RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

QED
QUALITY NETWORK FOR EATING DISORDERS

QED Community

Annual Report

2024 - 2025

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QED QUALITY NETWORK FOR EATING DISORDERS

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Foreword

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Emma Hagerty

QED Advisory Group Chair

Eating Disorders Clinical Lead at Aneurin Bevan University Health Board

I am pleased to introduce the 2024–2025 QED Community Annual Report. Since the launch of the QED community standards in 2019, it has been encouraging to see continued growth in the number of community teams participating in the Network, including representation from across the devolved nations. This expansion reflects a shared commitment to improving the quality and consistency of community eating disorder services.

This year's report demonstrates that many services are meeting a high proportion of the standards, while also recognising that important areas for improvement remain. The QED team has provided clear, practical recommendations to support services in addressing commonly unmet standards, helping to ensure that improvement activity is both targeted and achievable.

The report also highlights the dedication and hard work of Network members. The preparation for and participation in reviews require significant time, openness, and collaboration, and the quality of this engagement is evident throughout the findings.

I would like to thank the peer review teams and the QED project team for their continued professionalism and commitment; their contribution remains essential to this work. I am also especially grateful to the patient and carer representatives, whose insight is central to driving meaningful improvement across the Network.

I hope that more community teams will join the Network, supporting continued learning and driving further improvements in community eating disorder services.

Introduction

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Who we are

The Quality Network for Eating Disorders (QED) works with inpatient and community services to ensure and enhance the quality of care provided to patients and their carers. Established as an independent network in 2012, QED is part of a larger initiative by the Royal College of Psychiatrists Centre for Quality Improvement (CCQI), which includes approximately 30 quality networks, accreditation projects, and audit programmes. A full list of member services and their current accreditation status is available to view on our website

What we do

Through a comprehensive process of review, we identify and acknowledge high standards of organisation and patient care and support other services to achieve these. We support and engage inpatient units and community services in a process of quality improvement through peer-led reviews against a set of specialist standards for eating disorders. The process is supportive and promotes sharing of best practice between services. Involving patients and carers in QED is a priority, and people with first-hand experience of using eating disorder services are encouraged to get involved in all stages of the review process.

The network is supported by two crucial groups: the Advisory Group is a dedicated team who provide guidance to ensure the network's continued growth and visibility. Their input is instrumental in shaping national recommendations for both inpatient and community eating disorder services. Alongside them, the Accreditation Committee also plays a pivotal role in informing key accreditation decisions and upholding consistency of the process. Comprising professionals and experts by experience, both groups represent areas of expertise within the field of eating disorder services.

Introduction

Annual review cycle

The review process has 2 phases:

1. Completion of a self-review workbook
2. External peer-review which takes place between September and June

Each year, QED services undergo their self-review, followed by an in-person review. If the team chooses to pursue accreditation, their accreditation status remains valid for three years from the date of their initial presentation to the Accreditation Committee.

The results are fed back in local and national reports. Inpatient units or community services then take action to address any development needs that have been identified. The process is ongoing rather than a single iteration.

Jargon Buster

Self-review
A service will score themselves against the QED standards and identify key areas of achievement and improvement.

Peer review
A panel of reviewers including a patient/carer representative visits a service and assesses them against the QED standards in discussion, interviews and a tour of the premises.

Accreditation
These reviews are more thorough than the usual quality improvement reviews in that they require more evidence to validate self-ratings, use more information sources and more methods of data collection.

This Report

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The 2024-2025 QED community report provides an overview of the adherence to the QED 3rd Edition Community Standards from eight services across the United Kingdom (five from England, two from Wales and one from Northern Ireland).

The QED team collated the data from four developmental peer reviews and four accreditation reviews and carried out quantitative analysis to ascertain the overall compliance to the QED 3rd Edition Community Standards.

What to expect in this report:

This national report contains the aggregated results of the reviews undertaken by eight adult community eating disorder services during the 2024-2025 cycle (September 2024 to June 2025). It examines contextual data obtained from all services, including total caseload, referrals, number of cancelled appointments, did not attends, and discharges.

QED community member services' local reports provide teams with a summary of the number of criteria 'met', 'partly met' 'not met' or 'N/A', which then yields an average score for each individual standard. These averages enable us to obtain a measure of the team's overall performance for each section of the service standards.

The overall compliance for standard domains can be found on page 8.

How to use this report:

The report highlights key achievements and areas for improvement across services from each standard domain of the QED standards. Average scores met across the standard domains by services are also shown in graphs. To ensure the report is as useful as possible to member services, recommendations for how to meet the standards highlighted as being most commonly unmet are listed, and best practice examples and feedback from patients and carers are also provided for each standard domain.

Although a full summary detailing the average scores for each criterion for all participating teams is not included in this report, the QED team is happy to provide this data upon request. This data shows the current aggregated compliance of member community eating disorder services for each standard. If a service is undergoing accreditation, for a standard to be marked as fully met, a service must provide up-to-date evidence deemed sufficient by the review team.

QED 3rd Edition Community Standards

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The QED network assesses eating disorder services according to a set of standards. The network undergoes a standards revision process every two years. These standards are drawn from a variety of authoritative sources and incorporate feedback from patient and carer representatives, as well as experts from relevant professions and external organisations.

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.

The standards are split into eight subsections:

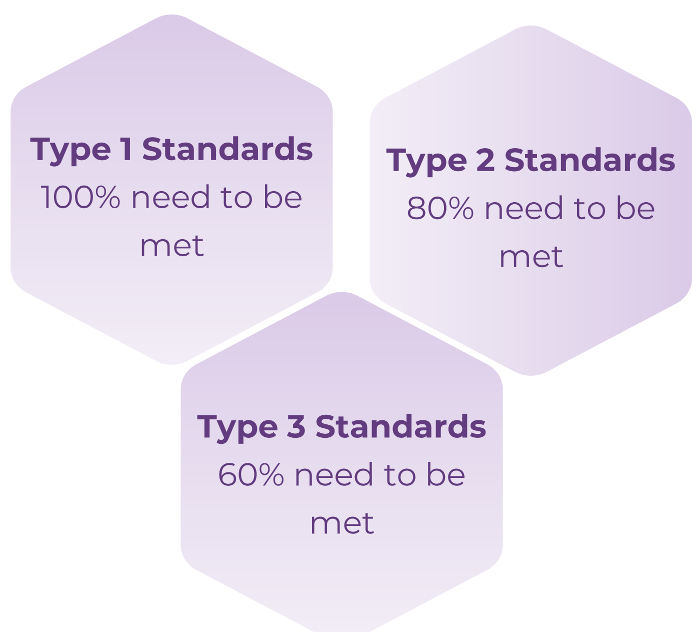
1. Access, Referral and Assessment
2. Staffing and Training
3. Care and Intervention
4. Information, Consent and Confidentiality
5. Rights and Safeguarding
6. Joint Working and Transfer of Care
7. Environment and Facilities
8. Service Management

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

Type 1: Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment. Accredited services need to meet 100% of these.

Type 2: Expected standards that most services should meet. Accredited services need to meet at least 80% of these.

Type 3: Desirable. Accredited services must meet at least 60% of these.



Data Collection

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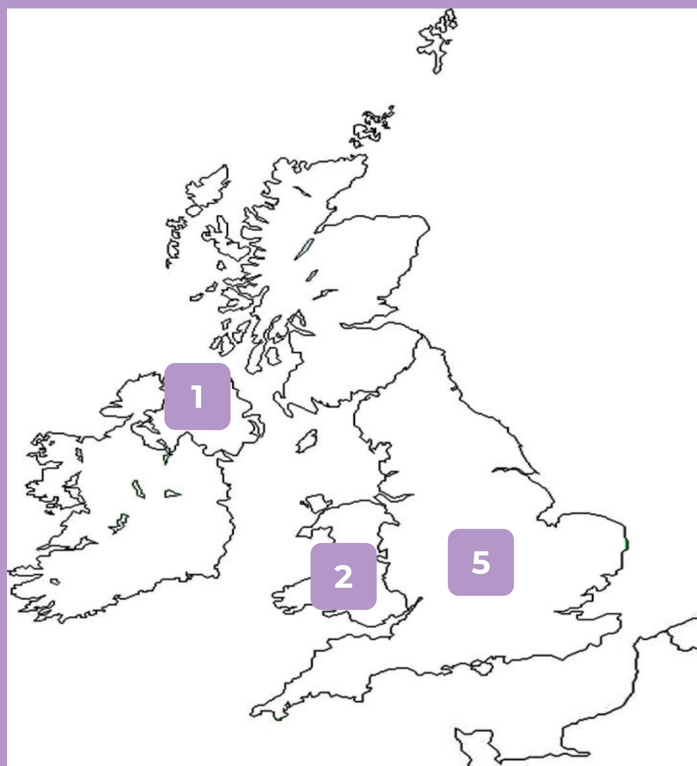
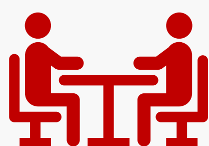


Location

- **Eight** services took part in the 2024 - 2025 cycle.
- **Four** developmental peer reviews.
- **Four** accreditation reviews.
- **100%** of services received a face-to-face review attended by peer reviewers from other specialist eating disorder services.
- Out of the **8** QED services who took part, **5** members are based in England, **2** in Wales and **1** in Northern Ireland.



17
Carers took part in interviews

33
Frontline Staff shared their experiences

10
Partner agencies provided feedback

18
Patients took part in interviews

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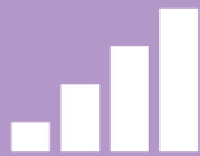
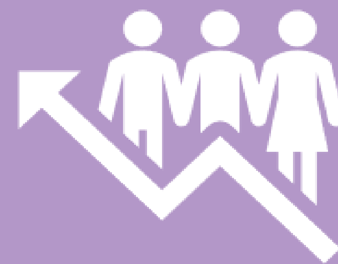
Contextual Data

Data was taken from the **eight** services' self-review workbooks. The numbers below are based on data collected within the last six months of the teams completing their workbook in the 2024 - 2025 cycle. All services were asked to provide up-to-date contextual data including total caseload, total number of referrals, average number of appointments that were not attended, number of patients discharged and number of cancelled appointments. The services range in size.



265

The average total case load for services was **265**, ranging from 35 to 896



197

The average total number of referrals into services was **197**, ranging from 51 to 355

The total percentage of appointments that were not attended was **7%** ranging from 3% to 11%

7%

The average number of patients discharged within the last six months was **153** ranging from 12 to 315

153

The total percentage of cancelled appointments was **11**%, ranging from 5% to 50%

11%

Overall Compliance with Standards

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All services were assessed on their compliance with the QED 3rd Edition Community Standards. Below is the average total adherence to each of the subsections of these standards (counting "Partly Met", and "Not Met" as not adherent, and "Met" as adherent) Standards marked as "N/A" or "Don't Know" have been excluded from analysis..

Section 1: Access, Referral, And Assessment

Section 2: Staffing And Training

Section 3: Care And Intervention

Section 4: Information, Consent and Confidentiality

Section 5: Rights and Safeguarding

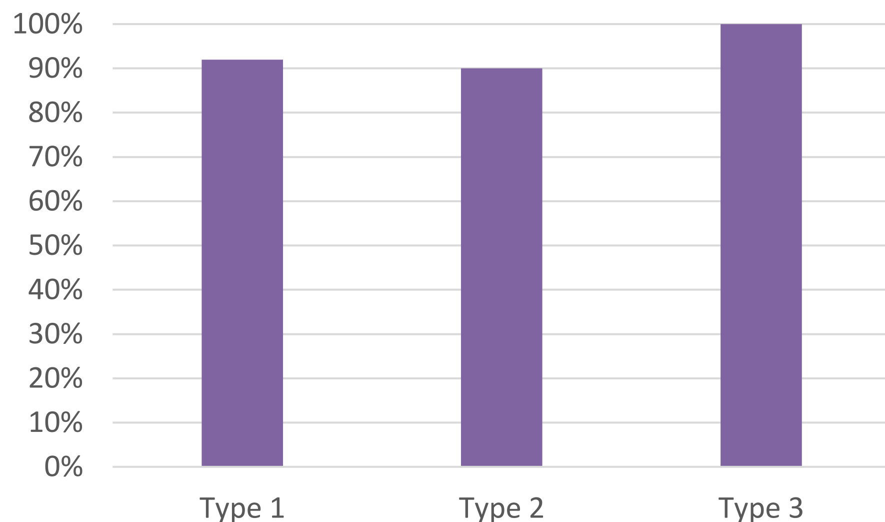
Section 6: Joint Working and Transfer Of Care

Section 7: Environment and Facilities

Section 8: Service Management

SECTION ONE: ACCESS, REFERRAL AND ASSESSMENT

Average % Met for each **standard type** in this subsection



Achievements

- **100%** of teams offer an appointment both in person and virtually and patient preference is taken into account (1.1.3 [3]).
- **100%** of services reported that when on the waiting list for treatment, there is a care plan in place that demonstrates that risk is monitored, there is a crisis plan, and there is 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 (1.2.7 [1]).

Areas of Development

- **75%** of services accept referrals for patients with diabetes or pregnant women with a lower threshold of eating disorder severity (1.2.6 [1]).
- At **75%** of services, patients have a risk assessment and management plan which is co-produced where possible (including carers, if the patient's consent is given), updated regularly and shared where necessary with relevant agencies, with consideration of confidentiality (1.3.4 [1]).

SECTION TWO: STAFFING AND TRAINING

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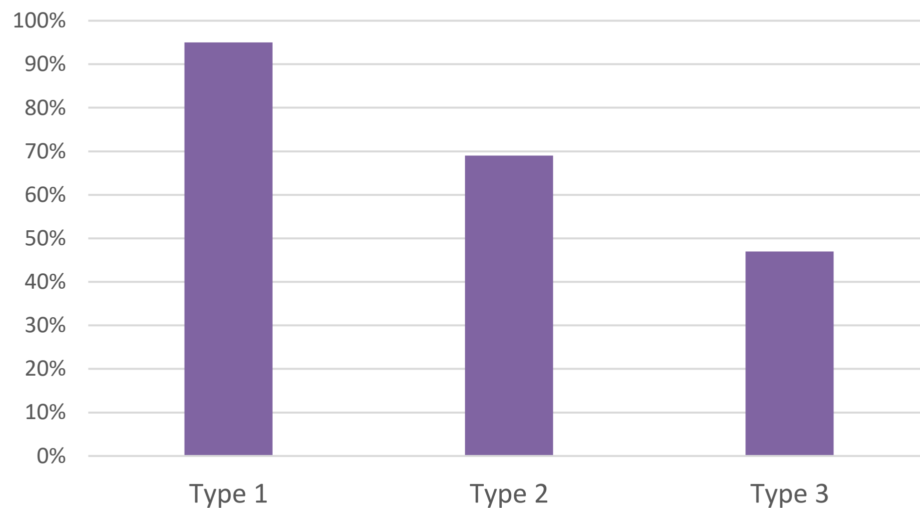
Average % Met for each **standard type** in this subsection



Achievements

- **100%** of services had a review of the staff members and skill mix of the team within the past 12 months, to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service (2.1.17 [1]).
- **100%** of services actively support staff health and well-being (2.3.1 [1]).
- Staff members can access leadership and management training appropriate to their role and specialty at **100%** of services (2.5.1 [2]).

Areas of Development

- **38%** of services have dedicated sessional input from family therapists to provide family therapy and support other clinicians within the team to work with patients, families, partners, carers and support networks (2.1.9 [2]).
- **25%** of services have dedicated sessional input from arts or creative therapists (2.1.14 [3]).

SECTION THREE: CARE AND INTERVENTION

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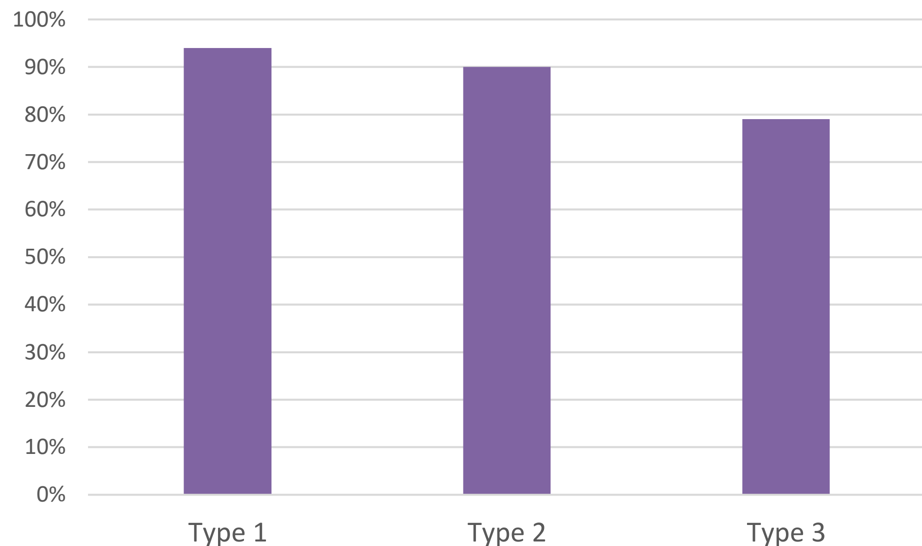
Average % Met for each **standard type** in this subsection



Achievements

- **100%** of teams reported supporting patients to undertake structured activities such as work, education and volunteering (3.2.2 [2]).
- **100%** of teams reported that they support patients to develop a plan for appropriate levels of exercise or movement as part of their recovery pathway (3.4.4 [3]).
- **100%** of services reported involving carers (with patient consent) in discussions and decisions about patient's care, treatment and discharge planning, including attending review meetings where the patient consents (3.5.1 [1]).

Areas of Development

- **63%** of services reported that they support patients to access local green spaces on a regular basis (3.2.3 [1]).
- In **57%** of services, patients, carers and prescribers can contact a specialist pharmacist to discuss medications (3.3.3 [3]).

SECTION FOUR: INFORMATION, CONSENT AND CONFIDENTIALITY

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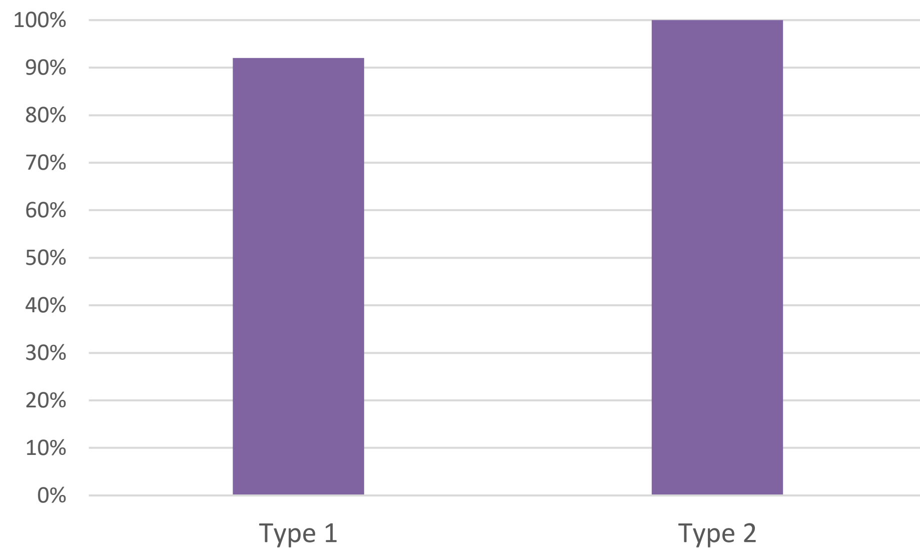


Achievements

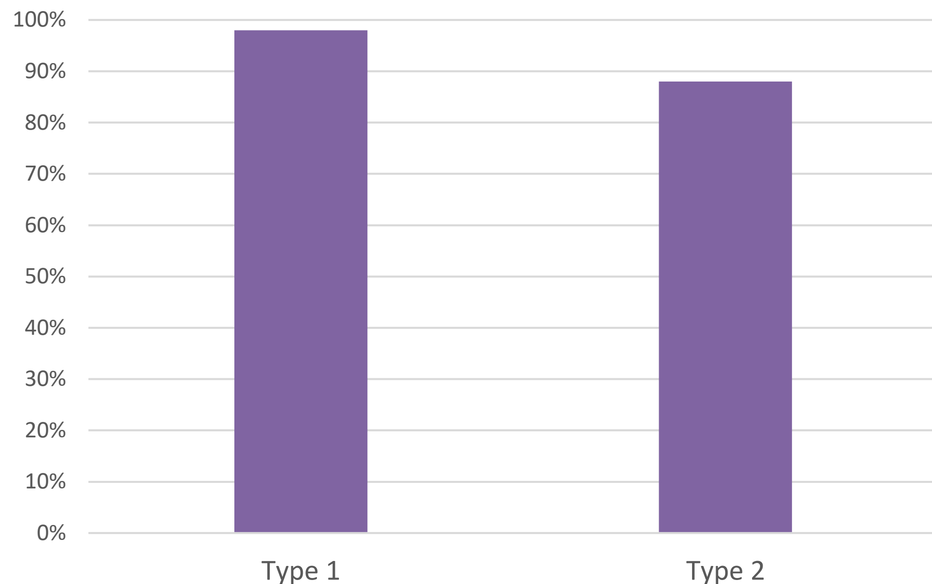
- At **100%** of services, information can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use formats for patients with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary (4.1.5 [2]).
- **100%** of services reported working with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation (4.1.6 [2]).

Areas of Development

- **88%** of services provided patients with accessible written information which includes information about their rights regarding consent to treatment, rights under the Mental Health Act, how to access advocacy services, how to access a second opinion, how to access interpreting services, how to view their health records and how to raise concerns, complaints and give compliments (4.1.1 [1]).
- **88%** of services provided each carer with accessible carer information (4.1.3 [1]).

SECTION FIVE: RIGHTS AND SAFEGUARDING

Average % Met for each **standard type** in this subsection



Achievements

- **100%** of teams reported that staff members treat patients and carers with compassion, dignity and respect (5.1.1 [1]).
- Staff members at **100%** of services are knowledgeable about, and sensitive to, the social, cultural and mental health needs of patients from minority or hard-to-reach groups in relation to eating disorders (5.1.3 [1]).
- **100%** of services reported patients feel welcomed by staff members when attending their appointments (5.1.5 [1]).

Areas of Development

- Patients felt listened to and understood by staff members at **88%** of services (5.1.2 [1]).
- **88%** of services had a strategy for improving access for male patients to the eating disorder service. This includes (but is not limited to) ensuring there is male staff, male-targeted literature and a gender-neutral clinical environment (5.1.4 [2]).

SECTION SIX: JOINT WORKING AND TRANSFER OF CARE

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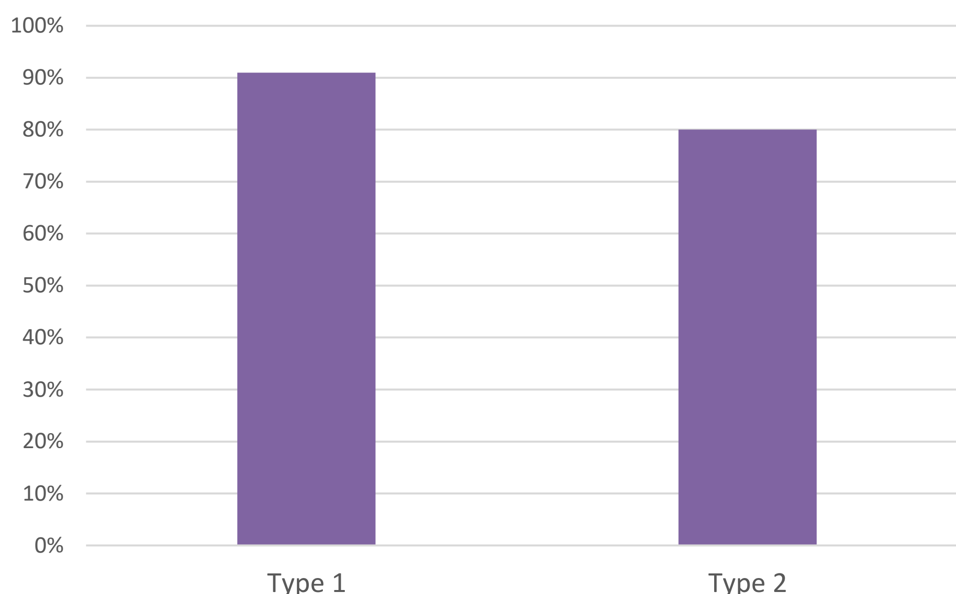
Average % Met for each **standard type** in this subsection



Achievements

- At **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 (6.2.3 [1]).
- **100%** of teams supports patients to access housing support, support with finances, benefits and debt management and social services (6.3.2 [1]).

Areas of Development

- **63%** of services offer continued support to families of patients who have moved away to university (6.2.8 [2]).
- For **75%** of services, where a patient is attending university, the service has a protocol for liaison and collaborative working with the patients' home/university service (6.2.7 [1]).

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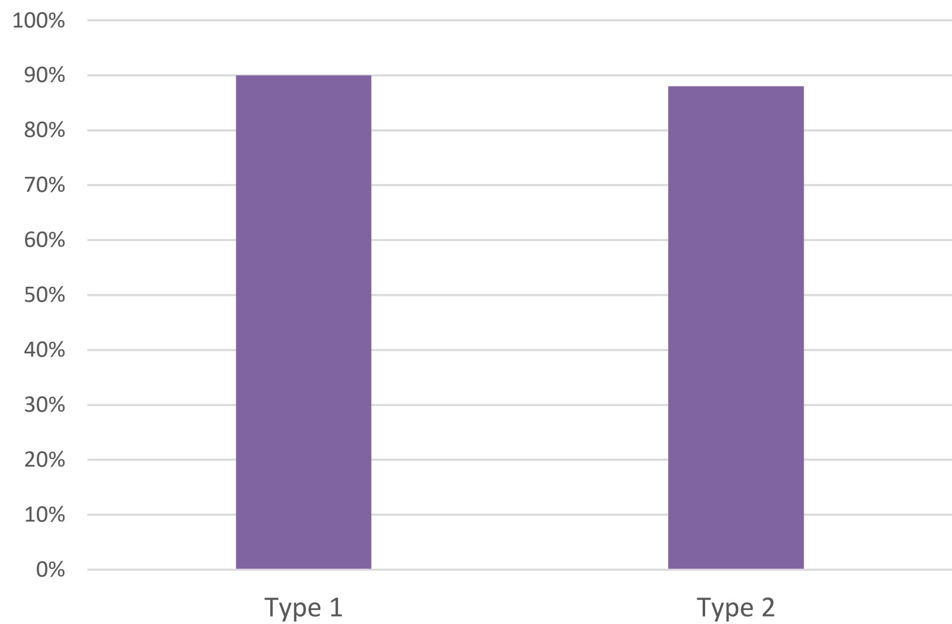
SECTION SEVEN: ENVIRONMENT AND FACILITIES



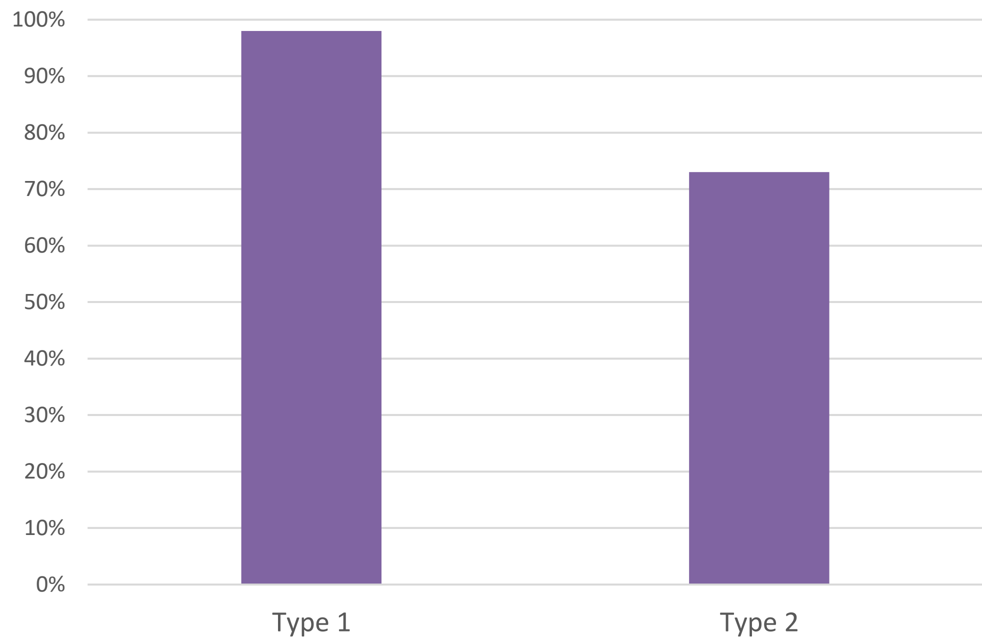
Achievements

- At **100%** of services, there are measures in place to ensure staff are as safe as possible when conducting home visits (7.1.4 [1]).
- **100%** of services' environments comply with current legislation on accessible environments (7.1.3 [1]).

Areas of Development

- At **75%** of services, clinical rooms are private and conversations cannot be heard (7.1.2 [1]).
- An audit of environmental risk is conducted annually, and a risk management strategy is agreed at **88%** of services (7.1.5 [1]).

SECTION EIGHT: SERVICE MANAGEMENT



Achievements

- **100%** of services ask patients and carers for their feedback about their experiences of using the service and this is used to improve the service (8.1.1 [1]).
- **100%** of teams are involved in Quality Improvement activity (8.3.4 [2]).

Areas of Development

- At **63%** of services, feedback from patients and carers is analysed and explored to identify any differences of experiences according to protected characteristics (8.1.2 [2]).
- For **38%** of services, 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 (8.2.3 [2]).

QED Team Recommendations

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We now present a series of recommendations and practical suggestions to help services address commonly unmet standards. These have been drawn from insights and observations gathered during peer review days.

1.1.1

The team 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.

Recommendation:

Services should carry out an annual review of who is using the service, comparing their own demographic data with local population statistics to identify any groups that may be under-represented.

They should summarise data from a 12-month period and outline what actions have been taken in response to any inequalities found, such as working with local community organisations, religious groups, or charities to increase awareness, adjusting referral pathways to remove barriers, or creating materials tailored to specific communities.

The report should briefly explain the impact of any actions taken so far and note any planned next steps for the coming year.

2.1.1

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, such as the minor and temporary reduction of non-essential services.

Recommendation:

Services should have a clear and reliable process for responding to low/unsafe staffing levels when they fall below agreed minimums. The process should direct staff on how raise concerns, access to additional support or bank staff, and an agreed contingency plan such as the short-term reduction of non-essential activities. We ask services to provide their operational policy or equivalent outlining how this is managed. We also recommend developing a simple flowchart or step-by-step guide so staff can easily understand what to do, who to contact, and how decisions are escalated during periods of reduced staffing.

3.1.4

Every patient has a written care and support plan, reflecting their individual needs and goals. Staff members collaborate with the patient and their carer(s) to develop the care plan, and they are offered a copy.
Guidance: Care planning tools to support quality of care planning and outcome measurement may be used to support this process e.g. DIALOG +.

Recommendation:
Services should focus on making care plans genuinely useful and meaningful by building in regular opportunities for staff, patients and (where appropriate) carers to sit down together and talk through goals, needs and progress. Using a simple, structured tool such as DIALOG+ or another framework the team already finds helpful can make these conversations clearer and more consistent. It would also be helpful for services to check that staff feel confident in care-planning approaches, for example through supervision or brief training sessions.

4.2.4

The team knows how to respond to carers when the patient does not consent to their involvement.
Guidance: The team may receive information from the carer in confidence. Where consent is not given, carers are provided with general information and support from the service without specific information about the patient being shared.

Recommendation:
Services should ensure that staff feel confident and supported when managing situations where a patient does not consent to carer involvement. To achieve this, teams would benefit from having a clear, accessible protocol that outlines what information can and cannot be shared, how to acknowledge and value the carer's perspective, and the types of general advice or support the service can still provide. It is also helpful for teams to have guidance on receiving information from carers in confidence, and on how to communicate boundaries sensitively and consistently. Regular refreshers in team meetings or supervision can reinforce this.

5.1.1

Staff members treat patients and carers with compassion, dignity and respect.

Recommendation:
Services should be able to demonstrate that staff consistently treat patients and carers with compassion, dignity and respect, and we recommend including brief evidence of how this is monitored in practice. Services may also wish to highlight how they support this through training on communication and trauma-informed care, regular reflective practice or supervision sessions, and efforts to involve patients and carers in shaping service improvements. These ongoing approaches help maintain compassionate interactions and ensure that the dignity of patients remains central to everyday practice.

6.2.1

A discharge letter is sent to the patient and all relevant professionals involved (with the patient's consent) 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.

Recommendation:
Services should be able to demonstrate that discharge letters are routinely sent to the patient and all relevant professionals within 10 days of discharge, with the patient's consent, and that these letters consistently include key information such as aftercare arrangements, crisis and contingency contacts, medication details including monitoring requirements, and the planned follow-up arrangements. Services may develop a proforma to ensure all necessary information is included in discharge documents and to standardise discharge processes across the service.

QED Team Recommendations

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7.1.1

The service environment is clean, comfortable and welcoming.

Recommendation:
Teams should ensure the service environment is comfortable and welcoming for patients and their carers. Teams can request an estates review through their trust if there are noticeable areas of need in the service. Teams are also encouraged to collaborate with patients on changes to the service environment to incorporate the patient voice into these changes. For example, teams can work with patients to create plans for environmental changes that can support a business case for the refurbishment of the service.

8.1.2

Feedback received from patients and carers is analysed to identify and act on any differences of experiences by protected characteristics.
Guidance: Complaints and compliments and other feedback sources include the option to share demographic information

Recommendation:
Teams should ensure that feedback from patients and carers is thoroughly analysed and explored, with attention to analysis based on protected characteristics. Teams should first collect data through surveys and questionnaires, outreach and engagement activities, as well as qualitative research using interviews or focus groups. Teams can then conduct qualitative or quantitative analyses. Finally, teams can create actionable recommendations, report findings transparently and continuously improve their service to address disparities. Many services have identified a lead within their team to conduct such audits and will link in with third sector organisations to establish links with communities.

Acknowledgments

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For their time, effort and insight, the QED project team send a warm thank you to the QED Patient and Carer Representatives, QED Advisory Group, QED Accreditation Committee, colleagues at the College Centre of Quality Improvement and Royal College of Psychiatrists, as well as all our QED member services.

QED Community Member services:

Aneurin Bevan Health Board, Specialist Eating Disorder Service

Belfast Health and Social Care Trust, Adult Eating Disorder Service

Derbyshire Healthcare NHS Foundation Trust, Derbyshire Eating Disorder Service

Hywel Dda University Health Board, Eating Disorder Service

Barnet, Enfield and Haringey Mental Health Trust, St Ann's Eating Disorder Service

Leicestershire Partnership NHS Trust, Adult Eating Disorder Service

North East London NHS Trust, NELFT Eating Disorder Service

Norfolk and Suffolk NHS Foundation Trust, Suffolk Adult Eating Disorder Service

Cambridge and Peterborough NHS Foundation Trust, Norfolk Community Eating Disorders Service; S3 Outpatients

Nottinghamshire Healthcare NHS Foundation Trust, Nottinghamshire Eating Disorder Service

Orri, Orri Intensive Day Unit for Eating Disorders

Cambridge and Peterborough NHS Foundation Trust, Cambridge and Peterborough Community Adult Eating Disorder Service

Tees Esk and Wear Valleys NHS Foundation Trust, Adult Eating Disorders Community Team

Oxford Health NHS Foundation Trust, Wiltshire Community Eating Disorder Services

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QNIC QUALITY NETWORK FOR INPATIENT CAMHS

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