

Report by the Public Services Ombudsman for Wales and the Health Service Ombudsman for England

of an investigation of a complaint about the Welsh
Assembly Government (Health Commission Wales),
Cardiff and Vale NHS Trust and Plymouth Teaching
Primary Care Trust

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Third Report

Session 2008-2009

Presented to Parliament pursuant to
Section 14(4) of the Health Service Commissioners Act 1993

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Foreword

I am laying before Parliament, under section 14 (4) of the Health Service Commissioners Act 1993 (as amended), this joint report of the investigation into a complaint made to the Public Services Ombudsman for Wales and the Health Service Ombudsman for England about the Welsh Assembly Government (Health Commission Wales), Cardiff and Vale NHS Trust and Plymouth Teaching Primary Care Trust.

The complaint was made by Mrs S¹ on behalf of her adult daughter, Miss S. Mrs S's complaint is that the NHS should have funded Miss S's care when Miss S, who lived in Wales, became ill whilst staying with a friend in England. Mrs S complained that she and her daughter had been forced to fund Miss S's care privately as Miss S's condition was serious and deteriorating and it appeared that the question of which NHS body was responsible for funding was unlikely to be resolved quickly. Our investigation found maladministration and service failure by Health Commission Wales, Cardiff and Vale NHS Trust and Plymouth Teaching Primary Care Trust which resulted in unremedied injustice and hardship for Mrs S and Miss S. The report details the remedy we have recommended to the Welsh Assembly Government, Health Commission Wales, Cardiff and Vale NHS Trust and Plymouth Teaching Primary Care Trust.

Our statutory powers have enabled us to investigate and report jointly, to consider maladministration and service failure, and any resulting injustice and hardship, in the round. We have been able to recommend remedy in the round. This report demonstrates how Ombudsmen working together can provide an independent, high quality and accessible complaints system when the complaint concerns the actions of a number of public bodies in more than one country. It also demonstrates how Ombudsmen's investigations can right individual wrongs and drive improvements in public services.



Ann Abraham
Parliamentary and Health Service Ombudsman

7 July 2009

¹ To protect the privacy of those involved, details that might identify individuals have been omitted so far as that can be done without impairing the effectiveness of the report.

Introduction

This report has been prepared under the *Public Services Ombudsman (Wales) Act 2005* and the *Health Service Commissioners Act 1993*, as amended.

Mrs S's complaint concerns events that span the jurisdictions of the Public Services Ombudsman for Wales and the Health Service Ombudsman for England. Using provisions in their respective statutes, both Ombudsmen have agreed that a joint investigation leading to the production of joint conclusions and proposed remedy in one report seemed the most appropriate. Mrs S has agreed to this approach. Under paragraph 12 of Schedule 1 to the *Health Service Commissioners Act 1993*, the Health Service Ombudsman for England gave authority for the relevant staff of the Office of the Public Services Ombudsman for Wales to carry out some of her functions in respect of the investigation.

The report is published by the Public Services Ombudsman for Wales under section 25 of the *Public Services Ombudsman (Wales) Act 2005*.

The report is preceded by a summary.

Summary

Mrs S's adult daughter, Miss S, lived in south Wales. However, while staying with a friend in the south west of England, she became depressed and developed anorexia nervosa. She came under the care of Plymouth Teaching Primary Care Trust (the PCT), initially as an out-patient and then, from October 2006, as an in-patient. In October 2006 the PCT approached a consultant psychiatrist in Miss S's home area (the Welsh Consultant) employed by Cardiff and Vale NHS Trust (the Trust) to ask him to take over her care. He declined. Miss S's condition deteriorated further and she was referred to the local specialist NHS eating disorders unit (the EDU). The referral was accepted, subject to funding, and an application was made to Health Commission Wales (HCW) for this. HCW refused to fund the admission, principally on the grounds that Miss S had never been assessed by the services in Wales, and because no follow-up plan had been put in place for when she was discharged. Mrs S then elected to have Miss S admitted to a private eating disorders centre, where she, together with her daughter, funded Miss S's care.

Mrs S complained to us on behalf of Miss S that the NHS should have funded Miss S's care. She complained that the family had been forced to take action as Miss S's condition was serious and deteriorating, and because it appeared that the question of which NHS body was responsible for funding was unlikely to be resolved quickly. She commented that it was out of the question for Miss S to have travelled to Wales for assessment, given her poor condition. Mrs S said that because of all this, she and her daughter were forced to use their life savings to pay for private treatment.

The Ombudsmen found maladministration or service failure in the following respects:

- HCW adopted an excessively inflexible approach to the request to fund Miss S's in-patient care. In particular, HCW:
 - failed to take into consideration all relevant factors (including that Miss S was not at home when she became ill and her only sources of social support were outside Wales);
 - failed to take into consideration the valid opinion of an English Consultant when it was reasonable to do so;
 - insisted that a detailed discharge or follow-up plan was in place when it was not reasonable in the particular circumstances to do so; and
 - failed to communicate adequately its conditions for funding.
- The Trust unreasonably refused the request to take over Miss S's care in October 2006.
- The PCT failed to provide short-term funding for Miss S's treatment and thereby placed her at clinical risk.

The Ombudsmen concluded that the maladministration and service failure identified above caused Miss S and her mother injustice and hardship: they were clearly caused significant distress by the failure to resolve the funding issues appropriately and expeditiously as Miss S's condition deteriorated rapidly, and they each spent considerable sums of money paying privately for treatment which the NHS should have funded.

The Ombudsmen recommended that HCW reimburse Mrs S and Miss S the money they had paid (approximately £31,000) for Miss S's care, together with the interest they would have received had it remained in their accounts. They also recommended that all three bodies pay Miss S and Mrs S £250 each to recognise the distress they had been caused. The Ombudsmen also made a number of procedural recommendations which were addressed to HCW.

This investigation also identified a number of general concerns about the adequacy of provision for patients with eating disorders in the Cardiff and Vale area, and in Wales in general. The Ombudsmen therefore recommended that the Trust carry out an urgent review of the provision for eating disorder patients in its area, in conjunction with the relevant local health boards. The Public Services Ombudsman for Wales also recommended that the Welsh Assembly Government gives consideration to carrying out a Wales-wide review of the adequacy of provision for the treatment of eating disorders in Wales, both from an out-patient and in-patient point of view.

HCW, the Trust, the PCT and the Welsh Assembly Government have agreed to accept the Ombudsmen's recommendations.

Report of an investigation of a complaint about the Welsh Assembly Government (Health Commission Wales), Cardiff and Vale NHS Trust and Plymouth Teaching Primary Care Trust

The complaint

- 1 Mrs S's adult daughter, Miss S, lived in south Wales. However, while staying with a friend in the south west of England, she became depressed and developed anorexia nervosa. She came under the care of Plymouth Teaching Primary Care Trust (the PCT), initially as an out-patient and then, from October 2006, as an in-patient. In October 2006 the PCT approached a consultant psychiatrist in Miss S's home area (the Welsh Consultant) employed by Cardiff and Vale NHS Trust (the Trust) to ask him to take over her care. He declined. Miss S's condition deteriorated further and she was referred to the local specialist NHS eating disorders unit (the EDU). The referral was accepted, subject to funding, and an application was made to Health Commission Wales (HCW) for this. HCW refused to fund the admission, principally on the grounds that Miss S had never been assessed by the services in Wales, and because no follow-up plan had been put in place for when she was discharged. Mrs S then elected to have Miss S admitted to a private eating disorders centre, where she, together with her daughter, funded Miss S's care.
- 2 Mrs S complained to us on behalf of Miss S that the NHS should have funded Miss S's care. She complained that the family had been forced to take action as Miss S's condition was serious and deteriorating, and because it appeared that the question of which NHS body was responsible for funding was unlikely to be resolved quickly. She commented that it was out of the question for Miss S to have travelled to Wales for assessment, given her poor condition. Mrs S said that because of all this, she and her daughter were forced to use their life savings to pay for private treatment.

The Ombudsmen's remit, jurisdiction and powers

- 3 The *Public Services Ombudsman (Wales) Act 2005* came into effect on 1 April 2006. One of the roles of the Public Services Ombudsman for Wales is to investigate complaints against the NHS in Wales. Under the terms of the *Public Services Ombudsman (Wales) Act 2005*, the Public Services Ombudsman for Wales may investigate matters related to alleged maladministration, failure in a relevant service provided by an authority, or alleged failure to provide a service.
- 4 Section 25 of the *Public Services Ombudsman (Wales) Act 2005* allows the Public Services Ombudsman for Wales to carry out joint investigations with certain other Ombudsmen (including the Health Service Ombudsman for England).
- 5 By virtue of the *Health Service Commissioners Act 1993*, the Health Service Ombudsman for England is empowered to investigate complaints against the NHS in England. She may investigate complaints of maladministration or of failure in, or to provide, a service, against NHS bodies, and others such as family health service providers and independent individuals or bodies providing a service on behalf of the NHS.
- 6 Section 17 of the *Health Service Commissioners Act 1993* allows the Health Service Ombudsman for England to consult with other Ombudsmen (including the Public Services Ombudsman for Wales) about the investigation of a complaint, where relevant, and under paragraph 12 of Schedule 1 to that Act she may delegate any of her functions to the staff of the Public Services Ombudsman for Wales.

Our investigation

- 7 The Health Service Ombudsman for England gave authority for an investigator from the Office of the Public Services Ombudsman for Wales to carry out her investigative functions.
- 8 The investigator obtained comments and copies of relevant documents from the three organisations complained about, and these have been considered in conjunction with the evidence supplied by Mrs S. Miss S provided a written statement. The investigator also obtained clinical advice from a professional adviser – an experienced consultant psychiatrist (the Adviser).
- 9 Mrs S and the three bodies complained about were given the opportunity to comment on a draft of this report before the final version was issued.
- 10 We have not included every detail of the investigation in this report, but we are satisfied that no matters of significance have been overlooked.

The basis for our determination of the complaint

- 11 We have assessed the actions of the PCT, the Trust and HCW against an overall standard with two components: the general standard, which is derived from general principles of good administration and, where applicable, of public law; and the specific standards, which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

- 12 Having established the overall standard, we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the body or individual complained about constitutes a departure from the applicable standard.
- 13 If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.
- 14 The overall standard that we have applied to this investigation is set out below.

The general standard

Principles of Good Administration

- 15 Since it was established, the Office of the Health Service Ombudsman for England (and previously for England and Wales) has developed and applied certain general principles of good administration in determining complaints of service failure and maladministration. In March 2007 the Health Service Ombudsman for England published these established principles in codified form, after consultation with others, including the Public Sector Ombudsmen in the United Kingdom, in a document entitled *Principles of Good Administration*.² This document was adopted and published by the Public Services Ombudsman for Wales in March 2008 as being appropriate guidance for Welsh public bodies in good administrative practice.

² *Principles of Good Administration* is available at www.ombudsman.org.uk or www.ombudsman-wales.org.uk

16 The document organises the established principles of good administration into six Principles. These Principles are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right, and
- Seeking continuous improvement.

17 We have taken the *Principles of Good Administration* into account in our consideration of Mrs S's complaint.

Principles for Remedy

18 In October 2007, after further consultation with other Public Sector Ombudsmen in the UK, the Health Service Ombudsman for England published a document entitled *Principles for Remedy*.³ This document sets out the Principles that should guide how public bodies provide remedies for injustice or hardship resulting from their service failure or maladministration. It sets out how public bodies should put things right when they have gone wrong, and confirms her own approach to recommending remedies. The *Principles for Remedy* flow from, and should be read with, the *Principles of Good Administration*. Providing fair and proportionate remedies is an integral part of good administration and good service, so the

same Principles apply. These Principles were also adopted and published by the Public Services Ombudsman for Wales as guidance to Welsh public bodies in March 2008.

19 We have taken the *Principles for Remedy* into account in our consideration of Mrs S's complaint.

The specific standards

20 The *National Health Service Act 1977* made it a duty for the NHS to promote services to improve health. For Wales, this Act, as amended,⁴ placed a duty on the National Assembly for Wales (since 1 March 2007 the duty is on the Welsh Ministers) to provide, to reasonable requirements, services for the diagnosis and treatment of illnesses (in England, the duties under the Act are on the Secretary of State). In Wales, the decisions about whether or not to fund certain specialist treatments (including the in-patient care of patients suffering from eating disorders) are made by HCW, which is an executive agency of the Welsh Assembly Government. In England, most such decisions about individual patients are made by primary care trusts (PCTs).

21 In 1999 the English Department of Health and the then Welsh Office published a *Code of Practice* (the Code) on the application of the *Mental Health Act 1983*.⁵ Chapter 27 of the Code deals with arrangements for aftercare.

³ *Principles for Remedy* is available at www.ombudsman.org.uk or www.ombudsman-wales.org.uk

⁴ Now superseded by the *National Health Service (Wales) Act 2006*, which came into force on 1 March 2007; however, the provisions referred to here remain essentially the same.

⁵ *Code of Practice, Mental Health Act 1983*, Department of Health and Welsh Office, March 1999.

This includes:

'27.1 While the [Mental Health] Act defines after-care requirements in very broad terms, it is clear that a central purpose of all treatment and care is to equip patients to cope with life outside hospital and function there successfully ... the planning of this needs to start when the patient is admitted to hospital ...

'27.10 Those concerned must consider the following issues:

a) the patient's own wishes and needs, ... ;

b) the views of any relevant relative, friend or supporter of the patient;

c) the need for agreement with authorities and agencies in the area where the patient is to live;

d) ... ;

e) ... ;

f) the establishing of a care plan, based on proper assessment and clearly identified needs ...'

(Note: as Miss S was not detained under the *Mental Health Act 1983*, the provisions of the Code do not, strictly speaking, apply; however, it is quoted here to illustrate good practice for all in-patients, whether detained or not.)

22 The National Institute for Health and Clinical Excellence (NICE) has produced guidance on the treatment of eating disorders.⁶ This includes:

'1.2.5.1 Most people with anorexia nervosa should be treated on an outpatient basis.

...

'1.2.5.3 Inpatient treatment should be considered for people with anorexia nervosa whose disorder is associated with high or moderate physical risk.

'1.2.5.4 Where inpatient treatment is required ... this should be provided within reasonable travelling distance to enable the involvement of relatives and carers in treatment, ...

'1.2.5.5 People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring ... in combination with psychosocial interventions.'

23 In 2006 HCW produced a draft commissioning policy for patients with eating disorders who fall within its remit.⁷ This includes:

'Health Commission Wales have responsibility for Tertiary Eating Disorder Services; this includes Specialist Inpatient and Daypatient Services.

'The priority will be to manage clients in the community, and admission will be the last resort ...

⁶ *Eating Disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*, NICE Clinical Guideline 9, January 2004.

⁷ *Tertiary Eating Disorders Commissioning Policy*, Health Commission Wales, August 2006.

'The patient must have been seen and assessed by the local [Community Mental Health Team] ...

'Referral for inpatient treatment should be considered for those patients where:

- the primary diagnosis is that of an eating disorder*
- outpatient treatment has been exhausted and is recognised as failing to bring about recovery*
- Body Mass Index is 15-13⁸ and weight loss has been rapid, such that there are concerns about the patient's physical and/or mental health (must be evidenced)*
- as an emergency refeeding presentation BMI should be 13 or below*
- ...'*

Events leading to the complaint

²⁴ Miss S works for the Trust and lived in its area. In September 2006 she took some time off and went to stay with a friend in the south west of England. She attended an out-patients clinic on 28 September 2006, was diagnosed with depression, and was prescribed an antidepressant. She received out-patient care and was subsequently admitted informally to a general psychiatric ward, managed by the PCT, on 27 October 2006 due to increasing concerns about her low mood and the small amount she was eating and drinking.

²⁵ On 31 October 2006 the PCT's notes include an entry stating that a staff grade doctor on the psychiatric team (the Staff Grade doctor) had telephoned the Trust and spoken to the Welsh Consultant. The note of the conversation in the PCT's records includes:

'Phone call made to [the Welsh Consultant] who stated they would not take anyone with an eating disorder. Explained to [the Welsh Consultant] that this was secondary to her primary problem which was low mood and fleeting suicidal thoughts. [The Welsh Consultant] not very helpful and stated he would only speak to the consultant ... and not to the people below her.'

²⁶ Miss S's consultant psychiatrist at the PCT (the English Consultant) wrote to the Welsh Consultant on the same day asking him to 'arrange transfer of this lady's care to [the] Trust'. In her letter she explained that since her admission, Miss S was continuing to show symptoms of depression, and was only eating and drinking small amounts. She noted that Miss S's Body Mass Index (BMI) was 16.5. She concluded:

'[Miss S] presents with a moderate depressive illness and suicidal ideation. She is losing [sic] weight and at times has failed to drink adequately. ... She denies any body image distortion necessary for a diagnosis of anorexia but she certainly has been avoiding fattening foods and is maintaining a low BMI although she denies any self induced vomiting, urging, or excessive exercise.'

⁸ Normal range 20-25.

'[Miss S] would like to return to Wales where she is currently living. ... We do not feel that we would be able to discharge her ... to travel to Wales for purely out-patient treatment. Despite a lot of support here ... she required admission to hospital and if she were to return to her own accommodation she would be living on her own and we would have concerns as to her risk of self harm and neglect.

'Since admission to the ward, [Miss S] has eaten and drunk enough to maintain her weight at 47 kg and not to become dehydrated. ... Our hope is if her mood lifts in response to her increase of anti-depressant last week that things may improve enough for her to be maintained in the community rather than require admission to a specialist eating disorder unit.

'I understand that you have limited resources available for the treatment and supervision of patients with an eating disorder, but we feel that [Miss S] could be held within a PCLT [Primary Care Liaison Team – a non-specialist mental health team] setting. ... However we feel strongly that [Miss S's] care needs to be transferred back to Wales where she is resident and works.'

The Welsh Consultant decided not to accept the transfer request.

27 On 15 November 2006 Miss S was referred to the EDU for assessment. By this stage her BMI had fallen to 15.4. On 30 November 2006 the EDU wrote to the English Consultant's registrar to inform her that they would be prepared to admit Miss S subject to funding being secured.

The letter included:

'The [EDU's] clinical team consider [Miss S's] referral to a specialist eating disorders and inpatient service as appropriate and urgent given her rapid rate of weight loss and her current low BMI; plus her positive motivational state.'

- 28 On 1 December 2006 the English Consultant wrote to HCW's Case Administration Manager to request funding for Miss S's admission to the EDU. She explained that they were requesting funding from HCW as Miss S was resident in Wales and registered with a Welsh GP. Her letter noted that Miss S's main sources of social support were in the south west of England.
- 29 Following a telephone call from the Case Administration Manager, the English Consultant wrote to her again on 4 December 2006. She explained that they had approached the Welsh Consultant about transferring Miss S's care to him, but *'his view was that her needs would not be met in the acute inpatient unit in his area and he was therefore reluctant to transfer her'*. On 5 December 2006 the Case Administration Manager faxed over a clinical pro forma for the team to complete.
- 30 On 12 December 2006 the Case Administration Manager contacted the Staff Grade doctor to say that Miss S should be transferred to the Welsh Consultant's team. The Staff Grade doctor wrote to the Welsh Consultant the same day. He noted that the Welsh Consultant had previously felt unable to manage Miss S on an acute in-patient ward. He said that Miss S's depression had improved, but her weight had continued to reduce since her admission. He explained that he had spoken to the Case Administration Manager, and that she had told

him that HCW was not willing to fund Miss S's care until she had been transferred to the Welsh Consultant's team. The Staff Grade doctor said that if the Welsh Consultant felt unable to care for Miss S, he should explain this to the Case Administration Manager in writing.

- 31 The Welsh Consultant wrote to the Case Administration Manager on 14 December 2006. He explained that he had had no involvement in Miss S's care, as she had become ill whilst in south west England. He said that he had been asked to take on Miss S's care, but *'the transfer did not take place due to the deterioration in [Miss S's] health and the revision of her diagnosis to that of eating disorder'*. He went on:

'As you may know, I am a general psychiatrist who works in a very busy generic adult psychiatric service. I have no specialist expertise in the treatment of eating disorders and no access to any of the specialist resources and trained staff that can manage patients with serious eating disorder safely and effectively.'

'In common with [the English Consultant's] team, we feel that Miss [S]'s needs can no longer be met from within the generic adult psychiatric provision and that her current condition should be assessed and treated by a specialist eating disorder service. I believe that Miss [S] has already been referred and provisionally accepted for assessment by [the EDU] which is part of the NHS.'

'As we are unable to provide Miss [S] ... with the specialist care that she urgently needs, and as there is no specialist eating disorder service in Wales, I wish to recommend that funding is made available to allow Miss [S] ... to be transferred to the [EDU] for further assessment and treatment as soon as possible.'

- 32 On 19 December 2006 solicitors instructed by Miss S wrote to the Case Administration Manager threatening legal action if HCW did not agree funding for Miss S's treatment at the EDU. HCW's Chief Executive replied on 20 December 2006. His letter concluded:

'To place the patient in the [EDU] would not be in her best interests as she clearly wishes to return to Wales. Therefore [HCW] recommends that the patient is transferred to Wales in order for local services to remain engaged with the patient and for local services to be fully involved in the patient's care pathway. [HCW] cannot be expected to cover for deficits in local services.'

- 33 On 2 January 2007 the Case Administration Manager wrote to the Welsh Consultant to outline HCW's criteria for commissioning in-patient treatment for eating disorders. She explained that it was necessary for the patient first to be referred to, and receive treatment from, the local area consultant psychiatrist. She then listed fourteen specific criteria for funding to be agreed (reproduced as an Annex to this report).

- 34 The Welsh Consultant wrote to the Case Administration Manager on 3 January 2007. He said he understood that Miss S's condition had deteriorated further, and he did not feel there was any way forward, other than for Miss S to be admitted to a specialist eating disorder unit. The English Consultant also wrote the same day in support of the application for funding.

- 35 HCW's individual patient commissioning panel considered the funding request on 4 January 2007, and decided not to agree to it. A pro forma on HCW's file records the reasons for the decision as being: *'No formal connection to local services. No clear pathway identified with regards to future care and support'*.

- 36 The PCT was informed of the decision by telephone later that day. On 6 January 2007 Miss S was discharged to the private eating disorder centre, where she remained until February 2008.
- 37 On 11 January 2007 the Case Administration Manager wrote to the Welsh Consultant to tell him formally the panel's decision. She reiterated (almost verbatim) the paragraph quoted above from the letter to Miss S's solicitors (paragraph 32).
- 38 Mrs S subsequently submitted a number of complaints, both to the Welsh Minister for Health and Social Services and to the PCT. Mrs S was dissatisfied with the PCT's initial response to her complaint, so the PCT commissioned an independent investigation by the Medical Director and Assistant Director of Nursing of another Trust. They completed their report on 18 October 2007. It recommended (amongst other things not relevant to this investigation) that:

'Staff should inform senior managers through the normal line management system where a patient's care and welfare is being undermined by resource issues. Where these are not subsequently addressed and the patient's condition is continuing to deteriorate to a point where there are substantial risks to their welfare, the concerns should be brought to the attention of the chief executive. This would have enabled a discussion of how best the [PCT] should manage the immediate clinical governance issues with the funding authority and if necessary to consider whether a transfer to a specialist unit should be made and funded in the interim by the [PCT] whilst further negotiations occurred with [HCW].'

What the complainant had to say

- 39 Mrs S said that they had not been keen for Miss S to be transferred to the Welsh Consultant's team as they understood that she would have no treatment or support available there, other than on a general psychiatric ward, which had not been a successful approach in south west England. She noted that the Welsh Consultant had also advised against it as an '*unsafe transfer*'.
- 40 Mrs S said that they were told in December 2006 that Miss S's condition was becoming critical, and that her life was at risk. She said that HCW's decision in January 2007 not to provide funding left her with no choice but to arrange a private admission. Mrs S said that she needed to ensure her daughter's survival and could not wait while the various organisations argued over who would pay. She said that the English Consultant agreed with the course they chose to take, and said she was led to believe that NHS funding for the costs of the placement would – eventually – be established as their legal right.
- 41 Mrs S said that HCW's position seemed to suggest that funding would be refused if follow-up facilities were not in place. She wondered if this was a tenable position. Mrs S said that she had used around £20,000 of savings which she had built up for her retirement, and her daughter had used about £11,000 (which she had saved towards a house deposit) to pay for treatment at the private centre. Mrs S said that once their money ran out, the private centre agreed to provide the rest of Miss S's treatment at no cost to the family.
- 42 In a written statement, Miss S said that she was told that HCW had refused to fund her treatment as she was not in a Welsh hospital.

She said she could see no benefit in transferring to Wales as the only option given to her was to transfer to an acute psychiatric ward, which was inappropriate for her needs. Miss S said she was not coping on a similar ward in south west England, but at least there she had the support of her mother and friends, which would not have been available in Wales. Miss S said she had not refused the option of a short assessment in south Wales as this was never suggested to her. She noted that in any case, when the Welsh Consultant was approached about the possibility of her being transferred, he had refused on the grounds that it would be unsafe.

43 Miss S said she questioned why HCW felt unable to accept the recommendations of several consultant psychiatrists in England, one of whom was a specialist in eating disorders, and what the clinical benefit would have been to move her whilst in a very frail physical and emotional state. She noted that HCW had suggested that the Welsh Consultant could have travelled to south west England to assess her, but she was not sure what would be gained by that, given that she had already been assessed in detail by two consultants.

44 Miss S said she contested an assertion made by HCW that she was *'in a place of safety'* in the English hospital. She said that the ward staff were unable to offer adequate support, and she continued to lose weight. Miss S said that by the time of her discharge, her BMI had dropped further to 13.5, which is considered to be *'critically ill'*. She questioned therefore why HCW did not treat her case as an emergency.

45 Miss S noted that the main reasons given by HCW not to fund treatment at the EDU were that there had been a lack of input from the local (Welsh) services and, in particular, a lack of a care pathway and discharge planning.

Miss S said that it seemed sensible for there to be close liaison between specialist treatment centres and local services; however, she questioned whether this was essential before admission to the specialist centre. Miss S said this could have been sorted out after she was admitted, rather than trying to do so while her condition was rapidly deteriorating and she was in an inappropriate placement. While she noted that HCW had said that not having a clear treatment pathway could have led to a risk to her continuing health, she considered that her current state of health should have been a more important consideration than something that might happen in the future. Miss S said that, in fact, HCW's decision not to fund her treatment had now made discharge planning more complicated as she had been forced to give up her rented property to pay for her care. Thus, she was not sure where in the Cardiff and Vale of Glamorgan area she would be living on discharge, and consequently which GP or community mental health team she would come under. Miss S concluded:

'In summary, I was admitted to psychiatric care in October 2006, and by December my condition had worsened and I required intensive lifesaving treatment for anorexia in a specialist centre. Throughout December and January Mum and I were left in an unacceptable position in which I was refused funding by [HCW] because I was not in a Welsh hospital or under a Welsh consultant and [the Welsh Consultant] being unable to accept my transfer to Cardiff as he could not manage my care appropriately there. Hence, although I was reluctant to be transferred to Cardiff as it appeared to have no clinical benefit, this is almost an irrelevance as I was not offered a bed.'

'By January my health deteriorated to a critical condition, which was being made worse by the constant terror of what was going to happen to me. There appeared no way past the apparent impasse with [HCW's] apparent determination that I should be transferred against medical advice to Wales where there were no specialist services available and [the Welsh Consultant was] unwilling to accept the transfer. Mum made the only possible decision available to her and paid for me to transfer to the [private centre] for lifesaving treatment rather than risk my life while bureaucrats continued to decide what, if anything, my life was worth. ... Mum and I have spent a significant amount of money in saving my life when there was no other way forward. Surely [HCW] have a duty to reimburse us for our expense? I was lucky so much that Mum was able to fund my healthcare when it seemed as if I was being left to die. I am concerned that there may be other people trapped in similar situations who are unable to be supported in this way by their families.'

What Health Commission Wales had to say

46 In its formal comments to the Public Services Ombudsman for Wales, HCW said that anorexia nervosa is a complex condition and is extremely difficult to treat. It said that specialist in-patient treatments should only be used when the patient requires an intensive care package, and only as a holistic pattern of care before and after admission. It said that in-patient admissions should generally be short-term and said, too, that it is vital that the patient has access to support and care within the community following discharge, otherwise the in-patient treatment will not have any positive impact beyond the short- or immediate-term.

47 HCW commented that the quality and availability of local services in Wales is variable and in many cases does not meet the needs of patients with eating disorders. HCW said it had experienced many cases where significant investment in in-patient packages of care (sometimes costing more than £500,000 per patient) gave no long-term benefit to patients on discharge, as the local services (that is, the relevant local health board and community mental health services) failed to put in place appropriate packages of care. It said it therefore did its utmost to ensure that any in-patient admission occurred with the full commitment of local services to engage with the patient and provide appropriate aftercare.

48 HCW said that due to where Miss S normally lived, she would fall, in the first instance, within the remit of the Welsh Consultant's team. HCW noted that Miss S was away from home when her health deteriorated; however, it considered it was still the Welsh Consultant who would have been responsible in the first instance for her care and for clinical advice.

49 HCW said it first became aware of Miss S's case following telephone calls, and then the English Consultant's letter of 4 December 2006 (dated 1 December 2006) requesting funding for a period of in-patient care at the EDU. HCW said the English Consultant had enclosed copies of her earlier correspondence with the Welsh Consultant. HCW had noted that the English Consultant's team had felt strongly that Miss S should be transferred to Wales. HCW said this correspondence showed that the English Consultant's team recognised the role of Miss S's local (that is, the Welsh Consultant's) team in managing the total treatment plan, but it noted that it had appeared that the Welsh Consultant felt unable to facilitate this. HCW noted that it was not made aware of the case when

discussions were first taking place between the English Consultant and the Welsh Consultant.

- 50 HCW said it was clear from the English Consultant's letter that further information was required, and in particular that it would be important to establish the position of the local services. It therefore asked the English Consultant to confirm the Welsh Consultant's response to her earlier letter to him of 31 October 2006. It said it understood the Staff Grade Doctor had written to the Welsh Consultant asking him to confirm his position to HCW. HCW said that the Welsh Consultant's letter was then received on 20 December 2006. It said that the Welsh Consultant stated that he was unable to offer suitable care and that he supported the English Consultant's team's funding request. HCW commented:

'For [HCW] this was a serious deficiency in the care the patient required. Effectively, [HCW] was being asked to consider funding a period of in-patient care without identification of a clear treatment pathway or any support on discharge. [HCW's] view was that this was in contradiction to NICE guidelines and the [Mental Health Act 1983] Code of Practice, and could lead to risk for the patient's continuing health.'

- 51 HCW said it therefore wrote to the Welsh Consultant on 2 January 2007 reminding him of the commissioning criteria and requesting details of plans to develop a package of care to meet Miss S's needs on discharge. HCW said that on reflection this letter could have been sent sooner, and it apologised for that. HCW said the Welsh Consultant replied on 3 January 2007 and stated that Miss S had refused a transfer for assessment. HCW noted that the letter contained no proposals about how Miss S's needs might be met after her discharge.

- 52 HCW said the case was considered by its individual patient commissioning panel, which concluded that the absence of input from local services would significantly compromise any benefit gained from in-patient treatment. It noted that Miss S was at that time in a '*place of safety*' – that is, a psychiatric unit. It said, too, that there was no clinical suggestion that Miss S's health was gravely compromised, was unstable, or that the matter should be treated as an emergency. HCW said that its staff had made repeated attempts to contact the Welsh Consultant by telephone (we have seen no written confirmation of this on HCW's file).

- 53 HCW said that its decision was conveyed to the Welsh Consultant on 11 January 2007 suggesting that Miss S be transferred to Cardiff for assessment. HCW said that that letter could have been worded better, and could instead have suggested that Miss S be assessed in situ by a member of the Cardiff team. It apologised for this not being made clear.

- 54 HCW said that it was informed on 11 January 2007 that Mrs S had elected to admit her daughter to the private centre. It said it understood Mrs S was very anxious about her daughter; however, it had been given no clinical indication at that time that Miss S's condition had become critical. It said that if that had been the case, it would have acted differently. HCW said it should have been informed of any change in condition that might have affected its decision, but the clinicians involved did not do this. HCW said that, but for Miss S's discharge to the private centre, it would have continued to liaise with local services to achieve a satisfactory outcome, and was in the process of doing so when it learnt Miss S had been transferred.

55 HCW said it was regrettable that it was not involved at an earlier stage when a transfer to Wales could have taken place with its attendant benefits. It recognised, however, that more robust communication was required with local services to avoid a repetition of the incident. It said that at the time the panel considered this case, HCW was in the process of meeting local services and local health boards across Wales to establish local network groups to work with HCW to create a cohesive care pathway for eating disorder patients. It said that the aim was to create local referral units to act as the point of contact for clinicians working with patients with an eating disorder. It said it also, as part of this work, aimed to develop contingency plans for the repatriation of patients admitted to healthcare services outside Wales. HCW apologised for the anxiety caused to Mrs S, and said that its Acting Chief Executive would write to her and Miss S with its apologies.

56 Subsequently, asked why it would not be possible for a plan of follow-up care to be arranged once a patient had been admitted to an in-patient facility, HCW said it was important to ensure that a patient '*would have access to a whole pathway of care*' and, in particular, that links were formed between in-patient and out-patient providers to ensure that the patient would have access to appropriate care on discharge. HCW said that details of the '*local services*' element of care could be formulated once a patient was admitted; however, it said that in this case there was no evidence that any contact had been made with local services, or any outline for the whole care pathway drawn up. HCW said that in addition, it was unclear in this case whether Miss S would ultimately decide to remain in south west England, or return to Wales. As a result, it had been uncertain which organisation would have been responsible for her care post-discharge.

What the Trust had to say

57 In its formal comments to the Public Services Ombudsman for Wales, the Trust said provision within its mental health service for eating disorder patients was limited. It said that the current position was that the treatment of such patients was led by community mental health teams, which included workers with varying degrees of expertise and interest in working with patients with eating disorders. It said that there was no specialist in-patient facility for patients with eating disorders within the Trust, and patients were therefore currently cared for in acute admissions wards at two sites. The Trust said its dietetic department also provided support, but this was not a specialist service, and was not separately funded for eating disorders.

58 Asked whether it had a specialist team or consultant specialising in the treatment of eating disorders, the Trust said that there was a limited service for patients suffering from bulimia nervosa. It said that this was an out-patient service provided by a consultant clinical psychologist one day per week. The Trust said that there was also a very limited unfunded psychological service providing out-patient cognitive behaviour therapy for patients with anorexic disorders who have a BMI of 15 or above. It said that only six patients could be seen at any one time due to the lack of a dedicated service. A consultant psychiatrist provided input for one session per week to assess patients, and there was also a whole-time-equivalent consultant clinical psychologist available for this work.

59 The Trust said that since November 2007 a small specialist steering group had been in operation, made up of one session from consultant psychiatrists with a special interest in eating disorders, one whole-time-equivalent clinical

- psychology post, and dietetic support. It said this steering group liaised closely with HCW, and met on a regular basis. The Trust said the steering group operated as a second opinion service for patients whom it was considered may require out-of-area treatment. It said relevant patients were assessed by this group, their needs were identified, and discussions then took place with HCW about specialist placement if that was necessary.
- 60 The Trust said that if the steering group had been in existence when Miss S was first referred by the PCT, it would have become involved in the case. It said Miss S's case would have been taken to the second-opinion panel after being assessed by the identified consultant; a decision would then have been made jointly with HCW about how best to proceed.
- 61 Asked how patients requiring in-patient care were managed, and about the referral pathways to specialist care, the Trust acknowledged that before November 2007 the referral and decision making process had been unclear. It said that HCW had since reviewed its services and the situation had improved with the introduction of the second-opinion clinic. The Trust noted, however, that the amount of funding available for out-of-area in-patient beds remained limited.
- 62 When it was put to the Trust that one of the reasons given by HCW for turning down the funding request was that no post-discharge follow-up plan had been put in place, it said that it would have been difficult to provide a comprehensive follow-up care plan for a patient who had never been assessed by the service. The Trust said that from the correspondence on file, it appeared that there had been some doubt as to whether Miss S had intended to return to Wales. The Trust said it was therefore 'confusing' why it should be required to put in place a follow-up plan for a patient who had not been known to the service and who may not have been returning to the area.
- 63 In a written statement, the Welsh Consultant said that as far as he could ascertain, the first contact he had about the case was late in the afternoon of 26 October 2006, when he received a telephone call from the Staff Grade doctor. The Welsh Consultant recalled that the Staff Grade doctor requested the transfer of Miss S, who was '*described as depressed, but whose symptoms were clearly those of anorexia nervosa*'. The Welsh Consultant said he understood Miss S was refusing to eat and was either on, or being considered for, intravenous feeding. The Welsh Consultant said he did not feel the account given to him by the Staff Grade doctor was sufficiently accurate or detailed to allow him to accept the referral, and he therefore asked to speak to the patient's consultant for further clarification.
- 64 The Welsh Consultant said that despite the inadequacy of the referral, the case was discussed by the ward team, and a bed made available subject to receiving adequate clarification from the English Consultant. The Welsh Consultant said that his team were extremely unhappy and concerned that the referral was '*clearly inappropriate*' and that they had neither the therapeutic space nor the skilled staff required to manage a very ill anorexic patient.
- 65 The Welsh Consultant said that the next (and main) contact he had about the case occurred on 30 October 2006 (sic) when he had a telephone call from the English Consultant. The Welsh Consultant said that the English Consultant described a young lady with a clear

and established eating disorder, who was losing weight fast and was in need of intravenous feeding and an urgent referral to a specialist eating disorder service. He noted that the eating disorder specialist who subsequently saw Miss S described her condition as that of '*free-falling anorexia nervosa*'. The Welsh Consultant said that the English Consultant had no doubt that Miss S was suffering from advanced anorexia nervosa and that she was in need of specialist, rather than general, psychiatric care.

- 66 The Welsh Consultant said he wrote strongly-worded letters in support of the case for urgent funding, and to facilitate the transfer of '*a very ill lady*' to specialist in-patient care.
- 67 The Welsh Consultant said that he did not recall Miss S's diagnosis of depression being raised as a primary issue of concern at any stage during or after the discussion he had with the English Consultant.

What the PCT had to say

- 68 In its formal comments on the complaint, the PCT said that it had accepted the recommendations of the external review of Mrs S's complaint (paragraph 38). It said, in particular, that if in future a patient's care and welfare was being undermined by resource issues, the matter would be brought to the attention of its Chief Executive, and the patient placed in the appropriate unit, funded by the PCT if necessary, while negotiations took place with the other organisation(s) concerned.

What the Professional Adviser had to say

- 69 The Adviser said that this case was complex as Miss S lived in south Wales and was registered with a GP there, but after she went to stay with a friend in the south west of England she became unwell. The Adviser noted that Miss S came under the care of the local (English) psychiatric service from 28 September 2006 and was admitted to hospital on 27 October 2006. He said that as time went on, the need for assessment and treatment by a specialist eating disorder unit emerged. He noted that in the NHS as currently organised, payment between different NHS bodies would be required for the specialist treatment, and that the body liable would not be the PCT (as Miss S was resident in Wales), but HCW.
- 70 The Adviser noted that Miss S had not had any contact with clinicians in her home area, and although the Welsh Consultant was identified as the relevant consultant for that area, he had never seen her. The Adviser noted that HCW's procedure suggested that a local (Welsh) consultant should assess any need for specialist treatment, recommend the treatment, and produce a follow-up plan; in this case the request for funding failed because none of this had been done. He noted it was not sufficient from HCW's point of view for the Welsh Consultant to give his full support to a detailed request for funding from the English Consultant.
- 71 The Adviser noted that when Miss S had been admitted to hospital she had weighed 47kg; after two months she weighed 40kg and had a BMI of 14. He said that, in his opinion, Miss S's physical condition had become sufficiently grave to warrant urgent transfer for re-feeding, either to an eating disorder unit, or to a medical ward in a general hospital if there was a ward and

- consultant physician (often a gastroenterologist) available who was experienced in managing such patients. The Adviser said that even if it could not be said that a transfer was essential at that point, it would be unreasonable to hope that Miss S would suddenly turn a corner and start to gain weight where she was.
- 72 The Adviser said that in the longer term Miss S might, after she had regained some weight, also have needed a period as an in-patient in an eating disorder unit for psychological management of her psychiatric condition. He noted that management in a general psychiatric ward had failed, albeit that it was theoretically possible that a placement in a different ward might have succeeded.
- 73 The Adviser said that in his experience, a Trust manager would discuss a case such as this with a 'home' clinician when funding for a specialist out-of-area service was requested. The Adviser commented that it did not appear reasonable to insist that a home clinician undertook a long journey to see a patient personally when there was already a valid and detailed opinion available; any additional information could be obtained by telephone or email, and plans for aftercare discussed. The Adviser said that in the unlikely event there was a clinical question which could not have been answered in this way, the Welsh Consultant should have been prepared to assess Miss S, and if necessary travel to do so. He could not see that it was reasonable to expect the Welsh Consultant to have been familiar with HCW's procedures, as this could have been explained to him by a Trust manager.
- 74 The Adviser noted that the English Consultant wrote to the Welsh Consultant on 31 October 2006, a few days after Miss S's admission, asking him to take over her care; this request was apparently declined by telephone, although there is no contemporaneous record of this. The Adviser said that if the Welsh Consultant honestly felt that he did not have the resources to manage Miss S, even for a short period, he would have had reasonable grounds to decline; however, at that date, when Miss S's depression was more prominent, and before it seemed that she had a difficult case of anorexia nervosa, she would not have appeared an unusual patient, and should have been thought to be manageable in the short term on the ward. The Adviser noted that in a later letter to HCW dated 14 December 2006, the Welsh Consultant stated '*we feel that Miss [S]'s needs can no longer be met from within the generic adult psychiatric provision*'. This implied that the Welsh Consultant recognised Miss S's needs might, earlier, have been met in a general ward. That said, the Adviser commented that it would have been difficult to assess Miss S's best interests overall, which may have been to remain in the south west of England where she had more support available from family and friends.
- 75 The Adviser said that by December 2006, when the Welsh Consultant was again asked to take over Miss S's care, it was clear that his resources would not have been suitable to care for Miss S in the state she had reached (albeit that if she had simply arrived home by some means or other, he would have had to take her and make whatever arrangements were necessary). The Adviser noted too that, at some point, it appeared Miss S became unwilling to return to Wales.

- 76 The Adviser said he sympathised with HCW's role of safeguarding public money, particularly given its stated previous experience of losing the benefits of expensive in-patient treatment because of inadequate follow-up. In terms of follow-up arrangements, the Adviser said that a responsible clinician should be identified (in normal circumstances someone who knew the patient) who would keep in touch with his or her progress on an in-patient unit and develop a plan as requirements became clearer. He said that in a case like Miss S's, only a very sketchy plan, of nominal value, could have been produced at the outset: it would have been unreasonable to insist on a fully worked-up plan. The Adviser thought it questionable that Miss S's own uncertainty about where she would live in the future was used as a reason for withholding treatment.
- 77 The Adviser said that the Welsh Consultant could, nevertheless, have produced a plan, if it had been made clear that HCW insisted on one. If Miss S improved, and then decided to return to Wales, the plan could have been elaborated or amended. He also said that if, alternatively, it transpired that Miss S intended to stay in England, the PCT could have liaised with the EDU and prepared a different plan.
- 78 The Adviser said that eating disorders are very common and every Trust should make provision for managing such patients, and should have a smooth pathway in place for referring on those who require more specialist treatment, such as in-patient care (which the Trust did not itself provide). The Adviser said he was surprised by the apparent low level of provision for eating disorders at the Trust; he would have expected a higher level of resource given its status and the large population it serves (around 500,000).
- 79 The Adviser said it is normal for community mental health teams to provide the mainstay of psychiatric treatment, and usually they have back-up available within a Trust through advice from a specialist team or person with a special interest in eating disorders. He said it was not clear in this instance whether the members of the Trust's steering group were willing or able to provide such support, and he doubted that the monthly staff support group was an adequate alternative.
- 80 The Adviser said that in its comments on the complaint, HCW had outlined sensible plans for making its systems known to local services, and for establishing points of contact. He noted, however, that difficulties will remain in the case of Welsh patients, admitted to services elsewhere in the United Kingdom, who do not want to be repatriated.
- 81 In conclusion, the Adviser said that he felt the outcome in this case was unreasonable: from a clinical view, Miss S should have gone to an eating disorders unit paid for by the NHS. Miss S's health was at risk, not because she might be admitted without a document specifying that *'in Wales/England she will be followed up on discharge by Consultant A/B and his/her team'*, (to conform with the NICE guidelines), but because she was very ill with a pressing need for admission. More effort should have been made to cover the two alternative discharge locations in simple plans that could have been reviewed and revised later.

Health Commission Wales's comments on the draft report

- 82 In its written comments on a draft version of this report, HCW said that eating disorder patients do not, as a rule, *'fall ill'*; rather, they develop the disorder over a period of time. It said this usually allows for the reasonable engagement of local services. HCW said its policy (paragraph 23) includes an *'exceptional circumstances'* clause which can cover circumstances such as those which arose in this case; however, it said that the decision making process must always be informed by the information known at the time. HCW said that its policies deal with reasonably foreseeable situations; it said that this was the only case in six years where the patient was under the care of services outside Wales and where local services did not engage appropriately. HCW said that it had examined the policies of comparable commissioners in England via the internet, and said that none of these referred to the *'very rare'* circumstances demonstrated by this case.
- 83 HCW said that in reaching the decision not to fund in-patient treatment, its individual patient commissioning panel did look at the evidence available to it at the time and did use its discretion. It said that the panel has a *'clear and demonstrable'* track record of dealing with cases on their merits. It said that this has been the case for many eating disorder cases where the evidence has supported the emergency status of the patient. It said that in those circumstances the panel has agreed to fund in-patient care before local discharge arrangements had been agreed. HCW said it responded flexibly when the clinical information provided showed a need for immediate action. HCW said that there have been, and continue to be, circumstances where patients present with a very low BMI of 12-13 and it had reacted, and will react, promptly.
- 84 Turning to Miss S's complaint, HCW said that it was continuing to pursue the matter and secure the involvement of the Welsh Consultant throughout the process, and could demonstrate that that was the case. It said that when a patient decides to pursue private treatment, there would normally be no further role for HCW until the patient presented for NHS services. It said in these circumstances HCW's normal policy is not to reimburse the cost of private treatment. HCW said that this particular case was complicated by the fact that neither Mrs S nor the Welsh Consultant followed its normal appeals process.
- 85 Turning to the requirement for a discharge plan to be in place before funding was agreed, HCW said that from its practical experience, if plans are left until the patient is admitted, the engagement of local services is much poorer and plans are not prepared in a timely manner. It said that the existence of a plan, or even a commitment to a plan, shows that local services have engaged in the care package, which is essential if there is to be long-term benefit from the in-patient admission. HCW said that where local services do not demonstrate this engagement when a patient is admitted, the result will be an unnecessarily long in-patient stay. It said that these are ineffective and harm the care available to other patients who require specialist care by needlessly reducing the resources available.
- 86 HCW said that, as stated earlier, it will act to mitigate risk to patients who need emergency admission by acting flexibly and admitting them before full plans are available; however, it said that in this case, it was not made aware of the degree of urgency and that is why it decided that local services should be responsible for Miss S's care at that time. HCW said that to avoid any doubt, it will incorporate its practice into future policies.

Findings

- 87 In reaching our findings we have taken account of the relevant standards and the advice of our Adviser. Mrs S has complained, on behalf of her daughter, that they were forced to pay for private treatment of Miss S's anorexia nervosa, which was properly the responsibility of the NHS to fund. Mrs S felt that they had no alternative but to pay for the treatment, given Miss S's deteriorating condition and because (it seemed to them) the funding issue was unlikely to be resolved swiftly.
- 88 We have considered whether there has been a failure of service, a failure to provide a service, or maladministration on the part of the three bodies complained about, and whether Miss S and her mother suffered injustice or hardship as a result. We will address the actions of the three bodies involved in turn.

Health Commission Wales

Findings of the Public Services Ombudsman for Wales

- 89 It is clear from the evidence I have seen that the clinicians who were caring for Miss S in the south west of England were of the opinion that her condition was such that she required a period of in-patient treatment. The clinician who assessed her at the EDU also agreed that that would be appropriate. The Adviser has said that in his opinion Miss S required a period of in-patient treatment. I am entirely satisfied that that was the case.
- 90 I have considered whether the NHS should have paid for Miss S's in-patient care. First, I should say that I have assumed that it is appropriate to regard Miss S as having been ordinarily resident in Wales throughout, given that before visiting the south west of England she lived and worked in south Wales and was registered with a GP there. The *National Health Service Act 1977* placed a responsibility on the National Assembly for Wales (now the Welsh Ministers) to provide (to reasonable requirements) services for the treatment of illness. The Assembly delegated decisions about whether to fund in-patient care of patients with eating disorders to HCW, which has a policy (in draft at the time of the events complained about) that sets out its criteria for funding such treatment. Miss S had been assessed as requiring treatment, and the treatment being recommended was one which the NHS funds if certain criteria are met. In Miss S's case this was a funding decision to be taken in Wales.
- 91 Normally, it would be expected that someone presenting with an eating disorder will undergo a period of out-patient treatment and, if that does not succeed, a funding request will be made by the patient's consultant for a period of in-patient care. The same team will then usually be responsible for the patient's care after he or she is discharged. However, this case was unusual in that Miss S first presented with her illness while she was away from home. As a result, she had not been assessed, or even seen, by the Welsh Consultant or his team. (Had this happened, and an aftercare plan been put in place, it is likely that Miss S's treatment in the EDU, or a similar facility, would have been funded promptly by HCW and this complaint would never have arisen.)

92 However, that is not as matters stood, and I consider that HCW's actions in this particular case were inflexible. While I acknowledge that no policy or procedure can cover every eventuality, it would have been open to HCW's individual patient commissioning panel to have taken into account the obviously relevant factor that the reason Miss S had not been seen by her home clinicians was that she was not 'at home' when she presented with her illness. HCW has now said, in its comments on the draft report, that the panel does act flexibly when required. It has said, too, that in this specific case, the panel did consider all relevant factors; however, this is not reflected in the record of the panel's deliberations (paragraph 35). It does seem to me that the evidence suggests that the panel did not take all relevant factors into account, and instead an overly prescriptive approach was taken. I consider that the inflexible approach in this case amounts to maladministration. I am particularly concerned that the panel did not appear willing to give weight to the opinion of the English clinicians who, after all, were directly involved in Miss S's care, had assessed her in person, and were fully aware of the facts of the case. HCW says that it was not made fully aware of the severity of Miss S's condition; however, there are letters to it from both the Welsh Consultant and English Consultant that set out the position. HCW says that its staff attempted, and failed, to get in contact with the Welsh Consultant by telephone, but there is no record of this on HCW's files. HCW therefore failed, in terms of the *Principles of Good Administration*, to be sufficiently 'customer focused' to take account of Miss S's particular circumstances.

93 While I note that HCW has since clarified that when it said Miss S should be assessed by a Welsh clinician, it would have been possible for the Welsh clinician to travel to the south

west of England to do this, the letter it sent did imply that Miss S would be expected to return to Wales for assessment. It is not surprising that Miss S was reluctant to return to Wales for assessment given her physical and mental state. I am also concerned that the panel appears not to have considered the very relevant issue of whether it was in Miss S's best interests to return to Wales at that point; not only because of her clinical condition, but also because her sources of support, in the form of family and friends, were in south west England, not Wales. I consider that the failure to take into account relevant information amounts to maladministration.

94 Turning to HCW's requirement that arrangements for follow-up care should be in place before an in-patient admission can go ahead, I acknowledge the general logic behind this requirement, and that significant investment in in-patient treatment has previously been undermined by poor follow-up arrangements at the local level, over which HCW has no control. That said, I am not persuaded that Miss S should have lost her opportunity for in-patient treatment on the basis of HCW's poor previous experiences, and because some local services may not have adequate follow-up arrangements in place. I am also mindful of the Adviser's comment that before Miss S was admitted, it would only have been possible to make the most basic of discharge plans. I have no doubt that a robust aftercare plan would have been necessary in the longer term, and certainly before Miss S was discharged, but at the time of the issues complained about, it seems unlikely that anything more than a very brief plan, of limited value, could have been drawn up with the urgency that was needed.

95 In addition, it was unclear where Miss S might ultimately be discharged. She might have wanted to return directly to Wales or, alternatively, preferred to have been discharged to the south west of England where her sources of support were strongest. As mentioned above, this is an important consideration, and one which I note is mentioned in the *Mental Health Act 1983 Code of Practice*. It seems to me that, again, HCW was being unreasonably inflexible in insisting that a firm discharge plan be put in place before Miss S was admitted to an eating disorders unit. This demonstrates an excess of inflexibility in decision making, which I consider to be maladministration.

96 The Adviser has said, and I agree, that it would have been possible to have drawn up a plan (if that were required) which outlined that, on discharge, Miss S would have been cared for by a particular team in Wales or England, depending on where she ultimately decided to stay. This could have been revised over time as she moved closer to discharge, and arrangements made with the local funding body in the area where she was going to live. I cannot accept that Miss S should effectively have been penalised for not knowing (when she was frail and very poorly) where she would live after she was discharged. There will inevitably be patients who live (for example, for work reasons) in a different part of Wales, or indeed the United Kingdom, away from their family, and it is not unreasonable for them to want to be with their families when they are very ill or recovering from serious illness. I consider that in this particular case HCW has, unreasonably, failed to take into account this relevant issue when considering the funding request. I consider that this amounts to maladministration.

97 I have identified above a number of examples of maladministration on the part of HCW in this case. Later we explain how this led to injustice or hardship to Miss S and her mother. I uphold the complaint against HCW.

The Trust

Findings of the Public Services Ombudsman for Wales

98 The Trust first became involved in this case when the Welsh Consultant was contacted by the English Consultant's team in October 2006 to take over Miss S's care. The Welsh Consultant refused. He argues that this was because his team lacked the resources and expertise to treat a patient suffering from advanced anorexia nervosa. While I note the constraints the Welsh Consultant faced, I am concerned that he refused to become involved in October 2006 because, as the Adviser has pointed out, Miss S's main problem at that time appeared to be depression, a condition that it would have been reasonable to expect the Welsh Consultant to manage on an in-patient ward. While the Welsh Consultant has said that the impression he received from the English Consultant during their telephone conversation on 31 October 2006 was that the anorexia was more serious (paragraphs 65 and 67), this is not supported by the English Consultant's letter to him of the same date (paragraph 26), which suggests that the depression was the most serious issue at that time. On balance, taking into account the information which was apparently available at the time to the Welsh Consultant, I conclude (having taken account of the professional advice I received) that it was not clinically reasonable for the transfer request to be refused outright in

October 2006. That was a failure to provide a service. That said, I recognise that by December 2006, when Miss S's condition had deteriorated and it was clear that the main problem was now her eating disorder, it would not have been clinically reasonable for the Welsh Consultant to have taken over her care. I am not, therefore, critical of his decision not to agree to the transfer of Miss S at that stage. In view of the failure to provide a service which I have identified, and the consequent injustice or hardship identified later in this report, I uphold the complaint against the Trust.

- 99 I am concerned, also, about the level of provision for eating disorder patients in the Trust's area. The Adviser has commented that this is surprising given that the Trust covers a population of around 500,000. I note that eating disorders are not unusual, and the Trust should ensure that there are adequate services available for patients suffering from them. The changes which have occurred since this complaint was made, outlined in the Trust's response to our enquiries, seem a reasonable step forward, and in particular should help manage negotiations with HCW about eating disorder patients who require in-patient treatment. That said, I share the Adviser's concerns that the service for eating disorder patients is limited, and I note the Trust's own statement that while it does provide an out-patient service for patients suffering from anorexia nervosa, this is limited and does not receive specific funding.

The PCT

Findings of the Health Service Ombudsman for England

- 100 In response to Mrs S's complaint, the PCT commissioned an external review of its actions which was carried out by two senior clinicians from another Trust. I commend the PCT for its willingness to seek an independent, senior view on Mrs S's complaint, and am content that it has confirmed that it will implement the resulting recommendations.
- 101 That report identified that it would have been appropriate for the dispute about funding Miss S's treatment to have been brought to the attention of the PCT's Chief Executive, and consideration given to the PCT funding Miss S's in-patient treatment on an interim basis until the matter had been resolved. While the responsibility for funding Miss S's treatment ultimately lay with HCW, I agree with the report's authors that the PCT should have considered funding treatment in the short term to ensure that Miss S was not put at clinical risk. The PCT failed to do this. I conclude, therefore, that the PCT failed to provide a service to Miss S. That said, I am content that the PCT has agreed to implement the recommendations of its external review. I also recognise that the clinicians treating Miss S did all they reasonably could to expedite the funding request through contact with HCW and the Welsh Consultant. In view of the PCT's failure to provide a service, and the consequent injustice and hardship outlined later in this report, I uphold the complaint against the PCT.

Conclusions

102 I have seen no evidence that the PCT has yet offered a formal apology to Mrs S or Miss S for failing to consider funding Miss S's treatment in the short term.

Maladministration and service failure

103 To sum up, we have found maladministration or service failure in the following respects:

- HCW adopted an excessively inflexible approach to the request to fund Miss S's inpatient care. In particular, HCW:
 - failed to take into consideration all relevant factors (including that Miss S was not at home when she became ill and her only sources of social support were outside Wales);
 - failed to take into consideration the valid opinion of the English Consultant when it was reasonable to do so;
 - insisted that a detailed discharge or follow-up plan was in place when it was not reasonable to do so; and
 - failed to communicate adequately its conditions for funding.
- The Trust unreasonably refused the request to take over Miss S's care in October 2006.
- The PCT failed to provide short-term funding for Miss S's treatment and thereby placed her at clinical risk.

Injustice and hardship

104 Taken in the round, we have concluded that the maladministration and service failure identified above caused Miss S and her mother injustice and hardship: they were clearly caused significant distress by the failure to resolve the funding issues appropriately and expeditiously as Miss S's condition deteriorated rapidly, and they each spent considerable sums of money paying privately for treatment which the NHS should have funded.

Recommendations

¹⁰⁵ In view of the failings identified and the injustice and hardship caused to Miss S and her family, and in line with the *Principles for Remedy*, we make the following recommendations.

We recommend specifically that **HCW**:

- Reimburses Mrs S and Miss S for the money paid for Miss S's private treatment, together with the interest they would have received had the money remained in their accounts.
- Reviews its administrative and procedural arrangements to ensure that Welsh patients who become ill while outside Wales are not placed at a disadvantage.
- Reminds the members of its independent patient commissioning panel that they need to take into account all relevant factors when making decisions.
- Makes clear to referring clinicians the criteria for funding to be approved, and ensures that they are contacted promptly to explain if they have failed to address any relevant points in the criteria.

We recommend specifically that the **Trust**:

- Carries out an urgent review, in conjunction with the relevant local health boards, of the provision for the treatment of patients with eating disorders in its area.

We recommend that **all three bodies**:

- Apologise to Miss S and Mrs S for the failings identified in this report.
- Each pay Miss S the sum of £250 in recognition of the distress she has been caused.
- Each pay Mrs S the sum of £250 in recognition of the distress she has been caused and the time and trouble involved in pursuing this complaint.

Specific additional recommendations of the Public Services Ombudsman for Wales

¹⁰⁶ I further recommend that the **Welsh Assembly Government** gives consideration to carrying out a Wales-wide review of the adequacy of provision for the treatment of eating disorders in Wales, both from an out-patient and in-patient point of view (bearing in mind the lack of in-patient treatment facilities in Wales and HCW's comments above that in-patient care is often compromised by inadequate out-patient arrangements post-discharge).

¹⁰⁷ The authorities concerned have seen a draft of this report and agreed to implement the recommendations listed at paragraph 105.



Peter Tyndall
Public Services Ombudsman for Wales



Ann Abraham
Parliamentary and Health Service Ombudsman

7 July 2009

Report Reference Numbers:
200701085 (Welsh Assembly Government)
200701674 (Cardiff & Vale NHS Trust)
200800010 (Plymouth PCT)

Annex

Funding criteria listed in HCW's letter of 2 January 2007 to the Welsh Consultant

- *There must be 2 concurring NHS Consultant views that the patient needs to access such specialist in-patient provision (one of which must be provided from the local tertiary/secondary service). Please not [sic] we will not accept the opinion of the specialist service Consultant.*
- *The use of NHS facilities must be optimised. Please provide detail to evidence [sic] that this has occurred.*
- *All local alternative options to provide an appropriate package of care must have been explored and explicitly excluded. Please detail.*
- *Both the referring and receiving Consultant are of the opinion that the unit is the most appropriate unit to meet the patients needs.*
- *The referring and receiving Consultants will agree the milestones to be achieved by the patient, which will signify that he/she is ready for discharge.*
- *For CAMHS cases, [HCW] will only commission services from those units, who participate in the QNIC audit.*
- *[HCW] will only fund placements for patients in services where there is a written agreement from the LHBs to fund explicit follow up care packages (daycare and outpatient services) and ensure prompt transfer back to local services, as soon as the discharge criteria are met.*

We would normally expect these criteria to be met within 3 months of admission. This would include the formulation and agreement of a future care plan, delivered by local services in Wales.
- *[HCW] will not fund any patients or relatives travelling. Those patients/relatives eligible to claim, must do so through the appropriate channels.*
- *No home visits are to be funded for those patients who require special/additional/enhanced observations.*
- *For children and adolescents, [HCW] will consider funding home visits on a monthly basis. The patient's Consultant at the provider unit must produce a treatment rationale [sic] with supporting information in respect of the need for the home visit.*
- *[HCW] would expect to fund non detained patients (Mental Health Act 1983) for a maximum of 3 months. Any extension of funding must be requested by the receiving Consultant, agreed by the referring Consultant and the subject of further consideration/approval by the Commission.*

- *That the referring Consultant is satisfied that the proposed package of care at the unit, will fully meet the patient's needs.*
- *That the referring Consultant and their team, will continue to monitor the patient's progress and continue to engage in CPA/ Case Conference/Discharge Planning Meetings as appropriate; and*
- *there is a nominated lead in local health (and where appropriate local authority) services for the provider to engage with.*

Could you please provide the patients [sic] name, address and date of birth. I would be grateful if you could complete the attached forms and return them to me at your earliest convenience.

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