

Tavistock and Portman NHS Foundation Trust

Other specialist services

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RNK01	The Tavistock Centre	Gender Identity Development Service	NW3 5BA
RNKX1	Gender Identity Development Services (GIDS) Leeds Base	Gender Identity Development Service	LS1 2LF

This report describes our judgement of the quality of care provided within this core service by Tavistock and Portman NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Tavistock and Portman NHS Foundation Trust and these are brought together to inform our overall judgement of Tavistock and Portman NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated the gender identity development service as **good** because:

- Children and young people received care delivered by a skilled multi-disciplinary team who were supported to develop specialist skills and knowledge.
- Managers provided staff with frequent and effective supervision and supported the staff team through regular meetings, appraisal and reflective practice groups. The team was cohesive and proud to work for the trust.
- Most young people and family members were extremely positive about the support which they received from the service.
- The service worked to address risk and recognised safeguarding concerns where they arose.
- There was a very strong focus on research and using evidence based practice as well as extending the research base and evidence within this specialist area. Clinicians had opportunities to attend and contribute to international conferences and publish

research findings. They also carry out service-specific audits with a focus on improving the outcomes for children, young people and families who used the service.

However:

- While staff understood the importance of risk assessment and management and told us they reviewed risks regularly, this was not always recorded in detail in young people's records.
- Some parents told us that they did not receive clear information about the pathway, and care and treatment plans within the service.
- There had been some breaches of the 18 week waiting time between referral and assessment. The number of breaches had increased over the past year due to the increase in referrals.
- Some parents and carers were reluctant to make a complaint as they feared this would affect the treatment of their child. We found no evidence to suggest this was the case but staff had not been proactive in encouraging complaints or providing reassurance.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as good because:

- While there had been an increase in referrals to the service, the service was fully staffed and caseloads were monitored and adjusted according to the experience of clinicians.
- The service had responded to concerns related to the management of risk by initiating the piloting of a 'first contact'. Young people and their families were contacted by telephone while waiting for an assessment so any issues and concerns could be addressed immediately.
- Staff had completed their mandatory training and had a good understanding of safeguarding children and adults. They understood the trust policy on safeguarding and knew who to contact when they needed to escalate concerns.
- Staff understood how to report incidents and near misses that happened while patients were within the service. The provider disseminated information about incidents within the service so that learning could be shared.

However:

- Incidents involving young people, which took place in their local areas and were managed by local community mental health teams, were not consistently reported and recorded by the gender identity development service. This meant there was a risk that learning would not be shared.
- While clinicians told us they discussed and addressed risk at each appointment, this was not always recorded in detail in young people's records.

Good



Are services effective?

We rated effective as **good** because:

- The gender identity development service carried out comprehensive assessments of young people including families.
- There were strong links between the team at the trust and the specialist endocrinology services at the Leeds General Infirmary and University College Hospital, London which linked with the service. The service linked with other involved partners including GP, local child and adolescent mental health services and schools, where necessary.

Good



Summary of findings

- The service was strongly involved in national and international networks, which promoted research and dissemination of best practice information about gender identity services.
- Staff used recognised outcome measures to determine the effectiveness of the care and treatment provided by the service.
- Staff had the opportunity to develop their professional expertise by accessing specialist training. The trust and service encouraged and promoted this.
- The teams were multidisciplinary and this allowed holistic approaches to be taken regarding the needs of young people and their families, using the different skills of the clinicians within the team.

However:

- While some links had been made with adult gender identity clinics throughout the UK, this was not consistent and depended on relations being made with specific clinics. This meant that there was not a coherent pathway, that was not reliant on geography, for young people to transfer into adult services at the ages of 17 or 18 years.
- Case notes were written on paper and then scanned onto the electronic patient record. Scanned records were difficult to read. This meant there was a risk that important information would be missed by clinicians.

Are services caring?

We rated caring as **good** because:

- Most feedback we received from young people and their families was very positive about the support provided and the kindness and consideration of staff.
- We observed that staff spoke about young people with respect and consideration. Staff were passionate about promoting the rights of and advocating for the user group and ensuring that the best care possible was provided.
- The trust and service had undertaken a number of initiatives to ensure that the “patient voice” was reflected throughout the service and the trust including involvement in a stakeholder group, which met regularly.
- Young people who used the service were involved in all interviews for new staff joining the service.

However:

Good



Summary of findings

- We received some negative feedback from parents who suggested that they were not always clear about the care pathways and had not had been given information about the care and treatment provided.
- The service did not have a system of providing a distinct 'care plan' to young people. Staff did not record in whether plans of care had been discussed with children, young people and families or whether they had agreed to them.

Are services responsive to people's needs?

We rated responsive as good because:

- While there had been some breaches in the waiting time targets, which were set at 18 weeks, the service worked proactively to manage risk and ensure that young people and their families had information about the service during this period. There had been a significant increase in referrals for the service to manage over the last year.
- The service engaged well with commissioners in order to share information about the service and ensure that there was an understanding of the service.
- The base in Leeds had been identified as being too small to meet the needs of people using the service and staff working within the service. A new site had been identified and the service was moving to this site during the period the inspection was being carried out.
- The service had established some outreach clinics in the south and south-west of England to further increase accessibility to the service. It was looking to expand further in this respect.

However:

- Some young people and family members told us that they did not have information about how to make a formal complaint. Some feedback we received indicated that because the service was highly specialist, some people were reluctant to complain and anxious about making complaints in case this affected the level of care provided. The service was not proactive in encouraging complaints and reassuring people who wished to make complaints.

Good



Are services well-led?

We rated well-led as **good** because:

Good



Summary of findings

- The staff team were proud to work for the service and the trust. They were aware of the senior leadership within the trust and the team based in Leeds were linked in with the rest of the service despite the distance.
- There were strong internal governance systems within the service with the service director having a good knowledge and understanding of the areas of risk and outstanding practice within the service.
- Information about the service was shared regularly through team meetings.
- There was a very strong research focus within the team and comprehensive internal auditing processes.

Summary of findings

Information about the service

The gender identity development service was established in 1989. It is a national, highly specialist multi-disciplinary out-patient service that works with children and young people, up to the age of 18, who experience difficulties with the development of their gender identity as well as their families and carers. The service accepts referrals from across the UK. The service also offers counselling to children and young people whose parents identify as transgender. There are clinics in both London and Leeds as well as regular outreach services in Exeter. The service

has close links with endocrinologists based at University College Hospital, London and the Leeds General Infirmary. Referrals are made to the service from local child and adolescent mental health services, GPs, other social care and education services as well as some third sector organisations.

This service has never been inspected before by CQC before.

Our inspection team

Our inspection team was led by:

Chair: Professor Tim Kendall, Director, National Collaborating Centre for Mental Health, Royal College of Psychiatrists; medical director and consultant psychiatrist, Sheffield Health and Social Care NHS Foundation Trust; visiting professor, UCL.

Team Leader: Judith Edwards, inspection manager for mental health, learning disabilities and substance misuse, Care Quality Commission

The team that inspected the gender identity development service comprised of a CQC inspector, an assistant inspector, a specialist advisor with a background in governance and management, a nurse and an expert by experience, who was a person with experience of using services.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection, we reviewed information about this service and sought feedback through a focus group of young people who used the services at the Tavistock and Portman NHS Foundation Trust.

We also spoke with three user-led peer support groups either before or during the inspection and received feedback through them about the services provided at the Tavistock and Portman NHS Foundation Trust.

We spoke with the lead commissioners of the service (NHS England).

Summary of findings

During the inspection visit, the inspection team:

- Visited both the London and the Leeds team bases and checked the reception areas, environment and offices where children, young people and families were seen.
- Spoke with 16 members of staff individually or in small groups including the service director, service manager, clinical lead in Leeds and other clinical and non-clinical staff.
- Attended four internal meetings including a research group meeting, an intake meeting, a 'first contact' meeting and a meeting of the audit and research team.
- Spoke with 11 children and young people who used the service either in a focus group or individually.
- Spoke with eight parents of children and young people who used the service in two focus groups or individually.
- Received feedback directly from 27 parents of young people who used the service, either by telephone or by email, before, during and immediately after the inspection visit.
- Collected feedback from 79 patients or family members of patients using comments cards.
- Checked the treatment records of six patients of the service, chosen at random, covering both the Leeds and London bases.
- Looked at a range of policies and procedures, including information requested from the service directly.

What people who use the provider's services say

During the inspection visit, most feedback we received was very positive with young people and their families telling us they felt very supported by the service and speaking of very positive experiences.

During the focus groups we spoke with eight family members and nine young people. The feedback from the focus groups was overwhelmingly positive. People told us that they had been provided with support from the service and this had included outreach work done with local schools. The eight young people, were very positive. They described the service as "life saving" and said how much they valued being able to speak to "someone who understands". However, some issues were raised about family members not always being clear about how to make formal complaints to the trust.

We received 79 comment cards from the service, of which 71 referred to the Leeds service. Seventy-seven of these cards were very positive about the service. One was mixed and one referred specifically to a clinical situation rather than general feedback about the service.

We also received direct feedback from family members of young people which reflected experiences of not feeling involved or informed about care planning and pathways.

Nine family members and one young person raised concerns relating to a feeling of lack of involvement or explanation about the treatment pathways. Eight young people or their families raised concerns specifically about the attitudes of staff. Eleven family members or young people told us that they felt that the service was not adapted to meet the individual needs of their families. Seven people specifically raised concerns about the waiting times between referral and assessment. Four people told us that they had not known how to complain or felt that complaints they had made had not been resolved satisfactorily or they were not aware of action taken following complaints that they had made.

The trust regularly carried out feedback surveys for young people and families. They provided us with information from their feedback surveys completed between 1 January 2015 and 31 December 2015. The feedback was overwhelmingly positive with 100% of responses in Leeds stating that the respondent felt listened to and 93% in London. Ninety nine per cent stated that they were treated well in Leeds and 96% in London. The lowest scores were in accessing convenient appointments (60% in London and 70% in Leeds) and convenient location (53% in London and 70% in Leeds).

Summary of findings

Good practice

- Staff in the gender identity development service were very positive about their experiences of working for the trust. All staff, without exception, told us that they felt well-supported with supervision and access to specialist training, attendance at relevant conferences and internal professional development events and meetings.
- The service had a strong focus on developing research within the field and working with partners internationally to ensure that best practice was developed in an area where there was not a strong evidence-base currently.
- The service had developed user/peer support groups, which provided additional support to young people and their families.

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should ensure that a proactive approach is taken to complaints and sharing information with young people and parents about what will happen to complaints when they are made.
- The trust should make sure that staff continue to involve and share information with all young people and parents or carers so that they are aware of the pathways and options for treatment throughout the period of care.

Tavistock and Portman NHS Foundation Trust

Other specialist services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Gender Identity Development Service	The Tavistock Centre

Mental Health Act responsibilities

The gender identity development service did not provide care and treatment to people who were detained under the Mental Health Act. This was not inspected as part of the comprehensive inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 applies to young people aged 16 and 17 and mental capacity assessments should be carried out to make sure the patient has the capacity to give consent. The Mental Capacity Act (MCA) does not apply to young people aged 16 or under.
- For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may be mature enough to make some decisions for themselves. When working with children, staff should assess whether a child has a sufficient level of understanding to make decisions regarding their care.
- The trust had a detailed consent to treatment policy and procedure that included guidance for clinicians on competence, consent, and refusal of treatment for children and young people; the procedure for obtaining consent for people aged 16-18; and the procedure for obtaining consent for people under 16.
- Staff in the team confirmed with us that they had received training related to confidentiality, capacity and competency related to the care of young people in the service. They showed good understanding of consent within the context of their work. As treatment was psychologically based, they worked with young people and their families over the assessment period to ensure that issues around consent were explored in detail.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The service had two bases, one in London and one in Leeds. In London, the base was at the Tavistock Centre, which was managed by the Tavistock and Portman NHS Foundation Trust. In Leeds, the building was managed by Leeds City Council.
- When we visited the Leeds service it was in the process of moving to a larger site in a nearby location close to the centre of the city.
- Staff and managers in the teams told us that concerns about repairs and the environment were picked up quickly and that repairs were addressed in a timely manner.
- Staff carried out therapy sessions in their offices in the London base. The décor was different depending on the member of staff. We saw that child-friendly visual aids and pictures were used.
- The reception in the Leeds site was decorated with pictures and drawings, which were done by young people who used the service. This was welcoming to people coming to the service.

Safe staffing

- At the time of our inspection there were no vacant posts for clinicians within the service.
- The service employed a service director, a clinical lead based in Leeds and 12.9 whole time equivalent (WTE) clinical psychologists, a consultant child and adolescent psychiatrist, 2.2 WTE specialist psychotherapists, two social workers and four family therapists. As well as this there was a service manager, one research psychologist and three assistant psychologists/research assistants and seven administrators/receptionists.
- The service director told us that there was not a current difficulty in recruitment as the staff team was stable. A number of members of staff told us that they had received their training within the service before moving into full-time positions. There was a low turnover rate within the service.

- Staff caseloads were monitored by the service director and the management team. A full time clinician held a caseload of roughly 100. However, caseloads were shared so one family would usually be allocated to more than one member of staff. We saw that members of staff who were new to the team had reduced caseloads.
- Some staff told us that the impact of increasing referrals had led to increases in the caseloads that individual clinicians were holding. There was a higher need for the service, which had not been reflected in increased staffing. As the service covered the whole of Great Britain, staff needed to travel which, they told us, was an increased pressure on the time that they were able to carry out clinical work.
- The total caseload in the service at the time of our inspection was 1358. These were young people who were accessing either assessment or treatment. This included 117 people who had not attended appointments in over six months and 153 people who were over 18. However as they were attending endocrine liaison clinics, they remained on the team caseload to ensure that treatment was not interrupted.
- Staff mandatory training was up to date across the service. Staff who were based in Leeds had the opportunity to access mandatory training in Leeds.

Assessing and managing risk to patients and staff

- The gender identity development service covered Great Britain and had bases in London and Leeds. This meant that the service had not been established to manage risk for every young person referred to the service where this risk would be better held locally.
- On referral to the service, risk was considered for each potential patient as a part of the intake process. In London, the team were piloting a new process to understand and address risk immediately through a 'first contact' meeting where initial referrals were discussed before being allocated for assessment. This meant that young people referred to the service received a phone call to check that information was current and that those referred to the service had an understanding of where to take concerns. Information

Are services safe?

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was also shared during these calls about local support available. These initial contacts were followed up weekly in a meeting to ensure that issues were addressed while young people were on the waiting list.

- Some families raised concerns with us about the management of risk within the service and particularly how they felt that the service did not prioritise treatment and assessment on the basis of presenting risk.
- The service was clear that risk was held by local child and adolescent mental health services (CAMHS). However, some young people were not known to CAMHS services when they were referred. The service told us that they made referrals to local CAMHS teams where they had concerns about young people's safety and risk levels.
- Assessments took place over three to six meetings depending on the individual and family situation. During the assessment period, risk was addressed at every meeting.
- We checked the records of six young people in both London and Leeds and saw that while risk was addressed, it was not always recorded in detail.
- Staff had all attended trust training related to safeguarding children and safeguarding adults. Trust records confirmed that almost all staff had completed safeguarding training. They were aware of the process in place to ensure risks were raised where necessary. Staff were able to give us examples of situations where safeguarding concerns had been raised and information had been shared with local CAMHS teams and local safeguarding teams.
- All the staff we spoke with were aware of the trust safeguarding team and knew where they could seek advice about safeguarding issues when necessary.

Track record on safety

- In 2015 (January – December), staff within the service had reported five incidents. Two incidents related to information governance concerns, one related to a theft within the service, and one related to verbal abuse.

- We saw that one of these incidents was recorded as a near miss. This meant that there was scope for learning from the near miss incident, which may prevent an incident in the future.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were able to explain the process of reporting incidents and near misses in the service. There was an incident form available on the trust intranet, which was sent to the service director and to a central point within the trust.
- We saw that incidents were discussed in team meetings and staff told us that incidents were also discussed within their individual supervision and sometimes within reflective practice sessions so that learning could be disseminated.
- Clinical discussion groups met fortnightly within the service where clinicians could bring and discuss specific work-related issues to share with the team. While there was a rota regarding who brought issues to the group, to ensure everyone got an opportunity, there was also scope for staff to add particular issues as they arose. This enabled a group learning culture throughout the service.
- Staff were able to discuss with us incidents within the service.
- We did not see evidence that incidents across the trust were discussed in team meetings.
- Situations where incidents occurred with young people, which were not directly related to the service itself, for example, if a young person had harmed themselves at home, this was not reflected as an incident within the service. The service was clear that risk was held at a local level by local CAMHS teams. However, these situations may have been an opportunity for learning lessons in a more systematic manner. This may have been a missed opportunity to formalise learning and improvement within the service.

Duty of candour

- Staff had undertaken specific training regarding the requirements in relation to the duty of candour. When we asked staff about actions taken in relation to this, they were able to give examples of letters of apology

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

that had been sent following errors or complaints made to the service. However, we spoke to some parents who told us that they did not feel that their concerns were acknowledged when they were raised.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Staff in the gender identity development service assessed young people and families over a number of visits, usually between three and six, where each visit was usually around a month apart.
- During the inspection, we checked the assessments and records for six patients chosen at random, from both the Leeds and London bases. We saw in the notes that assessments showed work was done to link with local services where children and young people were based. While the care record system linked with the national NHS spine, meaning that legal names were used, the service used an 'alias' system on the electronic records to ensure that children and young people's preferred name and pronoun were known and used within the service and for correspondence relating to them.
- While there was an electronic patient record system in place, clinicians used paper records, which were scanned onto the electronic record system by administrative staff. Paper notes were kept for a month. Scanned records were difficult to read electronically.
- Following the assessment process, there were a number of treatment options available to patients including referral to endocrinologists or other recommendations, including referral to local CAMHS.
- Young people and parents received copies of letters which were written by clinicians when information was shared with other services, including GPs. However, the service did not have a system of providing a distinct 'care plan' to young people and it was not clear in the notes whether children, young people and families had agreed to the plans of care, which had been discussed with them as they was no record of them being signed.
- Some families we spoke with told us that they were not aware of all the options available within the service when the assessments of young people were completed.

Best practice in treatment and care

- While there is little research evidence to delineate best practice for gender dysphoria in the UK, the service was committed to developing research and establishing best

practice by employing research assistants and a full time research psychologist. The research team and other members of the clinical teams met monthly to discuss current projects and a digest of current research and policy updates was distributed throughout the team.

- Clinicians within the service were active in the newly formed British Association for Gender Identity Specialists and attended the World Professional Association for Transgender Health (WPATH) conference internationally to ensure that information within the community was shared. The service was submitting papers to the next WPATH conference and supporting staff to attend.
- Research staff told us that there was a lack of longitudinal research work in the UK for a number of reasons including the ways that gender identity services were set up in the UK and other difficulties in following up people using the service in the long term. Young people's services were separate from adult services and adult services were designed very differently around the country.
- The service carried out a number of audits. For example, staff had carried out an audit of self-harm in the service in June 2015. The service ran a regular audit and outcomes group.
- Outcome measures were based on those determined by NHS England as commissioning for quality and innovation targets. NHS England was the commissioner of the service. This included a measurement of outcomes related to incidences of self-harm, children's global assessment score and the internal service evaluation questionnaires.
- The service ran two 'clinics' after children and young people had been assessed. These were early intervention clinics for younger children and 15+ clinics for young people over the age of 15. This was due to the different needs and pathways of the two age groups.

Skilled staff to deliver care

- All the staff we spoke with were positive about the opportunities, which they had to access supervision, both clinical and managerial, as well as regular reflective practice groups and case discussions.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Supervision was carried out regularly and this ranged in frequency from weekly for assistant psychologists and research assistants to monthly for experienced clinicians.

- Caseloads were adjusted for new members of staff so that newer members of staff had lower caseloads.
- We spoke to some newly appointed members of staff in London and in Leeds. They told us that they had accessed a trustwide induction as well as a service specific induction programme. This induction period included a strong focus on the importance of information governance and confidentiality.
- The service gave staff the opportunity to develop professionally with specialist training and access to national and international conferences in the field of gender dysphoria.
- There were regular meetings where continuous professional development was emphasised and this included inviting external speakers in to develop the staff team in areas such as autism.
- The whole gender identity development service had weekly team meetings. This included non-clinical staff such as the administration team. Each base, London and Leeds, had a local meeting and then the teams got together for a joint meeting using remote conferencing. Staff said, when we visited the Leeds base, that there had been some difficulties with the conferencing technology. However, the team were moving to a different office where it was hoped that this would be resolved.
- All the staff in the service had received an annual appraisal.

Multi-disciplinary and inter-agency team work

- The teams were multidisciplinary and comprised of clinical psychology, family therapy, psychotherapy, psychiatry and social work.
- The gender identity development service worked closely with endocrinology teams which were based at University College Hospital, London and the Leeds General Infirmary. Members of the team attended all endocrinology appointments with young people and their families to offer support.

- The team worked with children, young people, their parents, carers and siblings to ensure that the family was involved in the process of assessment and treatment.
- Staff in the team told us that took referrals from across Great Britain. They reported that they had a mixed response from local primary care providers and CAMHS providers. For example, in some areas, they had built up strong relationships with specific CAMHS teams, which had led to more effective joint working based on personal relationships and understanding between clinicians. However, in some areas, this did not exist. This meant that there was a risk that children and young people experienced more disjointed care where the teams locally did not link up as effectively with the national team based at the trust.
- The gender identity development service team were clear that they were reliant on local teams and local services to hold ongoing risk. We saw that where they referred or contacted local CAMHS services, they followed up regularly if they had not received responses, to ensure that information was effectively passed on.
- The service had developed good working relationships with some of the adult gender identity clinics around the country to assist with the transfer of patients from the young people's service to the adult service. For example, the lead clinician at the London gender identity clinic (Charing Cross Gender Identity Clinic) undertook monthly 'surgeries' at the Tavistock Centre where discussions were held with young people who were going to be transferring to that service, in preparation for treatment within the adult service. In Leeds, the service had developed links and had meetings with the Leeds and Sheffield gender identity clinics and had arranged to attend a team meeting at the Leeds adult service. The team had regular contact with the Exeter gender identity service for adults. Transition meetings could be arranged in Exeter.
- The service had developed links with some user-led organisations and groups to share information about the service. For example, the Intercom Trust in Devon and Allsorts in Brighton. During the inspection, we met representatives of Gendered Intelligence in London who worked with the clinic and accepted referrals to their mentoring scheme and peer support networks for older teenagers and young adults.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- When it was necessary, the service arranged local network meetings, including work with local schools and colleges to ensure that young people were linked in with local support networks.
- We had mixed feedback from families regarding working together with the service. Some families were very positive about the support that had been offered within their childrens' schools. However, some people fed back that this support was not available.
- Some families who fed back to us directly, told us that they had not received information about how to access local support groups or networks and they had sought this information themselves.
- In the Leeds service, we saw that information about local groups, including Mermaids, which is a support group for parents of children who identify as transgender, was displayed in the waiting room.

Consent to care and treatment and good practice in applying the Mental Capacity Act

- The Mental Capacity Act 2005 applies to young people aged 16 and 17 and mental capacity assessments should be carried out to make sure the patient has the capacity to give consent. The Mental Capacity Act (MCA) does not apply to young people aged 16 or under.
- For children under the age of 16, the young person's decision making ability is governed by Gillick

- competence. The concept of Gillick competence recognises that some children may be mature enough to make some decisions for themselves. When working with children, staff should assess whether a child has a sufficient level of understanding to make decisions regarding their care.
- The trust had a detailed consent to treatment policy and procedure that included guidance for clinicians on competence, consent, and refusal of treatment for children and young people; the procedure for obtaining consent for people aged 16-18; and the procedure for obtaining consent for people under 16.
 - Staff in the team confirmed with us that they had received training related to confidentiality, capacity and competency related to the care of young people in the service.
 - Staff showed a good understanding of consent within the context of their work. As treatment was psychologically based, they worked with young people and their families over the assessment period to ensure that issues around consent were explored in detail.
 - Hormone treatment was determined at the endocrinology clinics. Staff liaised with clinicians at University College London Hospital and Leeds General Infirmary.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We observed that staff spoke about young people with respect and consideration. Staff were passionate about promoting the rights of and advocating for the user group and ensuring that the best care possible was provided.
- Most feedback we received from young people and their families was very positive about the support provided and the kindness and consideration of staff. We received direct feedback from 27 parents before or during the inspection by phone or email. We spoke with two young people who had or were using the service. We also spoke with one young person and their family when they were attending an appointment during our visit.
- During the inspection, we attended four focus groups arranged by the trust with young people and their families, held separately. During these focus groups we spoke with eight family members and nine young people. The feedback from the focus groups was overwhelmingly positive. People told us that they had been provided with support from the service and this had included outreach work done with local schools. The eight young people, were very positive. They described the service as “life saving” and said how much they valued being able to speak to “someone who understands”. However, some issues were raised about family members not always being clear about how to make formal complaints to the trust.
- Nine family members and one young person raised concerns relating to a feeling of lack of involvement or explanation about the treatment pathways. Eight young people or their families raised concerns specifically about the attitudes of staff. Eleven family members or young people told us that they felt that the service was not adapted to meet the individual needs of their families. Seven people specifically raised concerns about the waiting times between referral and assessment. Four people told us that they had not known how to complain or felt that complaints they had made had not been resolved satisfactorily or they were not aware of action taken following complaints that they had made.

- We received feedback on 79 comments cards which were distributed within the service in the weeks leading up to the inspection. Seventy seven of these cards had positive feedback about the service. One had mixed feedback and one had information which related to a specific clinical decision that had been made.
- The service reviewed feedback regularly and carried out regular surveys of user experience. We were provided with the feedback which was collected across 2015. This was very positive across both the London and Leeds services.

The involvement of people in the care they receive

- We had mixed feedback from young people and families about their involvement in their care. Some people were very positive and felt that they had the opportunity to give feedback. However, some families reported to us that they felt they were not given sufficient opportunity to give input into the service, noting that there was a perception that some feedback and individuals were given preference.
- Some parents told us that they wanted more information about the process and what the possible outcomes regarding treatment after the initial assessment period would be.
- The service had a stakeholder reference group including young people which met three times a year in London. There were plans to set up a similar group based in Leeds.
- Young people from the service were involved in and attended groups which were established for all young people using trust services such as the regular pizza night for young people. However, as the service was nationally focussed, this was restricted to those who are able to go to London easily.
- The service ran ‘family days’ six times a year in Leeds, London and Exeter. These days were opportunities for those young people, their main carers and siblings to meet separately and discuss issues which had arisen but also to access support and meet each other. We had positive feedback about these family days.

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access to the service

- Throughout the service, staff told us about the increase in referrals. Since April 2009 there had been an average of 50% increase in referrals each year. For example, in 2012-2013 there were 314 referrals, in 2013-2014 468 referrals and in 2014-2015, 697 referrals. In 2015, the current 18 week target between referral and assessment had been breached 156 times. These breaches all occurred in the London service. There had been no breaches of the target in the Leeds service. The average waiting time to be seen in the service was 17.4 weeks in quarter 1 of 2015-2016, 15.4 weeks in quarter 2, and 16.5 weeks in quarter 3.
- The service was, in common with all the gender identity services nationally, part of the NHS England commissioned 'Task and Finish' group, which was currently involved in reviewing the pathways for gender identity services across England. As the lead commissioners, there were well-developed links between the service and NHS England specialist commissioners.
- We met with the specialist commissioning team from NHS England as a part of this inspection process. They confirmed that they had good working relationships with the service.
- The service accepted referrals from CAMHS services, GPs, schools and user-led groups. There was a specific decision made within the service not to restrict referrals to those already engaged with CAMHS as it may have led to a further delay in accessing treatment. For example, if children and young people had to wait to access CAMHS team before being referred on to the gender identity development service this would cause additional delay.
- Appointments were often arranged in advance with a letter being sent to young people and their families. The rate at which people did not attend arranged appointments was 8% in 2014/15.
- The service worked with some adult gender identity clinics to ease the pathway for young people moving into adult services. However, this was dependent on specific adult gender identity clinics as there was no cohesive national protocol for young people moving

into adult services. Pathways between young people's and adult gender identity services were entirely based on links with specific adult clinics which each operated in different ways. The gender identity development service was part of a national working group that produced a draft protocol for transfer from young people's to adult services, which was being considered by commissioners.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff carried out clinical work with children, young people and their families in their offices in London and in shared office space in Leeds. At the time of our inspection, the Leeds service was about to move into larger premises. Some staff spoke to us about the limitations due to the size of the current Leeds base.
- In London, clinicians had appropriate rooms in which to see young people and families. Rooms had visual aids including child friendly pictures, which helped to illustrate and explain feelings and gender dysphoria, including for those young people who identified as non-binary. This helped to put young people at ease.
- The reception area in London was shared with the other services. We saw that there was information available about how to make complaints about the service in the corridor areas and on the walls. There was a mixed gender toilet on the ground floor of the Tavistock Centre.
- In Leeds, there was a dedicated waiting room area which was decorated with pictures and drawings which young people had done. This was welcoming and involving. There was information available about the service, the trust and local support groups available in the waiting room area.

Meeting the needs of all people who use the service

- As a national service, the gender identity development service covered the needs of children and young people across Great Britain. The Leeds-based site had allowed the service to provide a more local service to young people in the north of England. There was a regular outreach clinic in Exeter provided by the team, as well as local arrangements to use the offices of specific CAMHS teams in Bristol and Gloucester. However, some families raised concerns with us about the distance that they

Are services responsive to people's needs?

Good 

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needed to travel to access the service. Funding for travel was provided for people who had low incomes but this could be a barrier for some people in accessing the service.

- The service had accepted that there was more work to do to specifically target and inform people in black and minority ethnic groups about the service. However, there were some local examples which the team was able to share with us where people from similar minority ethnic and religious backgrounds linked with others informally, and with their consent, to provide some peer support.
- The service had access to interpreters who were used at appointments where there was a need. Staff gave us examples of how British sign language interpreters were used in the service, not only for appointments but also for facilitating the participation of a young person at a family day.
- Both teams ran parent and teenage specific groups separately during summer holidays which ensured that the needs of different groups of people were met.
- Work was currently underway within the service to update and develop a website which would have more information about the service for young people may want to use the service in the future or who required information about the service.

Listening to and learning from concerns and complaints

- Between 1 January 2015 and 31 January 2016, there were eight complaints made to the service. Two of these were formal complaints and six were informal complaints, which were resolved locally. The themes around these complaints related to delayed or postponed appointments and/or the attitude of individual staff members.

- While the service ensured that all complaints were logged, there was not a clear distinction between formal and informal complaints and when a complaint should be dealt with locally as opposed to through the trust formal complaints procedure.
- We checked three specific complaints, which had been made to the service. We saw that they had been investigated in a timely manner and had included information which had been sent back to the complainants, including apologies where relevant.
- We received mixed feedback from patients and families about whether they had sufficient information about how to complain. We saw that information was available in the services. However, some parents told us that they were not aware of how to raise a complaint.
- Some parents told us that they felt they could not make a complaint because they were concerned how it would impact on the care of their child. While there was no evidence of any negative impact or that anyone who had made a complaint had been treated any differently, the fear and anxiety of raising complaints and concerns within a service expressed by many parents prior to the inspection, combined with the fact that the service is unique nationally, raises an additional need for reassurance for young people and parents wishing to complain. This had not been recognised and responded to by the service.
- Staff told us that they were aware of recent complaints to the service. We saw that complaints were discussed in team meetings. However, it was not clear how learning from complaints from across the trust was shared.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Without exception, the staff we spoke with at both sites and across the different professional backgrounds and grades were very proud to work for the trust and within the service. Staff were clearly enthusiastic about their jobs, local managers and the teams they worked in.
- Two members of staff compared their experiences of working at the trust very favourably with working previously in larger trusts and particularly praised the open and accessible nature of leadership within the trust.
- Staff were aware of the trust chief executive and senior managers. A non-executive director had visited the Leeds service. The service based in Leeds, which was the only service the trust ran which was not based in London, did not reflect an isolation or detachment which is not uncommon when there is a geographic distance. This was notable and a reflection of the cohesive leadership between the two bases.

Good governance

- There was a clear internal governance structure within the gender identity development service. The management team consisted of the senior staff within the service across different disciplines and covering the two sites. This management team worked effectively and coherently to ensure that information was shared throughout the service and within the trust.
- The service director had a good understanding of the team and where the strengths and difficulties lay, including issues related to workload pressures and staffing. All the staff had completed mandatory training and had substantial access to supervision and support.
- Incidents, complaints and feedback were discussed throughout the team with regular team meetings, which were inclusive and ensured that learning could be tracked. However, there was no central team risk register, which may have helped to highlight some of the issues and feed them into the trust risk register.
- There was little evidence of learning from incidents more broadly across the trust in a systematic way.

Leadership, morale and staff engagement

- Staff within the service were enthusiastic and committed to ensuring that they were delivering a good quality of care to patients and families. They demonstrated a willingness and drive to engage in service improvement.
- Staff we spoke with told us that they were aware of the trust whistleblowing policy. We received positive feedback from staff about their immediate line managers and the staff team. Staff across the service and at all levels, told us that they would feel confident in raising concerns if they had any.
- The trust offered specific leadership development programmes and we spoke to one member of staff who was accessing this programme.
- Staff told us that they were able to keep up to date with news across the trust through emails and with visits by senior trust staff to the services. They did not feel distant from the trust leadership.

Commitment to quality improvement and innovation

- The team were committed to research with four full time research assistants/assistant psychologists and a research psychologist. There were regular meetings where research was discussed. Processes were in place to disseminate research which took place within the service but also relevant international research within the field.
- Clinicians within the service were members of the British Association of Gender Identity Specialists, which was a recently formed group of clinicians who work in the field. This helped to ensure and establish best practice within the sector.
- The service had undertaken a number of audit and research projects through the year prior to the inspection. This included preparation of a number of papers which were being submitted to an international conference. Some of the specific audits carried out included work on referrals and social transitions in children under the age of 11, and rolling work including an audit of information related to self-harm, timescales

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for pathways into endocrine clinics and an audit of the use of the electronic patient record system. The service was currently auditing a pilot of telephone contact with family and young people on the waiting list.

- These initiatives demonstrated the service's commitment to quality improvement and the development of a research and evidence base. A number of projects had been carried out with partners across Europe.