NHS England

Interim Gender Dysphoria Protocol and Service Guideline 2013/14

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Interim Gender Dysphoria Protocol and Service Guideline 2013/14

Approved by the Clinical Priorities Advisory Group (CPAG) on 12 July 2013

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Interim NHS England Gender Dysphoria Protocol and Service Guideline 2013/14

1. Introduction

In 2012/13, NHS England's Clinical Reference Groups (CRGs) were asked to develop a number of draft service specifications and commissioning policies, to support the nationally consistent commissioning of specialised services across the country. These service specifications and commissioning policies were subject to a short public consultation. Feedback received during this consultation was used to further develop the specifications and policies for use in contracting with providers.

NHS England was unable to recommend adoption of the specifications and commissioning policies developed by the former Gender Services CRG (2012-13) because of the volume of feedback received in relation to those documents, in particular relating to equality and equity of access issues. At its March 2013 meeting, the Clinical Priorities Advisory Group (CPAG) supported the recommendation to not adopt the gender identity commissioning policy and specifications. NHS England has committed to a programme of work, led by Professor Steve Field and the equalities directorate, to address the inequality issues raised during consultation. The development of this protocol, to ensure consistent commissioning, is the first output from this piece of work, and specifically addresses equity of access. NHS England has used the widely consulted Scottish Protocol as the basis of this interim approach. This was to ensure a safe starting point where consensus could be established.

This protocol and guideline document is the culmination of extensive work to adapt the Scottish protocol so that it fits with NHS England structures; to ensure it meets the needs of patients; and establishes the right checks and balances to ensure safe delivery through the NHS commissioned services. Two stakeholder events were held in London in June, involving both patients and non-service related stakeholders, and separately with clinicians and services, in order that facilitated and honest debate could take place on the proposed document. The outputs of those events have been considered and included in the document.

The purpose of the interim protocol and guideline is to bridge the time period between the present, fragmented commissioning and provision of these services, and an agreed NHS England policy and service specification that will be developed through the CRG in the coming months in readiness for the 2014/15 contracting round. It will provide interim consistency, equality and equity of access across the country and drive out the significant variation currently experienced by patients.

There will be a financial impact should the interim protocol and guideline be adopted but this relatively small unit cost for a small cohort of patients relates in the main to Facial Hair Reduction for male to female transition.

2. Equality Statement

Throughout the production of this document, due regard has been given to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations

between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

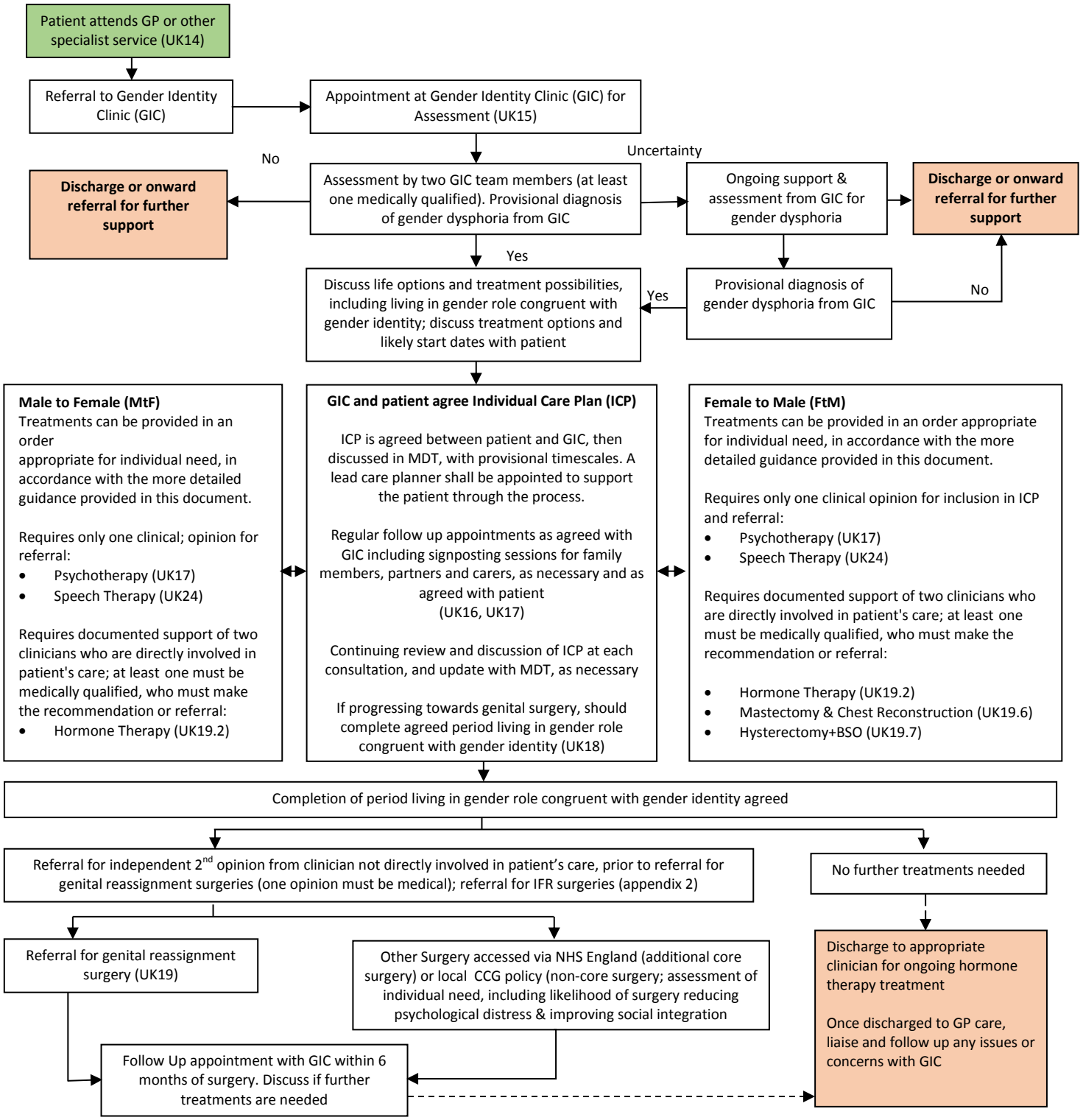
3. The Protocol

This interim Protocol and Service Guideline for Gender Identity Services commissioned by NHS England is largely derived from the 2012/13 NHS Scotland Protocol & Service Specification. It is intended for implementation from July 2013 and will, in due course, be superseded by a definitive English policy and services specification, based upon the recommendations of the Clinical Reference Group for Gender Identity Services. The protocol was approved at the Clinical Priorities Advisory Group (CPAG) meeting 12th July 2013. There was a delay in publishing as we awaited the release of the UK Intercollegiate Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria, which was released by The Royal College of Psychiatrists on the 25th October 2013.

This document should be used in conjunction with the UK Intercollegiate *Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria* and is cross-referenced to its relevant sections. It should be interpreted and implemented in a manner that is consistent with the UK Intercollegiate *Good Practice Guidelines*. This document is not intended to be exhaustive in content; issues not covered in this document should be managed in accordance with the UK Intercollegiate *Good Practice Guidelines*.

3.1 Protocol Flow Chart

When implementing the protocol, the patient should be a full participant in decisions about their healthcare and wellbeing and be given any information or support that they need in order to do so.



3.2 Protocol Notes

1. Transsexualism is the desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment (ICD-10 code F64.0).

2. Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristic).[1] Trans and gender variant people are not necessarily gender dysphoric.

3. Patients with atypical gender identity development but not diagnosed with gender dysphoria will be supported on to a treatment pathway appropriate to their need by the Gender Identity Clinic (GIC).

4. Some, but not all, patients may require formal psychiatric intervention to assist with psychiatric comorbidities and in such cases shared care may be appropriate.

5. Assessment, diagnosis and confirmation of gender dysphoria must be by a health professional who specialises in gender dysphoria and has general clinical competence in diagnosis and treatment of mental or emotional disorders, for example psychiatrists and psychologists. (Refer to page 22 of WPATH Standards of Care, V7 for further information)[2]

6. NHS England may commission a specialised Gender Identity Clinic (GIC) service from providers able to deliver the range of multi-disciplinary services described in this document, and offer effective and high-quality care for gender dysphoria. Historically, such services have been single-centre, consultant-led, multidisciplinary teams but other models, for example multi-centre, multi-disciplinary clinical networks involving General Practitioners with special interest in gender dysphoria, are not excluded. However, it is a requirement that both single-centre and multi-centre clinical network providers:

    - Have an effective multi-disciplinary team (MDT) that meets regularly, either in person or through electronic communication
    - Deliver patient care that is based upon individual care plans that are agreed and reviewed by the provider's multi-disciplinary team (MDT)
    - Are able to offer the complete range of multi-disciplinary services described in this document
    - Are able to meet team member training and quality standards that will be determined from time to time by NHS England.

7. A period of living in the gender role that is congruent with the individual's gender identity (sometimes called "real-life experience") *before* the provision of genital

[1] The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version, September 2011 (page 5), http://www.wpath.org/
[2] Ibid, (page 22)

reassignment surgery is required by authoritative guidelines; this is described in Appendix 1 below. The duration of this period is typically 12 to 24 months [UK18.3].

8. At the beginning of the period of living in the gender role that is congruent with the individual's gender identity, the GIC and patient should discuss the practicalities and requirements of the experience and details of patient and family support mechanisms as well as the possible treatments available.

9. The period of living in the gender role that is congruent with the individual's gender identity can be extended if the GIC and / or patient feel that further time is needed or if attendance at the clinic is inconsistent.

10. A lead professional will be named on all individualised care plans developed, to provide a link for the patient to the GIC and to ensure follow up of all patients at appropriate intervals. This individual will also ensure that the patient receives appropriate after care.

11. Throughout the process of gender reassignment all treatments, procedures, access criteria, associated risks and expectations should be clarified with the patient. An individualised programme of information provision, services, treatment, and surgery as appropriate to the person's individual needs and situation should be discussed and agreed as the patient progresses through the period of living in the gender role that is congruent with the individual's gender identity. Treatment can be reviewed and modified by agreement of those involved.

12. Patients who elect not to have surgery can continue on hormone therapy. This may be supervised by specialist endocrinologists or gynaecologists if this supervision is available. The appropriate clinician should assume responsibility for continued prescribing of hormone therapy (with support as required from the GIC). GICs should ensure that GPs are aware of the hormone management guidelines as detailed in the protocol. In cases where there is uncertainty about the stability of the patient's gender role, gender specialists should consider offering regular (e.g. annual) review appointments.

13. Surgical providers should inform primary care medical and nursing staff of the nature of the procedure, anticipated post-operative care needs, common complications and contact details of the surgical team and associated nursing staff (who provide post-operative care to local patients) as may be clinically appropriate. Good communication is necessary to optimise patient experience and promote a seamless transition from surgical unit to primary care-based care. Hair removal, by laser depilation or electrolysis, at tissue donor sites for genital surgery will be arranged according to guidance from or recommendations of the surgical provider.

14. All patients who have surgery should be offered an appointment with the GIC after surgery according to clinical need and within 6 months of surgery to discuss any issues and be provided with a post-operation plan. Information regarding the procedures and post-operation plan should be made available to primary care staff, including district and practising nursing staff. This should also be provided for the patient's GP.

Appendix 1 – The requirement for a period of living in the gender role that is congruent with the individual's gender identity before genital reassignment surgery (sometimes called "Real Life Experience")[3]

The rationale for a period of living in the gender role that is congruent with the individual's gender identity before genital reassignment surgery, living in an identity-congruent gender role is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

The social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from the Gender Identity Clinic and from peers can be invaluable in ensuring a successful gender role adaptation.

The duration of this period for at least 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

The GIC should clearly document a patient's experience in the gender role in their medical records, including the start date of living in their chosen gender role. Patients will be required to provide the GIC with verification that this criterion has been fulfilled e.g. collateral interviews, official documentation from employers, educational institutions or other formal organisations. The period of living in the gender role that is congruent with the individual's gender identity before genital reassignment surgery can be extended if the GIC and/or patient feel that further time is needed or if attendance at the GIC is inconsistent.

On completion of the period of living in the gender role that is congruent with the individual's gender identity before genital reassignment surgery, the patient and GIC will review and agree their treatment plan and revisit the discussion on treatments, procedures, access criteria, associated risks and expectations (refer to appendix 2 for information for treatment plan discussion).

Patients who elect not to have surgery can continue on hormone therapy. This may be supervised by specialist endocrinologists or gynaecologists, if this supervision is available. The appropriate clinician (usually the patient's GP) should be asked to assume responsibility for continued prescribing of hormone therapy (with support as required from the GIC). GICs should ensure that GPs are aware of the hormone management guidelines as detailed in the protocol. In cases where the patient wishes to continue hormone

[3] Adapted from The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version, September 2011 (page 61), http://www.wpath.org/

therapy and there is uncertainty about the stability of their gender role, the GIC should consider offering regular review appointments.

Appendix 2 – Treatment information to help inform Treatment Plan discussions

After a period of assessment, typically two to four consultations shared between two clinicians, one of which must be medically qualified, a provisional diagnosis should be agreed. If there is no diagnosis of gender dysphoria or atypical gender development, the GIC and patient should discuss appropriate options for future care. The GIC will write to the referring clinician and/or the patient's GP, informing of appropriate options for the future care of their patient and ask them to make any necessary referral. If a diagnosis of gender dysphoria or atypical gender development is made, the patient will continue with care in the GIC.

Once a diagnosis of gender dysphoria or atypical gender development is made, an Individual Care Plan (ICP) should be agreed between the GIC and the patient, after which the patient may access some treatments (to include psychotherapy, speech therapy and facial hair reduction) specified in the ICP through the GIC (or network). The responsible GIC clinician should discuss their patient's ICP with the GIC Multi-Disciplinary Team (MDT); once approved, other treatments specified in the ICP may be accessed through the GIC (or network). The treatments listed in the table below are those which are commissioned by NHS England and available through NHS England-commissioned GICs. The list is not intended to be prescriptive in terms of every patient having to access every treatment for their intended gender. Treatment should be flexible in response to individual needs and circumstances.

Treatments governed by the Gender Reassignment Protocol and Guideline	
Ongoing psychotherapy and counselling	Regular psychotherapy and counselling should be available throughout the patient's individualised gender dysphoria care pathway. This should be provided by therapists and counsellors with specialist knowledge of gender issues. Where such psychotherapy and counselling is not available within the GIC, GIC clinicians should signpost patients to external providers and support networks if required. The GIC should also provide information for patients' families, partners and carers. If necessary, GIC clinicians should signpost patients' families, partners and carers to external providers and support networks.
Hormone Therapy	NHS England expects GPs to co-operate with their commissioned GICs and to prescribe hormone therapy recommended for their patients by the GIC. They are also expected to co-operate with GICs in patient safety monitoring, by providing basic physical examinations (within the competence of GPs) and blood tests recommended by the GIC. The GIC is expected to assist GPs by providing relevant information and support, including the interpretation of blood test results. Hormone therapy should be monitored at least 6 monthly in the first 3 years and yearly thereafter, dependant on clinical need.
Facial hair removal	This is an essential treatment for MtF patients. Removal of facial hair relates directly to confidence and safety whilst undertaking the RLE. Electrolysis, laser and Intense Pulse Light (IPL) treatment may be used. See appendix 4.
Speech therapy	Speech and language therapy enables patients to work towards a voice which is more appropriate for their chosen gender. The GIC may request the patient's GP to refer them to a local provider. On the rare

	occasions that speech therapy proves to be unsuccessful, then voice modifying surgery may be considered through the NHS England IFR process.
Hair removal donor site	Successful hair removal from the donor site used for genital reconstructive surgery is key to avoiding further post-surgery complications. Laser depilation or electrolysis prior to surgery is recommended for this. See appendix 4.
Surgical treatments	
Male to Female (MtF)	Not all patients will undergo genital reassignment surgery. Patients will be referred for surgeries as agreed in their treatment plan. Procedures offered may include some or all of the following: • Penectomy (Removal of the penis) • Bilateral orchidectomy (Removal of the testes) • Vaginoplasty (Creation of the vagina) • Clitoroplasty & Labiaplasty (Creation of clitoris and labia)
Female to Male (FtM)	Not all patients will undergo genital reassignment surgery. All patients with a uterus receiving long-term testosterone therapy will be offered hysterectomy and bilateral salpingo-oophorectomy. Patients will be referred for surgeries as agreed in their treatment plan. • Bi-lateral mastectomy (removal of breasts) and chest reconstruction FtM patients may require this life-changing surgery early in their pathway so as not to perpetuate respiratory and other problems caused by wearing binders, and also to “pass” effectively in male gender (appendix 3) • Hysterectomy (Removal of uterus) • Vaginectomy (Removal of vagina) • Salpingo-oophorectomy (Removal of ovaries and Fallopian tubes) • Metoidoplasty (Creation of micropenis) • Phalloplasty (Creation of penis from using skin and muscle tissue from another site, e.g. abdomen, forearm or thigh) • Urethoplasty (Creation/join-up of urethra) • Scrotoplasty (Creation of scrotum) • Placement of an appropriate penile prosthesis (inflatable or malleable) • Placement of testicular prostheses • Subsequent specialist surgery to restore urinary or sexual function, if clinically indicated

Some patients may require more extensive core treatment procedures than those described in the Protocol and guideline. Additional core procedures will only be considered by the four NHS England Area Team Individual Funding Request (IFR) panels on an exceptional basis.

Additional core procedures are:

- Additional or revision surgery to breasts, chest or genitals
- Voice modifying surgery

Referrals made under the IFR process should be clear and contain all relevant clinical information so that the NHS England Area Team IFR panel is able to make a proper assessment of the justification for performing such procedures.

The NHS England Area Team IFR panel must base its decisions on clearly defined and published criteria: to ensure equitable access to these treatments for patients throughout England, NHS England Area Team IFR panels must also ensure that their decision making process is consistent with other Area Team IFR panel practice throughout England.

Procedures not exclusive to gender reassignment ("non-core" procedures)
Some patients may require other medical procedures as part of the process of transforming their body to be more congruent with their gender. Other procedures that are not considered within the Gender Reassignment Protocol can only be considered by the patient's Clinical Commissioning Group (CCG). Examples of such procedures are given in the table below.

"Non-core" surgical procedures are not routinely commissioned by the NHS and can only be provided on an exceptional clinical need basis. Patients will only be referred for this surgery following a clinical assessment by their GIC and where a symptomatic or functional requirement for surgery has been identified. All cases will be referred to the patient's GP's CCG for consideration and assessment against CCG Policy. Access criteria will consider age, body mass index (BMI), impairment of function, and psychological distress. Referral for consideration does not necessarily mean that surgery will be offered. **This must be communicated to the patient.**

Treatments that may be sought through the CCG Policy	
Breast augmentation (augmentation mammoplasty)	This should only be considered where there is a clear failure of breast growth in response to adequate hormone treatment. Review of breast development in anticipation of breast augmentation surgery should be made no earlier than after the completion of 18 months of adequate hormone treatment. It should be made clear to patients during individual treatment plan discussions that assessments of the appropriateness of breast augmentation will be made no earlier than after the completion of 18 months of adequate hormone treatment.
Facial Feminisation Surgery (FFS)	Treatments may include: • Thyroid chondroplasty / Tracheal shave (reducing size of larynx) • Rhinoplasty (nasal surgery) • Facial bone reduction • Blepharoplasty / Facelift
Lipoplasty / Contouring	Liposuction and / or body sculpture

Gamete storage	Using similar protocols as with those receiving radiotherapy and other gamete damaging procedures

Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.

Appendix 3 – Treatment criteria

Within this section you will find information on criteria for the recommendation for and prescription of hormone therapy, and for surgical procedures. Further more detailed information and evidence-based clinical guidance can also be found in the UK Intercollegiate *Good Practice Guidelines for the Assessment & Treatment of Adults with Gender Dysphoria* and *The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, 7th Version* (September 2011), http://www.wpath.org

Recommendation for prescription of feminising/masculinising hormone therapy

NHS England expects GPs to co-operate with their commissioned GICs and to prescribe hormone therapy recommended for their patients by the GIC. They are also expected to co-operate with GICs in patient safety monitoring, by providing basic physical examinations (within the competence of GPs) and blood tests recommended by the GIC. The GIC is expected to assist GPs by providing relevant information and support, including the interpretation of blood test results. The recommendation from a GIC to prescribe hormone therapy must be made by a medically-qualified person. The recommending doctor shares ethical and legal responsibility for the decision to prescribe with the physician who writes the prescription for hormone therapy.

The recommended content of the letter of recommendation to the patient's GP for feminising/masculinising hormone therapy is as follows[4]:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;
4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

Hormone Therapy

Criteria for the prescription of hormone therapy

The GIC must first ensure patients meet the following eligibility and readiness criteria as adapted from the World Professional Association for Transgender Health (WPATH)

[4] Ibid (page 26)

Standards of Care[5] before taking the decision to refer to the appropriate clinician for prescription of hormones.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Aged at least 17 years (see Appendix 5 for protocol details for children and adolescents aged under 18);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

The presence of co-existing mental health concerns does not necessarily preclude access to feminising/masculinising hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

A recommendation for hormone therapy may form part of the patient's Individual Care Plan (ICP), and must be agreed between the GIC and the patient. The decision to recommend hormone therapy should have the documented support of two clinicians who are directly involved in patient's care; at least one must be medically qualified, who must make the prescribing recommendation.

In most circumstances, the patient will have completed their GIC assessment prior to the GIC physician making a recommendation for hormone therapy. Typically, this will be around six months, but no less than 3 months, after the patient's first consultation. However, the GIC physician, the patient's GP or another medical practitioner involved in the patient's care may prescribe "bridging" endocrine treatments as part of a holding and harm reduction strategy while the patient awaits specialised endocrinology or other gender identity treatment and/or confirmation of hormone prescription elsewhere or from patient records.

There is no requirement for the patient to have commenced a social role transition before a recommendation is made for hormone therapy.

Full discussion of fertility issues, including the possibility of gamete storage, should precede endocrine treatment.

It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions.

Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria.

[5] The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, 7th Version, September 2011 (P 34-50), http://www.wpath.org

Hormone therapy can provide significant comfort to gender patients who do not wish to transition to a different gender role or undergo surgery, or who are unable to do so. Hormone therapy may be recommended for patients who do not want surgery following assessment following assessment by GIC clinicians and in accordance with the standards described above. In some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for transition to a different gender role or surgery.

Risks

It should be noted that there is limited data on the long term health risks of hormone treatment and patients should be made aware of the risks and the importance of long term monitoring. Some risks are identified in the following hormone management guides.

Continuous use of testosterone therapy in trans-men with an intact uterus increases their risk of developing endometrial hyperplasia and malignancy. Trans-men should be informed of this before commencing testosterone therapy and be strongly recommended to have a hysterectomy and bilateral salpingo-oophorectomy after receiving continuous testosterone therapy for 2-5 years.

Further information on the medical risks of hormone therapy can also be found in the UK Intercollegiate *Good Practice Guidelines* and WPATH Standards of Care, 7th Version (page 97) and on an official NHS Website.

Guidance on appropriate hormone management for patients undergoing gender transition and/or long-term trans-gender living may be found in the UK Intercollegiate *Good Practice Guidelines*.

Surgical treatment

Criteria for surgical procedures

To undergo such major irreversible procedures patients must be sufficiently physically fit and meet the criteria listed below as adapted from the WPATH Standard of Care, 7th version.

Bilateral mastectomy and FtM chest reconstruction

For transsexual men, this procedure is usually the first surgery performed and for some patients it is the only surgery undertaken. A recommendation for bilateral mastectomy and chest reconstruction may form part of the patient's Individual Care Plan (ICP), and must be agreed between the GIC and the patient. The decision to recommend this surgery should have the documented support of two clinicians who are directly involved in patient's care; at least one must be medically qualified, who must make the referral to the surgeon. The responsible GIC clinician should discuss this surgery as a component of their patient's ICP with the GIC MDT before making a referral for surgery. This is an irreversible procedure and timescales for when the surgery should take place should be agreed by the GIC in discussion with the patient.

Before referral for bilateral mastectomy and chest reconstruction, the patient will have completed their GIC assessment and may have engaged in a social role transition; in most circumstances, they will also have commenced treatment with masculinising hormones.

The decision to refer for surgery, and the timing of that decision, will be based upon an assessment of individual clinical need, and be agreed between the patient and clinician.Typically, a referral for this surgery will be around 9-12 months, but no less than 6 months, after the patient's first consultation. A decision to refer for surgery will be based upon individual patient need

Criteria for mastectomy and creation of a male chest in FtM patients[6]:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Aged at least 17 (see Appendix 5 for protocol details for children and adolescents aged under 18)
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

The letter of referral for bilateral mastectomy and chest reconstruction surgery to a surgeon should contain the following information; a copy of the letter should be sent to the patient and their GP.

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;
4. An explanation that the criteria for bilateral mastectomy and chest reconstruction surgery have been met, and a brief description of the clinical rationale for supporting the client's request for surgery;
5. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

Hysterectomy and bilateral salpingo-oophorectomy

Trans-men who undergo genital reassignment surgery will normally have hysterectomy and bilateral salpingo-oophorectomy as a component of that procedure.

Hysterectomy and/or salpingo-oophorectomy solely for the purpose of treatment of gender dysphoria requires two opinions, usually from members of the gender clinic team or network (one letter may have 2 signatories). The second opinion may also be from a General Practitioner with Specialised Interest (GPwSI) or the patient's GP. Patients should have a written copy of the decision and referral letter(s).

Criteria for hysterectomy and bilateral salpingo-oophorectomy in FtM patients :

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Aged at least 17 (see Appendix 5 for protocol details for children and adolescents aged under 18)

[6] Adapted from the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, 7th Version, September 2011, (page 59), http://www.wpath.org

4. If significant medical or mental health concerns are present, they must be reasonably well-controlled
5. 12 months continuous endocrine treatment as appropriate to the patient's goals (unless the patient has medical contraindications or is otherwise unable to take hormones).

These criteria do not apply to medical conditions requiring advice, opinion or treatment from a gynaecologist or oncologist, where direct referral by a physician is appropriate. Continuous use of testosterone therapy in trans-men with an intact uterus increases their risk of developing endometrial hyperplasia and malignancy. For trans-men who retain an intact uterus, this procedure must be strongly recommended for all those who have received continuous testosterone therapy for 2-5 years. Either hysterectomy and/or salpingo-oophorectomy, or alternative monitoring arrangements, must be agreed between the GIC and the patient.

The letter of referral for hysterectomy and bilateral salpingo-oophorectomy to a surgeon should contain the following information; a copy of the letter should be sent to the patient and their GP.

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;
4. An explanation that the criteria for hysterectomy and bilateral salpingo-oophorectomy have been met, and a brief description of the clinical rationale for supporting the client's request for surgery;
5. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

Genital reassignment surgery

Patients should only be referred for genital surgery once they have completed the period of living in the gender role that is congruent with the individual's gender identity before genital reassignment surgery agreed in their treatment plan with their GIC. The decision to offer this surgery will involve two opinions, one of which is from a member of the gender identity team or network that has clinical experience with the patient; the second opinion should come from a gender specialist who is not directly involved in the patient's care; at least one of the opinions should be given by a medically-qualified person. The case must have been discussed within the multidisciplinary team or network that has clinical experience with the patient. (UK19.9)

Criteria for genital surgery in FtM patients and MtF patients[7]:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Aged at least 17 (see Appendix 5 for protocol details for children and adolescents aged under 18);

[7] Adapted from Ibid (page 60),

4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);
6. A period of living in the gender role that is congruent with the individual's gender identity (sometimes called "real-life experience") *before* the provision of genital reassignment surgery is required by authoritative guidelines; the duration of this period is agreed between the GIC and patient, and is typically 12 to 24 months.

The letter of referral for genital reassignment surgery to a surgeon should contain the following information; a copy of the letter should be sent to the patient and their GP.

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;
4. An explanation that the criteria for genital reassignment surgery have been met, and a brief description of the clinical rationale for supporting the client's request for surgery;
5. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

A copy of the second opinion letter must be provided to the surgeon, along with the referral letter sent by the clinician giving the initial opinion and recommendation for genital reassignment surgery.

Breast augmentation and other surgeries that require approval through the CCG
Breast augmentation and other surgeries are not routinely offered as part of the gender reassignment protocol will only be considered for funding by the patient's GP's CCG. This should be communicated explicitly to all patients.

A recommendation for breast augmentation or other surgeries may form part of the patient's Individual Care Plan (ICP), and must be agreed between the GIC and the patient. The decision to recommend such surgeries should have the documented support of two clinicians who are directly involved in patient's care; at least one must be medically qualified, who must make the referral to the surgeon. The responsible GIC clinician should have discussed such surgeries as a component of their patient's ICP with the GIC MDT before making a referral for them, thereby ensuring at least two opinions have been sought during the care pathway. Surgery is an irreversible procedure and timescales for when surgery should take place should be agreed by the GIC in discussion with the patient.

Before referral for breast augmentation or other surgeries, the patient will have completed their GIC assessment and have engaged in the period of living in the gender role that is congruent with the individual's gender identity. Referral for breast augmentation surgery should only be considered where there is a clear failure of breast growth in response to adequate hormone treatment, unless there is an unequivocal medical contraindication to this. Review of breast development in anticipation of breast augmentation surgery should

be made no earlier than after the completion of 18 months of adequate hormone treatment. This should be made clear to patients during individual treatment planning.

Criteria for breast augmentation or other surgeries:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Aged at least 17 (see Appendix 5 for protocol details for children and adolescents aged under 18)
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled
5. For breast augmentation only, completion of 18 months continuous adequate feminising hormone treatment, unless there is an unequivocal medical contraindication to this.

The letter of referral for breast augmentation and other surgeries to a surgeon should contain the following information; a copy of the letter should be sent to the patient and their GP.

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;
4. An explanation that the criteria for breast augmentation and other surgeries, and a brief description of the clinical rationale for supporting the client's request for surgery;
5. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

Treatment for complications related to surgery and revision surgery for unacceptable surgical outcomes

The surgeon will provide treatment for complications related to surgery and revision surgery for unacceptable surgical outcomes, as agreed between the patient and their surgeon, up to the time of discharge of the patient from their service. In the case of subsequent functional impairment experienced by a trans-man after phalloplasty (typically, failure of inflatable penile prosthesis or continence problems), he should be referred back to the surgical team which, if clinically necessary, will provide surgery or recommend referral to appropriate local facilities following review of the patient. With this exception, patients who are satisfied with surgical outcome at the time of discharge and become dissatisfied at a later date are not automatically entitled to further surgical treatment; such treatment is not routinely offered as part of the gender reassignment protocol will only be considered for funding by the patient's GP's CCG. This should be communicated explicitly to all patients.

Appendix 4 – Hair Reduction

Facial hair reduction

The reduction of facial hair is seen as an essential part of gender reassignment for a trans-woman to facilitate the period of living in the gender role that is congruent with the individual's gender identity before genital reassignment surgery. The absence of facial hair is of psychological benefit and will produce a greater well-being for the patient as there should be little or no need to remove hair on a constant basis.

It is recommended that facial hair removal should commence prior to social gender role transition, as the beard must grow to visible lengths to be removed.

Laser and Intense Pulse Light (IPL) treatment for facial hair reduction is most effective on those with dark hair and fair skin and is unsuitable for treating non-pigmented hairs such as grey, white, blonde and red; the latter may require reduction by electrolysis. Some modern lasers are able to effectively treat racially pigmented skin[8].

A fixed number of sessions (one site test and eight sessions), will be funded for facial hair reduction for trans-women.

Hair removal from donor site

If hair is not adequately removed from areas directly involved in reconstructive genital surgery prior to surgery, it can become a post-operative complication causing risk to the patient and necessitating further surgery to rectify the complication.

FtM patients require hair removal prior to radial artery phalloplasty or radial artery urethroplasty; otherwise the patient would have hair-bearing skin on the inside of the neourethra. MtF patients require hair removal prior to vaginoplasty and labiaplasty.

Hair removal from the donor site can be performed with a surgeon's recommendation prior to completion of the period of living in the gender role that is congruent with the individual's gender identity before genital reassignment surgery, in order to reduce delays in surgery.

[17] Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria (Draft), RCPsych Intercollegiate SoC Committee, 2006.

Appendix 5 – Services for Children and Young People in England under 18

Children and young people experiencing gender dysphoria will access treatment and support via the gender reassignment protocol. Each patient will be considered on an individual basis by their gender identity clinic.

At present specialist gender identity development services for children and young people under 18 are available through the Gender Identity Development Service at The Tavistock and Portman NHS Foundation Trust, London, and their satellite clinics in Exeter and Leeds. Children and young people should contact their GP in the first instance and thereafter may be referred to the Gender Identity Development Service at The Tavistock and Portman NHS Foundation Trust, London.

Other professionals in Health, Social Services and Education departments as well as young people and their families can contact the Service directly to discuss a possible referral[9]. Further information can be found at http://www.tavistockandportman.nhs.uk/genderidentityissues.

Teenagers who are 17 years of age or older may be seen in Adult Gender Clinic. They are entitled to consent to their own treatment and follow the standard adult protocol, and this consent cannot be overruled by their parents.

Additional contact details:

Gender Identity Development Service
The Tavistock and Portman NHS Foundation Trust
Tavistock Centre
120 Belsize Lane
London
NW3 5BA
Tel: 020 8938 2030
Fax: 020 7431 8320
Web: www.tavi-port.org

The Gender Identity Development Service at The Tavistock and Portman NHS Foundation Trust is part of the NHS Camden Child and Adolescent Mental Health Service (CAMHS) which offers help to children and adolescents from birth until their 19th birthday, their families and carers as well as offering advice and consultation to other professionals working with children, adolescents and their families.
Further information on assessment and treatment of children and young people under 16 with gender dysphoria can also be found in the WPATH Standards of Care, 7th version (page 10, http://www.wpath.org).

[9] The Tavistock and Portman NHS Foundation Trust Gender Identity Development Service Booklet, 2009, http://www.tavistockandportman.nhs.uk/sites/default/files/Gender%20Identity%20Development%20Service%20leaflet%202009.pdf

Appendix 6 – Supporting information for GPs

There are 7 gender specialist clinics for adults in NHS England and referrals can be made to these clinics to explore with the patient the options available to them.

Exeter (The Laurels) Lead Clinician: Dr John Dean	Devon Partnership NHS Trust The Laurels Gender and Sexual Medicine Clinic 11-15 Dix's Field Exeter EX1 1QA
Leeds (Newsome Centre) Lead Clinician: Dr Amal Beaini	Leeds and York Partnership NHS Foundation Trust Leeds Gender Identity Service Outpatient's Suite, 1st Floor, Newsome Centre, Seacroft Hospital, York Road, Leeds LS14 6UH
London (Charing Cross) Lead Clinician: Dr James Barrett	West London Mental Health Trust Gender Identity Clinic 179 – 183 Fulham Palace Road London W6 8QZ
Northampton Lead Clinician: Dr Byran Timmins	Northamptonshire Healthcare NHS Foundation Trust Denetre Hospital London Road, Daventry , Northants NN11 4DY
Nottingham Lead Clinician: Dr Walter Bouman	Nottinghamshire Healthcare trust Nottingham Gender Clinic Mandala Centre Gregory Boulevard Nottingham NG7 6LB
Sheffield Lead Clinician: Prof. Kevan Wylie	Sheffield Health and Social Care NHS Foundation Trust Porterbrook Clinic 75 Osbourne Road Nether Edge Hospital Sheffield S11 9BF
Newcastle Lead Clinician: Dr Helen Greener	Northumberland, Tyne & Wear NHS Foundation Trust Northern Region Gender Dysphoria Service Benfield House Walkergate Park Hospital Newcastle Upon Tyne NE6 4QD

Further guidance, good practice resources & support organisations:

- NHS Inform website: Gender Dysphoria Introduction – http://www.nhsinform.co.uk/health-library/articles/g/gender-dysphoria/introduction.aspx

Appendix 7 - Addendum

Clarification of two opinions - hormone therapy.

When considering the introduction of hormone therapy and referrals for surgeries other than genital reassignment surgery, the interim protocol refers to that decision, in the case of hysterectomy “solely for the purpose of treatment of gender dysphoria require[ing] two opinions” and, in the case of other surgeries, has “the documented support of two clinicians who are directly involved in patient's care”. The two opinions or expressions of support may arise from a discussion and agreement, made during the course of the patient’s routine care, between two clinicians directly involved in their care (typically a medically qualified physician and a counsellor or psychotherapist) that the intervention is in the patient’s best interests and is consistent with guidance set out in the UK Good Practice Guidelines; this discussion and agreement should be adequately documented in the patient’s clinical records. A recommendation for hormone therapy or a referral for surgery must be made by a medically qualified physician.

Appendix 8 – Implementation Plan

Implementation

- Individuals already being seen by services are on an existing pathway.

- The date for implementation of the protocol is 1 August 2013 for all new patients seen by services from that date.

- The protocol will be shared with area teams, who will work with services with regard to the impact of the protocol and how soon the protocol can be applied for existing patients.

- The aim would be that the protocol would be applicable for all patients by 1 October 2013, in line with other specialised service specifications, but it is appreciated until the protocol was agreed the detailed work had not been undertaken so the implications have not been quantified.

- By 12 September 2013 area teams will confirm to the Assistant Head of Specialised Services, Operational Delivery Directorate, the impact of the protocol for services as a result of implementation for all patients by 1 November 2013.

Appendix 9 – UK Intercollegiate Good Practice Guidelines for the Assessment & Treatment of Adults with Gender Dysphoria

This document should be used in conjunction with the UK Intercollegiate *Good Practice Guidelines for the Assessment & Treatment of Adults with Gender Dysphoria* and is cross-referenced to its relevant sections. It should be interpreted and implemented in a manner that is consistent with the UK Intercollegiate *Good Practice Guidelines*. This document is not intended to be exhaustive in content; issues not covered in this document should managed in accordance with the UK Intercollegiate *Good Practice Guidelines*.

The UK Intercollegiate Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria was released on 25 October 2013.

It is available on the following link -
http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/collegereports.aspx