A. Service Specifications

Service Specification No:	
Service	Gender Identity Services for Adults (Surgical Interventions)
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 Prescribed Specialised Service

This service specification covers the provision of surgical interventions for individuals on the NHS pathway of care for gender reassignment. This service specification should be read in conjunction with NHS England's service specification for Gender Identity Services for Adults (Non-Surgical Interventions).

1.2 Description

Gender Identity Surgical Services include specialist assessment, surgical interventions and immediate associated after care.

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

NHS England commissions gender identity disorder surgical services from Specialist Gender Identity Surgical Providers. This includes specialist assessment, surgery and immediate associated aftercare. Clinical Commissioning Groups are responsible for commissioning other surgical procedures that are not specialised and that may form the NHS pathway of care for transgender people (as described in this specification).

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

All individuals referred to a specialist surgical service may exercise full personal autonomy in respect of their gender identity and presentation; and must have equal 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.

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

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

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

Provide a timely and sustainable service for trans people that meets the needs of the population, and incorporates the views of individuals.

Work with specialist Gender Identity Clinics to ensure timely and effective treatments, including post-surgical care needs.

Achieve an integrated approach to care with specialist Gender Identity Clinics 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 treatment 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 local and national 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. A core multi-disciplinary team will include surgeons with expertise in the procedures described in this service specification; consultant anaesthetists; consultant radiologists; and specialist nurses. The team will also include other clinicians 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.

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 from 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 enables 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 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

[1] Royal College of Psychiatrists; 2013

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 Referral for surgical intervention

Referrals for a surgical intervention must be made by a Lead Professional from a specialist Gender Identity Clinic that is commissioned by NHS England, with necessary accompanying clinical opinions as described in this service specification. See Appendix B.

2.7 Role of the specialist surgeon and surgical team

The treating surgeon must have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must demonstrate good communication with patients through multi-source feedback as part of their appraisal; and have close working relationships with NHS England-commissioned specialist, non-surgical gender dysphoria service providers and with other health professionals who have been actively involved in their clinical care.

Surgeons must demonstrate evidence of continuing training and mentoring in the relevant techniques, reported through appraisal.

Surgeons must perform a minimum of 20 procedures in a year of the general type commissioned from the provider (i.e. 20 masculinising chest surgery procedures and/or 20 masculinising genital reconstruction procedures, and/or 20 feminising genital reconstruction procedures), so that the skills of the entire unit are maintained**.**

Surgeons must engage regularly (at least once a year) with a group of peers (with national or international peers working in another organisation or surgical team), and share and review data on caseload, outcomes and complications experienced in their practice. The group of peers must publish an annual report.

Surgical teams must comply with contemporary, authoritative guidance on the management of gender dysphoria and specialised surgery intended to reduce gender dysphoria, including the *Standards of Care of the World Professional Association for Transgender Health* (*version 7, 2011*).

2.8 Infrastructure requirements

- Consultant-led clinical advice available 24 hours a day, 7 days per week
- Consultant anaesthetists
- Specialist nurses to support patients throughout the surgical pathway, as both in-patients and out-patients, from referral to discharge**.**

The service will be co-located with the following services:

- Radiology (including computed tomography (CT) Scanning,

Magnetic resonance imaging (MRI), ultrasound and Doppler tests)

- Transfusion services
- Infection prevention and control

The service will have access to the following services:

- Pain Service (age appropriate)
- Pathology services
- Respiratory physiotherapy service
- Physiotherapy
- Occupational Therapy
- Dietetics
- Psychological services relevant to surgery

Arrangements will be in place for urgent or emergency transfers of in-patients to High Dependency Units and Intensive Care Units.

Patients will be assessed and treated in a clinically-appropriate area. This will include giving the option of attending a separate clinic for patients on the gender dysphoria pathway or in a clinic separated in time from patients of a different group.

A health professional member of the surgical team will be available during daytime working hours to provide non-urgent advice to patients, and other practitioners providing care to patients who are not currently in-patients of the specialist surgery provider unit, such as urgent and emergency care services, General Practitioners and Gender Identity Clinics.

2.9 Assessment for readiness for surgical interventions

The surgeon will offer the patient a pre-operative consultation, and will provide them with information, and agree with them the surgical intervention to be provided, which will be consistent with the patient's gender expression goals, within the limits of what can reasonably be achieved with best surgical practice. See Appendix C.

2.10 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 surgeon 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 a treatment route which best suits their needs and preferences and is clinically appropriate.

2.11 Consent to surgery

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.

The Named Clinician and Lead Professional in the specialist Gender Identity Clinic will have previously made 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 surgeon will obtain consent for the proposed intervention at a specific pre-operative appointment, so as to allow an informed process and give the patient adequate time to consider any relevant options and alternatives. Each patient should receive detailed verbal, written and pictorial information on the following, in the context of the individual's own treatment goals:

- Different surgical techniques available (with option of referral to colleagues who provide alternative techniques)
- Advantages and disadvantages of each technique (cosmetic and functional)
- Limitations of a procedure to achieve "ideal" results
- Inherent risks and possible complications of the various techniques
- Appropriate aftercare

2.12 Nursing team

The Provider will have a nursing team that is experienced in meeting the health care needs of trans people. The role of the nursing team should include pre-operative care, whereby contact is made before surgery and information is shared on aftercare including hygiene, risk of infection and general lifestyle considerations. Post-operative care involves wound and physical care, and liaison with community and primary care services around the time of discharge from hospital.

2.13 Surgical interventions that are commissioned by NHS England, and referral criteria

The Provider will deliver certain surgical interventions intended to reduce gender dysphoria, and improve health, quality of life and social functioning in people who have gender dysphoria that is a consequence of incongruence between their identity, and their biologically-determined sex characteristics and the social role traditionally expected of people with such biologically-determined sex characteristics.

Surgery may be combined with other surgical procedures if: the eligibility criteria for each procedure are fulfilled; it is appropriate in the clinical judgment of the surgeon; and this is the patient's preference. If a surgeon recommends a multi-staged reconstructive procedure, the reasons should be explained to the patient and they should be given the option of a single or fewer-staged procedure, either at the same unit or elsewhere.

The Provider must offer a range of surgical techniques and must ask the referrer to re-refer the patient to an alternative provider if a technique that is not offered by their unit is in their patient's best interests and is more likely to

fulfil the individual's treatment goals.

The following specialist surgery and immediate associated after care is commissioned by NHS England:

- Masculinising chest surgery
- Masculinising and feminising genital reconstructive surgery
- Orchidectomy

The criteria for initiation of surgical treatments are listed in Appendix D.

Masculinising chest surgery

Surgeons providing masculinising chest surgery must be trained in onco-plastic breast surgery or be plastic surgeons with expertise in plastic surgery of the breast (undertaking a minimum of 20 similar procedures per annum).

The standard practice[2] procedures that are commissioned by NHS England are:

- Double Incision Technique
- Peri-Areolar Technique
- Liposuction for the purpose of masculinising chest surgery
- Nipple re-positioning techniques, including pedicled flaps
- Free, full-thickness nipple grafting
- Modification of the nipple-areolar complex
- Dermal implant and nipple tattoo

Masculinising genital surgery

The standard practice[3] procedures commissioned by NHS England are:

- Phalloplasty (various types)
- Metoidioplasty (with/without urethroplasty; with/without scrotoplasty)
- Post-operative training in penile prosthesis use

Commissioned only as components of the above procedures:

- o Hysterectomy
- o Bilateral Salpingo-oophorectomy
- o Vaginectomy
- o Placement of penile prosthesis (various types)

[2] If a Provider wishes to implement a new surgical intervention it must a) be determined whether a NICE Interventional Procedure Guidance is in place and b) propose to NHS England's Clinical Reference Group for Gender Identity that a proposition for a clinical commissioning policy be developed.

[3] If a Provider wishes to implement a new surgical intervention it must a) be determined whether a NICE Interventional Procedure Guidance is in place and b) propose to NHS England's Clinical Reference Group for Gender Identity that a proposition for a clinical commissioning policy be developed.

- Placement of testicular prosthesis (various types)
- Glans sculpting

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 the 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.

Feminising genital surgery

The standard practice[4] procedures commissioned by NHS England are feminising genital reconstruction, consisting of some or all of the following:

- Penectomy
- Bilateral Orchidectomy
- Vaginoplasty (various techniques; bowel vaginoplasty should only be performed if other vaginoplasty techniques are not possible because of inadequate donor site skin)
- Clitoroplasty
- Vulvoplasty

2.14 Surgical procedures that are not routinely commissioned by NHS England

- Phonosurgery
- Augmentation Mammoplasty
- Facial Feminisation Surgery, including Thyroid Chondroplasty and Rhinoplasty
- Lipoplasty / Contouring, Microdermabrasion and other cosmetic procedures
- Body hair removal (other than donor site for surgery)
- Hair transplantation
- Hysterectomy and bilateral salpingo-oophorectomy when they are performed as "stand alone" procedures
- Corrective surgical procedures relating to complications for poor outcomes that are recognised after 18 months of previous surgery
- Reversal of a previous gender reassignment surgical intervention (i.e. patients who are satisfied with the surgical outcome at the time of discharge and become dissatisfied with their decision at a later

[4] If a Provider wishes to implement a new surgical intervention it must a) be determined whether a NICE Interventional Procedure Guidance is in place and b) propose to NHS England's Clinical Reference Group for Gender Identity that a proposition for a clinical commissioning policy be developed.

date)

2.15 Patient dissatisfaction with technical outcome of surgery (all procedures)

Readmissions for treatment of complications for poor outcomes that are recognised within 18 months of previous specialised surgery will be provided by the original provider.

Should the patient not wish to continue treatment with the surgeon who performed the primary procedure, the surgeon should refer them directly to another surgeon working in an NHS England-commissioned, surgical unit, requesting that they provide a second opinion regarding options for achieving an acceptable outcome. The choice of surgeon who will provide any further treatment or revision procedure must be discussed and agreed with the patient.

If a patient reports problems or concerns related to surgery, and if more than 18 months has elapsed since the last specialist surgical procedure or revision, the patient should be referred directly to a relevant non-specialist provider (for example, a gynaecology urology service) for assessment, management and onward referral to another surgeon if appropriate. Subsequent surgical interventions are commissioned by the individual's Clinical Commissioning Group as they are not interventions performed for the alleviation of gender dysphoria related to gender incongruence.

NHS England does not have a commissioning policy for the reversal of previous gender reassignment surgical interventions that are requested by the individual (i.e. patients who are satisfied with the surgical outcome at the time of discharge and become dissatisfied with their decision at a later date).

2.16 Donor Site Skin Epilation

Some, but not all patients having genital surgery (masculinising and feminising) require donor site skin epilation. The assessment of need is made by the surgical team. If it is necessary, the surgical team will refer patients requiring donor site skin epilation to a provider of epilation services. Arrangements for epilation should be initiated as soon as the decision is made to offer surgery.

Epilation is provided exclusively for the purpose of reducing the risk of poor surgical outcome. Laser epilation will be used for patients with pigmented hair, unless it is demonstrated as ineffective or poorly tolerated by the patient. Electrolysis will only be used for patients who have depigmented or very fair hair, or have not tolerated laser epilation or have found it to be ineffective. The surgical team will collaborate with the epilation provider to assess when treatment is complete; as candidates for surgery are likely to have a typically-male serum testosterone level, the surgical team will observe the donor site skin for hair re-growth for a period of three months after cessation of epilation treatment, before making a clinical judgment regarding the permanency of epilation.

2.17 Discharge from the surgical provider

The Provider will provide and/or arrange any pre-operative assessments or preparatory interventions necessary for a good surgical outcome. The

surgeon will provide written reports to the referrer, with copies to the patient and the GP, following assessment, surgery and at discharge; they will provide additional written reports describing any other clinically-significant event or contact with the patient. Information that is relevant to ongoing good health will be given to the individual, such as information on: breast awareness; risk of cancers; and the potential benefits of regular screening.

Recommendations for wound care and the use of specialised wound care products will be made by the surgical team, directly to the patient's GP.

Patients may be discharged from routine surgical follow up when this is clinically appropriate but Providers will provide open access review at the request of the patient, referrer or the patient's GP for at least one year after surgery.

2.18 Interdependence with other Services

Links with other services include:

- Providers of non-surgical interventions for individuals with gender dysphoria
- Epilation providers

3. 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 specialised Gender Identity Service (that is commissioned by NHS England) of individuals from 17 years of age of individuals who have a diagnosis of 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.

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 2016[5] 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 population[6.]

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 2016/17[7]. The reasons for the increased numbers are unclear, though often surmised that it is attributable to: increased availability of treatment 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:

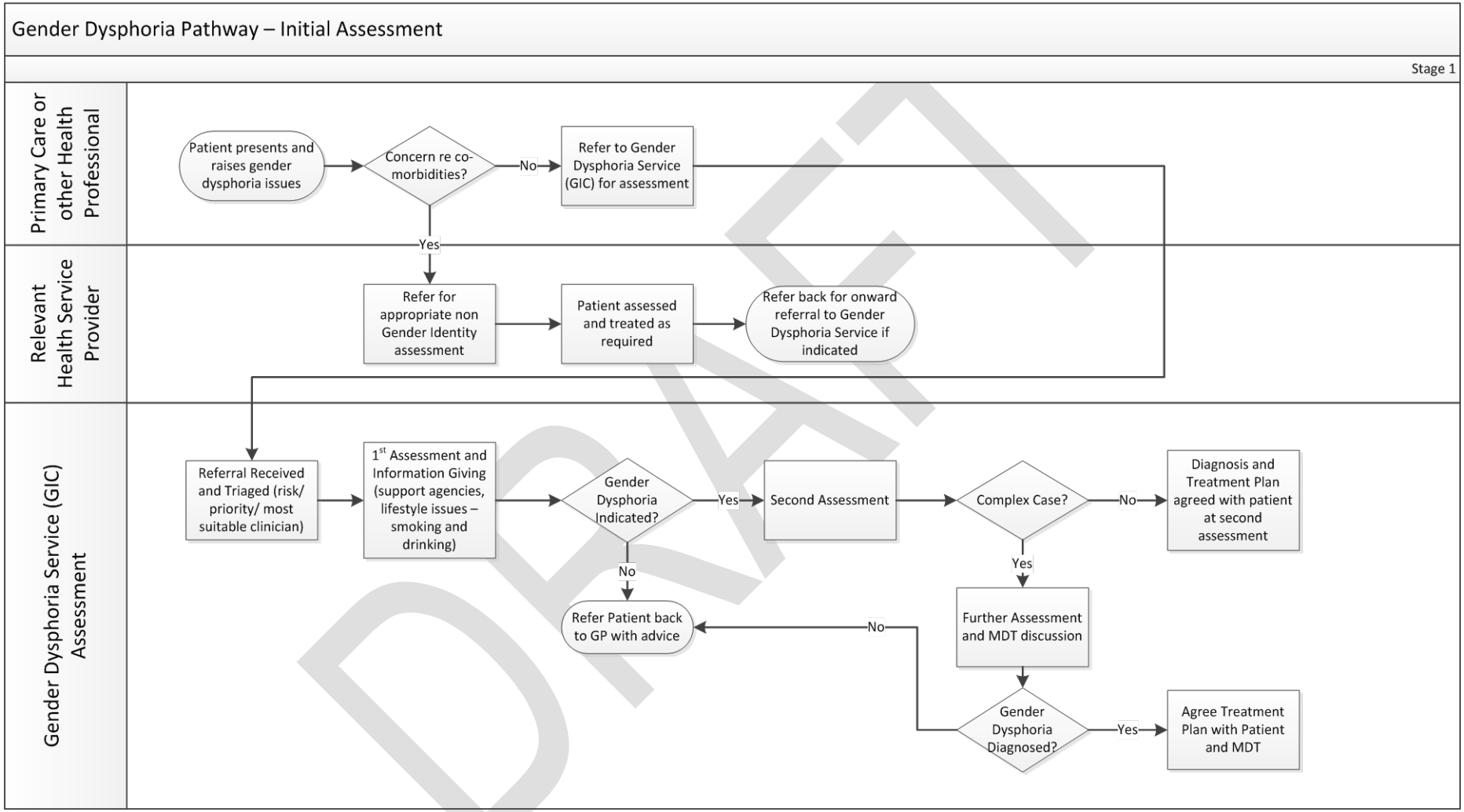
[5] Unpublished
[6] *Gender Variance in the UK;* Gender Identity Research and Education Society; 2009
[7] NHS England; April 2017

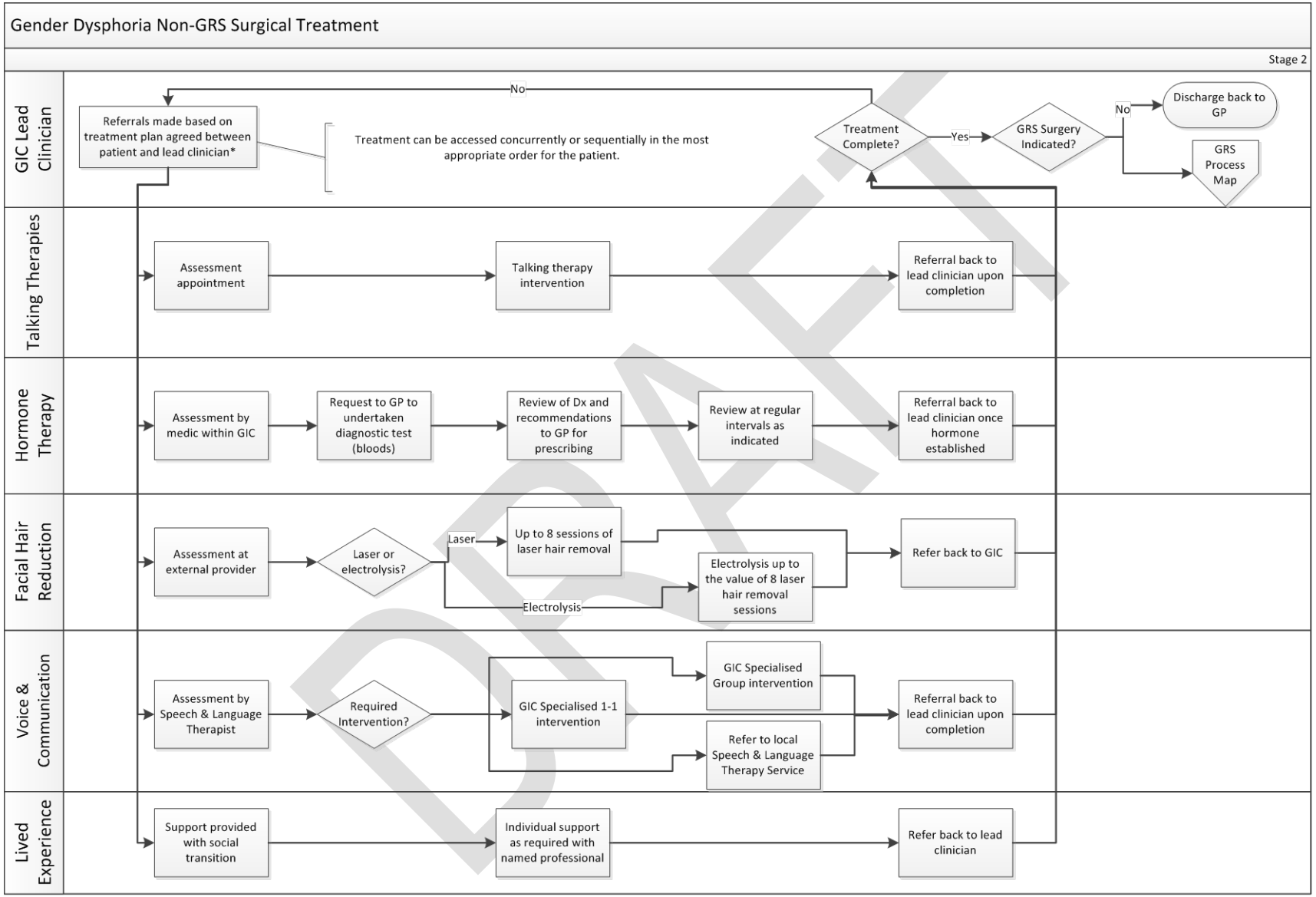
Number	Indicator	Data Source	Outcome Framework Domain	CQC Key question
Clinical Outcomes				
101	For masculinising chest surgery the % of revisions undertaken over a 12 month period.	HES	2, 3, 4	Effective, responsive
102	% of planned multi-stage procedures undertaken for patients receiving masculinising chest surgery.	HES	2, 3, 4	Effective, responsive
103	For masculinising genital surgery the % of revisions undertaken over a 12 month period.	HES	2, 3, 4	Effective, responsive
104	% of planned multi-stage procedures undertaken for patients receiving masculinising genital surgery.	HES	2, 3, 4	Effective, responsive
105	For feminising genital surgery the % of revisions undertaken over a 12 month period.	HES	2, 3, 4	Effective, responsive
106	% of patients referred for second opinion	HES	4, 5	Safe, effective, caring, responsive
Patient Experience				
201	Patient feedback	Self-declaration	4	Effective, caring, responsive
202	Patient information	Self-declaration	4	Effective, responsive

Structure and Process				
301	A patient is cared for in a multi-disciplinary environment, and there is a multi-disciplinary support available.	Self-declaration	1, 2, 3, 4, 5	Safe, effective, caring, responsive, well-led
302	Continued professional development	Self-declaration	1, 2, 3, 4	Safe, effective
303	Access to a named nurse	Self-declaration	1, 2, 3, 4	Safe, effective, caring, responsive
304	Patient pathway	Self-declaration	1, 2, 3, 4, 5	Safe, effective, caring, responsive
305	Clinical audit	Self-declaration	1, 2, 3, 4	Safe, effective, caring.

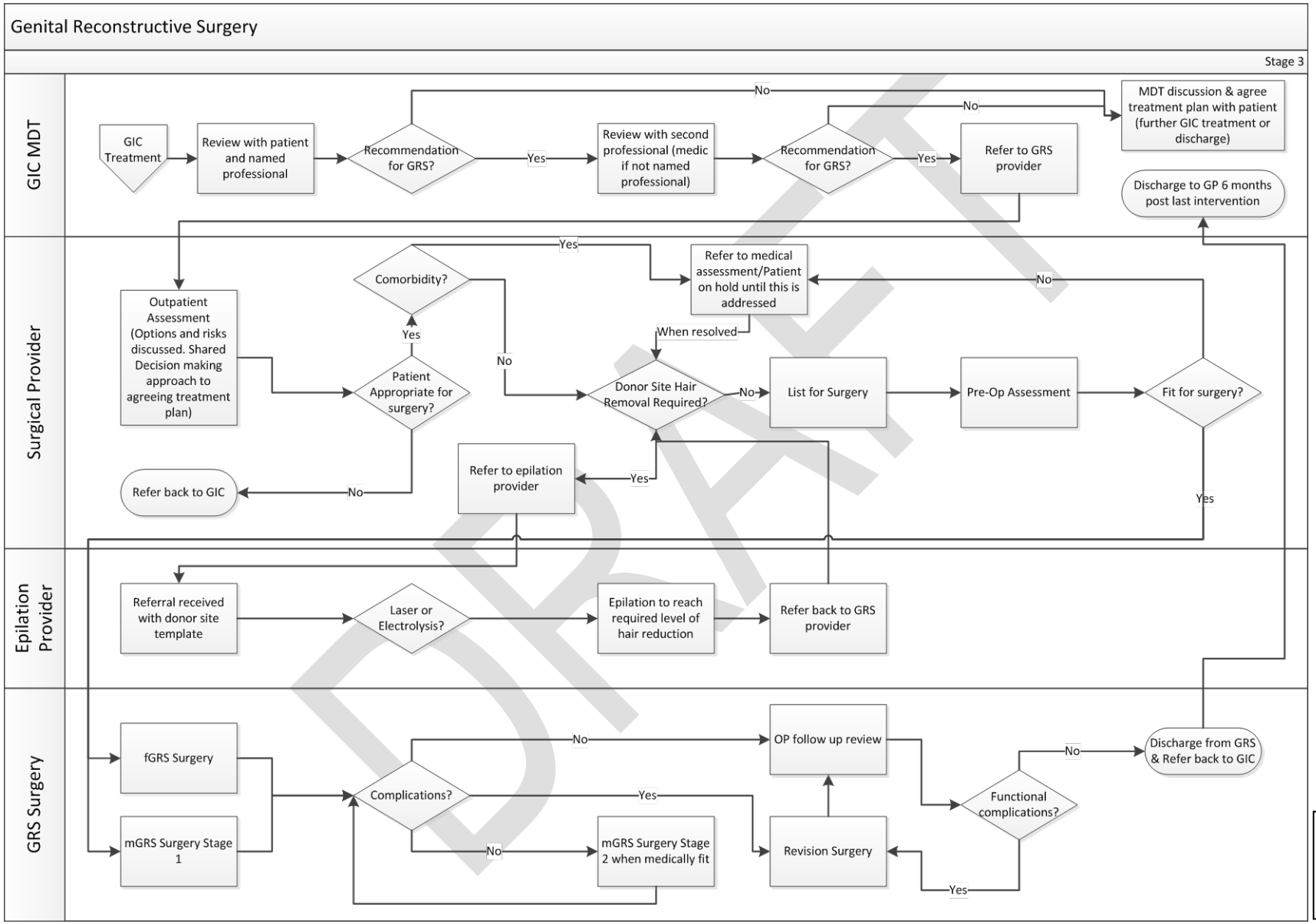
See Appendix E for more detailed description of the indicators

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

DRAFT FOR CONSULTATION, JULY – SEPTEMBER 2017

Appendix B: Referral for surgical intervention

Referrals for a surgical intervention must be made by a Lead Professional from a specialist Gender Identity Clinic that is commissioned by NHS England, with necessary accompanying clinical opinions as described in this service specification.

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, referrals to the specialist surgical team will not be accepted from other health professionals or other health services.

Before a referral for surgery is made, the Lead Professional in the Gender Identity Clinic will have met 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 time to ask questions, and to reflect on the advice of the Lead Professional to enable an informed decision on the treatment options, risks and benefits.

Appendix C: Assessment for readiness for surgical interventions

The surgeon will offer the patient a pre-operative consultation, and will provide them with information, and agree with them the surgical intervention to be provided, which will be consistent with the patient's gender expression goals, within the limits of what can reasonably be achieved with best surgical practice.

It is the surgeon's responsibility to determine that an individual is sufficiently healthy, physically and psychologically, to undergo surgery. If the surgeon has any doubts about the appropriateness of surgery, the surgeon will consult with the referrer before proceeding further.

Patients will undergo the relevant pre-op laboratory tests according to local protocol. The patient's GP will normally be asked to arrange these tests locally.

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 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 D: Criteria for initiation of surgical treatments

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

- 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
  - It is not a requirement for access to masculinising chest surgery to undertake a change in social role

Consensus opinion amongst surgeons is that prior treatment with testosterone for a period of six to nine months results in tissue changes that make masculinising chest surgery easier and may improve outcome. This is an expert-opinion based observation and is not supported by research evidence. Patients may wish to take this opinion into consideration when planning their surgery but prior treatment with testosterone is not a requirement and, in some cases, may be inconsistent with patients' other goals for gender expression.

Criteria for genital surgery (requires two letters of referral: one from a Lead Professional, 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)

Masculinising genital surgery

- 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 patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones)
- 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 must be taken into account.

Consensus opinion amongst surgeons is that prior treatment with testosterone for a period of two years results in tissue changes, such as clitoral growth, that make masculinising genital surgery easier and may improve outcome. It may also identify

the potential for hair growth on donor site skin that might be internalised during surgery. This is an expert-opinion based observation and is not supported by research evidence. Patients may wish to take this opinion into consideration when planning their surgery but prior treatment with testosterone is not a requirement and, in some cases, may be inconsistent with patients' other goals for gender expression.

Feminising genital surgery

- 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 patient's gender goals (unless the patient 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 must be taken into account

Patients who smoke

Consensus opinion amongst surgeons is that patients should not smoke for six weeks prior to surgery and for at least six weeks after surgery, particularly if they are having reconstructive surgery that involved the creation of pedicle flaps. Smoking increases risk of perioperative complications but also of major skin and tissue loss. For patients who smoke, a referral to a surgeon may still be made and an individualised discussion of risk and likely outcome included in the pre-operative counselling and consent process.

Patients who are overweight

A patient being significantly overweight increases their risk of peri-operative complication and may compromise the outcome of their surgery. Consensus opinion amongst surgeons is that patients with a BMI of 30 or more should lose weight before having genital surgery; and patients with a BMI of 40 or more should lose weight before having masculinising chest surgery. Referral to a surgeon may still be made and an individualised discussion of risk and likely outcome included in the pre-operative counselling and consent process.

Appendix E - indicators

Number	Indicator	Descriptor	Notes	Evidence documents	Data source	Domain	CQC question
	Clinical Outcomes - quantitative data where possible using national data need to minimise the burden						
101	For masculinising chest surgery the % of revisions undertaken over a 12 month period.	For masculinising chest surgery the % of revisions/complications undertaken over a 12 month period.	Revision procedures and treatments for complications or poor outcomes that are recognised within 12 months	Annual Report	HES	2, 3, 4	Effective, responsive
102	% of planned multi-stage procedures undertaken for patients receiving masculinising chest surgery.	For masculinising chest surgery the % of planned multi-stage procedures undertaken.		Annual Report	HES	2, 3, 4	Effective, responsive

103	For masculinising genital surgery the % of revisions undertaken over a 12 month period.	For the masculinising of genital surgery the % of revisions/complication rate undertaken over a 12 month period.	Revision procedures and treatments for complications or poor outcomes that are recognised within 12 months	Annual Report	HES	2, 3, 4	Effective, responsive
104	% of planned multi-stage procedures undertaken for patients receiving masculinising genital surgery.	% of planned multi-stage procedures undertaken for patients receiving masculinising genital surgery.		Annual Report	HES	2, 3, 4	Effective, responsive

105	For feminising genital surgery the % of revisions undertaken over a 12 month period.	For feminising genital surgery the % of revisions undertaken over a 12 month period.	Revision procedures and treatments for complications or poor outcomes that are recognised within 12 months	Annual Report	HES	2, 3, 4	Effective, responsive
106	% of patients referred for second opinion	% of patients, where not satisfied with procedure, referred to a second opinion post-surgery		Annual Report	HES	4, 5	Safe, effective, caring, 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 feedback from patients.		Operational Policy	Self-declaration	4	Effective, caring, responsive

202	Patient information	Patient information is provided to all patients and includes details as listed in the service specification.	• different surgical techniques available (with referral to colleagues who provide alternative options) • advantages and disadvantages of each technique • limitations of a procedure to achieve “ideal” results; • inherent risks and possible complications of the various techniques • appropriate aftercare	Operational Policy	Self-declaration	4	Effective, responsive
	Structure and Process - infrastructure requirements, staffing, facilities etc						

301	A patient is cared for in a multi-disciplinary environment, and there is a multi-disciplinary support available.	A patient is cared for in a multi-disciplinary environment, and there is a multi-disciplinary support available including: A nominated lead Clinician Surgeon Anaesthetist Specialist Nurse Psychologist		Operational Policy	Self-declaration	1, 2, 3, 4, 5	Safe, effective, caring, responsive, well-led
302	Continued professional development	Surgeons should demonstrate evidence of continuing training and mentoring in the relevant techniques and engage at least annually with national or international peers working in another organisation or surgical team.		Operational Policy	Self-declaration	1, 2, 3, 4	Safe, effective
303	Access to a named nurse	There should be a named specialist nurse to support patients throughout the surgical pathway, from referral to discharge.		Operational Policy	Self-declaration	1, 2, 3, 4	Safe, effective, caring, responsive

304	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
305	Clinical audit	The team participates in clinical audit activity on an annual basis		Operational Policy	Self-declaration	1, 2, 3, 4	Safe, effective, caring.