Report for Cambridgeshire Health Committee

Subject:	Response of CPFT to the Health Service Ombudsman's report regarding the investigation into a complaint made by Mr Nic Hart
Date:	**16th January 2018**
Author:	**Tracy Dowling Chief Executive**

1.	**BACKGROUND**
	The Health Service Ombudsman for England investigated the complaint made by Mr Nic Hart. The complaint was in relation to the care and treatment provided for his daughter, Averil Hart. Averil died on 15th December 2012 following a four year history of anorexia nervosa. The complaint regarded the care provided by a number of organisations. This report relates only to the care provided Cambridgeshire and Peterborough Foundation Trust (CPFT). The complaint was also about the response Mr Hart and his family received from each NHS organisation. Again this report only relates to the findings relating to the complaint administration by CPFT. The Ombudsman's report found that there were actions undertaken by CPFT which fell so far short of established good practice and the applicable guidance, that there was service failure. The report recognises the challenges the complaint presented in terms of complexity, scope, the serious nature of what had happened and the resulting emotion involved, but concluded that CPFT repeatedly failed to provide full written answers to Mr Hart's questions, and that CPFT's response to the formal complaint was significantly delayed. The Ombudsman therefore also found that there was maladministration of Mr Hart's complaint by CPFT. Averil had been an inpatient on the S3 eating Disorders Unit run by CPFT on the Cambridge University Hospitals Addenbrooke's site. Averil was discharged on 2nd August 2012, and was referred for follow –up by the Norfolk Community Eating Disorders Service (NCEDS) as Averil was due to commence at the University of East Anglia on Sunday 23rd September 2012. This service is also run by CPFT.

2.	SERVICE FAILINGS FOUND AND ACTIONS TAKEN TO ADDRESS THE SERVICE FAILINGS

This section of the report aims to set out the service failings identified by the serious incident review and the Ombudsman's report. It also states the actions which have been taken to address these failings.

Discharge and transfer of care

1. The risk assessment carried out at the time of Averil's discharge was not robust or explicit enough. It should have included a contingency plan to follow if Averil's condition deteriorated.
2. The care coordinator from NCEDS should have attended Averil's Care Planning Approach (CPA) meetings on the Eating Disorder Unit
3. Averil should have been offered weekly appointments to be weighed during the interim period.
4. Despite the efforts of the staff involved, staff shortages meant a gap in therapy and support for Averil at a very vulnerable time.

Action taken:

A care planning policy has been written for transfer or transition of care. Protocols have been signed up to and all transfers of service users between teams or services should now include a CPA meeting attended by representatives of the teams and external agencies, and carer / family who will be involved in the treatment pathway.
This was developed in July 2014, reviewed and amended in November 2016 and reviewed in April 2017.

Weekly audits of CPA were carried out until care plans were meeting a 90% compliance standard for 4 weeks. This was achieved by December 2013.

Non CPA care plans were also audited monthly until Trust standards were achieved.

Staff completed Clinical Risk Level 2 training.

A procedure for managing people on the waiting list has been developed, implemented and revised.

Appointment of the NCEDS Care Coordinator

1. The records kept of clinical supervision of the care co-ordinator were scant and poorly kept.
2. The care co-ordinator should have had the benefit of support from a multi-disciplinary team from the outset.
3. Holiday leave cover should have been arranged to ensure Averil's weekly monitoring continued whilst the care co-ordinator was on holiday

Action taken:

Specific guidelines about the clinical capacity of different staff, and the level of autonomy in decision making which they can exercise, have been produced and implemented. There are explicit criteria for clinical review of junior staff working involving direct contact with the client, and the notes.

These guidelines were implemented in June 2013, reviewed in December 2013 and in February 2015.

A high risk patient register has been produced and team guidelines have been developed, implemented and revised for the management of high risk patients. The guidelines include:

- Documented weekly discussion in the multidisciplinary team (MDT) with a senior clinician present
- A plan for monitoring the relevant clinical indicators
- Specific triggers for senior review in the event of inter-current events
- Specific triggers for action
- Liaison with other healthcare workers including the GP
- Explicit documentation of the rationale for the clinical decisions taken at each MDT.

The revision to the guideline added that patients designated as high risk who are deteriorating and requiring weekly weighing by NCEDS are seen by another member of the NCEDS team for review when their therapist is away (e.g. on holiday).

Communications between NCEDS and the UEA medical centre

1. Where care is shared, in this case with the UEA medical Centre, steps should be taken to establish effective two-way communication. This did not happen.

Action taken:

A guideline on medical monitoring has been written for GPs.
North Norfolk CCG has commissioned an enhanced service from their GPs for medical monitoring. A protocol has also been written for patients of any GPs who do not participate in the enhanced service. Arrangements for liaison are explicitly stated. Arrangements for liaison are explicitly stated in the Policy for the Management of High Risk Patients.
The recommendations for medical monitoring has been standardised in the high risk protocol.

Lack of clarity about the role of the CPFT healthcare assistant when Averil was admitted to Cambridge University Hospital.

1. The healthcare assistant deployed to ensure Averil did not display any behaviours to sabotage treatment, did not provide assistance with Averil's physical care. This should have been explained at the time and it is recommended that this assistant could have provided more support or flagged that her role was no longer needed.

Actions taken:

An adult eating disorder service policy regarding the involvement of carers in patient care for patients whose condition is currently life threatening was written in May 2013 and amended in November 2013.

3	**FURTHER ACTIONS FOLLOWING RECEIPT OF THE OMBUDSMANS REPORT WITH REGARD TO THE MANAGEMENT OF COMPLAINTS**
	The Trust has developed a Duty of Candour Policy which was not in place at the time of Averil's death. This came into use on 1st October 2014. The Trust is also in the process of developing an approach to 'learn from deaths'. This is a national requirement and as part of our approach in CPFT we have appointed a Family Liaison officer to support bereaved families. As part of our work on Zero Suicide the Trust is also considering how we support, and respond to bereaved families at this most difficult of times. This will include how we respond at the time of an incident, how we investigate with some independence, and how we demonstrate openness to failings in care and work with staff to support them in addressing any issues found. The speed with which formal complaints are responded to is not within NHS guidelines and there is an action plan in place to address this. As each complaint is signed off by the Chief Executive I have direct oversight of progress with this work.
4	**CONCLUSION**
	Averil Hart's death was an injustice and there were service failings and mal - administration of the complaint received from her Father. CPFT accept the findings of the Ombudsman's report and have taken actions to address these service failings. We continue to work to ensure that we can be assured that services are being systematically delivered in accordance with these policies and with good practice, and that staff are supported in delivering good services to some of our most vulnerable patients. The Insight Report published at the same time as the Ombudsman's Report demonstrates that there are challenges experienced across the country in the provision of eating disorder services. Some of the recommendations will require national action. CPFT is keen to engage with this work and to continue to learn from Averil's case, and to share this learning with other services. CPFT apologise for the failings in Averil's care and for the failings in the administration of the complaint. We will continue to ensure that these issues are addressed, and that monitoring is in place to provide the assurance of this.

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Date: 9th January 2018

Appendix 1: Summary of the Eating Disorder Services provided by CPFT

1. **Norfolk Community Eating Disorder Services (NCEDS) commissioned by Norfolk CCG** - A service for over 18's that will optimise quality and value for patients with Eating Disorders across Norfolk, excluding the localities managed by NHS Great Yarmouth and Waveney CCG. The service aims to improve both life expectancy and quality of life for adults with an eating disorder as locally as possible.
2. **Cambridgeshire and Peterborough Community Eating Disorder Services (CPCEDS) commissioned by C&PCCG** -A service for over 18's offering specialist assessment and psychological interventions to adults with eating disorders. Provides service for adults with moderate to severe eating disorders including anorexia nervosa, bulimia nervosa, and eating disorders not other specified including binge eating disorder.
3. **Adult inpatient eating disorder interventions (Ward S3 Addenbrookes) commissioned by NHSE** - Ward S3 is a 14 bed mixed-sex in-patient unit for adults aged 18-plus, based at Addenbrookes Hospital in Cambridge. It is a specialist unit for individuals with an eating disorder who have been assessed by the community team and are considered to need a more intensive approach to the treatment of their eating disorder
4. **Children and Young People inpatient eating disorder interventions (The Phoenix Centre, Darwin Site) commissioned by NHSE** - The Phoenix Centre offers inpatient and day treatment programmes for young people (age 13-18) with complex eating disorders whose needs cannot be met by generic child and adolescent mental health services or their community CAMHS or community specialist eating disorder service