

Primary care information

Prescribing for people who access Gender Identity Services (GIS)

NHS England is the direct commissioner of specialised gender identity services for individuals with a diagnosis of gender dysphoria.¹

Despite the absence of a national or locally agreed pathway from specialist to primary care for patients seen by NHS Gender Identity Services, there remains an expectation from these services that GPs will prescribe and monitor hormones in line with their recommendations. NHS Frimley does not have a Gender Identity Service within its footprint and lacks system experience to locally agree shared care arrangements to support good governance and safety.

Evidence: The Cass Review² highlighted that a considerable amount of research in this field has been published, the strengths and weaknesses of which are often misrepresented and overstated, both in scientific publications and social debate. Despite the longstanding use of masculinising / feminising hormones in the adults, the lack of long-term follow-up data on those starting treatment at an earlier age means there is inadequate information about the range of outcomes for this group. The Cass Report showed that inconsistent results were found for height/growth, bone health and cardiometabolic health. Evidence relating to gender dysphoria, body satisfaction, psychosocial and cognitive outcomes was insufficient to draw clear conclusions. No study assessed fertility in birth-registered females. Research on psychosocial interventions and longer-term outcomes of those who do not access endocrine pathways is as weak as research on endocrine treatment, leaving a gap regarding how best to support young people.

The British Medical Association guidance for GPs “*Managing patients with gender dysphoria*”³ explains the role of GPs managing patients with gender identity problems, including questions relating to patient records, confidentiality, bridging prescriptions and prescribing and monitoring responsibilities. This guidance aims to explain what should be provided in primary care and to highlight some of the underpinning ethical and legal considerations.

Professional behaviour, personal values and beliefs: Healthcare professionals must provide compassionate, inclusive and person-centred care, within the current relevant legal and regulatory context. It’s essential that all patients have access to appropriate, high-quality and respectful healthcare, where all interactions are non-judgemental, inclusive and free from discrimination or bias.

Professional judgement: Healthcare professionals should take a holistic view of the person’s individual needs, including any mental health or neurodevelopment issues that may impact on

¹ [service-specification-gender-dysphoria-services-non-surgical-oct-2022.pdf \(england.nhs.uk\)](#)

² [CassReview_Final.pdf](#)

³ [Gender incongruence in primary care \(bma.org.uk\)](#)

gender-related distress and must be competent to prescribe, working within their scope of practice.

Safeguarding: Healthcare professionals should be aware of the complex ways that safeguarding issues may be present, adhering to the principles of safeguarding and risk management to support vulnerable or at risk patients.

Safeguarding young people: Appropriate action should be taken for any children, young people or families identified who may be vulnerable, or at risk. The young person's gender identity may be consciously or unconsciously influenced and not necessarily the young person's sense of self. Young people need to be free to speak openly about any concerns, without the worry that they would be prevented from accessing the care they need. Sources of risk in this group include transphobic bullying, breakdown in relationships with families, online grooming or harm and cultural or religious pressure.

Safeguarding procedures may be necessary regardless of the endeavours and best intentions of family or carers in reducing risk of harm. Safeguarding protocols should be initiated immediately where the person is at risk of immediate, serious harm. Where there are concerns, the Frimley ICB Safeguarding Team may be contacted if further discussion would be helpful. Safeguarding: Frimleyicb.safeguarding@nhs.net or 01252 335161.

Age-appropriate prescribing

Primary care may direct young people and their families to local mental health resources available on the Frimley healthier together website.⁴ For more details about gender incongruence and dysphoria services for young people under 18 years, please see Frimley ICB document <https://www.frimley.icb.nhs.uk/policies-and-documents/medicines-optimisation/prescribing-guidelines-1/gender-identity/2768-primary-care-information-children-and-young-people-with-gender-incongruence-or-dysphoria/file>

Dr Cass advocates young patients are holistically treated at the same time as the gender incongruence because for those for whom a medical pathway is clinically indicated, it is not enough to provide this without also addressing wider mental health and/or psychosocially challenging problems. For young people, psychological therapy is to help them into the most robust state of mental health to go through medical transition, if that is what they want, rather than making decisions in a state of mental distress.

The NHS stopped the routine prescription of puberty blocker treatments to under-18s following publication of the Cass Review into gender identity services and are now only available under a research protocol within specialist services. The eligibility of individuals taking puberty blockers outside the study may be affected.

⁴ [Your Local Mental Health Resources :: Frimley Healthier Together \(frimley-healthiertogether.nhs.uk\)](https://www.frimley.icb.nhs.uk/policies-and-documents/medicines-optimisation/prescribing-guidelines-1/gender-identity/2768-primary-care-information-children-and-young-people-with-gender-incongruence-or-dysphoria/file)

New regulations⁵ restrict the **prescribing and supply** of puberty-suppressing hormones to children and young people under 18 and will apply to prescriptions written by UK private prescribers and prescribers registered in the European Economic Area (EEA) or Switzerland. The new arrangements apply to new prescriptions for gonadotropin-releasing hormone analogues - medicines that consist of, or contain, buserelin, gonadorelin, goserelin, leuprorelin acetate, nafarelin, or triptorelin. They will remain available for patients receiving the drugs for other uses, from a UK-registered prescriber.

Primary care prescribers must not accept a request to prescribe puberty suppressing hormone treatment or masculinising / feminising hormones to a young person under the age of 18 years. If a practice receives a request to prescribe for a young person under 18 years, please contact a member of the Frimley ICB Medicines Optimisation Team (frimleyicb.prescribing@nhs.net).

A number of young people have felt the need to seek private care whilst on the NHS waiting list. This may involve families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet with the ongoing trauma of prolonged waits for assessment. Children, young people and their families should be strongly discouraged from sourcing puberty suppressing or gender affirming hormones from unregulated sources or from on-line providers.

Any clinician who ascertains that a young person is being given drugs from an unregulated source should make the young person and their family aware of the risks of such treatment. It would also be important to explore what regulatory bodies may need to be informed if healthcare professionals registered with a UK professional body are prescribing or dispensing medication contrary to NHS protocols.

Young people aged between 17-25yr

As a consequence of long wait times, around 2,000 16-year-olds have been sent to adult services before they have been seen. This increases waiting lists for adult services and disadvantages older adults seeking NHS support. Because brain maturation and remodelling is now known to continue into the mid 20's, the Cass Review suggests consideration should be given to reaching a point of maturity before taking a decision, calling for unhurried, holistic, therapeutic support. The Review recommends that NHS England should ensure that each Regional Centre has a follow-through service for 17–25-year-olds to ensure continuity of care and support at a potentially vulnerable stage in their journey.

NHS adult patients

- NHS clinics will need to comply with relevant UK and national regulatory and professional guidance and will be CQC registered. This does not remove the prescriber's responsibility to satisfy themselves that the prescribing recommendation is appropriate for the patient.

⁵ [New restrictions on puberty blockers - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

The NHS London clinic for young people was closed due to clinical concerns and was the impetus for the Cass Review.

- NHS England's Specialised Services Circular SSC1620⁶ 'Primary Care Responsibilities in Prescribing and Monitoring Hormone Therapy for Transgender and Non-Binary Adults' states that GPs are encouraged to collaborate with GICs in the initiation and ongoing prescribing of hormone therapy.
- NHS England recommends that all requests to prescribe should be considered on a case-by-case basis and GPs should approach shared care and collaboration with gender identity specialists in the same way as they would any other specialist.

Clinical appropriateness - principles of prescribing

- **Have you taken account of relevant national and local policies, regulatory standards and guidance?**

When prescribing at the recommendation of a colleague, you must be satisfied that the prescription is needed, appropriate for the patient and within the limits of your competence. The General Medical Council (GMC)⁷ states that in order to inform the joint decision-making process "the clinician must make an assessment of the patient's health and be satisfied that any medicine or treatment they offer is clinically indicated (i.e. that in their reasonable professional judgement, a medical procedure or treatment is suitable and useful to reach a specific therapeutic goal with a certain probability)".

GMC guidance makes it clear that doctors are responsible for any prescriptions they provide and accountable for their decisions and actions when supplying or administering medicines, irrespective of the qualifications of the person making the recommendation.

- **Have you taken account of the evidence that informed the work of the Cass Review and the review's findings about the 'lack of high-quality evidence' in this area? Has this been shared with your patient?**
- **Is the prescription clinically appropriate for your patient?**
Drugs and other treatment should only be prescribed when a clinician has adequate knowledge of a patient's health and satisfied that the treatment serves the patient's needs. Has a holistic view of the person's individual needs been taken, including any mental health or neurodevelopment issues that may impact on gender-related distress? With the information supplied, is the treatment appropriate for the patient and within the limits of your competence? The clinician should question any recommendation which is considered unsafe.

Montgomery and informed consent⁸. Doctors are under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment,

⁶ [Specialised Services Circular NHS England](#)

⁷ [prescribing-guidance-updated-english-20210405_pdf-85260533.pdf \(gmc-uk.org\)](#)

⁸ [Montgomery and informed consent - The MDU](#)

to which a reasonable person in the patient's position would attach significance, and of any reasonable alternative or variant treatments. In its guidance “*Decision making and consent*” (2020), the GMC⁹ advises that doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action. The uncertainty of outcomes makes provision of sound information and properly informed consent very challenging in these situations, as noted by Dr Cass, as shown by a recent example¹⁰.

Shared care agreements (SCA) – NHS patients

Shared care guidelines/ agreements are formal local NHS agreements that enable GPs to accept responsibility for the safe prescribing and monitoring of specialist medicines where the patient’s care is shared between secondary/tertiary care and primary care. They are specific between the trust and GP practice and have been through the local governance processes. Our agreed shared care protocols can be found on the Frimley ICB website¹¹.

GPs should approach shared care and collaboration with gender identity specialists in the same way as they would any other specialist. GMC guidance¹² relating to shared care states that if you prescribe based on the recommendation of another doctor, nurse or other healthcare professional, you must be satisfied that the prescription is needed, appropriate for the patient and within the limits of your competence. Prescribers should take account of the principles which underpin shared care as set out by the GMC¹³. Considering this, the doctor and practice must only participate in a SCA if they have the competence and safe infrastructure to prescribe and fulfil their responsibilities within the SCA.

GPs are under no obligation to participate in a shared care agreement. The presence of a shared care arrangement does not mean that a practitioner must agree to taking part and should only prescribe if it is safe to do so. If the GP decides not to participate, the clinical responsibility for the patient remains with the specialist service. The GMC is very specific about shared care, in that all three parties (specialist, GP and patient) need to agree for it to take place.

Declining to take part in a shared care arrangement - there should be a justifiable reason

- 1. Lack of knowledge:** GMC Good Medical Practice requires doctors to be competent. The GMC would expect you to address this learning need. If a practitioner or practice is not able to do this, it should be justifiable as to the reasons why and should fall outside of what would be expected of a competent GP. As stated by the GMC¹⁴ if you are uncertain about your competence to take responsibility for the patient’s continuing care, you should ask for further information or advice from the clinician who is sharing care responsibilities or from another experienced colleague. If you are still not satisfied, you should explain this to the

⁹ [Decision making and consent - professional standards - GMC \(gmc-uk.org\)](https://www.gmc-uk.org/good_medical_practice/guidance/decision_making_and_consent)

¹⁰ [Transgender men getting 'postmenopausal' problems aged 28, study reveals \(telegraph.co.uk\)](https://www.telegraph.co.uk/health/2023/07/28/transgender-men-getting-postmenopausal-problems-aged-28-study-reveals/)

¹¹ [NHS Frimley - Medicines Optimisation documents \(icb.nhs.uk\)](https://www.icb.nhs.uk/medicines-optimisation)

¹² [Shared care - professional standards - GMC \(gmc-uk.org\)](https://www.gmc-uk.org/good_medical_practice/guidance/shared_care)

¹³ [prescribing-guidance-updated-english-20210405_pdf-85260533.pdf \(gmc-uk.org\)](https://www.gmc-uk.org/good_medical_practice/guidance/prescribing_guidance_updated_english_20210405_pdf_85260533.pdf)

¹⁴ [Good practice in prescribing and managing medicines and devices - professional standards - GMC \(gmc-uk.org\)](https://www.gmc-uk.org/good_medical_practice/guidance/good_practice_in_prescribing_and_managing_medicines_and_devices)

other clinician and to the patient and make appropriate arrangements for their continuing care.

Many primary and secondary care clinicians have concerns about their capacity and competence to work with this population and some are fearful of doing so given the surrounding social debate. NHS England intend to commission a professional training curriculum and competencies framework for staff working in the new gender services, but also for clinicians working in secondary care, primary and community care. Until then, online training¹⁵ is available for healthcare and education professionals dealing with people under 18 years, providing advice in undertaking such a consultation. RCGP training is currently under review.

2. **Safety:** A practice can decline to take part on safety grounds¹⁶. The GMC state that doctors have a duty to act on safety concerns. If due to system pressures, a practice is unable to implement a system to properly monitor patients on a shared care pathway and/or cannot be confident that the provider recommending medications can fulfil their responsibilities of the shared care guidance, then they have the right not to agree to take part in the process on the grounds of safety.
3. **Clinically appropriate treatment:** If prescribers are unable to reassure themselves that the medication is needed and appropriate for the patient and the specialist requesting the shared care pathway has been unable to provide appropriate clarification.

If a request to prescribe via a shared care arrangement is declined, the practice should inform the referring clinician of the outcome and that prescribing responsibility continues with them, see **Appendix A** for example of a standard response letter.

Agreeing to prescribe: For GPs accepting prescribing responsibility via an NHS shared care, the document should outline the roles and responsibilities of the specialists, GPs and clients and provide a phone number or email address where the primary care prescriber can obtain specialist advice if required. It is imperative that clients who take the preparations under medical supervision are monitored as recommended. We recommend a documented annual review where the prescriber should:

- Review prescribing and results from monitoring.
- Check that the person remains in touch with their specialist, as per shared care recommendations. Prescribers may wish to return prescribing to the specialist if this contact is recommended but ceased.
- Good quality data regarding long term clinical and psychological effects of “off label” prescribing of licensed medicines is sparse. Discuss benefits vs risks of treatment regarding long term use, particularly the lack of high quality evidence with respect to psychological

¹⁵ [Supporting CAYP with gender questions MindEd NHS England](#)

¹⁶ [Londonwide LMCs](#)

outcomes and clinical outcomes such as effects on fertility, cancer, endocrine or cardiovascular disease in the future.

- Highlight the importance of national screening / testing / advice linked to biological gender such as breast screening, measurement of PSA, cervical smears etc as appropriate. The annotation of records may need to be discussed.
- If appropriate, signpost to voluntary sector support or NHS local mental health support.

Bridging prescriptions: As a harm-reduction measure, the Royal College of Psychiatrists has suggested that GPs may prescribe a bridging prescription to cover the patient's care until they are able to access specialist services.

Due to long clinic waits, GPs are sometimes asked to initiate, monitor and titrate hormones for patients with gender incongruence before specialist involvement. NHS England's guidance¹⁷ states that when clinical responsibility for prescribing is transferred to general practice, it is important that the GP is confident and competent to prescribe the necessary medicines in order to provide the most appropriate level of care to the patient.

The GMC advises in their ethical hub¹⁸ (not intended to replace formal guidance) that GPs should **only consider** a bridging prescription for an individual patient when they meet all the following criteria:

- a) the patient is already self-prescribing or seems highly likely to self-prescribe with from an unregulated source (over the internet or otherwise on the black market);
- b) the bridging prescription is intended to mitigate a risk of self-harm or suicide; and
- c) the doctor has sought the advice of an experienced gender specialist and prescribes the lowest acceptable dose in the circumstances.

While a patient is waiting for a specialist assessment, GPs should attend to their patient's general mental and physical health needs in the same way as they would for other patients but are not obliged to prescribe bridging prescriptions.

Requests to prescribe following a private consultation¹⁹: It is recommended that all requests to prescribe from private providers are assessed using the same criteria to avoid bias.

Have you taken active steps of assurance that the person making the prescribing recommendation, including those from overseas, has sufficient expertise to assess and diagnose gender incongruence or dysphoria and is complying with relevant UK regulatory and professional guidance?²⁰ . Has the private clinic considered and treated any co existing conditions such as depression, anxiety or neurodiversity? **See Appendix B**

¹⁷ [NHS England » Responsibility for prescribing between primary and secondary/tertiary care](#)

¹⁸ [Trans healthcare - ethical topic - GMC \(gmc-uk.org\)](#)

¹⁹ [General practice responsibility in responding to private healthcare \(bma.org.uk\)](#)

²⁰ [service-specification-gender-dysphoria-services-non-surgical-oct-2022.pdf \(england.nhs.uk\)](#)

Is the private clinic CQC registered (overseas clinic will not be). Note: The CQCs decision to register/license the Gender Plus Hormone Clinic (private service predominantly aimed at the 16-25 age group and will prescribe hormones from the age of 16) is under legal challenge. Many staff from the “old” NHS service have moved here.

Having assessed the quality and governance of the private service, are you prepared to accept their shared care arrangement?

Shared Care is set up as an NHS service, and entering into a shared care arrangement may have implications around governance and quality assurance. It is recommended that practices do not enter into a private shared care agreement If you are not satisfied that the person making the recommendations has the qualifications, experience, knowledge and skills. All shared care arrangements are voluntary, so even where agreements are in place, practices can decline shared care requests on clinical and capacity grounds.²¹

Monitoring following a private consultation

Many gender clinics only “see” patients virtually, therefore request that monitoring, including blood tests should be undertaken in primary care. If practices receive requests from private providers to arrange tests or investigations, complying with such requests - regardless of the GP’s management and treatment of the patient - is outside the scope of NHS primary medical services. If the GP considers the proposed investigations to be clinically appropriate, is competent to both interpret them and manage the care of the patient accordingly, then the GP may proceed with arranging the tests or investigations. However, if the GP does not have the knowledge or capacity to undertake these actions, they should decline to organise the investigation and advise the patient and the provider that the services do not fall within NHS primary medical services and to make alternative arrangements.

Patients can transfer their care from private to NHS as per the NHS Constitution. Thus, if a patient would normally receive follow up in general practice following specialist treatment, they should receive this if they transfer from private care, whether in the UK or not. However, if follow up is of a specialist nature, or not within normal general practice remit, the patient should be referred to the appropriate service in the UK for this follow up. NHS England will normally only fund the treatment of a patient who has transferred from a private clinic where their NHS clinician is content the treatment is clinically indicated.

Preventative healthcare and screening

Access to biological specific screening programmes (such as cervical smears, breast screening, abdominal aortic aneurysm screening or prostate examinations) should be discussed with the patient. Doctors should work with patients to ensure that they understand the screening procedures available depending on their individual situation. This may also include providing access to information on how patients may opt out of gender-specific screening calls. Further information and guidance on NHS population screening for trans and

²¹ [General practice responsibility in responding to private healthcare \(bma.org.uk\)](https://www.bma.org.uk)

non-binary people can be found here²². Sheffield Health and Social Care has also produced a helpful leaflet.²³

Cervical screening opt-in process for transgender and non-binary people. An opt-in process for transgender and non-binary people to receive automatic routine invitations is available. GP practice managers and screening providers, including sexual health clinics and transgender services, should now begin to identify and invite eligible participants for a consultation to discuss the opt-in. A guide outlining the process to be followed and a recording of the recent NHS England webinar which describes the opt-in can be accessed on [FutureNHS](#) (login required).

Referrals

Phase 1 service providers will take over clinical responsibility for seeing children and young people on the national waiting list, as well as providing continuity of care for the GIDS open caseload at the point of transfer as part of a managed transition of the service. Young people currently receiving a service or on a waiting list will be contacted by the local CAMHS. This will be an additional holistic contact to offer support and explore current needs and any risks and will not affect waiting times. All the outcomes from these contacts will be communicated to the GP.

New referrals for children under 16 years may currently continue to be made using a referral and risk assessment document available [here](#) (on DXS) to NHS Arden & GEM Commissioning Support Unit who will hold the national waiting list on behalf of NHS England until referrals may be passed to a new provider in chronological order. This route is soon to end as the new specification will only allow referrals for CAYP into the specialist services from secondary care providers which would bring an end to direct referrals from primary care. GPs will refer to CAMHS or paediatrics. The GP should also share weblinks to trusted NHS information sources. The operational Delivery Network (ODN) referral management group will decide the appropriate pathway of care for that young person, ensuring the fastest access to the appropriate team. **If you have any questions on how to make a referral, call 01522 857799 or contact agem.cyp-gnrss@nhs.net with any queries.**

Young People 17+ on the waiting list are being added to the adult wait list at the point they joined the Childrens' list and will be advised to have a conversation about this with their GP, as they will not be seen before their 18th birthday. As a result of Cass Report recommendations, service provision for this cohort may change in the future.

²² [NHS population screening: information for trans and non-binary people - GOV.UK \(www.gov.uk\)](#)

²³ [Screening for trans and non-binary people Sept 2019-1.pdf \(shsc.nhs.uk\)](#)

Appendix A: example letter declining shared care arrangement.

Request for <<insert name of Practice>> to agree to shared care protocol.

Dear <<insert clinical lead name>>

RE: <<insert name of Shared care protocol>> relating to <<Patient Details>>

As you are aware general practice is under increasing pressure and is currently unable to cope with the workload. General practice is repeatedly asked to take on more work, with no resources to enable this work to be undertaken safely.

Due to current workload within general practice <<insert name of Practice>> is unable to agree to the proposed shared care guidelines and responsibility for prescribing and monitoring the treatment outlined within the protocol must rest with <<insert name of acute trust>>.

We are concerned that taking on further responsibilities under such a shared care protocol would put patient safety at risk at this time.

Yours sincerely,

On behalf of <<insert name of Practice>>

Appendix B- a template letter for GPs who are considering prescribing following a request to prescribe from a UK private provider for due diligence and to help set up appropriate shared care arrangements. The letter lists the evidence which private providers should be expected to supply to support a GP's request.

DRAFT LETTER FOR DUE DILIGENCE OF PRIVATE PROVIDERS

Dear Colleague,

Many thanks for your correspondence. In line with my professional and NHS England directions, I will only consider undertaking prescribing and monitoring of treatment for our patient, under your guidance, subject to your organisation providing evidence confirming the credentials of both your service and clinicians in the field of gender dysphoria (see below for details) and the provision of a signed shared care protocol in line with those provided by NHS-commissioned providers.

We do not accept requests from clinics who have not been assessed by CQC. CQC are the independent regulator of health and social care in England who work to protect the rights of vulnerable people. They register, monitor, inspect and rate services and take action to protect people. We do not accept requests for prescribing treatments for individuals under 18 years. For people 18-25 years, who are at potentially vulnerable stage in their journey, we require evidence that there has been consideration given to reaching a point of maturity before taking a decision to transition and / or take hormone treatment, and has been offered and / or received holistic, therapeutic support, including addressing any comorbidity such as anxiety, depression or neurodiversity.

NHS England advice states that GPs must ensure such requests comply with the following points:

- The request is from a reputable company that provides a safe and effective service.
- The circumstances of the request for the particular individual meet the general principles of the GMC's Good Practice in Prescribing and Managing Medical Devices
- The health professional making the request is an appropriate gender specialist. The GMC states 'an experienced gender specialist will have evidence of relevant training and at least two years' experience working in a specialised gender dysphoria practice such as an NHS Gender Identity Clinic. Evidence provided should include the following:
 - Formal links with NHS-commissioned specialised Gender Identity Clinics
 - Formal links with relevant professional associations
 - Previous time spent working in NHS-commissioned specialised gender identity services.
 - Evidence of ongoing continuous professional development
 - Participating in credible research related to gender nonconformity and gender dysphoria.

- The decision to recommend endocrine therapy should have the documented support of two gender specialists who are directly involved in the patient's care; at least one of whom must be medically qualified.
- The provider has an effective multidisciplinary team of gender specialists that meets regularly (either in person or electronically)
- The impact on the individual's fertility has been discussed with them and informed consent has been given.

We will not issue any prescriptions until these conditions have been satisfied.

Yours sincerely