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NHS England  
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Ref: Gender identity services for adults – BMA: 13/10/2017  

13 October 2017  

Dear Mr Glyde,  

Gender identity services for adults  
The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 170,000, which continues to grow every year.  

The Association welcomes the opportunity to respond to the consultation on gender identity services for adults. Please find enclosed our submission.  

The BMA’s response addresses key questions listed in the consultation document. We hope that our submission is useful – please do not hesitate to contact us for more information if required.  

Yours sincerely  

Raj Jethwa  
Director of policy
The BMA welcomes this consultation and the opportunity it presents to improve NHS healthcare delivery for trans people. We recognise the specific health needs of trans patients and the inconsistency in access to health care for these patients. The outcome of the consultation process will ideally lead to proper commissioning and resourcing of gender identity services to cover the entire patient journey. Many GPs currently feel under pressure to fill a gap in service provision and to act outside their competence – a properly commissioned, resourced and supported service will help to resolve this while also delivering the best possible care for trans people.

We are pleased that both short and long term prescribing arrangements are being considered in the consultation, as we believe that current arrangements for prescribing hormone treatment are not working well for patients or their doctors. To date, the provision of gender identity-related care has been poorly handled, and requires proper commissioning to rectify. This has resulted in exponential delays for patients in accessing specialist services, as well as a gap in provision which GPs have felt pressured to fill. GPs provide holistic care of patients as defined in their contracts; they are responsible for their prescribing decisions and worry about the potential harm to the patient of prescribing hormone medication off-licence without proper support or adequate expert knowledge. They must also consider the associated medicolegal risks of doing so. We suggest this is likely to be one of the reasons why trans patients report difficulties and inconsistencies in accessing treatment from primary care providers.

In response to questions 8 and 9, we outline GPs’ concerns in more detail and propose the creation of a network of GPs in each local area with a specialist interest in gender dysphoria, and the creation of a directed enhanced service so there is a national framework, which specifies a defined level of service provision and ensures the necessary investment in training for staff and service delivery in primary care in each locality. Patients would then have timely access to appropriate medication, prescribed by doctors who have confidence, experience and expertise in this aspect of medicine.

**Question (1)** The proposed service specifications aim to address inconsistency in care quality, differing levels of access and out-dated service models. To what extent do you think the specifications achieve this?

We believe the draft service specifications will help address some of the inconsistencies in care quality and the problems accessing gender identity services. Overall, we welcome the guiding principles for the development of the specialist gender identity services (e.g. recognition of the need for timely and appropriate treatment and for interventions to be personalised and based on shared decision-making with patients), and the general requirements they set out for providers of specialist services (e.g. to provide a high quality, timely and sustainable service, to work in an integrated way with primary care providers, to communicate well with other services involved in the pathway, and to participate in the
education of health professionals on the healthcare needs and support for trans people). The proposed specifications can also address some specific inconsistencies in current service provision, such as the variation in ages at which young people are referred to adult Gender Identity Clinics if a common age threshold of 17 years is set.

However, a care pathway that improves access and quality of care across the country, will also depend on the provision of adequate resources for specialist gender identity services to meet the growing demand,¹ to reduce the unacceptable delays in accessing treatment,² and to comply with the national 18-week maximum waiting time, as set out in the NHS constitution and the draft specifications. The Women and Equalities Select Committee’s inquiry into transgender equality identified, there are serious deficiencies “in the quality and capacity of NHS Gender Identity Services” and additional investment is needed in the education and training of healthcare professionals to address current workforce constraints in gender identity services.

Investment is needed in service provision and training at other points along the pathway for gender identity services too, especially in primary care. There is a limit to the workload and specialist knowledge that can be expected of general practitioners. In the three months to 31 December 2016 the number of full-time equivalent GPs fell by 445. 31% of GP partners in practices are unable to fill vacancies at all.³ These shortages impact significantly on the ability of all GPs to develop the expertise in gender dysphoria that is needed to prescribe with confidence and to monitor treatments. Additional work, including gender identity service provision, can only be absorbed into general practice where there is resource to develop the extra capacity and expertise required, and must comply with contemporary contractual requirements. Although the numbers seeking gender identity services is increasing, an individual GP is likely to deal with a very small number of such patients, further limiting the ability and opportunity to acquire expertise.

It is also important that there is the appropriate mix of specialists from secondary care. The process of gender reassignment can be emotionally demanding and consideration should be given to providing appropriate mental health care before, during, or after treatment. Doctors trained as psychiatrists provide the bulk of initial specialist assessments. It is therefore vital that this level of specialism, including understanding the complex issues related to body image and gender identity, continues. Assuming a trans patient ultimately is under the care of a specialist GP, it is important, especially where they live a significant distance away from a gender identity clinic (GIC), that they can be referred to a regional secondary care specialist.

Question (2) It is proposed that in the future all young people who need to access a specialist gender identity service and who are aged 17 years and above will be referred

¹ The NHS Audit, Information and Analysis unit also suggests that the total volume of new trans patient cases amounts to 800-900 per year
to an adult Gender Identity Clinic. To what extent do you support or oppose this proposal?

We agree with this proposal. We recognise the benefits of adopting a consistent age threshold for referrals to adult GICs and that setting it at 17 years will help prevent unnecessary delays in starting the adult pathway of care.

Question (3) It is proposed that in the future the specialist Gender Identity Clinics for Adults will not accept referrals of individuals who are not registered with a General Practice. To what extent do you support or oppose this proposal?

This is highly desirable because of the importance of patients being registered with a GP to ensure ongoing and wider healthcare support. NHS England should also consider the difficulties and barriers that trans people may encounter when trying to register with a GP, including the extent to which trans people do not register, the reasons why some may be deterred from or feel unable to register, and what could be done to make registration easier.

Question (4) It is proposed that only a designated specialist Gender Identity Clinic will be able to refer an individual for genital reassignment surgery. To what extent do you support or oppose this proposal?

We agree with this proposal. Specialist GICs designated by NHS England alone should be able to refer individuals for specialised genital reassignment surgery, because of the need for assessment, diagnosis and support from an expert multi-disciplinary team. Consultants, given their expertise are best placed to refer patients on, something the new NHS standard contract now allows them to do.

Question (5) It is proposed that in the future a decision to refer an individual for specialist genital reassignment surgery must be supported by a Registered Medical Practitioner. To what extent do you support or oppose this proposal?

We agree with this proposal, provided that the Registered Medical Practitioner (RMP) has specialist expertise in gender identity.

Question (6) We have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

Question (7) Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?
The equality and inequalities impact assessment addresses several important areas critical to the provision of appropriate patient-centred care. We would like to raise points regarding the following sections:

- **Gender reassignment (cultural awareness)**
  We welcome steps to support NHS staff to better understand and respond to the needs of trans people. The exclusion of trans people from national screening programmes is mentioned as an example of a barrier that needs to be addressed. We believe that more needs to be done to address this exclusion, and that screening programmes should change their procedures to ensure that invitations and services are organ-specific and not gender-specific. For example, by ensuring trans men with a cervix can opt into national systems for automatic invitations, rather than always requiring them to remember and request screening appointments from their GP.

- **Disability and/or Age (individuals who may have difficulty travelling)**
  It is recognised that the effects of inequitable geographical access to specialised services is compounded when trans individuals are older or have disabilities, which impact on their ability to travel to and from consultations, or travel safely for procedures as part of their healthcare. This could be addressed through greater investment in local service provision and the creation of networks of GPs with a special interest in gender care, who can work more closely with expert multi-disciplinary teams at local level and liaise with other GPs. The new adult gender identity service that has been announced by NHS Wales is an example of such an approach.4

**Question (8) Which option for future prescribing arrangements do you most prefer?**

We do not think that options A, B, or C as written provide an appropriate solution to the current concerns of GPs and transgender patients.

Option A is a continuation of current practice which we believe is unsatisfactory for GPs and for patients. Patients who have been seen by GICs have found it difficult to access drugs that the GICs have deemed necessary, but refused to provide, contrary to the requirements of EL (91) 127 on ‘Responsibility for prescribing between hospitals and GPs’. We are aware that some GICs deny any access at all to patients whose GPs are unable to commit to ongoing prescribing, which is an unethical situation. We have also received reports from GPs that, where they have provided prescriptions, they have received inadequate support or have been pressured into prescribing outside their field of expertise, contrary to GMC requirements.

We are concerned both about the safety of patients who are prescribed medication off-licence by a non-specialist prescriber, where there is a potential for harm to the patient and consequent medicolegal risk to GPs. Current communications from GICs rarely specify that patients have been made aware of the risks and legal consequences of off-label prescribing.

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4 https://www.wales.nhs.uk/news/45987
Option A does not address the special problems associated with ‘bridging prescriptions’ for patients who are self-medicating prior to assessment at the GIC.

Option B passes the problems identified in Option A along for a period of one month. In fact, the patient could be in a worse position if proper arrangements have not been ensured for the period following, having already started medication and then being faced with having to stop it again if proper arrangements have not been put in place. Patients have differing clinical needs and some will need support from the GIC for longer periods of time. Where patients have questions about their medication, or have developed problems with it, these often occur in the early weeks so it would be inappropriate for them then to have to see a clinician without the necessary specialist knowledge.

Option C as written does not address all the problems identified in Options A and B, and there are inherent dangers in setting an arbitrary timescale for handover, including inappropriate pressure being brought for transfer even when clinical grounds suggest otherwise. However, the flexibility is to be welcomed, and it could form the basis of a satisfactory solution if an adaptation of this combined with Option D, supported by the use of electronic prescribing systems by the GIC, and with proper commissioning of primary care input either through Option D or through the provision of an enhanced service. It would be vital that these arrangements conform to both the GMC’s good medical practice guidelines on practicing within one’s competence, and to best practice for shared care, particularly with regard to clarity, consent, resourcing, and educational support.

Option D is a medically acceptable way forward. We believe that this should be combined with a facility for GPs to continue to prescribe for their patients where both the GP and the patient feel this is appropriate, with this being delivered via a Directed Enhanced Service (DES) in line with NHS England’s Shared Care Agenda. It may be possible for this work to be done by a non-medical prescriber fully trained in gender identity care. A DES would help ensure a consistent level of service provision and encourage sufficient numbers of GPs in each locality willing to participate. We have outlined our alternative proposal in more detail below. Option D would also address the problems of ‘bridging prescriptions’ and ensure that there was a locally available intermediate tier of expertise.

**Question (9) Can you suggest any alternative prescribing arrangements?**

It is vital that trans people receiving care for gender reassignment have that care provided by skilled clinicians who are adequately resourced for the responsibilities and activity required. Therefore, proper commissioning is required for the entire patient journey. GPs are responsible for delivering care in accordance with their contractual responsibilities and cannot be regarded as the providers of last resort for uncommissioned services to the detriment of patient safety.

The development of local networks of specialist GPs, working more closely and collaboratively with GICs may also encourage greater experiential learning and assist with the transfer of skills and expertise at local level.
Prescribing for transgender patients is a difficult area as there is a limited evidence base and most medicines would have to be prescribed off-licence. For doctors, it is vital that they ensure the highest standards of care and treatment for their patients—declining to prescribe hormones in GIC should be seen in this context. ‘Any demand to have a prescription due to waiting lists or similar issues, should be seen as a failure or lack of clarity in commissioning, rather than an unreasonable withholding of prescription-only drugs.

The GMC has so far been unable to provide sufficient reassurance for doctors prescribing off-licence in relation to trans patients, and a Medical Defence Organisation has indicated to us that related medical defence claims could be difficult to defend, particularly with respect to bridging prescriptions. Our proposals reduce some of these concerns by ensuring a specific framework for service provision, consistency and a defined level of service. It would enable safe and supported prescribing, quality of service provision and ensure that transgender patients can access the services they need.

Furthermore, while the mainstay for medical care and treatment for trans patients would be their GP it is vital that necessary experts across the range of medical specialties are involved along the relevant diagnostic and treatment pathways. These may include endocrinologists, gynaecologists and psychiatrists. With their specialist training, especially regarding interview and communication skills as well as competency in comprehending and describing people’s experiences, psychiatrists have a long-standing important role in gender identity-related care. The BMA would therefore welcome clarity over skill mix to ensure that trans people receiving this care will receive the most appropriate and specialist help.

We also believe that where patients are self-medicating prior to specialist assessment, a local 'intermediate' service within primary care would be safer than the 'bridging prescription' model provided by general practice as suggested by the GMC. There also needs to be a fast track re-referral route back to Gender Identity Clinical specialty services, together with provisions for timely advice for primary care prescribers from GICs, should any problems arise.

BMA Wales, representing doctors based in Wales alongside other national offices for Scotland and Northern Ireland and the UK-wide BMA, has welcomed the development of a new adult gender identity service in Wales. It will be delivered by a multi-disciplinary Welsh Gender Team, who will support a network of GPs with a special interest in gender care. We believe this is a good example of investing in gender identity services to ensure timely access to care and for more care to be provided at a local level. It is also a positive example of involving the transgender community and ensuring doctors are well supported. We would advise that a degree of consistency between the two health services would be beneficial.5

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5 https://www.wales.nhs.uk/news/45987