Department of Health & Social Care

From Maria Caulfield MP
Parliamentary Under Secretary of State
Department of Health and Social Care

39 Victoria Street
London
SW1H 0EU

[redacted]

Alan Anthony Wilson
Senior Coroner
Blackpool & Fylde Coroners
PO Box 1066, Corporation Street
Blackpool
FY1 1GB

17th January 2023

Dear Mr Wilson,

Thank you for your letter of 28 March 2022 about the death of Natalie Melissa Turner. I am replying as Minister with responsibility for Mental Health and thank you for the additional time allowed.

Firstly, I would like to say how saddened I was to read of the circumstances of Ms Turner's death, and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In preparing this response, Departmental officials have made enquiries with NHS England as well as the relevant regulator in this instance, the Care Quality Commission. I note that a copy of the British Association for Counselling and Psychotherapy's (BACP) response to the report was shared with you on 10 May 2022.

I, the Department, and partnered health bodies at both a national and local level, take the report's concerns very seriously. Deaths like these should not happen, which is why improving eating disorders services and treatment 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 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', regarding the tragic death of Averil Hart, the Department has been working with NHS England, Health Education England, the General Medical Council (GMC), the National Institute for Health and Care Excellence (NICE) and the Royal College of Psychiatrists through a delivery group to address the recommendations. We understand the importance of working with such partners and remain committed to delivering improvements for this vulnerable group.

Regarding your matter of concern on guidance for general practitioners (GPs) on eating disorders, we agree that doctors should have the necessary knowledge and experience of mental health to assess patients holistically, considering the individuals' physical, social, and psychological needs.

GPs are responsible for ensuring their own clinical knowledge remains up-to-date and for identifying learning needs as part of their continuing professional development. This activity

should include taking account of new research and developments in guidance, such as that produced by NICE, to ensure that they can continue to provide high quality care to all patients.

For newly qualified doctors, we know that the GMC has been working with stakeholders to improve recognition and treatment of eating disorders. The GMC's Outcomes for Graduates includes that newly qualified doctors must illustrate their understanding of safe management and referral of patients with mental health conditions, including eating disorders. The GMC has also commissioned the Academy of Medical Royal Colleges to work with medical colleges on curricula content, aiming to ensure high standards in core clinical areas. As a priority, the first area being covered is eating disorders.

Similarly, to practice as a GP in the UK, GP trainees must undergo 3 years of specialty training (after their foundation years) in which they must demonstrate competence across the GP curriculum, which includes a focus on mental health, including eating disorders.

Further, GPs continue their professional development throughout their career. All UK registered doctors are expected to meet the professional standards set out in the GMC Good Medical Practice. In 2012, the GMC introduced revalidation, which supports doctors in regularly reflecting on how they can develop or improve their practice, gives patients confidence doctors are up to date with their practice and promotes improved quality of care by driving improvements in clinical governance. Wider training offers are also available to GPs, including the Royal College of General Practitioners online training course, which helps them to assess, manage and monitor patients affected by eating disorders, including knowing when to make referrals.

Similarly, Health Education England are developing training for primary care staff and others who have contact with people with an eating disorder. Beyond this, through the PHSO delivery group, NHS England is working with Health Education England and other partners to procure training courses that will increase the capacity of the existing specialist workforce, to allow them to provide evidence-based treatment to more people. The Department will continue to support this work to progress against key actions, including ensuring better awareness of eating disorder training and continuing professional development.

We also recognise the work of external partners, such as Beat, to push forward better training in medical courses and this was the necessary focus of Eating Disorder Awareness Week this year, which we supported and will continue to support as a Department. The Secretary of State for Health and Social Care at the time, Sajid Javid, endorsed a training package developed by Beat, in partnership with Health Education England and NHS England. This training was to support medical students and foundation doctors to identify and respond to a patient with a possible eating disorder.

To ensure good clinical practice, NICE guidance provides recommendations for professionals working with individuals who suffer from eating disorders.[1] This states that health, social care and education professionals working with people with an eating disorder should be trained and skilled in managing issues around information sharing and confidentiality, safeguarding and working with multidisciplinary teams. As stated previously, GPs are responsible for ensuring that they understand and adhere to NICE guidance.

Additionally, 'Medical Emergencies in Eating Disorders: Guidance on Recognition and Management' was published by the Royal College of Psychiatrists on 19th May 2022 to support clinicians with early identification and treatment for those with eating disorders. Its aim is to avoid preventable deaths, with an emphasis on medical management across physical

[1] https://www.nice.org.uk/guidance/ng69

and psychiatric care. It replaces 'Management of Really Sick Patients with Anorexia Nervosa' (MARSIPAN) guidance, which had previously been available.

We recognise that eating disorders have some of the highest mortality rates of any mental health disorder and that appropriate monitoring of anorexia nervosa patients by primary or secondary care providers is vital. Under the NHS Long Term Plan, we are 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 ICSs will have transformed services in place by 2023/24.

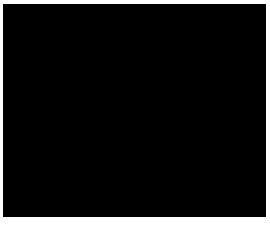
The Department acknowledges the importance of this funding and adherence to adult eating disorder patient care guidance, to ensure the highest standards of care. NHS England's work continues to highlight to systems the importance of early intervention services, as well as ongoing medical monitoring and ensuring access to care in the right place, and at the right time.

I know there is much more to do to improve the experiences and outcomes for people needing support with their mental health. The Government launched a public call for evidence on what can be done across government in the longer term to support mental health, wellbeing and suicide prevention. The call for evidence closed on 7 July 2022 and we are currently analysing over 5,000 responses received.

It is unacceptable that this death has happened, and we will take the shared learnings from this case to push progress forward. The Department takes the matters raised in this report seriously and will continue to engage on progress, in particular via the PHSO Delivery Group.

I hope this reply helps to reassure you that partners across the health system are working to make improvements on the basis of this report to prevent this happening in future. Thank you for bringing these concerns to my attention.

Kind regards,



MARIA CAULFIELD