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Department of Health & Social Care

From Gillian Keegan MP
Minister of State for Care and Mental Health
39 Victoria Street
London
SW1H 0EU

020 7210 4850

Joanne Kearsley
Senior Coroner
HM Coroners Court
Newgate House
Newgate
Rochdale
OL16 1AT

25 July 2022

Dear Ms Kearsley,

Thank you for your correspondence of 17 December 2021 to the Secretary of State for Health and Social Care, Sajid Javid, regarding the tragic death of Nichola Lomax.

I extend my deepest condolences to Ms Lomax's family and friends. I, the Department, and health bodies, at both a national and local level, take the Report's concerns very seriously. Improving eating disorders services is a key priority for the Government and a vital part of our work to improve mental health services.

Your report raises important concerns regarding adult eating disorder treatment and shared learning across the health system. Following the Parliamentary and Health Service Ombudsman (PHSO) report "*Ignoring the alarms: how NHS eating disorder services are failing patients*"[1], regarding the tragic death of Averil Hart, the Department of Health and Social Care has been working with NHS England and NHS Improvement (NHSEI), Health Education England (HEE), the General Medical Council, the National Institute for Health and Care Excellence and the Royal College of Psychiatrists through a delivery group to continue to address the recommendations. We understand the importance of working with such partners and remain committed to continue working to push forward improvements for this vulnerable group.

Regarding the matter of concern that you raise related to inadequate training of medical professionals regarding eating disorders - doctors should have the necessary knowledge and experience of mental health to assess patients holistically, considering the individuals' physical, social and psychological needs. Through the PHSO delivery group, NHSEI is working with HEE and other partners to procure training courses that will increase the capacity of the existing workforce to allow them to provide evidence-based treatment to more people, as they have set out in detail in their responses. The Department will continue to support and assure this work to progress against key actions, including ensuring better awareness of eating disorder training and continuing professional development. We recognise the work of external partners, such as Beat, to push forward better training in medical courses, and the necessary focus of Eating

[1] https://www.ombudsman.org.uk/sites/default/files/page/ACCESSIBILE%20PDF%20-%20Anorexia%20Report.pdf

Disorder awareness week this year on this issue, which we will continue to support as a Department.

Eating disorders have some of the highest mortality rates of any mental health disorder and appropriate monitoring of anorexia nervosa patients by primary or secondary care providers is vital. Under the NHS Long Term Plan, the Department is committed to ensuring a more integrated service across primary and secondary care for people with severe mental illnesses, including eating disorders, and to giving 370,000 adults with severe mental illness greater choice and control over their care and support them to live well in their communities by 2023/24. To support improvements in mental health care more generally, including eating disorder care, we remain committed to expanding and transforming mental health services in England and to investing an additional £2.3 billion a year in mental health services by 2023/24.

This investment has already begun, with all Integrated Care Systems (ICSs) receiving funding to transform adult community mental health services, including eating disorders, with the expectation that all ICS will have transformed services in place by 2023/24. In 2021/22, 33 ICSs are transforming adult eating disorder services, with the remainder due to begin transformation of services in 2022/23. In their response, NHSEI have set out the importance of this funding and adherence to adult eating disorder patient care guidance, to ensure the highest standards of care. NHSEI's work continues to highlight to systems the importance of early intervention services, as well as ongoing medical monitoring and ensuring access to care in the right place, and at the right time.

The Department recognises that NHS eating disorder services are facing increased demand. For example, the number of children and young people entering urgent treatment for an eating disorder increased by 73% in financial year 2020/21 compared to 2019/20 according to NHS data. Recognising this increase in demand, on 27 March 2021 the Department published its Mental Health Recovery Action Plan, backed by an additional £500 million of targeted investment, to ensure that right support is in place for this financial year.

As part of this funding £79 million is being used to significantly expand children's mental health services, including allowing 2,000 more children and young people to access eating disorder services. £58 million has been allocated to accelerate the adult community support to bring forward the expansion of integrated primary and secondary care for adults with severe mental illness, including eating disorders.

In addition, the Department is developing a new long term, cross-government Mental Health Strategy in the coming year. The Government will launch a public discussion paper this year to inform the development of this strategy. This will set us up for a wide-ranging and ambitious conversation about potential solutions to improve mental health and wellbeing.

This case is shocking and is a tragedy, and something taken very seriously in the Greater Manchester healthcare system, hence the collaborative system response and approach to improving services moving forward. This should and will be a "*never event*" in the Greater Manchester ICS's developing quality and safety model under the new Integrated Care Board (ICB). Unfortunately, cases like this have been seen

nationally as well, from which all regions must learn lessons and share good practice. All three ICS regions in the North West are part of the eating disorder lead provider collaborative and this will strengthen learning and development across the area too.

This case has accelerated the mobilisation of the dedicated Greater Manchester Mental Health system quality and safety group, which will be a system wide panel, including - social care, primary care, acute care, mental health, voluntary, community and social enterprise, all blue light services and service users and carers, and will be chaired by the executive medical lead for mental health. This panel will report to the Greater Manchester system quality and safety board, chaired by the chief Medical Director and supported by the Chief Nurse, and accountability for monitoring and quality improvement will be under the ICB (Chief Medical Director and Chief Nurse) supported by the Executive Medical lead for Mental Health and the wider clinical and care professional leadership group.

There has been a year on year rise in eating disorders and a particular rise through the pandemic across all ages, especially in young people and young adults. Nationally, the launch of MEED[2] in May this year will see the most significant quality improvement in eating disorders in the last 5 years in addition to the transformation of young people's eating disorder services. This is the "*Management of medical emergencies in eating disorders*" guidance developed by The Royal College of Psychiatrists (2020) and now embedded in the NICE guidance for eating disorders assessment, treatment and management. This is based on the previous MARSIPAN[3] and Junior MARSIPAN guidelines for managing severe anorexia nervosa, but MEED is all ages and all eating disorders with a shared language and risk assessment tool that can be used by all clinical and care professionals across the system. This includes social care colleagues to strengthen the safeguarding support for vulnerable adults. This tool is akin to the NEWS 2 tool, developed by The Royal College of Physicians for risk assessment and triage for those presenting with physical health illnesses and now a shared language across the urgent and emergency care system.

The traffic light system in MEED has been endorsed by NHSE/I and is being rolled out across the system in Greater Manchester and nationally now so that, like NEWS 2, we can see significant improvement in risk assessment and triage. There will also be a requirement for all ICSs to have a formally established whole-system MEED group, which we have started for young people and are now starting for adults, with a link across the two to ensure the transitions are also addressed. Greater Manchester have also accelerated the review of the whole adult eating disorders pathway, including revised protocols with our independent sector providers and greater collaboration with the voluntary, community and social enterprise sector providing both prevention and recovery support as well as carer support. The MEED groups will be responsible for training rollout with resource support from the Mental Health programme and our provider collaboratives which will be monitored through the system quality and safety group at a Greater Manchester level.

[2] https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233
[3] The Management of Really Sick Patients with Anorexia Nervosa

I hope this reply helps to reassure you that partners across the health system are working to make improvements as a result of this report to prevent this happening in future. The Department takes the matters raised in this report seriously and will continue to engage on progress via the PHSO Delivery Group, and through the new mental health strategy.

I hope this response is helpful.

GILLIAN KEEGAN

Joanne Kearsley, Senior Coroner for Coroner area of Manchester North

Dear Ms Kearsley

Royal College of Psychiatrists response to Coroner's Report into the death of Nichola Lomax

Purpose of response

To respond to those aspects of the Coroner's Report into the tragic death of Nichola Lomax that are relevant to the Royal College of Psychiatrists, in particular to what is referred to as the "MARSIPAN" guidelines in the Report. The updated guidance referred to in this document will have a different title (Medical Emergencies in Eating Disorders) but given the language in the Report, we are using "MARSIPAN" for ease of reference in this response.

We would first of all though like to take the opportunity to extend our sincere and deepest sympathies to Nichola's family, friends and all who cared for her.

Background

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom. The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers, and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

While these are extremely tragic circumstances on which to have to communicate, we hope that the information we provide in this note responds to the issues you raise that are relevant to the College, and that this may contribute to minimising the risk of similar events occurring in

the future. If you have any questions or would like to discuss any aspect of our response, please do not hesitate to contact us at [redacted]

This response has been developed with the support of the College's Eating Disorder Faculty, which is the part of the organisation that brings together psychiatrists working in eating disorders across the age range. It aims to secure the best outcome for people with eating disorders by:

- promoting excellent services,
- supporting the prevention of eating disorders,
- ensuring prompt treatment to achieve higher recovery rates and prevent complications,
- improving medical training in eating disorders,
- promoting quality and research,
- setting standards and
- being the voice of eating disorder psychiatry.

"MARSIPAN" Guidelines

The College role is one to influence, support and advise, and we do not have any statutory responsibility. For example, in light of the reference to the "MARSIPAN" guidelines in the Report, we have no formal levers by which we can assure ourselves of compliance with it, including the provision of the necessary funding and associated workforce resources to implement it.

That said, the College and its Eating Disorder Faculty have undertaken significant activity that seeks to improve services through mechanisms such as evidence-based guidance and training.

The impetus for publishing the "MARSIPAN" guidelines in 2010 was the tragic death of a young woman in hospital in 2008 It was developed in collaboration with the Royal College of Physicians and the Royal College of Pathologists, with a focus on ensuring the safe management of emergencies in anorexia nervosa. The document was published on the RCPsych website, and a number of conferences and training events were organised by the College to promote its dissemination.

As that original document only applied to adult care, Junior MARSIPAN guidance was developed in 2012, and in 2014, the adult document originally published in 2010 was revised. Owing to the insufficiency of randomised controlled trials in the field, the MARSIPAN guidance was initially based on expert consensus of best practice, rather than the

methods required by the NICE guidelines. However, it was quoted in the NICE Eating Disorder guidelines (NICE, 2017) in the context of the management of refeeding in hospitals. It is also referred to in the NHSE Commissioning guidance for specialist inpatient and community services. (National Collaborating Centre for Mental Health, 2019; NHS England, 2013).

Although the guidance was widely accepted by specialist services (particularly CAMHS eating disorder services and paediatrics), the College identified and acknowledged that many acute trusts did not implement it fully and consistently, which corresponds with your findings in this case. When exploring the reasons for this, we understood that the barriers to implementation included:

- the lack of targeted funding and training of the workforce
- the methodology and impact of RCPsych College Reports do not carry the same weight as the NICE guidelines
- an overlap with the NICE Nutrition Support for Adults guidelines (NICE, 2006), which acute trusts follow (even though that excludes eating disorders).

To address these issues, the College agreed on a major revision of MARSIPAN in 2019.This work is now close to completion and is due to be published in the first half of 2022. The main aims of the revision are to tackle the barriers identified previously to its implementation (to achieve wider acceptance and dissemination of these guidelines), and to widen the scope to include all eating disorders across the age range.

The revision has been supported by the College's National Collaborative Centre for Mental Health, and it has been developed via a robust methodology. Wide consultation on the draft has been taken forward with internal and external stakeholders, including other Faculties within the College, such as Child and Adolescent, General Adult and Liaison. We have and are still actively engaging with other medical Royal Colleges, the BDA, other charities such as BEAT, and experts by experience. We will be seeking endorsement from external stakeholders, including the Academy of Medical Royal Colleges (AOMRC). This process is important to ensure that clinicians, not just psychiatrists understand that they have a role to play in identifying and tackling eating disorders.

The College will also work with relevant stakeholders, such as HEE, AOMRC, RCGPs, RCPCH, RCEM, RCP and our College Curriculum committee to ensure that the guidelines are embedded in relevant undergraduate and postgraduate training materials.

However, implementation of the guidance will be dependent not just on dissemination but also on the leverage and resources that can and must emerge from those who are responsible for it. Therefore, we are also in discussion with NHSE/I to seek their active support and this engagement has been positive and we look forward to further work with and by them to help embed these new guidelines across the country.

Training

As reflected earlier in our response, to maximise the impact of these guidelines we will need to see a ramping up of the training and expansion of the workforce in mental health and beyond.

In terms of training, as Eating Disorder psychiatry is not a GMC recognised subspecialty, we have made significant efforts to address this gap. Following a national survey showing that most medical doctors receive fewer than 2 hours of training about eating disorders (Ayton and Ibrahim, 2018) and the PHSO report (Parliamentary and Health Service Ombudsman, 2017), we have been working with the GMC, HEE, Beat, NHSE PHSO implementation group, the RCPsych Curriculum committee, and examination panels. A summary of progress so far is shown below:

1. We published a Position Statement 'Improving Core Skills and Competence in Risk Assessment and Management of People with Eating Disorders: What all Doctors Need to Know', which provides a blueprint for training at all levels (Ayton et al., 2020) The key messages included:
    - There is an imperative to improve training in eating disorders for all undergraduate doctors in the interface between physical and mental health, alongside a greater emphasis on mental health in undergraduate training.
    - Postgraduate training in all specialties should include nutritional and psychological aspects of eating disorders, including recognition of severe malnutrition as a medical emergency, regardless of aetiology.
    - Leadership competencies should emphasise the need for all doctors to create and manage safe patient pathways across complex systems.
2. In collaboration with HEE and BEAT we developed online training materials about eating disorders for medical students and foundation trainees, which are freely available.

3. With funding and support from the GMC, we will be working with AOMRC on developing shared curricula about eating disorders for postgraduate training across relevant Royal Colleges. This work has started in January 2022.
4. The College Curriculum, Education and Training Committees are exploring how they can strengthen core and higher training in eating disorders. This work is still ongoing.
5. The RCPsych received funding from HEE to develop eating disorders credentialing, which will improve the standards of training for those who wish to specialise in the field. This work will be starting in the next few months.

Funding and Workforce

The implementation of best practice guidelines is dependent on appropriate funding and the development of the workforce, which we look to the Government to provide and support. There has been some welcome progress in resources in the recent past, particularly in relation to children and young people but to maximise the impact of the soon to be published guidelines this needs to be accelerated and expanded, in particular a larger focus on adults with eating disorders is crucial.

In terms of workforce developments, the data shows the scale of what needs to be done. According to the 2021 RCPsych Census, there are only 97 substantive consultants working in the field in the UK, and half of them are part time. Vacancy rates were recorded as 12%. Approximately half of the consultants work in independent specialist units, such as the Priory, which are not well integrated into local health care systems, and this may in some part explain the confusion and poor communication highlighted in your report.

These numbers are in stark contrast with the 23,954 patients needing hospitalisation for a primary or secondary diagnosis of eating disorder in 2020/21(NHS Digital, 2021). Many NHS specialist eating disorder services are running without or have minimal consultant psychiatrist input, a problem that was highlighted in a recent Reg 28 Report (Horstead, 2021). If there are insufficient specialists to help manage these patients and to advise colleagues who are unfamiliar with the condition, there remains the risk of similar tragedies in the future.

It is essential that all eating disorder services employ a consultant psychiatrist as part of specialist multidisciplinary teams, as they are the only professional group who have training both in the physical and mental

health aspects of eating disorders and assessing and managing complex cases. Consultants also have important roles in training, research and advising non-specialist services. The requirement for employing consultant psychiatrists is clearly specified in the NHSE Commissioning guidance and in the RCPsych Quality Network for Eating Disorders (QED), however, many NHS services have insufficient or no psychiatric input, and addressing this shortfall is essential for the prevention of future deaths. This will require an urgent expansion of training and consultant posts as part of the forthcoming investment into eating disorder services.

I hope you find this helpful and please let me know if I can be of any further help.

Yours sincerely,

[redacted] RCPsych Registrar

[redacted] RcPsych ED Faculty Chair

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National Medical Director and Interim
Chief Executive, NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

Ms J Kearsley, HM Senior Coroner
H M Coroner's Office – Manchester North
Floor 2&3 Newgate House
Newgate
Rochdale
OL16 1AT

[redacted]

[redacted]

18 February 2022

Dear Ms Kearsley,

Re: Regulation 28 Report to Prevent Future Deaths – Nichola Jane Lomax who died on 3 August 2020

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 4 December 2021 concerning the death of Nichola Jane Lomax on 3 August 2020. I would like to express my deep condolences to Nichola's family.

I note the inquest concluded Nichola's death was a result of the physical complications of the mental disorder anorexia nervosa, contributed to by neglect.

Following the inquest, you raised concerns in your Report regarding:

- Inadequate training of doctors and other medical professionals re eating disorders;
- Accessing specialist advice;
- Community monitoring of patients with an eating disorder; and
- Lack of recognition of the need to investigate.

I understand that colleagues in other organisations will also be responding to this. My response will therefore focus on what we are doing to improve adult eating disorder services in the NHS, both nationally and within the North West region.

Within NHS England and Improvement (NHSEI), we recognise that more needs to be done to support those with severe mental health problems, including eating disorders. The NHS Long Term Plan sets out an ambition to give adults and older adults with severe mental illness, including adult eating disorders, greater choice and control over their care and support them to live well in their communities. This programme also requires that, by 2023/24, all ICSs establish or expand dedicated community-based adult eating disorder services in line with published NHSEI guidance on improving community-based care for adults & older adults with eating

disorders.[1] By 2023/24 just under £1 billion of additional funding per year will be invested in community mental health services, including eating disorders.

Since April 2021 all ICSs have received funding to transform their adult community mental health services, including eating disorders. In 2021/22, 33 ICSs are transforming adult eating disorder services, with the remainder due to begin transformation of services in 2022/23. We are supporting this work with a significant training programme to upskill staff, as well as further activity to support key aspects of transformation such as imbedding early intervention models and improving connections with Primary Care.

Alongside community mental health transformation, there is also a cross-Government programme of activity to address wider issues with eating disorders, in response to recommendations for action made by the Parliamentary and Health Service Ombudsman's 2017 report "Ignoring the Alarms: How NHS eating disorder services are failing patients" and follow up 2019 report. As part of this work, NHSEI are currently developing the specification for a national all-ages clinical audit of eating disorder services, which will review the quality of care against NICE standards and seek to drive improvement of the identification and appropriate management of Eating Disorders and the quality and consistency of services.

I will now respond to each of your concerns in turn:

1. **Inadequate training of doctors and other medical professionals re eating disorders**

As part of community mental health transformation, NHSEI are working in partnership with Health Education England (HEE) on a number of different training courses for staff supporting individuals with eating disorders. These include "Whole Team Training for Eating Disorders" and "Eating disorder training for medical students, trainees and doctors" (commissioned with the VCS organisation Beat), which both promote use of MARSIPAN guidelines. HEE are also commissioning Beat to produce targeted eating disorder training for staff working in acute settings in 2022, which will include reference to MARSIPAN guidelines.

The Royal College of Psychiatrists is currently finalising "Guidance on Recognising and Managing Medical Emergencies in Eating Disorders" (replacing MARSIPAN and Junior MARSIPAN). We are in discussion with the College about how best to promote and embed this new guidance across all relevant clinical settings (including potential dissemination by liaison psychiatrists who work in general acute settings), and will also ensure training and guidance is updated to promote it. This guidance will be supported by all the Royal Colleges so it will be clear this product is relevant to staff outside of psychiatry.

This concern also reflects a wider challenge with the levels of training that doctors and other medical professionals receive on mental health. We believe this is imperative to support parity of esteem and improve patient care, particularly for

[1] Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers (england.nhs.uk)

eating disorders. This is not within our gift to deliver but we stand ready to support HEE, the General Medical Council and partners in their efforts to achieve this objective. I would recommend that this report is extended to the Medical Schools Council; who are able to influence the curriculums and training standards for doctors and medical professionals, in order to support this work.

Additional North West actions underway

Through the development of a Lead Provider Collaborative model for specialist Eating Disorder services, Cheshire & Wirral Partnership NHS Foundation Trust as lead provider for Specialised Eating Disorder services in the North West, are developing approaches to strengthen system leadership in the field of Eating Disorders. As part of this work, they have a number of priorities including the promulgation across the region of good practice in ED care; improving the clinical pathway for patients with Eating Disorders; the development of consistent protocols for the management of physical health risks of eating disorders in the community; and identification of workforce gaps in community services. Both the promulgation of best practice and the development of consistent protocols will have a positive impact on education and practice around Eating Disorder clinical management.

2. Accessing Specialist Advice

In 2019 NHS England and Improvement issued "Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care" national guidance for commissioners and providers. This highlights that one of the key functions of care for a comprehensive eating disorder service is to "offer advice, support and consultation to other services involved in a person's care".[2] Providers and commissioners are encouraged to develop pathways and protocols in line with this advice.

The introduction of mental health practitioners in Primary Care Networks (PCNs) should also enable easier access to specialist services. These staff are based in primary care but employed by mental health trusts, to support an integrated care pathway for people with severe mental illness, including eating disorders.

Additional North West actions underway

NHS bodies in Greater Manchester are committed to developing a model of community Eating Disorder services which fits that described in NHS England's 2019 guidance. This model, once in place, will be able to be perform the role of primary source of information and advice for all healthcare services that come into contact with patients with an Eating Disorder.

In addition, NHS England will work with the Specialised Eating Disorder services in the North West (CWP and The Priory) to clarify the expectation outlined in section 2.5 of the national service specification for Specialised Eating Disorder services around the scope of advice and guidance to acute medical and to psychiatric wards that this should include.

[2] Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers (england.nhs.uk) (p.8)

3. Community Monitoring of patients with an Eating Disorder

NHSEI's national guidance sets out a clear expectation that community eating disorder services develop integrated pathways with primary care and where responsibility for medical monitoring sits. The guidance is clear that that "Medical monitoring needs to be based on local medical monitoring agreements clearly established across the community eating disorder service and primary care network, with one consistent protocol agreed on by local commissioners. The protocol should be developed in collaboration with primary care services and clearly outline the responsibilities for each service (Table 2). A shared care pathway for medical monitoring should be produced."

Table 2: Responsibility for medical monitoring

CED service	Primary care
Person is at high medical risk and/or unable to reliably adhere to physical health monitoring in a primary care setting	Person is at moderate risk but recognises their need for health care and seeks it Person is at low medical risk Person is discharged from the CED service

The guidance further sets out "When responsibility for medical monitoring is assumed by primary care, the limitations of this need to be recognised and mitigated. The CED service should be accessible to provide specialist consultation to primary care to ensure results are interpreted correctly, regardless of whether a person is currently engaging with the CED service. To ensure that the CED service has capacity to reliably provide this, opportunities for upskilling other staff members (such as nurses) should be explored. A CED service that is accessible for consultation will facilitate GPs' safe acceptance of discharges from the CED service and reduce demand on the CED service's resources"

We are committed to ensuring a more integrated service across primary and secondary care for people with severe mental illnesses, including eating disorders. In order to receive system development funds for the expansion of adult community eating disorder services, when developing funding bids systems were required to "be clear on the arrangements for medical monitoring in partnership with primary care to manage the physical health needs of people with eating disorders" and 21/22 Mental Health Delivery Plan highlighted that systems should "ensure AED pathways have medical monitoring protocols in place with primary care".

Working with HEE, we have also commissioned eating disorder charity Beat to develop training to support staff in Primary Care which will include specific training on medical monitoring. NHSEI are currently exploring what additional resources could be developed to better support and engage Primary Care.

I noted earlier in this response work to introduce Mental Health Practitioners in Primary Care. Although these practitioners will not directly undertake the medical monitoring themselves, they will be able to liaise with the staff who will undertake it and help to ensure adequate oversight of the care of patients with severe mental illnesses, including eating disorders, across primary and secondary care.

Additional North West actions underway

NHS bodies in Greater Manchester are committed to developing a model of community Eating Disorder services which fits that described in NHS England's 2019 guidance. This model, once in place, will be in a position to undertake the medical monitoring of high risk and non-adherent patients whilst also offering specialist consultation to primary care for low-moderate risk patients and those discharged from the community Eating Disorder services.

4. Lack of Recognition of the need to Investigate

The National Medical Examiner is also concerned about deaths of people with eating disorders. In late 2021, the National Medical Examiner's team proposed a round table discussion with subject matter experts and stakeholders, including representatives from the Chief Coroner's office, with a view to publishing guidance for medical examiners through the National Medical Examiner's series of Good Practice papers. The round table discussion to inform this paper is due to take place in February 2022, with publication expected later in 2022.

The medical examiner system has been implemented at acute trusts on a non-statutory basis. Most trusts established medical examiner offices during 2020, after DHSC confirmed funding details in late December 2019. In the year to September 2021 (the most recent figures available) NHS trusts reported that medical examiners provided independent scrutiny of more than 185,000 deaths in England. The National Medical Examiner asked the regional medical examiner for the North West to confirm what involvement, if any, medical examiners had after the death of Nichola Jane Lomax. The lead medical examiner at Northern Care Alliance Foundation Trust confirmed that the medical examiner office was established after August 2020, and therefore, medical examiners were not involved in reviewing the circumstances of Ms Lomax's death.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

[redacted]
National Medical Director &
Interim Chief Executive, NHSI

Academy of Medical Royal Colleges

Ms Joanne Kearsley
Senior Coroner
HM Coroner's Court
Floors 2 and 3 Newgate House
Newgate
Rochdale OL16 1AT

11 February 2022

AoMRC response to Coroner's REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Academy of Medical Royal Colleges

10 Dallington Street
London, EC1V 0DB

[redacted]

Dear Ms Kearsley

Regulation 28: Report to Prevent Future Deaths Nichola Lomax

Thank you for the opportunity to respond to your findings from this tragic case. Where a death is potentially avoidable, the impact is immeasurably worse than it would otherwise be, and we want to extend our sympathies to the family of Nichola Lomax.

We are responding to the aspect of your report, reproduced below for ease of reference, that highlights the potential for a lack of awareness and understanding of MARSIPAN guidance to contribute to future deaths:

'...it reflects a complete absence of any understanding that MARSIPAN exists and indeed how to implement it in respect of the emergency treatment of an anorexic patient. Previous Regulation 28 reports suggests this remains an ongoing concern nationally and MARSIPAN is not being disseminated to practitioners on the ground. Whilst MARSIPAN can be accessed via a link in the NICE guidance on Eating Disorders, my concern is that Acute Trusts may not have sufficient regard to Guidance issued by Royal College of Psychiatry which is relevant to the medical care which they provide.'

The Academy of Medical Royal Colleges is the coordinating body for the UK and Ireland's 24 medical Royal Colleges and Faculties. We seek to help ensure that patients are safely and properly cared for by setting standards for the way postgraduate doctors are educated, trained and monitored throughout their careers. Individual royal colleges are independent organisations who are responsible for training and supporting their members in their particular clinical specialty.

Each college develops its own curriculum that must be approved by the General Medical Council (GMC). Postgraduate medical education is only one aspect of lifelong training for postgraduate doctors. Initiatives which focus solely on improving training curricula, whether for undergraduate or postgraduate doctors, important though they may be, will fail to address the bulk of the existing medical workforce who are not in formal training. Continuing Professional Development must also be considered, including Train the Trainer provision in order to ensure that doctors at all stages of their careers are kept up to date with all relevant knowledge.

One of the Academy's roles is to bring medical royal colleges together to identify and share best practice and ensure this is disseminated across all colleges. This includes education and training, guidance, and policies. We generate resources that our member organisations are free to take up or not, as they choose; we cannot mandate uptake.

We are keen to do all we can to improve the training of doctors, as part of wider efforts to ensure such tragic circumstances are not repeated, while acknowledging that medical curricula are already very full, making it challenging to add more content. In order to address this, we have gained a small amount of funding from the GMC to work with all relevant colleges to create a suite of shared curricula content that specialties can tailor to their own needs. The first area being covered is eating disorders.

The working group to create the shared content, or signpost to best practice that already exists, will be led by the Royal College of Psychiatrists, and the soon to be published updated guidance, formerly known as MARSIPAN, will be central to this work. You may also wish to be aware that, as part of its recognition of the importance that the colleges places on eating disorders, not just for psychiatrists but clinicians more widely, it published in 2020 a position statement to support better awareness and understanding of this issue across the healthcare family.

Improving core skills and competence in risk assessment and management of people with eating disorders: What all doctors need to know.

The updated guidance to replace the current MARSIPAN guidance provides an opportunity to both:

- Ensure clinicians have access to the most recent evidence-based information in relation to identifying and treating eating disorders

- Undertake a comprehensive dissemination plan, working with other key stakeholders such as NHSE/I, GMC and CQC to ensure that it is accessible to those who need to use it and clinicians are aware of where to source what they need.

The updated guidance from the Royal College of Psychiatrists will come to the Academy council (comprising the presidents of all the medical royal colleges) shortly for their cross-specialty support and adoption. The Academy will play its part in ensuring the revised guidance is circulated to all colleges and faculties.

To note, as is reflected in the dissemination plan proposed by the Royal College of Psychiatrists, they will need to work with others in getting it to the frontline, as there is currently no mechanism for them or us to circulate the guidance to individual frontline doctors. We simply do not have the means of contacting individual clinicians who are members of individual colleges and not of the Academy.

We look forward to working with the other agencies highlighted in your report to do all we can to ensure that these tragic events are not repeated.

Yours sincerely

[redacted]

[redacted]

Chief Executive Officer

Private and Confidential
Ms Kearsley
HM Senior Coroner
North Manchester

11th February 2022

Dear Ms Kearsley

I write on behalf of the Northern Care Alliance (NCA) in response to your Regulation 28 report received on 23 December 2021, issued following the inquest into the death of Nichola Lomax.

At the outset I would like to assure you that the NCA continues to take the issues raised by the investigations into Nichola's death very seriously and is continuing to take action to improve services.

In response to your specific areas of concern:

1. Inadequate training of doctors and other medical professionals re eating disorders

The NCA initial investigations highlighted a lack of awareness of MaRSiPAN guidance within the organisation and immediate actions were taken to address this, such as awareness posters, safety flashes and team presentations. Once the Trust investigation was complete, a formal plan to raise awareness of MaRSiPAN guidance and management of eating disorders in the acute setting was developed.

A QRG (Quick Reference Guide) has been developed for Salford, Bury and Oldham which informs all clinical staff of recognition, stratification and actions when a patient with Anorexia Nervosa is admitted to any of our acute hospitals. This also includes guidance on escalation and contact details for referral units in the community and Specialist Eating Disorders at the Priory. It has been disseminated around all staff within the Bury, Oldham, Rochdale and Salford Care Organisations. Why not Rochdale?

Two grand rounds were held at Fairfield General Hospital in November 2021 looking at management of eating disorders in an acute setting. Attendance was mandatory for all medics and as many nurses and advanced health practitioners (which includes dieticians) were asked to attend as possible. The presentation included emphasis on cascading learning to those who were not present. For those unable to attend due to clinical duties or leave, the presentation was recorded and has been circulated to all doctors, senior nurses and advanced health practitioners.

A training programme is currently in development with our local SEDU (Specialist Eating Disorder Unit), the Priory, and they have recently agreed to provide training to our dieticians. A meeting took place between the NCA, GMMH and Pennine Care in December 2021 to seek engagement for a training video and formulate a plan for its development. This view will include support and guidance on the Mental Health Act and the Mental Capacity Act including what legal options are open when managing complex eating disorders. Additionally, the training video will provide practical advice around having difficult conversations with patients etc. The video will be uploaded to the NCA intranet page so it can be easily accessible by all NCA employees.

In this meeting, there was discussion around setting up a MaRSiPAN working group at NCA level, and both Pennine Care and GMMH expressed a willingness to be involved. Identifying appropriate representation for this is underway.

Management of eating disorders in the acute setting has now been added to the junior doctor induction agenda and also forms part of the continuing education curriculum, to ensure on-going learning.

A Greater Manchester wide meeting was held on 27th January 2022 with all stakeholders, and all parties agreed to work collaboratively in management of patients with Anorexia Nervosa and will be extended to all mental health conditions. There will be a MaRSiPAN group set up and they will meet quarterly to review progress and ensure that lessons have been learnt and care for this specific group of patients is harmonised across the GM network.

2. Accessing specialist advice

It is acknowledged that at the time of Nichola's death and at the time of the inquest into her death, no pathway had been agreed between organisations to clarify how the clinicians at the NCA would access specialist advice in eating disorders. This pathway was in progress at the time of the inquest but has since been further developed.

The NCA learnt at the inquest that at the time of Nichola's death the community eating disorder service (CEDS) was not commissioned to accept her due to her low BMI. This was not within the knowledge of our clinicians and assumptions had been made that she was under services in the community, albeit the specifics of which team were not known.

It is our understanding that changes are being made to the Community Eating Disorder Service (CEDS) and what it can accept, such that they will be the go-to organisation for support when a patient attends an acute hospital. GMMH, who are commissioned to provide the CEDS, have confirmed that they can be contacted for specialist advice whilst waiting for the formal commissioning changes to take place. Confirmation has now been received on agreed arrangements for advice and guidance around eating disorders for Bury, Oldham and Rochdale's Care Organisations, and this will include first line advice for nutrition, escalating and sourcing of an in-patient bed. This information has been circulated to all of the NCA Care Organisations and will also be included within the guideline, referenced above.

Mental health services within Fairfield General Hospital will also be supplemented in the near future with the introduction of a CORE24 light service. This has been approved by the CCG and we understand that arrangements are in place to roll this out. We are advised that there is a commitment to expanding this to the full CORE24 service.

3. Nursing input and recording

You have raised a concern that the Trust's investigation team did not consider the nursing input into Nichola's care as part of its review. This was acknowledged as a failing at the inquest and evidence was given around changes to governance processes which are in progress, which will strengthen the governance and investigation of incidents going forward. The Bury Care Organisation (which manages Fairfield General Hospital) has relatively recently appointed a new Medical Director, Divisional Clinical Director for Unscheduled Care and a Divisional Director of Nursing all of whom are focusing on improvements to governance, investigations and lesson learning as part of their role.

You further raised a concern around the poor monitoring of Nichola's food intake and purging behaviours, as well as the standards of documentation around her fluids and nutrition. Bury Care Organisation's nutrition and hydration steering group has developed a nutrition improvement plan, which includes the development of new food charts as discussed at the inquest. In addition, this group is focusing on actions including:

- A requirement to weigh patients in the Emergency Department (ED) where an eating disorder is the reason for the attendance. This instruction has been shared with all registered nurses and assistant practitioners in the ED.
- Reminder that Mid Upper Arm Circumference should not be used to assess a Malnutrition Universal Screening Tool score except in stated exceptional circumstances. This is included in the electronic assessment
- The MUST assessment has changed to include the patient's recent eating history.
- The MUST assessment now auto-selects the correct risk care plan and shows the dietetics referral form to be completed if a patient is high risk.
- Food charts will be further updated to include a specific section for supplements and snacks.
- MUST training will be mandatory, with roll out of new training by March 2022.
- Focus on training for clinical support workers regarding food charts and supplements - to include trust induction, ward induction, care certificate and ad hoc training on the wards.
- Dieticians to attend handovers/board rounds, to increase staff awareness of which patients are high risk, have food charts or require supplements.
- Ward based training from Practice Educators (including 2 newly funded hospital-wide nursing educators) around nutrition, MUST, supplements.
- Re-introduction post-Covid, of link nurses for nutrition, with a consideration of new ways to encourage attendance at link nurse meetings.

GMMH have also agreed to support us in developing a teaching and advice pack for our ward nurses, to provide them with further guidance and support around recognition of behaviours common in eating disorders, such as purging, and this is in progress.

I trust that this letter provides reassurance to yourself, and to Nichola's family, that the NCA is continuing to take forward the improvements which were discussed at the inquest and is continually looking at ways to ensure we are providing the best possible service to our patients. Sadly, the system was not set up to provide full support to patients such as Nichola but we are assured through communication with other organisations involved that action is being taken to change this.

From an NCA perspective, we are committed to ensuring that the momentum of improvement continues.

Yours sincerely

Chief Officer

Northern Care Alliance
NHS Foundation Trust

Ms J Kearsley
Senior Coroner
Newgate House
Newgate
Rochdale

[redacted]

Popham Centre
Fairfield District General Hospital
Bury
[redacted]

Friday 12th August 2022

Dear Ms Kearsley

I write on behalf of the Northern Care Alliance NHS Foundation Trust to update you on developments in respect of action taken to improve services following the tragic death of Nichola Lomax and the inquest into her death heard in November 2021.

During the inquest into Ms Lomax's death, lesson learning evidence was provided to the Court by [redacted], detailing the steps taken since the incident and lessons learned by the Trust to effect change and improve services offered to patients presenting with an eating disorder. A full action plan was put in place in response to the Trust's investigation. It was identified during the Trust's investigation that prior to Ms Lomax's death, dissemination, and awareness of the Management of Really Sick Patients with Anorexia ("MARSIPAN") guidelines in place at the time was sporadic across the NCA's care organisations. The Trust undertook immediate steps whilst the investigation was ongoing to raise awareness of the guidelines.

A further update on the Trust's continued action to improve services and addressing your specific areas of concern raised in the Regulation 28 report issued following in the inquest was provided on 11 February 2022. Since this time, updated guidance around the recognition and management for Medical Emergencies in Eating Disorders ("MEED") was released by the Royal College of Psychiatrists in May 2022. This replaces the previous MARSIPAN guidance that was in place at the time of Ms Lomax's death.
The Trust is now taking steps to update all applicable guidance documents and policies to reflect the current MEED guidance. An NCA-wide steering group is in development to agree a NCA level MEED Quick Reference Guide. This will be monitored and progressed through system partners who will discuss and confirm governance arrangements under the Integrated Care System.

It was described in the Trust's regulation 28 response that engagement was being sought for a training video and formulating a plan for its development. I would like to advise you that this action has been superseded as a result of the updated MEED guidance. In response to MEED, a national app has been developed which includes a full suite of guidance and information with videos and support. The Trust is now working to roll the app out and raise awareness of this across all Care Organisations alongside updating associated policies and guidance. The first Steering Group is scheduled for early September. We will of course keep you appraised of organisational developments in due course.

Please do not hesitate to contact me if you have any questions or require any further information.

Yours sincerely,

[redacted]

Associate Director of Patient Safety

NHS
Greater Manchester
Mental Health
NHS Foundation Trust

PRIVATE & CONFIDENTIAL

Ms Joanne Kearsley, HM Senior Coroner
Manchester North Coroner's Office
Floors 2 and 3
Newgate House
Rochdale
OL16 1AT

Trust Management Offices
First Floor, The Curve
Bury New Road
Prestwich
Manchester
M25 3BL

[redacted]
Web: www.gmmh.nhs.uk
WE ARE SOCIAL

4 February 2022

Dear Ms Kearsley

Re: Nichola Lomax (deceased) Regulation 28 Preventing Future Deaths Response

On behalf of GMMH I would like to offer Ms Lomax's family our sincere condolences at this difficult time.

Ms Kearsley, thank you for highlighting your concerns during Ms Lomax's Inquest which concluded on 10th December 2021.

On behalf of the Trust can I apologise that you have had to bring these matters of concern to the Trust's attention. I hope the response below demonstrates to you and Ms Lomax's family that GMMH have taken the concerns you have raised seriously and will learn from this.

Please see the Trust's response in relation to the concerns you have raised and the actions taken by the Trust:

Accessing Specialist Advice

For National, NCA/GMMH/PRIORY

None of the practitioners in Nichola's case knew how to access specialist eating disorder advice including medical or dietetic advice. There are no pathways to assist acute clinicians in how to access this specialist advice. To this day the clinicians told the Court they would not know where to go other than to try and contact the Priory. The Court heard from the Priory they are not commissioned to provide advice.

Greater Manchester Mental Health NHS Foundation Trust (GMMH) welcomes the recent investment by Bury Clinical Commissioning Group (CCG) in the new GMMH clinical model for adult eating disorders which is compliant with national commissioning guidance. This funding commitment will enable the provision of more comprehensive care and treatment to adults with eating disorders under GMMH. This will enable GMMH Community Eating Disorder Services (CEDS) to build on previous advice provided regarding MARSIPAN and dietetic advice to Fairfield General Hospital (FGH) and other acute hospitals across Greater Manchester and to work closely with partner organisations to develop robust pathways to ensure access to specialist advice.

Specifically, the following actions have now been taken to enable acute care clinicians access to specialist advice:

- We have appointed a Consultant Psychiatrist in the GMMH Manchester Service who has established Standard Operating Procedures for the care of patients with Anorexia at Manchester

Royal Infirmary and Wythenshawe Hospitals. These will be used as a template for FGH and the Northern Care Alliance (NCA) to ensure clarity of pathways and standardisation of response and management.

- Due to workforce challenges locally and nationally in recruitment of Consultant Psychiatrists specialising in eating disorders, GMMH have to date been unable to successfully recruit a second Consultant Psychiatrist in GMMH, despite significant efforts. GMMH are currently exploring alternative medical roles across GMMH to enable us to provide this specialist advice consistently in all areas we serve.
- GMMH are working with colleagues initially at NCA and Priory to establish an effective network or virtual advisory group to then be shared with all acute hospitals with the GMMH footprint to ensure they also have access to specialist advice regarding the implementation of MARSIPAN guidance.
- A MARSIPAN Checklist and Quick Reference Guide to allow for MARSIPAN cases to be identified and management to be followed with contact details for GMMH CEDS are now in place at Emergency Departments and Acute Medical Units across NCA. Information has been disseminated across NCA that GMMH CEDS can provide dietetic advice and general support during office hours and can access support out of hours via the Mental Health Liaison Service. Robust procedures in FGH will include contacting GMMH CEDS within office hours to advise of a MARSIPAN admission, for provision of dietetic advice and discussion of discharge plan/onward referral to Specialist Eating Disorder Unit if indicated. GMMH CEDS will continue to action referrals to Specialist Eating Disorder Units as per the current procedure.
- GMMH CEDS are supporting NCA in the development of these pathways to be disseminated across NCA including criteria for access to GMMH and a meeting took place including NCA, Priory and GMMH week commencing 7th February 2022. Part of this work includes GMMH CEDS supporting NCA in the development of dietetic and nursing protocols/MARSIPAN guidance which will be available to acute staff on their intranet.
- A training event has been provisionally scheduled to take place in June 2022 with key stakeholders and Clinical Leads to ensure awareness of the new guidelines which will replace MARSIPAN following publication of these.

Referral Criteria for the Priory and Community Eating Disorder Service

For GMMH, PRIORY, BURY CLINICAL COMMISSIONING, ICB

In Greater Manchester the Community Eating Disorder Service (CEDS) do not accept patients who have a BMI of less than 14. The court heard this is in part due to the structure and commissioning of the service. Adherence to this criteria had the following implications for Nichola's care:

- **As the only service who can refer to the Priory, CEDS become aware of Nichola. CEDS involvement created the impression that they were providing care to her. This created a confused picture as to who was co-ordinating her care.**
- **This meant that monitoring of Nichola was undertaken by the GP practice who were not specialists and had limited knowledge of eating disorders. It would have been more clinically appropriate for CEDS to have taken on this role and the court heard that in many other areas of the country the CEDS accept patients with BMIs lower than 14 and have responsibility for the monitoring and co-ordination of the patients care.**

The Court heard evidence from a number of practitioners as to their understanding of the referral criteria for Nichola to be admitted to The Priory. The clear impression given by The Priory was that Nichola would not be accepted until 1) a bed became available but also 2) her BMI increased to somewhere around 12/13. The Court was told that the rationale for this is that a patient with a BMI below 13 is at high risk of refeeding according to MARSIPAN and more likely to require an acute hospital admission.

This impression meant that hospital clinicians and the GP understood that Nichola would not be accepted by the Priory until her weight had increased. However the court heard that the Priory can take someone with a BMI of less than 13 if medically stable and the benefits of specialist care

outweigh the risks of refeeding. Given the impression created by the Priory no attempt was made to obtain an emergency bed for Nichola who was medically stable for some time after the 11th June

CEDs across the country that care for patients with BMIs below 14 have medical staff within the team, which enables them to safely monitor and manage the significant physical health risks which accompany such low BMIs. As outlined above, this pathway was not commissioned in GMMH CEDS until very recently. In the absence of this specialist medical staff within the CEDS it was not possible to safely manage the care of these patients in the community, and the role of the CEDS was to facilitate admission, either to the specialist unit at the Priory, or for medical stabilisation in an acute hospital.

In future, having established a medical monitoring pathway within CEDS, it will be possible to care for patients with BMIs lower than 14. GMMH will accept referrals to the CEDS for patients who, in agreement with the referrer and GMMH are considered to be medically stable to be managed in the community, and this will not be based on BMI alone. We will continue to refer patients when appropriate to the Specialist Unit at the Priory and escalate the referral to NHS England if a bed is not available when required.

Delay in Re-Referral

For GMMH/PRIORY

Due to a misunderstanding following the telephone discussion between the Priory and FGH on 11th June Nichola was clearly removed from the Priory waiting list. This led to confusion for the GP practice who did not know why she had been removed. There was then a delay by the CEDS in re-referring Nichola which on balance likely led to a delay in a bed being available. This should not have occurred and more worryingly had not been noted as there had been no incident review of this case by either the Priory or the CEDS.

The CEDS internal review found that although FGH had advised the Priory that the bed was no longer needed, Nichola was never removed from the waiting list, as there was a conversation between the CEDS clinician and the Priory Consultant on 19 June 2020, which established that the bed was still required. As part of establishing robust protocols for NCA/acute hospitals, prior to discharge, a clear discharge plan will be identified with the receiving team to prevent the confusion that arose in this case.

Ms Kearsley, on behalf of the Trust can I thank you for bringing these matters of concern to the Trust's attention. Your conclusions have greatly assisted in raising the awareness and commitment of the GM system to work together to improve the care provided to adults with eating disorders who have acute medical care needs. There is a firm commitment from organisations to establish clear MARSIPAN pathways and protocols with associated training to ensure staff are knowledgeable and confident to enable the provision of safe and effective management in these cases.

I hope this response demonstrates to you and Ms Lomax's family that GMMH have taken the concerns you have raised seriously. If you have any further questions in relation to the Trust's response, please do let me know.

Yours Sincerely,

[redacted]

[redacted]
Medical Director
GMC 3548585

CO

PRIORY
Part of MEDIAN

[redacted]
Director of Risk Management
Priory
Fifth floor
80 Hammersmith Road
London, W14 8UD
[redacted]

Monday 21 February 2022

Ms Joanne Kearsley
Senior Coroner, Manchester North
HM Coroners Court
Floors 2 and 3
Newgate House
Newgate
Rochdale, OL16 1AT

25 FEB 2022

Dear Ms Kearsley

Death of Ms Nichola Lomax; Date of birth: 28 April 1984 – Date of death: 3 August 2020

I write in response to the Regulation 28 Report dated Thursday 23 December 2021 issued following the Inquest touching the death of Ms Nichola Jane Lomax. Please accept my apologies for the delay in sending our letter to you – unfortunately I had to take time away from work unexpectedly and it is only today upon my return that I have been able to finalise our response.

Your Regulation 28 Report has identified a number of matters of concern that are addressed to several organisations. The responsibility for achieving the required actions is shared by those organisations and Priory has liaised with the relevant organisations as required in response to the Inquest and your subsequent Regulation 28 Report.

We are satisfied that this liaison and dialogue will continue and improve particularly given the relatively recent introduction of the provider collaborative (in this case the Adult Eating Disorders Services, North West, NHS-Led Provider Collaborative 'EmpowerED') which will commission eating disorder services. The provider collaborative has a responsibility for ensuring that there is in place an effective dialogue, alliance and understanding between local services as a means of enhancing patient care pathways. The introduction of the provider collaborative is particularly helpful for those services with a responsibility for providing care and treatment to people with eating disorders given our acknowledgement that in such cases there is a requirement to have the involvement of several stakeholders. Such services include, as we saw in respect of Ms Lomax, general practice, acute hospitals and community and inpatient eating disorder services.

I now turn to the matters of concern that you have directed to Priory.

1. Accessing Specialist Advice

For clarification please note that Priory Hospital Cheadle Royal is commissioned to provide inpatient care and treatment to patients with an eating disorder. The service is not commissioned to provide interventions in the community other than to undertake patient assessments that may or may not result in patient admission.

A meeting, attended by Consultant Psychiatrist [redacted] and I was held with Northern Care Alliance and the Community Eating Disorders Service on Thursday 10 February 2022. During the meeting there was agreement that efforts would be made to enhance communication and understanding by virtue of developing a shared standard operating procedure and training. The standard operating procedure is under development and will in effect be a shared document which is owned by the relevant stakeholders. The standard operating procedure will also be shared with the provider collaborative and a request made for this to be an agenda item at the next liaison meeting.

2. Referral criteria for the Priory

We have identified referral criteria that we have concluded are accurate for the adult inpatient eating disorder services that Priory Hospital Cheadle Royal provides. It should be noted however that there is always a requirement for some flexibility and proportionality around such criteria given the particular circumstances of each individual patient for example their history, current presentation and any particular current risks that may impact upon their care and treatment. The inclusion and exclusion criteria are as follows:

Inclusion

The following criteria are proposed as being reasonable grounds for accepting a referral:

- 18-years of age and over
- Male or female
- Any clinically significant eating disorder – with a diagnosis in place
- The person has a body mass index of 10 or greater
- Medically stable and the benefits of an inpatient eating disorders admission outweigh the risk of refeeding syndrome
- Patients who are under a section of the Mental Health Act
- The patient requires nasogastric feeding
- There is bed availability either now or in the very near future and the ward has capacity for the patient to be accepted

Exclusion

The following criteria are proposed as being reasonable grounds for refusing a referral:

- The person is severely physically unwell requiring treatment beyond the expertise of the unit
- The person's body mass index is less than 10
- The person presents as having a serious mental disorder and is acutely unwell meaning that there may be interference with the required treatment for the eating disorder
- That the person presents as being a risk of significant violence to others

The inclusion and exclusion criteria are in the process of being shared and considered with our stakeholders however we anticipate they will be accepted given their similarity to those in use by inpatient wards elsewhere in the country.

3. Delay in re-referral

It was agreed during the meeting held on Thursday 10 February 2022 that in those instances where a patient is being cared for by the acute hospital i.e. Fairfield General Hospital, then the first point of contact in terms of making a referral to specialist inpatient eating disorder services will be the community eating disorders service with the agreement that a practitioner from that team will undertake an assessment and make recommendations for onward care (which is likely to be either continued inpatient care at the acute hospital, discharge into the community under the care of the community eating disorder team or admission to a specialist inpatient eating disorder unit care for example at Priory Hospital Cheadle Royal).

I trust that the actions outlined above will provide the assurances you seek in respect of this matter.

Yours sincerely,

[redacted]

Director of Risk Management (UK)

NHS
Health Education England

Directorate of Education & Quality
2nd Floor, Stewart House
32 Russell Square
London WC1B 5DN

Business Coordinator: [redacted]

Email: [redacted]

Joanne Kearsley
Senior Coroner for the Coroner area
of Manchester North

[redacted]

14th February 2022

Dear Joanne Kearsley,

RE: Nichola Jane Lomax – Regulation 28 Report

I write in response to your report of 17 December 2021 made under *the Coroners (Investigations) Regulations 2013*. Please may I start by offering my sincere condolences to Nichola Lomax's family following her death.

Your report raises concerns regarding the care that Nichola Lomax received, together with the training of doctors and other medical professionals in relation to mental health conditions and eating disorders. Your report also highlighted concerns around the knowledge and awareness of health professionals; specifically highlighting what appeared to be a lack of knowledge of the Management of Really Sick Patients with Anorexia Nervosa guidance (MARSIPAN). We note that Health Education England (HEE) has been identified as having a duty to respond and the report has also been sent to a number of bodies including: The Secretary of State for Health and Social Care; the Chair of the Faculty of Eating Disorders Royal College of Psychiatrists; the Chief Executive Officer of NHS England; The Chief Executive of the Academy of Medical Royal Colleges; together with local health agencies and providers who were involved in the care of Nichola Lomax prior to her death.

To respond to your concerns, I will first clarify HEE's role and in the education and training of the medical, nursing and health workforce. HEE is a non-departmental public body accountable to the Secretary of State and Parliament. We are part of the NHS and work with partners to plan, recruit, educate and train the health workforce. Though HEE serves the people of England by educating, training and developing healthcare professionals, we do not have responsibility for the design and delivery of undergraduate medical education. Each individual medical school sets its own undergraduate medical curriculum. Additionally in relation to postgraduate medical

education, the various curricula for postgraduate specialty training are set by individual Medical Royal Colleges against standards set by the General Medical Council.

Whilst the curriculum for medical education does not mandate how Foundation doctors learn about specific conditions, as different learners and educators will have preferred styles within their own setting. The 2021 Foundation Programme curriculum includes an explicit statement around parity between physical and mental health. Foundation doctors are now expected to learn about mental health issues much more than in the past. In addition, the MARSIPAN guidelines have been presented to Foundation School Directors and there has been other discussion on learning and eating disorders within the Foundation Programme.

As part of reviewing this case, we have shared your report with colleagues here within HEE, including our Dean with lead responsibility for Mental Health. Together with our Mental Health Programme, the UK Foundation Programme Office and our Deputy Chief Nurse. We believe that your report provides important learning and both the circumstances and concerns in your report are vitally important in demonstrating the need to increase awareness and understanding of the training and clinical guidance already available to practitioners.

I should also highlight some of the work that HEE has been involved in, either to support better awareness or strengthen professional practice through continuing professional development. This includes a new teaching package on eating disorders for foundation programmes that has been developed by the charity Beat Eating Disorder, in collaboration with Health Education England and the Royal College of Psychiatrists, and with the support of the General Medical Council. This training was created in response to the Parliamentary Health Service Ombudsman investigation into avoidable deaths from eating disorders and has been written by experienced clinical trainers and developed with input from senior clinicians, medical students, people with lived experience, and advisors from the General Medical Council and Health Education England. Further information on this training can be found here: https://www.e-lfh.org.uk/programmes/eating-disorders-training-for-medical-students-and-foundation-doctors/

Beating Eating Disorder has previously endorsed MARSIPAN and though HEE is not a member of the MARSIPAN working group, we have circulated information on their work and guidance. We understand that they are working towards issuing revised guidance in 2022 and we will then seek to ensure this is disseminated to relevant teams and colleagues here at HEE.

HEE is also working with NHSE/I and a range of stakeholders to continually enhance and develop the education and development offer in respect of eating disorders. We have a suite of training available for specialist eating disorders teams including Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), Cognitive Behavioural Therapy for eating disorders (CBT-ed), and Whole Team Training for eating disorders. We are currently launching on-line training for nursing staff and HEE has recently commissioned training for GPs and primary care staff. HEE's plans for 2022/23 also involve enhancing and expanding this suite of training across the breadth of the NHS workforce.

HEE is commissioning training to develop the skills and knowledge of professionals who have contact with young people with an eating disorder; this is in direct response to feedback from services around their identified training needs. This includes additional training in Avoidant Restrictive Food Intake Disorder, training to support parents, carers and families, and awareness training for staff who require the skills to identify early signs and symptoms of an eating disorder. Work is underway to develop an online resources hub, covering both the physical and mental health implications of an eating disorder.

I hope this response provides assurance that steps are being taken to make sure that there is shared learning from the death of Nichola Lomax. We recognise the importance of improving the awareness of learning and resources available to clinical practitioners involved in caring for people with mental health conditions. We also know that recovery may for many people be a life-long journey and so we recognise the importance of making sure our staff have the right learning and skills to give the right support at all stages of the patient journey.

Finally, on behalf of HEE, I thank you for bringing these matters to our attention.

Yours faithfully,

Executive Director of Education and Quality & National Medical Director

NHS
Bury
Clinical Commissioning Group

Headquarters:
Townside Primary Care Centre
1 Knowsley Place
Knowsley Street
Bury
BL9 0SN

[redacted]

[redacted]

HM Senior Coroner
Rochdale Coroner's Court
Newgate House
Newgate
Rochdale
OL16 1AT

3 February 2022

Dear Ms Kearsley

I write on behalf of Bury CCG in response to your Regulation 28 report received on 23 December 2021, issued following the inquest into the death of Nichola Lomax. I will address the CCG's response to each of your concerns individually below.

1. Referral Criteria for the Priory and Community Eating Disorder Service

It is acknowledged that at the time of Nichola's involvement with the service, the community eating disorder service (CEDS) commissioned by the CCG and provided by Greater Manchester Mental Health NHS FT (GMMH) had an acceptance criteria of a BMI of 14 or more, and that this meant that she was unable to access the service. The service for Bury patients was significantly under commissioned in relation to the level of presenting demand and was not commissioned to provide medical input to support monitoring of patients with more complex needs.

A business case to expand the service in line with national standards and Greater Manchester and local priorities has been agreed between the CCG and GMMH, and was formally approved by the CCG board on 22 December 2021. I understand that the court was provided with a copy of this business case by GMMH during the course of the inquest; a further copy can be provided if needed. The new model as agreed includes the addition of psychiatry/ medical input to the service (a Consultant Psychiatrist and a Physical Health Practitioner) which will allow patients with a BMI of less than 14 to be accepted by the service and monitored medically by a clinician who has experience and knowledge of eating disorders. In addition it will include:

- Increase in provision to meet the demand of 53 referrals per annum for Assessment.
- Increased psychological therapist and dietitian capacity to meet the demand for the service. This will enable the service to be responsive and achieve the same waiting times for treatment as for Children and Young People. It will also allow the service to continue to offer high quality NICE compliant/evidence-based interventions.

- The increased capacity of psychological therapist and dietitian time will allow for the service to have capacity to meet the treatment length of interventions for anorexia nervosa.
- A range of NICE compliant/evidence-based interventions delivered in both group and individual formats. This will enable service user choice.

- Psychiatry/medical input to enable robust medical monitoring and management and support for staff in other setting managing individuals with the physical risks of an eating disorder. As part of the new psychiatry/medical pathway, the service will also be able to offer phlebotomy and ECGs within the service to enable ease of access and more rapid results and therefore a safer pathway.
- Psychiatry time to enhance the service offered to referrals accepted by the service with increased physical/mental health complexity.
- A FREED pathway to enable a responsive service and treatments tailored to the needs to emerging adults with eating disorder to be delivered.
- A SEED pathway to enable a pathway for those individuals who meet criteria for a severe and enduring eating disorder.
- The service will continue to attend Care Programme Approach (CPA) of individuals referred to the intensive parts of the EDS pathway to contribute to care planning and discharge planning and a smooth transition back to GMMH EDS.
- The service will continue to offer regular coproduced and cofacilitated eating disorder training accessibility to staff, services users and carers in all boroughs via GMMH Recovery Academy and other bespoke training as required.
- The service will continue to offer carer psychoeducation, skills training, support, and a regular carers support group cofacilitated by staff and carers with expertise by experience.

The inclusion of Psychiatry time will also enhance the service offer to manage referrals of increased complexity including those with other physical health comorbidities e.g. Type 1 diabetes and mental health comorbidities e.g. individuals with significant depression and those with significant personality disorder traits/diagnoses, both of which have increased in referrals received by the service. The inclusion of psychiatry time would allow the service to support staff in other health settings including acute physical and mental health hospitals and the service is planning to develop MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa, 2014) groups across the footprint of the services, alongside the psychiatry colleagues providing inpatient eating disorder care at The Priory, Cheadle.

GMMH have been notified of the CCG commitment to invest and are working locally with recruitment across Greater Manchester to the roles requires to support the expansion of the service. GMMH are best placed to advise as to timescales for implementation of the business plan but the information we have currently is that the post for a consultant psychiatrist has been out to advert twice last year and there have been no applicants due to a national and local shortage. Various methods are being tried to identify a suitable applicant, including considering GPSI. I understand that work is underway nationally to look at training and a pathway for non-psychiatry staff in these roles, led by Health Education England and the Royal College of Psychiatry.

The referral criteria for the Priory is best addressed by other organisations but we understand from recent GM meetings that BMI should not be used as a threshold for determining admission as a matter of policy and it is not now relevant in referrals to the CEDS or from there to the Priory.

2. <u>Lack of Critical Services</u>

The mental health provision at Fairfield General Hospital in 2020 at the time of Nichola's attendances did not meet the current CORE 24 standard. At the board meeting on 22 December 2021 the CCG approved the funding to commission a CORE 24 light service as a step towards meeting the standards of a full CORE 24 model. This is a jointly commissioned service between Bury and Heywood, Middleton and Rochdale CCG (HMR CCG).

A business case for a full CORE 24 service was developed in conjunction with Pennine Care NHS Foundation Trust by a Task and Finish Group which had been set up to review the performance of the current service. The CORE 24 service will:

- Provide an all age 24/7 service to the A&E and all acute wards in Bury and HMR;
- Access to a medical staff for diagnostic assessment and treatment;
- Provide a self-harm follow up clinic within 72 hours.

In December 2020 the Bury Strategic Commissioning Board agreed to commissioned a pilot of an Urgent Emergency Care by Appointment service (UEC) which provides urgent appointments for people with mental health needs who would have otherwise accessed urgent care services at the ED, contacted NHS 111 or been directed to an ED by their GP. The service aims to provide an urgent mental health assessment within 24-72 hours to determine the person's mental health needs thereafter. The UEC service continues to achieve excellent outcomes in diverting activity away from front end A&E and provides bookable appointments for people presenting with urgent mental health needs.

Given the commitments made by Bury and HMR for the UEC by appointment service PCFT have produced a subsequent proposal for the commissioning and provision of a Core 24 "light" service across Fairfield General Site and Bury and Rochdale UCC. This request to the CCG is for a scaled down version of a Core 24 model encompassing the all-age element of a Mental Health Liaison service however recognises the ambition to achieve Core 24 standards as per NICE guidelines over time and taking a phased approach to investment. Greater Manchester Health & Social Care Partnership (GMHSCP) soon to become the GM Integrated Commissioning System (ICS) are supportive of the development of the Core 24 Light service offer and have already committed FGH's share of the GM transformation monies to allow PCFT to begin mobilising the service.

The key outcomes of a Mental Health Liaison CORE 24 light service include:

- Increased medical time
- Provision of an all-age service
- Provision of all-age assessment to the acute wards
- Provides the street triage service
- Reduces the waiting times for patients on medical wards
- Continuity of care for patients attending A&E or admitted to an acute ward.

The new service will provide:

- 1 WTE liaison consultant psychiatrist
- 1 WTE medical secretary
- 1 WTE admin staff
- 2 band 6 mental health practitioners
- Upskilling and re-banding of 3 band 5 nurses to band 6 roles
- 3 Band 2 support workers

Recruitment for these posts has started, although limitations of workforce availability are a concern. There will still be some gaps remaining until the service moves to a fully compliant Mental Health Liaison Core 24 model in that there is no clinical lead within this model and the service would not meet many of the Psychiatric Liaison Accreditation Network (PLAN) standards which are best practice standards for liaison psychiatry services.

Additional services are also in place to support the mental health crisis offer and mitigate the potential risks of the gaps remaining, including the UEC appointment service described above. On 3rd April 2020, Claire Murdoch (National Mental Health Director - NHS England and NHS Improvement) wrote to Mental Health Trust CEOs confirming that all mental health Trusts across the country, working alongside CCGs and ICS, to urgently take the following actions:

- Establish 24/7 open access telephone lines for urgent NHS mental health support, advice and triage, and through which people of all ages can access the NHS urgent mental health pathway/further support if needed.
- Ensure that the 24/7 open access crisis line telephone number(s) and contact details
- are available to the public, clearly on the website.

To meet these requirements, both the GM Mental Health Trusts have developed 24/7 open access for known and unknown service users. This meets key criteria in the GM responding to Mental Health crisis model.

Bury Peer Led Crisis service is also in place for people experiencing a mental health crisis and are at risk of suicide, it was launched in April 2021 as a 12-month pilot and approval is currently being sought to extend the term of the service based on the outcomes achieved. It is provided by a local organisation BIG in Mental Health and provides peer led support in a non-clinical environment to adults experiencing a mental health crisis including those who are at risk of suicide. The service has developed robust pathways with the PCFT Mental Health Liaison service and is an integral part of the Bury Mental Health Crisis Pathway.

In summary, it is acknowledged that the proposed new CORE 24 light service is still a little short of the full CORE 24 light, but it is a significant step towards providing a full service. It is a pragmatic and deliverable step forward in response to the lack of staffing and available investment to deliver a full core 24 service now in one cycle of investment. A full CORE 24 service will require further investment and workforce development and we understand that a GM business case has been submitted to NHS England to secure the necessary funding to convert the light service into the full service. In conjunction with the other initiatives described above, the mental health service offering is vastly improved.

3. Community Monitoring of patients with an Eating Disorder

Future plans for this are addressed in detail above; the medical monitoring of patients with an eating disorder will be included within the service offered by the community eating disorder service.

It is hoped that this response provides assurance to the court that the CCG is taking the gaps in commissioning of mental health services identified very seriously and that action has already been taken for improvement. Unfortunately, wide scale changes to the service provision cannot be achieved immediately but it is a priority for the CCG and we are working closely with our partners to ensure that the actions which we have committed to are progressed as quickly as possible.

Yours sincerely

[redacted]

[redacted]
Accountable Officer for Bury CCG

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Social Care Partnership
4th Floor
3 Piccadilly Place
London Road
Manchester M1 3BN

[redacted]

Date: 11 February 2022

Ms J Kearsley
HM Senior Coroner
HM Coroners Court,
Floors 2 and 3,
Newgate House,
Newgate,
Rochdale,
OL16 1AT

Dear Ms Kearsley

Re: Regulation 28 Report to Prevent Future Deaths – Nichola Jane Lomax 03/08/20

Thank you for your Regulation 28 Report dated 17/12/21 concerning the sad death of Nichola Jane Lomax on 03/08/20. On behalf of Greater Manchester Health & Social Care Partnership or GMHSCP (which pending legislation will develop into the GM Integrated Care Board (ICB) from the current shadow structures in July 2022), I would like to begin by offering our sincere condolences to Ms Lomax's family for their loss.

Thank you for highlighting your concerns during Ms Lomax's Inquest which concluded on 10th December 2021. On behalf of the Partnership, I apologise that you have had to bring these matters of concern to our attention but it is also very important to ensure we make the necessary improvements to the quality and safety of future services.

The inquest concluded that Nichola's death was a result of 1a) Liver Failure 1b) Anorexia Nervosa 2. Refeeding syndrome and cholecystitis.

Following the inquest, you raised concerns in your Regulation 28 Report to Greater Manchester Health and Social Care Partnership (GMHSCP) that there is a risk future deaths will occur unless action is taken.

I hope the response below demonstrates to you and Ms Lomax's family that GMHSCP have taken the concerns you have raised seriously and will learn from this as a whole system.

It is important to note that as part of the GMHSCP role of facilitating GM-wide mental health transformation programmes (and associated investment) and providing strategic support to locality commissioners and providers on development of specialist and community mental health services - we convened all the key stakeholders referenced in your report to discuss lessons to be learned in a collaborative way and as a system wide quality panel. This was chaired by the GMHSCP Executive Medical Lead for Mental Health and a review panel will be convened in 3 months. This will help ensure going forward a coordinated set of actions in response to this Regulation 28 Notice Report. We hope that the subsequent agency responses that you receive positively address all the key areas of concern at an individual and wider collective system level.

Please now see the Partnership's response in relation to the specific concerns you have raised for us, the actions agreed to be taken and how we can share the learning from this case.

Referral criteria for The Priory and Community Eating Disorder Service (No. 3). At a meeting convened by the GMHSCP on 28 January 2022, it was set out that Greater Manchester Mental Health NHS FT (GMMH) is working with the Northern Care Alliance (NCA) and the Priory to look at changing the previous eating disorder pathways and resolve any practical inconsistencies in criteria for admission. GMMH confirmed that BMI is no longer being used as a criterion for admission to their service at the Priory. Access will be based on specialist clinical assessment of the person's level of need, and so will give full attention to physical and mental health red flag signs and aligned to the national MARSIPAN framework.

While currently each locality CCG holds an individual contract with GMMH for the Adult Eating Disorder (AED) service they currently commission, in July 2022, these contracts will novate to the GM ICB and over the remainder of the 2022/23 financial year, will be brought into a single contract with each provider delivering specialist eating disorder services. This will enable a positive opportunity to resolve any further unwarranted variation in referral criteria and commissioned care pathways across GM.

In advance of this, GMHSCP MH Programme Team are working with partners to ensure the Children and Young Person's Eating Disorders working group that is already in place is broadened to become an all-age group. This will address wider transition issues between Children's and Adult Eating Disorder services - an area of particular concern for this patient group. Actions to ensure connectivity of evidence-based pathways that apply consistent referral criteria will be a key part of the work of this group. It will involve clinicians, commissioners, service providers and service users. This is something that has already been encouraged over the past year in the

development and expansion of the GMMH Adult Eating Disorders service, as further locality and GMHSCP investments have been agreed.

All this work will ensure dedicated space and attention in Greater Manchester to work through the issues highlighted in the Regulation 28 Report and share learning between all stakeholders. This will also include formal oversight and assurance through to the refreshed Quality Board function within GMHSCP and the GM ICB from July 2022.

Lack of critical services (No. 4).
GMHSCP acknowledges that the mental health provision at Fairfield General Hospital (FGH) in 2020 at the time Nichola was attending did not meet the national Acute Hospital Liaison Mental Health Core 24 standard. However, since this time the investment is now in place as agreed with both Bury and Heywood, Middleton, and Rochdale CCGs and GMHSCP. This will provide a Liaison Mental Health Core 24-Lite service at Fairfield Hospital. This is a firm step towards core 24 compliance and will enable an all-age offer, with increased joint working between alcohol, adult mental health and older people's services. As a result, Pennine Care Foundation Trust (PCFT) working with the Northern Care Alliance have now initiated the work to recruit to and mobilise this service. However, the ambition is to move to a fully compliant Liaison Mental Health core 24 service offer at FGH.

GMHSCP have submitted a formal proposal to NHS England to release just over £1 million (as the fair share allocation of national service transformation funding) to support strengthening the GM MH Crisis and Liaison services. This will provide additional investment to enable a Core 24 service offer at FGH and Tameside/Wrightington, Wigan and Leigh Hospitals. This will mean that further medical cover, clinical leadership will be in place, with further capacity to reach the PLAN accreditation standards. This work will support 100% GM-wide Core 24 cover across all the Acute Hospitals in the coming 2 year. This will exceed the national ambition through the NHS Long Term Plan for 70% cover across GM.

GMHSCP also acknowledges that the commissioned adult eating disorders service in Bury (like many areas of the country) was insufficient to meet local need. Since then, funding has now also been confirmed between Bury CCG and GMHSCP to implement the GMMH Adult Eating Disorders Business Case.

This will ensure across Greater Manchester commissioners and providers meet the NHS Long Term Plan goals for comprehensive community adult eating disorder services delivering enhanced service offers in line with current best practice clinical guidelines, including:

- The service accepting individuals with differing severities of eating disorders and offering a stepped care model in line with National Collaborative Centre for MH Guidelines (2019).
- Timely, effective, evidence-based treatments, care and support that meet the needs of individuals with the full range and severity of eating disorders
- NICE compliant/evidence-based psychological therapy will be offered in individual and group formats
- Early intervention pathway (First Episode & Rapid Early Intervention for Eating Disorders or FREED) as an evidence-based, specialist service model for 16- to

25-year-olds with an eating disorder of less than 3 years' duration – with a central focus on reducing the duration of an untreated eating disorder through rapid access to assessment and treatment optimising clinical outcomes
- Specific pathway for severe and enduring presentations with a focus on improving quality of life and reducing hospital admissions for individuals who meet a severe and enduring eating disorder (SEED) diagnosis
- Medical monitoring and management and support to staff working in medical settings.
- Specialist dietetic assessment and intervention
- Family therapy to ensure transitions from CYP Eating Disorder Services are optimal.
- Support and empower families, partners, carers and the person's support network
- Offer advice, support and consultation to other services involved in a person's care
- Coordinated care and work with other services to reduce and prevent gaps in care during service transitions
- Clear processes around managing risk and safety as well as unattended appointments.
- Appropriate clinical supervision to ensure professionals remain competent to deliver evidence-based treatment
- Improved awareness of the service in the community, the importance of early identification and reduce the stigma to increase help-seeking in the local population
- Collaboratively use routine outcome measurement to support a person to identify and meet their goals for recovery
- Actively seek out feedback from the people and their families who are experiencing the service

In addition to these core elements, the service will expand its offer to include medical monitoring and management via a Consultant Psychiatrist and Physical Health Practitioner. This will also enhance the service offer to manage referrals of increased complexity including those with other physical health comorbidities – with commissioned services planning to develop MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa, 2014) groups.

Close working is already underway with the North West Regional Provider Collaborative for Adult Eating Disorder Services, ensuring that specialised inpatient services are co-ordinated with community services, ensuring seamless pathways for people. This includes a Clinical Delivery and Pathway Group led by the Cheshire and Wirral Partnership NHS Trust who were an early adopter of the MARSIPAN framework nationally. They now lead the North-West Regional MARSIPAN group as part of their leadership role in the development and implementation of the clinical model of delivery for specialised adult eating disorders services (inpatient care) across the North West. The MARSIPAN groups will have system wide membership and this regional group will link with a GM MARSIPAN group.

Community monitoring of patients with an eating disorder (No. 5)
GMHSCP acknowledges that nationally there is a potential gap in support for a small number of patients deemed at moderate to high risk who often do not meet commissioned adult eating disorders service criteria, while repeatedly requiring access to Acute Hospitals. As such, the care for these patients often can fall back upon primary care unless an appropriate Adult Community Service is commissioned. As noted, above funding has now been confirmed between Bury CCG and GMHSCP to implement the GMMH Adult Eating Disorders Business Case and help close this gap by providing additional capacity to enable community monitoring of more patients with eating disorders.

As a Greater Manchester Health & Social care system we are therefore fully committed to closing the gap on the Adult Eating Disorder service provision as required by the NHS Long Term Plan and ensuring there is no unwarranted variation in commissioning practice. As such, on behalf of the GMHSCP, we thank you for bringing these matters of concern to our attention.

We can also confirm that we will, going forward, ensure that we continue to work together across the Greater Manchester health and care system so that changes in practice are actioned and reviewed. There is a firm commitment from all organisations to establish clear MARSIPAN pathways and protocols with associated training through the MARSIPAN, to ensure staff are knowledgeable and confident to enable the provision of safe and effective management in these cases (even in the context of national workforce limitations).

Actions taken or being taken to share learning across Greater Manchester.

1. Learning to be presented/shared with the Greater Manchester Quality Board. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. Shared learning from this and similar cases at Greater Manchester and borough level will be cascaded to professionals through relevant governance and learning forums.

In conclusion, key learning points and recommendations will be monitored to ensure they are embedded within practice. GMHSCP is committed to improving outcomes for the population of Greater Manchester.

I hope this response demonstrates to you and Ms Lomax's family that GMHSCP have taken the concerns you have raised seriously and are committed to work together as a system including our service users, carers and families to improve the care provided to adults with eating disorders who have acute medical care needs.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

[redacted]

[redacted]
Chair of GM Medical Executive, GMHSCP