Agenda Item No: 4

EATING DISORDERS OMBUDSMAN REPORT

To:	**Health Committee**
Meeting Date:	**16th January 2018**
From:	**Tracey Dowling, Chief Executive, Cambridgeshire & Peterborough Foundation NHS Trust**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with an overview of the actions being undertaken by Cambridgeshire & Peterborough NHS Foundation Trust following the serious incident in 2012 and the wider recommendations outlined in the Parliamentary and Health Service Ombudsman report published on 6th December 2017.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the actions being undertaken by CPFT to address the recommendations cited in the Ombudsman report.**

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1.0 INTRODUCTION

1.1 Members at the Health Committee meeting held on 14 December 2017 agreed to invite representatives from Cambridgeshire & Peterborough Foundation NHS Trust (CPFT) to attend the January meeting to scrutinise the organisations response to the Parliamentary and Health Service Ombudsman report.

1.2 An overview of the current provision of Eating Disorder Services managed by CPFT will be provided. The report will also focus on the organisational response to the recommendations made in the Ombudsman's report.

2.0 BACKGROUND

2.1 The Parliamentary and Health Service Ombudsman released a report "Ignoring the alarms: How NHS eating disorder services are failing patients" on the 6th December 2017. The report follows an investigation responding to a number of complaints received by the Ombudsman in regards to failings within NHS Eating Disorder services.

2.2 The main focus of the Ombudsman report is an investigation into a serious incident that occurred in 2012, resulting in the tragic death of a patient undergoing treatment at Cambridgeshire & Peterborough Foundation Trust (CPFT), Addenbrookes Hospital, Norfolk & Norwich University Hospital, GP practice and NHS England's response to the complaint.

2.3 The report identified five national areas of focus to improve services.

1. The General Medical Council (GMC) should conduct a review of training for all junior doctors on eating disorders to improve understanding of these complex mental health conditions.
2. Health Education England (HEE) should review how its current education training can address the gaps in provision of eating disorder specialists. If necessary HEE should consider how the existing workforce can be further trained and used more innovatively to improve capacity. It should also look at how future workforce planning might support the increased provision of specialists in this field.
3. The Department of Health and NHS England should review the existing quality and availability of adult eating disorder services to achieve parity with child and adolescent services.
4. The National Institute for Clinical Excellence should consider including co-ordination in its new Quality Standard for eating disorders to help bring about urgent improvements in this area.
5. Both NHS Improvement and NHS England have a leadership role to play in supporting local NHS providers and commissioners to conduct and learn from serious incident investigations. NHS E and NHS I should use forthcoming Serious Incident Framework review to clarify their respective oversight roles in relation to serious incident investigations. They should also set out what their role would be in circumstances where local NHS organisations are failing to work together to establish what has happened and why, so that lessons can be learnt.

2.4 The paper provided by Cambridgeshire & Peterborough Foundation Trust will provide an overview of the current provision of Eating Disorder Services in Cambridgeshire. CPFT will also share actions taken immediately following the Serious Incident and the current action plan in light of the Ombudsman report.

Source Documents	**Location**
Parliamentary and Health Service Ombudsman. Report "Ignoring the alarms: How NHS eating disorder services are failing patients"	https://www.ombudsman.org.uk/publications/ignoring-alarms-how-nhs-eating-disorder-services-are-failing-patients