

Tavistock and Portman NHS Foundation Trust

Gender identity services

Inspection report






The Tavistock Centre
120 Belsize Lane
London
NW3 5BA
Tel: 02074357111
www.tavistockandportman.nhs.uk

Date of inspection visit: 14 October 2020 to 6
November 2020
Date of publication: 20/01/2021

Ratings

Overall rating for this service

Inadequate 

Are services safe?	Requires Improvement 
Are services effective?	Requires Improvement 
Are services caring?	Good 
Are services responsive to people's needs?	Inadequate 
Are services well-led?	Inadequate 

Our findings

Gender identity services

Inadequate ● ↓↓

This was an announced, focused inspection of the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust.

The Gender Identity and Development Service (GIDS) is provided by the Tavistock and Portman NHS Foundation Trust. In October 2020, the service was working with 2093 young people. The service is based at the Tavistock Centre in London. The service has a regional centre in Leeds and satellite clinics in Exeter, Bristol and Birmingham. Most of the referrals to the service are from GPs and child and adolescent mental health services. The service also accepts referrals from other health, social care and education professionals and from voluntary organisations. Referrals are made for people under the age of 18 with features of gender dysphoria. Gender dysphoria describes a sense of unease that a person may have because of a mismatch between their assigned sex at birth and their gender identity. The gender dysphoria leads to clinically significant distress and/or social occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The service is commissioned by NHS England. The service is commissioned to provide assessments of young people, refer young people for medical treatment when appropriate and provide some continuing support when this is required. It is a national specialist service and is the only service available in England for children and young people with gender dysphoria. The service also treats children and young people from Wales.

The Tavistock and Portman NHS Foundation Trust provide outpatient psychosocial services only, and GIDS provides outpatient services for gender dysphoria. Any medical treatment is provided by other acute healthcare providers and the Tavistock and Portman NHS Foundation Trust refer into these as required. Medical treatment involves the prescribing of medicines that pause the physical changes of puberty and hormones that alter characteristics of gender. This medical treatment is provided by the endocrinology departments at University College Hospital London and Leeds General Infirmary. The CQC inspected and published reports on these services at the same time as the inspection and publication of GIDS.

Our last inspection of GIDS was in 2016. This took place as part of an overall inspection of the Tavistock and Portman NHS Trust. Following the inspection, we rated the trust as good overall. The domains of effective, caring, responsive and well-led were rated as good. The domain of safe was rated as requires improvement, although the improvements we said the trust must make related to a different service within the trust.

We undertook this inspection due to concerns reported to the CQC by healthcare professionals and the Children's Commissioner for England. Concerns related to clinical practice, safeguarding procedures and assessments of capacity to consent to treatment. This inspection focused on the Gender Identity Development Service (GIDS) only.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent at the service to prevent cross infection. Four inspectors and a CQC specialist advisor visited the service at the Tavistock Centre on 14 and 15 October 2020 to review patients' records and complete essential checks. Two inspectors visited the service

Our findings

in Leeds on 20 October 2020. Whilst on site we wore appropriate personal protective equipment (PPE) and followed local infection control procedures. The remainder of our inspection activity was conducted off-site. This included interviews by telephone, the use of video conferencing facilities and analysis of evidence and documents. Our final staff interview was completed on the 6 November 2020.

Separate from our inspection the High Court made a ruling on the 1 December 2020 around capacity and consent of children receiving hormone intervention for gender dysphoria. This ruling has not impacted on our findings. Our findings and judgements are based on the legal position at the time of our inspection.

Prior to, and during, the inspection we received intelligence from former members of staff and healthcare professionals not directly associated with the service. During the inspection visit, the inspection team:

- visited the service to look at the quality of the environments
- spoke with 22 young people who were using the service
- spoke with 13 parents of young people using the service
- reviewed information from 23 people who contacted the CQC through our website to share their experience of using the service
- reviewed information from six people on the waiting list who contacted the CQC through our website
- reviewed information from six service users and parents who wanted to share their experience via an independent organisation
- spoke with four members of the GIDS clinical executive team, the GIDS safeguarding lead, the GIDS service manager, the divisional director for gender service, the medical director, human resources director and a staff governor.
- spoke with 30 other staff members across the multidisciplinary team
- looked at 35 patients' records
- looked at a range of policies, procedures and other documents relating to the running of the service.

Overall summary

Our rating of this service went down. We rated it as inadequate because:

- The service was difficult to access. There were over 4600 young people on the waiting list. Young people waited over two years for their first appointment.
- Staff did not always assess and manage risk well. Many of the young people waiting for or receiving a service were vulnerable and at risk of self-harm. The size of the waiting list meant that staff were unable to proactively manage the risks to patients waiting for a first appointment. For those young people receiving a service, individual risk assessments were not always in place with plans for how to manage these risks. The number of patients on the caseload of the teams, and of individual members of staff, were high making caseloads difficult to manage and placing pressure on staff.
- Staff did not develop holistic care plans for young people. Records of clinical sessions did not include any structured plans for care or further action. Staff did not sufficiently record the reasons for their clinical decisions in case notes. There were significant variations in the clinical approach of professionals in the team and it was not possible to clearly understand from the records why these decisions had been made.

Our findings

- Staff had not consistently recorded the competency, capacity and consent of patients referred for medical treatment before January 2020. However, since this date these decisions had been recorded.
- The teams did not always include the full range of specialists required to meet the individual needs of the patients. Staff did not always work well together as a multidisciplinary team.
- Staff did not always feel respected, supported and valued. Some said they felt unable to raise concerns without fear of retribution.
- The service was not consistently well-led. Whilst areas for improvement had been identified and some areas improved, the improvements had not been implemented fully and consistently where needed.

However:

- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Feedback from young people and families currently being seen at the service was overwhelmingly positive about the care and support staff had provided.
- Staff referred young people to other providers for medical treatments that were consistent with good practice.
- Managers ensured that staff received training, supervision and appraisal. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Clinical premises where patients were seen were safe and clean.

Following the inspection, we took enforcement action against this provider under the Health and Social Care Act 2008 by imposing a condition upon their registration. This requires the trust to report to us on a monthly basis so we can monitor their progress with improving their waiting times.

Is the service safe?

Requires Improvement ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- Many of the young people waiting for or receiving a service were very vulnerable and at risk of self-harm. Despite this staff often did not assess the risks presented by young people and their families. Staff did not create plans to manage risks. The size of the waiting list meant that staff could not proactively monitor the risks to all patients waiting for their first appointment. However, in a few cases, where patients presented a particularly high risk, staff worked effectively with child and adolescent mental health services and children's social care services to ensure that young people were safe.
- Staff did not always work well with other agencies to safeguard young people. Most records did not include plans, agreed with other agencies, on sharing information and protecting young people.
- Not all staff had completed an appropriate level of training in safeguarding adults.
- The number of young people on the caseload of the teams, and of individual members of staff, was high and varied considerably between different members of staff, causing caseloads to be stressful and difficult to manage.

However:

Our findings

- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Clinical premises where patients were seen were safe and clean.

Detailed Findings

Safe and clean environment

Interview rooms were not fitted with alarms. Staff considered that the risk presented by interviews was low and did not require alarms to be installed.

The waiting area provided a comfortable space for young people to wait for appointments. There were four chairs in the waiting room all suitably distanced from each other.

All areas were clean, had good furnishings and were well-maintained. Interview rooms were bright with comfortable chairs.

Staff adhered to infection control principles, including handwashing. Between the onset of the Covid-19 pandemic in March 2020 and October 2020, the service conducted 6360 consultations. Only 7% had involved face-to-face meetings. Forty-one percent had been carried out by telephone. Fifty two percent had been carried out using video call facilities. Face-to-face consultations were only arranged for specific reasons, such as if a patient was particularly vulnerable. The service did not refer young people to the endocrinology service unless the young person had met a therapist in person. Therefore, some young people needed to attend the service in order for a referral to be made. When staff, young people and visitors attended the service, they were required to wear a face mask at all times. Hand sanitising gel was provided at the entrance to the building, at the entrance to all the corridors and in the toilets.

Safe staffing

The established number of clinical psychologists and psychotherapists for the service was 66.3 whole time equivalents (WTE). The established number of assistant psychologists was 6.6 WTE. The service employed 15 administrators, 1.8 consultant psychiatrists and 1.8 specialist nurses. The service also received support from service managers, project managers, research assistants and divisional level staff. The vacancy rate for the service was 17%. This included vacancies for 9.2 psychologists or psychotherapists, six administrators and three assistant psychologists.

During 2019/20, the staff turnover for the service was 23.5%. This is very similar to the total turnover for the trust which was 23.68%. During the same period, the sickness rate for the service was 2.19%. This is very similar to the overall rate for the trust of 2.5%.

The provider had determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach. The level of staffing was based on the budget for the service agreed with the commissioners. The staffing allocation had been calculated to take account of the waiting list and the current caseload for staff.

Our findings

The caseload for each member of staff varied considerably. Ten members of staff had a caseload of less than 10 young people. One member of staff had a caseload of over 100. Sixty-five percent of staff had a caseload over 40, including 34% of staff who had a caseload over 60. The overall average was 45.53. This increased to 52.5 when staff with a caseload under ten were removed from the calculation. This meant that staff were working with high numbers of clients which could be stressful and difficult to manage.

Cover arrangements for sickness, leave and vacant posts ensured patient safety. Staff worked on each case in partnership with a colleague. If a member of staff was off work due to leave or sickness, the case would be covered by their partner.

The service used bank and agency staff appropriately. Between April and June 2020, the service had not used any agency staff. The service had used bank staff to deliver 2% of the service during this time, meaning that permanent staff had provided 98% of the service.

The service had rapid access to a psychiatrist when needed. The service had an urgent concerns protocol. This protocol included arrangements for an on-call rota for psychiatrists who could see young people urgently.

Staff were not up-to-date with all appropriate mandatory training. The trust had designated 17 courses as mandatory for some or all their staff. Overall compliance with mandatory training was 86%. The service achieved compliance of over 90% for courses on equality, diversity and human rights (95%), infection prevention and control (96%) and safeguarding children level 3 (95%). However, compliance fell below 75% for training on preventing radicalisation (74%), resuscitation (70.21%), and adult basic life support (54%).

Assessing and managing risk to young people and staff

We reviewed the assessment and management of risk in 29 care records. Twenty-eight of these records included details of risks that were relevant to the young person. However, the recording of risk and of plans to manage these risks varied considerably. Some records demonstrated good practice, such as completing risk assessments jointly with child and adolescent mental health services. Others had limited information. For example, one record had very little information about risks, despite the referral letter stating that the young person had frequent suicidal thoughts and had previously harmed themselves by cutting.

Assessment of patient risk

Staff recorded the risks presented by the young person at the initial appointment, either in the record of the appointment or on a standard form. Staff had identified many young people as being vulnerable to specific risks. We found examples of young people who had made suicide attempts, young people who were vulnerable to sexual exploitation and young people who had a history of inappropriate or high-risk sexual behaviour. Records of risks were based on information provided by young people, parents and the person making the referral. Staff did not routinely update the risk assessment form, although updated information relating to risks was recorded in the notes of meetings with young people.

Staff used a recognised risk assessment tool. The service had introduced a standard risk assessment form in April 2020. This form had been completed on most of the records we reviewed. However, on some records, staff only completed very brief details. The risks were not always assessed by staff in relation to the impact of the risk and the likelihood of risk incidents occurring. On some risk assessment forms, staff had not recorded all the risks discussed in the notes of meetings. This meant that someone unfamiliar with the patient may find it difficult to identify the risks quickly.

Our findings

Staff did not create crisis plans for young people. However, both young people and their parents said they would contact their counsellor if they had any problems or their situation deteriorated.

Management of risk

Staff usually managed significant risks appropriately, although their approach was not always structured or consistent. The primary approach for managing risk was known as the 'network model'. Through this model, clinicians liaised with the young peoples' local services, including child and adolescent mental health services (CAMHS), children's social services, GP and special needs co-ordinators in schools, to ensure that risks were being appropriately managed. We saw some evidence of this model working well. For example, one record showed evidence of joint working with the patient's CAMHS and voluntary sector organisations. This included sharing information in accordance with an agreed protocol. Another record included a joint assessment by GIDS and CAMHS. When young people were subject to high levels of risk, several other agencies were involved in supporting and protecting them. However, the approach was not always consistent. On some records, the management of risk was poorly documented. Some records did not include a risk management plan to show how risks were being managed and which agencies were responsible. Two records for patients presenting a high level of risk did not include evidence to demonstrate that GIDS staff were fully involved in multi-agency meetings.

The service did not have the resources to sufficiently address risks associated with gender dysphoria of young people on the waiting list. The service had introduced an 'enquiries line' that young people on the waiting list or their parents could use to contact the service whilst waiting. This was to address the fact that the service could not proactively assess and manage all risks for the young person whilst they were waiting. The service relied on the child's local support agencies, such as CAMHS or the GP, to address serious risk issues that arose whilst the patient was waiting. However, some parents we spoke with said the support they had received from CAMHS was not relevant to their child's needs associated with gender dysphoria. Staff also said that the threshold to access CAMHS had increased, making it difficult for young people to access these services. The service had also carried out a pilot study to work with CAMHS to support young people on the waiting list, although this pilot had not demonstrated a significant impact. This meant that whilst serious risks to young people on the waiting list were managed by local services, who were in themselves stretched, young people's needs associated with gender dysphoria were often not being met and less serious risks were not addressed.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them. The trust had a policy for lone working. This included guidance for staff working in isolation. Staff usually worked in pairs and met with young people and parents either at the trust's offices or using video conferencing facilities. None of the staff raised any concerns about working alone.

Safeguarding

Clinical staff were trained in safeguarding young people. Ninety-four percent of staff who were required to do so had completed level three training in safeguarding children. Three out of the four staff who had not completed this training had recently joined the service. However, non-clinical staff said they would find it helpful to have safeguarding training above the basic, level one training in order to become more confident in dealing with situations of possible abuse that had arisen through their daily contact with vulnerable young people.

Our findings

Safeguarding adults training was completed at level 2 for 68% of staff required to do so. This did not reach the trust target of 80% compliance. Records showed that some work with families involved supporting vulnerable adults at risk of abuse. This meant that staff may not be able to identify and respond to safeguarding matters relating to the parents they worked with. Staff providing safeguarding supervision had not received specialist safeguarding supervision training.

The trust had produced a standard operating procedure specifically for the Gender Identity and Development Service. Staff were required to report any safeguarding concerns to a supervisor, regional lead or senior clinician. The matter would then be reviewed by the trust's safeguarding team or the GIDS safeguarding lead and referred to the relevant multi-agency safeguarding hub if necessary. The GIDS safeguarding lead said that this procedure would be reviewed in November 2020. Most staff we spoke with gave examples of safeguarding concerns they had raised. For example, a clinician referred a patient to the multi-agency safeguarding hub following concerns about parental neglect and sexual abuse. Another clinician made a referral about a 17-year-old young person who was living independently in inappropriate housing, experiencing poor physical health and was not receiving any support.

Staff could give examples of how to protect young people from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, one clinician gave an example of how they had worked with families that had held homophobic or transphobic attitudes. They explained that if this presented a risk to the young person, they would make a referral to children's social care services.

Staff knew how to identify young people at risk of, or suffering, significant harm. The service carried out work to support and protect young people in partnership with other agencies, such as CAMHS and children's social care services. We reviewed the records in relation to safeguarding young people for a sample of 22 patients. On 13 of these records, 60%, we found that there had been effective joint working with local agencies to support the young person. However, on three records we found insufficient evidence of multi-agency work. Two of these records involved patients who were at significant risk. The other six records showed some good practice and some areas for improvement. Clinicians said that the scope and quality of information sharing with multi-agency partners varied hugely depending on the local authority. Most records did not include any formal information sharing agreements with local services. This meant that whilst, in most cases, the structures and processes in place to safeguard young people worked well, there remained some risk that young people may not have been appropriately protected.

Staff access to essential information

Staff recorded all information on an electronic patient record system. Administrators scanned paper correspondence and uploaded this to the electronic record.

Information needed to deliver patient care was available to all relevant staff, although we found that staff kept records in an unstructured and poorly organised manner. This meant that it could be difficult to find important information quickly. For example, records did not include documents giving all the key information about young people such as details of the person or people with parental responsibility or professional contacts in other agencies such as schools and CAMHS. Records did not include care plans. Risk assessments did not include comprehensive risk management plans and some were not completed fully. Assessments were not recorded in a structured manner. This meant it would be difficult for someone unfamiliar with the young person to understand the work that had been carried out.

Track record on safety

Our findings

Between April 2019 and March 2020, there had been two serious incidents. Both of these incidents occurred in June 2019. In addition, there had been 64 reported incidents during this period. Between January and March 2020, there were 14 recorded incidents. One of these involved harm to a young person. This incident involved a young person taking an overdose of over-the-counter medicines after their therapeutic session evoked traumatic memories. One incident involved a member of the public posting abusive messages about the service on social media and one involved a member of the public leaving an abusive message on the service's voicemail. Other incidents related to information governance, communication and facilities.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Staff recorded incidents on an electronic incident record. Staff received training and information on incident reporting at a team meeting in July 2020.

Staff reported most incidents that should be reported. However, we found that some incidents identified during audits were not recorded in the electronic incident record. For example, an audit of capacity, competency and consent was carried out in March 2020. This audit found that assessments of capacity, competency and consent had not been recorded in accordance with the established procedures in eight of the 11 records reviewed. The absence of a structured assessment had not been recorded as an incident for any of these records, despite the absence of a formal record of assessment potentially leading to a risk of medicines being administered unlawfully.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when something went wrong. For example, a member of staff described an incident involving the young person's preferred name being written on a letter but their given name, which they did not like to use, was written on the envelope. The service sent the young person a formal apology for this.

Staff met to discuss feedback. For example, staff discussed cases where there were safeguarding concerns at regular case discussion forums, the monthly psychoanalytic forum, team meetings and reflective practice sessions. Staff discussed the suicide of a former patient and an information governance incident at a clinical governance meeting in July 2020.

Is the service effective?

Requires Improvement ● ↓↓

Our rating of effective went down. We rated it as requires improvement because:

- Staff's assessments of patients were unstructured, inconsistent and poorly recorded. Staff did not sufficiently record their reasoning in reaching clinical decisions. There were significant variations in the clinical approach of professionals in the team and it was not possible to clearly understand from the records why these decisions had been made.
- Staff did not develop care plans for young people. Many records provided insufficient evidence of staff considering the specific needs of young people, such as autistic spectrum disorders.
- Staff had only recently begun to record consent and capacity or competence clearly for young people who might have impaired mental capacity or competence. The records of young people who began medical treatment before January 2020 did not include a record of their capacity, competency and consent. When staff identified records without a

Our findings

written capacity assessment, they did not seek to address this or record it as an incident. However, staff had supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16.

- Staff did not consistently assess the physical healthcare needs of patients and how they could support them to access external services.
- The multi-disciplinary teams supporting the young people did not always include the specialists required to meet all the individual needs of patients under their care.
- Whilst staff were supported with ongoing supervision and appraisals it was not possible to see how these identified whether individual staff were performing in terms of meeting the requirements of the service and the young people they support.
- Whilst staff participated in clinical audit, they did not always act on the findings of audits to make improvements where needed.

However:

- Staff used some recognised rating scales to measure the impact of the service. They also participated in quality improvement projects.
- Managers provided an induction programme for new staff and there was access to ongoing specialist training.

Detailed findings

Assessment of needs and planning of care

We reviewed 35 care records. We found these records to be unstructured. Records did not provide evidence to show what staff were assessing. There was no clear rationale for clinical decision making.

Staff completed an assessment of each patient, although these assessments were completely unstructured. The specification for the service states that clinicians would assess young people during a course of between three and six sessions. Data from the trust shows that young people attended, on average, 10 assessment sessions. Eighteen percent of young people referred to an endocrinology service between March 2019 and March 2020 attended 25 or more assessment sessions. Although the trust had produced this data, it had not carried out any analysis to understand why there was such a high variation in the number of assessment sessions for each patient. Furthermore, there was no clearly defined assessment process. For example, there were no standard questions for staff to explore with young people at each session. Most records of assessment sessions were simply descriptions of conversations that had taken place between the clinician, the young person and their parents. None of the records included a clear statement of what the service was assessing. Whilst the criteria for considering referring young people for administration of hormone blockers was set out in the service specification, we saw no reference to this on any patient records. Although decisions about referrals to endocrinology were taken by at least two clinicians, it would be very difficult for the service to assess whether clinicians had made the correct decision in making a referral.

Although staff did not provide interventions for physical ill health, we did not see consistent evidence that staff routinely asked young people about their physical health, in order to refer them to external services if needed. We reviewed

Our findings

physical health monitoring on 24 records. On 18 records (75%) there was no mention of physical health. Four records (16%) included a discussion of physical health at the initial meeting. This meant that staff were not consistently screening for physical health problems, unless these were included in the referral from the young person's GP or local CAMHS.

Staff did not develop care plans that met the needs identified during assessment. Some records included a short care plan in letters to the young person's GP, but these were usually very brief. For example, one of these letters simply stated that GIDS would continue to support the patient and refer to the adult service when the patient reached the age of 18. Records did not include plans for assessment and care that were specific to needs or circumstances of the young person. This meant that it would be difficult to someone unfamiliar with the young person to understand what assessments had been carried out or what the plans were for further assessment and treatment.

Best practice in treatment and care

We reviewed 35 care records. These records were not completed in a consistent or structured manner. This meant that many records did not demonstrate good practice.

Staff provided a range of care and treatment interventions suitable for the patient group. Care and treatment consisted of an assessment by clinicians followed by ongoing occasional contact with the service, more frequent input from the service approximately every three months or a referral to the endocrinology clinic with ongoing input from the service. The endocrinology clinic prescribed medicines used to block hormones and, therefore, inhibit hormonal changes that take place in puberty. The aim of this model was to provide support, advice and treatment to assist young people experiencing features of gender dysphoria in reducing behavioural, emotional and relationship difficulties. Twenty-eight percent of young people assessed by the service were referred to endocrine clinics for medical treatment. The decision to refer young people to endocrine clinics was taken by at least two clinicians and reviewed at a meeting of senior staff. However, records we reviewed did not sufficiently record the needs of patients with autistic spectrum disorders. The service did not record how many patients had a diagnosis, or suspected diagnosis, of an autistic spectrum disorder. We reviewed a sample of 22 records, more than half of which referred to autistic spectrum disorder or attention deficit hyperactivity disorder (ADHD). Discussions with staff about autistic spectrum disorders focused on the communication needs of these patients. Records we reviewed did not record consideration of the relationship between autistic spectrum disorder and gender dysphoria.

Staff used recognised rating scales and other approaches to rate the extent of young peoples' needs and to monitor outcomes. For example, the service used the Children's Global Assessment Scale to assess adolescent global functioning after psychological support and physical treatment. The service also used Patient Rated Outcome Measures to assess the progress each patient felt they had made as a result of interventions by the service. This included specific measures for gender dysphoria and a self-harm questionnaire.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. For example, the service carried out an audit to see how many young people had received an assessment using the Children's Global Assessment Scale (CGAS). The audit found that 97% of young people who had been discharged between April and June 2020 had received an assessment using this tool. The audit showed a small increase in the average CGAS score from 63.1 at the initial assessment to 66.4 at a pre-discharge assessment. This meant there was, on average, a small increase in patient's global functioning during their treatment, although this did not indicate a significant change. In addition, the service completed quarterly audits of the completion of 'Safeguarding and Risk Forms' and the completion of safeguarding supervision forms to check that these forms were completed correctly. The service had begun work on a quality improvement initiative to improve consistency in managing waiting times.

Our findings

Skilled staff to deliver care

The staff team included clinical psychologists, psychotherapists, family therapists, specialist social workers and a counselling psychologist and assistant psychologists. The service also employed two psychiatrists, two specialist nurses and a large team of administrators.

Staff were experienced and qualified and had the right skills and knowledge to meet the primary needs of the patient group. However, staff did not necessarily have the skills or experience to meet the needs of young people with complex needs. For example, whilst some staff had previous experience of working with patients with autistic spectrum disorders, the service did not employ a specialist to focus on this area of clinical practice. This meant the service may not be sufficiently able to assess the needs of young people with complex needs.

Managers provided new staff with appropriate induction. The induction period for new staff was six months, although this could be extended to ten months if necessary. Clinical staff primarily learned from working alongside experienced colleagues. New staff received supervision once a week. The service had introduced an electronic platform where staff could access teaching materials, text and academic papers that new staff were required to read as part of their induction.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers ensured that staff had access to regular team meetings. Data from the trust showed that clinical staff within the service had received supervision in accordance with the trust's policy. The service in Leeds had recently reintroduced supervision for administrative staff. Staff said that supervision was helpful, providing the opportunity to discuss complex cases and safeguarding matters. However, records of supervision sessions were held confidentially between the supervisor and supervisee. This meant that these discussions lacked transparency and made it difficult for senior staff to monitor the quality of line management. Managers conducted appraisals using a standard development and appraisal form. Completion of this form involved a discussion with the member of staff about their work over the past year, a review of their performance against objectives and a review of their personal development plan. Appraisals also involved agreeing objectives for the year ahead. The trust had developed a training presentation for staff and managers to help them conduct effective appraisals. The service also held discussion forums for staff including weekly team meetings, clinical discussion forums and complex case panels.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers created continuing professional development plans collaborative with staff at annual appraisals.

Managers ensured that staff received the training for their roles. The service provided staff with training sessions at regular team meetings. For example, staff had received training sessions on autistic spectrum disorders, sexual abuse, gender presentation and the Mental Capacity Act.

There was variation in how managers dealt with staff performance. Concerns about poor performance could be identified through supervision or joint working with colleagues. Systems were in place for managers to work with staff to identify and address their development needs by creating an action plan. Managers could be supported by the trust human resources department when necessary. However, staff told us that performance varied enormously. For example, staff said that one member of staff worked with two young people each week whilst other staff worked with 17. They said these types of discrepancies in performance were not addressed.

Multidisciplinary and interagency teamwork

Our findings

Staff held regular and effective multidisciplinary team meetings within the service. Staff held regional team meetings each week and meetings for all staff once a month. At regional team meetings staff discussed practical matters, such as leave and rotas, and complex cases. At meetings for all staff, there were discussions about waiting times, referrals, complaints, patient satisfaction surveys and patient involvement.

Staff usually shared information about young people although they did not always provide effective handover notes. Young people were assigned to a new clinician when the clinician they had been working with left the service. On one patient record, we found that the outgoing clinician had prepared comprehensive handover notes. However, on another record we found there were no handover notes. This meant it could be difficult for the new clinician to provide a consistent service.

The teams did not always have good working links with primary care, social services, and other teams external to the organisation. The service did have good relationships and regular meetings with the endocrinology departments that provided medical interventions. We also found some good practice, including an example of joint assessments with the young person's CAMHS. However, in some cases, work with other agencies was unstructured, inconsistent and poorly recorded. Two records showed that staff from GIDS were not fully involved in multi-agency meetings.

Good practice in applying the Mental Capacity Act

Staff had received training in the Mental Capacity Act 2005. This training included details of the five statutory principles of the Act. The service had provided training on the Mental Capacity Act to over 50 staff at a team meeting in July 2020. A further training session for staff on assessing competency in children under the age of 16 was held at the team meeting in October 2020.

The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act. When staff had any concerns about a patient's competency or capacity, they could discuss the matter with senior colleagues at the complex cases panel. If the staff required further advice, they could contact an independent legal service.

For young people who might have impaired mental capacity, staff had not always assessed and recorded competency or capacity to consent appropriately, although the service had recently made some improvements. We reviewed 16 records of young people the service had referred to endocrinology services for hormone blockers. On six of these records where the patient had been referred for treatment before January 2020, there was no evidence of an assessment of the patient's capacity or competency. Some records showed that staff had discussed the effects of hormone treatment with the young people and recorded that the patient demonstrated an understanding of the potential benefits and side-effects, although these records still lacked a comprehensive, structured approach to the assessment of the patient's mental capacity. Since the introduction of a standard operating procedure for consent, capacity and competency, in January 2020 there had been improvements. This procedure had introduced a form for staff, young people and parents to sign confirming their consent to treatment. The procedure also introduced a checklist for staff to complete confirming that they have provided necessary information to young people and assessed all the components of young people's capacity, such as the ability to understand, retain and weigh up information, as well as being able to communicate their views. However, the absence of structured assessments prior to staff implementing the standard operating procedure in January 2020 meant that the service has not fully assessed the competency and capacity of some young people who were still receiving hormone blockers. At the time of the inspection we asked the trust to review this.

Our findings

Staff's approach to enabling young people to make their own decisions was unstructured and inconsistent although there was some evidence of good practice. Some records included very little information about the work carried out to help the young person make decisions. For example, on one record the evidence of capacity was limited to a statement that the young person was able to think about the pros and cons of treatment. Another simply said that the young person appeared to understand everything and is able to communicate their wishes. There were also some examples of good practice. For example, one record noted observations of family involvement. Also, in this record staff encouraged the young person to have a 'cooling off' period before proceeding with treatment to allow time for them to reflect on their decision. The service had produced a pictorial guide to the effects of hormone blockers. This had been designed for young people with autism or learning difficulties. Many young people said that staff had talked to them about their consent to treatment. Parents also said that decisions about treatment had been discussed at a number of sessions. This helped staff to assess young people's understanding and retention of the information provided. However, whilst staff demonstrated their work on helping young people to understand information about treatment, there were very few details on the records of staff engaging in the more difficult task of supporting young people weigh-up the foreseeable risks and consequences.

Staff audited the application of the Mental Capacity Act but did not always take action to address any learning that resulted from it. The service carried out audits of compliance with the standard operating procedure for consent, capacity and competency in March and September 2020. In the audit in March 2020, the service reviewed ten records of young people who had been referred to endocrinology for hormone blockers. Of these, only three contained a completed consent form and checklist for referral. Staff completing the audit had not recorded the absence of a structured assessment of capacity, competency and consent as a recordable incident. During our review of records, we found no evidence that staff had completed an assessment after the documentation was found to be missing. Again, this meant that staff had still not assessed the capacity and competency of young people receiving treatment, despite being aware that they had not done so. However, the audit carried out in September 2020 showed there had been improvements. This audit found that only three out of 29 referrals to endocrinology did not have a complete set of referral documents.

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated young people with compassion and kindness. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.
- Staff involved young people in their care and actively sought their feedback on the quality of care provided. They provided young people with details of organisations that could provide independent support and information.
- When appropriate, staff involved families and carers in assessment, treatment and care.
- Young people and parents could be involved in the design and delivery of the service.

Detailed findings

Our findings

During this inspection, we interviewed 22 young people receiving care and treatment from GIDS. We interviewed the parents of 13 young people using the service. Twenty-three people contacted the CQC through our website to share their experience of using the service. Feedback from these people was overwhelmingly positive. Six people on the waiting list for the service contacted us through the CQC website. These people were concerned about the length of time they had to wait.

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Throughout our interviews with staff they demonstrated a caring, supportive and understanding approach to patients. Clinicians talked about the importance of listening, engaging and understanding young people and families. Records showed examples of clinicians speaking with patients in a way that was supportive and appropriate to their age. Young people said that their clinicians always responded quickly if they contacted them between appointments.

Staff supported patients to understand and manage their care, treatment or condition. Throughout consultations, clinicians, young people and parents talked about how to manage the young person's situation. This involved, for example, discussion about problems at school as well as discussions about treatment.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, staff provided details of organisations that provided support and information to young people with gender dysphoria.

Patients said staff treated them well and behaved appropriately towards them. Feedback from young people about the staff was overwhelmingly positive. Young people described staff as knowledgeable, caring and understanding. Patients said they felt very safe with their clinicians and valued their non-judgemental approach.

Staff understood the individual needs of patients. However, there was no evidence of the service responding to young people's cultural and religious needs.

Staff maintained the confidentiality of information about patients. For example, clinicians routinely had consultations with young people and parents both jointly and on their own. This provided the opportunity for young people to discuss matters they may not have been comfortable discussing with their parents.

Involvement in care

Involvement of patients

Staff involved patients in discussions about their care and treatment. This included detailed discussions about possible medical interventions.

Staff communicated with young people so that they understood their care and treatment, including finding effective ways to communicate with young people with communication difficulties. Records showed that clinicians spoke with young people in a way that was supportive and appropriate to their age. The service had also provided an illustrated guide to puberty and hormone blockers for young people who may have found it difficult to read detailed text.

Our findings

Staff involved young people when appropriate in decisions about the service. The service had appointed a member of the executive team to be the lead in patient and public involvement. The service provided opportunities to train young people to sit on interview panels for the recruitment of new staff. There were also opportunities for young people to give feedback, to be involved in media activities, to take part in research and to be involved in other training and service development opportunities. At the time of the inspection, take up of these opportunities was low but staff were working to increase involvement.

Staff enabled young people to give feedback on the service they received. Young people and care givers were encouraged to complete an 'Experience of Service Questionnaire'. The questionnaire included 12 questions. This included questions about whether they felt listened to, were their views taken seriously and whether staff sufficiently explained the help available. Between January and March 2020, 44 young people and six parents had completed this questionnaire. The responses they provided were mostly positive. In response to the statement "Overall, the help I received here was good", 88% of young people and 86% of parents said this was certainly true. Respondents were also able to record comments. One young person said that staff were kind and listened to them. A parent said they trust the people they were working with and believed they had the child's best interests at heart. However, another young person said they found the process invasive and they felt staff had misunderstood what they were saying. A parent said they felt like they were being pushed into doing things they didn't want to do.

Young people could not access advocacy through this service. However, the service did give young people details of organisations that provided independent support and information.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. The service worked closely with the parents of young people using the service. Parents attended appointment with young people and were able to see clinicians in private. Feedback from parents was positive. Some parents described the service as being a 'life saver' and that they found a lot of the work to be family focused. Parents said that they were able to build positive relationships with their clinicians and that they trusted the staff to provide the right care, support and treatment for their child. The service also invited parents and siblings to 'Family Days' where families could meet with clinicians to learn more about the service. However, some parents said that they had had to wait a long time for an appointment and they did not receive any support whilst they were on the waiting list.

Staff enabled families and carers to give feedback on the service they received. Parents completed the 'Experience of Service Questionnaire'. Responses to this questionnaire were collated and reviewed by the trust.

Is the service responsive?

Inadequate ● ↓↓

Our rating of responsive went down. We rated it as inadequate because:

- The service was difficult to access. There were over 4500 young people on the waiting list for the service. Young people often waited over two years for a first appointment.

Our findings

- The service did not have specific regard to the needs of all patients including those with a protected characteristic. Staff only completed ethnicity data for half the patients referred to the service. Work with young people did not include cultural and spiritual support.

However:

- Staff offered flexibility in appointment times and followed up patients who missed appointments.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included facilitating transitions to adult gender identity services.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service had a website that provided clear information to young people and parents and carers about the service. It had links to helpful information and resources and contact details for the service.

Detailed findings

The number of referrals to the service had increased from 77 in 2009/10 to over 2700 in 2019/20. Between 2010 and 2017, the number of referrals had, on average, increased by well over 50% each year. However, the rate of increase had slowed to 6% in both 2018/19 and 2019/20. During the year from April 2019 to March 2020, the service received 2736 referrals. The covid-19 pandemic had caused a reduction in referrals. Between January and March 2020, there was a small reduction from an average quarterly rate of 701 between April and December 2019, to 632. There was a more significant reduction between April and June 2020, with the number of referrals falling to 339. The service expected the number of referrals to increase as referral agencies adapt to covid-19 arrangements.

There was a long waiting list for the service. The service was commissioned as a single national provider and the growth in referrals had exceeded the capacity of the service. On 30 June 2020, there were 4509 patients on the waiting list for the service. This had risen to 4677 in October 2020. The service had introduced some initiatives to reduce the waiting list. For example, the service in Leeds had worked collaboratively with a local voluntary organisation to provide sessions on gender identity for young people on the waiting list. The service encouraged patients over 17 years and six months to be referred to the adult service. The service had also carried out work with child and adolescent mental health services to support patients on the waiting list. However, none of these initiatives had had a significant impact. There were not enough new patient appointments available to reduce the number of patients on the waiting list. The numbers of patients who were discharged or referred on from the service was consistently less than the number accepted on to the waiting list. For example, between January and March 2020, the service accepted 456 new patients onto the waiting list but only discharged 128. This meant the service continued to be unable to meet the needs of those young people waiting.

The service had clear criteria for which patients would be offered a service. The service accepted referrals from GPs, CAMHS, other health, social care and education professionals and from voluntary organisations for children and adolescents with features of gender dysphoria. The criteria did not exclude patients who needed treatment and would benefit from it. Between April 2019 and March 2020, the service accepted 90% of referrals made to the service. However, data from the trust showed that 33% of young person only attend one session.

Our findings

The provider did not meet its target for the time from referral to triage/assessment. The service aimed to see patients within 18 weeks from the date of referral. An 18 week wait target is set out in the NHS standard contract. Out of 1089 patients being seen by the service, only 13% were seen within 18 weeks. In total 64% of patients waited more than 66 weeks to be seen, including 26% who waited two or more years. Once patients had been seen at their initial appointment, their second appointment usually took place within the next 11 weeks.

It was possible for the team to see urgent referrals quickly, although regional teams took different approaches to the waiting list. Overall, the service did not provide urgent interventions for young people although it did provide support to local services if that was required.

Where possible, staff offered patients flexibility in the times of appointments. Since March 2020, the service had offered appointments to young people and their parents by telephone or using video conferencing facilities. This had increased the flexibility for appointment times and addressed the concerns of many families who had previously travelled long distances to appointments.

Since the start of the Covid-19 pandemic, staff have conducted appointments with patients using telephone and video facilities. This has led to an increase in the number of appointments provided by staff from 3519 between January and March 2020 to 4032 between April and June 2020.

Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. Between April and June 2020, staff cancelled 2% of appointments. Staff rearranged these appointments as soon as possible.

Facilities that promote comfort, dignity and privacy

The service had a range of rooms and equipment to support treatment and care. The waiting room had chairs for up to six people. Interview rooms had comfortable furniture and adequate soundproofing. Toilets at the London service were gender neutral. The service did not have facilities to carry out physical examinations.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education opportunities. Staff talked to young people about how to manage difficult situations at school to help them maintain a positive experience of education. The service provided information for schools on how to support young people with gender dysphoria. The service contacted the special needs co-ordinator at the young person's school if the young person was having specific difficulties, such as bullying or disengaging from education. One young person told us that the liaison between the school and the service had been very helpful and had led to staff and pupils having a better understanding of gender dysphoria.

Meeting the needs of all people who use the service

Of the 339 referrals made to the service between April and June 2020, 71% were from natal female patients. Staff had recorded the ethnicity of only 51% of patients. Of these, 89% were recorded as being 'White-British'. Only one patient was recorded as being 'Asian or Asian British' and one patient was recorded as being 'Black or Black British'. We reviewed the records of two young people from black or minority ethnic groups. There was no evidence to show that the service had explored the cultural context of these young people.

Our findings

The service made adjustments for disabled people. There was step free access to the service in London and accessible bathrooms available on the site.

Staff ensured that young people could obtain information on treatments, local services and patients' rights. The service provided information about treatments such as hormone blockers.

The information provided was in a form accessible to the particular patient group. For example, the service provided an illustrated guide to puberty and hormone blockers for young people who may find it difficult to read detailed text. This included information on the negative side effects of hormone blockers, such as low mood, fatigue, weight gain and reduced activity. The service had a website that young people who used the internet could access and read all about the service and find links to further information. Information was clear, young person friendly and up-to-date.

Managers could provide staff and patients with interpreters and make information leaflets available in languages spoken by patients. However, the service had not needed to do so. The service provided therapy and support in English.

Listening to and learning from concerns and complaints

Between April 2019 and March 2020, the service had received 17 complaints. Three complaints were upheld. Three complaints were partly upheld. Four complaints were not upheld. Seven complaints were still being investigated. There had been three complaints in September 2020. These related to the waiting time for a first appointment, concerns from a parent about their child's ability to give consent to treatment and concern from a young person about their treatment after their clinician had left.

Some young people and parents we spoke with did not know how to make a complaint, but they all said that if they had any concerns they would feel comfortable speaking to the clinician. Parents said they were confident they would be able to find out how to complain if they needed to. Information about making a complaint was available on the website for the service.

When young people complained or raised concerns, they received feedback. Complainants received a final letter from the Chief Executive setting out the outcomes of the complaint and findings of the investigation.

Staff knew how to handle complaints appropriately. The process for handling complaints was set out in the trust's complaints procedure. This included performance standards such as acknowledging complaints within three days and responding to complaints within 25 days. If the investigation lasted longer than 25 days, young people were kept informed of the progress of the complaint.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. Staff discussed complaints at Clinical Quality and Governance meetings.

Is the service well-led?

Inadequate ● ↓↓

Our rating of well-led went down. We rated it as inadequate because:

Our findings

- The service was not consistently well-led. Whilst areas for improvement had been identified and some areas improved, the improvements had not been implemented fully and consistently where needed.
- Staff did not always feel respected, supported and valued. Some said they felt unable to raise concerns without fear of retribution.
- Managers were not always able to deal effectively with professional disagreement amongst team members.

However:

- Leaders had a good understanding of the young people who used the service and were visible in the service. There were initiatives for young people to give feedback on care and be involved in service development.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Young people we spoke with said those values came across in how staff interacted with them.

Detailed findings

Leadership

The service was led by a service director along with senior clinicians who formed the Gender Identity Development Service (GIDS) executive team. All staff on the GIDS executive team had relevant qualifications and many years' experience of working within the service. Leaders recognised that demands on the service and the leadership team had increased considerably in recent years due to increase in the number of young people referred to the service.

Leaders had a good understanding of the services they managed and identified the challenges the service faced. They could explain clearly how the teams worked to provide the service. Leaders were fully aware of the many challenges, such as the substantial rise in demand, very long waiting lists and high levels of external scrutiny, particularly within the national media. They also highlighted some improvements such as introducing standard operating procedures for safeguarding and consent to treatment. All of the GIDS executive team continued to have a caseload of young people and engaged in the casework discussion forums. Members of the GIDS executive team also participated in complex case reviews.

Leaders were visible in the service and young people and staff knew who they were. The executive team led the clinical quality and governance meeting with all the staff once a month. The service director welcomed discussions and feedback from young people and parents.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The values and ethos of the service focused on promoting non-judgemental acceptance of gender identities, taking a holistic approach and providing support to both young people and their families. Staff demonstrated these values throughout the inspection. Young people and parents told us that they valued and appreciated the supportive, non-judgemental approach taken by staff.

Culture

Our findings

Clinicians said they had developed collaborative and supportive relationships with their colleagues through supervision and staff forums. Staff also felt proud of the way service supported the young people they worked with. However, non-clinical staff did not always feel valued. These staff were often frustrated at being unable to make simple decisions without going through many layers of approval. This meant that it was difficult to make simple improvements to the service and have their voice heard.

Staff said they felt positive and proud about working for the provider and their team. Many staff said that they loved their work. However, some staff said high caseloads and constant external scrutiny meant they worked under relentless pressure. The service was subject to frequent media interest. The service had been subject to a judicial review in the High Court in October 2020. The service was also preparing for a thorough review by its commissioner, NHS England. Some staff said there was a sense of the team being 'under siege' from external pressures. Some staff also commented that although staff turnover was consistent with the average for the trust, it was still high at 24%. This turnover created pressure on long-standing members of staff to support new employees.

Staff did not always feel able to raise concerns without fear of retribution. Some staff, particularly those in non-clinical roles, said there was a fear of blame within the service. This meant they were reluctant to raise concerns.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The Speak Up Guardian presented an annual report to the trust board. In their report in May 2019, the Speak Up Guardian stated that staff at GIDS had raised concerns and that many of these staff felt worried about speaking in open groups.

Managers could deal with poor staff performance when needed, although there were examples of inconsistencies in performance that had not been addressed. Managers explained that when they identified poor performance, they agreed an action plan for improvement with the member of staff.

Teams worked well together although, when difficulties arose, managers did not always deal with them appropriately. Senior managers explained that there were a number of staff forums where clinicians had the opportunity to discuss concerns and differences of opinions. Some staff said that their team was good at challenging each other's clinical opinions. However, during the inspection, staff told us about situations involving differences of opinions between staff. These situations had led to a clinician resigning, a formal grievance, and a situation where staff felt it was difficult to engage with a senior member of staff.

Staff appraisals included conversations about career development and how it could be supported. At each appraisal, staff agreed their objectives and personal development plan for the year ahead.

The service did not provide any initiatives to promote equality and diversity in its day-to-day work. The trust's policy on equality, diversity and inclusion stated the trust's commitment and intent to creating an organisation that diverse, inclusive and provide opportunities for all. However, in relation to race equality, staff commented that the service predominantly employed white people. The workforce race equality standard report for the trust for 2019 showed that over 80% of staff were white.

The service's staff sickness and absence rates were similar to the average for the provider. During 2019/20, the turnover rate of 23.5% was the same as the turnover rate for the trust. The sickness rate of 2.19% was slightly below the sickness rate for the trust.

Our findings

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff could access the trust's 'Staff Advice and Consultation Service'. This service could give support to staff in coping with crises such as bereavement, relationship breakdown or experience of trauma.

The provider recognised staff success within the service. For example, at the regional team meeting in Leeds, staff reviewed compliments and thank-you cards that had been sent to the service. A member of staff was awarded the 'Star of the Month' award. At the meeting in September 2020, staff thanked a colleague for completing a particularly difficult piece of administrative work.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively to ensure that the needs of patients were met in a safe, structured and systematic manner. The GIDS service had a comprehensive action plan to address issues identified by the trust and improve service performance. This was written in March 2019. It contained seven areas of recommendation and over 55 specific actions. These covered areas of concern focused on during this inspection. While improvements were seen in some areas, such as introducing standard documentation for assessments of consent and capacity, there were still many areas where improvements had not been consistent. For example, actions to minimise variation in practice had not been fully achieved. There continued to be a wide variation in the number of sessions young people received, from two or three sessions to over 25 sessions, with some young people receiving more than 50 sessions. There also remained variation in assessments which were unstructured. Assessments did not demonstrate what staff were assessing or demonstrate clear criteria for decision making. There appeared to be no framework for discharge other than young people reaching the age of 18. Actions to manage the waiting list had not reduced the time young people waited, with current waits at 24 to 26 months. Record keeping was also poorly organised and it could be difficult to find important information.

There was a clear framework of what must be discussed at a team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The service had an established structure for executive team meetings, meetings for senior staff, clinical quality and governance meetings and regional team meetings. Each meeting had a standard agenda of items that were discussed. For example, at clinical quality and governance meetings staff discussed waiting times, complaints, feedback from young people and opportunities for young people to be involved in the service. At regional team meetings, staff discussed practical arrangements, such as leave and rotas, and casework. These meetings also provided opportunities for staff to discuss any concerns.

Staff undertook or participated in clinical audits. In most cases the audits were sufficient to provide assurance and staff acted on the results when needed. One exception we found was that staff had not taken sufficient action after an audit on consent and capacity found cases were missing necessary paperwork.

The service did not have consistent arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. For example, records did not include risk management plans to show which agencies were responsible for or involved in managing the risks to young people. However, the service did have well-established arrangements for supporting young people to be transferred to the service for adults. The service also had regular meetings with endocrinology services.

Management of risk, issues and performance

Our findings

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level. Two entries on the trust's risk register related specifically to GIDS. The risk register included details of the risk, a risk score and details of action being taken to mitigate the risk.

Staff concerns matched those on the risk register. Entries on the risk register related to stress placed on staff due to the level of internal and external scrutiny and the length of waiting times. Both these risks were assessed as being high.

The service had plans for emergencies, for example, adverse weather or a flu outbreak. The trust had developed a business continuity plan that provided details of what the trust would do in the event of a major incident.

Information management

The recording of information was insufficient to ensure safe and effective professional practice. Records of sessions with young people and their parents were often simply descriptions of discussions that had taken place. They did not include any analysis, structured assessment, professional curiosity or clinical decision making. One member of staff commented that clinicians often said they were too busy with direct patient work to complete records. Supervision notes were also held in confidence by the supervisor and supervisee. This meant the service did not have access to fundamental information about the competence of staff in respect of both work with young people and the provision of supervision.

The service used systems to collect data that could be over-burdensome for frontline staff and administrative support was not working efficiently. The service employed 15 administrators to support 66 clinical staff. Many staff said there was too much administrative work. One member of staff said the service would be improved if there was more time to think and less administrative work.

Information governance systems included confidentiality of patient records. Breaches of patient confidentiality were record as information governance incidents.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. This information was prepared by non-clinical staff and accessed by the executive team in the form of a monthly dashboard. However, there were concerns that the executive were reluctant to engage in discussions about data.

Staff who left the service were routinely offered an exit interview with a line manager or executive team member. They could make a specific request for exit interview with a member of staff from trust human resources department if they preferred.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. For example, the service provided updates and information in the 'News' section of its website.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff encouraged young people and their parents to give feedback by completing the 'Experience of Service Questionnaire'.

Our findings

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. The service collated reviewed feedback. Staff discussed this feedback at clinical quality and governance meetings. Collated feedback was included in the quarterly report to commissioners.

Directorate leaders engaged with external stakeholders. The service provided comprehensive reports to commissioners every three months.

Learning, continuous improvement and innovation

Some staff said they were given the time and support to consider opportunities for improvements and innovation. For example, staff had explored initiatives to reduce the waiting list. These initiatives had involved collaboration with CAMHS and voluntary sector organisations. Other staff said it could be difficult to embed improvements across the whole service and it was done at a local team level. They said it could be difficult to embed consistently and have their ideas considered by senior staff in other teams.

Staff used quality improvement methods and knew how to apply them. The service had provided training in quality improvement methods for non-clinical staff. The service was carrying out a quality improvement project to review the parity of waiting times in the different regional teams.

Our findings

Areas for improvement

Action the provider **MUST** take to improve

The service must ensure that it meets the needs of young people who are referred to the service. Regulation 9(1)(b)

The service must ensure that young people referred to the service do not have to wait unacceptable lengths of time for a first appointment. Regulation 9(1)(b)

The service must ensure that plans for care and treatment are established and clearly recorded on care records. Regulation 9(1)(b)

The service must ensure that appropriate staff with specialist skills are available to meet the needs of young people and that records of assessments include details of how care and treatment is planned in relation to those complex needs. Regulation 9(1)(b)

The service should ensure that it records the details of ethnicity for all young people and that it responds to young peoples' cultural needs. Regulation 9(1)(b)

The service must continue its work to ensure that assessments of capacity, competency and consent are recorded for all patients referred for medical treatment, including young people currently receiving treatment who were referred before January 2020. Regulation 11(1)

The service must ensure that staff assess the risks to all young people and record these risks appropriately. Regulation 12(1)(2)(a)(b)

The service must ensure that systems or processes are established and operated effectively to ensure compliance with regulations. The service must maintain securely an accurate, complete and contemporaneous record in respect of each young person, including a record of the care and treatment provided to the young person and of decisions taken in relation to the care and treatment provided. This includes ensuring that assessments and clinical decisions are structured and clearly recorded. Regulation 17(1)(2)(c)

The service must ensure that systems are in place so all staff are able to contribute to discussions about the service and that staff do not feel fearful that they will be blamed when they raise concerns. Regulation 17(1)(2)(e)

Action the provider **SHOULD** take to improve

The service should have effective systems in place to ensure that staff caseloads are kept to an equitable and reasonable level and to ensure that staff feel they have a manageable workload.

The service should ensure that staff are aware of young peoples' holistic needs including their physical health needs.

The service should continue its work with individual clinicians to review their competency and performance in terms of meeting the requirements of the service and the young people they support.

Our findings

The service should ensure that non-clinical staff have sufficient training to ensure they are confident in responding appropriately to potential safeguarding risks they encounter through their contact with young people using the service.

The service should ensure that all staff have completed an appropriate level of training in safeguarding adults.

The service should ensure that it continues to develop its multi-agency support and protection for young people, including the development of joint protocols and information sharing agreements.

Our inspection team

The team that inspected the service comprised of eight CQC inspectors, an assistant inspector, two inspection managers, two specialist inspectors of children's services, a head of hospital inspection and two specialist advisors with professional backgrounds in gender identity services. The lead of a current independent review of gender identity services for children and young people, commissioned by NHS England, attended all the interviews with the executive team, interviews with some other members of staff and participated in meetings to review the evidence collated during this inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care