NHS eating disorder services

House of Lords, 29 June 2023

Key points

In 2017, PHSO published *Ignoring the Alarms*, a landmark report which outlined recommendations to increase awareness of eating disorders among clinicians and improve quality of care.

Almost six years on, little progress has been made. Children and young adults with eating disorders are still experiencing avoidable harm. The COVID-19 pandemic and associated lockdowns resulted in an increase in eating disorders. This, combined with the additional pressure on the NHS means that mental health services continue to struggle with demand. It is more important than ever that lessons are learnt to improve eating disorder services.

There needs to be a cultural shift in the NHS and across government to ensure people are listened to, services are joined up and care plans are properly constructed. Clinicians need better support to protect patients; there must be an increase in the overall number of doctors to manage these services and training in eating disorders must be improved to avoid missed opportunities for patients and their families. The Government should treat this as a priority.

On 29 June, PHSO will lay a new report before Parliament: *Broken trust: Making patient safety more than just a promise*. This reviews 400 serious health complaints from the past three years, including 22 avoidable deaths. The report focusses on the need for accountability and patient safety being a top Government and NHS priority. Although the report is not specific to eating disorders these themes are crucial to reducing the risks faced by people with eating disorders.

PHSO and the role of the Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) was set up by Parliament to provide an independent and impartial service to handle complaints about the NHS in England, UK Government Departments, and other UK public organisations. PHSO is the final stage for complaints that have not been resolved through organisations' own complaints processes. As well as providing outcomes to complainants, PHSO makes recommendations and shares learning more widely to encourage improvement in the quality and safety of NHS services. PHSO's casework also helps Parliament scrutinise the NHS in England.

Ignoring the Alarms: How NHS eating disorder services are failing patients

In 2017, PHSO produced a report centring on the experience of Averil Hart and her family.[1] Averil, who had a history of anorexia nervosa, was 19 years old when she died in 2012 due to the failures of the four NHS organisations that should have cared for her. We found

[1] Ignoring the alarms: How NHS eating disorder services are failing patients (ombudsman.org.uk)(2017)

Averil's death was avoidable and that there were multiple missed opportunities in the months before she died. The report also highlighted two further case studies, both involving young women with eating disorders who were failed in their care and subsequently died. It was identified that if crucial opportunities had not been missed, both women would have likely survived.

The key contributory factors identified included a general lack of awareness about eating disorders among clinicians, a lack of eating disorder specialists, poor transition between child and adolescent to adult services and poor co-ordination between different services. As a result of these findings, PHSO made some wider recommendations to promote learning and avoid these tragic outcomes from happening again.

Recommendations made by PHSO in 2017

1. There should be a review of training for all junior doctors on eating disorders, informed by research being conducted by the Faculty of Eating Disorders at the Royal College of Psychiatrists.
2. The Department of Health and NHS England (NHSE) should review the existing quality and availability of adult eating disorder services to achieve parity with child and adolescent services.
3. The National Institute for Clinical Excellence (NICE) should consider including coordination as an element of their new Quality Standard for eating disorders.
4. Health Education England should review how its current education and training can address the gaps in provision of eating disorder specialists we have identified. If necessary, it should consider how the existing workforce can be further trained and used more innovatively to improve capacity. Health Education England should also look at how future workforce planning might support the increased provision of specialists in this field.
5. NHSE has a leadership role to play in supporting local NHS providers and CCGs to conduct and learn from serious incident investigations, including those that are complex and cross organisational boundaries.
6. NHSE should use the 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 like the Hart's, where local bodies are failing to work together to establish what has happened and why, so that lessons can be learnt.

Progress since 2017

In 2019 the Public Administration and Constitutional Affairs Committee found insufficient action had been taken under all the recommendations.[2] However, there has been some progress. NHS England updated its guidance on adult eating disorders for commissioners and in 2020 it announced it would scale up early intervention services to support young people in the early stages of eating disorders. Reviews have been carried out of the available curricula, with work also done to scope eating disorder training of the national workforce.

[2] PHSO report: Ignoring the alarms: How NHS eating disorders services are failing patients (parliament.uk) (2019)

Since 2019/20 PHSO has upheld 12 cases relating to eating disorders. We continue to see similar mistakes.

In October 2022, PHSO upheld a case relating to a 35-year-old woman who believed her food was being tampered with and refused to eat.[3] She was admitted to hospital and in the first three weeks of being cared for, her weight dropped significantly. She suffered multiple organ failure and her cause of death was recorded as severe malnutrition and delusional disorder. PHSO found a series of significant failings by the Trusts involved in her care, including a failure to monitor food and drink intake and not transferring her to an acute hospital for nasogastric feeding (liquid food given directly into the stomach via a tube) quickly enough. PHSO concluded that had things been done differently, she may have survived.

Action needed

- The Government needs to fulfil its promise to treat eating disorders as a key priority so there is meaningful change in this area and patients receive the quality of care they deserve.
- More work needs to be done to improve the training available for clinicians which is fundamental to improving awareness of eating disorders in the NHS.
- Leaders at all levels of the NHS must embed a culture of learning from mistakes, taking accountability for using that learning to improve care for patients and their families, and responding to mistakes with compassion.

[3] Urgent action needed to prevent eating disorder deaths | Parliamentary and Health Service Ombudsman (PHSO) (2023)