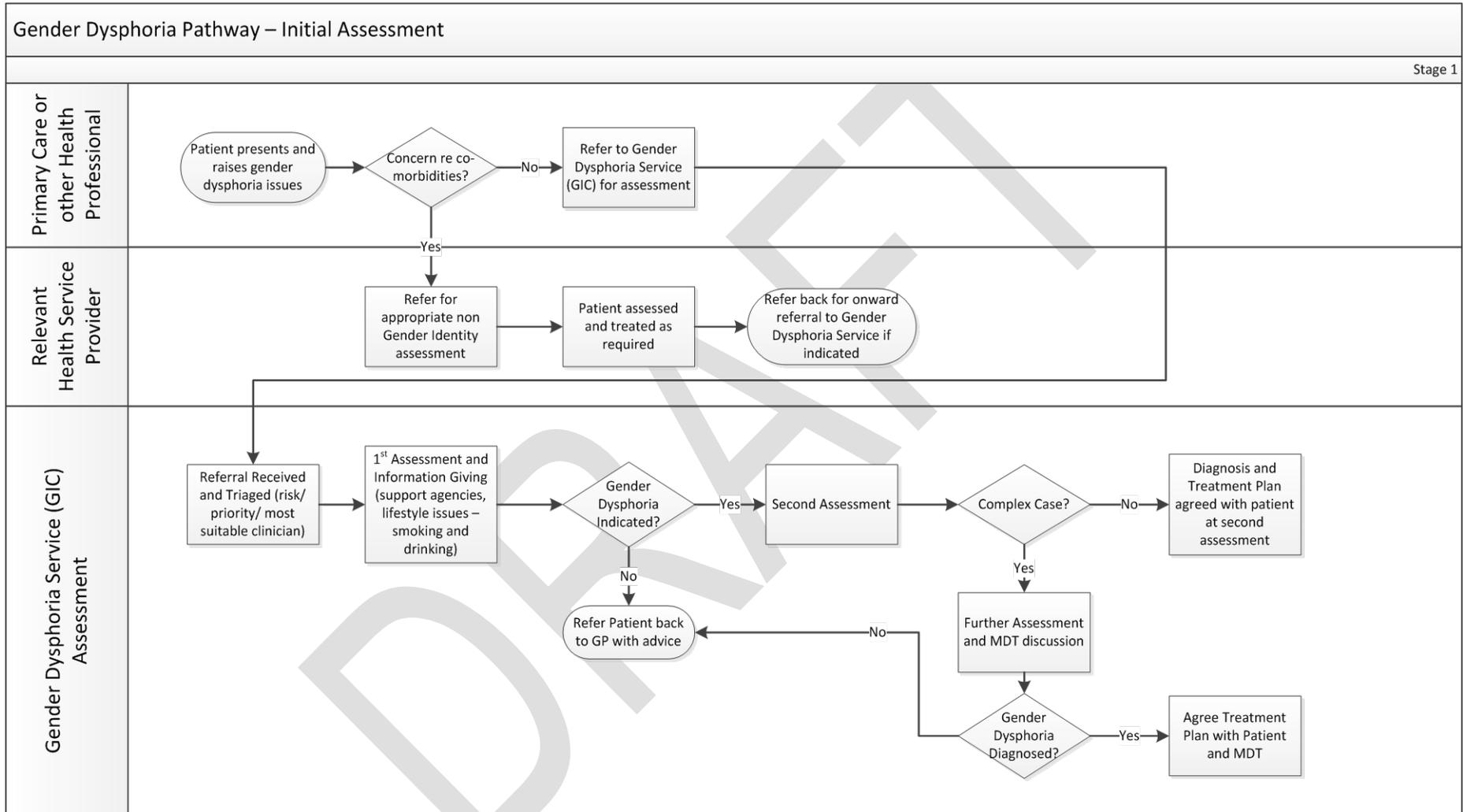
4.2 Indicators Include:

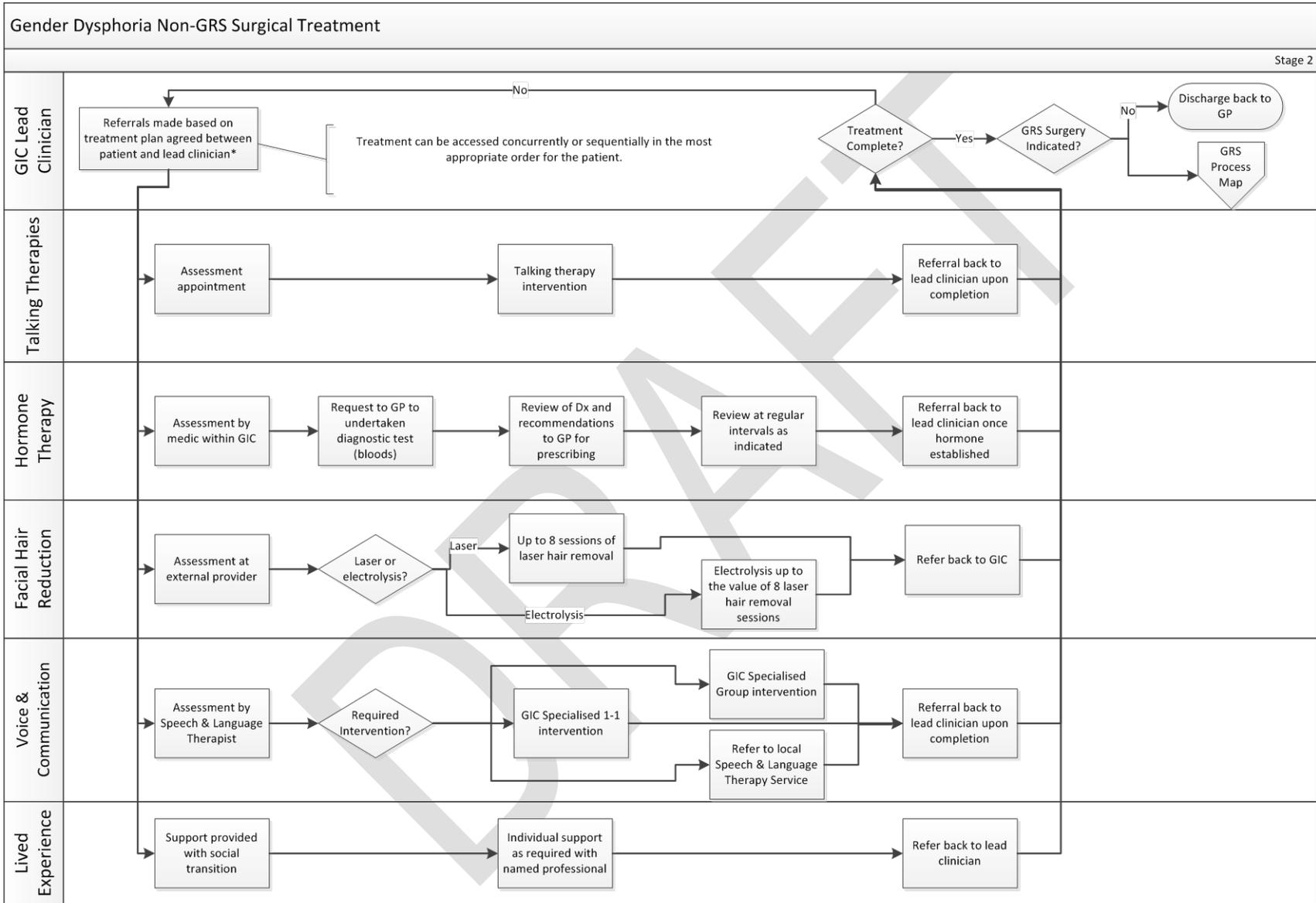
Number	Indicator	Data Source	Outcome Framework Domain	CQC Key question
Clinical Outcomes				
101	% of referrals acknowledged in writing by the provider with the referrer and individual within 14 calendar days.	HES	4	Effective, responsive
102	% of referrals received where the diagnosis does not have gender dysphoria as a consequence of gender incongruence.	HES	2, 4	Effective, caring, responsive

103	% of patients receiving more than two diagnostic assessment consultations.	HES	2, 4	Effective, responsive
Patient Experience				
201	Patient feedback	Self-declaration	4	Effective, caring, responsive
202	Patient information	Self-declaration	4	Effective, responsive
Structure and Process				
301	There is a Clinical Lead for the service.	Self-declaration	4	Safe, well-led, effective
302	There is a Named Professional and / Lead Clinician allocated for the duration of each patient's care.	Self-declaration	2, 4	Safe, effective, caring, responsive
303	Communication of treatment plan	Self-declaration	2, 4	Safe, effective, caring, responsive

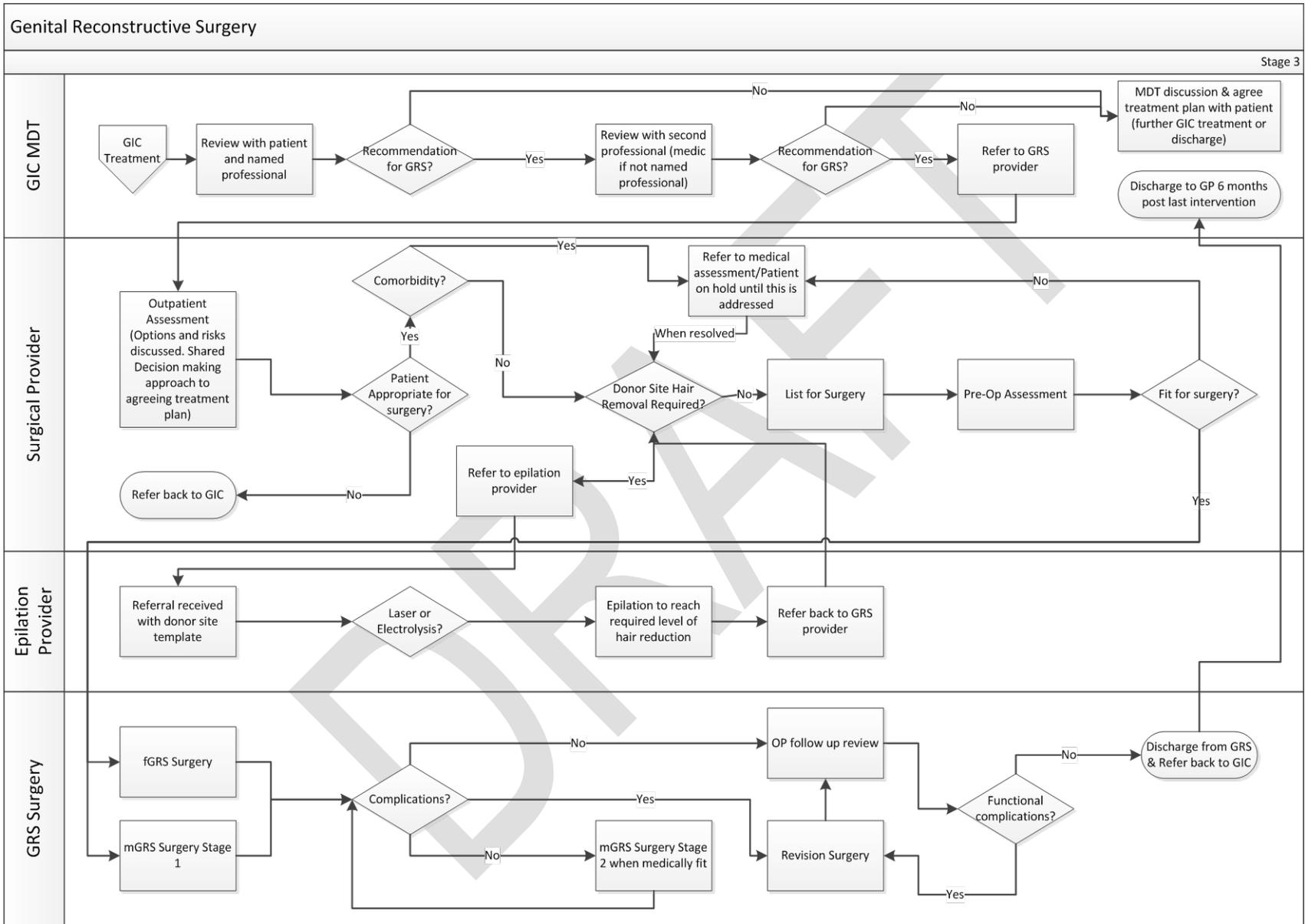
See [Appendix L](#) for more detailed description of these indicators.

Appendix A





*Referral for hysterectomy as a standalone procedure (non-specialised) or mastectomy with chest reconstruction can also occur at any time during the patients treatment plan.



Corrective surgery after 18 months is a CCG commissioning responsibility

Appendix B: New Referrals

All Providers designated against this service specification will operate in accordance with a nationally-consistent access policy.

Referrals may be made by General Practitioners (GP), other medically qualified professionals, and other professionals regulated by the Health and Care Professions Council. The Provider will acknowledge the referral in writing with the referrer and individual within 14 days.

The Provider will not accept self-referrals, as the collaboration with a GP in providing healthcare support, prescribing and monitoring of both treatment and potential adverse effects is essential.

Providers will not be unnecessarily prescriptive about the information to be included with the referrals (including insistence on use of template forms) but referrers will be encouraged to provide the following information:

- A description of the individual's experience of gender dysphoria, including duration
- The individual's clinical needs and expectations
- A summary of significant physical and mental health history
- History of substance misuse
- Risk assessment
- Forensic history
- Development history
- Information regarding and copies of correspondence related to any previous care for gender dysphoria
- The individual's current medication use (prescribed; self-medication; recreational)
- Significant social history
- Basic biometrics (height; weight; Body Mass Index; blood pressure)

Appendix C: Requests for transfers of care from specialised adult services

Transfers of care may be requested by other specialised providers of gender dysphoria care (that are commissioned by NHS England against this service specification) with the consent of the individual.

Transfer requests must be made by the individual's Lead Professional and include diagnostic coding, a summary of relevant care prior to transfer, a treatment plan with recommendations for on-going care, and patient consent to sharing of information between the initiating and receiving providers; where these criteria are not fulfilled the referral will be managed as a new referral.

Individuals will be offered a single 'induction' consultation by the receiving provider during which the diagnostic assessment and treatment plan will be reviewed and, unless there are compelling clinical reasons (these must be carefully explained to the individual), the receiving provider will continue the previously agreed care plan. The Provider will acknowledge the transfer request in writing with the referrer and individual within 14 days.

Individuals accepted for transfer of care will not be re-assessed unless there are compelling clinical reasons. A consultation with the receiving Provider will be offered at an interval consistent with the individual's treatment plan and previous care.

Appendix D: Transfers from the Gender Identity Development Service for Children and Young People

The objective of the transfer is a purposeful, planned movement of adolescents and young adults from a young person's service into an adult-oriented service. A well-planned transfer must focus on the needs of the individual and must provide coordinated, un-interrupted care and support to avoid negative consequences. The parents, carers and other family members will also value support, information and guidance in the process of transfer. There are therefore compelling reasons for close cooperation, communication and mutual support between the specialist team in the Gender Identity Development Service for Children and Young People and specialist teams in adult services.

Although the transfer to adult services will not be made until the young person is aged at least 17 years, a request for transfer of care may be made by the young person's service to the adult service before the young person's 17th birthday. This may be appropriate where joint working between the two services, including joint consultations with the young person, within a "lead-in" period is beneficial to ensure a timely and effective eventual transfer.

Young people who have completed a diagnostic assessment in the young person's service will not be re-assessed for diagnosis in the adult service. The adult service will be provided with the relevant diagnostic codes and agreed treatment plan, including the medical treatment plan if the young person is receiving endocrine interventions, and as part of the process for transfer the adult service will agree arrangements for continued prescribing with the young person's endocrine service. Endocrine interventions initiated by the young people's team should be stabilised and arrangements for continuing prescription agreed as part of the process of transfer.

Individualised risk management procedures should be in place and agreed across both services, particularly for more vulnerable young people or those with more complex needs.

In cases where the young person has not completed a diagnostic assessment but who fulfils the diagnosis for gender dysphoria but are wanting to explore options more fully, or who have very complex or psychosocial issues that mean physical interventions are not yet appropriate, the process of transfer likely to take longer and will require ongoing collaboration and planning between the young person's service and the adult service focused on the needs of the individual. The nature of the individualised plan will differ according to needs, but may necessitate a joint transfer clinic in appropriate cases. The process of transfer will complete by the young person's 20th birthday and the different outcomes may be:

- Where a diagnosis of gender dysphoria as a consequence of gender incongruence has been made, an agreed plan for transfer to adult gender identity services; or
- Where a diagnosis of gender dysphoria as a consequence of gender incongruence has not been made, a referral to an adult gender identity service for an assessment of diagnosis, or for access to specific time-limited psychological therapies; or

- Discharge from the young person's service and no transfer or referral to adult gender identity services.

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Appendix E: Assessment and Diagnosis

The Provider will undertake a specialised assessment for people who may have gender dysphoria; agree with them the most appropriate diagnostic coding; and agree a treatment plan. If the diagnosis is that the individual does not have gender dysphoria as a consequence of gender incongruence, the Provider will advise the individual and referrer on alternative services that might meet the individual's health and well-being needs.

The Provider will triage all new referrals, and assessments will be conducted according to individual need and circumstances. The majority of individuals will have two core assessment consultations; at least one of the consultations will be face-to-face. Baseline laboratory investigations and physical measurements (height; weight; blood pressure) may be requested during the assessment, if these are consistent with the individual's treatment objectives.

A number of studies suggest that trans people may be at higher risk of physical and mental health problems, sometimes because they have not had timely access to specialist gender identity services and sometimes as an unintended consequence of medical interventions used for the treatment of gender dysphoria. The Named Professional and Lead Clinician will assess and manage health risks as a routine part of each individual's initial assessment, and ongoing health risk management will form part of the regular clinical review process.

Initial assessment consultation

This consultation will be conducted by a regulated health professional (or by a supervised trainee). Information will be collected about: the individual's objectives for their engagement with the service; their gender identity and expression (current and historic); and basic bio-psycho-social history.

Diagnostic and treatment planning consultation

This consultation will be conducted by a medical practitioner or clinical or counselling psychologist (or by a supervised trainee). Information from the referrer and the initial consultation, together with any investigation results, will be reviewed and further explored with the individual. Diagnostic coding will be discussed and agreed with the individual. The individual's treatment goals will be discussed and agreed. A general assessment of capacity to consent to treatment will be made. A written treatment plan, with indicative timelines, will be discussed and agreed with the individual and shared with the GP and referrer. The treatment plan may recommend that the individual progress to a treatment process. Other outcomes may include a recommendation to the referrer or GP that the individual be referred to other services, or that a referral should be deferred to a later date because of other health or social issues that would prevent the individual from currently benefiting from the interventions offered by the specialised service network. All outcomes will be carefully explained to the individual.

Additional assessment consultations

A minority of individuals have complex or additional needs such that more than two core assessment consultations may be appropriate. This may include people with co-existing complex physical or mental health problems, communication difficulties or learning difficulties. In these circumstances, the clinician must explain to the individual the reason for the proposed additional consultations. The incidence of

extended consultations will be compared between providers, to identify un-warranted variation in clinical practice.

Family members

The Provider must not insist that the individual gives permission for 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.

Assessment of patients who have been granted a Gender Recognition Certificate

The Gender Recognition Act 2004 enables a trans person to apply to the Gender Recognition Panel to receive a Gender Recognition Certificate. Individuals who are granted a full Gender Recognition Certificate are considered in the eyes of the law to be of their acquired gender and they are entitled to all the rights appropriate to a person of their acquired gender.

An individual with a Gender Recognition Certificate will already have obtained a clinical diagnosis of gender dysphoria (as that is a requirement for the granting of a Gender Recognition Certificate). As such, the assessment and diagnosis element of the individual's contact with the Provider will be adjusted to reflect the existing diagnosis of gender dysphoria.

Possession of a Gender Recognition Certificate does not in itself provide the multi-disciplinary team with the clinical information that is necessary to assess an individual's suitability and readiness for the medical and other health interventions that are available along the NHS pathway of care. As such, individuals with a Gender Recognition Certificate will be assessed for readiness of interventions, including surgical interventions, as otherwise described in this service specification and will include the individual's:

- Expectations of the interventions and how they will impact upon them socially and psychologically
- Health history
- Understanding of the interventions and their potential benefits, risks and limitations
- Support network and strategies for thriving after the intervention
- Plans for preparation and aftercare following intervention

Appendix F: Physical examination

Physical examination, other than the measurement of height, weight and blood pressure, must not be performed routinely during the assessment process. Examination of genitalia and chest is not a routine part of the assessment process.

Physical examination may be recommended by the clinical team only if the individual's clinical history suggests that physical examination is likely to result in important benefit to the individual, or is likely to reduce an important risk of harm; or as a response to a specific request by the individual. Individuals must be told that they have the right to refuse physical examination and that refusal will not affect their care with the Provider, unless omission of examination is likely to significantly compromise their safety. In rare circumstances, a refusal of examination (by any medical practitioner in any setting) may increase the clinically-relevant risk associated with medical and surgical interventions, to such a degree that it would be unethical to proceed with those interventions.

Physical examination will be performed by a medical practitioner. The individual's views will be sought with regard to who shall examine them, which may include the GP, and providers will endeavour to fulfil their wishes with regard to the gender of the examining medical practitioner. Physical examination must not be performed by the medical practitioner involved in the patient's assessment process.

The examining medical practitioner must:

- Explain in advance what the examination involves, what information it is intended to yield, and why it is clinically justified
- Ensure the examination is held in private, in a secure, quiet and calm environment
- Always offer a chaperone (this must be documented in the individual's notes, as must an individual's choice to decline having a chaperone present)
- Ask the individual's preferred terms for parts of the body
- Defer examination to a later visit, allowing the individual to build a trusting relationship with the medical practitioner

*Chaperones for physical examination*⁷

The examining medical practitioner must offer the individual the option of having an impartial observer (a chaperone) present wherever possible. A chaperone should usually be a health professional and the examining medical practitioner must be satisfied that the chaperone will:

- Be sensitive and respect the individual's dignity and confidentiality
- Reassure the individual if they show signs of distress or discomfort
- Be familiar with the procedures involved in a routine intimate examination
- Stay for the whole examination and be able to see what the examining medical practitioner is doing, if practical

⁷ *Intimate Examinations and Chaperones*; General Medical Council; 2013

- Be prepared to raise concerns if they are concerned about the examining medical practitioner behaviour or actions

A relative or friend of the individual is not an impartial observer and so would not usually be a suitable chaperone, but the examining medical practitioner should comply with a reasonable request to have such a person present as well as a chaperone.

If either the medical examining practitioner or the individual does not want the examination to go ahead without a chaperone present, or if either party is uncomfortable with the choice of chaperone, the examination may be delayed to a later date when a suitable chaperone will be available, as long as the delay would not adversely affect the individual's health.

If the examining medical practitioner does not want to proceed without a chaperone present but the individual has refused to have one, the examining medical practitioner must explain their reasoning clearly, but ultimately the individual's clinical needs must take precedence. The examining medical practitioner may wish to consider referring the patient to a colleague who would be willing to examine them without a chaperone, as long as a delay would not adversely affect the patient's health.

Appendix G: Named Professional's role in treatment process

Individuals who progress to a treatment process, and individuals accepted for direct transfer of care between specialised services, will be allocated a 'Named Professional' for the duration of the episode of care. This will be a regulated health professional who will act as the individual's primary 'point of contact' with the service, provide basic information about interventions and the care process, and oversee and facilitate timely progress through the individual's treatment plan, including those elements of the care pathway that are delivered by other providers. They will liaise and share information with other clinicians involved in the individual's care with the specialised network and with the GP. With the individual's consent, they will also deliver supportive counselling according to need.

It is expected that contact with the Named Professional will be provided at a frequency of every three months. More frequent contact may be provided according to individual need; less frequent contact is acceptable with the consent of the individual but the minimum frequency of contact will be every six months (for example, this may be appropriate for an individual who is less distressed by dysphoria and is waiting for completion of multi-stage surgical intervention).

It will be explained to individuals why engagement with a Named Professional is essential and integral to the monitoring and management of their individual treatment plan. Providers must offer flexible access, including consultation by video communication, telephone and e-mail where this is appropriate to the individual's circumstances, though individuals are expected to attend face-to-face consultations at least once a year during the course of their care.

There is value in maintaining continuity of care by minimising change in the person acting as Named Professional for individuals as they progress from assessment to discharge, but this may be necessary because of changing individual and service needs, or individual choice.

Appendix H: Lead Clinician role in treatment process

A medical practitioner or clinical or counselling psychologist will be appointed as 'Lead Clinician' for individuals who progress to a planned intervention on the NHS care pathway.

The Lead Clinician will provide oversight of each individual's progress towards completion of their treatment plan. The Lead Clinician may be the same person as the Named Professional. The clinician providing specialised psychological therapy should not also hold the Lead Clinician role.

A professional in a Lead Clinician role must demonstrate evidence of training and have at least two years full time or equivalent experience in specialised gender dysphoria practice, or undertake regular mentoring with, and work under the supervision, of a professional with such experience. There is value in maintaining continuity of care by minimising change in the person acting as Lead Clinician for individuals as they progress from assessment to discharge, but this may be necessary because of changing individual and service needs, or individual choice.

The Lead Clinician will initiate the interventions documented in the treatment plan and described in this service specification (some interventions require two opinions as described), except for endocrine and other pharmacological interventions for which a recommendation from a medical practitioner is necessary.

All individuals who are offered a medical intervention will be given advice on smoking cessation, encouraged to take regular exercise and adopt a healthy lifestyle (so far as relevant to their circumstances).

Appendix I: Specialised, specific psychological interventions

Gender diversity exists alongside the spectra of health, class, age, ethnicity, culture, sexuality and ability. These are factors contributing to quality of life and fluctuations in psychological, physical health and wellbeing. The impact of cultural stigma and the medical treatment of gender dysphoria contribute independently and interact with these factors to create a diverse but particular range of resilience and support needs for people experiencing gender dysphoria. These needs are social, psychological and physical; and they differ in presentation, need and intensity based on the factors above. This requires skilled assessment and formulation of needs prior to offering appropriate interventions. The aims of specialised psychological interventions, alone or as part of a wider multi-disciplinary network are to:

- Provide an opportunity to access affirmative support, information, skills and resources to facilitate and adjust to psychological, physical, relational, social and practical changes and to promote wellbeing
- To advise and/or provide access to effective interventions based on psychological assessment and collaborative formulation, adapted to the needs of the person(s)
- Provide an opportunity for clarity, hope and agency in the person's particular experience and management of gender dysphoria

The Provider will make available specific psychological interventions that are adapted to the needs of the individual based on psychological assessment and collaborative formulation.

Psychological interventions will not be offered routinely or considered mandatory, but instead with the consent of the individual and focussed on specific psychological needs. Psychological interventions will be delivered in line with those demonstrating good evidence in other areas of healthcare and in line with the guidelines of the *National Institute for Health and Care Excellence* where they exist.

People experiencing gender dysphoria may experience a range of psychological and social concerns, both particular to the experience of gender dysphoria and common to the experiences of the wider population. Where these concerns affect quality of life, cause interference or distress with daily functioning, or are barriers to accessing otherwise suitable interventions from the provider, psychological interventions should be offered. These concerns could be broadly grouped into four main categories:

- Personal experience of distress resulting from gender dysphoria
- Impact of social marginalisation, invisibility and stigma; including experiences of shame, impact on social, emotional and identity development, Minority Stress, Trans related discrimination and abuse, internalised trans-phobia, relationship difficulties, sexuality
- Impact of social and medical transition; including explorations around presentation, identity and role, adjustment to change in relationships and experience of self, the impact of major surgery, impact of unmet expectations or the outcomes of medical interventions
- Understanding and managing co-occurring physical / mental health / neuro-developmental / learning disability within the context of gender dysphoria and the process of transition.

Psychological interventions can be offered as a primary intervention, consecutively or concurrently to medical treatments, surgery or other specialised service network-based interventions where this is indicated. This includes referral for psychological interventions post-operatively, whether planned or in response to need.

Psychological interventions will not be offered in the case of any unmanaged acute or severe and enduring mental health problems; active risk to self or others; problematic or unmanaged substance misuse; neurodevelopmental problems; or a person's unwillingness to engage in psychological interventions.

Concerns that are common to the wider population and are not primarily related to or strongly influenced by gender dysphoria require assessment and management in other NHS services. In such cases the provider should, with patient consent, liaise with non-specialist services. Psychological interventions should not be offered by the provider concurrently to psychological interventions offered by non-specialist services; this would be contrary to good practice guidance. Where a person is engaged in psychotherapy with non-specialist services and psychological needs related to gender dysphoria are identified, both services will, in collaboration with the individual, agree on the priority of psychotherapy interventions.

Usually, it will be most beneficial to the individual if psychological interventions are provided within the context of the multi-disciplinary team or network of the provider that is co-ordinating care. Individuals may access psychological therapies provided by another specialist provider that is governed by this service specification where it is agreed that this is in the person's best interests.

The minimum credentials for competency of mental health professionals working with adults who present with gender dysphoria are described in the *World Professional Association for Transgender Health Standards of Care v7 (2011)*. The assessing clinician will hold a relevant professional qualification with skills and experience in assessment relevant to the diversity of presentations of people accessing services under this service specification.

Dependent on experience and qualifications, psychological interventions may be delivered by:

- Single modality qualified therapists (for example: counsellors, psychotherapists, psychosexual therapists and relevant supervised trainee); such therapists must be accredited by the UK Council for Psychotherapy; British Association for Counselling & Psychotherapy; or College of Sexual and Relationship Therapists
- Dual / Multi modal trained therapists, therapists with core mental health training (for example, psychiatrist or nurse) and relevant supervised trainee; such therapists must be accredited by the organisations above
- Clinical or Counselling Psychologist and relevant supervised trainee, who are trained in at least two therapeutic approaches as well as diagnosis and professional consultation

Good practice for engaging in psychological interventions with transgender people has been published⁸. Providers will ensure adequate training, supervision, caseload

⁸ *Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients*; British Psychological Society; 2012 and *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*;

management and support to ensure clinicians are competent and able to provide affirmative interventions.

Due to the range of concerns and presentations across the life-span, the provider will make available a range of models of interventions. Each provider must offer specialised psychological assessment and integrative psychotherapy, as well as single mode psychotherapy or counselling outlined below. Where single modality therapists are employed, a range of therapy modalities from the list below should be available to enable choice and accessibility to appropriate intervention. Integrative psychotherapy is offered usually where there is increased complexity of presentation, such as in the case of co-occurring mental health conditions.

Providers will ensure access to individual psychological therapies, including at least two of the approaches below:

- Systemic and Narrative Therapy approaches
- Cognitive and Behavioural approaches
- Humanistic or Existential Counselling approaches

In addition to the list above, the following are desirable:

- Psychosexual Therapy
- Group Psychotherapy
- Family Therapy
- Couples/Relationship Therapy

Each Provider will work therapeutically with partners and families of the service user where this is clinically indicated. Therapy for partners and family members individually is not commissioned under this service specification.

Interventions, whether face-to-face, telehealth, or e-health must be delivered in line with good practice guidelines regarding accommodation, privacy, security and access.

In line with other NHS commissioned psychological interventions, it is clinical consensus that time-limited psychological interventions are effective for this client group, rather than open ended. Time or session limits, possibility of extension or review should be indicated when agreeing the intervention. Length of intervention will be based on the formulation and be related to the complexity of the concern, based on evidence of effectiveness or needs of the person accessing the intervention. Individual and group psychotherapies typically last between 6-20 sessions with clinically indicated extensions permitted in individual psychotherapy on a case-by-case basis.

Psychological interventions might include:

- Specialist Counselling – regular sessions of about an hour, usually of high to moderate frequency (weekly, fortnightly or monthly) with the same clinician over an agreed period or number of sessions; this may be with an individual, couple or family

- Individual Psychotherapy – regular sessions of about an hour of high frequency (weekly or fortnightly) with the same clinician over an agreed period or number of session
- Integrative Therapies with individuals, couples or families; regular meetings of about an hour, usually of high frequency (weekly or fortnightly) with the same clinician over an agreed period or number of sessions
- Group psychotherapy; these sessions are usually 90-120 minutes over an agreed period of time

In addition, psychological consultation will be available to provide opinion, advice, supervision and management of psychological approaches to care delivered by others where this is required.

Appendix J: Current arrangements for prescribing (please refer to the Consultation Guide for alternative options)

Endocrine and other pharmacological interventions may be recommended by a medically qualified practitioner in the specialist multi-disciplinary team where they are essential for the purpose of harm reduction, and where they are in the individual's best interest for reducing gender dysphoria, when assisting the individual in achieving gender expression congruent with their identity and consistent with their treatment goals. It is not a requirement for access to endocrine and other pharmacological interventions to undertake a change in social role.

Treatments may influence central nervous system function and cognition (thoughts and feelings) as well as sex-specific physical characteristics. They may augment physical interventions intended to modify secondary sex characteristics. They may mitigate the unwanted endocrine and metabolic effects of hypogonadism, which follow gonadectomy or the suppression of sex hormones produced by the body.

Endocrine and other pharmacological interventions may be recommended after an individual has completed their assessment and the patient and Lead Clinician have agreed to include such interventions in their treatment plan. Recommendations must give due consideration to contemporary and authoritative clinical guidance.

The recommending medical practitioner will assess the risks, benefits and limitations of pharmacological interventions for the individual, and will ensure that the individual meets the relevant eligibility criteria set out in the *World Professional Association for Transgender Health Standards of Care (2011)*:

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- If significant medical or mental concerns are present, they must be reasonably well-controlled

The medical practitioner will obtain written consent to the interventions under consideration from the individual, and provide a copy of the consent to the individual and their GP.

The medical practitioner will provide the GP with patient-specific 'prescribing guidance', which will consist of a written treatment recommendation, and adequately-detailed information about necessary pre-treatment assessments, recommended preparations of medications, and advice on dosages, administration, initiation, duration of treatment, physical and laboratory monitoring, interpretation of laboratory results and likely treatment effects.

Most recommendations will be for medications to be used outside the indications approved by the *Medicines and Healthcare Products Regulatory Agency*; the *General Medical Council* advises GPs that they may prescribe 'unlicensed medicines' where this is necessary to meet the specific needs of the patient and where there is no suitably licensed medicine that will meet the patient's need⁹.

The medical practitioner will provide the GP with advice on dose titration and the introduction of additional pharmacological interventions. The medical practitioner will

⁹ *Advice for Doctors Treating Transgender Patients*; General Medical Council; 2016

respond promptly to requests by GPs for advice regarding the interpretation of laboratory results and medication use.

Individuals receiving endocrine and other pharmacological interventions recommended by the provider will have these reviewed by a medical practitioner in the specialist multi-disciplinary team at least once in twelve months. More frequent review should be provided according to clinical need, particularly after treatment initiation or following significant changes in regimen.

The medical practitioner will provide the GP with written advice when the individual is discharged. The advice will include the individual's future need for endocrine and other pharmacological interventions, the anticipated duration of treatment (which may be life-long), the regimen recommended for on-going use, its intended effects and possible side-effects, long-term monitoring recommendations, and how they might access further information in the future.

Medication for masculinisation

- Testosterone preparations (includes testosterone injections and transdermal gels)
- Medications to suppress hypothalamic-pituitary-gonadal activity and menstruation

Medication for feminisation

- Estradiol preparations at doses necessary to achieve serum estradiol levels typical of a pre-menopausal woman. (includes oral estradiol, and transdermal estradiol as patches and gels; transdermal estradiol preparations should be offered to people over 40; ethinylestradiol will not be recommended)
- Medications to suppress hypothalamic-pituitary-gonadal activity and endogenous testosterone release (includes gonadotropin releasing hormone analogues and 5-alpha reductase inhibitors)
- Ornithine decarboxylase inhibitors may be recommended as an adjunct to facial hair reduction interventions.

An individual being significantly overweight increases their risk of adverse effects and complications related to treatment with estradiol and medications that block the effects of testosterone. There is strong evidence that an individual's risk of thrombosis increases as their Body Mass Index (BMI) increases. Consensus opinion amongst specialist medical practitioners is that individuals with a BMI of 40 or more should lose weight before using such hormone therapies. Whilst a BMI greater than 40 is not exclusion to this treatment, hormone therapy should only be recommended following an individualised discussion of risk, possible adverse effects and possible impacts on final treatment outcome.

There is strong evidence that an individual's risk of thrombosis is increased if they smoke, particularly if they are treated with estradiol. Consensus opinion amongst specialist medical practitioners is that individuals who smoke should desist whilst using hormone therapies, and particularly if they are treated with estradiol. Whilst smoking is not an exclusion to access to this treatment, hormone therapy should only be recommended following an individualised discussion of risk, possible adverse effects and possible impacts on final treatment outcome.

Appendix K: The Lead Clinician should consider the following information when referring an individual for facial hair reduction:

The two modalities that will be used for hair reduction are laser epilation (Alexandrite, Diode or, for darker skin types, Long Pulse Nd:YAG lasers only) and electrolysis. Electrolysis should only be recommended when laser hair removal is expected to be ineffective or is inappropriate due to the number and colours of hairs present.

The epilation modality to be employed for hair reduction is dependent on the individual's hair colour and skin type. Laser epilation is most effective with pale skin and coarse dark hair and it is less or not effective with lighter hair colours. Electrolysis is suitable for all hair colours and skin types.

Laser epilation must be used as first-line treatment for reduction of dark hair. If the hair is red or dark grey, laser treatment should be initially be limited to a patch test and two treatment sessions; unless meaningful epilation has been observed at least three months after the second session, electrolysis should be offered as an alternative. Electrolysis must be used for fair or non-pigmented hair, or if laser is, or is expected to be, ineffective or inappropriate due to the number and colours of hairs present.

Laser epilation practitioners should have attended a *Laser Core of Knowledge* course and have or be working towards a level 4 qualification in laser and light hair removal treatments, or equivalent.

Electrolysis must be provided by a practitioner who is a member of a relevant professional or who is able to demonstrate a level 3 qualification in electro-epilation (for example, Vocational Training Charitable Trust; National Vocational Qualifications).

For laser treatment the Lead Clinician must request that the epilation provider perform a patch test, and that the intervention is dependent upon a successful outcome of the patch.

Appendix L – quality indicators

	Clinical Outcomes - quantitative data where possible using national data need to minimise the burden							
101	% of referrals acknowledged in writing by the provider with the referrer and individual within 14 calendar days.	% of referrals acknowledged in writing by the provider with the referrer and individual within 14 calendar days.		Annual Report	HES		4	Effective, responsive
102	% of referrals received where the diagnosis does not have gender dysphoria as a consequence of gender incongruence.	% of referrals received where the diagnosis does not have gender dysphoria as a consequence of gender incongruence.		Annual Report	HES		2, 4	Effective, caring, responsive
103	% of patients receiving more than two diagnostic assessment consultations.	% of patients receiving more than two diagnostic assessment consultations.		Annual Report	HES		2, 4	Effective, responsive
	Patient Experience - PROMS PREMS can be difficult to gather if no national survey can put in process indicator if required							
201	Patient feedback	The provider has undertaken an exercise to obtain		Operational Policy	Self-declaration		4	Effective, caring, responsive

		feedback from patients.						
202	Patient information	Patient information is provided to all patients and includes details as listed in the service specification.		Operational Policy	Self-declaration		4	Effective, responsive
Structure and Process - infrastructure requirements, staffing, facilities etc								
301	There is a Senior Clinical Lead for the service.	There is a Senior Clinical Lead in place who has evidence of training and have at least three years' full time or equivalent experience in specialised gender dysphoria practice; and has significant management experience; and has significant evidence of continued professional development.		Operational Policy	Self-declaration		4	Safe, well-led, effective
302	There is a named/lead professional allocated for the duration of the	There is a named/lead professional allocated for the duration of the		Operational Policy	Self-declaration		2, 4	Safe, effective, caring, responsive

	patients care.	patients care.					
303	Communication of treatment plan	There is a written treatment plan, with indicative timelines, discussed and agreed with the patient and shared with the GP and referrer.		Operational Policy	Self-declaration		2, 4 Safe, effective, caring, responsive
304	Annual contact for patients receiving endocrine and pharmacological interventions	Patients receiving endocrine or pharmacological interventions have these reviewed annually by a medical practitioner.		Operational Policy	Self-declaration		1, 2, 3,4 Safe, effective, caring, responsive
305	Patient pathway	There should be a patient pathway in place as per the service specification.		Operational Policy	Self-declaration		1, 2, 3, 4, 5 Safe, effective, caring, responsive
306	Graduation clinics	Arrangements exist which include joint transition clinics to ensure the transfer of care of patients from adolescence to adulthood services.		Operational Policy	Self-declaration		2, 4, 5 Safe, effective, caring, responsive