

## NHS England: Equality and Health Inequalities Impact Assessment (EHIA)

A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal.

1 March 2024 (amended following public consultation)

1. **Name of the proposal:** **Gender Incongruence Service for Children and Young People:  
Prescribing Gonadotrophin Releasing Hormone Analogues (Puberty Suppressing Hormones)**

2. **Brief summary of the proposal**

NHS England proposes that Gonadotrophin Releasing Hormone analogues (GnRHa) are not recommended to be available as a routine commissioning option for treatment of children and adolescents who have gender incongruence. GnRHa are commonly referred to as 'puberty blockers' or puberty suppressing hormones.

*What is GnRHa?*

Administration of GnRHa initially produces an initial phase of stimulation of hormone receptors; continued administration leads to down-regulation of gonadotrophin-releasing hormone receptors, thereby reducing the release of gonadotrophins (follicle stimulating hormone and luteinising hormone) which in turn leads to inhibition of androgen and oestrogen production (NICE: British National Formulary for Children). GnRHa are currently prescribed through the NHS for children and young people with a diagnosis of persistent gender dysphoria from Tanner Stage 2 of pubertal development, alongside psychosocial and psychological support, though no formal clinical commissioning policy is in place.

*Who will be impacted by the policy?*

Children and young people aged between around 10 and 17 years – this will be a combination of a prospective cohort (i.e. future referrals to an NHS commissioned specialised gender incongruence service); and those currently in the service and not yet onwardly referred to an endocrine clinic.

For children and young people who, at the point the clinical commissioning policy takes effect on 1 April 2024:

- have been referred into an endocrine clinic by the former NHS Gender Identity Development Service but have not yet been assessed by a consultant endocrinologist for suitability of GnRHa; or
- are under the clinical care of an endocrine team at University College of London Hospitals NHS Foundation Trust or Leeds Teaching Hospitals NHS Trust following a referral by the former NHS Gender Identity Development Service

there is an expectation that GnRHa will continue to be administered / be initiated, if that is the informed choice of the young person / parents of a child under 16 years<sup>1</sup>, subject to the outcome of usual clinical review of the individual's existing individual care plan jointly between the individual's Lead Clinician and the young person / parents of a child under 16 years.

#### *What may be the impacts of the policy?*

The direct impact will be that for children and young people who are assessed and diagnosed with gender incongruence by an NHS commissioned Children and Young People's Gender Service, GnRHa would no longer be routinely commissioned as a clinical intervention on the NHS-commissioned pathway of care. Although adoption of the policy is not contingent on the formation of a clinical study, some children may be eligible for enrolment in a research framework that would provide access to GnRHa, while some young people may not be eligible (see below). The development of a research protocol is well underway and will be subject to the usual approvals through the National Institute for Health and Care Research. NHS clinicians within the Children and Young People's Gender Service would no longer prescribe GnRHa for children and young people as a response to gender incongruence or gender dysphoria outside of a research framework, should a research framework be feasible. The direct consequence of the policy is that some children and young people who may otherwise have been prescribed GnRHa and who are not eligible to join such a research framework or those who are eligible but who opt to not enrol in the research framework, will proceed with pubertal progression and development of secondary sexual characteristics of the natal sex. If the establishment of a research framework is not, in fact, feasible then no child or young person will be prescribed GnRHa as a response to gender incongruence / dysphoria.

Potential consequences of the policy may be an increase in the number of children and young people who seek GnRHa from unregulated sources; and some stakeholder groups have previously suggested<sup>2</sup> that withholding GnRHa will lead to an increase in emotional and

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<sup>1</sup> NHS England's adoption of the proposal would not be intended to compel young people / parents of children under 16 years to choose to continue with GnRHa if, after a consideration of the issues raised by the adoption of the policy, they make a decision to cease the intervention.

<sup>2</sup> Around 2020/21, when the Tavistock and Portman NHS Foundation Trust took the decision to cease making referrals to endocrine clinics in response to a legal ruling (referrals resumed in 2021 following judgment of the Court of Appeal).

psychological distress, leading to risk-taking behaviour particularly amongst adolescents. Conversely, some stakeholder groups have suggested<sup>3</sup> that GnRHa should be removed from the NHS pathway of care completely in the best interests of children and young people in view of the limited evidence around treatment aims, benefits, risks and outcomes<sup>4</sup>.

If the policy is adopted by NHS England following public consultation, it would be appropriate to make a consequential change to the related clinical policy for prescribing cross-sex hormones for young people with gender dysphoria.

*How does the policy relate to the recommendation of the Cass Review that a research framework should be established?*

In 2022 the independent Cass Review advised that consideration be given to the rapid establishment of the necessary research infrastructure to prospectively enrol young people being considered for GnRHa into a formal research programme with adequate follow up into adulthood<sup>5</sup>.

*“My interim report highlighted the gaps in the evidence base regarding all aspects of gender care for children and young people from epidemiology through to assessment, diagnosis, support, counselling and treatment. NHS England asked me to give some further thought as to how these gaps may be addressed.... Given the particular uncertainties regarding long-term outcomes of medical intervention, and the broader knowledge gaps in this area, there is an imperative to build research capacity into the national network .... A further concern is that adolescent sex hormone surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuits underlying executive function (i.e. maturation of the part of the brain concerned with planning, decision making and judgement). If this is the case, brain maturation may be temporarily or permanently disrupted by puberty blockers, which could have significant impact on the ability to make complex risk-laden decisions, as well as possible longer-term neuropsychological consequences. To date, there has been very limited research on the short-, medium- or longer-term impact of puberty blockers on neurocognitive development. In light of these critically important unanswered questions, I would suggest that consideration is given to the rapid establishment of the necessary research infrastructure to prospectively enrol young people being considered for hormone treatment into a formal research programme with adequate follow up into adulthood, with a more immediate focus on the questions regarding puberty blockers”.*

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<sup>3</sup> Responses to NHSE public consultation on proposed interim service specification for services for children and young people with gender dysphoria

<sup>4</sup> Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria; National Institute for Health and Care Excellence, 2020

<sup>5</sup> [Letter to NHS England](#), 19 July 2022

NHS England accepted that advice and incorporated wording to that effect in the proposed interim service specification for children and young people's gender incongruence services that was agreed in 2023 following a process of public consultation. NHS England has now established a National Research Oversight Board for Children and Young People's Gender Services. Membership includes the National Institute for Health and Care Research, the Medical Research Council, the Royal College of Paediatrics and Child Health and a range of other clinical and academic experts. The National Research Oversight Board has approved the development of a study into the impact of GnRHa on gender incongruence in children and young people with early-onset gender dysphoria. The study design and feasibility assessment is being taken forward through the National Research Collaboration Programme in place between NHS England and NIHR, with the study team planning to engage with stakeholders in the study design. Subject to the usual ethical and scientific approvals, NHS England anticipates that recruitment to the study will open in 2024.

Alongside this first proposed study, further engagement is also planned to identify the key evidence gaps for children and young people with later-onset gender dysphoria – recognising that there is even greater uncertainty in terms of the supporting clinical evidence base, less established clinical practice and less known about the natural history of gender incongruence / dysphoria in this group.

The definition of 'early onset' and 'late onset' will be developed by the clinical study team in due course.

In summary, the impacts of the proposed policy in terms of access to GnRHa are likely to be:

- Children and young people with gender incongruence / dysphoria will not be referred for consideration of GnRHa unless and until the proposed puberty suppressing hormone study opens to recruitment
- As an outcome of public consultation NHS England has removed the proposed 'exceptional circumstances' pathway that, if adopted, may have granted some individuals access to GnRHa outside of a clinical study
- Should the study open to recruitment, only children presenting with early-onset gender dysphoria (yet to be defined), and who meet any other key study entry criteria, will be able to enrol in the study
- Young people with later-onset gender dysphoria (yet to be defined) would not be eligible for referral for GnRHa; further consideration is being given to how best to work with a range of stakeholders to identify and articulate the material evidence gaps, and how to gather further evidence, to support future options for young people with later-onset gender dysphoria
- Should the proposed study not be granted the usual approvals, no child or young person receiving care for gender incongruence / dysphoria would be eligible for GnRHa
- Adoption of the policy is not planned to impact children and young people who were referred into an NHS-commissioned paediatric endocrinology service before 1 April 2024, and other patient groups such as children receiving GnRHa for Central Precocious Puberty

- The administration of GnRHa to natal males as part of a Gender Affirming Hormone intervention is intended to achieve a different clinical outcome, in that Gender Affirming Hormone treatment via physiologic doses of oestrogen alone is insufficient to suppress testosterone levels into the normal range for natal females and addition of an anti-androgen is necessary. The use of an anti-androgen will continue to be available for this purpose in natal males, not before middle adolescence, who are prescribed Gender Affirming Hormones from around 16 years of age<sup>6</sup>, and for natal males who are aged 17 years and above who are seen by adult Gender Dysphoria Clinics.

### 3. Prevalence

Estimates for the proportion of children, young people and adults with gender incongruence or gender dysphoria vary considerably. This reflects a number of factors such as: variable data reporting by providers; differences in diagnostic thresholds applied and inconsistent terminology; the methodology and diagnostic classification used – population surveys give a much higher estimate than numbers based on service use; and the year and country in which the studies took place. Few studies have taken place in the United Kingdom, and there are no published studies in young children.

The UK census (2021) reported that 93.47% of respondents in England (16 years +) recorded a “*gender identity the same as sex registered at birth*”; and that 0.55% of respondents recorded a “*gender identity different from sex registered at birth*”; and that 5.98% of respondents recorded as ‘*not answered*’<sup>7</sup>. Although the Official for National Statistics [advises](#) (November 2023) that “*the census estimates on gender identity are broadly consistent with the best available comparator of the GP Patient Survey and international comparators*” the UK census did not collect gender identity data for children below 16 years of age.

Published estimates for the proportion of people who are gender diverse range from 0.3% to 0.5% of adults, and around 1.2% of people aged 14-18 years (source: analysis by Public Health Consultant, NHS England, 2023). The number of referrals to specialised gender

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<sup>6</sup> See NHS England’s Clinical Commissioning Policy “Prescribing Gender Affirming Hormones as Part of the Children and Young People’s Gender Service”, as amended 2024. The Independent Cass Review advised NHS England in July 2022 that there should be “a more immediate focus on the questions regarding puberty blockers”, and NHS England has proceeded to follow this advice in regard to GnRHa when used for the purpose of puberty suppression separate to the administration of gender affirming hormones.

<sup>7</sup> The [Office for National Statistics](#) advises (November 2023) that “*there are some patterns in the data that are consistent with, but do not conclusively demonstrate, some respondents not interpreting the question [on gender identity] as intended; given other courses of uncertainty, not least the impact of question of non-response, we cannot say with certainty whether the census estimates are more likely to be an overestimate or an underestimate of the total number of trans people aged over 16 years in England and Wales*”.

incongruence services for children and young people in England is currently likely to be around 1 per 2000 population per year. The current referral profile suggests that the majority of referrals will be of adolescents following the onset of puberty.

Table: Patient Numbers (updated February 2024)

Patient Cohort	Number	Commentary
Number of children under 16 years of age who are likely to be directly impacted by the policy at current referral patterns.	5 per month	<p>Average figure - data from independent Multi-Professional Review Group is that between 10 August 2021 and 26 January 2024 the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust referred 137 children under 16 years to an endocrine clinic for assessment of suitability for GnRHa.</p> <p>However, clinical activity at the GIDS has steadily decreased in recent years due to staff attrition. Up to 2021 the Tavistock reported that around 15 – 20% of children and young people seen by GIDS were referred to an endocrine clinic and that 2545 patients were referred to an endocrine clinic in 2019/20 (including young people aged 16 years and over).</p> <p>NHS England does not hold data that would differentiate between individuals who present with early-onset gender dysphoria and those who present with late-onset gender dysphoria – and the clinical study team has yet to define these terms.</p>
Number of CYP who may be referred to an endocrine clinic per year under a new configuration of service providers, based on 2019/20 referral rate (before the judgment of Bell and Mrs A v Tavistock and Portman NHS Foundation Trust)	32 – 42 per month	As above – up to 2021 the Tavistock and Portman NHS Foundation Trust reported that around 15 – 20% of children and young people seen by GIDS were referred to an endocrine clinic and that 2545 patients

		were referred to an endocrine clinic in 2019/20 (including young people aged 16 years and over).
Number of patients under 16 years currently on the waiting list for GIDS, who may be impacted by policy	462 - 616	<p>There were 3,423 children under 16 years on the waiting list held by <i>NHS AGEM Commissioning Support Unit</i> as at 31 December 2023 (source: AGEM CSU); assume 90% of those are the commissioning responsibility of NHSE; of those, Tavistock and Portman NHS FT reports that around 15-20% would be referred to endocrine clinic at historical referral rates</p> <p>NHS England does not hold data that would differentiate between individuals who present with early-onset gender dysphoria and those who present with late-onset gender dysphoria - and the clinical study team has yet to define these terms.</p>
Number of patients aged 16 and 17 years currently on the waiting list for GIDS, who may be impacted by policy	315 - 420	<p>There were 2,336 young people aged 16 and above on the waiting list held by <i>NHS AGEM Commissioning Support Unit</i> as at 31 December 2023 (source: AGEM CSU); assume 90% of those are the commissioning responsibility of NHSE; of those, Tavistock and Portman NHS FT reports that around 15-20% would be referred to endocrine clinic at historical referral rates. <i>Note: these figures do not reflect the number of young people on the waiting list who will not be seen by GIDS by the time of their 18th birthday and / or who may be referred to an adult Gender Dysphoria Clinic from 17 years of age.</i></p>

		NHS England does not hold data that would differentiate between individuals who present with early-onset gender dysphoria and those who present with late-onset gender dysphoria - and the clinical study team has yet to define these terms.
Number of children and young people who will be receiving GnRHa for the purpose of puberty suppression from an NHS endocrine team on 31 March 2024; or who will be waiting for assessment by the endocrine team.	<71	Source: Planning assumptions provided by Tavistock and Portman NHS Foundation Trust on 27 February 2024.

#### 4. Main potential positive or adverse impact of the proposal for protected characteristic groups summarised

Please briefly summarise the main potential impact (positive or negative) on people with the nine protected characteristics (as listed below). Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below. Please note that these groups may also experience health inequalities.**

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
<b>Age:</b> older people; middle years; early years; children and young people.	<p>The impact of the policy would be that GnRHa will not be routinely available through the NHS (for individuals with gender incongruence) for individuals who share the protected characteristic of 'age' as it would only impact individuals aged between (around) 10 years and 17 years.</p> <p>The policy is not likely to impact children below the age of 10 years given that recommendations for GnRHa have not been</p>	Other forms of specialist clinical support will remain available through the NHS for this patient cohort; the NHS England interim service specification for gender incongruence (June 2023) describes a multi-disciplinary approach to care that focuses on psychoeducation, psychosocial and psychological approaches, and aims to reduce distress and promote wellbeing and functioning. The interim service specification also describes a more coordinated and integrated approach



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	<p>made by the GIDS at the Tavistock and Portman NHS Foundation Trust until the child has reached Tanner Stage 2 of pubertal development (<i>source: NHS Service Specification for Gender Identity Development Service, 2016</i>).</p> <p>As part of the planning for the closure of GIDS the Tavistock and Portman NHSFT has advised NHS England (November 2023) that over fifty percent of referrals made by the Tavistock for GnRHa are of children under 16 years of age.</p> <p>Should the proposed clinical study be established (anticipated 2024) children and young people with later on-set gender dysphoria will not be eligible for the study, though the study team has yet to define this term.</p> <p><u>GnRHa alongside Gender Affirming Hormones for Natal Males</u> The administration of GnRHa to natal males as part of a Gender Affirming Hormone intervention is intended to achieve a different clinical outcome, in that Gender Affirming Hormone treatment via physiologic doses of oestrogen alone is insufficient to suppress</p>	<p>between the specialist service and local services in the child or young person’s best interests.</p> <p>NHS England is leading a national transformation programme that plans to significantly increase clinical capacity in children and young people’s gender incongruence services over time – thereby increasing more timely service provision.</p> <p>As a risk mitigation measure, in April 2024 NHS England will have commissioned a rapid assessment service for every child or young person on the waiting list for CYP Gender Services, through local NHS children and young people’s mental health services. This will be a directly commissioned service for this cohort over-and-above existing mental health provision.</p> <p><i>Criteria for enrolment in a clinical study</i></p> <p>Alongside the first proposed study, further engagement is also planned by the National Research Oversight Board to identify the key evidence gaps for children and young people with later-onset gender dysphoria (yet to be defined) – recognising that there is even greater uncertainty in terms of the supporting clinical evidence base, less established clinical practice and less known about the natural history of gender dysphoria in</p>

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	<p>testosterone levels into the normal range for natal females and addition of an anti-androgen is necessary. The use of an anti-androgen will continue to be available for this purpose in natal males, not before middle adolescence, who are prescribed Gender Affirming Hormones from around 16 years of age, and for natal males who are aged 17 years and above who are seen by adult Gender Dysphoria Clinics.</p> <p>NHSE has concluded that the fact that the policy will mainly impact children and young people who share the protected characteristic of “age” does not result in unlawful discrimination. The policy is a reasonable, rational and clinically necessary response to the findings of NICE and the Cass Review that there is a lack of sufficient evidence relating to the safety and clinical effectiveness of GnRHa for children and young people with gender incongruence / dysphoria, including about the benefits, risks and long-term outcomes. It is therefore proposed that adoption of the policy would in itself be a risk mitigation measure.</p>	<p>this group. The clinical study team has yet to define these terms.</p>

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<p><b>Disability:</b> physical, sensory and learning impairment; mental health condition; long-term conditions.</p>	<p>Various literature suggests that a high proportion of children and young people with gender incongruence / dysphoria will also present with other significant comorbidities, though NHSE does not have specific data from the GIDS at the Tavistock and Portman NHS Foundation Trust nor from the commissioned endocrine clinics on the number of children and young people open to the GIDS who have a disability.</p> <p>The literature reports that a significant proportion of those presenting with gender dysphoria have a diagnosis of Autistic Spectrum Disorder (ASD). Around 35% of young people referred to the NHS-commissioned children and young people’s service present with moderate to severe autistic traits<sup>8</sup>. Individuals with ASD are likely to share the protected characteristic of “disability”. Around 70% of people with autism also meet diagnostic criteria for at least one (often unrecognised) psychiatric disorder that further impairs psychosocial functioning, for example, attention deficit hyperactivity disorder or anxiety disorders. Intellectual disability (IQ&lt;70) coexists in</p>	<p>Other forms of specialist clinical support will remain available through the NHS for this patient cohort; the NHS England interim service specification for gender incongruence (June 2023) describes a multi-disciplinary approach to care that focuses on psychosocial and psychological approaches, and psychoeducation.</p> <p>The interim service specification also describes a more coordinated and integrated approach between the specialist service and local services in the child or young person’s best interests including where the child or young person has complex co-presentations that may form the basis of a ‘disability’ under the Equality Act including autism, ADHD, other forms of neuro-disability and mental health problems.</p> <p>NHS England is leading a national transformation programme that plans to significantly increase clinical capacity in children and young people’s gender incongruence services – thereby increasing more timely service provision and greater integration with and support from local services.</p>

<sup>8</sup> Assessment and support of children and adolescents with gender dysphoria, Butler et al, 2018

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	<p>approximately 50% of children and young people with autism<sup>9</sup>.</p> <p>There is also an increased prevalence of children and young people presenting to the current service with severe forms of mental health problems which may in some cases constitute a 'disability' for the purpose of the Act<sup>10</sup>.</p> <p>The UK Government's LGBT Survey (2017) reported that 32.5% of respondents from the transgender and non-binary population self-identified as having a disability (respondents were aged 16 years and above).</p> <p>NHSE concludes from the information above that the current policy may have a disproportionate impact on individuals who share this protected characteristic. NHS England has concluded that no direct or indirect discrimination arises. The policy is a reasonable, rational and clinically necessary response to the findings of NICE and the Cass Review that there is a lack of sufficient</p>	<p>The new service offer will be accompanied by improved guidance and <a href="#">MindEd psycho-education resources on gender incongruence</a> in childhood and adolescence for local services and professionals that NHS England commissioned through (the former) Health Education England (published in 2023). These new support materials will mitigate the potential impact for children and young people becoming more entrenched in their ill health because their expectation of receiving GnRHa has been denied.</p> <p>NHS England also proposes to provide specialist consultation advice and liaison for local services and professionals to provide early indirect support for families who are newly identified with gender concerns by local services and professionals.</p> <p>At a local level NHS England, with local commissioners, has improved 24/7 crisis helplines and crisis response services. These are also supported by training resources for crisis practitioners, especially A&amp;E staff which will include specific LGBTQIA+ training resources developed by young people with lived experience.</p>

<sup>9</sup> Autism Spectrum Disorder in Under 19s: Support and Management, National Institute for Health and Care Excellence, 2021

<sup>10</sup> A 2024 [paper](#) found that the probability of self-reporting a long-term mental health condition was higher in transgender populations, though this was self-reported data by individuals aged 16 years and above. *Watkinson; Gender-Related Self-Reported Mental Health Inequalities in Primary Care in England: A Cross-Sectional Analysis Using the GP Patient Survey, 2024*

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	<p>evidence relating to the safety and clinical effectiveness of PSH for children and young people with gender incongruence / dysphoria, including about the benefits, risks and long-term outcomes. It is therefore proposed that adoption of the policy would in itself be a risk mitigation measure.</p>	<p>NHS England has also published (April 2023) a new <a href="#">National Framework</a> to Deliver Improved Outcomes in All-Ages Autism Assessment Pathways: Guidance for Integrated Care Boards. This will improve access to assessments and mitigate the impact of undiagnosed autism on some children and young people's experiences.</p> <p>As a risk mitigation measure, in April 2024 NHS England will have commissioned a rapid assessment service for every child or young person on the waiting list for CYP Gender Services, through local NHS children and young people's mental health services. This will be a directly commissioned service for this cohort over-and-above existing mental health provision.</p>
<b>Gender Reassignment</b>	<p>In considering the application of Equality Act 2010, section 7, to this service, the High Court in <a href="#">R (AA) v NHS Commissioning Board (2023)</a> found that not every child or young person referred to a specialised gender incongruence service will have the protected characteristic of gender reassignment. The Court held that children and young people who are referred to such a service do not – at the point of referral or while they remain on the waiting list - share the protected</p>	<p>Other forms of specialist clinical support will remain available through the NHS for this patient cohort; the NHS England interim service specification for gender incongruence (April 2023) describes a multi-disciplinary approach to care that focuses on psychoeducation, psychosocial and psychological approaches.</p> <p>The interim service specification also describes a more coordinated and integrated approach</p>

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	<p>characteristic of ‘gender reassignment’ as a class or cohort of patients. The whole cohort of patients cannot be treated as “proposing to undergo” a process (or part of a process) for the “purpose of reassigning” their sex “by changing physiological or other attributes of sex” as a class. However, as the Court found and as NHS England accepts, many children and young people in this position will, individually, have the protected characteristic of gender re-assignment at this stage although determining that will involve a case-specific factual assessment.</p> <p>It is for this reason that NHS England has determined to treat <u>all</u> of the children and young people who will be impacted by the policy as likely to share the protected characteristic of gender reassignment, and it has proceeded on that basis throughout the whole process of policy formation.</p> <p>In forming the conclusion that all children and young people impacted by the policy “are likely” to share the protected characteristic of gender reassignment, NHS England has been mindful of the conflicting evidence in this regard. On the one hand, the Tavistock and Portman NHS Foundation Trust has</p>	<p>between the specialist service and local services in the child or young person’s best interests.</p> <p>NHS England is leading a national transformation programme that plans to significantly increase clinical capacity in children and young people’s gender incongruence services – thereby increasing more timely service provision.</p> <p>NHS England’s policy will be accompanied by improved <a href="#">MindEd guidance and psycho-education resources</a> for local services and professionals which will mitigate the potential impact for children and young people becoming more entrenched in their ill health because their expectation of receiving GnRHa has been denied. These resources include specific advice to primary and secondary care professionals in respect of co-existing concerns including self-harm.</p> <p>NHS England also proposes to provide specialist consultation advice and liaison for local services and professionals to provide early indirect support for families who are newly identified with gender concerns by local services and professionals.</p> <p>At a local level NHS England with local commissioners has improved 24/7 crisis helplines and crisis response services. These are also</p>

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	<p>described the purpose of GnRHa as providing time to the child or young person to help determine <i>whether</i> to pursue a process of sex reassignment<sup>11</sup>, and on the other hand there is evidence that nearly all children and young people who received GnRHa from the Tavistock GIDS subsequently received masculinising / feminising hormones from around age 16 years<sup>12</sup>.</p> <p><u>Impacts and Consequences</u></p> <p>GnRHA would no longer be a routinely commissioned intervention for children and young people who have this protected characteristic. Some children and young people will not be eligible to enrol in the proposed clinical study (those with later-onset gender dysphoria though this term has yet to be defined by the study team) and some who are eligible (early-onset gender dysphoria, though this term is yet to be defined by the study team) may opt to not enrol or may not meet the criteria for access that will be developed by the clinical study team in due course. Also, enrolment in a</p>	<p>supported by training resources for crisis practitioners, especially A&amp;E staff which will include specific LGBTQIA+ training resources developed by young people with lived experience.</p> <p>As a risk mitigation measure, in April 2024 NHS England will have commissioned a rapid assessment service for every child or young person on the waiting list for CYP Gender Services, through local NHS children and young people's mental health services. This will be a directly commissioned service for this cohort over-and-above existing mental health provision.</p>

<sup>11</sup> Bell and Mrs A v Tavistock and Portman NHS Foundation Trust, 2020

<sup>12</sup> Ibid

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	<p>study may prove to not be an option for any child or young person, regardless of their wishes and treatment objectives, if the study does not receive the usual approvals or is otherwise deemed to be not feasible.</p> <p>The consequences of the policy may be an increase in the number of children and young people with this protected characteristic who seek GnRHa from unregulated sources; some stakeholder groups suggest that restrictions on gender affirming interventions may lead to an increase in risk-taking behaviour particularly amongst adolescents. Other stakeholders suggest that the policy will have positive impacts given the limited evidence around aims, benefits, risks and outcomes.</p> <p>NHS England has concluded that no direct discrimination occurs.</p> <p>NHS England has also concluded that no indirect discrimination arises by virtue of the fact that the policy will exclusively impact individuals who share this protected characteristic. The fact that a policy will exclusively impact a specific group does not, in itself, render the policy discriminatory. The</p>	<p>NHS England strongly discourages children and young people sourcing GnRHa from unregulated sources or on-line providers that are not regulated by UK regulatory bodies. The approach by NHS clinicians to children and young people who source such pharmaceuticals is described in the interim service specification for gender incongruence services.</p> <p>NHS England has commissioned Health Education England to deliver on-line <a href="#">MindEd resources directed at parents and local professionals</a>, and these will provide improved psycho-educational advice to mitigate the need for and will caution about accessing GnRHa from unregulated sources (published in 2023). Greater involvement by and closer working between local secondary health services (CYPMHS and community child health and paediatrics) with specialist service consultation advice and liaison will further mitigate this potential impact.</p> <p>As a risk mitigation measure, in April 2024 NHS England will have commissioned a rapid</p>



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	<p>policy is a reasonable, rational and clinically necessary response to the findings of NICE and the Cass Review that a key limitation to identifying the effectiveness and safety of GnRHa in regard to children and young people with gender incongruence is the lack of reliable comparative studies.</p> <p><u>Children and Young People with Gender Dysphoria who Continue on GnRHa Through an NHS Prescription Within an Existing Agreed Individual Care Plan</u></p> <p>Consideration must also be given as to whether direct or indirect discrimination arises in regard to individuals who share this protected characteristic, as adoption of the policy is not planned to impact children and young people who, at the point the clinical commissioning policy takes effect have been referred into an endocrine clinic by the former NHS Gender Identity Development Service but have not yet been assessed by a consultant endocrinologist for suitability of GnRHa; or are under the clinical care of an endocrine team at University College of London Hospitals NHS Foundation Trust or Leeds Teaching Hospitals NHS Trust following a referrals by the former NHS</p>	<p>assessment service for every child or young person on the waiting list for CYP Gender Services, through local NHS children and young people's mental health services. This will be a directly commissioned service for this cohort over-and-above existing mental health provision.</p> <p><i>Criteria for enrolment in a clinical study</i></p> <p>Alongside the first proposed study, further engagement is also planned by the National Research Oversight Board to identify the key evidence gaps for children and young people with later-onset gender dysphoria – recognising that there is even greater uncertainty in terms of the supporting clinical evidence base, less established clinical practice and less known about the natural history of gender dysphoria in this group. The clinical study team has yet to define these terms.</p>

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>Gender Identity Development Service. This group will share the protected characteristic of 'gender reassignment' as a class or cohort.</p> <p>As at January 2024 there were circa 340 children and young people under the clinical care of the endocrine team at UCLH NHSFT or Leeds Teaching Hospitals NHST, of whom around 70 are forecast to be receiving GnRHa on 31 March 2024 for the purpose of puberty suppression.</p> <p>NHS England has considered whether the policy for non-routine commissioning should also apply to children and young people within this group, on the basis that GnRHa should be withheld or withdrawn because of the same concerns about the lack of evidence around aims, benefits, risks and outcomes. However, there are additional ethical and clinical considerations in cases where there is an existing expectation of consideration for treatment / continued treatment<sup>13</sup>. This is particularly so in regard to the withdrawal of GnRHa in young people</p>	

<sup>13</sup> There are similar precedents in the NHS. For example, NICE may exclude patients already being prescribed a drug from the scope of a decision that a drug should no longer be routinely available through the NHS, though these decisions are also influenced by the cost-effectiveness of the drug as assessed by NICE rather than based solely on safety grounds.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>who will experience emergence or re-emergence of secondary sexual characteristics of the natal sex and who may have presented in public throughout adolescence with their suppression. On balance, NHS England has concluded that the scope of the proposed Non-Routine Commissioning Policy will not extend to children and young people in this group, subject to the outcome of usual clinical review of the individual's existing individual care plan jointly between the individual's Lead Clinician and the young person / parents of a child under 16 years.</p> <p>NHS England has concluded that no direct discrimination occurs.</p> <p>NHS England has also concluded that no indirect discrimination arises by virtue of the fact that GnRHa will continue to be routinely commissioned for this group. The policy is a reasonable, rational and clinically necessary response to the findings of NICE and the Cass Review that there is a lack of sufficient evidence relating to the safety and clinical effectiveness of PSH for children and young people with gender incongruence / dysphoria, including about the benefits, risks</p>	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>and long-term outcomes - and there are additional ethical and clinical considerations in regard to individuals in the proposed group who will not be subject to the policy that are distinct to those relating to individuals who will be directly impacted by the policy. NHS England's findings in this regard do not compel young people / parents of children under 16 years to choose to continue with GnRHa if, after a consideration of the issues raised by the adoption of the policy, they make a decision to cease the intervention.</p> <p><u>Impact on Later Surgery</u></p> <p>Some respondents to consultation objected to the statement that the potential impacts of the policy would be alleviated by other modes of specialist clinical support being made available, and that no acknowledgement had been given to the long term impacts to individuals experiencing irreversible change which could then only be corrected by surgery as an adult (for example, breast development, Adam's apple development, deepening of voice, thickening of jawline). The point was further made that facial feminisation and tracheal shave</p>	

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	<p>surgeries are unavailable on the NHS – and that this ought to be acknowledged in the EHIA in relation to people on a low income.</p> <p>The point being made here illustrates the difficulties about describing the aims and intended results of GnRHa – and the uncertainty about the aims and intended results of GnRHa highlights the difficulties in measuring the long-term impacts to individuals for the purpose of the EHIA. While some regard the rationale for prescription as being an initial part of a transition pathway, others regard it as a ‘pause’ to allow more time for decision making - with a decision <u>not</u> to pursue a transition pathway being a potential outcome.</p> <p>It is helpful to set out in detail the advice of the independent Cass Review in this regard:</p> <p><i>For those who will go on to have a stable binary trans identity, the ability to pass in later life is paramount, and many will decide that the trade-offs of medical treatment are a price that is fully justified by the ability to live</i></p>	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p><i>confidently and comfortably in their identified gender.</i></p> <p><i>The widely understood challenge is in determining when a point of certainty about gender identity is reached in an adolescent who is in a state of developmental maturation, identity development and flux.</i></p> <p><i>It is the latter option regarding a 'pause' for decision making about which we have the least information. The rationale for use of puberty blockers at Tanner Stage 2 of development was based on data that demonstrated that children, particularly birth registered boys who had early gender incongruence, were unlikely to desist once they reached early puberty; this rationale does not necessarily apply to later presenting young people, including the predominant referral group of birth-registered girls.</i></p> <p><i>We do not fully understand the role of adolescent sex hormones in driving the development of both sexuality</i></p>	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p><i>and gender identity through the early teen years, so by extension we cannot be sure about the impact of stopping these hormone surges on psychosexual and gender maturation. We therefore have no way of knowing whether, rather than buying time to make a decision, puberty blockers may disrupt that decision-making process”.</i></p> <p>Additionally, in order to determine whether the withholding of GnRHa in adolescence leads to later surgery, NHS England would need data and evidence on the incidence of individuals who receive GnRHa in adolescence and who nonetheless choose to undergo surgical interventions in adulthood to ablate secondary sexual characteristics such as breasts or thyroid cartilage. However, NICE was unable to identify any evidence about the impact of GnRHa on the extent of later surgery (NICE evidence review, 2020) – and no material evidence was offered by respondents to consultation.</p> <p>In conclusion:</p>	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<ul style="list-style-type: none"> <li>• There is no available evidence about the long-term impacts of GnRHa in regard to the extent of later surgery</li> <li>• NHS England notes the advice of Dr Cass - that some individuals will decide that the risks of taking GnRHa are justified - and NHS England accepts that these individuals may share the view that adoption of the proposed policy may have a detrimental impact in regard to later surgery</li> <li>• But NHS England also notes Dr Cass' advice that there are uncertainties about the intended results, outcomes and effects of GnRHa (and this was also the conclusion of the NICE evidence review)</li> <li>• NHS England has concluded that no direct or indirect discrimination arises for these reasons</li> </ul> <p><u>GnRHa alongside Gender Affirming Hormones for Natal Males</u></p> <p>The administration of GnRHa to natal males as part of a Gender Affirming Hormone intervention is intended to achieve a different clinical outcome, in that Gender Affirming Hormone treatment via physiologic doses of</p>	



Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>oestrogen alone is insufficient to suppress testosterone levels into the normal range for natal females and addition of an anti-androgen is necessary. The use of an anti-androgen will continue to be available for this purpose in natal males, not before middle adolescence, who are prescribed Gender Affirming Hormones from around 16 years of age, and for natal males who are aged 17 years and above who are seen by adult Gender Dysphoria Clinics. NHS England has concluded that no direct or indirect discrimination arises because the use of GnRHa alongside Gender Affirming Hormones is not clinically indicated in natal females.</p> <p><u>Comparator Group – Children with Central Precocious Puberty</u></p> <p>Consideration must also be given as to whether direct or indirect discrimination arises in regard to individuals who share this protected characteristic, as GnRHa will continue to be routinely available through NHS protocols<sup>14</sup> for children who present</p>	

<sup>14</sup> NHS England is not the responsible commissioner of clinical interventions for children with a diagnosis of Central Precocious Puberty; this responsibility rests with Integrated Care Boards who form their own clinical commissioning policies in regard to their own populations.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>with Central Precocious Puberty (CPP)<sup>15</sup>. This is a rare disease<sup>16</sup> caused by premature reactivation of the hypothalamic-pituitary-gonadal axis, resulting in the premature development of pubertal pulsatile secretion of gonadotropins in childhood.</p> <p>GnRHa is standard of care as a response to CPP (where patients meet clinical criteria) and the clinical approach is not contested. The various available agents have been licensed for CPP in the UK<sup>17</sup> and in many other countries for over 25 years following a consideration of the outcome of a number of clinical trials<sup>18</sup>. By contrast, GnRHa is not authorised for use in gender incongruence – they are in use ‘off-label’ – there is limited evidence on treatment aims, benefits, risks and outcomes;<sup>19</sup> and the clinical approach is contested<sup>20</sup>.</p>	

<sup>15</sup> GnRHa is also licensed as a response to various cancers and endometriosis in adults – these patient groups are not regarded as appropriate comparators for the purpose of this EHIA.

<sup>16</sup> The true epidemiology of CPP is unknown. A US study estimated that CPP in the general population was between 1:5000 to 1:10,000 children; in Europe, a Danish national study reported the prevalence of CPP as 0.2% for girls and less than 0.05% for boys; Spanish and French studies showed different annual incidence of CPP in both sexes; Mucaria, 2021

<sup>17</sup> British National Formulary for Children, National Institute for Health and Care Excellence

<sup>18</sup> A drug will only be licensed for a specific indication if there is good quality evidence around treatment aims, risks, benefits and outcomes.

<sup>19</sup> Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria; National Institute for Health and Care Excellence, 2020

<sup>20</sup> Interim report of the Cass Review, 2022

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	<p>In considering whether discrimination arises, it must be understood that the aetiology and epidemiology of CPP and treatment aims are quite different to that of gender incongruence. CPP is the <i>early onset</i> of puberty and secondary sexual characteristics (generally accepted as &lt;8 years in girls and &lt;9 years in boys) and it can range in seriousness from benign to malignant variants. The cause is often unclear but it can be attributable to a number of conditions that may require specialist investigation (Central Nervous System (CNS) tumours; CNS head trauma; genetics; neurofibromatosis type-1; cerebral palsy - <i>not exhaustive</i>). GnRHa for this cohort will be considered if the child has rapidly progressing symptoms or if bone age is significantly advanced beyond birth age. The physiological aims of GnRHa as a response to CPP are to halt pubertal progression and progressive physical development and to preserve or reclaim adult height potential.</p> <p>NHS England has concluded that no direct discrimination occurs.</p>	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>NHS England has also concluded that no indirect discrimination arises by virtue of the fact that GnRHa will continue to be routinely commissioned for this appropriate comparator group. The evidence base that supports the administration of GnRHa as a response to CPP is strong and the clinical approach is not contested; the aetiology and epidemiology of CPP is quite different to that of gender incongruence, though the aetiology of gender incongruence is in itself still largely unidentified<sup>21</sup>.</p>	
<p><b>Marriage &amp; Civil Partnership:</b> people married or in a civil partnership.</p>	<p>NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposed interim service specification does not have any significant impact on individuals who may share this protected characteristic.</p>	
<p><b>Pregnancy and Maternity:</b> women before and after childbirth and who are breastfeeding.</p>	<p>NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposed interim service specification does not have any significant impact on individuals who may share this protected characteristic.</p>	

<sup>21</sup> Claahsen - van der Grinten, H., Verhaak, C., Steensma, T. *et al.* Gender incongruence and gender dysphoria in childhood and adolescence—current insights in diagnostics, management, and follow-up. *Eur J Pediatr* **180**, 1349–1357 (2021).

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<b>Race and ethnicity</b> <sup>22</sup>	<p>Table: Children and young people referred to the current commissioned service between July and December 2022<sup>23</sup></p> <table border="1" data-bbox="669 453 1294 1219"> <thead> <tr> <th colspan="3" data-bbox="669 453 1294 512"><b>GIDS: Q2 &amp; Q3 Referred Patient Ethnicities</b></th> </tr> <tr> <th data-bbox="669 512 1106 555">Ethnic Group</th> <th data-bbox="1106 512 1200 555">Count</th> <th data-bbox="1200 512 1294 555">%</th> </tr> </thead> <tbody> <tr> <td data-bbox="669 555 1106 598">Any Other Ethnicity</td> <td data-bbox="1106 555 1200 598">3</td> <td data-bbox="1200 555 1294 598">0.6%</td> </tr> <tr> <td data-bbox="669 598 1106 641">Asian or Asian British – Any Other</td> <td data-bbox="1106 598 1200 641">5</td> <td data-bbox="1200 598 1294 641">1.0%</td> </tr> <tr> <td data-bbox="669 641 1106 684">Asian or Asian British – Indian</td> <td data-bbox="1106 641 1200 684">1</td> <td data-bbox="1200 641 1294 684">0.2%</td> </tr> <tr> <td data-bbox="669 684 1106 727">Black or Black British – Caribbean</td> <td data-bbox="1106 684 1200 727">2</td> <td data-bbox="1200 684 1294 727">0.4%</td> </tr> <tr> <td data-bbox="669 727 1106 770">Mixed – Any Other Background</td> <td data-bbox="1106 727 1200 770">15</td> <td data-bbox="1200 727 1294 770">3.0%</td> </tr> <tr> <td data-bbox="669 770 1106 813">Mixed – White &amp; Asian</td> <td data-bbox="1106 770 1200 813">1</td> <td data-bbox="1200 770 1294 813">0.2%</td> </tr> <tr> <td data-bbox="669 813 1106 857">Mixed – White &amp; Black Caribbean</td> <td data-bbox="1106 813 1200 857">2</td> <td data-bbox="1200 813 1294 857">0.4%</td> </tr> <tr> <td data-bbox="669 857 1106 900">Not Known – Not Requested</td> <td data-bbox="1106 857 1200 900">1</td> <td data-bbox="1200 857 1294 900">0.2%</td> </tr> <tr> <td data-bbox="669 900 1106 943">Not Stated – Client Unable to Choose</td> <td data-bbox="1106 900 1200 943">152</td> <td data-bbox="1200 900 1294 943">30.5%</td> </tr> <tr> <td data-bbox="669 943 1106 986">Other Ethnic Group – Chinese</td> <td data-bbox="1106 943 1200 986">1</td> <td data-bbox="1200 943 1294 986">0.2%</td> </tr> <tr> <td data-bbox="669 986 1106 1029">White – Any Other Background</td> <td data-bbox="1106 986 1200 1029">11</td> <td data-bbox="1200 986 1294 1029">2.2%</td> </tr> <tr> <td data-bbox="669 1029 1106 1072">White – British</td> <td data-bbox="1106 1029 1200 1072">200</td> <td data-bbox="1200 1029 1294 1072">40.2%</td> </tr> <tr> <td data-bbox="669 1072 1106 1115">White – Mixed White</td> <td data-bbox="1106 1072 1200 1115">2</td> <td data-bbox="1200 1072 1294 1115">0.4%</td> </tr> <tr> <td data-bbox="669 1115 1106 1158">White – Polish</td> <td data-bbox="1106 1115 1200 1158">2</td> <td data-bbox="1200 1115 1294 1158">0.4%</td> </tr> <tr> <td data-bbox="669 1158 1106 1201">Blank</td> <td data-bbox="1106 1158 1200 1201">100</td> <td data-bbox="1200 1158 1294 1201">20.1%</td> </tr> <tr> <td data-bbox="669 1201 1106 1219"><b>TOTAL</b></td> <td data-bbox="1106 1201 1200 1219"><b>498</b></td> <td data-bbox="1200 1201 1294 1219"></td> </tr> </tbody> </table>	<b>GIDS: Q2 &amp; Q3 Referred Patient Ethnicities</b>			Ethnic Group	Count	%	Any Other Ethnicity	3	0.6%	Asian or Asian British – Any Other	5	1.0%	Asian or Asian British – Indian	1	0.2%	Black or Black British – Caribbean	2	0.4%	Mixed – Any Other Background	15	3.0%	Mixed – White & Asian	1	0.2%	Mixed – White & Black Caribbean	2	0.4%	Not Known – Not Requested	1	0.2%	Not Stated – Client Unable to Choose	152	30.5%	Other Ethnic Group – Chinese	1	0.2%	White – Any Other Background	11	2.2%	White – British	200	40.2%	White – Mixed White	2	0.4%	White – Polish	2	0.4%	Blank	100	20.1%	<b>TOTAL</b>	<b>498</b>		<p>There is evidence that gender diverse individuals from BAME heritage are more likely to face discrimination on the basis of their race and gender and often within their religious community as well.</p> <p>The reasons for the low numbers of people from BAME communities in the Tavistock data is not well understood.</p> <p>NHS England’s interim service specification for a new configuration of providers describes the importance of routine and consistent data collection, analysis and reporting. We expect providers to report demographic data for the purpose of continuous service improvement initiatives, including to identify whether any particular groups are experiencing barriers in access to service provision.</p> <p>At a broader level, in 2021 NHS England established the National Healthcare Inequalities Improvement Programme (HiQiP), which works</p>
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<sup>22</sup> Addressing racial inequalities is about identifying any ethnic group that experiences inequalities. Race and ethnicity includes people from any ethnic group incl. BME communities, non-English speakers, Gypsies, Roma and Travelers, migrants etc.. who experience inequalities so includes addressing the needs of BME communities but is not limited to addressing their needs, it is equally important to recognise the needs of White groups that experience inequalities. The Equality Act 2010 also prohibits discrimination on the basis of nationality and ethnic or national origins, issues related to national origin and nationality.

<sup>23</sup> Source: Data return by Tavistock and Portman NHS Foundation Trust, February 2023

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>Analysis of ethnicity data from the Tavistock and Portman NHS Foundation Trust remains challenging given the (historically) high number of individuals seen by the GIDS for whom ethnicity data was not recorded or not available (50.8% of patient records according to the above table). An analysis by NHS England of ethnicity data relating to individuals on the waiting list that is now held by NHS AGEM Commissioning Support Unit is not possible as this data was not routinely recorded by the Tavistock GIDS at the point of referral.</p> <p>Of the data available, the highest proportion of individuals are “White” which accords with previous NHS analyses of individuals accessing gender incongruence services.</p> <p>A 2022 publication<sup>24</sup> reported that the majority of young people seen at the Tavistock GIDS self-identified with a white ethnic-background (93.35%) and 6.65% identified as being from ethnic minority heritage. It concluded that service engagement was comparable between the</p>	<p>with national programmes and policy areas across NHS England, to address inequalities and ensure equitable access, excellent experience and optimal outcomes. The terms of reference for the NHS England National Programme Board for Gender Dysphoria Services (2023 – 2026, to be agreed June 2023) will include a focus on addressing and reducing health inequalities aligned with the HiQiP.</p> <p><i>Criteria for enrolment in a clinical study</i></p> <p>Alongside the first proposed study, further engagement is also planned by the National Research Oversight Board to identify the key evidence gaps for children and young people with later-onset gender dysphoria – recognising that there is even greater uncertainty in terms of the supporting clinical evidence base, less established clinical practice and less known about the natural history of gender dysphoria in this group. The clinical study team has yet to define these terms.</p>

<sup>24</sup> Manjra II, Russell I, Maninger JK, Masic U. Service user engagement by ethnicity groups at a children’s gender identity service in the UK. *Clinical Child Psychology and Psychiatry*. 2022;27(4):1091-1105.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>subgroups, while the ethnic minority sub-group was offered and attended more appointments in 2018–2019. Due to the low ethnic minority sub-group numbers, findings need to be interpreted with caution.</p> <p>We may surmise that the policy may disproportionately impact individuals who are ‘White’. NHS England concludes that the policy does not unfairly discriminate against individuals who share this protected characteristic.</p> <p>A related issue is that we know from previous data collections that, generally, there is under-representation of people from Black, Asian and Minority Ethnic heritage accessing gender dysphoria services in England. The Office for National Statistics has <a href="#">advised</a> (November 2023), following analysis of the 2021 UK census, that “<i>the trans population is not spread equally across all groups of the population [which] made up 0.3% in the White [ethnic groups] compared with 1.6% of people in the black, Black British, Black Welsh, Caribbean or African ethnic group</i>” though the report notes the possibility of that respondents whose first language is not</p>	

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	English or Welsh may not have understood the question as intended.	
<b>Religion and belief:</b> people with different religions/faiths or beliefs, or none.	There is limited available evidence on the religious attitudes of trans people in the United Kingdom, although The Trans Mental Health Study found that most people who took part stated that they had no religious beliefs (62%). A data collection exercise of adult Gender Dysphoria Clinics undertaken by NHS England in 2016 reaffirmed the findings of this study but it is unclear as to the extent to which the findings may relate to children and young people. NHS England is of the view that the policy does not significantly impact individuals who share this protected characteristic.	
<b>Sex:</b> men; women	<p>At current referral patterns 69% of referrals to the current commissioned service at Tavistock GIDS are of natal females and 31% are of natal males<sup>25</sup>.</p> <p>This data accords with figures published by the Cass Review in March 2022 that show a trend since 2011 in which the number of natal females is higher than the number of natal</p>	<p>The terms of reference for the Cass Review include “<i>exploration of the reasons for the increase in referrals and why the increase has disproportionately been of natal females, and the implications of these matters</i>”.</p> <p>NHS England’s proposed interim service specification for a new configuration of providers describes the importance of building research</p>

<sup>25</sup> Source: Data return by Tavistock and Portman NHS Foundation Trust, February 2023



Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>males being referred. Prior to that the split in the caseload was roughly even between natal girls and natal boys, but by 2019 the split had changed so that 76% per cent of referrals were natal females. That change in the proportion of natal girls to boys is reflected in the statistics from the Netherlands (Brik et al “<i>Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria</i>” 2018).</p> <p>The policy may disproportionately impact individuals who are natal female based on this data. NHS England has concluded that no direct or indirect discrimination arises. The policy is a reasonable, rational and clinically necessary response to the findings of NICE and the Cass Review that a key limitation to identifying the effectiveness and safety of GnRHa in regard to children and young people with gender incongruence is the lack of reliable comparative studies.</p> <p>The independent report on the analysis of responses to NHS England’s separate public consultation on a proposed interim service specification for gender incongruence services for children and young people</p>	<p>capabilities for the purpose of continuous quality improvement initiatives. Also, in 2019 the Government Equalities Office announced that it would commission new research to explore the nature of adolescent gender identity and transitioning to better understand the issues behind the increasing trend of referrals of adolescents to NHS gender dysphoria service. Working with the new configuration of service providers and academic partners, NHSE will consider how to use the outcome of this research to inform its future approach to the commissioning of these services.</p> <p><i>Criteria for enrolment in a clinical study</i></p> <p>Alongside the first proposed study, further engagement is also planned by the National Research Oversight Board to identify the key evidence gaps for children and young people with later-onset gender dysphoria – recognising that there is even greater uncertainty in terms of the supporting clinical evidence base, less established clinical practice and less known about the natural history of gender dysphoria in this group. The clinical study team has yet to define these terms.</p>

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>(2023) reads: <i>“Some Group B respondents felt that the EHIA could have more thoroughly addressed the potential impact on those with the protected characteristic of sex – particularly the impacts on girls who, as recent statistics showed, were now much more likely to seek treatment from gender dysphoria services than boys. NHS England was encouraged to investigate and publicise the degree to which possible causations such as internalised homophobia, exposure to social media, trauma, bullying, difficulties in navigating bodily changes at puberty, experiencing sexual objectification, familial and social situations and social contagion had played a part in this trend”.</i></p> <p>Separately, the independent report on the analysis of responses to NHS England’s separate public consultation on the policy for Puberty Suppressing (2024) reads that some respondents to public consultation had suggested that the EHIA had not sufficiently reflected on how the withdrawal of GnRHa from the NHS pathway of care would differently and negatively impact natal males going through undesired puberty, for</p>	<p>The policy position has been proposed because there is a lack of sufficient evidence relating to the safety and clinical effectiveness of PSH for children and young people with gender incongruence / dysphoria, including about the benefits, risks and long-term outcomes. It is therefore proposed that adoption of the policy would in itself be a risk mitigation measure. Other forms of specialist clinical support will remain available through the NHS for this patient cohort; the NHS England interim service specification for</p>

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	example, in the development of an Adam's apple or the deepening of the voice.	gender incongruence (June 2023) describes a multi-disciplinary approach to care that focuses on psychosocial and psychological approaches, and psychoeducation.
<b>Sexual orientation:</b> Lesbian; Gay; Bisexual; Heterosexual.	NHS England does not hold data on the sexual orientation of individuals who are referred to or seen by the NHS commissioned service. The <a href="#">website</a> of the GIDS at the Tavistock and Portman NHS Foundation Trust describes the challenges in collecting this information from children and it reads: <i>"In our most recent statistics (2015), of the young people seen in our service who were assigned male at birth and for whom we have data, around 30% were attracted to males, 30% to females, and 30% to both males and females (or other genders). The remaining approximately 10% of those for whom we have data described themselves as not being attracted to either males or females, or as asexual. For young people assigned female at birth for whom we have data: over half were attracted to females, a quarter were attracted to males, just under 20% were to both males and females (or other genders), and a small percentage described themselves as asexual or as not being attracted to either males or females"</i> .	NHS England's proposed interim service specification for a new configuration of providers describes the importance of routine and consistent data collection, analysis and reporting. We expect providers to report demographic data for the purpose of continuous service improvement initiatives, including to identify whether any particular groups are experiencing barriers in access to service provision. NHS England's proposed interim service specification also describes the importance of building research capabilities for the purpose of continuous quality improvement initiatives. Working with the new configuration of service providers and academic partners, NHSE will consider how to use the outcome of this research to inform its future approach to the commissioning of these services.  The Cass Review has said that in forming further advice to NHS England it is considering further the complex interaction between sexuality and gender identity, and societal responses to both – the Review's Interim Report (2022) cited the example of <i>"young lesbians who felt pressured to identify as transgender male, and conversely transgender</i>

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact																																										
	<p>A large UK-wide study in 2012 (Trans Mental Health Study) reported the following:</p> <table border="1" data-bbox="667 411 1272 1070"> <thead> <tr> <th>Sexual Orientation</th> <th>N</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Bisexual</td> <td>145</td> <td>27%</td> </tr> <tr> <td>Queer</td> <td>126</td> <td>24%</td> </tr> <tr> <td>Straight or heterosexual</td> <td>104</td> <td>20%</td> </tr> <tr> <td>Pansexual</td> <td>79</td> <td>15%</td> </tr> <tr> <td>BDSM/Kink</td> <td>73</td> <td>14%</td> </tr> <tr> <td>Lesbian</td> <td>69</td> <td>13%</td> </tr> <tr> <td>Not sure or questioning</td> <td>64</td> <td>12%</td> </tr> <tr> <td>Other</td> <td>59</td> <td>11%</td> </tr> <tr> <td>Don't define</td> <td>55</td> <td>10%</td> </tr> <tr> <td>Gay</td> <td>51</td> <td>10%</td> </tr> <tr> <td>Polyamorous</td> <td>46</td> <td>9%</td> </tr> <tr> <td>Asexual</td> <td>41</td> <td>8%</td> </tr> <tr> <td><b>Total</b></td> <td><b>912</b></td> <td></td> </tr> </tbody> </table> <p>The 2021 census reported that 89.4% of the UK population (16+years) identified as straight or heterosexual, which is a marked variation to the findings of the above survey in 2012 (20%). It is unclear as to the extent to which these data can be extrapolated for the purpose of this EHIA, but it may be reasonable to surmise that there is likely to</p>	Sexual Orientation	N	Percentage	Bisexual	145	27%	Queer	126	24%	Straight or heterosexual	104	20%	Pansexual	79	15%	BDSM/Kink	73	14%	Lesbian	69	13%	Not sure or questioning	64	12%	Other	59	11%	Don't define	55	10%	Gay	51	10%	Polyamorous	46	9%	Asexual	41	8%	<b>Total</b>	<b>912</b>		<p><i>males who felt pressured to come out as lesbian rather than transgender</i>".</p> <p><i>Criteria for enrolment in a clinical study</i></p> <p>Alongside the first proposed study, further engagement is also planned by the National Research Oversight Board to identify the key evidence gaps for children and young people with later-onset gender dysphoria – recognising that there is even greater uncertainty in terms of the supporting clinical evidence base, less established clinical practice and less known about the natural history of gender dysphoria in this group. The clinical study team has yet to define these terms.</p>
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	<p>be a lower percentage of children and young people who are referred to a gender incongruence service who identify / will identify as straight or heterosexual than for the general population.</p> <p>NHS England has concluded that there is insufficient evidence to determine if a particular group or cohort will be disproportionately impacted by the policy.</p> <p>The independent report on the analysis of responses to NHS England’s separate public consultation on a proposed interim service specification for gender incongruence services for children and young people (2023) reads that some respondents believed that: <i>“the protected characteristic of sexual orientation had not been sufficiently addressed in the Equalities and Health Inequalities Impact Assessment due to their belief that gender dysphoria services have disproportionately impacted on homosexual or bisexual children and young people in the past”</i>.</p>	

## 5. Main potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). Please state **N/A** if your policy will not impact on patients who experience health inequalities.

Groups who face health inequalities <sup>26</sup>	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
<b>Looked after children and young people</b>	There is an over-representation percentage wise (compared to the national percentage) of looked after children seen by services for children and young people with gender incongruence <sup>27</sup> .	<p>NHS England’s interim service specification for Children and Young People’s Gender Services (2023) recognises that a significant number of children and young people with very complex needs may also be <i>Looked After</i> or may not live with their birth family and may require the active involvement from children’s social care and/or expert social work advice alongside support from the specialist service.</p> <p>As a risk mitigation measure, in April 2024 NHS England will have commissioned a rapid assessment service for every child or young person on the waiting list for CYP Gender Services, through local NHS children and young people’s mental health services. This will be a directly commissioned service for this cohort over-and-above existing mental health provision.</p>
<b>Carers of patients:</b> unpaid, family members.	Families and carers of the children and young people who are directly affected by	In mitigation of any adverse impacts NHSE will ensure clear communications directly to the families

<sup>26</sup> Please note many groups who share protected characteristics have also been identified as facing health inequalities.

<sup>27</sup> Interim report of the Cass Review, 2022

Groups who face health inequalities <sup>26</sup>	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	the policy, in terms of the impact to their overall wellbeing	and carers and to sign post them to additional support services if this is needed.
<p><b>Homeless people.</b> People on the street; staying temporarily with friends /family; in hostels or B&amp;Bs.</p>	<p>The charity <i>akt</i> reports that 24% of homeless people identify as “LGBT” but we do not have specific data on the prevalence of children 16 years and under who are homeless and who present with gender incongruence. A decision that GnRHa will not be routinely commissioned by the NHS will not have any specific impact on this group. Separately, if a clinical study is determined to be feasible, it will be for the National Research Oversight Board to define access criteria into such a study and to consider the equalities implications of the access criteria.</p> <p>NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the policy does not discriminate against this group; and that the policy will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.</p>	

Groups who face health inequalities <sup>26</sup>	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
<b>People involved in the criminal justice system:</b> offenders in prison/on probation, ex-offenders.	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the policy does not discriminate against this group; and that the policy will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	
<b>People with addictions and/or substance misuse issues</b>	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the policy does not discriminate against this group; and that the policy will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	
<b>People or families on a low income</b>	Some respondents to consultation invited NHS England to accept that inequity may arise as a consequence of adoption of the policy in that lower-income families will be disadvantaged by not being able to afford to source GnRHa from private clinics. NHS England cannot share that view because it is not able to support the sourcing of GnRHa from any source outside of the NHS because of a lack of sufficient evidence relating to the safety	NHS England has commissioned Health Education England to deliver on-line <a href="#">MindEd resources directed at parents and local professionals</a> , and these will provide improved psycho-educational advice to mitigate the need for and will caution about accessing GnRHa from unregulated sources (published in 2023). Greater involvement by and closer working between local secondary health services (CYPMHS and community child health and paediatrics) with specialist service consultation



Groups who face health inequalities <sup>26</sup>	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>and clinical effectiveness of GnRHa for children and young people with gender incongruence / dysphoria, including about the benefits, risks and long-term outcomes. It is therefore proposed that adoption of the policy would in itself be a risk mitigation measure. Moreover, NHS England is not aware of any <b>regulated</b> source of GnRHa for children and young people with gender incongruence / dysphoria outside of the NHS, hence NHS England's position being the following, regardless of the socio-economic status of the individual child or young person (source: NHS England's Interim Service Specification for CYP Gender Services, 2023).</p> <p><i>NHS England strongly discourages the sourcing of any medication from unregulated providers and unregulated sources such as the internet.</i></p> <p>NHS England is therefore of the view that the policy does not discriminate against this group.</p>	<p>advice and liaison will further mitigate this potential impact.</p>

Groups who face health inequalities <sup>26</sup>	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
<p><b>People with poor literacy or health Literacy:</b> (e.g. poor understanding of health services poor language skills).</p>	<p>There is evidence that there are lower levels of health literacy in communities that are socially and economically disadvantaged. NHS England is of the view that the policy does not discriminate against this group; and that the policy will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group. NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the policy does not discriminate against this group; and that the policy will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.</p> <p>See also: <i>People or Families on a Low Income</i> (above).</p>	
<p><b>People living in deprived areas</b></p>	<p>Some respondents to consultation suggested that children and young people from low-income homes would be discriminated against because they would not be able to utilise treatments from private clinics available to those from more affluent families. NHS England has responded in its consultation report by explaining that were the policy adopted,</p>	

Groups who face health inequalities <sup>26</sup>	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	<p>the NHS would discourage all individuals from sourcing GnRHa from unregulated private clinics.</p> <p>NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the policy does not discriminate against this group; and that the policy will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.</p> <p><i>See also: People or Families on a Low Income (above).</i></p>	
<p><b>People living in remote, rural and island locations</b></p>	<p>NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the policy does not discriminate against this group; and that the policy will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.</p>	
<p><b>Refugees, asylum seekers or those experiencing modern slavery</b></p>	<p>NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the policy does not discriminate against this group; and that</p>	

Groups who face health inequalities <sup>26</sup>	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	the policy will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	
Other groups experiencing health inequalities (please describe)		

## 6. Engagement and consultation

a. Have any key engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	No	Do Not Know
Proposed policy was subject to separate processes of stakeholder engagement and public consultation in 2023; the draft EHIA was published for engagement and consultation.		

## 7. What key sources of evidence have informed your impact assessment and are there key gaps in the evidence?

Evidence Type	Key sources of available evidence	Key gaps in evidence
Published evidence	<p>NICE evidence review 2020, and refresh in 2023</p> <p>Various published research, as identified elsewhere in this EHIA</p>	<p>The NICE evidence review confirms that there is limited evidence.</p> <p><i>Criteria for enrolment in a clinical study</i></p> <p>Alongside the first proposed study, further engagement is also planned by the National</p>

Evidence Type	Key sources of available evidence	Key gaps in evidence
	<p>Review of evidence identified by respondents to public consultation</p> <p>Review of evidence relied upon by World Professional Association for Transgender Health (Chapter 12, Standards of Care v8, 2023)</p>	<p>Research Oversight Board to identify the key evidence gaps for children and young people with later-onset gender dysphoria – recognising that there is even greater uncertainty in terms of the supporting clinical evidence base, less established clinical practice and less known about the natural history of gender dysphoria in this group. The clinical study team has yet to define these terms.</p>
<b>Consultation and involvement findings</b>	<p>Outcome of public consultation that was held by NHS England in 2023; review of evidence identified by respondents to public consultation</p>	<p>No material evidence was identified</p>
<b>Research</b>	<p>Interim advice from the Cass Review, 2022 and 2023</p>	<p>Potential benefits, potential risks, intended outcomes and efficacy of GnRHa</p>
<b>Participant or expert knowledge</b> For example, expertise within the team or expertise drawn on external to your team	<p>The EHIA responds to points that have been made by members of NHS England's Programme Board for Gender Dysphoria Services</p>	

**8. Is your assessment that your proposal will support compliance with the Public Sector Equality Duty?** Please add an x to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			
The proposal may support?	X	X	X

Uncertain whether the proposal will support?			
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**9. Is your assessment that your proposal will support reducing health inequalities faced by patients?** Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		X
The proposal may support?	X	
Uncertain if the proposal will support?		

**10. Outstanding key issues/questions that may require further consultation, research or additional evidence.** Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1	Potential benefits, potential risks, intended outcomes and efficacy of GnRHa	In 2022 the independent Cass Review advised that consideration is given to the rapid establishment of the necessary research infrastructure to prospectively enrol young people being considered for GnRHa into a formal research programme with adequate follow up into adulthood. NHS England accepted that advice and incorporated wording to that effect in the proposed interim service specification for children and young people's gender incongruence services that was subject to public consultation in 2022. NHS England has appointed a Clinical Trials Unit to develop the research protocol, including eligibility criteria, overseen by a newly established National Research Oversight Programme Board.
2	Potential benefits, potential risks, intended outcomes and efficacy of Gender Affirming Hormones	The independent Cass Review is expected to deliver final advice in March 2024 which may include advice on GAH.

**11. Summary assessment of this EHIA findings**

The policy will exclusively impact children and young people who are likely to share the protected characteristics of 'age' and 'gender reassignment'. The fact that a policy is likely to exclusively impact a specific group does not, in itself, render the policy discriminatory. NHS England has concluded that no direct or indirect discrimination arises. The policy is a reasonable, rational and clinically necessary response to the findings of NICE and the Cass Review that there is a lack of sufficient evidence relating to the safety and clinical effectiveness of GnRHa for children and young people with gender incongruence / dysphoria, including about the benefits, risks and long-term outcomes. It is therefore proposed that adoption of the policy would in itself be a risk mitigation measure. NHS England is cognisant of the potential impacts and consequences as detailed in this EHIA and through a process of public consultation it has sought views on the impacts, consequences and proposed mitigations through, and subsequent to, public consultation before making a final decision on whether to enact the policy.