Interim service specification for specialist gender dysphoria services for children and young people – public consultation

Closes 4 Dec 2022

Opened 20 Oct 2022

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Overview

NHS England commissions specialised services for people with gender dysphoria, and it is holding this consultation to seek views on a proposed interim service specification for services for children and young people with gender dysphoria.

Once agreed, this interim service specification will be operational for a limited time only until a new service specification is formed in 2023/24 that will be used by a new configuration of regional providers.

In order to complete this consultation, please review the following documents:

- Consultation guide (user_uploads/b1937-ii-interim-service-specification-for-specialist-gender-dysphoria-services-for-children-and-young-people-22.pdf)
- Specialist service for children and young people with gender dysphoria (phase 1 providers) (user_uploads/b1937-ii-specialist-service-for-children-and-young-people-with-gender-dysphoria-1.pdf)
- Equality and Health Inequalities Impact Assessment (user_uploads/b1937_iii_equalities-health-impact-assessment-interim-service-specification.pdf)

The public consultation will run from 20 October to 4 December 2022.

Why your views matter

NHS England is committed to working with patients, patient groups and other stakeholders in the development of its commissioning of services. This public consultation is an opportunity to check whether proposals are right and supported, whether the public understand their impact, and to identify any alternatives before decisions are made.

Give us your views

Online Survey ›
(https://www.engage.england.nhs.uk/specialised-

commissioning/gender-dysphoria-services/consultation/)

Related

Consultation guide (https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/supporting_documents/B1937iiInterimservicespecificationforspecialistgenderdysphoriaservicesforchildrenandyoungpeople22.pd
330.9 KB (PDF document)

Specialist service for children and young people with gender dysphoria (phase 1 providers) (https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/supporting_documents/B1937iiSpecialistserviceforchildrenandyoungpeoplewithgenderdysphoria.pdf)
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Equality and Health Inequalities Impact Assessment (https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/supporting_documents/B1937_iii_equalitieshealthimpactassessmentinterimservicespecification.pdf)
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Public consultation

Interim service specification for specialist gender dysphoria services for children and young people

20 October 2022

Contents

Purpose of this document

NHS England is committed to working with a wide range of patients, patient groups and other stakeholders in the development of its commissioning of services. A public consultation is an opportunity to check whether proposals are right and supported, the public understand their impact, and identify any alternatives before decisions are made.

NHS England is the responsible commissioner for specialised services for individuals with gender dysphoria, and it is holding this consultation to seek views on a proposed interim service specification for services for children and young people with gender dysphoria- this represents phase 1 of our service transformation programme. Once agreed, this interim service specification will be operational for a limited time only until a new service specification is formed in 2023/24 following final advice from the independent Cass Review. This will be used by a new configuration of regional providers- representing phase 2 of our service transformation programme.

The public consultation will run for 45 days from 20 October to 4 December 2022.

This consultation guide summaries the proposals and sets out:

- How care is currently provided.
- How the interim service specification could change care and the way that services are delivered, and the reasons for these changes.
- How the proposed changes will be implemented.

The document also has information about how you can share your views with NHS England. At the end of the consultation period, all feedback will be considered before the interim service specification is published.

We recommend that you read this consultation guide alongside the other documents published as part of the consultation. While this single consultation guide has been produced to summarise the proposals, the other documents provide additional detail.

Documents included in this consultation:

- **Interim service specification** – The service specification is a contractual document that describes the clinical service and sets out appropriate standards and quality measures that provider organisations must satisfy.
- **Equality and Health Inequalities Impact Assessment** (EHIA) – This document assesses the potential impact of the interim service specification on population groups that may be disproportionately affected by changes and make appropriate recommendations to mitigate any inequity.

Background

The term used to describe a discrepancy between birth-assigned sex and gender identity is 'gender incongruence'. Gender incongruence is frequently, but not universally, accompanied by the symptom of gender dysphoria: *"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".*

There is currently only one provider of specialist services for children and young people (up to the 18th birthday) with gender dysphoria in England – this is the Gender Identity Development Service (GIDS) for children and adolescents, delivered by the Tavistock and Portman NHS Foundation Trust in London.

The GIDS is also directly commissioned by NHS Wales, and the changes described in this document will impact on patients who are the commissioning responsibility of NHS Wales.

Interim service specification: the case for change

In September 2020, NHS England commissioned an independent and wide-ranging review of gender identity services for children and young people. The Review, which is ongoing, is being led by Dr Hilary Cass, past president of the Royal College of Paediatrics and Child Health. It was established in response to a complex and diverse range of issues including:

1. A significant and sharp rise in referrals

In 2021/22 there were over 5,000 referrals into the Gender Identity Development Service (GIDS) run by the Tavistock and Portman NHS Foundation Trust. This compares to just under 250 referrals in 2011/12.

2. Marked changes in the types of patients being referred which are not well understood

There has been a dramatic change in the case-mix of referrals from predominantly birth-registered males to predominantly birth-registered females presenting with gender incongruence in early teen years. Additionally, a significant number of children are also presenting with neurodiversity and other mental health needs and risky behaviours which requires careful consideration and needs to be better understood.

3. Scarce and inconclusive evidence to support clinical decision making

This has led to a lack of clinical consensus on what the best model of care for children and young people experiencing gender incongruence and dysphoria should be; and a lack of evidence to support families in making informed decisions about interventions that may have life-long consequences.

4. Long waiting times for initial assessment and significant external scrutiny and challenge surrounding the clinical approach and operational capacity at GIDS

This has contributed to the current service being unable to meet the scale of rising demand and concerns being raised by healthcare regulators about the standard of care.

Next steps

In February 2022, Dr Cass published an interim report in which she set out initial findings and advice from her Review. She emphasised the need to urgently move away from the current model of a sole provider, and to establish regional services that work to a new clinical model that can better meet the holistic needs of a vulnerable group of children and young people. She began to describe the need for these new services to work as networked centres that connected with other local services including children and young people's mental health services and primary care to support all a patient's clinical needs.

In July, Dr Cass gave further advice on the core components of this model. You can read the advice in full here.

In summary, she has said:

- 'Regional centres should be led by experienced providers of tertiary paediatric care to ensure a focus on child health and development, with strong links to mental health services. These will generally be specialist children's hospitals.
- 'They should have established academic and education functions to ensure that ongoing research and training is embedded within the service delivery model'.
- 'The services should have an appropriate multi-professional workforce to enable them to provide an integrated model of care that manages the holistic needs of this population'.
- 'Staff should maintain a broad clinical perspective to embed the care of children and young people with gender uncertainty within a broader child and adolescent health context'.
- In view of the uncertainties surrounding their use, consideration should be given to the rapid establishment of the necessary research infrastructure to prospectively enroll young people being considered for puberty blocking drugs

into a formal research programme, with adequate follow-up into adulthood.

Establishing New (Phase 1) Services

Given the urgent need to stabilise service provision for patients and begin building a more resilient service by expanding provision, we are establishing two 'Phase 1'[1] services. Consistent with Dr Cass' advice, these services will be led by specialist children's hospitals and, once established, will take over clinical responsibility for and management of all current GIDS patients as part of a managed transition, and they will begin to see children and young people who are currently on the GIDS waiting list.

One Phase 1 service will be based in London and will be led by a partnership between Great Ormond Street Hospital for Children NHS Foundation Trust and Evelina London Children's Hospital (part of Guys and St Thomas' NHS Foundation Trust), with South London and Maudsley NHS Foundation Trust providing specialist CYP mental health support.

A second Phase 1 service will be based in the North West, led by a partnership between Alder Hey Children's NHS Foundation Trust and the Royal Manchester Children's Hospital (part of Manchester University NHS Foundation Trust), where both trusts also provide specialist CYP mental health services.

The Tavistock and Portman NHS Foundation Trust and the endocrine teams based at University College London Hospitals NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust will play a vital role in supporting both Phase 1 services as they establish the new services building on their extensive experience of working with this patient group.

A single national transformation programme has been established to oversee a smooth and seamless transition for patients to the new Phase 1 services, including bringing the GIDS contract to a managed close because of these changes. The establishment of the Phase 1 services will happen as quickly as possible, but crucially at a pace that appreciates the complexity of the change, while minimising

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[1] When NHS England announced plans in July 2022 to establish new services we referred to them as 'Early Adopter' service providers. We are now using the term 'Phase 1' service providers instead.

disruption and any additional anxiety for patients. The aim is for the Phase 1 services to be operational by Spring 2023.

The Phase 1 services will be commissioned against an interim service specification which will replace the current service specification used by the GIDS. There is now an urgent need to agree this specification to give the Phase 1 services time to recruit staff and set up the new services a quickly as possible.

The interim service specification builds out from the existing specification to both incorporate advice from the Cass Review following its extensive stakeholder engagement, and to provide points of clarification in certain areas. It has been worked up and endorsed by the Phase 1 providers, as well as senior clinical leads including the National Medical Director for Specialised Services, the National Clinical Director for Children and Young People and the Associate National Clinical Director for Children and Young People's Mental Health. It is important to note that this is an interim service specification to support the rapid mobilisation of the new Phase 1 services. It will be replaced in due course with a final service specification which will be subject to a further period of engagement and public consultation at a later date and once further advice has been received from Dr Cass as part of her ongoing independent review. This will mark the start of Phase 2 of our service transformation programme when additional regional services will be commissioned.

What are the proposed changes?

The interim service specification proposes the following changes and points of clarification over the current service specification.

1. Composition of the clinical team – substantive change

The current service specification for GIDS describes that the service is delivered through a specialist multidisciplinary team with contributions from specialist social workers, family therapists, psychiatrists, psychologists, psychotherapists, paediatric and adolescent endocrinologists and clinical nurse practitioners. *The new interim service specification proposes to extend the clinical team so that it is a more integrated multi-disciplinary team that, in addition to gender dysphoria specialists, will include experts in paediatric medicine, autism, neurodisability and mental health.*

The reason for this proposal is to respond to evidence that there is a higher prevalence of other complex presentations in children and young people who have gender dysphoria, that the Phase 1 services will also address, working with local services where appropriate. The proposal also responds to the findings of the Care Quality Commission's 2021 inspection report of GIDS, which highlighted the need for a better multi-disciplinary mix of care providers for some children and young people referred to the service. Furthermore, the interim advice of the Cass Review concluded (page 69) that "*a fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity … this must include support for any other clinical presentations that they may have*".

2. Clinical leadership – substantive change

The current service specification for GIDS does not describe criteria for the clinical lead for the service. *The new interim service specification proposes that the clinical lead for the service will be a medical doctor.*

The reason for this change is to reflect that the new integrated clinical teams will have a broader range of clinical disciplines, including medical professionals, who will be addressing a broader range of medical conditions in addition to gender dysphoria;

and that oversight of the service by a medical doctor is appropriate given that the service may provide medical interventions to some children and young people..

3. Collaboration with, and support for, referrers and local services – substantive change

The current service specification for GIDS describes a tiered approach for progression through the clinical pathway: the first tier involves meetings between the GIDS team and local professionals involved in the care of the child or young person and the second tier involves the child or young person accessing local services for mental health needs with GIDS offering advice to local services. There are numerous references in the current GIDS service specification to joint working between GIDS and local services including through consultation and liaison. However, GIDS has struggled to provide this support to local services in a consistent way given the constraints on the service. *The new interim service specification proposes to retain this tiered approach to progression through the pathway and describes a more structured approach for collaboration with local services in the interests of the child and young person; a referral to The Service will require a consultation meeting between the Phase 1 service and the relevant local secondary healthcare team and / or the GP. Where the outcome of the initial professional consultation between the Service and the referrer is that the patient does not meet the access criteria for The Service, the child or young person will not be added to the waiting list - but the family and professional network will have been assisted to develop their formulation of the child or young person's needs and a local care plan and will be advised of other resources for support that are appropriate for individual needs. The proposed interim service specification also proposes that not all children and young people who meet the access criteria will need to be seen directly by The Service. A key intervention that will be delivered by The Service is the provision of consultation and active support to local professionals, including support in formulation of needs and risks and individualised care planning. The level and type of consultation offered to the professional network will be determined according to the individual needs of each case and through a process of clinical prioritisation.*

4. Referral sources – substantive change

The current service specification for GIDS states that referrals can be made by staff in health and social services, schools, colleges of further education and by voluntary organisations. *The new interim service specification proposes that referrals may be made by GPs and NHS professionals.* The reason for the proposal is to ensure that children and young people are already engaged with the local health system before a referral is considered by a local health professional into the highly specialist gender dysphoria service, including for the reason that a proposed core feature of the new pathway is a consultation meeting between the specialist service and local health professionals before a referral can be considered for acceptance. The proposal would impact on fewer than 5% of referrals at current referral patterns, in that around 65% of referrals into GIDS are currently made by GPs and around 30% are made by NHS professionals. This proposal relates only to the interim service specification for the Phase 1 services. The interim report of the Cass Review begins to describe a future clinical pathway approach that operates within a managed clinical network, including other statutory agencies, and this pathway will be worked up by NHS England in the coming months through engagement with the Cass Review and other stakeholders.

5. Social transition – clarification

The current GIDS service specification acknowledges that social transition in pre-pubertal children is a controversial issue, that divergent views are held by health professionals, and that the current evidence base is insufficient to predict the long-term outcomes of complete gender-role transition during early childhood.

The interim Cass Report has advised that although there are differing views on the benefits versus the harms of early social transition, it is important to acknowledge that it should not be viewed as a neutral act. Dr Cass has recommended that social transition be viewed as an 'active intervention' because it may have significant effects on the child or young person in terms of their psychological functioning.

In line with this advice, the interim service specification sets out more clearly that the clinical approach in regard to pre-pubertal children will reflect evidence that in most cases gender incongruence does not persist into adolescence; and that for adolescents the provision of approaches for social transition should only be considered where the approach is necessary for the alleviation of, or prevention of, clinically significant distress or significant impairment in social functioning and the young person is able to fully comprehend the implications of affirming a social transition.

Endocrine Interventions

Building the research protocol

The interim service specification reads:

> "*Consistent with advice from the Cass Review highlighting the uncertainties surrounding the use of hormone treatments, NHS England is in the process of forming proposals for prospectively enrolling children and young people being considered for hormone treatment into a formal research programme with adequate follow up into adulthood, with a more immediate focus on the questions regarding GnRHa. On this basis NHS England will only commission GnRHa in the context of a formal research protocol. The research protocol will set out eligibility criteria for participation.*"

In due course NHS England will share details of this work, including plans for how stakeholders and the public will be engaged and consulted on eligibility criteria.

Placing the use of GnRHa in the context of clinical research will have several important benefits:

- It responds directly to Dr Cass' advice that *'Without an established research strategy and infrastructure, the outstanding questions will remain unanswered and the evidence gap will continue to be filled with polarised opinion and conjecture, which does little to help young people, and their families and carers, who need support and information on which to make decisions'*. In this respect the NHS has the opportunity to make a major international contribution to the evidence base in this area.

- Secondly, it will ensure that there is greater transparency for children and their parents / carers around the uncertain clinical benefits and longer-term health impacts surrounding their use.

- Thirdly, it will further strengthen the consent and information sharing process to support informed decision making by young people.

Unregulated drugs

The current service specification for GIDS states that GIDS does not offer shared care with private clinicians, and that in cases where puberty blocking drugs or hormone drugs are prescribed or accessed outside the service, the GIDS will make the young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of any interventions, and will be unable to provide ongoing clinical supervision for the management of these interventions.

The proposed interim specification reads:

> *"Children, young people and their families are strongly discouraged from sourcing GnRHa and masculinising / feminising hormone drugs from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies. In such cases The Service will make the child or young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of the drugs and will advise the GP to initiate local safeguarding protocols.*
>
> *"Should a child or young person access GnRHa from unregulated sources or unregulated providers The Service will not assume responsibility for prescribing recommendations nor will it enter into shared cared arrangements in these circumstances.*
>
> *"Where a child or young person has obtained masculinising / feminising hormones from an unregulated source (such as the internet) The Service will not accept clinical responsibility for management of the endocrine intervention.*

> *“Where a child or young person has been prescribed masculinising / feminising hormones by an unregulated provider outside of the eligibility and readiness criteria described in the current NHS clinical commissioning policy The Service will not accept clinical responsibility for management of the endocrine intervention.”*

The reason for the revised wording is to provide greater clarity and retain and strengthen current safeguards. Senior clinicians have advised NHS England on the need for the new interim service specification to have much clearer wording in this regard so that the interim service specification is less open to interpretation, so that young people, families and professionals are clear on the approach that will be adopted by the NHS in such cases.

How will the proposed changes be implemented?

The proposed interim service specification will inform how the Phase 1 services deliver care and support to young people referred into the gender identity service over the next year.

In parallel, the Cass Review will continue its work to describe the new clinical model to which the Phase 1 services and the new regional services will work in the future. Once Dr Cass has delivered this advice the NHS will build a new service specification and put it out for stakeholder engagement and formal public consultation.

Give us your views on the proposed changes

NHS England would like to hear what patients, parents and carers, clinicians, providers and other interested parties think about the proposed interim service specification for gender dysphoria services.

These are the questions we’re asking as part of the public consultation:

1. **In what capacity are you responding?** (Patient / Parent / Clinician / Service Provider / Other; If you have selected 'Other', please specify.)

2. **Are you responding on behalf of an organisation?** (yes / no; If you have selected "yes", which organisation are you responding on behalf of?)

3. **To what extent do you agree with the four substantive changes to the service specification explained above?**

    A. **Composition of the clinical team**
    (Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

    B. **Clinical leadership**
    (Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

    C. **Collaboration with referrers and local services**
    (Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

    D. **Referral sources**
    (Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

4. **To what extent do you agree that the interim service specification provides sufficient clarity about approaches towards social transition?** (Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

5. **To what extent do you agree with the approach to the management of patients accessing prescriptions from un-regulated sources?**
   (Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

6. **Are there any other changes or additions to the interim service specification that should be considered in order to support Phase 1 services to effectively deliver this service?**
   (comments)

7. **To what extent do you agree that the Equality and Health Inequalities Impact Assessment reflects the potential impact on health inequalities which might arise as a result of the proposed changes?**
   (Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

You can provide your views with NHS England by completing the online survey: https://www.engage.england.nhs.uk/specialised-commissioning/specialist-gender-interim-specification

Your views will help NHS England to further shape and refine this interim service specification for gender dysphoria services, until a new service specification is agreed in 2023, which will be informed by a full consultation and engagement process.

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NHS England

Interim service specification:

Specialist service for children and young people with gender dysphoria (phase 1 providers)

20 October 2022

1. Service name	INTERIM SERVICE SPECIFICATION Specialist Service for Children and Young People with Gender Dysphoria (Phase 1 Providers)
2. Service specification number	GROUP EDITING
3. Date published	TBN
4. Accountable Commissioner	NHS England

5. Summary

This is an interim service specification for 'Phase 1' services pending the establishment of new regional services working to a new national service specification.

The Service will provide multidisciplinary assessment and care to children and young people and their families who will benefit from clinical support around the development of their gender identity, and interventions in response to a diagnosis of gender dysphoria, and consultation and support to local professionals.

The Service will adopt an integrated approach to assessing and responding to an individual's needs in view of the range of co-presentations that may typically present in this patient cohort and the range of complexity relating to gender identity development. The most appropriate clinical pathway for the child or young person will be determined through an integrated multidisciplinary team (MDT) approach.

Providers delivering The Service must be an established specialist tertiary paediatric unit with a strong partnership with mental health services; be an established academic centre with a strong track record of research in children and young people; and have robust safeguarding frameworks in place.

The clinical management approach should be open to exploring all developmentally appropriate options for children and young people who are experiencing gender incongruence, being mindful that this may be a transient phase, particularly for pre-pubertal children, and that there will be a range of pathways to support these children and young people and a range of outcomes.

Children and young people, their families/carers and the local services supporting them will engage with a care pathway which offers brief guidance and referral advice to professionals, initial consultation, ongoing consultation advice and liaison, and collaborative care with local services as well as specialist direct assessment and intervention.

Not all children and young people who present with issues of gender incongruence will require direct interaction with The Service; in many cases appropriate care can be provided locally with support and consultation by The Service. A significant proportion of children and young people who are concerned about or distressed by issues of gender incongruence, experience co-existing mental health, neuro-developmental and/or family or social complexities in their lives.

The relationship between these aspects and gender incongruence may not be readily apparent and will often require careful exploration.

The primary intervention for children and young people who are assessed as suitable for The Service is psychosocial (including psychoeducation) and psychological support and intervention; the main objective is to alleviate distress associated with gender dysphoria and promote the individual's global functioning and wellbeing.

Where children and young people present with co-existing disorders or presentations, these will normally be addressed by the appropriate local service alongside this Service.

6. Population and/or geography to be served

6.1 Population Covered

The defined patient cohort is children and young people up to their 18th birthday who are:

- Registered with a General Practitioner in England or who are otherwise the commissioning responsibility of NHS England; AND
- Who were under the care of the Gender Identity Development Service at the Tavistock and Portman NHS Foundation Trust; OR
- Who were on the NHS waiting list for the Gender Identity Development Service managed by the Tavistock and Portman NHS Foundation Trust; OR
- Who are referred to The Service because gender dysphoria may be present

Terminology

This service specification will refer to **gender incongruence** and **gender dysphoria**. The terms are not interchangeable. Gender incongruence is where the individual's experience of their gender identity does not align with their biological sex. Gender dysphoria is present when the gender incongruence causes clinically significant levels of distress to the individual. Not all individuals with gender incongruence will experience dysphoria.

6.2 Minimum population size

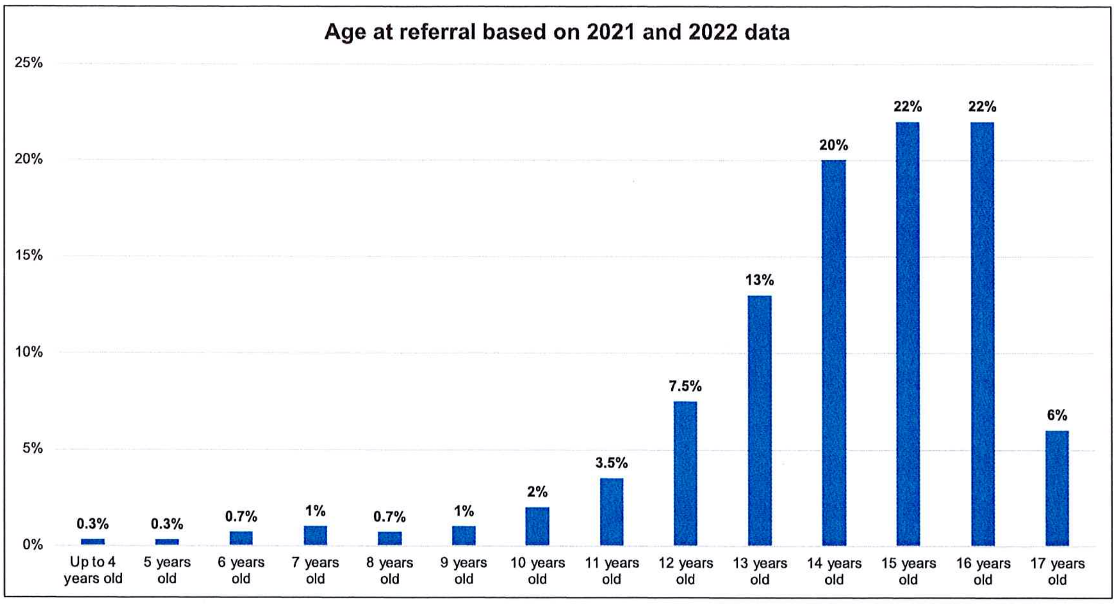
There is no official data on the number of people in England and Wales who present with a degree of gender variance. There is considerable variation in reported prevalence due to factors such as: variable data reporting by providers; differences in diagnostic thresholds applied and inconsistent terminology;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

The number of referrals is currently at 8.7 per 100,000 population per year in 2021/22 compared to 4 per 100,000 in 2020/21 and 4.5 per 100,000 in 2019/20.

The minimum population size for planning a service is estimated to be 5 million based upon current referral rates.

The current referral profile suggests that the majority of referrals will be of children and adolescents following the onset of puberty, and this will be reflected in the composition of the MDT and the clinic environment.

Table: Age at referral; percentage of eligible referrals; based on 2021 and 2022 data



Eligible Patient Cohort

The Service will assume a share of the responsibility for: the existing open caseload; and existing national waiting list of children and young people who are waiting to access a specialist gender dysphoria service. Although new referrals will be made to the Service it is recognised that it is unlikely that the interim Service will be able to offer direct assessment and / or intervention for patients who are new referrals, or to a large proportion of the existing waiting list, before these individuals are transferred to one of the new regional services as they become operational. Before that point, new referrals will be made to the Service as follows, allowing for a degree of individual flexibility, and a collaborative approach across commissioner and providers to ensure an appropriate and equitable distribution:

- Service provider/s in [North] will accept referrals from the following NHS regions: North East and Yorkshire; North West; Midlands
- Service provider/s in [London] will accept referrals from the following NHS regions: East of England; London; South West; South East

7. Service aims and outcomes

7.1 Service aims

Pending the establishment of a new national service specification that will describe the new regional service, this interim service specification describes an interim model for delivery that will:

- Provide initial guidance and referral advice to healthcare professionals
- Provide consultation, liaison and advice to referrers and the professional networks supporting children and young people
- Tailor an individual care plan following a standardised approach to assessment and diagnosis
- Provide psychoeducation and clinical interventions for children and young people with gender incongruence, including support for the family
- Provide advice in respect of and, referral to endocrine (hormone) intervention services
- Work with commissioners to regularly validate the waiting list confirming that individuals wish to be seen and that referral information is adequate to initiate care
- Screen and triage those on the waiting list and all new referrals to determine the most suitable clinical pathway
- Support local services in meeting the gender incongruence needs of children and young people where appropriate through professional liaison and collaboration,
- Through professional liaison and collaboration support local services meet the wider needs of children and young people (including mental health, neuro-developmental and safeguarding) and in risk mitigation
- Build and document the history and nature of gender incongruence

7.2 Outcomes

NHS Outcomes Framework Domains & Indicators

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

Service defined outcomes/outputs

- To deliver a plan defining demand split by regions and capacity and deliverable timeframes for first assessment within 3 months of service initiation.
- To provide continuing high-quality data:
  - A monthly SPC Chart on referrals by region, age, biological sex and aggregated
  - A monthly waiting list summary by region, age, biological sex and aggregated
  - Workforce plan including vacancy status
  - A monthly SPC Chart on first consultations by region, age, biological sex and aggregated
  - A monthly SPC Chart on work in progress (WIP) by region, age, biological sex and aggregated
  - A monthly SPC Chart on discharges by region, and aggregated
- Evidence of engagement with children, young people and families in design and review of service delivery
- Collection and reporting of children and young people's experience of the service

7.3 Audit and evaluation

The Service will take part in continuous data collection, reporting and audit to support the NHS in developing a better understanding of the relevant patient cohorts and for the purpose of evaluating and enhancing the benefits and value of the service model.

NHS England will commission a third party to support a Learning Healthcare System working with designated providers to build standardised workflows, apply continuous improvement and to create a standard data set for service evaluation through audit and research.

8. Service description

8.1 Future Service model

The future service model will be developed while this interim service specification is used to initiate the service development. Providers are encouraged to adopt a range of service provision strategies within a structured framework to determine which approaches should be standardised into the workflow.

As a developing area of clinical practice, commissioned providers must actively participate in an ongoing programme of quality improvement to enable continued refinement of models of patient access, assessment, treatment delivery and follow up. This will include:

- Proactive and visible clinical leadership within each service
- Strong links with primary and community care services
- Enhanced data collection, reporting and audit
- Sharing of data and learning between commissioned providers and with national commissioners
- Identification, sharing and rapid adoption of good practice
- Contributing to the prioritisation and focus of national service and quality improvement programmes and initiatives
- Active participation in and delivery of quality improvement initiatives, both at provider level and through a co-ordinated national network approach
- Regular review of service level data at each stage of the pathway and service user feedback, with prompt delivery of any resulting actions for

improvement, including where inequalities in access or outcomes are identified

It is important that the opportunity is taken to gather further evidence on the safety, potential benefits and harms of Gonadotropin-Releasing Hormone Analogues in children and young people with gender dysphoria.

In addition, well-structured research programmes will be developed by the National Institute for Health Research and academic partners to include for example: epidemiology; prediction; the course of gender querying; and outcomes of psychological treatments to reduce distress. Commissioned centres must:

- Contribute to the identification of study and treatment evaluation priorities through participation in a national steering group
- Deliver research and evaluation programmes within the service and in partnership with other commissioned service providers
- Ensure an enhanced data set is collected from assessment through to follow up to facilitate research and evaluation, including for those whom, following assessment, it is determined would not benefit from intervention by the Service

Providers will build clear relationships with the range of services and skills across all Integrated Care Systems within the regional catchment.

8.2 Current Pathways

The provider will deliver The Service through an integrated MDT. An individual's route will be determined by, among other things, the clarity, persistence and consistency of gender incongruence, the presence and impact of other clinical needs, and family and social context. A care plan should be tailored to the specific needs of the individual following careful therapeutic exploration; this plan may require a focus on supporting other clinical needs and risks with networked local services.

Screening, triage, and professional consultation & advice

The Service will screen individuals who are on the waiting list and new referrals. It will be important for The Service to identify individuals or sub-groups of individuals who are higher risk and this will necessitate consultations with the referrer and local professional network. The purpose of screening and triage is to:

Identify children and young people who are likely to meet the access criteria for The Service as defined by DSM-V (Appendix A)

- Identify children and young people who can be or need to be supported by local services including further support through professional consultation and advice from The Service, including those who meet the access criteria for The Service
- Identify additional mental health needs / neurodevelopmental needs / safeguarding risks that require local professional care planning and support
- Support clinical prioritisation for further specialist assessment and treatment

There are a range of different outcomes following the screening process including discharge with psychoeducation / signposting for family and professionals; professional consultation / advice or care navigation (with or without discharge); and direct assessment by The Service.

Overall clinical responsibility for a patient on the waiting list will remain with the referrer and the local professional network; recommendations are provided as general clinical management principles. A course of action will be agreed between The Service and the local professional network, which may include initial development of risk and care plan.

Referral pathway

A referral can be made by a healthcare professional, who must first make an initial enquiry of The Service prior to a request for professional consultation with The Service. Outcomes from the enquiry will include signposting or links to psycho-educational material, guidance on local referral and/or assessment options and/or a professional consultation meeting, (and who should attend this).

Referral to The Service for direct assessment and/or intervention will require a consultation meeting which is requested and attended by the relevant local secondary healthcare team and / or the GP. Following the professional consultation and agreement to accept a referral for assessment, The Service may advise or require the involvement of appropriate secondary healthcare as an element of the collaborative care plan with local services.

If, after professional consultation between a referrer and The Service, a child or young person is considered suitable for assessment by The Service, the referrer will be advised to proceed with the referral via a standardised referral form. The Service will agree with the referrer an initial formulation of the young person's needs and risks and a local care plan to support the child or young person. The type and level of ongoing support to the local professional network from the Service while the child or young person is on the waiting list for assessment will be commensurate with the needs of the child or young person.

Where the outcome of the initial professional consultation between the Service and the referrer is that the patient does not meet the access criteria for The Service at this time, the patient will not be added to the waiting list – but the family and professional network will have been assisted to develop their formulation of the child or young person's needs and a local care plan and will be advised of other resources for support that are appropriate for individual needs.

In some cases, a further consultation for referral may be appropriate following further local assessment and intervention and/or a process of watchful waiting.

Support to Local Professional Networks

Not all children and young people who meet the access criteria will need to be seen directly by The Service. A key intervention that will be delivered by The Service is the provision of consultation and active support to local professionals, including support in formulation of needs and risks and individualised care planning. The level and type of consultation offered to the professional network will be determined according to the individual needs of each case and through a process of clinical prioritisation.

In summary, the Service will:

- Offer referrers the opportunity for rapid access to make an initial enquiry to address gender incongruence concerns. This may include or lead to more substantive consultation, support and advice.
- Offer specialist support to the professional network in the development and formulation of individual care plans and risk management; this may include local health, social care and education professionals. In more complex cases this is likely to involve regular case consultation meetings and may involve joint consultation appointments with the family and referrer if that is necessary; in some cases this will involve alerting the local network to potential risks and unmet needs that had hitherto not been identified or addressed.
- Identify co-existing mental health, neuro-developmental or other conditions. The Service will formulate a collaborative care plan, co-produced with the local service/s identifying respective roles including local assessment and/or intervention support for co-existing conditions. The Service will not normally

undertake assessments or intervention for co-existing conditions which would be part of the local service's ordinary remit.

- Initiate agreed local protocols where child protection or safeguarding concerns are identified.
- Identify patients who require further specialist assessment and treatment by The Service and/or those who would benefit from further local monitoring and support. This will usually entail the agreeing of specific collaborative care arrangements between the local and the specialist Service clarifying their respective roles and responsibilities.

Standardised Assessment

All children and young people who are accepted for assessment and/or intervention by The Service will do so in the context of a collaborative care agreement with local secondary healthcare services who will identify a lead professional to co-ordinate local care and communication with The Service and the patient and their parents/carers.

All children and young people who are seen by The Service will receive a standardised comprehensive assessment that will identify and formulate a child or young person's needs including developmental history, history of gender incongruence and associated needs and risks. Assessments should be respectful of the experience of the child or young person and be developmentally informed.

Clinicians should remain open and explore the child or young person's experience and the range of support or treatment options and their implications that may best address their needs, including any specific needs of neurodiverse children and young people.

There is an increased prevalence of mental health needs in children and young people who present to gender identity services (such as depression; anxiety; risk-taking behaviours). There is also an increased prevalence of neurodevelopmental disorders including autistic spectrum disorder and ADHD though the cause of the relationship with gender identity is unclear.

A small but significant number of children and young people with very complex needs may also be looked after or may not live with their birth family and may require the active involvement from children's social care and/or expert social work advice. Assessment appointments will aim to identify coexisting needs and their impact on the child or young person, including gender incongruence.

A child or young person with mental health or neurodevelopmental needs and / or risk-taking behaviours that require additional assessment, intervention and support will be supported to access this through professional liaison and care navigation with local services including health, social care and education. The Service should confirm collaborative care arrangements for further assessment and treatment with local services through professional liaison.

Identification of coexisting conditions or needs will lead to an exploration of the relationship between the presentation and gender incongruence through an integrated approach by MDT members.

Assessments will focus on:

- Subjective sense of the child / young person's identity over time
- Their expression of gender identity across different contexts over time and different settings
- Their hopes and expectations and that of their family members/carers and their stance towards the child / young person's gender identification
- Developmental needs including cognitive functioning and capacity of the child / young person, and their understanding of gender
- Associated physical mental health and neurodevelopmental needs and their relationship with gender incongruence
- Risk including mental health, safeguarding including risk of vulnerability and exploitation and impact of any unregulated medications
- Psychosocial functioning and impact of the gender incongruence (eg on educational attendance and progress, or experience of bullying or harassment)
- With adolescents - psychosexual development and any sexual experiences
- Assessment of family functioning and quality of relationships within the family, including children and young people in care (or kinship care or who have been adopted) and the wider community
- Exploration of parent/carer and family views on the child or young person's gender identity journey and family support
- Peer relationships and wider social support
- Family's spiritual, cultural, or religious beliefs

The outcome of the initial assessment including formulation of needs and risks will be confirmed in writing with the GP and referrer and shared with the family. The outcome of assessment may either be discharge to local services, with support or consultation offered to the professional network as appropriate; and / or a referral to local services; or direct work with the child or young person.

Psychoeducation

Provision of or, signposting to psycho-education resources may be key outcomes of both an initial enquiry and a professional consultation meeting. Psycho-education material for children and young people, parents/carers and local professionals alike will include information on gender identity development including research evidence and how to support an exploratory approach that allows their child or young person time and opportunity to consider different options in a flexible and non-judgemental context.

Children, young people accepted for direct assessment and/or intervention, and their parents/carers, will receive further psycho-educational information, including the implications of medical treatment (and non-treatment). Parents, carers and families, (including siblings) will have the opportunity to access additional resources including facilitated group discussions with peers on a similar journey.

Direct work with pre-pubertal children, and their families

The clinical approach in regard to pre-pubertal children will reflect evidence that suggests that, while young people who are gender querying or who express gender incongruence may have started their journey as younger children, in most pre-pubertal children, gender incongruence does not persist into adolescence[1].

Generally, the approach will focus on a careful observation of how gender dysphoria develops as puberty approaches and is reached. The therapeutic approach for younger and pre-pubertal children is not directed at gender dysphoria itself but instead focused on other clinical presentations and needs, or familial/social circumstances that may impact on the child's psychological health and gender dysphoria.

The level of intervention will be commensurate to the individual's needs and may range from advice by The Service to the family and professional network where there are no concomitant issues, to more intensive clinical interventions that seek to address other clinical diagnoses delivered by local secondary services with support, advice and consultation by The Service.

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[1] This is the conclusion of the Endocrine Society's Clinical Practice Guidelines[1] that state "*combining all outcome studies to date, the gender dysphoria / gender incongruence of a minority of prepubertal children appears to persist in adolescence*"[1].

Psychological support and interventions provided directly by The Service will focus on children whose presentations are persistent and who have impaired functioning, with the aims of alleviating or preventing the onset of emotional problems, behavioural problems and social relationship problems, improving psychosocial health and global functioning. Support will be offered as part of the collaborative care agreement with local services and may be provided by the local and/or specialist service and, could be offered through individual / family work or group work.

In cases where a pre-pubertal child has effected, or is effecting, a social transition (or expresses a wish to effect a social transition) the clinical approach has to be mindful of the risks of an inappropriate gender transition and the difficulties that the child may experience in returning to the original gender role upon entering puberty if the gender incongruence does not persist into adolescence.

However, some children state that they want to make a social transition to their preferred gender role long before puberty, which means that increasing numbers of children may have made a partial or full social transition prior to the first attendance with The Service.

In summary, for pre-pubertal children the clinical approach and advice applied by The Service will be supportive and non-judgemental, balancing on a case-by-case basis a watchful approach overall with a more individualised approach in cases where the child's level of global functioning may be maintained or improved through a carefully observed process of exploration of social transition. Medical interventions will not be considered at least until puberty has been reached (Tanner Stage 2).

Direct work with adolescents, and their families

Psychological support and interventions provided directly by The Service, including family therapy/work, will focus on alleviating or preventing the onset of emotional problems, behavioural problems and social relationship problems, improving psychosocial health and global functioning, while responding to co-existing needs and conditions.

Clinicians should remain open and explore the young person's experience and the range of support or treatment options and their implications that may best address their needs, including any specific needs of neurodiverse children and young people. The overall aim is to reduce distress in the individual; support the development of positive self-image and self-esteem; promote the individual's global functioning; facilitate understanding and acceptance within the family unit.

Co-existing mental/physical health, neurodevelopmental and/or wider needs will be addressed through an overall treatment plan and in partnership with local professional services.

Interventions with adolescents should be at a level commensurate with the needs of the individual. More intensive clinical interventions may be needed that seek to address other clinical diagnoses and will be delivered by local secondary services with support, advice and consultation by The Service.

Factors that could influence the complexity and length of the intervention include:

- unstable or escalating mental health problems
- ongoing risk issues, and safeguarding issues
- concerns with regard to capacity to understand and consent
- family conflict about how to proceed
- inadequate support from the local network of agencies and services involved with the young person (where there are any concerns regarding mental health or social functioning).

Not all adolescents will want or benefit from social transition. The provision of approaches to support social transition may be considered in cases where:

- Gender dysphoria has been diagnosed, is consistent and persistent; AND
- Associated needs and risks have been considered and are being addressed or supported; AND
- The young person expresses a clear wish to affirm their gender transition and fully understands the implications of affirming a social transition (informed consent); AND
- The proposed clinical approach is necessary for the alleviation, or prevention of, clinically significant distress or impairment in social functioning in the individual.

In these cases the clinical approach will involve a focus on exploring or supporting (as appropriate to the individual) social transition through psychological support and interventions, family work/therapy and guidance for the local professional network.

Young people and their families will be supported in making difficult decisions regarding the expression of a gender role that is consistent with their gender identity, including the timing of changes to gender role and possible social transition.

The Service will aim to maintain a therapeutic relationship with young people and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a young person has already socially changed gender role prior to being seen by The Service.

Gonadotropin-Releasing Hormone Analogues (GnRHa) (puberty suppressants) and masculinising / feminising hormone drugs

Consistent with advice from the Cass Review highlighting the uncertainties surrounding the use of hormone treatments, NHS England is in the process of forming proposals for prospectively enrolling children and young people being considered for hormone treatment into a formal research programme with adequate follow up into adulthood, with a more immediate focus on the questions regarding GnRHa. On this basis NHS England will only commission GnRHa in the context of a formal research protocol. The research protocol will set out eligibility criteria for participation.

Prescribing from unregulated sources and unregulated providers

Children, young people and their families are strongly discouraged from sourcing GnRHa and masculinising / feminising hormone drugs from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies. In such cases The Service will make the child or young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of the drugs and will advise the GP to initiate local safeguarding protocols.

Should a child or young person access GnRHa from unregulated sources or unregulated providers The Service will not assume responsibility for prescribing recommendations nor will it enter into shared cared arrangements in these circumstances.

Where a child or young person has obtained masculinising / feminising hormones from an unregulated source (such as the internet) The Service will not accept clinical responsibility for management of the endocrine intervention.

Where a child or young person has been prescribed masculinising / feminising hormones by an unregulated provider outside of the eligibility and readiness criteria described in the current NHS clinical commissioning policy The Service will not accept clinical responsibility for management of the endocrine intervention.

Transition to adult services and discharge

The Service will provide support to young people up to their 18th birthday.

The Service will review the needs and progress of the young person in relation to their gender dysphoria and the goals of treatment and will step down or discharge their care to local primary care or secondary care services as appropriate.

For young people who have been seen by The Service and who are approaching their 18th birthday the Service will co-ordinate a transition and support plan with the professional network specific to the young person's needs. A referral may be made to an NHS-commissioned Gender Dysphoria Clinic from 17 years of age where the young person meets the access criteria.

Young people who are approaching 18 years and who, it is determined are unlikely to be seen by the Service before their 18th birthday, may continue to benefit from consultation and liaison support with their local healthcare services where appropriate and will be screened to identify the most appropriate treatment pathway for their needs.

A co-ordinated transfer to appropriate local adult services will be needed where complex presentations continue.

8.3 Essential Staff Groups

The key clinical leadership role will be through a medical consultant with significant experience in the developmental needs of children and adolescents.

The MDT will have (or have access to) the following competencies and experience (see also Appendix B). Practitioners will need access to clinical supervision across a range of clinical areas (eg, psychological, mental and physical health, safeguarding and gender identity development) to support their roles.

- Multi-agency working including provision of consultation, liaison and advice for complex cases, and care navigation
- Expertise in child safeguarding and assessment and management of risk-taking behaviours
- Childhood and adolescent development, including cognitive, social and sexual development; gender identity development and gender expression
- Paediatric medicine, including psychological health

- Child and adolescent mental health, including expertise in assessment and formulation, delivery of evidence based therapeutic interventions, trauma informed approaches; and family work/family therapy
- Neurodevelopment disorders including learning disability and autism spectrum conditions
- Gender incongruence; and gender dysphoria
- Expertise in sex development, and endocrine intervention
- Children and young people who may be Looked After or in Special Guardianship or who may be adopted.

8.4 Essential equipment and/or facilities

The provider must have in place premises that are appropriate to ensure effective delivery of the services described in this service specification; and in an age-appropriate environment that children and young people regard as safe and welcoming. Providers will be mindful that the majority of patients are likely to be of an age following the onset of puberty.

8.5 Interdependent Service Components – Links with other NHS services

The Service must be expert in working with a wide variety of agencies. It is expected that close working will be needed in particular with Children and Young People's Mental Health Services, child health and neurodevelopment services, voluntary community services, education professionals, children's social care and with general practitioners.

The Service should also be competent in their understanding of and close working with children and young people with social care needs – including adopted children and young people, and children in care, and in working with schools and colleges to facilitate wellbeing and full access for their education.

Collaborative care arrangements

Referrers, together with local healthcare services, will agree with The Service collaborative care arrangements particularly in relation to the young person's mental health, neurodevelopmental needs and / or risk-taking behaviours. Local services including children and young people's mental health services, paediatric healthcare services and local authorities will continue to provide the care that they would routinely offer young people and families as part of local or national commissioning

	arrangements across relevant care pathways. It is not the expectation that The Service will address these broader needs. Collaborative care arrangements should be clarified through professional liaison and confirmed in writing with all stakeholders including the young person and parents/carers.
8.6	**Additional requirements** The provider must have in place: • A robust system of clinical governance that ensures, *inter alia*, all clinical staff are trained in assessing and meeting the health needs of children and young people including those on the waiting list, have access to clinical supervision, and are deemed competent to deliver the interventions as per their role; this will include a documented approach to safeguarding that is consistent with NICE guideline NG76[2]. • A robust system of corporate governance, including a nominated senior manager, that demonstrates effective management, guidance, oversight and accountability by the host organisation; and supported by experienced communications and engagement teams. • Arrangements in place to ensure that the service delivers culturally appropriate and trauma informed 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. • Arrangements in place (including ongoing training) to ensure that all staff in public-facing roles have cultural sensitivity towards children and young people who may be gender diverse. • Arrangements in place to ensure that service design and improvement is co-produced with experts by experience and promotes equality, diversity and

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[2] https://www.nice.org.uk/guidance/ng76/chapter/Recommendations#principles-for-working-with-children-young-people-parents-and-carers

inclusion., This should include routine outcomes and experience monitoring and be able to demonstrate how improvement is achieved via means that are accessible, transparent and inclusive.

- Arrangements in place to ensure that feedback, comments and complaints by individuals and their families are acknowledged investigated and responded to promptly; and that the means to complain are publicised and accessible.

8.7 Commissioned providers

Providers delivering The Service must be an established specialist tertiary paediatric unit with strong links to mental health services and have established academic links.

NHS England will establish a framework for a co-ordinated and collegiate approach across all of the new regional services - focusing initially on development of the model and then moving to issues of operational delivery, service development, improvement and audit. This approach will help to ensure continuity of provision for children and young people if they move across sub / regional boundaries.

Providers will co-operate as part of a clinical network with other designated providers to support sharing of best practice, quality improvement and research processes and consistency against the service specification and model of care.

8.9 Links to other key documents

This interim service specification supersedes service specification E13/S(HSS)/e Gender Identity Development Service for Children and Adolescents (2016)

Other key documents:

NHS England Service Specification: Gender Identity Services for Adults (Non-Surgical Interventions); 2019 as amended; 1719

NHS England Clinical Commissioning Policy Prescribing of Cross Sex Hormones as part of the Gender Identity Development Service; 2016

The Cass Review Interim Report, February 2022

NHS England Statement: “Implementing the Recommendations of the Cass Review”, July 2022

Appendix A. DIAGNOSIS OF GENDER DYSPHORIA

DSM-5[3] provides one overarching diagnosis of gender dysphoria, with separate developmentally appropriate criteria sets for children and for adolescents[4].

DSM-5 defines gender dysphoria in **adolescents** as a marked incongruence between one's experienced/expressed gender and their natal sex, lasting at least six months, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's natal sex)
- A strong desire to be treated as the other gender (or some alternative gender different from one's natal sex)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's natal sex)

In order to meet criteria for the diagnosis, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The DSM-5 defines gender dysphoria in **children** as a marked incongruence between one's experienced/expressed gender and natal sex lasting at least six months, as manifested by at least six of the following (one of which must be the first criterion):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's natal sex)
- In boys (natal sex), a strong preference for cross-dressing or simulating female attire; or in girls (natal sex) a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
- A strong preference for cross-gender roles in make-believe play or fantasy play
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
- A strong preference for playmates of the other gender

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[3] Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, American Psychiatric Association, 2022

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

- In boys (natal sex), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (natal sex), a strong rejection of typically feminine toys, games, and activities
- A strong dislike of one's sexual anatomy
- A strong desire for the physical sex characteristics that match one's experienced gender

As with the diagnostic criteria for adolescents, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix B. MULTIDISCIPLINARY TEAM COMPETENCIES AND EXPERIENCE

Gender Incongruence and Gender Dysphoria in Children and Young People under 18 years of age

- Understanding of the wider social context in which specialist health services for gender dysphoria operate; and specifically, understanding of the operation of specialist NHS services for gender dysphoria and gender incongruence in the context of recent judicial, regulatory and commissioning decisions
- Understanding of the contested debate around different management approaches for responding to children and adolescents who have gender incongruence; and the limited evidence base to inform clinical approaches and service delivery; and limited data on outcomes
- Understanding of the various reasons why GPs and health professionals may make a referral to specialist gender services
- Understanding of the current NHS pathway for children and young people up to 17 years
- Understanding of diagnostic formulation of gender dysphoria in children and young people (currently DSM-V moving to ICD-11) on the NHS pathway of care
- Understanding of how gender dysphoria / incongruence presents in children and young people, and the resulting mental health and psychosocial needs of children and young people on the NHS pathway of care including while they are on the waiting list
- Understanding of approaches to care that are delivered by NHS specialist gender services, and support needs and support options for children and young people who have degrees of gender incongruence but who do not meet the diagnostic criteria for gender dysphoria
- Understanding of the intended outcomes for children and young people who are seen by NHS specialist gender services
- Understanding of the relationship / interface between:
    - The Gender Identity Development Service and Adult Gender Dysphoria Clinics
    - Specialist NHS gender dysphoria services and primary care
    - Specialist NHS gender dysphoria services and other statutory services

Multi-Disciplinary Clinical Leadership team

In addition to specific expertise in gender identity development and incongruence, the clinical leadership team of The Service should include strong, consultant level expertise in:

- Paediatric healthcare including child development and endocrinology

- Psychological healthcare including child cognitive and emotional development, psychological interventions and therapy, including consultation and liaison approaches to healthcare delivery
- Mental health diagnoses and intervention, including pharmacological interventions and in-patient mental healthcare
- The psychological and mental health aspects of healthcare for children & young people with physical healthcare need
- Neuro-developmental conditions, including autism and attention deficit with hyperactivity disorder (ADHD)
- Consent and mental capacity in a child development context where there may be a complex and contentious aspects.
- Designing, monitoring and redesigning or improving effective, efficient and responsive care pathways in collaboration with experts by experience

Knowledge and Experience of Specific Presentations and Interventions

Awareness of a range of mental and physical disorders; and knowledge of models of intervention and their application in practice. Including knowledge and experience of:

- Neurodevelopment disorders including autistic spectrum conditions
- Mental health disorders including depressive conditions; anxiety and trauma; eating disorders
- Endocrine conditions including Disorders of Sex Development
- Pharmacology, particularly in the context of gender dysphoria
- Range of risks that may present in the child or young person including deliberate self-harm; exploitation; high risk behaviours; substance abuse
- Family contexts for children and young people that include being a child in care, or kinship care (including special guardianship) or being adopted

Child and Young Person Development

- Knowledge of development in children and young people; including normative development; social and behavioural development; sexual development; gender identity development and gender expression
- Understanding of the differences in sexual identity and gender identity, and expression
- Knowledge and understanding of mental health problems in children and young people
- Knowledge and understanding of neurodevelopment disorders in children and young people
- Knowledge of the physical development of children and young people

	• Knowledge of the needs of young people who are moving from paediatric to adult services • Understanding of mental and physical health problems in children and young people in the context of impact to: - Educational attainment - Social development including formation of peer relationships
Family Development and Relationships	• Understanding of normative family development • Understanding of mental and physical health problems in children and young people in the context of impact to family relationships • Understanding of parents with additional needs and impact of their mental and physical health needs to children and young people
Assessment, Formulation and Diagnosis	• Ability to contribute to assessment, formulation and diagnosis while acting in a consultation role to the professional network (including specialist mental health assessment) • Ability to contribute to risk assessment and management while acting in a consultation role to the professional network
Cultural Competence	• Cultural competence and understanding of equality and diversity principles • Understanding of the wide diversity of children and young people who are referred to specialist gender services • Understanding of the social, emotional and mental health needs of relevant groups in the local communities who share protected characteristics
Multi-Agency Working	• Ability to work within and across different agencies (health; education; social services; youth justice; other) and an understanding of how these agencies operate including the local voluntary sector • Understanding of the role of education services in supporting children and young people with gender incongruence (supporting full access to the curriculum and pastoral support including, vulnerable children policies; toilet and changing room policies; pupils with special education needs and, addressing, exclusion, bullying and harassment) • Ability to act in a coordinating and consultation role in case work, working with professionals across different services and agencies

Safeguarding / Professional	• Recognise and respond to concerns about child protection and safeguarding • Knowledge of legal frameworks relating to children and young people • Knowledge of and ability to work within relevant professional and ethical guidelines • Knowledge of, and ability to work with, issues of confidentiality, consent and capacity

NHS England: Equality and Health Inequalities Impact Assessment (EHIA)

A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal.

12 October 2022

1. **Name of the proposal: Interim Service Specification for Specialised Services for Children and Young People with Gender Dysphoria (Phase 1 Services)**

2. **Summary of the proposal**

In 2020 NHSE commissioned an independent review of how the NHS should care for children and young people with issues of gender incongruence and gender dysphoria (the Cass Review). The Cass Review has concluded that: the current service model is neither safe nor sustainable in the long term; new regional services should be established rapidly, working to a different clinical model; and that services for children and young people with gender dysphoria should be hosted by tertiary paediatric units. NHSE announced in July 2022 that the contract for GIDS would be brought to an end through a managed process, and that it would establish two Phase 1 services that will work to a new interim service specification, pending the establishment of the new regional services from 2023/24. The draft interim service specification that describes the role of these services moves away from the current linear pathway in which all children and young people referred into the service are seen solely by a specialist gender dysphoria practitioner, with more emphasis on identifying and addressing complex co-presentations and a greater emphasis on formation of joint care plans with local professional networks.

The interim service specification proposes the following changes and points of clarification over the current service specification for GIDS:

i. Composition of the clinical team

The current service specification for GIDS describes that the service is delivered through a specialist multidisciplinary team with contributions from specialist social workers, family therapists, psychiatrists, psychologists, psychotherapists, paediatric and adolescent endocrinologists and clinical nurse practitioners.

The new interim service specification proposes to extend the clinical team so that it is a more integrated multi-disciplinary team that, in addition to gender dysphoria specialists, will include experts in paediatric medicine, autism, neurodisability and mental health.

The reason for this proposal is to respond to evidence that there is a higher prevalence of other complex presentations in children and young people who have gender dysphoria, that the early adopter services will also address, working with local services where appropriate. The proposal also responds to the findings of the Care Quality Commission, who in its 2021 inspection report of GIDS concluded that were shortfalls in the multidisciplinary mix required for some children and young people referred to the service; and the interim advice of the Cass Review which concluded (page 69) that "*a fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity … this must include support for any other clinical presentations that they may have*".

ii. Clinical leadership

The current service specification for GIDS does not describe criteria for the clinical lead for the service.

The new interim service specification proposes that the clinical lead for the service will be a consultant medical doctor.

The reason for this change is to reflect that the new integrated clinical teams will have a broader range of clinical disciplines, including medical professionals, who will be addressing a broader range of medical conditions in addition to gender dysphoria; and that oversight of the service by a medical doctor is appropriate given that the service may provide medical interventions to some children and young people by way of puberty blocking drugs and gender affirming drugs.

iii. Collaboration with, and support for, referrers and local services

The current service specification for GIDS describes a tiered approach for progression through the clinical pathway: the first tier involves meetings between the GIDS team and local professionals involved in the care of the child or young person and the second tier involves the child or young person accessing local services for mental health needs with GIDS offering advice to local services. There are numerous references in the current GIDS service specification to joint working between GIDS and local services including through consultation and liaison. However, GIDS has struggled to provide this support to local services in a consistent way given the constraints on the service.

The new interim service specification proposes to retain this tiered approach to progression through the pathway and describes a more structured approach for collaboration with local services in the interests of the child and young person; a referral to The Service will require a consultation meeting between the early adopter service and the relevant local secondary healthcare team and / or the GP. Where the outcome of the initial professional consultation between the Service and the referrer is that the patient does not meet the access criteria for The Service, the child or young person will not be added to the waiting list - but the family and professional network will have been assisted to develop their formulation of the child or young person's needs and a local care plan and will be advised of other resources for support that are appropriate for individual needs. The proposed interim service specification also proposes that not all children and young people who meet the access criteria will need to be seen directly by The Service. A key intervention that will be delivered by The Service is the provision of consultation and active support to local professionals, including support in formulation of needs and risks and individualised care planning. The level and type of consultation offered to the professional network will be determined according to the individual needs of each case and through a process of clinical prioritisation.

iv. Referral sources

The current service specification for GIDS states that referrals can be made by staff in health and social services, schools, colleges of further education and by voluntary organisations.

The new interim service specification proposes that referrals may be made by GPs and NHS professionals.

The reason for the proposal is to ensure that children and young people are already engaged with the local health system before a referral is considered by a local health professional into the highly specialist gender dysphoria service, including for the reason that a proposed core feature of the new pathway is a consultation meeting between the specialist service and local health professionals before a referral can be considered for acceptance. The proposal would impact on fewer than 5% of referrals at current referral patterns, in that around 65% of referrals into GIDS are currently made by GPs and around 30% are made by NHS professionals. This proposal relates only to the interim service specification for the early adopter services. The interim Cass Review begins to describe a future clinical pathway approach that operates within a managed clinical network, including other statutory agencies, and this pathway will be worked up by NHS England in the coming months through engagement with the Cass Review and other stakeholders.

v. Social transition

The interim service specification sets out more clearly that the clinical approach in regard to pre-pubertal children will reflect evidence that in most cases gender incongruence does not persist into adolescence; and that for adolescents the provision of approaches for social transition should only be considered where the approach is necessary for the alleviation of, or prevention of, clinically significant distress or significant impairment in social functioning and the young person is able to fully comprehend the implications of affirming a social transition.

vi. Unregulated sources of puberty blocker drugs and masculinising / feminising hormone drugs

The interim service specification clarifies the position in regard to children and young people who source these drugs from unregulated sources or unregulated providers. It states that, *inter alia*, children, young people and their families are strongly discouraged from sourcing GnRHa and masculinising / feminising hormone drugs from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies. In such cases The Service will make the child or young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of the drugs and will advise the GP to initiate local safeguarding protocols.

3. Evidence that has been considered

Sources of evidence are given below alongside the assessment of impacts to individuals who may share a protected characteristic. Additionally, evidence has been sourced from routine and exceptional reports that have been supplied to NHSE by the Tavistock and Portman NHS Foundation Trust; and from the interim advice offered by the Cass Review.

4. Who will be affected by the changes?

The following cohorts of individuals may be affected by the proposals:

- Children and young people currently under the care of GIDS, and their families
- Adult patients (18+) who remain under the care of GIDS
- Adult patients (18+) who are awaiting a transfer into an adult Gender Dysphoria Clinic following a transfer request by GIDS
- Children and young people who are currently on the waiting list for GIDS, and their families
- Children and young people who may be referred to an early adopter service as new referrals in the future

Table: Patient Numbers at June 2022

Patient Cohort	**Number**	**Rationale**
Children and young people up to 17 years currently under the care of GIDS, and their families	1279	Figure reported to NHSE by Tavistock and Portman NHS Foundation Trust in July 2022 Of this figure, NHS Wales is the responsible commissioner for 50 patients; and various other commissioning bodies are the responsible commissioner for 13 patients
Young people (17+) who have been seen by GIDS, and where a clinical decision has been made to transfer the patient to an adult Gender Dysphoria Clinic, and where the transfer is pending	255	Figure reported to NHSE by Tavistock and Portman NHS Foundation Trust in July 2022 Of this figure, NHS Wales is the responsible commissioner for 8 patients; and another commissioning body is the responsible commissioner for 1 patient
Adult patients (18+) who have been seen by GIDS, and where a clinical decision has not yet been made about appropriate onward pathway	270	Figure reported to NHSE by Tavistock and Portman NHS Foundation Trust in July 2022 Of this figure, NHS Wales is the responsible commissioner for 7 patients; and another commissioning body is the responsible commissioner for 1 patient

Children and young people up on the waiting list for GIDS for a first appointment	7696	Figures reported to NHSE by Tavistock and Portman NHS Foundation Trust in July 2022 Of this figure, NHS Wales is the responsible commissioner for 293 patients; and other commissioning bodies are the responsible commissioner for 87 patients
Children and young people who may be referred to one of the early adopter services in the future under current access arrangements (per year)	5234	This is the combined referral figure for 2021/22 as reported by Tavistock and Portman NHS Foundation Trust and NHS Arden and GEM CSU. This was a 133% increase over the previous year and it is yet unclear whether this represents a consistent trend.
Children and young people who may be likely to source puberty blocker drugs and masculinising / feminising drugs from unregulated sources	-	NHS England does not hold relevant data.

3. Main potential positive or adverse impact of the proposal for protected characteristic groups summarised

Please briefly summarise the main potential impact (positive or negative) on people with the nine protected characteristics (as listed below). Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below. Please note that these groups may also experience health inequalities.**

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
Age: older people; middle years; early years; children and young people.	Any consideration of the impact of the proposal to individuals who may share this protected characteristic has to recognise that the proposed interim Service	Children and young people already in the care of GIDS will be transferred to a Phase 1 service. A clinically led

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	Specification describes a clinical pathway exclusively for children and young people who are aged below 18 years. The age breakdown at point of referral is set out at Appendix A. Therefore the proposals will primarily affect children and young people who are below 18 years of age. NHSE has concluded that the fact that the proposals primarily impact children and young people who may share the protected characteristic of "age" does not result in unfair discrimination. The purpose of the proposed interim service specification is to describe an interim delivery model that is safe, and that is more focused on addressing a child / young person's overall health needs in an integrated way, including through support and consultation to local professionals.	process for the transfer of clinical responsibility from the Tavistock and Portman NHS Foundation Trust to a new provider will be established to mitigate risk. There is a cohort of adult patients who are aged 18 years and above who have not yet been discharged from GIDS. This cohort of adults will not be transferred to a Phase 1 service which will be hosted by tertiary paediatric units; instead an individual care plan will be formed that may involve a transfer to appropriate local services. There is a cohort of young people who are aged 17 years and above who are awaiting a transfer from GIDS to an adult Gender Dysphoria Clinic. This cohort of patients will not be transferred to a Phase 1 service; instead NHSE will deliver a consistent transfer protocol for GIDS and the seven GDCs to adopt to effect the transfer of all such patients by Spring 2023.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
		Referrers will be supported in identifying alternative appropriate services for young people aged 17 years who are referred on to the waiting list until waiting lists are stabilised, where this is possible.
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	Various literature reports that a high proportion of children and young people who are diagnosed with gender dysphoria will also present with other significant comorbidities, though NHSE does not have specific data in regard to children and young people currently under the care of GIDS or who are on the waiting list. The current NHSE Service Specification for GIDS and the wider literature report that a significant proportion of those presenting with gender dysphoria have a diagnosis of Autistic Spectrum Disorder (ASD). Around 35% of young people referred to GIDS present with moderate to severe autistic traits[1]. Individuals with ASD are likely to share the protected characteristic of "disability". Around 70% of people with autism also meet diagnostic criteria for at least one (often unrecognised) psychiatric disorder that further impairs psychosocial	

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[1] *Assessment and support of children and adolescents with gender dysphoria,* Butler et al, 2018

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	functioning, for example, attention deficit hyperactivity disorder or anxiety disorders. Intellectual disability (IQ <70) coexists in approximately 50% of children and young people with autism[2]. There is also an increased prevalence of children and young people presenting to GIDS with severe forms of mental health problems, which may in some cases constitute a 'disability' for the purpose of the Act. The Government's LGBT Survey (2017) reported that 32.5% of respondents from the transgender and non-binary population self-identified as having a disability. NHSE may conclude from the information above that the current proposals may have a disproportionate impact on individuals who share this protected characteristic. However, the proposed interim service specification will have positive impacts to individuals who share this protected characteristic as it describes a more integrated approach to responding to a child or young person's overall health needs including those that may fall within the scope of 'disability' for the	

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[2] *Autism Spectrum Disorder in Under 19s: Support and Management,* National Institute for Health and Care Excellence, 2021

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	purpose of the Act, such as autism, ASD and mental health problems.	
Gender Reassignment	Not all children and young people who will be impacted by the proposals are likely to share this protected characteristic: • Children and young people who are on the waiting list for GIDS, or who may be referred to a Phase 1 service in the future, or who are receiving an assessment by GIDS and who are without a diagnosis of gender dysphoria, do not share the protected characteristic of 'gender reassignment' as a class or cohort of patients. They cannot be treated as "proposing to undergo" a process (or part of a process) for the "purpose of reassigning" their sex "by changing physiological or other attributes of sex". To apply such a definition to these individuals is to make assumptions upon the aims and intentions of those referred, the certainty of those desires and their outward manifestation, and upon the appropriate treatment that may be offered and accepted in due course. • Children and young people who are under the care of GIDS and who have a clinical diagnosis of gender dysphoria may share the protected	A clinically led process for the transfer of clinical responsibility from the Tavistock and Portman NHS Foundation Trust to a new provider will be established to mitigate risk. The proposed interim service specification would prevent referrals by non-health professionals; for the reasons explained, it is not possible to determine whether children and young people who may be impacted by this provision are likely to share the protected characteristic of 'gender reassignment'. As a mitigation to any adverse impact, as new regional pathways are established it is planned that managed networks will be developed that will provide support resources for GPs, schools and families in regard to children and young people who present with less severe manifestations of gender incongruence or gender diversity or who otherwise do

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	characteristic of 'gender reassignment' though none of the relevant clinical information will be known to NHSE, which has no knowledge of each individual's situation in regard to treatment goals. The cohort of children and young people who are most likely to share this protected characteristic are therefore those who are currently under the care of GIDS with an individualised care plan in place. This cohort of patients will not be positively impacted by the terms of the proposed interim service specification, which intends to describe an interim delivery model that is safe, and that is more focused on addressing a child / young person's overall health needs in an integrated way. However – although not a direct impact of the proposed service specification itself – NHSE will be mindful that this cohort of individuals may be disproportionately impacted by the potential risks of a transfer of ongoing care to another provider, including: anxiety and distress about the perceived uncertainty of the outcome of the process of transfer; loss of clinical staff and interruption to ongoing care; inconvenience and anxiety about visiting a different provider.	not meet the access criteria for a specialised gender dysphoria service. The proposed interim service specification provides further clarity to the terms of the current GIDS service specification in regard to children and young who source puberty blockers drugs and endocrine drugs from unregulated sources; for the reasons explained, it is not possible to determine whether children and young people who may be impacted by this provision are likely to share the protected characteristic of 'gender reassignment'. These provisions are in line with the advice of senior clinicians and reflect, in part, the legal duties on NHS bodies in regard to safeguarding. The independent Multi Professional Review Group will continue to operate in the case of referrals of children under 16 years to the endocrine clinics until the research protocol is established. Mitigating actions in regard to children and young people who are currently

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
		under the care of GIDS, and their families, will focus on ongoing, clear and timely individual communication.
Marriage & Civil Partnership: people married or in a civil partnership.	NHSE is of the view that the proposed interim service specification does not discriminate against individuals who share this protected characteristic.	
Pregnancy and Maternity: women before and after childbirth and who are breastfeeding.	NHSE is of the view that the proposed interim service specification does not discriminate against individuals who share this protected characteristic.	
Race and ethnicity[3]	NHSE does not hold detailed data on the race and ethnicity of children and young people who are referred to GIDS or who are under the care of GIDS. In April 2022 the Tavistock reported to NHSE that of children and young people who were referred in quarter four of 2021/22 ethnicity data was not available for 66.1% of referrals. See Appendix A.	There may be wider issues that need to be addressed in identifying and addressing the potential inequalities issues that arise in the planning and delivery of gender dysphoria services. In the immediate term, the proposed interim service specification requires the early adopter providers to take

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[3] Addressing racial inequalities is about identifying any ethnic group that experiences inequalities. Race and ethnicity includes people from any ethnic group incl. BME communities, non-English speakers, Gypsies, Roma and Travelers, migrants etc.. who experience inequalities so includes addressing the needs of BME communities but is not limited to addressing their needs, it is equally important to recognise the needs of White groups that experience inequalities. The Equality Act 2010 also prohibits discrimination on the basis of nationality and ethnic or national origins, issues related to national origin and nationality.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	Of the data that is available, the majority of children and young people are recorded as "White British' (71.7% of patients excluding those who are not recorded to an ethnic group) which reflects previous data collection for adult gender dysphoria services that suggests that there is under-representation of Black, Asian and Minority Ethnic (BAME) people accessing gender dysphoria services in England. There is evidence that transgender people from BAME groups are more likely to face discrimination on the basis of their race and gender and often within their religious community as well. NHSE is of the view that the current proposals do not discriminate against individuals who share this protected characteristic.	part in continuous data collection, reporting and audit to support the NHS in developing a better understanding of the relevant patient cohorts and for the purpose of evaluating and enhancing the benefits and value of the service model. Separately a programme of work to develop the data strategy for adult Gender Dysphoria Clinics is currently underway within NHS England.
Religion and belief: people with different religions/faiths or beliefs, or none.	There is limited available evidence on the religious attitudes and beliefs of trans people in the United Kingdom, although The Trans Mental Health Study found that most people who took part stated that they had no religious beliefs (62%). A data collection exercise of adult Gender Dysphoria Clinics undertaken by NHS England in 2016 reaffirmed the findings of this study but it is unclear as to the extent to which the findings may relate to children and young people. NHSE is of the view that the current proposals do not	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	discriminate against individuals who share this protected characteristic.	
Sex: men; women	Figures published by the Cass Review in March 2022 show a trend since 2011 in which the number of natal females is higher than the number of natal males being referred. Prior to that the split in the GIDS caseload was roughly even between natal girls and natal boys, but by 2019 the split had changed so that 76% per cent of referrals were natal females. That change in the proportion of natal girls to boys is reflected in the statistics from the Netherlands (Brik et al "*Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*" 2018). As such, those who are natal female are more likely to be disproportionally affected by any negative implications of the change than those who are natal male, as they make up a greater proportion of the group of affected individuals. However, the proposed interim service specification does not unfairly discriminate against individuals who share this protected characteristic. The purpose of the proposed interim service specification is to describe an interim delivery model that is safe, and that is more focused on addressing a child / young person's overall	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	health needs in an integrated way, including through support and consultation to local professionals.	
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.	NHSE does not hold relevant data. However, the proposed interim service specification does not unfairly discriminate against individuals who may share this protected characteristic. The purpose of the proposed interim service specification is to describe an interim delivery model that is safe, and that is more focused on addressing a child / young person's overall health needs in an integrated way, including through support and consultation to local professionals.	

4. Main potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). Please state **N/A if your proposal will not impact on patients who experience health inequalities.**

Groups who face health inequalities[4]	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
Looked after children and young people	Positive impact - the proposed interim service specification requires that the clinical MDT has expertise in children and young people who may be Looked After or in Special Guardianship or who may be adopted.	
Carers of patients: unpaid, family members.	NHSE is of the view that the proposals do not discriminate against individuals who share this characteristic.	
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	The proposed interim service specification requires patients to be registered with a GP in order to access the service (this requirement maintains the provisions of the current service specification for GIDS).	Individuals who are homeless are more likely to encounter difficulties in registering with a GP. NHSE has issued guidance to GP practices, based on the Patient Registration Standard Operating Principles for Primary Medical Care (2015) that *"A homeless patient cannot be refused registration on the basis of where they reside because they are not in settled accommodation".*

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[4] Please note many groups who share protected characteristics have also been identified as facing health inequalities.

Groups who face health inequalities[4]	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	NHSE is of the view that the proposals do not discriminate against individuals who share this characteristic.	
People with addictions and/or substance misuse issues	NHSE is of the view that the proposals do not discriminate against individuals who share this characteristic.	
People or families on a low income	NHSE is of the view that the proposals do not discriminate against individuals who share this characteristic.	
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).	NHSE is of the view that the proposals do not directly discriminate against individuals who share this characteristic.	
People living in deprived areas	NHSE is of the view that the proposals do not discriminate against individuals who share this characteristic.	
People living in remote, rural and island locations	NHSE is of the view that the proposals do not discriminate against individuals who share this characteristic.	Over the longer term, the expansion of the number of services across the country may reduce current adverse impacts such as travel costs and inconvenience of travelling long distances.
Refugees, asylum seekers or those experiencing modern slavery	NHSE is of the view that the proposals do not discriminate against individuals who share this characteristic.	
Other groups experiencing health inequalities (please describe)		

6. Engagement and consultation

a. Have any key engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	**No X**	**Do Not Know**

7. What key sources of evidence have informed your impact assessment and are there key gaps in the evidence?

Evidence Type	Key sources of available evidence	Key gaps in evidence
Published evidence	As detailed in the current Service Specification for GIDS; or detailed in this impact assessment (above). As detailed in the interim report of the Cass Review (March 2022).	Limited published evidence around risk, benefits and outcomes of GnRHa and masculinising / feminising drugs (as per NICE evidence reviews 2020)
Consultation and involvement findings	As detailed in the interim report of the Cass Review (March 2022).	
Research		
Participant or expert knowledge For example, expertise within the team or expertise drawn on external to your team		

8. Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please add an x to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			
The proposal may support?	X	X	X
Uncertain whether the proposal will support?			

9. Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		
The proposal may support?	X	X
Uncertain if the proposal will support?		

10. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1	Future clinical model for responding to children and young people with gender incongruence / gender dysphoria.	The Cass Review will work with NHSE and other stakeholders to define the new clinical model for adoption by the new regional services from 2023/24. The phase 1 services will use an interim service specification until a new national service specification is adopted.
2	Risks, benefits and outcomes of GnRHa and masculinising / feminising drugs	Cass Review has described proposals for research activities; and following advice from the Cass Review NHS England is in the process of

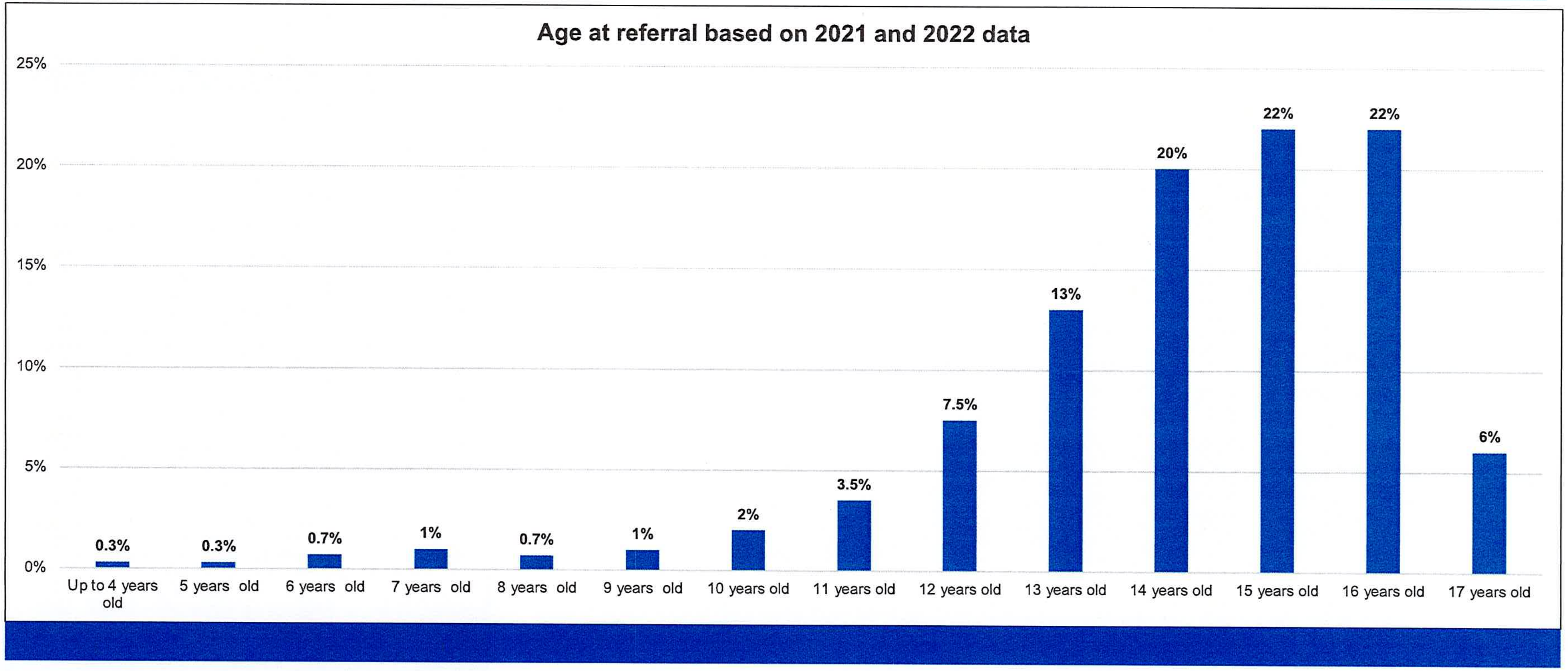
		forming proposals for prospectively enrolling children and young people being considered for hormone treatment into a formal research programme with adequate follow up into adulthood, with a more immediate focus on the questions regarding GnRHa.
3		

11. Summary assessment of this EHIA findings

The proposed interim service specification change is a reasonable and appropriate measure that is intended to confer benefit upon this cohort of children and young people by way of describing a safe service that will operate in a robust clinical governance framework, and that offers a more integrated approach to responding to a child or young person's overall health needs. A public consultation will be held from October 2022 that will seek views on the potential equality impacts of the proposals, and the findings of this EHIA will be reviewed in light of the submissions that are received.

Appendix A

Age at referral



Appendix B

Data return by Tavistock and Portman NHS Foundation Trust
Ethnicity of patients referred in Q4 of 2021/22

GIDS: Q4 Referred Patient Ethnicity

Ethnic Group	*Count*	*%*
Any Other Ethnicity	**1**	*0.2%*
Asian or Asian British – Any Other	**5**	*0.8%*
Black or Black British - Caribbean	**1**	*0.2%*
Mixed – Any Other	**1**	*0.2%*
Mixed – Black & White	**3**	*0.5%*
Mixed – White & Asian	**1**	*0.2%*
Mixed – White & Black Caribbean	**1**	*0.2%*
Not Known – Not Requested	**4**	*0.6%*
Not Stated – Client Refused	**8**	*1.2%*
Not Stated – Client Unable to Choose	**28**	*4.2%*
White – Any Other	**11**	*1.7%*
White – British	**160**	*24.3%*
White – English	**9**	*1.4%*
White – Irish	**2**	*0.3%*
Blank	**424**	*64.3%*
TOTAL	**659**	