

## Care Quality Commission inspection report on GIDS 2021

*We have underlined some key passages*

### **Assessing and managing risk to young people and staff P6**

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

### **Assessment of patient risk P6**

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

### **Management of risk P7**

“The service did not have the resources to sufficiently address risks associated with gender dysphoria of young people on the waiting list.”

### **Safeguarding P7**

“We reviewed the records in relation to safeguarding young people for a sample of 22 patients. On 13 of these records, 60%, we found that there had been effective joint working with local agencies to support the young person. However, on three records we found insufficient evidence of multi-agency work. Two of these records involved patients who were at significant risk. The other six records showed some good practice and some areas for improvement.”

### **Staff access to essential information P8**

“Staff recorded all information on an electronic patient record system. Administrators scanned paper correspondence and uploaded this to the electronic record. Information needed to deliver patient care was available to all relevant staff, although we found that staff kept records in an unstructured and poorly organised manner. This meant that it could be difficult to find important information quickly. For example, records did not include documents giving all the key information about young people such as details of the person or people with parental responsibility or professional contacts in other agencies such as schools and CAMHS. Records did not include care plans. Risk assessments did not include comprehensive risk management plans and some were not completed fully. Assessments

were not recorded in a structured manner. This meant it would be difficult for someone unfamiliar with the young person to understand the work that had been carried out."

### **Reporting incidents and learning from when things go wrong P9**

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

### **Our rating of effective went down. P9**

"We rated it as requires improvement because:

- Staff's assessments of patients were unstructured, inconsistent and poorly recorded. Staff did not sufficiently record their reasoning in reaching clinical decisions. There were significant variations in the clinical approach of professionals in the team and it was not possible to clearly understand from the records why these decisions had been made.
- Staff did not develop care plans for young people. Many records provided insufficient evidence of staff considering the specific needs of young people, such as autistic spectrum disorders.
- Staff had only recently begun to record consent and capacity or competence clearly for young people who might have impaired mental capacity or competence. The records of young people who began medical treatment before January 2020 did not include a record of their capacity, competency and consent.

### **Assessment of needs and planning of care P10**

"Furthermore, there was no clearly defined assessment process. For example, there were no standard questions for staff to explore with young people at each session. Most records of assessment sessions were simply descriptions of conversations that had taken place between the clinician, the young person and their parents. None of the records included a clear statement of what the service was assessing. Whilst the criteria for considering referring young people for administration of hormone blockers was set out in the service specification, we saw no reference to this on any patient records. Although decisions about referrals to endocrinology were taken by at least two clinicians, it would be very difficult for the service to assess whether clinicians had made the correct decision in making a referral."

### **Best practice in treatment and care P11**

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

“Twenty-eight percent of young people assessed by the service were referred to endocrine clinics for medical treatment. The decision to refer young people to endocrine clinics was taken by at least two clinicians and reviewed at a meeting of senior staff. However, records showed that the service may not have fully investigated or considered the needs of patients with autistic spectrum disorders. The service did not record how many patients had a diagnosis, or suspected diagnosis, of an autistic spectrum disorder. We reviewed a sample of 22 records, more than half of which referred to autistic spectrum disorder or attention deficit hyperactivity disorder (ADHD). Discussions with staff about autistic spectrum disorders focused on the communication needs of these patients. Records did not demonstrate consideration of the relationship between autistic spectrum disorder and gender dysphoria.”

“The audit showed a small increase in the average CGAS score from 63.1 at the initial assessment to 66.4 at a pre-discharge assessment. This meant there was, on average, a small increase in patient’s global functioning during their treatment, although this did not indicate a significant change.”

### **Good Practice in applying the Mental Capacity Act p13**

“We reviewed 16 records of young people the service had referred to endocrinology services for hormone blockers. On six of these records where the patient had been referred for treatment before January 2020, there was no evidence of an assessment of the patient’s capacity or competency. However, the absence of structured assessments prior to staff implementing the standard operating procedure in January 2020 meant that the service has not fully assessed the competency and capacity of some young people who were still receiving hormone blockers.”

The service had produced a pictorial guide to the effects of hormone blockers. This had been designed for young people with autism or learning difficulties.”

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

found that only three out of 29 referrals to endocrinology did not have a complete set of referral documents.

### **Waiting times P17**

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

“Of the 339 referrals made to the service between April and June 2020, 71% were from natal female patients.”

### **Governance P22**

“Our findings from the other key questions demonstrated that governance processes did not operate effectively to ensure that the needs of patients were met in a safe, structured and systematic manner. The GIDS service had a comprehensive action plan to address issues identified by the trust and improve service performance. This was written in March 2019. It contained seven areas of recommendation and over 55 specific actions. These covered areas of concern focused on during this inspection. While improvements were seen in some areas, such as introducing standard documentation for assessments of consent and capacity, there were still many areas where improvements had not been consistent. For example, actions to minimise variation in practice had not been fully achieved. There continued to be a wide variation in the number of sessions young people received, from two or three sessions to over 25 sessions, with some young people receiving more than 50 sessions. There also remained variation in assessments which were unstructured. Assessments did not demonstrate what staff were assessing or demonstrate clear criteria for decision making.”

### **Information management P23**

“The recording of information was insufficient to ensure safe and effective professional practice. Records of sessions with young people and their parents were often simply descriptions of discussions that had taken place. They did not include any analysis, structured assessment, professional curiosity or clinical decision making.”

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