

NHS England

**Service for Children and Young People with Gender Incongruence:
Referral Pathway Consultation**

Public Consultation Analysis and Summary Report | April 2024

Version: 1.5

Status: Final Draft Report

Authors: Katie Lund, Matthew Scott, and Maria Gallagher

Date: 17/04/2024

TONIC

CONTENTS

CONTENTS.....	2
EXECUTIVE SUMMARY	3
1. INTRODUCTION	8
2. HOW THE ANALYSIS WAS CONDUCTED	9
3. RESPONDENT DEMOGRAPHICS.....	12
4. DETAILED SUMMARY OF RESPONSES	13
Q1. Referrals to the waiting list may only be made by general paediatric services or Children and Young People (CYP) mental health services.....	13
Q2. Children under 7 years of age will not be added to the waiting list.	20
Q3. Young people aged 17 years will not be added to the waiting list of the children and young people’s gender incongruence service as a temporary measure in response to long waiting times.	26
Q4. Young people who reach 17 years of age while on the waiting list for the children and young people’s gender incongruence service will be removed from the waiting list; they may seek a referral into the adult gender service with their original referral date into the CYP service honoured.	33
Q5. The role of the pre-referral consultation service.	40
Q6. Views on any other element of the service specification.	47
Q7. To what extent do you agree that the Equality and Health Inequalities Impact Assessment reflects the potential impact on health inequalities which might arise as a result of the proposed changes?.....	51
Annex A. List of Organisations That Responded	57

EXECUTIVE SUMMARY

Introduction

NHS England is the responsible commissioner for specialised services for individuals with gender dysphoria, and, as such, held a consultation to seek views on changes to the referral pathway into the Children and Young People's (CYP) Gender Incongruence Service, how the national waiting list is managed, and how transfers are made from the waiting list into the service.

NHS England ran a consultation from 7th December 2023 to 6th March 2024 to hear from a wide range of patients, patient groups, and other stakeholders in the development of its commissioning of services in order to check whether proposals were right and supported, to ensure the public understand their impact, and to identify any alternatives before decisions are made.

NHS England commissioned TONIC, an independent social research organisation specialising in public consultations, to produce a summary of responses to the consultation. 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. 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.

Consultation Respondents

A total of 233 responses to the consultation were received. 36% were clinicians, 21% were parents or family members, 15% were patients or former patients, and 6% were service providers. 21% stated they were in the "other" category of respondent types. 42 of these responses indicated they were submitted on behalf of an organisation.

Summary of Responses

In this section we set out the overall results of the closed questions showing the percentage of respondents who agreed, disagreed or were neutral for each of the proposals. Alongside this, we show the top three themes from the analysis of their written responses, again broken down by those who agreed, disagreed or were neutral.

Q1. Referrals to the waiting list may only be made by general paediatric services or Children and Young People (CYP) mental health services.

59% disagreed with the proposal that referrals to the waiting list may only be made by general paediatric services or CYP mental health services, while 39% agreed and 3% were neutral.

There was agreement from the majority of clinicians (51%), service providers had mixed views (with 47% agreeing and 47% disagreeing), and there was disagreement from the majority of patients/former patients (86%) and parents / family members (59%).

Those who **agreed** raised the following themes:

- Supporting the requirement for a specialist to make the referral
- The necessity for a comprehensive assessment prior to referral

- Safeguarding considered crucial via professional gatekeeping

Those who **disagreed** raised the following themes:

- Increased waiting times and a burden to services
- Concerns regarding barriers to care and gatekeeping
- The necessity of direct referrals from GPs

Those who were **neutral** raised the following themes:

- A lack of training and understanding for key professionals
- Concerns about the resources and capacity in the system
- Potential bias based on professional beliefs

Q2. Children under 7 years of age will not be added to the waiting list.

51% agreed with the proposal that children under 7 years of age will not be added to the waiting list, 45% disagreed and 4% were neutral.

There was agreement with the proposal from the majority of clinicians (75%), service providers (73%), and parents / family members (53%). However, there was disagreement from most patients / former patients (89%).

Those who **agreed** raised the following themes:

- Children under 7 are too young to decide
- Increase the suggested minimum age threshold
- Ensure appropriate psychological support is available

Those who **disagreed** raised the following themes:

- Importance of early identification and support
- Felt the age limit was arbitrary
- Felt there was inherent understanding of gender identity prior to age 7

Those who were **neutral** raised the following themes:

- The need for support not just for those on the waiting list
- Consideration to be given on a case-by-case approach
- Only offer psychological support

Q3. Young people aged 17 years will not be added to the waiting list of the children and young people's gender incongruence service as a temporary measure in response to long waiting times.

38% agreed and 40% disagreed with the proposal that young people aged 17 years will not be added to the waiting list of the children and young people's gender incongruence service as a temporary measure in response to long waiting times. 22% of respondents were neutral.

There was agreement amongst the majority of clinicians (51%) and service providers (60%), but disagreement from 50% of patients / former patients, and 47% of parents / family members.

Those who **agreed** raised the following themes:

- Faster access to appropriate services
- Based on realistic expectations of service access for 17 year olds
- A seamless transition to the Adult service is crucial

Those who **disagreed** raised the following themes:

- Excluding 17-year-olds from youth services is inappropriate
- Long waiting times in the Adult service
- Delaying access to care for 17-year-olds considered to be discriminatory

Those who were **neutral** raised the following themes:

- Dependent on the Adult service acceptance of the referral
- Preventing gaps in care
- Underfunding and understaffing issues in the current system

Q4. Young people who reach 17 years of age while on the waiting list for the children and young people's gender incongruence service will be removed from the waiting list; they may seek a referral into the adult gender service with their original referral date into the CYP service honoured.

31% agreed and 48% disagreed with the proposal that those reaching 17 years of age will be removed from the CYP waiting list with referral to Adult services with original referral date. A further 21% neither agreed nor disagreed.

Half of clinicians (50%) agreed with the proposal, while the majority of parents / family members (70%) disagreed and there were more mixed views amongst patients / former patients and service providers.

Those who **agreed** raised the following themes:

- Important to honour the original referral date
- Automatic transfer mechanisms required
- Could improve the efficiency of the process and timeliness of care

Those who **disagreed** raised the following themes:

- Concerns about the referral process, administrative burden, and wider systemic issues
- The developmental stage and legal status of 17-year-olds
- Continuity of care and risk of falling through the gaps

Those who were **neutral** raised the following themes:

- The need for a more effective, efficient, and integrated referral and transition approach
- Conditional acceptance, as long as there are system improvements

Q5. The role of the pre-referral consultation service.

44% agreed and 34% disagreed with proposals around the role of the pre-referral consultation services, while 22% were neutral.

The majority of clinicians (62%) and service providers (73%) agreed. Parents / family members were more mixed, and there was disagreement from the majority of patients / former patients (64%).

Those who **agreed** raised the following themes:

- Need to mitigate additional barriers and potential gatekeeping
- Approval of the triage function
- Approval of support for patients whilst on the waiting list

Those who **disagreed** raised the following themes:

- Concerns about delays to care and barrier to access
- Support should not come at the cost of a place on the waiting list
- Unnecessary gatekeeping added

Those who were **neutral** raised the following themes:

- Confusion regarding the question being asked
- Lack of clarity and detail about the proposed service
- This would be dependent on the professionals' perspective

Q6. Views on any other element of the service specification.

The top five themes raised by respondents were:

- Concerns about under staffing and lack of trained staff
- Concerns about accessibility and overly complex referral processes
- Calls for greater patient autonomy and self-referral routes
- Requests for a comprehensive and integrated approach that included mental health
- Divided opinions about access to puberty blockers and hormone treatments

Q7. To what extent do you agree that the Equality and Health Inequalities Impact Assessment (EHIA) reflects the potential impact on health inequalities which might arise as a result of the proposed changes?

Nearly half (49%) were neutral, while 29% agreed and 26% disagreed. The largest percentage in most respondent types is for neither agreeing nor disagreeing. However, the majority of service providers (60%) disagree, more clinicians agree than disagree and there are broadly even numbers among patients / former patients and parents / family members.

Those who **agreed** raised the following themes:

- Recognition of systemic barriers
- Equality of treatment
- The need for continuous review and improvement

Those who **disagreed** raised the following themes:

- How the additional gatekeeping impacts different groups needs to be acknowledged
- This is more about political influence than healthcare
- Inadequate rationale given for the proposed changes

Those who were **neutral** raised the following themes:

- Insufficient detail and data provided to make decisions

A number of respondents felt that specific protected characteristics were insufficiently represented in the EHIA. Those most frequently mentioned were: age, disability, ethnicity, socioeconomic factors and sexual orientation.

1. INTRODUCTION

Following interim advice from the Cass Review in 2022, NHS England set out plans to start building a more resilient service by expanding provision and enhancing the focus on clinical effectiveness, safety, and patient experience. The first phase in these plans was to establish two new nationally networked services which – in keeping with Dr Cass’ advice – will be led by specialist children’s hospitals.

Prior to April 2024, there was only one provider of specialist services for children and young people with gender dysphoria in England; the Gender Identity Development Service (GIDS), delivered by the Tavistock and Portman NHS Foundation Trust in London.

In June 2023, NHS England published an [interim service specification for specialist gender incongruence services for children and young people](#) to support the new providers in developing their services. In light of the feedback from consultation, NHS England decided to form a separate service specification which described in greater detail the process for making referrals into the service, as well as the process for managing the national waiting list held by NHS Arden & GEM Commissioning Support Unit.

The Tavistock GIDS service closed on 31st March 2024. As part of the managed transition to new services, the waiting list for GIDS transferred from the Tavistock and Portman NHS Foundation Trust to NHS Arden & GEM Commissioning Support Unit to hold on behalf of NHS England. Children and young people on the waiting list will begin to be transferred to one of the new providers as the services begin to open, in chronological order using the date of referral to GIDS.

NHS England is the responsible commissioner for specialised services for individuals with gender dysphoria, and, as such, held a consultation to seek views on changes to the referral pathway into the Children and Young People’s (CYP) Gender Incongruence Service, how the national waiting list is managed, and how transfers are made from the waiting list into the service.

NHS England wanted to hear from a wide range of patients, patient groups and other stakeholders in the development of its commissioning of services. As part of this, they ran a public consultation for 90 days (from 7th December 2023 to 6th March 2024) as an opportunity to check whether proposals were right and supported, to ensure the public understand their impact, and to identify any alternatives before decisions are made.

This report sets out the findings from analysis of responses of this consultation.

2. 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.

Methodology

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.

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).

Data Cleansing

Prior to analysis taking place, the 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.

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.

In some cases, analysis of a respondent’s data resulted in multiple references to the same theme. This was particularly the case for longer responses. The report generally refers to the number of respondents that replied to a question or that had at least one reference belonging to a given theme within a question. The qualitative analysis drew on all the references coded to a theme.

Results for each of the consultation questions have been reported in line with the consultation headings used in the materials available to respondents.

The order of themes has been determined by the proportion of respondents coded under each coding theme. Themes with the highest number of respondents have been reported first, with all the others in descending order.

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 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%.

3. RESPONDENT DEMOGRAPHICS

A total of 233 responses to the consultation were received by NHS England.

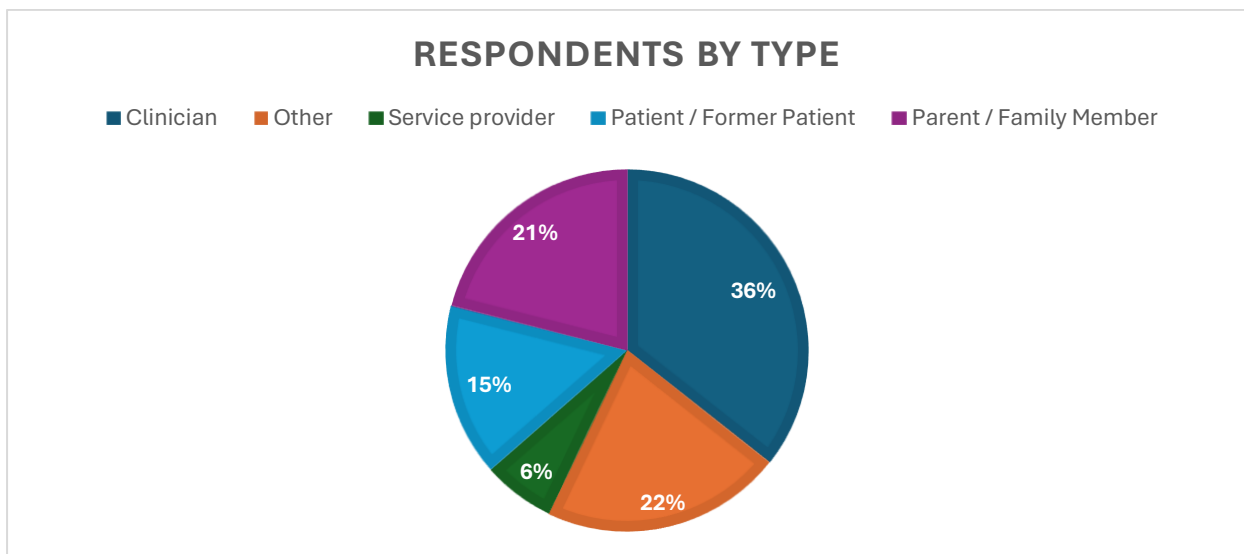
Respondent Types

Participants were asked in which capacity they were responding and whether they were doing so on behalf of an organisation. 36% were clinicians, 21% were parents or family members, 15% were patients or former patients, and 6% were service providers. 21% stated they were in the “other” category of respondent types, which included a broad range of individuals, roles and relationships to the issue.

Table 1. In what capacity are you responding to the consultation?

In what capacity are you responding?	Number	Percentage of total
Clinician	83	36%
Other	50	21%
Parent / Family Member	49	21%
Patient / Former Patient	36	15%
Service provider	15	6%
Total	234	100%

Figure 1. Respondents by type.



Organisations

42 responses indicated they were submitted on behalf of an organisation. Where these respondents had also listed the name of their organisation, we have compiled these in Annex A of this report.

4. 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.

Q1. Referrals to the waiting list may only be made by general paediatric services or Children and Young People (CYP) mental health services.

1.1 Background

New referrals to the national waiting list may only be made by NHS general paediatric services or CYP mental health services. If agreed, this change would not be applied retrospectively; those currently on the waiting list would not be affected, regardless of their referral source.

In view of the relatively high number of children and young people who present to gender incongruence services with other complex needs, such as mental health needs, neurodiversity or autism, this arrangement will ensure that a holistic needs assessment is undertaken by the NHS and an individual care plan put in place as appropriate before a referral is made into the specialised gender incongruence service. This also helps the NHS to respond to the previous concerns of the Care Quality Commission (the independent regulator of health services) about the lack of support or risk assessment around children and young people while they remained on the waiting list of the Tavistock GIDS.

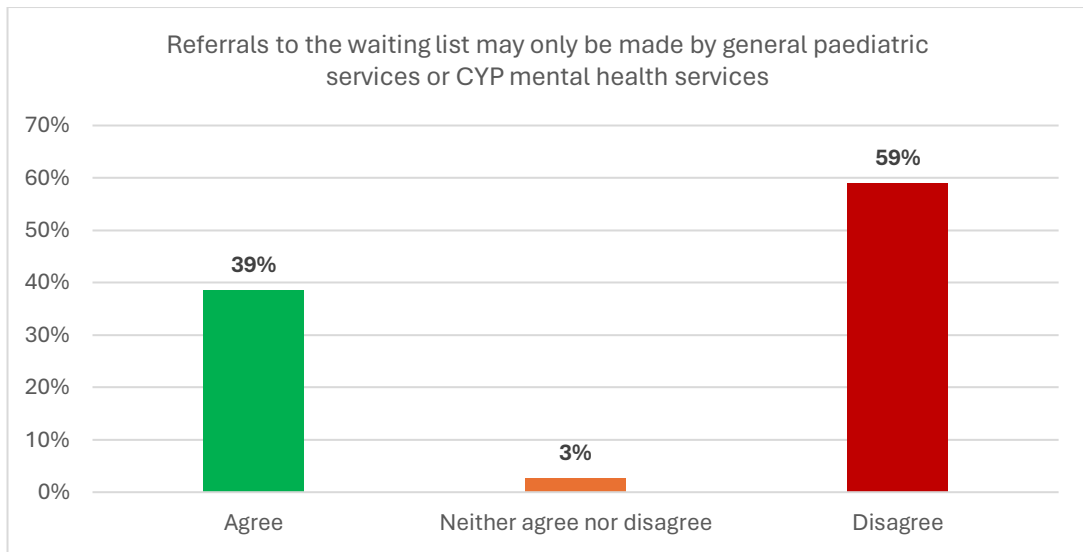
This arrangement will also facilitate a shared care approach, where relevant to the child or young person's needs, reflecting the terms of NHS England's interim service specification for CYP Gender Incongruence Services that describe how the specialist service and local services will collaborate in the best interests of the child or young person. A shared decision is made between the child or young person, the family and local service about the need for a referral to the specialist Gender Incongruence Service.

Children and young people who are registered with a Welsh GP would continue to follow the existing referral protocol put in place by NHS Wales, which is that all referrals are made via CYP mental health services.

1.2 Consultation Findings

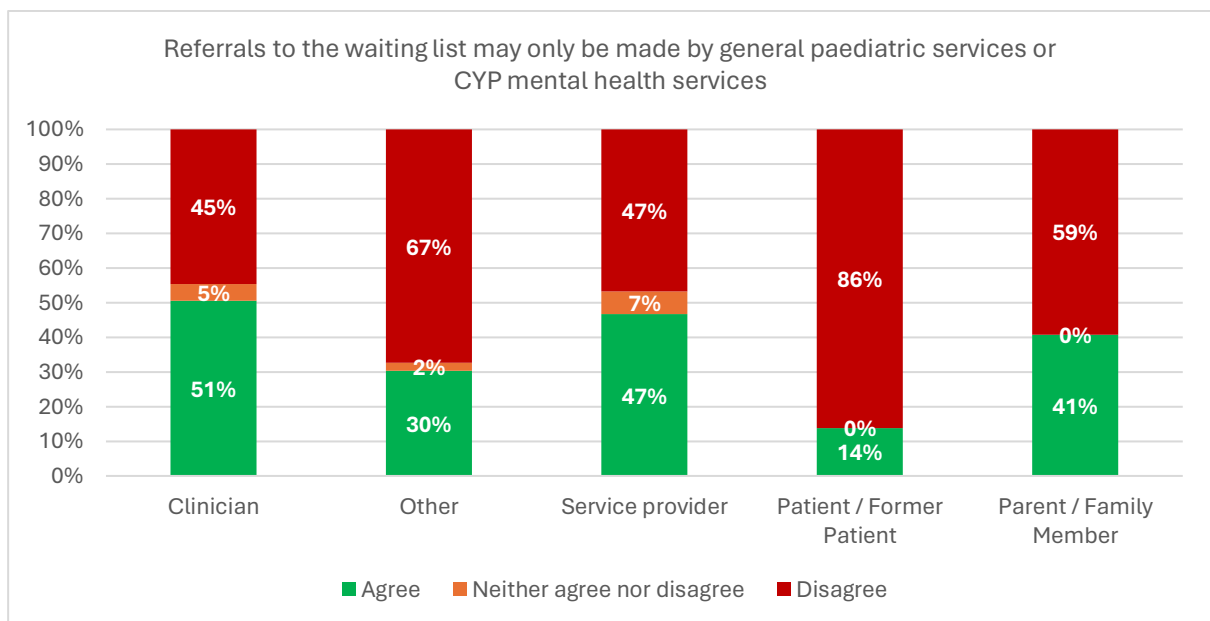
Overall, 59% of respondents disagreed with the proposal that referrals to the waiting list may only be made by general paediatric services or CYP mental health services. 39% agreed and 3% were neutral (see figure 2).

Figure 2. Referrals to the waiting list may only be made by general paediatric services of CYP mental health services.



When looking at this for the different respondent types (see figure 3), the majority of clinicians (51%) agreed with the proposal. Service providers had mixed views, with 47% agreeing and 47% disagreeing. However, there was disagreement from the majority of patients/former patients (86%), parents / family members (59%), and other respondents (67%).

Figure 3. Respondents by type.



1.3 Analysis of Comments

Overview

AGREE		DISAGREE		NEUTRAL	
Theme	No.	Theme	No.	Theme	No.
The requirement for a specialist to make the referral	38	Increased waiting times and a burden to services	74	A lack of training and understanding	23
The necessity for a comprehensive assessment prior to referral	18	Concerns regarding barriers to care and gatekeeping	65	Resource and capacity concerns	17
Safeguarding considered crucial via professional gatekeeping	7	Necessity of direct GP referrals	63	Potential ambivalence based on professional beliefs	4
		Importance of other referral options	38		
		General paediatricians are an inappropriate referral source	20		
		Proposal pathologises gender incongruence	18		

Reasons for Agreeing

The Requirement for a Specialist to Make The Referral (n=38)

Some respondents suggest that referrals to the waiting list should be made by professionals with specific expertise in paediatric and mental health care. This ensures that the referrers have a comprehensive understanding of the complex issues surrounding gender incongruence and are equipped to assess the child's needs accurately. These respondents also suggested that patients can be offered support by these professionals whilst they are on the waiting list, if needed. The removal of GPs from the list of referrers is considered a positive step, since respondents felt they lack specific skills, knowledge, and capacity to make appropriate referrals. Respondents believed that limiting the number of referral sources should reduce strain on tertiary services by reducing potentially inappropriate referrals.

"While acknowledging that CAMHS already has long waiting times and high thresholds, and paediatrician waiting times are growing, we still believe it is essential that referrals to the waiting lists are made by them. This will ensure that CYP who have important coexisting physical and mental health conditions are picked up before they are directed to a gender clinic."

The Necessity for A Comprehensive Assessment Prior to Referral (n=18)

Some participants emphasised the need for a comprehensive assessment of potential neurodevelopmental disorders and concurrent mental health issues prior to referral. They felt this should consider other factors, such as internalised homophobia and difficulties with pubertal changes. Such assessments, they suggested, are best conducted by specialist services, highlighting the importance of a thorough and holistic approach to care.

"It is important that thorough evaluation of mental health problems takes place first. Far too many young people have been referred who have other mental health needs or autism etc. my daughter was referred after one call with a GP which is highly inappropriate."

Safeguarding Considered Crucial Via Professional Gatekeeping (n=7)

It was suggested by some contributors that professional gatekeeping by qualified specialists is necessary to safeguard children and young people from premature or inappropriate referrals to gender incongruence services. They considered it to be crucial that those involved in professional gatekeeping should hold no bias towards gender beliefs and must fully discuss risks, harms and benefits of any treatment with the patient and their family. Some suggested there should be no gender affirmation at any stage of this process.

"I agree that referrals should be made by those with expertise in the field and who are able to fully discuss the risks and benefits of transitioning. Referrals should not be made by charities or pressure groups. Referrals should come from those who do not have a specialist interest and who may be biased away from fully discussing harms...Safeguarding is fundamental to the process."

Reasons for Disagreeing

Concerns Regarding Barriers to Care and Gatekeeping (n=65)

Some respondents voiced concerns that the proposal would create new obstacles for those seeking gender incongruence services. By limiting referrals to the Child and Adolescent Mental Health Service (CAMHS) and paediatric services, respondents fear it will be harder for individuals to access the care they need, suggesting that efforts should be made to make the process as easy and accessible as possible. There was concern expressed that there are transphobic opinions held within the NHS, and that this change could be considered 'gatekeeping', or deliberate obstruction to treatment. As a result, some felt that a vulnerable population may fail to receive the support they need, which would lead to a great deal of distress and uncertainty.

"I do not agree. This will represent unnecessary barriers that will likely lead to individuals having specific needs not being met. I do not agree that only a paediatric service or CYP Mental Health Services are able to recognise an individual has needs directly related to their gender identity that need proper assessment and gender related care is significant for that person. It is not necessary to rule out or screen for every other issue effecting a person before assessing how to help the individual who is experiencing gender dysphoria. A good proportion of Transgender adults are known to have conditions such as ASD from youth, however transitioning has still been the need they had from youth and is associated with improved lives and reduced pain."

Increased Waiting Times and a Burden to Services (n=74)

There were concerns raised by some that this proposal will exacerbate the strain on CAMHS and paediatric services, which are already facing challenges in meeting demand. There is concern this could lead to significant delays in accessing gender incongruence care, putting young people at risk during a critical period of their development. This was felt to also have a detrimental effect on other young people needing to access the services. They suggested details in the proposal gave no indication of how this will be managed, saying it could mask the true number of people waiting for gender services. Some noted that waiting lists are currently a postcode lottery, meaning that it can be very dependent on where a person lives as to how long they have to wait for care.

"Having worked as a clinician extensively in CYP mental health services, I believe this pathway would increase pressure on already stretched mental health services. Waiting times for CAMHS services exceed 2 year for initial assessment in many parts of the country, and both early intervention and 'core' CAMHS teams lack the training and knowledge required to make decisions about onwards referrals in regards to gender identity. Lengthier waits will both increase pressures and mean that care is further stretched between the young people that require mental health input."

Necessity for Direct GP Referrals (n=63)

Some participants believed that GPs should continue to have the ability to refer directly to gender incongruence services. They argued that GPs often have a broad and holistic understanding of their patients' health and hold a good and trusting relationship with the whole family, meaning they are in a good position to assess the need for specialised gender incongruence care, without the need for additional intermediary steps. It was stated that GPs previously provided the most common referral pathway to gender services and will still likely be the first professional figure a patient seeks support from, before being referred to the paediatric or mental health services. Removing them from the list of referrals was considered to be inefficient, adding another step to an already long and stressful process for the patient and not removing the burden from GPs. It was said to be unclear what benefit there were to be gained by removing GPs from the list of referral options and was considered another method of gatekeeping.

"The quality of referrals was not identified as a problem by the CQC. Given that 90% of referrals were deemed appropriate, it is unclear what benefit preventing GPs from making referrals to GIDS would have for either patients or the service."

Importance of Other Referral Options (n=38)

There was a call from some respondents for the inclusion of other referral options, including self-referral, parental referral, and the ability for a wider range of professionals to make referrals, such as social workers, therapists, and teachers. Respondents emphasised the importance of making gender incongruence services as accessible as possible to ensure that no one who needs care is excluded due to procedural barriers. It was also felt to be important that CYP can actively choose the person they feel most comfortable sharing their experience with, as it was noted that the removal of non-healthcare professionals affects the most marginalised members of the community as well as those with unsupportive families and GPs. Allowing others to refer was said

to be an opportunity to reduce the burden of relying solely on general paediatric services or CYP mental health services.

"Not all young people will feel able or be supported to access paediatric or mental health services and so should be able to be self-refer or have access through a trusted professional such as someone from a youth group/education provider."

General Paediatricians are an Inappropriate Referral Source (n=20)

The inclusion of general paediatricians was considered by some respondents to be inappropriate as it was felt this implies that the patient has a medical or physical condition, which they said was rarely the case. General paediatricians were said by some to lack the appropriate expertise within gender incongruence, as they are not usually involved in neurodevelopmental assessments and hold no additional experience in comparison with GPs.

"Strongly disagree!!! As a general paediatrician I strongly disagree that seeing a general paediatric consultant should be a gateway to referral. We do not have expertise in this area and this will be yet another patient group who have to jump through the hoop of sitting through a pointless clinic appointment to get to the place they actually need to be adding to our already over stretched waiting lists. As a department we would decline to see gender dysphoric patients referred solely for this reason and simply forward the original request for referral as we have nothing to add."

Proposal Pathologises Gender Incongruence (n=18)

The issue of conflating gender incongruence with mental illness was highlighted by some, arguing that the requirement for referrals from mental health services inappropriately pathologises transgender identities and that being transgender is not inherently a mental health issue. This, they argue, contributes to the stigmatisation of transgender individuals and misrepresents the nature of gender incongruence. In addition, CAMHS was said by some to not possess the full and necessary skill set to understand and assess transgender patients.

"By forcing transgender children to undergo psychiatric assessment separate to their preferred gender affirmation treatment you are trans pathologizing these children, being trans is not a mental health condition, to suggest so is both unscientific and transphobic. I recommend you follow the guidance of the WHO."

Reasons for Neither Agreeing nor Disagreeing

A Lack of Training and Understanding (n=23)

It was felt by some respondents that there is a need for all professionals involved in the referral process to be adequately informed and provided with evidence based training to ensure an effective and efficient system. They raised a question of whether support and training will be provided in dealing with potentially pressurising parents and patients who may bring with them strong and convincing, gender ideological beliefs and concerns, such as suicide and time pressure issues. A few respondents note their own lack of training in gender incongruence, expressing a desire to learn more.

"We are in agreement with this in principle. However, there is a risk that even this group of clinicians may find it challenging to ensure that the referrals they make are appropriate unless they have been provided with specific training in this area. We are particularly concerned about the ways in which clinicians will be supported to make evidence-based recommendations when they are likely to be placed under considerable pressure by parents, and potentially by their colleagues, who may come to these services with a particular ideological perspective."

Resource and Capacity Concerns (n=17)

Concerns were raised by some respondents about the feasibility of limiting referrals to CAMHS and paediatric services due to existing pressures, long waiting lists, and staff recruitment and retention issues. This was felt to have the potential to create a bottleneck effect, delaying access to gender incongruence services further. They voiced concerns that CAMHS waiting lists and pressures could lead to inappropriate referrals without exploring the case as a whole.

"Can see the rationale but this decision puts increased pressure on services (CYPMH and Paediatrics) that are already over stretched with demand and increased acuity particularly following Covid pandemic. Both services are also struggling to recruit and retain staff, with high levels of vacancies nationally at present, so additional funds to support this extra work is unlikely to result in new staff to absorb the impact. My preference would be to work towards this in next 2 - 3 years and consider alternative ways of managing referrals to gender services in interim."

Potential Ambivalence Based on Professional Beliefs (n=4)

Some contributors expressed concern that the effectiveness of the referral process could be influenced by the personal beliefs of the referring professional. They stated that if a referrer holds strong convictions about gender identity, it might sway the decision to refer, potentially leading to biased referrals based on belief systems rather than patient needs.

"Only professionals should be able to refer BUT then it depends on the stance of then professional referrer. If they believe that children can be born trans and just need to be identified and then affirmed you have a problem as the clinician is coming from a particular belief rather than a neutral professional position. These people will refer anyone who they believe might be 'trans.' The referral is based on the professionals belief system not the patients actual need."

Q2. Children under 7 years of age will not be added to the waiting list.

2.1 Background

There is no firm clinical evidence to determine whether a minimum age threshold should apply for referrals into the service and, if so, what that age threshold should be.

To date, there has been no minimum age threshold and children have been referred into the Tavistock GIDS from as young as 4 years.

For some people, this just seems too young, and they are concerned that it could result in unnecessary and inappropriate referrals being made. For example, we know that showing an interest in clothes or toys of the opposite sex - or displaying behaviours more commonly associated with the opposite sex - is reasonably common behaviour in childhood and is usually not indicative of gender incongruence.

On the other hand, some people would argue that there should not be a minimum age threshold as expert NHS support should be available to any child experiencing gender distress. Furthermore, they would argue that having no minimum age threshold may also provide an important safeguarding measure against children being encouraged or supported to take any premature action with regards to their gender identity which might narrow or close down future choices.

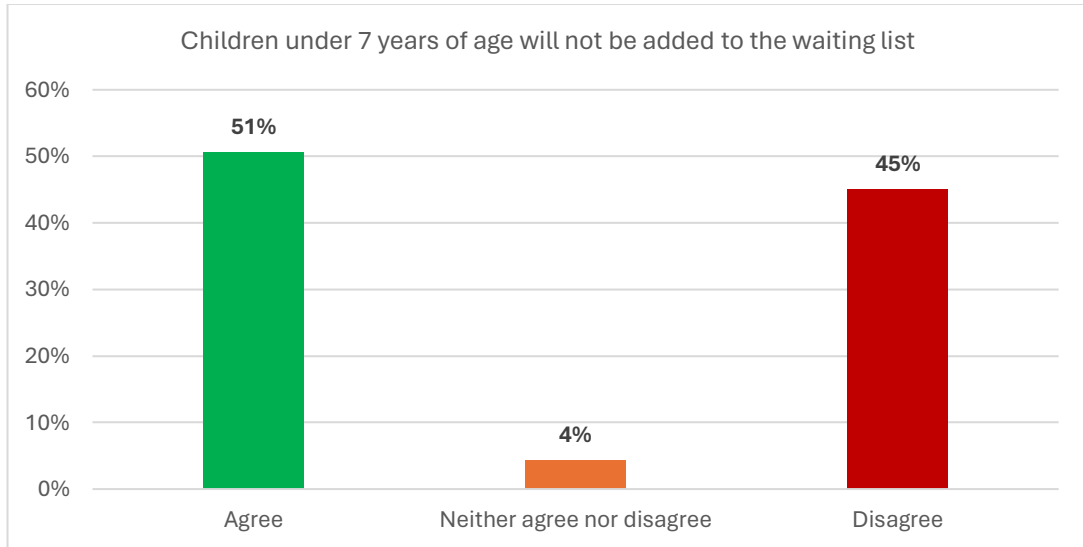
Having carefully considered these different perspectives, for the purposes of this consultation a minimum age threshold of 7 years for referral into the service is being proposed as by this time children may have more developed their cognitive, comprehension and communication skills to an extent that they will be able to engage with health professionals in the process of an holistic clinical assessment and formulation, as described in the published NHS interim service specification.

However, NHS England welcomes views on this proposal including the evidence that may support an alternative lower or higher minimum age threshold. A final decision will be taken following consideration of consultation responses. Nevertheless, any age threshold will need to be kept under review as further evidence emerges.

2.2 Consultation Findings

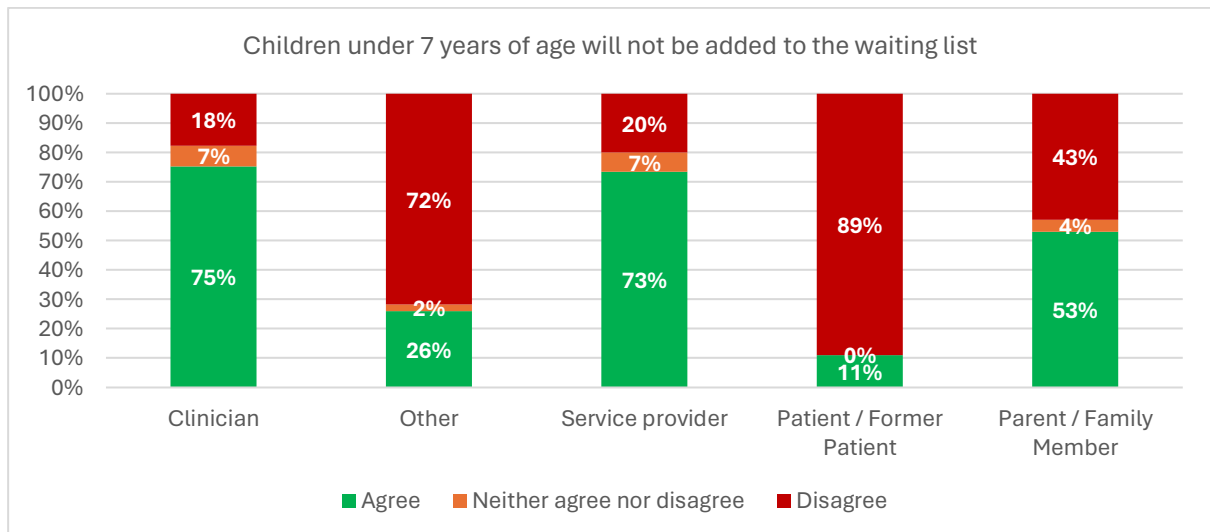
Overall, the majority (51%) agreed with the proposal that children under 7 years of age will not be added to the waiting list, however a significant number disagreed (45%) and 4% were neutral (see figure 4).

Figure 4. Children under 7 years of age will not be added to the waiting list.



When looking at different respondent types (see figure 5), there was agreement with the proposal from the majority of clinicians (75%), service providers (73%), and parents / family members (53%). However, there was disagreement from the majority of patients / former patients (89%) and other respondents (72%).

Figure 5. Respondents by type.



2.3 Analysis of Comments

Overview

AGREE		DISAGREE		NEUTRAL	
Theme	No.	Theme	No.	Theme	No.
Children under 7 are too young to decide	36	Importance of early identification and support	56	Need for support beyond waiting list	22
Increase of suggested minimum age threshold	19	Arbitrary age limit	35	Consider a case-by-case approach	10
Ensure psychological support is available	13	Inherent understanding of gender identity prior to age 7	30	Provide psychological support only	4
Belief in the natural resolution of gender non-conformity	11	Issues with long waiting times	24		
		Impact on affected children and families	11		

Reasons for Agreeing

Children Under 7 Are Too Young to Decide (n=36)

Some respondents agreed with the proposal based on the belief that children under 7 are too young to understand or make decisions about gender incongruence, suggesting that early childhood should be a period of gender exploration without external influence and possible encouragement, which could lead to potentially harmful medical intervention. Children were said to not require endocrine services before puberty begins and so any assessments before age 7 were deemed futile. The age limit was also felt to free up resources for the more urgent, time sensitive cases.

"Since gender incongruence in children under 7 is typically not considered urgent to be addressed medically and may also be subject to developmental changes, excluding them from waiting lists can help prioritise resources for those in more immediate need while ensuring appropriate assessment and care for younger children when necessary."

Increase of Suggested Minimum Age Threshold (n=19)

While agreeing with the proposal, some respondents suggest that the minimum age for referrals to gender services should be set at a higher age, based on developmental milestones showing that children older than 7 years of age lack the capacity to understand the consequences of entering a medical pathway. Suggestions were made for an increase in the age limit to at least 10 years of age. Concerns were expressed by these respondents regarding safeguarding in cases where they felt it was in the interest of the parents to encourage gender identity issues rather than the child's. They suggested there is a risk of wrongly diagnosing a child with a gender identity issue.

"Lifting the minimum referral age to 7 is a meagre improvement. An older threshold should be considered. Children of this age are unable to understand the nuanced concept of socially constructed gender and may be influenced by ideological teaching at school or more subtle messaging within the family, particularly if the child is gender non-conforming."

Ensure Psychological Support is Available (n=13)

Although some participants agreed with the age threshold, they qualified this by also calling for guarantees that psychological and behavioural support would be available for young children and their families to address any gender-related distress without immediate referral to specialised gender services.

"Again, in principle, we are in agreement with this. It is important that children are assessed well before the onset of puberty in order that any necessary therapeutic intervention can be provided without puberty complicating the clinical picture. At the same time, clinicians must have the knowledge and skills to be able to offer exploratory therapy, both with the child and their family, and to provide psychoeducation about the prevalence of typical - and transient - gender non-conformity within the general population. In our view, children referred to the waiting list must have presented with stable and distressing gender nonconforming behaviour, over a period of years, and in the absence of social transition."

Belief in the Natural Resolution of Gender Nonconformity (n=11)

Some participants believed that gender nonconformity in early childhood often resolves naturally without the need for intervention, and that services should focus on older children who continue to experience gender dysphoria. These respondents felt that children under 7 should be allowed to explore gender roles without any external influence or pathologisation, and that families and local services should be advised and educated in how best to support children's choices whilst re-assuring them that gender nonconformity does not automatically mean they are transgender.

"A vast majority of children with gender distress eventually grow out of it through puberty."

Reasons for Disagreeing

Importance of Early Identification and Support (n=56)

A number of participants highlighted that early identification and support services for children experiencing gender incongruence are crucial, arguing that waiting until the age of 7 could delay necessary psychological and social support and guidance for the child and their family. They expressed the view that early identification also allows clinicians to build up a picture of the child's gender incongruence, which would help inform the overall treatment plan. They stated that since medical intervention would not take place until at least puberty age, they raised questions as to why younger children should wait for referrals and about what benefits this would achieve.

"If a child is expressing and exploring gender for themselves, outside of the societal binary, then early support and help for them and their entire family, particularly mental health support and advice can only be a help."

Arbitrary Age Limit (n=35)

A number of participants argued that the age limit of 7 years is arbitrary and lacks clinical evidence, potentially excluding children who need early intervention which could lead to harm and suffering. Since the number of referrals under the age of 7 is low (1.3%), this change was suggested to have little or no impact on waiting times, but the negative effects on the lives of the children that cannot access support was said to be significant.

"The number of referrals is very small for this group and the NHS themselves have said that there is no clinical evidence to support a minimum age threshold for referrals. Preventing children under 7 years of age from being referred therefore does not seem to be sensible action, and I would suggest is due more to pressure from political factions than patient welfare."

Understanding of Gender Identity Prior to Age 7 (n=30)

Some respondents believed that some children would have a strong and inherent understanding of their gender identity from a very young age, making it inappropriate to impose an age limit on referrals. According to their feedback, these children, their families and teachers would be more likely to require support and advice, experience barriers to accessing care, and be at risk of mental and physical harm.

"Children younger the 7 can still experience gender incongruence, putting this into effect will only force them to endure years more of suffering, which can lead to far more problems in the long run."

Issues with Long Waiting Times (n=24)

Concerns were raised by some contributors that, given the long waiting times for gender incongruence services, children under 7 should be allowed to be placed on the waiting list to avoid further delays in receiving care, and that the decision should be to limit the age for the first appointment rather than the waiting list referral. Some pointed out that, should the child change their mind at any time, they can remove themselves from the waiting list.

"They can be added, just with lower priority than those whose puberty is approaching, if resources are stretched. Since it can take 5 years, if not more, before they finally get seen by a clinician, children younger than 7 should be allowed to be in the queue. It's not like they can't change their mind and remove themselves from the waiting list."

Impact on Affected Children and Families (n=11)

A number of respondents expressed concern about the impact of this proposal on families, suggesting that setting an age limit could leave children without professionals to talk to and families without necessary guidance and support.

"Children under 7 do present with gender incongruence. Families need specialist services and professional to support them with this. Leaving them to cope alone is unacceptable."

Reasons for Neither Agreeing nor Disagreeing

Need for Support Beyond the Waiting List (n=22)

Some respondents suggested that there should also be a focus on providing comprehensive support for children and their families and peers beyond just those on the waiting list. It was suggested that this should include providing local services with education and resources in order to support younger children questioning their gender, without gender affirming or encouraging social transition, but instead adopting a developmentally informed 'watch and wait' approach.

"... it will mean that concerned parents will seek advice from GPs or schools therefore training and consultation needs to be provided to enable them to deliver the required advice and support. Social Care will also need appropriate training and consultation to address safeguarding concerns in these children."

Consider a Case-by-Case Approach (n=10)

Some giving feedback had a perspective that decisions should be made on an individual basis, acknowledging the complexity and the need for skilled assessment in each case. They stated that there should at least be room for exceptional cases.

"Has to be carried out on a case by case basis, otherwise it excludes intersex and others who may benefit from early interventions."

Provide Psychological Support Only (n=4)

Some respondents felt that children and young people of any age should not receive medical treatment for gender dysphoria, instead only being offered psychological support.

"In my view children who are referred to GIDS should not under any circumstance have medical treatment (puberty blockers, cross sex hormones or surgery). If such a service exists it should be only for psychological assessment or support. So, to take that further I do not believe there should be a national service for any age. If children feel psychological distress related to gender dysphoria, then this should be assessed and managed within local psychological / psychiatric services which already exist."

Q3. Young people aged 17 years will not be added to the waiting list of the children and young people’s gender incongruence service as a temporary measure in response to long waiting times.

3.1 Background

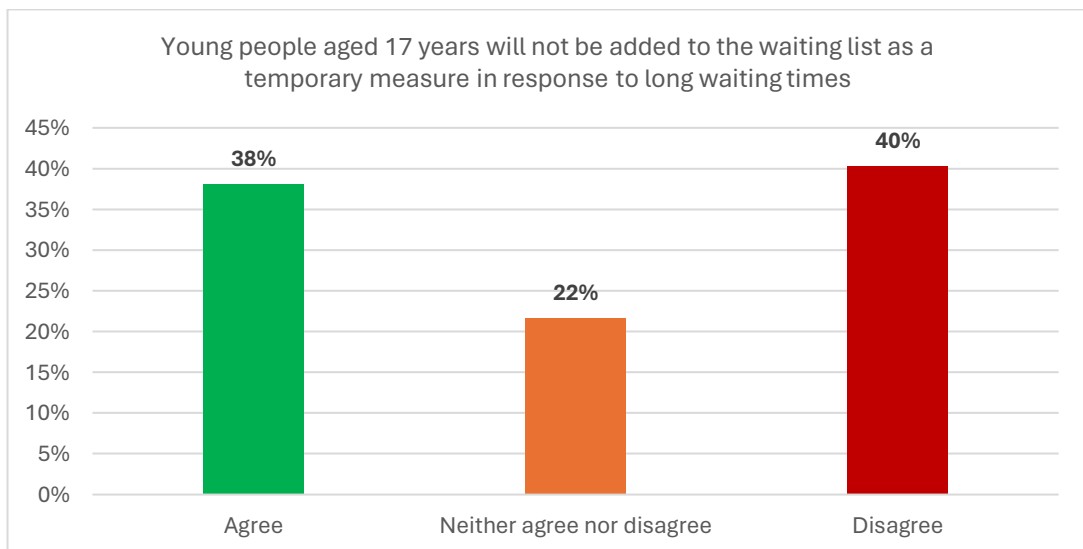
The maximum referral age of 16 is being proposed as a temporary measure and will be revised back to 18 once waiting times for the children’s service have reduced sufficiently. Although young people may be referred into adult gender services from age 17, waiting times for Adult services remain very long due to significant workforce capacity constraints which means it is highly unlikely that any young people who are newly referred into Adult services from age 17 would be seen until they are at least 18 years of age.

The CYP Gender Incongruence Service will see young people up to their 18th birthday. Reflecting current operational practice, young people who reach 17 years of age while on the waiting list for the children and young people’s gender incongruence service would continue to be removed from the waiting list. They will be advised to consider with their GP whether a referral to an NHS-commissioned Gender Dysphoria Clinic for adults is appropriate for them. If so, their original referral date into the CYP service will be honoured. This arrangement would be in place until the long waiting times into the CYP Gender Incongruence Service are materially reduced.

3.2 Consultation Findings

Overall, 38% agreed and 40% disagreed with the proposal that young people aged 17 years will not be added to the waiting list of the children and young people’s gender incongruence service as a temporary measure in response to long waiting times. 22% of respondents were neutral (See figure 6).

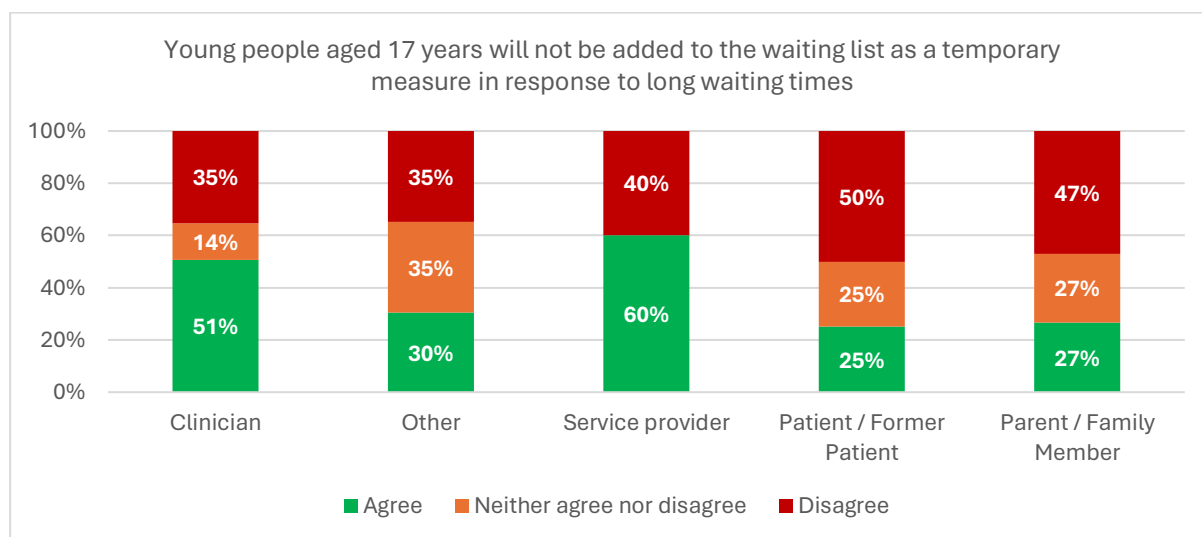
Figure 6. Young people aged 17 years will not be added to the waiting list as a temporary measure in response to long waiting times.



When considering the breakdown of these results by respondent type (see figure 7), it shows there is agreement amongst the majority of clinicians (51%) and service providers (60%).

There is disagreement from 50% of patients / former patients, and 47% of parents / family members. There were more mixed views in the other respondents category, with 30% agreeing, 35% disagreeing and 35% neutral.

Figure 7. Respondents by type.



3.3 Analysis of Comments

Overview

AGREE

Theme	No.
Faster access to appropriate services	35
Realistic expectations of service access	5
A seamless transition to Adult services is crucial	4
Focus on training and support	4

DISAGREE

Theme	No.
Excluding 17-year-olds from youth services is inappropriate	48
Long waiting times	30
Delaying access to care for 17-year-olds is considered discriminatory	19
Youth services should be extended beyond 18-years-old	10

NEUTRAL

Theme	No.
Dependent on Adult service referral acceptance	44
Care gap prevention	17
Underfunding and understaffing issues	17
Service transition clarity	6
Impact on waiting times	6
Age limit should be lower	6
Add to both waiting lists	5
Concern about additional referral steps	3

Reasons for Agreeing

Faster Access to Appropriate Services (n=35)

Some participants agree that referring 17-year-olds directly to Adult services could expedite their access to appropriate care due to the currently long waiting lists in both children's and Adult services. They felt that this way they would be more likely to be assessed sooner by the applicable age service at their first appointment.

"By the age of 17 they should be referred to the adult gender services, simply because the waiting lists for both young people, and adults are so long. That way they are more likely to be assessed sooner by the applicable age service at their 1st appointment."

Realistic Expectations of Service Access (n=5)

A number of contributors acknowledged that in practice, 17-year-olds were unlikely to be seen by children's services before they turn 18, advocating for immediate referral to Adult services.

"Although it is shameful that the waiting times are so long, the reality is that there is no chance of a 17-year-old being seen whilst under the age of 18, so their referral should be made to the adult services immediately to get them onto those waiting lists as quickly as possible."

A Seamless Transition to Adult Services is Crucial (n=4)

Some participants stressed the importance of ensuring a seamless and barrier-free transition from children's to Adult services, emphasising the need for clear referral pathways.

"Given current waiting times, this is a reasonable decision. However, the process by which young people are transferred into the adult service waiting list needs to be as seamless and simple as possible, and not present even further steps/barriers to inclusion on the adult waiting list."

Focus on Training and Support (n=4)

There was a call from some participants for increased training and support to staff in Adult services to ensure they can meet the needs of young adults transitioning from children's services, especially to support those with additional needs, like neurodiversity and learning difficulties.

"17-year-olds must be offered support and mental health services through their local CYPMHS to address any co-occurring mental health issues, such as depression, anxiety, eating disorders or trauma, or issues relating to autism or sexual orientation, until such time as all CYPMHS professionals are upskilled in management of patients experiencing gender-related distress. This additional training must be a key priority, in line with training developed for the MindEd hub."

Reasons for Disagreeing

Excluding 17-year-olds from Youth Services is Inappropriate (n=48)

Feedback from respondents stated that this age group are not yet adults and as such should not be excluded from the care they are entitled to in youth services because of poor management and a lack of resources. It was highlighted that these two services work to different clinical models; the adult model being centred around the affirmative pathway while youth services are designed around a psychotherapeutic explorative model, which they said provides the protection and guidance necessary as they consider their options for the future. During this period, it was stated, young people may lack the maturity to make informed medical transition decisions, and that it is also a pivotal point in their gender identity development, meaning they still require a service tailored to their developmental stage. Some stated that Adult services lack expertise with adolescents and do not offer the appropriate holistic assessments or psychological support, potentially commencing medicalisation without adequate safeguards. The act of singling out an age group (17-year-olds), was said by some participants to have a negative impact on vulnerable individuals, while continuing their access to children's service could be crucial for their mental health, emotional wellbeing, and feeling of validation. They felt there should not be a gap in healthcare where a young person is too young for a service yet too old for another. In addition, some suggested that many of these children will be autistic, taking longer to mature. It was put forward that those with an autistic diagnosis should be delayed in moving into Adult services until they are ready.

"Disagree. The concern is that CYP and Adult services will be working on different clinical models. At this stage, it is presumed, adult services will continue along a mainly affirmatory pathway, whilst CYP services are being designed around a psychotherapeutic exploratory model. The concern therefore is that adult services do not currently require any mental health assessment; nor has there been the same scrutiny of their approach that the Cass enquiry has been bringing to CYP services. This means that young people aged 17 years old will only be able to access a medicalising pathway. If young people aged 17 (or possibly, 16 if waiting lists begin to stretch back 2 years or more) are only to be accommodated on a pathway with a very different approach and ethos, the adult service requires urgent review."

Long Waiting Times (n=30)

Long waiting times were said by respondents to be a systemic issue for public services and the NHS. They disagreed with excluding certain ages or swapping between waiting lists as a solution, urging for service improvements and reductions in waiting lists instead. They said that if the current systems are unable to cope, there should be reputable mental and emotional support services enlisted to assist those most at risk.

"They are young people, this is a service for young people they are entitled to access it. Rather than wasting time and money on finding ways to reduce wait lists by denying access to care, why not provide a service capable of seeing those who need it? If there are so many children being referred rather than trying to deny access why not accept the service needs to grow?"

Delaying Access to Care for 17-year-olds is Considered Discriminatory (n=19)

A number of respondents expressed the view that it is critical that 17-year-olds have continuity of care and are not left without services or support due to age restrictions, emphasising the need for equal access to care.

"We are concerned that 17-year-olds could be offered care more suitable for adults, in lieu of specialist provision for children and young people being available. We would also advise that there is some thinking around transitional clinical care, and transitional safeguarding for young people aged 16-25. We are concerned that not adding 17 years to the waiting list for CYP gender services amounts to discrimination against this age group."

Youth Services Should Be Extended Beyond 18-years-old (n=10)

Some respondents believed the cut-off age for youth services should be extended above 18, arguing that neurodevelopment continues to around the age of 25, confirming that these individuals still require mental health support and assessment that Adult services currently do not offer. A few participants suggested the need for a new, transitional service to be created for 17 to 21/25-year-olds, stating this would bridge the gap between children and adults.

"Children of 17 years are not adults. Their brains are still developing. Taking a vulnerable young person off this list take and transferring them into the adult service could have a negative impact on them and they will potentially have no physiological support whilst waiting to be seen and no physiological assessment / holistic assessment of their needs in the adult service. I believe that young people ages 17-21 should stay in the CYP waiting list and an additional mental health support service especially for these young people on the waiting list should be created."

Reasons for Neither Agreeing nor Disagreeing

Dependent on Adult Service Referral Acceptance (n=44)

For some respondents, there was a conditional agreement that all Adult services must commit to promptly accepting 17-year-olds and that their place is not put on hold until their 18th birthday. They felt there should be safeguards put in place to prevent a care gap and that a watertight process should be put in place which makes sure all clinicians are fully aware of the new referral pathway to prevent patients falling between the gaps.

"It is essential to avoid any gap in care for young people. There would need to be safeguards in place to ensure that 17-year-olds immediately go onto the adult waiting list instead, and GPs would need to be informed about the referral process for 17-year-olds."

Care Gap Prevention (n=17)

Feedback from some respondents placed emphasis on preventing a care gap, making sure 17-year-olds continue to receive the care they need during moves between services.

"17-year-olds need to be placed somewhere and there should be a seamless service that caters for children and adults relevant to age. There shouldn't be a gap where too young for one but too old for another."

Underfunding and Understaffing Issues (n=17)

Respondents recognised that the root problem is the underfunding and understaffing of gender services and that this change fails to address such issues.

"The crux of the issue of waiting list issues, in my opinion, is understaffing and underfunding of the service so far. This doesn't seem to be being addressed in the proposal."

Service Transition Clarity (n=6)

A theme emerged regarding the need for clarity in the process of transitioning patients between youth and Adult services.

"The service specification needs to be clearer as to what the referral pathway for this group of young people will be. Young people aged 17 have the same right to healthcare access as their younger and older peers, and the current proposals which require the extra step of the young person being required to consult their GP in order to access the adult waiting list presents a disparity in access to gender services."

Impact on Waiting Times (n=6)

Some believe that the proposal won't change the fundamental issue of long waiting times.

"It doesn't seem likely to substantially affect waiting lists, as 17-year-olds added to the waiting list now will likely age out of the service before accessing their first appointment due to the existing high wait times."

Age Limit Should be Lower (n=6)

Considering the current waiting times, some respondents felt that all young people aged 15 or 16 and over should be added to the Adult services since they are very likely to be seen before turning 18 too.

"Given the waiting time, there is no point in 17-year-olds being referred to a children and young people's service. Arguably, there is little point in anyone over the age of 15 being referred to a children and young people's service - they're unlikely to be seen by the children and young people's service or by an adult service before they reach 18."

Add to Both Waiting Lists (n=5)

Suggestions were made for the young person to be added to both the children and adults services waiting lists and to be seen by whichever is available first.

"They should be referred to both the youth and adult services at the same time and be seen by whichever department gets to them first."

Concern about Additional Referral Steps (n=3)

There was concern from some contributors about creating additional steps in the process and potential barriers for 17-year-olds who already face long waiting times, and the impact this would have on them.

"We understand that the length of the waiting list for CYP Gender Identity services currently means that 17-year-olds are unlikely to access care before they turn 18, however we suggest that the pre-referral consultation service is afforded the function to refer directly onto the adult waiting list to prevent 17-year-olds from having to face an extra barrier to referral."

Q4. Young people who reach 17 years of age while on the waiting list for the children and young people’s gender incongruence service will be removed from the waiting list; they may seek a referral into the adult gender service with their original referral date into the CYP service honoured.

4.1 Background

The maximum referral age of 16 is being proposed as a temporary measure and will be revised back to 18 once waiting times for the children’s service have reduced sufficiently. Although young people may be referred into adult gender services from age 17, waiting times for Adult services remain very long due to significant workforce capacity constraints which means it is highly unlikely that any young people who are newly referred into Adult services from age 17 would be seen until they are at least 18 years of age.

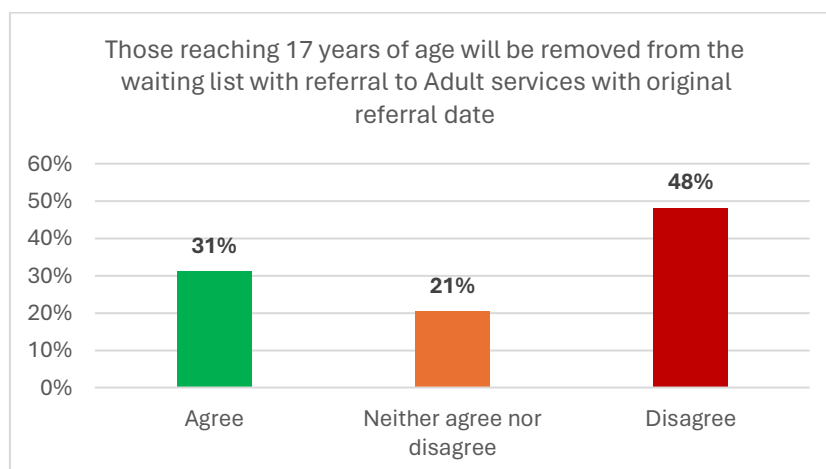
The CYP Gender Incongruence Service will see young people up to their 18th birthday. Reflecting current operational practice, young people who reach 17 years of age while on the waiting list for the children and young people’s gender incongruence service would continue to be removed from the waiting list.

They will be advised to consider with their GP whether a referral to an NHS-commissioned Gender Dysphoria Clinic for adults is appropriate for them. If so, their original referral date into the CYP service will be honoured. This arrangement would be in place until the long waiting times into the CYP Gender Incongruence Service are materially reduced.

4.2 Consultation Findings

Across all respondents, 31% agreed and 48% disagreed with the proposal that those reaching 17 years of age will be removed from the CYP waiting list with referral to Adult services with original referral date. A further 21% neither agreed nor disagreed with this proposal (see figure 8).

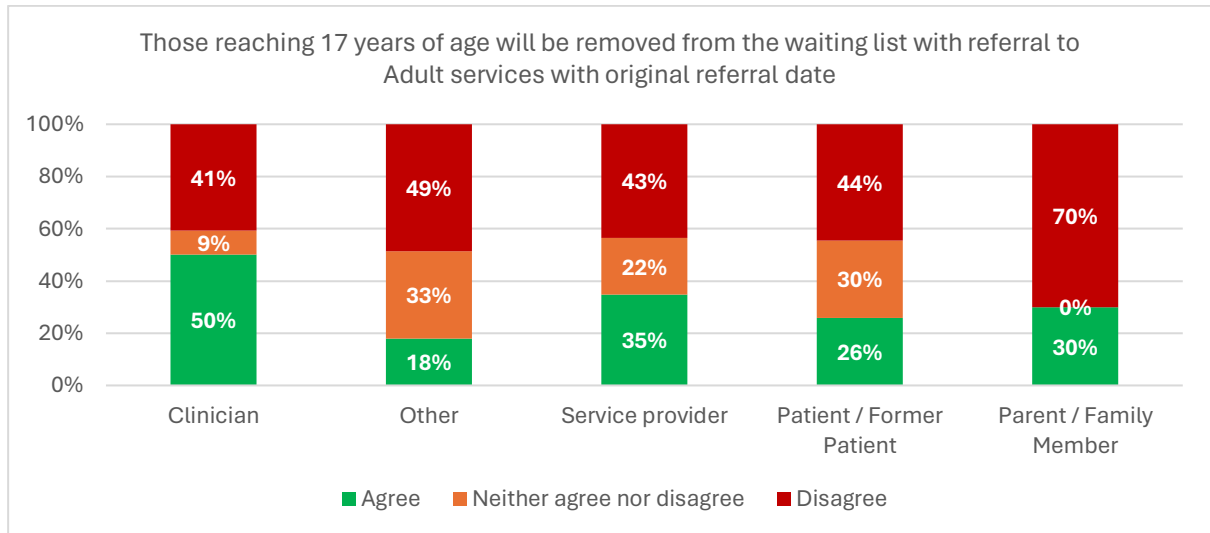
Figure 8. Those reaching 17 years of age while on the waiting list for the children and young people’s gender incongruence service will be removed from the waiting list.



As shown in figure 9, when breaking this down by respondent type, half of clinicians (50%) agreed with the proposal that those reaching 17 years of age will be removed from the waiting list with referral to Adult services with original referral date. The majority of parents / family members (70%) disagreed with this. There were more mixed views amongst:

- Patients / former patients: 44% agree, 30% neutral and 26% disagree
- Service providers: 35% agree, 22% neutral and 43% disagree
- Other respondents: 18% agree, 33% neutral and 49% disagree

Figure 9. Respondents by type.



4.3 Analysis of Comments

Overview

AGREE		DISAGREE		NEUTRAL	
Theme	No.	Theme	No.	Theme	No.
Honouring the original referral date	38	Referral process, administrative burden, and wider systemic issues	47	An effective, efficient, and integrated referral and transition approach	15
Automatic transfer mechanisms	17	The developmental stage and legal status of 17-year-olds	18	Conditional acceptance as long as there are system improvements	13
Efficiency of the process and timeliness of care	10	Continuity of care and risk of falling through the gaps	16		
Meeting support needs and ensuring wellbeing	10	Negative impact on mental health	12		
Policy and communication improvements	6	Differing clinical models	10		
		Need for a transitional service model	7		

Reasons for Agreeing

Honouring the Original Referral Date (n=38)

The importance of honouring the original referral date when transferring to Adult services was highlighted by some as being essential in ensuring continuity of care and fairness in the system, stating that they felt the proposal would be unacceptable without it. They suggested this was needed to ensure people were not delayed in accessing support. It was felt further delays would disadvantage individuals, due to both the long existing waiting lists for Adult services, and that it would be unfair for them to “miss their place in the queue”.

"This would only be acceptable as long as the original appointment date is honoured."

Automatic Transfer Mechanisms (n=17)

While in agreement, some called for an automated and direct transfer process from the children to the Adult service as soon as it becomes clear that the young person will be over the age of 18 by the time they are seen by the gender service. They suggested this will prevent delays, have less impact on the patient and referral clinicians, and ensure no one is missed due to manual

referral errors or oversight. This includes the possibility of using the National Referral Support Service to enable smoother transitions into Adult services.

"It is concerning that the patient must have their original referrer actively refer them into the adult service - rather than automatic. There is a high likelihood, due to poor communication, change in location, or the referrer no longer being in post, that the young person will not be efficiently transferred to the adult waiting list. We recommend that the transfer be automatically managed through NRSS, and this be communicated to the young person with an opt-out option provided."

Efficiency of the Process and Timeliness of Care (n=10)

Some respondents felt that transferring 17-year-olds to Adult services could result in faster access to care, considering the long waiting lists in both children's and Adult services. They felt the key goal should be to ensure people are assessed by the most appropriate service as quickly as possible and to guarantee that no young person is lost during the referral process.

"This is a sensible approach, in cases where the young person will not be seen by the CYP service within their 17th year. However, if they are a number of months away from a first appointment, it would be irresponsible for them to be transferred into a longer waiting list."

Meeting Support Needs and Ensuring Wellbeing (n=10)

Some respondents emphasised the need for Adult services to be prepared to address the diverse needs of transitioning individuals, including those with neurodiversity or learning disabilities. The need for additional resources and training in Adult services was mentioned to attempt to meet these needs adequately. The potential psychological impact of long waiting lists and the challenges of transitioning between CYP and Adult services was a concern which tempered their views of some that agreed with this proposal. It was said that this process could exacerbate stress, anxiety, and mental health issues, therefore there was a call for more supportive measures to be put in place during the transition period to help minimise the negative impact on wellbeing. Some suggested making the transfer optional for patients while being informed of the waiting times for both services.

"Agree provided there is assurance that the adult service can accommodate the additional support that this young adult may have, particularly as the rate of neurodiversity remains high."

Policy and Communication Improvements (n=6)

There was a call from some contributors for clear policies about the transition process, including better communication between services, patients, and their families to ensure everyone is informed about their options and the steps involved.

"As long as both they and their care providers are made aware of this option, absolutely."

Reasons for Disagreeing

Referral Process, Administrative Burden and Wider Systemic Issues (n=47)

Some felt that patients should never be 'removed' from a waiting list because of NHS waiting times, nor should they require a second referral, this was seen as an unfair and an unnecessary burden that could delay care or act as a barrier and create further stress for the patient as well as adding pressure and workload to overstretched GPs. Most other specialist services in the NHS continue to offer a place after a patient 'ages out' a paediatric service, or automatically transfers the referral to the Adult service, some respondents were questioning as to why gender services were adopting a different approach. Since there are contrasting acceptance criteria between the two services, and excessive waiting times for Adult services, there is concern that this change will mean that patients will be dropped from the service. This group argued for a more direct and guaranteeing approach, ideally using automatic transfers that do not require additional referrals. A few suggestions were made for the transition to be optional and that if there is a chance for an individual to be seen within the year, the transfer should not be made.

"If young people are removed from the waiting list when they turn 17, they should be automatically added to the adult healthcare system instead of being denied access and having to seek a new referral. It will add to their distress in having to wait to be included into another system."

The Developmental Stage and Legal Status of 17-year-olds (n=18)

Some respondents emphasised that at the age of 17, young people are still considered to be children by law and, in addition to this, may not be developmentally ready to attend Adult services. Respondents highlighted the importance of age-appropriate care and the potential legal implications of transferring care based on age alone rather than on an assessment of need.

"I think this approach to reduce waiting list numbers is completely wrong . It does not take into consideration the development stage that young people ages 17-21 yrs are going through."

Continuity of Care and Risk of Falling through the Gaps (n=16)

According to some, there were concerns about how the proposals may affect an individual's continuity of care. They emphasised the importance of not disrupting the therapeutic and support mechanisms these young people may rely on. They also raised the potential for disruption to support received or even a loss of support during the transfer from child to Adult services. They argue that simply transferring a young person to an adult waiting list, especially without a guaranteed timely follow-up, risks leaving them without critical psychological and medical support during a formative and potentially vulnerable period of their lives. The Adult services waiting lists were felt to be too long, so there was a request made for the NHS to tackle these issues. The concern was not just about maintaining a numerical place on a list but ensuring the qualitative aspects of care (such as understanding, trust, and the therapeutic progress) are not lost in the transition. Further concerns are raised about the potential for miscommunication, administrative errors, and a lack of follow-up, which could leave vulnerable young people without necessary support during a critical period. They called for a transition process with built-in checks

and balances to ensure no one is overlooked and that the transition does not result in a gap in care.

"This is likely to lead to certain unfortunate individuals having unnecessarily painfully long gaps in access to care which can have a deep effect on the quality of the rest of their lives."

Negative Impact on Mental Health (n=12)

The potential risks to mental health if young people are denied timely and appropriate care at a vulnerable stage in their development were raised by respondents. They felt the impact of service transitions on the wellbeing of young people emphasised the need for additional mental health support during transition.

"I repeat: If people need help, their age shouldn't be taken into account, especially when it causes a delay in their life to the detriment of their progression, mental health and happiness. They should not have to sacrifice themselves for NHS waiting list times. NHS waiting list times are a problem for the government and the NHS to solve, not the patients who need timely help."

Differing Clinical Models (n=10)

Some participants urged for an urgent review of the differences between the clinical models used in the CYP Gender Incongruence Service and Gender Dysphoria Clinics for adults. They believe that specialised support and safeguarding tailored to the needs of young people would be inadequate in Adult services. The adult model uses a mainly affirmative pathway meaning those who are referred to the service would be led down a largely medical route, compared with the psychotherapeutic exploratory model enlisted by youth services, as recommended by Dr Hilary Cass. Therefore, 17-year-olds would miss out on the appropriate support for their unique psychological, developmental, and social challenges they face whilst exploring their gender identity.

"Traditionally the adult service is not equipped to deal with this recent younger cohort and has not developed tools to support them. I feel that all young people ages 17-21 should be seen by CYP services OR the 'adult' service should be adapted to carry out a full holistic assessment including physiological assessments as in the CYP service for this very vulnerable group. It is an injustice to these young people not to have the same opportunities of care and could result in transition regret."

Need for a Transitional Service Model (n=7)

Some respondents suggested the need for a transitional service model that bridges the gap between child and Adult services, offering continuity of care up to the age of 25, that is sensitive to the developmental stages of young people.

"I would suggest that these CYP continue to be looked after in the CYP service, and that a new category be opened for patients age 17y to 25y - as they remain vulnerable to decisions that they may regret due to the nature of brain development up to age 25 years."

Reasons for Neither Agreeing nor Disagreeing

An Effective, Efficient and Integrated Referral and Transition Approach (n=15)

Respondents highlighted the need for a seamless and integrated approach to transferring from child to Adult services. They stated this should be about continuity of care, by ensuring Adult services are prepared to accept new referrals efficiently. They wanted to make sure a streamlined, reliable, and well managed system was in place to transfer patients between services, they suggested offering a direct transfer to the Adult service rather than requiring a burdensome re-referral, which would also reduce administrative pressures on GPs and make it less likely that patients are lost in the system.

"This system would only work if there was an adequate and reliable system to transfer patients between CYP and adult services, and to transfer those on the waiting list to adult services. I have heard many stories from trans young people about how difficult the transition from CYP services to adult services is, even when they have been seen by CYP services. A direct handover, managed by the CYP gender service would, in my opinion, be a better approach."

System Improvements (n=13)

Some respondents gave conditional acceptance of the proposal, as long as there was a commitment to make specific improvements to the system. These conditions included ensuring young people are added to adult waiting lists, that their original referral dates are honoured, and that there are safeguards to maintain the integrity, quality, and continuity of care. It was also said to be essential that GPs and clinicians are fully informed of the changes to the process and patients are given up-to-date information on waiting times.

"Again I am not against this as long as all GPs are fully informed of the correct process, and that Adult Services accept 17-year-olds onto their lists. Also it is important that there is a reliable system in place to move young people over to the adult list and ensure that they keep their previous waiting list place."

Q5. The role of the pre-referral consultation service.

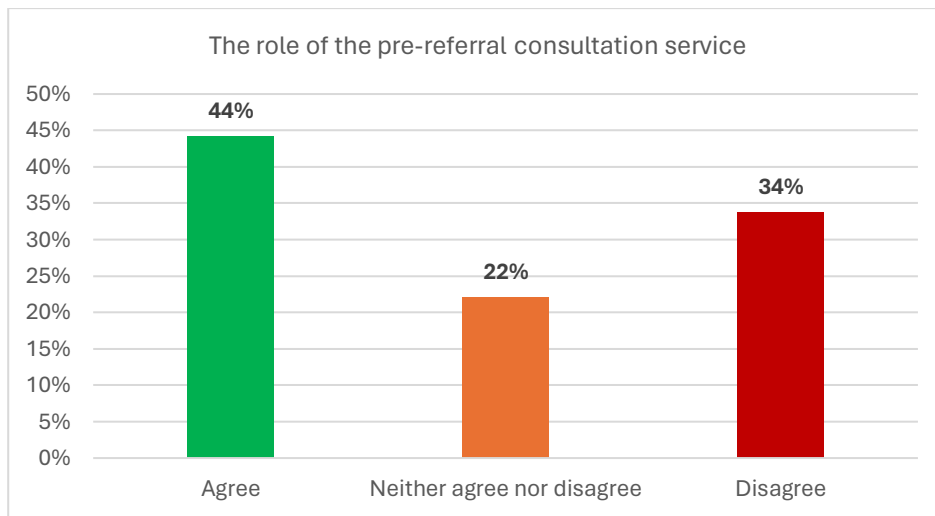
5.1 Background

A new referral consultation service will be offered by the new providers to help referrers support children and young people and families and determine suitability of a referral to the specialist gender incongruence service.

5.2 Consultation Findings

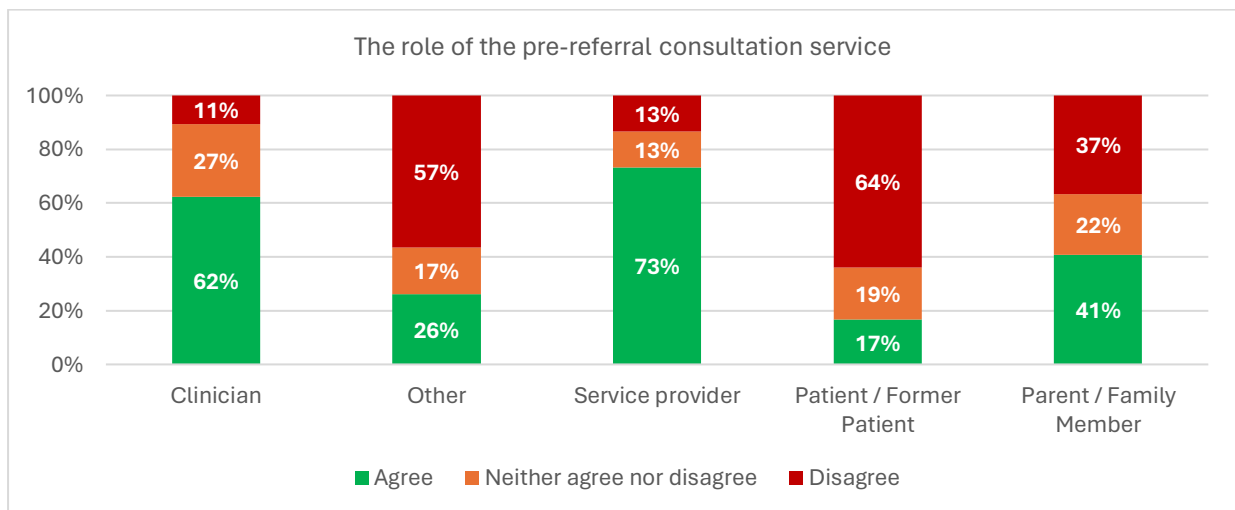
Overall, 44% agreed and 34% disagreed with the proposals around the role of the pre-referral consultation services. 22% neither agreed nor disagreed with this (see figure 10).

Figure 10. The role of the pre-referral consultation service.



When looking at the different respondent types (see figure 11), the majority of clinicians (62%) and service providers (73%) agreed with the proposed role of the pre-referral consultation service. Parents / family members were more mixed, with 41% agreeing, 37% disagreeing and 22% neutral. There was disagreement from the majority of patients / former patients (64%) and other respondents (57%).

Figure 11. Respondents by type.



5.3 Analysis of Comments

Overview

AGREE		DISAGREE		NEUTRAL	
Theme	No.	Theme	No.	Theme	No.
Concern about additional barriers and potential gatekeeping	11	Concerns about delays to care and barrier to access	33	Confusion regarding the question being asked	19
Approval of the triage function	10	Support should not come at the cost of a place on the waiting list	33	Lack of clarity and detail about the service	18
Approval of support for patients whilst on the waiting list	9	Unnecessary gatekeeping	23	Dependent on the professionals' perspective	7
A comprehensive assessment of needs	9	Pre-referral service staff are not gender specialists	20	Concern about potential removal from waiting list	7
Importance of high standards of care	8	Misleading reduction of wait times	15	Meeting should involve patient and family	5
Risk of capacity overload	7	Inefficient use of resources	14		
Support for community services is beneficial	6				
A way to safeguard against rushed medical pathway	5				

Reasons for Agreeing

Concern About Additional Barriers and Potential Gatekeeping (n=11)

While there was support for the service, some respondents were also concerned that it might create an additional barrier to care or that the service could become a gatekeeping mechanism rather than a support system, therefore there was a call to keep it a short and efficient process.

"...Though I worry that this would become another gate-keeping step and barrier to those who need help disguised as support."

Approval of the Triage Function (n=10)

The pre-referral consultation was seen as an important by a number of participants as a way to triage and prioritise referrals, ensuring that the only appropriate referrals are made but that all young people get the support they need. They hoped this would speed up the referral process and optimise the use of resources.

"The role of pre-referral is essential to evaluate the level of need of people, enabling them to optimise the use of resources."

Approval of Support for Patients whilst on the Waiting List (n=9)

Some respondents were approving of the proposed interim support being provided to CYP and their families whilst on the waiting list.

"I do think there should be pre-referral support for people exploring gender identity; specialist support to help people and their families navigate through this is crucial, time-sensitive and necessary."

A Comprehensive Assessment of Needs (n=9)

A comprehensive assessment of the young person's life and wellbeing, including mental health and developmental issues like autism or trauma is seen as crucial by some respondents. They stated that the focus should not be on their gender distress and approved that appropriate support would be provided for those that do not require a referral.

"ALL aspects of the young person should be considered during this process, and the default must not be referred to gender services. Mental health/autism/trauma etc. support should always be the first option."

Importance of High Standards of Care (n=8)

While there was approval for the services, some participants considered it important for this to be well resourced, offering a high standard of care, and staffed with experienced and sufficiently trained personnel. There was also a recognition that local support networks' quality might depend on each area, potentially impacting the effectiveness of the consultation service.

"This service needs to be of good quality and staffed by experienced personnel."

Risk of Capacity Overload (n=7)

Some who supported this proposal also raised concerns about the consultation service reaching its operational capacity quickly and becoming less effective over time as the service becomes stretched.

"Concern is that the CYPGS is very unlikely to be sufficiently staffed within 6 months or even the first year to deliver this service. The number of referrals for the consultation service could be 100+ a month, it's difficult to

envisage a time when the CYPGS would be adequately staffed to enable them to provide this resource. If not delivered, then CYPGS and Paediatric services will lack sufficient advice and support to care for these young people."

Support for Community Services is Beneficial (n=6)

The consultation service was welcomed for the support and expertise it could provide to community paediatric and CAMHS services that will be dealing with gender-related issues with CYP and their families.

"Feel this is a useful proposal as CYPMHS and Paediatric services will need and appreciate the support and guidance."

Safeguard Against Rushed Medical Pathway (n=5)

The service, it was suggested by some, could provide an important safeguard against moving too quickly to medical treatment without fully exploring other issues and comorbidities. It was stated by some respondents that this would enable a 'watch and wait' approach whilst providing psychoeducation regarding cases where gender incongruence naturally resolves itself following puberty. It was also considered important to these respondents to fully inform patients and family of the significant risks as well as benefits of the treatment.

"Referral to a specialist centre focuses all the attention on the gender dysphoria as the central thing, and also creates the expectation of doing something about it (i.e. medicalisation). If the focus could be taken off the gender fixation, and these children simply be part of regular psychiatric services where their gender dysphoria can be taken note of but not focused on, and proper attention be given to other psychiatric conditions, psychotherapy provided, while watching and waiting with the GD - would that not be better?"

Reasons for Disagreeing

Concerns about Delays to Care and Barrier to Access (n=33)

Some respondents felt that the pre-referral consultation service added unnecessary steps and complication in the referral process, thereby acting as a delay or barrier rather than as an aid. They emphasised that immediate referral should be prioritised for mental health reasons, suggesting that additional layers in the process could delay care and ultimately be detrimental to the patient.

"I am of the opinion this will primarily only delay patient's access to care. However, support for those on the waiting list is welcome, beyond this it seems likely to only cause harm to patients by adding additional steps to the process."

Support Should Not Come at the Cost of a Place on the Waiting List (n=33)

Support for patients experiencing distress whilst on the waitlist was considered valuable and was welcomed by some respondents. However, they stated this should not come at the cost of a place

on the waiting list and should be offered alongside a referral to the gender service rather than being an extra step before being granted access to the service.

“The pre-referral consultation service may provide support for those while on the waitlist but should absolutely not come at the cost of a place on it. Support should be offered alongside the current GP referral process, instead of creating more hoops to jump through for patients.”

Unnecessary Gatekeeping (n=23)

A significant concern raised by some was the perception that the pre-referral service would function as gatekeeping, limiting young people's access to the gender services they need. These respondents argued that creating more gates was counterproductive to providing support. Support should be offered, they said, alongside the current referral process, and should not cost a patient their place on the waiting list.

“Again, this is really just more gatekeeping. The most helpful route is letting more doors open.”

Pre-Referral Service Staff are not Gender Specialists (n=20)

Some participants expressed concern that paediatric and mental health staff within the pre-referral service would not have the appropriate expertise to make informed decisions about referrals. They were concerned that there may be bigoted or transphobic views which would create barriers for vulnerable patients seeking help. Referral was said to require the knowledge and understanding of gender specialists and was, therefore, seen as a flawed approach.

“Also, my personal experience with local paediatric services and mental health services suggests that they tend to not be specialists in gender care and may be working with (at best) antiquated care information.”

Misleading Reduction of Wait Times (n=15)

Some respondents expressed concern that the pre-referral service could obscure the actual size of the waiting list for gender services. By not placing individuals directly on the waiting list, they felt it may be challenging to track demand and allocate resources appropriately. Some see the pre-referral service as a way to artificially reduce the appearance of long waiting times without addressing the core issue of service demand and capacity.

“Not allowing patients to be placed directly on the Gender Service waiting list would hamper oversight. It would become harder to know how many people are waiting on the gender service and would make the problem look smaller than it is, which may in turn undermine resource allocation and other strategic decisions made at higher levels.”

Inefficient Use of Resources (n=14)

Some respondents disagreed with the proposed pre-referral consultation service because they saw it as an inefficient use of limited healthcare resources. Some have had negative experiences

with using pre-referral services because they are difficult to access, time-consuming and often end in referrals not being accepted. There was a sense among some that the functions of the pre-referral service might duplicate the work already being done by GPs, which they believed could be sufficient for making referrals without additional layers of consultation. They suggested that it would be more beneficial to directly improve the existing Gender Incongruence Service.

"This is an unnecessary step that takes away resources from an extremely overburdened system that does not have any to spare."

Reasons for Neither Agreeing nor Disagreeing

Confusion Regarding The Question Being Asked (n=19)

Some were unsure what the question was asking or suggested that the question isn't asking anything, that it is badly worded or is incomplete. Others pointed out that the Service Specification appeared to refer to a "referral consultation service" rather than a "pre-referral consultation service", which raised questions of ambiguity about what this would be and how it would work.

"This is a badly worded question, as what we're being asked to agree to is half a sentence, leaving room for misinterpretation."

Lack of Clarity and Detail about the Service (n=18)

There was confusion amongst some respondents about the nature, role, benefit and implementation of the pre-referral consultation service. They indicated they do not have enough information or understanding of the service to form an opinion.

"What is the pre-referral consultation service?"

Dependent on the Professionals' Perspective (n=7)

The stance of the professional involved in the pre-referral process is highlighted as a significant factor by some participants that could impact on the effectiveness of the service. There was an understanding that the effectiveness of the service would largely depend on the expertise and approach of the professionals employed. Some raised concerns that GPs had previously been offered e-learning modules which may have been biased, suggesting that primary care providers needed re-training through neutral modules, to ensure bias is taken out of all health services. Suggestions were made to monitor such a service to ensure that all advice given is in keeping with the most up-to-date evidence base. Some felt there should be more detail regarding the 'local support' offer, to ensure that only appropriate organisations support and train professionals.

"It all depends on the stance of the referring professionals. Some would refer all children they deem 'trans,' others would normalise and provide Psychoeducation. It all depends on who is employed to work in these services really."

Concern about Potential Removal from Waiting List (n=7)

There were concerns voiced by some that the pre-referral consultation service could risk unnecessary removal from the waiting list if it became another barrier in the process rather than a facilitator.

"The specification must remove the potential outcome of being removed from the waiting list (i.e. that the CYP 'does not meet the access criteria'). The CYP will have already engaged with at least two services (GP and paediatrics/CYPMHS), so a third gatekeeping process seems wholly disproportionate."

Meeting Should Involve CYP and Family (n=5)

The referral process, it was suggested by some, must be transparent - with the wellbeing of the CYP at the heart of it. Therefore, they stated that the pre-referral consultation meeting and decision making should include the CYP and their family, as this would allow them to understand the process and pose questions. They were concerned that exclusion could have a negative effect on their wellbeing.

"The consultation, advice and liaison meeting should directly involve parents. Families have little trust in your new service. The risk is that the Referral Consultation Service will be seen as even more professionals making decisions about a child's life, behind closed doors. Professionals should model transparency and accountability. Parents should have an opportunity to learn and to ask questions. You state that a key outcome of this service is that, where the referral is not accepted, the family will have been assisted to develop their formulation of the child's needs. This cannot happen if families are excluded from this key meeting."

Q6. Views on any other element of the service specification.

6.1 Background

NHS England also sought any other views that respondents had about any other element of the service specification.

6.2 Analysis of Comments

Overview

Theme	No.
Staffing and Resources	53
Access and Referral Process	29
Patient Autonomy and Self-Referral	19
Mental Health and Comprehensive Care	19
Puberty Blockers and Hormone Treatments	11
Ideological Bias and Professional Conduct	10
Communication and Information Clarity	9
Service Distribution and Local Support	8
Insufficient Reference to Safeguarding	5

Themes Described

Staffing and Resources (n=53)

Concerns were voiced by some respondents about understaffing and underfunding of services, stating that the service specification fails to address these fundamental issues and that without them, service improvements and lowering of wait times cannot be achieved. There were calls for increased investment and training for healthcare professionals. Views were expressed around the specialist nature of the service and the requirement for expert clinicians to provide the best and most appropriate care for this vulnerable group of patients.

"It seems this service specification doesn't focus on the primary problems of understaffing and underfunding; it's making out that the patients are the problem. Staff having mountainous workloads, contributing to issues with accurate record keeping, just isn't acceptable. Having *two* centres rather than the original single one won't solve any of this unless you plan to increase total staffing with good, quality training and vetting of staff. This doesn't appear to be on the service spec at all."

Access and Referral Process (n=29)

Some participants provided comment sharing concerns over the referral process, which they perceived as overly complex and potentially discriminatory, especially towards neurodiverse individuals. There were calls for direct, less bureaucratic referral pathways and the avoidance of additional gatekeeping barriers. Some suggested there was a lack of information in the specification on the appeals process or how to go about gaining a second opinion. There were also some questions regarding joint referral between CYP mental health services and paediatric services and who would be responsible for care arrangements while on the waiting list.

"Most of the proposal seems to be an attempt to shuffle patients around between different NHS departments in an attempt to make the waiting lists look shorter. No effort has been made to streamline the provision of gender incongruence services, and there has been no commitment made to increase staffing or resourcing.

Quite the reverse appears true in fact, with the proposals effectively introducing additional burdens, gatekeeping and red tape that will serve only to further drain resources and worsen patient outcomes. Efforts should be made to reverse the trend within the NHS to endlessly over-complicate processes, which is undoubtably a significant drain on limited NHS resources."

Patient Autonomy and Self-Referral (n=19)

There were calls from some for greater autonomy for young people, including self-referral options, referral from non-healthcare professionals, and advocacy for the Informed Consent Model. They suggested this would help young people navigate services independently, or provide another trusted person to talk to, which would be especially important for those who may not have parental support.

"It needs to be recognised that some children will not find it easy to talk to their parents about their difficulties, or parents may be unwilling to support them. Therefore, there should be a way that that children (for example from age 11) can refer themselves directly to the service or access a helpline, or can ask e.g. a teacher or pastoral worker for help."

Mental Health and Holistic Care (n=19)

The need for a holistic and integrated approach to care that includes mental health services and a broad spectrum of support was highlighted by some respondents. They suggested that current services were not comprehensive enough, and too fragmented, which could lead to people falling between the gaps in services.

"The fragmented care for our children causes me so much despair. That my child - their gender, mental health, neurodiversity - is portioned up so that these elements of their whole are dealt with in discrete packages just makes no sense whatsoever. Where is the holistic care? Why is there not one service that can address all these aspects without fragmentation, and do away with the delay and difficulty that causes?"

Puberty Blockers and Hormone Treatments (n=11)

There was a clear division of opinion amongst respondents regarding medical interventions such as puberty blockers and hormone treatments for young people. Some emphasised the safety and reversibility of these treatments, citing long-term international use, while others expressed

strong reservations, deeming them unsafe or 'ideologically driven' without sufficient evidence of their long-term safety.

'Ideological' Bias and Professional Conduct (n=10)

Some expressed their view that there was an 'ideological' nature to both the working and wording used within the service specification. There was concern expressed about ideological bias among clinicians, suggesting that staff with these viewpoints should not work with CYP with gender incongruence, while others call for the exclusion of 'gender affirmation' pathways and 'experimental treatments' altogether.

"There should be no ideologically driven clinicians within the service. Any such people should by definition be barred from working with distressed children and young people requiring psych care. Gender affirmation is only a pathway to a lifetime on drugs and the possibility of profoundly harmful surgeries as well as permanent psychic harm. No child is born in the wrong body. No adult can "cure" them via affirmation, drugs and surgeries."

Communication and Information Clarity (n=9)

Responses from some indicated that there was a lack of clear communication and detailed information provided about the services, which they said could contribute to confusion and potentially poor service utilisation.

"There is a substantial lack of consistency across the multiple policy documents that have been published. They need to be refashioned as a unified document that explains clearly what the service will do for all. This must include ensuring that the risks and benefits of the service options are clearly expressed, particularly for those who are neuro-diverse."

Service Distribution and Local Support (n=8)

Some felt that the service specification suggested patients could be referred far outside of their geographical area, which would act as a barrier to care. Instead, respondents called for a more distributed and local service that reduces travel burdens and offers more immediate support.

"I am concerned about the fact that patients could be referred far outside of their geographical area. This is a significant cost barrier to receiving healthcare and is a barrier to young people without supportive parents, who therefore have no means of travelling far."

Insufficient Reference to Safeguarding (n=5)

Comments were made by some respondents about the lack of reference to the role of safeguarding within the service specification, despite the encouragement by Dr Hilary Cass as an effective way to reduce risk, improve decision making, and manage uncertainty. This was said to be a particular concern for CYP being referred with comorbidities and those with homophobic parents or from pressurising and influencing environments.

"Not much mention of safeguarding in this document, other than where referrers may be directed to make a referral to Social Services. Hope to see safeguarding more specifically addressed as part of training materials, referral forms, pre-referral consultation service."

Q7. To what extent do you agree that the Equality and Health Inequalities Impact Assessment reflects the potential impact on health inequalities which might arise as a result of the proposed changes?

7.1 Background

NHS England sought views about the Equalities and Health Inequalities Impact Assessment (EHIA) and whether it reflects the potential impact on health inequalities which might arise as a result of the proposed changes.

7.2 Consultation Findings

Overall, nearly half (45%) neither agreed nor disagreed that the EHIA reflects the potential impact on health inequalities which might arise as a result of the proposed changes. 29% of respondents agreed and 26% disagreed (see figure 12).

Figure 12. EHIA reflects the potential impact on health inequalities which might arise as a result of the proposed changes.

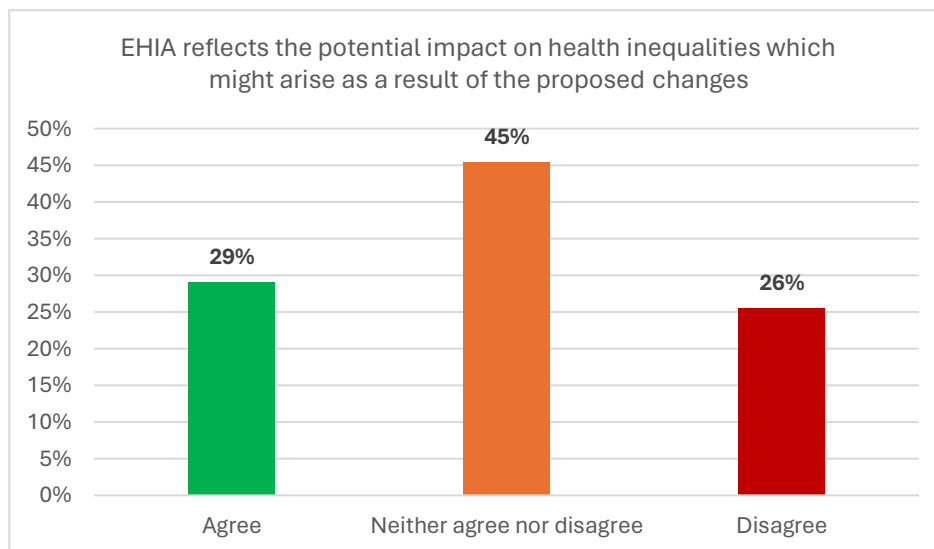
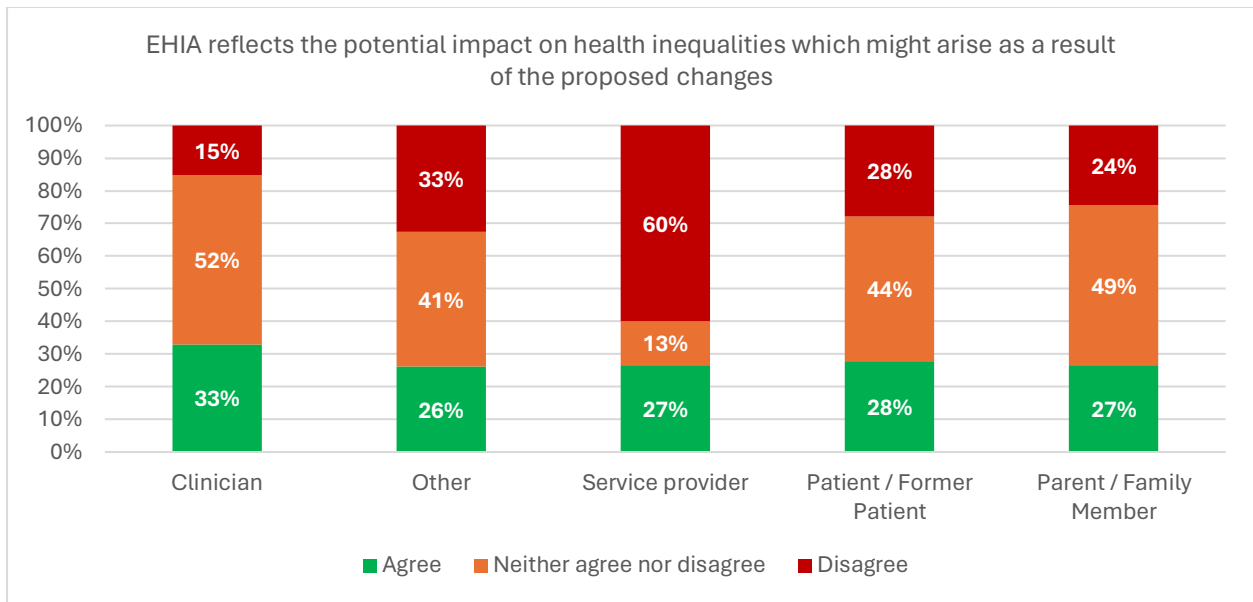


Figure 13 shows that when looking across the different respondent types, the largest percentage in most groups is for neither agreeing nor disagreeing that the EHIA reflects the potential impact on health inequalities which might arise as a result of the proposed changes. However, the majority of service providers (60%) disagree. More clinicians agree than disagree (33% compared to 15%) and there are broadly even numbers among patients / former patients (28% agree and 28% disagree) and parents / family members (27% agree and 24% disagree).

Figure 13. Respondents by type.



7.3 Analysis of Comments

Overview

AGREE

Theme	No.
Recognition of systemic barriers	15
Equality of treatment	2
Need for continuous review and improvement	1

DISAGREE

Theme	No.
Additional gatekeeping	9
Political influence over healthcare	7
Inadequate rationale for changes	4
Lack of trans involvement	3
Lacks information on specific actions	3
Protected characteristics insufficiently represented:	No.
Age	22
Disability	13
Ethnicity	12
Socioeconomic factors	6
Sexual orientation	6
Gender reassignment	5
Rural living	3

NEUTRAL

Theme	No.
Insufficient detail & data	18

Reasons for Agreeing

Recognition of Systemic Barriers (n=15)

Some respondents recognised that the current system has multiple gatekeeping steps which could be seen as barriers to accessing care. They agreed that these barriers are identified in the EHIA, and the potential additional barriers in the referral process are acknowledged.

"We believe that the EHIA accurately reflects the potential consequences of the proposed changes. In our view, comprehensive, exploratory MDT assessment, including psychoeducation and a formulation-based approach, will mitigate some of the potential challenges."

Equality of Treatment (n=2)

Some respondents acknowledge that the EHIA addresses the need for equal treatment for all service users, but there is a suggestion that prioritisation by certain characteristics could lead to further inequality, including the characteristic of being transgender.

"The EHIA should ensure that children and young people with protected characteristics of age, mental health issues and autism are protected from harms that may arise from transgender treatments. The protected characteristic of being transgender should not take precedence over the other protected characteristics. It is of concern that the choices made could result in increased dependency on the health service for hormone treatments, surgery and mental health support as well as risks of treatments associated with de-transitioning, rather than reducing dependency on health care."

Need for Continuous Review and Improvement (n=1)

One respondent felt that while the EHIA was a good start, it needs continuous review and must involve the full range of trans and non-binary people in its evaluation process to fully understand and address the scale of impact.

"It's a good start but there is a lot more to be done and it needs to be constantly reviewed by teams of individuals who fall across the trans and non-binary spectrum."

Protected Characteristics Insufficiently Represented in the EHIA

Age (n=22)

Some respondents noted that by altering the minimum age of referral to 7 and adding extra steps and re-referral for those aged 17, a number of patients would now be subject to additional barriers to care or risk falling through the gaps. They also argued that there is no scientific evidence for the minimum age requirement, as the proposal states.

"The current length of waiting lists means that someone referred at age 7 would not be seen until 11+, so there is no justification for blocking those under 7 being referred. The re-referral into adult services for those

who reach 17 whilst on the waiting list risks patients getting lost in the system, whereas an automatic referral into adult services with an opt-out option would be a much safer way to manage this."

Disability (n=13)

It was noted by some contributors that a high proportion of those questioning their gender identity are also neurodiverse. They voiced concerns about the lack of detail of how the new service would protect those with disabilities and reduce any of the identified adverse impacts. Additionally, it was pointed out that mental health services are already overwhelmed, and that restricting referral could exacerbate existing inequalities for people with disabilities.

"The current length of waiting lists means that someone referred at age 7 would not be seen until 11+, so there is no justification for blocking those under 7 being referred. The re-referral into adult services for those who reach 17 whilst on the waiting list risks patients getting lost in the system, whereas an automatic referral into adult services with an opt-out option would be."

Ethnicity (n=12)

Some participants raised the point that the EHIA acknowledges that those from minoritised ethnic communities are less likely to access health services but lacks solutions on how to address this.

"The assessment notes that Black people and People of Colour face additional barriers to accessing services but does nothing to offer mitigation against this."

Sexual Orientation (n=6)

Some respondents were concerned over the lack of regard for the protected characteristic of sexual orientation, despite acknowledging that a higher percentage of gender diverse identify as homosexual than the general population. The EHIA was said to lack relevant data on the subject and there was concern about the appropriateness of the language used within the sexual orientation section.

"The sexual orientation section makes for sobering reading, indicating what a total muddle has been enabled. Not to record sexual orientation is a total abandonment of sanity in this area; I am glad Cass refers to the issue. The list from the Trans Mental Health Study (why would that be a source for sexual orientation?) includes terms that have absolutely nothing to do with lesbian, gay and bisexual. 'Asexual', 'BDSM/Kink' and more are grotesquely distorting the issue of one's choice of sexual partner. The document manages to acknowledge that a lower percentage of CYP referred will be straight/heterosexual than in the general population. This should be setting every alarm bell ringing. Why isn't it?"

Gender Reassignment (n=5)

It was felt by some that the EHIA implies that not everyone who is referred to the service would be assigned with the protected characteristic of gender reassignment, at least until a clinical diagnosis had been made. This was seen as incorrect and that an individual should be protected, even if they only have the intent to transition or have socially transitioned.

"However, we continue to disagree with the suggestion that not all young people referred to the service would be impacted by the protected characteristic of 'gender reassignment'. An individual is protected from discrimination if they have expressed the intention to transition, are transitioning or have transitioned - this includes social transition. People who are perceived to be trans are also protected from discrimination on the basis of gender reassignment."

Socioeconomic Factors (n=5)

There was a call for more thought to be given for those without contact with parents or from low income backgrounds which add barriers to referral either through a lack of parental consent or difficulty in attending appointments.

"Many people who struggle to access care are in positions distinct from "normal family units". People experiencing homelessness, without contact with parents or otherwise unable to fit into the laid-out box allowing parental consent, will be deprived even further than their current situation. There must be concerted effort made to reach these patients and avenues by which they might also receive referrals, such as waiving the requirements or accepting unorthodox testimonies. "Maturity" is of no concern in the face of these very gender issues often being the cause of such difficulties."

Rural Living (n=3)

A few respondents comment on a lack of support and acknowledgement for those in rural living situations who struggle to access care, especially CYP who may lack the approval of their parents.

"Rural communities will be disproportionately impacted, due to the reduced availability of physical access to care. Outreach should be stepped up to expand knowledge and provision in un-urban areas. The service should actively seek for sufferers who are not aware of care options or even the nature of the issues they are facing, due to poor education and information access."

Reasons for Disagreeing

Additional Gatekeeping (n=9)

Some respondents were concerned that the proposed changes introduce more gatekeeping steps which could exacerbate existing health inequalities and that such decisions would not have been made in services relating to any other type of care.

""I feel the proposed system is out of kilter with all other referral pathways in the NHS. Requiring additional gatekeeping steps creates further delays and risks destabilising patients seeking referral. This group is one that already experiencing higher degrees of mental illness, stigma, and include a disproportionate number of neurodiverse people (I speak as a GP who is himself autistic) and needs to be swift, direct and supportive."

Political Influence Over Healthcare (n=7)

Some respondents were concerned that the changes are being driven by political rather than healthcare considerations, potentially leading to discrimination against LGBTQIA+ individuals.

"It's a negative move based on a political, rather than health, based Stance, and with a long term aim to eradicate all forms of healthcare services for people seeking to resolve their gender related issues, and as seen in many USA states is the first step in discrimination against the entire LGBTQI+ Community."

Inadequate Rationale for Changes (n=4)

Some felt that the rationale provided for not addressing concerns about inequalities was not robust enough. Some suggested that there is a lack of solid data and evidence for what has been cited and that more or better research needs to be carried out.

"The rationales provided for ignoring these concerns are insufficient and rely primarily on dismissive rhetoric or reference to decisions NHS England has already made, rather than evidence."

Lack of Trans Involvement (n=3)

There was a suspicion that the EHIA was not developed with adequate input from trans people or consideration of their needs.

"The proposed changes are clearly intended to harm trans children and young people, they are both unscientific and were made without any dialogue with the trans community. I see no other explanation than that this is a blatant attempt to further harm an already marginalised community."

Lacks Information on Specific Actions (n=3)

For some, the EHIA lacked information on specific actions the NHS will carry out as a means to combat the inequalities mentioned.

"I can't see many specifics in this impact assessment, just a lot of 'reduce inequalities.' But what does that look like? "

Reasons for Neither Agreeing nor Disagreeing

Insufficient Data and Lacking Detail (n=18)

Some respondents highlighted a lack of detailed information and data as a reason for their ambivalence, suggesting that more robust research or a better understanding is necessary. The EHIA is perceived as too vague by some respondents, who find it difficult to anticipate the full impact of the proposed changes without more specificity.

Further information about the proposed changes is needed in order for this to be thoroughly assessed."

Annex A. List of Organisations That Responded

42 responses stated they were being submitted on behalf of an organisation. Where these respondents also provided the name of their organisation, we have listed these below. It is important to note that we have not been able to independently verify whether these are the official response of each organisation.

Arbenneck
Association of Clinical Psychologists (UK)
British Medical Association
Clinical Advisory Network on Sex and Gender (CAN-SG)
Community Paediatrics, Leicestershire Partnership NHS Trust
Designated Child Safeguarding Professionals North East North Cumbria ICB
DHU HealthCare CIC
Evelina London, Guy's and St Thomas NHS Foundation Trust
FHFT
First Do No Harm South Africa
Great Ormond Street Hospital NHS Foundation Trust
Healthwatch Birmingham
HHFT, Basingstoke & North Hampshire Hospital
Leicestershire Partnership Trust
LGB Alliance
LGBT Foundation
Mermaids
National Network of Designated Healthcare Professionals for Children (NNDHP)
NHS Somerset
Oxleas NHS Foundation Trust
Phase one provider: South Hub NHS Children and Young People's Gender Service (London)
Porchlight - BeYou Project
Royal College of General Practitioners
Royal College of Paediatrics and Child Health
Royal College of Speech and Language Therapists
Somerset LMC
South East London Integrated Care System
South London and Maudsley NHS Foundation Trust
Stonewall
The Bayswater Support Group
The Christian Institute
The Gender Identity Research and Education Society (GIRES)
The Kite Trust
Thoughtful Therapists
Trans Learning Partnership
TransActual
Transgender Trend
Transparent Presence CIC
University Hospitals Plymouth



E: engage@tonic.org.uk
T: 0800 188 40 34
W: tonic.org.uk

TONIC