NHS Children and Young People’s Gender Services

Report on outcome of consultation

March 2026

Introduction

Between August and November 2025 NHS England held a public consultation on proposed changes to the service specification for specialist gender incongruence services for children and young people which, if adopted, would describe how current and future commissioned providers of NHS Children and Young People’s Gender Services will deliver the service.

This report describes how NHS England has considered the submissions made during public consultation, and includes a summary of the submissions made by respondents to consultation. Please refer to the report of the independent analysis of consultation submissions for a more detailed description of the submissions made by respondents (Appendix A).

Background

This revised version (subject to the consultation outlined in this paper) followed publication of an interim service specification in June 2023, which was developed in response to the interim advice of the independent review of NHS gender identity services for children and young people (the Cass Review).

The interim service specification described a more cautious and holistic approach to diagnosing and caring for children and young people presenting with gender incongruence in line with the interim recommendations of the Cass Review. NHS England held a public consultation on the interim specification in 2022.

Respondents to the consultation in 2022 were informed that NHS England would review, and possibly update, the interim service specification once the Cass Review had delivered final advice and recommendations.

Following a separate process of stakeholder engagement in April 2025, NHS England published a version of the service specification in August 2025 that proposed the following amendments, supported by an Equality and Health Inequalities Impact Assessment:

a. A description of a holistic assessment framework.
b. A description of the role and function of the National Provider Network.
c. Arrangements for data collection, audit and evaluation.
d. The role of the Children and Young People's Gender Service in leading a network of local services.
e. The inclusion of endocrinology as a core function within the Children and Young People's Gender Service's Multi-disciplinary Team.
f. Alignment of the service specification with the ancillary service specification Referral Pathway for Specialist Service for Children and Young People with Gender Incongruence (August 2024).
g. Alignment of the service specification with NHS England's clinical commissioning policy for Puberty Suppressing Hormones and with NHS England's clinical commissioning policy for Gender Affirming Hormones (March 2024) - and with recent government legislation that places restrictions on private prescribing.
h. The addition of provider-reported metrics.
i. A separate pathway for pre-pubertal children.

In the linked consultation, respondents were asked for their views on the proposed amendments, as well as views on the proposed Equality and Health Inequalities Impact Assessment. The consultation was structured through quantitative and qualitative questions, as well as providing opportunities for further 'free text' feedback.

An third party, TONIC, was commissioned by NHS England to produce an independent evaluation report of consultation submissions. This report can be found at Appendix A.

388 submissions were made, of which 42 were from organisations.

Whilst most respondents agreed with the quantitative questions, the qualitative responses revealed a deep divide, with two fundamentally opposed perspectives on children's gender services. These indicated not just policy disagreement, but also fundamentally incompatible views about gender, childhood development, medical ethics and what constitutes care versus harm. Whilst both perspectives expressed shared concerns around safeguarding, evidence-based care, vulnerable populations, accountability, transparency and system distrust, these concerns were defined in opposing ways.

NHS England has carefully considered the report of the analysis of consultation submissions and, having also taken advice from the Clinical Reference Group for Children and Young People’s Gender Services, it has made the following decisions:

Holistic assessment framework

The previous description of the clinical model in the interim service specification was replaced in the updated service specification with a description of the holistic assessment framework from the final Cass Report, alongside the Cass Report’s description of the process of diagnosis, formulation and individualised care planning.

The majority of respondents (66%) supported the inclusion of the holistic assessment framework as described in the service specification.

The majority of clinicians, parents, provider services and other stakeholders were supportive, but views amongst patients were mixed, with 38% in support and 54% not supporting.

NHS England has decided to retain the description of the holistic assessment framework. This change builds on the holistic approach established in the interim specification and provides greater clarity and transparency about the important change in approach to clinical assessment and the process of reaching a diagnosis.

The role and function of the National Provider Network

The majority of respondents (68%) supported the description of the role and function of the National Provider Network. This was the same for all stakeholder groups.

NHS England has decided to retain the description of the National Provider Network. A National Provider Network is not unique to children's gender services and the networks that exist for other clinical specialties have demonstrated the benefits that can be brought to patient care. The National Provider Network, hosted by Alder Hey Children's NHS Foundation Trust with an independent chair, will ensure that there is a consistent national approach to various elements of service delivery, including research, data collection, clinical audit, staff training and education, and the management of the National Multidisciplinary Team that reviews clinical recommendations for hormone intervention.

Arrangements for data collection, audit and evaluation

The majority of respondents (58%) supported the description of the arrangements for data collection, audit and evaluation. The majority of all stakeholder groups supported the proposal for data collection, audit and evaluation with the exception of patients, where 46% did not support the proposal based on privacy and security concerns, a lack of specificity about the data to be collected and suspicions about how the data will be used.

NHS England has decided to retain the description about arrangements for data collection, audit and evaluation. This includes the requirement for the collection of a common clinical data set across commissioned providers and a description of a coordinated, single national registry (into which the commonly collected data is reported) to support audit, service evaluation and quality improvement. This approach reflects best practice established in other areas of healthcare and mirrors recommendations in the Cass Review which emphasised the need for more consistent, comprehensive, accurate and meaningful data collection to support safe and effective clinical service provision through continuous quality improvement and service evaluation, and for academic research purposes.

Noting the concerns expressed during consultation about security and privacy, NHS England requires that all patient data collected and reported by the NHS is handled and processed securely in compliance with the General Data Protection Regulation. As the data will be processed under Outcomes and Registries Directions 2024, we have reconfirmed that the option for National Data Opt-Out does not apply to routine healthcare data collected from publicly funded healthcare providers. NHS England has been directed by the Secretary of State for Health and Social Care under section 254 of the Health and Social Care Act 2012 to establish and operate a system for the collection and analysis of the information specified for this service. The directions cover a number of purposes (see section 4.2 here https://digital.nhs.uk/binaries/content/assets/website-assets/corporate-information/directions-and-…) but most specifically relate to direct patient care and improving patient outcomes. Where there are proposals for the routine data to be used for other ‘secondary’ purposes, for example for research, these will be subject to additional considerations and protections, including appropriate study-specific approvals.

For greater transparency, NHS England will ensure the publication of the common clinical data fields to be routinely collected and reported by The NHS Children and Young People's Gender Services, as part of the service specification requirements.

The role of the Children and Young People's Gender Service in leading a network of local services

The majority of respondents (64%) agreed with the role of the Children and Young People's Gender Service in leading a network of local specialist services. This was the same across all respondent groups. Of those respondents who did not support the proposal, reasons were in some case diametrically opposed - some respondents were concerned that the effect of the local network would be to prevent or delay access to the specialist gender service, but others who did not support the proposal were worried that the effect of a local network would inappropriately accelerate or increase the number of patients accessing the gender service.

NHS England has decided to retain the description of the role of the NHS Children and Young People's Gender Service in leading a network of local services, with minor amendments to nomenclature. The changes will support the Cass Review's ambition for greater integration of the specialist gender services with other local services at a regional level, in order to support all of a child or young person's health needs.

The inclusion of endocrinology as a core function within the Children and Young People's Gender Service's Multi-disciplinary Team

There were mixed views on the inclusion of endocrinology as a core function within the multi-disciplinary team providing the gender service, with 48% agreeing and 47% disagreeing. Patients (74%) and service providers (75%) agreed with the proposal, and 54% of parents and nearly half of clinicians disagreed (49%).

Almost of all the submissions on this point focused on the potential role of the endocrinologist in the management of endocrine interventions, and many respondents used the process of consultation to express their views on whether the NHS should prescribe Gonadotropin-Releasing Hormone agonists (‘puberty blockers’) or exogenous hormones (‘cross sex hormones’) to children and young people for gender incongruence, though NHS England was not inviting submissions on this point.

NHS England has decided to describe more clearly in the service specification that the endocrinologist has a wider role in supporting the clinical team on matters such as identification/exclusion of potentially endocrine-based conditions that may be relevant to an individual’s symptoms, diagnosis or treatment as well as in regard to patients who may have previously received, or may wish to consider, an endocrine intervention specific to gender incongruence. NHS England has also made clearer that medical intervention is not the standard clinical approach, and we have explained that the role of the endocrinology team in relation to management of medical intervention will be further defined through a clinical commissioning policy later in 2026. NHS England is reviewing the evidence around the use of exogenous hormones in children and young people under 18 years for gender incongruence and gender dysphoria, and will consult on the evidence base in 2026. The current NHS clinical commissioning policy that describes the approach for exogenous hormones will be retired in 2026, and the terms of the service specification will be updated as appropriate in 2026 to align with the eventual new clinical policy position that is adopted.

NHS England’s clinical commissioning policy that prevents the routine use of Gonadotropin-Releasing Hormone agonists (puberty blockers) was agreed and adopted in 2024 and remains in place.

Approach for children and young people accessing hormone medications from unregulated sources

The interim service specification clarified NHS England's position in relation to children and young people who source prescriptions or medicines from unregulated sources or providers, including online providers that are not regulated by UK regulatory bodies. The interim specification 'strongly discourages' children, young people, and their families from sourcing medicines outside of NHS protocols. The revised specification further clarifies this position, including a confirmation that the NHS Children and Young People's Gender Service will not assume responsibility for the prescribing or monitoring of any medication initiated outside of the service.

The majority of respondents (56%) agreed with the proposed approach. Most stakeholder groups had the majority in agreement with this approach except for patients, where 72% disagreed. Those who disagreed with the proposal were generally supportive of a more permissive approach to the use of puberty suppressing hormones and exogenous hormones contrary to NHS policy.

NHS England has decided to retain the provisions around the approach to medications from unregulated sources. Unregulated healthcare services pose a risk to patient safety as they are not subject to the same level of scrutiny as registered services, and using medications from other unregulated sources is dangerous because of the various risks about contamination and counterfeit drugs. NHS England's approach is consistent with the advice that it offered primary care professionals in May 2025 - that GPs should not agree to a shared care agreement with an unregulated provider in regard to prescribing medications to a child under 18 years as a response to gender incongruence.

In response to submissions made on this point, in the section of the service specification that refers to the Government's restrictions on the private supply of Gonadotropin-Releasing Hormone agonists, NHS England has changed the reference from ‘puberty suppressing hormones’ to ‘Gonadotropin-Releasing Hormone agonists’ to align with the wording of the relevant legislation.

The addition of provider-reported metrics

59% of consultation respondents agreed with the inclusion of the proposed provider-reported metrics. Some respondents expressed concern that key research objectives present in the March draft specification were removed from the August version, particularly studies on epidemiology, prediction, course of gender questioning, and outcomes of psychological treatments. They stated that rolling out a national programme without conducting this essential research was unsafe.

Others emphasised metrics should focus on meaningful outcomes reflecting wellbeing and lived experience rather than administrative process data and should be co-produced with trans communities.

NHS England has decided to retain the proposed provider-reported metrics. Once sufficient routine data has been collected by the providers, including the extensive core common clinical data set agreed, this will provide an opportunity for review and further clinical outcome indicators will be developed and agreed, informed by evidence generated by the various activities of the National Gender Services Research Oversight Board, including the living systematic evidence reviews that will maintain an up-to-date evidence synthesis of the latest international research across the 4 themes of characteristics & pathways; social transition; hormonal interventions; and psychosocial interventions.

As noted above, NHS England will also ensure the publication of the common clinical data fields to be routinely collected and reported by NHS Children and Young People’s Gender Services, as part of the service specification requirements. We are conscious that this will provide more transparent, and rounded, information on the core data (including clinical and experiential data) to be routinely collected by commissioned providers.

Separate pathway for pre-pubertal children

The majority (53%) agreed with the proposed separate pathway for pre-pubertal children. This was the same for all groups with the exception of those responding as patients, where 51% disagreed with this approach.

NHS England has decided to retain this provision. Being mindful of the advice of the Cass Review that gender non-conforming children are most likely to desist before puberty, NHS England has accepted the Cass Review's recommendation for a separate pathway for pre-pubertal children and their families so that these children and their families are seen for early discussion.

Other changes to the proposed service specification:

Population Size

The graph has been updated to reflect most recent referral data.

Training and Education

The service specification describes that services will deliver training and education to clinical staff using a standard Professional Competence Framework for NHS Children and Young People's Gender Services, and standard curriculum content, that will be made available through NHS England in 2026/27.

Respondents were also asked whether there were any other changes or additions to the revised service specification that should be considered:

Respondents said…	**NHS England response …**
The holistic model must extend to age 25 to protect young adults Some respondents expressed concerns that 17-year-olds who were transferred to adult services would “fall off a cliff edge" upon entering services that were felt to still operate on an affirmative model that fast-tracked hormones and promoted and provided minimal therapy. They argued that because brain development continues until age 25, the holistic approach should continue for the same length of time, and that young adults should receive the same level of safeguarding and care as children.	The scope of the service specification for NHS Children and Young People’s Gender Services extends to an individual’s 18th birthday, reflecting that these services are delivered by dedicated paediatric hospitals. NHS England is exploring with potential partner organisations the feasibility of establishing a follow through service for 17-25-year-olds in line with the recommendation of the Cass Review. This work will require NHS England to identify a provider organisation(s) that is/are able to deliver the pathway, define a delivery model including though a proposed service specification for the purpose of public consultation, and to design the evaluation framework prior to the establishment of the service. In the meantime, the service specification for the NHS Children and Young People’s Gender Service has been changed to be clearer

	that a transfer to an Adult Gender Service may not be the most appropriate discharge route for all patients. For young people who are approaching their 18th birthday the NHS Children and Young People's Gender Service will consider an individual's specific needs having regard to the range of support and treatment options that may best address their identified needs.
Outcomes for those treated at GIDS should be published before new services are established Some respondents believed that, ahead of implementing any new services, NHS should publish long-term outcomes for the approximately 2,000 children who received puberty blockers and treatment at the Tavistock GIDS. Respondents argued that establishing new services without auditing this legacy data would ignore vital lessons regarding efficacy and distress.	The new model of NHS CYP gender care reflects recommendations reached following a review of the currently available evidence, extensive and wide-ranging engagement with patient, clinicians and other experts, including learning from the previous model of gender care provided by the former Gender Identity Development Service (GIDS). NHS England remains committed to continuing to build a stronger evidence base, including completing the data-linkage study, which forms part of the wider research programme now underpinning new NHS services for children and young people with gender incongruence. Whilst this study aims to provide valuable additional insights into the experiences of patients previously cared for under a former model of NHS gender care, by looking for linkages or

	associations observable with available healthcare records, NHS England does not consider it necessary, or appropriate, to delay improvements to services for children with gender incongruence whilst this individual study is completed.
The use of ICD-11 codes is necessary to de-pathologise trans identities Some respondents expressed support for using "Gender Incongruence" (ICD-11) to ensure care was not stigmatising. Respondents argued that trans identities should not be framed as mental illnesses, while maintaining that medical support should still be accessible.	For the purpose of describing the open caseload within the Children and Young People's Gender Service, the service specification makes numerous references to 'gender incongruence' as defined by ICD-11. This is appropriate, as all children and young people referred into the service will have a marked incongruence between their experienced/expressed gender and their natal sex. For the purpose of diagnostic assessment, the holistic assessment framework that is described in the service specification also refers to 'gender dysphoria' as defined by DSM-5 and references that Cass Review's observation that "*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*".

Clearing wait lists Some respondents called for the NHS to declare a state of emergency regarding trans healthcare and implement a crisis recovery plan comparable to those used for tackling COVID or cancer backlogs, in order to clear multi-year waiting lists. Some suggested removing overloaded services like CAMHS and paediatric services from the referral pathway, urging for direct and simple routes to patient-centred care.	NHS England's transformation programme for NHS Children and Young People's Gender Services is built upon the establishment of up to eight new regional services by 2026/27, working to the new clinical model described by the Cass Review. The proposal for referrals to be restricted to those made by NHS mental health services or paediatric services was subject to public consultation, the outcome of which was published by NHS England in 2024.
Whistle-blowers Some respondents suggested that NHS should implement a robust whistleblowing policy so that any safeguarding or affirming issues could be dealt with effectively, and to aid	This is outside of the scope of a service specification for a clinical service. All commissioned providers have 'whistle-blowing' policies in place.

protecting the service from ideological influence.	
Legal and ethical frameworks Some respondents raised concerns that the specification risked breaching both the Memorandum of Understanding on Conversion Therapy (MoU v2) and the Public Sector Equality Duty. Additionally, it was argued that excluding trans voices violated the NHS Patient and Public Participation Policy and Article 12 of the UN Convention on the Rights of the Child (the right to be heard).	NHS England is assured that the process for formation of the proposed service specification, and its proposed content, is lawful and appropriate, including the arrangements made for stakeholder engagement and public consultation.
Language Some respondents explicitly called for the service to use the terms "trans" or "transgender" in its clinical narrative, which they felt was necessary to avoid invalidating identities. Some also	As is the case for all NHS service specifications that describe a specialised clinical pathway, the population covered by the proposed service specification must be described in inambiguous terms with reference to a clinically appropriate, and meaningful, diagnostic framework/s. It is for this reason that the proposed service specification describes the patient cohort with reference to

requested specific reference to nonbinary patients and their unique needs.	DSM-5 (Gender Dysphoria) and ICD-11 (Gender Incongruence). The language used in the current proposed service specification is consistent with the language used in the existing, ancillary service specification that was adopted in 2024 and that describes who may be referred to the national waiting list for NHS Children and Young People's Gender Services.

Equality and Health Inequalities Impact Assessment

Respondents were also asked about the extent to which they agreed that the Equality and Health Inequalities Impact Assessment (EHIA) reflects the potential impact on equalities or health inequalities which could arise because of the proposed changes.

The majority (56%) felt that the EHIA did not reflect the potential impact on equalities or health inequalities which could arise because of the proposed changes. Only service providers felt the EHIA did reflect the potential impact of the proposed changes.

Respondents said…	NHS England response …
The EHIA fails to fully assess the impact on the basis of sexual orientation	The EHIA cannot explain the reasons for the demographic trend beyond the detailed findings of the Cass Review (2024). Rather, the EHIA has acknowledged the importance of building research

Some respondents felt that while the EHIA notes that same-sex attracted young people are disproportionately referred to gender services it does not investigate why. Respondents felt that evidence and clinical experience suggest that some youths pursuing a trans identity may actually be struggling with internalised homophobia, parental homophobia, or rigid gender stereotypes, rather than genuine gender-related distress. Failing to explore this was seen as a major safeguarding issue that could have serious negative consequences for gay and lesbian adolescents. Without understanding why same-sex attracted youth are over-represented, respondents felt that NHS England risks offering	capabilities for the purpose of continuous quality improvement initiatives, and it describes that NHSE will consider how to use the outcome of this research to inform its future approach to the commissioning of these services. The EHIA also describes that, based on the advice of the Cass Review, the holistic assessment framework that is detailed in the service specification explores sexual orientation and psychosexual development and how this influences an individual's gender presentation. The service specification sets out the workforce requirement of ensuring that the MDT includes practitioners with expertise in childhood and adolescent development, including sexual development which will also have a positive impact on those young people referred to the service who have the protected characteristic of sexual orientation.

irreversible treatments for distress rooted in sexuality, not gender.	
The EHIA fails to fully assess the impact on the protected characteristic of age Some respondents felt that the EHIA did not adequately consider that children's limited capacity for informed consent is itself a core safeguarding issue. They stated that age protections exist because young people are still developing, yet the assessment fails to explore how this affects their ability to understand and weigh the lifelong consequences of medical interventions. Respondents also questioned the claim made in the EHIA that "the model is safe and evidence-based," which appeared to	In regard to medical intervention, the service specification references two separate clinical commissioning policies that address the issue of consent as described by these respondents: - Puberty suppressing hormones are not prescribed for gender dysphoria to children under 18 years through the NHS pathway of care since 2024 - Exogenous hormones are not available to children under 16 years, and are not available to young people aged 16 or 17 years where, it is assessed through clinical assessment, that there are doubts about their ability to give informed consent. The service specification describes a new clinical model and approach for clinical assessment that is safe and evidence based as it is compliant with the findings and recommendations of the Cass Review and the evidence relied upon by the Cass Review, most notably in its description of the new Holistic Assessment

contradict the Cass Review's finding that the medical pathway is not supported by adequate evidence and cannot be assumed safe. Respondents who raised this issue believed that children and adolescents are highly vulnerable to parental, social, and online influence, and that the EHIA fails to examine how these pressures shape decision-making.	Framework. Dr Cass, in her final report, noted the need for future research and academic activity, and clinical audit, to further increase the evidence base and to inform continuous quality improvement by the services, and NHS England has described how this recommendation is being taken forward through a wide-reaching research programme.
The EHIA fails to fully assess the impact on disabled children and young people Children with learning disabilities, autism, complex mental health problems (including psychosis, drug addiction, self-harming, anxiety, and depression) and those in care are heavily over-represented in gender service referrals, yet the generic diagnosis of "gender	The EHIA acknowledges that a high proportion of children and young people with gender incongruence will also present with other significant comorbidities, including neurodiversity. The EHIA cannot explain the reasons for this beyond the detailed findings of the Cass Review (2024). Rather, the EHIA correctly describes how the adoption of the Holistic Assessment Framework will benefit individuals who have this protected characteristic as it will determine whether there are any cooccurring and/ or contributory elements of the individual's

incongruence" fails to explain why. The EHIA does not consider that neurodivergent or vulnerable children may misinterpret social or sensory difficulties as gender issues or be more susceptible to external influence. A one-size-fits-all diagnosis risks overlooking their actual needs and providing inappropriate or harmful care. By ignoring these safeguarding concerns, the assessment mistakenly frames cautious, evidence-based practice as discriminatory, when protecting vulnerable children from experimental interventions should be the priority.	presentation that are affecting their psychosocial wellbeing or functioning, and will form the basis of an individual care plan. The service specification itself reads: "*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 … 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*".
The EHIA fails to fully assess the impact on the protected characteristic of sex	The EHIA cannot explain the reasons for the demographic trend beyond the detailed findings of the Cass Review (2024) though, contrary to suggestions by some respondents, the EHIA does

The EHIA notes that around 65% of referrals are now adolescent girls yet concludes that “no discrimination arises.” This dismisses a major safeguarding concern that the cohort has flipped from mostly boys to mostly girls, an unprecedented shift that the assessment does not attempt to explain. The EHIA fails to consider why so many teenage girls are seeking gender services, despite well-known vulnerabilities in this group, including higher rates of sexual abuse and trauma, intense social and body-image pressures, regressive gender stereotypes, online influence, and misogyny. These factors could contribute	acknowledge that the demographic split has changed to predominantly natal females in recent years. The proposed service specification is mindful of the need for the process of assessment to explore potential underlying issues, as evidenced by the description of the new holistic assessment framework: “*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*”.

to gender-related distress without indicating a stable trans identity. If treatments are not evidence-based, girls – already the majority of referrals – will be disproportionately harmed. Medicalising distress rooted in trauma, social pressure, or misogyny does not promote equality for girls; it deepens their disadvantage. Simply noting the disproportionate impact and declaring “no discrimination” without investigating causes is a serious safeguarding failure. Some respondents also highlighted that the EHIA made no reference to the Supreme Court judgment in For Women Scotland v Scottish Ministers (2025), which clarified the definition of “sex" in	On the issue of the Supreme Court judgment, respondents to consultation have not identified any elements of the proposed NHS service specification that require revision as a direct response to the judgment.

UK equality law. They felt that this omission was critical and that the accommodation of the protected characteristic of gender reassignment must not compromise the existing legal protections based on biological sex.	
The EHIA fails to acknowledge the risks associated with restricting access to care Some respondents felt that the Equality and Health Inequalities Impact Assessment fails to adequately acknowledge the severe risks associated with restricted access to gender-affirming care. By framing the proposed changes as neutral or protective, the assessment underestimates the tangible harm inflicted on trans children and young people facing prolonged delays.	NHS England infers from the reference to the ‘*development of irreversible physical characteristics that could have been prevented’* that these submissions relate to the separate NHS clinical commissioning policy that prevents routine prescribing of GnRHa (puberty blockers) to children under 18. The service specification does not propose any changes to the clinical commissioning policy that was adopted by NHS England in 2024, and NHS England was not seeking views from respondents on the use of GnRHa. This is because in 2024 NHS England separately published the outcome of public consultation on the evidence that supported the formation of the policy position for the use of GnRHa, including an EHIA.

Withholding or delaying timely, affirming intervention is not a neutral act; it actively exacerbates health inequalities by contributing to deteriorating mental health, increased distress, and the development of irreversible physical characteristics that could have been prevented. The EHIA must recognise that “watchful waiting” without clinical support disproportionately disadvantages trans youth compared to their peers accessing other time-critical NHS services.	
The EHIA fails to fully assess the impacts of treatment Some respondents felt that the EHIA was created on the flawed assumption that increasing access to medical intervention equates to reducing health inequality, failing to acknowledge that providing	The basis for these submissions is not clear to NHS England. The effect of the proposed service specification is not to increase access to medical intervention, and the EHIA does not suggest otherwise. Rather, the service specification refers to the separate clinical commissioning policy that prevents the use of puberty suppressing hormones for children under 18 (2024) and to the amended clinical commissioning policy for exogenous hormones

unproven, irreversible treatments to children creates its own severe health inequalities. In this regard, respondents believed that the EHIA overlooked the findings of the Cass Review regarding the lack of evidence for puberty blockers and cross-sex hormones, and that by ignoring these clinical uncertainties it underestimated the long-term physical risks (such as metabolic issues, cardiovascular health, and loss of fertility) imposed on young people who cannot fully comprehend the lifelong implications due to their age and cognitive maturity.	(2024) that places restrictions on the use of exogenous hormones to young people aged 16 and 17 years in line with the recommendations of the Cass Review.
The EHIA does not fully assess the risk to the already marginalised The Equality and Health Inequalities Impact Assessment (EHIA) is currently unfit for purpose, reading as an	The level of detail set out in the EHIA and the consideration that NHS England has given to the issues is in itself evidence that NHS England has not approached the development of the EHIA as a ‘tick box’ exercise.

institutional “tick-box” exercise rather than a genuine analysis of risk. It fundamentally fails to recognise that the proposed barriers to care will not affect all children equally; they will disproportionately harm those who are already the most marginalised. e.g. neurodivergent, BAME/race, financially disadvantaged, Looked After Children, those in rural or remote locations, homeless youth.	
The protected characteristic of gender reassignment Some respondents felt that the EHIA incorrectly applied the adult “gender reassignment” protected characteristic to children. They stated that this protection was created to prevent discrimination against adults undergoing, or intending to	NHS England has correctly applied the law. The EHIA references the 2023 judgment of *R(AA and Others) v NHS Commissioning Board* in which the High Court held that not every child or young person referred to a specialised gender incongruence service will have the protected characteristic of ‘gender reassignment’ (upheld subsequently by the Court of Appeal). The Court found that children and young people who are referred to such a service do not – at the point of referral or while they remain on the waiting list -

undergo, legal and medical transition, and should not be applied to confused or distressed young people exploring identity in adolescence.	share the protected characteristic of ‘gender reassignment’ as a class or cohort of patients, but that children and young people under 18 years may have the protected characteristic depending on an assessment of their individual circumstances. It is less likely that younger children will have the protected characteristic.
The EHIA fails to adequately address the risk to neurodivergent children The EHIA fails to address the significant risk that the Holistic Assessment Framework will be weaponised against neurodivergent children, constituting disability discrimination. While the proposed specification links neurodiversity to gender distress, there were concerns that this would not be used for support but as a gatekeeping mechanism to delay or deny care. To mitigate this harm, the EHIA must be revised to ensure that any	The EHIA does in fact acknowledge that some respondents to the earlier process of stakeholder testing were concerned that the proposed Holistic Assessment Framework may disadvantage individuals who are neurodiverse, and that it may delay or prevent access to the CYP Gender Service. In response to these concerns the EHIA suggested that the adoption of the Holistic Assessment Framework will benefit individuals who are neurodiverse as it will determine whether there are any cooccurring and/ or contributory elements of the individual’s presentation that are affecting their psychosocial wellbeing or functioning, and will form the basis of an individual care plan.

neurodevelopmental screening is opt-out rather than mandatory, and that a diagnosis of neurodivergence does not negate or indefinitely delay access to gender-affirming care.	
The EHIA neglects private users Respondents felt that the EHIA fails to adequately assess the risks associated with the service's "hardline" stance against unregulated or private medication. It operates on the false assumption that condemning non-NHS care will stop it. In reality, the lack of timely NHS provision drives families to seek alternatives out of medical necessity, not convenience. By refusing to provide safety monitoring (harm reduction) for patients accessing	The relevant provisions in the proposed service specification relate to hormone interventions obtained from unregulated providers or unregulated sources. This is consistent with wider approaches taken in the UK by bodies such as the Medicines and Healthcare Products Regulatory Agency (MHRA) to warn the public against sourcing medicines from unregulated sources because of the risks. The EHIA does acknowledge that the approach "*may disproportionately impact families on a low income if in response, they seek access to (or continue with access to) hormone interventions from private providers*" but this is not in itself a persuasive reason for abandoning the proposed approach, which is based on serious safety concerns.

unregulated care, the NHS is actively choosing to increase risk rather than mitigate it. This stance creates a severe health inequality, disproportionately harming low-income families who resort to “DIY” methods because they cannot afford private clinics, yet are denied the safety net of NHS blood monitoring. Respondents also felt that it would force young people to hide their healthcare usage from clinicians for fear of safeguarding referrals or criminalisation, leading to unmonitored medical risks. To avoid negligence, respondents felt that the EHIA must recommend a clinical harm-reduction protocol that monitors patient safety regardless of the medication source, rather than	NHS England has decided to retain the provisions around the approach to medications from unregulated sources. Unregulated healthcare services pose a risk to patient safety as they are not subject to the same level of scrutiny as registered services, and using medications from other unregulated sources is dangerous because of the various risks about contamination and counterfeit drugs. NHS England’s approach is consistent with the advice that it offered primary care professionals in May 2025 (updated March 2026) - that GPs should not agree to a shared care agreement with an unregulated provider in regard to prescribing medications to a child under 18 years as a response to gender incongruence. The guidance is clear that a GP should always be prepared to refer their patient for an appropriate non-routine investigation where there is a concern that the child or young person may come to harm as an outcome of a medication from unregulated sources (for example, monitoring bone density; or venous thromboembolism). The proposed service specification strongly cautions individuals against using medications from unregulated sources.

abandoning these young people to manage complex healthcare alone.	
The EHIA doesn't acknowledge that the proposed service discriminates against older adolescents Some respondents felt that the EHIA failed to acknowledge that the proposed service structure discriminates against adolescents aged 16-17 by diverting resources to a new "early discussion" pathway for pre-pubertal children, thereby risking increasing wait times for adolescents for whom care is clinically urgent and time-sensitive. Respondents also felt that the assessment ignores the severe risk of adolescents "aging out" of the service before receiving care.	This is addressed by the EHIA, which reads: "*The service specification proposes a separate pathway for pre-pubertal children and their families so that they are seen for early discussion.* ***This may increase the waiting time for some older children who would otherwise have been accepted into the service sooner.*** *The proposal for a pathway for prepubertal children is line with Recommendation 23 of the Cass Review. The potential impacts to older children will be monitored by NHS England and the providers of the services, but the Cass Report was clear on the relative benefit of early discussion with pre-pubertal children'*. The approach for young people who 'age out' is described in a separate, published service specification (2024), and the EHIA that informed decision making around that specification considered the issue in detail.

The EHIA is underpinned by discredited evidence The EHIA is compromised by its uncritical reliance on the Cass Review as its primary evidence base. This reliance introduces significant bias, as the Review has been widely criticised internationally and by trans health experts for its methodological flaws, including the arbitrary exclusion of high-quality studies and the disregard of trans lived experience. By treating the Cass Review as indisputable fact, the EHIA perpetuates disproven narratives - such as the theory that social transition is inherently risky or that lesbian youth are being “pressured” into trans identification - while ignoring	NHS England acknowledges the debate that has surrounded the findings and recommendations of the report of the Cass Review since its publication in 2024, including about the Review’s methodology. NHS England is aware that within this debate there are strongly held views from those who support the Review’s findings and methodology as well as those who do not support them. NHS England is aligned with the various UK medical royal colleges who have welcomed the Review, and NHS England remains committed to implementation of the Cass Review’s recommendations in full.

peer-reviewed critiques (e.g., Noone et al., 2025) that highlight these errors. Furthermore, the assessment omits crucial evidence regarding the harms of withholding care, effectively erasing the positive impact of timely intervention on suicide risk and mental health. To be legally robust and ethically sound, the EHIA must be paused and re-evaluated using a broader, internationally recognised evidence base that includes the consensus of major medical bodies (such as WPATH) and, crucially, the input of the trans community itself. Proceeding with a specification built on such a contested foundation is reckless and risks causing institutional harm.	

There was a lack of consultation with those most affected Some respondents felt that the Equality and Health Inequalities Impact Assessment was fundamentally flawed as it lacks evidence of genuine engagement with trans children, young people, their families, or the specialist clinicians who treat them. They believed that health inequalities would be inevitably magnified when the voices of those most affected are excluded from the process.	The EHIA assesses the potential impacts of a number of proposed amendments to the interim service specification for NHS Children and Young People's Gender Services that was adopted in 2024, following public consultation. The most significant amendment is the proposed inclusion of the holistic assessment framework that is described by the Cass Review, and the final report of the Cass Review describes how engagement with children, young people and families informed the Review's recommendations, including the description of the holistic assessment framework (chapter 10). The process of public consultation between August and November 2025 gave respondents the opportunity to critique the EHIA.
The EHIA is transphobic The Equality and Health Inequalities Impact Assessment fails to recognise that the proposed service specification is rooted in a fundamental bias that views	NHS England acknowledges the debate that has surrounded the findings and recommendations of the Cass Review since its publication in 2024. NHS England is aware that within this debate there are strongly held views from those who support the Review's findings and methodology as well as those who do not support

trans identity and transition as negative outcomes to be avoided, rather than valid expressions of human diversity. By relying heavily on the Cass Review - which many respondents reject as ideologically compromised - the service design inherently pathologises trans youth. Respondents also felt that the assessment ignores what they considered the discriminatory nature of the “watchful waiting” approach, which disproportionately impacts neurodivergent youth by infantilising them and treating their agency with suspicion.	them. NHS England is aligned with the various UK medical royal colleges who have welcomed the Review, and NHS England remains committed to implementation of the Cass Review’s recommendations in full.

Respondents also felt that the EHIA failed to address the safeguarding risk posed by unsupportive or abusive parents. By prioritising caution over affirmation, the service risks colluding with transphobic family members to block access to care. Respondents therefore urged that the assessment acknowledges a system they felt was designed to gatekeep and delay, rather than support and affirm, and that it is by definition discriminatory against protected groups.	
The EHIA fails to assess the effect on other children Respondents pointed out that there was no mention of the effect of gender services treatment on other children who may be impacted at school and in sports, among other places, despite this	The EHIA has, correctly, assessed the potential impacts to individuals who are likely to be directly impacted by adoption of the proposed service specification.

viewpoint forming a core response in previous questions on the EHIA.	

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