



Referral Pathway for Children and Young People with Gender Incongruence

Trans Learning Partnership Consultation Response

To what extent do you agree with the below points?

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

We are strongly opposed to the proposal in its current form, as it will create unnecessary and inappropriate barriers to care, extending waiting times in direct contradiction to the purpose of closing GIDS. Instead, this policy should require simultaneous referrals to the gender service *alongside* referrals to CAMHS or general paediatrics. Our concern is that by requiring a referral to a secondary service before referral into the intended service, further delays to care will be created. This will be particularly exacerbated for children and young people waiting for referrals into CAMHS: recent [investigations](#) have highlighted that the waiting times for CAMHS are currently a postcode lottery, with young people waiting anything from ten days to four years for an appointment. While the policy states that the referral date to the secondary service will be used as the young person's referral date into the gender service, it is unclear how this would work fairly where young people referred into CAMHS will likely have to wait longer than their counterparts in paediatrics. It is also unclear what the procedure would be if the young person reached the top of the waiting list for the gender service before CAMHS.

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

While we understand NHS England's thinking, we are concerned about the wider impacts. Children under seven will not need any medical interventions, but children and their families may benefit from support from the Service, such as with understanding social transition or other future options. These can be invaluable protective factors for children experiencing distress. Furthermore, given the current waiting times and the possibility that the inclusion of CAMHS and paediatrics could extend this, parents may see fit to refer their child at a younger age so they're more likely to be able to access care at an appropriate age. As it is, this proposal, combined with the existing waiting times mean that in practice, the minimum age for the Service will be 11-12 years old. This could in turn limit the Service's ability to recruit young people with 'early onset gender dysphoria', assuming this refers to those experiencing

dysphoria prior to Tanner stage 2. Furthermore, as the EHIA notes, so few children of this age are referred, and with so few active interventions, that creating this barrier seems unnecessary.

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.

We are pleased to see that since the stakeholder engagement stage, this policy point has been reviewed and changed to a temporary measure. However, it has not been stated how long this policy is intended to be in effect, how its effectiveness will be assessed, and how and when a review of this will take place. This should be included in the policy so that it is clear that the NHS has a plan of action. We continue to be concerned about what support will be available for 17-year-olds as a result of this policy, and encourage NHS England to consider this more fully.

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.

We are pleased that individuals will be transferred to adult services with their waiting time honoured; however, we continue to be concerned about the burden being placed on 17-year-olds to facilitate this move themselves. We believe that NHS England and the gender services must take responsibility for the facilitation and management of a young person's transfer between these services - perhaps led by the new referral service - with the option to 'opt out' of this automatic transfer if the referral is no longer needed. The current policy proposal relies on NHS England holding the correct contact information, a young person's continued access to a supportive GP (which may no longer be the case given the time elapsed since initial referral and the [rise of transphobia in society](#)), and a level of executive function and ongoing self-advocacy - this will lead to additional challenges for these young people. Furthermore, NHS must review the place any individual is on the waiting list prior to transfer of referral - if they are likely to be seen by the Service prior to their 18th birthday, they should remain with the Service so as to avoid further delay given the longer waiting times for adult services.

The role of the pre-referral consultation service.

We are pleased to see NHS England engage with the challenges that face children and young people while on the extensive waiting list for these services. Ensuring there is support to reduce negative outcomes while waiting is vital. However, we continue to have concerns about practical elements of the service. For example, we are deeply troubled that children and young people will be 'screened out' of the referral process prior to an assessment at the Service. Secondly, we are extremely concerned that the 'desk-vetting' process suggests that this will happen through non-clinical staff making clinical-level decisions about which children and young people will be accepted into the Service prior to these assessments, and without any clear rejection criteria or information on how to appeal such a decision or request a second opinion. Furthermore, children and young people must be involved in any decision-making processes, which does not appear to be the case. Finally, we are concerned that this may be an inefficient use of public funds, as this service is only necessary as a result of other structural failures, namely the extensive waiting times and the additional barriers put in place elsewhere by NHS England.

Any other element of the service specification.

We are extremely disappointed with and concerned by these proposals, which will reduce access to the Service for a large proportion of individuals in need. We have identified the following additional gatekeeping mechanisms which will have a negative impact on access to the Service and therefore overall wellbeing:

- Confusion from GPs and incorrect or refused referrals to CAMHS/paediatrics;
- Inappropriate waiting times for CAMHS before the inappropriate waiting times for the Service compounding each other - while the specification claims that this should not cause delays into the service, the extensive waiting times and postcode lottery for CAMHS access gives us cause for concern;
- Lack of training in CAMHS/paediatrics to be able to appropriately assess these cases or provide appropriate support - particularly as we know that CAMHS are currently very unwilling to provide support to children and young people with an existing referral to GIDS;
- Desk-vetting process (potentially leading to the rejection of the referral);
- Outcome of consultation service (potentially leading to the rejection of the referral);
- Manual referrals onto adult services for those aged 17;

- Minimum age of referral in practice creating a minimum age of access to the service of 11;
- Gender Experience Summary (GES) posing additional challenges for those with executive dysfunction, or insufficient information leading to the rejection of a referral prior to clinical assessment. The GES provided to the sector asks very little detailed information about gender - it is unclear how the little information provided in this form is appropriate enough to screen children and young people out of the service.

This is all before a child or young person has any access to the Service, and requires them to constantly 'prove' themselves to a series of professionals not trained appropriately to deliver this support, and who, in this [particularly transphobic](#) era, could hold views that are harmful to the child or young person, without any professional education in this area to challenge any harmful beliefs. This will be extremely distressing for young people, and will further harm their wellbeing.

This constant need to 'prove' themselves can also work both as a deterrent and as an inappropriate motivator, forcing children and young people to make choices that they have not had the full freedom to explore. For example, some will find the process dejecting, potentially leading them to withdraw from it and developing further distress from the lack of support. On the flip side, the lack of supportive, affirmative environment that places trust with the young person may lead some to feel they have to fight for the care they ought to receive, and as such may end up undergoing treatments they may not have desired had they felt able to trust their care providers. As a result, the standards of care the Service is able to deliver will be severely hindered. This will be seen at every stage, with ill-informed and unqualified gatekeepers reinforcing limiting narratives, in turn removing the opportunity for young people to fully explore their feelings and therefore receiving personalised care.

The policy does not detail an appeals/second opinion process, nor does it reference any standard NHS policies to that effect. It must be made clear how individuals can challenge decisions that 'screen' them out of the process, whether from clinicians, or, particularly, through the desk-vetting process.

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?

We are disappointed to see that NHS England still considers it a safeguarding issue for children under 7 to be referred into the Service, as detailed above. We are pleased to see

NHS England acknowledge and cite data that demonstrates that queer sexualities are higher in trans populations than cis populations, as we know this is a vital dimension to our care, and discredits inappropriate and harmful claims held by anti-trans campaigners. We are pleased to see deeper thinking on the support needed by Looked After Children, and we would be keen to open discussions with NHS England as to what support the sector can also provide here. We would appreciate the EHIA being updated to clarify that while parental consent may usually be sought for young people under 16, this is not legally necessary if the young person is deemed Gillick competent.