Department of Health & Social Care

The Medicines (Gonadotrophin-Releasing Hormone Analogues) (Emergency Prohibition) (England, Wales and Scotland) Order 2024

and

The National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) (Amendment) Regulations 2024

Limited Impact Assessment

Date	29 May 2024
Origin (Domestic/International)	Domestic
Type of measure	Secondary legislation
Contact point	prescribingpolicy@dhsc.gov.uk
Reason for Limited Assessment	These legislative changes are a targeted emergency response to issues of patient safety. It has a duration of three months. A full impact assessment will be prepared for any permanent response to this risk, but for this short-term measure a limited assessment is proportionate and appropriate.

Purpose of this document

This assessment sets out the problem that needs to be addressed, the rationale for government intervention, the policy objectives and the expected effects. It outlines the supporting evidence base and presents a qualitative assessment of costs and benefits. It identifies any risks and associated mitigation. It also explains the expected arrangements for monitoring and evaluation.

Description of the problem and rationale for intervention

The recent independent review of gender identity services for children and young people (Dr. Hilary Cass, April 2024)[1] found that there is not a reliable evidence base upon which to make clinical decisions about use of GnRH analogues (puberty blockers) to treat gender dysphoria/incongruence, or for children and their families to make informed choices. The Review concluded that because of the limited evidence, and potential risks to patient safety, they should only be offered for this purpose under a research protocol and/ or with the agreement of the national multi-disciplinary team. The NHS has implemented these recommendations. The Cass Report has been accepted and endorsed by the UK governments, UK regulators and clinical leaders.

It is the Government's view that the same principles to ensuring the safety of children and young people should be taken regardless of the clinician or setting responsible for their care. The Government agrees with the Cass Report conclusions that for this group of children and young people safety can be best assured under the supervision of a national Multi-Disciplinary Team and with new initiations onto a medical pathway for gender dysphoria/incongruence done under the governance of a clinical trial. The government is aware that not all prescribing of these medicines is being done in accordance with this position, and is of the view that this presents a serious risk to patient safety.

[1] https://cass.independent-review.uk/home/publications/final-report/

Through this Order and the related NHS Regulations (**a** to **d** below), the Government seeks to implement the conclusions of the Cass Report in relation to prescribing GnRH analogues consistently for all children and young people, and to take immediate actions required to prevent harm. The effect together of the two pieces of legislation is to restrict new prescriptions of GnRH analogues for the treatment of gender dysphoria/incongruence in children, which would start a child or young person on a medical pathway, to NHS secondary and tertiary care or clinical trials only. NHS secondary and tertiary care will only prescribe in these circumstances with the agreement of the national Multi-Disciplinary Team. Taking this approach provides clarity and removes ambiguity for all parties – patients and their families, prescribers, employers and regulators. Only legislative action can achieve this across NHS, UK private and EEA prescribing.

In the case of EEA- and Switzerland-registered prescribers, dispensing pharmacists cannot easily verify the purpose for which a prescription has been written. For this reason all prescriptions of GnRH analogues from an EEA- or Switzerland-registered prescriber for people under the age of 18 will no longer be dispensed in the UK.

Policy objectives

The aim is to reduce and remove risks to patient safety by ensuring that a consistent approach to prescribing of GnRH analogues is taken by all prescribers. In doing so, the reform needs to avoid any unintended impacts (e.g. on appropriate use of puberty blockers for conditions besides gender dysphoria, or on existing patients for whom disruption may be harmful). This will be achieved by ensuring that the Order:

- **a.** Bans sale or supply of puberty blocker medicines against new prescriptions for under 18s which would start a child on a medical pathway for gender incongruence/dysphoria, from the UK independent sector;
- **b.** Bans sale or supply against all prescriptions for puberty blocker medicines for under 18s from EEA and Swiss prescribers;
- **c.** Provides exceptions for sale or supply against NHS prescriptions; and
- **d.** Is mirrored by changes to the NHS (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004, limiting NHS primary care prescribing of these medicines for gender incongruence/dysphoria in under 18s to patients already on a medical pathway only.

The Section 62 Medicines Act 1968 emergency prohibition Order (**a**-**c** above) will have a duration of three months before being reviewed and potentially amended, extended, replaced or discontinued. The NHS Regulations (**d** above) are indefinite.

The territorial application of the Order is England, Wales and Scotland. The NHS Regulations apply in relation to England only.

The Evidence Base

<u>Risks to patient safety:</u>

The Cass Review states that rationale for early puberty suppression remains unclear, with weak evidence regarding the impact on gender dysphoria, mental or psychosocial health. The effect on cognitive and psychosexual development remains unknown.

It also states that for the majority of young people, a medical pathway may not be the best way to manage their gender-related distress. For those young people 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. Further, use of puberty blockers in these circumstances blocks the normal rise in hormones that should be occurring into teenage years, and which is essential for psychosexual and other physical developmental processes such as brain/cognitive development and bone health. It also has implications for fertility. Use of puberty blockers may also reduce psychological functioning.

If puberty suppression is started too early in birth-registered males it can make subsequent vaginoplasty more difficult due to inadequate penile growth.

Given the limited evidence, complex case management, and child competence to consent to treatment with significant long-term implications, the Review recommends that every case considered for medical treatment should be discussed at a national Multi-Disciplinary Team. This cannot happen outside the NHS or outside a clinical trial.

These risks are described based on the independent review of evidence done for the Cass Report. It is not possible to accurately quantify these risks. The presence or absence of risk does not in itself imply an absence of benefit.

Limited evidence:

While a considerable amount of research has been published in this field, systematic evidence reviews demonstrated the poor quality of the published studies, meaning there is not a reliable evidence base upon which to make clinical decisions, or for children and their families to make informed choices.

The strengths and weaknesses of the evidence base on the care of children and young people are often misrepresented and overstated, both in scientific publications and social debate.

Health benefits of puberty blockers

Some patients and some clinicians are strongly supportive of puberty blockers, and some published studies are also positive. However, the problem with quality of research remains. Cass concluded that there is a very narrow indication for the use of puberty blockers in birth-registered males as the start of a medical transition pathway in order to stop irreversible pubertal changes but that other indications remain unproven. As with risks, it is not possible to accurately quantify the benefit for this indication.

Prescribing practice

On prescribing practice, the Review “understands and shares the concerns about the use of unregulated medications and of providers that are not regulated within the UK”. The Review also references pressure on families to obtain private treatment, and pressure on GPs to continue prescribing treatments on the basis that failing to do so will put young people at risk of suicide. NHS England, the General Pharmaceutical Council and the Royal College of General Practitioners have all expressed significant concerns about prescribing practice and pressure on prescribers and dispensers.

Numbers of patients affected

There are approximately 10,000 cases of gender dysphoria amongst under 18s in England (based on Cass Review prevalence estimates from Clinical Practice records). However, this may not include undiagnosed cases or cases unknown to the NHS. The rest of the UK may, based on relative population, account for a further 1,500-2,000 cases. Limitations with the methodology mean that all these estimates measure the number of patients who have received a diagnosis in childhood, regardless of whether their condition is still “live” or has been resolved.

Referrals to the Gender Identity Development Service (GIDS) have increased from under 250 in 2011/12 to approximately 5,000 in 2021/22.[2] Not all of these may lead to a confirmed diagnosis, and there is uncertainty arising from the accuracy and consistency of both prevalence and referral data.

The limited evidence suggests that the number of patients receiving puberty blockers on the NHS is relatively small. Data for 2022/23 from the NHS Business Services Authority suggests that around 600 patients under 18 had prescriptions for puberty blockers dispensed in the community (numbers in secondary care being much lower). It is not known what condition these prescriptions were for but based on a crude analysis of prevalence of other conditions, such as precocious puberty, we estimate that around 350 children are currently prescribed puberty blockers by the NHS for gender dysphoria. This estimate is tentative.

It is not known how many patients are obtaining puberty blockers through the private or EEA routes (investigation is ongoing). NHSE have estimated that 5,000 patients are currently on NHS waiting lists for referral, but it is not clear what their final diagnosis and treatment may be, or what bridging treatment they may be receiving outside the NHS.

In summary:

- A small minority of patients under 18 are prescribed puberty blockers on the NHS for gender dysphoria.
- An unknown number may be acquiring puberty blockers through the private or EEA routes.
- Prevalence and referrals are on an upward trend.

Conclusion

The evidence base is limited, uncertain and in some places inconsistent. Individual patient experience is not homogenous. The precise number of patients likely to be affected is also uncertain. However, the NHS guidelines remain that routine prescribing outside of the supervision of the national multi-disciplinary team or a clinical trial is not recommended.

Assessment of policy benefits

The Order and the Regulations will deliver:

- Reductions in clinical risk for all children currently using EEA prescriptions to obtain puberty blockers in the UK, and those who would otherwise seek to do so via this route;
- Reductions in clinical risk for new patients seeking to use UK private prescribing to obtain puberty blockers for gender dysphoria specifically;
- Reductions in clinical risk for new patients seeking to use NHS prescribing to obtain puberty blockers for gender dysphoria specifically; and
- Improved consistency of treatment.

Restrictions on prescribing are limited to under 18s. With the exception of EEA prescriptions, sale or supply of puberty blockers in children for reasons other than gender dysphoria, and use for gender dysphoria among existing patients, will remain permissible subject to the conditions in the legislation.

The restrictions on prescribing also offer the potential for health gains arising from more appropriate treatment being provided instead of puberty blockers. Evaluation of the Order and the Regulations will also enhance the evidence base. Both these effects may be enabled or initiated

[2] Cass Review. Page 85.

by the legislative changes, with their longer-term impact likely to be clarified as later decisions on permanent reform are considered.

Assessment of policy costs / risks

Implementation of these restrictions on prescribing will entail:

- One-off familiarisation costs for clinicians as the new rules are introduced. This will affect prescribers, pharmacists and other healthcare workers involved in patient support;
- Ongoing enforcement and monitoring costs, for both regulators and clinicians, in ensuring the restrictions are properly applied;
- A loss of any clinical benefit arising from puberty blockers within the scope of the restrictions. Such benefits may or may not have a robust evidence base, but they may be seen as very beneficial by those using them.
- Costs to pharmaceuticals (manufacturers) in terms of lost sales for puberty blockers.

The legislative changes also introduce risks:

- A risk to physical or mental health where patients' treatment is changed or disrupted;
- A risk to mental health where patients are unable to get treatment that they were expecting, or which they believed might be beneficial despite limited evidence;
- A potential increase in demand for NHS care, if people stop using alternative providers;
- A potential risk of confusion and uncertainty given that the Order is temporary, albeit with a more permanent solution likely to follow; and
- A potential risk of patients seeking unsafe treatment and/or the creation of "black market" demand.

These risks will be mitigated in part by the policy design (e.g. allowing existing patients to continue their treatment) and in part through provision of support through the NHS and the voluntary sector and guidance provided to patients and their families, prescribers and pharmacists.

<u>Behavioural response</u>

It is unclear how patients may react to the restrictions. In principle, a treatment which has limited evidence of benefit is not particularly attractive, but the comparator may be receiving no treatment at all, or at least experiencing a delay before treatment can be made available. It is also true that both information and misinformation are widely available to patients.

This means that some patients may, with the best of intentions, be motivated to seek treatment from unofficial or unapproved sources, including overseas. This is an indirect risk following on from the legislative changes, and one which will be mitigated by wider system design and care provision.

Impact on business

The impact on business is expected to be fairly limited because of the relatively small number of patients affected. Nevertheless, the rules may affect all clinicians and health professionals responsible for patient care. The rules will generally apply regardless of whether clinicians and health professionals are working in an NHS setting or the private sector or both.

In the short-term, patient-facing staff may need to respond to questions and concerns from patients and their families about the legislative changes. They will also need to be able to advise on appropriate alternative therapies or courses of action. It will be important for suitable services and advice to be available to avoid patients being left unsupported.

Limited consultation with pharmacies has suggested that EEA prescriptions do not form a large part of their business. It is difficult to properly check and validate such prescriptions, given that the

issuer is overseas, and this can create administrative problems for the dispenser. While the dispenser would lose sales revenue because of the restrictions on EEA prescribing, these difficulties would also be removed.

New private sector prescribing in the UK for gender dysphoria would be banned for new patients under the age of 18 (existing patients could continue). This would again reduce sales revenue but also administrative costs. It is not expected that the amount of business involved is large.

It is not clear whether any alternative therapies would be provided through the private sector, offsetting any revenue loss.

The ban on EEA prescribing of these medicines for patients under the age of 18 creates a small reduction in international trade, but in practice this would be of negligible size, particularly as UK prescriptions are not recognised in the EEA. It may affect the business model of any firms specialising in prescribing puberty blockers to UK patients, but the policy rationale would support such an effect.

Equality and distributional impacts

We are required to give due consideration to equality legislation, including the Public Sector Equality Duty. The relevant protected characteristics covered by this duty are age, disability, gender reassignment, pregnancy and maternity, race religion or belief, sex, and sexual orientation. A separate equality impact assessment has been conducted to assess the impact on the relevant protected characteristics.

In terms of distributional effects, the population affected is small but also very specifically focused on the under 18 age group. Any impacts will be felt by them and their families. There is evidence that gender dysphoria is increasingly more prevalent in birth-registered girls than boys, but other characteristics (deprivation, ethnicity etc.) are less significant. Distributional impacts are expected to be minimal.

Monitoring and evaluation

The Section 62 emergency Order has a duration of 3 months. After that, it may be extended for a further temporary period, modified in some way, made permanent through further legislative reform, or discontinued. The Regulations are indefinite.

Evaluation and monitoring of the legislative changes is an essential element, alongside wider care reform and research, to designing an appropriate long-term care pathway to support patients. The short 3-month timeframe of the Order does limit what can be done immediately, but data will still emerge for analysis. This will help validate assumptions, validate the logic model of how benefits will be realised, identify any concerns or improvements, and facilitate further progress.

Monitoring and evaluation of impacts within the NHS are expected to be led within NHS England. Private sector impacts are expected to be reviewed by DHSC. Both will likely be supported by bespoke consultation and research to inform longer term planning.

The list of medicines within scope of this legislation will also be monitored and updated as necessary.

Any permanent legislation will be accompanied by a full assessment of costs and benefits at the appropriate time.

Assessment of whether the benefits justify the costs

This is difficult to assess quantitatively given the weaknesses in the evidence base surrounding puberty blocker use for gender dysphoria.

What is known is that doing nothing preserves the safety risks identified.

Intervention to address these concerns, particularly intervention which improves the evidence base and which will be reviewed after a relatively short period, has a good chance to deliver an improvement in safety and care.

This chance is enhanced by the various rules and other policy design features which support particular groups of patients who might otherwise be adversely impacted by the restrictions on prescribing.

On this basis, the impact assessment concludes that the potential benefits of the temporary Order and the Regulations do justify the potential costs, with monitoring and review activity essential to maintaining that position.

It remains the case that puberty blockers form only one part of the regime for caring for patients with gender dysphoria. Other therapies, psychological help, fast access to care, minimal waiting times and bespoke diagnosis and monitoring are all essential to providing the standards of care required for patients in this very vulnerable situation.

Policy signoff (SCS): Gila Sacks	**Date: 29.05.2024**
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