

Specialised Gender Identity Services for Adults; Report on outcome of public consultation and update to Equality Impact Assessment



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Introduction

1. NHS England is the direct commissioner of health services that are prescribed as “specialised” for the alleviation of gender dysphoria.
2. In July 2017 NHS England published two proposed service specifications for specialised gender identity services for the purpose of public consultation (one for specialised surgical services; and one for specialised non-surgical services). The process of consultation was supported by a Consultation Guide and an Equality Impact Assessment (EIA).
3. Views were sought from respondents to consultation on the proposed service specifications and on the findings and conclusions of the EIA.
4. In May 2018 we published a [report](#) of an independent analysis of consultation responses.
5. NHS England’s Specialised Commissioning Oversight Group has agreed the final version of the service specifications, after considering a recommendation that was made in July 2018 by the Clinical Priorities Advisory Group in accordance with our established method for agreeing service specifications for specialised services. The service specifications will be used to inform a process of national procurement later in 2018/19 that will identify which organisations are best able to deliver specialised gender dysphoria services in compliance with the new specifications from 2019/20.
6. The purpose of this document is to describe how the consultation submissions influenced the final version of the service specifications.
7. This document also up-dates the previous EIA. It describes what impact (negative and positive) there may be to people with the protected characteristics afforded by the Equality Act 2010 on adoption of the service specifications, and also gives consideration to NHS England’s duty to reduce health inequalities under the NHS Act 2006. These considerations are informed by the responses to consultation, further advice offered by the Clinical Reference Group for Gender Identity Services and the changes that have been made to the proposed service specifications as an outcome of consultation.
8. This report is structured as follows:
 - Section 1: Headline changes that have been made to the service specifications since public consultation
 - Section 2: Update to issues addressed by the previous Equality Impact Assessment
 - Section 3: Other issues not addressed by the previous Equality Impact Assessment
 - Section 4: Other issues relating to the planned process of procurement

Section 1: Headline changes that have been made to the service specifications since public consultation

Non-Surgical Services

Changes	Reason
Extension of referral rights to permit self-referral to a Gender Dysphoria Clinic	Addresses the problems that some trans people have experienced, of GPs declining to refer them to a specialist gender dysphoria centre
Extension of model for delivery of care to multi-disciplinary teams in primary care, subject to positive early adopter evaluation from 2019/20, including evaluation of value and affordability	Provides a potentially credible way of increasing clinical capacity in response to increasing demand; addresses workforce sustainability challenge; and responds to concerns that some GPs consider themselves not competent to prescribe endocrine treatments for trans people
Nomenclature: Designated centres will be called Gender Dysphoria Clinics instead of Gender Identity Clinics	Emphasises that eligibility for access to the NHS pathway of care is dependent upon a formal diagnosis of gender dysphoria; NHS services are not available to individuals to explore gender identity issues in the absence of identified health care needs
Additional quality outcome metrics have been included, against which providers will report compliance	The additional outcome metrics will focus on Patient Reported Outcome Measures and Patient Reported Experience Measures
References to epilation services for facial hair removal have been removed pro tem pending the outcome of the process for developing a clinical commissioning policy for adoption in 2019/20	Respondents to consultation suggested that the current policy for facial hair reduction is not appropriate; a new policy will be adopted in 2019/20 that may either increase or decrease the level of provision depending on the outcome of our established method for developing a clinical commissioning policy

Surgical Services

Changes	Reason
Referrals for surgery will be made via a National Referral Management Service	Has the potential to assist the individual in making an informed choice of surgical provider based on a consideration of outcome data and other information
Additional quality outcome metrics have	The additional outcome metrics will focus

been included, against which providers will report compliance	on Patient Reported Outcome Measures and Patient Reported Experience Measures
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Section 2: Update to issues previously addressed by Equality Impact Assessment

Gender Reassignment

9. To be protected from gender reassignment discrimination, an individual does not need to have undergone any specific treatment or surgery to change from birth sex to preferred gender. The Equality and Human Rights Commission explains that this is because changing physiological or other gender attributes is a personal process rather than a medical one, for the purpose of the Equality Act¹. Thus, to be afforded this protected characteristic an individual can be at any stage in the transition process, including an individual who proposes to reassign their gender but who has not yet sought – or does not intend to seek - clinical intervention.
10. A number of respondents to consultation wanted the criteria for access to the NHS pathway extended to include any individual who considers themselves transgender, non-binary or otherwise gender variant, without the need for a formal diagnosis of gender dysphoria. The point was made by these respondents that some trans people, particularly non-binary people, who do not consider themselves to have gender dysphoria should have access to the various clinical interventions offered by the NHS for people with gender dysphoria.
11. Having considered these submissions we have retained the criterion of a formal diagnosis of gender dysphoria in order to access the NHS pathway of care, and in the future designated providers will be called Gender Dysphoria Clinics. As such, people who have the protected characteristic of “gender reassignment” but who do not have a diagnosis of gender dysphoria will continue to not be eligible for the various interventions on the NHS pathway of care.
12. We have concluded that the access criteria do not discriminate against individuals who share this protected characteristic. NHS England's principal statutory duty is to seek to secure improvement in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of physical and mental illness. The UK Parliament has exercised its power to direct NHS England to directly commission gender dysphoria services on the basis that gender dysphoria is one of a number of rare or very rare conditions. We therefore take the view that the commissioning obligation depends on a clinical diagnosis of gender dysphoria from a specialist clinical team.

Gender Reassignment: Non Binary People

13. In recognition of the diversity of identities for people accessing these services, and in particular non-binary people, the service specifications that were subject to consultation proposed that “*all individuals referred to a specialist surgical service*

¹ <https://www.equalityhumanrights.com/en/advice-and-guidance/gender-reassignment-discrimination>

may exercise full personal autonomy in respect of their gender identity and presentation". Although the specific references in the service specifications to the particular needs of non-binary people were broadly welcomed by respondents who self-categorised as "service user" there were concerns that the proposed model of care and clinical framework remains "*binary focused*". In addition, it was felt by these respondents that in practice non-binary people would continue to experience more difficulty in accessing appropriate care. It was suggested that it is not uncommon that non-binary people are required to undergo a more rigorous assessment or have to justify their presentation in order to access services, and that this is discriminatory.

14. In response to concerns that non-binary people in particular may experience barriers to access of care we have extended referral rights so that individuals may self-refer to a Gender Dysphoria Clinic, and we have stipulated that these individuals should not be disadvantaged by a Provider's insistence on obtaining a prescriptive set of data from the individual's GP as a pre-condition to assessment as this may, in practice, deny an individual the right of self-referral. This amendment to the service specification will therefore have a positive impact for people who share this protected characteristic.
15. Otherwise more generally, we have concluded that the proposed model of care and clinical framework do not discriminate against non-binary or other gender diverse individuals, and we are mindful of the further advice offered by the Clinical Reference Group (CRG) in March 2018, which was asked to respond to concerns that the proposed model of care and clinical framework remains "binary focused" and is therefore discriminatory:

"The CRG does not agree that the proposed model of care and clinical framework is "binary focused" or discriminatory towards non-binary people.

There is less clinical evidence for the efficacy of interventions described in the specifications in a gender-diverse, non-binary population than in a binary (male or female) population. This more limited evidence-base requires clinicians to take additional care in assessing and counselling patients about the potential benefits, limitations, and risks of intervention. Furthermore, individuals within the gender-diverse, non-binary population have widely-differing goals with respect to bio-psycho-social change, some of which may not be achievable through existing interventions; indeed, some interventions may facilitate some goals and inhibit or even prevent the achievement of others. This is particularly challenging for patients who want to maintain gender fluidity.

That the assessment and treatment planning process in the gender-diverse, non-binary population is different to the more 'standardised' approach that has become established in the care of the binary population does not equate with the process being discriminatory. The CRG intends the specification to promote the best-possible patient-centred care for each individual and urges the offering of careful, compassionate assistance to the gender-diverse, non-binary population. Providers should be required to guard against practice that, without adequate explanation or consent, directs those with non-binary identities towards interventions that are likely to have outcomes inconsistent with their non-binary identity-expression goals".

16. We have also accepted the CRG's advice that the requirement for an individual to demonstrate twelve continuous months lived in a gender role that is congruent with their gender identity [in order to access genital surgery] does not discriminate against non-binary people:

“This wording used requires a 12-month period of “living in a gender role that is congruent with their gender identity”, not ‘living as a man or as a woman’. The CRG notes that expression of identity is a human rights issue and self-determined by the individual; an individual’s identity expression goals must be explored and documented as part of the assessment process, and further developments over time (for example, fluidity or consolidation of identity) must also be explored and documented. Clinicians must not require patients to conform to the clinician’s personal expectation or preferred stereotype of their patient’s social gender role”.

Age (access to services)

17. In order to address inconsistent practice which often delays or prevents a young person's access to adult gender dysphoria services, the service specifications proposed a consistent age threshold of 17 years for access to adult services. Most respondents to consultation welcomed this approach, though there were other mixed views that called for a lower or higher age threshold.
18. The final version of the service specifications retain the threshold of 17 years and we have concluded that this does not discriminate against younger gender variant people, who have access to a dedicated specialised service for gender variant children and adolescents. In this regard it is germane that we are not raising the age threshold (and are not therefore removing access rights to people under 17 years) but lowering it given that some adult gender clinics have previously declined to accept referrals until a person's 18th birthday.
19. A related amendment was proposed for the separate service specification for the Gender Identity Development Service for children and adolescents, previously adopted by NHS England in 2016 following public consultation. It was proposed that this specification would be amended so that the Gender Identity Development Service could continue contact with young people up to 20 years (from 18 years) in appropriate cases with the agreement of the individual. This arrangement was intended to benefit young people from 18 years who are wanting to explore options more fully before considering a transfer to specialised adult services, or who have very complex or psychosocial issues that mean physical interventions are not yet appropriate, resulting in a process of transfer that may be likely to take longer.
20. Some respondents to consultation were concerned that this proposal may discriminate against young people on the grounds that it could inappropriately delay or prevent a transfer to adult services.
21. We have removed the proposed wording to retain the current commissioning arrangement, which is that the process of transfer or discharge from the Gender Identity Development Service will conclude by the age of 18 years. However, in the interests of securing an integrated service that facilitates a transfer to adult services in appropriate cases, and in the interests of increasing clinical capacity in

response to increasing demand for specialised services for gender variant young people, we will test the feasibility of developing Integrated Adolescent Services that will be related to, but separate to, designated Gender Dysphoria Services for adults. This will be a priority work programme for 2019/20 and will involve close working with the Gender Identity Development Service and with adult services.

Age (older people)

22. Within the previous EIA we acknowledged a perception expressed by some stakeholders that some gender clinics had “*implemented a policy of denying access to older trans people*” and we described that the service specifications proposed that there should be “*no upper age threshold for accessing either surgical or non-surgical interventions*”. However, several respondents felt that there could still be a greater emphasis on tackling age discrimination within the EIA, with consideration that older patients may desire faster interventions as “*2-3 years on waiting lists represents a far larger proportion of their remaining life expectancy*”.
23. We do not agree that different clinical protocols should apply to the adult population based on age, nor that waiting lists should be manipulated to give preference to individuals based on age. In regard to the particular needs of older patients we have stipulated in the service specification that service delivery must be personalised, with service flexibility and reasonable adjustments to delivery of care to match the individual’s needs and circumstances. In regard to waiting lists, it is NHS England’s ambition over time to reduce waiting times so that all individuals receive treatment in accordance with NHS Constitution requirements regardless of age or other personal circumstances.

Disability (individuals with significant medical or mental health concerns)

24. The service specification for non-surgical services proposed that referrals would 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 previous EIA acknowledged that adoption of this proposal may delay or prevent access to specialised gender identity services for individuals with a significant physical or mental health concern which could be regarded as a “disability” under the provisions of the Act, but concluded that this was not discriminatory on the grounds that referrals should not be accepted of individuals with acute physical or mental health problems that may affect the individual’s ability to engage in the assessment process.
25. There was significant opposition to this proposal amongst respondents based on a concern that it discriminated against people with this protected characteristic, and many respondents made the point that preventing people from accessing specialist gender services may exacerbate existing mental health problems.
26. The intention of the proposal was to align clinical practice as described in the service specification with accepted practice in the United Kingdom for obtaining informed consent from the patient as described generally by the General Medical Council. Ensuring that an individual has sufficient capacity to give informed consent to any clinical intervention is a fundamental principle for ensuring the safe

delivery of health interventions, and this is particularly important in the context of interventions that are irreversible.

27. In response to the concerns of respondents we have removed the previous wording that described “*acute physical and mental health problems*” as an exclusion criterion, and have instead clarified the intention of ensuring a safe process for obtaining informed consent:

“Individuals must be given sufficient time to reflect on the clinical advice and the potential treatment options before deciding what is best for them.

Clinicians should be mindful that it is possible that individuals may lack capacity. (Bold denotes added wording)

28. We have also amended the service specifications to reiterate the duties on providers to ensure that service delivery is personalised and based on shared decision making, with service flexibility and reasonable adjustments to delivery of care to match the individual’s needs and circumstances.

Disability (individuals who are overweight)

29. A person is considered overweight if they have a body mass index (BMI) between 25 and 29, and obese with a BMI of 30 and above. In England, 24.8% of adults are obese. Case law has established that people with obesity may, in some circumstances, be considered to have a ‘disability’ under the Act.
30. Some respondents objected to the proposal that patients who have a BMI of 40 or more (masculinising chest surgery) or 30 or more (genital surgery) should lose weight before having genital surgery. The EIA reported that the impact of this proposed provision will be that obese people may be less likely to access surgical interventions on the trans pathway of care until they lower their BMI.
31. We have maintained our conclusion that this provision does not unfairly discriminate against people with the protected characteristic of “disability” and that this is a clinically justified consideration. The consensus professional advice given to NHS England was that a patient being significantly overweight increases their risk of complications during the operation and may compromise the outcome of their surgery.
32. In any event the provision does not exclude obese people from surgical interventions. Rather, the specification describes that individualised discussions will take place with the surgeon, who may decide to proceed with surgery once risk has been assessed and consent has been given by the individual based on a proper consideration of the risks and benefits of the intervention.

Disability (individuals who misuse substances)

33. The service specifications described that an individual’s history of substance misuse is a relevant consideration in the process of assessment and diagnosis, and in assessing suitability for treatment interventions. Some respondents were concerned that this may discriminate against people with addiction problems.
34. We have maintained the provision on the grounds that this is a clinically justified consideration in the context of the relevant clinical interventions. In any event we

clarified in the EIA that individuals with addiction to non-prescribed drugs or alcohol are not considered 'disabled' under the Equality Act (in the absence of any other relevant disability) and do not share the benefit of a statutory protected characteristic.

Sex (surgical procedures that are not routinely commissioned)

35. We acknowledged in the previous EIA that some stakeholders felt the list of surgical interventions not currently routinely commissioned by the NHS to be discriminatory against trans-women because they relate more to the male-to-female pathway of care. Some respondents agreed with this statement, expressing confusion as to why this was not then addressed within the service specifications and fell outside the scope of the consultation. In particular, the exclusion of facial feminisation surgery and breast augmentation from the NHS pathway of care was felt to be creating an imbalance between the male-to-female and female-to-male pathways, leading to health inequalities.
36. In the EIA we explained that our established process for introduction of a new service specification does not include the introduction of treatments or interventions that are not currently routinely commissioned by NHS England. A separate [process](#) exists for this purpose via the formation of a clinical commissioning policy proposition for each proposed intervention or treatment. We explained that it is for NHS England's Clinical Reference Group for Gender Identity Services to consider whether to submit proposals to NHS England for the routine commissioning of treatments or interventions that are not currently routinely commissioned, based on an evaluation of the available evidence base.
37. We have since asked the Clinical Reference Group to establish the evidence base that would support clinical commissioning policies for (amongst others) breast augmentation and facial feminising surgery, for consideration for adoption in the 2019/20 year. In line with our established process for forming clinical commissioning policies we will publish the proposed policy and evidence review for public consultation, supported by a specific equality impact assessment, before making a final decision.

Race

38. The previous EIA reported that there is an under representation of people from Black and Minority Ethnic groups presenting to gender dysphoria services. The proposed service specifications addressed the need for services to be culturally appropriate but some respondents wanted greater detail of what is expected of services in terms of having "*arrangements in place to ensure the service is delivered culturally appropriate*" particularly in relation to the under-representation of BAME people in the current data on service users, and evidence that trans people are more likely to identify as having a disability than is average in the population.
39. Rather than attempting to be prescriptive in the service specification our intention is to support providers in developing solutions that are focused on the needs of their particular local communities as a means of demonstrating compliance with

the requirements of the service specification, in collaboration with local community and voluntary groups. The terms of reference for the Gender Identity Programme Board will be updated to include this as a specific objective once the process of procurement has identified which providers will deliver services from 2019/20. We also expect that this will also be a key responsibility of the National Trans Health Unit/s that NHS England may designate as an outcome of the process of procurement (see paragraph 77), and arrangements will be in place for regular and consistent monitoring of data reported by providers.

Pregnancy and maternity

40. The previous EIA stated that adoption of the proposed service specifications would have “*no impacts*” to individuals who are pregnant. Some respondents were concerned by a perceived lack of justification for this statement and wished to see greater elaboration on this topic. Others believed the assertion to be “false” as “*trans men can be pregnant and indeed have given birth*”.
41. We maintain our conclusion that adoption of the service specifications for specialised gender dysphoria services will not impact on, or discriminate against individuals who have this protected characteristic. Trans men who are pregnant will receive care relating to pregnancy and birth from local obstetric and maternity services, and as such that issue is out of scope of the development of service specifications for specialised gender dysphoria services.

Family members (not a Protected Characteristic)

42. Respondents, primarily those who self-categorised as family and friends of service users, raised two points regarding the role families of service users can play in gender identity services.
- Family therapy was viewed to be increasingly important given the proposal for seventeen-year olds to be referred to an adult Gender Clinic.
 - Respondents felt that there was not currently a plan in place to adequately support the partners and families of trans people. It was felt that families, partners and parents should be offered specialist counselling by the NHS.
43. In response to a specific question on this point from NHS England, the Clinical Reference Group did not advise that the delivery of family therapy should be a mandatory requirement as the necessary focus of the various interventions is the alleviation of gender dysphoria in the individual. However, the service specifications do stipulate that it is desirable that Gender Dysphoria Clinics deliver family therapy.

Religion

44. One respondent, who is developing a spiritual care framework with a gender identity service, welcomed NHS England’s acknowledgement of the need to ensure that patients’ spiritual needs do not prevent them from receiving the same quality of care as others. The respondent suggested that a lack of religious inclusion is an ongoing problem for many trans people and may have negative

effects on their wellbeing and overall outcomes. The respondent suggested that discussions of spiritual care should be a dedicated part of the remit of the patient's Named Professional, and that this should not be restricted to those people with a professed religion or belief, but should apply to all people accessing the care pathway. The respondent also suggested that even where suitable chaplaincy care is available, it is not always commissioned adequately or at all by current Gender Clinics.

45. We have not prescribed the precise remit of interaction between the individual and their Named Professional as this would not be appropriate and is outside the scope of a service specification. Instead, we will ask the Clinical Reference Group to consider the learning from the development of the spiritual care framework in 2019/20 once the process of procurement has concluded with a view to disseminating a professionally-owned best practice guidance to Gender Dysphoria Clinics.

Individuals with Differences of Sex Characteristics / Intersex Individuals (not a Protected Characteristic)

46. NHS England proposed that referrals from people whose "*presentation primarily relates to intersex conditions*" would not be accepted. Some respondents felt that this exclusion ran contrary to the aims of the EIA, particularly since the criteria for exclusion on this basis was unclear. It was noted that the gender identity of many people with differences of sex characteristics differed to the gender in which they were raised, meaning they may self-identify as trans and experience gender dysphoria. It was also suggested that there was no clear treatment pathway for adults who experience gender dysphoria due to differences of sex characteristics, and that specialist gender clinics were the best placed service for such individuals who identify as trans.
47. The intention of the proposed wording was, for the purpose of defining commissioning responsibilities, to distinguish services for people with gender dysphoria from services for people with differences of sex characteristics who do not have gender dysphoria. We have removed the previous wording so that there is no inference that individuals with gender dysphoria are excluded should they have differences of sex characteristics.

Sexual orientation; and Sex (women)

48. The report of the analysis of consultation responses reads:

"Some respondents, primarily members of the public, were concerned that the increasing number of trans people was indirectly homophobic, and in particular lesbo-phobic. These respondents believed that many young women identifying as trans were doing so because they felt it more acceptable to be a "stereotypical straight man" than a lesbian woman, particularly if "butch" or "androgynous". Respondents were concerned that such internalised homophobia was preventing lesbians from exploring their sexuality in ways that did not involve "life-changing decisions".

“Many individual members of the public feared that the proposals and NHS England’s adoption of a “gender-affirming” framework may lead to the “erasure” of women and “women-only” spaces. Respondents thought that women and young girls, particularly those who had experienced sexual assault, should have “safe and private spaces”, which they did not feel should contain transwomen. It was felt that “enshrining Gender Identity in law will erase all sex-based protections for women and girls.”

49. These considerations are outside the scope of NHS England’s process for adopting a specialised commissioning service specification, which is a commissioning tool and the purpose of which is to stipulate requirements for how an NHS service is delivered and monitored. We have shared the report of the analysis of consultation responses with the LGBT Team at the Government Equalities Office, which is the government department that leads work on policy relating to women, sexual orientation and transgender equality.

Inclusion Health

50. The previous EIA considered whether adoption of the proposed service specifications would discriminate against other groups of people who do not share protected characteristics under the Equality Act but who are often not well provided for by healthcare services, and have poorer health outcomes (called “Inclusion Health”). Traditional definitions cover people who are homeless and rough sleepers, vulnerable migrants (refugees and asylum seekers), sex workers and those from the Traveller community.
51. The service specification for Non-Surgical Services proposed that referrals would not be accepted of individuals who are not registered with a General Practitioner. The EIA concluded that people who belong to the above groups may be less likely to be registered with a General Practitioner, and may therefore be more likely to be denied access to specialist gender identity services. In view of this, we asked a specific question on this issue of respondents to public consultation.
52. The independent analysis of consultation responses reports that 52% of respondents strongly or tended to support the proposal, and 31% tended to or strongly opposed the proposal. The report reads as follows:

“Reasons why respondents supported the proposal

- *Being registered with a GP ensured that gender dysphoria care is integrated into a wider system of care which is provided by a GP. The General Medical Council stated that the requirement to be registered with a GP before a referral to a [Gender Identity Clinic] GIC can be made “may facilitate continuity of care and information sharing between the healthcare team.” Respondents said that a GP is the health professional who considers individuals’ health holistically and has access to individuals’ health records. It was suggested that the gender dysphoria care pathway should be supported by regular coordination between GICs and GPs and this would require the service user to be registered with a GP.*

- *GPs are able to help patients access a range of services that they may need to support what the GICs are providing support on, in order to aide any transition. For example, well-being teams, mental health services, weight management and smoking cessation support.*
- *It is standard practice to access NHS services through a GP and that there are no adequate reasons why it should differ in this situation.*
- *GP registration is particularly necessary in relation to hormonal treatment, as GPs are currently asked to prescribe and monitor hormone replacement therapy upon recommendation of the gender clinic. For this to be the case, it is necessary for service users to be registered with a GP.*

Reasons why respondents opposed the proposal

- *Those who opposed the proposal said that the requirement to be registered with a GP could exclude people who are unlikely to register with a GP and mean inequitable access to Gender Identity Clinics. Respondents who expressed this concern were primarily service users. Respondents identified the following groups at risk of being excluded from the services they need:*
 - *The homeless, who are often not registered with a GP. This was seen to be of importance due to an increased likelihood of trans people to be homeless as compared to general population.*
 - *Asylum seekers and refugees, who are often not registered with a GP. Due to their unstable housing situation they are sometimes unable to provide a proof of address and, as such, are often not yet registered with a GP.*
 - *Sex workers, who are less likely than the general population to be registered with a GP”.*

53. Having carefully considered the views submitted we have decided to retain the requirement for GP registration for the reasons identified by respondents who supported the proposal.

54. In response to the concerns of respondents who objected to the proposal we are mindful of guidance² that has been issued by NHS England that advises GP practices of the Patient Registration Standard Operating Principles for Primary Medical Care (2015):

“A homeless patient cannot be refused registration on the basis of where they reside because they are not in settled accommodation. For safety reasons they may need to change the places where they sleep rough on a daily basis.

² <https://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Documents/how-to-register-with-a-gp-leaflet.pdf>

There is no regulatory requirement to provide identity, address immigration status or an NHS number in order to register as a patient and contractual requirement for GPs to request this.

Those who are homeless, vulnerably housed or of no fixed abode, asylum seekers, refugees and overseas visitors, whether lawfully in the UK or not, are eligible to register with a GP practice even if they have to pay for NHS services outside of the GP practice.

The patient MUST be registered on the application unless the practice has reasonable grounds to decline. GP practices have limited grounds on which they can turn down an application”.

55. The guidance includes details of the NHS complaints system should an individual consider that a GP has acted unfairly contrary to the operating principles.
56. Notwithstanding the clarity that this guidance brings, we are mindful of the practical challenges that some individuals may have in registering with a GP, and we propose to explore further how to address this problem through the development of an extended model of care for gender identity services, based in primary care (see paragraph 68 - 73).

Section 3: Other issues not addressed by the previous Equality Impact Assessment

Self-referrals

57. We have amended the service specification to extend access to individuals who self-refer to a Gender Dysphoria Clinic (non-surgical services).
58. We have concluded that this will impact positively on people with the protected characteristic of “gender reassignment” as it responds to the concerns of respondents who described, in some cases, difficulties of securing a referral via their GP. We have also concluded that the proposal will not impact negatively on other groups with a protected characteristic.
59. However, we have retained the requirement that an individual must be registered with a GP (see paragraphs 51 - 55) and the collaboration of the GP will be essential in providing safe, quality care. We are mindful of the submissions made by trans people, the British Medical Association and primary care professionals that raised concerns about compliance with current arrangements for prescribing endocrine treatments, and the role of the GP in the pathway of care generally, and we will explore these concerns further through the development of an extended model of care based in primary care (paragraphs 68 - 73).

Referrals for genital surgery

60. For the purpose of public consultation we proposed to retain the requirement of our current commissioning protocol that a referral for genital surgery must be

supported by two letters of referral, one of which has to be from a Registered Medical Practitioner.

61. Most respondents supported the proposal, with the point being made that this is needed mainly for the safety of the individual as most surgical interventions are irreversible.
62. We have concluded that the requirement for a referral from a Registered Medical Practitioner does not discriminate against any specific groups of people who share a protected characteristic, as this requirement is consistent with usual medical practice.

“Informed consent” model

63. Many respondents called for the adoption of a model of “informed consent” which would replace a perceived over-reliance on unnecessary assessment and diagnosis consultations with a model in which individuals have more responsibility for which interventions they access, and when they may access them on their pathway. The perceived need for a model of informed consent was often described in the context of the needs of non-binary people and people whose presentation is not conventional for their gender.

64. We sought advice on this issue from the Clinic Reference Group for Gender Identity Services in March 2018, which advised us:

“The CRG advises NHS England that there is no generally-accepted definition of an “informed consent” model of care. A minority of people use the term “informed consent model” to describe an approach to treatment planning where the clinician, after having provided a capacitous patient with the information necessary for them to make an informed choice about commissioned treatment (or no treatment) options, must then provide them with that treatment if they request it - even if the clinician believes that use of that treatment is not in the patient’s best interests. This might better be described as “Absolute Informed Autonomy”, an absolute legal right to treatment for informed and capacitous patients; currently, the law and medical ethics recognise no such right”.

65. This EIA assesses where concerns around compliance with the Equality Act have been raised and either explains why we do not share these concerns or identifies mitigating action or steps to address these concerns. We have concluded that retention of the proposed clinical framework does not unfairly discriminate against people with protected characteristics. Rather, in line with contemporary clinical practice generally, it ensures safe delivery of care via specialist teams of clinicians who assess, diagnose and agree an individualised care plan with the patient based on shared decision making principles; and which provides assurance that NHS resources are being deployed and prioritised appropriately and responsibly in a transparent clinical and commissioning framework.

Epilation services for facial hair

66. In response to consultation submissions that NHS England's current protocol for commissioning epilation services for facial hair reduction is inadequate for many transgender people the proposed service specification has removed *pro tem* references to this aspect of the pathway pending the outcome of a [process](#) for forming a clinical commissioning policy, based on an evaluation of the evidence base that is being gathered under the leadership of the Clinical Reference Group for Gender Identity Services.
67. The outcome of this process may be either a reduction or increase in the delivery of facial hair epilation (proposals for an increase in the delivery model would need to be considered as part of NHS England's relative prioritisation process for investment in specialised services). In line with our established process for forming clinical commissioning policies we will publish the proposed policy and evidence review for public consultation, supported by a specific equality impact assessment, before making a final decision for adoption in 2019/20. Current arrangements for access to facial hair epilation will continue to apply as described in the interim commissioning [protocol](#) until adoption of a new policy.

Extension of the model for delivery of specialised services to multi-disciplinary teams based in primary care

68. The guide to consultation sought views on a number of potential options for arrangements for prescribing endocrine treatments. The EIA reported on the potential equality impacts for the options offered.
69. A range of views were offered, but a consistent theme amongst primary care professionals who responded to consultation was that current arrangements are not optimal. The British Medical Association proposed the development of local networks of specialist GPs, working more closely and collaboratively with specialist gender clinics to encourage greater experiential learning and assist with the transfer of skills and expertise at local level.
70. As an outcome of consultation we will test the feasibility of extending the current model for delivery of care to properly trained multi-disciplinary teams based in primary care settings, via the evaluation of an early adopter site, including an evaluation of value and affordability. The extension of the model of care to primary care settings would require Gender Dysphoria Clinics to establish formal links with these teams, which could be located within the footprint of every Sustainability and Transformation Partnership in England.
71. We have concluded that this proposal would, if adopted, impact positively on people with protected characteristics, and in particular:
- Gender Reassignment – Trans people would have more timely access to locally based services, in a system that removes various barriers to access under the current system
 - Age and Disability – Travelling times would be reduced as services will be more locally available, which may particularly benefit older people or people with physical health problems

- Race – Services can be developed that meet the particular needs of local communities, with increased collaboration with local community groups
- Inclusion Health – The extended model would be better placed to meet the particular needs of people who are homeless or who are otherwise considered to be vulnerable, and who may experience more problems in registering with a GP practice

72. The extended model for delivery would also assist NHS England to reduce inequalities between patients in access to health services and the outcomes achieved, as is the legal duty under s13G of the 2006 Act. In particular the extension of the model for delivery to locally based services will help to reduce current inequity in geographical access.

73. We are developing proposals to establish an early adopter pilot for two years from 2019/20 for formal evaluation, including through stakeholder engagement. A detailed equality impact assessment will be developed and published as part of the formal evaluation before decisions are made on wider roll out of the model across England.

Individuals in the criminal justice system

74. There are particular challenges in ensuring that people in the criminal justice system have equivalent access to, and experience of, the specialised services described in the service specifications.

75. In 2017 NHS England commissioned the *Community Innovation Enterprise* to report on a review of an assessment of the evidence base on meeting the health and social care needs of trans people in the criminal justice system. The report on the findings is for the purpose of informing policy and practice in the offender health system, including all ages and the range of provision. This includes an evaluation of the way in which the needs of transgender individuals are included in offender health and social care needs assessments and the implications for service provision and practice. The [report](#) “*Inside Gender Identity*” was published in January 2018.

76. The findings of the report will be used by the NHS England’s Programme Board for Gender Identity Services (established in 2018) which includes representation from NHS England’s Health & Justice commissioning function alongside the Specialised Commissioning team. The Programme Board’s [terms of reference](#) have a specific objective of ensuring that there is equivalent provision of access to specialised gender dysphoria for people in the criminal justice system, and this will be a priority work stream for 2019/20, working closely with colleagues from HM Prison and Probation Service.

Section 4: Other issues relating to the planned process of procurement

77. In June 2018 we shared a slide pack with individuals who are registered as stakeholders for the Clinical Reference Group for Gender Identity Services, for the purpose of engagement on two proposals that would be addressed by the planned process of procurement. The proposals were:

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- Appoint up to two Gender Dysphoria Clinics to perform the role of a Lead Provider (National Trans Health Unit)
- Establish a National Referral Management Service to assist individuals in their choice of surgical provider

78. We asked registered stakeholders to describe the extent to which they supported or opposed the following proposals, and to give reasons:

Proposal to designate one or two designated Gender Dysphoria Clinics to perform the role of National Trans Health Units (submissions received = 41)

Respondent Type	Strongly Support (n)	Tend to Support (n)	Neither Support or Oppose (n)	Tend to Oppose (n)	Strongly Oppose (n)
CCG	1				
Individual	3	6	1	1	1
Provider	6	2	1	1	
Clinician	1	2			3
Voluntary Group / Charity		2	1	1	1
Member of Public	1			1	
Other			2		1
Not stated			1	1	
TOTAL	12	12	6	5	6
	(29%)	(29%)	(15%)	(12%)	(15%)

Proposal to establish a National Referral Management Service for surgical referrals (submissions received = 40)

Respondent Type	Strongly Support (n)	Tend to Support (n)	Neither Support or Oppose (n)	Tend to Oppose (n)	Strongly Oppose (n)
CCG	1				
Individual	4	3	2	1	2
Provider	10				
Clinician	2	1			2
Voluntary Group / Charity	3	1		1	
Member of Public	1	1			
Other	1				2
Not stated	1	1			

TOTAL	23	7	2	2	6
	(57.5%)	(17.5%)	(5%)	(5%)	(15%)

79. We will consider the submissions (including the reasons given) in detail in the development of the procurement strategy between September and December 2018, and we will use the process of procurement to test the benefits that the proposals may bring to individuals who use specialised gender dysphoria services, including a consideration of value and affordability.

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