

NHS England and NHS Scotland

Analysis of public consultation on proposed service specifications for specialised Gender Identity Services for Adults

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Executive Summary

The consultation elicited responses from individuals, groups and organisations with differing interests, and at times opposing viewpoints, on the proposals. The presentation of this report includes a detailed description of responses by respondent type where this is helpful in understanding the context. Additionally, this section summarises the main respondent types and the general themes that formed their responses. Respondents were asked to self-categorise the capacity in which were they responding. The majority of responses were from respondents who categorised themselves as:

- Current, former or prospective user of gender identity services¹ (30.15% of respondents)
- Individual member of the public (26.8% of respondents)
- Clinician (16.75% of respondents)

Current, former or prospective user of gender identity services

There was significant similarity between the themes that were raised by respondents in this group and by organisations representing the interests of trans and non-binary people.

Respondents from this group, including those who welcomed aspects of the proposals, were often critical that the proposals do not go far enough in setting out a new model for how gender identity services are accessed and delivered.

“There are other possible opportunities for improving the productivity of gender identity services that involve fundamental changes in the model of care, for instance shifting assessment into primary care.” (Gender Identity Research and Education Society)

“We acknowledge and support the progress that is included within the draft clinical framework for Adult Gender Identity Services in the UK, which we do feel is an improvement on the current framework services are operating from. We do however have concerns that whilst a step in the right direction is positive, overall there has been a missed opportunity to remove all of the barriers and inequalities Trans and non-binary people face when accessing services.” (Trans Equality Legal Initiative)

¹ For the purpose of brevity and easy reading, we refer to this group of respondents as “service users” throughout this report. For the same reason, the category “Parent, Family Member, Carer or Friend of User of Gender Identity Services” is referred to as “Family and Friends of Service Users”.

In particular, the retention of the requirement for a referral to be made by a GP or health professional was criticised on the grounds that it is unnecessary medical gate keeping that acts as a barrier to accessing specialist services. In addition, service users felt that GPs are at times discriminatory towards trans people and often inexperienced in trans health care. As such, respondents wanted the ability to self-refer to a Gender Identity Clinic and they often referred to arrangements in Scotland which they said were an example of how a system of self-referral works in practice.

“We need to be moving towards a self-referral model instead of referral via GP - there is no reason for GPs to necessarily be involved in the referral process, and this model has worked successfully elsewhere (including in Scotland). This would not only solve the aforementioned issues (of accessibility to services), but would help prevent a GP’s personal opinion or ignorance on trans issues from becoming a barrier or delaying a patient’s referral.” (UK Trans Info)

Related to the issue of “clinical gate keeping” respondents called for the adoption of a model of “informed consent”. This 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.

“Under [the current] model, clinicians ultimately hold the power to prevent individuals from accessing treatment, particularly if they have a pre-existing mental health condition. NUS would prefer to see a model of de-pathologised informed consent. After going through the medical risks of transition (including specific risks depending on the individual’s health) it is up to the individual to decide whether they want to undergo treatment or not. This would see trans individuals be the ultimate decision makers throughout all stages of the treatment process.” (National Union of Students)

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. Although the specific references in the service specifications to the particular needs of non-binary people were broadly welcomed by respondents in this group, there were concerns that the proposed model of care and clinical framework remains “binary focused”. In addition, it was felt 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.

“We have a number of concerns about non binary people’s access to healthcare under the proposed specification. These are:

The inability to self-refer; non binary people are more likely to receive gate keeping at the referral stage from GPs who are less likely to understand non binary patients’ needs;

Treatments require a diagnosis of gender dysphoria. Some non-binary people do not experience gender dysphoria, and many who do are wrongly perceived to not experience gender dysphoria by clinicians. We believe access to these treatments should be available to anyone who needs them regardless of diagnosis

The requirement for patients to be living “in role” for over 12 months before accessing lower surgery discriminates against non-binary people for who there is no social consensus of what “living in role” looks like.” (Action for Trans Health)

Individual member of the public

Respondents in this group were often, but not exclusively, critical of what they perceived to be an overly liberal approach by the NHS in the treatments and interventions that are available to trans people. In contrast to the issues raised by trans people and trans groups, this group was concerned that the proposals remove clinical safeguards that they perceived to be necessary for ensuring that individuals can only access treatments after having gone through an inquiring process of assessment and diagnosis. NHS England’s acknowledgement that gender dysphoria is not a mental health condition was often criticised and disputed, and respondents wanted a more detailed description of what “gender dysphoria is”. A common theme from this group was the need for more focus on psychological assessment and ongoing mental health care. NHS England’s rejection of conversion therapy was criticised as fettering the abilities of clinicians in the treatment of gender dysphoria.

Respondents from this group often cited the specific risks to young people, whom they perceived to be more vulnerable to a misdiagnosis of gender dysphoria through a combination of evolving cognitive function and increased cultural pressure (from social media and trans lobby groups) to regard themselves as trans rather than gay, lesbian or bisexual. In this regard, there was concern at a perceived trend for teenage girls in particular to be pressured into believing they were trans rather than lesbian.

Themes arising from this group of respondents may be characterised by this response:

“The NHS should start to publicise national and local organisations which provide a more critical perspective on gender identity issues. These have started to spring up as families and individuals have become alarmed at the uncritical acceptance of self-identification as transgender has increased massively in recent years. The NHS should no longer uncritically publicise pro-transgender organisations that seek to provide support for families of people with gender dysphoria, as these organisations have tended to manipulate families into accepting gender reassignment with all the drastic and often traumatic disruption to family and kinship relationships that this has entailed.” (Christian Concern)

Clinician

The majority of respondents who self-categorised as “Clinician” were identifiable as General Practitioners. There was significant similarity in the themes raised by this group with responses from those who categorised themselves as “NHS Commissioner” (all such respondents were Clinical Commissioning Groups) and from submissions received from Local Medical Committees and Local Area Prescribing Groups.

This group tended to focus on proposals for future prescribing arrangements. Reflecting the submission made by the British Medical Association (Appendix 2) there was consensus within this group that the prescribing of endocrine treatments for trans and non-binary people was not generally within the expected competence of a general practitioner.

Respondents in this group wanted to highlight the capacity pressures within the primary care system, and they questioned what they perceived to be an attempt to re-divert clinical activity from specialist gender identity centres to general practice without a corresponding increase in resource. It was suggested that the problems experienced by trans people in accessing an appropriate service in primary care were due in part to NHS England’s failure to properly commission an end-to-end pathway.

“The Camden Medicines Management Committee would like to acknowledge the lived experience of trans people including the fact that there is a good deal of discrimination and stigma. The solution to this is not, however, to move un-resourced work from secondary to primary care, especially when there is a lack of confidence that such arrangements would be clinically safe.” (Camden Clinical Commissioning Group)

The need for an enhanced primary care service was suggested:

“Development of primary care-based services could be through the implementation of an optional ‘Enhanced Service’, responding locally to increased demands for service provision beyond what is required under the core general practitioner contract. The specification for such an enhanced service would need to define the role of the general practitioner, including guidance on prescribing and monitoring, as well as payment for providing the service. This could also include the development of ‘GP with a Special Interest in Transgender Care’ role.” (General Practitioner)

Respondents in this group also expressed concern at having to accept medico-legal responsibility for a field in which they believe they do not have the necessary training, specialist knowledge or expertise. It was often cited that part of the current problem is that the relationship between primary care and specialist gender identity services is far from optimal in that gender identity teams do not adequately support primary care teams in the provision of expert advice. A lack of communication from the gender identity team, delays in providing advice and the scarcity of accessible training tools were common themes raised by clinicians.

“The General Medical Council guidance suggests that GPs complete the RCGP online learning module on gender identity if doctors have a learning need. However more training and resources are needed to cover issues such as doses of medication and how often to check hormone levels ... GPs are encouraged to take a holistic approach to the care of transgender patients. Taking transgender patients seriously, treating them with respect and allowing them to feel listened to are paramount. To allow for this potentially long term therapeutic relationship to flourish, GPs need to be supported by secondary care, be adequately trained and funded to provide any extra service needed.” (Royal College of General Practitioners)

In addition, the experience of trans and non-binary people in primary care services was a common theme:

“While people using gender identity services indicates that whilst some GPs are described as ‘very helpful’ ‘knowing what to do’, ‘providing relevant information’ and ‘being willing to learn’, the Commission continues to receive reports of GPs restricting access to specialised services, not making appropriate referrals and refusing to administer hormone treatments prescribed by specialised gender identity services.” (Equality and Human Rights Commission)

Introduction

Between July and October 2017 NHS England and NHS Scotland held separate but related public consultations on proposals for new service specifications that, if adopted, describe how specialised gender identity services for adults will be commissioned and delivered in the future. Two service specifications were published: a service specification that describes the proposals for how non-surgical interventions will be provided by Gender Identity Clinics; and a separate service specification that describes proposals for the service and interventions that will be delivered by designated surgical units.

It was explained to respondents to consultation that once agreed, the final versions of the service specifications will be used to inform a process of competitive procurement that will determine which organisations are best placed to provide specialist gender identity services. The process of procurement will be managed by NHS England, with the involvement of NHS Scotland. The process of procurement will determine the organisations with whom NHS England will hold contracts for the provision of specialised surgical and non-surgical services for the population of England, and the organisations with whom NHS Scotland will hold contracts for the provision of specialised surgical services for the population of Scotland. NHS England also invited responses from the populations of Northern Ireland and Wales, some of whom may use specialised gender identity services based in England.

Respondents were invited to answer specific questions as well as to comment on any aspect of the proposed specifications. The process of consultation was supported by face-to-face events in Manchester, Brighton, London, Leeds and Cardiff.

The NHS England consultation asks a range of closed and open questions in relation to the surgical and non-surgical components of the service specifications. The NHS Scotland consultation sought views on the surgical specifications only. There were 806 responses to the NHS England public consultation, and 22 responses to the NHS Scotland public consultation.

Rocket Science UK Ltd was commissioned by NHS England and NHS Scotland to analyse the responses to the consultation and report the key findings. This report provides a comprehensive and impartial analysis of the 828 responses received on this consultation. Rocket Science is an independent research and consultancy organisation specialising in health, social care and employability. Headquartered in Scotland with offices in London and the North East of England, we have been contracted by the public sector to conduct research and analysis across the UK since our creation in 2001.

Methodology

This section outlines our methodology for research, analysis and reporting.

Rocket Science were sent written responses submitted through the NHS England and NHS Scotland consultation portals. In addition, we received around 53 responses from NHS England that were submitted via email or letter. These responses were then uploaded in NVivo for analysis.

The IP addresses of respondents were reviewed in order to be attentive to potential duplications of responses. While there were numerous responses from the same IP addresses, the responses were not identical. As such, the responses were not seen as duplications but treated as individual responses.

NVivo is an online qualitative analysis programme that enables the coding of responses into categories of key messages. All messages and viewpoints expressed in each written submission was coded using an NVivo framework. Once all responses were coded, the coding framework was reviewed and reorganised to bring together the key messages. NVivo then allows filtering by message to enable accurate analysis of these messages for this report.

Throughout this report we explore the views submitted by respondents. However, in considering the findings of the analysis, it is important to bear in mind that views gathered through an open consultation exercise cannot be regarded as representative of the views of the population as a whole. Rather they are the views of people who were aware of the consultation, have an interest in the subject under discussion, and have chosen to take part.

The aim of this report is to present an analysis of the comments received, representing the totality of the material submitted. The approach to the analysis took account of the range of responses received, and the varied material submitted, and provided a robust thematic framework for the analysis based on, but not constrained by, the discussion questions themselves. When discussing the prevalence of the views and opinions emerging from the multiple-choice question), the following terms are used to reflect the numbers responding to a particular question:

- **“Few”** means between 5 and 9%
- **“Some”** means between 10 and 19%
- **“Many”** means between 20 and 49%
- **“Most”** or **“majority”** means 50 to 74%
- **“Large majority”** or **“broad agreement”** means 75 to 89%
- **“Consensus”** means 90%

However, caution must be taken when interpreting the frequency of an issue being raised by respondents and referred to in the report. Some issues were raised more frequently because specific questions were asked about them. In turn, issues that were not specifically asked about in the consultation, are likely to be raised less frequently by respondents. In such cases, the following guidelines apply when reporting data from the open-text comments:

- If a certain thematic point (indicated in a bullet point throughout the report) was at least 50% of the time raised by one respondent type, it will be indicated that this thematic point has been “**primarily**” raised by one respondent type.
- If there is no clear pattern in respondent type on a particular thematic point, it will simply be stated that “**respondents**” raised this point, i.e. the respondent type will not be specified.

These terms (in **bold**) apply when the report refer to all respondents and to the individual respondent groups defined in Chapter one.

This report provides an accurate and comprehensive summary of the views expressed by respondents. It does not provide policy recommendations on how this consultation should be responded to. The views and opinions presented do not necessarily reflect the views of NHS England, NHS Scotland or Rocket Science.

Report Structure

This report is structured as follows:

- **Chapter One** provides a breakdown of the 828 respondents across both NHS England and NHS consultations
- **Chapter Two** contains respondent views on the non-surgical service specifications in the NHS England consultation, and the surgical service specifications from both the NHS England and NHS Scotland consultations
- **Chapter Three** explores respondent views on the proposed referral pathways and requirements. This section covers the 806 NHS England consultation responses only as the NHS Scotland consultation did not contain questions on this aspect of the service specification
- **Chapter Four** outlines respondent views on hormone treatment outlined in the service specifications. As with chapter three, this section covers the 806 NHS England consultation responses only as the NHS Scotland consultation did not contain questions on this aspect of the service specification
- **Chapter Five** summarises respondent views on the equality assessment contained in the service specifications. As with chapters three and four, this section covers the 806 NHS England consultation responses only as the NHS

Scotland consultation did not contain questions on this aspect of the service specification

- **Chapter Six** includes an analysis of the key other issues that were raised by respondents that were not in relation to the specific questions asked in the consultation document. This chapter contains views expressed by respondents to both consultations.
- **Chapter 7** highlights any feedback by respondents on both NHS England and NHS Scotland consultation process.

Chapter 1 Who responded?

There were 828 responses to the NHS England and NHS Scotland consultations. There were 806 written responses to the NHS England consultation, and 21 from the NHS Scotland consultation. There were a number of blank consultation responses submitted which have been excluded from these numbers. There were 10 respondents to the NHS England consultation who said they lived in Scotland.

1.1 NHS Scotland respondents

Respondents to the NHS Scotland consultation were asked for their name and organisation. Two of the 21 respondents identified themselves as individuals, with one saying explicitly that they are a current patient. Three respondents identified the organisation that they are part of. The survey did not ask them whether they were responding on behalf of this organisation, so we are unable to state that their views are of those organisations as opposed to individuals within the three organisations. The remaining 16 respondents did not identify themselves and have thus been categorised as 'other' for the purpose of the analysis in this report.

1.2 NHS England respondents

Respondents to the NHS England consultation were asked to identify themselves across a range of factors including:

- Capacity in which they are responding – e.g. clinician, service user, member of the public
- Gender
- Age
- Location
- Sexual orientation
- Religion
- Ethnicity
- Disability.

A detailed breakdown of the NHS England consultation respondents is provided below.

As outlined in Figure 1, most respondents were either service users, members of the public or clinicians. Most clinicians were GPs.

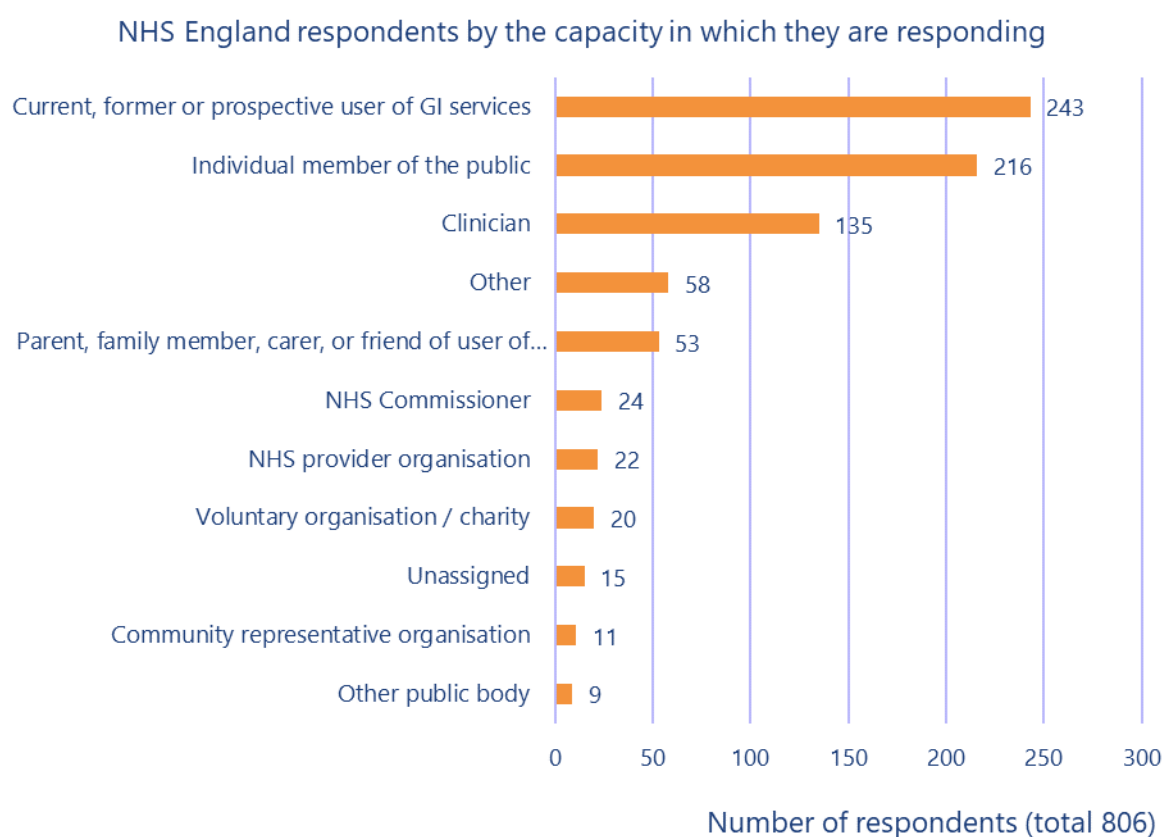


Figure 1

Figure 2 below breaks down the NHS England respondents by age group.

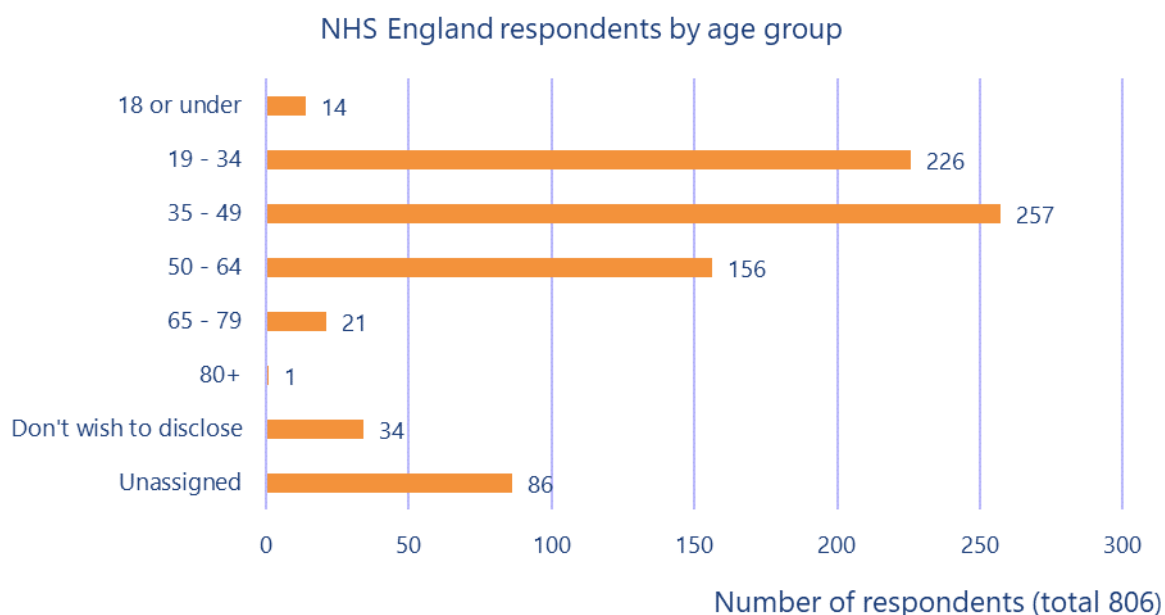


Figure 2

Figure 3 outlines NHS England respondents answer to the question 'what best describes how you think of yourself?

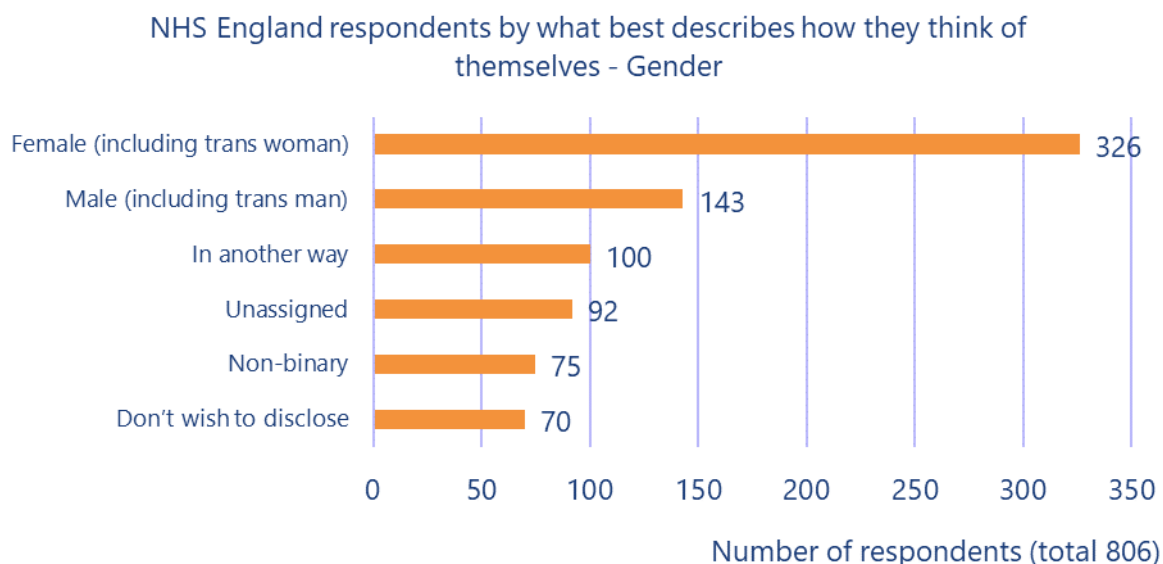


Figure 3

Figure 4 below shows where NHS England respondents were located. It is with noting that 16 respondents were from Wales, 10 from Scotland, 10 from Northern Ireland, and 31 were from organisations that were UK-wide.

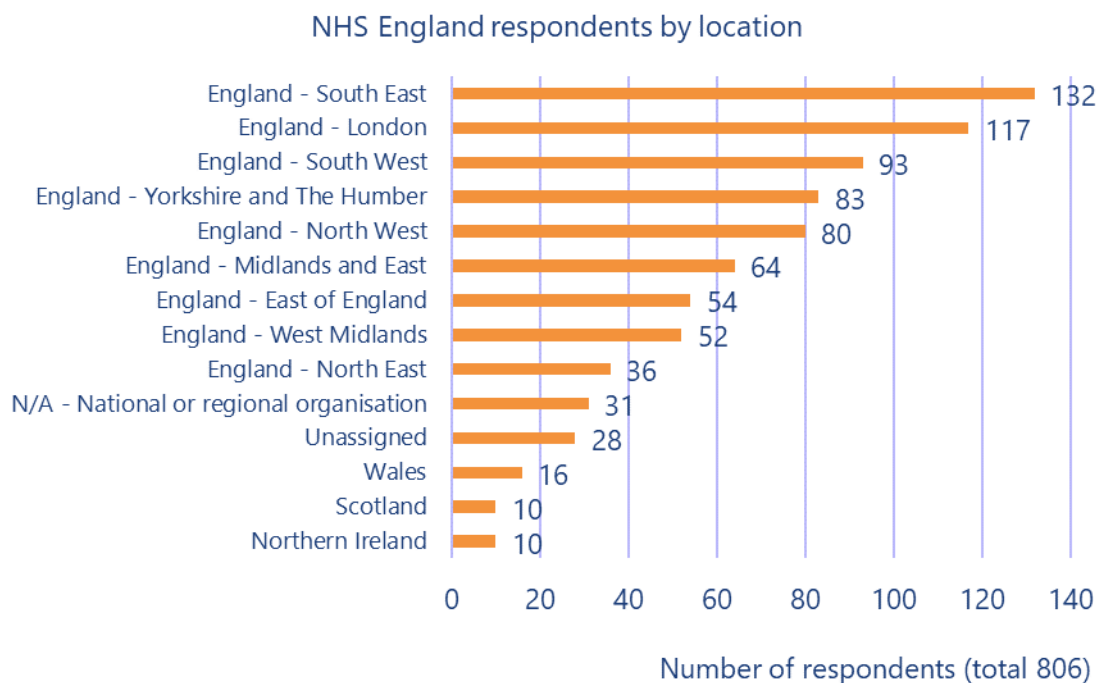


Figure 4

Figure 5 shows NHS England respondents by sexual orientation.

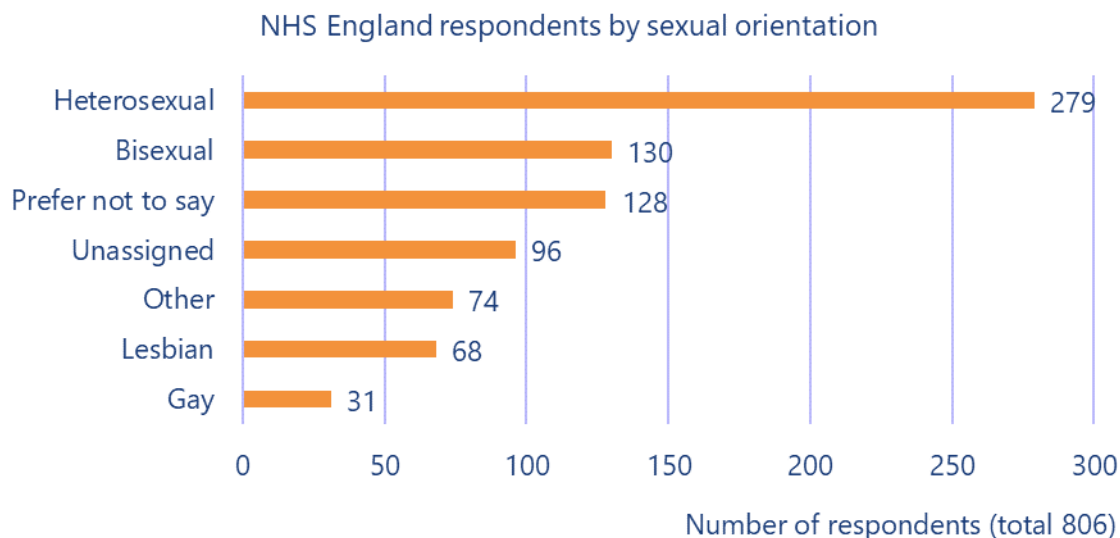


Figure 5

The NHS England consultation asked respondents whether they considered themselves to have a disability. Figure 6 below outlines their response.

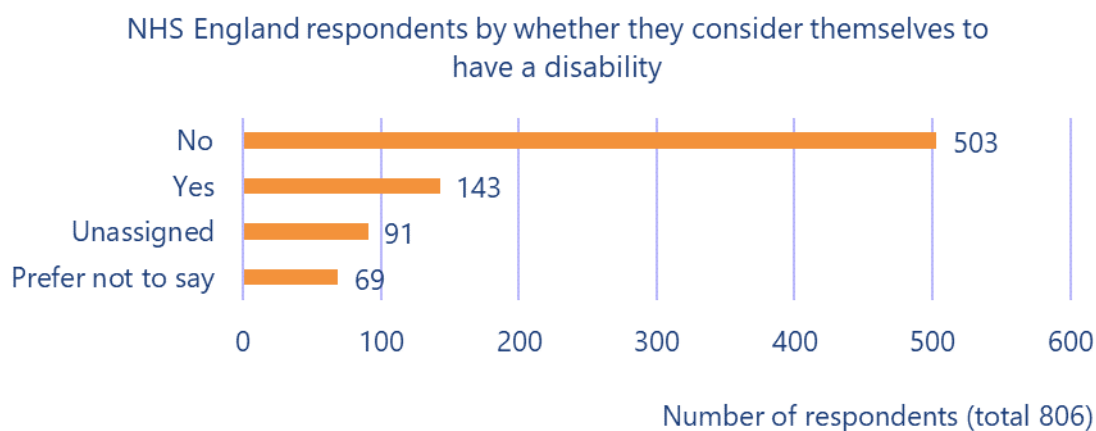


Figure 6

As outlined in Figure 7, almost all respondents that provided an ethnic origin identified themselves as Welsh, English, Scottish, Northern Irish or British.

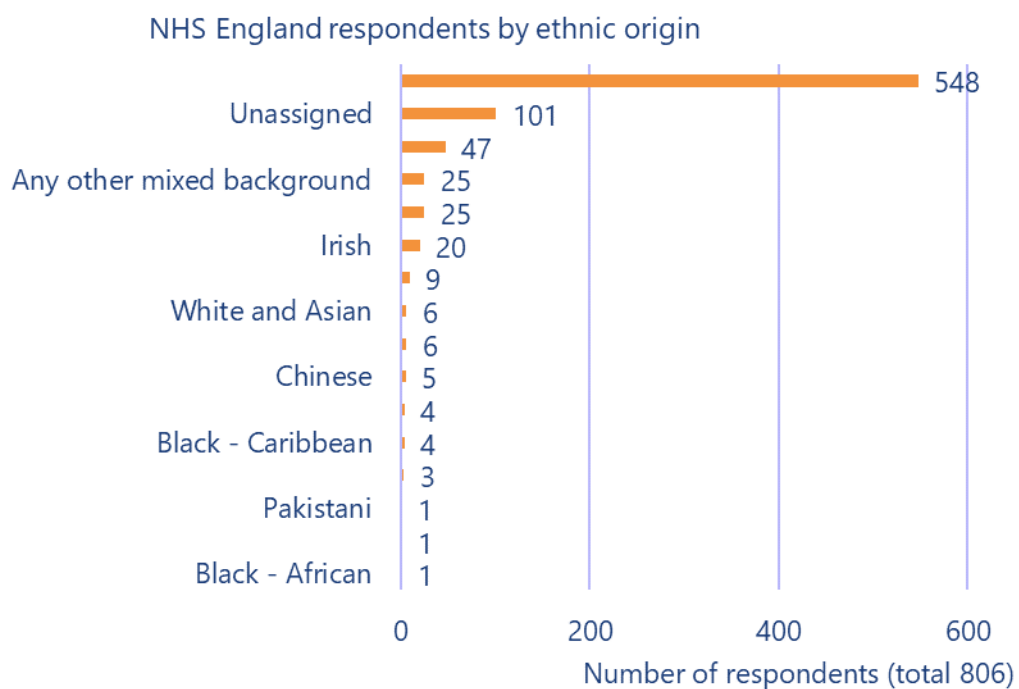


Figure 7

Figure 8 breaks down NHS England consultation respondents by religion.

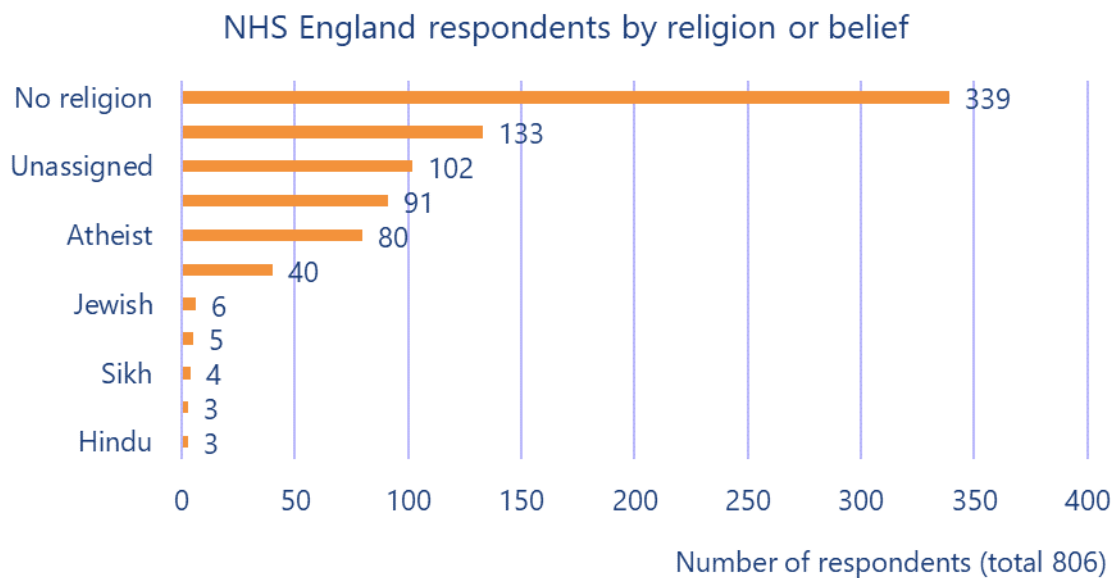


Figure 8

Chapter 2 Service Specification

Two service specifications were published: a service specification that describes the proposals for how non-surgical interventions will be provided by Gender Identity Clinics (GICs); and a separate service specification that describes proposals for the service and interventions that will be delivered by designated surgical units.

Respondents in NHS England's consultation were asked to provide their views on both the surgical and non-surgical service specifications. The NHS Scotland consultation asked only about the surgical service specification. Those responding to the NHS Scotland consultation often expressed a view on the non-surgical service specification. Where this occurred, it is included in the qualitative analysis throughout this chapter.

This chapter outlines the key messages arising from both consultations.

2.1 Overall views on the non-surgical service specifications

The proposed service specifications aim to address inconsistency in care quality, differing levels of access, and out-dated service models. Respondents were asked to what extent they agreed that the specification for non-surgical services achieved these aims. There were 10 elements of the specification that they were asked about:

1. Principles
2. Duties on providers
3. Staffing, structure and governance
4. New referrals and transfers of care
5. Assessment process
6. Role of named professional and lead clinician
7. Interventions that are delivered by the Gender Identity Clinic
8. Interventions that are delivered by other providers
9. Population covered, and population needs
10. Outcomes.

Respondents were asked to choose from one of three options:

- Fully
- To some extent
- Not at all.

For each of the ten sections of the non-surgical service specification, the most frequent response to whether the section will achieve the outlined aims is 'to some extent'.

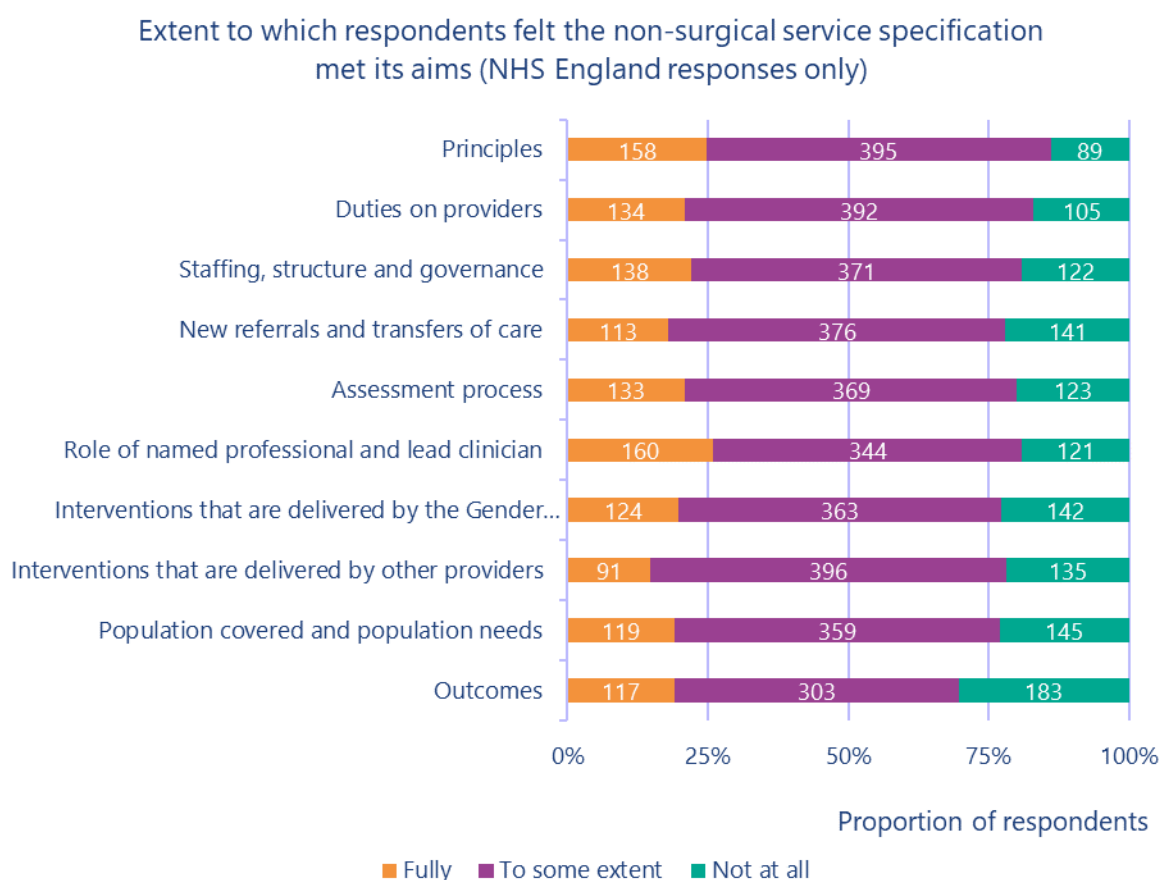


Figure 9

2.2 Overall views on the surgical service specifications

Both NHS England and NHS Scotland consultations asked for respondent views on the surgical service specifications. The overall views of respondents for each consultation is outlined below

The proposed service specifications aim to address inconsistency in care quality, differing levels of access, and out-dated service models. For the NHS England consultation, respondents were asked to what extent they agreed that various sections of the specification for **surgical services** achieved these aims.

The nine sections of the service specifications are as follows:

1. Principles
2. Duties on providers
3. Staffing, structure and governance
4. Referral for surgical intervention
5. Role of the specialist surgeon and surgical team
6. Assessment process
7. Patient dissatisfaction with technical outcome of surgery; and discharge arrangements
8. Population covered and population needs
9. Outcomes.

For each of the nine sections of the surgical service specification, the most frequent response to whether the section will achieve the outlined aims is 'to some extent'

Extent to which respondents felt the surgical service specification met its aims (NHS England consultation responses only)

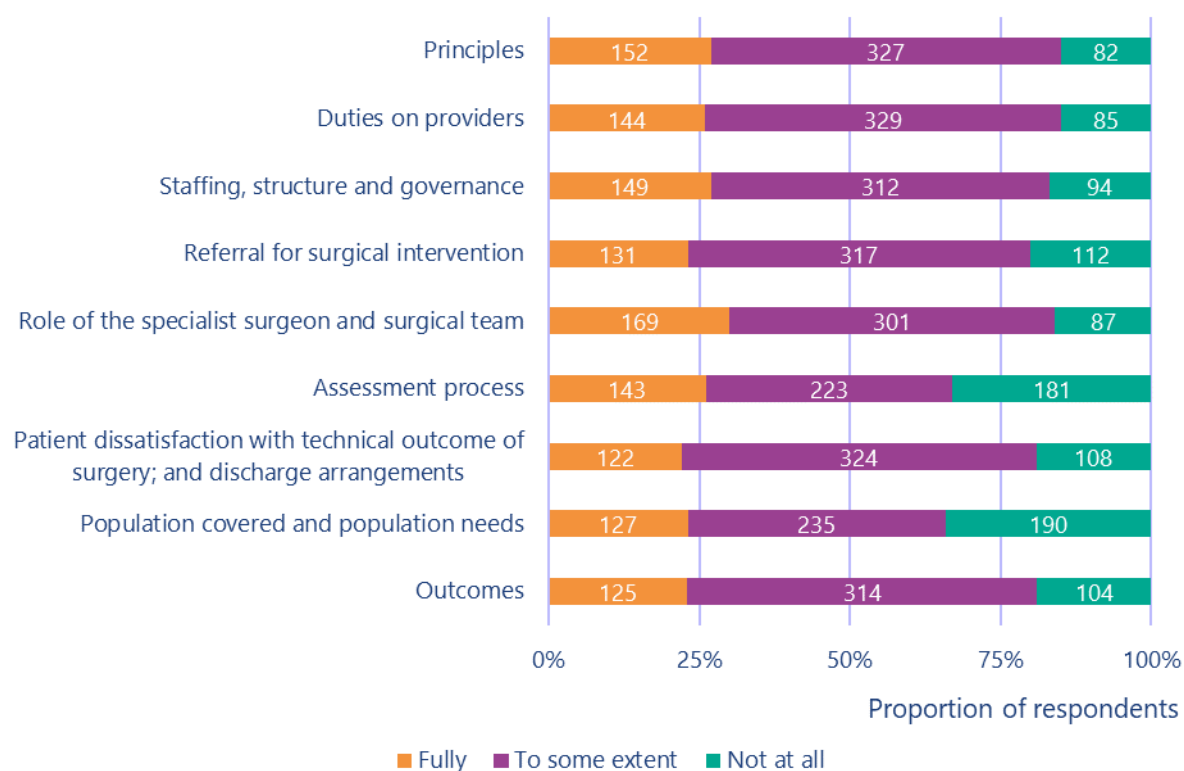


Figure 10

The proposed surgical service specification aims to ensure consistency in quality of care and equal levels of access to surgery. NHS Scotland consultation respondents were asked to what extent they thought the surgical specification achieves this. Figure 11 shows the NHS Scotland consultation answer to this question.

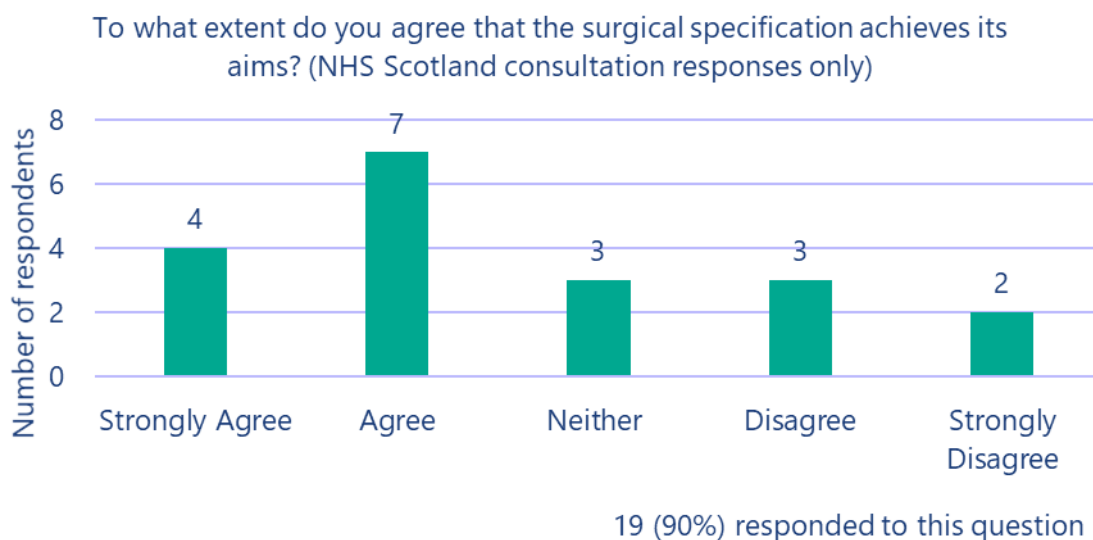


Figure 11

NHS Scotland respondents were also asked to what extent they agree that the surgical service specification covers all aspects of specialist gender surgery.

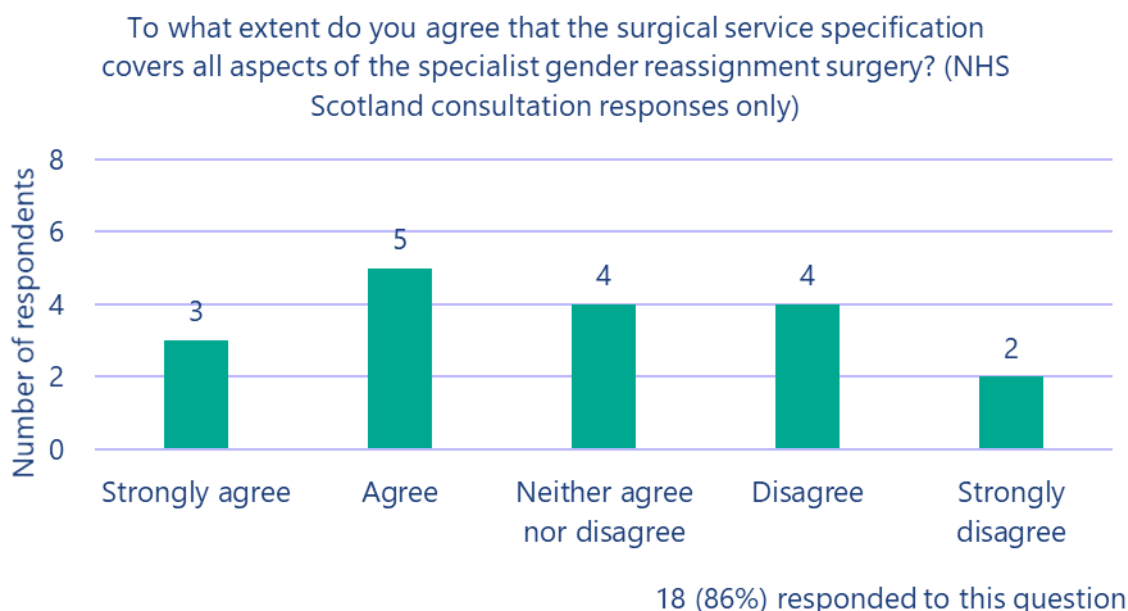


Figure 12

2.3 Detailed analysis by section of the service specifications

2.3.1 Principles

The proposed service specifications both described (the same) principles that informed their development. Around 60% of respondents agreed with the principles in the service specifications to some extent. Two key points were raised by respondents regarding the principles.

Equity of the principles

Respondents, primarily service users, were concerned around the equity of the principles. Concerns raised by this group of respondents included:

- Respondents were critical of the proposal that individuals with a Body Mass Index (BMI) of 40 or more should lose weight before hormone therapy or masculinising chest surgery, and those with a BMI of 30 or more should lose weight before having genital surgery. They believed these BMI thresholds to be arbitrary and questioned whether they are supported by medical research. It was emphasised that the requirement to lose weight quickly can potentially exacerbate mental health issues. Instead of BMI being a criterion, a holistic health assessment was considered more appropriate.
- The service specifications state that there will be equity of access for non-binary individuals. This explicit inclusion of non-binary people in the documents was generally welcomed but there were concerns that non-binary people's access to gender identity services may, in practice, still be compromised. Respondents from this group were particularly critical of the requirement for patients to have lived in their "gender role" for 12 months to access genital surgery, since there is no clarity in defining a non-binary "gender role". There were further criticisms that the proposed pathway only works in a binary framework and is therefore exclusionary of non-binary people. For example, respondents understood the proposals to mean that genital reconstruction is a requirement for a hysterectomy procedure; and chest surgery is referred to in the specifications as explicitly 'masculinising'. This point was primarily raised by service users and also by voluntary organisations/charities.

- NHS England has proposed that referrals will not be accepted of people whose “presentation primarily relates to intersex conditions”. Respondents felt that this exclusion was unjustified, particularly since the criteria for exclusion on this basis is not clear. Respondents noted that the gender identity of many intersex people is different to the gender they were raised in, and as such they may also self-identify as trans and experience gender dysphoria. It was also suggested that there is no clear treatment pathway for adults who experience gender dysphoria due to an intersex condition, and that GICs are the best placed service for intersex people who identify as trans.
- The service specifications state that in order to access gender identity services, individuals must be diagnosed with gender dysphoria. Respondents – primarily service users - were critical of this since, as one respondent explained, “*not all trans people experience gender dysphoria but may still require support from gender identity services*” (Other Respondent). In light of this, it was suggested that dysphoria should not be a pre-requisite to access gender identity services.
- The service specifications propose that GICs will not accept referrals of individuals with “acute physical or mental health problems that may affect capacity or the individual’s ability to engage in the assessment process”. There was significant opposition to this proposal amongst service users, who regarded this proposal as discriminatory against people with physical or mental health problems. Respondents suggested that the proposal was in breach of NHS England’s duties under the Equality Act 2010 as people with a disability are a group with a protected characteristic, and they disagreed with NHS England’s assessment (in the Equality Impact Assessment) that this proposal does not unfairly discriminate against individuals who share this protected characteristic. The concerns that respondents had about this proposal can be summarised as: it is an example of unfair and discriminatory gatekeeping that could be used by a GIC or GP to unfairly deny treatment to individuals; it may lead some individuals, particularly those with mental health problems, to keep their problems secret from the GP or GIC during consultations; there is evidence that trans people have a higher incidence of mental health problems than the general population, and that preventing access to specialist gender identity services compounds the risk of worsening mental health. A number of these points will be further discussed in Chapter 5 Equality Assessment.

Waiting time targets

Another concern raised by respondents was the targeted waiting times. One of the principles outlined in the service specifications is that “each individual will receive timely and appropriate treatment, as a minimum in accordance with national waiting time requirements.” Regarding this, many service users raised the following points:

- Respondents indicated that waiting lists should be reduced to meet the NHS 18-week referral to treatment standard. However, considering the current long waiting times to access GICs, respondents believed this to be unachievable unless there is a significant increase in funding and staff.
- More generally, respondents believed that the eventual service specifications should be buttressed with quantified waiting list targets.

2.3.2 Duties on providers

The service specifications propose that there will be a number of duties on providers including the provision of a high-quality service; an integrated approach to care between GICs, primary care and surgical providers; and collaboration in the sharing of best practice and in the development of research and innovation. Around 60% of respondents supported the proposed duties of providers in both specifications to some extent. Respondents across a broad range of categories raised the following points regarding duties on providers:

- Respondents generally supported the proposal for integration between GICs and primary care. However, respondents asked how integration will be measured, and suggested guidelines should be established on how GICs and primary care providers should work together. Overall, communication was seen to be key for the successful integration.
- It was welcomed that the service specifications require providers to “collaborate in national and international research projects to increase the evidence base for the commissioning and delivery of specialised services for trans people”.
- Respondents suggested that under current arrangements there is too much variation in the quality of care offered between different GICs, and they signalled their expectation that the new arrangements must ensure a consistent high service across all GICs.

2.3.3 Staffing, structure and governance

Nearly 60% of respondents supported the proposed staffing, structure and governance arrangements in both specifications to some extent. Comments from respondents were largely related to:

- Respondents said that the professional development training at GICs was delivered by lobby groups rather than medical staff which compromises the training. Respondents said that in the future, professional development training should be delivered by medically qualified staff only. These points were made primarily by individual members of the public; and respondents who are family or friends of service users.

- Respondents welcomed that the specific need for complaints to be responded to by providers, though some wanted a consistent time limit for responses to be imposed. It was suggested that there should be the possibility to submit complaints anonymously, and an assurance that the submission of a complaint would not prejudice an individual's treatment.
- The consultation documents are generally permissive in regard to the make-up of the GIC's multi-disciplinary team, though it is proposed that a specialist Voice and Communication Therapist is a mandatory role. Some respondents queried why other disciplines are not also considered to be mandatory. In particular it was felt that an endocrinologist should be a mandatory part of the multi-disciplinary team given the high number of trans people who receive hormone treatments. This point was raised primarily by service users of GI services, but also clinicians and NHS Commissioners. Other disciplines were proposed for mandatory status, including occupational health therapists and voice teachers. There was particular support for clinical and counselling psychologists to be a mandatory discipline. Illustrative of this point, the British Psychological Society said:

"We believe that there is an unnecessary emphasis on the medical aspect of treatment in this section, which underplays the role of psychosocial and psychotherapeutic intervention in the gender care pathway. All Gender Identity Clinics work to a biopsychosocial model, equal emphasis must be placed on each dimension of this model."

- More generally, it was suggested that in order to implement the specifications on staffing, structure and governance of GICs, more staff and training will be required.

2.3.4 Assessment process

Nearly 60% of respondents supported the proposed assessment process outlined in the non-surgical specification to some extent. There were mixed views from the different categories of respondent.

- Service users felt that the requirement to undergo two core diagnostic assessments before treatment commences is excessive. This was seen to be delaying the treatment for gender dysphoria unnecessarily, and it was suggested that the maximum time limit between the two assessments should be specified.
- Other respondents emphasised that the mental health of service users should be assessed in greater detail at the initial assessment. This was particularly emphasised in relation to the assessment of young people – a theme further covered in Chapter 3.

- It was stressed by service users and trans groups that there should be no invasive questioning during the assessment process, for example regarding the service users' sexual orientation and practices.

2.3.5 Role of the Named Professional and Lead Clinician

It is proposed that the Named Professional is a regulated health professional who will act as the service user's primary point of contact for the duration of the episode of care. It is also proposed that every individual will have a 'Lead Clinician', who can be a medical practitioner or clinical or counselling psychologist. 55% of respondents supported the proposed role of the Named professional and Lead Clinician in the non-surgical service specification to some extent. Key comments raised by respondents included:

- The role of the Named Professional was welcomed, on condition that this person can be easily contacted. Given the significant problems that service users have reported about poor communication from the GICs, it was felt that this role could only achieve the proposed benefits to patient care if there was easy and direct access to the Named Professional. This point was primarily raised by service users of GI services.
- Respondents generally wanted more detail about the role of the Named Professional. Specifically, there was confusion as to whether the Named Professional would primarily act as a case manager or be involved in the assessment and treatment of the service user. In addition, respondents requested further information as to what exactly is meant by a 'regulated health professional' in this context, and what professional accreditation a Named Professional must hold in order to be regarded as an expert in the range of interventions available to service users.
- Respondents - primarily service users of GI services - suggested that service users' request to change their Named Professional must be granted by GICs. This change in the Named Professional should happen "*without prejudice and without a threat of a denial of treatment.*" (Service User)
- In line with the point above, respondents - primarily service users of GI services - wanted to be able to change the Lead Clinician upon request, and to be able to easily access a second opinion if they are unsatisfied with decisions made by the Lead Clinician.
- Clinicians wanted further clarification on the necessary professional experience a Lead Clinician must have and the qualifications they must hold. While the service specification suggests that the Lead Clinician must have "at least two years full time or equivalent experiences in specialised gender dysphoria practice", it was suggested that the "*capabilities to do the job should be assessed, without an arbitrary time period.*" (Voluntary Organisation / Charity)

- Service users and clinicians queried why the Lead Clinician role was restricted to medical practitioners and psychologists. Instead, it was proposed that the role could be equally occupied by specialist clinical nurses and psychotherapists, who were perceived to have the same degree of expertise in specialised gender dysphoria.

2.3.6 Interventions that are delivered directly by the Provider (Gender Identity Clinics)

Nearly 60% of respondents supported the proposed interventions to be delivered by GICs to some extent. Respondents particularly commented on two elements of the services.

Voice and Communication Therapy

The non-surgical service specification proposes that each provider must “ensure access to an appropriate level of provision of specialist voice and communication therapy on the basis of clinical need and individual choice”. The points below were raised across numerous respondent types, including clinicians and service users:

- The service specification indicates that any “pre-existing voice difficulty will be treated by local speech language therapy services before specialist voice medication proceeds”. Respondents opposed this, as they feared it may delay treatment and, as such, exacerbate the level of gender dysphoria. In addition, since the commissioning of non-dysphoria related voice and communication therapy rests with an individual’s Clinical Commissioning Groups (CCGs), there could be inequity between CCGs.
- It was suggested that the provision of voice and communication therapy should be more locally embedded, for example through outsourcing this therapy to more local providers.

Specialised, specific psychological interventions

The non-surgical service specification outlines the psychological interventions that the GICs will make available to service users. These interventions are not mandatory, but are offered depending on an individual’s need and only with their consent.

- While respondents welcomed the provision of specific psychological interventions, a number of therapies which are not listed under the specialised, specific psychological interventions were identified. It was suggested that the following therapies should also be offered by GICs due to their mitigating effects on gender dysphoria:
 - Psychoanalytic and psychodynamic therapy
 - Occupational therapy
 - Interpersonal therapy.
- Respondents wanted family therapy to be available from all providers, rather than a “desirable” intervention as is currently proposed.
- The service specification proposes that GICs will not deliver, promote or refer individuals to any form of conversion therapy, as it is considered unethical and harmful. Regarding this, opinions were divided both between and within respondent type categories. Some respondents welcomed the service specification’s explicit rejection of conversion therapy. Others, feared that it would leave counsellors and therapists in a position where they can only ‘affirm’ a young person gender identity without exploring potential psychological causes.

2.3.7 Interventions that are delivered by other providers

The non-surgical service specification describes the interventions that would be delivered by other providers outside of a GIC. 64% of respondents supported the proposed interventions to be delivered by others in the non-surgical service specification to some extent. Respondents comments centred around facial hair reduction, and the criteria for surgical interventions.

Facial hair reduction

The non-surgical consultation document specifies that the Lead Clinician can refer an individual for a time-limited hair reduction intervention once this has been agreed as an intervention in their treatment plan. The two facial hair reduction methods covered are laser epilation and electrolysis, with the latter only being used if the former proves ineffective.

- Respondents considered the current eight sessions of hair removal being offered to be insufficient to achieve permanent results. It was emphasised that laser hair removal achieves quicker results than electrolysis, and that a fixed limit on the number of hair removal sessions is therefore unsuitable. It was suggested that hair removal treatment should be *“done to complete elimination otherwise the hair growth will become stronger again after cessation of the treatment and all the monies paid will therefore be wasted.”* (Voluntary Organisation / Charity)

- Attention was drawn to the possibility that this service specifications may create inequity of access, since facial hair removal for women with hirsutism is often not commissioned by Clinical Commissioning Groups.
- The consultation document outlines that the laser types being used are 'Alexandrite, Diode or, for darker skin types, Long Pulse Nd: YAG lasers only'. Regarding this, it was suggested that the exclusion of other lasers, such as Ruby or Intense Pulsed Light (IPL), are unjustified since they have also proven clinical effectiveness.

Criteria for surgical interventions

The consultation documents describe the criteria for mastectomy and genital surgeries. The comments below were primarily raised by service users of GI services, but also voluntary organisations/charities and 'other' respondents:

- The service specification outlines "12 continuous months of hormone therapy" as a criterion for genital surgery. Respondents emphasised that it is currently unclear whether this criterion applies to all individuals seeking all types of genital surgeries, or primarily to orchidectomy (the latter was specifically mentioned as part of this criterion in the consultation document).
- Another criterion for genital surgery outlined in the consultation documents is "12 continuous months of living in a gender role that is congruent with their gender identity". It is indicated that this requirement is not about qualifying for surgery but for "preparing and supporting the individual to cope with the profound consequences of surgery". Nevertheless, this criterion was considered inappropriate, since it is unclear what is regarded as "proof" of living in a gender role. It was furthermore indicated that this criterion is discriminatory as it requires "an individual to satisfy a clinician's idea of what presenting as a particular gender identity might look like and may prevent many from accessing healthcare because of their gender presentation" (other respondent). It was considered to be especially discriminatory towards non-binary people and those not wanting to officially change their name since they are often regarded as lacking "proof" of living in a "gender role". In addition, it was suggested that the consultation document's statement that this requirement is to prepare and support the individual to cope with the profound consequences of surgery "*is nonsense... this is a patronising approach - it implies that trans people need to be taught the consequences of transition.*" (UK Trans Info)

2.3.8 Role of the specialist surgeon and surgical team

The surgical service specification outlines the role of the specialist surgeon and surgical team. The specification includes, among other things, the criterion that surgeons must perform a minimum of 20 procedures a year of the general type commissioned by the NHS. 54% supported the proposed role to some extent.

- Respondents welcomed the requirement for surgeons to perform a minimum volume of procedures each year. However, it was also suggested by a few respondents that this minimum number comes with the risk of creating incentives for surgeons to perform particular procedures in order to fill their quota (as opposed to acting in the best interest of the patient).
- 87 respondents believed that the outlined role of the specialist surgeon and surgical team does not at all achieve the service specifications' overall aim to address inconsistency in care quality, differing levels of access, and out-dated service models. One of the reason they provided is the need for surgeons to have training and experience in the surgical techniques relevant specifically for trans patients, as opposed to more general operating techniques on cis people, was emphasised. This is perceived to be required since trans patients have different needs and outcome priorities than cis patients.

2.3.9 Assessment for readiness of surgical interventions

2.9 of the surgical service specification outlines the assessment for readiness of surgical interventions. This includes that the surgeon will offer the patient a pre-operative consultation, providing them with information and agreeing on a specific surgical intervention.

- 40% of respondents agreed with the proposed process for assessing the readiness of surgical interventions. The requirement for the surgeon to offer the patient a pre-operative consultation was welcomed, as it gives service users the ability to discuss several surgical options with the surgeon.
- A further 33% did not support the proposals at all; however, respondents did not provide detail as to why.

2.3.10 Patient dissatisfaction with technical outcomes of surgery; and discharge arrangements

It is proposed that 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.” In turn, this means that if a patient reports concerns about the surgery more than 18 months after the procedure took place, the patient will be referred to a relevant non-specialist service subject to approval from the individuals' Clinical Commissioning Group. 58% of respondents supported the proposal to some extent. Key issues raised by respondents included:

- There were concerns that the 18-month time-limit to raise concerns over technical outcomes is too short, as it can often take longer to see the final result of various procedures. In addition, service users may need more time to come forward about their poor operative result due to the intimate nature of surgical interventions. Therefore, it was suggested that it is wrong to assume that corrective surgeries beyond 18 months are not interventions performed for the alleviation of gender dysphoria. This point was primarily emphasised by voluntary organisations/charities, and service users.
- It was suggested that non-specialised providers of urological and gynaecological surgical services may not have the necessary expertise to deal with trans-specific corrective surgery. As an alternative, it was suggested that patients requiring corrective surgery should first be referred to a specialist surgical provider for assessment, and then referred back to standard care if needed.
- Respondents said that there is unclarity about the process for raising concerns about the outcome of surgical interventions.
- The service specification clarifies that NHS England does not have a commissioning policy for the reversal of previous surgical interventions. An NHS commissioner argued that the proposed service specification is too imprecise in that it should be more clearly stated that *“NHS England will not fund reversal of previous operations”* (NHS Commissioner). However, primarily “other” respondents said that the NHS should have a commissioning policy for the reversal of previous surgical interventions, especially since they perceived the numbers of those de-transitioning to be on the rise.
- Respondents wanted clearer guidelines on who is responsible for post-operative care, especially regarding wound and complication management.

2.3.11 Population covered and population needs

In point 3 of the non-surgical and surgical consultation documents, the population groups which are covered by both service specifications are outlined. Among others, the population groups include: residents in England, residents in Wales who are registered with a GP in England, 17 year olds and above being referred from a specialised Gender Identity Service. The specification also outlines those who are **excluded** from the service specification: those with acute physical or mental health problems, those who self-refer, and those whose gender dysphoria presentation relates primarily to intersex conditions. Nearly 60% of respondents supported the non-surgical specification proposals to some extent. Just over 40% of respondents supported the surgical specification proposals to some extent. Comments related to this proposal are covered later in this chapter (regarding equity of access) and in Chapter 3 in relation to the age of participants.

2.3.12 Outcomes

The non-surgical and surgical consultation documents outline the outcome framework (including the indicators used) of the service specifications. The outcomes cover: clinical outcomes, patient experience, and structure and processes. 50% of respondents supported the non-surgical specification proposals to some extent. 57% of respondents supported the surgical specification proposals to some extent.

30% of respondents to the non-surgical specification and 19% respondents of the surgical service specification believed that the outcome framework would not achieve the overall aim to address inconsistency in care quality, differing levels of access, and out-dated service models at all. Part of the reasons for this level of opposition was that respondents had problems fully understanding this section, indicating that they would like to see a more detailed and clearer display of the outcomes framework

It was felt that the outcome framework should also cover timescales, and specifically targets to reduce waiting for appointments at GICs.

2.3.13 New referrals and transfers of care

The non-surgical consultation document specifies that new referrals to GICs can be made by General Practitioners (GP), other medically qualified professionals, and other professionals regulated by the Health and Care Professionals Council. Nearly 60% of respondents supported the proposals to some extent. This question overlaps with the survey questions and corresponding open-text comments covered in 3.1 Views on the referral pathway to Gender Identity Clinics. As such, the open-text comments are covered there.

2.3.14 Surgical referrals

The surgical service specification states that referrals for surgical interventions must be made by a Lead Professional from a GIC that is commissioned by NHS England. 57% of respondents supported the proposals to some extent. This question on the surgical service specification overlaps with the survey questions and corresponding open-text comments covered in 3.2 Views on the referral pathway to Gender Identity Clinics. As such, the open-text comments are covered there.

2.4 Other concerns with the proposed service specifications

Respondents raised a number of points in the open-text comment in reference to specifications in the consultation document which were not covered by any of the multiple-choice questions asked. These points included:

- Loss of fertility
- Surgical interventions not being commissioned by the NHS England
- Shared decision-making
- Informed consent
- Flexible care pathways
- Gender dysphoria and mental health

Loss of fertility

- The non-surgical consultation document clarifies that NHS England does not commission gamete storage, as this is a commissioning responsibility for each individual's own Clinical Commissioning Group. It was feared that some individuals could be denied gamete storage by their CCG. This could lead to inequity of access between individuals residing in different CCGs. It was suggested that the NHS England should commission gamete storage; or it should provide clearer guidance to local CCGs on how to routinely provide gamete storage and retrieval for trans people. This point was raised by clinicians, service users, voluntary organisations/charities and NHS commissioners.
- It was suggested that the GP's involvement in the referral process was unnecessary, and that referral for gamete storage could be made directly by GICs.
- A few individual members of the public believed that under 18-year olds should not be allowed in law to undergo surgery that could result in infertility since under 18-year olds cannot fully appreciate the life-long implications of such a permanent procedure.

Surgical procedures that are not routinely commissioned by NHS England

The surgical services consultation document outlines a number of surgical procedures that are not routinely commissioned by NHS England. Among other things, these include: facial feminisation surgery, phonosurgery, body hair removal, breast augmentation, and hysterectomy and bilateral salpingo-oophorectomy when they are performed as "stand alone" procedures. The consultation does not address the introduction of new treatments to the commissioned pathway. However, respondents believed that the following surgical interventions should be considered by NHS England's Clinical Reference Group for Gender Identity Services for the purpose of developing clinical commissioning policies for these interventions. These points were raised primarily by service users, but also 'other' respondents, voluntary organisations/charities, NHS provider organisations and clinicians.

- Body hair removal, since it can contribute significantly to the alleviation of gender dysphoria in some patients on the male to female transition pathway.
- Breast augmentation surgery: this surgery was considered to be necessary, particularly since bilateral mastectomies are commissioned. The equality impact of this are further considered in Chapter 5 Equality Assessment.
- Facial feminisation surgery, including thyroid chondroplasty (tracheal shaves), and facial masculinisation surgeries. These interventions were considered to have the potential of alleviating gender dysphoria.
- Stand-alone hysterectomy and bilateral salpingo-oophorectomy (i.e. performed not simultaneously with genital surgical interventions). Respondents indicated that trans men have diverse needs and objectives, and that some may want to undergo hysterectomies without genital reconstruction. The provision of stand-alone hysterectomies and bilateral salpingo-oophorectomy were seen as particularly important due to the increased risk of endometrial and ovarian cancer for a trans man who has been taking testosterone. See for example:

“We are concerned that this draft does not offer enough clarity on the pathway for accessing hysterectomies when this is not taking place alongside other genital surgeries. We would like the non-surgical specification to state that non-surgical providers should liaise with the patient and GP to offer advice on hysterectomies and provide signatures if necessary to meet the requirements of the WPATH standards of care. Given that NHS England has previously said hysterectomies should take place in a specific time period, we would like NHS England to clarify (either in this document or elsewhere as appropriate) whether this recommendation remains in place, or has now been revoked.” (Trans Masculine Support and Advice UK)

- Respondents mentioned prosthetics (both penis and breast prosthetics) as being a cost-effective alternative to surgical interventions.

Shared decision making

Both specifications propose that decision making about medical interventions should be led by the principle of ‘shared decision making’. This is a process in which the individual can review all treatment options available to them and participate actively, in cooperation with their healthcare professional, in making a decision about the adequate treatment. The proposal for shared decision making was welcomed by respondents. It was emphasised, however, that the autonomy of the patient must remain intact. It was suggested that there should be mechanisms in place to ensure that decisions are patient-led with active involvement by the gender identity expert, and not vice versa.

Informed consent

Both specifications describe the need for patients to give ‘informed consent’ to their individual treatment pathway. ‘Informed consent’ includes deciding on an intervention while being aware of the variety of treatment options and their medical, social and emotional consequences. Regarding this, respondents raised the following points:

- The necessity for service providers to discuss all possible treatment outcomes, including:
 - The possibility to regret hormonal replacement therapy or surgery
 - The lack of rigorous long-term outcome data for some interventions

This point was primarily raised by individual members of the public and is further elaborated upon in this section below.

- Respondents expressed the need for the NHS England to provide more easily accessible information on the range of interventions and pathways available to gender dysphoria patients.

Flexible care pathway

Both service specifications describe the care pathway for gender dysphoria. Respondents emphasised the need for this pathway to remain flexible, since one particular approach does not suit everyone. In the service specification it is stated that individuals “may elect to defer some interventions until a later date and will, by mutual agreement, be discharged by the specialist service, pending re-referral when they are ready to continue treatment.” Respondents regarded a re-referral to be unnecessary, considering that service users may defer surgical interventions – such as for example phalloplasty - due to their being a lengthy surgical process involving multiple stages.

Gender dysphoria and mental health

In the consultation documents, it is specified that gender dysphoria “is not, in itself, a mental health condition”. Instead, it is defined as a “cognitive symptom characterised by persistent concerns, uncertainties, and questions about gender identity”. Respondents raised a variety of points regarding the relationship between gender dysphoria and mental health. All of the points below were primarily raised by individual members of the public, but also by family and friends of service users.

- Some respondents from these groups disagreed with the NHS's stance that gender dysphoria is not a mental health condition. Instead, they regarded gender dysphoria to be a mental health problem of a similar kind to body dysmorphic disorder (BDD). Following from this, they argued that gender dysphoria should be treated by psychiatrists and psychologists. The goal of the treatment should not be to "affirm" a person's gender, but to reconcile them with their body.
- Since gender dysphoria is not a mental health condition but still a "cognitive symptom", respondents from this group felt that there was a need to define more precisely what gender dysphoria is.
- Attention was drawn to the comorbidity rates of gender dysphoria with autism spectrum disorders (ASD) and attention-deficit/hyperactivity disorder (ADHD), but also past trauma, psychosis and depression. Respondents from these groups suggested a need for further research in this area. In addition, greater integration of mental health and special educational needs and disabilities support in the gender dysphoria care pathway was suggested.
- Many respondents from these groups voiced their concern that the current treatment pathway prioritises medical over psycho-social interventions. They believed that therapy and counselling should be mandatory before medical interventions are performed. This was seen to be particularly pertinent for young people who are still undergoing a period of identity formation. The concerns arising during this process of identity information, including those related to the gender, sexuality and body image, should be investigated in talking therapies as opposed to medical interventions. The treatment pathway for young people is further discussed in Chapter 3.

Chapter 3 Referral pathways

This chapter outlines the key messages from respondents when asked for their views on the proposed:

- Referral criteria and pathway for people to be referred to a Gender Identity Clinic (3.1 of this chapter)
- Referral criteria and pathway for people to be referred to genital surgical interventions (3.2 of this chapter).

3.1 Views on the referral pathway to Gender Identity Clinics

The service specifications proposed that in the future:

- “all young people who need to access a specialist gender identity service and who are aged 17 years and above will be referred to an adult Gender Identity Clinic” (3.1.1 of this chapter)
- “the specialist Gender Identity Clinics for Adults will not accept referrals of individuals who are not registered with a General Practitioner (GP)” (3.1.2 of this chapter).

3.1.1 Young people aged 17 years and above will be referred to an adult Gender Identity Clinic

Opinion on this proposal was largely divided. 55% of respondents to the NHS England consultation supported or strongly supported the proposal, while 38% of respondents tended to or strongly oppose the proposal. This is outlined in figure 13 below. Figure 14 breaks down NHS England respondent’s views by age, and figure 15 by respondent type. Key differences in respondent preferences included:

- 83% of service users supported the proposal
- 30% of family and friends of service users supported the proposal
- 14% of individual members of the public supported the proposal
- 71% of clinicians, who are mostly GPs, supported the proposal.

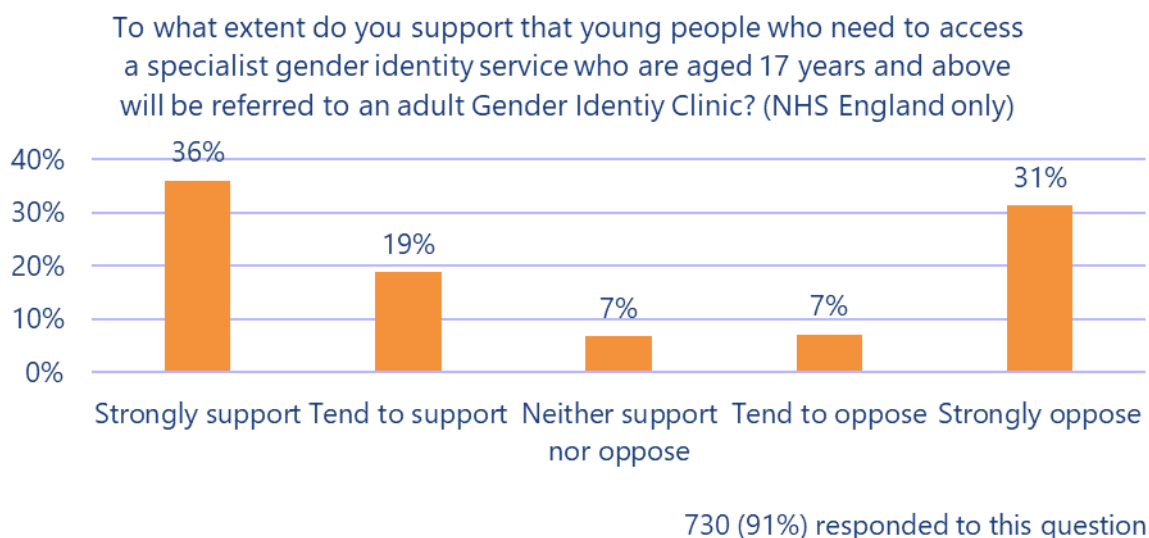


Figure 13

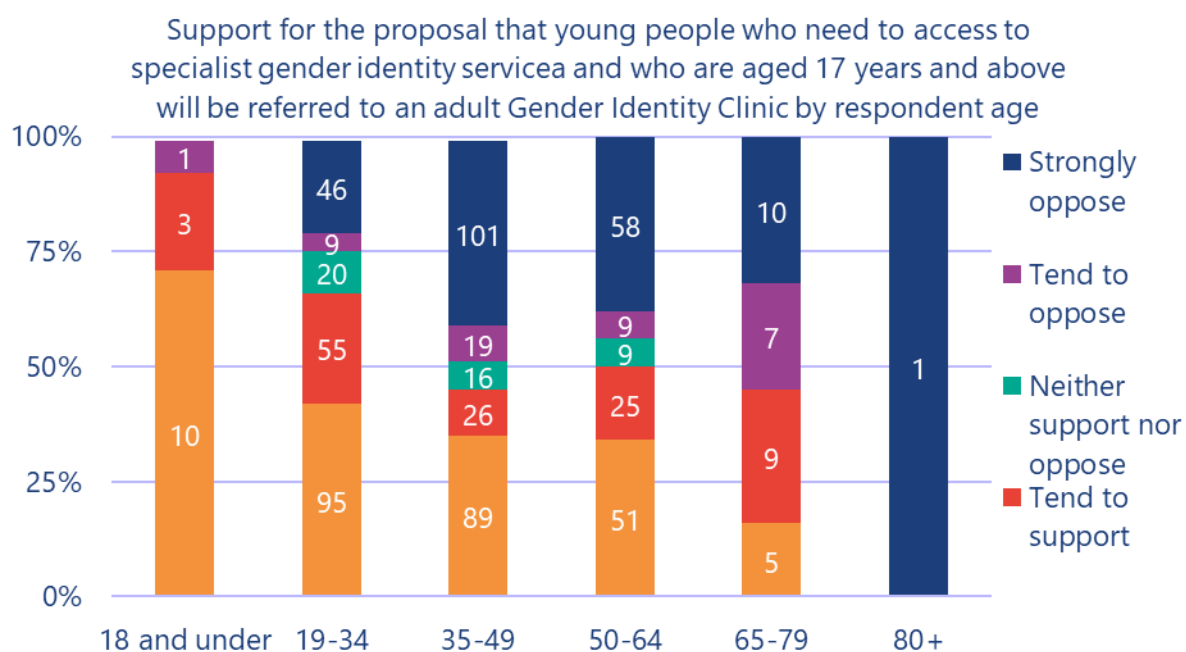


Figure 14

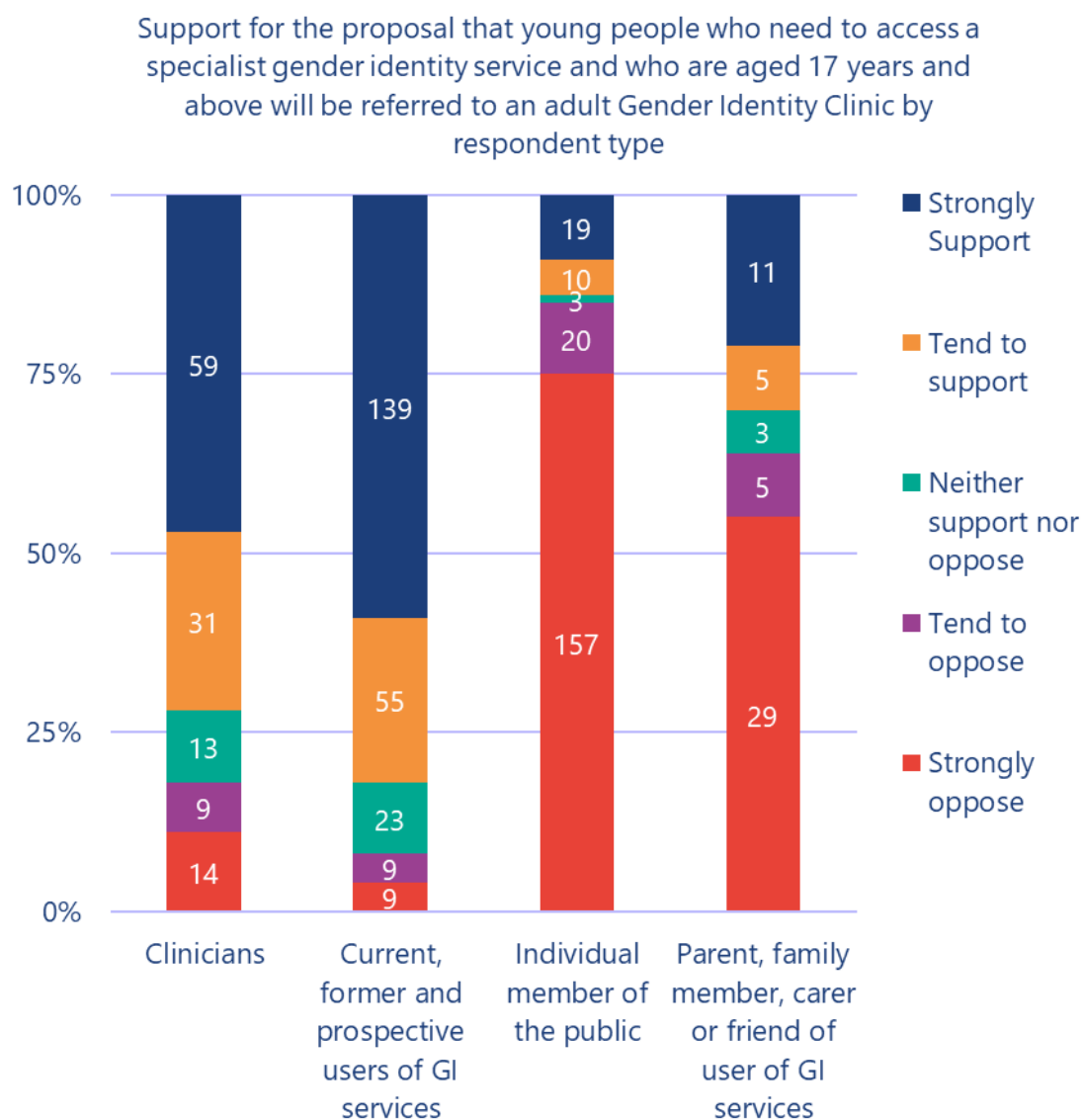


Figure 15

Reasons why respondents supported the proposal

- It was useful to have more clarity on the referral pathway as it will help to improve the quality and continuity of care. For example: *“Outlining the ages at which referrals will be accepted to various gender identity services (including GIDS) does work to improve consistency across clinics, as well as work toward preventing referrals to a clinic which will only see a person for a brief period of time based on their age.”* (UK Trans Info)

- It would increase the cooperation between young people and adult gender identity services.
- Respondents hoped that this proposal would avoid delays for young people in accessing Gender Identity Clinics.
- Respondents supported the flexibility for young people to stay within a young person's service until the age of 20 if desired. Respondents thought this was needed as young people have varying needs and levels of maturity. They also said that this transfer should be primarily decided by what the young person wanted. For example: *"We support the proposal that young people who are aged 17 and above would be referred to an adult GIC. This echoes the feedback from Future in Mind that children should have to tell their story as infrequently as possible Many 17 year olds have a clear idea of their gender and sexual identity and they do not want to be assessed with their parents, nor as though they are younger children. We would however suggest that clinicians with adult services have the opportunity to receive training in working with adolescents"*. (Royal College of Psychiatrists)

Reasons why respondents opposed the proposal

- Respondents felt that 17 years is too young to make a decision regarding hormonal replacement therapy or surgery. This was particularly a concern given that many interventions were considered irreversible. Reasons for this were:
 - That the brain of a young person is still developing at 17 years old and they are therefore more prone to risk-taking behaviour and imperfect decision making
 - That young people are also still developing their personality and through this young people may explore aspects of their gender identity. Respondents were worried that during this period young people hold onto readily available "labels" and groups to satisfy their need of belonging, and they considered the "trans" community to be one such group. Often, however, expressing their (gender) identity in a certain way may just be a "phase" for young people that passes with time. This issue is further explored in Chapter 5 Equality Assessment.
 - That 17 year olds may be too young to make decisions about interventions offered to adults. Respondents were particularly worried that this proposal was seen to *"fast track teenagers into the adult clinic where they will be treated like adults"*. (Individual Member Of The Public).
- Respondents said that the diagnostic assessments at Gender Identity Clinics were insufficient for young people given the specific challenges young people face. Respondents felt that more intensive psychological assessment and ongoing support were required.

- Respondents also stated that there was a lack of evidence around hormone replacement therapy and surgery. This concern was primarily expressed by individual members of the public. For example, the affects that puberty blockers can have on a young person's physical and socio-emotional development. Respondents also suggested that a number of young people want to reverse the transition they have undergone.
- Respondents also stated that they thought that widening the service to younger people would put further pressure on Gender Identity Clinics who already have long waiting lists.

Respondents identified changes they wanted to see made to youth and adult services

- Respondents suggested that multi-disciplinary teams with the skills to support young people on a range of issues, including Gender Identity, would be more appropriate. This was raised by respondents who were concerned that the adult services were heavily focused on medical interventions with inadequate psychological support for young people.
- Respondents said that the proposals were not clear which service young people aged between 16 and 17 would use as the proposal says that young people's service would now only accept referrals for young people up to the age of 16.
- Respondents suggested that the age for accessing Adult Gender Identity Clinics should be 16 to make it more consistent with other legal rights. This view was expressed by a variety of respondent types including service users of GI services, voluntary organisation/charities and clinicians.

3.1.2 Views on the proposal that Specialist Gender Identity Clinics for Adults will not accept referrals of individuals who are not registered with a General Practitioner (GP).

Once again, there was no consensus on this proposal 52% of respondents strongly or tended to support the proposal, and 31% tended to or strongly opposed the proposal. This is outlined in figure 16 below. Figure 17 breaks down NHS England respondent's views by respondent type. Key differences in respondent preferences included:

- 66% clinicians, who were mostly GPs, support the proposal
- 35% of service users support the proposal
- 50% of individual members of the public support the proposal.

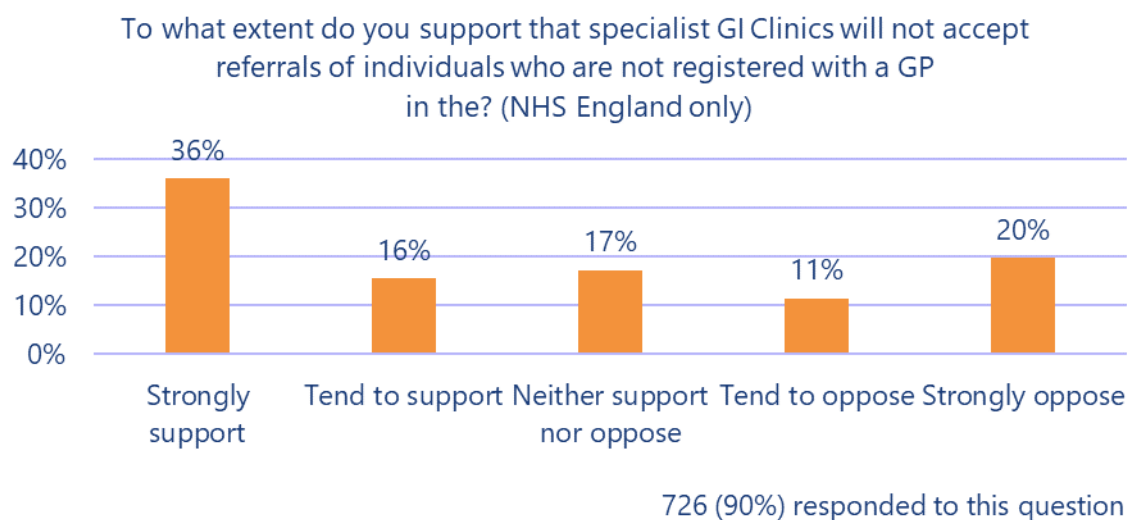


Figure 16

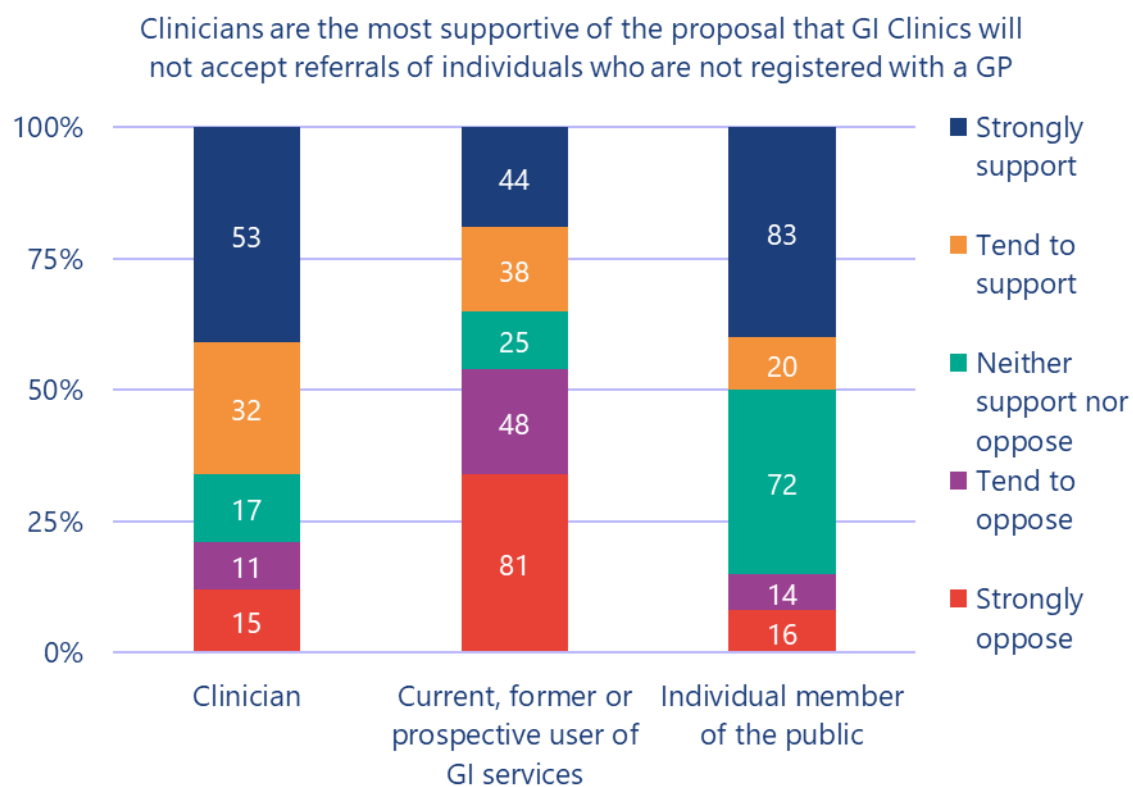


Figure 17

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 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 GIC. For this to be the case, it is necessary for service users to be registered with a GP. This point is further explored in Chapter 4 Hormonal Treatment.

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.

Respondents who did not support the proposal also identified a number of other reasons, including:

- GPs are often unwilling to make referrals to GICs and often hold transphobic attitudes (primarily Service Users; and Voluntary Organisations / Charities).
- GPs should not be involved in making a referral decision since they are not regarded as having the required level of expertise in this area. Gender identity services were seen to be as specialised services and, as such, beyond the remit of GPs. (Clinicians; and NHS Commissioners)
- GPs need to receive general training in trans-specific healthcare, and in the NHS's gender dysphoria pathway in particular. (Service Users)

Respondents identified changes they wanted to see made to the proposal

In response to the proposal that GICs will only accept referrals of individuals who are registered with a GP, respondents proposed a number of alternative arrangements:

- It was suggested that while GP registration could be a requirement once (hormonal) treatment commences, it should not be necessary for referrals to GICs. There was the perception that since individuals are assessed at GICs anyway, the need to be registered with a GP acts as an unnecessary barrier.
- A range of respondents proposed that individuals should be able to self-refer to GICs.
- It was suggested that individuals should be able to be referred to GICs via private care providers, regardless of whether the individual is registered with a GP.

The Royal College of Nursing supported the proposal but noted that *“individuals need to be fully supported through the process of registering with a GP and this should not be dependent on having a static address. We need to be mindful of the needs of the homeless, traveller and more marginal groups who traditionally have problems accessing primary care. Young people may have a GP in their home town and a different one, or none at all, where they are in further education and this could present problems. We also need to consider the needs of those who are imprisoned and receiving healthcare for gender identity and this process needs to align with the 2016 policy on the care and management of transgender prisoners”*.

3.2 Views on the referral pathway to gender interventions

The service specifications proposed that in the future:

- ‘only a designated specialist Gender Identity Clinic for Adults can refer an individual for specialised surgery (for the purpose of alleviating gender dysphoria)’ (3.2.1 of this chapter)

- ‘a decision to refer an individual for specialist surgery must be supported by a Registered Medical Practitioner’ (3.2.2 of this chapter).

3.2.1 Views on the proposal that only a designated specialist Gender Identity Clinic can refer for genital reassignment surgery

A majority (68%) of respondents to the NHS England consultation supported the proposal and 24% opposed the proposal. This is outlined in figure 38. Views were somewhat more divided in the NHS Scotland consultation with 58% supporting the proposal, and 43% in opposition. This is outlined in figures 18 and 19 below. Figure 19 shows the breakdown of NHS England consultation views by respondent type. Key differences in views are:

- 94% of clinicians in the NHS England consultation support the proposal
- 74% of individual members of the public in the NHS England consultation support the proposal
- 43% of service users in the NHS England consultation support the proposal.

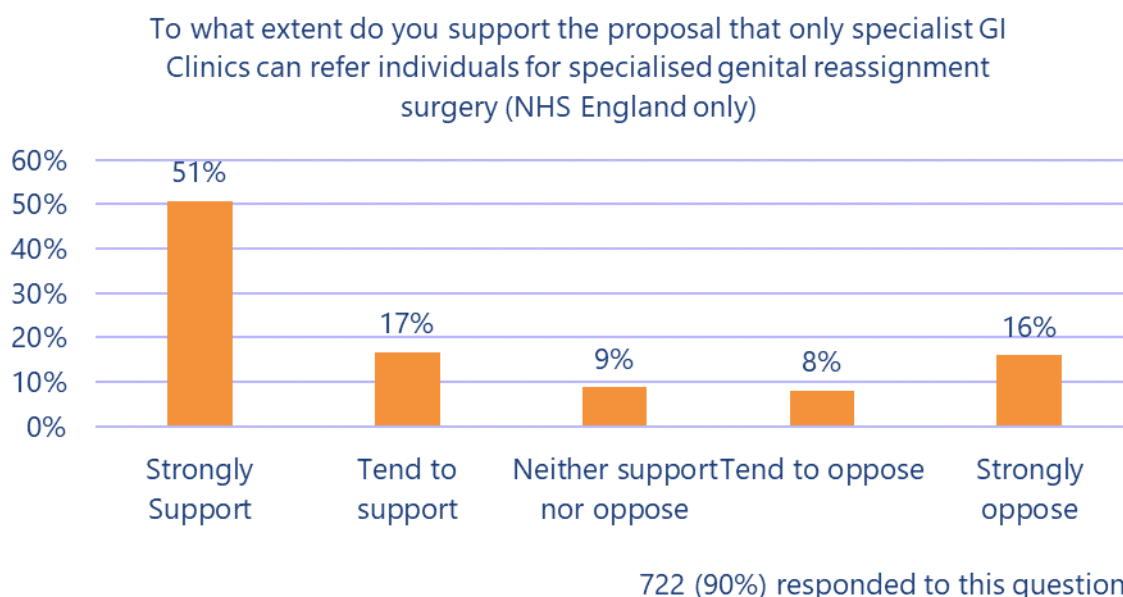


Figure 18

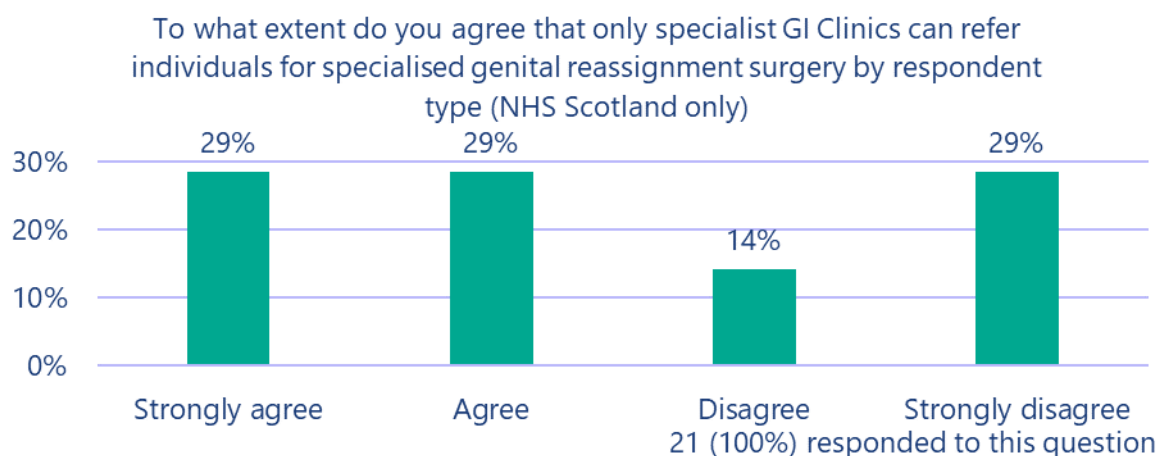


Figure 19

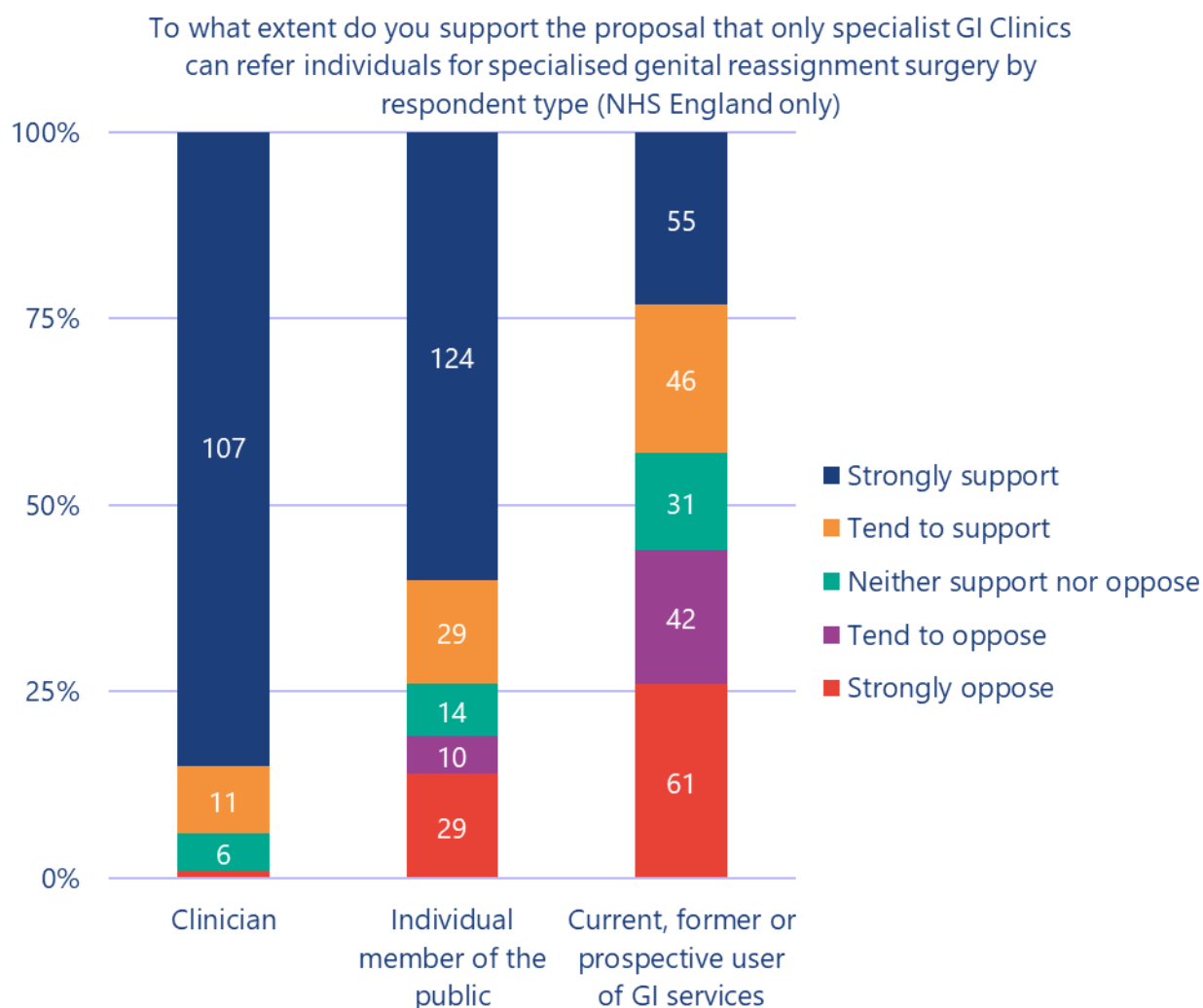


Figure 20

Reasons why respondents supported the proposal

- Respondents said that only GICs have the multidisciplinary teams and expertise to adequately assess and make an informed decision about an individual's suitability for genital surgery.
- Respondents said that the proposal ensures that a level of medical gatekeeping remains, and that individuals are not rushing into undergoing irreversible surgeries. It was felt only specialists at GICs can “ensure the appropriateness and probity of such referrals” (Clinician).
- Respondents said that the support for this question is on the condition that waiting times for GICs can be reduced.

Reasons why respondents opposed the proposal

- Respondents said that the GICs are not accessible enough to be the only source of referrals for specialist genital surgery. GICs were perceived to be inaccessible both in terms of receiving appointments and the distances service users need to cover to reach GICs. Service users were particularly concerned about this point. They said that it would create additional barriers for trans people to access the services they need. The proposal was deemed to be an unnecessary form of gate keeping. Concern was expressed that this proposal may delay referrals and increase the waiting time for service users to access genital surgery.

“This proposal will force trans people who are seeking NHS services to sublimate their own preferences, and choices, to the standard choices as offered by the few existing clinics, effectively destroying the core patient rights to choice, contained within in the NHS Constitution”. (Press for Change)

“We do not support this proposal because it would preclude individuals from accessing care through the independent sector. There is no evidence to support exclusion of individuals through such a route. So long as the care provided to an individual is comparable to that offered within the NHS system, as stated above, and this can be demonstrated through use of regular multi-disciplinary team meetings or similar (in accordance with our guidelines), this pathway of care should not be excluded”. (Royal College of Psychiatrists)

- A different perspective was offered by individual members of the public and from friends and family of service users who opposed the proposal but on the grounds that they were concerned that GIC clinics operate in a gender-affirming framework and, as such, will too readily refer individuals for specialist surgery.

Respondents identified changes they wanted to see made to the proposal

In response to the proposal, a number of options were identified by respondents to increase the flexibility of the referral route to surgery including:

- Respondents said that GPs should be allowed to refer individuals for genital surgery as GPs are closely involved in monitoring individuals' health. This point was made primarily by service users.
- Respondents said that they wanted the ability for people to continue to use both private and public health services for different parts of their journey. This would mean that private health care providers would also need to be able to refer service users to surgery. Respondents said this was important given the long waiting times at GICs which would lead to service users waiting unnecessarily for a referral for surgery as well as increase the case load of the GICs unnecessarily.
- Service users said they wanted to be able to refer themselves for surgery as it was their body and therefore their decision.

3.2.2 Views on the proposal that the decision to refer an individual for specialist genital surgery must be supported by a Registered Medical Practitioner

The majority (65%) of respondents to the NHS England consultation supported the proposal while 23% opposed it. Similarly, a majority (55%) of respondents to the NHS Scotland consultation supported the proposal, while 35% opposed it. This is outlined in figures 21 and 22 below. Figure 23 breaks down respondents by respondent type. Key variations in responses includes:

- 69% of clinicians in the NHS England consultation supported the proposal
- 83% of individual members of the public in the NHS England consultation support the proposal
- 49% of service users support the proposal.

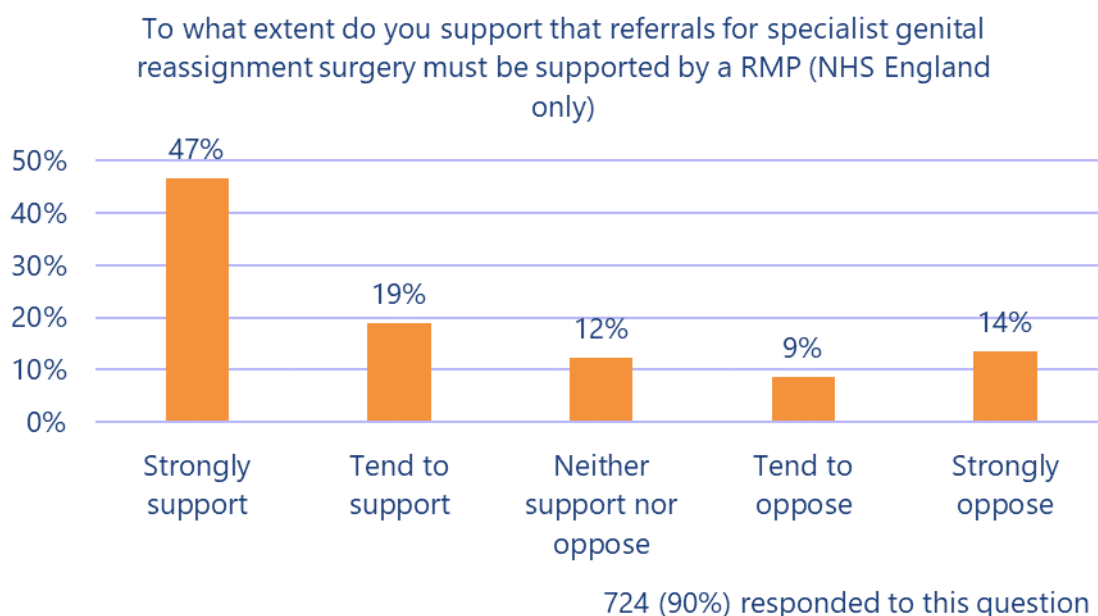


Figure 21

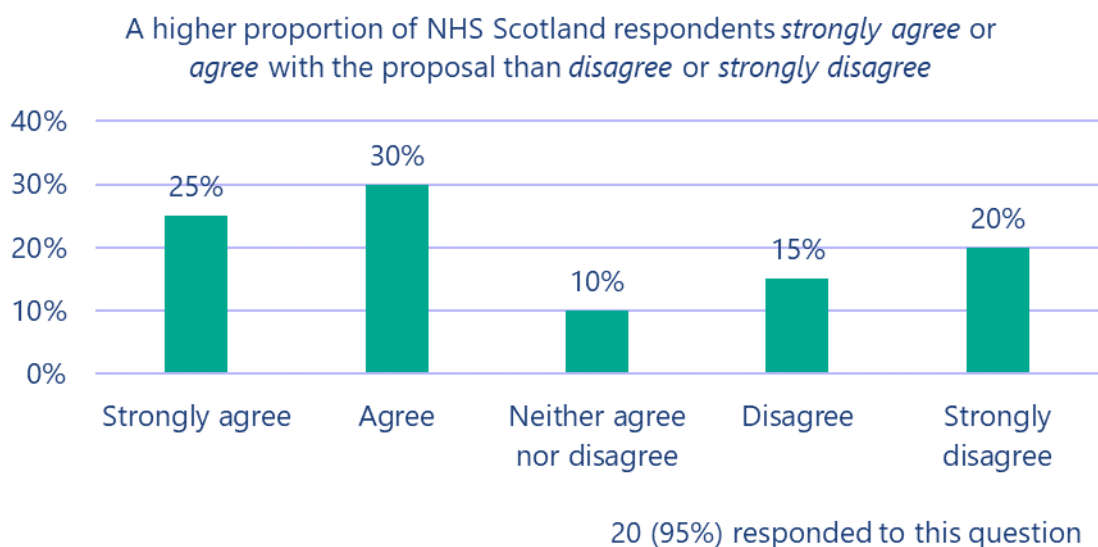


Figure 22

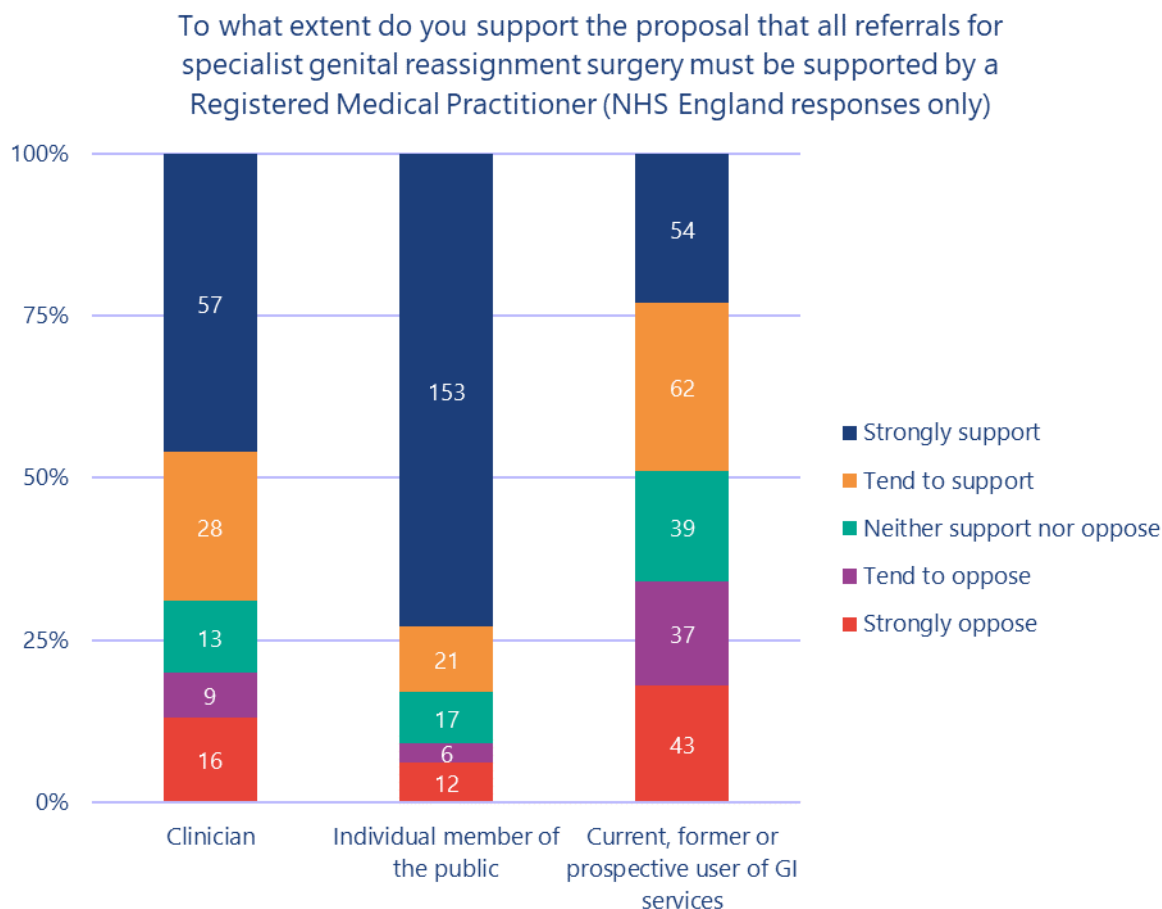


Figure 23

There was consensus amongst organisations representing Registered Medical Practitioners, for support for the proposal (Royal College of General Practitioners; Royal College of Psychiatrists; British Medical Association):

“We support this proposal, mainly for the safety of the service user as most surgical interventions are irreversible. It is also consistent with usual medical practice. Registered Medical Practitioners have the specialist knowledge to understand the holistic needs of people with gender dysphoria. However, for the ideal care to be offered to people with gender dysphoria, Registered Medical Practitioners should be supported by a wider multi-agency team.” (Royal College of Psychiatrists)

The Royal College of Nursing called for flexibility:

“We believe that it should definitely be a senior clinician with the appropriate training in the specialism and the skills and knowledge. This will probably be a registered medical practitioner, but not always.” (Royal College of Nursing)

The British Psychological Society did not support the proposal:

“We object to this as it infers that assessment for surgery is a medical process, when in fact assessment for suitability for surgery is predominantly psychological and psychosocial, and therefore can be conducted by a psychologist or a medical professional.” (British Psychological Society)

There was consensus amongst trans support groups, who opposed the proposal, often making the point that the proposal *“is inconsistent with their preferred informed consent model of provision, which is centred on the idea that a trans person themselves is best placed to make a judgement about what treatment is suitable for them.”* (National Union of Students)

Reasons why respondents supported the proposal

- Respondents said that genital interventions are medical in nature, and therefore the involvement of a RMP in the referral process was deemed necessary. This point was primarily raised by individual members of the public, but also by service users, and family and friends of service users.
- Respondents said it was important that a RMP other than the surgeon assesses an individual’s suitability for surgery.
- Respondents said that it is a necessary element of patient safety that a level of medical gate-keeping is retained in gender identity services. This was seen to be particularly important considering that trans groups lobby for self-referrals for genital surgery. This point was primarily raised by individual members of the public, but also by family and friends of service users.
- Respondents suggest that the registered medical practitioner should be a specialist in gender identity services and part of the multi-disciplinary team at GICs.

Reasons why respondents opposed the proposal

- Respondents said that the involvement of a RMP shifts the focus further towards a medicalised model of care.
- Respondents said it was felt that the involvement of a RMP in the referral process (and the need for a second person to approve the referral) for genital surgery represents an unnecessary layer of gatekeeping. This point was primarily raised by service users, but also clinicians and ‘other’ respondents
- Respondents were worried that the current proposal to involve a RMP will add to the waiting time for genital assignment surgery.

Respondents identified changes they wanted to see made to the proposal

In response to the proposal, a number of options were identified by respondents to increase the flexibility of the referral route to surgery including:

- Respondents suggested that private care providers should be allowed to refer individuals for genital surgery. This was considered necessary in light of the long waiting lists for GICs.
- Service users wanted to be able to self-refer for genital surgery. As such, they felt that the current proposal leads to a lack of patient autonomy.
- Respondents said that the involvement of a RMP in the referral process undermines the importance of non-medical clinicians. It was suggested that psychologists, specialist nurses or social workers (who are registered with the Health Care Professional Council) should be able to refer individuals for specialist genital surgery.

Chapter 4 Hormone treatment

This chapter outlines the views expressed by respondents on proposals for future arrangements for issuing prescriptions for hormone treatment. The NHS England consultation asked respondents to express a preference for how prescriptions could be issued, and to suggest any alternative proposals. The NHS Scotland consultation did not ask any specific questions on hormone treatment. Where NHS Scotland consultation respondents discussed hormone treatment, this is included in this Chapter's analysis.

4.1 Views on the prescribing options for hormone treatment

Respondents were given four options for their consideration, and for each option the positive and negative factors were described. Respondents were asked which of the outlined options they preferred. The options were as follows:

- A. The patient's own general practice remains responsible for prescribing on the recommendation of a Gender Identity Clinic (current arrangements)
- B. The Gender Identity Clinic is responsible for issuing the first prescription with patient's own general practice issuing subsequent prescriptions
- C. The Gender Identity Clinic is responsible for issuing prescriptions for around one year (or until the person's hormone treatment is stabilised) with the patient's own general practice issuing prescriptions after that time
- D. Develop a new role – GPs with a Special Interest in Gender Dysphoria. The specialist GP is responsible for issuing prescriptions for all relevant patients in the local area on the recommendation of a Gender Identity Clinic.

81% of respondents chose an option. Figure 24 outlines the proportion of respondents that supported each option.

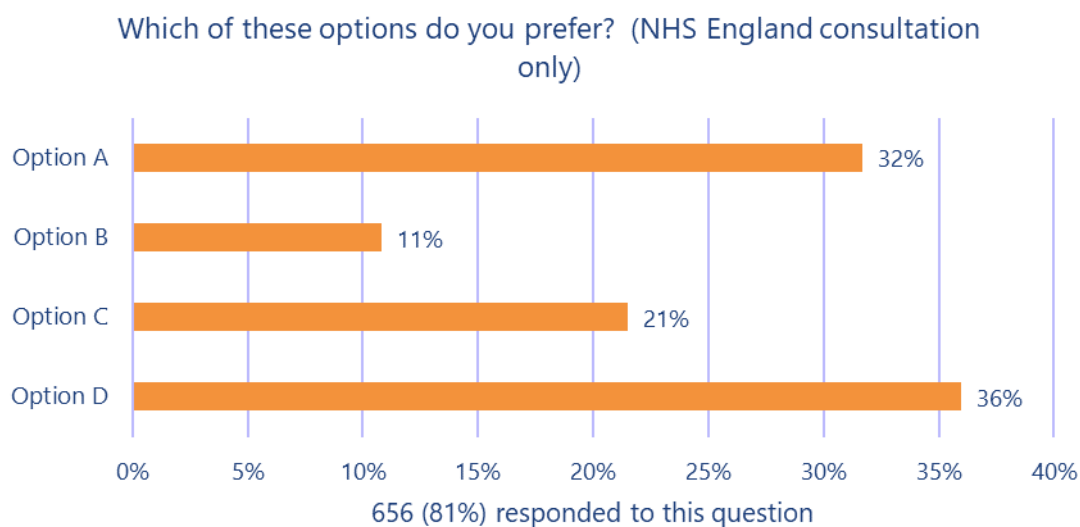


Figure 24

Figure 25 breaks this down by respondent age.

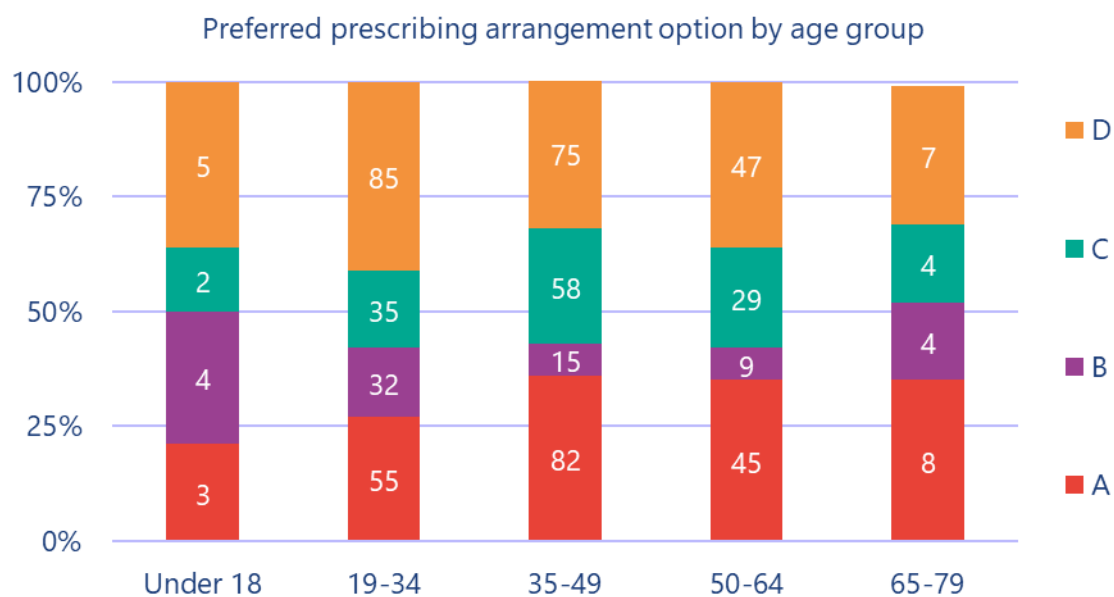


Figure 25

More than 30% of respondents in each age group selected Option D as their preferred prescribing arrangement.

Figure 26 describes preferred prescribing arrangements by gender.

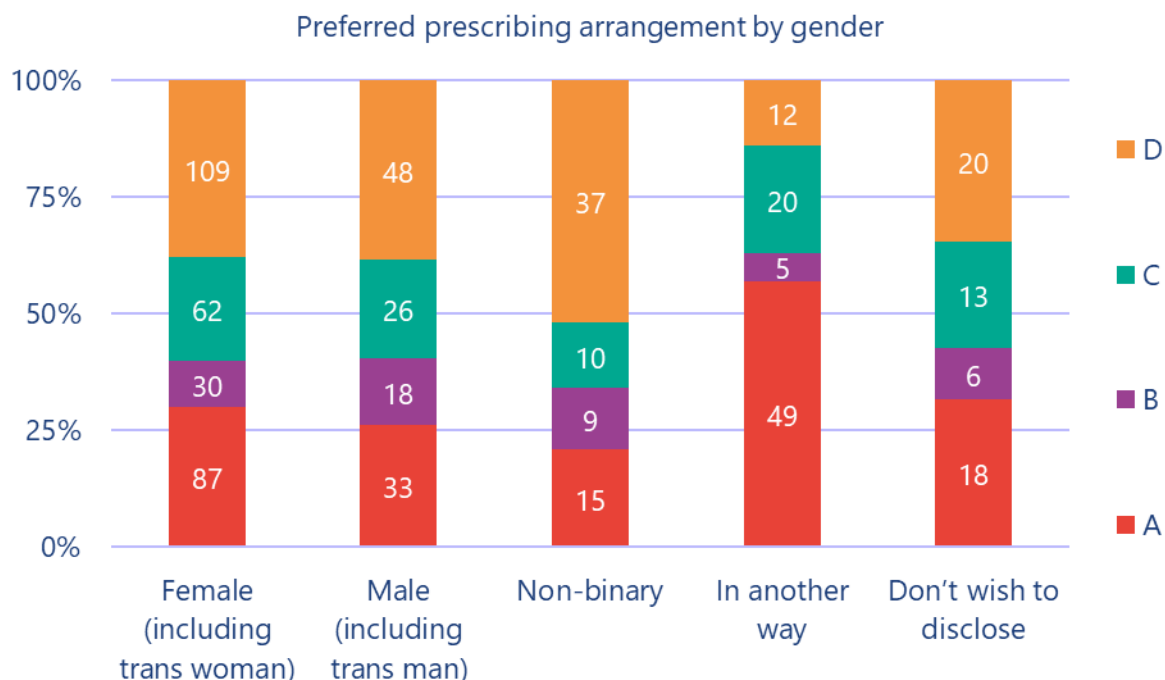


Figure 26

Amongst female (including trans women) and male (including trans men) respondents, Option D was the preferred prescribing arrangement with 38% of each group selecting this as their preference. Amongst non-binary respondents, over half (52%) selected Option D as their preferred prescribing arrangement. For those who would best describe how they think of themselves in another way, Option D was less popular and instead Option A was the preferred option. Amongst those who don't wish to disclose, Option A and Option D were the preferred options by 32% and 35% respectively.

Figure 27 examines which prescribing option is preferred by the three largest respondent type groups.

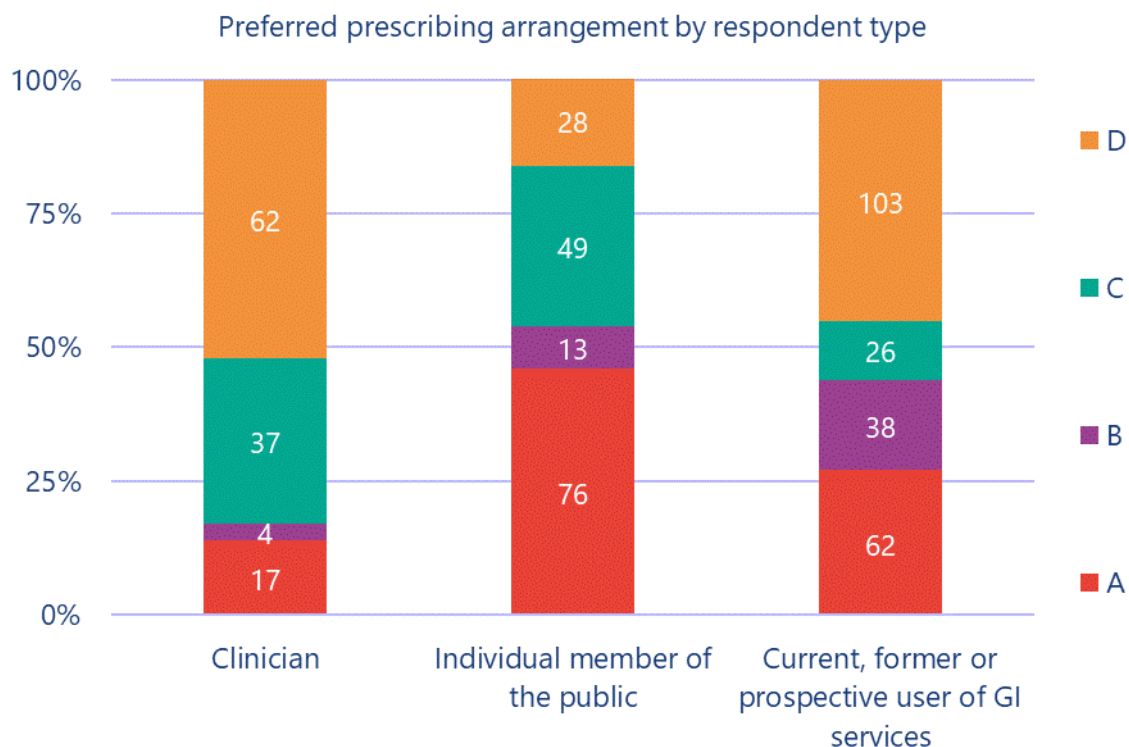


Figure 27

Option D was the preferred choice of clinicians and service users with 52% and 45% of respondents in these groups choosing this option respectively. Amongst individual members of the public the preferred prescribing option was Option A with 46% of respondents in this group selecting this option.

Figures 28 – 32 breaks down the preferences of respondents who were service users.

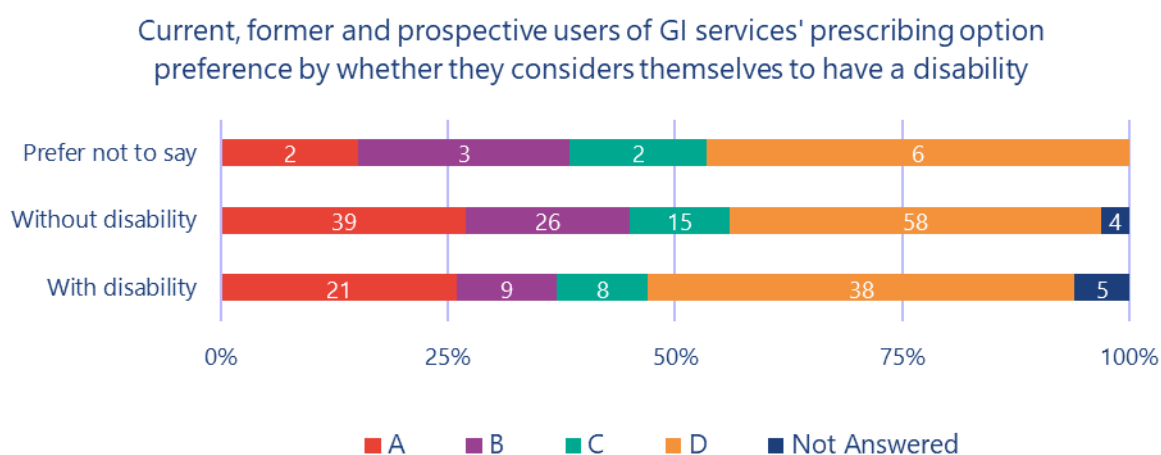


Figure 28

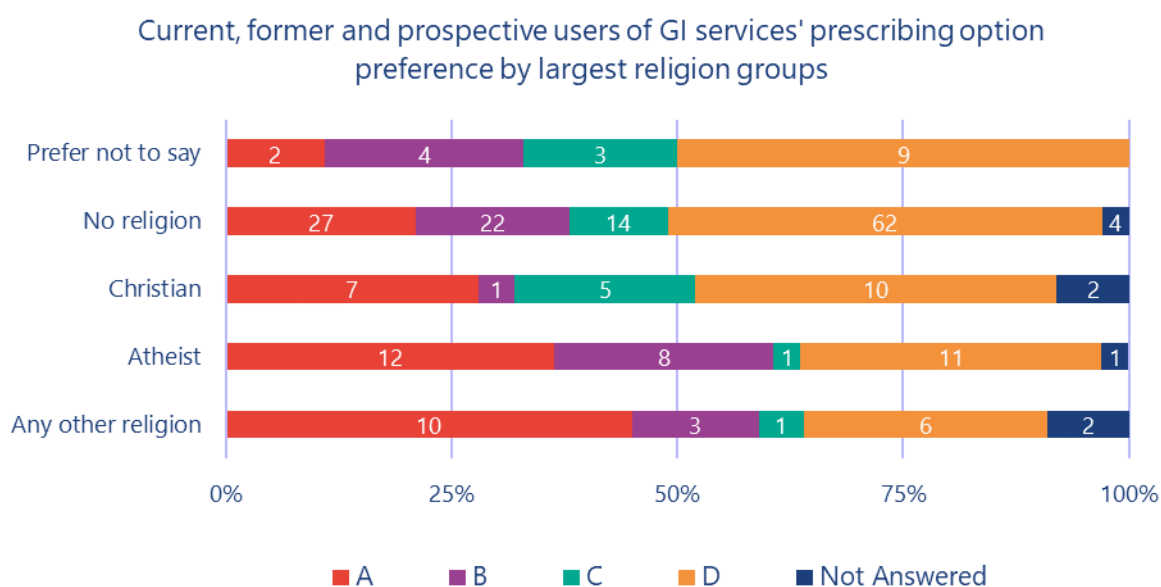


Figure 29

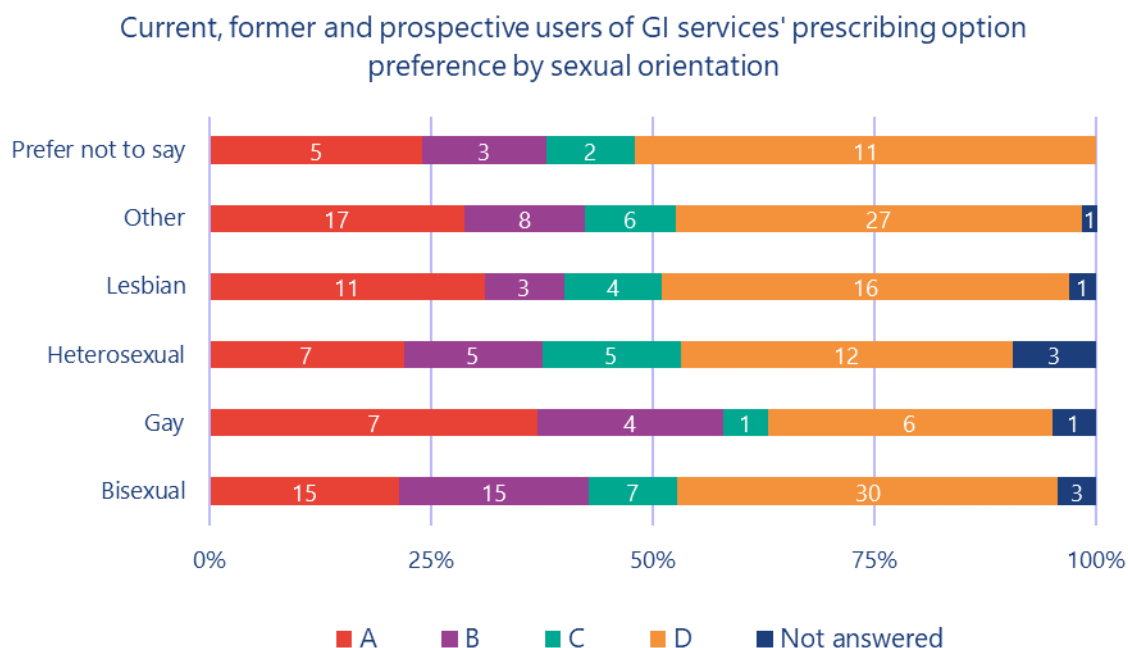


Figure 30

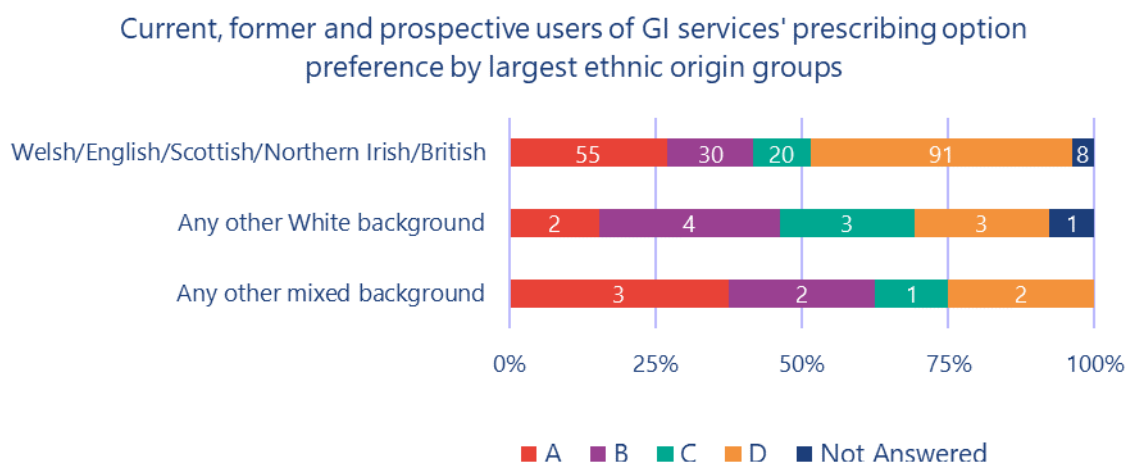


Figure 31

Option D was the preferred option across most age groups except for:

- Those 18 years or under – where the response numbers are too low to draw meaningful conclusions
- Respondents between the ages of 35 and 49 years, who preferred option A over option D.

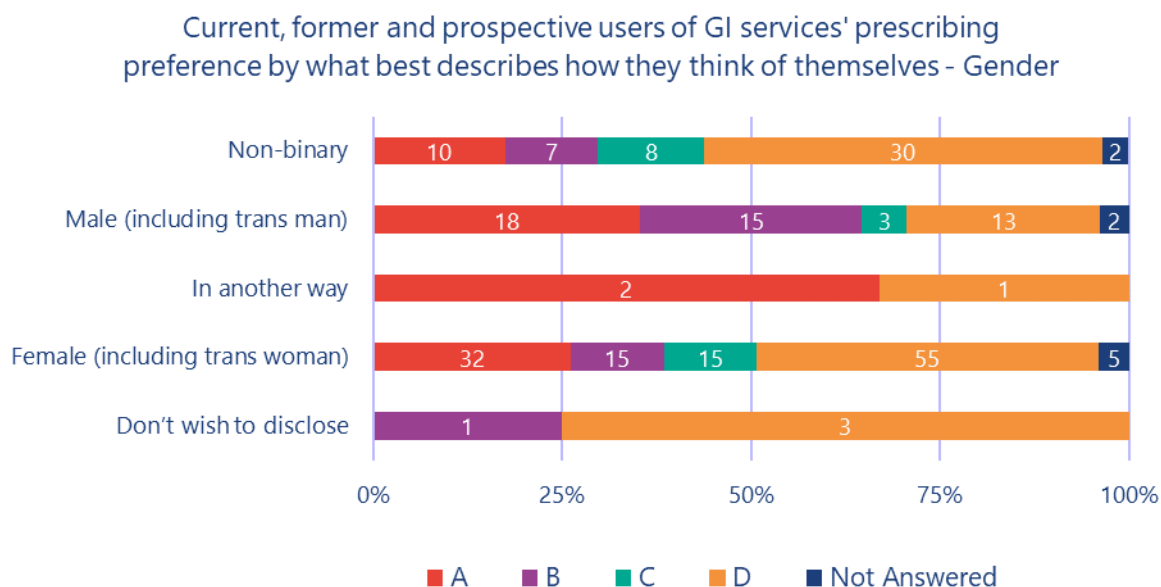


Figure 32

Option D was preferred by respondents across all Gender types except:

- For males (including trans males) who preferred option A
- For those who described themselves in another way – where the number of respondents is too low to draw robust conclusions.

In addition to the multiple-choice question, respondents were asked to describe any other options for prescribing arrangements for hormone treatment that should be considered. In the open-text comments, respondents covered the following issues:

- Detailed views on each of the four options
- Alternative arrangements for prescribing
- The role of GPs in prescribing.

4.2 Detailed respondent views on each option

NHS England's consultation documents explained that the proposals for prescribing were presented partly in response to a request from the British Medical Association's General Practitioners Committee to explore possible alternative models that fulfil the needs of patients, as it feels that the current common practice is not clearly defined and does not provide adequate support for prescribing practitioners. The BMA's response to consultation is included as Appendix 2. In summary, the BMA said:

"We do not think that options A, B or C as written provide an appropriate solution to the current concern of GPs and transgender patients ... Option D is a medically acceptable way forward. We believe that this should be combined with a facility for GPs to continue to prescribe for their patients where both the GP and the patient feel this is appropriate, with this being delivered via a Direct Enhanced Service".

There was broad agreement amongst clinicians who identified as General Practitioners and Clinical Commissioning Groups that prescribing hormone treatments for transgender people was outside the competence limits of most GPs.

"These patients require treatment with off label and unlicensed medication. The specialist is best placed to initiate, monitor and manage ongoing treatment and care. Since there are relatively few patients, there is an issue with training of GPs and maintaining knowledge, experience and skills in such treatments and management. No long term effects are known and long term monitoring is evolving. There needs to be a specific role and expertise developed. Patients should not be discharged from clinics. There should be lifelong shared care arrangement with a specialist GID prescriber. This should include monitoring and this should not be passed back to the GP". (Thames Valley Clinical Commissioning Groups)

This view was disputed by trans groups, and by most service users:

"While we appreciate GPs may not have specific knowledge around endocrinology, hormone treatment (after being guided by a specialist) is not unusually complicated and does not require unusual amounts of expertise over and above that of normal GP training. Leaving patients without access to healthcare is unacceptable and discriminatory". (Action for Trans Health)

"We do feel strongly however that the challenge to the current service model by the BMA in regards to local GP prescribing of hormones and monitoring of blood tests looks like simply an opportunity to utilise Trans service users as a basis to challenge the overall primary care contract requirements of engaging in shared care agreements with specialist providers. The case being made appears to be more political than clinical in nature as many of the existing clinical skills and expertise required in regards to managements of Trans service users' shared care

agreements are being utilised by GPs with other cisgender patients”. (Trans Equality Legal Initiative)

4.2.1 Option A

32% of respondents selected Option A as their preferred prescribing arrangement.

General Practitioners and Local Medical Committees did not agree that Option A represented the status quo and challenged the description of Option A as adequately representing the current prescribing arrangements. As one respondent commented:

“From discussions with our GP colleagues nationally within LMC conferences, we believe the rejection of prescribing and monitoring responsibility to be representative of GP practices across the country”. (Buckinghamshire Local Medical Committee)

Strengths of Option A

- Positive comments outlined the benefits of Option A for those who do not live near to a GIC. The location of GP surgeries being close to individuals’ homes facilitates the provision of ongoing support and monitoring and reduces the travel burden associated with travelling to a GIC. As one respondent put it:

“I don’t want to take a day off work every time I need a blood test, because that is what I need to do to get a GIC appointment.” (Service User)

- In addition, respondents said that if responsibility for prescribing is with a GP, individuals can discuss concerns with someone with whom they have an existing relationship and an established level of trust. However, service users and General Practitioners considered it important that the expertise of GICs was successfully shared with prescribing GPs, as it was felt that GPs do not have expertise in hormonal treatment for gender dysphoria patients to prescribe without specialist advice and support.
- Maintaining the current arrangements was regarded as beneficial for moving beyond *“exceptionalism in the treatment of trans people post-diagnosis”* (“other” respondent). It was felt that if GPs currently have the responsibility to oversee, for example, hormone replacement therapy for cis-gendered women, this should not differ for trans people.

Suggested improvements to Option A

While positive comments were offered about Option A, respondents also offered suggestions for how prescribing could be improved under this arrangement.

- It was suggested that GPs should be clear about their responsibilities and that they should have established ways for accessing clarification and support from those who have more specialised knowledge and experience within GICs
- Furthermore, Option A was considered to be suitable on condition that it ensures the prevention of long waiting times for those accessing prescriptions.

Weakness of Option A

Despite positive views about Option A, few respondents had concerns with aspects of this proposal.

- Service users and clinicians felt that GPs often do not have the adequate support or information to prescribe, and requests for information are regularly unsuccessful. As one respondent described:

“There is mention of ‘advice in a timely manner’ – my experience has been that advice requests from GICs have not been responded to in a timely manner (I have received advice 8 weeks after asking on occasion and sometimes not at all).”
(Clinician)

- It was felt that GPs may currently be reluctant or “overly cautious” to prescribe and that advice from GICs could increase a GP’s confidence to prescribe unlicensed hormones.
- It was suggested that patients should have the option to arrange prescriptions with the GIC if their GP is not “*open-minded when it comes to trans and non-binary patients.*” (Service User)
- There was a view amongst clinicians who were GPs that in some cases the GICs have acted unreasonably in insisting that the GP commit to prescribing responsibility as a condition before accepting the referral of their patient.

4.2.2 Option B

11% of respondents selected Option B as their preferred prescribing arrangement, making it the least popular option amongst respondents.

Strengths of Option B

- Respondents noted the benefits of having the prescribing process started by a professional from the GIC with specialised skills and experience. In addition, it prevents delay in the commencement of medication.
- Option B was seen to be a useful way of combining on the one hand, the skills and knowledge of GICs, and on the other hand, the beneficial feature of GPs being close to individuals’ homes. GPs will be supported in providing treatments which is advantageous as they may not initially have the necessary specialist

knowledge. It is felt that Option B facilitates GICs being a “source of advocacy and guidance”.

Weaknesses of Option B

- There was some concern about the seamlessness of the transfer of prescribing responsibility from the GIC to the GP. These concerns included the fear that GPs would not accept prescribing responsibility at the point of transfer, and unclarity about who would be doing and interpreting the blood tests.
- Primarily NHS commissioners and “other respondents” agreed in principle that that the GICs could provide a level of specialist care that GPs could not, but they suggested that certain individuals would benefit from a period of longer than one month under GIC monitoring. This was particularly the case since the hormone treatment needs dose adjustment for longer than a month. For example, one respondent stated:

“Hormonal treatment often needs dose adjustment. Doses should be stabilised by specialists before transfer of prescribing responsibility and therefore a longer period of specialist prescribing is required.” (NHS Commissioner)

4.2.3 Option C

21% of respondents selected Option C as their preferred prescribing arrangement.

Strengths of Option C

Favourable comments on Option C highlighted the advantages of transferring responsibility to a GP once a person’s hormone treatment had stabilised. This would give time for those with specialist knowledge in GICs to monitor treatment and resolve issues before handing over responsibility to less experienced GPs. In addition, it was suggested that Option C would benefit those who do not have access to a GP due to homelessness, or do not have access to a supportive GP in their local area.

“We would prefer Option C; this would allow for more integration between the specialist services and the patient’s ongoing support from their GP.” (Royal College of Nursing)

Suggested changes to Option C

- Respondents suggested that responsibility for prescribing is only transferred to the GP once the patient was stabilised rather than an arbitrary period of one year.

“There are inherent dangers in setting an arbitrary timescale for handover.” (British Medical Association)

- Additionally, it was suggested that GPs would need advice from specialist GIC teams after the transfer of prescribing responsibility had taken place, and this would need to be an efficient knowledge-sharing process. In order to address the problem of individuals having to travel to GICs, it was suggested that GICs could advise GPs on blood monitoring tests. The latter could then be carried out by GPs, with results then being forwarded on to the GIC.

Weaknesses of Option C

- Respondents were concerned about the travel burden on individuals that would result from the implementation of Option C. It was suggested that the financial and time commitment that is necessary to travel to a GIC threatens the principle of equal access. Specifically, it was highlighted that some hormone prescriptions, such as sustanon, require an injection every 3-4 weeks, leading potentially to disruption if individuals have to travel to a GIC each time. In addition, respondents raised concerns about the waiting times that they associate with attending appointments at GICs, for example if it is felt to be necessary to change a dosage of medication.
- It was suggested that prolonging the length of time for which the GIC holds prescribing responsibility would not solve the perceived problem of a lack of skills and knowledge amongst GPs, once the handover of responsibility had taken place. GPs would need to be willing and equipped to continue prescribing after one year. Therefore, there would need to be recognition of shared care, and training would need to be provided to ensure that standards of care in prescribing and monitoring hormone treatments is consistent across providers.

4.2.4 Option D

36% of respondents selected Option D as their preferred prescribing arrangement, making it the most popular option amongst respondents.

Strengths of Option D

- Respondents felt that Option D would prevent the problem of longer travel distances posed by Options B and C. The creation of a specialist GP would make:

“Access to hormone treatment more local and more accessible to trans patients.”
(Action for Trans Health)
- The new GPs with a Special Interest in Gender Dysphoria were viewed positively in that they would provide individuals with access to someone who has “met and dealt with trans people before, and is aware of our needs”. As one respondent expressed:

"I strongly support having at least one named GP for each region who has a specialisation in Gender Dysphoria, as perceived or actual fears that their own GP will treat them disrespectfully and not take appropriate action on their behalf has been a massive barrier to accessing treatment in my own experience and in the experiences of many trans people I know." (Service User)

Suggested changes to Option D

- While respondents felt that Specialist GPs could have a productive role in prescribing, it was suggested that individuals should not be required to go to a specialist if they are happy with their arrangement with their local GP. Therefore, it was suggested that individuals should have the option to utilise the services of the local Specialist GP.
- Respondents recognised that Specialist GPs would be more local and easily accessible when compared with GIC. However, there was a concern that accessing the services of Specialist GPs would still require significant travel. Therefore, one respondent expressed:

"Unless this is going to be actually local, it will just lock trans people further out of medical support." (Service User)

- It was suggested that prescriptions should not only be available through Specialist GPs. One respondent explained that they have multiple prescription requirements, e.g. for hormone therapy, respiratory and reflux problems and that the requirement to get the hormone therapy prescription from a GPwSI would lead to unnecessary complication and require coordination between GPs.

Weaknesses of Option D

- Concerns were expressed about access to GPs with Special Interest across different regions. It was felt that there may be an over-reliance on one individual GPwSI, which would lead to gaps in services if that individual became unavailable in unforeseen circumstances. In addition, respondents cautioned that an unacceptable "postcode lottery" may result if it proved not to be possible to recruit GPs into this role across all localities.
- Respondents requested more information about how GPs with Special Interest would be recruited and trained. It was also suggested that GPs with Special Interest would need to be commissioned at a national level in order to prevent variation in services across regions.
- It was suggested that it would be far more valuable to train and educate all medical practitioners, including GPs so that *"trans people are treated equally and with dignity and respect by all medical practitioners and not the chosen few"* (Clinician). In addition, it was stated that it would be preferable to teach on top of the existing GP role rather than create new roles.

- There was concern that there may be long waiting lists to access the services of the GPwSI. It was also suggested that the use of GPs with Special Interest may result in patients losing out on the personalised care with their own GP.
- While responses centred on the creation of the new role aspect of Option D, the retention of the need for the prescription to be recommended by a GIC was questioned. There was also concern that Option D felt like an attempt to *“let transphobic and obstructive GPs ‘off the hook’ with regard to their obligations.”* (Service User)

4.3 Role of GPs in prescribing

The need for guidance and training

The points below on the need for guidance and training of GPs were raised by some service users, some ‘other’ respondents, few family and friends of service users, and few clinicians.

- Many clinicians (who were mostly general practitioners) expressed concerns about responsibility for prescribing resting with GPs. Issues around GPs not being appropriately trained or funded to prescribe were raised. It was felt that the transfer of specialised prescribing into primary care would need to be supported by an increase in resources. It was felt GPs were being asked to act outside their expertise and competence. For example:

“As a GP, I do not have the skills, knowledge or time to monitor these meds. These hormones are dangerous if not monitored – risk of cancer etc. This must stay with the specialist clinic at least until stable but preferably continuously.” (Clinician)

- It was suggested that the number of patients that an individual GP would see are likely be so small that *“it will be impractical for a GP to maintain the skills required in order to fulfil their duty to do no harm to the gender identity patients”* (Clinician)
- Respondents discussed the importance of improving the training and support available to all health staff, not just those with responsibility for gender identity services to ensure responsiveness to the needs of trans patients. It was felt that GPs should receive more comprehensive training on how to administer hormone treatment, and training packages for GPs on gender identity should be “much more widely available and that there should be high levels of take-up of such training”. The current training tool available from the Royal College of General Practitioners was considered inadequate. For example:

“As a GP who is myself developing an interest in the area of gender variance due to the increasing cohort registered at my practice, I do not feel that the CR181 document and RCGP e learning is anywhere near enough to support me to do what has been asked of me

by my patients, such as initiating hormones as ‘bridging’ when on waiting lists, or to take over prescribing when they have started hormones via self-prescribing.” (Clinician)

- It was felt that additional guidelines and clarification on prescribing and monitoring should be offered so that it does not *“fall to trans service users and patients to have to follow this up themselves or jump through any further unnecessary hoops.”* (Service User)

Limited GIC involvement in prescribing

The points below were primarily raised by service users.

- It was felt that where GPs are willing and able to prescribe, there should be no need to involve other prescribers such as GICs. Waiting times for appointments at GICs mean that if GPs can prescribe, this should be welcomed. In addition, it was expressed that the aim should be to establish a norm whereby all patients have their long-term gender care managed by their GP in the same way to other health issues, rather than maintaining “exceptionalism” in treatment.
- Similarly, it was expressed the HRT should be prescribed and monitored at a local level with referrals to GICs only being necessary for surgery. GICs were felt to be unnecessary “gatekeepers” to HRT. One respondent urged the weighing up of *“whatever justification you have for maintaining a strained, outdated, confrontational, centralised system of ‘expert’ gatekeepers”* against the suffering that results from waiting to be seen at a GIC and start HRT. It was felt that as an alternative, local NHS services should be allowed to streamline gender care. The need for access to local services was raised, for example:

“Teens or any trans person should not have to wait for an appointment miles away for help.” (Individual Member Of The Public)

- In addition, it was felt that the extra workload on GICs that could result from them being responsible for prescribing and monitoring hormonal treatment could limit their ability to carry out assessments.

Discrimination in prescribing

The points below were raised by a few service users.

- Service users suggested that any option that retains prescribing responsibility with the GP would be pointless unless GPs are prevented from denying treatments inappropriately. It was felt that:

“GPs also often treat trans people with disrespect and ignorance, again due to a lack of training and/or prejudice.” (Community representative organisation)

- Respondents noted the perceived inequity when GPs are content to prescribe HRT for cis-gendered women but not to prescribe hormone treatments for trans and non-binary people.
- More clarification was sought about what action would be taken by NHS England in the event that a GP practice places a “blanket ban” on administering treatment to trans and non-binary people.

4.4 Alternative approaches to prescribing

In the open-text comment, respondents outlined a number of alternative approaches to prescribing. These included:

Additional prescribers and prescribing arrangements

- Respondents emphasised the potential role of endocrinology experts. Using local endocrinologists to prescribe and monitor hormones was felt to provide individuals with local access to specialist care. For example, one respondent (a service user) discussed their experience of asking their GP to refer them to a local endocrinologist who worked out of a diabetes unit, and found this to be quicker and more convenient than having to refer to a “distant GIC” for monitoring. It was also suggested that endocrinology departments could provide first prescriptions.

“There does not seem to be a requirement on gender identity clinics to have a hormone prescriber or endocrinologist, only the ability to obtain advice, which does not appear to be sufficient.” (Royal College of General Practitioners)

- Respondents offered suggestions for the involvement of additional types of practitioners in prescribing. It was suggested that prescriptions could be provided by non-medical prescribers supported by an endocrinology department, as it was felt that this arrangement would offer greater expertise than could be given by GPs. It was also suggested that nurses could play a role in prescribing and monitoring, and V300 prescribers could prescribe if they have suitable competencies. It was felt that community gender dysphoria teams which link in with gender dysphoria clinics could be established for prescribing. The additional arrangement of GID Clinics issuing Hospital FP10Hs and posting them to patients was offered.

Flexibility between GIC and GP in prescribing

- It was suggested that decisions on whether the GIC or GP has prescribing responsibility should depend on what is appropriate given the local context, and that there should be a level of choice for individuals. As one respondent described:

“It’s a balance between geographical access and the barriers that many patients still see

from GPs. Could patients have a choice between GP and GIC?" (NHS Provider Organisation)

- It was suggested that GPs could prescribe without any involvement from a GIC if they have sufficient expertise:

"We also believe that the options should be explicitly available that the GP prescribes hormones before or without intervention from the GIC, allowing for local and decentralised treatment where expertise allows." (Community Representative Organisation)

- It was suggested that all medical practitioners should be able to offer a first prescription after suitable preliminary health monitoring to avoid undue delay and distress to individuals.

"All medical practitioners if they recommend initiation of an endocrine prescription should be willing (and suitably qualified to obtain informed consent) to offer the first prescription (after suitable preliminary health monitoring) to avoid undue delay and distress to a patient who is usually experiencing significant life stressors during the assessment period. This frustration is heard many times from service users and we should be respectful of their needs and preferences and not only the preference of the service providers." (Royal College of Psychiatrists)

Use of electronic systems

- Respondents - primarily service users - discussed the need for communication to take place over emails and telephone calls rather than through easily missed or lost letters. It was felt that remote consultations, undertaken over the telephone or internet, would improve service-user engagement for many groups including disabled service-users and those who live some distance from a GIC. It was suggested that the development of relevant skills and procurement of appropriate technology for remote consultations was necessary. Respondents stated that GICs should make use of electronic prescribing. For example, the GIC could issue the initial prescription and then subsequently provide repeat prescriptions online. It was felt that this arrangement could remove pressure from GP services.
- Clinicians who supported options that would transfer prescribing responsibility to gender identity clinics noted that this could be facilitated through electronic prescribing, and suggested that adoption of new arrangements should not be considered unachievable *"just because prescribing at a distance is slightly more complicated and requires IT skills and arrangements"*. (Clinician)

Self-medication and bridging prescriptions

- Respondents – primarily service users - felt that self-medication should not be punished as it was suggested that many individuals will self-prescribe due to delays in being seen by a GIC. They said that there should be less stigma

surrounding self-medication. The consultation proposals for prescribing arrangement were seen to not provide detail about how to handle cases where an individual has been self-medicating. Respondents said that telling patients to stop self-medicating will not reduce risk and as an alternative, local specialists should be required to monitor self-medicating individuals and provide bridging prescriptions until assessment at a GIC can take place. It was viewed as important that self-medicating trans people should be transferred onto “*some form of legal, safe and regulated HRT.*” (Service User)

- The Royal College of General Practitioners noted the contentious nature of this issue: “*The GMC guidance suggests that GPs should prescribe “bridging” prescriptions for those who have been obtaining hormones through illegal channels. This has been met by anger and outrage by some GPs. They have since introduced three criteria which must be met in order to consider prescribing a “bridging” prescription. The issue of bridging prescriptions remains extremely controversial within the profession.*”
- Respondents – primarily service users - discussed the harms that can exist if individuals are not provided with bridging prescriptions whilst waiting for access to a gender clinic. This was seen to be a particularly pressing problem given the long waiting times that individuals can face. It was felt that GPs should not refuse blood tests to patients who are “self-medicating” or tell patients to stop taking hormone therapy, and should instead provide bridging prescriptions for these patients to reduce potential harm. The mental health benefits of bridging prescriptions to individuals were discussed. For example:

“I feel that better provision of bridging prescriptions should also be put into place. I was fortunate to have the means to access a prescription privately before I got to the GIC and can attest to the positive effects on my mental health that had while I waited for my NHS diagnosis.” (Service User)

- It was felt that Option A does not address the problems associated with bridging prescriptions for patients who are self-medicating prior to being assessed at the GIC. On the other hand, Option D was felt to address the problems of ‘bridging prescriptions’ by ensuring that there was a “locally available intermediate tier of expertise”. Specifically, it was felt that local specialists created through Option D would be confident in prescribing (e.g. low-dose bridging hormones or hormone blockers) to those on a waiting list for an adult clinic.
- To guide the issuing of bridging prescriptions, it was suggested by service users that GPs should be trained specifically in the care needs of trans people who are self-medicating and that GICs should issue general advice on basic requirements for eligibility and dosage requirements could be easily provided by GICs.

Off license medication

The following comments were raised across numerous respondent types:

- Concern was raised about non-specialists prescribing medication off license where there is a potential for *“harm to the patient and consequent medicolegal risk to GPs”* (British Medical Association). It was felt that GPs should not be under pressure to prescribe off license medication. As one respondent stated:

“General Practitioners should not be coerced into prescribing drugs that are off licence and of which they have no specialist knowledge. It would not be tolerated in any other specialty.” (Clinician)

- The limited evidence base on the effects of hormonal treatments was put forward by some respondents as a reason for necessary concern when prescribing.
- Respondents questioned why hormonal treatments are still off license. For example:

“I believe that the GICs have been around in one form or another for over 20 years so surely enough time has passed for the drugs to be recognised and established as helping with the treatment of gender dysphoria and labelled as such? If it is a question of no trials and studies being done to establish this, why is this not happening already?” (Service User)

Informed consent

Respondents – service users - raised the following points regarding “informed consent” in relation to prescribing arrangements.

- Respondents discussed the benefits of an ‘informed consent’ model of prescribing. This is based on the idea that it is individuals themselves who are best placed to assess whether they are ready to begin hormone therapy. It was noted that Options A, B, C and D would all require an initial assessment by a GIC before an individual could be referred on for treatment. One respondent stated:

“Let trans people decide their own treatment. Obviously, we should be aware of the risks and changes that come with hormones, but it doesn’t stop you being trans, and when you are trans and you know what you want, you should be allowed to get that without waiting 5 years for some cis people to confirm that you are in fact a tran.” (Service User)

- Respondents stated a preference for an informed consent model to reduce lengthy delays in treatment, where GPs would be less afraid to prescribe. One respondent outlined that “A Declaration of Understanding” by the patient could be used to remove pressures on GPs to cover themselves from a medico-legal perspective and that individuals could take legal responsibility for treatment. In addition, it was felt that GICs should not be needed to recommend hormonal

treatment. If a GP can explain what will happen and a trans person consents with informed consent, the GIC's role was viewed as unnecessary.

Shared care agreement

- Respondents – primarily clinicians - discussed the need for clear shared care arrangements between GPs and specialists. These shared care arrangements would need to be formally documented and agreed upon by GPs and specialists. As one respondent states:

“If GPs do take on prescribing e.g. after a period of stabilisation; I believe there needs to be a cleared shared care agreement, with details about monitoring/frequencies including lifelong monitoring if discharged from the gender identity clinic. As part of this there needs to be an agreed means of communicating blood results with the specialist gender identity clinic and this agreement should be signed by the specialist responsible.” –(Clinician)

- A shared care agreement could ensure that a specialist would provide “long term supervision and support” if any problems arise, in a similar way to the current prescribing arrangement for rheumatology patients on drugs such as methotrexate. The need for easy access to specialist advice by phone was expressed
- In addition, it was suggested that while Shared Care Protocols mean that clinical oversight is shared between specialists and GPs, GPs retain medicolegal responsibility for their prescribing, and therefore may “reasonably wish to decline this responsibility.” (Other Respondent)

NHS should not fund hormone treatment

- A few individual members of the public suggested that the NHS should not provide hormonal treatment. The cost of treatment was raised in a context of restricted NHS funding. One respondent stated private funding should therefore be considered as an alternative to NHS provision. It was stated that the “answer” to gender dysphoria is not to provide a medical intervention but ensure a change in society where individuals have the right to wear, behave and do as they like. It was felt that local GPs should not be required to prescribe hormonal treatment because they may have objections to this for “very good and ethical reasons”. Concerning the safety of hormonal treatment, it was stated that these are “dangerous drugs” that have not been “sufficiently tested for long term outcomes”.

Counselling prior to hormonal treatment

- It was also suggested that individuals should be required to have counselling or therapy prior to, or as an alternative to, hormonal treatment. Additionally, it was suggested that only consultant psychiatrists should have “the decision-making powers” around access to hormone treatments. It was felt that individuals

should have numerous consultations and have the opportunity to weigh up various options before deciding to begin hormonal treatment.

Chapter 5 Equality Assessment

NHS England prepared an Equalities Impact Assessment (EIA) for the proposed specifications for Gender Identity Services for adults. The service specifications were designed to:

- Reduce health inequalities
- Enhance “equality of opportunity”
- Prevent “discrimination, harassment, victimisation” of any individuals, in line with the Equalities Act 2010.

In response to the EIA, the Equality and Human Rights Commission commented:

“It is encouraging to see that the Consultation is supported by an equality and inequality impact assessment in line with NHS England’s responsibilities under the public sector equality duty ... This [assessment] examines how the potential proposals may impact on trans patients with different protected characteristics. The [assessment] should be updated with new evidence gathered through this consultation. This might include a more detailed assessment of why some people are reportedly being turned away from specialised services and also consideration of any barriers to accessing services which may face patients from some groups more than others”. (Equality and Human Rights Commission)

The EIA specifically considers potential negative and positive impacts upon groups with “protected characteristics”. These are:

- Age
- Disability
- Sex
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sexual Orientation
- Marriage and Civil partnership

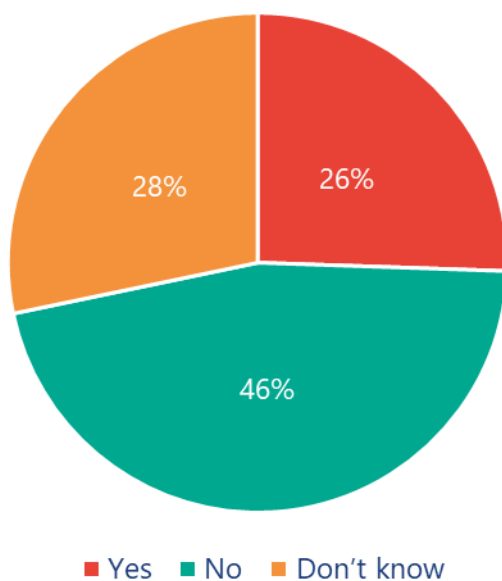
Respondents to the NHS England consultation were asked whether they felt the assessment of the equality and health inequality impacts of the proposals was accurate. This is shown in Figure 33. Figures 34 and 35 breakdown responses by gender and sexual orientation. Considering only those who answered yes or no, the key differences in responses by gender were:

- 60% of males (including trans males) said that assessment was accurate
- Around 40% of females (including trans female) and those who identified as non-binary said that assessment was accurate
- 21% of those who did not wish to disclose their gender said that assessment was accurate
- 2% of those who considered their gender in a different way to the above options said that assessment was accurate.

Considering only those who answered yes or no, the key differences in responses by sexual orientation were:

- 56% of those who identified as gay said that assessment was accurate
- Around 40% of those who identified as heterosexual, bisexual or in another way said that assessment was accurate
- 30% of those who identified as lesbian said that assessment was accurate
- 23% of those who preferred not to state their sexual orientation said that assessment was accurate.

Just under half of respondents felt that the assessment of the equality and health inequality impacts is not accurate



697 (86%) responded to this question

Figure 33

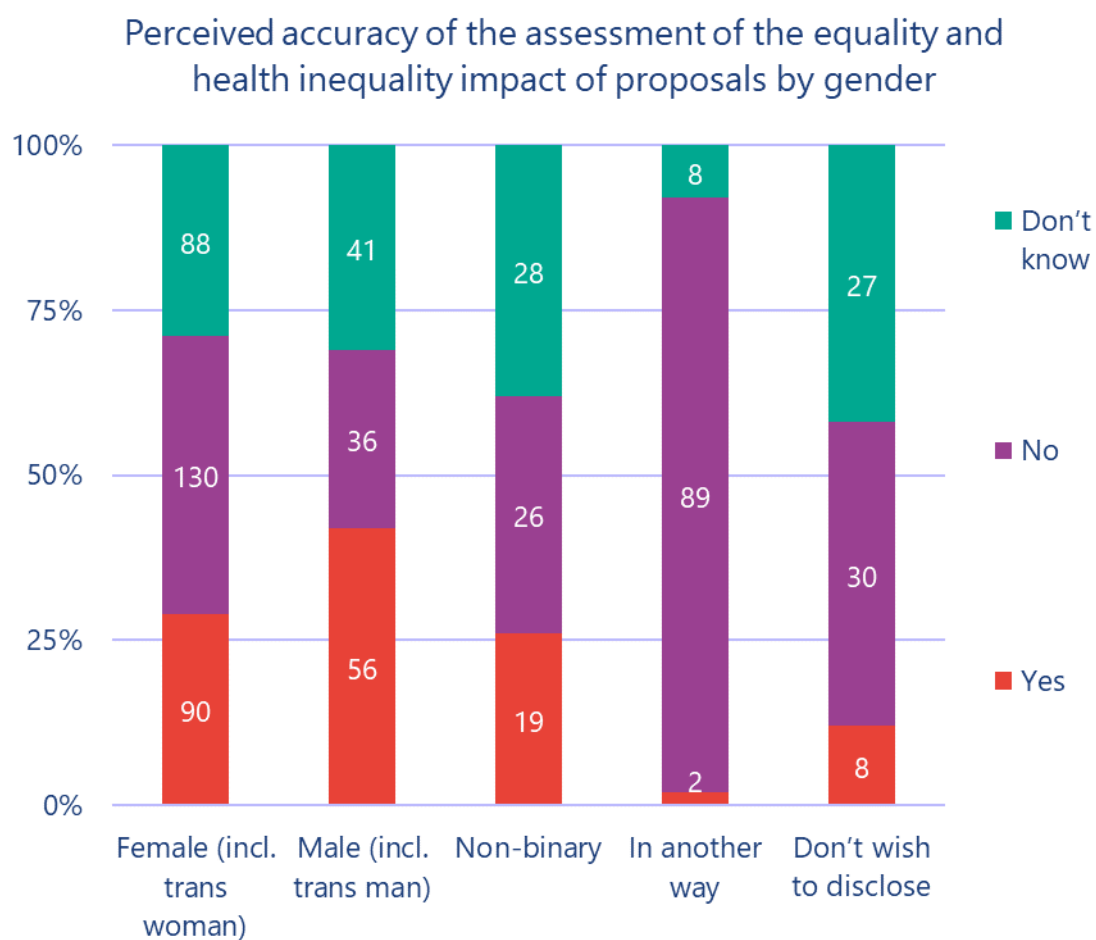


Figure 34

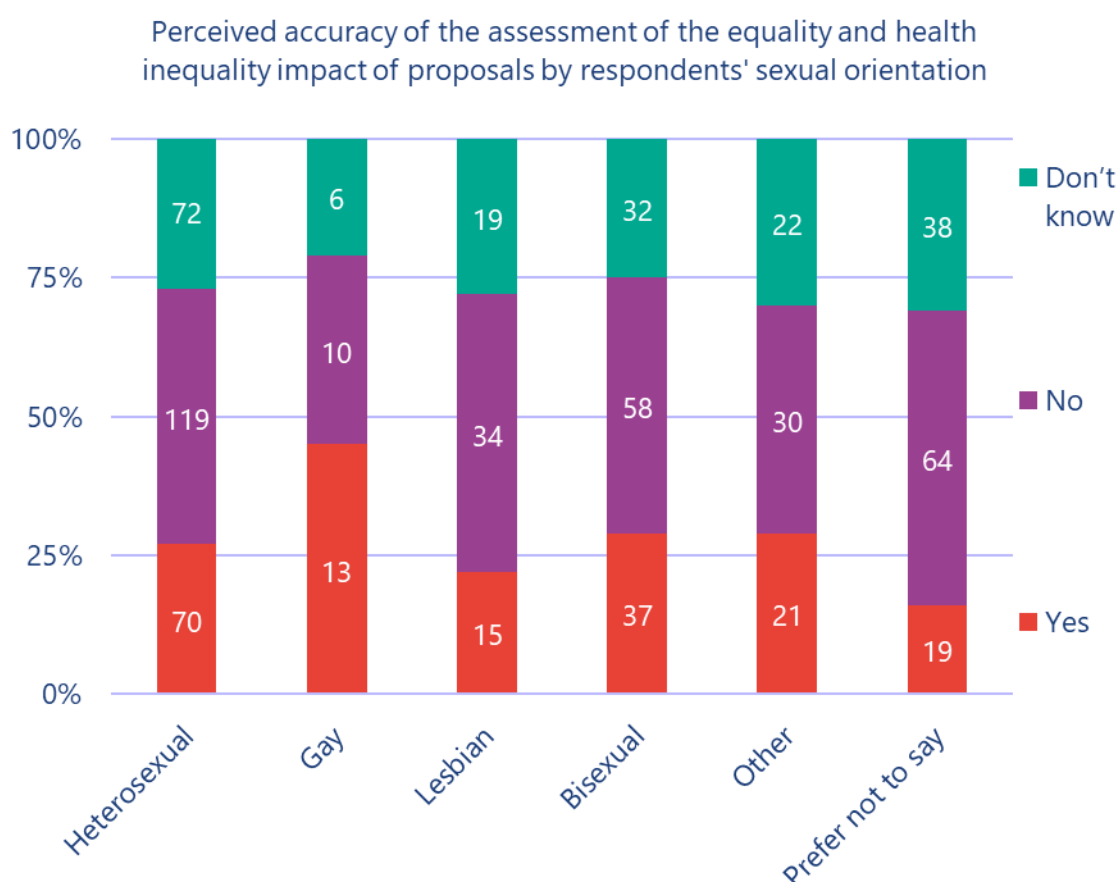


Figure 35

Respondents identified a number of potential impacts on each group with protected characteristics, highlighting omissions to the equality impact assessment and suggesting amendments. Respondents also commented on the equality impacts of the proposed services themselves, rather than just whether the impact assessment was accurate.

Age (older people)

Within the EIA, NHS England recognised a perception that some GICs had “implemented a policy of denying access to older trans people”. In response to such concerns, NHS England noted that the service specifications include the proposal 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”.

Acute physical and mental health conditions

A few service users said that the EIA was unfair to those with a disability. The most common reasons stated for this were:

- A “lack of clarity” around the definition of “acute physical or mental health problems”. Respondents felt that this clause left room for practitioners to unfairly exclude anyone not able-bodied. Respondents questioned at what point an individual was deemed no longer capable of giving informed consent, and felt that this should not be decided by any individual practitioner.
- A lack of any requirement for GICs to make “reasonable adjustments” or “adaptations” to facilitate the inclusion of those with disabilities. This was felt to be at odds with the Equality Act 2010.
- The proposals include additional assessment consultations which respondents said led to restricted access for those with disabilities, and the negative impacts of this. Respondents cautioned against assessing disabled people more rigorously than able-bodied individuals, as this was considered “discriminatory” and would increase their waiting times which may exacerbate underlying conditions.
- That the proposals were unnecessarily gate keeping of those with mental health conditions from accessing treatment. Respondents felt that the exclusion of those with chronic mental health conditions was being used as a “delaying tactic”, and that *“the prospect of people becoming stuck in a vicious circle of not being able to access treatment because of mental ill-health and the mental ill-health being caused by lack of access to treatment should be explored further”*.

Individuals who misuse substances (not a protected characteristic)

Respondents expressed similar concerns regarding treatment of those with a history of substance misuse. Respondents said that substance abuse could arise as “a coping mechanism for dysphoria”. Denying treatment on the grounds of substance abuse was thus felt to have the potential to “make the situation worse”. However, other respondents disagreed with this explanation, believing that “addictions will not go away as a result of gender reassignment.”

Disability (obese people)

Within the EIA, NHS England stated that:

“Individualised discussions may take place with the surgeon, who may decide to proceed with surgery on an obese person once risk has been assessed, but the impact of this proposed provision will be that obese people may be less likely to access surgical interventions on the trans pathway of care until they lower their BMI.”

Service users said that restricting access to surgical interventions for those with a Body Mass Index over 30 was not clinically justified and that it discriminated against this group. Concerns mentioned in Chapter 2 of this report (page 18) were reiterated. Respondents thought insufficient evidence existed to suggest that being overweight led

to surgical complications. Others felt that even if being overweight did increase surgical risks, this should not prevent access to surgery. It was suggested that overweight patients be made aware of the potential complications, but that it should be their decision as to whether to proceed.

The lived-in role and gender conformity

Service users welcomed the inclusion of non-binary people within the EIA, but felt this was contradicted by the requirement for patients to have lived in their “gender role” for 12 months to access genital surgery, since there is no clarity in defining a non-binary gender role. Respondents raised concerns that “gender identity” and “gender expression” were being conflated. They stated that outdated stereotypes, such as wearing a skirt rather than trousers, were being routinely used by specialists to assess whether someone was “trans enough” to be referred. External and arbitrary gender stereotypes were felt to act as a barrier to binary, gender-fluid and bi-gender people too. These concerns are summarised by one respondent below:

“It should not be assumed that all trans people aim to pass, or fully conform to a gender binary, and careful consideration should be given to appropriate accommodation for them.” (Service User)

Variations of Sex Characteristics

NHS England proposed that referrals from people whose “*presentation primarily relates to intersex conditions*” would not be accepted. Service users 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 variations 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 variation of sex characteristics, and that GICs were best placed service for such individuals who identify as trans.

Pregnancy

The EIA states that “there are no impacts” to those who are pregnant. 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”.

Sex (surgical procedures that are not routinely commissioned)

NHS England acknowledged in the 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, particularly service users, 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. The exclusion of facial feminisation surgery, breast augmentation and hair removal from NHS commissioned services was felt to be creating an imbalance between the male-to-female and female-to-male pathways, leading to health inequalities. Where possible, respondents wanted to see equivalent procedures in each pathway e.g. mastectomy for female-to-male being matched by breast augmentation for male-to-female, or testosterone-induced beard growth being matched by provision of facial electrolysis.

Race

- A few respondents referred to the under-representation of Black and Minority Ethnic groups as both service users and gender identity services staff.

“The under-representation of BAME people is, in part, due to the discrimination and treatment that members of these communities face within health services in general (as evidenced by the documents referenced within the consultation guidance). As such, it is not enough to simply say “there must be measures in place” - these measures must be considered in consultation with the trans and non-binary BAME communities and explicitly outlined”. (UK Trans Info)

- The National LGB&T Partnership 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 GIC users, and evidence that trans people are more likely to identify as having a disability than is average in the population.

The National LGB&T Partnership also noted that the information in Appendix K (facial hair removal) is lacking in guidance for clinicians referring people with dark skin.

Sexual orientation

Some respondents, primarily members of the public, were concerned that the increasing number of trans people was indirectly homophobic, and in particular lesbophobic. 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”.

Sex (women)

Reflecting the concerns raised in the previous section, 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.”*

Marriage and civil partnership (family members)

Respondents - primarily raised by 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 Identity 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.

Religion

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 GICs.

Concerns about geographical access, and waiting times

The Equality and Human Rights Commission wrote:

“Geographical distance from specialised treatment can be a problem for some patients, particularly for people who may have reduced mobility. The proposals set out in the consultation to provide local ‘GPs with a Special Interest in Gender Dysphoria’ and remote conferencing with specialised clinicians may go some way to tackling this problem. It will, however, be important to review the responses to the consultation to ascertain how trans patients regard the new specification and what if any concerns they identify with the accessibility of services”.

UK Trans Info wrote:

“We appreciate that [the proposal is that] appointments and assessments can take place over the internet as an accessibility tool. We would still like to see a more firm commitment towards national procurement of services local to the

service users to help with the costs and difficulty of travelling for those who can or would prefer to travel”.

The current geographical pattern of GIC services across the UK was thought to be uneven and thus inequitable, and to be contributing to health inequalities for:

- Individuals experiencing “deprivation”. Respondents stated that travel costs to GICs could be “prohibitively expensive” for anyone on a low-income, or “living in poverty”.
- Those with mobility issues or in areas where GICs were “geographically sparse”. Individuals who were unable to travel far were felt to be disadvantaged, as accessing services often required travelling great distances.
- Those in areas with poor public transport connections. Respondents living in rural or geographically isolated areas were felt to be at a disadvantage as transport options were limited and more expensive.
- Those having to manage work and/or family responsibilities.
- Those with mental health conditions such as anxiety or agoraphobia. Travelling great distances, often to unfamiliar areas, was felt to be particularly difficult, or even pose an “insurmountable” barrier, to those experiencing severe mental health issues.

Chapter 6 Other

The final survey question asked respondents to provide any other comments about the proposal. Here, respondents covered the following points:

Informed-consent model

Service users suggested that NHS England should adopt an “informed consent” model. In trans health care, “informed consent” refers to service users being able to decide their treatment pathway autonomously and at their own responsibility. It is contrasted with “gate keeping”, where the ultimate decision-making power regarding referrals, assessments and interventions rests with health professionals. As such, service users argued that the adoption of an informed-consent model would replace the perceived over-reliance on unnecessary assessment and diagnosis consultations characterising the current system. The reasoning behind an informed-consent model are well captured by the following respondent:

“I am very much in favour of an informed consent model, as I believe firstly that people should have the right to bodily autonomy (including regarding aspects of their body which our society considers “gendered”), and secondly that few people take the step of requesting gender-confirming interventions without having thought a great deal about the risks and benefits and reached a considered conclusion. Such a model would involve fewer administrative and clinical hoops for patients to jump through, which in turn would free up the time of GIC professionals and allow them to process referrals quicker and reduce waiting times.” (Service User)

Social pressures

Many individual members of the public suggested that wider societal factors and trends should be considered when assessing those presenting with gender dysphoria. They suggested that young people, and young women in particular, are subject to “social pressures” which may lead them to identify as trans:

- It was felt that young people may be at risk of “social contagion” and “indoctrination” by trans lobby and peer groups online. It was suggested that young people may identify as trans as it gives them entry into a social network where they feel accepted. Respondents worried that any long-term decisions made as a result of trying to “fit in” as a teenager may lead to future regret.
- Respondents identified a set of social “social pressures” faced by young women in particular. They felt that some teenage girls may be transitioning to “escape” the role of a woman in the context of “misogyny” and “sexism” in society. They

suggested that the latter may lead to body dysmorphia in women, which can then be falsely understood as gender dysphoria. The perceived increase in the number of teenage girls attending young people's gender identity services was seen as evidence that this was a societal phenomenon.

Perceived lack of research on gender dysphoria

Many individual members of the public, and many family and friends of service users suggested that the aetiology of gender dysphoria and outcomes of gender identity services are currently characterised by a lack of research. The following two points were raised in particular:

- Respondents from these groups wanted more research on what “causes” gender dysphoria. They perceived this to be necessary in the light of
 - The perceived rise of people accessing gender identity service
 - The “social pressures” on young people and women outlined above
 - The suggested high co-morbidity rates of gender dysphoria with autism spectrum disorders (ASD) and attention-deficit/hyperactivity disorder (ADHD), but also past trauma, psychosis and depression (see 2.4 of this report).
- Respondents suggested that there is currently a lack of long-term outcome data on hormone therapy and gender surgeries. As such, they believe the current interventions are not evidence-based. In particular, they emphasised the relative lack of attention given to the phenomenon of transition regret (those regretting having undergone hormone replacement therapy or surgery). They drew attention to the need for the NHS to monitor the rates of transition regret and the numbers of those undergoing de-transition interventions.

Feedback on the consultation process

Respondents provided feedback on the consultation process and the survey. The following points were raised:

- A few respondents felt that the consultation documents and the survey were inaccessible. It was suggested that future consultations and surveys should be easier to read and comment on.
- Many individual members of the public suggested that the survey question “Which of the following options best describes how you think of yourself?” should have offered separate response options for those who consider themselves cis-gendered females and trans women. They regarded being “female” as distinct from being in the category “Female (including trans

women)" which was offered in the survey. It was felt that the views of "women" and "trans women" may differ, for example:

"I am a born woman and will very possibly have different views to a transwoman - the two are not interchangeable at all." (Individual member of the public)

- More generally, service users felt that more weight should be given to the trans community's opinion, as opposed to the opinions of health professionals. Respondents suggested that conducting more consultations with people who have experience of accessing gender identity services would be beneficial. One respondent stated:

"I think a genuine consultation would include an information gathering phase on the experiences of trans people and how we need the service to change rather than dictating the change then seeking comment." (Service User)

Appendix 1 List of organisations

Below is a list of organisations that responded to the consultation. Other organisations may have responded to the on-line survey without providing the organisation's name.

Action for Trans Health

Action for Trans Health London

Avon Local Medical Committee

Barnsley Local Medical Committee

Bedfordshire and Hertfordshire Local Medical Committee

British Medical Association

British Psychological Society

Buckinghamshire Local Medical Committee

Calderdale Council's People Scrutiny Board

Cambridgeshire Local Medical Committee

Camden Medicines Management Committee

Christian Concern

Christian Medical Fellowship

County Durham and Darlington Area Prescribing Committee

Cristianos Laser Clinic Ltd

East and North Hertfordshire Primary Care Medicines Management Group

Edinburgh Action for Trans Health

Equality and Human Rights Commission

Gender Identity Research and Education Society

General Medical Council

Humberside Group of Local Medical Committees

Lesbian Rights Alliance

LGBT Foundation

Manchester Area Prescribing Committee

Manchester Local Medical Committee

Medway Gender & Sexual Diversity Centre

Morecambe Bay Local Medical Committee

Morf

National Aids Trust

National LGB&T Partnership

National Union of Students

Nuffield Health Brighton

Pan Mersey Transgender Collaboration Group

Press for Change

Royal College of General Practitioners

Royal College of Nursing

Royal College of Obstetricians and Gynaecologists

Royal College of Physicians

Royal College of Psychiatrists

Scottish Trans Alliance

Sefton Local Medical Committee

St Peters Andrology Centre

South Sefton Clinical Commissioning Group

Suffolk County Council

Surrey and Sussex Local Medical Committees

Thames Valley Clinical Commissioning Groups

Trans Equality Legal Initiative

Transgender Trend

Trans Masculine Support and Advice UK

UK Trans Info

Appendix 2 Response by British Medical Association

13 October 2017

Gender identity services for adults – BMA response

The BMA welcomes this consultation and the opportunity it presents to improve NHS healthcare delivery for trans people. We recognise the specific health needs of trans patients and the inconsistency in access to health care for these patients. The outcome of the consultation process will ideally lead to proper commissioning and resourcing of gender identity services to cover the entire patient journey. Many GPs currently feel under pressure to fill a gap in service provision and to act outside their competence – a properly commissioned, resourced and supported service will help to resolve this while also delivering the best possible care for trans people.

We are pleased that both short and long term prescribing arrangements are being considered in the consultation, as we believe that current arrangements for prescribing hormone treatment are not working well for patients or their doctors. To date, the provision of gender identity-related care has been poorly handled, and requires proper commissioning to rectify. This has resulted in exponential delays for patients in accessing specialist services, as well as a gap in provision which GPs have felt pressured to fill. GPs provide holistic care of patients as defined in their contracts; they are responsible for their prescribing decisions and worry about the potential harm to the patient of prescribing hormone medication off-licence without proper support or adequate expert knowledge. They must also consider the associated medicolegal risks of doing so. We suggest this is likely to be one of the reasons why trans patients report difficulties and inconsistencies in accessing treatment from primary care providers.

In response to questions 8 and 9, we outline GPs' concerns in more detail and propose the creation of a network of GPs in each local area with a specialist interest in gender dysphoria, and the creation of a directed enhanced service so there is a national framework, which specifies a defined level of service provision and ensures the necessary investment in training for staff and service delivery in primary care in each locality. Patients would then have timely access to appropriate medication, prescribed by doctors who have confidence, experience and expertise in this aspect of medicine.

Question (1) The proposed service specifications aim to address inconsistency in care quality, differing levels of access and out-dated service models. To what extent to you think the specifications achieve this?

We believe the draft service specifications will help address some of the inconsistencies in care quality and the problems accessing gender identity services. Overall, we welcome the guiding principles for the development of the specialist gender identity services (e.g. recognition of the need for timely and appropriate treatment and for interventions to be

personalised and based on shared decision-making with patients), and the general requirements they set out for providers of specialist services (e.g. to provide a high quality, timely and sustainable service, to work in an integrated way with primary care providers, to communicate well with other services involved in the pathway, and to participate in the education of health professionals on the healthcare needs and support for trans people). The proposed specifications can also address some specific inconsistencies in current service provision, such as the variation in ages at which young people are referred to adult Gender Identity Clinics if a common age threshold of 17 years is set.

However, a care pathway that improves access and quality of care across the country, will also depend on the provision of adequate resources for specialist gender identity services to meet the growing demand², to reduce the unacceptable delays in accessing treatment³, and to comply with the national 18-week maximum waiting time, as set out in the NHS constitution and the draft specifications. The Women and Equalities Select Committee's inquiry into transgender equality identified, there are serious deficiencies "in the quality and capacity of NHS Gender Identity Services" and additional investment is needed in the education and training of healthcare professionals to address current workforce constraints in gender identity services.

Investment is needed in service provision and training at other points along the pathway for gender identity services too, especially in primary care. There is a limit to the workload and specialist knowledge that can be expected of general practitioners. In the three months to 31 December 2016 the number of full-time equivalent GPs fell by 445. 31% of GP partners in practices are unable to fill vacancies at all.⁴ These shortages impact significantly on the ability of all GPs to develop the expertise in gender dysphoria that is needed to prescribe with confidence and to monitor treatments. Additional work, including gender identity service provision, can only be absorbed into general practice where there is resource to develop the extra capacity and expertise required, and must comply with contemporary contractual requirements. Although the numbers seeking gender identity services is increasing, an individual GP is likely to deal with a very small number of such patients, further limiting the ability and opportunity to acquire expertise.

It is also important that there is the appropriate mix of specialists from secondary care. The process of gender reassignment can be emotionally demanding and consideration should be given to providing appropriate mental health care before, during, or after treatment. Doctors trained as psychiatrists provide the bulk of initial specialist assessments. It is therefore vital that this level of specialism, including understanding the complex issues related to body image and gender identity, continues. Assuming a trans

² The NHS Audit, Information and Analysis unit also suggests that the total volume of new trans patient cases amounts to 800-900 per year

³ <https://www.theguardian.com/society/2016/jul/10/transgender-clinic-waiting-times-patient-numbers-soar-gender-identity-services>

⁴ <https://www.bma.org.uk/news/2016/december/one-third-of-gp-vacancies-remain-unfilled>

patient ultimately is under the care of a specialist GP, it is important, especially where they live a significant distance away from a gender identity clinic (GIC), that they can be referred to a regional secondary care specialist.

Question (2) It is proposed that in the future all young people who need to access a specialist gender identity service and who are aged 17 years and above will be referred to an adult Gender Identity Clinic. To what extent do you support or oppose this proposal?

We agree with this proposal. We recognise the benefits of adopting a consistent age threshold for referrals to adult GICs and that setting it at 17 years will help prevent unnecessary delays in starting the adult pathway of care.

Question (3) It is proposed that in the future the specialist Gender Identity Clinics for Adults will not accept referrals of individuals who are not registered with a General Practice. To what extent do you support or oppose this proposal?

This is highly desirable because of the importance of patients being registered with a GP to ensure ongoing and wider healthcare support. NHS England should also consider the difficulties and barriers that trans people may encounter when trying to register with a GP, including the extent to which trans people do not register, the reasons why some may be deterred from or feel unable to register, and what could be done to make registration easier.

Question (4) It is proposed that only a designated specialist Gender Identity Clinic will be able to refer an individual for genital reassignment surgery. To what extent do you support or oppose this proposal?

We agree with this proposal. Specialist GICs designated by NHS England alone should be able to refer individuals for specialised genital reassignment surgery, because of the need for assessment, diagnosis and support from an expert multi-disciplinary team. Consultants, given their expertise are best placed to refer patients on, something the new NHS standard contract now allows them to do.

Question (5) It is proposed that in the future a decision to refer an individual for specialist genital reassignment surgery must be supported by a Registered Medical Practitioner. To what extent do you support or oppose this proposal?

We agree with this proposal, provided that the Registered Medical Practitioner (RMP) has specialist expertise in gender identity.

Question (6) We have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

Question (7) Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or

compensate for the impacts we have identified and any others?

The equality and inequalities impact assessment addresses several important areas critical to the provision of appropriate patient-centred care. We would like to raise points regarding the following sections:

- **Gender reassignment (cultural awareness)**

We welcome steps to support NHS staff to better understand and respond to the needs of trans people. The exclusion of trans people from national screening programmes is mentioned as an example of a barrier that needs to be addressed. We believe that more needs to be done to address this exclusion, and that screening programmes should change their procedures to ensure that invitations and services are organ-specific and not gender-specific. For example, by ensuring trans men with a cervix can opt into national systems for automatic invitations, rather than always requiring them to remember and request screening appointments from their GP.

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

It is recognised that the effects of inequitable geographical access to specialised services is compounded when trans individuals are older or have disabilities, which impact on their ability to travel to and from consultations, or travel safely for procedures as part of their healthcare. This could be addressed through greater investment in local service provision and the creation of networks of GPs with a special interest in gender care, who can work more closely with expert multi-disciplinary teams at local level and liaise with other GPs. The new adult gender identity service that has been announced by NHS Wales is an example of such an approach.⁵

Question (8) Which option for future prescribing arrangements do you most prefer?

We do not think that options A, B, or C as written provide an appropriate solution to the current concerns of GPs and transgender patients.

Option A is a continuation of current practice which we believe is unsatisfactory for GPs and for patients. Patients who have been seen by GICs have found it difficult to access drugs that the GICs have deemed necessary, but refused to provide, contrary to the requirements of EL (91) 127 on 'Responsibility for prescribing between hospitals and GPs'.

We are aware that some GICs deny any access at all to patients whose GPs are unable to commit to ongoing prescribing, which is an unethical situation. We have also received reports from GPs that, where they have provided prescriptions, they have received

⁵ <https://www.wales.nhs.uk/news/45987>

inadequate support or have been pressured into prescribing outside their field of expertise, contrary to GMC requirements.

We are concerned both about the safety of patients who are prescribed medication off-licence by a non-specialist prescriber, where there is a potential for harm to the patient and consequent medicolegal risk to GPs. Current communications from GICs rarely specify that patients have been made aware of the risks and legal consequences of off-label prescribing.

Option A does not address the special problems associated with 'bridging prescriptions' for patients who are self-medicating prior to assessment at the GIC.

Option B passes the problems identified in Option A along for a period of one month. In fact, the patient could be in a worse position if proper arrangements have not been ensured for the period following, having already started medication and then being faced with having to stop it again if proper arrangements have not been put in place. Patients have differing clinical needs and some will need support from the GIC for longer periods of time. Where patients have questions about their medication, or have developed problems with it, these often occur in the early weeks so it would be inappropriate for them then to have to see a clinician without the necessary specialist knowledge.

Option C as written does not address all the problems identified in Options A and B, and there are inherent dangers in setting an arbitrary timescale for handover, including inappropriate pressure being brought for transfer even when clinical grounds suggest otherwise. However, the flexibility is to be welcomed, and it could form the basis of a satisfactory solution if an adaptation of this combined with Option D, supported by the use of electronic prescribing systems by the GIC, and with proper commissioning of primary care input either through Option D or through the provision of an enhanced service. It would be vital that these arrangements conform to both the GMC's good medical practice guidelines on practicing within one's competence, and to best practice for shared care, particularly with regard to clarity, consent, resourcing, and educational support.

Option D is a medically acceptable way forward. We believe that this should be combined with a facility for GPs to continue to prescribe for their patients where both the GP and the patient feel this is appropriate, with this being delivered via a Directed Enhanced Service (DES) in line with NHS England's Shared Care Agenda. It may be possible for this work to be done by a non-medical prescriber fully trained in gender identity care. A DES would help ensure a consistent level of service provision and encourage sufficient numbers of GPs in each locality willing to participate. We have outlined our alternative proposal in more detail below. Option D would also address the problems of 'bridging prescriptions' and ensure that there was a locally available intermediate tier of expertise.

Question (9) Can you suggest any alternative prescribing arrangements?

It is vital that trans people receiving care for gender reassignment have that care

provided by skilled clinicians who are adequately resourced for the responsibilities and activity required. Therefore, proper commissioning is required for the entire patient journey. GPs are responsible for delivering care in accordance with their contractual responsibilities and cannot be regarded as the providers of last resort for un-commissioned services to the detriment of patient safety.

The development of local networks of specialist GPs, working more closely and collaboratively with GICs may also encourage greater experiential learning and assist with the transfer of skills and expertise at local level.

Prescribing for transgender patients is a difficult area as there is a limited evidence base and most medicines would have to be prescribed off-licence. For doctors, it is vital that they ensure the highest standards of care and treatment for their patients – declining to prescribe hormones in GIC should be seen in this context. Any demand to have a prescription due to waiting lists or similar issues, should be seen as a failure or lack of clarity in commissioning, rather than an unreasonable withholding of prescription-only drugs.

The GMC has so far been unable to provide sufficient reassurance for doctors prescribing off-licence in relation to trans patients, and a Medical Defence Organisation has indicated to us that related medical defence claims could be difficult to defend, particularly with respect to bridging prescriptions. Our proposals reduce some of these concerns by ensuring a specific framework for service provision, consistency and a defined level of service. It would enable safe and supported prescribing, quality of service provision and ensure that transgender patients can access the services they need.

Furthermore, while the mainstay for medical care and treatment for trans patients would be their GP it is vital that necessary experts across the range of medical specialties are involved along the relevant diagnostic and treatment pathways. These may include endocrinologists, gynaecologists and psychiatrists. With their specialist training, especially regarding interview and communication skills as well as competency in comprehending and describing people's experiences, psychiatrists have a long-standing important role in gender identity-related care. The BMA would therefore welcome clarity over skill mix to ensure that trans people receiving this care will receive the most appropriate and specialist help.

We also believe that where patients are self-medicating prior to specialist assessment, a local 'intermediate' service within primary care would be safer than the 'bridging prescription' model provided by general practice as suggested by the GMC. There also needs to be a fast track re-referral route back to Gender Identity Clinical specialty services, together with provisions for timely advice for primary care prescribers from GICs, should any problems arise.

BMA Wales, representing doctors based in Wales alongside other national offices for Scotland and Northern Ireland and the UK-wide BMA, has welcomed the development of a new adult gender identity service in Wales. It will be delivered by a multi-disciplinary

Welsh Gender Team, who will support a network of GPs with a special interest in gender care. We believe this is a good example of investing in gender identity services to ensure timely access to care and for more care to be provided at a local level. It is also a positive example of involving the transgender community and ensuring doctors are well supported. We would advise that a degree of consistency between the two health services would be beneficial.⁶

END of BMA response to consultation

⁶ <https://www.wales.nhs.uk/news/45987>

Appendix 3 Breakdown of current, former and prospective user of GI services

Breakdown of current, former and prospective users of GI services (total number: 243)

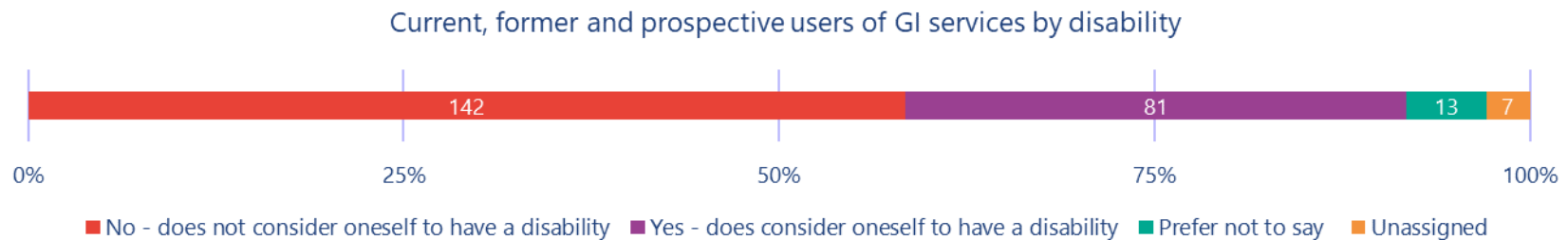
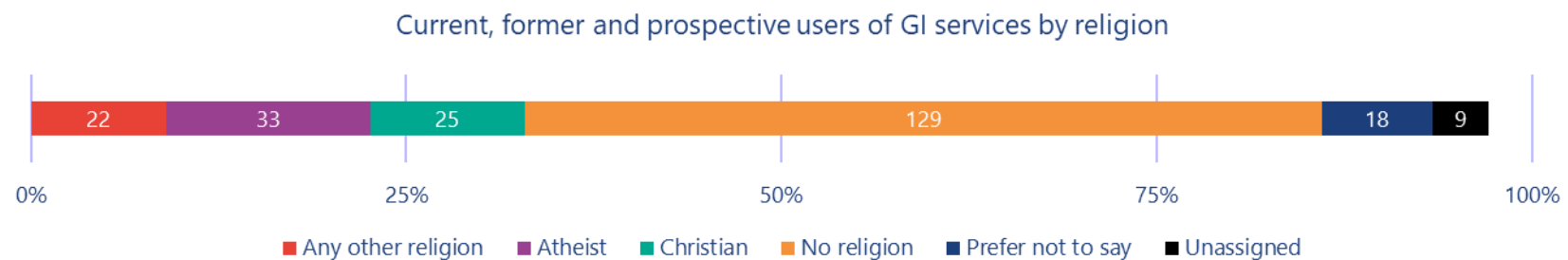


Figure 36



Additional groups: Buddhist (3 responses, 1%), Jewish (2 responses, 1%), Muslim (1 response, <1%), Sikh (1 response, <1%)

Figure 37

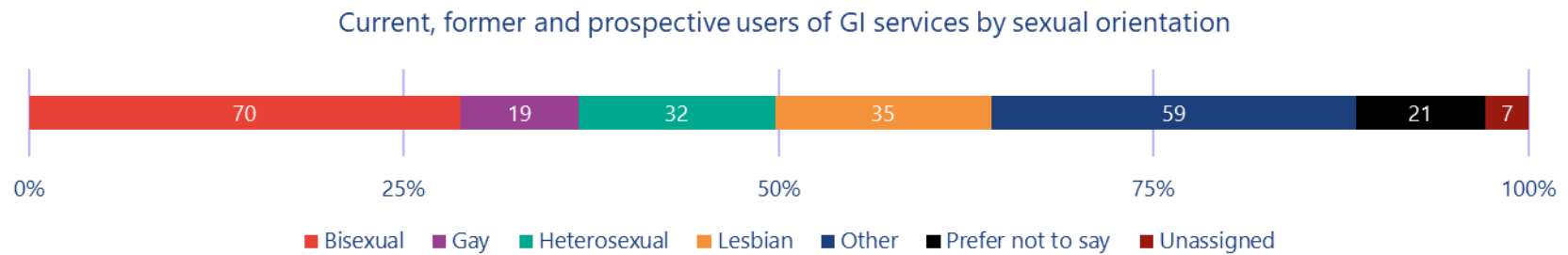
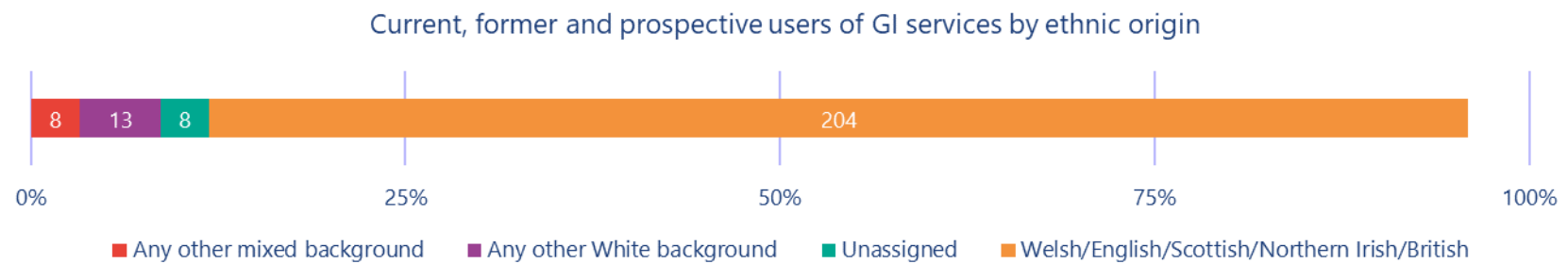


Figure 38



Additional groups: Any other ethnic group (1 response, <1%), Chinese (2 responses, 1%), Indian (1 response, <1%), Irish (2 responses, 1%), White and Asian (3 responses, 1%), White and Black African (1 response, <1%)

Figure 39

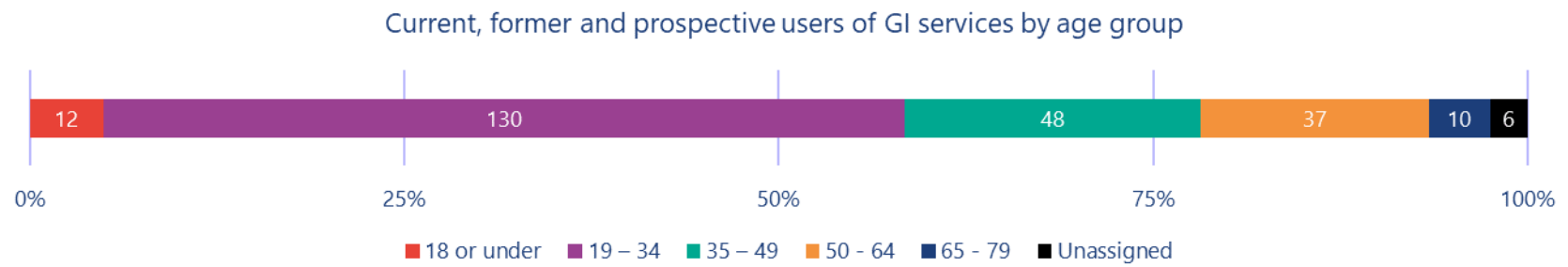


Figure 40