NHS England

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Service specification:
NHS Children and Young Peoples Gender Service 4 August 2025

1. Service name	SERVICE SPECIFICATION NHS Children and Young People's Gender Service
2. Service specification number	230602
3. Date published	
4. Accountable Commissioner	NHS England

5.	**Summary**
	The NHS Children and Young People's Gender Service (The Service) will provide care to children and young people who express gender incongruence and are likely to benefit from clinical support, and their families. The Service will adopt a holistic, multi-disciplinary integrated approach to assessing and responding to an individual's needs in view of the range of co-presentations that may typically present in this patient cohort, and the range of complexities relating to gender identity development. Levels of anxiety, depression and self-harm are high in this patient cohort, indicating a need for prevention and treatment of mental health difficulties in these patients. The most appropriate clinical pathway in the best interests of the child or young person will be determined through an integrated multidisciplinary team (MDT) approach using a holistic assessment and fully involving the child or young person and their family. Host providers delivering The Service must be an established specialist tertiary paediatric unit with a strong partnership with mental health services; be an established academic centre with a strong track record of research in children and young people; and have robust safeguarding frameworks in place. Designated providers will form a National Provider Network that will assume leadership responsibility for ensuring a consistent approach to core delivery functions including: the development of shared standards; operating protocols and clinical protocols; training and education; research and audit; learning activities; quality improvement; and will also provide a National Multi-Disciplinary Team forum for discussion of complex cases by exception.

In addition to the single overarching National Provider Network, each Service will act in a Lead Provider capacity and identify a smaller number of children and young people's mental health services and paediatric secondary care services to act as Designated Local Specialist Services within each area. This model will support integration between different children's services and facilitate early access to local services along flexible pathways that respond well to an individual's needs.

The clinical management approach should be open to exploring all developmentally and psychosocially appropriate options for children and young people who are experiencing gender incongruence. The clinical approach should be mindful that this may be a transient stage. The current evidence base suggests that children who present with gender incongruence at a young age are most likely to desist before puberty, although for a small number the incongruence will persist[1]. There will be a range of pathways to support these children and young people and a range of outcomes.

Not all children and young people who present with issues of gender incongruence will require direct interaction with The Service; in many cases the most appropriate care can be provided locally, with additional support and consultation by The Service. A significant proportion of children and young people who are concerned about, or distressed by, issues of gender incongruence experience co-existing mental health, neuro-developmental and/or personal, family or social complexities in their lives. The relationship between these presentations and gender incongruence may not be readily apparent and will often require careful exploration. Where children and young people present with co-existing conditions or presentations, these will normally be addressed by the appropriate local service alongside this Service.

The primary intervention for children and young people who are assessed as suitable for The Service is biopsychosocial and psychological support and intervention; the main objective is to alleviate distress associated with gender incongruence and promote the individual's global functioning and wellbeing. This includes psychoeducation, which in a paediatric health care setting involves providing families and children with information and skills to manage health conditions and improve overall well-being. This intervention utilises psychological approaches to achieve effectiveness and impact.

The approach for onward referral to a paediatric endocrinology clinic for the purpose of assessment for suitability for exogenous hormone intervention is described in NHS England's published clinical commissioning policy.

Puberty Suppressing Hormones are not a routinely available intervention because of the limited evidence about safety, risks, benefits and outcomes.

6. Population and/or geography to be served

6.1 Population Covered

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

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[1] Final report of the Cass Review (April 2024)

- Registered with a General Practitioner in England or who are otherwise the commissioning responsibility of NHS England; AND
- Who were under the care of the former Gender Identity Development Service at the Tavistock and Portman NHS Foundation Trust on 31 March 2024; OR
- Who were on the NHS waiting list for the former Gender Identity Development Service managed by the Tavistock and Portman NHS Foundation Trust on 31 March 2024; OR
- Who have been referred to The Service from 1 April 2024 because gender incongruence concerns may be present and which exceed the scope and expertise of local services.

Terminology
Gender incongruence of childhood (ICD11 HA61)
"Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about two years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis".

Gender Incongruence of Adolescence and Adulthood (ICD11 HA60)
"Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis".

6.2 Minimum population size

Incidence rates of recorded gender dysphoria for children and young people in England (age 0–18) increased from 0.14 per 10,000 persons in 2011 to 4.4 per 10,000 in 2021. Prevalence of gender dysphoria/incongruence was similar in natal males and natal females up to 2015, after which prevalence increased more quickly in natal females, and was approximately twice as high as in natal males by 2021. Incidence of gender dysphoria/incongruence increases with age, being rarely recorded in those under the age of 11; recorded prevalence is therefore highest in the 17–18 age group[2].

The number of referrals may be up to 1 per 2000 population per year. The current referral profile suggests that most referrals will be of adolescents following the onset of puberty.

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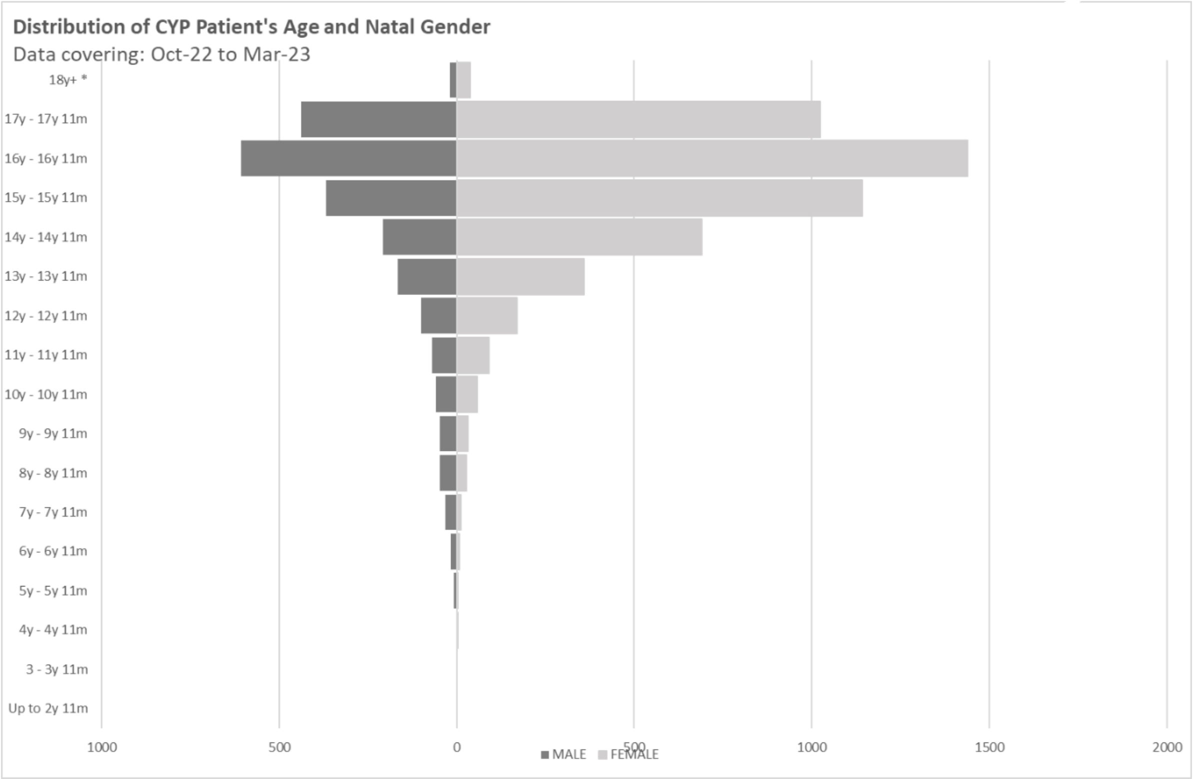
[2] Epidemiology of Gender Dysphoria and Gender Incongruence in Children and Young People Attending Primary Care Practices in England: Retrospective Cohort Study, January 2025; Jarvis et al



Distribution of CYP Patient's Age and Natal Gender

Data covering: Oct-22 to Mar-23

Eligible Patient Cohort

The Service will operate as a Lead Provider in a regional network and will take referrals of children and young people who are registered with a GP in a regional network that is defined by the National Provider Network in agreement with the Commissioner.

Young people who are unlikely to be seen by The Service by the time of their 18th birthday will be removed from the waiting list and advised to consult their GP about the appropriateness of a referral to an NHS-commissioned Gender Dysphoria Clinic for adults. In such cases, the Gender Dysphoria Clinic will honour the original referral date to the children and young person's service for the purpose of access into the adult service.

7. Service aims and outcomes

7.1 Service aims

The Service will:

- Act in a Lead Provider capacity and identify a smaller number of children and young people's mental health services and paediatric secondary care services to act as Designated Local Specialist Services within each area. The Service should work within existing relationships to allow this provision to be established as quickly as possible, utilising joint contracts between the Service and the Designated Local Specialist Services to support flexible multi-site working and increase the available workforce.
- Support local services in meeting the gender incongruence needs of children and young people where appropriate through professional liaison and collaboration.

- Through professional liaison and collaboration support local services to meet the wider needs of children and young people (including mental health, neuro-developmental and safeguarding) and in risk mitigation.
- Tailor an individual care plan following the holistic assessment, leading to multi-professional formulation and care planning.
- Provide psychosocial and clinical interventions for children and young people with gender incongruence, including support for the family.
- Provide information and advice in respect of and, onward referral to commissioned endocrine intervention services.
- Build research capabilities to conduct high quality studies across the clinical pathway.
- Build and document the history and nature of gender incongruence to establish evidence-based practice.

7.2 Outcomes

There are currently no outcome measures for this Service. However, a range of quality metrics have been developed which, through regular data collections, will support an enhanced understanding to the quality of the service delivered (see Appendix C). As relevant outcome/impact measures are developed the service specification will be updated.

The full definition of the outcomes and/or quality metrics together with their descriptions including the numerators, denominators and all relevant guidance will be accessible at NHS commissioning » Specialised services quality dashboards (england.nhs.uk) following the next scheduled quarterly refresh of **the dashboard metadata** document.

Service defined outcomes/outputs
The following list will develop over time as the national service moves from mobilisation phase to operational stability and development phase:

- To deliver a plan that maximises capacity, delivers assessments and delivers the full pathway of care.
- To provide continuing high-quality data:
- Workforce plan including vacancy status reported monthly
- A monthly Statistical Process Control (SPC) Chart on first consultations by region, age, natal sex and aggregated
- A monthly SPC Chart on work in progress (WIP) by region, age, natal sex and aggregated
- A monthly SPC Chart on discharges by region, and aggregated
- Evidence of engagement with children, young people and families in design and review of service delivery
- Collection and reporting of children and young people’s experience of the service, and of the family members
- Build Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) for routine deployment no later than one year following service initiation

7.3 Data, audit and evaluation

The Service will collect and report a consistent core clinical data set. This data set will be collected for all patients referred into the Service, including for those for whom, following assessment, it is determined there would not be benefit from intervention by the Service. Data reporting will be via a co-ordinated single data registry, which will enable a better understanding of the needs and experience of patients referred to the Service, and support local and national audit, service evaluation, quality improvement and continuous clinical service improvement.

It is envisaged that the registry data will be collected under NHS England's Outcomes and Registries Directions, 2024. The Directions allow NHS England to establish and operate a lawful and IG-compliant (Information Governance) information system to collect and analyse data for the purposes of improving clinical safety and patient outcomes. The collection of data relating to NHS-funded patients will be mandatory for direct care purposes.

8. Service description

8.1 Future Service model

The Service will adopt a range of service provision strategies within a structured framework to determine which approaches should be standardised into the workflow.

As a developing area of clinical practice, The Service must actively participate in an ongoing programme of quality improvement through the National Provider Network to enable continued refinement of models of patient access, assessment, treatment delivery and follow up. This will include:

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

It is important that the opportunity is taken to build further evidence on the safety, potential benefits and harms of both medical and non-medical interventions. A supporting research programme, jointly developed by NHS England and the National Institute for Health and care Research (NIHR), is being co-ordinated through the National Research Oversight Board for Children and Young People's Gender Services.

The Service must:

- Contribute to the identification of study and treatment evaluation priorities, including through participation in the National Research Oversight Board
- Support the development of academic rigour and expertise and actively deliver research and evaluation programmes within the Service and in partnership with other commissioned service providers
- Build clear relationships with the range of services and skills across all Integrated Care Systems within the regional catchment to optimise linked pathways of care.

8.2 **Pathways**

The referral pathway is described in NHS England's service specification: *National Referral Support Service for Children and Young People with Gender Incongruence.*

The Service will establish an integrated MDT. An individualised pathway will be determined in the child or young person's best interests by, among other things, the clarity, persistence and consistency of gender incongruence, the presence and impact of other clinical needs, and family and social context. Where screening by The Service identifies the presence of neurodevelopmental conditions, including autism spectrum disorder (ASD), a referral should be considered to the Paediatric Neurodevelopmental Service or Paediatric ASD Service for a diagnostic assessment.

An individual care plan will be tailored to the specific needs of the individual following careful therapeutic exploration; this plan may require a focus on supporting other clinical needs and risks with networked local services. The care plan will be regularly updated after MDT review at least every six months while the child or young person remains in the service.

Pre-pubertal children

The Service, either directly or acting in a Lead Provider capacity, will ensure that within each regional network a separate pathway is established for pre-pubertal children and their families, prioritising early discussion with a professional with relevant experience, in line with the recommendation of the Cass Review.

Standardised Assessment; Formulation; Diagnosis; and Individual Care Planning

The assessment is a first step in forming a relationship with a child/young person and their family/carers and developing an understanding of the child/young person as an individual in the context of their aspirations and needs. The assessment should lead to three further steps:

- A formulation of all the factors that are important to the child/young person's presentation
- A list of any relevant diagnoses
- An individualised care plan

See Appendix A for full description.

Assessment for endocrine intervention

Puberty Suppressing Hormones (puberty blockers / Gonadotropin-Releasing Hormone Analogues)
Puberty suppressing hormones are not a routinely available intervention because of the limited evidence about safety, risks, benefits and outcomes.

Exogenous masculinising and feminising hormones
Endocrinology should be a core function within The Service's multidisciplinary team so that shared expertise and decision making underpin referrals onto a medical pathway, including for the purpose of initiation of hormone treatments, prescribing, administration and monitoring, should that be mandated in NHS England's clinical commissioning policy at the time. The role of the National MDT in considering recommendations for assessment of suitability for exogenous hormones is described in the clinical commissioning policy. All children and young people should be referred for fertility counselling prior to going on to a medical pathway[3].

Prescribing from unregulated sources and unregulated providers

⚠ *Children, young people and their families are strongly discouraged from sourcing puberty suppressing or gender affirming hormones from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies. Possession of puberty suppressing hormones obtained without a valid prescription is a criminal offence.*

The Service will not assume responsibility for prescribing medication initiated outside of The Service. The Service will not offer clinical supervision for the management of the endocrine intervention; and it will not enter shared care arrangements with a health professional who is making recommendations for prescribing / is prescribing to the child or young person.

In such cases psychosocial support may be offered as clinically appropriate. The Service will make the child or young person and their family aware of the risks, contraindications and any irreversible or partially reversible effects of the interventions; and will make the GP or local health professional (as appropriate) aware. The Service will consider what safeguarding protocols may be appropriate for the individual child or young person's wider circumstances including the extent to which the parents / carers are able to protect or safeguard the child or young person. Safeguarding procedures may be necessary regardless of the endeavours and best intentions of the parents / carers in reducing risk of harm.

Safeguarding protocols should be initiated immediately where the child or young person is at risk of immediate or significant harm.

It would also be important for The Service (in conjunction with the GP or local health professional as appropriate) to explore what regulatory bodies may need to be informed if healthcare professionals registered with a UK professional body are prescribing medication contrary to NHS protocols.

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[3] Commissioning responsibility for fertility counselling, and gamete retrieval and preservation, rests with Integrated Care Boards.

Transition to adult services and discharge

The Service may provide support to young people up to their 18th birthday (exceptionally, up to 18 years and 3 months where more time is needed to conclude a transfer of clinical responsibility to an NHS adult gender service).

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

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

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

8.3 Essential Competencies

The Service must have a nominated Clinical Lead who has significant experience in the developmental needs of children and adolescents.

There should be a nominated medical practitioner who takes overall clinical responsibility for patient safety within The Service. The MDT will have (or have access to) the following competencies and experience (see also Appendix B).

Practitioners will need access to clinical supervision across a range of clinical areas (e.g., psychological, mental and physical health, safeguarding and gender identity development) to support their roles.

- Multi-agency working including provision of consultation, liaison and advice for complex cases, and care navigation
- Expertise in child safeguarding and assessment and management of risk-taking behaviours
- Childhood and adolescent development, including cognitive, social and sexual development; gender identity development and gender expression
- Paediatric medicine
- Psychological health
- Child and adolescent mental health, including expertise in assessment and formulation, delivery of evidence based therapeutic interventions, trauma informed approaches; and family work/family therapy
- Neurodevelopment disorders including learning disability and autism spectrum conditions
- Gender incongruence
- Expertise in sex development, and endocrine intervention
- Expertise to support children and young people who may be Looked After or in Special Guardianship or who may be adopted
- Communication, social and occupational functioning

8.4	**Essential equipment and/or facilities** The provider must have in place premises that are appropriate to ensure effective delivery of the services described in this service specification; and in an age-appropriate environment that children and young people regard as safe and welcoming. Providers will be mindful that the majority of individuals are likely to be pubertal or post-pubertal.
8.5	**Interdependent Service Components – Links with other NHS services** The Service must be expert in working with a wide variety of agencies. It is expected that close working will be needed in particular with Children and Young People's Mental Health Services, child health and neurodevelopment services, voluntary community services, education professionals, children's social care and with general practitioners. The Service should also be competent in their understanding of and close working with children and young people with social care needs – including adopted children and young people, and children in care, and in working with schools and colleges to facilitate wellbeing and full access for their education. Collaborative care arrangements All referrals to The Service will be made through NHS children and young people's mental health services or NHS paediatric services. Referrers, together with local healthcare services, will agree with The Service collaborative care arrangements particularly in relation to the young person's mental health, neurodevelopmental needs and / or risk-taking behaviours. Local services including children and young people's mental health services, paediatric healthcare services and local authorities will continue to provide the care that they would routinely offer young people and families as part of local or national commissioning arrangements across relevant care pathways.
8.6	**Additional requirements** The host provider must have in place: - A robust system of clinical governance that ensures, *inter alia*, all clinical staff are trained in assessing and meeting the health needs of children and young people, have access to clinical supervision as appropriate, and are deemed competent to deliver the interventions as per their role; this will include a documented approach to responding to child abuse and neglect that is consistent with NICE guideline NG76. - A robust system of corporate governance, including a nominated senior manager, that demonstrates effective management, guidance, oversight and accountability by the host organisation; and supported by experienced communications and engagement teams. - Arrangements in place to ensure that the service delivers culturally appropriate and trauma informed care and support; individuals must be able to access services in a way that ensures their cultural, language and communication needs do not prevent them receiving the same quality of healthcare as others. - Sufficient administrative and managerial support needed for efficient and timely delivery of services.

	• Arrangements in place (including ongoing training) to ensure that all staff in The Service have cultural sensitivity towards children and young people who may be gender diverse. • Arrangements in place to ensure that service design and improvement is co-produced with service users and their families, and promotes equality, diversity and inclusion. This should include routine outcomes and experience monitoring and be able to demonstrate how improvement is achieved via means that are accessible, transparent and inclusive. • Arrangements in place to ensure that feedback, comments and complaints by individuals and their families are acknowledged investigated and responded to promptly; and that the means to complain are publicised and accessible.
8.7	**Commissioned providers** Host providers delivering The Service must be an established specialist tertiary paediatric unit with strong links to mental health services and have established academic partnerships. NHS England will establish a framework for a co-ordinated and collegiate approach across all the new regional services - focusing initially on development of the model and then moving to issues of operational delivery, service development, improvement and audit. This approach will help to ensure continuity of provision for children and young people if they move across sub / regional boundaries. Designated providers will form a National Provider Network that will assume leadership responsibility for ensuring a consistent approach to core delivery functions including: the development of shared standards, operating protocols and clinical protocols; training and education; research and audit; learning activities; quality improvement; and a National MDT forum for discussion of complex cases by exception.
8.9	**Links to other key documents** This service specification supersedes the interim service specification for Children and Young People's Gender Incongruence Service that was published in June 2023 (amended March 2024). Other key documents: NHS England Service Specification: Referral Pathway for Specialist Service for Children and Young People with Gender Incongruence; August 2024 NHS England Clinical Commissioning Policy: Puberty Suppressing Hormones; March 2024 NHS England Clinical Commissioning Policy: Gender Affirming Hormones As Part Of The Children and Young People's Gender Service; March 2024 NHS England Service Specification: Gender Identity Services for Adults (Non-Surgical Interventions); 2019 as amended; 1719 The Cass Review Interim Report, February 2022 and Final Report, April 2024

	NHS England Statement: "Implementing the Recommendations of the Cass Review", July 2022 NHS England's Plan for Implementation of the Cass Review Recommendations; August 2024

Appendix A: Assessment, Formulation, Diagnosis and Individual Care Plan[4]

Holistic assessment

The purpose of assessment is to derive a multi-level formulation for a child or young person who presents to the NHS seeking help around their gender or experience of gender-related distress. Assessment should seek to understand the holistic needs of the child or young person and their family. This process should determine whether there are any cooccurring and/ or contributory elements of the individual's presentation that are affecting their psychosocial wellbeing or functioning and require support as the basis of an individual care plan. Presentations, pathways and outcomes for this cohort are very individual, and there needs to be a focus on helping each person to find the best pathway for them.

Assessments should be respectful of their experience and be developmentally informed. Not all children and young people will need an in-depth assessment and will get what they need from other forms of local support, informed by consultation and advice from specialist practitioners.

Clinicians along the pathway should remain open and explore the patient's experience and the range of support and treatment options that may best address their identified needs. Taking a collaborative needs-based approach supports the development of the child or young person's broader wellbeing and functioning with the aim of reducing distress, improving their psychological functioning, sense of wellbeing and quality of life.

Structure and content

The holistic assessment framework has been split into eight non-sequential domains centred around the individual child/ young person and their parents/carers. Weight given to each component is dependent on individual needs. These domains are consistent with assessment models used in the care of children, young people and families in other child, adolescent clinical care, and consider the individual as a whole.

Domains that connect more specifically to understanding gender development, gender incongruence and gender-related distress and dysphoria have also been incorporated drawing upon relevant literature.

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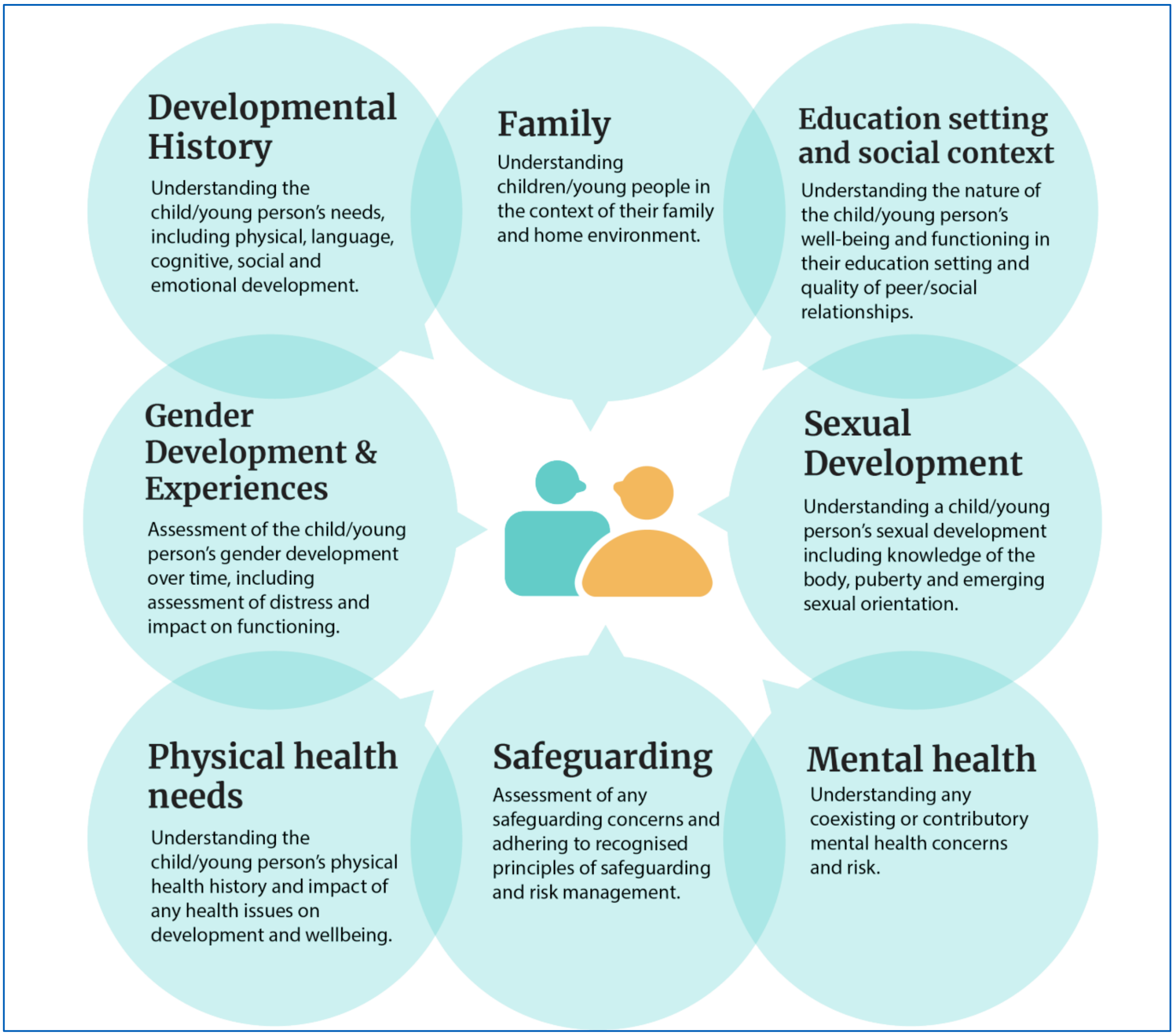
[4] Final Report of the Cass Review, April 2024



Developmental History
Understanding the child/young person’s needs, including physical, language, cognitive, social and emotional development.

Family
Understanding children/young people in the context of their family and home environment.

Education setting and social context
Understanding the nature of the child/young person’s well-being and functioning in their education setting and quality of peer/social relationships.

Gender Development & Experiences
Assessment of the child/young person’s gender development over time, including assessment of distress and impact on functioning.

Sexual Development
Understanding a child/young person’s sexual development including knowledge of the body, puberty and emerging sexual orientation.

Physical health needs
Understanding the child/young person’s physical health history and impact of any health issues on development and wellbeing.

Safeguarding
Assessment of any safeguarding concerns and adhering to recognised principles of safeguarding and risk management.

Mental health
Understanding any coexisting or contributory mental health concerns and risk.

When undertaking an assessment, clinicians should remain open-minded, have no preconceived outcome and should have an appreciation that the child/young person’s priorities may change over time. They should also be aware of parent/carer expectations and the impact these may have on the young person’s priorities, or alternatively the potential for significant disagreement/fragmentation within families about the nature of the child/ young person’s distress.

Family context
Understanding children in the context of their families and home environments, including family makeup, key relationships, strengths, resources and social circumstances, as well as parental/carer health and well-being, is a core principle of good practice across health and social care settings. It is particularly important in this group of young people given that there is evidence of an increased frequency of family parental physical and/or mental ill health and other family stressors in this group.

Development
A detailed developmental history seeks to gather information from parents/carers about the young person’s development, including physical, language, cognitive and social development.

Environmental, social and psychological factors unique to every child and family can affect development. During the transition from childhood to adolescence young people can experience substantial social, emotional and physical changes. This domain requires additional areas of focus where a neurodevelopmental condition is either confirmed or suspected.

Given the high prevalence of neurodiversity identified within this population, all those attending the NHS Children and Young People's Gender Service should receive screening for neurodevelopmental conditions. Where appropriate, consideration should be given to cognitive and language assessments.

Physical health needs

An understanding of the child or young person's physical health history and the impact of any health issues on development and wellbeing is important. Long-term health conditions can influence various aspects of children's development and may include elevated anxiety around health and wellbeing for both children and their parents. The child/young person may have needed to make complex adjustments both socially and emotionally. They could also have experienced trauma in relation to medical experiences or hospitalisations.

Mental health

Children and young people referred to specialist gender services have higher rates of mental health difficulties than the general population. Because gender incongruence is not considered to be a mental health condition clinicians are often reluctant to explore or address co-occurring mental health issues in children and young people presenting with gender distress. Regardless of any other causes for mental health conditions, living with gender issues and the process of transitioning (if this is felt to be the appropriate path for an individual) comes with challenges.

The mental health assessment within a gender clinic should follow the structure of a standard evidence-based core CAMHS assessment. There are many published examples of suggested structures for this assessment, which may involve the use of validated questionnaires for children and young people and their carers to inform further assessment.

In a standard mental health assessment, all of the other seven domains described as part of this holistic assessment framework are usually considered in depth in relation to mental health. Systematic questioning should include enquiry about mood, anxiety, emotional regulation, beliefs around weight, potential somatic symptoms, concentration, sleep and appetite, self-harm, and suicidal thoughts and behaviours. A mental state examination should be included as appropriate.

A mental health diagnostic formulation incorporates diagnosis, level of impairment, risk assessment, and consideration of predisposing, precipitating and perpetuating/maintaining factors and how they impact on current functioning. Identifying and treating mental health difficulties should be an integrated part of the care for children and young people presenting with gender issues. Evidence-based treatments to support mental health and resilience, should be available to children and young people presenting with gender issues as they would be to any other young people presenting to NHS services.

Education, peer relationships and social context

Consideration of the child/young person's functioning in relation to education, their broader well-being and the nature of their peer relationships is important in assessing their overall functioning and supports a holistic understanding of their strengths and vulnerabilities. It is important to obtain information about school attendance and any difficulties in educational achievement, as well as a recent Education, Health and Care plan for any young person with special educational needs.

Safeguarding
As with all health care provision, when working with children and young people safeguarding must be a consideration. There are complex ways in which safeguarding issues may be present. Clinicians working with children and young people experiencing gender issues have highlighted that safeguarding issues can be overshadowed or confused when there is focus on gender or in situations where there are high levels of gender-related distress. Sources of risk in this group include:

- transphobic bullying in school and in other settings
- breakdown in relationships with families
- online grooming or harm
- cultural or religious pressure.

In a small number of cases, the child's gender identity is consciously or unconsciously influenced by the parent. It is very important that the child/young person's voice is heard and that perceptions of gender identity represent the child/young person's sense of self.

There are also accounts of children and young people at safeguarding risk being lost to follow-up and/or of young people presenting to the emergency department with a safeguarding history that staff were unaware of because of changes of name and NHS number. Staff should remain alert to these complexities and know when to act, raising them during supervision and with the wider Multi-Disciplinary Team, and adhering to recognised principles of safeguarding and risk management as applied to children/young people and their parents/carers.

Clinicians should assess and consider safeguarding across each domain of the assessment framework, documenting issues fully within this dedicated domain.

Gender development and experiences
Clinicians should undertake an in-depth assessment of the child/young person's gender development over time, how this manifested and how it has been managed within the family. Clinicians should seek to understand whether any steps have been taken towards social transition and any impacts on well-being, or whether the child/young person wants to make changes.

An assessment of the presence and impact of any distress should be undertaken, including the impact and experience of puberty and pubertal changes. The clinician should examine the impact of any distress on, for example, daily functioning, social or relationship issues, any sensory issues that may be contributing to the distress and steps that may have been taken to manage this.

The child/young person's expectations and hopes about support pathways, their understanding of the range of pathways and outcomes, and the pros and cons of interventions at different points in time should also be considered, including potential fertility and broader health impacts.

Depending on the age and stage of development of each individual child/young person, this may need to be discussed with the child/young person and parent/carer, both together and apart to generate a thorough record of what has been observed, by whom and when, to gain a sense of their individual gender feelings and history. It is also important to understand whether there are any differences in perception between the child/young person and their parents/carers and whether this has been the cause of conflict or family breakdown.

Sexual development, knowledge and sexual orientation

Clinicians should seek to understand the child/young person's emerging sexuality and sexual orientation, consistent with assessments in other adolescent settings, where deemed appropriate to age and context. If this has been an area of concern for younger children, the clinician could capture this elsewhere, for example when looking at safeguarding, developmental history and exposure to adversity and trauma.

Formulation

The clinician working with the child/young person should use the information gathered to develop an evidenced formulation. This should be created and agreed with the child/young person and their parents/carers.

Formulation is used to make sense of and pull together information gathered through an assessment to create a shared understanding of the child/young person's strengths and assets, as well as difficulties and needs, to inform the development of an individualised holistic care plan. The formulation approach offers a structure for synthesising the information gathered during the assessment and for negotiating differences of opinion. It can be carried out at various levels of detail and complexity and can be helpful in identifying other factors that may be influencing gender-related distress and where there is agreement about areas to work on, even if differences of opinion remain. Importantly, it allows all parties to hold an open and mutually respectful position about a child/young person's gender identity whilst defining a personalised intervention package.

Diagnosis and differential diagnosis

The clinician's role in a consultation is to integrate information from a patient's history, assessment and any investigations or tests, in order to determine the most likely cause of their symptoms, and how best to address them.

In addition to the process of formulation described above, this often involves arriving at a formal diagnosis. The diagnostic process is a complex, collaborative activity that involves clinical reasoning and information gathering to understand the patient's problem. Differential diagnosis is the process of ruling out other possible diagnoses that present in a similar way. There are two widely used frameworks which provide diagnostic criteria. The International Classification of Diseases (ICD), which is the World Health Organization (WHO) mandated health data standard, and the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the classification system for mental health disorders produced by the American Psychiatric Association.

ICD-11 (WHO, 2022) has attempted to de-pathologise gender diversity, removing the term 'gender identity disorders' from its mental health section and creating a new section for gender incongruence and transgender identities in a chapter on sexual health. ICD-11 defines gender incongruence as being "characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex." It refers to a mismatch between birth registered and experienced gender but does not include dysphoria (distress) as part of its diagnostic requirements. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

DSM-5 (American Psychiatric Association, 2013), revised in 2022 (DSM5-TR) (American Psychiatric Association, 2022) is the most widely used framework for diagnosing gender dysphoria. In addition to describing the incongruence between experienced/expressed gender and assigned gender, DSM-5-TR specifies that “In order to meet criteria for the diagnosis, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.”

There is no clear consensus across international guidelines as to whether DSM-5 diagnosis of gender dysphoria or ICD 11 diagnosis of gender incongruence is preferred. However, in clinical practice the DSM-5 diagnosis of gender dysphoria is more widely used, this also applies to research publications.

Individualised care plan

The holistic needs assessment and subsequent formulation should lead to the development of an individualised care plan with input from the multidisciplinary team. There should be a tiered approach to any intervention package outlined in an individualised care plan which:

- addresses urgent risk
- reduces distress and any associated mental health issues and psychosocial stressors, so the child/young person is able to function and make complex decisions
- co-develops a plan for addressing the gender dysphoria, which may involve a combination of treatment options

Social Transition

Changes in gender expression whereby the child or young person presents to others in line with societally expected indications of gender identity different to that of their natal sex is known as ‘social transition’. This can be partial or in all forms and aspects of daily life. Appearance and behaviours (interests/activities or presentations socially defined and typically associated with another gender) are usually initiated by children or young people and often supported and facilitated by adults. The ability to express individuality and autonomy to change and adapt self-expression over time can be important to a child or young person’s development and wellbeing. However, the social and psychological impact that social transition may have, means that advice may be sought of clinicians within The Service. Social transition should be recognised as a significant decision and therefore, while it is not a clinical intervention, it will often be become a significant and valid subject within an individual’s care.

While there are different views on the benefits versus the harms of childhood social transition, it is important to acknowledge that it is not a neutral act and that information is needed about long-term outcomes to support decision making. Information and discussion about this with the MDT are important within care for a child or young person in The Service.

At the point of presentation to The Service some children and young people will have already socially transitioned or be in the process of effecting a social transition, while others may be considering this. It is important that the risks and benefits of social transition are discussed with the child or young person and family, referencing best available evidence. Decisions will be individual, and the agency to make the decision rests with the young person, along with their family. Individual autonomy to change or cease social transition is an important part of the discussion. This service specification recognises that children at different ages and developmental stages have different needs and that the detail of the different approaches to clinical support across the age ranges will develop as the services evolve and the evidence becomes available.

Appendix B MULTIDISCIPLINARY TEAM COMPETENCIES AND EXPERIENCE

Gender Incongruence in Children and Young People under 18 years of age	• Understanding of the wider social context in which specialist health services for gender incongruence operate; and specifically, understanding of the operation of specialist NHS services for gender incongruence in the context of recent judicial, regulatory and commissioning decisions • Understanding of the contested debate around different management approaches for responding to children and adolescents who have gender incongruence; and the limited evidence base to inform clinical approaches and service delivery; and limited data on outcomes • Understanding of the various reasons why professionals may make a referral to specialist gender incongruence services • Understanding of the current NHS pathway for children and young people up to 17 years • Understanding of diagnostic formulation currently DSM-V moving to ICD-11) on the NHS pathway of care • Understanding of how gender incongruence presents in children and young people, and the resulting physical, mental health and psychosocial needs of children and young people on the NHS pathway of care including while they are on the waiting list • Understanding of approaches to care that are delivered by NHS specialist gender services, and support needs and support options for children and young people who have degrees of gender incongruence • Understanding of the intended outcomes for children and young people who are seen by NHS specialist gender incongruence services • Understanding of the relationship / interface between: - The Service and Adult Gender Dysphoria Clinics - Specialist NHS gender incongruence / dysphoria services and primary care - Specialist NHS gender incongruence / dysphoria services and other statutory services
Multi-Disciplinary Clinical Leadership team	In addition to specific expertise in gender identity development and incongruence, the clinical leadership team of The Service should include strong, consultant level expertise in: • Paediatric healthcare including child and adolescent development and endocrinology • Psychological healthcare including child cognitive and emotional development, psychological interventions and therapy, including consultation and liaison approaches to healthcare delivery • Mental health diagnoses and intervention, including pharmacological interventions and in-patient mental healthcare • The psychological and mental health aspects of healthcare for children & young people with physical healthcare need • Neuro-developmental conditions, including autism and attention deficit with hyperactivity disorder (ADHD)

	• Consent and mental capacity in a child development context where there may be a complex and contentious aspects. • Designing, monitoring and redesigning or improving effective, efficient • and responsive care pathways in collaboration with experts by experience
Knowledge and Experience of Specific Presentations and Interventions	Awareness of a range of mental and physical disorders; and knowledge of models of intervention and their application in practice. Including knowledge and experience of: • Neurodevelopment disorders including autistic spectrum conditions • Mental health disorders including depressive conditions; anxiety and trauma; eating disorders • Endocrine conditions including Differences of Sex Development • Pharmacology, particularly in the context of gender incongruence • Range of risks that may present in the child or young person including deliberate self-harm; exploitation; high risk behaviours; substance abuse • Family contexts for children and young people that include being a child in care, or kinship care (including special guardianship) or being adopted
Child and Young Person Development	• Knowledge of development in children and young people; including normative development; social and behavioural development; sexual development; gender identity development and gender expression • Understanding of the differences in sexual identity and gender identity, and expression • Knowledge and understanding of mental health problems in children and young people • Knowledge and understanding of neurodevelopment disorders in children and young people • Knowledge of the physical development of children and young people • Knowledge of the needs of young people who are moving from paediatric to adult services • Understanding of mental and physical health problems in children and young people in the context of impact to: - Educational attainment - Social development including formation of peer relationships
Family Development and Relationships	• Understanding of normative family development • Understanding of mental and physical health problems in children and young people in the context of impact to family relationships • Understanding of parents with additional needs and impact of their mental and physical health needs to children and young people
Assessment, Formulation and Diagnosis	• Ability to contribute to assessment, formulation and diagnosis while acting in a consultation role to the professional network (including specialist mental health assessment) • Ability to contribute to risk assessment and management while acting in a consultation role to the professional network
Cultural Curiosity	• Cultural curiosity and understanding of equality and diversity principles • Understanding of the wide diversity of children and young people who are referred to specialist gender incongruence services • Understanding of the social, emotional and mental health needs of relevant groups in the local communities who share protected characteristics

Multi-Agency Working	• Ability to work within and across different agencies (health; education; social services; youth justice; other) and an understanding of how these agencies operate including the local voluntary sector • Knowledge of, and ability to work within, relevant professional and ethical guidelines • Understanding of the role of education services in supporting children and young people with gender incongruence (supporting full access to the curriculum and pastoral support including, vulnerable children policies; toilet and changing room policies; pupils with special education needs and, addressing, exclusion, bullying and harassment) • Ability to act in a coordinating and consultation role in case work, working with professionals across different services and agencies
Safeguarding	• Recognise and respond to concerns about child protection and safeguarding • Knowledge of legal frameworks relating to children and young people • Knowledge of, and ability to work with, issues of confidentiality, consent and capacity

Appendix C QUALITY METRICS

Unique Metric Code	What indicator	Rationale	Numerator	Denominator	Frequency	Target	Numerator Data Source	Denominator Data Source
GICYP07	Proportion of clinical staff in the service have received induction training (designed by the Academy of Medical Royal Colleges) within 3 months of joining the service.	All clinical staff must have received induction training (designed by the Academy of Medical Royal Colleges).	Number of clinical staff in the service who have received the induction training (designed by the Academy of Medical Royal Colleges) within 3 months of joining the service in the reporting period.	Number of clinical staff in the service in the reporting period.	Quarterly (lag by a quarter)	100%	Provider submission	Provider submission
GICYP08	Proportion of young people over 18 years and 3 months old who are registered with the service.	As outlined in the service specification: The Service may provide support to young people up to their 18th birthday (exceptionally, up to 18 years and 3 months)	Number of young people over 18 years 3 months old who are registered with the service in the reporting period	Number of children and young people under service in the reporting period	Quarterly	0%	Provider submission	Provider submission
GICYP09	Proportion of children and young people under the service who have an individual care plan which is confirmed in	Every patient reviewed by the service is required to have a tailored individual care plan utilising the Holistic Assessment Framework (HAF) as outlined in the	Number of children and young people under the service in the reporting period who have an individual care plan which is	Number of children and young people under the service who have had an initial assessment appointment in	Quarterly (lag by 3 weeks)	100%	Provider submission	Provider submission

	writing with the GP, and shared in writing with the family within 3 weeks of the appointment at which the ICP has agreed with the family.	Cass Review 2024.	confirmed in writing with the GP, and shared in writing with the family within 3 weeks of the appointment at which the ICP has agreed with the family.	the reporting period.				
GICYP01	Percentage of children and young people who attend an initial assessment appointment by the service within 6 weeks of transfer from the national waiting list	As outlined in the commissioning intentions document: All transferred referrals will have an initial assessment appointment by the service within 6 weeks	Number of children and young people who attend an initial assessment appointment by the service within 6 weeks of transfer from the national waiting list in the reporting period	Number of children and young people who are transferred from National Waiting List to the service in the reporting period	Quarterly	80%	Provider submission	Provider submission
GICYP02	Proportion of children and young people under the service who require a safeguarding referral to children's social care	The interim service specification states that children and young people under the service will be assessed to identify and respond to safeguarding needs of children and young people. Safeguarding concerns will result in a referral to	Number of children and young people under the service who have a safeguarding referral to children's social care in the reporting period	Number of children and young people under service in the reporting period	Quarterly	n/a	Provider submission	Provider submission

		safeguarding services.						
GICYP03	Proportion of children and young people who have completed planned psychoeducation sessions	The interim service specification states that one of the objectives of the assessment process will be that children and young people who are seen by the service will receive psychoeducational information that is appropriate to their needs.	Number of children and young people who have completed all planned psychoeducation sessions in the reporting period	Number of children and young people under service who are referred for planned psychoeducation sessions in the reporting period	Quarterly	100%	Provider submission	Provider submission
GICYP04	Proportion of parent/carer who have completed planned psychoeducation sessions	The interim service specification states that one of the objectives of the assessment process will be that children and young people who are seen by the service, and their parents/carers, will receive psychoeducational information that is appropriate to their needs. Parents, carers, and families, (including siblings) will have the opportunity to access additional resources including	Number of children who had a parent/carer present who completed all planned psychoeducation sessions in the reporting period	Number of children and young people under service who are referred for planned psychoeducation sessions in the reporting period	Quarterly	100%	Provider submission	Provider submission

		facilitated group discussions with peers on a similar pathway.						
GICYP05	Proportion of children and young people with improved Children's Global Assessment Scale (CGAS) on discharge compared to at baseline (during initial assessment appointment by the service)	This scale is completed by healthcare professional when patient enters the service. The Global Assessment Scale (GAS) is a tool used to evaluate an individual's overall functioning, particularly in the context of mental health. It provides a numerical score ranging from 1 to 100, where higher scores indicate better functioning and lower scores suggest more severe impairment.	Of those in the denominator, number of children and young people who had an improved CGAS secure score recorded before discharge compared to CGAS score at baseline (during initial assessment appointment by the service)	Total number of patient discharges who had a CGAS score recorded at baseline (during initial assessment appointment by the service) in the reporting period	Quarterly	100%	Provider submission	Provider submission
GICYP06	Proportion of young people over 18 years old who are transferred to adult gender services	Ensure service is operating in line with the protocol of transfer of clinical responsibility: For young people who have been seen by The Service and who are approaching their 18th birthday The Service will co-	Number of young people over 18 years old who are transferred to adult gender services in the reporting period	Number of young people over 18 years old who are discharged from children and young people gender services in the reporting period	Quarterly	n/a	Provider submission	Provider submission

		ordinate a transition and support plan with the professional network specific to the young person’s needs. A transfer may be made to an NHS-commissioned Gender Dysphoria Clinic from 17 years of age where the young person meets the access criteria (in line with the Protocol for Transfer of Clinical Responsibility the service to Adult GDC). The Service will discharge the young person around their 18th birthday.						