

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No:</b>	1780
<b>Service</b>	Gender Identity Services for Adults (Surgical Interventions)
<b>Commissioner Lead</b>	<i>For local completion</i>
<b>Provider Lead</b>	<i>For local completion</i>

#### 1. Scope

##### 1.1 Prescribed Specialised Service

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

##### 1.2 Description

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

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

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

#### 2. Care Pathway and Clinical Dependencies

##### 2.1 Background

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

of **gender dysphoria**.

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

*“A disorder characterized by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex (manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery)”*.<sup>1</sup>

## **2.2 Principles guiding the development of this service specification**

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

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

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

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

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

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

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

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

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

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

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

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

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<sup>1</sup> The revised ICD 11 refers to the wider category of 'gender incongruence' (not yet adopted).

trans people.

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

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

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

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

## **2.4 Staffing, structure and governance**

Each Provider will have:

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

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

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

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

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

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

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

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

Arrangements in place (including ongoing training) to ensure that all staff in public-facing roles have cultural sensitivity towards trans and gender diverse

people's health and social care needs.

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

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

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

## **2.5 Care Pathway**

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

The NHS pathway of care may be summarised as:

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

## **2.6 Referral for surgical intervention**

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

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

## **2.7 Role of the specialist surgeon and surgical team**

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

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

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

## **2.8 Infrastructure requirements**

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

The service will be co-located with the following services

- Radiology
- Infection prevention and control

The service will have access to the following services:

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

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

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

A health professional member of the surgical team will be available during daytime working hours to provide non-urgent advice to patients, and other practitioners providing care to patients who are not currently in-patients of the specialist surgery provider unit, such as A&E units, GPs and Gender

Dysphoria Clinics.

## **2.9 Assessment for readiness for surgical interventions**

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

## **2.10 Shared decision making**

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

## **2.11 Consent to surgery**

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

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

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

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

## **2.12 Nursing team**

The Provider will have a nursing team that is experienced in meeting the health care needs of individuals with gender dysphoria. The role of the nursing team should include pre-operative care, whereby contact is made before surgery and information is shared on aftercare including hygiene, risk

of infection and general lifestyle considerations. Post-operative care involves wound and physical care, and liaison with community and primary care services around the time of discharge from hospital.

### **2.13 Mortality and morbidity meeting**

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

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

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

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

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

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

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

The criteria for initiation of surgical treatments are listed in [Appendix D](#).

#### **Mastectomy and related chest reconstruction**

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

The standard practice<sup>2</sup> procedures that are commissioned by NHS England are:

- Double Incision Technique
- Peri-Areolar Technique

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<sup>2</sup> If a Provider wishes to implement a new surgical intervention it must a) be determined whether a NICE Interventional Procedure Guidance is in place and b) propose to NHS England's Clinical Reference Group for Gender Identity that a proposition for a clinical commissioning policy be developed.

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

### **Masculinising genital surgery**

The standard practice<sup>3</sup> procedures commissioned by NHS England are:

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

Commissioned only in conjunction with the above pathways:

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

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

### **Feminising genital surgery**

The standard practice<sup>4</sup> procedures commissioned by NHS England are feminising genital reconstruction, consisting of some or all of the following:

- Penectomy
- Bilateral Orchiectomy
- Vaginoplasty (various techniques; bowel vaginoplasty should only be performed if other vaginoplasty techniques are not possible because

<sup>3</sup> If a Provider wishes to implement a new surgical intervention it must a) be determined whether a NICE Interventional Procedure Guidance is in place and b) propose to NHS England’s Clinical Reference Group for Gender Identity that a proposition for a clinical commissioning policy be developed.

<sup>4</sup> If a Provider wishes to implement a new surgical intervention it must a) be determined whether a NICE Interventional Procedure Guidance is in place and b) propose to NHS England’s Clinical Reference Group for Gender Identity that a proposition for a clinical commissioning policy be developed.



of inadequate donor site skin)

- Clitoroplasty
- Vulvoplasty

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

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

- Phonosurgery
- Augmentation Mammoplasty (breast enlargement)
- Facial Feminisation Surgery, including Thyroid Chondroplasty and Rhinoplasty
- Lipoplasty / Contouring, Microdermabrasion and other cosmetic procedures
- Body hair removal (other than donor site for surgery)
- Hair transplantation
- Hysterectomy, bilateral salpingo-oophorectomy, penectomy and orchidectomy when they are performed as “stand alone” procedures
- Reversal of a previous surgical intervention for the treatment of gender dysphoria that is requested due to regret or other change of mind by an individual who no longer has a diagnosis of gender dysphoria<sup>5</sup>

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

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

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

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<sup>5</sup> As this is not a procedure on the pathway for the alleviation of gender dysphoria

## **2.16 Donor Site Skin Epilation**

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

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

## **2.17 Discharge from the surgical provider**

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

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

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

## **2.18 Interdependence with other Services**

Links with other services include:

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

## **3. Population Covered and Population Needs**

### **3.1 Population Covered By This Specification**

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

with a GP practice in England.

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

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

### 3.2 Population needs; and Expected Demographic Changes

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

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

## 4. Outcomes and Applicable Quality Standards

### NHS Outcomes Framework Domains

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

## 4.2 Indicators Include:

Number	Indicator	Data Source	Outcome Framework Domain	CQC Key question
<b>Clinical Outcomes</b>				
Generic Surgery				
101	% of patients returned to theatre during the primary admission	HES / SSQD reported quarterly	3, 4	effective, responsive
102	% of patient suffering from DVT/pulmonary embolic complications requiring treatment within a 3 months period post-surgery	HES / SSQD reported annually	3, 4	effective, responsive
103	% of patients readmitted due to complications within 3 months of discharge	HES / SSQD reported quarterly	3, 4	effective, responsive
Assigned Male at Birth: Genital Surgery				
104	% of revisions undertaken within 12 months of the primary procedure	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
105	% of patients suffering from rectal vaginal fistula	HES / SSQD reported annually	3, 4	effective, responsive
Assigned female at Birth: Genital Surgery				
106	% of revisions undertaken within 12 months of the primary procedure.	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive
107	% of patients requiring treatment for urethral problems in the last 12 months	HES / SSQD rolling annual reported quarterly	3, 4	effective, responsive

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

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

See [Appendix E](#) for more detailed description of the indicators

## 5. Provider locations

The services are delivered by the following organisations, designated by NHS England (as of January 2023):

### *Mastectomy and related chest reconstruction*

Brighton Hospital – Nuffield Health

Highgate Private Hospital London – Aspen Healthcare

Hull University Teaching Hospitals NHS Trust

Leicester Hospital – Nuffield Health

Mount Stuart Hospital, Torquay

Newcastle Hospital – Nuffield Health

Parkside Hospital London – Aspen Healthcare

Pennine Acute Hospital NHS Trust  
Plymouth Hospital – Nuffield Health  
Royal Cornwall Hospitals NHS Trust

*Masculinising genital surgery*

Chelsea and Westminster Hospital NHS Foundation Trust  
New Victoria Hospital London  
Parkside Hospital London – Aspen Healthcare

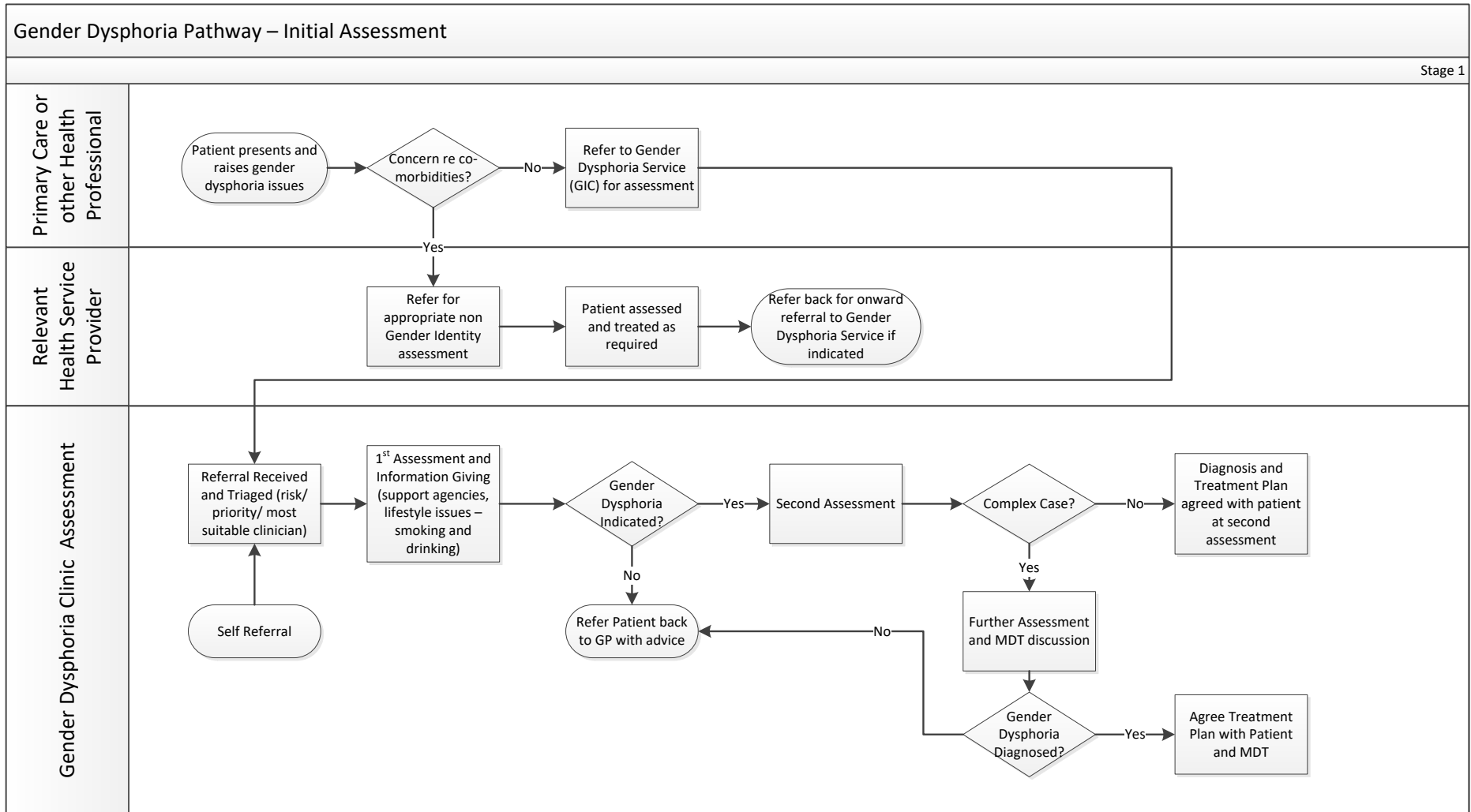
*Feminising genital surgery*

Brighton Hospital – Nuffield Health  
Parkside Hospital London – Aspen Healthcare  
St George's University Hospitals NHS Foundation Trust

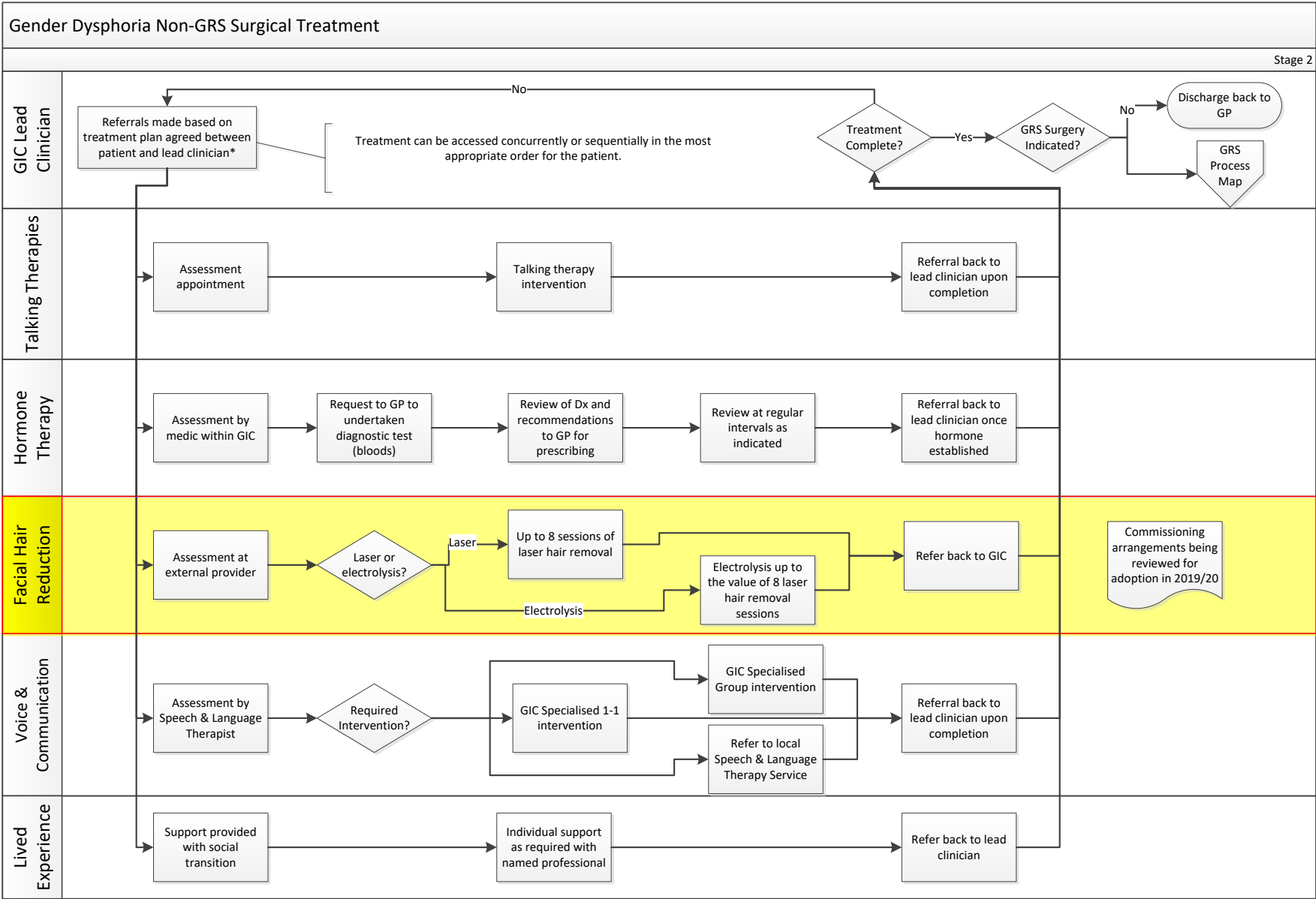
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# Appendix A

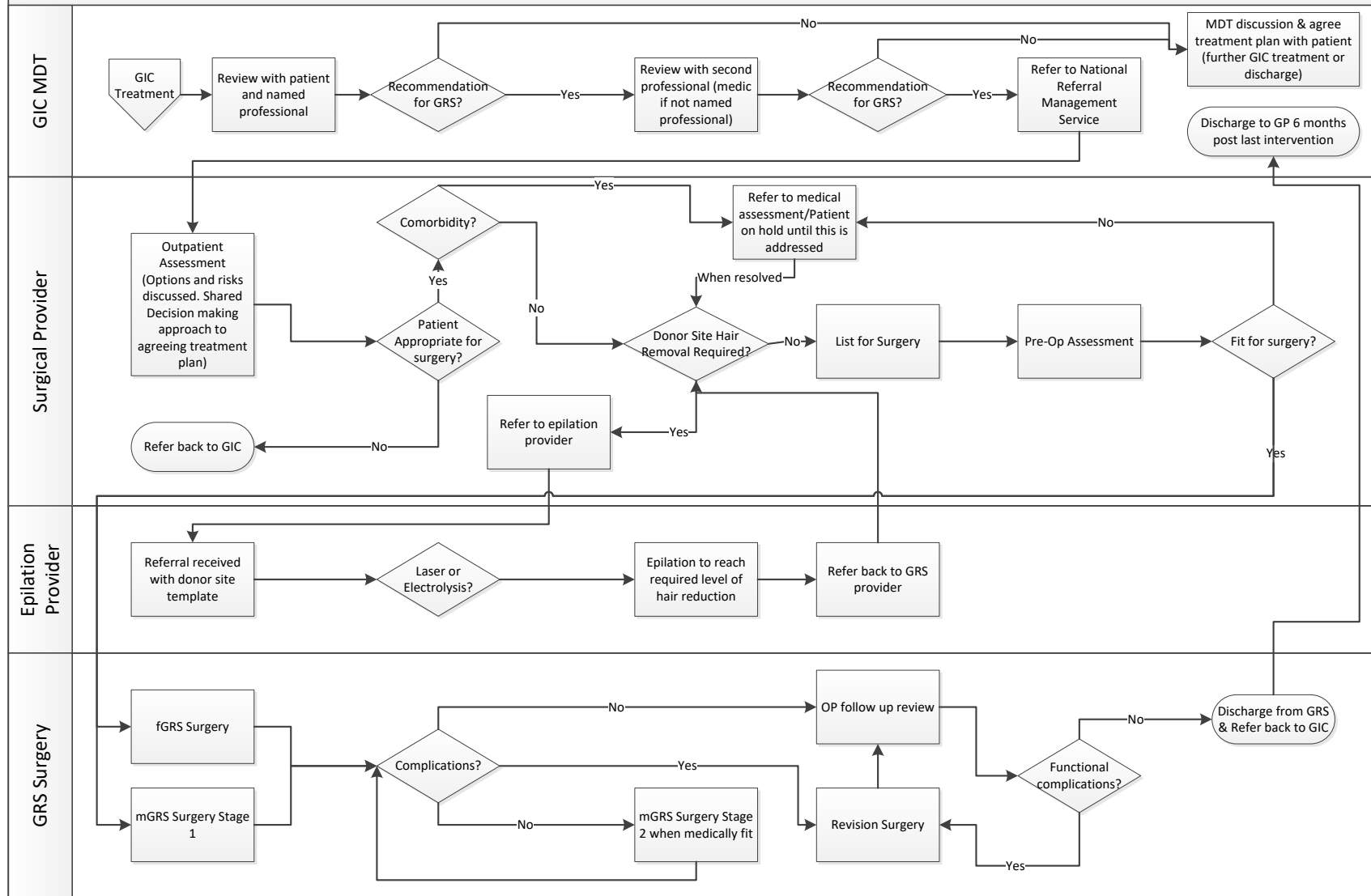






Genital Reconstructive Surgery

Stage 3



## **Appendix B: Referral for surgical intervention**

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

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

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

### *Individuals with a Gender Recognition Certificate*

If an individual has been granted a Gender Recognition Certificate (GRC), as an outcome of the process described in the Gender Recognition Act 2004 they will have had a diagnosis of gender dysphoria; and will, at the time their GRC was granted, have lived fully for the previous two years in their acquired gender and continued to do so; and they will have intended to live permanently in their acquired gender. This information is confirmed in a written report of a medical practitioner (with a licence to practise) or psychologist on the List of Specialists in the Field of Gender Dysphoria maintained by HM Courts and Tribunal Service. Such individuals are eligible for a referral for genital surgery subject to a single opinion from a Registered Medical Practitioner who has knowledge of the individual's care plan, and on the basis of informed consent<sup>6</sup>.

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<sup>6</sup> Should the Gender Recognition Act 2004 be amended or repealed such that the above-mentioned requirements are removed from the legal recognition process then the criteria for access to genital surgery shall be reviewed by NHS England and changes recorded in an amended version of this service specification.

## **Appendix C: Assessment for readiness for surgical interventions**

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

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

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

### ***Assessment of patients who have been granted a Gender Recognition Certificate***

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

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

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

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

## Appendix D: Criteria for initiation of surgical treatments

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

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

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

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

#### *Masculinising genital surgery*

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

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

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

#### *Feminising genital surgery*

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

#### *Patients who smoke*

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

#### *Patients who are overweight*

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

## Appendix E – indicators

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

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



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

	necrosis						
	<b>Patient Experience</b>						
<b>201</b>	The service reviews the national PROM/PREM data	Providers will receive data from the national PROM/PREM data source and will need to review as a team and establish service development plans to continually improve the service	NHS England will develop an online reporting tool for access by patients from 2019/20	Annual Report	Self-declaration	4	caring, responsive
<b>202</b>	Patient information is provided to all patients and includes details as listed in the service specification	Patient information is provided to all patients and includes details as listed in the service specification including at least information on: <ul style="list-style-type: none"> <li>• different surgical techniques available (with referral to colleagues who provide alternative options)</li> <li>• advantages and disadvantages of</li> </ul>		Operational Policy	Self-declaration	4	caring, responsive

		<ul style="list-style-type: none"> <li>• each technique</li> <li>• limitations of a procedure to achieve “ideal” results;</li> <li>• inherent risks and possible complications of the various techniques</li> <li>• appropriate aftercare</li> </ul>					
<b>Structure and Process</b>							
<b>301</b>	The core membership of the MDT is as per the service specification	<p>The core membership of the MDT is as per the service specification and includes:</p> <p>Consultant surgeons with expertise in the procedures described in this service specification;  consultant anaesthetists;  consultant radiologists;  specialist nurses</p>	The Senior Clinical Lead must demonstrate evidence of appropriate experience and expertise as described in the service specification	Operational Policy	Self-declaration	2, 4, 5	safe, effective, responsive, well-led

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

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

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

<b>Version Number</b>	<b>Date</b>	<b>Author / Approving Body</b>	<b>Status</b>	<b>Comment / Reason / Approving Body</b>
2	May 2019	Gender Identity Programme Board	Approved	Amendment to 2.14 to clarify that the following procedure is not funded by NHS England: reversal of a previous surgical intervention for the treatment of gender dysphoria that is requested due to regret or other change of mind by an individual who no longer has a diagnosis of gender dysphoria
2	May 2019	Gender Identity Programme Board	Approved	Amendment to 2.17; correction of typographical error; “pre-operative” changed to “post-operative”
2	May 2019	Gender Identity Programme Board	Approved	Addition to Appendix B to clarify referral criteria for individuals with a Gender Recognition Certificate
3	December 2019	Medical Projects Team	Approved	Addition of section 5: list of provider locations
4	December 2021	Medical Projects Team	Approved	Amendment to section 5: updated list of provider locations