Public Consultation on the NHS Children and Young People's Gender Service Specification

Consultation Summary Report to NHS England

December 2025

TONIC

Contents

1. Executive Summary

Background

In April 2024, the Cass Review published comprehensive recommendations for NHS Children and Young People's Gender Services. NHS England developed a revised service specification in response, incorporating holistic assessment frameworks, strengthened research requirements, and new governance structures including a National Provider Network (NPN) and Designated Local Specialist Services (DLSS).

Public Consultation

NHS England conducted a public consultation from 4th August to 2nd November 2025, receiving 388 responses. Respondents included parents (29%), clinicians (17%), patients (7%), and providers/services (1%). The consultation addressed nine areas including holistic assessment, management of unregulated prescriptions, the NPN's role, endocrinology services, pre-pubertal pathways, service quality metrics, and the Equality and Health Inequalities Impact Assessment (EHIA).

NHS England commissioned TONIC, an independent social research organisation, to analyse consultation responses. The analysis included quantitative analysis of closed questions and thematic analysis of written responses.

Key Findings

While most respondents tended to agree with the quantitative questions, in accordance with previous consultations the qualitative responses revealed persistent disagreement on the clinical approach and proposed service model, with respondents holding fundamentally opposing perspectives on the role of gender services, the balance between psychosocial support and medical intervention, and the underlying nature of gender incongruence.

Question 3: Holistic Assessment of Needs

66% of consultation respondents supported the inclusion of the holistic assessment of needs as defined in Appendix A to the service specification. Those who agreed with the holistic assessment of needs viewed it as comprehensive and compassionate, helping identify support needs beyond gender care and ensuring treatment considers all factors including trauma, development, and mental health. They emphasised the importance of objective, impartial assessment grounded in current evidence.

Those expressing concerns stated the framework presumed gender incongruence from the start, potentially obscuring other underlying causes. They argued that language suggesting factors like neurodivergence or trauma merely "influence" rather than potentially cause gender distress limited understanding. Some stated that children and young people should receive affirmation and appropriate interventions rather than unnecessary psychological exploration.

Question 4: Management of Unregulated Prescriptions

56% of consultation respondents agreed with the proposed approach to the management of patients accessing prescriptions from unregulated sources. However, those disagreeing pointed out that long wait times (up to five or more years) combined with service restrictions had created conditions forcing families to seek private care or unregulated sources out of desperation. They stated the NHS had created a vacuum in care and argued for an ethical duty to provide harm reduction, clinical oversight, and monitoring rather than withdrawal of care.

Those agreeing expressed concern about safeguarding and the potential for families to bypass NHS safeguards through private prescriptions.

Question 5a: National Provider Network Role and Function

68% of consultation respondents supported the description of the role and function of the National Provider Network. Some respondents emphasised the need for safeguards to prevent ideological commitment from stifling critical thinking, including diverse staffing, protection for clinicians raising concerns, and independent oversight with rigorous vetting of training sources.

Others argued that the NPN must meaningfully include transgender voices in governance and decision-making, expressing concern that without clear mechanisms for trans community representation, the NPN risked becoming a top-down structure making decisions about trans people without them.

Question 5b: Data Collection, Audit and Evaluation Arrangements

58% of consultation respondents supported the description of the arrangements for data collection, audit and evaluation. Those supporting viewed a mandatory national registry as essential for accountability and evidence-based practice, stating it should track all children referred including those on waiting lists, who dropped out, desisters, and detransitioners, with long-term follow-up extending 10–20 years into adulthood.

Those opposing expressed concerns about privacy, security, and ethical handling of sensitive data. They argued families must have the right to opt out without consequence for treatment access and criticised the specification for lacking detail on who would run the database, data access, and anonymisation procedures.

Question 5c: DLSS Network Model

64% of consultation respondents agreed with the role of the Children and Young People's Gender Service in leading a network of Designated Local Specialist Services. Some respondents expressed concerns that implementation would create additional bureaucracy, extend waiting times, and prevent access to necessary care. They stated the NPN would function as a centralised mechanism to enforce restrictive approaches, removing care from local contexts where families were best known. Others viewed the network model as improving geographic equity and access.

Question 5d: Paediatric Endocrinology as Core Function

There were mixed views from consultation respondents on the levels of support for the inclusion of endocrinology as a core function with the proposed Multi-Disciplinary Team, with 48% agreeing and 47% disagreeing. Those viewing endocrinology as essential described it as life-saving care providing access to puberty blockers and hormones that international evidence linked to improved mental health. They stated that hormone therapy was the main intervention relieving gender dysphoria and should be readily available within evidence-based frameworks.

Those opposing the inclusion of this as a core function stated most young people should receive non-medical, psychosocial care focused on mental health and developmental factors. They expressed concern that making endocrinology "core" implied medical intervention was standard rather than exceptional, contradicting the Cass Review's emphasis on holistic assessment.

Question 5e: Separate Pre-pubertal Pathway

53% of consultation respondents agreed with the proposed separate pathway for pre-pubertal children. Some respondents argued pre-pubertal children should not access specialist gender services at all, stating their needs were developmental and psychological, best addressed through mainstream CAMHS and family support. They expressed concern that referral to gender specialists risked pathologising normal childhood variation and creating self-fulfilling labels.

Others emphasised the pathway must not facilitate or encourage social transition, stating early social transition was not neutral and could entrench cross-sex identification, increasing likelihood of later medicalisation. Some respondents opposed separation, stating it created additional delays and fragmented care, and argued all patients should have equal access regardless of age pathway.

Question 6: Provider-Reported Metrics

59% of consultation respondents agreed with the inclusion of the proposed provider-reported metrics. 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.

Question 8: Equality and Health Inequalities Impact Assessment (EHIA)

56% of consultation respondents felt the EHIA did not fully reflect the potential impact on equalities or health inequalities which could arise because of the proposed changes. Respondents criticised the EHIA for failing to adequately assess impact on sexual orientation, age, disability, and sex, among other protected characteristics.

Full analysis of all themes and detailed consultation responses are outlined in the main body of the report.

2. Introduction

This report presents an independent analysis of responses to NHS England's public consultation on proposed changes to the service specification for specialist gender incongruence services for children and young people.

The consultation related to a revised draft service specification that set out how current and future providers of NHS Children and Young People's Gender Services would deliver care, following an interim specification adopted in June 2023 and a previous public consultation in 2022 which received 5,183 responses. The revised draft was developed to align the specification with the final report of the Cass Review (April 2024) and was informed by stakeholder testing with registered stakeholders between 7 and 25 April 2025, which indicated a continued divergence of views on the clinical approach and the proposed service model.

The consultation sought views on a set of defined proposals. These included the replacement of the previous clinical model with a holistic assessment framework drawn from the Cass Review; clarification of the role and function of a new National Provider Network; strengthened arrangements for data collection, audit and evaluation, including a single coordinated registry; the role of the Children and Young People's Gender Service in leading a network of Designated Local Specialist Services; and the inclusion of paediatric endocrinology as a core function within the multidisciplinary team. The consultation also asked for views on the approach to managing children and young people accessing prescriptions from unregulated or non-UK regulated providers, the proposal to establish a separate pathway for pre-pubertal children, and the inclusion of proposed provider-reported metrics to help commissioners monitor and assess service quality.

Respondents were invited to review the consultation document, the revised draft service specification, and the accompanying Equality and Health Inequalities Impact Assessment (EHIA).

The consultation was open for 90 days, from 4th August to 2nd November 2025. The consultation questionnaire asked respondents about their role and whether they were replying on behalf of an organisation and then sought levels of agreement and written comments on a range of questions.

NHS England stated that all feedback would be reviewed, that an independent third party would undertake an analysis of consultation responses and produce a written report, and that any revised final specification would be published on the NHS England website alongside that report.

3. How the analysis was conducted

Disclaimer

This report conveys the key messages arising from the analysis of the consultation responses. The report utilises the language and terminology used by respondents in order to provide the most reliable summary of these responses. We have illustrated some themes identified through the analysis with direct quotations from the response data. It intentionally does not provide challenge or critique on the key messages, for example by checking of links to published data as part of responses provided. Therefore, the views expressed, and language used in the report, do not represent the views of TONIC nor NHS England, but are a faithful analysis of the response data.

3.1 Analysis Methodology

NHS England commissioned TONIC, an independent social research organisation specialising in public consultations, to produce a summary of responses to the consultation. To achieve this, TONIC conducted a quantitative analysis for all responses to the closed (multiple choice) questions and used thematic analysis (Braun and Clarke, 2006) to summarise the written responses to the open (free text) questions.

Thematic analysis is a widely used method for identifying, analysing, and reporting patterns within text data. TONIC chose this approach as it provides a way to summarise themes in a large body of data, highlights similarities and differences across the dataset, and can generate unanticipated insights. The process facilitates the organisation and description of the dataset in detail and interprets various aspects of the research topic.

Our analysts followed the six steps involved in this process using specialist software to support the process:

1. A detailed reading of the data to become familiar with the text.
2. Initial codes are manually ascribed to the data and organised into meaningful groups relevant to consultation questions.
3. Codes conceptually related to one another are grouped together and identified as themes
4. Themes are reviewed to determine whether they are internally coherent and distinct from each other.
5. Defining and naming themes and subthemes, which provide structure to the analysis.
6. Writing up results, providing a narrative summary of the relationship between codes, subthemes and themes, including examples from the data to illustrate the essence of each theme.

3.2 Quality Assurance

TONIC is committed to developing and maintaining the highest standards of quality assurance at every stage of our research. Our quality assurance mechanisms for this project were:

- **Sampling**: Our senior analyst conducts regular testing of a representative sample of coded responses by all analysts to ensure quality and accuracy of the analysis completed.
- **Inter-rater reliability**: All analysts receive training and guidance for each analysis project. Results for different analysts analysing similar data sets were compared to guarantee reliability and consistency between different analysts and across the various questions.
- **Controlling for bias**: We put in place a number of research processes to control for and minimise bias in our analysis:

- Our analysts are qualified to a minimum of degree level in a relevant discipline, and receive regular training in thematic analysis, research methods and unconscious bias.
- Our analysis process follows the six steps of thematic analysis, ensuring in our coding practice that each individual response is fully considered in isolation.
- Multiple analysts conducted the analysis, and we conducted tests for inter-rater reliability.
- The draft code frames produced are peer reviewed as part of our quality assurance process, which includes controlling for bias through reflexive practice and group discussions.
- Quoted excerpts from responses used in the report were selected by the lead analyst as being typical examples of the responses containing the specific theme.

These processes combine to create a systematic approach to enhance the reliability and validity of the findings and to ensure that there is no bias in our findings. This is underpinned by the fact that TONIC are an independent research organisation with guiding principles from the British Psychological Society's Code of Ethics and Conduct (2021).

3.3 Data Cleansing

Prior to analysis taking place, a data cleansing process was carried out in Microsoft Excel in the following ways:

1. **Duplicates**: The raw dataset was assessed for duplicate responses by: examining all IP addresses from which a consultation response was submitted; checking qualitative answers for identically worded responses; and analysing the demographic information provided for similarities and differences.
2. **Blank submissions**: Entirely blank submissions were removed – i.e., responses from those who provided only demographic information but failed to answer any questions. In total, there were five such empty responses.
3. **Blank answers**: Content-free qualitative answers which consisted entirely of comments such as "I don't know", "no comment", "n/a", "yes"/"no" or contained simply hyphens or dots were removed and are not included in the figures illustrating response rates.

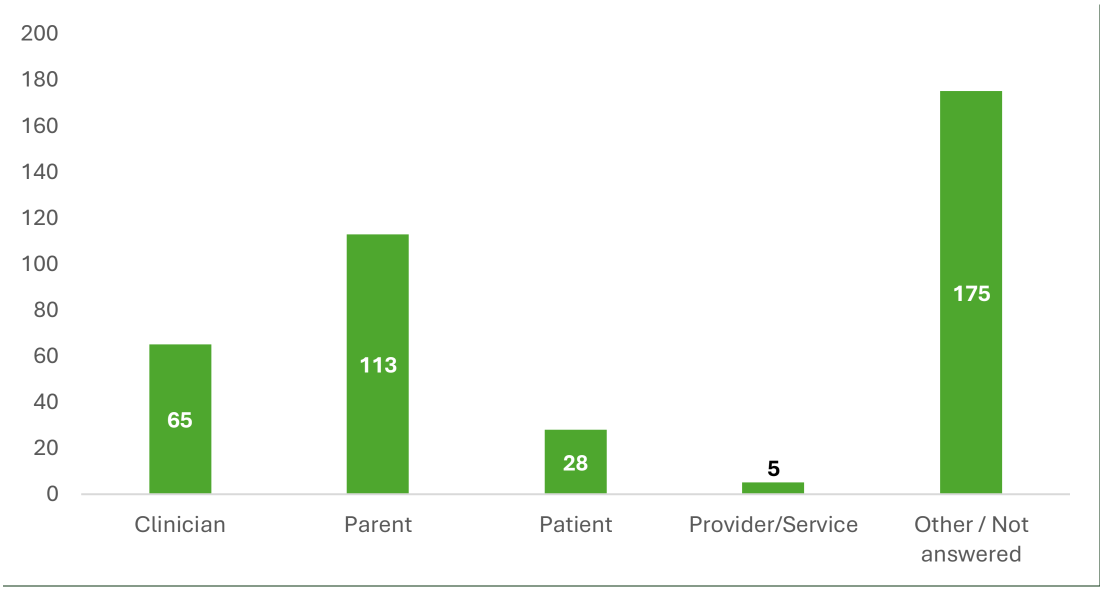
3.4 Notes on Reading the Consultation Analysis Report

Participation in the consultation was on a self-selecting basis. The findings in the report, therefore, carry the unavoidable risk of self-selection bias and are, therefore, not generalisable to the overall population.

Results for each of the consultation questions have been reported in line with the consultation headings used in the materials available to respondents. It is worth noting that the quantitative results presented in this report should be considered in the context of the accompanying qualitative response themes and explanations, and that the figures, in and of themselves, do not provide a complete picture. It is also worth noting that the number of respondents raising a theme does not necessarily correspond to the importance of the issues being put forward. Response frequencies, therefore, are included solely as a guide, not as an indication of priority. Unless displayed otherwise percentage figures are rounded to the nearest whole number and therefore may not always add up to 100%.

4. Respondent Demographics

The consultation exercise received 388 responses. 113 responses were from parents (29% of the total), 65 from clinicians (17%), 27 from patients (7%) and 5 from providers or services (1%). The remaining 178 were responded as "other" or did not provide an answer.



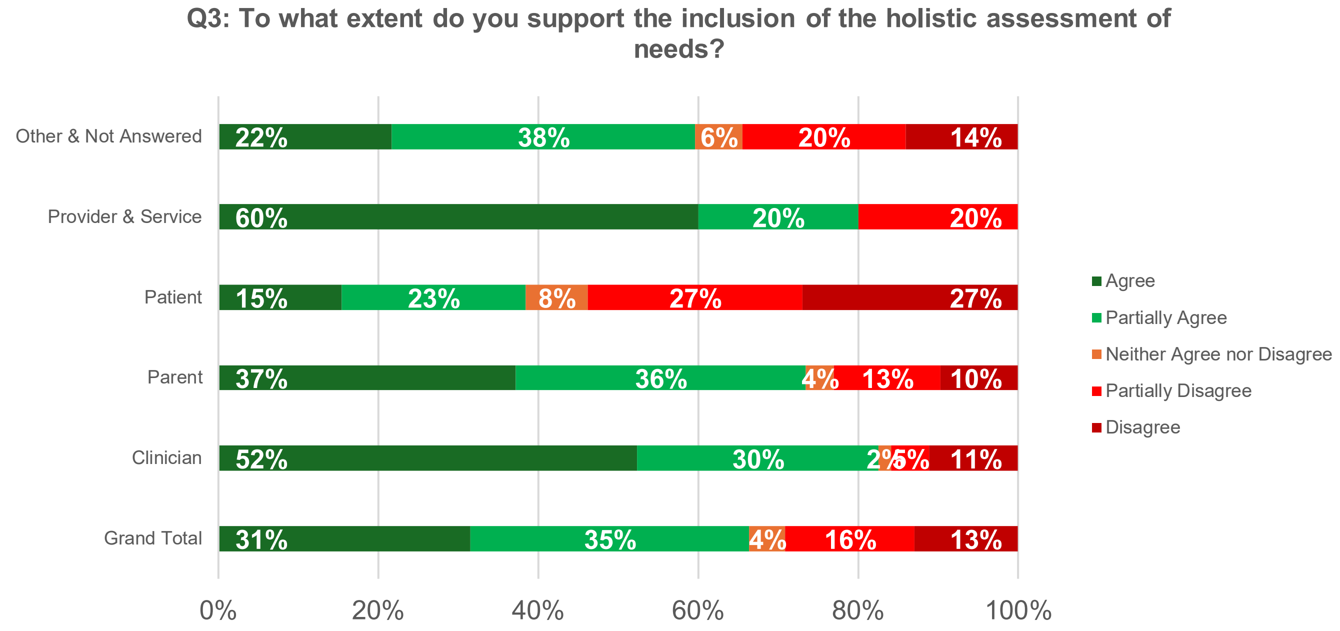
42 responses to the consultation were submitted on behalf of an organisation. A list of those organisations that provided a name are set out in Annex A.

5. Detailed summary of responses

This section sets out a detailed summary drawn from the analysis of all responses to the consultation, focussing on each question individually.

Question 3. To what extent do you support the inclusion of the holistic assessment of needs?

The majority (66%) supported the inclusion of the holistic assessment of needs as defined in Appendix A to the service specification. The majority of clinicians, parents, provider services and other stakeholders also supported this. However, it was more of a mixed picture for patients, with 38% in support, but 54% not supporting the inclusion the holistic assessment of needs.



Themes raised in response to Question 3

For

A comprehensive holistic assessment is a positive step towards treating the whole person

Respondents who agreed with the inclusion of the holistic assessment of needs primarily did so because they saw a compassionate and thorough holistic assessment of all needs and life situations (including family, development, education, and mental health) as valuable and what should be standard practice. They believed it would help identify what support is needed beyond gender care services and felt that it was important to not only focus on clinical factors and physical/sexual aspects in order to ensure that any treatment would not be reduced to a purely medical decision. Respondents believed that emphasis should be placed on mental health treatment and that special care must be taken to ensure that cases or gender incongruence are genuine in order to avoid mistakes and instances of regret. They encouraged that any assessment should be objective, impartial, and grounded in current evidence, and that it must not become a tick-box exercise or be influenced by a clinician's preconceived belief that social transition or medical intervention are the preferred routes for a gender-questioning young person.

Thorough diagnosis is required to distinguish gender incongruence from other issues

Some respondents expressed concerns that the holistic assessment framework presumes the existence of gender incongruence from the outset, rather than conducting genuine differential diagnosis to determine whether this is actually the case. They felt that the framework language suggests that factors such as neurodivergence, mental health problems, adverse childhood events, trauma, or same-sex attraction merely “influence” gender distress rather than possessing the potential to cause it. This was seen to limit true open-minded exploration and to runs the risk of confirming a presumption rather than investigating underlying causes. Respondents argued that the statement “gender incongruence is not a mental health condition” discourages psychological exploration and that assessment should remain open to the possibility that distress may resolve without medical intervention, which they believed research shows occurs in the majority of pre-pubertal cases. Respondents also stated that children and young people may not have sufficient psychosexual or cognitive maturity to engage meaningfully with gender identity interventions.

Assessments must consider the influence of social contagion, online media, and peer pressure

Some respondents felt that the holistic assessment framework did not sufficiently address the influence of social media, online influencers, peer groups, schools, and cultural messaging in shaping young people's understanding of gender and distress. Within the section on Education, peer relationships and social context, respondents felt that greater emphasis was needed on assessing these factors as contributors to or maintainers of gender-related distress, not merely as background context. Respondents also expressed concerns that online communities, activist groups, and external agencies operating within schools may promote ideological messages such as “it's possible to be born in the wrong body” which may influence vulnerable adolescents, present medical transition as the only solution, and contribute to a rise in referrals. Respondents therefore felt that assessments must include safeguards against social contagion, peer pressure, misogyny, homophobia, and online coaching, and ensure that any self-diagnosis influenced by online information is carefully reviewed.

Stronger safeguarding measures are needed to assess for trauma, abuse, and external influences

Some respondents who agreed with the holistic assessment framework supported its focus on safeguarding, while also feeling that the safeguarding measures proposed should be stronger. They stressed the importance of assessing for parental influence, grooming, trauma, sexual abuse, exposure to pornography, exposure to domestic abuse, same sex attraction, and any other concerns before proceeding with any treatment.

The framework should rely on biological reality rather than ideology

Respondents expressed concerns that the assessment framework adopts ideological terminology and assumptions rather than being grounded in biological fact, arguing that biological sex is observed at birth, not assigned, and that it cannot be changed. These respondents felt that the use of terms such as “assigned sex” or “natal sex” introduced ideological ambiguity into clinical practice. Respondents emphasise that clinicians must be clear about biological realities and the permanent impacts of medical transition, and that holistic assessment should focus on understanding and supporting young people rather than preparing them for irreversible medical interventions.

Existing diagnostic frameworks aren't suited for the current profile of adolescent referrals

Some respondents raised concerns that the ICD-11 and DSM-5 diagnostic frameworks, which were developed primarily for adult presentations and before the recent surge in adolescent referrals, are inadequate and unsuitable for the current adolescent-onset population, which now constitutes the majority of referrals to gender services. Respondents pointed out that they rely heavily on self-diagnosis and embed ideological assumptions about an innate "experienced gender" that can conflict with biological sex. It was also pointed out that the desire for medical treatment is included as part of the diagnostic criteria, with respondents feeling that this risks medicalising distress that may have multiple other causes and lacks validity or predictive power for this population.

The framework should support parental authority

Some respondents felt that the assessment framework failed to acknowledge the significant strain and breakdown in family relationships caused by ideological gender affirmation messaging and practices. Respondents who identified as parents reported being accused of bigotry, transphobia, or practicing conversion therapy when they expressed legitimate concerns, sought to explore alternative explanations for their child's distress, or practiced watchful waiting rather than affirmation. Respondents also stated that children had been encouraged to distrust and even estrange from families who did not immediately affirm their trans identity, with professionals (such as schools, CAMHS, and social services) often undermining parental authority and contributing to family conflict rather than supporting constructive dialogue. Respondents who raised this issue therefore urged that the section on "Family Development and Relationships" would need to be revised in order to recognise the vital protective role that families play, and that isolating children from cautious parents can be harmful. Respondents also urged that the assessment must avoid labelling concerned parents as transphobic and that it should support families through disagreement, recognising that parental concern normally stems from love and knowledge of their child's history, not prejudice.

Medical pathways should be approached with extreme caution and rigorous evidence

Some respondents mentioned that the holistic assessment framework should support an approach aligned with that recommended in the Cass Review: namely, one that prioritises mental health treatment, explores underlying factors, and requires rigorous evidence before any medical pathway.

Clinicians must be skilled and allowed to assess freely

Respondents also mentioned that for the model of care to succeed, it would be dependent on the skills and expertise of the staff within the service. Respondents believed that clinicians must be highly skilled in child development, mental health, neurodivergence and safeguarding, and that they must be free to assess with an open mind and protected from any internal or external pressure to conform to a model of affirmation.

The service should not encourage social transition

Some respondents felt that the framework did not go far enough in preventing premature social transition or in communicating the potential full impacts. Respondents felt that research had shown that children who socially transition are much more likely to proceed to medical transition, that the impacts on other children have not been considered, and that underlying causes such as autism, internalised homophobia, and body image issues must be thoroughly explored before any social transition occurs. Some respondents also believed that the NHS should not recommend social transition under any circumstances, and that staff must be trained to understand and communicate its potentially harmful effects.

The definition of gender development risks reinforcing regressive sex stereotypes

Some respondents questioned how the specification defines "gender development," noting that the term is vague and could imply movement toward sex-stereotyped norms. Some called for a more inclusive and culturally aware understanding, emphasising the importance of helping young people understand that gender expression can vary widely and has long existed in many societies (e.g., Two-Spirit, Muxe, Fa'afafine). These respondents felt that NHS should promote a more accepting cultural environment where children can explore identity safely.

Speech and Language Therapy must be fully integrated into the multidisciplinary assessment

Some respondents felt that Speech and Language Therapy (SLT) must be an integral part of the holistic assessment, given that many children and young people who access gender services are neurodiverse and have communication needs that affect participation, understanding, and informed consent. Respondents felt that Speech and Language Therapists could play a key role in identifying communication barriers, supporting consent through accessible communication, and addressing voice-related distress. In line with the Cass Review, respondents called for explicit inclusion of SLTs within multidisciplinary teams to ensure language, communication, and voice needs are fully embedded in holistic care.

Other themes mentioned by a small number of respondents:

- Some respondents stressed that safeguarding protocols are essential if the patient and/or parent is accessing unregulated/DIY drugs.
- Some felt that the reference to "transphobic bullying in schools and other settings" prematurely assumed that the child is already trans, and that it framed bullying and safeguarding concerns through a limited lens.
- Some respondents stated that there were a growing number of detransitioners, and that these individuals must be supported and tracked, and their cases used to inform future medical practice.
- Some also highlighted that holistic care for young people should not end at the paediatric stage – particularly as many children and young people will "age-out" while still on the waiting list.

Against

Holistic assessments act as bureaucratic barriers that will increase delays and gatekeep care

The most common theme among respondents who disagreed with the inclusion of the holistic assessment of needs did so because they felt it was being used as a mechanism for institutional delay, clinical doubt, and endless bureaucratic barriers rather than genuine care and support. They felt that the first assessment was so broad that it would add a huge wait time to a patient and significantly add to the number of hoops to jump through. Respondents stressed that the assessment should be employed as a means of supporting the child or young person and in planning for their appropriate care – not as a means of indefinitely delaying and/or denying it. In addition, it was pointed out that many children and young people will have already undergone CAMHS assessments before referral to gender services, therefore the framework should make use of these existing records and not force patients to repeat lengthy assessment processes.

Long waiting lists leave children and families without support and causes harm

In relation to the above fear that the holistic assessment would increase waiting times, some respondents raised the issue that waiting lists are already extremely long, and that currently there is little or no mental health support available from NHS, CAMHS, or other services. Respondents pointed out that trans patients already have to wait significantly beyond NHS's 18-week maximum, and that waiting times can extend into years when a patient enters a neurodivergent treatment pathway, all of which was seen as increasing the risk of harm and distress of a child or young person seeking gender affirming care, including severe mental health decline, self-harm, dangers from using unregulated medications, trauma from passing through an unwanted puberty, and suicide.

Neurodivergence is being used to deny or delay gender care

Some respondents felt that autism, ADHD, and the existence of other mental health conditions were being wrongly seen as causing transgenderism, and that there was a focus on treating these issues *instead* of the patient's gender incongruence, rather than *alongside* them. As above, this was seen by some as an excuse and tactic to deny or delay care. Respondents therefore felt that patients should be able to opt out of the holistic assessment if they deemed inappropriate, and/or that any treatment offered should be done simultaneously rather than sequentially (i.e., mental health conditions should be assessed and treated at the same time as gender affirming care, rather than the latter being seen as secondary and conditionally dependent on the outcome of the former).

The service must be built on trust of children and young people

Some respondents who disagreed with the inclusion of the holistic assessment of needs felt that it emanated from a place of clinical suspicion and lacked trust in a trans child's ability to know who they are and what they feel. Respondents believed that NHS's gender provision for CYP should have a foundation of belief and respect for the young person's self-knowledge and identity, and that a fundamental treatment of trans children as "mentally ill" risked further eroding trust among already marginalised groups, with significant implications for NHS legitimacy and long-term service engagement.

The proposed framework pathologises trans identities

Some respondents felt that the framework of the holistic assessment of needs appeared to make the assumption that gender incongruence was secondary to other issues, such as trauma, autism, and mental health problems, rather than a valid identity. This was seen by these respondents as treating a trans child or young person as a problem to solve rather than an identity to support.

The Cass Review is ideologically biased and methodologically flawed

Some respondents stated their belief that the Cass Review had been subjected to peer reviews and had been found to be faulty, methodologically poor, based on bad evidence, and to possess ideological bias – with some going as far as stating their belief that it had been "discredited". These respondents therefore objected to any protocols and policies which used the Cass Review as their basis and encouraged a thorough independent review of it, or that it should be rejected entirely.

The approach conflicts with international evidence and best practice guidelines

Some respondents felt that the holistic approach lacked empirical support, and that it conflicted with the evidence and conclusions of organisations such as WHO, WPATH, and the Endocrine Society, as well as the conclusions of other health organisations in Europe and elsewhere.

The holistic assessment framework is not truly holistic

Some respondents felt that they would agree with a truly holistic assessment but stated that the process outlined in the framework could not be categorised as such. They believed that true holism meant viewing and treating the whole person in their full context – physical, psychological, social, and cultural – and with a full range of treatment options made available to them, including puberty blockers and other hormones, as well as medical intervention. To these respondents, the holistic assessment proposed represented a narrow band of treatment, with many useful and desirable treatments “taken off the table”, and that it appeared most likely to lead to endless assessments, long waiting times and, ultimately, nothing more than talk therapy.

The holistic assessment framework risks functioning as a form of conversion therapy

Some respondents saw the holistic assessment as a form of conversion therapy in disguise, akin to trying to make trans children and young people comfortable with their assigned gender rather than supporting their identity. These respondents believed that conversion therapy had been repeatedly shown to be irreparably physically and psychologically dangerous to trans children and young people, with significantly increased risks of depression, self-harm and suicide.

Preventing social transition can cause harm

In accordance with other themes that suggested delaying or denying gender affirming care would cause significant harm to trans children and young people, some respondents also specifically mentioned that while the specification had described social transition as a non-neutral act it had failed to acknowledge that preventing social transition is also non-neutral and carries documented risks. Respondents felt that this echoed narratives used to restrict trans healthcare and that it was biased language designed to dissuade children and young people from social transition. These respondents believed that social transition is a harmless and fully reversible personal choice that should remain unpoliced by medical professionals.

Strong safeguards are required to protect patients from bias

Some respondents felt that the holistic assessment framework did not include a strong or clear safeguarding protocol that would protect trans and gender-diverse young people against unconscious and institutional bias. They were therefore unable to agree with the framework as it currently stands, and urged NHS to ensure that such safeguarding measures were put in place before the holistic assessment of needs was fully implemented.

Accessing private healthcare should not result in penalties or safeguarding suspicions

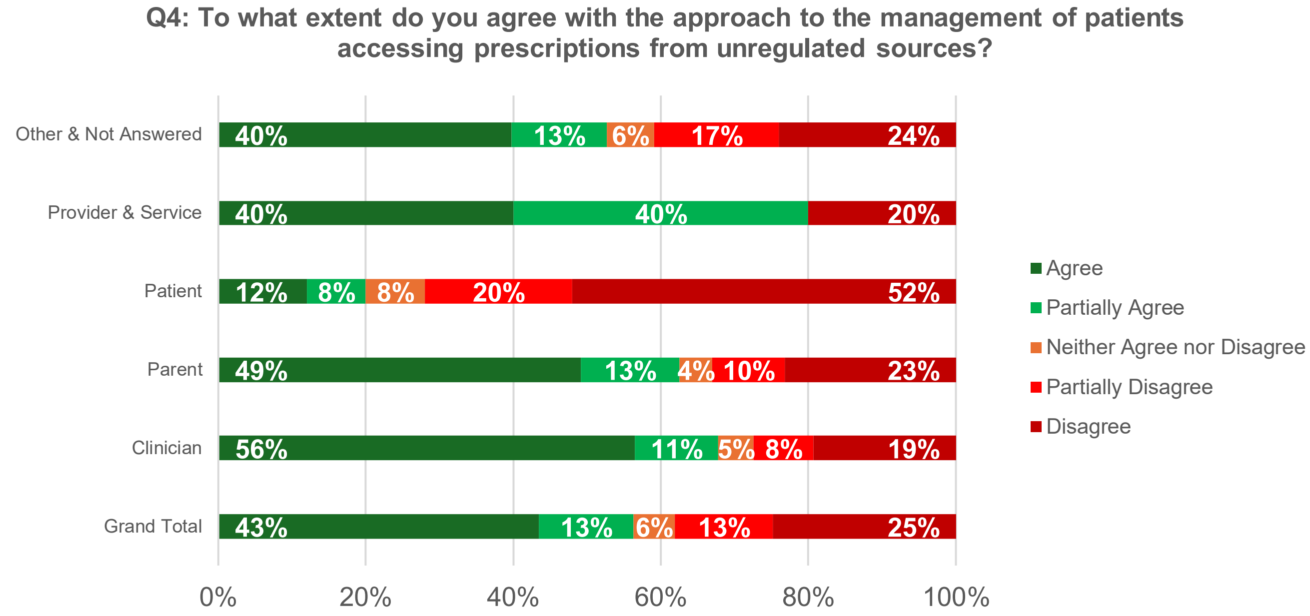
Some respondents expressed concerns that families using private gender healthcare were being punished by being treated as safeguarding risks or having treatment reversed by the NHS. Respondents felt that private healthcare use should not result in penalties or be viewed with suspicion, especially given long NHS wait times which left families with little alternative other than to seek alternative care. Respondents felt that NHS should accept that families may have used private treatment due to service inaccessibility and treat this information objectively and without consequence, as it does in other areas of healthcare.

Other themes mentioned by a small number of respondents

- Some respondents felt that the specification failed to comply with UK and international human rights law and subjected patients to unlawful interference in fundamental rights – for example, by withholding puberty blockers from transgender children when cisgender children still hold the right to postpone puberty – thereby exposing its creators to legal risk.
- Some respondents felt that the holistic assessment of needs was based on a discredited narrative which states that most trans children and young people eventually desist in their trans identity, whereas respondents stated that evidence shows that the vast majority of trans adolescents continue to identify as trans, and that most detransition is due to transphobia rather than confusion.
- Some respondents who disagreed with the holistic assessment of needs felt that the inclusions of sexual orientation in assessments risked pathologising young people and/or implying gender incongruence is a misinterpretation of same-sex attraction. These respondents felt that sexual orientation should not be examined as standard, but only if deemed strictly necessary.
- Some felt that the specification had been implemented and designed without meaningful co-production with trans young people and their families, and that it lacked transparency and accountability mechanisms.
- A few respondents stated that they believed gender care should be integrated within CAMHS and standard services, rather than separate tertiary clinics, with separation increasing the likelihood that trans patients would be refused services.

Question 4. To what extent do you agree with the approach to the management of patients accessing prescriptions from unregulated sources?

The majority (56%) agree with the proposed approach to the management of patients accessing prescriptions from unregulated sources. All stakeholder groups, with the exception of those who responded as patients, also had the majority in agreement with this approach. For patients, 72% disagreed with the proposed approach.



Themes

For

Accessing unregulated medication should trigger mandatory safeguarding referrals

Many respondents who agreed with the approach to the management of patients accessing prescriptions from unregulated sources did so because they believed the current safeguarding guidance was too weak and inadequate, interpreting it as "merely advising clinicians to warn patients and parents of the risks and inform the GP". Respondents raising this theme believed that any clinician who becomes aware that a child is accessing puberty blockers, cross-sex hormones, or anti-androgens from unregulated sources (including overseas online providers like Gender GP and private UK doctors) must make an immediate mandatory safeguarding referral to social services, and that all cases should trigger automatic social care referrals regardless of whether immediate harm is evident, with any UK doctors involved reported to the GMC. Respondents believed that accessing unregulated medication constituted substance misuse by the child, and child abuse by those supplying or facilitating it, including parents, with some pointing out that children as young as 14 are not merely obtaining puberty blockers, but also dangerous medications such as cyproterone, dutasteride, spironolactone, oestrogen, and testosterone. These respondents urged that the specification must make clear this is a serious child protection issue requiring proactive multi-agency involvement, and that simply warning families equates to buck-passing that fails a child's safety.

Allowing private prescriptions to transfer to the NHS undermines safeguarding protocols

Respondents felt that the updated specification (page 17) creates a loophole that allows NHS to continue prescribing cross-sex hormones if treatment was started privately – though framed as "harm reduction," it was felt that this enabled families to bypass NHS safeguards by obtaining initial prescriptions from private providers before transferring to NHS for continuation. These safeguards were seen as inadequate and not in accordance with the Cass Review's "extreme caution" guidance for under-18s. It was also pointed out that the third bullet point permits NHS continuation even when puberty blockers were prescribed illegally (if the child has reached Tanner stage 2), and that the red warning fails to clarify that unlawful prescribing may be criminal, not merely "unregulated." This was seen as contradicting the Gender Affirming Hormone (GAH) clinical policy and should therefore be resolved by removing exceptions for externally-initiated prescriptions.

Unregulated sources pose severe risks

Some respondents who agreed with the approach to unregulated sources highlighted that the use of unregulated medication may lead to significant harm to trans children and young people due to unknown quality, wrong dosages, adulterants, and lack of proper assessment.

People accessing unregulated prescriptions should be prosecuted

Some respondents believed that those involved in providing and obtaining unregulated medications, including suppliers and parents who facilitate access, should be considered as having committed a criminal offense and punished with severe consequences, including imprisonment

Hormonal drugs should not be prescribed at all

Some respondents stated their belief that no hormonal drugs should be prescribed, feeling that all hormonal drugs are dangerous, whether unregulated or otherwise, and that, ultimately, gender incongruence is a psychological issue that shouldn't be treated with medication.

NHS should discourage unregulated sources while providing safety advice

Some respondents who agreed with the approach to unregulated sources felt that NHS should strongly discourage the use of unregulated sources while also providing accessible safety information, regular blood tests, and advice on dangers if families do access them. Some also expressed concerns about potential negative effects that may be experienced when withdrawing from the use of hormone medication, encouraging that there should be support available for those who desist.

Other themes mentioned by a small number of respondents:

- Some suggested that the same restrictions should apply to adult services, in order to prevent the access and use of unregulated drugs.
- Some respondents believed that NHS shouldn't legitimise interventions which lack long term safety data, stating that there was currently insufficient tracking of fertility, bone density, cardiovascular health, and other long-term physical effects, and that follow-up data spanning 10-20 years should be required.

- Some respondents stated that private clinics offering gender services should be located, closed, and their proprietors and operators banned.
- Some pointed out that private surgeries are much more likely to be gender affirming and may have varying standards of quality, also lacking in accountability, regulation and oversight.
- Some stated their doubts that NHS possessed the resources to manage the long-term consequences of unregulated interventions, such as lifetime medicalisation, surgical revisions, complications, and detransition, and questioned where the resources and finances would come from.

Against

Families seek unregulated care out of desperation

Many respondents who disagreed with the approach to the management of patients accessing prescriptions from unregulated sources pointed out that long wait times (of up to five or more years) combined with Cass Review restrictions have created conditions that force families to seek private care and/or unregulated sources out of desperation, not choice. These respondents believed that NHS has created a vacuum in care, displacing risk rather than eliminating it, and failing in public health responsibility by refusing to engage with the reality of self-sourcing. It was also pointed out that overseas care is more in line with international best practice and that many so-called "unregulated sources" are considered safe and of good quality within their jurisdictions. Respondents believed that if waiting times were reduced to 6 months or less then the problem of accessing prescriptions from unregulated sources would not exist.

NHS has an ethical duty to monitor for external prescriptions

A significant number of respondents argued that the NHS has an ethical duty to provide harm reduction, clinical oversight, bridging prescriptions, monitoring (blood tests, hormone levels), and non-judgemental support for those accessing medication externally, rather than withdrawal of care. Some respondents expressed concern that refusing to support people who were not going to stop going to unregulated sources would, if anything, exacerbate the issue. They felt that the Cass Review Protocols would be more likely to hide information and discourage individuals from the healthcare service even more. Respondents believed that banning something would not stop people from using it and argued that it was morally wrong and legally questionable to do so.

Puberty blockers are safe, essential, and should be available via the NHS

Some respondents stated that puberty blockers are safe, reversible, and save lives. They argued that the ban on puberty blockers was unjustified, out of line with international practice, and specifically targeted trans youth discriminatorily. Some respondents felt that cisgenders could access blockers, proving it could not be a safety issue. They believed this could not be compared to other illegal or unregulated drug use.

The current approach is punitive and unsafe

Some respondents who disagreed with the current approach felt that it was punitive and abandoned vulnerable patients, using safeguarding as social control rather than genuine protection. They believed it created a two-tier system where the most vulnerable fell through the cracks (those that can afford private healthcare get care they need, but others don't). Some respondents argued that refusing care to those who accessed external sources isolated them, created shame, and drove them away from NHS services.

The Cass Review is flawed and creates unjustified barriers to medication

As highlighted earlier, there were some respondents who felt that the Cass Review was faulty, biased, poorly researched and based on bad evidence, and that it should be thoroughly reviewed or discounted entirely. They believed it had made it almost impossible for trans youth to access drugs they needed and had been instrumental in forcing them to turn to unregulated sources. Some respondents were said to have reached different conclusions, with the UK being seen as an outlier in rejecting gender-affirming care as standard practice. They pointed out that WPATH, Endocrine Society, NEIM studies, and international consensus support puberty blockers and hormones as safe and effective, therefore the UK policy was out of step with global medicine.

Safeguarding procedures are being misused to penalise supportive families

Some respondents argued that legitimate parental support was being framed as a safeguarding issue, and that the threat of child removal was being used to control families rather than protect children. They felt this misuse of the system was leading families to disengage from government services and become more likely to resort to extreme DIY measures.

Patients accessing private care should have a clear pathway into the NHS system

Some respondents believed that provisions should prevent anyone who started with regulated private care or overseas care from transferring to NHS. They felt that gender services should provide a pathway from legitimate private treatment into NHS care. Some respondents argued that a blanket refusal to engage with this issue lacked nuance and didn't account for regulated private care, perhaps overseas or in individual circumstances when the NHS simply can't help. They stated that accessing private healthcare should be considered separate from unregulated drug use.

Parents who seek external care are acting responsibly

Some respondents felt that parents seeking external care were acting out of love and rational decision-making due to NHS failing to provide sufficient care for their children. They argued that these parents should not be considered careless or abusive, but rather the opposite.

Access to medication should be assessed on a case-by-case basis

Some respondents believed that each situation should be considered individually based on capacity, clinical diagnosis, patient/family choice, and specific circumstances rather than a blanket “one-size-fits-all" policy. They argued that the term 'unregulated' covered a wide variety of sources, including those that were regulated and designated as safe in other countries.

Withholding care from trans patients is discriminatory

Some respondents felt that the approach demonstrated a lack of compassion for what patients were going through. They argued that in no other area of medicine would ongoing suffering be allowed through deliberate withholding of intervention. Some respondents stated that double standards applied to trans healthcare: discriminatory treatment meant that smokers, alcoholics, and drug addicts wouldn't be turned away.

Denying gender-affirming care causes harm

Some respondents believed that refusing to affirm a young person's gender identity could cause serious mental health harm, including depression, self-harm, trauma, and suicide risk. They felt that denying or delaying access to gender-affirming care was potentially life-threatening. Some respondents argued that such care should be accessible and timely, not treated as a last resort. They expressed concern that the proposed "holistic" or "exploratory" model risked functioning as conversion therapy under another name, introducing unnecessary gatekeeping that obstructed essential treatment. Respondents stated that while it claimed to be evidence-based, there was no robust data supporting prolonged psychosocial approaches as an alternative to gender-affirming care. Instead, they believed this framework created barriers where support and affirmation were urgently needed.

There should be independent research in unregulated drugs and sources

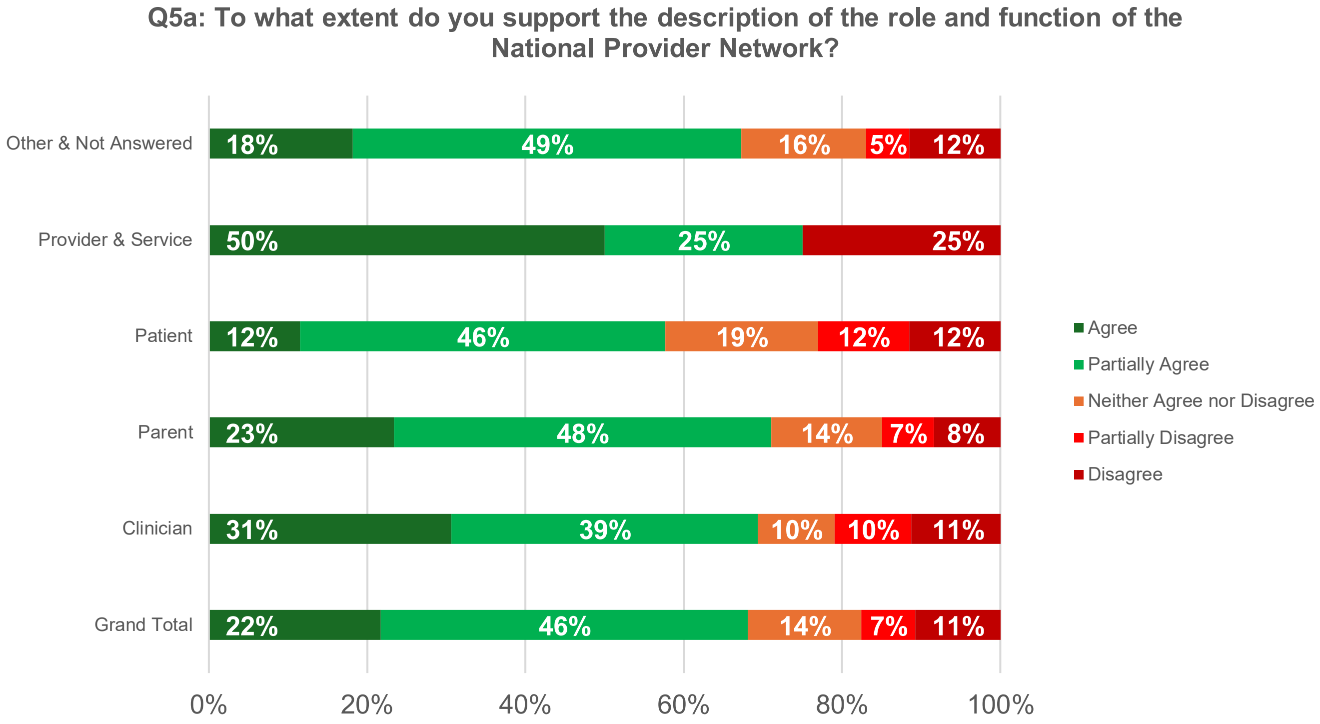
Some respondents argued that there should be independent research into unregulated drugs and sources to better understand the risks and harms, rather than relying on assumptions or anecdotal evidence. They felt that this research would help inform policy and practice in a more evidence-based way.

Themes mentioned by a small number of respondents:

- Some respondents believed that NHS should honour prescriptions from other regulated bodies and provide shared care arrangements, as is done in other areas of medicine. If GPs were to refuse shared care this was seen as likely to escalate the problem.
- Some felt that the decisions underpinning the approach represented a transparently ideological targeting of trans youth and were politically motivated rather than based on clinical need and genuine medical concern.
- Some stated that the policy inaccurately portrays the legal status of unregulated medications, failing to acknowledge that possession of GnRH antagonists is not illegal and that they are not controlled substances. Nor does it acknowledge that the status of unregulated medications may change in the future.
- Some respondents felt that NHS gender services should allow access through an informed consent model via GP, monitored by an endocrinologist, to provide timely care and eliminate the need for unregulated sources.

Question 5a. To what extent do you support the description of the role and function of the National Provider Network?

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



Themes

For

Safeguards are required to protect the Network from ideological capture

Some respondents felt that without explicit safeguards, the NPN risked repeating the problems at GIDS/Tavistock, where ideological commitment to gender affirmation stifled critical thinking and created unsafe practice. They believed that measures must be put in place in order to prevent "groupthink" through diverse staffing and leadership, protecting clinicians who raised concerns, ensuring strict adherence to evidence-based rather than ideology-led approaches, and establishing robust transparency and accountability mechanisms. Some respondents emphasised the need for independent oversight, rigorous vetting of training sources to avoid activist influence, and clear processes to ensure staff alignment with Cass Review recommendations and scientific evidence over external pressure from advocacy groups.

Concerns over deprioritisation of key research

Some respondents expressed concern that key research objectives present in the March draft specification were removed from the August version, specifically studies on epidemiology, prediction, the course of gender questioning, and outcomes of psychological treatments. Given the rise in referrals (particularly among those with autism), the course of gender transition and interest in youth, understanding of this cohort's aetiology, natural history, and diagnostic predictive power, some respondents considered such fundamental research a priority. They argued that rolling out a national programme offering irreversible hormone treatments without first conducting this essential basic research was unsafe. Some respondents felt that the NPN had a duty to promote research that would underpin evidence-based treatment rather than proceeding with medical interventions based on insufficient evidence and a weak policy.

Conditional support for the aims

There were some respondents who expressed conditional support for the aims, feeling that consistent, standard care aims are commendable, however they felt that in order to fully agree with the description of the role and function of the NPN it would need to be clearly defined as a framework which was not only clinically-led, but one which involved the voices of patients, young people, and others with "lived experience", with knowledge and practice flowing both ways.

The Network must operate explicitly within the framework of the Cass Review

Some respondents felt that the NPN must implement Cass Review recommendations and operate within its evidence-based framework. There were concerns around continued use of the older Gender Affirming Hormones (GAH) clinical commissioning policy to guide hormone recommendations, which respondents described as non-evidence-based and not aligned with Cass findings, emphasising the lack of suitable evidence for cross-sex hormones in minors. Respondents also stressed that the Network must be explicitly developmental rather than affirmative, co-ordinating evidence-based psychosocial assessment and safeguarding rather than normalising medical interventions.

There should be external oversight

Respondents believed that good governance would require independent oversight from external experts, including academics and international voices, in order to avoid bias.

Research is urgently needed

Some respondents believed that a recent and large increase in cases had occurred, especially amongst teenage girls, necessitating research into exactly why this is occurring, and with plans and procedures put in place based on the predicted and actual results of this research.

Other themes:

- Some respondents felt that the practical resources required for this model are currently unavailable.
- Some felt that GPs should be included in the provision of gender healthcare.
- Some respondents stated that the NPN should integrate more clearly with local mental health services.
- Some felt that frontline professionals (including counsellors and psychotherapists) appear to have been excluded, despite possessing relevant experience.
- Some pointed out that clinicians would require specific training to deliver the model effectively.

Against

The National Provider Network must meaningfully include trans voices in governance

Some respondents argued that the National Provider Network must meaningfully include transgender voices (including trans young people, families, advocacy organisations, and trans-led community groups) in its governance, decision-making, and oversight structures. They felt that the NHS was statutorily duty under patient and public participation policies to involve service users in service design and evaluation, yet the specification lacked clear mechanisms for trans community representation. Some expressed concern that without this, patient co-production at the highest levels meant the NPN risked becoming a centralised, top-down structure that made decisions about trans people without them, potentially functioning as a way to prevent care.

The Network risks becoming a bureaucratic layer that delays access to care

Some respondents believed that the NPN would delay access to care and function as another method of gatekeeping. They felt that multidisciplinary teams would become another bureaucratic obstacle to care, and that standardised care equalled slow care. Some respondents argued that it created new bottlenecks preventing access to care.

Centralised decision-making risks enforcing a restrictive and non-affirming culture

Some respondents expressed concern that the National Provider Network, rather than improving care, would function as a centralised mechanism to enforce restrictive, pathologising, non-affirming approaches to trans healthcare. They believed it removed care from the local, relational context where families and young people were best known, resulting in delays, detachment, and decisions made by distant committees rather than responsive clinical teams. Some felt there may also be issues in the governance and recruitment processes, in that individuals resulting in delay, detachment, and decisions made by distant committees rather than responsive clinical care were critical to care. It was also felt that individuals with pathologising views towards gender and affirmation may find positions to harm trans young people. They believed the NPN would ultimately represent state-sponsored enforcement of conversion therapy rather than evidence-based affirming care and support.

The framework ignores international best practice

As highlighted in other questions, some respondents again mentioned that they felt the framework placed too much emphasis on the Cass Review and not enough on best practice from other countries and organisations.

Standardisation prioritises bureaucracy over personalised care

Some respondents expressed concern that the NPN prioritised bureaucratic standardisation over personalised, relational, and context-sensitive care. They believed the NPN would create additional layers of distant decision-making through national multidisciplinary teams who would make life-altering decisions about young people they had never met, and that someone care from the local context where families and children were known was more compassionate, trauma-informed, and patient-centred care with clinical governance by committee, resulting in delays and denial of clinical flexibility to respond to individual needs. Some argued that standardisation was not inherently beneficial and lacked evidence as to its efficacy.

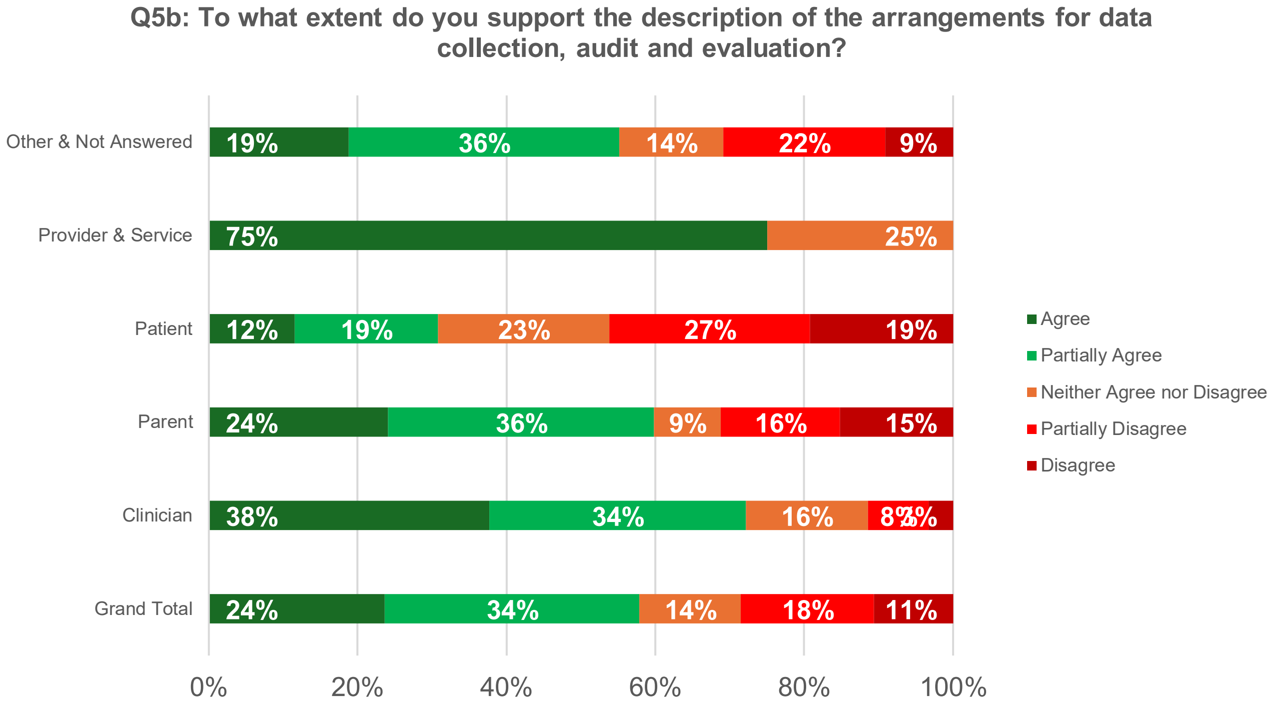
Not enough transparency and accountability

Some respondents felt that the Network lacked adequate provision for transparency and accountability. They raised concerns about the absence of independent oversight, public reporting of decisions, published terms of reference for committees, and mechanisms for families to challenge decisions or raise concerns about care.

Question 5b. To what extent do you support the description of the arrangements for data collection, audit and evaluation?

Background: Add

The majority (58%) supported the description of the arrangements for data collection, audit and evaluation. The majority of all stakeholder groups also supported this, with the exception of those responding as patients, where 46% did not support this.


Q5b: To what extent do you support the description of the arrangements for data collection, audit and evaluation?

Themes

For

Data collection must include all referrals

Some respondents who supported the description of the arrangements for data collection, audit and evaluation urged that the registry must track all children referred to gender services, not only those who received treatment, in order to capture desistance, developmental trajectories, and full pathway outcomes. It was felt that it must follow up with those who left the service, dropped out, or lost contact, as excluding these groups had previously produced biased research that over-represented positive outcomes. To avoid repeating these failures, the registry should include current patients, those on waiting lists, those who left without treatment, desisters, detransitioners, and those who transitioned to adult services. Retrospective research on previously treated children was considered essential, and without full cohort tracking, outcomes remained opaque and misleading.

A mandatory national dataset is essential

Some respondents who supported the arrangements for data collection believed that this was essential in order to remedy the "remarkably weak" evidence base identified by the Cass Review. There was therefore support for a mandatory national dataset that would enable meaningful comparisons, reveal comorbidities and safeguarding flags, and support long-term outcome tracking that would progress the service from anecdotal to evidence-based practice.

The August 2025 specification weakens the data requirements proposed in the March draft

Some respondents felt that the August specification significantly weakened the data-collection requirements when compared with the March 2025 draft. Removed provisions, including commitments to continuous data collection, reporting, and gathering evidence on the safety, benefits and harms of interventions, were seen to directly contradict the Cass Review's findings. It was highlighted that poor data collection hindered understanding of patient cohorts and outcomes, and that an agreed core dataset was essential for safe, evidence-based practice, or else these omissions would risk repeating the systemic failures seen at Tavistock.

Research should focus on non-medical approaches

Some respondents believed that there was already enough evidence to be sure that medical interventions carried serious risks, and that to continue studying the extent of that harm would be unnecessary and unethical. It was argued that the priority should now be on building evidence around non-medical approaches and understanding the broader context of gender-related distress in young people.

There should be long-term follow-up into adulthood

Some respondents felt that current data collection proposals focused on short-term process measures and patient satisfaction, which could not evaluate interventions with delayed and potentially irreversible biological and psychological effects. It was argued that follow-up must extend at least 10-20 years into adulthood to capture true long-term outcomes, including natural desistance, detransition, late-emerging complications (infertility, metabolic issues, bone density problems), adult regret, and detransition, employment and mental health outcomes. These respondents argued that short-term wellbeing did not predict long-term benefit, and that true outcomes could only be assessed after full neurological and psychosocial maturity. Without longitudinal data linked to hospitals, primary care, fertility, mental health, and mortality records, outcomes risked being misinterpreted. Referring young people to endocrine treatment or research trials without this long-term infrastructure was considered unsafe and unethical.

The registry must distinguish between clinical gender dysphoria and social identity

Some respondents felt that Section 6.2 of the service specification did not clearly distinguish between children with clinical gender dysphoria requiring medical intervention and the much larger group who simply identified as non-binary or gender diverse. Combining self-declared identity and clinical diagnosis risked pathologising normal gender exploration and could draw young people (especially vulnerable groups such as autistic young people and those with diagnostic criteria such as ADHD) into diagnostic and treatment pathways. Clear diagnostic criteria were needed, it was argued, to differentiate clinical pathology requiring intervention from social identity or exploration that might resolve naturally with support but without medical treatment.

Data collection should not be used to justify continued medical intervention

Some respondents expressed concern that the emphasis on data collection and research could be used to justify continuing medical interventions under the guise of "gathering evidence", when they believed the evidence of harm was already sufficient to warrant a full stop to such practices. The framing of ongoing treatment as research was seen as ethically problematic, particularly when it involved children and young people who these respondents felt could not provide fully informed consent to experimental treatments.

The registry will burden service providers

Some respondents felt that the data registry would place burdens on service providers, who also need to manage queries from patients and families about the data registry. It was deemed necessary, therefore, to include mention of this increased burden in the service specification.

Biological sex at birth must be recorded as standard

Some respondents believed that data collection should record biological sex at birth (male/female only) as a non-editable, mandatory field separate from any gender identity information or subsequent name/pronoun changes. This was viewed as essential for analysing sex-specific outcomes, safeguarding, monitoring sex-specific health conditions and research integrity.

There needs to be independent oversight

Some respondents who supported the description of arrangements for data collection, audit and evaluation also emphasised that independent oversight must be conducted by individuals and organisations without vested interests in particular outcomes or treatment approaches. These respondents stated that staff involved in data collection design must be carefully vetted in order to ensure that they do not have ideological commitments or personal stakes that could bias results, and evaluation should be performed by independent reviewers with appropriate expertise to critique findings properly, not solely by service providers or those advocating for specific treatment pathways.

Other themes:

- Some respondents again stated that there should be no gender services, only psychological support.
- Some said that the outcomes of different interventions should also be measured.
- Some stated their belief that no new clinical trials on puberty blockers should be conducted.

Against

Concerns over mandatory data collection

Some respondents raised significant concerns about privacy, security, and ethical handling of highly sensitive data on trans and gender-diverse children, particularly given the stigmatisation and politicisation of trans identities. It was feared that mandatory data collection without clear anonymisation procedures would harm families from accessing NHS services, especially given past NHS data breaches and recent incidents of unauthorised data access (e.g., Brighton GP practice investigation). Trust was already fragile within this community due to historical misuse of data for discriminatory purposes, it was argued. Without these safeguards, the registry risked becoming a tool of surveillance rather than service improvement and may have exposed vulnerable young people to harm including potential "outing" risks.

Patients must have the right to opt out of data collection

Some respondents stated that families must have the right to opt out of having their data used for purposes beyond direct care without any consequence for treatment access. It was felt that the specification's reference to mandatory participation conflicted with NHS ethical standards, informed consent principles, and General Capacity Act 2005, and UK GDPR requirements. Given already fragile trust, particularly among trans and gender-diverse patients who faced stigma, a mandatory collection with under-specified uses was believed to deter families from seeking NHS services altogether, forcing them to choose between care and privacy. It was argued that patients should be able to opt out while still receiving the same standard of treatment, with any data collection operation on an opt-in basis. Data collection should never be a condition for receiving care, these respondents felt.

The data framework requires independent oversight

Some respondents felt that the proposed data framework lacked transparency about who controlled the data, how it would be governed, and who would interpret findings. Independent oversight was considered essential to ensure accountability and prevent bias, including representation from diverse stakeholders. Without transparent publication of methodologies, audit processes, anonymised statistics, and clear frameworks for community engagement, it was argued that the system risked opacity and selective data interpretation that might service provider or policy agendas rather than young people's needs. Without independent oversight and transparent governance structures the system risked entrenching the opacity and selective data interpretation concerns raised about the Cass Review process, embedding systemic bias into national governance and further alienating service users and families.

Data collection metrics must be co-produced with trans young people and their families

Some respondents noted that no evidence was presented that the framework had been co-designed with trans youth, their families, or LGBTQIA+ communities. Without user-defined metrics and patient-reported outcomes reflecting what children and families themselves identified as important, the system produced incomplete pictures of impact and risked becoming a tool of institutional surveillance rather than genuine service improvement. It was argued that data collection must incorporate patient experience data, including complaints and feedback, and ensure evaluation prioritised outcomes that mattered to young people themselves, not just provider-defined clinical measures.

The specification does not explain what data will be collected and how it will be used

Some respondents felt that the specification’s description of the data registry was vague and lacked crucial details, pointing out that the current specification stated little more than “we’ll collect data and look at it.” Respondents felt that the following details should be outlined:

- What specific data will be collected
- Who will set up and run the database
- Who will fund it
- Who can access the data and for what purposes

- Who defines “quality”
- Who controls the interpretation of the data
- Whether participation is mandatory for clinicians
- How consent will be secured
- What anonymisation procedures will be used
- Whether and how patients can opt out
- What the lawful basis for collection is
- How risks will be mitigated
- When National Data Opt-out applies
- What secondary research uses are planned
- What data protection rights apply and how they can be exercised
- What key performance indicators will guide audit

Concerns that data will be interpreted through a biased or ideological lens

Some respondents expressed concerns that data would be interpreted selectively or through an ideologically biased lens in order to reinforce restrictive policies rather than improve care. There was also criticism of the Cass Review for inconsistent and selective use of evidence, and with fears that this approach would continue in data interpretation.

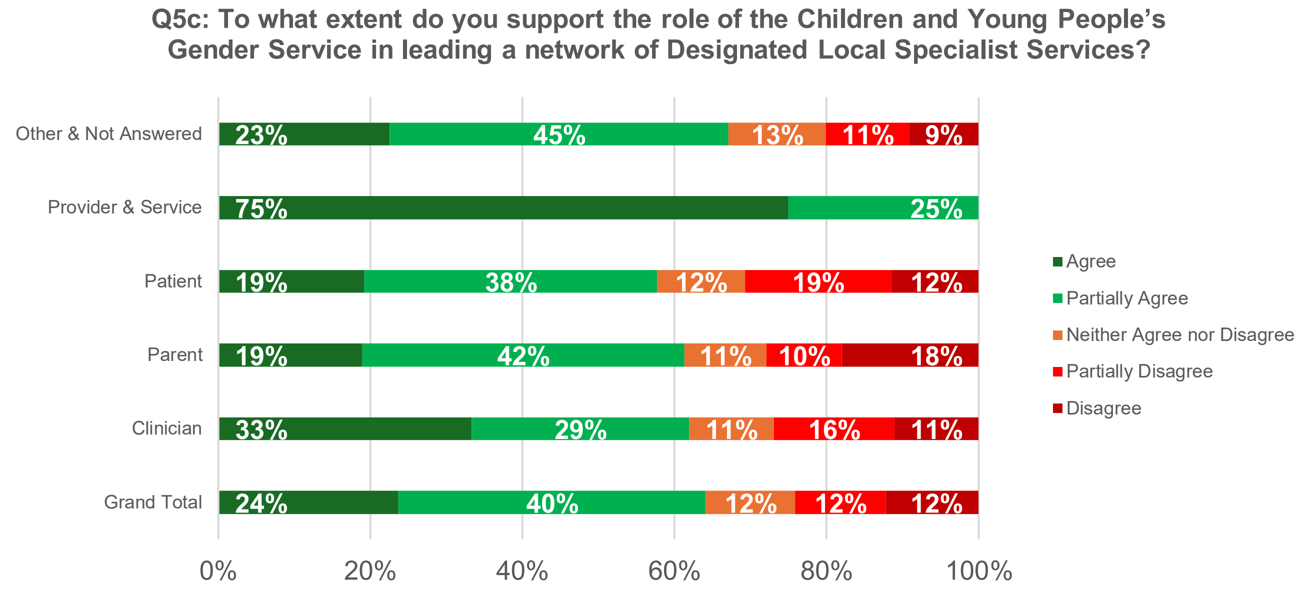
Other themes:

- Some respondents felt that mandatory data collection is discriminatory as it is not required in other healthcare areas.
- Some urged that data collection must not take precedence over the provision of compassionate care.
- Some respondents stated that no data should not be stored.
- Some felt that the data would be skewed as it would only come from patients who trust the system or are willing to accept privacy risks.

Question 5c. To what extent do you support the role of the Children and Young People's Gender Service in leading a network of Designated Local Specialist Services?

Background: Add

The majority (64%) agreed with the role of the Children and Young People's Gender Service in leading a network of Designated Local Specialist Services. This was the same across all respondent groups.



Themes

For

Local services must be protected from capture by gender ideology and activism

Some respondents expressed concerns that local services could be captured by gender ideology and activism. It was felt that gender-affirming therapists needed to be "weeded out" and that "activist" materials should be removed from clinical settings. As above, there were fears that Tavistock failures could be repeated under new branding. Respondents appeared to believe that NHS is rife with trans activists, and that GIDs staff were being employed again as part of gender service.

Local services must prioritise comprehensive assessment over automatic affirmation

Some respondents called for gender services to follow the Cass Review's emphasis on comprehensive assessment rather than an automatically affirmative model. "Specialist" shouldn't mean "affirmative", these respondents argued. Clinicians must be supported by clear national protocols, protected from pressure to refer for medical treatment, and backed by independent oversight mechanisms. The need for robust training, regular audits, and governance structures that included a range of perspectives, such as child protection specialists and individuals with lived experience of detransition, was highlighted. This viewpoint emphasised that consent to irreversible treatments and argued that safeguarding principles should guide decisions, reserved for carefully assessed, exceptional cases. It expressed concern about the capacity of children to consent to irreversible treatment, and that safeguarding should take precedence, prioritising cautious, holistic care over early medicalisation.

The model cannot succeed without addressing fundamental resource deficits in the NHS

While local service provision was considered desirable, some respondents highlighted what they saw as a lack of resources, funding, and capacity, believing that the DLSS model would not be able to succeed without addressing fundamental NHS service deficits, especially in rural areas. There were also concerns that it would not be possible to provide specialist care at high standards due to constraints within NHS, and that other areas of the service may suffer as a result of increased provision for gender incongruent children and young people.

Support for local services as a means to reduce waiting times and improve access

Some respondents expressed support for the role of Children and Young People’s Gender Service leading a network of Designated Local Specialist Services based on the potential to reduce long waiting times, improve geographic equity and avoid postcode lottery, provide earlier intervention and support closer to home, and integrate gender care with wider mental health and paediatric services. Respondents emphasised that localised provision could make services more accessible and responsive to individual needs, reducing the levels of isolation experienced under previous centralised models, and enabling earlier conversations to prevent unnecessary specialist referrals.

Clinical policies must be reviewed to ensure they do not undermine Cass recommendations

Some respondents felt that Clinical Commissioning Policy undermined both the Service Specification and Cass recommendations, with the policy treating hormones as a "routine option" despite Cass urging "extreme caution." It was argued that the bar for mental health being too low ("not escalating") meant that the policy needed full review before use.

Gender care should be embedded into primary healthcare

Some respondents felt that the long-term goal should be to embed gender care into primary healthcare, as in other countries where GPs were allowed to manage trans healthcare. Current lack of knowledge and support in primary care was seen as a major barrier. It was argued that DLSS must not become obstacles preventing progression to specialist services or adult GICs at age 18. Need clear pathways forward with outcome measures was emphasised. Addressing health inequity by bringing care closer to communities was considered important.

Mandatory training is required to ensure staff are supportive and affirming

Some respondents believed that many regions lacked knowledge, will, or capacity to provide supportive care, believing that there is a need for mandatory training in affirming principles, proper funding, and oversight to prevent a postcode lottery situation and the risk of transphobic or inadequately trained providers without strong governance.

Clear accountability structures are needed between national and local services

Some respondents felt that when care was divided between national and local services, it must be explicit who held ultimate clinical responsibility for each patient's care journey, with defined escalation of contact, pathways and transparent governance structures. These respondents argued that families needed a single accountable point of contact, not to be passed between services, with some wanting accountability to guarantee timely access to affirming care, and others wanting safeguards against inappropriate medicalisation, independent audits, and transparent data reporting. In addition, some respondents argued that Designated Local Specialist Services must publicly report access, waiting times, and outcomes disaggregated by geography, disability, race, and deprivation, with the Lead Provider coordinating consistent data collection and analysis across regions to enable meaningful oversight and service improvement.

GPs require clear guidance and training to support referrals effectively

Some respondents believed there was a significant gap in implementation, with no guidance provided for GPs on assessment, referral decisions, or supporting young people while waiting. These respondents felt that the Cass Review implied an expectation that GPs would reduce wait times, but that no specification provided the framework. Some respondents argued that GPs required clear training so they could be confident in referring, also noting that the role of paediatric services was unclear (e.g., general vs. community paediatrics).

Speech and Language Therapy must be integrated into the service model

Some respondents felt there was a need for proper consultation with Royal Colleges Speech and Language Therapy. It was argued that speech and language therapists, communication needs, and voice care were often overlooked. These respondents believed that services must genuinely integrate multiple professional perspectives beyond only mental health and endocrinology.

The relationship between local services and the National Network requires clarification

Some respondents who agreed with the proposed role also felt that there was no clearly defined relationship between Designated Local Specialist Services, Lead Providers and the NPN, and because these roles and relationships are vague it was impossible to know: who is responsible for what; who leads versus who follows; how information is supposed to move between services; how learning and best practice will be shared; and how gaps in local provision will be handled. Therefore, more information is required in order to comment fully and offer properly informed support.

Paediatric and adult services must be aligned to ensure ethical continuity

Some respondents felt that adult gender services remained dominated by affirmative ideology with minimal oversight. It was argued that both paediatric and adult services must follow the same ethical, evidence-based standards. Without alignment, transition at age 18 risked fragmented care and loss of accountability.

Against

Local services must operate on a gender-affirming model rather than a watchful waiting approach

Many respondents felt that their answer to this question very much depended on who was doing the "leading". They supported services that would promote gender-affirming care – including social transition and medical interventions – but not those that only adhered to psychological exploration, with "watchful waiting" being viewed as equivalent to conversion therapy. Healthcare should follow informed consent models used for other conditions and follow international best practice, free from biased staff with anti-trans views and/or those following the "discredited" Cass Review.

Specific gender services should be replaced by general mental health support

Some respondents expressed fundamental opposition to the existence of any children's gender service, arguing that such services were based on pseudoscience, queer theory, and harmful ideology rather than evidence-based medicine. It was believed that "gender distress" was a symptom of deeper issues that could resolve, and that the belief that children could be "born in the wrong body" was rejected. Medical intervention in the endocrine systems of physically healthy children was viewed as morally indefensible and in conflict with the Hippocratic oath's principle of "do no harm." Instead of specialised gender services, these respondents advocated for: integrating support into general mental health and psychiatric services that addressed underlying trauma, distress, or other psychological factors; criminalising unofficial gender services as harmful to vulnerable children; or implementing "supportive waiting" and family counselling without any medical pathway. The concern was that creating accessible local gender services would act as a "breeding ground" that encouraged social contagion, expanding numbers of children identifying as trans. Any service should avoid such an approach, helping children accept biological reality and their natal sex, not facilitating transition.

Services must address underlying causes such as trauma and social contagion

Some respondents viewed gender questioning as social contagion, trend, or trauma response, with local services seen as being at risk of becoming "breeding grounds" where children copied each other. Respondents felt that there was a need to explore underlying factors around trauma, abuse, autism, online grooming, and family dysfunction, with some arguing that most gender incongruent children and young people would naturally desist, and only a very small number would actually need treatment (e.g., those experiencing precocious puberty).

Local specialist services risk creating additional bureaucracy and delays

Some respondents expressed concerns that the implementation of a network of Designated Local Specialist Services would create additional layers of bureaucracy, extend waiting times, and prevent young people from accessing necessary care.

Services must treat young people as individuals rather than numbers

Some respondents stressed that the emphasis for any service should be to provide actual healthcare and treat trans CYP as humans rather than numbers and assessments to be processed. There were also concerns about the quality of care in local services, with respondents stating that it must be comprehensive, continuous, and specialised, and not a diluted version delivered by inadequately trained local providers. Respondents stated that young people needed proper clinical interventions, not just "supportive waiting."

Governance roles must be co-produced with trans youth to retain community trust

Some respondents felt there was demand for trans youth, their families, and community organisations to have real governance roles, beyond mere "consultation". It was argued that Designated Local Specialist Services must be co-produced with those who used them, with lived experience and peer support embedded throughout the network. CYP should be able to voice their needs and be listened to, these respondents believed.

Local services must be responsive to community needs rather than top-down control

Some respondents expressed concerns that a top-down "cautious national lens" would override local knowledge and responsiveness. It was felt that central service leaders should trust local services more and should be trusted to listen and respond to their communities, not just implement centrally-defined protocols.

The current system is fragmented and lacks clear lines of responsibility

Some respondents felt that services currently "pass the buck", that no one they dealt with seemed to want to take clear responsibility, and that it felt like they were navigating a maze. Families stated that they wanted co-ordinated care, and "care enough to act", with real human connection, not bureaucratic referral chains.

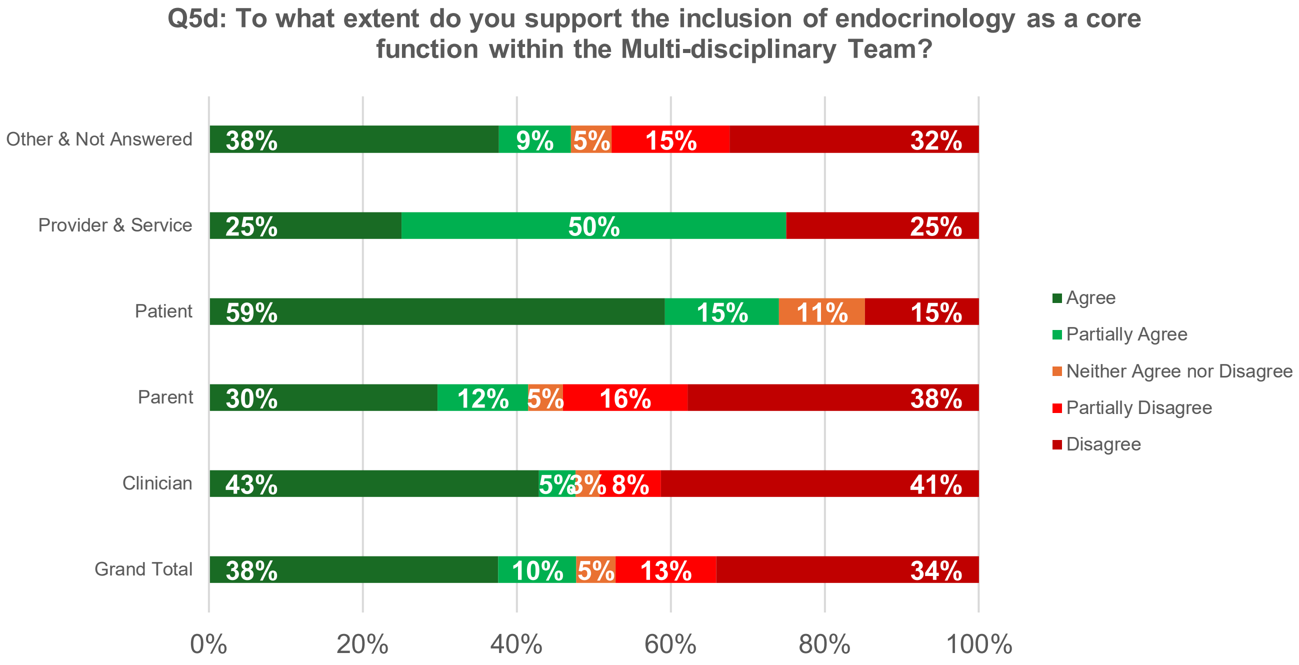
Co-morbidities must not be used to gatekeep access to care

Some respondents expressed concern that co-morbidities such as autism, ADHD, or mental health conditions were being used as reasons to delay or deny gender-affirming care. Respondents felt that these conditions should be managed alongside gender care, not used as barriers to access, and that the presence of co-morbidities should prompt additional support, not exclusion from services.

Question 5d. To what extent do you support the inclusion of endocrinology as a core function within the Multi-disciplinary Team?

Background: Add

There were mixed views on the levels of support for the inclusion of endocrinology as a core function with the proposed Multi-Disciplinary Team, with 48% agreeing and 47% disagreeing. Patients (74%) and service providers (75%) mainly agreed with this, whereas 54% of parents and nearly half of clinicians disagreed (49%).



Themes

For

Endocrinology must be a core function

Some respondents viewed endocrinology as essential, life-saving care for trans youth, providing access to puberty blockers and gender-affirming hormones that international evidence linked to improved mental health and quality of life. Having endocrinologists within the MDT allowed timely, expert monitoring and addressed gaps and gender-affirming hormones that international evidence linked to improved mental health and quality of life, it was felt. These respondents believed that the model supported fertility counselling and identification of intersex conditions. Respondents described hormone therapy as the main intervention that relieved gender dysphoria – comparable to other standardised medical treatments – and believed it should be readily available within evidence-based frameworks such as WPATH and the Endocrine Society. Some respondents argued that endocrinologist involvement helped normalise and legitimise care, ensuring young people received the same standard of specialist support as in other areas of medicine. Many highlighted the transformative impact of good endocrinology services, noting that early access could reduce the need for later, more invasive interventions, improve social development during adolescence, and ultimately reduce long-term costs for NHS.

Endocrinology services must facilitate access

Some respondents believed that endocrinology was essential and must be a core function, but only if it genuinely facilitated access rather than creating additional barriers. The key concern was that endocrinology could become a "clinical chokepoint" or "locked gate" that delayed or blocked timely care through endless committees, reviews, and sequential rather than parallel assessments. These respondents emphasised that endocrinologists must be allies enabling access – the current framework risked positioning endocrinologists as remote gatekeepers who only got involved after lengthy psychological assessments, contradicting international standards (WPATH, Endocrine Society) which recommended early, collaborative involvement with parallel – not sequential – evaluation. Major concerns were raised: sequential assessment models that delayed medical input until psychological exploration was complete, requirements to resolve all comorbidities first (autism, mental health) when those services had multi-year waits, fertility counselling being weaponised as another delaying tactic, and especially when invasive (or AFAB people, Symbolic Inclusion without actual prescribing (evidence: zero new prescriptions in a year despite 30 monthly referrals), extra barriers disguised as safety, where multiple disciplines meant more gatekeeping rather than comprehensive care. Some respondents wanted time-bound protocols, clear criteria, streamlined pathways, and measurable impact on service timeliness. These respondents argued that endocrinology must increase access and accelerate care, not reinforce the delays and distress caused by the current "climate of fear."

Endocrinologists must be trained to be sensitive to trans identities

Some respondents felt that endocrinologists working within the MDT must be specifically trained in gender-affirming care, with understanding and respect for trans identities and lived experiences. Care must be patient-centred with young people's wishes at the forefront, utilising informed consent, shared decision-making, and developmentally appropriate processes, it was argued. These respondents believed that endocrinologists should be apolitical, respect trans identities, and understand how social and psychological factors affected young people's wellbeing. The team must prioritise patient choices and ensure young people and families felt listened to, informed, and supported throughout their care journey – not subjected to clinicians who may intentionally undermine treatment or failed to respect patient identities.

Endocrinology should be available but viewed as a last resort for exceptional cases

Some respondents argued that endocrinology should be available within the service but viewed as a last resort for exceptional cases only, after exhaustive psychological exploration and therapeutic interventions had been attempted, or to assist those who have been harmed by previous hormone treatment. These respondents felt that the majority of young people would not require medical intervention if properly supported through psychological distress, trauma, or social factors. Endocrinology should not be positioned as a routine or early intervention, but reserved for the small minority who demonstrated persistent, consistent gender dysphoria over many years and who had exhausted all other options.

A fundamental shift in culture is needed

Some respondents felt there needed to be a fundamental shift in clinical culture – from gatekeeping and suspicion to trust and informed consent. The culture must move from treating medical care as something to be feared or withheld to life-recognising it as legitimate, affirmative healthcare that improved mental health outcomes and quality of life.

Other themes:

- Some respondents believed that endocrinology provision should be made available through trained primary care providers, such as GPs.
  Some felt that the current framework risks being too restrictive, and that its rigid criteria shouldn't signal that medical care is exceptional or experimental, but rather that it should empower endocrine professionals to provide evidence-based care coordinated with the young person's goals and needs.

Against

Endocrinology should not be a core function

Some respondents believed that endocrinology should not be a core function because most young people should receive non-medical, psychosocial care focused on mental health, developmental factors, and underlying issues such as trauma, autism, or family difficulties. These respondents worried that making endocrinology "core" implied that medical intervention was the standard rather than the exception, which they saw as contradicting the Cass Review's emphasis on holistic assessment. These respondents expressed concern about the evidence base for medical interventions and the potential for serious, lifelong risks. Some respondents argued that puberty was a natural developmental process that often resolved distress without medical intervention, and that past patterns of desistance and recent shifts in referral trends raised questions about underlying drivers of demand, with social contagion, they believed, significantly contributing to previous system failures.

Current evidence is insufficient to justify restricting hormonal treatments

Some respondents argued that there was insufficient evidence to justify puberty blockers or cross-sex hormones in children. The Cass Review and NICE both found the current evidence base to be extremely weak, with unclear benefits for long-term mental health and significant potential risks, including effects on cognitive development, bone density, fertility and cardiovascular health. These respondents felt that existing policies were outdated and not evidence-based. Before any further hormonal interventions were offered, services should release their existing data to support the linkage study recommended by Cass. These respondents believed that these treatments should only be used within robust, long-term research frameworks. Given the lack of proven safety or efficacy – and the near-epidemic rates in support the linkage study recommended by Cass – some respondents argued that these young people deserved protection through a moratorium on routine care until stronger evidence was available.

The reliance on gender incongruence diagnoses contradicts the findings of the Cass Review

Some respondents felt that the GAH policy relied on a diagnosis of gender incongruence, but the Cass Review showed this diagnosis had very poor predictive value – especially for the new cohort of adolescent girls, whose developmental pathways were not understood. These respondents argued that there was no evidence that traits like "clarity, persistence or consistency" had identify who will benefit from medical transition. Cass warned that some young people's distress may stem from psychosocial or cultural factors, making irreversible treatments inappropriate and true informed consent impossible. Given these uncertainties, some respondents questioned whether delaying medical intervention until 18 may be safer, preserving options while addressing underlying issues first.

Endocrinologists should act as advisors rather than prescribers

Some respondents believed that endocrinologists should serve only in a protective, advisory, and educational function rather than facilitating medical interventions. Their role should focus on biological assessment, risk evaluation, and safeguarding – providing families, children, and the wider MDT with clear, evidence-based information about puberty's natural developmental purpose, the potential harms of delaying it, and long-term impacts on fertility, bone health, neurodevelopment, and cardiovascular function. Historically, endocrine involvement had pushed puberty suppression and cross-sex hormones without robust evidence, so their guidance must instead help everyone understand that puberty was a natural process that often resolved gender-related distress without medication, these respondents argued. As specialist advisors – not core team members – some respondents felt they would be consulted only for the small number of cases that might qualify for clinical trials or had actual irreversible medical needs after exhaustive psychosocial care.

Designating endocrinology as a core function sends a confusing signal about the service model

Some respondents felt that if the service's focus was non-medicalised, holistic psychosocial pathways for the vast majority of young people – and puberty blockers were restricted to research trials while cross-sex hormones were expected to be prescribed to almost zero under-18s (based on NHS data since GIDS closure) – then why was endocrinology designated as a "core function"? Making it core signalled that medical intervention was routine and expected rather than exceptional and rare, these respondents argued. This contradicted the Cass Review's emphasis on psychological/developmental care and risked leaving the door open for medicalisation to "creep back in." It also raised concerns about over-treatment if endocrinology became an automatic part of every consultation, potentially deterring cautious parents from seeking help. The designation as "core" felt inconsistent with stated policy and evidence about how few young people should actually receive medical interventions, some respondents believed.

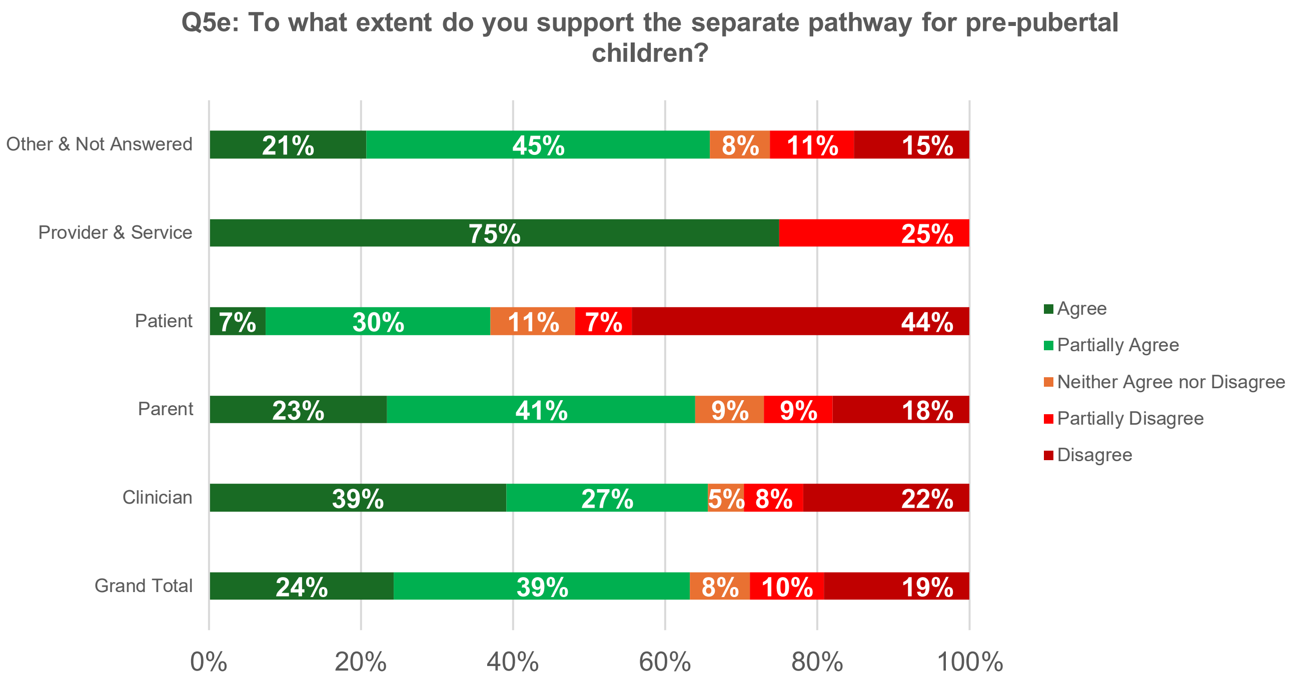
Referrals for older adolescents must not automatically lead to adult gender services

Some respondents argued that NHS England must ensure that any endocrine referrals for older adolescents did not automatically transition into adult gender services. Instead, there should be continued assessment, oversight, and transparent, preserving safeguarding throughout the transition.

Question 5e. To what extent do you support the separate pathway for pre-pubertal children?

Background: Add

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, were 51% disagreed with this approach.



Themes

For

Pre-pubertal children should be supported by mainstream services rather than specialist gender clinics

Some respondents argued that pre-pubertal children should not be seen by specialist gender services at all. Their needs were developmental, psychological, and family-based, best addressed through mainstream CAMHS, child development services, and family support systems, not gender-labelled clinics. Blurring young children for "gender services" risked pathologising normal childhood variation, creating a self-fulfilling label, and reinforcing the false idea that these children had a medical or gender identity problem requiring specialist intervention. Respondents believed that the focus should be on supporting families, exploring underlying factors (family dynamics, mental health, parental anxiety), and helping children build emotional resilience without fixating on "gender."

The pathway must not facilitate or encourage social transition in young children

Some respondents emphasised that the pathway must not facilitate or encourage social transition. These respondents stressed that early social transition was not a neutral act: it could entrench a child's cross-sex identification, increase the likelihood of later medicalisation, and limit natural development in pathways through which early gender-related distress often resolved. Much highlighted evidence from the Cass Review and the Multi-Professional Review Group that early or unsupported social transition could contribute to stress, anxiety, social withdrawal, or isolation – especially when children "live in stealth." Some respondents consistently argued that families needed clear, evidence-based guidance about the developmental risks of social transition and emphasised the gender-related distress in pre-pubertal children commonly resolved with time and support. They stressed the importance of clinician training, rooted in child development, safeguarding, and unbiased assessment, rather than affirmative approaches that may unintentionally steer families toward transition.

Gender non-conformity should be understood as normal variation

Respondents stressed that gender non-conformity was normal within human variation and that it needed acceptance, not medical pathways. Some respondents felt that early referral to gender specialists risked nudging families toward social transition, which was not neutral and could entrench an identity, increasing likelihood of later medicalisation. They stressed that non-conforming interests or presentation were normal variations in childhood and should not be interpreted as evidence of a different "gender identity" or as grounds for referral. The focus should help children understand sex and adult sexuality, and that their distress often stemmed from adults' ideological framing of their behaviour or social contagion rather than genuine gender issues.

The specification must clearly distinguish between gender non-conformity and social transition

Some respondents felt that regarding the specification's statement that "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 at their natal sex is known as 'social transition'", some respondents believed that this failed to clearly separate gender non-conforming behaviour from social transition, thereby risking inappropriate or harmful responses. In contrast, social transition—adopting opposite-name, pronouns, and being seen and treated as a significant girl/boy—entrenched identification as the opposite sex and represented a far more significant step.

Support for a distinct pathway

Some respondents expressed support for a distinct care pathway for pre-pubertal children as they believed that gender-related distress in this age group is typically transient and often resolves naturally as identity, body awareness, and psychosocial development progress. Citing historical data and developmental research suggesting high desistance rates, they maintained that most younger children, if supported without intervention, will ultimately become comfortable with their biological sex – especially once puberty begins.

The proposed pathway reflects gender ideology rather than child development evidence

Some respondents expressed concerns that the proposed pathway is shaped by gender-identity ideology rather than child-development evidence. They felt that terms like “assigned sex” and assumptions about “gender identity” reflect activist language, and that this risks pathologising normal gender non-conforming behaviour. Respondents believed that children should be supported to explore freely without being guided into identity frameworks, and that the service must avoid affirming approaches that could override safeguarding or developmental caution.

Against

The separate pathway relies on incorrect assumptions regarding desistance rates

Some respondents disagreed with the specification's statement that "children who present with gender incongruence at a young age are most likely to desist before puberty," which is used to justify a separate pathway. Respondents argued that this claim is factually incorrect, based on outdated and heavily contested research that studied gender non-conforming children rather than those with actual gender incongruence or dysphoria. Respondents therefore viewed this idea as a misinterpretation that conflates gender non-conformity with trans identity, feeling that its use to create structural separation sends a harmful message that younger children's identities are less valid or trustworthy. Some respondents also highlighted that the Cass Review's findings on desistance have been widely criticised internationally for poor methodology and bias.

A separate pre-pubertal pathway risks creating additional delays and fragmented care

Some respondents expressed concern that a dedicated pathway for pre-pubertal children could function as an additional gatekeeping stage that delays care rather than supports it. They feared children might spend years on this pathway only to "age out" before being seen, then face further delays when transferring into the main or adolescent service, potentially repeating this cycle again when moving to adult care. This raised concerns that the pathway could become a bureaucratic holding area rather than a source of meaningful support. Respondents also mentioned the risk of confusion and fragmented care, as different referral routes for pre-pubertal and older children could result in unclear transitions, inconsistent levels of support, and mismatched expectations about what help was actually available. Some worried this separation could invalidate younger children's experiences or imply their identities were provisional, leading families to feel mistrusted or dismissed.

A separate pathway is only acceptable if it is affirming and supportive

Some respondents stated they would only support a separate pre-pubertal pathway if it was affirming, supportive, non-pathologising, and based on updated research, not built around desistance assumptions. They believed it should guarantee timely access to puberty blockers when puberty began.

Separating pathways reinforces stigma

Some respondents felt that reinforced outdated assumptions about "desistance" and treated younger children's gender identities as less credible or stable. They believed this structural separation introduced stigma and institutionalised doubt, signalling that pre-pubertal children required extra scrutiny rather than support. Respondents emphasised that many children understand their gender well before puberty and that early affirmation can improve mental health, family relationships, and overall wellbeing. A separate pathway was viewed as likely to deter early disclosure, create bureaucratic delays, and undermine trust in services. Concerns around medical intervention were also raised, as they argued some approaches appeared to prioritise avoiding clinical thresholds without an age-based split. Overall, respondents favoured an integrated, developmentally sensitive approach that offered consistent, affirming psychosocial support to all children, with decisions about medical treatment made individually rather than determined by a separate pre-pubertal track.

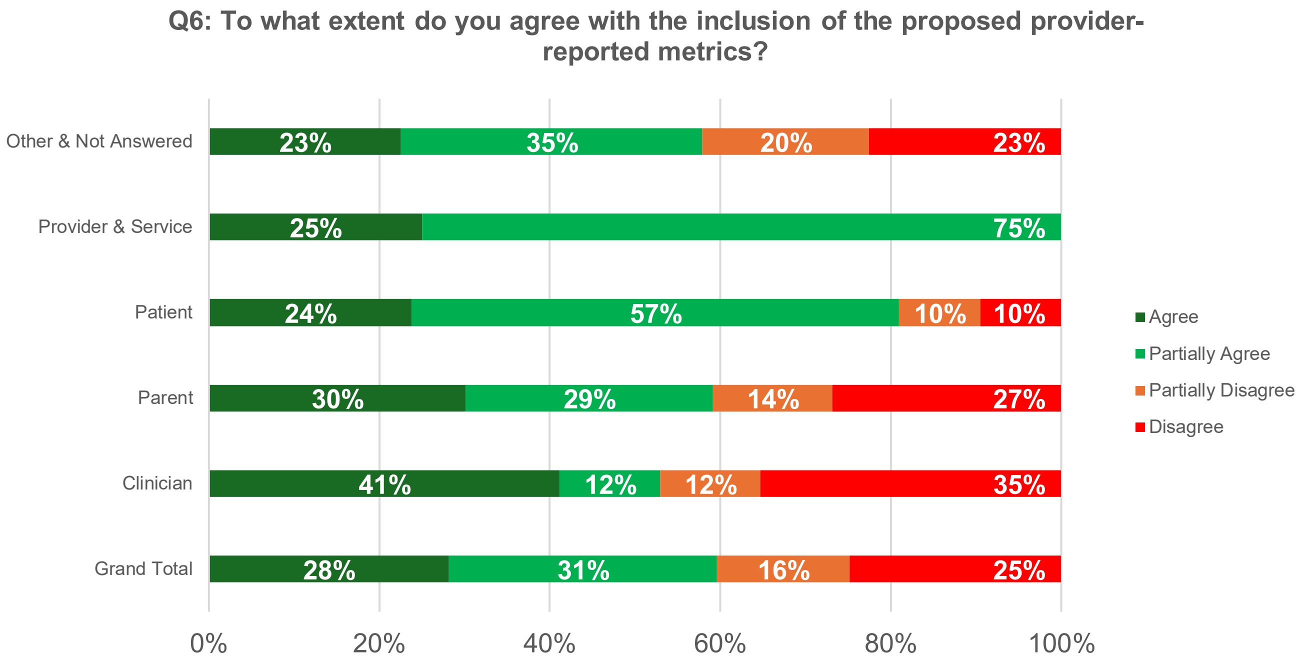
All patients should have equal access to treatment regardless of age pathway

Some respondents believed that there should be no restrictions to allowing children and young people access to puberty blockers or any other hormonal treatment.

Question 6. To what extent do you agree with the inclusion of the proposed provider-reported metrics?

Background: Add

The majority (59%) agreed with the inclusion of the proposed provider-reported metrics. This was the same for all stakeholder groups.



Themes

For

The proposed metrics are too focused on the administrative process

While some respondents agreed that metrics and transparency are important, they proposed that the current proposals focus too heavily on administrative data such as referrals, appointments, and protocol compliance rather than on outcomes that genuinely reflect quality of care. They stressed that meaningful measures should centre on young people's wellbeing, safety, mental health, satisfaction, and lived experience. Without patient-reported outcomes and experience measures, respondents felt that families would not know whether the service is actually helping, and that NHS would not be able to judge whether care is effective or equitable.

In addition to the measures suggested above, respondents also suggested that the following metrics be included:

- Reduction in distress
- Psychological safety
- Patient satisfaction
- Feeling listened to and respected
- Level of affirmation of gender
- Experiences of discrimination or stigma
- Autonomy and involvement in decisions
- Waiting times and timeliness of care
- Impacts of delays
- Continuity of care
- Trust in clinicians
- Clarity of information
- School attendance and engagement
- Social functioning
- Family support
- Access to peer and community support
- Quality of life
- Harm from gatekeeping
- Equity of access
- Reasons for dropout or disengagement

Metrics must be co-produced with trans communities

Respondents stated that provider-reported metrics are only meaningful if they are developed with trans young people, families, and community organisations, not simply imposed on them. Some respondents felt that there had been a deep mistrust created by past reforms and the exclusion of trans voices from major policy decisions, and that co-produced metrics would help alleviate and heal this.

Metrics must be transparent and independently reviewed to ensure accountability

Some respondents stated that metrics must be transparent, publicly reported, and independently reviewed to build trust and ensure accountability, emphasising that data should be openly published and scrutinised by independent experts and communities. Without openness, co-production, and external oversight, it was felt that metrics would risk becoming administrative box-ticking exercises rather than meaningful measures of safety, equity, and real outcomes.

Systematic monitoring is supported as essential for safety and evidence-based care

Some respondents who supported the proposed metrics emphasised that systematic monitoring was essential for accountability, safety, and the delivery of evidence-based care. They believed robust data would expose service failures, prevent ideological bias, ensure consistent standards, and provide early warning of harms, including for those who desist or detransition. Metrics were seen as necessary to track real-world outcomes, evaluate long-term effects, guide improvements, and build a transparent, trustworthy service. Some stressed that metrics must be used responsibly – focused on quality, not politics – and that they should inform continuous learning, protect young people, and allow services and clinicians to be held to account.

Demographic data must be collected to ensure equity of access

Some respondents argued that demographic data should be collected to ensure fair outcomes for groups such as disabled young people, racially minoritised young people, and those in different regions.

Mistrust in the NHS leads to fear that metrics will be misused

Some respondents expressed deep mistrust in the NHS and concern that any metrics collected could be misused, manipulated, or shaped by political agendas. They feared data may be selectively interpreted, biased by those collecting it, or used to justify restrictive or harmful practices rather than improve care. There was anxiety that past treatment failures, psychological support to all children, and decisions about medical treatment may not have sufficient psychosexual or cognitive maturity to engage meaningfully with gender identity information fairly, leading to scepticism about whether the metrics would genuinely protect young people or merely reinforce existing mistrust.

Qualitative feedback is needed to capture the lived experience of patients

Some respondents felt that while structured metrics could highlight patterns in access and service delivery, they could not on their own capture the lived realities, emotional safety, and day-to-day experiences of young people and families. This risk overlooking what matters most to those receiving care – whether they felt heard, respected, supported, and safe. Meaningful evaluation therefore needed space for subjective accounts, narrative feedback, and indicators that reflected wellbeing and trust, offering a fuller picture that numbers alone could not provide and ensuring services remain grounded in the realities of the communities they served.

Metrics risk incentivising gatekeeping rather than improving care quality

Some respondents raised concerns that metrics could end up reinforcing gatekeeping rather than improving care. Contributors worried that measuring transfers, safeguarding referrals, or "compliance" may incentivise services to delay, restrict, or prematurely discharge young people, especially given long waits in adult services. Data could be framed to justify risk-averse or conservative practice, turning metrics into tools that limit access instead of supporting continuity, affirmation, and patient-centred care.

Current tools may not accurately measure the impact of treatment

Some respondents felt that the current tools used did not accurately measure treatment or care, stating that poor mental health outcomes may exist as a result of encountering transphobic attitudes in society rather than because of incongruence or treatment.

The service and its metrics must be protected from ideological influence

Some respondents who agreed with the inclusion of the proposed provider-reported metrics emphasised that the service must be firmly protected from any ideological influence, and that all decisions should be based solely on evidence, safety, and clinical need. Respondents stressed that metrics and data should be used for accountability and patient protection – not to promote political or social agendas – and that independent, unbiased oversight is essential to prevent a repeat of past ideology-driven outcomes.

Against

Long-term metrics are required to evaluate the safety and physical impact of interventions

Some respondents argued that the proposed provider-reported metrics were insufficient for purpose, and that long-term metrics which flowed into and linked with adult care were essential because there was currently no reliable evidence about the lasting effects of medical and social interventions on children. They felt that short-term satisfaction scores and process measures were misleading, often reflecting temporary relief rather than genuine benefit, and that they would reveal little about regret, detransitioning, impaired bone density, fertility loss, cardiometabolic risks, or adverse drug effects. These respondents emphasised that without continuous data collection over many years, NHS could not know whether treatments were safe, effective, or harmful. Poor record-keeping and lack of follow-up in past services (as highlighted by the Cass Review) left a major evidence gap, and respondents warned that repeating this failure would expose children to interventions with unknown long-term outcomes. These respondents felt that robust, sex-disaggregated, longitudinal data was fundamental for safeguarding, governance, research, and ethical practice, and that only long-term, scientifically measurable outcomes – not short-term PROMs, PREMs, or clinician-rated tools – could provide the evidence base needed to properly evaluate young people and whether the service was genuinely safe and effective.

The framework has not stated what its outcome measures are

Some respondents felt that the entire metrics framework was fundamentally flawed because the service had not stated what its outcome measures were, with most of the proposed metrics being process measures with only one outcome measure, the Children's Global Assessment Scale (CGAS). Respondents argued that this was a general measure of functioning, not specific to gender services, and that it had been validated for UK children or diverse groups. They believed, therefore, that the service should first define its purpose and intended outcomes, and only after establishing these should it develop metrics to measure them, with process metrics as secondary.

Question 7. Are there any other changes or additions to the revised service specification that should be considered?

Background: Add

Themes

Note: Most themes raised in response to Question 7 had already been mentioned in response to earlier questions and will be counted and merged in the most relevant place. Additional themes were as follows:

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.

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.

Gender incongruence should not be treated with medical interventions

Some respondents argued that classifying "Gender Incongruence" as a non-medical condition created a paradox where the NHS provided medical treatment for a non-pathology. They suggested dropping gender diagnoses entirely, in favour of treating "gender distress" within a standard mental health framework to ensure underlying causes were addressed.

The use of ICD-11 codes is necessary to depathologise 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.

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.

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 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).

Language

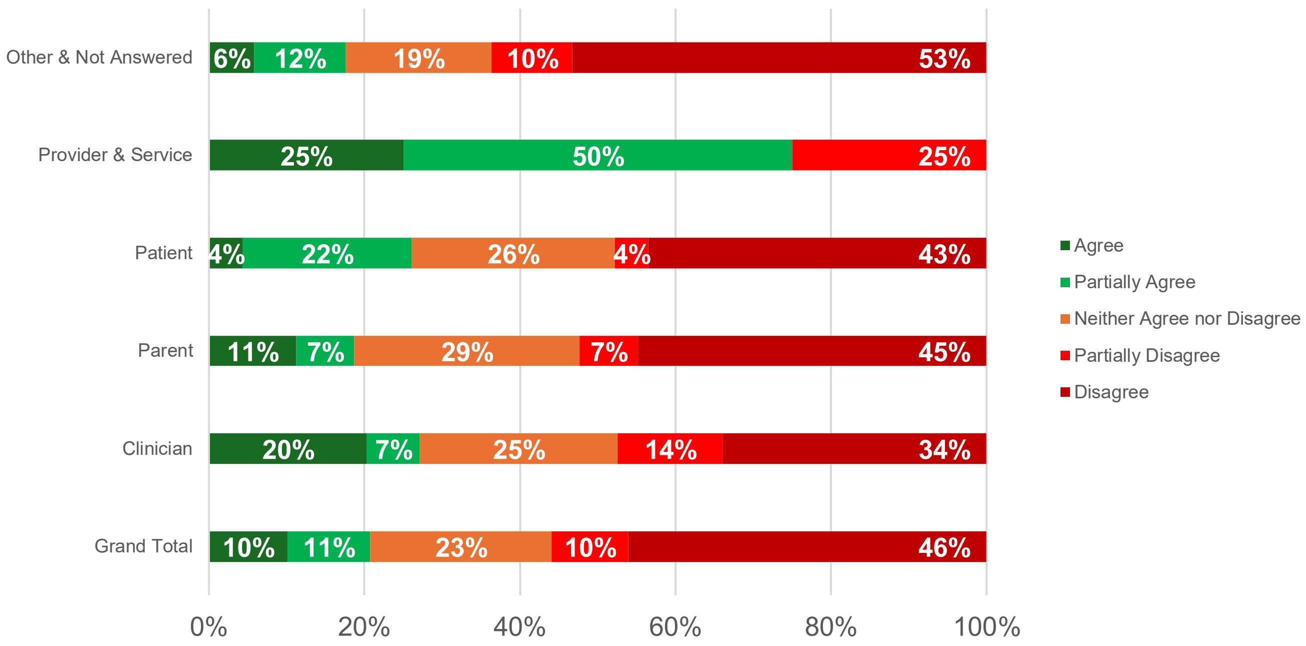
Some respondents explicitly called for the service to use the terms "trans" or "transgender" in its clinical narrative, which they felt was necessary to avoid invalidating identities. Some also requested specific reference to nonbinary patients and their unique needs.

Question 8. To what extent do you agree that the Equality and Health Inequalities Impact Assessment reflects the potential impact on equalities or health inequalities which could arise because of the proposed changes?

Background: Add

The majority (56%) felt that the Equality and Health Inequalities Impact Assessment (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.

Q8. To what extent do you agree the Equality and Health Inequalities Impact assessment reflects the potential impact on equalities or health inequalities which could arise because of the proposed changes?



Themes

The EHIA fails to fully assess the impact on the basis of sexual orientation

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 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 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.

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 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.

The EHIA fails to fully assess the impact on the protected characteristic of sex

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 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 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. 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 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.

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 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 undergo, legal and medical transition, and should not be applied to confused or distressed young people exploring identity in adolescence.

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 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 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 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.

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 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 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 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.

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

Other viewpoints put forward:

- Young people who desist or detransition are not mentioned even as a stakeholder group, yet they can face severe physical and mental-health inequalities after medicalisation.
- The EHIA fails to comply with international human rights and the Equality Act 2010.
- The EHIA ignores religious-modesty needs.
- Some respondents felt that there was an error in the EHIA, in that it stated that the pre-pubertal pathway aligns with Cass Recommendation 23, whereas the pre-pubertal pathway corresponds to Recommendation 4 (Recommendation 23 concerns services for 17–25-year-olds).

Annex A. List of organisations that responded

Name of organisation
2BU Somerset
ADHD Consultancy Limited
Bayswater Support Group
Biology in Medicine
British Medical Association
British Society for Paediatric Endocrinology and Diabetes (BSPED)
Cambridge University Hospitals NHS Foundation Trust
CLCH NHS trust
Clinical Advisory Network on Sex and Gender
Evans Psychotherapy
Gendered Intelligence
Hackney Sex Realists
Healthwatch Birmingham and Solihull
Kite Trust
Labour Women's Declaration
Lewisham and Greenwich NHS Trust
LGB Alliance
LGBT Foundation
National Centre for Eating Disorders
NHS
NHS Herefordshire & Worcestershire ICB
NHS Wales Joint Commissioning Committee
Our Duty
PrescQIPP CIC
Royal College of General Practitioners
Royal College of Speech and Language Therapists
Sex Matters
The Christian Institute
The Christian Medical Fellowship
The Pharmacists' Defence Association's LGBT+ Network
The Women's Organisation
Thoughtful Therapists
Trans Advocacy & Complaints Collective
TransActual
Transgender Trend
TransLucent.Org.UK
UCLH
W1 Concept Ltd.
Women's Declaration International UK (WDI UK)
Women's Rights Network