Tavistock and Portman NHS Foundation Trust

Gender identity services

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Gender identity services

Inspected but not rated

This was a short 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. 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.

The service is commissioned by NHS England (NHSE). 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.

Since our last inspection in October 2020, NHS England have been in the process of re-designing how services for children and young people with issues of gender incongruence are offered across England, following recommendations from the Cass Review and acting on the findings of the CQC's previous inspection. The GIDS will be closed. New regional providers will be established throughout England. This implementation which was initially due to take place in April 2023 has been delayed to March 2024.

To support the transition of service provision to the first new providers, responsibility for managing the GIDS waiting list has now transferred completely to NHS England, who now holds a single national waiting list from which the new providers will see children and young people. NHS Arden and GEM Commissioning Support Unit (CSU) is supporting NHS England in managing the national waiting list. Nottinghamshire Healthcare NHS Foundation Trust provide limited clinical input.

Since October 2022 GIDS has not been accepting any new referrals and are not involved in the management of the waiting list. Therefore, the previous breaches in relation to the waiting list identified at our last inspection are no longer valid. A condition on the trust to keep CQC updated on progress with managing the waiting list is removed as this is not applicable.

The service is only managing open cases. The trust will continue to hold clinical responsibility for these patients until they are either discharged or transferred to a new provider by 31 March 2024.

The Tavistock and Portman NHS Foundation Trust provide outpatient psychosocial services only, and GIDS provides outpatient services for young people experiencing difficulties with their gender identity development. 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 suppress the production of endogenous sex hormones. The endocrinology departments at The Leeds Teaching Hospitals NHS Trust (Leeds General Infirmary) and University College London Hospitals NHS Trust provide all medical interventions for GIDS patients.

We did not re-rate the overall service following this focused inspection. Our last inspection of GIDS was in October 2020. Following the inspection, we rated the service as inadequate. We rated the domain of safe and effective as requires improvement. We rated responsive and well-led as inadequate. We rated caring as good.

Our findings

We undertook this inspection to follow up on the actions taken by the service to address some of the breaches of regulation from our previous inspection and to see what improvements had been made. As the transfer of the young people to the new services had taken longer than expected we wanted to check that young people currently receiving care and treatment under the GIDS were receiving safe care.

Between July 2022 and January 2023, the trust had experienced a malware attack affecting the trust's electronic patient record system. We took this into account during our inspection and assessed how the service had managed this. This issue had affected several NHS and independent health providers.

We did not rate the service at this inspection. We found:

- The service had made some improvements since our last inspection in October 2020, but further work was needed to fully address the breaches of regulation and to ensure that improvements were embedded and sustained.
- The service had introduced a transfer of care and risk form that had been added to the electronic patient record. Staff completed an initial assessment of risk at the first consultation. All open cases had been rated for risk (using a red, amber, green system) so that clinical staff had an overview of individual risk.
- Safeguarding processes had been strengthened. All clinical and non-clinical staff had undertaken role relevant safeguarding adults and children training. Staff reported that the culture around reporting safeguarding had improved.
- Capacity and consent for young people receiving medical treatment was clearly recorded. All young people undergoing medical treatment had a care plan in place.
- Leaders had the skills, knowledge and experience to perform their roles. They fully understood the issues, priorities, the substantial challenges the service faced and were taking action to address them.
- Staff reported that the culture within the service was improving. They reported feeling more confident in raising any concerns. Staff were supported and involved in contributing to discussions about the service.
- Work was in progress to strengthen governance arrangements, leaders acknowledged that further development work was required to ensure previous breaches of regulation were addressed in full and improvements were sustained and embedded within the service.

However:

- The service was experiencing some challenges with staffing. There were high rates of staff attrition due to the forthcoming closure of the service. Staffing levels at the time of the inspection were sufficient to meet the needs of young people receiving treatment. The trust were closely monitoring the workforce and any potential risks during the time up to the transfer to new providers in March 2024.
- Work was in progress to address the ongoing shortfalls with record keeping. Records were not always of good quality. The service had been impacted by the care notes outage and difficulties with the care notes recovery programme.
- Staff were still not recording risk management plans clearly in the patient record.
- Young people not receiving medical treatment did not have a care plan in place.
- Capacity and consent was not recorded for young people that were not undertaking medical treatment.
- Although improvement actions had been identified for most audits, completed changes in practice had yet to be fully embedded.

Our findings

How we carried out the inspection

During the inspection visit, the inspection team:

- visited the service in London to look at the quality of the environment.
- spoke with 3 parents of young people using the service and 1 young person who was using the service. Interviews with carers and the young person were completed by telephone. Our final carer interview was on 22 September 2023.
- spoke with the trust Chief Nursing Officer, Chief Clinical Operating Officer and the Associate Director of Quality.
- spoke with the GIDS safeguarding lead, the clinical director of operations, associate clinical service director and interim clinical governance lead.
- spoke with 12 other staff members across the multidisciplinary team.
- looked at 16 care and treatment records.
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with 3 carers of young people using the service and one young person. Carers overall were positive about staff. They felt involved and informed about their child's care and treatment where appropriate. The young person reported that they were involved in their care and treatment.

All expressed frustration at the system, long waiting times, communication issues between GIDS and adult Gender Identity Clinic services and lack of any information from NHS England about future services and any on-going care.

Is the service safe?

Inspected but not rated

We did not inspect the whole of safe during this inspection and therefore did not rate the key question.

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Interview rooms were not fitted with alarms. There had been no incidents involving children and families. Staff considered that the risk presented by interviews was low and did not require alarms to be installed. Staff did not have personal alarms.

Our findings

All areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Corridor, waiting room and therapy rooms had artwork reflecting the journey of patients and their families.

Clinicians had space to hold confidential video calls when needed. Staff did not conduct outreach home visits unless there were exceptional circumstances.

Step free access was available via a lift.

Safe staffing

The service had enough staff with the right qualifications, skills, training and experience to meet the needs of young people who were receiving treatment at the time of the inspection. There was an ongoing risk due to staff leaving the service, but this was being closely monitored and with some limited internal recruitment the trust was managing to deliver the agreed service.

At the time of our inspection there were 47 clinicians in post, 42 of these were whole time equivalent (WTE) posts. Clinicians included, clinical psychologists, psychotherapists, clinical nurse specialists and a consultant psychiatrist. Since July 2022, 38 clinicians had left the service. High attrition rates were due to uncertainty about the service and when it would be decommissioned.

The established number of assistant psychologists was 4.0 WTE. The service employed 23 administrators. Since July 2022, 20 admin staff had left the service. In response to the possible clinical risk NHS England had agreed for the service to undertake internal recruitment for GIDS clinicians. The service had recently recruited two consultants to the Leeds service. Ongoing recruitment of admin staff continued to take place. The service reported that the numbers of staff in place met the service specifications as required by NHS England.

The service also received support from service managers, project managers, research assistants and divisional level staff.

At our inspection in October 2020, appropriate staff with specialist skills were not available to meet the needs of young people and records of assessments did not include how care and treatment was planned in relation to complex needs. During the inspection leaders reported that due to the forthcoming closure of the service several staff with specialist skills had left the service. The remaining staff were managing, as of 1 September 2023, 856 open cases. Within the remaining clinical team 22.3 WTE clinical staff were able to fully assess and diagnose a young person and 9.3 WTE staff were able to partially assess. The service continued to face substantial challenges with staffing the service safely and ensuring that individuals received the right level of care and support.

This risk was mitigated by the service holding weekly operational staffing review meetings, monthly clinical governance meetings and monthly meetings with NHS England. To ensure the safe transfer of the service to the new providers in March 2024 the GIDS decommissioning programme of work were closely monitoring all elements of workforce risk to the service. The cumulative and ongoing staff attrition remained a high risk for the service. These concerns were on the trust risk register and senior leaders were fully sighted on the risk.

Our findings

Staff were working only with young people that were already open to the service. The service was no longer open to accepting new referrals at the directive of NHS England. Caseloads were reviewed during supervision, at clinical governance and senior management meetings to ensure that existing staff were able to safely meet individual patient need. The service had reviewed each young person on the open caseload, 4% were risk rated red, 31% amber and 65% rated green.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The compliance rate for the service was 95%. The mandatory training programme was comprehensive and met the needs of patients and staff. It included safeguarding children and adults, clinical risk assessment, Freedom to Speak Up, Mental Capacity Act awareness, fire safety, infection prevention and control and information governance and data security.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received emails prompting them to complete their training when their training was up for renewal.

Assessing and managing risk to patients

Assessment of patient risk

At our last inspection, we found that the recording of risks and risk management plans varied considerably. At this inspection we found some improvements. The service had introduced a transfer of care and risk form that had been added to the electronic patient record.

We reviewed 16 care records and saw that staff had mostly completed a brief risk assessment information at the first consultation. Parents we spoke with also confirmed that staff spoke about any risks associated with the care and treatment being offered.

All clinical staff had undertaken clinical risk management training.

Management of patient risk

At the last inspection we noted that most patient records did not include a risk management plan to show how risks were being managed and which agencies were responsible. This time, we noted that there had been some improvement and further improvements were required to address the breach in full. The recording of risk and of plans to manage these risks continued to vary considerably. For example, where risk assessments identified triggers there was no associated risk management plan in place. Some risk management plans had not been updated within the last 12 months.

Staff were expected to complete risk management plans by the second consultation. Leaders within the service were aware that not all staff were completing risk management plans in line with the trust policy and were monitoring this through regular audits and updates at the clinical governance meetings. The service worked with and relied on the child's local support agencies, such as child and adolescent mental health services (CAMHS) or the GP to address any serious risk issues whilst the young person was being seen by the service, for example we saw that the service worked closely with the local CAMHS team where a young person was subject to a child protection plan.

At our last inspection, the service was not meeting the needs of people referred to the service who were on the waiting list. The service had not been accepting any new referrals since March 2023.

Our findings

The service had calculated the risk for each individual that was open to the service. All open cases had been risk assessed and given a rating of red, amber or green. Four per cent of cases had been RAG rated red. There was no regular review of these cases, but clinicians could bring any concerns to their clinical supervisor or senior managers within the service. Following the inspection, the service told us they were in the process of implementing a system to regularly review red rated cases.

At our last inspection, young people referred to the service were waiting unacceptable lengths of time for their first appointment. At this inspection we found that the service no longer managed a waiting list for young people with gender dysphoria. The waiting list had been transferred to NHS England in March 2023.

In agreement with NHS England and in preparation for the closure of the service, as of August 2023, 97% of the 17 years old and over on GIDS waiting list had been transferred to adult Gender Identity Clinic services (GICs). The service was also reviewing the 18+ caseload. At the time of the inspection there were 253 cases identified. Due to the issues with the malware outage117 cases were in the process of being reviewed by clinicians to ensure that appropriate referrals had been made to adult gender identity clinics GICs.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

At the last inspection not all clinical staff had been trained in safeguarding adults and non-clinical staff had not received the appropriate level of safeguarding training. At this inspection we found improvements. Staff received training on how to recognise and report abuse, appropriate for their role. All non-clinical staff had completed safeguarding level 1 and 2 children's safeguarding training. Admin staff we spoke with confirmed they had undertaken training, had clear guidance and understood the actions required to escalate any concerns to a clinician.

Clinical staff had completed adult safeguarding training.

The service now had a GIDS safeguarding email address and the safeguarding lead for the service was copied into all referrals to social care and local CAMHS. All staff we spoke with confirmed they were able to raise any safeguarding concerns and understood the process for raising safeguarding referrals and received safeguarding supervision when required. Staff reported the culture around reporting safeguarding had improved.

The service now had 6 safeguarding advocates across the organisation. The advocates were available to support staff and monitor the completion of safeguarding and risk forms in their areas. Since April 2022 the service held a monthly safeguarding oversight meeting and 3 of the advocates monitored the GIDS safeguarding email address. Advocates were able to share any safeguarding issues that the teams were experiencing.

We saw detailed supervision records where staff discussed individual cases and any safeguarding concerns. Plans were in place to audit records of safeguarding supervision. Most case discussion occurred during 1 to 1 individual staff supervision.

There had been a total of 10 safeguarding referrals within the last year. The safeguarding lead monitored progress with each referral.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act, for example the service worked with schools to address transphobia.

Our findings

Staff knew how to recognise adults and children at risk of or suffering harm and worked in partnership with other agencies to protect them. Frameworks for information sharing were in place. The service had developed an inter-agency information sharing form. Staff used this form to provide and share essential information with social services and CAMHS.

Staff access to essential information

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, and up to-date. However, records were stored securely and easily available to all staff providing care.

Information needed to deliver patient care was available to all relevant staff. At our last inspection 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. The service had found it difficult to make improvements in this area due to the malware attack that had affected the trust electronic record system. The malware attack between August 2022 and January 2023 had affected several NHS and independent health providers. The service had worked hard to ensure that all records had been recovered. Leaders reported that the malware attack had not impacted patient safety or quality of care.

At this inspection we found that the service had developed a standard operating procedure for healthcare records and a clinical notes and record keeping guide. We saw that there were some improvements in practice, but further improvements were required to address the breach in full. All patients we reviewed had a risk assessment. Young people receiving medical treatment had a detailed care plan in place. However, records did not clearly detail that risk management plans were in place, young people not having medical treatment did not have their capacity to consent recorded or a detailed care plan in place.

Leaders within the service were aware of the shortfalls with record keeping. Work was taking place to improve patient records with the addition of mandatory templates to record risk, safeguarding and consent. Plans were in place to address gaps in record keeping identified in Q1 and Q2 audits in 2022/2023. But as yet there had been no follow up audit to check whether the actions taken had led to an improvement in the completion of patient care records.

Track record on safety

The service had a good track record on safety.

In the 12 months prior to the inspection visit there had been 30 incidents. One of these incidents was confirmed as a serious incident. .

Reporting incidents and learning from when things go wrong.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

Staff knew what incidents to report and how to report them using the electronic incident reporting system. Staff raised concerns and reported incidents, serious incidents and near misses in line with trust policy.

Staff met to discuss the feedback and look at improvements to patient care. All incidents were reviewed at the monthly clinical governance meeting and discussed with operational, general, and service managers. Any lessons learned were shared with the wider team, for example following an incident admin staff were reminded to check patient information before it was sent to another provider.

Our findings

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, the service apologised to a patient when they had not been transferred to an adult gender identity clinic.

Is the service effective?

Inspected but not rated

We did not inspect the whole of effective during this inspection and therefore did not rate the key question.

Assessment of needs and planning of care

At our last inspection we found that staff did not develop care plans for young people. At this inspection we found some improvements, but further improvements were required to address the breach in full. Young people on the endocrine pathway had a detailed assessment and care plan in place. Records we viewed detailed how clinical decisions had been reached for the young person to start medical treatment.

However, young people who were not on the endocrine pathway did not have a care plan in place. The service detailed the care agreed in letter format which was sent to the young person and GP. Care plans were not always stored in the same place making them difficult to find. Leaders reported that new care planning and risk assessment process had been developed and timescales for implementation were by the end of December 2023.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on 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 assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence who were receiving medical treatment. However, this was not recorded for young people not receiving medical treatment.

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. Staff could also access independent legal advice if required.

At our last inspection the staff had 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. At this inspection we found some improvements. Clinicians had carried out a retrospective review of all cases referred to endocrinology prior to January 2020 to ensure that capacity and competence had been assessed prior to referral for medical treatment such as hormone blockers. All young people on the endocrine pathway receiving medical treatment had been assessed and their capacity to consent to treatment recorded clearly.

We spoke with three parents of young people using the service and one young person using the service. All confirmed that consent was discussed numerous times and at every appointment prior to any treatment being started.

Our findings

However, we found that staff did not always record consent for treatment for young people that were not receiving medical treatment. We found that the staff did not always consider this at the first assessment. Whilst staff we spoke with understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles, when necessary, this was not always recorded clearly, for example for one young person staff had recorded that Gillick competency should be completed for a young person where they had concerns about the young person's capacity. The patient record did not evidence that this had been completed, in line with the trust policy. This was an on-going issue that had been identified within the service through audits of how the MCA was applied. Action plans were in place to address shortfalls identified by the audits.

Is the service well-led?

Inspected but not rated

We did not inspect the whole of well-led during this inspection and therefore did not rate the key question.

Leadership

Leaders had the skills, knowledge and experience to perform their roles and run the service. They understood and were making improvements to manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Since our last inspection changes had been made to the leadership team at the trust. The trust had a new executive team in post including the Chief Executive Officer, Chief Nursing Officer, and Chief Medical Officer. The GIDS directorate had a new clinical operations director and a new interim governance lead.

Leaders had the skills, knowledge and experience to perform their roles. They fully understood the issues, priorities and the substantial challenges the service faced. The service remained under high levels of scrutiny and media interest. Leaders were balancing meeting the needs of people using the service, supporting staff and making plans to decommission the service safely. Whilst all this was taking place leaders were still focused on making improvements to the service and the care and treatment young people received.

Leaders were visible in the service, approachable and accessible for patients and staff. Staff reported they could raise any concerns they had with them.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

At our last inspection systems were not in place so that all staff were able to contribute to discussions about the service and there was a fear of blame in the service.

At this inspection we found improvements. Staff had access to reflective sessions, multi-disciplinary team meetings, weekly drop-in sessions, regional meetings and a weekly newsletter. The provider intranet had an area where staff were able to feedback on policies and any operational issues. Staff had also been contributing to a mapping exercise focused on additional staff needs before the service was decommissioned. Leaders had also invited the new early adopter teams and NHS England to meet with staff.

Our findings

Staff we spoke with confirmed the culture within the organisation was improving. They reported feeling more confident in raising any concerns.

There was ongoing work to create a culture of openness and transparency within the service. Overall teams worked well together. Any differences in opinion could be raised with senior managers and at a number of staff forums.

All staff said that senior leaders within the service were visible and approachable.

In May 2023, the Care Quality Commission carried out a focused piece of work around the current Equality Diversity and Human Rights (EDHR) arrangements within the trust. A number of recommendations were made following the review which the trust is following up on. During this inspection we heard that there had been little progress with equality and diversity improvement plans. We heard about discriminatory behaviours that people of colour experienced from individuals within the team.

Governance

Our findings from the other key questions demonstrated that governance processes were mostly operated effectively at team level and that performance and risk were managed well. However, further improvements were required to ensure that the service complied with the previous breaches of regulation.

Our findings from the other key questions demonstrated that governance processes did not always operate effectively.

At our last inspection we found that governance processes did not operate effectively to ensure compliance with regulations. The service was not maintaining an accurate, complete and contemporaneous record in respect of each young person including a record of the care and treatment provided, assessments and any clinical decisions made.

At this inspection we found some improvements, however further improvements were required to address the breach of regulation in full.

A new clinical governance lead had been in post since 2022. They told us that the governance processes were being reviewed to ensure that they were strengthened and to ensure that there were clear lines of responsibility and accountability. This work included having a clear structure for meetings, their function and tasks, reviewing standard operating procedures and having clear structures and frameworks for the service in place. Since May 2022, the service now had Clinical Governance functional Group specific to GIDS.

The service leadership team were aware of areas where improvements could be made and were committed to improving the service for patients. The GIDS service had a comprehensive action plan following our last inspection to address the breaches of regulation. This was reviewed monthly at the clinical governance group.

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.

The service had introduced an annual plan of audits and a system for reviewing and taking action in response to shortfalls identified in those audits. A weekly audit meeting was held where audits were planned and scheduled. The

results of completed audits were presented to the weekly audit meeting and then to the clinical safety governance practice project board where the results were discussed in more detail and an action plan created. Actions were added to an action log where they were monitored in terms of completion. There were systems for cascading actions up and down the organisation.

We reviewed a sample of audits. An audit of safeguarding and risk assessment forms in March 2022 identified 105 cases (out of 223 audited) without a completed form. By September 2023 the safeguarding lead was able to show there had been a clear improvement in this area. Out of 856 cases currently open to GIDS, only 28 of these did not have a completed safeguarding and risk assessment form in place.

An audit of GIDS care notes completed for Q2 2022/2023 sampled 50% of all new assessments (98 patients in total). In terms of capacity, competence and shared decision making 41% of records were inadequate and 16% required improvement. In terms of cultural and broader needs 8% were inadequate and 45% required improvement. For physical health 4% were inadequate and 23% required improvement. For care plans 1% were inadequate and 23% required improvement.

Plans were in place to address gaps in record keeping identified in Q1 and Q2 audits in 2022/2023. But as yet there had been no follow up audit to check whether the actions taken had led to an improvement in the completion of patient care records. Record keeping had been affected by an outage of the records system from July 2022 until January 2023. Audits of care notes due for Q1 and Q2 2023/2024 were in the planning stage.

Leaders accepted that although improvement actions had been identified for most audits changes in practice had yet to be fully embedded. The service was aware that re-auditing was required to ensure improvements had been made.

Management of risk, issues and performance

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.

Leaders were aware of the main risks in relation to the service they were providing and demonstrated a good understanding of how to improve performance.

Twelve 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. Some of the entries on the risk register related to waiting list times, accuracy of data, risks around transfer of the service and staff well-being.

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 service still had ongoing issues with the recording of information to ensure safe and effective professional practice. We found that the quality of recording varied between clinicians. The service had developed standard operating procedures for record keeping. Leaders were monitoring progress through their audit programme and were aware of the continued gaps in this area.

Our findings

Following the electronic care records outage, the service created a temporary system to store care records. Following restoration of the care record system administration staff had moved all patient records from the temporary system to the trust permanent system. Data cleansing was taking place continuously to ensure that young people transferred safely to adult GICs and when required to the new providers of the service.

Information governance systems included confidentiality of patient records. Breaches of patient confidentiality were recorded 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.

Engagement

Managers engaged actively with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector). There were local protocols in place for joint working between agencies involved in the care of children and young people.

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' and events section of its website. There was comprehensive information available on the service transformation programme and how people using the service would have their care transferred to the new early adopter services.

Patients had opportunities to give feedback on the service they received. Staff encouraged young people and their parents to give feedback by completing a feedback questionnaire.

Clinicians worked closely with paediatric endocrinology teams in Leeds and London. Leaders were working closely with NHS England to ensure the closure of the service and transfer of young people to the new gender incongruence services was being managed safely.

Our findings

Areas for improvement

Action the trust MUST take to improve:

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

The service must 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) (from November 2020 inspection).

The service must continue its work to ensure that assessments of capacity, competency and consent are recorded for all patients who are receiving care and treatment from the service. Regulation 11(1)

The service must ensure that where risks are identified that there is a clear risk management in place for all young people. Regulation 12(1)(2)(a)(b)

The service must continue 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)

Action the trust SHOULD take to improve:

The trust should continue to closely monitor staffing levels to ensure they meet the needs of young people currently using the service until the transfer of the service to the new providers.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one senior mental health specialist, three inspectors and one specialist advisor with experience of working with children and young people.

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	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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