SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	1719
Service	Gender Identity Services for Adults (Non-Surgical Interventions)
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1.0 Scope
1.1 Prescribed Specialised Service This service specification covers the provision of non-surgical Gender Identity Services for adults that are prescribed as specialised services. This document should be read in conjunction with NHS England's service specification for Gender Identity Services for Adults (Surgical Interventions). **1.2 Description** Gender identity services includes specialist assessment, non-surgical care packages, certain surgical interventions and immediate associated after care provided by specialist centres. **1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners** Clinical Commissioning Groups (CCGs) are responsible for commissioning certain non-specialist elements of the NHS pathway of care for individuals with gender dysphoria.
2. Care Pathway and Clinical Dependencies
2.1 Background **2.1.1 Gender dysphoria**

The term used to describe a discrepancy between birth-assigned sex and gender identity is **gender incongruence**; this term is preferable to the formerly-used terms of gender identity disorder and transsexualism. Gender incongruence is frequently, but not universally, accompanied by the symptom of **gender dysphoria**.

The current version of the International Statistical Classification of Diseases and Related Health Problems identifies 'transsexualism' (ICD 10 code F64) as "*a disorder characterized by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex (manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery)*".[1]

2.1.2 Extension of the model of care to *Trans Health Services*

Subject to the outcome of early adopter evaluation NHS England may extend the model for delivery of care to multi-disciplinary teams based in primary care settings, on a phased basis. Over time, specialist expertise for adults with gender dysphoria may be extended to multi-disciplinary teams based in primary care - called *Trans Health Services*. The extension of the model of care to *Trans Health Services* would require designated Gender Dysphoria Clinics to establish formal links with each *Trans Health Service* in its locality (each locality will be defined with precision from 2019/20).

The functions of a Gender Dysphoria Clinic in regard to *Trans Health Services*, if adopted, would be described by way of an addendum to this service specification by 2021/22. By way of general summary, and without prejudice to the content of the future addendum those functions may include:

- Extend MDT membership to clinical staff working in each *Trans Health Service*
- Provide clinical leadership through formation of a locality network, to provide oversight on issues such as training and education, peer review and peer support
- Establish a means of collaboration and joint working, particularly on complex cases
- Lead in the development of an integrated approach to overall care, including the voluntary sector and other appropriate agencies

2.2 Principles guiding the development of this service specification

Gender dysphoria is not, in itself, a mental health condition, reflecting contemporary professional opinion (Diagnostic and Statistical Manual of Mental Disorders (v5, 2013)).

It is optimal for the individual to be referred by their General Practitioner (GP) in view of the benefits of ongoing support by the GP, particularly after discharge from the specialist team. However, individuals may self-refer should

[1] The revised ICD 11 refers to the wider category of 'gender incongruence' (not yet adopted).

they choose to do so.

Providers will respect the right of an individual to self-refer. These individuals should not be disadvantaged by a Provider's insistence on obtaining a prescriptive set of data from the individual's GP as a pre-condition to assessment as this may, in practice, deny an individual the right of self-referral.

All eligible individuals referred to a Gender Dysphoria Clinic may exercise full personal autonomy in respect of their gender identity and presentation; and must have equitable access to the range of interventions described in this service specification. Equity of access and high quality care will be provided to all individuals who meet the criteria for access to the NHS pathway of care. Each individual will receive timely and appropriate treatment, as a minimum in accordance with national waiting time requirements**.**

Assessments and interventions will be personalised and based on shared decision making, with service flexibility and reasonable adjustments to delivery of care to match the individual's needs and circumstances.

2.3 Designated Gender Dysphoria Clinics will:

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

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

Work with specialised services for gender variant adolescents and young people to ensure a timely and effective transfer to adult services**.** Achieve an integrated approach to care with primary care providers and ensure close links with other expert centres at national and international levels**.**

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

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

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

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

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

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

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

2.4 Staffing, structure and governance

Each Provider will have:

A nominated Senior Clinical Lead, who has the key leadership role for the service overall. The Senior Clinical Lead must demonstrate evidence of appropriate experience and expertise in specialised gender dysphoria practice; significant management experience; and significant evidence of continued professional development.

A specialist multi-disciplinary team of professionals, with a mix of skills, experience and expertise that is appropriate to ensure the delivery of effective and high-quality services in accordance with the requirements of this service specification. The multi-disciplinary team will have the following competencies:

- Comprehensive mastery of clinical aspects of gender identity development and expression, formulation and diagnosis of gender identity-related bio-psycho-social concerns, and the management of gender dysphoria
- Expertise in sex development, and endocrine intervention in the treatment of gender identity-related bio-psycho-social concerns and gender dysphoria
- Expertise in physical health care needs that are specific to individuals with gender dysphoria
- Expertise in mental health care needs that are specific to individuals with gender dysphoria
- Expertise in social inclusion and care needs that are specific to individuals with gender dysphoria
- Expertise in gender-specific voice and communication development
- Good professional knowledge of specific psychological therapy, as relevant to the care of a trans and gender-diverse population
- Good professional knowledge of neuro-developmental conditions, including autism spectrum condition, and of adjustments to facilitate optimal communication with affected people
- Good professional knowledge of trichology
- Good professional knowledge of the care needs of individuals who are receiving specialised gender-related surgical procedures

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

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

Arrangements in place to ensure that the service delivers culturally appropriate care and support; individuals must be able to access services in a way that ensures their cultural, language and communication needs do not

prevent them receiving the same quality of healthcare as others**.**

Sufficient administrative and managerial support needed for efficient and timely delivery of services**.**

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

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

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

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

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

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

2.5 Care Pathway

The delivery model relies on access to specialist Gender Dysphoria Clinics usually via primary care, and the principle of multidisciplinary and interdisciplinary teams and networks who work and collaborate in the provision of care. Gender Dysphoria Clinics assess and diagnose individuals; directly provide some interventions and arrange for referrals to other services, including for medical and surgical treatments. Access to surgical intervention is only by referral from a specialist Gender Dysphoria Clinic that is commissioned by NHS England compliant with this specification. Some elements of the NHS care pathway are delivered by non-specialised services. A diagram of the pathway is at Appendix A.

The NHS pathway of care may be summarised as:

- Referral to a specialist Gender Dysphoria Clinic (self-referral; or by primary, secondary or tertiary care)
- Assessment for gender dysphoria, and diagnosis
- Individuals who meet the criteria for diagnosis of gender dysphoria related to gender incongruence are accepted on to the NHS care pathway and an individualised treatment plan is agreed
- Therapeutic interventions delivered by the specialist Gender Dysphoria Clinic; and / or referral for interventions with other providers

- Ongoing review and monitoring during and after interventions
- Conclusion of contact: discharge to primary care

2.6 New referrals

Self-referrals may be made by individuals themselves, provided the individual is registered with a General Practitioner (GP). Referrals may also be made by GPs, other medically qualified professionals, and other professionals regulated by the *Health and Care Professions Council*. See Appendix B.

2.7 Requests for transfers of care from specialised adult services

Transfers of care may be requested by other designated Gender Dysphoria Clinics. See Appendix C.

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

A request for transfer of care may be made by the designated Gender Identity Development Service for children and young people to a designated Gender Dysphoria Clinic before the young person's 17th birthday. This may be appropriate where joint working between the two services, including joint consultations with the young person, within a "lead-in" period is beneficial to ensure a timely and effective eventual transfer once the young person has reached 17 years. See Appendix D.

2.9 Assessment process for newly-referred individuals

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

2.10 Physical examination

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

2.11 Named professional's role in treatment process

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

2.12 Lead Clinician role in treatment process

A registered medical practitioner or clinical or counselling psychologist will be

appointed as ‘Lead Clinician’ for individuals who progress to a planned intervention on the NHS care pathway. See Appendix H.

2.13 Shared decision making

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

2.14 Capacity and informed consent

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

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

2.15 Loss of fertility

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

NHS England is not the responsible commissioner for gamete storage. An individual’s eligibility for NHS-funded gamete storage is determined in each case by the individual’s Clinical Commissioning Group.

2.16 The Provider’s role in the treatment process

Individuals on the gender dysphoria pathway will have different needs, and the pathway will not always be linear or sequential. The Provider will be flexible and adaptable in matching the type, timing and order of interventions, and the duration of the entire treatment episode.

Individuals returning for treatment after a planned deferral will have a single ‘re-engagement’ consultation with the Lead Clinician but will not be fully re-assessed unless there are compelling clinical reasons to do this (these must

be carefully explained to the patient).

2.17 Interventions that are delivered directly by the Provider

a. *Voice and Communication Therapy*

Each Provider must ensure access to an appropriate level of provision of specialist voice and communication therapy on the basis of clinical need and individual choice[2]. The number and frequency of sessions will be variable depending on the individual's needs, and is likely to comprise a combination of individual and group therapy sessions.

The objective of therapy is to facilitate changes in the individual's voice and communicative profile thereby improving quality of life and alleviating distress related to gender dysphoria.

In less complex cases it may be appropriate for voice and communication interventions to be provided by appropriately-supported, non-specialist, local speech and language services (commissioned by the individual's Clinical Commissioning Group) following a referral by the Provider.

Any pre-existing voice difficulty that would impede successful specialist voice modification should first be treated by local speech and language therapy services (for which commissioning responsibility rests with Clinical Commissioning Groups).

b. *Specialised psychological interventions*

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

Other evidence-based psychological therapies for couples or groups may be offered if, based on psychological assessment and collaborative formulation, they meet the needs of the individual engaged in this care pathway. See Appendix I.

Conversion therapy

Providers will not deliver, promote or refer individuals to any form of conversion therapy. The practice of conversion therapy is unethical and potentially harmful. For the purposes of this document 'conversion therapy' is an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any gender identity is inherently preferable to any other, and which attempts to bring about a change of gender identity, or seeks to supress an individual's expression of gender identity on that basis[3].

[2] The Royal College of Speech and Language Therapists' "*Trans and Gender-Diverse Voice & Communication Therapy Competency Framework*" (2018) defines the recommended competency in relation to voice and communication assessment, therapy and advice for service users who identify as Trans and/or gender-diverse.

[3] NHS England is a signatory to the "*Memorandum of Understanding on Conversion Therapy in the UK Version 2*" (2017)

c. ***Assessment for endocrine and other pharmacological interventions***

The Provider will assess an individual's suitability for hormone treatments for the alleviation of gender dysphoria.

Appendix J of this document describes arrangements for prescribing and monitoring of endocrine treatments.

2.18 Interventions delivered by other providers

The Provider may refer the individual for other interventions delivered by other providers should the intervention be routinely commissioned by the NHS.

2.19 Surgery for the treatment of gender dysphoria

This section should be read in conjunction with NHS England's service specification for "*Gender Identity Services (Surgical Interventions)"* which describes the specialist surgical procedures that are commissioned by NHS England for the treatment of gender dysphoria.

The Provider may refer an individual for a surgical intervention that is commissioned by NHS England as a prescribed specialised intervention.

Before a referral for surgery is made, the Lead Clinician will meet with the individual to review current treatment interventions, and to assess the individual's needs and readiness for the surgical intervention. The processes of shared decision making and of obtaining consent (as described earlier in this document) will provide the individual with necessary information, and will allow the individual sufficient time to ask questions, and to reflect on the advice of the Lead Clinician to enable an informed decision on the treatment options, risks and benefits. The possibility of the need for donor site skin epilation for some patients, and the likely implications for the timing of surgery, should be explained to the individual at this stage.

A referral for mastectomy and reconstruction of the chest requires one letter of referral from a Lead Clinician.

A referral for genital surgery requires two letters of referral: one from a Lead Clinician, the other from a similarly-qualified and experienced professional not directly involved in the individual's care and able to form an independent opinion; at least one letter of referral must be from a Registered Medical Practitioner with expertise in gender dysphoria. The letters of referral for genital surgery will confirm:

- Evidence of 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless the individual has a medical contraindication or is otherwise unable or unwilling to take hormones);
- Evidence of 12 continuous months of living in a gender role that is congruent with their gender identity; this must not entail a requirement for the individual to conform to externally imposed or arbitrary preconceptions about gender identity and presentation; this requirement is not about qualifying for surgery, but rather preparing and supporting the individual to cope with the profound personal and social consequences of surgery. Where individuals can demonstrate that they

have been living in their gender role before the referral to the Provider, this will be taken into account.

Hysterectomy (removal of uterus), bilateral salpingo-oophorectomy (removal of ovaries and fallopian tubes), penectomy (removal of penis) and orchidectomy (removal of testes) are interventions commissioned under this service specification when they are performed in conjunction with the above pathways by a specialist Gender Dysphoria surgical unit (described above). They are not commissioned by NHS England when they are performed as "stand alone" procedures; in such cases commissioning responsibility rests with the individual's Clinical Commissioning Group.

2.19 Conclusion of contact with the Provider

Individuals will be discharged from the care of the Provider:

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

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

2.20 Interdependence with other Services

Each Provider's Multi-Disciplinary Team will have access to the following expertise:

- Expertise in reproductive and sexual health, as relevant to the care of a trans and gender-diverse population
- Expertise in the care of people with severe mental illness, and competency to recommend reasonable adjustments in gender-related treatment planning for affected people
- Expertise in the care of people with learning disability and other special needs, including Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder, and competency to recommend reasonable adjustments in gender-related treatment planning for affected people
- Expertise in Forensic Psychiatry or Forensic Psychology, and competency to recommend reasonable adjustments in gender-related treatment planning for affected people
- Expertise in the care of people with severe physical illness and disabilities, including complex endocrine disorders, and competency to recommend reasonable adjustments in gender-related treatment planning for affected people.

3.0 Population Covered and Population Needs

3.1 Population Covered By This Specification

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

The Provider will receive referrals of individuals from 17 years of age who may have gender dysphoria that is a consequence of their gender identity being incongruent with their visible sex characteristics and/or the social role typically associated with those characteristics (gender incongruence). Subsequent interventions will only be accessed by individuals who have been diagnosed with gender dysphoria.

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

Exclusions

Referrals will not be accepted for individuals who are not registered with a GP given the benefits to the individual of ongoing support from their GP, particularly after discharge from the care of the specialist team.

3.2 Population needs; and Expected Demographic Changes

There is no official data on the number of people in England who present with a degree of gender variance. Difficulties in assessing prevalence are exacerbated by the limited evidence base. There is considerable variation in reported prevalence due to factors such as: variable data reporting by providers; differences in diagnostic thresholds applied and inconsistent terminology; the methodology and diagnostic classification used; and the year and country in which the studies took place.

Thus there is considerable variation in estimates, and the absence of reliable prevalence data exacerbates the challenges in planning and commissioning gender identity services. What is consistent across the literature is a recognition that the number of people pursuing treatment options – the incidence of expressed need - is rising significantly.

4. Outcomes and Applicable Quality Standards

NHS Outcomes Framework Domains

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

4.2 Indicators Include:

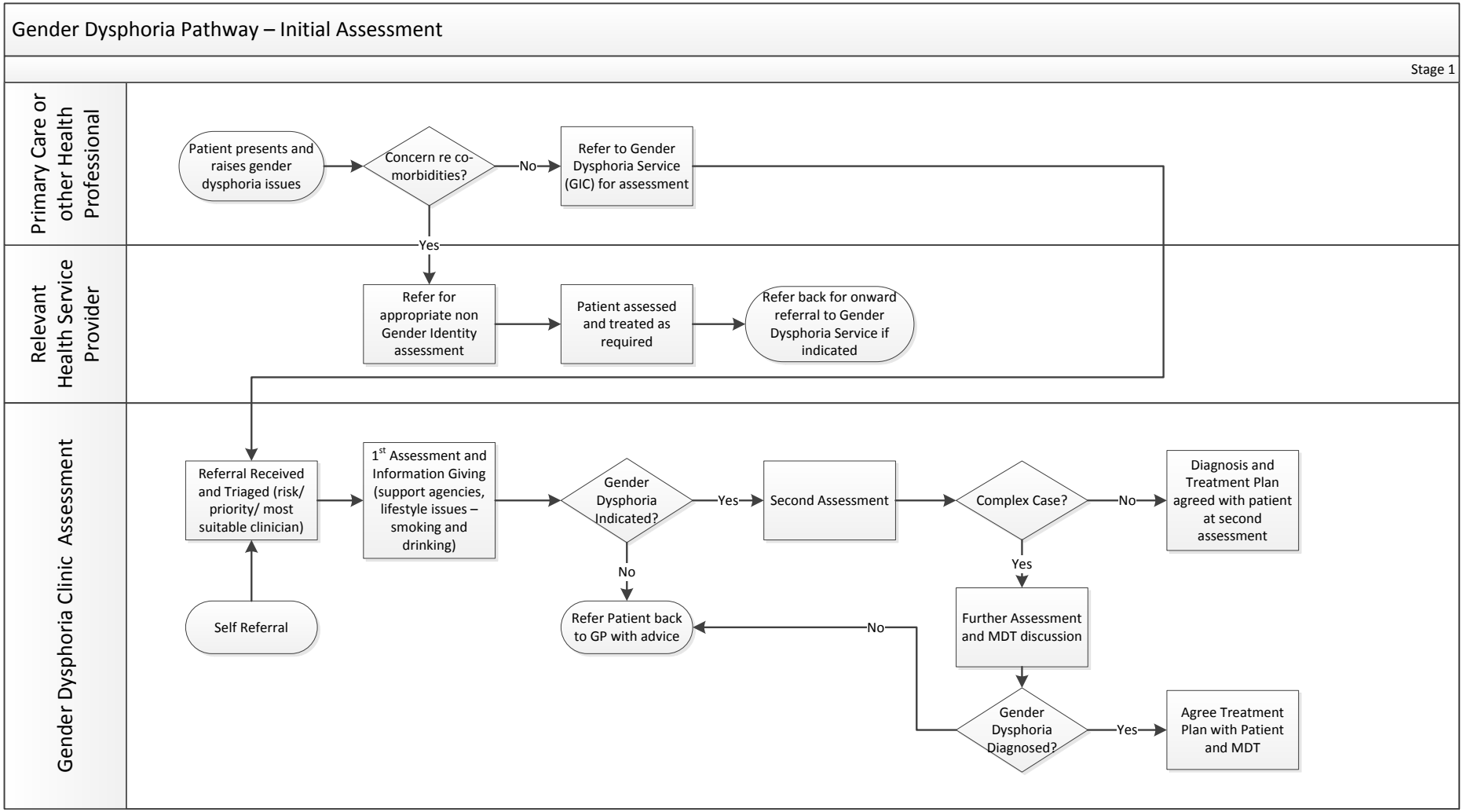
Number	**Indicator**	**Data Source**	**Outcome Framework Domain**	**CQC Key question**
Clinical Outcomes				
101	% of referrals acknowledged in writing by the provider with the referrer and individual within 14 calendar days	SSQD/HES	4	Effective, responsive
102	% of referrals received where the diagnosis after assessment is either Gender Dysphoria (as per DSM-V) or Gender Incongruence (as per ICD-11 when available)	SSQD/HES	2, 4	Effective, caring, responsive
103	% of patients receiving more than two assessment consultations	HES/SSQD	2, 4	Effective, responsive

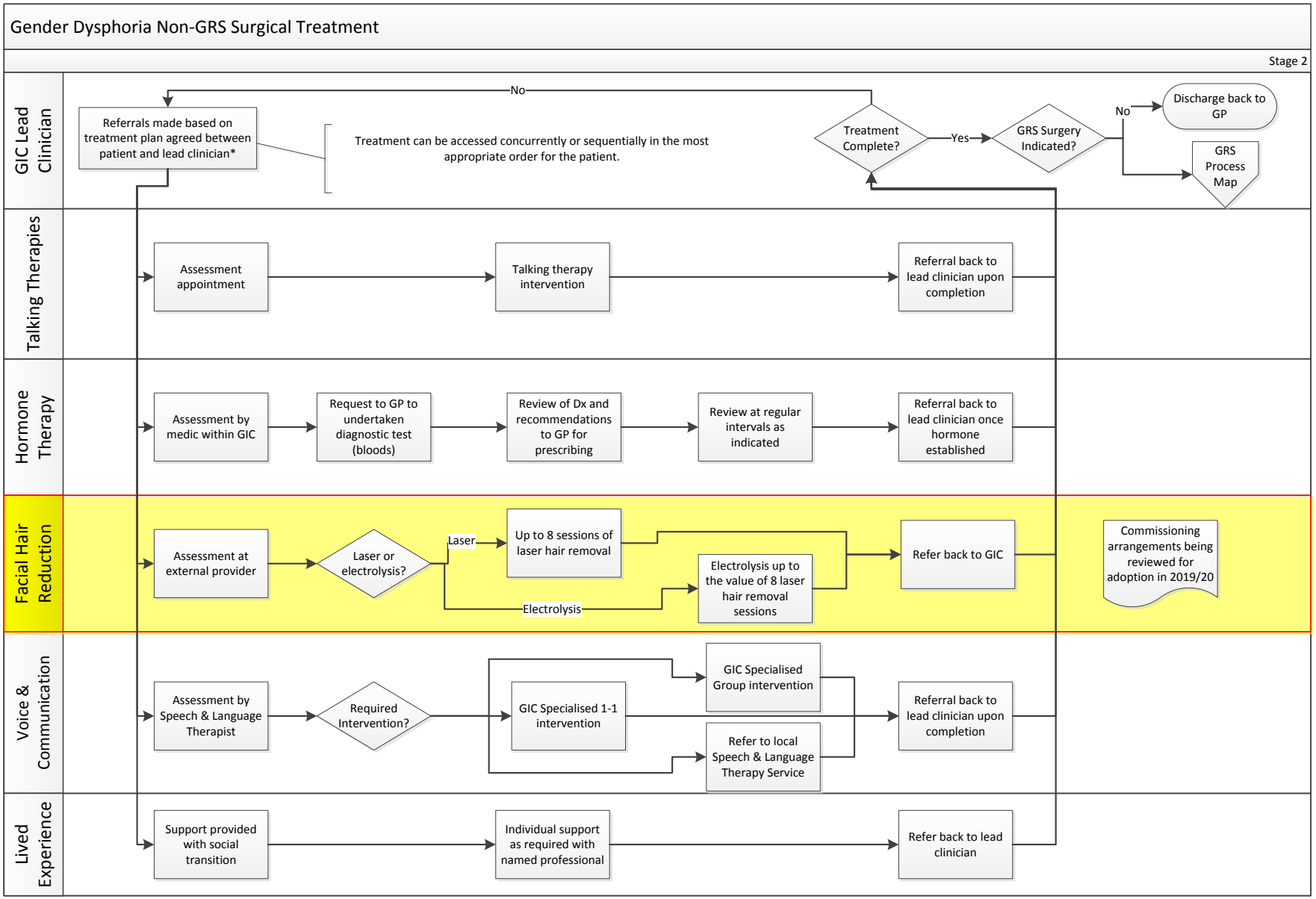
104	% of patients who do not enter into the treatment programme following two assessment consultations	HES/SSQD	2, 4	Effective, caring, responsive
105	Number of patients open to the service with polycythaemia following endocrine treatment (initiated by the service) needing venesection	HES/SSQD	3	Safe, effective, caring, responsive
106	Number of patients open to the service reporting DVT/PE following endocrine treatment (initiated by the service) where action is required	HES/SSQD	3	Safe, effective, caring, responsive
107	Number of patients open to the service with cardiovascular complications (e.g. MI or Stroke) post hormone treatment (initiated by the service)	HES/SSQD	3, 4	Safe, effective, caring, responsive
108	Number of patients requesting chest reconstruction surgery who do not request hormone treatment pre-surgery	HES/SSQD	3	Effective, caring, responsive
Patient Experience				
201	The service reviews nationally collected patient reported experience and outcome data	Self-declaration	4	Effective, caring, responsive
202	Patient information	Self-declaration	4	Effective, responsive

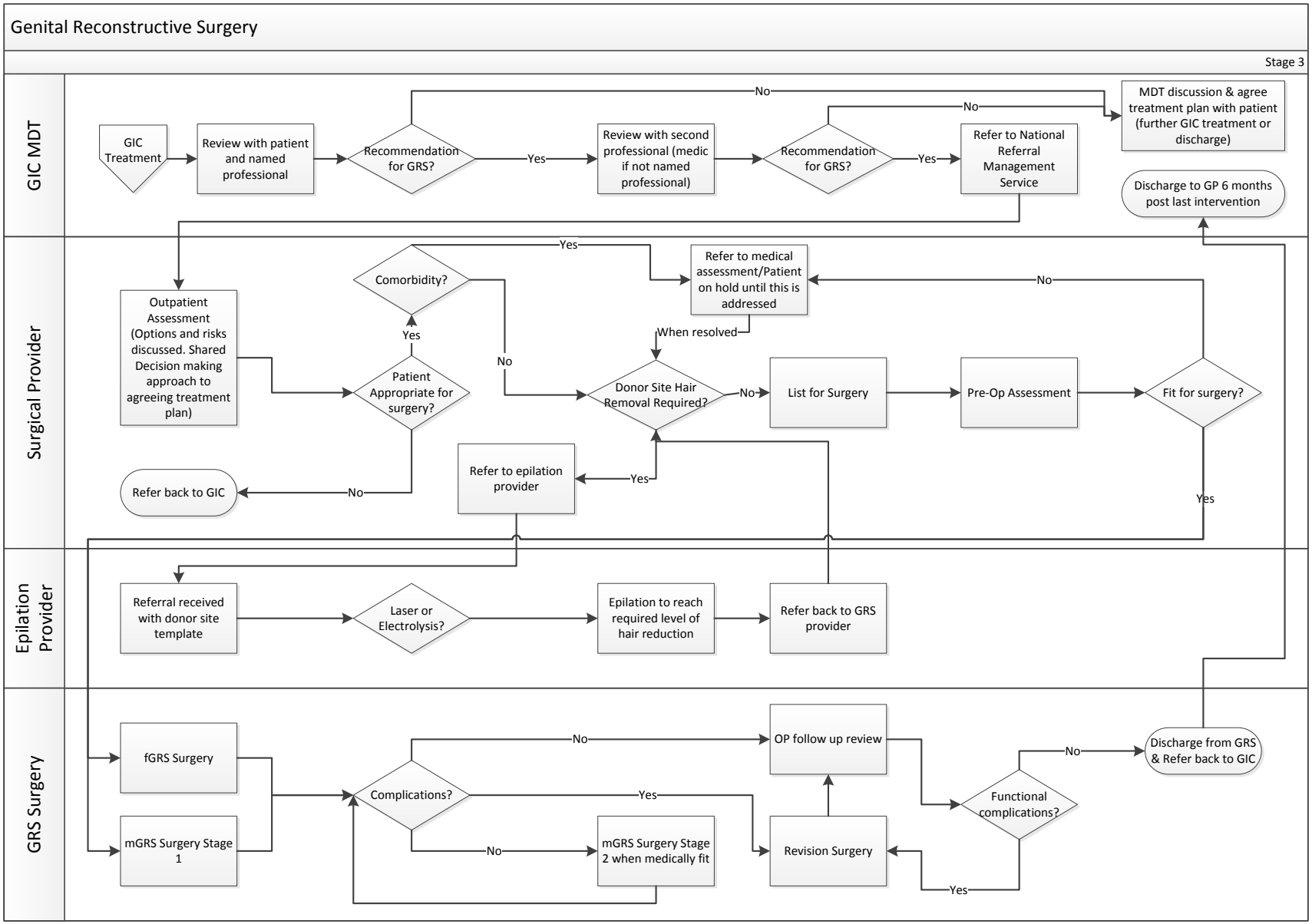
Structure and Process				
301	There is a Clinical Lead for the service	Self-declaration	4	Safe, well-led, effective
302	There is a Named Professional and Lead Clinician allocated for the duration of the patient's care.	Self-declaration	2, 4	Safe, effective, caring, responsive
303	There is a system of corporate governance, including a nominated senior manager who provides guidance, oversight and accountability	Self-declaration	5	Safe, effective, well-led
304	Patients receiving endocrine and pharmacological interventions are reviewed at least annually	Self-declaration	2, 3, 4	Safe, effective, caring, responsive
305	There is an agreed patient pathway	Self-declaration	2, 3, 4, 5	Safe, effective, caring, responsive
306	There are transition clinics in place	Self-declaration	2, 4	Safe, effective, caring, responsive
307	The team participates in clinical audit activity on an annual basis, participating in both local and national audits	Self-declaration	1, 2, 3, 4	Well-led, Safe, Effective, caring

See Appendix K for more detailed description of these indicators.

Appendix A


Gender Dysphoria Pathway – Initial Assessment
Stage 1
Primary Care or other Health Professional
Relevant Health Service Provider
Gender Dysphoria Clinic Assessment
Patient presents and raises gender dysphoria issues
Concern re co-morbidities?
No
Refer to Gender Dysphoria Service (GIC) for assessment
Yes
Refer for appropriate non Gender Identity assessment
Patient assessed and treated as required
Refer back for onward referral to Gender Dysphoria Service if indicated
Referral Received and Triaged (risk/ priority/ most suitable clinician)
1st Assessment and Information Giving (support agencies, lifestyle issues – smoking and drinking)
Gender Dysphoria Indicated?
Yes
Second Assessment
Complex Case?
No
Diagnosis and Treatment Plan agreed with patient at second assessment
Yes
No
Self Referral
Refer Patient back to GP with advice
No
Further Assessment and MDT discussion
Gender Dysphoria Diagnosed?
Yes
Agree Treatment Plan with Patient and MDT


Gender Dysphoria Non-GRS Surgical Treatment
Stage 2
GIC Lead Clinician
Referrals made based on treatment plan agreed between patient and lead clinician*
Treatment can be accessed concurrently or sequentially in the most appropriate order for the patient.
No
Treatment Complete?
Yes
GRS Surgery Indicated?
No
Discharge back to GP
GRS Process Map
Talking Therapies
Assessment appointment
Talking therapy intervention
Referral back to lead clinician upon completion
Hormone Therapy
Assessment by medic within GIC
Request to GP to undertaken diagnostic test (bloods)
Review of Dx and recommendations to GP for prescribing
Review at regular intervals as indicated
Referral back to lead clinician once hormone established
Facial Hair Reduction
Assessment at external provider
Laser or electrolysis?
Laser
Up to 8 sessions of laser hair removal
Electrolysis
Electrolysis up to the value of 8 laser hair removal sessions
Refer back to GIC
Commissioning arrangements being reviewed for adoption in 2019/20
Voice & Communication
Assessment by Speech & Language Therapist
Required Intervention?
GIC Specialised 1-1 intervention
GIC Specialised Group intervention
Refer to local Speech & Language Therapy Service
Referral back to lead clinician upon completion
Lived Experience
Support provided with social transition
Individual support as required with named professional
Refer back to lead clinician


Genital Reconstructive Surgery
Stage 3
GIC MDT
Surgical Provider
Epilation Provider
GRS Surgery
GIC Treatment
Review with patient and named professional
Recommendation for GRS?
Yes
No
Review with second professional (medic if not named professional)
Recommendation for GRS?
Yes
No
Refer to National Referral Management Service
MDT discussion & agree treatment plan with patient (further GIC treatment or discharge)
Discharge to GP 6 months post last intervention
Outpatient Assessment (Options and risks discussed. Shared Decision making approach to agreeing treatment plan)
Comorbidity?
Yes
No
Refer to medical assessment/Patient on hold until this is addressed
When resolved
Patient Appropriate for surgery?
Yes
No
Refer back to GIC
Donor Site Hair Removal Required?
No
Yes
Refer to epilation provider
List for Surgery
Pre-Op Assessment
Fit for surgery?
No
Yes
Referral received with donor site template
Laser or Electrolysis?
Epilation to reach required level of hair reduction
Refer back to GRS provider
fGRS Surgery
mGRS Surgery Stage 1
Complications?
No
Yes
No
mGRS Surgery Stage 2 when medically fit
OP follow up review
Revision Surgery
Functional complications?
No
Yes
Discharge from GRS & Refer back to GIC

Appendix B: New Referrals

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

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

Providers will respect the right of an individual to self-refer. These individuals should not be disadvantaged by a Provider's insistence on obtaining a prescriptive set of data from the individual's GP as a pre-condition to assessment as this may, in practice, deny an individual the right of self-referral.

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

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

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

Transfers of care may be requested by other designated Gender Dysphoria Clinics that are commissioned against this service specification. Transfer requests must include diagnostic coding, a summary of relevant care prior to transfer, a treatment plan with recommendations for on-going care, and patient consent to sharing of information between the initiating and receiving providers; where these criteria are not fulfilled the referral will be managed as a new referral. Individuals will be offered a single ‘induction’ consultation by the receiving provider during which the diagnostic assessment and treatment plan will be reviewed and, unless there are compelling clinical reasons (these must be carefully explained to the individual), the receiving provider will continue the previously agreed care plan. The Provider will acknowledge the transfer request in writing with the referrer and individual within 14 days. Individuals accepted for transfer of care will not be re-assessed unless there are compelling clinical reasons. A consultation with the receiving Provider will be offered at an interval consistent with the individual’s treatment plan and previous care.

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

The Gender Identity Development Service is commissioned to provide care and support for young people up to 18 years of age.

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

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

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

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

In cases where the young person fulfils the diagnosis for gender dysphoria but does not yet have a definitive treatment plan either because they are wanting to explore options more fully, or have related very complex or psychosocial issues that mean physical interventions are not yet appropriate, the process of transfer may be likely to take longer and will require ongoing collaboration and planning between the young person's service and the adult service focused on the needs of the individual. The nature of the individualised plan will differ according to needs, but may necessitate a joint transition clinic in appropriate cases.

By the age of 18 years the different outcomes may be:

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

- Discharge from the young person’s service and no transfer or referral to adult gender dysphoria services when this is clinically appropriate.

Appendix E: Assessment and Diagnosis

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

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

Initial assessment consultation

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

Diagnostic and treatment planning consultation

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

Additional assessment consultations

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

Family members

The Provider must not insist that the individual gives permission for family members or other people to attend appointments jointly with the individual. If a clinician advises the individual that it would be beneficial for a family member or other person to jointly attend an appointment, the reasoning must be explained to the individual,

and reassurance given that a refusal to give permission will not prejudice the individual's assessment or ongoing treatment.

Assessment of patients who have been granted a Gender Recognition Certificate

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

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

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

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

Appendix F: Physical examination

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

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

The examining medical practitioner must:

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

Chaperones for physical examination [4]

A chaperone should usually be a health professional and the examining medical practitioner must be satisfied that the chaperone will:

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

A relative or friend of the individual is not an impartial observer and so would not usually be a suitable chaperone, but the examining medical practitioner should

[4] *Intimate Examinations and Chaperones;* General Medical Council; 2013

comply with a reasonable request to have such a person present as well as a chaperone.

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

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

Appendix G: Named Professional's role in treatment process

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

The frequency of contact should be determined according to individual need, though usually the minimum frequency of contact will be every six months.

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

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

Appendix H: Lead Clinician role in treatment process

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

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

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

The Lead Clinician will initiate the interventions documented in the treatment plan and described in this service specification (some interventions require two opinions as described). All individuals who are offered a medical intervention will be given advice on smoking cessation, encouraged to take regular exercise and adopt a healthy lifestyle (so far as relevant to their circumstances).

Appendix I: Specialised psychological interventions

The aims of specialised psychological interventions, alone or as part of a wider multi-disciplinary network, are to:

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

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

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

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

Good practice for engaging in psychological interventions with transgender people has been published[5]. Providers will ensure adequate training, supervision, caseload management and support to ensure clinicians are competent and able to provide affirmative interventions.

[5] *Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients*; British Psychological Society; 2012 and *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*; American Psychological Association; 2015; and *Standards of Care (v7);* World Professional Association for Transgender Health; 2011

Appendix J: Arrangements for prescribing endocrine treatments

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

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

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

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

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

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

Most recommendations will be for medications to be used outside the indications approved by the *Medicines and Healthcare Products Regulatory Agency*; the *General Medical Council* advises GPs that they may prescribe 'unlicensed medicines' where this is necessary to meet the specific needs of the patient and where there is no suitably licensed medicine that will meet the patient's need[6].

GPs will be given advice on dose titration and the introduction of additional pharmacological interventions by the provider. The Provider will respond promptly to requests by GPs for advice regarding the interpretation of laboratory results and medication use.

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

[6] *Advice for Doctors Treating Transgender Patients;* General Medical Council; 2016

treatment initiation or following significant changes in regimen. The purpose of clinical monitoring during hormone use is to assess the degree of feminisation / masculinisation and the possible presence of adverse effects of medication.

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

Medication for masculinisation

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

Medication for feminisation

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

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

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

Appendix K – quality indicators

Number	Indicator	Descriptor	Notes	Evidence documents	Data source	Domain	CQC question
	Clinical Outcomes - quantitative data where possible using national data need to minimise the burden						
101	% of referrals acknowledged in writing by the provider with the referrer and individual within 14 calendar days	% of referrals acknowledged in writing by the provider with the referrer and individual within 14 calendar days		Annual Report	HES / SSQD	4	Well-led, effective
102	% of referrals received where the diagnosis after assessment is either Gender Dysphoria (as per DSM-V) or Gender Incongruence (as per ICD-11 when available)	% of referrals received where the diagnosis after assessment does not fulfil the diagnostic criteria of either Gender Dysphoria (as per DMS-V) or Gender Incongruence (as per ICD-11 when available); and therefore the patient does not require services from the service		Annual Report	HES / SSQD	2, 4	Effective, caring, responsive

103	% of patients receiving more than two assessment consultations	% of patients receiving more than two diagnostic assessment consultations before a complete management plan could be made		Annual Report	HES / SSQD	2, 4	Effective, caring, responsive
104	% of patients who do not enter into the treatment programme following two assessment consultations	% of patients who do not enter into the treatment programme following two consultations		Annual Report	HES / SSQD	2, 4	Effective, caring, responsive
105	Number of patients open to the service with polycythaemia following endocrine treatment (initiated by the service) needing venesection	Number of patients open to the service with polycythaemia following endocrine treatment (initiated by the service) needing venesection		Annual Report	HES / SSQD	3	Safe, effective, caring, responsive
106	Number of patients open to the service reporting DVT/PE following endocrine	Number of patients open to the service reporting DVT/PE following endocrine treatment (initiated by the service)		Annual Report	HES / SSQD	3	Safe, effective, caring, responsive

	treatment (initiated by the service) where action is required	where action is required					
107	Number of patients open to the service with cardiovascular complications (e.g. MI or Stroke) post hormone treatment (initiated by the service)	Number of patients open to the service with cardiovascular complications (e.g. MI or Stroke) post hormone treatment (initiated by the service)		Annual Report	HES / SSQD	3, 4	Safe, effective, caring, responsive
108	Number of patients requesting chest reconstruction surgery who do not request hormone treatment pre-surgery	Number of patients requesting chest reconstruction surgery who do not request hormone treatment		Annual Report	HES / SSQD	3	Effective, caring, responsive
	Patient Experience						
201	The service reviews the national PROM/PREM data	Providers will receive data from the national PROM/PREM data source and will review as a team and establish	On line reporting tool for access by patients will be adopted	Annual Report	Self-declaration	4	Caring, responsive

		service development plans to continually improve the service	by NHS England for 2019/20				
202	Patient information	Patient information (in paper or online) is provided to all patients and includes details as listed in the service specification		Operational Policy	Self-declaration	4	caring, responsive
	Structure and Process - infrastructure requirements, staffing, facilities etc.						
301	There is a Clinical Lead for the service	There is a Clinical Lead in place who meets the description in the service specification		Operational Policy	Self-declaration	2, 3, 4	Well-led
302	There is a Named Professional and Lead Clinician allocated for the duration of the patients care	There is a Named Professional and Lead Clinician allocated for the duration of the patients care		Operational Policy	Self-declaration	4	Effective, caring

303	There is a system of corporate governance, including a nominated senior manager who provides guidance, oversight and accountability	There is a system of corporate governance, including a nominated senior manager who provides guidance, oversight and accountability		Operational Policy	Self-declaration	5	safe, effective, well-led
304	Patients receiving endocrine and pharmacological interventions are reviewed at least annually	Patients receiving endocrine or pharmacological interventions have these reviewed annually by a medical practitioner		Operational Policy	Self-declaration	2, 3, 4	Safe, effective, caring, responsive
305	There is an agreed patient pathway	There should be a patient pathway in place as per the service specification		Operational Policy	Self-declaration	2, 3, 4, 5	Safe, effective, caring, responsive
306	There are transition clinics in place	Arrangements exist which include joint transition clinics to ensure the transfer of care of patients from adolescence to adulthood services		Operational Policy	Self-declaration	2, 4	Safe, effective, caring, responsive

307	The team participates in clinical audit activity on an annual basis, participating in both local and national audits	The team participates in clinical audit activity on an annual basis, participating in both local and national audits		Operational Policy	Self-declaration	1, 2, 3, 4	Well-led, safe, effective, caring

B. Service Specifications

Service Specification No:	1780
Service	Gender Identity Services for Adults (Surgical Interventions)
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 Prescribed Specialised Service

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

1.2 Description

1.3 Gender identity services includes specialist assessment, non-surgical care packages, certain surgical interventions and immediate associated after care provided by specialist centres.

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

Clinical Commissioning Groups are responsible for commissioning certain other surgical procedures that are not specialised and that may form the NHS pathway of care for individuals with gender dysphoria (as described in this specification).

2. Care Pathway and Clinical Dependencies

2.1 Background

The term currently used to describe a discrepancy between birth-assigned sex and gender identity is **gender incongruence**; this term is preferable to the

formerly-used terms of gender identity disorder and transsexualism. Gender incongruence is frequently, but not universally, accompanied by the symptom of **gender dysphoria**.

The current version of the International Statistical Classification of Diseases and Related Health Problems identifies 'transsexualism' (ICD 10 code F64) as:

> "*A disorder characterized by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex (manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery)*".[7]

2.2 Principles guiding the development of this service specification

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

Equity of access and high quality care will be provided to all individuals who meet the criteria for access to the NHS pathway of care.

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

Interventions will be personalised and based on shared decision making, with service flexibility and reasonable adjustments to delivery of care to match the individual's needs and circumstances.

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

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

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

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

Achieve an integrated approach to care with specialist Gender Dysphoria Clinics and ensure close links with other expert centres at national and international levels.

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

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

[7] The revised ICD 11 refers to the wider category of 'gender incongruence' (not yet adopted).

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

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

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

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

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

2.4 Staffing, structure and governance

Each Provider will have:

A nominated Senior Clinical Lead, who has the key leadership role for the service overall. The Senior Clinical Lead must demonstrate evidence of appropriate experience and expertise in specialised gender dysphoria practice significant management experience; and significant evidence of continued professional development.

A specialist multi-disciplinary team of professionals. A core multi-disciplinary team will include surgeons with expertise in the procedures described in this service specification; consultant anaesthetists; consultant radiologists; and specialist nurses. The team will also include other clinicians with a mix of skills, experience and expertise that is appropriate to ensure the delivery of effective and high-quality services in accordance with the requirements of this service specification.

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

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

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

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

Information and technology systems that enables the effective submission of data, including the reporting requirements of the national Referral to Treatment waiting time standards.

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

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

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

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

Systems that demonstrate how the Provider uses audit, data management and analysis, service reviews (including peer reviews) and other intelligence to evaluate effectiveness and drive ongoing service improvement**.**

2.5 Care Pathway

The delivery model relies on access via primary care, and the principle of multidisciplinary and interdisciplinary teams and networks who work and collaborate in the provision of care. Gender Dysphoria Clinics assess and diagnose individuals; directly provide some interventions and arrange for referrals to other services, including for medical and surgical treatments. Access to surgical intervention is only by referral from a specialist Gender Dysphoria Clinic that is commissioned by NHS England. Some elements of the NHS care pathway are delivered by non-specialised services. A diagram of the pathway is at Appendix A.

The NHS pathway of care may be summarised as:

- Referral to a specialist Gender Dysphoria Clinic from primary, secondary or tertiary care or by self-referral
- Assessment for gender dysphoria, and diagnosis
- Individuals who meet the criteria for gender dysphoria related to gender incongruence are accepted on to the NHS care pathway and an individualised treatment plan is agreed
- Therapeutic interventions delivered by the specialist Gender Dysphoria Clinic; and / or referral for interventions led by other providers, including for surgery
- Ongoing review and monitoring during and after interventions
- Conclusion of contact: discharge to primary care.

2.6 Referral for surgical intervention

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

Referrals will be made by the Lead Clinician to a National Referral Management Service (commissioned by NHS England) that will assist the individual in making an informed choice about the most appropriate surgical provider, including a consideration of available outcome data and the

individual's treatment goals.

2.7 Role of the specialist surgeon and surgical team

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

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

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

2.8 Infrastructure requirements

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

The service will be co-located with the following services

- Radiology
- Infection prevention and control

The service will have access to the following services:

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

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

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

A health professional member of the surgical team will be available during daytime working hours to provide non-urgent advice to patients, and other practitioners providing care to patients who are not currently in-patients of the

specialist surgery provider unit, such as A&E units, GPs and Gender Dysphoria Clinics.

2.9 Assessment for readiness for surgical interventions

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

2.10 Shared decision making

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

2.11 Consent to surgery

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

The Named Professional and Lead Clinician in the specialist Gender Identity Clinic will have previously made all efforts to ensure that individuals are aware of the longer-term consequences of the interventions offered to them. The consequences of treatment decisions can be significant and life-changing.

The operating surgeon will obtain consent for the proposed intervention at a specific pre-operative appointment, so as to allow an informed process and give the patient adequate time to consider any relevant options and alternatives. Each patient should receive detailed verbal, written and pictorial information on the:

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

2.12 Nursing team

The Provider will have a nursing team that is experienced in meeting the health care needs of individuals with gender dysphoria. The role of the nursing team should include pre-operative care, whereby contact is made

before surgery and information is shared on aftercare including hygiene, risk of infection and general lifestyle considerations. Post-operative care involves wound and physical care, and liaison with community and primary care services around the time of discharge from hospital.

2.13 Mortality and morbidity meeting

A mortality and morbidity meeting will be held every quarter with minutes taken, and discussed at an annual joint service review meeting with commissioners.

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

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

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

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

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

- Mastectomy and related chest reconstruction for individuals assigned female at birth
- Genital reconstruction

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

Mastectomy and related chest reconstruction

Surgeons must be trained in onco-plastic breast surgery or be plastic surgeons with expertise in plastic surgery of the breast.

The standard practice[8] procedures that are commissioned by NHS England are:

- Double Incision Technique

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

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

Masculinising genital surgery

The standard practice[9] procedures commissioned by NHS England are:

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

Commissioned only in conjunction with the above pathways:

- Hysterectomy
- Bilateral Salpingo-oophorectomy
- Vaginectomy
- Placement of penile prosthesis (various types)
- Placement of testicular prosthesis (various types)
- Glans sculpting

Hysterectomy (removal of uterus) and bilateral salpingo-oophorectomy (removal of ovaries and fallopian tubes) are interventions commissioned under this service specification when they are performed by a specialist Gender Identity surgical unit simultaneously with the genital surgical interventions for the purpose of the alleviation of gender dysphoria (described above). They are not commissioned by NHS England when they are performed as “stand alone” procedures; in such cases commissioning responsibility rests with the individual’s Clinical Commissioning Group.

Feminising genital surgery

The standard practice[10] procedures commissioned by NHS England are feminising genital reconstruction, consisting of some or all of the following:

- Penectomy
- Bilateral Orchidectomy

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

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

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

Penectomy (removal of penis) and orchidectomy (removal of testes) are interventions commissioned under this service specification when they are performed by a specialist Gender Identity surgical unit simultaneously with the genital surgical interventions for the purpose of the alleviation of gender dysphoria (described above). They are not commissioned by NHS England when they are performed as "stand alone" procedures; in such cases commissioning responsibility rests with the individual's Clinical Commissioning Group.

Surgical procedures that are not routinely commissioned by NHS England include (not exhaustive):

- Phonosurgery
- Augmentation Mammoplasty (breast enlargement)
- Facial Feminisation Surgery, including Thyroid Chondroplasty and Rhinoplasty
- Lipoplasty / Contouring, Microdermabrasion and other cosmetic procedures
- Body hair removal (other than donor site for surgery)
- Hair transplantation
- Hysterectomy, bilateral salpingo-oophorectomy, penectomy and orchidectomy when they are performed as "stand alone" procedures
- Reversal of a previous surgical intervention for the treatment of gender dysphoria

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

Referrals for readmissions for treatment of complications for poor outcomes will be considered by the National Referral Management Service to identify whether the referral should proceed in a specialised surgical service or in a local non-specialised service.

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

NHS England does not commission the reversal of previous surgical interventions for the treatment of gender dysphoria that are requested by the individual due to regret or other change of mind.

2.16 Donor Site Skin Epilation

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

Epilation is provided exclusively for the purpose of reducing the risk of poor surgical outcome. Laser epilation will be used for patients with pigmented hair, unless it is demonstrated as ineffective or poorly tolerated by the patient. Electrolysis will only be used for patients who have depigmented or very fair hair, or have not tolerated laser epilation or have found it to be ineffective. The surgical team will collaborate with the epilation provider to assess when treatment is complete and the permanency of epilation.

2.17 Discharge from the surgical provider

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

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

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

2.18 Interdependence with other Services

Links with other services include:

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

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

The service outlined in this specification is for patients ordinarily resident in England; or otherwise the commissioning responsibility of the NHS in England (as defined in guidance for "Establishing the Responsible Commissioner" and other Department of Health guidance relating to patients entitled to NHS care

or exempt from charges). For the purposes of commissioning health services, this excludes patients who, whilst resident in England, are registered with a GP practice in Wales, but includes patients resident in Wales who are registered with a GP practice in England.

The Provider will receive referrals from a specialised Gender Dysphoria Service (that is commissioned by NHS England) of individuals from 17 years of age who have a diagnosis of gender dysphoria that is a consequence of their gender identity being incongruent with their visible sex characteristics and/or the social role typically associated with those characteristics (gender incongruence).

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

3.2 Population needs; and Expected Demographic Changes

There is no official data on the number of people in England who present with a degree of gender variance. Difficulties in assessing prevalence are exacerbated by the limited evidence base. There is considerable variation in reported prevalence due to factors such as: variable data reporting by providers; differences in diagnostic thresholds applied and inconsistent terminology; the methodology and diagnostic classification used; and the year and country in which the studies took place.

Thus there is considerable variation in estimates, and the absence of reliable prevalence data exacerbates the challenges in planning and commissioning gender identity services. What is consistent across the literature is a recognition that the number of people pursuing treatment options – the incidence of expressed need - is rising significantly.

4. Outcomes and Applicable Quality Standards

NHS Outcomes Framework Domains

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**

Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

4.2 Indicators Include:

Number	Indicator	Data Source	Outcome Framework Domain	CQC Key question
Clinical Outcomes				
Generic Surgery				
101	% of patients returned to theatre during the primary admission	HES / SSQD reported quarterly	3, 4	effective, responsive
102	% of patient suffering from DVT/pulmonary embolic complications requiring treatment within a 3 months period post-surgery	HES / SSQD reported annually	3, 4	effective, responsive
103	% of patients readmitted due to complications within 3 months of discharge	HES / SSQD reported quarterly	3, 4	effective, responsive
Assigned Male at Birth: Genital Surgery				
104	% of revisions undertaken within 12 months of the primary procedure	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
105	% of patients suffering from rectal vaginal fistula	HES / SSQD reported annually	3, 4	effective, responsive
Assigned female at Birth: Genital Surgery				
106	% of revisions undertaken within 12 months of the primary procedure.	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive

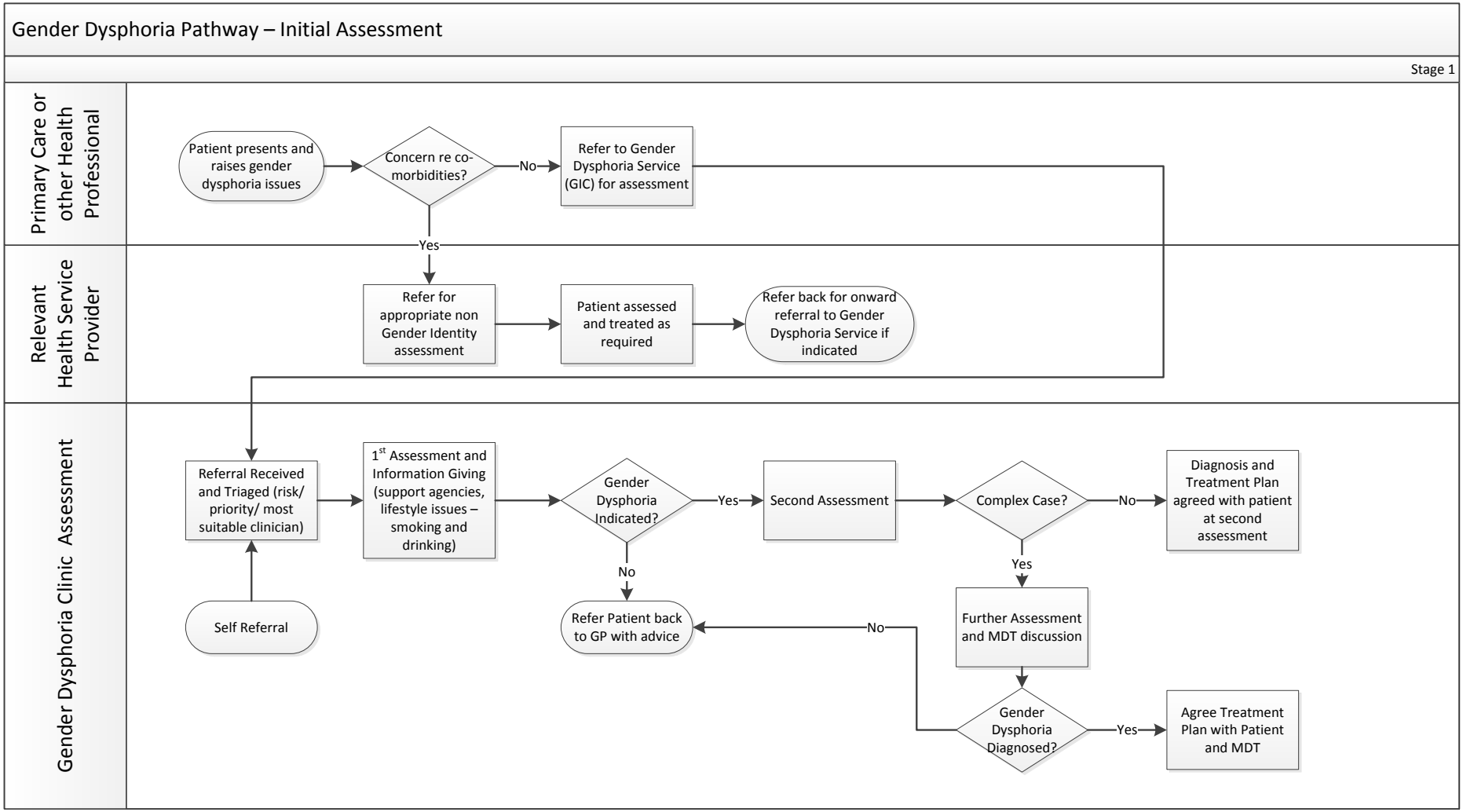
107	% of patients requiring treatment for urethral problems in the last 12 months	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
108	Number of patients suffering full or partial loss of graft	HES / SSQD reported annually	3, 4	effective, responsive
109	% of patients reporting prosthetic complications	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
Assigned Female at Birth: Chest Surgery				
110	For chest revisions % of patients with post-surgical complications including: haematoma; and nipple necrosis	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
Patient Experience				
201	The service reviews the national patient reported outcome and experience data	Self-declaration	4	effective, caring, responsive
202	Patient information is provided to all patients and includes details as listed in the service specification.	Self-declaration	4	effective, responsive
Structure and Process				
301	The core membership of the MDT is as per the service specification	Self-declaration	2,, 4, 5	safe, effective, responsive, well-led
302	Named MDT surgical members must undertake at least 20 procedures per annum	Self-declaration	1,2,3,4	safe, effective, caring
303	There is a consultant-led clinical advice available 24 hours a day, 7 days per week	Self-declaration	3,4,5	safe, effective, responsive

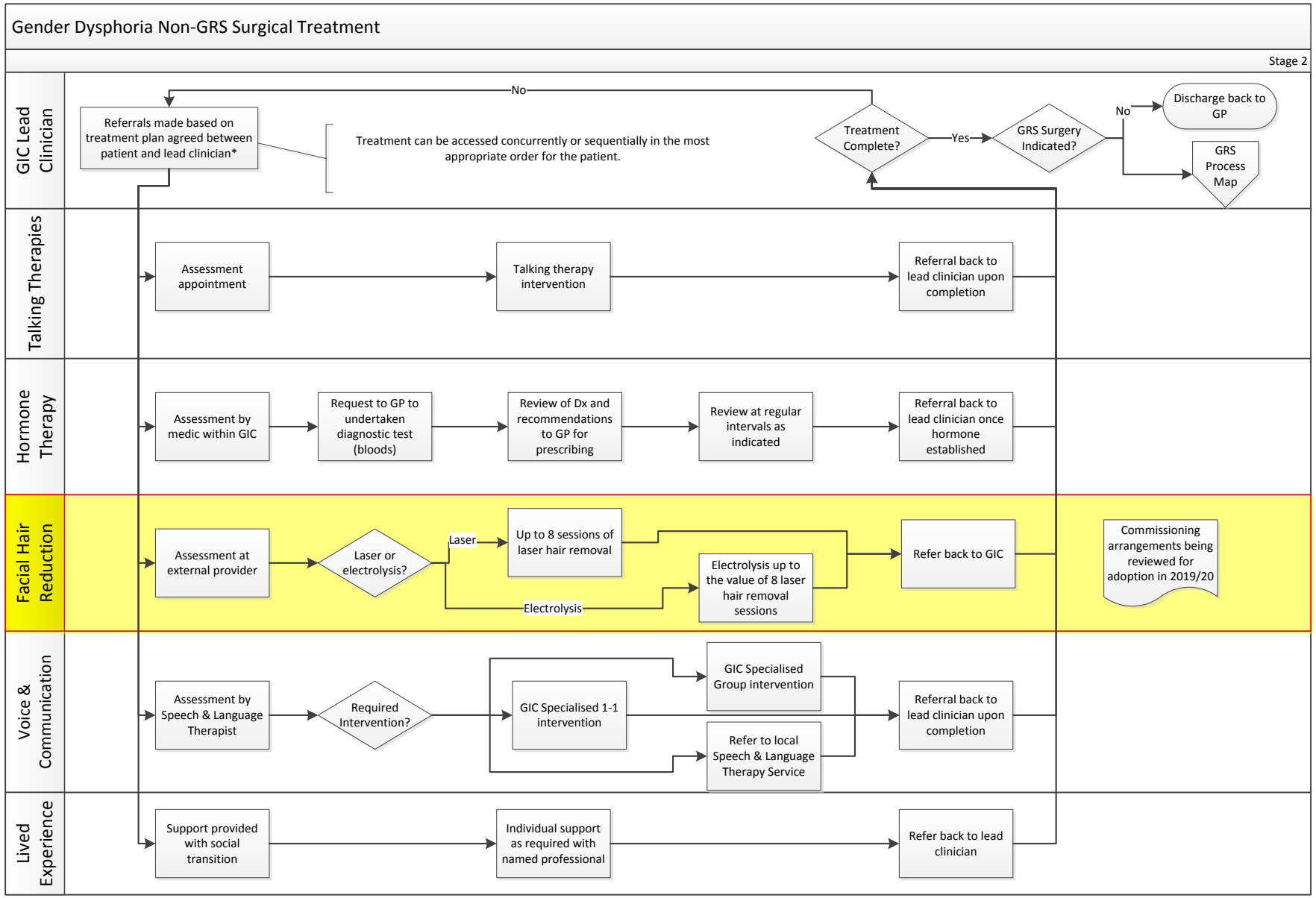
304	Access to a named nurse	Self-declaration	2, 3, 4, 5	caring, responsive
305	There is a system of corporate governance, including a nominated senior manager who provides guidance, oversight and accountability	Self-declaration	5	safe, effective, well-led
306	There is a process in place to ensure that patients are actively engaged in shared decision making	Self-declaration	2, 4	effective, caring, responsive
307	There should be a patient pathway in place as per the service specification	Self-declaration	2, 3, 4, 5	effective, caring, responsive
308	Clinical guidelines are in place and adhered to as detailed within the service specification	Self-declaration	3, 4	effective, caring, responsive
309	The team participates in clinical audit activity on an annual basis, and submits data to local and national audits as required	Self-declaration	1, 3, 4	effective, well-led

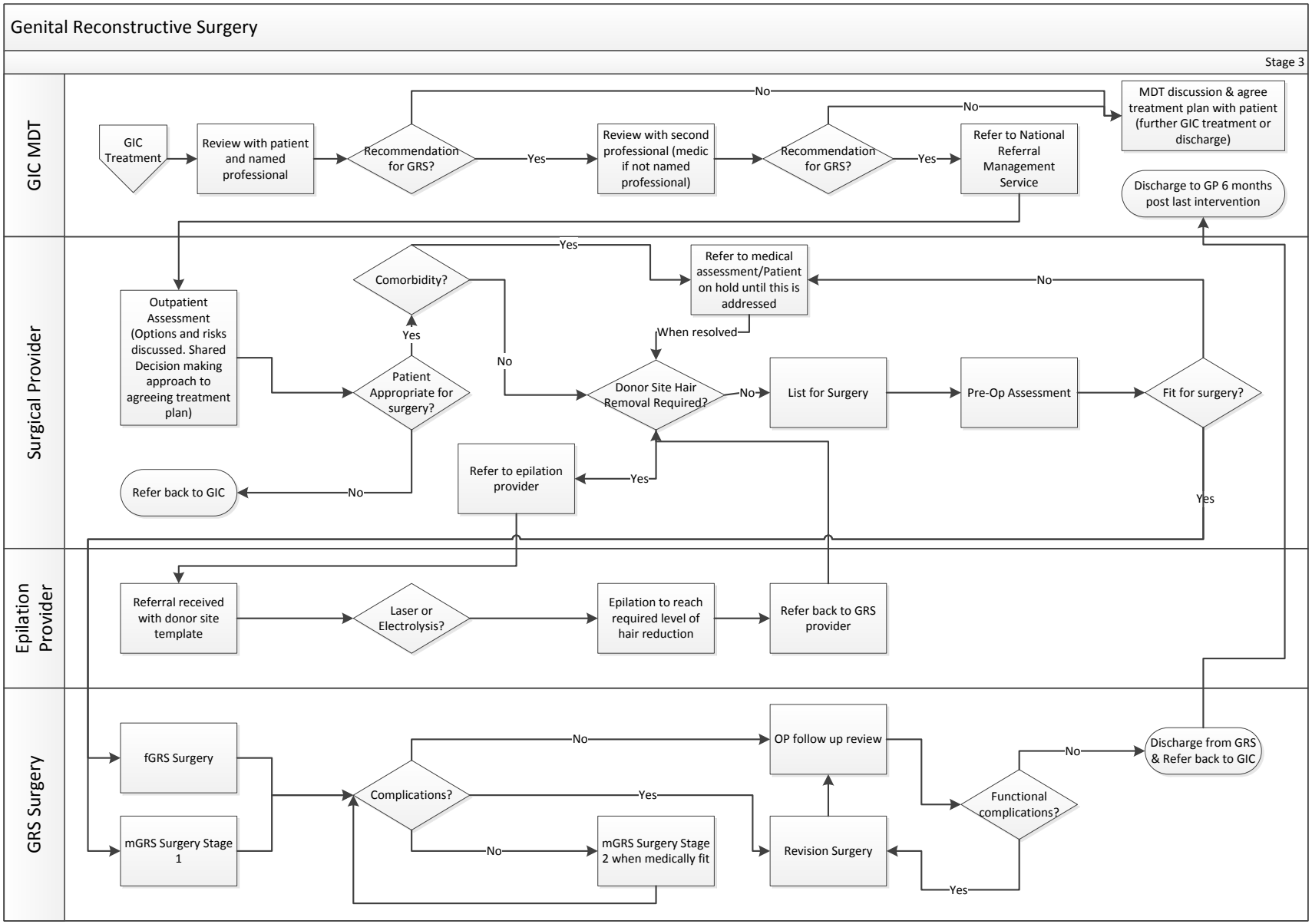
See Appendix E for more detailed description of the indicators

Date published: September 2018

Appendix A


Gender Dysphoria Pathway – Initial Assessment
Stage 1
Primary Care or other Health Professional
Relevant Health Service Provider
Gender Dysphoria Clinic Assessment
Patient presents and raises gender dysphoria issues
Concern re co-morbidities?
No
Refer to Gender Dysphoria Service (GIC) for assessment
Yes
Refer for appropriate non Gender Identity assessment
Patient assessed and treated as required
Refer back for onward referral to Gender Dysphoria Service if indicated
Referral Received and Triaged (risk/ priority/ most suitable clinician)
1st Assessment and Information Giving (support agencies, lifestyle issues – smoking and drinking)
Gender Dysphoria Indicated?
Yes
Second Assessment
Complex Case?
No
Diagnosis and Treatment Plan agreed with patient at second assessment
Yes
No
Self Referral
Refer Patient back to GP with advice
No
Further Assessment and MDT discussion
Gender Dysphoria Diagnosed?
Yes
Agree Treatment Plan with Patient and MDT


Gender Dysphoria Non-GRS Surgical Treatment
Stage 2
GIC Lead Clinician
Referrals made based on treatment plan agreed between patient and lead clinician*
Treatment can be accessed concurrently or sequentially in the most appropriate order for the patient.
No
Treatment Complete?
Yes
GRS Surgery Indicated?
No
Discharge back to GP
GRS Process Map
Talking Therapies
Assessment appointment
Talking therapy intervention
Referral back to lead clinician upon completion
Hormone Therapy
Assessment by medic within GIC
Request to GP to undertaken diagnostic test (bloods)
Review of Dx and recommendations to GP for prescribing
Review at regular intervals as indicated
Referral back to lead clinician once hormone established
Facial Hair Reduction
Assessment at external provider
Laser or electrolysis?
Laser
Up to 8 sessions of laser hair removal
Electrolysis
Electrolysis up to the value of 8 laser hair removal sessions
Refer back to GIC
Commissioning arrangements being reviewed for adoption in 2019/20
Voice & Communication
Assessment by Speech & Language Therapist
Required Intervention?
GIC Specialised 1-1 intervention
GIC Specialised Group intervention
Refer to local Speech & Language Therapy Service
Referral back to lead clinician upon completion
Lived Experience
Support provided with social transition
Individual support as required with named professional
Refer back to lead clinician


Genital Reconstructive Surgery
Stage 3
GIC MDT
Surgical Provider
Epilation Provider
GRS Surgery
GIC Treatment
Review with patient and named professional
Recommendation for GRS?
Yes
No
Review with second professional (medic if not named professional)
Recommendation for GRS?
Yes
No
Refer to National Referral Management Service
MDT discussion & agree treatment plan with patient (further GIC treatment or discharge)
Discharge to GP 6 months post last intervention
Outpatient Assessment (Options and risks discussed. Shared Decision making approach to agreeing treatment plan)
Comorbidity?
Yes
No
Refer to medical assessment/Patient on hold until this is addressed
When resolved
Patient Appropriate for surgery?
Yes
No
Refer back to GIC
Donor Site Hair Removal Required?
No
Yes
Refer to epilation provider
List for Surgery
Pre-Op Assessment
Fit for surgery?
No
Yes
Referral received with donor site template
Laser or Electrolysis?
Epilation to reach required level of hair reduction
Refer back to GRS provider
fGRS Surgery
mGRS Surgery Stage 1
Complications?
No
Yes
No
mGRS Surgery Stage 2 when medically fit
OP follow up review
Revision Surgery
Functional complications?
No
Yes
Discharge from GRS & Refer back to GIC

Appendix B: Referral for surgical intervention

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

A decision about an individual's suitability for surgical interventions to alleviate gender dysphoria requires careful assessment and support from a specialist multi-disciplinary team, taking into account medical, psychological, emotional and social issues in combination. As such, and given the potential range of complexities that may be experienced by individuals on the NHS pathway of care and the potential treatments, referrals to the specialist surgical team will not be accepted from other providers or health professionals.

Before a referral for surgery is made, the Lead Clinician in the Gender Dysphoria Clinic will have met with the individual to review current treatment interventions, and to assess the individual's needs and readiness for the surgical intervention, both as described in the criteria below and as an assessment of the individual's physical health generally. The processes of shared decision making and of obtaining consent (as described earlier in this document) will provide the patient with necessary information, and will allow the individual sufficient time to ask questions, and to reflect on the advice of the Lead Clinician to enable an informed decision on the treatment options, risks and benefits.

Appendix C: Assessment for readiness for surgical interventions

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

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

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

Assessment of patients who have been granted a Gender Recognition Certificate

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

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

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

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

Appendix D: Criteria for initiation of surgical treatments

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

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- Aged 17 years or older
- If significant medical or mental health concerns are present, they must be reasonably well controlled
- Hormone therapy is not a pre-requisite
- It is not a requirement for access to masculinising chest surgery to undertake a change in social role

NHS England has received advice from surgeons who specialise in these procedures that prior treatment with testosterone for a period of six to nine months results in tissue changes that may improve outcomes. This is an expert-opinion based observation and is not supported by research evidence. Patients may wish to take this opinion into consideration when planning their surgery but prior treatment with testosterone is not a requirement and, in some cases, may be inconsistent with patients' other goals for gender expression.

Criteria for genital surgery (requires two letters of referral: one from a Lead Professional, the other from a similarly-qualified and experienced professional not directly involved in the individual's care and able to form an independent opinion; at least one letter of referral must be from a Registered Medical Practitioner with expertise in gender dysphoria)

Masculinising genital surgery

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

NHS England has received advice from surgeons who specialise in these procedures that prior treatment with testosterone for a period of two years results in

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

Feminising genital surgery

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

Patients who smoke

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

Patients who are overweight

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

Appendix E – indicators

Number	Indicator	Descriptor	Notes	Evidence documents	Data Source	Domain	CQC Key question
	Clinical Outcomes - quantitative data where possible using national data need to minimise the burden						
	Generic Surgery						
101	% of patients returned to theatre during the primary admission	% of patients returned to theatre during the primary admission		Annual Report	HES / SSQD reported quarterly	3, 4	effective, responsive
102	% of patient suffering from DVT/pulmonary embolic complications requiring treatment within a 3 months period post-surgery	% of patient suffering from pulmonary embolism requiring treatment within a 3 months period post-surgery		Annual Report	HES / SSQD reported annually	3, 4	effective, responsive
103	% of patients readmitted due to complications within 3 months of discharge	% of patients readmitted due to complications within 3 months of discharge		Annual Report	HES / SSQD reported quarterly	3, 4	effective, responsive

	Assigned Male at Birth: Genital Surgery						
104	% of revisions undertaken within 12 months of the primary procedure	% of revisions undertaken within 12 months of the primary procedure		Annual Report	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
105	% of patients suffering from rectal vaginal fistula	% of patient suffering from rectal vaginal fistula		Annual Report	HES / SSQD reported annually	3, 4	effective, responsive
	Assigned Female at Birth: Genital Surgery						
106	% of revisions undertaken within 12 months of the primary procedure	% of revisions undertaken within 12 months of the primary procedure			HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive

107	% of patients requiring treatment for urethral problems in the last 12 months	% of patients requiring treatment for urethral problems in the last 12 months		Annual Report	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
108	Number of patients suffering full or partial loss of graft	Number of patients suffering full or partial loss of graft		Annual Report	HES / SSQD reported annually	3, 4	
109	% of patients reporting prosthetic complications	% of patients reporting prosthetic complications		Annual Report	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
	Assigned Female at Birth: Chest Surgery						
110	For chest revisions % of patients with post-surgical complications including: · Haematoma · Nipple	For chest revisions % of patients with post-surgical complications including: ·Haematoma ·Nipple necrosis		Annual Report	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive

	necrosis						
	Patient Experience						
201	The service reviews the national PROM/PREM data	Providers will receive data from the national PROM/PREM data source and will need to review as a team and establish service development plans to continually improve the service	NHS England will develop an online reporting tool for access by patients from 2019/20	Annual Report	Self-declaration	4	caring, responsive
202	Patient information is provided to all patients and includes details as listed in the service specification	Patient information is provided to all patients and includes details as listed in the service specification including at least information on: • different surgical techniques available (with referral to colleagues who provide alternative options) • advantages and disadvantages of		Operational Policy	Self-declaration	4	caring, responsive

		each technique • limitations of a procedure to achieve “ideal” results; • inherent risks and possible complications of the various techniques • appropriate aftercare					
	Structure and Process						
301	The core membership of the MDT is as per the service specification	The core membership of the MDT is as per the service specification and includes: Consultant surgeons with expertise in the procedures described in this service specification; consultant anaesthetists; consultant radiologists; specialist nurses	The Senior Clinical Lead must demonstrate evidence of appropriate experience and expertise as described in the service specification	Operational Policy	Self-declaration	2, 4, 5	safe, effective, responsive, well-led

		One of the above core members shall be nominated as Clinical Lead, and will provide leadership for the overall service All clinical staff identified above will be trained in meeting the health needs of trans people					
302	Named MDT surgical members must undertake at least 20 procedures per annum	Named MDT surgical members must undertake at least 20 procedures per annum		Annual Report	Self-declaration	1,2,3,4	safe, effective, caring
303	There is a consultant-led clinical advice available 24 hours a day, 7 days per week	There is a consultant-led clinical advice available 24 hours a day, 7 days per week		Operational Policy	Self-declaration	3, 4, 5	safe, effective, responsive

304	Access to a named nurse	There should be a named specialist nurse to support patients throughout the surgical pathway, from referral to discharge		Operational Policy	Self-declaration	2, 3, 4, 5	caring, responsive
305	There is a system of corporate governance, including a nominated senior manager who provides guidance, oversight and accountability	There is a system of corporate governance, including a nominated senior manager who provides guidance, oversight and accountability		Operational Policy	Self-declaration	5	safe, effective, well-led
306	There is a process in place to ensure that patients are actively engaged in shared decision making	There is a process in place to ensure that patients are actively engaged in shared decision making	This may be through signed care plans.	Operational Policy	Self-declaration	2, 4	effective, caring, responsive

307	There should be a patient pathway in place as per the service specification	There should be a patient pathway in place as per the service specification Pathway details should include of referring clinics		Operational Policy	Self-declaration	2, 3, 4, 5	effective, caring, responsive
308	Clinical guidelines are in place and adhered to as detailed within the service specification	Clinical guidelines are in place and adhered to as detailed within the service specification		Operational Policy	Self-declaration	3, 4	effective, caring, responsive
309	The team participates in clinical audit activity on an annual basis, and submits data to local and national audits and any others as required	The team participates in clinical audit activity on an annual basis, and submits data to local and national audits and any others as required		Operational Policy	Self-declaration	1, 3, 4	effective, well-led