Jennifer
Safeguarding Adult Review
Overview Report

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1. Introduction

1.1 This Review has been commissioned by the Independent Chair of Bury Integrated Safeguarding Partnership (BISP), following a decision recommended by the Case Review Group (CRG), and in accordance with the Care Act (2014), that this case met the criteria for a Safeguarding Adult Review (SAR). This SAR will be undertaken as a concise Practice Review, utilising the principles of Child Practice Reviews in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

1.2 The period under review encompasses the period when the Covid-19 pandemic was affecting the lives of all UK citizens and the way in which statutory services were being delivered.

2. Summary of Learning Themes

2.1 The following are the main learning themes:

- Lack of knowledge and use of MARSIPAN guidelines reduced the quality of care Jennifer received.
- Gaps in service provision meant there was no suitable service that could immediately meet Jennifer's needs, as a result Jennifer's care was transferred back to primary care which was not appropriate.
- Miscommunication and misunderstandings led to delays in Jennifer receiving the care she required with catastrophic consequences.
- Lack of a comprehensive risk assessment meant there was no comprehensive plan of care.
- Opportunities to understand Jennifer's lived experience were missed.
- Indicators that other issues were potentially exacerbating Jennifer's ill health were not fully explored.
- The 'opt – in' model in mental health services demonstrates that the most vulnerable patients may be missed.

3. Purpose of a Safeguarding Adult Review

3.1 The purpose of a SAR is to:

- Determine whether decisions and actions in this case comply with the policy and procedures of named services and BISP;
- Examine inter-agency working and service provision for the adult and family;
- Determine the extent to which decisions and actions were adult focused;
- Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults;
- Identify any actions required by the BISP to promote learning to support and improve systems and practice.

4. Succinct summary of case

4.1 Jennifer was one of three children born to the same parents. Father reported Jennifer was a good artist and loved drawing, knitting and crochet. In her younger days Jennifer had a good social circle but as time passed she became quite reclusive. Jennifer could be bubbly and sociable, the life and soul of the party, and had a good sense of humour. Jennifer worked in childcare for six years after leaving school. Jennifer was reported to love her job, loved children and was brilliant with them. Father reported that Jennifer's condition impacted so she was no longer able to work.

4.2 Jennifer had an eighteen year history of an eating disorder (Bulimia). Her father believes the media, in particular YouTube was partly responsible by showing how. Jennifer had been an inpatient in 2011 and 2016. Father reported that during these admissions, rather than help, Jennifer learned new ways of hiding her condition. At times Jennifer would get angry and frustrated by her condition. Jennifer's father reported her food bills were ridiculous, she would eat everything and then be sick. Since 2017 Jennifer had disengaged with services, with the exception of her GP. Until June 2018 there was regular weighing of Jennifer by her GP but this then ceased. Father reported that for the last couple of years Jennifer would hide in the house and didn't want anyone there; she had even disengaged from her family as she didn't want to see their reaction to how she was.

4.3 Jennifer was in a long-term relationship for eight years prior to her death.

4.4 At the beginning of 2020 Jennifer felt unwell and on three occasions attended Fairfield General Hospital "FGH"A&E having been transported by ambulance from home. She attended on the 13th January, 23rd March and the 28th April 2020. On each of these occasions she was treated for low potassium. On one occasion Ambulance staff made a referral to Adult Care.

4.5 In January 2020 Jennifer's weight was noted to be 31.6kg (Body Mass Index (BMI) 11.6) although it is not known if she was actually weighed, or whether this was self-report, and therefore whether this was accurate. There was no recorded weight in March or April and no discharge follow up was suggested for her GP and there was no referral of Jennifer to any specialist services.

4.6 On the 1st June 2020 Jennifer attended her GP practice having been found by a family member unable to walk and "*like she could die at any minute*". The Advanced Clinical Practitioner at the GP practice recognised the life-threatening condition. Jennifer weighed 26.7kg and her was BMI 10. Jennifer was sent immediately to A&E at FGH and referred her to the Community Eating Disorder service ("CEDS") within Greater Manchester Mental Health Trust ("GMMH").

4.7 CEDS made a referral for inpatient admission to the Specialist Eating Disorder Unit at the Priory Hospital Cheadle Royal as they recognised her need for inpatient admission. However CEDS did not accept Jennifer as their patient as they do not accept anyone with a BMI less than 14.

4.8 At FGH Jennifer was admitted until the 3rd June to treat her electrolyte imbalance. She was not admitted to address her risk of refeeding. Jennifer was referred to psychiatry for them to assess her capacity for discharge. Jennifer was asking to stay in hospital and was eating orally. No attempts were made to discuss her case with the Priory Hospital Cheadle Royal and she was discharged on the 3rd June.

4.9 The CEDS and GP were concerned about Jennifer's discharge, CEDS wrote a letter for Jennifer to take with her to the hospital. Jennifer was once again asked to attend A&E went back to FGH on the 5th June 2020. On this occasion she was admitted until the 11th June 2020.

4.10 On the 11th June 2020 there was a discussion between the medical doctor and the Priory Hospital Cheadle Royal regarding possible inpatient admission to the Priory Hospital Cheadle Royal. There was a miscommunication which led to Jennifer being discharged from the medical ward and the Priory Hospital Cheadle Royal removing her name from the waiting list.

4.11 When this error was noticed by CEDS a re-referral was made to the Priory Hospital Cheadle Royal. There was no bed to offer Jennifer at that time so between the

11th June 2020 and the 22nd July 2020 Jennifer was monitored by her GP and the advanced clinical practitioner within the GP practice. Jennifer attended regularly during that time for weighing and blood tests. Despite this Jennifer's condition deteriorated and she was admitted to hospital on the 27th July 2020. Jennifer's condition deteriorated further and she sadly died on the 3rd August 2020.

5. Methodology

5.1 Following notification of the circumstances of Jennifer's case, and agreement by the Independent Chair of BISP to undertake a Safeguarding Adult Review, the Review Panel was established. A reviewer/chair, Nicki Walker-Hall, was commissioned by BISP. An initial set up meeting was held and the following methodology agreed.

5.2 Each agency reviewed their records and drew up chronologies. The single agency chronologies were merged and used to produce an interagency chronology. This was analysed by the reviewer and the panel members who developed hypotheses, to further inform the key focus areas for exploration and consideration.

5.3 Each agency were required to complete a Learning Summary report concentrating on the key focus areas. A brief summary of any significant incident/s from January 2004 (relating to the terms of reference) the author deemed relevant to the case, were to be included if it was believed that additional learning could be extracted.

5.4 Key practitioners were identified and asked to attend a practitioner's event. This event focussed on Jennifer's journey through the system in order to reflect on and share learning and also to identify opportunities for improved working within and between agencies in the future.

5.5 A separate managers/commissioners event was held to consider wider issues around commissioning and service provision.

5.6 The reviewer supported by the most appropriate person working with Jennifer endeavoured to meet Jennifer's family to gain an understanding of their experiences of the services provided. Jennifer's father agreed to share his antecedent report provided to the coroner. The reviewer is grateful to him for the insight it has provided into Jennifer and the families experiences of the services offered to her, and has included some of the content of that report within this report.

5.7 The reviewer completed a draft report which was analysed by the panel. Partner organisations via the Panel then had an opportunity to agree actions to address the blockages and barriers identified. The panel also considered the most appropriate method to share the learning across the workforce in Bury.

5.8 It is intended learning from the full report will be made available to the public but only after consideration by the Safeguarding Adult's Board.

6. Key Focus Areas

6.1 The following key focus areas were agreed:

- **Covid-19 –** How did Covid-19 specifically impact on service delivery in this case?
- **MARSIPAN[1] – (Management of Really Sick Patients with Anorexia Nervosa) –** Consider whether these guidelines were followed in the management of Jennifer. If not why not and what was the alternate management plan for Jennifer's Anorexia Nervosa. What training is available and have those staff involved in the care of patients with Anorexia Nervosa received training?
- **Transition and discharge points –** Consider the effectiveness of preparation and plans at all points of transition and discharge.
- **Information sharing –** Consider the level and quality of information sharing both within and across agencies.
- **Management of risk –** Consider occasions when risks were present. How were these risks identified, analysed and translated into safety plans? How was risk managed across some key deliverers, acute medical care, mental health and social care? How were Jennifer's family involved in safety planning? Were there gaps in inclusion of, and services to, the family?
- **Multi-agency working –** Consider whether partners were holistic in their approach to Jennifer. Is there evidence of multi-agency working or were agencies working in silo? What are the barriers and enablers to multi-agency working?
- **Mental Capacity Act –** Is there evidence that practitioners have assessed Jennifer's mental capacity at key points. Give consideration to best interest/unwise decision making, fluctuating capacity and executive functioning in those with long-term conditions.
- **Service Design and Commissioning –** Has the way services are designed and commissioned created gaps in service for Jennifer?
- **Engagement –** What might have impacted on Jennifer's engagement with services? What constraints are there on services?
- **Assessment –** What assessments were made and what could have been made. Explore why they did/did not happen. Consider the use of the Care

[1]

Act 2014, was a Care Act assessment or carers assessment considered/evident.

- **Mental health support –** Consider what support Jennifer was offered/receiving for her mental health. Was alternate, potentially more appropriate, support available and how could this be accessed?
- **Professional Curiosity and Escalation –** Consider whether professionals were sufficiently curious and whether escalation processes were used appropriately in this case.
- **Discriminatory practice –** Is there evidence of discriminatory practice relating to Jennifer's age? If so why might that have occurred?

7. Engagement with family

7.1 Extensive efforts have been made to include family members in the review. The reviewer is grateful to Jennifer's father for his contribution to the review. The reviewer would have welcomed an opportunity to speak with Jennifer's partner and her sister but had learned that they had not felt able to provide antecedent reports; father advised their situation had not changed. The panel concluded it would not be acceptable to contact them.

8. Review team

8.1 The Review Team consisted of the reviewer, Nicki Walker-Hall, and members of the BISP Review Subgroup, which included senior safeguarding representatives from the following agencies:

- Pennine Care Foundation Trust
- Greater Manchester Police
- Adult Social Care
- NHS Bury CCG (now transitioned into Greater Manchester Integrated Care Board)
- Northern Care Alliance NHS Foundation Trust
- BISP Manager
- Greater Manchester Mental Health NHS Foundation Trust
- Priory Hospital Cheadle Royal

Nicki has worked in safeguarding roles for over twenty years. Nicki has an MA in Child Welfare and Protection and an MSc in Forensic Psychology. Nicki is an experienced author of both children and adult safeguarding reviews; she has a background in health.

9. Timescales

9.1 There is an expectation that a review should be completed within 6 months of initiating it, unless there are good reasons for a longer period being required. In this instance, this timescale was not met. Initiation of the review was impacted by the volume of SAR's being conducted within Bury.

10. Analysis pertaining to the Key Lines of Enquiry

10.1 **Covid-19 –** How did Covid-19 specifically impact on service delivery in this case?

10.1.1 The time period for review includes the early and peak period of the Covid-19 pandemic when services were scrambling to swiftly make changes to their ways of operating to increase safety and prevent the spread of Covid-19. There is clear evidence that Jennifer was considered vulnerable as the Covid-19 pandemic began. It was identified within the GP records that Jennifer was shielding due to her health condition. There is documented evidence that she received a courtesy call and planned telephone consultations which had been modified due to the pandemic (although contact between Jennifer and the Practice took place via telephone contact on numerous occasions pre pandemic).

10.1.2 Two months after the initial lockdown, the GP practice had agreed that if patients had no Covid-19 symptoms they would see them face to face. It is clear Jennifer was seen face to face on a number of occasions.

10.1.3 National guidance meant that at times inpatient services were required to be placed in containment and as such closed to admissions, affecting periodically bed availability and aspects of care and treatment linked to community rehabilitation.

10.1.4 Otherwise all aspects of the inpatient care and treatment continued as usual, with staff working on site, providing face-to-face care and treatment.

10.1.5 The events leading up the death of Jennifer were affected by the Covid-19 pandemic from March 2020 onwards. Acute departments, in particular ED areas were facing unprecedented pressures during this time and were avoiding admissions to hospital unless life threatening, due to the associated risks on contacting Covid-19. Jennifer's father believed this had influenced the decision to send Jennifer home indicating he believed that hospital staff thought she would be safer there.

10.1.6 From hospital records there is no evidence of EDU being in containment or closed to admissions during the time Jennifer was on the waiting list and so service delivery was not affected at that time. Therefore, this key focus area is not relevant to Priory Hospital Cheadle Royal specifically.

10.1.7 The Access and Crisis Team was providing a variety of face to face, telephone, and video consultations as part of the business continuity plans in the event of the pandemic. Jennifer specifically asked for a telephone assessment, which was arranged at her request.

10.1.8 On call psychiatry met with Jennifer face to face in hospital at request of medical staff who were treating her, there was no impact from Covid-19.

Learning point 1: The early and peak stages of the Covid-19 pandemic brought heightened and genuine anxieties across the nation. This was particularly relevant to Healthcare staff who continued to working on the frontline, with no, or inadequate, Personal Protective Equipment (PPE) and no vaccines. Whilst Covid-19 undoubtedly impacted on many services mode of delivery, it appears that in this case the impact was kept to the minimum in relation to the delivery of services to Jennifer. What we cannot know is the impact of shielding on Jennifer's

mental state and whether this had an increased impact on her underlying health conditions.

10.2 MARSIPAN – (Management of Really Sick Patients with Anorexia Nervosa).

10.2.1 During the review period Jennifer received care for the physical aspects of her eating disorder either in the community via her GP practice or as an in-patient in a secondary care setting. Discussions were had, and arrangements were being made, for Jennifer's care to be delivered within a tertiary care setting but this was not achieved.

10.2.2 It is important to recognise the context for those working with Jennifer in the secondary care setting. There had been no admissions within the setting for anyone with a severe eating disorder since 2014 and those working with Jennifer, during the review period, had not received training regarding eating disorders. This makes it more understandable as to why the MARSIPAN guidelines were not fully followed in the management of Jennifer.

10.2.3 Whilst those working in the specialist service (tertiary care), within the Priory Hospital Cheadle Royal were well cited on the guidelines, it was not the same for other professionals. Some health professionals knew of the guidelines existence, and did on occasion refer to them, but they did not have a working knowledge of them and there were no associated policies, procedures or protocols to advise staff.

10.2.4 Within the hospital Jennifer's medical consultant took the lead for her care however, focus was on stabilising Jennifer's electrolyte levels sufficiently for her to move to a specialist service.

10.2.5 The medical consultant was supported by the in-hospital dietetic service and the psychiatric service. The acute dietetic team did not have the required level of specialist knowledge regarding eating disorders at that time. The dietetic service had been instructed by the then manager that, because they hadn't received training and didn't have specialist knowledge around eating disorders and refeeding, they could only get involved in the day to day management of Jennifer's diet. Dieticians worked with Jennifer around menus and increasing her calorie intake. The dieticians also monitored Jennifer's weight however, Jennifer was weighed on different scales so they never really established what her accurate weight was. Sometimes Jennifer had a BMI of 11, sometimes 10 and on one occasion 9; dieticians didn't have a sense of what trajectory Jennifer's weight was on. What was clear was the continued decline in Jennifer's weight from her admission in January 2020 up until her last admission. Practitioners were using the Malnutrition Universal Screening Tool (MUST) to assess Jennifer's level of risk of malnutrition.

10.2.6 In June 2020, early in Jennifer's admission, discussions were initiated by Jennifer's consultant with the on-call psychiatrist in relation to the presenting risks, with a request they conduct an assessment of Jennifer's mental capacity in line with the statutory requirements of the Mental Capacity Act[2]. The acute ward's discussion with the on-call psychiatrist was specifically about determining Jennifer's mental capacity to make a decision about the proposed treatment plan by the medical

[2]

ward. They had deemed her medically fit to be discharged and able to engage with the discharge plan with regards to her eating but wanted her mental capacity assessing. There had been no concerns expressed to the psychiatrist about needing to refeed Jennifer or to undertake any particular medical intervention, thus the assessment completed by the psychiatrist was solely regarding her mental capacity to engage with the discharge plan.

10.2.7 The fact that the psychiatrist was only directed to assess mental capacity in this regard demonstrates that the wider thinking regarding refeeding was not part of the proposed plan of care and that there was no clear plan of care that cared for Jennifer holistically.

10.2.8 In June 2020 there was confusion regarding Jennifer's admission to the Priory Hospital Cheadle Royal. This will be considered further in section xxx, but what is significant to this key line of enquiry is a lack of awareness or consideration by the specialists within Priory Hospital Cheadle Royal that they would have a far greater understanding of MARSIPAN and of the associated processes, than those clinicians working in a general medical setting who never or rarely work with such cases and have extremely limited knowledge of MARSIPAN.

10.2.9 When Jennifer was discharged from hospital, because she was not transferred to the Priory Hospital Cheadle Royal, her care transferred back to her GP, who was supported by the practices Advanced Practitioner. Neither had, or should have had, the level of expertise regarding eating disorders to manage Jennifer's care, unsupported by a specialist eating disorder service, within the community. Whilst Jennifer was known to the Community Eating Disorder Service (CEDS) she was not one of their clients throughout the review period. Jennifer had been referred to CEDS but hadn't been accepted because her condition at that time was outside the services criteria.

10.2.10 The reviewer learned that when new guidance is issued nationally, it is the role of quality leads to respond to this and instigate making the necessary changes; that did not happen with the MARSIPAN guidelines.

10.2.11 The reviewer has learned that since Jennifer's case significant action has been taken to address the concerns raised by the coroner. NCA have developed a checklist to assist staff to identify the level of risk for those patients admitted with medical issues relating to eating disorders. Currently there is a standing operating procedure (SOP) in development for use across the whole of Greater Manchester and training based on the Medical Emergencies in Eating Disorders (MEED) guidelines, which have superseded the MARSIPAN guidelines. NCA have also developed a MEED refeeding policy which is out for consultation and an eating disorder group is in an embryonic phase of development.

10.2.12 Jennifer's GP indicated that whilst her was aware of the MARSIPAN guidelines he didn't use them and chose to use the NICE guidelines as they were more user friendly and it was usual practice to use NICE guidelines for all conditions. MEED training has been delivered to GP's, with additional information having been circulated throughout GP practices. The GP confirmed awareness of the MEED guidelines but was still using the NICE guidelines. It is planned that GP leads will go through medical monitoring and management for those with eating disorders with their contemporaries.

Learning point 2: It is clear that during the period under review practitioners caring for Jennifer did not have full knowledge and understanding of the MARSIPAN guidelines, had no internal policies or guidance based on the guidelines and had not been trained in their use; GP's were referring to NICE guidance. Those professionals who did have a working knowledge of the guidelines were yet to be leading on Jennifer's care as she had not been admitted to the specialist unit. Since this case there have been significant developments and work is in progress to address the gaps.

10.3 Transition and discharge points.

10.3.1 A lack of knowledge and experience of working with clients whose eating disorder has reached that of a medical emergency, impacted on the decision making around fitness to discharge and after care.

10.3.2 Following non-engagement with a planned mental health assessment in April 2020, the Access and Crisis Team reviewed the referral information to consider whether escalation of the case to the Police for a Concern for Welfare or Duty AMHP for a Mental Health Act Assessment was required. The referral did not indicate that Jennifer was a risk to herself or others, nor did it mention that Jennifer was experiencing symptoms of a severe and enduring mental illness. Although the case referred to Jennifer having a diagnosis of Anorexia and Bulimia, no further details were provided, and as Jennifer had been seen by NWAS, who it was believed by the Access and Crisis team should have checked baseline observations, including weight, it was considered that escalation of the case was not necessary at this time.

10.3.3 An opt-in letter was sent to Jennifer, requesting that she contact the team within 10 days to arrange an alternative appointment. The referrer and GP were also informed that the patient had not engaged with the mental health assessment and informed of the plan to send an opt-in letter. Eating Disorders are a severe and enduring illness but due to the lack of information is was difficult to establish whether it was under control, whether the diagnosis was correct etc. At the time, the Outpatients Department were not on electronic records systems so the Access Team had limited access to the records. The Outpatients department have been on our EPRS for approximately 12 months

10.3.4 Within the hospital daily multi-disciplinary meetings (MDTs) took place; practitioners from CEDS also attended these meetings which was good practice. During the review period there wasn't a consultant psychiatrist within the MDTs to offer advice and expertise however, since this case they are now present.

10.3.5 Whilst the MDT meetings were good practice what didn't happen during Jennifer's admission in June 2020, was any invitation to attend being extended to the GP or the Advanced Practitioner within the GP practice as Jennifer neared the point of discharge. This was crucial as it would be they who would be overseeing Jennifer's care in the community and would have afforded them an opportunity to raise their concerns and have them discussed across the whole team.

10.3.6 In the absence of a specialist eating disorder service involvement, CEDS took on a consultation and coordination role even though Jennifer did not fit the services criteria.

10.3.7 For the on call psychiatrist who saw Jennifer in June, they were in liaison with the medical staff on the ward where she was a patient. They were asked to assess her mental capacity and found her to have capacity at the time of assessment, in regard to the decision about her eating and the plan to discharge her home.

10.3.8 The reviewer learned that the Priory Hospital Cheadle Royal does conduct pre-admission assessments but this assessment needs to be completed close to a patient's admission into a hospital setting to ensure all decisions and actions were in line with the patients condition. This assessment would not have been appropriate when discussion were being had between the service and the medical consultant in June 2020, and as a date for admission had not subsequently been identified no such assessment took place.

10.3.9 In the absence of transfer to the specialist unit, Jennifer was discharged from hospital, Jennifer's care transferred to her GP and to the advanced practitioner within the GP practice. A clinician from the GP practice spoke to the medical consultant on the ward directly in June 2020 to inform them that patient should not be discharged as this was not appropriate for primary care to manage but unfortunately this did not prevent discharge and Jennifer's care transferred to the practice. This was a great responsibility especially for the advanced practitioner who was newly qualified. The GP reports frustration at the situation and numerous contacts by both email and letter to try and resolve the situation.

10.3.10 The lack of a plan of care devised by those with specialist knowledge of eating disorders, in April 2020 reduced the potential for Jennifer's eating disorder to be effectively managed in the community. By June 2020 Jennifer's care needs were such that they could only have been managed by a specialist eating disorder service.

10.3.11 In the days prior to Jennifer's death, it is known that conversations were had in regards to the Priory Hospital Cheadle Royal's admission criteria and Jennifer's potassium levels and BMI as this fluctuated whilst remaining very low. Sadly Jennifer passed away before she could transition to the Priory Hospital Cheadle Royal.

Learning point 3: Points of transition and discharge did not go smoothly. Jennifer's care was transferred back to primary care despite Jennifer needing input from the specialist eating disorder unit. Whilst those in primary care regularly monitored Jennifer they were not able to give the constant monitoring and support Jennifer required.

10.4 Information sharing.

10.4.1 During Jennifer's first admission to ED within the time period of this case review, she had no involvement from mental health services. Jennifer declined psychiatric input indicating she had had this previously. There is limited evidence to suggest any information sharing took place between mental health services previously involved as the patient self-reported views about previous treatment. There was no liaison with the GP who was the provider of primary care around her condition at this time.

10.4.2 An autogenerated letter was shared with the GP in relation to Jennifer's ED attendance and presenting complaint, but further discussion and information sharing in relation to the individual presentation, could have facilitated practitioners' earlier recognition and requirement for psychiatric input.

10.4.3 This case has demonstrated the importance of timely, clear and effective communication. Whilst information was shared between the hospitals, psychiatry and with the GP practice this was not always with the clarity required and with an associated holistic plan of care. There was nobody with sufficient specialist knowledge of eating disorders overseeing Jennifer's care and acting as a conduit for information sharing.

10.4.4 When Jennifer was seen within the GP practice for specific or seemingly unrelated reasons, this would be considered in isolation, unless bulimia was raised by Jennifer. As a consequence and despite Jennifer being seen on a number of occasions, months could pass without a GP mentioning her eating disorder.

10.4.5 From April 2020 there was reference within GP records to occasional monitoring of Jennifer's weight and BMI but this does not appear to have been discussed with the wider team to look at a plan of support. Jennifer did attend for regular blood tests and there is evidence that the results were acted upon, however, again, these appear to have been looked at in isolation – for instance, prescribing of potassium supplements, or iron deficiency anaemia.

10.4.6 The GP practice demonstrated good practice in regards to repeated attempts to facilitate referral and support for Jennifer by contacting The Willows, The Priory Hospital Cheadle Royal and FGH. At one point contacting FGH to ensure Jennifer was admitted to an in-patient bed. These repeated attempts highlight challenges and system blockages that ultimately stopped an effective plan of support being achieved for Jennifer.

10.4.7 Since this case the GP practice have had discussions within their clinical meeting regarding holistic approaches to care and have been undertaking case discussion of complex cases in clinical meetings 1-2 times a week.

10.4.8 In April 2020 NWAS discussed the case with Adult Social Care, who referred to the Access and Crisis Team for mental health support. When Jennifer did not engage with the assessment, the team liaised with the referrer (ASC) and the GP to inform them that Jennifer had failed to engage with the assessment and that a 10-day opt-in letter had been sent. It was requested that the referrer and/or GP contact the Access Team with any concerns relating to the plan.

10.4.9 The fact that the referral to the Access and Crisis Team was made by ASC and not NWAS meant that NWAS's information relating to physical observations was not shared. Had this been shared it may have influenced the management of the case. The reviewer is concerned that the Access and Crisis Team seem to be under the misapprehension that NWAS would weigh a patient and be aware of their BMI as they have indicated that had not received information that Jennifer's physical observations were out of range or her BMI had put her in the clinically vulnerable category, more consideration to the use of MARSIPAN or MEED would have been considered.

10.4.10 In June 2020, there was a telephone call between a medical doctor at Fairfield General Hospital and a Dr within the Priory Hospital Cheadle Royal to discuss the care and treatment for Jennifer. It has been noted that both parties have very different recollections of the conversation which led to a very different understanding of the care and treatment required for Jennifer. As Jennifer was not directly an inpatient within the Priory Hospital Cheadle Royal at the time, there is no information noted within her Priory Hospital Cheadle Royal electronic medical files regarding this conversation to provide clarity.

10.4.11 This conversation resulted in the Dr removing Jennifer from the Priory Hospital Cheadle Royal waiting list. This was challenged by the commissioning team but, no immediate action was taken to place Jennifer back into the waiting list. The decision to remove Jennifer from the Priory Hospital Cheadle Royal waiting list was communicated to the GP in writing 5 days later. CEDS on being informed, re-referred Jennifer.

10.4.12 Whilst there was no bed for Jennifer during this period, it has been noted that due to miscommunication, this could have resulted in a delay to Jennifer receiving appropriate inpatient care and treatment.

Learning point 4: Whilst information was shared between services the level and quality of the information shared was not sufficient for the recipient to have a clear understanding of what the issues were and what was required to address the issues. Miscommunication and misunderstandings led to delays in Jennifer receiving the care she required with catastrophic consequences. The sharing of incomplete information between ASC and the Access and Crisis Team meant when the Access and Crisis Team were making their decision as to whether to escalate the case, they made an assumption that Jennifer's physical observations were within the normal range.

10.5 Management of risk

10.5.1 Throughout the entire review period there was a lack of use of a risk assessment tool to clearly understand the level of risk Jennifer's condition indicated. Covid-19 was impacting on the way services were operating at this time. Applying the criteria within MEED it is clear that throughout the review period Jennifer was at high impending risk to life. Jennifer's BMI was 11 or under and she had biochemical abnormalities which, although correctable and corrected whilst in hospital would quickly reoccur.

10.5.2 NCA understood that the criteria for admission to SEDU was a BMI of over 13, meaning Jennifer was not able to access SEDU. However, NCA's understanding changed during the last admission when they were advised that electrolytes would need to be increased to facilitate the move to SEDU when a bed became available.

10.5.3 The lack of use of a risk assessment tool meant there was no clear identification of the level of risk and therefore no adequate safety plan. Jennifer fell between the gaps of commissioned services. CEDS had clarity on what the service had been commissioned to deliver; Jennifer fell outside of their remit when she was in the community, this left the GP and advanced practitioner to manage and monitor Jennifer. Because neither CEDS or the Priory Hospital Cheadle Royal had any

active involvement with Jennifer there was no safety planning by any practitioner with additional knowledge of eating disorders.

10.5.4 There is no evidence of family involvement throughout the entire review period. Whilst it was a family members comment that prompted Jennifer to seek assistance from her GP, and this was acted upon, there was no direct contact with any family member during the review period. Whilst consent was needed, no request for permission to contact the family was made by any professional.

10.5.5 There is no evidence within the GP records of safety plans, although there is evidence of communication between the key deliverers which, in the main, seems to have been pre-empted by the GP Practice.

10.5.6 There is evidence of referrals being made (community dieticians, mental health) However, the community dieticians declined the referral and there is no evidence anything further was explored. There is evidence a mental health referral was made, although unclear within GP records as to which service this was to or whether this was accepted or declined.

10.5.7 In terms of Jennifer's referrals for mental health support, whilst there is no record of receipt of the GP referral, the ASC referral was accepted, and, although her reported symptoms of anxiety could have been managed within primary care it is a positive that, because Jennifer had a diagnosed eating disorder, was using substances and reported to be homeless, it was considered Jennifer was vulnerable and a mental health assessment was offered. It was also seen as a positive that Jennifer was seeking support as she had contacted NWAS herself and reported a willingness to engage with services and appeared to want support.

10.5.8 When Jennifer did not engage with mental health services she was not just discharged. The initial referral document was reviewed, however it was not considered necessary to escalate the case to the Police for a concern for welfare, or the Duty AMHP for a Mental Health Act assessment, as there was no information in the referral that caused significant concern. Despite being documented that Jennifer had a diagnosed eating disorder, the Access and Crisis team were reassured that she had been reviewed by a medical professional at the time of the NWAS attendance, and no escalation was required at this time. It was felt appropriate to share the details of the non-engagement with the referrer and GP for them to consider whether further escalation was required.

10.5.9 Jennifer, once medically fit did meet the criteria for the Priory Hospital Cheadle Royal however the communication between the Priory Hospital Cheadle Royal and external services was often misconstrued. This resulted in the community services not being able to fully manage the risks as there was a lack of understanding on the actions taken by the Priory Hospital Cheadle Royal. Whilst Jennifer had not been sufficiently monitored within the GP practice until she was wrongly discharged in June 2020, following this discharge the advanced practitioner was extremely diligent in monitoring Jennifer's condition.

10.5.10 As indicated previously, as Jennifer was not directly a patient within the Priory Hospital Cheadle Royal there had been no formal pre assessment which would have led to care planning and risk assessments being completed upon admission. It was verbalised to the commissioner that no bed would be available for a number of weeks.

10.5.11 There is a shortage of specialist eating disorder beds nationally, at a time when the number of people with eating disorders is on the increase. When the lack of a bed was escalated in this case to NHS England this did not prove helpful as no bed was found, indeed they indicated the waiting time was months.

Learning point 5: Whilst practitioners discussed areas where there were risks e.g. low potassium, low BMI, what they didn't do was to complete a comprehensive risk assessment that looked at all the risks and gave a clear understanding of what the risks were and the level of risk; restrictions and changes to the way practitioners were working as a result of Covid-19, impacted. Fully understanding the level of risk and any protective factors is crucial to making a comprehensive plan of care.

10.6 Multi-agency working

10.6.1 During the investigation themes and barriers to multi-agency working were evident. Within Fairfield General hospital, mental health services are provided by Pennine Care Mental Health Trust. The investigation highlights the initial guidance and referral criteria, and pathways were not fully understood at the time of events from both the hospital dietetics service, and wider multi-disciplinary team within the ward environment in NCA. It also highlighted referral pathways for patients with an eating disorder, required sharing with GP practices across the borough.

10.6.2 There is no provision for an eating disorder specialist dietician across the NCA. Therefore, was a lack of continuity across agencies to provide specialist guidance and support. Local specialist nutritionist could have provided continuity of care along with a mental health eating disorder specialist.

10.6.3 Barriers were evident in relation to the patient's presentation and reporting feeling otherwise well separate from presenting symptoms and assuming capacity, declined any involvement from an SEDU until her fourth admission during the identified period where concerns were highlighted around her mental health.

10.6.4 It was only during Jennifer's fourth admission to hospital that further multi-agency involvement between the psychiatrist and SEDU was considered, and questions raised in relation to Jennifer`s mental health and requirement for refeeding.

10.6.5 Although there is evidence of referrals and contact with other agencies in April 2020, there is no evidence of a multiagency approach to plan how to manage Jennifer's condition both physically and mentally, or how Jennifer could be supported with activities of daily living. There was a referral to OT for a walking frame in the GP records, but no discussion of how Jennifer was managing with any other health needs or social intervention, such as hygiene needs or shopping. The referral was specifically for a walking frame. There is no evidence within the records that Jennifer was discussed at the integrated neighbourhood team meetings, or if this was considered. There is no evidence within the documentation of why this was not considered given Jennifer's presentation. It is unclear whether Jennifer's age was a factor or methods of consultations. Time

limitations for GP consultations can often present as a barrier to holistic assessment, however, there is no documented evidence this was the case.

10.6.6 NWAS referred to ASC with safeguarding concerns and for assessment. Jennifer was spoken to by ACS and advised that she suffered with eating disorders Bulimia and Anorexia and that the only food she was keeping down was banana on toast. Jennifer explained that this has been an ongoing issue which was impacting on her physical health. Jennifer asked if contact could be made via phone or a home visit due to pain and anxiety.

10.6.7 A SW from ASC referred Jennifer to the Bury Access and Crisis Team with the information above but there is no evidence within the referral of inclusion of NWAS's findings, including Jennifer's baseline observations.

10.6.8 The referral was triaged by two Practitioners in the Access and Crisis Team, and it was agreed that a routine Mental Health Assessment would be offered to establish Jennifer's needs. A telephone assessment was arranged but Jennifer did not engage. Several attempts were made to contact Jennifer without success. The referral was reviewed and a decision made that it was not considered necessary to escalate the case to the Police for a concern for welfare check, or a Mental Health Act Assessment. This decision was made based on the fact that Jennifer had been reviewed recently by NWAS, so it was considered that physical observations had been within normal range which was inaccurate.

Learning point 6: The current pathways and processes around referral for assessments are both confusing and convoluted. Whilst there is opportunity for NWAS to refer directly to Mental Health Services the pathway and practice of doing so needs to be promoted.

10.6.9 On Call Psychiatry recorded their assessment within medical notes and so were not on the electronic records system Paris that was in use by Access Team at the time. Use of different recording systems can be a barrier to information sharing and continuity of care.

10.6.10 As Jennifer was on the waiting list for admission into PH Cheadle Royal, part of the requirement was to ensure the commissioners were kept up to date with expected admission dates. Although there was an expected three-week time scale, this was dependent on many factors including the discharge of a patient to create a vacancy. Throughout the time Jennifer was waiting for admission, there was regular communication between PH Cheadle Royal and commissioners, and largely agreement, this was not always understood by all parties.

10.6.11 The PH Cheadle Royal has two wards out of thirteen dedicated to those with eating disorders. The PH Cheadle Royal is not commissioned to provide any formal advisory service for eating disorders as the service commissioned is purely for inpatient care and treatment on the Eating Disorder wards. This did not prevent contact being made, and support was offered to the community team, as they needed it via telephone contact. In the inquest, it is recorded that when asked, many of the community practitioners working with Jennifer did not know who to contact other than specialists within PH Cheadle Royal. This shows there has been a long standing working relationship between those within PH Cheadle Royal and those working within the community services.

Learning point 7: Pathways of care and consistent policy and practice across partner agencies is crucial to delivering seamless care to patients. This review has identified that whilst individuals were expressing their concerns to each other and doing their best within the constraints of their services policy, design and experience, the way services were set up had left gaps that Jennifer's case fell through.

10.7 Mental Capacity Act

10.7.1 There was limited awareness that Jennifer may be unreliable when informing staff from all specialties, of her nutritional intake, vomiting, medication availability and community appointments. The opinion of the local psychiatry team was relied upon when the patient's capacity was considered. It was stated the patient had capacity in relation to this decision, the medical team believed at the time NG feeding could only be administered voluntarily, with consent from the patient. There is no evidence any issues or potential issues with capacity were identified especially in relation to the high risks associated with Jennifer's presentation and declining a NG tube. Further exploration regarding whether Jennifer was exhibiting disguised compliance was required

10.7.2 There was a lack of knowledge by professionals that Jennifer was drinking alcohol to excess. This was also not known to her father, and so was not considered in relation to its impact on her mental capacity.

10.7.3 There is no evidence within GP records that consideration was given to Jennifer's decision making or whether her health may have impacted on this. There is no documented evidence that MCA was considered during any of the GP consultations. The GP informed the reviewer there had never been anything to raise suspicion that Jennifer's mental capacity was impaired. Jennifer was engaging and attending appointments. Since this case the GP practice have received refresher training.

10.7.4 As part of the assessment process, prior to any admission into the Priory Hospital Cheadle Royal, there will be consideration into an individual's capacity and ability to consent to any admission. It is known that Jennifer's engagement with services and treatment was sporadic over time and therefore would have been part of the assessment into admission. When initial contact was made to PH Cheadle Royal, there was clear communication that a bed was not available and it would be some weeks before any admission could take place. Due to this delay, no physical assessment took place as this would be completed just before any planned admission to ensure the criteria for admission was met and the patient was not physically unwell beyond the capabilities of the skills and knowledge of staff within the PH Cheadle Royal. Any assessment that would have taken place would have incorporated mental capacity.

10.7.5 The Access and Crisis Team were unable to assess Jennifer's mental capacity as she did not engage with the service. There is no evidence in the referral that NWAS made to ASC that they had assessed Jennifer's mental capacity.

10.7.6 An on Call Psychiatrist was asked by the Medical Team on Ward 7 to assess the Mental Capacity of Jennifer in regards to the proposed treatment plan and plan to discharge home. A mental health assessment was carried out and Jennifer was

deemed to have capacity at that time around this and was discharged at this time. The causative nexus is an essential part of any mental capacity assessment as it provides a clear rationale for whether the person being assessed has capacity to make a specific decision. It is unclear if specialist input from a psychiatrist from the SEDU would have reached a different outcome.

10.7.7 The team considered that there was also the protective factor identified that she was going home to a partner who she described as being supportive in regard to helping her have small meals, and there had been a referral by her GP to the eating disorder service in Cheadle. Jennifer was not open to the secondary care mental health services in Pennine Care at this time and the consultant who oversaw the assessment of Dr M recommended follow up appointment in Outpatient's Department was offered.

Learning point 8: There is some evidence that practitioners were considering Jennifer's mental capacity although they were looking to psychiatric colleagues to undertake the assessment rather than complete the assessment themselves. Conducting mental capacity assessments should be part of all practitioners business. Practitioners should be enabled to have a global conversation regarding mental capacity. There are dangers in looking to other specialists to complete mental capacity assessments. In this case insufficient information sharing to the psychiatrist, on one occasion, led to an assessment of Jennifer's mental capacity to agree or not to the discharge and treatment plan. This assessment missed an opportunity to assess Jennifer's mental capacity to agree to a refeeding programme and transfer to a SEDU. Jennifer's partner was thought to be a protective factor but the reviewer has not been provided with any evidence that Jennifer's family and partner were ever contacted to establish whether this was factually correct.

10.8 Service Design and Commissioning

10.8.1 It is clear that the way services have been designed and commissioned has created gaps in service that directly affected Jennifer's care.

10.8.2 The criteria for the CEDS team meant that during the whole of the review period Jennifer's condition was out of the scope for their service as she was deemed to require a service with greater expertise.

10.8.3 When Jennifer was admitted to hospital there was no consideration if the patient should have commenced inpatient refeeding during the admissions to hospital within this timeframe. However, an inpatient dietician within FGH would not have been able to assess if refeeding needed to be considered, as it is not a specialist eating disorder service.

10.8.4 The trusts internal investigation highlighted the gaps in service provision and training need for staff. It also highlighted the wider commissioning within the locality for specialist provision of services for patients with eating disorders and the limited availability of beds and access to specialist support and treatment for SEDU`s.

10.8.5 It was also highlighted that the community specialist eating disorder team is provided by (GMMHSC) NHST trust. However, it was unclear if they could be consulted for advice for an inpatient and that a formal referral would be required.

10.8.6 There is evidence within GP records from April 2020 that the GP Practice made significant attempts to liaise with other services to ensure Jennifer accessed the most appropriate treatment. However, this appeared to be to no avail. There is no evidence of consideration of escalation of the issues created by service design and commissioning to commissioners.

10.8.7 The specialist eating disorder units within The Priory Hospital Cheadle Royal is focused on the care and treatment for those service users who no longer can be managed within the community and require inpatient care and treatment. This service compromises of two mixed gender wards, with capacity to admit 29 patients in total. There is no commissioned eating disorder service associated to PH Cheadle Royal in relation to outpatients or the delivery of specialist advice to community services.

10.8.8 The admission criteria associated with the eating disorder units ensures that any individual admitted into the ward is physically well enough as the hospital specialises in mental health and although will support with physical health, does not specialise in this area and cannot respond like a general hospital could.

Inclusion criteria:

• 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 criteria:

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

10.8.9 Prior to any agreement of an admission into Priory Hospital Cheadle Royal an assessment will take place to look at the above criteria. There is an acknowledged flexibility in this which will be seen via each individual assessment and their health (mental health and physical health) at the time of the assessment.

10.8.10 Jennifer was offered an assessment with Access Team on a Saturday, when Eating Disorder Services and the Outpatient Psychiatric Departments are closed. There was an opportunity to discuss the case with the on call Consultant for Psychiatry, however, this was not considered necessary due to the lack of information available relating to Jennifer's eating disorder. It is worth noting that the Access and Crisis Team do not always offer assessment. The criteria for assessment is where there are symptoms of a serious mental illness or the patient is at risk of self-harm/suicide. This was not the case with Jennifer's referral

10.8.11 Pennine Care are not commissioned to treat patients with eating disorders – it is unclear why there was recommendation for the GP to refer Jennifer to CMHT when this is not the pathway for treatment and may indicate need for clarity about treatment pathways.

10.8.12 On Call Psychiatry attended to see Jennifer at the request of medical staff on wards at Fairfield General Hospital – this system does not allow for continuity as different doctors working all the time. Of note PCFT psychiatrists are not commissioned to look after inpatients with eating disorders. Clinicians who do have patients under their care requiring hospital treatment for their eating disorders will work closely with the medical wards, commissioned inpatient eating disorder service and community eating disorder specialist to ensure essential collaboration takes place.

Learning point 9: The way services have been designed and commissioned has created gaps in service that directly affected Jennifer's care and are not sufficiently robust for other service users. A lack of specialist provision for those with severe eating disorders is leaving them with suboptimal care. It has also created a situation where those health professionals with arguably the least specialist knowledge of eating disorders are monitoring and providing care in the most risky period when patients are waiting for a specialist bed to become available.

10.9 Engagement

10.9.1 Covid-19 may have impacted on engagement with services for Jennifer due to the associated risks and pressure on services. Restrictions on visiting and attending hospital with family or carers will have been in place during this period due to the risks above.

10.9.2 Understanding the risks and obtaining Jennifer`s personal insight into the signs of deterioration of her eating disorder, will have undoubtedly have been a factor which often would require a team with specialist skills and expertise to identify and support.

10.9.3 There is evidence to suggest there was contact with and involvement of the family during each admission, however Jennifer's father has indicated that there needed to be greater involvement of the family by all services at other times. Jennifer's

father and her GP identified that Jennifer had learned ways of masking theseverity of her disorder.

10.9.4 Jennifer engaged with the GP Practice in the most part. There were occasions where she did not attend for appointments or did not respond to SMS text messaging bit this was not at a level to cause the practice concern. At Jennifer's request, there were a high proportion of telephone contacts, a situation made more difficult in the first two months of the Covid-19 pandemic. Jennifer attended the surgery for blood tests and participated well in telephone consultations. However, there were repeated requests for Jennifer to make appointments to discuss her pain relief medication; Jennifer did eventually contact the surgery regarding this.

10.9.5 The Access and Crisis Team offered Jennifer a telephone assessment, which she requested due to her anxiety. The fact that Jennifer failed to engage with the assessment could be an indication that her mental or physical health had deteriorated further. The Access and Crisis Team did not believe that there was any information in the referral that suggested the case should be escalated following non-engagement.

10.9.6 It is not known if Jennifer's increased alcohol intake impacted on her ability to engage.

Learning point 10: There was a mixed picture in terms of Jennifer's engagement with services. On the whole she did engage with blood tests and monitoring of her weight; she appears to have been less engaged in reviewing her pain relief. The pandemic undoubtedly made a difference to the way services engaged with patients and vice versa but it is a positive that other mediums were regularly used to maintain contact, and where only a face to face appointment would be sufficient, these were well attended.

10.10 Assessments

10.10.1 During the time frame being looked at for this review, there was only one assessment which was completed between Priory Hospital Cheadle Royal staff and those seeking to commission the service. This resulted in a brief report looking at suitability for placement in line with the service being sought with links made to admissions criteria (please see focus area 7). As Jennifer was placed on the waiting list, this assessment confirmed Jennifer was suitable for the service, although the caveat of physical health was in place as Jennifer needed to be well enough physically for admission.

10.10.2 There was a lack of use of the Mental Health Act by all services. There is no evidence within the GP records of consideration of a Care Act assessment or referral to adult social care, or discussion with the integrated neighbourhood teams regarding any care and support needs. The GP confirmed that concentration was on getting Jennifer medically fit. The GP reported two issues impacting on them referring to ASC. The first was an issue of consent from the patient to the referral and the second, was a perception that when GP's make referrals for patients to ASC they are asked if the patient is medically stable; as Jennifer wasn't that became the GPs priority prior to considering her wider care

and support needs. It is not clear whether the treating GPs experience is a accurate reflection of the situation.

10.10.3 The Access Team were not able to provide a mental health assessment for Jennifer as they had no direct contact with her. A Mental Health Act assessment would have reviewed eligibility for an assessment under the Care Act 2014.

10.10.4 On call Psychiatry met with Jennifer twice in June of 2020 to complete Mental Capacity assessments in relation to discharge and onward referral to the Eating Disorder service. Review by the Clinical Director for NCA in Bury found these assessments to be adequate but has suggested that in future on call doctors could seek senior review as opposed to discussion.

Learning point 11: In general there was a lack of assessment in this case. Concentration on getting Jennifer medically fit meant that no holistic assessment to consider all Jennifer's care and support needs was ever completed. Such an assessment may have identified further concerns around Jennifer's alcohol use that could have led to further referrals and treatment. Whilst assessments took place at points of admission, no further assessments were undertaken during the admission to demonstrate whether there had been progress or deterioration. There was a lack of risk assessment.

10.11 Mental health support

10.11.1 There was a delay in referral to mental health services possibly due to the lack of recognition of the severity of Jennifer's eating disorder. A referral was made by the GP to community mental health services (CMHT) in June 2020, however, there is no evidence within GP records to indicate whether this referral was accepted or declined. There is no documented evidence regarding what follow up the practice were offering pending mental health service involvement, or if any other services were considered.

10.11.2 The referral was directed by the CMHT to the Access and Crisis team. The referral indicated that Jennifer was experiencing symptoms of anxiety. It was reported that there were no self-harm or suicidal concerns and no further symptoms of a serious mental illness. A referral of this nature would ordinarily be rejected on the grounds that it did not meet the services criteria. However, despite this, Jennifer was offered an appointment for a mental health assessment with the Access and Crisis Team, to review her presenting complaint and complete a fill biopsychosocial assessment. This decision was based on concerns that Jennifer had a confirmed eating disorder diagnosis, was using substances, was experiencing symptoms of anxiety, was homeless and lacked a support network. Unfortunately this, and the referral by the on call Psychiatrist for follow up in the Outpatient's Department were not attended.

10.11.3 The Access and Crisis Team wrote to the GP to inform them that Jennifer's appointment had not been attended and referred her back to her GP.

Learning point 12: Despite Jennifer's severe eating disorder and anxiety diagnoses, Jennifer received no ongoing mental health support throughout the whole period under review. Had Jennifer been admitted to or under the care of the SEDU, mental health support and care would have been an integral part of the

care she would have received. The 'opt – in' model in mental health services demonstrates that the most vulnerable patients may be missed.

10.12 Professional Curiosity and Escalation

10.12.1 There is little evidence within the GP records of professional curiosity until June 2020 whereby there appears to be a more focused approach to Jennifer's eating disorder. The documentation shows numerous contacts relating to pain relief medication – although it appears that prescriptions were auto generated without discussion with Jennifer. There were also numerous blood tests and results, but the documents only show discussions regarding electrolyte supplements such as potassium. These discussions appear to focus on the blood test result with little in the way of holistic health discussion.

10.12.2 During a GP consultation in October 2019 a discussion took place with Jennifer regarding Iron deficiency anaemia. The consultation simply stated dietary restrictions ++ and history of eating disorder. There was no documented exploration of what the dietary restrictions were or how these impacted on Jennifer's general health and wellbeing.

10.12.3 A primary care consultation had taken place in June 2020 whereby it was reported Jennifer smelled strongly of alcohol and admitted to drinking that day – no further exploration of this was documented. Jennifer's GP informed the reviewer that there was no evidence that Jennifer had an issue with alcohol.

10.12.4 When Jennifer reported to primary care that she was having difficulty walking due to her feet swelling, a referral was made for walking aids but there is no evidence that discussion took place as to how she managed with other tasks.

10.12.5 Other referrals such as to the community dieticians were declined by the service however, documentation does not show whether other options were considered by the GP. A mental health referral was made in mid-June 2020 only a few weeks before Jennifer sadly died.

10.12.6 Throughout the document, you will see that the incidents of miscommunication and how this impacted significantly on both staff within Priory Hospital Cheadle Royal and external commissioners/ mental health teams understanding. It can be seen that a significant lack of understanding on what was being communicated by Priory Hospital Cheadle Royal and external colleagues directly impacted on the risks associated to the care and treatment afforded to Jennifer. The reviewer learned that there are legal services available to assist practitioners decision making in complex cases; these were not approached in this case.

10.12.7 As Jennifer was not directly a patient within any Priory Hospital Cheadle Royal service, and no Priory Hospital Cheadle Royal staff had met with Jennifer directly, there was no oversight into her presentation other than what was being verbally provided via those who contacted the Priory Hospital Cheadle Royal for advice.

10.12.8 When Jennifer was removed from the waiting list of Priory Hospital Cheadle Royal, the external commissioner was not aware of this action being taken at the time and therefore the understanding of the risks associated to Jennifer was unclear. It can be seen that by the lack of clear communication at a critical time in Jennifer's life, there was an inability to fully understand the risks. If the external

commissioner communicated to via email as a follow up to a verbal communication in regards to the removal of Jennifer from admission waiting list, this may have provided them an opportunity to have responded in a timely way thus allowing Jennifer to remain on the waiting this and preventing further delays.

10.12.9 Although there is no contract or commissioned service in place for outpatient services or any form of support in the community, it can be seen that the community services reached out to ask for advice, guidance and support when in need. At this time, it could have been appropriate to understand current management plans and strategies which would then inform any advice and guidance provided. It does not appear any telephone call went into this level of detail.

10.12.10 Jennifer was offered an appointment with the Access and Crisis Team despite not meeting the criteria for an assessment (no evidence of a serious mental illness or risk to self, and/or others in relation to deliberate self-harm/suicidal thoughts. An assessment was offered due to curiosity and was considered necessary to obtain further information relating to the care needs of Jennifer.

10.12.11 When Jennifer was discharged into GP care, the GP was clear that Jennifer was not suitable due to her clinical needs for primary care; this was not escalated to commissioners. The GP reports that because of the length of response time following escalation by commissioners that he did not have confidence an escalation of this nature would resolve the issue.

Learning point 13: Opportunities to understand Jennifer's lived experience were missed. Indicators that other issues were potentially exacerbating Jennifer's ill health were not fully explored. When gaps in service provision meant there was no suitable service that could meet Jennifer's needs this should have led to escalation to commissioners, this did not happen. When frontline practitioners did raise their concerns with managers, no solutions that would address Jennifer's needs were forth coming.

10.13 Discriminatory practice

10.13.1 Jennifer was placed on the admissions waiting list when contact was made from those seeking to commission a service. There was information made available at the time to inform there was a delay in admission approx. 3 weeks although this was subject to change. At this stage, no formal assessment was undertaken by a member of Priory Hospital Cheadle Royal staff as this would be scheduled as close to an admission date as possible to ensure up to date and accurate information was available. The assessment, although not completed for Jennifer does not show any evidence of being discriminatory in nature as it seeks to provide a full and accurate overview of an individual, their background and their care and support needs thus informing risk assessment and care plans.

10.13.2 The admission criteria and exclusion criteria does not show any evidence of discrimination towards Jennifer as it seeks for someone to be physically medically stable to ensure an individual's care and support needs can be met within the service.

10.13.3 There is no evidence that Jennifer's age was a discriminatory factor for any part of the care and treatment associated with the interaction involving Priory Hospital Cheadle Royal.

Learning point 14: Whilst there is no evidence of discriminatory practice regarding Jennifer's age, there was no consideration given to Jennifer's ability regarding decision- making or her needs when she reported difficulty in mobility, and how that would have impacted on her ability to undertake any activity of daily living.

11. Examples of Good Practice:

- It is evident throughout the records that the specialist clinician from the SEDU, had a thorough understanding, and appeared confident in the use, of MARSIPAN guidelines. The specialist clinician included reference to MARSIPAN guidance when expressing concerns about Jennifer's discharge.
- The specialist clinician was willing to provide advice and guidance to the medical team even though they were not commissioned to do this as Jennifer was not a Priory Hospital Cheadle Royal patient. Current practice via the pre-admission assessment is in line with good practice to ensure this is completed close to admission to ensure full and accurate information is available. This process also ensures those who are awaiting admission are not assessed and then wait long periods of time thus increasing anxiety.
- It can be seen that there has been there is an established link between the community services and Priory Hospital Cheadle Royal supporting those who require intensive care and community care.
- Current policy and practice within Priory Hospital Cheadle Royal seeks to explore an individual's capacity as close to admission as possible to ensure any actions taken are timely and informed. Auctioning based on old assessments could result in highly restrictive action being taken under legislation which may not be appropriate due to changes in presentation.
- At the time of seeking admission into the service, the criteria that was in place ensured there was thought and consideration into the physical health needs of patients include Jennifer. This was on a regular basis looked at to ensure Jennifer remained suitable for admission or if needed was directed to general hospitals for treatment and stabilisation. The consultant who provided advice and guidance on request was able to demonstrate an understanding of the admission criteria and when being asked for advice was able to redirect as appropriate.
- There is evidence of good practice of repeated attempts to facilitate referral and support for Jennifer by contacting The Willows, The Priory Hospital Cheadle Royal and FGH. At one point contacting FGH to ensure Jennifer was admitted to an in-patient bed. Although, sadly, this was Jennifer's last admission to A&E. However, the repeated attempts made to refer Jennifer appropriately highlighted challenges and system blockages that ultimately stopped effective plan of support for Jennifer.

- The Practice have highlighted discussions will take place at the next clinical meeting regarding holistic care approach. Since this case the Practice have been undertaking case discussion of complex cases in clinical meetings 1-2 times a week.
- The GP Practice offered Jennifer face-to face consultations, even during the Covid-19 pandemic, where it was though she was high risk, and this was more appropriate. Jennifer did attend the face There was an attempt of co-ordination by the GP Practice to try to ensure Jennifer had some form of treatment plan from April 2020. The GP Practice followed up a referral to A&E with a telephone call in July 2020 to ensure Jennifer was admitted into an inpatient bed.
- A telephone encounter on the 1st of June whereby Jennifer stated her family had told she looked like would die pre-empted a face-to-face consultation for the same day. During this face-to-face consultation Jennifer's weight and BMI were recorded.
- Regular blood test monitoring and acting on the results. The Practice booked a face-to-face appointment on the same day as a concerning telephone consultation whereby by Jennifer reported her family had become very worried about her. Subsequently there was a mixture of telephone contacts and face-to-face contacts during the summer of 2020.
- The access and crisis team offered Jennifer an assessment, despite her not meeting the criteria for a mental health assessment.
- The Access and Crisis Team, liaised with other services to inform them that Jennifer had failed to engage with a mental health assessment. Jennifer was also sent a DNA opt-in letter, providing her with further opportunities to engage in an assessment. When Jennifer did not contact the service, she was discharged from the Access and Crisis Team and the GP was informed of the steps taken by mental health services.
- Jennifer received a full assessment and physical examination and clinical investigations in line with MARSIPAN within the ED department including BMI, muscle power, blood tests and ECG, and regular review and intervention from presenting cardiac symptoms.
- There is evidence of consistent assessment and review of Jennifer's condition and information sharing within NCA on all admissions and an MDT approach to care and treatment provided.
- There is evidence of assessment of capacity around pressure damage, which was reviewed by the tissue viability team, and also informal review of capacity is evidenced
- There is evidence to suggest regular family contact and involvement in place during each admission, family were kept involved and consulted on matters with consent from Jennifer.

Appendix i – key to acronyms/ abbreviations

A&E	Accident & Emergency
BISP	Bury Integrated Safeguarding Partnership
BMI	Body Mass Index
CCG	Clinical Commissioning Group
CRG	Case Review Group
ECG	Electrocardiogram
ED	Emergency Department
GM	Greater Manchester
GP	General Practitioner
KLOE	Key Lines of Enquiry
LA	Local Authority
MARSIPAN	Management of Really Sick Patients with Anorexia Nervosa
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
OT	Occupational Therapy
SAR	Safeguarding Adult Review
SEDU	Specialist Eating Disorder Unit
ToR	Terms of Reference