RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

QED
QUALITY NETWORK FOR EATING DISORDERS

QED Community Report 2021

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Foreword

I am delighted to introduce the 2021 QED Community Annual Report. QED has worked with inpatient services all over the UK for 10 years. The new community branch was set up in 2019 which means that QED works across all specialist eating disorder services.

Both inpatient and community teams have worked under considerable pressure over the last two years of the pandemic. We have strived to continue to provide effective services to our service users, their families and carers, despite the many challenges we have faced. This report is testament to all of this hard work.

The report indicates a high level of compliance with the standards. It also highlights one standard that most of the teams are not meeting, information, consent and confidentiality.

I am sure that being part of the network can help teams work towards making improvements in their services and to a greater level of consistency across services. I hope that more community teams join the network over the course of this year.

I would like to thank those services who participated his year. I also want to thank the peer reviewers, clinicians, service users and carers and the QED project team who made these reviews possible.

Kris Irons, Specialist Director, Priory Group
QED Advisory Group Chair

Introduction

The Quality Network for Eating Disorders (QED) works with adult 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 reviews: 2021

The data presented in this report covers six community eating disorder service reviews including two accreditation reviews, which took place in 2021. All services were reviewed against the QED 2nd Edition Community Standards using either a peer review (based around discussion and self-review) or an accreditation review collecting evidence to validate the self-review via audits, protocol review and patient, carer, and staff surveys. Both types of review also completed interviews to gather qualitative feedback from patients, carers, frontline staff and partner agencies. Each service received a review by a multi-disciplinary peer review team, including a member of the QED project team and a patient or carer representative.

There was a lot of variety between services, such as in the make-up of their staffing complement, and the interventions offered. This highlighted the importance of 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.

Service locations

The six teams involved in this report were from England and Northern Ireland (See Appendix 1).

2nd Edition Community Standards

The QED assess eating disorder services in accordance with a set of standards. The standards are drawn from a range of authoritative sources and incorporate feedback from patient and carer representatives, as well as experts from relevant professions.

The standards are used to generate a series of data collection tools for use in the self and peer review processes. Participating teams rate themselves against the standards during their self-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. Accredited services need to meet 100% of these.

Type 2 standards are standards we expect services to meet. Accredited services need to meet at least 80% of these.

Type 3 standards are criteria that an exceptional service should meet or are standards that are not the direct responsibility of the team. Accredited services must meet at least 60% of these.

Standards domains

The QED 2nd Edition Community Standards are grouped into 8 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

Report Information

What to expect in this report:

This national report contains the aggregated results of the reviews undertaken by six adult community eating disorder services during the 2021 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 2nd Edition of the QED Community Standards. Mean scores met across the standard domains by services are also shown in graphs. Recommendations for each standard domain are also detailed.

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 the report:

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

A QED Community member service's local report provides the team 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 the team's overall performance for each section of the service standards.

Contextual data

Data taken from the six services' self reports:

The average total case load for services was 210. Ranging from 60 to 650

The average total of referrals received for services was 257. Ranging from 68 to 835

The average total of accepted referrals for services was 194. Ranging from 37 to 619

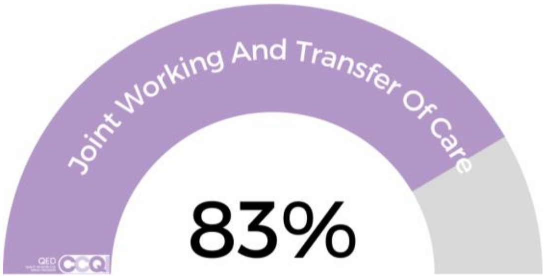
the average number of appointments that were not attended was 30. Ranging from 7 to 116

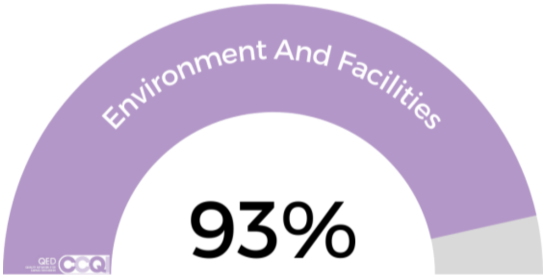
The average number of people discharged was 96. Ranging from 27 to 232

The average number of cancelled appointments was 23. Ranging from 0 to 83

Compliance with standards

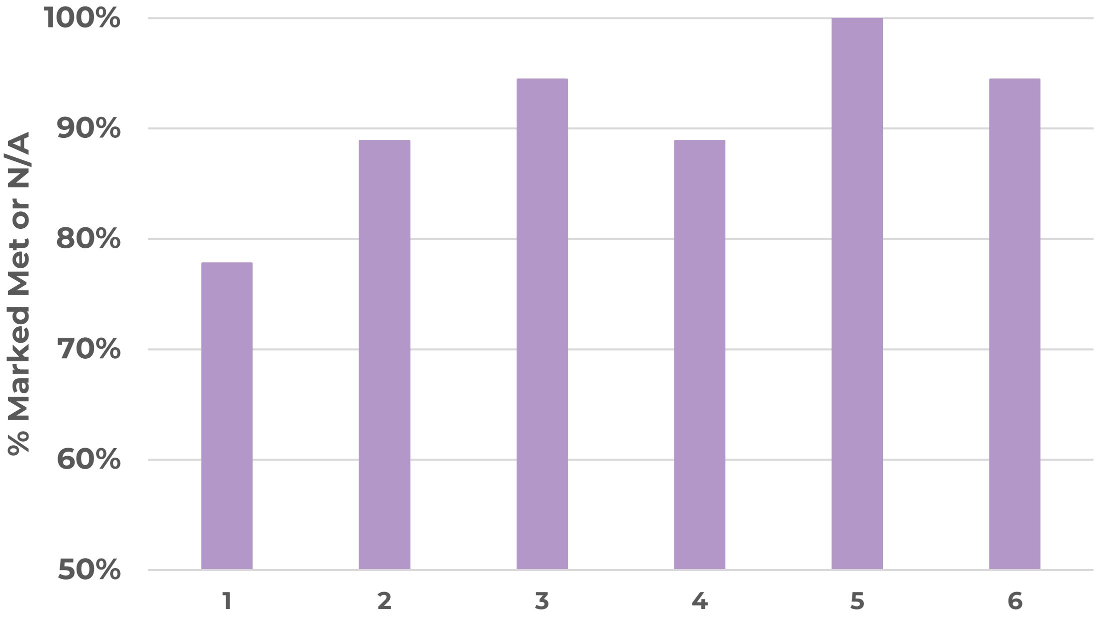
All services were assessed on their compliance with the second edition of the QED Community standards. Below is the average total adherence to each of the subsections of these standards (counting “N/A”, “Partly Met”, and “Unmet” as not adherent, and “met” as adherent).





Section 1: Access, Referral and Assessment

Total Met Standards



*Each bar represents a community service

Achievements

- 100% of teams assess referred patients within their locally agreed timelines.
- 100% of teams offer patients a comprehensive and evidence based assessment. Covering medication, psychosocial needs, suicide risk and eating disorder history.
- 100% of teams co-produce a risk assessment and management plan with the patient. They also update this regularly and share this with relevant agencies where necessary. This assessment considers risk to self, risk to other and risk from others.

Improvements

- Two of the six teams do not review demographic data annually. They therefore do not review this data annually to compare local population statistics to address inequalities of access to certain population groups.
- Two of the six teams do not have a protocol in place that is designed to be followed for patients on the waiting list. This protocol should involve how to access support for carers, frequency of follow ups with a defined time scale and medical monitoring.

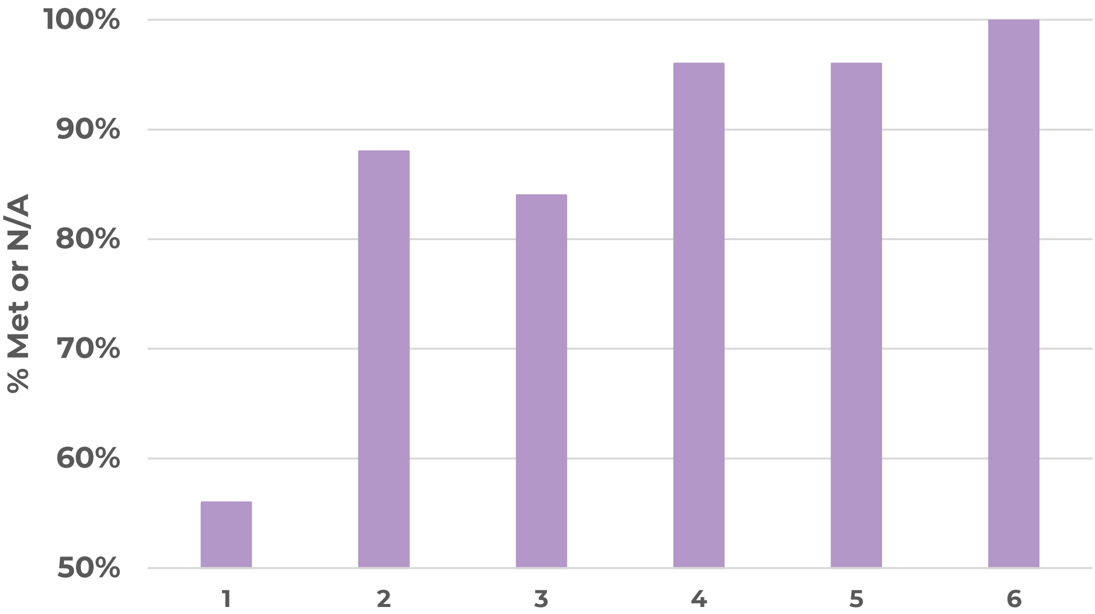
Section 1: Access, Referral and Assessment

QED Team Recommendations

	Standard criteria	Recommendations
Standard 1.1.1	The service reviews data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access that are identified.	Services should add demographic data to initials forms, if not already added. Teams should arrange an annual meeting to discuss the findings, with the MDT and patient/carer representatives involved, to plan how to address the areas of improvement. Minutes from these meeting should be recorded.
Standard 1.2.7	There is a protocol to follow for patients who are on the waiting list, including support for carers and frequency of follow ups with a defined timescale and medical monitoring.	Teams should make sure a written protocol is in place which clearly outlines the timeframes of which patients and carers are contacted. Teams should keep track of these communications to ensure they are happening routinely.
Standard 1.3.1	For non-emergency assessments, the team makes written communication in advance to patients that includes: - The name and title 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 or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).	Teams should create template emails that can be used to ensure patients receive all the outlined information. The QED recommend the team also take this opportunity to make contact with carers when given consent. This will ensure everyone is informed and up to date ahead of the assessment.

Section 2: Staffing and Training

Total Met Standards



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Achievements

- 100% of teams provide monthly clinical supervision to all clinical members of staff (or within a timeframe specified by their professional body).
- 100% of services actively support staff health and well-being, and staff agreed with this when questioned.
- In 100% of teams, the staff members reported feeling comfortable challenging decisions and raising concerns they may have about standards of care.
- 100% of teams offer post incident support to staff, patients and carers who have been affected by a serious incident.

Improvements

- Two of the six teams do not provide training in the following:
  - Risk assessment and risk management.
  - Managing distorted perceptions of food and body image, managing clients with co-morbidity and understanding the impact of trauma.
- Two of the six teams do not provide training in Carer awareness, family inclusive practice and social systems, including carers rights in relation to confidentiality.
- Two of the six teams do not offer reflective practice sessions at least every six weeks.

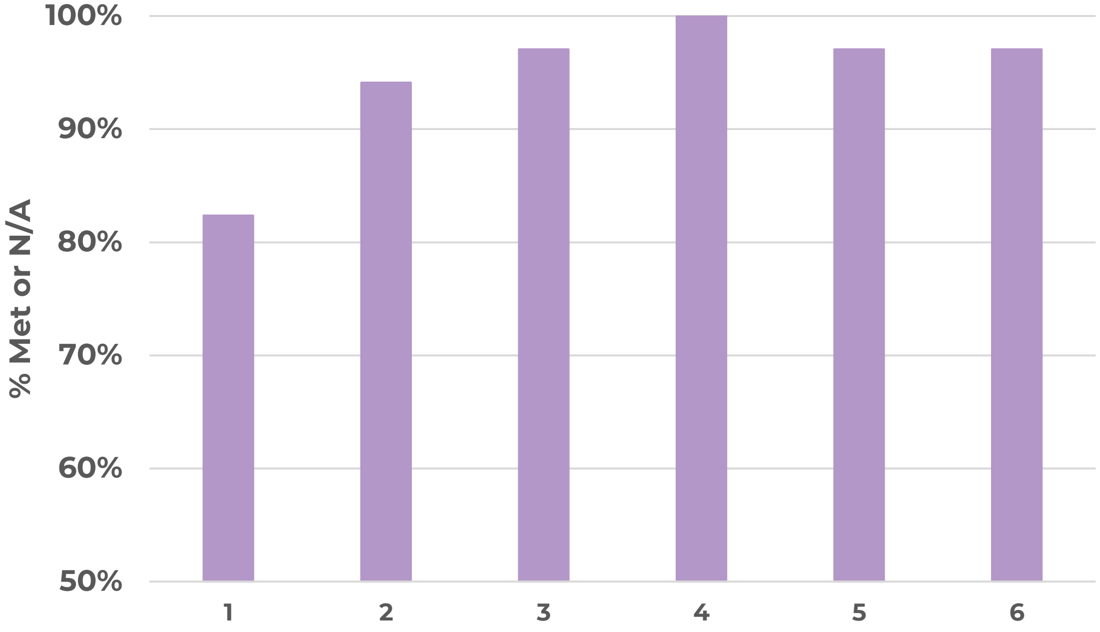
Section 2: Staffing and Training

QED Team Recommendations

	Standard criteria	Recommendations
Standard 2.4.1g	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: Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	Ensure that all staff are informed about the importance of the role of carers. This is important for services aspiring to deliver excellent care. This training should also highlight the stresses and concerns that carers can go through during this time, to ensure staff can respond to carer queries with compassion and understanding.
Standard 2.4.1h	... This training includes: Managing distorted perceptions of food and body image, managing clients with co-morbidity and understanding the impact of trauma within eating disorders.	This training should highlight to all staff the impact of co-morbidity, distorted perceptions and trauma. Without this knowledge, staff will not be able to provide care at the standard required.
Standard 2.2.1	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting staff members.	Services should look to involve patients and carers through writing questions or attending the interview themselves. This should be offered to those currently involved in the service and those discharged.
Standard 2.5.2	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.	Teams should set aside time every six weeks to ensure this meeting goes ahead. These meetings not only allow the service to raise issues but it also helps staff feel listened to, improving morale.

Section 3: Care and Intervention

Total Met Standards



*Each bar represents a community service

Achievements

- 100% of teams support patients to undertake activities to support them to build their social and community networks.
- 100% of teams involve carers in discussions about patients care, treatment and discharge planning, when patient is given.

- 100% of teams support patients to undertake structured activities such as work, education and volunteering.
- 100% of teams have an agreed set of care pathways that define frequency of clinical review and define treatment interventions.

Improvements

- Three of the six teams failed to meet the standard asking the team to make sure patients have a written care plan, reflecting their individual needs and that staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy.

- Two of the six teams do not actively encourage carers to attend carer support networks or groups, and/or do not have a designated staff member who supports carers.

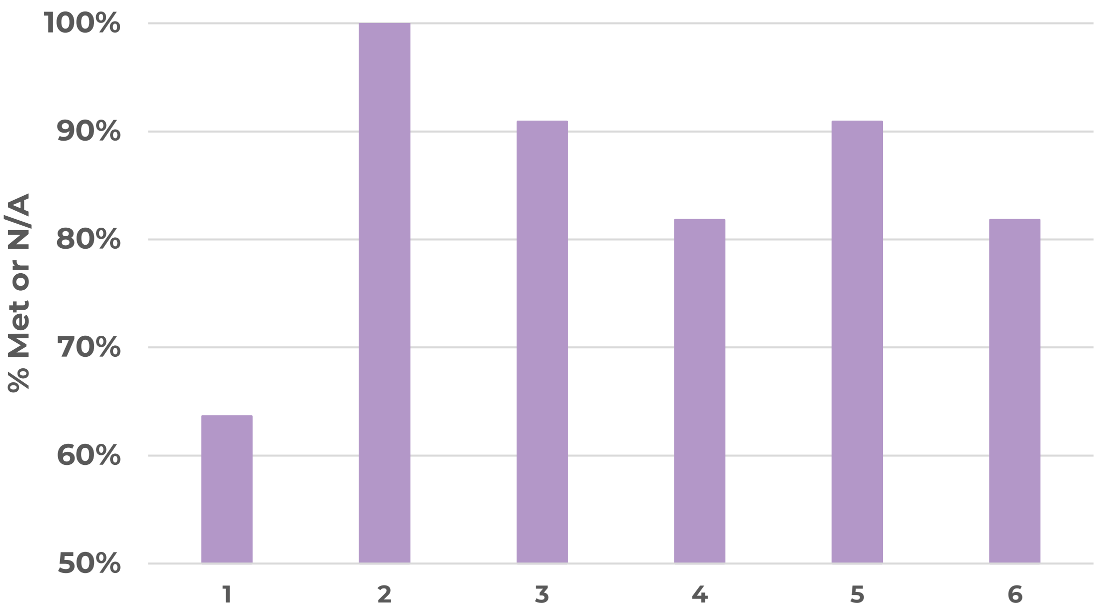
Section 3: Care and Intervention

QED Team Recommendations

	Standard criteria	Recommendations
Standard 3.1.4	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy.	Most services implement a care plan, where services can fall short is through collaboration and offering the patient a copy. Service should make sure patients are involved in the care plan and that the plan reflects this collaboration. Team should also make sure it is standard procedure to offer a copy to the patient .
Standard 3.5.4	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.	Service should make sure they have facilitated carer groups set up through the service. These can be led by a peer support worker and/or psychology staff. Nominating a carer support lead in the service is a great way to ensure carers feel supported.
Standard 3.2.2	There is dedicated sessional time from psychologists to: - Provide assessment and formulation of patients' psychological needs; - Ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway.	Services that do not have a psychologist in post should make sure they have a appropriately trained member of staff covering this role (e.g. a Psychotherapist with appropriate training). The team should also ensure they have a psychologist they are able to contact if and when needing consultation.

Section 4: Information, Consent and Confidentiality

Total Met Standards



*Each bar represents a community service

Achievements

- 100% of teams speak in a manner that reduces jargon and assures patients and carers clearly understand what is being said.
- 100% of teams make sure that all patient information is kept in accordance with current legislation.
- 100% of teams have an understanding, across all staff, of how to respond to carers when a patient does not consent to their involvement in their carer.

Improvements

- Five of the six teams do not provide accessible written information to patients, which a staff member takes them through as soon as possible, which covers:
  - Their rights regarding consent to treatment;
  - Their rights under the Mental Health Act;
  - How to access advocacy services;
  - How to access a second opinion;
  - Interpreting services;
  - How to view their records;
  - How to raise concerns, complaints and give compliments.

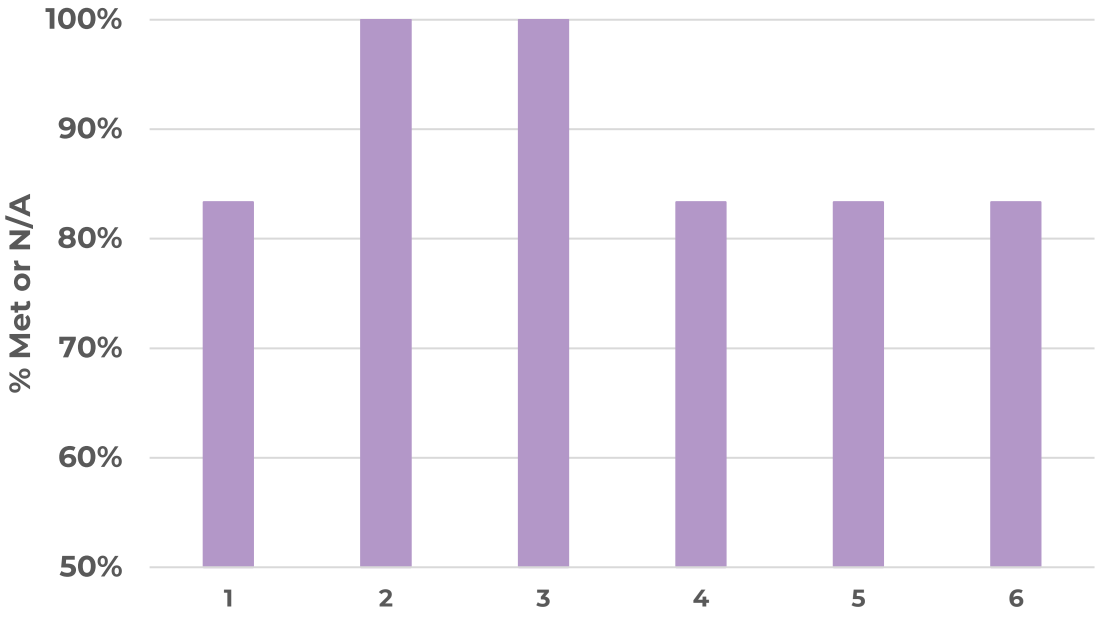
Section 4: Information, Consent and Confidentiality

QED Team Recommendations

	Standard criteria	Recommendations
Standard 4.1.1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: - Their rights regarding consent to treatment; - Their rights under the Mental Health Act; - How to access advocacy services; - How to access a second opinion; - Interpreting services; - How to view their records; - How to raise concerns, complaints and give compliments.	As the most commonly unmet standard across the reviews in this report, this standard is of particular importance. Teams should make sure information about each of these points are on written information given to the patient. Each of these points should be explained to the patient to ensure they are fully informed.
Standard 4.1.2	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment.	Services should make sure this information in offered both verbally and in written format. The QED also advise giving general information to carers when without consent, as long as the carer is aware their loved on is at the service.
Standard 4.1.4	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.	This should be written into standard protocol for the service, to ensure this is offered routinely.

Section 5: Rights and Safeguarding

Total Met Standards



*Each bar represents a community service

Achievements

- 100% of teams have shown that they treat patients and carers with compassion, dignity and respect.
- 100% of services showed that their patients feel listened to and understood by staff.
- 100% of services have shown that patients feel welcomed by staff… members when attending the team base for their appointments.
- 100% of teams record which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.

Improvements

- Two of the six teams failed to meet the standard

Which outlines that 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. These groups may include:

- Men;
- Black, Asian and minority ethnic groups;
- Asylum seekers or refugees;
- Lesbian, gay, bisexual or transgender people;
- Travellers.

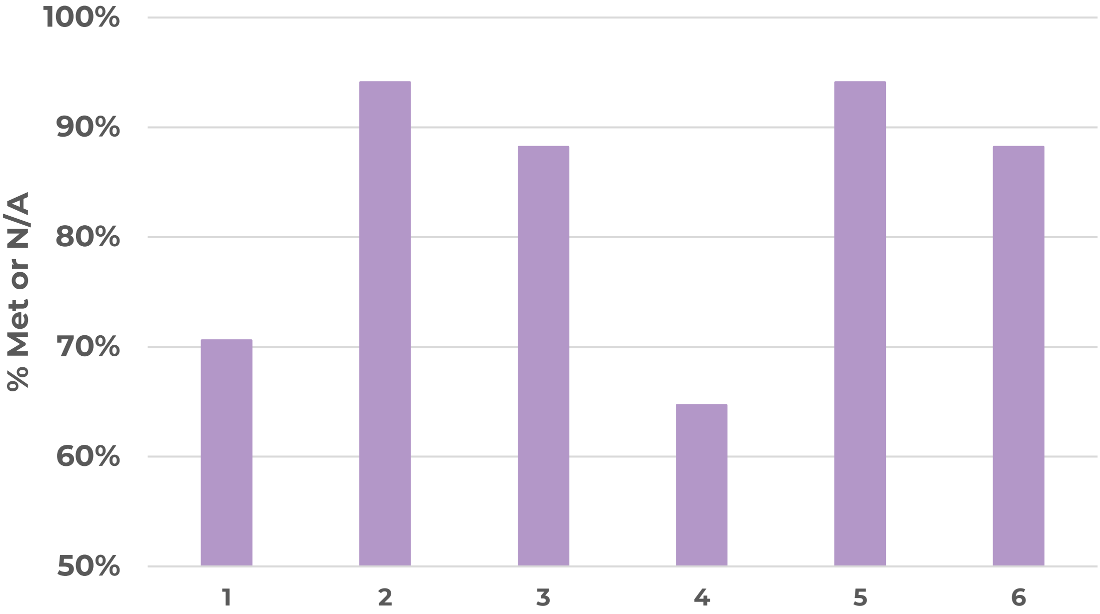
Section 5: Rights and Safeguarding

QED Team Recommendations

	Standard criteria	Recommendations
Standard 5.1.3	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.	Services should ensure that they engage in regular meetings to discuss equality, diversity and inclusion. This standard can be used as guidance of the different groups that can be discussed and how the service can work to reach out to these groups. The wording of this standard has been changed to say "LGBTQ+" rather than "Lesbian, gay, bisexual or transgender people" to encompass all sexual orientation.
Standard 5.1.4	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.	Services should make sure they are aware of the male patient experience of the service. Teams can ask a previous or current male patient to help review the services environment and resources, to try and create more inclusivity for this group.
Standard 5.1.5	Patients feel welcomed by staff members when attending the team base for their appointments.	Teams should make sure they are fully aware of patients names in meetings and be sure to introduce themselves whenever meeting a new patient.

Section 6: Joint Working and Transfer of Care

Total Met Standards



*Each bar represents a community service

Achievements

- 100% of teams have shown that, 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% of teams have made sure that patients can access mental health... services 24 hours a day, seven days a week.
- 100% of services support patients to access:
  - Housing support;
  - Support with finances, benefits and debt management;
  - Social services.

Improvements

- Two of the Six teams failed to meet the standard that asks that a discharge letter is sent to the patient and all relevant parties within 10 days of discharge. The letter must include 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.
- Two of the six services do not have a protocol in place to liaise with university services.

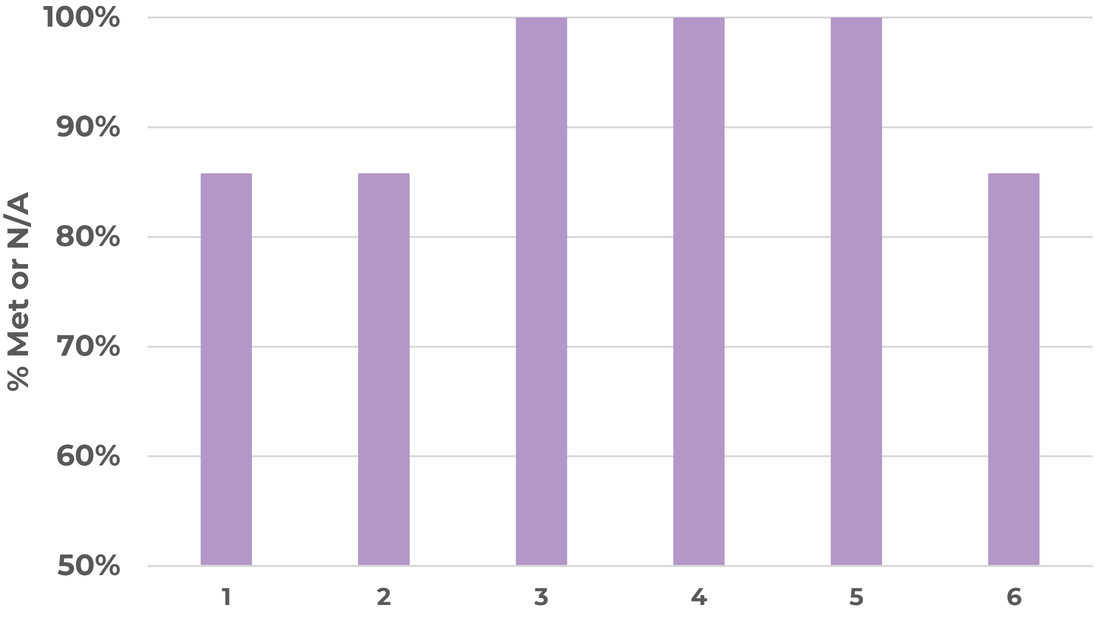
Section 6: Joint Working and Transfer of Care

QED Team Recommendations

	Standard criteria	Recommendations
Standard 6.2.1	A discharge letter is sent to the patient and all relevant parties within 10 days of discharge. 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.	Teams should create template emails to ensure the information going out to patients is consistent and includes all the information listed. The team should name who is responsible for this and keep track of how often this is/isn't adhered to in the 10 day timeframe.
Standard 6.2.7	Where a patient is attending university, the service has a protocol for liaison and collaborative working with the patient's university service.	Service should make sure they have a written protocol that clearly outlines how this process takes place for staff.
Standard 6.2.8	The service offers continued support to families of patients who have moved away to university.	The service should look to appoint a carers support lead who is responsible for contacting carers. They should make sure that carers are called and emailed regularly, even when the patient is being supported by a university service.

Section 7: Environment and Facilities

Total Met Standards



*Each bar represents a community service

Achievements

- 100% of teams have access to clinical rooms which are private and allow for conversations which can not be overheard.
- 100% of service have an environment which complies with current legislation surrounding disable access.
- 100% of teams complete an annual audit of environmental risk and ensure a risk management strategy is agreed.
- 100% of services have an environment that is clean, comfortable and welcoming.

Improvements

- Two of the six teams do not have an alarm system in place which allows patients, carers and staff members have easy access to panic buttons or personal alarms.
- One of the six service did not have a dedicated staff room.

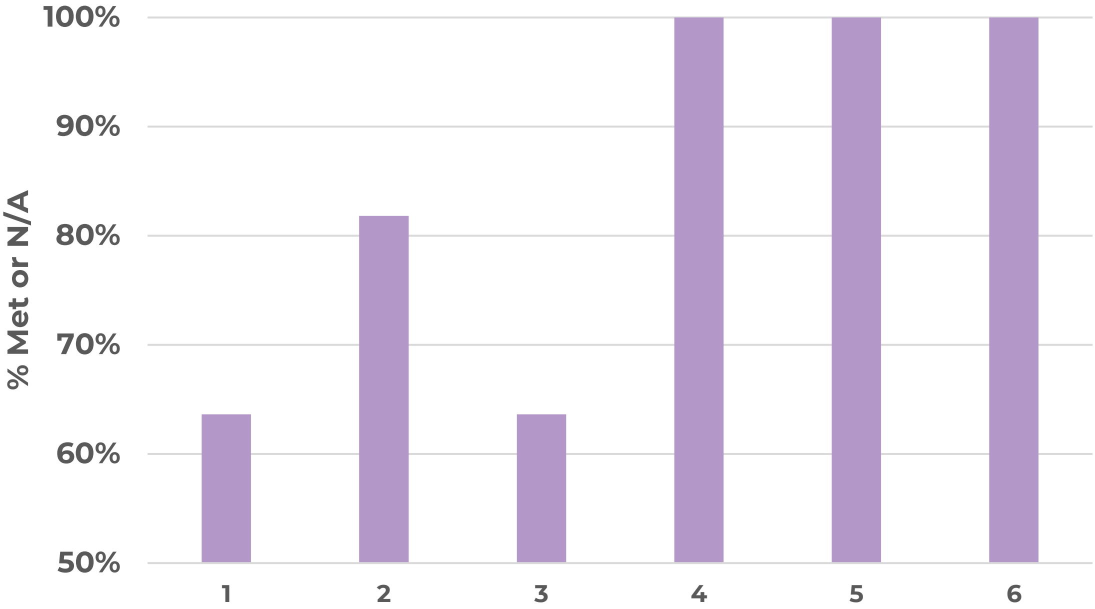
Section 7: Environment and Facilities

QED Team Recommendations

	Standard criteria	Recommendations
Standard 7.1.6	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for patients, carers and staff members.	Services should make sure that they have access to personal alarms for all who visit the service. This helps create a safe atmosphere for all.
Standard 7.1.7	Staff members have access to a dedicated staff room.	Services should make sure they have a dedicated staff room. Services that do not have the facilities should attempt to create a space for staff to relax when required.
Standard 7.1.5	An audit of environmental risk is conducted annually and a risk management strategy is agreed.	This audit should be recorded with a management plan which clearly outlines next steps, who is responsible for the steps, and the timeframe of which to attain them.

Section 8: Service Management

Total Met Standards



*Each bar represents a community service

Achievements

- 100% of services ask for patients and carers feedback about their experiences of using the service and this is used to improve the service.
- 100% of services have shown that patients are actively involved in shared decision-making about their mental and physical healthcare, treatment…
- … and discharge planning and supported in self-management.
- 100% of teams showed that lessons learned from untoward incidents and complaints are shared with the team and the wider organisation, and there is evidence that changes have been made as a result of sharing the lessons.

Improvements

- Three of the six teams do not use quality Improvement methods to implement service improvements.
- Two of the six service do not encourage patients and carers to be involved in quality improvement initiatives.
- Two of the six teams failed to meet the standard outlining that clinical outcome data are reviewed at least six monthly and shared with commissioners, the team, patients and carers, and used to make improvements to the service.

Section 8: Service Management

QED Team Recommendations

	Standard criteria	Recommendations
Standard 8.3.4	The team use quality improvement methods to implement service improvements.	The service should set specific time aside to discuss how best to implement quality improvement methods.
Standard 8.3.5	The team actively encourages patients and carers to be involved in QI initiatives.	Services should always look to involve patients and carers in developments. This experience can lead to vastly improve patient and carer experience.
Standard 8.2.3	The service's clinical outcome data are reviewed at least six monthly. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.	This data should be regularly collected, placed into a report, and circulated with those listed. Teams should clearly highlight the challenges raised, with next steps highlighted alongside suggested timeframes to achieve them.
Standard 8.1.1	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.	Teams should offer multiple ways for patients and carers to provide feedback anonymously. The QED recommends setting up online surveys which can be access via QR codes on the ward that patients/carers can scan to fill out.

3rd Edition Community Standards

Both the inpatient and community standards are reviewed every two years to improve the standards validity and accessibility. In May 2022 we published the 3rd Edition of the QED Community Standards after revision of the 2nd Edition Community Standards.

During the revision, we brought together staff from the Royal College of Psychiatrists, from services within the QED network and the QED Advisory group, which includes people from a variety of occupations as well as patient/carer representatives. This group submitted comments on the 2nd Edition standards and then attended a workshop to discuss changes to be implemented.

New Standards

There have been several new inclusions of standards. A particular focus of several new standards have been centred around staffing requirements in accordance to the Adult Eating Disorders (AED) Guidance from the National Collaborating Centre for Mental Health.

Example New Standard

Standard 2.1.7 - There is dedicated sessional input from medical professionals (e.g. clinical nurse consultant, GP, physician) to:
- Facilitate medical monitoring, blood tests, electrocardiograms (ECGs)
- Liaise with other medical professionals (e.g. gastroentrerologists and primary care)

Rewording of standards

Other changes include rewording of standards to specify more clearly the expectations of services, and to improve inclusivity of standards when referring to certain groups

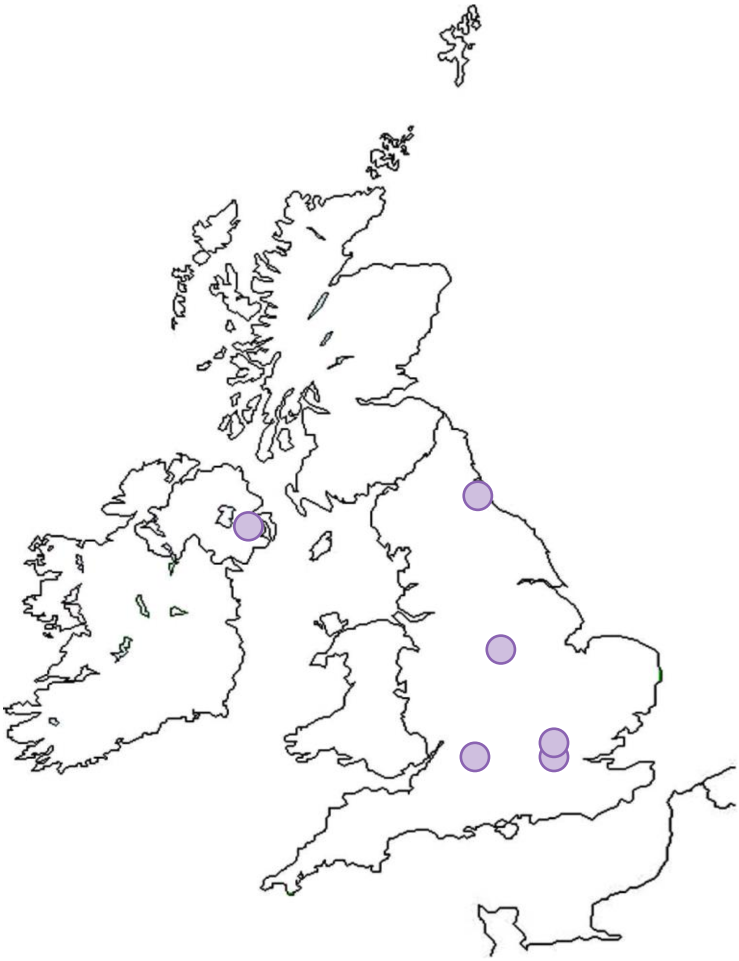
Example rewording

Standard 5.1.3 in the 2nd edition referred to "Lesbian, gay, bisexual or transgender people“. This has now be changed to “LGBTQ+ people” to include a wider spectrum of sexual orientation.

Appendix 1: List of services involved

- Barnet, Enfield and Haringey NHS Foundation Trust - Iris Ward Eating Disorders Outpatients
- Belfast Trust – Adult Eating Disorder Service
- Leicestershire Partner NHS Trust – Community Adult Eating Disorder Service
- ORRI Intensive Day Treatment for Eating Disorders
- Oxford Health NHS Foundation Trust - Wiltshire Community Eating Disorders Service
- Tees, Esk & Wear Valleys NHS Foundation Trust - Adult Mental Health Eating Disorder Service

The order presented does not correlate with the numbers displayed on figures (pp. 8-12)



Appendix 2: All standards data

1		Section 1: Access, Referral And Assessment	Percentage Met
1.1		Accessibility	
1.1.1	1	The service reviews data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access that are identified.	67%
1.1.2	3	Everyone can access the service using public transport or transport provided by the service.	83%
1.1.3	1	The service provides information about how to make a referral and waiting times for assessment and treatment.	100%
1.2		Referral And Waiting Times	
1.2.1	1	A clinical member of staff is available to discuss emergency 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 emergency referral which should be passed across immediately.	100%
1.2.3	1	The team assess patients, who are referred to the service, within locally-agreed timeframes.	100%
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.	83%
1.2.5	1	Referrals for people with diabetes or pregnant women are accepted into the service with a lower threshold of eating disorder severity.	83%
1.2.6	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.	100%
1.2.7	2	There is a protocol to follow for patients who are on the waiting list, including support for carers and frequency of follow ups with a defined timescale and medical monitoring.	67%
1.3		The Initial Assessment	
1.3.1	1	For non-emergency assessments, the team makes written communication in advance to patients that includes: - The name and title 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 or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).	83%

1.3.2	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	Patients have a comprehensive evidence-based assessment which includes their: - Mental health and medication; - Psychosocial and psychological needs; - Strengths and areas for development; - Suicide risk;- Eating disorder history (assessment performed in line with NICE guidelines).	100%
1.3.4	1	A physical health review is conducted by a professional with specialist ED knowledge as part of the initial assessment or as soon as possible. The assessment includes consideration of:- Physical health checks (including blood pressure, skin and mouth condition, and squat (SUSS) test);- Medical complications of an eating disorder; - Details of past medical history; - Current physical health medication, including side effects and compliance with medication regime; - Any co-morbidities which may increase risk (e.g. pregnancy or diabetes);- Lifestyle factors.	83%
1.3.5	1	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.	100%
1.3.6	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within one week of the assessment.	83%
1.4		Following Up Patients Who Do Not Attend Appointments	
1.4.1	1	The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient.	100%
1.4.2	1	If a patient does not attend for an assessment / appointment, the assessor contacts the referrer.	100%
2		**Section 2: Staffing And Training**	
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.	67%
2.1.2	1	When a staff member is on annual leave or long-term sick leave, 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	There has been a review of the staff members and skill mix of the team within the past 12 months.This is to identify any gaps in the team and todevelop a balanced workforce which meets the needs of the service.	83%
2.2		Staff Recruitment, Induction And Supervision	
2.2.1	2	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting staff members.	83%
2.2.2	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies.	83%
2.2.3	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body.	100%
2.2.4	2	All staff members receive line management supervision at least monthly.	100%
2.2.5	2	Patients and carers who volunteer with the service receive monthly supervision.	100%
2.3		Staff Well-Being	
2.3.1	1	The service actively supports staff health and well-being.	100%
2.3.2	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.	100%
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:	83%
2.4.1a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	83%
2.4.1b	1	Physical health assessment.	83%
2.4.1c	1	Safeguarding vulnerable adults and children.	83%
2.4.1d	1	Risk assessment and risk management.	67%
2.4.1e	1	Recognising and communicating with patients with cognitive impairment or learning disabilities.	83%
2.4.1f	1	Statutory and mandatory training.	83%
2.4.1g	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	67%
2.4.1h	1	Managing distorted perceptions of food and body image, managing clients with co-morbidity and understanding the impact of trauma within eating disorders.	67%
2.4.2	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	100%
2.4.3	2	Experts by experience are involved in delivering and developing staff training face-to-face.	83%

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.	100%
2.5.2	3	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.	67%
2.5.3	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 or whistleblowing.	100%
3		**Section 3: Care And Intervention**	
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.	100%
3.1.2	2	The service has an agreed set of care pathways that define frequency of clinical review and define treatment inteventions. This ensures that all patients accessing the service get an equal service.	100%
3.1.3	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews.	100%
3.1.4	1	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy.	50%
3.1.5	1	All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	100%
3.2		Therapies And Activities	
3.2.1	1	Patients begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within a locally-agreed timeframe. Any exceptions to this are documented in the case notes.	100%
3.2.2	1	There is dedicated sessional time from psychologists to: - Provide assessment and formulation of patients' psychological needs; - Ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway.	83%
3.2.3	2	There is dedicated sessional time from psychologists to support a whole team approach for psychological management.	83%
3.2.4	1	There is dedicated sessional input from occupational therapists to: - Provide an occupational assessment for those patients who require it; - Ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs.	100%
3.2.5	3	There is dedicated sessional input from creative therapists.	83%
3.2.6	1	There is dedicated sessional input from dietitians to:- Provide nutritional assessments for all patients;- Ensure the safe and effective provision of evidence-based nutritional interventions adapted to patients' needs.	100%

3.2.7	2	The team supports patients to undertake structured activities such as work, education and volunteering.	100%
3.2.8	1	The team supports patients to undertake activities to support them to build their social and community networks.	100%
3.2.9	1	The service provides one of the NICE-recommended/evidence-based treatments for each of the disorders for which they are commissioned.	100%
3.2.10	2	The service provides two or more of the NICE-recommended/evidence-based treatments for each of the disorders for which they are commissioned.	100%
3.2.11	1	Patients with binge eating disorder are informed that all psychological treatments have a limited effect on body weight and this is recorded.	100%
3.2.12	1	Patients with severe and high risk illness whose condition has not improved with treatment or who have declined treatment are offered ongoing support and care with a specialist eating disorder clinician, with a focus on a personal recovery model.	100%
3.3		Medication	
3.3.1	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	100%
3.3.2	1	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime.	100%
3.3.3	1	Patients, carers and prescribers can contact a specialist pharmacist to discuss medications.	100%
3.3.4	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.	100%
3.3.5	1	For patients who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	100%
3.4		Physical Healthcare	
3.4.1	1	Staff members arrange for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient’s care plan.	100%
3.4.2	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%
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, including bank and agency staff, are able to identify and manage an acute physical health emergency.	100%

3.4.5	1	The service has a protocol for screening, monitoring, psychoeducation and management of bone health.	100%
3.4.6	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.	100%
3.4.7	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.	83%
3.4.8	1	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at six weeks, at three months and then annually unless a physical health abnormality arises.	100%
3.5		Carer Engagement And Support	
3.5.1	1	Carers (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.	83%
3.5.3	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	83%
3.5.4	3	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.	67%
4		**Section 4: Information, Consent And Confidentiality**	
4.1		Providing Information To Patients And Carers	
4.1.1	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: - Their rights regarding consent to treatment; - Their rights under the Mental Health Act; - How to access advocacy services; - How to access a second opinion; - Interpreting services; - How to view their records; - How to raise concerns, complaints and give compliments.	17%
4.1.2	1	Patients (and carers, with patient consent) are offered written and verbal information about the patient’s mental illness and treatment.	83%
4.1.3	2	The team provides each carer with accessible carer’s information.	83%
4.1.4	1	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.	83%
4.1.5	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.	83%
4.1.6	2	The service uses interpreters 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%
4.1.7	1	When talking to patients and carers, health professionals communicate clearly, avoiding the use of jargon.	100%

4.2		Capacity, Consent And Confidentiality	
4.2.1	1	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation.	100%
4.2.2	1	Confidentiality and its limits are explained to the patient and carer, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	83%
4.2.3	1	All patient information is kept in accordance with current legislation.	100%
4.2.4	1	The team knows how to respond to carers when the patient does not consent to their involvement.	100%
5		**Section 5: Rights And Safeguarding**	
5.1		Treating Patients With Compassion, Dignity And Respect	
5.1.1	1	Staff members treat patients and carers with compassion, dignity and respect.	100%
5.1.2	1	Patients feel listened to and understood by staff members.	100%
5.1.3	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.	67%
5.1.4	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%
5.1.5	1	Patients feel welcomed by staff members when attending the team base for their appointments.	100%
5.2		Risk And Safeguarding	
5.2.1	1	The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	100%
6		**Section 6: Joint Working And Transfer Of Care**	
6.1		Intensifying Treatment	
6.1.2	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.	83%

6.1.3	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.	83%
6.1.4	1	A named worker is provided to inpatient services throughout admission and they are involved in care planning, admission and discharge planning meetings and CPAs.	83%
6.2		Discharge Planning And Transfer Of Care	
6.2.1	2	A discharge letter is sent to the patient and all relevant parties within 10 days of discharge. 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.	67%
6.2.2	1	The community team makes sure that patients who are discharged from hospital are followed up within three days.	83%
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 the community service, evidence-based psychological treatment starts within two weeks, even when new to the community team.	83%
6.2.5	1	There is active collaboration between Children and Young People's Eating Disorder Services 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.	83%
6.2.6	2	Teams provide specific transition support to patients when their care is being transferred to another community team, or back to the care of their GP.	100%
6.2.7	1	Where a patient is attending university, the service has a protocol for liaison and collaborative working with the patient’s university service.	67%
6.2.8	2	The service offers continued support to families of patients who have moved away to university.	67%
6.2.9	1	Care plans for patients transitioning between university and home are developed in collaboration with both the university and home service, patients and their families (where appropriate). Plans 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.	83%

6.3		Interface With Other Services	
6.3.1	1	Patients can access help from mental health services 24 hours a day, seven days a week.	100%
6.3.2	1	The team supports patients to access organisations which offer: - Housing support; - Support with finances, benefits and debt management; - Social services.	100%
6.3.3	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 perinatal team/unit unless there is a specific reason not to do so.	67%
6.3.4	1	The service has invited their local district general hospital to collaborate in a MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa) group, and the team provides specialist ED input into any agreed MaRSiPAN pathway.	67%
6.3.5	2	The service provides risk assessment tools, consultation and advice to all local referrers.	100%
7		**Section 7: Environment And Facilities**	
7.1		Service Environment	
7.1.1	2	The service environment is clean, comfortable and welcoming.	100%
7.1.2	1	Clinical rooms are private and conversations cannot be over-heard.	100%
7.1.3	1	The environment complies with current legislation on disabled access.	100%
7.1.4	1	Staff members follow a lone working policy and feel safe when conducting home visits.	100%
7.1.5	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed.	100%
7.1.6	1	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for patients, carers and staff members.	67%
7.1.7	2	Staff members have access to a dedicated staff room.	83%
8		**Section 8: Service Management**	
8.1		Patient And Carer Involvement	
8.1.1	1	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.	100%
8.1.2	2	Services are developed in partnership with appropriately experienced patients and carers, who have an active role in decision making.	83%
8.1.3	1	Patients are actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.	100%
8.2		Clinical Outcome Measurement	
8.2.1	1	Clinical outcome measurement data, including progress against user-defined goals, is collected as a minimum at assessment, after six months, 12 months and then annually until discharge. Staff can access this data.	83%
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.	83%

8.2.3	2	The service's clinical outcome data are reviewed at least six monthly. The data are 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	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this.	100%
8.3.2	1	When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.	100%
8.3.3	1	Lessons learned from untoward incidents and complaints 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%
8.3.4	2	The team use quality improvement methods to implement service improvements.	50%
8.3.5	2	The team actively encourages patients and carers to be involved in QI initiatives.	67%