Case 200400447: Lothian NHS Board

Introduction

1. On 30 May 2004 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) about the care and treatment of her daughter (referred to in this report as Miss A) by the Royal Edinburgh Hospital (REH) in the period from November 1998 to March 2003. Miss A was then 19 and her pre-eminent condition was severe anorexia nervosa. Sadly, Miss A's condition continued to worsen and she died in September 2004 (aged 20). Shortly afterwards Mrs C brought additional complaints to the Ombudsman's office about Miss A's ongoing treatment from March 2003 until her death, all of which care was funded and under the overall clinical governance of Lothian NHS Board (the Board).

2. While Mrs C raised her initial complaint under the NHS Complaints Procedure, the Board had not had an opportunity to address the further issues raised after Miss A's death. Because of the particularly stressful circumstances, and with the full co-operation of the Board, this office accepted the further complaints. This report addresses all the issues raised by Mrs C.

3. The specific complaints from Mrs C which I have investigated (*and my conclusions*) are that :

(a) the Young Persons Unit of the Royal Edinburgh Hospital failed to provide Miss A with the appropriate care and treatment (*partially upheld, see paragraphs 26 to 29*);

(b) the Board was not able to provide Miss A with the appropriate care and treatment (*upheld, see paragraphs 57 to 59*);

(c) the Board did not provide the necessary support to Miss A's family (*partially upheld, see paragraphs 64 to 65*).

Summary of the investigation, conclusions and recommendations

4. The investigation of this complaint involved obtaining and reading the relevant documentation, medical records (from eight hospitals and services) and complaint files. I have had a number of meetings with Mrs and Mr C (Miss A's father) and staff of the Board. I have obtained the views of medical and nursing advisers (referred to in this report as the advisers) with specialist knowledge of the psychological and physiological treatment of anorexia nervosa. A number of written enquires have been made of the Board who have provided me with copies of the policies and documents referred to in this report. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs and Mr C and the Board have been given an opportunity to comment on a draft of this report. An anoymised draft of the report has been shared with the Scottish Executive Health Department (SEHD) and NHS Quality Improvement Scotland (QIS). SEHD provided details of current initiatives in hand or proposed by the NHS Regional Planning Groups and their partners together with updates on related action by NHS QIS and NHS Education for Scotland. This information is referred to in this report and set out in full at Annex 5.

5. The advisers told me that Miss A's anorexia nervosa was particularly severe in nature and throughout my investigation many of the health professionals involved commented on the particular challenges this raised in providing treatment. I note that the medical records frequently reflect awareness by health professionals of the limitations of the current provision and a frustration that the options for Miss A's treatment were so far from ideal. I also note that the advisers both expressed a strong view that Miss A's treatment and care within a number of the hospitals was excellent, but that its long-term benefit was severely hampered by the necessity for treatment to be delivered so far from Miss A's home and in so many different settings.

6. In summary, I concluded that there was a failure in the service provided to Miss A for which responsibility lies with the Board. There is a small but vitally important unmet need for adult in-patient psychiatric and related mental health services for patients with an eating disorder. I have identified a wider need for acute in-patient medical services with appropriate specialist knowledge and expertise for patients with eating disorders whose physical condition requires medical input. Again such services need to be fully integrated with the relevant

psychiatric, mental health and other appropriate medical services. These needs are not limited to the the Board area but apply to a greater or lesser extent to Scotland as a whole. I have also identified a shortfall in the levels of knowledge about, and awareness of, the legal position with respect to some treatments for eating disorders amongst health practitioners in Primary and Secondary Care settings. On that basis I uphold or partially uphold all aspects of Mrs C's complaint.

7. In the light of the conclusions, the Ombudsman recommends that the Board ensure access to adequate in-patient mental health services for patients with eating disorders. Such services should be subject to prescribed clinical review and oversight by NHS Lothian with a lead clinician identified as responsible for each patient. In addition the Board should ensure that these mental-health services have access to acute in-patient medical services with the specialist knowledge and expertise needed to treat patients with eating disorders, again with appropriate oversight by NHS Lothian.

Further action by the Ombudsman and NHS Lothian

8. Action by the Board alone cannot address the lack of provision identified for the whole of Scotland or the problems of lack of awareness amongst health professionals. The Ombudsman is referring the need for services throughout Scotland identified in this report to the SEHD for consideration as part of overall strategies in relation to Eating Disorder services throughout Scotland (Annex 5 details these strategies) and to NHS QIS who are currently developing Scottish Guidelines for Eating Disorder services. It is the intention that this office will have an on-going dialogue with NHS QIS as these guidelines are developed. There are currently guidelines in England and Wales for Eating Disorders produced in January 2004 by the National Institute for Clinical Excellence.

9. The Board have accepted the recommendations and will keep this office informed of progress towards and the method of achieving these.

10. As there are issues which concern treatment while a patient is detained under the Mental Health Acts the report will also be brought to the attention of the Mental Welfare Commission for Scotland.

Medical and general background

11. Miss A was first referred to the services at the REH in 1998, aged 14, for treatment of Obsessive Compulsive Disorder (OCD). Subsequently she developed severe anorexia nervosa (anorexia) in addition to OCD. Her care was provided in nine different hospital facilities in both Scotland and England and within the NHS and the independent health sector. This care was funded by the Board throughout. Because of this I have reviewed Miss A's medical records from a number of institutions outwith the Ombudsman's direct jurisdiction. I am grateful to them for their co-operation. This report raises a number of concerns about Miss A's care and treatment in institutions outside my jurisdiction which I cannot address in this report. A copy of this report will be forwarded to all the institutions involved in Miss A's care for their consideration. A chronology of the key events, dates and locations is provided in Annex 4. The chronology is an integral part of this report as its length and complexity sadly demonstrate the lack of any available continuous, integrated care pathway which Miss A's condition particularly required.

12. Miss A was a detained in-patient under mental health legislation for considerable periods of time during this complaint. She was detained both in Scotland and England where different regulations apply. On at least one occasion this difference contributed to problems in providing treatment (see paragraph 42) and was thus an added difficulty in providing treatment for Miss A outside of Scotland. It is also important to note that the regulations with respect to mental health legislation at the time of these events restricted the ability of an independent health sector clinic to treat patients detained under the Mental Health (Scotland) Act 1984. This limitation aimed to avoid any perception that the clinic might financially benefit from continuing to detain someone against their wishes. This placed considerable limits on the available provision for detained patients in Scotland as there was latterly only a small private provision (approximately 15 beds) for adult in-patient anorexia sufferers and no NHS facility. The Mental Health (Care and Treatment) (Scotland) Act 2003, which came in to effect in October 2005, introduced consideration of detention orders by a Mental Health Tribunal which acts independently of the psychiatrists working for the institution involved. This change has helped overcome the previous difficulty and the current independent sector provision in Scotland is currently around 50 beds, all of which are located in the Central Belt. There is still no direct NHS provision.

13. Consultant Psychiatrist 2 told me that he would consider that, for Scotland as a whole, there is a current need for (approximately) five in-patient beds for patients with severe anorexia and for Eating Disorders overall (very approximately) 50 beds are needed.

14. To assist the reader of this report a brief overview of the condition has been provided by the advisers and appears in Annex 3.

Investigation

(a) Care and treatment at the Royal Edinburgh Hospital

15. Mrs C complained that Miss A had been referred to the Young Persons Unit (YPU) at the REH for treatment of her obsessive compulsive disorder but had been inappropriately treated alongside other patients, in particular patients with anorexia, and this had led to Miss A developing anorexia herself. Mrs C was also concerned that not enough was done to address Miss A's OCD or its underlying cause. Mrs C also complained that staff did not communicate adequately with Miss A's family who were often unsure about what was happening with her treatment. Mrs C also told me that the psychiatric and medical staff involved in Miss A's care often contradicted each other and relied on the family to make decisions about treatment that the family were not experienced or qualified to make. Mrs C expressed concern that when Miss A became 18 there was no plan in place for her transition to adult services or for her on-going treatment. This led to considerable uncertainty and anxiety on the part of Miss A (and her family) which contributed to her worsening anorexia. Mrs C raised her concerns in writing with the consultant in charge of Miss A's care at the REH (Psychiatric Consultant 1) on 9 October 2002 and raised further detailed points with the Board in a letter of 22 August 2003.

16. Mrs C told me that she had spoken to staff several times about Miss A mixing with patients with anorexia and had asked them on several occasions if Miss A had an eating disorder and was told that she did not. Mrs C believed staff were not sufficiently alert to the potential problems. The adviser commented that anorexia very often develops between 14 and 17 years of age with obsessional symptoms appearing at an earlier age. The adviser noted that it was quite probable that Miss A's actions were influenced by those of other patients but that Miss A's anorexia was not something that she could simply have 'caught' or learned from others. The adviser told me that anorexia is a condition that develops over time and this can

lead to a difference in views between health professionals who are looking for a pattern developing over time and relatives who are observing a change in behaviour in the patient.

17. Mrs C told me that Miss A's OCD developed as a result of severe bullying at school which was never properly recognised or addressed by the school or the YPU. Mrs C told me that Miss A only received limited counselling and there were a considerable number of staff changes which led to gaps in the therapy provided. The adviser commented that it is clear from the medical record that the YPU recognised bullying was a major factor in Miss A's developing OCD and had made considerable efforts to address the issue with her but that Miss A had strongly resisted discussing the bullying and became very distressed when it was raised. The adviser expressed some concern at the lack of any clear plan to treat Miss A's OCD but told me that anorexia nervosa and OCD are often inversely linked; that is while anorexia nervosa improves, OCD becomes worse and it is reasonable to address the anorexia nervosa first as it is the potentially more harmful condition. The adviser noted that, because of the severity of Miss A's anorexia nervosa once it developed, there were not many opportunities for staff to try to address Miss A's OCD.

18. The psychiatric records do demonstrate that there was regular communication with the family. However, there was a high level of staff turn-over (in particular when Miss A's key-worker left) and the medical records do not indicate any co-ordination of this communication. In response to the concerns raised by Mrs C in October 2002 a review meeting was held between Mr and Mrs C and the lead clinicians for Miss A. Mrs C told me that she was advised at this meeting there were to be changes in the structure of the YPU and that indeed she felt communication improved after this meeting.

19. Mrs C's concerns about the difficulties caused when Miss A's care was transferred to a medical environment from the REH, is one which persists through all of Miss A's treatment. The transfers became necessary when Miss A's physical condition deteriorated to the point where she required hospitalisation for intravenous (IV) re-hydration or insertion of a naso-gastric (NG) tube for artificial feeding. While under the care of the REH, at this time, Miss A was transferred at different times to the Royal Infirmary of Edinburgh (RIE), the Royal Hospital for

Sick Children in Edinburgh and St John's Hospital at Howden (St John's). Mrs C told me that doctors in the general medical wards would often disagree or contradict the doctors at the REH about what treatment Miss A required and/or for how long this treatment should be carried out. Mrs C specifically complained that in February 2003 she was told by doctors at the YPU she had to agree to Miss A being PEG fed. Mrs C felt she was not medically competent to make this decision herself and matters were further confused when a doctor at the RIE told Mrs C he did not consider Miss A's condition was so severe it warranted this treatment which was only to be used in the most extreme circumstances. In the end Mrs C refused to make the decision and she told me she considered that the doctors at the YPU refused to take responsibility for making a decision and did nothing.

20. In his response letter of 31 October 2003 the Chief Executive of the then Lothian Primary Care Trust (now Lothian Primary Care Operating Division) commented that staff at the YPU were disappointed that the RIE had not been more assertive in ensuring Miss A's nutrition. While he was unable to comment on the views of the doctor at the RIE with regard to PEG feeding, he confirmed that it was the view of YPU staff that PEG feeding was the only reasonable option in this situation. There is correspondence in the psychiatric file that indicates a considerable amount of thought and discussion on the part of Consultant Psychiatrist 1 about the legality of PEG feeding Miss A against her own wishes. This correspondence also indicates the view of staff that Miss A's parents were not willing to give permission for her to be PEG fed. I note this is subtly different from the view Mrs C expressed to me, namely that they did not feel they were medically competent to make this decision in the face of the different medical opinions and felt it more appropriate to leave it to the doctors to decide. Whatever the different views, there is evidence of careful deliberation by Consultant Psychiatrist 1 and concern on his part over the contrary views of medical staff at the RIE but a lack of understanding between Mrs and Mr C and the team from the REH.

21. It is clear from several entries in the medical records that there was a degree of difference and difficulty between medical and psychiatric staff on the question of treatments for refeeding. An example of this occurred when Miss A was admitted to the RIE on 5 June 2001 for refeeding and was immediately returned to the REH because doctors at the RIE were unwilling to refeed without Miss A's consent, although staff at REH felt she was in a dangerous physical state and should not be

returned.

22. The issue of medical intervention to feed Miss A against her own wishes is one that caused difficulties on a number of occasions. The adviser told me that while the Mental Health Act Commission in England had issued guidance on the subject, the position in Scotland was less clear. The 2003 Act has set out principles which clarify matters to a considerable degree.

23. Mrs C told me that while Miss A was made aware of her changing rights as she became a legal adult, her family were not given sufficient advice or support about their role in her care. In particular Mrs C felt that she was unsupported when Miss A returned to the family home and the family were not kept informed about Miss A's transfers to and from the REH and the general medical wards for re-hydration. Mrs C felt Miss A was simply abandoned by the YPU when she became an adult with no proper care planning before this time. Mrs C considered that she had had to fight to find a suitable place for Miss A's treatment until Miss A was finally transferred to a private clinic in Central England (Independent Clinic 1) in March 2003 (several months after her 18th birthday).

24. In his letter of 31 October 2003 the Chief Executive stated that Miss A had not been abandoned by the YPU but that it had been felt that Miss A's care should transfer to an appropriate adult facility. He stated that there were no adult specialist eating disorder beds in Lothian and Miss A was transferred to the care of adult services at the REH and St John's until a suitable in-patient place could be found for her.

25. The adviser commented that there is evidence in the clinical record of good discussions between staff and Miss A about her future care as she approached legal adulthood. The adviser could not find evidence of similar discussions with Mrs and Mr C about their altered role in Miss A's care after this time. The adviser noted that it was around this time that the family began to express a loss of confidence in Miss A's care and treatment and considered that, had there been more proactive discussions with the family about the future, this may have alleviated a number of their concerns. The adviser expressed concern that there was no local in-patient unit for Miss A to move on to. This limited the abilities of staff to ensure proper integrated planning for Miss A's care and treatment. The

adviser told me that the clinical record demonstrates that the consultants in charge of both the YPU and adult services at REH made strenuous efforts to secure a place for Miss A but told me that the reality is that there are very few units in the UK (NHS or Independent) that could provide the care Miss A needed, given the severity of her disorder and particularly as she was detained under mental health legislation. I would note that there was no suitable unit in Scotland at that time and there is still none within an NHS facility in Scotland, although such a facility does now exist within the Independent Health Care sector.

(a) Care and treatment at the Royal Edinburgh Hospital (REH): Conclusion

26. The clinical advice I have received is that Miss A had a particularly debilitating level of anorexia and that the nursing and medical team at the YPU achieved exceptionally good results in these especially difficult circumstances. I acknowledge the feelings of Mrs C that Miss A's anorexia was causally linked to her treatment for OCD, but accept the clinical view that anorexia, particularly of this severity, does not develop from contact with other patients with anorexia. I note the advisers' concerns about an apparent lack of planned treatment for Miss A's OCD, but again acknowledge the priority that was given to her physical needs. I support Mrs C's view that the family were not adequately involved in discussions over Miss A's future care and the advisers' view that such discussions may have been of real benefit.

27. My first major conclusion and concern is that there was a failure to involve the family sufficiently in future planning. I conclude that there were no meaningful discussions about Miss A's future care and treatment because there were no options for staff to discuss. This deficit left staff in a difficult position as they tried to form a workable plan with little or no success. This was a direct consequence of the lack of appropriate facilities for adult in-patient services for eating disorder patients in Scotland as a whole The adviser told me that Miss A's condition made her exceptionally vulnerable to change. It is, therefore, all the more critical that in-patient facilities for eating disorder patients are provided in a familiar environment with appropriate lead time and planning for any change. This can only happen where there is a known care pathway with known treatment facilities.

28. My second major conclusion and concern relates to the adverse effect of the repeated lack of agreement between psychiatric services and general medical services. In many areas of healthcare practice there are differences in approach and opinions as to the best treatment. Different views are wholly appropriate except where they lead to a degree of anxiety and uncertainty that is detrimental to treatment. I concluded that this happened many times in Miss A's treatment (see also Complaint (b)). In paragraph 27 I concluded that there is need for adult in-patient services for eating disorders within the NHS in Scotland. I further concluded that there is a need for dedicated medical expertise for those with eating disorders (adult or young person) and that such a service must be integrated with the services outlined in paragraph 27 (and other existing services).

29. Miss A's care at the YPU was generally of a high standard in challenging circumstances, but that aspects of her care were severely hampered by the lack of integrated acute medical services and the limited options available. I do not find a failure in clinical judgement but I conclude that there was a service failure by the Board. I, therefore, partially uphold this complaint.

30. In the light of the conclusions, the Ombudsman recommends that the Board ensure access to adequate in-patient mental health services for patients with eating disorders. Such services should be subject to the proscribed clinical review and oversight by NHS Lothian with a lead clinician identified as responsible for each patient. In addition the Board should ensure that mental-health services have access to acute in-patient medical services with the specialist knowledge and expertise needed to treat patients with eating disorders. Again this will require appropriate oversight by NHS Lothian.

31. The Ombudsman recognises that action by the Board alone cannot address the lack of provision identified for the whole of Scotland or the problems of lack of awareness amongst health professionals. The Ombudsman is referring the need for services throughout Scotland identified in this report to the SEHD for consideration as part of overall strategies in relation to Eating Disorder services throughout Scotland (Annex 5 details these strategies) and to NHS QIS who are currently developing Scottish Guidelines for Eating Disorder services.

32. It is pertinent to note that the current in-patient provision is provided only within the Independent Health Care Sector. Where this continues to be the case particular regard must be given to the process for clinical review and oversight. As a minimum this should meet the standard expected by the *Health Department Letter (HDL 2005(41)): Quality of Clinical Services Provided by the Independent Sector on Behalf of the NHS.* As NHS QIS are responsible for reviewing such arrangements as part of the clinical governance process this office will also draw the concerns raised in this case to their attention.

(b) Care and treatment funded by the Board

33. Miss A's treatment from March 2003 onwards was provided by a number of institutions. Annex 4 details these care episodes. Mrs C recognised that much of Miss A's care was very good, but complained that the family were often not aware of plans to transfer Miss A and were eventually left to fend for themselves when Miss A refused to return to hospital following a home visit in June 2004. Mrs C raised particular concerns about aspects of Miss A's care while an in-patient at Independent Clinic 1 and a lack of co-ordination between psychiatric and medical staff in the time leading up to Miss A's death in St John's in September 2004.

34. During Miss A's time as a patient at Independent Clinic 1 she had five admissions to the local NHS district general hospital (NHS Hospital 1) for IV re-hydration or insertion of naso-gastric (NG) tube for artificial feeding. Miss A resisted NG feeding and often pulled the tube out. As a consequence of this she required to be readmitted to NHS Hospital 1 to have the tube re-sited. On several occasions this process was followed by an x-ray to ensure that the tube was correctly situated (there is a danger of the tube being inserted into the lungs with potentially fatal consequences). Miss A also had her arms placed in splints and later in plaster to try to prevent her removing the tubes; this was of limited success. Throughout this time Miss A was detained under mental health legislation in England. Mrs C complained that Miss A had an excessively high number of x-rays for a young person. Mrs C also complained that placing Miss A in splints and then plaster casts was not research-based good practice and amounted to an excessive restraint.

35. The mental health adviser commented that the decision to treat Miss A with a mechanical restraint (plaster cast) rather than repeated manual physical restraint every time a feed was introduced was possibly reasonable given the extreme circumstances; that is the high risk of death from dehydration and/or starvation. The adviser noted that Miss A was extremely resistant to treatment, but the clinical records indicate she responded reasonably well to the regime at Independent Clinic 1. The mental health adviser also told me that the records indicate a discussion amongst staff about the use of splints and plaster casts when they were first used, but there did not appear to be any process for regular review and reassessment as she would have wished. The adviser also told me that this is a highly unusual intervention which she had not come across elsewhere, and does constitute restraint.

36. The medical adviser commented that the decision to place Miss A in splints and then plaster casts appeared (from the record) to have been taken by a relatively junior member of the medical staff at NHS Hospital 1 without the level of input from senior medical or psychiatric staff which he felt would be appropriate to this unusual treatment. The medical adviser also commented that the number of x-rays did appear to be excessive, although he accepted that there was a balance to be struck between the risks of the repeated x-rays and the risks of aspiration (food entering the lungs). The adviser noted that the approach to x-rays was not consistent and some staff performed x-rays while others did not. The medical adviser expressed concern that Miss A was admitted to NHS Hospital 1 on five occasions between 30 May 2003 and 13 October 2003 and was cared for by five different medical consultants. Most admissions were for 24 hours or less. The medical adviser noted that there appeared to be minimal contact between the psychiatric team and the medical team and no opportunity for the medical team to form the professional relationship with Miss A which he considers essential for the successful management of Miss A's physical problems. The medical adviser summarised :

> 'I feel that the care of the physical consequences of advanced anorexia nervosa requires an experienced physician who is an integral part of the eating disorders team working in close partnership with the psychiatric members of the team. Continuity of care is an important aspect of the care of anorexia nervosa.'

37. The medical records from Independent Clinic 1 indicate that staff were very concerned that Miss A's treatment required them to place her under mechanical restraint in this way and advised the Psychiatric Consultant responsible for Miss A at NHS Lothian (Psychiatric Consultant 2) that they were no longer able to treat her and Miss A was anxious to return home. In fact Miss A remained in Independent Clinic 1 for several more weeks. Once again there was no alternative placement available for her. However, the dietician who had been working with Miss A then left Independent Clinic 1 and they no longer felt it was possible to treat her there. At this point Miss A was not detained under mental health legislation and was transferred to an independent clinic in the West of Scotland (Independent Clinic 2) on 16 October 2003 as a voluntary patient (it was not licensed to accept detained patients). I note that there is no reference in the clinical records to Mrs C being involved in any of the discussions about Miss A's future placement, and Mrs C told me she was not aware that Miss A was to be moved until the last minute. Although Miss A was now 19 the plan was still that she would ultimately be discharged to the family home and her family were expecting to be actively involved in the planning of her care.

38. The placement at Independent Clinic 2 was not successful and it was necessary for staff there to detain Miss A under mental health legislation and this meant transferring her back to the REH on 29 October 2003 as this was the only place legally and practically able to admit her. Mrs C told me she only became aware of this and the difficulties of treating Miss A in Independent Clinic 2, when she received a call from staff at the REH advising that Miss A had been admitted there during the night.

39. It is clear from the clinical records that staff at the REH were not expecting Miss A's transfer from Independent Clinic 2 and there was considerable difficulty in finding a place for her in a ward in the REH as the consultant in charge of the REH ward considered it to be wholly unsuitable for her. Once again Consultant Psychiatrist 2 made considerable efforts to find a suitable place for Miss A at one of the few facilities able to take an adult in-patient with anorexia nervosa and again this meant Miss A being admitted to a hospital in England far from home.

40. Miss A was an in-patient at a specialist unit in Southern England (NHS Hospital 2) from 4 November 2003 until she discharged herself after refusing to return after a home visit in June 2004.

41. The psychiatric adviser commented that Miss A made good progress in NHS Hospital 2 and responded well to the treatment regime there, although she was clearly still very ill and would require long-term care. The adviser also noted that Miss A tried to abscond from the unit on a number of occasions and was always anxious to return home. The various relevant medical records indicate that the overall plan was to allow Miss A several home visits of increasing duration and ultimately discharge her home to the care of the Anorexia Nervosa Intensive Treatment Team (ANITT) in the summer of 2004. ANITT is an out-patient multi-disciplinary team established by Consultant Psychiatrist 2 for adults with eating disorders within the Board area. It started operating in late April 2004. The team support patients in their own community environment and aim to provide them with consistency and continuity of care.

42. Miss A returned home for a period of leave in early April 2004. At this time she was involuntarily detained under mental health legislation in England. The records indicate discussions between staff at NHS Hospital 2 and Consultant Psychiatrist 2 with regard to the situation should Miss A decide not to return voluntarily at the end of her home leave, and appropriate contingency plans were put in place for this. The period of leave went well and a further, longer visit was arranged for late April / early May. Miss A refused to return after this period of leave and was detained by staff at the REH prior to transfer back to NHS Hospital 2, as had been pre-arranged, on 8 May 2004.

43. Miss A's detention order expired on 7 June 2004 and the plan was to allow her home for a further short time and then arrange an extended period of leave. There is a record in the medical file from Consultant Psychiatrist 2 (copied to the consultant in charge of Miss A's care at NHS Hospital 2 and the ANITT team) referring to the fact Miss A was now a voluntary patient and the implications of this if she failed to return from her upcoming leave. It also indicates that there were no current plans for her discharge from the unit but a general plan of discharge in mid to late July 2004. It was also noted that Consultant Psychiatrist 2 would be away during the planned short leave. In the event Miss A refused to return from short

leave and, as she was now a voluntary patient, not clinically unwell enough at that time to be sectioned, she could not be detained and returned as before.

44. Mrs C told me that when Miss A refused to return to NHS Hospital 2 in late June 2004 her family found it very difficult to know who was giving them support and who they could turn to and that this was not what they had been told to expect. Their own GP was unable to offer any assistance and admitted that she knew very little about the treatment of anorexia nervosa. Mrs C told me that she felt Miss A's refusal to eat when she was still very ill should have meant she was detained again and forcibly fed. Mrs C told me that she believes that a lack of action at this point allowed Miss A to compromise her own physical condition to such an extent that it led to her death.

45. The records indicate that there was a problem in identifying a plan for the immediate future when Miss A refused to return. This was in part caused by the planned absence of Consultant Psychiatrist 2, the unavailability of other medical staff to support the ANITT team, and the unplanned nature of Miss A's self-discharge.

46. In the following weeks Miss A refused to eat and received intensive support from the ANITT team but deteriorated rapidly. Miss A was detained under the Mental Health (Scotland) Act 1984 and admitted to an Independent Clinic near Edinburgh (Independent Clinic 3) on 19 July 2004. Independent Clinic 3 is a privately-run hospital which is permitted to treat patients with anorexia nervosa detained under mental health legislation. Independent Clinic 3 opened in September 2003 and accepted referred patients from the NHS in late 2003 - it had not, therefore, been an option earlier in Miss A's care.

47. The mental health adviser told me that Independent Clinic 3 has a high level of expertise in managing patients with eating disorders and that the staff had the skills to work with Miss A, although it was very difficult for them to manage because of the severity of her illness. Miss A was very resistant to treatment and twice took an overdose of medication despite being under constant observation. Although the team at Independent Clinic 3 were able to implement NG feeding and hydration they did not have the facilities for IV rehydration or the intensive medical care Miss A, once again, required. Miss A was transferred to and from St John's on eight

occasions between 25 July 2004 and 3 September 2004.

48. The medical adviser told me that all the referrals to St John's were appropriate and that the severity of Miss A's clinical condition was understood by the staff there. He expressed concern that there was not sufficient recognition of the physiological consequences of her protracted illness which led to Miss A being discharged back to Independent Clinic 3 sooner than was advisable on more than one occasion. He noted that St John's had a very clear management plan for patients with anorexia nervosa but that this may have been over-rigidly implemented. The adviser told me that each individual admission was assessed independently of the overall picture of her deteriorating condition and without recognising the repeating pattern of admission, rehydration, discharge and relapse. The medical adviser noted that once again there were a number of different clinicians involved in Miss A's care over the eight admissions. There was medical expertise available at St John's but input from this clinician was limited with a lack of clear communication between medical staff and psychiatric staff – both NHS and at Independent Clinic 3.

49. The records contain several references to a difference in interpretation of the impact of the mental health legislation on the ability of staff to feed Miss A without her permission. The medical and mental health advisers felt active re-hydration and nasogastric feeding should have been given at an earlier stage as there was a risk to Miss A's life. The advisers considered there was a lack of support from mental health staff at Independent Clinic 3 to facilitate the necessary medical treatment at St John's. It is also noted in the records that staff at St John's were very concerned about the role and ability of the staff supplied by Independent Clinic 3 to observe Miss A, but as there was no overall care plan for Miss A there was no ability to raise and address these concerns at an appropriate level. The records indicate that the staff supplied by Independent Clinic 3, were often agency staff or unqualified carers.

50. The medical adviser concluded that Miss A was given good and appropriate medical treatment by St John's staff for each individual episode, but that there was a failure to provide Miss A with the overall appropriate treatment.

51. Both advisers again noted the difficulties caused to Miss A and the staff

struggling to treat her by the lack of an integrated acute medical service or continuity of care provision.

52. Mrs C told me that during the time Miss A was admitted to Independent Clinic 3 and until the time of her death in September 2004, the family had no idea who was responsible for her and no-one seemed able to tell them or answer their many phone calls. Mrs C told me that again the psychiatric team were telling her Miss A should be forcibly fed, but that when she asked the medical doctors they would not do so. Mrs C told me that staff at St John's were allowing Miss A to get up and walk around when she should be have been made to rest and that Miss A had had a fall on the ward because of this which no-one would explain to the family at the time.

53. In response to the draft report NHS Lothian commented that they did not consider that the management plan at St John's was overly rigid but rather clear and precise. The Board commented that one to one supervision was provided for Miss A by staff employed directly by Independent Clinic 3 throughout her in-patient admissions to St John's. The Board told me that St John's nursing staff were unhappy that Miss A was allowed to wander around the ward and expressed the inappropriateness of this to the Independent Clinic 3 staff on many occasions. This was also reported to the Independent Clinic 3 management team. Miss A was under the supervision of the staff from Independent Clinic 3 at the time of the fall.

54. In response to my enquiries the Board told me that it had been recognised that there were communication problems between staff at St John's and Independent Clinic 3 and several meetings had been held since Miss A's death to discuss improved ways of working. The Board advised me that changes have already been made and they are continuing to work on revised arrangements for 'shared' care in these situations. The Board provided me with a draft protocol for the Admission of Severe Anorexia Nervosa Patients to St John's Hospital. I asked the medical adviser to review this.

55. The medical adviser commented that the draft protocol set out clear guidelines for the objective physical criteria for admission to medical care, but he was concerned that, without an integrated co-ordinated care plan there remains the danger of patients being repeatedly transferred back and forth between services to

little effect.

56. In response to the draft report NHS Lothian provided details of a proposal for a regional consultant to be appointed with responsibility for Eating Disorders – this is referred to in Annex 5. Both advisers reviewed this proposal. While they acknowledged the need to have an identified clinical lead they expressed concern that the proposals did not address the need for a broader range of mental health specialists to be trained and available to support medical staff in each region. The medical adviser told me that because of the very small number of such especially ill patients, regionally delivered care may not permit the development of the necessary experience and consequent expertise.

(b) Care and treatment funded by the Board: Conclusion

57. Miss A's care between March 2003 and her death in September 2004 was provided in seven different hospitals; both NHS and independent health sector, in England and in Scotland, in psychiatric and general medical wards. It is distressing to note again that Miss A's condition meant she was very vulnerable to change, but it was not possible to provide her with a stable, long-term treatment environment. I commend the development of the ANITT and recognise its potential to address some of the problems encountered by Miss A's family. I also commend the actions taken by St John's, Consultant Psychiatrist 2 and Independent Clinic 3 to address the problems caused by the admission of detained anorexic patients to a general medical ward, but note the advisers' concerns about the rigid nature of the new criteria.

58. Neither adviser considered that there was any specific fault or inaction that led to or hastened Miss A's death. Both commended much of her care and treatment, but both also concluded that, while there may be nothing that would have made a difference, the lack of adequate adult in-patient services and integrated acute medical care once again had a detrimental impact on Miss A's care. The advisers remain concerned that any future planning for Eating Disorder services needs to be comprehensive in terms of the mental health specialisms involved and in addressing the specific problems raised by the need for acute medical care for a small number of psychiatric patients.

59. In light of the medical and mental health advice I have received I have

concluded that there was a service failure by NHS Lothian. I uphold this aspect of the complaint.

60. This conclusion reflects that noted for Complaint (a). The Ombudsman therefore, refers to the recommendations in paragraphs 30 and 31.

(c) The Board did not provide the necessary support to Miss A's family

61. I referred throughout this report to the number of occasions where Mrs C felt there was insufficient communication between the family and the staff responsible for Miss A's care. Mrs C also told me that it was very often unclear who had responsibility for Miss A's treatment and that the family frequently felt they were left to cope in an impossible situation or that they were expected to make medical decisions they were not qualified to make. In particular Mrs C told me that they were never told how Miss A sustained a bump to her head shortly before she died or that she was then in a terminal condition with septicaemia.

62. The various medical records contain many references to interactions with Miss A's family although this is of variable intensity. There are instances where the records reflect a conversation with or level of understanding by the family which does not match Mrs C's view of events. The multiplicity of organisations involved in providing Miss A's care, with the lack of clear pathways for that care referred to in complaint (a) and (b), also meant no clear or consistent lines of communication between Miss A's family and health staff.

63. The proposal for Regional Consultants referred to in Annex 5 would ensure that there was a single point of responsibility for each patient. However, I note the advisers' concerns that the proposal does not provide for an integrated care plan between mental and physical health. Without such planning there remains the potential for confusion over responsibilities for treatment and communication for severely physically ill patients like Miss A.

(c) The Board did not provide the necessary support to Miss A's family: Conclusion

64. There were several occasions where Mrs C did not know who was responsible for Miss A and who to approach with her concerns. There was often a disparity between Mrs C's understanding of the situation and that of the health staff, again

with no clear point of communication available to recognise or resolve this difference. As an example, the medical record for St John's on 13 September 2004 indicated that the Consultant Physician's view was that Miss A's condition was entering a terminal phase and that she probably had septicaemia. The medical record does not indicate any conversation to this effect with her family, although it noted the physician's view that Mrs C was aware how ill Miss A was. Mrs C told me that the family were aware Miss A was seriously ill, but had not realised she had developed septicaemia and were not aware of how close she was to dying.

65. I have not found any instance where there was a deliberate failure to communicate with or support Miss A's family or any lack of willingness on the part of staff to engage with the family. I conclude that once again it was the complexity of the care pathway that prevented there being a clear and known communication point for the family which left them feeling unsupported and confused about where to turn to for help or information. I uphold this aspect of the complaint.

66. In light of this conclusion the Ombudsman recommends that when addressing the recommendations of paragraphs 30 and 31, the Board consider how the needs of relatives and carers of patients might best be addressed within any new provision and that thought be given to the particular problems that present when a patient is cared for outside of Scotland or the health board area.

Summary conclusion

67. In bringing her complaint to this office Mrs C told me that she hoped to prevent unnecessary suffering for other families affected by anorexia nervosa. My investigation has reached a number of conclusions but in essence repeats the views of Mrs C, borne out of her own experience, as stated in her original letter of complaint to this office:

> "Medical hospitals are ill equipped and ignorant of the disease [anorexia nervosa]. GPs should also be educated about this disease. I think there should be separate wards for these patients and more funding."

68. The lack of suitable facilities and the lack of knowledge amongst many (but certainly not all) health professionals was identified and acknowledged by those

responsible for Miss A's care and treatment and by the advisers. In adding the conclusions of this office to these already concurring views it is to be hoped that it will help to avoid unnecessary suffering for others (patients and families) affected by anorexia nervosa.

27 June 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Miss A	The aggrieved, Mrs C's daughter
ANITT	Anorexia Nervosa Intensive Treatment Team, part of the REH
Consultant Psychiatrist 1	The psychiatrist responsible for Miss A's care at the YPU
Consultant Psychiatrist 2	The psychiatrist responsible for Miss A's care at the REH
Independent Clinic 1	The Clinic where Miss A was an in-patient between 18 March 2003 and 13 October 2003
Independent Clinic 2	The Clinic where Miss A was an in-patient between 13 October 2003 and 29 October 2003
Independent Clinic 3	The Clinic where Miss A was an in-patient between 19 July 2004 and her death in September 2004
NHS Hospital 1	The hospital in England Miss A was admitted to while an in-patient of Independent Clinic 1
NHS Hospital 2	The hospital in England Miss A was admitted to between 4 November 2003 and her voluntary discharge in June 2004

NHS QIS	NHS Quality Improvement Scotland
REH	The Royal Edinburgh Hospital
RIE	The Royal Infirmary of Edinburgh
SEHD	The Scottish Executive Health Department
St John's	St John's Hospital at Howden
The Board	Lothian NHS Board
YPU	The Young Persons Unit at the Royal Edinburgh Hospital

Annex 2

Glossary of terms

Anorexia Nervosa (Anorexia)	See Annex 3
IV rehydration	Fluids inserted through an intravenous drip
NG (tube) Feeding	Liquid nutrition through a tube inserted through the nose and into the stomach
PEG feeding	Liquid nutrition through a tube inserted directly into the stomach
OCD	Obsessive Compulsive Disorder

Annex 3

WHAT IS ANOREXIA NERVOSA?

An explanation provided by the Ombudsman's medical adviser.

In Anorexia Nervosa there is a morbid, overwhelming fear of normal weight and weight gain. This is usually accompanied by a gross disorder of perception as a result of which the sufferer is deluded about their own body image which they perceive as obese, no matter how thin in reality. This results in self-starvation and avoidance of high calorie foods in particular. There is an intense preoccupation with a need to avoid 'fatness' and to be thin. Sufferers do not regard themselves as ill and will commonly resort to subterfuge (vomiting, purgation, excessive exercise) to lose weight and disguise weight loss (loose, baggy clothes).

In its milder forms the condition is common (approximately 2% of high achieving females). The condition commonly occurs around puberty and mainly affects females (the female to male ratio is approximately 10:1) but the incidence and spectrum appears to be increasing.

In its severe forms, the condition is not within the control of the sufferer who is not in touch with reality in the specific issues of their own body size and the consequences of self starvation, that is, they don't usually think they will die. Attempts to make the sufferer put on weight can cause extreme distress and psychological pain that in some cases can precipitate suicide.

The name of the condition is unfortunate (anorexia = loss of appetite, nervosa = of a nervous cause) because appetite (the desire to eat) is often retained, indeed increased, even in starvation but severely restrained by the fears of the sufferer. In the severe forms, the condition has one of the highest mortality rates in psychiatric practice, >10%.

Anorexia Nervosa should be distinguished from the different condition of Bulimia Nervosa with which only some features are shared.

Annex 4

Chronology of Events

November 1998	Attends YPU as an out-patient (aged 14)
April 1999	Admitted to REH for 5 days
April 1999 – September 2000	Attends the YPU Day Programme
16 September 2000 – 14 March 2001	Admitted to YPU
20 April 2001	Attends the YPU Day Programme
14 May 2001	Admitted to YPU
YPU	
5 June 2001	Admitted to the Royal Infirmary of Edinburgh for refeeding (discharged to the YPU the same day without treatment)
3 July 2001	Admitted to the Royal Infirmary of Edinburgh for refeeding
5 July 2001	Discharged to the YPU
6 July 2001	Admitted to the Royal Hospital for Sick Children Edinburgh for refeeding
18 July 2001	Discharged to the YPU
21 July 2001	Admitted as out-patient to the Royal Hospital for Sick Children, Edinburgh for checking/resiting of naso-gastric tube. Discharged to the YPU
28 July 2001	Admitted as outpatient to the Royal Hospital for Sick Children, Edinburgh for checking/resiting of naso-gastric tube. Discharged to the YPU
21 May 2002	Admitted to Royal Infirmary of Edinburgh following overdose
23 May 2002	Discharged to the YPU
3 September 2002	Referral to adult services but remains in YPU
21 January 2003	Absconded from YPU
23 January 2003	Returned to YPU involuntarily
28 January 2003	Admitted to the Royal Infirmary of Edinburgh for IV rehydration and refeeding

3 February 2003	Discharged to the YPU without agreement of YPU
6 February 2003	Admitted to St John's for IV rehydration
17 February 2003	Discharged back to The Royal Edinburgh Hospital
1 March 2003	Admitted to St John's for IV rehydration
9 March 2003	Discharged back to The Royal Edinburgh Hospital
18 March 2003	Transfer from The Royal Edinburgh Hospital to Independent Clinic 1
Independent Clinic 1	
13 October 2003	Transfer from Independent Clinic 1 to Independent Clinic 2 in Glasgow
29 October 2003	Transfer from Independent Clinic 2 to The Royal Edinburgh Hospital
4 November 2003	Transfer to NHS Hospital 2
NHS Hospital 2	Does well but frequently absconds and expresses a wish to go home
28 April 2004	Meeting with psychologist and Consultant Psychiatrist 2 to prepare for discharge back to ANITT team
7 June 2004	Detention under Mental Health legislation lapsed
12 June 2004	Pass home - Miss A later refused to return
15 June 2004	Home visit by psychologist from ANITT
22 June 2004	Home visit by psychologist from ANITT
23 June 2004	ANITT case discussion and care plan initiated
25 June 2004	Support visit from ANITT staff at home
29 June 2004	Seen by psychologist as part of ANITT team
6 July 2004	Medical review
13 July 2004	Refusal to attend medical appointment and continued refusal to eat
15 July 2004	Review at home by Consultant Psychiatrist 2
19 July 2004	Involuntarily detained under mental health legislation – admitted to Independent Clinic 3
Independent Clinic 3	
25 July 2004	Admitted to St John's for IV rehydration
26 July 2004	Discharged to Independent Clinic 3
28 July 2004	Admitted to St John’s for IV rehydration
29 July 2004	Discharged to Independent Clinic 3

29 July 2004	Readmitted to St John's
4 August 2004	Discharged to Independent Clinic 3
6 August 2004	Readmitted to St John's
8 August 2004	Discharged to Independent Clinic 3
10 August 2004	Readmitted to St John's
11 August 2004	Discharged to Independent Clinic 3
11 August 2004	Readmitted to St John's
11 August 2004	Discharged to Independent Clinic 3
2 September 2004	Readmitted to St John's
2 September 2004	Discharged back to Independent Clinic 3
3 September 2004	Readmitted for IV rehydration and NG feeding
15 September 2004	Died from anorexia nervosa and pneumonococcal septicaemia

Annex 5

Information provided by the Scottish Executive Health Department on eating disorder related initiatives.

Regional Planning

This important agenda continues to be advanced, with greater attention to the organisation of services by NHS Board Regional Planning Groups. Each are progressing a range of initiatives including developing local Managed Care/ Clinical Networks and Integrated Care Pathways for better supported and coordinated patient journeys and family involvement. The following summarises work underway or planned in each area.

North of Scotland

In 2005 funding was committed by Grampian, Highland and Tayside NHS Boards to develop a Managed Care Network for those aged 18+ with an eating disorder. A Lead Clinician was appointed in November last year, other key appointments have followed and a Steering Group was formed.

Efforts have been made to ensure appropriate representation from all geographical areas, from users and carers and from primary care and a draft MCN Project Plan has been discussed and is under revision.

NHS Tayside is currently involved with colleagues from the South East regional group in drafting a Service Level Agreement with the private sector. This will be reviewed by the North of Scotland MCN to see if a recommendation, at least in the short term, should be made to adopt a similar approach for the North. A review of all options for intensive treatment is also underway with an aim of developing the most cost effective service as possible, provided as close to home as possible for North of Scotland patients.

Activity information on inpatient usage and cost is being collected and collated.

The Lead Clinician and colleagues are also involved in consideration of inpatient

provision for patients under 18.

A Website is currently under construction to provide information for professionals, patients and carers, members of the MCN and the public. An electronic Guideline is also being developed for use by GP's. (Initially this is for NHS Grampian but the intention is for it to be suitable for all areas).

In terms of current services within the area, Grampian has a long established multidisciplinary out patient service. Highland has a specialist service with input from a psychiatrist, dietician, and nurse therapists and Tayside is currently drafting plans for a Tayside specialist out patient service for eating disorders.

Other initiatives include a conference in Aberdeen planned for this November titled "Eating Disorders for Non-Specialists" aimed at primary care and generic mental health workers. Grampian have started running a week long "taster" secondment in eating disorders for psychiatric nurses and is an early adopter site for the computerised Generic Clinical System.

The lead clinicians and colleagues are involved in the Royal College of Psychiatrists survey on Eating Disorder Service Provision across the UK and North of Scotland clinicians remain involved in the Quality Improvement Scotland review of the NICE guidelines on eating disorders (see further below).

South and East Scotland (SEAT)

There has been significant progress with plans to develop a SEAT-wide Tiered Service for People with Eating Disorders to work across the region with a wide range of teams and partners on all tiers of provision.

The SEAT Eating Disorders Planning Group has agreed to adopt the Framework for Mental Health Services guidance on Eating Disorders based on a tiered model underpinned by the development of integrated care pathways. A proposal outlining how Tier 4 intensive support services could be delivered is being discussed this month by the Regional Planning Directors Components include:

Following a pilot project in 2003/04 NHS Lothian developed in early 2005 an

innovative service – Anorexia Nervosa Intensive Treatment Team (ANITT) - to meet the needs of a small group of people with severe or chronic Anorexia Nervosa who require more intensive therapy, physical monitoring and support.

ANITT was set up on the premise that intensive therapy traditionally delivered in an inpatient setting may often be best delivered in the community by a dedicated multi-disciplinary team. This service is not intended to replace inpatient admissions altogether, but aims to reduce the number and duration of inpatient admissions by providing fuller outpatient support as well as more intensive aftercare support in a community setting, thus reducing the speed and frequency of relapse.

A similar model has recently been agreed (and funding secured for Fife), and Tayside are now seeking to secure funding for a similar team in the near future.

A Regional Consultant post is being established, the main responsibilities of which will include:

- safe and appropriate treatment of those patients with severe Eating Disorders, particularly severe Anorexia Nervosa;
- acting as a gateway into inpatient services;
- being available for advice or specialist consultation for patients;
- establishing a Managed Clinical Network;
- developing Integrated Care Pathways for Eating Disorders, in line with the current NICE guidelines and forthcoming NHS QIS guidelines;
- developing close links with Adolescent Services, to ensure smooth transition of patients in the 16 – 18 age range;
- linking with Regional Consultants in the West and the North of Scotland, as part of a National Clinical Network; and
- establishing close ties with the voluntary and self-help organisations.

The Regional Consultant will be supported by a range of professionals with a specialist interest, experience and practice in the care and treatment of people with eating disorders. This will include Clinical Psychology, Dietetics, Nursing and Psychiatry.

Feedback from patients and their carers has indicated the very practical support they received from psychology assistants to be an important part of their therapeutic care plan. Building on this, Lothian ANITT is keen to pilot the use of Peer Support Workers for this client group. Employing a recovery ethos and maximising an individual's own capacity the Peer Support Worker would lend their own lived experience to their work with the client. They would also have a key role to play in developing and maintaining appropriate support for carers and families.

To further promote and develop good practice, the Network will establish regular supervision and training sessions for clinicians working with people with eating disorders and develop and maintain learning materials for use by staff working at tier 1 and 2 as well as more specialist resources for tier 3 and 4 practitioners. The network will also develop a Partnership Agreement between SEAT partners and private sector inpatient units.

While developing Tier 4 services will impact positively on the number of inpatient admissions and length of stay there will continue to be a need to admit to the private sector. To ensure consistency of approach and adherence to the principle and standards that SEAT Board areas are working to independent providers will be asked to sign a formal partnership agreement. This will ensure a consistency of approach on care and treatment in both community and inpatient settings.

West of Scotland

The West of Scotland has agreed to establish a formal planning group for which will be accountable to the full West of Scotland planning group with clear authority and accountability.

A key task is to supervise the implementation of QIS/NICE guidelines across the region. The Group has also been tasked to:-

- identify the core service building blocks required at regional and local level to deliver the guidelines across adult and adolescent services;
- coordinate the input from local NHS Board implementation plans;
- consider implications for the commissioning of inpatient and "shared care" services;

- assess, cost and prioritise regional implementation plans to deliver the guidelines;
- specify, commission and contract for regional inpatient activity as part of a continuum of service responses within an integrated care pathway across inpatient and community services; including where necessary advising constituent NHS Boards on service and other contributions to be made for equity of access and care; and to
- ensure regional contracts allow for variable specialist support from regional services to local services, recognising different pace of development of local service building blocks and local critical mass.

In fulfilling its remit the Group is also accountable to the existing West of Scotland Paediatric Regional Planning Group for the adolescent elements of the proposals, to ensure coherence within the framework of CAMHs responsibilities of that group, and the interface with West of Scotland adolescent inpatient commissioning.

The newly combined Glasgow and Clyde NHS Board have developed a Managed Clinical Network for eating disorders covering adult and adolescent services. The service development is funded for implementation this year.

This Managed Clinical Network will link and ultimately integrate with the West of Scotland Regional service. The adult service is in line with the tiered model proposed within the published NICE guidelines and the Framework for Mental Health Services for Scotland on eating disorders.

Tier one is delivered through the Primary Care Mental Health Teams and Women's Centre for Health. Tier 2 is delivered through the CMHT's with new funding to support link staff. Tier 3 will be delivered through the new specialist team linking to tier 2 and tier 4 with funded liaison staff. Tier 4 inpatients will be provided through the independent sector (Priory). A nurse consultant and senior psychologist will coordinate the Network and sessional medical input has been agreed.

The adolescent community service will collocate with the adult service and link to mainstream CAMHs services and the regional adolescent unit. It is envisaged these services will create a synergy through collocation, joint training etc.

NHS Education for Scotland, (NES)

NES is now actively engaged with Higher Education providers of health and social care education, around the development of a specific educational resource for use in undergraduate programmes, to ensure that contemporary material on mental health themes, including Eating Disorders, is available for inclusion in all undergraduate and pre registration programmes. This work has just commenced.

NHS Quality Improvement Scotland

NHS QIS has recently completed their review of the National Institute of Clinical Excellence, (NICE) guideline on eating disorders to determine their relevance and application for Scotland. NHS QIS has also considered those aspects not covered within the NICE consideration that could benefit the Scottish position. As you may know (NICE clinical guidelines are mandatory for England and Wales but are advisory for Scotland).

Overall, NHS QIS has determined that the NICE guidelines are largely relevant for Scotland, (as you would expect). However, the different legal framework in Scotland and differences in the way services are provided mean some recommendations need adjusted for application here. NHS QIS also see merit in placing an emphasis on some aspects not captured in the NICE guideline, for example: the role of dietetics; individual care planning; choice of treatments; and the role of the multi-disciplinary team. There is also the issue of chronic care, an aspect that fell out with the scope of the NICE guideline.

NHS QIS are now working on a report to set clear recommendations for Scotland on the management of eating disorders, priorities for implementation and consideration of resource implications. NHS QIS expect to publish the report this summer, following consultation.