

To: • TransActual on behalf of clinical and  
academic signatories  
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cc. •

6 August 2026

Dear TransActual,

## **Masculinising and Feminising Hormone Treatment Evidence Reviews**

Thank you for your letter dated 28<sup>th</sup> May 2026 where you outline your concerns regarding the evidence reviews undertaken to support the determination of national clinical policy on the use of masculinising and feminising hormone treatments for young people (YP) with gender incongruence / dysphoria. I will aim to answer each of your points in turn.

### **1. Lack of clear rationale**

You question why, having previously accepted the recommendations within the Cass Report, NHS England then commissioned a separate evidence review process to inform its national clinical policy on masculinising and feminising hormones in YP.

We expect that the available evidence base will continue to grow in relation to gender care, and NHS England and the National Institute of Health and Care Research (NIHR) are taking specific steps to support this, through a jointly co-ordinated national gender research programme. It is therefore important that clinical policy decisions are made on the basis of the latest available evidence.

In line with NHS England's published, and consulted upon, 'Methods' for clinical policy development ([NHS England » Methods: national clinical policies](#)) we commission evidence reviews of the latest published research literature to support the formation of a policy proposition and subsequently a recommended commissioning position, as part of standard practice. The evidence review process provides an objective synthesis of available research, directly relevant to the treatment and patient group(s) concerned.

In the future, as other good quality research is completed and findings are published, these studies can inform future evidence reviews and associated clinical policy development.

The living evidence review process, commissioned by NIHR as part of the wider joint [programme of research underpinning the design and delivery of children and young people's](#)

services, is currently getting underway. Whilst this will not be as specific as the type of evidence reviews we require to make clinical policy decisions on specific treatments or treatment approaches in particular patient groups, it will provide a helpful overview of new research in this important area of healthcare to provide improved information for individuals and their families, clinicians, commissioners and the wider public.

## 2. Lack of Peer Review

The NHS England evidence reviews are compiled from the evaluation of studies published in peer reviewed journals indexed in major bibliographic databases. They adhere to Cochrane rapid review methods guidance recommendations for rapid reviews of effectiveness. The Policy Working Group (PWG) agree the Population, Intervention, Comparison, and Outcomes framework (PICO) for the review and are then asked to comment on the draft review regarding the relevance of the included papers, including if any key published papers are potentially missing, and if the interpretation of the evidence findings is reasonable. The policy proposition is then developed on the basis of the evidence reviews. As part of public consultation, interested stakeholders are asked whether all peer reviewed and published studies have been appropriately included and considered. Sometimes, interested stakeholders identify additional studies that might be relevant and NHS England will review those against the PICO to determine if they should have or have already been considered.

Public consultation is not equivalent to independent academic peer review. We do not seek academic journal acceptance and publication of the rapid evidence reviews. Much like the NICE Clinical Guideline process, the reviews are technical documents that are published alongside other documents supporting policy development, such as the Patient Impact Assessment and the Equalities and Health Inequalities Impact Assessment. Consultation on the draft policy with its supporting documents is more appropriate for developing clinical commissioning policy because it captures essential patient experience, addresses potential local health inequalities, and ensures ethical accountability for funding decisions. Through consultation NHS England can assess if the draft policy is fair, practical, and appropriate to the community it impacts.

## 3. Methodological Limitations and Risk of Bias

You raise that NHS England subdivided the approach for under-18s evidence review into 10 separate and extremely specific PICOs. The 10 PICOs were developed to align with the different hormone regimens and treatment indications within the YP cohort.

You state that fragmentation of PICOs is likely to result in sparse evidence and could be chosen by review authors to produce a desired result. Whilst the [Cochrane Handbook](#) does say: *“Splitting comparisons carries its own risk of there being too few studies to yield a useful synthesis.”*, it also says: *“However, lumping is likely to introduce heterogeneity, which will not always be explained by a priori specified factors, and this may lead to a combined effect that is clinically difficult to interpret and implement. For example, when multiple intervention types are ‘lumped’ in one comparison (as in objective (i) above), and there is unexplained heterogeneity, the combined intervention effect would not enable a clinical decision as to which intervention should be selected.”*

Hence, the development approach taken is consistent with the Cochrane Handbook and enables each population, indication and regimen of interest to be considered for commissioning on its own merits. Specifying PICO framework details helps to minimise bias and the reviews are undertaken by external independent providers. The direction was taken from the PWG after detailed discussion regarding the populations, current treatment combinations and regimens, hence 10 PICOs were agreed based on expert advice.

On the exclusion of some studies, Chen et al 2023 did not present results according to hormone regimen and indication and therefore would not have enabled proper clinical decision making for the clinical commissioning policies. The use of GnRH analogues in this cohort is not routinely commissioned in England; therefore, any hormone regimen that could be commissioned cannot be based upon evidence of people who have already been treated with GnRH analogues because the treatment effects of masculinising or feminising medicines may be different for those who have received previous treatment with GnRH analogues.

You have specifically highlighted that the University of York evidence review found 53 studies, compared to the 11 included in the NHS England evidence reviews. The aim of the York review was to synthesise evidence published up to April 2022 which reports outcomes of feminising/masculinising hormones in adolescents experiencing gender dysphoria/incongruence. The aim of NHS England rapid reviews is to synthesise the evidence for use of specific hormone regimens in specific populations to inform clinical commissioning policy. We would expect there to be a difference in volume and actual included references because receipt of puberty suppression was not within scope for our reviews and many study populations include those who have received puberty suppression. The abstract conclusion of the York study was that *“There is a lack of high-quality research assessing the use of hormones in adolescents experiencing gender dysphoria/incongruence. Moderate-quality evidence suggests mental health may be improved during treatment, but robust study is still required. For other outcomes, no conclusions can be drawn. More recent studies published since April 2022 until January 2024 also support the conclusions of this review.”*

You raise the point of extrapolating data reported from adult studies. These agents are used during a critical period of physical development in young people. Some effects may be irreversible, fertility and future reproductive options may be affected, and long-term outcomes are less certain, such as cardiovascular effects, bone health. We need to consider potential adverse effects which may impact young people differently to adults.

#### **4. Misreporting and Misapplication of Findings**

Due to the rareness of conditions that can be the subject of clinical policy proposals, NHS England is used to considering and interpreting evidence of very low certainty and clinical policies have been approved for routine commissioning where the evidence is assessed as such. When carefully considering these YP evidence reviews where evidence was reported, the assessment of the Specialised Services Clinical Panel was that there was very limited evidence of benefit which was too weak to consider a routine commissioning position at this time. Following public consultation, any evidence that has been raised will be considered, reported on and reviewed again by Clinical Panel.

The clinical policy development methodology provides an opportunity for interested stakeholders to comment on the evidence relied upon through a process of public consultation. NHS England takes this feedback very seriously. Evidence that has been raised as part of that process that is believed to have been omitted, under-represented, insufficiently considered or incorrectly reported is currently being reviewed.

Thank you for raising the Grannis et al., 2023 study, as other stakeholders have done. We agree that there was a data extraction error in the review for “Feminising medicines comprising oestrogen monotherapy for children and young people with gender incongruence who identify as a female gender and wish to undergo a binary physical transition” and the text has been amended to state that there were no statistically significant differences between groups for the outcomes of depression, suicidality and social anxiety.

## **5. Impacts of Treatment Withdrawal**

Those individuals who are already receiving GAHT within the NHS will continue on treatment until a decision is made otherwise between the patient and clinician.

NHS England has not made a final decision on the future use of gender affirming hormone therapy in YP. This will be made in due course once the evidence raised during public consultation has been fully considered.

Yours sincerely,



**James Palmer**

National Medical Director, Specialised Services  
NHS England