Adult Community Eating Disorder Services

Initial year summary report

Editors: Karishma Talwar & Jessica Butler

Publication ref: CCQI352

Contents

Foreword

I am really pleased to introduce the first national report for the community branch of the Quality Network for Eating Disorders (QED).

QED is part of the College Centre for Quality Improvement (CCQI). The CCQI runs a programme of quality networks and accreditation schemes working with a wide range of mental health services. Across the networks, we work with nearly 1600 services and are delighted to be now working with community eating disorder services.

QED has worked with inpatient eating disorder services around the UK since 2012. The new community branch means that QED now works across all specialist eating disorder services and can provide a bridge between inpatient and community services.

The report highlights many areas of very good practice within services and examples of high levels of compliance with the standards. It also shows some areas where there is still disparity between teams and standards that several teams are not meeting. I hope being part of the network can help services to work towards making improvements in these areas and an increased consistency in the quality of care around the UK.

I would like to thank all the services that participated in this first year of reviews. It is great to see your commitment to improving quality in your service. I hope you find this report helpful. For teams thinking about joining the network, I hope the report demonstrates some of the benefits of participating.

I would also like to thank all the peer-reviewers who attended visits during this first year – clinicians, patients and carers. I would also like to thank the QED advisory group for their support with developing this important new stream of work and the project team who have done a fantastic job of delivering this first year of reviews.

Peter Thompson
Senior Associate Director (CCQI)

Introduction

The Quality Network for Eating Disorders (QED) works with inpatient and community services to assure and improve the quality of services treating people with eating disorders and their carers.

Through a comprehensive process of review, we identify and acknowledge high standards of organisation and patient care, and support other services to achieve these.

Involving service users and carers in QED is a priority, and people with first-hand experience of using eating disorders services are encouraged to get involved in all stages of the review process.

Community pilot

Nine adult community eating disorder services participated in the initial cycle*. The community pilot ran from May 2019 to September 2020. Services took part in peer reviews rather than accreditations, meaning that they were discussion-based, centring on the host team's achievements but also reflecting on areas for improvement.

There was a lot of variety between services, for example, the breadth or diversity of their geographical coverage, the make-up of their staffing complement, and the interventions offered. This highlighted the need for standardisation in order to ensure equality of access for patients, but also made apparent just how much our teams have to offer others in the way of experience and innovation.

*10 services signed up for the initial cycle but due to COVID-19 one service was unable to take part.

Member service locations

In the initial year, we had involvement from services in England, Wales, Northern Ireland and Scotland.

Review process

The reviews aim to improve services incrementally by applying standards and using the principles of the clinical audit cycle. The standards are applied through a process of self-review and external peer review where members visit each other's service. The self-review questionnaire is a checklist of QED standards against which teams rate themselves, supplemented with more exploratory items to encourage discussion around achievements and ideas for improvement. The self-review process helps staff to prepare for the external peer review and become familiar with the standards.

During the peer review, data are collected through interviews with frontline staff, patients and carers about the service. Representatives from local agencies (other health services, social services and the voluntary sector) are also invited to take part in a discussion about multi-agency working. The results are fed back in local and national reports. Services then take action to address any developmental needs that have been identified.

What is in this report?

This national report contains the aggregated results of the reviews undertaken by nine adult community eating disorder services during the initial review year. It examines contextual data obtained from all services, including current caseload, referrals, total caseload, number of cancelled appointments and did not attends, and discharges. The main body of the report highlights key achievements and areas for improvement across services from each standard domain of the First Edition of the QED Community Standards. Mean scores met across the different types of standards by services are also shown in graphs. Recommendations for each standard domain are also detailed (see pages 25 to 27 for a full list of recommendations).

Finally, a full summary detailing the average scores for each criterion for all participating teams is included (see Appendix 2). This enables teams to benchmark themselves against other teams who participated in the initial year.

How to use this report

Average scores for teams involved in the initial year are detailed in this report so you can see how well you are performing against the standards compared with the other community teams. You can also compare your team's activity, resources and outcomes with those of the network as a whole. We recommend that you use this report in conjunction with your local report to inform discussions with your commissioners and to demonstrate your team's performance.

Your team's local report provides you with a summary of the number of criteria met, partly met and not met, which then yields an average score for each individual standard. These averages enabled us to obtain a measure of your team's overall performance for each section of the service standards.

Contextual data

All services were asked to provide up-to-date contextual data covering the six months prior to each peer-review, including current caseload, referrals, total caseload, number of cancelled appointments and did not attends, and discharges. Below are the totals and averages of the contextual data collected.

At the time of data collection
the total caseload across all teams was **1565**

The average caseload was
224

The total number of referrals accepted across all teams was **515**

The average of all
accepted referrals was **86**

The total number of referrals received by all teams over the 6 months prior to each peer-review was **1264**

The average of all referrals
was **181**

The total number of appointments not attended (DNA's) across all teams was
44

The average of all DNA
appointments was **9**

The total number of discharges across all teams was **680**

The average of all
discharges was **113**

The total number of cancelled appointments across all teams was **36**

The average of all cancelled
appointments was **9**

The standards

The First Edition of the QED Community Standards, against which the performance in the initial year was assessed, can be found in Appendix 2.

The standards are drawn from a range of authoritative sources and incorporate feedback from patient and carer representatives, and experts from a range of relevant professions.

The standards were used to generate a series of data collection tools for use in the self- and peer review processes. Participating teams rate themselves against the eight sections of the QED Community Standards via an annual process of self and peer review. This model aims to facilitate incremental improvements in service quality.

Types of standard

Standards are categorised as a type 1, 2 or 3.

Type 1 standards relate to patient safety, rights or dignity. Failure to meet these standards would represent a significant threat to patients and/or would break the law.

Type 2 standards are standards we expect services to meet.

Type 3 standards are criteria that an excellent service should meet or are standards that are not the direct responsibility of the team.

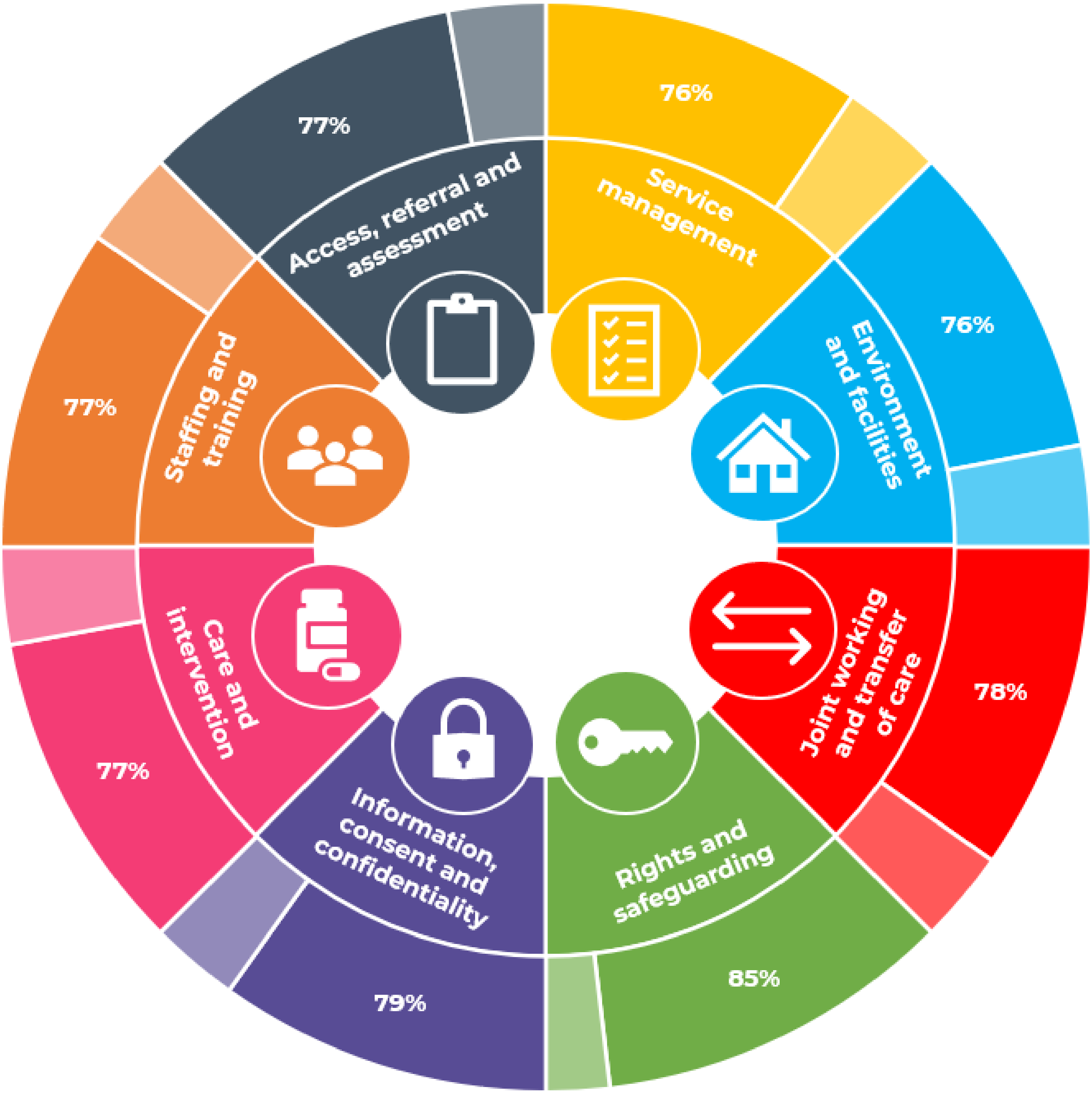
Standards domains

The QED Community Standards are grouped into eight standard domains:

1. Access, referral and assessment
2. Staffing and training
3. Care and intervention
4. Information, consent and confidentiality
5. Rights and safeguarding
6. Joint working and transfer of care
7. Environment and facilities
8. Service management

Overall performance of member services

The infographic shows the percentage of met standards in each standard domain.



Access, referral and assessment

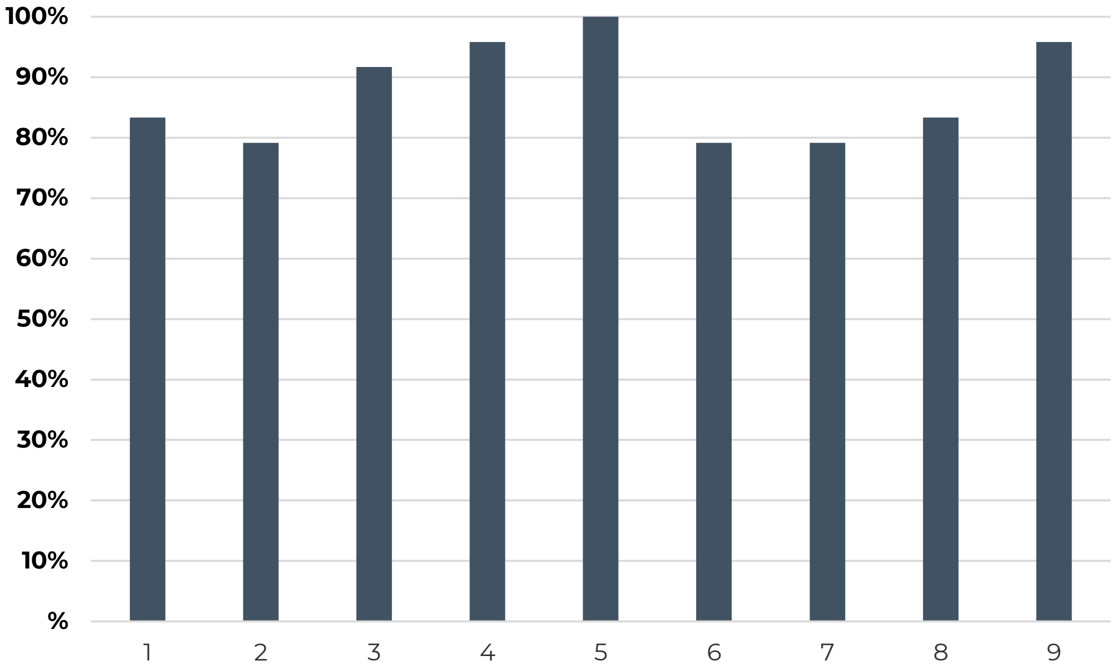


Figure 1: Access, referral and assessment: percentage of met standards

Key achievements

100% of services have a local strategy in place to promote and monitor equality and diversity, prevent discrimination and to address any barriers to access

100% of services have easier access to eating disorder care for people with diabetes and pregnant women

In 100% of services, initial assessments are completed by a staff member who is trained in specialist eating disorder assessment and formulation

Areas for improvement

67% of services provide patients and carers with information on expected waiting times for assessment and treatment

44% of services pass on referrals made through a single point of access to the community team within one day, or urgent referrals within four hours

78% of services have care plans in place to ensure risk is monitored, that there is a crisis plan and a named professional within the eating disorders service

Recommendations for services

1. Review care plan templates to ensure that key information, such as crisis planning, is captured consistently.
2. Develop a template letter for patients on the waiting list which includes information on waiting times as standard.
3. Conduct an audit of time taken for referrals to pass from a single point of access to the community team. A system should be put in place to manage referrals within the specified timeframes.

> *The transition between inpatient services and the community service was smooth. I felt supported throughout.*
> **Patient**

> *I was provided with a plan when my loved one began their treatment with the service, at their first assessment meeting.*
> **Carer**

> *I waited around six weeks for my first appointment and did not know who to contact for support while I was waiting.*
> **Patient**

> *I would benefit from having more out of hours access to the service, as at times I do not feel supported if I am struggling between these sessions.*
> **Patient**

Good practice: Flexible working, *Stirling Eating Disorder Service*

The service offers flexibility to patients by ensuring the location and timings of appointments are convenient, and provide options to fit in with their schedules. Patients also noted the usefulness of signposting information and being able to access a support group while on the waiting list.

Staffing and training

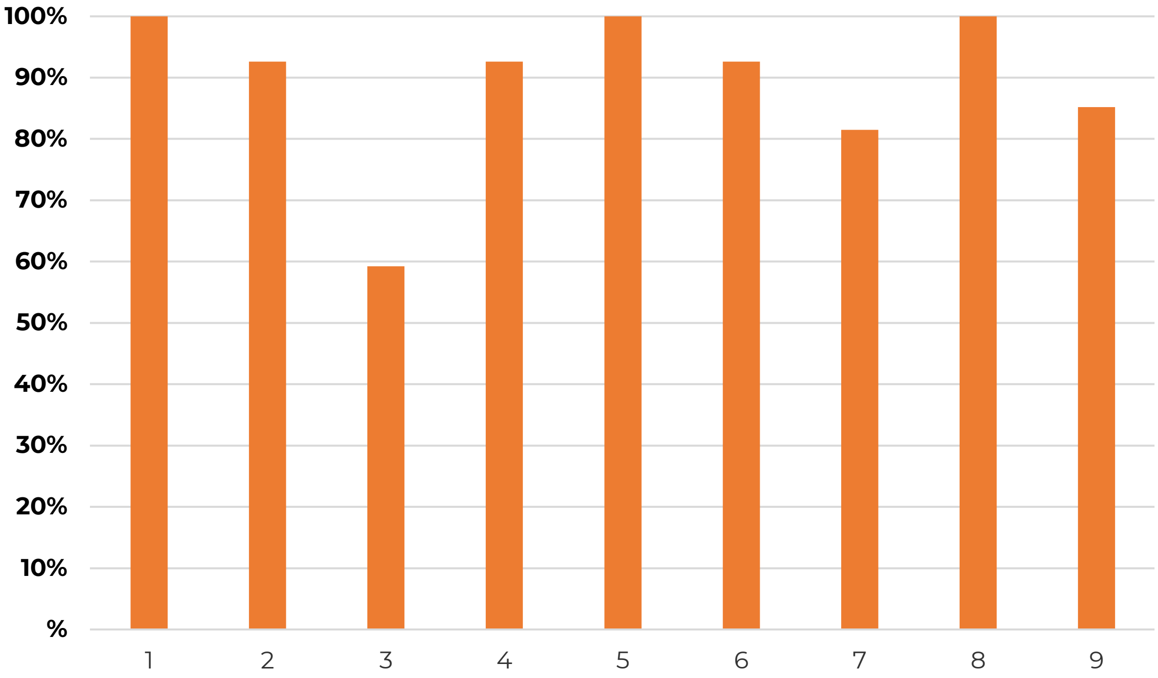


Figure 2: Staffing and training: percentage of met standards

Key achievements

100% of services have a clear supervision structure so that staff members receive professional, clinical and line management supervision and understand who is responsible for each of these elements

In 100% of services, the team has designated time at least once a month to meet as a group to reflect upon the process and the impact of the clinical work

In 100% of services, staff members, patients and carers who are affected by a serious incident are offered post incident support

Areas for improvement

56% of services involve patients and carers in the interview process for recruiting staff members

56% of services have a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels

56% of services involve patients and carers in delivering staff training face-to-face

Recommendations for services

1. Develop a clear protocol to ensure safe staffing levels at all times, and ensure staff are familiar with the procedure. This could include reviewing the skill mix of the available staff, the clinical presentations of patients and pending discharge plans.
2. Try to involve patient and carer representatives in the design of interview questions.
3. Use patient and carer forums to develop key information to be used as part of staff inductions.

> *The staff are brilliant, and as it is a small team, I feel staff can really get to know us.*
> ***Patient***
>
> *The staff are very attentive, friendly and approachable and treat [patients] with dignity and respect.*
> ***Carer***

> *Having no support on weekends can be difficult, and I have not found the crisis contact helpful when I have utilised it.*
> ***Patient***
>
> *It may be helpful for me to be involved in staff interviews, to be able to give my input on characteristics in staff which future patients may appreciate.*
> ***Patient***

Good practice: Sharing responsibilities, *Wiltshire Community Eating Disorder Service*

To ensure the ‘Family and Friends’ group is accessible to all, staff who do not usually work at weekends have been running the group and sharing the responsibility of doing so on Saturdays. This has had the added benefit of the group being facilitated by staff members from various backgrounds who are able to offer diverse insights.

Care and intervention

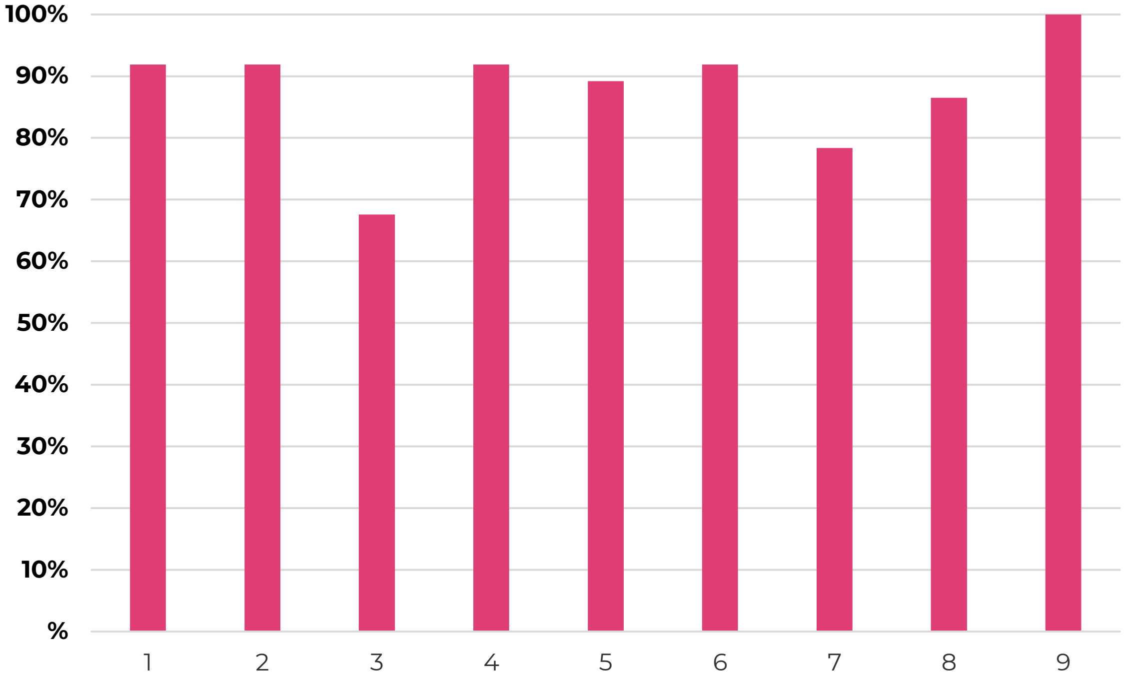


Figure 3: Care and intervention: percentage of met standards

Key achievements

100% of carers (where appropriate and with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning

100% of services provide two or more of the NICE recommended treatments for each of the disorders for which they are commissioned

100% of services begin patients' evidence-based interventions, of intensity and duration consistent with NICE guidance which are appropriate for their bio-psychosocial needs and motivation

Areas for improvement

67% of services set medication treatment goals with the patient. The risks, QTC prolongation and benefits are reviewed, a timescale for response is set and consent is recorded.

67% of services inform patients with binge eating disorder that all psychological treatments have a limited effect on body weight and this is recorded

67% of services provide a social and occupational assessment for those patients who require it to ensure the safe and effective provision of social and occupational interventions

Recommendations for services

1. Include a section about medication treatment goals in case notes and make sure this is reviewed regularly.
2. Ensure that patients with binge eating disorder are provided with information, such as a leaflet, about the limited effects of psychological therapy.
3. As part of their initial assessment, speak to patients about their social and occupational needs to determine whether they need a social and occupational assessment.

> *The progression from meal support through to 'normality' was fantastic and individualised to my own pace.*
> ***Patient***
>
> *The eating disorder team communicated effectively with other agencies involved in my care.*
> ***Patient***

> *I would appreciate being given the opportunity to develop coping mechanisms or further information on how I can help myself when I am at home.*
> ***Patient***
>
> *I did not know about the carer skills support group for us and our family.*
> ***Carer***

Good practice: Innovative self-management, *Norfolk Community Eating Disorders Service*

To support patients while on the waiting list or between appointments, the team have developed 'Keeping Myself Safe' plans designed to promote independence and self-management.

Good practice: Thoughtful information provision, *St Ann's Hospital Outpatient Eating Disorder Service*

To ensure patients and carers were aware of all the details on possible treatment interventions at the service, staff ensured these were explained in full, outlining each interventions' benefits and possible side effects. This was followed-up by written information, and regular check-ins with patients to ensure their treatment remains focused on their goals.

Information, consent and confidentiality

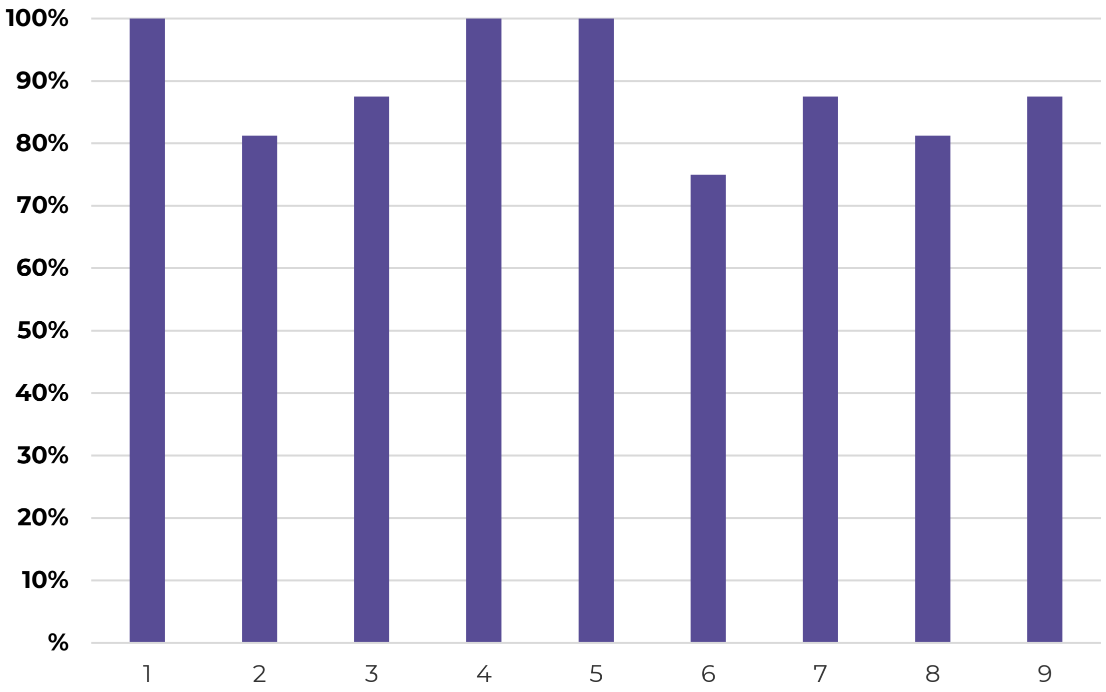


Figure 4: Information, consent and confidentiality: percentage of met standards

Key achievements

100% of services understand carers have a right to access them for information and support even if the patient does not consent to confidential information to be shared

100% of health professionals at community services communicate clearly and avoid the use of jargon when talking to patients and carers

100% of services have systems in place to ensure that any advance directives or statements that the patient has made are taken into account

Areas for improvement

78% of services offer patients and their family/carers written and verbal information about the patient's mental illness

56% of services can provide information in languages other than English, and have this information available in easy-to-use formats for people with sight/hearing/cognitive difficulties or learning disabilities

78% of services provide each carer with carer's information

Recommendations for services

1. Include written and verbal information about the patient's mental illness in an information pack given out at the start of treatment.
2. Use referral data and local demographic information to identify patient groups and ensure information is in a format that is accessible.
3. Consult a focus group of carers about which information they would have found most helpful when their loved one was first assessed by the service and use this to inform a pack of key leaflets given to carers.

> *The service has been supportive and proactive in involving my loved ones where appropriate.*
> ***Patient***
>
> *The therapeutic interventions offered by the service were explained to me and I was told what may or may not work for me.*
> ***Patient***

> *I was not given information or advice on how to help my loved ones' get better. I sought this information out for myself.*
> ***Carer***
>
> *I didn't receive any information on the service...an overview might have been helpful.*
> ***Patient***

Good practice: Innovative information sharing, *Leicester Adult Community Eating Disorder Service*

The team works with patients and carers to develop information packs and regularly updates the website specifically created for the service. The website includes downloadable information so that patients (and anyone else) can access this wherever they are and whenever is convenient for them, during or after treatment.

Rights and safeguarding

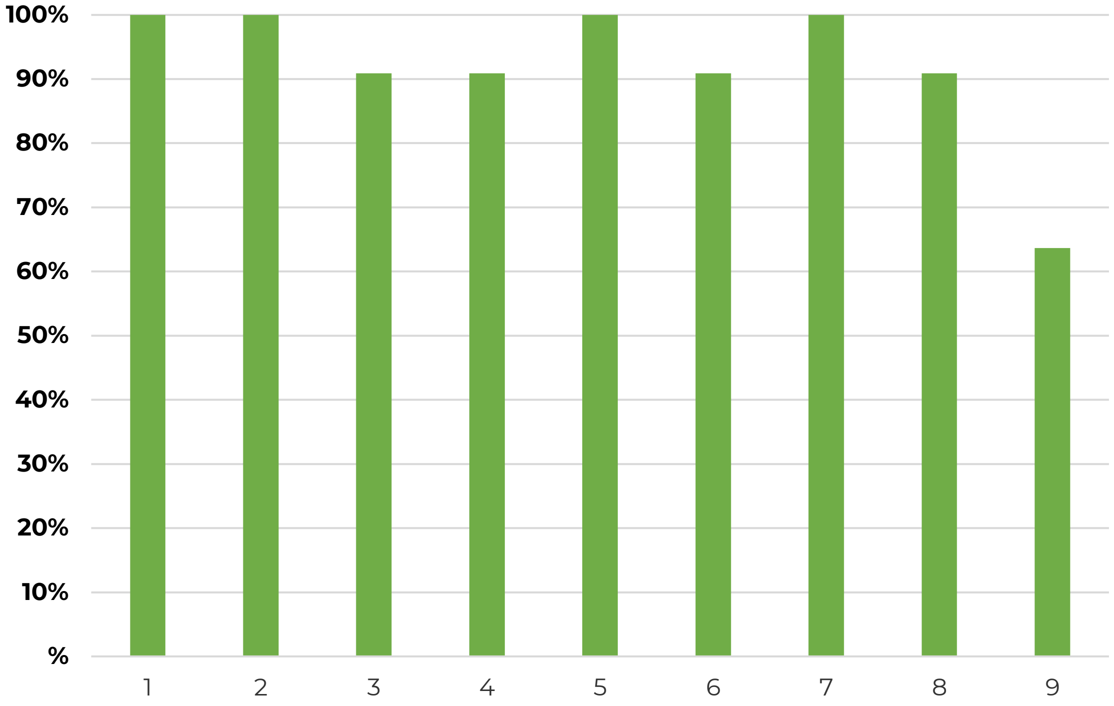


Figure 5: Rights and safeguarding: percentage of met standards

Key achievements

100% of services provide patients (and carers where applicable) verbal and written information on their rights under the Mental Health Act if under a community treatment order (or equivalent) and this is documented

100% of services' staff are knowledgeable about, and sensitive to, the mental health needs of patients from minority or hard-to-reach groups

100% of services' staff members treat patients and carers with compassion, dignity and respect

Areas for improvement

In 89% of services, carers feel supported by staff

67% of services have a strategy for improving access for male patients to the eating disorder service. This may include but is not limited to:
- Ensuring there are male staff
- Male targeted literature
- A gender neutral clinical environment.

Recommendations for services

1. Ensure that there is a designated member of staff who can respond to patient and carer queries and provide support.
2. Develop a strategy to ensure that men can access the service. This could include working with patient and carers to identify areas to change, conducting an environmental audit to identify how the service could be made gender neutral, and developing a leaflet about eating disorders in men which is available for patients.

> *Staff are friendly and approachable, and I feel listened to and respected.*
> ***Patient/carer***
>
> *Staff always take the time to talk to me when I contact them or when I am in reception waiting.*
> ***Patient/carer***

> *It would be helpful to have a suggestion box or feedback form for us and our carers to provide suggestions and feedback.*
> ***Patient***
>
> *I did not receive any information on carers support groups.*
> ***Carer***

Good practice: Carers feedback, *S3 Outpatients Eating Disorder Service*

The S3 Outpatients Eating Disorder Service has a well-established carers group. Carers who access the group find it a useful way to provide feedback to the service. The relationship between the service and the carers group has been built through working in collaboration with carers, and carers feel comfortable bringing up any issues or concerns to the staff team.

Joint working and transfer of care

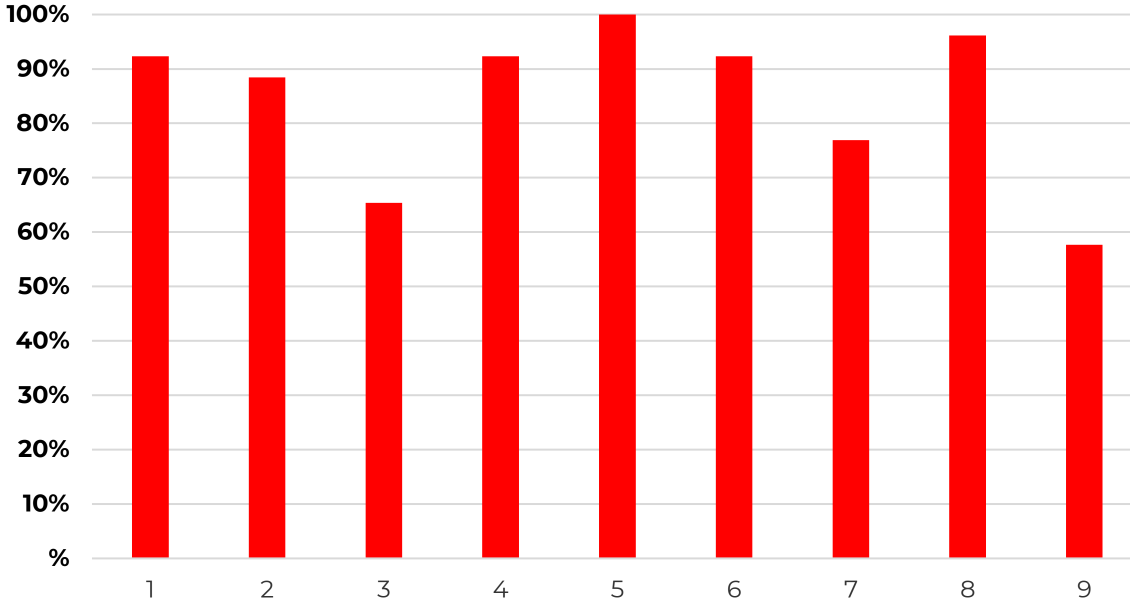


Figure 6: Joint working and transfer of care: percentage of met standards

Key achievements

100% of services support patients to access organisations which offer:
- Housing support;
- Support with finances, benefits and debt management;
- Social services;
- Employment and education

In 100% of services, when patients are transferred between community services there is a handover which ensures that the new team have an up to date care plan and risk assessment

Areas for improvement

44% of services have a clear protocol for liaison and collaborative work with the patient's university service

56% of services offer continued support to families of patients who have moved away to university

33% of services liaise with primary care teams to ensure that patients with severe chronic eating disorders are on their registers of people with severe and enduring mental illness

Recommendations for services

1. For patients that move away for university, services should ensure that regular contact is maintained via email or phone and allocate a member of staff to follow up with university services for complex cases.
2. Offer families of patients who have gone to university continued support if needed. A contact person could be assigned to a carer or a carer group organised to provide a space to talk about concerns.
3. Include a section in patient notes which prompts staff to contact primary care teams if the patient has a severe chronic eating disorder.

> *I was not involved in discussions about the stage at which I might leave the service. I am not confident my needs will be met after MANTRA, and I am worried about going back to the GP.*
> ***Patient***

Good practice: Effective communication in transfer of care, *Oxford & Buckinghamshire Adult Community Eating Disorder Services*

The team showed effective joint working with a local service which an eating disorder patient was being transferred to. This included frequent communication, updates, and timely completion of paperwork to ensure the transfer of care was smooth for all parties.

The external service were particularly complimentary about the eating disorder service's insight and awareness in knowing the patient could no longer receive the care they needed in their setting, and worked alongside the service and the patient to make this decision.

Environment and facilities

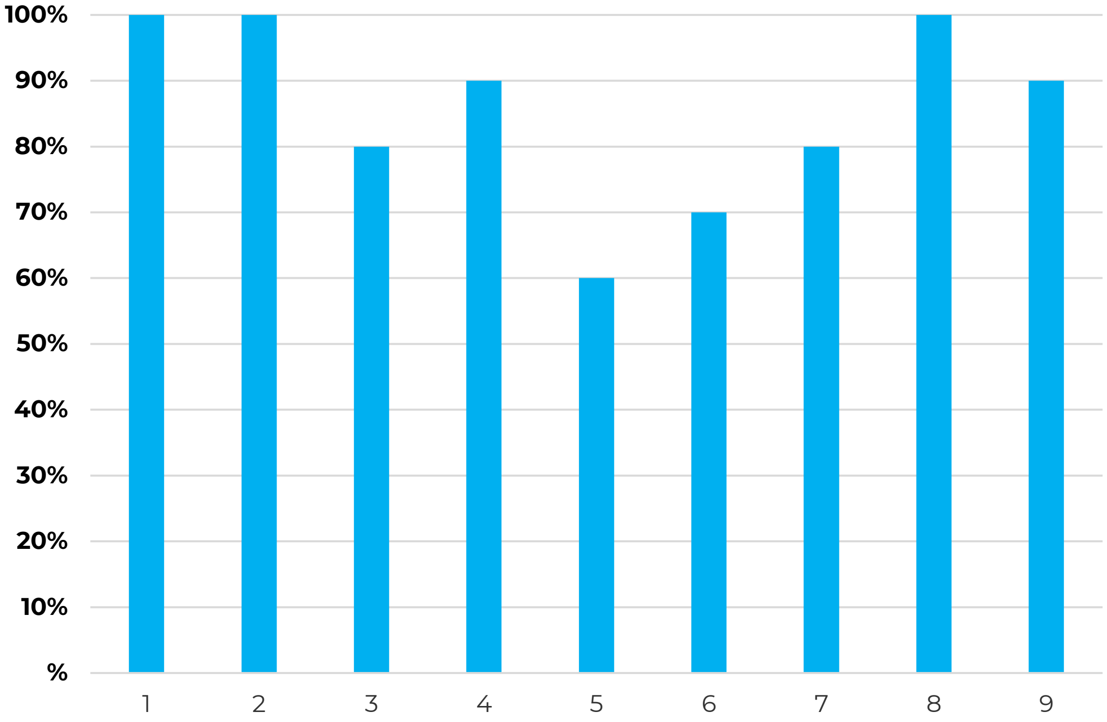


Figure 7: Environment and facilities: percentage of met standards

Key achievements

In 100% of services, furniture is arranged so that doors are not obstructed in rooms where consultations take place

In 100% of services, all staff take ownership of maintaining a clean, comfortable and welcoming environment

In 89% of services, the environment complies with current legislation on disabled access (Equality Act 2010)

In 89% of services, staff members follow a lone working policy

Areas for improvement

78% of services have an alarm system in place (e.g. panic buttons) that is easily accessible to staff at all times

78% of services' staff members follow an agreed response to alarm calls

In 78% of services, clinical rooms are private and conversations cannot be overheard

In 78% of services, staff members have access to a dedicated staff room

Recommendations for services

1. Review the alarm system in place to ensure it is easily accessible to staff and patients. If it does not comply, the service manager should raise this at a board meeting.
2. Services should review their protocol to responding to alarm calls. Services could include information about responding to alarm calls in new starters' induction packs.
3. Conduct an audit of clinical rooms to ensure they are private spaces. If they are not, the service manager should raise this at a board meeting.

> *I found the environment very comfortable and welcoming, and the rooms where I have had my appointments feel calming.*
> ***Patient***

> *I like the service environment and feel the one-to-one therapy rooms are nice and spacious.*
> ***Patient***

> *The rooms are not very comfortable, and the environment isn't well decorated which is not conducive to putting us at ease during sessions.*
> ***Patient***

Good practice: Therapeutic environment, *Belfast Adult Eating Disorder Service*

The service is thoughtful about the areas patients use for their appointments, adding features to make the environment comfortable and welcoming such as diffusers and neutral colour schemes in therapy rooms.

Service management

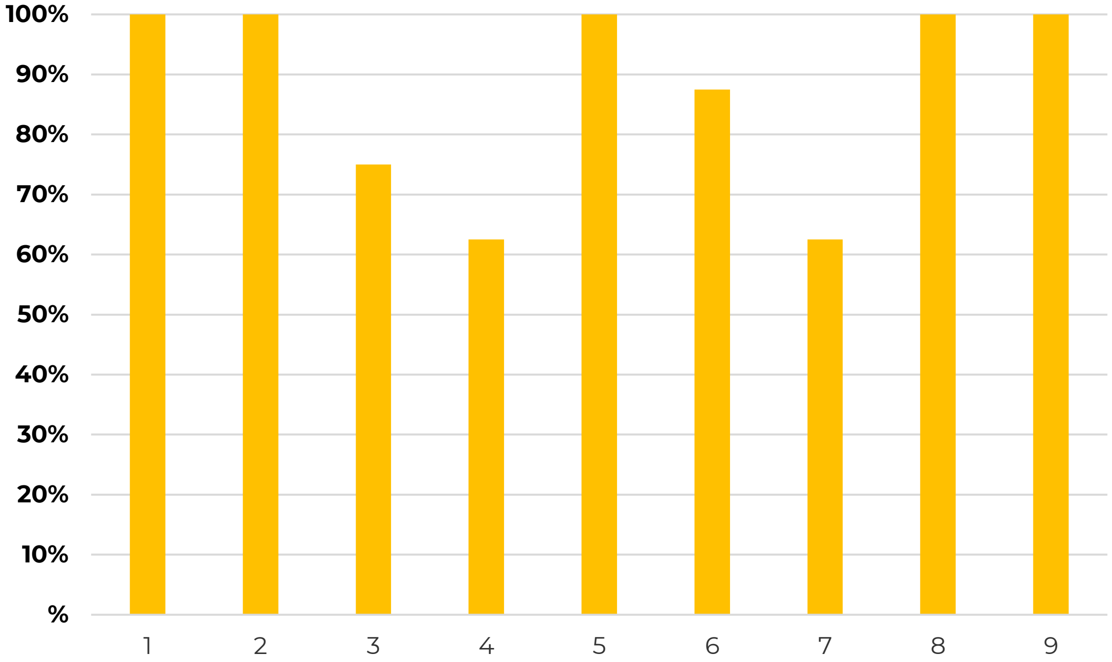


Figure 8: Service management: percentage of met standards

Key achievements

100% of services review patients' progress against

67% of services review clinical outcome data at least six-monthly. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.

100% of services share lessons learned from incidents with the team and the wider organisation

78% of services are developed in partnership with patient and carer representatives

89% of services encourage patients and carers to provide feedback confidentially about their experiences of using the service, and their feedback is used to improve the service

Recommendations for services

1. Meetings should be organised with patient and carer representatives, the team, and commissioners to discuss how to improve the service using clinical outcome data.
2. Organise annual meetings with patient and carer representatives to discuss potential developments to the service and to get input on how the service could improve.
3. Include information about how patients and carers can give feedback about the service in packs given at the beginning of treatment.

> *Staff have been very helpful to me as a carer, and proactive in organising one-to-one meetings to discuss any issues.*
> ***Carer***
>
> *Treatment at the service for my loved one has made her see the possibility of recovery and that she does have a life beyond the eating disorder.*
> ***Carer***

> *I would like to be more involved in the service and receive more support where possible, such as through groups or meetings with other carers.*
> ***Carer***
>
> *I feel it would be beneficial to have earlier support from other agencies my loved one may need support from.*
> ***Carer***

Good practice: Maintaining positive relationships, *Aneurin Bevan Specialist Eating Disorders Service*

Patients, carers and multi-agency partners said that the service is well-managed and accessible. It was clear that the service works hard at maintaining relationships, especially with external agencies who reported the service frequently went out of their way to assist them, through issuing training and holding meetings when required.

Full list of recommendations

Access, referral and assessment

1. Review care plan templates to ensure that key information, such as crisis plans, is captured consistently.
2. Develop a template letter for patients on the waiting list which includes information on waiting times as standard.
3. Conduct an audit of time taken for referrals to pass from a single point of access to the community team. A system should be put in place to manage referrals within the specified timeframes.

Staffing and training

1. Develop a clear protocol to ensure safe staffing levels at all times, and ensure staff are familiar with the procedure. This could include reviewing the skill mix of the available staff, the clinical presentations of patients and pending discharge plans.
2. Involve patient and carer representatives in the design of interview questions.
3. Use patient and carer forums to develop key information to be used as part of staff inductions.

Care and intervention

1. Include a section about medication treatment goals in patient case notes and make sure this is reviewed regularly.
2. Ensure that patients with binge eating disorder are provided with information, such as a leaflet, about the limited effects of psychological therapy.
3. As part of their initial assessment, speak to patients about their social and occupational needs to determine whether they need a social and occupational assessment.

Information, consent and confidentiality

1. Include written and verbal information about the patient's mental illness in an information pack given to the patient at the start of treatment.
2. Use referral data and local demographic information to identify patient groups and ensure information is in a format that is accessible.
3. Consult a focus group of carers which information they would have found most helpful when their loved one was first assessed by the service and use this to inform a pack of key leaflets given to carers.

Rights and safeguarding

1. Ensure that there is a designated member of staff who can respond to patient and carer queries and provide support.
2. Develop a strategy to ensure that men can access the service. This could include working with patient and carer representatives to identify areas to change, doing an environmental audit to identify how the service could be made gender neutral, and developing a leaflet about eating disorders in men which is available for patients.

Joint working and transfer of care

1. For patients that move away for university, services should ensure that regular contact is maintained via email or phone and allocate a member of staff to follow up with university services for complex cases.
2. Offer families of patients who have gone to university continued support if needed. A contact person could be assigned to a carer or a carer group organised to provide a space to talk about concerns.
3. Include a section in patient notes which prompts staff to contact primary care teams if the patient has a severe chronic eating disorder.

Environment and facilities

1. Review the alarm system in place to ensure it is easily accessible to staff and patients. If it does not comply, the service manager should raise this at a board meeting.
2. Services should review their protocol for responding to alarm calls. Services could include information about responding to alarm calls in new starters’ induction packs.
3. Conduct an audit of clinical rooms to ensure they are private spaces. If they are not, the service manager should raise this at a board meeting.

Service management

1. Meetings should be organised with patient and carer representatives, the team, and commissioners to discuss how to improve the service using clinical outcome data.
2. Organise annual meetings with patient and carer representatives to discuss potential developments to the service and to get input on how the service could improve.
3. Information about how patients and carers can give feedback about the service should be included in information packs given at the beginning of treatment.

Appendix 1: List of services involved in the initial year

- Aneurin Bevan Specialist Eating Disorders Service
- Belfast Adult Eating Disorder Service
- Leicestershire Community Adult Eating Disorder Service
- Norfolk Community Eating Disorders Service
- Oxford and Buckinghamshire Community Eating Disorder Services
- St Ann's Hospital Outpatients Eating Disorder Service
- S3 Outpatients, Addenbrookes Hospital
- Stirling Eating Disorder Service
- Wiltshire Community Eating Disorders Service

Appendix 2: Aggregated results

Standard number	**Standard type**	**Section 1: Access, referral and assessment**	**Percentage of services meeting standard**
1.1		**Accessibility**	
1.1.1	1	The service has a local strategy in place to promote and monitor equality and diversity, prevent discrimination and to address any barriers to access.	**100%**
1.1.2	2	The service has a strategy in place to ensure reasonable access for all in the catchment area.	**100%**
1.1.3	1	Clear information is made available, in paper and/or electronic format, to patients, carers and healthcare practitioners on: - A simple description of the service and its purpose; Clear referral criteria; - How to make a referral, including self-referral if the service allows; - Clear clinical pathways describing access and discharge (and how to navigate them); - Main interventions and treatments available; - Contact details for the service, including emergency and out of hours details; - Written criteria for acceptance of referrals.	**78%**

1.2		**Referral and waiting times**	
1.2.1	1	A clinical member of staff is available to discuss urgent referrals during working hours.	**100%**
1.2.2	2	Where referrals are made through a single point of access, these are passed on to the community team within one working day unless it is an urgent referral. Urgent referrals are passed on within four hours.	**44%**
1.2.3	1	The team assess patients, who are referred to the service, within a timeframe which complies with national standards as set by commissioners.	**78%**
1.2.4	1	Outcomes of referrals are fed back to the referrer, patient and carer (where appropriate with the patient’s consent) in writing. If a referral is not accepted, the team advises the referrer, patient and carer on alternative options.	**78%**
1.2.5	1	The team sends a letter detailing the outcomes of the assessment to the referrer, the GP and other relevant services within 14 days of the assessment.	**89%**
1.2.6	1	The team provides patients and carers with information about expected waiting times for assessment and treatment.	**67%**

E1.2.7	1	Referrals for people with diabetes or pregnant women are accepted into the service with a lower threshold of eating disorder severity.	**100%**
1.2.8	1	The service has a protocol for prioritising patients on the waiting list according to clinical need. Factors to consider include but not limited to: - Severity and risk (including psychosocial risk); - Recent onset/good prognosis; - Transfer from inpatient or day patient or other specialist community services (CAMHS or Adult); - Pregnancy or impact on young children.	**89%**
1.2.9	1	When on the waiting list for treatment, there is a care plan in place to ensure risk is monitored, that there is a crisis plan and a named professional within the eating disorder service for the patient, carer (if appropriate) and the GP to contact if they have concerns or questions.	**78%**
E1.2.10	2	There is a protocol to follow for patients who are on the waiting list, including support for carers, frequency of follow ups with a defined time scale and medical monitoring.	**67%**
1.3		**The initial assessment**	

1.3.1	1	For planned assessments the team makes written communication in advance to patients that include: - The name and designation of the professional they will see; - An explanation of the assessment process; - Information on who can accompany them; - How to contact the team if they have any queries, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there.	**89%**
E1.3.2	1	The initial assessment is conducted by a staff member who is trained in a specialist ED assessment and formulation.	**100%**
1.3.3	1	The initial assessment should include: - Assessment of ED compliant with NICE guidance; - A full psychiatric history including co-morbidity; - A review of their physical health, including co-morbidity (e.g: pregnancy, diabetes); - Nutritional assessment; - Social care needs; - Mental state; - Physical exam.	**100%**
1.3.4	1	When indicated, an appropriately trained psychiatrist is available to undertake a psychiatric assessment.	**100%**

1.3.5	1	A physical health review is undertaken by a specialist with ED knowledge and takes place as part of the initial assessment. The review includes but is not limited to: - Medical complications of an eating disorder; - Details of past medical history; - Current physical health medication, including side effects and compliance with medication regime; - Lifestyle factors.	**100%**
1.3.6	1	The service should have the capacity to provide the following as part of the physical health assessment and ongoing review: - Height and weight; - Blood pressure and pulse; - Skin and mouth condition; - Squat (SUSS) test; - ECG; - Blood test.	**89%**
1.3.7	1	If initial assessment identifies co-existing physical conditions that increase risk (e.g. diabetes, pregnancy), the assessing practitioner liaises with, or refers to, a doctor and this is recorded.	**100%**

1.3.8	1	Patients have a documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers: - Risk to self; - Risk to others; - Risk from others.	**89%**
1.4		**Following up patients who do not attend appointments**	
1.4.1	1	The service has a DNA and cancellation policy that is accessible to patients and carers.	**67%**
1.4.2	1	The team follows up patients who have not attended an appointment/assessment or who do not want to engage as per local policy.	**100%**
1.4.3	1	If a patient does not attend for an assessment, the assessor contacts the referrer.	**100%**

Standard number	Standard type	Section 2: Staffing and training	Percentage of services meeting standard
2.1		**Staffing levels**	
2.1.1	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: - A method for the team to report concerns about staffing levels; - Access to additional staff members; - An agreed contingency plan.	**56%**
2.1.2	1	When a staff member is on annual leave or off sick, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.	**100%**
2.1.3	1	The service has a MDT team, which will usually include psychiatry nursing, psychology/psychotherapy, dietetics, and also ideally includes OT and Social work. Where not all these disciplines are within the team, the team can demonstrate a rationale for that, and that show patient care is not compromised.	**78%**
2.2		**Staff recruitment, induction and supervision**	
2.2.1	2	Patient or carer representatives are involved in the interview process for recruiting staff members.	**56%**

2.2.2	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies.	**100%**
2.2.3	1	The service has a clear supervision structure so that each individual receives, professional, clinical and line management supervision and understand who is responsible for each of these elements.	**100%**
2.2.4	1	All clinical staff members have access to monthly group or individual clinical/therapy supervision, using a psychological supervision model delivered with someone with appropriate experience.	**100%**
2.2.5	1	For staff delivering specific psychological therapy models, supervision is provided by a supervisor who is adequately trained to deliver supervision in that specific therapy model in eating disorders. Frequency of supervision is commensurate to the size of caseload with this specific therapy and level of experience of the therapist.	**100%**
2.2.6	1	All staff members receive professional supervision at a frequency consistent with profession guidelines.	**100%**
2.2.7	1	All staff members receive line management supervision at least monthly.	**89%**
2.2.8	2	Patients and carers who volunteer with the service receive monthly supervision.	**22%**

2.3		**Staff well-being**	
2.3.1	1	The service actively supports staff health and well-being.	**89%**
2.3.2	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.	**89%**
2.3.3	1	Staff members, patients and carers who are affected by a serious incident are offered post incident support.	**100%**
2.4		**Staff training and development**	
2.4.1	1	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:	**89%**
2.4.1a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	**100%**
2.4.1b	1	Physical health assessment.	**89%**
2.4.1c	1	Risk assessment and risk management.	**100%**
2.4.1d	1	Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities.	**78%**

2.4.1e	1	Statutory and mandatory training.	**100%**
2.4.1f	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	**78%**
2.4.2	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	**100%**
2.4.3	2	Patients and carers are involved in delivering staff training face-to-face.	**56%**
2.5		**Leadership, team-working and culture**	
2.5.1	2	Staff members can access leadership and management training appropriate to their role and specialty.	**89%**
2.5.2	1	The team has designated time at least once a month to meet as a group to reflect upon the process and the impact of the clinical work.	**100%**
2.5.3	3	The team has received training in reflective practice and maintaining a psychologically informed environment.	**78%**
2.5.4	2	Team managers and senior managers promote positive risk-taking to encourage patient recovery and personal development. They ensure staff members have appropriate supervision and MDT support to enable this.	**89%**

2.5.5	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns.	**100%**

Standard number	Standard type	Section 3: Care and intervention	Percentage of services meeting standard
3.1		**Reviews and care planning**	
3.1.1	1	Patients know who is co-ordinating their care and how to contact them if they have any questions.	**89%**
3.1.2	2	The service has an agreed set of care pathways that define frequency of clinical review and define treatment interventions. This ensures that all patients accessing the service get an equal service.	**78%**
3.1.3	1	Risk assessments and risk management plans are updated according to clinical need or in line with local policy.	**100%**
3.1.4	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews.	**89%**
3.1.5	1	Every patient has a written care plan, reflecting their individual needs. Staff members actively seek to collaborate with patients and their carers (with patient consent) when developing the care plan.	**78%**
3.1.6	1	The patient (and carer, with the patient's consent) are offered a copy of the care plan and the opportunity to review this.	**89%**
3.1.7	1	All patients have a documented diagnosis and a clinical formulation.	**100%**

3.2		**Therapies and activities**	
3.2.1	1	Patients begin evidence-based interventions, of intensity and duration consistent with NICE guidance which are appropriate for their bio-psychosocial needs and motivation. Any exceptions to the above are documented in the case notes.	**100%**
3.2.2	2	The service is able to provide a social and occupational assessment for those patients who require it to ensure the safe and effective provision of social and occupational interventions.	**67%**
E3.2.3	1	Services demonstrate that they are able to provide nutritional assessment and provision of nutritional interventions.	**89%**
E3.2.4	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency.	**100%**
3.2.5	1	The patient and the team can request a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment.	**100%**
E3.2.6	1	The use of a micronutrient supplements is recommended in both inpatients and outpatient weight restoration.	**89%**

E3.2.7	2	The service has a clearly defined strategy for ensuring optimal and efficient use of resources to balance the need for evidence-based therapies for less severe cases and care for those with severe and enduring illness.	**56%**
3.2.8	1	The service provides one or more of the NICE recommended treatments for each of the disorders for which they are commissioned.	**100%**
3.2.9	2	The service provides two or more of the NICE recommended treatments for each of the disorders for which they are commissioned.	**100%**
E3.2.10	1	Patients are supported to make an informed choice of psychological therapy from those recommended within the NICE guidance and that are available within the service.	**100%**
E3.2.11	1	Patients with binge eating disorder are informed that all psychological treatments have a limited effect on body weight and this is recorded.	**67%**
E3.2.12	2	When providing psychological treatments for patients with binge eating disorder, consideration is given to the provision of consecutive interventions focusing on the management of comorbid obesity.	**78%**

E3.2.13	1	Psychological therapies offered to out-patients with anorexia nervosa include an explicit focus on reducing risk, encouraging weight gain, healthy eating and reducing other symptoms related to an ED and to facilitate psychological and physical recovery as appropriate.	**100%**
E3.2.14	1	Patients with severe and high-risk illness whose condition has not improved with treatment or who have declined treatment should be offered ongoing support and care with a specialist eating disorder clinician, with a focus on a personal recovery model.	**89%**
3.3		**Medication**	
3.3.1	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions), QTC prolongation and benefits are reviewed, a timescale for response is set and patient consent is recorded.	**67%**
3.3.2	1	Patients (and their carers, with patient consent) are helped to understand the purpose, expected outcomes, interactions, limitations, side effects and how to safely reduce or come off their medications and to enable them to make informed choices and to self-manage as far as possible.	**89%**

3.3.3	1	Medication reviews take place at a frequency according to the evidence base and individual need.	**78%**
E3.3.4	1	Where patients with bulimia nervosa or binge eating disorder are offered a trial of high dose anti-depressant medication, this is done alongside other treatments.	**67%**
3.3.5	3	Patients, carers and prescribers are able to contact a specialised pharmacist and/or pharmacy technician to discuss medications.	**44%**
3.4		**Physical healthcare**	
3.4.1	1	Staff members arrange for patients to access screening, monitoring and treatment for physical health problems in conjunction with primary care. This physical risk monitoring plan is well integrated with psychological therapy and is documented in the patient's care plan.	**100%**
E3.4.2	2	There is a care pathway in place to assess and manage physical co-morbid conditions and risk integrated with other physical health teams e.g. diabetes and/or pregnancy.	**89%**
3.4.3	1	Patients are offered personalised healthy lifestyle interventions appropriate to an eating disorder setting, such as advice on appropriate physical activity and access to smoking cessation services. This is documented in the patient's care plan.	**100%**

3.4.4	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency.	**100%**
E3.4.5	1	The service has a protocol for screening, monitoring, psychoeducation and management of bone health.	**89%**
E3.4.6	1	The service has the capacity to provide at least weekly blood tests and physical health reviews from an eating disorder specialist for patients at high risk, as defined by MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa).	**78%**
E3.4.7	1	The service has a protocol for an integrated approach to psychoeducation, monitoring of frequency and physical health risks associated with common compensatory behaviours such as vomiting and laxative misuse, and exercise.	**100%**
3.4.8	1	Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	**100%**
3.5		**Carer engagement and support**	
3.5.1	1	Carers (where appropriate and with patient consent) are involved in discussions and decisions about the patient’s care, treatment and discharge planning.	**100%**

3.5.2	1	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.	**89%**
3.5.3	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	**89%**

Standard number	Standard type	Section 4: Information, consent and confidentiality	Percentage of services meeting standard
4.1		**Providing information to patients and carers**	
4.1.1	1	Patients have access to written information which staff members talk through with them as soon as is practically possible. This information covers: - Their rights regarding consent to care and treatment; - How to access advocacy services (including independent mental capacity advocate and independent mental health advocate); - How information on how to request a second opinion; - How to access interpreting services; - How to raise concerns, complaints and compliments; - How information on how to request access to their own health records.	**89%**
4.1.2	1	Patients and their family/carers are offered written and verbal information about the patient's mental illness.	**78%**

4.1.3	2	The team provides information and encouragement to patients to access local organisations for peer support and social engagement, when appropriate. This is documented in the patient's care plan and includes access to: - Voluntary organisations; - Community centres; - Local religious/cultural groups; - Peer support networks; - Recovery colleges.	**78%**
4.1.4	2	The team provides each carer with carer's information.	**78%**
4.1.5	1	Staff understand carers have a right to access them for information and support even if the patient does not consent to confidential information to be shared.	**100%**
4.1.6	1	Patients are offered copies of letters about their health and treatment, dependent on clinical risk.	**89%**
4.1.7	1	Information for patients and carers is written simply and clearly.	**100%**
4.1.8	2	Information can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary.	**56%**

4.1.9	2	The service uses translators who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	**100%**
4.1.10	1	When talking to patients and carers, health professionals communicate clearly, avoiding the use of jargon.	**100%**
4.2		**Capacity and consent**	
4.2.1	1	Assessments of patients' capacity to consent to care and treatment are performed in accordance with current legislation and documented in the patients' notes. When patients don't have capacity, best interest's processes involving professionals and carers (where appropriate) are followed. These assessments should be undertaken: - At the initial assessment; - At regular intervals as required by the relevant legal requirement; - If the patient's capacity changes; - If the treatment plan changes; - If the patient, family or professionals request it.	**89%**
4.2.2	1	There are systems in place to ensure that the service takes account of any advance directives or statements that the patient has made.	**100%**

4.3		**Patient confidentiality**	
4.3.1	1	Confidentiality and its limits are explained to the patient and carer at the initial assessment, both verbally and in writing.	**89%**
4.3.2	1	Patients' preferences for sharing information with their carer are established, respected and reviewed throughout their care.	**89%**
4.3.3	1	All patient information is kept in accordance with current legislation.	**100%**
4.3.4	1	Patients are informed of any breach of confidentiality, and the reason why it is important to their continuing care is explained.	**100%**

Standard number	Standard type	Section 5: Rights and safeguarding	Percentage of services meeting standard
5.1		**Rights under the Mental Health Act**	
5.1.1	1	There is a protocol in place to deliver a Mental Health Act assessment when required.	**100%**
5.1.2	1	Patients (and carers where applicable) are given verbal and written information on their rights under the Mental Health Act if under a community treatment order (or equivalent) and this is documented in their notes.	**100%**
5.2		**Safeguarding protocols**	
5.2.2	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.	**100%**
5.3		**Treating patients and carers with compassion, dignity and respect**	
5.3.1	1	Staff members treat patients and carers with compassion, dignity and respect.	**100%**
5.3.2	1	Patients do not feel stigmatised by staff members and the service can evidence efforts to reduce weight and ED based stigma within the service.	**100%**

5.3.3	1	Patients feel listened to and understood by staff members.	**100%**
5.3.4	2	Carers feel supported by staff members.	**89%**
5.3.5	1	Staff members are knowledgeable about, and sensitive to, the mental health needs of patients from minority or hard-to-reach groups in relation to eating disorders. This may include: - Men, black, Asian and minority ethnic groups; - Asylum seekers or refugees; - Lesbian, gay, bisexual or transgender people; - Travellers.	**100%**
5.3.6	2	The service has a strategy for improving access for male patients to the eating disorder service. This may include but is not limited to: - Ensuring there are male staff - Male targeted literature - A gender neutral clinical environment.	**67%**
5.3.7	1	Staff members wear their Trust ID at work and this is easily visible.	**100%**
5.3.8	1	Patients and carers feel welcomed by staff members when attending the team base for their appointments.	**100%**

Standard number	Standard type	Section 6: Joint working and transfer of care	Percentage of services meeting standard
6.1		**Intensifying treatment**	
E6.1.1	1	When outpatient treatment is not effective, the service has a protocol for deciding: - When to discharge; - When to intensify; - When to provide support of clinical management or supportive monitoring; - Alternative intervention from the MDT.	**100%**
E6.1.2	1	When a decision is made to intensify treatment, intensive community options should be considered before the inpatients admission (where available).	**78%**
E6.1.3	1	Inpatient treatment or day patient treatment is considered according to NICE Guidance.	**100%**
6.1.4	1	The community service provides a named worker to inpatient services throughout admission and they are involved in care planning, admission and discharge planning meetings and CPAs.	**89%**
6.2		**Discharge planning and transfer of care**	

6.2.1	1	A discharge letter is sent to the patient and all relevant parties within 14 days of discharge or transition between service. The letter includes the plan for: - On-going care in the community/aftercare arrangements; - Crisis and contingency arrangements including details of who to contact; - Medication, including monitoring arrangements; - Details of when, where and who will follow up with the patient as appropriate.	**89%**
6.2.2	1	Patients who are discharged from hospital to the care of the community team are followed up within one week of discharge, or within 48 hours of discharge if they are at risk.	**100%**
6.2.3	1	When patients are transferred between community services there is a handover which ensures that the new team have an up to date care plan and risk assessment.	**100%**
6.2.4	2	When high-risk patients are transferred from inpatient/day patient to community, evidence based psychological outpatient treatment starts immediately (within two weeks), even when this involves being taken onto a new community team.	**78%**

6.2.5	1	There is active collaboration between Children and Young People's Eating Disorder and Adult Eating Disorder Services for patients who are approaching the age for transfer between services. This starts at least six months before the date of transfer and actively involves patients and carers.	**100%**
6.2.6	1	The team follows a protocol to manage high risk patients who drop out against medical advice. This includes: - Recording the patient’s capacity to understand the risks of self-discharge; - Putting a crisis plan in place; - Contacting relevant agencies to notify them of the discharge.	**89%**
E6.2.7	1	Patients who are at moderate to high risk should not have a service withheld because of failure to register with a GP.	**78%**
E6.2.8	1	Services should make an assertive effort to support patients to register with a GP.	**100%**
6.3		**Continuity of care**	
E6.3.1	1	Patients that are university students can access treatment in both their home and university towns.	**100%**
E6.3.2	1	When working with university students, the local and home service should work together to ensure seamless continuity of care both in and outside of term time.	**89%**

E6.3.3	1	The service should have a clear protocol for liaison and collaborative work with the patient's university service.	**44%**
E6.3.4	2	The service offers continued support to families of patients who have moved away to university.	**56%**
E6.3.5	2	The service is proactive and assertive in following up with university students who DNA or evade treatment.	**78%**
E6.3.6	1	Care plans for patients going to university should be developed in collaboration with the university service and families (where appropriate) which include arrangements for the following: - Physical health monitoring - Who to contact in case of emergency - Contingency plans in the event of DNAs - Plans for follow-up meetings	**78%**
6.4		**Interface with other services**	
6.4.1	1	The service actively supports staff health and well-being.	**89%**
6.4.2	1	The service liaises with primary care teams to ensure that patients with severe chronic eating disorders are on their registers of people with severe and enduring mental illness.	**33%**

6.4.3	1	The team supports patients to access organisations which offer: - Housing support; - Support with finances, benefits and debt management; - Social services; - Employment and education.	**100%**
6.4.4	1	Patients with drug and alcohol problems have access to specialist help e.g. drug and alcohol services.	**100%**
6.4.5	1	The service/organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: - Assessment; - Care and treatment (particularly relating to prescribing psychotropic medication); - Referral to a specialist eating disorder team/unit unless there is a specific reason not to do so.	**78%**
6.4.6	2	The service has a formal link with an advocacy service for use by patients and carers.	**100%**
E6.4.7	1	Teams have invited their local district general hospital to collaborate in a MaRSiPAN group, and the team provides specialist ED input into any agreed MaRSiPAN pathway.	**89%**
E6.4.8	2	The service provides risk assessment tools, consultation and advice to all local referrers.	**89%**

Standard number	Standard type	Section 7: Environment and facilities	Percentage of services meeting standard
7.1		**Service environment**	
7.1.1	1	Clinical rooms are private and conversations cannot be overheard.	**78%**
7.1.2	1	The environment complies with current legislation on disabled access (Equality Act 2010).	**89%**
7.1.3	1	Staff members follow a lone working policy and feel safe when conducting home visits.	**89%**
7.1.4	1	An audit of environmental risk is conducted annually, and a risk management strategy is agreed.	**78%**
7.1.5	1	Furniture is arranged so that doors, in rooms where consultations take place, are not obstructed.	**100%**
7.1.6	1	There is an alarm system in place (e.g. panic buttons) that is easily accessible to staff at all times.	**78%**
7.1.7	1	Staff members follow an agreed response to alarm calls.	**78%**
7.1.8	1	All staff take ownership of maintaining a clean, comfortable and welcoming environment.	**100%**

7.1.9	1	Emergency medical resuscitation equipment, as required by Trust/organisation guidelines, is available immediately (available for use within the first minutes of a cardiorespiratory arrest) and is maintained and checked weekly, and after each use.	**89%**
7.1.10	2	Staff members have access to a dedicated staff room.	**78%**

Standard number	Standard type	Section 8: Service management	Percentage of services meeting standard
8.1		**Patient and carer involvement**	
8.1.1	2	Services are developed in partnership with patient and carer representatives.	**78%**
8.2		**Clinical Outcome Measurement**	
8.2.1	1	Clinical outcome measurement data is collected at beginning of treatment, after 6 months, 12 months and then annually until discharge.	**89%**
8.2.2	2	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	**100%**

8.2.3	2	The service's clinical outcome data are reviewed at least 6-monthly. The data is shared with commissioners, the team, patients and carers, and used to make improvements to the service.	**67%**
8.3		**The service learns from feedback, complaints and incidents**	
8.3.1	1	Patients and their carers are encouraged to feed back confidentially about their experiences of using the service, and their feedback is used to improve the service.	**89%**
8.3.2	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	**89%**
8.3.3	1	Staff members share information about any serious incidents involving a patient with the patient themselves and their carer, in line with the Duty of Candour agreement.	**89%**
8.3.4	1	Lessons learned from incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	**100%**

Date of publication: December 2020

Publication number: CCQI352