



The Tavistock and Portman
NHS Foundation Trust

GIDS REVIEW ACTION PLAN

26th March 2019



GIDS Review – Action Plan

Gender Identity Development Service

1. The Tavistock and Portman has been delivering the Gender Identity Development Service for children and young people for thirty years. It has been one of the largest and leading services of its kind in the world. The service aims to assess and treat young people with gender dysphoria on a case by case basis, working with young people and families to identify the best approach for them as individuals, whether or not they wish to proceed to physical intervention. This vision of the service underpins the actions set out in this plan to strengthen the service.

The GIDS review

2. Following the raising of concerns, the Trust's Medical Director was commissioned to carry out a Review to explore the issues raised. Oversight of the Review was provided by a Non-Executive Director and a member of the Council of Governors.
3. The Review did not identify any immediate issues in relation to patient safety or failings in the overall approach taken by the Service in responding to the needs of the young people and families who access its support. It has, however, identified some important areas where improvements could be made in the operation and transparency of the service.
4. The Trust's Board of Directors considered the GIDS Review at its February meeting. It endorsed its conclusions and accepted all its recommendations. This Action Plan sets out the steps we will take to implement the recommendations and the timetable for achieving this. In doing so we will seek the input of those with lived experience and other experts in this field.

Background to recommendations

5. The Review identified a service which exhibited many good examples of thoughtful and innovative clinical practice. It did also highlight a service which had faced major pressures in terms a very significant growth, in recent years, both in the number of

referrals but also the number of staff working in the service. Many of the recommendations reflect the need to better standardise and codify practice in the service, given its scale, and the need to identify and address unwarranted variation. Alongside this, the Review also identified the value of strengthening referral processes to give the service greater control over referrals and to facilitate a more explicit highlighting of cases with additional complexity at the outset.

6. The Review highlighted the need for the service and Trust management to ensure there are more robust mechanisms for the hearing and, most notably, resolving points of concern raised by staff within the service. The Trust will undertake a wider check of these issues across the organisation. At the same time the Review recommended the need for actions to be taken to better protect the service from a highly contested external environment.
7. Finally, the Review reinforced the need for the Service to continue to be curious about changes in the societal and evidential context in which it operates including changes in patterns of referral and presenting issues and for the Trust to increase further its commitment to research around long-term outcomes for people who use the service. The Trust is uniquely placed, given the size of the patient populations it serves, and its history of working with other international centres, to build up the evidence base in this field and share its findings

NHS England

8. The GIDS service is directly commissioned by NHS England as a national specialised service, and it has oversight of issues around quality, access, patient experience and resource deployment. The GIDS service works to a service specification and clinical commissioning policy that is set by NHS England and formed through expert reference groups, stakeholder engagement and public consultation. It is a long-standing intention that NHS England will review the current service specification and clinical commissioning policy in 2019/20.
9. The Review and resultant Action Plan acknowledge the value of working with NHS England on a number of areas that will be relevant to NHS England's planned work in 2019/20, such as (but not limited to) developing clinical protocols for physical interventions, strengthening referral processes and defining pathways for individuals who present with additional complexity.

Reporting and Accountability

10. The Action Plan gives clear dates for the completion of agreed actions. The Trust Board of Directors and its Council of Governors will receive reports on progress against the Plan.
11. The Action Plan will be presented to NHS England once agreed by the Board, and a process for joint working agreed. There will be a collaborative approach, focused on the needs and best interests of our patients and their families.
12. As part of the Action Plan the Trust is developing a routine data set for the GIDS service which it will publish on a regularly basis.

Paul Jenkins
Chief Executive
March 2019

GIDS Review action plan; to be read in conjunction with Review report dated February 2019 at Annex A where Recommendations are set out in full

Recommendation area	How will we implement it	Who will be responsible	Milestones for completion
<p>A - Explore whether the GIDS operates to a clear model and its delivery has appropriate resources.</p>	<p>1. GIDS will work to minimise unwarranted variation in its practice and to ensure that all staff are provided with guidance on expectations. To achieve this the service will:</p> <ul style="list-style-type: none"> • Develop a dynamically updated operational protocol • Detail and include all relevant sub protocols and updates covering various aspects of practice and pull these together as an overarching service guide with a glossary of key operational definitions 	<p>Lead: GIDS Director</p> <p>Contributors:</p> <ul style="list-style-type: none"> - Service Manager - Project Manager - Director's PA 	<p>September 2019</p>
	<p>2. GIDS will produce specific protocols that are based on benchmarked good practice where available and detail expectations in areas where variation is unwarranted; These will include the following:</p> <ul style="list-style-type: none"> • Details of task at assessment • Protocols for age and puberty based possibilities for intervention • Response to complex presentations 	<p>Lead: CYAF Director</p> <p>Contributors:</p> <ul style="list-style-type: none"> - GIDS Senior Leadership Team 	<p>September 2019</p>

Recommendation area	How will we implement it	Who will be responsible	Milestones for completion
	<ul style="list-style-type: none"> • Gaining and recording consent • Safeguarding practices (SOP) • Differentiating sexuality related issues • Physical interventions protocols • Timely discharge <p>The service will implement a schedule of review with oversight from the GIDS Exec that ensures protocols are kept up to date.</p>		
	<p>3. The Board and Directorate need to be kept up to date about the impact of external and internal factors on the capacity of the service to manage workflow. This will be achieved through:</p> <ul style="list-style-type: none"> • Monitoring activity and quality data • Developing a forum to address quality improvement • Ensuring the wider Trust trust/Directorate and Board are kept apprised of any impact on GIDS' capacity to work to the live operational protocol. 	<p>Lead: GIDS Director</p> <p>Contributors</p> <ul style="list-style-type: none"> - GIDS Senior Leadership Team - Service Manager 	<p>July 2019</p>

<p>4.</p>	<p>4. The GIDS standard assessment model as commissioned by NHSE of 4-6 assessment sessions needs to be applied with some flexibility, given the complexity of individual cases, including for patients previously seen in private services or self-medicating. GIDS will:</p> <ul style="list-style-type: none"> • Review what services and approach are appropriate for a range of more complex presentations. • Scope pathways through the service, including a review of how cases are defined and how additional complexities are identified and managed. • The pathway work will consider what staff resource and seniority are needed for decision making across the range of pathways and for cases involving additional complexity. 	<p>Lead: CYAF Director</p> <p>Contributors</p> <ul style="list-style-type: none"> - Service Manager [audit] - Member of the GIDS leadership team 	<p>July 2019</p> <p>Further work on resources until November 2019</p>
	<p>5. In order to minimise unwarranted variability in practice, GIDS will develop a schedule for quarterly audits and reporting including auditing the following:</p> <ul style="list-style-type: none"> • Content and quality of assessment decision-making • Adherence to agreed pathways, such as time for completing assessments across all care pathways taking into account additional complexities 	<p>Lead: GIDS Director</p> <p>Contributors</p> <ul style="list-style-type: none"> - Associate Director of Quality - GIDS Leadership Team 	<p>May 2019 for establishment of forum</p> <p>July 2019 for data flowing</p>

	<ul style="list-style-type: none"> • The detail, content and depth of discussion of recommendations • Documentation and reports <p>GIDS will ensure there is a clear and 'SMART' management plan for any unwarranted variation as identified in audits</p>		
<p>B - Explore whether there is evidence that the service is managing its referral rate in a safe and adequate manner.</p>	<p>6. GIDS will improve its referral process. It will achieve this by:</p> <ul style="list-style-type: none"> • Specifically spelling out any changes to the referral process and information required from referrers to process a referral • Widely communicating the process to all relevant stakeholders 	<p>Lead: GIDS Director</p>	<p>September 2019</p>
	<p>7. GIDS will ensure that its limited resources are used appropriately as a nationally commissioned highly specialist NHS service. GIDS will achieve this by:</p> <ul style="list-style-type: none"> • Identifying reasonable and appropriate criteria/guidance for which young people the service is most appropriate for. • More clearly defining referral criteria/guidance for local CAMHS services referring patients to GIDS. 	<p>Lead: GIDS Director</p>	<p>September 2019</p>

	<ul style="list-style-type: none"> Developing specific protocols for the management of complex cases, including those who are already receiving private treatment or who have significant co-morbidity 		
	<p>8. GIDS will make service improvements to reduce unnecessary variation in practice and improve transparency about decision-making. It will do this by:</p> <ul style="list-style-type: none"> Implementing and monitoring cross-supervision arrangements Improving oversight of co-working arrangements Undertaking quarterly audits of assessment reports Producing a list of other measures to prevent and monitor unexplained variation in practice 	<p>Lead: GIDS Director</p> <p>Contributors:</p> <ul style="list-style-type: none"> - Service Manager [data] - GIDS Leadership Team - CYAF Director - HR Business Partner 	<p>March 2020 for full completion</p>
	<p>9. GIDS will improve the management of young people on the waiting list by:</p> <ul style="list-style-type: none"> Continue designing and implementing rapid cycle QI projects to enhance management of young people on the waiting list and improve patient experience Incorporating results of these initiatives into routine practice. 	<p>Lead: Director of Strategy</p> <p>Contributors:</p> <ul style="list-style-type: none"> - Quality Improvement Team - GIDS Project Manager 	<p>Ongoing</p>
	<p>10. GIDS will improve the process of learning from incidents and complaints by ensuring that the new quality forum reviews all serious incidents and complaints and produces 'SMART' action plans that are monitored through</p>	<p>Lead: GIDS Director</p> <p>Contributors</p> <ul style="list-style-type: none"> -GIDS Exec -CYAF Governance 	<p>Quality group established by end May 2019</p>

	<p>this group and through the Trust process as appropriate.</p> <p>11. GIDS will ensure there is senior oversight of assessment decisions in cases where complaints have prompted a change in the assessment team</p>		
	<p>12. The Trust and the GIDS will both improve process in relation to managing concerns raised by staff. This will be done by</p> <ul style="list-style-type: none"> • Documenting timescales for clear written responses from GIDS exec and other senior staff to any concerns raised. • Introducing a Quarterly Audit schedule of concerns and responses provided to the Executive Management Team. <p>13. The Trust will review and, refresh, where necessary its policies and procedures for raising concerns, clarifying appropriate channels, what to expect from the process and how the Trust will respond. This review will consider best practice in other similar organisations. When complete this will be disseminated to all staff and made easily accessible to all through publication on the staff intranet and internet sites, as is currently the case.</p>	<p>Lead: Director of HR & Corporate Governance</p>	<p>End of July 2019</p>

<p>C - Explore whether appropriate safeguarding practices and procedures are being applied to children being seen within the service.</p>	<p>14. GIDS will further improve safeguarding definition and process in relation to Children and Young People who use the GIDS service. It will do his by:</p> <ul style="list-style-type: none"> • Developing a Standard Operating Procedure (SOP) for Safeguarding in GIDS • Detailing safeguarding challenges and expected responses • Defining and documenting relationships with key leads at service and Trust level • Setting clearer expectations for documentation in relation to safeguarding issues • Setting out expectations for contact about safeguarding issues with external agencies, and ensuring these are well communicated • Setting out clear expectations in relation to safeguarding supervision and its documentation 	<p>Lead: Medical Director</p> <p>Contributor:</p> <ul style="list-style-type: none"> - GIDS Safeguarding Lead - Trust named Doctor - Trust safeguarding Lead 	<p>September 2019</p>
	<p>15. In order to monitor safeguarding processes and outcomes, GIDS will develop an audit plan to cover retrospective and prospective periods on all aspects of safeguarding management supervision and</p>	<p>Lead: GIDS Director</p> <p>Contributor:</p> <ul style="list-style-type: none"> - GIDS Safeguarding Lead - Trust named Doctor - Trust safeguarding Lead 	<p>September 2019</p>

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	<p>documentation. It will follow this with quarterly audits on the following:</p> <ul style="list-style-type: none"> • safeguarding practices • external referrals made by any agency in the network 		
	<p>16. GIDS will ensure that its learning from safeguarding CYP with the very particular needs of this service user population are used to improve practice nationally by:</p> <ul style="list-style-type: none"> • Contributing to improvements in safeguarding guidance nationally • Engaging with external safeguarding boards 	<p>Lead: GIDS Director</p> <p>Contributor:</p> <ul style="list-style-type: none"> - GIDS Safeguarding Lead - Trust named Doctor - Trust safeguarding Lead 	<p>September 2019</p>

<p>D - Explore whether consent was being appropriately explored with children seen within the service.</p>	<p>17. GIDS will better document obtaining consent by:</p> <ul style="list-style-type: none"> • Ensuring that documentation of the process to achieve consent is specifically recorded within clinical records • Routinely documenting decisions for which consent has been reached • Ensuring signed consent taken from the service user and or family, especially for any decisions for treatment on the physical pathway in addition to consent sought at endocrine clinic <p>GIDS will detail more clearly from the onset of each case the range of measures required to reach informed consent for a move to the endocrine service. Young people and their families will be involved in the review of this process to ensure that any changes made are clearly relevant and understandable for a range of different ages and presentations eg ASD. for young people and their families, the range of measures required to reach informed consent, covering information, capacity, consistency of thinking over time and freedom from external pressures.</p>	<p>Lead: GIDS Director + 1 GIDS Senior Leadership Team Member</p>	<p>July 2019</p>
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	<p>18. GIDS will publish its Consent Protocol which will include sub-protocols on:</p> <ul style="list-style-type: none"> • joint working and coordination with the endocrine clinics • the requirements for further consent to be sought for different phases of treatment 	<p>Lead: CYAF Director</p> <p>Contributors:</p> <ul style="list-style-type: none"> - Associate Director of Contracts - GIDS Leeds Service Lead 	<p>July 2019</p>
	<p>19. GIDS will improve its process around capacity and consent discussions including how these are documented by:</p> <ul style="list-style-type: none"> • Ensuring these are recorded on the patient record system • Case discussion forms are completed in every case • Quarterly audits and reporting with immediate effect 	<p>Lead: GIDS Director + 1 GIDS Senior Leadership Team Member</p>	<p>July 2019</p>

<p>E - Explore whether there is evidence that staff have been asked to do unreasonable amounts of work and/or whether it is perceived that this is the case.</p>	<p>20. GIDS is committed to providing thinking space and to protect staff from individual and systemic pressures. It will achieve and monitor this by</p> <ul style="list-style-type: none"> • Mapping out and communicating to staff all the opportunities for thinking and support, and ensuring that staff avail themselves of these. • Ensuring that opportunities for thinking in the wider Trust are also accessible to all GIDS staff • Undertaking quarterly audits of numbers of cases based on bandings. These audits to be analysed for impact and plans to mitigate are reported to the GIDS Exec, and to CYAF Director as required. • Audit data will be used to better plan resource both in terms of time and seniority for cases on a complex pathway 	<p>Lead: GIDS Director</p> <p>Contributors -GIDS executive team Director of CYAF</p>	<p>First audit June 2019</p>
	<p>21. Beyond existing cross supervision arrangements, GIDS will ensure that variation in practice is minimised by making sure it:</p>	<p>Lead: GIDS Director</p> <p>Contributor: - GIDS Senior Leadership Team</p>	<p>Ongoing</p>

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	<ul style="list-style-type: none"> • Assesses the potential for silo working and adjusts service provision as needed • Plans for ongoing review of caseloads held by individual practitioners, such as the identification of dormant cases • Develops a reporting schedule to the Directorate and Trust level governance forums 		
	<p>22. GIDS will improve confidence in the skills of clinicians in the service by developing a formal curriculum and training to document all staff are provided with required skills for gender work. This training will be mandatory for all new staff</p>	<p>Lead: Director of Nursing</p> <p>Contributors:</p> <ul style="list-style-type: none"> - Deputy Dean - Director of Strategy 	<p>March 2020</p>

<p>F - Explore whether there is evidence that the senior staff employed within GIDS have been aware of the concerns raised and: Ignored them; and / or Attempted to silence those that have raised the concerns.</p>	<p>23. In order to ensure that GIDS receives the support it needs to address concerns there will be representation from the Directorate in the clinical governance forums within the GIDS service.</p> <ul style="list-style-type: none"> • Systems will be developed to ensure that the wider Directorate and Trust regularly review audits and reports of GIDS activity. • GIDS will publish its audit programme • GIDS will form part of the new Trust quality review framework and GIDS activity will be reviewed and discussed at the Clinical Quality, Safety and Governance Committee 	<p>Lead: Medical Director</p> <p>Contributors</p> <ul style="list-style-type: none"> -Director of CYAF -GIDS Director -GIDS Quality team 	<p>End of October 2019</p>
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<p>G - Explore whether the Director of children, young adults and family services (CYAF) was aware of the above and acted to ensure that Trust board is aware and sighted on the issues.</p>	<p>24. GIDS and the Trust will ensure that its programme of research is given oversight from the Trust. It will do this by:</p> <ul style="list-style-type: none"> • Developing a Research Project Implementation Plan • Ensuring there is ongoing research into patterns of referrals, as well as the long-term outcomes for CYP who use the service • Working with stakeholders to develop a longer-term research strategy for this area of work • Contributing to the national and international evidence base, through its ongoing research collaborations and attendance and presentations at international conferences 	<p>Lead: Director of Research and Development</p>	<p>October 2019 – GIDS Research Strategy</p> <p>Ongoing monitoring</p>
	<p>25. The Trust will undertake a review of how it interacts with the external environment and manages the large volume of information and media requests. GIDS will develop systems to minimise the impact of external gender activity on the clinical work in the service and the burden of responding to enquiries by reviewing and publishing data sets to address the bulk of questions.</p>	<p>Lead: Director of Marketing and Communications</p>	<p>July 2019</p> <p>Ongoing monitoring.</p>

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	<p>26. In order to protect a framework of neutrality, and in line with existing Trust policy, GIDS staff will be expected to declare affiliations or associations with any external organisations or lobbies through Gifts, Hospitality and Conflict of Interest Policy process. Existing staff will be reminded of the policy and the issue will included in the local induction arrangements for new starters.</p>	<p>Lead: Director of HR & Corporate Governance</p>	<p>July 2019</p> <p>Ongoing declarations.</p>
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TERMS OF REFERENCE
RAISING CONCERNS REVIEW

Introduction

You are asked to undertake a review of the approach and methods used for raising concerns within the Trust. During the course of your review you should explore the following reference areas:

- What are the existing arrangements for raising concerns which should include a description of these, their strengths and where they might be improved.
- The understanding amongst the Board of Directors and Executive Directors about their roles in managing / seeking assurance on these matters.
- The understanding of staff, more widely, on the processes of raising concerns. This should include exploring barriers that may or may not exist.
- An assessment of any areas where the process for raising concerns have not worked effectively and the learning which should be taken from these cases.
- What can be learnt from best practice in other NHS organisations.

It is your role to determine the facts arising out of these areas for exploration and highlight opportunities for learning and process improvement.

This review is being conducted outside of the formal Trust procedures.

Method of Review

In approaching this review you are asked to:

- Interview as many directors and non-executive directors as practically possible but as a minimum should include:
 - Director of Adult and Forensic Services
 - Director of Children, Young Adults and Family Services
 - Director of Education and Training / Dean of Postgraduate Studies
 - Deputy Chief Executive
- Interview the Freedom to Speak Up Guardian and Chair of Staff Side.
- Develop and launch a Trust wide survey exploring the issues.
- Facilitate three open staff forums to explore areas identified in the scope of this review.
- Consult with representatives of the Council of Governors
- Through the Trust's Freedom to Speak up Guardian consult with the office of the National Freedom to Speak up Guardian

If throughout the course of your review you identify any further areas which may assist with concluding the process, then you should discuss these and seek my approval.

Authority

You act with my authority in conducting this review.

Objectives

Your review should establish the facts in relation to the areas described above, draw conclusions using a balance of probabilities approach and then make recommendations, where appropriate.

Recommendations

Your report may make recommendations to address any system issues identified in the report related to the Trust's approach to raising concerns. You may also report good practice that becomes apparent.

Resources

You should appoint such staff as necessary to ensure the effective conduct and completion of the review.

Oversight

Helen Farrow, Non-Executive Director has been appointed to provide oversight of this review to ensure its integrity and delivery to the timetable.

Timetable

You should conclude your review within six weeks of the date of this document and provide your final report prepared in time for consideration at the May Board of Directors meeting, unless these timetables are revised with my agreement.

Annex A

A review in to concerns raised about the Gender Identity Development Service

Author: Dr Dinesh Sinha, Medical Director
Oversight: Helen Farrow, Non-Executive Director on
trust board and Celestine Keise, Governor in the council
February 2019

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Part 1: Executive Summary

GIDS is an innovative and specialist service for the assessment of gender dysphoria. It has been based in the Tavistock and Portman NHS Foundation Trust for approximately 30 years. The review of the GIDS service followed instruction received from Paul Jenkins CEO in late August 2018 and was conducted following the approval of the terms of reference by the board on the 25th September 2019. It addresses the terms of reference and was commissioned following concerns raised by a member of staff and a subsequent message from a group of 'concerned parents'. The review was following a period of rapid increase in the size of the service both in terms of the number of referrals received, which had significantly increased since at least 2015 and also in the number of staff delivering the service. At the same time, there has been greater social interest and consequent intense scrutiny in this area of practice.

I conducted wide-ranging interviews based on a number of questions that were raised in accordance with the terms of reference. There were 31 interviews conducted and these included a number of interviewees who wished to remain anonymous. The review into a trust service operating in this area of clinical practice and within the current context was a potentially distressing experience for interviewees. For this reason, I am grateful that most interviewees transparently engaged with the terms of the review. There were repeated comments that while coming for the review was difficult, it was accompanied by the hope of something constructive emerging from the findings and recommendations.

The review report bases its findings on facts interrogated in various interviews and evidence provided by interviewees, including data, audits and papers. We recognised and agreed that conducting new audits would be outside the scope of the review, due to the concerns raised being over a number of years and changes in service structures. The findings from the review suggest that while the service works to a reasonable model specification, more work is needed to clarify the model and create a dynamic resource, which comprehensively details the task at assessment, benchmarks good practice and contains all the required protocols. Similarly, the service has made significant efforts to

manage referrals safely, including those on the waiting list, which continue to challenge available resources. However, the service cannot simply continue to do just more of the same and needs to agree various measures to clarify relationships with referrers, such as articulating clearer referral criterion in agreement with commissioners. It also needs to further enhance learning from complaints and processes for dealing with concerns from young people and clinicians.

There was a nuanced and differentiated description about various kinds of safeguarding concerns and responses, as they emerged. There had also been more recent service wide improvement efforts, such as in safeguarding structures and documentation. These need to be embedded and evidence gathered on an ongoing basis, along with further work on developing shared understanding of safeguarding in this clinical setting, including with external stakeholders. Concerted efforts were reported to reach informed consent in assessment and subsequently for various decisions with young people and their families. However, a common theme across these findings was possible variability in practice, which suggested the need for greater standardisation.

Findings related to concerns about staff working hours and caseloads suggested that gross numbers need granulation to understand the nature of the work. Work is ongoing and needs to continue to ensure reasonable levels of caseload and clinical activity. These should ensure a frame for thoughtful exploration, particularly in the context of pressures, such as from the growing waiting list and individual commitment. These efforts need to be accompanied by creating a minimum set of training and skills for clinicians within GIDS.

It was apparent that the various concerns explored, as cited by the terms of reference were known by the senior leadership of GIDS and that there had been repeated efforts to hear about concerns. However, the findings suggested that it was more difficult to always have a clear picture of possible actions considered or/ and taken in response to the concerns. This seemed to be due to a combination of factors including communication difficulties, operational pressures, lack of explicit processes and possible concern about the impact of any changes. Finally, the findings were that that the director and the directorate had been aware of concerns and involved in considering changes, some of

which had been implemented. However, the extent of support from the directorate and overall trust had been deficient and contributed to a sense of disconnect between the service and the wider organisation.

The review makes 26 recommendations to address the findings and conclusions. These recommendations are meant to engage the service and the wider trust in providing a high quality service with the capacity for thoughtful exploration, which is the hallmark of the services provided by the trust.

Finally, a detailed action plan detailing those who are responsible, when actions will be completed and assurance oversight will need to be put in place, if the board accepts these recommendations.

Dr Dinesh Sinha

Part 2: Introduction and Methodology

1. In late Aug 2018, I received instructions from Paul Jenkins, Chief Executive of the Tavistock and Portman NHS Foundation Trust to conduct a review in connection with a number of concerns raised by a member of staff about the Gender Identity Development Service (GIDS).

2. The review commenced after I was provided with a terms of reference following board approval on the 25th September 2018. In summary, the terms of reference required me to explore whether the following were cause for concern and produce a report detailing my findings:
 - The GIDS operates to a clear model and its delivery has appropriate resources.

 - There is evidence that the service is managing its referral rate in a safe and adequate manner.

 - Appropriate safeguarding practices and procedures are being applied to children being seen within the service.

 - Consent was being appropriately explored with children seen within the service.

 - There is evidence that staff have been asked to do unreasonable amounts of work and/or whether it is perceived that this is the case.

 - There is evidence that the senior staff employed within GIDS have been aware of the concerns raised and:
 - Ignored them; and / or

 - Attempted to silence those that have raised the concerns.

- The director of children, young adults and family services (CYAF) was aware of the above and acted to ensure that Trust board is aware and sighted on the issues.
3. In the course of my investigation, I have conducted 31 interviews with various individuals, including several on a confidential basis and detailed notes were taken during interviews. I have offered all interviewees the opportunity to comment on the factual accuracy of their interview records and propose amendments where necessary. Amendments were incorporated into interview records where I accepted their validity.
 4. All interviewees were provided with information at the outset of their interviews in relation to their role in the review. I also discussed the ways in which the information they provided would be recorded, stored and used, and need to keep their involvement in the review confidential. It has been agreed with the CEO that the transcripts are to be kept confidential to protect the confidentiality of all interviewees.
 5. I have obtained and reviewed a number of documents from interviewees and the GIDS service, as evidence. These are relevant to the matters that are being reviewed. It has been agreed with the CEO that the additional evidence is to be kept confidential to protect interviewee anonymity. I will refer to having noted evidence within this report, where this is helpful.
 6. The review was led by Dr Dinesh Sinha, Medical Director. Helen Farrow, Non-Executive Director on trust board and Celestine Keise, Governor in the council provided oversight to the review and have also observed some of the interviews.
 7. Where I make findings of fact and draw conclusions within this report, I do so based on the interviews that were conducted and the information available to me to the best of our knowledge and belief. Where I have encountered conflicting evidence, I have sought to make findings based on the balance of information from interviews and evidence.

Part 3: Relevant Policies, Procedures and Guidelines

8. Serious Incident Learning and Procedure, Consent to Treatment Policy and Procedure, Grievance Policy and Procedure, Discipline Policy and Procedure, Safeguarding of Adults at Risk Policy and Procedure, Safeguarding Children Procedure, Clinical Risk Assessment Procedure, Trust Publication Guidelines, Raising Concerns and Whistleblowing Procedure, Bullying and Harassment Procedure, Clinical Supervision Procedure

Part 4: Chronology of Events – Evidence Base and Findings

9. It is reported that several staff from the GIDS service approached various members of trust staff in 2017 to report concerns and discuss difficulties that they were experiencing while in their roles within the GIDS service.
10. Several staff, including those who were on the verge of leaving or had left the service also approached the member of staff. The member of staff produced a report in Aug 2018. The review followed instruction received from the Chair and CEO in late August 2018 and was conducted following the approval of the terms of reference by the board on the 25th September 2019
11. The interviews were conducted using questions framed around the terms of reference along with additional queries, as required. Arrangements were also made, including with the advice of Gill Rusbridger, Trust Freedom to Speak up Guardian for conducting confidential interviews for anyone wishing to participate on an anonymous basis. As part of these measures, some interviews have been conducted off site, as required.
12. However, the number of interviews looked likely to significantly increase, due to a number of GIDS staff and others wanting to contribute to the review. It became apparent that a longer time frame would be needed, in order to allow the review to accommodate the increase in the number of interviews that would be conducted and allow sufficient space to explore responses. Hence, an extension to the time available to complete the GIDS Service Review was agreed. Following the extension, the review

interviewed 31 interviewees in total, including many who were keen on remaining anonymous and information about their backgrounds being kept confidential.

Part 5: Findings in relation to the specific issues set out at section 3 of the Terms of Reference

Context

13. The GIDS is a specialist service for the assessment of gender dysphoria operating in the Tavistock and Portman NHS Foundation Trust. The review of the GIDS was commissioned following the concerns brought up in the member of staff's paper. This was following a period of significant and rapid increase in the size of the service both in terms of the number of referrals received, which had significantly increased since at least 2015 and also in the number of staff delivering the service. At around the same time, there has been greater social interest in this area of practice accompanied by consultation regarding changes in law. Consequently, this resulted in increasing public and media interest in the assessment and interventions available for this group of young people.

14. A particular issue that emerged for the trust and clinical staff within the service has been the pressure from strongly held views by various pressure groups, namely the trans-affirmative and trans-critical lobbies. This continual interest, critical scrutiny and often very strongly held opinions has created an atmosphere of significant persecution for staff and the need to repeatedly address some of the issues emerging from groups having definite agendas. At the same time, it is worth acknowledging that some of these views and extremes of opinion can be reflected within the staff group.

A	Explore whether the GIDS operates to a clear model and its delivery has appropriate resources.
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15. I asked interviewees several questions around the understanding of the model of the GIDS service, its adequacy and evidence that it worked, their experience of using it and actually knowing that it was working, and lastly, if they had a view of the resources available within the service to deliver the stated model.

16. In response, I heard repeatedly from various interviewees that the model of the service was based on a network model, to indicate that the service worked as a national service in conjunction with local services, as its young people who presented with gender dysphoria could be from across the UK. The service was also noted to be functioning, as essentially a CAMHS service based on a family life cycle and providing stepped care.
17. I heard that GIDS was a multidisciplinary team (MDT) seeking to explore the issue of gender dysphoria that could not be driven by a single theoretical construct due to the multifactorial reasons for gender dysphoria, but with a degree of flexibility and also aimed to explore any comorbid issues. The assessment process was described, as a therapeutic intervention needing 4-6 sessions over 6 months to correlate with the diagnostic criterion for gender dysphoria and being undertaken by two clinicians at a time. I have seen evidence of the model specifications from the NHSE and other relevant documentation.
18. There was a relatively common view that it was possible to extend this frame for the initial assessment, leading up to an assessment report and that there were no overt problems in doing an extension of the frame. Interviewees referred to the NHSE protocol, as guiding the service design and model, while making it clear that it was not purely a diagnostic service but rather attempting to provide flexibility to allow exploration. However, several interviewees felt a sense of implicit pressure from seniors to maintain throughput and keep to the frame rather than extend, due to the pressure of the waiting list.
19. I considered the difference between what was being described and the concerns about there not being sufficient thought or the absence of a theoretical model. There was an assertion that the role of the service was to help young people negotiate and explore the distress surrounding their gender dysphoria, rather than necessarily work out the aetiology. This felt like a contentious area for some interviewees, who were of the view that it was important to formulate the gender dysphoria with an understanding of what had led to it in the first instance, though on the other hand there were concerns that this stance constituted an attempt at reparative therapy.

20. The lack of a stated theoretical model expressed, as a concern in the member of staff's paper was addressed by many interviewees pointing out that the two assessors brought their separate often differing backgrounds to the clinical scenario, which was helpful in helping the young people and their families think through the right actions for the future and that this was no different to what would happen in any MDT service. At the same time, it was freely acknowledged that this was not meant to be a psychological therapy service or working to a specific modality and that perhaps there was confusion between a model versus a modality in the concerns that have been raised.

21. There were concerns about the lack of an articulate and live policy document around what happened in the assessment, as a way of guiding the thinking and exploring, its impact on variance in practice. There were examples given where certain seniors in the service were reported, as doing fewer assessment sessions before coming to their conclusions. Overall there seemed to be concerns identified about the relative lack of a full set of protocols for assessment decisions, transparency in making choices of co-working partners for the assessments and the experience of junior assessment partners having a say in the decision making. There were also concerns about how to address particularly complex presentations, such as where there was significant conflict between the families and the clinicians or significant comorbidity and finally variability in practice. I have seen and heard evidence suggestive of variance in practice.

22. In the interviews, a majority of interviewees asserted that a significant degree of thought was given within the process of the assessment and further treatment for the issues presented. There was widespread recognition that there were often difficulties encountered while seeing families and young people within the frame of the service. This could be due to several young people and their families presenting with their minds apparently made up and with the presumed insistence on being put forward for the medical treatments. This could put a significant amount of pressure on the assessment pair, as they had to negotiate this insistence on moving forward by the young person with the purpose of the assessment, which was to explore various issues, including possible distress around gender dysphoria.

23. There was certainly acknowledgement of the frame of the service having become much more difficult in the period since 2015. This had perhaps also been contributed to by a dynamic of urgency from having an increasing numbers of waiters on the waiting list, resulting in staff feeling under what was often described, as a significant pressure to see a lot of young people and also pressure internally for individuals to address the waiting list. This appeared to have continued for a period till there was acknowledgement that the waiting list breaches could not be contained by doing more of the same.
24. However, even in this situation nuanced and complex decision-making was described in trying to introduce uncertainty into the frame, for example when families or young people felt completely certain coming for the assessment of the conclusions or indeed taking a contrary position to allow sufficient exploration to happen. There was also description of a variety of methods by which individual clinicians acting in pairs during the assessment, would seek advice and support from the individual supervisors and various group forums, including large team meetings, reflective spaces offered by exec team member, sub team meetings, fifth Tuesday meetings, away days etc. about particular issues that repeatedly emerged within sessions. I have heard and seen evidence of such discussions and forums.
25. A persistent theme from various interviewees were the problems in responding to challenges both internally within the service and externally, particularly from groups in the external environment, who were at two ends of the spectrum. There appeared a combination of impacts from these pressures from the external environment and the reflection of such stances within the team by various team members, which could at times prevent spaces to think. Interviewees reported that there seemed excessive concern that taking any actions might lead to an adverse impact on the service, when facing such intense scrutiny in the external and highly politicised environment.
26. There was a recurrent sense of feeling that problems or issues emerging in the model, such as the pressures experienced from family and young people to progress were heard, and that there was a sufficient interest from senior staff but far more difficulty in actually putting forward changes, possibly due to concerns that these could be misunderstood leading to a backlash from one of the external groups.

27. The service had made an effort to move from a direct control model by a small group of seniors, as it expanded, to a more recent distributed leadership model by forming various sub teams according to geographical regions. However, it seems that some of these changes had taken a significant amount of time to happen and perhaps not kept entirely abreast of the chronology of growth experienced by some interviewees, following a phase of growth where the pressure of working and dealing with external scrutiny had felt very difficult.
28. Interviewees were of the view that the service was relatively well resourced though on discussion many interviewees pointed out that the extensive waiting list indicated that there continued to be a mismatch between demand and capacity for the service. There were views expressed that the resource had to be utilised in a way where it would have the best impact, rather than continuing to do the same.

My conclusions and recommendations are as follows:

29. I conclude that while the service has a model for its operation, there remain several issues in terms of its understanding that contribute to variation in practice, possibly also predicated by the influx of new staff in to the service. The previously followed principles of learning by experience can no longer be entirely relied upon in an expanding service. Hence, the GIDS service needs to create a system for a dynamically updated operational protocol, which provides sufficient guidance to new staff and is available for current staff.
30. This service level live operational protocol needs to include details of the task at assessment and benchmark good practice. This enhanced operational protocol should include all relevant protocols and updates for various aspects of practice, such as protocols for age and puberty based possibilities for intervention, response to complex presentations, gaining and recording consent, safeguarding practices, differentiating sexuality related issues etc. along with processes to keep it updated, as practice continues

to improve. The operational protocol needs to become the document to consult for any key operational definitions.

31. The model described in the findings has various challenges, not least due to the external context of resource difficulties for CAMHS services and debates about the nature of gender dysphoria. Hence, there needs to be a feedback process to the directorate and in turn to the board that the model of the service, as described in the live operational protocol is being followed.

32. I anticipate that a standard model of 4-6 assessment sessions followed by the assessment report and possible recommendation for the treatment pathway would provide a reasonable framework for many of the cases being referred with a degree of flexibility, as described in various interviews. However, the service needs to ensure that the model has a defined provision for more complex cases and seek to agree this pathway with NHSE Commissioners. Complex cases need early identification from the point of referral and allocation of additional resources both in terms of the seniority of staff involved, the need for liaison and the degree of oversight in decision-making.

33. A process needs to be created and reported on to the directorate, including using frequent deep down audits of the content and quality of assessment decision-making and following the pathways, as described in the new operational protocol. These audits need to be applied to staff of all seniorities within the service and their goal should be to reduce significant variation in practice, such as time for completing assessments, detail and depth of content and discussion of recommendations, as appropriate.

B	Explore whether there is evidence that the service is managing its referral rate in a safe and adequate manner.
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34. I asked interviewees several questions around safety and adequacy of the procedures in the management of risk. I also asked them, if they were aware of incidents and complaints to do with the management of referrals within the service.
35. Interviewees told me about intake meetings, processes for collecting information about risk, including the cover sheet attached to case notes and responses of the team to inadequate referrals. These included calls made to referrers to find information about risk and suggest actions, including further referral to local services, if required to manage risk. The team sought more information so that referrals could be accepted, if appropriate, and I was informed of recent improvements. There was ongoing work through projects to better manage referrals, who had been entered onto the waiting list, particularly when the length of waiting time had continued to increase over the past few years and was now at around 18 months. I have seen evidence of waiting list pilots and was informed about a rota to manage enquiries.
36. There was concern that there were no specific enough referral criteria available for referrers and that this made it virtually impossible for the service to refuse referrals. This was presented as a reluctance to refuse any young people, as there was concern that they would be negatively impacted by refusal. There was a theme of such concerns being heard, often over some length of time but lack of clarity about why possible actions could not be progressed, which led to frustration.
37. There was a degree of preoccupation with those on the waiting list, while acknowledging that this was a national service and that risk had to be locally held. This was particularly, as the network model could be imperilled by cuts made to local CAMHS services. This would mean that there was often a reluctance by local services to engage these young people, as they were seen as belonging to the national service due to the identified issue of gender dysphoria, even if there were a host of comorbid reasons, including issues around risk.

38. There was a repeated description of the use of team-based procedures to help think about risk. This included supervision, meetings to discuss referrals and other team meetings where particular issues of risk were addressed. I have heard and seen evidence related to such practices.

Addressing Concerns

39. I asked about concerns being brought up by young people and their families and processes to manage these concerns, as they emerged. I also asked about processes for addressing concerns raised by clinicians.

40. Young people and family concerns were reasonably addressed, including through use of formal and informal team structures and also involving the trust's formal complaints procedures, when required. Most interviewees were aware of recent serious incidents and learning from those had been discussed within team settings as appropriate. Complaints were managed directly by the exec and there was some concern that broader themes from complaints were not adequately discussed within team settings and that more could be done to improve the processes of learning from complaints.

41. As stated previously, there was a persistent theme of reported difficulties in internal communication that made concerns from clinicians more difficult to manage and seemed connected with perceptions about the leadership, with possible lack of sufficient support from within the directorate and the trust. The leadership of the service was described, as being in a state of being unable to act, due to the intense scrutiny and pressure from external pressure groups and reflections of this in the demands being put forward by clinicians. There were some interviewees who thought the criticism from some staff was linked to disagreements and unhappiness with the changes possible.

Sexuality versus Trans issues

42. Certain issues where concerns had not been addressed, such as the adequate exploration of sexuality within clinical settings was brought up in the member of staff's paper. In exploring this issue, there seemed no particular concerns held by a majority of interviewees around there being a lack of sufficient openness to hearing about the experience of homophobia by clinical staff within face to face clinical meetings.

43. However, some interviewees stated that the response to complaints from family members and young people was to remove the clinicians involved and reallocate the case to others. There was concern that this was perceived and experienced, as less than robust enough support from the senior leadership team for clinicians facing issues in exploring gender dysphoria.

44. There were no consistent reports of a lack of spaces to hear concerns or shutting down of discussion. However as noted, there was a sense of frustration at responses not being sufficiently communicated or in some instances the responses not reflecting what individual clinicians felt would be more appropriate. There was some concern at the lack of reflective spaces specific to the issue of exploring sexuality versus gender issues within assessments, while there was also an acknowledgement that some of the conflict in the discussions reflected the external space within which the service existed.

45. In this context, I also heard that while there were repeated experiences of various team settings including team meetings, fifth Tuesdays, away days and other such forums where issues were raised and heard by the senior team, it was much harder to have a clear sense of response. It was unclear if the difficulties experienced were simply due to a lack of sufficient communication about decisions that were possible and taken, or if decisions were not taken in an adequate enough time due to concerns about the fallout from decisions with the possibility that this left individuals feeling that their concerns were not given a reasonable response.

46. I have seen evidence of discussions covering a wide range of topics, including in away days and 5th Tuesdays. I was provided with a schedule of various team forums and examples of minutes of discussions.

My conclusions and recommendations are as follows:

47. Given the repeated concerns voiced by interviewees about the lack of sufficient referral criteria, the service needs to have a defined engagement with commissioners to specify referral criteria, as appropriate for a national service dealing with gender dysphoria. This will also assist clinicians in identifying complex referrals from the beginning, as envisaged in the previous recommendation.

48. The service needs to better identify reasonable and appropriate criterion for refusal of referrals in agreement with commissioners and in keeping with its role as a national service. There is a need for clarity in the use of referral criterion for local CAMHS services, which could be a continuing focus of improvements. Specific protocols may be required for managing complex cases, such as where the young person is already receiving private treatment or has significant comorbidity.

49. Preventing excessive and unexplained variation in practice, while allowing sufficient transparency to the assessment framework is crucial. Hence, I also recommend measures to incorporate features, such as cross supervision arrangements rather than relying on vertical lines of supervision, reasonable oversight of co-working arrangements and regular audits of assessment reports.

50. There needs to be continuing enhancements to the management of young people on the waiting list and incorporation of results from audits currently ongoing, which may lead to further actions and recommendations.

51. There needs to be an enhancement of the process for learning from incidents internally within the service, including with evidence, such as minutes of forums where serious incidents are discussed.

52. A similar process needs to be set to learn from complaints, particularly as several interviewees have expressed concerns about the service's robustness in responding to complaints from young people and families. There should be continuing involvement of and oversight from senior clinicians to the eventual decisions from the assessment, in instances where complaints prompt changes in the assessment team.

53. There needs to be a clearly written down plan in agreement with HR for managing concerns from staff, in keeping with the theme of visible and explicit processes. This needs to include timescales for clear written responses from exec and other senior staff for any concerns brought by individuals and the dovetailing of these processes with trust processes for managing concerns from staff, such as by the use of relevant trust level policy and procedures. These changes will help address the repeated concerns from a minority of clinicians about being subject to bullying, when they repeatedly brought up concerns. An audit of concerns and responses needs to be made available to the directorate on a quarterly basis.

54. In turn, individuals who bring up concerns will be expected to adhere to service level and overall trust processes in the management of concerns within clinical settings. The findings suggest that there is actual and/or perceived confusion and delay both within the service and in the use of trust wide processes for escalation of difficulties that are not resolved at various levels. There also needs to be a service wide attempt to engage staff and make them aware of these new service level processes and how they relate to trust wide HR processes.

C	Explore whether appropriate safeguarding practices and procedures are being applied to children being seen within the service.
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55. I asked interviewees about their safeguarding practices, adequacy and consistency of the use of safeguarding procedures, concerns around the number of external safeguarding referrals made and finally, if safeguarding was adequately addressed or remained an issue within the service.

56. Staff working within the service were very aware of safeguarding and were able to speak in a nuanced and differentiated fashion about the various kinds of safeguarding processes and their responses to concerns, as they emerged. These included scrutinising referrals for safeguarding issues, including the most common issues that would present to any CAMHS service. There were multiple forums, including supervision, team meetings, sub team meetings, away days, fifth Tuesdays, where safeguarding had been discussed (I saw evidence of discussions) and could be discussed. Several interviewees spoke about a process of working with young people, their families, seeking suitable advice and support from more experienced professionals within the service and also trust support structures, such as the named Doctor and the children safeguarding lead.

57. There had also been a recent improvement in practice, as a safeguarding lead had been appointed within GIDS and there was access to social work background professional colleagues within each of the sub teams. Often, young people were already within the safeguarding remit by the time they were referred to the national service and on other occasions referrals could be referred by local services within the network or directly by the GIDS team. Several interviewees felt that there could not be any conclusions drawn from the number of external safeguarding referrals and the adequacy of safeguarding procedures, due to the above dynamics in a national service.

58. However, there were concerns about the use of the network model and its impact on safeguarding, due to the challenges of having access to sufficient local services in a financially strained external environment. There have been more recent attempts to ensure adequate documentation using standardised safeguarding forms, a concern

commented on by some interviewees. I have seen evidence of discussions in team settings, more recent attempts to improve documentation and external presentations.

59. There were concerns expressed about difficulty in having a shared understanding of safeguarding, as there could be the view that it was a safeguarding issue, if a child having gender dysphoria was even brought to the service for an assessment. Several interviewees spoke about their experience of facing such views or lack of sufficient understanding of the context, including by trust professionals and also in external settings, where issues such as gender dysphoria could prompt a diversity of opinions even within the community of safeguarding professionals. There was concern that chronic difficulties with divergent views, could lead to a consequent impact on transparency.

My conclusions and recommendations are as follows:

60. I recommend that the trust is unequivocal in holding the position that simply bringing a child to the service for exploration of gender dysphoria does not constitute a safeguarding issue. However, it is reasonable to acknowledge that this can often be a complex population with presentations that can require the need for further deep exploration.

61. In this context, safeguarding concerns and practices need to be evidenced through quarterly audits and these should begin with immediate effect. There needs to be consideration of the possibility of collecting information about external referrals made by any agency in the network, as part of ongoing case management. The recent appointment of a safeguarding lead for the service has been a significant step forward and it is important that the continuing enhancements in safeguarding framework within the service are accompanied by respectful support from central safeguarding resources.

62. There is a need for the service to find avenues to contribute to improvements in safeguarding guidance nationally and engage with external safeguarding boards in an effort to improve practice in this area.

D	Explore whether consent was being appropriately explored with children seen within the service.
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63. I asked interviewees about their processes for gaining consent and if these were safe and adequate.

64. I was told of concerted efforts to reach informed consent and that these included repeated discussion in assessment on various decisions with young people and their families. There were forums within the service, which were also contributed to by external speakers to discuss particularly contentious issues around consent, such as complex presentations involving autism spectrum disorders and comorbid issues.

65. Clinicians spoke about discussing various aspects requiring consent, such as social transition, decisions around referral to endocrine clinic for hormone blocking drugs and finally decisions around the use of cross sex hormones. Assessment reports formed the evidence for consent and there was an expectation that all clinicians described consent around the decisions reached and/or difficulties with reaching informed consent. There was a mandatory need to confirm decisions for cross sex hormones in team meetings. I have heard and seen evidence of work to develop understanding of ethics and processes around consent.

66. Some interviewees expressed concerns about the use of hormone blockers and their consideration, as providing an interregnum for further exploration of gender dysphoria. Evidence provided by the service appeared to support the shift in impact of using hormone blockers, in that a majority of young people then went on to have cross sex hormones.

67. There were also some concerns expressed about the lack of uniform process beyond team discussion and that there was no mandatory need for gaining signed consent from young

people and their families at GIDS. There was a process of taking signed consent at endocrine clinic and I have seen evidence of documentation used.

68. Several interviewees were aware of issues of longer-term difficulties with consent, particularly with young people and their understanding of issues, such as fertility and its impact on their adult lives. Clinicians appropriately described involving parents, seeking advice from supervisors and group forums within the service and also involvement of the service in setting up sounding board sessions with experts on consent. There was concern about delays in developing more information tools, such as leaflets for certain groups. It was acknowledged that this was an area where best practice was still developing and that the service was playing its part in the development of best practice procedures.

My conclusions and recommendations are as follows:

69. There was a description of thoughtful attempts for gaining consent in the best case scenarios, while keeping the importance of the exploration of gender dysphoria central to the assessment. This framework needs to be enhanced by making it mandatory to have a thorough description of the attempts made to reach consent, the decisions for which consent has been reached and a signed consent taken from the service user and or family, especially for any decisions for treatment on the physical pathway, even before young people and their families reach the endocrine clinic. Hence, there should be clear communication at the beginning of engagement to set expectations of young people and their families about the range of measures required to reach informed consent.

70. There needs to be continuing thoroughness in documenting joint working and coordination with the endocrine clinic during the phase of treatment and in reaching further stages of consent, such as currently required for the prescribing of cross sex hormones.

71. Capacity and consent discussions need to be flagged in care notes and the service should include a heading for discussion of consent in assessment reports and case discussion forms. These measures should be accompanied by regular audits and reporting with immediate effect.

E	Explore whether there is evidence that staff have been asked to do unreasonable amounts of work and/or whether it is perceived that this is the case.
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72. I asked interviewees if the pressures of staff working both in terms of the number of cases being seen by individual members of staff and the number of hours were known within the service and frequently talked about. I also asked if the service had done anything to support staff.

73. Several interviewees pointed to a lack of knowledge by the member of staff of the nature of caseloads held by clinicians within the service, which could include a combination of active assessment cases being seen regularly and follow-ups, which were often in a holding wait and watch stage being followed up every 3 to 6 monthly. Similarly, treatment cases on either hormone blocking medication or cross sex hormones were seen on a less frequent interval and their care shared with the endocrine clinic. Also, given the nature of assessments with two clinicians on each occasion, each clinician would only take the lead in documentation and follow-up in half of the assessment cases, which again reduced the pressure from caseloads. Caseloads were reviewed in supervision meetings and I saw evidence of service level attempts to scrutinise caseloads. I have seen evidence of work on caseloads and expected face to face activity.

74. However, it was acknowledged that the number of cases held by individuals, particularly during the period described as a phase of significant pressure, was excessive. This period was complicated by both internal pressures, where some individuals took on excessive

caseloads to demonstrate higher functioning and also contributed to by the push to not breach the waiting list and later to keep the waiting periods within control.

75. Several interviewees felt that being overly busy was in common with staff in other trust services. Some interviewees also pointed out that the service was relatively easier to progress in, due to the number of staff, who left following recruitment and the rapid expansion in staff numbers since 2015.

76. Some interviewees spoke about the experience of support from the service for managing workload and work hours being dependent upon differences in sub teams. This was described as a team issue, in that the exec member would supervise seniors who would then supervise certain 8As who would then have band 7 supervisees. It was reported by some interviewees that the experience of being supported or not in being able to have lesser caseloads and more flexibility in managing complex caseloads could be dictated by differences in sub teams.

My conclusions and recommendations are as follows:

77. My findings suggest that there is a need to have explicit processes to preserve thinking space and to make sure that individual or systemic pressures, such as from the waiting list do not impact on the model and its thoughtful implementation in exploring gender dysphoria. I recommend a quarterly audit of numbers and cases based on banding to be reported to directorate and reflecting the need for provision of more resource both in terms of time and seniority for cases on a complex pathway.

78. Audits of clinical activity need to be complemented by a significant degree of oversight for monitoring variations in practice including, as described before, arrangements for cross supervision to prevent silos of supervision and co-working. There needs to be continuing improvements in the ongoing review of cases held by individual practitioners,

such as the identification of dormant cases. These changes need to be accompanied by scrutiny from the directorate and trust level governance forums.

79. Given the significant difficulties voiced by many interviewees in feeling assured about an agreed set of skills needed for gender workers in this clinical setting, I recommend that the service works with others, such as the Department of Education and Training in recommending a curriculum and training, which will provide required skills for gender workers and that this becomes mandatory for new clinicians joining the service.

F	<p>Explore whether there is evidence that the senior staff employed within GIDS have been aware of the concerns raised and:</p> <ul style="list-style-type: none"> ○ Ignored them; and / or ○ Attempted to silence those that have raised the concerns.
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80. I asked interviewees if the concerns, as above were known by senior staff within the service and if the directorate had been aware of the concerns raised by the member of staff, even before his paper was published.

81. It was clear from the description of chronology of events that senior staff both within the service and within the directorate had been independently aware about the various concerns for some length of time, including questions raised about the model by some staff, staffing pressures within the service including from the waiting list, managing referrals safely and adequately, safeguarding issues within this population of young people and management of concerns both from young people, their families and staff.

82. These issues had been repeatedly discussed in various settings, including forums within the service and in meetings held with key individuals, particularly members of the executive of GIDS and I was provided with evidence of some of these conversations. Some

interviewees, particularly executive members and senior members of GIDS and the trust contributed to my understanding of the chronology of events. I was aware of information related to some of the concerns described in a report to the trust board by GIDS in July 2018.

83. A repeated theme which emerged was the evident capacity of the seniors within GIDS to provide spaces for hearing and reflecting on the concerns being raised, matched by the persistent experience of junior staff that the responses were not decisive. There was a sense of the senior team being distracted and preoccupied with pressures, from both the operational functioning and also the external political environment. There was a repeated mention of the service often feeling prevented from acting due to pressures and unable to make the decisions required. There was significant support for their having been little deliberate suppression, as a reason for the non-resolution of long standing issues.

My conclusions and recommendations are as follows:

84. I recommend that there is representation from the directorate in the clinical governance forums within the GIDS service and that various audits and reports are discussed and minuted at CYAF directorate forum. Any reports of concern need to be escalated through the appropriate work streams and subcommittees leading to the CQSG and other suitable trust level forums. I recommend also that the GIDS service becomes part of the new quarterly quality review framework, as proposed in the trust’s CQC action plan.

G	Explore whether the director of children, young adults and family services (CYAF) was aware of the above and acted to ensure that Trust board is aware and sighted on the issues.
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85. Several interviewees particularly those of lower bands were either completely or insufficiently aware of the interactions between the overall directorate and the GIDS service. It was felt that the director for CYAF was supportive of the service, as several

interviewees had observed her in team meetings and away days, though there was some uncertainty about the extent of support and involvement.

86. Most interviewees, apart from those in the GIDS executive were unaware of the chronology of events leading to the review or of evidence to support the directors and directorates interventions. There were generally some feelings of concern and even sympathy for the members of exec in particular the service lead, as being caught in quite a difficult position between the operational demands of a rapidly expanding service and a challenging external environment, though with little sense of overall trust processes to support either the executive or the service. There was some concern expressed about a possible disconnect of the service with the rest of the trust.

87. Some interviewees expressed specific concerns about leadership styles of certain individuals that continued within the service, in spite of recent changes to the leadership structure.

My conclusions and recommendations are as follows:

88. The trust has a responsibility to support and encourage continuing development of structures within the GIDS service. The trust has recently secured a significant research grant, which will assist ongoing efforts to improve understanding of various issues, such as patterns of referrals, long term outcomes etc. and improve evidence in this area of clinical practice.

89. I recommend that the trust reviews its interaction with the external space, including on issues such as data requests and responding to media queries to enable the service to operate in a more contained space and protect the clinicians of the service from feelings of persecution and anxiety. This could mean that data is published at regular intervals

through the year after consistent quality review and analysis, rather than the trust and in turn senior clinicians having to deal with continual requests.

90. In order to protect a framework of neutrality which encourages exploration I recommend that any affiliations or associations by GIDS staff with any external organisations or lobbies need to be transparently declared and should prompt questions of conflict-of-interest.

Part 6: Report Conclusion

91. It is important to state that the service must be a safe haven for exploration of gender identity and gender dysphoria with absolutely no attempt at reparative or conversion therapy, in keeping with the Government's LGBT action plan 2018.
92. On the basis of my findings, I concluded that the service had significant strengths in its area of innovative practice with a wide ranging national population. However, there remains room for further improvements.
93. Throughout the course of my review, I have identified specific issues relating to individuals, this report will not cover the specifics of these which will require further exploration through an appropriate Trust procedure.
94. My conclusions and recommendations are to address systemic issues and provide a better framework for the service, help the service become more explicit with its processes and for the trust to help develop a more contained setting for its often difficult work in the field of gender dysphoria in this population.
95. Finally, If the board accepts these recommendations (summarised in annexe 1) then a detailed action plan detailing those who are responsible, when it will need to be done by and assurance oversight will need to be put in place.

Annex 1

Summary of Conclusions and Recommendations

A	Explore whether the GIDS operates to a clear model and its delivery has appropriate resources.
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1. I conclude that while the service has a model for its operation, there remain several issues in terms of its understanding that contribute to variation in practice, possibly also predicated by the influx of new staff in to the service. The previously followed principles of learning by experience can no longer be entirely relied upon in an expanding service. Hence, the GIDS service needs to create a system for a dynamically updated operational protocol, which provides sufficient guidance to new staff and is available for current staff.

2. This service level live operational protocol needs to include details of the task at assessment and benchmark good practice. This enhanced operational protocol should include all relevant protocols and updates for various aspects of practice, such as protocols for age and puberty based possibilities for intervention, response to complex presentations, gaining and recording consent, safeguarding practices, differentiating sexuality related issues etc. along with processes to keep it updated, as practice continues to improve. The operational protocol needs to become the document to consult for any key operational definitions.

3. The model described in the findings has various challenges, not least due to the external context of resource difficulties for CAMHS services and political debates about the nature of gender dysphoria. Hence, there needs to be a feedback process to the directorate and in turn to the board that the model of the service, as described in the live operational protocol is being followed.

4. I anticipate that a standard model of 4-6 assessment sessions followed by the assessment report and possible recommendation for the treatment pathway would provide a reasonable framework for many of the cases being referred with a degree of flexibility, as described in various interviews. However, the service needs to ensure that the model has

a defined provision for more complex cases and seek to agree this pathway with NHSE Commissioners. Complex cases need early identification from the point of referral and allocation of additional resources both in terms of the seniority of staff involved, the need for liaison and the degree of oversight in decision-making.

5. A process needs to be created and reported on to the directorate, including using frequent deep down audits of the content and quality of assessment decision-making and following the pathways, as described in the new operational protocol. These audits need to be applied to staff of all seniorities within the service and their goal should be to reduce significant variation in practice, such as time for completing assessments, detail and depth of content and discussion of recommendations, as appropriate.

B	Explore whether there is evidence that the service is managing its referral rate in a safe and adequate manner.
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6. Given the repeated concerns voiced by interviewees about the lack of sufficient referral criteria, the service needs to have a defined engagement with commissioners to specify referral criteria, as appropriate for a national service dealing with gender dysphoria. This will also assist clinicians in identifying complex referrals from the beginning, as envisaged in the previous recommendation.
7. The service needs to better identify reasonable and appropriate criterion for refusal of referrals in agreement with commissioners and in keeping with its role as a national service. There is a need for clarity in the use of referral criterion for local CAMHS services, which could be a continuing focus of improvements. Specific protocols may be required for managing complex cases, such as where the young person is already receiving private treatment or has significant comorbidity.
8. Preventing excessive and unexplained variation in practice, while allowing sufficient transparency to the assessment framework is crucial. Hence, I also recommend measures to incorporate features, such as cross supervision arrangements rather than relying on

vertical lines of supervision, reasonable oversight of co-working arrangements and regular audits of assessment reports.

9. There needs to be continuing enhancements to the management of young people on the waiting list and incorporation of results from audits currently ongoing, which may lead to further actions and recommendations.
10. There needs to be an enhancement of the process for learning from incidents internally within the service, including with evidence, such as minutes of forums where serious incidents are discussed.
11. A similar process needs to be set to learn from complaints, particularly as several interviewees have expressed concerns about the service's robustness in responding to complaints from young people and families. There should be continuing involvement of and oversight from senior clinicians to the eventual decisions from the assessment, in instances where complaints prompt changes in the assessment team.
12. There needs to be a clearly written down plan in agreement with HR for managing concerns from staff, in keeping with the theme of visible and explicit processes. This needs to include timescales for clear written responses from exec and other senior staff for any concerns brought by individuals and the dovetailing of these processes with trust processes for managing concerns from staff, such as by the use of relevant trust level policy and procedures. These changes will help address the repeated concerns from a minority of clinicians about being subject to bullying, when they repeatedly brought up concerns. An audit of concerns and responses needs to be made available to the directorate on a quarterly basis.
13. In turn, individuals who bring up concerns will be expected to adhere to service level and overall trust processes in the management of concerns within clinical settings. The findings suggest that there is actual and/or perceived confusion and delay both within the service and in the use of trust wide processes for escalation of difficulties that are not resolved at various levels. There also needs to be a service wide attempt to engage staff

and make them aware of these new service level processes and how they relate to trust wide HR processes.

C	Explore whether appropriate safeguarding practices and procedures are being applied to children being seen within the service.
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14. I recommend that the trust is unequivocal in holding the position that simply bringing a child to the service for exploration of gender dysphoria does not constitute a safeguarding issue. However, it is reasonable to acknowledge that this can often be a complex population with presentations that can require the need for further deep exploration.

15. In this context, safeguarding concerns and practices need to be evidenced through quarterly audits and these should begin with immediate effect. There needs to be consideration of the possibility of collecting information about external referrals made by any agency in the network, as part of ongoing case management. The recent appointment of a safeguarding lead for the service has been a significant step forward and it is important that the continuing enhancements in safeguarding framework within the service are accompanied by respectful support from central safeguarding resources.

16. There is a need for the service to find avenues to contribute to improvements in safeguarding guidance nationally and engage with external safeguarding boards in an effort to improve practice in this area.

D	Explore whether consent was being appropriately explored with children seen within the service.
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17. There was a description of thoughtful attempts for gaining consent in the best case scenarios, while keeping the importance of the exploration of gender dysphoria central to the assessment. This framework needs to be enhanced by making it mandatory to have a thorough description of the attempts made to reach consent, the decisions for which consent has been reached and a signed consent taken from the service user and or family,

especially for any decisions for treatment on the physical pathway, even before young people and their families reach the endocrine clinic. Hence, there should be clear communication at the beginning of engagement to set expectations of young people and their families about the range of measures required to reach informed consent.

- 18. There needs to be continuing thoroughness in documenting joint working and coordination with the endocrine clinic during the phase of treatment and in reaching further stages of consent, such as currently required for the prescribing of cross sex hormones.
- 19. Capacity and consent discussions need to be flagged in care notes and the service should include a heading for discussion of consent in assessment reports and case discussion forms. These measures should be accompanied by regular audits and reporting with immediate effect.

E	Explore whether there is evidence that staff have been asked to do unreasonable amounts of work and/or whether it is perceived that this is the case.
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- 20. My findings suggest that there is a need to have explicit processes to preserve thinking space and to make sure that individual or systemic pressures, such as from the waiting list do not impact on the model and its thoughtful implementation in exploring gender dysphoria. I recommend a quarterly audit of numbers and cases based on banding to be reported to directorate and reflecting the need for provision of more resource both in terms of time and seniority for cases on a complex pathway.
- 21. Audits of clinical activity need to be complemented by a significant degree of oversight for monitoring variations in practice including, as described before, arrangements for cross supervision to prevent silos of supervision and co-working. There needs to be continuing improvements in the ongoing review of cases held by individual practitioners, such as the identification of dormant cases. These changes need to be accompanied by scrutiny from the directorate and trust level governance forums.

22. Given the significant difficulties voiced by many interviewees in feeling assured about an agreed set of skills needed for gender workers in this clinical setting, I recommend that the service works with others, such as the Department of Education and Training in recommending a curriculum and training, which will provide required skills for gender workers and that this becomes mandatory for new clinicians joining the service.

F	<p>Explore whether there is evidence that the senior staff employed within GIDS have been aware of the concerns raised and:</p> <ul style="list-style-type: none"> ○ Ignored them; and / or ○ Attempted to silence those that have raised the concerns.
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23. I recommend that there is representation from the directorate in the clinical governance forums within the GIDS service and that various audits and reports are discussed and minuted at CYAF directorate forum. Any reports of concern need to be escalated through the appropriate work streams and subcommittees leading to the CQSG and other suitable trust level forums. I recommend also that the GIDS service becomes part of the new quarterly quality review framework, as proposed in the trust’s CQC action plan.

G	<p>Explore whether the director of children, young adults and family services (CYAF) was aware of the above and acted to ensure that Trust board is aware and sighted on the issues.</p>
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24. The trust has a responsibility to support and encourage continuing development of structures within the GIDS service. The trust has recently secured a significant research grant, which will assist ongoing efforts to improve understanding of various issues, such as patterns of referrals, long term outcomes etc. and improve evidence in this area of clinical practice.

25. I recommend that the trust reviews its interaction with the external space, including on issues such as data requests and responding to media queries to enable the service to operate in a more contained space and protect the clinicians of the service from feelings of persecution and anxiety. This could mean that data is published at regular intervals through the year after consistent quality review and analysis, rather than the trust and in turn senior clinicians having to deal with continual requests.

26. In order to protect a framework of neutrality which encourages exploration I recommend that any affiliations or associations by GIDS staff with any external organisations or lobbies need to be transparently declared and should prompt questions of conflict-of-interest.