C01/S/a

NHS STANDARD CONTRACT
FOR SPECIALISED EATING DISORDERS (ADULTS)

SCHEDULE 2 – THE SERVICES - SERVICE SPECIFICATIONS

Service Specification No.	C01/S/a
Service	Specialised Eating Disorders (Adults)
Commissioner Lead	
Provider Lead	
Period	2013/14
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

The majority of people with eating disorders fall into the following categories:

- Anorexia Nervosa
- Bulimia Nervosa
- Eating Disorder not otherwise specified (EDNOS) which includes Binge Eating Disorder.

This service specification covers intensive treatments (inpatient and intensive day-patient) for anorexia nervosa and very occasionally severe bulimia nervosa. It does not cover community eating disorder services commissioned by CCGs.

It should be noted that there may be changes over time in the diagnostic presentation of individual sufferers.

Anorexia Nervosa

Individuals with Anorexia Nervosa restrict their food intake to a severe degree resulting in significant weight loss. This may be accompanied by other abnormal weight control mechanisms such as excessive exercise, self-induced vomiting, or laxative misuse. Sufferers are typically pre-occupied with a drive for thinness, a fear of fatness, feelings of guilt associated with eating and distortion of their body image. Some people will not have these typical weight and shape concerns, and will express atypical over valued ideas, e.g. fear of, or preoccupation with being feeling

full or bloating,, to explain their weight loss. Onset is typically in teenage years or early twenties. The majority of sufferers are women, although around 10% are men. Anorexia Nervosa is associated with significant physical and psychiatric co-morbidity. Mortality rates for the disorder increase with chronicity and aggregate mortality rates are estimated at 5.6% per decade.

Severe Anorexia Nervosa is defined in weight terms as an individual with a body mass index (BMI) of <15 (BMI – weight in kilograms divided by height in metres squared). Clearly other factors such as rapidity of weight loss and metabolic disturbance due to starvation or purging behaviours in addition to BMI determine medical risk and therefore consideration for admission. The majority of people suffering from anorexia nervosa including those with a BMI of 15 and under can be successfully treated in community by outpatient eating disorder services. Only a small minority of those suffering from severe anorexia nervosa require inpatient treatment. Men can be physically compromised, e.g. hypothermia, weakness at a relatively higher BMI and therefore there should be a lower threshold for consideration for possible admission.

Mild/moderate Anorexia Nervosa is defined as an individual with a BMI of 15-17.5 where the condition is stable and there is a lower risk of rapid deterioration.
The lifetime prevalence of anorexia nervosa in young women is 0.1-0.9% (average 0.3%) with an annual incidence in primary care of 14 per 100,000 in young women (Currin et al 2005). Expressed in terms of the whole population the incidence of anorexia nervosa per 100,000 of population is reported as between 4.2-4.7 in the UK and 7.2-7.7 in Denmark. (Smink et al 2012). The annual incidence of anorexia nervosa in men is less than 1 per 100,000 of population. Whilst the peak age of anorexia nervosa is in the mid teens, most sufferers fall within the age range of adult services. There is an increased prevalence of anorexia nervosa and bulimia nervosa in gay men but no increased risk in lesbian women. (Meyer et al 2007).

Bulimia Nervosa

Bulimia Nervosa is characterised by cycles of binge-eating, alternating with compensatory episodes of purging/over-exercising/or food restriction. Binge eating is associated with a sense of loss of control, emotional distress and shame. Bulimia nervosa may be associated with significant physical risk including life threatening electrolyte disturbances – there are also a significant number of other physical sequalae associated with the condition. Bulimia nervosa is also associated with significant psychiatric co-morbidity, notably anxiety disorders, depression, impulse control disorders and substance misuse disorders (Hudson et al 2007) and is often accompanied by many symptoms of wider physical and psychological discomfort and stress. Sufferers with bulimia nervosa are of normal weight or in the overweight range.

In community-based studies, the prevalence of bulimia nervosa has been estimated between 0.5% and 1% in young women with an even social class distribution (Hay &

Bacaltchuk, 2003).

Eating Disorders not otherwise specified (EDNOS) and Binge Eating Disorder

EDNOS is the most common form of eating disorder. Sufferers may closely resemble people with Bulimia Nervosa and Anorexia Nervosa without fitting the criteria for the diagnosis exactly. EDNOS is a disorder that may be as severe in presentation as that found in other diagnostic categories. Binge Eating Disorder is a specific sub set of EDNOS, whose sufferers tend to respond better to treatment.

(The figures given for both prevalence and incidence should be treated with caution as they do not necessarily reflect the actual numbers of service users with the disorder presenting to services.)

There is no reliable hard data on the proportion of people with an eating disorder or anorexia nervosa who will require intensive inpatient specialist service input. We have therefore included an estimate, based on estimated bed usage and average length of stay in specialist Eating Disorder (ED) units (estimated as not all bed activity is known).

It is estimated that approximately 900 individuals need admission to Adult Inpatient services per year. (Population of England is 50 million, average length of stay is 18 weeks, Royal College Psychiatrists paper CR 170 recommends that 6 beds per million population is required). This equates to approximately 300 beds.

Evidence base for Eating Disorders

Mental Health National Service Framework. DH 1999
National Institute for Health and Care Excellence (NICE) Guidelines for Eating Disorders Jan 2004.
Guidelines reviewed in 2010 and no new guidance from new data given.

2. Scope

2.1 Aims and objectives of service

The aims of the service/s are to:

- Limit the physical and psychiatric morbidity, social disability and mortality levels caused by eating disorders.
- Effectively treat people with very complex eating disorders and /or severe morbidity
- Minimise the length of time between referral and admission to the inpatient service

The specification covers the specialised service that is provided in an inpatient setting and intensive day patient settings, and a limited amount of outreach/outpatient work for people with very severe and intractable eating disorders.

Patients will have a diagnosable eating disorder according to 'The Diagnostic and Statistical Manual of Mental Disorders version 4' (DSM1V) and/or 'The International Statistical Classification of Diseases and Related Health Problems version 10' (ICD 10) or its successor who require treatment for weight restoration or stabilisation or management of abnormal weight control mechanisms.

The service will deliver the aim to improve both life expectancy and quality of life for adults with an eating disorder by:

- Making timely and accurate diagnosis
- providing appropriate treatment in line with best practice
- providing high quality proactive treatment and care
- ensuring smooth and managed transition from children's to adult care
- Support parents and families of adults with an eating disorder, as well as the affected adult.
- Support patients to manage their eating disorder independently in order that they can aspire to a lifeless hindered by their condition.
- Ensuring effective communication between patients, families and service providers.
- Provide a personal service, sensitive to the physical, psychological and emotional needs of the patient and their family.

2.2 Service description/care pathway

Patients with eating disorders who require inpatient care generally fall into one of

four categories:

1. Rapid weight loss with evidence of system or organ failure, which is potentially life threatening.
2. Outpatient psychological treatment has not been sufficient to effect a change or improvement.
3. Those at low weight (usually chronically unwell), who are not able to manage in daily life, who require help with weight stabilisation or modest weight restoration, often in the context of medical instability. These patients frequently have severe psychiatric co- morbidity and/or difficult social/ family circumstances.
4. In exceptional circumstances it may be appropriate to admit a patient suffering from severe and medically unstable Bulimia Nervosa for a symptom interruption admission, e.g. a patient with diabetes, pregnancy, or not responded to intensive community treatment.

In brief Inpatient services include:

- Assessment
- Advice-liaising with referring community eating disorder/mental health services
- Provide expert oral re-feeding, individualised through nutrition care plans, with staff trained and supervised in skills of oral re-feeding and motivational behavioural change.
- Provide (high quality – provided by suitably qualified staff usually clinical psychologist or counselling psychologist or other professional who is highly qualified in delivering evidenced based therapies, who is supervised by a senior professional with wide experience in eating disorders), evidenced based psychological interventions (Motivational Enhancement Therapy (MET), Cognitive Behavioural Therapy (CBT), Cognitive Analytic Therapy (CAT), Inter-Personal Therapy (IPT), focal psychodynamic,) and family interventions focused on the eating disorder, e.g. Maudsley Collaborative care Skills Model.
- Provide a high quality daily group programme overseen by an occupational therapist that offers opportunities for motivational enhancement, psycho-education, dietetic /nutrition psycho-education, (delivered by a dietician), development of emotional coping skills, independent living skills, social skills, adaptive future lifestyle skills plus recreation and social activities
- Provide Nasogastric (NG) tube feeding (overseen by dietetics). The majority of units will provide this. Services that do not provide n-g tube feeding will need protocols in place for when they would consider n-g feeding. Those who do not provide n-g feeding will need to have clear protocols in place for when they need access to NG feeding. Access to safe high quality NG feeding may be within eating disorder units within their region and local medical hospitals, using which is clinically appropriate. It is recognised that those units who provide this will incur extra staffing and staff training costs.
- Provide Intensive medical monitoring, e.g. ability to do daily blood tests with access to results same day as routine.
- Services will be able to take patients detained under the Mental Health Act. The majority of Eating Disorder Units (EDU) will be able to provide this. Units who do

not take detained patients need to develop a policy for when they would consider detention under the mental health act. Those units who do not admit detained patients need a clearly defined pathway for referral for second opinion and pathway for admission to an EDU in the geographical area who do take detained patients. This will help ensure that informal patients are protected from neglect when patients remain stuck in their progress or are deteriorating with increasing or ongoing high levels of medical risk. It is recognised that those units who admit and treat detained patients have additional costs associated with this particularly in regard to staff and that these patients will on average use more resource as they will be more unwell and less able to work with an agreed care plan and require extra work with respect to the mental health act process.

- Information and support for carers, e.g. provision of carer's support group, carer's assessment skills based carer training, (Maudsley Collaborative Care Skills Model).
- Provide inpatient care for men. (Not all units will be able to do this but at least one in a geographical area will need to provide this) In order to provide this men must have their own bedroom with access to their own bathroom and male only sitting area.

Services are provided on a 24 hour basis by a multi-disciplinary team with expertise in treating psychological and medical complications of eating disorders including re-feeding patients and achieving weight gain (occasionally under the Mental Health Act) and ensuring the appropriate risk management arrangements necessary for such interventions are in place.

Intensive Day-patient services include:

- Assessment
- Advice/liaising with referring community eating disorder/mental health services
- Provide expert oral re-feeding, individualised through nutrition care plans, with staff trained in and supervised in skills of oral re-feeding and motivational behavioural change
- Provide medical monitoring, with access to regular medical input, including for example daily blood tests
- Provide (high quality – provided by suitably qualified staff usually clinical psychologist or counselling psychologist or other professional who is highly qualified in delivering evidenced based therapies, who is supervised by a senior professional with wide experience in eating disorders), evidenced based psychological interventions (MET, CBT, CAT, IPT, DBT, focal psychodynamic,) and family interventions focused on the eating disorder, e.g. Maudsley Collaborative care Skills
- Provide a high quality daily group programme overseen by an occupational therapist that offers opportunities for motivational enhancement, psycho-education, dietetic /nutrition psycho-education (delivered by a dietician), development of emotional coping skills, independent living skills, social skills,

adaptive future lifestyle skills plus recreation and social activities
- Bespoke packages of intensive day treatment for individuals who would otherwise be admitted as an inpatient or as a step down from inpatient care as part of a discharge pathway, to reduce length of inpatient stay if clinically appropriate and improve outcomes.
- Information and support for carers, e.g. provision of carer's support group, skills based carer training (Maudsley Collaborative Care Skills Model)

The specification covers male and female inpatient service for people 16 years and above. Those who are between ages 16-18 years will usually be admitted to child and adolescent services. However flexibility to admit 16-18 year olds to adult inpatient eating disorder services is present if it is developmentally and clinically appropriate. This would be agreed with the individual, family and community services in advance of admission. A risk assessment would be undertaken. Advice and joint working will be in place for Child and Adolescent Mental Health Services (CAMHS) Tier 4 and other CAMHS services. Any Adult Eating Disorder Unit admitting 16 and 17 year olds will need to be able to provide expert family interventions specifically focused on the eating disorder (e.g. Maudsley Collaborative Care Skills model).

Where an individual has co-morbid problems or complex needs the service will work with other services through the Care Programme Approach (CPA) to agree a care coordinator and define roles and responsibilities. Where there is a local community Eating Disorder Service, a team member will be identified as the Eating Disorder Case Manager (who may also be the care co-ordinator) and lead on treatment of the individual whilst in the community.

Service Model

Assessment

The inpatient service will:
- Work in close collaboration with the referring agency in order to agree joint expected goals from any proposed admission
- Offer a pre-admission assessment (This will not always be possible e.g. in the case of more urgent referrals but is best practice).
- Provide a comprehensive inpatient assessment of physical health in line with current guidance (including BMI, physical examination, blood tests, electrocardiogram (ECG), mental and psychological health, social and motivation factors and a full risk assessment in accordance with CPA good practice guidelines.
- Clearly communicate to the service user, referrer, and General Practitioner (GP) the outcome of the assessment which may include recommendations to the referrer and advice about ongoing clinical management.
- Offer a service that maximises engagement.
- Offer carer assessments and involvement where appropriate.

- Have the ability to admit urgent referrals including those detained under the Mental Health Act. (see above for clarification)
- Work collaboratively with appropriate health and social care services to ensure suitable ongoing care following discharge.

Care planning

All patients will be managed within the Care Programme Approach. Care coordination will frequently be carried out by a professional in a general mental health team, sometimes by a professional in an community eating disorders team. The care plan is jointly developed and agreed in conjunction with the patient, the inpatient service, their specialist community eating disorder team and other relevant services.

The care plan should include preadmission care, including frequency and responsibility for monitoring medical and psychiatric risk, and indications, procedure and location for urgent/emergency admission.

The care plan should clearly define the intensity of treatment and the goals for inpatient treatment. In the majority of cases this will include anticipated criteria for discharge. The care plan should include a plan for managing and monitoring the service user's physical and psychiatric health and any associated risk factors.

The care plan will identify and take account of additional needs and identify how these will be addressed. If other clinicians and services are involved then roles and responsibilities will be clearly defined within the plan.

The care planning process will take account of the needs and appropriate involvement of the individual, their families and carers.

Interventions etc

The inpatient service will:

- Provide a high quality intervention aimed at weight restoration or medical stabilisation or the reduction of severe or resistant behaviours associated with the eating disorder.
- Be able to provide high quality oral re-feeding, individualised through nutrition care plans, from staff that are trained and supervised in support for oral re-feeding and motivational behavioural change.
- Nasogastric insertion and feeding, (majority of inpatient units, see above page 4 for details).
- Daily biochemistry, frequent nursing observations, management of abnormal weight control behaviours (for example - water loading, excessive exercising, self-induced vomiting and laxative abuse), the ability to conduct daily ECG,

management of challenging behaviour, treatment of pressure sores (and immediate cardiac resuscitation).

- Provide (high quality – provided by suitably qualified staff usually clinical psychologist or counselling psychologist or other professional who is highly qualified in delivering evidenced based therapies, who is supervised by a senior professional with wide experience in eating disorders), evidenced based psychological interventions (MET, CBT, CAT, IPT, DBT, focal psychodynamic) and family interventions focused on the eating disorder, e.g.Maudsley

Collaborative care Skills

- Provide a high quality daily group programme overseen by an occupational therapist that offers opportunities for motivational enhancement, psycho-education, dietetic /nutrition psycho-education (delivered by a dietician), development of emotional coping skills, independent living skills, social skills, adaptive future lifestyle skills plus recreation and social activities
- Provide individualised nutrition care plans overseen by dietetics
- Providing a range of individual and psycho/social group interventions as part of the inpatient treatment package indentified in the care plan.
- Provide a multidisciplinary approach in line with current NICE guidance, which includes access to a variety of non psychological interventions including occupational therapy and dietetics.
- A focus on recovery
- Work with individuals to formulate and deliver their care plan.
- Work collaboratively with the individual's specialised Community Eating Disorder Service and other services, e.g. general mental health teams to ensure the jointly agreed outcomes are being met.
- Utilise the Mental Health Act 1983 (amended 2007) where appropriate (see above for details)
- Work with other services as determined by the care plan.
- Work with carers in order to support individuals.
- Take carers needs into consideration as part of the treatment process.
- Provide advice and information in respect of eating disorders. Provide consultation and support around eating disorders issues to referring agencies.
- Provide support to patients and carers whilst patients are on therapeutic leave as part of the care plan.
- Provide robust discharge planning which will include, crisis planning and relapse prevention planning.
- Provide a psychotherapeutic culture that provides structure and containment.

The Day-patient service will:

- Provide a high quality intervention aimed at weight restoration or medical stabilisation or the reduction of severe or resistant behaviours associated with the eating disorder.

- Be able to provide high quality oral re-feeding, individualised through nutrition care plans, from staff who are trained and supervised in support for oral re-feeding and motivational behavioural change.
- Daily biochemistry, management of abnormal weight control behaviours (for example - water loading , excessive exercising, self-induced vomiting and laxative abuse), the ability to conduct daily ECG ,
- Provide (high quality – provided by suitably qualified staff usually clinical psychologist or counselling psychologist or other professional who is highly qualified in delivering evidenced based therapies, who is supervised by a senior professional with wide experience in eating disorders), evidenced based psychological interventions (MET, CBT, CAT, IPT, DBT, focal psychodynamic) and family interventions focused on the eating disorder, e.g.Maudsley

Collaborative care Skills

- Provide a high quality daily group programme overseen by an occupational therapist that offers opportunities for motivational enhancement, psycho-education, dietetic /nutrition psycho-education (delivered by a dietician), development of emotional coping skills, independent living skills, social skills, adaptive future lifestyle skills plus recreation and social activities
- Providing a range of individual and psycho/social group interventions as part of the inpatient treatment package indentified in the care plan.
- Provide a multidisciplinary approach in line with current NICE guidance, which includes access to a variety of non psychological interventions including occupational therapy and dietetics.
- A focus on recovery
- Work with individuals to formulate and deliver their care plan.
- Work collaboratively with the individual's specialised Community Eating Disorder Service and other services, e.g. general mental health teams to ensure the jointly agreed outcomes are being met.
- Work with other services as determined by the care plan.
- Work with carers in order to support individuals.
- Take carers needs into consideration as part of the treatment process.
- Provide advice and information in respect of eating disorders. Provide consultation and support around eating disorders issues to referring agencies.
- Provide robust discharge planning which will include, crisis planning and relapse prevention planning.
- Provide a psychotherapeutic culture that provides structure and containment.

Outpatient/outreach function:

- Some continued follow up and treatment in the outpatient setting can be provided to reduce risk of relapse and readmission, in the service user's best interest. This should be agreed with all services involved, through the process of CPA. In the vast majority of cases follow up will be provided by the relevant community eating disorder service and would only be agreed in exceptional

cases where the community service was unable to meet the treatment needs of the patient.

Referral processes and sources

Each Cluster area should develop a care pathway model to include access and egress protocols. Most areas do not have direct access to assessment for admission from primary care.

Referrals can be accepted from:

- Community Eating Disorder Services
- Community mental health services
- Acute hospital medical wards
- Mental health hospital psychiatric wards
- Primary care

The referral information should include (as an optimum):

- Summary of presenting condition
- Detailed history, including current eating disorder symptoms and dietary intake.
- Any significant psychiatric or physical co-morbidity
- Height, weight and BMI, rate of weight loss
- Results of diagnostic investigations e.g. ECG, blood, serological investigations, bone scans
- Any special needs
- Medication
- Individual specific outcomes the Community Eating Disorder Service/ referrer/patient would like from the inpatient admission.

Referral to a Specialist Eating Disorders Inpatient / day patient Services may be considered for service users in the following situation:

Urgent/unplanned admissions: These would be for those patients requiring urgent intervention principally due to physical health difficulties- this might include patients whose physical health is acutely compromised as a consequence of their eating disorder. They will demonstrate a degree of rapid weight loss, and/or extremely low BMI, with associated physical sequalae which place them at high risk. The aim of admission is to try to help the individual achieve a position of greater physical and psychiatric stability through medical intervention and/or re-feeding. Crisis admissions may be short, or may be continuous with admission for ongoing weight restoration and symptom recovery. Admission will usually be to Specialist Eating Disorder Inpatient Units, or to Acute Medical Inpatient Units if medical monitoring or treatment is required that is not available in a specialist eating disorders service (e.g. intravenous treatment or cardiac monitoring – see the Royal College of Psychiatrists and Royal College of Physicians London report ‘Management of Really Sick Patients

with Anorexia Nervosa 2010' (MARSIPAN). Individuals treated by local acute medical services should have regular input from the Specialist Community Eating Disorder Service. These admissions may turn into a symptom recovery admission if the patient is motivated to do this

- **Symptom recovery:** Weight restoration and psychotherapeutic treatment – these admissions are longer term and are indicated for individuals who have been admitted in crisis and for whom further treatment is indicated, or for those with severe Anorexia Nervosa or individuals with EDNOS at low body weight who have been unable to make progress in the community despite appropriate community treatment.
- **Planned:** To address a particular aspect of their eating disorder - targeted admissions. These are usually short to medium term admissions usually involving the provision of an individual package of care to treat a severe or resistant behaviour such as self-induced vomiting, (e.g. biochemically unstable severe bulimia nervosa or bulimia nervosa complicated by very poorly controlled diabetes with increased medical risk, excessive exercising, food avoidance and obsessional behaviours related to food, weight or eating. If the diagnosis is anorexia nervosa then weight restoration is usually a goal. Short admissions may also be offered to individuals with enduring and severe eating disorders who may require an admission to stabilise their weight and improve social and occupational function.

Other inpatient facilities may be appropriate in the care of individuals with eating disorders. These are:

- Psychiatric Unit admissions - service users with co-morbid psychiatric difficulties may be admitted to generic/acute adult mental health wards for their co-morbid difficulties. Support from the local Specialist Eating Disorder Community Services should be provided in line with a regional MARSIPAN policy.
- Acute Hospital Medical admissions – As above for physical health difficulties. In such cases regular support from the local Specialist Eating Disorder Community Services should be provided in line with a regional MARSIPAN policy.

Response times

Following a request for an inpatient assessment or admission the specialist centre will offer advice and the immediate management of the patient and undertake an assessment within 5 working days if non urgent, or 2 working days if urgent.
The timescale for admission will depend upon the service user's condition and will be agreed with the Community Eating Disorder Team/referrer to maximise service user engagement, motivation and response to treatment. Although a last resort, applying the Mental Health Act should be considered from the outset for high risk patients refusing treatment.

Equity of access to services

The service provided uphold equality and diversity legislation and should not discriminate on the basis of the following characteristics :

- Ethnicity
- Legal status (e.g. asylum seekers)
- Disability
- Gender
- Age
- Sexuality
- Religion
- Other disadvantaged communities including people who are excluded due to education or skills levels, unemployment or where they live

Discharge criteria and planning

Effective transfer and discharge arrangements are essential.
A regionally agreed MARISPAN policy will include, in addition to a discharge policy, also an admission and transfer protocol.

Criteria for Discharge:

Criteria for discharge will be dependent on the type of admission and agreed goals of admission.

Urgent/unplanned Admission

- Achieved adequate medical stabilisation, in terms of either modest weight restoration as agreed or weight stabilisation. Achieved stabilisation of relevant blood indices, e.g. serum potassium.
- Improvement in Eating Disorder behaviours, which might include, established regular eating pattern and completing prescribed meal plan, resolution or marked improvement in purging behaviours, binge eating, or other abnormal eating behaviours, managing to shop for food and prepare meals independently.
- Co-morbid psychiatric conditions are adequately treated and there is low or acceptably managed psychiatric risk
- Has appropriate housing and social support in place
- Has appropriate psychiatric and eating disorder service follow up in place
- Agreement for appropriate services, e.g. community care package
  An urgent/unplanned admission may change into a symptom recovery admission if the patient is motivated and engages in this, in which case the symptom recovery criteria would apply.

Symptom recovery Admission:

- Weight restoration to normal weight or weight at which patient can reliably continue independent weight restoration/ weight maintenance with less intensive input as a day-patient (if available) or outpatient treatment.
- Resolution or marked improvement in Eating Disorder behaviours, which might include, established regular eating pattern and completing prescribed meal plan, resolution or marked improvement in purging behaviours, binge eating, or other abnormal eating behaviours, managing to shop for food and prepare meals independently. This is evidenced by periods of gradually extending leave and demonstrating increasing mastery e.g. of emotional coping skills, psycho-social functioning, independent living skills and social skills'.
- The outcome is the development of a psychological understanding and developing psychological tools and application of this to the patient's continued recovery.
- Improved social functioning, improved contact with friends and relatives, ideally evidence of increased engagement in adaptive educational, employment, leisure and social activities' and reduced participation in maladaptive activities such as excessive exercise, body checking or obsessional routines.
- Co-morbid psychiatric conditions are adequately treated and there is low or acceptably managed psychiatric risk.
- Has appropriate housing and social support in place.
- Has appropriate psychiatric and eating disorder service follow up in place.

Planned Admission

- Resolution of, or significant improvement in, the relevant targeted eating disorder behaviour/s, which have precipitated the admission. For example, purging behaviours, excessive exercise, phobic eating, enduring anorexia nervosa medical/weight stabilisation and patient is managing this more independently. This is evidenced by periods of gradually extending leave and demonstrating increasing mastery e.g. of emotional coping skills, psycho-social functioning, independent living skills and social skills'.
- If for medical stabilisation modest weight restoration –achieved adequate medical stabilisation, in terms of either modest weight restoration as agreed or weight stabilisation. Achieved stabilisation of relevant blood indices, e.g. serum potassium.
- Improved social functioning, improved contact with friends and relatives, ideally evidence of increased engagement in adaptive educational, employment, leisure and social activities' and reduced participation in maladaptive activities for example, excessive exercise, body checking or obsessional routines.
- Co-morbid psychiatric conditions are adequately treated and there is low or acceptably managed psychiatric risk.
- Has appropriate housing and social support in place.
- Has appropriate psychiatric and eating disorder service follow up in place.

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

* - Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

Specifically, this service is for adults with an eating disorder requiring specialised intervention and management, as outlined within this specification.

2.4 Any acceptance and exclusion criteria

2.4.1.Acceptance criteria

The majority of people with eating disorders fall into the following categories:

- Rapid weight loss with evidence of system or organ failure, which is potentially life threatening.
- Outpatient psychological treatment has not been sufficient to effect a change or improvement.
- Those at low weight (usually chronically unwell), who are not able to manage in daily life, who require help with weight stabilisation or modest weight restoration, often in the context of medical instability. These patients frequently have severe psychiatric co- morbidity and/or difficult social/ family circumstances.
- In exceptional circumstances it may be appropriate to admit a patient suffering from severe medically unstable Bulimia Nervosa for a period of treatment. E.g., a patient with diabetes, pregnancy, or not responded to intensive community treatment.

2.4.2 Exclusion criteria

Inpatient or day patient services are not available to those:

- who have weight issues in the absence of a recognised eating disorder
- who are under 16 years of age (Inpatient services for those under 18 are covered by the CAMHs Tier 4 specification) However there is a period of overlap between CAMHs and Adult services as it may be developmentally

and clinically appropriate to admit to adult units from age 16 years. (see top of page 5 for details)

2.5 Interdependencies with other services

In line with the MARSIPAN Report, specialist inpatient/community eating disorder services should provide advice, guidance and support to medical and psychiatric wards, as well as primary care colleagues caring for people with eating disorders.

A designated regional Specialist Eating Order Inpatient Unit will be identified by Commissioners to take the lead on the development and subsequent management of a regional MARSIPAN Group and Policy.

It is recognised that some specialised inpatient services may also provide additional services. These may either be specified separately or added to this specification.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

The service should be registered with the Care Quality Commission (CQC).

Quality standards have been developed by the Royal College of Psychiatrists, Quality Network for Eating Disorders (QED). The service should meet all type 1 standards and the majority of type 2 standards.

The standards can be found at:
http://www.rcpsych.ac.uk/:.systempages/gsearch.aspx?cx=001100616363437152483%3aidnunf1yavs&cof=FORID%3a9&q=eating+disorder+quality+standards

The specification should be read in conjunction with and ensure compliance with:

- NICE 2004 Clinical Guideline CG9 - Eating Disorders, Core interventions in the treatment and management of Anorexia Nervosa, Bulimia Nervosa and related eating disorders.
- Mental Health Act 2007
- Mental Capacity Act 2005 & Deprivation of Liberty 2009
- The National Service Framework (NSF) for adults with mental health problems (1999)
- Mainstreaming Gender and Women's mental health – implementation guide 2003
- Mental Health and Social Exclusion (2004)
- Engaging and changing (2003) – Developing effective policy for the care and treatment of black and minority ethnic detained patients.
- Refocusing the Care Programme Approach Policy and Positive Practice Guidance (DH, March 2008).
- New Ways of Working.
- MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (2010)
- Royal College of Psychiatrists Guidance on feeding in ED (new version in prep)

The above publications set out the Government's and Royal College policy intention and vision in relation to service delivery for people with mental ill health through:-

- Legislative framework, and proposed reforms
- Guidance in respect of client groups, and their specific needs, which should be integral to the planning of services.

4. Key Service Outcomes

Inpatients

- Weight gain
- Reduction in abnormal eating behaviours
- Reduction in eating disordered cognitions
- Clarification of diagnoses
- Medical stabilisation
- Improved psychological functioning
- Improved quality of life and social functioning; people regain the skills required to live as independently as possible, as determined by the patient
- Liaison and provision of advice to referring community ED services/mental health teams/primary care
- Improved community support (family and friends)
- All services will report BMI at admission and discharge, pre and post treatment Eating Disorder Examination Questionnaire (EDE-Q) and Health of the Nation Outcome Scales (HONOS) scores and patient and carer feedback.

References

Sullivan, P. F. 1995, "Mortality in anorexia nervosa", *Am.J.Psychiatry*, vol. 152, no. 7, pp. 1073-1074.